York Teaching Hospital NHS
NHS Foundation Trust

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

on: **Wednesday 25th November 2015**

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	Patrick Crowley's Office, 2nd Floor Admin Block, York Hospital	Non-executive Directors
9.00am – 12.30pm	**Board of Directors meeting held in public**	**The Boardroom, 2nd Floor Admin Block, York Hospital**	**Board of Directors and observers**
12.30pm - 1.00pm	Lunch		
1.00pm – 2.15pm	Board of Directors meeting held in private	The Boardroom, 2nd Floor Admin Block, York Hospital	Board of Directors

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

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

On: **Wednesday 25th November 2015**

At: **9.00am – 12.30pm**

In: **The Boardroom, 2nd Floor Admin Block, York Hospital, Wigginton Road, York**

A G E N D A					
No	***Time***	***Item***	***Lead***	***Paper***	***Page***
Part One: General					
1.	9.00 – 9.15	**Welcome from the Chairman** The Chair will welcome observers to the Board meeting.	Chair		
2.		**Apologies for Absence and Quorum** • Juliet Walters, Chief Operating Officer	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 28 October 2015** To review and approve the minutes of the meeting held on 28 October 2015	Chair	B	11
5.		**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chair		
6.		**Patient Story**	Chief Nurse	Verbal	
7.	9.15 – 9.45	**Chief Executive Report** To receive an update on matters relating to general management in the Trust.	Chief Executive	C	23

No	Time	Item	Lead	Paper	Page
8.		**CQC reports and action plan** To receive the reports and the action plan.		D	29
Part Two: Quality and Safety					
9.	9.45 – 10.30	**Quality and Safety Performance issues** To be advised by the Chair of the Committee of any specific issues to be discussed. • Patient and Quality Safety Report • Medical Director Report • Chief Nurse Report • Safer Staffing • Falls Report • Pressure Ulcers	Chair of the Committee	E E1 E2 E3 E4 E5 E6	97 109 141 151 159 169 179
10.		**Head of Midwifery Annual Report** To receive the Head of Midwifery Annual Report.	Chief Nurse	F	187
Part Three: Finance and Performance					
11.	10.30 – 11.15	**Finance and Performance Issues** To receive a summary of the discussions at the meeting framework from the Turnaround Avoidance Programme – Delivering Success • Finance Report • Efficiency Report • Performance Report	Chair of the Committee	G G1 G2 G3	207 221 235 241
11.15 – 11.30 **Break**					

No	Time	Item	Lead	Paper	Page
Part Four: Workforce					
12.	11.30 – 11.55	**Workforce Strategy Committee minutes** To receive the minutes from the last meeting of the 13 October 2015.	Chair of the Committee	H	251
13.		**Workforce Metrics and Update Report** To receive a report updating the Board on the workforce metrics.	Deputy Chief Executive	I	257
Part Five: Procurement					
14.	11.55– 12.10	**Procurement Annual Report** To receive the Procurement Annual Report.	Finance Director	J	269
Part Six: Governance					
15.	12.10- 12.30	**Minutes from the Corporate Risk Committee** To receive the draft minutes from the Corporate Risk Committee.	Chair of the Committee	K	279
16.		**Review of Using Electronic Papers** Comments from the Board on the use of electronic papers.	Chair	L	289
Any Other Business					
17.		**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 16 December 2015 in the Boardroom, York Teaching Hospital.			
18.		**Any other business** To consider any other matters of business.			

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.

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Register of directors' interests
November 2015

York Teaching Hospital NHS
NHS Foundation Trust

Additions: No changes

Changes: No changes

Deletions: No changes

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Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS founda-
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	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

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

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
Juliet Walters (Chief Operating Officer)	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 representative	Nil
Mr Mike Proctor (Deputy Chief Executive)	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
Dr Ed Smith Interim Medical Director	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Jim Taylor Interim 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 Lecture Room, St Catherine's Hospice, Scarborough on 28 October 2015.

Present:	**Non-executive Directors**	
	Ms S Symington	Chairman
	Mrs J Adams	Non-executive Director
	Mr P Ashton	Non-executive Director
	Mr M Keaney	Non-executive Director
	Ms L Raper	Non-executive Director
	Mr M Sweet	Non-executive Director
	Professor D Willcocks	Non-executive Director
	Executive Directors	
	Mr P Crowley	Chief Executive
	Mr 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	
	Mrs S Rushbrook	Director of Systems and Networks
	Mrs W Scott	Director of Out of Hospital Services
In Attendance:		
	Mr M Hindmarsh	Head of Operational Strategy
	Mrs A Pridmore	Foundation Trust Secretary
Observers:	Mr M Fletcher	Grant Thornton
	Ms P McMeekin	York Teaching Hospital
	Mrs S Miller	Public Governor – Ryedale and East Yorkshire
	Mrs J Anness	Public Governor – Ryedale and East Yorkshire
	Mrs J Moreton	Public Governor – Ryedale and East Yorkshire

The Chairman welcomed the Governors and members of the public to the meeting. The Chairman congratulated Mr Jim Taylor on his appointment as Medical Director and welcomed him to the Board meeting.

15/153 Apologies for absence

Apologies were received from Mr B Golding, Director of Estates and Facilities

The Chair asked Mrs Pridmore to confirm the meeting was quorate. Mrs Pridmore confirmed the meeting was quorate.

15/154 Declaration of Interests

There were no further declarations of interest.

15/155 Minutes of the meeting held on the 19 August 2015

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

15/156 Matters arising from the minutes

There were no matters arising.

15/157 Patient Story

Mrs Geary shared with the Board some of the pledges that had been made by new nurses as part of their preceptorship. She outlined the benefits of the preceptorship course for new nurses and the importance of the pledges nurses make to themselves. Their pledges will be revisited in six months.

Mrs Geary read out some examples of the pledges.

Mr Crowley explained that the introduction of the preceptorship course came from supporting nurses who were in difficulties. It was established by Mrs Geary and has been very successful. Mrs Geary explained how this pastoral support is reinforced over the first 12 months of a nurse's career.

The Board noted the importance and value of the preceptorship course and was pleased to hear some of the pledges being made.

15/158 Report from the Chief Executive

CQC Quality Summit – Mr Crowley reflected on the CQC Quality Summit that took place at the beginning of October.

Before the CQC report was published, a clear message was released in the organisation that the Trust would accept the report with humility and would provide an appropriate response. Actions will be picked up as part of the performance management arrangements. The overall rating for the Trust was 'in need of improvement'.

Mr Crowley summarised the main findings included in the report:

- Caring - green
- Effective – three-quarters green
- Responsiveness – three-quarters green
- Well Led – two-thirds green, one-third amber (On discussion with staff it was noted that comments made in Bridlington had been mis-represented)
- Safety – requires improvement. (this related to the Trust's reliance on locum and temporary staff)

In terms of sites:

- Community – green
- York – three-quarters good
- Bridlington – three-quarters good
- Scarborough half good and half amber. This demonstrates significant improvement from where Scarborough's position three years ago. Mr Proctor explained, that at that time the hospital was compliant with only one of sixteen standard areas. Mr Crowley added that the achievement also needs to be looked at in the context of the external environment three years ago. Scarborough is a safe hospital, and the whole organisation continues to seek to improve its safety all the time.

Mrs Adams expressed her concern that safety in the report requires improvement. She was keen that the organisation uses the reports to make changes. Mr Crowley explained that the issue around safety related largely to staffing. He added that Mrs Geary as Chief Nurse has provided the Board with significant assurance around staffing. The CQC were in the Trust for four days and the report reflects the Trust's assessment, that the reliance on temporary staff and locums is too high.

Mr Crowley added that the Standardised Hospital Mortality Indictor (SHMI) of 101 reflects the safety in the hospital and is supported by the Risk Adjusted Mortality Indicator (RAMI) of 86. These results demonstrate the organisation continues to improve against key performance measures.

National position – Mr Crowley referred to the current NHS financial position. He explained that he believes it will worsen. As a result there is increasing regulatory intervention. He added that there is a clear disconnect between income and delivery of services in the system.

Mr Crowley referred to a number of examples of current challenges in the system.

- The Whitby contract and the MSK project. As a result of their experience, Mr Crowley believes CCGs will now be more cautious of undertaking tenders for services, which may lead to less competition in the system.

- Mr Crowley referred to recent challenges on the York site and explained that although there was engagement from other agencies and organisations this needed to continue and in some areas there needed to be more engagement.

- The safer staffing system has now been withdrawn and it is expected that professional judgment will be used to determine the appropriate staffing levels rather than using an imposed ratio.

- The current discussions around the junior doctor's contract are also a further example of deterioration in the environment.

In terms of the work of the Trust, Mr Crowley confirmed:

- The Trust is responding to the CQC report and developing an action plan and will continue to work hard to improve the areas identified in the report.
- The Trust will continue to develop the Turnaround Avoidance Programme and service line reporting, engage with Monitor and continue the programme in an overt way.

Stroke external review – Mr Crowley reminded the Board of the changes that had been made to the stroke pathway earlier in the year and that before any permanent option was put in place an external review would be undertaken. This has now taken place and he confirmed that the review endorsed the current pathway. As a result the Stroke Working Group is now planning the steps to implement the pathway on a permanent basis from February 2015. The change to the pathway was for the service to be suspended at Scarborough and patients to be seen in York.

Ms Symington thanked Mr Crowley for his report and commented that it was very helpful to have a clearer understanding of the wider environment and to reflect on our own performance.

Mr Ashton asked if it would be possible to reflect the CQC themes, in the Quality and Safety agenda in the same way as the Turnaround Avoidance Programme had been reflected in the agenda for the Finance and Performance Committee. Mr Crowley confirmed he would look to see how that could be achieved.

Mr Keaney asked if there was any way of telling where the Trust was in comparison to other organisation. Mr Bertram explained it was difficult to get that information. He suggested that the Trust is slightly better than the middle of the pack. Mr Proctor added that there is a lack of information at present coming from the centre.

Mr Crowley added that it was difficult to judge, but in the recent past he has talked about a number of organisations that have a level of planned deficit that has grown beyond expected levels. He added Finance Directors are exiting organisations, the latest being the Finance Director at Doncaster and Bassetlaw NHS Foundation Trust.

York is in the position where it is very clear what the level of deficit is. The focus of the organisation has been on doing everything possible to prevent any further deterioration. He explained that some of the challenge the Trust is facing reflect the income mix. Mr Crowley outlined the different income mix that Harrogate NHS Foundation Trust has to York. He reflected that Trusts that provide special services such as the eye hospitals or children's hospitals have not got the same challenges and are doing well.

The Board noted the report and comments.

15/159 Quality and Safety Committee

Ms Raper referred to the minutes of the Quality and Safety Committee meeting held on 20th October 2015. She reflected that the Committee asked for the risks from the CQC report should be reflected in the Corporate Risk Register so the Committee can continue to have oversight of all quality and safety key risks.

Quality and Safety miscellaneous – Mrs Raper raised the number of cancelled appointments and asked Mr Taylor and Mrs Geary to update the Board. Mrs Geary outlined the challenges (including recruitment) that are being managed. She added that the risk is being assessed.

Mrs Rushbrook added that within York there is a central contact centre that speaks to patients and agrees the date and time of their appointment on the phone. That system is

not in place at Scarborough currently. Patients in Scarborough receive a letter giving a date and time for the appointment, which may not be convenient to the patient, and the patient then cancels. The Board asked when the central contact centre would be created in Scarborough. Mrs Rushbrook confirmed it would be at the beginning of the next calendar year. Until the system is in place, there will continue to be delays.

Ms Raper reported the Committee was pleased to see the Trust has continued to have internal benchmarking for pressure ulcers. The Committee was pleased to also receive a detailed timetable for the production of the Quality Report. She reminded the Board that this had been a concern of the Committee and Executives in the past. The Committee was pleased to see the Medical Director report included information about nutrition.

The Committee had looked at the Director of Infection Prevention and Control Annual Report in some detail last month. This month the Committee had reviewed the quarterly report.

The Committee was pleased to see the quarterly patient experience report.

Ms Raper reported that both the Child Safeguarding Annual Report and the Midwifery Annual Report would be presented to the Board in November.

Ms Raper asked Mr Taylor to update the Board on the SHMI information. Mr Taylor confirmed the SHMI for the quarter covered by the winter months was 101. The component elements were:

- York 96, an improvement on the last report where York scored 97.
- Scarborough was 108; at the last report Scarborough was 107. This reflects a slight deterioration in the position by 1 point from the last report.

Both hospitals are within expected safety parameters and within the expected trajectory. Work is ongoing to seek to continually improve this important measure.

Mrs Rushbrook added that work with the clinical teams to improve the coding of co-morbidities has now resulted in a letter from the CCG complaining the coding is too good!

Acuity and Dependency Audit and Safer Staffing – Ms Raper reflected on the extensive debate held at the Quality and Safety Committee on the acuity and dependency and safer staffing report and asked Mrs Geary to update the Board on the two documents.

Mrs Geary explained that the Acuity and Dependency Audit is undertaken on a six monthly basis. The audit has resulted in some detailed recommendations. The audit will be repeated again in January 2016. Mrs Geary referred to the levels of care used in the audit and advised that the 3B level (the level relates to patients requiring 1:1 care following falls risk assessment) would not be used in future as it has created confusion with validation.

Referring to the Safer Staffing paper Mrs Geary explained that this paper was mandated during 2014, but the requirements have been changed and Trusts are expected to use ‘professional judgment’ on the staffing levels. Mrs Geary added that all nursing vacancies

were now managed through the Chief Nurse's office. The level of nursing vacancies is 91.4 across in-patient areas. She explained that over recent months there had been an increase in the level of attrition and currently the rate was over 3% (320 nursing staff have left the organisation in the last three months), of those 75% have retired. In terms of new staff coming in 75 new registered nurses recently joined the Trust and there is an active European recruitment campaign and a centralised recruitment campaign (Initially for 60 nurses).

Mrs Geary referred to the detailed work being undertaken around aligning budgets to the ESR system and establishments. She confirmed this work was near completion and had identified some anomalies in vacancy levels which were being addressed.

In the York area there are 1700 training places for nursing. Mrs Geary explained the Trust would have to successfully recruit 25% of those training nurses to satisfy the Trust's demand. Mr Proctor added he is working with Mrs Geary and local educational establishments to encourage trainees in healthcare professional and nursing to make our Trust the employer of choice. Mr Proctor is proactively engaging with local educational establishments to communicate this message.

Professor Willcocks endorsed Mr Proctor's comments.

Mrs Geary commented that now senior nurses are using professional judgment the skill mix and numbers are changing. She added that the ratio 1:8 introduced as part of the safer staffing initiative is no longer being used. The skill mix is now being extended to housekeeping and has already allowed Mrs Geary to establish how she can fund a ward beverage service.

Mr Sweet asked about the hydration trial that had taken place on ward 23 and the subsequent business case that had not been accepted due to cost. Mrs Geary confirmed that she was now establishing an equivalent service through existing budgets.

Ms Symington added that workforce planning is one of the biggest risks faced by the Trust. She asked that the work being undertaken should be strategic and responsive to a clear vision of workforce requirements in 2-5 years.

Ms Symington thanked Ms Raper for her report.

15/160 Quarterly Infection Prevention Control Report

Ms Geary presented the report. She reminded the Board that it had reviewed the Annual Report in detail last month. This report outlined the activity over the last quarter. She reported the Trust had now seen its first wards currently closed following an outbreak of Norovirus. In York 5 wards were closed which has resulted in 100 outliers across the site, creating bed pressures throughout the Trust. Currently work is underway to identify an index case. Mr Proctor added that in his experience if there is an early outbreak of Norovirus then it tends to be a feature of environment for longer.

The Board thanked Mrs Geary for her report.

15/161 Community services

Mrs Scott presented her report. She advised that the single point of access call handling service will be brought in house in December. Key features of the system include ensuring referrals can be made directly from electronic records and the ability to create a platform for telemedicine.

Professor Willcocks thanked Mrs Scott for her report and congratulated her on her model of good partnership working. She suggested that mental health and voluntary services should also be integrated. Mrs Scott explained that the main route for partnership working is through the Alliance Board. She explained she was involved in conversations about bringing together different HUB models. The voluntary sector is embedded into the HUBS in York and Selby.

Ms Symington added she recently met with the Lay Chairman for the Vale of York CCG and he was keen to talk about traction and pace of Community Hubs. Mr Proctor added that an increase in traction and pace will be achieved through the discussions that are taking place.

Mr Crowley reflected on the recent discussions with the CCG about their policy on spot purchasing beds. He added that this policy had now been changed and York Hospital is now able to spot purchase beds when needed.

Ms Raper asked about the confidentiality of information when working in a community mobile environment. Mrs Rushbrook confirmed that she could not give a 100% guarantee, but she could confirm that considerable effort has been made to ensure the systems are as secure as they can be.

15/162 Finance and Performance Committee

Mr Keaney presented the Finance and Performance Committee information. He reflected on the format change of the agenda. He reported on the significant improvements in the diagnostic performance and some challenges in relation to the two-week cancer fast-track and the 62-day target. He reflected that in terms of 18 weeks the Trust the main concerns remained within Ophthalmology and Max Fax. He asked Mrs Walters to report on operational performance with a key focus on Emergency Department delivery.

Mrs Walters explained that in terms of 18 weeks, the Trust had achieved 93.77% for the incomplete target and had further reduced the backlog. Concerns remained within Ophthalmology and Max Fax and outsourcing of procedures was continuing.

Mrs Walters referred to the emergency care standard describing the significant ongoing challenges across the emergency departments including workforce shortages. She explained there has been a 4.5% increase in attendances when comparing September 2014 to September 2015, which equates to an additional 700 patients seen. There has also been a 10.8% increase in non-elective admissions. Work is underway as part of the acute and emergency strategy to address the challenges including workforce shortages. The Trust is working with the Emergency Care Intensive Support team (ECIST) and the Acute Frailty network. It was reported the acute frailty units on both sites would be operational by December.

There remain a significant number of patients that are medically fit to leave hospital but their discharge is delayed for a variety of reasons including Social Care input. Mrs Scott is leading on the development of the Discharge to Assess model, which allows patients to

be discharged home or to a community bed and have their assessment take place after the discharge so freeing up beds in the acute facility. This has been prioritised by the System Resilience Group and is expected to be introduced during December.

Referring to the emergency department, Mrs Walters described a recent example at York where on one evening the Department was under significant pressure as there were over 60 patients in the Department of which over half required primary care treatment. However, because of the change in contract to Yorkshire Doctors it was not possible to transfer these patients across to the out-of-hours service as this was not part of their contract. Mrs Walters explained that there needed to be flex between the teams and that she was continuing to raise this as an issue with the VoY CCG.. Ms Raper suggested that this may be an appropriate subject for the Board to Board meeting being held on 5 November.

Mr Keaney asked about Yorkshire Doctors Urgent Care Centre contract at Scarborough. Mrs Walters explained that the arrangements were for minor illness, however, Yorkshire Doctors were also contracted to deliver minor injury and were struggling to do so. It was reported Yorkshire Doctors were unable to cover the contract from 10pm until 8am due to staffing difficulties and that these patients were being seen in the ED. It was noted there were ongoing discussions with Yorkshire Doctors and the S&R CCG as the contract was not being delivered as per the specification. A further meeting with Yorkshire Doctors was planned later in the week to agree a way forward.

The Board expressed frustrations at the arrangements.

Mr Keaney asked Mr Bertram to present the finance report. Mr Bertram reminded the Board that the deficit he reported last month was £6m, in October this has increased to £6.4m. In the trading month of September income and expenditure balanced which in the current market was an achievement. He explained that he had hoped to be in a position that he could report the deficit had reduced slightly as historically the income in September has been higher than it was this year. Between August and September 2014 income was £2m higher, whereas this year it was only £1.4m higher. Spend was £38.7m which is noticeably lower the peak expenditure in July, this demonstrates the control measures that have been put in place are beginning to impact on financial performance.

Mr Bertram reported that a new provision of £0.4m had to be made following detailed reconciliation work with the CCG which exposed an issue relating to readmissions activity and suggested the Trust had assumed too much income.

Mr Bertram went on to describe the reduction of the penalties being levied on the Trust.

Efficiency Report – Mr Bertram updated the Board on the CIP delivery. He explained that 64% of the target had been achieved, of which just under half is recurrent.

Mrs Adams noted the reduction in nurse agency spend and asked how the Trust was encouraging staff to join the bank. Mrs Geary explained that efforts continue to encourage staff through incentives and offering weekly pay.

Ms Raper asked about the targets included in Lord Carter's work and if the Trust had received any further details. Mr Bertram explained that nothing has been received by the Trust at present, but he would be attending a meeting with treasury staff, DH staff and a member of the Carter team to discuss the efficiency systems employed by the Trust. He hoped at that meeting to have an opportunity to hear more about the Carter review.

Mr Crowley added that the Carter review identified £5 billion worth of saving to be delivered by 2020, but since then the political will has been to encourage a faster delivery of the savings. This has resulted in a delay in the publication of the expectations for Trusts.

Ms Raper asked if the new Business Development Manager would provide support to the whole organisation. Mr Bertram confirmed that the role was a corporate role that would provide support across the Trust.

Mrs Adams asked about the diagnostic performance and if there was a safety issue in relation to the lack of a back up CT scanner in Scarborough. Mrs Walters explained that Radiology is addressing this as a priority.

15/163 Winter Plan

Mr Hindmarsh was welcomed to the meeting and invited to present the Winter Plan. Mr Hindmarsh's presentation outlined the key features of the plan. The Board commented that the plan was an excellent document.

Mr Sweet asked about the comment in the document that there would be no additional GP services. Mr Hindmarsh explained that further discussions were taking place to get a response from the CCG in York that would help support the plan, but currently it is not anticipated that Primary Care will be making any special arrangements to cover recognized peak and pressure over the Christmas and New Year period. The Board expressed disappointment that Primary Care was not making a positive contribution to the Winter Plan .

Professor Willocks noted that the plan did not feature the voluntary organisations and suggested that working with them would provide additional support.

Mrs Adams asked if the funding for the winter plan had been agreed and incorporated in to budgets. Mr Bertram confirmed that was the case. In surgery a £400k investment was being considered. The additional budget would protect and increase income.

Mr Sweet asked about winter monies. Mr Bertram explained that all CCGs were given allocations earlier in the year. He added that the Trust was notified earlier this week of some winter monies that were available to bid for from NHSE.

The Board thanked Mr Hindmarsh for his presentation and agreed that they would like to receive a follow up presentation in March 2016 and that in the meantime the F&P Committee would keep the plan under review

Action: The Board to receive a full evaluation of the winter plan in March 2016.

15/164 Workforce Metrics and update report

Mr Crowley presented the report. He highlighted the key messages including the increase in absence rates. He reflected that reducing the absence rates had been work undertaken over a number of years.

Mr Crowley referred to the increase in turnover of staff in the last year. He reflected that this increase is seen across almost all staff groups. He added that one of the important decisions the Trust has taken recently is to pay the living wage. This has helped to reduce the attrition rates. (Anecdotally the CYC are losing staff to local supermarkets who offer higher rates of pay. This also presents a recruitment challenge for the Council).

Mr Crowley referred to the appraisal section of the report. He noted that prior to the merger a significant amount of work was undertaken to improve the system which led to a high degree of success. Mr Crowley explained the changes made in the last 18 months over the Statutory and Mandatory training and reflected on the level of rigor in the system. Mr Crowley explained that the revised system will link the appraisal system to the Statutory and Mandatory training and pay progression.

Mrs Symington commented that in her view successful organisations have successful appraisal processes.

Mr Crowley commented on the employee relations in the report and confirmed he would work with Miss McMeakin on appropriate interventions that might be put in place before staff get into difficulties.

Mrs Adams noted that the family and friends test results seemed very low particularly in one directorate. She commented that it was important for the organisation to be seen as an employer of choice. Mr Crowley explained that there were particular issues with the one directorate which were being addressed

Professor Willcocks referred to the pay expenditure table and suggested that the table should be regularly reviewed by the Board. It was agreed the table should be included in the performance report information.

Ms Symington added that becoming an employer of choice is a very strategic aim for the Trust, as well as having a compelling retention strategy.

Action: Mrs Rushbrook to incorporate the pay expenditure table into the performance report.

The Board noted the report.

15/165 Environment and Estates Committee

Mr Sweet presented the minutes from the first meeting of the Committee. He explained that the meeting had provided an induction session for the Committee the members. The intention is to follow the same framework of the Quality and Safety and Finance and Performance Committee arrangements, but the Environment and Estates Committee will, initially, only meet on a quarterly basis with those meetings being held across the sites of the Trust.

The Board noted the minutes.

Terms of Reference – Mr Sweet asked the Board to confirm approval of the Terms of Reference. The Board approved them.

NHS protect Security Management Report – Mr Sweet presented the report explaining that it provided significant assurance to the Committee. The report indicated the need for the Trust to formalise its approach to any form of violence and similar matters on its sites. An overarching policy was currently being written to complete the required action.

15/166 Monitor Quarterly Return

Mr Bertram presented the quarterly report. He outlined the detail in the report. The Board approved the submission.

15/167 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 25 November 2015, in the Boardroom, York Teaching Hospital

15/168 Any other business

Ms Symington reminded the Board that it had been arranged that a Board to Board meeting with the Vale of York CCG would be held on the morning of 5 November and in the afternoon there was a further Board to Board with the Council of Governors.

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 grades in the future to be presented to the Board when developed	Mr Crowley	future
15/114 Quality and Safety Committee	Present a progress paper on the Implementation of the Nursing and Midwifery Strategy	Mrs Geary	January 2016
15/117 Community Care update	Provide further detail on the re-ablement discussions when available. Include the issue around review of re-ablement service with the system leadership discussions.	Mrs Scott Mrs Walters	When available Report to Board when completed

15/139 Report from the Chief Executive	Include reflections on the Alaska visit in the Board to Board discussion.	Mr Crowley	5 November
15/147 Food and Drink Strategy	The Board agreed to test the food on an annual basis.	Mr Golding	31 March 2016
15/147 Food and Drink Strategy	Feedback to the Board on the use of volunteers in the provision of a beverage service of inpatients.	Mrs Geary	January 2016

Action list from the minutes of the 28 October 2015

Minute number	**Action**	**Responsible office**	**Due date**
15/163 Winter Plan	Review the Winter Plan	Mrs Walters	March 2016
15/164Workforce Metrics and update report	Incorporate the pay expenditure table into the performance report.	Mrs Rushbrook	Immediate

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 25 November 2015

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	November 2015
Version number	Version 1

Chief Executive's Report

1. Chief Executive's Overview

Once again this month I would like to use my report to reflect on some of the on-going issues in the wider NHS and to set the context for our discussions.

At the NHS Providers conference a few weeks ago, Secretary of State for Health Jeremy Hunt described the NHS's financial situation as the most difficult in its history. He cited pay restraint, controls on agency spend, procurement and efficiency, and the Five Year Forward View, as ways in which providers are being supported to overcome the financial challenge. My personal view is that, whilst some of these measures may temporarily stop the issues from spiralling in places, this will not solve a problem of this magnitude and will not address the fundamental problem of the mismatch between budget and tariff allocations, and the services we are expected to provide.

It is becoming increasingly apparent that the 'low hanging fruit' in terms of savings and efficiencies have already been exploited over the five or so years we have been embarking on our efficiency regime. Real change such as that outlined in the Five Year Forward View needs a significant shift in thinking and a commitment to whole-system change. One has to question how this can really be achieved given the significant cuts to local government budgets for social care, and there needs to be a recognition of the level of investment and cooperation that would be needed to really deliver this.

A further sign that the current funding pressures show little sign of easing came in the form of the Department of Health's review of the Tariff Objection Mechanism. Last year, for the first time, NHS organisations were able to comment on tariff proposals, with the agreement that, if enough organisations objected, the proposals would be reviewed. For the 2015/16 financial year, this 'tariff objection mechanism' was triggered, and ultimately resulted in an additional £500m being allocated from commissioners to providers.

In recent months, the Department of Health has consulted on potential changes to the objection mechanism. These changes will make it more difficult for providers (and mathematically impossible for Foundation Trusts and non-Foundation Trusts alone) to trigger the formal objection process. NHS Providers has written to the Secretary of State to formally voice concerns over these changes on behalf of providers, stating that "The net effect of disenfranchising providers in this way will be poorer financial outcomes for NHS Trusts and Foundation Trusts, which is on no-one's interest."

This serves to further illustrate the lack of engagement between the centre, local commissioners and providers regarding the reality of the financial situation.

Our local financial position remains critical, and whilst we are not yet in special measures or turnaround, this remains a significant risk. Finance Director Andrew Bertram will elaborate further via his finance report, however our recent slippage from plan is due in large part to income lost through cancelled elective work as a result of lost capacity during the norovirus outbreak, and high levels of non-elective demand. It is critical that we stop this deterioration, and as such we are focussing on income generation (both recouping lost income and attracting new income) through our turnaround avoidance programme.

Through the Executive Board we are also, as a matter of priority, working through ways that we can better preserve our elective capacity, and, importantly, the income associated with it. I am sure you appreciate that our stated strategy to separate acute and elective capacity at every opportunity is critical, both now and for the future sustainability of our services. This includes the planned development of services at Bridlington Hospital.

At the last Executive Board we reflected on the recent time out session on the Turnaround Avoidance Programme. The key message from those present at the time out was a call for a stronger focus on compliance, and a need for us to be more directive in terms of the programme delivery and holding people to account.

The importance of staff engagement was also highlighted, and there was a commitment from Executive Board members to helping share the message throughout the organisation and to encourage staff to understand the TAP and make a contribution.

Earlier this month we had a further push on raising awareness among staff for the turnaround avoidance programme, to ensure a broader understanding of the top-line messages and to encourage participation in the staff suggestion scheme.

Living wage

The Living Wage Foundation has announced its recommended rate of increase for the Living Wage. As you will recall, we were the first NHS Trust in the country to adopt the living wage, and its introduction has meant that around 800 of our lowest-paid staff benefit from a higher rate of basic pay than that which is set out in NHS terms and conditions. This is separate to the living wage that was referenced by the Chancellor in his budget speech earlier this year. We have calculated the impact of introducing the recommended increase in the Living Wage, and at the new rate it would apply to 1,100 staff and cost around £0.9m. This is a significant increase and in our current financial context, one that would be extremely challenging for us to implement.

Given we are only one of a handful of Trusts to do so, we would be seen as committing avoidable discretionary expenditure and would come under the scrutiny of our regulators.

We have a six month period within which to implement any change, and I have written to our staffside colleagues to inform them of the difficulty we would have in providing this uplift. The Living Wage is a personal priority of mine and is aligned with my values and, I hope, those of the entire Board, however we must also ensure that the organisation remains financially sustainable in what are increasingly precarious circumstances.

Junior doctors' strike

Board members will be aware that junior doctors have voted overwhelmingly in favour of strike action in protest at the Government's proposed changes to their contracts.
The planned dates for the industrial action are 08:00 Tuesday 1 December to 08:00 Wednesday 2 December, where only emergencies will be covered. Two further periods of action are planned between 08:00 and 17:00 on Tuesday 8 December and Wednesday 16 December. These will be a full walk out where emergencies will not be covered.

We have an excellent and committed medical workforce, and we respect their right to voice their concerns is this way. Staff are not obliged to tell us whether or not they will be taking part in the strike action, however we are asking our junior medical workforce to work with us to keep us informed and help us retain a safe level of essential services. It is likely that we will still need to postpone some non-urgent appointments and procedures, and we are working through the operational implications of this.

In the News

There have been no issues of significant note with regard to media coverage over the past month, although there continues to be a high level of interest nationally in the junior doctors' contract. We have as a Trust been involved in several health promotion campaigns, including breast cancer and pancreatic cancer awareness, antibiotic awareness and the pressure ulcer reduction campaign, which continue to place our nursing and medical staff as local spokespeople and help keep our organisation in the news in a positive way.

2. Recommendation

The Board is asked to note the report.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley, Chief Executive**
Date	**November 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

CQC Improvement Plan

Action requested/recommendation

The Board of Directors are asked to note the improvement plan and that it has been formally approved by the Care Quality Commission.

Summary

This report has the CQC Improvement Plan appended for information. It is a high level plan that details the actions that need to be completed to comply with the requirement notices within the overall CQC Quality Report for the Trust.

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

The report has reference to the CQC requirement notices.

Progress of report	Board of Directors
Risk	There is a risk of not delivering staffing requirements due to national shortages in various staff groups

Resource implications	There are possible resource implications from the review of Critical Care Services in North Yorkshire. However until the review has been reported these are currently unknown
Owner	Patrick Crowley, Chief Executive
Author	Fiona Jamieson, Deputy Director of Healthcare Governance
Date of paper	November 2015
Version number	Version 1

1. Introduction and background

The Board of Directors will be aware of the requirement of the organisation to respond to the Care Quality Commission , (CQC) with details of the actions that will be taken to ensure that the requirement notices articulated in their overarching Quality Report are to be met.

The CQC advised that this is to be a high level plan, that they will monitor with the Trust via quarterly engagement meetings. The Improvement Plan is attached at Appendix A for information.

2. Internal Monitoring of the Plan

Internal monitoring of the plan has been established and will report to the Board on a monthly basis. Any slippage of the plan will need to be agreed with the CQC.

The CQC have advised that they will assess some information on a data basis, for example statutory and mandatory training. However they reserve the right to return to the Trust at any time to check on progress against any of the actions.

There are some risks around the delivery of some of the staffing requirements and this is due to the lack of availability nationally of some staff groups (for example Emergency Care Consultants). The organisation must therefore ensure that it takes action that evidences that all reasonable steps have been taken to either 1) recruit staff and/or 2) explore different models of care delivery.

A Corporate Risk has been added to the Corporate Risk Register around the possibility of the non-delivery of actions identified in Requirement Notices.

Actions due for delivery by the end of November 2015 are currently on track for completion by the due date.

3. Conclusion

This paper provides detail around the Improvement Plan to deliver the actions associated with CQC Requirement Notices. It identifies the method of review of actions by the CQC and how we will monitor progress against actions within the organisation.

4. Recommendation

The Board of Directors are asked to note the improvement plan and that it has been formally approved by the Care Quality Commission.

5. References and further reading

CQC York Teaching Hospitals NHS Foundation Trust Quality Report

Author	**Fiona Jamieson, Deputy Director of Healthcare Governance**
Owner	**Patrick Crowley, Chief Executive**

Date	**November 2015**

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RCB
Our reference	SPL1-2096018167
Location ID	RCB
Trust / Location <delete as appropriate> name	York Teaching Hospitals NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	Regulation
<Treatment of disease, disorder or injury	Regulation 12(1), (2)(a), 2(b) & 2 (e) HSCA (RA) Regulations 2014 Safe care and treatment.
	How the regulation was not being met:
	The provider had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe as they had not when planning and delivering the care reflected published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice. The trust was not ensuring effective patient flow into and out of critical care, specifically in relation to: delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit. The trust was not ensuring that there is adequate access for patients to pain management and dietetic services within critical care. Not all equipment was tested in a timely manner and in line with the trust's policy, especially checks on fridges and resuscitation equipment *inspection report>* This was in breach of Regulation 9(1)(b)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to

	regulation 12(1), (2)(a), 2(b) & 2 (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must take action to ensure that all patients in A & E have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011 The provider must address the breaches to the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care. The provider must ensure that patient flow into and out of critical care is improved, specifically in relation to: delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit. The provider must ensure that there is adequate access for patients to pain management and dietetic services within critical care. The provider must ensure all equipment is tested in a timely manner and in line with the trust's policy, especially checks on fridges and resuscitation equipment.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. The organisation took immediate action post inspection to ensure that all patients in A&E have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011. This action is complete

2. The organisation has an agreed programme with commissioners that aims to improve performance against national targets for, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care. It is also working with ECIST to improve A&E performance and most recently been identified as one of 28 communities receiving support through the Emergency Care Improvement Programme.

3. The organisation has an Acute Strategy which details the multi facted approach to improving patient flow throughout the organisation. Some facets of the plan have been

delivered and others are still in progress. This is led by the Medical Director together with the Chief Operating Officer and Clinical Directors responsible for the acute care pathway.

4. A review is to be undertaken of current resources within the dietetics team with a subsequent options appraisal being made to the Board. A business case for the establishment of an Acute Pain Team in Scarborough is under development and will be considered by the Board of Directors

5. The organisation has a well established programme of planned preventative maintenance checks for EME, and the same is replicated for non clinical equipment. Domestic staff are responsible for the monitoring of food fridges, and nursing staff are responsible for the monitoring of drugs fridges.

   A collaborative process between nursing and pharmacy staff is being established to ensure that the monitoring of fridges takes place and is escalated when necessary. The daily checking of resus equipment is the responsibility of nursing staff and compliance with this will be monitored and escalated

Who is responsible for the action?	1. Medical Director 2. Chief Operating Officer 3. Medical Director/Chief Operating Officer 4. Deputy Chief Executive 5. Chief Nurse and Chief Pharmacist

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

1. The improvement has been made and has been sustained. Performance is regularly reported to the Board.

2. The organisation is working to a trajectory of improvement of performance against national targets which is monitored weekly and reported to the Board of Directors on a monthly basis

3. The organisation has already taken steps to improve flow by looking and piloting models of ambulatory care

4. An option appraisal for dietetics and business case for an Acute Pain Service in Scarborough is to be considered by the Board of Directors.

5. Improvement will be measured on these issues through regular audit and review with outcomes being reported into the Board of Directors

Who is responsible?	1. Medical Director 2. Chief Operating Officer 3. Medical Director 4. Medical Director 5. Chief Nurse , Chief Pharmacist and Director of Estates and Facilities

What resources (if any) are needed to implement the change(s) and are these resources available?
1. The resource has been identified and is in place 2. The organisation is outsourcing work to third party providers to assist with the delivery of some backlogs of activity, additional outpatient clinics and operating lists are also being used to manage volumes of activity 3. This will be established on agreement of the review recommendations 4. To be identified through options appraisal and business cases 5. There are no additional resource implications

Date actions will be completed:	1. The action is complete 2. Ongoing improved programme of improvement agreed with commissioners 3. 31 January 2016 4. 28 February 2016 5. Actions are already in place

How will people who use the service(s) be affected by you not meeting this regulation until this date?
We will seek to ensure that patients are always kept safe, where we can, in pressure areas, we will outsource activity to ensure patients are treated in a timely manner.

Completed by: (please print name(s) in full)	Fiona Jamieson
Position(s):	Deputy Director of Healthcare Governance
Date:	30 October 2015

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RCB
Our reference	SPL1-2096018167
Location ID	RCB
Trust / Location <delete as appropriate> name	York Teaching Hospitals NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	Regulation
<Treatment of disease, disorder or injury	Regulation 12(1), (2)(a), 2(b) & 2 (e) HSCA (RA) Regulations 2014 Safe care and treatment.
	How the regulation was not being met:
	Regulation 18(1) HSCA (RA) Regulations 2014 Staffing. How the regulation was not being met: The provider had not taken the appropriate steps to ensure that, at all times, there are sufficient numbers of suitably skilled, qualified and experienced persons employed for the purposes of carrying on the regulated activities. This was in breach of Regulation 9(1)(b)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels: • nursing staff on medical and surgical wards;

	• consultant cover within the A & E; • registered children's nurses on children's wards, and other appropriate clinical areas and • radiologists • community inpatient services.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. The organisation has successfully recruited an additional 73 RCNs who take up post in October 2015 to work in its acute sites. It has an open and centralised rolling recruitment campaign for RNs which will be reviewed on a monthly basis. We also have an active recruitment campaign targeting nurses from the EU.
2. The Trust is engaged in a continual recruitment programme for ED Consultants and most recently has introduced a recruitment and retention premia to enhance this. The Trust is also working with ECIST, ECIP and its Acute Board to explore the potential for alternative models of care that reduce the reliance on the ED consutant workforce.
3. There is an open rolling recruitment for Paediatric Nurses
4. The organisation is staffed to establishment on radiologists
5. The organisation has taken steps to increase staffing in community inpatient services

Who is responsible for the action?	1. Chief Nurse 2. Medical Director 3. Chief Nurse 4. Medical Director 5. Director for Community Services

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

1- Partly actioned , the organisation has recruited 73 additional nurses with a further 60 planned , progress will be reported to the Board of Directors on a monthly basis
2- Process of continuous recruitment and looking at alternative roles
3- Paediatric Nurses recruited to establishment
4- Already actioned
5- Already actioned

Who is responsible?	Chief Nurse Medical Director Chief Nurse Medical Director Director for Community Services

What resources (if any) are needed to implement the change(s) and are these resources available?	
1,2,3 Resource to cover agreed staffing establishment was always in place	
Date actions will be completed:	1 73 Nurses by 30 October 2015 2 Aim to recruit additional ED Consultants – June 2016 3 Paediatric Nurse interviews by 31 Dec 2015 4 Achieved 5 Achieved

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The organisation will continue to use its own bank staff to cover any staff absences/vacancies

Completed by: (please print name(s) in full)	Fiona Jamieson
Position(s):	Deputy Director of Healthcare Governance
Date:	30 October 2015

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RCB
Our reference	SPL1-2096018167
Location ID	RCB
Trust / Location <delete as appropriate> name	York Teaching Hospitals NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	Regulation
<Treatment of disease, disorder or injury	Regulation 17 (1), (2)(b) & (2) (e) HSCA (Regulated Activities) Regulations 2014 Good governance.
	How the regulation was not being met:
	How the regulation was not being met: People who used the service and others were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered personto identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from carrying on the regulated activity. We found that the trust did not have a clear clinical strategy for both critical care and outpatients & diagnostics and that staff we spoke with did not feel engaged in agreeing the future direction. We found that not all pathways, policies and protocols were reviewed and harmonised across the trust. This was in breach of Regulation 10(1)(b) & (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 (1), (2)(b) & (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

	The provider must take action to ensure that the governance and risk management arrangements are strengthened to ensure risks are identified and acted upon in a timely manner. The provider must ensure that there is a clear clinical strategy for both critical care and outpatients and diagnostics and that staff are engaged in agreeing the future direction and involved in the decision-making processes about the future of the service. The provider must ensure that pathways, policies and protocols are reviewed and harmonised across the trust, to avoid confusion among staff, and address any gaps identified.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. The organisation is currently undertaking the Monitor 'Well Led' review and will act on any subsequent recommendations
2. The organisation has taken steps to develop a local clinical strategy for critical care
3. Each individual division has a its own strategy for the management of outpatients, There is a strategy for Radiology
4. The organisation has jointly commissioned a review of critical care services across North Yorkshire which will inform the new clinical strategy. The review is due to conclude on 12 November with a report being expected in January 2016.
5. The organisation already has a programme of harmonisation and review of policies. It is looking to appoint a Clinical Improvement Fellow (interviews W/C 2 Nov) and a Deanery Leadership Fellow for a year to lead on the project of harmonising and reviewing clinical guidelines. Deanery Leadership Fellow to be advertised in November 2015.

Who is responsible for the action?	1. Chief Executive 2. Medical Director 3. Medical Director 4. Medical Director 5. Director of Workforce and Learning

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

1 Outcome of the Well Led Review to be reported to the Board of Directors in January 2016
2 Local strategy completed. External review taking place in November 2015 to report January 2016
3 Completed
4 On an interim basis, the Vale of York CCG have agreed to fund one additional critical care bed in York , with a proviso of reviewing this position once the review of Critical Care Services across North Yorkshire has concluded and recommendations agreed.
5 Clinical guidelines in existence which conform to NICE Guidelines will continue to be used and will be relaunched as they are updated.

Who is responsible?	1Chief Executive 2Medical Director 3Medical Director

	4Medical Director 5 Director of Workforce and Learning

What resources (if any) are needed to implement the change(s) and are these resources available?
1,2,3 Resource was already in place 4 This will be dependent of recommendations and commissioner funding 5 Quality Improvement Lead part department funded, Deanery Leadership fellow part post grad part Deanery funded

Date actions will be completed:	1. 31st January 2016 2. 31st January 2016 3. Completed 4. 31st January 2016 5. 31st March 2017

How will people who use the service(s) be affected by you not meeting this regulation until this date?
In critical care, our commissioners have agreed to fund 1 additional bed in York and will review this once recommendations pertaining to the external review have been agreed.

Completed by: (please print name(s) in full)	Fiona Jamieson
Position(s):	Deputy Director of Healthcare Governance
Date:	30 October 2015

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RCB
Our reference	SPL1-2096018167
Location ID	RCB
Trust / Location <delete as appropriate> name	York Teaching Hospitals NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	Regulation
<Treatment of disease, disorder or injury	Regulation 18(2)(a) HSCA (RA) Regulations 2014 Staffing.
	How the regulation was not being met:
	How the regulation was not being met: The provider did not have suitable arrangements in place in order to ensure that persons employed for the regulated activity are appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users safely and to an appropriate standard including by receiving appropriate training, professional development, supervision and appraisal. This was in breach of Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure there are suitable arrangements in place for staff to receive appropriate training and appraisals in line with Trust policy, including the completion of mandatory training, particularly the relevant level of children and adult safeguarding training and basic life support so that they are working to the up to date requirements and good practice.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve
1. The organisation has taken steps to ensure that all staff complete statutory and mandatory training with compliance being reported regularly to the Board. Compliance is currently at 81%. Current training levels for Safeguarding Adults Awareness – 91% Safeguarding Adults level 1 - 76% Safeguarding Adults level 2 - 74% Safeguarding Children level 1 - 89% Safeguarding Children Level 2 - 77% Safeguarding Children Level 3 - 72% Basic Life Support - 82% 2. The organisation has implemented a new process that will ensure that all staff receive annual appraisals

Who is responsible for the action?	1 Chief Executive 2 Chief Executive

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?
For actions 1 and 2 improvements have been established, are measurable and are reported to the Board

Who is responsible?	1 and 2 Chief Executive

What resources (if any) are needed to implement the change(s) and are these resources available?
1,2,3 Resource to cover agreed staffing establishment is in place

Date actions will be completed:	Actions are to be achieved annually

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Actions have been delivered with the exception of appraisal rates which will continue to be monitored and reported to the Board of Directors

Completed by: (please print name(s) in full)	Fiona Jamieson
Position(s):	Deputy Director of Healthcare Governance
Date:	30 October 2015

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RCB
Our reference	SPL1-2096018167
Location ID	RCB
Trust / Location <delete as appropriate> name	York Teaching Hospitals NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	**Regulation**
<Treatment of disease, disorder or injury	Regulation 10(1) and 10(2)(a) HSCA (RA) Regulations 2014 Dignity and respect.
	How the regulation was not being met:
	How the regulation was not being met: The provider did not so far as was reasonably practicable, make suitable arrangements to ensure the dignity and privacy of service users. This was in breach of Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10(1) and 10(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure that patients' privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit based on ward 16 at York hospital.to the up to date requirements and good practice.
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
1. The organisation has taken steps to ensure that patients' privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit on Ward 16. Whilst it is at times unavoidable from a patient safety perspective for patients to experience being in a mixed sex environment patients are advised if this is the case, and given an option of being nursed on the NEU or elsewhere. Patients are also given information informing why they might find themselves on a mixed sex environment.	

