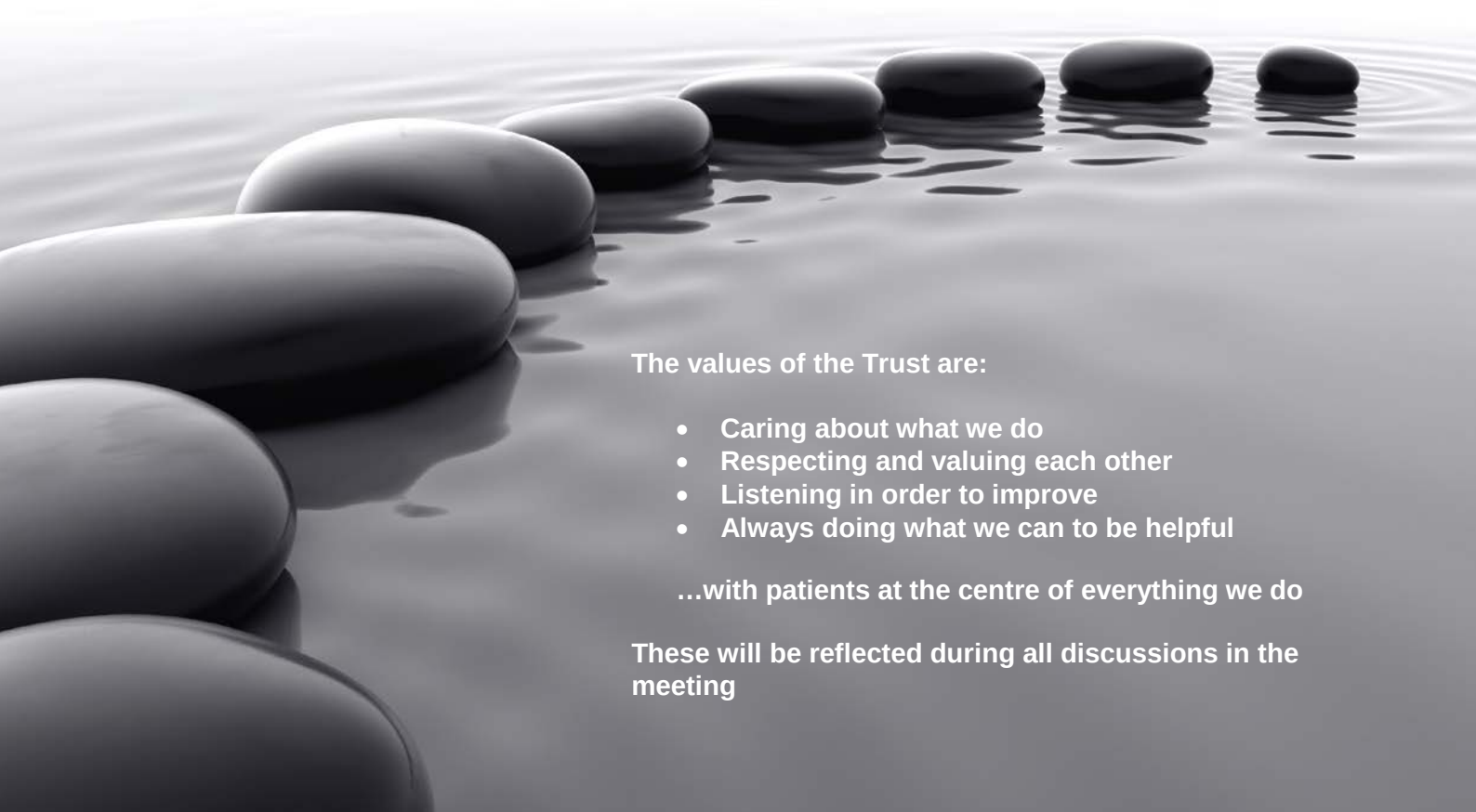
York Teaching Hospital NHS
NHS Foundation Trust

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

on: **Wednesday 25 May 2016**

in: **The Boardroom, 2nd Floor Admin Block, York Hospital, Wigginton Road, York, YO31 8HE**

Time	Meeting	Location	Attendees
8.15am – 8.55am	Non-Executive Director Meeting with Chair	Booth 5, Ellerby's Restaurant	Non-executive Directors
9.00am – 10.30am	Year End Board of Directors	Boardroom, York Hospital	Board of Directors
10.45am	Board Photograph		
11.00am – 12.30pm	Board of Directors to consider confidential information held in private	Boardroom, York Hospital	Board of Directors
12.30pm – 1.30pm	Lunch – Ellerby's Restaurant		
1.30pm – 4.30pm	**Board of Directors meeting held in public**	**Boardroom, York Hospital**	**Board of Directors and observers**



The values 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**

…with patients at the centre of everything we do

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 25 May 2016**

At: **1.30pm – 4.30pm**

In: **Boardroom, York Hospital**

A G E N D A					
No	**Time**	**Item**	**Lead**	**Paper**	**Page**
Part One: General					
1.	1.30 – 1.40	**Welcome from the Chairman** The Chair will welcome observers to the Board meeting.	Chair		
2.		**Apologies for Absence and Quorum** • Michael Proctor	Chair		
3.		**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chair	A	7
4.		**Minutes of the Board of Directors meeting held on 27 April 2016** To review and approve the minutes of the meeting held on 27 April 2016.	Chair	B	11
5.		**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chair		

No	Time	Item	Lead	Paper	Page
Our quality and safety ambition: our patients must trust us to deliver safe and effective healthcare					
6.	1.40-2.10	**Patient Story** Two stories will be heard by the Board: **1** Ward 37 patient led supported by Beverley Geary **2** Organ donation presentation supported by Mike Keaney	 Jamie Todd (Directorate Manager) Lee Fry (Matron) Sarah Jane Plant (Specialist Nurse Organ Donation) John Berridge (Clinical Lead Organ Donation)	Verbal	
7.	2.10 - 2.35	**Chief Executive Report** To receive an update on matters relating to general management in the Trust.	Chief Executive	C	27
8.	2.35 - 3.05	**Quality and Safety Performance issues** To be advised by the Chair of the Committee of any specific issues to be discussed. • Patient Safety and Quality Report • Medical Director Report • Medical staffing issues • Chief Nurse Report • Safer Staffing • Quarterly Falls Report • Quarterly Pressure Ulcer Report	Chair of the Committee	D D1 D2 Verbal D3 D4 D5 D6	33 43 77 101 127 137 151
9.		**Trust Complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulation 2009** To receive and approve the report.	Chief Nurse	E	159

No	Time	Item	Lead	Paper	Page
10.	3.05-3.20	**Out of Hospital Care Strategy** To receive for approval the Out of Hospital Care Strategy.	Out of Hospital Services Director	F	167
10 minute break					
Our people and capabilities ambition: the quality of our services is wholly dependent on our teams of staff					
11.	3.20-3.55	**Workforce Strategy Committee** To receive the draft minutes from the Workforce Strategy Committee meeting held on 18 May including revised terms of reference.	Chair of the Committee	G	203
12.		**Workforce Report** To receive an update on workforce issues.	Chief Executive	H	221
13.		**Workforce and Organisational Development Strategy** To receive for approval the Workforce and Organisational Development Strategy.	Chief Executive	I	233
14.		**The Golden Thread** To receive a paper on the approach the Trust takes to the day to day activities related to our strategic ambitions.	Chair	J	247
Our finance and performance ambition: our sustainable future depends on providing the highest standards of care within our resources					
15.	3.55-4.15	**Finance and Performance issues** To be advised by the Chair of the Committee of any specific issues to be discussed. • Operational Performance Report • Finance Report	Chair of the Committee	K K1 K2	261 273 283

No	Time	Item	Lead	Paper	Page
		• Trust Efficiency Report • Reference cost process		K3 K4	299 305
16.	4.15-4.20	**Minutes from the Corporate Risk Committee** To receive the draft minutes from the meeting.	Chair of the Committee	L	339
17.		**Monitor Self Certification** To approve the self certification covering condition G6 of the licence.	Foundation Trust Secretary	M	347
Any other business					
18.	4.20-4.30	**Any other business** - Property update led by Director of Estates and Facilities To consider any other matters of business.			
19.		**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 29 June 2016 held at St Catherine's Hospice, Scarborough The Board meeting in July will be held in Bridlington, the location of the August Board meeting is to be confirmed and September Board will be held in Scarborough as previously advertised.			

Items for decision in the private meeting:

There are no specific decisions to be taken in the private meeting

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 Chair 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 having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960.

Register of directors' interests
May 2016

York Teaching Hospital NHS
NHS Foundation Trust

Additions: No Change

Changes: No changes

Deletions: No changes

A

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS founda-
Ms Susan Symington (Chair)	**Non-executive Director—**Beverley Building Society **Director** - Lodge Cottages Ltd	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	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 **Member of the Board of Directors—**William Temple Academy 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** —Leeds City College **Chairman and Director -** Leeds College of Music **Member—**The University of Leeds Court	Nil
Michael Keaney (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
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	**Chair—Charitable Trustee** **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

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 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
Juliet Walters (Chief Operating Of-ficer)	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)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr James Taylor Medical Director	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Boardroom York Hospital on 27 April 2016

Present: **Non-executive Directors:**

Ms S Symington	Chair
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 A Bertram	Director of Finance
Mrs B Geary	Chief Nurse
Mr M Proctor	Deputy Chief Executive
Mr J Taylor	Medical Director
Mrs J Walters	Chief Operating Officer

Corporate Directors:

Mr B Golding	Director of Estates and Facilities
Mrs W Scott	Director of Out of Hospital Care
Mrs S Rushbrook	Director of Systems and Networks

In Attendance:

Mrs A Pridmore	Foundation Trust Secretary

Observers:

Mrs A Bolland	Public Governor – Selby
Mrs M Jackson	Public Governor – York
Mrs L Pratt	Healthwatch – York
Mrs L Brown	Member of staff (Head of Communications)
Miss P McMeekin	Member of staff (Deputy Director of Workforce)
Mr N Wilson	Member of staff (Deputy Director of Strategy)
Mr M Hindmarsh	Member of staff (Head of Operational Strategy)

The Chair welcomed the Governors, members of staff and members of the public to the meeting.

16/051 Apologies for absence

Apologies were received from Mr P Crowley, Chief Executive. Ms Symington asked Mrs Pridmore to confirm that the meeting was quorate. Mrs Pridmore confirmed that the meeting was quorate.

16/052 Declarations of interest

The Board noted the declarations of interest.

16/053 Minutes of the meeting held on the 30 March 2016

It was proposed and accepted by the Board that an amendment should be made to the following paragraph.

Mrs Walters added that 112 beds had been closed during February in Scarborough. She provided assurance to the Board that everything possible was being done to address the outbreak. She added that it had been shown that no practices adopted by the site had resulted in a spread of the infection.

It was agreed the amended paragraph should read

Mrs Walters added that 112 beds had been closed during February in Scarborough. She provided assurance to the Board that everything possible had been done to address the outbreak. She added that at **the time of reporting** it had been shown that no practices adopted by the site had resulted in a spread of the infection

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

16/054 Matters arising from the minutes

16/041 Quality and Safety Committee – The Board was advised that an external review had been undertaken following the outbreak of Norovirus in Scarborough. It was noted that the report was not available at present, but it was anticipated that it would be reviewed by the next Quality and Safety Committee in May.

Action: To review the report at the Quality and Safety Committee.

16/055 Patient Story

Mrs Walters introduced the patient story and played a radio interview with a patient who had been treated at Scarborough hospital. The Board listened to the interview. In summary the patient had waited seven hours in the emergency department for a blood test. Mrs Walters explained that nothing the Trust could say would reduce or change the upsetting experience of the patient.

She added that the description of events given in the interview reflected the pressures we know to exist in our emergency departments. Incidents of this type illustrate that a conventional ED model of care is no longer appropriate in Scarborough. Mrs Walters explained that to deliver an effective and sustainable emergency care service the Trust needed to change how it worked. Mrs Walters advised that the Trust was now involved with the national programme for acute medical model test. She felt that the introduction of a new model of care using the support of the national programme will improve the experience of our service users. By changing the workforce and medical model and having the right IT systems providing the right information, Scarborough would be able to provide a safe sustainable and high quality emergency care service.

Mr Proctor agreed that this patient story was extremely disappointing.. He asked if the results of the blood test would have been acted on straight away, his point being that if the patient was not going to receive treatment when the results were known, was it right for the patient to be asked to attend the Emergency Department so urgently. Mrs Adams commented that 650 patients had waited over eight hours for treatment in the last month and that did not represent a department serving the patients well.

The Board had a robust discussion about the challenges in the Emergency Department and Mrs Adams was keen to ensure that the Executive Directors did not under estimate the sometimes disappointing experience of patients in the emergency department, particularly in Scarborough.

It was agreed that the intention was to reorganise the department so that it provided the best possible services for patients.

Ms Symington added that Mr Golding had planned a Board visit to the Emergency Department in Scarborough in April, but as the Board meeting had been moved to York due the industrial action this visit will now take place in June.

Mr Ashton asked if Northern Doctors would be part of the provision of the future service and success of the department. Mrs Walters confirmed that they were part of the solution.

Mrs Rushbrook added that the Board should note that the number of patients in the waiting area in Scarborough was split between the emergency department and the urgent care centre, which made the area feel busier than it would if it was just the emergency department.

The Board understood and were saddened by the number of patients who have had to wait for a long time in the Emergency Department. The Board was encouraged by the comments from Mr Proctor and Mrs Walters about the new models of care and looked forward to hearing about a sustainable and high quality service being delivered in Scarborough under a new model.

It was agreed that the Board would focus again on this in May.

16/056 Report from the Chief Executive

Junior doctor's strike - Mr Proctor talked about the junior doctor's strike. The strike had been held on the day before and the day of the Board meeting. Mr Proctor advised that the hospital sites had continued to perform well. Patients had been treated quickly and safely in the Emergency Departments. Attendance had been down at York and in Scarborough attendance had been at about normal levels for the first day of the strike. Both hospitals had had sufficient bed availability and the consultants had provided a good service for patients. Approaching 1000 patients had had their outpatient appointment or operations cancelled, which had created both minor and major inconvenience for patients.

Mr Taylor advised he had undertaken an informal safety walk round the hospital in York. He confirmed that the hospital was running well and safely and there had been sufficient clinical cover.

Ms Raper was appreciative of the assurance and asked how the Trust would continue the discussions with junior doctors. Mr Taylor explained that in the medium term the Trust would continue to engage with the junior doctors through the current systems. The process for the appointment of the guardian role had started; the job had been advertised recently and applications would close on 1 May. Mr Taylor explained that the relationships the Trust had with the junior doctors' changed all the time because of the rotations. Only a few junior doctors of the current cohort would be with the Trust in the autumn when the new contract was introduced. Currently the Trust was reviewing the detail and the complexity of the new contract.

Mr Proctor asked the Board to join him in thanking the consultants and non-training doctors, along with all the support staff, for their hard work and commitment during the strike.

Bootham Park Hospital - Mr Proctor advised that a report on the closure of Bootham Park Hospital was about to be published. He advised that the independent report did level some criticism at a number of organisations, but our Trust was not criticised.

Well Led – Performance report – Mr Proctor referred to the performance report and advised that it had been agreed to undertake a review of the information included in the report. He explained how the review of the performance report linked to the Well Led Review and asked board members to let Mrs Rushbrook have any comments or suggestions of items that might be included in the next stage of development of the report. He suggested that the revised report in pilot form would be available for the Board to review in June.

Mr Proctor commented on the inclusion of the Board Assurance Framework at a Glance in the Board pack. He explained that the document represented the risks to the ambitions of the Trust included in the Trust's 'Our Commitment to You' document. Ms Symington added that the purpose of including the document in the Board pack was to ensure that the Board focused on the strategic direction and risks to the organisation. She advised that the Board would look at the document again at the end of the meeting.

Strategic away day – Mrs Walters summarised the day. She advised that the purpose of the event had been to help directorates to start to develop their clinical strategies in line with the mission, values and revised ambitions statements of the Trust, taking into account the national and regional context. The Executive Directors had shared the revised 'Our Commitment to You' with the delegates at the event. Mrs Walters advised that the day had been very positive and a good start to the development of the strategies. She advised that the next stage would be for the Directorates to present their strategies to the Executive Directors in October 2016.

Mrs Walters commented that she was impressed at the Directorates' desire to engage with stakeholders and work in partnership.

Mrs Scott added that the Directorates, as part of the planning process were assessing the opportunities to deliver more services 'out of hospital' in community settings. She reflected on the change of language that she had witnessed at the strategy time out session in that Directorates were much more aware of the importance of working in partnership with other agencies and delivering care closer to home.

Mr Taylor added that he felt it had been an excellent event that provided an opportunity for senior staff to talk to each other. Ms Symington commented that she was impressed with the quality the contributions and added that she had found the event inspiring.

The Board noted the comments from Mr Proctor.

16/057 Communications Strategy update

Mrs Brown was welcomed to the meeting by Ms Symington. Mrs Brown reminded the Board that she had brought the communications strategy to the Board six months ago and she was presenting a six month update to the Board. She updated the Board on progress on the completion the action plan associated with the communications strategy approved in September 2015. Mrs Brown highlighted areas where work had progressed well, including the completion of media training for all directors, and the areas where progress had been slower than anticipated, including the use of team brief and the development of the intranet. Mrs Brown assured the Board that the action plan would be revised on the 12 month anniversary of the strategy.

Mrs Brown commented on the staff engagement work and advised that there had been a survey on the communication channels used in the organisation. She advised that the feedback from the survey had mainly been very positive. One of the key findings was that not all staff felt they understood what was going on in the organisation. Mrs Brown advised that currently she was discussing various options with Mr Crowley to improve the team briefing exercise.

Mr Golding was supportive of the survey and review. He explained that it affected his team as they were a quite scattered group of staff.

Mrs Brown commented on the stakeholder engagement in relation to the STP. She explained that it had been agreed that a single communications forum would be developed as a sub group of the System Leaders Board. This should help to create a more comprehensive approach to communications across a number of organisations. Ms Symington asked if there would be some new resource identified to support that work. Mrs Brown advised that she was not sure if additional resources would be available.

Ms Raper commented that the development of this group should provide better alignment with staff communications. She advised she had been at a seminar with Wrightington, Wigan and Leigh Trust, who had streamlined some of their systems around issues of safety, specifically serious incidents. Mrs Brown agreed that there were lots of different approaches that Trusts could take.

Mrs Adams commented on the communication links between the Trust, patients and the general public. She asked if the new group would provide a forum for consistent messages. Mrs Brown confirmed that it was one of the objectives of the group.

Professor Willcocks commented on the challenge of working across professional areas and felt a collaborative environment would be beneficial to the organisation.

Mr Sweet asked about the uptake of the team brief produced on video. Mrs Brown explained that it varied from area to area. She explained that on average there was about a 10% uptake. Mr Bertram added that some managers used the video as the basis of the team brief.

Ms Symington added that in her experience effective, disciplined team briefing was central to clear communications with staff at all levels and that every member of staff should be briefed by their team leader.

Referring to the next steps, Mrs Brown outlined the priority areas for the next six months including partnership working, stakeholder analysis and branding/visual identity.

Ms Symington thanked Mrs Brown for her presentation and invited her to attend the Board in six months to present a further update.

Action: Mrs Brown to present a further update on the strategy at the November Board meeting.

16/058 Quality and Safety Committee

Mrs Adams introduced the report from the Quality and Safety Committee. She advised that this month the Committee had welcomed Donald Richardson and Diane Palmer to the Committee due to the absence of the Medical Director, Mr Jim Taylor.

Mrs Adams highlighted that the Committee had agreed upon the quality priorities to be included in the Quality Report for the coming year. There had been debate around how to maintain focus consistently on the things that really matter from a patient point of view. Maintaining focus would give the best chance of seeing continuous improvement. This month the Committee reaffirmed its commitment keeping End of Life care firmly on the quality agenda.

Corporate Risk Register - Referring to the Corporate Risk Register, the Committee was very pleased to see that that the lack of mental health liaison services for children and adolescents had been escalated onto the Chief Nurse's corporate risk register. Mrs Adams explained that the Trust was seeing an increase number of cases of self harm amongst teenagers and that there had been attempted suicides on Trust premises. Putting this on the CRR was the first step in mitigating this risk and the Committee will be checking each month on progress towards finding a solution to this issue with our partners.

Nurse Staffing - Mrs Adams advised that as part of the safety agenda this month, the Committee discussed nurse staffing, specifically around the how the Trust was striving to make the very best use of the workforce that was already in place. Mrs Geary talked about Lord Carter's expectations around the utilisation of workforce and explained that the Trust had struggled to achieve the KPIs associated with e-rostering. She advised that a senior nurse, Mrs Becky Hoskins, working in conjunction with HR, had been asked to focus on a detailed piece of work around e-rostering to ensure that the Trust was using rosters in the most efficient and effective way. At present Mrs Hoskins was undertaking a assessment of the process and had written a project plan that would be agreed by Executive Board. Professor Willcocks asked if Mrs Hoskins had identified some measure to see the impact of the new system. Mrs Geary confirmed she had.

Mrs Adams added that the joined up thinking and working between HR, their systems and ward level intelligence was important and she hoped that it would result in getting better levels of care from the same number of staff.

Acuity and Dependency audit - Mrs Geary referred to the acuity and dependency audit. She explained that in the past it had used evidence based tools such as the safer nursing care tool. Lord Carter, as part of his recommendations, had proposed the introduction of 'care hours per patient per day'. Mrs Geary advised that she had very recently received a letter that informed the Trust that it was required to collect the data around 'care hours per patient per day' and report retrospectively from 1 May. She advised that further guidance should be received by the Trust in the near future. Mrs Rushbrook added that she was not sure that the measure was the most appropriate tool to use and suggested that the measure should be viewed with some caution as it did not necessarily address the acuity of patients. Mrs Geary advised that that the information was required to be uploaded on 15 June.

Agency costs - Mrs Adams asked if the Executive Directors could give the Board an update on the developing situation around the implementation of the agency cap and the tightening of restrictions on off framework agencies. Mrs Adams wanted to view the Trust's performance in the context of what is happening across the region.

Professor Willcocks added that the Deputy Director of HR, Miss Polly McMeakin, had received intelligence from other organisations about some "game playing" in relation to the agency cap. Mr Bertram advised that he, Mrs Geary and Mrs Walters had recently met and it had been agreed that Mr Bertram would be the lead director responsible for the agency spend, with day to day management of medical staff the responsibility of Mrs Walters, Mr Taylor and Miss McMeakin. For nursing staff the responsibility would lie with Mrs Geary and the Chief Nurse team. Mr Bertram added that he would develop a report for the Board to keep track of agency spend. Mr Bertram advised that this year the cap on agency spend was £17.2m.

Junior doctors - Mrs Adams added that the Committee had had a discussion around the safety risks within the medical workforce. The Committee continued to discuss the current vacancy levels in some of our key specialties but she thought it would be useful for the Board to hear from Mr Taylor about the new agency rules and the potential drying up of the junior doctor pipeline in the region.

Mr Taylor talked about appointment of junior doctors. He explained that it was possible that the recent strike could have a significant (negative) impact on recruitment. He advised that currently not all junior doctor posts were filled. Mr Taylor outlined the process for the appointment of junior doctors He explained that the candidates were interviewed and ranked by the Deanery; this ranking affected the choice of junior doctors available to the Trust. The junior doctor's preference was to be trained in big centres rather than in local hospitals which impacted on York and Scarborough. Mr Taylor advised that he had not seen the number of junior doctors coming through this year as yet. He added that some junior doctors were opting out of the system and were applying to work abroad.

It was agreed that the Quality and Safety Committee would continue to scrutinise junior doctor recruitment from a quality and safety perspective and the Workforce and Organisational Development Committee would review from a recruitment and retention perspective.

Infection Control – Mrs Adams advised that the Committee had reviewed the quarterly Director of Infection Prevention and Control (DIPC) Report and that the report included a full year of performance around infection control. She highlighted that in the last couple of

months there had been a couple of specific issues that had arisen, for example the Norovirus outbreak in Scarborough. Mrs Adams asked Mrs Geary to comment.

Mrs Geary advised that there were three areas she wished to cover, the norovirus outbreak, wound infection issues and the number of MRSA and MSSA cases seen in the Trust this year.

MRSA/ MSSA/ C-Diff cases - Mrs Geary advised that there had been 8 MRSA cases during the year, which made the Trust a regional outlier. She assured the Board that the Trust had learnt from the incidents actions had been identified and were being implemented.

Mrs Geary advised that there had been 34 MSSA cases during the year, which was a significant improvement on previous years and the Trust was now close to the national mean.

With regard to C-Diff, Mrs Geary advised the Trust had seen 65 cases of C-Diff during the year, of which 17 were not due to lapses in care, leaving a balance of 48 cases which was the Trust's trajectory for the year. There a still a number of outstanding PIRs so therefore this number could reduce further.

Norovirus – Mrs Geary advised that 16 wards were closed during quarter 4 as a consequence of the outbreak. Currently there were 4 wards in York, 9 in Scarborough, 4 in Bridlington and 1 in the community rehabilitation facility closed due to Norovirus. The CCG was undertaking a 'look back' exercise, the result of which would be discussed at the Quality and Safety Committee.

Mrs Geary advised that the new governance arrangements for the Infection Control Committee were working well and were developing a positive environment.

Incident Reporting – Mrs Adams referred the Board to the incident reporting section of the Committee's discussions. She advised that the Committee had noted a significant increase in the number of serious incidents in the last 2 months. The Committee had understood that around half of the clinical serious incidents (not including the pressure ulcers and fall) were due to 12 hour ED trolley waits. The committee also noted the unprecedented number of 8 hour ED waits, long ambulance waits and the high crude mortality rates. The concern at Quality & Safety Committee was around keeping patients safe in these conditions.

Mr Taylor commented that a review of all deaths in the Emergency Department had been undertaken and there had been no failures in care identified for patients on either the York or Scarborough sites. The 12 hour trolley waits were on both sites, but the majority were seen in Scarborough. This was as a result of patient flow being compromised by the level of the Norovirus outbreak, along with other capacity and environmental issues in the Emergency Department. Mr Taylor added that the Trust declared the 12 hour trolley waits as a serious incident cluster and currently work was underway to agree a joint investigation with other stakeholders.

Mrs Adams commented that she was uncomfortable that the Trust clustered a number of the 12 hour waits together under 1 serious incident. She asked if the Trust had a duty of candour to apologise to each individual patient that had to wait this long. Mr Taylor explained that the Trust did apologise to every patient that had not received the level of

service they should expect, but it is not part of the duty of candour. The serious incident process requires the Trust to apologise to a patient.

Mrs Adams advised that the Committee would like to officially report a Never Event to the Board, a case of wrong site surgery. Mrs Adams asked Mr Taylor to provide some further detail.

Mr Taylor advised that the event had occurred in dermatology and related the removal of a lesion. The patient had two moles and the wrong mole was removed. The patient has since had the correct mole removed. The incident resulted in low level of harm and an investigation was being undertaken. New systems had been put in place to prevent the situation arising again.

Maternity - Mrs Adams referred to the maternity item discussed at the Committee. She advised that the Committee was pleased to hear about the work of Mrs Kim Hinton, the Directorate Manager, to transfer the learning from the review of the Scarborough Maternity Unit clinical governance to the York site. She explained that it very much tied in with the theme of incident reporting and learning cultures.

Nevermore - Mrs Adams referred to the 'Nevermore' publication and advised that there had been some considerable offline exchanges around the news that production of 'Nevermore' has been put on hold. The committee felt that this was a backward step and she hoped that a way of reinstating it without incurring additional cost could be found. Mr Taylor advised that publication of 'Nevermore' had resumed and information for the next addition was being collected. The next publication of 'Nevermore' would be after the Patient Safety Conference in June.

Mr Taylor invited all Board members and Governors to attend the Patient Safety Conference that would be taking place on 21st June at York University.

Mrs Adams referred to the patient experience items included in the agenda of the Committee, including the patient experience quarterly report. She highlighted the excellent work taking place under Mrs Hester Rowell in terms of the PALS service, volunteers, complaints handling and use of the Friends and Family test. She added that the two reports the Committee selected to talk about were the Annual Adult Safeguarding Report and the End of Life care piece.

Mrs Geary advised that it had been a busy year with an increase in referrals in deprivation of liberty (DOLs) issues as related to the 'Cheshire West' ruling. The DOLs procedures were now more embedded in the organisation and more training had been undertaken. Mrs Geary advised that Adults and Child safeguarding had now been integrated into one team. She reminded the Board that 'prevent training' had been included on the Corporate Risk Register for some time, but had now been able to be removed as the training was fully in place. Mrs Geary was keen to celebrate the success of the Team.

The Board noted the good work that had been undertaken over the last 12 months.

Ms Raper commented that she was the Board nominated safeguard link and she would like to endorse the comments made by Mrs Geary.

End of Life Care – Mrs Adams referred to the report. She explained that the Committee had decided to include two reports here. One was a reissue of the Trust's internal annual report into End of Life care that was tabled late at last month's Board. The other was a summary report from Mrs Kath Sartain explaining how the Trust had performed in the most recent care of the dying national audit, a benchmarking exercise across about 12 key standards of care.

Mrs Geary advised that the audit had been undertaken in 2015 and involved 142 Trusts. At each Trust 80 patients were included in the audit and asked to complete a questionnaire that reflected the 8 priorities. The results of the audit showed that the Trust had improved significantly and achieved 5 of the 8 priorities. An action plan had been devised and the service was confident that it was either currently delivering all eight standards or would be in the near future.

Professor Willcocks added that there were elements of practice within the Trust that had received national attention, including the last days of life plan and the 7 day service. In terms of education, Professor Willcocks felt there was a need to push on clinical education research and engage patients more, so that the service could be improved further. In terms of IT, Professor Willcocks felt there was more that could be done to help support the staff and that resolving the mortuary issues at Scarborough would also benefit the patients and their families.

The Chair thanked Mrs Adams for her report.

16/059 Finance and Performance Committee

Mr Keaney advised that his report to the Board this month would concentrate on updating the Board on the actions going forward.

He summarised the financial year end position as follows:

- The level of spend on agency staff for the year was £24m. For 2016/17 the Trust has (in common with other organisations) a cap imposed on the level of spending on agency staff it can make. The cap is £17.2m.
- The deficit for the 2015/16 year was £11.8m. For the financial year 2016/17 the Trust has agreed to a control total surplus of £10m.

From a performance perspective, Mr Keaney summarised the challenges that exist at the end of the year as follows:

- The Trust had failed the Emergency Care Standards target for 23 consecutive months. For March 2016 the achievement of the Emergency Care Standard 95% 4-hour wait target was 84.3%**.** There were 2300 breaches across the Trust during the last quarter.
- The Trust had fines of £450,000 for March and £3m for the year levied by the CCG.

Mr Keaney asked Mrs Walters to give a presentation outlining the recovery plan for the Acute and Emergency Care. Mr Keaney advised that Mrs Walters had presented this at the Finance and Performance Committee.

Mrs Walters outlined the challenge for the Trust and explained the national context of the challenges and where the Trust sits in relation to the challenges. Mrs Walters outlined the particular challenges in the different sites (Scarborough and York) and explained how there were a number of interconnecting improvements that were being put in place that would support recovery of acute and emergency care.

Mrs Walters detailed the processes in the Emergency Department that would be adopted and went on to outline how patient flow could be improved. Mrs Walters outlined how improvements in discharge processes could also support recovery, along with system wide working and improving workforce models.

Mrs Walters outlined the overarching aims of the recovery plan and the improvement trajectory for 2016/17 along with the risks that existed.

The Board noted the presentation and the plan for 2016/17. Mrs Adams commented that the aggregate performance of 84.3% for the Emergency Care Standard potentially hid the position at Scarborough during the month, where performance dropped to between 55-60%. She added that she felt the scale of the problem at Scarborough was different to that at York.

Mrs Rushbrook explained that Scarborough Emergency Department only treated type 1 patients. (Type 1 A&E department is defined as a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients). The performance system required the Trust to look at type 1 and type 3 patients together. (Type 3 A&E department is defined as primarily designed for the receiving of accident and emergency patients. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community. A defining characteristic of a service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment). One of the challenges at Scarborough is that, as it only deals with type 1 patients in the Emergency Department, the number of patients that are admitted looks high and making the Trust appears to be an outlier. If the Trust aggregated the type 1 and type 3 patients the activity improved.

Mrs Walters added that the emphasis on Scarborough was part of the acute medical programme. Mrs Adams added that she was very clear on her understanding of the model village concept, but Scarborough did not have enough specialist physicians to provide the service. She acknowledged there were some very well trained Advanced Clinical Practitioners (ACP), but not qualified clinicians. Mrs Walters explained that the current work was looking at Scarborough differently in terms of how emergency care services could be delivered, which was why there was significant work being undertaken to identify a new model of care. Mrs Walters added that the development of the model was being clinically devised and managed by asking specialists to work with the Emergency Department so that patients were reviewed by the most appropriate specialist. She reminded the Board that a geriatrician was already part of the Emergency Department team.

Professor Willcocks asked about the implications for the Elderly Directorate in providing support to the Emergency Department. She noted that the Elderly Directorate were one of the least cost effective directorates Professor Willcocks asked if there was an analysis on what the elderly department was doing in relation to ED. Mrs Walters explained that the

Elderly Department was keen to support the Emergency Department and this was discussed at the Clinical Strategy away day recently held.

Mr Keaney thanked Mrs Walters and asked Mr Bertram to comment on the financial outcome of the year, the expectations for the new financial year and the associated risks, the uncertainty around the targets, caps and contract issues.

Mr Bertram referred the Board to his finance report and outlined the year end position. He explained the impairments included in the calculation. Mr Bertram added that the year end predicted position was an £11.2m deficit; he believed that an out turn of £11.8m, whilst disappointing, was within acceptable levels.

Mr Bertram referred to the Cost Improvement Programme (CIP) He advised that overall delivery was £27.4m in March 2016, which was 106% of the £25.8m annual target. The delivery of recurrent versus non recurrent continued to be a challenge. He added that he would like the Board to join him in thanking the Corporate Efficiency Team and Directorates for their hard work in achieving the target.

Mr Bertram referred the Board to the cash forecast and asked the Board to note the position at the year end. He advised that during the next financial year the Trust would continue to keep expenditure suppressed where ever possible and aim to improve the income and manage the debt levels tighter so that the cash position of the next financial year was protected.

Mr Bertram referred to the submission that would be made to Monitor at the end of the week. He asked the Board to note the financial position at the end of the quarter and the proposed submission to Monitor. The Board noted the planned submission.

Mr Bertram referred to the sustainability fund that has been allocated to the Trust. He confirmed the allocation was £13.6m and had four conditions attached, namely:

- The Trust must comply with the agency rules that have been put in place
- The Trust must comply with access targets and trajectory objectives agreed
- The Trust must remain within control totals
- The Trust must comply with the Carter Review.

He advised that there was still no national guidance available to confirm the business rules. Mr Bertram felt that this was due to discussions that were continuing between the Treasury and the Department of Health. As a result of not having the guidance there was no clarity about the impact on the organisation if it breached one of the conditions.

Referring to the new financial year, Mr Bertram confirmed that nothing would change around the grip and control that was put in place earlier in 2016.

In terms of the contract negotiations, Mr Bertram advised that the East Riding Contract and NHSE specialist contract had been agreed. Recently it had been agreed to go to arbitration with the Scarborough and Ryedale CCG and York CCG contracts. The papers were submitted at the beginning of the week. The gap between the Trust and Scarborough and Ryedale CCG was about £3m and the gap between the Trust and the York CCG was about £10m. Mr Bertram advised that the reason for the dispute was around the CCGs affordability levels. Both CCGs were required to submit plans to NHSE, which were rejected, and the CCGs had subsequently undertaken further negations with the Trust. Unfortunately those negotiations failed and it was agreed to go through the

arbitration process. Mr Bertram expected the process to be very quick and anticipated that those invited to attend the panel would include Mr Crowley and Mr Bertram. He advised that there were some risks to arbitration over the contract, particularly around cash payments which the Trust could not afford to see delayed. He also was concerned about the reputational aspects of being involved in the arbitration process.

The Board asked if the arbitration would affect the relationship the Trust has with the CCG. Mr Proctor advised that the Trust was very clear about the CCG's position and understood the pressure the CCG had been put under. He added that the CCG was being influenced by a party with no accountability to maintain services in the area.

Mr Sweet asked about the contractual fines that would be included in the next financial year. Mr Bertram advised that as the organisation had accepted the sustainability funding and control total, it would not be subject to the fines seen last year, with the exception of MRSA and C-Diff fines. Mr Sweet asked about the re-admission penalties. Mr Bertram explained that £4m for re-admission penalties had been included in the plan, but at this stage there was no clarity nationally on what regime would be followed.

Mr Ashton reminded the Board that when the plan was submitted to NHSI there were a number of caveats and risks attached to the plan. Mr Ashton asked how many of those have been addressed. Mr Bertram confirmed that all currently remain and the Finance Corporate Risk Register had been updated to include them, although some risk scores had yet to be confirmed.

Mr Keaney thanked Mr Bertram for his updates.

16/060 Review of the Winter Programme

Ms Symington welcomed Mr Hindmarsh to the meeting and invited him to give his presentation.

Mr Hindmarsh summarised the plan that had been presented to the Board in October 2015 and reminded the Board of the aims of the plan. Mr Hindmarsh highlighted the context for York and Scarborough and outlined the comparison and variations between the winters of 2015 and 2014. Mr Hindmarsh provided some detail about the operational performance of the plan and the challenges and successes identified during the winter. He highlighted the lessons learned and explained how that would be used in the development of the next winter plan. Mr Hindmarsh talked about the additional work that had been undertaken at Bridlington during the winter and advised that an additional 218 patients have been treated at Bridlington.

Mr Keaney asked what the impact would have been on income if those patients had not been able to be treated in Bridlington. Mr Hindmarsh confirmed that it would have been lost income.

Professor Willcocks felt the presentation and implementation of the winter plan made a compelling case for making changes in the control systems. She suggested the Trust should work with stakeholders to develop more inclusive systems.

The Board thanked Mr Hindmarsh for his presentation.

16/061 Self Assessment against the Monitor Licence

Mrs Pridmore presented the updates to the self assessment against the Monitor Licence and asked the Board to note the updated document. The Board noted the document.

16/062 Minutes from the Workforce Strategy Committee

Professor Willcocks presented the draft minutes from the Committee. She advised that the Committee had looked carefully at the business to be conducted by the Committee. The Committee had also reviewed the Workforce and Organisational Development Strategy. She advised that the Committee was planning to present the strategy to the May Board.

She advised that the Committee was planning to present the strategy to the May Board.

16/063 Workforce Briefing

Ms Symington welcomed Miss McMeekin to the Board. She invited her to present the Workforce Briefing Report.

Miss McMeekin referred to the junior doctor's contract. She reminded the Board that the Government had now imposed the contract on junior doctors. As a result the BMA were now considering the possibility of judicial review to quash the decision to impose the contract. The judicial review would be on the basis that the Government had not undertaken an equality assessment and the contract had not been consulted on properly, was premature and irrational. The Secretary of State had now completed the equality impact assessment and published it and individual Trusts are being asked to complete local equality impact assessments.

The development of the rota software associated with the contract would not be available until after the end of May. In August the new rotation of junior doctors would join the Trust. The Trust had been required to provide the new junior doctors with a rota in advance of them arriving in the Trust. Mrs McMeekin explained that as a result the rotas had been worked out manually and circulated to the new cohort of junior doctors. She advised that the response had been very positive.

Miss McMeekin added that there was a very political angle to the dispute and it was very challenging for trusts to work with. The BMA was concerned about safety around working hours and shift patterns.

Miss McMeekin referred to the consultant contract negotiations and advised that the contract was pivotal to the delivery of a 7 day service. She advised that negotiations had stalled recently because of the junior doctor negotiations.

Miss McMeekin updated the Board on the agency staffing issues. She advised that any breaches of the cap must be reported to NHS Improvement. She advised that some recently published data showed that the Trust was average for the number of breaches and in line with Bradford Teaching Hospital. She added that the Trust was being very transparent about the occasions when the cap was breached. Miss McMeekin advised that she had sought out what 'good organisations' were doing and had established that some organisations that look good might not be as transparent with their declarations. The Board asked how it was decided that it was necessary to breach the cap. Miss McMeekin advised that the decision lay with senior management. For medical staff the

decision included Mr Taylor and for nursing it included Mrs Geary and members of her senior team.

The Board discussed the key elements that would support the reduction on the reliance on agencies and agreed that it was effective e-rostering, effective recruitment and agile rotas going forward.

Miss McMeekin referred to the recent open day. She advised that the day was very successful with 100 applications for healthcare support workers being received and 400 people coming to the event. Mrs Geary agreed that it had been a very successful day. She and her team had interviewed a number of nurses for roles in the Trust with immediate start dates.

16/064 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 25 May 2016, in the Boardroom, York Hospital

16/065 Any Other Business

Mrs Symington asked the Board to review the Board Assurance Framework at a Glance document again and consider if the key risks included in the document had been covered in the Board meeting. The Board concluded that the key issues had been discussed during the Board meeting.

Action list from the minutes of the 27 April 2016

Minute number	Action	Responsible office	Due date
16/041 Quality and safety Committee	Review the report on the Norovirus outbreak at Scarborough at the Quality and Safety Committee	Mrs Geary	May 2016
16/057 Communications Strategy Update	Present a further update on the Communications strategy at the November Board meeting.	Mrs Brown	November 2016
16/062 Minutes from the Workforce Strategy Committee	Workforce and Organisational Development Strategy to be presented to the Board	Mr Proctor	May 2016

Outstanding actions from previous minutes

Minute number and month	Action	Responsible officer	Due date
15/087 Diverse Workforce	A proposal around investment in training for specialist and middle grade doctors in the future to be presented to the Board when developed	Mr Crowley	future
15/117 Community Care update	Provide further detail on the re-ablement discussions when available.	Mrs Scott	When available
15/147 Food and Drink Strategy	The Board agreed to test the quality of food on an annual basis.	Mr Golding	May 2016
16/047 NHS Staff Survey	Provide an update report on the progress against the action plan from the Staff Survey to the Board**.**	Mr Crowley	September 2016
16/048 Environment and Estates Committee	Programme in a session on health and safety into the Board day	Mrs Pridmore	To plan

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 May 2016

Chief Executive's Report

Action requested/recommendation

The Board is asked to note the report.

Summary

This report provides an overview from the Chief Executive.

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 regulations

There are no references to CQC outcomes.

Progress of report	Board of Directors
Risk	No risk.

Resource implications	No resource implications.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	May 2016
Version number	Version 1

Chief Executive's Report

1. Chief Executive's Overview

System-wide strategic planning

I was recently invited to join a team of senior leaders to brief Jim Mackey, Chief Executive of NHS Improvement, and Simon Stevens, Chief executive of NHS England, to brief them on the Sustainability and Transformation Plan (STP) for our area. We were invited as one of four highest risk STPs, largely due to the geography of the patch. Overall they were impressed by the clarity of purpose that pre-existed and was now developing further. The Board will be briefed more fully on this later in the board meeting.

Board Assurance Framework

It has been agreed that the Board Assurance Framework (BAF) summary document will be presented to Board each month. The document, which has been approved by the executive directors, is attached to this report, and can used for reference throughout the meeting to ensure that any identified risk is being addressed at the subcommittees of the Board and at the Board meeting itself.

Recruitment

Last month we held our first recruitment marketplace event at York Hospital. The event was a huge success with over 400 people attending to find out about the vacancies that we have available.

We had a total of 24 stands advertising a variety of roles across the Trust from nursing through to catering.

On the day we interviewed 33 nurses, of which 31 were offered jobs, and over 100 potential Healthcare Assistants attended the information sessions.

There was also significant interest in non-clinical apprenticeships, portering and catering posts.

I would like to thank everyone who took time out of their weekends to make this event such a success, and we are looking to hold a similar event in Scarborough.

Another recent nurse recruitment initiative which has proved successful was the recommend a friend scheme, and we are now rolling this out across other hard to recruit posts. The scheme offers an extra day's annual leave to any member of staff who recommends someone that goes on to work for the Trust.

Sustainability

We are committed to delivering sustainable healthcare and to reducing our carbon emissions, and have ambitious plans in terms of what we can deliver.

We recently opened our new energy centre at Bridlington Hospital which will achieve guaranteed savings of over £100,000 in the first year - a 30% reduction on current energy

bills and operating costs. A similar project at Scarborough Hospital is scheduled for completion in the summer.

We are becoming national leaders in this field, and the work has received a number of awards and external accolades.

In the news

We have received widespread and sustained coverage in both the Bridlington and Scarborough media in recent weeks, as a result of the decision by commissioners to stop funding the free shuttle bus service operating between Scarborough and Bridlington Hospitals.

The local Bridlington paper is operating a petition, and many local groups are unhappy about the decision. As a Trust, it is not possible for us to subsidise or fund such a service if the commissioners have taken the difficult decision that they are no longer able to fund it. It is likely that this topic will continue to receive a high level of local interest.

There are a number of national awareness weeks and campaigns taking place and teams within the Trust have been working hard to raise awareness locally, both in terms of the main campaign themes and also what we are doing as part of our own services.

One example of this is Dementia Awareness Week, and a host of activities took place across the organisation. Importantly, we have made a pledge to adopt John's Campaign, an initiative which recognises the important role that carers play and their right to stay and support people with dementia. As part of this campaign we will be revisiting our visitors' guidance in order to promote and encourage more flexible visiting.

We have also been encouraging our staff to get involved in 'The Big Conversation' aimed at raising public awareness about the importance of talking more openly about dying, death and bereavement as part of Dying Matters Week.

Finally, we have once again been chosen as one of the 40 Top Hospitals by CHKS. For over ten years we have received this award, and I do believe that no matter how difficult it may feel on a day-to-day basis, awards such as this are signs that we are contining to perform well in relative terms.

2. Recommendation

The Board is asked to note the report.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley, Chief Executive**
Date	**May 2016**

Board Assurance Framework – At a glance.

Our Board Assurance Framework is structured round our 4 key ambitions. The BAF identifies the strategic risks to the achievement of our ambitions.

Quality and Safety - Our patients must trust us to deliver safe and effective healthcare.		**Workforce -** The quality of our services is wholly dependant on our teams of staff	
1 We fail to improve patient safety, the quality of our patient experience and patient outcomes, all day, every day	Green	1 We fail to ensure that our organisation continues to develop and is an excellent place to work	Amber
2 We fail to listen to patients and staff, act on their feedback, and share with them the changes we make.	Amber	2 We fail to creatively attract the right people to work in our trust, in the right places, at the right time	Amber
3 We fail to innovative in our approach to providing the best possible care, sympathetic to different communities and their needs.	Amber	3 We fail to retain our staff	Amber
4 We fail to separate the acute and elective care of our patients	Amber	4 We fail to care for the wellbeing of our staff	Green
5 We fail to reform and improve emergency care	Red	5 We fail to provide first class learning and development opportunities, enabling our staff to maximise their potential	Amber
6 We fail to embrace existing and emerging technology to develop services for patients	Green	6 We fail to develop learning, creating new knowledge through research and share this widely	Amber
Environment and Estates - We must continually strive to ensure that our environment is fit for our future		**Finance and Performance -** Our sustainable future depends on providing the highest standards of care within our resources	
1 We fail to work as part of our overall community to provide the very best health outcomes, in the most appropriate setting	Amber	1 We fail to work to and maintain financial stability alongside our partners, building alliances to benefit our patients	Amber
2 We fail to respect the privacy and dignity of all of our patients	Green	2 We fail to provide the very best value for money, time and effort	Green
3 We fail to positively manage our impact on the wider environment and keep our own environment clean and tidy	Green	3 We fail to exceed all national standards of care	Red
4 We fail to develop our facilities and premises to improve our services and patient care	Green	4 We fail to plan with ambition to create a sustainable future.	Amber

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Quality & Safety Committee – 17 May 2016, York Hospital Boardroom

York Teaching Hospital NHS Foundation Trust

Attendance: Jennie Adams, Libby Raper, Philip Ashton, James Taylor, Beverley Geary, Liz Jackson

Observing: Tara Wickramasekera - Leeds Institute of Health Sciences

	Agenda Item	Comments	Assurance	Attention to Board
	Last meeting notes dated 16 April 2016	The minutes were approved as a true and accurate record.		
	Matters arising not on the agenda elsewhere: • Update on CQC actions – supporting evidence for actions completed • Nevermore publication • Dashboard review CRR: MD5	The Committee were pleased to note that the publication 'Nevermore' will be returning in August. JT explained that the publication has been on hold whilst recruitment to a vacant Patient Safety post was pending. The Committee queried if the National Maternity Benchmarking report was available. BG confirmed that this will be circulated when published. The Committee drew its attention to the CQC action plan and the actions relating to the Committee that are marked as complete and asked if evidence was available to provide assurance. These actions include pain, dietetics and intensive care. JT advised the Committee that the Critical Care external review report has now been agreed and a draft action plan has been put together alongside both CCGs. This will be coming to the next Committee meeting to provide assurance. JT added that there remains a capacity issue on the Scarborough site. The critical care review looks at adding an extra bed to each site and the transfer of long term workload to the York site. The Committee queried if the Junior Doctors strike in April had any further impact on the outpatient provision in Ophthalmology noting the spike in cancelled appointments in April in the information booklet and expressing		

	Agenda Item	Comments	Assurance	Attention to Board
		some concern that these patients can be at risk of sight loss. JT explained that the Ophthalmology clinics are run by consultants and the allied health staff so the strike had no further effects. Following the review of the Ophthalmology service an action plan has been put in place, the department has been reorganised and a flag has been placed on CPD to identify emergency patients. The department are running out of space and an urgent solution is required. An analysis is taking place to inform options and the time span of completion will depend on the selected option. This issue remains on the Medical Director's Risk Register. Sue Rushbrook is leading a review of the information included in the performance dashboard and the Committee members agreed to send any comments to Sue.		
	Risk Register for the Medical Director and Chief Nurse	The Committee reviewed the two risk registers, noting the inclusion of CAMHS to the Chief Nurse Risk Register, and agreed that all risks were covered by agenda items except for MD3 Information Governance which received increased focus at previous meetings. The Committee queried the completion dates included on the Medical Directors Risk register. AP advised that the Risk Registers are reviewed by Fiona Jamieson on a monthly basis and quarterly by the Risk Meeting, Audit Committee and Board. BG added that the completion dates are misleading as this date is set to review the actions that have been taken. The Committee suggested reviewing a directorate risk register each month to gain assurance that risks are kept up to date and escalated appropriately. BG advised that the new PMM structure commenced in January and each directorate meets monthly with Executive members in attendance. Risks have been discussed at the PMMs and going forward the meetings will become bi monthly and the directorates will bring their risk register for review. Patient safety and risk will be standing agenda items for the clinical directorates.	The Committee were assured by the PMM process that risks above 15 would be highlighted and escalated to corporate risk registers.	The Committee to raise at Board. BG and JT

	Agenda Item	Comments	Assurance	Attention to Board
	Patient Safety			
	Nurse Staffing CRR Ref: CN2	BG advised the Committee that the vacancy position continues to improve. The Recruitment Market Place was a success with many people being interviewed on the day; this will be repeated in Scarborough. The EU recruitment campaign has come to end as the procured 60 nursing posts have been recruited to. An English language test (IELTS) has been introduced as a requirement for European and International nursing recruitment. Neighbouring Trusts have recruited from India and half the nurses remain in India unable to pass the IELTS test. EU recruitment will be suspended while a look back exercise is carried out and attrition rates evaluated. Focus remains on local recruitment with an advert out for qualified nursing staff and plans to visit university recruitment fairs. BG explained to the Committee that the acuity and dependency of patients in Archways Community Hospitals has changed and Ginni Smith is reviewing the staffing mix. Referring to the Safer Staffing Return the Committee raised concern around staffing levels on the high acuity medical wards which was underlined by following a Patient Safety Walk Round on Beech and Chestnut Ward. BG confirmed that Helen Hey has met with key members of directorates to discuss budgeted and actual establishments. The current challenges are the management of high sickness rates and the fact that the escalation wards (Ward 24 and Graham) remain open and staff are being redeployed on a shift by shift basis to cover these. This raises an additional concern as there is no other capacity for decant and deep clean. Ward 24 is expected to close by the 1st June and the Elderly Directorate has been asked to put a plan in place.		BG to comment at Board

	Agenda Item	Comments	Assurance	Attention to Board
		BG advised the Committee that the new measurement of care hours per patient day will be included in the report from next month explaining that this is calculated by adding the number of registered nurses and HCAs hours each day and dividing by the number of patients. This calculation is a recommendation from the Carter report and was intended to increase the effective utilisation of staff. The Committee showed some concern around this crude calculation which does not take in to account the skill mix of staff, BG explained that triangulating this with other staffing data should mean that staff can be deployed effectively, however professional judgement will still be vital. BG added that there is a positive early indication around revalidation, with no nurses stating that they won't revalidate.		
	Medical Staffing CRR Ref: MD2	JT advised the Committee that there have been no significant changes in Medical Staffing. Work is being undertaken with Polly McMeekin around international recruitment for hard to recruit to, specialised areas. The Trust continues to be proactive with recruitment and in the current market are obliged to offer incentives. The Committee discussed the agency cap, JT explained that this is having less of an effect on the medical workforce and the cap can be broken if there is a patient safety issue; however there is no clear definition of a patient safety issue. The Trust is currently on track with agency spending and a paper will be going to the Workforce Planning Committee for discussion.		
	Infection Prevention CRR Ref: CN 7&8	The Committee discussed the instances of MSSA, PA advised that unported cannulas and blood cultures were discussed at the Patient Safety Group meeting in relation to instances of MSSA. BG explained that Infection Prevention has a work plan for improvements. Katrina Blackmore is focussing on learning and improving and there is still more work to be undertaken. BG highlighted to the Committee that instances of MSSA and Clostridium		BG to comment at Board

	Agenda Item	Comments	Assurance	Attention to Board
		Difficile are reducing. There has been one instance of MRSA in the last month and the Committee queried the compliance with screening. BG explained that a discussion that took place at the Surgical PMM has highlighted that patients are screened at pre assessment; however it is then recorded as a new admission when they then come in for surgery, so the patient should be rescreened. BG advised the Committee that a restructure of the infection Prevention Nursing team will take place in the next three months and the team will focus on behaviour and education across all Trust sites. BG has asked the team to provide measures of the outcome of ANTT training. The responsibility around instances of bacteraemia will remain within directorates and the IPC team will become a specialist resource for all areas, working collaboratively and enabling others. The committee looked at the IPC action plan and observed the need for a more collaborative approach that made IPC the responsibility of each clinical team – assisted and advised by the specialist team. The Committee discussed the norovirus outbreak on the Scarborough site. The CCG are leading on the work and have advised that the report will be completed at the end of June. In the absence of the external report, BG explained that a detailed analysis has taken place and themes and areas in need of improved practice have been identified.	The Committee were assured by the issues being captured at PMMs.	
	Serious incidents (SIs) & incident reporting CRR Ref: MD1, MD2,	The Committee noted the inclusion of a duplicate SI seen in a previous Medical Directors report and asked that the administration process be monitored. The Committee queried the delay between the incident taking place and the report being included in the Medical Directors report. JT explained that all incidents are fed back to the clinical teams in the moment so that any urgent		JT to comment at Board on work around improving the incident reporting

	Agenda Item	Comments	Assurance	Attention to Board
	MD4, CN2	actions can be initiated promptly. The Committee focussed its attention on the SI containing a cluster of 12 hour breaches in October and November 2015. The recommendation from this SI focuses on system analysis and acute patient flow rather than the individual patients and the Committee asked for further information. JT confirmed that each individual case was discussed by the SI Committee and no harm was identified. These cases were all consequential effects of patient flow. BG added that the duty of candour is always adhered to and a Matron speaks to each patient on the ward and records the conversation in the notes.		process for Sis and Datix
	CRR: CN 9&10	The Committee discussed the SI involving CAMHS. JT explained that the Clinical Director was involved the morning after this incident so informal actions could be put in place straight away. Paediatrics have conducted an audit which shows a significant increase in these incidents year on year. Mitigations are being put in place that will help care for these patients however medical and nursing staff are not trained to deal with these situations and there are no mental health beds available across the Trust. The Committee were pleased to note the 24/7 mental health liaison service in the Emergency Department but understood the urgent need to liaise with commissioners to provide a service for young in-patients with mental health issues. The Committee discussed the Datix reporting system and paper based pilot taking place with the junior doctors. The Committee were pleased to hear that the paper reports from the junior doctors were being entered on to the datix system. JT advised the Committee that the lack of junior doctor reporting relates to the culture within medicine and it is important to identify and understand the barriers to this. The Committee focussed its attention on the NLRS Organisation Patient Safety Incident Report and noted that the Trust was below average however not in the bottom quartile. JT agreed to liaise with the higher reporting Trusts		JT/BG to comment on mental health liaison challenge for young people

	Agenda Item	Comments	Assurance	Attention to Board
		to understand what systems they are using. The committee reiterated that increased incident reporting was a quality priority for the current year and that recent data was not encouraging in this respect. The Committee raised some concern around the sudden drop in numbers of reported serious harm and death and queried if this could be a data quality issue. JT agreed to discuss this with the Health Care Governance Team.		
	Quarterly Falls Report and Quarterly Pressure Ulcer Report	Quarterly Falls Report. BG advised the Committee that the Trust continues to see an increase in reporting and a reduction in falls resulting in moderate or severe harm which is a very positive picture. The Committee queried if there is ward level ownership of the actions from the RCAs. Matron's conduct the root cause analysis investigation and present these at a panel which provides a good learning opportunity. The Committee discussed in detail the issues on Ward 37 where a cluster of falls with harm have occurred, attracting external scrutiny. BG explained that this ward has developed a bespoke training programme and interventions which reflect the cohort of high risk patients in this area. Work is being undertaken with the CCG around length of stay on this ward. The committee queried if more use could be made of the volunteer workforce in terms of falls prevention. BG advised that there has been positive feedback from ward areas with volunteers becoming part of the ward teams and that this was a role they were suited and trained for. Quarterly Pressure Ulcer Report. The number of reported pressure ulcer incidents remains on a downward trend. Ginni Smith and Lyeanda Berry are undertaking some focussed work around the management of pressure ulcers in the community. There is still some improvement work to be done around documentation.		

	Agenda Item	Comments	Assurance	Attention to Board
	Additional Patient Safety Items	EWTT and Nursing Dashboard. BG explained to the Committee that EWTT replaced the Nursing Care Indicators and the Nursing Dashboard has been developed alongside this to provide further information and assurance. The Ward to Board assurance around quality of care has been reviewed by the Chief Nurse Team and it has been agreed that EWTT will be discontinued and the Dashboard will be enhanced, all risks rated as red will be added to Assistant Director of Nursing action plans which will be discussed weekly with Matrons. These risks will be managed by the ADN and escalated appropriately to the Nursing Exec Group. The enhanced dashboard along with the ward accreditation tool will give a full picture of the risks within nursing. Maternity Services. The Committee reviewed the very detailed report provided about maternity services and were encouraged by the level of detail included. The Committee agreed that the investigation conducted was very robust and included governance, patient safety and risk management followed by a very detailed action plan; however still birth information had not been included in the report and the analysis of claims was lacking in depth. BG agreed that there should be an executive summary with key risks and mitigations. There is work to be undertaken around learning from incidents but overall a positive tangible cultural shift can be seen. The Committee the improvement in the rapid screening of stroke patients and the decrease in the number of ward transfers.	The Committee were assured by this streamlined approach.	
	Clinical Effectiveness			
	Electronic Prescribing Medicines Administration (EPMA) CRR: MD1	The Committee noted the roll out date of August 2016. JT confirmed that demonstrations of the system are taking place and the pilot will commence in July rather than in May as had been hoped. He was unaware of any significant technical setback responsible for this delay.		

	Agenda Item	Comments	Assurance	Attention to Board
	Mortality	The Committee discussed the new avoidable mortality process. JT advised that Allan Hutchinson, from the Improvement Academy in Bradford, will be conducting training on the new method in July. The Trust are part of the pilot and will be the first in the region to receive the training. Once training has taken place the Trust will move over to the new method. JT confirmed that all deaths will be screened and any identified as avoidable will have an in depth review. Meanwhile the existing review process continues.		
	Additional Clinical Effectiveness Items	The Committee were aware that new CHKS data had recently been compiled and they felt that there was a need for this and/or other clinical performance benchmarking data to come to the committee to provide assurance on clinical matters. A variety of sources had been used from time to time – PROMS, CQC Intelligent Monitoring, Dr Foster, Stethoscope etc. JT agreed to look into this to identify something appropriate and reliable and bring it to the committee.		
	Patient Experience			
	Friends and Family Test Annual Complaints Report	The Committee noted the upward trend in the response rate to the Friends and Family test; however the response rate is still low. BG advised that this is being monitored by the Patient Experience Steering Group, the trend is moving towards the national average however the Trust aspires to be better. Previously the narrative collected from the Friends and Family test was positive but is now consistent with data collected from complaints with delays being a particular feature. The Committee questioned the usefulness of this data, agreeing that more quality data is collected through the complaints procedure. The Committee referred to the Complaints Annual Report and the greater depth of analysis into themes and focus on learning.	The Committee were assured by the deeper analysis into complaints themes and evidence of learning.	
	Additional Patient Experience Items CRR: CN6	Safeguarding. The Committee noted the positive implementation of a dedicated child safeguarding advisor for the Emergency Departments and were pleased to note the planned team walk rounds to raise awareness of the service. The improvement in safeguarding training rates was appreciated but the target rate of compliance had now increased. There is also more to do around		BG to comment on good progress in this area

	Agenda Item	Comments	Assurance	Attention to Board
		FGM training for key areas. BG advised the Committee that the process of rechecking staff DBS checks is being looked in to; however the cost would be significant. If any member of staff receives a police caution the Trust is notified by the police. The Committee agreed that staff should be reminded of their responsibility to disclose any such issue. It was felt that this issue might be more appropriate for discussion on the WOD agenda.		
	Additional items			
	Risk Register round up	All risks included on both risk registers were discussed under agenda items with the exception of Information Governance.		
	Next meeting of the Quality and Safety Committee: 21st June 2016 at the University of York.			

Patient Safety & Quality Report

May 2016

Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

Patient Experience

480 PALs contacts were recorded across the Trust in April, 41.7% of these were related to requests for information and advice (200). There were 24 complaints at York and 12 at Scarborough in April; a decrease of 10 for the Trust compared to March.

The Friends & Family Test (FFT) is no longer a CQUIN but forms part of the Trust's Commissioner contracts.
The Trust achieved a 27.0% response rate to the Inpatient FFT in April, the highest response rate since the CQUIN was removed. The 90% target for the % of respondents recomending the Trust was achieved across all sites.
The Trust achieved a 16.0% response rate to the ED FFT in April. The Trust is yet to achieve the 90% target for the % of respondents recommending the Trust, however Scarborough saw an improvement from 65.3% in March to 80.7% in April.
The Trust achieved a 1.3% response rate to the Community FFT. The 90% target for the % of respondents recommending the Trust has been consistantly achieved.
Response rates to the Maternity FFT have seen a decrease in April across all 4 stages with the exception of Postnatal - achieved 38.1%.
The Staff FFT was released in Q4. A 26% response was achieved, with 34.6% of respondents being 'Extremely likley' to recommend the Trust for care or treatments and 17.3% being 'Extremely likely' to recommend the Trust as a place to work.

Measures of Harm

1 Never Event was declared in April categorised under 'Wrong Site of Surgery'.

17 Serious Incidents were declared in April (8 x York, 7 x Scarborough & 2 x Community).
7 of the SIs were attributed to 'clinical incident', 6 were attributed to 'slips, trips and falls' and 4 to pressure ulcers.

Infection Prevention

1 patient was identified with healthcare associated MRSA bacteraemia during April. The patient was under Specialist Medicine at York.

3 cases of Cdiff were identified during April; all at Scarborough. The yearly threshold for 2016/17 remains at 48 cases however monthly allocation allows for more cases during the winter months.
In 2015/16, 65 cases of C-Diff were declared against the threshold of 48. 19 cases were successfully appealed as not due to lapses in care and there are another 3 cases pending review. The Trust is therefore currently within the 2015/16 threshold and final figures will be reported once all reviews have been held.

9 MSSA cases were identified during April; 4 at York and 5 at Scarborough. .

There were 5 E-Coli cases identified during April; 2 at York, 2 at Scarborough and 1 at Community - Malton.

Quality and Safety - Miscellaneous

Stroke
All Stroke targets were achieved for the Trust in March and Q4. Of note, 100% of patients who experienced a TIA were assessed and treated within 24 hours at York and Scarborough in March. The Trust has also achieved this target consistantly throughout 2015/16.

Cancelled Operations
48 operations were cancelled within 48 hours of the TCI due to lack of beds in April; this is within the monthly maximum of 65.

Cancelled Clinics/Outpatient Appointments
189 clinics were cancelled with less than 14 days notice across the Trust in April; 118 at York and 63 at Scarborough.
1,001 outpatient appointments were cancelled for non clinical reasons; this exceeds the monthly maximum of 721 and will result in General Condition 9 which is initially a Performance Notice.

Ward Transfers between 10pm and 6am
The number of inappropriate ward transfers in April was within the monthly maximum threshold of 100 - 78 across the Trust.

Care of the Deteriorating Patient

The Trust achieved 78% in the proportion of Medicine and Elderly patients receiving a senior review within 12 hours of admission in April. York achieved 90% (against the 85% target) and Scarborough achieved 63% (against the 80% target).

The Trust achieved 87.2% in the proportion of Medicine and Elderly patients seen by a doctor within 4 hours of admission against the 80% target. The target was also achieved across both sites; York - 84.1% and Scarborough 92.2%.

The Trust has an internal target of 90% of routine observations being undertaken within 1 hour of the prescribed time. The Trust has continually failed to achieve target throughout 2015/16 and achieved 86.8% in April.

Drug Administration

There were 6 insulin errors reported in April; 1 at York, 1 at Scarborough and 4 Community. A total of 116 have reported in the last 12 months.

20 Prescribing errors were reported in April; 12 at York and 8 at Scarborough.

Mortality

The latest SHMI report indicates the Trust to be in the 'as expected' range. The Oct 2014 - Sep 2015 SHMI saw a 2 point reduction at York and no change for the Trust or Scarborough. Trust - 99, York 93 and Scarborough 107.

There were 189 Inpatient deaths across the Trust in April; 113 at York and 65 at Scarborough.

13 ED deaths were reported in April at York and 4 at Scarborough.

CQUINS update

Q4 2015/16 Complete.

Litigation

Indicator	Site	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Clinical Claims Settled	York	1	2	3	3	3	3	1	1	1
	Scarborough	5	2	2	7	1	2	0	1	2

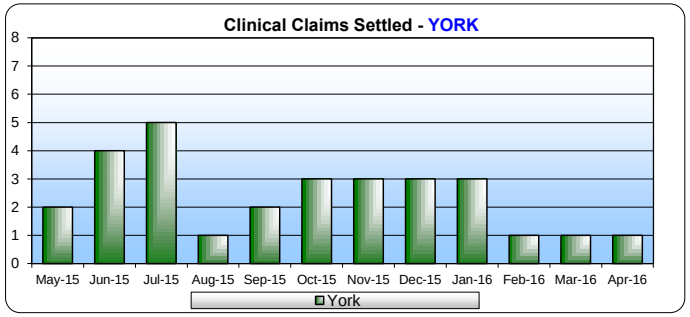
3 clinical claims were settled in April; 1 attributed to York and 2 attributed to Scarborough.

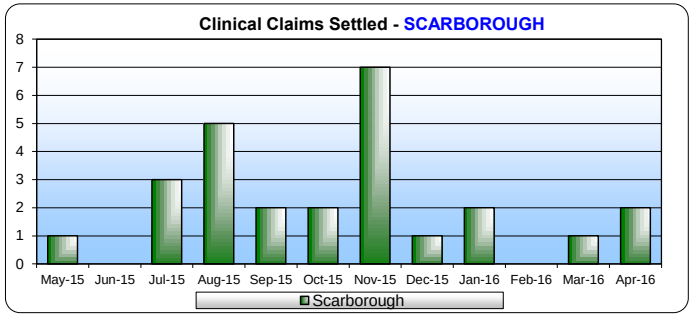
8 clinical negligence claims were received for York site and 10 were received for Scarborough. York had 2 withdrawn/closed claims and Scarborough had 0.

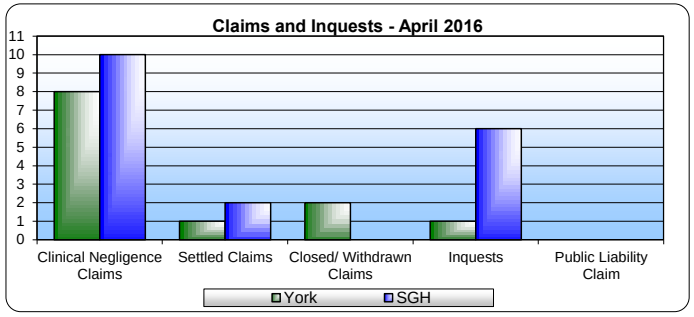
There were 7 Coroner's Inquests heard in April; 1 York & 6 Scarborough.

Litigation

Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Clinical Claims Settled	York	2	4	5	1	2	3	3	3	3	1	1	1
source: Risk and Legal	Scarborough	1	0	3	5	2	2	7	1	2	0	1	2







Themes for Clinical Claims Settled 01 Jan 2012 to 09 Dec 2015

Incident type	York Number	Damages	Sboro Number	Damages
Anaesthetic error	1	£27,500	0	£0
Delay in treatment	2	£1,176,000	8	£4,886,655
Failure to act on CTG	1	£13,500	0	£0
Failure to adequately interpret radiology	7	£53,150	6	£76,463
Failure to diagnose/delay in diagnosis	2	£4,500	1	£45,000
Failure to investigate further	11	£1,198,619	11	£1,211,971
Failure to refer to other speciality	4	£2,047,500	0	£0
Failure to retain body part	1	£25,000	0	£0
Inadequate consent	2	£12,500	3	£79,000
Inadequate examination	4	£147,500	3	£149,847
Inadequate interpretation of cervical smear	1	£37,500	0	£0
Inadequate nursing care	6	£67,000	6	£35,500
Inadequate procedure	2	£10,130	2	£48,750
Inadequate surgery	9	£1,103,750	9	£593,066
Inappropriate discharge	1	£315,000	3	£18,000
Intraoperative burn	3	£25,000	1	£5,000
Lack of appropriate treatment	2	£45,672	6	£407,196
Lack of risk assessment/action in relation to fall	2	£24,250	0	£0
Lack of risk assessment/action in relation to pressure ulcer	1	£7,000	1	£50,000
Maintenance of equipment	1	£5,000	0	£0
Not known	0	£0	3	£60,000
Prescribing error	2	£22,500	0	£0
Lack of monitoring	1	£150,000	1	£80,000
Results not acted upon	6	£47,500	2	£352,000

Patient Experience

PALS Contacts
There were 480 PALS contacts in April.

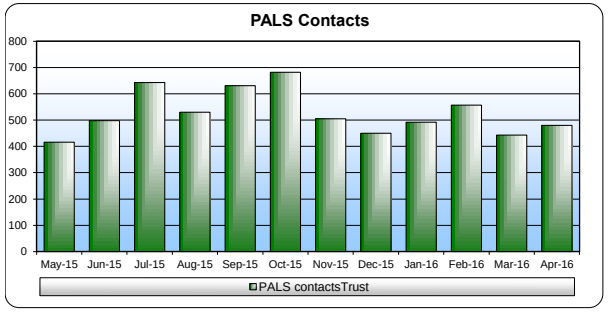
Complaints
There were 36 complaints in April; 24 attributed to York and 12 attributed to Scarborough.

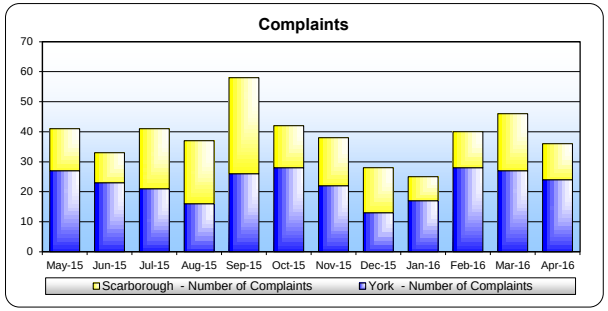
New Ombusman Cases
There were 2 New Ombusman Cases in April – both at Scarborough.

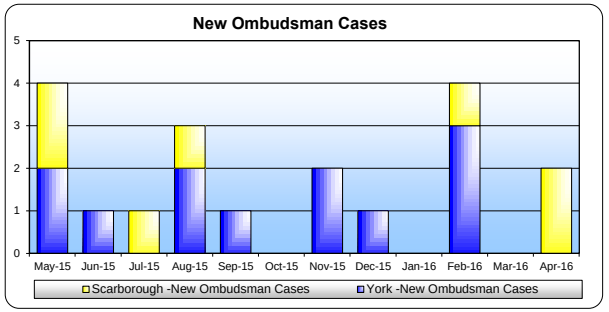
Compliments
47 compliments were received by the Chief Executive in April 2016.

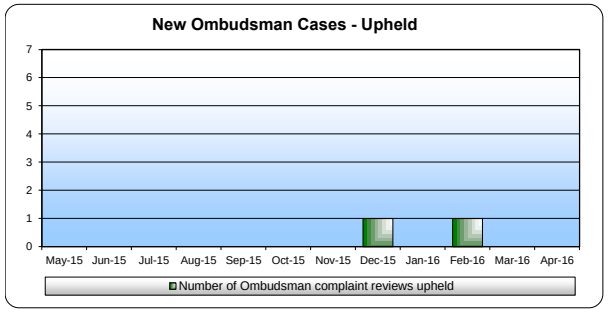
Patient Experience

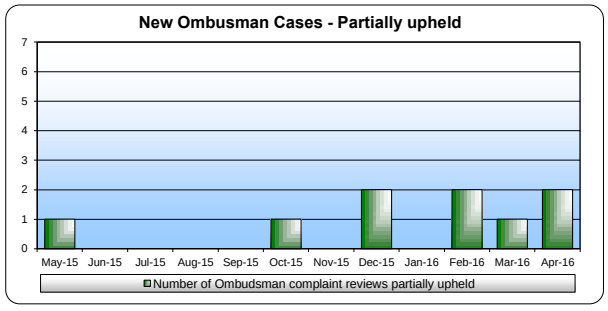
Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
PALS contacts	Trust	416	498	643	530	631	682	505	450	492	557	443	480
Complaints	Trust	41	33	41	37	58	42	38	28	25	40	46	36
New Ombudsman Cases	Trust	4	1	1	3	1	0	2	1	0	4	0	2
New Ombudsman Cases - Upheld	Trust	0	0	0	0	0	0	0	1	0	1	0	0
New Ombudsman Cases - Partially upheld	Trust	1	0	0	0	0	1	0	2	0	2	1	2
New Ombudsman Cases - Not upheld	Trust	1	2	1	1	1	1	0	6	0	2	4	2

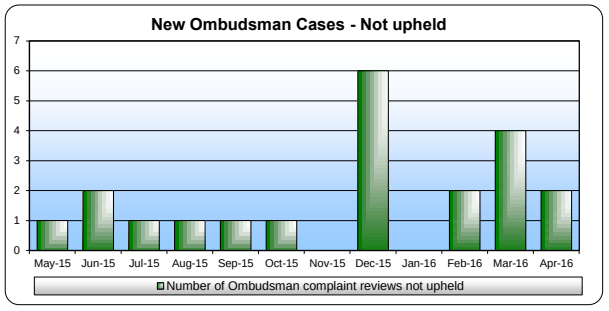












Compliments received by Chief Executive

Directorate	Oct – Dec 15	Jan – Feb 16	Mar-16	Apr-16
Acute & General Medicine	10	5	0	10
AHP	2	1	0	1
Anaesthetics/Theatres & Critical Care	2	3	0	1
Child Health	0	0	0	1
Community Services	0	1	0	0
Elderly Medicine	2	7	0	4
Emergency Medicine	9	11	4	7
Estates and Facilities	0	0	0	1
General Surgery & Urology	7	10	4	5
Gynaecology/Obstetrics	1	3	0	2
Head & Neck	2	1	0	0
Ophthalmology	3	4	1	4
Radiology	0	0	0	1
Specialist Medicine	10	2	1	5
Trauma & Orthopaedics	4	4	1	5
Unknown/no directorate given	13	1	0	0
Total	**65**	**53**	**11**	**47**

Patient Experience

Complaints and PALs contacts breakdown - April 2016

Complaints by directorate/division (Datix)	All Sites
Allied Health Professionals	0
Acute & General Medicine	8
Child Health	4
Community Services	0
Elderly Medicine	5
Emergency Medicine	5
Estates and Facilities	0
General Surgery & Urology	4
Head and Neck and Ophthalmology	0
Laboratory Medicine	0
Obstetrics & Gynaecology	3
Orthopaedics and Trauma	2
Pharmacy	0
Radiology	2
Specialist Medicine	1
Theatres, Anaesthetics & Critical Care	2
Other	0
TOTAL	**36**

Complaints by subject (Datix)	All Sites
Access to treatment or drugs	0
Admissions, Discharge and Transfer Arrangements	10
Appointments, Delay/Cancellation	4
All aspects of Clinical Treatment	21
Communications/information to patients (written and oral)	14
Facilities	0
Privacy and Dignity	1
End of Life Care	0
Patient Care	10
Prescribing	3
Restraint	0
Staff Numbers	0
Transport	1
Trust Admin/Policies/Procedures inc pt record management	2
Values and Behaviours (Staff)	5
Waiting times	0
Patient Concerns	0
TOTAL	**71**

Due to new reporting the number of complaints/PALs contacts by subject is greater than the total number of complaints because each subject within the complaint can be identified as opposed to just the one deemed to be the 'primary'.

PALS Contacts by Subject	All Sites
Action Plan	2
Admissions, discharge, transfer arrangements	11
Aids / appliances / equipment	0
Appointments, delay/cancellation (inpatient)	14
Appointments, delay/cancellation (outpatient)	42
Staff attitude	17
Any aspect of clinical care/treatment	59
Communication issues	36
Compliment / thanks	46
Alleged discrimination (e.g. racial, gender, age)	0
Environment / premises / estates	3
Foreign language	0
Failure to follow agreed procedure (including consent)	1
Hotel services (including cleanliness, food)	1
Requests for information and advice	200
Medication	2
Other	13
Car parking	2
Privacy and dignity	1
Property and expenses	12
Personal records / Medical records	9
Safeguarding issues	3
Signer	0
Support (e.g. benefits, social care, vol agencies)	2
Patient transport	4
TOTAL	**480**

Friends and Family

Indicator		Target	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Inpatients – York	York IP Response Rate	Monitoring Only	17.4%	18.3%	20.6%	17.4%	18.9%	18.6%	13.8%	11.9%	22.3%	19.9%	21.2%	25.2%
Inpatients – Scarborough	Scarborough IP Response Rate		16.5%	15.3%	21.3%	18.2%	18.0%	18.2%	17.5%	15.1%	19.9%	19.0%	24.0%	25.4%
Inpatients - Bridlington	Bridlington IP Response Rate		47.5%	46.0%	51.6%	69.0%	62.0%	50.2%	24.6%	32.3%	52.6%	47.7%	53.7%	52.4%
Inpatients – Combined	**Trust IP Response Rate**		**19.2%**	**19.4%**	**22.6%**	**20.3%**	**21.2%**	**20.3%**	**15.6%**	**14.0%**	**23.6%**	**21.5%**	**24.2%**	**27.0%**
ED – York	York ED Response Rate	Monitoring Only	8.6%	8.3%	10.0%	9.2%	7.4%	9.6%	10.0%	10.7%	16.0%	19.2%	15.6%	17.1%
ED - Scarborough	Scarborough ED Response Rate		7.3%	6.1%	6.3%	5.8%	4.9%	3.0%	3.6%	7.0%	10.1%	12.8%	11.1%	11.8%
ED – Combined	**Trust ED Response Rate**		**8.2%**	**7.6%**	**8.8%**	**8.0%**	**6.5%**	**7.4%**	**7.9%**	**9.9%**	**14.7%**	**18.0%**	**14.7%**	**16.0%**
Maternity – Antenatal		None	27.5%	31.7%	29.1%	23.7%	29.3%	22.9%	1.9%	9.8%	27.0%	12.8%	26.8%	21.8%
Maternity – Labour and Birth			25.6%	26.7%	28.5%	23.3%	36.2%	26.1%	3.9%	25.1%	20.2%	5.5%	5.6%	4.7%
Maternity – Post Natal			29.0%	29.3%	27.3%	25.5%	40.5%	27.3%	3.8%	0.0%	17.1%	29.3%	35.0%	38.1%
Maternity – Community			18.4%	20.3%	18.7%	19.8%	20.9%	26.2%	2.8%	5.1%	16.0%	16.7%	24.7%	17.4%

The Friends & Family Test is no longer a CQUIN for 2015/16, but will be monitored under Schedule 4 of the Trust's commissioner contracts.

From April 2015 day cases and patients under 16 have been included in the Inpatient performance in line with NHS England requirements. This has significantly increased the numbers of eligible patients so had a significant effect on the response rates. NHS England guidance states that response rates are not directly comparable between 2014-15 and 2015-16.

The Trust quality standard for Friends and Family Test Performance is to achieve 90% of responses either extremely likely or likely to recommend.

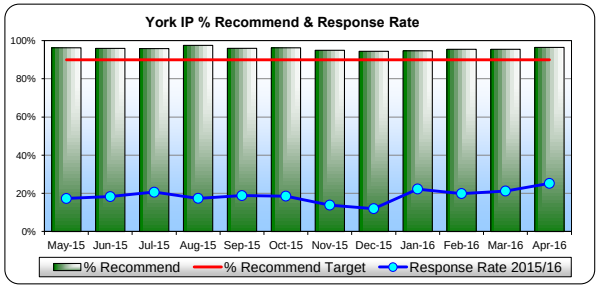
The focus for the Trust is to gain and understand patient feedback and encourage Directorates to use that feedback to drive improvements. Each ward displays a 'Knowing How We're Doing' board which is a giant poster sharing FFT data and comments from that particular ward, along with news and improvements on that ward. By showing patients that we listen to their views and try to make improvements, we hope to encourage more responses and suggestions. The next step for 'Knowing How We're Doing' boards is to roll them out to Outpatient areas across the Trust.

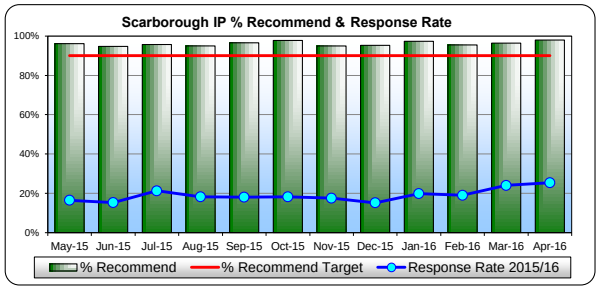
Friends & Family: Inpatients & ED

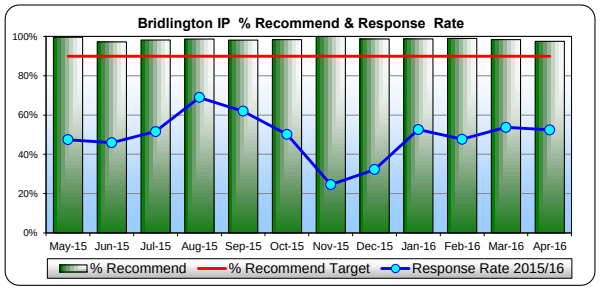
The Friends & Family Test (FFT) has now been rolled out across the Trust, including all Inpatients and Daycases, (previously daycase s and patients <16 were excluded) those attending ED, Community patients and women accessing maternity services being asked the question; "would you recommend this ward/ED/antenatal/labour and postnatal service to your family & friends?". The Friends and Family Test is no longer a CQUIN Target for 2015/16, however the focus for the Trust remains 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.

