York Teaching Hospital NHS
NHS Foundation Trust

The programme for the next meeting of the Trust's Board of Directors day, which will take place:

on: **Wednesday 25th February 2015**

in: **The Boardroom, York Hospital**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Ward 37 Seminar Room	Non-executive Directors
9.15am – 12.00 Noon	**Board of Directors meeting held in public**	**Boardroom**	**Board of Directors and observers**
12.15pm – 2.00pm	Board of Directors to consider confidential information held in private (including buffet lunch)	Boardroom	Board of Directors
2.15 pm – 2.45 pm	Remuneration Committee	Chief Executive's Office	Non-executive Directors & Chief Executive
3.00pm - 4.30pm	Vale of York CCG	Boardroom	Board of Directors and Directors from the Vale of York CCG

The values, drivers and motivations of the Trust are:

- **Caring about what we do**
- **Respecting and valuing each other**
- **Listening in order to improve**
- **Always doing what we can to be helpful**

These will be reflected during all discussions in the meeting

York Teaching Hospital NHS
NHS Foundation Trust

Restricted – Management in confidence

The next meeting of the Trust's Board of Directors held in public will take place

On: **Wednesday 25th February 2015**

At: **9.15am – 12 Noon**

In: **The Boardroom, York Hospital**

A G E N D A					
No	**Item**	**Lead**	**Comment**	**Paper**	**Page**
Part One: General **9.15am – 9.45am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for Absence** Sue Holden, Director of Workforce and OD Anne Pridmore, Foundation Trust Secretary Michael Sweet, Non Executive Director	Chairman			
3.	**Declaration of Interests** To receive any changes to the register of directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chairman		A	7
4.	**Minutes of the Board of Directors meeting held on 28th January 2015** To review and approve the minutes of the meeting held on 28th January 2015	Chairman		B	13
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman			

No	Item	Lead	Comment	Paper	Page
6.	**Patient Experience** To receive an update on the Patient Experience Team including discussion about the Enter and View report about Scarborough Hospital published by Healthwatch	Head of Patient Experience		Verbal C	 29
Part Two: Quality and Safety 9.45am-10.30am					
7.	**Quality and Safety Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Patient and Quality Safety Report • Medical Director Report • Chief Nurse Report • Safer Staffing • Early Warning Trigger Tool • Acuity and Dependency	Chairman of the Committee		D D1 D2 D3 D4 D5 D6	43 51 85 117 141 151 163
8.	**End of Life Care Quarterly Report** To receive the End of Life Care Quarterly Report	Medical Director	Dianne Willcocks	E	171
Part Three: Finance and Performance 10.30am-11.30am					
9.	**Finance and Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Operational Performance Report • Finance Report • Trust Efficiency Report	Chairman of the Committee		F F1 F2 F3	219 229 239 251
10.	**Draft Financial and Annual Plan 2015/16** To consider and approve the draft plan prior to submission to Monitor on 27 February 2015	Director of Finance	Mike Keaney	To be tabled	

No	Item	Lead	Comment	Paper	Page
Part Four: Estates information 11.30am -11.35am					
11.	**Fire Safety Policy and Annual Report** To receive the Annual Report and approve the policy.	Director of Estates and Facilities		G	257
Part Five: Governance 11.35am-12.00 Noon					
12.	**Report of the Chairman** To receive an update from the Chairman including Chairman's Action for the approval of a Business Case to support the Network Infrastructure upgrade at a value of £0.958m in 2015 and a further £1.627m in 2016/17.	Chairman		H	279
13.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		I	283
14.	**Improving Corporate Accountability by Aligning Strategy, Structure and Assurance** To receive an update on and agree the progress made on the project plan for the review of the Trust's corporate governance structures and arrangements.	Head of Internal Audit		J	287
Any other business					
15.	**Gap Analysis – Implementation of the new Equality Information standards**	For information only – Director of Workforce and OD		K	293
16.	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 25 March 2015 in the Boardroom, York Teaching Hospital.				
17.	**Any other business** To consider any other matters of business.				

The meeting may need to move into private session to discuss issues which are considered to be ‘commercial in confidence’ or business relating to issues concerning individual people (staff or patients). On this occasion the Chairman will ask the Board to resolve:

That representatives of the press, and other members of the public, be excluded from the remainder of this meeting regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960.

The items included in the private agenda for discussion in February are:
Clinical Services
Corporate Risk Committee Minutes

Register of directors' interests
February2015

York Teaching Hospital NHS
NHS Foundation Trust

Additions: Juliet Walters—Chief Operating Officer

Changes: No changes

Deletions: No deletions

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Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS founda-
Mr Alan Rose (Chairman)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member—**The University of York Court **Member—**The University of York Ethics Committee	Nil
Jennifer Adams *Non-executive Director*	**Non-executive Director** Finance Yorkshire PLC	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Philip Ashton (Non– Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Member of the Board of Directors—** Diocese of York Education Trust	Nil	Nil
Ms Libby Raper (Non-Executive Director)	**Director—**Yellowmead Ltd	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Governor and Vice Chair**—Leeds City College **Chairman and Director -** Leeds College of Music **Member—**The University of Leeds Court	Nil
Michael Keaney Non-executive Directors	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

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	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mr Michael Sweet (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Professor Dianne Willcocks (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Trustee and Vice Chair—**of the Joseph Rowntree Foundation and Joseph Rowntree Housing Trust **Chair—**Advisory Board, Centre for Lifelong Learning University of York **Member—**Executive Committee YOPA **Patron—**OCAY **Chairman** - City of York Fairness and Equalities Board **Member –**Without Walls Board	**Director—**London Metropolitan University **Vice Chairman—**Rose Bruford College of HE	Nil
Mr Patrick Crowley (Chief Executive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

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Mrs Sue Holden ***Executive Director of Workforce and Or-ganisational Devel-opment***		**Director –** SSHCoaching Ltd		**Member -**Conduct and Standards Committee – York University Health Sciences **Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Dr Alastair Turnbull ***(Executive Director Medical Director)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Andrew Bertram ***(Executive Director Director of Finance)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member** of the NHS Elect Board as a member representa-tive	Nil
Mr Mike Proctor ***(Deputy Chief Execu-tive)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Spouse a senior member of staff in Community Services	Nil
Beverley Geary Chief Nurse	TBA	TBA	TBA	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	TBA	TBA

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	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 consultan-cies 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 com-missioning 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
Beverley Geary Chief Nurse	TBA	TBA	TBA	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	TBA	TBA

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Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Boardroom, The York Hospital, on 28 January 2015.

Present:	**Non-executive Directors**	
	Mr A Rose	Chairman
	Mrs J Adams	Non-executive Director
	Mr P Ashton	Non-executive Director
	Mr M Keaney	Non-executive Director
	Ms L Raper	Non-executive Director
	Mr M Sweet	Non-executive Director
	Professor D Willcocks	Non-executive Director
	Executive Directors	
	Mr P Crowley	Chief Executive
	Mr M Proctor	Deputy Chief Executive, Chief Operating Officer
	Mr A Bertram	Executive Director of Finance
	Mrs B Geary	Chief Nurse
	Mrs S Holden	Executive Director of Workforce and OD
	Dr A Turnbull	Medical Director
	Corporate Directors	
	Mr B Golding	Corporate Director of Estates and Facilities
	Mrs S Rushbrook	Corporate Director of Systems and Networks
Attendance:	Mrs L Provins	Head of the Business Intelligence Unit
Observers:	Mrs S Miller	Governor for Ryedale and East Yorkshire
	Mrs J Moreton	Governor for Ryedale and East Yorkshire
	Mrs M Jackson	Governor for City of York
	Mrs A Bolland	Governor for Selby
	Mrs P Worsley	Governor for City of York
	Mr A Butler	Governor for Selby
	Mr S Hinchcliffe	Governor for Whitby

The Chairman welcomed the observers to the meeting.

15/001 Apologies for absence

Apologies for absence were received from Mrs A Pridmore, Foundation Trust Secretary.

15/002 Declarations of Interests

The Board of Directors **noted** the current list of interests declared. The Board were reminded that if there were any changes to the interests declared they should advise Mrs Pridmore.

15/003 Minutes of the meeting held on the 26 November 2014

The minutes were approved as a true record of the meeting.

15/004 Matters arising from the minutes

The following matters arising from the minutes were discussed:

15/004.1 *14/171 Quality and Safety Committee – Pastoral Care*

Mrs Holden gave an update on the provision of pastoral care for employees recruited from overseas, stating that plans were progressing. A small working group has been set up between Nursing and HR and the Trust may be able to use some of the material contained in the Hull York Medical School (HYMS) Welcome Pack. The idea was to help overseas employees, especially with the planned recruitment in Spain, with the provision of information about local GPs, supermarkets, advice on social support and local religious groups, etc.. For the planned Spanish recruitment, there would be a welcome meeting and one of the Governors, who spoke Spanish, had kindly offered to attend and support.

It was noted that the first cohort would be working at Scarborough Hospital, but any second cohort would also be based at Scarborough as this is where the accommodation was located. Mentoring for the Spanish nurses would be provided as part of the preceptorship pack. Mrs Holden commented that experience from elsewhere had shown there was a direct correlation between helping overseas staff to feel part of the local community and the length of time that the staff stay with the organisation and remain part of the community. She noted that Scarborough had previously recruited abroad and a number of those nurses were still at the hospital, approximately 9 years later. Mrs Holden asked if members of the Board could be available for the welcome meeting.

Action: Mrs Holden asked the Board to make them selves available for the welcome meeting

15/004.2 *14/175 Living Wage*

Mr Bertram provided confirmation that the living wage increase was introduced on the 1st January 2015 and eligible staff would see an increase in their pay from this month. The Press coverage in York had been very good. Prof. Willcocks asked whether there had been any Press coverage at Scarborough and Mr Crowley stated that press releases had been circulated to all areas. Mr Crowley and Mr Proctor would also raise the organisation's adoption of the living wage when they attend the local scrutiny committees in the near future.

15/004.2 *14/181 Governance Review*

Mrs Holden briefed the Board that the revised Values document, which had previously been to the Board, had been submitted to the JNCC for comments and the document would be brought back to the Board in February.

It was noted that, at the recent mock CQC visit, staff had a mixed understanding of the Values. This had been discussed at Directors and Mr Crowley stated that there was a

difference between knowing the values and being able to recite them. It was more important that staff could demonstrate living the values than just reciting them. Mrs Holden stated that the linkage between the Values and the Personal Responsibility Framework should help understanding, but also provided an opportunity to highlight examples of the Values in action, especially in respect of the day-to-day directorate functions. Directors were reminded that the four values were on the front of every set of Board papers.

The Values work would also be supported by a refresh of the appraisal framework, which had been taken to the Staff Side last week, and would go to the Workforce Strategy Committee meeting next week. The refresh was very visual and comprised a matrix approach, supported by competencies and abilities.

Action: Final version of the values document to be presented to the Board in February

15/004.3 *14/142 CQC Visit*

Mr Crowley stated that the impression from the mock CQC inspection held on the 19th January had been very positive and that staff had been well prepared. A repeat inspection is due to be carried out on the 9th February. Dr Turnbull noted that the IPC walk round at Scarborough had been positive, due to the environmental changes that had taken place.

The CQC had made a very comprehensive request for documents, which had been sent, and the executives were now involved in making a self-assessment. This was the first time the Trust had been asked to make a self-assessment and this required a single word response to the five domains, together with a narrative attached to each of the domains. Dr Turnbull stated that the self-assessment had been difficult, as there was limited data with which to benchmark, but the executives had rated each of the domains "good" (the second highest of the four levels), using the most recent CQC "intelligent monitoring" (risk-based) score of 6 (the least risk) as a guide. The executives had also discussed the narrative at length, recognising both good and bad, and highlighting what needed to be done differently. A copy of the self-assessment was circulated to the Board and subsequently to the Governors.

The executives were now working on a presentation that would be given to the CQC on the first day of the assessment. Mr Crowley stated that the presentation would be circulated electronically, for comment on style, tone and content, and he asked if comments could be returned before the end of February. A project group had been set up to co-ordinate responses and logistics and an initial communication had been sent out to staff. Mrs Geary stated that the Trust had recognised areas for improvement, which was important, as the CQC did not like surprises. It was important to be able to articulate any difficulties being encountered, together with what is being done and any progress to date. However, it should be noted that the CQC could ask for immediate action to be taken if they had concern at the time of the inspection.

Clifton Park independent treatment centre in York is being inspected this week and it was felt important that any feedback and direct engagement with (seconded) staff should be captured. The CQC public meetings for the Trust's inspection were due to be held on the Wednesday and Thursday evenings in the Lecture Theatre. These would be advertised

in the press and the Trust would be sent posters to display around the organisation. Mr Rose noted that there was no date as yet for the CQC to meet with the Governing body.

The recent Leeds and York Partnership Trust inspection was discussed and it was noted that this had been described in the press as a 'tale of two cities', which it was agreed would not be what we would wish for in the case of our Trust. Mr Crowley stated that it was important to set the overall context, which would be that the Trust was at different stages of evolution in terms of culture and function and this was alluded to in the self-assessment.

15/005 Patient Experience – Volunteer Service Update

Ms Mallows provided an overview to the Board of volunteering across the Trust, together with delivery against plan and aspirations for optimising patient and volunteer experience in the future. Currently, feedback is good, but very ad hoc and plans are in place to develop surveys to provide a more formal source of feedback. The workforce strategy is about visibility and sharing of good practice. It was noted that there needed to be more collaboration outside of the hospital, especially with the voluntary organisations in the community. In relation to age profile, Mrs Holden stated that it would be useful to work with schools and actively look at how the Trust becomes more attractive as a career opportunity. There was also a consensus that volunteering needs to be more targeted in relation to the university and medical school. The Chairman proposed that a letter of appreciation be sent from the Board to each of the voluntary organisations that help provide volunteering support at the various sites.

Action: Chairman & Ms Mallows to arrange for Board letters to be sent.

15/006 Quality and Safety Committee

Ms Raper had a number of specific items she wished to raise from the Quality and Safety Committee:

Ms Raper stated that the last meeting took place in December at a time of significant pressure for the Trust; therefore priority was given to matters of patient safety. Some items received more focus than others, in order to ascertain the appropriate assurance. Other items will be picked-up in subsequent meetings or are already on this meeting's agenda. Ms Raper noted some adjustments to the notes that would be picked up as part of the Quality and Safety Committee meeting.

SHMI – Mortality is looked at by the group on a regular basis, together with a number of other measures (e.g. RAMI, HSMR), which are all slightly different and run to different timescales. The latest SHMI figures covering the period July 2013 to June 2014 had just been made available and were circulated. Dr Turnbull noted that the SHMI had risen by 2.5 to 102 and this was a cause of concern and work had been initiated to look at this. The high mortality groups remain unchanged. The Board discussed whether this was due to the higher pressure to discharge patients and Dr Turnbull stated that this would depend on how soon death occurred. He advised the Board that the Patient Safety Team would be looking at this as it was clearly disappointing. He also stated that it should be remembered that there was a lag to the availability of this data and that the recent

ongoing period of pressure experienced by the Trust would be part of the next batch of figures.

Dr Turnbull advised that regionally most hospitals were seeing a rise in their SHMI -- even the normally exemplar Trusts -- so this organisation was not alone. Dr Turnbull confirmed that this would be part of the "intelligent monitoring" by the CQC, but that a figure of 101/102 still reflects a "normally performing" organisation; however, there was still a disparity between the two sites, which it is believed reflects demography and different coding practices. He did stress that it does need careful monitoring and the critical part for the Trust was the weekly mortality review of all deaths, which is discussed regularly by the consultants. The current situation with regard to mortality is that there has been a higher number of deaths, with approximately 60 deaths occurring two weeks ago against a normal range of 30 to 40. However, the context to this was that the overall number of admissions and acuity of patients had also risen. He stressed that assurance should be gained from the ongoing mortality review, together with the fact that if any issues or trends were noted these would be acted-on very quickly.

Serious Incidents – Ms Raper stated that serious incidents were discussed at the Quality and Safety meeting to enable more detailed understanding; however, concern was raised at the timeliness of learning and the realistic nature of the recommendations. She noted that a detailed timeline would be brought to the committee. On further questioning, the Medical Director assured the Board that the Risk & Legal team followed-up closely on the execution of SI action plans.

"Sign-up to safety" – This work was seen as significant and the committee were extremely supportive. Dr Turnbull stated that the work was driven by the NHSLA and was based around the high numbers of claims and complaints received from the Emergency Departments and Obstetric Units around the country.

Patient Safety during long waiting times in the Emergency Department – Ms Raper advised that this was an important discussion for the committee and will remain on the agenda for the next few months. The item was in response to a specific request from the Chairman for Board assurance on this matter. The mock Care Quality Commission (CQC) inspection had noted concerns around the overflow area in Emergency Department (ED) but, apart from that, areas were clean and tidy and the Senior Nurse had been able to provide lots of detail. Assurance was also taken from the SI reports reviewed and no concerns had been raised from a safeguarding perspective. Mrs Geary stated that during peak times an extra Healthcare Assistants (HCA) had been put into ED and elderly patients had been put into beds to try to mitigate any harm due to the long period of time in ED.

Dr Turnbull stated that it was difficult to give assurance (re Scarborough) that no harm had occurred or that quality and safety had not been compromised. He noted that quality must have been affected during this time and this was evident by the SIs and major incident declared. It should also be remembered that a number of elective procedures had to be cancelled and there has been an impact on infection prevention and control (IPC) figures. He stressed that decisions were considered in the context of quality and safety and not taken lightly. During peak pressures, clinicians had to make decisions about whether it was safe to discharge patients earlier than normal and also review the threshold for admissions. Daily meetings had taken place with the executives and "silver

command", at which individual patients had been discussed in detail. Mr Crowley stated that the important question was not whether the Trust would fail the quarter, but whether the right decisions had been made. He stressed that his task had been to seek assurance on a daily basis that the Trust was doing the right thing, but also to give permission to disregard the impact of the target and ensure that safety and care of patients were the priority at all times.

Mr Proctor advised the Board of the planning in relation to escalation areas. At York, Ward 24 planning had started at the end of the Summer and, during the peak times, Ward 38 had opened 10 beds and additional beds had been opened at Malton. The Trust had also carried a number of vacancies and sickness during this period, but a decision was taken to use Clinical Nurse Specialists and Matrons to staff extra escalation areas. He stated that no areas were opened without full discussion and appropriate staffing in place. Mr Rose commented on the excellent levels of assurance being given.

Safer Staffing – Ms Raper noted that there had been significant pressures in the system, but that there were a high number of exceptions in the report. Mrs Geary commented on the areas of concern and the levels of sickness experienced around Christmas and the New Year. She stated that the Matrons looked at staffing daily on a shift-by-shift basis and had encountered difficulties filling gaps with agency and bank staff. She noted that at a recent regional meeting it was evident that this had been the same picture across the country. Mrs Geary highlighted the various measures being put in place to address shortages, including international recruitment, but also that there is a shortage of nurses being trained nationally. Mrs Holden noted that one Trust is training their own cohort of nurses, but that this will still take 3 to 4 years to produce any benefit. Another concern was the number of nurses retiring at 55 and that many of these would be senior experienced nurses.

Baby Friendly Initiative – It was noted that the Baby Friendly Initiative (BFI) had been achieved at Scarborough.

Mr Crowley commended the testing discussion and acknowledged that categorical assurance could not be given, but highlighted the multiple strands of assurance being provided during a time of high sustained levels of pressure in the system.

15/007 Patient Experience Quarterly Report

Mrs Geary stated that the report was developing and the Steering Group would continue to look at ways to capture positive experience and feedback.

Mrs Geary reported that Healthwatch York carried out an "Enter and View" visit in October, but the Trust is still awaiting the report. Healthwatch North Yorkshire carried out an "Enter and View" visit at Scarborough and the findings will be brought to the next Board meeting. It was noted that Healthwatch York has set up a hotline, which is web based and interactive for health services users in the area. They were also shortly to set up a web-based invitation for patients and others to provide written input on our Trust for the forthcoming CQC inspection. Healthwatch York is acting as the coordinator of this for their peer organisations in North Yorkshire and East Riding of Yorkshire.

A revised structure is in development for the Patient Experience Team, which will focus on delivering the Patient Experience Strategy. Kay Gamble is scheduled to present to a future Board meeting.

Action: Kay Gamble, Head of Patient Experience to present to a future Board

15/008 Quarterly Report from the Director of Infection Prevention and Control

Dr Turnbull stated that the Infection Prevention and Control report will develop, especially with regard to how it relates to patient safety. He noted that it has been 528 days since the Trust last had a case of MRSA and 250 days since a case of carbopenamase.

However, C Difficile numbers were up to 42 against a trajectory to date of 50. The latest RCA investigations were awaited, but Dr Turnbull advised the Board that this was linked to the pressures the Trust had been facing with large numbers of patients requiring antibiotics due to a higher incidence of pneumonia. The requirement for antibiotic review had been tightened to 48 hours in response to the increased numbers. Dr Turnbull has also written out to medical staff and senior nurses to highlight this, together with the need for better hand hygiene compliance, especially as variable levels of compliance with hand hygiene had been noted at the mock CQC inspection.

Dr Turnbull stated that a careful watch was being kept on MSSA numbers, which were above trajectory and measures were being put in place, such as line nurses to help staff care for patients with in-dwelling invasive devices.

Dr Turnbull advised that the Trust had a good level of preparedness in the event of an Ebola case. To date the Trust has not had to deal with any cases.

The Board discussed C Difficile and slight concern was noted especially in light of hand hygiene compliance. Dr Turnbull stated that the next step would be to mandate hand hygiene training, which would require all staff to attend, especially as the walk round had evidenced no lack of facilities and gel was available. There was awareness that the number of times staff had to wash their hands was onerous, but it was very important and poor practice would not be tolerated. Another initiative being looked at was the IPC team working with patients to empower them to challenge staff about hand hygiene before contact.

The Board approved the quarterly report.

15/009 Finance and Performance Committee

Mr Keaney stated that the minutes from the Finance and Performance Committee highlighted the difficulties and challenges facing the Trust. Performance was challenging especially in relation to the 4 hour Emergency Department target and Ambulance Turnaround times. He commended the hard work being done across the Trust in relation to all the different projects in place to try to optimise performance. He noted that the committee had also received an update on Operation Fresh Start at Scarborough.

Mr Proctor stated that performance had been poorer in January, but that there was no one action or intervention that provided the answer and there was danger in trying to over

simplify the difficulties facing the Trust. He highlighted the high numbers of admissions that had taken place and how patient flow could be affected by the sex of the patients waiting to be admitted, which required whole bays of patients to be moved to accommodate another group of patients. The staff were then required to make these changes as well as dealing with the acuity of patients in their care. He stated that detailed processes were in place and meetings were being held at 11am and 3pm daily, at which details of every discharge were gone through. The levels of information available were greatly assisting teams coming together to ensure that outstanding elements of pathways were expedited to facilitate discharge. The Clinical Directors from Medicine and Elderly had also reviewed the admission criteria for AMU, to try to improve patient flow.

Mr Proctor stated that the number of patient transfers could also have a huge impact on staff time, as each transfer took a minimum of 20 minutes, which meant 10 patient transfers could take 4 hours of nursing time. A piece of work looking at transfers was being done to see whether portering staff could be used instead of trained nurses. He emphasised that turnaround of patients was massive at the current time and this was a real challenge to staff. Another piece of work was looking at whether there could be a single admission and patient assessment in ED, which negated the need for further assessment on transfer to AMU as this would help to stop the funnelling through AMU. The Trust was also keen to progress the amalgamation of AMU and the Short Stay Unit, but this required work on job planning and on-call rotas.

Mrs Rushbrook stated that electronic solutions were being explored, so that information was available to understand the delays and facilitate resolution. Some of the changes being looked at were only small, but understanding the impact was critical. Rebuilding the system was important and especially getting the best out of any additional effort that is put in.

The Board discussed performance and whether the Trust would be able to achieve the targets set. Mr Crowley stated that the important factor was patient safety, rather than the targets. It was acknowledged that it was the position of the Non-executive team to challenge performance and seek assurance regarding external requirements (e.g. Monitor and/or national targets). It was agreed that a tremendous amount of assurance had been received, despite all the pressures and issues facing the Trust. Mr Keaney noted that it would be useful to have a sheet detailing all the actions being taken and whether the actions were achieving the required result. He stated that the Finance and Performance Committee needed to review the short term acute strategy, so that there was a greater understanding of the issues and plans to address them.

Operation Fresh Start was discussed, together with whether it was adding value. Mr Proctor stated that he did think it was adding value, but that not all the elements were in place yet. The plan continues to develop and currently the ward-level Discharge Liaison Officer (DLO) positions were being filled. It is an incredibly detailed process at both macro and micro levels, to a degree that has not been experienced before. It provides a broad view of the hospital and allows decisions to be made in the moment about how to action issues arising. The DLO position is really powerful and will facilitate the process of discharge, especially in relation to any elements that are blocking the system. The system in place is allowing managers to be able to predict how many patients in the ED will require beds. Mr Proctor noted that, despite pressures, Scarborough had recently

achieved the 4 hour target of 95% on 3 days, which had not been done since about October and no 12 hour waits have been recorded. The methodology is designed to maximise efficiency.

Mr Crowley stated that historically, for a number of reasons, Scarborough has not managed optimal performance, but the project that Mrs McGale is leading is working to change the culture. He confirmed that the York site will start to use the analysis from this project and incorporate elements into rebuilding the system. The work needs to be allowed to embed and that achieving targets does not necessarily mean that the Trust has a sustainable system in place. The investigation with Monitor last quarter allowed these discussions to take place and there was an understanding that the whole system is compromising care. Mr Crowley stated that the Trust needs to hold its position and allow actions to be implemented to facilitate a sustainable system. He stressed that this was about being a learning organisation.

Mr Proctor stated that decisions on how and when escalation areas were opened were made after full discussions and that patient safety was a paramount factor in these discussions. He noted that in previous years the opening of escalation areas had been on a very reactive basis, but the Trust could now demonstrate a more planned approach. There was a better use and sharing of data that informed performance and a collective responsibility taken for actions in conjunction with the Executive Board. This was evidenced by the emerging understanding that the 4 hour target was not just about the Emergency Department, but needed to be a whole system approach.

Mr Crowley advised that there was an ongoing debate with Monitor, especially in relation to the levels of demand and assumptions made. He stated that the Trust could demonstrate a good understanding of what was happening and the response being made to it. He also highlighted the daily regional conference calls, which had taken place to discuss the pressure in the system. On these, the Trust was able to demonstrate a clear level of very current detail and understanding of its position, often way beyond what most other Trusts were able to do, which had provided assurance to our CCGs.

Trust Efficiency Report

Mr Bertram reported that there was an in-year £0.9 mil planning gap, but that this figure rose to £2.3 mil if the high risk plans were not counted. £18.4 mil has been delivered in 9 months, against a full year target of £24 mil. He commented that the team was working hard with all the directorates to produce a final push in quarter 4 and directorates currently exceeding their target were being asked if there was scope to go even further. However, he stressed that the pressures within the system were compromising delivery and that when directorates were under this kind of pressure, discussing efficiency savings was difficult and the priority was always the safe delivery of services.

Locum spend was highlighted as a concern, together with the impact of cancelling clinics and operations, which contributed to the delivery of RTT and then further investment was needed to cover the work that had been cancelled. The recurrent level of CIP plans is also getting lower every month and effort was required to convert savings to recurrent. Next year the predicted level of savings the Trust is required to make is approximately £27 mil and Mr Bertram was concerned at how realistic this would be.

The current £1.2 mil deficit was within Monitor's threshold to retain the CoSRR rating of 4, however this was fragile.

Mr Bertram advised that a quarter one settlement had been secured around the marginal rate income and ambulance turnaround fines were being reinvested, which was reflected in the income position. The Board discussed the extra capacity that had been opened during the recent pressures and Mr Bertram confirmed that the Trust had not received any extra funding. The extra capacity was opened on the basis of patient safety and the CCGs had not been asked to fund this, although he did stress that negotiations were ongoing around whether the CCGs would support the Trust taking the decision to provide extra capacity.

The Trust was also discussing the system-wide pressures with the CCGs, which has left the organisation with a 4 hour performance fine of £808k, especially as issues with social care provision contributed to the pressures. It was recognised locally that the Trust had responded safely and well to the levels of demand and part of this was down to opening extra capacity. The Trust had obviously been hit hard by the 30% non-elective activity tariff and the Trust was seeking further support for this from the CCGs, so that this could be reinvested. Another discussion taking place was around the slippage in resilience funding and whether this should be given to the Trust as schemes that should have taken some of the pressure from the system had not been up and running. Mr Bertram confirmed that these discussions are in the early stages and no assumptions have been made in the current figures.

Mr Ashton asked whether the Trust will be able to recover the planned elective activity position. It was acknowledged that a number of actions were being taken and Mr Bertram stated that the Executive Board had been asked to take any opportunity to increase elective activity within the last two and a half months of the financial year; however, it is unlikely that the Trust will fully recover the position.

Mr Crowley highlighted the success of the decision to move orthopaedics to Bridlington, as this had allowed the elective work to continue, which would certainly have been cancelled had it still been at Scarborough.

Mr Crowley also advised the Board that the Sexual Health tender for North Yorkshire had been awarded to the Trust, however, news of the City of York Sexual Health tender is still awaited.

15/010 Quarterly Workforce Performance Report

Mrs Holden stressed that it was important to remember that everything depends on the staff within the organisation and the need to keep them motivated and committed is difficult. Staff are tired due to the pressures being experienced and then the organisation is asking the same staff to increase elective activity where possible. It should be recognised that the organisation is asking a lot of its staff and ways need to be explored to demonstrate appreciation. Alternative rates of pay have been agreed for some medical staff and the nursing bank at Scarborough, which has increased take-up of extra shifts. Mrs Holden stated that this was a much safer alternative than employing locum and agency staff, who may not be familiar with the hospital or areas. She noted that despite the pressures being experienced, the vacancy rate has reduced.

Mrs Holden stated that another area being looked at was appraisal uptake, as the way it is recorded does not provide a true reflection of the rate within each quarter. An appraisal matrix has been devised to allow meaningful discussions to take place, but in a simpler format. The matrix also facilitates the discussions being had at the relevant time, rather than in a pre-programmed way.

Mrs Holden stated that the general part of the report is about starting to look at what the Trust will require in the next 5 to 10 years and why interventions and actions being taken now are important, as they will provide some of the solutions in the longer-term. The report highlights the increasing age population amongst the Trust's staff and the need to positively discriminate towards a younger workforce in the future. She was clear that there were no quick fixes and that to start securing the future workforce of the organisation work was required now. Nursing was just one of the areas of concern. The profile highlighted that band 6 and above were the more experienced nurses who had a protected right to retire at age 55. This posed a double threat to the organisation, with the potential to lose very experienced staff early, especially in times of pressure such as this.

The Trust needs to create flexible opportunities, which allowed greater diversity, in order to secure future staffing. The consultant age profile, together with external issues such as changes to pensions and tax allowances, is having an effect. Increasingly, there are consultants who want to retire to secure their pension, but do not want to stop working, but that creates problems trying to bring them back on National terms and conditions. Mrs Holden stated that the Trust needs to look at the provision of alternative contracts to make it more attractive for staff to continue working. Mr Turnbull noted that defence (insurance) costs are also extremely high and impact on the ability to continue working. Other Trusts are starting to look at different contractual opportunities and this will inform future planning.

It was noted that due to the historical lack of investment in district nurse training there is no longer enough experienced staff to provide supervision. Another group of staff with an ageing profile was in Estates and, again, the Trust needed to actively encourage young people to join the organisation. Mrs Holden highlighted that in the next 5 years there would be a 36% loss of medical consultants, anaesthetists and general surgery and urology consultants and this, coupled with difficulties in recruitment, will present a significant problem.

The Board supported the strategic work being undertaken by the Workforce Strategy Committee.

15/011 Sustainable Development Annual Report

Mr Golding stated that the report provided an update on work since 2012, but also looked to set targets for the Sustainability Group to measure performance going forward. Together with the report was the Sustainable Development Management Plan, which he was asking the Board to adopt. He suggested that a group needed to be set up to harmonise work across the wider organisation, ensuring integration of processes and procedures. The report evidenced how the Trust was performing against the Good Corporate Citizenship Assessment. A self-assessment had been undertaken in all but

two areas and these would be published on a National database and allowed comparison with 40 other early adopter organisations, of which 13 were Acute Trusts.

Mr Golding stated that carbon energy projects were delivering savings and it was vital that this work was replicated at Scarborough. One of the projects involving travel and transport had also won recognition from the York Press Business Awards for green travel initiatives.

The Sustainable Development Management Plan set out best practice and provided a tool to monitor progress going forward. It would also be useful, as Commissioners were now starting to drive this agenda and it allowed the Trust to raise awareness. Mr Golding stated that there needed to be more engagement with staff and champions from each of the services.

Concern was expressed about capacity to do this work and multiple reporting if too many groups were set up to look at elements of the same work. Mr Golding stated that the group would bring together and articulate all the elements that made the organisation a sustainable one. Mr Rose noted that if the group being set up was to close a perceived gap in assurance then this should be part of the Governance Review, as it would be a new Board Committee. Mike Sweet would potentially be the Non-Executive Chair, but details need to be progressed.

The Board agreed to adopt the plan and the targets.

15/012 Health & Safety Policy

Mr Golding stated that the policy had been reviewed and no changes made.

The Board **approved** the Health and Safety Policy.

15/013 Update on the changes at Whitby

Mr Bertram stated that the Whitby contract had been due to be terminated at the end of March 2015. However, Hambleton, Richmondshire and Whitby CCG had formally asked the Trust to continue providing the service until the end of June, which had been agreed (including financial terms). Two providers had been short-listed and an announcement will be made in March.

Staff working on the site would remain with the Trust and in effect the Trust's position would alter to that of a tenant. Community paediatrics was raised, but Scarborough & Ryedale were aware that it had not operated well as a community-only service and that becoming part of the acute service had provided governance and resilience. Therefore it had been agreed that community paediatrics would remain as part of the Trust's paediatric service.

Mr Rose thought it may be useful to reflect on the Whitby experience and changes in the Summer and to also consider the relationship with the new provider.

15/014 Report of the Chairman

Mr Rose commented on the financial position and that it was unlikely that things would be any easier in the next financial year.

Mr Rose referred to the Board-to-Board on the 11th February 2015, which Scarborough & Ryedale CCG had initiated. The intention was to have a forward-looking agenda that covered the vision for the medium-term future.

Mr Rose advised the Board that Mrs Symington had met the other Trust Chairs in the region and a handover had begun, in preparation for April.

15/015 Report of the Chief Executive

Mr Crowley praised the work of the Head of Communications and the Communications Team following the declaration the major incident at Scarborough. The team had been tested by the massive amount of press interest and had coped fantastically. He also highlighted that the pressures at Scarborough had been handled independently due to the inability to transfer-out patients and the pressures being experienced by the whole region. Mr Crowley commended the staff involved and commented on how supportive the command and control system put in place had been. Partners in the region had been impressed with the way the situation at Scarborough had been handled.

15/016 Monitor Quarterly Return

Mr Bertram noted the return included a table that detailed the performance issues and the Continuity of Service Risk Rating (CoSRR), which would be sent to Monitor for the Quarter 3 return.

15/017 Annual Plan Process and Explanation

Mr Bertram stated that Monitor required a one-year operational plan to be submitted by the Trust for 2015/16, which would be a refresh of the previous submission. A draft would be brought to the February Board, before being sent to Monitor on the 27th February. The final plan would be brought to the March Board, before being submitted to Monitor on the 10th April. A group of Governors is being given the opportunity to review and discuss the plan.

Mr Bertram advised the Board the reductions in activity required by the CCG as part of the Better Care Fund and Community Hubs was significant. Discussions were being held at the Collaborative Improvement Board as it was felt that the assumptions being made were unachievable, but probably the result of National Policy and Strategy to move more funding into Social Care. These discussions were holding-up contract negotiations, but he was hopeful that the CCG would be in a position to offer the Trust a contract in the next week or two.

Mr Bertram also advised the Board that Monitor had received approximately 7,000 objections to the proposed tariff; 6,000 of these were from Mental Health organisations. This did mean that Monitor had to discuss a possible review of the tariff at their Board meeting today, more than 51% of relevant organisations had objected. This would create difficulties in respect of providing the financial information around the one year plan

refresh. He also noted that it was likely that a complete refresh of the 5 Year Strategy would be requested later this year.

15/018 Business Cases

2014-15/88 Orthopaedic Consultant Expansion – Arthroplasty Surgeon, York

Mr Proctor stated that a certain amount of procedures currently being undertaken could be not be done at Bridlington, for safety reasons, due to patients with significant co-morbidities not being suitable. He noted that there is an ambition to be able to do all these procedures, but there are currently no plans in place due to the level of investment required, but the work done at Bridlington ensured its viability. However, this does mean that there is a shortfall in elective and non-elective work. This appointment would also facilitate more cross-site working and would increase the current Clinical Director's time to provide more senior management time. Mr Crowley stated that the Trust needed to support senior clinical leadership, but that does require investment. This appointment would also mean that the level of work currently sub-contracted out by the Trust would reduce. Mr Bertram noted that the costs of this case had been revised, following Executive Board discussion and challenge.

The Board approved this business case.

2014-15/100 Carbon and Energy Reduction Project, Scarborough and Bridlington Hospitals

Mr Golding stated how successful the same scheme at York had been and that savings were guaranteed. The scheme would enable the Trust to do make some major infrastructure improvements. Concern was raised as to what the Trust was committing to today and in the future. Mr Golding stated that if the Trust did not go ahead it would only be liable for the £81k worth of work done to date. The next stage would be installation, which was ready to go, as the preferred bidder had been selected. Funding was discussed and Mr Golding stated that the Trust could borrow at a better rate than the funding available centrally, but that the loan would be repaid from the savings made.

Mr Bertram stated that the loan interest repayment requirement did not materially impact on the CoSRR rating.

The Board approved the business case.

15/019 Dates of the associated Committee meetings from January 2015 to April 2016

Mr Ashton stated that the Audit Committee date of the 16th March may need to be changed. Ms Raper stated that there would not be a Workforce Strategy Committee on the 11th August.

15/020 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 25th February 2015 in the Boardroom, The York Hospital.

15/021 Any other business

No further business was discussed.

Outstanding actions from previous minutes

Minute number and month	Action	Responsible office	Due date
13/134 Dementia Strategy	To include an update on the dementia strategy in his board report on a quarterly basis.	Dr Turnbull	February 2014
14/055.1 2013 - 14/127: Bridlington Orthopaedic Elective Surgery	Evaluation Report pending the release of further capital	Mr Bertram	November 14
14/041 Patient Experience - Matron refreshment	Update the Board on the progress of the introduction of the new nursing structure	Mrs Geary	January 15
14/083 Finance and Performance Committee	Include dementia screening in his Medical Director report.	Dr Turnbull	July 2014
14/131Quality and Safety Committee	A further report of the F&F should be presented to the next Board meeting	Mrs Geary	October 2014
14/131Quality and Safety Committee	Update the Board on the completed development of the Quest tool at the Board meeting in November.	Mrs Geary	November 2014
14/148 Matters arising – Workforce Mitigations	Take the paper to the next Workforce Strategy Committee meeting.	Mrs Holden	Next Workforce Strategy meeting
14/149 Quality and Safety Committee – SHMI	Bring monthly trends on mortality data to the Quality and Safety Committee	Dr Turnbull	Next Quality and Safety Committee
14/154 Finance and Performance Committee	Discuss the pay rates at the next meeting.	Professor Willcocks	At the next Workforce Strategy Committee
14/174 Procurement update	Develop and bring to the Board a food and drink strategy.	Mr Golding	During 2015
14/177 Community	Action: The Board to receive a	Mr Sweet/ Mr	February

Services	presentation on community services at the February Board meeting.	Proctor	2015
14/173 Finance and Performance Committee	Prepare and circulate a paper identifying all the actions the Trust is undertaking around recruitment.	Mrs Holden	Immediate

Action list from the minutes of the 28 January 2015

Minute number	Action	Responsible office	Due date
15/004 Matters arising 15/004.1 /*14/171 Quality and Safety Committee – Pastoral Care*	Mrs Holden asked the Board to make them selves available for the welcome meeting	Mrs Holden	
15/004.2 *14/181 Governance Review*	Final version of the values document to be presented to the Board in February	Mrs Holden	February
15/005 Patient Experience – Volunteer Service Update	Chairman & Ms Mallows to arrange for Board letters to be sent.	Mr Rose	February
15/007 Patient Experience Quarterly Report	Kay Gamble, Head of Patient Experience to present to a future Board	Mrs Geary	February

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Healthwatch (North Yorkshire) Enter and View – Scarborough Hospital

Action requested/recommendation

The Quality & Safety Committee is requested to read this report in conjunction with the Healthwatch (North Yorkshire) Enter and View Report of Scarborough Hospital.

The Trust should now take forward the recommendations and report back to Healthwatch on progress made against the recommendations.

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).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes
1, 4, 9, 16

Progress of report	Appendix Report has been widely circulated by Healthwatch (NY) to their key stakeholders which includes the CCG, CQC, Monitor, patients and public

	via their newsletter. Board of Directors, Corporate Directors and Governors have also received the appendix.
Risk	Potential for Organisational Reputation to be negatively affected.
Resource implications	Resource implications in relation to recommendation 1
Owner	Beverley Geary, Chief Nurse
Author	Kay Gamble, Lead for Patient Experience
Date of paper	February 2015
Version number	Version 1

Board of Directors – 25 February 2015

Healthwatch (North Yorkshire) Enter and View – Scarborough Hospital

1. Introduction and background

Healthwatch is an independent consumer champion created to gather and represent the views of the public. Healthwatch plays a role at both national and local level and tries to ensure that the views of the public and people who use services are taken into account

Local Healthwatch was launched in April 2013, and took on the work of the Local Involvement Networks (LINks) and additionally:

- represents the views of people who use services, carers and the public on the Health and Wellbeing boards set up by local authorities.
- report concerns about the quality of health care to Healthwatch England, which can then recommend that the CQC take action.

Our Trust is served by three Local Healthwatch organisations; North Yorkshire, City of York and East Riding. This report is in relation to the Enter and View carried out by Healthwatch North Yorkshire but will be referred as Healthwatch throughout.

The Local Government and Public Involvement in Health Act 2007 allows for authorised Healthwatch representatives to undertake visits of premises of Health and Adult Social Care providers within Local Authority areas such as North Yorkshire. These visits are described as "to enter, view and observe".

In October 2014 the Trust was notified that an Enter and View visit would take place at Scarborough Hospital on 12th November between 10am and 4pm.

The purpose of the visit was for Healthwatch to:

- gather the views of patients, relatives and carers in relation to their experience of the services being provided
- identify examples of good working practice
- make observations as care is being provided to patients, and their interactions with staff and the surroundings

2. Enter and View Findings

The attached Appendix details the full report from the Enter and View visit at Scarborough Hospital.

2.1 Trust Response to Report and Recommendations

The Trust was given 20 working days to respond to the report in terms of factual accuracy.

A meeting between the Chair of Healthwatch – Sir Michael Carlisle; David Ita, Healthwatch Manager; Beverley Geary, Chief Nurse and Lucy Brown, Head of Communications took place on 8th January 2015 to provide an opportunity for both organisations to give feedback and discuss the findings from the report whilst agreeing a way forward with the

recommendations. Some minor amendments to the report were agreed.

3. Conclusion

The Trust wrote to Healthwatch providing our response to each of the recommendations made.

Response to specific recommendations:
There are a number of recommendations where work is already underway and significant progress has been made.

Recommendation 1: *There is an urgent need to update the signage and environment to be more accessible and user friendly*

We are aware of the limitations of the hospital site and are investing significant funds in making improvements to the hospital and its facilities. In relation to comments about rest stops on the main corridor, we will explore the possibility of introducing benches, and we will consider how we might improve signage and way finding on the site.

Recommendation 2: *Standardise all procedures across wards, including dementia signs and compliment/complaints forms*

The Trust has recently agreed, following consultation with community groups, to standardise the Forget Me Not symbol across all wards in-line with national guidance and this will ensure that wards are consistent. A programme of Dementia Awareness has been rolled out across the whole Trust with a large number of staff having attended this training. The programme of Dementia Awareness continues to be rolled out.

All wards provide information leaflets on how to provide feedback, raise a concern or make a complaint. The Trust has recently produced a draft '*Your Experiences Matter'* leaflet in collaboration with key stakeholders including Healthwatch York. The focus for the Trust is to seek, listen and respond to all feedback whether that is a concern, complaint or a compliment.

Additionally, all wards now ask patients to provide feedback through the national Friends and Family Test. The inpatient wards at Scarborough Hospital consistently achieve a monthly response rate of above 40%, with positive feedback on the whole.

In January 2015 wards began to display feedback from patients on 'Knowing How We Are Doing' boards and will feed back to patients and their family what has been done as a result of their feedback through 'You Said, We Did'.

Recommendation 3: *Personalise bed areas using patient names and not just numbers, as this forms part of your commitment to person-centred care and reduces the perception that each patient is just a statistic*

As a Trust we must strike a balance between confidentiality, privacy and dignity, and safety in terms of patient identification. This issue has previously been considered in some detail and the decision was taken not to display patient names above beds. This is consistent across the organisation.

Whilst bed numbers are used to identify patients by those caring and treating them, we do not refer to the patient as a number when providing care and treatment, and would not address patients in this way.

The view that there is a “perception that each patient is just a statistic” is in no way supported by feedback from patients or relatives, and is not something that we recognise.

Recommendation 4: *Decide which wards are for what conditions and adhere to the plan as much as possible*

The Trust has dedicated wards for particular specialties, as do all hospitals. Healthcare has changed and become increasingly specialised, and over time we have seen an increase in the number of patients we admit who are elderly and/or with complex medical conditions. At the same time, advances in surgical techniques mean shorter stays for many patients, and more day cases. This means that the current configuration of wards, which has been largely unchanged for some years, does not always meet the pattern of admissions.

The impact of this is that when we are busy (and this happens regularly throughout the year, not just in winter) we have more elderly/medical patients than we have beds on dedicated wards. This results in patients being admitted to other areas, usually surgical, where there are beds available. This is not ideal for patients, or indeed staff.

We are looking at our bed base to see what changes might be made to improve this, and we are also taking a number of steps to improve patient flow and reduce the pressure on beds.

Recommendation 5: *As much as possible, reduce the reliance on agency staffing, which should hopefully save costs.*

This is already a key priority for the Trust and work is well underway to address this.

We have to ensure that we have safe staffing levels, both for nursing and medical staff, and using temporary and agency staff is one way of doing this. Our increase in spending on temporary staffing is due to difficulties in recruiting nursing staff and doctors within certain specialties. This is an ongoing issue, and it is not just our Trust that is seeing this trend, as Trusts are all attempting to recruit from the same pool of people and in some specialties this is increasingly difficult.

This has been compounded by recommendations in the Francis Report that staffing levels should be increased nationally, and universities are responding by increasing the number of nurse training places, however, the benefit of this increase will not be realised for two to three years.

We ran a number of ‘one stop’ recruitment events in October 2013 and again in March and September 2014, in both Scarborough and York, and recruited 47 nurses into permanent posts.

In December 2014 the Board of Directors approved the recruitment of a cohort of nurses from Spain using an experienced agency. The training is of a high standard and there are high numbers of nurses who are looking for posts. Several other Trusts have successfully recruited nurses in this way. The first round will take place in early March followed by a second round in April, with the aim of recruiting up to 40 nurses. It is anticipated that these nurses will be in post late spring and early summer.

Recommendation 6: *There is a great need for a forum to be created for regular senior management and staff liaison, where staff can be empowered to be involved in some of the decisions that will inevitably affect their day to day work.*

As an NHS organisation, indeed in line with most of the public sector, we have well-established forums for staff and senior management to meet to discuss issues. Where these issues have the potential to affect staff and their day-to-day work, there are formal communication and consultation processes that are followed. There exists a wide range of other mechanisms for involving and engaging staff, and we have recently made several changes to our internal communications processes in response to staff feedback. This new approach was launched in September 2014.

For example, the Chief Executive and the Chief Nurse hold regular drop-in sessions across the Trust. These began in November 2014. 'Blue Thursday' was introduced in September 2014. This is a new initiative whereby members of the senior nursing team work on the wards.

The Staff Friends and Family Test was rolled out across the Trust during July 2014, which ask if staff would recommend the Trust to family and friends if they needed treatment and whether they would recommend the Trust as a place to work. The feedback received has been largely positive, and we are keen to increase the response rate so that we can gather further detailed feedback from staff.

A confidential helpline has also been launched which allows any member of staff with a concern to leave a confidential message which will be escalated to the appropriate senior manager.

Recommendation 7: *Consider asking all patients on admission and discharge whether they currently look after anyone and use this information to identify appropriate support within the community for the cared for person*

Patients are, as a matter of routine, asked for information about their social circumstances when they are admitted, however this is an area that we would like to explore in more depth and we will take it to our Patient Experience Steering Group for discussion. Dependent on the outcome of that discussion, there is the potential to work in partnership with Healthwatch North Yorkshire on how we might better meet the needs of carers.

Response to other points raised in the report:
Regarding driving conditions on the site, we have not received feedback or complaints of this nature, and feedback suggests that driving conditions on the site have improved since the opening of the new visitor car park.

A new discharge lounge is opening in the former West entrance to the hospital, which will be staffed and will provide comfortable accommodation for patients to wait for their transport home once they have been discharged from hospital.

We are required to publish our nurse staffing ratios, and these are generally at expected levels across the organisation.

In terms of staff development, we do not recognise the comments from a staff member regarding funding their own development. The Trust has an expansive training and development programme for staff, and they are well supported in accessing these opportunities. It may be the case that individuals fund courses that are not core to their professional development, however the Trust funds a large number of training and development opportunities and makes time available for staff to attend these where appropriate.

In relation to staff requests for scrubs a review of nursing uniforms has been undertaken across the Trust and we are currently looking at the procurement of uniforms.

4. Recommendation

The Quality & Safety Committee is requested to read this report in conjunction with the Healthwatch (North Yorkshire) Enter and View Report of Scarborough Hospital.

The Trust should now take forward the recommendations and report back to Healthwatch on progress made against the recommendations.

5. References and further reading

Enter and View – Scarborough Hospital – appendix 1

Author	**Kay Gamble, Lead for Patient Experience**
Owner	**Beverley Geary, Chief Nurse**
Date	**February 2015**

Enter and View Report | Single Provider

healthwatch North Yorkshire
Improving Health & Social Care Together

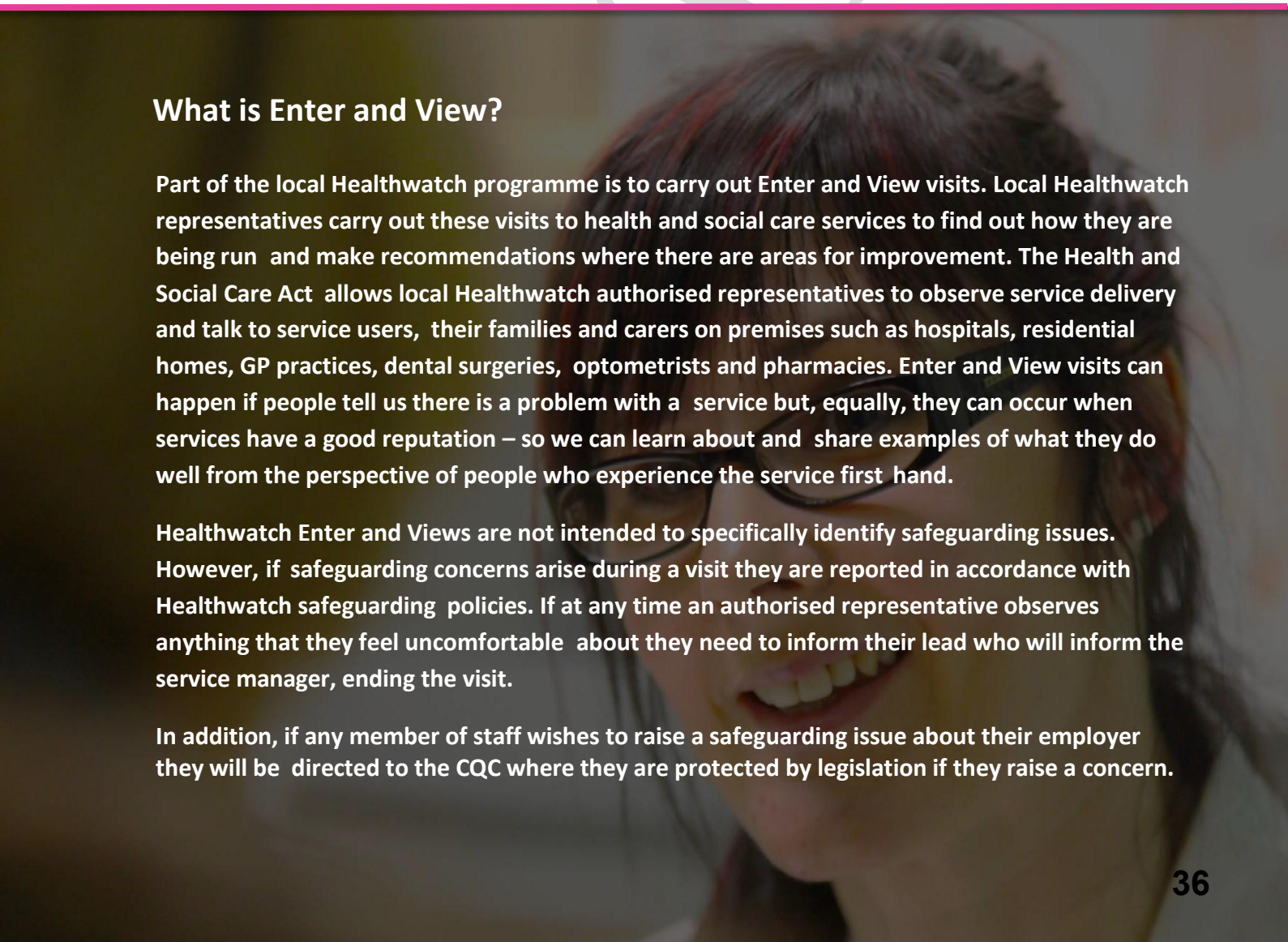
Details of visit:	
Service address:	**Woodlands Drive, Scarborough, North Yorkshire YO12 6QL**
Service Provider:	**York Teaching Hospitals NHS Foundation Trust – Scarborough Hospital**
Date / Time:	**12th November 2014 / 10am – 4pm**
Authorised Representatives:	**Gill Stone (Visit Lead), Chris Gosling, Sue Staincliffe, Adrienne Calvert, Julie Janes, David Ita (Supervisor).**
Contact details:	Healthwatch North Yorkshire, Blake House, 2A St Martins Lane, York. YO1 6LN

Acknowledgements

Healthwatch North Yorkshire would like to thank the service provider, patients, visitors and staff for their contribution to the Enter and View programme.

Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all patients, relatives or carers and staff, only an account of what was observed and contributed at the time.



What is Enter and View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they need to inform their lead who will inform the service manager, ending the visit.

In addition, if any member of staff wishes to raise a safeguarding issue about their employer they will be directed to the CQC where they are protected by legislation if they raise a concern.

Purpose of the visit

- To gather the views of patients, relatives and carers in relation to their experiences of the services being provided.
- Identify examples of good working practice.
- Make observations as care is being provided to patients, and their interactions with staff and the surroundings.

Strategic drivers

- Contribute to our wider programme of work gathering evidence on our three Health and Social Care priorities for 2014/15, which is; Hospital Discharge and post Hospital support arrangements, GP Out of Hours services, and Support for unpaid Carers.
- Looking at the quality of care being provided, and the variation (if any), within the main hospitals serving the citizens and communities of North Yorkshire County.

Methodology

This was an announced Enter and View visit.

Following the formal notification of the visit sent to both the service provider and the clinical commissioning group responsible for commissioning this service, the visit lead arranged a telephone conference with the service providers' nominated person(s) in order to; complete a pre-visit questionnaire, explain the visit process, and answer any questions that the service provider may have about the visit. The visit lead also shared the visit plans with the service provider, including the areas of the service that the visit team planned on visiting, so that relevant staff would be notified in advance, thereby minimising or avoiding disruption to the normal day to day running of the service.

The visit team of six authorised representatives (including the visit lead) split into pre-arranged pairs and visited Wards - Cherry and Chestnut (Medical Admissions), Ann Wright, Oak (Care of Elderly), Stroke ward and Beech (medical). Also visited were Willow and Ash wards (Day unit surgery and Day care), Accident and Emergency, Graham ward (escalation) and Pharmacy. In total over 40 patients and relatives/carers, were spoken to, in addition to the nursing and ancillary staff who provided information and details about 'life on each ward'.

After time limited deliberations at the end of the visit, we communicated the key (headline) findings of our visit to the service providers' nominated person(s) namely; Kay Gamble – Trust Lead for Patient Experience, Emma Day – Assistant Director of Nursing (Scarborough Hospital) and Joanne Southwell - Assistant Director of Operations (Scarborough Hospital).

We explained the protocol of "what happens next" following our visit, including timings and expectations. This allowed the service provider to respond immediately to some of our findings, as well as ask the visit team any questions.

Ethical consideration

On entry to Wards we always introduced ourselves to the senior member of staff present and informed them of the reason for our visit. In most of the wards visited we were expected, however there were 2 sections of the hospital that we were not expected - A&E and Stroke ward. We ascertained from staff which patients we should not approach due to their medical condition, cognitive ability or our possible breach of infection control. This protocol was strictly adhered to.
Prior to any conversation being held with a service user we introduced ourselves by name and showed our HW authorisation badge, gave them an explanatory leaflet on Healthwatch 'Enter and View'' purpose and procedure and then obtained their permission to continue with the conversation. It was also made clear to each service user that whatever they divulged to us in respect of their experience as a patient in the hospital would be anonymised for the purpose of this report.

In addition to our discussion with patients, we spoke to many staff and ancillary workers and family members who were visiting. We walked around the ward observing equipment, bay areas, bathrooms, signage, ward literature and general cleanliness and safety of the ward.
All authorised representatives were briefed prior to ward visits to be alert and attentive to the care, wellbeing, dignity, privacy and safety of patients.

Summary of Findings

At the time of our visit, our overall observations show that the hospital was not operating to a very good standard of care, although there was one main positive.

- Patients were generally complimentary of nursing staff, and the passion and commitment of nursing and other care staff are unquestionable.
- Nursing Staff to patient ratio inconsistent across wards with low staff morale.
- Signage and access within and without the hospital is confusing and misleading
- Patient Care (wellbeing, dignity, respect and safety) not consistent across all wards.
- Patient movement within and out of the hospital unexplained and confusing.
- Dementia awareness and dementia friendly wards not consistent.
- Complaints and compliments procedure inconsistent or not evident across all wards.
- Patient waiting times at A&E were well within the prescribed limits.

Results of Visit

Scarborough Hospital is York Teaching Hospitals NHS Foundation Trust's second largest hospital, which was acquired in July 2012. It has an Accident and Emergency department and provides acute medical and surgical services, including trauma and intensive care services to the local population of Scarborough, Ryedale, Whitby and Bridlington, in addition to the influx of visitors to the North East Yorkshire coast.

Environment (including Premises)

We found that the warning signage into the hospital was inadequate, with reports of "several near misses of collision" according to a frequent driver to the premises. Main Entrance to premises benefits from a volunteer to "meet and greet", which is very helpful especially as site map and actual ward directions are not compatible. The wide very long corridor (tunnel) between wings was intimidating and unwelcoming with no rest areas, minimal signage and no colour coded line to follow to destination.

The Discharge Lounge (Howarth ward) is an area sectioned off from a ward treating day patients. The area is not conducive to comfort or wellbeing with items of equipment scattered around, poor quality furniture and furnishings. It also potentially creates safety issues as it is unsupervised and near an external access door. Staff informed us that confused and wandering patients would not be accepted into the Discharge Lounge.

The corridor outside Willow Ward is used as a store for trolleys and broken beds, and overall, with the exception of the main entrance, the premises are stark, unwelcoming and confusing to navigate.

Wards

On the wards visited there appeared to be inconsistency in procedure and practice. Some wards have coloured coded bed areas (Ann Wright and Beech), others do not (Cherry and Chestnut). Some wards use "Forget me Nots" to identify dementia patients (Chestnut), others do not (Ann Wright and Cherry).

ALL wards visited do however use "red socks" to identify patients with stability issues.
Ward designations, like Elderly Medical, appear to be arbitrarily changed. For example, Willow ward was the Surgery Day Unit, but on Monday 10th November 2014 it was changed to Medical - open 24/7 but not equipped for 24/7 use. Staff instructed by management that, "as long as the 7 Patients have a bed, chair and suction, then it is deemed functional". There was no stationery or drugs and all 7 patients were acute medical, plus this is meant to be a 6 bed ward.

Ash Ward (surgery day care) currently has 16 beds, 4 of which are occupied by medical patients. Advertised ward opening hours are 7am - 8pm (Monday – Friday), 7am-12pm (Saturday). However the ward is actually open 24/7.

On every ward visited every bed is a number –not a patient name. There is no reference to the patient occupying the bed. On enquiring from a Health Care Worker about Mr X's actual condition the reply was "what bed number?"

The procedure and comment forms for compliments and complaints on patients' hospital experience were not visible across all wards.

Patient Care (Wellbeing, Dignity, Respect and Safety)

In the main patients and carers were complimentary about the care they received from the nursing staff in the hospital; however some areas for concern were observed. On Stroke Ward, the wife of a patient was anxious and afraid to speak to Healthwatch because Consultant in bay and may hear what she is saying and then ban her from the unlimited access she currently had to her husband. On

the Sub-Acute Stroke bay, the monitor bell rang for 5 minutes before a passing Physiotherapist responded. There was no Nurse in the bay where patients require 24/7 monitoring.

On Willow Ward, a patient and bed had been put in a treatment room with no window or ventilation. Staff cannot see through the door and visibility is not available from the nurse's station. Also Willow ward admits challenging patients, which could be a potential safety issue as this unit is next to an external exit through which confused patients could wander.

On Chestnut and Beech wards we were informed by patients that there was a lot of noise with patient and staff activity at night disrupting sleep. Several patients commented that they had been moved around several wards, including a patient on the Stroke ward. A female patient waited in A&E 14 hours to be admitted to Cherry ward, then Haldane ward, then Beech ward - 3 ward moves in 2 days.

On Beech Ward, a trauma patient sitting in his chair exposing his genitalia, ignored by passing staff until a Healthwatch representative advised a Physiotherapist of the situation, who subsequently provided the patient with hospital pyjamas.

On Oak Ward, an elderly female patient, wearing "red socks", was in the bathroom alone with her walking frame, trying to wash her face in a bowlful of hot water without soap or flannel. Healthwatch representative called for a Healthcare Worker to assist the patient back to bed.

We were however pleased to find 3 volunteers on Ann Wright ward assisting patients who had difficulty eating, identified by the "red tray". Staff were also assisting patients who had eating difficulties.

Nursing and Ancillary Staff

Overwhelmingly patients thought that the nursing staff were excellent in the care they provided - indicative of how well staff contain their difficulties and frustrations amongst themselves and do not let their frustrations affect their dedication to work.

We observed variable, to NHS guidelines, staffing levels across the wards visited both for day and night staff. Heard staff discontent, frustration and animosity on such issues as the new sickness policy recently introduced, self-financing their career development, which has to be carried out in "own time" at home with no cost implications to the Trust.

On one ward nursing staff informed us that there is a lack of continuity, where "bank and agency" staff are used on all shifts, primarily because the unit is not staffed to be a ward open 24/7. There was evidence of skilled surgical nurses having to deal with medical patients, which means staff morale is very low. This recently resulted in high staff turnover with another experienced nurse (10years service), recently leaving.

On another ward, staff have to go to Recovery to discharge day patients leaving the ward because Theatre staff do not discharge patients.

Additional Findings

In our initial proposal for an Enter and View visit to Scarborough hospital, it was stated that Hospital discharge was a major area of observation for Healthwatch across North Yorkshire for 2014/15. Our observations of the Pharmacy department confirmed that the process of drug dispensing at discharge has been streamlined to allow speedier discharge for patients across the wards.

- A Medication Passport for discharge patients details the medication being prescribed.
- The process includes Pharmacy discharge trolleys on wards with Pharmacists facilitating the signing of prescriptions and reconciling a patients drugs as well as an explanation to the patient who may have queries.
- The A&E department at the time of Healthwatch observations was well organised, well-staffed, clean and hygienic. Patients waiting times were well within the prescribed limits, and something the hospital should be commended for.
- At A&E, staff felt management were not responsive to a request for 'scrubs' that they had been requesting for some time now. And also the increased reliance on agency staff were causing a real issue for permanent staff, as their overtime incentives were reportedly taken away, and agency staff are paid much more, not necessarily better qualified, and are not subject to the same rigorous checks and balances as other staff.
- Although not unique to Scarborough Hospital, there is currently no process for identifying patients who are also unpaid carers, either on admissions or at discharge. This process could help alleviate the anxiety of unpaid carers about the person they are caring for, who may have been left at home without support.

Recommendations

This report highlights the good practice that we observed and reflects the appreciation that patients felt about the care and support provided. However as a result of our observations, there are a few recommendations we would like to make:

- There is an urgent need to update the signage and environment to be more accessible and user friendly, as this would limit any distress to vulnerable patients, and inevitably lead to a better patient experience.
- Standardise all procedures across wards, including dementia signs and compliment/complaints forms, as this allows for improves outcomes for patients and supports staff that may need to move between wards.

- Personalise bed areas using patient names and not just numbers, as this forms part of your commitment to person-centred care, and reduces the perception that each patient is just a statistic.
- Decide which wards are for what conditions and adhere to the plan as much as possible, as the frequent changes to ward functionality is potentially a real risk to patient/staff safety and improved patient outcomes.
- As much as possible, reduce the reliance on agency staffing, which should hopefully save costs. Focus instead on improving staff benefits and morale.
- There is a great need for a forum to be created for regular senior management and staff liaison, where staff can be empowered to be involved in some of the decisions that will inevitably affect their day to day work.
- Consider asking all patients on admission and discharge whether they currently look after anyone (family, friend, neighbour etc.), and use this information to identify appropriate support within the community for the cared for person.

Service Provider response

Please provide a response to the overall report via email and we will incorporate it into the final version of this report. Your response should focus primarily on any factual inaccuracies you identify, which may need correcting. You may also want to consider indicating which (if any) of the above recommendations you will act on, or are already acting on, as we will make reference to any such progress being made in our final report.

Quality & Safety Committee – 17th February 2015 Boardroom, York Hospital

Attendance: Libby Raper, Philip Ashton, Jennie Adams, Alastair Turnbull, Diane Palmer, Liz Jackson, Cat Lunness

Apologies: Anna Pridmore, Beverley Geary

	Agenda Item	Comments	Assurance	Attention to Board
1	**Last meeting notes dated 20 January 2015**	The minutes from the previous Committee meeting were approved as a true and accurate record.		
2	**Matters arising** - Sign up to safety comments	Cat Lunness, Head of Patient Safety was welcomed to the meeting as an observer. The Committee noted with little dismay the number of papers provided, and reminded all that the intention remains to reduce to a minimum papers additional to the revised Patient Safety and Quality Report. The Committee gave due consideration to the items on the agenda. Due to the time restraints of the meeting and detail required on some items the Committee selected key areas to focus on. In BG's absence a meeting has been arranged prior to Board to discuss any concerns and actions with her. **Emergency Medicine** - The Committee asked for an update and any evidence of how patient safety and quality may have been affected during the long waiting times in the Emergency Department.		AJT and BG to discuss at Board of Directors.

	Agenda Item	Comments	Assurance	Attention to Board
		AJT advised that no serious or critical incidents have been highlighted from this time. Hull and York Medical School has raised a concern over the impact on the education of the students in Emergency Medicine. The Committee queried the systems for flagging incidents and if they were as robust as they should be. AJT showed some concern over under reporting. The investigation in to the 12 hour trolley breaches is to be discussed at the next SI meeting, due to take place on the 18th February, an update will come to the March Quality and Safety Committee. The Committee went on to discuss the impact on the quality of patient care. The increase of ward transfers and outlying patients has had a direct impact on the spread of infection with an increase in cases of Clostridium Difficile and noro-virus. The Committee highlighted the risk factor of outlying patients not being visited by Consultants as often as they would if they had a bed on the correct specialist ward and understood the difficulty of putting actions in place to reduce these instances with the current bed occupancy pressures. AJT assured the Committee that the backlog of cancelled elective activity is being worked through. **CQC Preparation** - AJT updated the Committee on further preparation for the CQC visit in March. The Committee were satisfied with the preparation that has been undertaken and highlighted the	The Committee acknowledged the work being undertaken to address this issue.	AJT to discuss at Board of Directors.

	Agenda Item	Comments	Assurance	Attention to Board
		importance of staff engagement, comprehension of the Trust values and embedding actions amongst staff. The Committee await discussion of this issue in more detail at future meetings. The Committee raised concerns over Nurse staffing levels and asked that staff be updated on the work taking place to fill the current vacancies and made aware that this is a recruitment issue not a financial issue. AJT assured the committee that there has been a change in the capacity of the two overflow wards on the Scarborough site and one on the York site, which is illustrated in the Safer staffing report.		
3	**Quality and safety Performance Report**	The Committee made regular reference to this report throughout the meeting, illustrating points with data and information. **Clostridium Difficile** - The Committee showed a level of concern over the number of identified cases of Clostridium Difficile. AJT explained that the Trust is still below trajectory, however there is a risk that the trajectory could be exceeded in February. A high proportion of the cases have occurred on the Scarborough site which may be due to the higher anti-biotic prescribing rates. 50% of the cases on the Scarborough site had occurred in one area. DP explained that a factor in this was the large bed capacity of the ward. Work has been undertaken on the structure of the staffing, which includes a change in leadership. The Infection Prevention Team have also had a high level of involvement. The Committee wished to highlight that the location and environment of a	The Committee were assured by the comments of the members that there was enough focus on supporting staff in this area rather then inspecting them. The	AJT to brief board.

	Agenda Item	Comments	Assurance	Attention to Board
		ward is as important as the theme. **Stroke** – The Committee raised concerns over the deterioration in the number of patients who receive a scan with in an hour of arriving in Hospital. AJT highlighted that the number is still above target. The Committee discussed the small cohort of Physicians in Scarborough and how achieving the 12 hour review would be contingent of recruiting more to make the rota viable. The Workforce Strategy Committee have the General Medicine senior review as an ongoing piece of work that ties in with the Patient Safety Strategy, the Quality Report and the work around mortality.	Committee await the results of the changes put in place. The Committee were assured that this is an adequately highlighted risk.	AJT to discuss the Medical Staffing workforce strategy at Board.
4	**Supplementary Medical Director Report** - CQC preparation - PROMS update - Stethoscope report	**Medical Prescribing** - The Committee welcomed the progress on medical prescribing and expressed the importance of tight scrutiny on this issue. AJT advised the Committee that Systems and Network services are now prioritising this work but this has caused progress to be slower then expected. **Mortality Review Report** - The Committee reviewed the Mortality Review Report noting the helpful executive summary. The Committee commented on the little impact that day of admission has on the day of death. AJT advised that a Consultant led Mortality review is now being enforced with currently up to 70% completion of reports. Departments completing the forms have already been able to identify learning. The report	The Committee acknowledged the work being undertaken and look forward to receiving an updated report from DP.	

	Agenda Item	Comments	Assurance	Attention to Board
		showed that relatively few patients had not had a ceiling of care or an inappropriate DNACPR in place. Governance Groups are being utilised to involve General Practitioners in the process Site Location – The Committee noted the previously agreed action to review the inclusion of site specific information for Community Hospitals. To be reviewed in June 2015. **Patient Reported Outcome Measures data** – AJT introduced the tabled PROMs data to the Committee. A data set with a limited number of procedures had been selected and the Trusts position had not changed with respect to the quality of life resulting from each procedure. The numbers of procedures vary greatly with higher numbers of hip and knee replacements	The Committee were assured by the information and discussion.	
5	**SI Report**	The Committee received 2014 data showing the number of serious incident reports that had been submitted on time, how many extensions had been sought and how many were de-logged. AJT explained processes of investigation and scrutiny of the two types of serious incident. DP advised the Committee of the big increase in the number of SIs due to the change in reporting of Pressure Ulcers and patient falls. Training for staff undertaking investigations and writing the reports has been put in place.	The Committee were encouraged by the numbers in the report and agreed to review this data 6 monthly. A breakdown of outstanding SI reports will be provided by DP at the April meeting.	
6	**End of Life Care Quality Report**	End of life care is a high priority for the organisation. AJT highlighted two risks as being the implantation of the 7 day service and the implementation and compliance with the care plan		

	Agenda Item	Comments	Assurance	Attention to Board
		in all areas. Following the national care of the dying audit practice has changed. A new care plan has been put in place and a re-audit will take place following the use of the first 90. The Committee discussed DNRCPR compliance in the trust and the importance of accuracy when completing the form. DP advised the Committee that a new form is now in use with training commencing in March. The Committee noted that this item would be a separate issue for discussion at Board and so restricted itself to headline discussion.		
7	**Maternity Services – Scarborough**	The Committee discussed Scarborough Maternity Services in detail. AJT advised that the internal report has been completed and that the report from the external review is awaited. The Committee can not be assured that the review was as robust as needed until the final report has been received, however there will be an opportunity for subsequent work. A further meeting with the Department is scheduled for this week to discuss short term and long term plans. The Committee discussed the different actions that are being deliberated and put in to place. The Committee agreed on the importance of learning to be shared and embedded with staff in the department so that they can recognise why changes are being implemented.		To be discussed at Private Board.
8	**Quality Report**	The Committee were delighted to have early site		

	Agenda Item	Comments	Assurance	Attention to Board
	- List of proposed items for the Quality Report	of this draft of proposed items for the Quality Report and agreed that the report should be crisp and consistent with delivery of tight targets. DP explained that targets had not yet been included as some were waiting to be agreed with Commissioners. The Committee discussed the targets for Friends and Family, Pressure Ulcers, Falls, 12 hour Senior Review in the context of reported performance. A discussion took place around what else should be included in the report and it was agreed that the Committee would send all comments to DP via email.		
9	**Acuity Audit**	The Committee reviewed the document and agreed actions to be discussed with BG prior to the Board of Directors.		
10	**Supplementary Chief Nurse Report** - Nursing Dashboard - PREVENT report - Falls Report - Pressure Ulcer update	In the absence of BG the Committee did not discuss in detail the Supplementary Chief Nurse Report. The Committee had reviewed reported performance on Patient Experience, Measures of Harm and Safety Thermometer when discussing Agenda Item 3.		
11	**Early Warning Tool Report**	The Committee acknowledged the Early warning trigger tool report and noted the continued need for focus on implementation.		
12	**Safer Staffing Report**	The Committee noted the areas for and the work to be undertaken with the community units and agreed this needed further discussion with BG.		

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee showed significant concern over the vacancy data provided in the in the supplementary staffing exception report and noted the risk in relation to capacity. Further assurance to be sought from BG.		BG to discuss at Board of Directors.
13	**Any other business**	The Committee agreed that priority issues arising from the CQC inspection will be discussed at the April meeting.		
14	**Other** Work Programme	The Committee agreed to update the time of the meeting on the 17th March to 10:00 – 12:00		

Patient Safety and Quality Report

February 2015

Our ultimate objective: To be trusted to deliver safe, effective healthcare to our community.

Index and Performance Summary

York Teaching Hospital NHS
NHS Foundation Trust

	Target Type*					Committee																
Summary Information	M	N	C	L	I	F	Q	Threshold	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Patient Safety and Quality Executive Summary	x	x	x			x	x	n/a												
Mortality Information	M	N	C	L	I	F	Q	Threshold	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Summary Hospital Level Mortality Indicator (SHMI)							x	100	97			98			99			102		
Patient Experience	M	N	C	L	I	F	Q	Threshold	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Litigation - Clinical Claims Settled					x		x	n/a	7	4	2	5	2	7	1	6	1	3		
Complaints					x		x	n/a	51	38	58	57	46	47	43	60	31	39		
PALS contacts					x		x	n/a	495	474	528	531	488	570	653	552	443	620		
New Ombudsman cases					x		x	n/a	0	2	2	3	0	0	0	0	0	3		
Friends and Family Inpatients			x				x	40%	31.30%	33.90%	34.20%	41.70%	40.20%	37.60%	38.20%	44.10%	38.40%	37.70%		
Friends and Family A&E			x				x	20%	19.48%	21.55%	33.94%	22.78%	19.98%	16.70%	15.90%	21.50%	16.00%	19.30%		
Friends and Family Maternity - Antenatal					x		x	n/a	41.3%	33.6%	26.0%	27.7%	33.1%	37.2%	39.8%	42.8%	32.2%	30.6%		
Friends and Family Maternity - Labour and Birth					x		x	n/a	44.1%	33.3%	32.9%	19.4%	16.2%	20.4%	17.2%	39.7%	15.8%	19.9%		
Friends and Family Maternity - Post Natal					x		x	n/a	47.0%	39.2%	37.5%	24.8%	20.9%	29.4%	26.5%	47.1%	19.4%	27.9%		
Friends and Family Maternity - Community Post Natal					x		x	n/a	34.2%	37.2%	24.7%	21.1%	22.7%	17.2%	19.5%	18.4%	18.2%	21.3%		
Friends and Family Staff (% at quarter end)			x				x	n/a			8%			8%			N/A			
Quality and Safety: Measures of Harm	M	N	C	L	I	F	Q	Threshold	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Serious Incidents					x		x		21	20	19	12	13	23	12	24	24	15		
Incidents Reported					x		x	n/a	1012	1247	1210	1239	1112	1150	1166	1023	1383	1236		
Incidents Awaiting Sign Off					x		x		1240	1394	1877	-	1870	1497	1408	858	272	1444		
Patient Falls			x				x		226	282	251	270	232	247	228	179	214	242		
Pressure Ulcers - Newly Developed					x		x		41	33	36	18	28	33	45	36	16	65		
Pressure Ulcers - Transferred into our care					x		x		80	127	98	113	86	77	90	83	60	135		
Degree of harm: serious or death					x		x		15	18	8	3	4	9	8	9	11	10		
Degree of harm: medication related					x		x		69	61	69	54	43	49	42	33	195	107		
VTE risk assessments		x					x	95%	97.1%	97.1%	97.6%	97.5%	97.2%	96.1%	97.4%	97.4%	96.9%	97.0%		
Never Events		x					x	0	0	0	0	0	0	0	0	0	0	0		
Quality and Safety: Drug Administration	M	N	C	L	I	F	Q	Threshold	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Insulin Errors					x		x	n/a	6	6	13	11	6	8	6	14	N/A	N/A		
Omitted Critical Medicines					x		x	n/a	33	21	23	23	32	23	16	22	18	15		
Prescribing Errors					x		x	n/a	22	13	11	22	27	17	21	20	N/A	N/A		
Preparation and Dispensing Errors					x		x	n/a	10	10	11	12	11	12	8	11	N/A	N/A		
Administrating and Supply Errors					x		x	n/a	37	46	47	56	42	41	35	43	N/A	N/A		
Quality and Safety: Safety Thermometer	M	N	C	L	I	F	Q	Threshold	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
% Harm Free Care - York		x					x		93.4%	93.0%	93.4%	93.6%	94.6%	95.7%	94.6%	94.8%	94.9%	94.2%		
% Harm Free Care - Scarborough		x					x		92.1%	89.4%	90.9%	90.7%	89.5%	93.8%	92.2%	91.7%	88.1%	93.9%		
% Harm Free Care - Community		x					x		93.6%	85.7%	84.3%	91.3%	91.4%	92.0%	88.6%	95.2%	92.9%	86.8%		
% Harm Free Care - District Nurses		x					x		91.2%	91.3%	91.8%	94.0%	93.1%	94.0%	94.3%	95.6%	94.9%	94.0%		
% Harm from Catheter Associated Urinary Tract Infection - York		x					x		1.5%	2.6%	1.9%	2.2%	1.9%	1.6%	1.5%	1.2%	2.1%	0.7%		
% Harm from Catheter Associated Urinary Tract Infection - Scarborough		x					x		2.4%	2.7%	4.3%	4.3%	5.6%	3.3%	4.1%	2.1%	4.0%	1.0%		
% Harm from Catheter Associated Urinary Tract Infection - Community		x					x		2.7%	0.9%	0.9%	1.0%	1.0%	0.0%	2.9%	1.0%	0.0%	1.8%		
% Harm from Catheter Associated Urinary Tract Infection - District Nurses		x					x		1.8%	1.2%	1.5%	0.8%	1.0%	0.2%	0.7%	0.6%	0.7%	0.6%		
Patient Safety Walkrounds					x		x													
Community Information	M	N	C	L	I	F	Q	Threshold	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Community Hospital Summary					x	x	x													
Maternity Dashboards	M	N	C	L	I	F	Q	Threshold												

Target Type*: M - Monitor; N - National; L - Local; C - CQUIN; I - Internal
Sub Group**: F - Finance and Performance; Q - Quality and Safety

York Teaching Hospital NHS
NHS Foundation Trust

Patient Safety and Quality
Executive Summary

The Trust SHMI for the period July 2013 to June 2014 is 102, which represents an increase. The Trust SHMI was 99 for the previous reporting period.

15 Serious Incidents (SIs) were declared in January and one Major Incident. Seven of the SIs were as a result of Category 3 pressure ulcers and one Category 4 pressure ulcer. There were also three patient falls wich resulted in serious injury.

No Never Events were reported.

Patient falls remains the most frequently reported incident category.

7 cases of toxin positive c. difficile were identified in January.