Who is responsible for the action?	1 Chief Nurse

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?
This will be monitored via regular audit and reported to the Board

Who is responsible?	1 Chief Nurse

What resources (if any) are needed to implement the change(s) and are these resources available?
Not applicable

Date actions will be completed:	30 November 2015

How will people who use the service(s) be affected by you not meeting this regulation until this date?
We will ensure that patients are advised that they might find themselves in a mixed sex bay and give them the option of receiving their care on another ward

Completed by: (please print name(s) in full)	Fiona Jamieson
Position(s):	Deputy Director of Healthcare Governance
Date:	30 October 2015

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RCB
Our reference	SPL1-2096018167
Location ID	RCB
Trust / Location <delete as appropriate> name	York Teaching Hospitals NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	**Regulation**
<Treatment of disease, disorder or injury	Regulation 17 (2)(c) HSCA (Regulated Activities) Regulations 2014 Good governance
	How the regulation was not being met:
	How the regulation was not being met: People who used the service and others were not protected against the inappropriate sharing of patient records as they were not kept securely. This was in breach of Regulation 20(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure that patient records are fully secured when stored, specifically within the school nursing records. Regulation 17 (2)(c) HSCA (Regulated Activities) Regulations 2014 Good governance
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
1. Action has been taken to undertake a new risk assessment of the building containing school nursing records. As a result some minor adjustments have been made to this facility that provide additional security	
Who is responsible for the action?	2 Director of Estates and Facilities
How are you going to ensure that the improvements have been made and are	

sustainable? What measures are going to put in place to check this?	
A re-audit of the facility on completion of the minor works	
Who is responsible?	1 Director of Estates and Facilities
What resources (if any) are needed to implement the change(s) and are these resources available?	
The cost of minor works .	
Date actions will be completed:	30 November 2015

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The facility is secure and patrolled by the organisations Security Team

Completed by: (please print name(s) in full)	Fiona Jamieson
Position(s):	Deputy Director of Healthcare Governance
Date:	30 October 2015

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RCB
Our reference	SPL1-2096018167
Location ID	RCB
Trust / Location <delete as appropriate> name	York Teaching Hospitals NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	**Regulation**
<Treatment of disease, disorder or injury	Regulation 18(2)(a) HSCA (RA) Regulations 2014 Staffing.
	How the regulation was not being met:
	How the regulation was not being met: The provider did not have suitable arrangements in place in order to safeguard service users as persons employed for the regulated activity were not appropriately supported when working alone in the community. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must review arrangements to support staff working alone in the community to ensure their safety.
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
The organisation is currently engaged in re drafting its lone worker policy to more explicity apply to all lone workers within the organisation	

Who is responsible for the action?	3 Deputy Director of Human Resources
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Local protocols are in place to ensure the safety of lone workers	
Who is responsible?	1 Director of Community Services
What resources (if any) are needed to implement the change(s) and are these resources available?	
Resource implications will be considered as part of the re-development of the policy.	
Date actions will be completed:	31 January 2016

How will people who use the service(s) be affected by you not meeting this regulation until this date?
See above re local protocols being in place

Completed by: (please print name(s) in full)	Fiona Jamieson
Position(s):	Deputy Director of Healthcare Governance
Date:	30 October 2015

York Teaching Hospital NHS Foundation Trust

Quality Report

Wigginton Road, York, YO31 8HE
Tel: 01904 631313
Website: www.yorkhospitals.nhs.uk

Date of inspection visit: 17 – 20, 30 - 31 March and 11 May 2015
Date of publication: 08/10/2015

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the trust from 17 to 20 March 2015 and undertook unannounced inspections on the 30 and 31 March 2015 and the 11 May 2015. We carried out this comprehensive inspection as part of the CQC's comprehensive inspection programme.

We inspected the following core services:

- The York Hospital – urgent and emergency care, medical care, surgical care, critical care, maternity care, children's and young people's services, end of life care, outpatient services and diagnostic imaging.
- Scarborough Hospital – urgent and emergency care, medical care, surgical care, critical care, maternity care, children's and young people's services, end of life care and outpatient services and diagnostic imaging.
- Bridlington Hospital - medical care, surgical care, end of life care and outpatient services and diagnostic imaging.
- Community Health Services – including:
- Community health inpatient services at White Cross Court Rehabilitation Unit, Archways Intermediate Care Unit, St Monica's Community Hospital, New Selby War Memorial Hospital, Malton Community Hospital and Whitby Community Hospital Community end of life care
- Community health services for children, young people and families
- Community health services for adults
- Community end of life services

Overall, the trust was rated as requires improvement. Safety, responsiveness and well led were rated as requires improvement. Effective and caring were rated as good.

The trust leadership had generally been stable over the last few years but had recently seen some changes: two appointments had been made, a chief operating officer in 2015 and in the latter part of 2014 a new director of nursing. A new chairman was to start in April 2015. The trust was half way through a five year integration plan following the acquisition of Scarborough and North East Yorkshire NHS Trust and had also acquired community services in 2011. These acquisitions had considerably increased the size and complexity of the Trust. At the time of inspection, as part of its programme of continued improvement, the trust was in the process of reviewing its governance and reporting arrangements.

Our key findings were as follows:

- Care and treatment was delivered with compassion and patients reported that they felt they were treated with dignity and respect.
- Patients were able to access suitable nutrition and hydration, including special diets. Patients were satisfied with their meals and said that they had a good choice of food and sufficient drinks throughout the day.
- We found the hospitals were visibly clean, hand-washing facilities and hand cleaning gels were available throughout the services and we saw good examples of hand hygiene by all staff. The last episode of MRSA septicaemia was more than 500 days prior to the inspection.
- The provider was unable to consistently provide safe staffing levels across the trust. There were shortages of: nursing staff on some medical and surgical wards; consultant cover within A & E; and community inpatient staff. The trust was actively trying to recruit to the majority of these roles.
- There was additional concerns regarding the operation of ward 24, the winter pressures ward at York district hospital, which was often reliant on a majority of hospital bank and agency workers to staff it.
- Patients were not always protected from the risks of delayed treatment and care as the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets were not being achieved.
- There were concerns that patients arriving in both A & E departments did not receive a timely clinical assessment of their condition.
- The trust was not achieving its own target of 75% compliance with mandatory training which included safeguarding training.
- The trust had no mortality outliers. However, the Summary Hospital-level Mortality Indicator (SHMI) for Scarborough hospital of 107 was higher than both the Trust overall (102) the England average (100) in June

2014. At York hospital for the same period the indicator was 98. 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.

- There was no hospital-wide pain team at Scarborough; the critical care unit staff supported patients requiring pain management in-house. We were told that staff, including the consultant intensivists, were experienced and able to competently manage work relating to pain management.
- Protocols, guidelines and pathways of care in all three hospital sites were variable and not yet fully established.
- There had been significant work to develop services to support the needs of people living with dementia.
- The design and environment of the contraceptive and sexual health service clinic at Monkgate in York did not allow for full confidentiality.
- There were 10,000 records not completely secured at one of the trust's community locations.
- Governance arrangements and assurance that issues had been identified and acted upon in a timely manner required improvement.
- The culture within the trust was, in the main, positive and open. Staff wanted to work more collaboratively across the three acute hospitals and community and felt that this area was improving. There were however, some frustrations voiced by staff especially at the Scarborough and Bridlington hospitals regarding the acquisition and lack of senior leadership and presence on site.

We saw several areas of outstanding practice including:

- The appointment of a senior paediatric specialty trainee 'quality improvement fellow' for one year has led to improvements such as the use of technology in handover sessions, with further plans for development of electronic recording of clinical observations and the PAWS assessment.
- We saw positive partnership working with and support from CAMHS in York, which ensured that the acute inpatient wards had seven-day support. The community nursing team also had a CAMHS nurse specialist allocated to the team who provided psychological support for families and staff.
- The trust had developed non-cancer pathways to support quality care for patients who were at the end of life. Specific innovations included pathways for patients with COPD and heart failure and included working on advance care planning initiatives to ensure patients' preferences and choices were clear.
- The innovative way in which central venous lines were monitored, which included a central line clinical pathway. The critical care unit were finalists for an Institute for Healthcare Improvement (IHI) safety award for this pathway.
- The medical service had an innovative facilitating rapid elderly discharge again (FREDA) team, which provided multidisciplinary support and rehabilitation to elderly outlying patients.
- Ward 25, an integrated orthopaedic and geriatric ward, worked closely with the A&E department, and actively identified elderly patients with a fractured neck of femur, to speed up flow to the ward and on to theatre, had demonstrated positive outcomes of speedier rehabilitation and reduced length of stay, with the majority of patients returning to their usual place of residence.
- Phlebotomy outreach clinics in the local community, have led to improved access to the service.
- Availability of pathology services in the oncology outpatient department, meant that up-to-date blood results were available for patients when they saw the consultant in clinic. Treatment changes were based on up-to-date information.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

For York hospital:

- ensure all patients have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011.
- ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels including;

nursing staff on medical and surgical wards; consultant cover within A & E; and registered children's nurses on ward 17 and other clinical areas where children were treated..
- ensure there are suitable arrangements in place for staff to receive appropriate training and appraisals in line with Trust policy, including the completion of mandatory training, particularly the relevant level of children and adult safeguarding training and basic life support so that they are working to the up to date requirements and good practice.
- address the breaches to the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care.
- ensure that patients' privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit based on ward 16.

For Scarborough hospital:

- ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels, especially in A & E, on the medical and surgical wards, operating department practitioner (ODP) cover within theatres, radiology and senior medical cover in relation to cross-site working. Additionally within critical care the provider must ensure staffing levels are adequate to ensure clinical education, unit management, clinical coordination, continuity of care, and effective outreach.
- ensure that there is adequate access for patients to pain management and dietetic services within critical care.
- ensure improvements are made in the 18 week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
- ensure that staff, especially within medicine, outpatients & diagnostics and critical care, complete their mandatory training, and have access to necessary training, especially basic life support, mental capacity and consent (Outpatients and diagnostic staff), safeguarding vulnerable adults and safeguarding children.
- ensure that pathways, policies and protocols are reviewed and harmonised across the trust, to avoid confusion among staff, and address any gaps identified.
- ensure that patient flow into and out of critical care is improved, specifically in relation to delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit.
- ensure that all equipment is tested in a timely manner and in line with the Trust's policy, especially checks on fridges and resuscitation equipment.
- ensure that there is a clear clinical strategy for both critical care and outpatients and diagnostics and that staff are engaged in agreeing the future direction and involved in the decision-making processes about the future of the service.

For Bridlington hospital:

- ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels; especially in relation to staffing of the medical and surgical areas.
- review the uptake and monitoring of training, and ensure that staff are compliant with mandatory training requirements, especially in the areas of moving and handling, fire safety, safeguarding vulnerable adults, and safeguarding children.

For community services:

- ensure there are sufficient numbers of suitably skilled, qualified and experienced staff, in
- line with best practice and national guidance, taking into account patients' dependency levels for community inpatient services.
- review the uptake and monitoring of training, and ensure that staff in community services are compliant with mandatory training requirements.
- ensure that patient records are fully secured when stored.
- review arrangements to support community staff working alone to ensure their safety.

In addition there were actions the trust should take and these are listed at the end of each of the individual location and community service reports.

Professor Sir Mike Richards

Summary of findings

Chief Inspector of Hospitals

Summary of findings

Background to York Teaching Hospital NHS Foundation Trust

York Teaching Hospital NHS Foundation Trust (YTHFT) provides a range of acute hospital and specialist healthcare services for approximately 530,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles. The trust provides community-based services in Selby, York, Scarborough, Whitby and Ryedale. Trust-wide there are approximately 1,170 beds, over 8,700 staff and a turnover of approximately £442,612m in 2013/14.

The Indices of Multiple Deprivation indicates that York is the third least deprived city (out of the 64 largest cities in the UK) and is the 87th least deprived borough out of the 326 boroughs in the UK. North Yorkshire is a relatively prosperous county compared to the rest of England, although there are pockets of deprivation. Eighteen Lower Super Output Areas (LSOAs) within North Yorkshire are amongst the 20% most deprived in England. Fourteen of these LSOAs are in the Scarborough district (around Scarborough and Whitby), two in the Craven district (around Skipton), one in the Selby district and one in the Harrogate district.

Bridlington is in the East Riding of Yorkshire and has a relatively high deprivation indices compared with other parts of the East Riding. The annual death rates in the Bridlington and Driffield area, at 11.9 deaths per 1,000 people, are higher than the East Riding average of 10.0 deaths per 1,000 people. Bridlington North has the highest annual death rate and the East Wolds and Coastal area has the lowest annual death rate, at 15.4 deaths per 1,000 people and 8.2 deaths per 1,000 people respectively. (Annual District Death Occurrence files & Vital Statistics [Office for National Statistics] & Exeter System).

Major disease and illness is more prevalent in the Bridlington and Driffield area than in the East Riding as a whole. For example, coronary heart disease, affects 6.1% of patients in the Bridlington and Driffield area compared with the 4.7% East Riding average. There is the same prevalence in the Bridlington and Driffield area and the East Riding for dementia, which has a 0.4% prevalence rate in both areas. The most prevalent chronic illness in the Bridlington and Driffield area is hypertension, which affects 16.8% of patients. (Quality and Outcomes Framework, NHS Information Centre).

The trust formally acquired Scarborough & North East Yorkshire NHS Trust from 1 July 2013. It also took over the management of most of the community based services in the Selby, York, Scarborough, Whitby and Ryedale areas in April 2011. There is a five year integration plan in place: 2012 - 2017. It is a university teaching trust and an integral part of Hull York Medical School.

We inspected all three acute hospitals and most community services (see below) as part of the CQC comprehensive inspection programme.

York Hospital is the York Teaching Hospitals NHS Foundation Trust's largest hospital. It has over 700 beds and offers a range of inpatient and outpatient services. It has an Accident and Emergency department and provides acute medical and surgical services, including trauma, intensive care and cardiothoracic services to the population and visitors to York and North Yorkshire. There are 12 operating theatres in the main theatre suite and six operating theatres in the day unit.

Scarborough Hospital is the Trust's second largest hospital. It has an Accident and Emergency department and provides acute medical and surgical services, including trauma and intensive care services to the population and visitors to the North East Yorkshire Coast. There are five operating theatres and approximately 300 beds.

Bridlington Hospital is a satellite hospital of the acute hospital in Scarborough. It provides elective surgical, rehabilitation, and outpatients services to the local Bridlington community and the wider East coast. The hospital has two rehabilitation wards Waters and Johnson. Lloyd ward and Kent ward are the surgical wards. There is also the Shephard Day Case Unit and Lawrence Unit for medical elective services. The hospital

also has other services on site, such as a minor injuries and GP access centre, the GP MacMillan Wolds Unit, Buckrose Ward and a renal dialysis unit which are run by other providers.

Community inpatients facilities were provided at White Cross Court Rehabilitation Unit, Archways Intermediate Care Unit, St Monica's Community Hospital, New Selby War Memorial Hospital, Malton Community Hospital and Whitby Community Hospital. The number of beds in each hospital varied from 12 to 29. Community services for adults with long-term conditions were also provided in people's own homes and clinics across the geography of the Trust.

Community health services for children, young people and families included a range of services delivered to people in the City of York and in parts of North Yorkshire. Core services included health visiting, school nursing, and a contraceptive and sexual health service. These services were complemented by specialist teams.

Community palliative and end of life care services were delivered within people's own homes with access to the acute trust, neighbouring trusts and hospices. Care was delivered by community GPs, hospital doctors, nurses, community nurses, specialist palliative care nurses, healthcare assistants and allied health professionals.

Our inspection team

Our inspection team was led by:

Chair: Stephen Powis, Medical Director, Royal Free Hospital, London

Head of Hospital Inspections: Adam Brown, Care Quality Commission

The team included CQC inspectors and a variety of specialists including medical, paediatric and surgical consultants, junior doctors, senior managers, nurses, midwives, palliative care nurse specialist, a health visitor, allied health professionals, children's nurses and experts by experience who had experience of using services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The inspection team inspected the following eight core services at both York hospital and Scarborough hospital:

• Urgent and emergency

• Medical care (including older people's care)

• Surgery

• Critical care

• Maternity and family planning

• Services for children and young people

• End of life care

• Outpatient and diagnostic services

At Bridlington hospital we inspected the four core services which were provided on this site: medical care, surgery, end of life care and outpatient and diagnostic services.

We also inspected community services which included:

- Community inpatients at White Cross Court Rehabilitation Unit, Archways Intermediate Care Unit, St Monica's Community Hospital, New Selby War Memorial Hospital, Malton Community Hospital and Whitby Community Hospital.
- Community adult services
- Community children's services
- Community end of life care

These are reported on separately.

Summary of findings

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held listening events in Scarborough on the 12 March 2015, where 12 people attended and in York on the 16 March 2015 where 17 people attended and shared their views and experiences of the Trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone. We also attended additional local groups to hear people's views and experiences.

We held focus groups and drop-in sessions with a range of staff including nurses and midwives, junior doctors, consultants, allied health professionals including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out the announced inspection visit between 17 and 20 March 2015 and undertook an unannounced inspection in the evening on 30 March and the 31 March 2015 at York and Scarborough hospitals. A further unannounced to Scarborough was undertaken on the 11 May 2015.

What people who use the trust's services say

The results of the CQC Inpatient Survey 2013 showed the trust performed around the same as other trusts for all questions.

The Cancer Patient Experience Survey results for 2014/ 2014 for inpatient stays showed the trust was in the top 20% for 18 indicators and within the middle 60% of other trusts for the remaining indicators. There were no indicators within the bottom 20% of trusts.

Results of the Patient-Led Assessments of the Environment (PLACE) 2014 showed that the trust scored for cleanliness 99 (the England average was 98), food 85 (the England average was 90), privacy, dignity and wellbeing 82 (the England average was 87) and for facilities 94 (the England average was 92).

Between March 2013 and October 2014 the trust performed better than the national average in the Friends and Family test results for the percentage of people who would recommend the service to others apart from the months September 2013 and October 2014.

Written complaint numbers have remained at a consistent level for a number of years. An increase in the figures 2012/13 is explained by the merger of York and Scarborough, bringing the two sets of complaints data together in a single figure from that point onwards.

The local Healthwatch reported that the themes coming out of engagement with local people about the trust. The main themes were that 79% of people who responded felt they were treated with kindness and respect; 70% felt their treatment needs were met and 79% felt the services kept them safe from harm.

Facts and data about this trust

There are 12 locations registered with CQC of which ten are hospitals associated to this teaching trust, three of which would be classified as acute district general hospitals, three community hospitals with two Rehabilitation Hospital. There are also a number of Satellite Renal Units.

In 2013/14 there were approximately 1,171beds trust-wide of which:

1103 General and acute

44 Maternity

24 Critical care

Summary of findings

In 2013/14 there were approximately 7,210.30WTE (whole time equivalent) staff working within the Trust of which:

709.95 Medical

2098.15 Nursing

4402.20 Other

For 2013/14 the trust had a revenue budget of £442,612m with a full cost of £443,566m and a deficit of £951k.

Data provided by the Trust indicated that there were over the last year:

- Electives & Day cases: 73,000
- Emergency Admissions: 50,000
- Outpatients: 780,000
- Births: 5,000
- Community Contacts: 112,000
- ED Attendances: 188,000

The trust was last inspected by CQC in July 2013. We inspected maternity and accident and emergency (A & E) services in both Scarborough and York hospitals. York hospital was compliant with the regulations however Scarborough A&E department required improvement. We re-inspected the A&E department in December 2013 and found it to be compliant.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	**Requires improvement** 

Summary

Incidents were reported, however staff confirmed that feedback and learning was incidents required improvement. Safeguarding training for staff was below the required levels set by the Trust. Nurse staffing was recognised as a significant risk to the organisation, especially within Scarborough hospital. There were also role specific staffing issues across the Trust, for example A&E consultants. There were also concerns about the management and staffing of the winter pressures ward at York hospital.

Duty of Candour

- The Board were aware of the Duty of Candour and received regular briefings.
- There was a "Being Open" policy in place.
- Training and presentations had been provided for staff along with posters and information about being open with patients and the duty of candour.
- Staff we spoke with were aware of the requirements of Duty of Candour.
- Staff were requested to record in writing in patient's notes and the Datix incident reporting system when patients had been spoken with and written to.

Safeguarding

- The safeguarding strategy was underpinned by safeguarding policies and procedures.
- There were named leads for children's and adult services, including at Trust Board level. The chief nurse had safeguarding as part of their portfolio of responsibilities and staff reported that safeguarding was given more priority than previously.
- There were quarterly updates to the Board via the Quality and Safety board committee.
- The chief nurse was the nominated lead for safeguarding at Board level. Both adult and children's safeguarding teams were aligned under the chief nurse. A senior lead for safeguarding was appointed and commenced full time in post on 1 October 2014.There was a designated nurse for safeguarding children, a

named doctor for child protection, and a consultant paediatrician lead for Looked After Children. In addition there were two named nurses for children and lead nurses for both adult safeguarding and learning disability.
- There was a full time named midwife for child protection across YTHFT based at Scarborough Hospital supported by a half time midwifery child protection advisor based at York Hospital.
- There was safeguarding training available for staff but in many areas there was poor completion especially level 2 training. The overall compliance rates for 2013-14 were: Level 1 (e-learning for every staff member) 59% compliance; Level 2 (face to face for all staff who work with children & young people, and adults who are parents or carers) 36% compliance; and Level 3 (face to face training for all staff who work predominantly with children, young people & families) 70% compliance
- Safeguarding "Prevent" training was on the risk register as most areas were not on target to achieve the required training level in 2014/15.
- There was representation from the Trust on the Child sexual exploitation group which was a sub-group of the Children's Safeguarding Board.
- Policies had recently been rewritten and circulated for consultation. These included the Safeguarding Children Policy and the Allegations of Abuse or Neglect Against YTHFT Employees Policy & Procedure

Incidents

- There has been one never event reported as wrong site surgery at Scarborough Hospital in general surgery.
- Of all the serious incidents (SIs) requiring investigation slips, trips and falls accounted for 38% and pressure ulcers grade 3 for 33% of incidents.
- 94% of all incidents were reported with no or low harm.
- The trust was reporting fewer incidents per 100 admissions than the England average. Our analysis indicated that this was not statistically different.
- Rate of falls increased overall between July 2013 and January 2014. From April 2014 the number of falls ranged from 214 per month to 282 except in November 2014 when they dropped to 179 falls.
- The trust was performing worse than the national average for the development of pressure ulcers. The prevalence rate for grade 3/4 pressure ulcers was consistently above the national average accounting for 79% of all serious incidents reported,

although there had been a steady decrease throughout the year. The occurrence of newly developed pressure ulcers from July 2013 onwards was overall consistent until a significant rise to 65 in January 2015.
- There had been improvements in the rate of catheter urinary tract infections, which had decreased in July 2013, then remaining low throughout the year.
- Incidents were reviewed at a senior management group on a weekly basis which included the medical director and chief nurse.
- There was an SI committee that met monthly to review SIs and was chaired by a member of the consultant body.
- There was an electronic reporting system in place for incidents and staff were aware of how to use this. Staff reported that they were confident in using the system. However, most staff said that on an individual level feedback and learning was inconsistent.
- Some learning was shared across services from incidents, and discussions had at governance and ward meetings. However, we found actions from incident investigations were not always timely or led to changes in practice.

Staffing

- There was a nursing and midwifery strategy in place which dovetailed with patient experience, patient safety and infection and prevention control. The first year of the strategy included the development of nursing care indicators for the Trust. The first quarterly report of which had just been presented to Board.
- Since the acquisition there had been a growth in substantive consultants, reducing reliance on some locum appointments and significant investment in nursing posts (£5.2m post-acquisition).
- Trust-wide the staffing concerns were low numbers of junior medical staff, nursing vacancies, especially on the Scarborough site and some dependency on locums. At the time of the inspection there were 42 nurse vacancies at Scarborough hospital (30 on the wards and 12 in outpatients) and 56 vacancies at York (all ward-based).
- Staff were unable to tell us if their establishments were based on the use of an acuity tool. Board papers indicated that the staffing establishment was set on the number of beds on each ward.
- Nurse staffing issues were most acute during the day, with some wards falling below an 80% fill rate for RNs.
- Where low numbers of RNs were evident, the trust tried to provide greater numbers of healthcare assistants (HCAs),

although this was not always possible. This was reflected in the staffing figures. For example, The elderly wards 23, 26 and 35 at York hospital had RN fill rates of 79.3%, 75.1% and 73.2 % respectively, with 97.6%, 111.9% and 117.2% fill for HCAs.

- There was additional concerns regarding the operation of ward 24, the winter pressures / escalation ward at York district hospital, which was often reliant on a majority of hospital bank and agency workers to staff it. The budgeted establishment was 17.6 whole time equivalent (WTS) Registered Nurses (RNs) and there were only 9.6 WTE RNs in post. Some of the temporary staff had been in post since this ward opened as an escalation ward which helped to mitigate the risk of staff not being familiar with the ward or the policies and procedures.
- Additionally where wards showed an over 100% fill rate for care staff this was due to the enhanced supervision requirement of some patients.
- There was a workstream in place to review the role of healthcare assistants and what enhanced roles they may develop to support registered nurses, for example, observations and taking blood sugars.
- The trust had recently introduced advanced care practioner roles: there were two working in the acute medical unit at York; one in elderly medicine at York; six recently trained to work in A&E (four of which were in Scarborough). There were a further 12 staff on the training programme.
- Data for August 2014 to March 2015 showed that staff had been moved 157 times from Bridlington to ensure that wards at Scarborough had sufficient staffing levels.
- Wards and departments had planned and actual staff numbers on display.

Are services at this trust effective?

Good

Services within the trust were rated as good for delivering effective care. Policies and pathways were based on NICE and other best practice guidelines, and were available to staff and accessible on the trust's intranet site. The trust had no mortality outliers. We witnessed strong and respectful multidisciplinary team (MDT) working during our inspection, and this was corroborated by feedback from all disciplines spoken with.

Evidence based care and treatment

Summary of findings

- We saw that National Institute for Health and Care Excellence (NICE) guidance, The Royal Colleges' guidance and other national best practice guidance was disseminated to departments with, in many instances, a lead clinician taking responsibility for ensuring implementation.
- Staff we spoke with were aware of NICE and other guidance that affected their practice and were able to talk to us in detail about patient treatment pathways.
- National audits were contributed to as expected, and we were given evidence of changes made by specialities in response to their outcomes.
- We saw that the departments were adhering to local policies and procedures. Staff we spoke with were aware of how they affected patient care.
- The trust had a standard operating procedure in place for Ionising Radiation (Medical Exposure) Regulations.
- The diagnostic imaging department carried out quality-control checks on images to ensure that imaging met expected standards.

Patient outcomes

- The trust had no mortality outliers. However, the Summary Hospital-level Mortality Indicator (SHMI) for Scarborough hospital of 107 was higher than both the Trust overall (102) the England average (100) in June 2014. At York hospital for the same period the indicator was 98. 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.
- Patients arriving in the A & E departments did not receive a timely clinical assessment of their condition. The trust was not working to the College of Emergency medicine guidelines regarding clinical triage of patients arriving in the departments. Figures supplied by the trust showed that only 44% of patients were clinically assessed within 15 minutes at York. This was also highlighted to the Trust as a concern at Scarborough.
- Patients who walked into the A & E department at both Scarborough and York, or who were brought by friends or family, were directed to a receptionist. Once initial details had been recorded, patients were asked to sit in the waiting room while they waited to be assessed by a nurse. If the receptionist thought that their injury or ailment was a minor one, they would wait to see an emergency nurse practitioner. Some of these patients were not clinically screened or triaged at all.

- We raised this as concern with the Trust at the time of the inspection. At Scarborough hospital the trust had implemented a nurse led streaming service between 8am to 10pm each day: figures indicated that between 1 April 2015 - 10 May 2015 52% of patients had been seen by a clinician within 15 minutes of arrival.
- National audit results for patient outcomes were the same as or better than national averages for most services. For example, the York hospital results for the Myocardial Ischaemia (heart attack) National Audit Project (MINAP) for 2013/14 were better than national averages for most indicators. There were some other areas that indicated a deterioration in service such as the Sentinel Stroke National Audit Programme for the Scarborough hospital.
- Overall, the trust had a shorter length of stay than the England average for both elective and non-elective admissions, and overall, medical re-admission rates were better than England averages. However, Scarborough hospital had a longer stay than the England average for non-elective medical admissions.
- The Trust's outcomes for Patient Reported Outcome Measures (PROMS) between April 2013 and December 2014 for hips, knees and groin hernia repair showed that the percentage of patients who had improved following each procedure was in line with the figures reported nationally.
- The follow-up to new ratio for appointments at the Trust was consistently worse than the national average from September 2013 to April 2014: York Hospital has performed worse than average with Bridlington and Scarborough performing better than the national average throughout the same period. No further national data was available at the time of the inspection. There was no hospital-wide pain team at Scarborough hospital; the unit staff supported patients requiring pain management in-house. We were told that staff, including the consultant intensivists, were experienced and able to competently manage work relating to pain management.

Multidisciplinary working

- We witnessed strong and respectful multidisciplinary team (MDT) working during our inspection, and this was corroborated by feedback from all disciplines spoken with.
- Daily ward rounds were carried out in which the clinical care of every patient was reviewed by members of the multidisciplinary team, which were led by the consultant managing the patient's care.

- Staff told us that there was effective communication and collaboration between teams, which met regularly to identify patients requiring visits or to discuss any changes to the care of patients.
- Discharge letters were sent to the patient's GP and a copy of the letter provided to the patient.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Consent forms identified the procedure to be undertaken and its associated risks. There were documented records of the healthcare professional responsible for consulting the patient, and the forms also included patient signatures to indicate that they were providing consent to undergo any proposed procedure.
- All patients we spoke with told us that they had been asked for their consent before surgery. They said that the risks and benefits had been explained to them and they had received sufficient information about what to expect from their surgery.
- Staff had readily accessible guidance and information, and knew who to contact for advice and support if needed.
- Staff demonstrated a good understanding of consent, mental capacity and best interest decisions, and accessed training through an e-learning platform.
- This was illustrated, for example, on Ward 37 at York, the elderly mental health assessment ward. The ward regularly had significant numbers of patients with limited mental capacity, confusion and often challenging behaviour. Ward 37 was a locked ward, and all patients were assessed for mental capacity on admission to seek consent to remain on a locked ward.
- Deprivation of liberty safeguards (DoLS) were in place for patients who lacked capacity to consent.

Are services at this trust caring?

Good

Summary

We found that services provided at the trust were caring and compassionate. Patients confirmed that they were treated with dignity and respect, that they were involved in their care decisions and felt generally well informed.

Analysis of patient feedback and surveys showed that on the whole patients were satisfied with the care and treatment at the trust.

Compassionate care

Summary of findings

- We observed positive, kind and caring interactions between staff and patients on wards, clinics and in patients' homes.
- Call bells on the wards were mostly answered promptly and were in reach of patients who needed them.
- Patients told us that, although staff were very busy, the standard of care they had received was good and all their clinical needs had been met.
- The NHS Friends and Family Test recommendation rate was consistently above the England average between March 2013 and November 2014 except for two months which were September 2013 and October 2014. The Friends and Family Test requires all patients, after discharge from hospital, to be asked: How likely are you to recommend our ward to friends and family if they needed similar care or treatment?
- The trust performed around the same as other trusts in relevant questions in the CQC's Inpatient Survey 2013.
- The cancer patient experience survey results for 2013/2014 for inpatient stays showed the trust was in the top 20% nationally for 18 out of 34 questions with the remainder similar to other trust nationally.
- The Patient-led Assessments of the Care Environment (PLACE) for both 2013 and 2014 indicated that the Trust performed worse than other trusts in relation to privacy, dignity and wellbeing with scores of 82 and 83% compared with the England average of 88 and 87%

Understanding and involvement of patients and those close to them

- Patients reported that they felt able to talk to staff about any concerns, either about their care, or in general.
- We saw that staff discussed care issues with patients and relatives where possible and these were generally clearly documented in patient notes.

Emotional support

- We observed members of staff who were responsive to and supportive of patient's emotional needs. For example, we observed nurses, play specialists and other staff providing emotional care and support to children who were upset.
- There was a bereavement service which was easily accessible.
- There were services available that patients could be referred to, for example, counselling services, psychologists and mental health teams.

Are services at this trust responsive?
Summary

Requires improvement

Summary of findings

We found that staff were responsive to people's individual needs. However, the trust was failing to meet the national waiting time targets, such as the 18-week referral to treatment time (RTT) target, the A&E target and the achievement of cancer waiting times.

Surgery had systems in place to plan and deliver services to meet the needs of local people, including the provision of a newly designed surgical ward and assessment unit at Scarborough hospital. For critical care services service and strategic planning was at an early stage and there was a lack of certainty in terms of the future design of the service and the immediate mitigating actions in terms of delayed discharge, delayed admissions and high capacity.

There were effective processes in place to support patients with learning disabilities and a dementia strategy which was being refreshed. Some patients raised concerns about being nursed in mixed-sex accommodation on the nursing enhanced unit.

Information about the trust's complaints procedure was available for patients and their relatives. However, the siting of the PALS was not responsive to people's needs. PALS staff did not have immediate access to a private space and were seeing some patients and carers in a corridor.

Service planning and delivery to meet the needs of local people

- The majority of the trust's services were commissioned by three clinical commissioning groups based on the needs of the local populations.
- The major challenge for the trust was to provide medical care services for an increasing elderly population, which was expected to increase significantly over the next five years. There was also expected to be a significant service requirement for the management of dementia and other long-term conditions.
- The trust had identified that reconfiguration, particularly of the acute medical beds, was required to meet patient needs. The reconfiguration was in progress, and some changes had already been implemented.
- There was also a review of the surgical provision and work was in progress to deliver more elective cases at Bridlington hospital to help relieve the pressure on beds in Scarborough. Orthopaedic surgery had been developed in Bridlington and there were plans to reconfigure ophthalmology services.
- As part of the Theatres and Anaesthetics Directorate, the critical care units of at York Hospital and Scarborough Hospital were officially merged in April 2013. We found that the more practical aspects of the merger, particularly in terms of joint working, did

not start until September 2014 or later. It was evident that the changes were relatively new and were still becoming embedded. We discussed, and requested documentation, around service planning and there was evidence of early discussions about critical care services for both York Hospital and Scarborough Hospital.

- The executive team highlighted specific areas that required development to meet the needs of local people, for example the Scarborough obstetric and paediatric services.
- The trust had introduced 'Operation Fresh Start' at Scarborough, an initiative to improve patient flow and allow managers to make decisions about the number of patients requiring beds who were admitted to the hospital. Ward-level discharge liaison officers were in post to facilitate the process of patient discharge and a patient flow manager had recently been appointed. Staff told us that the system was making a difference.

Meeting people's individual needs

- There was a board lead for equality and diversity: a non-executive director with the executive lead as the director of corporate development.
- For patients who did not speak English, or who had other communication difficulties there were a number of interpreting services available which included: by telephone; face-to-face; sign language. There was also typetalk, hearing loops and document translation to braille/audio/CD.
- A learning disability nurse was available to support patients with learning disabilities in acute settings. Staff were available to work with patients who needed extra support. For example, some patients were able to attend mock appointments and be supported by the learning disability team, who explained appointment and diagnostic processes to help to allay people's fears and phobias.
- Patients we spoke with told us that their care was individualised, and we observed discussions around care and treatment, and documentation that demonstrated this.
- Staff told us they had access to information about different cultural, religious and spiritual needs and beliefs.
- Staff reported that they sometimes had difficulty in answering buzzers, and felt that patients were at times "queuing for the toilet", or unable to be sat out of bed for meals, as staffing numbers were too low.
- Male and female patients were being cared for in the same bay in the nursing enhanced unit based on ward 16 at York hospital.

The unit consisted of two six-bedded bays, which allowed closer observation of level one dependency patients. Three female patients raised concerns with us about being nursed in mixed-sex bays.

- As part of the enhanced recovery programme in orthopaedics, patients were involved in the preparation and planning before admission, pre-operative assessment, recovery and early mobilisation. This meant that patients were better prepared to manage when they were back at home.
- There were two stoma nurses and an upper gastrointestinal specialist nurse who provided advice and support for patients during their pathway of care. Nurses saw patients in a clinic and provided follow-up care at home.

Dementia

- There was a dementia strategy in place for 2013 – 2015 with work to update the strategy for 2016 – 2019 to be completed by November 2015.
- The re-design of a pathway of care for patients with dementia had been completed and was in use by medical staff when a patient was admitted acutely to AMU, surgery or orthopaedics across both acute sites.
- Work had been undertaken by the Nursing Documentation Steering Group in the resign of essential care plans. This includes a revised COMFEE tool and care plan for communication, for use with all patients with dementia or cognitive impairment. The care plan was being piloted on ward 26 at York hospital, White Cross Court and Ann Wright Ward.
- There were Commissioning for Quality and Innovation (CQUIN) results for quarter one and two of 2014/15 that indicated that the Trust had achieved the successful implementation of the dementia pathway overall but there were challenges within the surgical and orthopaedic directorates, where compliance with the pathway required improvement. The CQUINs included: the number of patients admitted over 75 years as an emergency admission who were reported as having a known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question (achieved 90.6%); the number of the above patients reported as having had a diagnosis assessment including investigations (achieved 100%) and the number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners (achieved 100%).

- York hospital had a Mental Health Assessment Liaison Team (MHALT) who reviewed patients with dementia and provided clinical input five days per week. This team provided a standard assessment of patients with dementia.
- Scarborough hospital has recently had approval for the implementation of a MHALT nursing team. A band 7 and three band 6 nurses commenced in post in January 2015.
- There was a standardised assessment of function related to the assessment by an allied health professional (AHP) but this had yet to be implemented. The AHP's used an assessment tool but it was not standardised across the Trust.
- Both the dementia pathway and delirium pathway provided standardisation of assessment on admission.
- The forget me not flower symbol as an identifier for patients living with dementia had been in use in Scarborough Hospital for some time.
- As part of the national dementia CQUIN the trust captured feedback from carers. This was then reviewed and actions implemented. The patient information booklet titled "This is about me" for use by staff across the trust was changed as a result of feedback. Out of 43 carers contacted 36 said they felt supported by staff.
- From April 2014 to November 2104 a total of 1,119 staff completed dementia level 1 and 186 staff completed level 2 training.
- There were senior clinical leads for dementia; an assistant director of nursing and an elderly care clinician.
- There has been work undertaken in relation to improving the inpatient environment on both acute sites. This has included the refurbishment of wards 37 and 23 on the York site and Oak ward at Scarborough. The refurbishment of ward 37 was in accordance with Stirling University dementia good design principles. All three wards are care of the elderly and had a high number of patients admitted with dementia.

Access and flow

- Acute flow and capacity compromised the quality of care at times, especially at Scarborough hospital and in a number of services, for example A&E, cancellations of surgery, and care within the acute medical unit at York hospital.
- Once patients were within the treatment areas of A&E at York, their initial needs were responded to in a timely manner. However, there were delays of over an hour in nurse assessment for ambulance patients. This was caused by crowding in A&E, mainly due to difficulty admitting patients to wards. There was little evidence of an effective or co-ordinated

hospital-wide approach to improving patient flow through the department. In the year leading up to our inspection, the department had been unable to meet the national target of admitting or discharging 95% of patients within four hours.

- Patients who had been referred by GPs to the acute medical unit at York sometimes had to use a ward waiting room, which regularly overflowed into the corridor. Ward records showed that there had been up to five patients waiting, at any one time, in the corridor in the two weeks prior to the inspection. This had been exacerbated by the need to change the use of 10 beds on the adjacent ward, which had been used by AMU for frail elderly patients, into winter pressure beds.
- Bed occupancy levels were consistently above the England average which may have added to the flow and capacity problems within the hospitals.
- The trust was failing to meet the national waiting time targets, such as the 18-week referral to treatment time (RTT) target, the A&E target and the achievement of cancer waiting times.
- The surgical directorate was not meeting its targets for the 18-week RTT pathway in five of the eight surgical specialties.
- Between April and December 2014, there were 334 elective operations cancelled at York hospital at the last minute for non-clinical reasons. The main non-clinical reason for cancellation of elective surgery was a lack of available beds (NHS England, 2014).
- The Scarborough critical care service was running at a consistently high occupancy rate of 100% and above. For example, over the New Year of 2014, the unit had run at between 100% and 104% capacity. At high capacity, some patients were transferred and managed by a member of the outreach team on the post-anaesthetic care unit (PACU). Ideally, according to national guidance, occupancy rates should be between 80% and 85%.
- The Scarborough critical care service was a significant outlier in terms of non-clinical transfers out. We were informed that a business case had been submitted relatively recently to increase the bed capacity on the unit to deal with delayed discharges, delayed admissions, high running capacity and non-clinical transfers out.

Learning from complaints and concerns

- The Trust's Patient Experience Team was within the Chief Nurse's directorate. There was a lead nurse for patient

Summary of findings

experience and they were supported by the head of patient experience. The team had three main functions: handling concerns and complaints; Patient Advice and Liaison Service (PALS) and patient and public involvement (PPI).

- Information and learning from complaints was presented to the Board's Quality and Safety committee on a quarterly basis.
- The chief nurse was leading a piece of work to further develop themes and tracking of complaints alongside identifying any services / wards that had high levels of complaints.
- The trust had recently started to display patient experience boards which included "You said, we did.." information as part of its feedback to patients and visitors about improvements made following concerns raised.
- PALS staff were observed to have a caring and supportive approach with a good telephone manner. However, the siting of the PALS was not responsive to people's needs. PALS staff were seeing patients and carers in a corridor. Where possible the staff told us they found a private space and could pre-book a room if the meeting was planned.

Are services at this trust well-led?

Requires improvement

Governance arrangements and assurance that issues had been identified and acted upon in a timely manner required improvement. Corporate level risks and the Board Assurance Framework (BAF) were presented to the Board as indicated from the papers within the private (part two) Board minutes of September 2014. However, not all significant concerns identified during the inspection were highlighted as risks. Additionally, during the inspection, staff we spoke with had difficulty in locating the BAF. . The trust was however, reviewing its governance structures and developing a new BAF. The urgency to act on concerns and ensure that lessons were learnt required improvement.

Staff were mostly positive regarding the leadership of the organisation and had seen the chairman, chief executive and some non-executives. However, some staff on the Bridlington site in particular, felt that the acquisition of the hospital had not been well managed and that there was a disconnect between the executive trust team and staff working in Bridlington. Staff told us they felt less regarded and less important than at other sites.

There was a clearly articulated vision and strategy for the Trust and an ongoing five year integration plan following the acquisition of Scarborough & North East Yorkshire NHS Trust.

In the main the culture was open and transparent. There were a number of examples of innovation, improvement and sustainability.

Summary of findings

Vision and strategy

- The trust had a clear ultimate objective to "Be trusted to deliver safe, effective healthcare to our community" supported by a set of values and four locally agreed standards to: improve quality and safety; develop and enable strong partnerships; create a culture of continuous improvement and: improve our facilities and protect the environment.
- The vision, values and objectives were set out in documents. Senior management were able to describe the vision and objectives.
- The trust acquired both Scarborough & North East Yorkshire NHS Trust and community services for the wider York catchment and the north-eastern part of North Yorkshire in 2012 and 2011 respectively.
- A five year integration plan 2012-2017 had been developed to manage the acquisition process. The trust was midway through the integration, which was taking place in stages, and most recently had seen the integration of the critical care services across the two hospital sites.
- The trust indicated that at the time of the acquisition both organisations had a lack of investment in services and estate, together with management instability; different cultures, inconsistent leadership &. disenfranchised staff; poor governance, and difficulty in recruiting medical, nursing and specialist staff.
- Some of the community health services, remained in transition as contracts were being renegotiated with local commissioners. The trust had in place a lead director for community services to further develop and improve the momentum of that integration.
- There were clinical alliances with other organisations, especially Harrogate and District NHS foundation trust and Hull and East Yorkshire hospitals NHS Trust.
- There was a also a strategic plan in place for the trust for 2014 -19. Within it there was a summary of key developments going forward for most of the services within the trust.
- There was a patient safety strategy in place for 2014-16 which focussed on six specific areas: ensuring constancy of care; reduction of harm; reduction of mortality; end of life care; infection prevention and control and; action on areas of frequent harm.
- Progress and delivery of the strategies and plans were monitored through the Board and its supporting committees.

- The development of directorate strategies was variable, for example staff were able to articulate the surgical services strategy but staff in critical care were unsure as to the future direction of their service.