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb-16	Mar-16	Apr-16
Trust Inpatient Response Rate (including daycases)	None - Monitoring Only	none	19.1%	21.4%	16.7%	23.1%	21.5%	24.2%	27.0%
York Inpatient Response Rate (including daycases)	None - Monitoring Only	none	17.3%	19.0%	14.8%	21.1%	19.9%	21.2%	25.2%
York Inpatient % Recommend	None - Monitoring Only	none					95.5%	95.5%	96.5%
York Inpatient % Not Recommend	None - Monitoring Only	none					1.9%	1.3%	1.0%
Scarborough Inpatient Response Rate (including daycases)	None - Monitoring Only	none	16.0%	19.2%	17.0%	21.0%	19.0%	24.0%	25.4%
Scarborough Inpatient % Recommend	None - Monitoring Only	none					95.5%	96.5%	98.0%
Scarborough Inpatient % Not Recommend	None - Monitoring Only	none					1.1%	1.6%	0.5%
Bridlington Inpatient Response Rate (including daycases)	None - Monitoring Only	none	49.4%	60.3%	35.5%	51.4%	47.7%	53.7%	52.4%
Bridlington Inpatient % Recommend	None - Monitoring Only	none					99.0%	98.4%	97.5%
Bridlington Inpatient % Not Recommend	None - Monitoring Only	none					0.0%	0.0%	0.6%

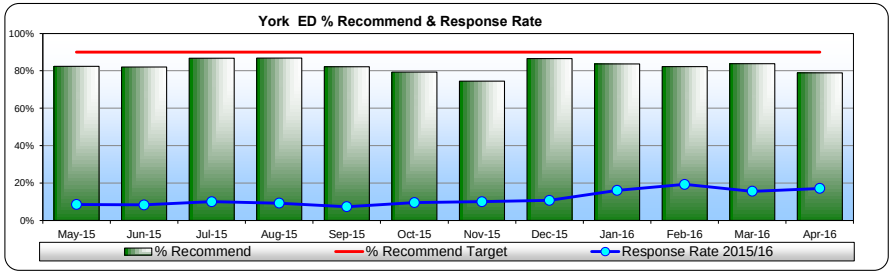
Daycase patients and young people (<16 years) included in FFT April 2015

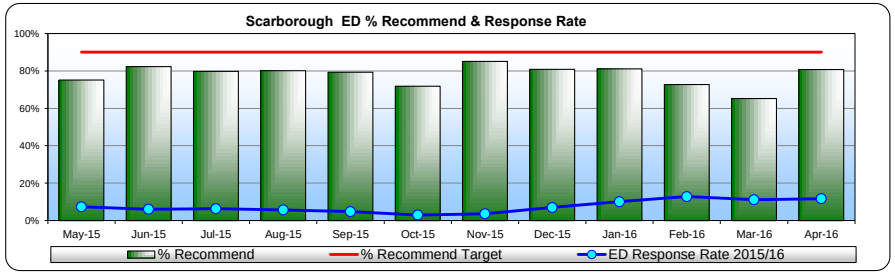






Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb-16	Mar-16	Apr-16
Trust Emergency Department Response Rate	None - Monitoring Only	none	7.8%	7.8%	8.3%	15.8%	18.0%	14.7%	16.0%
York Emergency Department Response Rate	None - Monitoring Only	none	8.4%	8.9%	10.1%	17.0%	19.2%	15.6%	17.1%
York Emergency Department % Recommend	None - Monitoring Only	none					82.3%	83.8%	78.9%
York Emergency Department % Not Recommend	None - Monitoring Only	none					10.4%	10.9%	12.9%
Scarborough Emergency Department Response Rate	None - Monitoring Only	none	6.7%	5.7%	4.1%	11.3%	12.8%	11.1%	11.8%
Scarborough Emergency Department % Recommend	None - Monitoring Only	none					72.7%	65.3%	80.7%
Scarborough Emergency Department % Not Recommend	None - Monitoring Only	none					17.5%	24.1%	11.9%





Headline Scores

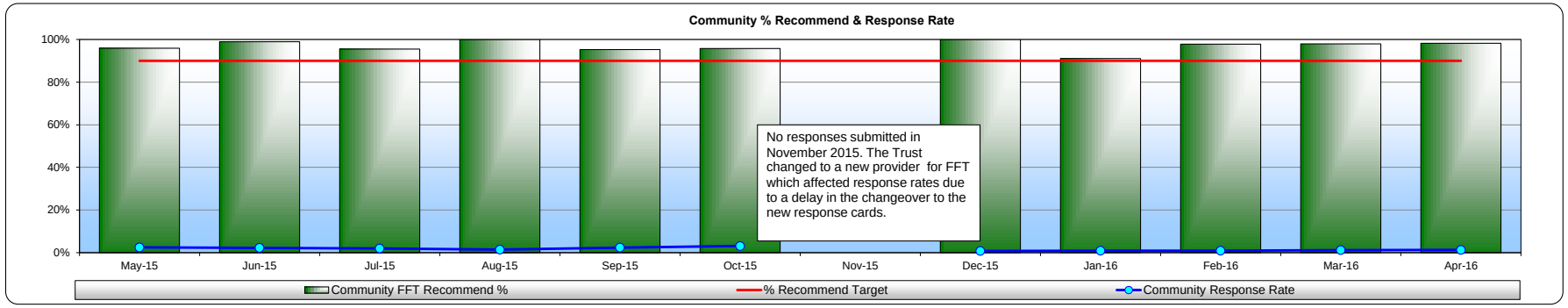
Recommend (%) $\dfrac{\text{Extremely Likely + Likely}}{\text{Extremely Likely + Likely + Neither + Unlikely + Extremely Unlikely + Don't know}} \times 100$

Not Recommend (%) $\dfrac{\text{Extremely Unlikely + Unlikely}}{\text{Extremely Likely + Likely + Neither + Unlikely + Extremely Unlikely + Don't know}} \times 100$

Friends & Family: Community

FFT Implemented in Community since January 2015

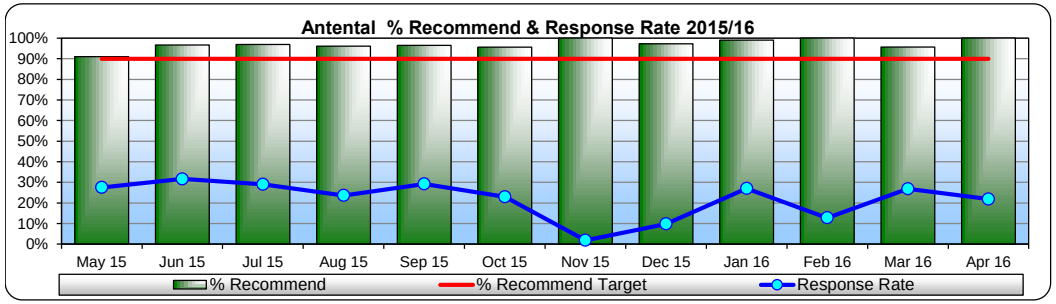
Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb-16	Mar-16	Apr-16
Community Response Rate	None - Monitoring Only	none	2.5%	1.9%	1.2%	1.0%	0.9%	1.1%	1.3%
Community FFT % Recommend	None - Monitoring Only	none					97.9%	98.0%	98.3%
Community FFT % Not Recommend	None - Monitoring Only	none					0.0%	0.0%	0.0%

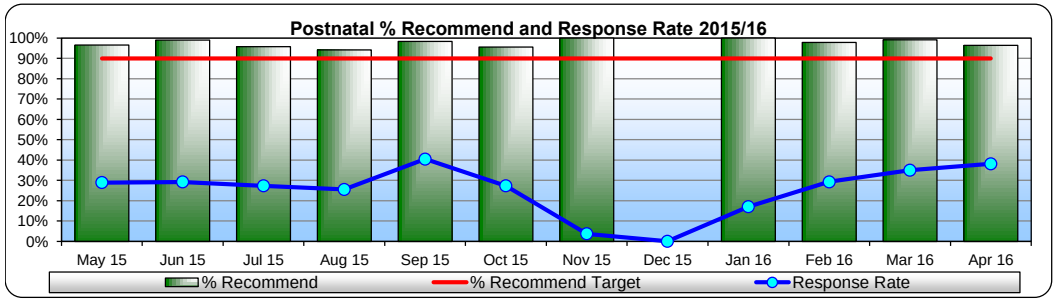


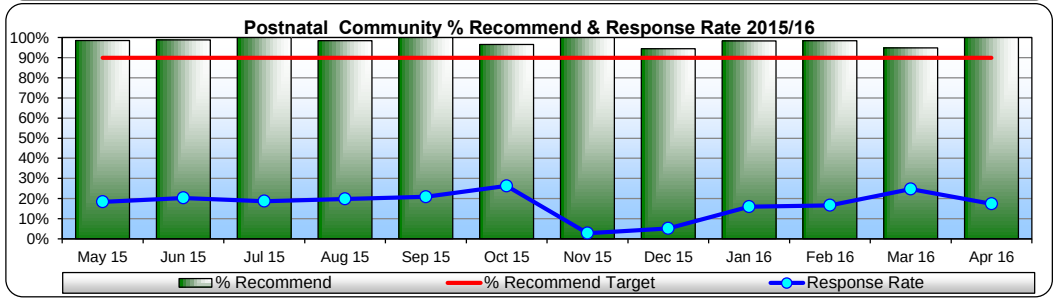
Service/Area	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb-16	Mar-16	Apr-16
Community Inpatient Services	None - Monitoring only	None	121	153	148	106	44	37	33
Community Nursing Services	None - Monitoring only	None	72	41	5	35	0	2	4
Specialist Services	None - Monitoring only	None	73	58	34	23	3	10	4
Children & Family Services	None - Monitoring only	None	2	11	8	2	0	0	0
Community Healthcare Other	None - Monitoring only	None	60	54	63	13	0	1	17

Friends & Family: Maternity

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Antenatal Response Rate	None - Monitoring only	none	28.5%	27.3%	12.2%	21.8%	12.8%	26.8%	21.8%
Antental % Recommend	None - Monitoring only	none					100.0%	95.7%	100.0%
Antental % Not Recommend	None - Monitoring only	none					0.0%	1.1%	0.0%
Labour and Birth Response Rate	None - Monitoring only	none	27.8%	29.5%	18.3%	10.4%	5.5%	5.6%	4.7%
Labour and Birth % Recommend	None - Monitoring only	none					100.0%	95.7%	100.0%
Labour and Birth % Not Recommend	None - Monitoring only	none					0.0%	4.4%	0.0%
Postnatal Response Rate	None - Monitoring only	none	29.5%	30.7%	11.0%	27.1%	29.3%	35.0%	38.1%
Postnatal % Recommend	None - Monitoring only	none					97.9%	99.2%	96.4%
Postnatal % Not Recommend	None - Monitoring only	none					1.1%	0.0%	0.0%
Postnatal Community Response Rate	None - Monitoring only	none	21.1%	19.8%	12.2%	19.2%	16.7%	24.7%	17.4%
Postnatal Community % Recommend	None - Monitoring only	none					98.4%	94.9%	100.0%
Postnatal Community % Not Recommend	None - Monitoring only	none					0.0%	1.0%	0.0%







2014/15 Performance

Indicator	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Antenatal Response Rate	41.3%	33.6%	26.0%	27.7%	33.1%	37.2%	39.8%	42.8%	32.2%	30.5%	27.6%	36.0%
Labour and Birth Response Rate	44.1%	33.3%	32.9%	19.4%	16.2%	20.4%	17.2%	39.7%	15.8%	19.9%	27.9%	38.5%
Postnatal Response Rate	47.0%	39.2%	37.5%	24.8%	20.9%	29.4%	26.5%	47.1%	19.4%	27.9%	31.9%	32.6%
Postnatal Community Response Rate	34.2%	37.2%	24.7%	21.1%	22.7%	17.2%	19.5%	18.4%	18.2%	21.3%	14.6%	23.1%

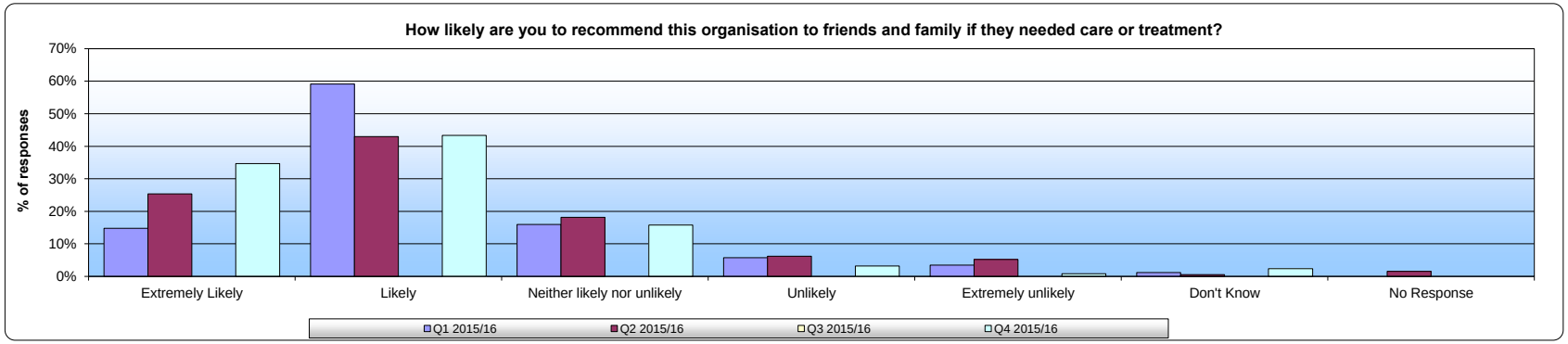
Friends and Family: Staff

York Teaching Hospital NHS
NHS Foundation Trust

As part of the National Friends and Family CQUIN 2014/15, the Trust was required to submit evidence which demonstrates implementation of staff FFT across all Acute and Community areas.

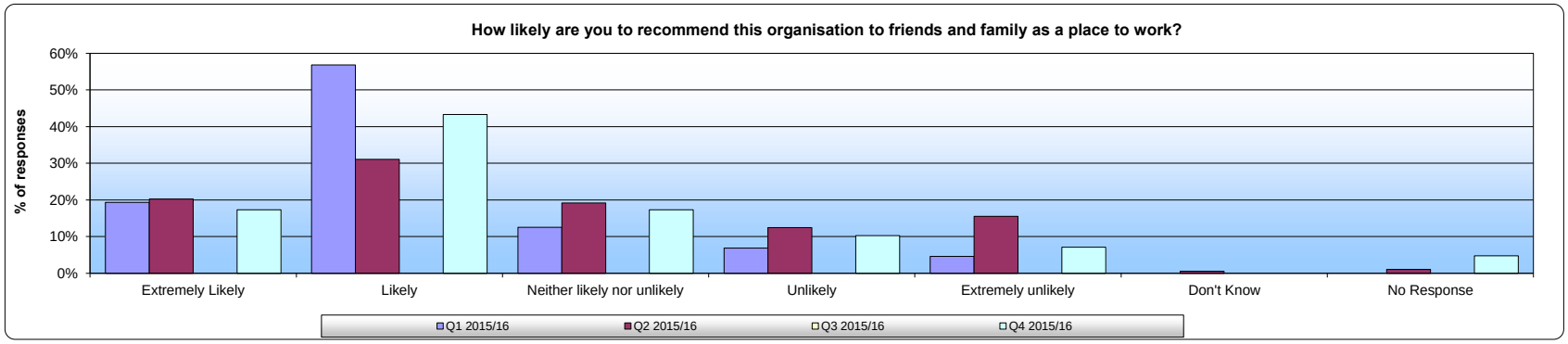
Staff FFT data was collected and submitted quarterly for Q1, Q2 and Q4 after the end of each quarter. For Q3 (when the annual NHS staff survey is undertaken) there was no requirement to undertake Staff FFT. A proportion of staff should have the opportunity to respond to Staff FFT in each of the three quarters, with all staff having the opportunity once per year, as a minimum requirement.

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16
Response rate - Proportion of Trust employees who responded to the survey	None - Monitoring Only	none	49%	35%	Not available	26%
Number of Trust employees who responded to the survey	None - Monitoring Only	none	88	193	Not available	127



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 2015/16	14.8%	59.1%	15.9%	5.7%	3.4%	1.1%	0.0%
Q2 2015/16	25.4%	43.0%	18.1%	6.2%	5.2%	0.5%	1.6%
Q3 2015/16	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Q4 2015/16	34.6%	43.3%	15.7%	3.1%	0.8%	2.4%	0.0%

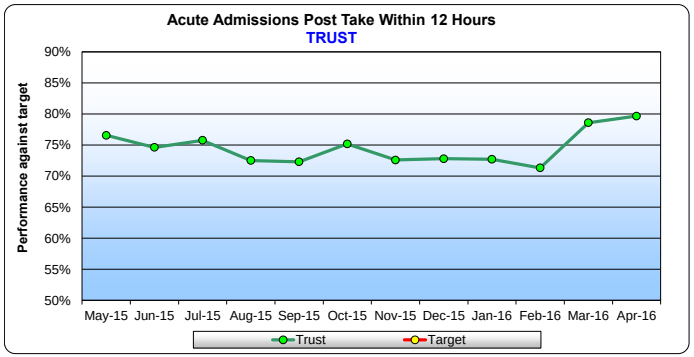


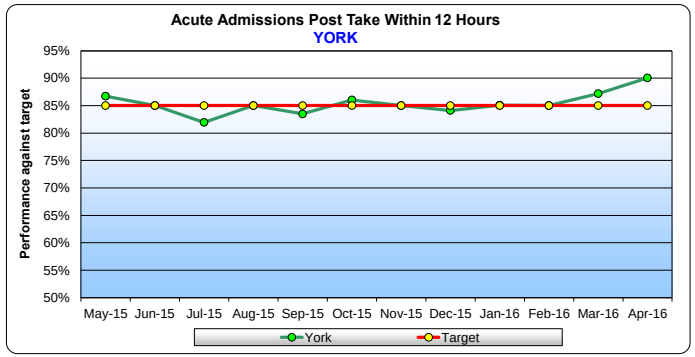
How likely are you to recommend this organisation to friends and family as a place to work?

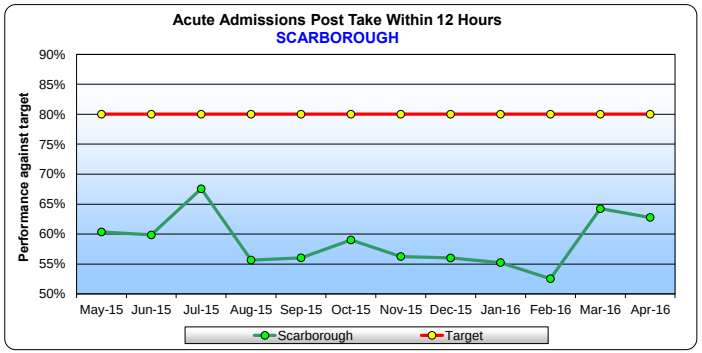
Quarter	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't Know	No Response
Q1 2015/16	19.3%	56.8%	12.5%	6.8%	4.5%	0.0%	0.0%
Q2 2015/16	20.2%	31.1%	19.2%	12.4%	15.5%	0.5%	1.0%
Q3 2015/16	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Q4 2015/16	17.3%	43.3%	17.3%	10.2%	7.1%	0.0%	4.7%

Quality and Safety: Care of the Deteriorating Patient

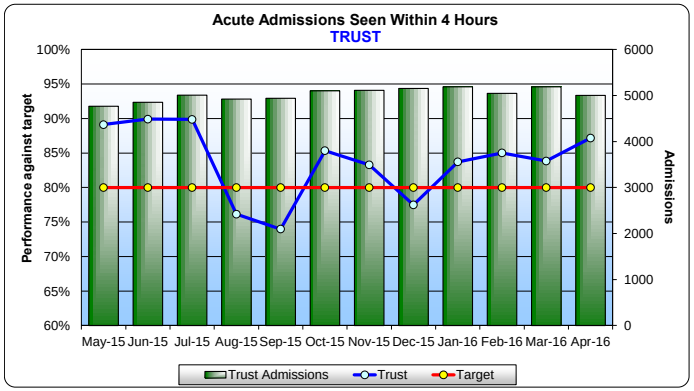
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (SCARBOROUGH)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	80%	61%	60%	57%	57%	53%	64%	63%
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (YORK)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	85%	86%	83%	85%	86%	85%	87%	90%

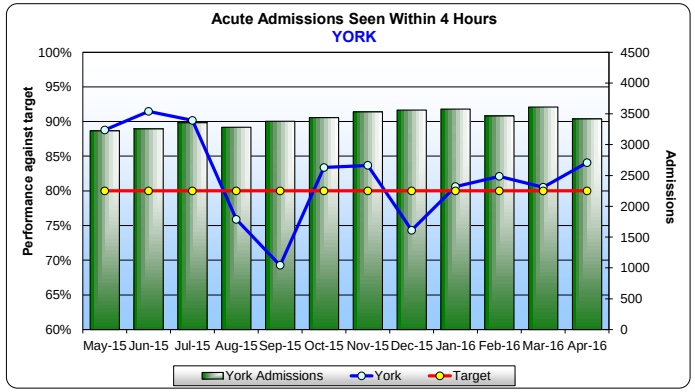


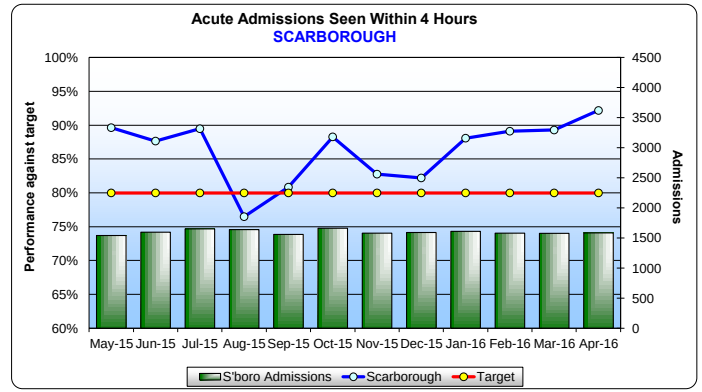




Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	**80% by site**	87.5%	80.1%	82.0%	84.2%	85.0%	83.8%	87.2%

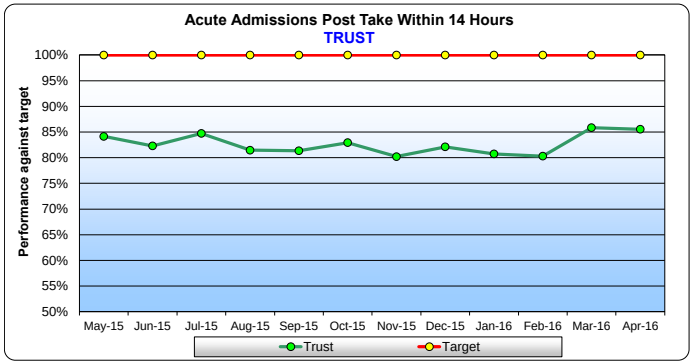


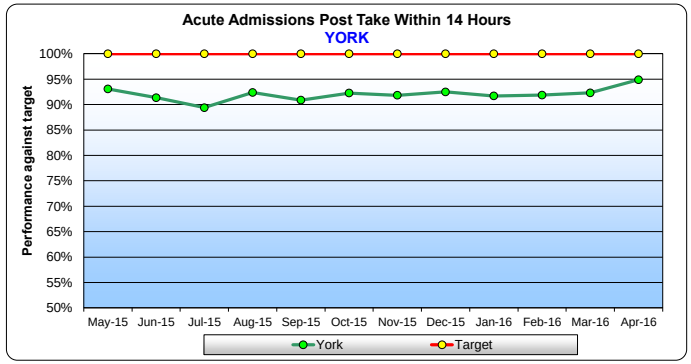


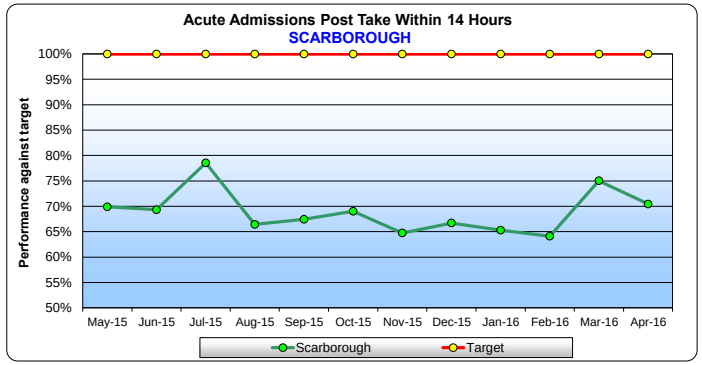


Quality and Safety: Care of the Deteriorating Patient

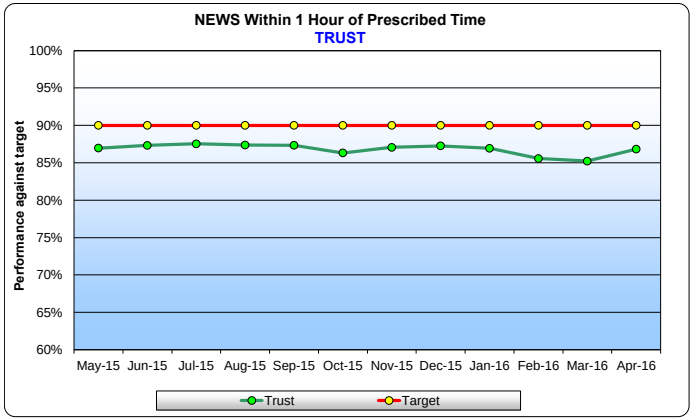
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI		83.9%	82.5%	81.8%	82.3%	80.3%	85.9%	85.6%

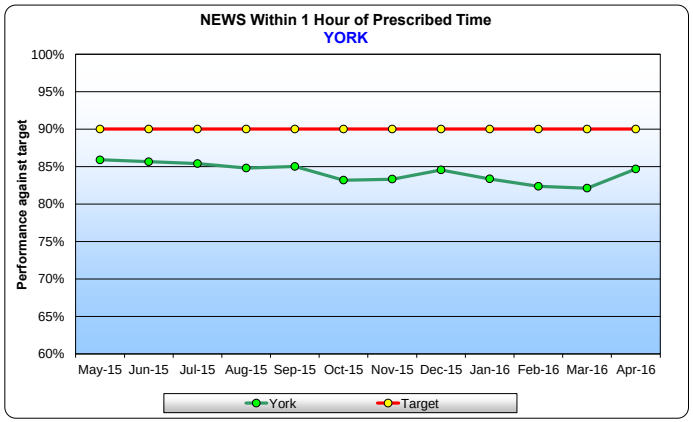


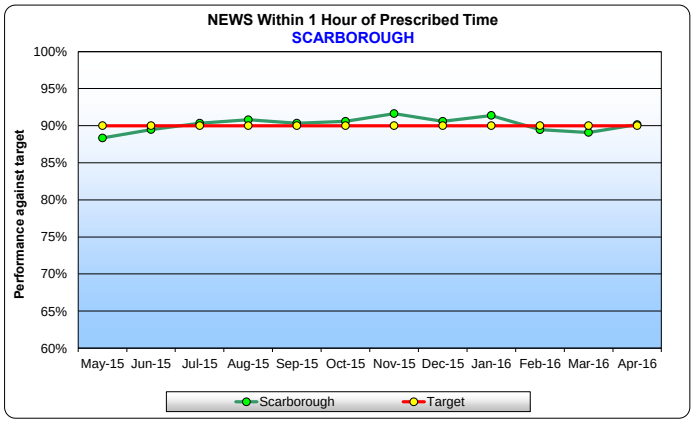




NEWS within 1 hour of prescribed time	None - Monitoring Only		87.0%	87.4%	86.9%	85.9%	85.6%	85.2%	86.8%







Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 17 SIs reported in April; York 8, Scarborough 7 & Community 2.
Clinical Incidents: 7; York 1 & Scarborough 6.
Slips Trips & Falls: 6; York 5 & Scarborough 1.
Pressure Ulcers: 4; York 2 & Community 2.

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 April there were 141 reports of patients falling at York Hospital, 84 patients at Scarborough and 51 patients within the Community Services. This is a slight reduction on the number reported in March (274), however figures may increase as more investigations are completed.

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during April was 1,228; 622 incidents were reported on the York site, 449 on the Scarborough site and 157 from Community Services.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 987 incidents awaiting sign-off by the Directorate Management Teams.

Pressure Ulcers (source: Datix)
During April 24 pressure ulcers were reported to have developed on patients since admission to York Hospital, 19 pressure ulcers were reported to have developed on patients since admission to Scarborough and 25 pressure ulcers were 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.

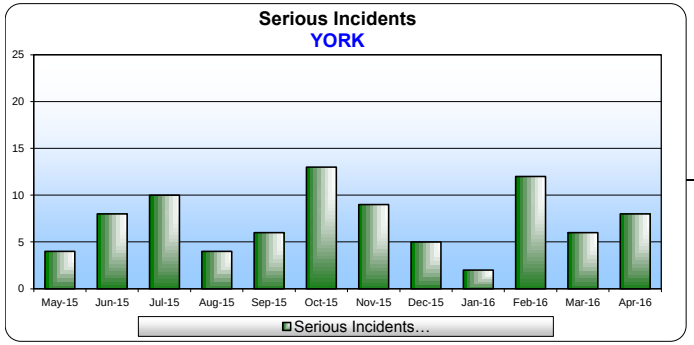
Degree of Harm: Serious/Severe or Death (source: Datix)
During April a total of 6 patient incidents were reported which resulted in serious or severe harm or death. Numbers are subject to change as levels of harm are reviewed and investigations are completed.

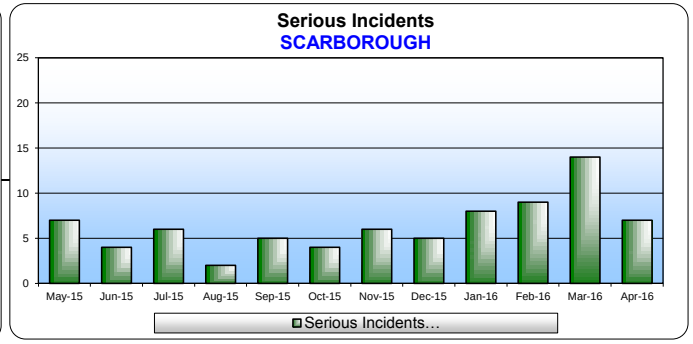
Medication Related Issues (source: Datix)
During April there was a total of 119 medication related incidents reported although this figure may change following validation.

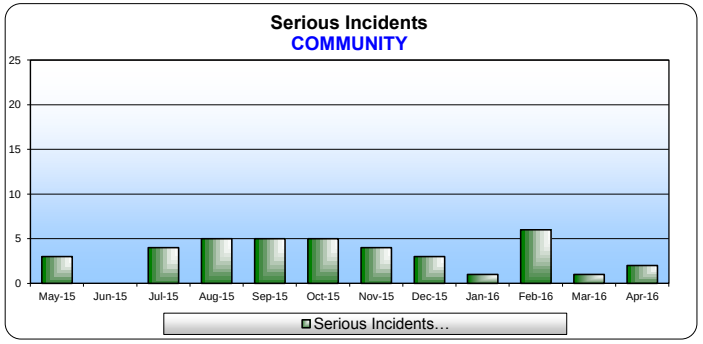
Never Events – 1 Never Event was declared in April categorised under 'Wrong Site of Surgery'.

Measures of Harm

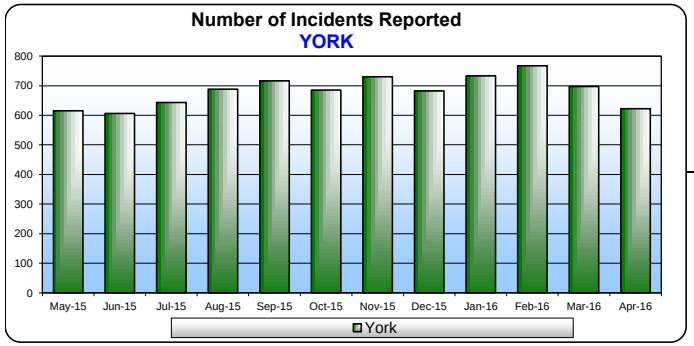
Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Serious Incidents source: Risk and Legal	York	4	8	10	4	6	13	9	5	2	12	6	8
	Scarborough	7	4	6	2	5	4	6	5	8	9	14	7
	Community	3	0	4	5	5	5	4	3	1	6	1	2
Serious Incidents Delogged source: Risk and Legal (Trust)		0	0	0	0	0	0	0	0	0	0	0	0

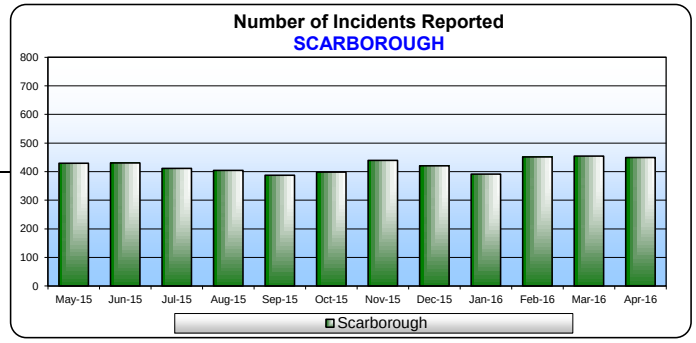


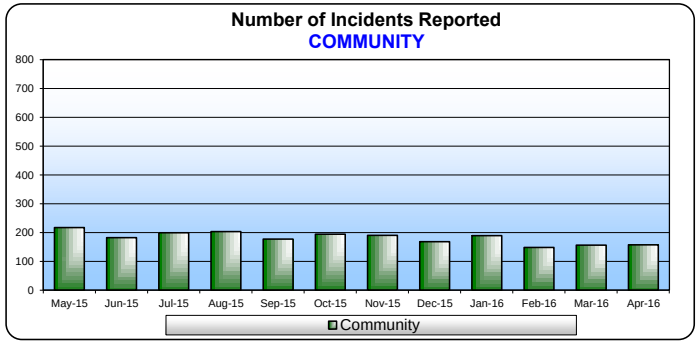




Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Number of Incidents Reported source: Risk and Legal	York	615	606	643	688	716	685	730	682	733	767	697	622
	Scarborough	429	430	411	404	387	398	439	420	391	451	454	449
	Community	217	182	199	203	177	194	190	168	189	148	156	157
Number of Incidents Awaiting sign off at Directorate level		863	947	1178	1229	1183	839	889	1149	1344	1389	1348	987

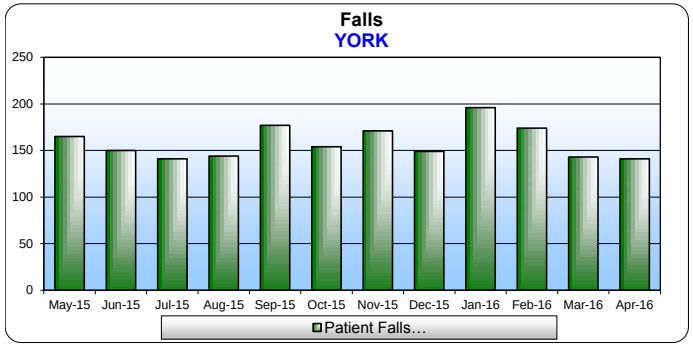


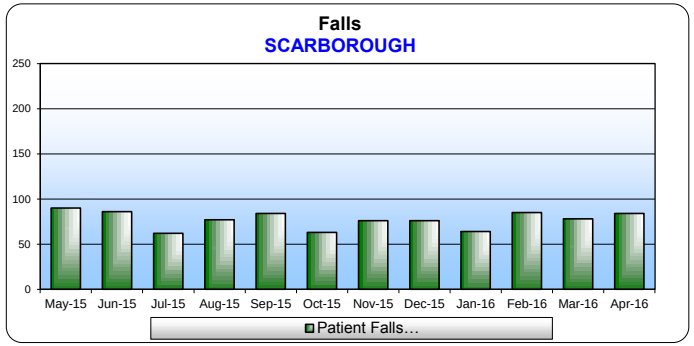


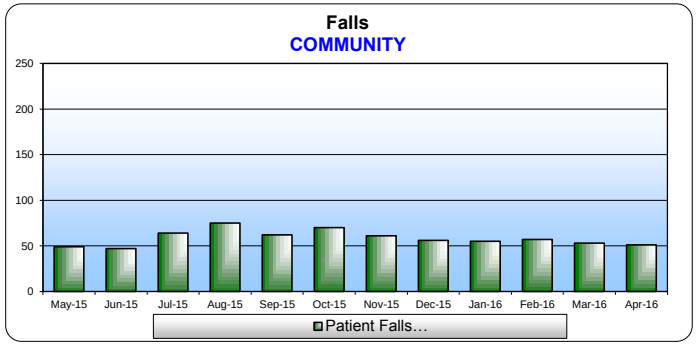


Measures of Harm

Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Patient Falls source: DATIX	York	165	150	141	144	177	154	171	149	196	174	143	141
	Scarborough	90	86	62	77	84	63	76	76	64	85	78	84
	Community	49	47	64	75	62	70	61	56	55	57	53	51

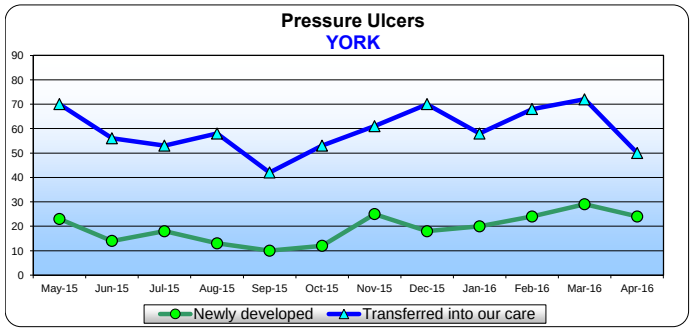


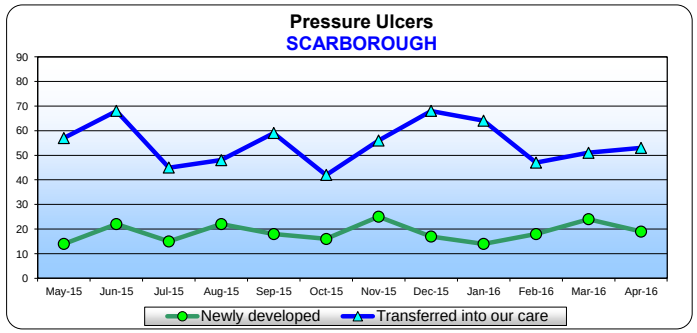


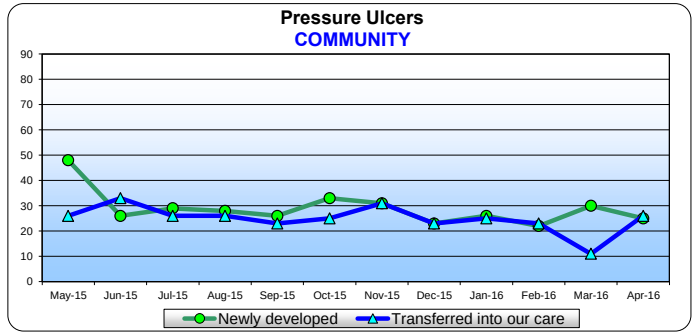


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Indicator			May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Pressure Ulcers source: DATIX	York	Newly developed	23	14	18	13	10	12	25	18	20	24	29	24
		Transferred into our care	70	56	53	58	42	53	61	70	58	68	72	50
	Scarborough	Newly developed	14	22	15	22	18	16	25	17	14	18	24	19
		Transferred into our care	57	68	45	48	59	42	56	68	64	47	51	53
	Community	Newly developed	48	26	29	28	26	33	31	23	26	22	30	25
		Transferred into our care	26	33	26	26	23	25	31	23	25	23	11	26



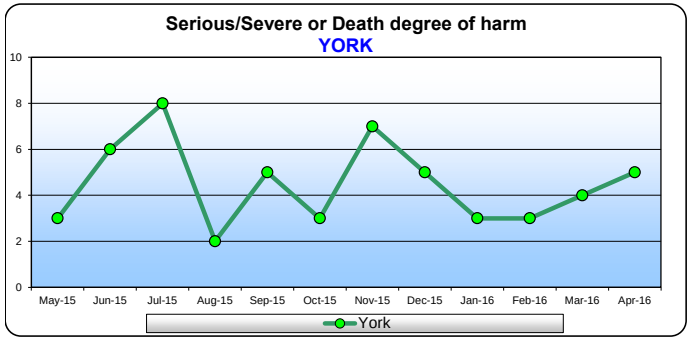


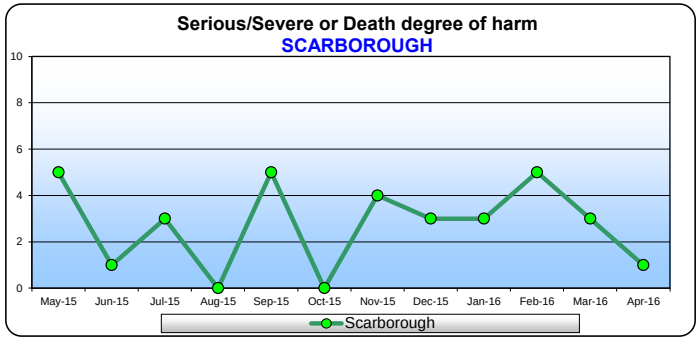


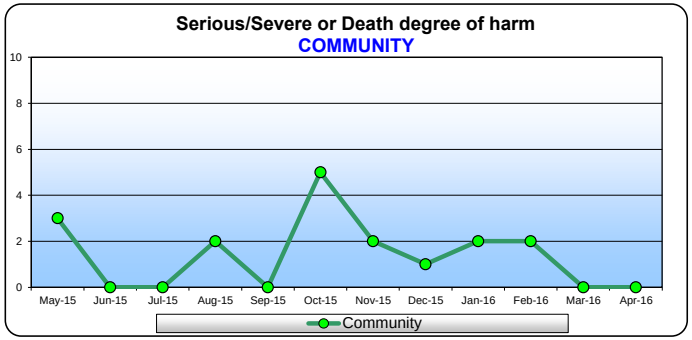
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised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

Measures of Harm

Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Degree of harm: serious/severe or death source: Datix	York	3	6	8	2	5	3	7	5	3	3	4	5
	Scarborough	5	1	3	0	5	0	4	3	3	5	3	1
	Community	3	0	0	2	0	5	2	1	2	2	0	0

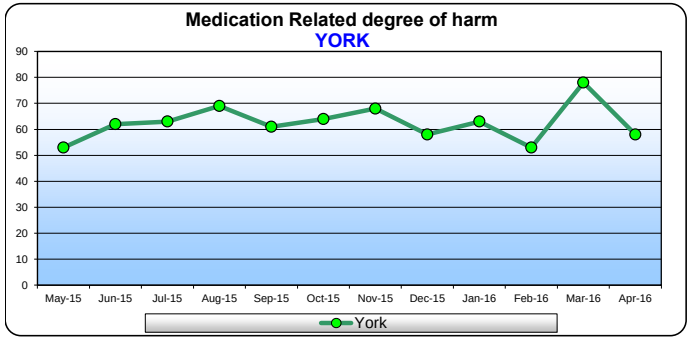


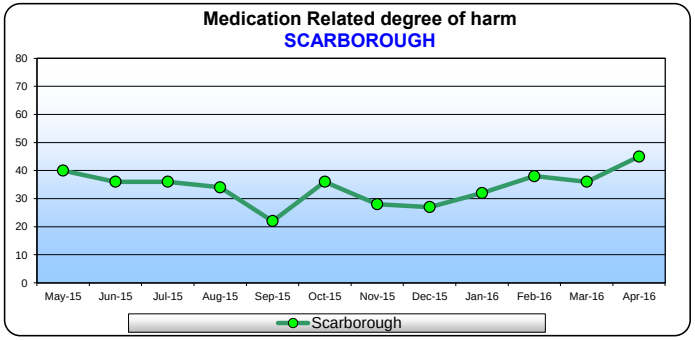


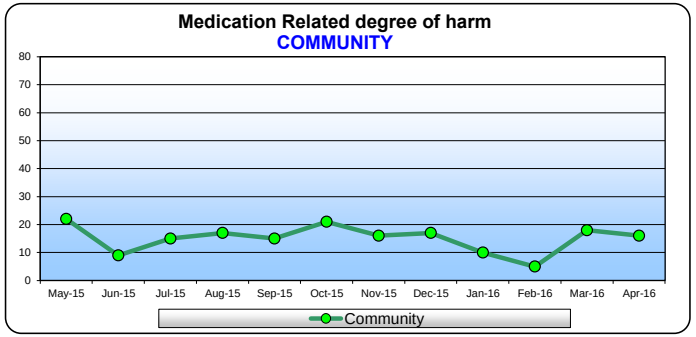


Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Degree of harm: Medication Related Issues source: Datix	York	53	62	63	69	61	64	68	58	63	53	78	58
	Scarborough	40	36	36	34	22	36	28	27	32	38	36	45
	Community	22	9	15	17	15	21	16	17	10	5	18	16

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.

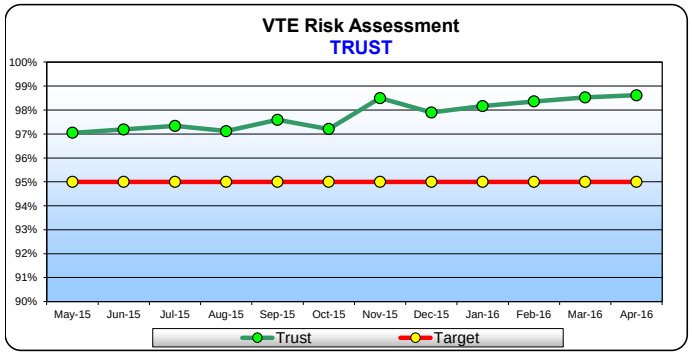


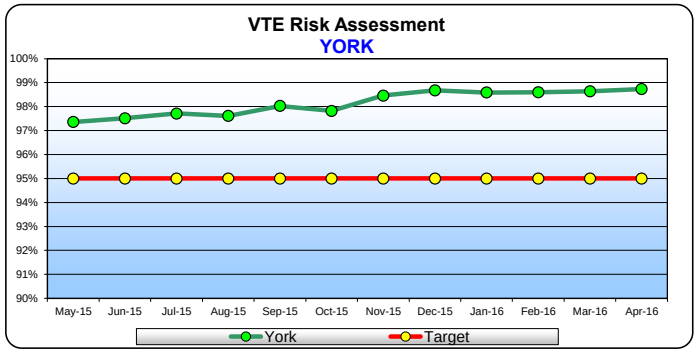


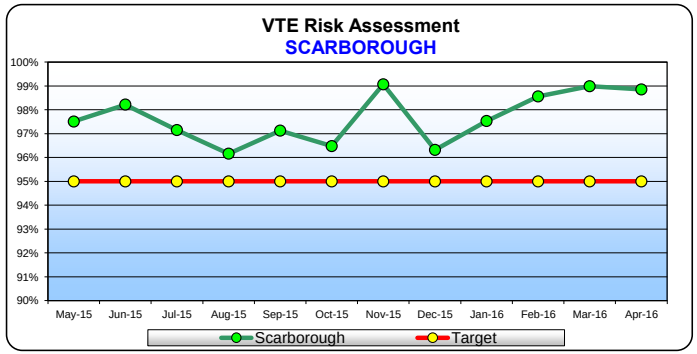


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
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	95%	97.1%	97.4%	97.9%	98.4%	98.4%	98.5%	98.6%
		York	95%	97.5%	97.8%	98.3%	98.6%	98.6%	98.6%	98.7%
		Scarborough	95%	97.7%	96.8%	97.3%	98.3%	98.6%	99.0%	98.9%







Never Events

Indicator	Consequence of Breach	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
SURGICAL									
Wrong site surgery	As below	>0	1	0	0	0	0	0	1
Wrong implant/prosthesis		>0	0	0	0	0	0	0	0
Retained foreign object post-operation		>0	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	0
Maladministration of potassium-containing solutions		>0	0	0	0	0	0	0	0
Wrong route administration of chemotherapy		>0	0	0	0	0	0	0	0
Wrong route administration of oral/enteral treatment		>0	0	0	0	0	0	0	0
Intravenous administration of epidural medication		>0	0	0	0	0	0	0	0
Maladministration of insulin		>0	0	0	0	1	1	0	0
Overdose of midazolam during conscious sedation		>0	0	0	0	0	0	0	0
Opioid overdose of an opioid-naïve Service User		>0	0	0	0	0	0	0	0
Inappropriate administration of daily oral methotrexate		>0	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	0
Entrapment in bedrails		>0	0	0	0	0	0	0	0
Transfusion of ABO incompatible blood components		>0	0	0	0	0	0	0	0
Transplantation of ABO incompatible organs as a result of error		>0	0	0	0	0	0	0	0
Misplaced naso- or oro-gastric tubes		>0	0	0	0	0	0	0	0
Wrong gas administered		>0	0	0	0	0	0	0	0
Failure to monitor and respond to oxygen saturation		>0	0	0	0	0	0	0	0
Air embolism		>0	0	0	0	0	0	0	0
Misidentification of Service Users		>0	0	0	0	0	0	0	0
Severe scalding of Service Users		>0	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	0

Drug Administration

Omitted Critical Medicines
The audit of critical medicines missed during April indicated 1.96% for York and 2.88% for Scarborough.

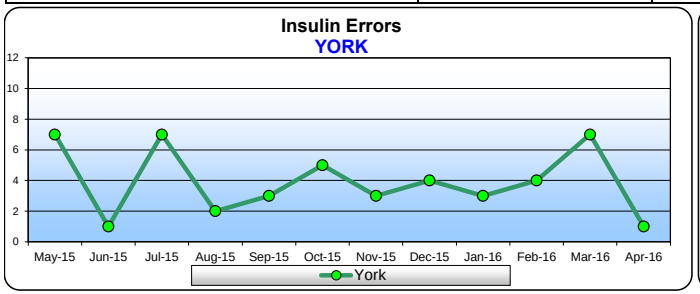
Prescribing Errors
There were 20 prescribing related errors in April; 12 from York, 8 from Scarborough and 0 from Community.

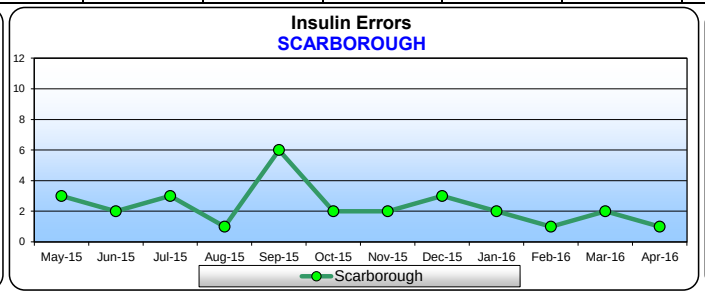
Preparation and Dispensing Errors
There were 17 preparation/dispensing errors in April; 7 from York, 6 from Scarborough and 4 from Community.

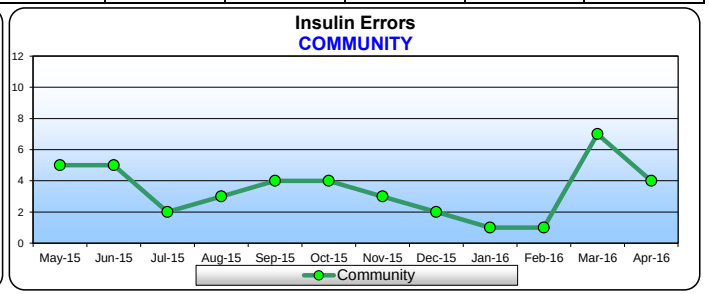
Administrating and Supply Errors
There were 52 administrating/supplying errors in April; 19 were from York, 24 from Scarborough and 9 from Community.

Drug Administration

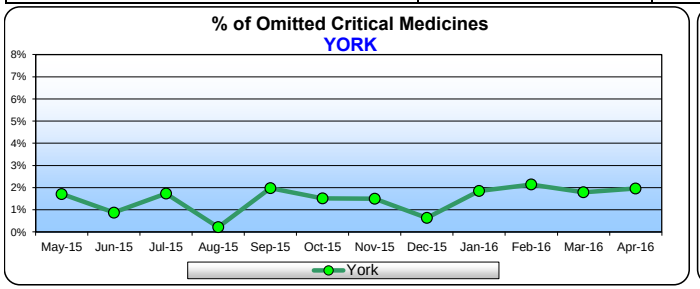
Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Insulin Errors source: Datix	York	7	1	7	2	3	5	3	4	3	4	7	1
	Scarborough	3	2	3	1	6	2	2	3	2	1	2	1
	Community	5	5	2	3	4	4	3	2	1	1	7	4

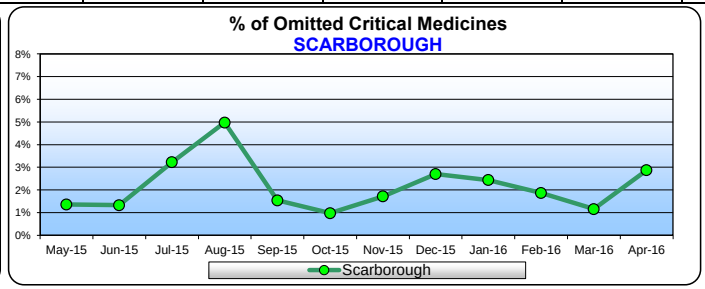


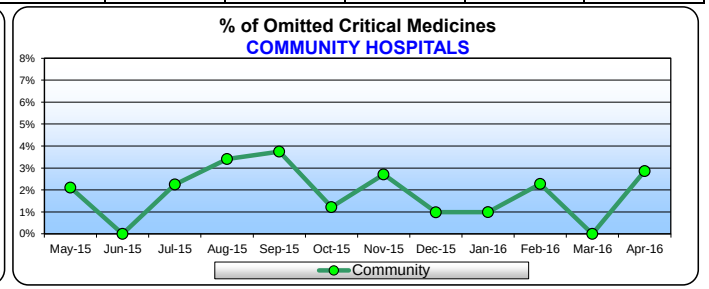




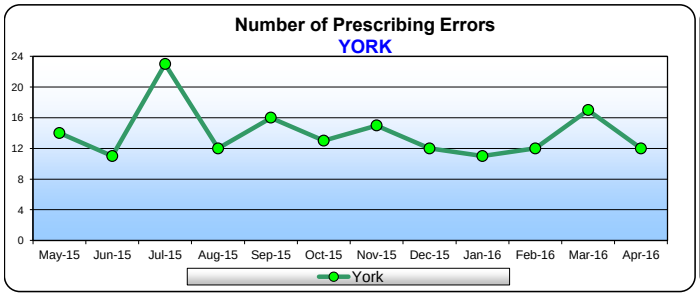
Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Number of Omitted Critical Medicines source: Datix	York	9	4	8	1	9	6	6	3	9	10	8	9
	Scarborough	3	3	7	10	3	2	4	7	6	5	3	8
	Community Hospitals	2	0	2	3	3	1	2	1	1	2	0	2

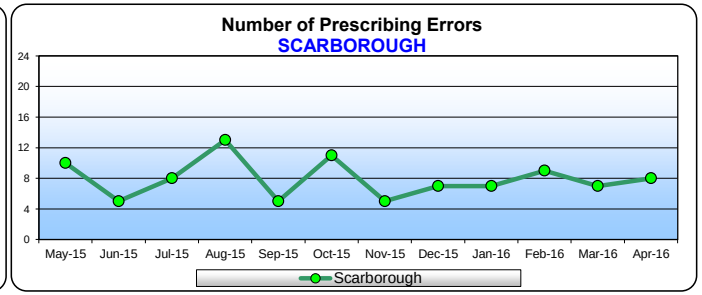


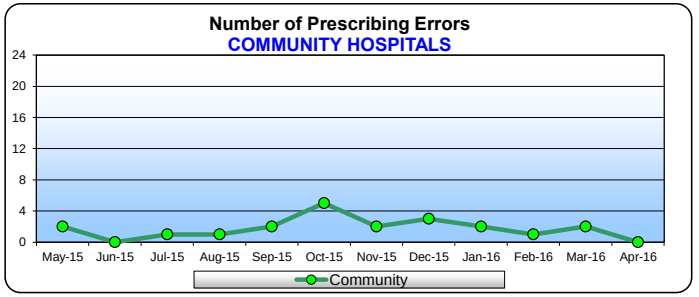




Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Number of Prescribing Errors source: Datix	York	14	11	23	12	16	13	15	12	11	12	17	12
	Scarborough	10	5	8	13	5	11	5	7	7	9	7	8
	Community Hospitals	2	0	1	1	2	5	2	3	2	1	2	0

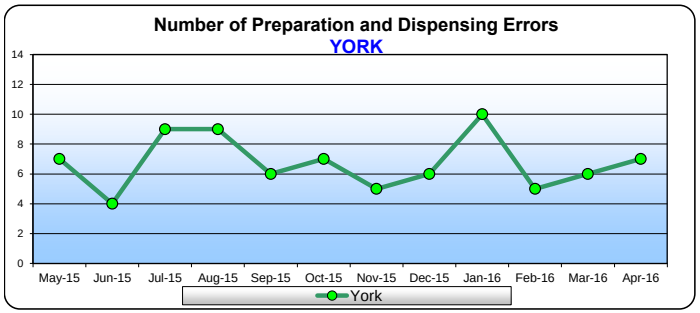


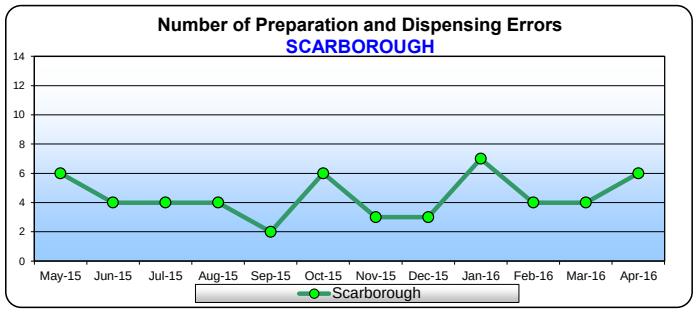


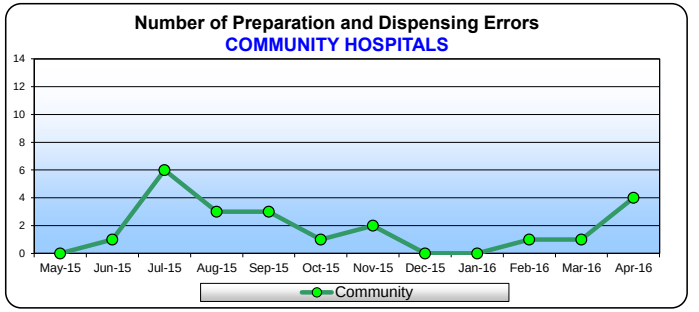


Drug Administration

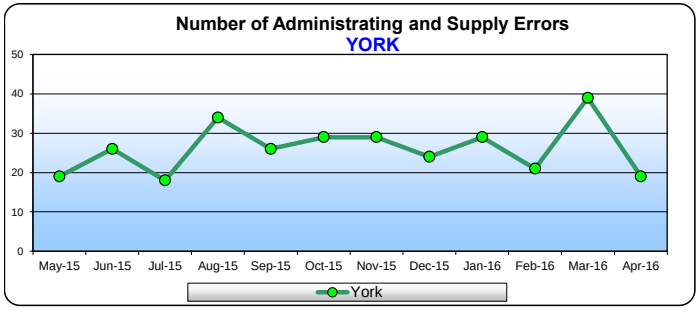
Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Number of Preparation and Dispensing Errors source: Datix	York	7	4	9	9	6	7	5	6	10	5	6	7
	Scarborough	6	4	4	4	2	6	3	3	7	4	4	6
	Community Hospitals	0	1	6	3	3	1	2	0	0	1	1	4

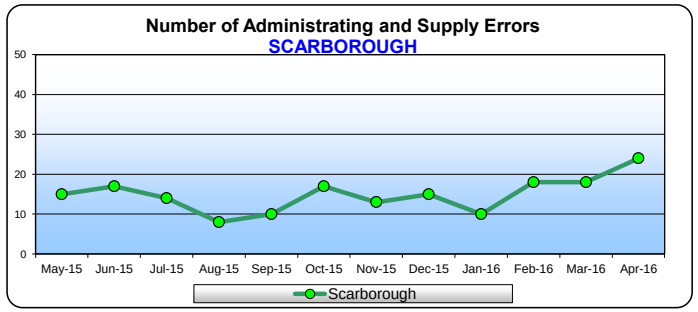


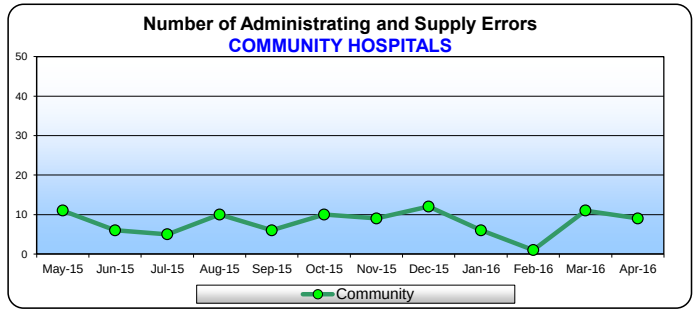




Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Administrating and Supply Errors source: Datix	York	19	26	18	34	26	29	29	24	29	21	39	19
	Scarborough	15	17	14	8	10	17	13	15	10	18	18	24
	Community Hospitals	11	6	5	10	6	10	9	12	6	1	11	9







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 April the percentage receiving care “free from harm” following audit is below:

·York: 95.3%
·Scarborough: 93.3%
·Community Hospitals: 93.1%
·Community care: 97.7%

Harm from Catheter Associated Urinary Tract Infection

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

·York: 0.8%
·Scarborough: 2.3%
·Community Hospitals: 1.4%
·Community Care: 0.0%

VTE

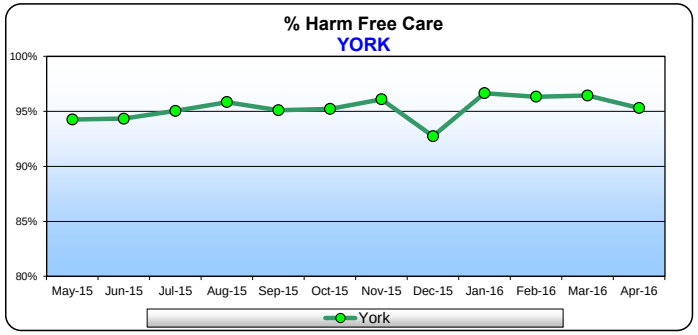
The percentage of patients affected by VTE as measured by the Department of Health definition, monthly measurement of prevalence:

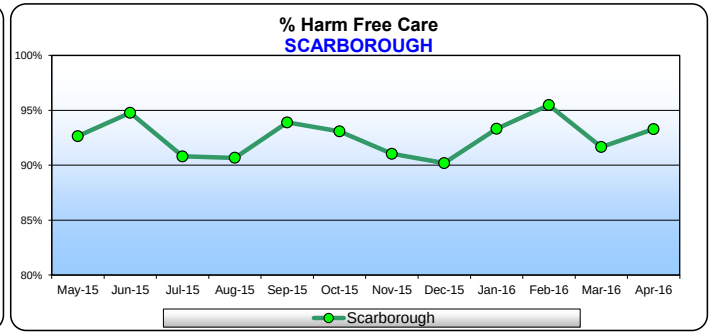
·York: 1.2%
·Scarborough: 0.3%
·Community Hospitals: 1.4%
·Community Care: 0.0%

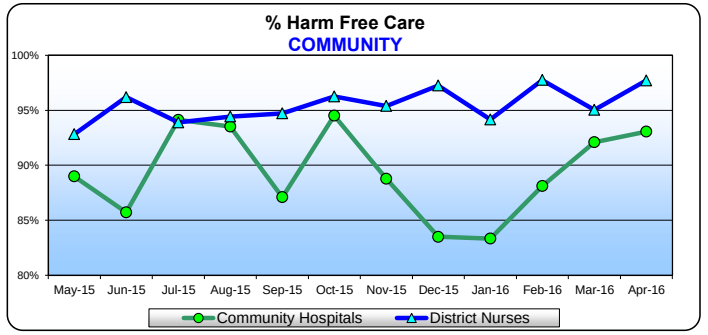
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month. Whitecross Court and St Helen's are not included in the Community Hospital figures as they are part of the acute bed base.

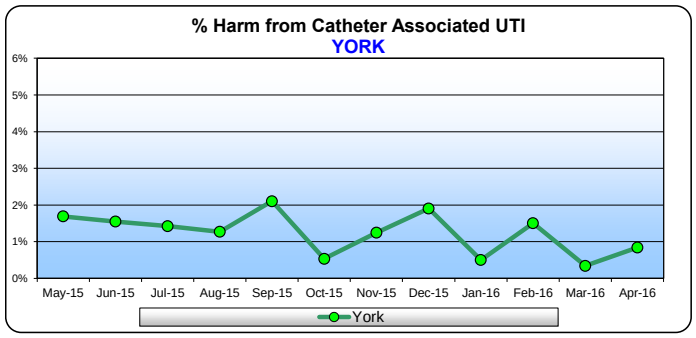
Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
% of Harm Free Care source: Safety Thermometer	York	94.3%	94.3%	95.0%	95.8%	95.1%	95.2%	96.1%	92.7%	96.7%	96.3%	96.4%	95.3%
	Scarborough	92.6%	94.8%	90.8%	90.7%	93.9%	93.1%	91.0%	90.2%	93.3%	95.5%	91.7%	93.3%
	Community Hospitals	89.0%	85.7%	94.1%	93.5%	87.1%	94.5%	88.8%	83.5%	83.3%	88.1%	92.1%	93.1%
	District Nurses	92.8%	96.2%	93.9%	94.4%	94.7%	96.2%	95.4%	97.2%	94.2%	97.8%	95.0%	97.7%

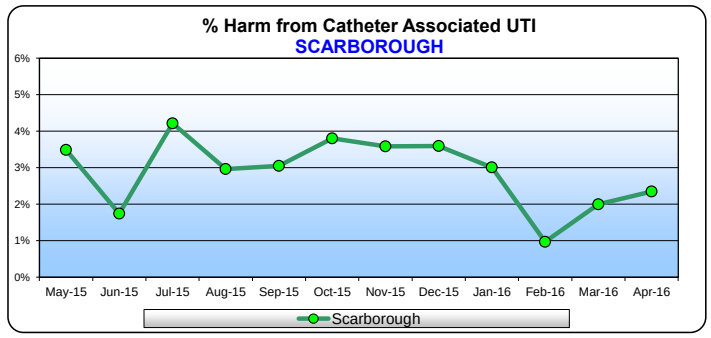


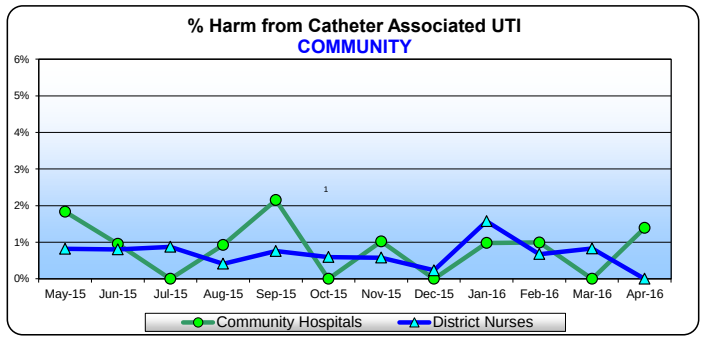




Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	1.7%	1.5%	1.4%	1.3%	2.1%	0.5%	1.2%	1.9%	0.5%	1.5%	0.3%	0.8%
	Scarborough	3.5%	1.7%	4.2%	3.0%	3.1%	3.8%	3.6%	3.6%	3.0%	1.0%	2.0%	2.3%
	Community Hospitals	1.8%	1.0%	0.0%	0.9%	2.2%	0.0%	1.0%	0.0%	1.0%	1.0%	0.0%	1.4%
	District Nurses	0.8%	0.8%	0.9%	0.4%	0.8%	0.6%	0.6%	0.2%	1.6%	0.7%	0.8%	0.0%



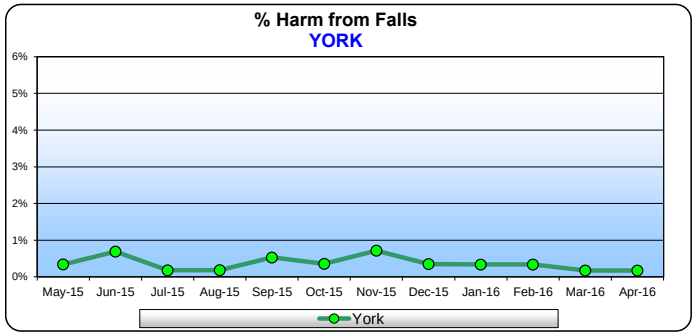


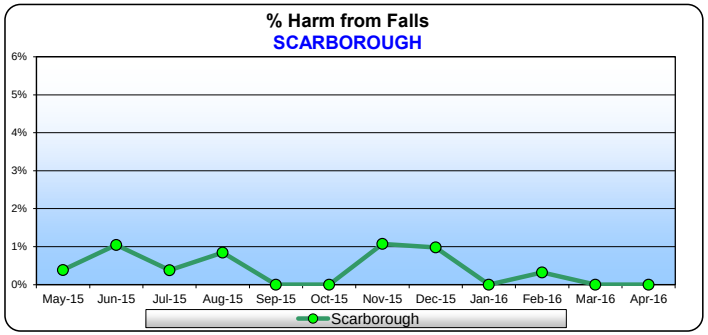


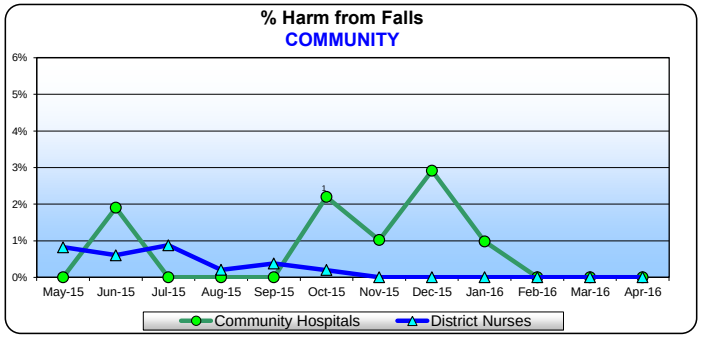
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month. Whitecross Court and St Helen's are not included in the Community Hospital figures as they are part of the acute bed base.

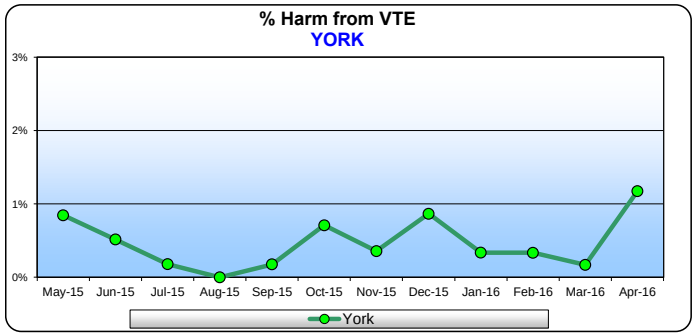
Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
% of Harm from Falls source: Safety Thermometer	York	0.3%	0.7%	0.2%	0.2%	0.5%	0.4%	0.7%	0.3%	0.3%	0.3%	0.2%	0.2%
	Scarborough	0.4%	1.0%	0.4%	0.8%	0.0%	0.0%	1.1%	1.0%	0.0%	0.3%	0.0%	0.0%
	Community Hospitals	0.0%	1.9%	0.0%	0.0%	0.0%	2.2%	1.0%	2.9%	1.0%	0.0%	0.0%	0.0%
	District Nurses	0.8%	0.6%	0.9%	0.2%	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

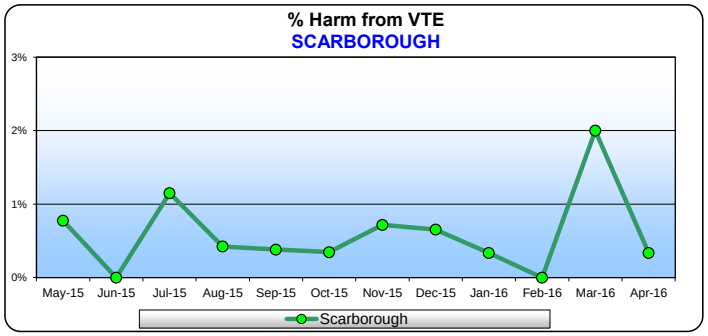


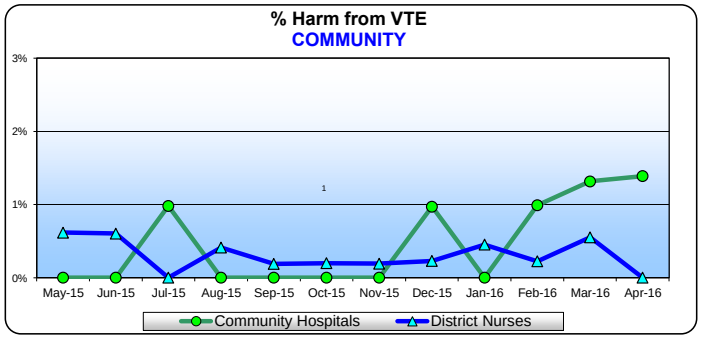




Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
% of VTE source: Safety Thermometer	York	0.8%	0.5%	0.2%	0.0%	0.2%	0.7%	0.4%	0.9%	0.3%	0.3%	0.2%	1.2%
	Scarborough	0.8%	0.0%	1.1%	0.4%	0.4%	0.3%	0.7%	0.7%	0.3%	0.0%	2.0%	0.3%
	Community Hospitals	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	1.0%	1.3%	1.4%
	District Nurses	0.6%	0.6%	0.0%	0.4%	0.2%	0.2%	0.2%	0.2%	0.5%	0.2%	0.6%	0.0%



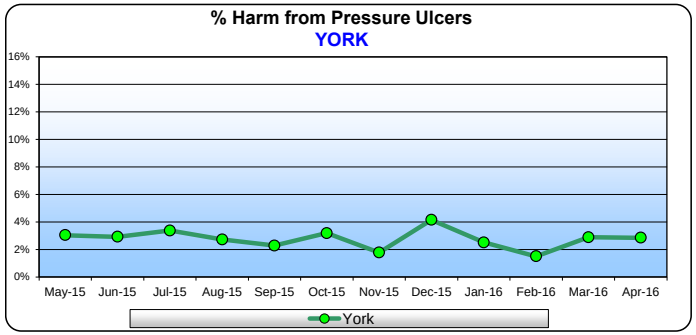


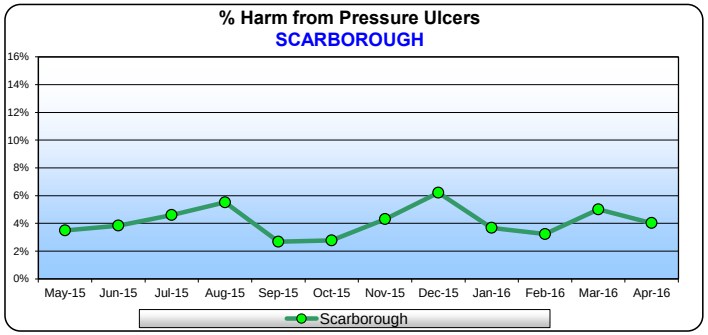


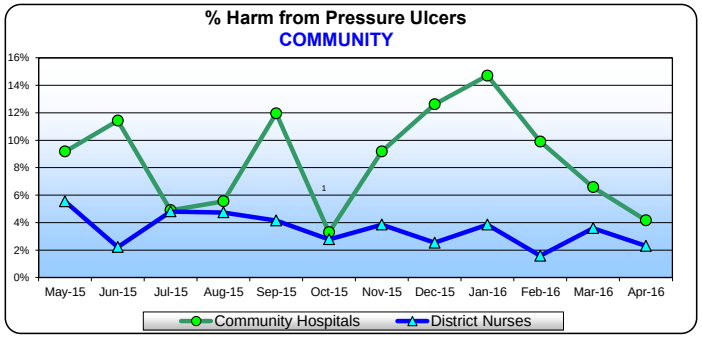
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month. Whitecross Court and St Helen's are not included in the Community Hospital figures as they are part of the acute bed base.

Indicator		May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
% of Pressure Ulcers source: Safety Thermometer	York	3.0%	2.9%	3.4%	2.7%	2.3%	3.2%	1.8%	4.2%	2.5%	1.5%	2.9%	2.9%
	Scarborough	3.5%	3.8%	4.6%	5.5%	2.7%	2.8%	4.3%	6.2%	3.7%	3.2%	5.0%	4.0%
	Community Hospitals	9.2%	11.4%	4.9%	5.6%	12.0%	3.3%	9.2%	12.6%	14.7%	9.9%	6.6%	4.2%
	District Nurses	5.5%	2.2%	4.8%	4.7%	4.2%	2.8%	3.8%	2.5%	3.8%	1.6%	3.6%	2.3%







Mortality

Indicator	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15
SHMI – York locality	102	98.7986	96	93	93	95	98	99	97	96	95	93
SHMI – Scarborough locality	106	107.7479	108	104	105	107	108	109	107	108	107	107
SHMI – Trust	**104**	**102**	**101**	**97**	**98**	**99**	**102**	**103**	**101**	**101**	**99**	**99**

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 indicates the Trust to be in the 'as expected' range. The Oct 2014 - Sep 2015 SHMI saw a 2 point reduction at York and no change for the Trust or Scarborough. Trust - 99, York 93 and Scarborough 107.

April saw a decrease in the number of Inpatient deaths; a total of 189 were reported for the Trust; 113 at York and 65 at Scarborough. For the same period last year a total of 168 inpatient deaths were reported for the Trust, therefore there has been a 12.5% increase year on year. 101 of the inpatient deaths reported in April 2016 were under Geriatric Medicine (53.4%).

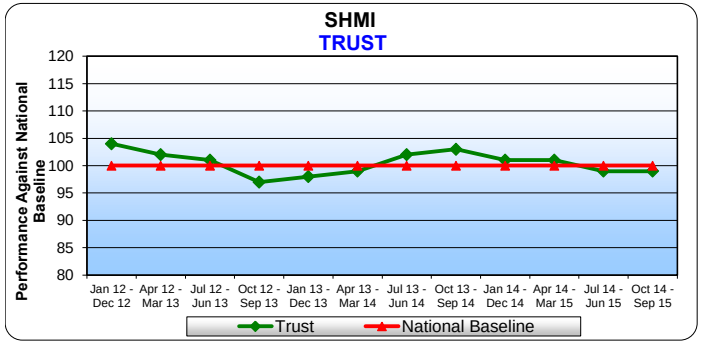
The number of ED deaths at York increased from 6 in March to 13 in April. A total of 133 have been reported in the last 12 months (May 2015 – April 2016) which equates to 11 per month on average.

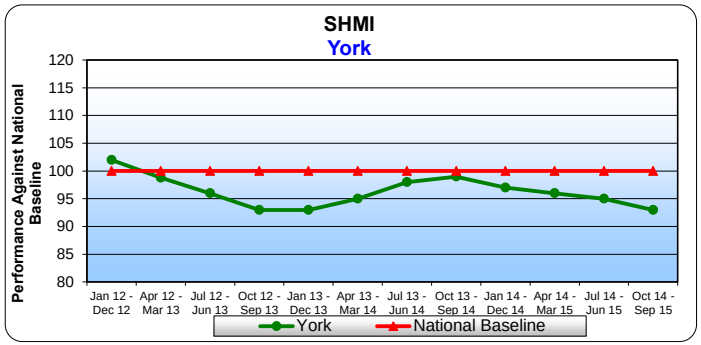
There were 4 ED deaths at Scarborough in April, a decrease from 16 in March. A total of 86 have been reported in the last 12 months (May 2015 – April 2016) which equates to 7 per month on average.

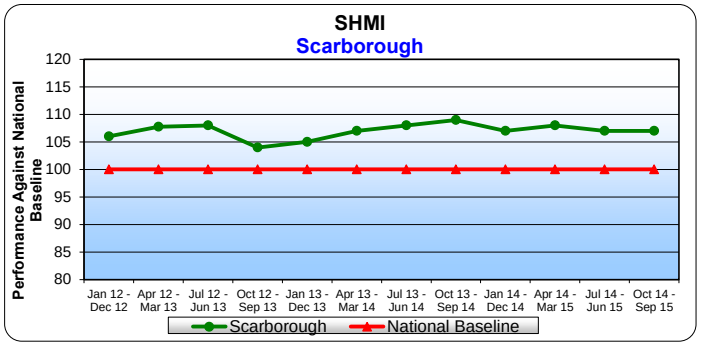
Mortality

York Teaching Hospital NHS
NHS Foundation Trust

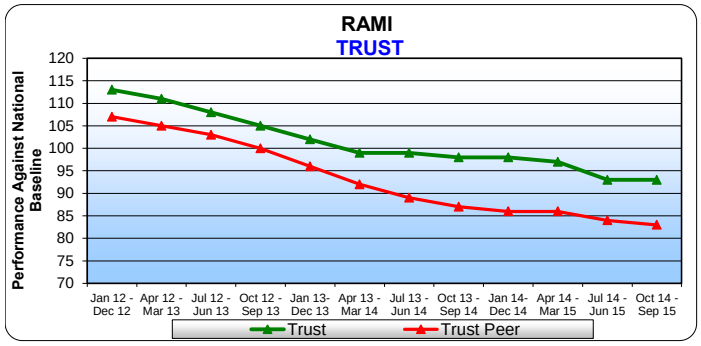
Indicator	Consequence of Breach (Monthly unless specified)	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	99	102	103	101	101	99	99
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	95	98	99	97	96	95	93
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	107	108	109	107	108	107	107

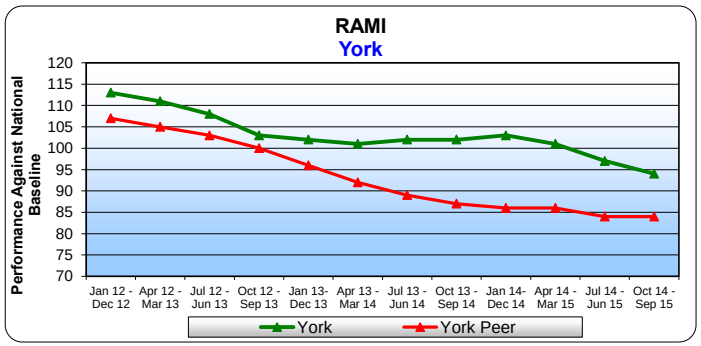


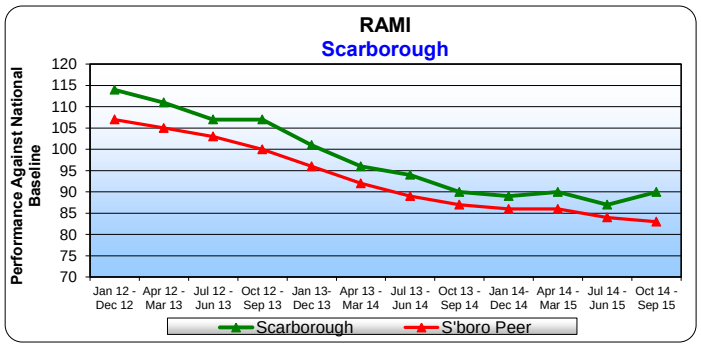




Indicator	Consequence of Breach (Monthly unless specified)	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15
Mortality – RAMI (TRUST)	**none - monitoring only**	99	99	98	98	97	93	93
Mortality – RAMI (YORK)	**none - monitoring only**	101	102	102	103	101	97	94
Mortality – RAMI (SCARBOROUGH)	**none - monitoring only**	96	94	90	89	90	87	90



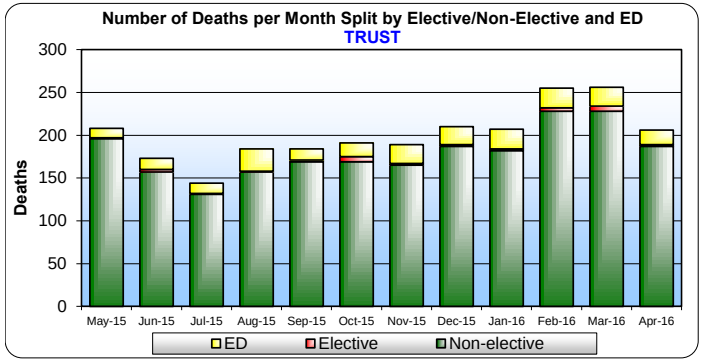


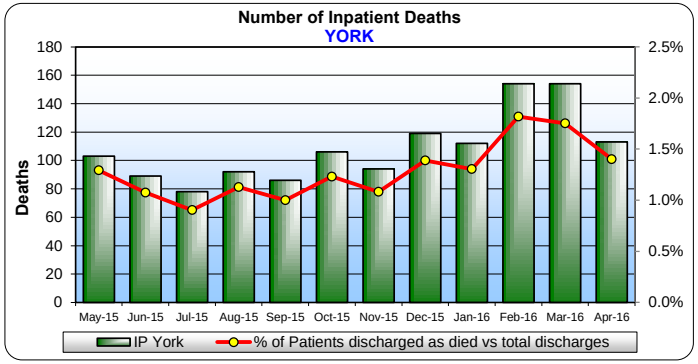


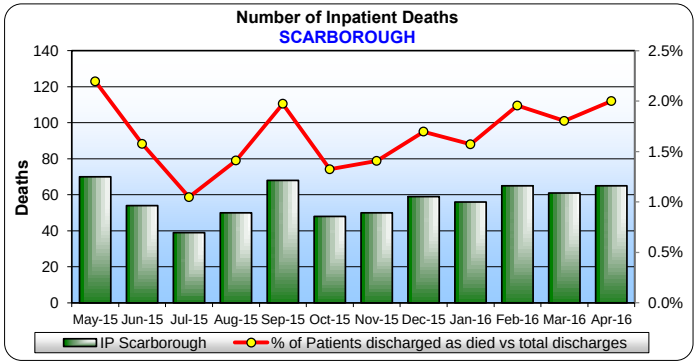
Mortality

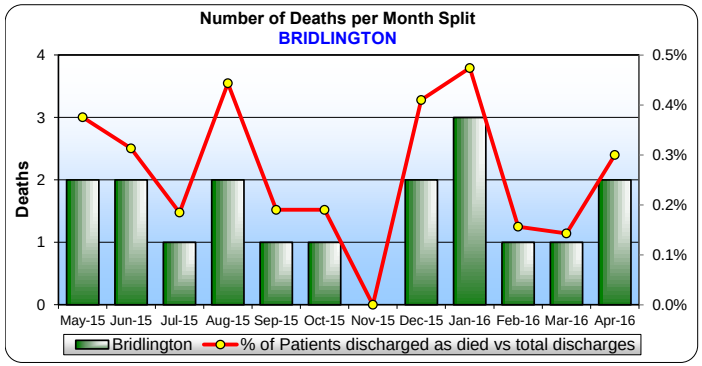
York Teaching Hospital NHS
NHS Foundation Trust

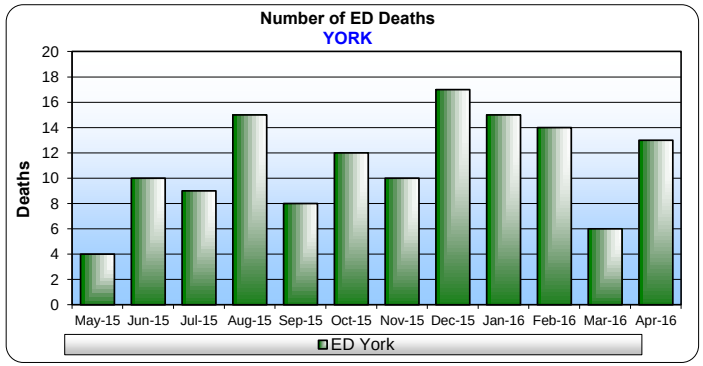
Indicator	Consequence of Breach (Monthly unless specified)	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Number of Inpatient Deaths	None - Monitoring Only	525	461	531	650	232	234	189
Number of ED Deaths	None - Monitoring Only	37	51	59	68	23	22	17

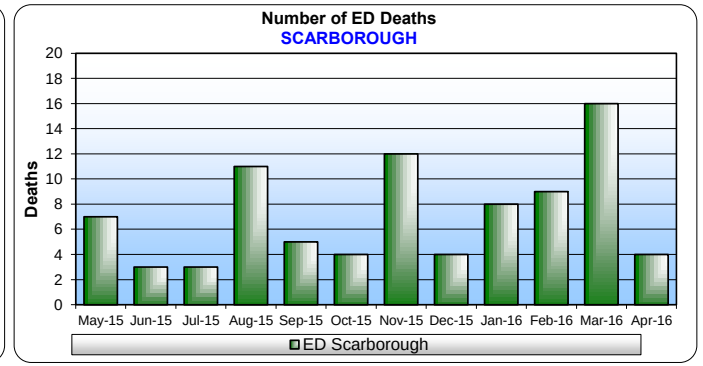


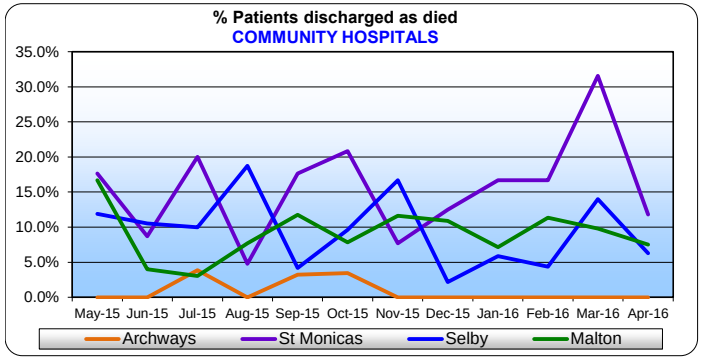


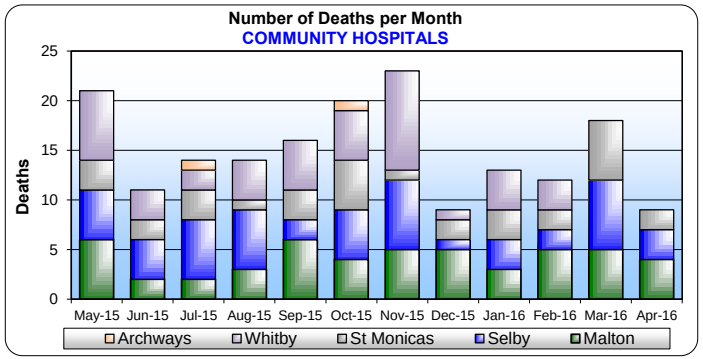












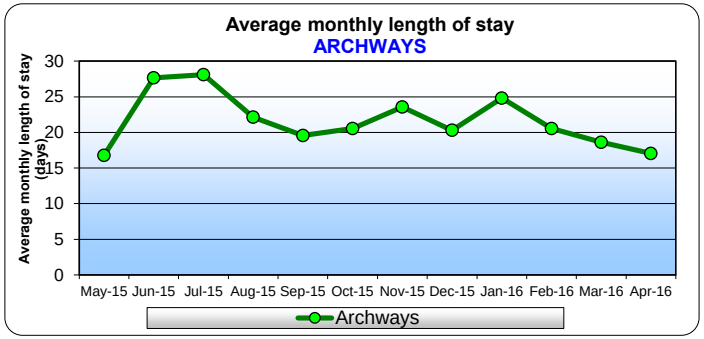
Month	Malton	Selby	St Monicas	Archways	Brid
May-15	6	5	3	0	2
Jun-15	2	4	2	0	2
Jul-15	2	6	3	1	1
Aug-15	3	6	1	0	2
Sep-15	6	2	3	0	1
Oct-15	4	5	5	1	1
Nov-15	5	7	1	0	0
Dec-15	5	1	2	0	2
Jan-16	3	3	3	0	3
Feb-16	5	2	2	0	1
Mar-16	5	7	6	0	1
Apr-16	4	3	2	0	2

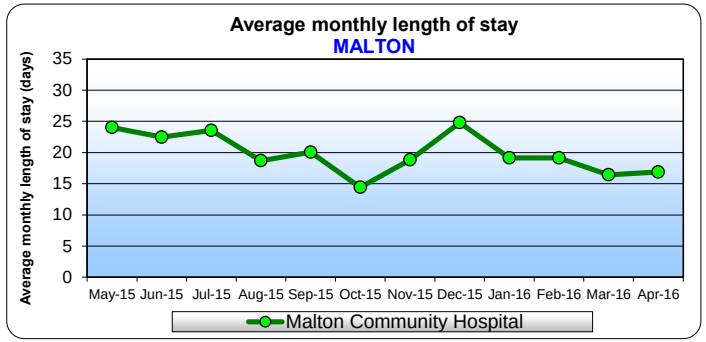
Patient Safety Walkrounds – April 2016

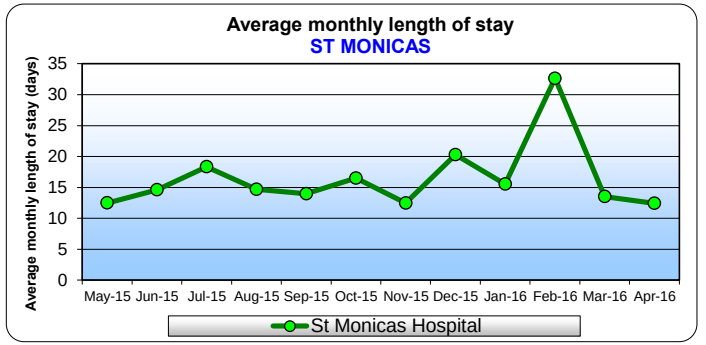
Date	Location	Participants	Actions & Recommendations
08/04/2016	Ward 34, Sleep Service & Cardiac Rehab	Sue Rushbrook – Director Nigel Durham – CD Sharon Lewis – Directorate Manager Christine Morris – Matron Mike Sweet - NED	Postponed, rescheduled for 08/06/2016
12/04/2016	St Monica's - Easingwold	Diane Palmer – Deputy Director Audrey Willis – Ward Manager Jennie Adams - NED	The WIFI is not available throughout the unit so this will prevent the introduction of EPMA. Action: SNS are aware and will change provision for future roll out. There are only two independent nurse prescribers and one of those is leaving. Action: to recruit/train more nurse prescribers. The Sister is leaving and there are already RN vacancies on the unit. Action to advertise and recruit to vacancies. There is CCTV but it is not linked to York site. Action to consider if the CCTV can be linked to York site. Dirty laundry is only collected twice/week. Action: discuss with Estates if provision can be increased or for alternative collection point to be identified outside of the ward.
18/04/2016	Theatres, Endoscopy, Scarborough Hospital	Brian Golding – Director John Mensah – Deputy Clinical Director Gemma Ellison - Directorate Manager Pauline Guyan – Matron Mike Keaney - NED	Postponed, rescheduled for 30/06/2016
28/04/2016	White Cross Court	Polly McMeekin – Deputy Director Ginni Smith – Assistant Director of Nursing Marianne Pipes – Ward Manager Mike Sweet - NED	No handwashing facilities in gym, changing room or drug preparation area, batteries (in handwash dispensers) need replacing Action: ward manager to resolve. Cluttered shelving in gym of equipment books and paper Action: ward manager to ensure shelves are cleared. Ward female toilet broken Action: ward manger to request repair. SOPs in bathrooms not recorded for 3 days Action: ward manger to discuss with domestic services. Unsupervised patient at risk of falls in dining room at lunchtimes Action: ward manager to ensure supervision and to consider volunteers to support mealtime activities.