4 cases of MSSA bacteraemia were identifed in January.

0 cases of MRSA bacteraemia have been identifed.

Compliance with VTE risk assessment is 97%.

Compliance with dementia screening for patients admitted to hospital was 85.9% in January.

Overall performance with the Emergency Department 4 hour standard was 89.5% in January.

Diane Palmer
Deputy Director - Patient Safety

Mortality

York Teaching Hospital NHS
NHS Foundation Trust

Indicator	Apr 11 - Mar 12	Jul 11 - Jun 12	Oct 11 - Sep 12	Jan 12 - Dec 12	Apr 12 - Mar 13	July 12 - June 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14
SHMI – York locality	110	105	105	102	99	96	93	93	95	98
SHMI – Scarborough locality	115	117	112	106	108	108	104	105	107	108
SHMI – Trust	**112**	**108**	**107**	**104**	**102**	**101**	**97**	**98**	**99**	**102**

Definition
SHMI: The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England using a standard methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute NHS trusts in England and either die while in hospital or within 30 days of discharge.

RAMI: Risk Adjusted Mortality Index uses a methodology to calculate the risk of death for hospital patients on the basis of clinical and hospital characteristic data including age, sex, length of stay, method of admission, HRG, ICD10 primary and secondary diagnosis, OPCS primary and secondary procedures and discharge method. Unlike SHMI, it does not include deaths after discharge. The Trust is not managed externally on its RAMI score.

Analysis of Performance
The latest SHMI report for the period July 2013 to June 2014 indicates the Trust to be in the 'as expected' range. In January 2014 the York site saw a spike in the number of patient deaths which was outside normal range, this time period is contained in the latest SHMI release.

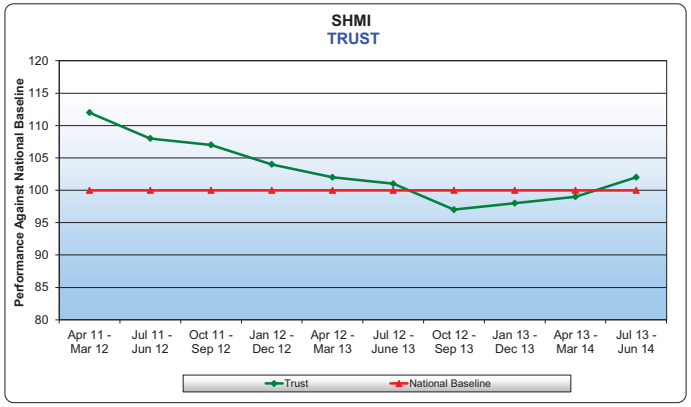
Analysis of SHMI categories is ongoing to identify differences between the York and Scarborough sites, together with any areas of ‘excess deaths’ where audits will be undertaken.

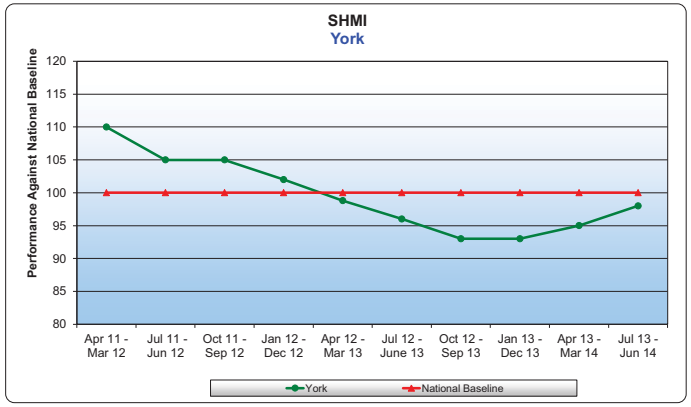
There has been a 5.3% increase in Deaths at York and Scarborough Hospitals for the period Apr-Jan 14/15 Vs. Apr-Jan 13/14 with deaths following a non-elective admission up 6%. Deaths following admission via Emergency Department are up 5.8% however this is mirrored in overall admissions via Emergency Department which are up 4.64%. Deaths following admission via GP up 12.6% however overall admissions via GP are up 12.5%.

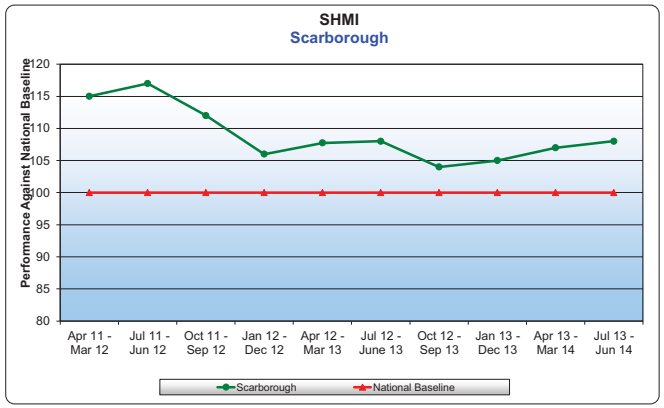
The Trust has seen the highest percentage increase in Apr-Dec 2013 & 2014 have been in those diagnosed with Other Bacterial Diseases, Hypertensive Diseases & those with Influenza & Pneumonia (based on ICD-10 diagnostic chapters with more than 50 deaths in Apr-Dec 2013 & 2014).

Mortality

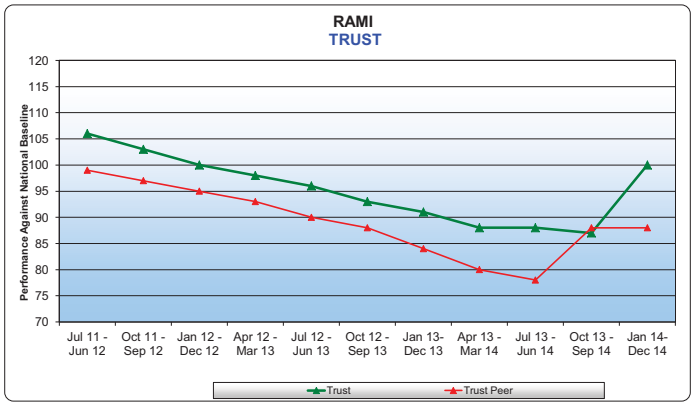
Indicator	Consequence of Breach (Monthly unless specified)	Jan 12 - Dec 12	Apr 12 - Mar 13	July 12 - June 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	104	102	101	97	98	99	102
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	102	99	96	93	93	95	98
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	106	108	108	104	105	107	108

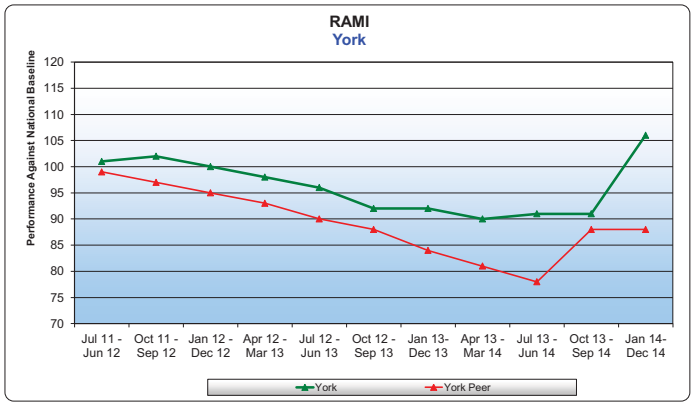


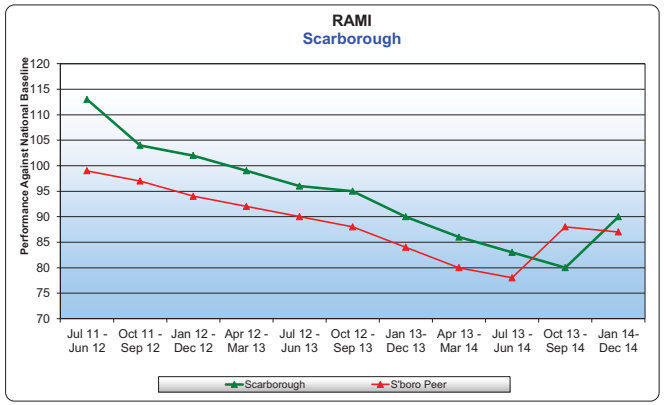




Indicator	Consequence of Breach (Monthly unless specified)	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Jul 13 - Jun 14
Mortality – RAMI (TRUST)	**none - monitoring only**	98	96	93	91	88	88	100
Mortality – RAMI (YORK)	**none - monitoring only**	98	96	92	92	90	91	106
Mortality – RAMI (SCARBOROUGH)	**none - monitoring only**	99	96	95	90	86	83	90

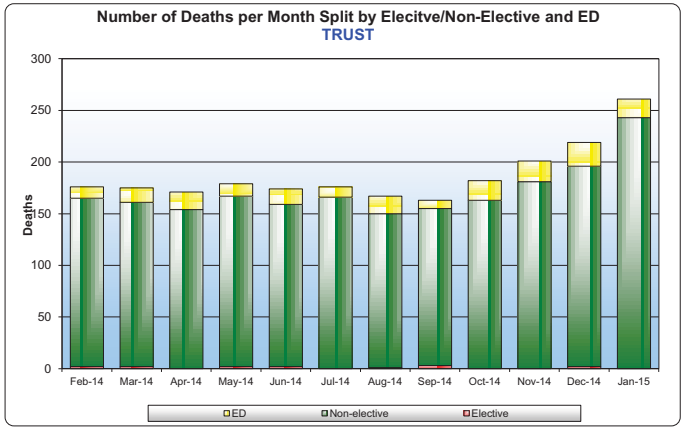


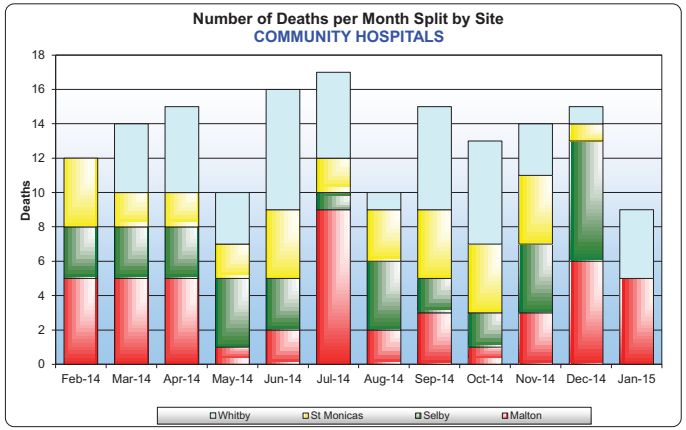




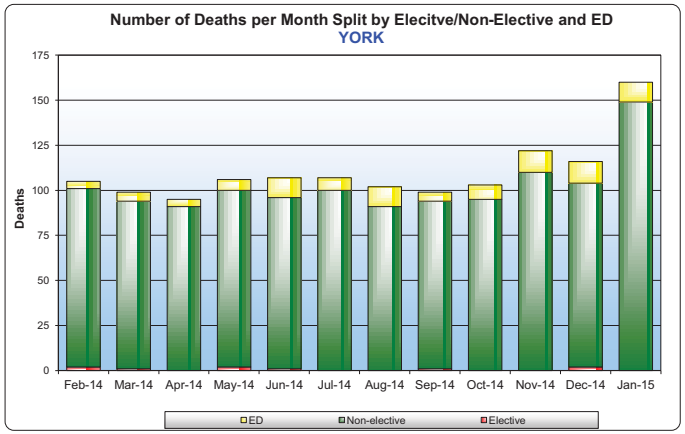
Mortality

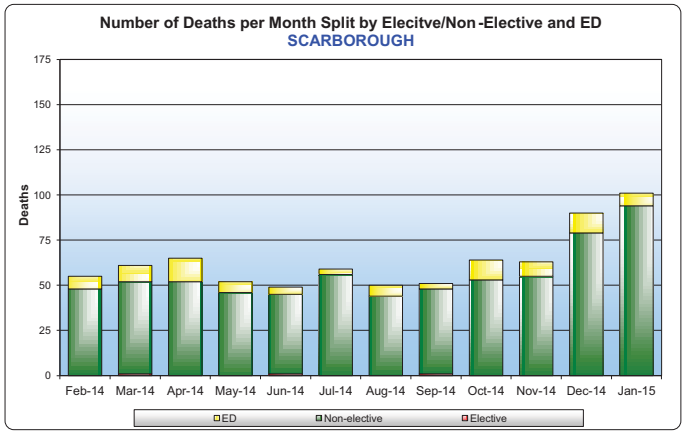
Indicator	Consequence of Breach (Monthly unless specified)	Q1	Q2	Q3	Nov	Dec	Jan
Number of Inpatient Deaths (excludes deaths in ED)	None - Monitoring Only	480	471	540	181	196	243

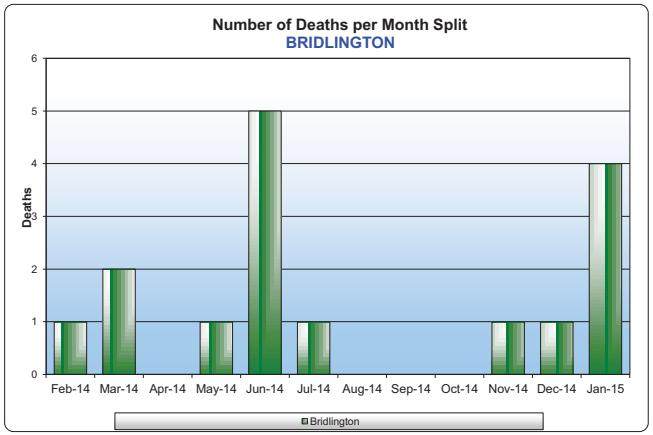




Month	Malton	Selby	St Monicas	Whitby	Bridlington
Feb-14	5	3	4	0	1
Mar-14	5	3	2	4	2
Apr-14	5	3	2	5	0
May-14	1	4	2	3	1
Jun-14	2	3	4	7	5
Jul-14	9	1	2	5	1
Aug-14	2	4	3	1	0
Sep-14	3	2	4	6	0
Oct-14	1	2	4	6	0
Nov-14	3	4	4	3	1
Dec-14	6	7	1	1	1
Jan-15	5	0	0	4	4







Litigation

Indicator	Site	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Clinical Claims Settled	York	4	0	2	1	3	1	5	1	2
	Scarborough	0	2	3	1	4	0	1	0	1

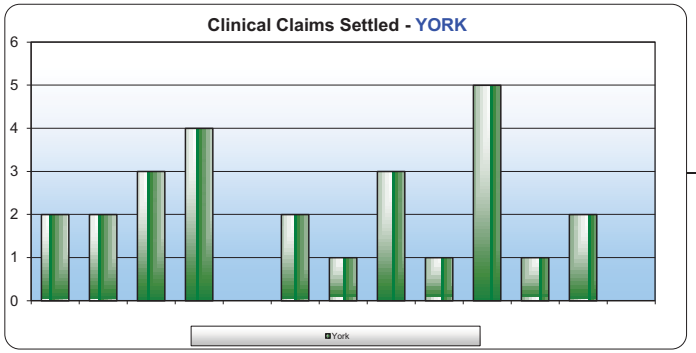
Two clinical claims attributed to York and one clinical claim attributed to Scarborough was settled in January.

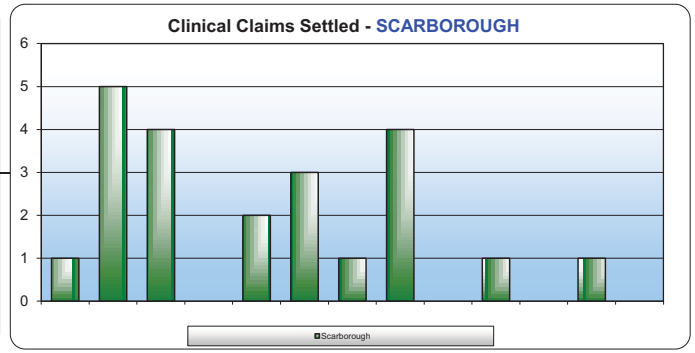
In January, eight clinical negligence claims for York site were received and four were received for Scarborough. York had two withdrawn/closed claims and there were eleven from Scarborough.

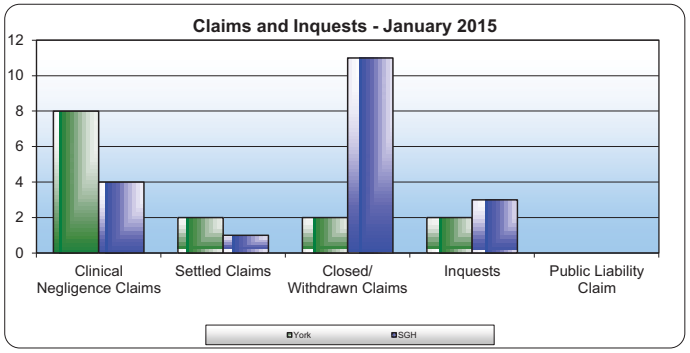
There were five Coroner's Inquests heard in January; two York and three Scarborough.

Litigation

Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Clinical Claims Settled	York	2	2	3	4	0	2	1	3	1	5	1	2
source: Risk and Legal	Scarborough	1	5	4	0	2	3	1	4	0	1	0	1







Themes for Clinical Claims Settled 01 Jan 2012 to 30 Sept 2014

Incident Type	Total Damaged	Total Number Reported	Number (York)	Number (Scarborough)
Failure to refer to other specialty	£2,047,500	4	4	0
failure to investigate further	£1,344,590	16	6	10
Delay in treatment	£1,265,000	3	1	2
Inadequate surgery	£1,249,316	14	6	8
Lack of appropriate treatment	£387,868	7	2	5
Inappropriate discharge	£333,000	4	1	3
Inadequate examination	£210,847	6	3	3
Failure to adequately interpret radiology	£107,613	11	6	5
Inadequate nursing care	£88,500	9	5	4
Not Known	£60,000	3	0	3
Inadequate procedure	£58,880	4	2	2
Results not acted upon	£49,500	7	6	1
Inadequate interpretation of cervical smear	£37,500	1	1	0
Intraoperative burn	£30,000	4	3	1
Anaesthetic error	£27,500	1	1	0
Inadequate consent	£26,500	3	2	1
Failure to retain body part	£25,000	1	1	0
Lack of risk assessment/action in relation to fall	£24,250	2	2	0
Prescribing error	£22,500	2	2	0
Failure to act on CTG	£13,500	1	1	0
Lack of risk assessment/action in relation to pressure ulcer	£7,000	1	1	0
Maintenance of equipment	£5,000	1	1	0

Patient Experience

Complaints
Complaints registered in York relate to York Hospital and Community Services.
Complaints registered in Scarborough relate to Scarborough Hospital and Bridlington Hospital.
There were 23 new complaints registered to the York site and 16 to the Scarborough site in January.

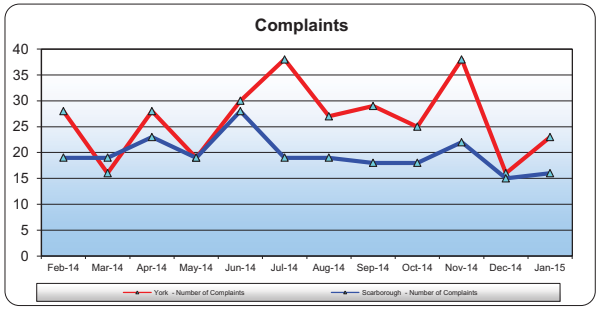
PALS contacts
There were 461 PALS enquiries at York Hospital and 159 PALS enquiries at Scarborough in January. The highest number of contacts were in the category "requests for information and advice", however of note are 66 contacts in the 'compliment/thanks" category.

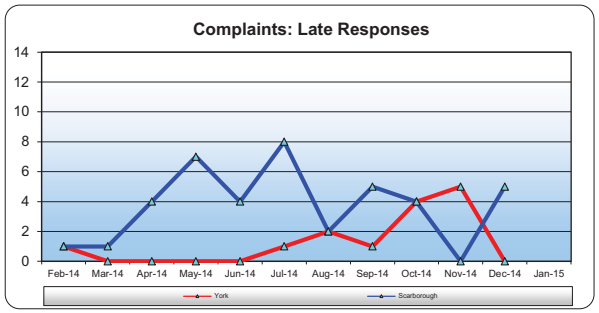
New Ombudsman Cases
Not available due to remapping of reporting system.

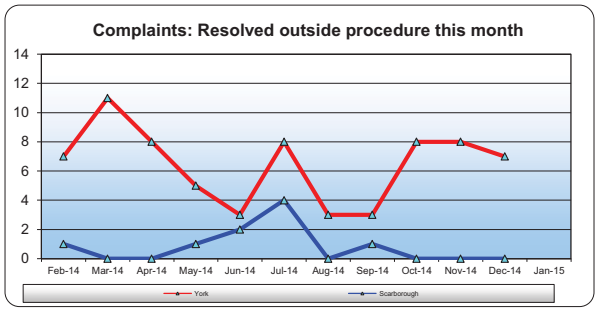
Complaints – Late Responses
Not available due to remapping of reporting system.

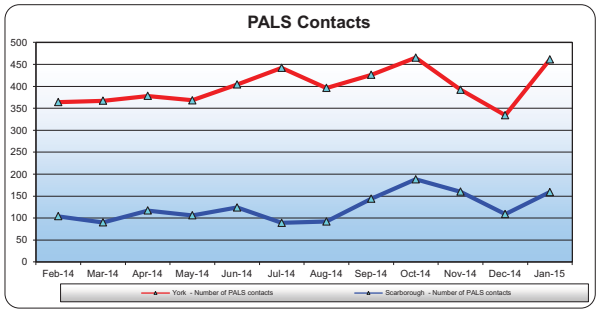
Patient Experience

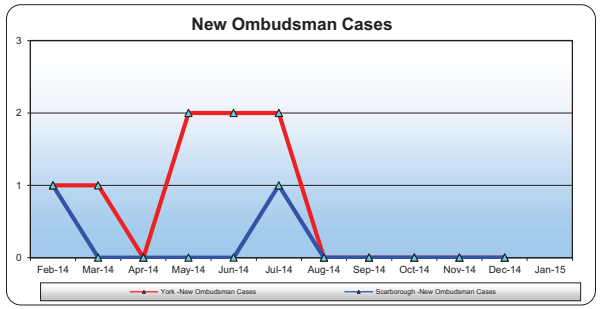
Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Complaints	York	28	16	28	19	30	38	27	29	25	38	16	23
	Scarborough	19	19	23	19	28	19	19	18	18	22	15	16
PALS contacts	York	364	367	378	368	404	442	396	426	465	392	334	461
	Scarborough	104	90	117	106	124	89	92	144	188	160	109	159
New Ombudsman Cases	York	1	1	0	2	2	2	0	0	0	0	0	Not Available
	Scarborough	1	0	0	0	0	1	0	0	0	0	0	Not Available
Complaints - Late Responses	York	1	0	0	0	0	1	2	1	4	5	0	Not Available
	Scarborough	1	1	4	7	4	8	2	5	4	0	5	Not Available
Complaints - Resolved outside procedure this month	York	7	11	8	5	3	8	3	3	8	8	7	Not Available
	Scarborough	1	0	0	1	2	4	0	1	0	0	0	Not Available











Patient Experience

January 2015

Complaints by Directorate/Division (Datix)	York	S'boro	Total
Child Health (Y)	0	0	0
Clinical Support Services (S)	0	0	0
Community Services (Y)	1	0	1
Corporate (Y,S)	0	0	0
Elderly Medicine (Y)	2	2	4
Emergency Medicine (Y)	4	5	9
Facilities (Y,S)	1	0	1
General Surgery and Urology (Y), Surgery (S)	3	1	4
Head and Neck and Ophthalmology (Y)	1	1	2
Medicine (General and Acute, Y), Medicine (S)	2	1	3
Obstetrics and Gynaecology (Y)	2	0	2
Operations (Y)	0	0	0
Orthopaedics (Y)	2	0	2
Pharmacy (Y)	0	0	0
Physiotherapy (Y)	0	0	0
Radiology (Y)	2	1	3
Sexual Health (Y)	0	0	0
Specialist Medicine (Y)	4	2	6
Theatres Anaesthetics and CC(Y)	0	2	2
Total	24	15	39

Complaints by Subject (Datix)	York	S'boro	Total
Admissions, discharge and transfer arrangements	1	1	2
Aids, appliances, equipment, premises	0	0	0
All aspect of clinical treatment	14	7	21
Appointment delay/cancellation (inpatient)	1	1	2
Appointments delay/cancellation (outpatient)	1	0	1
Attitude of staff	5	5	10
Communication/information to patients (written and oral)	1	1	2
Complaints handling	0	0	0
Consent to treatment	0	0	0
Failure to follow agreed procedure	0	0	0
Hotel services, including food	0	0	0
Mortuary and post mortem arrangements	0	0	0
Other	0	0	0
Patients' privacy and dignity	0	1	1
Patients' property and expenses	0	0	0
Patients' status, discrimination	0	0	0
Personal records	0	0	0
Policy and commercial decision of Trust	0	0	0
Total	23	16	39

PALS Contact by Subject	York	S'boro	Total
Action Plan	6	0	6
Admissions, discharge, transfer arrangements	22	6	28
Aids / appliances / equipment	2	0	2
Appointments, delay/cancellation (inpatient)	23	5	28
Appointments, delay/cancellation (outpatient)	32	15	47
Staff attitude	15	4	19
Any aspect of clinical care/treatment	41	36	77
Communication issues	49	19	68
Compliment / thanks*	66	0	66
Alleged discrimination (eg racial, gender, age)	1	0	1
Environment / premises / estates	3	8	11
Failure to follow agreed procedure (inc. consent)	3	0	3
Hotel services (including cleanliness, food)	0	0	0
Requests for information and advice	140	49	189
Medication	2	0	2
NCMP	0	0	0
Other	0	0	0
Car parking	6	4	10
Privacy and dignity	0	0	0
Property and expenses	19	8	27
Personal records / Medical records	8	0	8
Safeguarding issues	2	0	2
Signer	4	0	4
Support (eg benefits, social care, vol agencies)	3	0	3
Patient transport	14	5	19
Welfare benefits	0	0	0
Total	461	159	620

PALS themes this month, eg staff attitude, increased numbers in an area, topics (Y,S)
a) 22 issues relating to transfer and discharge arrangements
b) 18 waiting list issues. Scheduled for procedures and then cancelled
c) 15 issues relating to staff attitude
d) 5 cancelled operations
e) 36 treatment

Friends and Family

Indicator		Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Inpatients – York	York IP Response Rate	Q4: 40% Combined	29.2%	31.4%	34.5%	39.0%	36.1%	31.7%	34.9%	39.4%	35.1%	32.9%
Inpatients – Scarborough	Scarborough IP Response Rate		30.9%	29.3%	27.4%	40.1%	44.4%	43.1%	39.5%	50.0%	37.9%	41.2%
Inpatients - Bridlington	Bridlington IP Response Rate		73.5%	82.0%	60.8%	86.0%	71.1%	83.6%	72.3%	77.2%	85.9%	77.0%
Inpatients – Combined	**Trust IP Response Rate**		**31.3%**	**33.9%**	**34.2%**	**41.7%**	**40.2%**	**37.6%**	**38.2%**	**44.1%**	**38.4%**	**37.7%**
ED – York	York ED Response Rate	Q4: 20% Combined	10.5%	14.6%	27.1%	14.5%	9.4%	8.5%	9.6%	15.4%	14.2%	14.8%
ED - Scarborough	Scarborough ED Response Rate		34.8%	33.1%	45.2%	35.9%	36.8%	31.5%	27.4%	32.7%	19.1%	28.2%
ED – Combined	**Trust ED Response Rate**		**19.5%**	**21.6%**	**33.9%**	**22.8%**	**20.0%**	**16.7%**	**15.9%**	**21.5%**	**16.0%**	**19.3%**
Maternity – Antenatal		None	41.3%	33.6%	26.0%	27.7%	33.1%	37.2%	39.8%	42.8%	32.2%	30.6%
Maternity – Labour and Birth			44.1%	33.3%	32.9%	19.4%	16.2%	20.4%	17.2%	39.7%	15.8%	19.9%
Maternity – Post Natal			47.0%	39.2%	37.5%	24.8%	20.9%	29.4%	26.5%	47.1%	19.4%	27.9%
Maternity – Community			34.2%	37.2%	24.7%	21.1%	22.7%	17.2%	19.5%	18.4%	18.2%	21.3%

The FFT Steering Group and project workstreams continue to meet and take forward the implementation and development of FFT across the Trust. The focus for the Trust, in addition to roll out is to ensure that the qualitative feedback gained through FFT is used effectively to inform patients of what the Trust is doing to improve their experience of our Services.

Attention is now being focussed on ensuring the Trust achieves the CQUIN target of 20% response rate target in ED over Q4. The response rate increased on both sites in January; achieving a combined percentage of 19.3%, very close the end of Q4 target. Text messaging began in Scarborough ED during January and it is hoped that this will have a positive impact on the achievement of this target.

The Trust achieved 37.7% against the Inpatient target, which is a small reduction from December performance. The CQUINS requirement is to achieve 40% across inpatients in March 2015.

The focus for the Trust is ensuring we get back on target and to also to ensure the Trust uses the valuable qualitative feedback received from patients.

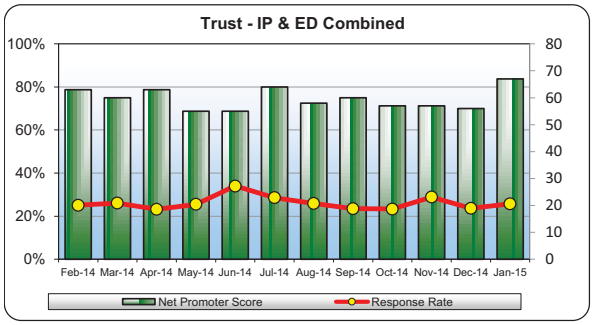
The Trust achieved 8% during Q1 and Q2 for Staff Friends and Family. Staff Friends and Family Q3 figures are awaited with a national reporting deadline of the 3rd of March.

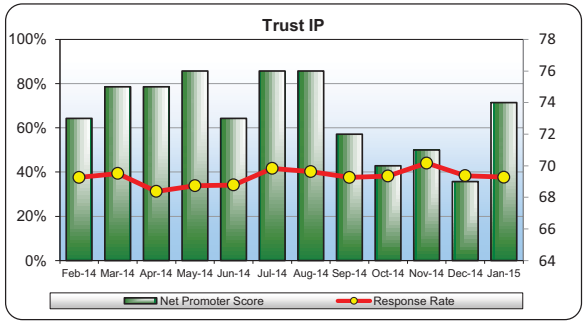
Friends & Family: Inpatients & ED

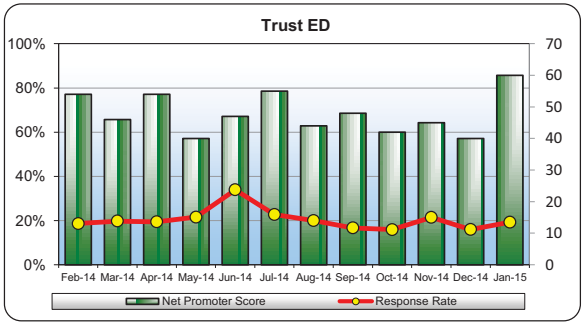
The Friends & Family Test (FFT) has now been rolled out across the Trust, with all adult inpatients, those attending ED and women accessing maternity services being asked the question; "would you recommend this ward/ED/antenatal/labour and postnatal service to your family & friends?". The Trust achieved CQUIN requirements for Q4 and now focuses on the 2014/15 requirements for increased response rate in ED and Inpatients; roll out to community hospital inpatients, all outpatients, day cases and community services. The FFT Steering Group and project workstreams continue to meet and take forward the implementation and development of FFT across the Trust. The focus for the Trust, in addition to roll out is to ensure that the qualitative feedback gained through FFT is used effectively to inform patients of what the Trust is doing to improve their experience of our Services.

	2013-14			2014-15		
	Q2	Q3	Q4	Q1	Q2	Q3
Combined IP & ED Response Rate	20.0%	30.4%	25.8%	27.6%	26.1%	25.2%

		Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Trust	Response Rate	25.1%	26.1%	23.2%	25.5%	34.0%	28.6%	25.9%	23.5%	23.3%	28.9%	23.7%	25.7%
	Net Promoter Score	63	60	63	55	55	64	58	60	57	57	56	67

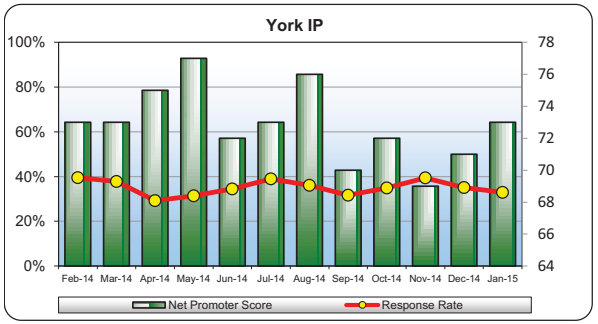


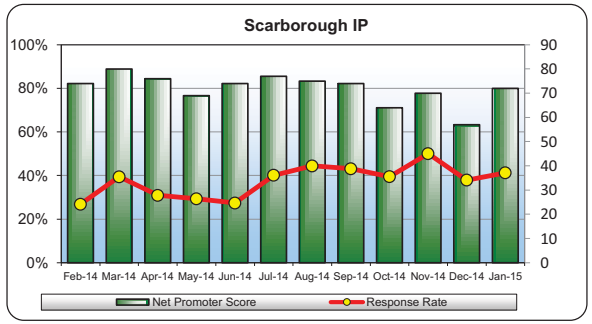


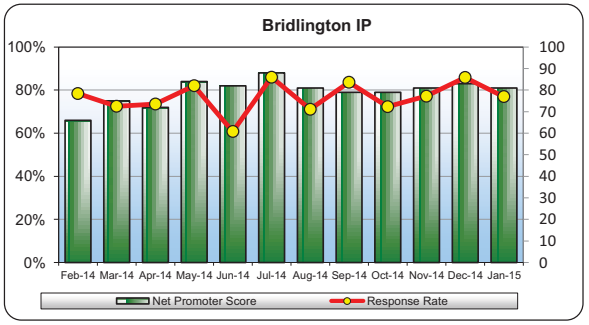


Inpatient Performance

		Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
York IP	Response Rate	39.5%	37.8%	29.2%	31.4%	34.5%	39.0%	36.1%	31.7%	34.9%	39.4%	35.1%	32.9%
	Net Promoter Score	73	73	75	77	72	73	76	70	72	69	71	73
Sboro IP	Response Rate	26.8%	39.4%	30.9%	29.3%	27.4%	40.1%	44.4%	43.1%	39.5%	50.0%	37.9%	41.2%
	Net Promoter Score	74	80	76	69	74	77	75	74	64	70	57	72
Brid IP	Response Rate	78.4%	72.5%	73.5%	82.0%	60.8%	86.0%	71.1%	83.6%	72.3%	77.2%	85.9%	77.0%
	Net Promoter Score	66	75	72	84	82	88	81	79	79	81	83	81
Combined	Response Rate	37.6%	39.4%	31.3%	33.9%	34.2%	41.7%	40.2%	37.6%	38.2%	44.1%	38.4%	37.7%
	Net Promoter Score	73	75	75	76	73	76	76	72	70	71	69	74



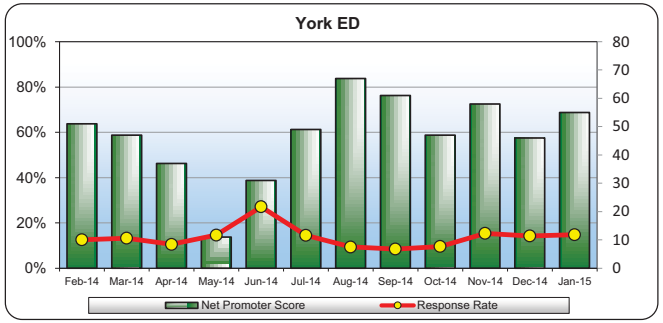


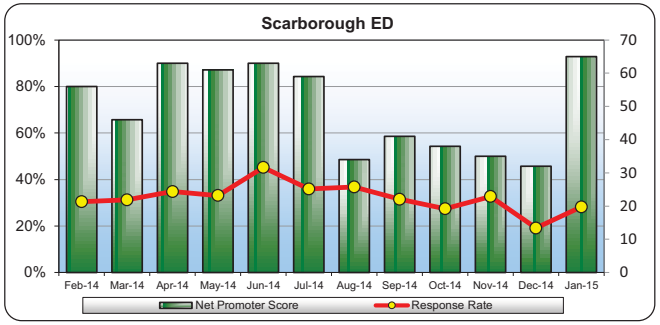


Friends & Family: Inpatients & ED

ED Performance

		Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
York ED	Response Rate	12.6%	13.2%	10.5%	14.6%	27.1%	14.5%	9.4%	8.5%	9.6%	15.4%	14.2%	14.8%
	Net Promoter Score	51	47	37	11	31	49	67	61	47	58	46	55
Sboro ED	Response Rate	30.4%	31.3%	34.8%	33.1%	45.2%	35.9%	36.8%	31.5%	27.4%	32.7%	19.1%	28.2%
	Net Promoter Score	56	46	63	61	63	59	34	41	38	35	32	65
Combined	Response Rate	18.7%	19.8%	19.5%	21.6%	33.9%	22.8%	20.0%	16.7%	15.9%	21.5%	16.0%	19.3%
	Net Promoter Score	54	46	54	40	47	55	44	48	42	45	40	60





Responses

Inpatient		Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
York IP	Eligible	1985	2092	2003	2182	2153	2187	1930	2123	2313	2110	2210	2065
	Responses	783	791	584	686	748	852	696	672	808	831	775	680
Sboro IP	Eligible	764	869	872	830	810	895	855	917	912	816	866	782
	Responses	205	342	269	243	222	359	380	395	360	408	328	322
Brid IP	Eligible	111	98	113	194	166	164	142	165	188	158	163	183
	Responses	87	71	83	159	101	141	101	138	136	122	140	141
Combined	Eligible	2860	3059	2988	3206	3129	3246	2927	3205	3413	3084	3239	3030
	Responses	1075	1204	936	1088	1071	1352	1177	1205	1304	1361	1243	1143

ED		Feb-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
York ED	Eligible	3697	4118	4079	4356	4283	4451	4305	4265	4418	4131	4003	3750
	Responses	465	545	429	636	1162	647	404	362	426	636	570	554
Sboro ED	Eligible	1915	2343	2388	2614	2580	2793	2712	2346	2379	2240	2195	1939
	Responses	583	733	831	866	1167	1003	998	739	652	732	419	546
Combined	Eligible	5612	6461	6467	6970	6863	7244	7017	6611	6797	6371	6198	5689
	Responses	1048	1278	1260	1502	2329	1650	1402	1101	1078	1368	989	1100

Wards with high % response rates

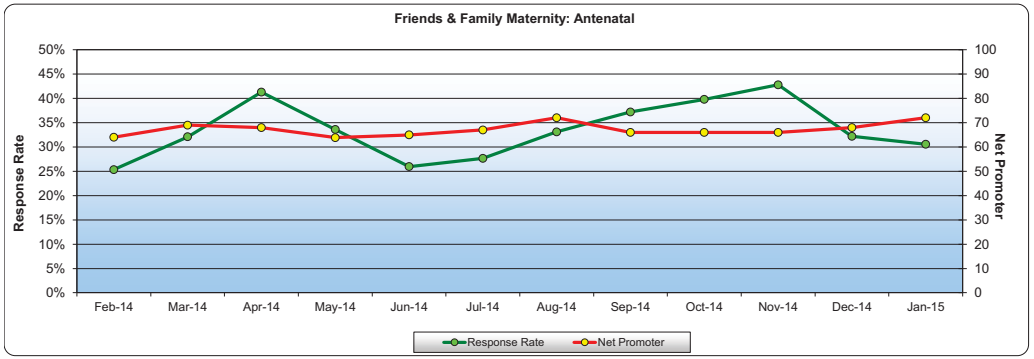
York	Ward 23 - 56.6%
	Ward 11- 48.7%
Scarborough	CCU - 95.7%
	Ann Wright - 100%
Bridlington	Johnson- 79.2%

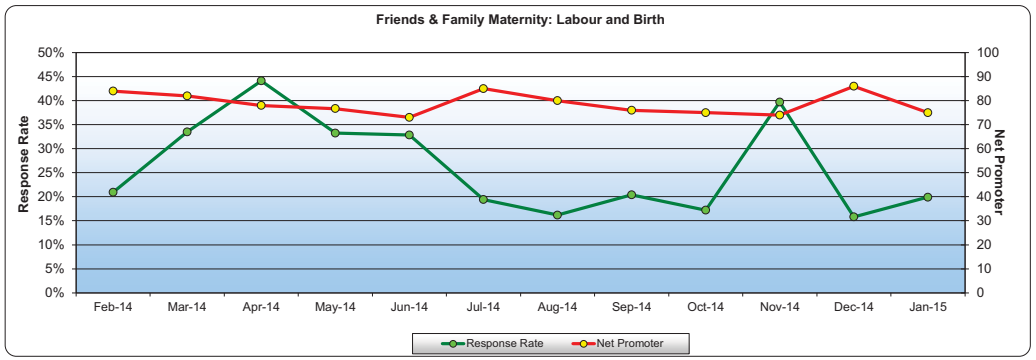
Wards with low % response rates

York	Ward 24 - 4.3%
Scarborough	Maple - 4.6%

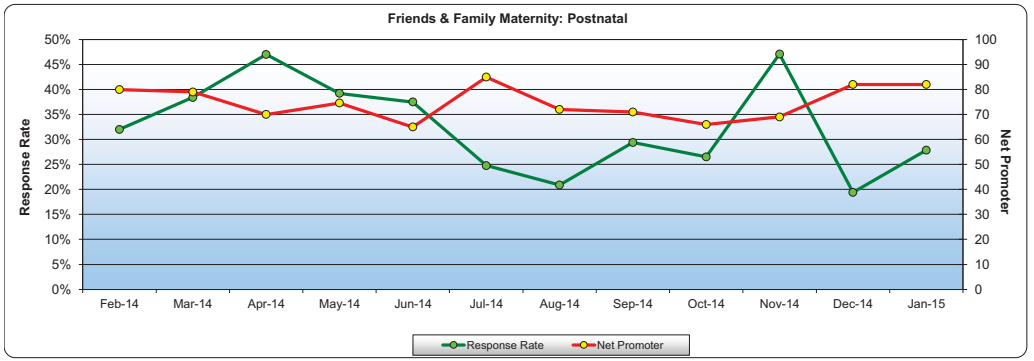
Friends & Family: Maternity

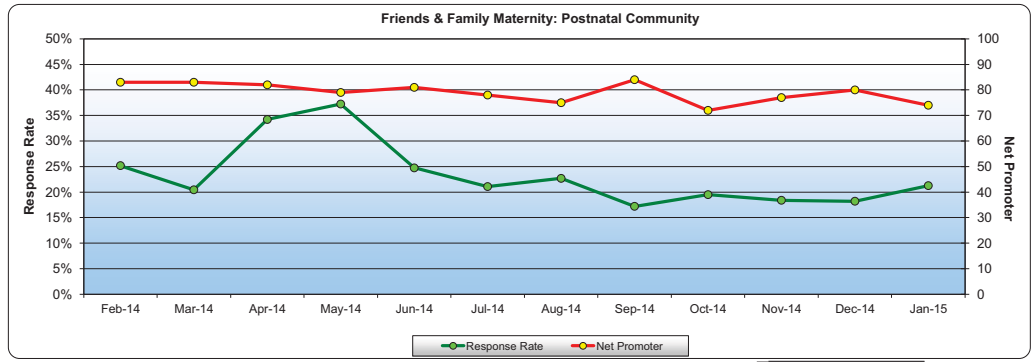
Indicator	Consequence of Breach (Monthly)	Threshold	Q1	Q2	Q3	Nov	Dec	Jan
Antenatal Response Rate	None - Monitoring Only	**none**	33.6%	32.4%	38.3%	42.8%	32.2%	30.6%
Antenatal Net Promoter	None - Monitoring Only	**none**	66	68	67	66	68	72
Labour and Birth Response Rate	None - Monitoring Only	**none**	36.4%	18.6%	23.5%	39.7%	15.8%	19.9%
Labour and Birth Net Promoter	None - Monitoring Only	**none**	76	80	77	74	86	75





Postnatal Response Rate	None - Monitoring Only	**none**	41.1%	24.8%	30.6%	47.1%	19.4%	27.9%
Postnatal Net Promoter	None - Monitoring Only	**none**	70	76	71	69	82	82
Postnatal Community Response Rate	None - Monitoring Only	**none**	31.6%	20.0%	18.7%	18.4%	18.2%	21.3%
Postnatal Community Net Promoter	None - Monitoring Only	**none**	81	79	76	77	80	74



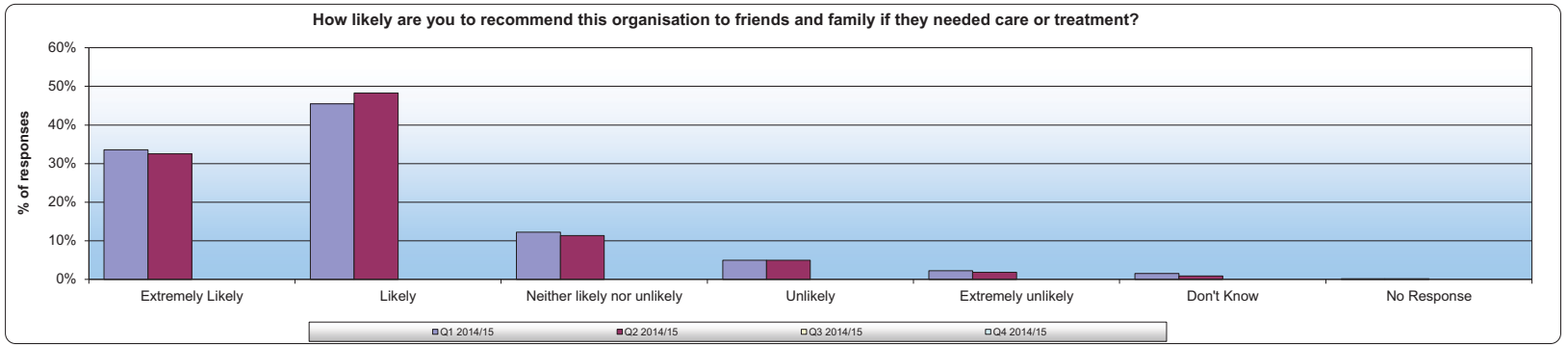


Friends and Family: Staff

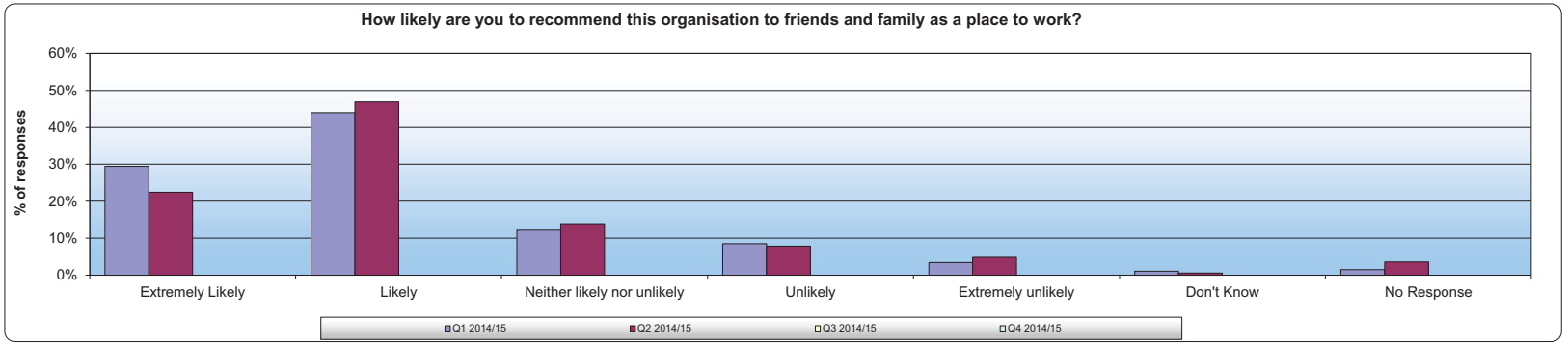
York Teaching Hospital NHS
NHS Foundation Trust

As part of the National Friends and Family CQUIN 2014/15, the Trust is required to submit evidence which demonstrates implementation of staff FFT across all Acute and Community areas.
So far in Quarter 1 & 2 responses have been collected from staff via an online survey or paper survey.

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual
Response rate - Proportion of Trust employees who responded to the survey	None - Monitoring Only	**none**	**8%**	**8%**	**Not Available**	
Number of Trust employees who responded to the survey	None - Monitoring Only	**none**	**673**	**704**	**Not Available**	



How likely are you to recommend this organisation to friends and family if they needed care or treatment?							
Quarter	**Extremely Likely**	**Likely**	**Neither likely nor unlikely**	**Unlikely**	**Extremely unlikely**	**Don't Know**	**No Response**
Q1 2014/15	33.6%	45.5%	12.2%	4.9%	2.2%	1.5%	0.1%
Q2 2014/15	32.5%	48.3%	11.4%	5.0%	1.8%	0.9%	0.1%
Q3 2014/15	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Q4 2014/15							



How likely are you to recommend this organisation to friends and family as a place to work?							
Quarter	**Extremely Likely**	**Likely**	**Neither likely nor unlikely**	**Unlikely**	**Extremely unlikely**	**Don't Know**	**No Response**
Q1 2014/15	29.4%	44.0%	12.2%	8.5%	3.4%	1.0%	1.5%
Q2 2014/15	22.4%	46.9%	13.9%	7.8%	4.8%	0.6%	3.6%
Q3 2014/15	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Q4 2014/15							

Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 15 SIs reported in January:
12 hour breach; 2 incidents resulting in 7 breaches (York)
Delay in Diagnosis; 1 (York)
Slips Trips Falls 4; 2 (York), 2 (Scarborough)
Pressure Ulcers 8; 5 (York), 3 (Community)

Patients Falls and Found on Floor (source: Datix)
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During December there were 131 reports of patients falling at York Hospital, 71 patients at Scarborough and 12 patients within the Community Services. This is an increase from the number reported in November but remains comparable with previous months. These figures may increase as more investigations are completed. January data is unavailable due to remapping of reporting system.

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during January was 1,236; 727 incidents were reported on the York site, 409 on the Scarborough site and 100 from Community Services. This is a 10% decrease from December.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 1444incidents awaiting sign-off by the Directorate Management Teams. Risk and Legal are working with the Directorates to facilitate the timely completion of incident investigations.

Pressure Ulcers (source: Datix)
During December 10 pressure ulcers were reported to have developed on patients since admission to York Hospital and 6 pressure ulcers were reported to have developed on patients since admission to Scarborough Hospital. This is a reduction against previous months. In addition, during December there were no pressure ulcers reported as having developed on patients in our community hospitals or community care.
These figures should be considered as approximations as not all investigations have been completed.
January data is unavailable due to remapping of reporting system.

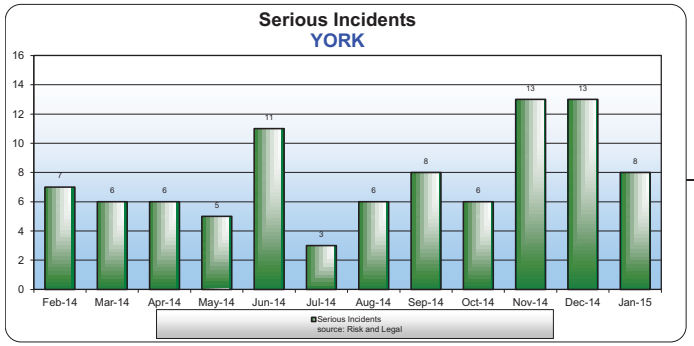
Degree of Harm: Serious/Severe or Death (source: Datix)
During January a total of 10 patient incidents were reported which resulted in serious or severe harm with zero resulting in death.

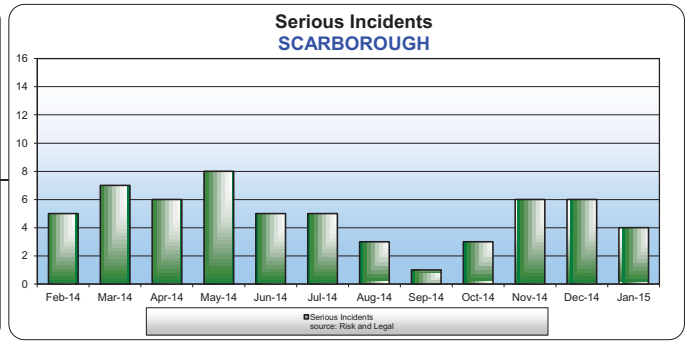
Medication Related Issues (source: Datix)
During January there was a total of 107 medication related incidents reported, although this figure may change following validation. A change of recording was made in December to improve capture of Medication Related Issues.

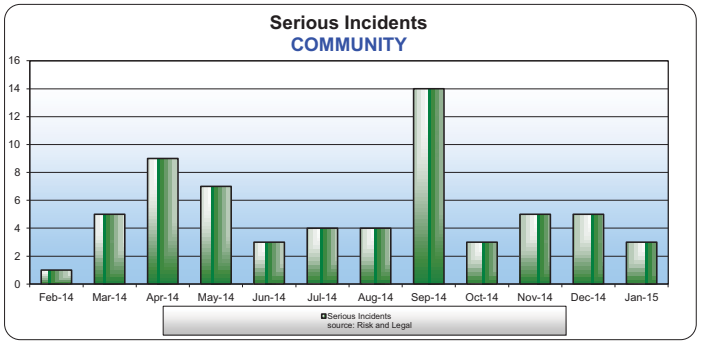
Never Events - none

Measures of Harm

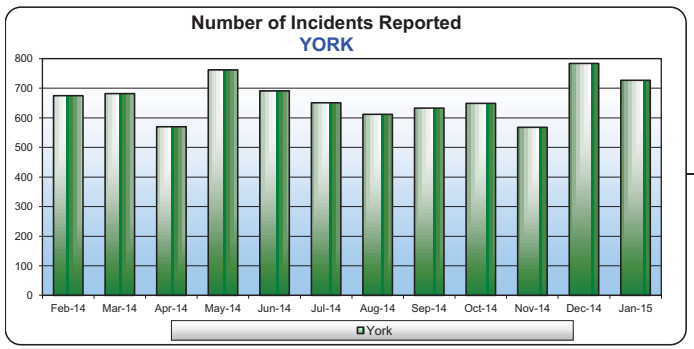
Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Serious Incidents source: Risk and Legal	York	7	6	6	5	11	3	6	8	6	13	13	8
	Scarborough	5	7	6	8	5	5	3	1	3	6	6	4
	Community	1	5	9	7	3	4	4	14	3	5	5	3

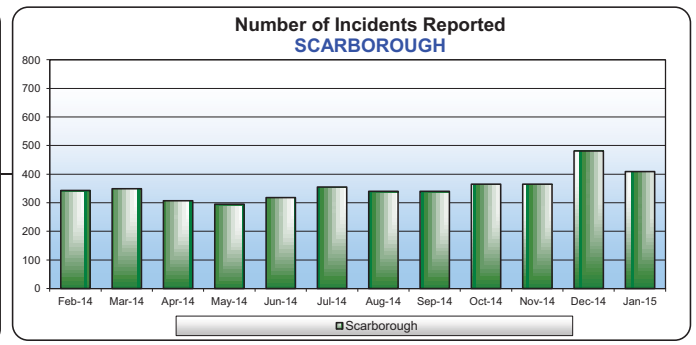


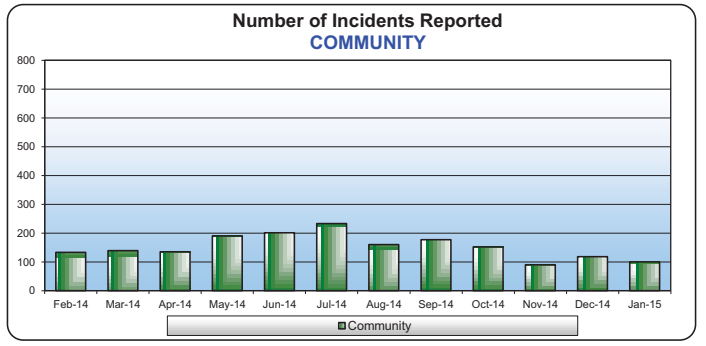




Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Number of Incidents Reported source: Risk and Legal	York	675	682	570	762	691	651	612	633	649	568	784	727
	Scarborough	343	349	307	295	318	355	340	340	365	365	481	409
	Community	133	139	135	190	201	233	160	177	152	90	118	100
Number of Incidents Awaiting sign off at Directorate level		1145	1286	1240	1394	1877	-	1870	1497	1408	858	272	1444

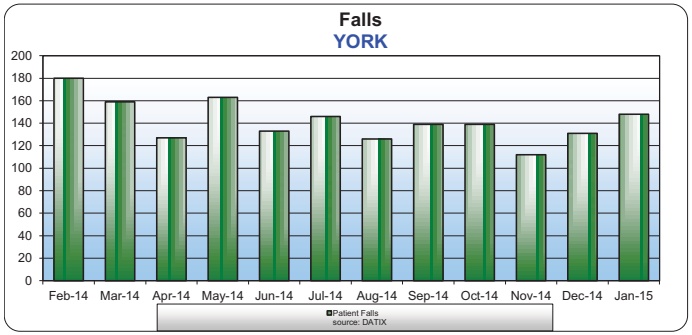


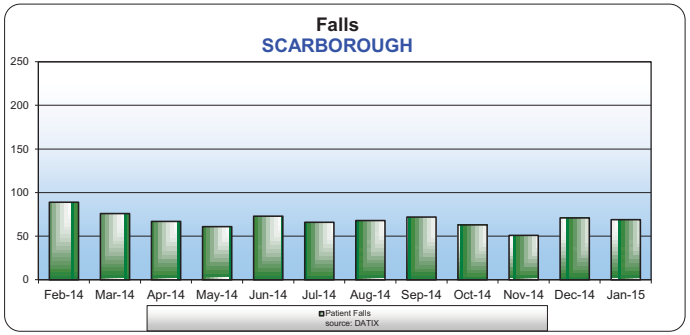


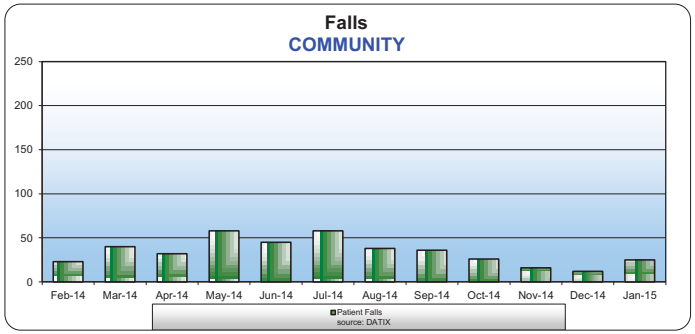


Measures of Harm

Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Patient Falls source: DATIX	York	180	159	127	163	133	146	126	139	139	112	131	148
	Scarborough	89	76	67	61	73	66	68	72	63	51	71	69
	Community	23	40	32	58	45	58	38	36	26	16	12	25

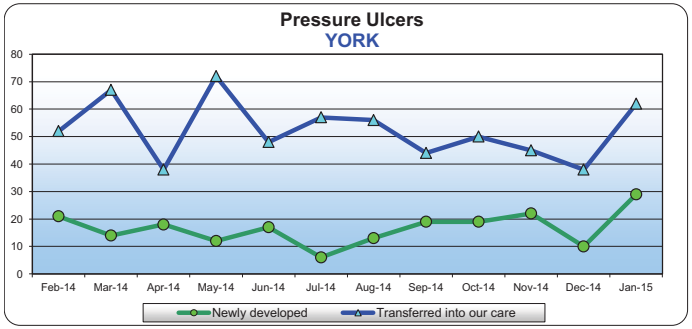


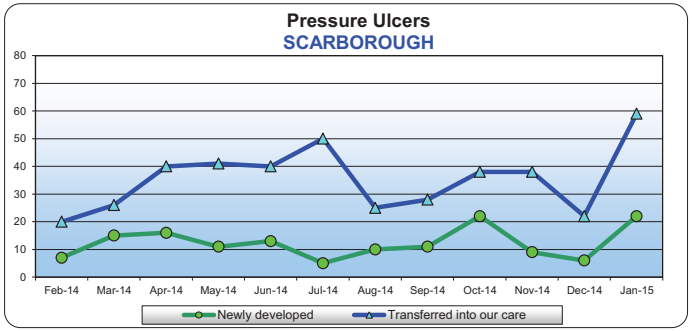


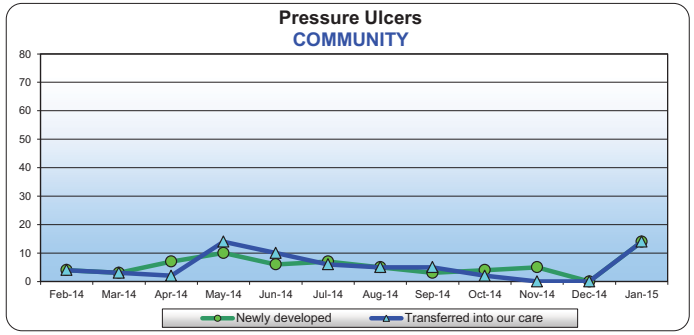


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Indicator			Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Pressure Ulcers source: DATIX	York	Newly developed	21	14	18	12	17	6	13	19	19	22	10	29
		Transferred into our care	52	67	38	72	48	57	56	44	50	45	38	62
	Scarborough	Newly developed	7	15	16	11	13	5	10	11	22	9	6	22
		Transferred into our care	20	26	40	41	40	50	25	28	38	38	22	59
	Community	Newly developed	4	3	7	10	6	7	5	3	4	5	0	14
		Transferred into our care	4	3	2	14	10	6	5	5	2	0	0	14



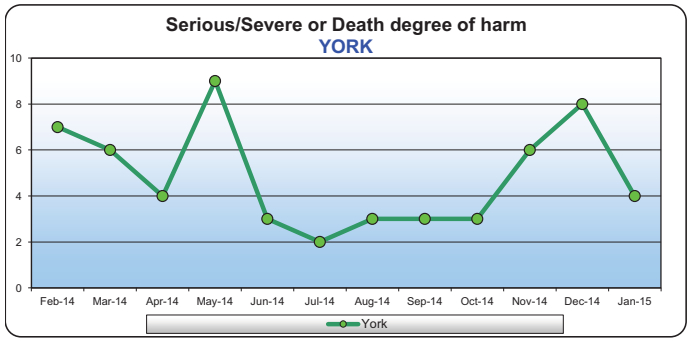


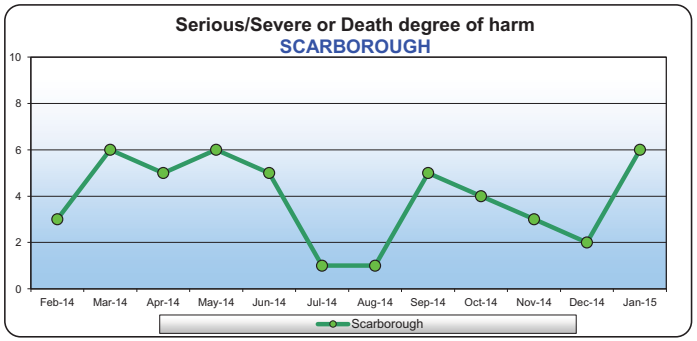


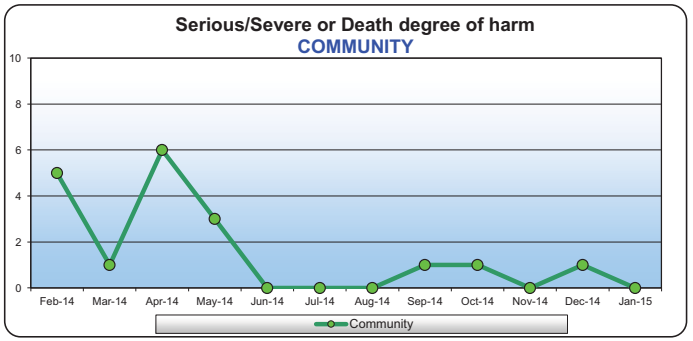
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised as a 'Deterioration of a previously reported ulcer'.

Measures of Harm

Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Degree of harm: serious/severe or death source: Datix	York	7	6	4	9	3	2	3	3	3	6	8	4
	Scarborough	3	6	5	6	5	1	1	5	4	3	2	6
	Community	5	1	6	3	0	0	0	1	1	0	1	0

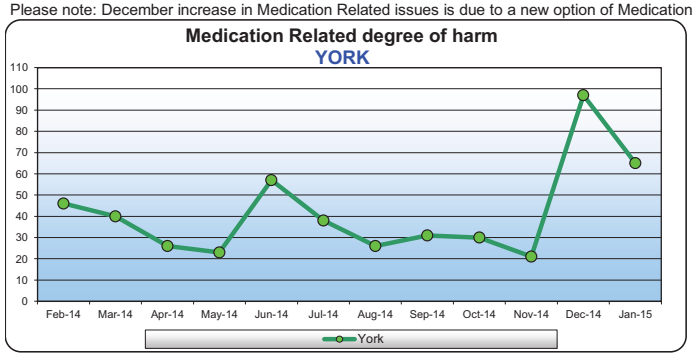


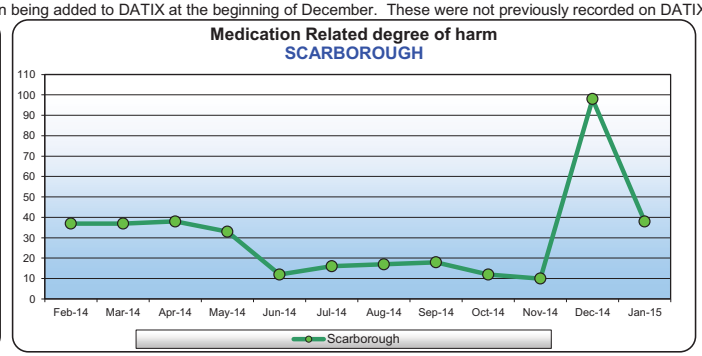


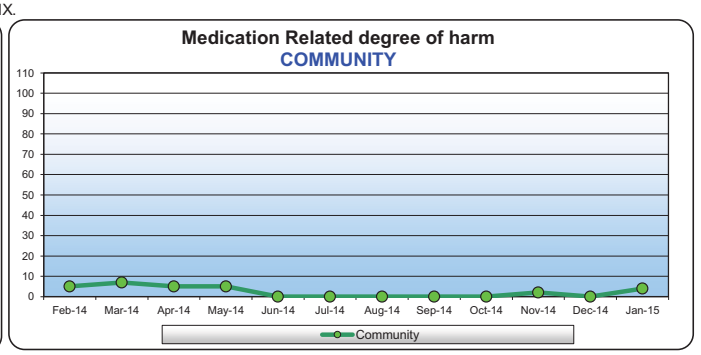


Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Degree of harm: Medication Related Issues source: Datix	York	46	40	26	23	57	38	26	31	30	21	97	65
	Scarborough	37	37	38	33	12	16	17	18	12	10	98	38
	Community	5	7	5	5	0	0	0	0	0	2	0	4

Please note: December increase in Medication Related issues is due to a new option of Medication being added to DATIX at the beginning of December. These were not previously recorded on DATIX.

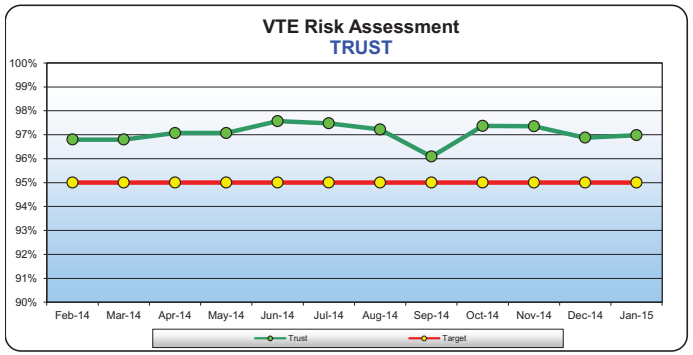


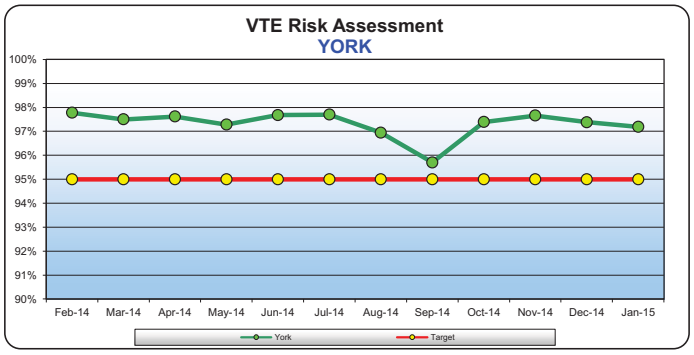


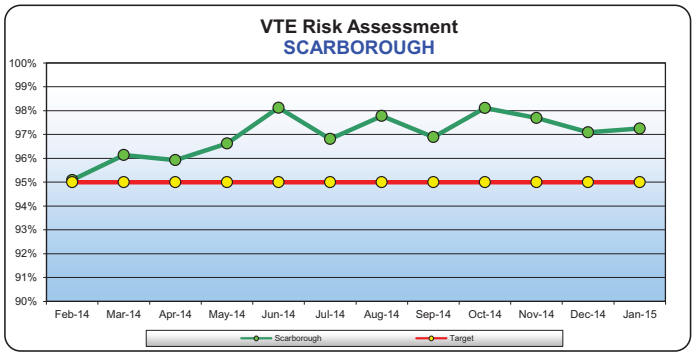


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q1	Q2	Q3	Nov	Dec	Jan
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance source: CPD	£200 in respect of each excess breach above threshold	Trust	90%	97.2%	96.9%	97.1%	97.4%	96.9%	97.0%
		York	90%	97.7%	96.8%	97.4%	97.7%	97.4%	97.2%
		Scarborough	90%	96.8%	97.2%	97.6%	97.7%	97.1%	97.3%







Drug Administration

Insulin Errors
There were 11 insulin related errors reported at York and Communities, and 3 at Scarborough/Bridlington in November. December and January figures not yet available due to remapping of the reporting system.

Omitted Critical Medicines
The audit of critical medicines missed during January indicated 3.8% for Scarborough, 1.15% for York and 0% for Community Hospitals.

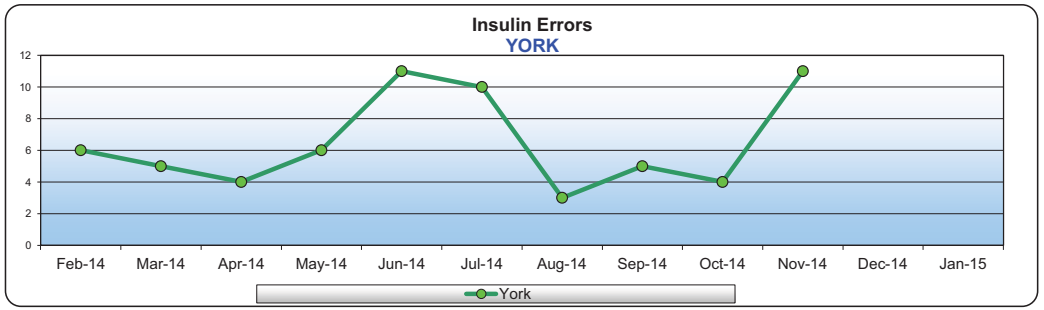
Prescribing Errors
There were 20 prescribing related errors in November; 5 from Scarborough, 13 from York and 2 from Community. December and January figures not yet available due to remapping of the reporting system.

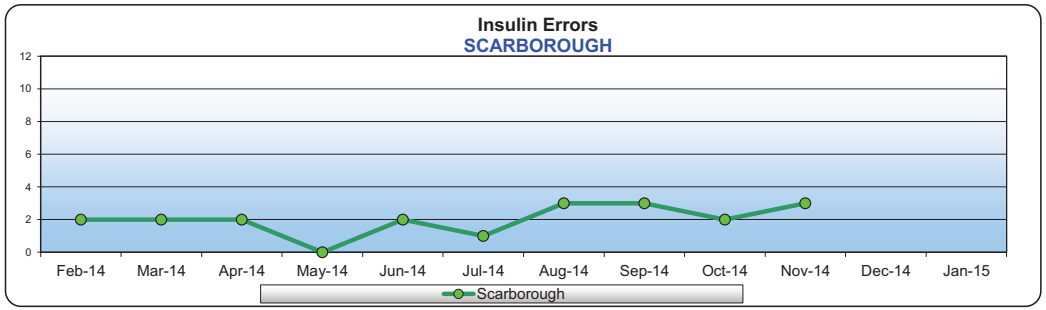
Preparation and Dispensing Errors
There were 11 preparation/dispensing errors in November; 3 from Scarborough, 8 from York and none from Community. December and January figures not yet available due to remapping of the reporting system.

Administrating and Supply Errors
There were 43 administrating/supplying errors in November; 32 from York, 6 from Scarborough and 5 from Community. December and January figures not yet available due to remapping of the reporting system.

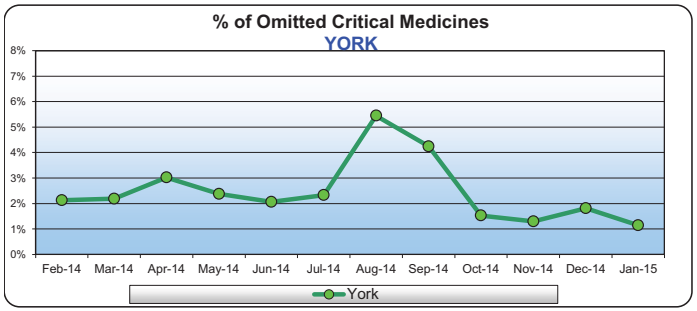
Drug Administration

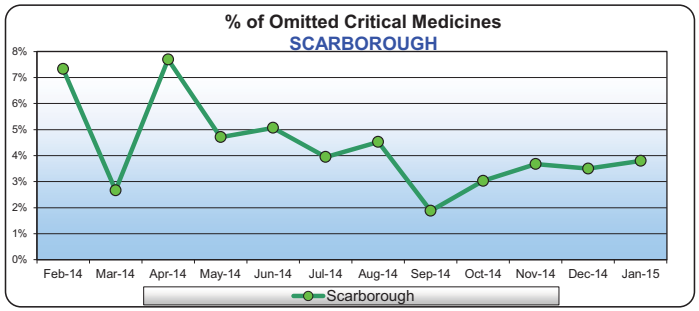
Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Insulin Errors	York	6	5	4	6	11	10	3	5	4	11	Not Available	Not Available
source: Datix (one month behind)	Scarborough	2	2	2	0	2	1	3	3	2	3	Not Available	Not Available

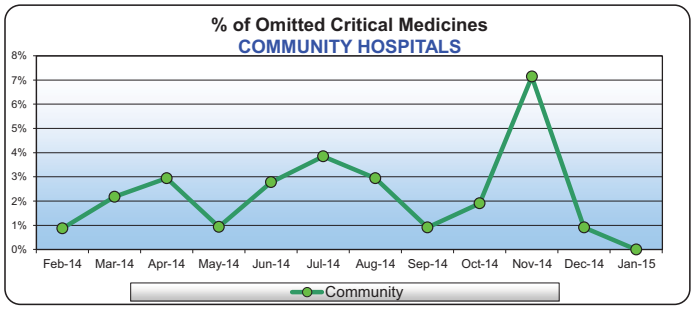




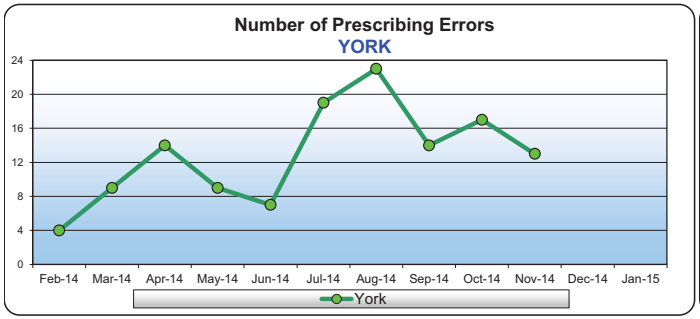
Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Number of Omitted Critical Medicines	York	11	10	13	11	9	10	20	18	7	6	8	6
source: Datix	Scarborough	17	6	17	9	11	9	9	4	7	9	9	9
	Community Hospitals	1	2	3	1	3	4	3	1	2	7	1	0

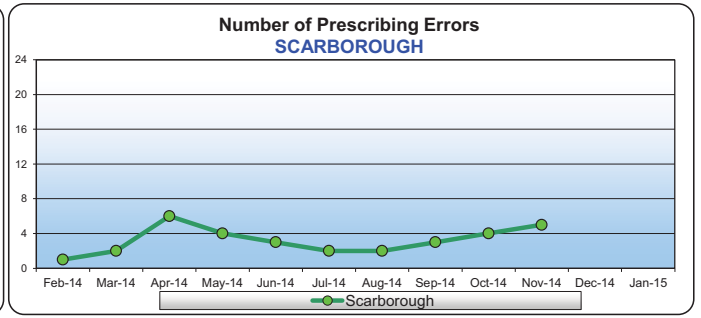


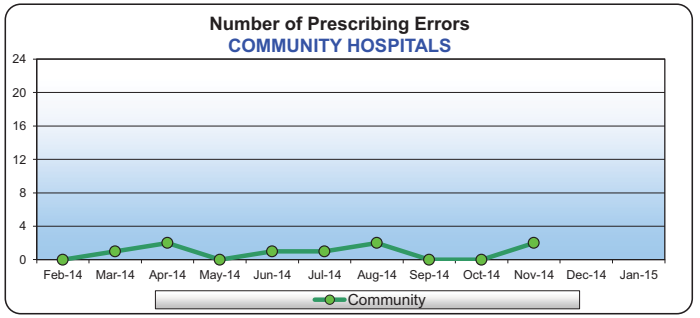




Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Number of Prescribing Errors	York	4	9	14	9	7	19	23	14	17	13	Not Available	Not Available
source: Datix (one month behind	Scarborough	1	2	6	4	3	2	2	3	4	5	Not Available	Not Available
	Community Hospitals	0	1	2	0	1	1	2	0	0	2	Not Available	Not Available

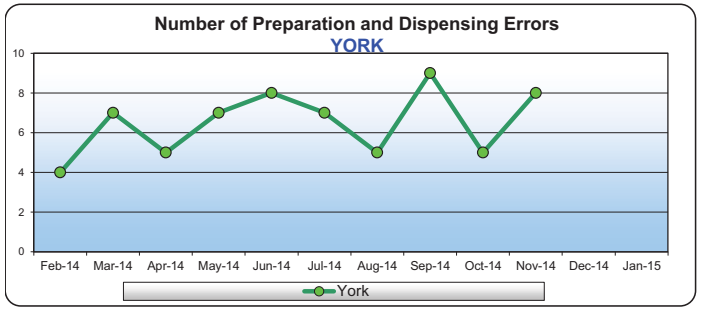


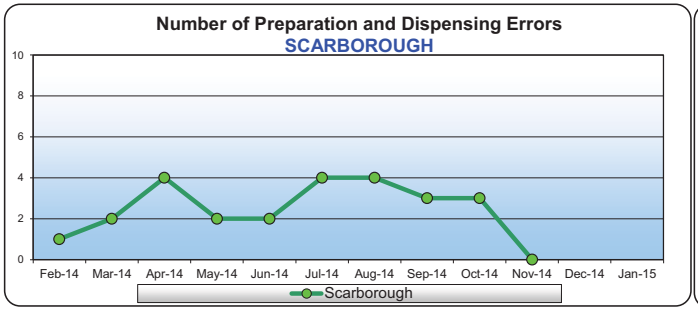


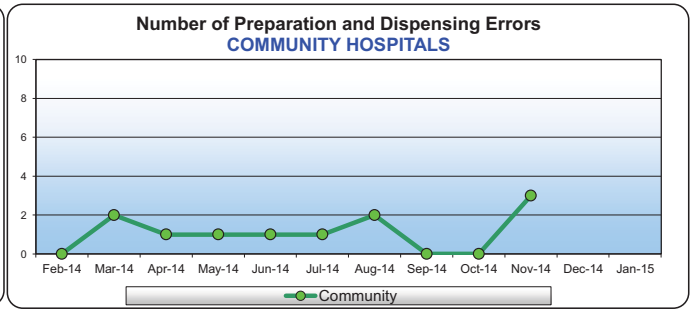


Drug Administration

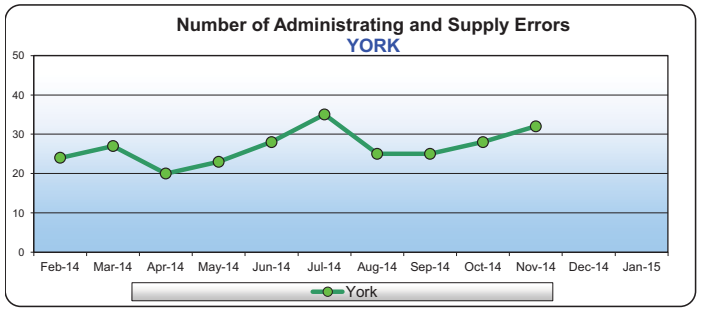
Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Number of Preparation and Dispensing Errors source: Datix (one month behind	York	4	7	5	7	8	7	5	9	5	8	Not Available	Not Available
	Scarborough	1	2	4	2	2	4	4	3	3	0	Not Available	Not Available
	Community Hospitals	0	2	1	1	1	1	2	0	0	3	Not Available	Not Available

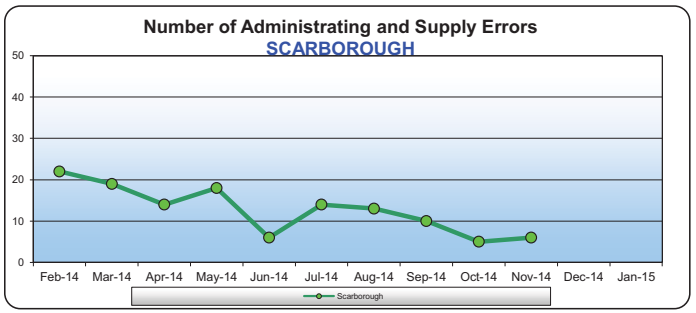


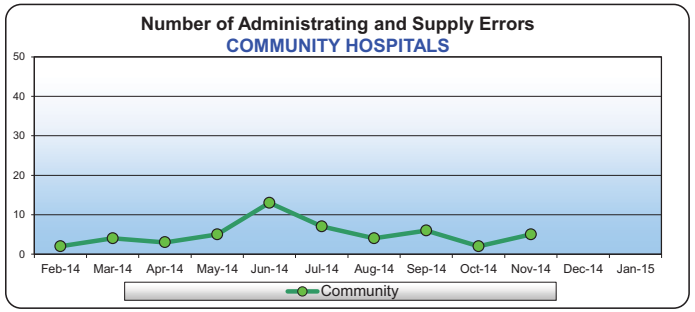




Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
Administrating and Supply Errors source: Datix (one month behind	York	24	27	20	23	28	35	25	25	28	32	Not Available	Not Available
	Scarborough	22	19	14	18	6	14	13	10	5	6	Not Available	Not Available
	Community Hospitals	2	4	3	5	13	7	4	6	2	5	Not Available	Not Available







Measures of Harm: Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month.