Governance, risk management and quality measurement

- A review of the governance of the organisation was ongoing at the time of the inspection to strengthen the governance framework. This was expected to be completed by the end of March 2015. The work was being led by the Chief executive with involvement from the non-executive directors.
- Corporate level risks and the Board Assurance Framework (BAF) were presented to the Board as indicated from the papers within the private (part two) September 2014 Board minutes. However, not all significant concerns identified during the inspection were highlighted as risks. Additionally, during the inspection, staff we spoke with had difficulty in locating the BAF. Responsibilities and accountabilities for the management of risk were being reviewed and were articulated within the existing BAF and risk register. The arrangement of the BAF dated September 2014 was planned to fit with the Director's portfolios. Senior staff who we interviewed in the main understood their roles and responsibilities. However, responsibilities regarding risk were not set out explicitly within the risk strategy.
- At the time of inspection, we were unable to fully understand the structure of the assurance framework both in terms of documentary evidence and from interviews with staff.
- The corporate risk register reflected the risks in the service risk registers. However, not all risks we identified were on the risk register. For example during the inspection we were informed that a new urgent care centre (run by another provider) was opening adjacent to the emergency department at Scarborough Hospital two weeks after the inspection. The service shared the same reception and initial screening staff with the ED. At the time of the inspection there were no formally agreed standard operating procedures or formally agreed contracts in place; training was proposed to take place during the week that the unit opened. In addition the agreed opening was during the Easter bank holiday. The trust's governance had not highlighted this to be a risk to the organisation, and there was no risk mitigation plans in place. We fed back to the Trust our concerns during the inspection and wrote to the trust requesting further assurances regarding the safety of service element run by the Trust which included evidence of training

and additional staffing. Evidence from the trust and unannounced inspection indicated that most but not all staff had been trained and that during the day an ED nurse was allocated to deliver the initial screening of patients.

- At the time of the inspection we raised concerns regarding a possible theme for some of the headache/head injury incidents reported at both York and Scarborough A&E departments. The executive were aware of the incidents. However, a themed review had not been completed to ascertain whether there were systematic failures in the streaming and clinical assessment of these patients.
- Following the inspection the trust, in a letter dated 27 March 2015 informed us that the reports for the specific incidents had been completed and have been reviewed by the Serious incident group. Some actions have already been implemented and we were told that none of the cases related to the process for streaming and clinical assessment.
- Following the inspection there was a further serious incident recorded at Scarborough hospital in relation to a head injury which was being investigated by the Trust.
- Executive directors had recognised that their most significant risk was staffing vacancies, especially within the Scarborough site. Work had latterly being progressed to develop alternative posts and to recruit overseas.
- At the time of inspection there were external reviews ongoing concerning the governance of obstetrics and paediatrics at Scarborough following serious incidents.
- Data collection to analyse and monitor where improvements to services could be made required improvement. For example recording and analysing whether a person's choice of preferred place of care at the end of life was achieved and the accurate recording of mandatory training figures.
- Risks have been highlighted within the estate and significant investment to address this has been delivered, especially on the Scarborough site. There was evidence of a ward replacement programme (for example Lilac ward at Scarborough hospital), car parking, theatre refurbishment, engineering resilience and backlog maintenance.
- There was comprehensive performance information available at board level which contained a full range of information.
- There was a weekly safety meeting at director level which received information regarding serious incidents, deaths and complaints. In addition there was in place a Serious Incident committee which reviewed all root cause analyses of incidents and held a log of the outstanding recommendations and actions.

- There was a good focus on quality. There was a Quality and Safety board committee with structures below to support delivery. This separate board committee allowed time for Board members to scrutinise in detail the safety measures and quality data.
- There was a system of clinical audit. The Audit committee were exploring how this could be strengthened to provide quantifiable assurance similar to internal audit processes.
- There was a range of other committees and groups sat below Board levels which provided assurance upwards to the Board.

Leadership of the trust

- Senior leadership at the trust had been stable for a long period of time, but had recently seen some changes: two appointments had been made, a chief operating officer and in the latter part of 2014 a new director of nursing.
- The senior team were able to articulate the challenges facing the trust and identify actions to be taken.
- The chief executive had an open door policy and also held surgeries with the chief nurse for staff to attend.
- The non-executive directors were visible within the organisation, through both the committee structure and lead responsibilities for certain areas or sites.
- Staff were mostly positive regarding the leadership of the organisation and had seen the chairman, chief executive and some non-executives. However, some staff on the Bridlington site felt that the acquisition of the hospital had not been well managed and that there was a disconnect between the executive trust team and staff working in Bridlington. Staff told us they felt less regarded and less important than at other sites.
- Staff told us they felt that the outpatients departments were often forgotten about when the executive team visited Scarborough Hospital because most visits were to the wards rather than other departments.
- Staff working in the Scarborough Hospital did not feel that they were part of the York Teaching Hospitals Foundation Trust. They felt that integration with the trust had left them “as the poor relation”. Staff on the whole did not feel that the acquisition had been managed well, more a takeover without taking into consideration existing structures and staff concerns.
- The trust was strengthening its management of staff sickness / absence and performance. There was a new personal development review structure in place which was based on the Trust’s values and objectives.
- Within nursing services there were regular nurse leadership forums, a yearly nursing and midwifery conference.

Summary of findings

- There were board leads for community services. A director had been appointed to focus on the development of community services over a three year period
- The leadership of the Trust appeared to be internally focussed. There was little evidence of looking beyond the trust for ideas and new ways of working.

Culture within the trust

- There was an open and supportive culture throughout the trust, the majority of staff were positive regarding the culture and visibility of the executive staff. However, there were some criticisms about lack of presence of the senior management at both Scarborough and Bridlington hospitals.
- Staff at all levels stated that the clinical integration of the different sites was not yet fully achieved and that cultural & performances differences remained. In the main, staff at Scarborough and Bridlington identified that policy and system changes would be implemented using practice from York Hospital rather than those in place at Scarborough or Bridlington. A frequent comment was the 'York way' when implementing change.
- Staff working in community services also raised similar concerns regarding the integration with in the trust insomuch as the provider was very much focussed on acute services.
- There was investment in organisational development to support continuous improvement.
- In order to gain a greater insight into staff experience the chief nurse had undertaken a pilot of a Cultural Barometer, during September – December 2014. The analysis of this data was being shared with the wards to help them improve aspects such as communication and team working. Consideration was being given to rolling out this barometer across all inpatient areas.

Fit and Proper Persons

- The trust had undertaken a fit and proper person assessment on all executive and non-executive staff, and were midway through checks on all other directors and senior managers.
- We were provided with the files for all executive and non-executive staff. We reviewed seven of these files, and all had appropriate checks carried out. We checked files of existing and newly recruited staff and the checks were of the same standard. Non-executive directors also went through a similar process.

Summary of findings

- The trust had developed a policy for the Fit and Proper Person Requirement. The policy stated the fitness of directors would be reviewed on a regular basis to ensure they remained fit for their roles.

Public engagement

- There was evidence of public engagement by the trust
- The vision, values and objectives were set out in documents and widely disseminated throughout the hospitals and community services. They were also on the trust's website.
- Public and patient involvement and experience was under review and included a restructuring of the department.
- Governors of the trust were well engaged. Governors were active within groups across the trust and had a representational role across the geography which the Trust covered.
- There was an active foundation trust membership of over 12,400. There were regular newsletters to members and invitations to events about specific elements of the trust's work.
- There was a patient experience team which was being strengthened. The team covered the patient and liaison service (PALS), friends and family test, and patient experience.
- The trust participated in national patient surveys and gained qualitative information through active user reference and support groups across the Trust including: Renal Patient & Carer Reference group; Maternity Services Liaison group; Eye Clinic Partnership group; York District Cancer Partnership group; Older People's Liaison group; Stroke Patient and Carer group and the York Limbless Support group.

Staff engagement

- A number of trust-wide mechanisms have been developed to engage with staff. These included a staff reward and recognitions programme; a weekly email bulletin; staff briefing from the CEO to managers which was then cascaded to other staff; "Staff Matters" which was a monthly magazine for staff; leadership workaround's.
- The chief nurse had implemented a "Blue Thursday" which involved nurse managers, one day a month working within a clinical area.
- A listening event for RNs had been held and feedback had indicated that the RNs felt disengaged. As a consequence there was investment in the band 7 RNs with a focus on leadership. There was a sister's action and support group and a professional nurse leaders forum.

- There were some examples of staff evidence / concerns being used to make changes within the trust.

Innovation, improvement and sustainability

- The trust had a cost improvement programme (CIP) in place. Quality impact assessments had been carried out by a clinician. A new consultant had been appointed to continue this role but they had not taken up post at the time of the inspection.
- Staff appeared focussed on delivering good quality care for their patient group and all those interviewed appeared passionate about quality as a driving force.
- 64% of all staff within the trust who responded to the NHS staff survey felt they were able to contribute towards improvements at work. This was worse than the England average of 68%.
- Innovation and improvement was a part of the staff awards process and examples were highlighted in staff newsletters and on notice boards within the hospital corridors for public to read.
- The trust had developed non-cancer pathways to support quality care for patients who were at the end of life. Specific innovations included pathways for patients with COPD and heart failure and included working on advance care planning initiatives to ensure patients' preferences and choices were clear.
- The trust had developed a mandatory end of life care training programme for medical, nursing and care staff that addressed issues identified through audit, feedback and observation. For example, the trust had identified that conversations about DNA CPR decisions were not happening or being recorded as they should. As a result, the trust has identified the need for advance communication skills training specific to these types of conversations and were developing training to meet those needs.
- In York, we saw a range of good examples of positive working arrangements within CAMHS to support acute paediatric services. We saw close working relationships between acute and mental health clinicians with responsive CAMHS support for various scenarios such as self-harm, chronic fatigue and eating disorders. We were told that CAMHS provided a seven-day service to the inpatient ward; this is unusual for a district general hospital setting. The community nursing team had a CAMHS specialist nurse placed with the team who provided the staff with supportive psychological supervision sessions.
- The SCBU at Scarborough had introduced and developed the role of the band three neonatal support worker. They had worked with Edexcel to develop a diploma that allowed the support worker to perform additional neonatal roles. The

course also included components for maternity and paediatrics so that these staff could help in these areas. The SCBU manager explained how other units were showing an interest in this development.

- The Children's directorate manager explained that they were proud of the work children's services had put into the development of a dedicated website for the children's acute and community services. We saw the offline draft version of the website, which will include a range of support and information for children, young people and families.
- Critical care in York had developed processes for the monitoring of central lines, which included a central line clinical pathway. The unit were finalists for an Institute for Healthcare Improvement (IHI) safety award.
- Within critical care in York a flow chart had also been introduced as part of the weekly ward round, specifically focussing on mental capacity. The flow chart included a best practice checklist, contact information and a prompt for checking if deprivation of liberty safeguards authorisation was required or not.
- The surgical directorate had a dedicated clinical simulation theatre at York used for simulating anaesthetic, paediatric and obstetric emergencies. This allowed teams to rehearse events.
- The trust had commissioned the development of a new 31-bed surgical ward and assessment unit – Lilac Ward at Scarborough. This was the first ward nationally to have been built using an evidence-based, best practice design solution called 'repeatable rooms'. The design of the four-bedded bays made efficient use of space while maximising the distance between bed heads. It also maximised the visibility of external landscaping to patients and the visibility of patients to nursing staff.
- The trust had developed the Bridlington site to deliver elective orthopaedic surgery and there were plans to expand this further by looking at other elective surgery that could be safely relocated to Bridlington.
- Within medicine there were a number of examples of innovation, improvement and sustainability, such as the FREDA team facilitating rapid discharge for elderly patients; the creation of a dispensing pharmacy within AMU to improve patient flow; the development of a fractured neck of femur pathway including the orthopaedic /elderly integrated ward developed to care for patients to improve rehabilitation, minimise length of stay and improve the number of discharges back to usual place of residence and 'Perfect week'. Perfect

week was a week when all staff and stakeholders strived to ensure all systems operated perfectly and then used the learning to develop 'Operation Fresh Start': This included the development of an early warning trigger tool to identify wards where problems were occurring and the development of a discharge liaison team. An additional pharmacy discharge team had also recently been established in Scarborough, which had improved medicines reconciliation on admission, speeded up the response to discharge prescriptions, and helped reduce critical medicine omissions. An early warning trigger tool had also been developed to identify wards where problems were occurring.

- The elderly medical strategy included work towards the development of community schemes, such as hubs and care home in-reach schemes. An example of this was already in place, and involved working with a nursing home that provided interim placements for patients who were not ready for active rehabilitation. For example, patients who were non-weight bearing for a period of time: they could be transferred to a less clinical environment in the nursing home until they were able to weight bear. Patients would then be transferred back to Bridlington Hospital for proactive rehabilitation with a planned expected date of discharge.
- The York A&E department was undertaking a six-week pilot project to investigate the effectiveness of an ambulatory care unit. This was aimed at rapidly diagnosing and treating patients presenting with conditions such as non-cardiac chest pain, deep venous thrombosis and infections requiring intravenous antibiotics. It was hoped that, by treating them in the unit, an admission to a hospital ward could be avoided.
- The trust had secured an agreement with St Catherine's Hospice at Scarborough to have access to nurse-led beds for patients who were likely to die within the next seven days. This created choices for patients in the last days of life when the hospice would not normally be an option. This project was recognised as best practice by Hospice UK and had been reported in the Telegraph on 20 January 2015 as a new way of providing care and choice.
- Community services were a national pilot site (Better Care Fund initiatives) for the development of community hubs to support the delivery of care nearer to home. Two multidisciplinary community hubs, based at Malton and Selby, had been

established to support seven-day assessment for residents of care homes; this enabled early intervention and reduced the need for crisis intervention or unnecessary admission to hospital.

- Within community inpatient services we observed an excellent and highly professional allied health professional (AHP) team working at well-integrated levels with all other staff for the benefit of patients. Staff were encouraged to make suggestions and good links were reported with the university, further informing and stimulating AHP practice. Discharge pathways were clearly defined and there were attempts to resolve delays caused by social services working through referrals by ensuring that those patients likely to need long-term care were identified early following admission and the referral sent through at that point.
- The child and adolescent sexual health (CASH) service was in the process of being re-accredited for the national quality award 'You're Welcome' (the Department of Health's quality criteria for young people friendly health services). The CASH service used a 'sexual exploitation tool book'. This included a pro-forma that was completed for all people under the age of 18 and that took into consideration Gillick competency and Fraser guidelines

Overview of ratings

Our ratings for York Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Requires improvement	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Bridlington hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Scarborough hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement	Good	Good	Good	Good	Good
Community inpatient services	Requires improvement	Good	Good	Good	Good	Good
Community end of life care	Good	Good	Good	Good	Good	Good
Community services for children and young people	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Overview of ratings

Our ratings for York Teaching Hospital NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and diagnostics.

Outstanding practice and areas for improvement

Outstanding practice

- The innovative way in which central lines were monitored, which included a central line clinical pathway. The York critical care unit were finalists for an Institute for Healthcare Improvement (IHI) safety award.
- The medical service at York had an innovative facilitating rapid elderly discharge again (FREDA) team, which provided multidisciplinary support and rehabilitation to elderly outlying patients.

Areas for improvement

Action the trust MUST take to improve

For the trust overall:

- The provider must ensure that people who used the service and others are protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from carrying on the regulated activity.
- The provider should, in partnership with the wider health and social care community, consider how the high proportion of delayed transfer of care due to patients awaiting care packages in their own home (37%) or waiting for nursing home placement or availability (22.1%) could be improved.

For York hospital:

- The provider must ensure all patients have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011.
- The provider must ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; nursing staff on medical and surgical wards; consultant cover within A & E; registered children's nurses on ward 17 and other appropriate clinical areas, and radiologists.
- The provider must ensure there are suitable arrangements in place for staff within the medicine and surgery, outpatient and diagnostic services to receive appropriate training and appraisals in line with trust policy, including the completion of mandatory training, particularly the relevant level of children and adult safeguarding training and basic life support so that they are working to the up to date requirements and good practice.
- The provider must address the breaches to the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care.
- The provider must ensure that patients' privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit based on ward 16.

For Scarborough hospital:

- The provider must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels, especially in A & E, on the medical and surgical wards, children's wards and other appropriate clinical areas, operating department practitioner (ODP) cover within theatres, radiology and senior medical cover in relation to cross-site working. Additionally within critical care the provider must ensure staffing levels are adequate to ensure clinical education, unit management, clinical coordination, continuity of care, and effective outreach.
- The provider must ensure that there is adequate access for patients to pain management and dietetic services within critical care.

Outstanding practice and areas for improvement

- The provider must ensure improvements are made in the 18 week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
- The provider must ensure that staff, especially within medicine, outpatients & diagnostics and critical care, complete their mandatory training, and have access to necessary training, especially basic life support, mental capacity and consent (outpatients and diagnostic staff), safeguarding vulnerable adults and safeguarding children.
- The provider must ensure that pathways, policies and protocols are reviewed and harmonised across the trust, to avoid confusion among staff, and address any gaps identified.
- The provider must ensure that patient flow into and out of critical care is improved, specifically in relation to delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit.
- The provider must ensure that all equipment is tested in a timely manner and in line with the trust's policy, especially checks on fridges and resuscitation equipment.
- The provider must ensure that there is a clear clinical strategy for both critical care and outpatients and diagnostics and that staff are engaged in agreeing the future direction and involved in the decision-making processes about the future of the service.

For Bridlington hospital:

- The provider must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels; especially in relation to staffing of the medical and surgical areas.
- The provider must review the uptake and monitoring of training, and ensure that staff at Bridlington Hospital are compliant with mandatory training requirements, especially in the areas of moving and handling, fire safety, safeguarding vulnerable adults, and safeguarding children.

For Community Services:

- The provider must ensure there are sufficient numbers of suitably skilled, qualified and experienced staff for community services, in line with best practice and national guidance, taking into account patients' dependency levels.
- The provider must review the uptake and monitoring of training, and ensure that staff in community inpatient services are compliant with mandatory training requirements.
- The provider must ensure that patient records are fully secured when stored.
- The provider must review arrangements to support staff working alone in the community to ensure their safety.

In addition there were actions the trust SHOULD take and these are listed at the end of each of the individual location and community service reports.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(1), (2)(a), 2(b) & 2 (e) HSCA (RA) Regulations 2014 Safe care and treatment. How the regulation was not being met: The provider had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe as they had not when planning and delivering the care reflected published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice. The trust was not ensuring effective patient flow into and out of critical care, specifically in relation to: delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit. The trust was not ensuring that there is adequate access for patients to pain management and dietetic services within critical care. Not all equipment was tested in a timely manner and in line with the trust's policy, especially checks on fridges and resuscitation equipment. This was in breach of Regulation 9(1)(b)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12(1), (2)(a), 2(b) & 2 (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

The provider must take action to ensure that all patients in A & E have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011.

The provider must address the breaches to the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care.

The provider must ensure that patient flow into and out of critical care is improved, specifically in relation to: delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit.

The provider must ensure that there is adequate access for patients to pain management and dietetic services within critical care.

The provider must ensure all equipment is tested in a timely manner and in line with the trust's policy, especially checks on fridges and resuscitation equipment.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(1) HSCA (RA) Regulations 2014 Staffing.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met: The provider had not taken the appropriate steps to ensure that, at all times, there are sufficient numbers of suitably skilled, qualified and experienced persons employed for the purposes of carrying on the regulated activities.

This was in breach of Regulation 9(1)(b)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider must ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels:

- nursing staff on medical and surgical wards;
- consultant cover within the A & E;
- registered children's nurses on children's wards, and other appropriate clinical areas;
- radiologists;
- community inpatient services.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1), (2)(b) & (2) (e) HSCA (Regulated Activities) Regulations 2014 Good governance. How the regulation was not being met: People who used the service and others were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to

This section is primarily information for the provider

Requirement notices

enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from carrying on the regulated activity.

We found that the trust did not have a clear clinical strategy for both critical care and outpatients & diagnostics and that staff we spoke with did not feel engaged in agreeing the future direction.

We found that not all pathways, policies and protocols were reviewed and harmonised across the trust.

This was in breach of Regulation 10(1)(b) & (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 (1), (2)(b) & (2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider must take action to ensure that the governance and risk management arrangements are strengthened to ensure risks are identified and acted upon in a timely manner.

The provider must ensure that there is a clear clinical strategy for both critical care and outpatients and diagnostics and that staff are engaged in agreeing the future direction and involved in the decision-making processes about the future of the service. The provider must ensure that pathways, policies and protocols are reviewed and harmonised across the trust, to avoid confusion among staff, and address any gaps identified.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) HSCA (RA) Regulations 2014 Staffing.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10(1) and 10(2)(a) HSCA (RA) Regulations 2014 Dignity and respect. How the regulation was not being met: The provider did not so far as was reasonably practicable, make suitable arrangements to ensure the dignity and privacy of service users. This was in breach of Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10(1) and 10(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	How the regulation was not being met: The provider did not have suitable arrangements in place in order to ensure that persons employed for the regulated activity are appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users safely and to an appropriate standard including by receiving appropriate training, professional development, supervision and appraisal. This was in breach of Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure there are suitable arrangements in place for staff to receive appropriate training and appraisals in line with Trust policy, including the completion of mandatory training, particularly the relevant level of children and adult safeguarding training and basic life support so that they are working to the up to date requirements and good practice.

This section is primarily information for the provider

Requirement notices

The provider must ensure that patients' privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit based on ward 16 at York hospital.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) HSCA (RA) Regulations 2014 Staffing. How the regulation was not being met: The provider did not have suitable arrangements in place in order to safeguard service users as persons employed for the regulated activity were not appropriately supported when working alone in the community. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must review arrangements to support staff working alone in the community to ensure their safety.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2)(c) HSCA (Regulated Activities) Regulations 2014 Good governance.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met: People who used the service and others were not protected against the inappropriate sharing of patient records as they were not kept securely.

This was in breach of Regulation 20(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider must ensure that patient records are fully secured when stored, specifically within the school nursing records.

York Teaching Hospital NHS
NHS Foundation Trust

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

Attendance: Libby Raper, Philip Ashton, Jennie Adams, Jim Taylor, Helen Hey, Liz Jackson

Apologies: Beverley Geary, Anna Pridmore

Observers: Mark Fletcher and Wendy Cookson from Grant Thornton

	Agenda Item	Comments	Assurance	Attention to Board
1	**Last meeting notes dated 20 October 2015**	The Committee welcomed Mark and Wendy from Grant Thornton, Helen Hey, Deputy Chief Nurse, who was attending in BGs absence and JT attending his first Committee in his new role of Medical Director. The Committee thanked Ed Smith for his contribution as joint Interim Medical Director, and noted its readiness to welcome further contributions both with very occasional deputising for the MD and also with regard to specific agenda items once the portfolio review has been completed over the next period. LR gave an overview of the topics covered by the Committee for the new attendees. The Committee agreed the minutes as a true and accurate record.		
2	**Matters arising**	CQUINS – The Committee highlighted the discussion that took place at the Patient Safety Group, that the sepsis screening target was unlikely to be achieved with a huge increase required in the last quarter. HH confirmed that this is managed by Diane Palmer.		

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee reviewed the established reporting route for the matters from the Patient Safety Group, and confirmed with JT that this was via his additional MD report item in to this Committee. PA attends the PSG in the context of his Chair of Audit role. Pressure Ulcer Reporting – HH advised that a draft centralised action plan has been devised that will monitor all actions coming out of pressure ulcer root cause analysis rather than them being held in the directorates. This will be signed off at the December Steering Group and an update will come to the Committee in January. The Committee raised concern over the change in the definition of each category. HH explained the panel process and the cautious approach to the new definitions. The decision to de-log any pressure ulcer as a serious incident is discussed at panel and practical exclusion criteria will be put in place. Not changing the approach of the panel will ensure that lessons are still learnt even when the incident is de-escalated. The Committee understood the difficulty in following a trend when criteria is changed, however would still like to see the trend chart with an identifier in place as to when the change occurred. Nutrition and Hydration – The Committee requested a date as to when an update around this issue could be expected. HH agreed to follow this up. Female Genital Mutilation – The Committee requested that assurance be provided that training has been completed by the end of November 2015. HH agreed to follow this up. Safer Staffing and the National Reporting and Learning System are covered by their own agenda items.	The Committee were assured by the cautious approach to this change.	

	Agenda Item	Comments	Assurance	Attention to Board
3	**Risk Register for the Medical Director and Chief Nurse**	The Committee welcomed the updated Risk Registers and agreed that their inclusion was to ensure that the system works appropriately and to aid the Committee in understanding and focussing appropriate time to the major risks. Chief Nurse - The Committee commented that the Chief Nurse Risk Register was very helpful but were surprised at the risk rating for nurse staffing. HH advised that nurse staffing is continuously monitored. The Committee queried the ommitance of the risk relating to staff numbers receiving appraisals and statutory and mandatory training and felt that this may be included on the HR risk register. JT advised the Committee of the difference between the headline figure for CDIFF and the underlying figure following investigation. Medical Director – The Committee noted the top risk as being Medicine Errors, and confirmed that this has been an area of consistent and strong focus in the recent past. The Committee queried where Clinical Guidelines fit as a risk. The issue was raised in Patient Safety Group that clinical guidelines were not appropriately accessible to staff. The appointment of an Improvement Fellow has taken place to undertake work to improve this process which is being led by Paul Laboi. JT agreed to add this to the risk register. The Committee queried the low number of risks included on the registers. HH explained that only the high risk issues had been included. The Committee asked that lower risks also be included next time.		

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee asked that sub headings be added to both risk registers to highlight the risks relating to the key recommendations from the CQC, as flagged at board. JT advised that Fiona Jamison is currently triangulating the information.		
4	**Quality and Safety Performance Report**	The Committee noted the information included in the report and agreed to hold a structured conversation around the executive highlights. **Patient Experience** – HH took the Committee through the staffing issues and recent changes that have taken place in the Patient Experience team, including the recruitment of a new complaints manager. There have been some reporting issues, with a member of staff counting their activity rather than incidents, causing an increase in numbers reported. HH confirmed that the priorities will be presented at the Patient Experience Steering Group this week and highlighted that one of the top priorities was to have the complaints procedure in place. The Committee agreed that the use of the 'Knowing how we're doing' boards needs to be addressed. **Measures of harm** – The committee noted that there had been no never events and queried the rise in the total number of SIs, specifically the number of clinical incidents. JT advised the Committee that a number of SIs have been retrospectively declared following review and provided an example of one of these incidents. **Infection Prevention** – The Committee noted that the CDIFF trajectory requires continued focus and concern and queried the factors that may contribute to this risk. JT advised that Katrina Blackmore is leading on a new PIR	The Committee were assured by the increased focus around this issue.	To go to Board.

	Agenda Item	Comments	Assurance	Attention to Board
		process which is ward based making investigations and learning more timely. A significant risk is the increased workload of the Elderly Medicine team and non-specialist nurses caring for outlying patients. HH advised that the bed occupancy and the norovirus outbreak did not affect the CDIFF rate, however there was a struggle to isolate patients promptly. HH explained that when transferring patients risks should be balanced and a sensible route to decision making should be taken. The Committee discuss norovirus, HH advised that the instances have calmed down and the Trust is in line with the national picture. Nurses and Doctors are being cohorted with risks being balanced in terms of staffing numbers. The increased use of agency staff also increases the risk of incidence. **Quality and Safety Miscellaneous** – The Committee noted the increased number of inappropriate ward transfers and queried if this was a reflection of the management of demand. HH advised that factors prompting out of hours transfers will be looked in to and fed back to the Committee. Stroke – The Committee noted that only 50% of Scarborough stroke patients were receiving scans within the hour. JT explained that the diagnosis takes place in Scarborough before the patient is transferred to York so the relocation of the service should have no impact. The Patient Safety Group had a discussion around an hour being an incredibly demanding target. The Committee raised concern around governance routes and how issues are escalated to the Committee. JT confirmed that governance will be reviewed when all roles in the Medical Director team are established.		

	Agenda Item	Comments	Assurance	Attention to Board
		Care of the Deteriorating Patient – The Committee noted the slight improvement to the number of patients receiving a senior review within 12 hours on the Scarborough site and queried if this could have an effect on the Scarborough SHMI. JT explained that both acute sites now code deaths identically. An agreement has been made with the CCG to make patients summary care records available, which include patient's primary care core morbidities. JT will be liaising with David Humphriss over Scarborough Physician shift patterns as there are currently differences in Job Plans, staffing and culture. **Drug Administration –** The Committee noted the information included under drug administration and HH advised that this is a potential CQUIN for 2016/17. **Mortality** – The Committee agreed that Mortality was discussed in detail at board so did not go in to further discussion. **CQUIN Update** – As discussed under matters arising.		
5	**Key reports** **Chief Nurse Report** **Supplementary Medical Director Report**	**Chief Nurse Report** LR advised that she had attended a session at an NHS Providers event at which the Cheshire West ruling had been discussed, and the mental health providers in attendance had expressed significant concern. All other elements of the Chief Nurse report are covered by agenda items. **Supplementary Medical Director Report** The Committee were disappointed in the staff uptake of the flu campaign. HH advised that peer vaccinating is taking place with matrons and the Chief Nurse Team all administering vaccines.		To go to Board.

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee discussed the SIs included in the report and the confusion over the report regarding sub-optimal care. It was also noted that there was no assurance in place to show that the recommendations from each SI were being completed and currently these recommendations are not smart, measureable objectives. JT assured the Committee that the SI process is being looked at, an external review of the process has taken place, the constitution of the SI Group is being reviewed, a governance lead will be in place in every directorate and the involvement of internal audit is being considered. The Committee look forward to an update on the review of this process at the February meeting.	The Committee took some assurance from the work being undertaken around SI reporting and look forward to an update on the new process in February.	
6	**Maternity services patient experiences survey and Annual Report**	The Committee noted the changes to the Maternity Services Annual Report and thanked all of those involved; the report is now clearer and easier to follow. The Committee were pleased to have early site of the Maternity Services patient experience survey and noted that its contents is embargoed until 7th December. HH advised the Committee that challenges and priority areas for action will be identified.		To go to Board.
7	**Pressure Ulcers**	HH drew the Committees attention to the gradual decline the total number of Pressure Ulcer incidences, advising that the Trust is below the national average. Reoccurring learning points are being identified at RCA panels; Patient non-concordance will be raised at Senior Nurses and accurate assessment on admission and transfer remains a priority. A review of the Tissue Viability Teams continues; different levels of capacity and expertise have been identified	The Committee took assurance from the on-going attention to this issue.	

	Agenda Item	Comments	Assurance	Attention to Board
		across all sites. The Committee queried the issues in relation to equipment. HH advised that on occasion the equipment is being used incorrectly by the patient. There have been issues around the lack of availability of recommended equipment in community; the contract with Harrogate stores is under review. HH also advised that staff are not currently considering bespoke padding for patients and gave an example of a patient with breathing difficulties leaning forward and getting pressure ulcers on their elbows. The Committee highlighted that charitable funds can be approached for funding for equipment.		
8	**Safer Staffing**	The Committee noted this huge piece of on-going work, which is monitored by the Workforce Strategy Committee, and raised concern over the lack of available nursing staff. HH advised the Committee that all possible forms of recruitment have been explored except for international recruitment which would be nurses from the Philippines and India. Local and European recruitment continues and is being monitored closely. The Committee showed some level of concern over the move back to professional judgement over safer staffing levels making it more difficult for Non-Executives to gain assurance. HH advised the Committee that the funded nursing establishment is good which raises the expectation of the level of staff needed. Work is still being undertaken to up-skill HCAs and other ward workers to free up nursing time and HCA recruitment continues to back fill those that are moving to a higher band. The Committee discussed the increase in staff leavers and the work being undertaken around retention. HH confirmed	The Committee were assured by the on-going focus on this work.	To go to Board and link with the Workforce Strategy Committee.

	Agenda Item	Comments	Assurance	Attention to Board
		that exit paperwork is being improved and the main reasons for staff leaving are lifestyle choice and no longer wanting to work in an acute environment, there is no evidence to suggest the staff are leaving to other acute establishments. The Committee queried the winter staffing plans. HH advised that Ward 24 in York and Graham Ward in Scarborough will be opened, 24 nurses have been redeployed from other wards and both wards will have appropriate leadership with both a band 6 and 7 in place.		
9	**NLRS additional information**	JA advised the rest of the Committee about a detailed conversation with Fiona Jamieson regarding the validation process. There are now two matrixes on Datix to log the risk and the harm of each incident and staff are getting confused between the two. The Risk Committee review all moderate risk and validate them, Fiona will be producing an audit trail. The Committee questioned whether all low risks are being regularly reviewed as to their grading, and indicated that they would be looking in the future for assurance around the capture of all significant risks on the appropriate register. The Committee expressed some on-going reservations around the robustness of this area of work, and requested that an update be provided in January around the revised governance meetings.		
10	**Falls Update**	HH advised the Committee that the incidence of falls continues to go down. The new electronic tool and the education around it was launched in September. This tool will flag the need for a falls assessment on transfer. An equipment review has taken place which showed a lack of	The Committee were assured by the amount and presentation of the data included in the reports.	

	Agenda Item	Comments	Assurance	Attention to Board
		falls sensors and a bid has been put in for charitable funds. Staff have been advised to always use professional judgment when using falls equipment. The Committee were pleased to see the increase in reporting but the level of harm coming down. The Committee thanked the author for the report, covering all point and charts showing trends and shifts.		
11	**Quality Report - 6 month**	The Committee welcomed this interesting report and were pleased to note the implantation of the agreed process for reviewing progress. The Committee discussed compliance with Theatre Safety Briefings in the context of this having been a significant area of focus in the recent past as well as an item of specific interest to Governors. JT advised the Committee that there was no concern, engagement has been refreshed and the theatre nursing staff are responsible for ensuring that the safety briefing has taken place and this is logged on CPD. There is some issue around who attends as Ward rounds take place at the same time, responsibility is divided between teams. The Committee queried which Quality and Safety Committee the End of life forum reports in to. HH agreed to check and update the Committee.		To go to Board, highlighting Patient Experience.
12	**Quality Report for 2016/17**	The Committee noted the report and agreed to handle all comments outside of the meeting.		
13	**Dates and times of Quality and Safety for 2016/17**	Dates and times for future meetings were included for information.		
14	**Annual Report of the**	The initial draft of the Annual Report of the Quality and		

	Agenda Item	Comments	Assurance	Attention to Board
	Quality and Safety	Safety Committee was included for information. Any comments to be sent to LR.		
15	**Any other business**	The Committee agreed that there were no other items of any other business to be discussed.		
16	**Other** Work Programme			

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Patient Safety & Quality Report

November 2015

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

Patient Experience

There has been a further increase in the number of PALS contacts on the York site from 631 in September to 682 in October. Data is not currently available for the Scarborough site.

Complaints data is not currently available for October.

The Friends & Family Test is no longer a CQUIN for 2015/16, but forms part of the Trust's Commissioner contracts.

The percentage of inpatients recommending the Trust has continued to exceed the 90% target on all sites. Furthermore, the percentage of patients recommending in October exceeded September on all sites (York 96.25%, Sboro 97.81%, Brid 98.39%).

The response rate for York ED has increased in October to 9.56% (September 6.52%). However, the % of patients recommending the department dropped from 82.20% in September to 79.35% in October.

The response rate for Scarborough ED remains low and has decreased further in October to 2.97% (September - 4.85%). In addition the proportion of patients recommending the department has also continued to decrease - 71.83% (September 79.31%).

Measures of Harm

22 Serious Incidents (SIs) were declared in October (13 x York, 4 x Scarborough and 5 x Community). 7 of the SIs were attributed to 'clinical incident', 9 were attributed to 'slips, trips and falls' and 6 to pressure ulcers.

There were no 'Never Events' reported.

Infection Prevention

5 cases of Cdiff were identified in October, (York 4 & Scarborough 1). The YTD total is now 40 against an annual maximum of 48, therefore above trajectory.

No new cases of MRSA were identified in August. There has been a total of 6 MRSA since April 2015, 5 in Scarborough and 1 at York.

6 patients were identified with MSSA taking this above the 2015/16 trajectory.

There were also 6 cases of E-Coli.

Quality and Safety - Miscellaneous

Stroke
In September 93.8% of patients had 90% of their stay on a stroke unit, this is against the local target of 80%. The Trust achieved the Target for the percentage of patients scanned within 24 hours of hospital arrival and for those patients who experienced a TIA were assessed and treated within 24 hours. The Target for the percentage of patient scanned within 1 hour of hospital arrival was not achieved.

Cancelled Operations
The number of operations cancelled within 48 hours of the TCI due to lack of beds increased significantly in October to 77 from 8 in September. Year to date 322 patients have had their surgery cancelled within 48 hours due to a lack of beds.

Cancelled Clinics/Outpatient Appointments
The number of cancelled clinics with less than 14 days notice decreased compared to September (168) to 164, this is still within the maximum of 200 per month. There was a corresponding increase in the number of cancelled appointments - 876 in October. This exceeds the monthly maximum of 745 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 rose in October at 107 against 84 in September (61 in York and 46 in Scarborough) and is above the monthly maximum of 100.

Care of the Deteriorating Patient

York achieved 86% of Medicine and Elderly patients receiving a senior review within 12 hours of admission, with Scarborough seeing an improvement achieving 59% in October (Sept 53%).

85% of Medicine and Elderly patients were seen by a doctor within 4 hours of admission, across both sites.

The Trust has an internal target of 90% of routine observations being undertaken within 1 hour of the prescribed time. Currently achieving 86.3% overall, with Scarborough showing a continual improvement and achieving 90.6% in September.

Drug Administration

The number of insulin errors decreased from 11 in September to 10 in October across the Trust. York saw an increase from 1 to 5 in October.

Prescribing errors incrreased from 20 in September to 21 in October across the Trust, with an increase at Scarborough and Community hospitals.

Mortality

The Apr 14 - Mar 15 SHMI remained static at 101 , with both York seeing a 1 point reduction and Scarborough seeing a 1 point increase.

RAMI has seen a slight improvement although remains above the Peer.

The number of deaths in October was in line with previous months.

CQUINS update

Quarter 2 2015/16 CQUINS; all schemes are RAG rated as green.

Litigation

Indicator	Site	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Clinical Claims Settled	York	1	1	2	2	4	5	1	2	3
	Scarborough	1	3	1	1	0	3	5	2	2

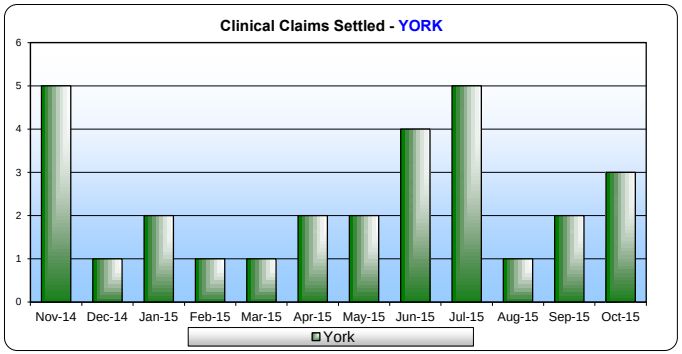
In October, 5 clinical claims were settled; 3 attributed to York & 2 attributed to Scarborough.

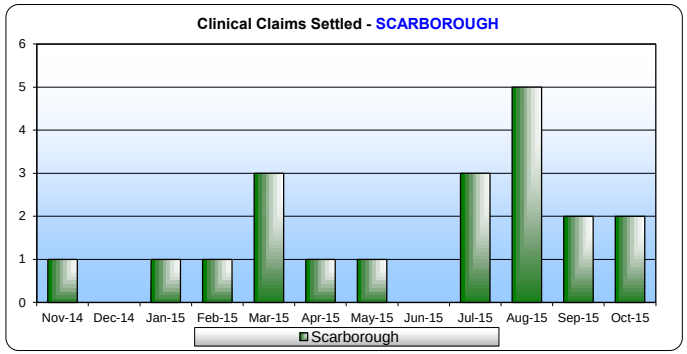
9 clinical negligence claims were received for York site and 12 were received for Scarborough. York had 1 withdrawn/closed claims and Scarborough had 10.

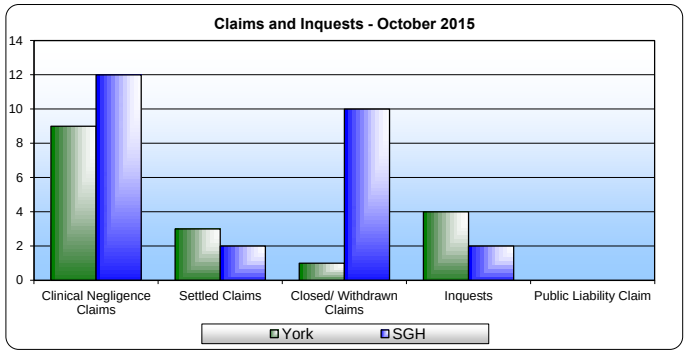
There were 6 Coroner's Inquests heard (4 York & 2 Scarborough).

Litigation

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







Themes for Clinical Claims Settled 01 Jan 2012 to 28 Feb 2015

Incident Type	Total Damaged	Total Number Reported	Number (York)	Number (Sboro)
Failure to investigate further	£2,323,090	19	9	10
Failure to refer to other speciality	£2,047,500	4	4	0
Inadequate surgery	£1,286,816	16	8	8
Delay in treatment	£1,266,000	4	2	2
Lack of appropriate treatment	£387,868	7	2	5
Inappropriate discharge	£333,000	4	1	3
Inadequate examination	£297,347	7	4	3
Lack of monitoring	£230,000	2	1	1
Failure to adequately interpret radiology	£108,113	12	7	5
Inadequate nursing care	£93,500	10	5	5
Not known	£60,000	3	0	3
Inadequate procedure	£58,880	4	2	2
Results not acted upon	£49,500	7	6	1
Failure to diagnose/delay in diagnosis	£48,000	2	1	1
Inadequate interpretation of cervical smear	£37,500	1	1	0
Intraoperative burn	£30,000	4	3	1
Anaesthetic error	£27,500	1	1	0
Inadequate consent	£26,500	3	2	1
Failure to retain body part	£25,000	1	1	0
Lack of risk assessment/action in relation to fall	£24,250	2	2	0
Prescribing error	£22,500	2	2	0
Failure to act on CTG	£13,500	1	1	0
Lack of risk assessment/action in relation to pressure ulcer	£7,000	1	1	0
Maintenance of equipment	£5,000	1	1	0

Patient Experience

Complaints
Data currently not available for October.

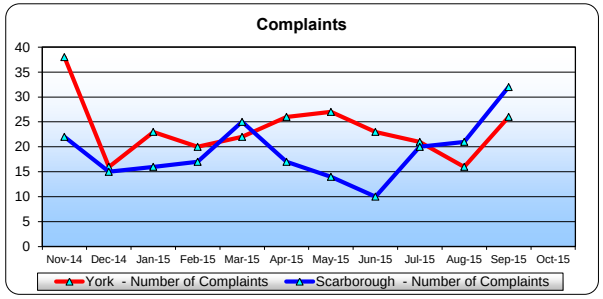
PALS contacts
There were 682 PALS enquiries at York Hospital in October, Scarborough figures are not currently available

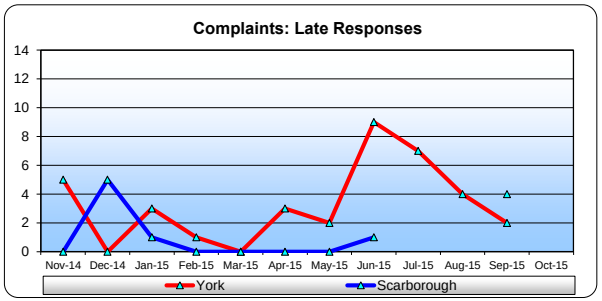
New Ombudsman Cases
Data currently not available for October.

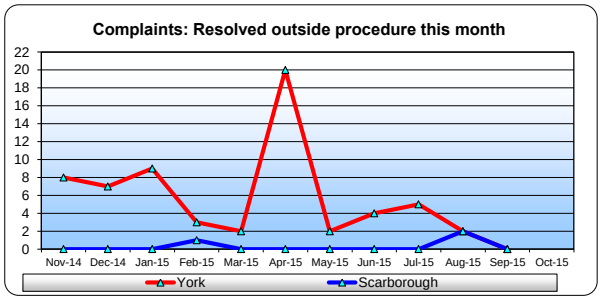
Complaints – Late Responses
Data currently not available for October.