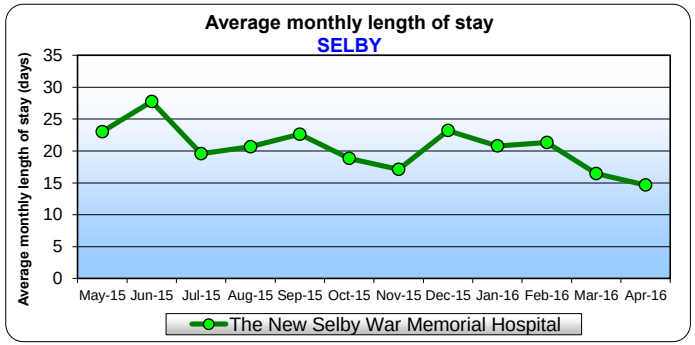
Community Hospitals

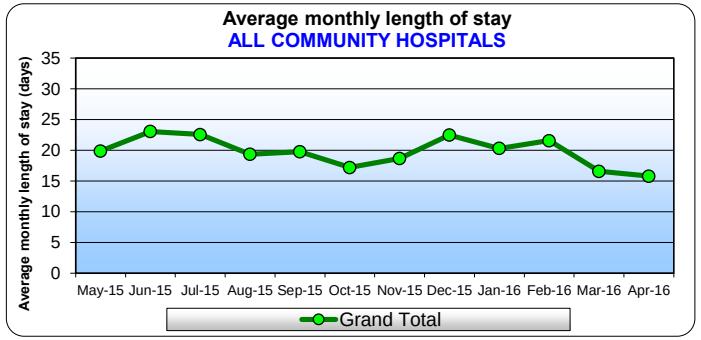
Indicator	Hospital	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Community Hospitals average length of stay (days) Excluding Daycases	**Archways**	22.5	22.0	22.5	20.9	20.6	18.6	17.0
	Malton Community Hospital	20.0	24.3	20.5	19.4	19.2	16.4	16.9
	St Monicas Hospital	21.4	19.3	19.3	18.8	32.6	13.5	12.4
	The New Selby War Memorial Hospital	24.0	23.6	23.0	20.4	21.3	16.4	14.7
	Total	21.9	22.7	21.5	20.0	21.6	16.6	15.8





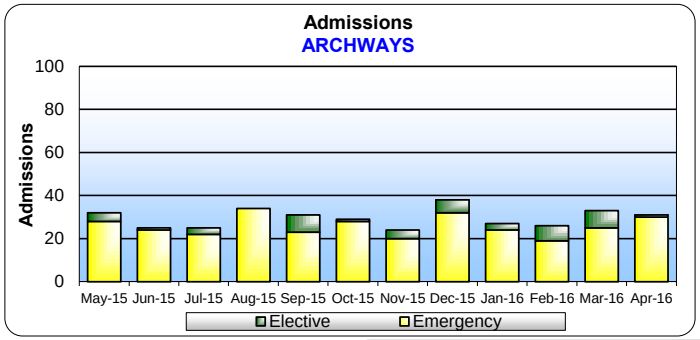


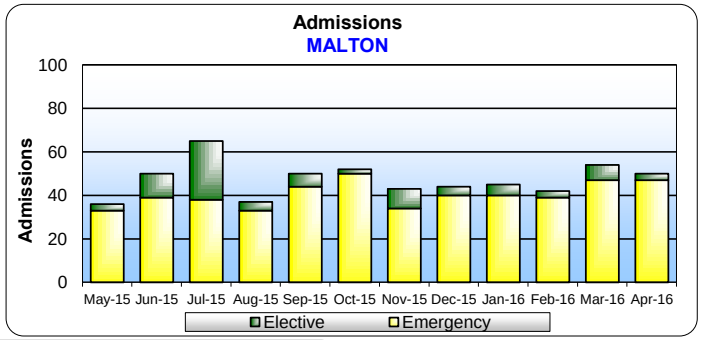


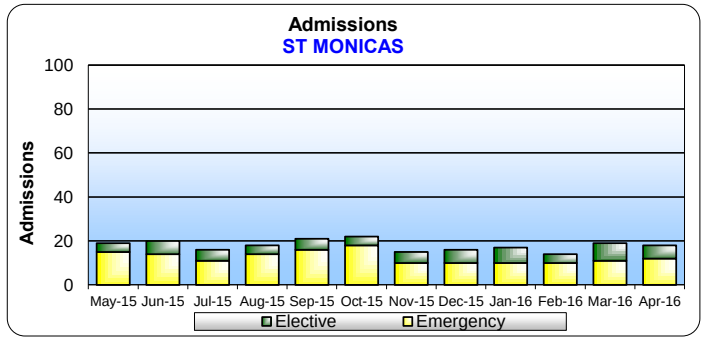


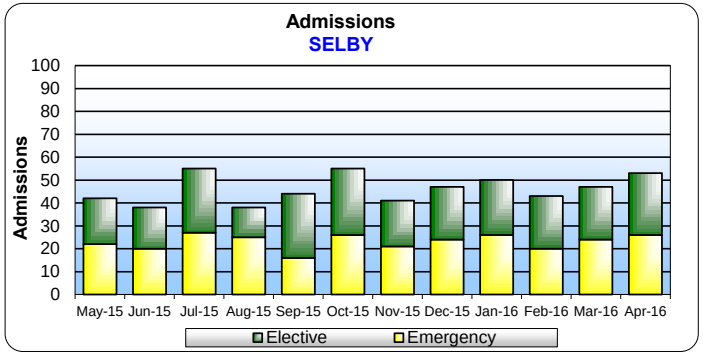
Community Hospitals

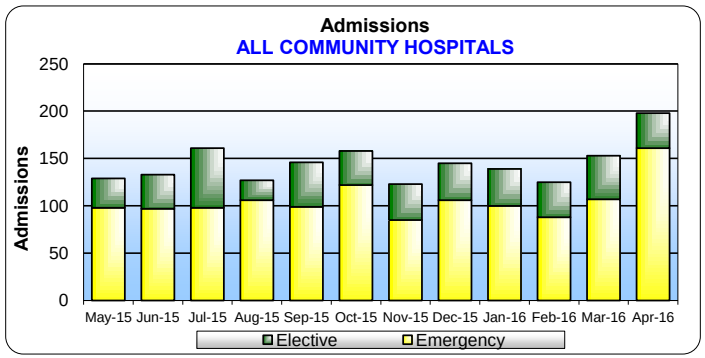
Indicator	Hospital		Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	**Archways**	**Elective**	8	9	13	16	7	8	1
		Emergency	74	85	76	74	19	25	30
	Malton Community Hospital	**Elective**	41	12	18	13	3	7	3
		Emergency	110	127	114	133	39	47	47
	St Monicas Hospital	**Elective**	15	13	18	18	4	8	6
		Emergency	40	48	30	33	10	11	12
	The New Selby War Memorial	**Elective**	66	70	67	73	23	23	27
		Emergency	69	67	71	70	20	24	26
	Total	**Elective**	130	104	116	120	37	46	37
		Emergency	429	460	482	310	88	107	161











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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 May 2016

Medical Director's Public Briefing

Action requested/recommendation

Board of Directors are requested to:

- Consider our annual report to the Human Tissue Authority
- Be aware of progress with the Electronic Prescribing and Medicines Administration
- Consider the latest report from the National Reporting and Learning System
- Consider the medicines prescribing incidents from March 2016
- Note consultants new to the Trust
- Consider the Quality Priorities Report (2015/16).

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).

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 other than those specifically referenced in the paper.
Resource implications	None identified.
Owner	Mr Jim Taylor, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	May 2016
Version number	1

Board of Directors - 25 May 2016

Medical Director's Report

1. Introduction and background

In the report this month:

Patient Safety

- Annual report to the Human Tissue Authority
- Electronic Prescribing and Medicines Administration update
- National Reporting and Learning System update
- Prescribing incidents

Clinical Effectiveness

- Consultants new to the Trust

Patient Experience

- Quality Priorities Report (2015/16)

2. Patient Safety

2.1 HTA report 2015-2016

York Teaching Hospital NHS Foundation Trust currently holds a single Post Mortem licence under the Human Tissue Act 2004 with a single licence number of 12093 - this also incorporates Scarborough Hospital as a satellite of York Hospital but with its own Mortuary facilities and body store. This report details changes occurring between 1st April 2015 and 31st March 2016 and outlines progress against HTA regulatory standards.

Organisation and structure:
There have been no changes in the Designated Individual - Mr Trevor Hair, (Head Biomedical Scientist) for Histology, Cytology and the Mortuary; however the Trust now has a new Medical Director, Dr Jim Taylor who replaced Dr Alastair Turnbull in May 2015.
Consent taker training:
The Trust currently sends all of its paediatric post mortem cases to Leeds Teaching Hospital; where there is a specialist paediatric pathologist. The Trust uses the consent form from Leeds – form HP WQN564. Printed multipart forms are available throughout Maternity on both sites as required.
Consent taker training for Maternity staff:
This was undertaken on 22nd May 2015 in Maternity York Teaching Hospital. On 22nd July 2015 this was repeated at Scarborough Hospital for maternity staff. The training consisted of a number of presentations, including:
The HTA and regulatory issues – Mr T Hair
The Perinatal Post Mortem – Dr C Bratten
Mortuary Issues and Consent taking – Mr K Breheney/ Ms D Elmer
Consent in the Mortuary Setting – Ms B Shelley
How to complete the Consent Form – Ms S Oakes (Leeds).
Planned consent taker training is due May 2016.
The DI is attending the Consent Training Day run by the AAPT later I the year on 20th May

2016 at Coldbath Square, London

Staff training:
In July 2015 three the York Mortuary Manager was selected as one of the Disaster Victim Identification group to attend at the Chelsea and Westminster Mortuary during the repatriation of those killed in the terrorist attack on Port El-Kantoui, Tunisia. Kevin was subsequently thanked personally by Commander Richard Walton, Counter Terrorism Command (SO15) and was also awarded the Trust Star Performer award for September 2015. Chris Williams (APT) SGH Mortuary attended the “Eye retrieval” Course run by the NHSBT tissue and eye bank service. James Mason (APT) York Mortuary attended Assessor Training for AAPT examination in March 2016

Governance and quality systems:
In mid-January 2016, the entire Histology department from Scarborough Hospital was relocated onto the York site with the subsequent closure of this laboratory at Scarborough. The Histology department is now utilising a single integrated LIMS computer system (Telepath) and has integrated standard operating processes on the York site. The use of post mortem mortuary facilities has ceased at Scarborough Hospital mortuary and post mortem facilities have been moth-balled, Coroners PM’s which were being done at Scarborough are being undertaken at James Cook University Hospital, with those Coroners PM’s from the Selby area being undertaken at York.

CQC inspection:
The Trust was inspected by the CQC on 17-20th March 2015. Both Mortuaries were visited and staff were interviewed. No issues were raised by the CQC regards the Mortuary and the Bereavement Care service across both sites were recognised as being of a “Good“ standard.

CPA accreditation:
The Histology laboratory at York Teaching Hospital is fully CPA accredited. Both York and Scarborough Mortuaries are now fully CPA accredited.

HTA inspection:
An HTA inspection of Scarborough mortuary was conducted on 20/21st May 2015. A large number of non-compliances were identified – these were all rectified by 25th February 2016 and the inspection report on the HTA website now reflects this – Scarborough is listed as a satellite site for York Teaching Hospital NHS FT, licence number 12093.
HTA Reportable Incidents (HTARI) – One HTARI incident has been reported in 2016 – CAS 34155-F3N7 concerning disposal by incineration of Products of Conception which should have been respectfully cremated. The Trust has been informed that this is not a HTARI but that they will pass the information on to the CQC.

In response to the non-compliances raised by the HTA, new windows and doors have been fitted to the entrance and visitors areas of the SH Mortuary, temperature monitoring equipment has been added to the BodyStore facility and a full video monitoring suite of cameras and internal TV screens have been put up inside the SGH Mortuary. Following the loss of all Histopathologists at Scarborough Hospital, Post Mortems have ceased at Scarborough Hospital. Proposals are underway as of December 2015 to redevelop the Scarborough Mortuary including increasing the number of fridges and a significant rebuild of the premises.

Archiving and disposal:
All slides and blocks have been moved from the SH site and are now on site and stored securely at York Teaching Hospital. Any blocks and slides preceding 2008 are now in secure offsite storage with Restore.

New Guidance from HTA:
Sensitive disposal of Foetal Remains:
New guidance on the Sensitive Disposal of pregnancy remains following pregnancy loss or termination have been received from the HTA regarding cremation, burial or incineration of this tissue – this was published in March 2015. Trust guidance has been revised in line with this and updated on Q-Pulse as of 23/01/2015.
The local crematorium in York has been contacted to check that it is able to dispose of the additional tissue we expect to generate from these changes.

Service Level Agreements:
A new Service Level Agreement has been signed between York Teaching Hospitals NHS FT and the North Yorkshire County Council. The local crematorium at Scarborough (Woodlands Crematorium) has been contacted with regards disposal of foetal remains and the Trust hope to have a Service Level Agreement signed with this crematorium shortly so that we can cease using Hull crematorium for disposal of Scarborough tissue.

2.2 EPMA

Progress Report: 11.05.16

Summary of Key Dates:

System development complete	End of May 2016
User Acceptance Testing (phased)	June 2016 onwards
Shadow Testing on wards	July 2016
Initial rollout phase (pilot)	July 2016 onwards
Rollout Phase 1 (c. 7 months duration)	August 2016 onwards

Project Progress to date:
EPMA Prescribing & Administration screens undergoing wide clinical engagement
Training approach agreed: key messages defined & training clip requirements identified
System Testing plan agreed with wider EPMA project team
Clinical Safety Hazard Log completed with agreed mitigation measures
Communications strategy drafted
Rollout order drafted for sign off at EPMA Project Board
Additional power points installed as required for drug trolleys
Completion of technical testing

Development Progress to date:
90% of the coding (programming) for EPMA is complete
Enhanced allergy review functionality ready for rollout as precursor to EPMA
Identification & verification of Formulary drugs data in FDB Drug database is 98% complete
Pharmacy technical testing is complete
Technical solution for business continuity defined
Whilst the IT development will be driven by the functional specifications there will be an iterative nature to it depending on feedback received at each of the demonstration stages.

Anticipated progress next quarter:
Remaining development work completed
User Acceptance Testing completed incl. shadow testing on wards
FDB acceptance testing completed
Business continuity plan shared with wider organisation
Rollout order confirmed & super users identified on pilot ward
Devices in place on pilot ward(s)
Training packages completed & accessible via learning hub

Agreed mechanism in place for agency staff re access / training

Key Risks:
The Clinical Safety Hazard log will provide assurance to the Trust of the clinical safety of the product. Project Risk Register (including pre-rollout risks) is in place and reviewed monthly. The current red risks are detailed below:
Interface between electronic & paper systems e.g. Theatres
Potentially insufficient staff to support rollout
Business continuity solution & potential risk to discharges

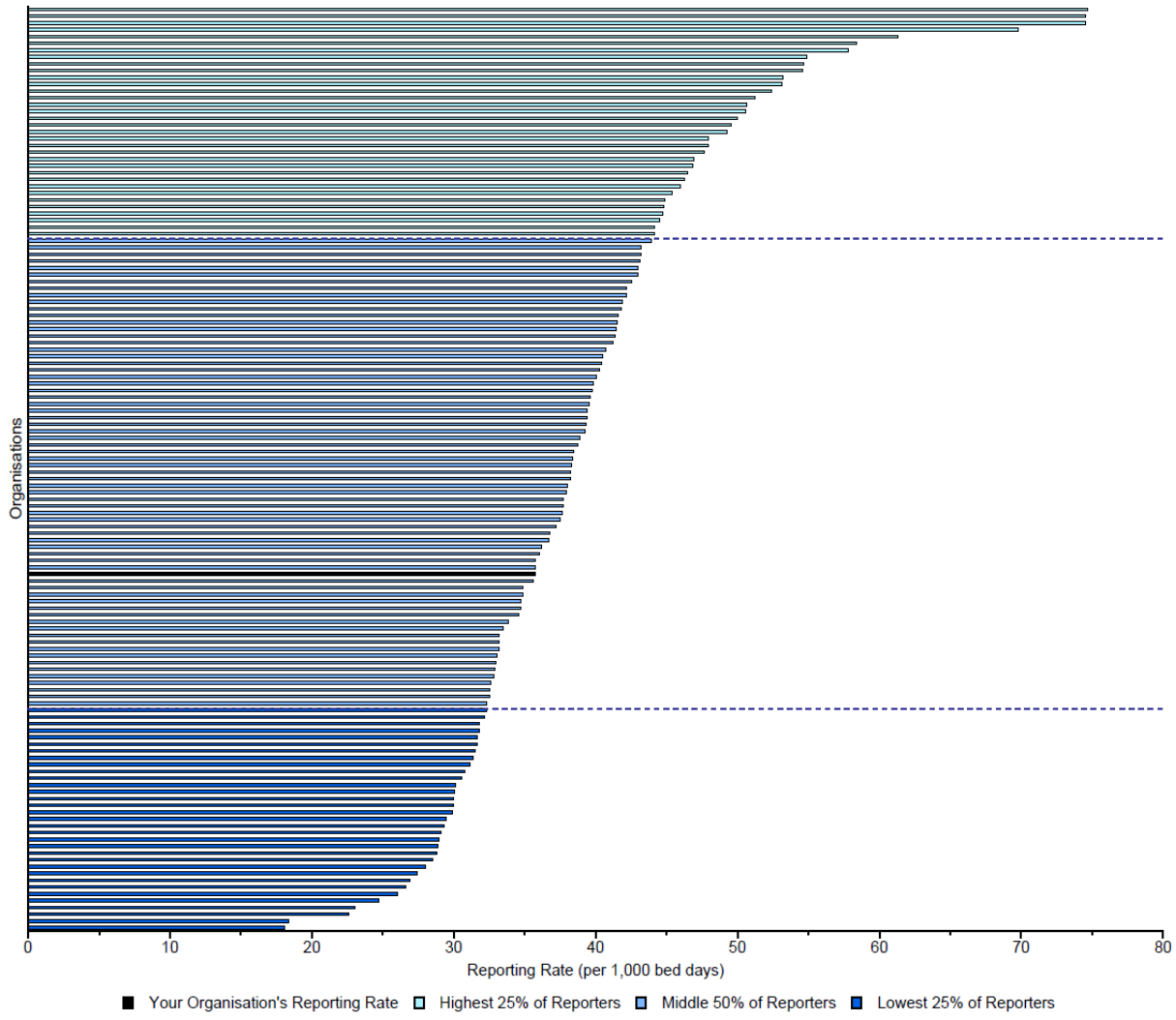
2.3 NRLS - update

Organisation Patient Safety Incident Report
Reported incidents between 01 April 2015 to 30 September 2015
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Organisation type: Acute (non-specialist) organisation

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 01 April 2015 to 30 September 2015. Your organisation reported 6,081 incidents (rate of 35.74) during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 136 Acute (non-specialist) organisations.



The median reporting rate for this cluster is 38.25 incidents per 1,000 bed days.

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

How regularly do you report?

Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 6 out of the 6 months between 01 April 2015 to 30 September 2015.

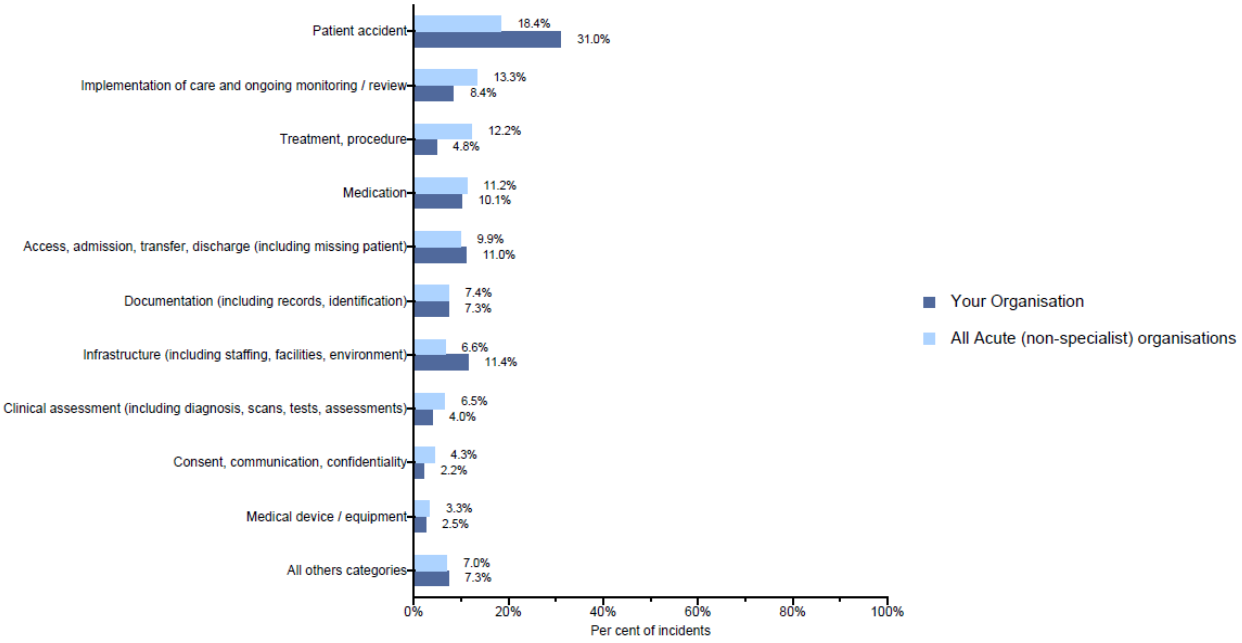
Report regularly: Incident reports should be submitted to the NRLS at least monthly.

Fifty per cent of all incidents were submitted to the NRLS more than 27 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 78 days after the incident occurred.

Report serious incidents quickly: It is vital that staff report serious safety risks promptly both locally and to the NRLS, so that lessons can be learned and action taken to prevent harm to others.

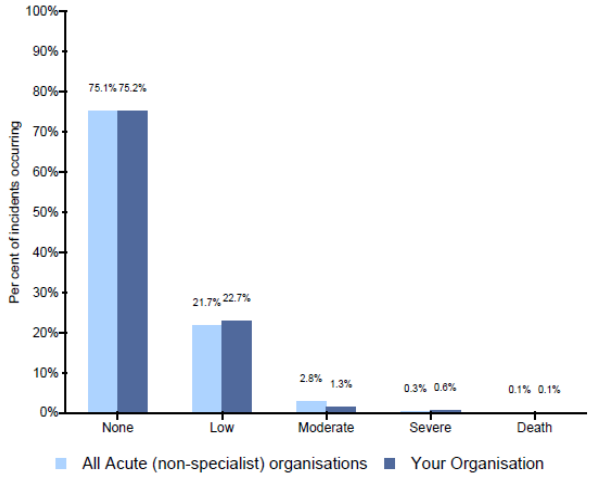
What types of incidents are reported in your organisation?

Figure 2: Top 10 incident types



If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

Figure 3: Incidents reported by degree of harm for Acute (non-specialist) Organisations



Degree of harm

	None	Low	Moderate	Severe	Death
Your figures:	4,575	1,383	81	38	4

Do you understand harm?

Nationally, 72 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

Recognising and reporting incidents resulting in severe harm or death is an important sign of an organisation's reporting culture. If the numbers of incidents reported as severe harm or death are low compared with peers you should check that your reports reflect all incidents you are aware of through sources such as mortality review, inquests, litigation or complaints.

For further information on the reporting of serious incidents please see NHS England's guidance

http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/about-reporting-patient-safety-incidents/

2.4 Prescribing Incidents for March

There were 125 medication AIRS during this period

High Risk Medicines

Chemotherapy

62772 Chemo SGH Delay in administration of chemotherapy as not prescribed

Gentamicin

61899	Ward 16	Essential check completed, Gentamicin given inappropriately
62488	SCBU SGH	Incorrect dose interval for Gentamicin
62744	Ward 14	Gentamicin given to patient with renal impairment, incorrect dose also given

Heparin

62449 Ward 31 Patient with confirmed heparin induced hrombocytopenia prescribed therapeutic dalteparin

62808 Community Heparin incorrectly prescribed, should have been Dalteparin

Insulin

62017 Ward 26 Missed insulin as not cross referenced on drug chart

62694 Ward 24 Insulin not prescribed on admission

Methotrexate

62825 Ward 29 Methotrexate prescribed and administered (albeit correctly) against trust policy. Staff not aware of policy

New oral anti coagulant drugs

62269 G1 Incorrect prescription of anticoagulants on discharge

Warfarin

61854 AMB Warfarin not prescribed for 3 days

High risk processes

Allergy

61634 Ward 14 Patient with documented allergy to Amiodarone prescribed Amiodarone in error. The prescriber intended to prescribe Amlodipine

61833 Ward 26 Patient who was allergic to beta blockers was prescribed and administered Bisoprolol

61979 Stroke YDH Trimethoprim prescribed and administered to patient with Trimethoprim allergy

62799 Cherry Two doses of Tazocin administered to a penicillin allergic patient

62026 Ward 24 Frusemide given to a patient who is allergic to it

61825 Ash Penicillin allergic patient administered two doses of Tazocin

Discharges

62269 G1 Incorrect prescription of anticoagulants on discharge

61908 Ward 31 Discharged on incorrect doses of medicines

62157 CCU YDH Incorrect dose of ticagrelor on eDN

Medication related SIs

None this month

AIRS that caused moderate to severe harm
None this month

Other Significant AIRS

WEB	62825	Location	Ward 29
Incident	Methotrexate prescribed on drug chart and administer against trust policy. Correct dose and day of administration on chart. Doctor who prescribed and nurse who administered methotrexate informed of policy. Both new members of staff for the trust and said they were not aware of the policy.		
Investigation	To ensure all new staff are aware of trust policy regarding Methotrexate.		
Comments and actions from MSG	How can we ensure new staff are aware of this? This is already in the induction training for medical and nursing staff and is included in the SOPs that new pharmacy staff have to read. It will also be included in the medication compliance/safety visits. However, this highlights a challenge to remind staff of many of the NPSA alerts. NB and AB offered to develop a list of 12 messages that we can deliver on a rolling program through safety briefing and junior doctor's newsletters. The use of screen savers will also be investigated.		
WEB	62449	Location	Ward 32
Incident	Patient with confirmed HIT and prescribed warfarin. INR sub therapeutic at 1.4 on 20/3/16. Prescribed therapeutic dose dalteparin on green LMWH chart which was given at 17:50. No reference to reason for prescribing dalteparin in medical notes but presumed to be because INR sub therapeutic. Dalteparin prescription was not cross referenced on main drug chart. Patient had two drug charts which both had "heparin - HIT" in the allergy box. CPD allergy status also stated HIT as a reaction for heparin. Indication on the warfarin chart was ticked as PE(new), no reference to HIT Noted by ICU doctors in ICU clerking that patient was given therapeutic dalteparin. ICU doctors called to review patient on was as at approx. 7pm on 20th had sudden deterioration with decreased sats, increased respiratory rate, drowsy and hypotensive. Dalteparin chart immediately crossed off. Platelets low at 61 at 8pm on 20/3/16 but had not been checked since 13/3/16 (normal).		
Investigation	To feedback to individuals concerned, incident mentioned in ICU handover Monday morning and ICU pharmacist will research alternative anticoagulation while INR sub therapeutic. ICU Pharmacist will also endorse warfarin chart with HIT indication and not to be given any heparin/LMWH		
Comments and actions from MSG	There may have been confusion about the abbreviation ‘HIT’ and if people knew what this meant. HH to discuss with the EPMA team as to how this would alert on EPMA and if it would link to LMWH. DB to talk to haematology to discuss recommendations for monitoring of platelets so this can be shared to all staff.		
WEB	Web62266	Location	Aspen
Incident	Pt on Aspen transferred from CCU. Prescribed Tazocin review 48 hours. Now had 10 days Tazocin. Unsure who to contact as CPD says Dr x but he has referred pt. to Dr y who is not here until end of week. Spoke to Dr x who said he is not looking after the pt. but he sent me an email written by Dr z advising 5 days Tazocin then stop. The junior doctor for Dr y did not know the patient but agreed to review him this afternoon and said the nurses could withhold the 2pm dose. I also contacted the consultant microbiologist who will follow up this afternoon to see if the antibiotic has been stopped.		
Investigation	A/W investigation – Dr Houghton		
Comments	Issues around long course of IV antibiotics and patient ownership. To be		

and actions from MSG	followed up next time

Action in relation to trends

Issue	Over the past few months there have been several incidents where there has been a delay in patients receiving MRSA eradication.eg Patient screened for MRSA. Infection control informed us 24/03/2016 around 18:00 the Patient was MRSA positive, Bleeped the Orthopaedic SHO, and asked to write him up for treatment. Didn't arrive. Bleeped again today, different SHO than yesterday who wasn't aware of the situation but also hadn't arrived before evening handover 25/3/16.
Action requested by MSG	HH has spoken to the antimicrobial pharmacist to see if a local policy can be developed for infection control nurses to issues eradication therapy

3. Clinical Effectiveness

3.1 Consultants new to the Trust

Karthikyan Dhandapani
York
Anaesthetics (Pain)
Start date: 06/04/2016

Mohammed Shareef
York
Dermatology
Start date: 01/04/2016

Konstantinos Lasithiotakis
Scarborough
Surgery
Start date 04/04/2016

Deepak Chandrajay
York
Chemical Pathology
Start date 01/04/2016

4. Patient Experience

4.1 Quality Priorities 2015-16

The Trust agreed several Quality and Safety priorities for improvement during the year 2015-16. The purpose of this report is to provide an update on progress with the priority programmes of work.

The Quality and Safety priorities are divided into three sections:

- Patient Safety – improving care of acutely ill and deteriorating patients, reducing harm to patients from falls and infection prevention and control

- Clinical Effectiveness and Outcomes – monitoring the prevalence and incidence of pressure ulcers, monitoring critical medicines and antimicrobials and reduction in mortality rates

- Patient Experience – expanding systems for patients to provide feedback on care and treatment received and excellence in end of life care.

This is the final report on progress with the priority programmes of work for 2015 – 2016.

Improving care of acutely ill and deteriorating patients

By the end of March 2016, we pledged that;
- The Post-Take Ward Round Checklist will be embedded for all acute medicine, elderly and acute surgery inpatients
- 90% of patients who have an acute kidney injury (AKI) will have stage of AKI recorded in their discharge summary, medicines review relating to AKI and type and list of blood samples required for monitoring
- 90% of patients with severe sepsis will have antibiotics initiated within one hour of presentation
- Patients will have a review by a senior doctor within 14 hours of arrival to the Medical Admission Units.

Progress

Post-Take Ward Round (PTWR) Checklist
Completion of the PTWR Checklist is a key part of the early review and patient assessment. It is a mandatory requirement and should be completed for medicine and surgical patients following acute admission to hospital.

Audits (Figs 1 and 2) of the use of PTWR checklist in acute medicine and surgery (both sites) demonstrate use to be 96% during Q4. Where the checklist has been used, all items on the checklist had been acknowledged in 85.3% of records reviewed.

Figure 1. Compliance with the use of the PTWR Checklist; All areas

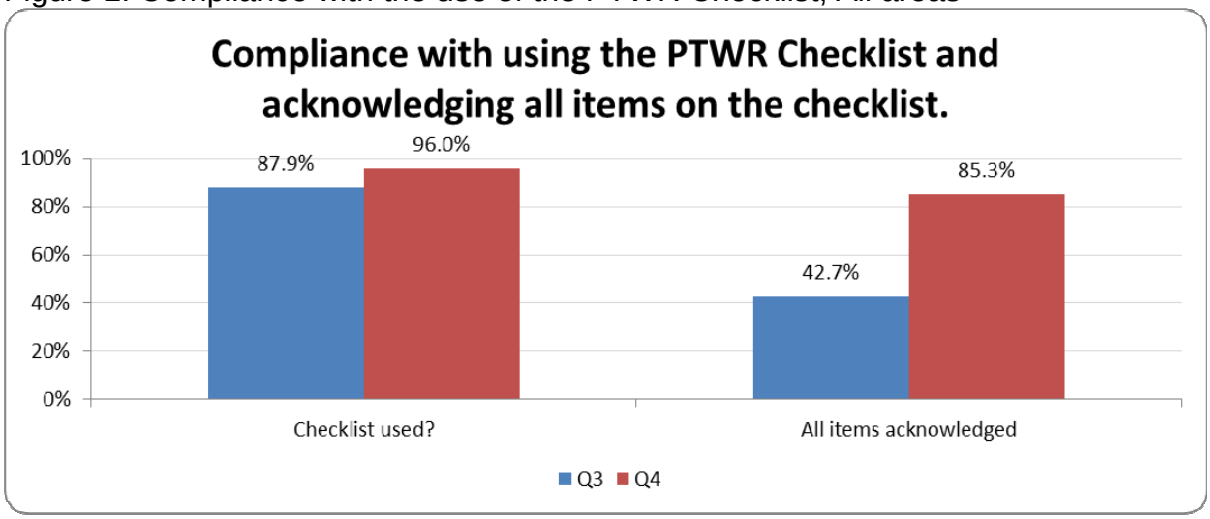
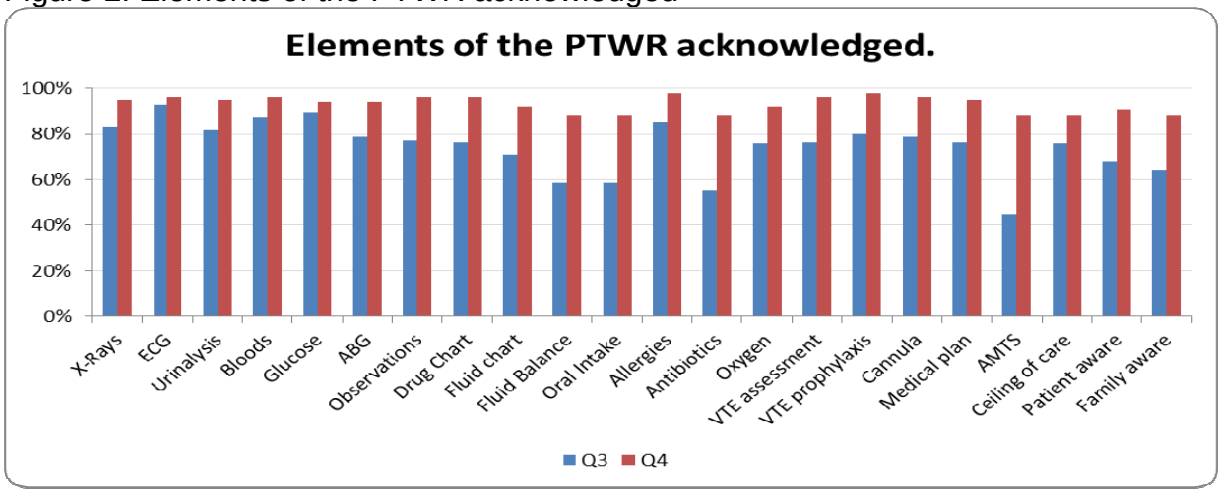
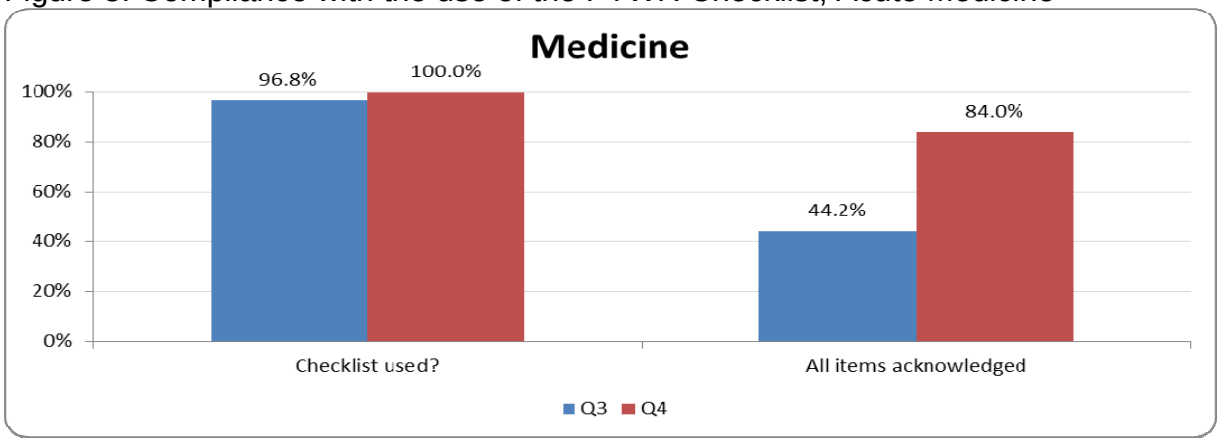


Figure 2. Elements of the PTWR acknowledged



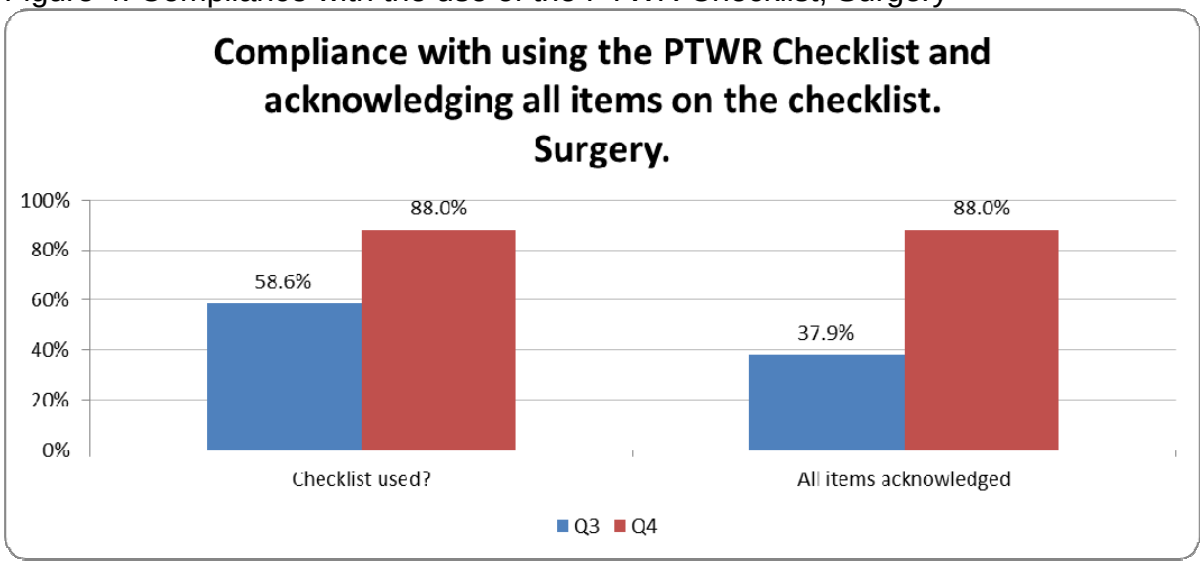
In medicine, the checklist was well embedded by March 2016. Figure 3 illustrates that the checklist was being used in 100% of cases. The number of elements acknowledged had risen from 44.2% overall in Quarter 3 to 84%.

Figure 3. Compliance with the use of the PTWR Checklist; Acute Medicine



In surgery, the checklist was introduced in September 2015, since that time there have been significant improvements in use (fig 4).

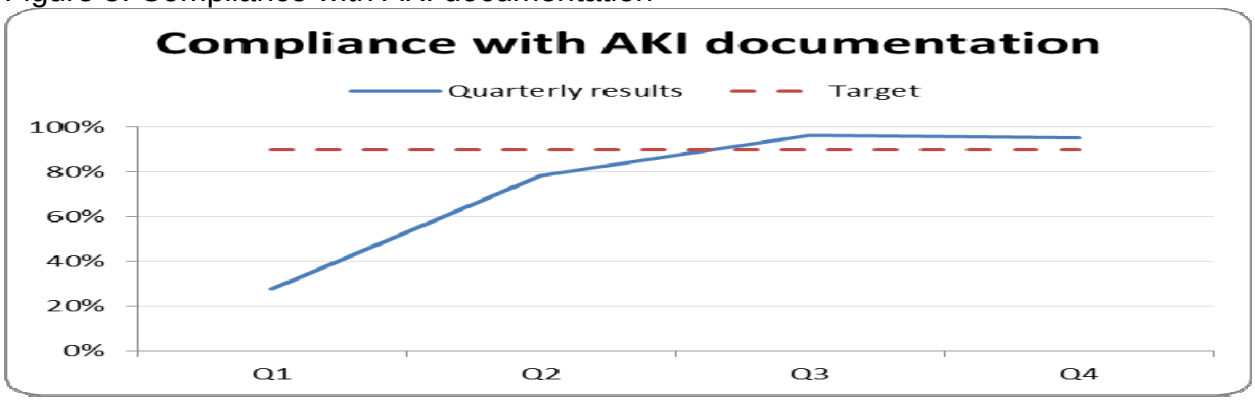
Figure 4. Compliance with the use of the PTWR Checklist; Surgery



Acute Kidney Injury (AKI)

Around 75% of patients with AKI now have a process automated within CPD to document the stage of AKI, details of medicine reviews and bloods required for on-going monitoring. Figure 5 shows that the target was achieved during Quarter 3 and has been sustained during Quarter 4.

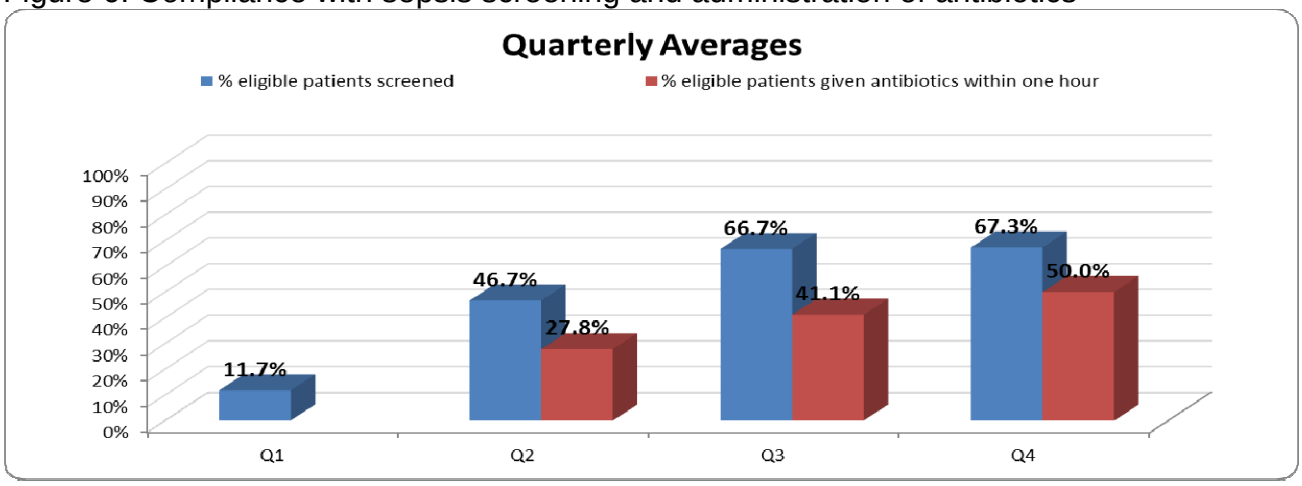
Figure 5. Compliance with AKI documentation



Severe Sepsis – administration of antibiotics within one hour

Figure 6 illustrates improvement throughout the year for screening for severe sepsis and administration of antibiotics within one hour of arrival to hospital, although we are not achieving the 90% target.

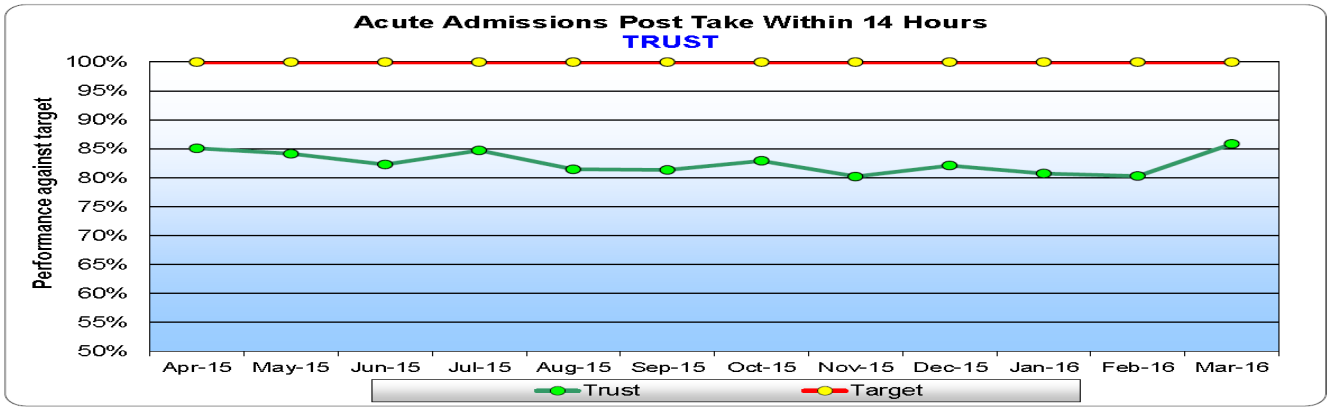
Figure 6. Compliance with sepsis screening and administration of antibiotics



Senior medical review within 14 hours of arrival to Medical Admissions Unit

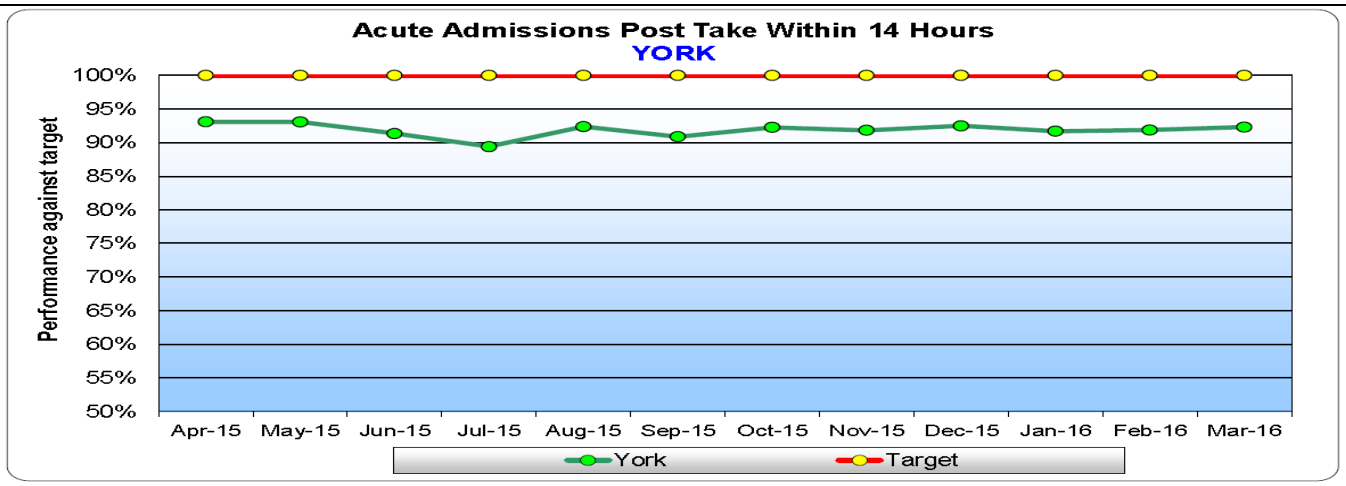
Overall, over 80% of patients are receiving a senior medical review within 14 hours of admission to our acute hospital sites (Fig 7), however this is below the Trust standard.

Figure 7. Percentage of acutely admitted medical patients receiving a senior medical review within 14 hours across the Trust



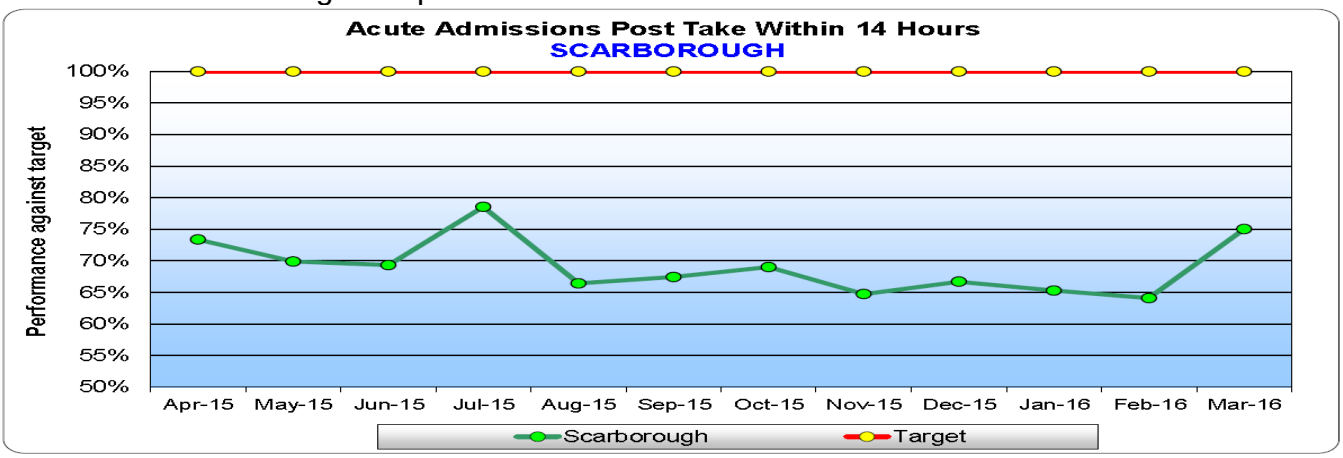
For patients admitted to York Hospital, senior medical review usually takes place within 14 hours in 90% of cases (Fig 8).

Figure 8. Percentage of acutely admitted medical patients receiving a senior medical review within 14 hours at York Hospital



For patients admitted to Scarborough Hospital, senior medical review takes place within 14 hours in less than 80% of cases (Fig 9).

Figure 9. Number of acutely admitted medical patients receiving a senior medical review within 14 hours at Scarborough Hospital



Reducing harm to patients

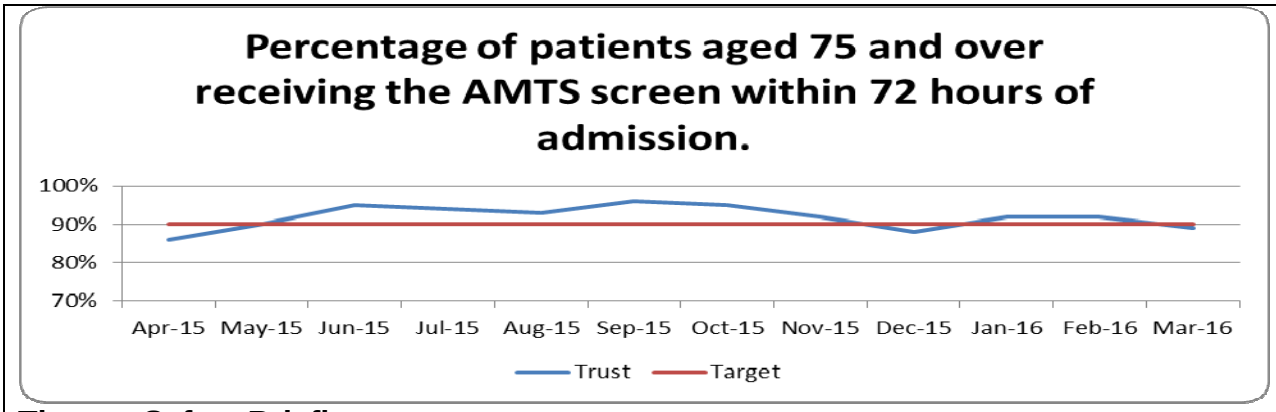
By the end of March 2016, we pledged that;

- Over 90% of patients (aged 75 years and over) acutely admitted with delirium or dementia, will have a dementia specific assessment and be referred for further diagnostic advice and specialist treatments on all our hospital sites. In addition we will ensure that carers of people with dementia and delirium feel adequately supported.
- In theatre, the surgical safety checks will include a team safety briefing at the beginning of the operating list and a STOP at the point of knife to skin.
- We will reduce serious injury to patients following a fall in hospital by a further 20%.
- We will enhance supported discharge for patients following a stroke.

Dementia Assessments

Dementia screening is included in the admission checklist within CPD as a prompt for clinicians to complete within 72 hours of admission for eligible patients. Compliance is monitored daily and any outstanding assessments are flagged to individual wards and clinical areas. Figure 10 illustrates that we achieved the standard in nine of the 12 months.

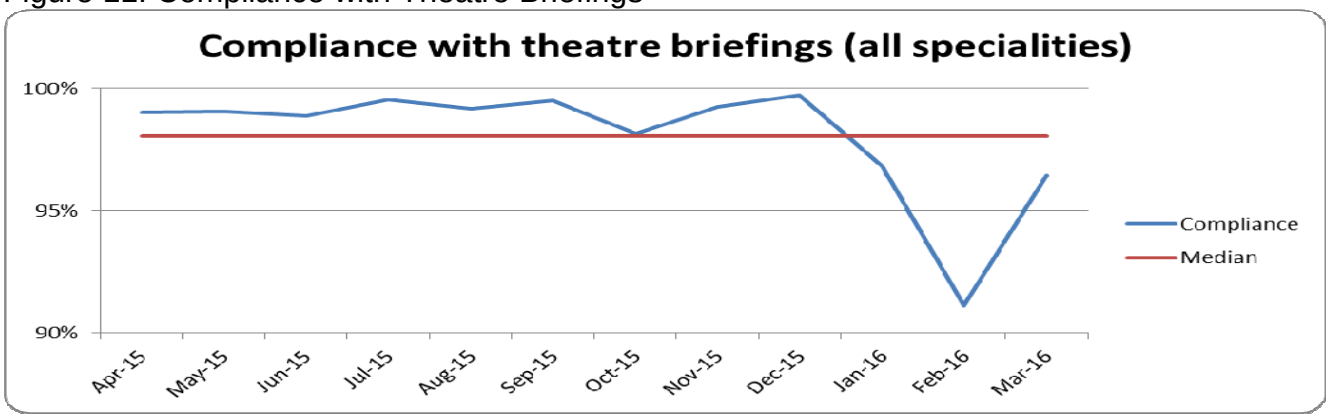
Figure 10. Percentage of patients aged 75 and over receiving the AMTS screen within 72 hours of admission



Theatre Safety Briefings

Compliance with theatre briefings is captured within the CPD system and demonstrates sustained compliance mainly above 95% (Fig 11) although this dropped to 91% during February 2016. A median value calculated for the period Apr 15 – Mar 16 shows 98.1% compliance.

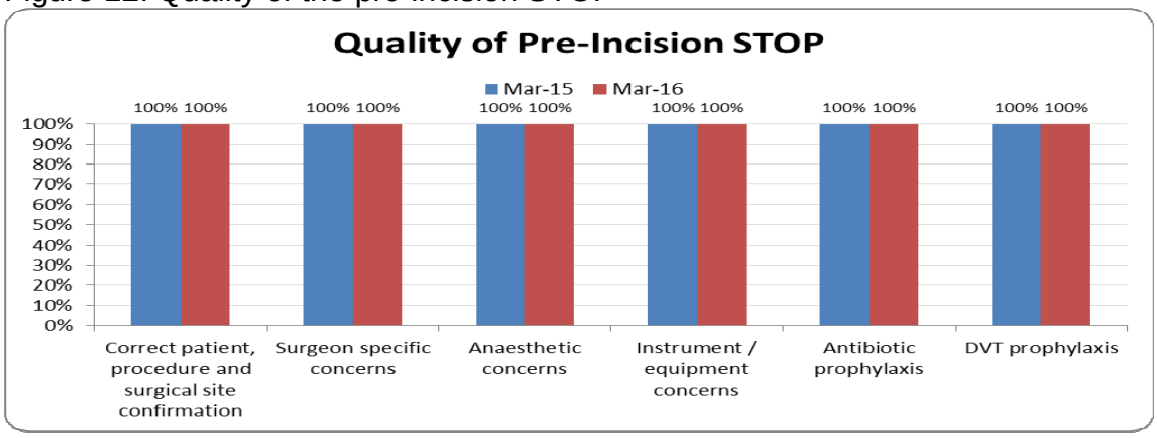
Figure 11. Compliance with Theatre Briefings



Pre-Incision STOP

Members of the Patient Safety Team visited Main Theatres at York and Scarborough site throughout February and March 2016 to observe the Safety Briefings and use of the WHO checklist. Specialties observed included General Surgery, Urology, Vascular, Trauma and Orthopaedics, Obstetrics and Gynaecology, Plastics and ENT. The Safety Briefing and the WHO surgical checklist were assessed against the same standards used during the audit in 2015. Of the 12 procedures observed, the Pre-Incision STOP checks were completed in all cases as illustrated in figure 12.

Figure 12. Quality of the pre-incision STOP



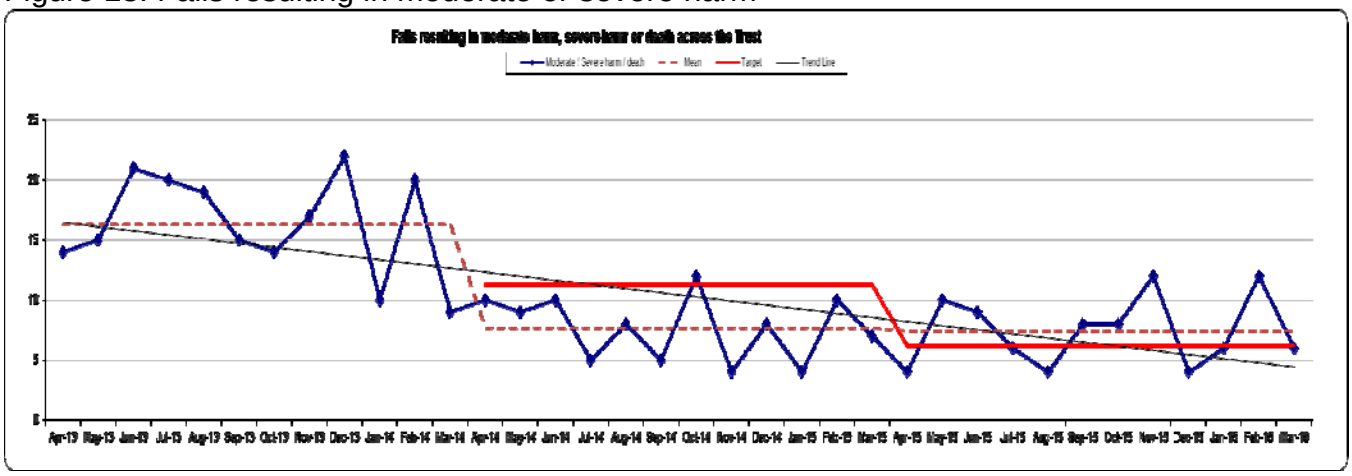
Reducing harm from falls

Figure 13 shows the total number of falls resulting in moderate harm, severe harm or death identified on the incident reporting system (Datix) from April 2013 – March 2016.

In 2013 – 2014, the Trust reported 196 falls resulting in moderate or severe harm. A 30% target

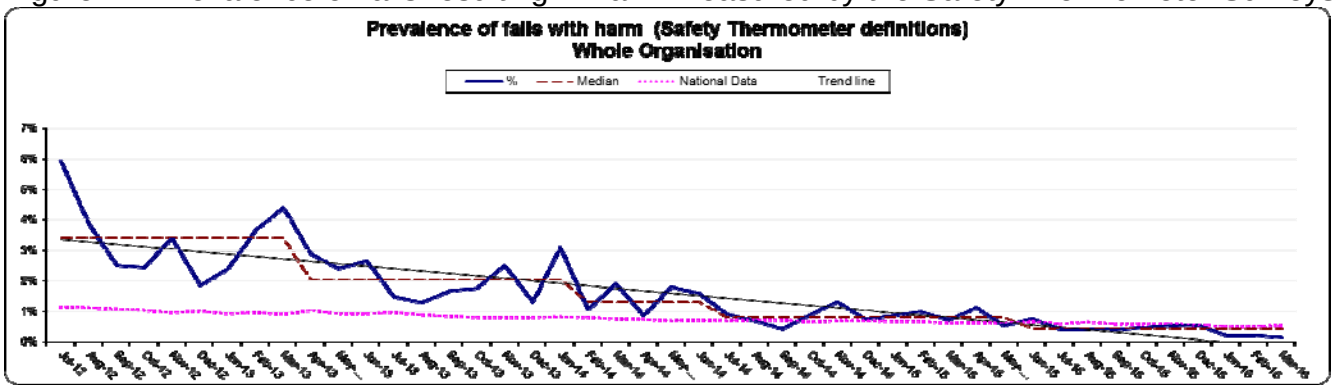
reduction was agreed indicating no more than 137 falls resulting in moderate or severe harm to occur in 2014 – 2015. At the end of 2014 – 2015, the Trust reported 92 falls resulting in moderate or severe harm showing a 54% reduction in comparison with the previous year. A further 20% reduction during 2015 – 2016 provided a target of no more than 98 falls resulting in moderate or severe harm. The Trust's final position for 2015 – 2016 shows that we reported 89 falls that resulted in moderate or severe harm, therefore maintaining the 2014 – 2015 position and a 55% reduction overall since April 2014.

Figure 13. Falls resulting in moderate or severe harm



The prevalence of falls resulting in harm is measured by the Safety Thermometer Survey undertaken each month. Figure 14 indicates that we have demonstrated a sustained reduction and are now below the national data point.

Figure 14. Prevalence of falls resulting in harm measured by the Safety Thermometer Surveys.



Enhancing supported discharge for patients following a stroke

The Early Supported Discharge team in York have supported 266 patients with a diagnosis of stroke, following admission to York Hospital in 2015-2016.

The team is a multidisciplinary rehabilitation team comprising Occupational Therapists, Physiotherapists, Dietitians and Speech and Language Therapists. Over the past year the team have continued to work closely with ward staff in order to ensure timely patient transfer and high quality communication at all levels. The team has a strong commitment to service review and improvement playing a key role in providing education and advice to these patients and their families.

The number of patients supported by the service has increased by 9% over the last year, we have had no re-admissions/ unsafe discharges, 90% of patients have received contact from the team within 24 hours of hospital discharge and 88% have been visited by a member of the team within 48 hours of hospital discharge. The service continues to receive positive feedback from patients and their families.

Infection prevention and control

- We continue, through effective audit/surveillance and Post Infection Review (PIR) to monitor and benchmark rates of Healthcare Associated infection (HCAI) aiming to demonstrate a continual reduction below the national mean
- We aim to improve practice in relation to invasive device management through enhanced and specific education and training initiatives (ANTT, Device management role).

Healthcare Associated Infections

Figures 15, 16 and 17 demonstrate that following targeted infection prevention intervention, a downward trend towards the national mean of HCAI assuring of positive impact on patient safety and outcome.

Figure 15. MRSA Incidence

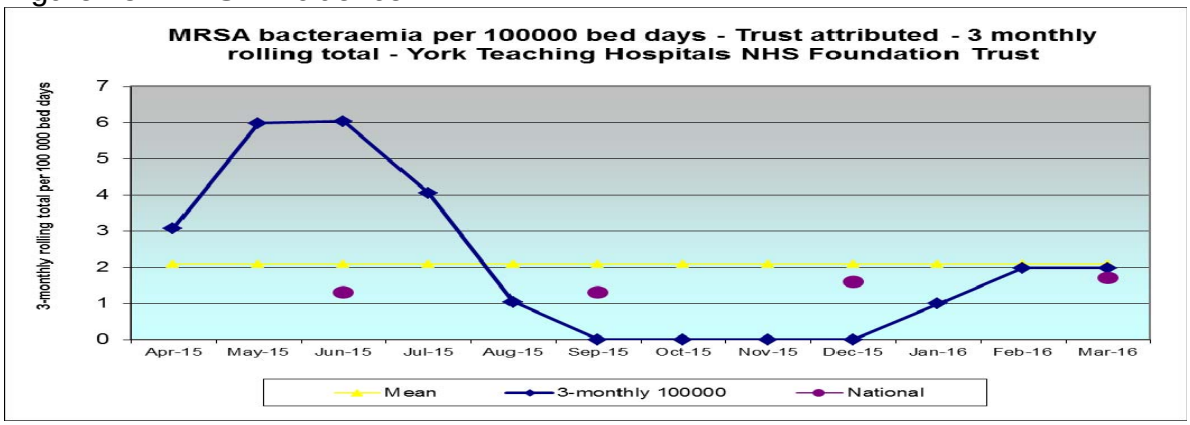


Figure 16. MSSA Incidence

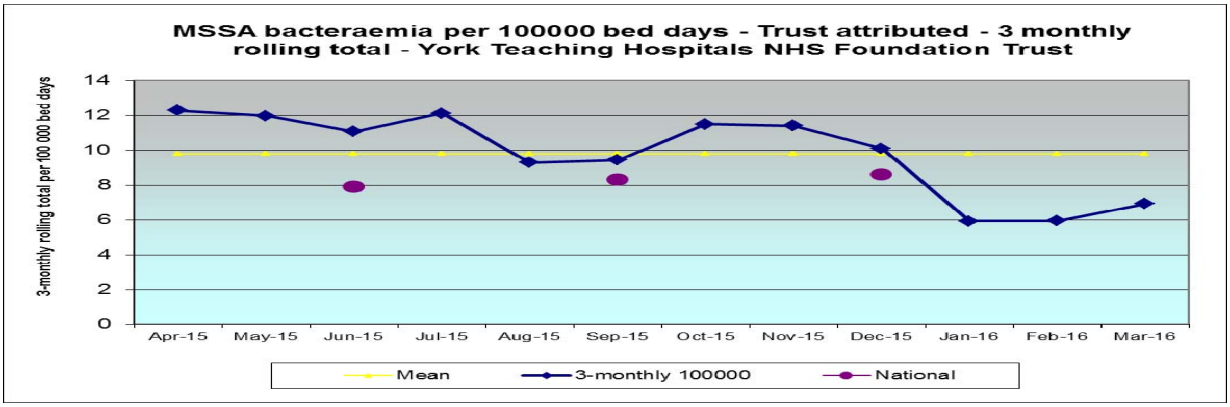
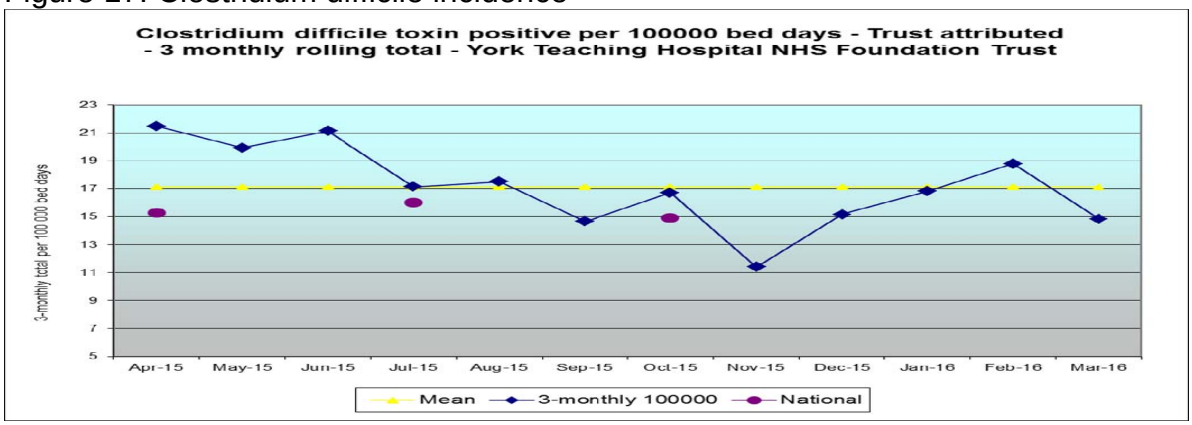


Figure 17. Clostridium difficile incidence



Monitoring the prevalence of pressure ulcers

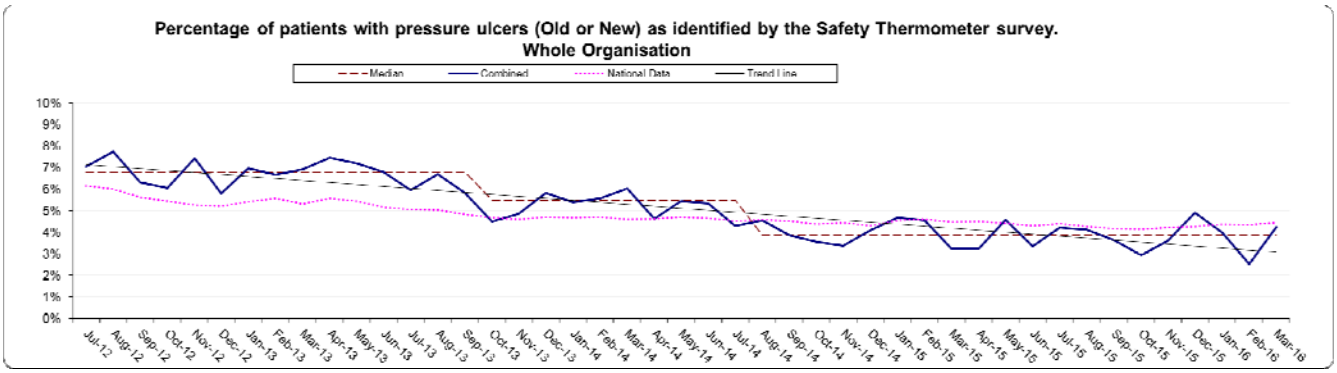
By the end of March 2016, we pledged that;

- We report the prevalence of patients in our care who have a category 2-4 pressure ulcer (old or new) as measured using the Safety Thermometer tool and aim to maintain the prevalence in line with the national benchmark
- We continue to learn from pressure ulcer development by reporting all Category 3 and 4 pressure ulcers as Serious Incidents and aim to reduce the incidence by 20%.

Prevalence of pressure ulcers

We continue to monitor the prevalence of pressure ulcers across the Trust using the Safety Thermometer Survey. A reduction is noted within our prevalence and we are now below the national average (Fig 18).

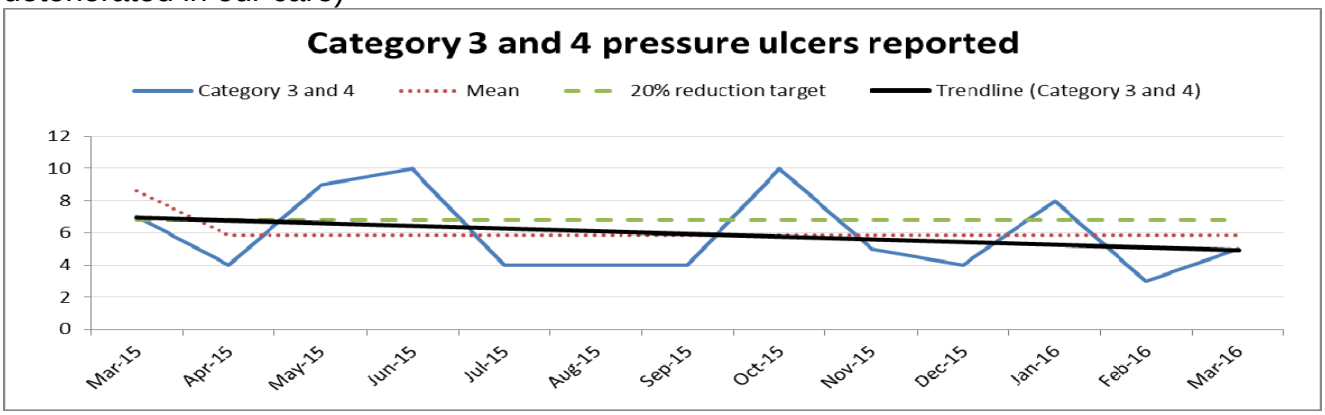
Figure 18. Prevalence pressure ulcers measured by the Safety Thermometer Surveys.



Incidence of pressure ulcers

The number of Category 3 and 4 pressure ulcers reported into the Datix incident reporting system is shown in Figure 19.

Figure 19. The number of Category 3 and 4 pressure ulcers reported (newly developed or deteriorated in our care)



Monitoring critical medicines and antimicrobials

By the end of March 2016, we pledged that;

- We will monitor the prescription of antimicrobials; specifically the indications for the prescription and the review dates and improve compliance with the antimicrobial prescribing policy
- We will monitor and reduce the number of missed doses
- We will have designed and tested processes for implementation of Electronic Prescribing and Medicines Administration (EPMA) throughout the Trust.

Prescribing of antimicrobials

Over the year 2015/16, the compliance with the antimicrobial prescribing standards has slowly and steadily increased. The standard set is that all antimicrobial prescriptions should have both the indication and the duration documented on the medicine chart. In April 2015, 87% of antimicrobial prescriptions had an indication documented and 89% had a duration or review date documented on the prescription chart. Audited monthly, we noted a reduction in compliance throughout August and September. This is thought to be as a result of new doctors joining the Trust during that period. Overall, the results showed steady increases to reach 93% compliance with documenting indication and duration in March 2016. In the financial year 2015/16 we had a local CQUIN agreed with our CCG with respect to this audit and we achieved the 85% target agreed.

Missed doses

We continue to monitor through Safety Thermometer surveys the prevalence of missed medications each month. The graphs below indicate improvements in all areas monitored.

Figure 20 indicates the prevalence of blank administration boxes found during the surveys each month. This may indicate that a medication has not been administered or signed for by staff on the ward. Prevalence was noted to be 2.8% in March 2016

Figure 20. Empty administration boxes

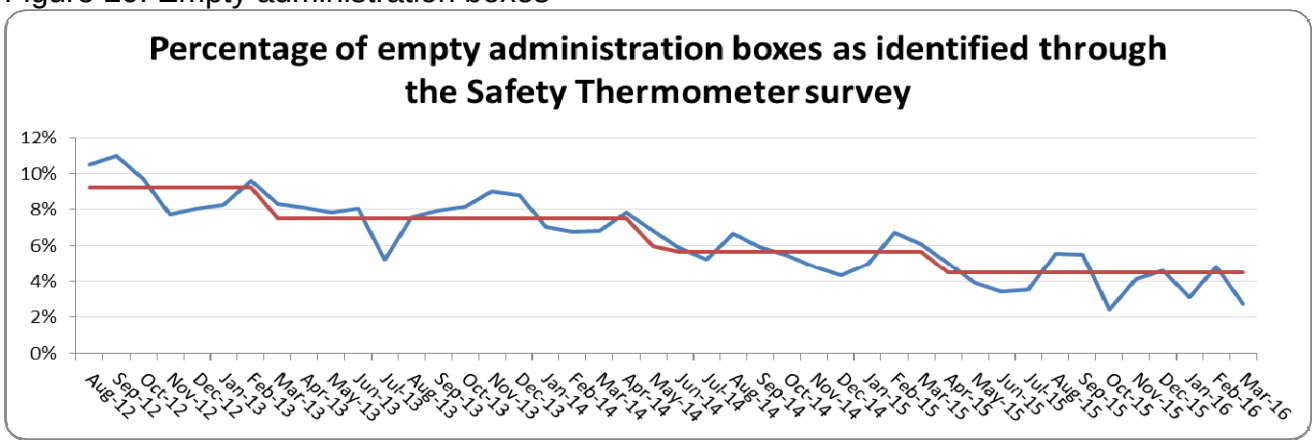
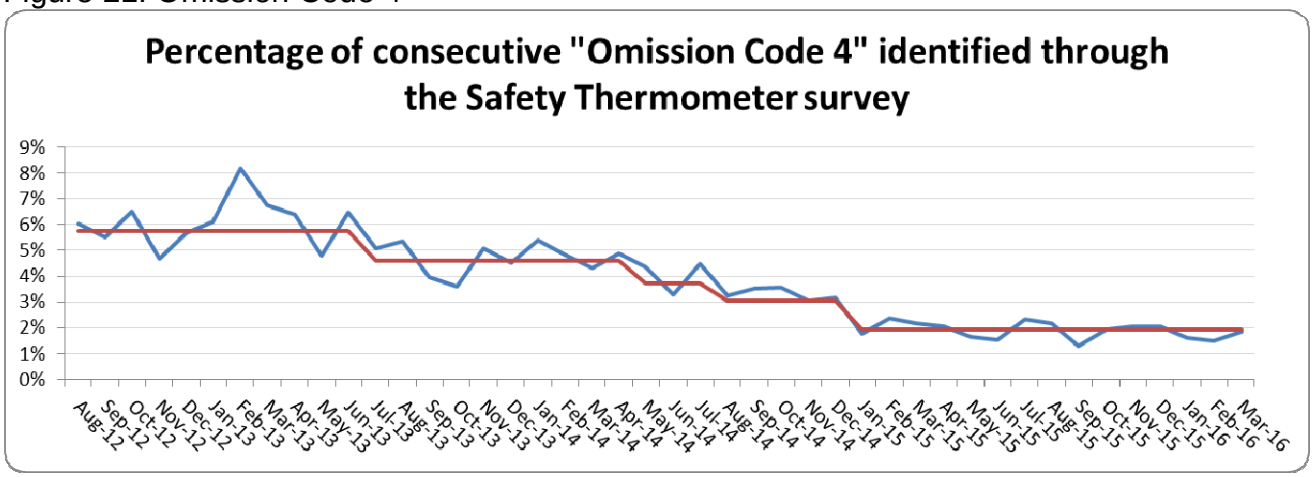


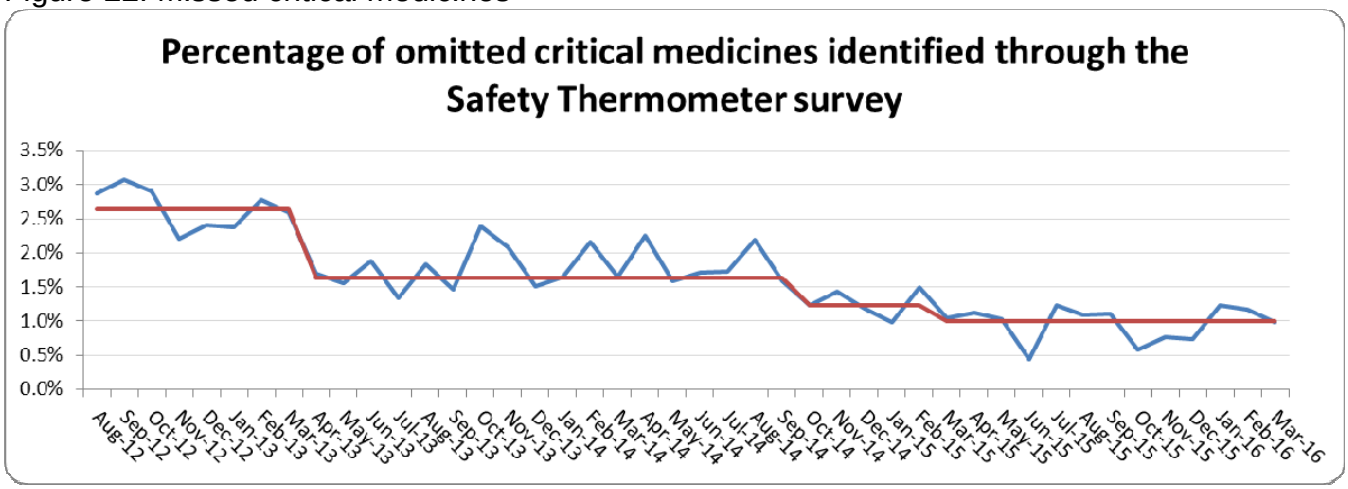
Figure 21 indicates the prevalence of “Omission Code 4” on prescription charts where this is documented for two or more consecutive doses. Omission Code 4 indicates that the medicine was not available to administer at the time and it is recognised that this should rarely occur on two consecutive occasions as there are processes in place to allow for ordering the medicine in most cases. Prevalence was 1.8% in March 2016.

Figure 21. Omission Code 4



Missed critical medicines are also monitored and results are shown in figure 22, again showing a reduction in prevalence of missed critical medicines. Prevalence in March was found to be 1%.

Figure 22. Missed critical medicines



Implementation of EPMA

Figure 23 indicates the key dates for development and roll out of the EPMA system.

Figure 23. EPMA Key dates

System development complete	End of May 2016
User Acceptance Testing (phased)	May 2016 onwards
Shadow Testing on wards	June 2016
Pilot	July 2016
Rollout Phase 1 (c. 7 months duration)	August 2016 onwards

The EPMA Prescribing & Administration screens are currently undergoing wide clinical engagement. An approach to staff training has been agreed and a System Testing plan has been developed with the wider EPMA project team. Technical testing has been completed and the EMPA Rollout order has been drafted for sign off at EPMA Project Board. A communications strategy has been developed to support the roll out plans.

Development Progress to date:

- 90% of the coding (programming) for EPMA is complete
- Enhanced allergy review functionality ready for rollout as precursor to EPMA
- Identification & verification of Formulary drugs data in FDB Drug database is 98% complete
- Pharmacy technical testing is complete
- Technical solution for business continuity defined

Whilst the IT development will be driven by the functional specifications there will be an iterative nature to it depending on feedback received at each of the demonstration stages.

Reduction in mortality rates

By the end of March 2016, we pledged that;

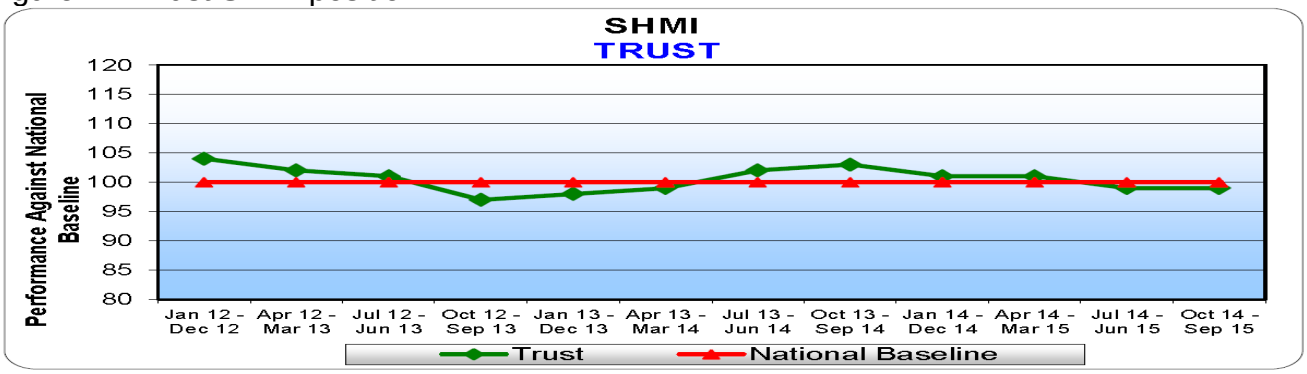
- We will continue the consultant-led systematic review of all in-patient deaths in the acute hospital and GP led review in our community hospitals.
- We will continue to work towards achieving a SHMI of less than 100 for both acute hospital sites.

Mortality Reviews

The Trust requires all deaths that occur within our organisation to have a Mortality Review undertaken. The Mortality Review Steering Group continues to monitor the mortality review process. This consultant led process has been in place since May 2013 and a target of completing the review process within six weeks of the death is an agreed standard. Themes and learning from the mortality reviews are collated to generate directorate level and organisation level quarterly reports.

SHMI
Figure 24 shows the Trust's SHMI position October 14 – September 15 to be 99.

Figure 24. Trust SHMI position



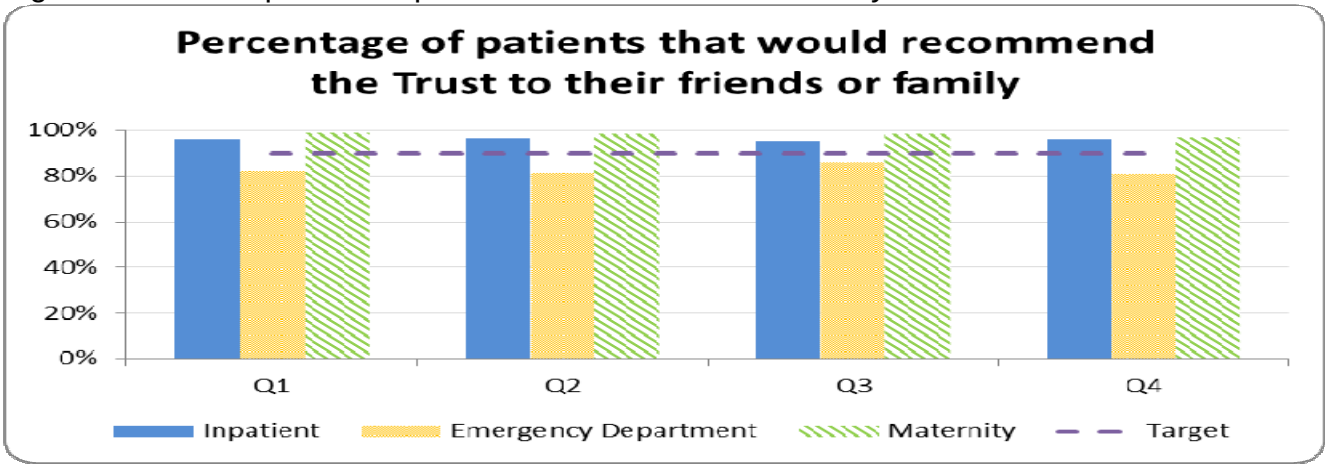
Expanding systems for patients to provide feedback on care and treatment received
By the end of March 2016, we pledged that;

- The Trust will have developed and launched a Patient Experience Strategy.
- Across the Trust the Friends and Family Test will achieve a 90%+ score for patients reporting they would recommend the Trust to their Friends and Family if they needed similar care or treatment.
- 'Knowing How We Are Doing Boards' will be rolled out to all wards and departments across the Trust and reviewed on a rolling quarterly basis.
- Working with individual directorates we will provide local information reports to improve the patient experience.

Patient Experience Strategy
The strategy has been approved by the Trust Board of Directors and was launched at the Nursing and Midwifery Conference in September 2015.

Friends and Family Test
The Friends & Family Test is no longer a CQUIN for 2015 / 16 but this will be monitored under Schedule 4 of the Trust's commissioner contracts. From April 2015, day cases and patients under the age of 16 have been included in line with NHS England requirements. The percentage of inpatients that would recommend our Trust as a place to be treated remains above 95% as shown in figure 25. We are achieving above 90% as a Trust average across all three areas.

Figure 25. Trust Inpatient responses to the Friends and Family Test



'Knowing How We Are Doing' Boards
One final refresh of all boards was completed on 31st March 2016. In March, 57 new Boards

were displayed within acute and community hospital wards, Emergency Departments and maternity units. *'Knowing How We Are Doing Boards'* were also created for outpatient departments.