Harm Free Care

The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In January the percentage receiving care “free from harm” following audit is below:

·York: 94.2%
·Scarborough: 93.9%
·Community Hospitals: 86.8%
·Community care: 94.0%

VTE

The percentage of patients affected by VTE as measured by the Department of Health definition, monthly measurement of prevalence:

·York: 0.3%
·Scarborough: 0.7%

Harm from Catheter Associated Urinary Track Infection

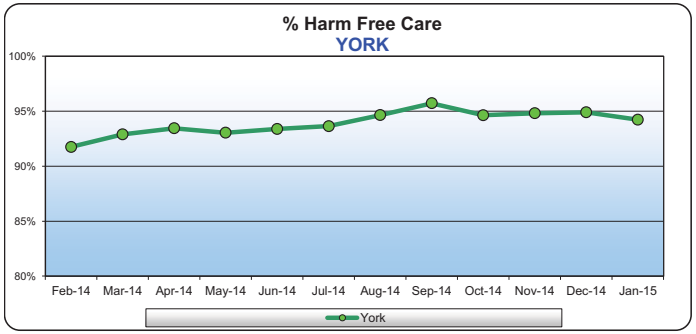
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence:

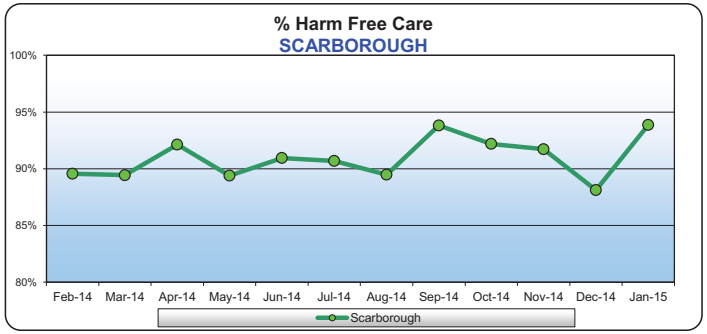
·York: 0.7%
·Scarborough: 1.0%
·Community Hospitals: 1.8%
·Community Care: 0.6%

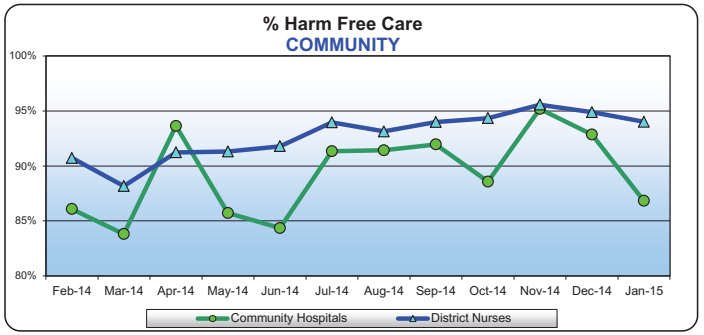
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month.

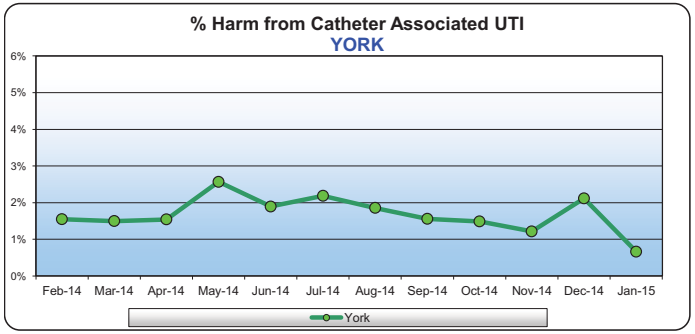
Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
% of Harm Free Care source: Safety Thermometer	York	91.7%	92.9%	93.4%	93.0%	93.4%	93.6%	94.6%	95.7%	94.6%	94.8%	94.9%	94.2%
	Scarborough	89.6%	89.4%	92.1%	89.4%	90.9%	90.7%	89.5%	93.8%	92.2%	91.7%	88.1%	93.9%
	Community Hospitals	86.1%	83.8%	93.6%	85.7%	84.3%	91.3%	91.4%	92.0%	88.6%	95.2%	92.9%	86.8%
	District Nurses	90.7%	88.2%	91.2%	91.3%	91.8%	94.0%	93.1%	94.0%	94.3%	95.6%	94.9%	94.0%

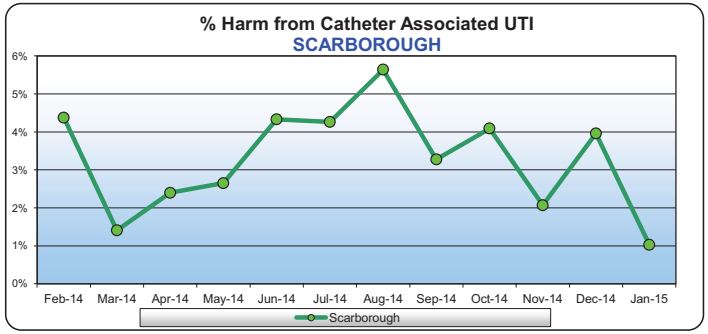


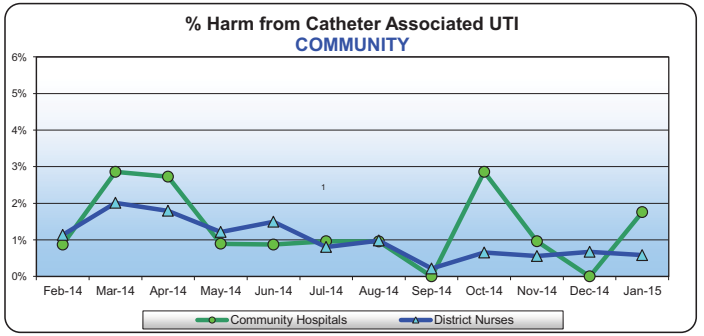




Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	1.5%	1.5%	1.5%	2.6%	1.9%	2.2%	1.9%	1.6%	1.5%	1.2%	2.1%	0.7%
	Scarborough	4.4%	1.4%	2.4%	2.7%	4.3%	4.3%	5.6%	3.3%	4.1%	2.1%	4.0%	1.0%
	Community Hospitals	0.9%	2.9%	2.7%	0.9%	0.9%	1.0%	1.0%	0.0%	2.9%	1.0%	0.0%	1.8%
	District Nurses	1.1%	2.0%	1.8%	1.2%	1.5%	0.8%	1.0%	0.2%	0.7%	0.6%	0.7%	0.6%



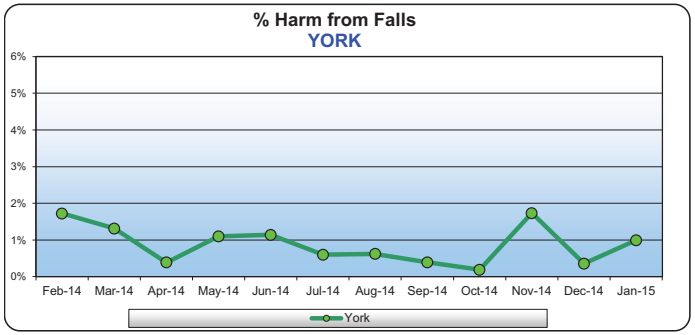


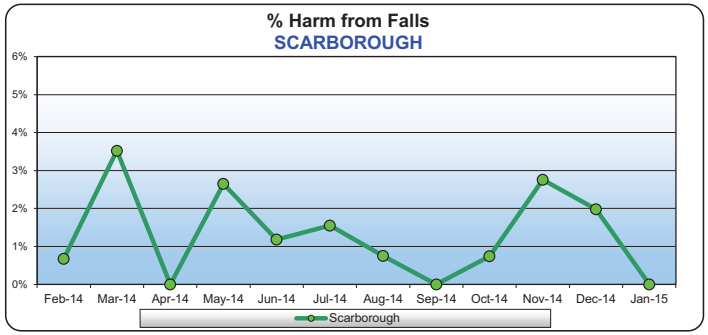


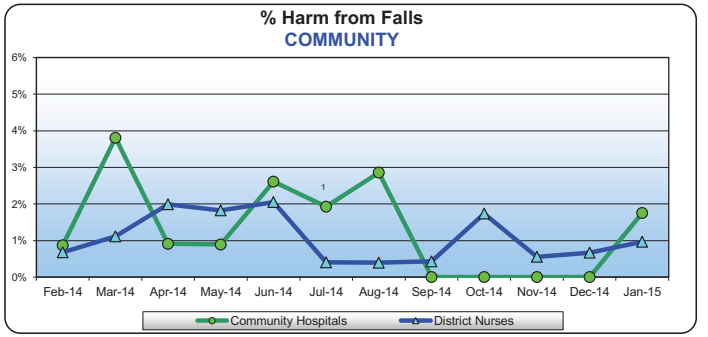
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month.

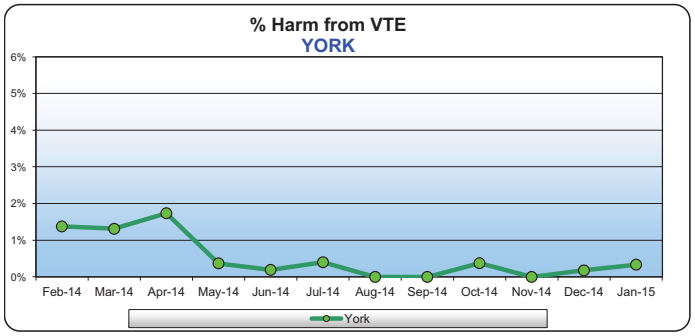
Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
% of Harm from Falls source: Safety Thermometer	York	1.7%	1.3%	0.4%	1.1%	1.1%	0.6%	0.6%	0.4%	0.2%	1.7%	0.4%	1.0%
	Scarborough	0.7%	3.5%	0.0%	2.7%	1.2%	1.6%	0.8%	0.0%	0.7%	2.8%	2.0%	0.0%
	Community Hospitals	0.9%	3.8%	0.9%	0.9%	2.6%	1.9%	2.9%	0.0%	0.0%	0.0%	0.0%	1.8%
	District Nurses	0.7%	1.1%	2.0%	1.8%	2.1%	0.4%	0.4%	0.4%	1.7%	0.6%	0.7%	1.0%

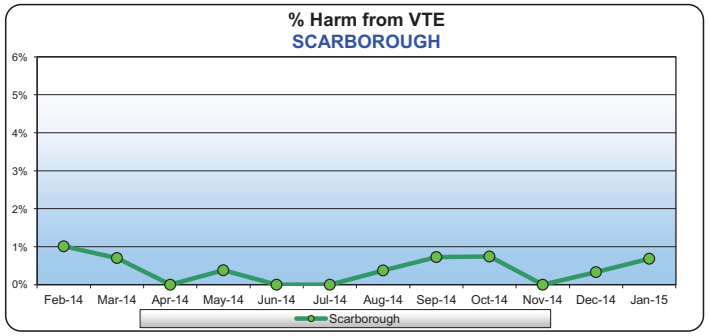


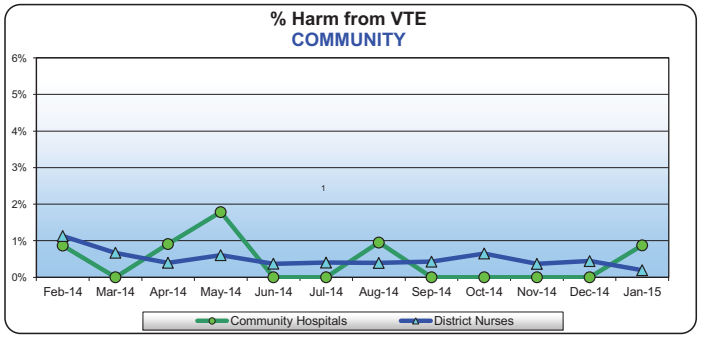




Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
% of VTE source: Safety Thermometer	York	1.4%	1.3%	1.7%	0.4%	0.2%	0.4%	0.0%	0.0%	0.4%	0.0%	0.2%	0.3%
	Scarborough	1.0%	0.7%	0.0%	0.4%	0.0%	0.0%	0.4%	0.7%	0.7%	0.0%	0.3%	0.7%
	Community Hospitals	0.9%	0.0%	0.9%	1.8%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.9%
	District Nurses	1.1%	0.7%	0.4%	0.6%	0.4%	0.4%	0.4%	0.4%	0.7%	0.4%	0.4%	0.2%



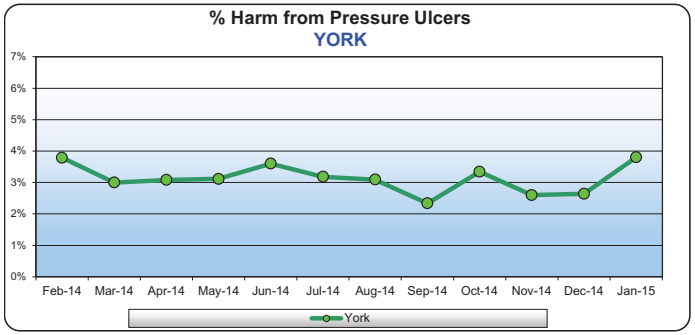


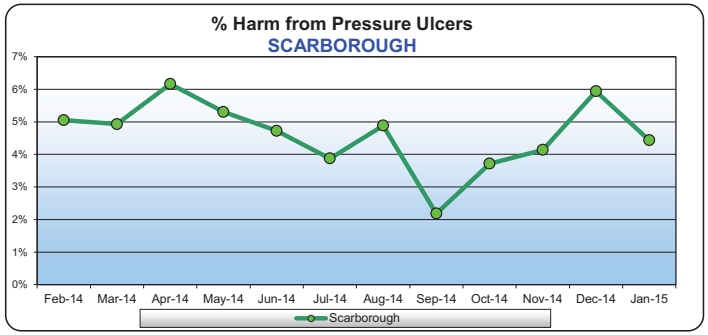


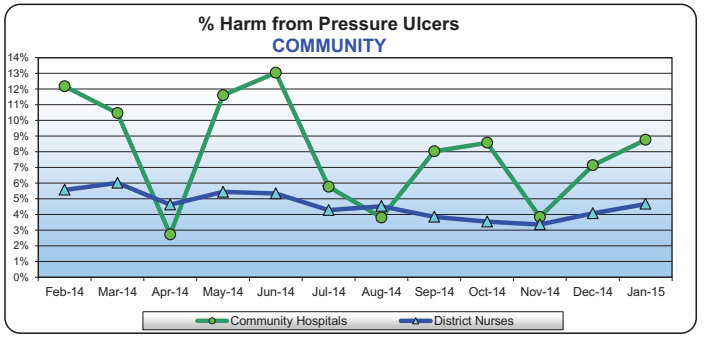
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month.

Indicator		Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
% of Pressure Ulcers source: Safety Thermometer	York	3.8%	3.0%	3.1%	3.1%	3.6%	3.2%	3.1%	2.3%	3.3%	2.6%	2.6%	3.8%
	Scarborough	5.1%	4.9%	6.2%	5.3%	4.7%	3.9%	4.9%	2.2%	3.7%	4.1%	5.9%	4.4%
	Community Hospitals	12.2%	10.5%	2.7%	11.6%	13.0%	5.8%	3.8%	8.0%	8.6%	3.8%	7.1%	8.8%
	District Nurses	5.6%	6.0%	4.6%	5.4%	5.3%	4.3%	4.5%	3.9%	3.5%	3.4%	4.1%	4.7%







Never Events

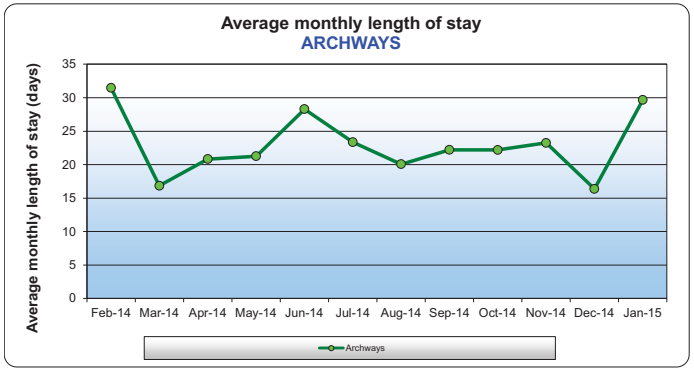
Indicator	Consequence of Breach	Threshold	Q1	Q2	Q3	Nov	Dec	Jan
SURGICAL								
Wrong site surgery	As below	**>0**	**1**	**0**	**0**	0	0	0
Wrong implant/prosthesis		**>0**	**0**	**0**	**0**	0	0	0
Retained foreign object post-operation		**>0**	**0**	**0**	**0**	0	0	0
MEDICATION								
Wrongly prepared high-risk injectable medication	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	**0**	**0**	**0**	0	0	0
Maladministration of potassium-containing solutions		**>0**	**0**	**0**	**0**	0	0	0
Wrong route administration of chemotherapy		**>0**	**0**	**0**	**0**	0	0	0
Wrong route administration of oral/enteral treatment		**>0**	**0**	**0**	**0**	0	0	0
Intravenous administration of epidural medication		**>0**	**0**	**0**	**0**	0	0	0
Maladministration of insulin		**>0**	**0**	**0**	**0**	0	0	0
Overdose of midazolam during conscious sedation		**>0**	**0**	**0**	**0**	0	0	0
Opioid overdose of an opioid-naïve Service User		**>0**	**0**	**0**	**0**	0	0	0
Inappropriate administration of daily oral methotrexate		**>0**	**0**	**0**	**0**	0	0	0
GENERAL HEALTHCARE								
Falls from unrestricted windows	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	**0**	**0**	**0**	0	0	0
Entrapment in bedrails		**>0**	**0**	**0**	**0**	0	0	0
Transfusion of ABO incompatible blood components		**>0**	**0**	**0**	**0**	0	0	0
Transplantation of ABO incompatible organs as a result of error		**>0**	**0**	**0**	**0**	0	0	0
Misplaced naso- or oro-gastric tubes		**>0**	**0**	**0**	**0**	0	0	0
Wrong gas administered		**>0**	**0**	**0**	**0**	0	0	0
Failure to monitor and respond to oxygen saturation		**>0**	**0**	**0**	**0**	0	0	0
Air embolism		**>0**	**0**	**0**	**0**	0	0	0
Misidentification of Service Users		**>0**	**0**	**0**	**0**	0	0	0
Severe scalding of Service Users		**>0**	**0**	**0**	**0**	0	0	0
MATERNITY								
Maternal death due to post-partum haemorrhage after elective caesarean section	As above	**>0**	**0**	**0**	**0**	0	0	0

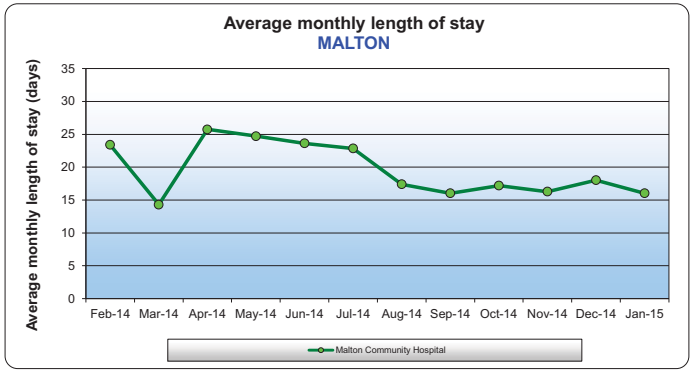
Patient Safety Walkrounds – January 2015

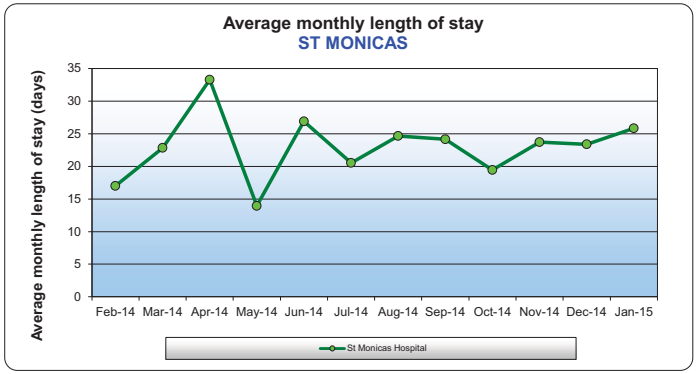
Date	Location	Participants	Actions & Recommendations
12/01/2015	Radiology Dept, Scarborough Hospital	Mike Proctor - Director Ian Renwick – Clinical Director Ken Kay – Superintendent Radiographer Steve Mackell – Directorate Manager Lorraine Ford - Radiology Quality & Risk Manager Jennie Adams - NED	Awaiting report.
23/01/2015	Head and Neck Outpatients & Orthodontics, York Hospital	Brian Golding - Director James Taylor – Clinical Director David Pullen – Directorate Manager Pauline Guyan – Matron Dianne Wilcox - NED	Sharps bin mixed in with cardboard waste. Action- identify solution and close out Datix. DNA rates. Action- consider alternative communication strategies for particular groups. Intermittent failure of lifts to level causing trip hazard. Action- report to Estates Helpdesk. High risk procedures in dental laboratory. Action- Review changes to processes and environment in conjunction with H&S manager.

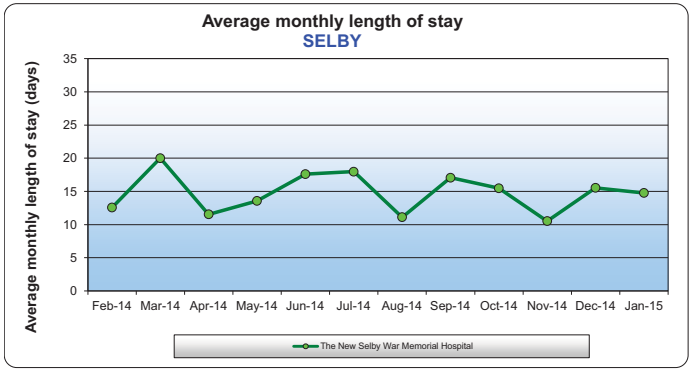
Community Hospitals

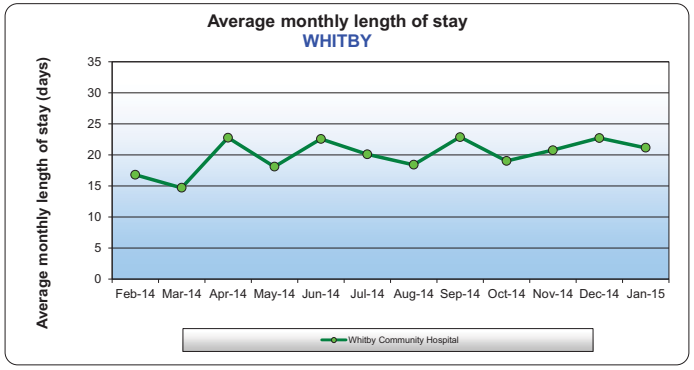
Indicator	Hospital	Q1 Actual	Q2 Actual	Q3 Actual	Nov	Dec	Jan
Community Hospitals average length of stay (days)	Archways	23.4	22.1	20.6	23.2	16.4	29.7
	Malton Community Hospital	24.5	18.6	17.1	16.3	18.0	16.0
	St Monicas Hospital	24.5	23.2	22.0	23.7	23.4	25.8
	The New Selby War Memorial Hospital	13.8	15.6	13.7	10.5	15.5	14.8
	Whitby Community Hospital	21.1	20.3	20.9	20.8	22.7	21.2
	Total	20.4	19.4	18.1	17.2	19.1	19.6

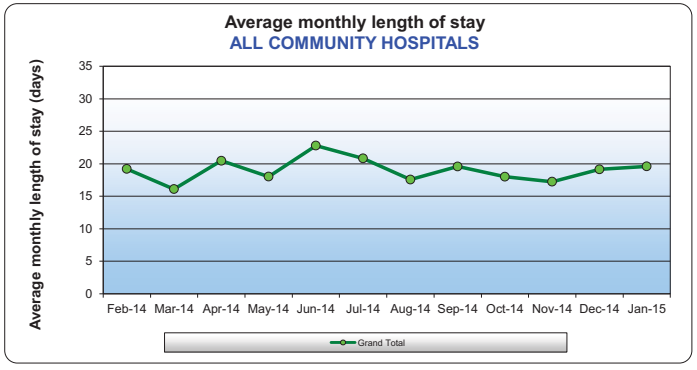






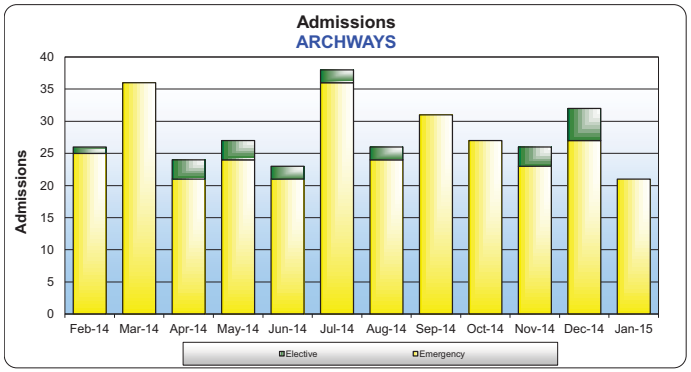


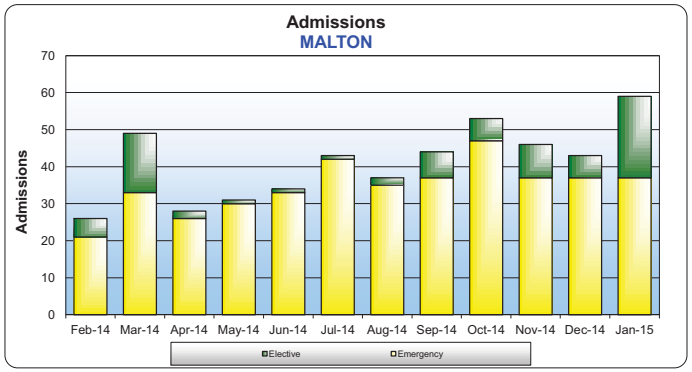


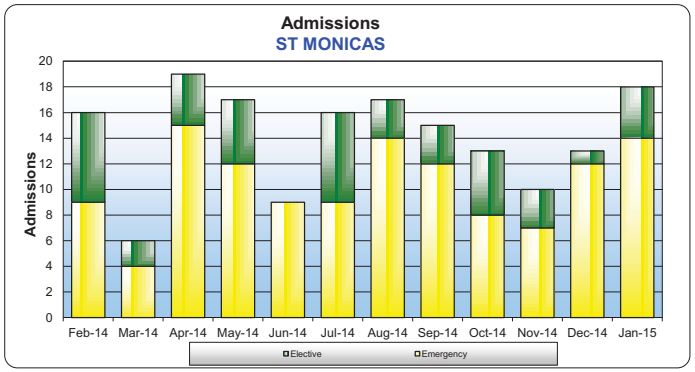


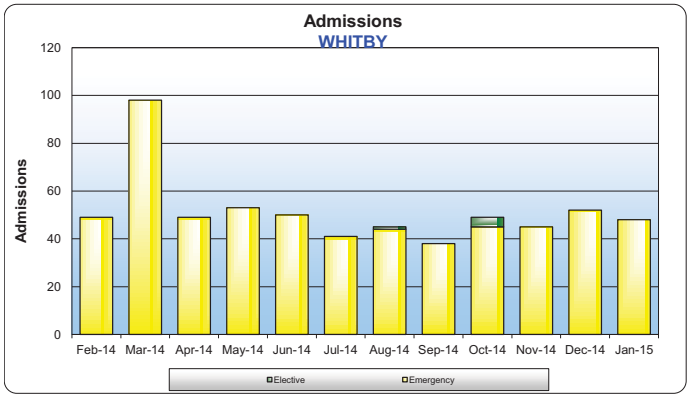
Community Hospitals

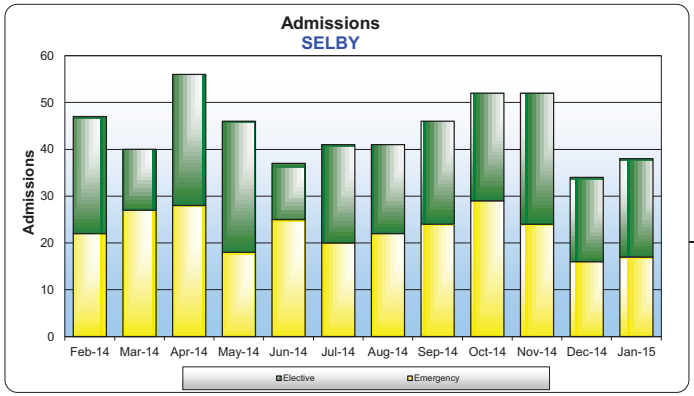
Indicator	Hospital		Q1 Actual	Q2 Actual	Q3 Actual	Nov	Dec	Jan
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	8	4	8	3	5	0
		Emergency	66	91	77	23	27	21
	Malton Community Hospital	Elective	4	10	21	9	6	22
		Emergency	89	114	121	37	37	37
	St Monicas Hospital	Elective	9	13	9	3	1	4
		Emergency	36	35	27	7	12	14
	The New Selby War Memorial	Elective	68	62	69	28	18	21
		Emergency	71	66	69	24	16	17
	Whitby Community Hospital	Elective	0	1	4	0	0	0
		Emergency	152	123	142	45	52	48
	Total	Elective	89	90	111	43	30	47
		Emergency	414	429	436	136	144	137

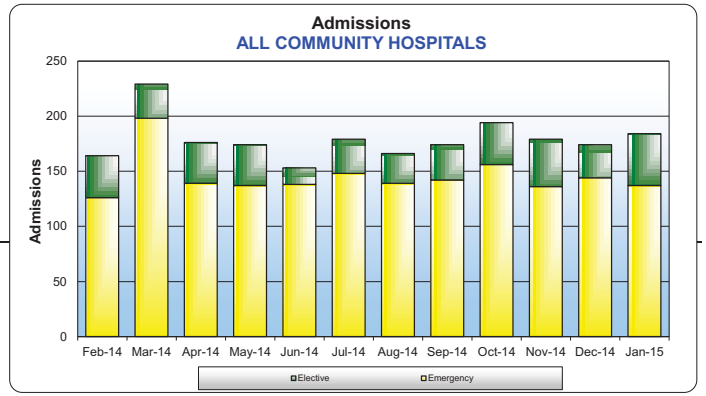












Maternity - York

Metric	Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Flag Source	February	March	April	May	June	July	August	September	October	November	December	January	Av. Monthly YtD
Bookings	1st m/w visit	CMIS from Jan CPD	≤302	302-329	≥330	prev. stats	317	295	276	297	253	302	254	325	314	296	246	311	299
Bookings <13 weeks	No. of mothers	CMIS from Jan CPD	≥90%	76%-89%	≤75%	CQUIN	83.6%	88.1%	82.2%	82.8%	87.7%	90.1%	86.6%	85.8%	86.9%	87.8%	87.8%	88.0%	86.5%
Bookings ≥13 weeks (exc transfers etc)	No. of mothers		< 10%	10%-20%	>20%	CQUIN	16.4%	11.9%	17.8%	17.2%	12.3%	9.9%	13.4%	14.2%	13.1%	12.2%	12.2%	12.0%	13.5%
Bookings ≥ 13wks seen within 2 wks	No. of mothers	Mat Rec	≥90%	76%-89%	≤75%	CQUIN							100%	100%	100%	100%			100%
Births	No. of babies	CMIS	≤295	296-309	≥310	prev. stats	234	285	250	292	289	308	317	308	319	244	264	269	283
No. of women delivered	No. of mothers	CMIS	≤296	296-310	≥311		234	285	243	290	289	302	311	303	316	239	261	265	279
Homebirth service suspended	No. of closures	Comm. Manager	0-3	4-6	7 or more		2	4	0	2	0	0	0	1	1				1
Homebirth service suspended	No. of women	Comm. Manager	0	1	2 or more		1	0	0	0	0	0	0	0	1				0
Escalation Policy implemented	No. of times	Comm. Manager	3	4-5	6 or more		0	2	1	2	4	4	2	1	5				2
Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	1	1	0	0	0	0	0	0	0	0
SCBU closed to admissions	In utero transfers	Transfer folder	0	1	2 or more		0	0	0	5	0	1	1	0	0	0		1	1
M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	31.0	28.5	29.0	29.0	29.0	29.8	30.5						29.7
HCA's	Ratio	Matron				staffing paper	19.43	19.43	19.43	19.43	18.83	19.43	19.03						19.3
1 to 1 care in Labour		Risk Team	≥75%	61%-74%	≤60%				79.4%	76.2%	77.9%	79.8%	83.6%	78.5%	79.0%	86.6%	83.9%	82.3%	80.7%
L/W Co-ordinator supernumary %		Risk Team					80	65	71	51	50	45	61	48	43	56		70	57.4
Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	76	76	76	76	76	76	76	76	76	76	76	76	76
Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10		10	10	10	10	10	10	10	10	10	10	10	10	10
Supervisor : M/w ratio 1 :	Ratio	Rota	12	13-15	15	SHA	13	14	14	14	14	14	14	14	14	14	14	14	14
Sponateous Vaginal Births	No. of svd	CMIS	≥65%	64%	≤63%		61.5%	59.6%	58.0%	58.5%	65.6%	62.7%	61.4%	64.4%	58.2%	58.2%	57.5%	79.3%	60.6%
Operative Vaginal Births	No. of instr. births	CMIS	≤15%	16-19%	≥20%	prev. stats	15.8%	12.6%	22.4%	19.9%	14.6%	12.7%	13.2%	11.2%	14.9%	15.9%	18.0%	17.4%	15.1%
C/S Deliveries	Em & elect	CMIS	≤24%	24.1-25.9	≥26%	prev. stats	22.6%	27.7%	25.8%	26.0%	23.3%	27.3%	22.8%	21.1%	25.6%	24.3%	22.2%	19.2%	24.8%
Eclampsia	No. of women	CMIS	0		1 or more		0	0	0	1	0	0	0	0	1	0	0	0	0
Undiagnosed Breech in Labour	No. of women	CMIS	2 or less	3-4	5 or more	prev. stats	0	0	0	2	1	3	0	0	1	1	1	2	1
ICU transfers	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	0	0	0	2	0	0	0	0	0	1	1	0
HDU on L/W	No. of days	Handover Sheet					17	11	10	30	30	20	20	15	25	15		15	19.5
Uterine Rupture from Jan 14	No of women	CPD	0	1	2 or more		0	0	0	0	0	0	0	0	0	0	0	0	0
BBA	No. of women	Risk Team - Datix	1	2-3	4 or more	prev. stats	2	3	4	5	3	4	3	7	4	2	8	4	4
Meconium Aspirate	No. of babies	SCBU sister	0	1	2 or more	prev. stats	1	0	0	0	0	0	0	0	0	0	0	1	0
Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	0	0	0	0	0	1	0	0	1	0	1	1	0
SI's	Total	Risk Team	0	1	2 or more		0	0	0	1	0	0	0	0	0	0	0	0	0
PPH > 2L	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		2	1	1	5	4	4	1	2	2	0	2	1	2
Shoulder Dystocia - True	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	RCOG	0	2	1	3	5	2	3	7	5	1	6	4	3
3rd/4th Degree Tear	% of tears (vaginal	CMIS	≤1.5%	1.6-6.1%	≥6.2%	RCOG	4.4%	6.8%	5.4%	5.3%	6.4%	6.3%	2.3%	3.5%	2.2%	2.2%	3.0%	1.5%	4.4%
YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		96.0%	95.0%	96.0%	94.0%	92.0%	91.0%	91.0%	91.0%	89.0%	91.0%	92.0%	86.0%	92.7%
YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		81.0%	81.0%	78.0%	83.0%	74.0%	71.0%	71.0%	46.0%	46.0%	50.0%	50.0%	79.0%	67.4%
Training cancelled	No. of staff affected	Risk Team	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0	0
Informal	Total	Matron	0	1-4	5 or more		0	1	3	0	3	3	1	1	1	2			2
Formal	Total	Matron	0	1-4	5 or more		1	0	2	0	0	1	0	2	0	4			1
New Claims	Total	Directorate Manager	0	1	2 or more		1	0	1	0	0	0	0	0	0	0			0

Maternity - Scarborough

Metric	Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Flag Source	February	March	April	May	June	July	August	September	October	November	December	January	Av. Monthly YtD
Bookings	1st m/w visit	IS - Evolution	≤200	201-249	≥250	prev. stats	190	201	193	183	185	187	176	192	193	139	136	151	183
Bookings <13 weeks	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN			94.3%	88.1%	94.6%	87.1%	84.7%	87.4%	87.2%	92.4%	90.4%	87.0%	86.5%
Bookings <13 weeks (exc transfers etc)	No. of mothers	IS - Evolution	< 10%	10%-20%	>20%	CQUIN			5.7%	11.9%	5.4%	12.9%	15.3%	12.6%	12.8%	7.6%	9.6%		13.5%
Bookings ≥ 13wks seen within 2 wks	No. of mothers		≥90%	76%-89%	≤75%	CQUIN			3%		5%	11%							6%
Births	No. of babies	IS - Evolution	≤170	171-189	≥190	prev. stats	128	119	119	119	125	134	158	146	148	129	138	142	135
No. of women delivered	No. of mothers	IS - Evolution	≤170	171-189	≥190		126	118	116	119	124	132	158	146	145	127	136	138	133
Homebirth service suspended	No. of closures	Comm Team Leader	0-3	4-6	7 or more		0	0	0	0	1	0	0	0	0	0	0	0	0
Homebirth service suspended	No. of women	Comm Team Leader	0	1	2 or more		0	0	0	0	1	0	0	0	0	0	0	0	0
Escalation Policy implemented	No. of times	Matron	3	4-5	6 or more		0	0	0	0	1	0	0	0	0	1	0	0	0
Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	1	0	0	0	0	0	0	0	0
SCBU closed to elective admissions	In utero transfers	Risk Team	0	1	2 or more		4	4	7	26	10	4	21	10	8	8	20	0	11
M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	44.0	44.0	44.0	43.0	43.0	43.0	41.0	38.0	38.0	38.0		38.0	42.2
HCA's	WTE	Matron				staffing paper	18.3	18.3	18.3	17.9	17.1	17.1	16.7	15.9	15.9	15.8		15.4	17.6
1:1 care in labour		IS - Evolution	≥75%	61%-74%	≤60%		97.6%	99.2%	88.0%	86.0%	87.0%	88.0%	88.0%	92.0%	93.0%	91.3%	91.3%	90.6%	93.1%
L/W Co-ordinator Supernumary %		L/W Manager					55.3%	64.5%	64.5%	70.9%	75%	58%	50%	50%	58%	50%		55%	60%
Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	40	40	40	40	40	40	40	40	40	40		40	40
Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10		3	3	3	3	3	3	3	3	3	3		3	3
Supervisor : M/w ratio 1 :	Ratio	Matron	15	16-19	20	SHA	14	14	14	14	14	14	14	14	14	14		14	14
Sponateous Vaginal Births	No. of svd	IS - Evolution	≥65%	64%	≤63%		71.9%	72.3%	76.7%	68.9%	64.0%	76.5%	70.3%	76.0%	71.0%	72.4%	69.9%	77.5%	70.8%
Operative Vaginal Births	No. of instr. births	IS - Evolution	≤15%	16-19%	≥20%	prev. stats	4.7%	5.9%	3.4%	6.7%	6.5%	3.8%	9.5%	9.0%	5.5%	4.7%		5.8%	5.6%
C/S Deliveries	Em & elect	IS - Evolution	≤24%	24.1-25.9	≥26%	prev. stats	21.9%	21.0%	19.8%	23.5%	29.0%	18.9%	20.9%	15.2%	22.8%	22.8%	22.8%	22.5%	22.7%
Eclampsia	No. of women	IS - Evolution	0		1 or more		0	0	0	0	0	0	0	0	0	0		0	0
Undiagnosed Breech in Labour	No. of women	Risk Team	2 or less	3-4	5 or more	prev. stats	0	0	1	1	0	0	0	0	0	0		0	0
ICU transfers	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0		0	0
HDU on L/W	No. of days	Risk Team					3	1	3	0	0	2	2	2	2	3		4	2.2
P/N Hysterectomies < 7days p/n	No. of women	IS - Evolution	0	1	2 or more		0	0	0	0	0	0	0	0	0	0		0	0
BBA	No. of women	IS - Evolution	1	2-3	4 or more	prev. stats	1	0	0	0	0	3	2	0	2	1		3	1
Meconium Aspirate	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	1	0	0	1	0	0	0	0	0	0			0
Stillbirths Antepartum	No of babies	Risk Team	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0		
Stillbirths Intrapartun	No. of babies	Risk Team	0	0	1	prev. stats	0	0	0	0	0	0	0	0	0	0	0	1	
Diagnosis of HIE	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	1	0	0	0	0	0	0		0	0
SI's	Total	Risk Team	0	1	2 or more		1	0	1	0	0	0	0	1	1	0		0	0
PPH > 2L	No. of women	IS - Evolution	1 or less	2-3	3 or more		1	0	2	0	0	2	0	1	3	0		1	1
Shoulder Dystocia - True	No. of women	IS - Evolution	1 or less	2-3	3 or more	RCOG	1	0	0	1	1	0	1	0	0	0		1	0
3rd/4th Degree Tear	% of tears (vaginal	IS - Evolution	≤1.5%	1.6-6.1%	≥6.2%	RCOG	4.0%	0.0%	0.4%	0.7%	1.6%	0.0%	1.3%	0.7%	2.1%	0.0%		0	1.4%
YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		93.0%	93.0%	91.0%	90.0%	94.0%	93.0%	93.0%	93.0%	94.0%	84.0%	0.0%	66.0%	92.2%
YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		92.0%	0.0%	0.0%	0.0%	77.0%	92.0%	92.0%	92.0%	92.0%	100.0%	0.0%	93.0%	78.3%
Training cancelled	No. of staff affected	Risk Team	0		≥1		0	0	0	0	0	0	0	8	0	0	0	0	1
Informal	Total	Matron	0	1-4	5 or more		3	2	0	1	0	1	2	3	1	1		0	1
Formal	Total	Matron	0	1-4	5 or more		1	0	2	0	0	0	1	4	0	0		0	1
New Claims	Total	Risk Team	0	1	2 or more		2	1	0	1	0	1	1	0	0	0		0	0

D2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Director's – 25 February 2015

Medical Director's Report

Action requested/recommendation

Board of Director's should be aware of:

- Summary Hospital level Mortality Indicator (SHMI)
- Update on PROMs
- HCAI report
- Consultants joining the Trust
- Antimicrobial prescribing audit
- EPMA update.

Summary

This report provides an update from the Medical Director on Patient Safety related issues.

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).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no direct references to CQC outcomes, although most indicators in this report are monitored as part of CQC regulation compliance.

Progress of report	This report is only written for the Board of Director's.
Risk	No additional risks have been identified others than those specifically referenced in the paper.
Resource implications	None identified.
Owner	Dr Alastair Turnbull, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	February 2015
Version number	Version 1

Board of Director's – 25 February 2015

Medical Director's Report

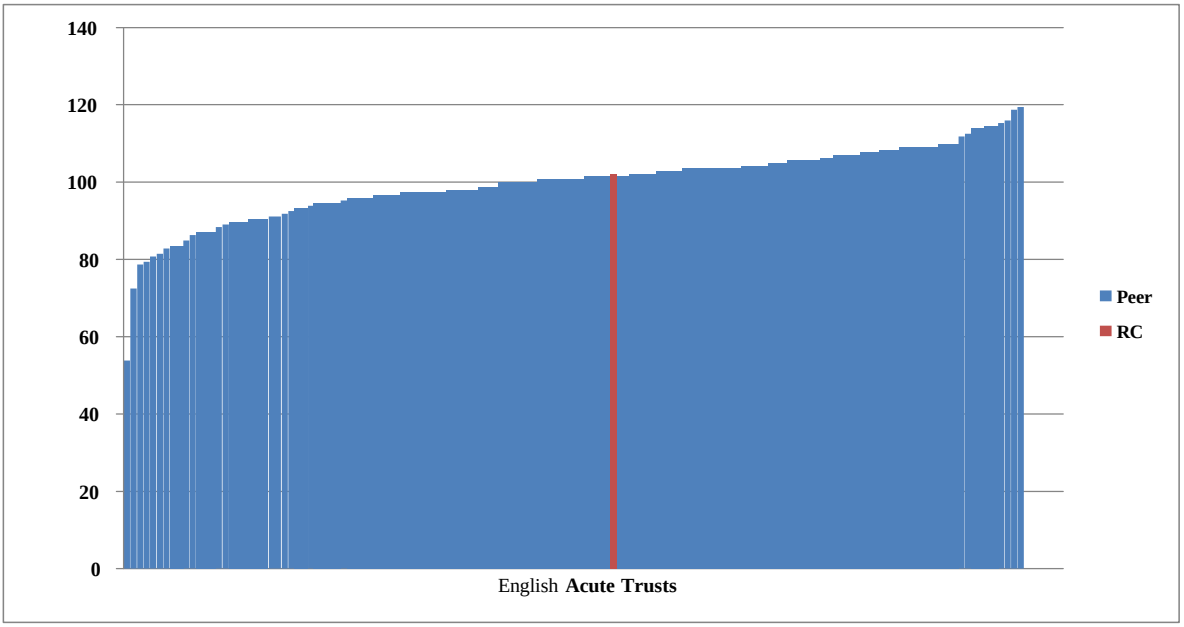
1. Introduction and background

In the report this month:

- Summary Hospital level Mortality Indicator (SHMI)
- Update on PROMs
- HCAI report
- Consultants joining the Trust
- Antimicrobial prescribing audit
- EPMA update.

2. SHMI

This report provides an update on the current SHMI position for the reporting period July 2013 to June 2014. Overall there were still groups where the Trust had more deaths than expected.



Overall position

Hospital	Spells	Observed Deaths	Predicted Deaths	SHMI Index
Scarborough	24060	1122	1041.92	1.077
York	52163	1818	1842.34	0.987
Trust	76223	2940	2884.26	1.019

Top three condition groups for excess deaths

Condition	Spells	Deaths	Predicted	Excess
Acute cerebrovascular disease	1073	215	187.56	27.44
Other connective tissue disease	1152	43	22.92	20.08
Congestive heart failure; non hypertensive	702	128	111.27	16.73

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Scarborough Hospitals

Condition	Spells	Deaths	Predicted	Excess
Acute cerebrovascular disease	433	91	76.92	14.08
Other connective tissue disease	263	14	4.48	9.52
Congestive heart failure; non hypertensive	268	60	42.04	17.96

York Hospitals

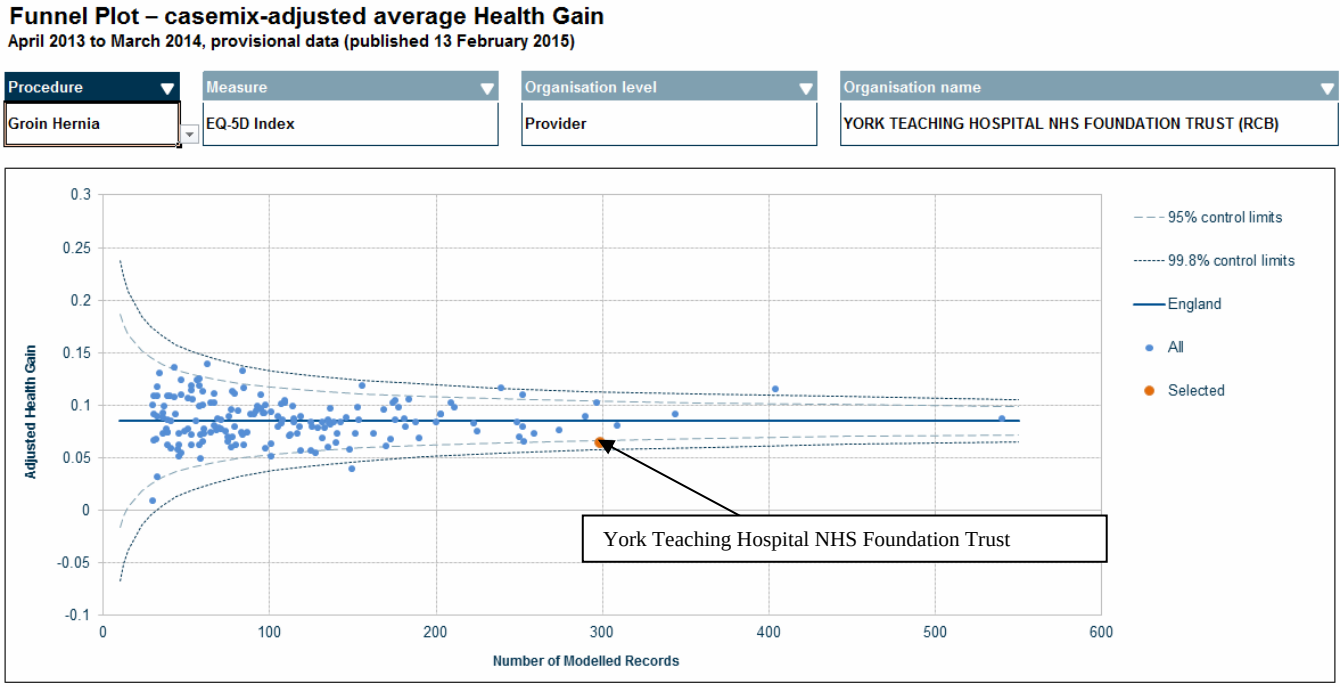
Condition	Spells	Deaths	Predicted	Excess
Acute cerebrovascular disease	640	124	110.65	13.35
Other connective tissue disease	889	29	18.43	10.57
Congestive heart failure; non hypertensive	434	68	69.24	-1.24

The SHMI of the Yorkshire trusts is reported for information

Trust	SHMI	Trust	SHMI
Sheffield	0.902	Calderdale & Huddersfield	1.102
Leeds	1.039	Hull & East Yorkshire	1.053
Airedale	0.893	York	1.019
Bradford	0.963	Doncaster & Bassetlaw	1.104
Mid Yorkshire	0.905	Barnsley	1.037
Harrogate	0.992	Rotherham	1.059

3. Update on PROMs

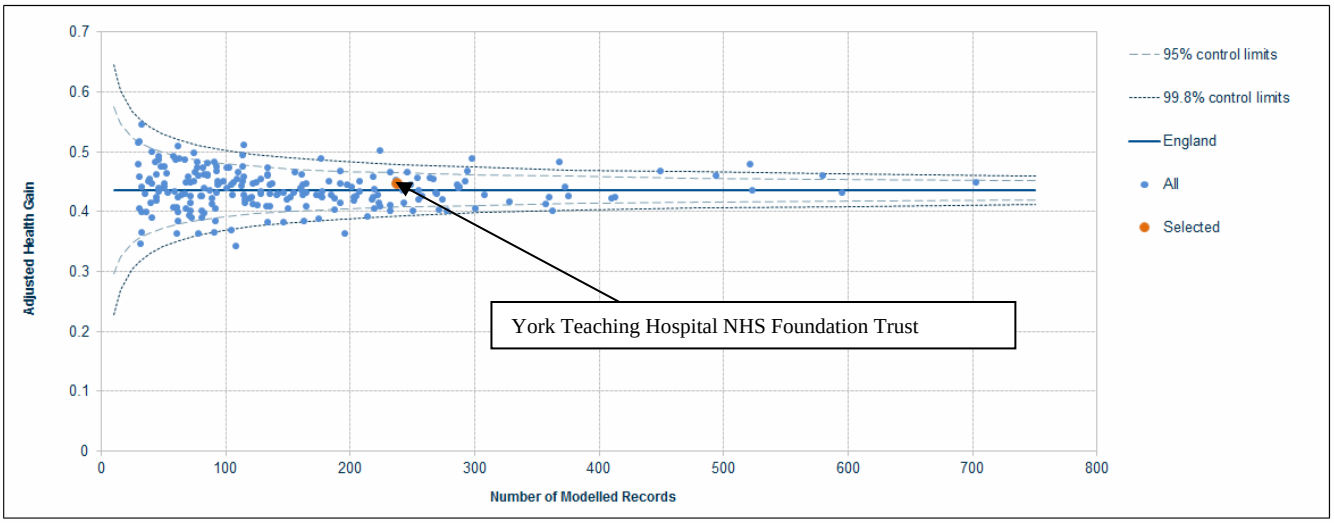
This report provides an update on PROMs



Funnel Plot – casemix-adjusted average Health Gain

April 2013 to March 2014, provisional data (published 13 February 2015)

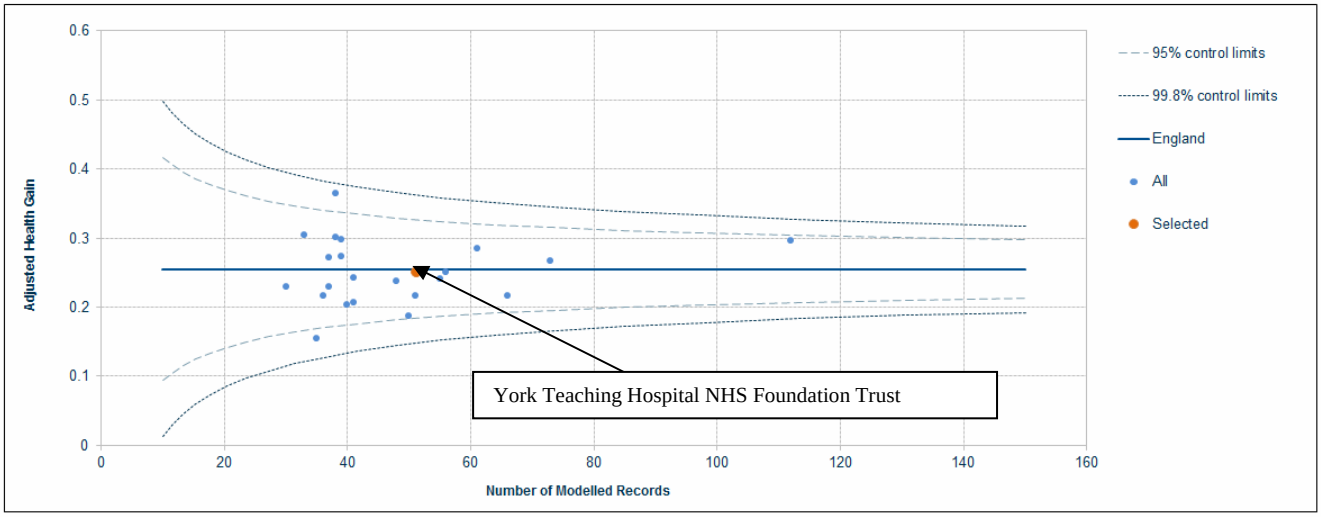
Procedure	Measure	Organisation level	Organisation name
Hip Replacement Primary	EQ-5D Index	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)

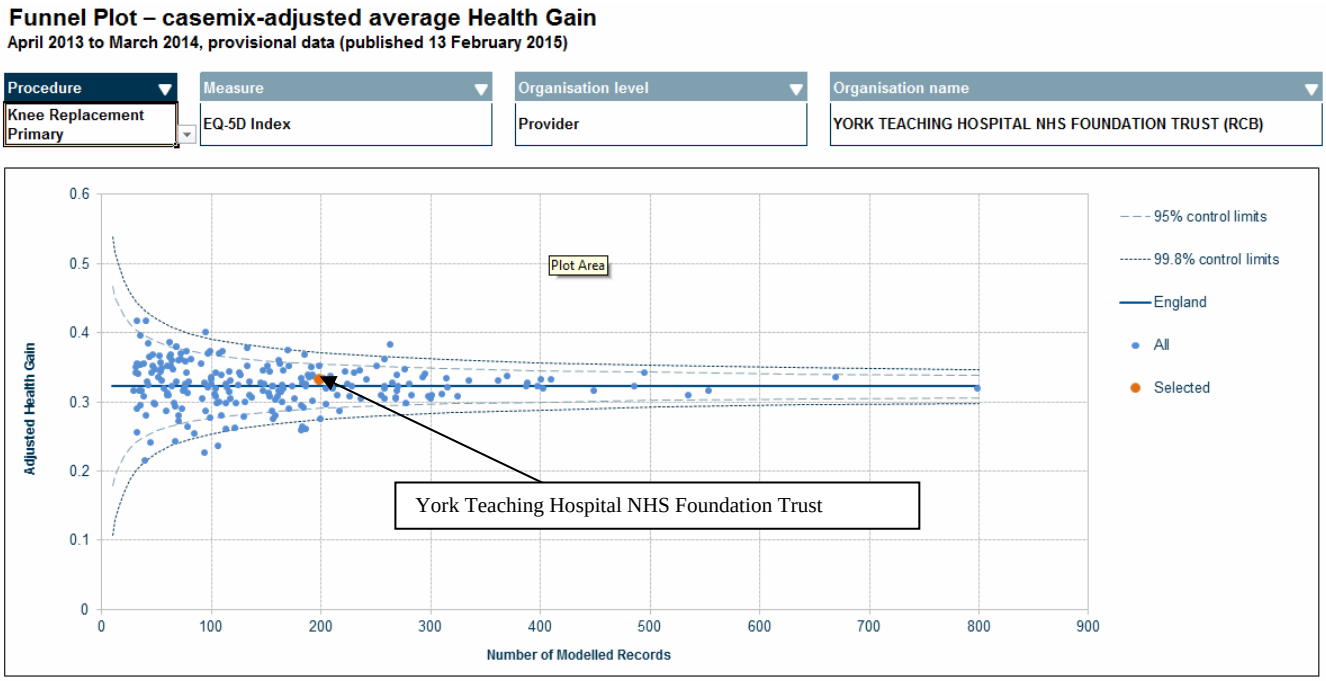


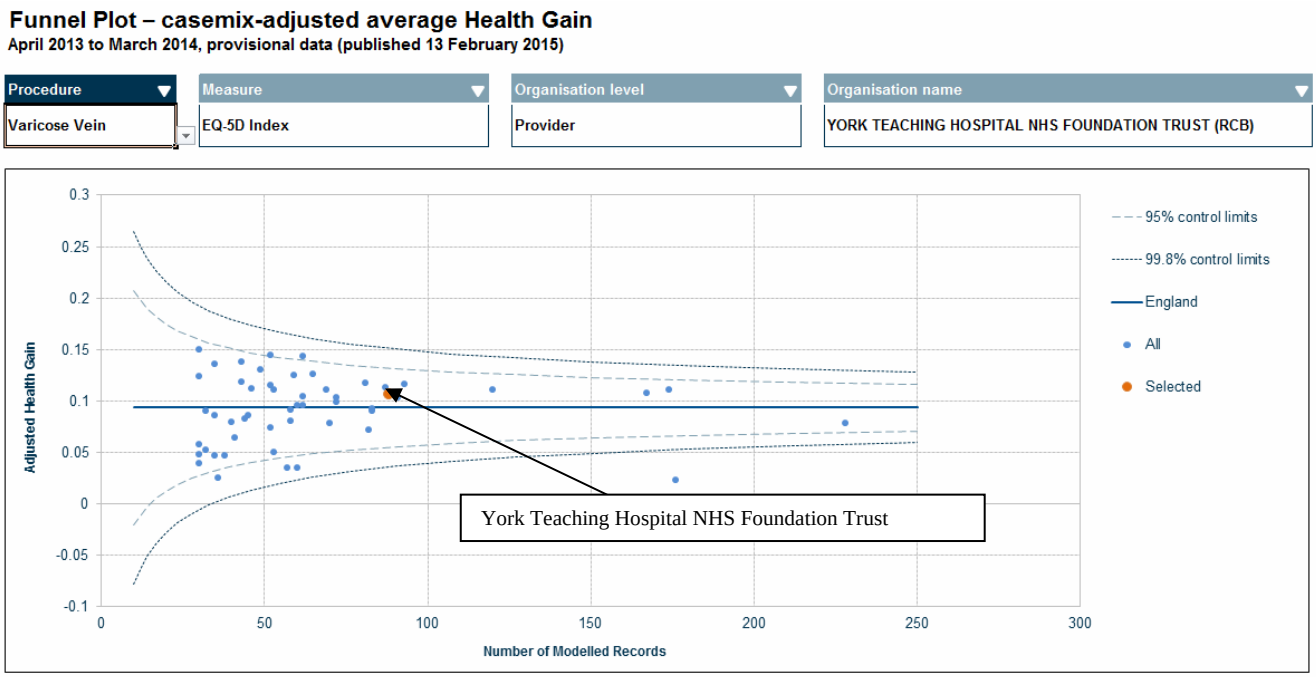
Funnel Plot – casemix-adjusted average Health Gain

April 2013 to March 2014, provisional data (published 13 February 2015)

Procedure	Measure	Organisation level	Organisation name
Hip Replacement Revision	EQ-5D Index	Provider	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST (RCB)







4. HCAI Quarterly report

The HCAI in York and the Humber is presented at Appendix A.

5. Consultants new to the Trust

Dr Dipa Chatterjee
Consultant in Nephrology

Dr Christopher Hayes
Consultant Cardiologist

Mr Adnan Faraj
Consultant in Trauma and Orthopaedics

6. Antimicrobial prescribing audit

SUMMARY OF ANTIBIOTIC PRESCRIPTION AUDIT RESULTS
January – December 2015

indication on antibiotic prescription	Jan	Feb	Mar	Apr	May	Jun
York Hospital	85%					
Scarborough Hospital	81%					
Trust average	83%					

duration / course length on antibiotic prescription	Jan	Feb	Mar	Apr	May	Jun
York Hospital	84%					
Scarborough Hospital	84%					
Trust average	84%					

% patients >65 years co-prescribed VSL#3 (NB the audit did not investigate if any of the patients >65 years who were not on VSL#3 met any of the exclusion criteria)	Jan	Feb	Mar	Apr	May	Jun
York Hospital	71%					
Scarborough Hospital	79%					
Trust average	75%					

% of in-patients prescribed antibiotics	Jan	Feb	Mar	Apr	May	Jun
York Hospital	24%					
Scarborough Hospital	36%					

ELDERLY MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	**83**					
Antibiotic prescriptions with INDICATION	**86%**					
Antibiotic prescriptions with DURATION / REVIEW	**93%**					
% patients >65 years co-prescribed VSL#3 *^	**96%**					

MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	**91**					
Antibiotic prescriptions with INDICATION	**82%**					
Antibiotic prescriptions with DURATION / REVIEW	**81%**					
% patients >65 years co-prescribed VSL#3 *^	**73%**					

SPECIALIST MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	**2**					
Antibiotic prescriptions with INDICATION	**100%**					
Antibiotic prescriptions with DURATION / REVIEW	**100%**					
% patients >65 years co-prescribed VSL#3 *^	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**

ORTHOPAEDICS & TRAUMA DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	**11**					
Antibiotic prescriptions with INDICATION	**73%**					
Antibiotic prescriptions with DURATION / REVIEW	**64%**					
% patients >65 years co-prescribed VSL#3 *^	**60%**					

GENERAL SURGERY & UROLOGY	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	**40**					
Antibiotic prescriptions with INDICATION	**80%**					
Antibiotic prescriptions with DURATION / REVIEW	**75%**					
% patients >65 years co-prescribed VSL#3 *^	**42%**					

Obs & Gynae DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	**0**					
Antibiotic prescriptions with INDICATION	**n/a**					
Antibiotic prescriptions with DURATION / REVIEW	**n/a**					
% patients >65 years co-prescribed VSL#3 *^	**100%**					

HEAD & NECK DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	**1**					
Antibiotic prescriptions with INDICATION	**100%**					
Antibiotic prescriptions with DURATION / REVIEW	**100%**					
% patients >65 years co-prescribed VSL#3 *^	**50%**					

NB With effect from January 2015, Directorate results are derived from the consultant assigned to each patient on CPD on audit day.

* The audit did not investigate if any o the patients of 65 years of age, who were not prescribed VSL#3, met any of the exclusion criteria

^ VSL#3 prescribing results are based on “by ward” results, not “by Consultant” results

7. EPMA update

Electronic Prescribing & Medicines Administration (EPMA) is a key priority for the organisation, underpinning the Medicines Optimisation Strategy. The last six months have established many of the essential building blocks of the EPMA project. Work stream leads have been identified and staff appointed to support the project. Much work has been done to define the requirements of the Clinical, Nursing and Pharmacy staff that will be using the EPMA system to ensure that the system supports and enables best practice in patient care and medicines processes. These requirement documents are informing the development of the technical specification to ensure that the system delivers the expected benefits.

Pharmacy is working with IT to define the Trust Formulary drugs on the database that underpins the EPMA system. In the next quarter we anticipate prototype prescribing screens to be ready for sharing with the organisation. We will be looking for identified clinical leads to help review and test these early prescribing screens. This is essential to the development of the system and will provide valuable feedback to influence the ongoing development of medicines administration and pharmacy screens.

8. Recommendations

Board of Director’s should note the updates on:

- Summary Hospital level Mortality Indicator (SHMI)

• Update on PROMs • HCAI report • Consultants joining the Trust • Antimicrobial prescribing audit • EPMA.	
Author	**Diane Palmer, Deputy Director for Patient Safety**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**February 2015**

Introduction

The purpose of this quarterly Healthcare Associated Infections (HCAI) report is to provide detailed NHS Trust and Clinical commissioning group level information on trends in reported HCAIs within Yorkshire and the Humber. This report includes surveillance data for the most recently available quarter (July to September 2014) and data from the previous three quarters. Summary information is provided on episodes of *Clostridium difficile* infections (CDI), methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus (*MSSA), and *Escherichia.coli (E.coli)* bacteraemia as well as outbreaks of viral gastroenteritis and an update from the enhanced surveillance of carbapenemase-producing organisms (CPOs) in the Yorkshire and Humber PHE Centre. The format of this report has changed to comply with the nationally recommended specification for the provision of local updates on HCAI.

Features

This report includes:

- The presentation of mandatory data derived from the national HCAI Data Capture System (HDCS)
- Data presented by NHS Acute Trust and Clinical Commissioning Groups (CCGs). CCGs are groups of General Practices that are responsible for commissioning most health and care services for patients in England and were operational from April 2013.
- The use of funnel plots and statistical process control charts, visual display tools that identify existing variation in rates of HCAIs between Acute Trusts and CCGs.
- The first presentation of data from the enhanced surveillance of carbapenemase-producing organisms (CPOs) in Yorkshire and the Humber.

Acronyms used in this report

CCG	Clinical commissioning group
CDI	*Clostridium difficile* infection
CPO	Carbapenemase-producing organism
HCAI	Healthcare associated infection
MRSA	Meticillin Resistant *Staphylococcus aureus*
MSSA	Meticillin Sensitive *Staphylococcus aureus*
OBD	Occupied bed days
PIR	Post-infection review
SD	Standard deviation

Summary – Key Points

410 cases of **CDI** were reported in Yorkshire and the Humber between July and September 2014 which represents a small overall reduction in absolute numbers of cases. One third of cases (140) were apportioned to acute trusts with the highest burden reported from Teaching Hospital Trusts. Of these Sheffield Teaching Hospitals Trust reported an increase from 25 in quarter 2 to 34 cases in quarter 3 and the reported incidence rate in this trust was significantly higher than the national average for this quarter. However no trusts reported incidence significantly higher than their average over the past four years. The next quarterly HCAI report will include additional data on CDI toxin testing and test positivity by acute trust which should permit further interpretation of any variations observed.

8 cases of **MRSA** bacteraemia were reported In Yorkshire and the Humber during July to September 2014; 2 trust-assigned cases (one in Bradford and one in Doncaster) and 6 CCG-assigned cases, predominantly in West Yorkshire with two cases in Leeds and two in Bradford. No trusts reported MRSA bacteraemia incidence significantly higher than that seen previously or than the national average for this quarter.

273 cases of **MSSA** bacteraemia were reported in Yorkshire and the Humber in July to September 2014. Harrogate & Rural District was the only CCG to report incidence significantly higher than that expected this quarter (n=15; 9.48 cases per 100,000 population). 73 cases were apportioned to acute trusts within Yorkshire and the Humber. No trusts reported significant increases in trust-apportioned MSSA bacteraemia incidence over this quarter and all trusts were within the expected bounds around the national average rate.

The number of blood cultures examined varies considerably across Yorkshire and the Humber Trusts and is affected by Trust size and case-mix. However both Harrogate and York have a *S. aureus* positivity proportion higher than expected whilst Rotherham Hospital has a positivity rate lower than expected in comparison to the Yorkshire and Humber mean.

1,075 cases of ***E. coli*** bacteraemia were reported within Yorkshire and Humber in July to September 2014, a marginal increase on 1,027 cases in April to June. (This figure excludes 20 cases in Bassetlaw CCG). The small discrepancy between numbers of cases reported by laboratory and by CCG occurs where a Yorkshire and Humber resident's practice is in a CCG outside of Yorkshire and the Humber.

165 outbreaks of **viral gastroenteritis** (suspected and confirmed) were reported from health and social care settings during this quarter representing moderate levels of activity, consistent with season. There were 39 incidents reported from hospital Trusts but the highest burden was in care homes with 126 outbreaks reported during the period.

28 cases with **CPOs** (carbapenemase-producing organisms) were confirmed in July to September 2014. 25% of all confirmed CPO cases (n=7) reported receiving healthcare overseas in the last 12 months. Of the cases admitted to local hospitals approximately half were clinical infections and half were detected on screening. This period included an outbreak of five cases of NDM Klebsiella pneumoniae which occurred between July and October 2014 on a renal ward at Bradford Royal Infirmary. Following intensive contact screening, no further cases were identified. Also of note within this quarter was the occurrence of two patients who were diagnosed with two different organisms exhibiting the same carbapenamase. Local enhanced surveillance of (CPOs) in Yorkshire and the Humber is in its early stages and data completeness should improve during the next quarter.

Clostridium difficile Infection

There were 410 cases of CDI reported in Yorkshire and the Humber this quarter with 140 cases apportioned to acute trusts within the PHEC. No trusts reported incidence significantly higher than their average over the past four years although Sheffield teaching hospital's incidence was significantly higher than the national average for this quarter (Figure 2).

The next quarterly HCAI report will include additional data on CDI toxin testing and test positivity by acute trust.