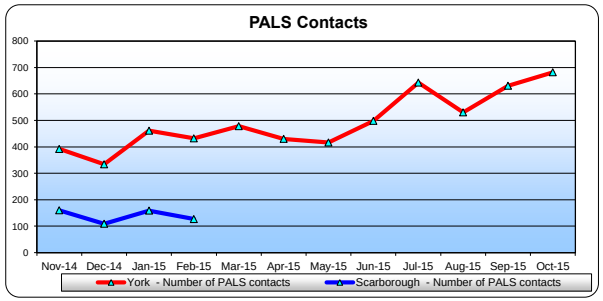
Patient Experience

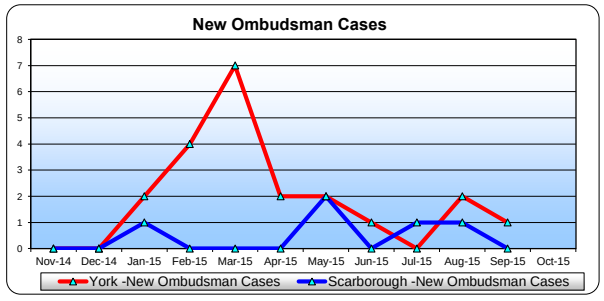
Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Complaints	York	38	16	23	20	22	26	27	23	21	16	26	0
	Scarborough	22	15	16	17	25	17	14	10	20	21	32	0
PALS contacts	York	392	334	461	432	478	430	416	498	643	530	631	682
	Scarborough	160	109	159	127	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
New Ombudsman Cases	York	0	0	2	4	7	2	2	1	0	2	1	Not Available
	Scarborough	0	0	1	0	0	0	2	0	1	1	0	Not Available
Complaints - Late Responses	York	5	0	3	1	0	3	2	9	7	4	2	Not Available
	Scarborough	0	5	1	0	0	0	0	1	0	0	4	Not Available
Complaints - Resolved outside procedure this month	York	8	7	9	3	2	20	2	4	5	2	0	Not Available
	Scarborough	0	0	0	1	0	0	0	0	0	2	0	Not Available











Friends and Family

Indicator		Target	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Inpatients – York	York IP Response Rate	Monitoring Only	39.4%	35.1%	32.9%	38.4%	45.4%	16.0%	17.4%	18.3%	20.6%	17.4%	18.9%	18.6%
Inpatients – Scarborough	Scarborough IP Response Rate		50.0%	37.9%	41.2%	52.4%	55.8%	16.4%	16.5%	15.3%	21.3%	18.2%	18.0%	18.2%
Inpatients - Bridlington	Bridlington IP Response Rate		77.2%	85.9%	77.0%	90.2%	69.5%	56.0%	47.5%	46.0%	51.6%	69.0%	62.0%	50.2%
Inpatients – Combined	**Trust IP Response Rate**		**44.1%**	**38.4%**	**37.7%**	**44.7%**	**49.4%**	**18.6%**	**19.2%**	**19.4%**	**22.6%**	**20.3%**	**21.2%**	**20.3%**
ED – York	York ED Response Rate	Monitoring Only	15.4%	14.2%	14.8%	14.0%	19.2%	8.3%	8.6%	8.3%	10.0%	9.2%	7.4%	9.6%
ED - Scarborough	Scarborough ED Response Rate		32.7%	19.1%	28.2%	36.8%	29.8%	6.7%	7.3%	6.1%	6.3%	5.8%	4.9%	3.0%
ED – Combined	**Trust ED Response Rate**		**21.5%**	**16.0%**	**19.3%**	**21.6%**	**22.8%**	**7.8%**	**8.2%**	**7.6%**	**8.8%**	**8.0%**	**6.5%**	**7.4%**
Maternity – Antenatal		None	42.8%	32.2%	30.6%	27.6%	36.0%	26.4%	27.5%	31.7%	29.1%	23.7%	29.3%	22.9%
Maternity – Labour and Birth			39.7%	15.8%	19.9%	27.9%	38.5%	31.0%	25.6%	26.7%	28.5%	23.3%	36.2%	26.1%
Maternity – Post Natal			47.1%	19.4%	27.9%	31.9%	32.6%	30.4%	29.0%	29.3%	27.3%	25.5%	40.5%	27.3%
Maternity – Community			18.4%	18.2%	21.3%	14.6%	23.1%	24.3%	18.4%	20.3%	18.7%	19.8%	20.9%	26.2%

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.

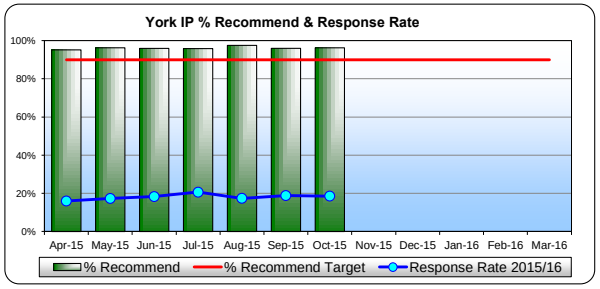
The focus for the Trust is to gain and understand patient feedback and encourage Directorates to use that feedback to drive improvements. Each ward displays a 'Knowing How We're Doing' board which is a giant poster sharing FFT data and comments from that particular ward, along with news and improvements 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.

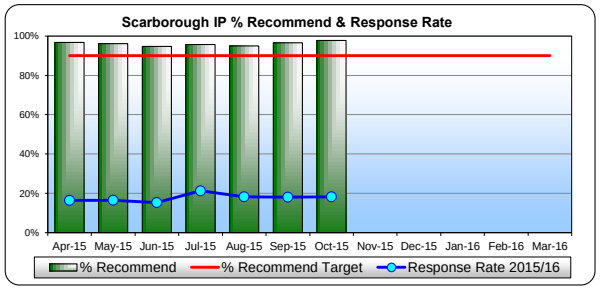
Friends & Family: Inpatients & ED

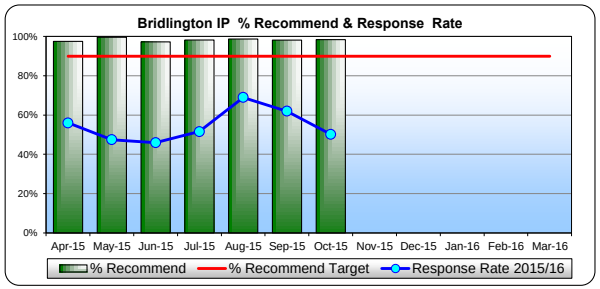
The Friends & Family Test (FFT) has now been rolled out across the Trust, including all Inpatients and Daycases, (previouslydaycase s and patients <16 were excluded) those attending ED, Community patients and women accessing maternity services being asked the question; "would you recommend this ward/ED/antenatal/labour and postnatal service to yourfamily & 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	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Aug-15	Sep-15	Oct-15
Trust Inpatient Response Rate (including daycases)	None - Monitoring Only	none	39.80%	40.10%	43.90%	21.40%	20.33%	21.15%	20.27%
York Inpatient Response Rate (including daycases)	None - Monitoring Only	none	35.58%	36.39%	39.00%	18.99%	17.42%	18.86%	18.55%
York Inpatient % Recommend	None - Monitoring Only	none					97.53%	95.98%	96.25%
York Inpatient % Not Recommend	None - Monitoring Only	none					0.75%	1.00%	1.12%
Scarborough Inpatient Response Rate (including daycases)	None - Monitoring Only	none	42.52%	42.25%	49.44%	19.22%	18.16%	18.02%	18.21%
Scarborough Inpatient % Recommend	None - Monitoring Only	none					95.02%	96.61%	97.81%
Scarborough Inpatient % Not Recommend	None - Monitoring Only	none					1.39%	0.85%	0.40%
Bridlington Inpatient Response Rate (including daycases)	None - Monitoring Only	none	80.68%	78.19%	78.06%	60.33%	68.97%	61.98%	50.19%
Bridlington Inpatient % Recommend	None - Monitoring Only	none					98.71%	98.16%	98.39%
Bridlington Inpatient % Not Recommend	None - Monitoring Only	none					0.32%	0.61%	0.81%

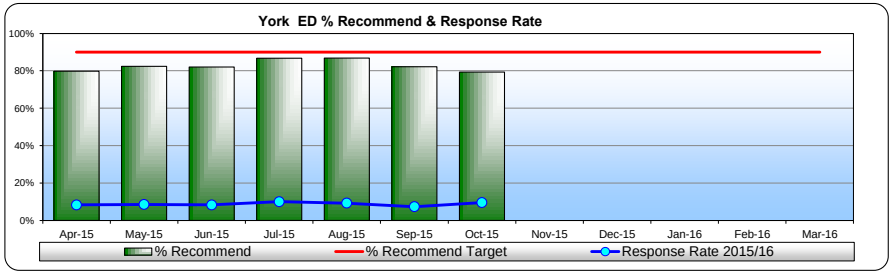
Daycase patients and young people (<16 years) included in FFT April 2015

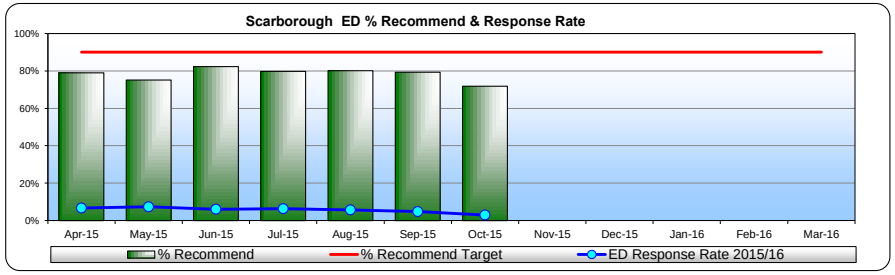






Indicator	Consequence of Breach (Monthly)	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Aug-15	Sep-15	Oct-15
Trust Emergency Department Response Rate	None - Monitoring Only	none	19.90%	17.70%	21.30%	7.78%	7.97%	6.52%	7.37%
York Emergency Department Response Rate	None - Monitoring Only	none	10.85%	13.00%	16.08%	8.90%	9.22%	7.36%	9.56%
York Emergency Department % Recommend	None - Monitoring Only	none					86.84%	82.20%	79.35%
York Emergency Department % Not Recommend	None - Monitoring Only	none					8.92%	12.43%	12.83%
Scarborough Emergency Department Response Rate	None - Monitoring Only	none	34.90%	26.46%	31.44%	5.67%	5.75%	4.85%	2.97%
Scarborough Emergency Department % Recommend	None - Monitoring Only	none					80.12%	79.31%	71.83%
Scarborough Emergency Department 5 Not Recommend	None - Monitoring Only	none					16.27%	13.79%	19.72%





Headline Scores

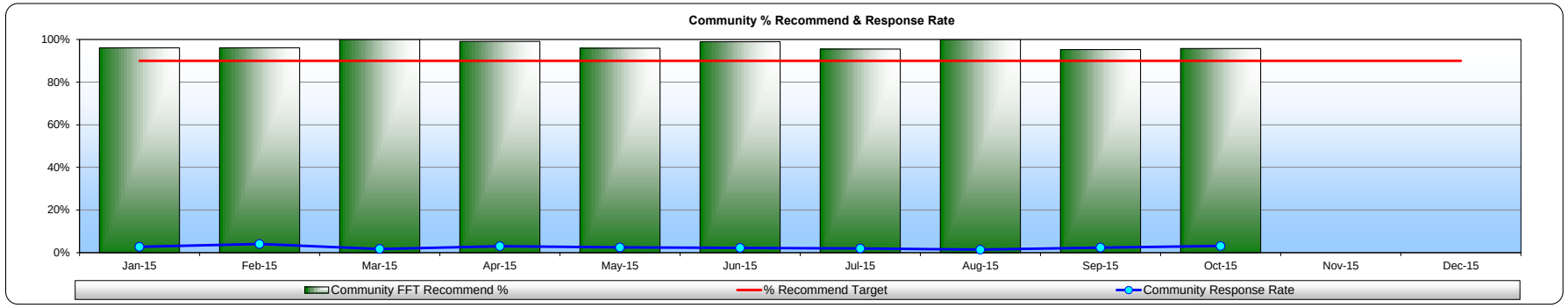
Recommend (%) $\dfrac{\text{Extremely Likely + Likely}}{\text{Extremely Likely + Likely + Neither + Unlikely + Extremely Unlikely + Don't know}} \times 100$

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 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Aug-15	Sep-15	Oct-15
Community Response Rate	None - Monitoring Only	none	2.50%	1.86%			1.33%	2.35%	3.05%
Community FFT % Recommend	None - Monitoring Only	none					100.00%	95.33%	95.83%
Community FFT % Not Recommend	None - Monitoring Only	none					0.00%	0.00%	0.69%

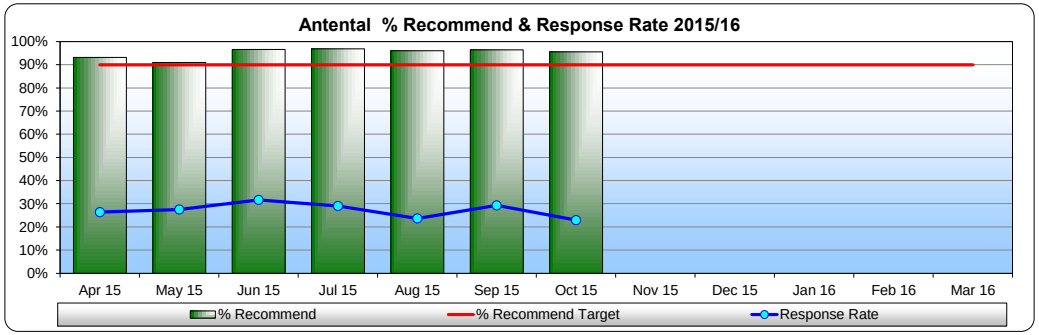


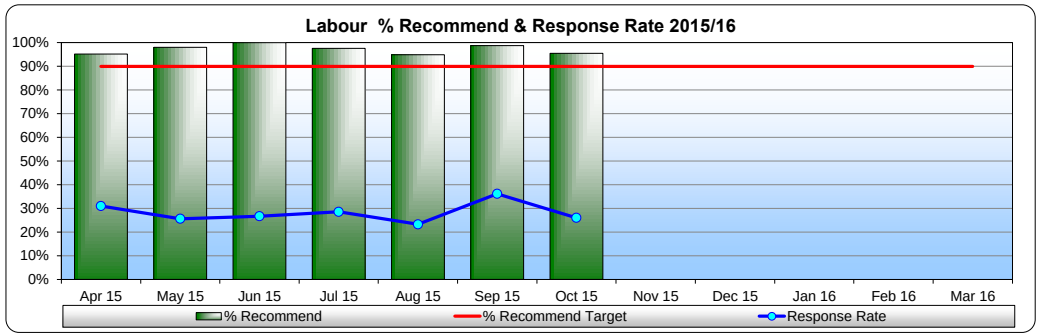
Service/Area	Consequence of Breach (Monthly)	Threshold	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Aug-15	Sep-15	Oct-15
Community Inpatient Services	None - Monitoring only	None	153	148			41	61	81
Community Nursing Services	None - Monitoring only	None	41	5			2	0	35
Specialist Services	None - Monitoring only	None	58	34			7	16	13
Children & Family Services	None - Monitoring only	None	11	8			0	1	2
Community Healthcare Other	None - Monitoring only	None	54	63			11	29	13

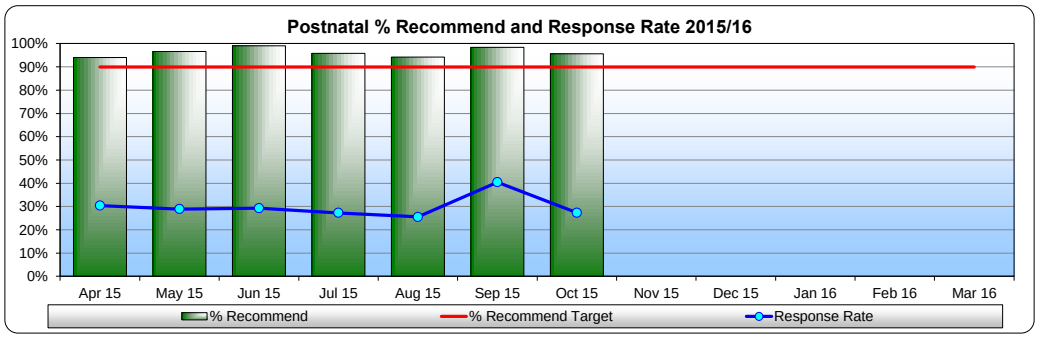
Friends & Family: Maternity

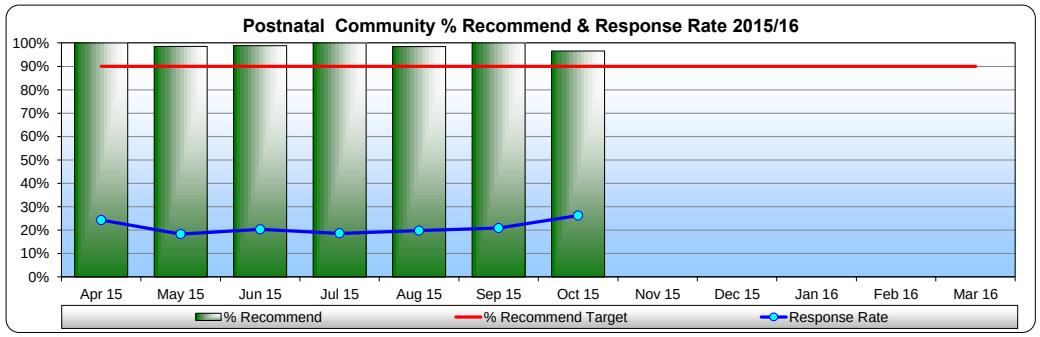
York Teaching Hospital NHS
NHS Foundation Trust

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Antenatal Response Rate	None - Monitoring only	none	32.4%	38.3%	31.4%	27.3%	23.67%	29.27%	22.92%
Antental % Recommend	None - Monitoring only	none					96.08%	96.46%	95.60%
Antental % Not Recommend	None - Monitoring only	none					0.00%	0.88%	1.10%
Labour and Birth Response Rate	None - Monitoring only	none	18.60%	23.50%	28.84%	29.45%	23.28%	36.18%	26.06%
Labour and Birth % Recommend	None - Monitoring only	none					94.90%	98.76%	95.50%
Labour and Birth % Not Recommend	None - Monitoring only	none					1.02%	0.00%	0.90%
Postnatal Response Rate	None - Monitoring only	none	24.8%	30.6%	30.9%	30.7%	25.52%	40.46%	27.33%
Postnatal % Recommend	None - Monitoring only	none					94.19%	98.37%	95.60%
Postnatal % Not Recommend	None - Monitoring only	none					2.33%	1.63%	1.10%
Postnatal Community Response Rate	None - Monitoring only	none	20.00%	18.70%	19.87%	19.78%	19.81%	20.88%	26.24%
Postnatal Community % Recommend	None - Monitoring only	none					98.44%	100.00%	96.55%
Postnatal Community % Not Recommend	None - Monitoring only	none					0.00%	0.00%	2.59%









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%

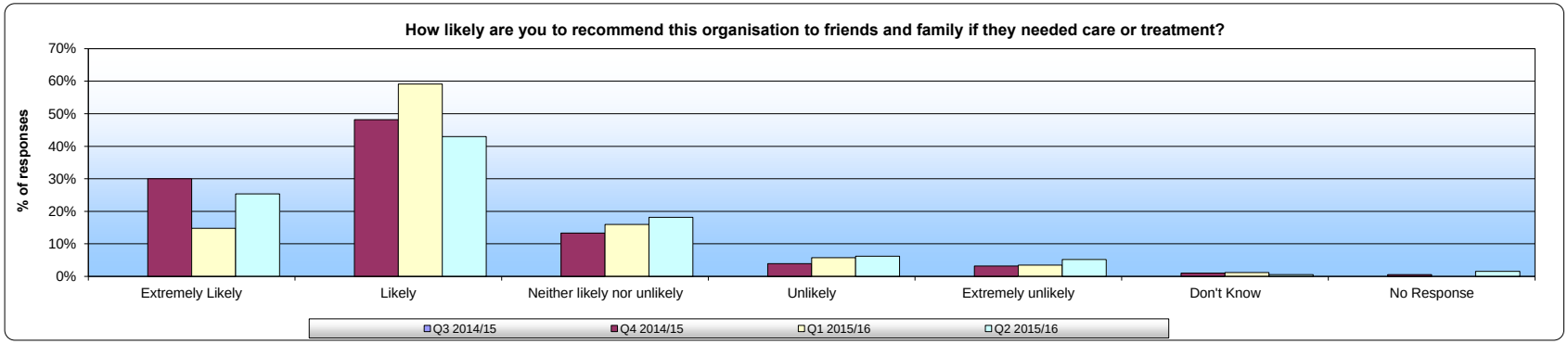
Friends and Family: Staff

York Teaching Hospital NHS
NHS Foundation Trust

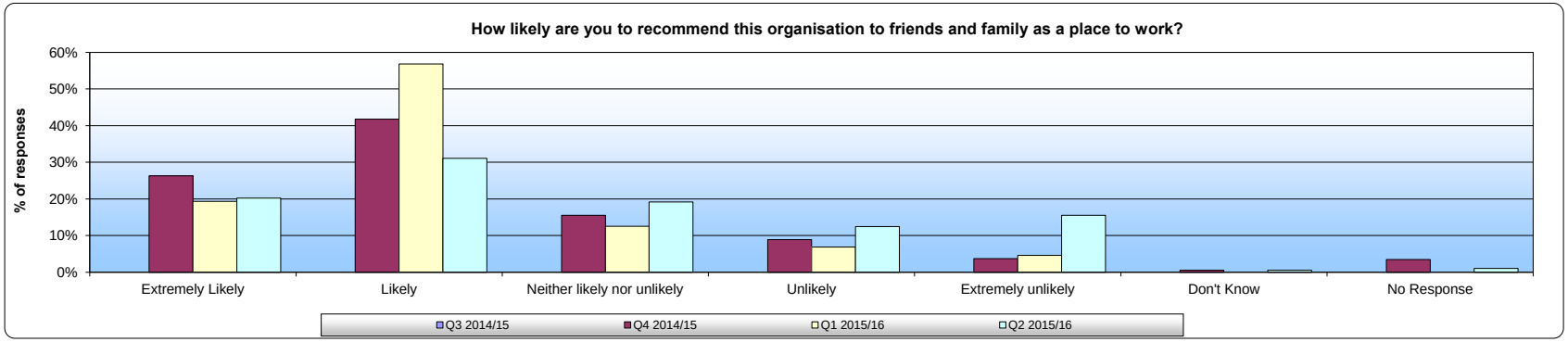
As part of the National Friends and Family CQUIN 2014/15, the Trust was required to submit evidence which demonstrates implementation of staff FFT across all Acute and Community areas.

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	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16
Response rate - Proportion of Trust employees who responded to the survey	None - Monitoring Only	none	Not Available	38%	49%	35%
Number of Trust employees who responded to the survey	None - Monitoring Only	none	Not Available	407	88	193



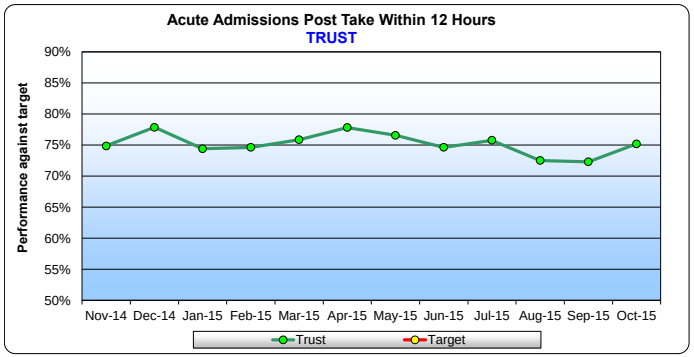
How likely are you to recommend this organisation to friends and family if they needed care or treatment?							
Quarter	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't Know	No Response
Q3 2014/15	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Q4 2014/15	30.0%	48.2%	13.3%	3.9%	3.2%	1.0%	0.5%
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%

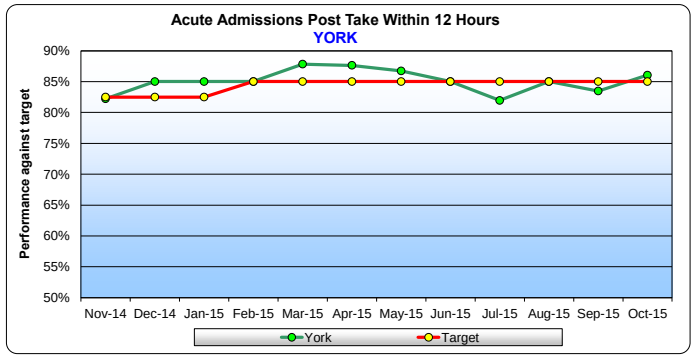


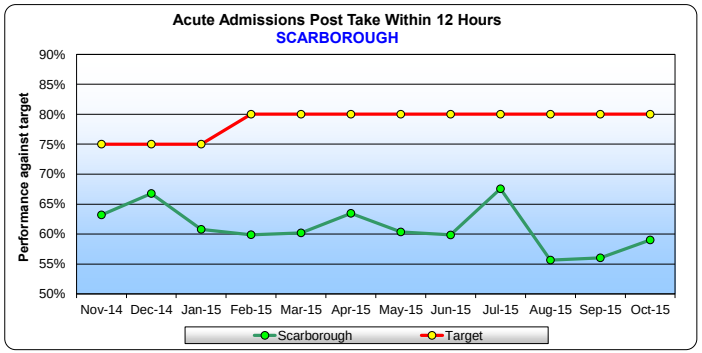
How likely are you to recommend this organisation to friends and family as a place to work?							
Quarter	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't Know	No Response
Q3 2014/15	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Q4 2014/15	26.3%	41.8%	15.5%	8.8%	3.7%	0.5%	3.4%
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%

Quality and Safety: Care of the Deteriorating Patient

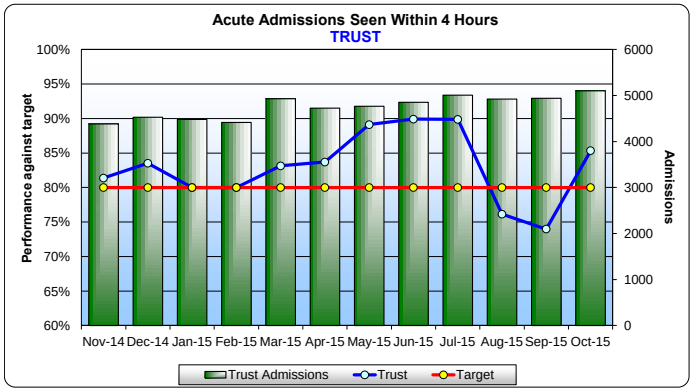
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (SCARBOROUGH)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI for 2015/16	80%	67%	60%	61%	60%	56%	56%	59%
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 for 2015/16	85%	84%	86%	86%	83%	85%	83%	86%

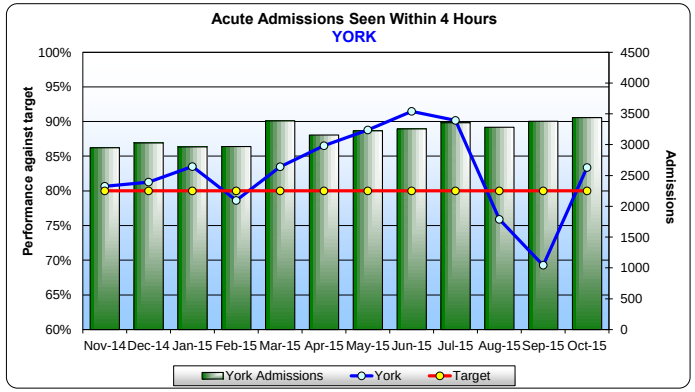


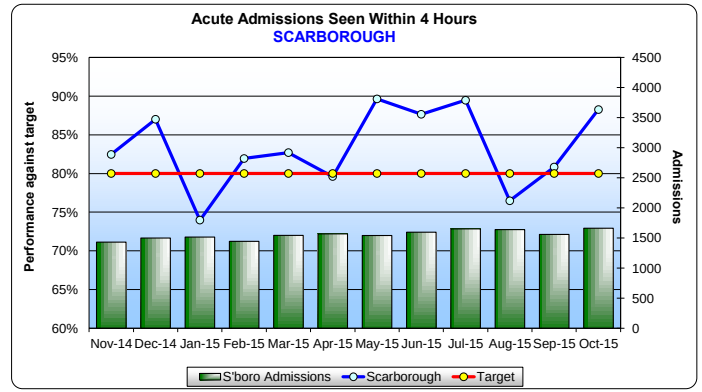




Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI for 2015/16	**80% by site**	83%	81%	88%	80%	76%	74%	85%

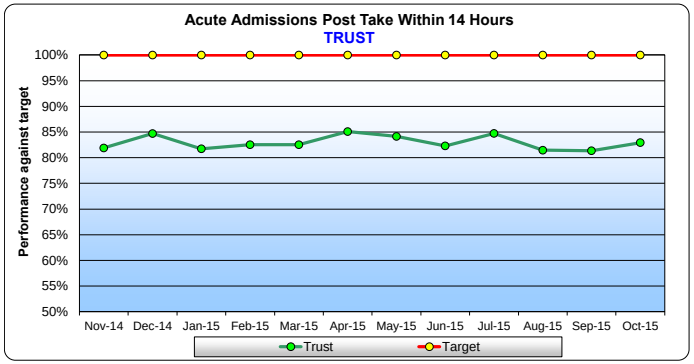


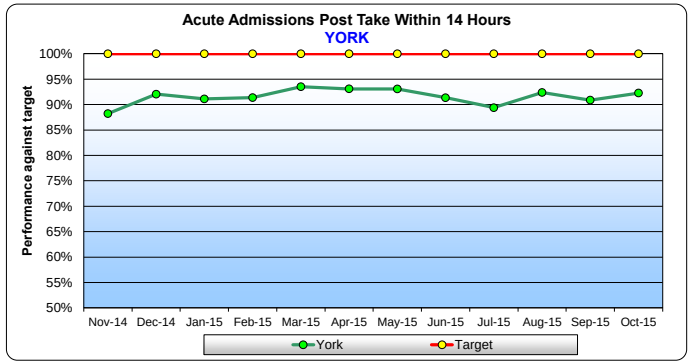


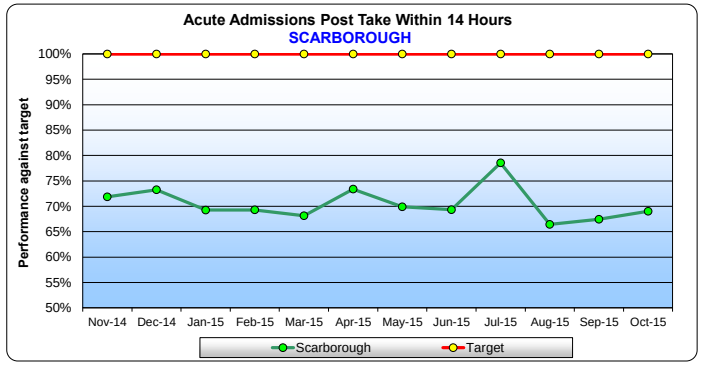


Quality and Safety: Care of the Deteriorating Patient

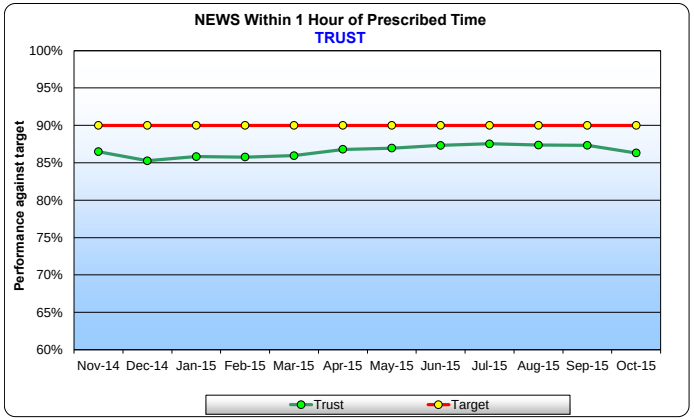
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI for 2015/16		84.3%	82.2%	83.9%	82.5%	81.5%	81.4%	82.9%

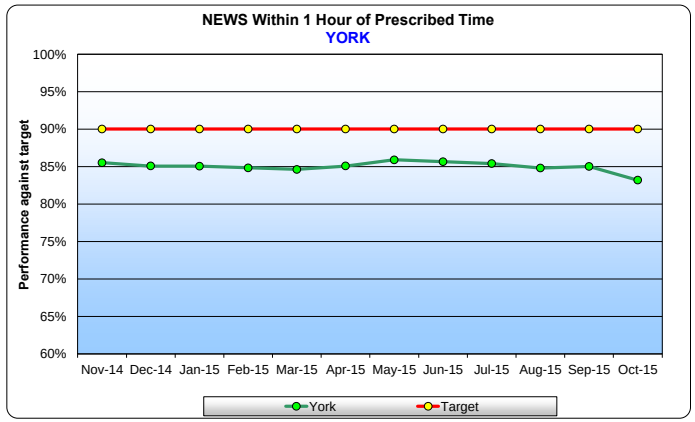


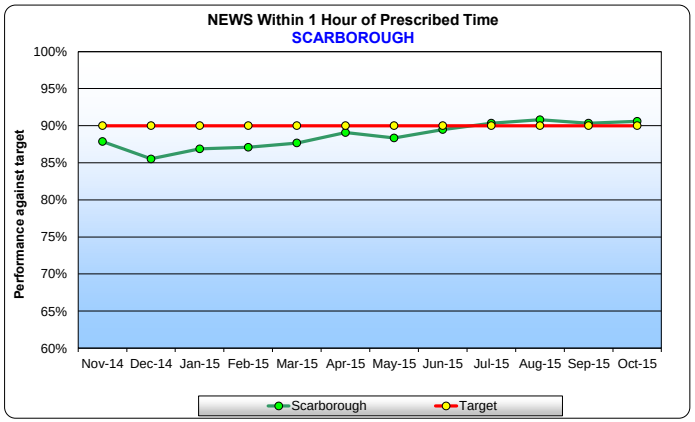




NEWS within 1 hour of prescribed time	None - Monitoring Only		86.3%	85.9%	87.0%	87.4%	87.4%	87.3%	86.3%







Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 22 SIs reported in October; York 13, Scarborough 4, Community 5 & Bridlington 0.
Clinical Incidents: 7; York 6, Scarborough 1.
Slips Trips & Falls: 9; York 5, Scarborough 2 & Community 2.
Pressure Ulcers: 6; York 2, Scarborough 1, Bridlington 0 & Community 3.

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 October there were 156 reports of patients falling at York Hospital, 63 patients at Scarborough and 71 patients within the Community Services. This is a decrease from the number reported in September (331), 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 October was 1,234; 660 incidents were reported on the York site, 386 on the Scarborough site and 188 from Community Services. This is a –2.14% decrease from September.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 839 (decrease from 1183 at the end of September) incidents awaiting sign-off by the Directorate Management Teams. Risk and Legal are working with the Directorates to facilitate the timely completion of incident investigations.

Pressure Ulcers (source: Datix)
During October 13 pressure ulcers were reported to have developed on patients since admission to York Hospital, 15 pressure ulcers were reported to have developed on patients since admission to Scarborough and 32 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.

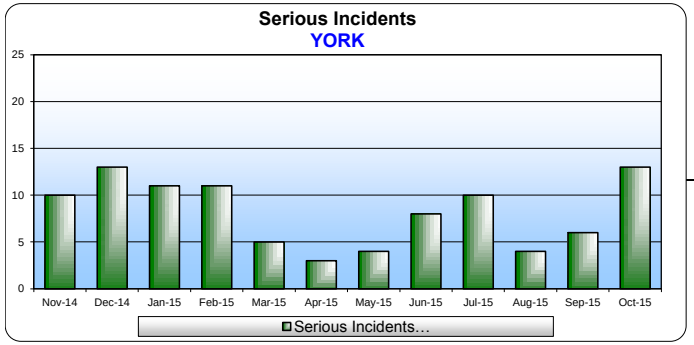
Degree of Harm: Serious/Severe or Death (source: Datix)
During October a total of 9 patient incidents were reported which resulted in serious or severe harm or death (preliminary data subject to validation).

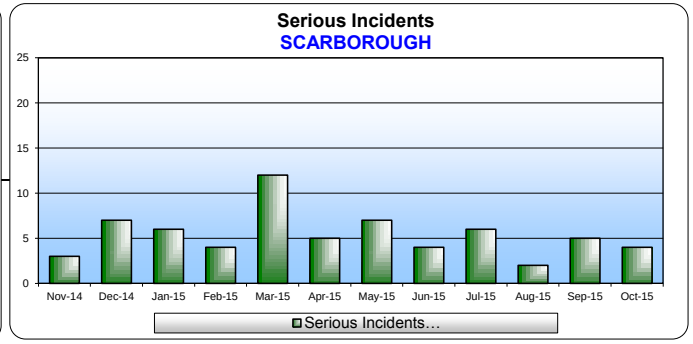
Medication Related Issues (source: Datix)
During October there was a total of 105 medication related incidents reported, although this figure may change following validation.

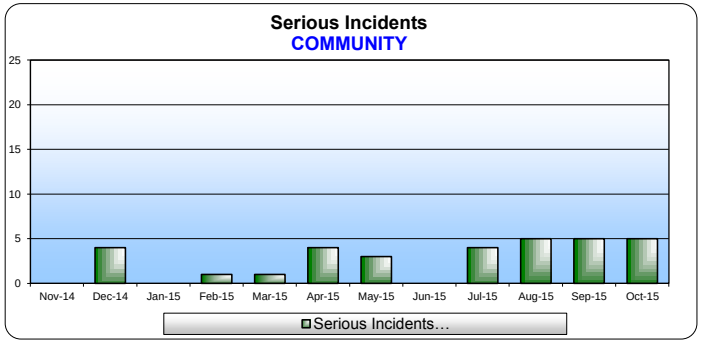
Never Events - There were zero Never Events declared in October.

Measures of Harm

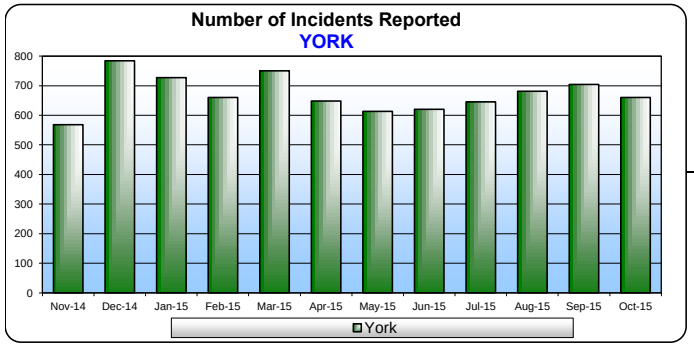
Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Serious Incidents source: Risk and Legal	York	10	13	11	11	5	3	4	8	10	4	6	13
	Scarborough	3	7	6	4	12	5	7	4	6	2	5	4
	Community	0	4	0	1	1	4	3	0	4	5	5	5
Serious Incidents Delogged source: Risk and Legal (Trust)		4	2	3	1	2	1	0	0	0	0	0	0

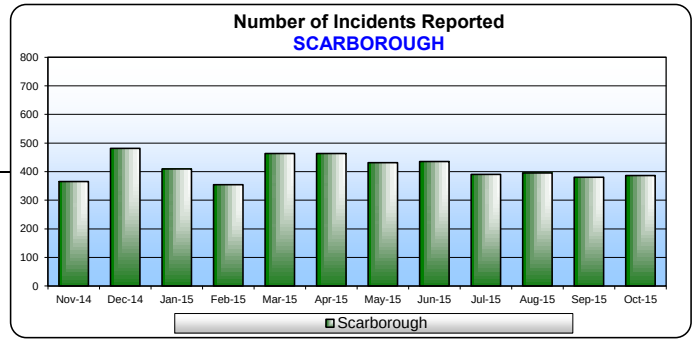


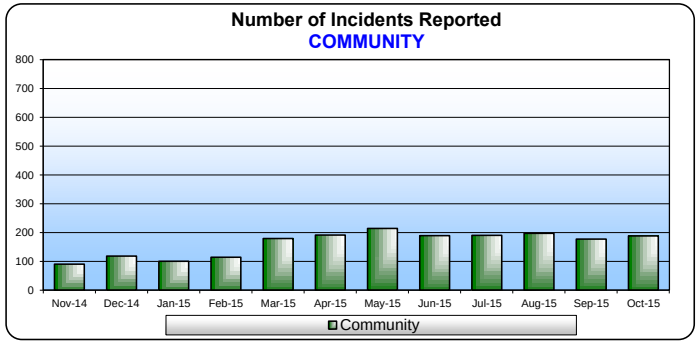




Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Number of Incidents Reported source: Risk and Legal	York	568	784	727	660	750	648	613	620	645	681	704	660
	Scarborough	365	481	409	354	463	463	431	435	390	395	380	386
	Community	90	118	100	114	179	191	214	189	190	197	177	188
Number of Incidents Awaiting sign off at Directorate level		858	272	1444	516	546	1302	863	947	1178	1229	1183	839

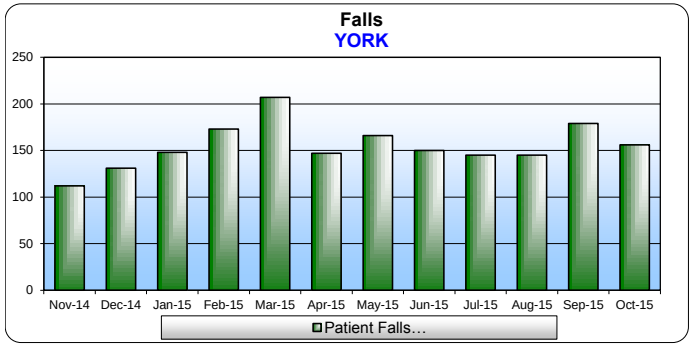


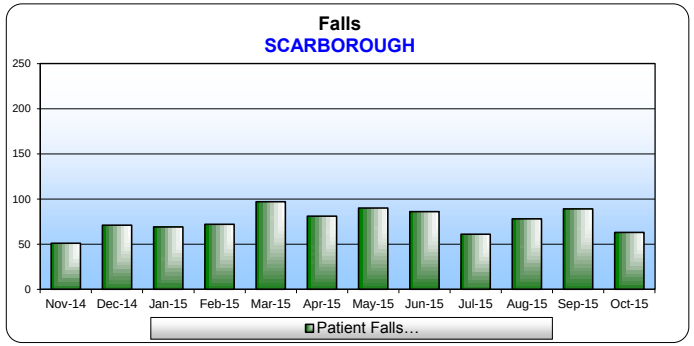


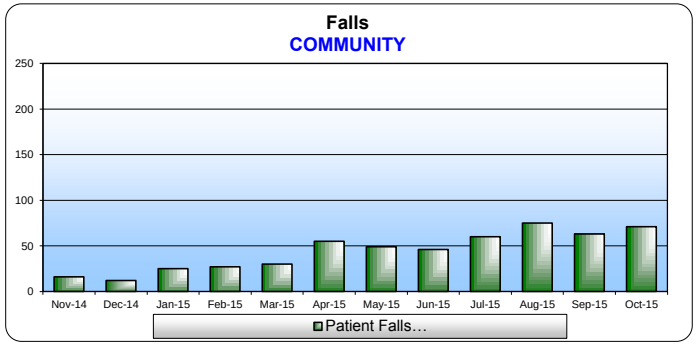


Measures of Harm

Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Patient Falls source: DATIX	York	112	131	148	173	207	147	166	150	145	145	179	156
	Scarborough	51	71	69	72	97	81	90	86	61	78	89	63
	Community	16	12	25	27	30	55	49	46	60	75	63	71

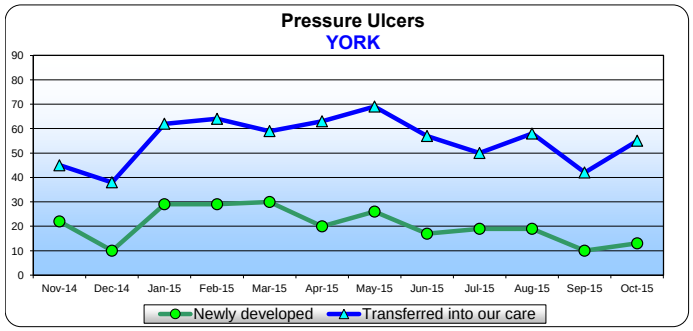


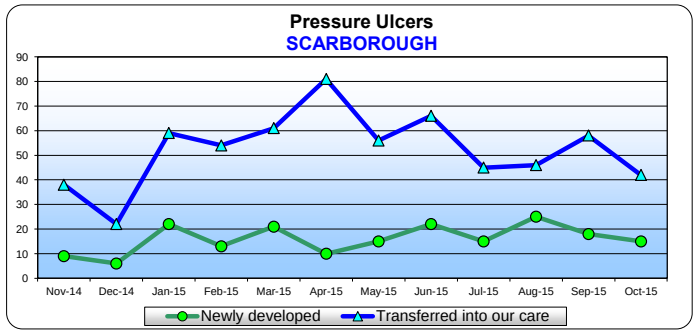


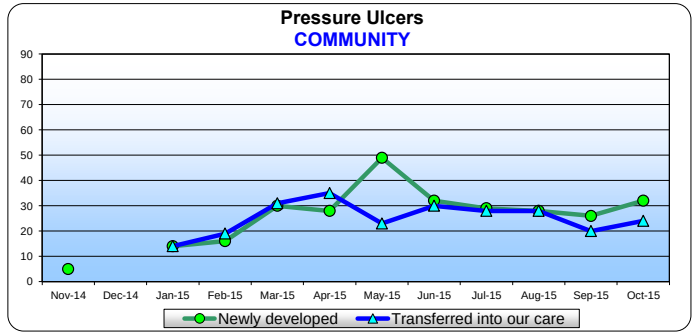


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Indicator			Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Pressure Ulcers source: DATIX	York	Newly developed	22	10	29	29	30	20	26	17	19	19	10	13
		Transferred into our care	45	38	62	64	59	63	69	57	50	58	42	55
	Scarborough	Newly developed	9	6	22	13	21	10	15	22	15	25	18	15
		Transferred into our care	38	22	59	54	61	81	56	66	45	46	58	42
	Community	Newly developed	5		14	16	30	28	49	32	29	28	26	32
		Transferred into our care			14	19	31	35	23	30	28	28	20	24



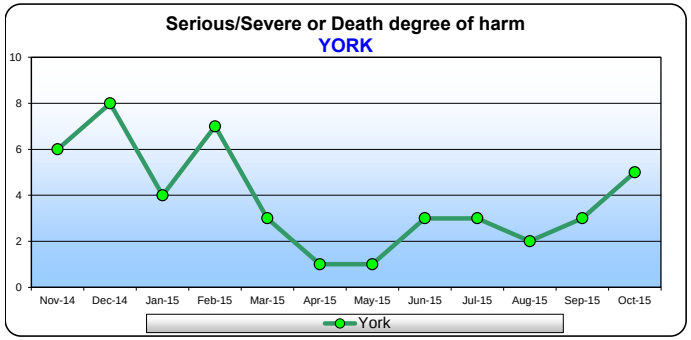


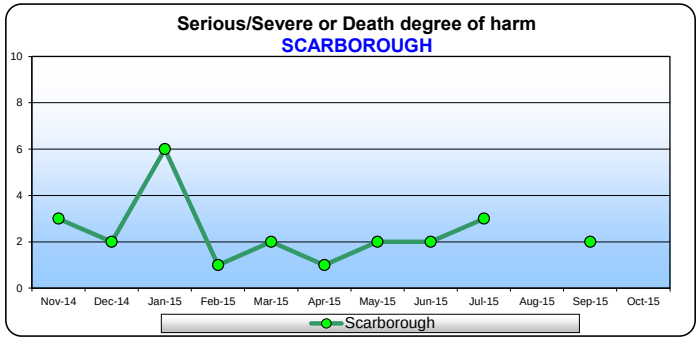


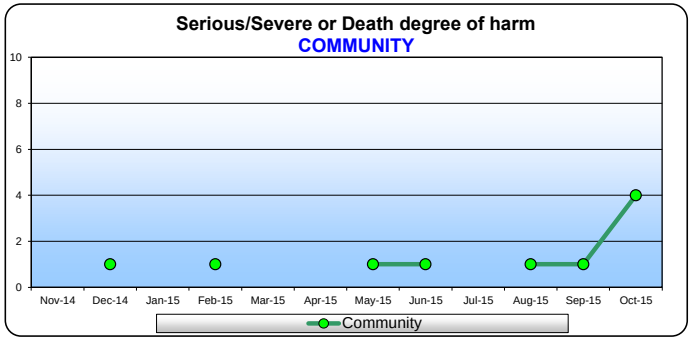
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised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

Measures of Harm

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

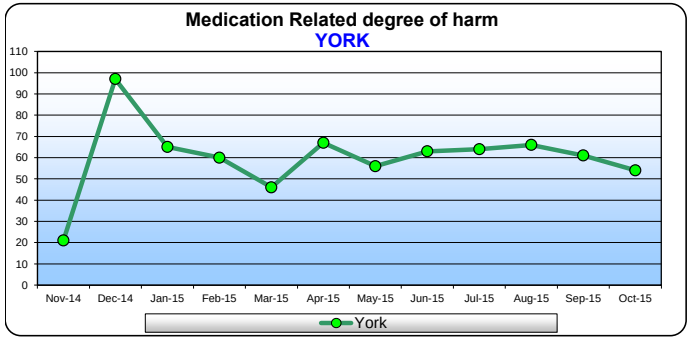


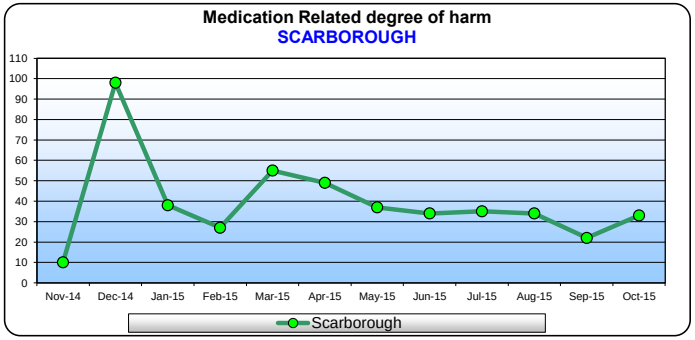


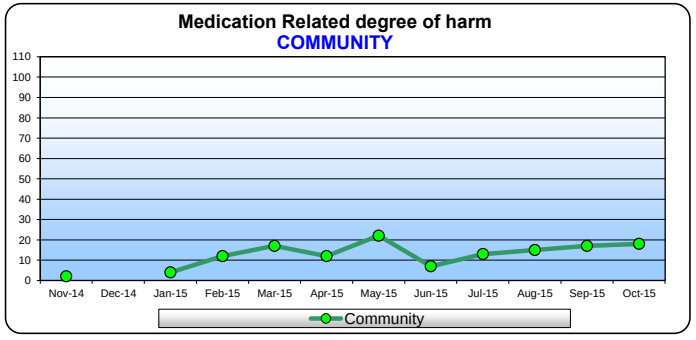


Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Degree of harm: Medication Related Issues source: Datix	York	21	97	65	60	46	67	56	63	64	66	61	54
	Scarborough	10	98	38	27	55	49	37	34	35	34	22	33
	Community	2	0	4	12	17	12	22	7	13	15	17	18

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.