Local Information Reports
New Ward-level FFT reports were introduced during November 2016. We have revised the process for reporting of complaints that are due or overdue to improve the timeliness of a response. The Patient Advice and Liaison Service (PALS) are now producing monthly reports of cases and subject themes for directorates to review and directorate-specific work continues to create action plans from Local Healthwatch reports and national survey findings.

Excellence in end of life care
By the end of March 2016, we pledged that;
- We will be achieving best practice standards with end of life care.
- All patients will have appropriate and inclusive DNACPR decision making.

Best Practice Standards
The End of Life (EoL) Care Forum now reports regularly into the Board of Director's through the Quality and Safety Committee and an annual report will be submitted in January 2016**.** A meeting is held quarterly with senior clinicians and a Non-executive Director. We have commenced joint working with the End of Life Care Programme Board for Scarborough & Ryedale and the Vale of York CCGs.

The last days of life care plan has had limited uptake in some areas across the Trust. Nursing education is progressing within the acute and community and there are regular update sessions. There is a plan to improve medical education in EOL during 2016 - 2017.

Bereavement services are being developed across the Trust with specific focus on developing the service in Scarborough Hospital. A seven day specialist palliative nursing service is to commence in November 2015 as a pilot project. A formal review of all EOL Care complaints is now in process and an EOL Care strategy is in place for the Trust. Discussion is underway around the development of a locality wide Electronic palliative care co-ordination system. Key areas of shared information will help improve communication and care.

DNACPR decision making
DNACPR training is now available electronically and a training programme to develop senior nurses to support the process is underway. Audits are completed regularly on York site for DNACPR and this process will be developed at Scarborough Hospital and community sites during 2016-17**.**

5. Recommendations

Board of Directors are requested to:

- Consider our annual report to the Human Tissue Authority
- Be aware of progress with the Electronic Prescribing and Medicines Administration
- Consider the latest report from the National Reporting and Learning System
- Consider the medicines prescribing incidents from March 2016
- Note consultants new to the Trust
- Consider the Quality Priorities Report (2015/16).

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Mr James Taylor, Medical Director**

Date	**May 2016**

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Board of Directors – 25 May 2016

Chief Nurse Report – Quality of Care

Action requested/recommendation

The Board is asked to note the Chief Nurse Report for May 2016.

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	May 2016
Version number	Version 2

Board of Directors – 25 May 2016

Chief Nurse Report – Quality of Care

1. Background

The Chief Nurse report provides information on progress towards the delivery of our quality priorities, updates on the implementation; and highlights any risks to delivery of the Nursing & midwifery and Patient Experience Strategies.

The nursing and midwifery strategy has four main focus areas:

- Patient experience
- Patient safety
- Measuring the impact of care delivery
- Staff experience

The nursing dashboard (appendix 1) gives an overview of the quality of care delivered across the organisation and identifies key risks.

2. Patient Safety

2.1 Nursing and Midwifery Staffing

The recruitment and retention of Nursing and Midwifery staff remains a high priority. At the end of April 2016, the registered nurse vacant posts for adult inpatient areas was 120.72fte with 54.54 fte vacant HCA posts. Of these, 93.26ftefte RN posts and 35.4fte HCA posts have been recruited to and the individuals will commence in post over the coming months. This leaves an unfilled RN vacancy position of 27.46fte and 24.14fte HCAs within the inpatient areas across the Trust.

Recruitment of Nurses, Midwives and Healthcare Assistants is continuing through the Trust. 55 European nurses will have commenced in employment on the York site with 1 also at Scarborough by the end of April 2016. 2 European nurses have resigned from the Trust due to personal circumstances unrelated to their employment with the Trust. A further 5 European nurses are due to commence during June and July 2016. The Trust continues to support these nurses with their arrival and induction into the Trust. Further EU interviews are scheduled for 20 May 2016 and further campaigns are being scheduled to the end of this financial year following the decision made at the April Board of Directors to continue EU recruitment.

Sitting alongside the European recruitment is the campaign to attract final year nursing students to apply for Staff nurse positions with the Trust, with a view to commencing in employment in August/September 2016. Since January 2016 the Trust has offered posts to 88 final year nursing students posts across the Trust. In addition 4 nurses who have returned to nursing practice following a career break have also been appointed. Further interviews are taking place during May and June 2016.

The Trust held a very successful Recruitment Market Place on Saturday 23 April with over 400 members of the public attending in search of jobs across the whole range of services at the hospital. The Trust interviewed 33 nurses on the day and 31 of these have now been offered positions within our organisation. The Trust will also be attending recruitment fairs in late May, June and July at other universities.

Healthcare Assistant recruitment continues with over 100 people attending the information sessions which were held during the Recruitment Market Place. Interviews for posts will be taking place during May 2016 with a view to commencement in post in July 2016.

During April, 15 new applications to the Nurse Bank were processed and completed; 5 for Registered nurses and 10 for Healthcare Assistants. A further 37 (10 RN and 27 HCA) applications are being progressed.

A further 87 applications from existing Registered Nurses and Healthcare Assistants were processed during April. Of these 56 were qualified nurses with 31 Healthcare Assistants. A further 6 applications are still being progressed.

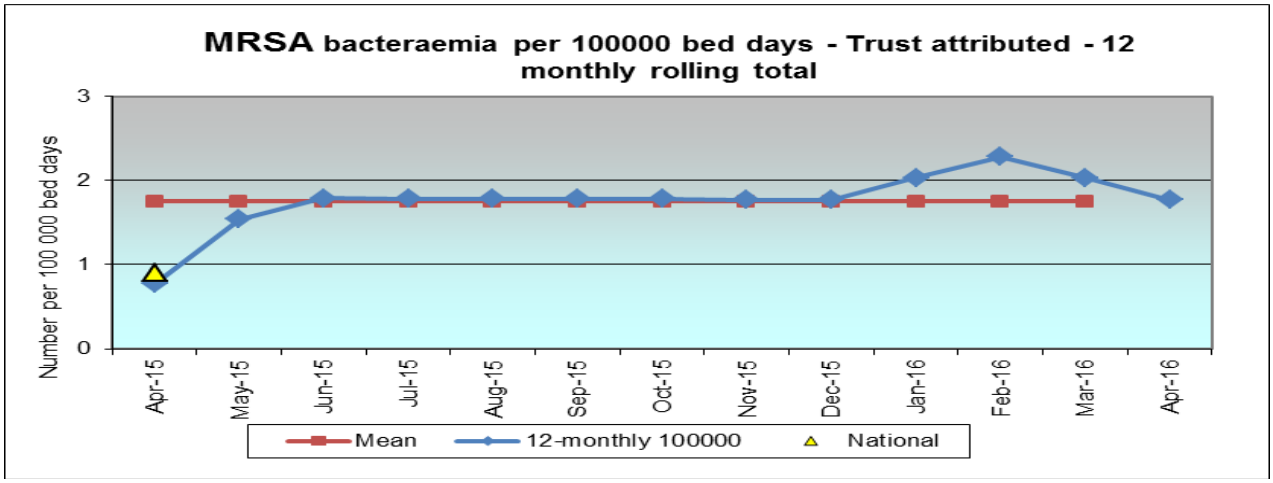
The Safer Staffing return for April 2016 is detailed in a separate paper.

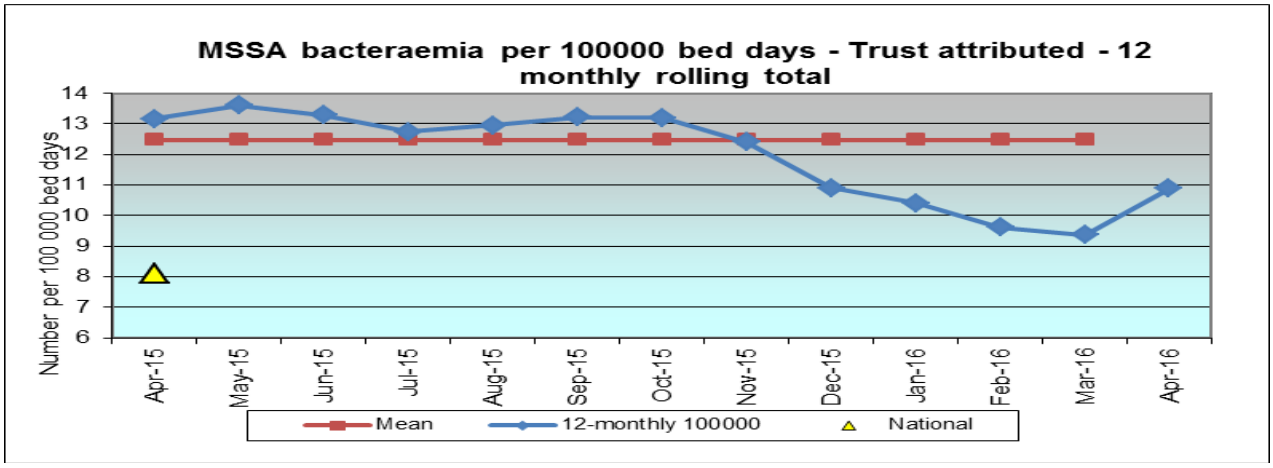
2.2 Infection Prevention & Control

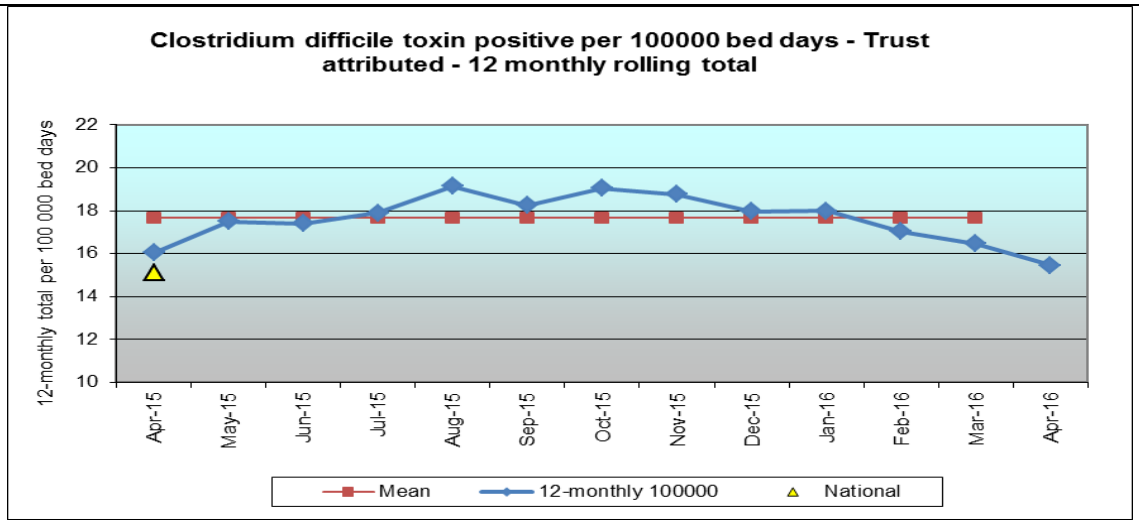
2.2.1 Healthcare Associated Infection

Healthcare Associated Infection (HCAI) incidence continues on a downward trend towards national and regional mean. I am pleased to report to the Committee that Regional incidence data show the Trust is no longer an outlier. MSSA incidence for April has increased however; this is due to a delay in obtaining blood culture specimens within 48hours of admission and severely ill patients. The IP team will discuss further collaborative action to improve at the Trust and Junior Doctor Patient Safety Groups and are working with medical leads to improve timeliness of blood culture specimens in septic patients

Table 1 below illustrates the improvement to date.







In addition, following the introduction of the ANTT training hand hygiene compliance has maintained at 95% average. We are currently making preparations for participation in the WHO Surgical Hand Hygiene initiative.

The Committee are aware that following a review of Governance arrangements a new Executive led Hospital Infection Prevention Steering Group (HIPSG) was introduced. This group has commissioned a proactive deep clean programme to be undertaken during the coming months and the IP team are currently working with other disciplines' to agree priority areas (based upon risk) and timeframes.

2.2.2 Noro-virus

The prolonged noro-virus outbreak at Scarborough during the week to Easter prompted regular update meetings with the CCG, NHSE and PHE**.** As a result of the impact of the ward closures and the apparent protracted incidence it was agreed that a lessons learned exercise would be undertaken by the CCG. Terms of reference are being drawn up and internally additional training and support is being offered to key staff groups to mitigate any risks identified as a result of the outbreak. The recommendations and any local actions will be reported to the Committee on receipt from the commissioned author.

2.2.3 Work-plan

As a result of the new Governance and reporting arrangements for IPC a detailed work-plan has been developed (appendix 3). The plan takes into consideration the recommendations from the PHE and NHSE input as a result of recent outbreaks and will be shared with partners. The delivery will be managed by the Infection Operational Group (IPCOG) and monitored by HIPSG.

2.3 Children's Safeguarding

2.3.1 Emergency Department Safeguarding Children work:

The ACHILD & ABCD safeguarding children risk assessment tools were introduced in both ED's in April 2015. In order to support and embed this development a Child Protection Advisor has been allocated dedicated time in ED to assist with assessments for referral to Children's Social Care, advice, support and the embedding of the risk assessment tools.
We continue to work closely with all three Local Authorities Children's Social Care departments to analyse the impact of increased understanding & use of the tools by ED staff. The hypothesis is that the embedded implementation of these assessment tools should lead to fewer, but more appropriate referrals to Children's Social Care, as well as improved information sharing with other relevant health professionals.

2.3.2 Training

As the Committee are aware there has been a significant improvement in the uptake of Safeguarding Children Training, which now averages 84% across all three levels (from 53% a year

ago). However the Vale of York Clinical Commissioning Group expect uptake of 95% so work to improve uptake continues.

The newly appointed Lead Nurse for the Child Sexual Assault Assessment Centre (CSAAC) and the Named Doctor for Child Protection have recently completed their Forensic Medical Examiner's training which will increase capacity to deliver the more specialised programme. A further Consultant Paediatrician who delivers sessions within the CSAAC will complete this course in 2017.

2.3.3 FGM

FGM mandatory reporting has been implemented within the Trust and compliance with training uptake for relevant staff continues to be monitored, with excellent compliance in most relevant areas. Areas where further work needs to be undertaken to improve compliance, these include: Obstetrics & Gynaecology (Consultants & Registrars -26.4% compliant), Gynaecology Nursing staff (35.5% compliant), York Paediatric Nursing staff (17% compliance), & SCBU staff at SGH (8% compliant). The Named Midwife for Safeguarding Children is continuing to monitor & promote compliance in these areas. The Named Midwife has also worked closely with the three Local Safeguarding Children Boards to deliver brief training events to multi-agency practitioners re FGM.

2.3.4 Ward Walk Rounds

Following the success of the Adult Safeguarding initiative from April the Childrens team has undertaken monthly 'walk rounds' to departments within the hospitals where staff do not primarily work with children; but may encounter children, either as patients aged 16-18 years (a child is anyone who has not yet reached their 18th birthday; Children Act 1989), or as the children of their patients or as visitors. The aim of these 'walk rounds' is to ensure that all departments are aware of how they can seek advice & support in relation to any concerns that a child may be being abused or neglected (e.g. as a result of an adult patient's medical condition), how to access the Safeguarding & Child Protection Policy, and how to make a referral to Children's Social Care. Contact details for the Safeguarding Children Team are left with the department, with advice to get in touch with the Team if they have any relevant concerns.

3. Effectiveness

3.1 Nursing Dashboards

The nursing dashboard continues to be populated each month and will be developed further in the next few months to include additional metrics. The site level nursing dashboards for Bridlington, Scarborough, York are attached at appendix 1.

The committee is aware that EWTT (appendix 2) was introduced to replace Nursing Care Indicators and to give a more detailed picture as to the quality of care delivered at ward level, these were also used to indicate where some additional support may be required. Given we are now able to look at all areas by way of the dashboard the decision has been made to discontinue the EWTT and to add some more indicators to the dashboard. In addition the revised document will provide supplementary information around risks and mitigations, updates will be given at future meetings.

3.2 The effective and efficient deployment of substantive and temporary nursing staff

As previously documented the Chief Nurse has commissioned a piece of work to examine the current e-roster systems to ensure the safest and most effective deployment of staff. A task and finish group of key stakeholders has now been established to look at the effective utilisation of substantive and temporary nursing staff. The group will focus on:

1) Indicative data (overview of rosters)
2) Clinical engagement (listening exercise, case for change)
3) Evidential data (deep dive reviews, metrics, compliance with roster principles)
4) Clinical leadership (competence, confidence, accountability, ownership)
5) Effective processes (creation, approvals, swaps, use of auto-roster, delivery levers,

internal system functionality, software functionality)

A detailed analysis of each of the areas is being carried out and will be reported at the end of May. A detailed project plan is in place to support reviews at local level, with the aim of adding value, in terms of better outcomes, experience and use of resources

3.3 Friend and Family Test Results

FFT Promotion Week took place from 14 – 18 March 2016. During the week information for staff, patients and visitors was displayed in the hospital, to raise awareness of FFT and how the information received is used to improve services. Internal and external communications were a priority, including a press release (leading to local press coverage) regular social media posts (with photographs of Chief Nurse Team and matrons) and coverage in staff matters and the Chief Executive's staff brief. The governors supported the week with a presence in ED on the two sites. We continue to meet our target for 90% of patients to recommend the Trust. The response rate for inpatients and ED for February and March 2016 has continued with an upward trend. The March 2016 response rate was 24.19% for inpatients (national average 24.1) and 15.6% for ED (national average 13.3%).

Reports on themes from narrative comments are now received to complement the numerical data. These show 3734 positive comments and 1805 negative comments) the top themes are: overall positive experience; waiting times/delays; and staffing levels.

3.4 Child Sexual Assault Assessment Centre

During the last 6 months we have appointed a Lead Nurse for the newly developed Child Sexual Assault Assessment Centre (CSAAC), which is jointly funded by NHS England & the Office of the Police & Crime Commissioner. This has allowed development of the service to include significant progress towards meeting all of the standards of the Faculty of Forensic & Legal Medicine forensic cleaning requirements, development of leaflets about the CSAAC for parents & children/young people prior to attending the Centre, feedback documents for those who have attended to tell us about what we could do to make the service more 'user friendly', and follow up to be offered (as appropriate) to those who have attended for assessments.

3.5 Section 11, Children Act 2004 Requirements

Earlier in the year the North Yorkshire & City of York Safeguarding Children Boards held a combined "Section 11 Challenge Day". As a Trust we were pleased to be able to report that we were compliant with all of the Safeguarding Children Boards' and Section 11 requirements, other than one element which asked how often the Trust repeats Disclosure and Barring Scheme checks on staff.

As an organisation we do not repeat these checks after initial checks prior to appointment, this is common practice and there is no mandate from the DH to do so. 'Health care staff' is a notifiable occupation following any Police arrest, caution or prosecution where safeguarding issues are identified.

4. Nurse Revalidation

As previously reported the Nursing and Midwifery Council (NMC) refreshed the approached for nurses and midwives to remain on the register in 2015. After significant consultation the new process was enacted on 1April 2016. The new process is called revalidation and aligns to the requirements for medical staff introduced previously.

Revalidation requires each nurse to develop an electronic portfolio of evidence that reflects their practice in nursing or midwifery. The portfolios contain eight elements, namely:

- Evidence of practice hours
- Evidence of continual professional development
- Practice related feedback
- Written reflective accounts
- Evidence of reflective discussions
- Health and character reference
- Professional indemnity arrangement
- Confirmation (confirmer signed form)

The Trust worked towards supporting staff through this process in 2015 by developing a 'Revalidation' facility on the Trusts Learning Hub. When this was ready the facility was widely publicised in formal sessions and drop in events held on all hospital sites.

The 'open' events were really well attended and feedback in terms of individuals understanding was very positive. In addition, for the staff due for revalidation in April, May and June 2016 (the first cohort) bespoke, invite only sessions were put on to ensure individuals felt supported.

The system appears to have worked well. Feedback has been positive and nurses and midwives are finding the process much easier than anticipated. There have been no nurses indicating that they are not choosing to revalidate. Additionally, the initial information from colleagues in Human Resources indicates no impact of revalidation on nursing or midwifery turnover.

The team who have managed the introduction of revalidation consider the process has worked well; however, we are mindful that the majority of nurses require support with revalidation in October and November. A meeting is scheduled for this month to consider the next steps to support these large cohorts through the process and will continue to monitor the impact of revalidation in the Trust.

5. Patient Experience

5.1 Complaints

The quality and timeliness of complaint responses remains a top priority. New data on timeliness of responses is being provided to the Chief Nurse to support Directorate Performance Management Meetings.

Engagement with matrons, directorate managers and assistant directors of nursing is on-going to foster directorate-level ownership, supported by clear policy and guidance.

The annual complaints report (under regulation 18) is submitted in a separate paper.

5.2 PALS

PALS will be moving onto the Datix Web system from July 2016, which should reduce the time spent on administration, improve the depth and insight of reporting, and increase the ability to triangulate with other sources of data. Plans to identify a more visible and accessible office are underway.

A new poster (featuring a matron photograph), encouraging patients/visitors to raise any questions/concerns in the first instance directly with the ward staff, is being produced to be displayed at the entrances to wards.

5.3 Volunteering
A dedicated manager is now in place to lead the development of the volunteer service. A 2016-17 work-plan has been drafted and will be presented to July 2016 Patient Experience Steering Group for ratification. The Deputy Lead for Patient Experience and York Administrator visited South Tees NHS Foundation Trust to learn from their successful volunteering service. Current priorities include ensuring that all DBS records are up to date for long-serving volunteers and developing a volunteer induction programme which ensures that all volunteers have consistent information to keep themselves and patients safe whilst carrying out their role.
5.4 National Inpatient Survey
A special workshop session of the Patient Experience Steering Group was held on 4 May to review the results of the 2015 inpatient survey and create an action plan. Actions in five key areas were agreed: celebrating success; reducing noise; welcoming and encouraging feedback; empowering patients; experience of discharge. The outputs and progress of this will be reported to the Patient Experience Steering group.
6. Recommendation
The Board is asked to note the Chief Nurse Report for May 2016.
7. References and Appendices
Appendix 1 - Nursing Dashboard Appendix 2 – Quality Effectiveness and Safety Trigger Tool (EWTT) Appendix 3 - Work Plan

Author	**Beverley Geary, Chief Nurse**
Owner	**Beverley Geary, Chief Nurse**
Date	**May 2016**

Appendix 1

Nursing Dashboard - York

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Cum Total	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU				3	2	3	1	2	3	1	8	2	4	4	2
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	1	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU				1	0	0	0	0	0	0	1	0	0	1	2
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU				2	2	2	1	2	0	1	5	1	3	3	0
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	1	0	0	2	0	2	1	1	0	0
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				14	10	11	18	18	15	18	23	18	18	21	9
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				0	1	0	0	0	1	2	0	0	0	0	1
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%			94.39	94.33	95.03	95.83	95.1	95.22%	96.09%	92.73%	96.66%	96.33%	96.44%	95.30%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS				10	9	8	7	11	3	7	11	3	9	2	5
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				9	4	8	1	9	6	6	3	9	10	8	9
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				2	1	1	0	1	3	2	3	0	0	1	6
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				3	1	0	0	0	1	0	2	2	2	0	1
	VTE Other	VTE Other		Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team				79.20	96.52	86.24	105.30	104.66	87.43	85.39	98.15	68.51	68.75	86.14	70.2
		Inpatient area vacancies - HCA	Number	CN Team				15.07	17.59	15.99	25.92	30.91	40.81	34.15	31.05	55.87	58.53	34.83	24.8
	Sickness	Sickness (In Patient Areas)	%	Workforce Info				3.70%	3.28%	2.56%	3.11%	3.43%	4.47%	3.96%	3.74%	3.99%	4.36%	3.56%	
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%			85.00	88.90	90.80	87.60	85.4	85.8	90.3	88	88.9	86.7	86.9%	89.55%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%			106.90	97.00	95.60	93.70	94.3	94.3	96.6	94.5	93.7	94.2	95.1%	96.43%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%			104.30	119.50	118.30	104.90	99.5	100	95.4	93.6	95.6	92.4	93.1%	98.06%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%			116.40	119.70	120.10	109.00	106.7	109.1	106.5	103.3	105.1	103.7	104.3%	106.29%
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info				25.90	27.70	25.90	28.62	29.2	27.94	31.9	32.55	33.7	39.2	38.1	
	Agency Fill Rate	Fill Rate	%	Workforce Info				52.40	57.00	62.70	53.11	44.9	43.31	43.1	36.69	42.4	33.9	36.8	
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0		2	0	0	0	0	0	0	0	0	0	1	0	1
		MRSA Screening - Elective	Compliance %	Signal	95%			97.03%	96.71%	95.10%	97.00%	97.20%	96.61%	97.85%	94.63%	75.64%	70.54%	74.41%	71.79%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%			74.89%	77.19%	76.36%	78.67%	78.21%	74.49%	79.69%	75.26%	79.09%	74.95%	76.53%	79.41%
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	59		38	2	2	0	3	2	4	3	5	5	4	1	0
	MSSA	MSSA Bacteraemia	Cummulative	IC Team	29		21	2	2	3	0	1	5	0	1	0	2	3	4
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team			50	2	4	1	4	2	3	4	4	4	10	6	2
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Governance				4	9	10	4	6	13	9	5	2	12	6	7
	Critical Incidents	CI's reported	Number	Datix - Healthcare Governance				2	1	4	6	0	0	0	0	0	0	0	0
	Never Events	Never Events declared	Number	Datix - Healthcare Governance				0	1	0	0	0	0	0	0	0	1	0	1
Patient Experience	Friends and Family	Inpatient Friends & Family Test	%Recommend	Signal				96.26	95.95	95.84	97.53	95.98	96.25	94.96	94.43	94.68	95.48	95.48	Not yet available
			%Not Recommend	Signal				1.13	1.79	0.93	0.75	1.00	1.12	1.60	2.46	1.53	1.92	1.34	Not yet available
		A&E Friends and Family Test	% Recommend	Signal				82.42	82.06	86.76	86.84	82.20	79.35	74.50	86.57	83.70	82.27	83.83	Not yet available
			% Not Recommend	Signal				12.53	12.92	8.06	8.92	12.43	12.83	18.30	7.89	11.28	10.44	10.92	Not yet available
		Maternity (Ante Natal)	% Recommend	Signal				85.00	95.18	97.67	93.93	95.24	86.79	100.00	93.75	97.80	100.00	91.00	Not yet available
			% Not Recommend	Signal				15.00	0.00	0.00	0.00	3.17	1.89	0.00	0.00	--	--	0.02	Not yet available
		Birth	% Recommend	Signal				21.20	21.10	96.00	96.00	98.50	95.50	91.67	98.50	96.80	100.00	100.00	Not yet available
			% Not Recommend	Signal				0.00	0.00	0.00	0.00	0.00	0.90	8.30	0.00	--	--	--	Not yet available
		Maternity (Post Natal)	% Recommend	Signal				15.18	20.08	100.00	100.00	97.06	95.60	100.00	100.00	100.00	97.10	99.00	Not yet available
			% Not Recommend	Signal				0.40	0.00	0.00	0.00	1.47	1.09	0.00	0.00	--	--	--	Not yet available
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team				17	10	6	5	8	24	not available	not available	18	22	28	23
		Staff Attitude	Number	PE Team				0	1	1	1	3	2	not available	not available	1	2	3	3
		Patient Care	Number	PE Team				9	5	2	2	2	4	not available	not available	5	1	3	1
		Communication	Number	PE Team				8	4	3	2	3	5	not available	not available	2	3	5	3

Nursing Dashboard - Scarborough

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trust Trajectory	Cum Total	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU			1	4	3	4	4	1	3	5	1	2	7	2
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	1	0	0	0	0	0	1	0	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU			1	2	2	2	2	1	3	3	1	1	5	1
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU			0	2	1	1	2	0	0	2	0	0	2	1
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS			5	2	1	2	4	8	8	8	4	11	6	7
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS			0	0	0	0	0	0	2	0	0	0	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%		0.93	0.95	0.91	0.91	93.89%	93.08%	91.04%	90.20%	93.31%	95.48%	91.67%	93.29%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS			9	5	11	7	8	11	10	11	9	3	6	7
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS			3	3	7	10	3	2	4	7	6	10	3	8
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			0	0	1	1	0	0	1	0	1	0	2	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			1	0	1	0	1	1	1	1	0	0	0	1
	VTE Other	VTE Other	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			1	0	1	0	0	0	0	1	0	0	4	0
Workforce	Vacancies	Inpatient area vacancies-RN	Number	CN Team			36.53	41.70	44.25	44.65	43.75	40.37	29.89	37.93	36.93	42.83	41.67	38.59
		Inpatient area vacancies - HCA	Number	CN Team			18.00	9.52	-0.17	-0.38	-7.56	-3.86	1.85	1.35	5.95	2.65	4.24	7.88
	Sickness	Sickness (In Patient Areas)	%	Workforce Info			5.56%	4.58%	5.15%	4.98%	5.16%	4.61%	5.08%	6.67%	6.46%	6.63%	3.43%	
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%		78.20%	85.70%	86.80%	81.50	80.5	81.7	83.8	87.5	86.6	83.7	80.8%	85.27%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%		92.50%	93.30%	93.50%	90.00	89.8	92.3	104.6	102.5	92.6	91.8	88.2%	89.92%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%		95.00%	109.80%	112.00%	113.20	109.4	109.2	94.1	90.8	104.9	100.5	100.5%	99.61%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%		117.60%	120.20%	115.40%	119.50	105.9	103.8	103.4	106.8	113.5	118.9	114.0%	115.87%
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info			45.70%	52.60%	51.00%	48.64%	51.80%	59.40%	62.00%	57.17%	73.70%	65.80%	58.60%	
	Agency Fill Rate	Fill Rate	%	Workforce Info			28.00%	30.00%	33.30%	27.72%	22.70%	19.40%	18.70%	14.63%	11.30%	11.20%	12.40%	
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0	3	1	2	0	0	0	0	0	0	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%		87.01	84.42	91.18	95.31	98.89	95.92	92.36	74.38	96.67	90	90.66	45.71
		MRSA Screening - Non-Elective	Compliance %	Signal	95%		96.66	94.20	89.44	89.93	85.76	90.32	91.55	86.60	97.48	86.47	84.13	87.82
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	48	16	6	3	2	0	1	0	0	2	1	0	1	2
	MSSA	MSSA Bacteraemia	Cummulative	IC Team	<30	14	3	1	1	0	2	1	2	1	2	0	0	4
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team		38	6	3	3	0	4	3	4	3	6	3	1	1
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Governance			5	3	6	2	4	4	6	4	6	9	12	7
	Critical Incidents	CI's reported	Number	Datix - Healthcare Governance			2	1	5	1	0	0	0	0	0	0	0	0
	Never Events	Never Events declared	Number	Datix - Healthcare Governance			0	0	0	0	0	0	0	0	0	0	0	0
Patient Experience	Friends and Family Test	Inpatient Friends and Family Test	%Recommend	Signal			96.07	94.78	95.74	95.02	96.61	97.81	95.00	95.32	97.38	95.52	96.45	not yet available
			%Not Recommend	Signal			1.59	0.26	1.26	1.39	0.85	0.40	1.00	1.10	0.56	1.07	1.62	not yet available
		A&E Friends and Family Test	% Recommend	Signal			75.14	82.31	79.76	80.12	79.31	71.83	85.10	80.85	81.10	72.73	65.25	not yet available
			% Not Recommend	Signal			19.77	9.52	13.69	16.27	13.79	19.72	9.20	12.77	11.81	17.48	24.11	not yet available
		Maternity (Ante Natal)	% Recommend	Signal			23.46	21.82	95.34	21.18	98.00	100.00	100.00	100.00	100.00	100.00	100.00	not yet available
			% Not Recommend	Signal			0.60	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	--	--	not yet available
		Birth	% Recommend	Signal			34.78	38.80	96.00	93.75	100.00	100.00	100.00	100.00	98.00	100.00	92.30	not yet available
			% Not Recommend	Signal			1.74	0.00	0.00	2.00	0.00	0.00	0.00	0.00	0.00	--	--	not yet available
		Maternity (Post Natal)	% Recommend	Signal			22.70	20.10	100.00	100.00	100.00	96.20	100.00	90.90	97.10	100.00	100.00	not yet available
			% Not Recommend	Signal			0.00	0.00	0.00	0.00	0.00	0.00	0.00	9.10	2.90	--	--	not yet available
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team			7	1	11	3	11	13	Not Available	Not Available	1	5	7	4
		Staff Attitude	Number	PE Team			1	0	2	1	3	0	Not Available	Not Available	0	0	0	0
		Patient Care	Number	PE Team			4	1	5	1	4	2	Not Available	Not Available	0	1	2	0
		Communication	Number	PE Team			2	0	4	1	4	5	Not Available	Not Available	0	0	2	1

Nursing Dashboard - Bridlington

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Commit ted	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU				1	0	0	0	0	1	2	2	0	0	2	0
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	1	1	0	0	0	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU				1	0	0	0	0	0	1	1	0	0	2	0
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	1	0	0	0	0	0	0
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				3	11	0	2	3	0	1	0	0	0	2	3
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				0	0	0	0	0	0	0	0	0	0	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - COUIN HARM FREE %	95%			0.90	0.91	0.90	0.91	91.94%	95.55%	92.40%	91.49%	95.30%	93.65%	95.11%	94.94%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - COUIN HARMS				0.00	3.00	1.00	0.00	1	1	1	1	0	1	1	0
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				1.00	0.00	1.00	0.00	2	0	0	0	3	0	1	0
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				1.00	1.00	0.00	0.00	0	0	0	0	0	0	1	1
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				0.00	1.00	0.00	0.00	0	0	0	0	0	0	0	0
	VTE Other	VTE Other		Safety Thermometer - VTE TREATMENT TYPE				0.00	0.00	0.00	0.00	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies - RN	Number	CN Team				0.80	0.74	8.18	8.00	0.4	0.52	5.52	7.08	0.28	0.78	11.08	5.78
		Inpatient area vacancies - HCA	Number	CN Team				2.64	1.00	2.07	1.42	-0.2	0.08	0.08	1.68	2.68	2.68	3.3	1.68
	Sickness	Sickness (In Patient Areas)	%	Workforce Info				5.57%	9.70%	3.16%	11.39%	9.05%	5.06%	6.36%	5.99%	8.65%	6.46%	7.89%	
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 90 - 100%			97.20	100.70	96.90	90.20	90	90.8	94.7	96.9	92.6	93.4	90.3%	93.42%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 90 - 100%			104.30	84.30	95.50	79.60	73.8	73.8	93.2	90.7	70.7	80.1	75.5%	84.09%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%			79.00	95.60	81.40	85.80	82.3	85.2	73.8	97.9	94.9	92.2	88.9%	93.82%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%			135.20	129.50	121.30	121.50	108.4	112.7	146	166.1	151.3	152.4	140.3%	150.00%
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info				40.00%	56.30%	70.70%	49.24%	61.40%	02.00%	00.50%	70.95%	01.40%	01.00%	03.30%	
	Agency Fill Rate	Fill Rate	%	Workforce Info				20.50%	20.80%	20.20%	37.39%	19.50%	0.00%	7.78%	3.39%	1.20%	2.80%	2.00%	
Infection Prevention	MRSA	MRSA Bacteraemia	Accumulated number of patients	IC Team	0	Green	3	2	0	0	0	0	0	0	0	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%			99.67	99.67	99.00	99.55	99.33	94.95	95.1	99.79	99.11	99.67	99.02	95.92
		MRSA Screening - Non-Elective	Compliance %	Signal	95%			83.33	83.33	100.00	88.89	85.07	100	83.33	100	100	--	86.67	100
	C.Difficile	C Diff Toxin Trust Attributed	Accumulated number of patients	IC Team	48	Green	3	0	1	0	1	0	1	0	0	0	0	0	1
	MSSA	MSSA Bacteraemia	Accumulated number of patients	IC Team	<30	Red	0	0	0	0	0	0	0	0	0	0	0	0	1
	E Coli	E Coli Bacteraemia	Accumulated number of patients	IC Team			4	0	1	0	0	0	1	0	0	0	2	0	0
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - healthcare governance				0	1	0	0	0	0	0	0	2	0	0	0
	Critical Incidents	CI's reported	Number	Datix - healthcare governance				0	0	0	0	0	0	0	0	0	0	0	0
	Never Events	Never Events declared	Number	Datix - healthcare governance				0	0	0	0	0	0	0	0	0	0	0	0
Patient Experience	Friends and Family	Inpatient Friends and Family Test	%Recommend	Signal				99.65%	97.26%	98.21%	98.71%	98.16%	98.30%	100.00%	98.73%	98.77%	99.02	98.40	not yet available
			%Not Recommend	Signal				0.00%	1.37%	0.36%	0.32%	0.61%	0.01%	0.00%	0.00%	0.92%	0.00	0.00	not yet available
		A&E Friends and Family Test	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	not yet available
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	not yet available
		Maternity (Ante Natal)	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	not yet available
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	not yet available
		Birth	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	not yet available
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	not yet available
		Maternity (Post Natal)	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	not yet available
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	not yet available
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team				1	1	0	0	0	1	not available	not available	0	1	0	0
		Staff Attitude	Number	PE Team				0	1	0	0	0	0	not available	not available	0	0	0	0
		Patient Care	Number	PE Team				1	0	0	0	0	0	not available	not available	0	1	0	0
		Communication	Number	PE Team				0	0	0	0	0	0	not available	not available	0	0	0	0

Nursing Dashboard - Trustwide

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Cumm. Total (Financial)	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - New PU			213	21	15	16	19	19	13	18	16	15	16	21	8
		Cat 4	No. of Patients (PP)	Safety Thermometer - New PU			5	0	0	0	2	0	1	0	0	0	2	0	1
		Cat 3	No. of Patients (PP)	Safety Thermometer - New PU			31	4	2	1	3	2	2	4	3	1	5	1	2
		Cat 2	No. of Patients (PP)	Safety Thermometer - New PU			127	14	10	12	11	9	4	12	9	8	7	17	3
		Unstageable	No. of Patients (PP)	Safety Thermometer - New PU			49	3	3	3	3	8	6	2	4	6	2	3	2
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - New PU			1	0	0	0	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS			383	29	33	41	33	36	31	33	31	28	36	35	21
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS			20	8	2	0	0	1	1	4	0	0	0	0	1
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE	95%	Red		92.89	94.27	93.73	94.06	94.22	95	94.28	92.79	94.4	95.99	94.13	95.52
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - UTI - NEW UTI			265	29	26	20	20	24	23	17	21	20	17	19	19
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS			173	16	7	18	16	17	9	12	10	19	18	14	21
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type			32	3	5	3	2	1	4	3	3	1	0	6	8
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type			31	6	3	2	1	1	2	2	3	2	3	1	2
	VTE Other	VTE Other	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type			15	2	1	1	3	1	0	0	1	0	1	4	0
Workforce	Vacancies	Inpatient area vacancies - RN (month end)	Number	CN Team				117.33	142.44	148.57	168.94	167.67	148.05	127.31	158.87	125.36	128.13	147.27	120.72
		Inpatient area vacancies - HCA (month end)	Number	CN Team				30.41	30.51	18.47	30.29	26.08	39.05	34.15	31.05	55.57	58.53	34.83	54.54
	Turnover	Registered Nurses	%	Workforce Info				10.36%	11.10%	11.21%	11.63%	12.33%	11.53%	12.24%	11.68%	11.83%	14.10%	15.04%	11.10%
		Healthcare Assistants	%	Workforce Info				15.14%	10.89%	11.78%	12.31%	12.15%	12.23%	12.01%	12.24%	10.06%	13.23%	12.81%	9.26%
	Sickness	Trustwide nursing / HCA sickness	%	Workforce Info				3.75%	4.01%	4.35%	3.76%	3.82%	5.17%	4.37%	4.64%	4.64%	4.45%	4.31%	
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%	Green		94.85%	93.39%	93.95%	91.31%	91.70%	92.80%	92.00%	91.20%	90.40%	92.80%	88.80%	91.74%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%	Red		103.27%	95.96%	95.93%	96.67%	88.60%	93.50%	95.40%	88.90%	89.70%	91.10%	91.60%	87.89%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%	Green		93.07%	103.03%	100.65%	100.10%	98.50%	96.70%	100.70%	93.70%	98.00%	96.30%	97.84%	97.02%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%	Red		107.02%	107.16%	106.51%	104.03%	100.60%	109.30%	104.60%	114.20%	115.00%	110.70%	108.48%	119.80%
	Bank & Agency	Overall Fill Rate	%	Workforce Info				77.12%	82.24%	87.38%	80.29%	74.26%	77.55%	77.04%	70.76%	79.40%	75.30%	74.67%	
		Bank Fill Rate RN	%	Workforce Info				29.43%	31.93%	29.66%	28.35%	29.14%	43.74%	36.98%	36.20%	46.38%	42.94%	34.71%	
		Bank Fill Rate HCA	%	Workforce Info				38.24%	39.74%	43.07%	51.09%	56.02%	51.13%	53.85%	52.56%	67.07%	60.31%	60.18%	
		Bank - RN Hours filled	Number of Hours	Workforce Info				8,501	8,192	8,167	8,480	8,868	9,458	10,100	10,499	14,508	14,266	15,115	
		Bank - HCA Hours filled	Number of Hours	Workforce Info				9,158	9,178	10,372	9,616	9,089	9,508	10,711	11,161	13,716	13,879	15,494	
		Agency Fill Rate RN	%	Workforce Info				39.85%	43.64%	54.73%	48.66%	42.01%	34.12%	40.36%	32.56%	30.26%	29.82%	31.09%	
		Agency Fill Rate HCA	%	Workforce Info				48.48%	49.73%	47.72%	34.40%	23.35%	26.06%	22.78%	20.93%	16.55%	18.66%	20.17%	
		Agency - RN Hours filled	Number of Hours	Workforce Info				11,512	11,199	15,068	14,553	12,783	7,379	11,021	9,444	9,465	9,905	11,824	
		Agency - HCA Hours filled	Number of Hours	Workforce Info				11,604	11,419	11,494	6,476	3,789	4,847	4,530	4,444	3,385	4,295	5,193	
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0	Red	1.00	2	2	0	0	0	0	0	0	1	1	0	1
		MRSA Screening - Elective	Compliance %	Signal	95%	Red		93.46	93.21	92.11	94.72	94.48	95.69	94.32	89.85	78.4	70.83	73.81	68.21
		MRSA Screening - Non-Elective	Compliance %	Signal	95%	Red		78.95	76.69	81.11	82.95	80.52	79.71	83.65	83.98	79.94	79.62	80.26	82.21
	C.Difficile	C Dif Toxin Trust Attributed	Cummulative	IC Team	48	Amber	3.00	8	6	3	8	3	5	2	8	7	5	3	3
	MSSA	MSSA Bacteraemia	Cummulative	IC Team	<30	Red	9.00	5	3	4	2	3	6	2	2	2	2	3	9
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team			5.00	8	8	4	6	6	6	3	14	11	15	7	5
	Hand Hygiene	Hand Hygiene Compliance 95%	Compliance %	IC Team	95%	Green		92%	93%	94.6	94%	94%	94%	94.93%	94%	94%	94%	97%	95%

		Metric	Measure	Data Source	Trajectory	RAG	Comm. Total (Financial)	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Goverance Team				14	12	20	11	16	21	19	12	11	27	21	17
	Critical Incidents	CI's reported	Number	Datix - Healthcare Goverance Team				5	2	10	7	0	0	0	0	0	0	0	0
	Never Events	Never Events declared	Number	Datix - Healthcare Goverance Team				0	1	0	0	0	0	0	0	0	1	0	1
Patient Experience	Friends and Family	Inpatient Friends and Family Test	%Recommend	Signal				96.81%	95.91%	96.14%	97.01%	96.51%	96.98%	95.46%	95.26%	96%	96.01%	96.19%	Not yet available
			%Not Recommend	Signal				0.95%	1.38%	0.92%	0.75%	0.90%	0.88%	1.26%	1.83%	1.19%	1.44%	1.20%	Not yet available
		A&E Friends and Family Test	% Recommend	Signal				80.38%	82.12%	85.05%	85.09%	81.49%	78.34%	76.10%	85.61%	83.31%	80.95%	80.86%	Not yet available
			% Not Recommend	Signal				14.56%	12.04%	9.43%	10.83%	12.77%	13.75%	16.90%	8.70%	11.36%	11.41%	13.02%	Not yet available
		Maternity (Ante Natal)	% Recommend	Signal				90.99%	96.64%	96.90%	96.08%	96.46%	95.60%	100%	97.22%	99.01%	100%	95.65%	Not yet available
			% Not Recommend	Signal				1.80%	0.00%	0.00%	0.00%	1.70%	1.10%	0	0	0	0	1.09%	Not yet available
		Labour & Birth	% Recommend	Signal				98.04%	100.00%	97.60%	94.90%	98.76%	95.50%	93.75%	98.97%	98.75%	100%	95.65%	Not yet available
			% Not Recommend	Signal				0.99%	0.00%	0.80%	1.02%	0	0.90%	6.25%	0	0	0	4.35%	Not yet available
		Maternity (Post Natal)	% Recommend	Signal				96.59%	99.03%	95.79%	94.09%	98.37%	95.60%	100%	0	100%	97.87%	99.15%	Not yet available
			% Not Recommend	Signal				1.14%	0.00%	0.00%	2.33%	1.62%	1.10%	0	0	0	1.06%	0%	Not yet available
		Community Post Natal	% Recommend	Signal				98.51%	98.82%	100.00%	98.44%	100%	95.68%	100%	94.44%	98.31%	98.41%	94.85%	Not yet available
			% Not Recommend	Signal				1.49%	0.00%	0.00%	0.00%	0	2.59%	0	5.56%	1.69%	0	1.03%	Not yet available
	Complaints	Complaints Total	Number	PE Team				25	12	17	8	20	42	Not Available	Not Available	19	31	36	27
		Staff Attitude	Number	PE Team				1	2	3	2	6	7	Not Available	Not Available	1	3	3	3
		Patient Care	Number	PE Team				14	6	7	3	6	6	Not Available	Not Available	5	3	5	1
		Communication	Number	PE Team				10	4	7	3	8	5	Not Available	Not Available	2	3	8	4

Appendix 2

Early Warning Trigger tool

The Quality, Effectiveness and Safety Trigger Tool identifies the potential for deteriorating standards in the quality of care delivered in a defined area, usually a Ward or Clinical Team. It was introduced to replace Nursing Care Indicators and to give a more detailed analysis of the quality of care on our ward areas.

It is based on the principles of early warning systems; for example the NEWS or MEWS (those tools concerned with identifying and acting to prevent physiological deterioration of individual patients).

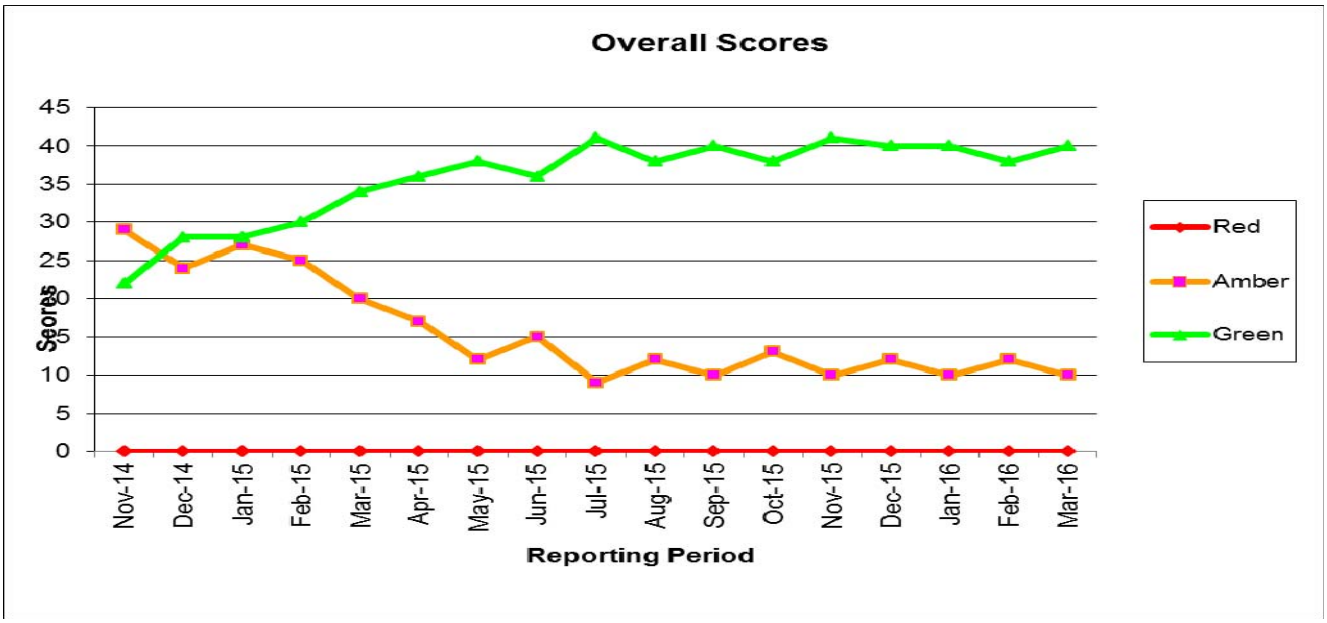
The EWTT tool examines is based on 16 questions for each ward area, each question having its own weighting in terms of importance for resolution.

Where a ward has a cumulative ward score of 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

During the quarter January to March 2016, the EWTT submissions have continued with 50 wards completing the information each month. The last three months has shown a continuation of the number of wards remaining at a green rating compared with the position at the end of December 2015 (80%). During the last quarter, no ward has triggered red on the tool.

Chart 1 below provides the month on month scores



By the end of March 2016 In Community 5 out of the 6 inpatient units have remained green rated during the last quarter which is consistent with the period ending 31st December 2015. The average trigger tool score in Community is 7, a slight improvement on the previous quarter. Abbey ward and War Memorial Ward are not included in this data following their

transfer to Humber.

In Bridlington, all 4 wards have continued to remain green rated with three of the four wards improving their score month on month during the last quarter. The average trigger tool score is 5, a slight increase on their position at the end of December 2015 (4.75).

In Scarborough, 4 wards (27%) out of 15 are amber rated at the end of March 2016, an increase of 2 wards since December. The average trigger tool score is 10.33, an increase on their position at the end of December 2015 (8.47).

In York there are 5 wards out of 25 who are amber rated (20%), an improving position since the end of the last quarter. The average score at the end of March was 9.46, an improvement on their December reported average score of 10.88.

There are 6 wards which have remained at amber throughout the last quarter. These wards are:

- Archways
- Acute Medicine Unit (York)
- Ward 14
- Ward 15
- Ward 28
- Ward 34

All of these wards have reported vacancies, in 3 cases unfilled shifts and in 4 cases sickness problems, low compliance with appraisals and hand hygiene have also been reported. 4 of the wards have not achieved 30% response rates for friends and family and, in 4 cases capacity demands have been reported as a factor during the last quarter.

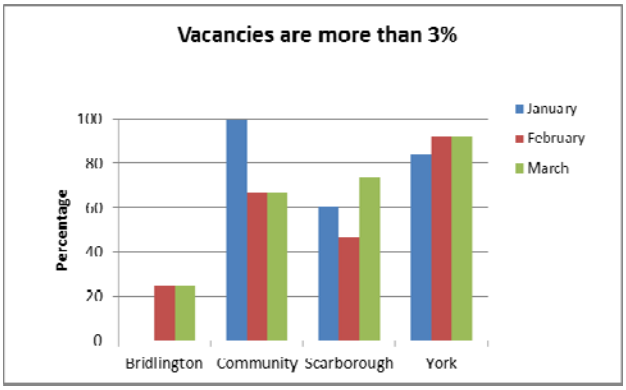
2.2. Staffing Measures

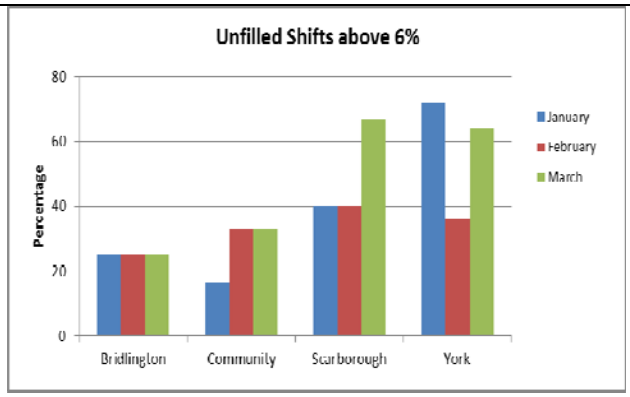
Vacancies, unfilled shifts and sickness have continued to be recurring themes for the wards over the last fifteen months. There are 38 wards reporting vacancies above 3%, a deceased of 2 wards since December 2015. This however is not unexpected and is evidenced through the workforce data reported to the Board during the last twelve months. One vacancy on each ward would take the vacancy percentage above 3%. Similarly in terms of sickness, having one person off sick would trigger sickness above 3.1% for a ward.

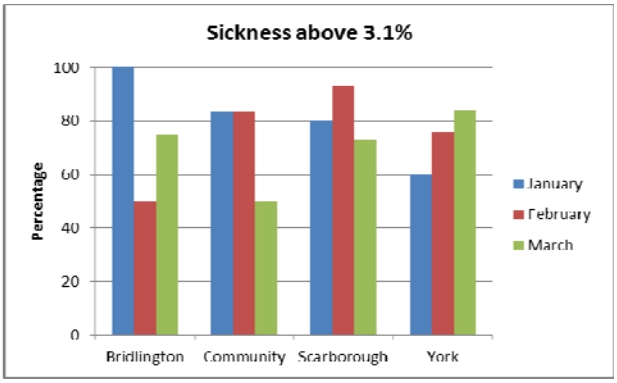
25 wards are reporting their inability to fill shifts, with unfilled shifts exceeding 6% at the end of March 2016. This is due in part to vacancies but also the recent work undertaken to scrutinise all requests for agency staff.

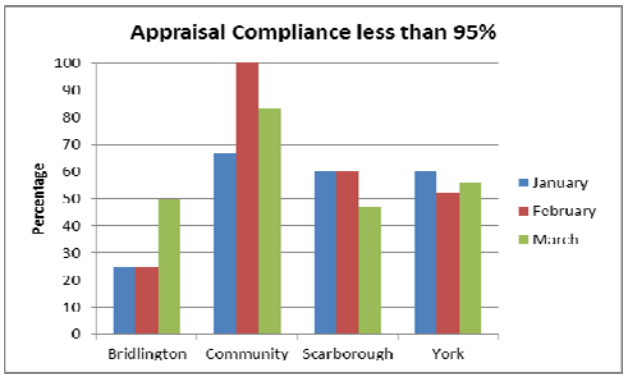
Completion of appraisals are also being affected by staff sickness, the vacancy position and the acuity and dependency of patients on the wards with 44% of wards reporting on this metric.

The charts below summarised the position across the Trust sites





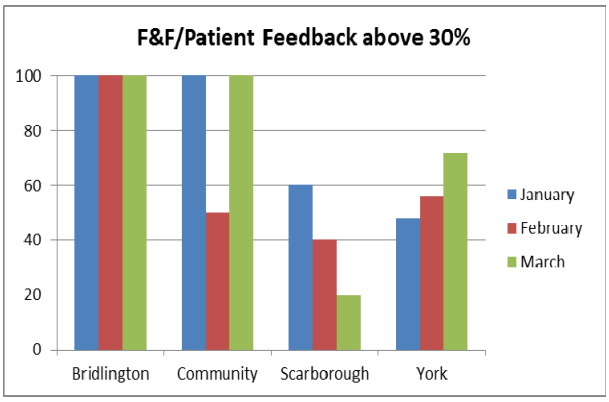


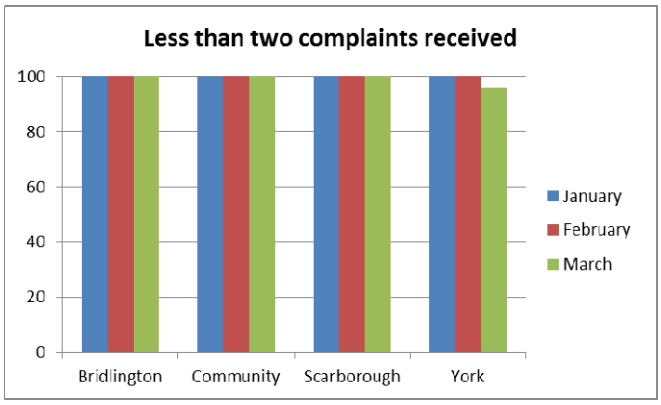


2.3 Patient Experience

There are two metrics which come under the Patient Experience the first of these is the Friends and Family Test. At the end of December, 38 out of 51 wards (76%) were reporting that there patient feedback was above 30%, this is an improvement of 5 wards since December 2015.

The second metric is less than two complaints. All 49 wards have reported in March 2016 that they have received less than two complaints in that month. This is a slight decrease on the reported position at December 2015.



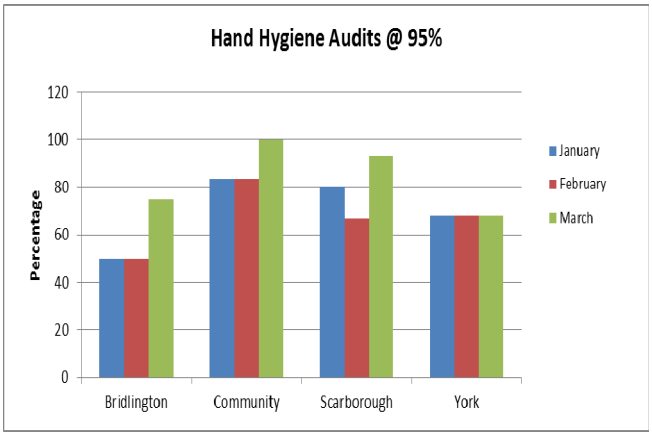


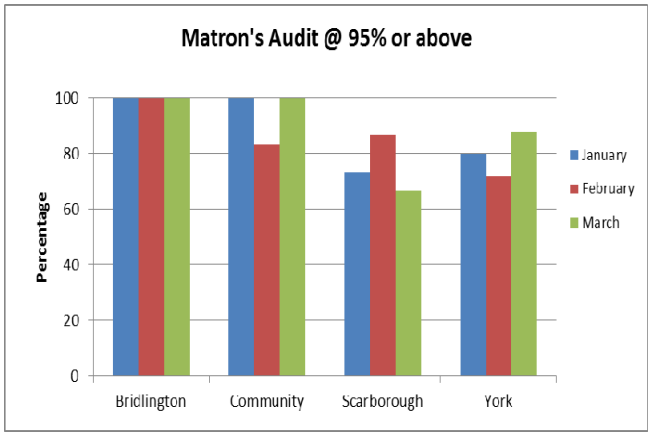
2.4 Environment

There are three metrics related to environment. There has been a reduction in reported hand hygiene compliance across a number of wards during the last quarter. In Bridlington the position deteriorated during January and February, returning to 75% by the end of March. This may be due to no audit being carried out as opposed to actual compliance of infection control standards being poor.

Matron's environmental audits have remained consistent during the quarter with 7 wards

achieving less than 95%. This is an improvement of 1 wards since the end of December 2015.





All wards with the exception of one, on the York site, are reporting that their wards are clean and tidy.

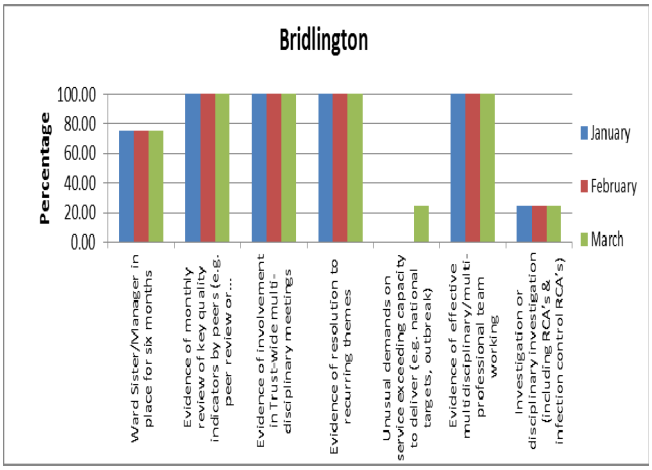
2.5 Other Indicators

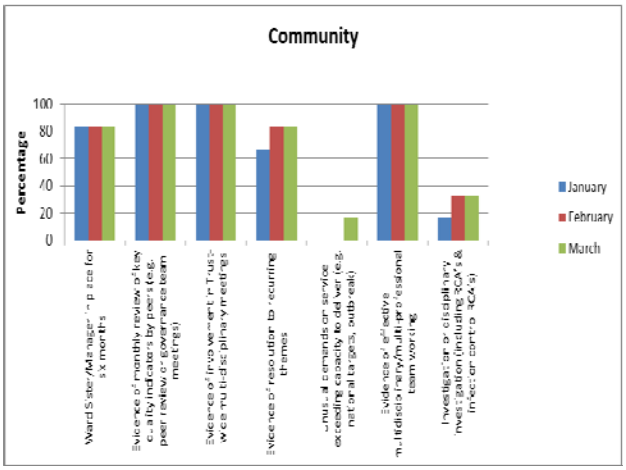
The EWTT contains a further 7 metrics which provide some further context for the ward. At the December submission 9 wards were reporting that they had new ward sisters in place during the last six months, compared with 11 at the end of December 2015.

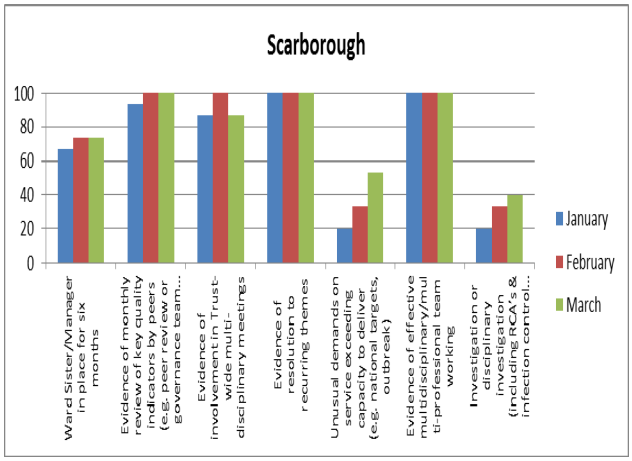
No wards are reporting that they are unable to evidence their key performance indicators, whilst 2 wards have reported at the end of March 2015 that they do not have evidence of participation in Trustwide MDT meetings. One ward, in community is reporting that it does not have evidence of addressing recurring themes on its ward.

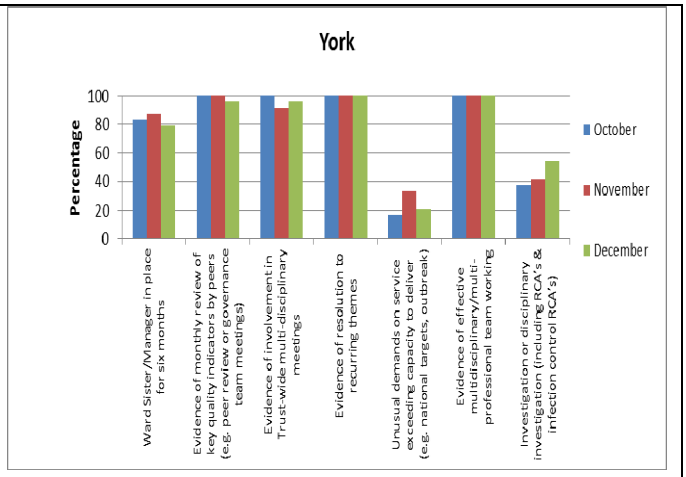
The last three months has seen an increase in capacity demands on wards, with 14 wards continuing to report this at their March submission.

At the March submission 14 wards were reporting involvement in some form of investigation. This may include Pressure Ulcer or Falls investigations or investigations relating to staffing. The charts below provide a summary of these indicators by site







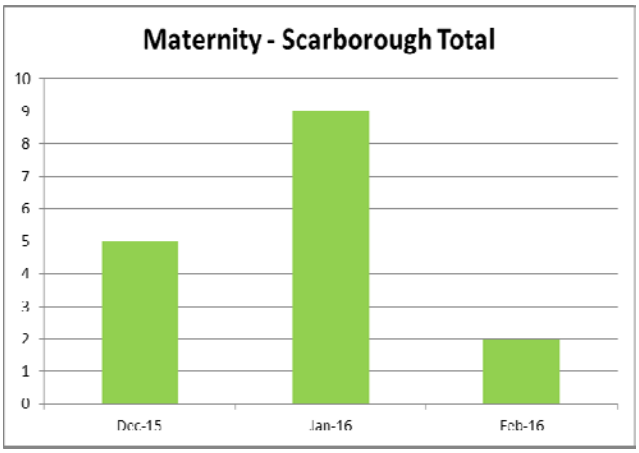


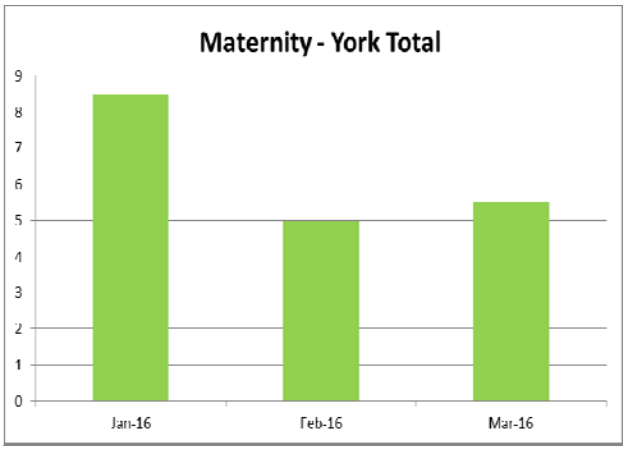
As previously stated, consideration is being given to the Nursing Dashboard replacing the EWTT as a means to capture ward based data each month. This will reduce duplication and help improve consistency of data being reported. The nursing dashboard metrics will be expanded and will include a narrative section to document exception reporting.

2.6 Maternity EWTT

In October 2015, the Maternity EWTT was launched. It is based on the same metrics for the inpatient wards, but due to the configuration of the service management of maternity services, it wasn't possible to capture the metric submissions in the same way. Therefore, for York, as there are two maternity wards, a mean score for the ward based metrics was introduced which is then combined with the service level metric scores

The Charts below provide the breakdown of the total scores for maternity services at the Scarborough and York sites.





Maternity services on both sites are currently rated as green. The key themes emerging from the maternity EWTT are consistent with the inpatient areas – unfilled shifts, sickness rates, appraisal completion as well as matrons environment audits and 30% response rates to Friends and Family tests. Each ward as well as the overall service on each site has developed action plans to address areas for action and these are being monitored by the Matrons on each site as well as the Head of Midwifery.

3. Summary and Next Steps

The data from this quarter continues to show a number consistent themes across the

organisation;

- sickness,
- vacancies
- unfilled shifts
- appraisal compliance
- Friends and Family test/Patient Feedback at 30%

Monitoring against each of these metrics will continue each month.

Discussions are continuing regarding the future use of the Early Warning Trigger Tool as many aspects are a duplication of the nursing dashboards which are produced each month by the Chief Nurse Team. It is anticipated that monthly population of the Trigger Tool will cease with further metrics being introduced on the dashboards.

Infection Prevention and Control Work Plan 2016/17

Objective	Activity	Q1 Status	Responsible Lead/Group
1. Systems			
Strengthen and improve governance; reporting and escalation processes	Development of a revised governance structure following external review in 2015 *Operational level;* Outcomes of Post Infection Review (PIR) surveillance, audit, outbreak investigations, period of increased incidence reports and Serious Incident investigations will be reviewed at the Infection Prevention Operational Group (IPOG) *Strategic level;* Escalation via the IPOG regarding key issues to the Trust Infection Prevention Steering Group (TIPSG) for review and further escalation of significant risk factors and actions to Quality and Safety Committee and Board of Directors Regular Review of Risk Register with discussion of intractable risks at IPOG with escalation to TIPSG as required	Revised governance structure in place from January 2016	Lead; Deputy DIPC Group; Director of Infection Prevention (DIPC) and Infection Prevention Doctor
Continue to develop universal responsibility for implementation of safe Infection Prevention (IP) practice	*Strategic level;* Individual ownership and responsibility for Infection Prevention to be integral to all YTHFT employee job descriptions IP to be represented at Clinical and Directorate Governance sessions and Patient Safety Group *Operational level;* To be evaluated and documented at appraisal by clinical managers supported by Infection Prevention Team (IPT)	IP is written into all job descriptions and the latest version of appraisal paperwork makes explicit the expectations on staff with reference to IP practice	Lead; Deputy DIPC Group; Human Resources, Director of Infection Prevention (DIPC) and Infection Prevention Doctor Director of Patient Safety
Improve Infection Prevention (IP) practice throughout YTHFT in relation to associated policies and guidelines in the management of Health Care Associated Infections (HCAI)	*Strategic level* ; Provide trust wide educational resources via YTHFT Learning hub and Infection Prevention portal. Incorporate external educational resources as adjuncts to in house training packages. Focus audit and surveillance strategy to monitor outcomes and establish objectives for required learning Ensure all Policies and Guidelines are updated that reflect best practice, latest research findings and national recommendations. DIPC to agree with Medical Director (MD) representation at Clinical Governance sessions *Operational level;* Infection prevention Nurses to support clinical staff in practical application of IP principles using the above resources encompassing Isolation Practice Standards, correct use of PPE in relation to selection, donning, doffing and safe disposal of single use items	Briefcase assessing ANTT competency completed. Records on ESR illustrate 77%. Practical sessions planned for areas showing significant levels of untrained staff for ANTT IP required learning is at 90% for level 1 and 88% for level 2 Representation secured at Patient Safety Group	Lead; Deputy DIPC Group; Medical Lead, Director of Infection Prevention (DIPC) Infection Prevention Doctor Infection Prevention Nurses (IPN) Lead Nurses Occupational Health Physician

Improve compliance with Fit Testing for respirator use within YTHFT	*Strategic;* Develop a trust wide strategy that will ensure the safety of Health Care Workers (HCW) while managing patients with infectious respiratory illnesses Work with multi-disciplinary team members i.e. Occupational Health, Health and Safety, Lead Nurses, Medical Leads and resource providers to develop processes to monitor training and competencies *Operational;* Advise clinical staff on correct use of respirators with regard to appropriate choice, when to use, single use v reusable and how to decontaminate	Several multi-disciplinary meetings have taken place - universal agreement on training content, where the training needs to be focussed, how to maintain an accurate register of fit tested staff and which members of staff can fit test colleagues. Next steps are to put fit testing training requirements onto the Learning Hub, and launch training via e-learning and practical sessions	Lead; Deputy DIPC Group; Director of Infection Prevention (DIPC) Infection Prevention Doctor Infection Prevention Nurses (IPN) Lead Nurses, Health and Safety Lead, Medical Devices Lead
Mitigate operational risks while ensuring safety of patients	*Strategic level;* Infection Prevention to be involved in all operational planning that has direct impact on patient safety. Collaborative working in the development and implementation of the Isolation Policy that directly impacts on patient flow. *Operational level;* IPN to work closely with the operational team and join the operational meeting at least daily during outbreaks that result in ward closures. IPN to evaluate side room use and prioritise using risk assessment on a case by case basis	In operation from 2015 key area of concern is lack of isolation capacity (see Risk Register)	Lead; Deputy DIPC Group; Medical Director Director of Infection Prevention (DIPC) and Infection Prevention Doctor IPN

2. Environment			
IP to be involved in new developments and capital projects to design in Infection Prevention to the national standaeds	*Strategic level;* IPT to attend all pertinent Capital Management Group meeting to discuss new projects *Operational;* IPN to risk assess using the Trust approved Risk Assessment Tool and review all building sites as per YTHFT policy	In place	Lead; Capital Team Group; Deputy DIPC Group; Director of Infection Prevention (DIPC) and Infection Prevention Doctor
Ownership of environment and maintenance of standards to be embedded at ward and department level	*Strategic level;* Work with Chief Nurse Team to develop ward accreditation tool *Operational level;* Audit and Surveillance and IPN to continue to carry out supplementary audits with reference to the ward environment, i.e. Period of Increased Incidence (PII) audit, Hand Hygiene Facilities Audit etc.	IPN have attended the meeting and evaluate the ward accreditation tool Audit by IPN continue throughout the year New PII audit tool developed and implemented march 2016	Lead; Deputy DIPC/Helen Hey, Group; IPN, Lead Nurses
Continuous improvement of environmental standards and IP involvement in YTHFT ward reconfiguration strategy	*Strategic level* ; Work with operational, decontamination and estates teams to develop a decant and refurbishment and remodelling strategy *Operational level* ; Prioritisation of wards in need of refurbishment and specialist decontamination, considering incidence of Health Care Associated Infection and outbreaks resulting in closure of the unit	Meeting convened between IPT, Ops, domestics and estates in preparation for decant commencing beginning of June IP to attend ward remodelling meetings regarding reconfiguration	Lead; Deputy DIPC, Director of Operations Group; IPN, Lead Nurses, Estates and Facilities, Domestic Services

3. HCAI			
Reduce incidence of Health Care Associated Infections to meet local and national targets	*Strategic level;* *a)* Work closely with YTHFT commissioners and share knowledge that aims to reduce infection rates using lessons learned from the Post Infection Review (PIR) b) Escalate identified concerns using the new governance structure to address concerns that cannot be managed at local level c) Work in partnership with the Antimicrobial Stewardship team to develop an antimicrobial formulary based on outcomes from PIR particularly in relation to *C.difficile* d) Work with multi-disciplinary teams to ensure compliance with invasive device monitoring and improvement in clinical competency regarding management of such devices e) Utilisation of audit and surveillance services to monitor and identify trends for a targeted approach to Trust specific issues d) Feedback of risk and outcomes to Patient Safety Group *Operational level;* *a)* IPN to incorporate learning from PIR into all training platforms and to support clinical staff with prompt antimicrobial review, ensuring correct dose, indication for use and course length is integral to the prescription b) IPN to support clinical staff in identification of risk patients, ensuring prompt sampling and isolation c) IPN to work with acute admission wards to ensure emergency admission screening for MRSA achieves >95% d) IPN to work with Clinical Skills Team, Sepsis Team, Critical Care Outreach, Specialist Nurses, Matrons and training providers to maintain high standards and competency in clinical skills that impact directly on patient safety e) IPN to support clinical staff in high quality microbiology sampling that informs treatment and management of the patient f) Deliver ANTT training at ward level to promote safe practice relating to invasive device management	Commissioners have been invited to all PIR since 1st May Trust wide and ward based education based on lessons learned using case studies implemented and are ongoing IPN deployed to support admitting wards to improve levels of emergency screening A multi-disciplinary meeting has been arranged (17th May)to discuss finding from PIR in relation to MSSA bacteraemia IPN to participate in the Professional Nurse Lead Forum, Senior Team Meetings and Sisters meetings	Lead; Deputy DIPC Group; Commissioners Director of Infection Prevention (DIPC)and Infection Prevention Doctor Infection Prevention Nurses (IPN) Lead Nurses Patient Safety Group
Improve the identification at ward level of vulnerable patients at risk of developing HCAI	*Strategic level;* Via implementation of local lessons learned and Trust wide dissemination of latest national guidance and current recommendations based on the best available evidence *Operation level;* Dissemination of learning as proposed by the IPT Training and Development Group using multi-platform resources that target all YTHFT staff members e.g. formal Required Learning teaching modules, ward based teaching, message of the month and Trust wide Lessons Learned document	All Required Learning presentations updated and sent to CLaD April 2016 Ward based teaching sessions to be resumed in the summer of 2016	IPN

4. Service users			
Improve patient experience by ensuring service user information relating to IP is easily accessible and clear	*Strategic level;* Work with Patient Experience, PALS, Communications Team, Governors and Friends of York Hospital to improve the quality and pertinence of IP patient information *Operational level;* Continued redevelopment of service user leaflets and make them available in multiple formats. IPT to ensure there is clear guidance for all service users using available resources e.g. front of house information screens, internet, external news bulletins (radio) clear and concise signage at the entrance to all hospitals and wards on either a seasonal or permanent basis. Clear patient guidance located at key points on the ward e.g. highlighting the location of hand hygiene facilities	IP information leaflets for service users updated and includes audio versions (February 2016) for C. difficile advice All communication platforms previously listed provides advice and guidance on IP issues Internet site for IP updated April 2016 New signage for hand hygiene resources developed by IPN and hand hygiene product providers, due to launch imminently	Lead; Deputy DIPC Group; Communications Team, PALS, Infection Prevention Doctor, Governors, IPT
5. Mandatory Surveillance			
Reduction in Catheter Associated Urinary Infections (CAUTI) incidence	*Strategic level;* Responding to the local CQUIN for CAUTI audit of urinary catheter management results to inform changes in practice and to measure Trust performance against national indicators *Operational level;* Implementation of standardised catheter packs, daily assessment and monitoring document and passport to ensure consistent good practice relating to urinary catheter management. Completion of Trust wide Urinary Catheter Guidelines Dec. 2015	Audit of the Elderly Directorate now completed - now being rolled out across medical directorate, Audits commenced in medicine April 2016	Director of Infection Prevention (DIPC) Deputy DIPC and Infection Prevention Doctor Infection Prevention Nurses (IPN) Audit and Surveillance Nurses Lead Nurses Deputy Director of Patient Safety
6. Decontamination			
With decontamination lead improve Trust wide compliance with all aspects of decontamination	*Strategic level;* a)Via the Decontamination Steering Group ensure that there are systems, processes and facilities in place for safe decontamination of equipment including endoscopy b) Advise on procurement of equipment that ensures effective decontamination c) Provide Trust wide guidance on safe decontamination of equipment *Operational level;* Provide clear guidance on cleaning/decontamination frequencies for clinical equipment at ward level	New endoscopy decontamination unit now in use, further provision of endoscopy services in planning process Decontamination of equipment guidelines in place due for review March 2017	Lead; Decontamination Steering Group Group; Water Safety Committee Estates and Facilities Director of Infection Prevention (DIPC) Deputy DIPC and Infection Prevention Doctor Infection Prevention Nurses (IPN) Audit and Surveillance Nurses Lead Nurses

7. Water Safety			
Ensure the efficacy and safety of water systems throughout YTHFT	*Strategic level;* In collaboration with the Technical Consultant & Authorising Engineer for YTHFT to ensure all systems and processes are in place to comply with national water management regulations *Operational level;* IPT will provide representation at all Water Safety Committee Meetings in order to - a) Contribute to a written scheme in the form of a Water Safety Policy or Plan b) Establish status and validity of Risk Assessments for Legionella and P. aeruginosa and status of the identified fault rectification c) Identify level of training of associated members of staff employed in water quality management d) Update status of PPM Programme implementation and defect logs e) Monitor current water bacteriological analysis results and associated management process f) Determine Usage Evaluation and flushing protocols	Water Quality Audits secure web portal access provided May 2016 New appointment letters sent out as per protocol April 2016	Lead; Water Safety Committee Group; Estates and Facilities Microbiology Consultant Infection Prevention Nurses (IPN) Health and Safety Representative Lead Nurses
8. Infection Prevention Staffing Resource			
To initiate Infection Prevention & Control service project plan to evaluate resources required to ensure an effective IP service across YTHFT	*Strategic level;* a) Evaluate current IP resources b) Review where infection prevention and control input is required in each operational unit, exploring how this can be delivered c) Review the structure of the IPT service to ensure effective IP across YTHFT. d) Review the role of the Infection Prevention Nurse ensuring time is built into job plans for education and training e) Review the role of the IP Link Nurse g) Determine whether the on-call service is a valuable resource	Review of on-call services began May 2016 Review of expenses for cross site working began May 2016	Lead; Director of Infection Prevention (DIPC) Deputy DIPC Human Resources
Developed through local learning and gap analysis of the Health and Social Care Act (HSCA) – Code of Practice (2009), NICE quality standard QS 61 (2014), NICE improvement guideline PH36 (2011), C. difficile How to deal with the problem (2008) and Epic3 guidance (2014) PHE local recommendation			

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 May 2016

Safe Nurse and Midwifery Staffing Report

Action requested/recommendation

The Committee 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).

Reference to CQC outcomes

Outcome 13

Progress of report

Risk

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 Projects Manager

Date of paper	May 2016
Version number	Version 1

Board of Directors - 25 May 2016

Safe Nurse and Midwifery Staffing Report

1. Introduction and background

The Board of Directors are aware that from May 2014 all organisations were required to report actual versus planned nurse staffing levels. This is the twenty-fourth submission to NHS Choices of actual against planned staffing data for day and night duty in hours and by ward.

A detailed breakdown for April 2016 staffing levels is attached at Appendix 1.

The data from this report continues to be produced from the revised tool which was introduced in June 2015.

2. High level data by site

	Day		Night	
Site 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	83.3%	102.7%	50.0%	200.0%
Bridlington And District Hospital	93.4%	93.8%	84.7%	150.0%
Malton Community Hospital	82.7%	109.5%	100.0%	100.0%
Scarborough General Hospital	85.3%	99.6%	89.9%	115.9%
Selby And District War Memorial Hospital	96.0%	89.3%	96.7%	106.7%
St Helens Rehabilitation Hospital	95.8%	93.3%	93.3%	96.7%
St Monicas Hospital	101.2%	96.1%	100.0%	100.0%
White Cross Rehabilitation Hospital	98.3%	90.7%	80.0%	100.0%
York Hospital	89.6%	98.1%	96.4%	106.3%

3. Exceptions

Archways

Archway's is a Community unit that historically cared for 'slow stream' rehab patients. An increase in acuity was seen and establishment was increased to 2:1 RN to HCA ratio to reflect this. The unit currently has a number of vacancies for RN's and as the Board are aware there are plans for the reconfiguration of community services. The staffing is reviewed regularly – based upon patient dependency and acuity and a full review of skill mix and

staffing modelling will be undertaken by the AND for Community & Childrens services.

There are four wards where RN staffing during the day has fallen below 80% during April. These wards were Chestnut, Holly and ICU in Scarborough and, Ward 28 in York. The reasons for this were due to RN vacancies. In all cases where planned staffing levels were not met, additional healthcare assistants were rostered to work.

There were three wards where RN planned staffing levels fell below 80% during night shifts. These wards were Stroke in Scarborough due to vacancies and, Kent and Lloyd in Bridlington due to low bed occupancy levels resulting in staff being redeployed to other wards.

A detailed exception breakdown is detailed below.

Enhanced Supervision

A number of areas show an over 100% fill rate – usually in care staff. This is due in part to the use of enhanced supervision for patients who require a higher level of observation. These areas were:

Bridlington	**Scarborough**	**York**	
Waters	Ann Wright	AMU	Ward 17
	Chestnut	Ward 23	Ward 28
	Oak	Ward 33	Ward 35

Ward 28 HCA staffing levels are particularly high at 191.7% due to a very complex patient who needs to enhanced supervisions permanently.

Provision of Safe Ward Cover

The Matrons are responsible for ensuring staffing levels are as safe as possible throughout the day and night. This means that staffing is assessed throughout the day and for out of hours and weekends and effective and safe plans are implemented. This does result in staff moving from their base wards on occasions and where necessary, increase Healthcare Assistant provision to support the shortfall of registered nurses due to vacancies. These wards were:

Bridlington	**Community**	**Scarborough**		**York**	
Johnson	Archways	Ann Wright	Beech	AMU	Ward 15
	Fitzwilliam	Cherry	CCU	Ward 23	Ward 28
	Selby IPU	Chestnut	Holly	Ward 29	Ward 33
		ICU	Maple	Ward 35	
		Stroke			

Bed Occupancy

Lloyd and Kent Wards at Bridlington changed their ratio of registered and unregistered staff dependent on bed occupancy levels and the effective use of staff with staff being deployed to other ward areas. Waters Ward currently has 20 beds when it is routinely staffed for 16 beds. G2 and G3 share a healthcare assistant, the healthcare assistant was predominantly

on G2 during April 2016.

The Surgical Assessment Unit on Lilac ward remained open longer than usual during April to help manage activity. This resulted in a higher level of staffing.

Actions and Mitigation of risk
Daily staffing meetings are taking place to deploy staff to high risk areas.

4. Vacancies by Site

The vacancy information for the adult inpatient areas below, has been taken from the ward budgeted establishments from the finance ledger and the staff in post data from ESR as at the end of April 2016. The vacancies pending start has been collated from central records following the introduction of centralised recruitment in HR.

SUMMARY - IN PATIENT UNITS	**Budgeted Establishment @ 30th April 2016**		**Staff in Post @ 30th April 2016**		**Current Vacancies**		**Posts recruited to** (includes EU recruitment and local recruitment)		**Unfilled Posts**	
	RN	**HCA**	**RN**	**HCA**	**RN**	**HCA**	**RN**	**HCA**	**RN**	**HCA**
York	50.23	312.40	442.36	272.75	64.61	39.65	74.60	46.58	-9.99	-6.93
Bridlington	45.10	33.29	39.32	31.61	5.78	1.68	2.60	0.80	3.18	0.88
Scarborough	239.76	159.30	201.17	151.42	38.59	7.88	19.40	9.20	19.19	-0.32
Community	69.99	66.49	57.67	60.99	12.32	5.50	2.06	4.40	10.26	1.10
Total	**862.08**	**571.48**	**740.52**	**516.77**	**121.30**	**54.71**	**98.66**	**60.98**	**22.64**	**-5.27**

The board are aware that the Chief Nurse team ran a very successful recruitment market place in April, additional RN's were interviewed on the day and employment checks are taking place. Whilst a number of these are newly qualified or due to qualify later in the year, a number are experienced RN's. We currently have 93.26fte vacancies pending start, this includes individuals who have been recruited through local generic recruitment, 81.86fte who have been recruited through the Newly Qualified campaign and a further 5fte who have been recruited through the European recruitment campaign who will be commencing in June/July 2016. The Newly Qualified campaign continues and interviews are being held during May and June 2016.

Healthcare Assistant interviews are scheduled to be held during May with a view to these new staff commencing in post in July 2016.

5. Future Reporting – Care hours per patient per Day

Previously units of measurement have been developed to inform the evidence base for staffing models such as skill mix or staff to patient ratio at a point in time. However, it is now recognised that these may not reflect varying staff allocation across the day and do not

include the wider multi-disciplinary team. Also due to the different ways in which this data is recorded there is no consistent way of interpreting productivity and efficiency and comparison between different organisations is complex.

The Lord Carter review highlighted the importance of ensuring the workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources. The review recommended that Care hours Per Patient Per Day (CHPPD) is collected monthly from April 2016 and daily from April 2017.

CHPPD is calculated by adding the hours of RN's on shift to the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 hours by numbers of patients at midnight.)

From May CHPPD will become the principle measure of nursing and care support with the expectation that it will form part of an integrated quality framework / dashboard. The first return will be submitted via Unify by 12 noon on 15th June and will be reported to the Board at the June meeting.

Given that the plan is to include other staff groups (AHPs will be measured from April 2017) further work will be required to collect and collate information on other staff groups.

6. Recommendation

The Committee is asked to receive the exception report for information.