Table 1: Trust-apportioned CDI cases in patients over 2yrs of age from October 2013 to September 2014, Yorkshire and the Humber

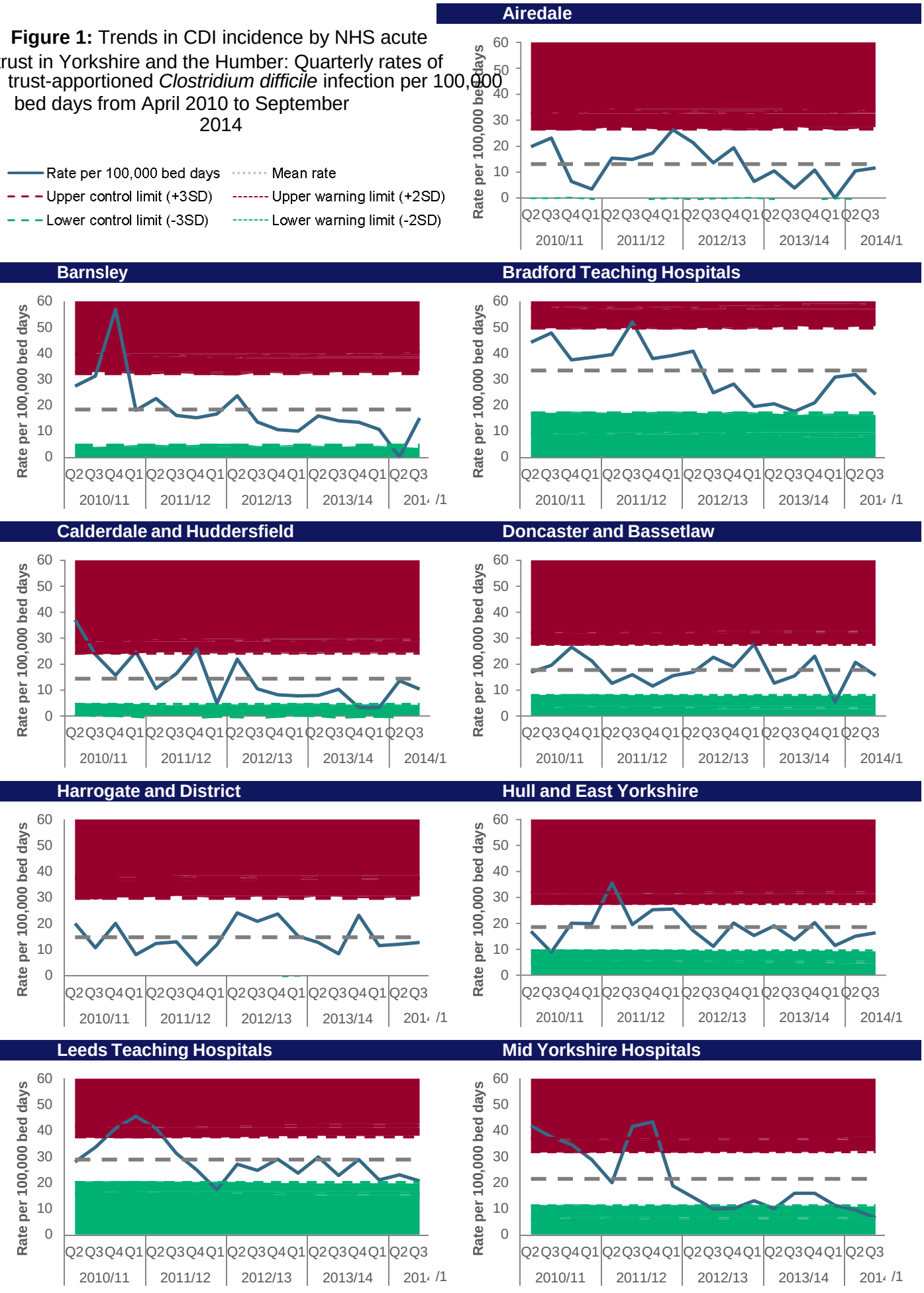
Source: HCAI Mandatory Surveillance; AT = Area Team; NYH = North Yorkshire and the Humber; SY = South Yorkshire and Bassetlaw; WY = West Yorkshire

Trust Type	NHS AT	Trust Name	2013	2014			Trend	Q3 vs Q2
			Q4	Q1	Q2	Q3		
Teaching	NYH	Hull & East Yorkshire	18	10	13	14		↑
	SY	Sheffield Teaching	18	13	25	34		↑
	WY	Leeds Teaching	41	30	32	28		↓
		Bradford Teaching	10	15	15	11		↓
Normal	NYH	Harrogate & District	6	3	3	3		→
		Northern Lincs & Goole	5	5	4	5		↑
	SY	York Hospitals Barnsley	21	13	12	10		↓
		Hospital	5	4	0	5		↑
		Doncaster & Bassetlaw	17	4	15	11		↓
		The Rotherham	7	7	8	5		↓
		Airedale	3	0	3	3		→
	WY	Calderdale & Huddersfield	2	2	8	6		↓
		Mid Yorkshire	13	9	7	5		↓
Specialist	SY	Sheffield Children's	2	2	0	0		→
Yorkshire and the Humber			**168**	**117**	**145**	**140**		↓
England			**1249**	**1159**	**1197**	**1353**		↑

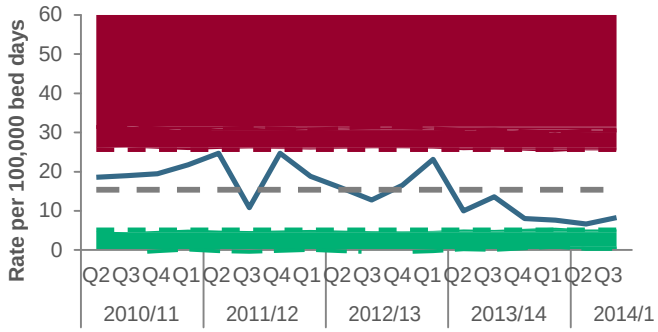
Table 2: All CDI cases in patients over 2yrs of age by CCG from October 2013 to September 2014, Yorkshire and the Humber

NHS AT	CCG	2013	2014			Trend	Q3 vs Q2
		Q4	Q1	Q2	Q3		
North Yorkshire and the Humber	East Riding Of Yorkshire	22	18	20	31		↑
	Hambleton, Richmondshire & Whitby	13	6	11	14		↑
	Harrogate and Rural District	16	6	6	11		↑
	Hull	16	14	25	21		↓
	North East Lincolnshire	8	8	9	6		↓
	North Lincolnshire	9	5	9	9		→
	Scarborough and Ryedale	17	10	6	8		↑
	Vale Of York	31	17	17	25		↑
	Total	**132**	**84**	**103**	**125**		↑
South Yorkshire and Bassetlaw	Barnsley	16	12	11	24		↑
	Bassetlaw	9	1	6	9		↑
	Doncaster	28	14	26	29		↑
	Rotherham	21	12	24	13		↓
	Sheffield	47	35	56	65		↑
	Total	**121**	**74**	**123**	**140**		↑
West Yorkshire	Airedale, Wharfdale & Craven	11	3	9	13		↑
	Bradford City	7	8	5	7		↑
	Bradford Districts	26	34	29	33		↑
	Calderdale	11	8	15	10		↓
	Greater Huddersfield	11	7	5	10		↑
	Leeds North	16	18	16	13		↓
	Leeds South and East	25	27	35	25		↓
	Leeds West	30	26	26	19		↓
	North Kirklees	16	11	11	9		↓
	Wakefield	35	17	21	15		↓
	Total	**188**	**159**	**172**	**154**		↓
Yorkshire and the Humber		**432**	**316**	**392**	**410**		↑
England		**3,298**	**3,006**	**3,440**	**3,971**		↑

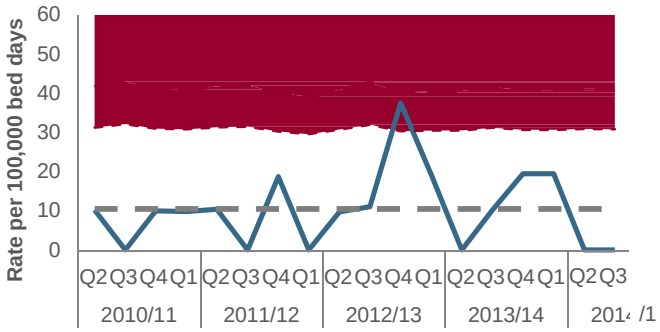
Figure 1: Trends in CDI incidence by NHS acute trust in Yorkshire and the Humber: Quarterly rates of trust-apportioned *Clostridium difficile* infection per 100,000 bed days from April 2010 to September 2014



Northern Lincolnshire and Goole



Sheffield Children's Hospital



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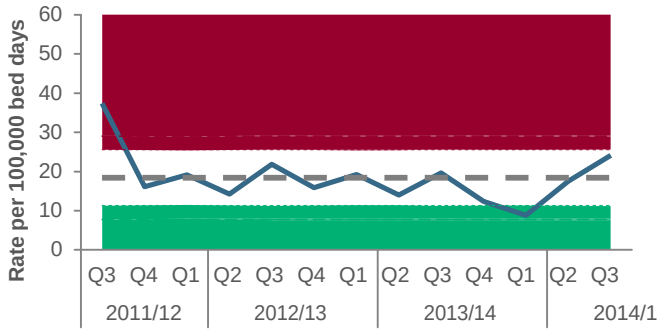

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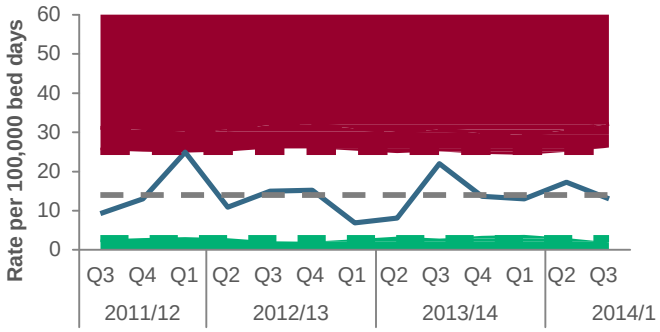


York Hospital

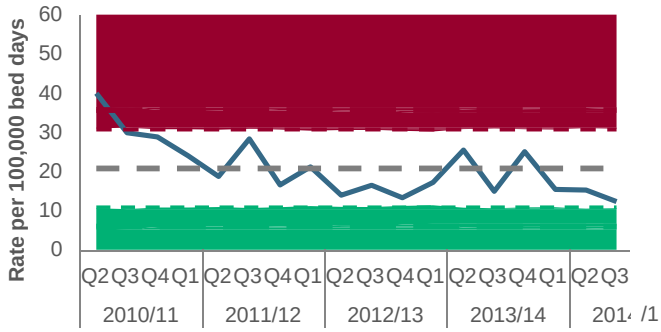
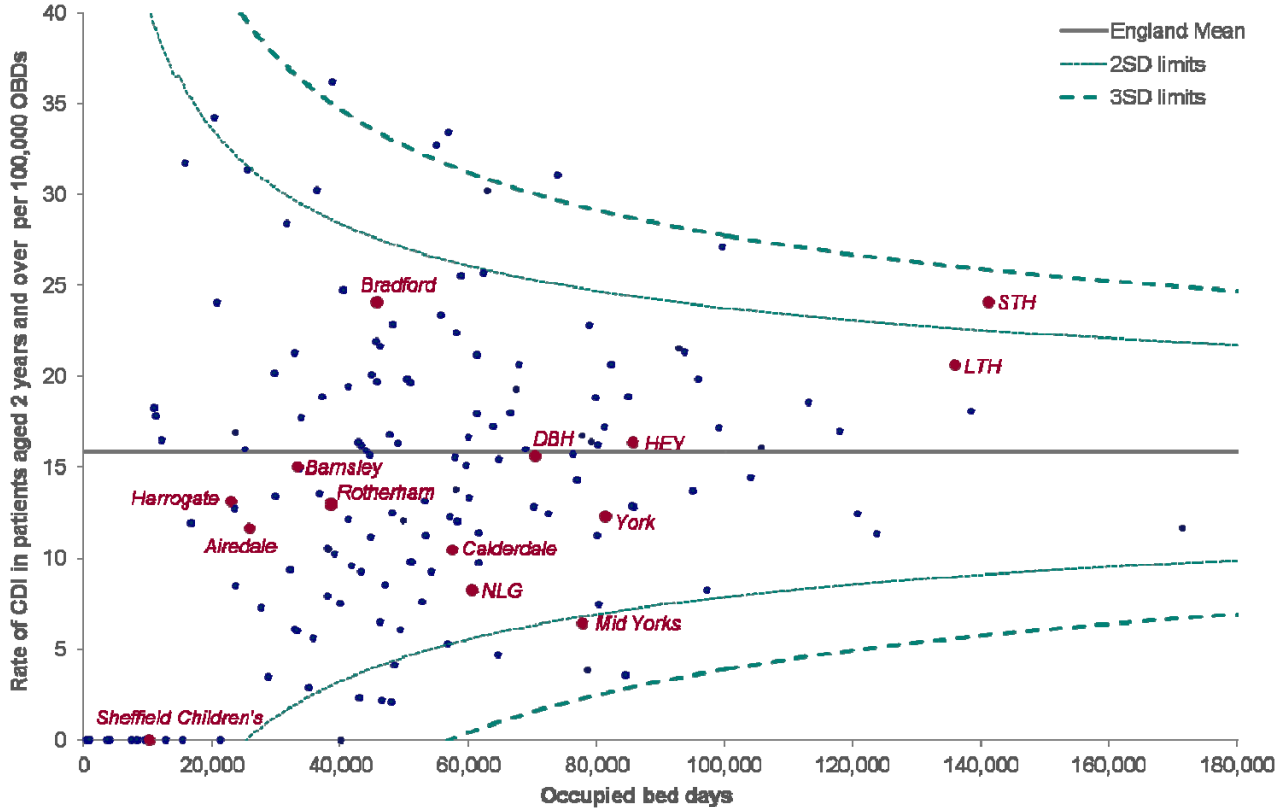
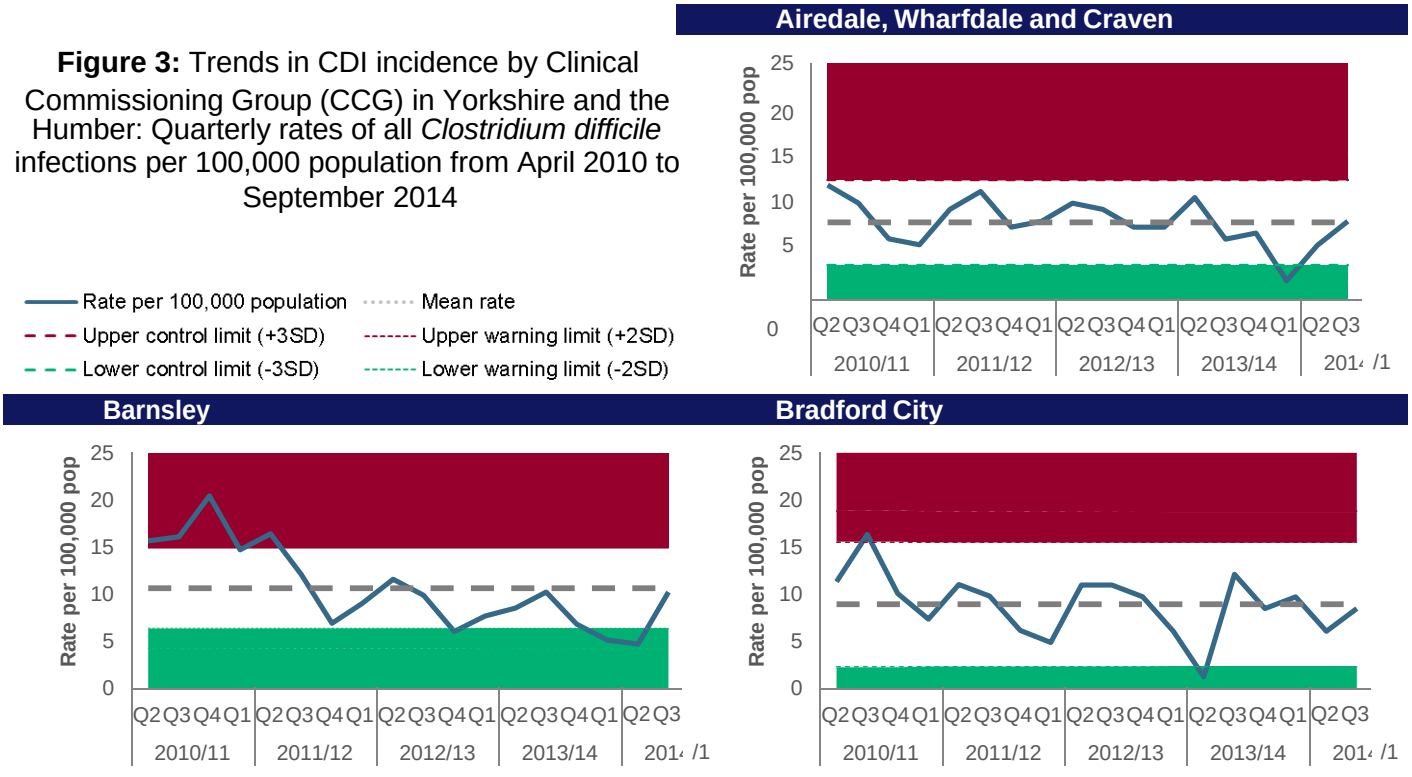


Figure 2: Trust-apportioned CDI rates in patients over the age of 2 years per 100,000 bed days for all England acute trusts from July to September 2014
Source: HCAI Mandatory Surveillance; Points represent all acute NHS trusts in England. Trusts within Yorkshire and the Humber are highlighted; Dashed lines represent control limits at 2 and 3 standard deviations (SDs) around the national mean to allow for identification of outlying trusts

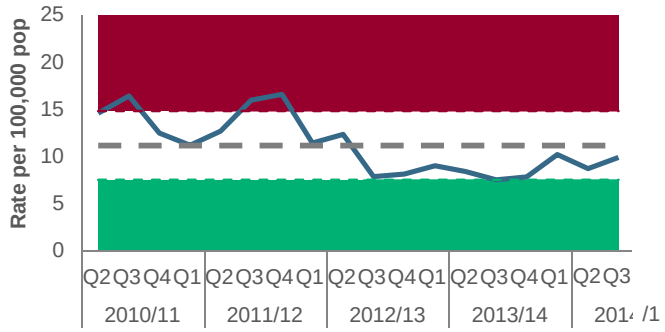


NLG = Northern Lincolnshire and Goole; DBH = Doncaster and Bassetlaw Hospitals; Mid Yorks = Mid Yorkshire Hospitals; HEY = Hull and East Yorkshire Hospitals; LTH = Leeds Teaching Hospitals; STH = Sheffield Teaching Hospitals

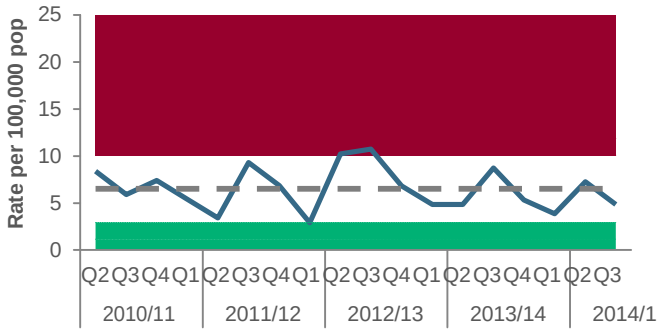
Figure 3: Trends in CDI incidence by Clinical Commissioning Group (CCG) in Yorkshire and the Humber: Quarterly rates of all *Clostridium difficile* infections per 100,000 population from April 2010 to September 2014



Bradford Districts



Calderdale



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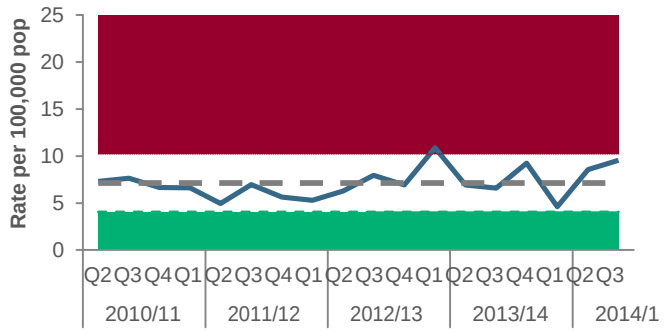

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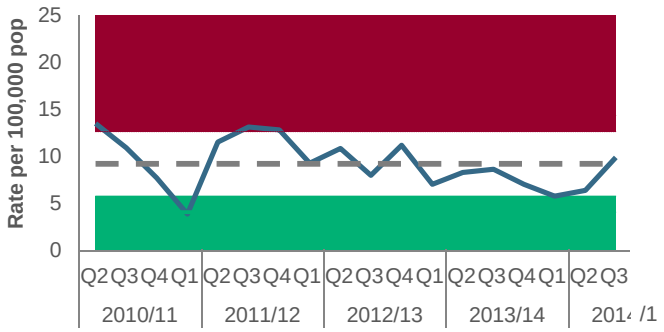

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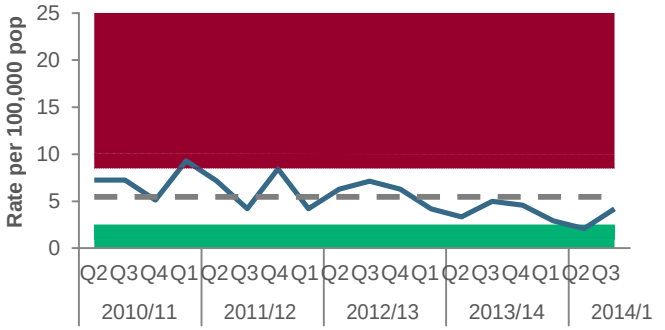

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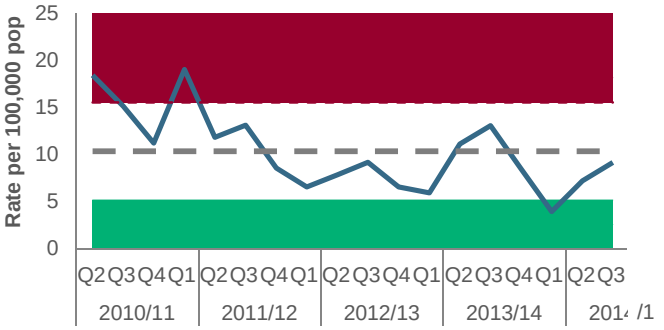

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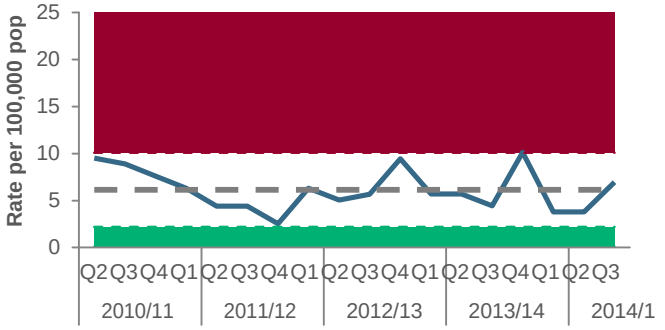

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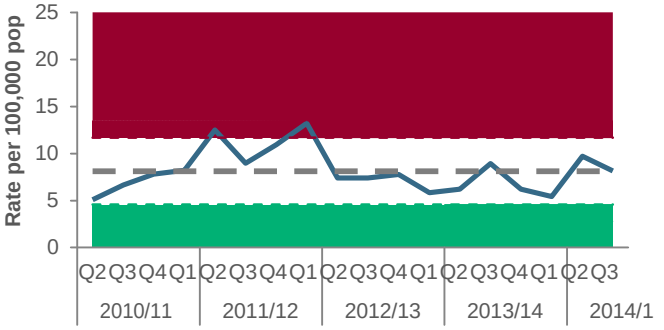

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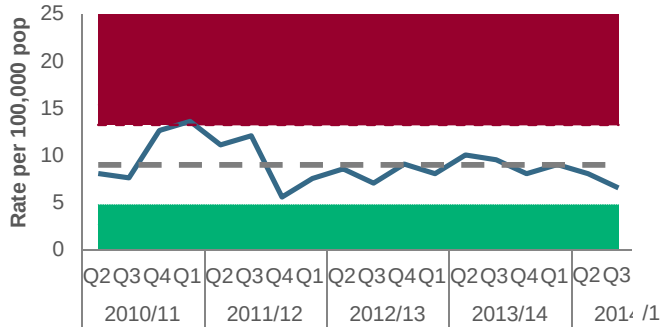

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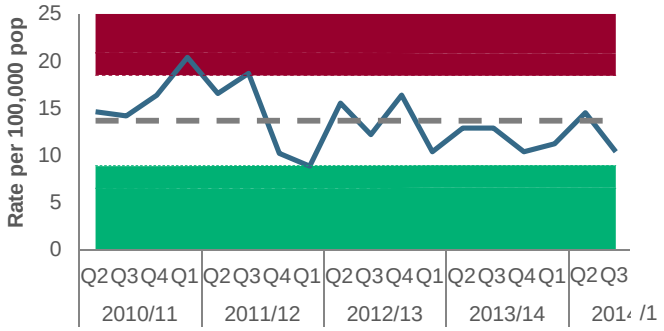

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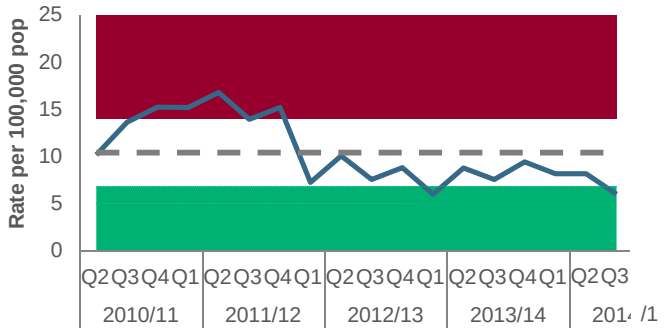

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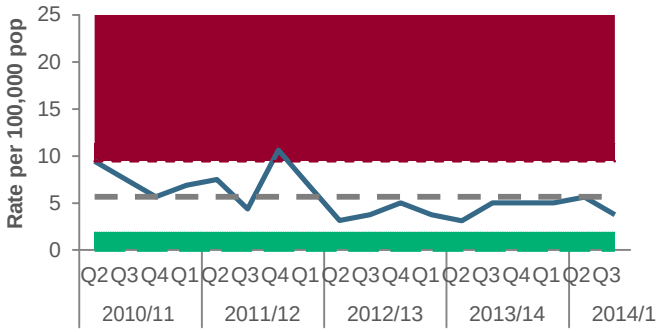

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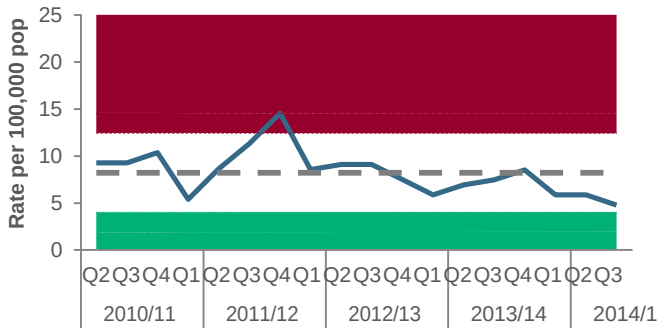
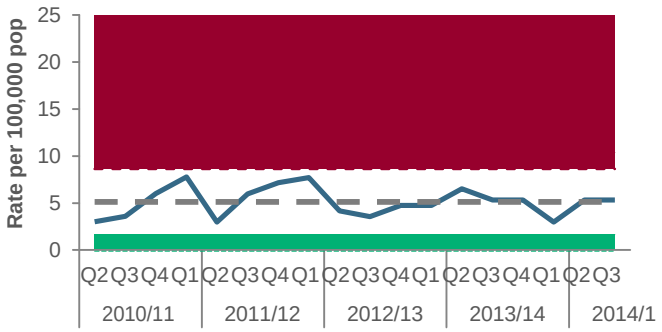


North Lincolnshire



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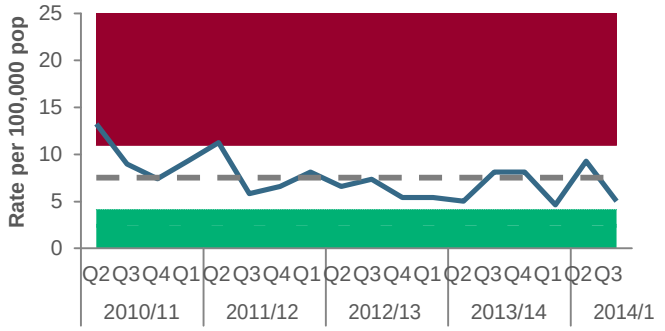

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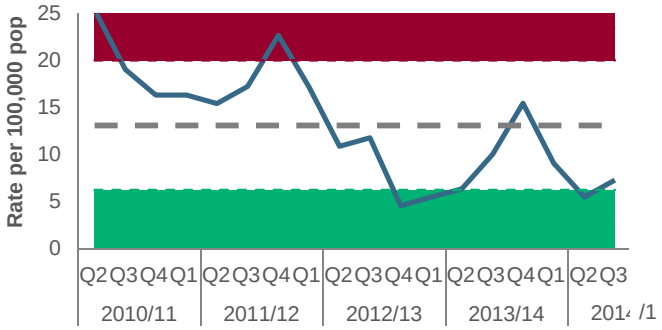

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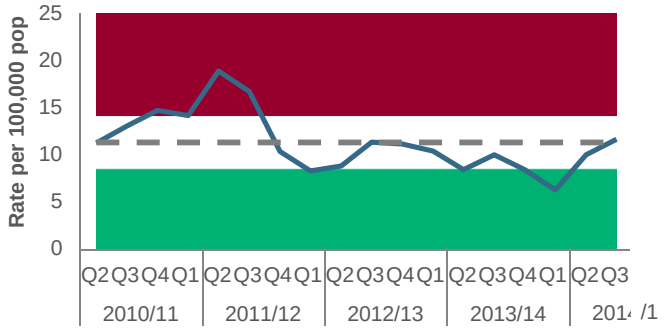

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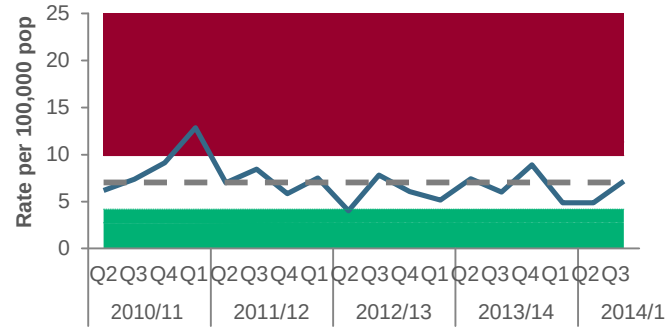
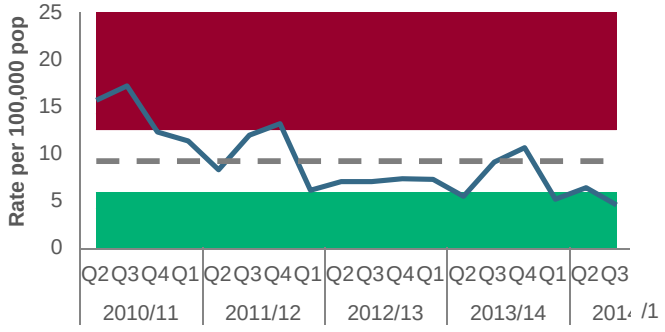


Wakefield



MRSA Bacteraemia

In July to September 2014, there were 2 trust-assigned and 6 CCG-assigned cases of MRSA bacteraemia in Yorkshire and the Humber following the Post Infection Review (PIR) process. One case was also reported in Bassetlaw but this is excluded from YH totals. No trusts reported MRSA bacteraemia incidence significantly higher than that seen previously or than the national average for this quarter.

Table 3: Trust-assigned MRSA bacteraemia cases from October 2013 to September 2014, Yorkshire and the Humber

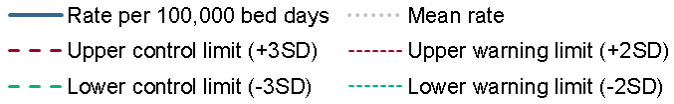
Source: HCAI Mandatory Surveillance; Cases assigned to trust or CCG as a result of the post infection review (PIR) process; AT = Area Team; NYH = North Yorkshire and the Humber; SY = South Yorkshire and Bassetlaw; WY = West Yorkshire

Trust Type	NHS AT	Trust Name	2013	2014			Trend	Q3 vs Q2
			Q4	Q1	Q2	Q3		
Teaching	NYH	Hull & East Yorkshire	1	0	0	0		
	SY	Sheffield Teaching	2	1	1	0		
	WY	Leeds Teaching	1	2	4	0		
		Bradford Teaching	0	2	1	1		
		Harrogate & District	0	0	0	0		
	NYH	Northern Lincs & Goole	2	1	0	0		
		York Hospitals	0	0	0	0		
		Barnsley Hospital	0	0	0	0		
	SY	Doncaster & Bassetlaw	1	0	0	1		
		The Rotherham	0	0	0	0		
		Airedale	1	1	0	0		
	WY	Calderdale & Huddersfield	1	0	1	0		
		Mid Yorkshire	1	1	1	0		
Specialist	SY	Sheffield Children's	0	0	0	0		
Yorkshire and the Humber			**10**	**8**	**8**	**2**		
England			**107**	**106**	**73**	**70**		

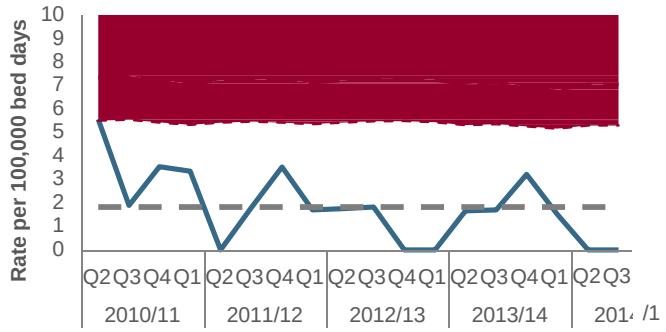
Table 4: CCG-assigned MRSA bacteraemia cases from October 2013 to September 2014, Yorkshire and the Humber

NHS AT	CCG	2013	2014			Trend	Q3 vs Q2
		Q4	Q1	Q2	Q3		
North Yorkshire and the Humber	East Riding Of Yorkshire	0	1	1	0		
	Hambleton, Richmondshire & Whitby	2	1	0	0		
	Harrogate and Rural District	0	1	0	0		
	Hull	0	0	1	0		
	North East Lincolnshire	0	0	0	0		
	North Lincolnshire	0	0	1	1		
	Scarborough and Ryedale	1	0	0	0		
	Vale Of York	0	1	2	0		
	Total	**3**	**4**	**5**	**1**		
South Yorkshire and Bassetlaw	Barnsley	2	1	0	0		
	Bassetlaw	0	1	0	1		
	Doncaster	0	0	0	0		
	Rotherham	0	0	0	0		
	Sheffield	0	2	2	0		
	Total	**2**	**4**	**2**	**1**		
	Airedale, Wharfdale & Craven	0	0	0	0		
	Bradford City	0	0	1	1		
	Bradford Districts	1	0	0	1		
	Calderdale	2	0	0	0		
	Greater Huddersfield	0	1	0	0		
	Leeds North	1	0	0	0		
	Leeds South and East	0	1	2	0		
	Leeds West	1	0	1	2		
	North Kirklees	2	1	0	0		
	Wakefield	1	1	0	1		
	Total	**8**	**4**	**4**	**5**		
Yorkshire and the Humber		**13**	**11**	**11**	**6**		
England		**112**	**100**	**91**	**86**		

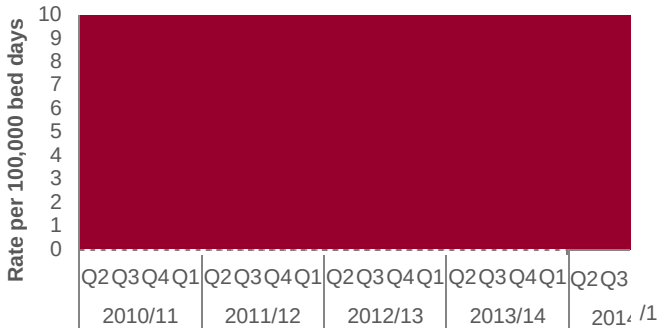
Figure 4: Trends in MRSA bacteraemia incidence by NHS acute trust in Yorkshire and the Humber: Quarterly rates of trust-apportioned/assigned* MRSA bacteraemia per 100,000 bed days from April 2010 to September 2014
*PIR assignment of cases from April 2013



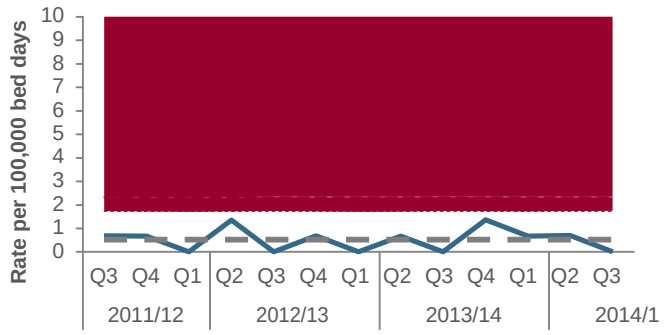
Northern Lincolnshire and Goole



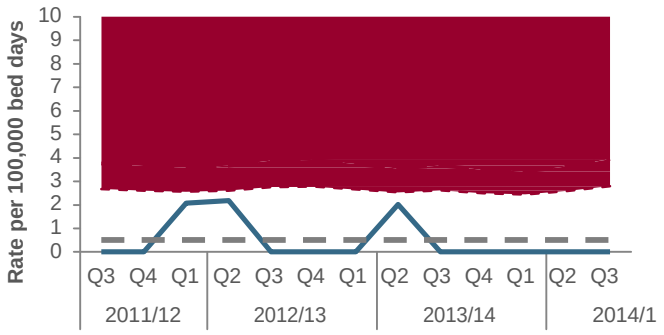
Sheffield Children's Hospital



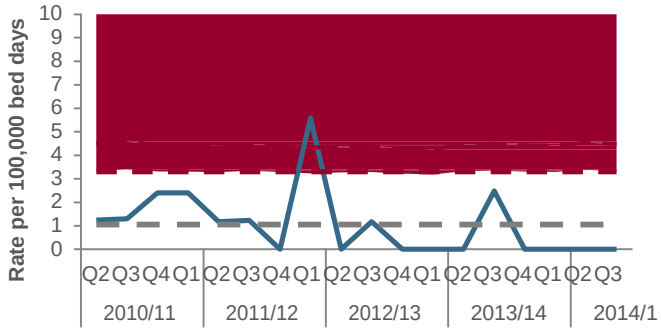
Sheffield Teaching Hospitals



The Rotherham



York Hospital



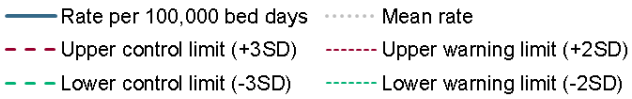
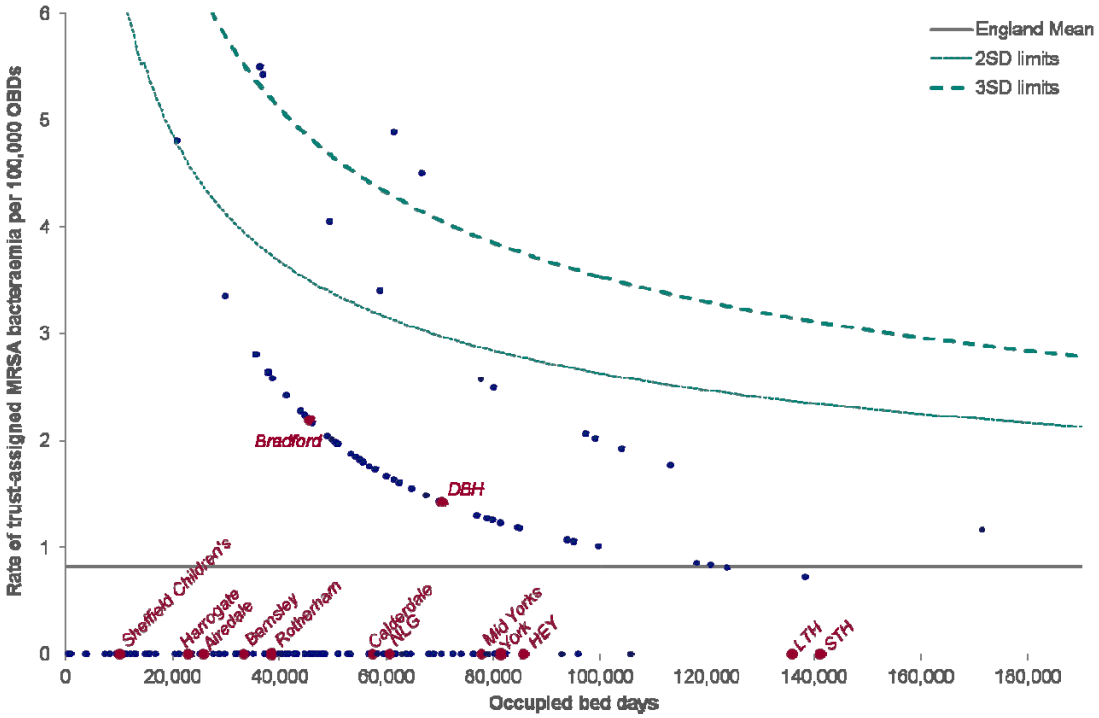


Figure 5: Trust-assigned MRSA bacteraemia rates per 100,000 bed days for all England acute trusts from July to September 2014

Source: HCAI Mandatory Surveillance; Points represent all acute NHS trusts in England. Trusts within Yorkshire and the Humber are highlighted; Dashed lines represent control limits at 2 and 3 standard deviations (SDs) around the national mean to allow for identification of outlying trusts

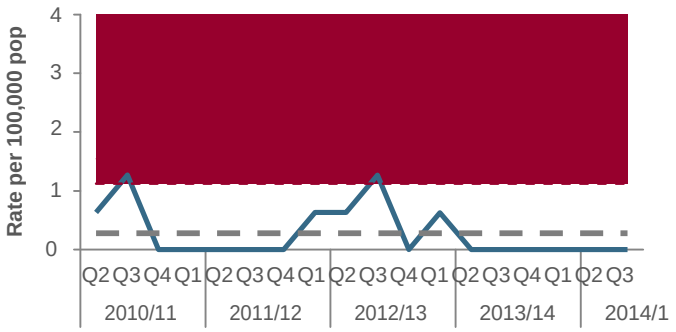


NLG = Northern Lincolnshire and Goole; DBH = Doncaster and Bassetlaw Hospitals; Mid Yorks = Mid Yorkshire Hospitals; HEY = Hull and East Yorkshire Hospitals; LTH = Leeds Teaching Hospitals; STH = Sheffield Teaching Hospitals

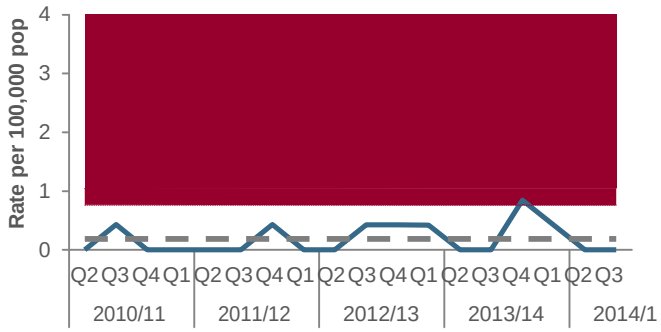
Figure 6: Trends in MRSA bacteraemia incidence by Clinical Commissioning Group (CCG) in Yorkshire and the Humber: Quarterly rates of CCG-assigned/apportioned* MRSA bacteraemias per 100,000 population from April 2010 to September 2014

*PIR assignment of cases from April 2013

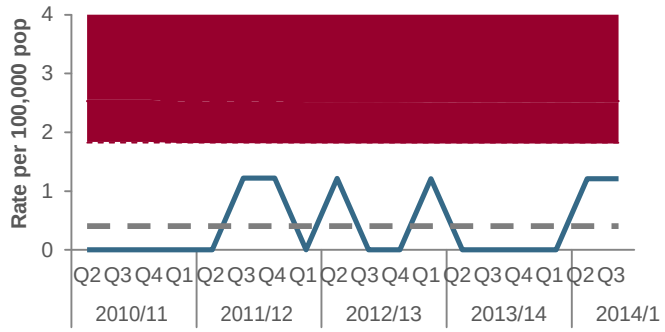
Airedale, Wharfdale and Craven



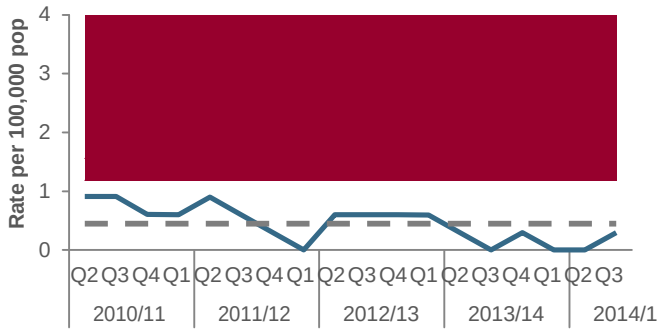
Barnsley



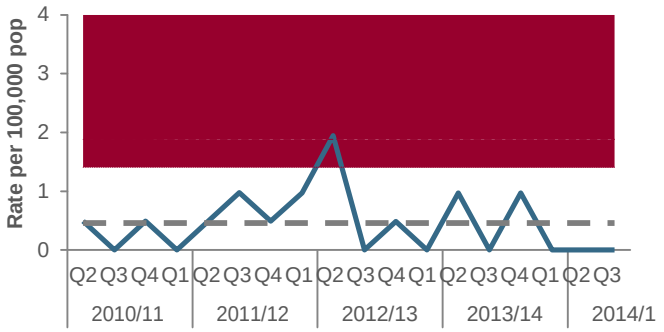
Bradford City



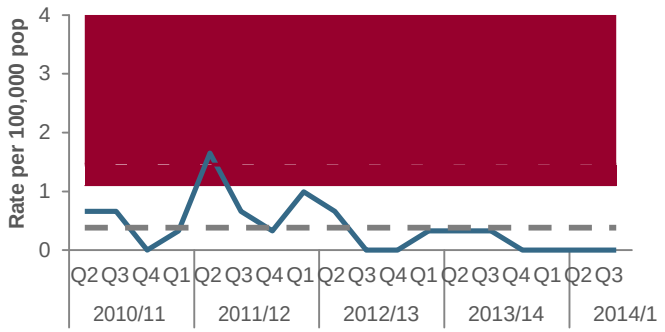
Bradford Districts



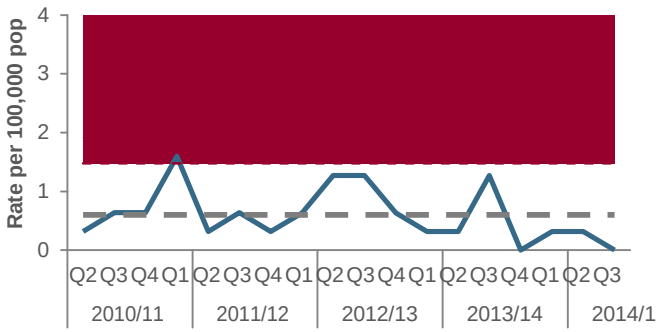
Calderdale



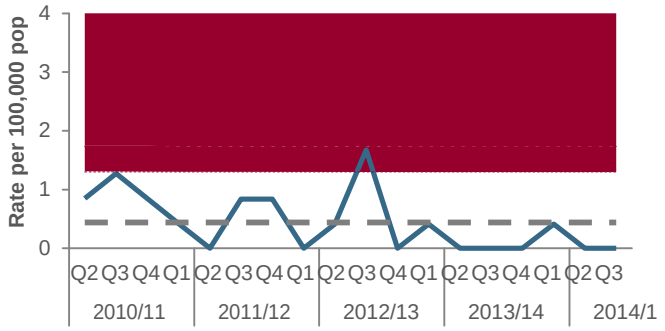
Doncaster



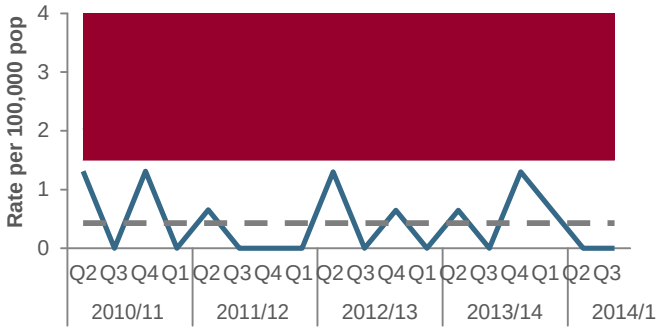
East Riding of Yorkshire



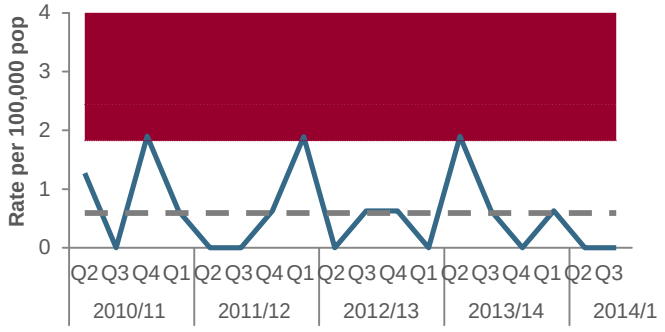
Greater Huddersfield



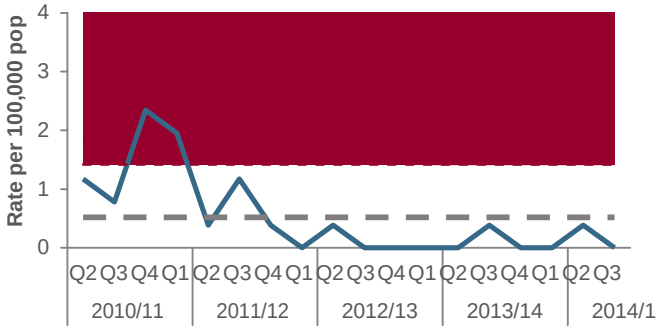
Hambleton, Richmondshire and Whitby



Harrogate and Rural District



Hull



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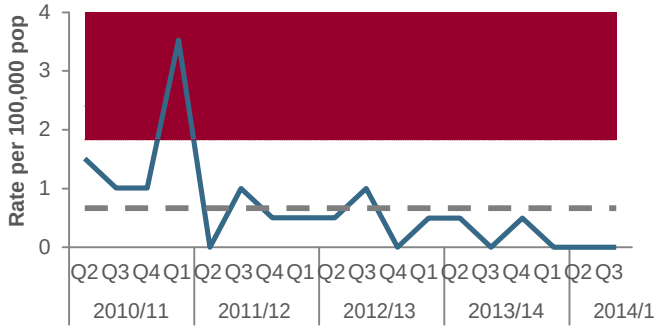

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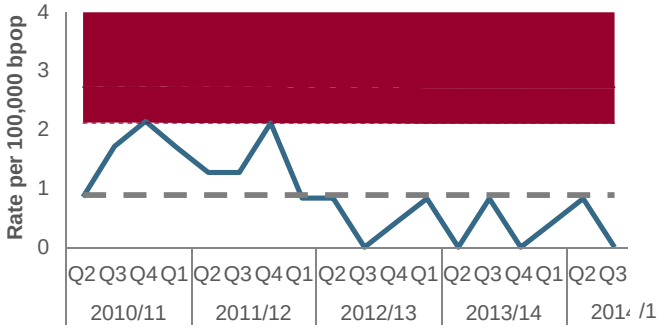

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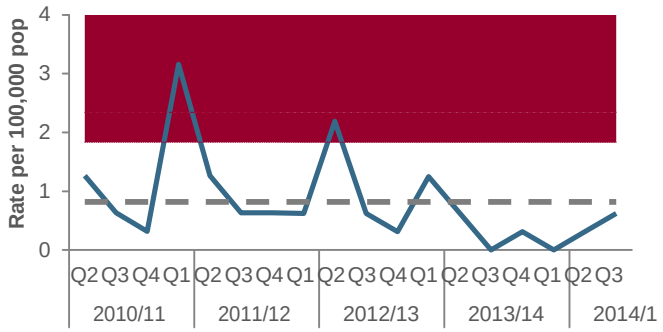
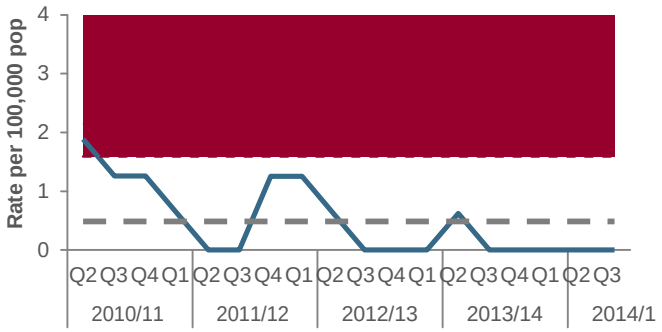
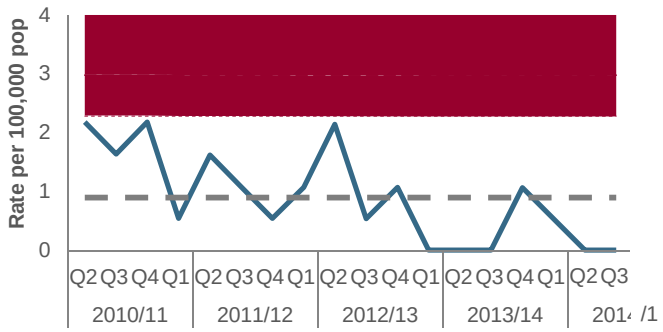


North East Lincolnshire



North Kirklees



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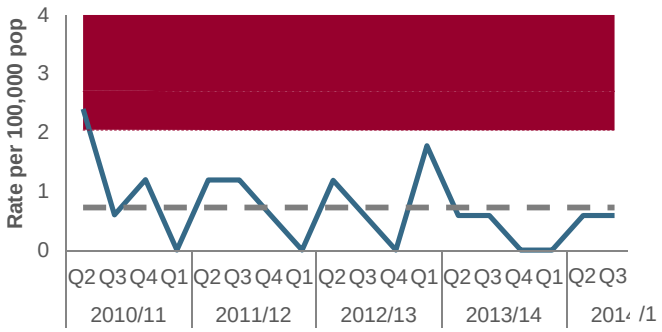
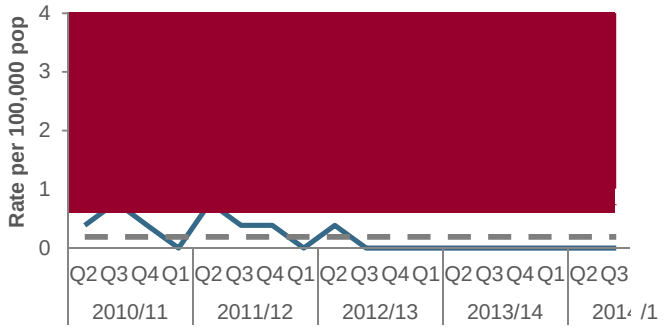
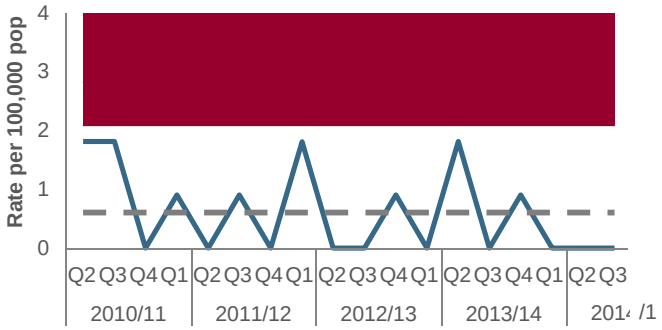


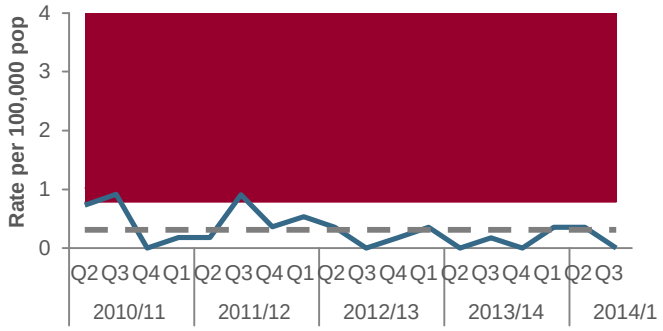
Rotherham



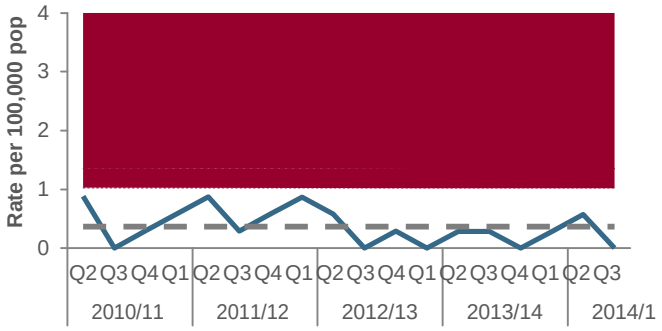
Scarborough and Ryedale



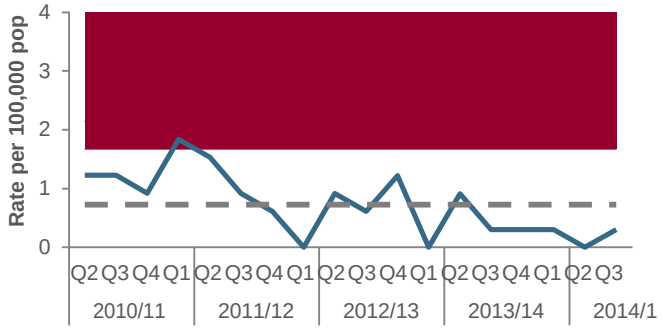
Sheffield



Vale of York



Wakefield



MSSA Bacteraemia

273 cases of MSSA bacteraemia were reported in Yorkshire and the Humber in July to September 2014. Harrogate & Rural District was the only CCG to report incidence significantly higher than that expected this quarter (n=15; 9.48 cases per 100,000 population). 73 cases were apportioned to acute trusts within Yorkshire and the Humber. No trusts reported significant increases in trust-apportioned MSSA bacteraemia incidence over this quarter and all trusts were within the expected bounds around the national average rate.

Table 5: Trust-apportioned MSSA bacteraemia cases from October 2013 to September 2014, Yorkshire and the Humber

Source: HCAI Mandatory Surveillance; AT = Area Team; NYH = North Yorkshire and the Humber; SY = South Yorkshire and Bassetlaw; WY = West Yorkshire

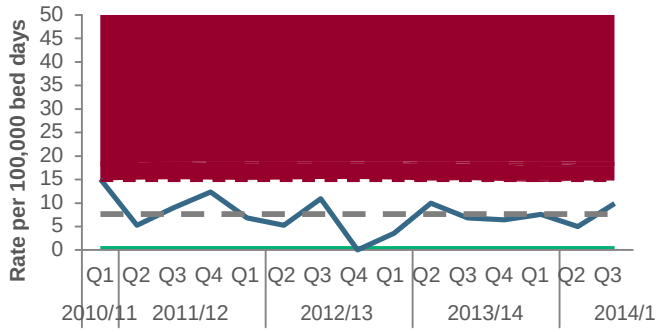
NHS AT		Trust Name	2013 Q4	2014 Q1	2014 Q2	2014 Q3	Trend	Q3 vs Q2
	Teaching		11	16	12	10		
SY		Sheffield Teaching	6	17	12	11		
WY		Leeds Teaching	12	16	15	11		
		Bradford Teaching	7	3	5	6		
	Normal	Harrogate & District	4	5	0	4		
	NYH	Northern Lincs & Goole	4	5	3	6		
		York Hospitals Barnsley	6	11	14	9		
		Hospital	2	0	0	1		
	SY	Doncaster & Bassetlaw	2	5	10	7		
		The Rotherham	2	4	2	0		
		Airedale	2	0	1	2		
	WY	Calderdale & Huddersfield	3	7	1	1		
		Mid Yorkshire	6	5	3	5		
	Specialist	SY Sheffield Children's	1	2	0	0		
		Yorkshire and the Humber	**68**	**96**	**78**	**73**		
		England	**596**	**689**	**680**	**675**		

Table 6: All MSSA bacteraemia cases by CCG from October 2013 to September 2014, Yorkshire and the Humber

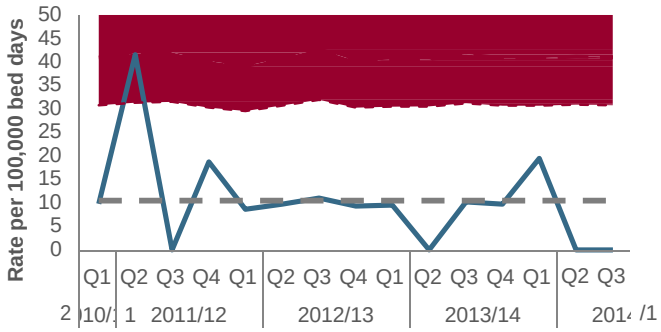
NHS AT	CCG	2013 Q4	2014 Q1	2014 Q2	2014 Q3	Trend	Q3 vs Q2
North Yorkshire and the Humber	East Riding Of Yorkshire	11	13	13	16		
	Hambleton, Richmondshire & Whitby	6	13	8	6		
	Harrogate and Rural District	10	10	6	15		
	Hull	19	25	20	19		
	North East Lincolnshire	11	9	6	12		
	North Lincolnshire	7	8	7	14		
	Scarborough and Ryedale	6	4	7	9		
	Vale Of York	16	15	20	23		
	Total	**86**	**97**	**87**	**114**		
	Barnsley	11	6	11	14		
	Bassetlaw	5	2	5	5		
	Doncaster	13	13	25	10		
	Rotherham	9	19	13	8		
	Sheffield	23	44	33	31		
	Total	**61**	**84**	**87**	**68**		
West Yorkshire	Airedale, Wharfdale & Craven	5	2	8	12		
	Bradford City	8	3	6	5		
	Bradford Districts	18	14	14	14		
	Calderdale	14	9	13	6		
	Greater Huddersfield	11	11	7	8		
	Leeds North	5	4	13	10		
	Leeds South and East	10	14	22	11		
	Leeds West	11	15	10	7		
	North Kirklees	7	4	5	13		
	Wakefield	10	21	9	10		
	Total	**99**	**97**	**107**	**96**		
	Yorkshire and the Humber	**241**	**276**	**276**	**273**		
	England	**2,213**	**2,404**	**2,315**	**2,417**		

Figure 7: Trends in MSSA bacteraemia incidence by NHS acute trust in Yorkshire and the Humber: Quarterly rates of trust-apportioned MSSA bacteraemia per 100,000 bed days from January 2011 to September 2014

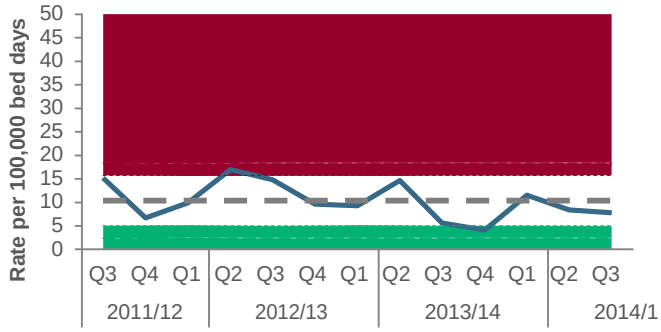
Northern Lincolnshire and Goole



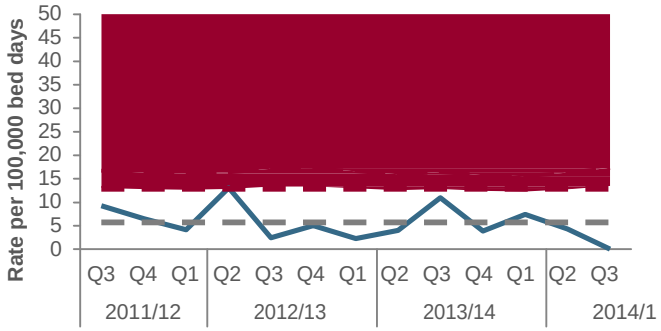
Sheffield Children's Hospital



Sheffield Teaching Hospitals



The Rotherham



York Hospital

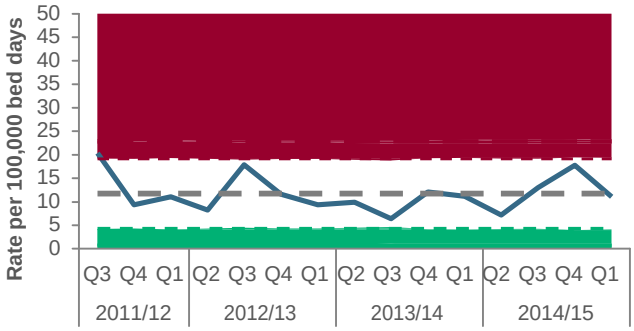
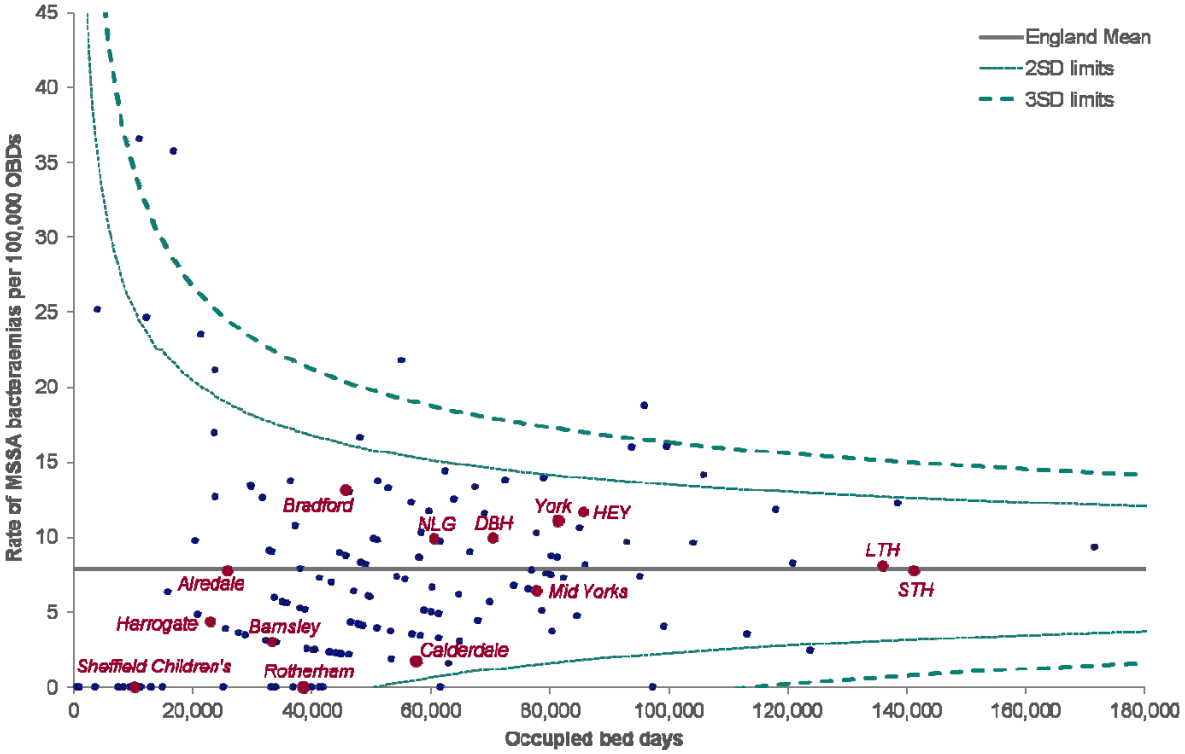


Figure 8: Trust-apportioned MSSA bacteraemia rates per 100,000 bed days for all England acute trusts from July to September 2014
Source: HCAI Mandatory Surveillance; Points represent all acute NHS trusts in England. Trusts within Yorkshire and the Humber are highlighted; Dashed lines represent control limits at 2 and 3 standard deviations (SDs) around the national mean to allow for identification of outlying trusts



NLG = Northern Lincolnshire and Goole; DBH = Doncaster and Bassetlaw Hospitals; Mid Yorks = Mid Yorkshire Hospitals; HEY = Hull and East Yorkshire Hospitals; LTH = Leeds Teaching Hospitals; STH = Sheffield Teaching Hospitals

Figure 9: Percentage of all blood cultures examined that are positive for *Staphylococcus aureus* by acute trust in Yorkshire and the Humber, July to September 2014
Source: HCAI Mandatory Surveillance; Points represent all acute NHS trusts in Yorkshire and the Humber with the exception of Doncaster and Bassetlaw Hospitals (data not available for Q3 2014)

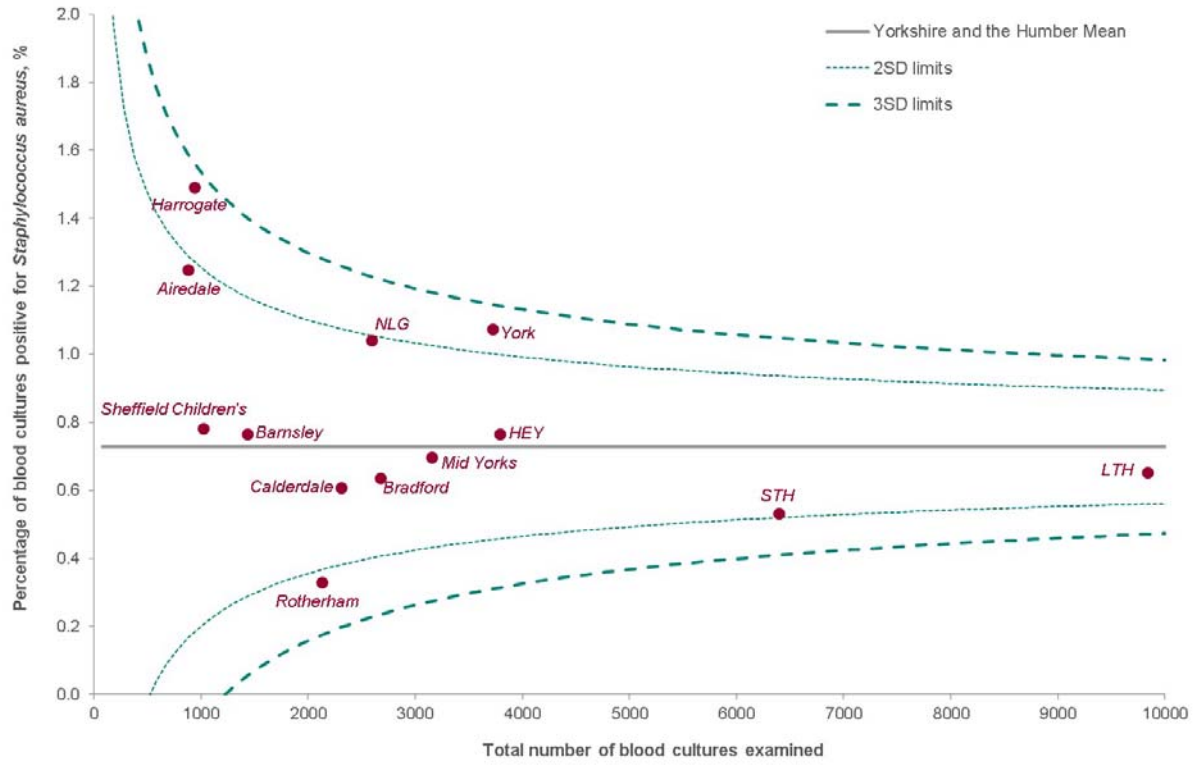
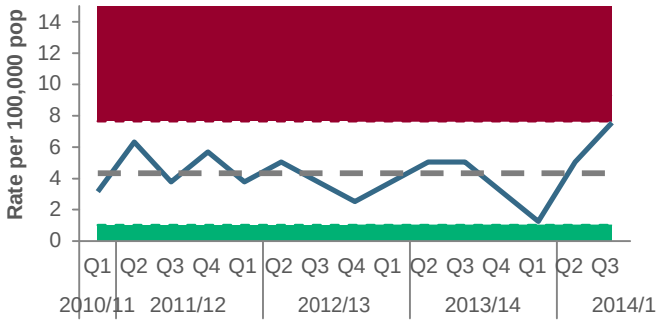
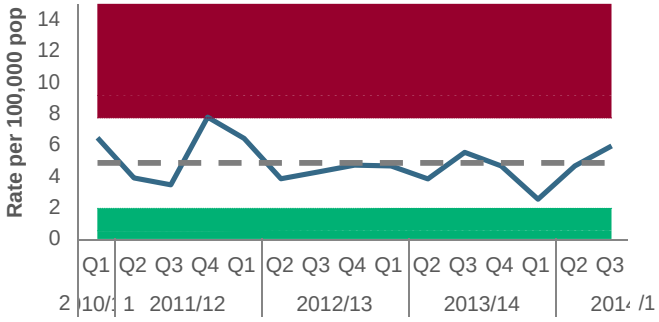


Figure 10: Trends in MSSA bacteraemia incidence by Clinical Commissioning Group (CCG) in Yorkshire and the Humber: Quarterly rates of all MSSA bacteraemia cases per 100,000 population from April 2010 to September 2014

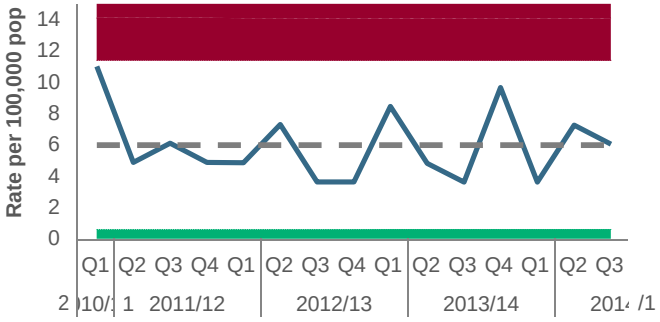
Airedale, Wharfdale and Craven



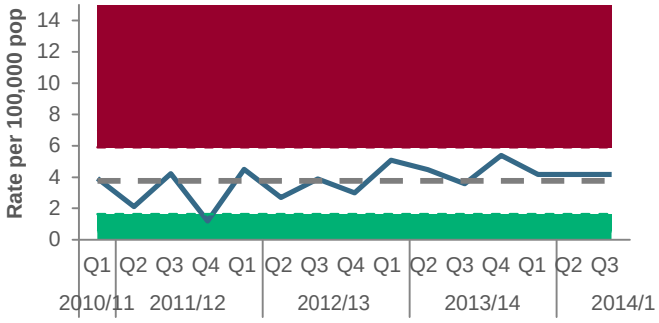
Barnsley



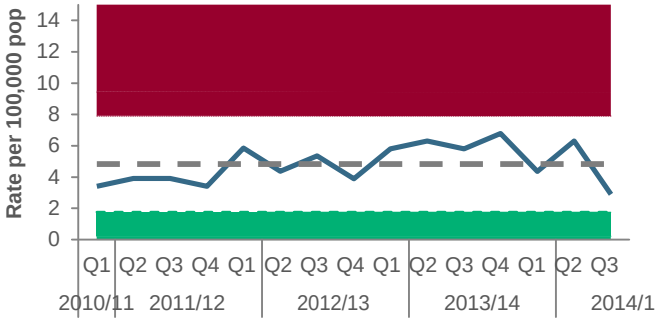
Bradford City



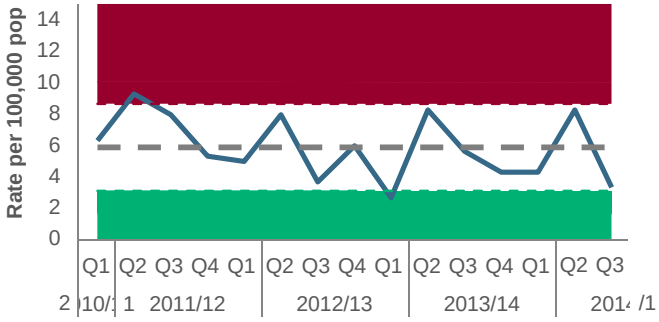
Bradford Districts



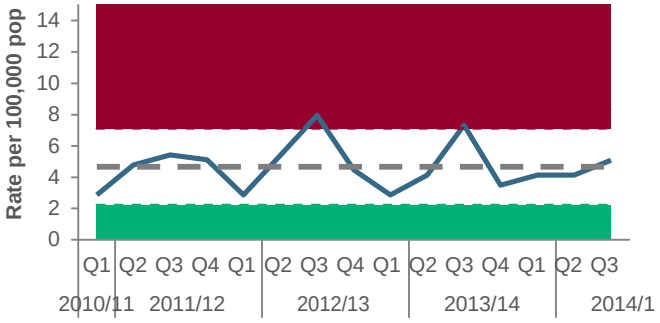
Calderdale



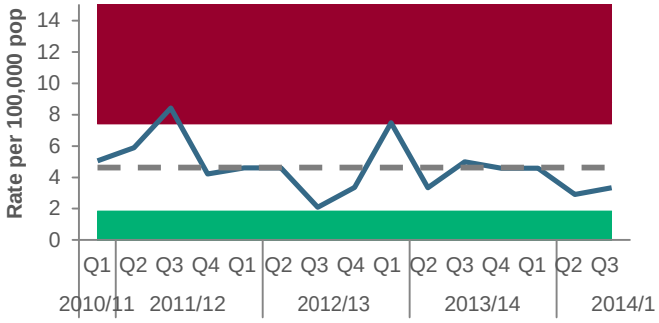
Doncaster



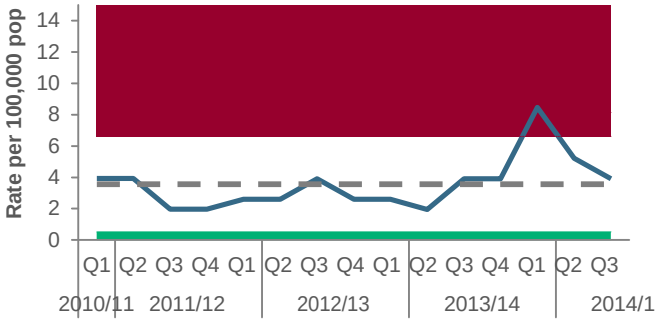
East Riding of Yorkshire



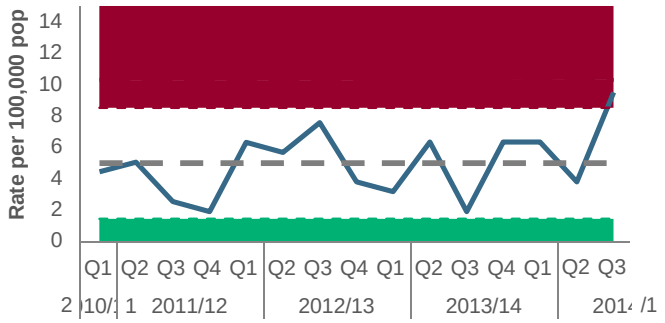
Greater Huddersfield



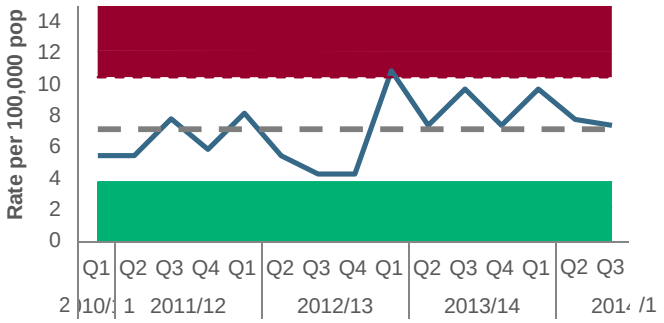
Hambleton, Richmondshire and Whitby



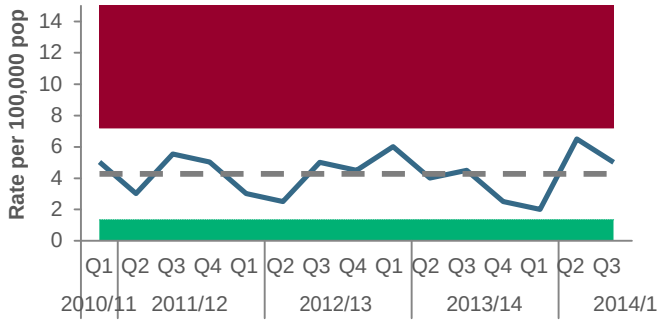
Harrogate and Rural District



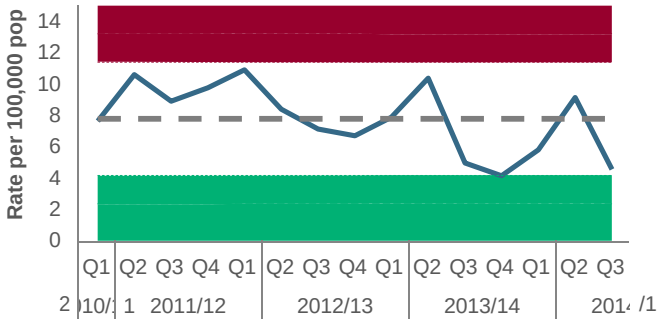
Hull



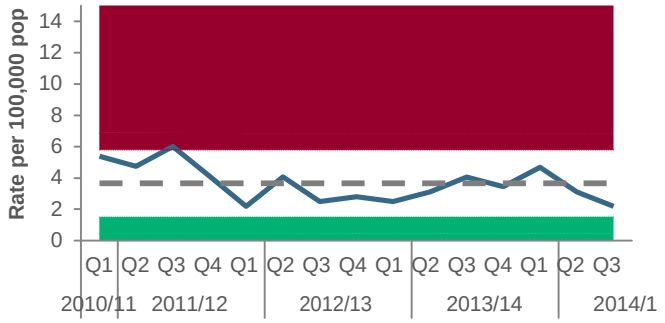
Leeds North



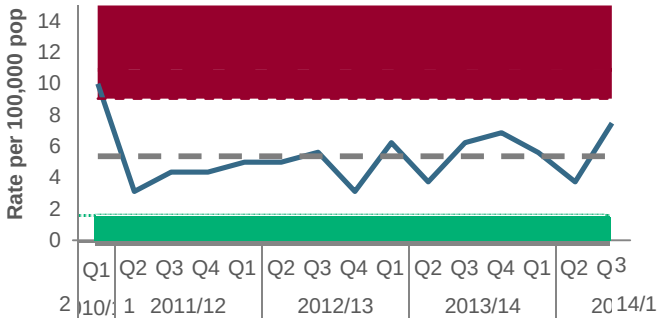
Leeds South and East



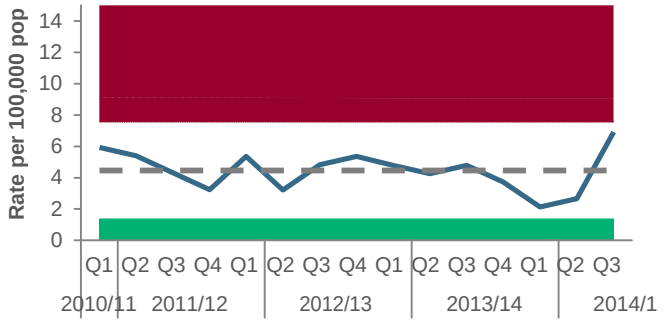
Leeds West



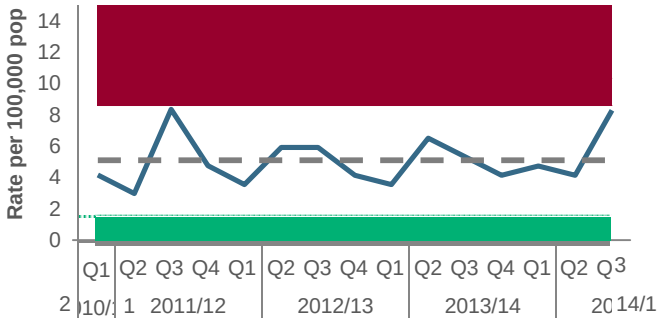
North East Lincolnshire



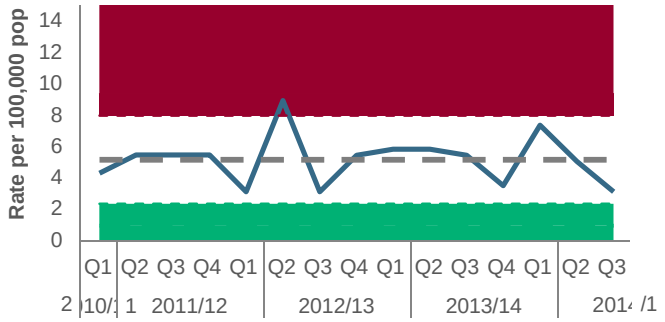
North Kirklees



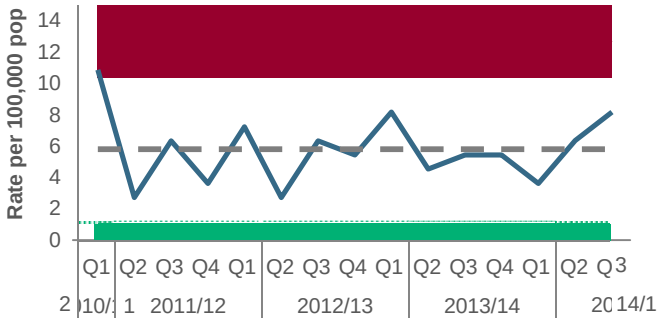
North Lincolnshire



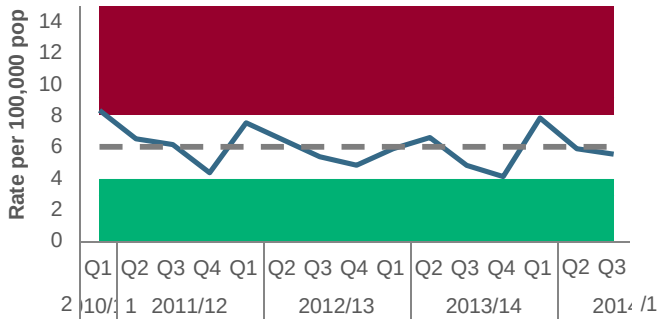
Rotherham



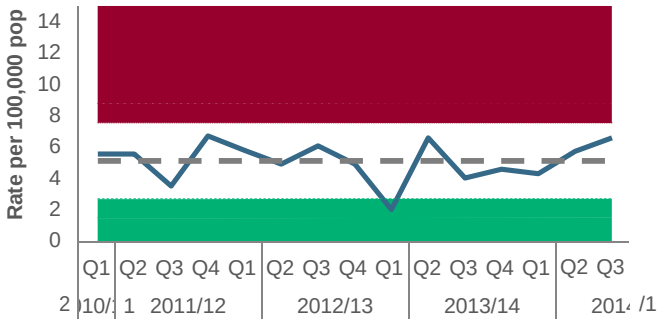
Scarborough and Ryedale



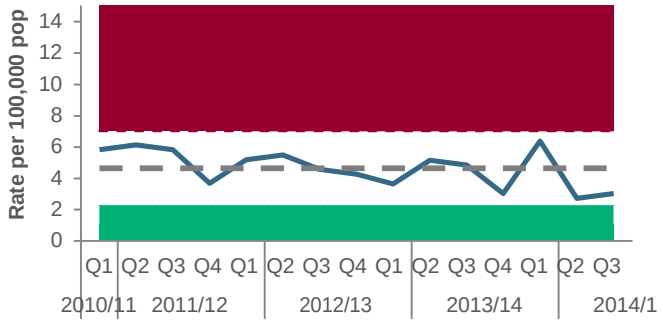
Sheffield



Vale of York



Wakefield



E. coli Bacteraemia

There were 1,075 cases of *E. coli* bacteraemia attributed to CCGs within Yorkshire and Humber in July to September 2014, a marginal increase on 1,027 cases in April to June. (This figure excludes the 20 cases in Bassetlaw CCG). The small discrepancy between numbers of cases reported by laboratory and by CCG occurs where a patients practice is in a CCG outside of Yorkshire and the Humber.

Table 7: *E. coli* bacteraemia cases by NHS acute trust from October 2013 to September 2014, Yorkshire and the Humber

Source: HCAI Mandatory Surveillance; AT = Area Team; NYH = North Yorkshire and the Humber; SY = South Yorkshire and Bassetlaw; WY = West Yorkshire

Trust Type	NHS AT	Trust Name	2013	2014			Trend	Q3 vs Q2
			Q4	Q1	Q2	Q3		
Teaching	NYH	Hull & East Yorkshire	112	98	73	100		
	SY	Sheffield Teaching	130	128	147	169		
	WY	Leeds Teaching	139	138	153	153		
		Bradford Teaching	61	65	69	65		
Normal	NYH	Harrogate & District	26	19	26	28		
		Northern Lincs & Goole	60	73	68	75		
		York Hospitals	114	114	121	124		
	SY	Barnsley Hospital	42	38	39	52		
		Doncaster & Bassetlaw	84	100	87	85		
		The Rotherham	63	50	52	51		
	WY	Airedale	27	31	25	34		
		Calderdale & Huddersfield	57	63	66	52		
		Mid Yorkshire	85	90	103	101		
Specialist	SY	Sheffield Children's	5	0	5	11		
Yorkshire and the Humber			**1005**	**1007**	**1034**	**1100**		
England			**8623**	**8380**	**8886**	**9475**		

Table 8: All *E. coli* bacteraemia cases by CCG from October 2013 to September 2014, Yorkshire and the Humber

NHS AT	CCG	2013	2014			Trend	Q3 vs Q2
		Q4	Q1	Q2	Q3		
North Yorkshire and the Humber	East Riding Of Yorkshire	60	62	60	67		
	Hambleton, Richmondshire & Whitby	34	17	37	29		
	Harrogate and Rural District	22	24	28	23		
	Hull	64	63	38	60		
	North East Lincolnshire	24	25	32	28		
	North Lincolnshire	27	39	24	41		
	Scarborough and Ryedale	33	19	27	27		
	Vale Of York	70	68	73	70		
	Total	**334**	**317**	**319**	**345**		
South Yorkshire and Bassetlaw	Barnsley	43	45	52	61		
	Bassetlaw	18	19	29	20		
	Doncaster	66	78	54	59		
	Rotherham	74	64	57	60		
	Sheffield	117	99	131	148		
	Total	**318**	**305**	**323**	**348**		
West Yorkshire	Airedale, Wharfdale & Craven	23	27	31	23		
	Bradford City	14	10	12	13		
	Bradford Districts	49	67	51	61		
	Calderdale	29	36	36	32		
	Greater Huddersfield	38	30	37	24		
	Leeds North	32	27	27	34		
	Leeds South and East	56	58	66	59		
	Leeds West	37	31	41	48		
	North Kirklees	35	25	49	32		
	Wakefield	59	71	64	76		
	Total	**372**	**382**	**414**	**402**		
Yorkshire and the Humber		**1006**	**985**	**1027**	**1075**		
England		**8,623**	**8,380**	**8,886**	**9,475**		

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Chief Nurse Report – Quality of Care

Action requested/recommendation

The Board is asked to note the Chief Nurse report for February 2015.