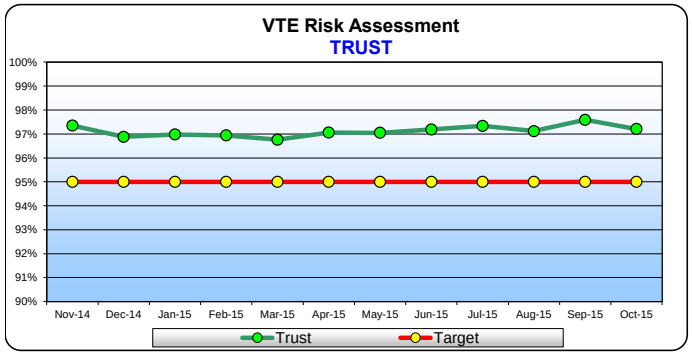


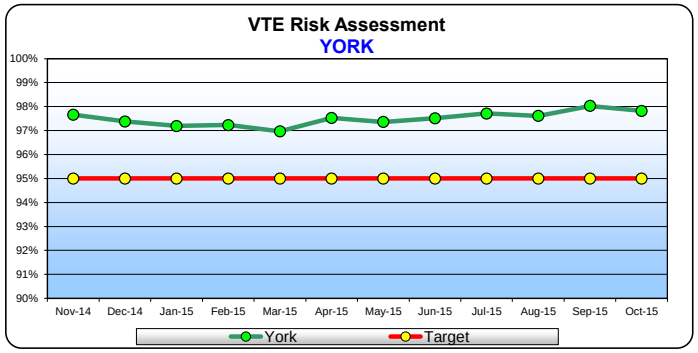


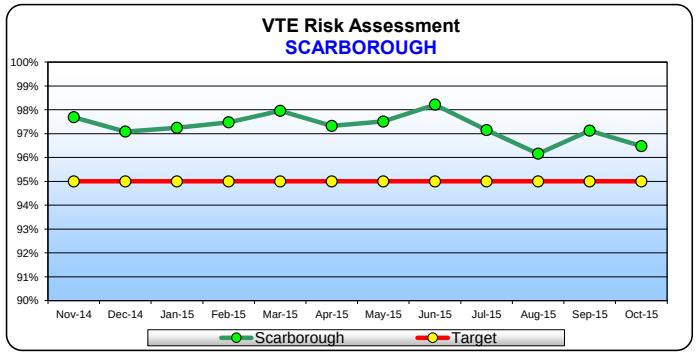


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
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%	96.9%	97.1%	97.4%	97.1%	97.6%	97.2%
		York	95%	97.4%	97.1%	97.5%	97.8%	97.6%	98.0%	97.8%
		Scarborough	95%	97.6%	97.6%	97.7%	96.8%	96.2%	97.1%	96.5%







Never Events

Indicator	Consequence of Breach	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
SURGICAL									
Wrong site surgery	As below	**>0**	**0**	**0**	**1**	**0**	0	0	0
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**	**0**	0	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 October indicated 1.51% for York and 0.98% for Scarborough.

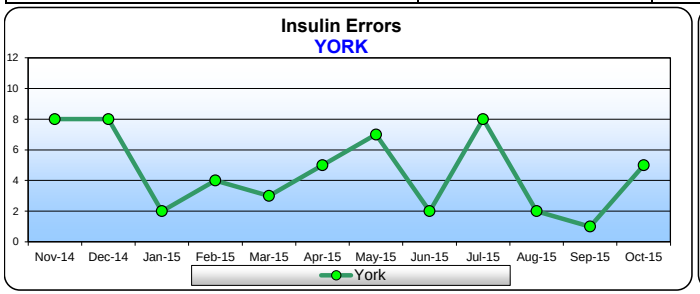
Prescribing Errors
There were 21 prescribing related errors in October; 9 from York, 9 from Scarborough and 3 from Community.

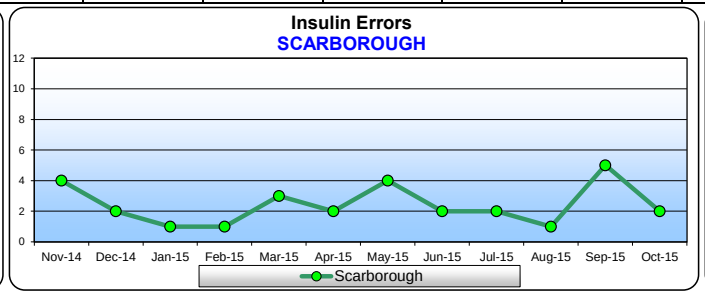
Preparation and Dispensing Errors
There were 15 preparation/dispensing errors in October; 6 from York, 6 from Scarborough and 3 from Community.

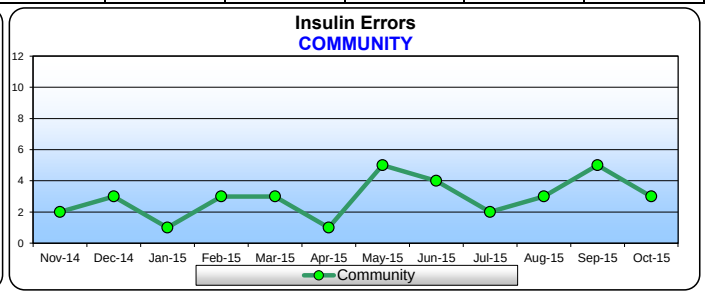
Administrating and Supply Errors
There were 50 administrating/supplying errors in October; 26 from York, 16 from Scarborough and 8 from Community.

Drug Administration

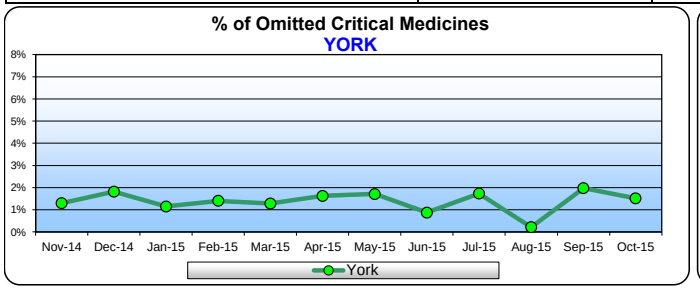
Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Insulin Errors source: Datix	York	8	8	2	4	3	5	7	2	8	2	1	5
	Scarborough	4	2	1	1	3	2	4	2	2	1	5	2
	Community	2	3	1	3	3	1	5	4	2	3	5	3

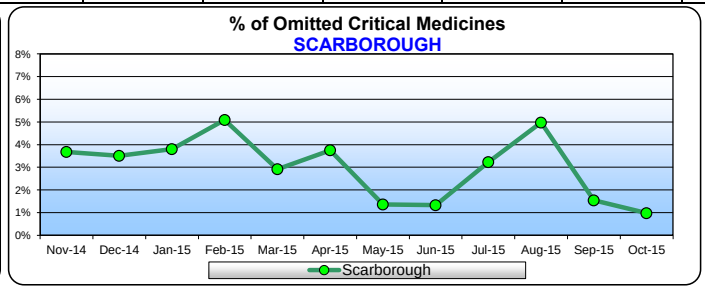


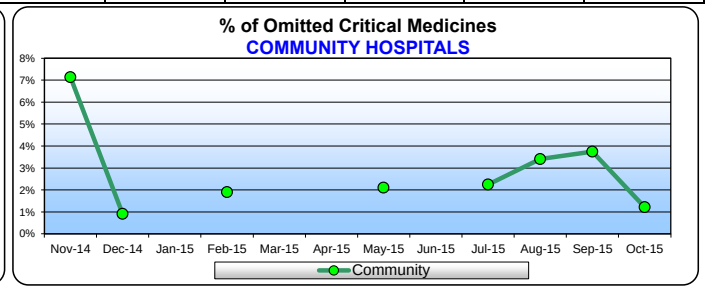




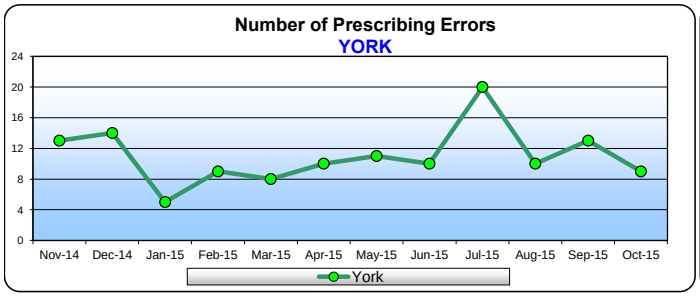
Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Number of Omitted Critical Medicines source: Datix	York	6	8	6	6	6	7	9	4	8	1	9	6
	Scarborough	9	9	9	12	7	9	3	3	7	10	3	2
	Community Hospitals	7	1	Not Available	2	Not Available	Not Available	2	Not Available	2	3	3	1

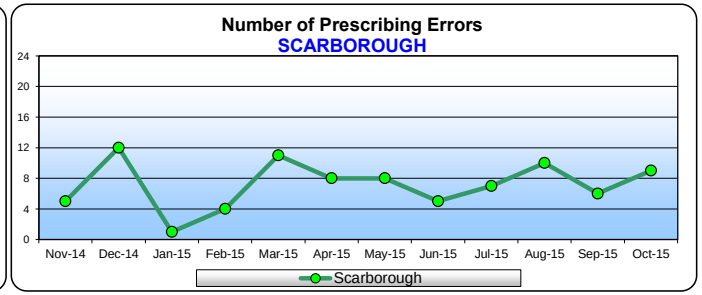


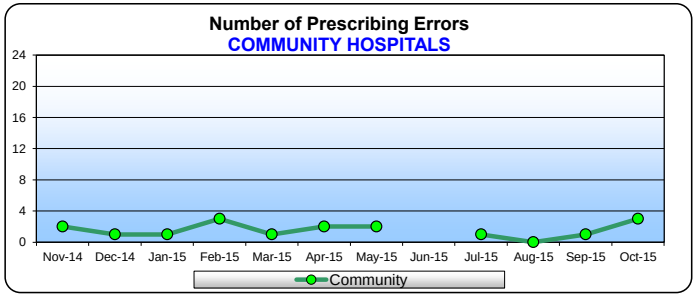




Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Number of Prescribing Errors source: Datix	York	13	14	5	9	8	10	11	10	20	10	13	9
	Scarborough	5	12	1	4	11	8	8	5	7	10	6	9
	Community Hospitals	2	1	1	3	1	2	2	Not Available	1	0	1	3

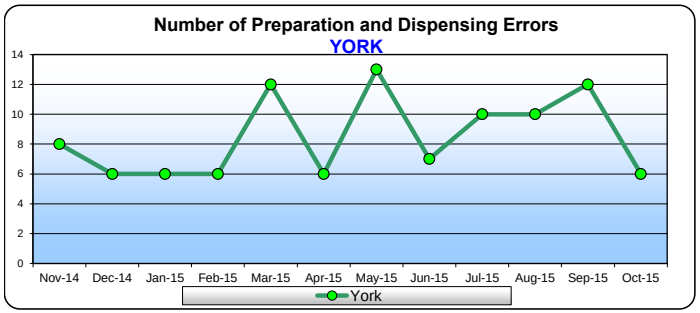


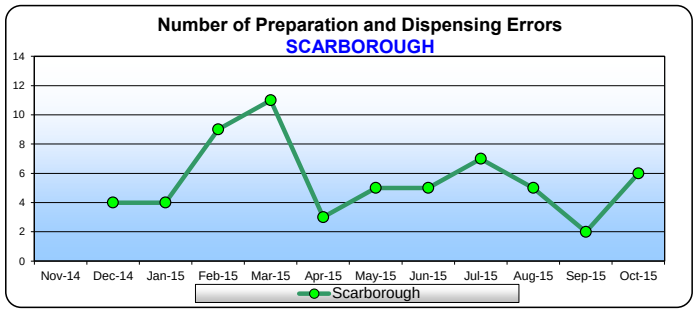


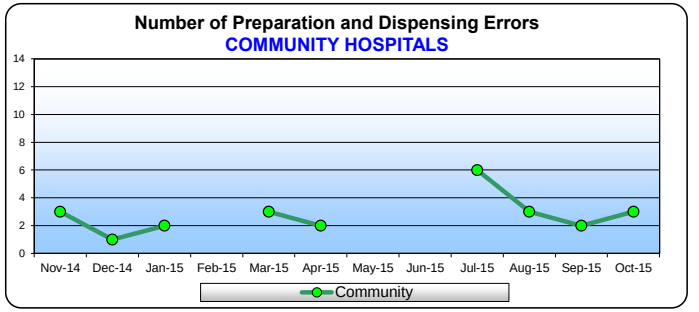


Drug Administration

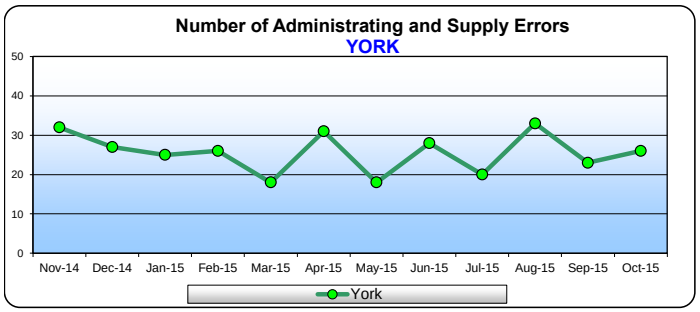
Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Number of Preparation and Dispensing Errors source: Datix	York	8	6	6	6	12	6	13	7	10	10	12	6
	Scarborough	Not Available	4	4	9	11	3	5	5	7	5	2	6
	Community Hospitals	3	1	2	Not Available	3	2	Not Available	Not Available	6	3	2	3

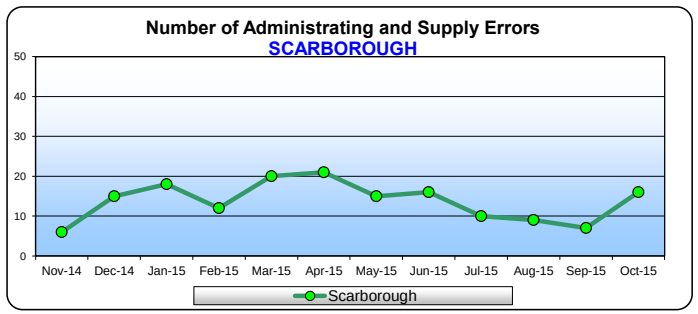


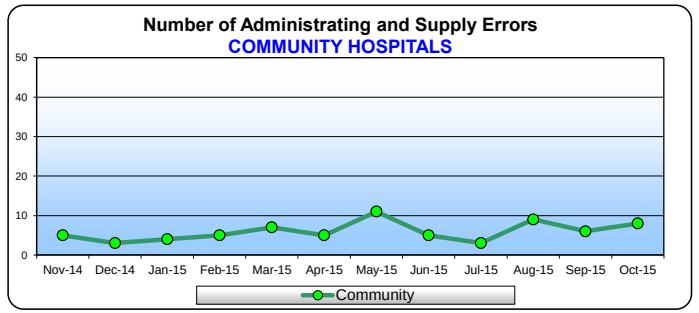




Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
Administrating and Supply Errors source: Datix	York	32	27	25	26	18	31	18	28	20	33	23	26
	Scarborough	6	15	18	12	20	21	15	16	10	9	7	16
	Community Hospitals	5	3	4	5	7	5	11	5	3	9	6	8







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

·York: 95.2%
·Scarborough: 93.1%
·Community Hospitals: 94.5%
·Community care: 96.2%

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: 0.5%
·Scarborough: 3.8%
·Community Hospitals: 0.0%
·Community Care: 0.6%

VTE

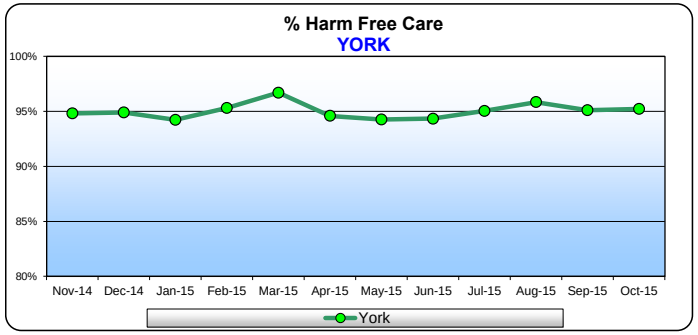
The percentage of patients affected by VTE as measured by the Department of Health definition, monthly measurement of prevalence:

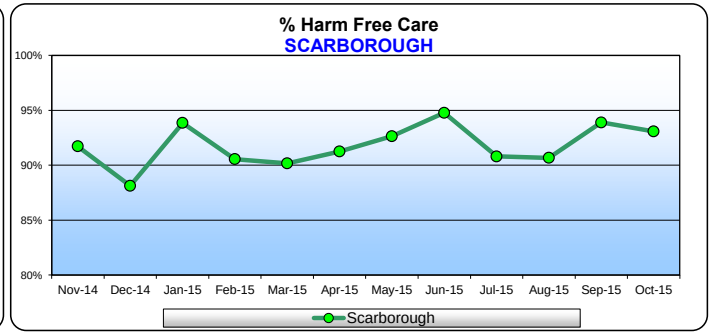
·York: 0.5%
·Scarborough: 0.5%
·Community Hospitals: 0.0%
·Community Care: 0.2%

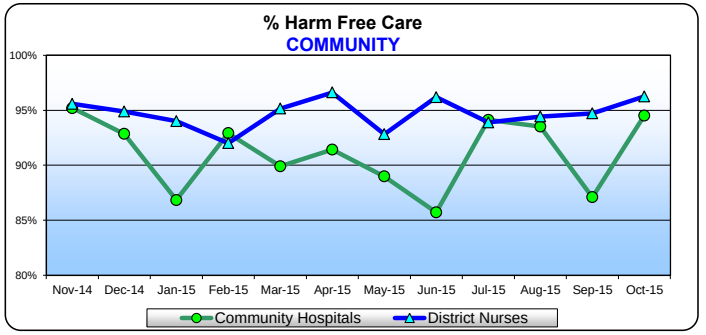
Safety Thermometer

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.

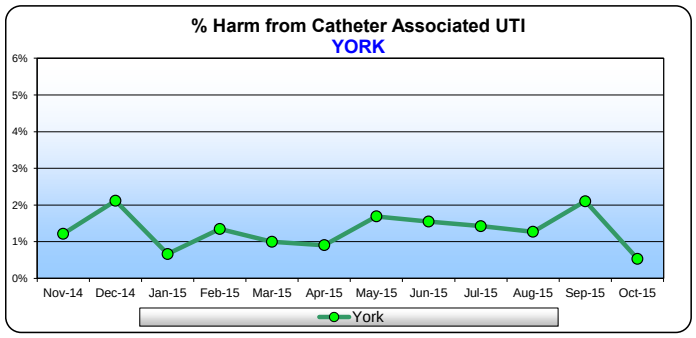
Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
% of Harm Free Care source: Safety Thermometer	York	94.8%	94.9%	94.2%	95.3%	96.7%	94.6%	94.3%	94.3%	95.0%	95.8%	95.1%	95.2%
	Scarborough	91.7%	88.1%	93.9%	90.6%	90.2%	91.3%	92.6%	94.8%	90.8%	90.7%	93.9%	93.1%
	Community Hospitals	95.2%	92.9%	86.8%	92.9%	89.9%	91.4%	89.0%	85.7%	94.1%	93.5%	87.1%	94.5%
	District Nurses	95.6%	94.9%	94.0%	92.0%	95.2%	96.6%	92.8%	96.2%	93.9%	94.4%	94.7%	96.2%

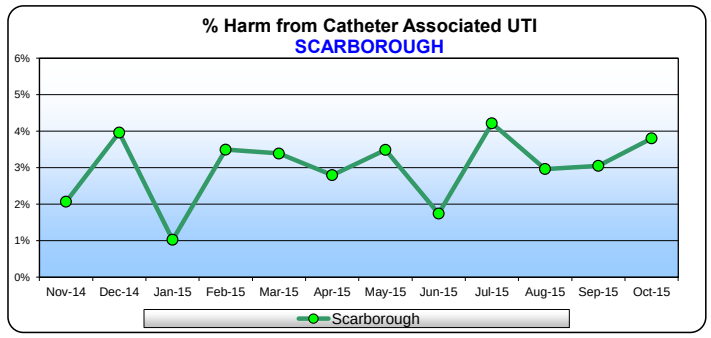


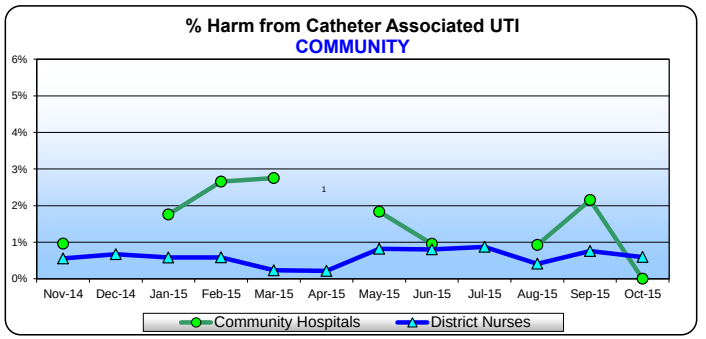




Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	1.2%	2.1%	0.7%	1.3%	1.0%	0.9%	1.7%	1.5%	1.4%	1.3%	2.1%	0.5%
	Scarborough	2.1%	4.0%	1.0%	3.5%	3.4%	2.8%	3.5%	1.7%	4.2%	3.0%	3.1%	3.8%
	Community Hospitals	1.0%	0.0%	1.8%	2.7%	2.8%	0.0%	1.8%	1.0%	0.0%	0.9%	2.2%	0.0%
	District Nurses	0.6%	0.7%	0.6%	0.6%	0.2%	0.2%	0.8%	0.8%	0.9%	0.4%	0.8%	0.6%



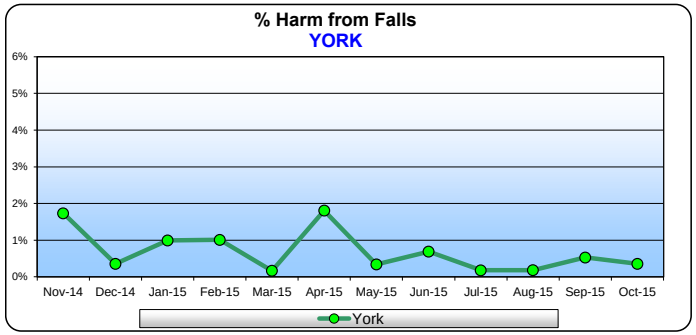


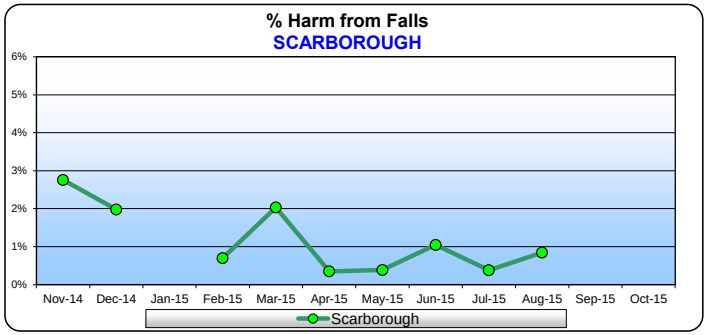


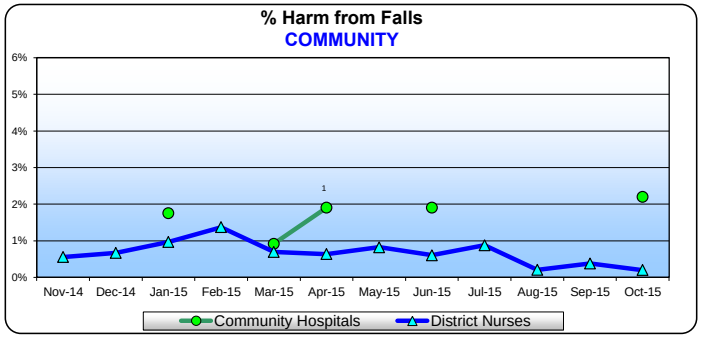
Safety Thermometer

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.

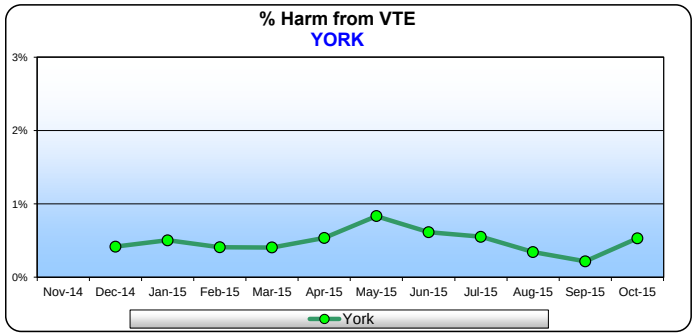
Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
% of Harm from Falls source: Safety Thermometer	York	1.7%	0.4%	1.0%	1.0%	0.2%	1.8%	0.3%	0.7%	0.2%	0.2%	0.5%	0.4%
	Scarborough	2.8%	2.0%	0.0%	0.7%	2.0%	0.3%	0.4%	1.0%	0.4%	0.8%	0.0%	0.0%
	Community Hospitals	0.0%	0.0%	1.8%	0.0%	0.9%	1.9%	0.0%	1.9%	0.0%	0.0%	0.0%	2.2%
	District Nurses	0.6%	0.7%	1.0%	1.4%	0.7%	0.6%	0.8%	0.6%	0.9%	0.2%	0.4%	0.2%

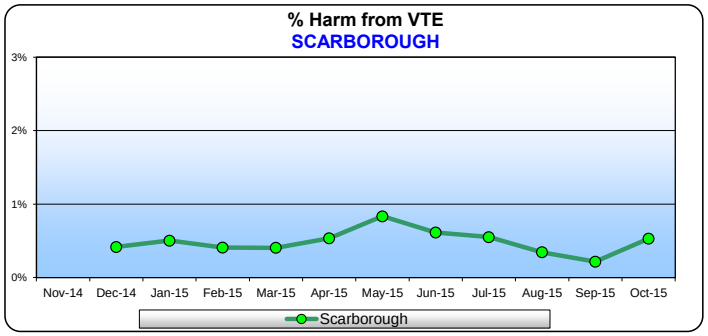


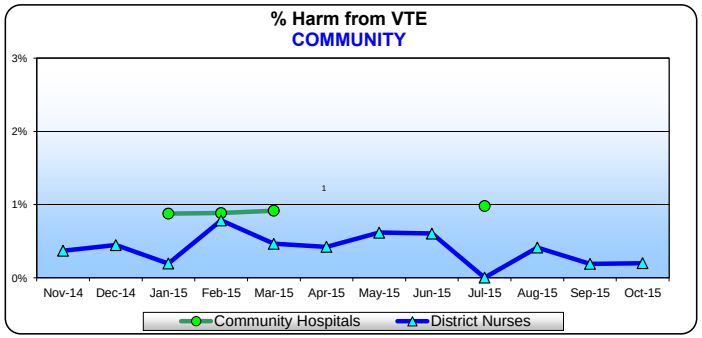




Indicator		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
% of VTE source: Safety Thermometer	York	0.0%	0.4%	0.5%	0.4%	0.4%	0.5%	0.8%	0.6%	0.6%	0.3%	0.2%	0.5%
	Scarborough	0.0%	0.4%	0.5%	0.4%	0.4%	0.5%	0.8%	0.6%	0.6%	0.3%	0.2%	0.5%
	Community Hospitals	0.0%	0.0%	0.9%	0.9%	0.9%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%
	District Nurses	0.4%	0.4%	0.2%	0.8%	0.5%	0.4%	0.6%	0.6%		0.4%	0.2%	0.2%



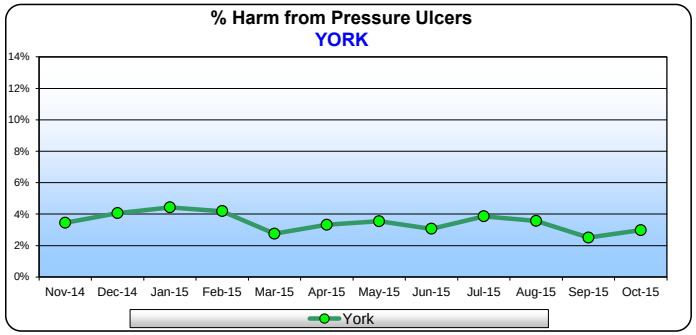


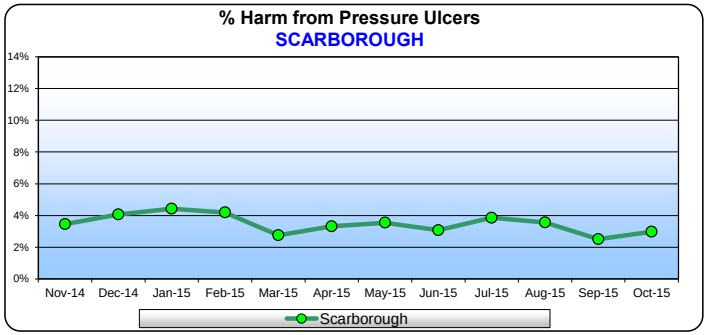


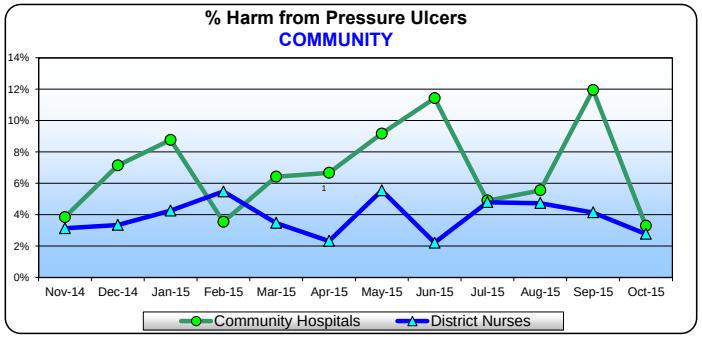
Safety Thermometer

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		Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15
% of Pressure Ulcers source: Safety Thermometer	York	3.4%	4.1%	4.4%	4.2%	2.7%	3.3%	3.5%	3.1%	3.9%	3.6%	2.5%	3.0%
	Scarborough	3.4%	4.1%	4.4%	4.2%	2.7%	3.3%	3.5%	3.1%	3.9%	3.6%	2.5%	3.0%
	Community Hospitals	3.8%	7.1%	8.8%	3.5%	6.4%	6.7%	9.2%	11.4%	4.9%	5.6%	12.0%	3.3%
	District Nurses	3.1%	3.3%	4.3%	5.5%	3.5%	2.3%	5.5%	2.2%	4.8%	4.7%	4.2%	2.8%







Mortality

Indicator	Jul 11 - Jun 12	Oct 11 - Sep 12	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
SHMI – York locality	105	105	102	98.7986	96	93	93	95	98	99	97	96
SHMI – Scarborough locality	117	112	106	107.7479	108	104	105	107	108	109	107	108
SHMI – Trust	**108**	**107**	**104**	**102**	**101**	**97**	**98**	**99**	**102**	**103**	**101**	**101**

Definition

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

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

Analysis of Performance

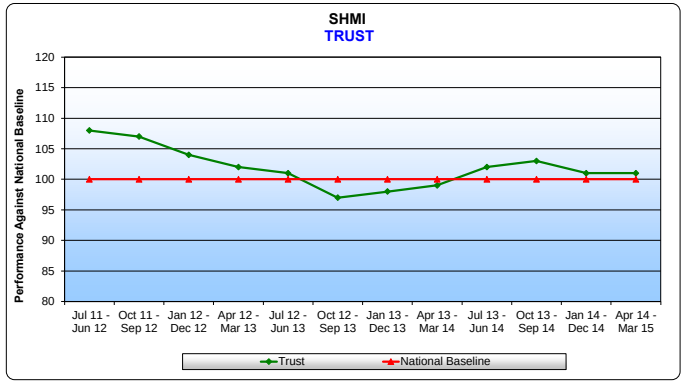
The latest SHMI report for the period January - December 2014 indicates the Trust to be in the 'as expected' range. Both York and Scarborough had a 2 point reduction from the previous release.

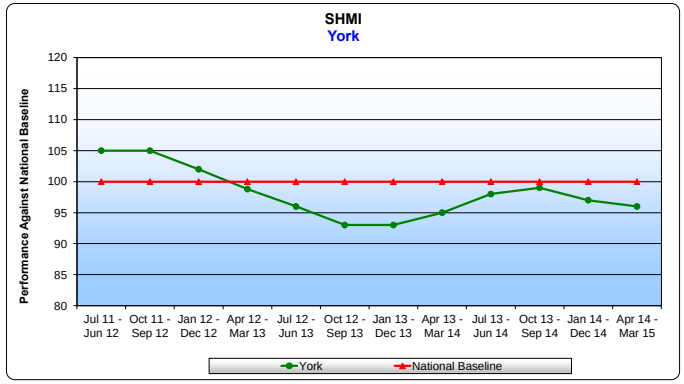
The number of inpatient deaths in September was in line with previous months. The percentage of deaths against all discharges at York has decreased slightly from 1.1% in August to 1% in September (September 2014 was 1.2%). However Scarborough saw an increase from 1.4% in August to 1.9% in September (September 2014 was 1.5%).

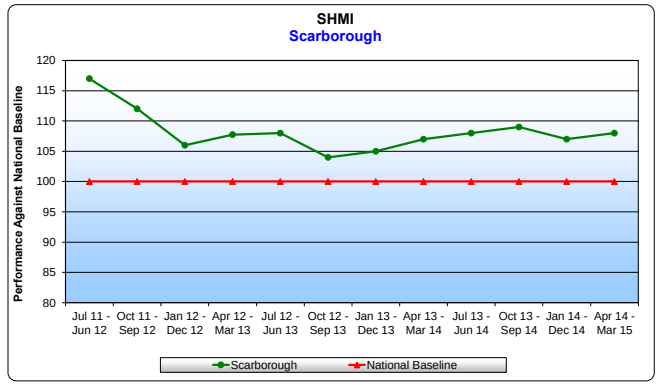
The number of ED deaths in September was also in line with previous months.

Mortality

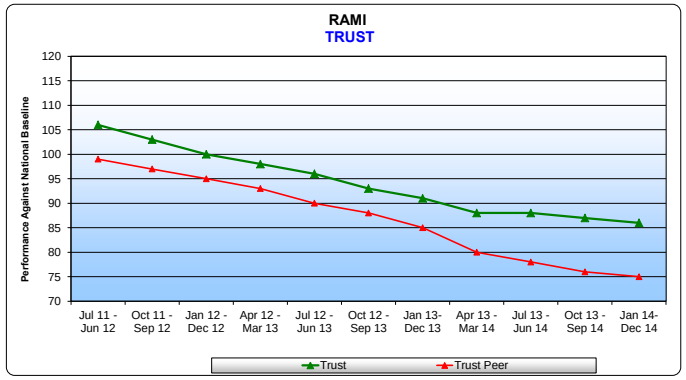
Indicator	Consequence of Breach (Monthly unless specified)	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	97	98	99	102	103	101	101
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	93	93	95	98	99	97	96
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	104	105	107	108	109	107	108

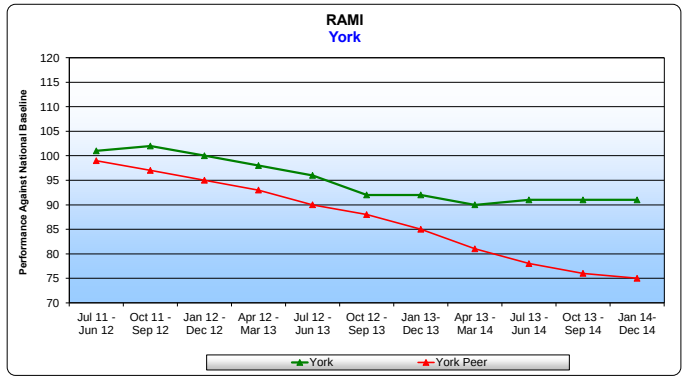


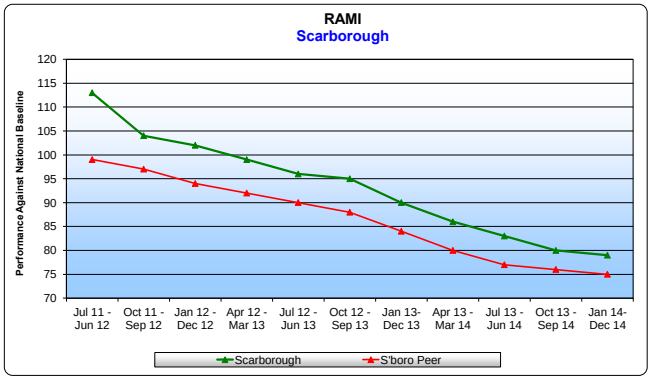




Indicator	Consequence of Breach (Monthly unless specified)	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sept 14	Jan 14 - Dec 14
Mortality – RAMI (TRUST)	**none - monitoring only**	96	93	91	88	88	87	86
Mortality – RAMI (YORK)	**none - monitoring only**	96	92	92	90	91	91	91
Mortality – RAMI (SCARBOROUGH)	**none - monitoring only**	96	95	90	86	83	80	79

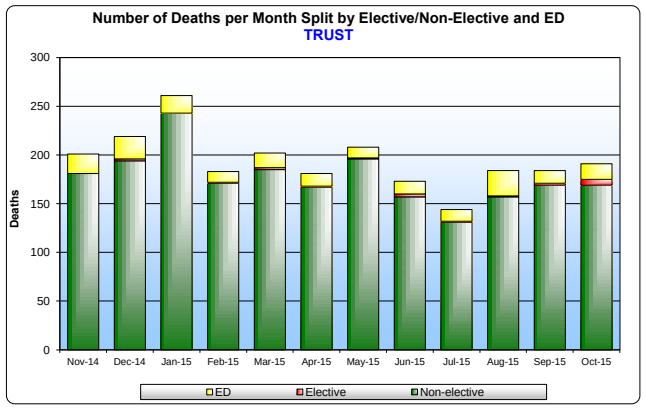


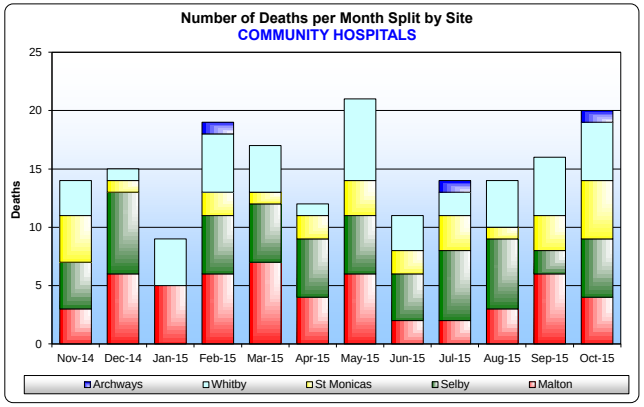




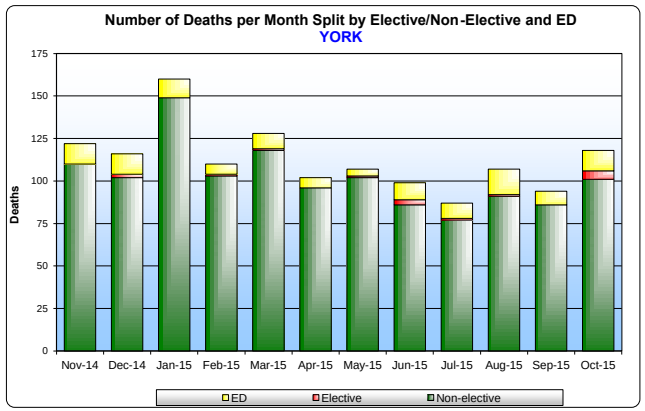
Mortality

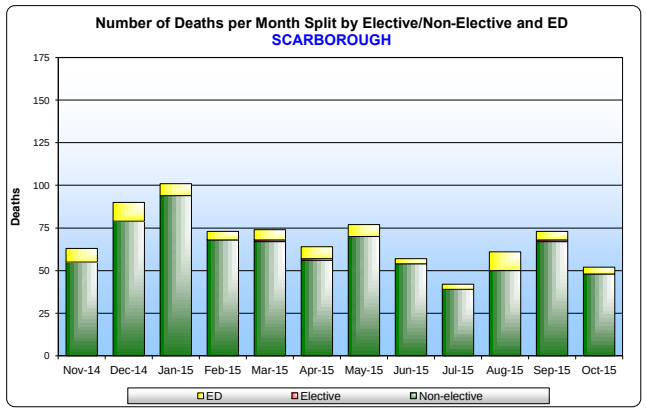
Indicator	Consequence of Breach (Monthly unless specified)	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Number of Inpatient Deaths (excludes deaths in ED)	None - Monitoring Only	540	602	525	461	158	171	175