7. 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

Lord Carter Report "Operational productivity and performance in English acute hospitals: Unwarranted variations". 2016

Author	**Nichola Greenwood, Nursing Workforce Projects Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**May 2016**

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

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

Comments

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		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - 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				
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1080	876	900	1164	660	660	330	539	81.1%	129.3%	100.0%	163.3%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ash	100 - GENERAL SURGERY		900	885	900	900	660	616	0	110	98.3%	100.0%	93.3%	-
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Beech	300 - GENERAL MEDICINE		1440	1170	1260	1200	990	803	660	671	81.3%	95.2%	81.1%	101.7%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Cherry	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1800	1464	1440	1458	1650	1320	1320	1210	81.3%	101.3%	80.0%	91.7%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1440	1110	1080	1074	660	660	660	682	77.1%	99.4%	100.0%	103.3%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2250	1987.5	900	817.5	1320	1111	330	528	88.3%	90.8%	84.2%	160.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Duke of Kent	420 - PAEDIATRICS		1575	1372.5	450	450	660	660	330	330	87.1%	100.0%	100.0%	100.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Hawthorn	501 - OBSTETRICS		720	720	360	360	660	660	0	0	100.0%	100.0%	100.0%	-
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1080	798	900	1068	660	660	660	660	73.9%	118.7%	100.0%	100.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE		2700	2115	450	187.5	1650	1529	0	0	78.3%	41.7%	92.7%	-
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Lilac	101 - UROLOGY	100 - GENERAL SURGERY	1800	1590	1800	1710	660	770	660	902	88.3%	95.0%	116.7%	136.7%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Maple	100 - GENERAL SURGERY		2250	2025	1125	1162.5	1320	1144	660	638	90.0%	103.3%	86.7%	96.7%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Oak	430 - GERIATRIC MEDICINE		1440	1230	1980	1938	990	825	990	1177	85.4%	97.9%	83.3%	118.9%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Stroke	430 - GERIATRIC MEDICINE		1080	1038	720	720	990	748	330	583	96.1%	100.0%	75.6%	176.7%
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Johnson	430 - GERIATRIC MEDICINE		900	876	1260	1242	660	649	330	341	97.3%	98.6%	98.3%	103.3%
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		1125	997.5	900	877.5	660	396	0	242	88.7%	97.5%	60.0%	-

Only complete sites your organisation is accountable for				Day				Night				Day		Night	
Hospital Site name	Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
		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				
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Lloyd	100 - GENERAL SURGERY		630	525	630	262.5	176	132	0	11	83.3%	41.7%	75.0%	-
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Waters	430 - GERIATRIC MEDICINE		900	922.5	900	1080	660	649	330	396	102.5%	120.0%	98.3%	120.0%
YORK HOSPITAL - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1464	1296	870	828	660	671	660	649	88.5%	95.2%	101.7%	98.3%
YORK HOSPITAL - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1620	1488	1080	1026	990	968	561	649	91.9%	95.0%	97.8%	115.7%
YORK HOSPITAL - RCB55	15	120 - ENT	101 - UROLOGY	1800	1646.25	1350	1357.5	990	968	330	352	91.5%	100.6%	97.8%	106.7%
YORK HOSPITAL - RCB55	16	100 - GENERAL SURGERY		2347.5	2220	997.5	975	1221	1210	561	528	94.6%	97.7%	99.1%	94.1%
YORK HOSPITAL - RCB55	17	420 - PAEDIATRICS		1440	1308	360	342	990	1034	330	297	90.8%	95.0%	104.4%	90.0%
YORK HOSPITAL - RCB55	23	430 - GERIATRIC MEDICINE		1575	1320	1350	1530	660	660	990	979	83.8%	113.3%	100.0%	98.9%
YORK HOSPITAL - RCB55	25	430 - GERIATRIC MEDICINE		1260	1110	1080	972	660	660	990	979	88.1%	90.0%	100.0%	98.9%
YORK HOSPITAL - RCB55	26	430 - GERIATRIC MEDICINE		1575	1410	1350	1305	660	660	990	990	89.5%	96.7%	100.0%	100.0%
YORK HOSPITAL - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1620	1266	900	1686	660	660	660	1265	78.1%	187.3%	100.0%	191.7%
YORK HOSPITAL - RCB55	29	110 - TRAUMA & ORTHOPAEDICS		1440	972	720	600	660	660	330	286	67.5%	83.3%	100.0%	86.7%
YORK HOSPITAL - RCB55	31	370 - MEDICAL ONCOLOGY		2025	1890	900	847.5	660	660	330	319	93.3%	94.2%	100.0%	96.7%
YORK HOSPITAL - RCB55	32	320 - CARDIOLOGY		1464	1302	1080	1080	660	660	990	968	88.9%	100.0%	100.0%	97.8%
YORK HOSPITAL - RCB55	33	301 - GASTROENTEROLOGY	361 - NEPHROLOGY	1440	1164	1080	1092	660	649	990	1078	80.8%	101.1%	98.3%	108.9%
YORK HOSPITAL - RCB55	34	340 - RESPIRATORY MEDICINE	301 - GASTROENTER	1440	1266	1080	1044	660	660	990	990	87.9%	96.7%	100.0%	100.0%
YORK HOSPITAL - RCB55	35	430 - GERIATRIC MEDICINE		1260	1212	1080	1140	660	660	990	1023	96.2%	105.6%	100.0%	103.3%
YORK HOSPITAL - RCB55	37	430 - GERIATRIC MEDICINE		1057.5	990	1867.5	1560	660	583	660	605	93.6%	83.5%	88.3%	91.7%
YORK HOSPITAL - RCB55	39	430 - GERIATRIC MEDICINE		1260	1068	1080	1008	660	649	660	649	84.8%	93.3%	98.3%	98.3%
YORK HOSPITAL - RCB55	36 - Acute Stroke Unit	430 - GERIATRIC MEDICINE		1440	1398	1260	1182	990	979	990	946	97.1%	93.8%	98.9%	95.6%
YORK HOSPITAL - RCB55	Acute Medical Unit	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	4500	3705	3600	3135	2640	2178	1980	2167	82.3%	87.1%	82.5%	109.4%
YORK HOSPITAL - RCB55	Coronary Care Unit	320 - CARDIOLOGY		1800	1657.5	315	262.5	1320	1122	0	0	92.1%	83.3%	85.0%	-
YORK HOSPITAL - RCB55	Extended Stay Area	100 - GENERAL SURGERY	120 - ENT	945	960	472.5	480	374	374	0	0	101.6%	101.6%	100.0%	-
YORK HOSPITAL - RCB55	G1	430 - GERIATRIC MEDICINE		1440	1194	720	714	660	660	660	649	82.9%	99.2%	100.0%	98.3%
YORK HOSPITAL - RCB55	G2	501 - OBSTETRICS		1080	1044	540	504	660	638	330	649	96.7%	93.3%	96.7%	196.7%

Hospital Site name	Only complete sites your organisation is accountable for: Ward name	Main 2 Specialties on each ward: Specialty 1	Main 2 Specialties on each ward: Specialty 2	Day: Registered midwives/nurses: Total monthly planned staff hours	Day: Registered midwives/nurses: Total monthly actual staff hours	Day: Care Staff: Total monthly planned staff hours	Day: Care Staff: Total monthly actual staff hours	Night: Registered midwives/nurses: Total monthly planned staff hours	Night: Registered midwives/nurses: Total monthly actual staff hours	Night: Care Staff: Total monthly planned staff hours	Night: Care Staff: Total monthly actual staff hours	Day: Average fill rate - registered nurses/ midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses/ midwives (%)	Night: Average fill rate - care staff (%)
YORK HOSPITAL - RCB55	G3	501 - OBSTETRICS		720	690	360	312	660	605	0	0	95.8%	86.7%	91.7%	-
YORK HOSPITAL - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		4950	4897.5	450	457.5	3630	3630	330	308	98.9%	101.7%	100.0%	93.3%
ARCHWAYS INTERMEDIATE CARE UNIT	Archways	925 - COMMUNITY CARE SERVICES		720	600	900	924	660	330	330	660	83.3%	102.7%	50.0%	200.0%
MALTON COMMUNITY HOSPITAL - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		1125	930	1575	1725	660	660	660	660	82.7%	109.5%	100.0%	100.0%
SELBY AND DISTRICT WAR MEMORIAL HOSPITAL - RCB07	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1125	1080	1125	1005	660	638	330	352	96.0%	89.3%	96.7%	106.7%
ST HELENS REHABILITATION HOSPITAL - RCBTV	St Helens	430 - GERIATRIC MEDICINE		900	862.5	1125	1050	660	616	330	319	95.8%	93.3%	93.3%	96.7%
ST MONICAS HOSPITAL - RCB05	St Monicas	925 - COMMUNITY CARE SERVICES		607.5	615	772.5	742.5	330	330	330	330	101.2%	96.1%	100.0%	100.0%
WHITE CROSS REHABILITATION HOSPITAL - RCBP9	Whitecross Court	430 - GERIATRIC MEDICINE		900	885	1125	1020	660	528	330	330	98.3%	90.7%	80.0%	100.0%
	Total			73450.5	65148.75	50520	49578	43021	39952	26202	28996				

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 25 May 2016

Patient Falls Q4 report including trends, actions and learning from Serious Incident (SI) Reports relating to inpatient falls January – March 2016

Action requested/recommendation

To consider the Q4 report on Patient Falls, and note the progress.

Summary

A reduction in the number of patient falls incidents and specifically serious injury from falls remains a priority for the Trust. A target of reducing falls resulting in moderate or severe injury by 30% was agreed for 2014 – 2015 and the Trust achieved a 55% reduction by 31st March 2015. Our aim was to achieve a further 20% reduction in falls resulting in moderate or severe harm by 31st March 2016. An update with progress against this target is provided in Section 4.

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

This paper supports the overall principles of the CQC outcomes.

Progress of report	Quality and Safety Committee
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse.

Author	Darren Fletcher, Patient Safety Manager Diane Palmer, Deputy Director of Patient Safety
Date of paper	10th May 2016
Version number	Version 1

Board of Directors - 25 May 16

Patient Falls Q4 report including trends, actions and learning from Serious Incident (SI) Reports relating to inpatient falls January – March 2016

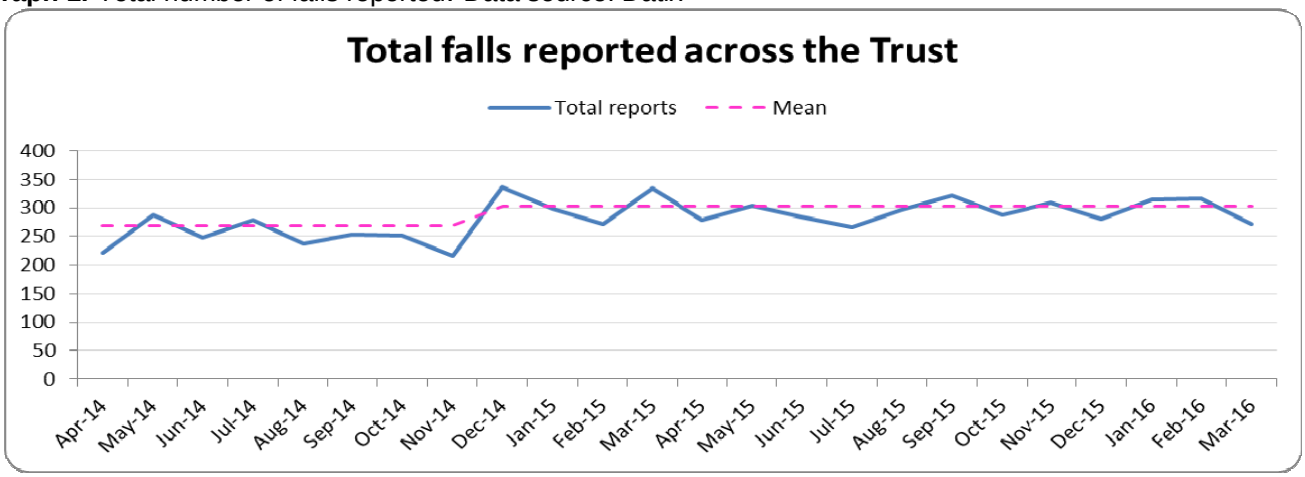
1. Introduction and background

A reduction in the number of patient falls incidents and specifically serious injury from falls remains a priority for the Trust. A target of reducing falls resulting in moderate or severe injury by 30% was agreed for 2014 – 2015 and the Trust achieved a 55% reduction by 31st March 2015. Our aim was to achieve a further 20% reduction in falls resulting in moderate or severe harm by 31st March 2016. An update with progress against this target is provided in Section 4.

2. Total number of patient fall incidents reported

The total number of patient falls reported across the Trust are shown in Graph 1. This indicates a 9.3% increase in reporting compared to 2014 – 2015 and provides a mean value of 294 falls per month for 2015 – 2016.

Graph 1. Total number of falls reported. Data source: Datix



The number of falls reported during Q4 2015 – 2016 at York acute site are listed in Table 1. The figures indicate an increase in incident reports in comparison to Q3. The number of falls resulting in moderate of severe harm has remained the same. Most falls resulted in no physical harm however, many reports are un-coded at the time of reporting as investigations are on-going.

Table 1. Total number of fall incidents reported at York Hospital site during Q4 2015 - 2016. Data source: Datix

Severity of incident	Q3 2015 - 2016	Q4 Jan – March 2016			Q4 total 2015 - 2016
		Jan	Feb	Mar	
All Falls	475	196	174	142	512
No Harm	373	140	127	88	355
Low Harm	83	39	23	15	77
Moderate Harm	3	0	3	1	4
Severe Harm / Death	8	3	1	3	7
Un-coded	16	14	20	35	69

The number of falls reported during Q4 2015 – 2016 at Scarborough acute site (including Bridlington Hospital) are listed in Table 2. Whilst 43 reports remain un-coded at the time of reporting, the overall number of reports submitted is similar to Q3. Most falls resulted in no physical harm however there has been a small increase in incidents resulting in severe harm compared with Q3 (Q3=7, Q4=8).

Table 2. Total number of fall incidents reported at Scarborough acute site during Q4 2015 - 2016. Data source: Datix

Severity of incident	Q3 2015 - 2016	Q4 Jan – March 2016			Q4 total 2015 - 2016
		Jan	Feb	Mar	
All Falls	215	64	85	78	227
No Harm	155	44	46	35	125
Low Harm	43	12	23	16	51
Moderate Harm	4	0	1	1	2
Severe Harm / Death	3	1	4	1	6
Un-coded	7	7	11	25	43

The number of falls reported during Q4 2015 – 2016 at Community Hospitals is shown in Table 3. At the time of reporting, 52 incidents remain un-coded. The total number of incident reports has reduced and there is a slight reduction in the number of incidents resulting in harm when compared with Q3. Five falls were reported during Q4 that resulted in moderate or severe harm of which three occurred at Archways Hospital.

Table 3. Total number of fall incidents reported at Community Hospitals during Q3 2015 - 2016. Data source: Datix

Severity of incident	Q3 2015 - 2016	Q4 Jan – March 2016			Q4 total 2015 - 2016
		Jan	Feb	Mar	
All Falls	176	52	57	47	156
No Harm	120	26	26	15	67
Low Harm	37	9	17	6	32
Moderate Harm	1	0	2	0	2
Severe Harm / Death	5	2	1	0	3
Un-coded	13	15	11	26	52

3. Wards reporting 20 or more patient falls October – December 2015

18 wards reported 20 or more patient fall incidents during Q4 and are displayed in Table 4.

Ward 37 staff reported the most falls during Q4 and is the highest number reported during any quarter of 2015 - 2016. Further analysis shows that;

- one patient fell nine times all resulting in no harm
- one patient fell six times with the last fall resulting in severe harm
- one patient fell five times all resulting in no harm
- one patient fell four times all resulting in no harm

- five patients fell three times with one incident resulting in moderate harm and one resulting in severe harm.

Ward 26 staff reported 47 falls;

- Two patients fell four times all resulting in no harm
- Three patients fell three times with one fall resulting in severe harm.

Ward 23 staff reported 41 falls;

- One patient fell four times all resulting in no harm
- Three patients fell three times all resulting in no or low harm.

Whitecross Court staff reported 38 falls;

- One patient fell 14 times during their admission all resulting in no or low harm
- One patient fell four times all resulting in no or low harm
- Two patients fell three times all resulting in no or low harm.

Johnson Ward staff reported 32 falls;

- One patient fell eight times all resulting in no or low harm.

Archways staff reported 23 falls;

- One patient fell five times. One fall is recorded as no harm and the remaining falls are un-coded at the time of reporting.

Table 4. Wards reporting 20 or more falls during Q4 2015/2016

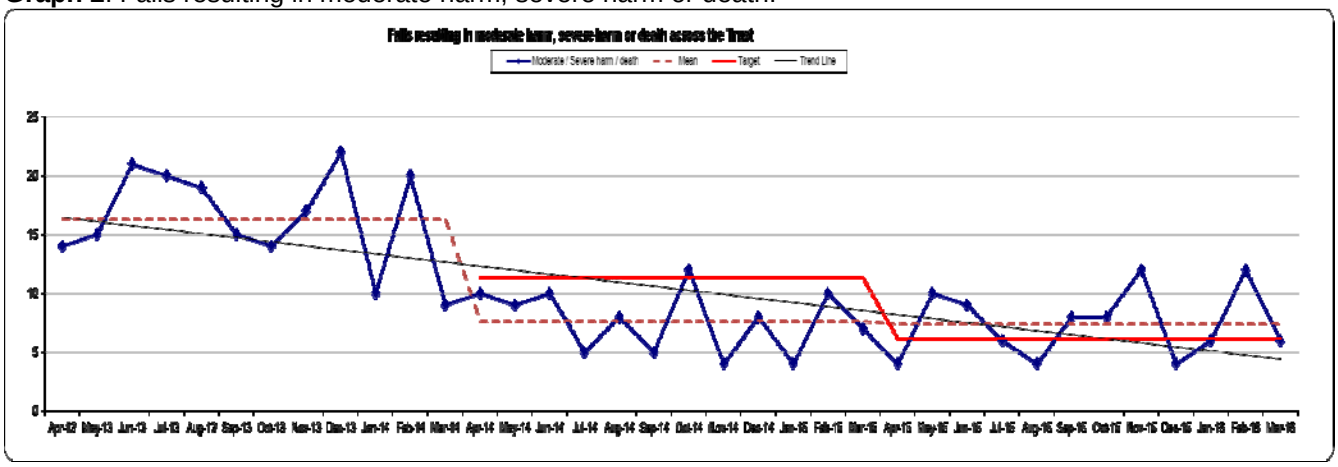
Ward / Area	Number of falls reported during Q3 2015 – 2016	Jan-16	Feb-16	Mar-16	Number of falls reported during Q4 2015 - 2016
Ward 37	**54**	27	15	24	**66**
Ward 26	**38**	18	16	13	**47**
Ward 23	**57**	13	18	10	**41**
Whitecross Court	**34**	10	9	19	**38**
Ward 35	**37**	16	13	8	**34**
Johnson Ward	**28**	7	8	17	**32**
Ward 24	**6**	17	8	6	**31**
AMU	**39**	12	11	7	**30**
St Helens Hospital	**22**	14	7	7	**28**
Ward 25	**17**	10	13	4	**27**
Stroke Ward (SH)	**12**	8	6	12	**26**
Selby Hospital	**33**	7	14	5	**26**
Ward 36 (ASU)	**19**	6	8	11	**25**
Oak Ward	**30**	7	8	10	**25**
Ward G1	**19**	10	11	3	**24**
AMB	**4**	9	5	9	**23**
Archways Hospital	**32**	7	8	8	**23**
Ward 32	**14**	5	11	5	**21**

4. Falls resulting in moderate or severe harm

Graph 2 shows the total number of falls resulting in moderate harm, severe harm or death identified on the incident reporting system (Datix) from April 2013 – March 2016.

In 2013 – 2014, the Trust reported 196 falls resulting in moderate or severe harm. A 30% target reduction was agreed indicating no more than 137 falls resulting in moderate or severe harm to occur in 2014 – 2015. At the end of 2014 – 2015, the Trust reported 92 falls resulting in moderate or severe harm showing a 54% reduction in comparison with the previous year. A further 20% reduction during 2015 – 2016 provided a target of no more than 98 falls resulting in moderate or severe harm. The Trust's final position for 2015 – 2016 shows that we reported 89 falls that resulted in moderate or severe harm, therefore maintaining the 2014 – 2015 position and a 55% reduction overall since April 2014.

Graph 2. Falls resulting in moderate harm, severe harm or death.



24 incidents resulting in moderate or severe harm have been reported during Q4 2015-2016 from 18 areas. 26 incidents were reported in Q3. The wards reporting these incidents are shown in Table 5.

Table 5. Wards reporting falls that resulted in moderate or severe harm during Q4 2015 - 2016

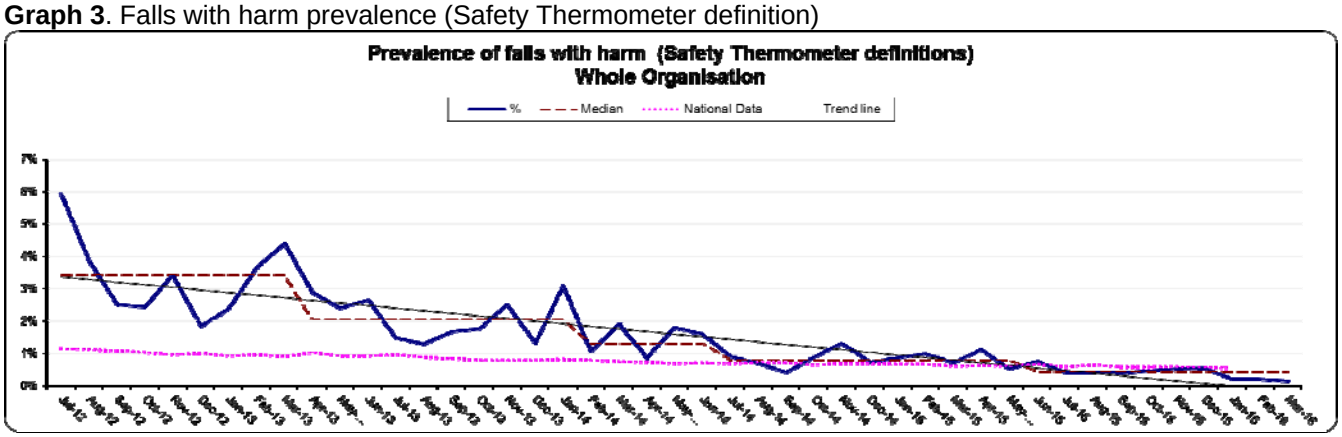
		2015 – 2016 Q3	2015 – 2016 Q4
Archways Hospital	Total Falls	32	23
	Moderate / Severe Harm	0	3
Ward 37	Total Falls	54	66
	Moderate / Severe Harm	2	3
Maple Ward	Total Falls	16	14
	Moderate / Severe Harm	0	2
Ward 39	Total Falls	20	19
	Moderate / Severe Harm	1	2
AMU (YH)	Total Falls	39	30
	Moderate / Severe Harm	1	1
CCU (SH)	Total Falls	6	14
	Moderate / Severe Harm	0	1
Graham Ward	Total Falls	7	14
	Moderate / Severe Harm	1	1
Johnson Ward	Total Falls	28	32
	Moderate / Severe Harm	2	1
Lilac Ward	Total Falls	11	9
	Moderate / Severe Harm	0	1

Oak Ward	Total Falls	30	25
	Moderate / Severe Harm	1	1
Stroke (SH)	Total Falls	12	26
	Moderate / Severe Harm	0	1
Ward 16	Total Falls	6	8
	Moderate / Severe Harm	0	1
Ward 25	Total Falls	17	27
	Moderate / Severe Harm	0	1
Ward 26	Total Falls	38	47
	Moderate / Severe Harm	0	1
Ward 28	Total Falls	13	19
	Moderate / Severe Harm	1	1
Ward 34	Total Falls	12	16
	Moderate / Severe Harm	0	1
Whitby Hospital	Total Falls	18	17
	Moderate / Severe Harm	0	1
Whitecross Court	Total Falls	34	38
	Moderate / Severe Harm	2	1

5. Patient falls - prevalence

Graph 3 shows the prevalence of falls with harm as identified through the Safety Thermometer surveys from July 2012 to March 2016. Prevalence for our organisation was above the national average until July 2014 and is now below the national data point.

Graph 3. Falls with harm prevalence (Safety Thermometer definition)



6. Actions and Learning from SIs

A total of 22 SI investigation reports have been completed since the previous report in December 2015. Arrows indicate an increase or decrease in comparison to Q3. Analysis of these incidents indicate that:

- 95% of patients had a falls risk assessment completed prior to the incident occurring
- 73% of patients had a falls risk assessment completed within 6 hours of admission
- 59% of patients had a falls risk assessment completed within 6 hours of ward transfer
- 89% of patients had their falls risk reassessed every 7 days
- 38% of patients had a target COMFE (intentional rounding) frequency of 2 hours or more prior to the fall
- 71% of patients had a COMFE (intentional rounding) visit in the two hours preceding the fall
- 100% of patients had a bedrail assessment completed

- 35% of patients had bedrails in use that may have contributed to the fall
- 59% of patients had a fall going to or from the toilet
- 36% of falls occurred during the night (between midnight and 6.30am)
- 14% of patients had a ward move during their admission between 10pm and 7am
- 100% of patients were identified at risk of falling.

A review of the completed investigation reports highlights the possible contributory factors which are shown in Table 6. Historic results are shown for comparison where available.

Table 6. List of possible contributory factors identified

	2014 - 2015			2015 - 2016			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Confusion prior to fall incident	54%	62%	60%	46%	45%	35%	68%
Evidence of sepsis	31%	25%	20%	23%	18%	5%	27%
Lying and standing blood pressure not measured	77%	67%	83%	85%	60%	33%	29%
Inaccurate risk assessments	15%	33%	30%	46%	27%	50%	32%
Patient not following advice (no cognitive impairment)	46%	60%	12%	23%	45%	30%	18%
Staff unaware of the falls risk	-	-	-	-	-	18%	14%
Reduced level of light	-	-	-	-	-	45%	27%
Trip hazards	-	-	-	-	-	10%	0
Equipment involved	-	-	-	-	-	10%	5%
Inadequate COMFE frequency	-	-	-	-	-	53%	41%

Preventative measures that were noted to have been put in place are shown in table 7.

Table 7. List of preventative measures

	2014 - 2015			2015 – 2016			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Outcome of assessment discussed with patient / carer	64%	64%	65%	62%	75%	60%	50%
Bed at lowest level (unless receiving clinical care)	100%	90%	100%	80%	100%	94%	100%
Falls Patient Information Leaflet given to patient / carers	15%	8%	61%	62%	53%	53%	50%
Falls risk sign placed above the head of the bed when identified high risk	43%	71%	60%	80%	86%	63%	70%

The identified risk factors and implementation of associated interventions are shown in Table 8. The percentages indicate where an appropriate intervention has been completed or deemed not to be appropriate.
Analysis indicates that 65% of patients (13 patients in total) had evidence of delirium / dementia and is a significant increase in comparison to Q3. 38% of these patients (5) had hourly COMFE rounding in place. Seven patients were identified to have a history of dizziness / postural hypotension and five of these patients had a lying and standing blood pressure check completed and recorded.
Three patients were noted to have problems with footwear and in only one case it was identified that the patient had appropriate footwear at the time of the fall.

Table 8. Identified risk factors and associated interventions

	Q3	Q4
% of patient with a history of falls	**60%**	**80%**
% of these patients referred to Physiotherapy	83%	81%
% of patient with a history of dizziness / postural hypotension	**25%**	**35%**
% of these patients where L/S BP was measured	80%	71%
% of these patients where measures in place to ensure appropriate hydration	100%	100%
% of these patients where a fluid chart was in place	100%	86%
% of patient with a history of fainting episodes	**0**	**15%**
% of these patients where ECG requested / performed if appropriate	N/A	100%
% of these patients where BM checked	N/A	66%
% of these patients where doctor informed if BM <4 or >8	N/A	100%
% of patient experiencing medication related drowsiness	**10%**	**10%**
% of these patients where a medication review was requested	100%	100%
% of these patients where night sedation was minimised	50%	100%
% of patient with poor balance, transfers or walking	**65%**	**85%**
% of these patients referred to Physiotherapy	85%	82%
% of these patients referred to Occupational Therapy	85%	76%
% of these patients where appropriate aids / equipment were utilised	100%	100%
% of these patients nursed near to the Nurses station	92%	88%
% of these patients where their bed was near a toilet	92%	85%
% of these patients where cohort nursing was in place	85%	59%
% of these patients where supervised toileting was in place	85%	76%
% of patient that had problems with footwear / foot care	**11%**	**15%**
% of these patients that had suitable footwear	100%	33%
% of these patients that were given non-slip bed socks	100%	66%
% of these patients referred to Physiotherapy	100%	66%
% of these patients that had condition of feet and nails checked	100%	66%
% of these patients referred to Podiatry	100%	66%
% of patient that had reduced confidence / coping strategies	**70%**	**70%**
% of these patients referred to Occupational Therapy	86%	93%
% of these patients referred to Physiotherapy	93%	93%
% of these patients where supervised mobility was in place	79%	86%
% of patient that had evidence of delirium / dementia	**30%**	**65%**
% of these patients that were given non-slip bed socks	86%	62%
% of these patients nursed near to the Nurses station	100%	69%
% of these patients where their bed was near a toilet	100%	69%
% of these patients where cohort nursing was in place	86%	46%
% of these patients had hourly COMFE rounding in place	33%	38%
% of these patients that had a low bed in use	86%	62%
% of these patients with bed / chair sensors in use	86%	54%
% of patient that had continence problems	**30%**	**40%**
% of these patients where measures in place to ensure appropriate hydration	83%	100%
% of these patients where night time drinks were limited (in nocturia)	67%	88%
% of these patients that had urinalysis checked	67%	88%

% of these patients that were referred to a doctor if results abnormal	83%	100%
% of these patients where appropriate aids / equipment were utilised	83%	100%
% of these patients had appropriate COMFE rounding in place	67%	75%
% of these patients where supervised toileting was in place	67%	75%
% of patient that had problems with vision	**50%**	**60%**
% of these patients that had glasses with them	100%	83%
% of these patients that had glasses checked as clean and in good condition	100%	83%
% of these patients had appropriate COMFE rounding in place	70%	75%
% of patient that had problems with hearing	**25%**	**30%**
% of these patients that had hearing aids with them	100%	100%
% of these patients that had hearing aids checked as in good working order	100%	100%
% of these patients referred to audiology if appropriate	80%	100%
% of these patients had appropriate COMFE rounding in place	60%	83%

7. Summary of the patient falls investigation learning discussed at Falls Panel during Quarter 3

A total of 22 Serious Incident Falls Investigations have been presented at Falls Panel during Q4.

Three patients were found on the floor next to their bed after nursing staff had recently checked on the patients. All patients were noted to be suffering with confusion.

A patient was found on the floor next to their bed within one hour of arrival at a community hospital. Formal admission to the unit, including the completion of risk assessments had not been completed at the time of the fall.

Two patients lost their balance whilst transferring to their chair causing them to fall. One patient was assessed as independently mobilising and the second patient failed to use the nurse call bell despite being advised to do so.

Three patients with confusion attempted to get out of bed when bedrails were in situ;

- Confusion was not identified as part of the falls assessment in one incident
- Confusion increased due to sepsis in one incident
- A new diuretic medication had been commenced in one incident.

Two patients slipped whilst getting off the commode. Both patients were independent and medically fit for discharge awaiting care packages to be arranged.

A patient assessed as requiring falls sensors disconnected the monitor and mobilised independently to the toilet. Nursing staff found the patient on the floor in the toilet.

A patient fell shortly after nursing staff left the bay area. The patient was found on the floor next to another patient's bed. The patient was showing signs of confusion prior to admission although appeared orientated during the falls assessment.

Two patients were assisted to the toilet by nursing staff and were asked to use the call bell to alert staff when they had finished. In both incidents, the patients failed to alert nursing staff when they were ready to return to their bed area;

- in one incident, the nurse remained outside of the toilet door and heard a noise from inside. The nurse knocked then opened the door at which point the patient fell backwards out of the doorway

- in the second incident, the patient attempted to mobilise independently.

A patient with cognitive impairment was being observed every 15 minutes by nursing staff. The patient had an unwitnessed fall in between the 15 minute observations.

Nursing staff found a patient on the floor next to their chair. The patient claimed to be attempting to reach their walking stick however it was noted that the patient did not have a walking aid. The patient was medically fit and awaiting a care package to be arranged.

A patient mobilising independently fell whilst going to the toilet. The patient had not received therapy assessments due to the short time they were admitted to the ward. No apparent injury resulted however an x-ray identified a fractured neck of femur. The patient was admitted due to a fall at home and it is not clear if the previous fall caused the fracture.

A patient with cognitive impairment fell whilst trying to offer assistance to another patient that was shouting for help.

A patient with a history of several falls from bed during the admission spell had their bed against a wall and bedrails in situ along the other side. After staff had assisted the patient with lunch, the bedrails were left down and the patient was found on the floor at the side of the bed.

A patient was found on the toilet floor after nursing staff heard a noise. It was noted that one of the bars designed to support patients in standing up from the toilet was not in the down position.

A patient used the Nurse Call Bell to summon help with attending the toilet. The patient did not wait for staff to arrive and attempted to mobilise independently. The patient fell as they reached the end of the bed.

Ward 37
The Trust has had 3 falls with harm within 1 month on ward 37 at the York site, this appropriately flagged a concern both internally and externally through the SI process.

Following the quality and safety sub group of the Contract Management Board, the team invited and supported a joint visit to ward 37 for senior nurses and CCG colleagues. Significant assurance was acquired in respect of the care given on the ward particularly around the falls mitigation plans put in place.

The principle risk to patients was found to be the unacceptable and protracted length of stay on the ward, this is due to a number of factors and principally relates to a lack of suitable commissioned care places for this group of patients both from a social and health care perspective.

The team agreed that a deep dive into a small number of patients who had experienced long stays was needed in addition a review of the discharge planning processes and the presentation of the cases at sit-rep meeting was required.

8. Community District Nursing

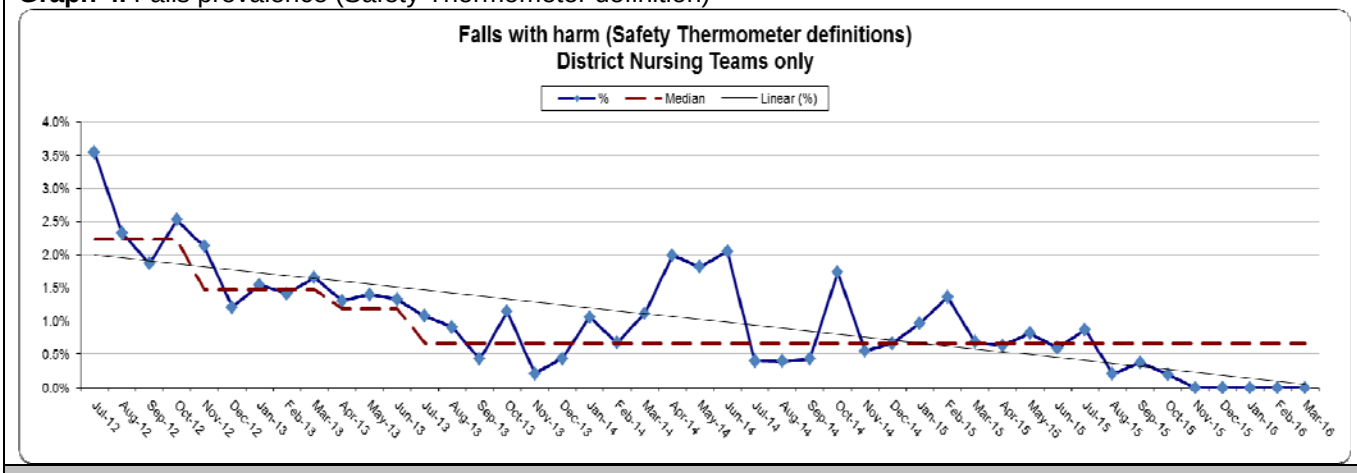
The total number of falls reported by Community District Nursing Teams during Q4 2015 - 2016 are listed in Table 8 and displayed by level of harm. Q3 results are shown for comparison. Reporting of falls remains low for Q4. No falls resulting in moderate or severe harm have been reported during Q3 or Q4.

Table 8. Falls reported by Community DN Teams

Severity of incident	Q3 2015 - 2016	Q4 Jan – March 2016			Q4 total 2015 - 2016
		Jan	Feb	Mar	
All Falls	9	1	0	5	6
No Harm	5	1	0	3	4
Low Harm	3	0	0	0	0
Moderate Harm	0	0	0	0	0
Severe Harm / Death	0	0	0	0	0
Un-coded	1	0	0	2	2

The prevalence of falls with harm as identified by Community District Nursing Teams using the Safety Thermometer survey is shown in Graph 4. This indicates a sustained reduction from August 2015 with no falls with harm reported since November 2015.

Graph 4. Falls prevalence (Safety Thermometer definition)



9. Conclusions / Recommendations

Incidence of reported falls remains high and may be a reflection of an improved reporting culture. Although we have not recognised a further 20% reduction in falls that result in moderate or severe harm during 2015 - 2016, we have achieved a 55% reduction in comparison to 2013 – 2014. This report has indicated that;

- 18 wards have reported 20 or more falls during Q3
- 59% of patients had a falls risk assessment completed within six hours of transfer
- 89% of patients were re-assessed every seven days and is a significant improvement on 29% reported in Q3
- 38% of patient with delirium / dementia / confusion had hourly COMFE rounds in place
- 35% of patients had bedrails in use that may have contributed to the fall
- 59% of patients fell going to or from the toilet
- 32% of risk assessments were found to be inaccurate prior to the incident occurring
- 100% of patients were identified at risk of falling prior to the incident occurring
- There is poor compliance with interventions associated with delirium / dementia, particularly around the use of hourly COMFE round frequencies
- Three patients were found to have problems with footwear / foot care. Only one of these patients were found to have appropriate footwear at the time of the incident
- Lying and standing blood pressures were checked and recorded in 71% of patients where this was indicated following the falls assessment
- Cohort nursing was implemented for 59% of patients where this was indicated as an intervention.

The following actions are recommended;

- An audit reporting on the use of bedrails should be undertaken
- Ward environment checklists should be developed and areas reporting high numbers of falls should be assessed against best practice
- Patients with cognitive impairment that need assistance to mobilise should be on hourly COMFE rounds.
- Findings from this report should be shared with staff to raise awareness that inappropriate COMFE frequencies were noted in 62% of investigations where patients were cognitively impaired
- The importance of accurate falls risk assessments should be reiterated to staff
- The importance of ensuring patients have access to appropriate footwear should be re-enforced with staff
- Staff should be reminded to check and record lying and standing blood pressures for patients identified at risk of falls and in particular, patients with a history of dizziness or postural hypotension
- Interventions to mitigate against the risk of falls in patients with cognitive impairment should be addressed by staff following the risk assessment.

10. References and further reading

NICE Guidelines CG161 – Assessment and prevention of falls in older people
FallSafe project, Royal College of Physicians

Author(s)	**Darren Fletcher, Patient Safety Manager** **Diane Palmer, Deputy Director for Patient Safety**
Owner	**Beverley Geary, Chief Nurse**
Date	**11 May 2016**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 25 May 2016

Pressure ulcer reduction – Quarterly update

Action requested/recommendation

The following actions are recommended as a result of this report:

- Reducing the overall incidence of unstageable pressure ulcers should be a continued area of focus.
- There is a need for focused improvements on risk assessments.
- Work needs to be undertaken continuously to understand what is needed to help staff manage patients who are finding it difficult to comply with, or to remember advice given to relieve their pressure areas.

Summary

Reduction in the development of pressure ulcers remains a priority for the Trust. This year (2015-16) we aimed to reduce the incidence of Category 3 and 4 pressure ulcers, which developed or deteriorated in our care, by 20%.

This report provides an update on the incidence of pressure ulcers which have been reported via the Trust incident reporting system (Datix) and the prevalence of pressure ulcers reported via the Safety Thermometer audit. Also presented is a review of the pressure ulcer related Serious Incident (SI) investigations which have been completed in Quarter 4.

The end of year position is a reduction in Category 3 and 4 pressure ulcers of 34.5 per cent, which exceeds Trust target.

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

This paper supports the overall principles of the CQC outcomes.

Progress of report	This report was presented to the Pressure Ulcer Steering Group.
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse.
Author	Diane Palmer, Deputy Director of Patient Safety Lisa Pinkney, Patient Safety Manager
Date of paper	1 May 2016
Version number	Version 5

Board of Directors - 25 May 2016

Pressure Ulcer Reduction – Quarterly Update (Quarter 4)

1. Background

Reduction in the development of pressure ulcers remains a priority for the Trust. This year (2015-16) we aimed to reduce the incidence of Category 3 and 4 pressure ulcers, which developed or deteriorated in our care by 20%.

This report provides an update on the incidence of pressure ulcers which have been reported via the Trust incident reporting system (Datix) and the prevalence of pressure ulcers reported via the Safety Thermometer audit. Also presented is a review of the pressure ulcer related Serious Incident (SI) investigations which have been completed in Quarter 4.

2. Total number of pressure ulcers reported

The total number of pressure ulcers reported in the Trust during Quarter 4 was 188. This represents a slight increase since previous quarterly figures during 2015/16, but a decrease when compared to last year's Quarter 4 (2014/15).

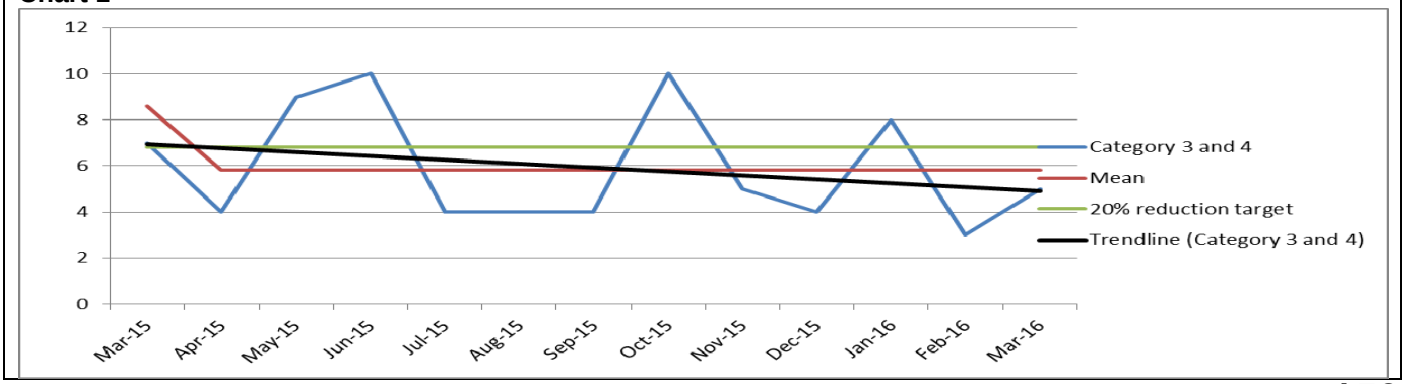
Table 1. Total number of ulcers reported in the Trust each Quarter and monthly in Quarter 4. Data source: Datix

	Q4 (14/15) Updated	Q2 (15/16)	Q3(15/16)	**2016** Jan	Feb	March	Q4 (15/16) total
Cat 2	131	119	111	31	37	47	**115**
Cat 3	13	11	14	7	3	4	**14**
Cat 4	2	3	5	1	0	1	**2**
Unstageable	47	44	52	18	19	20	**57**
Total	**202**	**177**	**182**	**57**	**40**	**52**	**188**

3. Trust targets-Category 3 and 4 reductions

Chart 1 shows the number of combined Category 3 and 4 ulcers reported by month across the Trust since March 2015. Despite a peak of Category 3s and 4s reported (10) during June and October 2015, the trend continues to show a constant reduction in reported pressure ulcers since March 2015. The end of year position (2015-16) therefore stands at a total of 70 Category 3 and 4 ulcers, when compared with last year's (2014-15) end of year position of 107. This represents a 34.5 per cent reduction in the pressure ulcers resulting in severe harm, which developed or deteriorated in our care.

Chart 1



4. New Category 2, 3 and 4 pressure ulcer incidents reported in hospital sites in Quarter 4, 2015/16 (developed *or* deteriorated in our care)

The number of pressure ulcers reported in Quarter 4 by hospital sites, are displayed in Table 2, with updated Quarter 3 data included for comparison. The number of Category 2 ulcers has remained static in Scarborough and community hospital sites, but increased in the York acute site. York hospital also reports a significant increase in Unstageable ulcers, although Scarborough sites report a decrease since Quarter 3. These figures may alter when Datix reports are reviewed and updated.

Category 4 ulcers across sites remain low, with none reported in Community Hospitals.

Table 2. Total number of pressure ulcers reported by site during Q3 and Q4, 2015/2016. Data source: Datix

	York Acute		*Scarborough Acute (inc. Brid) updated*		*Community Hospitals*	
	Q3 updated	*Q4*	*Q3 updated*	*Q4*	*Q3 updated*	*Q4*
Cat 2	*33*	*42*	*34*	*34*	*10*	*10*
Cat 3	*2*	*4*	*3*	*2*	*1*	*1*
Cat 4	*1*	*1*	*0*	*1*	*0*	*0*
Unstageable	*9*	*20*	*17*	*11*	*3*	*4*
Total	*45*	*67*	*54*	*48*	*14*	*15*

5. New Category 2, 3 and 4 pressure ulcer incidents reported in Community Care in Quarter 3, 2015/16 (developed *or* deteriorated in our care)

The numbers of pressure ulcers reported in Community Care during Quarter 4 are displayed in Table 3, with Quarter 3 data included for comparison. This shows a decrease in the number of all pressure ulcers, and a decrease to zero Category 4 ulcers for Quarter 4.

Table 3. Total number of pressure ulcers reported in community during Q3 and Q4, 2015/2016. Data source: Datix

Community Services		
	Q3 (updated)	Q4
Cat 2	44	39
Cat 3	9	7
Cat 4	4	0
Unstageable	27	26
Total	84	72

6. Wards reporting five or more pressure ulcers in Quarter 4, 2015/2016 (developed or deteriorated in our care)

At the time of reporting, four wards reported five or more ulcers during Quarter 4. The wards differ in the main from the last quarter's report. Wards which have continued to report five or more are Ward 26 and ICU/HDU (York). Table 4 shows monthly figures and the total number of pressure ulcers reported during Quarter 4, and these figures are compared with Quarter 3.

Table 4. Wards reporting five or more pressure ulcers in Quarter 4 2015/2016

Ward / area	Number of ulcers reported during Q3 15/16	Jan 16	Feb 16	March 16	Number of ulcers reported during Q4 15/16
Oak	1	1	4	1	6
ITU/HDU (York)	9	4	1	1	6
Ward 26	8	2	3	3	8
Ward 34	1	0	2	3	5

Table 5 indicates the eight wards across the Trust which reported Category 3 and 4 ulcers in Quarter 4. Ward 26 reported Category 3 ulcers in both Quarters 3 and 4, but all other wards did not report any Category 3s and 4s in the previous quarter.

Table 5. Wards reporting Category 3 and 4 pressure ulcers in Quarter 4 2015/16

	2016 Q4			
	Jan	**Feb**	**Mar**	**Total Q4**
Accident & Emergency Department				
Category 3	**1**			**1**
Beech Ward				
Category 3	**1**			**1**
Cherry Ward/AMU				
Category 4	**1**			**1**
Malton Hospital				
Category 3	**1**			**1**
Maple Ward				
Category 3	**1**			**1**
Ward 26				
Category 3			**1**	**1**
Ward 33				
Category 3			**1**	**1**
Ward 34				
Category 3		**1**		**1**
Category 4			**1**	**1**
Total	**5**	**1**	**3**	**9**

7. Safety Thermometer Pressure Ulcer Prevalence Report

Charts 2 to 5 illustrate the pressure ulcer prevalence in accordance with the Safety Thermometer definition. Chart 2 shows the percentage of patients with pressure ulcers (old and new), across the whole organisation. There continues to be a trend in reduction of harm, and the Trust prevalence of ulcers (median 3.86%) has remained below national data figures (median 4.45%) since August 2014.

Chart 2.

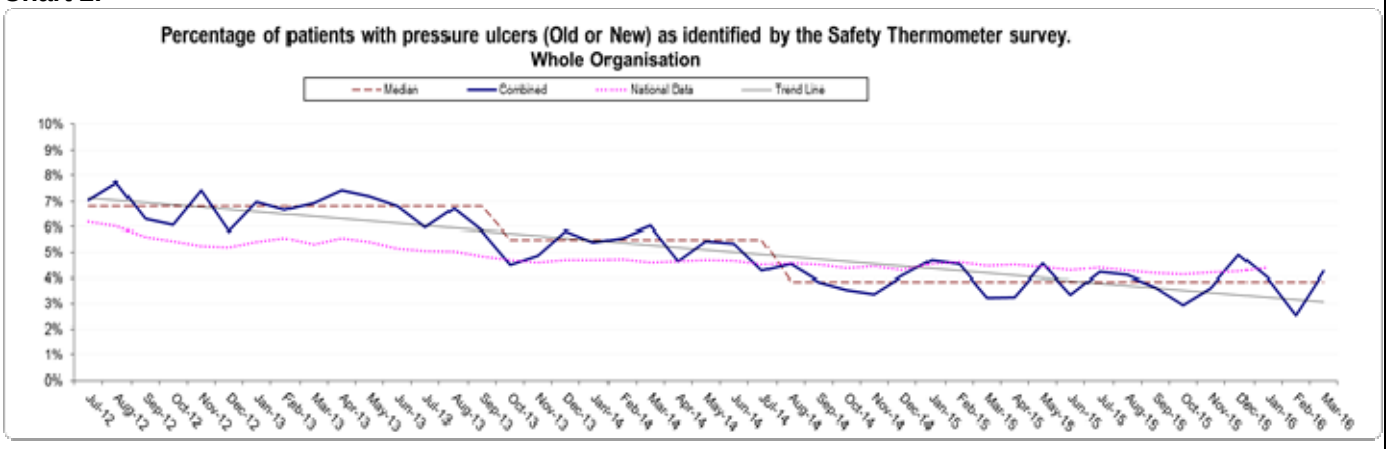


Chart 3 shows that, for acute sites within the Trust, median results have remained static at around 3.5% since August 2014, and prevalence continues to follow a downward trend since July 2012.

Chart 3.

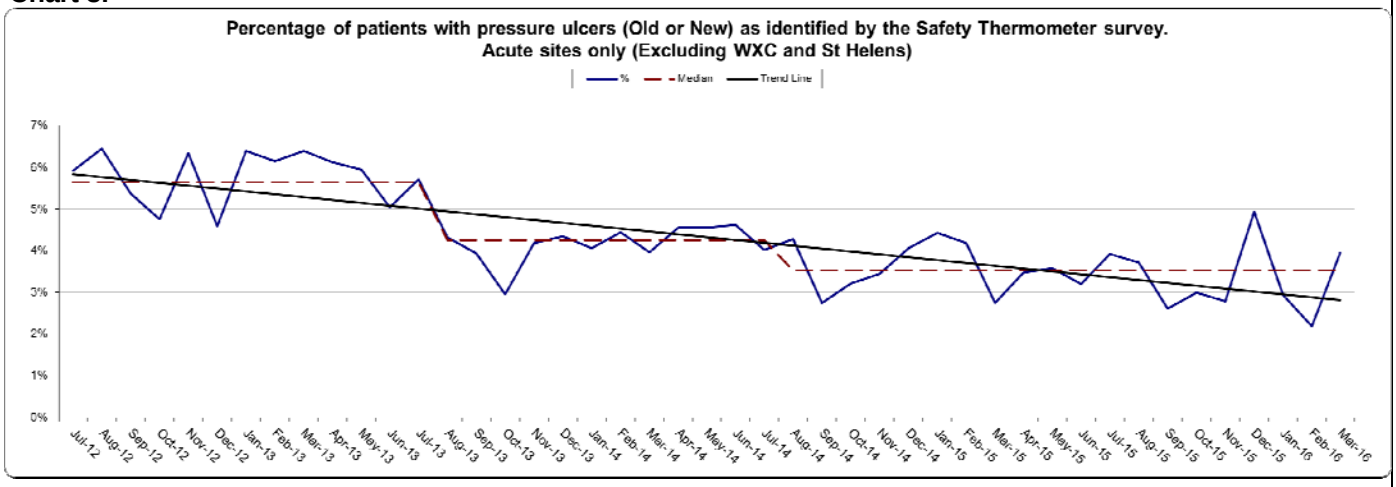


Chart 4 illustrates that, in community hospitals, there has been a rise in the number of pressure ulcers since Quarter 3, which reflects the inclusion of St Helen's and WXC in the figures since April 2015. The median remains lower than previous financial years at 4.28%.

Chart 4.

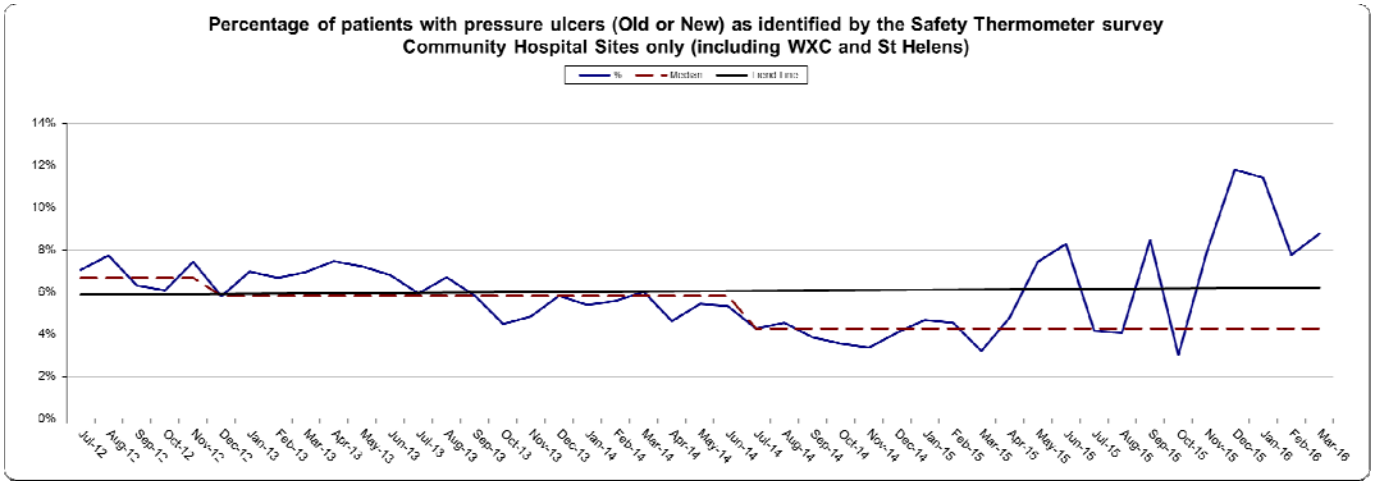
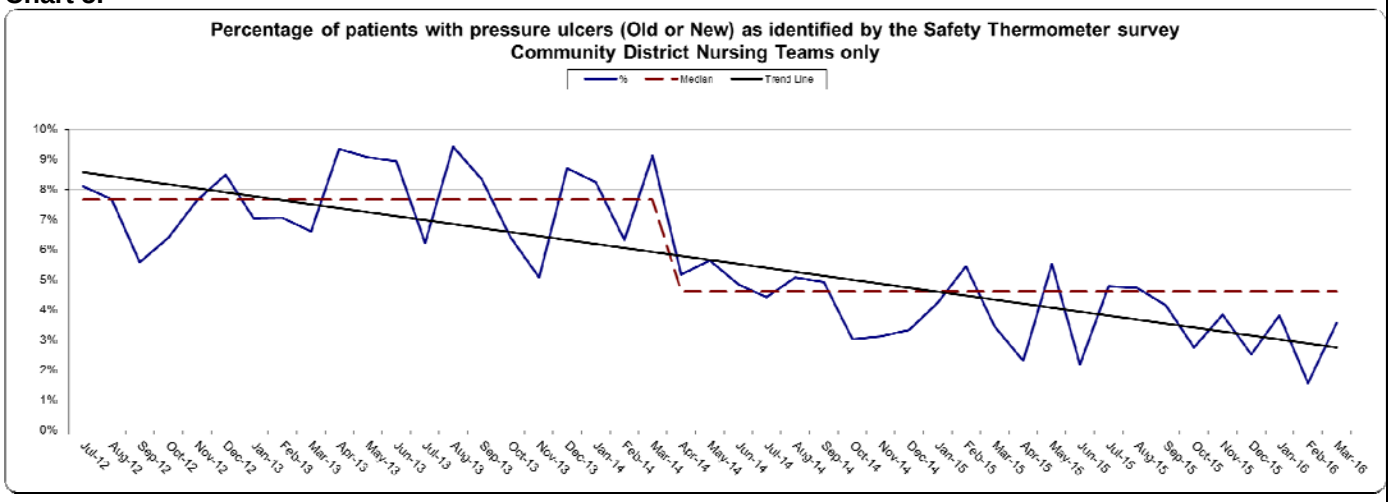


Chart 5 shows that, for Community Care (district nursing teams), pressure ulcer prevalence remains lower than in previous years (4.62% median) and prevalence continues to reduce overall.

Chart 5.



8. Actions and learning from SIs.

A total of 4 SI investigation reports have been completed in the Q4 2015/16 reporting period. All reports refer to Category 3 pressure ulcers.

One patient had a pressure ulcer to the sacrum
One patient had pressure ulcers to both heels
One patient had a pressure ulcer to the buttocks
One patient had a pressure ulcer to the left outer aspect of the foot (little toe)

Analysis of these reports shows that;

- 75% of the incidents relate to the deterioration of a previously known pressure ulcer
- 75% of the incidents had a risk assessment completed as per policy
- 75% of the incidents had the risk assessment reviewed as per policy
- 50% of the incidents were not initially assessed correctly
- 75% of the incidents identified non-concordance as an issue
- 50% of the incidents identified issues with prevention interventions
- 25% of the investigations identified issues with pressure relieving equipment
- 50% of the incidents reported no identified tissue viability link nurse
- 75% of the incidents reported an apology was given

A review of the completed investigation reports highlights the possible contributory factors which are shown in Table 6.

Table 6. List of possible contributory factors identified

Non-concordance	75**%**
Disease progression	50%
Inaccurate assessments	50%
Equipment problems	25%

Summary of learning
In three out of four cases analysed, patients were identified as having issues with understanding or complying with advice. One patient suffered with increasing confusion, which meant she could not comply with zero pressure. Another patient was dependent on carers to implement pressure ulcer treatment. A third patient, who was wheelchair bound due to spina bifida, declined advice from both ward staff and tissue viability nurses to reposition regularly.

Two of the four patients had inaccurate or delayed risk assessments. One assessed the patient as independent, and as at low risk of a pressure ulcer, when a later assessment reported high risk. Another patient, who was referred to above, with increasing confusion, was admitted after a fall, and was identified as having a pressure ulcer to the heel in theatre, but no action was taken on admission to the ward afterwards, which included a delay in the first Waterlow assessment (7

days).

One patient had problems with appropriate foot wear. The patient was wearing new orthotic shoes, but following physiotherapy these contributed to the pressure ulcer to the foot.

9. Conclusions and recommendations

Based on analysis of the data arising from the reports above, there are several concluding points:

- There has been a decrease in Category 3 and 4 ulcers for Quarter 4 across the Trust, which is now below the Trust reduction targets, and updated figures for Quarter 3 show that that numbers of Category 3 and 4 ulcers were also lower than the reduction target.
- Year-end positions show that the number of Category 3 and 4 pressure ulcers have reduced by approximately 34.5 per cent.
- During Quarter 4 there was a slight increase from the previous quarter in the total number of reported pressure ulcers, but a decrease when compared to last year's Quarter 4 report.
- There has been an increase in all pressure ulcers in the York acute site in Quarter 4, particularly Unstageable ulcers. However, Scarborough sites report a decrease in Unstageable ulcers. For Scarborough acute site and community hospitals Category 2 pressure ulcer figures remain static.
- Community services report a decrease in all pressure ulcers and no Category 4 ulcers.
- Four departments reported five or more pressure ulcers which have developed or deteriorated in our care during the last quarter. Two of these wards are the same as the previous quarter.
- Eight departments reported Category 3 and 4 ulcers during Quarter 4.
- The prevalence of pressure ulcers is below the national data point this quarter. Trend lines continue to show an overall reduction.
- Lack of concordance continues to influence the development of pressure ulcers.
- Risk assessment of pressure ulcers needs further improvement.
- New appliances offered to patients may increase the risk of pressure ulcers.

The following actions are recommended as a result of this report:

- Reducing the overall incidence of unstageable pressure ulcers should be a continued area of focus.
- There is a need for focused improvements on risk assessments.
- Work needs to be undertaken continuously to understand what is needed to help staff manage patients who are finding it difficult to comply with, or to remember advice given to relieve their pressure areas.

Author	**Lisa Pinkney, Patient Safety Manager** **Diane Palmer, Deputy Director for Patient Safety**
Owner	**Beverley Geary, Chief Nurse**
Date	**1 May 2016**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 25 May 2016

Complaints Annual Report

Action requested/recommendation

The committee are asked to confirm that the report meets the requirements of the NHS Complaint Regulations 2009.

Summary

The Trust received 471 formal complaints in 2015-16. Of these 54% were upheld or partially upheld.

19 new cases were referred to the Parliamentary and Health Service Ombudsman and 28 outcomes were received. 33% of outcomes were partially upheld or upheld.

Learning from complaints is a core part of the Trust's clinical governance, and examples are given in this report.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☐
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

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

Reference to CQC outcomes

There are no references to CQC outcomes but there is a close link with CQC outcome 17, complaints.

Progress of report	The report will first be presented to Quality & Safety Committee. Then the Board of Directors. The information has previously been reported in the Patient Experience Quarterly Reports.
Risk	No risk
Resource implications	None
Owner	Beverley Geary, Chief Nurse
Author	Hester Rowell, Lead for Patient Experience
Date of paper	May 2016
Version number	Version 1

Complaints Annual Report: 2015-16

The NHS Complaint Regulations require every NHS organisation to produce a complaints annual report.

Effective complaints management is a key part of the Trust's Patient Experience Strategy 2015-2018 which has five overarching commitments:

- Involving patients in decisions about their care and delivering a service that is responsive to their individual needs
- Listening to our patients, welcoming feedback and sharing the results from ward to board
- Responding to feedback so people can see how their views and experiences are making a difference
- Learning from what patients tell us about their experiences, both what was good and what we could do better
- Nurturing a culture of openness, respect and responsibility.

The information set out below meets each requirement as set out in the NHS Complaint Regulations.

18.—(1) Each responsible body must prepare an annual report for each year which must—

(a) specify the number of complaints which the responsible body received;
(b) specify the number of complaints which the responsible body decided were well-founded;
(c) specify the number of complaints which the responsible body has been informed have been referred to—
(i) the Health Service Commissioner to consider under the 1993 Act; or
(ii) the Local Commissioner to consider under the Local Government Act 1974; and
(d) summarise—
(i) the subject matter of complaints that the responsible body received;
(ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;
(iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.

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

Quarter	Site Name	Total New	Total Resolved	Number Upheld	Number Partially Upheld	Number Not Upheld
Q1	York Teaching Hospitals NHS FT	118	77	3	54	20
Q2	York Teaching Hospitals NHS FT	136	93	6	71	16
Q3	York Hospital	59	50	21	12	17
	Scarborough Hospital	40	51	15	18	18
	Bridlington Hospital	4	3	1	1	1
	Community Services	4	5	0	1	4
Q4	York Hospital	70	56	11	21	24
	Scarborough Hospital	35	31	10	8	13
	Bridlington Hospital	3	3	0	1	2
	Community Services	2	0	0	0	0
TOTAL		**471**	**369**	**67**	**187**	**115**

These are the number of complaints reported via the statutory KO41 return to the Health and Social Care Information Centre. Only in Q3, after the implementation of the new information management system Datix Web, was site-level data available.

2. Complaints referred to the Parliamentary and Health Service Ombudsman

	New	Outcome received		
Month		Upheld	Partially upheld	Not upheld
Apr	2	0	0	0
May	4	0	1	1
Jun	1	0	0	2
Jul	1	0	0	1
Aug	3	0	0	1
Sep	1	0	0	1
Oct	0	0	1	1
Nov	2	0	0	0
Dec	1	1	2	6
Jan	0	0	0	0
Feb	4	1	2	2
Mar	0	0	1	4
Total	**19**	**2**	**7**	**19**

Our uphold rate is 32%. This is compared to a national average for all acute Trusts (at Q3 2015-16, which is the latest data available) of 48%.

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

The data below shows the complaints received by subject and by directorate.

Please note that, from Q3, multiple subjects were logged for each complaint. This acknowledges that complaints are rarely about a single issue and provides greater insight for the Trust about what patients and relatives are concerned about.

Directorates have regular meetings with the Patient Experience Team to review their open complaints. These are now being developed to have a greater focus on learning and improvement.

Directorate	Q1	Q2	Q3	Q4
Allied Health Professionals	0	0	5	2
Acute & General Medicine	21	19	21	23
Child Health	3	2	6	2
Community Services	7	3	3	3
Elderly Medicine	12	11	9	12
Emergency Medicine	15	23	9	16
Estates and Facilities	1	3	0	1
General Surgery & Urology	19	19	15	14
Head and Neck and Ophthalmology	11	5	8	2
Laboratory Medicine	0	0	1	0
Obstetrics & Gynaecology	9	11	9	9
Orthopaedics and Trauma	12	20	10	7
Pharmacy	0	1	0	0
Radiology	1	8	4	0
Specialist Medicine	3	2	6	9
Theatres, Anaesthetics & Critical Care	5	4	1	9
Other	0	5	1	2

Subjects	Q1	Q2	Q3	Q4
Access to treatment or drugs			1	5
Admissions, Discharge and Transfer Arrangements	5	6	10	21
Appointments, Delay/Cancellation	7	1	6	9
Attitude of Staff	13	12		0
All aspects of Clinical Treatment	78	86	69	109
Commissioning	0	1		0
Communications/information to patients (written and oral)	8	12	21	58
Facilities				3
Privacy and Dignity	5	5		14
Complaints Handling	0	2		0
Personal Records	0	2		0
Others	3	9		0
End of Life Care			2	2
Mortuary			1	0
Patient Care			27	59
Prescribing			4	7
Patient Concerns				1
Restraint				1
Staff Numbers			2	6
Transport				
Trust Admin/Policies/Procedures			1	3
Values and Behaviours (Staff)			17	34
Waiting times			1	9

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

The Chief Nurse Team has overall responsibility for the quality and timeliness of responses. During the year they have made improvement in this respect a key priority.

Every complaint receives a full investigation led by a matron or senior manager. New guidance and training has been provided, this year, to these investigating officers to help them provide open, empathetic responses which answer the issues raised, say sorry where something has gone wrong and explain what has been learned and will be done different in the future.

A new data management system, Datix Web, was implemented in September 2015. This has enabled a new depth of reporting by site, directorate, subject and sub-subject. New, detailed reports have been provided throughout the year to Patient Experience Steering Group for assurance. These include both numeric data and narrative comments.

The new system has removed the system of paper files, enabling better joint work between directorates and with the Patient Experience Team. It has reduced the administrative workload for the patient experience team, enabling the staff to have greater focus on quality improvement.

Learning from cases which have been upheld or partially upheld by the Parliamentary and Health Service Ombudsman has been that responses need to be clear about what has been learned and what actions have been taken to improve for the future. Saying sorry for errors or lapses in care is not sufficient on its own.

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

Learning from complaints is an essential strand of the Trust's clinical governance at ward, directorate and organisation levels.

Examples of learning this year include:

5.1. Record keeping

Inadequate record keeping is a theme that has been identified from complaints and ombudsman recommendations. After a successful pilot in September and October 2015 a new nursing care plan document has been introduced. This brings together documentation into a single booklet, which is consistent across the Trust. This is helping ensure that clinical observations are well-recorded and staff can clearly see any gaps.

5.2. Communication with patients and families

Communication with patients and families is at the heart of many complaints and an area where clinical and non-clinical staff can always improve their practice. Learning and development for communications and patient experience is delivered through a wide range of channels. These include:

- The Patient Experience Team provide training to new nurses as part of the nurse preceptorship programmes.
- The Sage and Thyme course is delivered by the Department of Psychological Medicine. This is open to all staff and designed to communicate with distressed patients and carers.
- An advanced communications skills course for clinical staff is delivered by the Lead Nurse for End of Life Care in partnership with St Leonard's Hospice.

5.3. Prostate Pathway

Feedback, including complaints to the Urology Directorate showed that the Prostate Pathway could be improved. In a dedicated clinic time for patients with raised PSA was needed to ensure that these patients were seen within the required two-week period. This is now in place and the directorate aims to see raised PSA patients within seven days.

5.4. Community rehabilitation

An outstanding example of how we have learned from patient concerns, is within our community hospitals at White Cross Court and St Helen's Rehabilitation Hospital. Patients' families said that their relatives would like to socialise more during their stay. Some patients felt isolated outside of their one-to-one sessions. As a result, mid-morning refreshments, a group chair exercise class and chair games were organised. Patients have now requested that the class runs on weekends and bank holidays so they don't miss the opportunity to participate.

5.5. Management of delirium

A complaint was made regarding the care of a patient on Ward 25 suffering from delirium. The ward had already been part of a *Prevention of Delirium Programme,* but this complaint demonstrated the need to ensure that the learning was taken into practice. The team have

reflected on what happened and planned further discussion at their June timeout session. They will be taking the learning into the development and implementation of the new neck of femur care pathway.

5.6. Emergency Department

The emergency department, by its nature, cares for patients in stressful situations. Whilst much positive communication has been received, there has also been significant learning from complaints this year. This includes having specific nurses allocated to patients in each cubicle so that any changes in their condition are effectively monitored in a timely manner and the risk of missing a significant deterioration is reduced.

During the year, unfortunately, on occasions patients admitted by ambulance could not be immediately accommodated in the department. Complaints were received about the time spent waiting with the paramedics before being admitted to the department. Reducing waiting times to be seen is a top priority for the department and experts from the Emergency Care Improvement Programme have been supporting our Emergency Department team to help with this. The shared waiting area where many patients were waiting is no longer used, and building work is underway to increase the number of cubicles in the department.

5.7. Diabetes Management - Scarborough

A relative complained that their relative had suffered three incidences of diabetic ketoacidosis (DKA) whilst an in-patient at Scarborough Hospital. The patient was admitted to Acute Medical Unit, then transferred to Stroke Unit, Graham Ward and Beech Ward.

The investigation found that there was a need to improve inpatient diabetes management at Scarborough Hospital as a priority. The Lead Diabetes Nurse Specialist has an action plan including new insulin charts and a programme of education for ward staff to improve the management of diabetes, hypoglycaemia and DKA.

6. Looking Ahead to 2016-17

Managing complaints remains a key priority for the Trust and for the Patient Experience Team.
The Trust has set a quality priority for this year:

Our Patient Experience Strategy is to listen, report and respond and learn. To provide assurance that we are completing this cycle and delivering improvements from feedback we will pilot and evaluate a system for case file audit for complaints. A sample of closed cases will be audited for:

- Compliance with Trust policy and best practice for case handling
- Evidence that lessons learned have been completed.

The Trusts policy for complaints and concerns will be revised and updated. In particular the focus will be on ensuring that roles and responsibilities are clearly defined and escalation procedures are in place if quality or timescale standards are not met.

Author	**Beverley Geary, Chief Nurse**
Owner	**Hester Rowell, Lead for Patient Experience**
Date	**May 2016**

Board of Directors – 25 May 2016

Out of Hospital Care Strategy 2016-2021

Action requested/recommendation

The Board of Directors is asked to approve the Out of Hospital Care Strategy.

Summary

This document sets out how York Hospital NHS Foundation Trust will deliver better care for people 'close to home'. It focuses on care provided out of hospital (this includes "traditional" community services and those services that have to date, been provided in a hospital setting but can be transferred into a community setting). It highlights the key priorities for the next five years (2016 to 2021) and outlines the crucial changes that we will need to make over this period of time.

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

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	Strategy discussed at Board to Board session in March 2016 and presented at Trust Away Day in April 2016. Strategy document approved by Corporate Directors and reviewed by the Community Services Group (Governors) in May 2016.

Risk	Associated risks have been assessed
Resource implications	Resources implications are detailed in the document.
Owner	Wendy Scott, Director of Out of Hospital Care
Author	Steve Reed, Head of Strategy for Out of Hospital Services
Date of paper	May 2016
Version number	V7

York Teaching Hospital NHS
NHS Foundation Trust

Out of Hospital Care Strategy 2016-2021

Community First

Welcome to York Teaching Hospital NHS Foundation Trust's out of hospital care strategy.

The out of hospital care directorate employs over 1400 staff, which represents nearly 16% of the organisation's total workforce. These staff, from both clinical and non-clinical backgrounds, deliver a wide range of services from many locations across North Yorkshire serving a population of over 450,000 people.

This strategy describes our ambition to work with our local communities, our staff and our partners to transform the way in which we deliver services in the community.

We have listened carefully to what service users, carers and families have told us matters to them. We know that they want accessible, coordinated services so that they only have to tell their story once. They also want their care to be delivered as close to home as possible. They tell us that they want to make decisions with us about their care and they want their families and carers to feel involved and supported.

We know that we cannot deliver our services in isolation; we are committed to working with other partners to improve the care that we provide. Our local population is living longer and many of our service users have complex needs. In order to manage increasing demand and competing priorities we have to seek new ways of providing integrated services that deliver high quality services and value for money.

This strategy sets out our key priorities over the next five years and seeks to describe how we will deliver our services to meet the needs of our local population.

Wendy Scott
Director of Out of Hospital Care

Executive Summary

This document sets out how we will deliver better care for people close to home. It focuses on care provided out of hospital (this includes "traditional" community services and those services that have to date, been provided in a hospital setting but can be transferred to be delivered in community settings). It will highlight the key priorities for the next five years (2016 to 2021) and outline the crucial changes we will make during this time. York Teaching Hospital NHS Foundation Trust is the major provider of healthcare to the residents of York, Scarborough, Selby, Ryedale and Bridlington. This strategy has been developed in response to the rapidly changing health and social care environment in which these services are developed.

Scope

The Out of Hospital Strategy encompasses those services that we provide via the community services contract, those we provide outside of acute hospitals and the work we are undertaking with partner organisations in the local health and social care system. As a signal of our commitment to delivering services out of hospital we recently brought together our Community Services and Allied Health Professional Directorates to form a new Out of Hospital Care Directorate. Outside of the scope of this document is work within the community setting which involves children and young people; the Child Health Directorate are working in partnership with commissioners to develop a local strategy in response to the recently published Facing the Future Together for Child Health 2015 standards.

The Case for Change

Data tells us that, overall, our local communities are less deprived than the national average. However, we do serve a population that are older than the England average, with 20% of people in the Vale of York and 25% of people in Scarborough and Ryedale, over the age of 65 years. It is expected that the number of people over the age of 85 years will grow by 16-18% by 2020. Nationally we know that 15 million people are living with one or more long term conditions and for those aged over 75 years, over 50% will have three or more long term conditions. This growth in population and disease prevalence is creating increased demand for services, with 17,000 additional beds estimated to be required by 2021 if we continue with current models of care. We also know that the relative affluence of our population and overall better than average health outcomes disguises significant health inequalities, with a 12 year gap in life expectancy for men between the most and least deprived areas of Scarborough, and a 7 year gap for women in Selby.

Many individuals require admission to hospital at some point in their lives, usually as a result of an acute illness or injury. However, research suggests that we may do harm to older people if we delay their transfer or discharge home after their acute recovery phase is completed. In addition to the decompensation and loss of confidence that they experience, studies have shown that 10 days of bed rest can cause the equivalent of 10 years muscle ageing in those aged over 80 years. As well as being harmful, hospital care is expensive. Minimising costs where appropriate is essential if the NHS financial challenge set out in the Five Year Forward View, (the NHS requires £22bn of savings to be identified by 2020 for projected funding and spending levels to balance) is to be achieved. Studies have shown that care provided out of hospital can provide a better experience for patients at lower costs, however, shifting resources into community services from other sectors can be challenging.

We also know that in order to deliver services that meet people's expectations we need greater integration which will mean people can '*plan their care with people who work together to understand them and their carer(s), allowing them control, and bringing together*

services to achieve the outcomes important to them'. We have started this process as part of the model of care in Selby and Ryedale (Care Hub developments funded via the Better Care Fund). We also know that we need to move beyond simply integrating care and consider the health of populations i.e. we need to adopt a place-based approach to planning and working with communities to improve health outcomes.

Principles and Vision

We will work within the local system to adopt a 'Community First' culture which focuses on prevention and self-care; delivers care closer to home and allows the system to manage growing demand by increasing efficiency through integration.

We have developed the following principles:

1. Promote independence through prevention and self-care;
2. Person centred, co-produced support involving families and carers;
3. Co-produced new model of care with home as first choice, delivered over seven days;
4. Co-ordinated, integrated and joined up care that people can easily navigate;
5. Timely and rapid response to prevent admission to hospital or a care home;
6. Seamless interface to facilitate safe and timely discharge from hospital;
7. Remove duplication, ensuring cost-effectiveness and value for money.

New Ways of Working

In order to make 'Community First' a reality we will develop a planned programme of work grouped under three key themes:

1. Developing integrated community services to support localities – we will work with other providers and the public to design new integrated care models supporting local populations. We will implement a workforce development programme that supports self-management and peer support.
2. Developing the interface between acute and community services – we will work across the system to implement a 'discharge to assess' approach into an integrated independence service, developing community geriatrician and advanced clinical practitioner roles to work with local GPs. We will grow our capacity within home-based services to ensure more people can be supported at home with a resultant review of the purpose of our community inpatient beds.
3. Moving services from acute to community settings – we will bring together primary and secondary care clinicians to review care pathways to develop community based alternatives and will look to expand the range of planned care services delivered from our community buildings.

Working Together

We recognise that we cannot make this change alone. We have adopted a system leader's role, working with partners in an evolving governance framework. This includes core membership of the local System Leaders Board and active participation in the Ambitions for Health (Scarborough) and Integration and Transformation (York) Boards. We will work with emergent primary care organisations, including the Vale of York Clinical Network, and third sector partners together with local authority colleagues to ensure a sustainable future for North Yorkshire. We aspire to formalise this approach through the development of an accountable care system in York, building on the local progress of our Provider Alliance Board.

Enablers

We will need more than new services and new ways of working in order to be effective and deliver our vision. We will need to ensure that we have a workforce that has the skills to deliver the new care pathways and is supported in making the cultural changes required. We will need information technology that supports seamless and effective communication across services, ensures effective use of new digital technology to support self-care and reduces administrative burdens on staff to free up time to provide care. Our community estate will need to support the new care models with fewer requirements for isolated facilities and a reduction in physical beds, moved towards hub and campus accommodation with partner services. We need to ensure that we can measure the impact of what we do, with timely access to robust outcome data and intelligence from our communities to ensure that the changes we make are improvements.

Next Steps

We have identified a series of developments that we will focus on during 2016-17. These will form the basis of our Out of Hospital Programme and include:

- Adopting a discharge to assess approach and testing the three pathways identified;
- Developing integrated enhanced care teams, wrapped around primary care;
- Developing an 'independence service', integrating intermediate care and reablement, and building home-based capacity including a review of our bed based intermediate care provision;
- Developing a workforce development programme that will embed our focus on prevention, coaching and self-care;
- Work with operational directorates to further develop the out of hospital elements of their directorate strategies, identifying opportunities to move services from acute to community settings;
- Developing a home based ambulatory care service.

Why do we need to change?

Scope and Current Services

> *"NHS community health services are at the forefront of NHS care and support without the high public profile of other NHS services. Never the less they often reach deepest into our lives. They are part of our neighbourhoods; they come into our homes and are with us for the long-term. They partner with colleagues in the NHS, social care, education, charities and local government to personalise care packages which support people to maintain their independence for as long as possible."* Community Health Services: A Way of Life

Community services are both general health and integrated health and care services that take place at home or nearby in local care settings. They include nursing and therapies; multi-disciplinary teams to help people with complex needs remain at home or return home from hospital sooner; and a range of clinical and support services in community hospitals and local care centres.

It is important to note the distinction between services provided under the contract for 'Community Services' awarded to the Trust in 2011 through the 'Transforming Community Services' process and those services provided by the Trust outside of hospital settings. This strategy encompasses both of these.

York Teaching Hospital NHS Foundation Trust (YTH) was awarded the contract to manage community services in 2011 as part of the national Transforming Community Services Programme. These services stretch across the Trust's footprint (with the exception of Pocklington, Bridlington and, from March 2016, Whitby) serving a population of almost half a million across the communities of the City of York, Selby and District, Ryedale and Easingwold and Scarborough. This stretches over a geographical area of 3,400 square miles.

YTH has signalled its commitment to delivering care out of hospital through the creation of an Out of Hospital Care directorate. Initially this directorate will incorporate the previous 'community services' directorate and the directorate of allied health professionals and psychological medicine. This brings together a wide range of services, delivered in a range of settings both in the community and in an acute hospital setting. Our ambition is to grow this directorate, reflecting the increasing drive to provide care and support closer to home.

Community services employ 810 people in adult community services and 570 in our allied health professionals' directorate, with services provided from a range of localities, including community hospitals in Malton, Selby and Easingwold, three inpatient units in York and 7 health centres. The Single Point of Access for Community Services (not including community therapies) handles over 80,000 referrals a year. There are around 2,000 patients on the district nursing caseload and intermediate care teams support around 200 new patients every month. Community therapy teams manage around 9,000 new referrals each year and 1,800 patients were admitted to community inpatient beds in 2015.

A wide range of services are provided as part of this contract including:

- Community nursing;
- Community therapies;
- Intermediate care and rapid response – Community Response Teams;
- Community hospital inpatient care;

- Community Rehabilitation and Intermediate Care Units;
- Single Point of Access to Community Services;
- Specialist nursing services.

As part of the Better Care Fund, a national initiative to pool health and social care funds to invest in new models to deliver integrated care, the Trust has delivered pilot services within Care Hubs serving the populations of Selby and District and Ryedale. Within the Care Hub are:

- Community Response Teams providing intermediate care integrated with social care reablement services;
- Care home inreach schemes involving Consultants, GPs and specialist nurses;
- Older Persons Clinics providing complex care planning from Consultant Geriatricians;
- Social prescribing through a Community Enabler.

The scope of this strategy also reaches beyond the boundaries of services within the community contract. Fundamental to its delivery is the partnership working with a range of local providers and stakeholders. These include (but are not limited to) primary care, social care, voluntary and community organisations, local government, mental health providers and the independent care home sector. Within the Vale of York Clinical Commissioning Group (VoYCCG) area, a Provider Alliance Board has been established, bringing senior leaders from these organisations together to develop and deliver shared work streams.

The strategy also incorporates a range of services delivered by YTH within its main acute contracts, traditionally delivered in acute hospital settings. As more services are identified to be delivered closer to people's own homes this range will grow. The Trust will exploit the opportunities offered as an integrated provider of both acute and community services to challenge the traditional models of care.

Outside the scope of this document, is work within the community setting which involves children and young people. Neonatal, children and young people's community services are delivered by the child health directorate who are currently working with CCG colleagues to develop a child health strategy which includes the recommendations from the Royal College of Paediatric and Child Health (Facing the Future Together for Child Health 2015 standards). These standards apply across the unscheduled care pathway to improve healthcare and outcomes for children, focussing on the acutely mild to moderately unwell child. They aim to ensure there is always high-quality diagnosis and care (safe, effective and caring) early in the pathway, providing care closer to home where appropriate (right care, right time and right place). The standards will ensure specialist child health expertise and support are available directly into general practice services, where the needs of the child and their family are known. The standards will build good connectivity between hospital and community settings; primary and secondary care; and paediatrics and general practice.

There are three overarching principles and 11 standards in total. Standards one to six focus on supporting primary care, to care for the child in the community, preventing unnecessary attendance at an emergency department or unnecessary admission to hospital. It will of course be necessary for some children to be cared for in hospital, and standards five to eight focus on reducing length of stay and enabling children to go home again as safely and as quickly as appropriate (while preventing unnecessary reattendance and readmissions). Standards nine to eleven look more widely at connecting the whole system, streamlining the patient journey and improving the patient experience. Facing the Future Together for Child Health represents a standard of care which children and their parents and carers can expect from the healthcare professionals looking after them.

Local Demographics and Health

Overall, the communities served by YHT are less deprived than the England averages. The 2015 Joint Strategic Needs Assessment (JSNA) updates for the Vale of York and Scarborough and Ryedale CCGs give an insight into local demographics. They show that the population of the Vale of York CCG is 353,000 with 20% of these being over the age of 65 years (compared to 18.1% on average in England) and 3% over the age of 85 (compared to 2.8% on average in England). It is predicted that there will be an increase of 17.7% in the over age 85 years population by 2020. The Scarborough and Ryedale CCG population is shown to be 110,500 with 25% of these being over the age of 65 years and 3% over the age of 85 years. It is predicted that the over age 85 years population will rise by 15.7% by 2020.

The JSNA updates highlight that Vale of York CCG has a higher prevalence of stroke than the England average with a high number of admissions for heart attacks, stroke and kidney diseases for people with diabetes. Coronary heart disease prevalence is also higher than the national average. For Scarborough and Ryedale CCG the report highlights that long term conditions including asthma, cardiovascular disease, Chronic Obstructive Pulmonary Disease (COPD), hypertension and stroke are all significantly higher than national averages, contributing to higher than national average rates of premature death from cardiovascular disease.

The population is a mix of urban centres and rural areas and despite the overall lower deprivation there are areas of specific deprivation with 14 of the 18 most deprived Lower Super Output Areas (LSOA) for North Yorkshire being in Scarborough. The Vale of York has 10 LSOAs which are within the 20% most deprived in England (9 of these are in York, 1 in Selby). The figures also fail to account for rural poverty caused by higher living costs related to heating and travel. The table overleaf shows the 2015 health profiles for the main populations covered by the Trust.

	Population	Life expectancy	Health needs	Local priorities
Ryedale	52,000 Deprivation lower than England average but 10% children live in poverty	1 year better than national average for men National average for women Gap between most and least deprived areas is 4.4 years for men and 5 years for women	Worse than England average for: • Excess weight • Excess winter deaths • Killed or injured on roads	Reducing inequalities in cardiovascular disease Reducing prevalence of obesity Reducing harm caused by alcohol
Scarborough	108,000 Deprivation lower than England but 19% children live in poverty. Long term unemployment is significant worse than the England average	1 year worse than national average for both men and women Gap between most and least deprived areas is 12.5 years for men and 5.6 years for women	Worse than England average for: • Excess weight • Prevalence of opiate use • Smoking related deaths • Deaths from cardiovascular disease • Killed or injured on roads	Reducing inequalities in cardiovascular disease Reducing prevalence of obesity Reducing harm caused by alcohol
Selby	85,000 Deprivation lower than England but 12% children live in poverty.	At national average for men and women Gap between most and least deprived areas is 4.7 years for men and 6.9 years for women	Worse than England average for: • Excess weight • Excess winter deaths • Deaths from cancer • Killed or injured on roads	Reducing smoking prevalence Reducing prevalence of obesity Reducing harm caused by alcohol
York	202,000 Deprivation lower than England but 12% children live in poverty	At national average for men and women Gap between most and least deprived areas is 7.4 years for men and 5.8 years for women	Not significantly worse than England average for any indicator	Giving every child a good start in life Alcohol Mental health

National Context

People today are living longer, healthier lives than ever before. Once fatal diseases can be cured or managed, this adds years or even decades to a person's life. This is an extraordinary achievement and testament to the many who have dedicated their lives to improving people's health and wellbeing. But progress brings challenges, people may be living for longer but they are often living with several complex conditions. In 2014, over 15 million people in England lived with one or more long term conditions. At age 35 years, only 10% of the population will suffer from two or more chronic conditions, by age 60 this rises to 50% and for those aged over 85 years it is 80%. For those aged over 75 years, 50% of people will have 3 or more chronic conditions, 10% will have 5 or more.

As a result of this, demand for acute hospital care is increasing in England. Demographic change alone is estimated to lead to 1.7% annual growth in demand for acute hospital services and this is expected to be compounded by changes in disease prevalence. The Nuffield Trust estimates that without changes in the way in which care is provided, 17,000 new hospital beds will be needed in England by 2021-22.

Research has highlighted the harm done to patients by de-conditioning associated with hospital stays. For older people, within 24 hours of admission muscle power reduces by 2-5% and circulating volume (blood) by up to 5%. Within 7 days, circulating volume can reduce by up to 20%, oxygen uptake reduces by 8-15%, muscle strength reduces between 5-10%, functional reserve (lung) capacity by 15-30% and skin integrity reduces. 10 days in a hospital bed leads to the equivalent of 10 years ageing in the muscles of people aged over 80. Not only is hospital based care unaffordable, it harms the people it exists to help.

The NHS Five Year Forward View, published in 2014 and developed by all the major national health bodies, set out a clear direction of travel for the NHS through to 2020. It showed that the projected gap between spending and funding would be £30 billion by 2020 if action is not taken to change how care is delivered. Although the 2015 Comprehensive Spending Review confirmed the government's election promise to fund the £8 billion requested from central government to meet the gap, this leaves £22 billion of efficiency savings for the NHS to deliver.

The guidance argues for a more engaged relationship with patients and carers, setting up partnerships with local communities, the need for local flexibility in breaking down barriers in how care is provided and the need for care to be provided more locally. There is a strong focus on the importance of prevention and empowering people with long term conditions in managing their own health. It also proposes new care models, which were to be tested through local 'vanguard' sites. As well as urgent and emergency care networks and smaller viable hospitals these models included:

- Multi-specialty community providers (MCPs) – primary care led models where groups of practices work together to deliver services to a local population, including many that would traditionally be provided in an acute hospital setting;
- Primary and Acute Care Systems (PACS) – vertically integrating primary care with acute providers providing care to defined populations.

'Delivering the Forward View: NHS planning guidance 2016/17-2020/21' provided detailed advice for the NHS on implementing the Five Year Forward View. It highlights the move towards place based planning for populations rather than organisation based planning. It specifies that local leaders need to come together as a team to produce a Sustainability and Transformation Plan (STP), developing a shared vision with local communities and planning

a programme of activities to deliver this. Our local Sustainability and Transformation Plan will set out how collectively we will:

1. Close the health and wellbeing gap through a 'radical' upgrade in prevention, patient activation, choice and control and community engagement;
2. Close the care and quality gap through new care model development, improving against clinical priorities and rolling out digital healthcare;
3. Close the finance and efficiency gap through achieving financial balance across the local health system and improving the efficiency of NHS services.