Summary

The Chief Nurse report provides assurance against the implementation of the Nursing & Midwifery Strategy and evidence in support of our Quality Account. It outlines key priorities and progress.

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

Consideration is given to the equality and diversity issues during the development of the report including the impact of the care given to patients.

Reference to CQC outcomes

Outcomes 4, 5, 8, 9, 16 & 17.

Progress of report	Quality and Safety Committee
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	February 2015
Version number	Version 1

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Chief Nurse Report – Quality of Care

1. Key priorities

Nursing and Midwifery Strategy
The Nursing and Midwifery identifies priorities' for the years 2013-2016 and is aligned to national recommendations and the Chief Nursing Officers strategy for nursing (the '6C's') and has four focus areas:

- Patient Experience
- Delivering High Quality Safe Patient Care
- Measuring the impact of care delivery
- Staff Experience

The action plan detailing progress on the strategy has been updated during January and it attached for members information, at appendix 1. Key achievements include:

- Significant progress with the Falls Reduction Programme
- Introduction of a leadership programme to support ward sisters
- Significant progress in changes to the Patient and Public involvement agenda
- Introduction of the Nursing Dashboard
- Introduction of the Early Warning Trigger Tool

Key risk areas remain the ability to recruit to registered nurse posts, particularly at the Scarborough sites. The Committee is aware of the safer staffing action plan which has shared with the Board last month.

<u>Cultural Barometer</u>

In order to gain a greater insight into staff experience the Chief Nurse Team has undertaken a pilot of the Cultural Barometer, during September – December 2014. The analysis of this data is now being shared with the wards to help them improve aspects such as communication and team working. Consideration is being given to rolling out this barometer across all inpatient areas

<u>Clinical Documentation</u>

The Committee is aware of the review of nursing documentation to streamline and simplify core information and ensure consistency across sites. The documentation steering group has developed new intentional rounding and core care plans. These have been produced in conjunction with ward sisters and piloted across three wards. The documented will be reviewed during February to assess the documents, obtain feedback and make any further amendments. Early indications suggest an improvement in record keeping standards and anecdotal feedback from clinical teams is positive.

When the core care plans have been introduced across sites, an audit will be undertaken.

The group is now setting priorities for the this year, which will include a revised

Electronic Discharge Note for nursing staff and to develop an improved intra hospital transfer document based on Situational Background Assessment Recommendation (SBAR).

Nursing Dashboard

The Board is aware that a Nursing Dashboard has been in development for several months. The first dashboard has now been developed to provide month on month assurance to Nursing Board, Quality and Safety Committee and, the Board of key nursing metrics across the organisation. The key metrics included are:

- Patient Safety - Falls, Pressure Ulcers, Safety Thermometer, Catheter acquired UTIs, Critical Missed Medicines, Deep Vein Thrombosis and Pulmonary Embolisms
- Workforce – vacancies, sickness, safer staffing return, NHS fill rates, internal bank fill rates
- Infection Prevention – MRSA bacteraemia, MRAS screening elective and non elective patients, C.Diff, MSSA bacteraemia, E Coli Bacteraemia and, Hand Hygiene
- Risk Management – Serious Incidents, Critical Incidents and Never Events
- EWTT – trust wide metric measurements
- Patient Experience – friends and family net promoter scores and patients complaint by staff attitude, patient care and communication.

Further work is being undertaken to develop site specific and directorate dashboards and we are exploring the ability to provide information monthly at ward level. However discussions are taking place with Systems and Network services about the information that will be necessary. A copy of the nursing dashboard is attached at appendix 2

2. Safer Staffing

In January 2015, NICE issued guidance for consultation on A&E safer staffing levels. The Trust is now assessing its position in relation to this draft guidance and will be developing an action plan to address the four recommendation themes. A report will be brought to the Committee in due course.

The Chief Nurse team has audited compliance of the daily staffing briefing tool. The audit has shown that in 96% (Scarborough) and 98% (York), the tool is being used to support clinical staff in understanding the staffing needs on the wards, across the Trust sites. However, the need for further attention to populating some aspect of the tool is necessary. A review of the tool has been undertaken and changes made, to include red flag areas and this new documentation was implemented in February 2015.

Each month the data from the tool will be analysed, and triangulated with vacancies, sickness and bank and agency fill rates to ensure appropriate use and deployment of staff.

The Safer Staffing report for February 2015, provides the current position on vacancies across the Trust.

The acuity and dependency audit of inpatient areas was undertaken during January 2015. Early analysis of the data has been undertaken which shows that on average 1100 beds were occupied each day during the audit, with 48% of those patients requiring normal ward care with the remaining 52% requiring a greater level of nursing care. A separate report providing data outcomes from this audit is available.

The community acuity and dependency audit was undertaken during January 2015.

The data for this is currently being analysed and a report will be brought to the Quality and Safety Committee in March 2015.

2. Nurse Revalidation

The Nursing and Midwifery Council has commenced its pilot of nurse revalidation. The Chief Nurse team is now assessing the implications for the Trust on the national implementation of nurse revalidation, due in December 2015. A separate paper will be taken Board of Directors in March 2015 to provide the Board with an understanding of the proposed structure of NMC revalidation, the difference between nurse and medical revalidation and, the implications for the Trust. The paper proposes the establishment of project group to take forward the work necessary in preparedness for December 2015.

3. Nursing Performance Management Meetings

As part of the new nursing quality assurance framework, the Chief Nurse team plan to introduce nursing Performance Management meetings across the Trust, following the standard Trust format.

Representatives from the Chief Nurse team and directorates will meet to discuss nursing issues, primarily focussing on wards that have been flagged as red under the Early Warning Trigger Tool to monitor action plans and support clinical areas.

4. Patient Experience

The Board is aware that Health Watch (North Yorkshire) undertook an 'enter and view' visit at Scarborough on 12th November 2014. A separate report is provided on this.

Dementia Delivery Group:
The group is planning to develop a revised strategy this year (end of September). A significant amount of work has been undertaken on the existing strategy. Priority this year is to embed the delerium element for the CQUIN and develop a plan for supporting patients in the community in patient settings and also in outpatient environments. The group are also developing the existing patient/carers questionnaire to ensure that the information we capture is relevant and shared effectively.

Knowing How We Are Doing:
The wards are starting to receive their quarterly laminated patient experience information, which is displayed at ward level, informing patients, relatives and staff about the family and friends results and "You said, we did". These have been positively received so far. The patient experience team work closely with the ward sisters when populating these to ensure they reflect what actions the ward have taken when improvements are required.

5. Medicines Management

The patient safety agenda requires the Trust to develop safe and effective mechanisms for the safe administration of medicines.

Statutory and mandatory training

Following the change to 3 yearly medicines management updates and the introduction of the learning hub, we are now at 72% compliance with this training.

Compliance

A mock CQC inspection was carried out on 19th January. Pharmacists and technicians supported this and visited the vast majority of wards across all sites. The issues identified included:

- compliance with fridge monitoring and/or wrong document being used. The medicine management technicians are undertaking ward visits to ensure the staff understand the documentation which is to be used.
- prescribing standards amongst medical staff. Dr D Border is addressing these concerns with the specific doctors identified.
- medicines administered against unclear or incomplete prescriptions. These are being addressed on each occasion with ward leaders.
- medicines left out on the side in open clinical rooms, POD lockers unlocked with medicines in.

For the second visit on the 9th February all outpatient areas will be visited.

Non medical prescribing

The request for the annual declaration of competence will be sent out by the 13th February. Expressions of interest for those who would like to undertake a non medical prescribing course will be called for during February. There are currently 105 independent non-medical prescribers made up of mainly Clinical Nurse Specialists and community District Nurses. In addition there are 59 community nurse prescribers who are a mixture of district nurses and health visitors and, there are a further 25 nurses, pharmacists and physiotherapist in training.

Electronic Prescribing Medicines Administration (EPMA)

The Electronic Prescribing Medical Administration project continues and recruitment is taking place during February 2015 to appoint a band 6 specialist nurse to further support the project. Work is progressing with Systems and Network services on the IT solutions for medicines administration with further work identified on the documentation required.

Critical Missed Medicines

The average missed dose of critical medicines for 2014 was 1.6%. This is based on point prevalence. This represents a decrease of 1.57% on 2013, when the average missed dose rate was 3.17%. The medicines management team continue to work with individuals to address areas of concern.

6. Recommendation

The Board is asked to note the Chief Nurse report for February 2015

Author	**Beverley Geary, Chief Nurse**
Owner	**Beverley Geary, Chief Nurse**
Date	**February 2015**

January 2015 update:

York Teaching Hospital NHS
NHS Foundation Trust

Nursing and Midwifery Strategy Implementation Plan: Year 2

The Nursing and Midwifery strategy sets out priorities to achieve high quality nursing care over the next 3 years and was approved at Board in May 2013.The implementation plan outlines current work streams and priorities and demonstrates progress to date. The strategy has been aligned to the Chief Nursing Officers 6 C's in order to ensure compassion in care and to embed these values and behaviours in all Nursing and Midwifery practice.

C1 -Care
C2 -Compassion
C3 -Competence
C4 -Communication
C5 -Courage
C6 -Commitment

Priority 1	**Improve Patient Experience**

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
1a	C1 C4	Develop Patient Public Involvement (PPI) strategy.	Revised Dec 2014	• Work plan agreed in Patient Experience Committee. • Delay in the development of a strategy due to the in-depth review of PPI activity in order to inform the new strategy. • Service users being involved in development of maternity bereavement service Scarborough site. • MSLC chair being involved in Friends & Family Test (FFT) action plan written by Head of Midwifery • Recommendations for in-depth review approved at Executive Board. • New appointment to lead PPI agenda and the integration of Patient Experience	• Strategy currently being scoped with group set-up to develop strategy. Strategy planned to be launched June 2015 • PE implementation plan developed to take forward recommendations from the PE Review	Lead Patient Experience/ Chief Nurse	Amber

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
				team (Kay Gamble) • New lead to start writing the strategy			
1b	C2 C4	Undertake a review of the Patient Experience service, function and capacity and make recommendations to the Nursing Board.	June 2014	• Questionnaires re: training circulated. • Review of processes completed. • Review of the Patient Experience Team (PET) completed • Results of training questionnaire presented at the Patient Experience Committee. • Outcome of review of PET agreed at PPI Steering Group • Board of Directors agreed recommendations. • New job description Agenda for Change (AFC) matched. New Lead in Post	• Completed	Chief Nurse Team	Green
1c	C4 C5	Strengthen the role of ward sister and district nursing sister in the management of and learning from complaints in their areas	July 2014	• Afternoon of discussion and presentations planned on Patient experience and complaints management for Professional Nurse Leadership Forum (PNLF). • NHS Elect training commenced. • Midwifery Ward sisters involved in the management of complaints with support from the Matron • Complaints and patient experience included in Maternity mandatory training for all staff • Discussions took place at PNLF. • NHS Elect training completed.	• Community update: • Datix to include lessons learnt box • Development of Datix Dashboard • Development of Incident tracker to feedback lessons learnt at PNLF (Community) • Clinical Governance Lead to be appointed for community services	Matrons, PPI team and Community Safety & Performanc e Manger	Green
1d	C1 C4	Continue to develop the patient experience steering group to include further work	Dec 2014	• The dementia delivery group is reviewing what PPI activity is undertaken across sites and is developing a plan to further build on the work to date.	• Dementia Delivery Group is developing a more extensive questionnaire to capture carers experience	Chief Nurse Team / PPI team	Amber

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
		around PPI. Undertake a benchmarking exercise as to what groups are the Trust involved in and what are we doing in house, (i.e. older peoples forum on York site)		• Healthwatch presented at the Patient Experience PNLF, which was well attended by ward sisters and clinical nurse specialists. The ward sisters worked in groups, reviewing complaints and best practice. Pledges were made to improve the patient experience and will be reviewed in 6 months. • MSLC group. Communication sub group attended by Maternity Matron looking at FFT processes and staff experience. • Home birth support group has been set up to involve users also. • Integral to PPI strategy • Dementia delivery group developed an action plan	in both the acute and community settings. • PPI activity recorded through Clinical Effectiveness database with activity being reported through the use of BriefCases which are reviewed at the PESG. • PE Team structure being developed which will review the PPI post which is currently vacant		
1e	C5 C6	Explore and agree the priorities of the new Matron group in the delivery of the PPI agenda	Sept 2014	• Development programme planned for April 2014, started working with Organisational Development Integrated Learning (ODIL) team re: on-going programme • Development plan in place • Coaching taking place.	• Work continues to embed into practice • PE Strategy will link with ODILs PE Training Strategy • Once PE Structure in place PPI Leads across the trust will be identified to take forward PPI in-line with the PE Strategy	Matrons/ Chief Nurse Team/ Lead for Patient Experience	Green
1f	C2 C4	Review of Trust visiting policy in order to meet the needs of patients and relatives.	Revised Sept 2014	• New Matron group to review and revise policy in conjunction with the protected meal time policy and present recommendations to Matrons meeting / Nursing Board • Nursing Board dates timetabled. • Review visitors code integrated across all directorates/services.	• Work progressing and on target.	Matrons	Amber

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
1g	C6	Introduce Friends and Family Test for OPD, Community services and community inpatient areas.	Oct 2014	• FFT commenced in community hospitals ahead of roll out, data report will be produced June 2014 • Up and running in community services inpatient units. Work progressing to roll out in community nursing teams (patients seen at home)	• FFT rolled out across Outpatients, Community Services, Day Case, Inpatients, ED and Maternity. Focus now on rolling out to Child and Young People. • Knowing How We Are Doing Boards are now being rolled out to all inpatient wards	Patient Experience Team	Green
1h	C1 C2 C4	Improve Patient involvement in the Safeguarding Adults Process Early identification (at start of hospital journey) of vulnerable adults and embed prevention of and protection from abuse in care planning	Revised Dec 2014	• Generic patient information Leaflet development – awaiting approval and publication. Cost scoping exercise delayed publication – revised target date Dec 2014 • Family/patient specifically involved in Safeguarding Adults Process leaflet – awaiting approval and publication. PPI to be included in membership of Safeguarding Adults Governance Group completed. • PPI to be included in membership of Safeguarding Adults Governance Group • Vulnerable adult recognition on ED admission proforma (Scarborough Acute). Vulnerable adult recognition on ED admission proforma completed at both York and Scarborough. Revised action – Audit after 3 months for value.	• Budget secured. Leaflet had to be amended to include Care Bill. To patient information for approval and comment, then to Healthwatch consultation. Expected publication April 2015. • Completed – Kay Gamble included in Safeguarding Adults Governance Group Membership. • Awaiting Scarborough feedback. Draft pro forma developed and linked to Patient Supervision Policy which is in consultation period until 3/2/2015.	Lead Nurse for Safeguarding Adults	Amber
1i	C1 C2 C3	Develop guidance for Mental Health Support in acute setting to support patients who	April 2015	Phase 1 1) Task and Finish Group - established 2) Policy Development – on-going 3) Staff Training (MH First Aid) – partial	• Action Plan revised in conjunction with Mental Health Crisis Concordat involvement. New actions as	Lead Nurse for Safeguarding Adults	Amber

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
		have develop Mental ill-health in acute settings		completed 4) Service Level agreement with MH Provider – on-going Phase 2 1) Business case for MH support Team 2) Recruitment	follows: a. To establish service level agreement with L&YPFT and TEWV – UPDATE TEWV and L&YPFT reviewing all service level agreements so there are anticipated changes to current service. MH Leads keeping us informed. b. Commitment (strategic and operational) to external project and multi-agency working under Mental Health Crisis Concordat (Completed) c. Scope of needs analysis for acute areas – UPDATE Meeting with ED Leads and ADNs to establish Early Feb 2015. d. Analysis of external Training – UPDATE Awaiting feedback from delegates. e. Training Needs Analysis developed and awaiting approval on completion of above. f. Policy Development – UPDATE Service		

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
					Specification for MH Service in ED developed with York ED Lead – expected draft completion End Feb 2015 g. Linked Policies to be reviewed/developed a) Patient Supervision (Draft out for consultation) b) Missing persons policy c) Safeguarding Adults policy d) Mental Health Policy DETAILED ACTION PLAN AVAILABLE AND REVIEWED MONTHLY.		
1j		Maternity Friends and Family Test Feedback	Ongoing	• Quarterly action plans developed in Maternity from qualitative FFT feedback with user representatives input • Quarter one report tabled at Maternity Services Liaison Committee 02.10.2014. • Confirmed user input into the action plan • Confirmed involvement from the Clinical Commissioning Group (CCG)	• Next meeting planned 6/2/15	Head of Midwifery	Amber

Priority 2	Delivering High Quality Safe Patient Care

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
2a	C5	Strengthen nursing	Ongoing	• Reviewed the It's My Ward Programme	• Work is progressing to	ODIL	Green

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
	C6	leadership by empowering ward sisters, charge nurses & district nursing sisters to ensure all care is of a high standard and meets values of the organisation		with skills days on-going. • Ward Sisters meeting commenced, Director of Nursing Q&A session at each. • Increased attendance and input at PNLF • Consultation with Ward Sister planned re: reporting structures. • Plan to work with ODIL to review and evaluate the IMW programme. • Plans to further develop the philosophy behind 'It's my ward' programme to develop 'It's my well run ward'.	develop a leadership programme based on 'It's my Ward' programme to support the development of the band 6 nurses. First cohort planned for 12 to 16 January 2015. • 'It's my ward' programme to develop 'It's my well run ward' first course date 17 December 2014 (5 sessions booked). Community update: • Band 7 District Nurse Team Leader to be recruited for all community localities	Chief Nurse Team	
2b	C1 C6	Ensure the right staff are in the right place at the right time.	Ongoing (planned April & Oct)	• Safer Staffing Project commenced • Meeting with Keith Hurst took place in April 2014, Matrons trained in the awareness of the AUKUH tool, presentation to Ward Sisters during May 2014. • Acuity Audit commenced for 2 weeks in June. • Staffing SOP reviewed and daily staffing meetings in place. • Publishing of daily staffing at ward level commenced • Submission of staffing data via UNIFY commencing June 2014 • Acuity and dependency audit repeated in September 2014. Waiting results.	• Acuity and dependency audit repeated in January 2015 in both Acute and Community inpatient areas. • Labour Ward acuity tool commenced in September 2014 • Community Nursing dependency audit undertaken January 2015	Chief Nurse Team	Green

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
				• Safer staffing declared data discussed at the September Board. Agreed to explore a more meaningful way of presenting the staffing information that will provide the NEDs with the assurance that they need regarding staffing. • Need accurate up to date information re: use of temporary workforce and ratio. • Additional paper completed reviewing issues around Scarborough - vacancies by area, including Bank / Agency activity and the recruitment. • Looking at worst case scenario for winter and contingency plan (keeping 1:8 ratio)			
2c	C1 C2 C6	Work with patient safety and compliance teams to ensure delivery of patient safety strategy.	April 2014 and ongoing	• Pressure Ulcer Reduction Plan updated and action plan for 2014/15 developed – update to Board June 2014. • Business case developed to identify nursing resource required to support Electronic Prescribing. • Supervisors of midwives will be undertaking work around medication errors and missed meds • Pressure Ulcer Panel in place to assure learning. • Work to reduce missed medications continues. • EPMA (Electronic Prescribing and medicines administration) project gives us a great opportunity to iron all of the issues before full implementation. Jennie Booth Lead Nurse Medicines Management is setting up a forum of	• The pressure Ulcer Reduction Plan continues to be monitored monthly by the Pressure Ulcer Steering Group. Progress is satisfactory. • The Pressure Ulcer Panels are continuing to be held and learning is agreed at the Panel and strategic actions reviewed by the Pressure Ulcer Steering Group. • The Patient Falls Panels meet monthly with learning agreed at Panel and considered by the Organisational Falls Steering Group. • Reduction in the number of	Patient Safety Team & Chief Nurse Team	Amber

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
				clinicians to take forward. • September 2014 - introduction of Falls Panel. This is based on the philosophy of the pressure ulcer Panel. To assure the Trust of actions taken, change in practice and dissemination of learning. • Reduction in falls resulting in serious harm. December 2014 launched new inpatient falls policy. • New resources and training package launched for inpatients falls reduction.	patient falls which results in serious harm remains a priority and is monitored by the Organisational Falls Steering Group. • Training on falls reduction continues.		
2d	C5 C6	Continue to review nursing documentation in order to reduce paperwork and to have consistent records across the organisation	ongoing	3 work streams full established that focus upon: 1. Pathways - This work is significant as there are over 26 pathways. The first plan is to look at the generic aspect of all pathways and then wok with IT to determine how this moves from paper to electronic. Work is on-going and progressing as planned. Next stage is link to IT systems. 2. Single record of care - The draft is complete and is out with ward sisters for consultation. The Comfee tool has been changed within this and has been well received. The final draft will be complete within the next month. New Comfee tool revised and launched. Now being used. Admission packs of core care plans (pain, hygiene, mobility,	Community update: • A significant amount of paperwork has been reduced with assessments electronic • Community Documentation Group is established. Acute Inpatient update: • Combined nursing documentation being piloted • No update on electronic discharge nursing document at this stage.	Chief Nurse Team	Amber

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
				communication etc.) ready to be piloted October 2014. Combined nursing assessment on acute wards now electronic 3. Discharge- Electronic discharge nursing document has been written in draft and is planned for approval in June. This will then require a pilot and implementation plan. Draft in place. Due to be piloted December 2014 – care of the elderly wards.			
2e	C1 C3	Lead the work on falls reduction across the organisation, review the documentation and assessment process in order to streamline and ensure a consistent approach across the organisation	Sept 2014	• Falls Steering Group set up, membership agreed. • Terms of reference approved. • Delivery groups at both main sites and community. • Strategy to be developed. • Revised risk assessment and implementation plan in draft. To be shared with ward sisters via the documentation steering group in June 2014. • New Inpatient Falls policy ready to be launch. Postponed as electronic tool not finalised for implementation. To be launched during Blue Thursday. • New resources in place to support staff (patient information leaflet, patient poster, falls sticker, staff poster) • New Falls training package for inpatient staff ready for roll out.	• A new Falls Risk Assessment tool was developed and approved in October 2014. The tool needs to be made electronic. Waiting for confirmation when this will be added to the IT work plan (no date). The Trust is not NICE compliant while it uses the old tool. Have introduced a new paper NICE compliant version in identified high risk areas. This is supported by a comprehensive training package. • New falls inpatient policy launched December 2014.	Chief Nurse Team	Amber

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
				• September 2014 – first Falls Panel held (review of RCA to assure learning disseminated).			
2f	C1 C2	Introduce Advanced Clinical Practitioner's to facilitate early decision making and timely access to treatment.	May 2014 And ongoing	• Second cohort of trainees recruited to development of the ACP role continues in collaboration with clinical and educational teams	• Work continues. • No new update.	CLAD, Chief Nurse Team	Green
2g	C1	Infection Prevention (IP) Improve and sustain competency in IP clinical practice and invasive device management that ensures the prevention of avoidable harm from Healthcare Associated Infection (HCAI) through: Implementation and audit of the IP Annual Plan, policies and guidelines that reflect regulatory and legislative requirements and IP risks/priorities. Effective use of IP performance data and the Trust performance framework to ensure	Permanent Objective	• Weekly feedback of IP performance data to Quality and Safety Group and Directorate Leads. • Quarterly performance data presented to Board of Directors via DIPC report Trust Performance Framework and meetings (PIM`s) • IV specialist role appointed to the IPT. • Proactive programme of high level HPV disinfection delivered to high risk areas during Aug/Sept. • Directorate Risk Registers • IP and Internal Audit reports • PIR/RCA reports • E-Learning packages implemented via CLAD learning Hub	• CDI and MRSA bacteraemia incidence remain under trajectory. MSSA bacteraemia incidence remains over local trajectory, reduction strategy and initiatives developed. • Minimal proactive HPV disinfection delivered on SGH site, lack of decant space hinders progress. Service continues on York site • Agreement reached to replicate the IV specialist role on SGH site to commence Feb 2015 • ANTT e-learning package procured, to be integral to IP Statutory and Mandatory training. • Directorate Assurance framework implemented Jan 2015 • Compliance with	IPT, Chief Nurse Team Matrons	Amber

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
		accountability and responsibility for the prevention and control of HCAI and patient safety from Ward to Board. E-Learning packages that facilitate education and understanding Develop a Directorate Assurance Framework New Matron team to devise an approach to prioritise this agenda and raise awareness in their clinical areas			antimicrobial stewardship continues to improve as does the prescribing of probiotics. • IP Risk Register revised • Clinical Support visits continue with variation in practice and compliance reported to nursing leads		
2h	C3 C4 C6	Formalise Trust wide approach to shared learning from Safeguarding Adults Investigations where actions are identified.	Sept 2014	• Full Matron/ward sister involvement in Safeguarding Adults Investigation • Completed – matron consultation and involvement in Safeguarding Adults Investigations. • Evidence can be provided as part of anonymised case studies.	• Work progresses to embed in practice.	Matrons / Lead Nurse for Safeguarding Adults	Green
2i		Third and forth degree tear rate	Dec 14	• Multidisciplinary working group to audit, review practise and recommend actions to reduce rates • Work progressing on schedule • This is not unique to York Trust. There is new National work underway. York Trust will take an active role in this piece of work.	• Work continues. Specialist equipment ordered. Rates have decreased since this work commenced.	Head of Midwifery	Amber

Priority 3	Measuring the impact of care

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
3a	C5 C6	Introduce Early Warning Trigger Tool to highlight potential problem areas and to ensure nurses and midwives have meaningful data to influence the delivery of care.	Sept 2014	• Testing phase on-going, pilot commenced • Early warning trigger tool being trialled on Hawthorn ward • The Trust has been using the National Early Warning Score and deteriorating patient escalation policy for 12 months. The policy is currently under review by the deteriorating patient group. • Over the past year we have seen an overall improvement in hospital mortality and a reduction in cardiac arrests.	• EWTT implemented across all wards community IPUs – November 2014 • Quarterly EWTT reporting to Board commenced January 2015 • NEWS & Sepsis 6 implemented in all community IPUs • Electronic MEOWS commenced in Maternity December 2014	Chief Nurse Team	Green
3b	C3 C5	Introduce Nursing Dashboard to give an overview of key quality indicators for all areas	May 2014 and ongoing	• Draft Dashboard developed, project team identified to work in conjunction with the EWTT • This has been developed as a stand alone dashboard and is complete other than the background ward specific information. • Maternity dashboard established and reviewed at Directorate Clinical Governance meetings • Dashboard presented at the June Professional Nurse Leadership Forum (PNLF). More work re: data collection needed • The Dashboard is working progress. • Further support is required from IT (relating to populating and drawing of data)	• Trust wide Nursing dashboard developed; work now to enable drilling down by site, directorate and ward. • Maternity dashboard recently reviewed and up	Chief Nurse Team	Green

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
y	C1 C3	Explore feasibility of IT solutions to documentation	Ongoing	• Assessment documents now electronic • A business case has been written to support a band 7 project role for a senior nurse to support the development, training and education at ward level and to provide the clinical expertise (workforce). • Further work is being undertaken to move more nursing documentation using the IT system.	• SMART phones to be piloted in community nursing	Chief Nurse Team /IT	Amber
3d	C1 C6	Develop a Nursing Policy and procedures' Group in order to ensure all polices are up to date and reflect current best practice	June 2014 and ongoing	• Initial meeting to plan TOR, wider meeting to involve all key stake holders planned for April 2014. • Maternity guidelines groups established cross site	• Work is progressing, no new update.	Chief Nurse Team	Amber
3e	C3 C6	Evaluate the Productive Ward programme and agree next steps	April 2014	• Evaluation of impact of targeted work at Scarborough site very positive for most areas. • Meeting planned to consider future approach – evaluation undertaken – project suspended due to project support needed for safer staffing initiative. • Work is progressing to ensure 'It's My Ward' programme with an additional module called 'It's my well run ward'. • An accelerated leadership programme is being developed for band 6 nurses. This is an exciting development for aspiring nurse leaders to develop and enhance their leadership skills.	• No change in position	Chief Nurse Team	Green
3f	C2 C3 C4	Work with the compliance unit to review delivery of	Dec 2014	• A review of all audits undertaken at ward and department level will start in June.	• Patient safety rounds have continued and have	Chief Nurse Team / Compliance	Green

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
		actions from visits to clinical areas in order to provide assurance to the Nursing Board re: quality of care		This will link to the CQC 5 questions. The plan is to streamline and reduce repetition and develop achievable actions plans. The group will process map in June and develop recommendations and subsequent implementation plan. • Patient safety walk a rounds planned, undertaken on G1 • Process mapping completed and all clinical audits reviewed. An up dated plan to be developed. • Audit schedule linked into the CQC 5 questions.	provided valuable feedback. • CQC mock preparedness walk rounds took place 19 January 2015. A second mock inspection is planned for 9 February 2015.	Unit	
3g	Ci C2 C4 C6	Open and Honest	Revised Dec 2014	• Introduce this initiative to publish patient safety and experience data. • Task and finish group set up. Pilot begun on both acute sites	• Work progressing and on schedule	Chief Nurse Team	Green
3h	C3 C4 C6	Safeguarding Adults Team to report quarterly Safeguarding Adults Activity to Matrons and ward Sisters at relevant meetings.	Sept 2014	• Quarterly reporting of activity to Safeguarding Adults Governance Group • Board reporting • Quarter report to be circulated to matrons following approval at Safeguarding Adults Governance Group (standing agenda item)	Actions completed. • Quarterly reporting of activity to Safeguarding Adults Governance Group continues • Board reporting - next due March 2015 Board. • Quarter report to be circulated to matrons will commence for next quarter report due end January 2015.	Lead Nurse for Safeguarding Adults	Green

Priority 4	Staff experience

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
4a	C2 C4	Utilise staff survey feedback to understand key themes and identify priorities.	April 2014 and ongoing	• Family and Friends staff questionnaire was undertaken in June. The results shared with matrons. • Staff 'listening exercises' considered in Maternity following staff survey results. Multidisciplinary group arranged to develop action plan. • Maternity newsletter developed for staff to help improve communication • From September all nurses will be able to speak to the Chief Nurse on a one to one basis at a series of new monthly surgeries planned to take place across the Trust. • A Culture Barometer has been developed and to be piloted December 2014.	• Culture Barometer piloted at White Cross Court, ward 15 and ward 33. Work plan being developed.	Chief Nurse Team with HR Workforce team	Green
4b	C4 C6	Ensure all Nurses and Midwives receive a valid appraisal which includes an agreed development plan	Ongoing	• Ongoing work in all Directorates' to achieve annual appraisal. • Chief Nurse Team meeting with external partners to explore electronic solutions to include revalidation – meeting taken place. • Attendance at NMC Re-validation event June 2014. • HR is working on an IT solution for appraisal and is currently in the early stages, with a steering group set up. The IT Company is showcasing the example in June. • On-going monitoring of appraisal rates by matrons	• Implications of nurse revalidation being assessed (commences December 2015) • Appraisal completion monitored through EWTT	Matrons, Ward Sisters	Amber
4c	C3	Explore and consider the training	Ongoing April 2015	• Review of Statutory & Mandatory training requirements for Nursing & Midwifery	• Single point of application developed with Leeds Met	Chief Nurse Team/	Green

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
		requirements of nurses and midwives and identify alternative methods of delivery.		staff commenced, task and finish group set up to conduct this work and report to nursing Board • Mandatory maternity specific training reviewed annually in line with current guidance	for DN students • Review of nursing and midwifery stat and mandatory training compliance being undertaken (January 2015) and action plan being developed.	ODIL	
4d	C4 C6	Develop the knowing how we are doing boards to reflect what patients and relatives and staff want to see and include positive patient feedback and also work that we have done to reflect patient feedback and measure the effectiveness of this change	September 2014	• Sisters and Matrons discussion and suggestions have begun. Recommendations made May 2014. • The ward sisters have met with one ADN and their opinions have been acknowledged. It has been agreed that the laminate will be removed form the boards, which will leave them blank. The boards will then be converted in July to include daily safer staffing and patient experiences, using family and friends and patient feedback. "Use said, we did". • Positive patient feedback given on monthly mandatory maternity training, at staff meetings with Matron and sent out to staff via e-mail.	• Changes made to knowing how we are doing boards to fit client group. • New posters from rolled out from December 2014.	Chief Nurse Team with HR Workforce team	Green
4e	C5 C6	Consider centrally supported recruitment process to reduce duplication, ensure recruitment in a timely fashion.	April 2014 and ongoing	• Work continues with an aim to reduce vacancies • One stop shop recruitment is working well, as did the city tour to Glasgow with a number of registered nurses recruited. The recruitment process is working well, with changes to the VC process and DBS. • Cross site recruitment for midwives at	• Generic HCA recruitment programme continues • Generic RN recruitment programme to be developed, in conjunction with HR	Chief Nurse Team with HR Workforce team	Green

NO	6C's	Action	Target	Evidence	January 2015 update	Lead	Status
				Band 5 commenced in Maternity • Fast Track recruitment process for Band 5 and Health Care Assistants (HCA's)			
4f	C4 C6	Continue to work with HR to utilise e-rostering to make the most efficient use of resources. Introduce e-rostering at Scarborough site	Sept 2014	• Principles of e-roster commenced on paper roster at Scarborough site • Maternity in preparation for e-roster implementation • Community inpatients have implemented a process for Admin team to input the rota with support from e-rostering manager and HR.	• E Rostering to commence on Scarborough site 9th Feb. 2015 , Ash ward to be first ward then roll out planned in phases	Chief Nurse Team with HR Workforce team	Green
4g	C4 C6	Conduct an evaluation of the local induction arrangements for Nurses and Midwives	Dec 2014	• New Matrons group to work with Ward Sisters to introduce a robust system across the organisation that represents local priorities. • Induction packages reviewed and in place for band 5&6 midwives. Band 7 development package commenced.	• Completed.	Matrons	Green
4h	C1 C4 C6	Development of Supervision model and implementation	Revised Dec 2014	• A task and Finish group set up to develop a Supervision of patients Guidance following incidents across sites.	• Draft policy in consultation period until 2/2/2015. • Completion expected April 2015	Lead Nurse for Safeguarding Adults / Director of Nursing	Amber

<u>Assurance Processes</u>

- Nursing Board for approval, monitoring, identifying risks and progress
- Exceptions discussed at Matrons 1:1's and NMT
- Quarterly update to Board of Directors via Chief Nurse report

Beverley Geary
Chief Nurse

Safer Staffing Nursing Dashboard

		Metric	Measure	Data Source	Trajectory	RAG	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer			15	14	19	22	26							
		Cat 4	No. of Patients (PP)	Safety Thermometer			0	0	11	0	1							
		Cat 3	No. of Patients (PP)	Safety Thermometer			2	1	2	0	5							
		Cat 2	No. of Patients (PP)	Safety Thermometer			11	5	0	16	16							
		Unstageable	No. of Patients (PP)	Safety Thermometer			3	8	6	6	4							
	Falls	Falls	No. of Patients (PP)	Safety Thermometer			38	37	39	39	42							
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer			2	6	4	1	1							
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer			94.15	93.66	94.39	93.17	93.29							
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer			19	27	18	27	12							
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer			23	18	23	18	16							
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer			4	5	2	4	5							
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer			0	2	0	2	2							
Workforce	Vacancies	Trust wide Vacancies Overall - RN at end of each month	Number	CN Team				48.05	55.96	84.00	90.83							
		Trustwide Vacancies Overall - HCA at end of each month	Number	CN Team				13.51	2.62	9.01	12.24							
		Inpatient area vacancies -RN	Number	CN Team														
		Inpatient area vacancies - HCA	Number	CN Team														
	Sickness			Workforce Info					3.98									
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%	Green	97.71	117.10	91.28	92.45	87.32	85.36						
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%	Green	107.00	125.14	106.87	107.94	101.01	88.87						
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%	Green	94.00	112.14	90.04	93.55	91.45	99.64						
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%	Red	114.00	115.49	113.75	117.38	87.74	112.25						
	NHSP Fill Rate	Fill Rate	%	Workforce Info			69.78	69.75	70.74	52.71								
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info			82.10	88.10	85.97	83.10								
Infection Prevention	MRSA	MRSA Bacteraemia	Accumulated number of patients	IC Team	**0**	Green	0.00	0.00	0.00	0.00	0.00							
		MRSA Screening - Elective	Compliance %	Signal			89.12	90.42	88.10	86.58	86.23							
		MRSA Screening - Non-Elective	Compliance %	Signal			73.33	71.73	71.28	69.22	67.84							
	C.Difficile	C DIF Toxin Trust Attributed	Accumulated number of patients	IC Team	**59**	Green	22	24	28	38	45							
	MSSA	MSSA Bacteraemia	Accumulated number of patients	IC Team	**29**	Red	23	29	34	42	46							
	E-Coli	E-Coli Bacteraemia	Accumulated number of patients	IC Team			50	57	68	78	89							
	Hand Hygiene	Hand Hygiene Compliance 95%	Compliance %	IC Team	**95%**	Amber				86.00	90.00	90.00						
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix							15.00							
	Clinical Incidents	CI's reported	Number	Datix														
	Never Events	Never Events declared	Number	Datix														
Early Warning Trigger Tool	EWTT (Trust-wide inpatient areas only)	Ward Leader for more than six months	Number compliant	EWTT Monthly Returns					47	47	44							
		Vacancies at less than 3%	Number compliant	EWTT Monthly Returns					15	21	21							
		Unfilled shifts is less than 6%	Number compliant	EWTT Monthly Returns					37	34	31							
		Sickness absence rate less than 3.1%	Number compliant	EWTT Monthly Returns					10	12	8							
		Evidence of monthly review of key quality indicators by peers	Number compliant	EWTT Monthly Returns					48	46	50							
		Appraisal rate 95% or above	Number compliant	EWTT Monthly Returns					11	17	21							
		Evidence of involvement in Trust-wide multi-disciplinary meetings	Number compliant	EWTT Monthly Returns					51	49	50							
		month and return rate from F&F Test is greater than 30%	Number compliant	EWTT Monthly Returns					33	33	37							
		Less than two formal complaints in previous month (wards) or less than 3 (A&E or Depts)	Number compliant	EWTT Monthly Returns					50	47	54							
		Evidence of resolution to recurring themes	Number compliant	EWTT Monthly Returns					50	51	52							
		Unusual demands on service exceeding capacity to deliver (e.g. national targets, outbreak)	Number compliant	EWTT Monthly Returns					40	47	36							
		Hand hygiene & BBE 95%	Number compliant	EWTT Monthly Returns					0	7	10							
		Matrons environment audit 95% or above	Number compliant	EWTT Monthly Returns					34	32	36							
		Ward/department appears tidy	Number compliant	EWTT Monthly Returns					50	51	53							
		Evidence of effective multidisciplinary/multi-professional team working	Number compliant	EWTT Monthly Returns					51	52	54							
		RCA's & infection control RCA's)	Number compliant	EWTT Monthly Returns					36	41	41							
Patient Experience	Friends and Family	Inpatient Friends and Family Test	Net Promoter (Trust wide)	Signal			72	70	71	69								
		A&E Friends and Family Test	Net Promoter (Trust wide)	Signal			48	42	44	40								
		Maternity (Ante Natal)		Signal			66	66	66									
		Maternity (Post Natal)		Signal			71	66	69									
	Complaints	Complaints Total	Number	PE Team					55	22	16							
		Staff Attitude	Number	PE Team					3	1	4							
		Patient Care	Number	PE Team					36	11	4							
		Communication	Number	PE Team					16	10	8							

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Staffing Exception Report

Action requested/recommendation

The Board of Directors is asked to receive the exception report for information

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).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

Outcome 13

Progress of report	Quality & Safety Committee
Risk	Any risks identified in the report
Resource implications	Potential resources implications where staffing falls below planned or where acuity or dependency increases due to case mix.
Owner	Beverley Geary, Chief Nurse
Author	Nichola Greenwood, Nursing Workforce Project Manager

Date of paper	February 2015
Version number	Version 1

Board of Directors – 25 February 2015

Staffing Exception Report

1. Introduction and background

The Board of Directors are aware that from May 2014 all organisations are required to report actual versus planned staff in public. This is the ninth submission to NHS choices of data of actual against planned staffing for day and night duty in hours; by ward.

As previously reported work continues to refine the reports in order to give an accurate reflection of the staffing levels on a shift by shift basis in order that the Board are assured that all areas are staffed appropriately and safely. As a result we have continued to base the return on the average bed occupancy rates by ward at 12 midday and 12 midnight, given that the staffing establishment is set on the number of beds on each ward; taking bed occupancy rates into consideration gives a more precise reflection of the safety of the staffing levels.

A detailed breakdown is attached at appendix 1.

2. High level data by site

	Average Fill Rate			
	Day		Night	
Hospital Name	**Average fill rate - registered nurses / midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses / midwives (%)**	**Average fill rate - care staff (%)**
Archways intermediate Care Unit	88.2%	79.1%	99.8%	97.3%
Bridlington And District Hospital	85.2%	78.2%	95.9%	122.5%
Malton Community Hospital	109.2%	100.9%	102.7%	89.7%
Scarborough General Hospital	77.6%	85.7%	88.5%	107.8%
Selby And District War Memorial Hospital	80.5%	89.6%	106.6%	98.1%
St Helens Rehabilitation Hospital	104.2%	95.6%	111.3%	104.2%
St Monicas Hospital	113.1%	83.2%	100.0%	100.0%
Whitby Community Hospital	90.5%	87.3%	92.0%	91.9%
White Cross Rehabilitation Hospital	82.9%	85.9%	168.4%	98.0%
York Hospital	88.9%	92.1%	105.8%	119.4%

3. Exceptions

All the Trust sites continued to be very busy during January 2015 and vacancies and sickness continued during this period.

Over 100%

Enhanced Supervision

A number of areas show an over 100% fill rate – usually in care staff. This is due to the 'specialling' of patients who require a higher level of observations such as those who wander, are very high risk of fall or have mental health issues. These areas were:

Scarborough	York	
Ann Wright	Ward 14	Ward 33
Stroke Ward	Ward 17	Ward 34
	Ward 25	Ward 36
	Ward 26	Ward 39
	Ward 28	Acute Medical Unit
	Ward 29	Short Stay Ward
	Ward 32	G1

Low patients numbers

The data is analysed on the basis of bed occupancy reference points of midday and 23:59 hours each day. Staffing levels are determined on the basis of full bed occupancy. Where beds are not occupied at the bed occupancy reference points, this represents a higher staffing percentage on ward areas, as follows:

Bridlington	Community	Scarborough	York
Kent	White Cross Court	CCU	Ward 28
		Duke of Kent	Ward 29
		Cherry	G2
		Hawthorn	G3

Provision of Safe Ward Cover

A number of areas have had to increase the number of non registered staff to ensure basic care needs are delivered due to vacancies, sickness or variations of operative procedures affecting the wards. This has resulted at times in additional staff being rostered to work to ensure safe patient care. These ward areas are:

Bridlington	Community	Scarborough	York
Waters	St Monica's	Holly	Ward 15
Lloyd	St Helen's		Ward 32
			Ward 35

Additional Bed Capacity

Due to the high activity across the Trust in January 2015, it was necessary to open the Extended Stay Unit, in York, outside its usual operational hours as an escalation area.

Under 80%

Vacancies, Sickness and the Trust's ability to fill shifts can reduce the average percentage staffing levels each month.

Vacancies

Bridlington	Community	Scarborough	York
Lloyd	Archways	CCU	Ward 33
		Cherry	Ward 34
		Oak	ICU
		Maple	
		Ash	
		ITU	
		Graham	

Actions and Mitigation of risk

At least daily staffing meeting are taking place to deploy staff to high risk areas. Where there is low activity these staff are moved to other wards in order to improve levels.

During the current pressures matrons and ADNs are meeting twice daily to ensure safe deployment of staff.

4. Vacancies by Site

The vacancies reported below, for inpatient areas, are based on information provided on a weekly basis by matrons as part of their weekly vacancy reporting. The information below shows the position as at 6th February 2015

	Bridlington		Community		Scarborough		York	
	RN	HCA	RN	HCA	RN	HCA	RN	HCA
Actual Vacancies	6.62	2	8.6	1	33.80	12.19	66.45	14.72
Pending Start	0	0	0	0	2	4.8	14.89	2.8
Outstanding Posts	6.62	2	8.6	1	31.80	7.39	51.56	11.92

Registered nurse vacancies have increased at Bridlington from 1.8wte at the end of December and 0.4 in November 2014. In the Community inpatient areas that has been an increase from 4wte vacancies at the end of December 2014.

At Scarborough Hospital, Registered nurse vacancies have increased slightly from 30.58wte in January and 26.24 in December 2014. At York Hospital, registered nurse vacancies have increased from 35.32wte since the end of December 2014 and, 35.2 wte reported in November 2014.

HCA vacancies have increased across all sites since the last reported position in December 2014.

Recruitment Plans

The Board is aware of the Trust's plans recruit internationally and arrangements have been made through Search recruitment for interviews to take place on 4th & 5th March and 21st &

22nd April 2015 in Spain with anticipated start dates in April/May 2015.

The Trust is exploring arrangements for a local nurse recruitment fair in April 2015.

The Trust is exploring the feasibility of having a HCA pool, across York and Scarborough sites, who can be deployed to wards to help support last minute gaps and the needs for enhanced supervision.

The Assistant Directors of Nursing are reviewing non ward areas to establish the feasibility of moving staff to support inpatient areas.

HCA recruitment has been organised for 12th February in Scarborough and 19th February in York. Further open days are arranged for April 2015.

5. Sickness, Bank and Agency Fill Rates

The activity pressures within the hospital have continued into January. Nurse staffing has been a contributory factor.

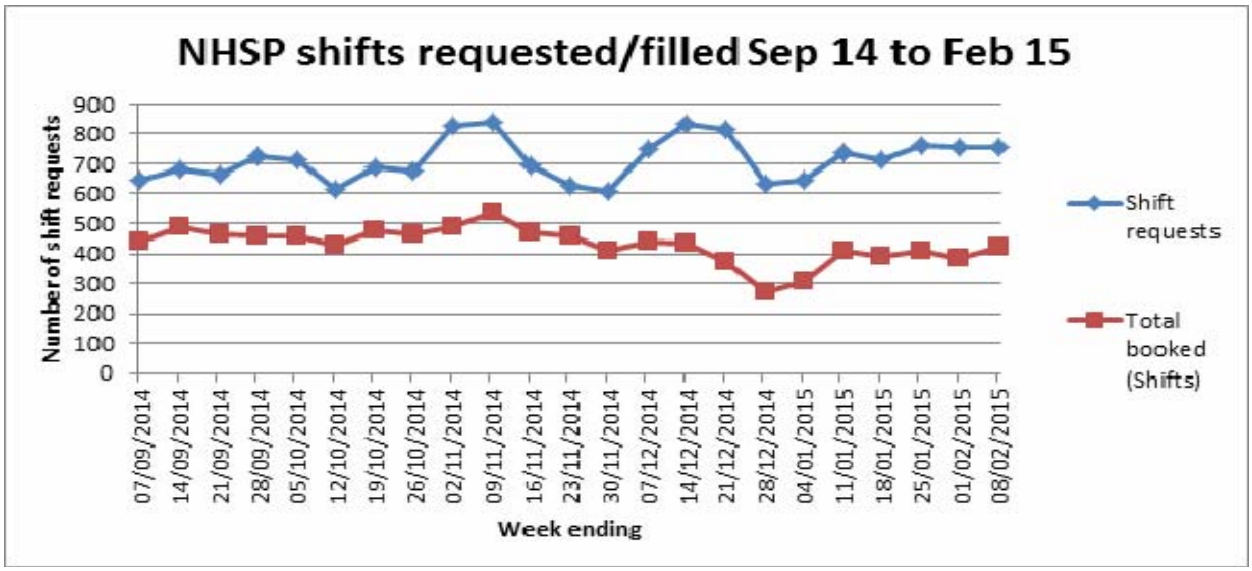
Sickness

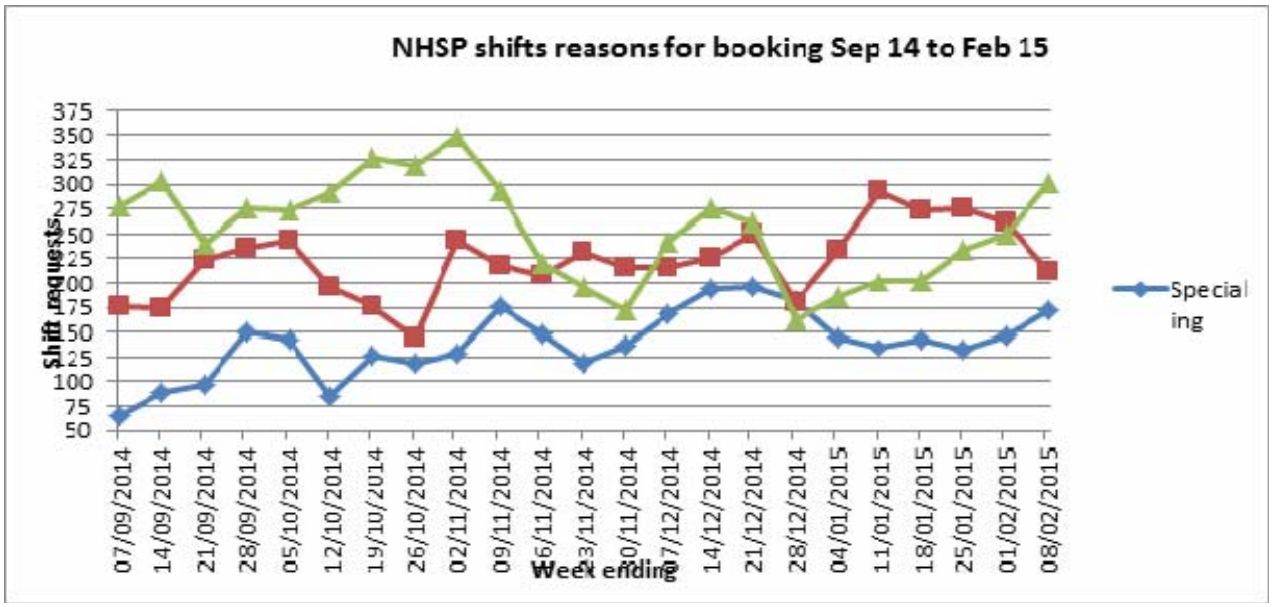
The overall absence rate for the Trust for the month of December 2014 was 4.05%. This was not significantly different to the rate in the previous month. By site, sickness within the Nursing and Midwifery workforce was, as follows;

- York Acute Hospital – 4.00%
- Scarborough Acute Hospital – 5.37%
- Community Services – 6.14%

NHSP fill rate (York) – January

57.0% of hours requested through NHSP were filled – this was an increase of just over 4% in fill rate from the previous month, although it is still much lower than the average fill rate in the current year to date (66.8%). The fill rate for qualified hours was 49.6% and the fill rate for unqualified hours was 63.0%. The top reasons for booking shifts continue to be sickness, vacancy and specialing accounting for more than 85% of all requests.





Internal bank fill rate (Scarborough) - December

Overall fill rate of bank shifts requested through the internal bank was 83.25%. Although these fill rates remain high, this was the second month in a row where there was a reduction in fill rate. The fill rate for qualified shifts was 82.40% and the fill rate for unqualified shifts was 84.79%. The percentage of shifts filled by agency increased this month for both RN shifts and unqualified shifts with almost half of all RN shifts in December filled by external agency. Of particular note is that A&E at Scarborough made requests for RNs totalling 12.3 FTE of which 7.8 FTE was filled with external agency staffing.

6. Daily Staffing Briefing Audit

In January 2015, an audit was carried out of the use of the daily staffing briefing tool between the period October 2014 to December 2015. This audit report has been shared with the Quality & Safety Committee. The audit findings will now be shared with Matrons and the proposed actions addressed. A re-audit of the briefing tool will take place during September 2015.

7. Recommendation

The Board of Directors is asked to receive the exception report for information.

8. References and further reading

National Quality Board. "*How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability".* 2013

Author	**Nichola Greenwood, Nursing Workforce Project Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**February 2015**

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

http://www.yorkhospitals.nhs.uk/about_us/reports_and_publications/safer_staffing_data/

Only complete sites your organisation is accountable for				Day				Night				Day		Night	
		Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
YORK HOSPITAL - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1805.777946	1618.42	1084.89426	911.5	678.5	652	678.5	654.25	89.6%	84.0%	96.1%	96.4%
YORK HOSPITAL - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1924.352679	1495.92	1282.901786	995.5	975	1046.5	650	688.5	77.7%	77.6%	107.3%	105.9%
YORK HOSPITAL - RCB55	15	120 - ENT	101 - UROLOGY	1733.012048	1475.5	1299.759036	1128.5	1009.232628	946.25	336.4108761	373	85.1%	86.8%	93.8%	110.9%
YORK HOSPITAL - RCB55	16	100 - GENERAL SURGERY		2380.482456	1808.75	1018.114035	876.75	1293.163265	1265	601.9897959	674	76.0%	86.1%	97.8%	112.0%
YORK HOSPITAL - RCB55	17	420 - PAEDIATRICS		597.4137931	1236.5	398.2758621	285.5	458.0689655	902.67	0	297.34	207.0%	71.7%	197.1%	-
YORK HOSPITAL - RCB55	23	430 - GERIATRIC MEDICINE		1821.959096	1445.58	1138.724435	1111	701.4752155	639.5	701.4752155	651	79.3%	97.6%	91.2%	92.8%
YORK HOSPITAL - RCB55	25	430 - GERIATRIC MEDICINE		1776	1455.5	1110	1100	677.1662371	672	677.1662371	734.83	82.0%	99.1%	99.2%	108.5%
YORK HOSPITAL - RCB55	26	430 - GERIATRIC MEDICINE		1828	1372.39	1142.5	1278.06	701.5	643.33	701.5	799.58	75.1%	111.9%	91.7%	114.0%
YORK HOSPITAL - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1898.4375	1760.5	1054.6875	959.33	622.4375	653	622.4375	671.5	92.7%	91.0%	104.9%	140.0%
YORK HOSPITAL - RCB55	29	110 - TRAUMA & ORTHOPAEDICS		1673.730044	1385.66	836.8650218	675	634.5909091	651	317.2954545	346.5	82.8%	80.7%	102.6%	109.2%
YORK HOSPITAL - RCB55	31	370 - MEDICAL ONCOLOGY		1920	1697.25	853.3333333	782.75	660.7048301	663.5	330.352415	321.41	88.4%	91.7%	100.4%	97.3%
YORK HOSPITAL - RCB55	32	320 - CARDIOLOGY		1843	1503	1382.157652	1299.17	697.3387283	669.75	697.3387283	849.5	81.6%	94.0%	96.0%	121.8%
YORK HOSPITAL - RCB55	33	301 - GASTROENTEROLOGY	361 - NEPHROLOGY	1818.269231	1328.67	1363.701923	1112.5	688.5193133	710.5	688.5193133	709.5	73.1%	81.6%	103.2%	103.0%
YORK HOSPITAL - RCB55	34	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1819.897331	1446.08	1364.922998	1130.58	681.5225873	679.5	681.5225873	692.75	79.5%	82.8%	99.7%	101.6%
YORK HOSPITAL - RCB55	35	430 - GERIATRIC MEDICINE		1816	1312.5	1135	1330	686.8771552	640.25	686.8771552	933.25	72.3%	117.2%	93.2%	135.9%
YORK HOSPITAL - RCB55	36 - Acute Stroke Unit	430 - GERIATRIC MEDICINE		1768.109029	1452.5	1105.068143	1040.5	989.3330494	846.33	659.5553663	714	82.1%	94.2%	85.5%	108.3%
YORK HOSPITAL - RCB55	37	430 - GERIATRIC MEDICINE		1373.571429	1113	1602.5	1444.25	707.5238095	640	707.5238095	728.5	81.0%	90.1%	90.5%	103.0%
YORK HOSPITAL - RCB55	39	430 - GERIATRIC MEDICINE		1387.894737	1170	1156.578947	1038.33	711.7915254	640	355.8957627	388	84.3%	89.8%	89.9%	109.0%
YORK HOSPITAL - RCB55	Acute Medical Unit	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2618.902077	2166	2182.418398	1764	1542.203219	1516.5	1233.762575	1255.83	82.7%	80.8%	98.3%	101.8%
YORK HOSPITAL - RCB55	Coronary Care Unit	320 - CARDIOLOGY		1492.5	1511.5	186.5625	72	1134	1188	0	0	101.3%	38.6%	104.8%	-
YORK HOSPITAL - RCB55	Extended Stay Area	100 - GENERAL SURGERY	120 - ENT	614	842.58	307	353.08	254.5540541	498	0	63.75	137.2%	115.0%	195.6%	-
YORK HOSPITAL - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3938.55	4146.92	358.05	179	2991.5	3529.5	271.9545455	99	105.3%	50.0%	118.0%	36.4%
YORK HOSPITAL - RCB55	Short Stay Ward	300 - GENERAL MEDICINE		1764.759036	1281.68	1323.569277	1527.5	651.9677744	662.5	651.9677744	892.67	72.6%	115.4%	101.6%	136.9%
YORK HOSPITAL - RCB55	G1	502 - GYNAECOLOGY		1605	1614	802.5	748.5	614	679	307	739.5	100.6%	93.3%	110.6%	240.9%
YORK HOSPITAL - RCB55	G2	501 - OBSTETRICS		1290.844553	1219.5	645.4222766	548	550.4203297	682	275.2101648	567.75	94.5%	84.9%	123.9%	206.3%
YORK HOSPITAL - RCB55	G3	501 - OBSTETRICS		410	771.5	205	312	291.3333333	671.17	0	0	188.2%	152.2%	230.4%	-
ARCHWAYS INTERMEDIATE CARE UNIT	Archways	925 - COMMUNITY CARE SERVICES		930	820.5	1162.5	919	356.5	355.75	713	693.75	88.2%	79.1%	99.8%	97.3%
MALTON COMMUNITY HOSPITAL - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		915.12	999.08	1601.46	1615.5	674.1699196	692.5	674.1699196	604.5	109.2%	100.9%	102.7%	89.7%
SELBY AND DISTRICT WAR MEMORIAL HOSPITAL	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1142.98951	919.59	1142.98951	1023.83	333.826087	355.76	667.6521739	655	80.5%	89.6%	106.6%	98.1%
ST HELENS REHABILITATION HOSPITAL - RCBTV	St Helens	430 - GERIATRIC MEDICINE		867	903.58	1083.75	1036.5	330.75	368	330.75	344.75	104.2%	95.6%	111.3%	104.2%
WHITBY COMMUNITY HOSPITAL - RCBG1	War Memorial	925 - COMMUNITY CARE SERVICES		930	814.5	1395	1207.75	372	341	744	682	87.6%	86.6%	91.7%	91.7%
WHITBY COMMUNITY HOSPITAL - RCBG1	Abbey	925 - COMMUNITY CARE SERVICES		688.5	651	1147.5	1013	369.6	341	369.6	341	94.6%	88.3%	92.3%	92.3%
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Johnson	430 - GERIATRIC MEDICINE		1068.61639	927	1496.062945	1201.5	666.3154762	555.67	333.1577381	335.68	86.7%	80.3%	83.4%	100.8%
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		717.1875	807.75	573.75	683.5	235.75	337	0	199.5	112.6%	119.1%	142.9%	-

Only complete sites your organisation is accountable for				Day				Night				Day		Night	
		Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
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BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Waters	430 - GERIATRIC MEDICINE		1076.5625	929.75	1076.5625	1203.5	661.25	651	330.625	378	86.4%	111.8%	98.4%	114.3%
ST MONICAS HOSPITAL - RCB05	St Monicas	925 - COMMUNITY CARE SERVICES		503.8306452	570	762.9435484	635	372	372	372	372	113.1%	83.2%	100.0%	100.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1365	1149.5	1137.5	1170.5	672.2222222	671	336.1111111	582	84.2%	102.9%	99.8%	173.2%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ash	100 - GENERAL SURGERY		1108.59375	472.75	886.875	507.33	671.3963783	220.5	0	42	42.6%	57.2%	32.8%	-
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Beech	300 - GENERAL MEDICINE		1822.5	1456.5	1594.6875	1234.5	1101.389728	781	734.2598187	638	79.9%	77.4%	70.9%	86.9%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Cherry	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2202.344666	1697.5	1761.875733	1507.5	1534.020152	1461.75	1227.216121	1351.25	77.1%	85.6%	95.3%	110.1%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2496.813559	1955.67	453.9661017	338	1437.301533	1133	359.3253833	406.5	78.3%	74.5%	78.8%	113.1%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1829.400705	1586	1372.050529	1091.67	714.7222222	660	714.7222222	693	86.7%	79.6%	92.3%	97.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Duke of Kent	420 - PAEDIATRICS		1198.940397	1350.25	299.7350993	443.25	447.059867	692.92	223.5299335	319	112.6%	147.9%	155.0%	142.7%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Maple	100 - GENERAL SURGERY		2239.027331	1624.35	1567.319132	1203.53	1282.861736	931.25	641.4308682	601.42	72.5%	76.8%	72.6%	93.8%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Haldane	100 - GENERAL SURGERY	502 - GYNAECOLOGY	1320	1139.92	1100	1010.34	639.6190476	672.92	319.8095238	322.5	86.4%	91.8%	105.2%	100.8%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1368.130016	1095	1140.108347	1209	680.8	628.75	680.8	671.42	80.0%	106.0%	92.4%	98.6%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE		2340	1810.5	390	417.5	1571.428571	1759.5	0	0	77.4%	107.1%	112.0%	-
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Oak	430 - GERIATRIC MEDICINE		1631.764706	1222.42	1602.794118	1124	696.7647059	630	696.7647059	663	66.7%	70.1%	90.4%	95.2%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Stroke	430 - GERIATRIC MEDICINE		1789.103139	1262.75	894.5515695	790	1073.27027	977	357.7567568	297	70.6%	88.3%	91.0%	83.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Hawthorn	501 - OBSTETRICS		870.1073345	740.75	435.0536673	348.75	658.0283401	724.5	0	320.75	85.1%	80.2%	110.1%	-
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Lloyd	100 - GENERAL SURGERY		1035	656.67	862.5	48	90	42	90	10.5	63.4%	5.6%	46.7%	11.7%
WHITE CROSS REHABILITATION HOSPITAL - RCB5	Whitecross Court	430 - GERIATRIC MEDICINE		928.6181278	769.83	1160.77266	997.67	356.5	600.5	356.5	349.5	82.9%	85.9%	168.4%	98.0%
YORK HOSPITAL - RCB55	24	430 - GERIATRIC MEDICINE		1117.5	1276.33	894	1077.16	687.8218299	599.5	343.9109149	683	114.2%	120.5%	87.2%	198.6%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Graham	430 - GERIATRIC MEDICINE		1342.894737	924.25	895.2631579	915.83	1047.710526	651	698.4736842	629.42	68.8%	102.3%	62.1%	90.1%
	Total			81966.008	70165.09	56232.0785	49976.91	41339.80304	41194.52	25149.82115	28232.35				

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D5

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Quality Effectiveness and Safety Trigger Tool (EWTT)

Action requested/recommendation

The Board is asked to:

1. Receive the exception report for information.
2. Agree the proposed monthly key headline reporting and, quarterly reporting arrangements
3. Agree the changes to the escalation processes for acute wards and community based wards
4. Note the establishment of the Nursing PMM meetings.

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).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Nursing Board & Quality & Safety Committee
Risk	Associated risks have been assessed

Resource implications	None identified
Owner	Beverley Geary, Chief Nurse
Author	Nichola Greenwood, Nursing Workforce Project Manager
Date of paper	February 2015
Version number	Version 1

Board of Directors – 25 February 2015

Quality Effectiveness and Safety Trigger Tool (EWTT)

1. Introduction and background

In September 2014, the Board of Directors received an evaluation paper on the introduction of the Quality, Effectiveness and Safety Trigger Tool which had been developed through NHS South West, as an early warning system for acute ward areas.

In November 2014, the acute wards areas of the Trust commenced implementation of the Trigger Tool. Ward submissions are made on the first Wednesday of each month and the first three months of data is now available. This report provides a headline summary of the ward submissions and gives detail of the key areas for action across the acute inpatient ward areas.

2. EWTT Data

The EWTT tool is based on 16 questions for each ward area, each question having its own weighting in terms of importance for resolution.

Where a ward has a cumulative ward score is less than 12 the ward is 'green' RAG rated; a score of 12 – 20 is rated Amber and those wards with scores over 21 are RED rated. The cumulative score for each ward then determines whether any escalation is necessary, in accordance with the agreed escalation procedures, previously shared with the Board.

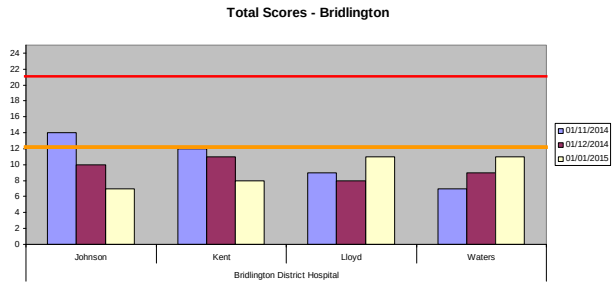
2.1 Total Scores

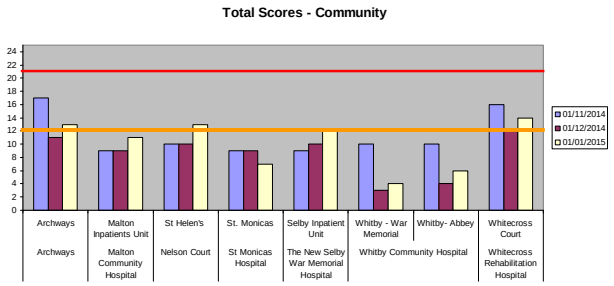
51 wards have completed the EWTT in both November and 52 in December 2014, following the opening of Ward 24 at York Hospital and 54 in January 2015 with the opening of Willow and Graham wards at Scarborough Hospital. The increase in wards due to the opening of escalation wards during the winter period.

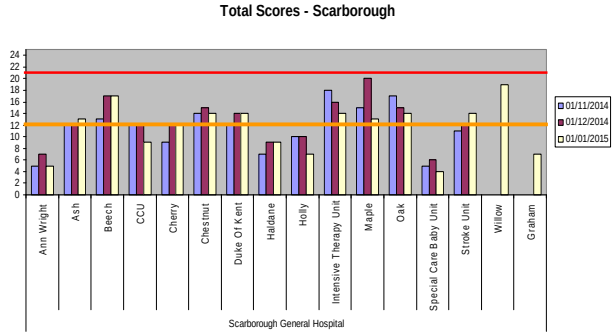
In November 2014, 22 wards (43%) were green rated across the Trust; increasing to 28 wards in December 2014 (54%) and January 2015 (52%).

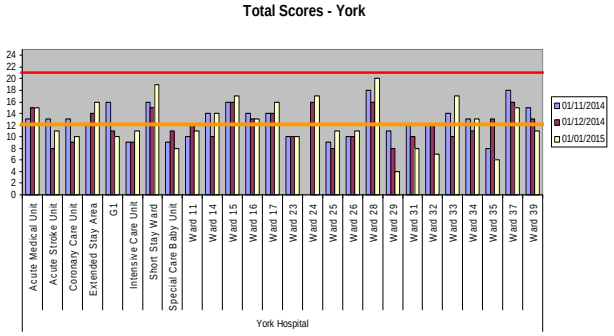
By January 2014, the green rated areas in Community have decreased from 87.5% to 57% by January 2015, increased in York from 32% to 53.85%. In Bridlington 100% of wards were green rated in December 2014 and January 2015. In Scarborough, 37.5% of wards were green rated in January 2015, an increase of 8.93%. Further analysis of this is detailed later in the report.

The charts below provides total scores, by ward, across the Trust sites. No ward has reported a score above 21 during the last three months, the highest scores being on Maple Ward, at Scarborough, in December and, Ward 28 in York in January 2015.









2.2 Result Themes

2.2.1 Amber Ward Areas

Of the 54 ward areas who submitted returns in January, there are 26 wards who rate as amber. The key themes identified within each of these areas are vacancies (80.77%), unfilled shifts (65.38%) and sickness (84.62%). In extracting these three areas from the ward results, there are 6 ward areas across the Trust that remain at amber in respect of the remaining 13 metrics which have been analysed. These areas are:

- Stroke Unit, Willow and Beech at Scarborough Hospital and,
- Ward 28, Short Stay Ward and Ward 24 at York Hospital.

Both Willow Ward and Ward 24 are escalation wards that were opened towards the end of 2014 to help with the winter pressures. For the remaining four areas, the recurring themes are appraisals, patient feedback and the friends and family test, hand hygiene compliance and, matron's environmental audit.

2.2.2 Staffing Measures

Chart 5 below, provides information on the four staffing metrics within the tool. York and Scarborough wards are reporting vacancies rates higher than 3% (80.77% and 50% respectively). 57.69% of wards on the York site have recorded an increase of over 6% of unfilled shifts for December and January, this is reflected in the increase in sickness and the unavailability of temporary staff over the holiday periods.

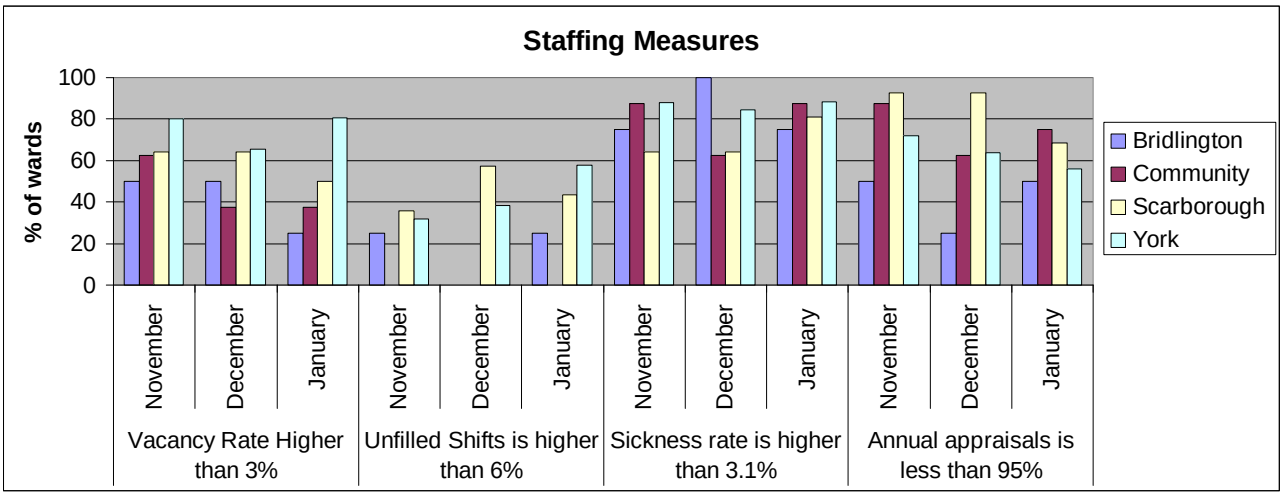
In terms of sickness, there has been a reduction in Bridlington but in Community, York and Scarborough, there has been an increase, which concurs with the information provided in the January 2015 safer staffing paper to Trust Board.

The appraisal rates have also continued to improve slightly across the Trust despite the staffing pressures.

The Board is aware of ongoing work to address staffing issues through the

development of a detailed action plan on recruitment and the development of alternative staffing models for ward areas.

Chart 5

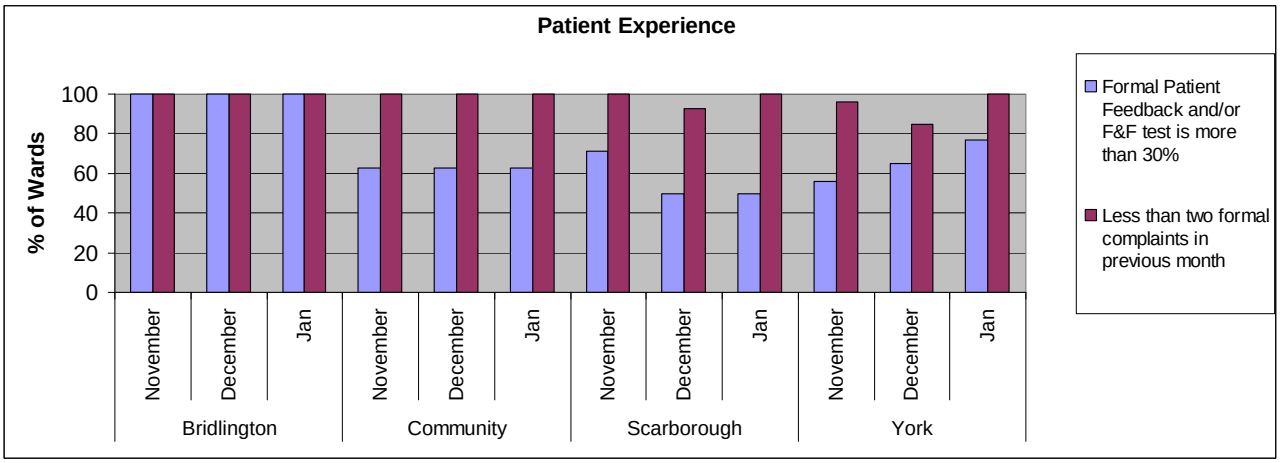


2.2.3 Patient Experience

66% of wards are reporting that their formal patient feedback and/or friends and family test is more than 30%, Scarborough remaining static at 50% and York increasing from 65 to 77%.

100% of wards have reported that they have not received more than two complaints at their January submission; an increase from 90%.

Chart 6



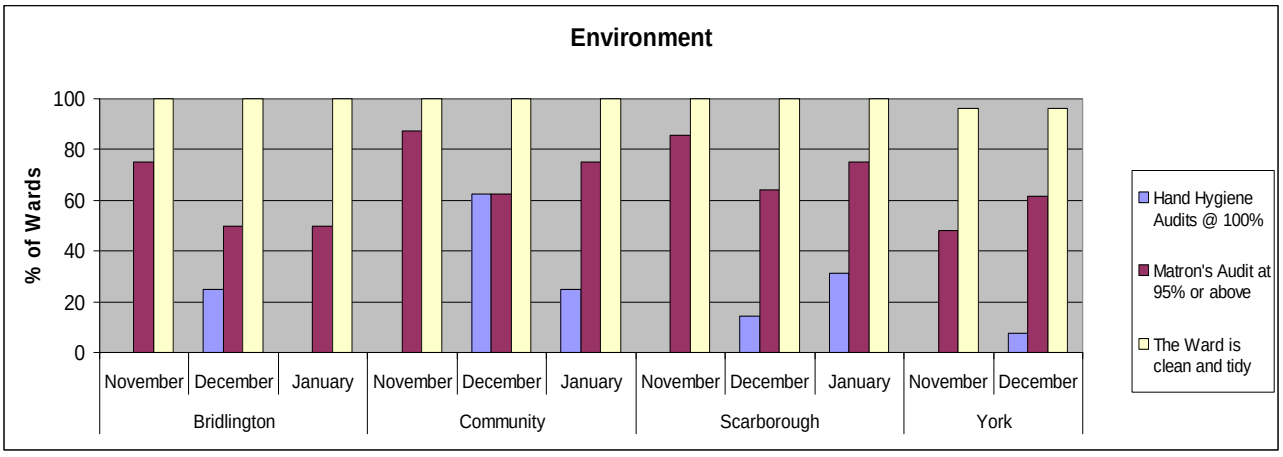
2.2.4 Environment

Chart 7 below provides details on the environmental metrics. In terms of hand hygiene, hand hygiene audits recommenced in November 2014 using a revised audit so no comparative data for October 2014 is available. The January submission reported that 18.5% of wards were achieving compliance. Following discussion with Infection Control team, a decision has been made that this metric should be reduced to 95% as this is the Infection Control Team's standard, following the introduction of their new audit tool. It is anticipated that this change will see an improvement in reporting of this metric.

In terms of tidy clean wards, matron's audits as well as senior leader walkrounds have highlighted that the wards are becoming cluttered. There has been a 5%

improvement trust-wide in matron's environment audits being above 95%, now standing at 66.67%. A trust-wide de-clutter was been organised during January and February 2015 to support wards in removing unwanted and broken items from the wards. 98.15% of wards were reporting tidier wards at the January submission.

Chart 7

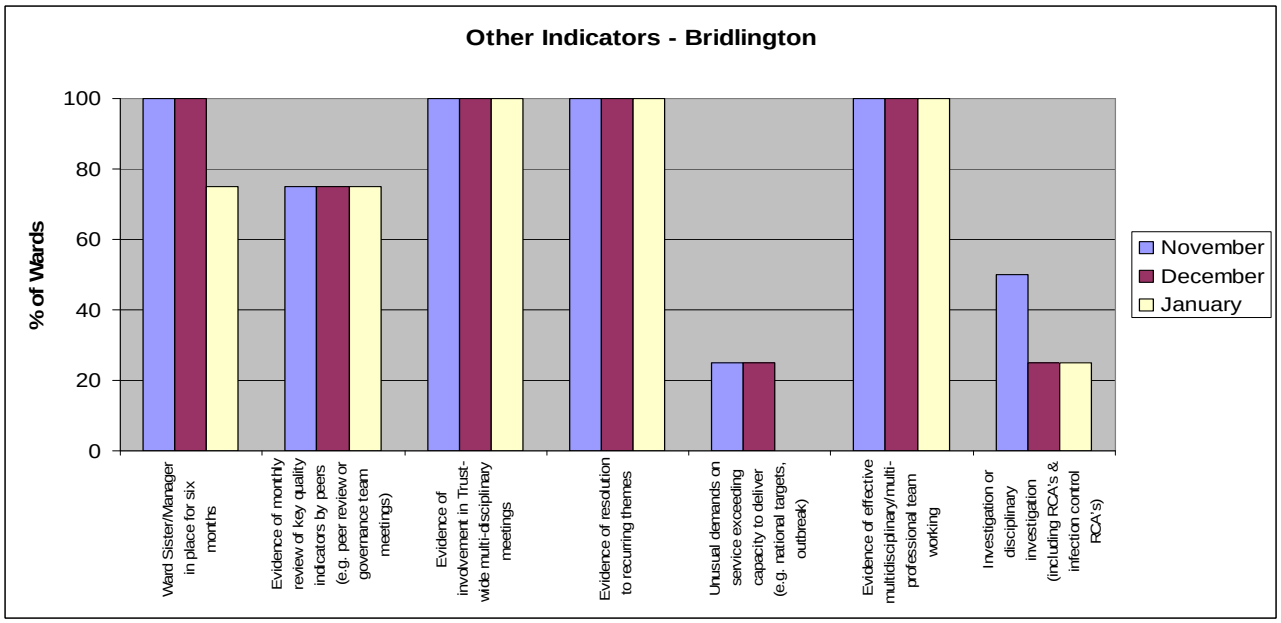


2.5 Other Indicators

Seven other associated ward health measures are assessed each month, looking at clinical governance and ward activity.

Chart 8 below provides information for Bridlington. Evidence of involvement in multi-disciplinary meetings and MDT professional team working, resolution of recurring themes has remained consistent for the last three months. One ward has a new ward sister, reducing the overall score by 25% in this metric, as there are only 4 wards in Bridlington. Only one ward in involved in some form of investigation which remains consistent with the reporting in December 2014. The unusual demands reported in both November and December appear resolved.