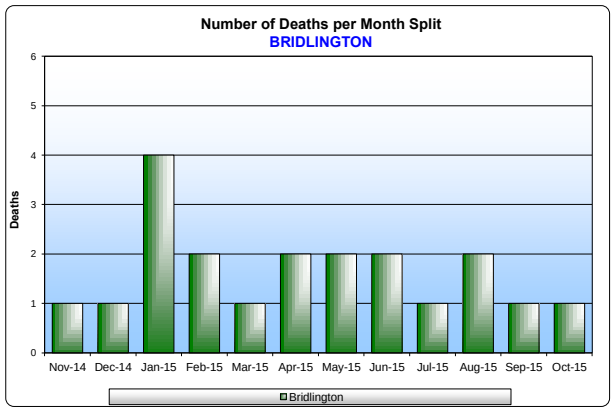




Month	Malton	Selby	St Monicas	Whitby	Archways	Bridlington
Nov-14	3	4	4	3	0	1
Dec-14	6	7	1	1	0	1
Jan-15	5	0	0	4	0	4
Feb-15	6	5	2	5	1	2
Mar-15	7	5	1	4	0	1
Apr-15	4	5	2	1	0	2
May-15	6	5	3	7	0	2
Jun-15	2	4	2	3	0	2
Jul-15	2	6	3	2	1	1
Aug-15	3	6	1	4	0	2
Sep-15	6	2	3	5	0	1
Oct-15	4	5	5	5	1	1





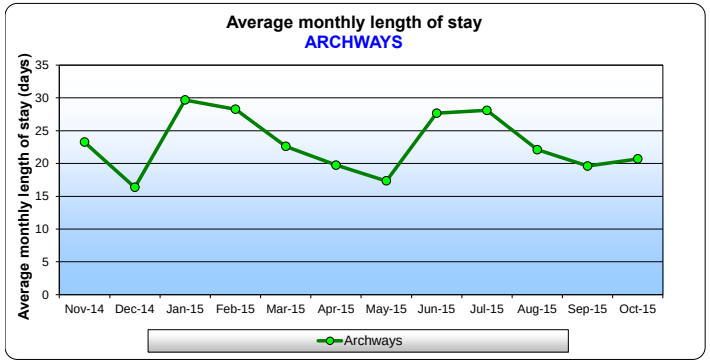


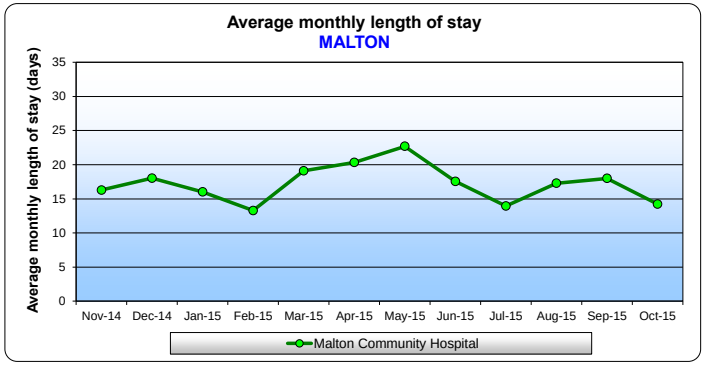
Patient Safety Walkrounds – October 2015

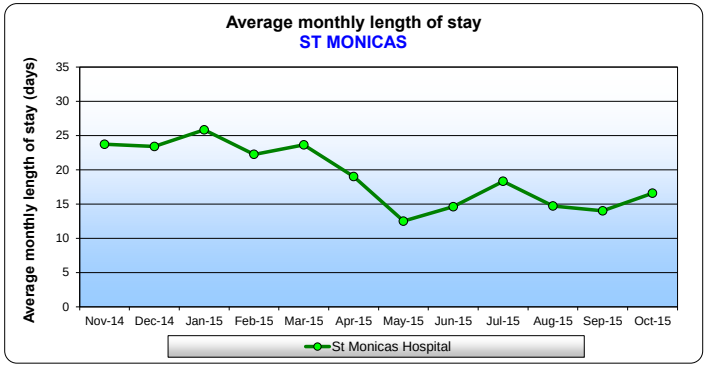
Date	Location	Participants	Actions & Recommendations
26/08/2015	Cardio Respiratory Unit, York Hospital	Bev Geary - Director Nigel Durham – Clinical Director Jane Allen – Head of Department Sharon Lewis – Directorate Manager Chris Morris – Matron Mike Sweet – Non-Executive Director	Difficult to recruit band 7 cardio physiologists due to lack of availability in this specialist area. Vacancies have been sent to Vacancy Control and attempts to recruit will continue. There is a large volume of paperwork in storage associated with pacemakers. The Directorate are exploring an electronic solution with Systems and Network Services. The unit is too small for the needs of the service. There has been an increase in capacity and demand. There is only one lift available. Relocation has been raised with Estates. Endoscopy have been approached regarding the possible use of the unit. This remains an unresolved problem and is recorded on the risk register. Due to the large volume of DNAs reminder letters are now sent, which has improved attendance rates.
02/09/2015	Diabetes Centre, York Hospital	Sue Rushbrook - Director Jonathan Thow – Head of Department Sharon Lewis – Directorate Manager Chris Morris – Matron Mike Keaney - Non-Executive Director	Risk identified around blood glucose monitoring on the wards – agency nurses are not able to perform this task as they are not trained to use the POCT equipment and have no access. Action – Matron to discuss with Chief Nurse, Dr Thow to discuss with Patient Safety and POCT Lead. Endocrine testing is being done by nursing staff in OPD in York but not Scarborough. Action – Training needs to be determined. Succession planning is needed for Diabetes Nursing Service at Scarborough.
14/09/2015	Wards 11, 14, 16 and Breast Unit, York Hospital	Sue Holden - Director Stevan Stojkovic – Clinical Director Liz Hill – Directorate Manager Wendy Brown – Matron	Report outstanding
01/10/2015	Ann Wright, Stroke and Oak Wards, Scarborough Hospital	Mike Proctor - Director Edward Jones – Clinical Director Jamie Todd – Directorate Manager Ginni Smith – Matron Dianne Willcocks - Non-Executive Director	Patient signage above bed not being correctly utilised. Action - Matron to work with the ward sisters and re-emphasise the need to display the appropriate patient information. Patient experience data / statistics / signage out of date. Action – Mike Proctor to discuss with Chief Nurse Team to identify timescale for update / review of patient experience information at ward level.
07/10/2015	Ward 28, Ward 29, Orthopaedic OPD and Orthopaedic Theatres	Brian Golding - Director Nick Carrington – Clinical Director Paul Rafferty – Directorate Manager Liz Charters – Matron Libby Raper - Non-Executive Director	The visit started with a review of actions from the previous walkround and progress had been made in most areas. The only action still outstanding relates to trauma patients records being paper based. It was agreed to check that this is in SNS plans. Having achieved full establishment since the previous walkround the 2 wards now have vacancies of 9 WTE., for a variety of reasons. There is some flexing between wards 28 and 29 to cover this – but the opportunities are limited. The only recent SI related to a pressure ulcer from a misfitted cast, and the team were able to explain how learning from this had been shared. The ward felt that they possibly could report more incidents. It was agreed that they would benchmark against other wards. The wards are high users of 1:1 support for risk of falls. It was explained that they cohort patients at risk so that fewer staff are required. The direct GP admissions currently go to a redundant day room. This area is not fitted with nurse call, and the ward is not staffed to cover it. It was recognised that the creation of an assessment area would deal with this and link to the new ways of working under discussion around acute pathways. Ward 28 is 30 bedded with 2 escalation beds. It was noted that the 2 escalation beds are permanently in use. In these areas there is only 1 oxygen point for 3 beds.
09/10/2015	Ward 33 and Renal Unit	Diane Palmer - Deputy Director Sharon Lewis – Directorate Manager Chris Morris – Matron Janet King – Renal Unit Manager Philip Ashton - Non-Executive Director	Ward 33 Electronic door locks are needed to reduce risk. Action DP to discuss with Brian Golding The ward has a large number of RN vacancies and 2 RNs on maternity leave which results in extensive use of agency nurses. As there is no recognition of prior learning for agency nurses they are often restricted in clinical activities. Action – Matron and Charge Nurse to focus staff recruitment and retention. In learning from incidents staff now attend to patients who require insulin first and they have established a priority based system for medical review. A prompt on the Electronic Board of which patients require insulin may help. Action DP to discuss with Dr Richardson. Renal Unit Actions from the previous Walkround had been completed. The walls between side rooms 11 and 12 are very damp and the air conditioning unit leaks constantly. Action – DP to discuss with Brian Golding There is a concern about the ability to access the fire exits in an emergency as access is via a store room. Action – Sister to arrange a test walk-through with a bed.
15/10/2015	Maternity Services – Scarborough Hospital Hawthorne Ward, Delivery Suite, Maternity Led Unit, O&G Clinic, Womens Unit, Colposcopy, Early Pregnancy Unit, Antenatal Clinic, Antenatal Day Assessment	Ed Smith - Director Jim Dwyer – Clinical Director Liz Ross – Head of Midwifery Sue Jackson – Labour Ward Manager Sue Symington - Chair	No office space on Labour Ward, therefore clinical handover in staff sitting room, no private office area to take confidential phone calls and discuss cases, limited desk space/computer access. Action - to explore possibility of providing office space once bereavement suite work complete. Women sometimes complain it's too warm (needs to be warm for babies) - Supply information for women – consider poster. Would like an extra midwife or increased admin support. Action - Manager to raise with senior team.
23/10/2015	Selby War Memorial Inpatient Unit	Sue Rushbrook - Director Sharon Hurst –Locality Manager Helen Helps – Ward Manager Mike Sweet - Non-Executive Director	The flooring was "slip tested" as requested by Kingsley Needham. Results are not known and the floor covering remains unchanged. Action – Locality Manager to review results of floor tests.

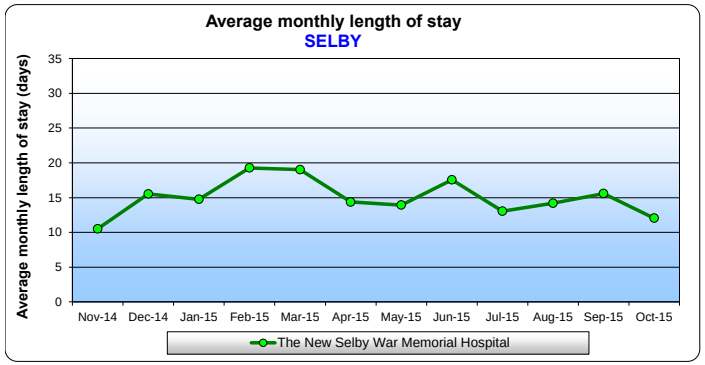
Community Hospitals

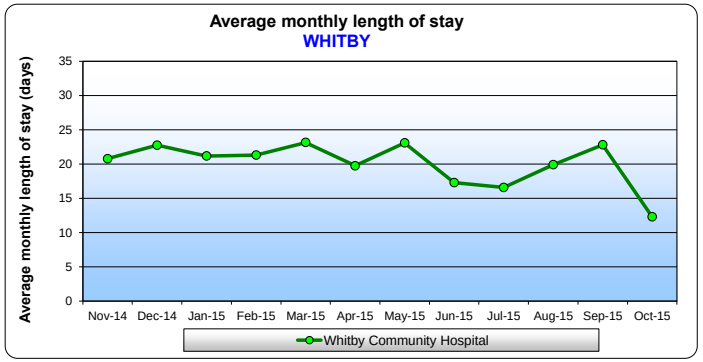
Indicator	Hospital	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Community Hospitals average length of stay (days)	Archways	20.6	26.8	21.1	23.0	22.1	19.6	20.7
	Malton Community Hospital	17.1	16.0	19.9	16.1	17.3	18.0	14.2
	St Monicas Hospital	22.0	24.0	15.5	15.5	14.7	14.0	16.6
	The New Selby War Memorial Hospital	13.7	17.6	15.3	14.2	14.2	15.6	12.1
	Whitby Community Hospital	20.9	21.9	20.0	19.5	19.9	22.8	12.3
	Total	18.1	20.2	18.5	17.4	18.0	18.3	14.1

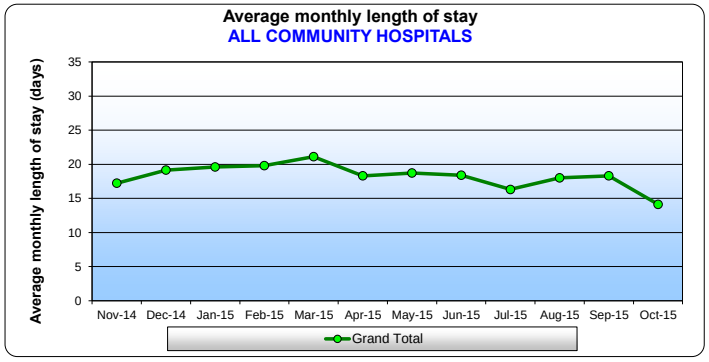






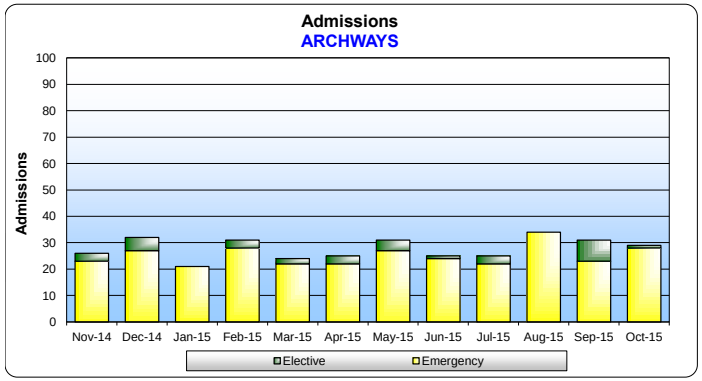


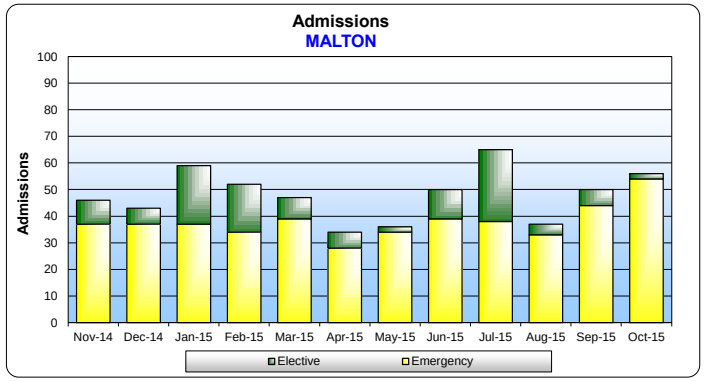


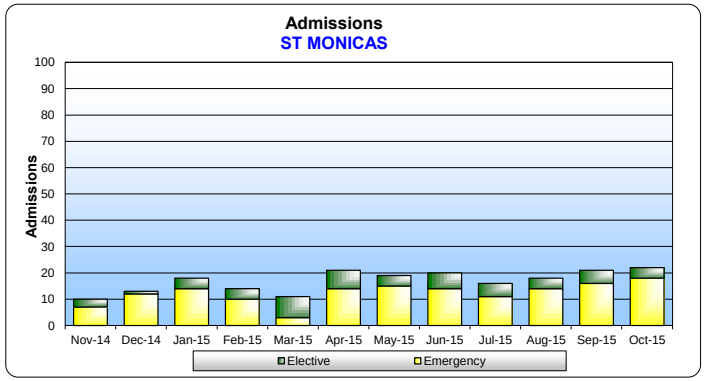


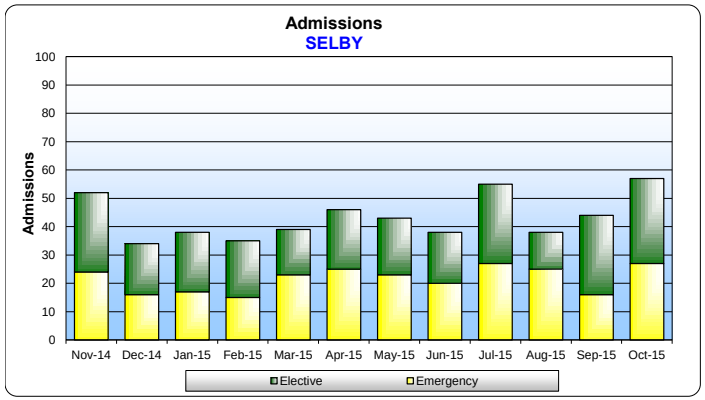
Community Hospitals

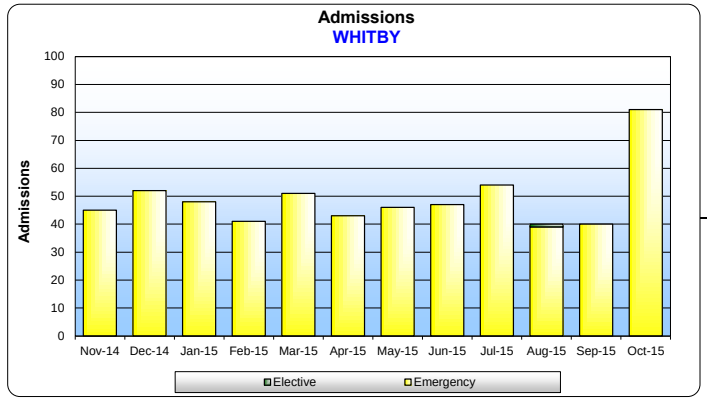
Indicator	Hospital		Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	8	5	8	11	0	8	1
		Emergency	77	71	73	79	34	23	28
	Malton Community Hospital	Elective	21	48	19	37	4	6	2
		Emergency	121	110	101	115	33	44	54
	St Monicas Hospital	Elective	9	16	17	14	4	5	4
		Emergency	27	27	43	41	14	16	18
	The New Selby War Memorial	Elective	69	57	59	69	13	28	30
		Emergency	69	55	68	68	25	16	27
	Whitby Community Hospital	Elective	4	0	0	1	1	0	0
		Emergency	142	140	136	133	39	40	81
	Total	Elective	111	126	129	106	22	47	37
		Emergency	436	403	441	492	145	139	208

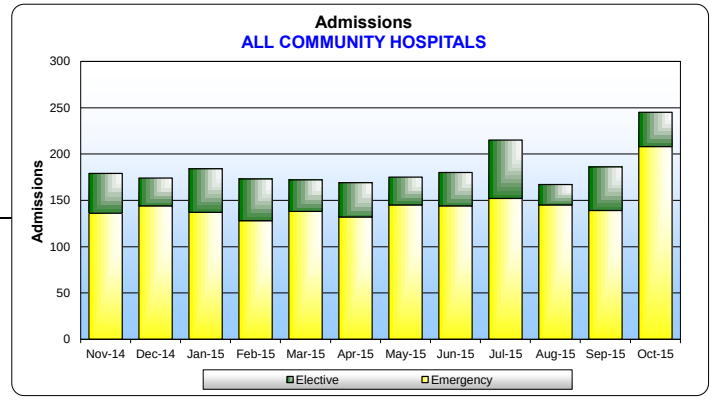












E2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

Medical Director's Report

Action requested/recommendation

Board of Directors are requested:

- To be aware of progress with the Flu Campaign
- To consider the results from the antibiotic prescribing audit and to be advised of actions taken for improvement
- To be aware of progress with the Patient Safety Strategy/Sign up to Safety Campaign
- To be advised of consultants new to the Trust
- Consider the Trust latest Summary Hospital level Mortality Indicator (SHMI).

Summary

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

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

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

Progress of report	The contents of this report have been presented to Executive Board.
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	November 2015
Version number	Version 1

1. Introduction and background

In the report this month:

Update on flu campaign
Antimicrobial Prescribing Audit
Patient Safety Strategy/Sign up to Safety Campaign update
Consultants new to the Trust
Summary Hospital level Mortality Indicator (SHMI).

2. Update on Flu Campaign

Staff should be encouraged to get their flu vaccinations. Details of 'drop-in' sessions are posted on Staff Room.
At the end of October only 26% of eligible frontline clinical staff had received the vaccination. A breakdown of staff groups who have received the flu vaccination is listed below.

	Headcount	Uptake	%
Doctors	830	214	26%
Nurses	2428	588	24%
AHPs	1013	366	36%
Clinical Support	2665	634	24%
Total	6936	1802	26%

3. Antimicrobial prescribing audit

Compliance with antimicrobial prescribing continues to be audited on a monthly basis. Results summarised below indicate that the clinical indication is recorded on average in 88% of cases throughout the Trust, with compliance being slightly higher on the York site than Scarborough/Bridlington.

Indication on antibiotic prescription	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
York Hospital	85%	87%	89%	86%	82%	86%	91%	87%	86%	91%
Scarborough Hospital	81%	76%	86%	89%	90%	87%	93%	83%	82%	82%
Trust average	83%	82%	87%	87%	85%	87%	92%	86%	85%	88%

The course length of the antibiotic is recorded on average in over 83% of cases.

Duration / course length on antibiotic prescription	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
York Hospital	84%	88%	91%	88%	82%	89%	91%	83%	81%	84%
Scarborough Hospital	84%	88%	85%	92%	90%	83%	89%	81%	84%	82%
Trust average	84%	88%	89%	89%	85%	86%	90%	82%	82%	83%

The average number of patients prescribed antibiotics during October was 22% for York site and 27% for Scarborough/Bridlington.

% of in-patients prescribed antibiotics	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
York Hospital	24%	25%	23%	25%	21%	19%	19%	24%	23%	22%
Scarborough Hospital	36%	36%	27%	28%	26%	26%	32%	22%	28%	27%

Due to lack of availability of VSL#3 from the supplier, this has not been prescribed during September and October.

4. Patient Safety Strategy/Sign up to Safety Campaign - update

Severe Sepsis
To aid the identification of patients with sepsis the Trust has introduced a screening tool. Audit of compliance with use of the screening tool commenced in Quarter 1. Reporting outcomes of administration of antibiotics commenced in Quarter 2 (to satisfy CQUIN requirements).

During Quarter 1, 11.7% of patients in the sample were being screened for sepsis, there has been a significant improvement in Quarter 2 with screening being done in 46.7% of the sample patients. For patients with severe sepsis, administration of antibiotics within one hour of presentation was only achieved in 27.8% of cases during Quarter 2 (audit not undertaken in Q1).

Compliance with screening continues to improve, with audit during October indicating 64% compliance, however administration of antibiotics within one hour of presentation is only achieved on average in 25% of cases. A system of rapid feedback to consultants within the Emergency Departments and AMUs has recently been established, to support monitoring of compliance on a weekly basis.

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 of the use of PTWR checklist in acute medicine (both sites) demonstrate use to be between 80-100%. Audits will continue and clinicians will be given feedback on the where improvements are needed.

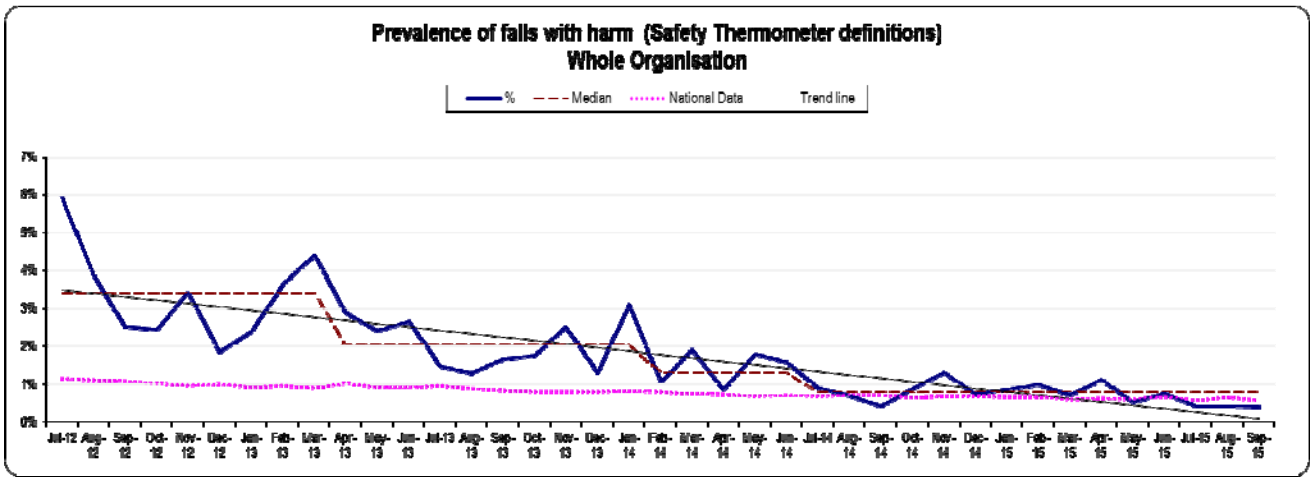
Within acute surgery a new PTWR Checklist was introduced in September and audits to monitor use indicate variation of compliance from 0-80%. This variation in use is largely due to the checklist being new and there being some variation in understanding of how the checklist should be used. Audit results are being discussed with consultant staff and we anticipate a sustained improvement.

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. Training and education has taken place with Doctors and Pharmacists to ensure that the remaining patients have the same documentation. September results show that 92.5% of patients had all of the documentation within the Electronic Discharge Notification (EDN) giving a Q2 average of 78.3%.

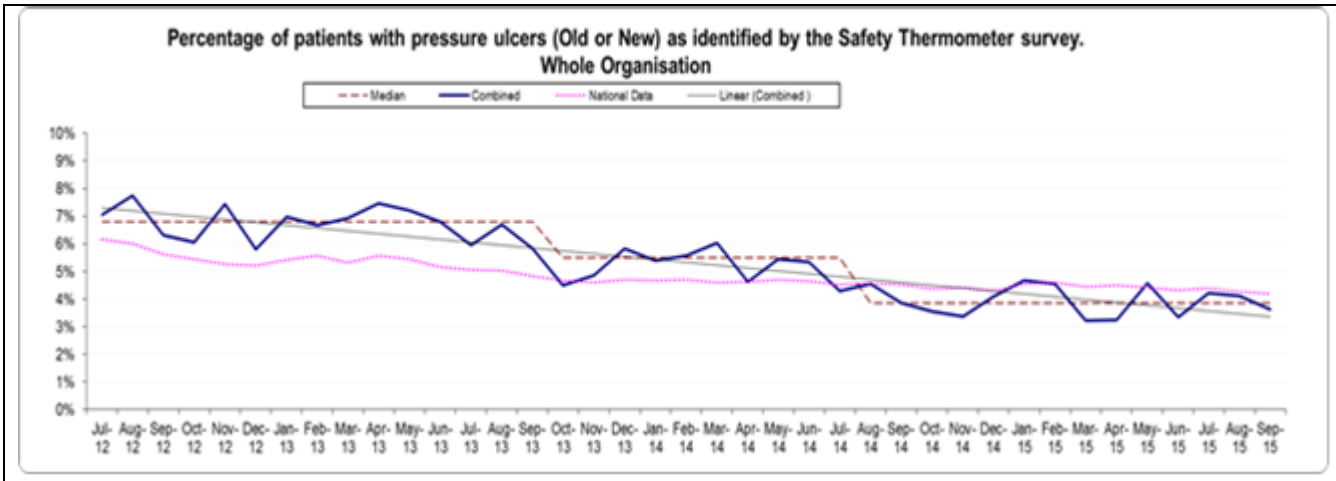
Senior medical review within 14 hours of arrival to Medical Admissions Unit
Overall, over 80% of patients are receiving a senior medical review within 14 hours of admission to our acute hospital sites. For patients admitted to York Hospital, senior medical review takes place within 14 hours in 90% of cases, however this is only being achieved in 67% of cases at Scarborough Hospital.

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. 88% of patients were screened within 72 hours of admission during September 2015.

Reducing harm from falls
The number of patients experiencing serious injury following a fall in our care continues to reduce. We are aiming for a further reduction in moderate or severe harm from patient falls by 20% during 2015 – 2016, which would be an average of six falls per month (18 per quarter) by March 2016. During Q1, we identified a total of 25 patient falls which have resulted in moderate harm, severe harm or death and 15 during Q2, which results in us being currently above target by seven cases, however there has been a reduction (47 to 40) when compared with the same time period during 2014-15. Additional work on training programmes for medical staff and the risk assessment and implementation tool being implemented on the acute sites should result in further reduction of serious harm from falls.
The prevalence of falls resulting in harm is measured by the Safety Thermometer Survey undertaken each month. The graph below illustrates that we have shown a sustained reduction and are now below the national data point.



Reducing harm from 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 as illustrated in the graph below we are now below the national average.



The number of Category 3 and 4 pressure ulcers reported into the Datix Reporting System indicated a slight increase in reports during May and June however subsequent months have seen a reduction in the reporting of Category 3 and 4 pressure ulcers and at the time of reporting we are achieving the 20% target reduction.

Implementation of EPMA
By March 2016 the EPMA system will be in pilot at both York and Scarborough acute sites following completion of detailed design and testing phases. We anticipate full rollout to start in April 2016 and to take around six months across the three main hospital sites. 70% of the programming is now complete.

The EPMA system will be underpinned by a detailed drug database from First DataBank who is a leader in the field of clinical decision support. Their database includes functionality that has been shown to contribute to the reduction of many prescribing errors. Clinical decision support includes interaction warnings as well as high risk medicine alerts; cumulative dosing and dose range checking. Robust enforced recording of allergy status will be a pre-requisite for EPMA and this will contribute significantly to the reduction of prescribing errors.

Excellence in end of life care
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 on the Q drive and a training programme to develop senior nurses in DNACPR decision making is being developed.

Audits are completed regularly on York site for DNACPR, with evidence of good compliance reported. A similar audit process will be developed for Scarborough Hospital and community sites.

5. Consultants new to the Trust

Dr Jagannath Gopalappa
Consultant Diabetes & Endocrinology - York
Commenced 1st October 2015

Mr Kanak Patel
Consultant Maxillo Facial - York
Commenced 1st October 2015

Dr Rebekah Molyneux
Consultant Renal Medicine - York
Commenced 5th October 2015

Miss Anna Ikponmwosa
Consultant – Vascular Surgery - York
Commenced 19th October 2015

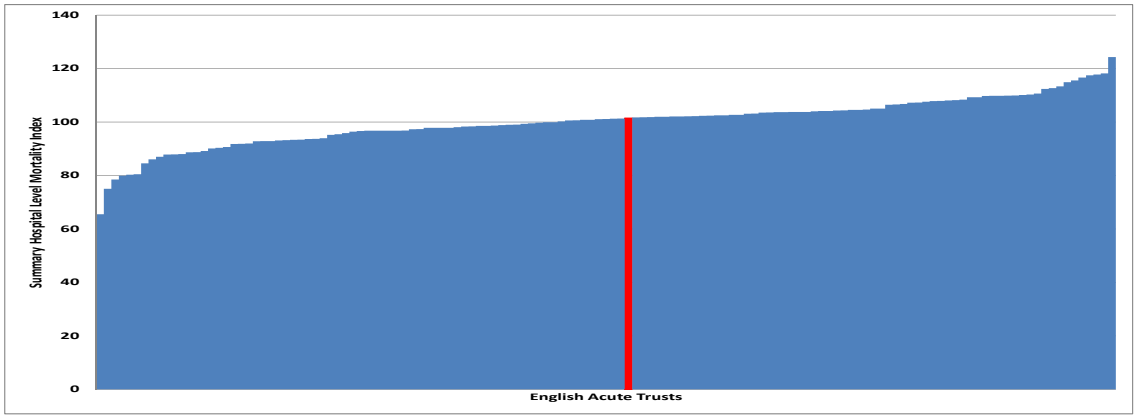
Miss Leila Fahel
Consultant in O&G - York
Commenced 2nd October 2015

6. Summary Hospital level Mortality Indicator (SHMI) update

The updated SHMI was published by the Health and Social Care Information Centre on the 28th October. This cover the reporting period April 2014 to March 2015. The Trust SHMI for the period is 100.6, which indicates a slight reduction from 101.2 in the period ending December 2014.

There were 20 excess deaths 14 less than in the last report. There were more observed and expected deaths than the previous report and activity had also increased.

Cases	Observed Deaths	Expected Deaths	SHMI	Excess Deaths
79696	3148	3128	100.6	20



SHMI April 2014 to March 2015

There were a number of SHMI categories where the Trust had more deaths than expected,

those with ten or more in the table below. Congestive heart failure indicates 31 excess deaths compared with 19 in the previous report, septicaemia has increased by four, urinary tract infections increased by two but for the other conditions fewer excess deaths were reported with acute cerebrovascular disease excess deaths reduced by four and other connective tissue disease reduced by seven.

Condition	SHMI Category	Admissions	Deaths	Predicted	SHMI	Excess
65	Congestive heart failure nonhypertensive	698	146	114.66	127.34	31.34
66	Acute cerebrovascular disease	1112	223	198.78	112.19	24.22
2	Septicaemia and Shock	395	120	102.18	117.44	17.82
101	Urinary tract infections	1877	133	115.79	114.86	17.21
113	Other connective tissue disease	1251	37	24.26	152.53	12.74
130	Superficial injury contusion	719	28	16.77	166.95	11.23

There were also groups with fewer deaths than expected (listed below), of particular note is pneumonia as this seems to represent the biggest change during the quarter January to March 2015.

Condition	SHMI Category	Admissions	Deaths	Predicted	SHMI	Excess
73	Pneumonia	2691	561	578.25	97.02	-17.25
42	Mental retardation Senility & organic mental disorders	409	39	49.68	78.51	-10.68
98	Other gastrointestinal disorders	870	23	30.42	75.60	-7.42
122	Fracture of lower limb	728	9	15.78	57.03	-6.78
64	Cardiac arrest & ventricular fibril	51	23	29.41	78.19	-6.41
58	Coronary atherosclerosis and other heart disease	893	9	15.35	58.64	-6.35
69	Aortic peripheral and visceral artery aneurysms	210	21	27.28	76.99	-6.28
120	Fracture of neck of femur (hip)	876	77	83.20	92.54	-6.20
70	Aortic and peripheral arterial embolism or thrombosis	163	9	14.77	60.95	-5.77
50	Epilepsy convulsions	828	10	15.74	63.54	-5.74
117	Short gestation low birth weight	331	0	5.61	0.00	-5.61

The SHMI for Yorkshire trusts is reported in the table below for information.

Trust	SHMI	Trust	SHMI
Sheffield	91.0	Calderdale & Huddersfield	108.9
Leeds	101.7	Hull & East Yorkshire	107.0
Airedale	93.4	York	100.6
Bradford	96.8	Doncaster & Bassetlaw	110.8
Mid Yorkshire	88.7	Barnsley	99.2
Harrogate	99.1	Rotherham	109.4

7. Recommendations

Board of Directors are requested:

To be aware of progress with the Flu Campaign
To consider the results from the antibiotic prescribing audit and to be advised of actions taken for improvement
To be aware of progress with the Patient Safety Strategy/Sign up to Safety Campaign
To be advised of consultants new to the Trust
Consider the Trust latest Summary Hospital level Mortality Indicator (SHMI).

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Mr Jim Taylor, Medical Director**
Date	**November 2015**

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E3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

Chief Nurse Report – Quality of Care

Action requested/recommendation

The Committee is asked to note the Chief Nurse report for November 2015.

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	Executive Board & 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	November 2015
Version number	Version 1

Board of Directors – 25 November 2015

Chief Nurse Report – Quality of Care

1. Key priorities

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

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

The strategy is in its final months and an evaluation and assessment of delivery of the objectives initially outlined will be undertaken and presented to the committee early in the new year. Planning is already underway with key stakeholders to determine priorities for a new strategy which will be developed in the new year.

The Early Warning Trigger tool was introduced as part N&M Strategy and replaced previous Nursing Care Indicators. The EWTT continues to be completed each month by all wards and in-patient units; the last submission was 4th November 2015. At the present time no wards are red rated, the highest score being 19 for Ward 15 at York and, 17 for Maple Ward at Scarborough Hospital. Vacancies, sickness and unfilled shifts remain consistent themes across most ward submissions. A detailed breakdown is presented to Q&S committee on a quarterly basis and the Assistant Directors of Nursing are working with Matrons and wards on action plans which are presented to The Executive Nursing Forum.

2. Staffing

The Trust continues to have a number of nursing vacancies and work is being undertaken recruit more nurses to the Trust through generic nurse recruitment campaigns, EU recruitment and through final year student nursing campaigns

As a result of the re-introduced generic recruitment 30 nurses will be interviewed for positions in early November and further interviews will be held at the end of the month. In addition, the first cycle of interviews has been held for European nurses with 7 nurses being offered employment by the end of October. Two further cycles of interviews will be held in November. The Trust is now working to support their timely arrival to the UK.

Following a successful recruitment campaign a cohort of newly qualified nurses took up posts across the Trust. Their NMC Pin numbers enabling them to begin their nursing careers in our organisation. These nurses are being supported through a revised 10 month preceptorship programme.

The October Nursing and Midwifery staffing levels report (actual versus planned) is detailed in a separate paper.

3. Infection Prevention Update

Infection Prevention continues, through audit, surveillance and Post Infection Review (PIR) to monitor and benchmark rates of Healthcare Associated infection aiming to reduce rates to below the national mean.

MRSA incidence remains at 6 with no further cases since June (135 days up to 4th Nov 2015)

MSSA incidence remains below that of 2014/15 for the year to date however improvement is still required to bring incidence within trajectory for 2015/16. In addition to the initiatives already in place that include ANTT and electronic recording of cannula insertions on CPD to enable monitoring of on-going care, each case will now be reviewed the same day by the Infection Prevention Doctor, Deputy DIPC and/or Senior Infection Prevention nurse to establish:

- Venous Infusion Phlebitis (VIP) score has been completed and acted on if necessary
- That ANTT training has been undertaken by senior staff and is on going for all staff.
- The primary source of infection

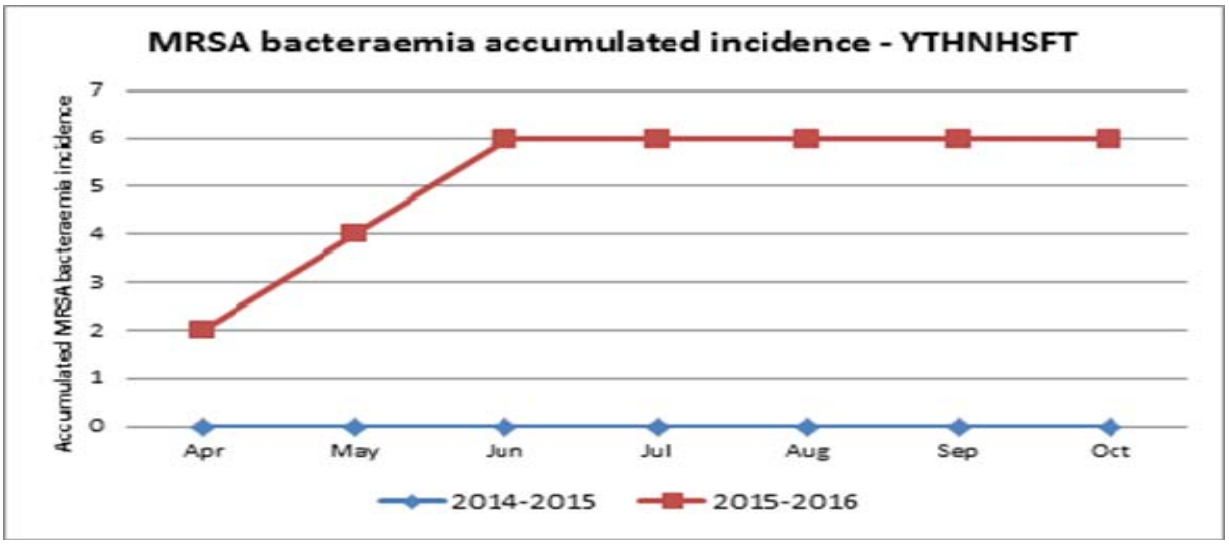
Clostridium difficile incidence continues to increase regionally and nationally. Post Infection review and antimicrobial compliance audit highlight that prescribing in line with formulary continues to improve but due to the acute nature of illness particularly amongst the elderly, the need for essential antimicrobial therapy leads to sporadic cases in a population that naturally carries C.diff as part of their normal bowel flora. There have been no clusters or outbreaks of this infection over the last quarter. There has been 6, potentially 8 cases where no `lapses in care` have occurred; these have been agreed with Commissioners meaning no financial penalty will be incurred. Further cases are to be reviewed.

Monitoring of the indication and appropriate use of broad spectrum antibiotics to reduce risk and incidence of C.diff continues by the antimicrobial stewardship team, in particular in relation to sepsis management when such treatments are prescribed. A `hotline` to pharmacy to enable medical staff to discuss broad spectrum use will enable prompt review and follow up by Microbiologists of need and appropriateness.

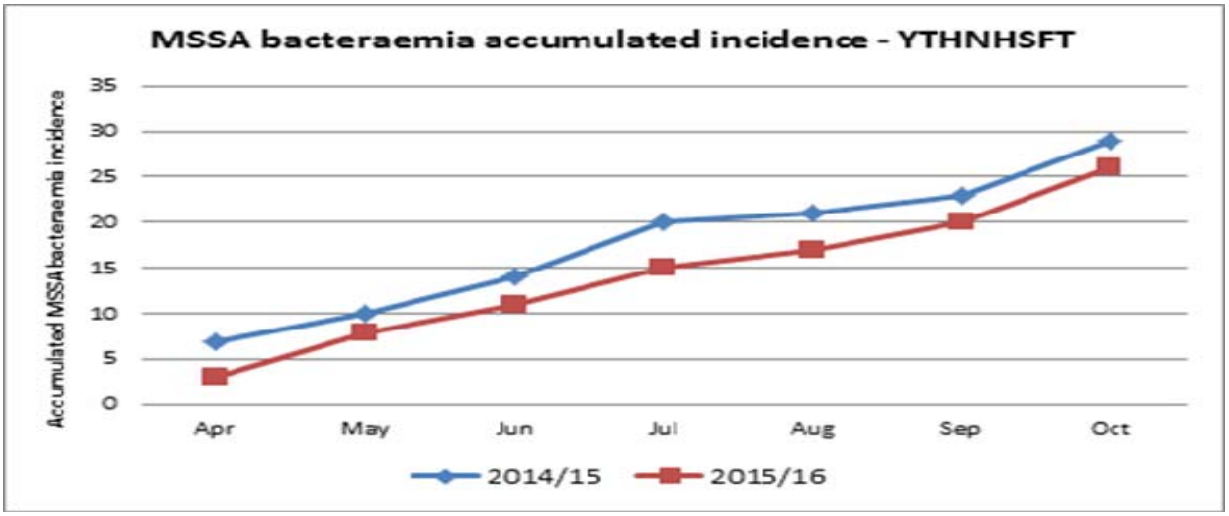
Data below outlines comparative HCAI incidence for the past 2 years.

MRSA bacteraemia	2014/15 (accumulated)	2015/16 (accumulated)
Apr	0	2
May	0	4
Jun	0	6
Jul	0	6
Aug	0	6
Sept	0	6

Oct	0	6

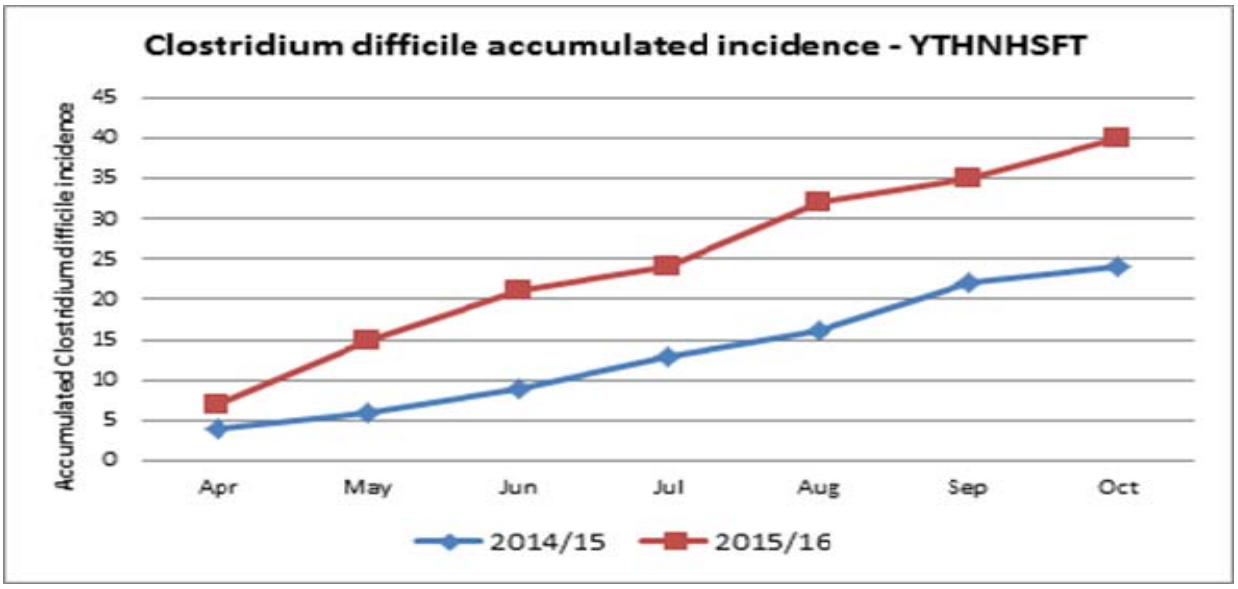


MSSA bacteraemia	2014/15 (accumulated)	2015/16 (accumulated)
Apr	7	3
May	10	8
Jun	14	11
Jul	20	15
Aug	21	17
Sept	23	20
Oct	29	26



CDI toxin positive	2014/15 (accumulated)	2015/16 (accumulated)

Apr	4	7
May	6	15
Jun	9	21
Jul	13	24
Aug	16	32
Sept	22	35
Oct	24	40



Norovirus

Since the onset of the Norovirus outbreak on the 17th October, 8 wards have been affected with an average duration of ward closure to date of 8 days; staff and patients have been affected. Outbreak control measures of ward closure, isolation and environmental disinfection have been implemented at onset in addition to the permanently locked connection doors on the York site. However, the prevalence and virulence of the virus this year appears to be greater than in previous causing greater incidence and impact. Discussion with community colleagues has been initiated via the Senior Nurse forum to explore ways of providing care in the community where re-hydration of uncomplicated cases may be an option to lessen impact on acute services. Data below describes the impact of the outbreak.