The King's Fund has produced a range of documents supporting organisations to identify the key priorities and outcomes required to meet the challenges associated with caring for an ageing population. 'Making our Health and Care systems fit for an ageing population' outlined 10 key components of care that should be in place:

1	Healthy, active ageing and supporting independence
2	Living well with simple or stable long-term conditions
3	Living well with complex co-morbidities, dementia and frailty
4	Rapid support close to home in times of crisis
5	Good acute hospital care when needed
6	Good discharge planning
7	Good rehabilitation and reablement after acute illness or injury
8	High quality nursing and residential care for those who need it
9	Choice, control and support towards the end of life
10	Integration to provide person-centred co-ordinated care

In 2013, the King's Fund, in recognition of the focus on the necessary structural changes in the 2008 Transforming Community Services programme, produced 'Community Services: How they can transform care' which identified the following main steps:

- Reduce complexity of services;
- Wrap services around primary care;
- Build multi-disciplinary teams for people with complex needs;
- Support these teams with specialist medical input and redesigned approaches to consultant services – particularly for older people and those with chronic conditions;
- Create services that offer an alternative to hospital stay;
- Build an infrastructure to support the model based on these components including much better ways to measure and pay for services;
- Develop the capability to harness the power of the wider community.

The report goes on to say that this approach requires locality based teams that are grouped around primary care and natural geographies and with a multi-disciplinary team, offering 24/7 services as standard and complemented by highly flexible and responsive community and social services. It advises that the new service needs to be capable of very rapid response and to work with hospitals to speed up discharge.

In 2013, the National Collaboration for Integrated Care and Support (bringing together the main national bodies for health and social care along with the National Voices coalition of health and social care charities) published 'Integrated Care and Support: Our Shared Commitment'. This formed a call to action for health and social care organisations to make integrated care and support happen. The document provided a definition of integrated care,

developed through engagement with people who use services, and stated, "*I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me*". As with the Five Year Forward View, the document emphasised the importance of local systems coming together with their communities to be innovative in delivering this. The shared vision for the collaborative was for integrated care and support to become the norm over the following five years (to 2018).

The National Voices paper 'Integrated care: what do patients, services users and carers want?' emphasises that whilst patients and users of services identify integration as a key priority, this is an expectation that professionals work together 'as a team around the patient' rather than an interest in organisational integration. The paper also emphasises that services working in a planned and co-ordinated way was a means to delivering the things that people told them matter to them – continuity of care; smooth transitions; fast access; effective treatment; respect for their preferences; support for self-care and the involvement of family and carers. **It is important to remember that integration is a means to these ends rather than an end in itself.**

In 2015-16, the national Better Care Fund initiative mandated local areas to pool part of health and social budgets (equating to £3.8 billion nationally) to improve outcomes for the public, provide better value for money and ensure services are more sustainable. The pooled budget was shared between the NHS and local authorities to fund services that would deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. The performance element of the fund focussed on the avoidance of hospital admission. The guidance for 2016-17 suggests that this focus will be widened to include delays in transfers of care, a recognition of the importance in integrated services working to support a rapid transition to people's usual place of residence following an acute hospital admission.

The 2015 'Population health systems: Going beyond integrated care' from the King's Fund challenges those involved in implementing the changes laid out above to 'join up the dots' with public health and extend this to consider the broader health of local populations. It recognises that health is affected by a wide range of determinants and therefore improving population health is not just the responsibility of health and social care services but requires co-ordinated efforts across population health systems. They identify a small number of examples from other countries where this has been successfully employed. The move to considering population health fits closely with concepts of 'place based' care where services are built around localities and their communities.

In 2015, Think Local, Act Personal convened a summit of national leaders who described their shared commitment towards engaging and empowering communities to achieve sustainable health and well-being. This commitment is to create the conditions for strong and inclusive communities:

- create communities and places that enable people to live healthier lives, nurture strong connections between people and empower the most marginalised to have a voice in local decision making;
- design local services that enable aspiration and contribution, strengthening community connections rather than replacing them;

- remove the barriers and create the right conditions for community-centred approaches to flourish;
- encourage commissioners and communities to develop shared plans.

In addition to the guidance supporting a move to new models of integrated care (as opposed to 'health' and 'social' care) is research supporting moves to transfer care out of hospital settings. In 2011, the Health Foundation produced 'Getting out of hospital?' which reviewed the available evidence comparing the effectiveness of hospital based care with community equivalents. It concluded that, whilst the evidence on cost suggesting that savings could be made was not yet sufficient to be certain that this would always be the case, the findings on patient satisfaction were less equivocal. Patients expressed greater satisfaction with treatment at home regimes compared with hospital inpatient care. The findings also showed that health outcomes in most studies were broadly similar for community based services and inpatient care.

These findings were replicated in the 2015 Monitor report 'Moving healthcare closer to home' which noted that schemes are likely to have clinical outcomes that are equal to hospital care and sometimes better. Their financial analysis showed that, when implemented well, schemes could deliver care at a lower cost than comparable care in an acute setting in the longer run. However, they also noted that even where schemes offer lower cost per patient interventions it is difficult for local systems to realise the savings. This is due to the need to close inpatient capacity to make savings and the confidence in commissioners and providers that community schemes can absorb existing activity and predicted demand rises before doing this. The report also notes that it can take up to three years to see the impact of schemes. It concludes that well designed schemes can bring patient benefits and may be able to deliver care at lower cost over time. It advises that such schemes should be developed, such as providing more proactive care to prevent people from entering crisis to address the immediate challenges facing acute hospitals.

Strengths, Weaknesses, Opportunities and Threats Analysis

We have conducted an analysis of the strengths, weaknesses, opportunities and threats presented for us as a provider of community services.

Strengths	Weaknesses
Integrated provider of acute and community services Community services rated 'Good' by CQC Track record of implementing change in community Relationship with local authorities and GP federations – including through the Provider Alliance Board	Historic under investment in community services, Workforce recruitment challenges particularly in Scarborough and Ryedale, Geographical spread of services impact on economies of scale, Under-developed market for long term care
Opportunities	**Threats**
System is signed up to delivering new models of out of hospital care Relatively high number of community beds offers opportunity to review community bed base resources differently to support home based models of care	The health and social care system is financially challenged, YFT projected deficit in 15/16 Procurement of community services could distract from transformation efforts

Factors Driving Change

In summary, the following factors are driving this strategy:

- The harm done to people by the de-conditioning impact of bed based care;
- Meeting the predicted rise in demand from our ageing population;
- National policy directive to move to new models of care in order to meet the £22 billion efficiency challenge to 2020;
- The need to deliver the seamless, co-ordinated care people who use our services deserve;
- To implement the best practice identified nationally, and internationally, in delivering place-based, population health;
- To close the gap in health inequalities across our communities.

What will our priorities be?

> *"The nature of the 'patient' or 'service user' in a community context is very different from other parts of the NHS. Other parts of the NHS clearly deal with patients who recognise themselves to be patients, seeking specific care and treatment for specific needs, in institutions designed for that purpose. Community services support people in their homes and neighbourhoods when providing care. They have the privilege of access to the homes of the people they support and are guests there. They support people with information, motivation and advice about health and lifestyle, especially in the context of health visiting and school nursing. The label* patient *is neither useful nor meaningful for many of these important services."* Community Health Services: A Way of Life

National Priorities

The national guidance and best practice documents summarised to date present a clear direction of travel for out of hospital services. Services will need to:

- Focus on prevention and supporting individuals to self-care;
- Be joined up, with traditional health, social and voluntary sector organisations integrating around the needs of individuals;
- Be able to respond rapidly to support people in, or before, a crisis;
- Have a seamless interface with hospital based services to ensure patients can return home as soon as possible;
- Redesign the roles of specialists to ensure these can support new models of care;
- Work with local communities and stakeholders in designing new models of care that are delivered in the community rather than hospital;
- Be delivered consistently over seven days.

The key outcomes that services must deliver can be found in the national outcomes frameworks for the NHS, Adult Social Care, Public Health and the Better Care Fund. In delivering this strategy, it will be important to consider how developments contribute to these outcomes. The high level outcomes are displayed in the table below. Both the Vale of York CCG and Scarborough and Ryedale CCG have confirmed their intention to move towards outcome based contracts for community services. Whilst these outcomes are still to be finalised, it is anticipated that these will draw from the national frameworks.

NHS Outcomes Framework	Adult Social Care Outcomes Framework
1. Preventing people from dying prematurely 2. Enhancing quality of life for people with long-term conditions 3. Helping people to recover from episodes of ill-health or following injury 4. Ensuring that people have a positive experience of care 5. Treating and caring for people in a safe environment and protecting them from avoidable harm	1. Enhancing quality of life for people with care and support needs 2. Delaying and reducing the need for care and support 3. Ensuring that people have a positive experience of care and support 4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm
Public Health Outcomes	**Better Care Fund Outcomes**
1. Improving the wider determinants of health 2. Health protection 3. Health improvement 4. Healthcare, public health and preventing premature mortality	1. Reducing the number of emergency admissions 2. Reducing delayed transfers of care 3. Improving the effectiveness of reablement 4. Reducing admissions to residential and nursing care 5. Improving patient and service user experience 6. Reducing falls (local measure)

Trust Strategic Vision

York Teaching Hospital NHS Foundation Trust has the ultimate objective **to be trusted to deliver safe, effective and sustainable healthcare within our communities**. Through our values of **caring** about what we do; **respecting** and valuing each other; **listening** in order to improve and always doing what we can to be **helpful**, the Trust seeks to:

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

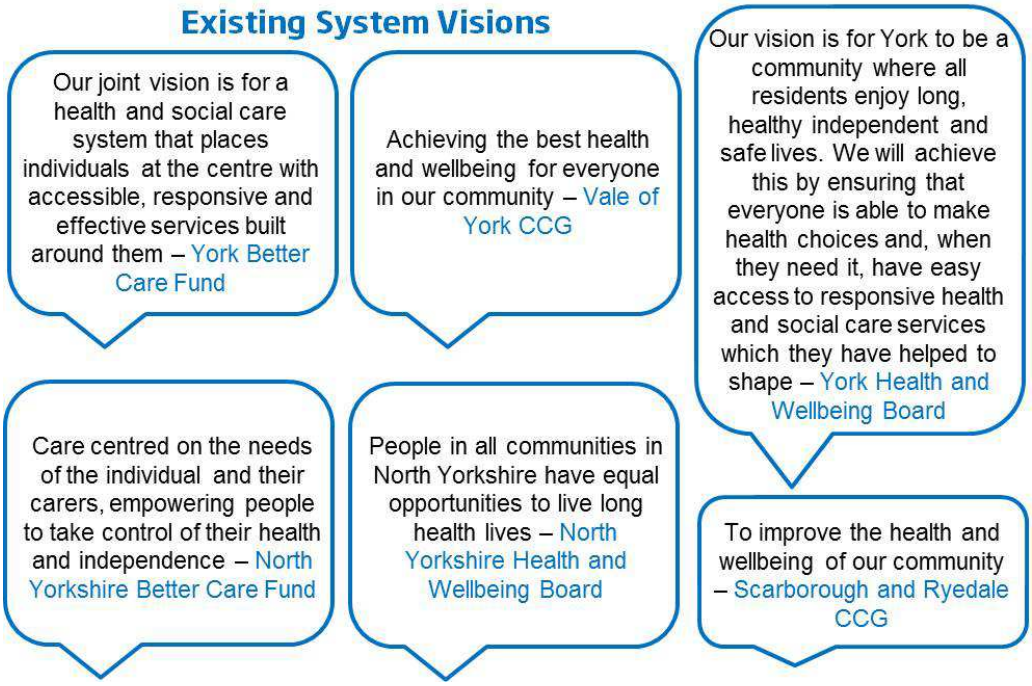
The Trust's key strategic themes are to:

- Be a valued and trusted partner within the local care system(s);
- Save and improve lives through reliable and safe care;
- Recognise our role and potential in promoting health and wellbeing;
- Drive service efficiency to deliver planned financial performance;
- Develop out of hospital care and lead the integration of services throughout the whole system in each of our localities;
- Be the community and secondary care provider of choice for the population we serve;
- Seek and cultivate alliances with other secondary care organisations which benefit our populations;
- Maintain and grow our Provider services in the interests of developing integration;
- Work with partners to reconfigure services across our localities - specifically:
    - Separate elective and emergency care delivery;

  - Maintain the viability of Scarborough hospital as a provider of acute, consultant led obstetrics and paediatric care;
- Develop and reform emergency care with less emphasis on admission and greater focus on rapid diagnostics, assessment and ambulatory care;
- Increase our market share for elective services;
- Develop and grow our specialist services;
- Recruit and retain the necessary workforce and ensure we offer opportunities for each member of staff to maximise their potential;
- Become a high quality, high volume deliverer of research.

Local System Strategic Vision

In developing a vision for out of hospital services it is important to consider the visions and priorities of the wider system. Some of these are displayed in the diagram below.



A whole system event was held in the Vale of York in June 2015, involving commissioners and providers from a range of services. The event discussed the feedback collated by the CCG from engagement activities with local people who told them:

"I only want to tell my story once"
"I want good information to help me plan my care"
"I want to feel safe and trust my provider"
"I want fast access to care and support"
"I want my care to be coordinated through a key link person"

It concluded that the collective vision for integrated care was "*We will support and enable the population of the Vale of York to improve their health and wellbeing by organising our services around the needs of the person, their family and the community to provide integrated care and support.*"

Developing an Accountable Care System in York

Currently, the health and care community in York is facing unprecedented financial and service delivery pressure. This is due to some of the factors listed previously but also that:

- Our current care pathways are particularly unfit for older people and the current way care is funded and structured does not support clinical teams in radically redesigning care for this key group;
- The health and care system will overspend by more than £50M in 2015/16. This includes both a significant overspend on the CCG funding allocation and also importantly, and for the first time, an overspend on provider budgets in both York Hospital NHS Foundation Trust and City of York Council adult social care. There is absolute understanding across all partners that an overspend of this level is unacceptable and unsustainable and requires radical solutions that both reduce overhead costs and support the delivery of integrated and more efficient care pathways. The emerging consensus is that doing more of the same is not a viable option and that planning and delivery at scale through the merging and sharing of both clinical and non-clinical resources is required;
- The system is also failing to meet its urgent care targets in-year with recognition across all organisations that this is a result of system-wide issues, particularly in relation to the care of frail older people. There is a shared desire to improve urgent care, again through radical pathway redesign and the delivery of new care models that span primary, community acute and social care;
- Related to the point above, care pathways for too many patients are currently highly fragmented and disjointed, with too many 'hand-offs' and an inappropriate 'default' to hospital care for many people who would be better treated in their own homes or in community facilities by primary, community and social care teams;
- It is recognised that the local system is paternalistic and risk averse in its approach to supporting health and social care need, in turn this has driven a culture of dependency and an over reliance on statutory service provision. There is little emphasis on early intervention and access to alternative provision and support that in turn empowers individuals to manage their own condition;
- There is limited opportunity or incentive to focus on city-wide 'wellness' or prevention of ill health. The current funding and regulatory systems do not allow individual organisations to prioritise work in this area, which will be required to improve population health for future generations and reduce the financial burden of ill health in York in future years;
- Local GP Practices are experiencing overwhelming demand for primary care services. Primary care development and reform are an essential component of system transformation, ensuring this is effectively supported and resourced is essential.

In particular the current system:

- Doesn't support strong system leadership;
- Has high transaction costs coupled to short-term contracts which are a disincentive to health and social care providers to come together to deliver better quality healthcare within the limited resources available;
- Doesn't support integrated IT systems and telehealth which have been shown to support improved care for this group in other systems in the UK and internationally.

There is a history of partnership working across York as an integrated care pioneer and there is an aspiration across acute, primary and social care and between commissioners and providers to develop new models of care that will improve clinical quality and patient experience and, over time, will offer benefits to population health.

In relation to the provider landscape, York Hospital NHS Foundation Trust is the local acute and community provider and already delivers a diverse range of integrated services from both acute and community sites across York, Selby, Scarborough, Ryedale and Bridlington. We are committed to working in partnership with other organisations and agencies to ensure the delivery of high quality, integrated care.

The Vale of York GPs have recently outlined their intention to integrate primary and community care services, delivering integrated provision to support a defined geographical area. There are now emerging plans for GP practices to 'cluster' or create 'hubs' to ensure that local, accessible enhanced primary care is provided taking a place-based approach. The two groups need to be supported to work together (and with colleagues from City of York Council) to design new care pathways that are both more cost effective and improve experience and outcomes (as they reduce duplication and enable more people to be cared for outside of hospital).

It is recognised by the organisations within the York health and care system that current organisational and financial structures do not support this integrated working and that internationally other systems have addressed similar issues successfully by creating Accountable Care Systems (ACS) or Accountable Care Organisations (ACO). There is therefore a desire to explore further the option of developing a model that delivers accountable care in York that creates a single health system or organisation for the whole population incorporating both health and care services and with a single budget covering provision and commissioning.

In achieving accountable care in York it is recognised that this must address the documented issues which are flagged in the Vale of York CCG turnaround plan. This would include improving individual and population health, promoting primary and preventative care and lessening the need for expensive services. Over time, the aim would be for the population to experience improved health outcomes and lower costs, thereby reducing reliance on intensive care intervention.

Commissioning Intentions

The Vale of York system-wide integration event in June 2015 identified a series of high level actions for moving towards the new system vision. These included:

- Create new team identities based on a defined locality with a sense of community;
- Create seamless multi-professional and multi-disciplinary teams across all partner organisations with a skill set to meet local needs;
- Work to improve professional roles through bringing specialist skills into locality teams;
- Empower teams to take decisions that put the person and their needs and choices first; identifying "what matters to you" not "what is the matter with you";
- Work to organise and co-ordinate services with people rather than refer people to services;
- Work constructively as a flexible system that is informed by feedback, learning from mistakes, errors and successes;
- Ensure that all services have the ability to respond to patient need rapidly when needed, supporting the delivery of high quality, effective care;
- Implement a new informatics system that draws information from across agencies through an interoperable platform;
- Join up commissioning budgets and approaches to support integration and to share risk and reward;

- Rebalance investment towards prevention and early intervention to optimise health and well-being and support independence;
- Seek out examples of duplication as a system and actively remove and disinvest in these services.

In its case for procuring community services, Scarborough and Ryedale CCG set out the changes they expected to see in moving towards their vision. These included:

- Providing easy access to high quality, responsive primary care – GPs and primary care teams will be at the centre of co-ordinating out of hospital care;
- A greater emphasis on keeping people healthy, preventing ill-health and reducing health inequalities – all healthcare professionals will have a role to play;
- Clearly understood planned care pathways to ensure care is delivered outside of the hospital setting;
- Providing services that are available and accessible in the community to meet the needs of the population;
- Providing rapid response to urgent needs to prevent the need to access hospital services;
- Health and social care providers working together with the patient at the centre to proactively manage long-term conditions, frail elderly and end of life care outside of hospital;
- Patients having a named co-ordinator and GPs and patient teams having rapid access to specialist skills closer to home;
- Early supported discharge into proactive organised community care so that patients spend an appropriate time in hospital if required.

Organisations have come together in the Scarborough and Ryedale area to form the Ambitions for Health programme. This will tackle a range of issues facing the local health and social care system, including a dedicated out of hospital workstream.

Our Vision for Out of Hospital Care

Based on the national drivers and local system perspectives we have developed a vision for out of hospital care. This is:

Community First.

We will work within the local system to adopt a 'Community First' culture which focuses on prevention and self care; delivers care closer to home and allows the system to manage growing demand by increasing efficiency through integration.

We will deliver this vision by adopting the principles shown in the diagram below. This also shows how the principles relate to the national planning guidance. The following section explains each of the principles in more detail.

Principles for Out of Hospital Services

1. Promote independence through prevention and self care.

We recognise that we need to move from being a paternalistic service provider which does things to and for people, creating a culture of dependence, to supporting and empowering people to take responsibility for their own care needs. We will draw on the existing strengths of staff in community services to develop a coaching culture across our workforce, building the expertise and confidence to manage their long term conditions (as they do already for the 99% of time when professionals are not present).

We will work with the public health unit, local authority and voluntary sector colleagues on initiatives to support the prevention of ill-health, including the wider factors that impact on an individual's health and well-being. This could include the redefining of specialist input to target those at risk of ill-health rather than, as now, those with the most acute needs. We will exploit the potential of personal health budgets to allow people to take control of decisions regarding their care and support.

2. Person-centred, co-produced support involving families and carers

We need to move from asking "what is the matter with people" to basing our interventions on "what matters to them". We need to focus on helping people to achieve the things that are important to them and this will require involving people in developing care plans and listening to what they tell us.

We need to recognise the role of families and carers and the wealth of knowledge they possess. By fully including them as part of the care team we can harness this and ensure that their views are heard and acted upon. We also need to recognise the importance of carers in preventing people from accessing higher levels of care and support and ensure that their needs are considered when assessments take place.

3. Co-produced new models of care (services) with home as first choice, delivered over seven days

Working on the principle that those who are affected by a service are best placed to help design it we must ensure a broad range of stakeholders can come together to design the new models of care that will transform our system. Whilst recognising the importance of standardisation in delivering our efficiency requirements we need to free local innovation to design the models that best meet the needs of local communities.

As part of our culture of 'Community First' we need to ensure all services are designed to be delivered in, or as near to, a person's own home or place of residence as possible. We need to challenge ourselves as to why a particular service cannot be delivered at home, rather than making the case for moving services out of acute settings. To deliver this will require us to spend less money on 'beds' and spend more on home based support services.

Recognising that people's care needs do not correspond to office hours we need to ensure that services are available at the times they are needed, across seven days of the week.

4. Co-ordinated, integrated and joined-up care that people can easily navigate

We know that often the frustrations reported by users of our services arise from trying to navigate the 'system' with confusion over the different people involved in their care. As part of delivering more person-centred care we need to ensure that the staff supporting an individual work together, regardless of their employing organisation. We need to model this in how organisations work together in the system and listen to what staff working on the front-line tell us are the barriers to doing this.

As we develop new models of care we need to reduce, not increase, complexity in the system, making it easier for professionals and those who use services to access the right support, first time. Linked to the need to avoid duplication we need to ensure that people only have to tell their story once and not be subjected to repeated assessments. We will ensure that integration is a means to delivering the best care, rather than an end in itself.

5. Timely and rapid response to prevent admission to hospital or a care home

We recognise that if community based services are to offer a credible alternative to hospital admission they must be able to respond quickly to identified needs. Whether addressing a crisis or providing support to prevent a crisis occurring, services need to provide an urgent response to prevent further deterioration, giving confidence to individuals, their families and carers and, not least, to referrers.

In order to achieve this we must plan for sufficient capacity in services, where teams are constantly working at 100% of capacity there is no flexibility to respond urgently as required. We need to understand the demand and activity associated with key services in order to do this, including where this cuts across a number of services providing similar functions.

6. Seamless interface to facilitate safe and timely discharge from hospital

We know that prolonged hospitalisation harms the people we aim to care for and therefore we need to ensure that we provide robust intermediate care services that allow people to return to their home as soon as it is safe to do so. As an integrated provider we need to simplify the process to move from acute to community settings and create a culture where patients are 'pulled' from hospital back into the community at the earliest opportunity.

We need to understand the needs of patients coming home from hospital to make sure community services are designed to meet these, building the confidence of hospital teams to allow patients' care to continue in their own homes. We also need to ensure that we reduce the de-conditioning impact of hospitalisation by promoting independence wherever possible for inpatients. This will facilitate their transition home and also minimise the support required for individuals upon returning home.

7. Remove duplication, ensuring cost-effectiveness and value for money

We must ensure that every pound spent is used to its greatest possible effect. This means we must be relentless in our efforts to remove waste, particularly duplication, from our services. This could be ensuring assessments that have already taken place are not repeated; for instance through 'trusting' assessments that have already been completed, or simplifying referral processes so the right person attends first time.

We need to benchmark with peers and adopt best practice; to do this we have to ensure that our information is robust and consistently collected.

What will we do differently?

> *"The NHS needs to be free to both develop its new models of community-based, person-centred care and deliver its traditional services at the same time. Transition is not instant; it takes time, commitment, experimentation, imagination, investment and conviction."* Community Health Services: A Way of Life

If our vision is to become a reality, we will need to transform how we work. This will not happen overnight but we need to ensure that all efforts and action are moving us toward this. As a system, we need to commit to making this happen; ensuring resources are dedicated to the change we want to see. We will need to prioritise the developments that can make the greatest impact or those that enable wider change to be delivered. The actions we will need include:

- Deliver care closer to home, where it makes sense to do so; delivering care at home must be the default position;
- Be based on clinical evidence and best practice;
- Aim to deliver fewer hand offs, repeated assessments and delays;
- Support people/families to keep well and stay healthy;
- Detect problems early and prevent deterioration (early diagnosis, assessment and care planning) – most studies suggest that 20-30% of admissions in people over 75 years old can be avoided if appropriate alternative services are available, most notably intermediate care services;
- Keep people out of hospital and long term care where appropriate to do so – increasing bed numbers in response to increasing demands may in fact increase length of stay with no actual benefit on patient throughput;
- Facilitate timely and supported discharge;
- Deliver services in a joined up way with partners/other stakeholders;
- Empower patients to be independent, instead of promoting dependency – to do this, we have to listen to what is important to the person, traditional assessments have a tendency to focus on what is important to us.

Making the vision a reality - Developing Care Hubs in 2015/16

In 2015 York Teaching Hospital FT worked with partners (including North Yorkshire County Council, local GPs, voluntary service organisations and our commissioners) to test new ways of working in Selby and Ryedale. Our 'care hubs' provide enhanced support to people to allow them to remain in their own homes during a health crisis or to return home sooner following a stay in hospital. Health and social care staff work together providing short term support when people need it most. Between February and November 2016, over 1,150 people had received support from the teams – with around 2,500 contacts every month.

Our teams were established with a learning culture, meaning they are always seeking ways to improve and develop their service. With this in mind both teams held large events in September and October 2016 where they invited people with an interest in the service to come and tell them what was going well, and what they could do better. This included a range of people who had used the service who were able to share their moving experiences of the difference it had made to their lives, and to those who provided care and support to them.

Within our 'care hub' developments we have also looked to provide support to people who live in care homes. A consultant who specialises in the care of older people carried out reviews in partnership with GPs, specialist nurses and care home managers. These looked at the medicines people were taking, stopping those that offered little benefit, and the care plans that were in place. They discussed with individuals and their families what their preferences were and jointly agreed the best treatment options. Over 500 care home residents have now been reviewed and plans are in place for this to continue in 2016. In Ryedale, these reviews resulted in over 200 medicines being stopped and over 150 new care plans being put in place.

Within our Ryedale service we were also excited to trial a new partnership with the voluntary sector. Coast and Vale Community Action (CAVCA) support community and voluntary organisations across Scarborough and Ryedale and have re-located to base themselves in the hub. We worked together to develop a new 'Community Enabler' role, employed by CAVCA, who can provide signposting and guidance to those using our services to find community support to maintain their independence. This could include local activity clubs, help with managing correspondence or dementia services.

What is next for 2016-2017?

The developing care hubs were designed with commissioners to understand how we could deliver services in the community that would be fit for the future and fit with our vision for 'community first'. We know that we cannot do this alone. The King's Fund recently published 'Place Based Systems of Care' which outlined the changes the NHS organisations needs to make to work differently with partners in our communities. The report drew attention to the development in York of a 'Provider Alliance Board' where those who provide health and care services (including voluntary organisations) come together to agree on new ways of working.

The Provider Alliance Board is developing a blue print for a new model of care in the community. Working in defined geographical areas we want to bring together those working in the community into integrated teams, working in partnership with local GP surgeries. This will help us to deliver what people have told us matters to them – only needing to tell their story once, better co-ordination between the different individuals who provide support and helping them to achieve the goals that are important to them.

New Pathways of Care - 2016-2021

In order to deliver the seven priorities that we have identified and to make 'Community First' a reality, we will incorporate the local commissioning intentions and learning from our Care Hub pilots into a planned programme of works. We have organised these into three key themes which are as follows:

1. Developing integrated community services to support localities;
2. Developing the interface between acute and community services;
3. Moving services from acute to community settings.

In the following section we will show what we will do differently under each of the themes and describe the associated outcomes.

1. Developing integrated community services to support localities

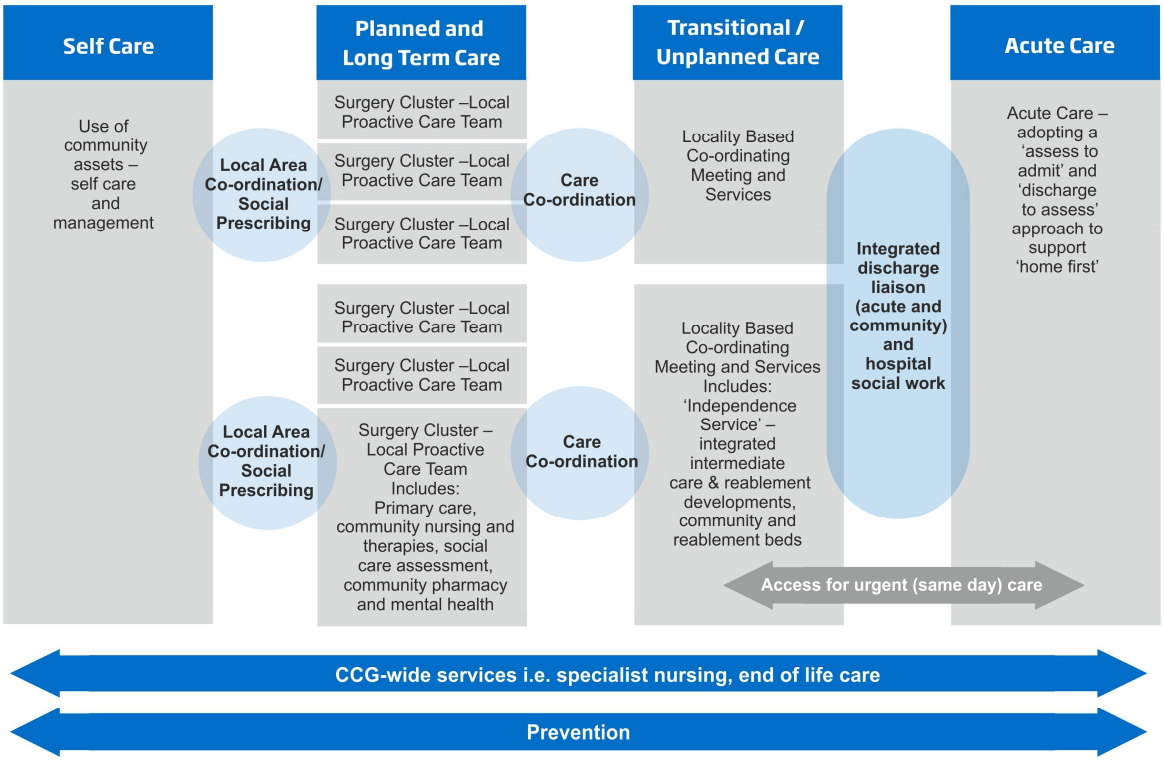
Current pattern of care

The people who work in and use our services tell us that the quality of care received from individual teams is good, with staff going above and beyond to support people on their caseloads. We know that this breaks down where individuals need support from multiple teams. This can be co-ordinated, but requires significant effort from individuals and professionals to navigate. Roles and functions of teams in the community can vary from place to place, as do levels of commissioned capacity. Years of focus on individual organisational performance has created artificial barriers which are a frustration to frontline staff.

We also know that there is a complexity resulting from the range of different services and teams, operated by different providers. These often perform similar functions and many have criteria or referral processes that can be confusing to those trying to access services. A focus on delivering care and measuring process steps has made it harder for staff to consider the whole person and undertake prevention activities.

What will we do differently?

Providers (across all health and social care settings and the third sector) and commissioners have come together to design **new integrated care models** to support our localities. The section 'How we will work together' gives more details on the changes to localities and partnerships that will underpin this transformation. The new care models reflect the need for local innovation but provide a template for design that incorporates the key features expected. The diagram overleaf shows an overview of the model.



At the Transitional / Unplanned Care level we would expect the functions of rapid response and facilitated and supported discharge to be delivered. At the Planned and Long Term Care level we would see maximising independence, complex care management and planned ongoing care be delivered. **Care co-ordinators** working across GP surgeries would provide a navigation function for both individuals and professionals.

We will also implement a workforce development programme for **developing self-management and peer support** ensuring that this runs through all of our services. We will continue to work with partners to develop our models of **support to care homes** ensuring that residents can access high quality preventative support and also a timely response to deteriorations in health.

2. Developing the interface between acute and community services

Current pattern of care

We know that the current provision of intermediate care services (those that can provide short term support to allow someone to remain at home or return home sooner) is inconsistent across the communities we serve. We also have different models of care in place in different areas. For referrers, particularly our acute hospitals who care for patients from across a range of localities, this can be confusing and makes referrals into services less likely to happen. Insufficient capacity in some areas can mean people are not able to receive the support in a timely enough manner to prevent admission or can need additional days in hospital until capacity becomes available.

Whilst our Care Hub pilots in Ryedale and Selby bring intermediate care and reablement closer together, there is much more that we can do across all of our localities to join up the

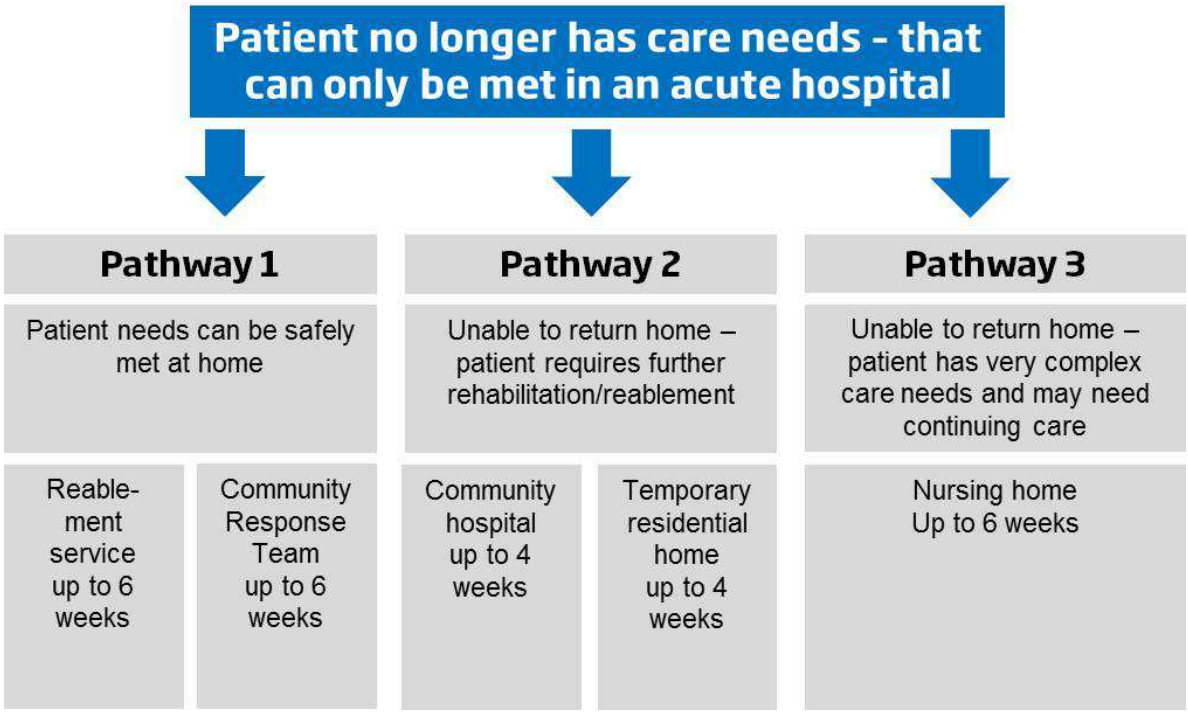
support that teams can offer. For referrers the distinction between the services is often unclear, with referrals being sent to the team perceived to respond in the timeliest manner.

Audits of our community inpatient facilities have shown that a significant proportion of people could be cared for at home, if services were available. We recognise that our community hospitals in particular are highly valued in their local areas. We know that criteria for the community inpatient beds is ill-defined and there is a perception that these beds exist to support the acute hospital sites.

With the exception of our community inpatient beds and the recent Care Hub pilot developments we have little medical input to community services. The medical models for our community inpatient beds are varied with a mixture of GP and consultant delivered services and variation in the level of input (that has been historically commissioned). We also know that our acute hospitals operate an 'assess to discharge' model where patients remain in hospital beds to undergo assessments for their long term care needs.

What will we do differently?

We will work with system partners to develop a **'discharge to assess' model** where patients only stay in an acute setting until they are medically optimised. After this time, the majority would move home with support from **integrated intermediate care and reablement** with any assessments required taking place at home. This will improve the quality of the assessments undertaken, reducing the current duplication of assessments taking place in both hospital and home settings. For those who cannot safely return home, we will develop alternative pathways to promote independence and allow required assessments to take place in a more appropriate environment. The following model illustrates the proposed approach.



In order to deliver this model we will need to ensure a consistent offer across all our localities from an **integrated intermediate care and reablement service**. This will facilitate timely discharge from hospital settings as well as providing a rapid response to prevent people from needing admission in the first place. We will develop **community consultant**

geriatrician and **advanced clinical practitioner roles** and also work with local GPs to ensure that services are able to manage the medical needs of those being supported.
We will develop more generic roles with less specialism working across health and social care in both acute and community settings, for example **integrated discharge liaison teams**. They will help individuals and professions to navigate the system and provide case management for individuals to ensure they receive the support they need, without delay.

We will also **review our provision of community inpatient beds** (including the number of virtual beds that can provide wrap around services in a person's own home); reducing our number of physical beds through the development of home-based alternatives. We will ensure that the function of our community inpatient beds is explicit, developing models of sub-acute care (including ambulatory care); specialist rehabilitation and end of life care.

3. Moving services from acute to community settings

Current patterns of care

We know that currently the majority of activity carried out by the Trust takes place on our acute hospital sites. The split in primary and secondary care has meant that 'specialist' services have traditionally been carried out by hospital provider trusts, concentrating services within their estate. Initiatives over previous years to move care 'out of hospital' have focussed on the transfer of services to community based providers, including primary care. This created the potential for the fragmentation of specialist services, and threats to the viability of acute specialist services.

A number of specialties have started to move services traditionally delivered in acute settings into community locations. Musculoskeletal services, neurology, dermatology and diabetes are all pursuing new models of care delivery.

What will we do differently?

We will continue to bring together primary and secondary care clinicians to **review care pathways to identify opportunities to develop community based alternatives**. We will need **contracting and payment mechanisms to be modernised** to reflect the new care models and the role of the specialist will need to be redefined.

We will review the care delivered to our inpatients, such as **intravenous therapy** where patients can spend weeks in hospital in order to receive daily infusions of medication, and look to develop home or community based alternatives. Wherever possible, we will develop self-care alternatives ensuring that we continue to promote independence, especially in those managing chronic conditions.

We will also look to **expand the range of planned care services** (whether delivered as outpatient or day case interventions) that are delivered in our community buildings. This will ensure that people have access to the widest range of services possible close to their home and also ensure that we make the most cost-effective use of our estate possible.

The strategy can be summarised on the following 'plan on a page'.

York Teaching Hospital NHS
NHS Foundation Trust

Out of Hospital Care Strategy - Community First

We will work within the local system to adopt a 'Community First' culture which focuses on prevention and self care; delivers care closer to home and allows the system to manage growing demand by increasing efficiency through integration.

DRIVERS:

- Harm caused by bed based de-conditioning;
- Predicted rise in demand from an ageing population;
- Need for new models of care to meet £22bn efficiency challenge;
- Need to deliver seamless, co-ordinated care;
- Implement best practice in delivering place-based population health;
- Close the gap in health inequalities across our communities.

DEVELOPMENTS:

Developing integrated community services for localities	• New integrated care models • Programme of self-management and peer support • Care co-ordinators • Supporting care homes
Developing the interface between acute and community services	• Discharge to Assess / Early Supported Discharge • Integrated intermediate care and reablement services • Community Geriatrician / Advanced Clinical Practitioner roles • Integrated discharge liaison services • Optimise use of community beds
Moving services from acute to community settings	• Review care pathways to identify community based alternatives • Musculoskeletal services • Ambulatory care pathways • A wider range of planned care services in community settings

PRIORITIES:

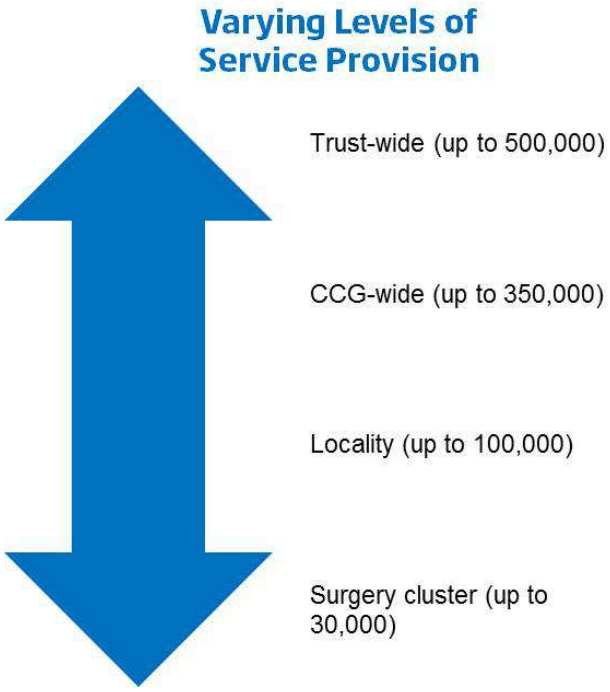
- Promote independence through prevention and self care
- Person-centred, co-produced support involving families and carers
- Co-produced new models of care (services) with home as first choice (delivered over seven days)
- Co-ordinated, integrated and joined up care that people can easily navigate
- Timely and rapid response to prevent admission to hospital or a care home
- A seamless interface to facilitate safe and timely discharge from hospital
- Remove duplication, ensuring cost-effectiveness and value for money

ENABLERS: Workforce; Information Technology; Estates; Knowing how we are doing

Caring about what we do | Respecting and valuing each other | Listening in order to improve | Always doing what we can to help

How will we work together to deliver these changes?

In developing these care models we recognise that there will be a need to work at different levels in order to ensure that services are responsive to local need, can achieve efficiencies and economies of scale and are resilient. As we move to a more 'place-based' approach we will need to ensure that our services share boundaries with partners and come together around natural geographies. The model below illustrates the different levels that services will need to work at.



For each service we will need to determine the most appropriate level of operation. We have worked through the Provider Alliance Board and other forums to define the boundaries of surgery clusters and localities. We will then work through Public Health teams to identify the needs of the populations within these new localities, ensuring that as services are redesigned this is targeted towards the needs identified.

We are clear that this strategy cannot be delivered in isolation. Although there are clearly elements within the Trust's control to deliver, many parts require the wider system to come together to make this happen. We have already seen leads within local systems coming together in a variety of settings in order to do this. Our local Sustainability and Transformation Plan will see partners signing up to a collective vision and blueprint for the future by June 2016. We will ensure that the right governance structures are in place to facilitate this and will continue to work with commissioners to ensure that contracting and payment frameworks support, rather than hinder our collective efforts.

The emerging governance structures locally include the development of a System Leaders Board where leaders of local organisations come together to share collective responsibility for decisions that impact across organisations. Underneath this the York Integration and Transformation Board and Scarborough Ambitions for Health Board oversee transformation programmes for their respective areas. Commissioners are coming together to develop a joint strategic commissioning approach and providers are working together in York through the Provider Alliance Board. GPs within the Vale of York have formed a single entity, the Vale of York Clinical Network, to strengthen the collective role of primary care. We have

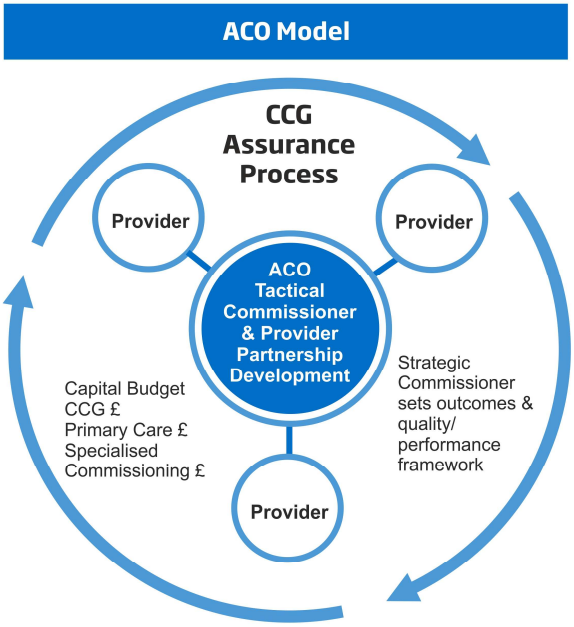
committed through our third sector umbrella bodies and local HealthWatch to adopt a co-production approach to service redesign.

A potential roadmap for the delivery of an Accountable Care approach in York has been developed for consideration, with support from Capsticks Solicitors.

The key principles to guide the development and assessment of the option of creating an Accountable Care System or Organisation (ACS/ACO) model for York are likely to include:

- Key partner / stakeholder endorsement - this is vital both to the success of the approach and to minimise the very real risk of legal challenge;
- The CCG will commission for health outcomes through a capitated funding contract with the ACS/ACO;
- Form should follow function, but the ACS/ACO should comprise all main service providers (including primary care), on a "all in" principle, committed to working in partnership to agreed values in some form of "alliance" or joint venture approach;
- The parties may not favour any prime contractor model of commissioning which houses all the activity and control within one Trust/Organisation but could use that model to test-bed the benefits and disadvantages of a preferred ACS/ACO approach. It is likely for capacity and risk avoidance reasons that this will be York Hospital NHS Foundation Trust;
- The CCG could significantly reduce its overhead costs by devolving transaction responsibilities to the ACS/ACO and potentially through co-commissioning with the City of York Council, NHS England, or potentially another CCG;
- As already described, the ACS/ACO approach is new to the UK, has had mixed success internationally (including, for example, early cost containment followed by overheat) and is untested for challenge by other bodies as anticompetitive. It is imperative therefore that risk is fully assessed and mitigated and that early intervention measures are agreed as part of any sign off process.

The diagram below highlights the key components of the proposed York ACO model



What enablers will be required to support the changes?

We will need more than new services and new ways of working in order to be effective and deliver our vision. We will need to ensure that we have a workforce that has the skills to deliver the new care pathways and is supported in making the cultural changes required. We will need information technology that supports seamless and effective communication across services, ensures effective use of new digital technology to support self-care and reduces administrative burdens on staff to free up time to care. Our estate will need to support the new care models with fewer requirements for isolated facilities and a reduction in physical beds, moved towards hub and campus accommodation with partner services. We need to ensure that we can measure the impact of what we do, with timely access to robust outcome data and intelligence from our communities to ensure that the changes we make are improvements.

Workforce

We will invest in our workforce to ensure that they have the skills required to deliver the new care models. This will include a focus on health promotion, coaching in self-care and intra-disciplinary working (where staff are able to undertake some elements of each others roles to reduce duplication). We need to ensure that career frameworks are in place to attract new staff and that development opportunities exist so that we retain our current workforce. We will need to design new roles, taking into account the new care pathways and likely availability of key professional groups.

We will develop a programme of organisational development support to ensure that the cultural changes required in implementing 'Community First' can be embedded across all of our services.

Information Technology

We will work with system partners to ensure that a shared, inter-operable care record exists; allowing services working together to deliver care and support for individuals to communicate effectively. This will support efforts to reduce duplication as assessments can be shared easily across organisations and people do not need to repeat their story multiple times. We need to ensure that our workforce has mobile access to these records, allowing records to be updated in real time and a move from duplicate electronic and paper records to a true digital record.

We need to embrace technological developments that support self-care, enabling people to take control of their own conditions. Where appropriate, we need to make greater use of telecare and telemedicine. In our community hospitals, we need to ensure that we make full use of the electronic patient record and supporting functions.

Estates

Our new care models will be less dependant on physical infrastructure than we are now. If we truly adopt a home first approach, we will deliver less care in our current buildings. We therefore need an estates strategy that supports a move to more campus style accommodation with partner organisations. This will facilitate co-location of staff and services. With our focus on 'place-based' care these will ideally be located in the communities we serve.

Knowing how we are doing

In this strategy we have been explicit about the need to redesign services to deliver better outcomes for people. In order to know if we have succeeded in this, we will need robust measurement systems and real time data that can tell us if the changes we have made are making a difference. We will use this intelligence to refine our approach, ensuring that we do more of what works and less that doesn't improve outcomes for people.

In order to do this, we will need a mixture of quantitative data and qualitative feedback from those who use our services (and their carers and families). We also need to ensure that those who work in the system can act as our eyes and ears, with meaningful opportunity to influence the changes we need to make and to feedback on their impact.

Next Steps

We have identified a series of developments that we will focus on during 2016-17. These will form the basis of our Out of Hospital Programme and include:

- Adopting a discharge to assess approach and testing the three pathways identified;
- Developing integrated enhanced care teams, wrapped around primary care;
- Developing an 'independence service', integrating intermediate care and reablement and building home-based capacity including a review of our bed based intermediate care provision;
- Developing a workforce development programme that will embed our focus on prevention, coaching and self care;
- Work with operational directorates to develop the out of hospital elements of their directorate strategies, identifying opportunities to move services from acute to community settings;
- Developing a home based ambulatory care service.

References

The following sources were used in the production of this strategy.

'Community Health Services: A Way of Life' NHS Providers, 2015
'Health Profile 2015: Selby' Public Health England, 2015
'Health Profile 2015: Scarborough' Public Health England, 2015
'Health Profile 2015: Ryedale' Public Health England, 2015
'Health Profile 2015: York' Public Health England, 2015
'Integrated, personal and sustainable community services for the 21st century' Northern, Eastern and Western Devon Clinical Commissioning Group, 2014
'Integrated Care and Support: Our Shared Commitment' National Collaboration for Integrated Care and Support, 2013
'Moving healthcare closer to home' Monitor, 2015
'Risks of Unnecessary Waiting' Presentation by Dr Ian Sturgess, Associate Medical Director, Monitor [taken from Emergency Care Improvement Programme website 8/1/15 www.ecip.nhs.uk/tools-and-resources/event-resources]
'Five Year Forward View' NHS England, 2014
'Delivering the Forward View: NHS planning guidance 2016/17-2020/21' NHS England, 2015
'Summary of our Five Year Strategic Plan 2015-2020' University Hospitals of Morecambe Bay NHS Foundation Trust, 2015
'Draft Integrated Community Services Strategy' East Leicestershire and Rutland Clinical Commissioning Group, 2014
'Transforming our health care system' The King's Fund, 2013
'Making our Health and Care systems fit for an ageing population' The King's Fund, 2014
'Community Services: How they can transform care' The King's Fund, 2014
'Integrated Care and Support: Our Shared Commitment' National Collaboration for Integrated Care and Support, 2013
'Integrated Care: what do patients, service users and carers want?' National Voices, 2012
'Population health systems: Going beyond integrated care' The King's Fund, 2015
'Getting out of hospital?' The Health Foundation, 2011
'North Yorkshire Joint Strategic Needs Assessment: Annual Update 2015 – Scarborough Ryedale CCG Summary' North Yorkshire County Council, 2015
'North Yorkshire Joint Strategic Needs Assessment: Annual Update 2015 – Vale of York CCG Summary' North Yorkshire County Council, 2015
'NHS Outcomes Framework 2015 to 2016' Department of Health, 2015
'Our Shared Commitment' York Teaching Hospital NHS FT, 2014
'Vision and Principles for Integration' Output from Vale of York system-wide event 23 June 2015
'An Accountable Care Approach in the Vale of York – Discussion Paper' System Leaders Board paper, March 2016

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York Teaching Hospital NHS Foundation Trust

Workforce & Organisational Development Committee – 18th May 2016 – Classroom 4, Postgrad Centre, York Hospital

Attendance: Dianne Willcocks, Chairperson, Libby Raper, Bev Geary, Anne Devaney, Sue Symington, Anna Pridmore, Polly McMeekin, Tracy Astley (minutes)

Apologies: Mike Proctor

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes 11 April 2016**		The minutes were approved as a true record of the meeting.		
2.	**Matters arising**		**CQC action plan** regarding paediatric nursing and safeguarding. The Committee discussed the action identified at the last meeting and agreed that PM and AP would liaise after meeting regarding any outstanding actions. **Medical staffing update** – It was agreed that the discussion around Medical Staffing should be postponed until the next meeting when a robust paper outlining the issues and providing some data would be presented. The Committee discussed the purpose of the Committee and agreed that its focus was on the "big picture" aspects of workforce and organisational development. PM explained the Trust is concentrating on growing areas such as	The Committee was assured by the comments made by PM and noted the paper that would be provided to the next meeting of the Committee in July 2016	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			mental health and psychiatry whilst reducing in surgery, anaesthetics and radiology. She explained the issues with obtaining temporary medical staff from agencies to fill gaps as not one covers all professions. PM will provide a paper for July meeting that profiles the Trust's current establishment, the challenges ahead and the options going forward. The Committee requested that Jim Taylor also be invited to the next meeting.		
2.1	**STP Workforce Planning**		AD gave verbal update on the back ground to the STP and linked its development to the Five Year Forward Review. AD reminded the Committee that there were additional funds available for implementation of the plan. AD advised that there was an STP meeting being held on 18 May which should help to establish grounds for the plan. SS stated that the plan needs to be ambitious, transformational and sustainable in order to attract the money. PM reported that she has set up a meeting with HR Directors from Hull and NLAG with the intention of meeting them on a regular basis. Regarding nursing, BG advised that she meets with colleagues on a regular basis and attends regional meetings on a quarterly basis. LR raised concerns about the risks related to the STP and asked that risks related to workforce that are identified be considered by the Committee..		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
2.2	**Living Wage**		PM advised that there had not been any significant progress during the last month. She confirmed that the Trust would very much like to continue with the living wage but there needs to be realistic about what the Trust could do. PM reminded the Committee that discussions had been held with the unions suggesting variations to national terms and conditions so the Trust can continue to pay the living wage. The challenge for the Trust being one of affordability. She advised that the discussions with the Trade Unions have shown that at this stage, they are not able to accept any deviation from the current national terms and conditions. She advised that discussions continue through the JNCC. PM reminded the Committee of the requirements to remain a living wage employer and explained that the Trust is out of that time frame. At present the Trust is paying the living wage at 2014 rates, which is still above the normal rate for staff on those bands of pay. The Committee noted the work and discussions and accepted the position. It was agreed that the issue would continue to be discussed with the unions and if there was any development PM would update the Committee.	The Committee was disappointed that the living wage commitment could not be progressed at this stage, but were assured that the Trust was still in discussions with the unions.	
3	**Terms of Reference**		The Committee discussed the Terms of Reference. The Committee proposed a number of minor amendments and asked that the updated version be included in the Board papers for the May Board. It was agreed that AP/PM would meet to discuss		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			the work programme for the Committee.		
4.	**Corporate Risk Register for Workforce and Organisational Development**		PM gave overview. She advised that at present there are 4 risks on the HR Corporate Risk Register. PM anticipated that Risk no. HR3 related to centralised recruitment would be removed as the action had been completed. LR asked if it was a standard process for DBS checks to be repeated for long term employees. PM confirmed that DBS checks were only carried out if employees change jobs or their circumstances change which they are obliged to do under the terms and conditions of employment. SS enquired if there were any new risks? PM confirmed there were not. SS asked when does the Trust think that staff sickness, recruitment and retention difficulties become a risk to the organisation. PM advised that industry standards would suggest that a turnover rate below 15% represented a low rate. At present the staff turnover rate about 11%. PM added that there is a drive on retention at present, especially with international recruitment. SS noted that the Trust does not publish information on what the monetary cost of staff sickness is in the Trust . PM reported that Patrick Crowley sent out a bespoke email to directorate managers regarding cost of sickness and enquiring how they are managing it. PM referred to the return	The Committee noted the risks included in the register and the change being proposed. The Committee was assured by the work being undertaken to strengthen existing systems and policies to ensure they are fully implemented across the Trust.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			to work interviews and explained that she was concerned that these were not taking place as often as they should be. She confirmed that the HR department were supporting Managers in improving compliance. The Leavers Questionnaire is being modified by HR. PM further advised the Committee that the sickness absence training was now taking place and there is a radical re-write of the Sickness Absence Policy that is on-going.		
5.	**Workforce and Organisational Development Strategy**		Committee agreed that the Workforce and Organisational Development Strategy linked directly into the Trust's ambitions. It was agreed that the strategy was coherent and easy to explain with colleagues. It was agreed that some modifications were required, specifically around: Health & Wellbeing - community and staff engagement to the Art Strategy should be added. It was agreed that PM/LR would liaise about the wording. Learning – The Committee requested that built in to the strategy was the ability to have more flexibility to achieve step up and step down in roles. It was agreed that PM/AD to liaise about the wording. Research – The Committee requested that Colleges were referenced in the document. It was agreed that the Committee would	The Committee were assured by the draft strategy and keen to see it become operationalised.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			recommend approval of the Strategy to the Board with the commitment that the Committee would undertake an early review of progress against the Strategy.		
6.	**Profiling of clinical appointments, including verbal update on junior doctors' contract**		It was agreed that this paper would be deferred until the next meeting in July 2016.		
7.	**E-rostering and projected impact / benefits**		PM gave overview of the paper. She explained that there were two different models - de-centralised e-rostering at York and centralised model at Scarborough. PM updated the Committee on the progress of work specifically around the requests for agency and temporary staffing . PM explained the work that Becky Hoskins is undertaking around the nurse bank and the e-rostering. She advised that. Sian Longhorne/Becky Hoskins set up a Task & Finish group with others to support the work and ensure issues are resolved. BG added that there is training available for everybody involved. BG explained that one of her concerns was the difficulties of getting staff to change due to cultural behaviour around annual leave and days off. The Committee asked for an update for July meeting with strategy for addressing the issues.	The Committee was pleased to hear about the work being undertaken and the progress being made.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
8.	**Workforce Metrics and Update report - incl. Art Strategy**		PM informed the Committee that due to unplanned sickness the Art Strategy had been delayed. Referring to the Safer Working Guardian/Freedom to Speak Up post, she advised that interviews had been arranged and would take place in the next week. She advised that from 7 candidates there are 3 strong applicants who had been invited to interview. PM gave overview of the role in respect of who they report to, their responsibilities and requirements. PM gave an overview of the paper. She commented that HR was identifying a large number of individuals who had reached Stage 3 of the sickness process. She advised that the situation is being reviewed.. PM advised that turnover in staff was falling and the reduction in temp nurses is on track. With regard to temporary medical staffing, the majority of recruitment is within framework but is above the cap due to agencies setting rates high.	The Committee noted the report and agree it would be discussed at the Board meeting at the end of May	
9.	**Internal Audit Report - Appraisal**		PM gave overview of the Internal Audit Report related to appraisal She highlighted that there were concerns regarding the lack of registering appraisals that have been done. She advised that recommendations have been made to improve overall appraisal completion rates, the consistency of appraisal discussions and documentation and the accuracy of information reported to Workforce Information. PM explained that there was further work being undertaken linking appraisals with the Talent Management policy which was being reviewed. HR is working closely with Mike Proctor's	The Committee was concerned about the issues outlined in the report, but took some assurance from the comments made.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			team to develop this. It was planned that the document would be discussed at the next EPG meeting being held next month, following which the paper would be included in the WFODC for the July meeting.		
10.	**Results of junior doctor induction audit**		AD gave over view of the Internal Audit Report on junior doctors induction. AD advised that the roles and responsibilities for the Junior Doctor Local Induction process have been clarified across all specialities and a standardised Local Induction Handbook has been adopted by 22/27 Specialities, that is subject to annual review. AD is confident that they are moving in the right direction. AD confirmed that the five areas mentioned in Section 6 of the audit are in all handbooks. The issue regarding the re-establishing a governance and assurance reporting process for Education. It was agreed that AD would update Mike Proctor on the developments so that he could provide a further report to the Committee in July.	The Committee were concerned about the comments in the report.	
11.	**Date and time of future meetings**		The Committee noted the meetings for the remainder of this year and noted that further meetings dates would be made available in the near future.		
12.	**AOB**		There was no other business.		
13.	**Next Meeting**		The next meeting is arranged for 20 July 2016 in Room 1 Park House at 1pm.		

York Teaching Hospital NHS
NHS Foundation Trust

WORKFORCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE:
Summary of Governance

Version 1
May 2016

York Teaching Hospital NHS Foundation Trust

WORKFORCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE:

Summary of Governance

WORKFORCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Terms of Reference

1	**Status**
1.1	The Workforce and Organisational Development Committee is a committee of Board of Directors.
2	**Purpose of the Committee**
2.1	The Workforce and Organisational Development Committee ensures the Board of Directors receives assurance about the Trusts strategy on workforce and organisational development
3	**Authority**
3.1	The Board of Directors has provided delegated authority to the Workforce and Organisational Development Committee to seek assurance around the workforce and organisational development issues identified in the Trust and to propose solutions to any workforce or organisational development issues.
4	**Legal requirements of the committee**
4.1	There are no specific legal requirements attached to the functioning of the Committee. The Committee will however be made aware of any legal requirements the Trust is expected to fulfil relating to workforce and organisational development.
5	**Roles and functions**
5.1	To develop, implement and manage the Workforce and Organisational Development Strategy and provide updates to the Board on an adhoc basis
5.2	The Committee will work in conjunction with the other Board Committees sharing information and agreeing the location for the discussion of certain topics
5.3	The Committee will review implications of the strategy from an equality and diversity perspective and raise any concerns to the Board.
5.4	The Committee will ensure the organisation continues to develop as an excellent place to work
5.5	The Committee will identify creative approaches to attract the right people to work in the Trust and ensure people are working in the right places at the right time
5.6	The Committee will identify approaches to retain staff
5.7	The Committee will oversee the development and implementation of first class learning and development opportunities, enabling staff to maximise their potential
5.8	The Committee will oversee the creation of new knowledge through research and ensure this knowledge is shared widely across the organisation and beyond

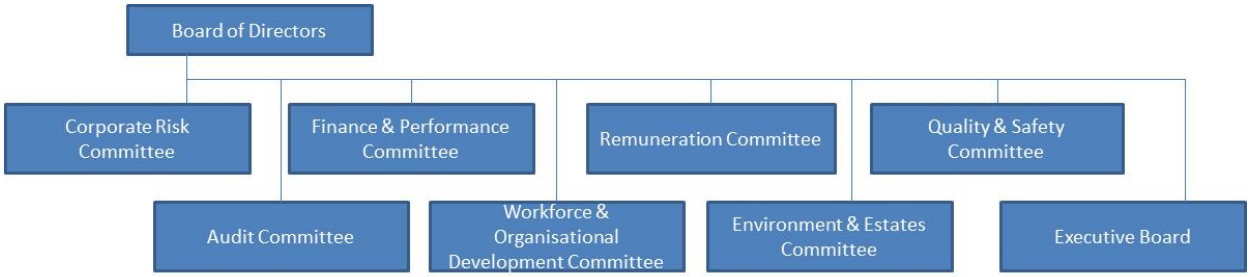
5.9	The Committee will gain assurance about the risks and mitigations around workforce and organisational development
5.10	The Committee will escalate any areas of concern identified to the Board of Directors for further discussion and resolution
5.11	The Committee will submit notes to the Board of Directors following each meeting. The Committee can call additional meetings are required.
5.12	Issues will on occasions be discussed in private by the Board of Directors on the advice of the Workforce and Organisational Development Committee.
5.13	The Committee will review on a regular basis the CQC action plan and consider if there is sufficient evidence to demonstrate compliance with the actions related to Workforce and Organisational Development
5.14	Receive Internal Audit Reports on an adhoc basis
5.15	Receive information from any other forum including the Fairness forum.
5.16	Address all issues related to workforce and organisational development in the context of an evolving NHS
6	**Membership**
6.1	The membership of the Workforce and Organisational Development Committee will comprise:- • 3 NEDs – Dianne Willcocks (Chair), Sue Symington and Libby Raper Any Director is able to attend at any time on an occasional basis subject to notifying the Chair in advance. Should a NED member not be available for a meeting an alternative NED will be requested to attend the meeting. The following Directors and officers will be in attendance: • Mike Proctor (Deputy Chief Executive) If Mike is unavailable an Executive Director must attend in his place • Polly McMeekin (Deputy Director of Workforce) • Foundation Trust Secretary (Anna Pridmore) • Secretary to the meeting (Tracy Astley) • Other officers as maybe required. If those in attendance are unable to attend, an appropriate deputy should attend the meeting. The appropriate deputy must be fully briefed.

7	**Quoracy**
7.1	The Committee will be quorate with the 2 NED members and an Executive Director attending. The Chair of the meeting will ensure that a deputy is appointed to preside over a meeting when the Chair is unavailable or has a conflict of interest.
8	**Meeting arrangements**
8.1	The Committee will meet every other month, prior to the Board of Directors meeting (minimum of 6 times per year) and all supporting papers will be circulated at least 5 working days in advance of the meeting. Copies of all agendas and supplementary papers will be retained by the Foundation Trust Secretary in accordance with the Trust's requirements for the retention of documents. In the Deputy Director of Workforce's Secretary will supply the Secretariat service to the meeting.
8.2	The agenda will be circulated in advance of the papers to the Chairman. The standing items will be provided to the Committee not less than 5 days before the meeting. Any additional papers that should be discussed at the Committee should be notified to the Chairman and Secretariat of the Committee not less than 7 days in advance of the meeting and circulated a minimum 5 days prior to the meeting.
8.3	The Chair of the Workforce and Organisational Development Committee has the right to convene additional meetings.
8.4	Where members / attendees of the Workforce and Organisational Development Committee are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the secretary of the group and provide a deputy.
9	**Review and monitoring**
9.1	The Workforce and Organisational Development Committee will maintain a register of attendance at the meeting. Attendance of less than 80% will be brought to the attention of the Chair of the Committee to consider the appropriate action to be taken. The attendance record will be reported as part of the annual report. An annual report will be presented to the Board of Directors.
9.2	The terms of reference will be reviewed every two years.

Author	**Anna Pridmore, Foundation Trust Secretary**
Owner	**Dianne Willcocks Non-executive Director (Chair)**
Date of Issue	
Version #	**1**
Approved by	**Board of Directors**
Review date	

Governance structures

WORKFORCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE



Standing Agenda

No.	Agenda item	Comments	Attention to Board
1.			
2.			
3.			
4.			
5.			

Workforce and Organisational Development Committee
Work Programme 2016 -17

20th July 2016 • STP Workforce work stream • Boundaries and protocol for working with the other board committee • Review of Workforce and Organisational Development Strategy - Research • Learning and research update • CQC action plan • Workforce metrics • Junior Doctors Contract • Freedom to speak up guardian • Internal Audit Reports • Risk Register and CQC action plan	**13th September 2016** • STP Workforce work stream • Profiling of clinical appointments at all levels • E-rostering – projected impact/ benefits • ED staffing models and impact for associated directorates/services • Staff retention • Workforce metrics • Junior Doctors contract • Internal Audit Reports • Risk Register and CQC action plan • Review of Workforce and Organisational Development Strategy – excellent place to work
15th November 2016 • Review of Workforce and Organisational Development Strategy • Workforce metrics • Use of agency staff • Internal Audit Reports • Risk Register and CQC action plan • Review of Workforce and Organisational Development Strategy – Recruitment and Retention	**18th January 2017** • STP Workforce work stream • Profiling of clinical appointments at all levels • E-rostering – projected impact/ benefits • Workforce metrics • Junior Doctors contract • Profiling of clinical appointments at all levels • Internal Audit Reports • Risk Register and CQC action plan

	• Review of Workforce and Organisational Development Strategy – Health and Wellbeing
March 2017 • Annual Report • Workforce metrics • Staff survey • Profiling of clinical appointments at all levels • Internal Audit Reports • Risk Register and CQC action plan • Review of Workforce and Organisational Development Strategy - Learning	**May 2017** • Review of the Terms of Reference • Workforce metrics • Internal Audit Report • Risk Register and CQC action plan • Review of Workforce and Organisational Development Strategy – Developing our staff and our organisation

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 May 2016

Workforce Report – May 2016

Action requested/recommendation

The Board of Directors is asked to read the report and discuss.

Summary

The attached document provides information up to April 2016, relating to key Human Resources indicators including; sickness and recruitment and retention.

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

Outcomes 12, 13 & 14

Progress of report	Board of Directors
Risk	No risk

Resource implications	There are Human Resources implications identified throughout this report.
Owner	Patrick Crowley, Chief Executive
Author	Polly McMeekin, Deputy Director of Workforce
Date of paper	May 2016
Version number	Version 1

Board of Directors – 25 May 2016

Workforce Report – May 2016

1. Introduction and background

This paper presents key workforce metrics up to April 2016 (where available). The narrative will detail trends and any actions which are being taken to address specific issues. Of particular note:

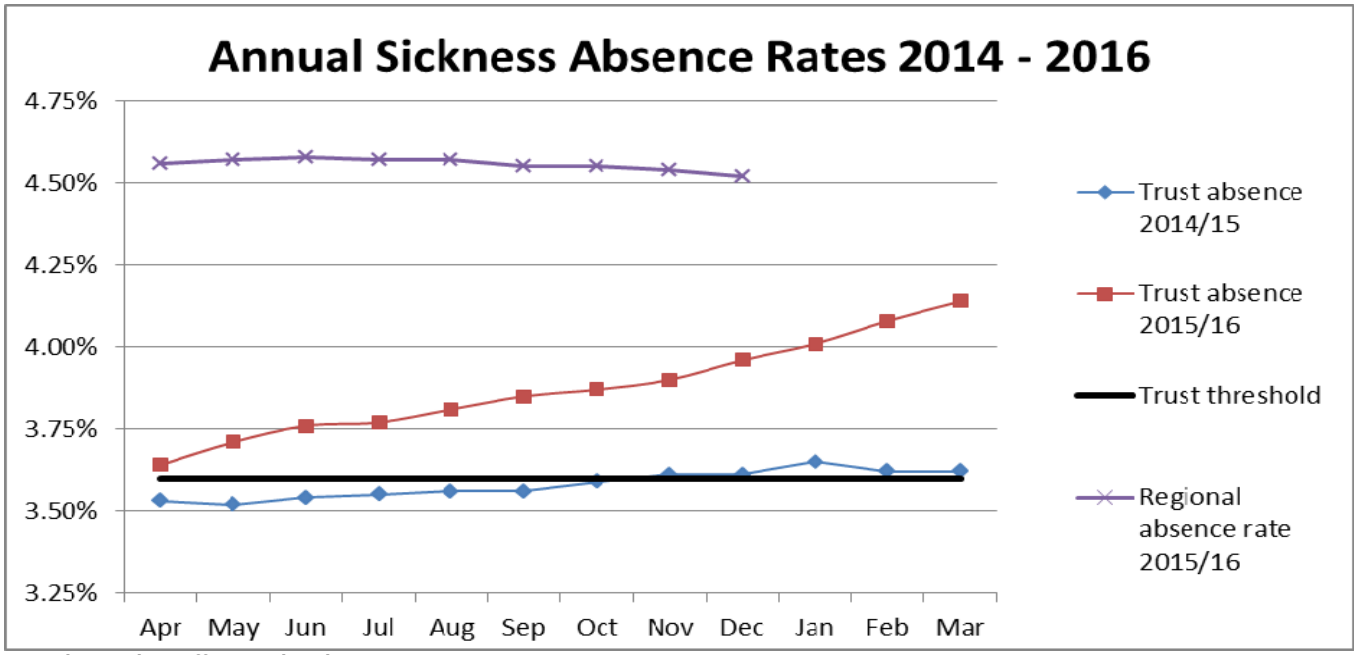
- A continued upward trajectory in sickness absence rates, although the Trust absence rate continues to be below the regional average.
- National negotiations have reached agreement on the junior doctor contract.
- A continuation in the positive trend in bank fill rates for temporary nurse staffing and a significant reduction in the use of off framework agency for both nursing and medics in the last month.
- The Trust held its first large scale recruitment market place in April. This was very successful with more than 400 people attending on the day.
- A recent audit of appraisals resulted in an outcome of significant assurance.

2. Workforce Report

2.1 Sickness Absence

Graph 1 – Annual sickness absence rates

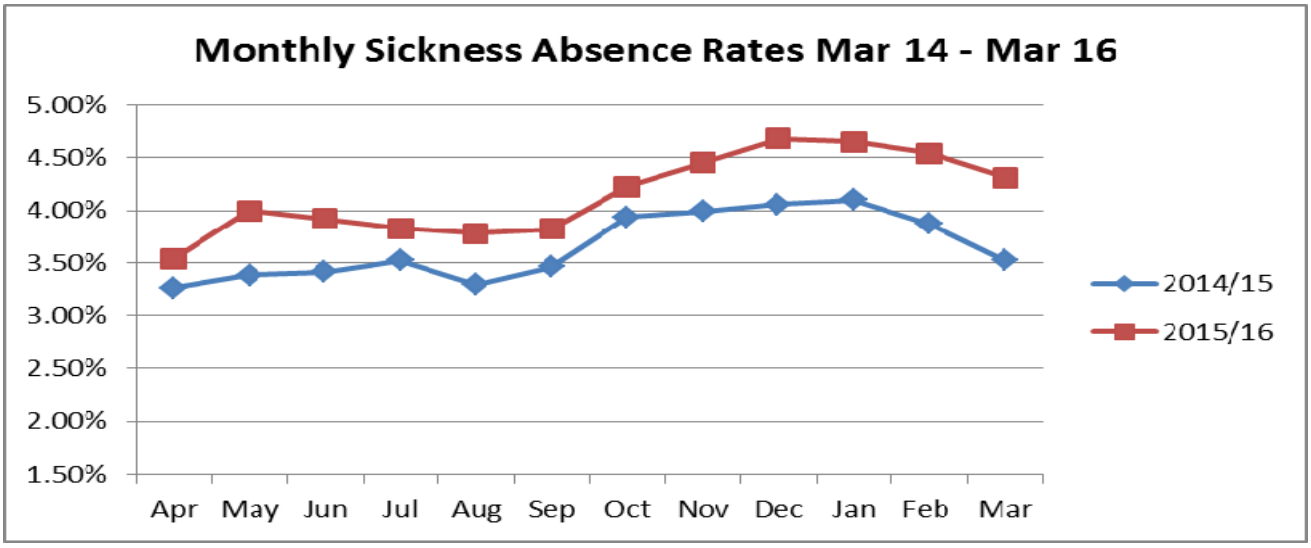
The graph below compares the rolling 12 month absence rates to the Trust's locally agreed threshold and to the regional (Yorkshire and Humber) sickness absence rates. Although the Trust's absence rate continues to be well below the regional absence rate the cumulative annual absence rate has continually increased over the last year and has been above 4% for the past three months.



Source: Electronic Staff Record and HSCIC

The graph below shows the monthly absence rates from April 2014 to March 2016. Whilst this demonstrates similar patterns (i.e. seasonal variations) in both years, it also shows that in every month of the last year, the absence rate is higher than it was in the same month of the previous year. The monthly absence rate in March 2016 was 4.31%, whilst in March 2015 the rate was 3.52%.

Graph 2 – Monthly sickness absence rates



Source: Electronic Staff Record

The actions being taken to address the increasing absence rates were detailed in last month's report. Individualised Chief Executive communication has now been sent out to Directorate Management teams reinforcing the importance of proactive management of sickness absence.

The top three reasons for sickness absence based on both days lost (as FTE) and number of episodes are shown in the table below:

Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
Anxiety/stress/depression – 20.32% of all absence days lost	Gastrointestinal – 19.73% of all absence episodes
MSK problems, inc. back problems –18.29% of all absence days lost	Cold, cough, flu – 15.83% of all absence episodes
Gastrointestinal –8.69% of all absence days lost	Anxiety/stress/depression –9.30% of all absence episodes

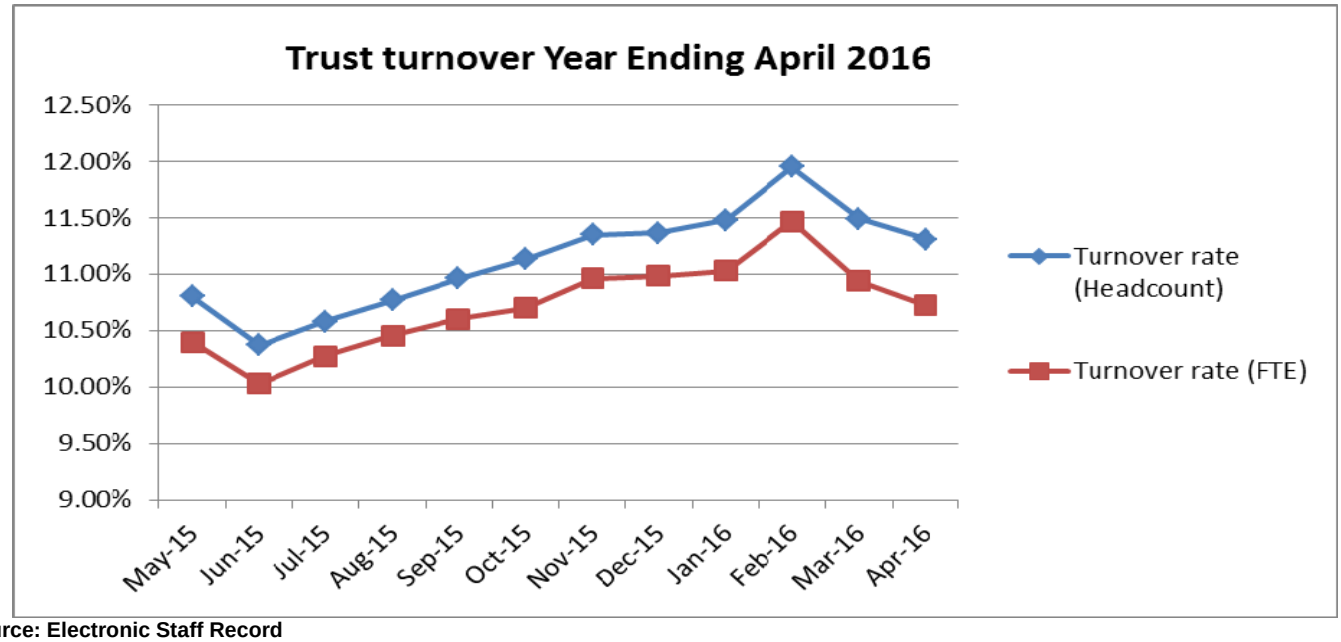
2.2 Turnover

The turnover rates shown below exclude all staff on fixed term contracts, including all junior doctors on rotational contracts. This is a common convention used across the NHS for calculating turnover. The figures also exclude staff subject to TUPE.

There was a further slight reduction in the annual turnover rate in April 2016. Based on full time equivalent leavers the annual turnover rate in April 2016 was 10.72%; based on headcount the rate was 11.31%. This equates to 886 leavers in the 12 month period.

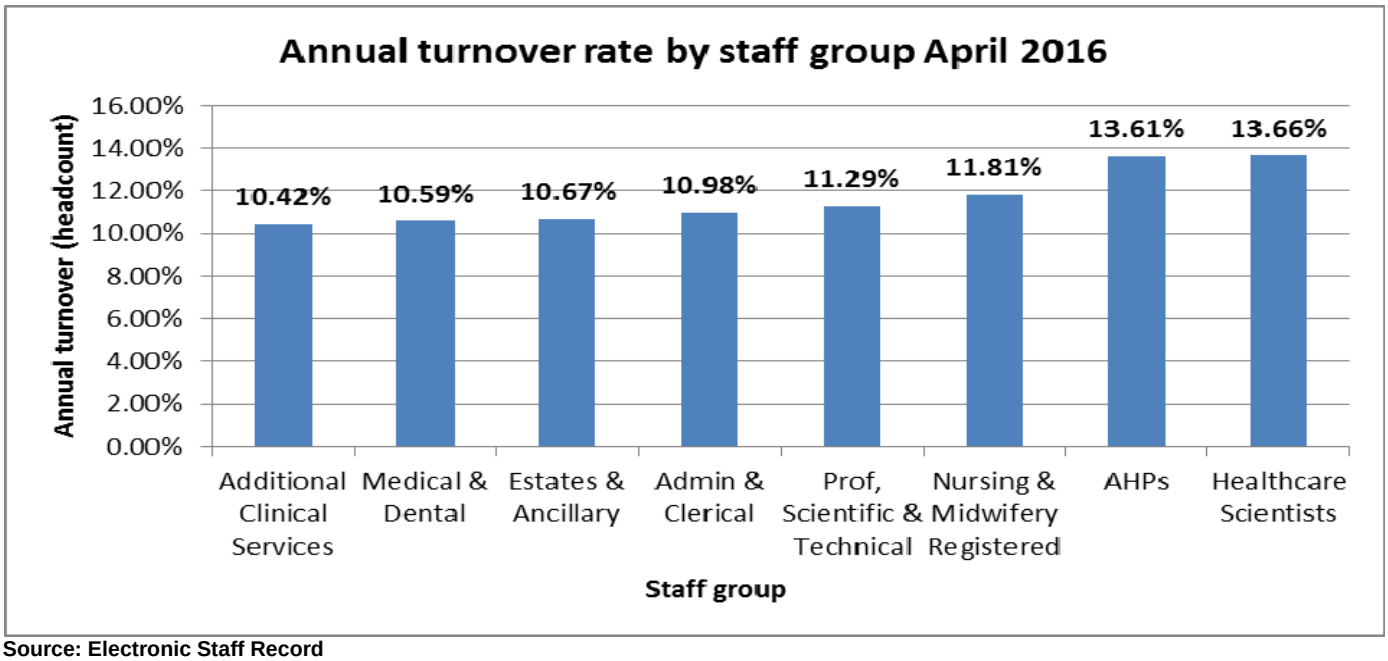
Almost 70% left due to voluntary resignation and around a quarter left due to retirement, including flexible retirement. Almost 3% of leavers left through the mutually agreed resignation scheme (MARS) or redundancy and a similar figure due to dismissal.

Graph 3 – Overall Turnover Rates



Source: Electronic Staff Record

Graph 4 – Turnover by staff group



Source: Electronic Staff Record

The two staff groups with the highest rates of turnover are Allied Health Professionals and Healthcare Scientists.

The turnover rate of 13.61% amongst AHPs represented 75 leavers. The retirement rate amongst this group is lower than the rate across the organisation, accounting for fewer than 18% of leavers. This is reflective of the age profile of this particular staff group. Voluntary resignation due to relocation was the leaving reason in more than a fifth of cases.

Healthcare Science is a smaller staff group and the turnover rate of 13.66% represents 28 leavers. The retirement rate in this group was the same as the organisation rate. The MARS accounted for 14% of leavers from this group.

2.3 Medical Workforce – Junior Doctor Contract

From 9th to the 18th May there was a pause to the implementation of the junior doctor contract to allow for negotiations to continue facilitated by ACAS. The purpose was to resolve the outstanding issues taken forward from previous discussions finalise and confirm areas already agreed, and develop further measures that address the wider concerns of junior doctors. In summary these include:

- a new approach to pay and reward;
- actions to support equality dimensions of the contract;
- refinements to previous rota rules;
- improvements to flexible pay premia (FPP) and other terms;
- clarification of the role of the guardian;
- commitments from HEE and GMC.

This new agreement is subject to formal agreement by the BMA members.

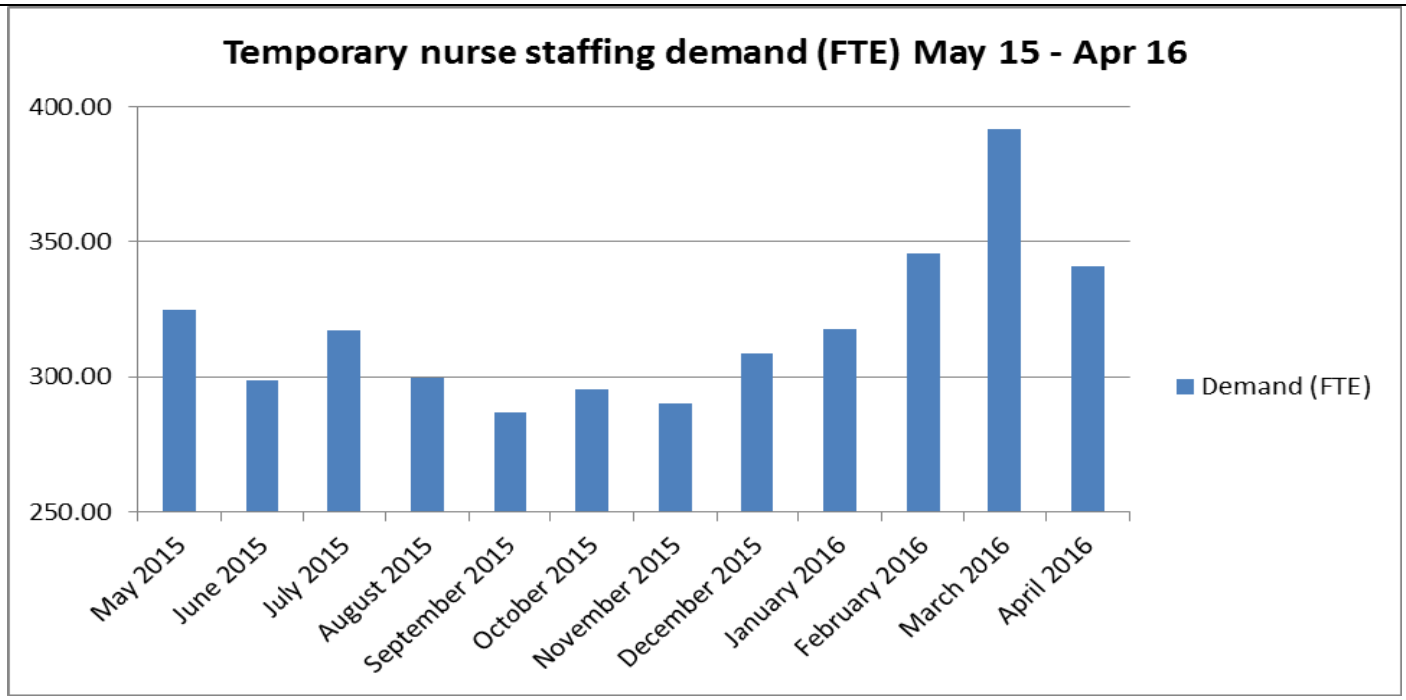
The Trust's appointment of the Safer Working Guardian was made during May. Seven applicants were shortlisted from a total of fourteen applications. The Assessment Centre was conducted on 17th May with three applicants brought forward for formal interview on 19th May. A third stage selection process is currently being arranged for some time in early June. As specified in the Junior Doctor contract a junior doctor was involved in the selection of the candidate. Clarified over the past few days the guardian will report to the Board at least once a quarter. It will include data on all rota gaps on all shifts. A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps should be included in a statement in the Trust's Quality Account, which must be signed off by the Trust Chief Executive.

2.4 Temporary staffing

Temporary nurse staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has on average equated to around 318 FTE staff per month. This increased to more than 390 FTE in March 2016 but reduced again in April 2016 to 341 FTE.