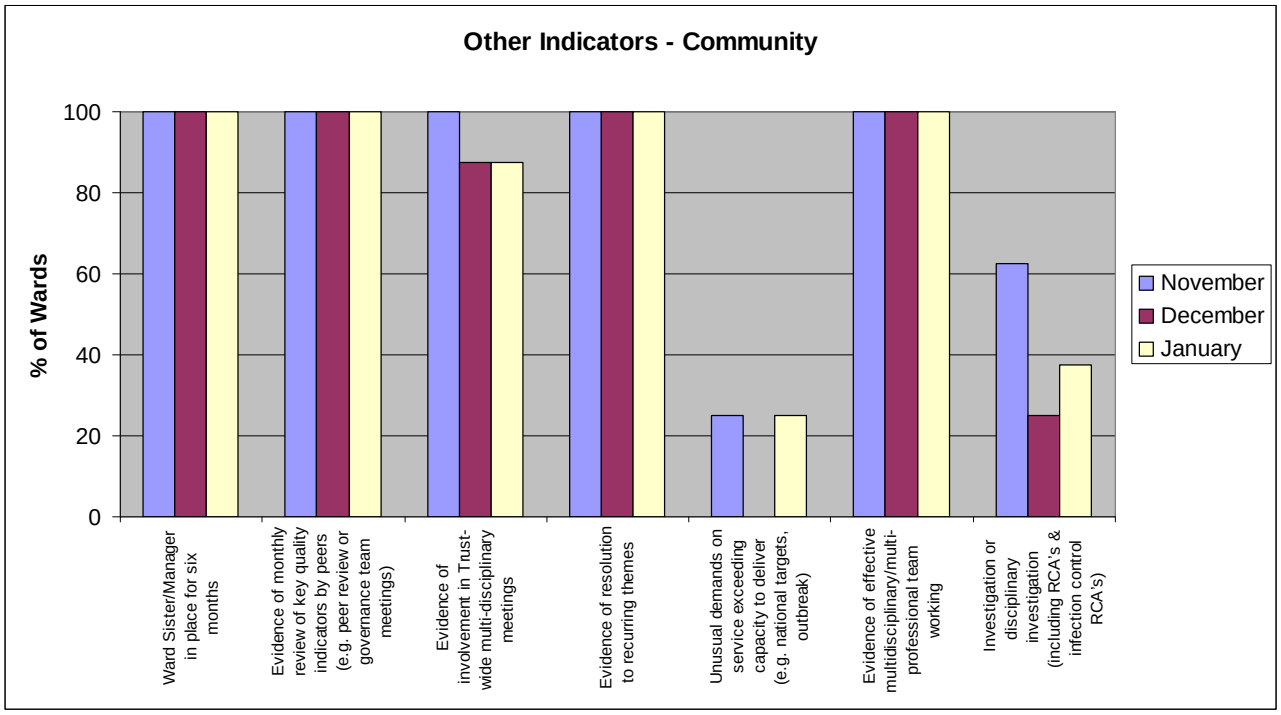
Chart 8



In Community, all the ward areas reporting remains relatively consistent across these 7 metrics, with the exceptions being ward involvement in investigations rising for the January submission by 12.5% and, there has been a slight reduction (12.5%) reduction in involvement in Trust-wide MDT meetings. Two wards (St Helen's and Malton Inpatient

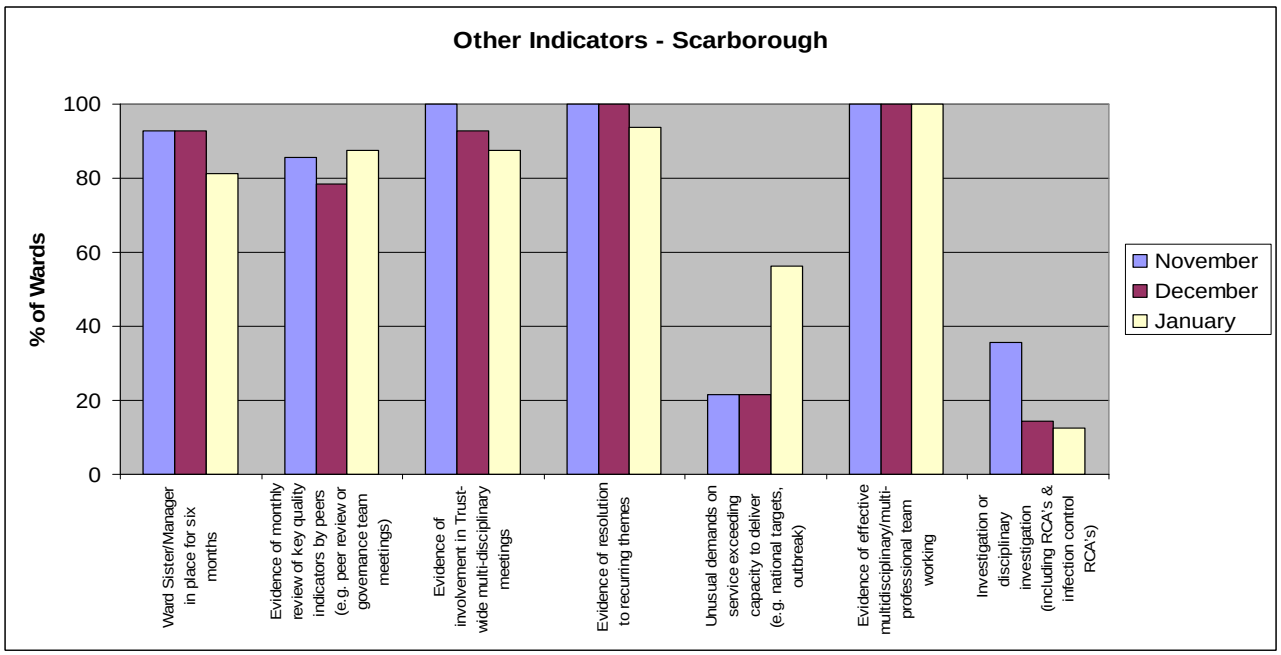
unit) reported unusual demand on its services, during November and January. Neither areas has provided any narrative to explain their response. Further analysis of this will be taking place through the Assistant Director of Nursing for community services.

Chart 9



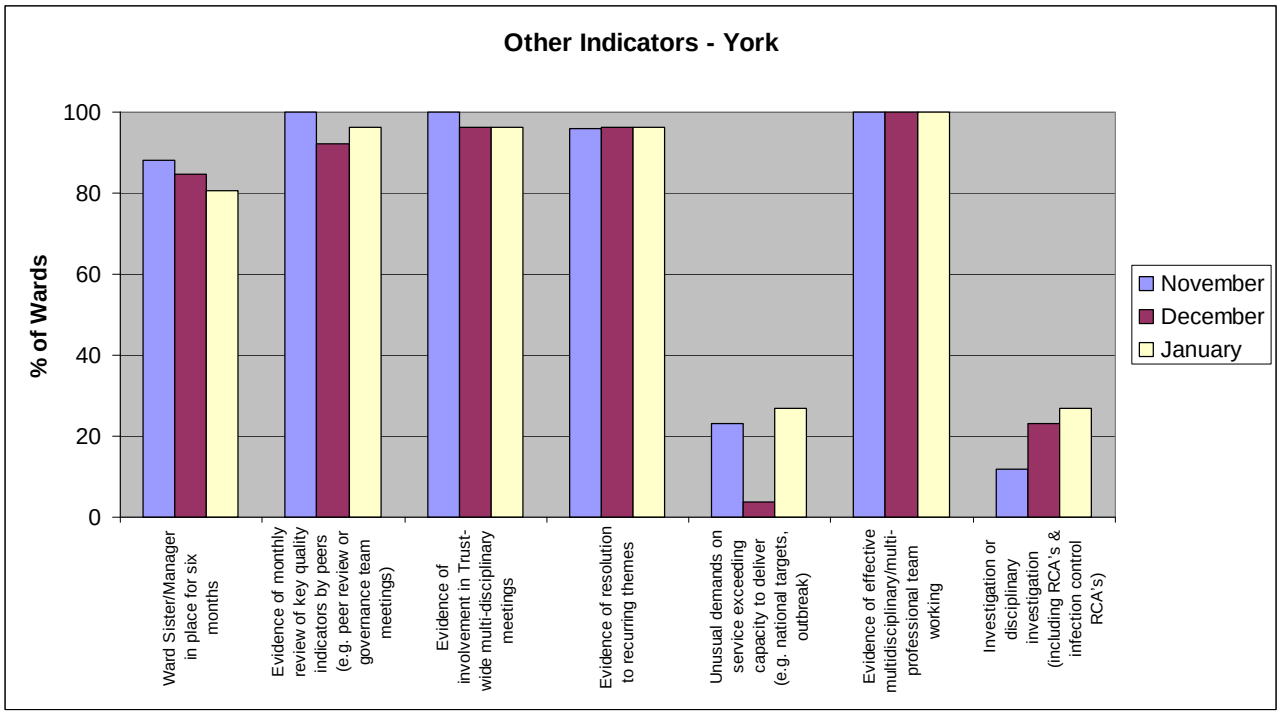
In Scarborough (chart 10 below), 9 wards (56.25%) reported unusual demands on their service for the January submission. Two wards have had new ward sisters reported in their January submission. There has been a reduction in the wards being able to evidence their involvement in MDT activities and resolution of recurring themes for the January submission, possibly due to the unusual demands on their services at the end of the year.

Chart 10



In York (chart 11), the reporting over the last three months for these metrics has remained relatively static, the exceptions to this are the unusual demands on the service which reduced from 23% to 4% in December 2014 but rose again for the January 2015 submission to 27%. Ward level involvement in investigations rose slightly in January 2015 from 23% to 27%.

Chart 11



3. Action Planning & Next Steps

From the analysis of the three months data available from the wards, three consistent themes of sickness, vacancies and unfilled shifts are affecting the majority of the clinical areas. The Board will be aware from the Chief Nurse Report in January 2015 that an action plan has been developed to corporately address these areas. Local, ward based action plans, are being developed by ward sisters on the Extended Stay Unit, SCBU (York), Chestnut Ward, Ward 14 and Ward 31 address the remaining metrics. These action plans are being reviewed by the Chief Nurse Team to ensure that there is a consistent reporting format and will reviewed through Nursing PMM meetings which are being established and, through Nursing Board to share best practice and understand common themes.

The Wards complete their next return on 4th February 2015. In accordance with the Escalation process, at appendix 1 & 2, those wards who have been amber for three consecutive months (excluding the metrics of sickness, vacancies and unfilled shifts) will be escalated to a red rating and a meeting will be held with the relevant Assistant Director of Nursing, Matron/Locality Manager and Ward Sister/Manager and deputy to discuss process to reducing their ward level scores.

As the Board is already aware, vacancies, sickness and unfilled shifts are being addressed through the Safer Staffing Action plan which was shared with the Committee last month.

3.1 Escalation Processes for Acute Wards and Community Services

Following the introduction of the EWTT tool, we have reviewed the escalation process for both acute wards and community based wards. The revised escalation process for community is attached at Appendices 1 & 2.

3.2 EWTT for Maternity Areas

The EWTT tool in its current format does not work for maternity based services in its current format, as they work as a pool of staff who are deployed amongst a variety of

working areas, unlike a conventional ward which has its own designated staffing. The Chief Nurse Team is therefore working with maternity services to understand these differences and will be looking to develop a maternity EWTT. Once developed and implemented, it will be reported on through the existing EWTT reporting arrangements.

3.3 Future EWTT reporting arrangements

With the EWTT tool being implemented in November 2014, its reporting falls out with the traditional quarterly reporting arrangements within the Trust. It is therefore proposed to incorporate the key headlines each month within the Chief Nurse's reports with a full quarterly report being provided to be Board commencing April 2015, reporting on the three months January to March 2015.

3.4 Nursing PMMs

As part of the new nursing quality assurance framework, the Chief Nurse team plan to introduce nursing Performance Management meetings across the Trust, following the standard Trust format.

Representatives from the Chief Nurse team and directorates will meet to discuss nursing issues, primarily focussing on wards that have been flagged as red under the Early Warning Trigger Tool to monitor action plans and support clinical areas.

4. Recommendation

The Board is asked to:

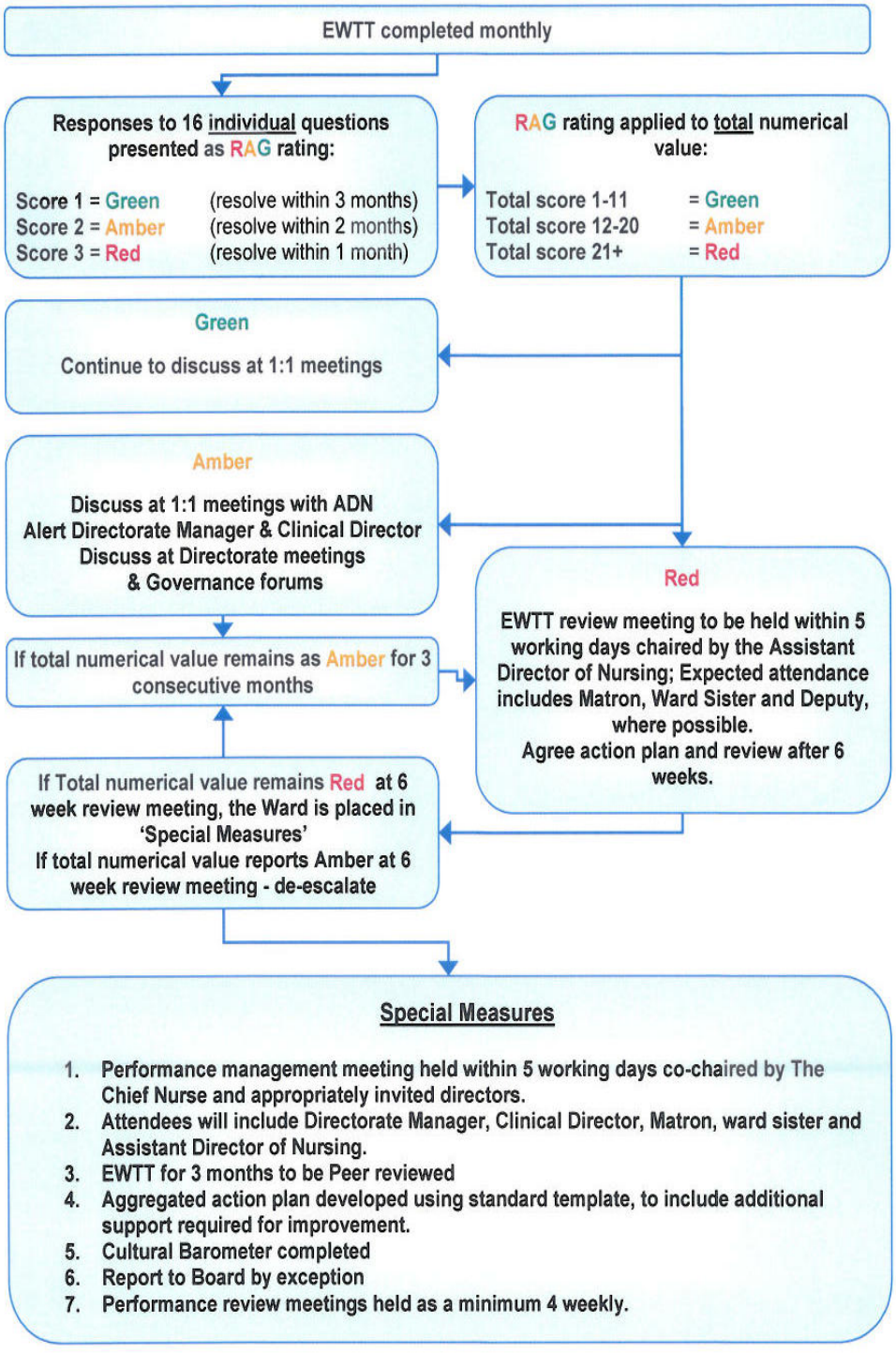
1. Receive the exception report for information.
2. Agree the proposed monthly key headline reporting and, quarterly reporting arrangements
3. Agree the changes to the escalation processes for acute wards and community based wards
4. Note the establishment of the Nursing PMM meetings.

5. References and further reading

1. Hard Truths – The Journey to Putting Patient First (Department of Health (2014) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf#
2. Compassion in Practice (Department of Health, December 2012) http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf
3. Quality in the New Health System (National Quality Board (2013) - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212927/Quality-in-the-new-system-maintaining-and-improving-quality-from-April-2013-FINAL-2.pdf
4. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Robert Francis (2010 & 2013) http://www.midstaffspublicinquiry.com/report

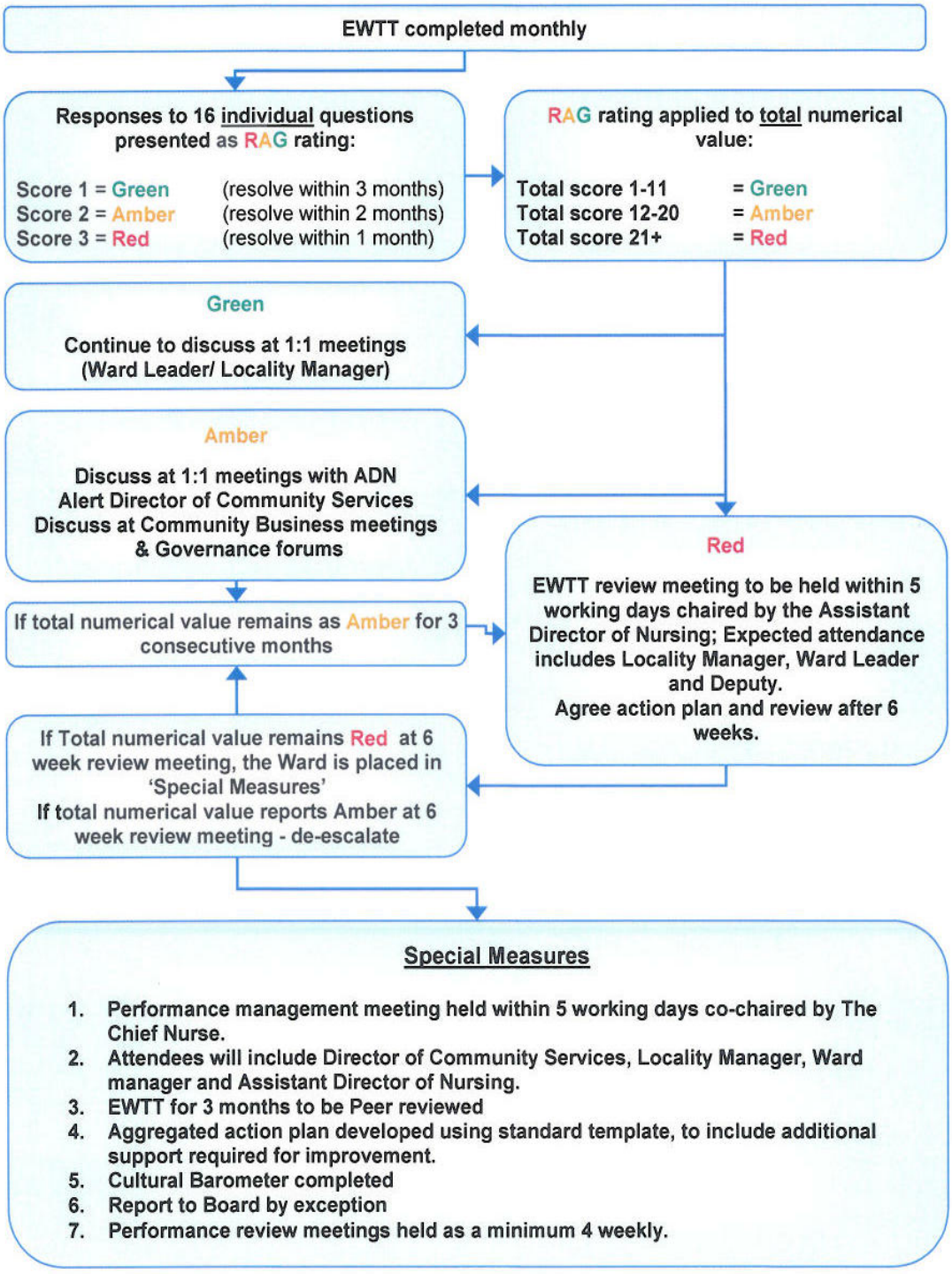
Author	**Nichola Greenwood, Nursing Workforce Project Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**February 2015**

Flowchart to outline the process for action and escalation to 'Special Measures' status using an Early Warning Trigger Tool (EWTT)



Flowchart to outline the process for action and escalation to 'Special Measures' status using an Early Warning Trigger Tool (EWTT)

FOR COMMUNITY HOSPITALS/UNITS



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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Acuity & Dependency Audit – January 2015

Action requested/recommendation

The Board of Directors is asked to:

- receive the initial findings of the acuity and dependency audit
- note that further work is being undertaken to determine the skill mix
- note that a further audit will be undertaken in July 2015

Summary

This paper provides the Board of Directors with the initial findings from the acuity and dependency audit which was undertaken in January 2015.

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

Consideration is given to the equality and diversity issues during the development of the report including the impact of the care given to patients.

Reference to CQC outcomes

Outcomes 4 & 13

Progress of report	Nursing Board and the Quality & Safety Committee
Risk	Associated risks have been assessed.
Resource implications	To be identified.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	February 2015
Version number	Version 1

Board of Directors – 25 February 2015

Acuity & Dependency Audit – January 2015

1. Introduction

Ensuring we have the right skills with the right skills ain the right place is Action Area 5 within Compassion in Practice (NHSCB 2012). The strategy emphasises the need for developing evidenced –based, patient-need driven staffing levels in care settings, the strategy also advocates twice yearly public board level discussions to ratify and agree nurse staffing levels.

The Safer Nursing Care Tool (SNCT) is one method that can be used to assist the determination of optimal nurse staffing levels. It is a validated tool which supports the assessment of patient acuity and dependency and includes formulas to determine the nursing establishment for acute hospital wards based on the patients clinical needs.

This paper provides the Board of Directors with the initial findings from the acuity and dependency audit which was undertaken in January 2015.

2. Background

As reported to the Board in December 2014, a comprehensive assessment was previously undertaken (during 2012-13) to determine acuity and dependency levels and to agree staffing models. These were signed off by the Workforce Strategy Committee and most ward areas received a detailed budgeted establishment, these establishments are the current staffing templates.

Further work was undertaken in the Autumn of 2014 to assess RN to patient ratio, examine previously agreed staffing models. In addition, preparatory work including conducting a point prevalence audit as part of the monthly Safety Thermometer data collection in November and December.

An extra- ordinary Quality and Safety Committee was held in December 2014 to review the findings and triangulate this with other data, the agreement was made to conduct a full acuity and dependency (A&D) audit during the month of January

The A&D audit was repeated as recommended and agreed; from 5th January 2015, at 3pm each day Monday to Friday for a 20 day period using the Safer Nursing Care Tool (SNCT),

Methodology
It is essential that the patient's condition is assessed to an agreed classification to allow benchmarking to take place with other organisations; the classifications have been adapted to support measurement across a range of wards and specialities. (table 1.)

The tool has been amended to include category '3b' this is a locally agreed level which has been introduced in order to assess activity around enhanced supervision, this will provide trust wide data to inform other work-streams and identify practices for 1:1 across the organisation.

The current recommendation is that the acuity and dependency audit is undertaken at least twice yearly, with data collected on every patient on participating wards. The data should be collected daily Monday to Friday for 20 days as a minimum. The acuity and dependency measurements must be consistent. (The Shelford Group)

Table 1

A brief overview of the Safer Nursing Care Tool

Summary	
Level 0	Needs met by provision of normal ward cares.
Level 1a	Acutely ill patients requiring intervention or those who are unstable with greater potential to deteriorate.
Level 1b	Patients who are in a stable condition but are dependant on nursing care to meet most or all of the activities of daily living.
Level 2	May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit.
Level 3	Patients needing advanced respiratory support and / or therapeutic support of multiple organs.
Level 3b	Patients requiring 1:1 care following falls risk assessment *(this is a trust developed level in order that we can identify the number of patients who require 'specialling' in order to provide evidence for other work stream, this will not be included in future full audits*)

As previously reported, the SNCT is validated for use in acute hospitals on general ward areas. It is not validated for high intensity areas including ICU, CCU, AMU or community settings. Tools for specialist areas are currently being developed. However, in order to focus attention on the safer staffing project and to embed data collection techniques, we included all areas in the audit with the exceptions of the emergency departments.

3. Audit Results

The audit was undertaken over all areas from Monday to Friday for a period of 4 weeks. The data collection was conducted by ward sisters and the patient safety team and validated by matrons.

The data has shown that over the 20 day period of the audit an average of 1119.5 beds per day were occupied across Trust sites. Of these, an average of 546.45 (48.9%) patients per day were regarded as Level 0 patients, 106 patients (9.46%) at level 1a, 422 (37.7%) patients at level 1b, 22 (2%) patients level 2, 9.75 (0.87%) patients at level 3a and, 13 (1.15%) patients at level 3b.

Work continues with the Safeguarding adults team to further refine assessment criteria for enhanced supervision.

By site, the dependency of patients, over the 20 day period was:

	Level 0	Level 1a	Level 1b	Level 2	Level 3	Level 3b
Bridlington	746	28	537	6	0	1
Community	1684	12	1447	0	0	1
Scarborough	2707	549	2353	103	97	57
York	5792	1529	4107	338	98	199
Total	**10929**	**2118**	**8444**	**447**	**195**	**258**

Appendix 1 provides data by site and ward against each level of dependency. Further detailed analysis of the data is required and this work will be undertaken over the next month with concurrent work to triangulate all data sets.

The addition of level 3b in the audit has shown over 250 occasions where enhanced supervision has taken place. Further analysis is necessary to understand the need for the enhanced supervision and the implications for nurse staffing in the future.

As previously reported the SNCT should not be used in isolation to make a judgement on safe staffing levels. Professional judgement, RN to patient ratio, staff to bed ratio and activity monitoring are all metrics that need to be taken into consideration when setting safe budgeted establishment. This work is ongoing.

4. Next Steps

Further analysis of the information collected during January is required to understand the A&D audit data, previous work will be refreshed and an assessment the current data against other metrics; including skill mix and RN to patient ratios will be undertaken.

An assessment against the NICE Safer Staffing Guidance is currently being undertaken and this will be reported at a future Committee meeting.

It is recommended that the safer nursing care tool is undertaken every six months and this audit will therefore be repeated in July 2015. At that point, and themes and patterns that may begin to emerge and will be examined in detail.

Work is ongoing to review previously RAG rated areas to identify high risk areas – including out of hours and, exploring feasibility of changing shift patterns (for example, the introduction of twilight shifts) and also where HCAs would be a valuable asset to provide basic nursing care.

5. Conclusions

In line with recommendations from NHSCB (2012) a six monthly acuity and dependency audit was undertaken during the month of January 2015.

The Safer Nursing Care Tool was used. This is validated for use in for acute hospitals; however this does not include areas such as CCU, AMU, ED or community hospital sites and further work is ongoing by the Shelford group to develop new tools for specialist areas. Additional work to develop to better reflect complexities of caring for older people in acute care wards is also ongoing, however, in the absence of this we have included a local level (3b) to identify patients who require enhanced supervision, for example those who are at risk of falls.

In order to embed the data collection at ward level, CCU, AMU and community hospital sites were included in the audit.

The SNCT comes with a caveat that it should not be used in isolation as safe staffing is

influenced by a number of factors, and that a national workforce tool cannot incorporate all of these factors, it is therefore recommended triangulation of other data should be carried out including professional judgement methods to increase confidence in recommended staffing levels and provide balanced assurance; before any changes to skills mix or establishment are made

Other work to establish safer nurse staffing levels includes, analysis of the NICE safer staffing, RN to patient ratios and, professional judgement. Further work is ongoing to triangulate all of this information and to identify areas of high risk.

6. Recommendation

The Board of Directors is asked to:

- receive the initial findings of the acuity and dependency audit
- note that further work is being undertaken to determine the skill mix
- note that a further audit will be undertaken in July 2015

7. References

NHS Commissioning Board (2012) *Compassion in Practice, Nursing, Midwifery and Care Staff. Our Vision and Strategy* Leeds: NHSCB

Safer Nursing Care Tool (2014) *Implementation Resource Pack.* The Shelford Group.

Author	**Beverley Geary, Chief Nurse**
Owner	**Beverley Geary, Chief Nurse**
Date	**February 2015**

Site	Ward	Level 0	Level 1A	Level 1B	Level 2	Level 3A	Level 3B
Bridlington	Johnson	297	1	214	0	0	1
	Kent	104	0	116	0	0	0
	Lloyd	126	0	18	0	0	0
	Waters	219	27	189	6	0	0
	Totals	**746**	**28**	**537**	**6**	**0**	**1**
Scarborough	Ash	217	2	66	0	0	22
	Ann Wright	81	3	262	0	0	8
	Beech	371	47	191	7	1	3
	Chestnut	270	38	229	3	0	1
	Duke Of Kent	149	31	14	2	0	0
	Graham	179	13	173	0	0	1
	Haldane	329	8	59	0	0	0
	Holly	74	31	279	1	0	8
	Intensive Therapy Unit	0	0	2	19	92	0
	Maple	254	7	130	0	0	0
	Oak	93	6	545	0	0	14
	Aspen Unit	117	26	6	0	0	0
	Special Care Baby Unit	1	1	158	0	1	0
	Stroke Unit	131	20	109	2	0	0
	Willow	94	2	4	0	0	0
	Totals	**2707**	**549**	**2353**	**34**	**94**	**57**
York	Eleven	307	17	281	0	0	0
	Fourteen	341	208	59	0	0	0
	Fifteen	372	15	220	5	0	0
	Nurse Enhanced Unit Ward 16	64	32	53	0	0	0
	Sixteen	364	18	45	0	0	0
	Seventeen	213	20	2	1	0	0
	Twenty Three	279	24	277	0	0	0
	Twenty Four	305	35	25	8	0	9
	Twenty Five	45	309	111	0	0	21
	Twenty Six	259	43	275	0	0	8
	Twenty Eight	306	5	267	0	0	11
	Twenty Nine	270	0	134	0	0	0
	Thirty One	53	196	96	0	0	0
	Thirty Two	309	22	196	0	0	17
	Thirty Three	345	50	183	0	0	12
	Thirty Four	182	0	364	67	0	0
	Thirty Five	287	10	269	2	0	15
	Thirty Seven	207	0	176	0	0	31

	Thirty Nine	164	0	187	0	0	27
	Acute Stroke Unit	133	32	203	2	0	1
	Extended Stay Area	274	6	13	0	0	0
	G1	249	6	178	0	0	2
	High Dependency Unit	4	16	4	71	44	0
	Intensive Care Unit	6	10	3	65	52	0
	Special Care Baby Unit	3	2	166	22	1	0
	Short Stay Ward	337	52	182	0	0	40
	Totals	**5792**	**1529**	**4107**	**338**	**987**	**199**

THE SNCT is not validated for use in the following areas

York	Acute Medical Unit	77	375	128	29	1	5
	Coronary Care Unit	37	26	10	66	0	0

Scarborough	Cherry	252	133	106	7	0	0
	CCU	95	181	20	62	3	0

Community	Archways	250	1	175	0	0	0
	St Helen's Rehabilitation Hospital	107	1	265	0	0	0
	Fitzwilliam	306	7	233	0	0	0
	St. Monicas	171	3	51	0	0	0
	Selby Inpatient Unit	190	0	267	0	0	0
	Abbey	210	0	85	0	0	0
	War Memorial	219	0	160	0	0	1
	White Cross Court	231	0	211	0	0	0
	Totals	**1684**	**12**	**1447**	**0**	**0**	**1**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

End of Life Care Report

Action requested/recommendation

To agree the Trust strategy for End of Life Care and support the paper recommendations.

- IT to improve communication
- To implement a 7 day service
- To gain engagement from all clinicians in the use of the last days of life care plan and the 5 priorities of care
- Improve on access to communication training
- Bereavement services business and environmental case
- Comfort boxes to be available cross site

Summary

This report provides the headings addressing the key lines of enquiry required for End of Life Care requested by the CQC.

There are supporting documents available including the Trust End of Life Care Strategy.

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).

It is anticipated that the recommendations of this paper are not likely to have

any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

The report refers to CQC key lines of enquiry for End of Life Care.

Progress of report	Quality and Safety Committee
Risk	Moderate
Resource implications	Change in staff hours to provide a 7 day service
Owner	Karen Cowley, Specialist Medicine Directorate Manager
Author	Kath Sartain, Lead Nurse for End of Life Care
Date of paper	February 2015
Version number	Version 1

Board of Directors – 25 February 2015

End of Life Care Report

1. Introduction and background

The York Teaching Hospital NHS FT End of Life Care Strategy aims to ensure that the 5 priorities of care (Recognise, communicate, involve, support and plan and do) is incorporated into every patient experience.

The End of life leads (Dianne Willcocks, Dr Carina Saxby, Dr Anne Garry, Karen Cowley and Kath Sartain) will provide annual and quarterly reports on key organisational issues affecting End of Life Care to the Health and Safety committee and the Trust Board. The annual report will be provided in July each year and summarise the preceding year.

This report core focus is relating to the Trust's position following the 5 key lines of enquiry identified by CQC. There are 3 attachments with this report which expand the information; Trust Strategy for End of Life Care, an action plan responding to the Strategy and a gap analysis of the service provided.

2. CQC key lines – Safe, Effective, Caring, Responsive and Well Lead

Is the end of life care delivered in the Trust safe?

The priority is to deliver safe effective end of life care. Mike Richards (2014) states 'care of the dying is Urgent Care with only one opportunity to get it right.

It is essential that we learn from events and seek to improve care overall. The following are areas in how the Trust is aiming to be safe in its end of life care delivery:

- The lead nurse is to commence reviewing incidents via the electronic reporting system and ensured that action was taken to address any issues identified relating to EOLC. All clinicians are encouraged to report any incidents to learn as an organisation.
- The EOLC and Specialist palliative care business meeting reviews any serious incidents. These are discussed at the meetings. Any actions are disseminated promptly to all involved.
- The mortuary service reported incidents and link to the lead nurse in influencing change
- Responded to the MRHA alert and replaced all syringe drivers to ensure safety
- Aiming to deliver a 7 day palliative care service in 2015 to improve access to specialist advice
- DNACPR is monitored through audit and the policy is across the Trust. An educational training video will be available across the region by March and the Trust will replace the video to be in line with regional procedure. Audit reporting of all deaths in York hospital seek to inform on how effective the form is completed. Last quarter 70% were complete.
- Learning from planned audit programme
- Introduction of the Care Plan for Last days of Life reflecting the National Leadership

Alliance Guidance across the Trust however there are clinical areas which are currently not using the care plan. This is an area to develop over the next year
- Clear symptom control guidance with is available cross site
- Joint cross site working, provision of education and documentation
- There is need to develop IT information sharing to ensure care delivery is safe

Is the Trust effective in the delivery and outcomes of care?

The Trust cross site completed the National Care of the dying Audit 2014. Both sites only achieved 1/7 of the organisational key performance indicators.

Since the findings the senior team have:

- identified a non executive director for end of life care;
- improved on the bereavement information and support,
- formalised mandatory training for all staff in end of life, and initiated an end of life training programme.
- A personalised care plan is available for the patients in the last days of life

The Lead Nurse is currently working with the directorate to establish a 7 day service to enable specialist face to face care to be available for the patients and staff.

The care plan for last days of life is currently being monitored through an audit programme which will publish via a briefcase. There is a strategy to seek feedback and identify core themes, aiming to improve the provision of care. Currently there is limited up take in the hospital and community settings, which is a concern.

The Multi disciplinary team's (MDT) meet on all sites. In response to peer review, each MDT receives advice and support from the chaplaincy service, broadening the impact on patient care. The palliative care teams support other MDT's as advised by peer review. There is limited attendance at the Cancer of unknown primary MDT.

The education for end of life is developing, providing for all staff members. The Trust have received further funding for the next year for education and this will be directed at improving 5 priorities of care being implemented across different grades of clinical and domiciliary staff.

Each palliative care team has trained nursing staff who are non medical prescribers, benefitting the advice and efficiency for the patients in need of medication changes. The nurse prescribers monitor and can produce an audit trail of prescriptions.

The service is working effectively across multi-agency

Is the Trust Caring?

The Trust aim to provide compassion and competent care. An educational programme is available for the nursing teams on a monthly basis and a specific programme is designed for the doctors. The team are looking to widen training to provide specific course in communication training for all grades of staff aiming to impact on the quality of care and compassion delivered.

The comfort boxes for patient's families at end of life is enhancing the care given at this difficult time.

How responsive are the services in meeting the patient's need?

The Trust works closely with the other stakeholders in end of life care provision, working together to have an overall strategy through the End of Life Board. The Trust Strategy (attached) reflects the aims and objectives of the board strategy. A key aim is to maximise care, preventing duplication and keeping the patient needs central.

Through the teams work programme, initiatives have been developed to benefit the patient and family at the end of life.

The following have arisen from the staff: memorial boxes in bereavement, comfort boxes for relatives supporting their family member who is dying; nurse led bed programme with St Catherine's Hospice for patients in the last 7 days of life and the care home syringe driver loan service.

There is a cross site business meeting which will address key areas to work together and develop the services in end of life care.

The AMBER project identifying those patients who are in the last 1-3 months of life currently is embedded on a York ward and plans to implement in partnership with the critical care outreach team on the Scarborough site are underway.

There are non medical prescribers across acute and community settings, impacting and responsive to the needs of patients.

The bereavement services are not currently cross site and the specialist medicine directorate aim to reflect the same provision on all sites.

Does the Trust provide a well led structure promoting an open and fair culture in delivering high quality care?

The Trust appointed a non executive director with a special interest in end of life care; an end of life lead nurse and created a senior team including the management and clinicians.

The aim is to have an overarching strategy, work plan and identify the areas of development. Regular information is shared with the chief nurse and medical director.

The Trust responded quickly to the announcement of the More Care Less Pathway Report (Neuberger 2013) and have now the cross site care plan available. This is still in its pilot phase and feedback is being sought from all areas.

There is representation from the Trust at the End of Life Board and the locality work streams. Both these meetings work to the regional and national end of life guidance

3. Conclusion

The end of life care agenda for the Trust has focus and currently has numerous work streams underway.

There is a desire to improve and make a difference to patients at end of their lives and for end of life care to be a key priority across all settings.

4. Recommendation

To agree the Trust strategy for End of Life Care and support the paper recommendations.

- IT to improve communication
- To implement a 7 day service
- To gain engagement from all clinicians in the use of the last days of life care plan and the 5 priorities of care
- Improve on access to communication training
- Bereavement services business and environmental case
- Comfort boxes to be available cross site

5. References and further reading

One Chance to get it right, Leadership Alliance for the Care of Dying People (2014)
More Care Less Pathway Neuberger (2013)

End of Life Advisory Board (2014) Mike Richards

Author	**Kath Sartain, Lead Nurse for End of Life Care**
Owner	**Karen Cowley, Specialist Medicine Directorate Manager**
Date	**February 2015**

End of life Care Strategic Objective	Goal	Action Plan	Completion date	Lead
1.Raise awareness of death and dying amongst patients, carers, staff and the general public.	Involvement with national and local initiatives to encourage debate and discussion about death and dying	Engage with the "Dying Matters" week annually (May2015) Increase knowledge and awareness of Advance Care Planning (ACP) amongst patients and professionals as a forum for discussing the future (See education section below)	Ongoing	All teams
2.Ensure that patient's preferences and needs are identified in a supportive fashion early in their disease trajectory, that these are recorded accurately and shared appropriately with all relevant health and social care providers	To have provision to send discharge data from SPCT Education about ACP for professionals and patients Shared electronic records for patients at the end of life To continue to work closely and improve working with discharge teams to achieve patient preferences for preferred place of care (PPC)	Ongoing discussions with IT department to input into patient D/C letters or develop our own See education section below Work closely with CCG through the Programme Board and locality groups to support and develop a system like ePaCCs For teams to be aware of the rapid discharge pathway and to use as required. For the rapid discharge pathway to be added to champions training package for year 2 To produce a fast track flow chart to help discharge teams Review the number of fast track and identify delays in discharge to be escalated to the Board Review meetings with hospice at home teams and discharge teams 3 times	ASAP May 2015 May 2015 June 2015	Eofl lead nurse Consultants EofL lead nurse Consultants End of Life Care facilitators EofL lead nurse EofL lead nurse SPCT

End of life Care Strategic Objective	Goal	Action Plan	Completion date	Lead
		per year		
3.Ensure patients have 24/7 access to specialist palliative care advice and 7 day access to specialist palliative care assessment.	Ensure adequate staffing for service. Currently aiming to have each site, Scarborough and York hospitals and York community to run their own 7 day service.	Cultural changes – HR consultation and listening exercise Business case for enhanced hours Case of need – data collection and IT provision	March 2015 January 2015 March 2015	HR Directorate Lead Nurse
4.Ensure care is delivered through a skilled, confident and compassionate workforce.	Education priorities: Last hours and days of life AMBER care bundle Communication skills Symptom control Spiritual and emotional care	To develop an educational strategy for EOLC Aim to have EOLC champions Trust wide with increased skills and knowledge Provide specific training for EOLC including key prioritieseg ACP on each site Education folders Develop e-learning programme Explore learning through alternative ways/ cross fertilisation from hospice to acute Promote e-ELCA key modules and work with CLAD in providing	March 2015 Ongoing 2016	EofL lead nurse End of life care facilitators –York, Scarborough and community SPCT and EofL lead nurse As above EofL lead nurse/Consultants

End of life Care Strategic Objective	Goal	Action Plan	Completion date	Lead
		availability of these Launch National e-learning End of Life education package across Trust		EofL lead nurse
	Guidance for the McKinley syringe driver and introduction and training across the Trust	Regular training for McKinley, AMBER and communication skills	Guidance and initial training complete 2014/5	SPCT and EofL lead nurse
	Hospital specialist palliative care team to have access to continuing professional development	Regular monthly education sessions (Trust Grand Round & HPCT journal club) Collate list of national conferences /courses that may be relevant to team Identify funding streams where required	Ongoing	SPCT
5.Promote integrated End of Life Care frameworks across primary, secondary, community and voluntary care settings.	Lead, contribute and influence end of life care (EOLC) across York teaching Hospital FTNHS including generalist and specialist palliative care	Representation on end of life strategy board. To work with the board strategy to improve care for patients and their families Locality membership on both York and	Ongoing Ongoing	EofL Lead Nurse Consultants EofL lead nurse

End of life Care Strategic Objective	Goal	Action Plan	Completion date	Lead
		Scarborough locality boards		Consultants
		York Teaching Hospital FTNHS EOLC Forum	Ongoing	Ward and specialist teams
		Regional representative on sub group (member of the Trust currently chair) and regional group	Ongoing	
		Provide quarterly reports to the Trust board	Achieved 2014	End of life leads
	Work across non cancer teams to build expertise	Work with Renal, heart failure and respiratory teams to build in principles of ACP, 5 priorities of care and sharing of knowledge		
		Continue with the strong oncology and haematology team support across sites	All ongoing	SPCT
		Build up relationships in elderly care and share knowledge Review areas which use the care plan or SPCT less and explore the reasons for this		
	Sharing of good practice locally, regional and nationally	Poster and presentation at national conferences Local talks	Ongoing	SPCT

End of life Care Strategic Objective	Goal	Action Plan	Completion date	Lead
	Trust palliative care guidelines Secure funding for the SLA arrangements with the local hospices Contribute to DNACPR locality and regional projects	To review and update the current guidelines affirming through the business meetings Specialist palliative care business plan Secure objects of SLA To have a representative on the regional group To have a local group and policy To have access to E learning training and work across the Region to implement the region training when accessible Monitor through audit	March 2015 Ongoing	Directorate Consultant – Dr Garry and resuscitation officer
6.Use nationally approved tools to support patients at the end of life and to allow us to benchmark ourselves against national standards	Consistent and appropriate use of ACP GSF AMBER care Bundle	Educate patients and staff about ACP and inclusion of patients on GSF registers Consolidate use of AMBER in York hospital site. Discuss co-ownership of AMBER with medical team in Scarborough hospital before commencing	Ongoing in education programme Ongoing May 2015	End of life Care Facilitators End of Life facilitators York K Broadley Scarborough
7.Ensure patients and carers needs across the key domains of specialist palliative care –physical, psychological, spiritual and social are assessed and	Development of care plan for patients in the last days of life following the “More Care Less Pathway” and “One Chance to get it right” publications	Withdrawal of the LCP from all areas of the Trust Introduction of the care plan for the last days of life to be available across the acute, community hospital and	January 2013 November 2014	Medical Director SPCT

End of life Care Strategic Objective	Goal	Action Plan	Completion date	Lead
met in a timely and compassionate fashion.	Achieve the 5 priorities of care for all patients at the end of life	community settings and measure its usage To provide education over a time period supporting the roll out including support for the clinical areas within the first 6 months and review Base line audit to assess 20 care plans on each acute site and re-audit following introduction of care plan - use the findings to inform future care plan adaptations A task and finish group to respond to feedback of the care plan. To measure user information Bench mark the care plan across the regional area through network meetings Continue to educate and build the knowledge of the EOLC ward champions Build in communication skills to the EOLC education training and use all opportunities to demonstrate good practice Family's Voice research project Symptom guidelines within the care	Nov 2014 – current Baseline completed Nov 2014 To reaudit March 2015 April 2015 Ongoing Nov2014-current Review 2016 Review 2016	SPCT SPCT EofL lead nurse EndofLife care facilitators End of Life Care facilitators Dr Saxby/Dr Garry EofL lead nurse/Consultants

End of life Care Strategic Objective	Goal	Action Plan	Completion date	Lead
		plan Symptom guidelines available via the web pages Educational sessions to all grade of staff. Junior Dr cards Roll out successfultrial of care boxes for families of dying patients across the Trust Environmental report for Scarborough mortuary Work with operational team to identify areas to cater for EOLC eg quiet rooms Implementation of comfort boxes Bereavement survey Bereavement business case Bereavement facilities review Funeral tender York,Scarborough and Bridlington hospitals	Ongoing Achieved – review 2016 May 2015 December 2015 March 2015 December 2015 October 2015	SPCT EofL Lead nurse End of life Care faciitators

End of life Care Strategic Objective	Goal	Action Plan	Completion date	Lead
Maintain a high standard of End of Life care for all patients receiving treatment from York Foundation Trust. This care extends to the family members or carers of the patient.	Achieve the 5 priorities of care for all patients approaching the end of life 1. The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly by doctors and nurses. 2. Sensitive communication takes place between staff and the person who is dying and those important to them. 3. The dying person, and those identified as important to them, are involved in decisions about treatment and care. 4.The people important to the dying person are listened to and their needs are	Use of the end of Life Care Plan (see above) and the education surrounding its implementation and maintenance Contribute and influence Trust initiatives and policy/guidance development as requested to improve quality of EofL care delivered ie • Loan arrangement and agreement document for care homes to have access to Mc Kinley syringe drivers 24 hours a day • Care after death policy replaced with guidance for staff for care after death in line with National documentation • Review of external Trust web pages for palliative care • Operational policy for SPCT to be merged to one document • Contribute to DNACPR policy Continue National peer review • To maintain folders with evidence on both sites , ensuring team development recorded	Nov 2014 – current Achieved Reviewed Jan2015 Jan 2015 May 2015 Completed Nov 2014	SPCT EofL Lead nurse EofL lead nurse Eof L lead nurse SPCT Consultants SPCT EofL lead nurse/Consultants SPCT

End of life Care Strategic Objective	Goal	Action Plan	Completion date	Lead
	respected. 5.Care is tailored to the individual and delivered with compassion – with an individual care plan in place.	• Await further guidance from the national team • Continue with the work plan and implementation Patient and public involvement To learn from the feedback and understand the recurring themes • Trust has committed to the research 'family voices'; a patient/family diary recording the qualitative information of the last days of life • To learn and inform education and training from feedback, share with the Trust board and directly support those completing the diary • Work with Non-Executive director to gain feedback through Health watch Audit and work programme • Business meetings to plan and review all audits • Current audits : Care after death, last days of life, educational development, • 3 times per year Trust wide	Nov 2014-current May 2015 Ongoing Ongoing Ongoing To commence Feb 2015	Dr Saxby/Dr Garry End of Life Care lead group End of life care lead group Consultants/SPCT SPCT Eof L nurse and SPCT End of life care

End of life Care Strategic Objective	Goal	Action Plan	Completion date	Lead
		business meeting via video link • Bi monthly meeting with NED, *Lead Nurse for EOLC,* Consultants and directorate manager • Ensure statistical data from CPD is available to inform strategic direction Complaints and compliments • Review all EOLC complaints and systematically develop action plans for changing practice • Analyse and report through quality and safety committee	Ongoing May 2015 Ongoing at business meetings and End of Life care lead group Ongoing	leads End of life care lead nurse End of Life lead nurse End of Life lead nurse

End of Life Care Strategy
York Teaching Hospital NHS Foundation Trust

OUR VISION:

To ensure that all patients with advanced, progressive incurable illness have appropriate help to live as well as possible until they die. In the final days of life to ensure we provide excellent end of life care for each individual patient, their family members and their carers including care after death. The Trust aims to ensure that the 5 priorities of care is incorporated into every patient experience.

(End of life care for the context of this strategy is any care provided to a patient, family member or carer when that patient is in the last year of life. It extends into the period immediately after the patient has died and the commencement of bereavement support)

Context

This strategy has been developed after review of the key outcomes from the following documents; National End of life care Strategy 2008, Mid Staffordshire report (Francis report) Feb 2013, Route to Success July 2010, More Care Less Pathway 2013, and One chance to get it right 2014.

It also reflects the recently developed strategy of the Joint End of Life Care Programme Board for Scarborough & Ryedale and the Vale of York CCGs. The latter was formed in 2013 and has membership from York Foundation Trust, Scarborough & Ryedale and York CCG's, Saint Catherine's and St Leonard's Hospice as well as the health and social care sectors for Scarborough & Ryedale and York.

The Trust welcomes the inclusion of End of Life care as one of the CQC's 8 key areas of inspection which acknowledges the importance of this area of care within the acute hospital and community settings.

The Programme Board's vision is for everyone to have the best possible end of life experience ensuring people are treated, wherever possible:

- As an individual with dignity and respect
- In familiar surroundings
- In the company of family or friends (if they wish)
- with their psychological, spiritual and religious care needs assessed and met
- with pain and other symptoms managed as effectively as possible

The Programme Board's principal objectives are to:

- Increase public awareness and discussion of death and dying: This will make it easier for individuals to discuss their own preferences around end of life care and should also act as a driver to improve overall service quality
- Ensure that all people are treated with dignity and respect at the end of their lives
- Ensure that pain and suffering amongst people approaching the end of life care is

- Ensure that all those approaching the end of life have access to physical, psychological,
- social and spiritual care
- Ensure that people's needs, priorities and preferences for end of life care are identified, documented, reviewed, respected and acted upon wherever possible
- Change the perception of "Death is failure" to "A good death is a successful care outcome"
- Develop transparent processes for access to rapid response 24/7 end of life care.
- Ensure that the many services people need are well coordinated, so that patients receive seamless care
- Ensure that high quality care is provided at the end of life, and after death
- Ensure that carers are appropriately supported both during a patient's life and after bereavement
- Ensure that health and social care professionals at all levels are provided with the necessary education and training to enable them to provide high quality care
- Ensure that services provide good value for money for the taxpayer

Scope

The scope of the York Foundation Trust strategy encompasses care provided in York Foundation Trust Acute and Community hospitals as well as patients receiving care from Foundation Trust community services in York and Selby. It refers to care provided to adults with any advanced, progressive and incurable illness in the last year of life and to the care provided by Foundation Trust staff to the family members and carers of those patients. It is relevant to all staff from those first encountering patients to Chief Executive and Trust Board.

OUR OBJECTIVES

1. **Raise awareness of death and dying amongst patients, carers, staff and the general public**.
   The Trust will engage with local and national initiatives such as Dying Matters to increase debate and discussion around end of life care.

2. **Ensure that patient's preferences and needs are identified in a supportive fashion early in their disease trajectory, that these are recorded accurately and shared appropriately with all relevant health and social care providers.**
   Advance Care Planning is the cornerstone to identifying the patient's preferred priorities and place of care. Patients and carers will be offered the opportunity to prioritise and choose their preferred options of care.

3. **Ensure patients have 24/7 access to specialist palliative care advice and 7 day access to specialist palliative care assessment.** It is important that patients, their family members, carers and generalist staff have access to specialist palliative care advice 24 hours a day and to specialist assessment and advice 7 days a week

4. **Ensure care is delivered through a skilled, confident and compassionate workforce.** Investment in the education and training of our workforce is key to the delivery of high quality end of life care.

5. **Promote integrated End of Life Care frameworks across primary, secondary, community and voluntary care settings.** Patients in the last year of life receive care across many settings and with the involvement of many health and social care providers. Timely and accurate communication of a patient's health needs, preferences and priorities of care to all relevant providers of care is essential to the seamless care we aim to provide.

6. **Use nationally approved tools to support patients at the end of life and to allow us to benchmark ourselves against national standards.** Advance care planning and the Gold Standards Framework are two of the national tools recommended for patients in the last year of life.

7. **Ensure patients and carers needs across the key domains of specialist palliative care –physical, psychological, spiritual and social are assessed and met in a timely and compassionate fashion**. Developing a workforce with the right skill mix to provide an holistic assessment of patient's needs, signpost/ refer appropriately and give reliable evidence based advice is a key part of the delivery of high quality end of life care

Ownership and responsibilities

The Scarborough & Ryedale and Vale of York End of Life Care Programme Board is responsible for driving through the changes needed for operational pathways and cost profiles. In York and Scarborough& Ryedale there will be locality groups whose role is to support the implementation of the strategic plan. York Foundation trust has representation on both the programme and locality boards. Within the Trust there is an End of life Care Lead Nurse whose remit is to work with the palliative care clinical leads, the palliative care team and other service providers to empower staff to deliver the Trust strategic objectives for End of Life Care. The clinical leads Dr Anne Garry and Dr Carina Saxby, the Lead Nurse for End of Life Care Nurse Kath Sartain, the Director of Specialist Medicine Karen Cowley and Prof Dianne Willcocks, the Non-Executive director with responsibility for end of life care meet quarterly to review the End of Life workplan. A quarterly report is submitted to the Quality and Safety committee and to the Trust Board via Prof Willcocks and the medical director, Dr Alastair Turnbull.

Implications for York Foundation Trust

<u>Workforce</u>

Investment in the education and training of generalist and specialist staff – development of a comprehensive education strategy and programme to deliver this

Ensuring the correct skill mix is available to care for patients, their family members and carers

Staffing for 24/7 access to specialist palliative care advice and 7 day specialist palliative care assessment

Exploring shared training opportunities

Possible increase in Palliative Care Consultant time across both sites and York community

<u>IT</u>

Development of a locality wide EPaCCs (Electronic palliative care co-ordination system)

Improved communication between existing systems within the Trust and with external service providers to improve information sharing between partner organisations

Improve collection of outcome data to evidence quality of care

Priorities 2014/15

- ► Collaboration with nursing homes to develop skills, expertise and support for educational learning
- ► Appointment of an End of life Care Facilitator at SGH and York
- ► Review medical staffing arrangements following Consultant retirement (York).
- ► Continuous cycle of Cancer Peer Review development in line with National standards
- ► Explore possible North Yorkshire Strategy with Hospice Network
- ► Review of community service and structure to progress integrated coverage
- ► Development of Specialist Palliative Consultant role to enhance End of Life Care at Scarborough and York sites
- ► Roll out of Last days of Life Care Plan and Family's Voice research project
- ► Participate in the NCDAH
- ► Establish meetings with Non Executive Director, Prof Willcocks and clarify reporting structure to the Board
- ► To continue with a robust educational programme for all levels of staff

Priorities 2015/16

- ➢ Development of improved communication of information for palliative care patients on discharge
- ➢ Involvement in the development of EPaCCs as led by the CCG
- ➢ Development of an education strategy/work programme to provide guidance and costings to ensure all staff have the appropriate level of skill (generalist and specialist) for the delivery of high quality end of life care
- ➢ Development of education programme for Advance Care Planning and communication skills
- ➢ Development and delivery of education about 5 priorities of care
- ➢ Development of AMBER in specific ward environments
- ➢ Upgrading of bereavement services at Scarborough hospital to provide equity across both sites
- ➢ Specialist clinical nurse educational development programme
- ➢ To increase access for patients with a non malignance to specialist palliative care
- ➢ Rapid discharge pathway to integrated within the care setting

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Background

Within York Teaching Hospital NHS Foundation Trust, 1911 of the total number of deaths occur in the acute hospitals (York, Scarborough and Bridlington). The highest number of deaths occur on Care of the Elderly wards. Prior to 2013, the Liverpool Care Pathway (LCP) was well embedded across the trust and a high number of deaths were supported by the use of the LCP. There had been no negative feedback from patients receiving care supported on the LCP, however the Trust responded to the national guidance and withdrew its use in 2013..

The executive board is clearly engaged in raising standards in end of life care. The senior end of life care team comprising of Lead nurse for end of life care, (Kathryn Sartain 01723 236254) cross site specialist palliative care consultants,(Dr Garry, Dr Saxby, Dr Hulme) directorate manager (Karen Cowley 01904 721345) and the Non - Executive Board member (Dianne Willcocks), with specific responsibility for care of the dying meets regularly and submits a quarterly report for the executive board. The lead nurse has regular meetings with the Chief Nurse to inform of end of life care issues.

There is an end of life care board which provides a structure for all strategic planning work and has an overarching strategy across all domains for clinical and commissioning areas. To implement work plans there is a locality board in Scarborough and York has recommenced a locality board in 2015.

The lead nurse for end of life care overarches all Trust sites providing leadership and management for end of life care. The lead nurse also has time allotted to St Leonard's Hospice, York aiming to bring services together.

The specialist palliative care services are provided by 3 separate teams within the Trust (as below) and a key priority has been to have one overarching strategy for specialist palliative care and end of life care across all teams.

York Hospital Palliative Care Team (YHPCT) 01904 725835

The HPCT consists of:

- 3.3WTE permanent Macmillan Palliative Care Nurse Specialists
- 1 fixed term contract End of life care facilitator (1 WTE) – due to finish December 2015. Awaiting confirmation of funding support from Macmillan Cancer Support
- Consultant in Palliative Medicine – 0.8 WTE
- 2 PA Hospice Medical Director sessions
- Specialist Registrar in Palliative Medicine - part time from the Yorkshire Palliative Medicine rotation.
- Medical Secretary (0.8 WTE)

Scarborough Hospital Palliative care Team (SHPCT) 01723 342446

The HPCT consists of:

- 2 WTE permanent Macmillan Palliative Care Nurse Specialists
- 0.6 WTE permanent and 0.8 WTE fixed term contract End of life care facilitator – due to finish 2015. Awaiting confirmation of funding support from Macmillan Cancer Support

- SLA agreement with local hospice Consultant in Palliative Medicine (medical director) 4 PA's
- Team Secretary (0.8 WTE)

York Community Palliative care Team (YCPCT) 01904 724476

- 6.9 WTE permanent Macmillan Palliative Care Nurse Specialists
- 2 PA's Consultant in Palliative Medicine
- 0.6 WTE Family care worker
- 1.0 WTE OT with special interest in specialist palliative care
- 1.2 WTE Physiotherapist with special interest in specialist palliative care

Scarborough Community Palliative Care Team

This service is provided by Saint Catherine's Hospice; however the Lead Nurse for end of life care and HPCT have strong links with the hospice and work together on key work plans across the locality.

The Specialist Palliative Care Teams (SPCT) are fully funded by the Trust and have clinical and educational roles within the Trust. The service offered is an advisory one, in which patients remain under the care of the referring team. The SPCT's have operational policies (which are currently being merged) and has adopted the referral criteria agreed by the Yorkshire Cancer Network.

The YHPCT is currently available Monday to Friday between 8am and 4:00pm.SHPCT and YCPCT both are available 8:30- 4:30 pm. Face to face specialist palliative care seven days a week is not currently available, but is in the process of seeking staff consultations to progress to provide a 7 day service. Out of hours 24 hour specialist palliative care telephone advice is available from the On-Call Palliative Medicine Consultant in the region who can be contacted via either of the two local hospices. For Scarborough patients there is access to a telephone advice service run by Saint Catherine's Hospice called Palcall.

Availability of HPCT and specialist palliative care services are publicised as part of end of life teaching programmes, on the palliative care section of the trust website and in the end of life folders on each ward area. The community team members are linked to specific practices to ensure continuity and cover leave through a buddy system ensuring continuity.

Both acute sites received 947 referrals in the year 2013/14; 15% of which were for patients with non-malignant disease; however some disease data is unrecorded and this percentage is not accurate. Work to improve this is recorded in the service action plan.

32% of the patients supported by the Specialist Palliative Care Team on the Scarborough site since April 2014 have had a diagnosis other than cancer. There is a particular interest in heart failure, with the clinical lead (Professor Miriam Johnson) pioneering research and clinical practice in this area. The Trust and CCG have also secured an agreement with Saint Catherine's Hospice to have access to Nurse Led Beds for patients who are dying within the next 7 days. This creates choice for patients in the last days of life when hospice would not normally be an option. This project was recognised as best practice by hospice UK and recorded in the Telegraph January 20th 2015 as a new way of providing care and choice.

York site recognise this is an area to improve and Dr Bill Hulme, medical director of St Leonard's Hospice has commenced a heart failure clinic, reflecting the learning from Professor Johnson.

Table 1 Numbers of Referrals

YEAR	York Acute 2013-2014	York Acute April-Dec 2014	Scarborough Acute 2013-2014	Scarborough Acute April-Dec 2014	York Community 2013-2014	York Community April-Dec 2014
Total Referrals	394	455	492	341	1185	656
Cancer Contacts	251	256	383	229	1145	656
Non Cancer Referrals % (new patients only)	40	Unable to obtain	109 (22%)	112	40	
Disease not identified Patients	127	199				

Table 2: Summary of Overall SPCT Referral Data -2014

The teams aim to respond to urgent referrals on the same day or within one working day, and routine referrals within 2 working days in acute settings. In the Community setting non urgent referrals are responded to between 3-5 days. In practice in the acute service over the last 12 months the vast majority of patients are seen within 1 working day.

The SPCT also aim to attend weekly cancer site specific MDT meetings, as well as York site oncology, hematology ward rounds on a weekly basis. However the HPCT are currently prioritising ward round attendance.

5 permanent Clinical Nurse Specialists are Independent Nurse Prescribers. The SPCT expect the treating team caring directly for a patient to prescribe any recommendations / alterations to medication. The aim of this approach is to help educate medical staff in appropriate prescribing for symptom management. However, on occasions, this can lead to delays in patients receiving appropriate medication. Where the treating team's medical staff are not immediately available, palliative care team members may prescribe the relevant medication themselves in order to improve symptom management and expedite patients access to medication. The prescribing practice of the individual prescribers are encouraged to audit, and reflect the results within the teams.

The Teams utilise the following to support evidence based practice in prescribing:

- Palliative Care Formulary 4 (PCF4) Fourth Edition. Twycross, R. Wilcock, A. Charlesworth, S. Dickman, A. Oxford: Radcliffe Medical Press
  (The trust have funded online access to this formulary for pharmacy and all members of the HPCT www.palliativedrugs.org)

- The Syringe Driver. Continuous subcutaneous infusions in Palliative Care. Second edition. Dickman, A. Schneider, J. and Varge, J. Oxford University Press 2005

All specialist palliative care services, record their contacts on the Trust wide IT system CPD ensuring continuity of care when patients transfer to different settings. SPCT's fully involve all referred patients in discussions about their care, treatment, prognosis, discharge and preferred place of death. Such conversations are documented. The YCPCT also offers patients written summaries of individual consultations.

Each HPCT discuss all patients on the caseload on a weekly basis at a multidisciplinary Meeting (MDT) attended by all core members of the HPCT. A member of the HPCT join the community teams for the community locality MDT each week.

As part of the Specialist Palliative Care (SPC) peer review measures, the HPCT has worked with providers across the locality to develop a 'Locality SPC Multidisciplinary Team Meeting' (SPC MDT). The locality SPC MDT meeting is to enable those patients and/or carers with particularly complex needs to be discussed by a broader team. The MDT consists of all consultants in palliative medicine (2), nurse specialists from community and hospital, representation from hospice inpatient services, and social work and rehabilitation services. The HPCT MDT also has chaplaincy service representation and in Scarborough only a research nurse with a specialty interest.

All 3 SPCT have planned to have a business meeting 3 times per year to plan the service strategy including relevant audits (Appendix 3). An annual report of the SPCT's work including the next year's strategy is planned for 2015 and will be disseminated to the Chief Operating Officer, Chief Nurse, Operational Services Manager and other key personnel.

End of Life Care: Last Year of Life

The Trust has acted on the Department of Health's National End of Life Strategy recommendations, undertaking a Last Year of Life education project which has been rolled out across the wards. The Trust has joined the national acute hospitals Transform programme and plans to use this approach set out in Routes to Success to form the basis of the Last Year of Life. The AMBER care bundle has been introduced on York site to 2 wards with a plan to embed on further wards in the next year. Further work needs to be done to firmly embed use of the tool and change in practice. The AMBER care bundle encourages staff to recognise those patients whose recovery may be uncertain and who may only have a few months left to live. It encourages open discussion of ceilings of care decisions, and of patients' wishes about their care and treatment. Over the past year AMBER has been on hold due to staff changes, however the teams are fully staffed and a plan to continue AMBER roll out on identified York wards. Currently Scarborough site has not commenced AMBER but the team has completed some preliminary discussions with the critical out reach team and aim to pilot in one ward area in 2015.

Funding is in the process of being secured for the end of life care facilitators on both York and Scarborough sites through Macmillan Cancer Support. The directorate has financially planned in future Trust funding following support from Macmillan.

Interpreters are available for patients or families who do not speak English and can be accessed through the Trust intranet. The Trust is also working to ensure equality of access to include support for the deaf, visual impaired and those patients with learning disabilities.

Patients with identified needs welfare needs can be referred to cancer information and support on both sites where benefits advice for patients in the known to the Trust can assess support.

There is a York Teaching Hospital NHS Foundation Trust DNACPR policy in place, developed and agreed by a multi-agency working group, which supports the use of the regional DNACPR form. The policy has recently been reviewed following the recent high court ruling Tracey vs Cambridge. Clinicians are expected to clearly document in the medical notes, the circumstances surrounding the decision together with who was involved in the decision making process. The policy includes a framework for making decisions around resuscitation and guidelines on having conversations with patients and families. Responsibility for making the DNA CPR decision lies with a senior doctor who has medical responsibility for that patient (Consultant, Specialty doctor or Specialist Registrar (SpR). Patient information leaflets are available and are accessible for patients on the York Trust palliative care web page. These are being reviewed regionally and once this is agreed the Trust will plan to adopt this. Whilst in Hospital, the DNACPR form remains in front of the case notes. The DNACPR decision should be reviewed prior to transfer or discharge; if it remains valid the original form should be transferred with the patient after appropriate discussion and communication should be made with community teams.

The Trust has undertaken a snapshot audit of all DNACPR documentation through the patient safety team and work will continue strive to improve document completion and clear effective communications with patient and families.

Palliative care symptom guidance leaflets produced by the Yorkshire Cancer Network are also available from the HPCT and on the palliative care section of the Trust intranet.

The recent significant negative media coverage around end of life care in hospitals has had a noticeable and significant impact on clinicians. In addition, the recent high court ruling around DNACPR has further exacerbated this. Clinicians have expressed anxieties around end of life conversations, withdrawal of treatment and DNACPR alongside increasing workload pressures generally. Plans are commencing in providing specific education for clinicians regarding this.

End of Life Care: Last Days of Life

The Trust has withdrawn the Liverpool Care Pathway (LCP) in line with national guidance. Regular guidance and updates have been disseminated to staff across the organisation.

All adult wards have been advised to follow the '5 priorities of care for the Dying Patient' which are available on every ward. Staff should ensure that all decisions, conversations and care are clearly recorded in the current relevant care plans & medical notes.
A Locality wide group has developed a care plan to support the individual approach to care in the last days of life; this will be in the form of:

- Individualised medical care plan for the last days/hours of life
- Individualised nursing care plan for the last days/ hours of life
- Care after death
- Symptom guidance

The care plan has been launched for a pilot period across all settings with the SPCT supported each individual patient during the initial six months. Feedback will be evaluated and amendments made to the documentation as required through a task and finish group.

New symptom management guidance has been agreed across the Trust which covers key symptoms in the last days of life. This guidance is available on all wards (laminated A4), intranet (palliative care webpage) and in the care plan. A small pocket card is being produced for the junior Dr's and will be available in the next few months.

Leaflets '*Information about the services and facilities for the relatives and friends of patients who are dying'* is available across the Trust in the care plan for the last days of life.

Within the Trust a Care after Death guidance contains standards and this guidance will be developed over the next few months and be launched across the Trust. Key clinical staff have contributed to the formation of these guidelines and it links into the national guidelines.

Due to the uncertainty and media intensity around end of life care, the Hospital and community Palliative Care Teams have maintained a high profile across the clinical areas. Referral to SPC is available on all ward sites.

Wherever possible, patients who are dying are offered side rooms but this is sometimes limited by the need for side rooms for infection control reasons. Following education programme a Scarborough house keeper has led on Comfort Boxes, which include basic items to try to make relatives more comfortable when staying with dying patients. This excellent project is planned to be rolled out across all sites, providing care for relatives of dying patients.

Also at Scarborough Hospital there are 2 flats available for relatives to stay at distressing times. Families can be offered a concessionary parking permit throughout the Trust.

Although wards do not have dedicated family rooms, staff try to use an office or other room to conduct sensitive conversations. This at times can prove to be very difficult to achieve,

due to the busy ward environments. Results from the National Care of the Dying Audit Hospitals confirm that some conversations are held with the patient (where capable of participating in discussions) or their relative or significant other, but this is an area we need to strive to improve.

The chaplaincy team is mainly Christian, and provides support to patients, families and staff. Results from the National Care of the Dying Audit Hospitals suggest that spiritual care is not always documented. The chaplaincy team is aware and contributes to the end of life care education programmed and aiming to improve this. The Trust chaplains are keen to work closely with the HPCT's. Recently the Scarborough Chaplin has relocated to York site, and the recruitment process is currently underway.

Equipment

Syringe pumps (McKinley T34) and locked boxes were introduced with a robust training system in 2013 and are stored in the equipment stores which ensure consistent availability of pumps across the Trust. Community and provision for care homes have a separate supply of pumps. All clinical areas have their own universal key for the locked boxes. Pumps can be accessed 24 hours a day by contacting equipment library.

There is a rolling education programme across the Trust for the syringe pumps. An education eLearning package has been adapted from the McKinley Company and is available for all areas. The face to face training includes medical device training and drug information for drivers. The task force groups deliver the same education for staff from acute, hospice, community and care homes. There is a new syringe driver chart which has just been agreed through medicine management. The purpose of the chart is for it to be cross site, therefore if a patient rapidly needs to be discharged home, the chart can follow the patient, ensuring medication is continued. This will need to be reviewed and measured in the next 6 months for its impact and any for any incidents reported.

Care after Death / Bereavement

The Trust has a Care after Death Guidance in place, with clear instruction to ensure patients receive appropriate care after death. Notification of Death forms are completed by medical staff in the bereavement office (Appendix 1) and have noted this is an area of care we as a Trust need to improve and an action plan will be drawn up to address this. All paperwork is issued by the bereavement office. Families are asked to contact the office to arrange a suitable time to collect the paperwork. The Registrar of Births Deaths and Marriages has regular appointments available in the Trust. The Care after Death guidance both include direction to ensure timely transfer from hospital in order to meet patients' cultural and religious needs, both in and out of hours. A system to inform GPs of patient deaths in a timely manner is in place. The Trust has written a funeral tender to provide provision for those patients who are unable to fund a funeral. The Trust also provides a funeral for those parents who suffer the loss of a still birth, pre 24weeks miscarriage and neonatal loss. This is currently going out to tender in York region and to be replicated in the other acute sites.

Facilities for families after death in York are excellent but in Scarborough require improvement. At Scarborough families are required to wait in the busy main hospital corridor when attending appointments to collect paperwork from the general office. Currently there is a business case to start to improve the care of the bereaved at Scarborough.

All relatives at York are given a ‘What to do during your Bereavement’ booklet, and in Scarborough the DWP information booklet is given but this is the extent of bereavement support offered. Through the business plan and development of bereavement services in Scarborough it is planned to adapt the bereavement booklet to be cross site. There are good relations with the local York CRUSE and Saint Catherine’s Hospice who provide all bereavement care in Scarborough area.
Facilities are available for families to view patients after death, and recent estates work on the Scarborough Mortuary has improved a difficult building.
To build on the collaborative work in providing specific memorial events for our families e.g. Mothering Sunday memorial, memory boxes for young children and for bereaved parents.

Discharge Planning (Rapid Discharge at End of Life)

York Teaching Hospital NHS Foundation Trust Discharge Team coordinates all Fast Track (FT) discharges on behalf of the continuing healthcare team. If the patient is already under the care of the HPCT and wishes to be discharged to their own home, the HPCT will liaise the discharge team. For all patients whose prognosis may be hours, the process will be as speedy as possible.

Alongside the Fast track process, a Rapid Discharge at End of Life Integrated Pathway for all rapid discharges has been recently developed to improve the documentation, co-ordination and sharing of information. This has not been disseminated across the Trust due to the many changes currently underway and the plan is to have robust approach to deliver this effectively
York site
April 2013 –Mar 2014 Data
Total number of patients referred to Fast Track =. 179
April 2014 – Dec 2014 Data
Total number of patients referred to Fast Track =.135
Scarborough currently does not collect this information. This will be commenced in 2015.

The teams (HPCT, Discharge Team) meet to ensure good communication, any issues are identified.

Work has been undertaken through the end of life forum/ locality group to improve rapid access to TTOs when a Fast Track patient is being discharged the same day. The pharmacist with a specialist interest is currently working on the ensuring key drugs are always available in the Trust pharmacy.

Gaps still exist in ensuring accurate data is collected in hospital and that timely reporting is provided to monitor standards against practice.

Integrated working

In order to drive forward improvements in end of life care across the Trust, the HPCT work closely with numerous clinical teams. This includes specific work with the renal team, respiratory and neurology team.

Regionally, the lead nurse for end of life care and consultants contribute to the Yorkshire and Humber Regional End of Life group, the Acute Hospitals End of Life network, the regional DNACPR group

The Trust is also a member of the national Transforming End of Life Care in Acute Hospitals programme.

Data, including Measuring Quality and Outcomes

The HPCT are fully conversant with the Trust's governance processes and report incidents in accordance with this. All patients receiving care from the specialist palliative care team are discussed at a weekly Clinical Review meeting. Any incidents are also discussed as part of this meeting or the business meeting. The HPCT use learning from incidents to inform the content of end of life education.

Action points from SUIs are discussed as part of the team's clinical governance meetings and changes implemented as appropriate.

The lead nurse is copied into all end of life complaints and actions are escalated through the senior team to board. Regular contacts occur with the PALS and patient experience team. The aim is to:

- Capture information on key themes and the proportion of complaints that relate to end of life care
- Understand how hospital Trusts are learning from complaints and concerns in end of life care including pathways of care in the last hours / days.
- Action plan and implement a change to practice

The HPCT collect and analyse activity data as part of their routine practice and report annually to the Trust and the National Council for Palliative Care (NCPC). Data on number of deaths by ward is also collected and the team undertakes a programme of audit activity. Limitations with data collection are currently occurring due to the significant demand to IT. Transfer of Information needs to improve as specific end of life communication is not always corresponded. The HPCT aim to have specific discharge information on advance care planning, DNACPR, preferred place of care conveyed the to GP and community services.

National Care of the Dying Audit- 4th Round 2014

York Teaching Hospital NHS Foundation Trust has participated in the National Care of the Dying Hospital Audits. The standards of care in this audit were based on national policy and the audit questions were informed by the 44 recommendations of the Independent Review of the LCP undertaken in 2013. The audit involved a case note review of a sample of all patients dying in hospital, regardless of whether or not their care was supported by the LCP in the last hours/days of life.

Key findings:

- At the time of the 2014 audit, York Teaching Hospital NHS Foundation Trust achieved 1/7 Organisational KPIs.

Since the 2014 audit the Trust has achieved:

- Appointment of a lay person to the Trust board with a specific responsibility for care of the dying, Dianne Willcocks as non-executive lead for End of Life
- York site only the 5 required units of information for Bereavement care
- Care plan for the last days of life commenced all areas 2014

- Education and training in care of the dying should be mandatory for all staff caring for dying patients.

Due to recent developments, the Key Performance Indicators (KPIs) still not achieved are:

- 7 day face to face working (currently under consultation)
- Bereavement support and bereavement feedback
- All clinical areas to have appropriate documentation in recording hydration and nutritional care

The clinical KPIs with the lowest score for achievement were assessment of hydration and nutritional requirements, and spiritual care of patients and relatives.

Nationally and locally discussions regarding spirituality were only recorded for a minority of patients and relatives.

Patients' care was supported by the LCP and reflected that the LCP had become embedded in practice in the Trust.

The following national recommendations have implications for the Trust:

- Hospitals should provide a face-to-face specialist palliative care service from at least 9am to 5pm, 7 days per week.
- All hospitals should undertake local audit of care of the dying, including the assessment of the views of bereaved relatives, at least annually.
- The decision that the patient is in the last hours or days of life should be made by the multidisciplinary team and documented by the senior doctor responsible for the patients' care. This should be discussed with the patient where possible and appropriate, and with family, carers or other advocates.
- Pain control and other symptoms in dying patients should be assessed 4- hourly.
- Decisions about the use of Clinically Assisted Nutrition (CAN) and Clinically Assisted Hydration (CAH) are complex and should be taken by a senior experienced clinician supported by a multidisciplinary team. This should be discussed with the patient where possible and appropriate, and with family, carers or other advocates.
- Hospitals should have an adequately staffed and accessible pastoral care team to ensure the spiritual needs of dying patients and those close to them are met.

Following the More Care, Less Pathway Report (2013), usage of the Liverpool Care Pathway for the Dying fell prior to being withdrawn in January 2013. To monitor standards of care in the last days of life across the Trust, the HPCT have undertaken a briefcase audit of medical and nursing notes on 20 case notes of patients who are identified to be in their last days of life. The briefcase for York and Scarborough are attached in Appendix 1.

A new audit is to capture the pilot of the new documentation for the last days of life and will be used as a baseline.

Bereaved Carers' Survey

A pilot of the Bereaved Carers' Survey is to be undertaken in 2015. All relatives / carers will be given a survey by the bereavement office during a specific period of time. Responses will be analysed and results disseminated as appropriate. It is expected that this will be an iterative survey.

Prescribing Practice

A pharmacy group is due to commence in February 2015 and part of that group will be to audit prescribing practices.

Education and Training

The Trust commenced mandate training in end of life care in 2014. The SPCT provide a large amount of education, both formally, but also informally as part of attendance at medical ward rounds and when reviewing patients. The HPCT includes a Care of the Dying Facilitators whose roles are to monitor and support staff with care at the end of life.

Key current education provided:

The HPCT work across the Trust to collaborate on joint education programmes for staff where possible, for example:

- Care Plan for Last days of Life training
- End of life care champions
- 1 day end of life care training for RN and HCA
- EoLC Communication skills training: the approach used has been adapted and implemented in partnership with the local hospices
- Preceptorship training for band 5 nurses
- Junior Dr training in palliative care – Deanery rotation
- Grand Round
- T 34 syringe driver training
- Induction training
- Medical students
- Symptom management
- Hospice education programme
- 'It's my ward' band 6 leader programme

Basic life support training includes discussion about the DNACPR policy and expectations and is mandatory for all staff with direct patient/ client contact, including those who manage patients with anaphylaxis (e.g. following immunisation) or to support staff managing patients requiring defibrillation (AED). The Trust has a video training tool which will be replaced with the regional DNACPR e-learning package is currently in development.
An aim is to introduce the e- ELCA modules for clinical staff to be able to have the e learning recorded through Trust records.
All training is aiming to be recorded through the training department although this needs further work to ensure the system is robust.
There is currently a gap in the AMBER training. This is due to staff changes and once the team are at full compliment this training will re start on York site. Scarborough is currently discussing working with the critical care team and to identify a clinical area. An audit of the numbers of deaths across the Trust, identifying the clinical areas which have a high death rate. This will inform and direct the ward to work with. Recent summaries of the education projects are recorded in Appendix 2.

Summary

Areas of good practice

- Senior level engagement, including Trust Board, in improving end of life care
- Specialist Palliative Care Consultants work across Hospital, Community and Hospice teams, contributing to integrated team working
- Responsive service provided by HPCT/YCPCT
- Independent prescribing of HPCT
- MDT for heart failure patients
- Provision of written summaries of consultations for patients in the community
- Locality SPC MDT meeting to discuss all patients with complex needs
- Development and implementation of the Care Plan for the Last days of Life
- Supporting leaflet for relatives of patients at the end of life
- Patient information provision including leaflets on Facilities, Pallcall, OOH phone service for Scarborough patients (with informed consent process for referral)
- Attendance by HPCT on wards with role modelling
- Development of rapid discharge pathway – action plan for implementation
- Provision of comfort bags to families staying with patients at the end of life
- The Trust is a member of the national Transforming End of Life Care in Acute Hospitals programme
- Mandatory end of life education across the Trust
- End of life education strategy and positive feedback of education delivery
- Collaborative working across the locality on key projects, including a Care Plan for Last days of Life, producing joint Standards in End of Life care, Symptom Management guidance, and a joint educational approach
- Trust wide DNACPR policy
- Development of guidance for Care of the Dying in the last days of life
- Contribution to End of Life Board with integrated working across the locality, also linking with commissioners
- Staff member is Chair of Sub regional end of life group
- Registrar of births, deaths and marriages has regular appointments at the hospital
- Specialist Palliative Care attendance at Calman cancer site-specific MDT meetings
- Funeral tender
- Nurse led bed project
- Good working relations between the hospices, social care, Macmillan and Marie Curie

Risk/Challenge

- Patient experience data
- No plans for introduction of EPaCCS across the locality. Accurate identification of community-identified GSF register patients when admitted to hospital needs to be implemented
- IT
- Further development of documentation to support care in the last days of life and launch of 5 priorities of end of life care bench marking across the region
- Although AMBER has been implemented in 2 wards it is not fully embedded in routine practice. Also needs to be rolled out to Scarborough wards.
- Facilities for families need to be improved at ward level
- Appropriate environment for sensitive conversations with families on the wards

- Documentation of provision of spiritual care
- Access to bereavement support for families
- Need for more sensitive environment for bereaved families when collecting paperwork on Scarborough site
- Accurate and timely reporting of number of staff who have completed any end of life education
- Not currently meeting national recommendation for provision of 7 day face to face service for HPCT
- Provision of benefits advice for patients with non-malignant disease and to increase number of non malignant care given
- Timely and accurate data reporting of fast-track discharges
- Need for syringe driver e-learning and e- ELCA package to be recorded on Trust records
- Reliable process for end of life complaints reporting
- Clearer feedback processes following incident reporting to ensure learning

Appendix 1

Audits

BriefCASE Clinical Audit of Service Effectiveness Brief Report

York Teaching Hospital NHS
NHS Foundation Trust

Audit to Monitor Care After Death Policy
Project No. 2791

Introduction Caring for people who are close to death demands compassion, kindness and a skilled application of knowledge. The priorities of the Trust are that patients receive excellent care in their last few days/hours of life, extending to after death.