Ward Name	Bay	Onset date	Re-opened	Total No of Days of Outbreak	Patients	Staff
Ward 34	All	17/10/2015	27/10/2015	11	18	2
Oak Ward	All	20/10/2015	02/11/2015	14	14	4
G1	Bay 2	21/10/2015	27/10/2015	7	7	4
Ward 26	All	23/10/2015	4/11/15	12	19	7
Ward 35	All	24/10/2015	30/10/2015	7	17	3
Ward 23	All	27/10/2015	Ongoing*		9	11
Ward 15	All	27/10/2015	Ongoing*		16	16
Ward 37	All	26/10/2015	03/11/2015	9	8	3

*at time of reporting

4. Patient Experience

Patient Experience Team

Following the arrival of the Lead for Patient Experience in June 2015, a review of the team structure has been undertaken into the new portfolio areas:

- Complaints & PALS
- Surveys, FFT and patient and public involvement
- Volunteering (transferred to the Patient Experience Team from HR from August 2015)

The patient experience team are currently challenged in terms of staffing both due to gaps and vacancies, sickness and staff movement. This presents risks in delivering the aspirations of the service and also management of complaints within agreed time-frames. Whilst mitigations of these risks have been put in place a discussion is planned at November Patient Experience Steering Group to prioritise key work-streams for a short period of time until new personnel are in post.

Complaints management function and delivery of this service will remain an absolute priority.

Team developments include:

- Deputy lead seconded to NHS England until April 2016; FFT project manager leaving at end of November 2015
- New part time (17 hrs. per week) patient experience project manager recruited (starts 17 November)
- Recruitment on-going to replace Band 3 complaints administrator (temp currently providing cover)
- Interviews for a substantive Band 6 Patient Experience Team leader held in November–now appointed to
- New volunteer administrator for York (0.5 WTE) started in post 2 November 2015.

Strategy & Implementation Plan

The Patient Experience strategy was launched at the Nursing and Midwifery conference on 21 September 2015 and a detailed implementation plan presented to Patient Experience Steering Group in September.

The immediate priorities are:

Maintain core business

Maintain core business during the period of staffing changes
Achieve full team staffing, resolving current HR issues

Service development

- Implement the newly procured, single contract from FFT and national patient surveys
- Review the Trust complaints handling process against national best practice, identify gaps and implement improvements
- Consult on, revise and obtain approval for a new complaints policy
- Migrate the Trust complaints and Patient Advice and Liaison Service onto the Datix Web information management system
- Develop a Patient Experience Team process for identifying themes and trends from all sources of patient experience feedback, including social media
- Review the Trust Patient Advice and Liaison Service, agree and implement a service development plan to achieve greater visibility, accessibility and integration with the Patient Experience Team
- Embed volunteering within the Patient Experience Team and complete outstanding applications, selection interviews and inductions.

Friends and Family Test & Knowing-How-We're-Doing-Boards

A new supplier, 'Patient Perspective' has been appointed from 1 November 2015. This supplier won the tender on the basis of their focus on tailored information for different staff groups which will support learning and improvement. The first two weeks of November will be a transition period between the new suppliers. Old cards are no longer in use and the new versions are being rolled out.

The Patient Experience Team will be targeting support at areas with low response rates and/or low % recommend rates. The recent introduction of text messaging has been introduced for ESA and Day Unit and has increased response rates for these areas.

63 Knowing-how-we're-doing-boards are displayed across the Trust, in inpatient, emergency department, outpatient, community inpatient and maternity areas. 31 were updated in Q1. 18 were updated in Q2. A concerted effort is being made in November to ensure that every area has an up to date board.

Volunteer/governor support has been agreed for key areas (including ED) once the new supplier's systems are established (from Mid-November)

National Maternity Survey 2015

We have recently received the results of the National Maternity Survey which was carried out by the Picker Institute on behalf of the organisation. The findings and recommendations are detailed in a separate paper to the committee. However, this information is embargoed until the CQC release the national results, this is expected in early December.

5. Safeguarding Adults Update

Care Act
The Trust has representation at NYCC, ERYC and CYC safeguarding adult's policy review groups. The aim of these groups is to develop a consistent approach to managing safeguarding concerns whilst "Making Safeguarding Personal"

Progress of these projects are reported to the relevant Safeguarding Adults Boards and internally to the Trust's own Safeguarding Adults Governance Group.

There has been some confusion over the role of the Lead Agencies (Local Authority) in expectations regarding investigating a safeguarding concern.

One Lead Agency appears to have a robust plan of approach and multi-agency. This is not consistent with another Lead agency the Trust support with the investigation of concerns. This has been raised and it is understand that clarity is to be gained at a senior level.

Deprivation of Liberty Safeguards (Cheshire West
The Law Commission produced a consultation paper on 7th July 2015 and organisations affected have been asked to comment. The proposed scheme from the Law Commission was presented to the Trust Safeguarding Adults Governance Group on 13th October.

The proposed scheme is called "Protective Care Arrangements" which outlines plans to allow acute hospitals to self-authorise for a period of 28 days. The scheme has implications for consultants responsible for the care of patients which may require authorisation under the deprivation of liberty safeguards. It suggests a specific care plan and full liaison with the patient, carers and family.

Implementation of this ruling is included in the Risk Register.

6. Recommendation

The Committee is asked to note the Chief Nurse report for November 2015.

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

E4

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

Safe Nurse and Midwifery Staffing Report

Action requested/recommendation

The Committee is asked to receive the exception report for information

Summary

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 seventeenth submission to NHS choices of actual against planned staffing data for day and night duty in hours and by ward.

A detailed breakdown for October 2015 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.

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 This report is only written for the Quality and

	Safety Committee
Risk	No 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	November 2015
Version number	Version 1

Board of Directors – 25 November 2015

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 seventeenth submission to NHS choices of actual against planned staffing data for day and night duty in hours and by ward.

A detailed breakdown for October 2015 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	95.2%	91.0%	119.4%	87.1%
Bridlington And District Hospital	89.8%	85.2%	73.9%	112.7%
Malton Community Hospital	83.9%	106.5%	100.0%	90.3%
Scarborough General Hospital	81.7%	109.2%	92.3%	108.8%
Selby And District War Memorial Hospital	107.1%	89.0%	51.6%	196.8%
St Helens Rehabilitation Hospital	97.6%	96.8%	138.7%	100.0%
Whitby Community Hospital	94.0%	94.4%	100.0%	100.0%
St Monica's Hospital	95.9%	97.4%	100.0%	97.8%
White Cross Rehabilitation Hospital	97.6%	98.1%	64.5%	90.3%
York Hospital	85.8%	100.0%	94.3%	109.1%

3. Exceptions

Enhanced Supervision

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

Scarborough	York	
Ann Wright	AMU	Ward 23
	Ward 33	Ward 34
	Ward 35	Ward 36
	Ward 37	

A review of enhanced supervision to ensure appropriate use is being progressed.

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 or vice versa. These wards were:

Bridlington	Scarborough	Community	York
Johnson	Ann Wright	Abbey	AMU
	Ash	Archways	Ward 25
	Beech	Fitzwilliam	Ward 26
	CCU	Selby	Ward 28
	Chestnut		Ward 29
	Holly		Ward 39
	Maple		
	Oak		
	Stroke		

Bed Occupancy

Kent, Lloyd and Waters 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. G2 and G3 share a healthcare assistant and during August, the healthcare assistant was predominantly on G2, which increased its staffing levels.

Ward 29 has also provided some support to other wards when their bed occupancy was low during the month.

Activity demands on some wards have resulted in the ESA in York remaining open some nights; resulting in increased actual staffing.

Vacancies, Sickness and Annual Leave

The Trust's ability to fill shifts due to sickness and vacancies reduce the average percentage staffing levels each month. The following wards have reported reduced actual staffing for these reasons:

Scarborough	Community	York
Ann Wright	Archways	AMU
Beech	Selby	ICU
CCU	St Helens	Ward 17

ICU	Whitecross Court	Ward 23
Lilac		Ward 25
Maple		Ward 28
Oak		Ward 35
Stroke		

Newly Qualified Nurses

Newly qualified nurses who were awaiting receipt of their NMC registration have been employed by the Trust as Healthcare assistants, working occasionally above the ward agreed levels. The majority of nurses are now in receipt of their registration and will be subsumed into RN staffing levels.

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

4. Vacancies by Site

On 5 August 2015, the Chief Nurse Team introduced a new monthly vacancy monitoring tool, which is completed by ward sisters/managers. The new reporting system is designed to ensure increased accuracy of reporting.

The ward sisters/managers reported their vacancies on 4th November 2015 for the adult in-patient areas as follows:

	Reported vacancies		**Vacancies filled pending start**		**Unfilled Vacancies**	
	RN	**HCA**	**RN**	**HCA**	**RN**	**HCA**
Bridlington	5.53	-0.20	0.00	0.00	5.53	-0.20
Community	15.98	4.14	2.60	2.00	13.38	2.14
Scarborough	38.15	-2.20	6.80	0.00	31.35	-2.20
York	93.92	32.82	18.65	11.68	75.27	21.14
Total	**153.58**	**34.26**	**28.05**	**13.68**	**125.53**	**20.88**

Since the end of October up to 12th November 2015, a 24 further registered nurses have been offered posts. Of these, 15 are from the current european recruitment campaign where candidates are, at this stage, expressing a preference for York Hospital and a further 9 from local recruitment. Of the 24, 3 are for Scarborough Hospital and 21 for York Hospital. Further local and European interviews are taking place at the end of November and during December.

There has been recent investment in additional nursing positions within Community which are included in the vacancy information above. These vacancies are currently being advertised with interviews taking place at the end of November.

The healthcare assistant vacancy position will reduce at the end November when further interviews take place.

This revised style of data collection for vacancies has further demonstrated the need to Reconciliation and alignment of the budgets with the ward establishments is progressing. This may result is an increased vacancy position as a result of budgetary changes.

5. Sickness, Bank and Agency Fill Rates

Sickness

The overall absence rate for the Trust for the month of September 2015 was 3.82**%.** By site, sickness within the Nursing and Midwifery workforce across the inpatient areas was, as follows:

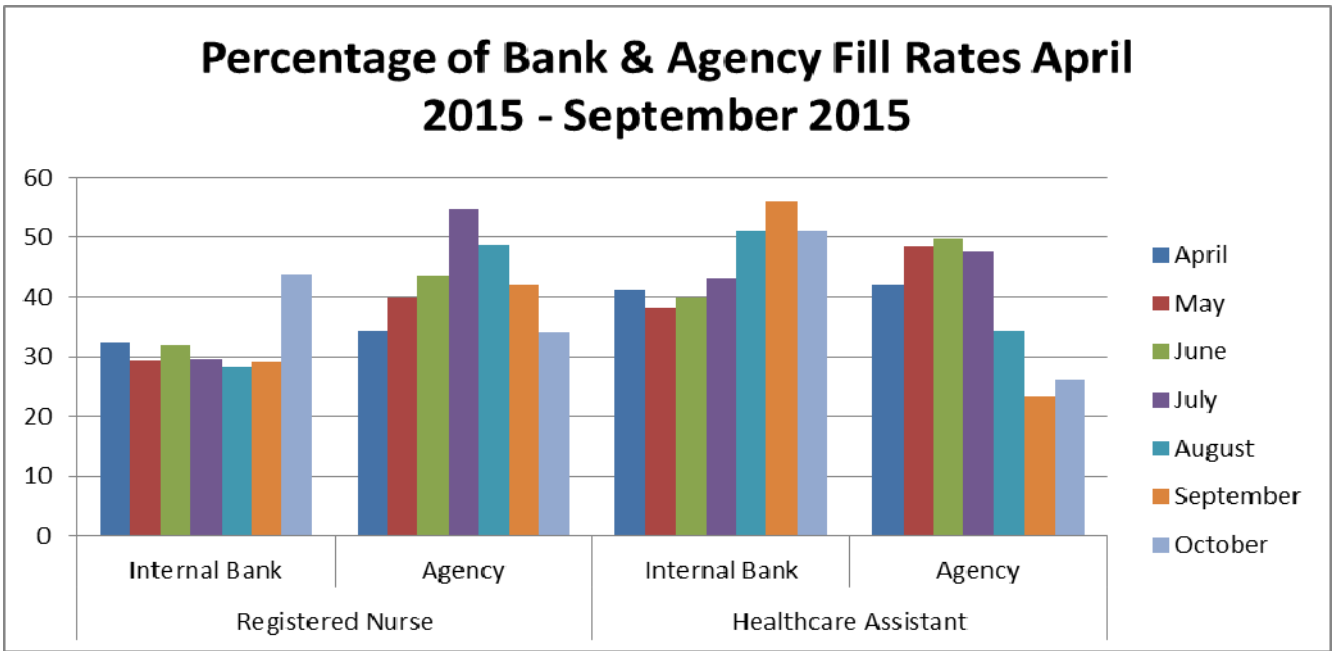
- York Acute Hospital – **3.43%**
- Scarborough Acute Hospital – **5.16%**
- Community Services – **3.11%**

Temporary Staffing

Overall fill rate of bank shifts requested through the internal bank was 47.15% an improvement of 8.66% from September 2015. The fill rate for qualified shifts was 43.74%, an increase of 14.6% on September whilst, the fill rate for unqualified shifts was 51.13%, a decrease of 4.89% due to an increase of shifts required and our ability to fill these due to the October half term period.

The percentage of shifts filled by agency reduced this month for both RN shifts and unqualified shifts with 30.40% of shifts being filled by external agency with a reduction of 4,346 hours on September 2015. This equated to 34.12% fill rate for registered nurses and 26.06% fill rate for unqualified shifts.

The chart below provides the data on agency filled shifts by registered and unregistered nurses since April 2015.



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	
Author	**Nichola Greenwood, Nursing Workforce Projects Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**November 2015**

Fill rate indicator return

Staffing: Nursing, midwifery and care staff

Org: RCB

Period: tober_2015-16

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

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

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

Comments

Validation alerts (see control panel)	Only complete sites your organisation is accountable for				Day				Night				Day		Night	
	Hospital Site Details		Main 2 Specialties on each ward		Registered		Care Staff		Registered		Care Staff					
	Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1116	840	930	1290	682	682	341	638	75.3%	138.7%	100.0%	187.1%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ash	100 - GENERAL SURGERY		1162.5	922.5	930	990	682	649	0	11	79.4%	106.5%	95.2%	-
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Beech	300 - GENERAL MEDICINE		1488	1314	1302	1338	1023	935	682	704	88.3%	102.8%	91.4%	103.2%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Cherry	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1860	1668	1488	1440	1705	1485	1364	1276	89.7%	96.8%	87.1%	93.5%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1488	1230	1116	1128	682	693	682	693	82.7%	101.1%	101.6%	101.6%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2557.5	1950	465	990	1364	1243	341	484	76.2%	212.9%	91.1%	141.9%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Duke of Kent	420 - PAEDIATRICS		1627.5	1410	465	555	682	682	341	330	86.6%	119.4%	100.0%	96.8%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Hawthorn	501 - OBSTETRICS		744	744	372	372	682	682	0	0	100.0%	100.0%	100.0%	-
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1116	948	1116	1188	682	682	682	682	84.9%	106.5%	100.0%	100.0%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE		2790	2160	465	255	1705	1485	0	0	77.4%	54.8%	87.1%	-
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Lilac	101 - UROLOGY	100 - GENERAL SURGERY	1860	1462.5	1860	1627.5	682	682	682	671	78.6%	87.5%	100.0%	98.4%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Maple	100 - GENERAL SURGERY		2325	1845	1162.5	1702.5	1364	1287	682	737	79.4%	146.5%	94.4%	108.1%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Oak	430 - GERIATRIC MEDICINE		1860	1392	1674	1794	1023	913	1023	1122	74.8%	107.2%	89.2%	109.7%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Stroke	430 - GERIATRIC MEDICINE		1116	996	744	720	1023	803	341	440	89.2%	96.8%	78.5%	129.0%
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Johnson	430 - GERIATRIC MEDICINE		930	876	1302	1308	682	660	341	385	94.2%	100.5%	96.8%	112.9%
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		1162.5	990	1395	817.5	682	374	0	242	85.2%	58.6%	54.8%	-
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Lloyd	100 - GENERAL SURGERY		660	652.5	330	315	187	132	187	33	98.9%	95.5%	70.6%	17.6%
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Waters	430 - GERIATRIC MEDICINE		930	787.5	930	930	682	484	341	319	84.7%	100.0%	71.0%	93.5%
	YORK HOSPITAL - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1512	1374	900	876	682	682	682	682	90.9%	97.3%	100.0%	100.0%
	YORK HOSPITAL - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1674	1416	1116	1068	1023	1001	583	572	84.6%	95.7%	97.8%	98.1%
	YORK HOSPITAL - RCB55	15	120 - ENT	101 - UROLOGY	1860	1597.5	1395	1380	1023	979	341	341	85.9%	98.9%	95.7%	100.0%
	YORK HOSPITAL - RCB55	16	100 - GENERAL SURGERY		2430	1980	1035	1267.5	1265	1243	583	583	81.5%	122.5%	98.3%	100.0%
	YORK HOSPITAL - RCB55	17	420 - PAEDIATRICS		1116	1074	744	540	1023	979	0	0	96.2%	72.6%	95.7%	-
	YORK HOSPITAL - RCB55	23	430 - GERIATRIC MEDICINE		1627.5	1545	1395	1522.5	682	671	1023	1034	94.9%	109.1%	98.4%	101.1%

Validation alerts (see control panel)	Only complete sites your organisation is accountable for				Day				Night				Day		Night	
	Hospital Site Details		Main 2 Specialties on each ward		Registered		Care Staff		Registered		Care Staff					
	Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
	YORK HOSPITAL - RCB55	25	430 - GERIATRIC MEDICINE		1488	1122	930	1074	682	682	1023	957	75.4%	115.5%	100.0%	93.5%
	YORK HOSPITAL - RCB55	26	430 - GERIATRIC MEDICINE		1627.5	1417.5	1395	1485	682	682	1023	957	87.1%	106.5%	100.0%	93.5%
	YORK HOSPITAL - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1674	1326	930	1080	682	682	682	671	79.2%	116.1%	100.0%	98.4%
	YORK HOSPITAL - RCB55	29	110 - TRAUMA & ORTHOPAEDICS		1488	954	744	582	682	616	341	352	64.1%	78.2%	90.3%	103.2%
	YORK HOSPITAL - RCB55	31	370 - MEDICAL ONCOLOGY		2092.5	2017.5	930	915	682	682	341	341	96.4%	98.4%	100.0%	100.0%
	YORK HOSPITAL - RCB55	32	320 - CARDIOLOGY		1518	1260	1116	1086	682	682	1023	958	83.0%	97.3%	100.0%	94.6%
	YORK HOSPITAL - RCB55	33	301 - GASTROENTEROLOGY	361 - NEPHROLOGY	1488	1290	1116	1134	682	682	1023	1067	86.7%	101.6%	100.0%	104.3%
	YORK HOSPITAL - RCB55	34	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1488	1284	1116	1176	682	671	1023	1221	86.3%	105.4%	98.4%	119.4%
	YORK HOSPITAL - RCB55	35	430 - GERIATRIC MEDICINE		1302	1098	1116	1188	682	682	1023	1034	84.3%	106.5%	100.0%	101.1%
	YORK HOSPITAL - RCB55	37	430 - GERIATRIC MEDICINE		1116	1086	1302	1392	682	682	682	924	97.3%	106.9%	100.0%	135.5%
	YORK HOSPITAL - RCB55	39	430 - GERIATRIC MEDICINE		1488	1194	930	960	682	660	341	715	80.2%	103.2%	96.8%	209.7%
	YORK HOSPITAL - RCB55	36 - Acute Stroke Unit	430 - GERIATRIC MEDICINE		1860	1590	930	1014	1364	1320	682	715	85.5%	109.0%	96.8%	104.8%
	YORK HOSPITAL - RCB55	Acute Medical Unit	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	4650	4027.5	3720	3472.5	2728	2398	2046	2420	86.6%	93.3%	87.9%	118.3%
	YORK HOSPITAL - RCB55	Coronary Care Unit	320 - CARDIOLOGY		1860	1582.5	330	300	1364	1254	0	0	85.1%	90.9%	91.9%	-
	YORK HOSPITAL - RCB55	Extended Stay Area	100 - GENERAL SURGERY	120 - ENT	990	945	495	502.5	374	418	0	132	95.5%	101.5%	111.8%	-
	YORK HOSPITAL - RCB55	G1	502 - GYNAECOLOGY		1488	1368	744	624	682	682	682	660	91.9%	83.9%	100.0%	96.8%
	YORK HOSPITAL - RCB55	G2	501 - OBSTETRICS		1116	1056	558	492	682	649	341	649	94.6%	88.2%	95.2%	190.3%
	YORK HOSPITAL - RCB55	G3	501 - OBSTETRICS		744	684	372	330	682	660	0	0	91.9%	88.7%	96.8%	-
	YORK HOSPITAL - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5580	4552.5	465	360	4092	3388	341	275	81.6%	77.4%	82.8%	80.6%
	WHITBY COMMUNITY HOSPITAL - RCBG1	Abbey	925 - COMMUNITY CARE SERVICES		697.5	705	1162.5	1162.5	341	341	341	341	101.1%	100.0%	100.0%	100.0%
	WHITBY COMMUNITY HOSPITAL - RCBG1	War Memorial	925 - COMMUNITY CARE SERVICES		930	855	1395	1327.5	341	341	682	660	91.9%	95.2%	100.0%	96.8%
	ARCHWAYS INTERMEDIATE CARE UNIT	Archways	925 - COMMUNITY CARE SERVICES		744	708	930	846	341	407	682	594	95.2%	91.0%	119.4%	87.1%
	MALTON COMMUNITY HOSPITAL - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		1162.5	975	1627.5	1732.5	682	682	682	616	83.9%	106.5%	100.0%	90.3%
	ELBY AND DISTRICT WAR MEMORIAL HOSPITAL - RCE	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1162.5	1245	1162.5	1035	682	352	341	671	107.1%	89.0%	51.6%	196.8%
	ST HELENS REHABILITATION HOSPITAL - RCBTV	St Helens	430 - GERIATRIC MEDICINE		930	907.5	1162.5	1125	341	473	341	341	97.6%	96.8%	138.7%	100.0%
	ST MONICAS HOSPITAL - RCB05	St Monicas	925 - COMMUNITY CARE SERVICES		630	592.5	810	765	341	341	341	341	94.0%	94.4%	100.0%	100.0%
	WHITE CROSS REHABILITATION HOSPITAL - RCBP9	Whitecross Court	430 - GERIATRIC MEDICINE		930	907.5	1162.5	1140	682	440	341	308	97.6%	96.1%	64.5%	90.3%
		Total			79257	67924.5	53283	53715	45133	41657	27610	29909				

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

Patient Falls Reduction – Quarterly update

Action requested/recommendation

The total number of patient falls incidents reported remains high across the Trust although it is recognised that the number of falls resulting in moderate or severe harm have reduced. The Trust achieved the target of 30% reduction in falls resulting in moderate or severe harm for 2014-2015 and aims to reduce this number by a further 20% during 2015 – 2016. Figures for April to September 2015 indicate that we are currently slightly above target. A continued focus on falls prevention and implementation of revised policies and processes is necessary.

Analysis of the patient falls SI investigations has identified that there has been an improvement in the re-assessment of patients every seven days. This has risen from 46% in Q1 to 83% in Q2, however, there remains a lack of understanding with the process of re-assessment of patients at risk of falls at the point of transfer and when a patient's condition changes.
A consistently high proportion of falls resulting in harm are occurring between 12:00am and 06:30am.

The following actions are recommended;

- Continue to support and promote the use of the risk assessment tool to ensure risk assessments lead to suitable interventions
- Promote the Lying and Standing Blood Pressure e-learning
- Ensure that patients and carers receive the information leaflets to aid understanding in minimising falls risk in hospital
- Develop robust processes to support the management of patients with cognitive impairment.

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. We are aiming to achieve a further 20% reduction in falls resulting in moderate or severe harm by 31st March 2016.

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 has been approved by the Organisational Falls Steering Group and Quality and Safety Committee prior to submission to the Board.
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse.
Author	Diane Palmer, Deputy Director of Patient Safety Darren Fletcher, Patient Safety Manager
Date of paper	November 2015
Version number	Version 1

Board of Directors – 25 November 2015

Patient Falls Reduction – Quarterly update

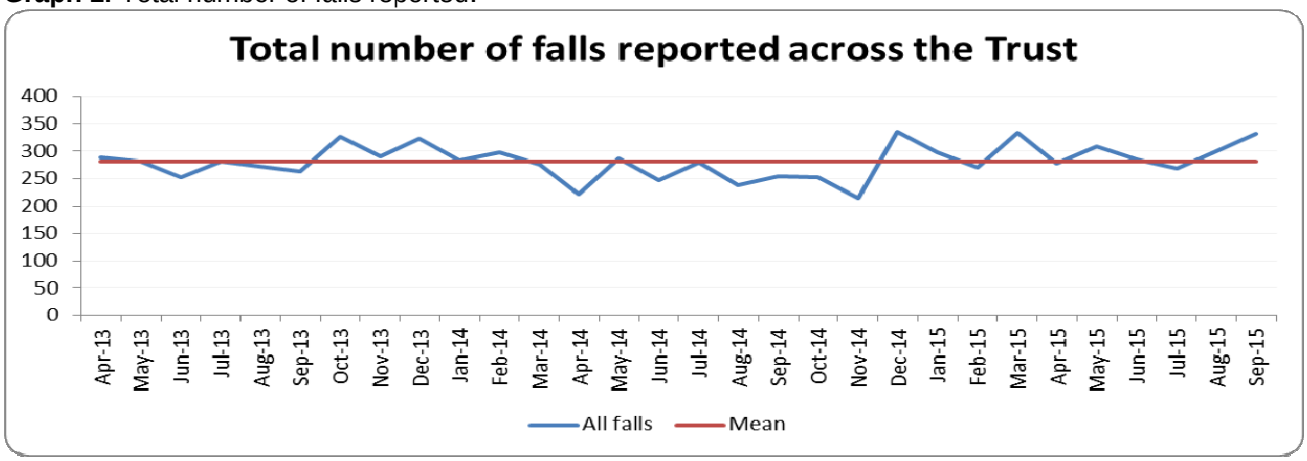
1. Introduction and background

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. We are aiming to achieve a further 20% reduction in falls resulting in moderate or severe harm by 31st March 2016.

2. Total number of fall incidents reported

During the 18 month period from April 2013 – September 2015, the Trust has reported a mean value of 281 falls per month as shown in Graph 1. An increase is noted from December 2014, which may be attributable to a combination of increased awareness resulting in increased reporting and increased pressures within the Trust.

Graph 1. Total number of falls reported.



The number of falls reported during Q2, 2015 – 2016 at York acute site are listed in Table 1 and indicates that there have been a similar number of falls reported when compared with Q1. An increase in falls resulting in severe harm (from 6 to 8) is noted and a decrease in the number of falls resulting in moderate harm (from 5 to 0), although a significant number of reports are awaiting validation and therefore data may change as these are processed.

Table 1. Total number of fall incidents reported at York Hospital site during Q2 2015 - 2016. Data source: Datix

Severity of incident	2015 Q1 Total	Q2 Jul - Sep 2015			Q2 Total
		Jul-15	Aug-15	Sep-15	
All Falls	460	142	146	176	464
No Harm	340	95	88	62	245
Low Harm	101	30	32	23	85
Moderate Harm	5	0	0	0	0
Severe Harm / Death	6	5	0	3	8
Uncoded	8	12	26	88	126

The number of falls reported during Q2, 2015 – 2016 at Scarborough acute site (including Bridlington Hospital) are listed in Table 2. A slight decrease in the number of falls reported when compared with Q1 is noted (257 to 229), the number of falls resulting in moderate harm has also decreased (6 to 3) as has the number of falls resulting in severe harm (5 to 2). A

significant number of reports are awaiting validation and therefore data may change slightly as these are processed.

Table 2. Total number of fall incidents reported at Scarborough acute site during Q2 2015 - 2016. Data source: Datix

Severity of incident	2015 Q1 Total	Q2 Jul - Sep 2015			Q2 Total
		Jul-15	Aug-15	Sep-15	
All Falls	257	62	77	90	229
No Harm	183	27	45	33	105
Low Harm	62	29	17	16	62
Moderate Harm	6	0	2	1	3
Severe Harm / Death	5	1	0	1	2
Uncoded	1	5	13	39	57

The number of falls reported during Q2, 2015 – 2016 at Community Hospitals is shown in Table 3. The total number of falls reported has increased compared with Q1 (136 to 191) whilst the number of falls that result in moderate or severe harm has reduced (3 to 2). Community Hospitals implemented a revised risk assessment and intervention process during 2014- 2015 with focused training sessions around falls prevention delivered to Nurses and Health Care Assistants, which may have contributed to the increased reporting and the continued reduction in harm resulting in serious incident.

Table 3. Total number of fall incidents reported at Community Hospitals during Q2 2015 - 2016. Data source: Datix

Severity of incident	2015 Q1 Total	Q2 Jul - Sep 2015			Q2 Total
		Jul-15	Aug-15	Sep-15	
All Falls	136	60	73	58	191
No Harm	81	27	47	11	85
Low Harm	42	18	5	1	24
Moderate Harm	1	0	1	0	1
Severe Harm / Death	2	0	1	0	1
Uncoded	10	15	19	46	80

3. Wards reporting 20 or more patient falls (July – September 2015)

At the time of reporting, 17 wards/areas have identified 20 or more patient falls during Q2 of 2015 - 2016. The number of falls for those 17 wards, and a summary breakdown by severity are illustrated in Table 4. The number reported during Q2 2014 – 2015 are also shown for comparison. Several wards which reported a high number of falls in 2014 - 2015 have continued to report high numbers in the same period of 2015 - 2016. AMU, Oak Ward, St Monica's, Ward 28 and Whitecross Court has shown a significant increase compared with the same period last year.

It must be noted that AMU has merged with SSW in June 2015 and therefore has a larger bed-base which will influence the overall number of falls reported for that area.

Oak Ward have consistently reported between 30 and 40 falls each quarter since Q3 of 2014 – 2015. The high number is not accounted for by individual patients who fall frequently.

Further analysis of the incidents at St Monica's indicates that there were four patients during this period that were recurrent fallers. One patient fell seven times, one patient fell three times and two patients fell twice.

Ward 28 reported recurrent fallers during this period. One patient was reported to have fallen four times, one patient fell three times and four patients fell twice.

Whitby Hospital have reported in excess of 20 falls per quarter since January 2015.

Reviewing the incidents for White Cross Court, it is apparent that one patient fell 21 times during this period whilst an inpatient at Whitecross Court. Two patients fell five times, four patients fell three times and two patients fell twice.

Table 4. Wards reporting 20 or more falls during Q2 2014 and 2015

Ward / Area	Number of falls reported during Q2 2014 – 2015	Number of falls reported during Q2 2015 - 2016
ASU	18	24
AMU / Ward 22	11	**48***
Ann Wright	26	22
Beech	21	31
Johnson	35	26
Oak	26	**40**
Selby	26	28
St Helens	16	20
St Monica's	6	**22**
Ward 23	29	44
Ward 26	33	40
Ward 28	11	**24**
Ward 35	40	39
Ward 37	50	53
Ward 39	22	43
Whitby	11	**21**
WXC	12	**55**

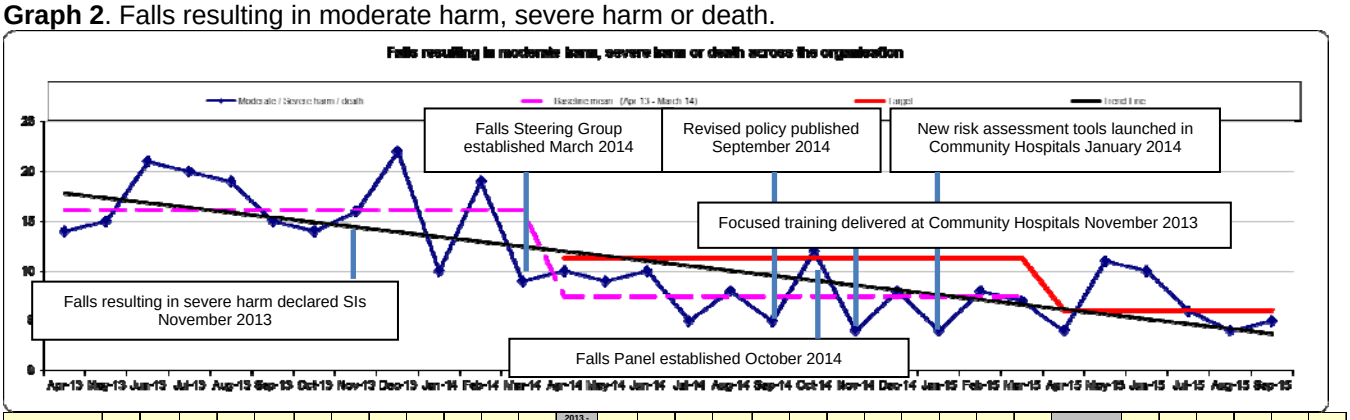
Note: AMU merged with SSW in June 2015 which will account for some of the increased reporting during Q2.

4. Falls resulting in 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 – September 2015. Validation and review of Datix incident reports has taken place during 2014 - 2015 and as a result, the level of harm may have been re-categorised. Whilst this would impact on the categorisation of falls resulting in harm, it is also recognised that a revision of the policy, improved assessment tools, learning from investigations and focused staff training may also have contributed to a reduction in harm.

The Trust is aiming for a further reduction in moderate or severe harm of 20% during 2015 – 2016. This translates to an average of six falls per month (18 per quarter) by March 2016. During Q1, we identified a total of 25 falls which have resulted in moderate harm, severe harm or death and 15 during Q2. Figures for Q2 may alter as incident investigations are completed, however although we are currently above target by seven cases, there has been a reduction (47 to 40) when compared with the same time period during 2014-15.

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



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013 - 2014 Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014 - 2015 Total	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Number of falls resulting in moderate harm, severe harm or death	14	15	21	20	19	15	14	16	22	10	19	9	194	10	9	10	5	8	5	12	4	8	4	8	7	Cumulative total to date: 90	4	11	10	6	4	5

15 incidents resulting in moderate or severe harm have been reported during Q2 2015-2016 from eleven areas. The wards reporting these incidents are shown in Table 5. Incident report numbers from Q1 of 2015 – 2016 are shown for comparison. Seven wards (York AMU, Ann Wright, Johnson, Oak Ward, Ward 26, Ward 39 and Whitby Hospital) listed in Table 5 are also noted to be in Table 4; Wards reporting 20 or more falls during Q2.

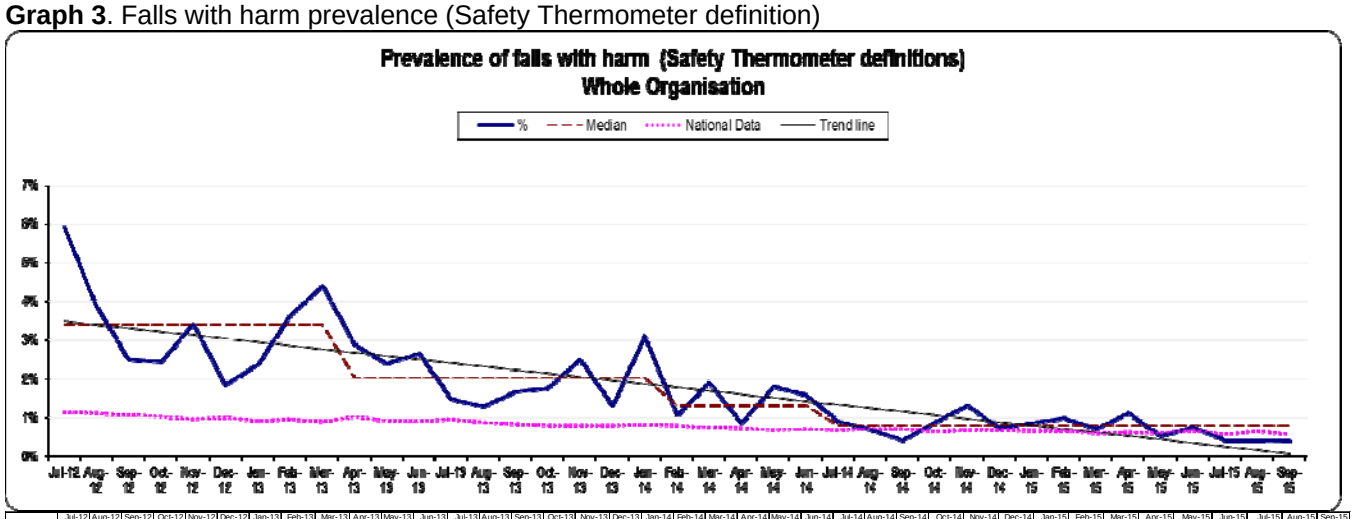
Table 5. Wards reporting falls that resulted in severe harm during Q2 2015 - 2016

		2015 – 2016 Q1	2015 – 2016 Q2
AMU (York)	Total Falls	35	48
	Moderate / Severe Harm	0	3
Ann Wright Ward	Total Falls	21	22
	Moderate / Severe Harm	0	1
Johnson Ward	Total Falls	24	26
	Moderate / Severe Harm	3	2
Lilac Ward	Total Falls	10	11
	Moderate / Severe Harm	0	1
Oak Ward	Total Falls	35	40
	Moderate / Severe Harm	1	1
Ward 25	Total Falls	9	14
	Moderate / Severe Harm	1	1
Ward 26	Total Falls	40	40
	Moderate / Severe Harm	2	1
Ward 33	Total Falls	11	9
	Moderate / Severe Harm	0	1
Ward 34	Total Falls	22	15
	Moderate / Severe Harm	0	1
Ward 39	Total Falls	20	43
	Moderate / Severe Harm	0	1
Whitby Hospital	Total Falls	24	21
	Moderate / Severe Harm	0	2

5. Falls Prevalence

Graph 3 shows the prevalence of falls with harm as identified through the Safety Thermometer surveys from July 2012 to September 2015. A reduction in the prevalence of falls is noted and has been sustained since July 2014. Our current position is below the national data point.

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



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Denominator	1473	1396	1396	1519	1493	1414	1477	1513	1500	1529	1416	1543	1413	1476	1440	1423	1442	1460	1520	1524	1462	1512	1506	1517	1448	1456	1452	1466	1603	1522	1625	1605	1527	1513	1556	1581	1468	1464	1542
Numerator	87	54	35	37	51	26	35	55	66	44	34	41	21	19	24	25	36	19	47	16	28	13	27	24	13	10	6	13	21	11	14	16	11	17	8	12	6	6	6
%	5.91%	3.87%	2.51%	2.44%	3.42%	1.84%	2.37%	3.64%	4.40%	2.88%	2.40%	2.66%	1.49%	1.29%	1.67%	1.76%	2.50%	1.30%	3.09%	1.05%	1.92%	0.86%	1.79%	1.58%	0.90%	0.69%	0.41%	0.89%	1.31%	0.72%	0.86%	1.00%	0.72%	1.12%	0.51%	0.76%	0.41%	0.41%	0.39%

6. Actions and Learning from SIs

A total of 22 SI investigation reports have been completed since the previous report in July 2015. Analysis of these incidents indicate that:

- 100% of patients had a falls risk assessment completed prior to the incident occurring
- 86% of patients had a falls risk assessment completed within 6 hours of admission
- 83% of patients had their falls risk reassessed every 7 days
- 50% of patients had a target COMFE (intentional rounding) frequency of 2 hours or more prior to the fall
- 82% of patients had a COMFE (intentional rounding) visit in the two hours preceding the fall
- 95% of patients had a bedrail assessment completed
- 18% of patients had bedrails in use that may have contributed to the fall
- 50% of patients had a fall going to or from the toilet
- 41% of falls occurred during the night (between midnight and 6.30am).

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

Table 6. List of possible contributory factors identified

	2014 - 2015			2015 - 2016	
	Q2	Q3	Q4	Q1	Q2
Confusion prior to fall incident	54%	62%	60%	46%	45%
Not wearing glasses if usually worn	43%	29%	45%	23%	4%
Evidence of sepsis	31%	25%	20%	23%	18%
Lying and standing blood pressure not measured	77%	67%	83%	85%	60%
Inaccurate risk assessments	15%	33%	30%	46%	27%
Patient not following advice (no cognitive impairment)	46%	60%	12%	23%	45%
Bed rails	8%	0	24%	15%	18%

Preventative measures that were noted on reviewing the investigation reports are shown in table 7.

Table 7. List of preventative measures

	2014 - 2015			2015 – 2016	
	Q2	Q3	Q4	Q1	Q2
Outcome of assessment discussed with patient / carer	64%	64%	65%	62%	75%
Bed at lowest level (unless receiving clinical care)	100%	90%	100%	80%	100%
Adequate footwear available	77%	92%	92%	100%	83%
Falls Patient Information Leaflet given to patient / carers	15%	8%	61%	62%	53%
Medication review undertaken where appropriate	88%	100%	96%	100%	100%
Nursed in an easily observable area when identified at high risk	63%	50%	74%	77%	63%
Falls risk sign placed above the head of the bed when identified high risk	43%	71%	60%	80%	86%

7. Summary of the patient falls investigation learning discussed at Falls Panel during Quarter 2

Although all patients had a falls risk assessment completed prior to the incident, in 10 cases inaccurate assessments or lack of re-assessments leading to lack of interventions may have contributed to the fall.

One patient identified as having postural hypotension and the inability to retain information was found on the floor at the side of his bed. The risk assessment was not reviewed when the patient was transferred to another ward and lying and standing blood pressure were not routinely monitored.

One patient at high risk of falls fell from a recliner chair at the Nurses station. This intervention was made so that the patient didn't disturb others in the bay and to allow nurses to observe the patient more readily, however investigation identified that the patient should have been moved into the high risk observation bay.

One patient fell in the visitor's toilet as the bay toilet was out of order. The brakes were not applied to the commode and the patient fell whilst using the commode for support. The call bell in the toilet did not alert ward staff despite being activated by the patient.

A patient identified as having low blood pressure on admission fell during the early hours whilst mobilising unassisted. Lying and standing blood pressure had not been measured.

One patient fell whilst standing from their bed using a drip stand for support. The drip stand moved causing the patient to lose balance and fall.

A patient with dementia fell whilst trying to get out of bed. Bed rails were in situ at the time.

Four incidents occurred where no lessons could be learned and were deemed to be unavoidable falls.

8. Community District Nursing

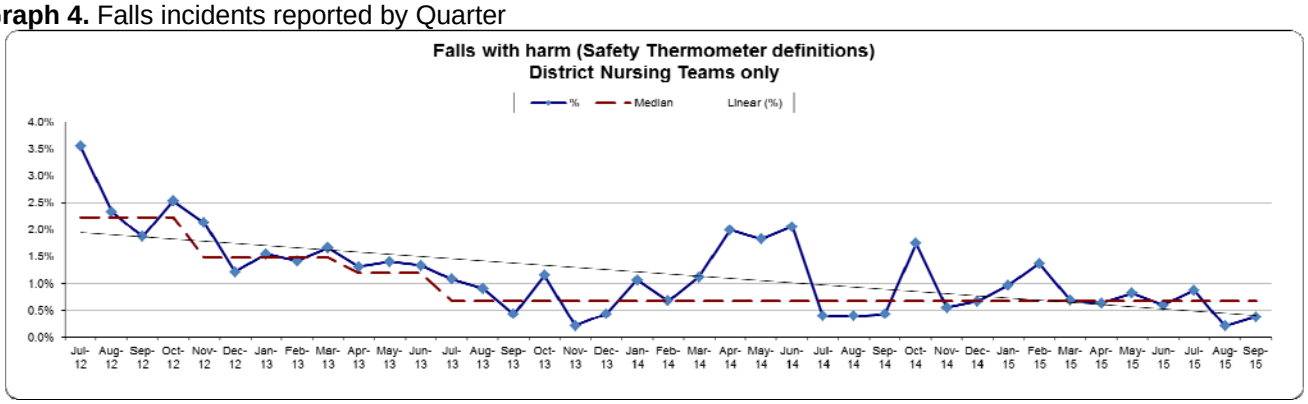
The total number of falls reported by Community District Nursing teams during Quarter 2 are listed in Table 8 and displayed by level of harm. Quarter 1 results are shown for comparison. The data indicates a slight reduction in the overall number of falls reported and that the none of the incidents resulted in serious injury.

Table 8. Falls reported by Community DN Teams

Severity of incident	2015 Q1 Total	Q2 Jul - Sep 2015			Q2 Total
		Jul-15	Aug-15	Sep-15	
All Falls	20	5	3	9	17
No Harm	14	1	2	3	6
Low Harm	4	3	0	1	4
Moderate Harm	0	0	0	0	0
Severe Harm / Death	0	0	0	0	0
Uncoded	2	1	1	5	7

The prevalence of falls as identified by Community District Nursing Teams using the Safety Thermometer survey is shown in Graph 4. The overall trend represents a significant decrease.