Graph 5 – Temporary nurse staffing demand



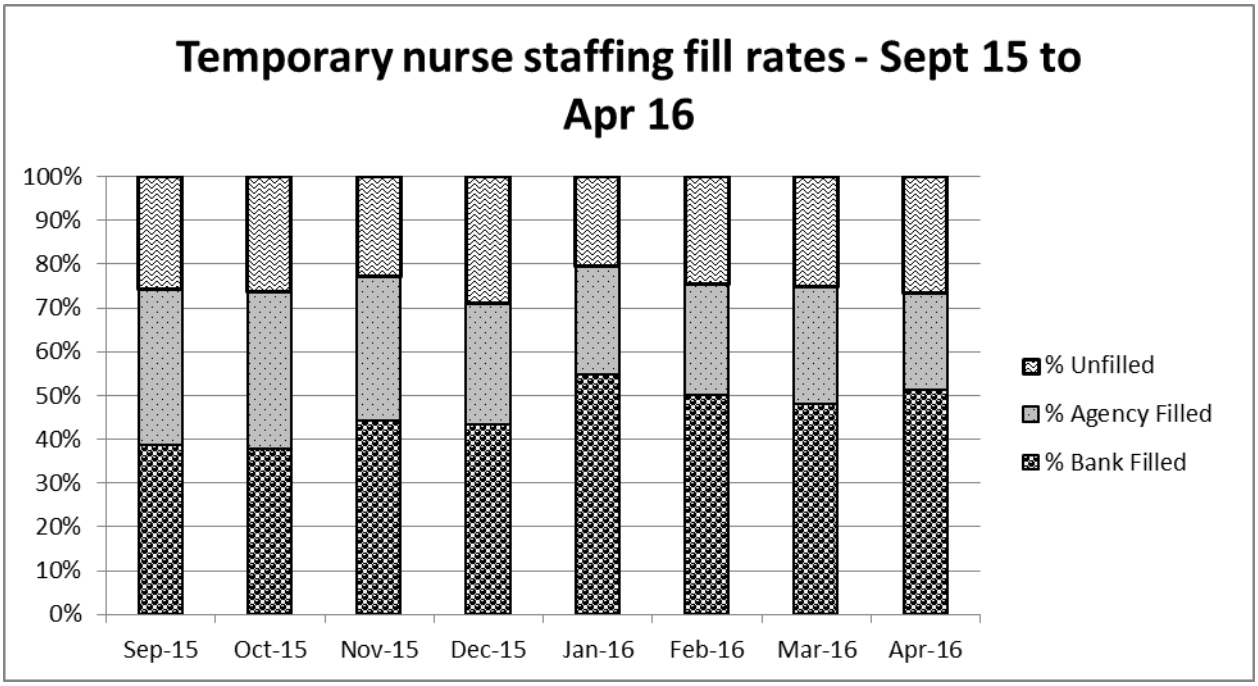
Source: HealthRoster

In November 2015 new incentives were introduced for undertaking work on the internal nurse bank. This had an immediate positive impact on the proportion of temporary staffing requirements filled by bank. This has continued into the current calendar year and in the first four months of 2016, average bank fill rates have been above 50%.

There is a differential in bank fill rates between sites with the average bank fill rate at Scarborough being 63% in the first four months of the year and at York the average bank fill rate being 41% over the same period.

Agency fill rates reduced by 4.7% between March and April 2016 from 26.68% to 21.98%. This and the reduction in demand is likely to be a reflection of both seasonal variations and enhanced levels of scrutiny on temporary staffing requests at a senior level within the nursing team.

Graph 6 – Nursing Temporary Staffing Fill Rates



Source: HealthRoster

Agency usage reporting to NHS Improvement

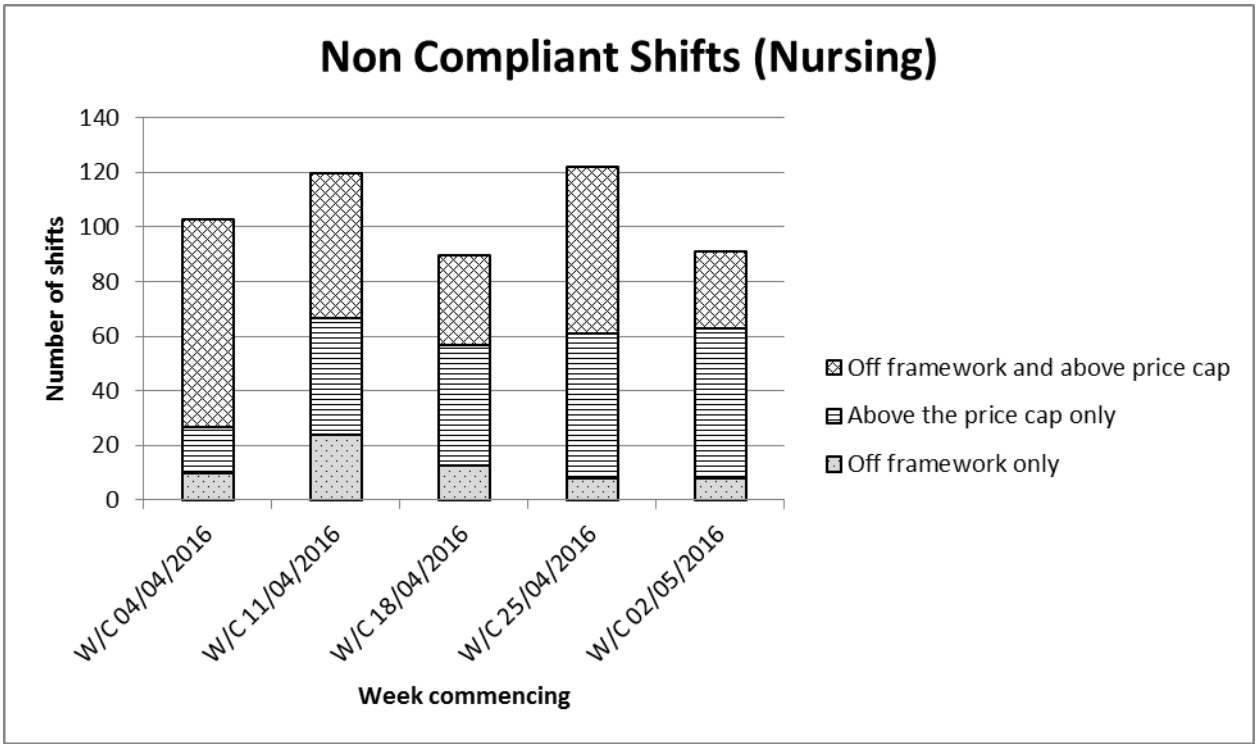
There continues to be a requirement to report on a weekly basis to NHS Improvement all agency usage which is not compliant with the rules that have been introduced in phases since November 2015. The third and final phase was introduced on 1st April 2016. These rules relate to use of off framework agencies and price caps on agency use for all staff groups.

All shifts and bookings which are required to be reported to NHS Improvement are subject to senior level scrutiny and are only approved where there would be a patient safety implication of leaving the shift unfilled. Retrospective review of all the shifts breaching the new regulations will be considered weekly by the Executive Team. Allocation of the Transformation and Sustainability monies is dependent on demonstrating compliance with the rules.

Teams across HR, senior nursing, procurement, operations and finance continue to work closely to ensure compliance with the rules, including negotiations with agency suppliers.

Since the introduction of the final phase of the rules in April, there has been a significant reduction in usage of off framework agency for supply of temporary staffing as shown in the graphs below. Those shifts categorised as 'above the price cap only' are shifts which are booked with agencies on an approved framework but whose rates are still to come in line with the caps. NHS Improvement guidance to agencies is that they must demonstrate plans and actions to come in line with the capped rates by November 2016. However, Trusts are still required to report these shifts in their weekly submission.

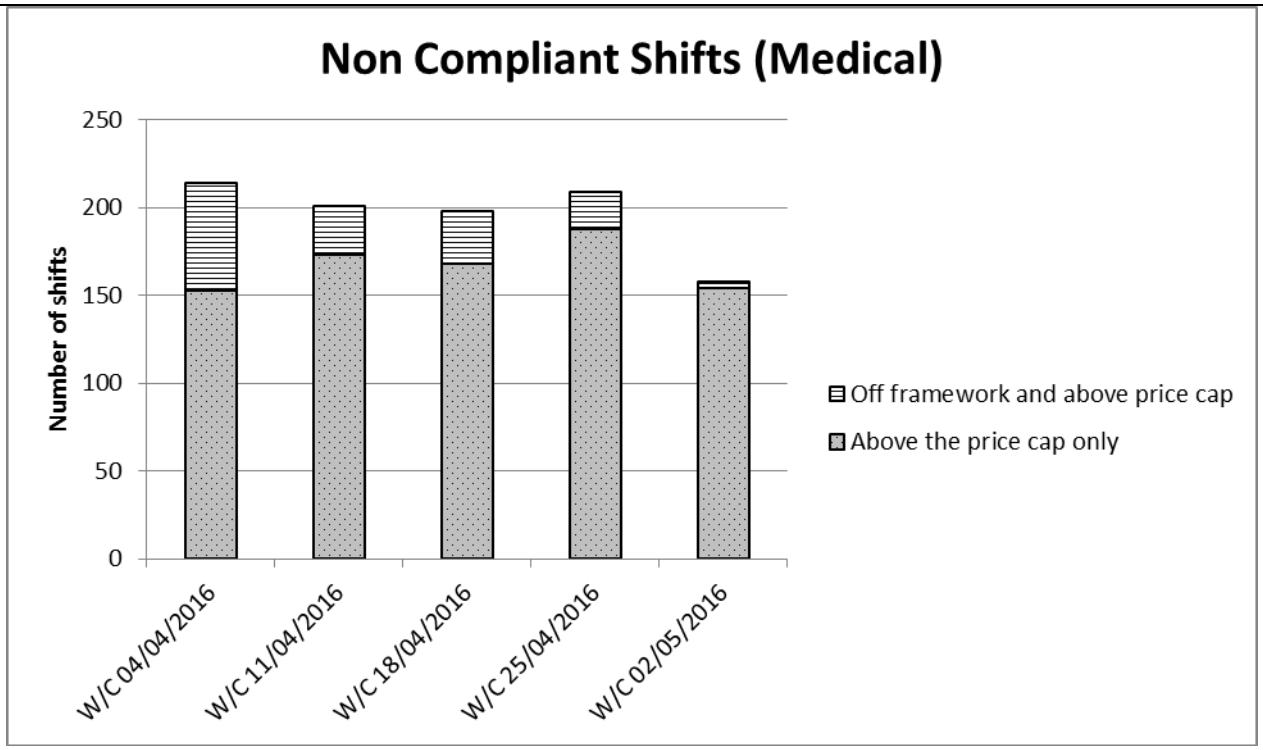
Graph 7 – Non compliant nursing agency shifts April 2016



Source: HealthRoster

As the following graph shows there has also been a significant reduction in off framework shifts for agency usage to cover temporary medical staffing requirements in the last month.

Graph 8 – Non compliant medical agency shifts April 2016



2.5 Employee Relations Activity

The table below describes the number and type of employee relations activity in each of the last three months.

Employee Relations Activity	**Feb 2016**	**Mar 2016**	**Apr 2016**
Number of Disciplinaries (including investigations)*	12	9	13
Number of Grievances	13	11	13
Number of Formal Performance Management Cases (Stage 2 and 3)*	5	6	6
Number of Employment Tribunal Cases*	4	4	3
Number of active Organisational Change cases in consultation (including TUPE)	7	8	8
Number of long term sick cases ongoing	224	234	222
Number of short term sick cases (Stage 2 and 3)	153	136	134

*denotes staff on medical and dental terms and conditions are excluded from the figures as these are reported by the Professional Standards Team (MHPS).

2.6 Staff Survey 2015 – Corporate Action Plan

Information has been added to Staff Room which gives an overview of the results of the Staff Survey 2015 and supporting materials for the five areas for improvement that have been identified and that the Trust is asking people to take action on. These materials were shared in April at HR Drop In sessions at both York and Scarborough and have been displayed on the communications board at York Hospital with an opportunity for staff to leave suggestions in a box. Staff have been asked to think about questions relating to the five areas via one of the weekly communications bulletins in April.

The Trust's Chairman has also produced an article on appraisals (one of the five areas for improvement) which will be published in Staff Matters shortly.

2.7 Recruitment

The Trust held its first large scale Trust wide recruitment market place event on Saturday 23 April 2016.

This was hugely successful with more than 400 attendances on the day and hundreds of interactions on Facebook in the build-up to the event. There were enquiries about a diverse range of roles within the Trust, from people living both locally and much further afield.

On the day, Health Care Assistant events had around 114 attendees and 33 staff nurse interviews were conducted from which 31 appointments will be made.

Those attending the event were able to take part in tours of Emergency Department, Intensive Care Unit and Theatres and also able to visit the Simulation Suite.

The event was such a success that there are plans to hold more in the future, the next being planned to take place in Scarborough in September 2016.

2.8 Appraisals

Internal Audit recently undertook a review of the Trust's appraisal process, the outcome of which was an opinion of 'significant assurance' on the extent to which the appraisal process is being effectively complied with across the Trust.

The findings of the report included that; there are effective systems and processes in place to ensure Trust staff are appraised annually; there are clearly defined lines of accountability relating to staff appraisals; the new Appraisal Guidance document is readily available and provides expectations form the appraising of all staff on Agenda for Change; a review of a sample of staff found that in 77% of cases an appraisal had been completed and that there is an effective system in place to monitor and report appraisal activity and results.

2.9 Workforce Planning Return

Each year the Trust is required to submit to Health Education England Workforce Planning Return detailing planned workforce requirements for the following five years. This return is intended to inform decisions on commissioning of education and training places. This year's return has been requested in two parts. The first part is a demand forecast only for the next year, i.e. what we expect our staffing demand to be in March 2017. The remainder of the return for demand forecasts up to 2021 and responses to a collection of narrative questions about our workforce strategy and plans for the shape of the workforce, new roles etc., is to be completed later this year.

A summary of the return will be provided to the Board once it is complete. The return will need to reflect changes in the workforce which are required in order to deliver the recommendations in the Carter report.

3. Conclusion

This report has detailed key workforce metrics highlighting any issues or trends. In those areas

where there are issues, actions which have already been identified have been detailed. The impact of actions will become apparent in subsequent reports.
4. Recommendation
The Board of Directors is asked to read the report and discuss.

Author	**Polly McMeekin, Deputy Director of Workforce**
Owner	**Patrick Crowley, Chief Executive**
Date	**May 2016**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 May 2016

Workforce and Organisational Development Strategy

Action requested/recommendation

The Board is asked to approve the Workforce and Organisational Development Strategy.

Summary

This strategy sets out our vision as an organisation for the next 5 years to ensure our workforce is fit for purpose to deliver our ultimate objective.

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

Regulation 18: Staffing.

http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf

Progress of report	Workforce Strategy Committee – 18 May 2016
Risk	No risk.
Resource implications	No direct resource implications from the strategy.
Owner	Michael Proctor, Deputy Chief Executive
Author	Michael Proctor, Deputy Chief Executive
Date of paper	May 2016
Version number	Version 7

York Teaching Hospital NHS
NHS Foundation Trust

Workforce and Organisational Development Strategic Aims and Objectives

Foreword

This strategy sets out our vision as an organisation for the next 5 years to ensure our workforce is fit for purpose to deliver our ultimate objective:

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

We need our workforce to be motivated and driven to put our patients at the centre of everything we do. To achieve this we need to attract good people to work for us who live the values of the organisation and keep them working for us through development opportunities at every level that maximises every individual's potential. We want our staff to have a sense of wellbeing which is built upon the celebration of the privilege we are given to touch people's lives.

We are facing unprecedented challenges which require us to embrace and adopt different ways of working which deliver new models of care. We believe that this strategy provides the framework to help us achieve this and to ensure our organisation becomes an even better place to work within for all our staff and for many to provide an employment 'home' for their entire working lives.

An Excellent Place to Work

To ensure our organisation continues to develop and is an employer of choice

Strategic Aim		Objectives	
	Values and Behaviours Ensure the Trust values and behaviours - Caring about what we do; respecting and valuing others; always being helpful and listening in order to improve are embedded within the culture.		• Fully utilise values based recruitment to recruit the right people. • Embed the Trust values and behaviours in the employee induction; appraisal, training process and leadership & development programmes. • Develop and empower our leaders to role model the Trust values.
	Personal Responsibility Develop a culture of personal responsibility by rewarding staff for their performance.		• Ensure the Incremental Pay Progression Policy remains current and is fully utilized. • Extend the roll out of the Incremental Pay Progression policy so it is equitable for all staff.
	Culture of Transparency Embed a culture of honesty and openness where staff are able to reflect on their practice and learn from mistakes.		• Cultivate a culture of safety. • Maximise opportunities to learn from mistakes and share best practice. • Embed a culture free from bullying and other oppressive behaviours.
	Equality and Diversity Embrace diversity and equality of opportunity to ensure the Trust is truly reflective of the population we serve.		• Engage staff in the equality agenda and work in partnership with our trade union colleagues to develop shared objectives. • Fully embrace the Equality and Delivery System (EDS2) and Race Equality Standard to benchmark and develop targeted action plans. • Provide greater visibility of the Trust's Fairness Forum.

Recruitment and Retention

To creatively attract **and retain** the right people to work in our Trust, in the right places at the right time

Strategic Aim	Objectives
Developing our capability and capacity to deliver services seven days per week Develop the optimal skill mix to deliver high quality services seven days per week	• Maximise the benefits and efficiencies presented by utilising eRostering. • Foster a transparent, fair and honest job planning process which flexes to the evolving needs of the service.
Staff Engagement Retain our workforce by improving staff engagement	• To listen and act on feedback from staff to further enhance service delivery. • Recognise each individual employee's contribution throughout the annual appraisal process and their future aspirations to be reflected in local succession planning. • Fully implement the Freedom to Speak Up recommendations. • Senior management to be visible and approachable. • Continue to develop a comprehensive approach to staff reward and recognition to further enhance the psychological contract.
Recruiting the best Develop innovative recruitment practices	• Develop innovative recruitment practices (including social media) to attract candidates to the Trust. • Improve the flexibility of the workforce by incentivising the internal Bank. • Fully utilise and support volunteers to enhance the patient experience.

Health and Wellbeing

To improve the health and wellbeing of our workforce

Strategic Aim	**To enhance the health and wellbeing of our workforce**	**Objectives**	• Promote and deliver proactive interventions to encourage a healthy lifestyle. These include encouraging physical activity and safeguarding against mental health illness and musculoskeletal injuries. • Fully participate in the national Healthy Workforce pilot sharing and implementing best practice from across the NHS. • Provide a safe and supportive working environment. • Work in partnership with Occupational Health and trade unions to develop innovative flexible working practices. • Support line managers in the management of sickness absence whilst reducing presenteeism. • Increase flu vaccination uptake for clinical staff. • Lead by example by offering healthier food options (hyperlink to Food & Drink strategy). • Enhance the patient experience by creating artwork and utilising art to improve the environment (hyperlink to Art Strategy). • Provide learning opportunities both within leadership programmes and as free standing events to raise the awareness and understanding of the role of leaders in maintaining their own & their team's resilience and ability to respond to on-going change in the organisation /wider H&SC system. • Provide the opportunity for leaders to develop & explore the contribution that they make in supporting staff to maintain their own wellbeing.

Learning

To develop a learning environment that supports our current and future workforce development

Strategic Aim	Objectives
NHS Workforce of the Future Support the development of education and training for undergraduates and apprentice level through to postgraduates to develop the optimal skill mix to deliver high quality care in the organisation/system through engagement of all staff groups. Strive to achieve a position where students recognise the Trust as an Employer of choice in the future. Encourage a culture of learning and practice in a safe environment and to cultivate a culture of safety everyday practice. Learning from patient safety data and good practice case studies.	• Work in partnership with education providers to develop innovative new roles to support the workforce of the future. • Maximise capacity within clinical roles by up-skilling support roles (Agenda for Change bands 1-4). • Develop the provision of high quality education practice placements for students • Develop and support our Learning Environment Managers, Mentors, Assessors and Educational Supervisors to ensure they have the appropriate qualifications and skills to support students • Review and act on student/trainee evaluations and feedback. • Implement placement data collection processes and mechanisms to ensure accurate and timely management information & maximize funding potential. • Maximise opportunities to learn from mistakes and share best practice focusing on technical and non-technical skills.
Knowledgeable Leadership Provide leadership development opportunities that reflect current best practice in leadership & address the current requirements of the organisation and wider health and social care system to improve services and health outcomes for patients. Develop specific “System Leadership” programmes & related OD interventions in partnership with colleagues throughout the Heath, Social Care, voluntary sector and wider community.	• Provide a range of leadership development programmes that are designed meet the needs of the developing leaders at all levels in the organization and local health and social care system. • Listen and act on feedback from staff and patients to further enhance service delivery. • Adapt training delivery opportunities to meet the demands and needs of the workforce in the organisation. • Maintain links with external leadership providers, (NHS Leadership Academy) and signposting staff to appropriate programmes.

Developing our Staff and Our Organisation

To provide first class learning and development enabling our staff to maximise their potential.

Strategic Aim	**Create an empowering culture of learning and development in our workforce** Develop a workforce fit for purpose & constantly striving to achieve the best for patients, service throughout the organisation/system.	**Objectives**	• Embrace workforce redesign and re-skill mix to support new models of care (e.g. Calderdale). • Implement a Talent Management programme through PDR identification to support workforce development. • Support a 'grow our own' strategy and programme to release and support those staff suitable and willing to progress. • Establish a central mechanism to enable the workforce equity of access to learning and development opportunities that meet role/personal objectives, and organisational requirements. • Ensure robust delivery of education and training and broaden the ways into training and development, especially to attract more young people and improve diversity within the workforce. • Provide access to a range of development opportunities that supports the creation of culture of empowerment including 1:1 coaching; partnership coaching; team coaching; health coaching; OD consultancy, action learning sets, leadership development programmes, 'Effective Conversations' and 'Quality Improvement Learning'.

	Implementation of a development programme for all support staff Ensure all support staff feel valued, and have the skills and competencies to effectively contribute to service delivery.		• Every support worker to have an annual appraisal and personal development plan that reflects their needs and aspirations, over and above mandatory training requirements. • Produce a development programme for support staff, based on identified needs. • All managers of support staff to be appraised on their performance in delivering these plans. • All HCAs/GSWs recruited that are 'new to role, new to care' to achieve the Care Certificate within the nationally recommended timeframe. • Use appraisals as a means to assess Care Certificate standards for existing front line support staff.
	Get In, Get On, Go Further The Trust is committed to the development of its support workforce, and widening participation through increasing employment opportunities for the local population.		• Implement approaches to support and encourage our local population to view the Trust as: • A provider of a broad range of clinical and non-clinical, high quality, apprenticeship opportunities. • A provider of education and training programmes to ensure Care Support Workers meet nationally recommended training standards e.g. all Care Support Workers to be given the opportunity to be trained and achieve the national Care Certificate. • Supportive of those staff that wish to develop their NHS career and enable greater numbers and diversity of support staff with qualifications. • Use apprenticeships and higher apprenticeships to develop staff into more senior support roles and registered professions. • To work in partnership with clinical educators, specialist nurses, managers and other health professionals to develop innovative ways to support training and development of a workforce constantly striving to achieve the best for patients, service and organisation.

	Continue with, and further develop, established partnership working Working with regional and local partners to ensure that the healthcare support workforce receives the investment and development it needs, be highly skilled, and flexible, able to meet the future healthcare challenges.		• Commit to recruiting and developing our support workforce giving them new skills and competencies that will equip them for the future and provide real opportunities for those who wish to progress. • Support the national strategic framework Talent for Care and work in partnership to deliver its key strategic intentions.

Research

Creating new knowledge through research and share this widely

Strategic Aim	Objectives
Strengthen the research culture within the Organisation	• Encourage a 'Curiosity Culture' within our organisation to inspire staff to practice evidence based care and to develop new knowledge • Develop research champions within our teams • Publicise and celebrate our research activity widely
Actively encourage staff to pursue research	• Recruit and retain research enthusiastic and research active staff • Encourage mentorship from the more experienced to the new researchers • Provide effective research supervision • Whenever possible find ways to say 'yes' to research proposals
Create opportunities for patients and their families to be informed about and be involved in research	• Publicise research programmes in relevant areas and make the opportunity to be involved in research clearly visible and available to our patients and their families.
Work in partnership with the Yorkshire and Humber Clinical Research Network to deliver our recruitment targets	• Agree a target that balances the need of the Network and maintains the financial stability of the department • Deliver research recruits to time and target • Develop a flexible research workforce that delivers high quality research and accepts that funding relies on recruitment to studies.
Build our relationship with local universities and colleges	• Explore and develop research opportunities with local academic institutions • Explore the possibility of creating clinical academic posts

	Increase income through commercial research		• Develop our reputation for delivery to time and target to attract commercial research studies • Identify and develop our specific opportunities in ophthalmology and other specialist areas

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The Golden Thread

Susan Symington
Chair

York Teaching Hospital NHS
NHS Foundation Trust

Board Time Out

22 January 2016

At our Board Time Out in January we reviewed our organisational strategy:

- Our mission
- Our values
- Our ambitions for the 5 years ahead

York Teaching Hospital NHS
NHS Foundation Trust

Our Commitment to You Refresh

The output of the Time Out was a refresh of Our Commitment to You: a brief, high level strategic document which can be shared both internally and externally.

Our ultimate objective was refreshed,

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

in line with The Five Year Forward Plan and the development of Sustainability and Transformation plans where the emphasis is on collaboration with partners.

York Teaching Hospital NHS
NHS Foundation Trust

Our Values

Our values, which describe the behaviours we expect from all of our staff remain unchanged.

We put patients at the centre of everything we do, by…

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

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Our ambitions for the five years ahead

Our ambitions have changed and developed, and are based on 4 truths which are captured in 4 ambitions.

- **Our patients trust us to deliver safe and effective health care -** *our quality and safety ambitions*
- **Our sustainable future depends on providing the highest standards of care within our resources -** *our finance and performance ambitions*
- **The quality of our services is wholly dependant on our teams of staff -** *our people and capability ambition*
- **We must continually strive to ensure that our environment is fit for our future -** *our facilities and environment ambition.*

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The work of the Board

The refresh of Our Commitment to You has enabled us to start to frame the work of the Board around our clearly stated ambitions.

- **The Board agenda is arranged under the 4 ambitions**
- **The vital sub-committees of the board each focus on one of the 4 ambitions**
- **The refreshed Board Assurance Framework is arranged under the 4 ambitions**

Our aim is to ensure that all of the work of our Board, is clearly focussed and directed at the achievement of our 4 key ambitions.

York Teaching Hospital NHS
NHS Foundation Trust

Our Commitment to You & The Well Led Review

The development of Our Commitment to You chimed with the Well Led Review.

We received the final report from our Well Led review on 29 January, which included 21 recommendations. The first four, below , were described as urgent.

- *Produce a document translating the Trust's vision and values, and strategic priorities from the integrated business plan, into a set of strategic objectives, supported by measurable outcomes.*
- *Consult internally and externally on the proposed strategic objectives.*
- *Publicise and cascade the final set of strategic objectives throughout the organisation, so they can form the basis of directorate, team and individual objective setting.*
- *Use the new strategic objectives as the starting point for a new board assurance framework.*

York Teaching Hospital NHS
NHS Foundation Trust

Our Commitment to You, The Well Led Review and Appraisal

As the work of our Board is increasingly focussed on the achievement of our 4 ambitions, it has been logical to focus the **annual performance review** of each individual member of the Board under the 4 ambitions: To date the Chair, the Chief Executive, the NEDs and shortly the Executives will all have their annual objectives expressed under each of these 4 ambitions.

York Teaching Hospital NHS
NHS Foundation Trust

Annual Objectives 2016-17. The Chair

Quality and Safety Ambitions Our patients must trust us to deliver safe and effective health care including, integrated care, separation of acute and elective care, patient safety, improved emergency care, innovative approaches and listening to patients	**People and Capacity Ambitions** The quality of our services is wholly dependant on our teams of staff including recruitment, retention, wellbeing, learning and development and research
• Ensure that the trust has clear strategic plans in all areas which are focused on the sustainable long term future of our trust. • Ensure that the board monitors these plans • Ensure that the board as the very best governance processes to ensure awareness of the major risks to the achievement of our strategic plans. • Ensure that the trust follows up effectively on external reviews including the CQC inspection and the Well Led Review. • Listen to what our patients say. • Ensure that our trust is proactively involved in the production of our STP and provides 2 excellent chapters to our Sustainability and Transformation Plan and ensure the board monitors resulting action.	• Ensure that the trust has clear strategic plans in all areas which are focused on the sustainable long term future of our trust. Ensure the board monitors these plans. • Work with the chief executive and all board members to ensure we have an excellent board of directors, including learning and development plans and succession plans for the board. • Work with the lead governor to ensure that the council of governors are well led and well informed • Work with the council of governors to ensure the recruitment of new governors in September. • Work with governors to ensure a growing membership of our trust. • Listen to what our staff say.
Finance and Performance Ambitions Our sustainable future depends on providing the highest standards of care within our resources including financial stability, best value for money and time, technology, exceed national standards, plan with ambition	**Facilities and environment ambitions** We must continually strive to ensure our environment is fit for the future including the community overall, privacy and dignity of patients, the environment and facilities and premises.
• Ensure that the trust has clear strategic plans in all areas which are focused on the sustainable long term future of our trust. • Work with the board to ensure the trust meets all agreed standards of care • Work with the board to ensure the trust meets all financial targets • Ensure the board monitors these plans • Ensure that the board maintains oversight of the integration in work which relates to CIPs, Carter and the TAP programme.	• Ensure that the trust has clear strategic plans in all areas which are focussed on the sustainable long term future of our trust. • Ensure the board monitors these plans. • Support the development of all our sites to provide improved services for our patients.

York Teaching Hospital NHS
NHS Foundation Trust

Annual Objectives 2016-17. The Chief Executive

Quality and Safety Ambitions Our patients must trust us to deliver safe and effective health care including, integrated care, separation of acute and elective care, patient safety, improved emergency care, innovative approaches and listening to patients	**People and Capacity Ambitions** The quality of our services is wholly dependant on our teams of staff including recruitment, retention, wellbeing, learning and development and research
• To ensure the trust has strategic plans to achieve these ambitions. • To strive to lead the organisation in the achievement of the highest standards of patient care and patient safety. • With executive colleagues, to lead the follow up work in relation to the Well Led Review • With executive colleagues, to lead the follow up work in relation to CQC report • With executive colleagues, to lead the strategic development of our chapters of the Sustainability and Transformation Plan. • With executive colleagues, to lead the reform and improvement of emergency care for the benefit of our patients. • To listen to feedback from our patients. • To support the Chief Nurse and the Medical Director to deliver safe and effective care.	• To ensure the trust has strategic plans to achieve these ambitions • To strive to create a working environment where every member of staff is valued and has opportunities to learn and develop. • To develop, support and challenge all of the executive director team. • Working with executive colleagues, ensure the recruitment of the right people in the right places at the right time • Work with executive colleagues to ensure appropriate action is taken as a result of our 2015-16 Staff Survey. • To listen to feedback from our staff. • Work with board colleagues to raise the profile of the board internally.
Finance and Performance Ambitions Our sustainable future depends on providing the highest standards of care within our resources including financial stability, best value for money and time, technology, exceed national standards, plan with ambition	**Facilities and environment ambitions** We must continually strive to ensure our environment is fit for the future including the community overall, privacy and dignity of patients, the environment and facilities and premises.
• To ensure the trust has strategic plans to achieve these ambitions • To strive to lead our trust to sustainable financial balance at the year end • Supporting the Finance Director in the achievement of our financial targets • Supporting the Chief Operating Officer in the achievement of our performance targets. • Supporting our Director of IT in the development of technology which enables us to achieve our plans. • Working with colleagues, support the integration of the work which relates to CIP, Carter and TAP. • To lead the strategic thinking in our chapters of the Sustainability and Transformation Plan.	• To ensure the trust has strategic plans to achieve these ambitions • To support the Director of Estates and Facilities in the achievement of our strategic capital plans • To lead the strategic work with relates to the separation of elective and acute activity in Scarborough. • To lead the strategic work which relates to the development of Bridlington Hospital.

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Annual Objectives 2016-17. The Non Executive Directors.

Quality and Safety Ambitions Our patients must trust us to deliver safe and effective health care including, integrated care, separation of acute and elective care, patient safety, improved emergency care, innovative approaches and listening to patients	**People and Capacity Ambitions** The quality of our service sis wholly dependant on our teams of staff including recruitment, retention, wellbeing, learning and development and research
• Continued monthly chairing of this formal sub committee of the board by a NED. • Continued commitment to Patient Safety Walkabouts including night time walkabouts. • To scrutinise follow up work in relation to the Well Led Review • To scrutinise follow up work in relation to CQC report • To support the development of our chapters of the Sustainability and Transformation Plan. • A commitment to reforming and improving emergency care in our trust for the benefit of our patients.	• Continued bi-monthly chairing of this formal sub committee of the board by a NED. • A commitment to working with and supporting the executive to ensure assurance to the board. • To support the chair in the recruitment of new Governors in September. • To work together to ensure the smooth retirement of Philip Ashton from the board, particularly in relation to the Audit Committee. • Leading succession planning for the NED Team. • Chairing recruitment panels • Chairing appeal panels • To raise the profile of the board internally • To monitor progress as a result of our 2015 Staff Survey. • To continue to support executive colleagues throughout the trust.
Finance and Performance Ambitions Our sustainable future depends on providing the highest standards of care within our resources including financial stability, best value for money and time, technology, exceed national standards, plan with ambition	**Facilities and environment ambitions** We must continually strive to ensure our environment is fit for the future including the community overall, privacy and dignity of patients, the environment and facilities and premises.
• Continued monthly chairing of this formal sub committee of the board by a NED. • Interrogation of finance and performance information • A commitment to supporting the integration of the work which relates to CIP, Carter and TAP.	• Continued bi-monthly chairing of this formal sub committee of the board by a NED. • A commitment to separating elective and non elective activity in Scarborough. • Continued commitment to Patient Safety Walkabouts including night time walkabouts

York Teaching Hospital NHS
NHS Foundation Trust

The Golden Thread

Our aim is to make explicit the golden thread through our organisation which **connects our strategic purpose and ambitions, to the day-to-day work of our board, our directors and in time, all of our staff.**

An identifiable golden thread running through our organisation is at the very heart of the principles of the Well Led and organisational performance.

York Teaching Hospital NHS
NHS Foundation Trust

Making it happen….

Enabling this golden thread to link our strategic ambitions to our day to day activities requires us to:

- Communicate, effectively
- Share, openly
- Measure, effectively
- Celebrate!

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Finance and Performance Committee – 17 May 2016 - Boardroom, York Hospital

York Teaching Hospital NHS Foundation Trust

Attendance: Mike Keaney, Chairman, Michael Sweet, Andrew Bertram, Lucy Turner, Juliet Walters, Sue Rushbrook, Steven Kitching, Anna Pridmore

Apologies: Gordon Cooney, Graham Lamb

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes 19 April 2016**	The agenda covered the following AFW and CRR items AFW EF1 DoF1,2, 4,7 CRR CE1 DoF 1-3	The Committee asked for typographical error to be corrected. The minutes included reference to 'trail'; the reference should have been to 'trial'. The remainder of the minutes were approved as a true record of the meeting.		
2.	**Matters arising**		There were no matters arising		
3	**Risk Register**		JW talked about her risk register. She explained the challenges that were currently being managed and outlined the mitigations being put in place. The Committee discussed the revised expectations around the Emergency Department trajectory. JW advised that the Trust had been asked to re-submit trajectories for the year so that it showed the Trust achieving the trajectory of 91.48% (instead of 90%) by the end of March 2017. It was noted by the Committee that the Trust had achieved the submitted trajectory for April. The Committee asked if any further information had been released on the business rules associated	The Committee noted the discussion on risk and were assured that the right risks had been identified in the Chief Operating Officer's register The Committee expressed concern that the business rules	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			with the Sustainability Funding. AB confirmed that there was at present no further detail available around the business rules. He explained that he had recently had a discussion with the Treasury and had understood that work was still being completed on the detail of the rules. AB advised that the Contract terms include '*all penalties will apply that are listed unless the organisation has signed up for the Sustainability Fund and achievement of the control total*, *in which case all penalties will be waived'.* Ambulance Turnround Times (ATT) – AB asked if the ATT should be included in the risk register. LT explained that the Trust's trajectory was to reduce the number of breaches. The Trust had not been required to specify by how many. AB advised that it was not clear at this stage whether any link existed between ATT and sustainability funding. It was agreed that it would be added to the risk register.	had still not been published, but noted the information about the phasing in the contract.	
4.	**CIT Monthly Status summary**		The Committee noted the interim report from the Corporate Improvement Team. It was noted that the TAP programme and the Carter requirements are being incorporated into the CIT programme. AB outlined the projects included in the report, highlighting the first five were key projects that had been discussed at Board. AB advised that there would be a new format report	The Committee was assured by the information included in the report and the comments made.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			provided to the Committee in the next couple of months that will take into account the Carter work. The Committee were advised that the Trust had started to receive further information around the Carter recommendations that had been released and work had begun to consider how recommendations could be implemented. AB commented that engagement with the Carter work was a condition of the Sustainability Fund. **Business Case Activity Report** – AB explained that the report had been included to demonstrate the business cases that were currently being considered. He added that the panels which meet on a bi-weekly basis are being effective and providing some excellent challenge to the development of the business cases.		
5.	**Work Stream 1: Operational Reports**		MK asked JW to update the Committee on the Acute Medical Model at Scarborough. JW outlined how the Trust would promote the new model and described using video and animation productions which would be shown round the Trust. She explained that the approach would be different for different types of patients. JW explained that plans were being worked on and some funding had been secured so that larger scale testing could be undertaken. JW explained that there were some constraints that were being worked through, but it was anticipated that the systems would be put in place over the next six months.	The Committee were pleased to hear the progress that had been made with the development of the Acute Medical Model at Scarborough and noted the challenges and work that still needed to be completed.	JW to update the Board on operational performance including ED performance

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			MK asked why performance in Scarborough had been so good recently (achieving 100%). JW explained that it was just an occasion when everything worked together perfectly. She added that good improvements are being seen in Scarborough and are having an effect. She acknowledged that there were still challenges to overcome, but that the actions that have been put in place are starting to show some benefits. LT presented the operational report. **Cancer –** LT reported that the Trust had achieved all cancer targets in March 2016 and for quarter 4 of 2015/16. She advised that from October there will be some further breach allocation guidance in place that will change the proportion of breaches or non-breaches that are attributable to the Trust when patients are transferred form one Trust to another. LT reported on the weekly conference call that is taking place with the Cancer Pathway Teams at Hull and East Yorkshire NHS Trust. She advised that these calls allow the cancer team to flag any delays for patients who have had their care transferred to Hull. **18-weeks** – LT advised that the Trust achieved the incomplete target in April, performance was 92.64% (Target: 92%). She advised that the following specialties failed the	The Committee was pleased to see the continued improvement in delivery of the cancer performance.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			incomplete target :- General Surgery - 89.45% Urology - 89.30% Maxfax - 84.22% She advised that there are no contractual speciality level fines associated with failure of the incomplete pathway in 16/17. LT reported that the Trust submitted an annual Sustainability Fund trajectory to NHSE, which targets 92% performance monthly, on aggregate, with zero 52 week breaches and the Trust is compliant against these standards in April. LT reported that the Trust's admitted backlog has increased by 66 from 3rd April to 1st May (7.4%). The MaxFax admitted backlog has increased by 76 (47.5%) patients in this time period and Urology's has increased by 30 (25.6%). The most notable decreases have been in T&O (-30) and Opthalmology (-13). LT referred to the surgical capacity and reported that it had been severely reduced in April as a result of the restriction on off-framework, over-cap agency staff usage, as well as the 2 days of Junior Doctors strike which included 18 hours withdrawal of emergency care on the 26th and 27th April. She advised that there are currently 10.5 WTE nurse vacancies in surgery at York, and an action plan has been developed and implemented to reduce these vacancies. A proportion of the	The Committee noted the comments. The Committee noted the work that was being undertaken and the challenges that still existed. It was assured by the approach and use of other facilities.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			vacancies have been recruited to, with start dates ranging from June-Sept. In addition, there have been 34 elective cancellations of patients on an 18 week pathway in April (Mar 98) due to bed shortages. All specialties are working through their plans for recovering the unplanned theatre cancellations on their admitted backlogs. Work is still being outsourced to the independent sector in Gynaecology, Orthopaedics, Ophthalmology and ENT. York Urology patients are being offered the choice of Bridlington and York ophthalmology patients are being offered treatment by New Medica in Scarborough; both of these initiatives have seen a higher than anticipated uptake by patients. General Surgery is exploring the possibility of using the private provider Medinet whilst theatre staffing remains challenging. The Committee asked for an update on the completion of the Bridlington Business Case. AB advised that it was planned that the business case would come to the June Board. **Emergency Department -** JW reported on the ED performance, she advised that the Trust's April Sustainability and Transformation Fund Trajectory was 85% and the Trust was compliant with this measure, achieving a combined performance (all types) of 86.73%.	The Committee were pleased to see that the Trust had achieved the trajectory and the improvements that had been made in the ED departments. It was assured by the comments made by JW on the work being undertaken to continue to ensure the Trust provides a sustainable Emergency Department.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			JW reflected on the national performance in Emergency Departments during March and advised that performance was 87.3% with Trust's performance ranging from 68% to 98%. MK asked about the performance of 71% in Scarborough on type 1 patients and asked if it was associated to the Norovirus outbreak. JW advised that it was not related to the closed ward due to Norovirus and explained that it was related to some of the process systems in the department, workforce challenges and sluggish discharge of patients. She advised that the Medical Director is leading a piece of work with the Consultants around senior review. SR explained how the process works once a ward has re-opened and patients can be discharged from the ward. She highlighted that it takes a number of days for the ward to discharge any patients that had been waiting for other stakeholder support when the ward was closed. **Attendances-** JW reported that in April 16 attendance in the ED department across the Trust was 15,129 compared to 16,498 in April 15 (-8.3%), which is also below the average monthly attendances during 2015-16 (16,440). The decrease has been seen in the main EDs where the number is the lowest over the last year, although there has also been a reduction in attendances in UCC/MIUs. **Breaches-** JW advised that the total number of		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			breaches during the month was 2,008 (1,164 admitted, 844 non-admitted) across all sites. The number of patients waiting over 8 hours in A&E decreased from 657 in March to 390 in April (York 182; Scarborough 208); a decrease of 267(41%) or an average of 8.7 per day. **Conversion rate –**JW reported on the number of patients that were seen in the ED department and admitted for treatment. She noted that the rate remained higher in 2015-16 than was seen in 2014-15 and April 16 saw a conversion rate of 27.3% at York Hospital, and 47.7% at Scarborough Hospital. She added that as a result of the transfer of minor illness and injury to the Urgent Care Centre at Scarborough Hospital rate is expected to be higher, due to the nature of attendances in ED itself. (Trust total: 33.1%) **Non-elective Admissions (excluding Maternity and Paediatrics) –** JW reported on the non-elective admissions across the Trust. She advised that in April 16 there were 4,029 admissions, a 5.8% rise when compared to April 15 (3,808). The figures include an increase of 391 admissions (39%) where patients stayed less than 24 hours. The largest percentage rise was seen in GP admissions (1,093 to 1,209; 10.6%). **Workforce –** JW advised that a recent ED specific recruitment campaign for Band 5 nurses had identified 11 applications. **Discharge Liaison Officers (DLO) –** JW advised		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			that all staff had been recruited and would be in place by the end of May. **Front door model (York) –** JW advised that work continues with stakeholders to develop the model. **Impact of ward closures during winter –** MK asked if the Executive Team would have done anything differently over the winter which might have prevented ward closures. JW advised that she had not identified anything. She explained that the Trust will always be subject to ward closures.		
6.	**Work Stream 2: CQUIN delivery**		LT presented the CQUIN status summary report which detailed the 2016/17 CQUIN that had now been agreed. The Committee understood that there were still some final transformational CQUIN discussions to be completed. LT agreed she would update the report for the next meeting and include the values and a view of where the risks to achieving the CQUIN might sit. SR added that the Committee should not forget the benefit to patients that CQUIN brings. She gave the example of the focus on sepsis will help to ensure people are identified and treated earlier.	The Committee noted the work and the challenges that have resolved.	
7.	**Work Stream 3: Finance Report**		AB presented the finance report. He highlighted that at the end of month 1 the Trust is ahead of plan by £0.3m and has a deficit of £0.8m against a planned deficit of £1.1m. AB explained that there is no evidence that expenditure trends have surged forward in the first	The Committee were assured by the information provided in the report and the comments made by AB.	AB to update the Board

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			month of the new financial year and good grip and control measures remain in place. AB referred to the enhanced agency expenditure analysis information included in the report. He explained that a suite of charts have been developed to provide the Committee and Board with more assurance around expenditure in the various agency categories. He advised that the charts indicate that the Trust spent £19,000 less than plan on agency staff and he advised that no further action needed to be taken at this stage. JW added that she would expect to see the use of agency staff drop further as the level of sickness comes down. **16/17 contract issues –** AB advised that the contract have not been sighed as yet, but are in the final stages of being pulled together. Scarborough and Ryedale CCG have agreed to remove the cap on follow-up, but are asking for a clause to be added that mandates the Trust works to the work programme included in the contract. He added that a Heads of Terms document is being formed which will also include the requirement to undertake timely reconciliation of monthly activity.		
8.	**Work Stream 3: Efficiency Report**		SK presented the report. He advised that the overall delivery for April 2016 is £1.0m which is 3.8% of the overall annual target. He advised that the position last year at April 2015 was £1.7m. The in-year planning position shows a gap of £8.5m	The Committee noted the disappointment of the team in the achievements this month and recognised the work that was being undertaken. The Committee were assured by the	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			at April 2016, the gap in April 2015 was £5.3m. Work is underway with the directorates to identify schemes to close the gap. The four year planning gap at April 2016 is £33.2m; the gap in April 2015 was £30.8m. SK advised that there are relatively strong plans in place for years 1 and 2 of the plan with £30.6m worth of plans identified against a target of £42m. The Committee discussed the psyche around the motivation to continue to make savings as it becomes more and more difficult. SK advised that 50% of the savings identified in April 2016 have been delivered recurrently.	plans to address the gaps.	
9.	**Work Stream 3: Service Line Reporting**		SK presented the report on Service Line Reporting. He referred to the reference cost submission and advised that the Trust is required to complete and submit the reference costs to the Department of Health (DoH). SK explained that Board, Audit Committee or an appropriate subcommittee of the Board assurance is a required element of the Reference Cost process. SK explained that the Committee was being asked to agree to discharge responsibility for the completion of the submission to the Finance Director. SK drew the Committees attention to the assurance items included in the paper and the companying	The Committee were assured by the comments made by SK and AB. It was agreed that AB should maintain responsibility for the submission of the Reference Cost information.	AB to update the Board

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			report from PWC. He explained that PWC reviewed all Trust submissions on 3 year cycle. The Trust has been left as one of the last trusts as there have never been any concerns about the reference cost submissions made by the Trust. The Committee agreed that responsibility should be with the Finance Director. The Committee asked to see the action plan from the PWC audit when it was available.		
10.	**Work Stream 3: Head of Business Development**		AB explained that he had asked Sarah Barrows (new Head of Business Development) to provide an oversight of the work she is involved with. The Committee reviewed the report and noted her involvement with the Tender register and the development of the Service Level Agreement Register and standard templates. The Committee noted the development of a private patient strategy and understood it would be a piece of work that would develop slowly and link in with other work the Trust was involved with.	The Committee were assured by the comments made and the associated paper.	
10.	**Work Stream 4: Workforce**		The committee noted the supplementary temporary staffing report.		
11.	**Any other business**		There was no other business.		
12.	**Next Meeting**		The next meeting is arranged for 21 June 2016, location to be advised due to building work being undertaken on 2nd floor.		

Public Performance Report

May 2016

Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**92%**	92.8%	93.8%	94.0%	93.0%	93.8%	93.0%	92.6%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**0**	3	0	0	0	0	0	0
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	Not applicable	**Not applicable**	75.6%	76.3%	77.8%	74.2%	74.0%	73.3%	69.6%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	Not applicable	**Not applicable**	95.2%	95.1%	95.3%	95.3%	95.1%	95.6%	95.3%

Access Targets: Cancer

NB: Cancer Figures Run One Month Behind Due to National Reporting Timescales

Indicator	Consequence of Breach	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Jan	Feb	Mar
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	93.9%	91.9%	95.2%	93.5%	91.7%	94.5%	94.1%
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	91.4%	94.0%	94.8%	95.1%	93.1%	98.5%	94.0%
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	96.2%	99.3%	99.5%	98.6%	99.2%	98.7%	97.9%
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	94.4%	97.3%	95.5%	96.2%	97.1%	94.9%	100.0%
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	99.6%	100.0%	100.0%	99.2%	98.9%	98.8%	100.0%
62 day 1st Treatment	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**85%**	87.8%	85.1%	84.5%	85.8%	84.8%	84.1%	89.3%
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	98.4%	92.0%	97.0%	90.4%	92.0%	90.6%	87.5%
62 Day Consultant Upgrade	General Condition 9	**85%**	50.0%	-	-	-	-	-	-

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**95%**	88.3%	91.5%	87.1%	85.0%	84.8%	83.4%	86.7%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**0 > 30min**	539	315	336	590	213	223	154
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**0 > 60min**	415	139	190	611	217	224	170
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q1 15/16**	**Q2 15/16**	**Q3 15/16**	**Q4 15/16**	**Feb**	**Mar**	**Apr**
	NHS VALE OF YORK CCG	30mins - 1hr	163	88	91	183	73	73	55
		1hr 2 hours	114	47	74	122	50	47	65
		2 hours +	26	19	18	69	35	13	15
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	152	94	127	184	71	80	51
		1hr 2 hours	101	28	42	128	49	54	30
		2 hours +	28	1	7	40	16	20	12
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	146	82	86	135	53	48	28
		1hr 2 hours	76	23	36	96	34	39	19
		2 hours +	22	1	4	35	12	19	13
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	27	13	10	19	8	7	5
		1hr 2 hours	14	6	2	21	10	8	2
		2 hours +	3	0	0	9	4	4	0
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	1	1	0	2	2	0	1
		1hr 2 hours	0	1	0	2	1	0	0
		2 hours +	0	0	0	1	0	1	0
	OTHER	30mins - 1hr	50	37	22	25	6	15	14
		1hr 2 hours	27	12	6	20	6	8	9
		2 hours +	4	1	1	12	0	11	5
Total number of patients waiting over 8hrs in A&E	General Condition 9	Q1 - Establish baseline	732	431	1060	1656	592	657	390
Trolley waits in A&E not longer than 12 hours	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**0 > 12 hrs**	0	1	18	32	20	12	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%**	97.5%	97.1%	98.4%	To follow	98.9%	To follow	To follow

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**A banding of "Significantly higher that expected" in SHMI using the "Extract Poisson Distribution" method for deriving upper and lower confidence limits, applied to each sub-group reported**	95	98	99	97	96	95	93
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9		107	108	109	107	108	107	107

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**48**	21	14	15	15	5	3	3
Number of Clostridium difficile due to "lapse in care"	Establish baseline and set trajectory	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**(TBC)**	24	16	23	33	15	7	5
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases	**Quarterly:** General Condition 9	**30**	11	9	10	7	2	3	9
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	6	0	0	2	1	0	1
Confirmed cases of MRSA Bacteraemia to be notified to commissioner by next working day	General Condition 9	**100%**	n/a	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 21 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	n/a
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
All High Risk (non-day case) Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95%**	85.1%	85.6%	83.1%	74.0%	69.2%	74.1%	68.1%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95%**	72.2%	75.1%	74.5%	75.0%	73.9%	75.6%	82.2%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**99%**	95.2%	99.4%	99.1%	99.6%	99.6%	99.6%	99.2%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	0	3	3	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	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	9	0	8	4	2	1	8
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	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	205	40	182	210	81	109	48
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%**	97.1%	97.4%	97.9%	98.4%	98.4%	98.5%	98.6%
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%**	99.8%	99.7%	99.8%	To follow	99.9%	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%**	n/a	n/a	Reports currently unavailable from the HSCIC due to a change in system.				
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 - 87% Q2 - 89% Q3 - 91% Q4 - 93%**	89.1%	89.7%	88.7%	91.8%	93.9%	88.8%	86.8%
Delayed Transfer of Care to be maintained at a minimum level	As set out in General Condition 9 - Trust only to be accountable for Health delays.	**<1%**	1476	1459	1754	1872	497	750	566
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	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**	452	486	448	482	169	178	189
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	**End Q2 745; end Q4 721**	2365	2509	2492	2599	885	883	1001
% Compliance with WHO safer surgery checklist	General Condition 9	**100%**	100.0%	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**	419	476	489	466	158	138	1 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**	1435	1491	1551	1530	517	435	1 month coding lag
Reduction in avoidable transfers within the Trust after 10pm. Excludes transfers for clinical reasons or for patients transferred to a more appropriate ward	General Condition 9	**100 per month (Baseline 374; Q1;-330; Q2-280;Q3-250;Q4-220)**	302	258	308	317	123	104	78

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	99.7%	99.1%	99.7%	99.2%	100.0%	98.1%	99.5%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	General Condition 9	**Best Practice Standards**	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced quarterly .						
Immediate Discharge letters - 24 hour standard: Overall Trust Position Monthly report and quarterly audit . Action plan to be provided where the target failed in any one month. 25 cases from SR and 25 cases from ERY.	General Condition 9	**>98% for admitted patients discharged and >98% for A&E patients discharged**	Quarterly audit						
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Rydale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology). 25 cases from SR and 25 cases from ERY	General Condition 9	**Q1 - 94% Q2 - 95% Q3 - 96% Q4 - 97%**	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)	General Condition 9	**Q1 - 90% Q2 - 92% Q3 - 94% Q4 - 96%**	Quarterly audit						
All Red Drugs to be prescribed by provider effective from 01/04/2016	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
All Amber Drugs to be prescribed by provider effective from 01/04/2016	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	87.0%	87.4%	86.9%	85.9%	85.6%	85.2%	86.8%

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
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**	1	0	0	1	1	0	1

District Nursing Activity Summary

Indicator	Source	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	-	2978	3162	3453	3111	1136	950	1025
	Community nurse/service	-	1045	920	1172	1373	417	498	458
	Acute services	-	1274	1095	1220	1263	490	392	381
	Self / Carer/family	-	600	909	789	818	298	268	252
	Other	-	382	339	462	368	133	86	149
	Grand Total	-	6279	6425	7096	6933	2474	2194	2265
Community Adult Nursing Contacts	First	-	4817	4521	5020	5202	1764	1667	1771
	Follow up	-	44236	49597	55696	65682	20404	22376	22902
	Total	-	49053	54118	60716	70884	22168	24043	24673
	First to Follow Up Ratio	-	9.5	10.5	10.9	12.1	11.6	13.4	12.9
Community Hospitals average length of stay (days)	Archways	-	22.5	22.0	22.5	20.9	20.6	18.6	17.0
	Malton Community Hospital	-	20.0	24.3	20.5	19.4	19.2	16.4	16.9
	St Monicas Hospital	-	21.4	19.3	19.3	18.8	32.6	13.5	12.4
	The New Selby War Memorial Hospital	-	24.0	23.6	23.0	20.4	21.3	16.4	14.7
	Whitby Community Hospital	-	20.0	19.2	12.8	0.0	21.4	0.0	0.0
	Total	-	21.9	22.7	21.5	20.0	21.6	16.6	15.8
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	9	13	16	7	8	1
		Emergency	74	85	76	74	19	25	30
	Malton Community Hospital	Elective	41	12	18	13	3	7	3
		Emergency	110	127	114	133	39	47	47
	St Monicas Hospital	Elective	15	13	18	18	4	8	6
		Emergency	40	48	30	33	10	11	12
	The New Selby War Memorial	Elective	66	70	67	73	23	23	27
		Emergency	69	67	71	70	20	24	26
	Whitby Community Hospital	Elective	0	0	0	0	0	0	0
		Emergency	136	133	191	0	0	0	46
	Total	Elective	130	104	116	120	37	46	37
		Emergency	429	460	482	310	88	107	161

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Complaints and PALS												
New complaints this month	41	33	41	37	58	42	38	28	25	40	46	36
Number of Ombudsman complaint reviews	4	1	1	3	1	0	2	1	0	4	0	2
Number of Ombudsman complaint reviews upheld	0	0	0	0	0	0	0	1	0	1	0	0
Number of Ombudsman complaint reviews partly upheld	1	0	0	0	0	1	0	2	0	2	1	2
Late responses this month (at the time of writing)***	2	10	7	4	6	0	8	0	0	0	0	0
Top complaint issues												
Aspects of clinical treatment	27	21	27	29	30	15	30	24	21	39	49	21
Admission/discharge/transfer arrangements	3	1	1	0	5	5	2	3	4	7	10	10
Appointment delay/cancellation - outpatient	2	0	0	2	0	2	3	1	2	1	6	4
Staff attitude	7	3	3	3	6	-	-	-	-	-	-	-
Communications	1	3	2	2	8	5	7	9	13	24	21	14
Other	1	1	2	0	7							
New PALS queries this month	416	498	643	530	631	682	505	450	492	557	443	480
PALS queries at same time last year	369	406	442	488	426	463	392	334	461	432	0	0
Top PALS issues												
Information & advice	155	171	237	233	296	309	202	171	196	211	191	200
Staff attitude	14	23	24	14	19	17	18	13	21	16	9	17
Aspects of clinical treatment	63	72	101	64	76	75	66	53	68	91	48	59
Appointment delay/cancellation - outpatient	35	46	59	39	60	55	49	40	37	28	30	42

**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 recorded as upheld*
****note: if extensions are made in agreement with the complaint, responses are not considered late*

Serious Incidents												
Number of SI's reported	14	12	20	11	16	22	19	13	11	28	21	19
% SI's notified within 48 hours of SI being identified*	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% SI's closed on STEIS within 6 months of SI being reported	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of Negligence Claims	15	12	14	8	14	21	21	15	12	12	12	18
Extension requests made at least 4 weeks prior to deadline of report due date, and reason given is acceptable to CCG (Threshold - 90% by Q4)	2	0	1	0	1	2	3	0	6	0	1	1
Duty of Candour demonstrated within SI Reports (Threshold 100%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of reported SI's, investigated and closed as per agreed timescales**** (Threshold (90%)	85%	83%	93%	100%	92%	94%	75%	100%	71%	100%	100%	93%

* this is currently under discussion via the 'exceptions log'

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Pressure Ulcers**												
Number of Category 2	49	34	37	44	34	29	46	36	31	37	48	46
Number of Category 3	8	10	4	3	3	7	4	3	7	2	6	3
Number of Category 4	1	0	0	1	1	3	1	1	1	1	1	2
Total number developed/deteriorated while in our care (care of the organisation) - acute	38	35	33	35	27	27	48	37	35	41	53	43
Total number developed/deteriorated while in our care (care of the organisation) - community	47	27	29	28	27	34	33	21	25	23	30	25
Falls***												
Number of falls with moderate harm	2	5	0	3	3	4	4	2	1	6	2	1
Number of falls with severe harm	8	4	5	1	5	3	10	1	5	6	5	4
Number of falls resulting in death	0	0	1	0	0	1	0	1	0	1	0	0
Safeguarding												
% of staff compliant with training (children)	65%	68%	74%	80%	80%	81%	82%	82%	82%	84%	85%	86%
% of staff compliant with training (adult)	64%	69%	74%	80%	81%	82%	82%	82%	83%	83%	84%	85%
% of staff working with children who have review CRB checks												

Note ** and *** - falls and pressure ulcers subject to validation. Fall resulting in death currently being investigated as Serious Incident and the degree of harm will be confirmed upon completiion of investigation.
All falls and pressure ulcer data has been refreshed to reflect imrovements in identification, monitoring and reporting of falls and pressure ulcers.
**** - data revised to exclude SIs which have been delogged since declaration

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Board of Directors - 25 May 2016

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 30 April 2016.

At the end of April the Trust is reporting an Income and Expenditure (I&E) deficit of £0.8m against a planned deficit of £1.1m for the period. The Income & Expenditure position places the Trust ahead of 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 Finance and Performance Committee

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	May 2016
Version number	Version 1

Briefing Note for the Board of Directors Meeting 25 May 2016

Subject: April 2016 (Month 1) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for April 2016

The Trust's I&E account shows an opening month deficit of £0.8m against a planned deficit of £1.1m. The Trust is therefore currently reported as £0.3m ahead of plan. This is an encouraging start to the financial year given the current and well documented risks to our plan and the bounce back concern following the quarter four extreme expenditure control measures.

The position includes a fully comprehensive expenditure position, sourced in the usual way through all normal expenditure feed systems. Income is reported with a high degree of estimation as this is the first month of the financial year and average specialty price trends have yet to be established. Having said that the income estimation process is thorough and where coded activity exists, such as outpatients, actual tariffs have been used.

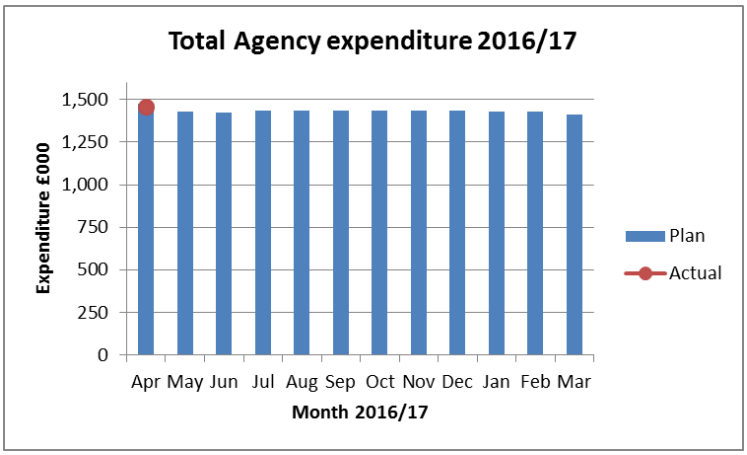
There is no evidence that expenditure trends have surged forward in the first month of the new financial year with good grip and control measures remaining in place. Some expenditure categories have seen intentionally delayed or postponed requisitions coming through but these have all been manageable to date from within the planned provisions made.

The opening CIP position is disappointing and reflects poorly against past month one performance; however, at this stage the key message is to remain focused on the programme of delivery. This is an area subject to enhanced internal monitoring and any worrying trends will be identified and rectified early.

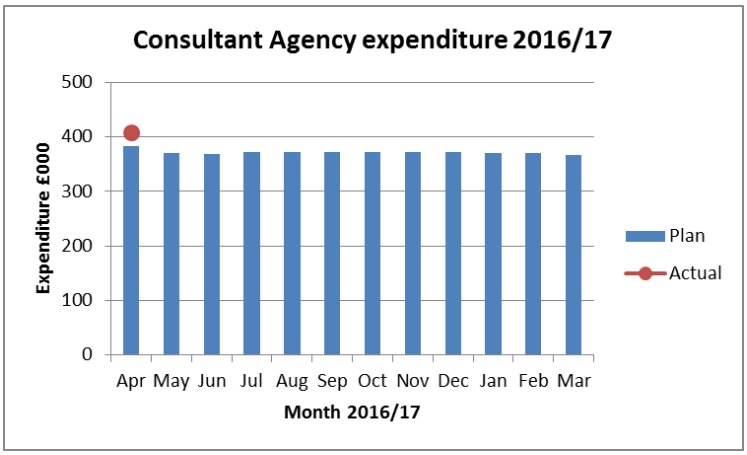
Enhanced Agency Expenditure Analysis

As discussed previously at the Board we have developed our agency staff cost reporting to ensure full visibility against the Trust's overall improvement trajectory. The Board are aware that NHSI has set the Trust an upper cap limit of £17.2m for its 2016/17 agency expenditure. As a reminder the agency spend for 2015/16 totalled £24m.

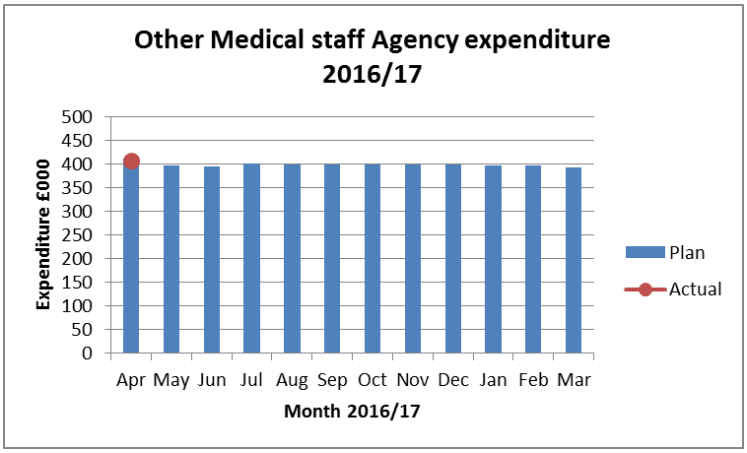
We have developed a suite of charts that set indicative targets for agency expenditure in the categories of Consultant, Other Medical, Nursing and Other Staff. The sum of each of these targets reconciles back to our capped plan of £17.2m.



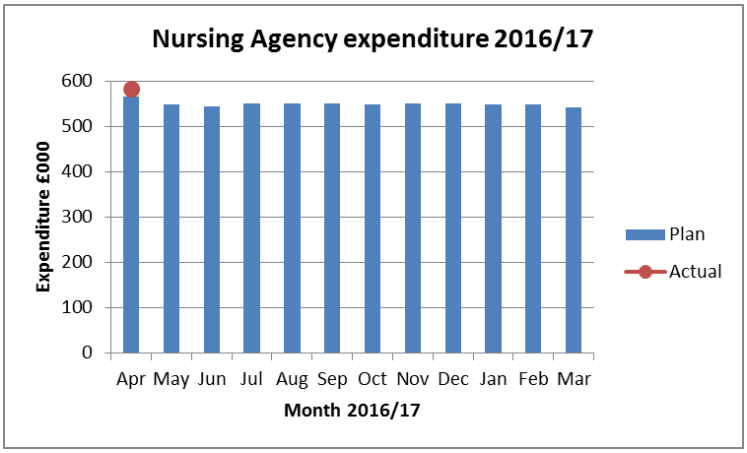
This first chart shows the monthly overall agency target; set at approximately £1.4m per month. The plan is illustrated by the bars. Actual April spend was £19k less than plan. At this stage no additional action beyond that already being taken is required to manage expenditure levels.



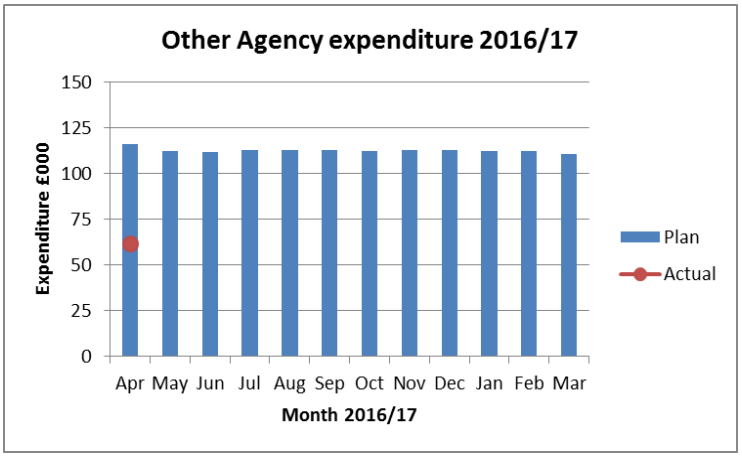
Consultant medical staff agency expenditure has marginally exceeded the monthly target. This is an area the Board will need to monitor closely.



Other medical staff (junior staff) agency expenditure is in line with plan. Despite a good start in April this is an area of expenditure that represents significant risk to the Trust's finances and to securing our sustainability funding. This is an area the Board will need to monitor extremely closely.



Nursing staff agency expenditure has marginally exceeded the monthly target. This is an area the Board will need to monitor closely.



The final chart shows non-medical and non-nursing agency staff expenditure. In relative terms this is low level agency usage and the fact that we have used less than anticipated in month has helped neutralise the marginal overspends on Consultant and Nursing agency staff expenditure.

2016/17 Contract Issues

Contract negotiations have been underway for some time now with all the Trust's commissioners. The Board are aware that formal arbitration was avoided on all contracts with a clear Arbitration Panel ruling that PbR principles must run in all contracts and with further commissioner concessions made in relation to the Trust's Community contracts.

At the time of writing this report, whilst contracts have not been formally signed, we are in the closing stages of completing the activity schedules and contract wording to reflect the nature of the agreements reached for 2016/17.

Of note for the Board is the fact that contained within each of our main acute contracts (VoY CCG and S&R CCG) are significant commissioner assumptions around QIPP delivery. In the main these QIPPs are unsubstantiated with limited, or no, detail concerning delivery. Whilst the principle of PbR running fully in all contracts has been clarified, the fact that base contract levels have been adjusted for QIPP exposes the Trust to a cash flow risk. We have agreed protection from our two main commissioners in the form of contract payments being made in equal tenths (as opposed to the usual equal twelfths). To mitigate this risk further we are seeking a process for more timely activity reconciliations within the contracts but wording has yet to be agreed in this regard.

Finance Performance Report

May 2016

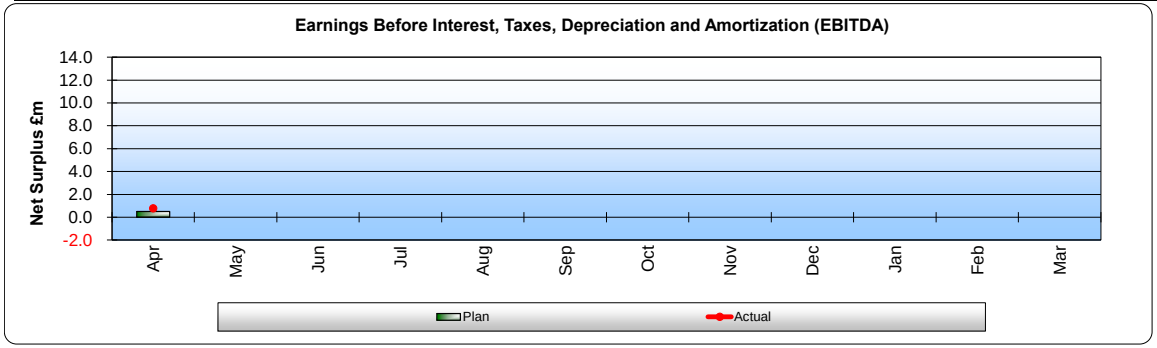
Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

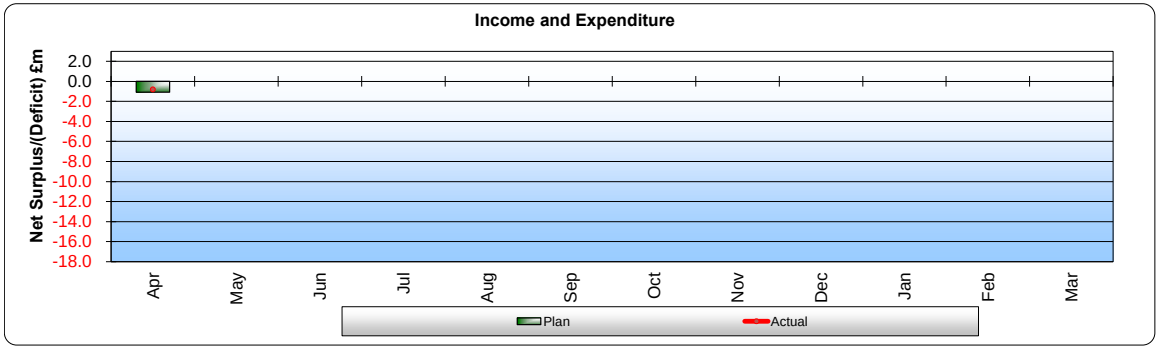
Summary Income and Expenditure Position
Month 1 - The Period 1st April 2016 to 30th April 2016

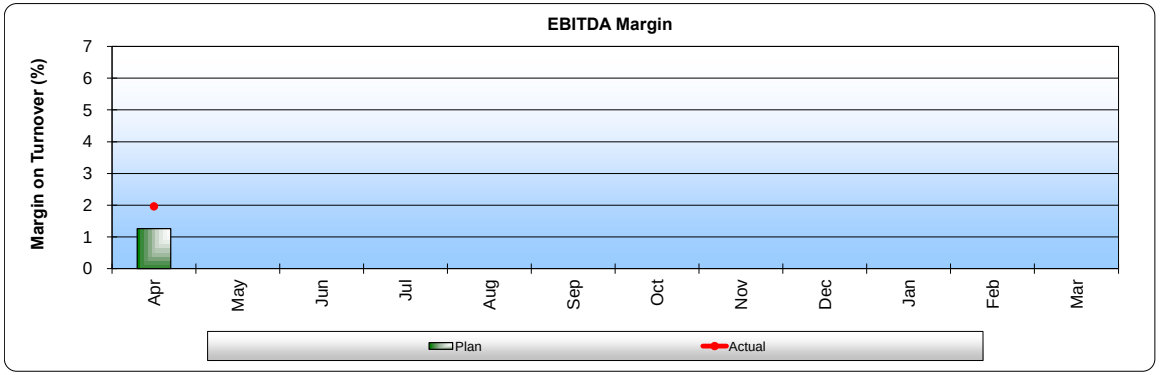
York Teaching Hospital NHS
NHS Foundation Trust

Summary Position:

* The Trust is reporting an I&E deficit of £0.8mm, placing it £0.3m ahead of the operational plan.
* Income is £0.6m behind plan, with clinical income being £0.9m behind plan and non-clinical income being £0.3m ahead of plan.
* Operational expenditure is behind plan by £0.9m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £0.8m (1.96%) compared to plan of £0.5m (1.26%), and is reflective of the reported net I&E performance.







	Annual Plan	Plan for Year to Date	Actual for Year to Date	Variance for Year to Date	Forecast Outturn	Annual Plan Variance
	£000	£000	£000	£000	£000	£000
NHS Clinical Income						
Elective Income	26,596	2,162	1,964	-198	26,596	0
Planned same day (Day cases)	38,750	3,122	2,981	-141	38,750	0
Non-Elective Income	109,502	8,821	8,803	-18	109,502	0
Outpatients	65,547	5,332	5,383	51	65,547	0
A&E	14,522	1,206	1,103	-103	14,522	0
Community	30,174	2,431	2,343	-88	30,174	0
Other	149,945	12,346	11,912	-434	149,945	0
	435,036	**35,420**	**34,489**	**-931**	**435,036**	**0**
Non-NHS Clinical Income						
Private Patient Income	976	81	76	-5	976	0
Other Non-protected Clinical Income	1,799	150	207	57	1,799	0
	2,776	**231**	**283**	**52**	**2,776**	**0**
Other Income						
Education & Training	15,049	1,254	1,210	-44	15,049	0
Research & Development	3,167	264	255	-9	3,167	0
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	739	62	66	4	739	0
Other Income	17,104	1,425	1,723	297	17,104	0
Transition support	10,045	837	837	0	10,045	0
	46,104	**3,842**	**4,091**	**249**	**46,104**	**0**
Total Income	**483,916**	**39,493**	**38,863**	**-631**	**483,916**	**0**
Expenditure						
Pay costs	-329,980	-26,838	-26,091	747	-329,980	0
Drug costs	-50,745	-4,198	-4,363	-165	-50,745	0
Clinical Supplies & Services	-47,733	-3,942	-3,643	299	-47,733	0
Other costs (excluding Depreciation)	-51,412	-4,001	-3,932	69	-51,412	0
Restructuring Costs	0	0	-72	-72	0	0
CIP	25,438	-18	0	18	25,438	0
Total Expenditure	**-454,432**	**-38,997**	**-38,101**	**896**	**-454,432**	**0**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**29,484**	**496**	**762**	**265**	**29,484**	**0**
Profit/ Loss on Asset Disposals	0	0	-0	-0	0	0
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation	-12,000	-1,000	-1,000	0	-12,000	0
Interest Receivable/ Payable	100	8	16	7	100	0
Interest Expense on Overdrafts and WCF	0	0	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0	0	0
Interest Expense on Non-commercial borrowings	0	0	0	0	0	0
Interest Expense on Commercial borrowings	-487	-38	-36	2	-487	0
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	0	0	0	0
PDC Dividend	-6,627	-552	-552	0	-6,627	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**10,170**	**-1,085**	**-811**	**275**	**10,170**	**0**

Contract Performance
Month 1 - The Period 1st April 2016 to 30th April 2016

York Teaching Hospital NHS
NHS Foundation Trust

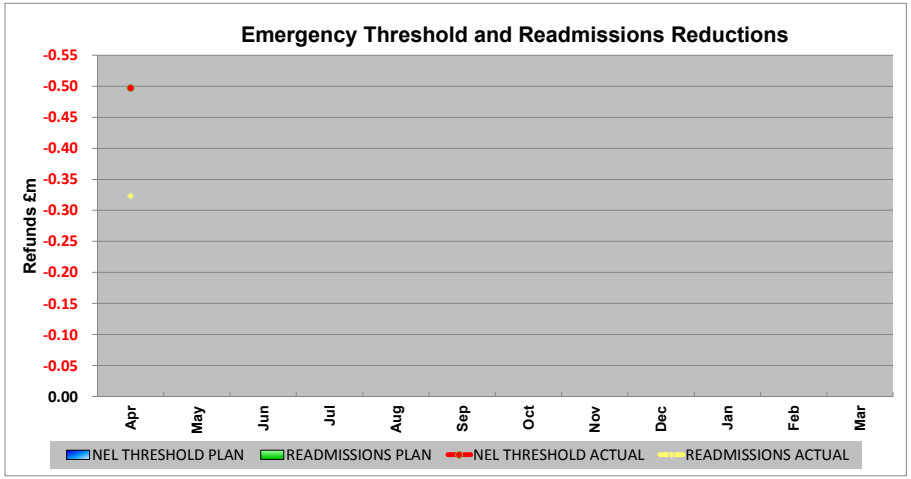
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	0	0	18,383	18,383
Scarborough & Ryedale CCG	0	0	6,617	6,617
East Riding CCG	0	0	3,504	3,504
Other Contracted CCGs	0	0	1,103	1,103
NHSE - Specialised Commissioning	0	0	2,411	2,411
NHSE - Public Health	0	0	1,146	1,146
Local Authorities	0	0	357	357
Total NHS Contract Clinical Income	**0**	**0**	**33,520**	**33,520**

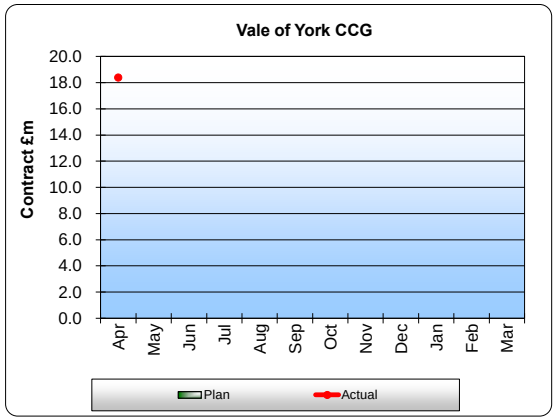
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	0	0	1,089	1,089
Risk Income	0	0	0	0
Total Other NHS Clinical Income	**0**	**0**	**1,089**	**1,089**

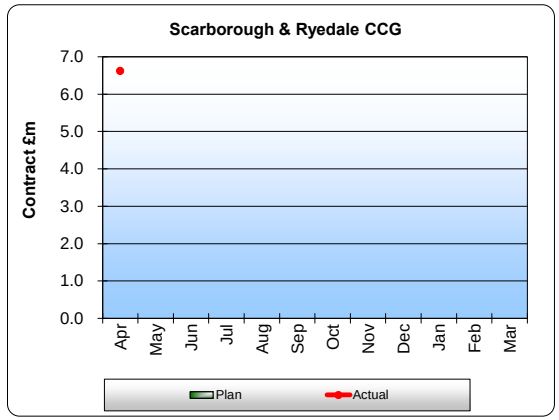
Specialist registrar income moved to other income non clinical	-120
Winter resilience monies in addition to contract	0

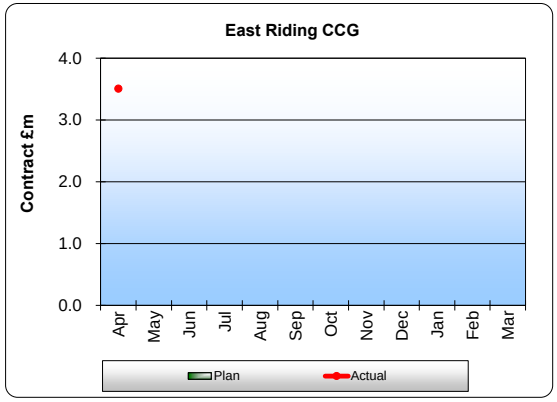
Total NHS Clinical Income	**0**	**0**	**34,489**	**34,489**

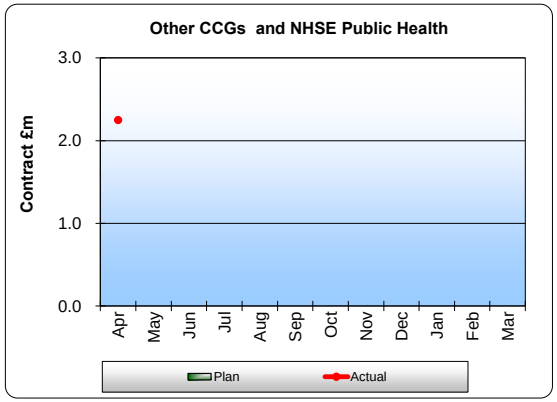
Activity data for April is partially coded (46%). There is therefore some element of income estimate involved for the uncoded portion of activity.

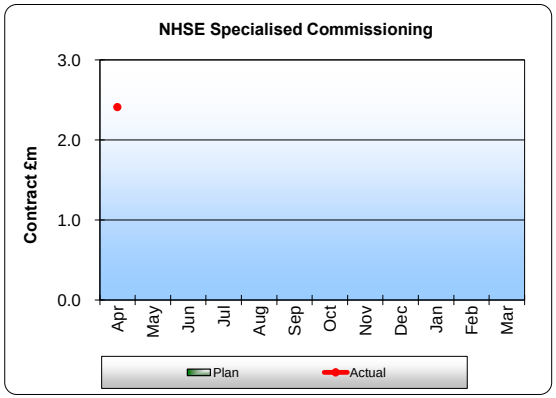


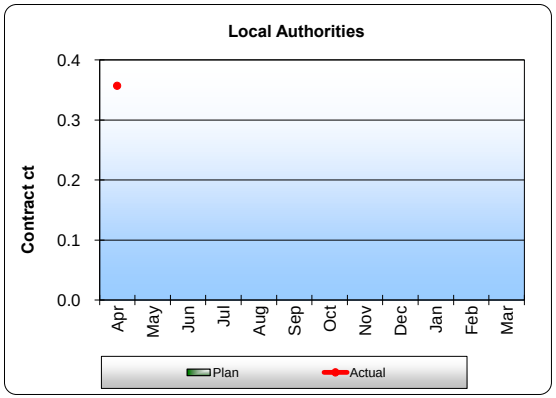












Expenditure Analysis
Month 1 - The Period 1st April 2016 to 30th April 2016

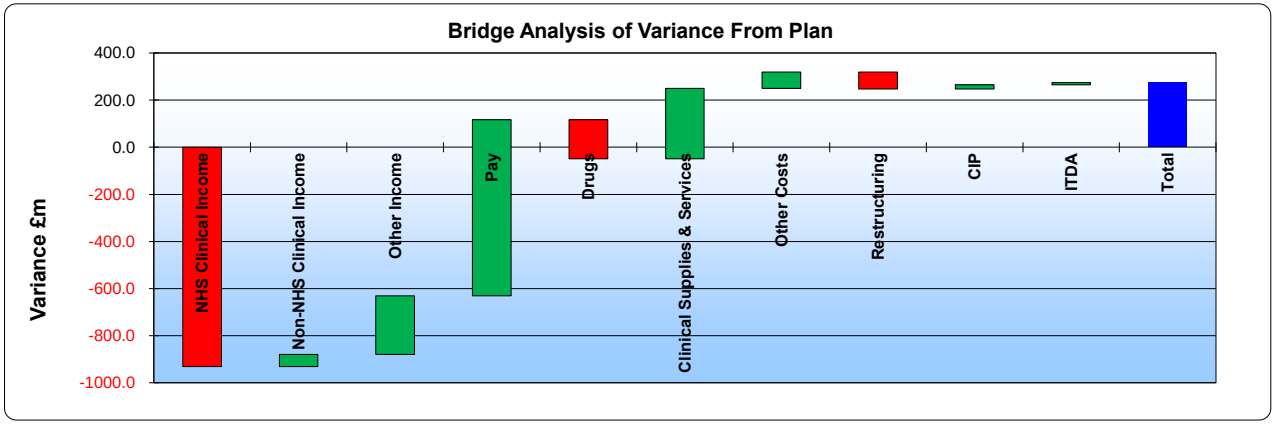
York Teaching Hospital NHS
NHS Foundation Trust

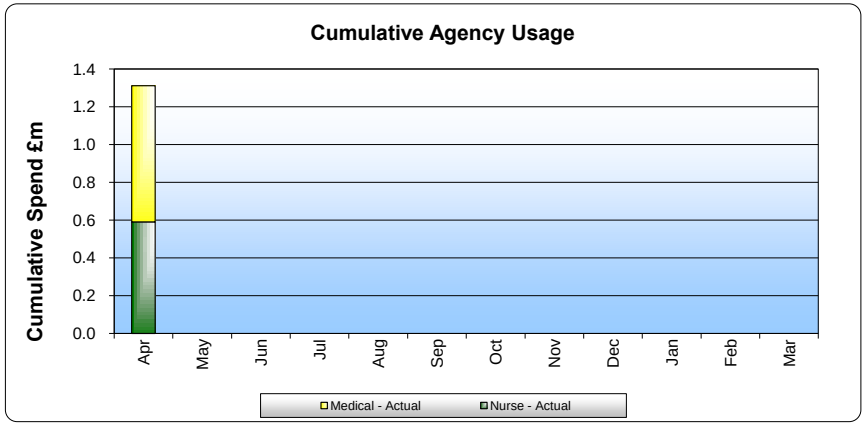
Key Messages:

There is a favourable expenditure variance of £0.9m at the end of April 2016. This comprises:

* Pay budgets are £0.7m favourable, linked to vacant posts. Agency expenditure is in line with the Monitor Plan at £1.4m
* Drugs budgets are £0.16m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is in line with plan.
* Other budgets are £0.3m favourable.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	58,536	4,819	4,063	0	155	0	337	4,554	264	0	
Medical and Dental	30,553	2,528	2,147	0	18	0	384	2,549	-21	0	
Nursing	97,559	7,969	6,591	41	28	504	591	7,756	213	0	
Healthcare Scientists	11,216	915	750	25	17	0	25	817	97	0	
Scientific, Therapeutic and technical	15,235	1,267	1,160	5	0	1	6	1,172	95	0	
Allied Health Professionals	25,282	2,104	1,808	8	29	2	6	1,854	251	0	
HCAs and Support Staff	43,476	3,680	3,393	61	10	7	3	3,473	207	0	
Chairman and Non Executives	161	13	13	0	0	0	0	13	0	0	
Exec Board and Senior managers	13,980	1,153	1,116	1	0	0	4	1,121	33	0	
Admin & Clerical	35,987	2,970	2,727	21	8	17	9	2,782	188	0	
Agency Premium Provision	5,816	485	0	0	0	0	0	0	485	0	
Vacancy Factor	-7,821	-1,066	0	0	0	0	0	0	-1,066	0	
TOTAL	**329,980**	**26,838**	**23,767**	**162**	**265**	**532**	**1,365**	**26,091**	**747**	**0**	



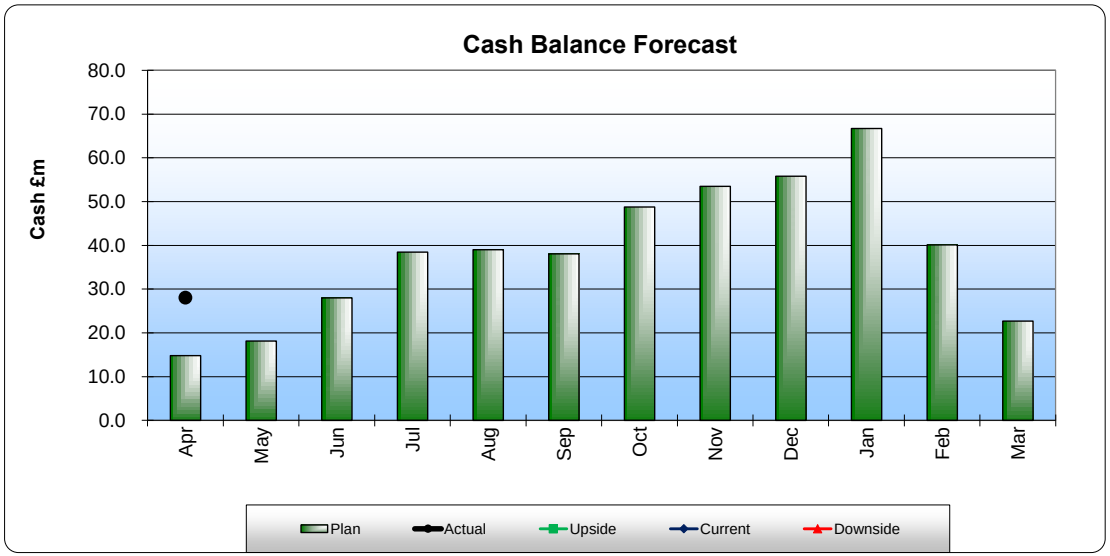


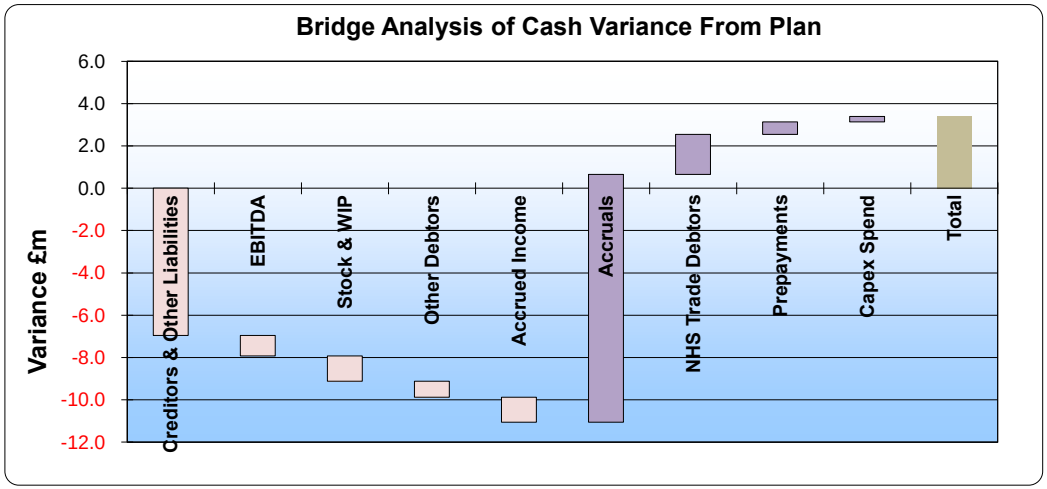
Cash Flow Management
Month 1 - The Period 1st April 2016 to 30th April 2016

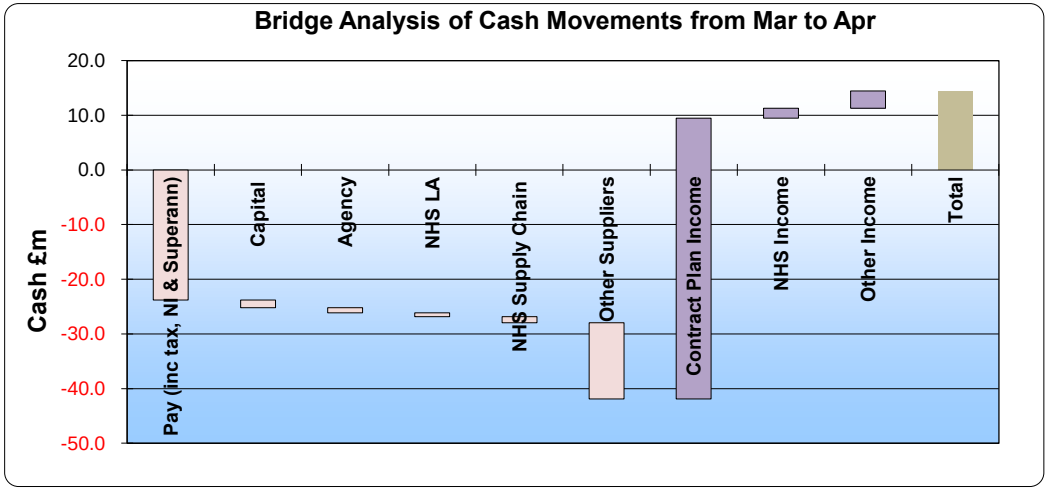
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The cash position at the end of April was £28m.
* The position was significantly influenced by early receipt of the £10m transitional funding.
* This resulted in a final position above the monitor plan.