Aim To support the monitoring of the care after death policy and to identify compliance with the policy, documenting evidence of the cause of death in the notes, appropriate filing of the notification of death form, next of kin details are recorded and completion of a DNA CPR form in its entirety.

Standards
Monitoring of cause of death documented in the notes, appropriate filing of the notification of death form, next of kin details recorded in the notes and the completion of the DNA CPR form in its entirety.

Method
The Bereavement Services Officers on the York site collated the above information from the deceased's casenotes on a daily basis and record this information on a spreadsheet. This information was gathered from September 2013 to September 2014.

Summary of Findings

Results
The results below are recorded from September 2013 until September 2014.

The findings have highlighted that there is no cross site compliance as this audit and policy has not been introduced on all sites.

- The average percentage of cause of death being recorded in the notes is 43%.
- The average percentage of notification of death in the notes is 68%.
- The average percentage of next of kin recorded in the notes is 97%.
- The average percentage of DNA CPR forms in the notes is 90%.
- The average percentage of incomplete DNA CPR forms is 30%. The information most commonly omitted from the form is next of kin details and contact telephone numbers.

Conclusion
- The policy needs reviewing to cover the whole Trust
- The percentage of the cause of death being recorded in the notes needs to be significantly improved. Since March 2014 a new form has been implemented for the doctors to fill out in place of writing in the notes which has led to an average percentage of 68% of causes of deaths being recorded in the notes.
- The percentage of notification of death forms in the notes is unlikely to increase much more as, although all of the elderly wards include the notification of death form in the notes, some of the medical wards keep the form on the ward for their own purposes.
- The percentage of next of kin details recorded in the notes is excellent and this standard needs to be maintained.

- With 90% of deceased patients having a DNA CPR in their notes, 30% of these are incomplete. The information that is most commonly omitted from the form is next of kin details and contact telephone numbers. Reasons for the forms being incomplete will need to be monitored.

Should be SMART: *Specific* *Measurable* *Assignable* *Realistic* *Time related*		
Actions Planned	**Responsibility**	**Timescale**
1a) To review care after death policy to become priorities across all sites.	Kath Sartain, End of Life Lead Nurse	March 2015
1b) Clear communication of the introduction of new guidelines to all staff	Kath Sartain, End of Life Lead Nurse	March-September 2015
To collate data cross site between September and December and review.	Bereavement Officers	September-December 2015
a) To monitor reasons for incomplete DNACPR. b) Results to be fed in to the DNACPR Trust meeting.	Bereavement Officers Kath Sartain, End of Life Lead Nurse	Continuous

<York Hospital, Specialist Medicine, Bereavement Services>
Person Completing Project: <Leanne Covey>
<December 2014 **Supervisor: Kath Sartain**

BriefCASE Clinical Audit of Service Effectiveness Brief Report

York Teaching Hospital NHS
NHS Foundation Trust

Care of the Dying Audit - Project No. 2728

Aim

The aim of this audit is to establish current practice before the implementation of the last days of life care plan in September 2014.

Standards

National Care of the Dying Audit Tool

Method

A Casenote review of 20 casenotes was under taken for patients that had died in January 2014.

Summary of Findings

Results – Key Findings (For complete list of findings see Appendix A)

75% had documented evidence of discussions within the last episodes regarding prognosis. 38% discussions took place with consultants. 65% had documented evidence to discontinue recording of vital signs. 70% had documented evidence that review took place daily following recognition that they were dying. 85% were reviewed by a senior doctor every three days. 90% had documented evidence of nursing assessment per shift. 75% had documented evidence of cause of deaths in the medical notes.

Documentation

45% no religion was documented. 95% patients' wishes and preferences were not documented. 95% discussions who to involve in decisions were not documented. 80% preference of place of death not documented. 80% discussions re. patients' last hours/days of life not documented, of this 53% had no documented reason for lack of discussion. 95% no documented discussions with patients re. spiritual needs, of this 65% had no documented reason for lack of discussion. 90% no discussions with patients' relatives re. spiritual needs. 55% incorrect DNACPR Forms in place. 95% no documented evidence of ability to take oral nutrition. 95% no documented evidence re. need for CAN. 90% no documented evidence re. ability to take oral hydration. 60% no evidence that patients received mouth care in the last 24 hours. 80% no documented evidence that care of the body took place. 95% no documented evidence that GP was informed of the patients' death.

Prescribing

Six (out of 20) were not prescribed for any of the five key drugs.

Decision making

30% had no decision made to stop routine recording of vital signs in the last 24 hours. 80% had no decision made to stop blood tests in the last 24 hours.

Please note that 85% of the patients' primary diagnosis was non-cancer. 65% of deaths occurred between 5pm and 9pm or on a weekend. 80% of deaths took place on medical wards.

Conclusion

The results demonstrate that we have gaps in the documentation and communication of patients' last days of life. It is hoped that improvement will be made with the implementation of the Last Days of Life Care Plan.

Actions Planned	Responsibility	Timescale
To implement the Last Days of Life Care Plan.	Palliative Care Team/ Karen Cowley	September 2014
Re-audit	End of Life Lead Nurse	September 2015

York, Specialist Medicine – Palliative Care
June 2014

Person Completing the Project: Debbie Bayes
Supervisor: Layla Al-Ani

Total patients		20	
Question	**Response**	**No.**	**%**
Did death occour between 5pm-9pm or at a weekend	Yes	13	65%
Source of admission	Home	16	80%
Primary Diagnosis at death - CANCER	Non Cancer	17	85%
Dementia	Yes	7	35%
COPD	Yes	9	45%
Religious Affiliation	Not documented	9	45%
Patient's wishes and preferences documented	No	19	95%
Patient's ADRT documented	No	19	95%
Patient's DNACPR documented	Yes	17	85%
Patient's Lasting Power of Attorney documented	No	20	
Discussion with patient re who to involve in decisions documented	No	19	95%
Documented preferred place of death in last episode of care	No	16	80%
Documented preferred place of death	Hospital	2	
	N/A	16	
	Own home	2	
If not hospital reason for not prefered place of care	Pt too ill to transfer	3	
	Unkown	17	
Dept death took place	Medical	16	80%
Documented evidence within the last episode regarding prognosis	Yes	15	75%
Documented evidence of discussion regarding prognosis	Consultant	6	30%
	Patient	2	10%
Subsequent Documented discussion with patient / family	Yes	12	60%
Documented discussion with patient re last hours /days of life	No	16	80%
If no, why	Pt lacked mental capacity	2	
	Pt was unconcious	5	
	No documented reason for lack of discussion	8	
Documented discussion with relative/carer re last hours /days of life	Yes	15	75%
Documented discussion with patient re spritual needs	No	19	95%
If no, why	No documented reason for lack of discussion	13	65%
Documented discussion with relative/carer re spiritual needs	No	18	90%
Documented evidence of being seen by spiritual adviser	No	17	85%
Documented evidene of DNACPR being completed on admission	Yes	17	85%
Which grade Dr made that decision	Consultant	10	50%
If ST3 or less was form countersigned	No	1	
Form completed correctly	No	11	55%
Prescribed for pain	No	9	45%
Prescribed for agitation	No	6	30%
Prescribed for nausea	No	11	55%
Prescribed for noisy breathing	No	11	55%
Prescribed for dyspnoea	No	8	40%
6 patients were not prescribed for any of the 5 key drugs		6	30%
Documented that a continuous subcutaneous infusion (CSCI) was being administered	Yes	4	20%
Routine recording of vital signs last 24 hrs	Discontinue	13	65%
	No decision	6	30%
Blood tests last 24 hrs	Discontinue	3	15%
	No decision	16	80%
Blood sugar monitoring last 24 hrs	No documented decision	5	25%
Oxygen last 24 hrs	Continued	9	45%
	No documented decision	7	35%
Antibiotics last 24 hrs	Discontinued	7	35%
	No documented decision	4	20%
Documented evidence re ability to take oral nutrition	No	19	95%
Documented evidence re need for CAN	No	19	95%
At the time of death was CAN in place	No	19	95%
Documented evidence re ability to take oral hydration	No	18	90%
Documented evidence re the need for CAH	No	16	80%
Documented evidence received oral fluids last 24 hrs	No	16	80%
Documented evidence received mouth care last 24 hrs	No	12	60%
At the time of death was CAH in place	No	17	85%
Was patient review daily following recognition they were dying	Daily including weekends	14	70%
Documented review by senior Dr at least every 3 days	Yes	17	85%
Documented nursing assessments at least per nursing shift	Yes	18	90%
Documented evidence that care of the body took place	No	16	80%
Documented evidence that requested specific rituals were performed	No	19	95%
Documented evidence that the relative/carer were given written information	No	11	55%
Documented evidence that GP was informed	No	19	95%
Was cause of death included in medical notes	Yes	15	75%

Care of the Dying Audit – Project No 2773

BriefCASE Clinical Audit of Service Effectiveness Brief Report

York Teaching Hospital NHS
NHS Foundation Trust

Care of the Dying Audit - Project No. 2773

Aim
The aim of this audit is to establish current practice before the implementation of the last days of life care plan in October 2014.

Standards
National Care of the Dying Audit Tool

Method
A Casenote review of 20 casenotes was under taken for patients that had died between January and March 2014.

Summary of Findings

Results – Key Findings (For complete list of findings see overleaf)
85% had documented evidence of discussions within the last episodes regarding prognosis. 75% had their religion documented. 85% had documented discussion with relative or carer re last hours/ days of life. 65% of patients were reviewed by a Doctor daily following recognition they were dying. 95% had documented evidence of nursing assessment per shift.

Documentation
100% patients' wishes and preferences were not documented. 75% discussions of who to involve in decisions were not documented. 17 (out of 20) had preferred place of death not documented. 80% discussions re patients' last hours/days of life not documented. 100% no documented discussion with patient re. Spiritual needs, of this 55% had no documented reason for lack of discussion. 95% had no discussions with patient's relatives re. Spiritual needs. 70% incorrect DNARCPR forms in place. 60% no documented evidence of ability to take oral nutrition. 75% no documented evidence re. need for CAN (Clinically Artificial Nutrition). 50% no documented evidence re. ability to take oral hydration. 90% no evidence that patients received oral fluids in last 24 hours. 60% no evidence that patients received mouth care in the last 24 hours. 75% no documented evidence that care of the body took place. 65% no documented evidence that GP was informed of the patient's death.

Prescribing
Four (out of 20) were not prescribed for any of the five key drugs.

Decision making
60% had routine recording of vital signs in the last 24 hours continued. 60% had blood tests continued in the last 24 hours. 70% had oxygen continued in last 24 hours and 45% had antibiotics continued in the last 24 hours.

Please note that 85% of patient's primary diagnosis was non-cancer. 65% of deaths occurred between 5pm and 9pm or on a weekend. 75% of deaths took place on a medical ward.

Conclusion
The results demonstrate that we have gaps in the documentation and communication of patients last days of life. It is hoped that improvement will be made with the implementation of the Last Days of Life Care Plan.

To implement the Last Days of Life Care Plan.	Palliative Care Team	October 2014
Re-Audit	Palliative Care Team	First 20 Care Plans Used

Scarborough, Specialist Medicine – Palliative Care

October 2014

Person Completing the Project:
Debbie Bayes and Christine Wilson
Supervisor:Kath Sartain

Question	Response	No.	%	Total Patients
Did death occur between 5pm-9pm or at a weekend	Yes	13	65%	20
Source of admission	Home	15	75%	20
Primary Diagnosis at death - CANCER	Cancer	3	15%	20
Primary Diagnosis at death - NON CANCER	Non Cancer	17	85%	21
Religious Affiliation	Documented	15	75%	20
Patient's wishes and preferences documented	No	20	100%	20
Patient's ADRT documented	No	20	100%	20
Patient's DNACPR documented	Yes	18	90%	20
Patient's Lasting Power of Attorney documented	No	20	100%	20
Discussion with patient re who to involve in decisions documented	No	15	75%	20
Documented preferred place of death in last episode of care	No	17	85%	20
Documented preferred place of death (3 patients)	Hospice	2	67%	3
	Own home	1	33%	3
If not hospital reason for not preferred place of care	Pt died before being able to transfer	3	100%	3
Dept death took place	Medical	15	75%	20
Documented evidence within the last episode regarding prognosis	Yes	17	85%	20
Documented discussion with patient re last hours /days of life	Yes	4	20%	20
	No	16	80%	20
If no, why	Pt lacked mental capacity	9	56%	16
	Pt was unconscious	2	13%	16
	No documented reason for lack of discussion	5	31%	16
Documented discussion with relative/carer re last hours /days of life	Yes	17	85%	20
Documented discussion with patient re spiritual needs	No	20	100%	20
If no, why	Pt lacked mental capacity	8	40%	20
	Pt was unconscious	1	5%	20
	No documented reason for lack of discussion	11	55%	20
Documented discussion with relative/carer re spiritual needs	No	19	95%	20
Documented evidence of being seen by spiritual adviser	No	20	100%	20
Documented evidence of DNACPR being completed on admission	Yes	17	85%	20
Which grade Dr made that decision	Consultant	9	53%	17
If ST3 or less was form countersigned	No	1	50%	2
	Yes	1	50%	2
Form completed correctly	No	14	70%	20
Prescribed for pain	No	14	70%	20
Prescribed for agitation	No	14	70%	20
Prescribed for nausea	No	13	65%	20
Prescribed for noisy breathing	No	11	55%	20
Prescribed for dyspnoea	No	7	35%	20
4 patients were not prescribed for any of the 5 key drugs		**4**	**20%**	**20**
Documented that a continuous subcutaneous infusion (CSCI) was being administered	No	17	85%	20
Routine recording of vital signs last 24 hrs	Continued	12	60%	20
Blood tests last 24 hrs	Continued	13	65%	20
Blood sugar monitoring last 24 hrs	Continued	3	15%	20
	Never in POC	16	80%	20
Oxygen last 24 hrs	Continued	14	70%	20
Antibiotics last 24 hrs	Continued	9	45%	20
Documented evidence re ability to take oral nutrition	No	12	60%	20
Documented evidence re need for CAN	No	15	75%	20
At the time of death was CAN in place	No	19	95%	20
Documented evidence re ability to take oral hydration	No	10	50%	20
Documented evidence re the need for CAH	No	10	50%	20
Documented evidence received oral fluids last 24 hrs	No	18	90%	20
Documented evidence received mouth care last 24 hrs	No	12	60%	20
At the time of death was CAH in place	No	10	50%	20
Was patient review daily following recognition they were dying	Daily including weekends	13	65%	20
Documented nursing assessments at least per nursing shift	Yes	19	95%	20
Documented evidence that care of the body took place	No	15	75%	20
Documented evidence that requested specific rituals were performed	No	20	100%	20
Documented evidence that the relative/carer were given written information	No	11	55%	20
Documented evidence that GP was informed	Yes	13	65%	20
Was cause of death included in medical notes	Yes	10	50%	20

National Care of the Dying Audit 2014

This audit, which occurs every two years led by the Royal College of Physicians and Marie Curie Cancer Care, reports on organisational and clinical KPI's. The organisational KPI's, our results, action plans and current position are set out below. Each hospital site has participates individually so that site specific issues can be identified more clearly.

Description	National % of Trusts that achieved KPI	Achieved Yes/No Scarborough	Achieved Yes/No York	Action Plan	Current Position
Access to information relating to death and dying	41%	No	No	Relates to the provision of 5 specific leaflets. All 5 available in trust but only 4 routinely given out as 1 (The Bereavement Booklet) is given out by registrar rather than ward. To discuss with registrar about ward provision of leaflet need to task each team to discuss this	The DWP Bereavement Booklet referenced in the NCDAH is now displayed in the York Bereavement Suite using the CQC driven service headings of "Safe, Caring, Effective, Responsive, and Well Lead" have identified key areas to address. Action plans are being developed. The palliative care teams and end of life care facilitators will be actively involved in the dissemination of this information to all clinical staff caring for patients at the end of life using ward visits and formal/informal education programmes – York compliant from Nov 2014Scarborough site remains non compliant as no formal bereavement service available. This is currently under review
Access to specialist support for care in the last days of life	21%	No	No	National recommendations are that patients should have access to Specialist Palliative Care face to face assessments 7 days a week 9-5 and 24/7 telephone support advice. End of life nurse exploring option analysis to support 7 day working	Currently in a review process with HR to address 7 day working across both acute sites and Selby and York community. Trust employees are aware of the period of change and their concerns are being listened to. In Scarborough, Whitby and Ryedale

Description	National % of Trusts that achieved KPI	Achieved Yes/No Scarborough	Achieved Yes/No York	Action Plan	Current Position
					community, the service provider is St Catherine's Hospice.
Care of the dying: continuing education, training and audit	40%	No	Yes	End of life care facilitators now in post (MPET funded) with formalised education programme. End of life care now part of mandatory training for nursing staff Areas to be addressed • Medical staff training • Communications skills for all staff Substantive funding for EofL facilitators MPET funds end 2015	We now have End of Life Care Educators in post in the community and both acute sites. Monthly full day education sessions on End of Life Care. Specialist Palliative Care Team provides the mandatory training for End of Life Care for all disciplines. Kath Sartain and Anne Garry are reviewing the medical staffing training along with the Yorkshire and Humber regional group for End of Life Care Karen Cowley and Kath Sartain are addressing continued funding with MPET to ensure education facilitators remain permanent posts.
Trust Board representation and planning for care of the dying	28%	No	No	Now achieved. Prof Dianne WIllcocks is NED lead on Trust Board attending End of Life Care Leads meetings. Quarterly and annual reports from these meetings submitted to Q+S committee and to Trust Board by the Medical Director	York and Scarborough sites now compliant July 2014
Clinical Protocols for the prescription of medications at the end of life	98%	Yes	Yes	Protocols continue to be available on ward or as part of individual Last Days of Life care plan	Ongoing education programme to support the safe and effective use of medication by clinical staff
Clinical provision/protocols	34%	No	No	Failed because of absence of pathway or care plan to allow for clear	The Trust have agreed to launch the Care Plan for the Last Days of Life on

Description	National % of Trusts that achieved KPI	Achieved Yes/No Scarborough	Achieved Yes/No York	Action Plan	Current Position
promoting privacy, dignity and respect up to and including after death of patient				documentation of a MDT decision making process for diagnosing dying – this will be in place from Sept 2014. All other components fulfilled	the 10 November across both acute sites, community, in Selby and York, and from 1 December in Scarborough, Whitby and Ryedale community. Focused education drive provided. York and Scarborough hospital sites compliant Nov 2014 York and Selby Community compliant Dec 2014
Formal feedback processes regarding bereaved relatives views of care delivery	34%	No	No	This will be incorporated as "real time" feedback from relatives by using "Family's Voice" project along with care plan. *To decide whether this is adequate as won't capture views of carers if patients were not on care plan – need to consider doing bereavement follow up- 1 month a year*	'Family's Voice' research project will capture relatives and carers thoughts from Nov 2014.

Appendix 2

Education Summary – York Hospital

At York hospital there is one palliative care educator supported by the specialist palliative care team, consisting of four clinical nurse specialists and the palliative care consultant. Overall support and guidance is provided by the end of life lead nurse.

As part of the end of life education programme at York hospital we provide a monthly education day which covers end of life tools (ACP, ADRT, AMBER, CPLDL), discussions around a good death, and the five priorities of care, Spirituality, DNACPR, symptom management and communication. We offer thirty five places to both registered nurses and HCA's and the sessions are always fully booked.

There are monthly end of life statutory and mandatory education sessions for trained nurses/ HCA's and allied health professionals. During this forty five minute session we cover End of life tools, five priorities of care, key medication at the end of life and a scenario discussion on patient care at the end of life.

Alongside planned training sessions we also offer bespoke training in response to the needs of the staff. This is usually provided on the ward and tends to be regarding the use of syringe drivers, the use of the care plan for the last days of life and symptom management guidance.

We currently developing the end of life ward champion role throughout York hospital and by the 21st May all allocated champions will have attended the education day. From that we aim to develop their role to provide a link between the wards and the specialist palliative care team. They will act as a knowledge resource for their colleagues and assist with the provision of a productive ward. Regular ward champion meetings will ensure their knowledge and skills are continuingly updated and training needs met.

Future plans include the development of communication sessions with pre-recorded scenarios to explore.

Training undertaken for the End of Life Care Initiative as at 15 January 2015 at Scarborough

WARDS	REGISTERED NURSES	COURSE COMPLETED	HCAs	COURSE COMPLETED
Stroke	22	7	9	5
Cherry	28	9	21	12
Beech	20	8	12	7
Oak	21	7	19	6
Holly	14	2	13	1
Haldane	14	8	9	4
Chestnut	18	8	14	5
Ann Wright	17	15	13	11
Maple	28	7	12	5
CCU	24	14	4	3
Graham				
Johnson	16	3	15	3
Waters	14	7	12	6
Totals	236	95	153	68
%		40.26%		44.44%

Appendix 3

New Planned Audits

1. Amber

2. Educational audit

3. Referrals and response rate

4. Non medical prescribing

5. Work planning at February business meeting

Effectiveness Project/Clinical Audit Registration Form *(Please complete sections 1-16)*	**No.**

1. Site	☒ York ☐ Scarborough ☐ Bridlington ☐ Whitby ☐ Malton
2. Project Type (cross all that apply)	☐ National Audit ☐ Clinical Audit ☒ Re-Audit ☐ Local Service Evaluation ☐ Patient Survey ☐ Staff Survey ☐ QIP ☐ Focus Group
3. Project Title	AMBER care bundle to be introduced to ward 33/34
4. Aim	To have the principles of AMBER embedded on both wards effectively

5. Criterion / Standards you are auditing against

Standard of Care	Target %	Exceptions
To measure an improvement of identifying and delivering care in the last year of life by using the nayional amber audit tool		maternity outpatients paeds

Source (please cross and specify) ***** **Please attach a copy** *****

☐ NICE ☐ National Service Framework ☐ Royal College ☐ Local Policy ☐ Other ☐ Not Applicable

Please specify and send a copy of source:

6. Project Details – Why are you investigating this area of care? (please cross all that apply)

☐ Specialist Programme (e.g. SPI)	☐ Patient and Public Involvement	☐ High cost/volume
☐ Potential for change	☐ Patient Complaints	☐ Common problem
☒ Confirm care is meeting standards	☐ Significant event/risk issue	☐ Wide variation in practice
☐ Develop potential research topic	☐ Other (please specify):	

7. Priority	☐ National ☒ Trust ☐ Directorate ☐ Commissioner ☐ Other (specify):
8. Data Collection	☐ Prospective ☐ Retrospective **Sample Size:** ***** **Please send a copy of your data collection form/survey with form** *****
9. Methodology	Retrospective case note review

10. Person Completing Project

First Name: Julie	Surname: Dale	Email: Julie'dale@york.nhs.uk
Designation: Specialist Nurse		Extn/Bleep: 5835
Directorate: Specialist Medicine	Speciality Please State: palliative care	

11. Project Supervisor	First Name: Kath	Surname: Sartain

12. Involvement (please cross all that apply)

☐ Multi-disciplinary Team ☒ More than one directorate ☐ More than one organisation

☐ Other (please specify):

13. Audit Start Date	February 2015	**14. Audit Report (BriefCASE) expected Completion Date**	Feb 2016

15.	**Intend to report findings ***	☒ Internally (please specify where): Externally: ☐ Meeting ☐ Conference ☐ Journal Publication ☐ Other **Please specify:**
16. Method of feedback to patients		
17. Support required?		☒ Casenotes ☐ Advice ☒ Facilitation ☐ No Input

* **It will not be possible to share findings externally without approval. This will not be granted retrospectively.**

Please save and email to: Effectiveness Team (YORK)

If you have any queries please contact the Effectiveness Team:

York – extn 5168, 5104 or 5101

Scarborough – extn 2302

York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee –17 February 2015 – Neurosciences Room

Attendance: Mike Keaney Chairman
Jennie Adams, Andrew Bertram, Steve Kitching, Juliet Walters, Lucy Turner, Sue Rushbrook, Mandy McGale

Apologies: Anna Pridmore, Mike Sweet

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last Meeting Notes Minutes Dated 20 January 2015**	The agenda covered the following AFW and CRR items AFW EF1 DoF1,2, 4,7 CRR CE1 DoF 1-4	Agenda Item 2 – 3rd paragraph second line should read amalgamation of AMU and Short Stay Ward (not ED) Agenda Item 3 – 5th paragraph should read 'particularly as elective cancellations [not delivery] were high 3rd Para should read 'for the first time York broke the local KPI threshold fpr the number of transfers after 10pm and there has been in an increase in C-diff cases". The reminder of the notes were approved as a true record of the meeting		
2	**Matters arising**		There were no matters arising		
3	**Short Term Acute Strategy**		MMcG gave an overview of Operation Fresh Start, which has been in place for six weeks on the Scarborough site. She reported that she is pleased with progress and that patient flow has improved.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			There have been improvements in both Ambulance Turnaround times and compliance with the 4 hr target, despite confirmed norovirus on both the Scarborough and Bridlington sites. Willow Ward was de-escalated on Fri 13th Feb and routine electives have not been cancelled for the w/c 16th Feb. Lilac Ward will open on the 16th March. Partnership working is continuing to work well; particularly with transfers to Hull RI for cardiac procedures and a more integrated working relationship between social workers and discharge liaison. Both of these initiatives have reduced delays for patients. The Scarborough site Patient Flow Manager started in post on 16th February and is currently on a two week induction. JW noted that everyone was working extremely hard but it was now critical that there is a detail plan for emergency care across the whole organisation. This should include trajectories back to delivery of the 4 hr standard. She noted this will be part of the overall Trust's 'Performance Recovery Plan' which she will be working on with LT. This plan will come to the next F&P meeting for scrutiny and will detail all key enablers and the tangible performance benefits associated with them. SR noted that attendances have decreased at the Scarborough site and this is a risk in terms of the level of breaches that can be sustained. Any effect on attendances caused by Northern Doctors will also		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			be critical. JW stated that we need to be able to respond to changing and challenging circumstances whilst still delivering key targets that are currently a significant patient safety and quality issue.		
4.	**Finance Report**		AB introduced and gave an overview of the format of the new style Finance report, which now features as part of the Performance booklet. The report is still the subject of refinement and future development, and he invited comments 'offline' on the content and format by Committee members. He advised that the I&E position had further deteriorated from £1.2m deficit in December to £2.8m deficit in January, against a planned position of £3.4m surplus. This position resulted in a CoSRR score of 3; behind the planned position of 4. He informed the committee that a significant contribution to the in-month movement was due to the estimated income for December moving adversely by £1m. This risk was raised last month with the Board, and relates to the risk of assessing uncoded activity using prior month's case mix. In the event the actual activity coded was different to that reported in previous months, particularly in relation to the elective and non-elective split. With regard to the underlying in-month movement he referred to the impact of premium costs from the continued requirement to use of agency and locum staff to fill key nursing and medical posts, and the high levels of non-elective activity effectively displacing elective capacity. He also reminded the committee of the discussions that had been held with commissioners regarding the non-elective marginal	The committee were concerned about the report and the further deterioration in the month end position. The committee noted the work that had been undertaken and were assured by the comments made, but recognise the challenge to the year end position.	AB to update the Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			rate CCG saving for Q1 only, and that this has been reflected in the income assumptions. MK enquired what actions were being taken with Directorates to address this situation. AB confirmed that Directorates had been urged to undertake elective activity wherever non-elective demand permits. NHS England had also confirmed nationally that elective activity above contract would be paid at 115% tariff in the final quarter as an added incentive. Directorates had also been urged to stop or defer all discretionary spend where it is safe to do so until the next financial year, and an extra push on year end CIP delivery was being encouraged. AB reminded the committee that further discussions are continuing with commissioners regarding the reinvestment of ED fines, the receipt of slippage on resilience funding to acknowledge the additional cost of escalation areas and other investment incurred by the Trust in managing winter pressures, and the reinvestment of non-elective marginal rate/ 30 day readmissions funding withheld from Q2 onwards. At this stage the reported position makes no further assumptions regarding the receipt of this income. JA asked whether the Trust could use its strategic capital to support the revenue position if it continued to deteriorate. AB responded by saying that it was not clear, although it is belief that it is protected and would need DH authority. He confirmed that he had no intention of using this capital resource to support the revenue position. JA noted the vacancy factor that applied to staff		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			expenditure, and from a safety perspective asked whether the delivery of this adversely impacted on safe nursing levels. AB confirmed that previous analysis on this subject had demonstrated that the vacancy factor was primarily delivered by staff groups other than nursing.		
5	**Efficiency Report**		SK updated the Board on the current position. 8 Overall delivery is £20.6m in January 2015, which is 86% of the £24m target. This has improved from the December 2014 position by £2.2m. This position is marginally behind the January 2014 delivered position of £21m (90%) of target. The in year planning gap is (£0.7m) in January 2015, however if high and medium risk plans are removed this gap increases considerably to (£2.8m), it should be noted high & medium risk plans are removed from governance calculations for Q4. Although the planning gap remains high, SK was cautiously optimistic that the full year CIP target can be achieved, although a significant proportion is likely to be non recurrent. Recurrent delivery remains a key risk with £7.6m (37%) of the £20.6m being delivered recurrently. A high level review of non recurrent delivery has been carried out and of the £13m delivered to date, £5m is assessed as true non recurrent, which leaves £8m to be reviewed for potential to be converted to recurrent. Recent history has shown 20-30% of these non recurrent schemes have been converted to recurrent;		AB to update the Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			however pressure has been applied throughout the year to make schemes recurrent, so this percentage is offered with a note of caution. **SLR Update report** – Due to time constraints it was agreed this report would be presented to the March 2015 Finance & Performance Committee. **The Efficiency Programme – Context & future plans -** SK presented a paper on the future efficiency and affordability challenge. Monitor has indicated that the affordability challenge, for the NHS, is set to peak in 2015/16 at 6.6% of current commissioning budgets, from 3.1% in 2014/15. It was noted a number of reputable organisations, including the Office for Budget Responsibility, recognise that the long run efficiency and productivity improvements in the NHS range from 0.4% to 1.4%. In this context York Trust has performed extremely well with recurrent delivery averaging 2.85% per annum over the last four years. Further context to the above achievement is that York Trusts recently published Reference Cost index rates the Trust at 97 which is 3% below the national average of 100; this also includes in the region of £10m of transition costs which would indicate our underlying position is nearer to 95%, i.e. 5% below average costs. It was however recognised that the significant challenge remains and future plans include, further development of the Efficiency Matrix; a closer working relationship with the Service Improvement team to exploit opportunities; new approaches to		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			delivery by providing specific support embedded within the directorate team. External support continues to be explored including a discussion with Monitor about their new **Provider Sustainability Directorate** - Monitor is planning to take a new approach to supporting providers. Having spent significant sums on external consultancy bodies and committed Trusts to a similar level of expenditure, Monitor has recognised this is not a sustainable position both for them and provider Trusts. Therefore they are going to develop an in house team and engage with Trusts directly. The Director of Finance has recently visited Monitor to discuss what opportunities might exist for York in this model. The senior Finance Team have also visited Nestle in the last two weeks to have a look at the Nestle continuous improvement and excellence program. This program was extremely impressive and gave the team food for thought; a significant amount of this work is transferable to us and has been extremely successful in Nestle.		
6	**Operational Report**		LT noted that the Trust continued to fail the 18 week admitted target in line with local CCG agreement. A letter has been received from Monitor which provides air cover for Q4 as all 18 wk fines are to be waived and the Trust will receive 115% tariff for any additional activity over contract plan. Work is ongoing with Directorates to maximise this opportunity and recover lost income. LT and SNS are working with Directorates to		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			populate a Capacity and Demand model for 18 weeks at speciality level. Once this is complete and after check and challenge meetings, this model will form the basis for trajectory setting, at speciality level, for 18 wk delivery. LT commented that 234 elective patients had been cancelled in January and this was contributing to the significant increase in the 18 wk admitted backlog. SR notes that NHS England had offered the Trust a team of 6 Validators to look at our incomplete backlog. Whilst in Hull this team identified 9,000 potential clock stops, they identified only 39 patients from our Trust. Although this is excellent from a Data Quality perspective, it was disappointing from a performance delivery point of view. LT reported that 3 cancer standards remain an issue; 14 Day Fast Tracks, 14 Day Breast Symptomatic and 62 Day Cancer. The team was disappointed that a high level of patient choice breaches in November had led to Q3 failure of the Breast Symptomatic target. LT noted that 62 Day delivery was not assured for Q4 due to internal elective cancellations and also significant issues at tertiary centres in terms of elective cancellations. It is also likely that the Trust will not deliver the required standard for 14 day Fast Track cancers for Q4. However, the significant improvement in compliance for skin in this target should be noted [from 23.81% delivery in Dec to 82.42% in February). JW noted that she would expect the same level of detailed pathway work to happen for the Cancer Performance Recovery Plan.	The Committee were assured by the report given by JW. They were assured by the comments she had made about the	JW to update the Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			The Committee noted York site ED performance and JW commented that this was a significant patient safety issue. LT stated that the Trust will not deliver the 4 hr target in Q4. JW commented that there was further work to do to ensure senior medics were present in ED when they were most required and a requirement to introduce Daily Ward rounds. These actions will be built into the Performance Recovery Plan. LT highlighted two CQUIN indicators that are currently RAG rated red. ESD for Stoke on the York site has not delivered the required % of CoY patients discharged into the service. However, LT noted that after a meeting with the CCG yesterday, if further evidence can be supplied from the Trust assuring the CCG that all eligible patients are discharged into the service, the CQUIN Reconciliation Group will recommend full payment of this indication for Q3. The deterioration in performance for 12 hr senior review on the Scarborough site was again noted by the committee. LT stated that this was due to workforce issues. JA and JW commented that we needed to look at another way of delivering this standard and exploring alternatives to consultant grades, SR noted that she and other Executive Directors had undertaken a teleconference with Monitor to discuss Q3 performance and highlight issues of potential non compliance for Q4. There has been no further comeback from Monitor at this stage,	development of the Recovery Plan.	AB to update the Board on the Monitor teleconference

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			MK summed up and highlighted that taken on the information alone, the position is very challenging, but following the comments made by JW the Committee felt very assured by the work being undertaken to address the issues. He took some assurance from JW that more detailed Recovery Plans, with realistic trajectories, were being worked up and would be available for the next meeting.	The Committee were assured by the production of a more detailed Recovery Plan	
7	**Next meeting**		The next meeting is arranged for 17th March 2015		

F1

York Teaching Hospital NHS
NHS Foundation Trust

Monthly Performance Report

January 2015

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Nov	Dec	Jan
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail:** £400 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**90%**	90.9%	81.6%	82.0%	76.4%	83.8%	79.4%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail**: £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TCB	**95%**	96.8%	95.9%	95.5%	95.7%	96.0%	95.7%
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	**Specialty fail:** £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**92%**	93.3%	93.4%	93.0%	93.1%	93.0%	92.2%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	1	0	0	0	0	0

Access Targets: Cancer

NB: Cancer Figures Run One Month Behind Due to National Reporting Timescales

Indicator	Consequence of Breach	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Oct	Nov	Dec
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	86.1%	85.9%	85.4%	87.0%	85.0%	84.3%
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	45.6%	78.6%	90.5%	93.8%	84.7%	93.4%
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	98.6%	97.9%	98.4%	98.1%	99.5%	98.2%
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	96.4%	94.9%	95.3%	90.6%	96.9%	95.3%
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	100.0%	99.1%	100.0%	100.0%	100.0%	100.0%
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	87.8%	87.6%	85.0%	84.6%	85.4%	84.96%
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	96.6%	93.8%	92.5%	93.8%	91.4%	92.9%
62 Day Consultant Upgrade	General Condition 9	**85%**	50.0%	-	-	-	-	-

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Nov	Dec	Jan
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£200 fine per patient below performance tolerance (maximum 8% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	93.9%	92.6%	89.1%	90.2%	86.5%	89.5%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**> 30min**	481	489	514	129	208	115
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**> 60min**	207	255	371	67	201	108
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q1 Actual**	**Q2 Actual**	**Q3 Actual**	**Nov**	**Dec**	**Jan**
	NHS VALE OF YORK CCG	30mins - 1hr	176	70	154	34	80	46
		1hr 2 hours	94	19	109	14	77	51
		2 hours +	7	13	54	1	41	26
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	141	202	176	55	55	29
		1hr 2 hours	52	88	77	25	27	10
		2 hours +	4	12	25	2	12	2
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	96	122	127	27	51	29
		1hr 2 hours	26	73	54	16	21	10
		2 hours +	0	9	13	1	5	2
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	27	34	17	4	5	4
		1hr 2 hours	5	12	13	5	3	2
		2 hours +	0	2	1	0	0	0
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	5	1	2	1	0	2
		1hr 2 hours	0	1	1	0	1	0
		2 hours +	0	0	0	0	0	0
	OTHER	30mins - 1hr	36	60	38	8	17	5
		1hr 2 hours	19	25	16	3	8	2
		2 hours +	0	1	8	0	6	3
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**> 12 hrs**	0	2	2	0	2	7
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	97.4%	96.9%	To follow	97.2%	To follow	To follow

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Apr 12 - Mar 13	July 12 - June 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**TBC**	99	96	93	93	95	98
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	**TBC**	108	108	104	105	107	108

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Nov	Dec	Jan
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**59**	12	10	16	4	10	7
Number of Clostridium difficile due to "lapse in care"	*TBC*	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**108**	30	20	28	11	10	11
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) cases	**Quarterly:** General Condition 9	**35**	14	9	19	5	8	4
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	0	0	0	0	0
Notification of MRSA Bacteraemia to be notified to commissioner within 2 working days	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 14 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a	n/a	n/a
Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	87.9%	88.7%	88.5%	87.7%	87.1%	86.2%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	71.2%	72.7%	70.1%	68.9%	69.2%	68.0%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Nov	Dec	Jan
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 fine per patient below performance tolerance	**99%**	97.6%	98.3%	98.5%	99.0%	97.9%	95.1%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	2	0	0	0
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hosp	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	1	0	0	0	3	7
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	63	75	242	55	134	189
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	£200 in respect of each excess breach above threshold	**95%**	97.2%	96.9%	97.1%	97.4%	96.9%	97.0%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.7%	99.6%	To follow	99.8%	To follow	To follow
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	5.9%	6.5%	5.1%	5.5%	6.0%	4.0%
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 89% Q2 - 90% Q3 - 92% Q4 - 95%**	85.9%	86.4%	86.3%	87.0%	85.4%	93.5%
Delayed Transfer of Care to be maintained at a minimum level	TBC	**TBC**	1548	1988	1612	566	609	493
Trust waiting time for Rapid Access Chest Pain Clinic	None	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance					
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**200 per month**	348	518	563	176	172	181
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**Baseline 784; end Q2 745; end Q4 722**	2236	2287	2381	758	773	879
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	371	352	2 month coding lag	127	2 month coding lag	2 month coding lag
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	1247	1192	2 month coding lag	468	2 month coding lag	2 month coding lag
Reduction in the number of inappropriate transfers between wards and other settings during night hours (Reduction in avoidable site transfers within the Trust after 10pm)	General Condition 9	**Q2 onwards 80 p.m. (TBC)**	256	269	353	102	148	128

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Nov	Dec	Jan
Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	General Condition 9	**80% by site**	87.9%	84.0%	83.4%	81.4%	83.5%	79.4%
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	93.7%	98.6%	98.3%	97.3%	98.5%	97.8%
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Proportion of stroke patients who spend >90% of their time on a stroke unit	Non delivery of 90% at Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £5k in line with respective finance baselines (TBC)	**80%**	86.9%	90.5%	86.2%	79.7%	88.2%	one month behind
Proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours of seeing a health professional	Non delivery of Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £2k in line with respective finance baselines (TBC)	**70% (TBC)**	86.7%	86.0%	82.0%	80.0%	80.5%	one month behind
Proportion of patients presenting with stroke with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	General Condition 9	**65%**	95.0%	100.0%	100.0%	100.0%	100.0%	one month behind
Percentage of stroke patients and carers with joint care plans on discharge from hospital to have a copy of their care plan (except RIP or who refuse health/social care assessment/intervention)	General Condition 9	**70%**	n/a	n/a	n/a	n/a	n/a	n/a
Patients who require an urgent scan on hospital arrival, are scanned with in 1 hr of hospital arrival (TBC)	No financial penalty	**50%**	82.6%	71.2%	70.8%	75.0%	68.4%	one month behind
Proportion of stroke patients scanned within 24 hours of hospital arrival	No financial penalty	**90% (TBC)**	91.6%	96.5%	93.2%	88.5%	94.7%	one month behind
Immediate Discharge Letters (IDLs) handed to patients on Discharge	General Condition 9	**98%**	Annual letter of assurance to be provided to CMB					
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver quarterly trajectories at Trust aggregate level for each quarter will result in the application of a £10K sanction relating to each underperforming quarter. Maximum sanction of £40k per fiscal year. The penalty will be applied by the commissioners in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	Quarterly audit					
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver the quarterly target will result in the application of a £6k penalty per quarter. Maximum sanction of £24k in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 94%**	Quarterly audit					
All Red Drugs to be prescribed by provider effective from 01/04/14	£50 penalty for any request to primary care for prescription of Red Drugs (TBC)	**100% list to be agreed**	CCG to audit for breaches					
All Amber Drugs to be prescribed by provider effective from 01/04/14	No financial penalty	**100% list to be agreed**	CCG to audit for breaches					
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	86.6%	86.9%	86.3%	86.5%	85.3%	85.8%

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Nov	Dec	Jan
Never Events	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	0	0	0	0	0	0

District Nursing Activity Summary

Indicator	Source	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Nov	Dec	Jan
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	n/a	1862	1871	1975	697	608	597
	Community nurse/service	n/a	964	1018	767	231	276	252
	Acute services	n/a	741	912	845	295	291	314
	Self / Carer/family	n/a	409	398	291	86	84	121
	Other	n/a	224	253	226	69	76	67
	Grand Total	n/a	4200	4452	4104	1378	1335	1351
Community Adult Nursing Contacts	First	n/a	2584	2657	2759	906	939	1038
	Follow up	n/a	31371	30399	29999	8978	10472	10902
	Total	n/a	33955	33056	32758	9884	11411	11940
	First to Follow Up Ratio	n/a	12.1	11.4	10.9	9.9	11.2	10.5
Community Hospitals average length of stay (days)	Archways	n/a	23.4	22.1	20.6	23.2	16.4	29.7
	Malton Community Hospital	n/a	24.5	18.6	17.1	16.3	18.0	16.0
	St Monicas Hospital	n/a	24.5	23.2	22.0	23.7	23.4	25.8
	The New Selby War Memorial Hospital	n/a	13.8	15.6	13.7	10.5	15.5	14.8
	Whitby Community Hospital	n/a	21.1	20.3	20.9	20.8	22.7	21.2
	Total	n/a	20.4	19.4	18.1	17.2	19.1	19.6
Community Hospitals admissions. Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	8	4	8	3	5	0
		Emergency	66	91	77	23	27	21
	Malton Community Hospital	Elective	4	10	21	9	6	22
		Emergency	89	114	121	37	37	37
	St Monicas Hospital	Elective	9	13	9	3	1	4
		Emergency	36	35	27	7	12	14
	The New Selby War Memorial	Elective	68	62	69	28	18	21
		Emergency	71	66	69	24	16	17
	Whitby Community Hospital	Elective	0	1	4	0	0	0
		Emergency	152	123	142	45	52	48
	Total	Elective	89	90	111	43	30	47
		Emergency	414	429	436	136	144	137

Complaints and PALS	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**
New complaints this month	51	38	58	57	46	47	43	60	31	39		
Complaints at same month last year	52	48	49	59	42	56	52	45	27	52		
Number of complaints upheld (cumulative)*	75% of Q1 complaints generated actions for improvement			not known yet	not known yet	not known yet	not known yet	not known yet	not known yet	not known yet		
Number of complaints partly upheld (cumulative)**												
Number of Ombudsman complaint reviews	0	2	0	3	0	0	0	0	0	3		
Number of Ombudsman complaint reviews upheld	0	0	0	0	0	0	0	0	0	0		
Number of Ombudsman complaint reviews partly upheld	0	1	1	2	0	0	0	0	0	1		
Late responses this month (at the time of writing)***	4	7	4	9	4	1	8	5	5	4		
Top 3 complaint issues												
Aspects of clinical treatment	39	27	34	39	37	35	31	44	18	21		
Admission/discharge/transfer arrangements	5	2		3	2		5	4	0	2		
Appointment delay/cancellation - outpatient	3				1				4	1		
Staff attitude		4	6	10	6	5		5	5	10		
Communications			5	3	0	4			0	2		
Other							2		0	0		
New PALS queries this month	495	474	528	531	488	570	653	552	443	620		
PALS queries at same time last year	488	521	462	563	498	445	536	419	385	503		
Top 3 PALS issues												
Information & advice	107	118	168	140	158	192	42	150	136	189		
Staff attitude	61	0	0	0	15	0	0	0	17	19		
Aspects of clinical treatment	53	87	99	104	93	86	89	105	66	77		
Appointment delay/cancellation - outpatient	0	66	59	67	56	65	24	63	41	47		
**note: upheld complaints are reported quarterly to allow for investigation timescales*												
***note: we do not record partly - if a complaint generates 1 or more actions for improvement then it is reorded as upheld*												
****note: if extensions are made in agreement with the complaint, responses are not considered late*												
Serious Incidents												
Number of SI's reported	19	21	20	19	13	13	35	12	25	15		
% SI's notified within 2 working days of SI being identified*	89%	76%	70%	94%	100%	100%	100%	100%	100%	100%		
% SI's closed on STEIS within 6 months of SI being reported	50%	0%	0%	0%	0%	0%	0%	8%	0%	0%		
Number of Negligence Claims	11	14	16	15	21	8	16	8	8	12		
* this is currently under discussion via the 'exceptions log'												

Pressure Ulcers**												
Number of Category 2	43	40	37	22	29	28	31	32	30			
Number of Category 3	12	9	10	5	5	8	7	6	3			
Number of Category 4	1	0	0	0	0	0	1	1	0			
Total number developed/deteriorated while in our care (care of the organisation) - acute	35	27	24	15	24	28	39	32	42			
Total number developed/deteriorated while in our care (care of the organisation) - community	32	29	27	19	18	20	22	37	18			
Falls***												
Number of falls with moderate harm	10	8	7	3	3	3	6	1	7			
Number of falls with severe harm	8	6	4	1	2	2	3	2	5			
Number of falls resulting in death	0	0	0	0	0	0	0	0	0			
Safeguarding												
% of staff compliant with training (children)			45%	45%	47%	51%	54%	53%	55%	58%		
% of staff compliant with training (adult)			39%	40%	43%	40%	42%	43%	45%	56%		
% of staff working with children who have review CRB checks												
Prevent Strategy												
Attendance at the HealthWRAP training session	3 in total	3 in total	3 in total	3 in total	3 in total	3 in total	3 in total					
Number of concerns raised via the incident reporting system	nil	nil	nil	nil	nil	nil	nil					

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Finance Report

Action requested/recommendation

The Board is asked to note the contents of this report.

Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 31 January 2015.

At the end of January the Trust is reporting an Income and Expenditure (I&E) deficit of £2.9m against a planned surplus of £3.4m for the period. The Income & Expenditure position places the Trust behind its Operational plan.

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).

This report is for noting only and contains no recommendations. It is therefore not expected to have any particular impact upon the requirements of, or on the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	February 2015
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Briefing Note for the Finance & Performance Committee Meeting 17 February 2015

Subject: January 2015 (Month 10) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for January 2015

The reported position for January 2015 has seen a marked deterioration from a deficit of £1.2m at December to a £2.8m deficit at January. Against our planned year-to-date surplus of £3.4m we are currently operating £6.2m short.

Of note is that the estimated income position for December (reported in December) has moved adversely by £1m. This risk was raised in last month's board report. As is usually the case for in-month reporting, average specialty estimate prices are used as the activity is uncoded at the time of producing the monthly statement. Levels of uncoded activity for December were particularly high due to the earlier than usual close down and reporting timetable. For December the case mix subsequently coded was different to that reported in previous months, particularly in relation to the non-elective and elective split. The impact has been a reduction in income reported from the December report.

The Board should be aware that for this month's reported position no assessment of additional commissioner support, beyond that already reported and agreed, has been included. The Board are also aware that the Trust has had to open additional unplanned escalation areas, source staff through expensive locum and agency options and has extended the scope and remit of certain services to help meet recent high levels of emergency demand. Specific discussions are progressing around the following areas of support:

- There is some slippage on schemes agreed as part of the nationally funded winter resilience schemes. This slippage relates to both Trust schemes and initiatives planned with other providers. The Trust is seeking access to this slippage to help meet the additional costs of current emergency demand.
- Reinvestment of ED 4-hour target breach fines and ambulance turnaround penalties (beyond those already agreed). There is widespread acceptance amongst stakeholders that the Trust has performed well in coping with recent exceptional levels of emergency demand and there is acknowledgement of shared system responsibility in terms of Social Care and Primary Care. Agreement in principle has been reached with commissioners to reinvest a proportion of these penalties and negotiations continue.
- Given the recent exceptional levels of demand, the level of emergency admission marginal rate "savings" made by the CCG have exceeded planning expectations. Negotiations continue over access to the use of these funds were they have not been committed against specific schemes.

The extent to which these negotiations reach agreement around Trust re-investment will directly reduce the reported position. No assumption around success has been made at this stage and the raw position is reported. Clearly, agreement with commissioners is essential to secure an improved financial position for the Trust. Finishing the financial year with a deficit position will result in an equal and corresponding reduction in cash available for the Trust's capital investment programme. There are no alternative sources of cash to finance any outturn deficit.

This position returns a provisional COSR rating of 3, which is lower than our planned position.

CIP performance remains behind the required savings level but has improved from that reported last month. This issue is dealt with in detail in the efficiency report.

Income Analysis

The income and expenditure report clearly shows a further falling behind plan in relation to elective activity, whilst non-elective activity continues to significantly exceed plan (even at the 30% payment rate). The Board are fully aware of the current operational pressures within the system compromising elective activity.

Contract penalties have increased further this month, following an established trajectory. Details are provided in the finance report and performance report. Securing the reinvestment of elements of these penalties is crucial to the Trust's overall financial position.

In addition to the continuation of negotiations concerning the re-investment of ambulance turnaround penalties the Board should be aware of two further developing strategies in relation to seeking recompense for the exceptional non-elective activity pressures and associated impact on costs of managing patient flow.

Expenditure Analysis

Pay budgets and provisions have followed previous trends and are £4.5m overspent for January. This is reflective of the additional unplanned capacity the Trust has had to provide and the extraordinary costs of high agency and locum usage.

Concerted attempts to recruit substantively must continue as an annual forecast agency expenditure bill of around £10m represents a significant premium on costs.

Drug expenditure has deteriorated and is now showing a £1.5m overspend but this is, in the main, directly related to high out of tariff drug costs for which direct recharges are made to commissioners. The level is running ahead of plan though and will be of concern to the Trust's commissioners. There are no other material pressures to report in terms of other operational budgets.

Contracting Matters

Discussions are underway with all commissioners in relation to 2015/16 contracts, despite the absence of a national tariff. I will update the Board on the latest position during the meeting.

Other Issues

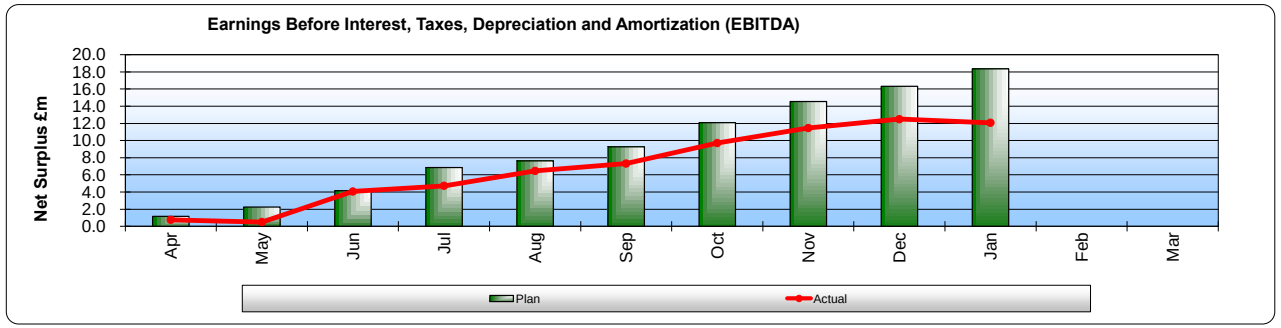
At this stage in the financial year there are no other Trust finance issues I would wish to bring to the attention of the Board. Cash levels are satisfactory and capital programme spending is as expected.

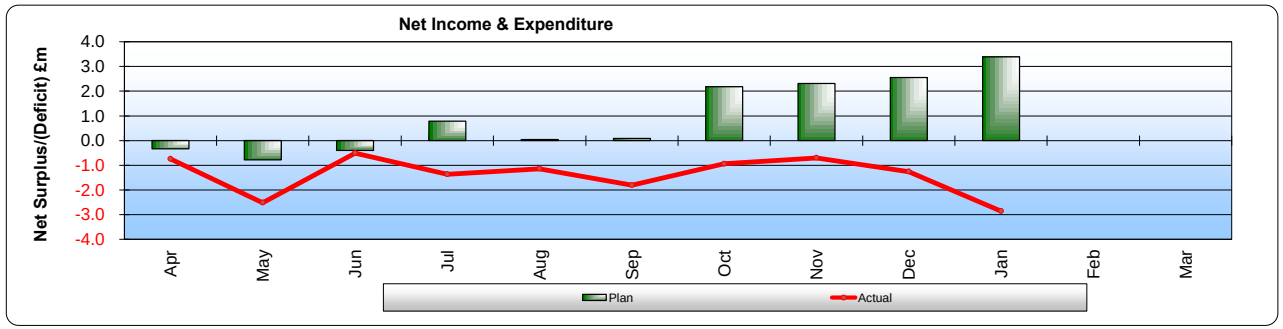
Summary Income and Expenditure Position
Month 10 - The Period April 2014 to January 2015

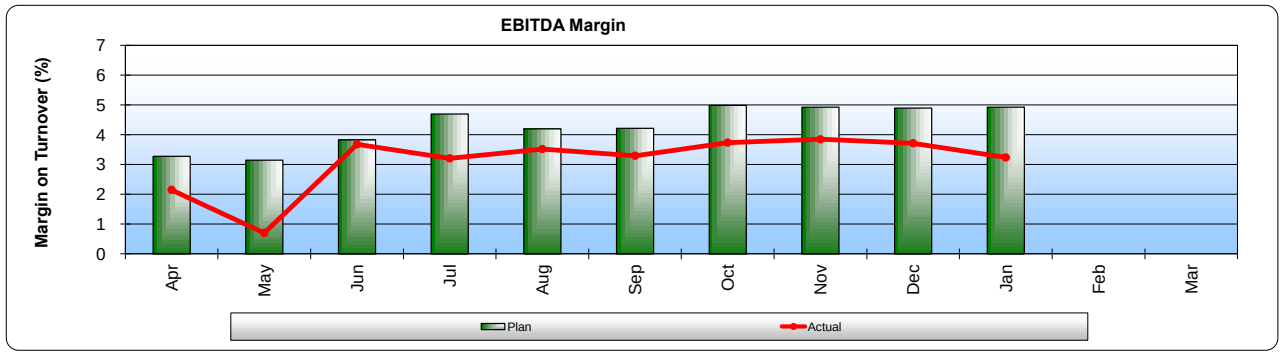
York Teaching Hospital NHS
NHS Foundation Trust

Summary Position:

* The Trust is reporting a net I&E deficit of £2.8m, placing it £6.3m behind the operational plan.
* Income is overall on plan, with clinical income being £3.0m behind plan broadly matched by non-clinical income being ahead of plan.
* Expenditure is ahead of plan by £6.3m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £12.1m (3.24%) compared to plan of £18.4m (4.93%), and is reflective of the reported net I&E performance.







	Annual Plan	Plan for Period	Actual for Period	Period Variance
	£000	£000	£000	£000
NHS Clinical Income				
Elective Income	27,256	22,693	20,228	-2,465
Planned same day (Day cases)	35,718	29,684	29,390	-294
Non-Elective Income	96,041	80,270	83,574	3,304
Outpatients	61,095	50,792	49,201	-1,591
A&E	13,411	11,213	11,516	303
Community	35,289	29,408	29,251	-157
Other	129,048	106,906	104,682	-2,224
	397,858	**330,966**	**327,842**	**-3,124**
Non-NHS Clinical Income				
Private Patient Income	976	813	918	105
Other Non-protected Clinical Income	1,722	1,435	1,486	51
	2,698	**2,248**	**2,404**	**156**
Other Income	0	0	0	0
Education & Training	14,434	12,028	12,680	652
Research & Development	2,005	1,671	3,135	1,465
Donations & Grants received (Assets)	0	0	0	0
Donations & Grants received (cash to buy Assets)	600	500	500	0
Other Income	17,714	14,818	15,664	846
Transition support	12,218	10,182	10,182	0
	46,971	**39,199**	**42,162**	**2,963**
Total Income	**447,527**	**372,413**	**372,408**	**-5**
Expenditure				
Pay costs	-295,263	-244,347	-248,813	-4,466
Drug costs	-42,032	-34,993	-36,258	-1,265
Clinical Supplies & Services	-44,968	-37,340	-36,826	514
Other costs (excluding Depreciation)	-47,279	-38,737	-38,204	533
Restructuring Costs	0	0	-229	-229
CIP	3,419	1,368	0	-1,368
Total Expenditure	**-426,123**	**-354,049**	**-360,330**	**-6,281**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**21,404**	**18,364**	**12,078**	**-6,286**
Profit/ Loss on Asset Disposals	0	0	0	0
Fixed Asset Impairments	-300	0	0	0
Depreciation	-10,854	-9,045	-9,045	0
Interest Receivable/ Payable	100	83	143	60
Interest Expense on Overdrafts and WCF	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0
Interest Expense on Non-commercial borrowings	-415	-348	-287	61
Interest Expense on Commercial borrowings	0	0	0	0
Interest Expense on Finance leases (non-PFI)	0	0	-23	-23
Other Finance costs	0	0	-52	-52
PDC Dividend	-6,804	-5,667	-5,667	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**3,131**	**3,388**	**-2,853**	**-6,241**

Contract Performance
Month 10 - The Period April 2014 to January 2015

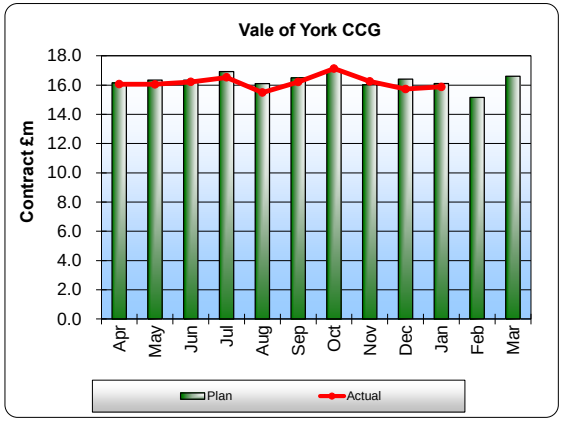
York Teaching Hospital NHS
NHS Foundation Trust

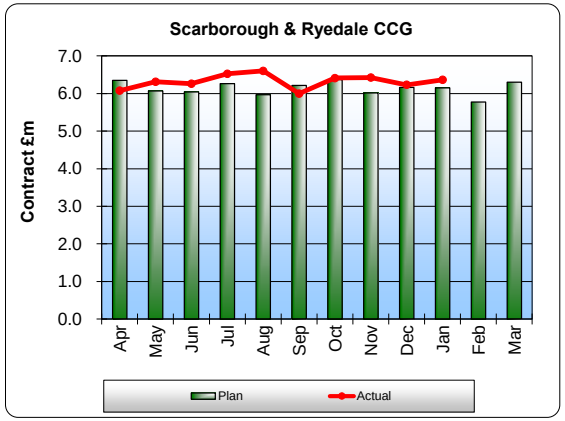
Contract	Contract Value	Contract to Date	Actual to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	195,649	163,893	161,525	-2,368
Scarborough & Ryedale CCG	73,707	61,627	63,222	1,595
East Riding CCG	36,943	30,897	30,887	-10
Other Contracted CCGs	22,195	18,558	18,802	244
NHSE - Specialised Commissioning	34,690	29,033	28,655	-378
NHSE - Public Health	15,367	12,826	12,445	-381
Local Authorities	5,317	4,434	4,116	-318
Total NHS Contract Clinical Income	**383,868**	**321,268**	**319,652**	**-1,616**

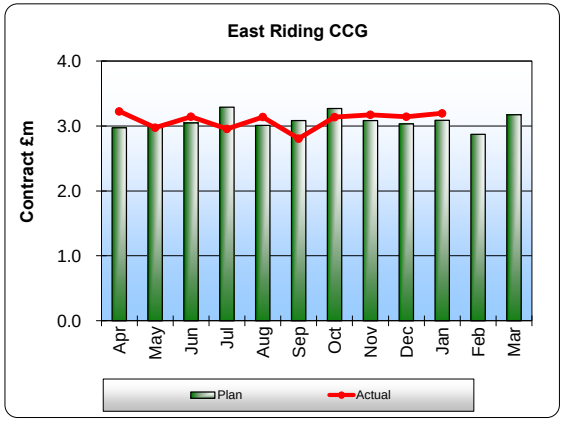
Plan	Plan Value	Plan to Date	Actual to Date	Variance
	£000	£000	£000	£000
Non-Contract Activity	7,644	6,404	8,030	1,626
Risk Income				
Total Other NHS Clinical Income	**7,644**	**6,404**	**8,030**	**1,626**

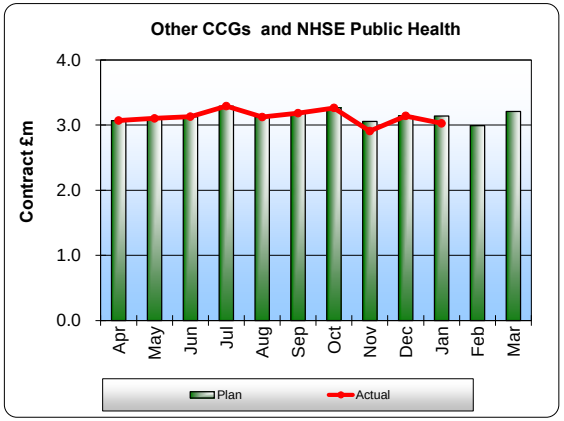
Total NHS Clinical Income	**391,512**	**327,672**	**327,682**	**10**

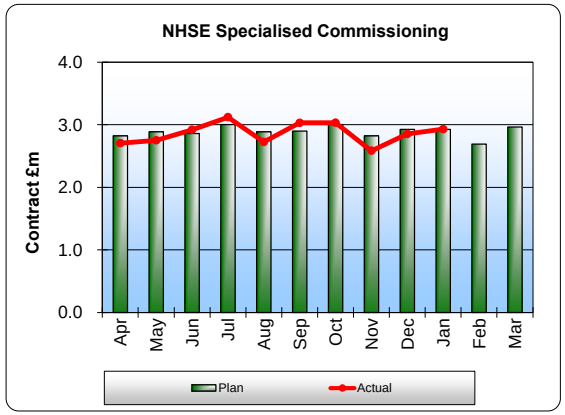
Specialist registrar income moved to other income non clinical	-1039
Winter resilience monies in addition to contract	1,199
Agrees to Clincial Income reported to board	**327,842**

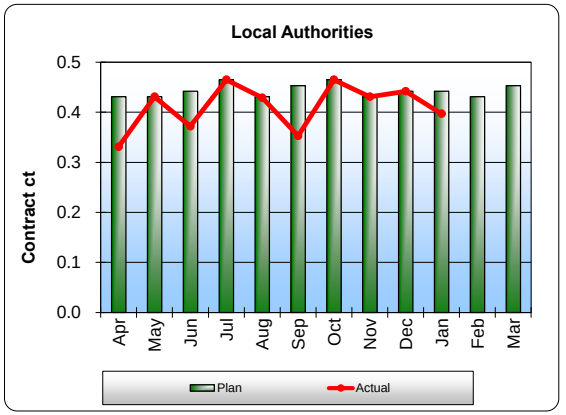












Expenditure Analysis
Month 10 - The Period April 2014 to January 2015

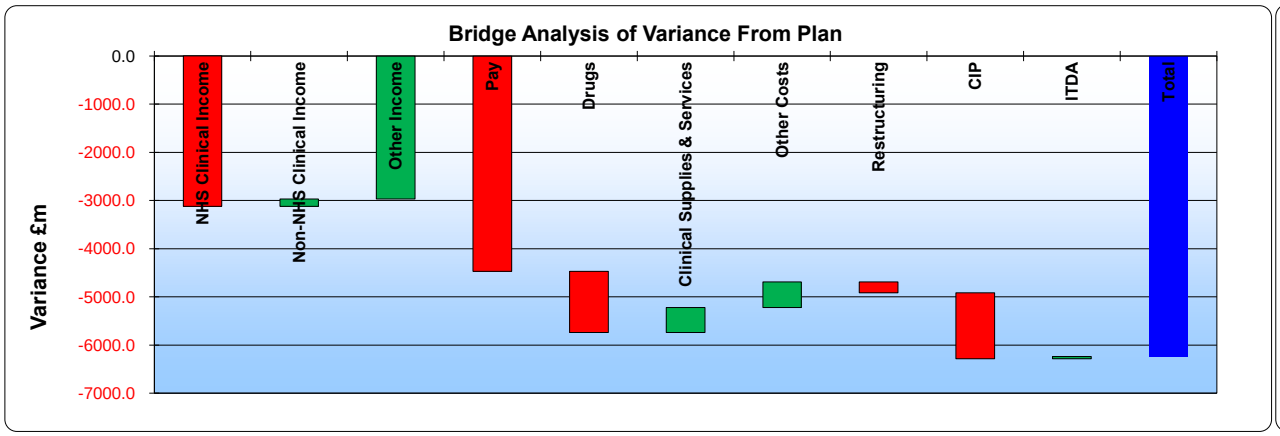
York Teaching Hospital NHS
NHS Foundation Trust

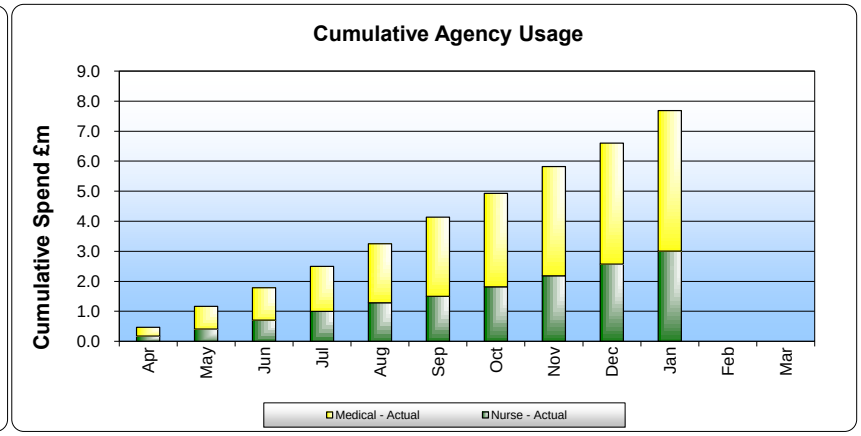
Key Messages:

There is an adverse expenditure variance of £6.3m at the end of January 2015. This comprises:

* Pay budgets are £4.5m adverse, predominantly due to the premium paid for agency staffing.
* Drugs budgets are £1.3m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £1.4m behind plan.
* Other budgets are £0.9m favourable.

Staff Group	Annual Plan	Period Plan	Period Contract	Period Overtime	Period WLI	Period Bank	Period Agency	Period Total	Period Variance	Previous Variance	Comments
Consultants	52,033	43,172	39,534	0	1,451	0	1,445	42,430	742	792	
Medical & Dental	28,264	23,446	22,192	0	129	0	3,236	25,556	-2,110	-1,681	
Nursing, Midwifery & Health Visting	104,531	86,752	76,601	323	264	3,425	3,004	83,617	3,135	2,561	
Professional & Technical	8,739	7,251	6,550	78	97	0	601	7,327	-75	-70	
Scientific & Professional	15,442	12,831	11,917	68	1	0	189	12,176	656	581	
P.A.M.s	21,252	17,671	15,668	59	322	0	67	16,116	1,555	1,443	
Healthcare Assistants & Other Support Staff	30,053	25,034	24,107	406	130	28	103	24,774	260	264	
Chairman and Non-Executives	163	135	135	0	0	0	0	135	1	1	
Executive Board and Senior Managers	13,059	10,826	10,648	5	1	0	0	10,653	173	172	
Administrative & Clerical	32,359	26,882	25,369	178	81	2	402	26,031	851	761	
Vacancy Factor	-10,606	-9,650	0	0	0	0	0	0	-9,650	-8,883	
TOTAL	**295,290**	**244,350**	**232,722**	**1,117**	**2,476**	**3,454**	**9,046**	**248,815**	**-4,465**	**-4,060**	





Cash Flow Management
Month 10 - The Period April 2014 to January 2015

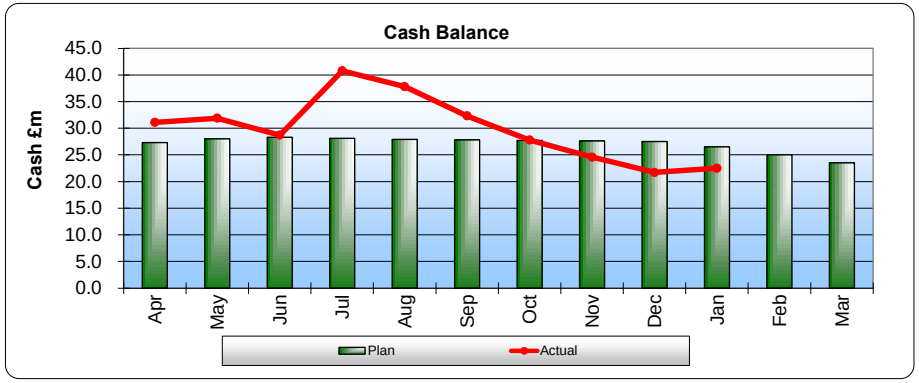
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The receipt of strategic capital of £12m in June 2014 provided a boost to the Trust's overall cash balance. However, overall the trajectory of cash balances is downwards as the Trust makes progress with its capital programme, but also linked to the underlying I&E trading position.

* Work is underway to bring payables up to date for the year end, with the number of outstanding invoices expected to reduce significantly over the next two months. The year end agreement of balances process is also supporting our debt recovery programme. Our three largest debtors are NHS England, North Yorkshire County Council and Harrogate FT. Significant work is in progress to reduce all of these values, and good progress is being made in this regard.

* The Continuity of Service Risk Rating (CoSSR) has reduced to 3, primarily as a result of a worsening position of the Debt Cover rating, which is reflective of the reported I&E position.

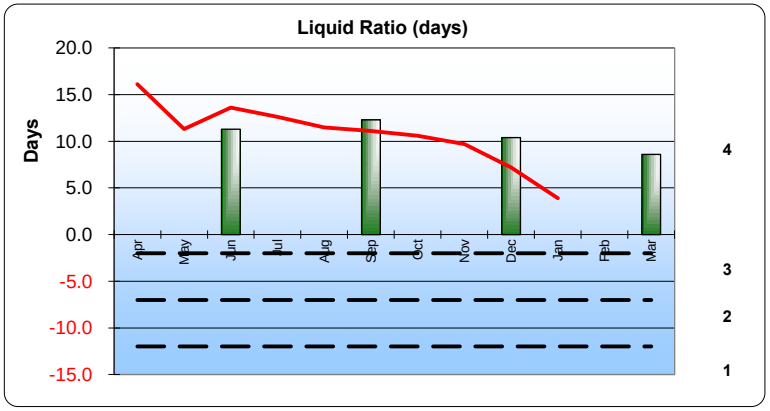


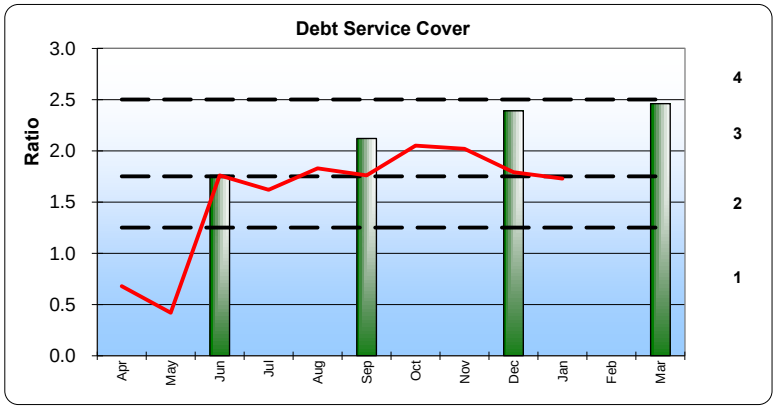
	Not Due	1 Month	2 Months	3 Months	3 Months +	Total
	£m	£m	£m	£m	£m	£m
Payables	2.9	0.5	0.2	0.1	0.4	4.1
Receivables	2.7	7	26.3	0.4	2.8	39.2

Significant Aged Debtors (+6mths)

NHS England	**£442K**
Harrogate and District NHS FT	**£458K**
North Yorkshire County Council	**£465K**

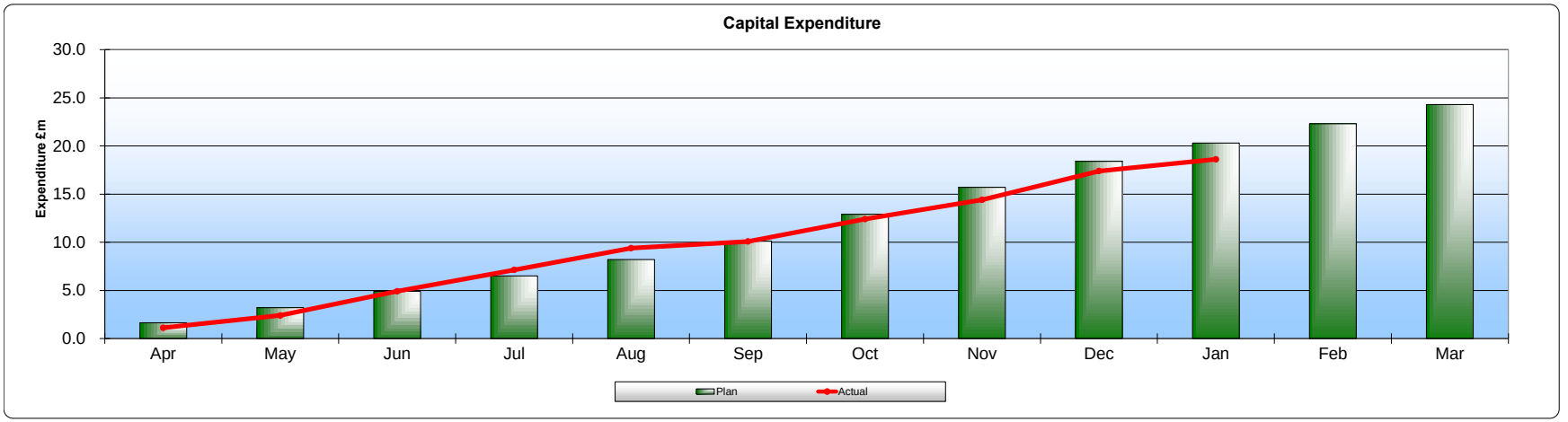
COSRR Area of Review	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquid Ratio (50%)	4	4	4	4
Debt Service Cover (50%)	3	3	2	3
Overall Continuity of Service Risk Rating	4	4	3	4





Key Messages:

* Strategic capital is supporting investments at Scarborough and Bridlington. Mapel 2 is expected to be handed over in March 2015.
* There has been a over spend associated with the York Kitchen and Restaurant.
* There has been some slippage against the fire alarm upgrade at York, the Scarborough lifts, ward security at York and Scarborough, and Estates Backlog maintenance.
* Forecast outturn expenditure is expected to be £23.125m, which is 5% behind plan. This includes spend on the recently approved business case for the update of the Trust Wireless Network.



Scheme	Total Approved Scheme Expenditure	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£	£	£	£	£	
York ED Phase 2	1,414	-	107	150	-150	
PACS	1,910	1,800	1,525	1,800	0	
BDH Standby Generator & Control Replacement	603	145	151	200	-55	
Maple 2	5,612	5,140	4,346	5,000	140	
Maternity Theatre Upgrade SGH	1,000	87	22	150	-63	
Refurbishment of Main Production Kitchen & Mallard Restaurant	3,200	2,780	3,126	3,550	-770	
York Ambulance Handover and Observation Facilities	722	411	522	550	-139	
Renal Unit Harrogate District Hospital	800	620	616	620	0	
Carbon and Energy Fund	4,635	1,086	1,097	1,086	0	
Other Capital Schemes < £500k	24,003	3,689	2,527	3,276	413	
Estates Backlog Maintenance - Scarborough	1,861	1,230	285	480	750	
Estates Backlog Maintenance - York	2,441	955	578	1,194	-239	
CPMG Minor Approvals	1,162	1,062	583	769	293	
Medical Equipment	650	650	590	850	-200	
IT Capital Programme	1,700	1,700	1,463	2,300	-600	
Capital Programme Management	1,150	1,650	1,068	1,150	500	£500k variance due to contingency used against Caterting refurb overspend
TOTAL CAPITAL PROGRAMME	**52,863**	**23,005**	**18,607**	**23,125**	**- 120**	Underspend on plan

Funding	Total Approved Funding	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£	£	£	£	£	
Depreciation	11,000	11,000	11,000	11,000	-	
Loan	4,380	4,380	4,380	4,380	-	CT Scanners ahead of plan, matched loan funding
Proceeds from Disposals					-	
Proceeds from Donations	730	730	730	730	-	
PDC - Safer Hospitals	986	986	986	986	-	
Strategic Capital Funding	5,909	5,909	5,909	6,029	- 120	Slip Strategic Capital to match forecast outturn
Other						
TOTAL FUNDING	**23,005**	**23,005**	**23,005**	**23,125**	**-120**	

Efficiency Programme
Month 10 - The Period April 2014 to January 2015

York Teaching Hospital NHS
NHS Foundation Trust

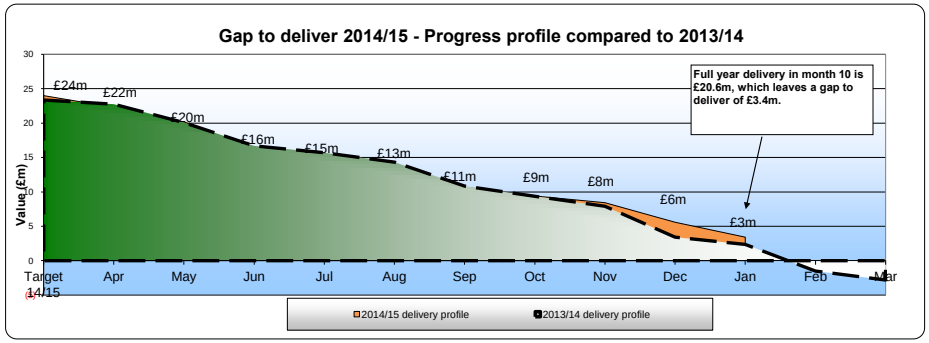
Key Messages:

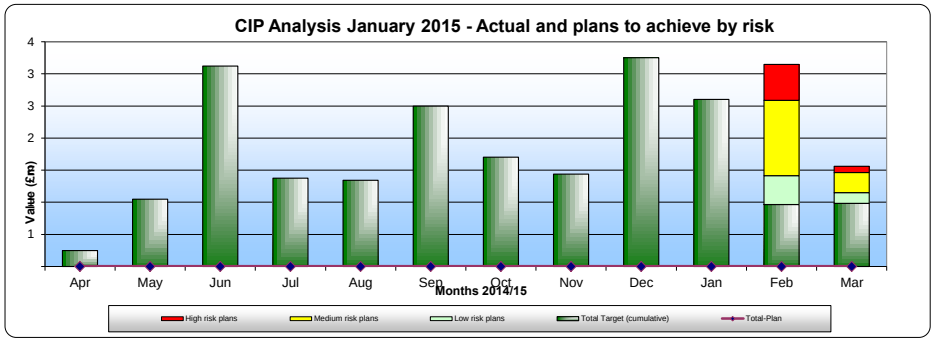
* Delivery - £20.6m has been delivered against the Trust annual target of £24m, leaving a delivery gap of (£3.4m).
* Part year Monitor variance - The part Monitor variance is adverse by (£1.4m), which is a £0.6m improvement from the December 2014 position.
* In year planning - The in year planning gap is (£0.7m); if high and medium risk plans are removed the gap increases to (£2.8m).
* Four year planning - The four year planning gap is (£15.8m), this position has improved from the December 2014 position by £1.2m.
* Recurrent delivery - Recurrent delivery is £7.6m which is 1.8% of operational expenditure

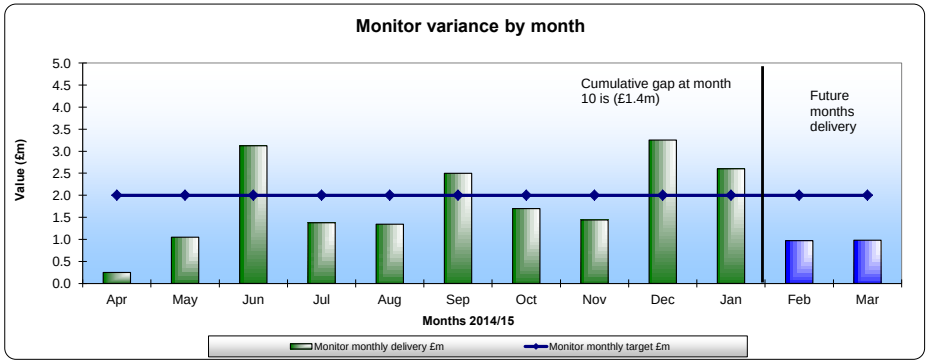
Executive Summary - January 2015	
	Total £m
TARGET	
In year target	24.0
DELIVERY	
In year delivery	20.6
In year delivery shortfall	-3.4
Part year delivery shortfall - monitor variance	-1.4
PLANNING	
In year planning surplus/(gap)	-0.7
FINANCIAL RISK SCORE	
Overall trust financial risk score	(2 RED/AMBER)

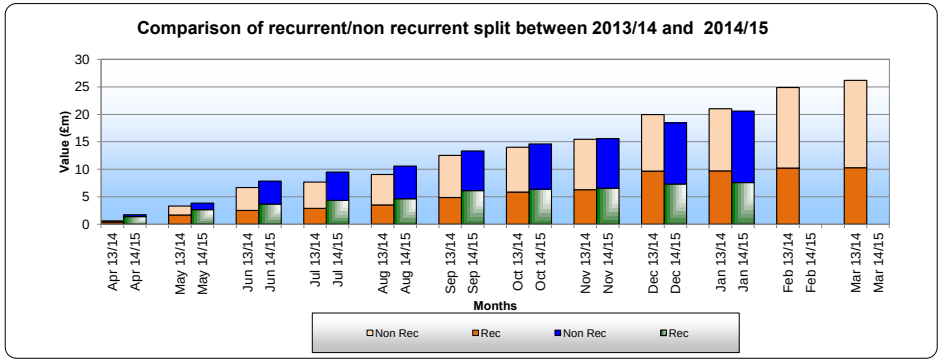
4 Year Efficiency Plan - January 2015					
Year	2014/15	2015/16	2016/17	2017/18	**Total**
	£m	£m	£m	£m	**£m**
Base Target	24.0	16.8	16.8	16.8	**74.4**
Plans	23.3	18.3	11.1	5.8	**58.6**
Variance	-0.7	1.5	-5.7	-11.0	**-15.8**
%	**97%**	**109%**	**66%**	**35%**	**79%**

Risk Ratings			
Financial			
Score	December	January	Trend
1	11	16	↑
2	9	9	→
3	7	3	↓
4	3	2	↓
5	2	2	→
Governance			
Score	December	January	Trend
Red	9	9	→
Green	23	23	→









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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Efficiency Programme Update – January 2015

Action requested/recommendation

The Committee is asked to note the January 2015 position with its future potential risks to delivery. Significant and sustained action is required to close these gaps.

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2014/15 target is £24m and full year delivery in January 15 is £20.6m, leaving a gap to be delivered of (£3.4m). There is a planning gap of (£0.7m) following a review of all in year plans. If high and medium risk plans are removed this increases to (£2.8m).

The Monitor variance is (£1.4m) behind plan.

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).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Finance & Performance Committee
Risk	The Efficiency Programme presents a significant financial risk to the organisation.
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Andrew Bertram, Director of Finance
Author	Steve Kitching, Head of Resource Management
Date of paper	February 2015
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Briefing note for the Finance & Performance Committee Meeting 17th February 2015
Briefing note for the Board of Directors Meeting 25th February 2015

Subject: January 2015 - Efficiency Position
From: Steven Kitching, Head of Resource Management

Summary reported position for January 2015

Current position – highlights and risks

Delivery - Overall delivery is £20.6m in January 2015 which is 86% of the £24m annual target. This has improved from the last reported position in December 2014 by £2.2m. This is running marginally behind the January 2014 delivered position of £21m (90%) of target. The relative Directorate positions are shown in Appendix 1 & 2 attached.

In year planning – The in year planning gap is (£0.7m) in January 2015, however if high & medium risk plans are removed the planning gap increases to (£2.8m). This position is considerably behind the January 2014 position which was a (£1.3m) gap excluding high & medium risk plans.

Four year planning – The four year planning gap is now (£15.8m) this month, which has improved by £1.2m from December 2014.

Recurrent vs. Non recurrent – Of the current £20.6m delivery £7.6m (37%) is recurrent, which has improved by £0.3m from the December 2014 position of £7.3m. This position is behind the January 14 position which was £9.7m (46%) delivered recurrently. The work continues to identify recurrent schemes. Further reference to the overall programme and recurrent delivery is made in the Efficiency Programme – Future Plans, paper, on the agenda.

Quality Impact Assessments (QIA) – The quality Impact Assessments are currently on hold as Dr Ian Jackson has now retired, the Finance Director and Medical Director are currently in discussion to identify a replacement. The position remains unchanged from December 2014. 23 areas have self assessed and are rated as green, which leaves 5 clinical areas and 4 corporate areas to finalise self assessment, see table 1 below. The majority of clinical areas remaining are areas where there have been gaps in the Directorate management team. Appendix 1 attached provides further detail, by Directorate.

Key risks – Although the planning gap has improved marginally within the month, the gap remains a concern, given we are now reporting progress at month 10.

The decline in recurrent achievement is also a significant concern.

The significant changes to the Directorate and Finance Manager structures have and continue to offer a **short term risk** to the programme, and the consequences of this are evident in the month 10 position; 14 areas (42% of the total, failed to deliver anything new in January 2015). It is noted the majority of DM/FM posts are now filled.

We currently have 5 directorates, 3 clinical and 2 corporate, who have delivered less than a third of their target at month 10, see table 1 below.

Table 1 – Month 10 % delivery

Directorate	% Delivery
Ops Management – Scarborough	14
ED Scarborough	17
Ops Management – York	29
Medicine for the Elderly – Scarborough	30
ED York	31

Proposed actions to address the key risks -

- Financial review meetings, chaired by the Director of Finance, are ongoing with every Directorate Finance Manager and will be completed by the end of February 2015; planning and delivery of CIP has been a key agenda item. The meetings to date have started to identify areas where recurrent conversion can be actioned.

- A full review of non recurrent delivery is underway; of the £13.0m non recurrent delivery as at January 2015, a very high level review has identified £5m of schemes, which are considered to be true non recurrent schemes. This leaves a balance of £8m to be reviewed.

- Recent history has shown 20-30% of these schemes have been converted to recurrent; however pressure has been applied throughout the year to make schemes recurrent, so this percentage is offered with a note of caution.

- CET support is being re-targeted at areas where the opportunity is deemed greatest for in year delivery and specific correspondence and support has been targeted at areas where delivery has been particularly sluggish.

- We are now starting to use the Efficiency Matrix information in the CIP review meetings; this should start to impact on the 15/16 & 17/18 planning positions. The 2015/16 planning position has improved by £2.9m, over the last 2 months. The current Matrix is included as part of the Efficiency Programme – Future Plans, paper, noted above.

- The Matrix will also allow the team to focus efforts on areas of opportunity although the bulk of opportunities identified will fall over the next 2 financial years. It should be noted as we start to work through the Matrix particularly in areas such as SLR the major pieces of work are data validation work-streams currently; the significant benefit to this has been clinical input in the areas where work is underway.

- A work plan is currently being developed alongside the Corporate Improvement Team to ensure all opportunities are identified, again this will offer short/medium term opportunities, and this work is ongoing.

RISK SCORES - JANUARY 2015 - APPENDIX 1

DIRECTORATE	FINANCE					GOVERNANCE			
	R	RA	A	AG	G	R	RA	AG	G
RADIOLOGY	1	2	3	4	5				
TACC YORK	1	2	3	4	5				
WOMENS HEALTH	1	2	3	4	5				
GEN MED SCARBOROUGH	1	2	3	4	5				
SPECIALIST MEDICINE	1	2	3	4	5				
GS&U	1	2	3	4	5				
ED YORK	1	2	3	4	5				
OPHTHALMOLOGY	1	2	3	4	5				
CHILD HEALTH	1	2	3	4	5				
HEAD AND NECK	1	2	3	4	5				
TACC SCARBOROUGH	1	2	3	4	5				
ED SCARBOROUGH	1	2	3	4	5				
COMMUNITY	1	2	3	4	5				
GEN MED YORK	1	2	3	4	5				
SEXUAL HEALTH	1	2	3	4	5				
MEDICINE FOR THE ELDERLY	1	2	3	4	5				
T&O YORK	1	2	3	4	5				
MEDICINE FOR THE ELDERLY SCARBOROUGH	1	2	3	4	5				
THERAPIES	1	2	3	4	5				
T&O SCARBOROUGH	1	2	3	4	5				
LAB MED	1	2	3	4	5				
PHARMACY	1	2	3	4	5				
CORPORATE									
OPS MANAGEMENT SCARBOROUGH	1	2	3	4	5				
MEDICAL GOVERNANCE	1	2	3	4	5				
OPS MANAGEMENT YORK	1	2	3	4	5				
SNS	1	2	3	4	5				
CORPORATE NURSING	1	2	3	4	5				
ESTATES AND FACILITIES	1	2	3	4	5				
AL&R	1	2	3	4	5				
HR	1	2	3	4	5				
CHIEF EXEC	1	2	3	4	5				
FINANCE	1	2	3	4	5				
TRUST SCORE	1	2	3	4	5				

RISK SCORES - JANUARY 2015 - APPENDIX 2

DIRECTORATE	Yr1 Target (000's)	4Yr Target (000's)	Yr 1 Plan v Target		Yr 1 Delivery v Target		Y1 Recurrent Delivery v target		4 Yr Plan v Target		Risk Score	
			%	Score	%	Score	%	Score	%	Score	Total Score	Monitor Rating
RADIOLOGY	1,901	3,800	44%	1	38%	1	2%	1	49%	1	4	1
TACC YORK	2,264	5,349	61%	1	61%	1	46%	1	35%	1	4	1
WOMENS HEALTH	2,342	4,464	45%	1	36%	1	19%	1	61%	2	5	1
GEN MED SCARBOROUGH	965	2,441	43%	1	38%	1	6%	1	65%	2	5	1
SPECIALIST MEDICINE	1,984	5,891	41%	1	41%	1	14%	1	67%	2	5	1
GS&U	1,938	5,471	67%	1	66%	1	34%	1	70%	2	5	1
ED YORK	501	1,426	35%	1	31%	1	13%	1	77%	3	6	1
OPHTHALMOLOGY	875	2,667	75%	2	58%	1	58%	2	37%	1	6	1
CHILD HEALTH	1,247	2,999	85%	2	54%	1	19%	1	79%	3	7	1
HEAD AND NECK	480	1,863	87%	2	78%	2	44%	1	69%	2	7	1
TACC SCARBOROUGH	806	2,178	93%	3	86%	2	37%	1	57%	1	7	1
ED SCARBOROUGH	298	897	17%	1	17%	1	14%	1	103%	5	8	2
COMMUNITY	1,648	4,390	30%	1	43%	1	34%	1	100%	5	8	2
GEN MED YORK	1,672	5,114	87%	2	56%	1	13%	1	92%	5	9	2
SEXUAL HEALTH	491	1,129	84%	2	73%	2	42%	1	80%	4	9	2
MEDICINE FOR THE ELDERLY	174	1,717	78%	2	72%	2	23%	1	104%	5	10	2
T&O YORK	789	2,331	92%	3	90%	2	17%	1	83%	4	10	2
MEDICINE FOR THE ELDERLY SCARBOROUGH	806	1,653	105%	5	30%	1	25%	1	89%	4	11	2
THERAPIES	1,367	3,772	97%	4	79%	2	30%	1	83%	4	11	2
T&O SCARBOROUGH	324	1,298	136%	5	138%	5	58%	2	75%	3	15	3
LAB MED	1,672	4,022	103%	5	103%	5	80%	3	82%	4	17	4
PHARMACY	(188)	611	101%	5	101%	5	101%	5	186%	5	20	5
CORPORATE												
OPS MANAGEMENT SCARBOROUGH	329	638	46%	1	14%	1	2%	1	45%	1	4	1
MEDICAL GOVERNANCE	77	180	56%	1	56%	1	17%	1	31%	1	4	1
OPS MANAGEMENT YORK	239	419	29%	1	29%	1	0%	1	70%	3	6	1
SNS	1,137	2,557	75%	2	54%	1	18%	1	63%	2	6	1
CORPORATE NURSING	334	496	79%	2	79%	2	16%	1	55%	1	6	1
ESTATES AND FACILITIES	2,878	7,804	71%	2	69%	1	27%	1	94%	5	9	2
AL&R	185	420	101%	5	101%	5	0%	1	68%	2	13	3
HR	446	1,169	99%	4	101%	5	14%	1	74%	3	13	3
CHIEF EXEC	75	448	435%	5	435%	5	242%	5	75%	3	18	4
FINANCE	251	1,116	192%	5	192%	5	113%	5	102%	5	20	5
TRUST SCORE	**30,308**	**80,731**	**87%**	**2**	**84%**	**4**	**32%**	**1**	**78%**	**4**	**11**	**2**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Fire Safety Policy and Annual Report

Action requested/recommendation

The Board of Directors is asked to note the contents of the report including the annual statement of fire safety.

The Board of Directors is also asked to approve that the Trust's Fire Safety policy review date is further extended from February 2015 to February 2016 as no changes to the policy are necessary.

Summary

The York Hospital NHS Foundation Trust annual fire report is presented at the end of each calendar year to the Board of Directors. The report is an update/overview in relation to fire safety issues.

During 2014 the Trust has continued to meet its obligations under the current legislation and has remained broadly compliant in achieving and maintaining those obligations.

Fire Safety was subjected to internal audit scrutiny in order to provide the Board with certain levels of assurance in meeting its obligations. The Trust received a finding of Significant Assurance.

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).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of, or the protected groups identified, by the Equality Act.

Reference to CQC outcomes

CQC Outcomes 10 and 11.

Progress of report	H&S/NCRG
Risk	No risks.
Resource implications	No resource implications.
Owner	Brian Golding, Director of Estates & Facilities
Author	Mick Lee, Fire Safety Advisor (York) Kevin Hudson, Fire Safety Advisor (Scarborough)
Date of paper	February 2015
Version number	Version 1

Board of Directors – 25 February 2015

Fire Safety Policy and Annual Report

1. Introduction and background

The York Hospital NHS Foundation Trust annual fire report is presented at the end of each calendar year to the Board of Directors. The report is an update/overview in relation to fire safety issues.

During 2014 the Trust has continued to meet its obligations under the current legislation and has remained broadly compliant in achieving and maintaining those obligations.

Fire Safety was subjected to internal audit scrutiny in order to provide the Board with certain levels of assurance in meeting its obligations. The Trust received a finding of Significant Assurance.

2. Fire Safety Update

During 2014 the Trust has continued to meet its obligations under the current legislation and has remained broadly compliant in achieving and maintaining those obligations.

We continue to struggle in carrying out the recommended evacuation drills for the ward blocks, although, as a result of an alarm activation during 2014 Ward 23 did achieve this compliance.

As part of the ongoing commitment to make good/upgrade breaches to the structural passive fire protection at York hospital, work continued during 2014 in the following areas: Lab/Med all floors, Maternity (Inc S.C.B.U. and the “G” Wards), Wards 11, 15 & 21. A budget has been made available to continue this work during FY2015/16 with the Admin Block as a possible next phase. All such work will be carried out by a third party accredited contractor, which ensures a standard of work which will satisfy current legislation and provide the Trust with an acceptable level of auditable quality assurance and compliance.

The routine maintenance of installed fire protection systems such as the emergency lighting and the fire alarm continues to be undertaken by Estates engineers, and approved/accredited contractors.

Portable fire extinguisher maintenance and annual servicing across all Trust premises has now come in house, and is undertaken by a suitably qualified member of the Estates maintenance team working out of the Scarborough Estates Dept.

During 2014 Officers from North York’s Fire & Rescue carried out a Fire Safety Audit of the following Trust properties:

York	Scarborough
· St Monica’s Hospital	· Nil

St Monica's hospital gained a satisfactory outcome and received positive feedback from the inspecting officer. *(Audit report from inspecting officer attached at appendix 2 to this report)*

Throughout the year operational crews from Acomb and York stations continued to carry out regular site familiarisation training as have the fire crews from Scarborough and Bridlington.

The Fire Advisor(s) from both Eastern & Western regions continue to review all existing Fire Risk Assessments (FRA) producing agreed action plans where necessary to achieve compliance. A total of 101 assessments/reviews were carried out in the Western region and a further 63 completed over the Eastern region. In addition they continue to offer specialist advice to the Trust in respect of all new major capital works projects such as the building of the new ward block at Scarborough and the re-design of the former Mallard (now Ellerby's) restaurant at York.

The Fire Safety Advisors continue to undertake the statutory/mandatory training obligations on behalf of the Trust, delivering annual refresher, induction and Fire Warden training, where applicable. We have seen an increase in the uptake of e-learning and fire warden training with the latter being introduced at Scarborough during 2014. 2014 also saw the introduction of the new learning hub which has had a positive impact in regards to the uptake of online fire training. Overall compliance has risen dramatically during 2014. *(See Table 2)*

The Trust Fire Safety Advisor (York) continues to provide support to York University in delivering the annual lecture on hospital fire safety awareness to the new degree intake, of trainee nurses.

3. Internal Audit

During 2014 Trust Fire Safety was subjected to internal scrutiny in order to provide the board with certain levels of assurance in meeting its obligations. The audit, for the first time, looked at fire safety across the Trust estate and didn't concentrate on any one site more than any other; topics looked at covered training, risk assessments and the management of systems. The Trust received a finding of **Significant Assurance**.

4. Fire Alarm Activations (Trust wide)

There were 35 fire alarm activations at the main York hospital site with a further 21 activations across the Eastern region sites, giving a total across the Trust of 56. This represents an increase of 14 on the 2013 figures. The increase can be attributed in part to some more unusual causes during 2014 such as the use of aerosols, ie deodorant air freshener etc, and the capital works projects being undertaken across the Trust estate. Whilst it is disappointing that the overall total has gone up, there have been some encouraging reductions in some of the more traditional individual alarm causes such as toasters, steam etc. It is also important to stress that there were no alarm activations which were the direct result of any fires. *(Table 1 below shows comparison with 2013 data).*

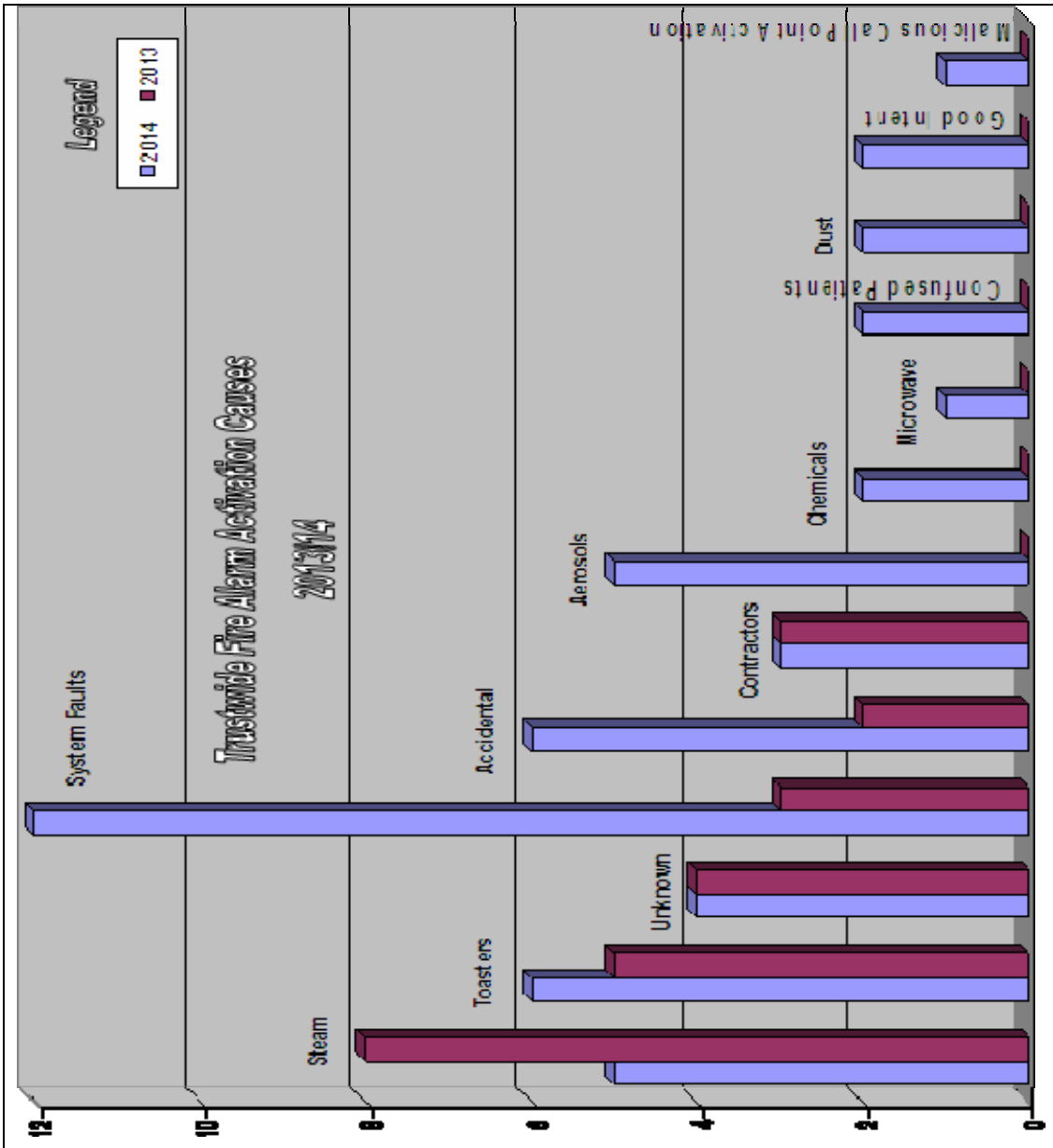
Location	Cause of Activation	2014	2013	Up/Down	Comments
York	Steam Leak	5	8	Down 3	
York	Toaster's	2	5	Down 3	
York	Unknown Cause	4	4	No Change	
York	System Faults	6	3	Up 3	
York	Accidental	4	2	Up 2	
York	Contractors	3	3	No Change	
York	Aerosols	5		New 2014	Air Freshener/Deodorants
York	Chemicals	2		New 2014	Deep cleaning of ward areas
York	Microwave	1		New 2014	
York	Patients	2		New 2014	Both – Patients on Ward 37
York	Dust	1		New 2014	Blown into detector head on Ward
Scarborough	Toaster	2			
Scarborough	Call-Point (Malicious)	1	3	Down 2	
Scarborough	System Faults	5			
Scarborough	Good Intent	3			
Scarborough	Dust	1			Contractors Sweeping up
Bridlington	Call-Point	1			
Bridlington	Fire	2			Waste bin & a Smokers bin
Bridlington	System Fault	1			
Bridlington	Accidental	2			
Bridlington	Toaster	2			
Whitby	Good Intent	1			

(Table 1)

Scarborough 2013 – 11 Activations
Bridlington 2013 – 3 Activations
Springhill 2013 – 3 Activations
Heycliffe House 2013 – 1 Activation
York Hospital 2013 – 25 Activations

Total for 2013 across Eastern region = 18
Total for 2014 across Eastern region = 21
Up 3

Total for 2013 across Western region = 25
Total for 2014 across Western region = 35
Up 10



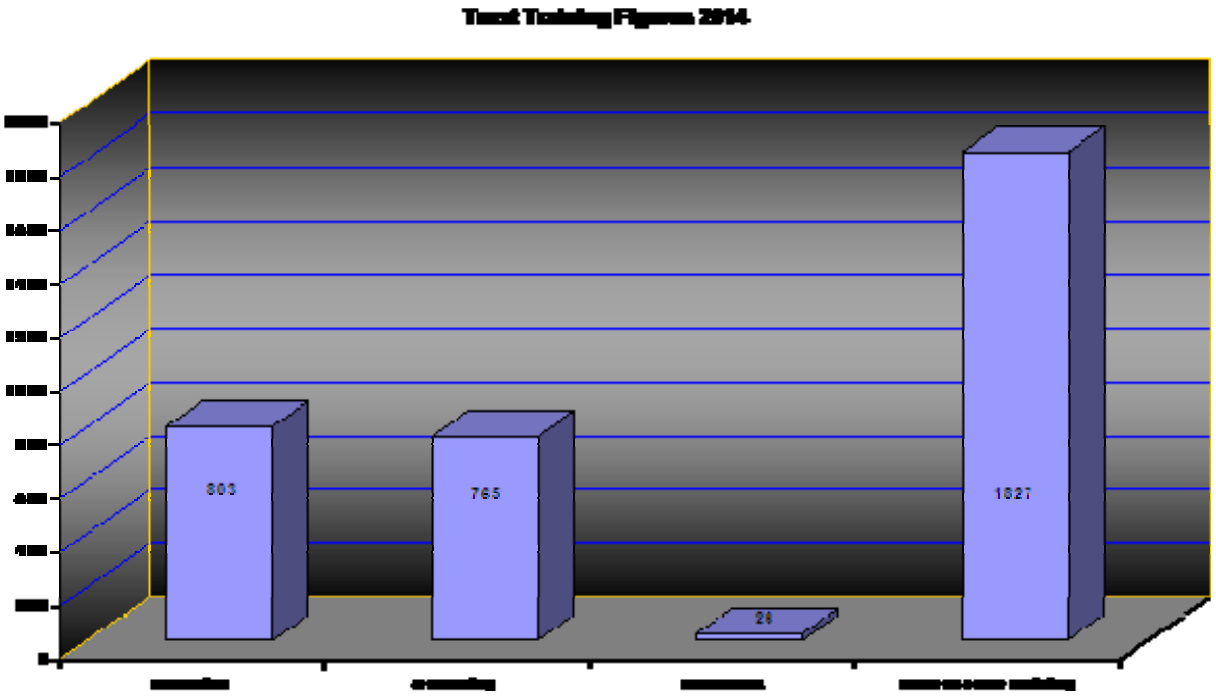
(Fig 1)

5. Training

Total manpower figures (2014): 9,200	Figure supplied by CLaD
York Staff trained (face to face) during 2014:	1,303
Scarborough Staff trained (face to face) during 2014:	524
E-Learning **Induction** **Other** *(workbook)*	765 803 26
TOTAL ACROSS TRUST	3421
Approximately 9,200 Trust personnel will be required to undertake fire safety training over a 3 year period. During 2014 Fire Training was re-organized across the Trust and the requirement for face to face training was changed to a 3 year	

schedule. Therefore on an annual basis we would now expect to train a third of that total manpower figure (approximately 3,100). That annual target was exceeded during 2014. The CLaD compliance figure of 81% represents a **current** snapshot of personnel who, over the period 2012 – 2014 have received/completed some form of fire safety training. That percentage figure is obviously very fluid as individuals slip in and out of that 3 year cycle.

(Table 2)



(Fig 2)

Fire Wardens trained at York during 2014 – 28
(Approx 400 fire wardens trained at York since 2009)

Fire Wardens trained at Scarborough during 2014 - 51

6. Fire Advisor Statements

6.1 EASTERN REGION: (Includes Scarborough, Bridlington, Whitby & satellite sites)

2014 has been another good year with regards to Fire Safety. Staff continue to show a commendable pro-active approach which has again been reflected in the training stats for the year. (there has been a small down turn in the number being trained this year face to face in the Scarborough area this has been primarily down to late announcement of the training dates and problems with the allocation of rooms etc) there still seems to be a reluctance for managers to attend fire training but the senior clinical staff show no such reluctance, training numbers for these individuals continue to rise.

The number of fire alarm activation has risen slightly during 2014 in comparison with 2013. We must look to drive these numbers down particularly as some fire authorities have stated their intension to introduce charges in certain instances for their attendance to these incidents. No trends are immediately noticeable other than the alarm becoming another year older and thus less reliable.

Following the acquisition of the Whitby Hospital site, the site had been neglected over a number of years in regard to its fire safety strategy, the fire doors across the site were in need of repair, as no joiner had been on site for many years, these doors have now been

serviced and are not by any means pristine, but they would now provide better resilience in any fire situation, following a full inspection, and repairs made where necessary, the main concern was the newly refurbished (by the PCT pre acquisition) fire alarm system the main problem being the lack of detection in ward areas, and also the age of the wiring, the company who carried out the works have connected new appliances to old cabling, this has caused many faults on the system, needing many call outs to engineers and subsequent cost to the trust. The installation of extra detection in the ward areas is on going, and will be completed in the next few weeks and the problems with the wiring has been much improved following soft ware upgrades to the system, thus less expense to the trust from unwanted call outs to contractors and our maintenance staff alike. The older fire doors on the Scarborough site are being systematically up graded by the installation of cold smoke seals this is an on going project and should be complete by the end of 2015.

6.2 Western Region (Includes York, Malton, SWMH, St Monica's & Satellite sites)

It has been another very encouraging year with regards to Trust Fire Safety. Staff continue to demonstrate a commendable pro-active approach to their fire safety awareness and any individual responsibilities. It has once again be pleasing to note the example set by those in senior positions across the Trust i.e. Directors, Consultants, Senior managerial staff etc, setting the standard when it comes to the uptake of attending any mandatory fire safety training.

We will still need to remain vigilant and to take every precaution in trying to reduce the number of unwanted fire signals and false alarm calls, whilst it was disappointing to see our total calls rise during 2014 the increase, could, for the most part be attributed to areas outside our control.

During 2014 the Fire Brigades Union (FBU) continued with their industrial action in their ongoing dispute with central and local government. Over those periods we asked for increased vigilance by all personnel and as a result we had no fire alarm activations.

A major priority for the coming year (2015) will see work commencing on the upgrade of the installed fire protection systems at Malton hospital and the replacement of the fire alarm system at York. Next year we will be planning the replacement of the fire alarm at the Scarborough site.

7. Recommendation

The Board of Directors is asked to note the contents of the report including the annual statement of fire safety.

The Board of Directors is also asked to approve that the Trust's Fire Safety policy review date is further extended from February 2015 to February 2016 as no changes to the policy are necessary.

Author	**Mick Lee, Head of Fire Safety**
Owner	**Brian Golding, Director of Estates & Facilities**
Date	**February 2015**

Appendix 1

Annual Statement of Fire Safety 2014

NHS Organisation Code: RCB	*NHS Organisation Name: YORK TEACHING HOSPITALS NHS FOUNDATION TRUST*	
I confirm that for the period 1st January 2014 to 31st December 2014, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and (please tick the appropriate boxes):		
1	*There are no significant risks arising from the fire risk assessments.*	*√*
OR 2	*The organisation has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment.*	*N/A*
OR 3	*The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks.**	*N/A*
**Where a programme to mitigate significant risks HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk.* *Date: N/A*		
4	*During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire & Rescue Authority? (Delete as appropriate)* *If Yes - Please outline details of the enforcement action in Annex A – Part 1.*	*No*
5	*Does the organisation have any unresolved enforcement action pre-dating this Statement? (Delete as appropriate)* *If Yes Please outline details of unresolved enforcement action in Annex A – Part 2.*	*No*
AND 6	*The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method.*	*√*
Director (Trust Fire Safety)	*Name: B GOLDING* *Director of Estates & Facilities*	
	E-mail: brian.golding@york.nhs.uk	
Contact details:	*Telephone: 01904 72 5149*	
	Mobile: N/A	
Chief Executive Name:	*P CROWLEY*	
Signature of Chief Executive:		
Date: 12 January 2015		
Completed Statement to be forwarded to the Health & Social Care Information Centre *No longer required* ***The above certificate is attached to Annual Fire Safety Report as recommended by the Internal Audit Report 2014***		

ANNEX A

Part 1 – Outline details of any enforcement action during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply.
N/A
Part 2 – Outline details of any enforcement action unresolved from previous years, including the original date, and the action the organisation has taken so far. Include any outstanding proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.
N/A

NHS Organisation Code RCB
NHS Organisation Name: YORK TEACHING HOSPITALS NHS FOUNDATION TRUST

Appendix 2

NORTH YORKSHIRE
FIRE & RESCUE SERVICE

NYFRS Reference: Premises: 00119994
Job: 1068629

Northallerton Fire Station
Crosby Road
Northallerton
North Yorkshire
DL6 1AB

When telephoning please ask for: Claire Brenner

Tel: 01609 751010
Fax: 01609 751019
Email: claire.brenner@northyorksfire.gov.uk

15 September 2014

Dear Sir or Madam

THE REGULATORY REFORM (FIRE SAFETY) ORDER 2005

St Monicas Hospital, Long Street, Easingwold, York, YO61 3JD

With reference to the fire safety audit of your premises on 15 September 2014, I would confirm that the outcome was considered to be broadly compliant with the Regulatory Reform (Fire Safety) Order 2005.

It will still be necessary to review your Fire Risk Assessment regularly (recommended to be at least once a year) and on the occasion of one of the following:

- There is reason to suspect that it is no longer valid, or
- There has been a significant change to the matters to which it relates.

The responsible person shall make all required changes to an assessment as a result of any such review.

Any enquiries concerning these matters may be addressed to the inspector named above.

Yours faithfully

Claire Brenner
Assistant Fire Safety Inspector

Audrey Willis
St Monicas Hospital
Long Street
Easingwold
York
YO61 3JD

Appendix 3

Trust Directorate Fire Safety Training – Compliance Rates
(Supplied by CLaD)

Fire Safety Awareness - Current Compliance Levels January 2015			
Site	Directortae	Staff group	Compliance percentage
York Acute	AHP & Psychological Medicine Directorate	Additional professional, technical & scientific	100%
York Acute	AHP & Psychological Medicine Directorate	Additional Clinical Services	97%
York Acute	AHP & Psychological Medicine Directorate	Allied health professionals	95%
York Acute	AHP & Psychological Medicine Directorate	Administrative and Clerical	85%
York Acute	Applied Learning & Research Directorate	Medical & dental	0%
York Acute	Applied Learning & Research Directorate	Nursing & midwivery registered	92%
York Acute	Applied Learning & Research Directorate	Additional professional, technical & scientific	100%
York Acute	Applied Learning & Research Directorate	Administrative and Clerical	94%
York Acute	Chairman & CEO Directorate	Medical & dental	100%
York Acute	Chairman & CEO Directorate	Administrative and Clerical	94%
York Acute	Chief Nurse Team Directorate	Nursing & midwivery registered	92%
York Acute	Child Health Directorate	Medical & dental	62%
York Acute	Child Health Directorate	Nursing & midwivery registered	70%
York Acute	Child Health Directorate	Additional Clinical Services	80%
York Acute	Child Health Directorate	Administrative and Clerical	87%
York Acute	Emergency Department Directorate	Medical & dental	24%
York Acute	Emergency Department Directorate	Nursing & midwivery registered	67%
York Acute	Emergency Department Directorate	Additional Clinical Services	65%
York Acute	Emergency Department Directorate	Administrative and Clerical	50%
York Acute	Estates & Facilities Directorate	Additional professional, technical & scientific	100%
York Acute	Estates & Facilities Directorate	Administrative and Clerical	92%
York Acute	Estates & Facilities Directorate	Estates & ancillary	90%
York Acute	Finance Directorate	Administrative and Clerical	88%

York Acute	Finance Directorate	Estates & ancillary	78%
York Acute	General & Acute Medicine Directorate	Medical & dental	42%
York Acute	General & Acute Medicine Directorate	Nursing & midwivery registered	76%
York Acute	General & Acute Medicine Directorate	Additional professional, technical & scientific	94%
York Acute	General & Acute Medicine Directorate	Additional Clinical Services	70%
York Acute	General & Acute Medicine Directorate	Administrative and Clerical	87%
York Acute	General Surgery & Urology Directorate	Medical & dental	39%
York Acute	General Surgery & Urology Directorate	Nursing & midwivery registered	69%
York Acute	General Surgery & Urology Directorate	Additional Clinical Services	81%
York Acute	General Surgery & Urology Directorate	Administrative and Clerical	76%
York Acute	Head & Neck Specialities Directorate	Medical & dental	55%
York Acute	Head & Neck Specialities Directorate	Nursing & midwivery registered	68%
York Acute	Head & Neck Specialities Directorate	Additional professional, technical & scientific	83%
York Acute	Head & Neck Specialities Directorate	Additional Clinical Services	85%
York Acute	Head & Neck Specialities Directorate	Allied health professionals	100%
York Acute	Head & Neck Specialities Directorate	Administrative and Clerical	93%
York Acute	Human Resources Directorate	Medical & dental	100%
York Acute	Human Resources Directorate	Nursing & midwivery registered	78%
York Acute	Human Resources Directorate	Additional professional, technical & scientific	60%
York Acute	Human Resources Directorate	Additional Clinical Services	100%
York Acute	Human Resources Directorate	Allied health professionals	100%
York Acute	Human Resources Directorate	Administrative and Clerical	98%
York Acute	Laboratory Medicine Directorate	Medical & dental	71%
York Acute	Laboratory Medicine Directorate	Nursing & midwivery registered	100%

York Acute	Laboratory Medicine Directorate	Additional professional, technical & scientific	98%
York Acute	Laboratory Medicine Directorate	Additional Clinical Services	100%
York Acute	Laboratory Medicine Directorate	Administrative and Clerical	100%
York Acute	Medical Governance Directorate	Nursing & midwivery registered	100%
York Acute	Medical Governance Directorate	Additional Clinical Services	100%
York Acute	Medical Governance Directorate	Administrative and Clerical	78%
York Acute	Medicine for Elderly Directorate	Medical & dental	44%
York Acute	Medicine for Elderly Directorate	Nursing & midwivery registered	70%
York Acute	Medicine for Elderly Directorate	Additional Clinical Services	78%
York Acute	Medicine for Elderly Directorate	Administrative and Clerical	77%
York Acute	Operations Management	Nursing & midwivery registered	68%
York Acute	Operations Management	Additional Clinical Services	67%
York Acute	Operations Management	Allied health professionals	100%
York Acute	Operations Management	Administrative and Clerical	70%
York Acute	Opthalmology Directorate	Medical & dental	65%
York Acute	Opthalmology Directorate	Nursing & midwivery registered	88%
York Acute	Opthalmology Directorate	Additional professional, technical & scientific	95%
York Acute	Opthalmology Directorate	Additional Clinical Services	80%
York Acute	Opthalmology Directorate	Allied health professionals	100%
York Acute	Opthalmology Directorate	Administrative and Clerical	94%
York Acute	Orthopaedics & Trauma Directorate	Medical & dental	46%
York Acute	Orthopaedics & Trauma Directorate	Nursing & midwivery registered	56%
York Acute	Orthopaedics & Trauma Directorate	Additional professional, technical & scientific	100%
York Acute	Orthopaedics & Trauma Directorate	Additional Clinical Services	57%

York Acute	Orthopaedics & Trauma Directorate	Administrative and Clerical	50%
York Acute	Pharmacy Directorate	Additional professional, technical & scientific	88%
York Acute	Pharmacy Directorate	Additional Clinical Services	100%
York Acute	Pharmacy Directorate	Administrative and Clerical	100%
York Acute	Radiology Directorate	Medical & dental	83%
York Acute	Radiology Directorate	Nursing & midwivery registered	86%
York Acute	Radiology Directorate	Additional professional, technical & scientific	100%
York Acute	Radiology Directorate	Additional Clinical Services	78%
York Acute	Radiology Directorate	Allied health professionals	85%
York Acute	Radiology Directorate	Administrative and Clerical	89%
York Acute	Sexual Health Directorate	Medical & dental	86%
York Acute	Sexual Health Directorate	Nursing & midwivery registered	100%
York Acute	Sexual Health Directorate	Administrative and Clerical	100%
York Acute	Specialist Medicine Directorate	Medical & dental	68%
York Acute	Specialist Medicine Directorate	Nursing & midwivery registered	84%
York Acute	Specialist Medicine Directorate	Additional professional, technical & scientific	100%
York Acute	Specialist Medicine Directorate	Additional Clinical Services	89%
York Acute	Specialist Medicine Directorate	Allied health professionals	0%
York Acute	Specialist Medicine Directorate	Administrative and Clerical	88%
York Acute	Systems & Network Services Directorate	Administrative and Clerical	93%
York Acute	Theatres Anaesthetics & Critical Care	Medical & dental	62%
York Acute	Theatres Anaesthetics & Critical Care	Nursing & midwivery registered	71%
York Acute	Theatres Anaesthetics & Critical Care	Additional professional, technical & scientific	52%
York Acute	Theatres Anaesthetics & Critical Care	Additional Clinical Services	85%

York Acute	Theatres Anaesthetics & Critical Care	Administrative and Clerical	82%
York Acute	Theatres Anaesthetics & Critical Care	Estates & ancillary	100%
York Acute	Womens Health Directorate	Medical & dental	48%
York Acute	Womens Health Directorate	Nursing & midwivery registered	98%
York Acute	Womens Health Directorate	Additional Clinical Services	100%
York Acute	Womens Health Directorate	Administrative and Clerical	100%
Scarborough Acute	Acute and Emergency Medicine Directorate	Medical & dental	51%
Scarborough Acute	Acute and Emergency Medicine Directorate	Nursing & midwivery registered	68%
Scarborough Acute	Acute and Emergency Medicine Directorate	Additional Clinical Services	62%
Scarborough Acute	Acute and Emergency Medicine Directorate	Administrative and Clerical	89%
Scarborough Acute	AHP & Psychological Medicine Directorate	Additional Clinical Services	94%
Scarborough Acute	AHP & Psychological Medicine Directorate	Allied health professionals	99%
Scarborough Acute	AHP & Psychological Medicine Directorate	Administrative and Clerical	83%
Scarborough Acute	Applied Learning & Research Directorate	Medical & dental	100%
Scarborough Acute	Applied Learning & Research Directorate	Nursing & midwivery registered	88%
Scarborough Acute	Applied Learning & Research Directorate	Additional professional, technical & scientific	100%
Scarborough Acute	Applied Learning & Research Directorate	Administrative and Clerical	82%
Scarborough Acute	Chairman & CEO Directorate	Administrative and Clerical	100%
Scarborough Acute	Chief Nurse Team Directorate	Nursing & midwivery registered	45%
Scarborough Acute	Chief Nurse Team Directorate	Additional Clinical Services	0%
Scarborough Acute	Chief Nurse Team Directorate	Administrative and Clerical	40%
Scarborough Acute	Child Health Directorate	Nursing & midwivery registered	100%
Scarborough Acute	Child Health Directorate Scarborough	Medical & dental	39%
Scarborough Acute	Child Health Directorate Scarborough	Nursing & midwivery registered	91%

Scarborough Acute	Child Health Directorate Scarborough	Additional Clinical Services	94%
Scarborough Acute	Child Health Directorate Scarborough	Administrative and Clerical	93%
Scarborough Acute	Estates & Facilities Directorate	Additional professional, technical & scientific	100%
Scarborough Acute	Estates & Facilities Directorate	Administrative and Clerical	61%
Scarborough Acute	Estates & Facilities Directorate	Estates & ancillary	89%
Scarborough Acute	Finance Directorate	Administrative and Clerical	88%
Scarborough Acute	General and Acute Medicine Directorate	Additional professional, technical & scientific	100%
Scarborough Acute	General Medicine Scarborough	Medical & dental	34%
Scarborough Acute	General Medicine Scarborough	Nursing & midwivery registered	89%
Scarborough Acute	General Medicine Scarborough	Additional professional, technical & scientific	20%
Scarborough Acute	General Medicine Scarborough	Additional Clinical Services	86%
Scarborough Acute	General Medicine Scarborough	Administrative and Clerical	67%
Scarborough Acute	General Surgery & Urology Directorate	Medical & dental	58%
Scarborough Acute	General Surgery & Urology Directorate	Nursing & midwivery registered	88%
Scarborough Acute	General Surgery & Urology Directorate	Additional professional, technical & scientific	100%
Scarborough Acute	General Surgery & Urology Directorate	Additional Clinical Services	91%
Scarborough Acute	Head & Neck Specialities Directorate	Medical & dental	40%
Scarborough Acute	Head & Neck Specialities Directorate	Additional professional, technical & scientific	100%
Scarborough Acute	Head & Neck Specialities Directorate	Additional Clinical Services	100%
Scarborough Acute	Head & Neck Specialities Directorate	Administrative and Clerical	100%
Scarborough Acute	Human Resources Directorate	Nursing & midwivery registered	75%
Scarborough Acute	Human Resources Directorate	Additional professional, technical & scientific	33%
Scarborough Acute	Human Resources Directorate	Additional Clinical Services	70%
Scarborough Acute	Human Resources Directorate	Administrative and Clerical	91%

Scarborough Acute	Laboratory Medicine Directorate	Medical & dental	100%
Scarborough Acute	Laboratory Medicine Directorate	Additional professional, technical & scientific	100%
Scarborough Acute	Laboratory Medicine Directorate	Additional Clinical Services	100%
Scarborough Acute	Laboratory Medicine Directorate	Administrative and Clerical	100%
Scarborough Acute	Medical Governance Directorate	Nursing & midwivery registered	100%
Scarborough Acute	Medicine for Elderly Directorate	Medical & dental	42%
Scarborough Acute	Medicine for Elderly Directorate	Nursing & midwivery registered	77%
Scarborough Acute	Medicine for Elderly Directorate	Additional Clinical Services	91%
Scarborough Acute	Medicine for Elderly Directorate	Estates & ancillary	67%
Scarborough Acute	Operations Management	Nursing & midwivery registered	91%
Scarborough Acute	Operations Management	Additional Clinical Services	100%
Scarborough Acute	Operations Management	Administrative and Clerical	87%
Scarborough Acute	Operations Management	Administrative and Clerical	20%
Scarborough Acute	Operations Management	Estates & ancillary	0%
Scarborough Acute	Opthalmology Directorate	Medical & dental	50%
Scarborough Acute	Opthalmology Directorate	Nursing & midwivery registered	90%
Scarborough Acute	Opthalmology Directorate	Additional Clinical Services	100%
Scarborough Acute	Opthalmology Directorate	Allied health professionals	75%
Scarborough Acute	Othopaedics & Trauma Scarborough	Medical & dental	80%
Scarborough Acute	Othopaedics & Trauma Scarborough	Nursing & midwivery registered	100%
Scarborough Acute	Othopaedics & Trauma Scarborough	Additional professional, technical & scientific	100%
Scarborough Acute	Othopaedics & Trauma Scarborough	Additional Clinical Services	95%
Scarborough Acute	Othopaedics & Trauma Scarborough	Administrative and Clerical	100%
Scarborough Acute	Othopaedics & Trauma Scarborough	Estates & ancillary	100%

Scarborough Acute	Pharmacy Directorate	Additional professional, technical & scientific	93%
Scarborough Acute	Pharmacy Directorate	Additional Clinical Services	100%
Scarborough Acute	Pharmacy Directorate	Administrative and Clerical	100%
Scarborough Acute	Radiology Directorate	Medical & dental	100%
Scarborough Acute	Radiology Directorate	Nursing & midwivery registered	66%
Scarborough Acute	Radiology Directorate	Additional Clinical Services	57%
Scarborough Acute	Radiology Directorate	Allied health professionals	78%
Scarborough Acute	Radiology Directorate	Administrative and Clerical	100%
Scarborough Acute	Sexual Health Directorate	Nursing & midwivery registered	100%
Scarborough Acute	Specialist Medicine Directorate	Medical & dental	40%
Scarborough Acute	Specialist Medicine Directorate	Nursing & midwivery registered	86%
Scarborough Acute	Specialist Medicine Directorate	Additional Clinical Services	92%
Scarborough Acute	Specialist Medicine Directorate	Administrative and Clerical	100%
Scarborough Acute	Systems & Network Services Directorate	Administrative and Clerical	95%
Scarborough Acute	Theatres Anaesthetics & Critical Care	Nursing & midwivery registered	100%
Scarborough Acute	Theatres Anaesthetics & Critical Care	Additional professional, technical & scientific	100%
Scarborough Acute	Theatres Anaesthetics & Critical Care	Additional Clinical Services	69%
Scarborough Acute	Theatres Anaesthetics & Critical Care	Administrative and Clerical	0%
Scarborough Acute	Theatres Anaesthetics & Critical Care	Medical & dental	40%
Scarborough Acute	Theatres Anaesthetics & Critical Care	Nursing & midwivery registered	89%
Scarborough Acute	Theatres Anaesthetics & Critical Care	Additional professional, technical & scientific	100%
Scarborough Acute	Theatres Anaesthetics & Critical Care	Additional Clinical Services	100%
Scarborough Acute	Theatres Anaesthetics & Critical Care	Administrative and Clerical	88%
Scarborough Acute	Womens Health Directorate	Medical & dental	62%

Scarborough Acute	Womens Health Directorate	Nursing & midwivery registered	97%
Scarborough Acute	Womens Health Directorate	Additional Clinical Services	94%
Scarborough Acute	Womens Health Directorate	Administrative and Clerical	67%
Scarborough Acute	Chaplaincy Volunteers	Administrative and Clerical	0%
Scarborough Acute	SNEY Trust Board	Nursing & midwivery registered	0%
Community	AHP & Psychological Medicine Directorate	Additional Clinical Services	96%
Community	Applied Learning & Research Directorate	Administrative and Clerical	100%
Community	Chairman & CEO Directorate	Administrative and Clerical	100%
Community	Chief Nurse Team Directorate	Nursing & midwivery registered	100%
Community	Child Health Directorate	Students (nursing)	100%
Community	Child Health Directorate	Nursing & midwivery registered	71%
Community	Child Health Directorate	Additional professional, technical & scientific	67%
Community	Child Health Directorate	Additional Clinical Services	64%
Community	Child Health Directorate	Administrative and Clerical	59%
Community	COMMUNITY Directorate	Medical & dental	11%
Community	COMMUNITY Directorate	Nursing & midwivery registered	71%
Community	COMMUNITY Directorate	Additional Clinical Services	74%
Community	COMMUNITY Directorate	Allied health professionals	94%
Community	COMMUNITY Directorate	Administrative and Clerical	85%
Community	COMMUNITY Directorate	Estates & ancillary	0%
Community	Emergency Department Directorate	Nursing & midwivery registered	100%
Community	Estates & Facilities Department	Estates & ancillary	86%
Community	Estates & Facilities Department	Additional professional, technical & scientific	100%
Community	Estates & Facilities Department	Administrative and Clerical	75%

Community	General and Acute Medicine Directorate	Nursing & midwivery registered	82%
Community	General and Acute Medicine Directorate	Additional professional, technical & scientific	100%
Community	General and Acute Medicine Directorate	Additional Clinical Services	83%
Community	General and Acute Medicine Directorate	Administrative and Clerical	100%
Community	General Medicine Scarborough	Medical & dental	60%
Community	General Surgery & Urology Directorate	Additional Clinical Services	100%
Community	General Surgery & Urology Directorate	Nursing & midwivery registered	89%
Community	Head & Neck Specialities Directorate	Administrative and Clerical	100%
Community	Head & Neck Specialities Directorate	Additional professional, technical & scientific	67%
Community	Head & Neck Specialities Directorate	Additional Clinical Services	100%
Community	Human Resources Directorate	Nursing & midwivery registered	100%
Community	Medical Governance Directorate	Nursing & midwivery registered	0%
Community	Medical Governance Directorate	Administrative and Clerical	100%
Community	Medicine for Elderly Directorate Scarborough	Medical & dental	14%
Community	Medicine for Elderly Directorate Scarborough	Nursing & midwivery registered	83%
Community	Medicine for Elderly Directorate Scarborough	Additional Clinical Services	93%
Community	Orthopaedics & Trauma Directorate	Additional Clinical Services	90%
Community	Orthopaedics & Trauma Directorate	Nursing & midwivery registered	92%
Community	Pharmacy Directorate	Additional professional, technical & scientific	100%
Community	Radiology Directorate	Additional Clinical Services	100%
Community	Radiology Directorate	Administrative and Clerical	71%
Community	Radiology Directorate	Allied health professionals	78%
Community	Sexual Health Directorate	Medical & dental	80%
Community	Sexual Health Directorate	Nursing & midwivery registered	81%

Community	Sexual Health Directorate	Additional Clinical Services	79%
Community	Sexual Health Directorate	Administrative and Clerical	92%
Community	Specialist Medicine Directorate	Medical & dental	0%
Community	Specialist Medicine Directorate	Nursing & midwivery registered	50%
Community	Specialist Medicine Directorate	Additional Clinical Services	0%
Community	Specialist Medicine Directorate	Administrative and Clerical	100%
Community	Systems & Network Services Directorate	Administrative and Clerical	100%
Community	Theatres Anaesthetics & Critical Care	Nursing & midwivery registered	100%
Community	Theatres Anaesthetics & Critical Care	Additional Clinical Services	100%
Community	Theatres Anaesthetics & Critical Care	Nursing & midwivery registered	63%
Community	Theatres Anaesthetics & Critical Care	Additional professional, technical & scientific	100%
Community	Theatres Anaesthetics & Critical Care	Additional Clinical Services	100%
Community	Theatres Anaesthetics & Critical Care	Estates & ancillary	100%
Community	Womens Health Directorate	Nursing & midwivery registered	100%
Community	Womens Health Directorate	Additional Clinical Services	100%
Community	Womens Health Directorate	Administrative and Clerical	100%

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Chairman's Items

Action requested/recommendation

The Board of Directors is asked to note the report.

Summary

This paper provides an overview from the Chairman.

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).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

There is no reference to CQC outcomes.

Progress of report	This paper is only written for the Board of Directors.
Risk	No risks
Resource implications	No resource implications

Owner	Alan Rose, Chairman
Author	Alan Rose, Chairman
Date of Paper	February 2015
Version number	Version 1

Board of Directors – 25 February 2015

Chairman's Items

1. Strategy and Context

Preparations continue for the Hospital(s) inspection in mid-March (18-20th). As I have said before, although we are working hard to raise awareness of the inspection and related issues, we wish that time to be "business as usual" rather than "special". We wish to be proud to work for good hospitals, offering good services, albeit we know there will be issues to address and areas for improvement.

This month the Board met with the Governing body of the Scarborough & Ryedale Clinical Commissioning Group (S&RCCG) and we shared our perspectives on challenges ahead. The focus was their "Vanguard" bid, which has our support, focused on ensuring the success of Scarborough Hospital. We have a similar meeting today with our other main commissioner – Vale of York Clinical Commissioning Group (VoYCCG); the focus here will be on their "Vanguard" bid, again with our support, which centres on enhancing community services.

In the short- and medium-term, finances will become a major issue for our Trust, as we begin to suffer from the same structural imbalances that are driving the majority of NHS Providers to be in deficit and the majority of Commissioners to be in surplus for the years ahead. No wonder the real tariff deflator factors (the lever that drives this) are under legal challenge. Our end of year deficit this year should be manageably small, but the emerging plan for 2015/16 currently looks to be too high to be acceptable.

We should be aware that the local Commissioning Support Unit (CSU) in Yorkshire and Humber has failed to qualify to be a potential provider of services from 2016, as these services are thrown open to "the market". This means other providers (private or NHS) will be bidding to win the work from the commissioners. This should not affect our Trust directly, but will affect our commissioners and are an indication of further discontinuities in the health and social care economy we work within.

I am delighted to note that the Yorkshire Ambulance Service (YAS) has followed our leading example and have declared themselves to be a "Living Wage" employer from this April.

2. Governance & Governors

I am also delighted to welcome to the Director team Juliet Walters, our new Chief Operating Officer (COO), who commenced work at the Trust this month. Operating stresses remain severe at the Trust, so this is a key area of focus.

The Secretary of State and Monitor, following a new report by Sir Robert Francis, has emphasised to us our responsibilities to allow staff the "freedom to speak up" (newspeak for "whistleblowing"). We need to ensure that channels for this are absolutely clear and that we are professional and straightforward in assessing such feedback. No doubt this issue will be probed by the CQC.

Our Lead Governor and FT Secretary have worked hard this year to raise the tempo on the briefings we provide Governors on topics of interest to them and which are important to the Trust. There is at least one special briefing each month and recent/upcoming sessions include:

Sustainable Development, CQC inspections, EPMA (electronic medicines prescribing), Nursing & Dementia, Recruitment and Meet the new COO.

At a meeting last week, Governors expressed to me their concern about the important change developing in the underlying finances of the Trust. They are now acutely aware that after several years of relatively stable and break-even/slightly positive underlying margin, the Trust is now forecasting a small deficit for the current year and the likelihood of a larger deficit in the coming year. They will be seeking more understanding of this from the Board, and our planned responses, in the months ahead.

3. Recommendation

The Board of Directors is asked to note the report.

Author	**Alan Rose, Chairman**
Owner	**Alan Rose, Chairman**
Date	**February 2015**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Chief Executive Report

Action requested/recommendation

The Board is asked to note the content of the report.

Summary

This report is designed to provide a summary of the operational issues the Chief Executive would like to draw to the attention of the Board of Directors.

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).

It is anticipated that the comments in this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	Report developed for the Board of Directors.
Risk	No specific risks have been identified in this document.

Resource implications	The paper does not identify resources implication.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	February 2015
Version number	Version 1

Board of Directors – 25 February 2015

Chief Executive Report

The Trust continues to be challenged by the high level of non-elective demand and both major hospitals have continued to be on red alert throughout the period. However, I am pleased to report that there has been a gentle improvement in our 4 hour performance that we should be encouraged by and this is no small part as a result of the huge amount of work on both sites, at all levels, to improve patient flow whilst continuing to manage all our patients safely and effectively. The position in Scarborough was further compromised by an outbreak of Norovirus that resulted in multiple ward closures but despite this we have seen an overall improvement in a number of key measures such as avoiding any patient diverts, reducing outliers and reducing the backlog of patients waiting transfer to Hull for acute procedures. It is very early days for "operation fresh start" but the signs are good in Scarborough and I am equally optimistic in York as a more systematic approach to discharge and patient flow becomes the norm. These improvements are as a result of strong leadership on both sites and I would like to thank the Directors for their visibility and support throughout the organisation during this difficult period. We must of course continue to thank and appreciate the efforts of all our staff who demonstrate every day their commitment and sense of value, putting the patient at the centre of everything we do and being caring and helpful. This is despite the very significant operational pressures that have been sustained for such a long time and it is essential we continue to work hard in the organisation and with partners to reduce these as best we can.

I would like to formally welcome Juliet Walters as Chief Operating Officer and Jenny Hey as Director of Operations to the organisation who, together with Mandy McGale, will form the senior operational management team across our main hospital sites. Hopefully the cavalry have arrived!

Psychiatric Liaison As you know the Trust has been working with successive commissioners for many years to address the issue of poor quality psychiatric liaison within York Hospital. This work has most recently been with LYPFT and VOYCCG on the establishment of a mental health liaison service into the Emergency Department and a formal pilot commenced in January. I am pleased to report that two months into the successful pilot we have received confirmation from the CCG that they will be commissioning this service for 2015/16. The Board is aware that we have been carrying the lack of this commissioned service on our corporate risk register for some time and it is pleasing that negotiations have come to a satisfactory conclusion and that this risk can now be moved to the treatment plan. This decision has been in no small part as a result of the brave decision taken by this Board to support the pilot non-recurrently as providers, in partnership with LYPFT, to help prove the case.

Joint Advisory Group (JAG) Accreditation I am pleased to report that I received the formal confirmation that the endoscopy unit in Scarborough has met all the requirements to be awarded JAG accreditation for 2015 and I would like to once again thank the whole team for all the hard work they put in to ensure this was the case. Earlier this month our unit in York was assessed and as anticipated the current (physical) unit received some criticism, particularly with regard to privacy and dignity and patient flow, issues we are very much aware of. However, the visiting team was keen to stress how impressed they were with the quality of service provided and noted that the team dynamics, at all levels, were extremely

good. As such they were recommending a deferred judgement, rather than a predicted fail for environmental reasons, and we will be working with them over the coming months to assure them of the commitment we have to developing appropriate facilities for the service.

CQC Inspection The preparation for the CQC inspection continues to gather pace having completed the second mock inspection earlier this month. The Directors are working closely with Directorate management teams to improve compliance in a number of areas and reinforce the message that we must treat the assessment as an opportunity rather than a threat. During the assessment it should be business as usual although I recognise that any form of scrutiny at a time when we are so busy can feel like an intrusion. All staff are being encouraged to be open and honest with the assessors and treat the feedback we get in the spirit that is intended. The communication with the CQC is building as we get closer and we are in the process of setting up focus groups and meetings with key individuals as requested and I would ask that if required to attend one or other of these sessions that you are as flexible with your time as possible. I know I don't have to ask! We will of course have the opportunity to brief you more fully at the Board meeting.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley Chief Executive**
Date	**February 2015**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Governance Review – Improving Corporate Accountability by Aligning Strategy, Structure and Assurance – Update

Action requested/recommendation

The Board of Directors is requested to consider and agree the progress made against the Project Plan for the review of the Trust's corporate governance structures and arrangements.

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).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

The project will support the Trust's readiness for the forthcoming CQC inspection.

Progress of report	This is a follow up from a previous Board of Directors report
Risk	Risks of not proceeding have been highlighted and reported.

Resource implications	Resources implication detailed in the report
Owner	Patrick Crowley, Chief Executive
Author	Helen Kemp-Taylor, Governance Review Project Lead
Date of paper	February 2015
Version number	Version 1

Board of Directors – 25 February 2015

Governance Review – Improving Corporate Accountability by Aligning Strategy, Structure and Assurance – Update

1. Introduction and background

The project was agreed and approved by the Board of Directors in August 2014.

It aims to connect and align a number of work streams including actions relating to the Integrated Business Plan; the Internal Audit Report "Strengthening Corporate Accountability through Staff Conduct and Competence" and guidance from the CQC on the "Fit and Proper Persons Test" requirement.

The aim of the project is to provide greater clarity of purpose and leadership, more purposeful transactions within the organisation and to remove any redundancy or duplicated effort at both an individual and collective level. It will provide stronger assurance to the Board and align the organisation's strategy against a clear and transparent structure.

The project plan, agreed by the Board of Directors (BoD), is kept under review by the Stakeholder and Steering Groups to ensure it remains appropriate, and relevant additional items will be considered for inclusion as the work progresses.

2. Progress

The agreed project plan is on target as set out below. Work streams 1 & 2 are almost complete. The Stakeholder Group has met on four occasions and has approved all outputs and outcomes to date together with setting out the next steps. The Steering Group has met on three occasions to date and provides a key link with the BoD.

Workstream 1 - Reporting Lines are Clear and Meetings are Purposeful

Agreement has been reached on the status conventions for Strategic, Corporate and Operational meetings and these definitions continue to be tested as work progresses. Terms of Reference for each meeting group are being reviewed and revised as necessary and consistent templates for agendas and exceptions to be reported have been developed.

Further work in respect of Operational and External meetings will be continued as Phase 2 of the project

The overarching Integrated Governance Structure which sets out clear reporting lines for the Trust's strategic and corporate meetings was presented to and approved by the BoD at its January meeting.

Workstream 2 - The Trust maximises the performance contribution from Directors and Senior Managers by setting out clear expectations of them.

Corporate Directors' portfolios have been reviewed and revised to reflect current leadership and professional responsibilities and accountabilities, and reflecting changes in

the BoD makeup. These were agreed by the Remuneration Committee on the 26th November.

Each Corporate Director now has an agreed organisational structure for their senior teams, and has identified those senior managers in their structure who has 'significant governance responsibility' and therefore should be subject to the 'Fit and Proper Person Test' (FPPT) .Training is to be provided for these managers and directors in February to introduce the Trust's approach to these requirements. Respective job descriptions and contracts of employment are being updated, and identified staff will be required to self assess their "fitness" and make a formal declaration accordingly as part of the appraisal process.

A visual illustration of individual directors portfolios, attendance at meetings and structures (including those senior managers eligible for the FPPT) is to be discussed at the BoD February workshop.

A matrix setting out the consistent application of titles to roles, responsibilities and accountabilities (including chairing corporate meetings) has been agreed and directors are making these changes within their structure.

Workstream 3 - Decisions are made expediently and are delegated to the lowest appropriate level to support effective operational performance.

Training and development for chairs of corporate meeting groups is being provided and identified as terms of reference for Strategic and Corporate meeting groups are being revised.

A process is being designed by the Foundation Trust Secretary to ensure that key regulatory and compliance issues are managed effectively and enshrined in policies as appropriate. The ongoing review of policy management will incorporate this work.

Workstream 4 – The Board of Directors receives meaningful assurance on the business of the organisation, and key issues are escalated appropriately.

The risk management policy and strategy has been revised and is to be presented to the BoD for approval in February.

The Corporate Governance Manual is being compiled as each action in this review is completed.

3. Next Steps

The Stakeholder Group will continue to meet on a monthly basis and will focus on the final stage of the project plan, which will be reviewed and agreed by the Steering Group before progress is reported to the Board in April.

Actions planned for completion before the end of March 2015 are as follows:

Workstream 1- Reporting Lines are Clear and Meetings are Purposeful

The Board of Directors is asked to consider its needs following the implementation of the revised meeting structure and delegations, with a view to rationalising the Board of Directors meeting agenda in view of the increased assurance this provides.

The Governance Reference Manual will continue to be developed as work is completed.

Workstream 2 - The Trust maximises the performance contribution from Directors and Senior Managers by setting out clear expectations of them.

Updated Job descriptions and terms and conditions of employment for all those senior managers identified as being subject to 'fitness testing' are required to be in place by June 2015.This will complete all agreed actions on this work stream.

Workstream 3- Decisions are made expediently and are delegated to the lowest appropriate level to support effective operational performance.

A review of delegations set out in regulatory documents – SOs, SFIs etc to be undertaken to ensure alignment with decision making delegated to agreed meetings and individuals / roles agreed in the revised structure.

Once the revised governance structure is in place it should allow a move to exception reporting to the BoD whereby only key corporate risks are reported. All other risks should be embedded and managed in the governance structure. Progress will be incremental to enable the effectiveness of both the revised governance structure and risk management policy and strategy to be tested.

Workstream 4– The Board of Directors receives meaningful assurance on the business of the organisation, and key issues are escalated appropriately.

Following structural changes as part of this review, there will be a high level review with the BoD to clarify what the assurance framework is for and how it is to be developed and used to focus discussion. This is expected to reflect performance management outcomes and routine performance reports, and a review of the sources of assurance for sufficiency (against the revised structure and accountabilities). Consideration is to be given as to whether an integrated performance and assurance framework is appropriate.

4. Recommendation

The Board of Directors is requested to consider and agree the progress made against the Project Plan for the review of the Trust's corporate governance structures and arrangements.

Author	Patrick Crowley, Chief Executive
Owner	Helen Kemp-Taylor, Governance Review Project Lead
Date	February 2015

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 February 2015

Gap Analysis – Implementation of the new Equality Information standards

Action requested/recommendation

The Board is requested to :

- Acknowledge the requirement for more detailed and meaningful data building on what we currently consistently capture
- Identify gaps in data capture and develop a plan to address this which will report progress through the Fairness Forum
- A dedicated lead development person from IT to work with the Fairness Forum to address the new ISB 1605 standard.
- Provide evidence through board reports where the use of data has informed planning and decision making.
- Ensure we work with partners to enhance our ability to demonstrate our compliance with our duty of care obligations (we are currently work with Vale of York CCG and Leeds York Partnership NHS Foundation Trust for shared EDS2 assessment with local organisations and representatives of the community)

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

This paper sets out areas where the Trust currently fails to meet its equality and inclusivity obligations. The whole focus of the paper is to highlight where as a Trust we could improve our awareness, planning and evidence of considering our obligations under the Equality Act 2010. New standards being introduced by NHS England will become operational during 2015, as a Trust we need to focus on how:

- we utilise data already in the system
- we develop systems and processes to address gaps in data
- we evidence how we have used data to inform decision making at

- we identify actions taken to mitigate risk of failure to comply

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Board of Directors
Risk	Risks are identified in the report
Resource implications	Resource implication detailed in the report
Owner	Sue Holden, Director of Workforce and OD
Author	Margaret Milburn, Equality and Diversity Facilitator
Date of paper	January 2015
Version number	Version 1

Board of Directors – 25 February 2015

Gap Analysis – Implementation of the new equality information standards

1. Introduction and background

The Equality Act 2010 requires us to have **due regard** to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a protected characteristic and persons who do not share it

As a public sector organisation we are required to publish information to demonstrate our compliance with the above at least annually and equality objectives (commencing 2012) at least every 4 years.

A new Accessible Information Standard (ISB1605) due to be published early 2015 will require health and social care organisations to identify and record the information and communication support needs of patients and service users (and where appropriate their carers or parents) where these needs relate to or are caused by a disability, impairment or sensory loss. The standard will also require organisations to take action to ensure that those needs are met.

To achieve compliance there needs to be a review of how we use current IT and administrative systems to enable consistent identification and recording of disabled patients', service users/ carers' and parents' information and communication support needs, and will require changes to processes in recording and responding to those needs.

In acting upon recorded information and communication support needs, organisations will be required to provide personal correspondence (such as appointment letters, text messaging, emailing) and patient information (such as leaflets) in alternative formats (such as Braille and 'easy read,' or via email) and communication support for appointments (such as British Sign Language interpreters). This has already been highlighted by 'Healthwatch' in reports which have been seen by the Board.

Finally, NHS England Equality and Diversity Council have agreed a **Workforce Race Equality Standard (WRES)** with a view to it being included in the NHS standard contract 15/16. There are nine metrics in total:

- three focus on workforce data
- five are based on data from national staff survey indicators (the focus on differences between the experience and treatment of white staff and BME staff in the NHS)
- Boards are broadly representative of the communities they serve.

2. Discussion

Many people assume that they understand the term **due regard** however there are specific principles established by case law which expand what we have a 'duty' to address. These

principles are outlined below:

- **Knowledge** – an approach and state of mind
- **Timeliness** – the duty must be complied with before and at the time that a particular policy is under consideration or decision is taken i.e. in the development of policy options and in making a final decision, the duty is not satisfied by justifying a decision after it has been take.
- **Real consideration** of the three aims of the duty must form an integral part of the decision making process and **not** a tick box exercise, it must be exercised in substance with rigour and an open mind in such a way that it influences the final decision
- **Sufficient information** the decision maker must consider what information s/he has and what further information may be needed in order to give proper consideration to the equality duty
- **No delegation** public bodies are responsible for ensuring that any third parties who exercise functions on their behalf are capable of complying with the equality duty and that they do so in practice.
- **Review** - we must have regard to the aims of the equality duty not only when a policy is developed and decided upon but also when it is implemented and reviewed. The equality duty is a continuing duty.

(Brown V's Secretary of State for Work and Pensions 2008)

Considerations

We are required to produce information to demonstrate our compliance with the equality duty which should fall in to two main categories:

- The production of information to show our compliance information to identify equality issues e.g. monitoring information about employees or service users, information about the effect of activities on people with different protected characteristics, any engagement
- information about steps taken to have due regard e.g. records of how we have had due regard in decision making, consideration of steps to mitigate adverse impacts

Three out of four of **our equality objectives** established in 2012 relate to collection and use of data:

- Improve data collection, analysis and monitoring for protected characteristics
- Further develop engagement and involvement of patients, carers, governors and staff to reflect local demographics
- Develop strong partnerships with social care and GP's to ensure patient pathways are free from barriers between providers for everyone

At the last Board you received a report which outlined our early actions in starting to demonstrate our compliance , however this paper failed to provide the depth of information which we will be required to evidence in relation to how we :

- use data which includes protected characteristics to inform our business planning and decision making
- evidence we have made decisions which have been specifically influenced by our knowledge of access issues for users and carers in our services

- develop processes where we regularly and systematically review our services through the lens of users with protected characteristics and identify where improvements could be made.

We are not starting form a zero base, as part of our access to services work a plan has been developed to look at how we start to build up from information we already have (knowing someone is Deaf or has a hearing impairment and requires an interpreter) to areas where we currently have no data (sexual orientation) and therefore assume a hetero-sexual relationship.

We must also be mindful that accuracy and completeness of data affects usefulness plus consistency of data from Census, CPD and ESR and other systems to enable meaningful analysis.

Working with others
We need to create closer working relationships with other partners GP's, local authority and charities to ensure we lead the way in developing consistency in how we record data, compatibility of systems and use it in our shared planning (JSNA). We will also start to build on our work in supporting staff that identify as LGBT to contribute to our understanding of how we make services more accessible and start to create a more open and inclusive culture via our LGBT staff network and corporate membership of York LGBT Forum.

Engagement
A significant and probably crucial shift is through developing our engagement strategy to ensure it is fully inclusive and minority groups see we are listening and acting on their experiences. By creating an active engagement we will be better placed to pre-empt situations where bias or discrimination is experienced and enhance relationships with our staff and service users.

If we use the CQC domains, how confident are we that a user who is Deaf or has a hearing impairment is receiving a safe (have they fully understood the implications of care), effective (have we managed to provide all needs in one visit by planning to have an interpreter present), caring (have we informed the service user where to meet an interpreter and alternative means of contact other than a telephone number, provided privacy for a consultation which may require a bigger room to accommodate a carer and interpreter), responsive and well led service (do we have a culture where leaders consider the needs of others' in advance).

3. Conclusion

It is essential that we plan to capture relevant and meaningful data to enable:

- effective monitoring of access to services, patient experience and outcomes
- a workforce that reflects the community we serve
- conscious, transparent and informed decisions

Quantitative and qualitative data will enable us to learn and develop into an organisation that is trusted to deliver the best care possible.

4. Recommendation

The board is requested to :

- Acknowledge the requirement for more detailed and meaningful data building on what we currently consistently capture
- Identify gaps in data capture and develop a plan to address this which will report progress through the Fairness Forum
- A dedicated lead development person from IT to work with the Fairness Forum to address the new ISB 1605 standard.
- Provide evidence through board reports where the use of data has informed planning and decision making.
- Ensure we work with partners to enhance our ability to demonstrate our compliance with our duty of care obligations (we are currently work with Vale of York CCG and Leeds York Partnership NHS Foundation Trust for shared EDS2 assessment with local organisations and representatives of the community)

5. References and further reading

The Essential Guide to the Public Sector Equality Duty – Equality and Human Rights Commission July 2014

Meeting the Equality Duty in Policy and Decision Making – Equality and Human Rights Commission October 2014

Workforce Race Equality Standard – the defined metrics – NHS England December 2014

http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/
ISB 1605 Accessible Information Main Submission Draft – NHS England August 2014
ISB 1605 Accessible Specification Draft
ISB 1605 Accessible Information Implementation Plan Draft

NHS Equality Delivery System (EDS)

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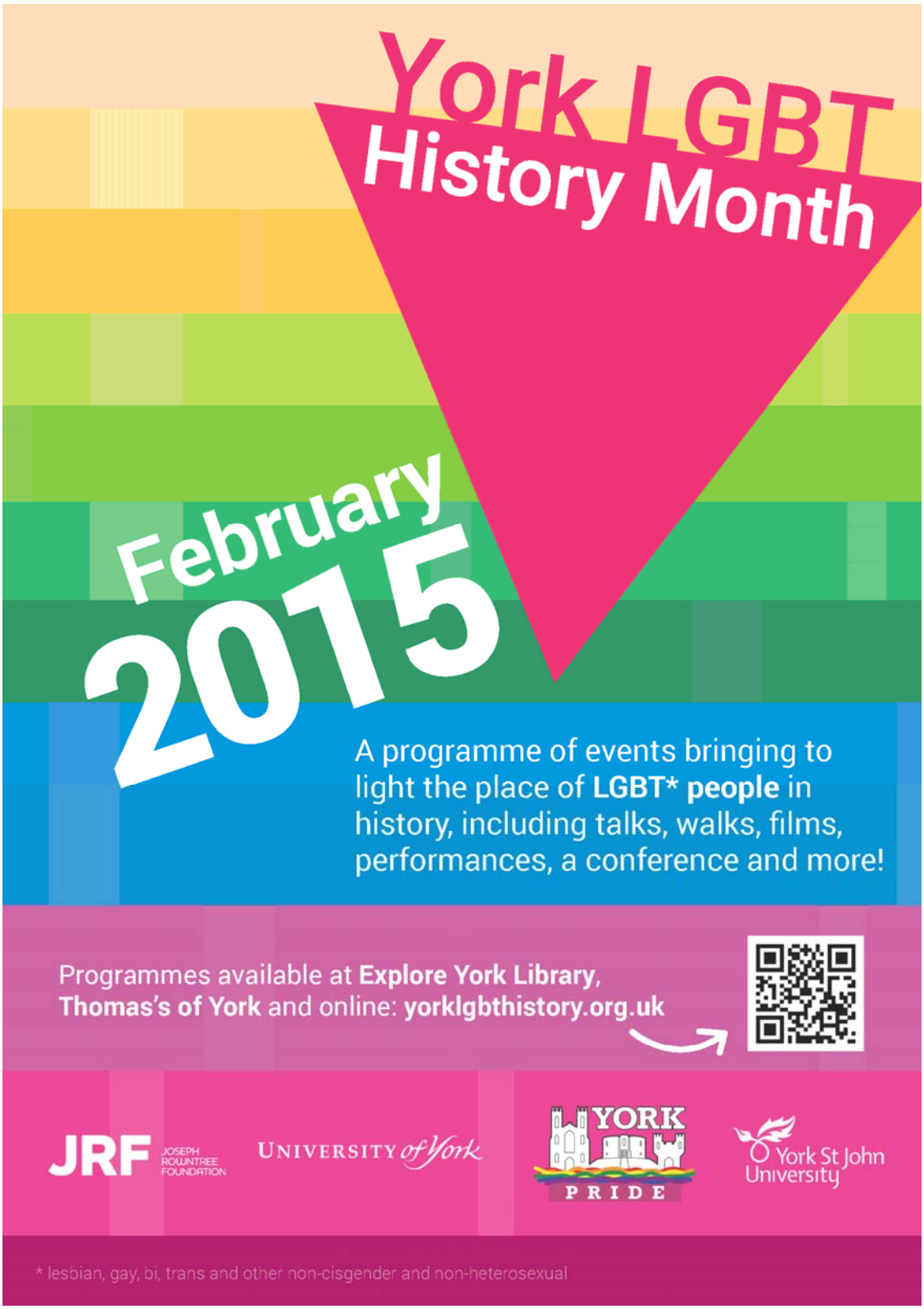
Date	**January 2015**


York LGBT History Month
February 2015
A programme of events bringing to light the place of LGBT* people in history, including talks, walks, films, performances, a conference and more!
Programmes available at Explore York Library, Thomas's of York and online: yorklgbthistory.org.uk
JRF JOSEPH ROWNTREE FOUNDATION
UNIVERSITY of York
YORK PRIDE
York St John University
* lesbian, gay, bi, trans and other non-cisgender and non-heterosexual

NHS England

Workforce Race Equality Standard

- the defined metrics

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- the defined metrics

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The NHS Workforce Race Equality Standard

Introduction

The Equality and Diversity Council EDC have agreed that a Workforce Race Equality Standard (WRES) be consulted on, with a view to it being included in the NHS standard contract 15/16. Over the last three months extensive consultation has taken place with key stakeholders regarding the WRES. We are pleased to say the WRES has been warmly welcomed as a positive step forward to deliver our responsibilities under the equalities agenda. The Standard forms the first stage in a process of addressing workforce equality issues.

The WRES will, for the first time, require organisations employing almost all of the 1.4 million NHS workforce to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) Board representation. All providers, as holders of the NHS Standard Contract 15/16, except 'small providers' will be expected to implement the WRES from April 2015. An annual report will be required to be submitted to the Co-ordinating Commissioner outlining progress on the Standard.

The metrics

There are nine metrics .Three of the metrics are specifically on workforce data and five of the metrics are based on data from the national staff survey indicators. The latter will highlight any differences between the experience and treatment of white staff, and BME staff in the NHS with a view to close those metrics. The final metric requires provider organisations to ensure that their Boards are broadly representative of the communities they serve.

The following table outlines the proposed metrics. Further detailed guidance will be issued early 2015.

Workforce Race Equality Standard November 2014 for implementation from April 2015

	Workforce Race Equality indicators
	Workforce metrics For each of these three workforce indicators, the Standard compares the metrics for white and BME staff.
1.	Percentage of BME staff in Bands 8-9 and VSM compared with the percentage of BME staff in the overall workforce
2.	Relative likelihood of BME staff being recruited from shortlisting compared to that of white staff being recruited from shortlisting across all posts
3.	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note. This indicator will be based on data from a two year rolling average of the current year and the previous year.
	National NHS Staff Survey findings. For each of these five staff survey indicators, the Standard compares the metrics for each survey question response for white and BME staff. For 4. below, the metric is in two parts
4.	**Q 3**. In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review? If so e) Were any training, learning or development needs identified? f) Did your manager support you to receive this training learning and development?
5.	**KF 18**. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	**KF 19**. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	**KF 27**. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	**Q 23**. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Boards. **Does the Board meet the requirement on Board membership in 9.**
9.	Boards are expected to be broadly representative of the population they serve.