Cash Flow Management
Month 1 - The Period 1st April 2016 to 30th April 2016

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

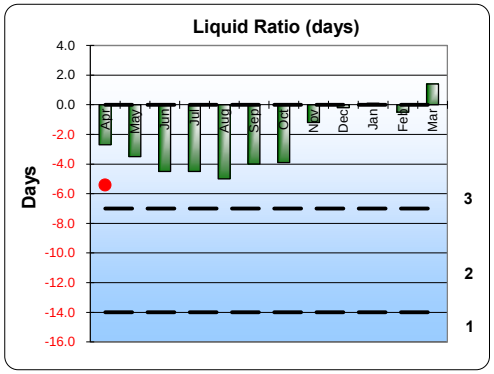
* The receivables balance at the end of April was £7.04m, which is below plan.
* The payables balance at the end of April was £8.66m, which is below plan.
* The Financial Sustainability Risk Rating (FSRR), which is assessed as a score of 3 in April, and is reflective of the I&E position.

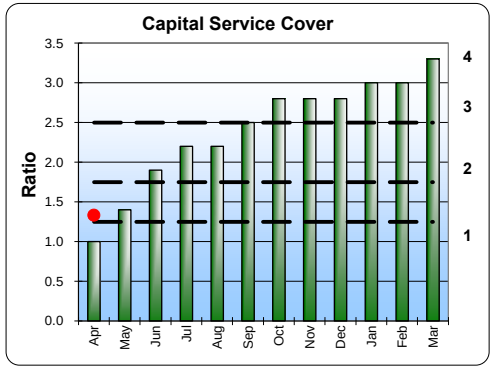
Significant Aged Debtors (+6mths)

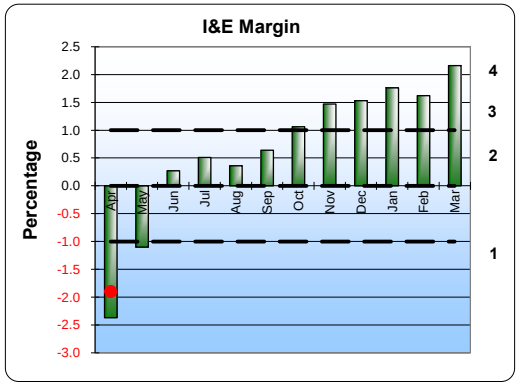
Harrogate and District NHS FT	**£509K**
Depuy Ireland	**£303K**
NHS Vale of York CCG	**£131K**

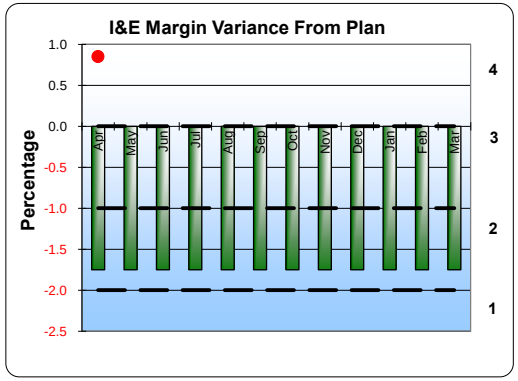
	Under 3 mths	3-6 mths	6-12 mths	12 mths +	Total
	£m	£m	£m	£m	£m
Payables	6.51	0.73	0.81	0.61	8.66
Receivables	5.42	0.37	0.41	0.84	7.04

FSRR Area of Review	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (25%)	4	3	3	4
Capital Service Cover (25%)	4	1	2	4
I&E Margin (25%)	4	1	1	4
I&E Margin Variance From Plan (25%)	2	2	4	4
Overall Financial Sustainability Risk Rating	4	2	3	4









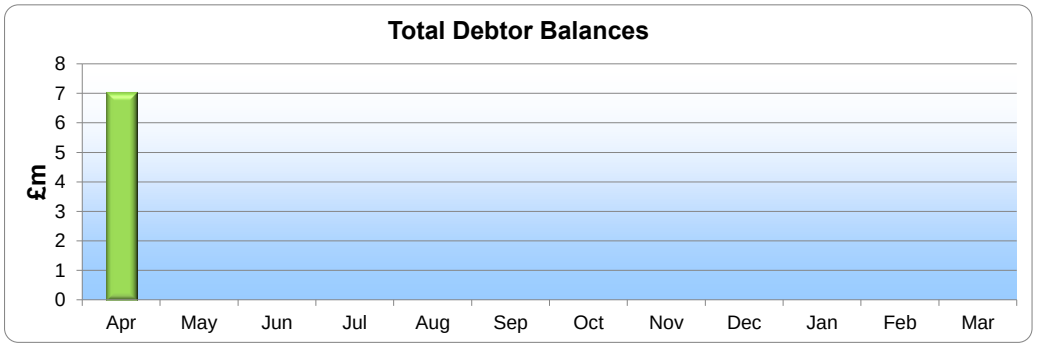
Debtor Analysis

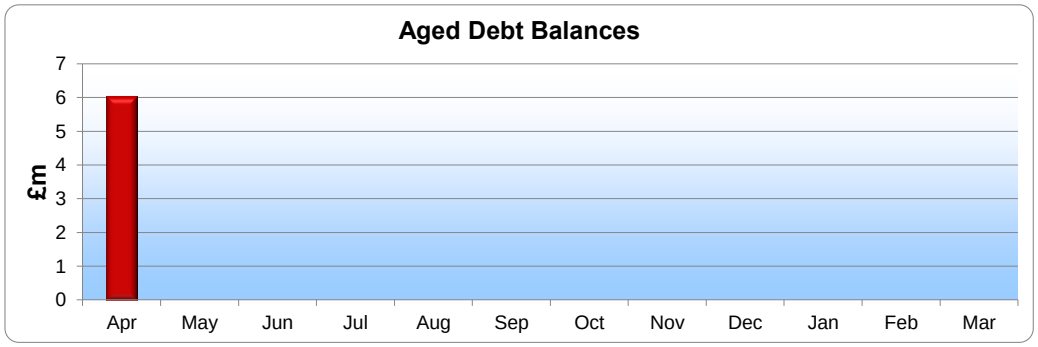
Month 1 - The Period 1st April 2016 to 30th April 2016

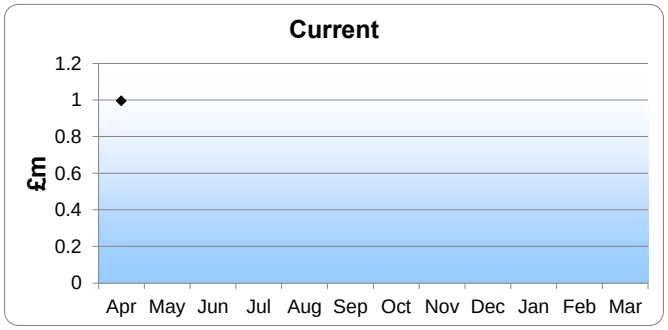
York Teaching Hospital NHS
NHS Foundation Trust

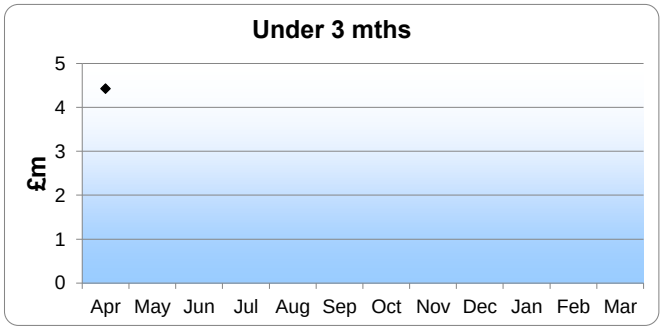
Key Messages:

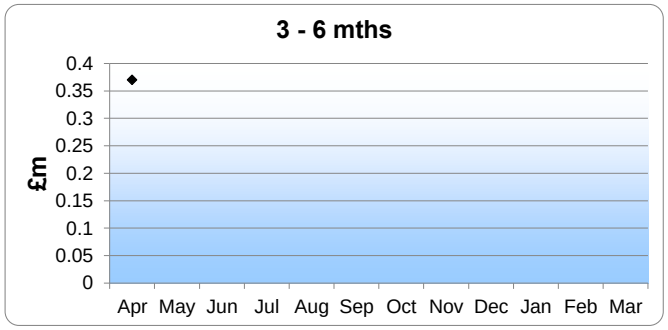
* At the end of April, the total debtor balance was £7m.
* Aged Debt was £6m, however £5.5m of this is under 3 months old.
* Debtors over 6 months have reduced from the closing position of 15/16 as debt collection activity continues to progress.

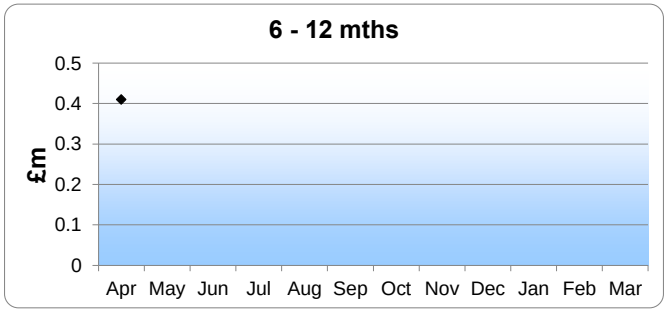


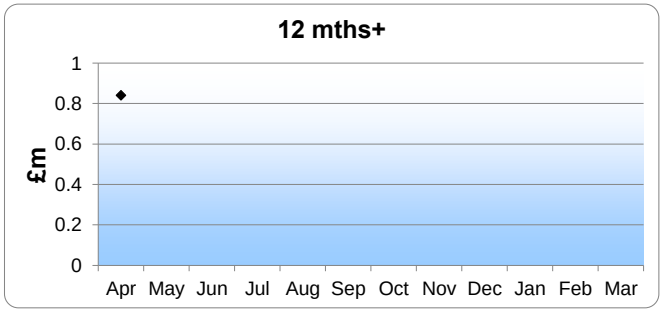












Capital Programme

Month 1 - The Period 1st April 2016 to 30th April 2016

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

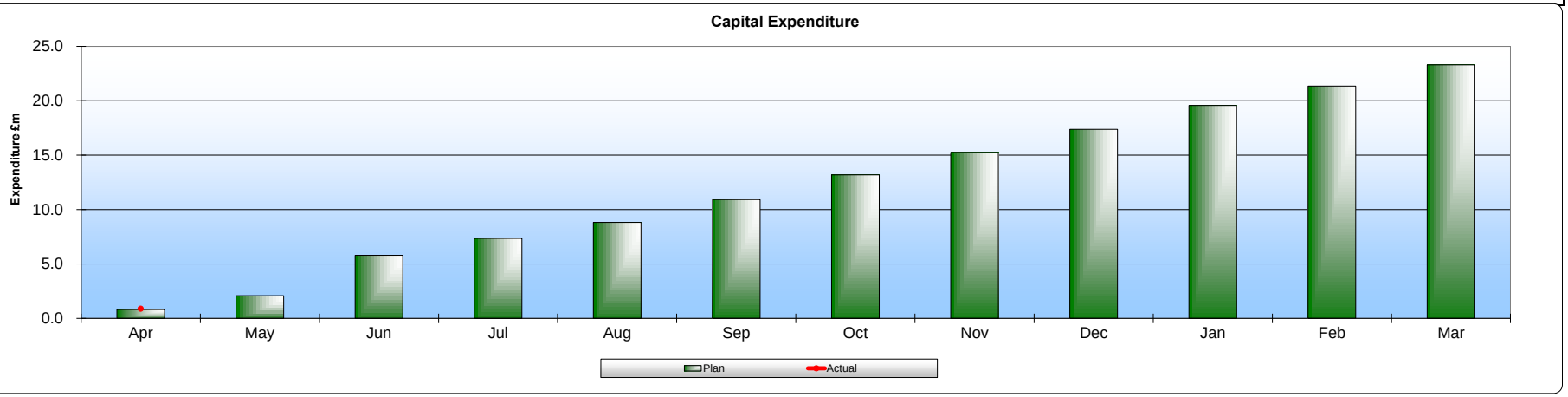
*This years capital programme funding is £23.3m.

* This includes the purchase of Tampit Lodge for £1m

* Schemes to be completed this year include the Malton Urology Scheme for £1.6m, the convertion of Theatre 10 at a cost of £1.1m and York ED improvements phase 2 costing £615k this financial year.

* Strategic funding will be spent on the replacement of the Scarborough Estates and Facilities Portakabins plus completion of the Fire Alarm Scheme, the Lift Replacement scheme and the Ambulance Handover project

* Loan Funding will be spent on Radiology Replacement equipment across both York and Scarborough sites and the Endoscopy Development scheme.



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
Urology Facilities Malton	1,600	-	1,600	0	
Purchase of Tenpit Lodge Easingwold	1,000	-	1,000	0	
Theatre 10 to cardiac/vascular	1,100	-	1,100	0	
Radiology Replacement	4,450	-	4,450	0	
Radiology Lift Replacement SGH	840	-	840	0	
Fire Alarm System SGH	890	-	890	0	
Other Capital Schemes	3,662	145	3,662	0	
SGH Estates Backlog Maintenance	1,450	11	1,450	0	
York Estates Backlog Maintenance - York	1,450	-	1,450	0	
Medical Equipment	450	68	450	0	
IT Capital Programme	-	194	-	0	
Capital Programme Management	950	78	950	0	
Star Appeal	243	6	243	0	
SGH replacement of estates portakabins	1,132	-	1,132	0	
Endoscopy Development	3,500	-	3,500	0	
Contingency	500	-	500	0	
TOTAL CAPITAL PROGRAMME	**23,303**	**877**	**23,303**	**-**	A level of capital creditors is included in the total spend figure.

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£	£	£	£	
Depreciation	12,000	871	12,000	-	
Loan Funding b/fwd	-	-	-	-	
Loan Funding	6,950	-	6,950	-	
Charitable Funding	787	6	787	-	
Strategic Capital Funding	3,566	-	3,566	-	
TOTAL FUNDING	**23,303**	**877**	**23,303**	**0**	

Efficiency Programme

Month 1 - The Period 1st April 2016 to 30th April 2016

York Teaching Hospital NHS
NHS Foundation Trust

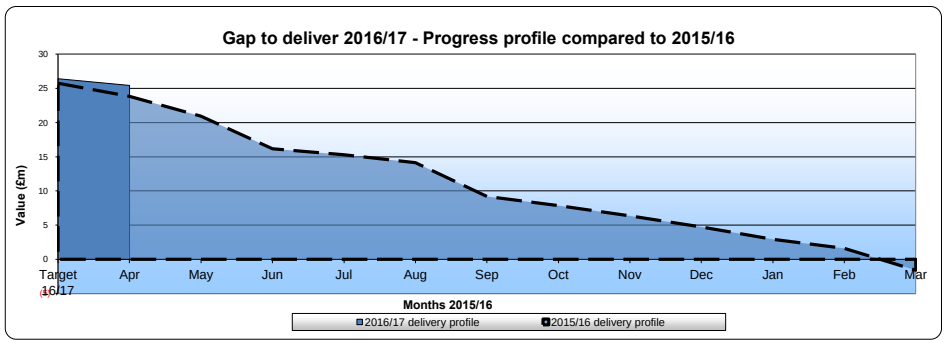
Key Messages:

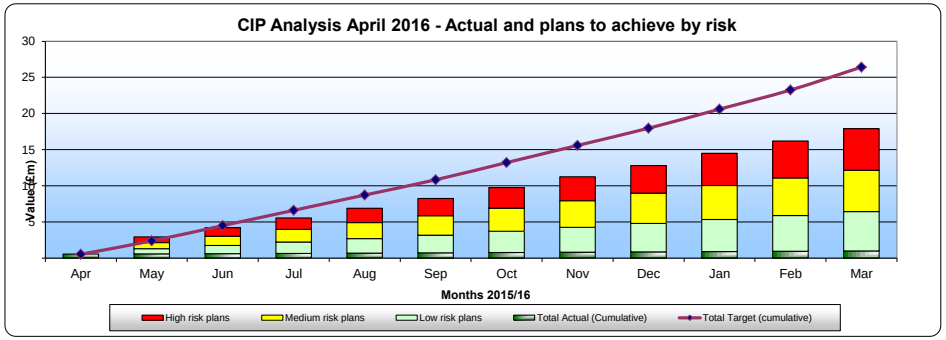
* Delivery - £1m has been delivered against the Trust annual target of £26.4m, giving a shortfall of (£25.4m)
* Part year NHSI variance - The part year NHSI variance is 0.
* In year planning - The 2016/17 planning gap is currently (£8.5m)
* Four year planning - The four year planning gap is (£33.2m).
* Recurrent delivery - Recurrent delivery is £0.5m, which is 2% of the 2016/17 CIP target.

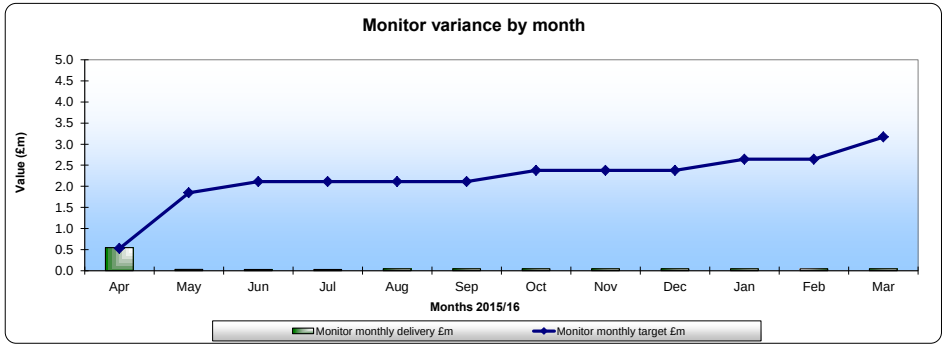
Executive Summary - April 2016	
	Total £m
TARGET	
In year target	26.4
DELIVERY	
In year delivery	1.0
In year delivery (shortfall)/Surplus	-25.4
Part year delivery (shortfall)/surplus - NHSI variance	0.0
PLANNING	
In year planning surplus/(gap)	-8.5
FINANCIAL RISK SCORE	
Overall trust financial risk score	(1 - RED)

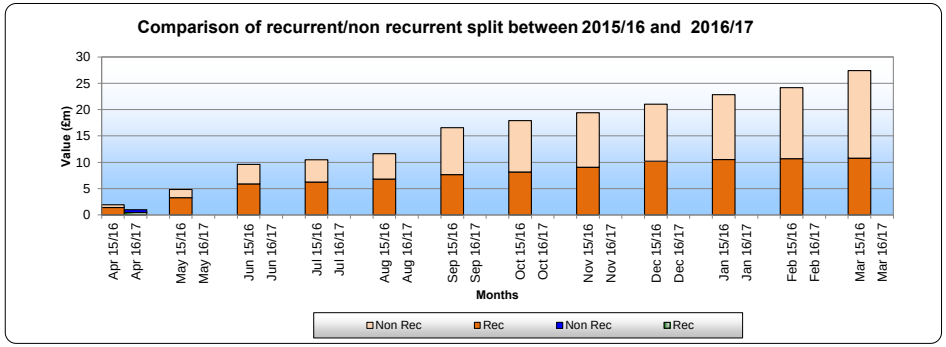
4 Year Efficiency Plan - April 2016					
Year	2016/17	2017/18	2018/19	2019/20	**Total**
	£m	£m	£m	£m	**£m**
Base Target	26.4	15.5	15.5	15.5	**73.0**
Plans	17.9	12.7	5.0	4.2	**39.8**
Variance	-8.5	-2.9	-10.5	-11.3	**-33.2**
%	**68%**	**81%**	**32%**	**27%**	**55%**

Risk Ratings			
Financial			
Score	April		Trend
1	25		➔
2	2		➔
3	0		➔
4	0		➔
5	0		➔
Governance			
Score	April		Trend
Red	23		➔
Green	3		➔







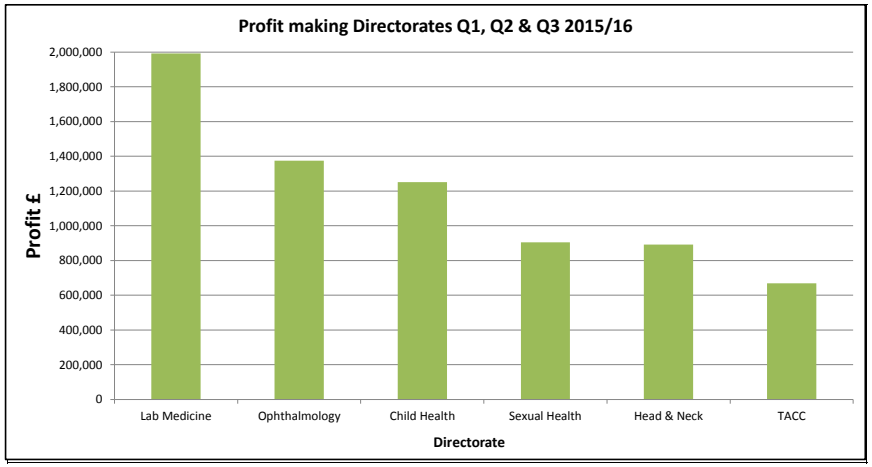


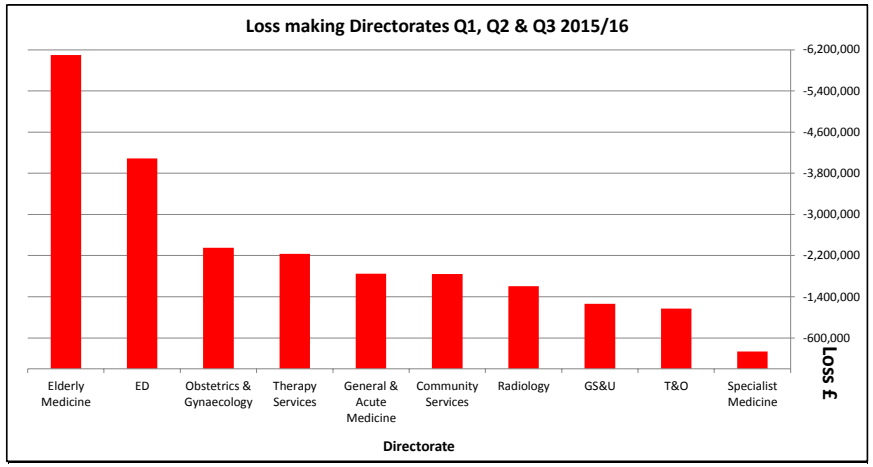
Service Line Reporting
Month 1 - The Period 1st April 2016 to 30th April 2016

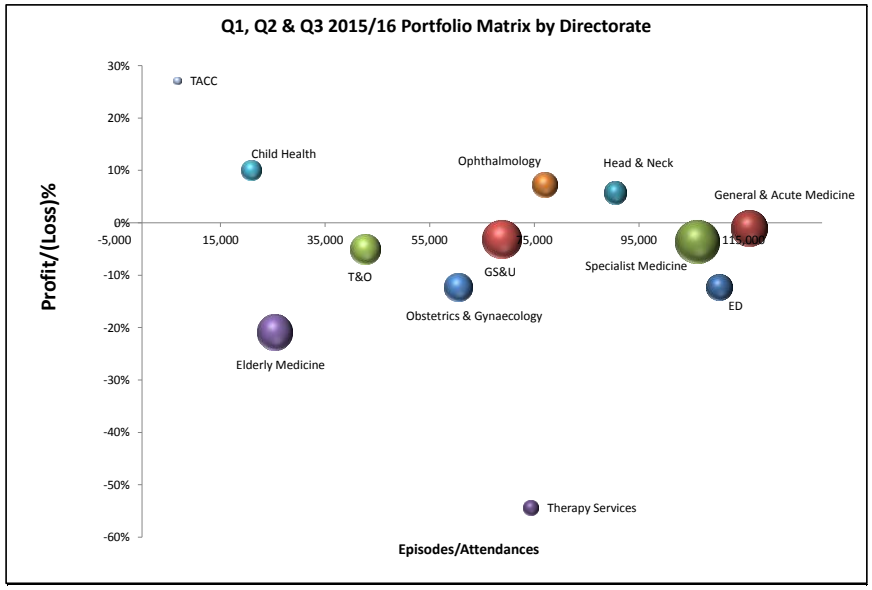
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Current data is based on Q1, Q2 & Q3 2015/16
* It is expected Q4 2015/16 will be completed towards the end of June 2016
* Directorate teams are being asked, on a quarterly basis, to confirm that the consultant PA's allocations used within the SLR system are correct
* Deep dive work is continuing within a number of Directorates







DATA PERIOD	Q1 , Q2 & Q3 2015/16
CURRENT WORK	* Q4 2015/16 SLR data is now the key focus following the publication of Q3 data. Q4 2015/16 is expected to be completed towards the end of June 2016 * The annual Reference Cost calculation is also a key focus for the team ahead of the final submission date of July 28th * Deep dive work for TACC, Womens Health, Specialist Medicine and General & Acute Medicine is underway to agree the income and expenditure allocation methods * Work with Directorate teams is currently on-going to improve the quality of consultant PA allocations used within the SLR system for each quarterly reporting period
FUTURE WORK	* The SLR team are continuing to work with Directorate teams to improve the quality of outpatient staffing group costs within SLR * Future work around junior doctor PA allocations will improve the quality of the SLR data and also to inform the annual mandatory Education & Training cost collection exercise *Preparatory work for the Education & Training mandatory submission will soon begin ahead of the August deadline

BENEFITS TAKEN SINCE SYSTEM INTRODUCTION	**£2.7m**

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Board of Directors - 25 May 2016

Efficiency Programme Update – April 2016

Action requested/recommendation

The Board is asked to note the April 2016 position.

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2016/17 target is £26.4m and delivery, as at April 2016, is £1.0m.

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, Finance Director
Author	Steve Kitching, Head of Corporate Finance & Resource Management
Date of paper	May 2016
Version number	Version 1

Briefing note for the Board of Directors Meeting 25 May 2016

Subject: April 2016 - Efficiency Position
From: Steven Kitching, Head of Corporate Finance & Resource Management

Summary reported position for April 2016

Current position – highlights

Delivery - Overall delivery is £1.0m in April 2015 which is (3.8%) of the £26.4m annual target. This position compares to a delivery position of £1.9m (7.3%) in April 2015.

Part year delivery is £0.55m which is in line with the profiled plan submitted to NHSI.

The relative Directorate positions are shown in Appendix 1 & 2 attached.

In year planning – There is an in year planning gap of (£8.5m) at April 2016, the comparative position in April 2015, was a gap of (£5.3m). Work is continuing with Directorate teams to close this in year gap.

Four year planning – The four year planning gap is (£33.2m). The position in April 2015 was a gap of (£30.8m). We have a relatively strong planning position for years 1&2 of the plan with £30.6m (73%) worth of plans identified against a target of £42m.

Recurrent vs. Non recurrent – Of the £1.0m delivery, £0.5m (50%) has been delivered recurrently.

Quality Impact Assessments (QIA) – All schemes have been sent out to Directorate teams to self-assess for their safety impact. We are currently working with Mr Khafagy to review the QIA process.

Overview
We have had a relatively slow start to the year with £1.0m CIP delivered in April 2016, which is behind the April 2015 delivery of £1.9m. I would remind the Board that in Q1 last year; all recurrent CIP delivery was enhanced by 20%, which did have a positive impact on delivery. A clearer position of early progress will be more evident in the May 2016 report.

I would like to draw the Board's attention to the following specific areas.

Efficiency target profiling

In line with the informal Monitor recommendations we have profiled the CIP target this year, with the expectation that April is one of the most challenging months in terms of CIP delivery. We have delivered in line with the NHSI profile in April 2016.

Non-recurrent to recurrent conversion

Letters have now been sent to all Directorate teams with details of their target for 2016/17 and the expectation that a plan is required to deliver their share of the £6m, non-recurrent to recurrent adjustment required to reduce our target nearer to a more manageable level of £20m for the year. The expectation is that this adjustment will be made before the end of Q1 2016/17.

Differentiation of efficiency targets

It has been agreed with the Director of Finance that in the vast majority of cases efficiency targets would remain unchanged and only where the initial assessment of the Carter opportunity left a significant shortfall would targets be adjusted. It was felt that full differentiation of Directorate targets could impact adversely on engagement in the Efficiency Programme, which Monitor had particularly highlighted as a positive element of the efficiency programme at York Trust.

RISK SCORES - APRIL 2016 -APPENDIX 1

DIRECTORATE	FINANCE						GOVERNANCE	
	R	RA	A	AG	G	Trend	R	G
OPHTHALMOLOGY	1	2	3	4	5	→		
RADIOLOGY	1	2	3	4	5	→		
EMERGENCY MEDICINE	1	2	3	4	5	→		
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1	2	3	4	5	→		
SPECIALIST MEDICINE	1	2	3	4	5	→		
WOMENS HEALTH	1	2	3	4	5	→		
PHARMACY	1	2	3	4	5	→		
HEAD AND NECK	1	2	3	4	5	→		
TACC	1	2	3	4	5	→		
GEN MED SCARBOROUGH	1	2	3	4	5	→		
MEDICINE FOR THE ELDERLY	1	2	3	4	5	→		
GEN MED YORK	1	2	3	4	5	→		
CHILD HEALTH	1	2	3	4	5	→		
SEXUAL HEALTH	1	2	3	4	5	→		
GS&U	1	2	3	4	5	→		
ORTHOPAEDICS	1	2	3	4	5	→		
LAB MED	1	2	3	4	5	→		
COMMUNITY	1	2	3	4	5	→		
CORPORATE								
HR	1	2	3	4	5			
MEDICAL GOVERNANCE	1	2	3	4	5	→		
SNS	1	2	3	4	5	→		
CHIEF NURSE TEAM DIRECTORATE	1	2	3	4	5	→		
FINANCE	1	2	3	4	5	→		
ESTATES AND FACILITIES	1	2	3	4	5	→		
CHAIRMAN & CHIEF EXECUTIVES OFFICE	1	2	3	4	5	→		
OPS MANAGEMENT YORK	1	2	3	4	5	→		
LEARNING ORGANISATIONAL DEVELOPMENT & RESEARCH	1	2	3	4	5	→		
TRUST SCORE	1	2	3	4	5	→		

RISK SCORES - APRIL 2016 - APPENDIX 2

DIRECTORATE	Yr1 Target (£000)	4Yr Target (£000)	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
OPHTHALMOLOGY	763	2,795	26%	1	0%	1	0%	1	9%	1	4	1
RADIOLOGY	1,693	3,295	27%	1	0%	1	0%	1	14%	1	4	1
EMERGENCY MEDICINE	453	1,860	44%	1	0%	1	0%	1	30%	1	4	1
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1,280	3,462	53%	1	0%	1	0%	1	39%	1	4	1
SPECIALIST MEDICINE	2,912	6,928	76%	1	0%	1	0%	1	48%	1	4	1
WOMENS HEALTH	1,683	3,430	27%	1	0%	1	0%	1	48%	1	4	1
PHARMACY	374	1,065	63%	1	0%	1	0%	1	79%	1	4	1
HEAD AND NECK	850	2,050	66%	1	0%	1	0%	1	27%	1	4	1
TACC	2,248	6,274	33%	1	0%	1	0%	1	41%	1	4	1
GEN MED SCARBOROUGH	959	2,399	26%	1	0%	1	0%	1	26%	1	4	1
MEDICINE FOR THE ELDERLY	1,513	3,774	70%	1	0%	1	0%	1	56%	1	4	1
GEN MED YORK	1,846	5,686	47%	1	1%	1	1%	2	82%	1	5	1
CHILD HEALTH	1,072	2,374	67%	1	3%	2	0%	1	38%	1	5	1
SEXUAL HEALTH	635	1,329	29%	1	8%	2	0%	1	74%	1	5	1
GS&U	1,964	5,109	55%	1	3%	2	3%	2	80%	1	6	1
ORTHOPAEDICS	1,228	3,521	98%	2	4%	2	0%	1	76%	1	6	1
LAB MED	794	2,881	97%	2	7%	2	6%	2	50%	1	7	1
COMMUNITY	1,457	3,714	213%	5	0%	1	0%	1	98%	2	9	2
CORPORATE												
HR	376	1,007	0%	1	0%	1	0%	1	0%	1	4	1
MEDICAL GOVERNANCE	121	241	0%	1	0%	1	0%	1	0%	1	4	1
HR	750	1,772	52%	1	2%	1	0%	1	22%	1	4	1
CHIEF NURSE TEAM DIRECTORATE	389	730	2%	1	2%	2	0%	1	1%	1	5	1
FINANCE	417	1,203	5%	1	5%	2	1%	1	2%	1	5	1
ESTATES AND FACILITIES	2,701	7,099	89%	1	11%	2	11%	3	81%	1	7	1
CHAIRMAN & CHIEF EXECUTIVES OFFICE	147	478	15%	1	15%	3	9%	3	4%	1	8	2
OPS MANAGEMENT YORK	205	568	140%	5	4%	2	0%	1	59%	1	9	2
LEARNING ORGANISATIONAL DEVELOPMENT & RESEARCH	217	627	109%	3	3%	2	0%	1	184%	5	11	2
TRUST SCORE	**29,046**	**75,672**	**67%**	**1**	**3%**	**2**	**2%**	**2**	**54%**	**1**	**6**	**1**

Board of Directors - 25 May 2016

Service Line Reporting and Reference Cost Update Report

Action requested/recommendation

The Board of Directors is asked to:

Note the contents of the report and the current process and controls around delivery of the 2015/16 Reference Costs submission using the SLR system, in order to approve the costing process ahead of the collection.

Summary

This report provides an update on the process used to deliver the 2015/16 Reference Cost submission.

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	No risk
Resource implications	Resources implications are detailed in the report.
Owner	Andrew Bertram, Finance Director
Author	Victoria Pryszczyk, Head of SLR & Costing
Date of paper	May 2016
Version number	Version 1

Board of Directors - 25 May 2016

Service Line Reporting (SLR) & Reference Costing Update Report

1. Introduction and background

The purpose of this report is to provide an oversight of the process used to produce the 2015/16 Reference Cost submission (using the SLR system) in order to provide assurance that the requirements are being met for the required Board approval.

2. Reference Costs Background and Requirements

Reference Costs Background

The Reference Cost submission is an annual mandatory cost collection return that all providers of NHS healthcare are required to complete and submit to the Department of Health (DoH).

NHS Improvement (NHSI) is now accountable for the reference costs collection, with the DoH continuing to collect reference costs on its behalf.

NHSI has adopted the DoH's Reference Cost Guidance and incorporated it into the Approved Costing Guidance which, together with the HFMA Acute Health Clinical Costing Standards, constitutes NHSI's 'approved reporting currencies' and 'approved guidance' – the guidance that NHS Foundation Trusts and NHS Trusts must apply to the recording and allocation of costs.

Requirements

Board assurance is a required element of the Reference Cost process with the DoH Reference Cost Guidance stating that the Board of each NHS Trust and NHS Foundation Trust, or its Audit Committee or other appropriate sub-committee is required to confirm the following in relation to the reference cost return:

a) the Board or its appropriate sub-committee has approved the costing process ahead of the collection;
b) the Director of Finance has, on behalf of the board, approved the final reference cost return prior to submission;
c) the reference cost return has been prepared in accordance with Monitor's Approved Costing Guidance, which includes the reference cost guidance
d) information, data and systems underpinning the reference cost return are reliable and accurate;
e) there are proper internal controls over the collection and reporting of the information included in the reference costs, and these controls are subject to review to confirm that they are working effectively in practice; and
f) costing teams are appropriately resourced to complete the reference costs return, including the self-assessment quality checklist and validations accurately within the timescales set out in the reference costs guidance.

3. Reference Cost Index

In November 2015 the 2014/15 national reference costs results were published, with the Trust returning an overall index score of 100. The index score of 100 indicates that we have costs

equal to the national average.

This index score has moved up 3 points, from 97 in the 2013/14 submission, bringing our activity costs closer to the national average.

This score provides a good level of assurance that the reference costing system and the underlying data feeds are providing consistent data and accurate cost information outputs.

4. SLR/PLICS System Background

Costing Software
The costing software used at the Trust is Prodacapo, provided by Bellis-Jones Hill.

The system was first implemented in 2009 and rebuilt in 2013/14 to incorporate Scarborough activity data and costs. Since then the system has been used to produce trustwide quarterly Service Line Reports / Patient Level Costing information and annual trustwide reference cost submissions since 2013/14.

The latest available SLR/PLICS work and allocations are used to underpin the reference cost model each year. For the 2015/16 reference cost submission this year we are using the Q4 2015/16 SLR model as the basis. The benefit of creating the reference cost model in this way is that any improvements and changes carried out through the year, due to new information and Directorate engagement, are fed into reference costs leading to more accurate cost allocations.

5. Treatment of Costs

HFMA Acute Health Clinical Costing Standards
The costing standards provided by HFMA, which form part of Monitor's Approved Costing Guidance, provide Trusts with guidelines on how pools of costs should be treated.
The SLR & Costing team use this guidance, where possible, to trace costs within the system.

Details of our costing methodologies were given to PWC during a recent reference cost audit, with PWC making no recommendations on this area.

Improving Accuracy of Consultant Expenditure Allocations
Throughout the year, for the purpose of SLR/PLICS, the Directorate teams have been asked to update and validate the consultant expenditure allocations each quarter to reflect actual activity within the period rather than the SLR & Costing team using annual planned activity from the consultant job plans.

The benefit of using actual activity allocations rather than planned activity is that the consultant costs will be more accurately traced to the correct patients and services in the correct proportions.

Deep Dives & Cost Centre Tracker
Throughout the year, the SLR & Costing team have been, and are continuing to work with the Finance Managers and Directorate Management Teams to populate a cost centre tracker, documenting and agreeing the treatment of income and expenditure within the costing system.

By ensuring the treatment of income and expenditure is accurate; the Trust can confidently use the SLR/PLICS data to gain a greater understanding of the costs of services that we provide.

This process and documentation provides assurance that the costing team understand the

costs held within each cost centre, and can accurately trace them to the appropriate patients of services.

6. Audit

Internal SLR Audit Report
During March 2016 Internal Audit carried out a review of the SLR/PLICS system and processes used to produce the SLR/PLICS data. The final report was published on 7th April 2016 with an opinion of significant assurance.

This provides good assurance that the underlying processes used to produce costing information are robust.

External Reference Cost Audit
During December 2015 PWC were on site to carry out an audit of our 2014/15 reference cost submission and the processes used to underpin the submission.

The audit was carried out on behalf of NHSI.

The draft audit report was received on 18 April 2016 with an option of 'Materially Compliant'. This result provides further assurance on the work and submissions carried out by the team.

The report contained four recommendations, for which actions plans have been submitted.

Once the final version of the audit report is received, the findings of this audit will be presented to the Finance and Performance and the Audit Committees.

7. Assurance for Board Approval

Board Confirmation
Detailed below are responses required to enable the Board to consider if it is satisfied to confirm the six requirements needed to approve the process.

The Board of each NHS Trust and NHS Foundation Trust, or its Audit Committee or other appropriate sub-committee is required to confirm the following in relation to the reference cost return (or provide details of non-compliance):

a) the Board or its appropriate sub-committee has approved the costing process ahead of the collection;

This report is the process used to seek approval for the costing process used to produce the Reference Cost return.

b) the Director of Finance has, on behalf of the board, approved the final reference cost return prior to submission;

A meeting has been scheduled for 28 July 2016 for the Head of SLR & Costing to present the final submission to Director of Finance in order to approve, submit and sign off the return.

c) the reference cost return has been prepared in accordance with Monitor's Approved Costing Guidance, which includes the reference cost guidance

The purpose of the external audit carried out by PWC in December 2015 was to consider whether our 2014/15 reference costs submission was prepared in accordance with Monitor's costing guidance.

The outcome of 'Materially Compliant' provides assurance that our process of producing the

reference cost return is in accordance with Monitor's Approved Costing Guidance, which includes the Reference Cost guidance.

The audit report provided four recommendations requiring us to provide an action plan to further improve our level of compliance. The action plans have been communicated back to PWC and we are now awaiting the final version of the report.

One of the recommendations was around Board approval, which is being addressed with this report.

The other three recommendations relate to patient activity; rehab in community hospitals, MSK physiotherapy outpatient data and palliative care inpatient activity.
We have responded with action plans for these and confirm they will be implemented ahead of the submission for this year.

A copy of the draft audit report including our response has been included with this report.

d) information, data and systems underpinning the reference cost return are reliable and accurate;

The SLR & Costing team work closely throughout the year with the SNS Information Team and Development Team who play a vital role in providing and loading the SLR/PLICS and reference cost patient activity data from CPD into the costing system.

The Information Team have a good understanding of the reference cost process and requirements, and ensure that the activity data is complete and passed through the correct DoH Grouper software before being received by the costing team.

Where activity data is recorded outside of CPD, i.e. Diabetic Retinal Screening, elements of Community data and pharmacy data, the costing team collects this data manually directly from the appropriate department or service.

Comparing activity figures year on year for each of the various departments and services allows the SLR & Costing team to identify any gaps in the data or where data has been double counted.

The Development Team support the costing team in making development changes to the costing software in order to allow for accurate costing and changes in reporting requirements.

In addition, the costing team also receives support from Bellis-Jones Hill, the supplier of Prodacapo, our costing software, to ensure that the system processes are reliable, accurate and running correctly.

The reference cost quantum is prepared in accordance with the Reference Costs guidance to ensure that we are reporting the correct costs.

Appendix 1 shows the reconciliation for the submission this year, which has been reconciled to the audited annual accounts. The cells in yellow are yet to be costed and included, and will be added later in the process and before the final submission.

e) there are proper internal controls over the collection and reporting of the information included in the reference costs, and these controls are subject to review to confirm that they are working effectively in practice;

Internal controls are in place within the SNS Directorate to ensure that, for overall reporting

purposes, patient activity data is complete and correct. Some of the policies and procedures were provided to PWC as part of the recent reference costs audit.

The costing team also have numerous procedure notes that detail processes and costing methodologies used. There were also provided to PWC as part of the recent reference cost audit.

The internal SLR audit carried out during March 2016 examined the costing system; the same system used to produce reference costs, with the objective of providing assurance that the Trust produces accurate costing information for internal and external reporting. The outcome of the report was an opinion of 'significant assurance'.

The costing team have various checklists and error reports to view the progress being made throughout the calculation and submission period. One example is tracking that costs input into the system are fully traced and reconcile to the outputs.
The Head of SLR & Costing monitors the checklists and error reports on a regular basis to ensure completion and accuracy of all tasks.

The costing team ensure that output unit costs are benchmarked against the national average to highlight and signpost any potential mistakes in the costing process, so that they can be rectified before the final submission deadline.

The progress and developments of the SLR/PLICS and reference costs process is communicated to the SLR Project Board on a monthly basis, which is attended by the Director of Finance, the Deputy Director of Finance, the Head of Corporate Finance and the Head of SLR & Costing.

f) costing teams are appropriately resourced to complete the reference costs return, including the self-assessment quality checklist and validations accurately within the timescales set out in the reference costs guidance.

The SLR & Costing team is both small and specialised. The expertise within the team is used to plan, manage, process and deliver the overall reference cost submission and to implement developments in line with the guidance.

Since January 2016 the SLR & Costing team has, for the first time since before the Scarborough integration, been fully resourced in terms of staff. The team is made up of 5 members of staff, full and part-time, with a total of 3.83 wte's. We feel that is adequate for the current internal and external costing requirements.

The self-assessment quality checklist forms part of the reference cost submission workbook and must be completed in order for the workbook to be submitted.

The Head of SLR & Costing has produced a detailed timetable for the reference cost period showing key dates, work in progress periods and validation time. This gives assurance that time has been planned for validation and completion of the quality checklist.

Appendix 2 shows the costing team timetable.

Appendix 3 shows the self-assessment quality checklist with possible responses in full along with our current or intended responses in bold.

7. Recommendation	
The Board is asked to note the process used to prepare, calculate and submit the reference cost return as detailed in this report, and approve the process for the upcoming submission (point a)). As per the reference cost guidance, the Board is also required to confirm points b) to f) using the information provided in this report as assurance. In addition, the Board is asked to discharge any further sign off responsibility for the 2015/16 Reference Cost return to the Director of Finance.	
Author	**Victoria Pryszczyk, Head of SLR & Costing**
Owner	**Andrew Bertram, Finance Director**
Date	**May 2016**

2014/15 Reference Cost Audit

York Teaching Hospital NHS Foundation Trust

20 May 2016

DRAFT

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Contents

Distribution List

Monitor:	Yash Patel, Pricing Enforcement and Case Management Director
	Amit Patel, Tariff Case Management & Compliance Manager
CC'd:	Andrew Bertram, Director of Finance, York Teaching Hospital NHS Foundation Trust
	Victoria Pryszczyk, Head of Service Line Reporting and Costing, York Teaching Hospitals NHS Foundation Trust

1. Executive summary

Compliance rating	*Assessment of adequacy of action plans to address findings*

Materially Compliant

	Action plan provided?	Assessment of adequacy of action plans to address findings?
Board approval and finance director sign-off of cost return	Yes/No	TBC
Mapping of costing method	Yes/No	TBC

1.1 Summary of findings

The purpose of the audit is to provide assurance that reference costs have been prepared in accordance with Monitor's Costing Guidance. York Teaching Hospital NHS Foundation Trust (the Trust) is one of the selected providers being audited in 2015/16 to improve the quality of cost information used to set national and local prices.

The Trust provides a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale. The Trust manages ten hospital sites.

In April 2011 the Trust took over the management of community-based services in Selby, York, Scarborough, Whitby and Ryedale. In July 2012 the trust acquired Scarborough and North East Yorkshire Healthcare NHS Trust, bringing Scarborough and Bridlington Hospitals into the organisation. The Trust's annual turnover is over £400million.

The Trust uses the Prodacapo costing system and a bespoke electronic patient record system. There is a strong business intelligence function at the Trust with embedded service line management and patient level costing. The reference cost team demonstrated a strong understanding of reference cost guidance, the Trust's costing system and good project management in preparing the 2014/15 reference cost return.

There was good engagement of the senior finance staff and other senior management on the 2014/15 reference cost submission with oversight of the Director of Finance evidenced. Costing data is also used for decision making across the Trust.

Risk Assessment

The primary driver behind the Trust's selection was the fact that its reference cost submission had not been subject to audit in the previous two years. All Trusts not selected for audit last year will be audited as part of the 2015/16 programme.

York Teaching Hospital NHS Foundation Trust have an RCI of 100, at the median for all acute NHS trusts in England for 2014/15.

Overall Conclusion

Based on the results of our work set out in Appendix 1, we have concluded that the Trust's 2014/15 Reference

Cost Return's preparation is **materially compliant** with Monitor's Costing Guidance (see Appendix 2 for rating classification including materiality considerations).

We identified the following areas for the Trust to consider in order to further improve its processes:

1. **Board assurance process**

The reference cost submission has not been presented to the board or sub-committee since 2013 and therefore is not fully compliant with the guidance which requires the Board or delegated sub-committee to undertake assurance on the return each year. It was evidenced that there was sufficient review by the Director of Finance in 2014/15.

2. **Mapping of costing method**

We noted three areas where the Trust's costing methodology or activity used to calculate unit costs were not in line with guidance. These were not material to the quantum.

- All rehabilitation in community hospitals are costed at the same unit cost as there was insufficient information to calculate different costs for the different HRGs. This approach is unlikely to reflect the actual costs incurred in delivering the different types of rehabilitation.
- Specialist palliative care activity was not obtained in time for the 2014/15 submission deadline and the 2013/14 activity was reported. This understated activity and overstated unit costs for this service.
- The costing team could not obtain up to date activity details for £5.8m of community physiotherapy, but due to resource constraints in the costing team this was not identified as an issue before the submission deadline. The trust reported an understated activity of 69,162 for 2014/15, approximately half that in 2013/14.

The total costs affected by these issues were £13m, 3.4% of the quantum and therefore below the defined materiality threshold.

To be completed once Action Plan available

[Management has prepared an action plan to address [all, x of y] findings. Our conclusion on the adequacy of management's action plans to address the findings raised is provided in the above table.]

2. Background and scope

2.1 Background

The Assurance programme for 2015/16 considers whether trust reference cost returns for 2014/15 have been prepared in accordance with relevant regulatory obligations contained within Monitor's provider licence.

The relevant currently in force regulatory obligations are the requirements to comply with Monitor's Costing Guidance (which includes 2014/15 Reference Cost Guidance and the Healthcare Financial Management Association (HFMA) costing standards on a 'comply or explain' basis).

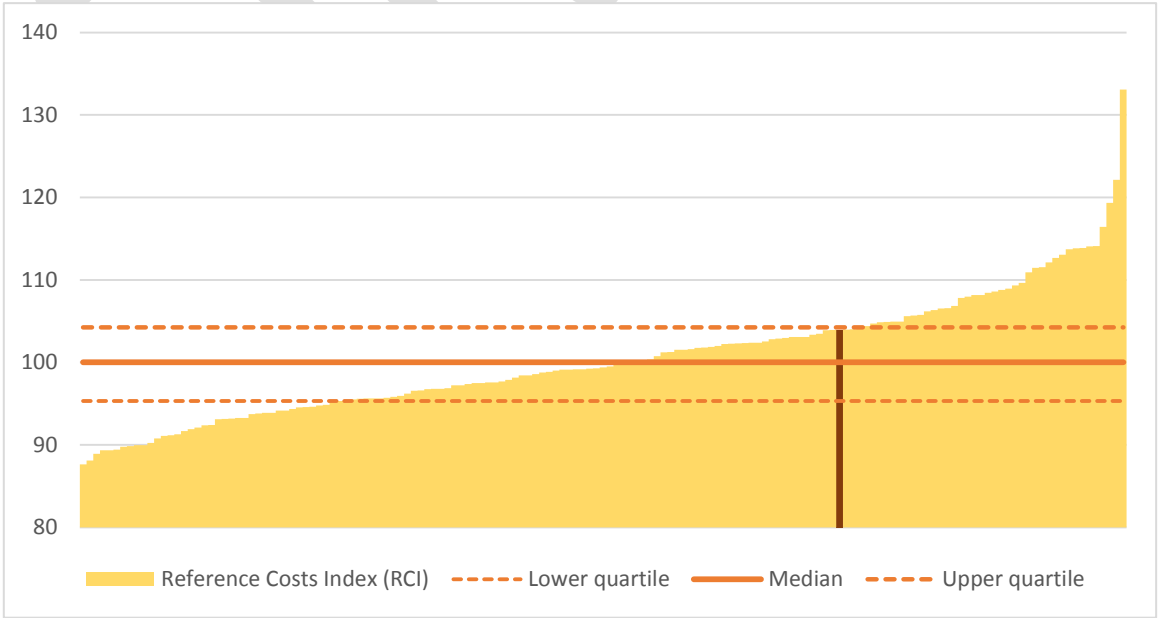
Approach to risk assessment and selection

In planning the programme we performed a risk assessment of providers to inform the audit process and select trusts for audit. This risk assessment considered the following factors:

- The length of time since the previous Reference Cost Return (each trust should be audited every two years);
- The outcome of any previous audits;
- Whether or not providers submitted their returns on time;
- Providers' correction rate of non-mandatory data validations identified following submission;
- The extent of differences between providers' operating expenses total in their annual accounts and their reference cost quantum (defined as the Trust's total costs relevant for reference costs once mandatory exclusions have been taken into account);
- The provider's reference cost index; and
- The proportion of uncoded activity reported in 2014/15.

The primary driver behind the Trust's selection was the fact that its reference cost submission had not been subject to audit in the previous two years. All trusts not selected for audit last year will be audited as part of the 2015/16 programme.

York Teaching Hospital NHS Foundation Trust – RCI compared to all acute trusts in England



The Reference Costs Index (RCI) evaluates a trust's cost relative to other NHS trusts. It compares the actual

cost of delivering a trust's activity with the cost of delivering the same activity at national average cost. Where a trust's costs are more expensive to the national average, the RCI will be greater than 100, and where they are cheaper the RCI will be below 100.

York Teaching Hospital NHS Foundation Trust have an RCI of 100, at the median for all acute NHS trusts in England for 2014/15. Non elective admissions account for 33% of the Trust's reference costs, and have an RCI of 92, i.e. are 8 per cent cheaper than nationally. Elective admissions account for 16% of their reference costs and have an RCI of 93, while outpatient activity accounts for 18% and have an RCI of 99.

2.2 Scope and limitations of scope

Our work, and the basis of our conclusions, is limited to the procedures outlined in Appendix 1.

Management is responsible for the implementation of the action plans to address the findings set out in Section 3. We have provided an assessment as at the date of this report over whether management's action plan appears reasonable to address the issues identified within the specified timeframe. PwC is not responsible for the implementation of the action plans contained within this report.

Our work involved testing the allocation of financial information and this report does not express any assurance with regard to the accuracy of the Trust's underlying financial data or processes.

Our findings and recommendations are limited to the tests and procedures that we have performed (as described in Appendix 1).

3. Detailed findings

3.1 Introduction

This detailed findings section summarises areas identified that are non-compliant with the Costing Guidance. It also summarises areas for further improvement in processes and governance arrangements supporting completion of the reference cost return.

Appendix 1 summarises the procedures we have performed to assess compliance with the Costing Guidance.

3.1.1 Board approval of cost return

Finding

Process for reporting reference costs to the Board

Ahead of submission the Department of Health's Reference Cost Guidance 2014/15 states that the Trust's reference cost submission should be subjected to the same scrutiny and diligence as other financial returns submitted by the Trust. Each year the Board should satisfy itself with assurances over the Trust's costing processes and systems, and that the Trust will submit its reference cost return in accordance with the guidance.

Within the Trust's reference costs procedure notes, there were no documented process for how the Board will obtain appropriate assurance over the reference cost return each year, as required by the Department of Health's reference cost guidance 2014/15.

We confirmed that for 2014/15 the Board had delegated responsibility for reference cost return oversight to the Director of Finance and an assurance report had not been presented to the Board since 2013.

Implications

Without clear documentation of the process for signing off the annual reference cost return, the Board may not obtain adequate assurance over the regulatory return in future submissions.

Failure to seek and evidence board or sub-committee approval for the submission of the return removes an important layer of assurance over the validity of the reference costs process and a requirement of the DH guidance.

Action plan

Management Actions	**Responsible person**
The Head of SLR & Costing will produce an annual report for the Board of Directors, ahead of the submission, detailing the costing process and approach to be used for the production of reference costs, requesting that the process be approved by the Board.	Head of SLR & Costing **Target date:** June 2016 **PwC Assessment of Adequacy** [Adequate / Inadequate]

3.1.2 HRG level testing

Finding

Rehabilitation in community hospitals

The Trust costed all inpatients receiving rehabilitation in community hospitals the same as there was insufficient information to calculate different costs for the different HRGs. It is likely that the costs incurred in delivering the different types of rehabilitation are not apportioned accurately.

The total cost for all the inpatient rehabilitation HRGs was £6.7m, which is 1.7% of the total quantum. This area is covered by a block contract.

Community physiotherapy activity

The costing team could not obtain up to date activity details for community physiotherapy, but due to resource constraints in the costing team this was not identified as an issue before the submission deadline. The trust reported an understated activity of 69,162 for 2014/15, approximately half that in 2013/14. The musculoskeletal service activity is not part of the SUS national data submission.

The total cost for the community physiotherapy HRGs was £5.8m, which is 1.5% of the total quantum.

Specialist palliative care activity

The 2013/14 OP (Non-face to face) specialist palliative care activity was overstated as it was not spotted that the majority of contacts recorded had taken place on a ward. For 2014/15, the costing team corrected the data manually and left only genuine non-face to face attendances, where the patient was not already an inpatient.

For inpatients; the specialist palliative care data is collected manually and was not available in time for the 2014/15 reference cost deadline. The trust therefore used the 2013/14 activity of 8,422 instead of the actual activity of 13,107.

The total cost for specialist palliative care inpatient HRGs was £0.5m, which is 0.13% of the total quantum.

Implications

Where costs and/or activity have been misreported or incorrectly allocated, this reduces the accuracy of the Trust's reporting within the submission and the validity of reference costs at a national level.

Action plan

Management Actions	**Responsible person**
Rehabilitation in community hospitals In the absence of an unbundled HRG from the Reference Cost Grouper, the SLR & Costing team will work closely with the IT Development Team and Bellis-Jones Hill, the costing software provider, to identify a manual method of identifying the most appropriate unbundled Rehab HRG using the ICD-10 and OPCS codes available within the data. In addition, the Head of SLR and Costing will discuss the underlying data issue to the Information Manager and Clinical Coding Manager to look for a possible solution at source for future activity.	Head of SLR & Costing **Target date:** June 2016 **PwC Assessment of Adequacy** [Adequate / Inadequate]
Community physiotherapy activity The Head of SLR & Costing will work with the Information Team to ensure a	

process is created for the MSK data to be received separately to the main outpatient data set. Work will then take place with the Development Team to append the activity into the costing system.

Specialist palliative care activity

The Head of SLR & Costing will create an activity collection log to track that all activity for the reference cost period has been requested and received ahead of the open submission window.

Appendix 1. Procedures to Assess Compliance with Reference Cost Guidance

Our conclusion on the whether the Trust's 2014/15 reference cost return has been prepared in line with Monitor's Costing Guidance is based on the outcomes of the below procedures.

Expected cost return controls	Audit Procedures	Reference to Findings
1. Policies and procedures: Trusts have documented policies and procedures for preparation of cost returns that: • reflect Monitor's latest costing guidance • are available to, and understood by, all staff involved in the cost return process • set out clear ownership for the accuracy of activity data • detail the process for reporting information to board level • set out what stakeholders are to be engaged in the cost return process. Trusts have a mechanism in place for capturing changes in guidance and updating their policies and procedures.	Obtain documented policies and procedures and inspect to assess whether these: • reflect Monitor's latest costing guidance • are available to, and understood by, all staff involved in the cost return process • set out clear ownership for the accuracy of activity data • detail the process for reporting information to board level • set out what stakeholders are to be engaged in the cost return process. Inquire as to where policies and procedures are stored and how staff involved in costing can access. Consider clinical staff, non-clinical staff, staff from informatics and clinical coding, and finance staff.	See finding 3.1.1
2. Self-assessment quality checklist: Per the DH Reference Cost Guidance (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402356/Reference_costs.pdf) each Trust should prepare a self-assessment quality checklist ahead of submitting its return. The checklist requires Trusts to assess whether: • total costs have been reconciled to the signed annual accounts • activity data used to complete the return has been fully reconciled to Trust Hospital Episode Statistics data • sense checks have been performed and documented prior to	Inquire as to whether Trusts have prepared a self-assessment checklist prior to submission. Obtain the self-assessment checklist and consider the completeness in responses compared to good practice outlined in the reference cost guidance. Inquire as to who reviewed and signed off the checklist, e.g. Board/DoF. Request evidence to confirm that activities set out in the self-assessment have been performed ahead of submission.	No issues noted.

Expected cost return controls	Audit Procedures	Reference to Findings
submission • benchmarking of cost and activity data using the national benchmarker • assurance has been obtained in the year over data quality • assurance has been obtained over the reliability of costing and activity systems • all non-mandatory validations have been resolved prior to submission.		
3. Board approval and finance director sign-off of cost return The Board of each NHS trust and NHS foundation trust, or its Audit Committee or other appropriate sub-committee, is required to confirm in advance of the reference costs submission that it is satisfied with the trust's costing processes and systems, and that the trust will submit its reference cost return in accordance with latest guidance. In providing this confirmation, Boards or their appropriate sub-committees may wish to satisfy themselves that procedures are in place to ensure that the self-assessment quality checklist can be completed at the time of the reference cost submission. A Trust's reference costs submission should be subjected to the same scrutiny and diligence as any other financial returns submitted by the Trust.	Obtain board minutes detailing approval of cost return prior to submission and consider whether the board has satisfied itself with the adequacy of trust processes for completion of the return.	See finding 3.1.1
4. Resourcing of costing, coding and reporting processes Trusts should ensure that they have adequate resources in place to produce an accurate cost returns and to perform adequate coding of spells. Staff involved should have adequate experience and qualifications. Where Trusts have invested in IT systems to facilitate automation staff operating systems should be appropriately qualified.	Inquire as to roles and responsibilities for preparation of returns. Inquire as to the experience of the key individuals in preparing returns and whether there have been significant changes in Trust staff during the year. Consider the number and qualifications of coders. Consider how Trusts have assurance over operation of IT systems used in the costing and coding process.	No issues noted.

Expected cost return controls	Audit Procedures	Reference to Findings
5. Reconciliation of reference cost returns to audited annual accounts Within reference cost workbooks Trusts are required to reconcile their reference costs to their audit annual accounts.	Obtain the Trust's reconciliation and audit annual accounts for 14/15. Trace all line items to annual accounts and obtain an understanding of large reconciling items. Often there are large errors in this reconciliation including: • drugs and devices exclusions • cost of non-NHS private patients • services excluded from reference costs Sample testing of cost reference costs where large adjustments are being made in the reconciliation, in particular around high risk specialties.	No issues noted.
6. Reconciliation to activity data Activity data should be reconciled to month 13 Service Level Agreement Monitoring (SLAM) data to confirm that all relevant activity has been captured. Management should have clear documentation on all data feeds used in reference costing so that there is clarity over how costs are allocated. Unbundled services should be removed as part of reconciliation. Good practice would be for Trusts to feed activity data in to a central data warehouse.	Obtain documentation of activity data feeds used in reference costing process. Obtain reconciliations of returns to SLAM and test to activity feeds. Where differences are identified obtain explanations for these and assess for reasonableness. Sample testing to verify accuracy of coding and activity data. Include testing of unbundled services removed to confirm appropriateness. Sample testing to verify accuracy of coding and activity data. Include testing of unbundled services removed to confirm appropriateness.	No issues noted.
7. Assurance over clinical coding/classification of activity Trusts should have a clearly documented process for clinical coding which includes expected controls: • Documented systems to capture and code clinical activity • Adequate resource of qualified clinical coders and auditors • Assurance processes over the efficacy of clinical coding • Clinical engagement and review of coded activity data	Data analysis will evaluate the quality of clinical coding at the trust across a number of specialties. • This analysis will evaluate the quality of clinical coding for each specialty according our 5 key coding indicators. • The analysis will also identify specific issues within these areas that will be investigated in more detail, with the RCI impact of these issues. • A further high level analysis on reference cost activity will use this more detailed analysis as a guide. On-site controls review:	No issues noted.

Expected cost return controls	Audit Procedures	Reference to Findings
	• Obtain the Trust's policies and procedures for PAS data including controls over data entry, training requirements, alignment to the NHS data dictionary, and how assurance is gained over data. • Obtain the Trust's process documentation for clinical coding. • Walkthrough of processes to validate controls. • Discuss key lines of enquiry with Trust and validate explanations. Detailed testing: • Test activity data feeds used in reference cost return and underlying costing approach. • Test reconciliations of returns to SLAM and test to activity feeds. Where differences are identified obtain explanations for these and assess for reasonableness. • Where significant risks are identified, sample testing of clinical coding to patient records for targeted specialities and HRGs – approach is validating the Trust's controls are operating effectively within the relevant areas identified.	
8. Mapping of Costing Method Trusts should be able to map their costing process from cost centres through to individual HFMA cost pools. There should be a clear path from how costs are mapped in the GL, to cost pools and then cost pools to HRGs. This will allow them to clearly demonstrate how all costs have been allocated and the basis for doing so.	Obtain the Trust's mapping of its costing method. This should clearly illustrate how direct costs, indirect costs and overheads are captured, allocated to cost pools and then HRGs. Agree the inputs (costs in quantum) to the reconciliation to the Annual Accounts. Agree the mapping to the completed cost return. Assess the basis for apportionment for reasonableness with reference to HFMA guidance and test that this has been followed in completing the return. In particular focusing on pay costs as this is the largest area of cost. Test a sample of costs through to source records to confirm reasonableness of allocation and that this has been followed. Outliers / 'inliers' to from risk assessment to inform the selection of items.	See finding 3.1.2

Appendix 2. Basis of our classifications

Compliance ratings – Reference Cost Audit

Compliance rating	Assessment rationale
Non-compliant	A finding that could result in a: • ***Significant*** departure from the specified guidance; or • ***Significant*** inaccuracies in the 2014/15 Reference Cost Return defined as either: - errors identified resulting in 1% or greater difference in the total quantum of costs or total activity relevant to the reference cost return - HRGs with identified errors total 5% or more of the total quantum of costs relevant to the reference cost return (using the highest of market forces factor adjusted national mean unit cost for HRGs where we consider the costing may be understated or the trust's unadjusted submitted reference cost for relevant HRGs) Illustrative examples: • No process for verifying the apportionment basis for cost drivers / allocations or this may not have been undertaken in the past two years • The presence of material journaled adjustments within the costing system that cannot be supported by management • Unexplained material adjustments within the reconciliation to accounts or activity system • Material errors or misstatements in the allocation approach, including through poor activity recording and/or clinical coding practices
Materially compliant	A finding that could have a: • ***Minor*** departure from the specified guidance; or • **Minor** inaccuracies in the 2014/15 Reference Cost Return defined as either: - errors identified resulting in less than 1% difference in the total quantum of costs or total activity relevant to the reference cost return - HRGs with identified errors total less than 5% of the total quantum of costs relevant to the reference cost return (using the highest of market forces factor adjusted national mean unit cost or the trust's unadjusted submitted reference cost for relevant HRGs – see details on assessing materiality at HRG level below) Illustrative examples: • Cost drivers / apportionment bases substantially verified during 14/15 with evidence provided for engagement with wider Trust management • Failure to evidence Board assurance over process but no significant issues identified in the preparation of the return • No documented policies and procedures but audit identified that guidance followed in preparing cost return • Immaterial unexplained or unsupported adjustments in the reconciliation to accounts or activity system • Immaterial errors or misstatements in the allocation approach, including through issues found in activity recording and/or clinical coding practices Significant issues or risks to be reported in action plan for improvement even if not material

Conclusions on adequacy of action plans

Finding rating	Assessment rationale
Inadequate	The action plan proposed by management is not considered adequate to address the issues identified within the specified timeframe.
Adequate	We consider the action plan proposed by management to be adequate to address the issues identified within the specified timeframe.

Appendix 3. Limitations and responsibilities

Limitations of scope

We have undertaken a review of the 2014/15 Reference Cost Return at York Teaching Hospital NHS Foundation Truston behalf of Monitor, subject to the limitations outlined below.

This document has been prepared only for Monitor and solely for the purpose and on the terms agreed with Monitor in our agreement dated 2 October 2015. We accept no liability (including for negligence) to anyone else in connection with this document. A draft of the document may be shared with the Trust to confirm factual accuracy and the Audit Committee if requested by Monitor in writing so that it can review the action plans contained within the report.

Our assessment of compliance with Monitors guidance in preparing the Reference Cost Return is limited to for the period specified only. Historic evaluation of compliance is not relevant to future periods due to the risk that:

- the design of existing processes or controls may become inadequate because of changes in operating environment, law, regulation or other; or
- The degree of compliance with policies and procedures may deteriorate.

Management is responsible for the implementation of the action plans to address the findings set out in Section 3. We have provided an assessment as at the date of this report over whether management's action plan appears reasonable to address the issues identified within the specified timeframe. PwC is not responsible for the implementation of the action plans contained within this report.

Our work involved testing the allocation of financial information and this report does not express any assurance with regard to the accuracy of the Trust's underlying financial data or effectiveness of its processes. Our findings and recommendations are limited to the tests and procedures that we have performed (as described in Appendix 1).

Appendix 2
Reconciliation of reference costs to the audited annual accounts

Line	Description	Notes: FTs	Notes: NHS Trusts	£
1	**Operating expenses**	1. SOCI Note 3	TRU01 sc100 + sc110	£477,998,569
2	Less: Actual cost of non-NHS private patients			
3	Less: Actual cost of non-NHS overseas patients (non-reciprocal)			
4	Less: Actual cost of other non-NHS patients			
5	Less: Total other operating income split into	6. Op Inc (type)	TRU01	
5a	Non-salaried education and training income			-£3,405,864
5b	Salaried education and training income			-£10,458,520
5c	Research and Development: Centrally funded			-£4,336,239
5d	Research and Development: Privately funded			-£507,579
5e	Other			-£35,043,414
6	Add: Not allowable non-contractual income			£11,195,562
7	Less: Actual cost of centrally funded awards under the Clinical Excellence Awards Scheme			-£40,486
8	Less: Actual funds received for Foundation Trust application			
9	Less: PFI/LIFT exclusions			
10	Less: Impairments	7.Op Exp (type)		
10a	New build impairments			
10b	Other impairments			-£3,120,617
11	Add: Reversal of impairments	6. Op inc		
11a	New build reversals			
11b	Other reversals			£1,403,506
12	Less: Depreciation related to donated or government granted non-current assets			-£391,749
13	Add: Donations or government grants received to fund non-current assets		TRU05 sc287 + sc288 + sc300	£471,654
14	[insert full details of additional adjustment]			
15	[insert full details of additional adjustment]			
16	[insert full details of additional adjustment]			
17	[insert full details of additional adjustment]			
18	[insert full details of additional adjustment]			
19	Less: Adjustment for provider-to-provider agreements			
20	Add: Other gains and losses	Part year FTs only	TRU01 sc160	
21	Less: Finance income (FTs) or investment revenue (NHS trusts)	1.SOCI Note 8	TRU01 sc150	-£130,209
22	Add: Finance expenses financial liabilities (FTs) or finance costs (NHS trusts)	1.SOCI Note 9	TRU01 sc170	£359,824
23	Add: PDC dividends payable	1.SOCI	TRU01 sc190	£6,842,000
24	Add: Finance expenses - unwinding of discount			£15,893
25	**Less: Services excluded from reference costs**			
25a	Ambulance trusts - specified services			
25b	Cystic fibrosis drugs			
25c	Discrete external aids and appliances			
25d	Health promotion programmes: Contraception and sexual health			
25e	Health promotion programmes: Oral health promotion			
25f	Health promotion programmes: Stop smoking education programme			
25g	Health promotion programmes: Substance misuse			
25h	Health promotion programmes: Weight management			
25i	Health promotion programmes: Other health promotion programme.			
25j	Home delivery of drugs and supplies: administration and associated costs			
25k	Home delivery of drugs and supplies: drugs, supplies and associated costs			
25l	Hospital travel costs scheme			-£64,546
25m	Learning disability services			
25n	Local Improvement Finance Trust (LIFT) and Private Finance Initiative (PFI) set up costs			
25o	Mental health trusts - specified services			
25p	Named providers - specified services			
25q	NHS continuing healthcare, NHS-funded nursing care and excluded intermediate care for individuals aged 18 or over			
25r	NHS continuing healthcare, NHS-funded nursing care for children			
25s	Patient transport services (PTS)			
25t	Pooled or unified budgets			
25u	Primary medical services			
25v	Prison health services			
25w	Screening programmes			
25x	Specified hosted services			
28	**Total reference costs submission quantum (sum lines 1 to 27)**			**£440,787,786**

Quantum before exlusions	£440,787,786
check	£0

Appendix 3 - SLR & Costing team timetable

Key

- **Costing team work**
- **Key dates**
- **For info**

		Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
		W/C	04-Apr	11-Apr	18-Apr	25-Apr	02-May	09-May	16-May	23-May	30-May	06-Jun	13-Jun	20-Jun	27-Jun	04-Jul	11-Jul	18-Jul	25-Jul
Task	**Task Description**	W/E	08-Apr	15-Apr	22-Apr	29-Apr	06-May	13-May	20-May	27-May	03-Jun	10-Jun	17-Jun	24-Jun	01-Jul	08-Jul	15-Jul	22-Jul	29-Jul
1	Agree Bellis-Jones Hill support																		
2	Test Submission Workbook provided by DOH																		
3	Final Submission Workbook provided by DOH																		
4	Meet with SNS regarding CPD data required	06-Apr																	
5	Request Non-CPD (not inc Community) activity data by 22nd April			22-Apr															
6	Request Community activity data by 29th April				29-Apr														
7	Final accounts sign off			22-Apr															
8	Activity data received from SNS				25-Apr														
9	Activity data received from SNS - February and March Freeze									25-May									
10	Reference Cost Model Build (BJH)				28-Apr														
11	Quantum Calculation - first view				25-Apr														
12	Quantum Calculation - final					06-May													
13	All costs traced to cost object (all the way through) by											10-Jun							
14	Costing Team initial model WIP																		
15	Create output draft submission																		
16	First Submission Ready												17-Jun						
17	Initial Submission Period (Open Submission)																		
18	Target date to submit initial workbook													20-Jun					
19	Final date to submit initial workbook																	22-Jul	
20	Validation, benchmarking and changes																		
21	Changes completed by 22nd July																	22-Jul	
22	Create output final submission and reconciliation																		25-Jul
23	DoF Approval/Signoff																		28-Jul
24	Regionally Managed **Final Submission deadline**																		**28-Jul**

Appendix 4 – Self-assessment quality checklist

Current or intended position by the final submission date shown in bold and underlined

	Check	Response
QC 1	Total costs: The reference costs quantum has been fully reconciled to the signed annual accounts through completion of the reconciliation statement workbook in line with guidance	• **Fully reconciled to within +/- 1% of the signed annual accounts** • Fully reconciled to within +/- 1% of the draft annual accounts [state reason]
QC 2	Total activity: The activity information used in the reference costs submission to report admitted patient care, outpatient attendances and A&E attendances has been fully reconciled to provisional Hospital Episode Statistics and documented	• Fully reconciled and documented • Partly reconciled • n/a – reconciliation completed but to another source [state reason] • Not reconciled **Final activity not yet received due to freeze dates – the intention is to fully reconcile and document**
QC 3	Sense check: All relevant unit costs under £5 have been reviewed and are justifiable	• All relevant unit costs under £5 reviewed and justified [state reason] • n/a – no relevant unit costs under £5 within the submission **It is too early in the process to view any output unit costs – if there are any they will be reviewed and justified**
QC 4	Sense check: All relevant unit costs over £50,000 have been reviewed and are justified	• All relevant unit costs over £50,000 reviewed and justified [state reason] • n/a – no relevant costs over £50,000 within the submission **It is too early in the process to view any output unit costs – if there are any they will be reviewed and justified**
QC 5	Sense check: All unit cost outliers (defined as unit costs less than one-tenth or more than ten times the previous year's national mean average unit cost) have been	• All unit cost outliers reviewed and justified [state reason] • n/a – no unit cost outliers within the submission

	Check	Response
	reviewed and are justifiable	**It is too early in the process to view any output unit costs – if there are any they will be reviewed and justified**
QC 6	Benchmarking: Data has been benchmarked where possible against national data for individual unit costs and for activity volumes (the previous year's information is available in the National Benchmarker)	• All cost and activity data within the submission has been benchmarked using the National Benchmarker prior to submission • All cost and activity data within the submission has been benchmarked using another benchmarking process [state] • Some but not all cost and activity data within the submission has been benchmarked using the National Benchmarker prior to submission • Some but not all cost an activity data within the submission has been benchmarked using another benchmarking process [state] • No benchmarking performed on the cost data prior to submission **It is too early in the process to view any output unit costs and therefore too early to benchmark – our intention is to benchmark all costs and activity using the National Benchmarker, also using our unit costs from last year and the daily data provided by DoH during the open submission window**
QC 7	Data quality: Assurance is obtained over the quality of data for 2015-16	• An external audit has been performed on data quality • **An internal audit has been performed on data quality** • Internal management checks have provided assurance over data quality • Assurance has been obtained over data quality but not for 2015-16 • No assurance has been obtained over data quality

	Check	Response
QC 8	Data quality: Assurance is obtained over the reliability of costing and information systems for 2015-16	• **An external audit has been performed on costing and information system reliability** • An internal audit has been performed on costing and information system reliability • Internal management checks have provided assurance over costing and information system reliability • Assurance has been obtained over costing and information system reliability but not for 2015-16 • No assurance has been obtained over costing and information system reliability
QC 9	Data quality: Where issues have been identified in the work performed on the 2015-16 data and systems, these issues have been resolved to mitigate the risk of inaccuracy in the 2015-16 reference costs submission	• All exceptions have been resolved and the risk of inaccuracy in the 2015-16 reference costs submission fully mitigated • Some exceptions have been resolved but not all • Exceptions have yet to be resolved • n/a - no exceptions noted **It is too early in the process to have resolved all issues – our intention is that, if any, all exceptions have been resolved and the risk of inaccuracy in the 2015-16 reference costs submission fully mitigated**
QC 10	Data quality: All other non-mandatory validations as specified in the guidance and workbooks have been considered and any necessary revisions made	• All non-mandatory validations have been considered and necessary revisions made • All non-mandatory validations have been considered and some but not all necessary revisions have been made [specify and state reason] • Some non-mandatory validations have been considered and necessary revisions made

	Check	Response
		[specify and state reason] • No non-mandatory validations have been investigated [state reason] • n/a - no non-mandatory validations have occurred **<u>It is too early in the process to have validated all non-mandatory issues – our intention is that, if any, all non-mandatory validations will be considered and necessary revisions made</u>**

Corporate Risk Committee –5th April 2016

Attendance: Sue Symington, Philip Ashton, Patrick Crowley, Fiona Jamieson, Anna Pridmore, Melanie Liley, Juliet Walters

Apologies: None

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes 4th February 2016**		The minutes of the previous meeting were agreed as a true record.		Minutes already circulated to the Board
2	**Matters Arising**		There were no matters arising that were not on the Agenda	.	
3	**Risk Management Update**		FJ presented Paper B on Risk Management. Focus was placed on the datix developments currently taking place and a discussion evolved about barriers and obstacles to incident reporting FJ advised that nationally, the reason most people do not report incidents, is because they rarely receive any feedback. FJ explained the challenges involved in feeding back to all reporters. WE agreed that to change this perception our trust will amend the initial acknowledgement to reporters and communicate clearly the review process which their datix has triggered.	.Assurance of risk management processes and reporting	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			Action: FJ to take this forward FJ advised that her team are looking at a method of providing feedback. There is a mechanism within datix to facilitate this. The team will consider this and feedback to the CRC.. **Action FJ to continue to work on developing the feedback** FJ presented the incident trends for the period April – December 2015, and highlighted that for the first time staffing issues were in the top 5 reported incidents with nurse staffing being the largest group affected by the reported unavailability of staff. Patient Slips trips and falls remained the highest number of incidents reported, although most resulted in low or no harm. FJ took the group through the levels of harm attributed to Clinical Incidents by category , by quarter for the period April 2015 – February 2016. This illustrates that most patients experience low or no harm, with 1% of patients experiencing moderate harm and 1% experiencing severe harm. A small number of patients incidents resulted in death, this did not amount to 1%.. FJ also talked the Committee through the Serious Incident profile for the trust indicating the number of investigations currently on going by type, and those	Assurance of the Board being sited on reporting trends	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			where the investigation had been completed but not yet closed by our Commissioners. Appendix A provided details of incidents by directorate, number and type. FJ advised that significant work had been undertaken to ensure that outstanding recommendations resulting from Serious Incident Investigations had been followed up and closed where appropriate on an evidence based approach. SS asked how we might report SI information to the Board differently and a discussion to place which concluded that a detailed report to be provided every 6 months to the Board which detailed • SI activity • Trends and themes • Spotlight on specific issues arising • Completion of actions • Some of the supporting information from Appendix A **Action:** **FJ to provide SI reports to Board twice a year.**	Assurance that the Board is sited on activity relating to Serious Incidents	
4.	**Corporate Risk Register Review**		FJ presented Paper C, The Risk Register Review to the Committee, introducing for the first time a section on those risks scoring 20 or above. The Committee approved of the approach but		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			suggested it could be further developed by adding more narrative under each risk in order to fully appreciate the risk and its mitigations. **Action: FJ to develop the approach in the next paper.** The Committee considered those issues recommended for removal and gave approval for the removal of: DOF6 and COO5. FJ advised that there have been no increases to the rating of any corporate risk in the current reporting period. FJ advised that both the Directors of Estates and Facilities and Systems and Network Services is currently reviewing directorate risks and this may result in some new corporate risks emerging. FJ also talked the group through some examples of where directorates had scored a risk at 15, but whilst the risk was important to the directorate, it did not make the level of Corporate Risk. The Committee found this helpful. **Directors Presentations** Juliet Walters , Chief Operating Officer attended to brief the committee on the Corporate Risks relating	Assurance to the Board that issues of the management of risks within the organisation	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			to her portfolio including the rationale for the removal of C005 (diagnostic targets). The issues discussed were those on which the Board of Directors were regularly sited on. The Committee asked if there were any newly emerging risks on the horizon. JW advised not currently although this could change. Melanie Liley attended to present the Corporate Risks for Out of Hospital Services Directorate. ML advised she had only recently been appointed to the role and had been reviewing the Corporate Risks currently identified, and would be giving greater consideration to them. Of particular interest to the Committee was the risk around the difficulties in providing end of life care in the community. ML explained that this was an issue that resided more with the Commissioner, around the lack of services. The issue for the directorate is around the impact that this has on district nursing staff, who often find themselves providing the service in the event of there being no alternative. ML also advised DCS5 has changed in as far as the MSK service has now been re awarded to the Trust after the successful bid pulled out of the contract. The risks remains as a significant number of staff resigned from their posts rather than work for an independent provider. The risk is therefore around		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			the shortfall in establishment and recruitment is taking place to address this. DCS7 : ML discussed the difficulties caused by the lack of integration of IT systems within the community. She reported that discussions were taking place with the Director of Systems and Network Services regarding the development of an integrated care record. The Committee thanked ML for her presentation, and welcomed her to her new post.	Assurance to the Board that issues of the management of risks within the organisation	
5	**Revised Board Assurance Framework Model**		SS /AP presented Paper D, which was the revised Board Assurance Framework Model , recently approved by the Board of Directors on 30 March 2016. AP advised whilst the framework was approved the content of the model was still in the process of being worked up and would be quality assured by Corporate Directors. The work was due to be completed by the end of June 2016. The Committee noted the work being undertaken.	Assurance to the Board on the development of the Board Assurance Framework Model	
6	**Board Assurance Framework at A Glance**		AP presented Paper E, The Board Assurance Framework at a Glance. It focuses on the identification of the strategic risks to the achievement of organisational ambitions, the	Assurance to the Board on the development of the Board Assurance Framework Model	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			method of oversight and the RAG rated assurance levels. The paper demonstrated how the BAF might look like in practice, for example • risks to achieving an organisational objective being achieved • cross reference where appropriate to the CRR • Controls and response • Assurance • Gaps in Control and assurance • Assurance level, that is RAG rating The Committee noted the work in progress and requested that AP continue her work in populating the model . **Action** **AP to complete the population of the model**		
7.	**Next Meeting**		The next meeting is arranged for 14th June 2016. Meeting time to be extended Chief Nurse and Medical Director to attend.		

York Teaching Hospital NHS Foundation Trust

Board of Directors – 25 May 2016

Certificates for approval

Action requested/recommendation

To approve the Chair and the Chief Executive to sign the additional annual certificate required as part of the year end.

Summary

Following the introduction of the Risk Assessment Framework, the Trust is required to complete a number of additional statements and certificates over the next couple of months. These include the following statements:

- Certificate on the availability of resources certificate
- Systems for compliance with licence conditions and related obligations
- Joint Ventures and Academic Health Science Centres Certificate
- Training of Governors – statement as required by s.151 (5) of the 2012 act

In May the Trust is required to submit the Certificate on the availability of resources and systems of compliance with licence conditions and related obligations. The attached is the submission released by Monitor that will be submitted at the end of May.

In June the Trust will be required to submit a completed Corporate Governance Statement which I am currently working on along with the Ventures and Academic Health Science Centres Certificate and training of Governors.

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	The paper has been discussed by the Corporate Risk Committee.
Risk	The risks are identified in the report.
Resource implications	There are no resource implications included in the report.
Owner	Patrick Crowley, Chief Executive
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	May 2016
Version number	Version 1

Self-Certification Template

FT Name: York Teaching Hospital NHS Foundation Trust

Organisation Name:

NHS Foundation Trusts are required to make the following declarations to Monitor :

1 & 2 *Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*
3 *Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence*
4 *Corporate Governance Statement - in accordance with the Risk Assessment Framework*
5 *Certification on AHSCs and governance - in accordance with Appendix E of the Risk Assessment Framework*
6 *Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act*

Declarations 1 and 2 above are set out this template, which is required to be returned to Monitor by 31 May 2016.
Declaration 3 is included in the APR 2016/17 Final Financial Template, which is required to be returned to Monitor per communications on final operational plan
Declarations 4, 5 and 6 above are set out in a separate template, which is required to be returned to Monitor by 30 June 2016.

Templates should be returned via the Trust portal, marked as a Trust Return with the activity type set to Annual Plan Review.

How to use this template

1) Copy this file to your Local Network or Computer.
2) Select the name of your organisation from the drop-down box at the top of this worksheet.
3) In the Certifications G6 worksheet, enter responses and information into the yellow data-entry cells as appropriate.
4) Once the data has been entered, add signatures to the document, as described below.
5) Use the Save File button at the top of this worksheet to save the file to your Network or Computer - note that the name of the saved file is set automatically -
6) Copy the saved file to your outbox in your Monitor Portal.

Notes: *Monitor will accept either:*
1) electronic signatures pasted into this worksheet (always use Paste-Special to do this) or
2) hand written signatures on a paper printout of this declaration posted to Monitor to arrive by the submission deadline.

Worksheet "Certification G6"

Declarations required by General condition 6 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed
	AND	
2	The board declares that the Licensee continues to meet the criteria for holding a licence.	Confirmed

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature		Signature	
Name	Susan Symington	**Name**	Patrick Crowley
Capacity	Chair	**Capacity**	Chief Executive
Date	25 May 2016	**Date**	25 May 2016

Further explanatory information should be provided below where the Board has been unable to confirm declarations 1 or 2 above.

A

B