Graph 4. Falls incidents reported by Quarter



9. Conclusions / Recommendations

The total number of patient falls incidents reported remains high across the Trust although it is recognised that the number of falls resulting in moderate or severe harm have reduced. The Trust achieved the target of 30% reduction in falls resulting in moderate or severe harm for 2014-2015 and aims to reduce this number by a further 20% during 2015 – 2016. Figures for April to September 2015 indicate that we are currently slightly above target. A continued focus on falls prevention and implementation of revised policies and processes is necessary.

Analysis of the patient falls SI investigations has identified that there has been an improvement in the re-assessment of patients every seven days. This has risen from 46% in Q1 to 83% in Q2, however, there remains a lack of understanding with the process of re-assessment of patients at risk of falls at the point of transfer and when a patient's condition changes.
A consistently high proportion of falls resulting in harm are occurring between 12:00am and 06:30am.

The following actions are recommended;

- Continue to support and promote the use of the risk assessment tool to ensure risk assessments lead to suitable interventions
- Promote the Lying and Standing Blood Pressure e-learning
- Ensure that patients and carers receive the information leaflets to aid understanding in minimising falls risk in hospital
- Develop robust processes to support the management of patients with cognitive impairment.

10. References and further reading

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

Author	**Diane Palmer, Deputy Director for Patient Safety** **Darren Fletcher, Patient Safety Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**November 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

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 remain an area of focus
- Continued training in pressure ulcer prevention through accurate use of tools, including the Waterlow assessment and the COMFE tool should continue with focus on those wards reporting the highest incidence of pressure ulcer development
- The information required at handover should be clarified
- The process for referral to a TVN when a Category 3 or 4 ulcer has been identified should be clarified
- The process for recording skin assessment and pressure ulcer treatment should be revised and then clearly communicated to relevant staff
- Provision of equipment should be reviewed
- Recognition that a patient has a right to decide whether or not to accept advice and treatment.

Summary

Reduction in the development of pressure ulcers remains a priority for the Trust. We aim to reduce the incidence of Category 3 and 4 pressure ulcers, which are develop or deteriorate in our care by 20%, during 2015-16.

This report provides an update on the number 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 2.

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 has been revised following presentation at the Falls 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
Date of paper	18 November, 2015
Version number	Version 2

Board of Directors – 25 November 2015

Pressure ulcer reduction – Quarterly update

1. Background

Reduction in the development of pressure ulcers remains a priority for the Trust. We aim to reduce the incidence of Category 3 and 4 pressure ulcers, which are developed or deteriorated in our care by 20%, during 2015/16.

This report provides an update on the number 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 2.

2. Total number of pressure ulcers reported

The total number of pressure ulcers reported in the Trust during Quarter 2 was 171. This represents a slight decrease when compared with the previous 3 reporting time periods.

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

	Q1 (14/15)	Q2 (14/15)	Q3 (14/15)	Q4 (14/15)	Q1 (15/16)	Q2 (15/16)
Cat 2	152	90	122	135	121	118
Cat 3	43	17	24	14	21	9
Cat 4	2	0	2	2	2	2
Unstageable	33	31	62	51	40	42
Total	230	138	210	202	184	171

The Trust has agreed a priority target to reduce Category 3 and 4 pressure ulcers by 20% during 2015/16. No more than 21 cases per quarter are required to achieve the target reduction. In Quarter 1 23 cases were reported, in Quarter 2 11 cases have been reported, which means that we are currently achieving the reduction target, although figures for Quarter 2 may alter as more investigations are completed.

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

The number of pressure ulcers reported in Quarter 2 by hospital sites, are displayed in Table 2, with Quarter 1 data included for comparison. Comparing Quarter 1 with Quarter 2, York acute site reported fewer ulcers overall in Quarter 2, but both Scarborough and Community Hospitals reported a small overall increase in ulcers which had developed or deteriorated.

The number of unstageable ulcers has increased across all sites. Intensive work is now being done to address issues with categorisation of unstageable ulcers so this may reduce in future reports. A plan with new processes is being developed to reduce the number of unstageable pressure ulcers.

Category 4 ulcers remain low with none reported in Community Hospitals. The number of Category 3 ulcers reported in York Hospital and Community Hospitals has reduced in Quarter 2 when compared with Quarter 1. The number at Scarborough Hospital remains the same.

Table 2. Total number of pressure ulcers reported by site during Q1 and Q2, 2015/2016. Data source: Datix

	York Acute		*Scarborough Acute*		*Community Hospitals*	
	Q1	*Q2*	*Q1*	*Q2*	*Q1*	*Q2*
Cat 2	*35*	*30*	*35*	*32*	*14*	*15*
Cat 3	*4*	*0*	*4*	*4*	*2*	*0*
Cat 4	*1*	*1*	*0*	*1*	*0*	*0*
Unstageable	*5*	*7*	*7*	*13*	*1*	*4*
Total	*45*	*38*	*46*	*50*	*17*	*19*

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

The number of pressure ulcers reported in Community Care during Quarter 2 are displayed in Table 3, with Quarter 1 data included for comparison. This shows an overall reduction in the total number of pressure ulcers developed or deteriorated in our care, and a significant reduction in both Category 3 and unstageable ulcers, with no Category 4 ulcers identified. The rise in Category 2 ulcers may signify ulcers being reported earlier, or that deterioration is being prevented.

Table 3. Total number of pressure ulcers reported in community during Q1 and Q2, 2015/2016. Data source: Datix

Community Care		
	Q1	Q2
Cat 2	37	41
Cat 3	11	5
Cat 4	1	0
Unstageable	27	18
Total	76	64

5. Wards reporting five or more pressure ulcers in Quarter 2, 2015/2016 (developed or deteriorated in our care)

At the time of reporting, seven wards reported five or more ulcers during Quarter 2. The wards differ slightly from the last quarter's report (Fitzwilliam Ward, Johnson Ward and Oak Ward continue to report five or more ulcers). These pressure ulcers were all newly developed or deteriorated whilst in our care. Details for these areas are split into monthly figures and totals across Quarter 2, additionally they are compared with Quarter 1 (Table 4).

Table 4. Wards reporting five or more pressure ulcers in Quarter 2 2015/2016

		Q1	Jul-15	Aug-15	Sep-15	Q2 Total
Ann Wright	Category 2	2	0	2	2	4
	Category 3	0	1	0	0	1
	Category 4	0	0	0	0	0
	Unstageable	1	1	0	1	2
	Total	3	2	2	3	7

		Q1	Jul-15	Aug-15	Sep-15	Q2 Total
Beech	Category 2	1	0	0	4	4
	Category 3	0	0	1	0	1
	Category 4	0	0	0	0	0
	Unstageable	0	3	0	0	3
	Total	1	3	1	4	8

		Q1	Jul-15	Aug-15	Sep-15	Q2 Total
Johnson	Category 2	6	1	3	1	5
	Category 3	0	0	0	0	0
	Category 4	0	0	0	1	1
	Unstageable	0	0	1	0	1
	Total	6	1	4	2	7

		Q1	Jul-15	Aug-15	Sep-15	Q2 Total
Malton	Category 2	6	2	4	0	6
	Category 3	0	0	0	0	0
	Category 4	0	0	0	0	0
	Unstageable	0	0	0	1	1
	Total	6	2	4	1	7

		Q1	Jul-15	Aug-15	Sep-15	Q2 Total
Oak	Category 2	4	1	3	2	6
	Category 3	1	0	1	1	2
	Category 4	0	0	0	0	0
	Unstageable	2	3	0	0	3
	Total	7	4	4	3	11

		Q1	Jul-15	Aug-15	Sep-15	Q2 Total
Ward 31	Category 2	1	2	2	1	5
	Category 3	0	0	0	0	0
	Category 4	0	0	0	0	0
	Unstageable	0	0	0	0	0
	Total	1	2	2	1	5

		Q1	Jul-15	Aug-15	Sep-15	Q2 Total
Whitby	Category 2	2	1	3	1	5
	Category 3	0	0	0	0	0
	Category 4	0	0	0	0	0
	Unstageable	0	0	0	0	0
	Total	2	1	3	1	5

6. Safety Thermometer Pressure Ulcer Prevalence Report

The charts below illustrate the pressure ulcer prevalence in accordance with the Safety Thermometer definition. Chart 1 shows the percentage of patients with pressure ulcers (old and new), across the whole organisation. There is a general reduction in harm, and the Trust prevalence of ulcers (median 4%) is below national data figures (median 5%).

Chart 1.

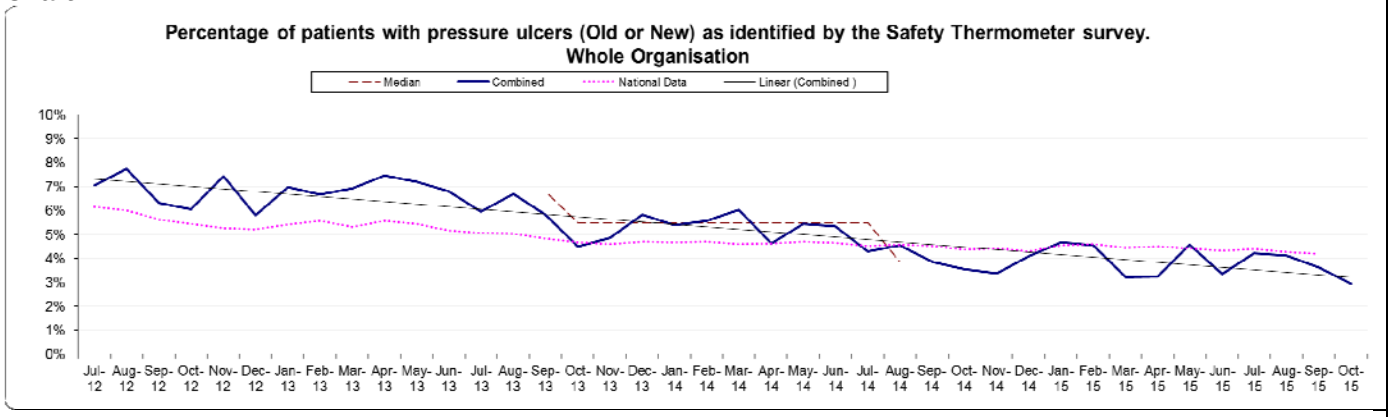


Chart 2 shows that, for acute sites within the Trust, median results have remained static at around 3.5% since August 2014, and prevalence on a steep downward trend since July 2012.

Chart 2.

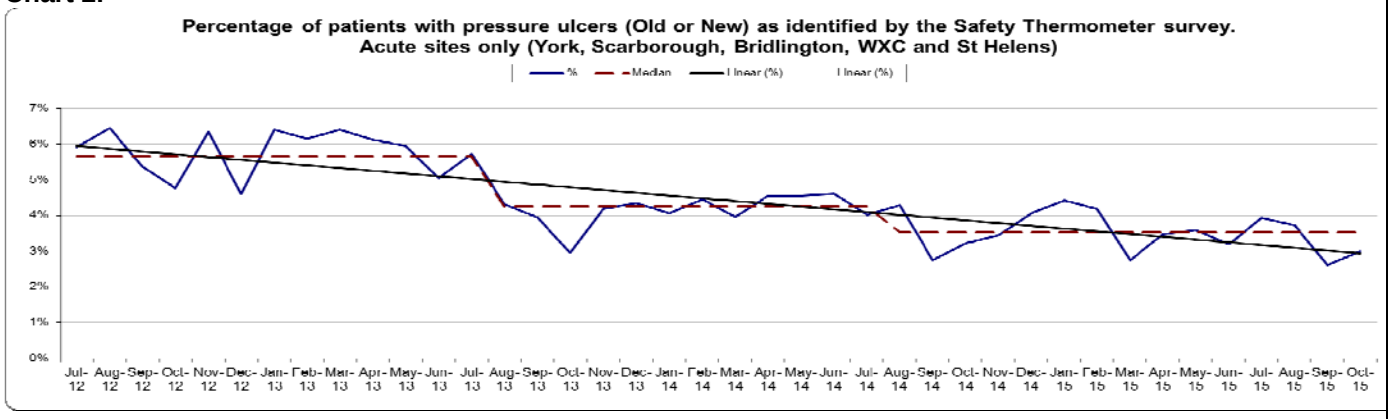


Chart 3 illustrates that, in community hospitals, there is an overall reduction in the median (around 6% instead of 10%) since last year's figures. There is a downward trend since last year.

Chart 3.

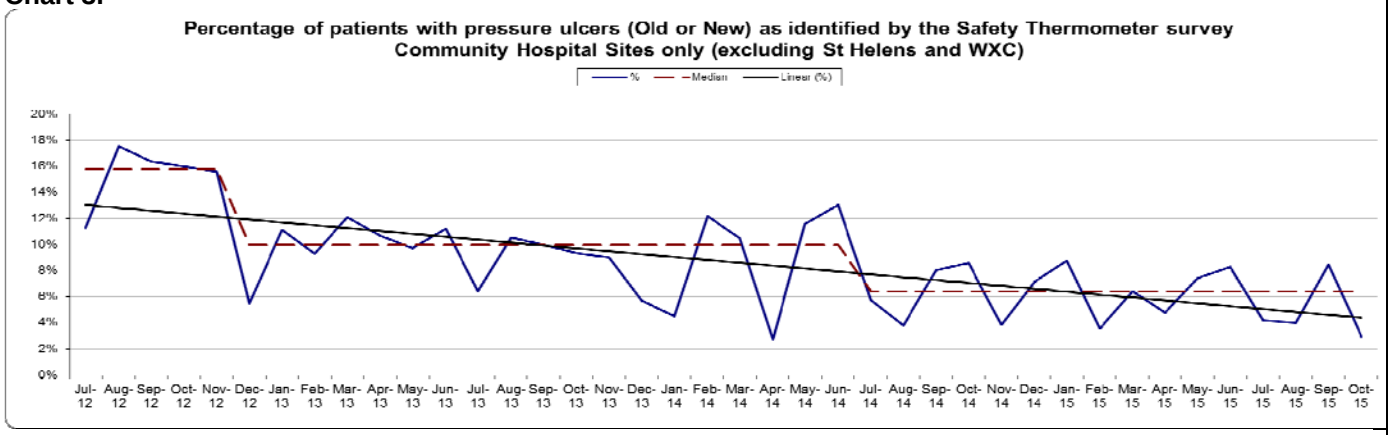
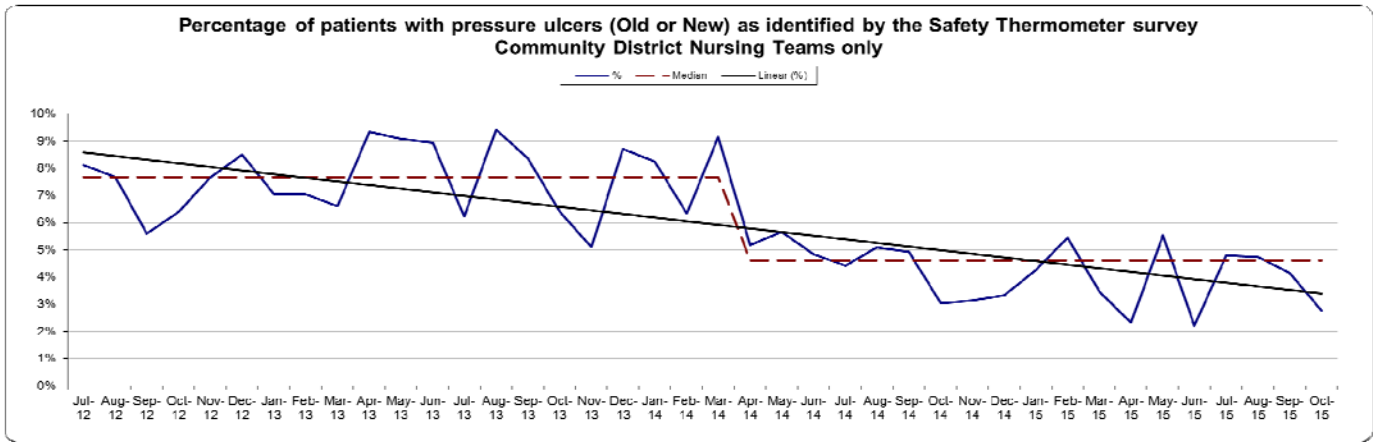


Chart 4 shows that, for Community Care (district nursing teams), pressure ulcer prevalence remains lower than in previous years (around a 5% median) and has continued to reduce overall.

Chart 4.



7. Actions and learning from SIs.

A total of 13 SI investigation reports have been completed in the Q2 2015/16 reporting period. Of the 13 reports, one related to a Category 4 pressure ulcer, with the remainder all being Category 3 pressure ulcers.

Analysis of these reports shows that;

- 69% of the incidents relate to the deterioration of a previously known pressure ulcer
- 54% of the incidents had a risk assessment completed as per policy
- 69% of the incidents had the risk assessment reviewed as per policy
- 46% of the incidents were not initially assessed correctly
- 30% of the incidents were not reassessed correctly
- 38% of the investigations identified issues with pressure relieving equipment
- 38% of the investigations identified issues with staff competence.

A review of the completed investigation reports highlights the possible contributory factors which are shown in Table 5.

Table 5. List of possible contributory factors identified

Non-concordance	46%
Poor communication between clinical teams	61%
Disease progression	100%
Choice of dressing	10%
Inaccurate assessments	54%
Equipment problems	38%
Staff knowledge	54%
Poor documentation	30%
Lack of referral to Tissue Viability Nurse	23%

Summary of learning
In six cases the patients the patients had difficulty following or remembering advice about pressure relief given to them by healthcare professionals.

For three patients, staff did not refer promptly to the TVN when a Datix report had been completed. There was an assumption that the Datix report would result in a review without referral being made.

One patient was not given a cushion for use when sitting out of bed, despite needing an air mattress for pressure relief whilst in bed.

One patient developed elbow pressure damage from resting his arms on the wooden arms of the chair.

Waterlow risk assessments were not always completed accurately.

There were issues raised around poor communication which was mainly due to lack of structured written and verbal handovers by clinical teams.

Two cases reported the need for a tissue viability link nurse, to facilitate communication and education.

8. Conclusions and recommendations

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

- The overall number of pressure ulcers reported has decreased slightly
- The number of Category 3 and 4 pressure ulcers reported overall is reducing
- The number of reported unstageable ulcers is high
- Seven wards have reported five or more pressure ulcers which have developed or deteriorated in our care in the last three months
- The prevalence of pressure ulcers remains below the national data point
- Accuracy of risk assessment for patients at risk of developing pressure ulcers requires further education and evaluation
- Communication and referral processes between staff groups need to be improved
- Recording of pressure ulcer assessment and treatment needs to improve
- Provision and access to equipment may be contributing to development of pressure ulcers
- Lack of concordance may be influencing the development of pressure ulcers.

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

- Reducing the overall incidence of unstageable pressure ulcers should be an area of focus
- Continued training in pressure ulcer prevention through accurate use of tools, including the Waterlow assessment and the COMFE tool should continue with focus on those wards reporting the highest incidence of pressure ulcer development
- The information required at handover should be clarified
- The process for referral to a TVN when a Category 3 or 4 ulcer has been identified should be audited
- The process for recording skin assessment and pressure ulcer treatment should be revised and then clearly communicated to relevant staff
- Provision of equipment should be reviewed
- Recognition that a patient has a right to decide whether or not to accept advice and treatment. Work to be undertaken to understand what care staff need to help them manage patients who are finding it difficult to comply with or 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	**18 November 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

Head of Midwifery Annual Report of Maternity Services

Action requested/recommendation

The Board is asked to accept this report as an annual summary of the maternity services activity 2014/15.

Summary

This report summarises the significant amount of work undertaken by Maternity services during the last year. Achievements and challenges have been recognised within the report with plans outlined to continue to provide a safe quality service whilst continually improving and developing in line with local, regional and national priorities.

The executive summary is in line with the Nursing and Midwifery Strategy evidencing:

Patient experience
Service user involvement is valued with engagement taking place in the Maternity Services Liaison Committee, midwifery led unit, parent education, bereavement suite planning and family and friends feedback. Plans are to increase and improve this over the next year.

The Midwifery Led Unit has reopened with reviewed guidance to allow access to a wider range of women.

Delivering high quality patient care
There has been a significant amount of work carried out during a review of the service with development of actions to reduce risks in the future. The Kirkup report was considered as part of the action planning following the review.

Reducing stillbirths is a national, regional and local priority. Work is being undertaken with the Strategic Clinical Network to achieve this.

Two public health issues have been prioritised this year and for the coming year to work towards reducing smoking in pregnancy and increase breastfeeding rates.

Measuring high quality patient care
The development of a regional maternity dashboard will enable to service to benchmark themselves against other Trusts in the Yorkshire and Humber region.

Data collection and quality remains a challenge for the service to submit

screening KPIs and ensure accurate data, particularly around smoking and breast feeding.

Safe staffing requirements and levels have been assessed with an annual review of the midwifery staffing strategy and business cases submitted from this work.

Staff experience
The service recognises the greater amount of mandatory training requirement in maternity. This has increased with more safeguarding training and supervision requirements and the number of part time staff (55%) requiring the same amount of training days as full time staff.

The NMC removal of statutory supervision of midwives is a concern to the directorate as the Supervisors provide a lot of support to midwives in practice.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

CQC outcomes 1, 4, 6, 13, 16, 17, 21

Progress of report	Quality and Safety Committee Board of Directors
Risk	No risk
Resource implications	No resources implications

Owner	Beverley Geary. Chief Nurse
Author	Elizabeth Ross. Head of Midwifery
Date of paper	November 2015
Version number	2

Board of Directors – 25 November 2015

Head of Midwifery Annual Report of Maternity Services

1. Introduction and background

Careful planning of Maternity service is required to deliver safe, high quality care for women to have a positive experience with a high level of satisfaction. We aim to make service improvements, provide choice of birthplace, as close to home as is safe and sustainable to do so, to promote healthy lifestyles, confident parenting and have a highly trained workforce to deliver high quality, safe and effective services.

The Maternity service undertakes 5900 bookings and 4900 births per year across community and two main Hospital sites in York and Scarborough. It covers antenatal, intrapartum and postnatal care, including antenatal and newborn screening, community midwives, homebirths and antenatal education.

There has been no increase in this activity in recent years.

2. A summary of care provided by Maternity service in 2014/15

The following is a summary of the service provided;

2.1 Midwifery workforce strategy

An annual review has been undertaken of the three year Midwifery workforce strategy 13/15.

The review was undertaken to ensure the strategy for developing the midwifery workforce remains relevant and takes into consideration any changes to national and local provision.

Overall Trust wide midwife staffing ratios are within the national recommendations of 1 Midwife per 29.5 births for Hospital and Midwifery Led Units.

The current midwife to birth ratio is 1:28.7 births across site, however there are differences on each site; York 1: 31.9 (below recommendations) Scarborough 1: 23.2 (above)

A third of midwives are over the age of 50 years (this was previously higher). We have seen a change this year with more midwives under 50 than before.

Age under 50 years	Age over 50 years	Full time	Part time
66%	34%	45%	55%

There are a number of staff in senior positions due to retire in the next 2 years, succession planning is in place with a new band 6 to 7 development programme introduced in maternity.

Training requirements for midwives working part time are the same for midwives working full time hours. This has a significant impact on resources as 55% of midwives work part time. The annual review has taken into consideration recommendations from a serious case

review, CQC standards and recent publications (Working together to safeguard children March 2015 and Intercollegiate document, Safeguarding children and young people; roles and competencies for health care staff March 2014).

The recommendations are for an additional antenatal visit for all women who are assessed as high risk in line with safeguarding processes and an increase in safeguarding children training and supervision. This impacts directly on the midwifery staffing resource.

Birthrate plus launched a new national intrapartum acuity tool. We commenced using this in November 2014. Acuity and staff available are measured in real time (every 4 hours) on each Labour Ward to inform if staffing levels are appropriate to deliver the care required and recommended from national documents and professional bodies.

The reports generated from the birthrate plus acuity tool indicate a need to increase the staffing resource on York Labour Ward.

NICE published 'safe midwifery staffing for maternity settings' in February 2015. This is being considered with further guidance expected from NICE on how to apply the guidance this year. Maternity 'red flag' events are also being considered for use by maternity as recommended in this document.

Year 2/3 changes made from the workforce strategy have included cross site posts:

- Diabetes specialist midwife
- Community midwifery manager
- Maternity risk manager

Business cases submitted have been to:

- increase maternity triage
- increase midwifery staffing on Labour Ward at York site (following results from the birth rate plus acuity reports)
- have a HCA role on Scarborough site postnatal ward overnight
- have a Band 3 Maternity support worker on York site postnatal ward
- increase antenatal day unit staff to incorporate triage at Scarborough site
- have a review of Labour Ward theatre staffing on York site

A review of 1st assistant role in theatre on Scarborough site has taken place following concerns regarding training and competence. The role was reviewed using the 'Calderdale framework' which identified the role should be a registrant (it has previously and is still currently undertaken by band 3 unqualified clinical support workers). Due to changes in the medical staffing establishments the role is now undertaken by junior doctor 4 nights a week (Monday-Thursday). A business case to develop an appropriate role for the additional 3 nights a week is being discussed at executive PMM's.

Band 7 Team Leaders have been reduced in Community following a restructure with a plan to increase Maternity support worker roles in Community to support the midwives role and caseload size (which is currently 1:110, above recommended size of 1:96)
Development and training has been reviewed and 4 Health Care Assistants have been supported to undertake Maternity support work programme at Leeds University.

Aspirational roles that the service have considered are:

- Consultant midwife (recommended Safer childbirth 2007)
- Perinatal mental health midwife (NICE recommendation)
- Bereavement midwife (SANDS and RCM)

- Public health midwife and substance misuse midwife (NICE)

Risks and plans to mitigate risks:

- **Midwifery staff ratios on York site do not meet national recognised standards.** (commented on in CQC report and evidenced in Birth-rate plus reports)

The Midwifery workforce strategy details plans towards meeting these standards.

Maternity support workers have commenced in Community teams to support the midwives role and free up some of their capacity.

Staffing and acuity is monitored in real time on Labour Ward every 4 hours.

Midwife on call rota commenced to support Labour Ward at time of high acuity (Sept 15)

- **Age profile. 34% midwives over 50 with a number in senior positions due to retire in next 2 years**.

Recruitment of newly qualified staff continues with the age profile improving from previous years. Succession planning is in place with a newly developed Band 6 to 7 development programme commenced across site.

- **Increased mandatory training requirement in Maternity** (including increased safeguarding children training and supervision). High number of part time workers (55%) requiring same amount of training days. Unable to meet all safeguarding training and supervision requirements without extra resource.

Identified as a risk in workforce strategy and directorate risk register and detailed in business case to implement workforce strategy.

- **Appropriate staffing of Maternity theatre at Scarborough (commented on in CQC report).** Require registrant for 1st assistant role 3 night per week.

This role is currently undertaken by Band 3 role and junior medical staff. Requirement identified for a registrant to undertake this role. Business case submitted to gain support for this.

- **Limited specialist roles following national recommendations** (commented on in CQC report). No consultant midwives, perinatal mental health, substance misuse.

These are part of the midwifery workforce strategy as aspirational roles at present.

2.2 Medical staffing

Work continues making progress towards a fully integrated service. The medical staff are managed by a clinical director, covering both sites with a deputy clinical director on each site.

Integration of senior medical staff is being helped by sessions being undertaken by some consultants on the opposite site. Both areas now have resident consultants to cover some nights, to allow more senior decision making out of hours and less reliance on registrar grade doctors. Nationally, there are now fewer registrars which is recognised as causing challenges both nationally and regionally.

Risks and plans to mitigate risks

- Fewer registrars leaving gaps in rota.

Agency used frequently to fill the gaps at a high cost to the Directorate.

2.3 Staff experience

Staff survey

In September 2014, a sample of staff were invited to take part in the 12th annual national NHS Staff Survey with a response rate of 35.38% for O&G

An action plan was developed from this and staff advocate meetings commenced with a view to improve communication and gain feedback from staff through a named advocate.

Staff involvement

A listening exercise took place on Scarborough site as part of the maternity service review. A similar exercise facilitated by ODIL is planned on York site this year.

Examples of actions from staff feedback and work to improve communication are:

- O&G 'Newsflash' (a quarterly update from the directorate management team)
- a letter outlining expectations of professional behaviour from Head of Midwifery and Clinical Director (with staff encouraged to report poor behaviour)
- Positive patient and colleague feedback comments e-mailed to staff
- Staff nominated for star awards.
- Ward G3 meetings aimed at improving communication, developing a sense of ward identity and increasing staff positivity and motivation.
- A support network for new starters and newly qualified midwives which includes a closed Facebook group to share resources and articles and face-to-face meetings.
- Named preceptor for all new starters, review of the preceptorship pack and a 'buddy' is now assigned to each newly qualified midwife as someone to talk to about non-clinical issues and provide an extra level of support and regular meetings with the Head of Midwifery

This was commenced by two junior midwives (these midwives have been nominated for a Trust star award and a regional NHS leadership award)

The same two midwives have commenced regular positive feedback for colleagues shared via e-mail with the aim to improve staff morale. The feedback is sent to them from colleagues and then shared with staff.

Development of staff:

Following attendance at 'It's My Ward' leadership programme examples of staff projects are; improving care for women in the latent phase of labour in order to improve patient experience and support safety. Patient information available on the Trust website.

External training and development accessed includes Neonatal Life support, Advanced Life Support in Obstetrics and Preparation of Supervisors of Midwives course.

Risks and plans to mitigate risks

- **Staff wanting improved communication**

Achievement: New initiatives outlined above in response to staff survey results to aim to improve communication

- **High number of senior midwives due to retire over next 2 years.**

Succession planning and staff development opportunities accessed.

2.4 Risk Management

Scarborough Maternity service review

During a period of 12 months in 2014 there were 9 significant incidents relating to Maternity Services at Scarborough Hospital.

An extraordinary Quality and Safety Performance Improvement meeting was called by the Medical Director and Chief Nurse and attended by the directorate management team. A comprehensive internal review of all maternity services delivered from Scarborough Hospital with involvement of an external Obstetrician and Midwife was agreed.

The external Consultant Obstetrician and external Head of Midwifery completed a report with the directorate management team completing an internal report.

Both reports outlined areas of concern and included a comprehensive list of recommendations. Both reports with action plan has been to Trust Board.

The Kirkup report into failings at Morecambe Bay Hospitals was published in March 2015. The Head of Midwifery undertook a review of this report and included recommendations from it in the above service action plan.

It is recognised that many staff gave their time to talk to the external reviewers and we have thanked them for their positive contributions to this process. Their feedback is recognised as an integral part of the external report and provided us with a detailed and honest picture of some of the concerns they have.

We appreciate that being party to a review can cause anxiety for staff and therefore we committed to holding sessions following the review for staff to feedback on the action plan, contribute ideas and to ask any questions about the process and outcomes.

We plan to commence a similar review at York site in November 2015 and review and update the Scarborough review in spring 2016.

Maternity dashboard has been reviewed in light of development of a regional Yorkshire and Humber dashboard lead by the Strategic Clinical Network. The new style dashboard will be commenced later this year and will enable York to benchmark regionally.

Maternity 'Risk matrix' has been developed to log all risks including serious incidents, claims and complaints, recommendations, actions and updates from these.
This is being supported by the risk and legal department.

Claims look back was undertaken in October 2014 to identify themes from historical claims. Working groups were developed from this to look at each theme and develop action plans to reduce future risks. This includes reducing risks from CTG interpretation, recognition of small babies and WHO theatre checklist.

Risks and plans to mitigate risks

- **Inconsistent follow up and learning from complaints, claims and incidents**

Achievement: Risk Matrix developed with identified leads for each section. Working groups following claims look back.

- **To identify improvement and learning from Scarborough service review**

Action plan regularly followed up at PMM. York site service review planned to commence in November 2015 including a listening exercise for staff. Audit of risk management in Maternity services in spring 2016.

Achievement: Good progress made with action plan

2.5 Patient Experience and user involvement

The Maternity Services Liaison Committee (MSLC)

This service user forum has been under review during 2015 and been regrouped and chaired by the Vale of York CCG with new terms of reference and membership to include a wide range of service users including the National Childbirth Trust, Association of Improvements in Maternity Services, Refugee Action York, Doulas, Homebirth support representatives, breast feeding peer supporters and Kyra women's project (supporting women with perinatal mental health problems)

The group plan to focus on 4 key areas in 2015/16;

- Reducing stillbirth (fetal movements in pregnancy and reducing smoking)
- Homebirth
- Perinatal mental health
- Breast feeding

Members of the group supported a 'café' style engagement event in February 2015. This was held in a Children's Centre with the aim to gain input from women regarding what parent education they would like to be provided in York. Unfortunately it was not well represented. A midwifery team leader has recently attended each Children's centre in York and Selby to gain women's views on parent education, 40 women and 7 partners gave feedback which was discussed at the MSLC meeting in September. Provision of some face to face classes in Childrens Centres is planned for the future.

A stall at the York Hospital Open Day with user representatives and Supervisors of Midwives took place on 10 September to raise the profile of this group and attract interest from the public.

Friends and Family Test
FFT has been successfully implemented in Maternity services with 4 touch points.

Maternity services were finalists in the Patient Experience Network National Awards (PENNA) 'Listening in order to improve' for successful implementation of the Maternity FFT.

Matron Chris Foster took the lead in implementing this and ensuring the qualitative feedback is shared with staff and service users and themes from feedback is acted upon.

A key initiative following FFT and complaints feedback was an introduction of extended visiting for partners/ chosen companions on Ward G2 postnatal. For some families this has enhanced their experience.

Achievement: Good family and friends feedback. Quarterly qualitative feedback report shared with staff and user representatives. Action plan developed from this. Evidence of changes following feedback.

Risks and plans to mitigate risks

- **Limited engagement with a wide range of service users**

Plans to explore possibility of Facebook page for Maternity services to provide information and engage service users.

- **MSLC not fully established following the review.**

Explore opportunities to develop this group with the Vale of York CCG (who currently host this group)

2.6 Patient Safety

Open and Honest care – national maternity safety thermometer
The Maternity Safety Thermometer was tested in a pilot phase from June 2013 and was launched in October 2014. It is available for any organisation wishing to use it for their improvement work. It measures the following 'harms';

- Maternal Infection
- Perineal Trauma
- Postpartum haemorrhage
- Baby Apgar score 6 or less at 5 mins
- Women's perception of safety

Whilst York is undertaking this data collection, the use of data to improve the service locally has been questioned (as the data is taken from a snap shop in time once a month with very small numbers). A meeting has been requested by the Head of Midwifery with the national lead to discuss best use of the data.

Work with the Strategic Clinical Network, women's and children on national maternity priorities;

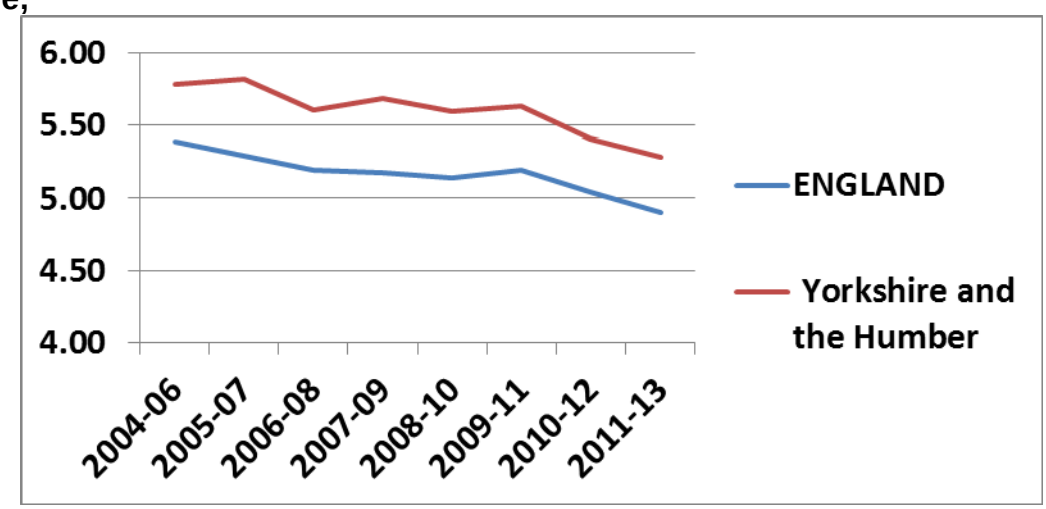
- Reduction in stillbirth and neonatal death rate
- Reduction in preterm delivery rate
- Maternal morbidity, especially major haemorrhage – reduce avoidable harm
- NHSE/RCOG patient safety board
- Perinatal mental health
- Pre conceptual health - smoking, obesity
- Maternity services as 'window' on NHS – major life event – we can do better, *Dr Catherine Calderwood, National Clinical Director*

Yorkshire and Humber priorities;

- Stillbirths (Domain 1/5) (Stillbirth projects. York are a pilot site)
- Admissions to and transition from Neonatal Units (Domain 1/5)
- Maternal Morbidity and Critical Care (Domain 3/5)

- Perinatal Mental Health (Domain 1/3/5)
- Pre Term Deliveries (Domain 1/5)
- Maternity Services Configuration (Domain 1/3/5)

England and Yorkshire and the Humber 3 year rolling stillbirth rates per 1000 total births are;



York rate per 1000 births was 4.4per 1000 in 2014/15 (5 per 1000 in 2013/14)

Work towards reducing stillbirths;

York are a pilot site for implementation of the national stillbirth care bundles
Element 1: Smoking Cessation
Element 2: Small for Gestational Age (SaBiNE project – Saving Babies in North England)
Element 3: Reduced Fetal Movements
Element 4: Effective Fetal Monitoring
Development of a stillbirth peer review process

Workgroups are in place to implement and action recommendations.
Kirkup report; A report of the Morecambe Bay investigation by Dr Bill Kirkup published (March 2015). This report outlines the failings in Furness General Hospital Maternity service with serious concerns over clinical practice. The report makes 44 recommendations for Morecambe Bay Trust and wider NHS aimed at ensuring the failings are properly recognised and acted upon.

The findings and recommendations from this report form part of the Maternity service action plan following the internal and external review.

Risks and plans to mitigate risks

- **National maternity safety thermometer data not found to be useful locally**

Meeting planned with national lead to discuss.

- **Response to Kirkup report**

Included in the Maternity service action plan for follow up.

2.7 Environment

Theatre upgrade on Scarborough site is now complete following a significant delay. The upgrade included bringing ventilation standards in line with national recommendations for theatres. This work had a significant impact upon the service at Scarborough site, with closure of the Midwifery Led Unit in 2013 for the duration of the project.

Midwifery Led Unit (MLU)
The Midwife Led Unit at Scarborough re-opened 15th April 2015 following completion of the above project. It is the only birthing unit in the region providing women from North Yorkshire and East Yorkshire the opportunity and choice to have a home-from-home style birth.
The service is aiming to encourage more women to access the unit to increase activity. Guidance on which women can use the MLU has been revised and expanded. Midwives, Lead Consultants from Obstetrics, Paediatrics, Anaesthetics, Supervisors of midwives and service users have been involved in this work.

Bereavement facilities. Scarborough snowdrop appeal
The Snowdrop appeal was successful in raising over £120,000 to develop a bereavement suite on the Labour ward at Scarborough. Work is due to begin on this project in November 2015 with an expected completion date of March 2016

Environment upgrades: A new wet room has been installed on Ward G2 (Postnatal Ward York) and Hawthorne Ward (ante/postnatal Scarborough) has new flooring and decoration.

Achievements: Completion of theatre project. Reopening of MLU. Successful charity appeal for bereavement suite. Improved environments.

Risks and plans to mitigate risks

- **Low use of MLU following re opening.**

Guidance for use reviewed to increase access for women.

2.8 Supervision of Midwives

Local Supervising Authority Midwifery Officer (LSAMO) annual audit 19 August 2015
The report is awaited however there was one immediate concern raised to action;

- No consistent process for safe storage of community midwives diaries.

This was highlighted by the NMC in a report on Guernsey maternity services. A process has been developed including destruction of diaries over 2 years old in line with Trust policy.
The previous LSA annual audit took place in March 2015 with good progress made on the action plan so far. In summary;

> The reported stated the York and Scarborough team of Supervisors of Midwives have worked really hard to establish themselves as a coherent and consistent team. The team demonstrate their commitment and effectiveness in delivering the core function of the statutory framework and have supported midwives and women through a number of challenging scenarios.
>
> Overall the Trust should take assurance for the fact that they have an effective and committed team of Supervisors of Midwives that are meeting the required framework. There was a wide range of support within the organisation and some good leadership skills seen within the team.

The short timescale between audits is due to the LSAMO new responsibilities to cover a greater geographical area of Cumbria, North East of England and Yorks and Humber.

Kings Fund report into Maternity services at Morecambe Bay published in January 2015 following the Parliamentary and Health Service Ombudsman's report into midwifery regulation (Dec 2014)
This report made recommendation to remove statutory supervision for midwives from legislation (The additional layer of regulation currently in place for midwives).
This was accepted by the Nursing and Midwifery Council (NMC) in January 2015.
The NMC, as health care professional regulator should have direct responsibility and accountability for nurses and midwives

The NMC recognise that the practice support and clinical supervision side of statutory supervision is highly valued and therefore does have a part to play in revalidation

The changes are expected to take place over the next 2-3 years. Until then the current statutory supervisory function will continue.

LSA investigations into midwifery practice
There were 6 investigations in midwifery practice over the last year. Themes from these investigations were CTG interpretation, drug administration, appropriate escalation of concerns, record keeping and not following guidance.

Midwives were recommended to have local action plans which included development plans with their named supervisor of midwives.

Achievements: Supervisors of Midwives working cross site as a coherent and consistent team demonstrating commitment and achievement in the role and support to midwives.

Risks and plans to mitigate risks

- **No robust process for safe storage of midwives diaries**

Immediate recall of diaries for safe storage. Policy development commenced.

- **Supervision of midwives to cease in April 2017**

Awaiting decision from NMC and outcome of National maternity service review.

2.9 Integration

Work continues towards a fully integrated service. There has been an increase in cross site working and support with Midwives and Obstetricians involved in this.

Cross site senior roles are now in place; clinical director, risk management midwife, antenatal and new-born screening midwife, community midwife manager and diabetes specialist midwife. The governance structure and meetings have been reviewed cross site as part of the action plan following the Scarborough service review.

Achievement: Continued working towards a fully integrated service outlined above.

Risks and plans to mitigate risks:

- **Limited engagement to work towards a fully integrated service**

Review of governance arrangements and increase in staff working cross site

2.10 CQC inspection 2015

Care Quality Commission inspection 17 to 20 March 2015 (Report received October 15)
Two separate reports; York (rated good) and Scarborough (requires improvement)
The report is being presented to staff groups and an action plan developed from this.

Overall summary of findings across both sites;

> *Staff were caring and treated women with respect. The service was responsive and delivered in a way that met the needs of the women accessing them.*
> *The service was well led.*

2.11 Service development and achievements

Smoking cessation
Reduction of smoking in pregnancy is a high priority for maternity services and CCG and part of national work to reduce stillbirths.
The national ambition is to reduce smoking at time of delivery to 11% by the end of 2015.
The national figure is 11.4% (down from 12% last year)

> York 2014/15 rate is 11.3% and Scarborough 15.3%

Scarborough have a higher rate of women who smoke and become pregnant. This is a public health issue in the Scarborough area.

Carbon monoxide monitoring is carried out at booking and 28 weeks gestation as a minimum for all pregnant women with referrals to the smoking cessation service as appropriate.

Smoking in pregnancy was part of Maternity mandatory training in 2013/14 with targeted update training delivered in 2014/15 to Community Midwives.

Customised growth charts: Implementation commenced at York site on 1st April 2015. The aim of customised growth charts is to identify small for gestation age babies and plan for timely birth (with reduction of stillbirth). Scarborough site had implemented this in 2012.

NIPE Smart is a bespoke IT screening management and reporting tools system. York and Scarborough have now commenced using this software.

The newborn and infant physical examination (NIPE) is one of the antenatal and newborn NHS population screening programs.

NIPE screens newborn babies within 72 hours of birth, and then once again between 6 to 8 weeks for conditions relating to their heart, hips, eyes and testes. York are also a pilot site for cardiac screening (Oxygen saturation monitoring) prior to the planned national rollout at the end of the year. This screening commenced in July 2015 across site.

Parent education;
York site undertook a review of the provision of parent education in 2013 and moved towards on line classes for easy access and consistency of information and advice.

The uptake and feedback from the on line provision has been good, however feedback regarding face to face contact and information sharing has been missed by some women. Following discussion at the Maternity Services Liaison Committee a trial of face to face

classes is taking place in Childrens centres with feedback requested from women attending.

Maternity services (Scarborough site) were shortlisted for the RCM partnership working award for joined up working with children's centres, health visitors and midwifery to provide accessible parent education in Scarborough, Malton, Whitby and Bridlington. The award ceremony took place on 3 March 2015. Unfortunately we did not win however we are proud to have been shortlisted.

UNICEF Baby Friendly Initiative (BFI)
Maternity services are now fully accredited to BFI standards (achieved in January 2015). The standards are to promote, protect and support breast feeding and bonding with baby.

The UNICEF Baby Friendly Initiative is the first ever national intervention to have a positive effect on breastfeeding rates in the UK. Breastfeeding protects babies against a wide range of serious illnesses including gastroenteritis and respiratory infections in infancy as well as asthma, cardiovascular disease and diabetes in later life. We also know that breastfeeding reduces the mother's risk of some cancers.

Breast feeding initiation rates are 68% in 2014/15 (72% York which is an increase of 6% in 6 years and 59% Scarborough which appears to have dropped significantly, however the actual data is thought to be inaccurate this year).

A local audit has been undertaken which is showing much higher rates, therefore the data entered onto CPD is being scrutinised and has shown a significant amount of missing data. The infant feeding co-ordinators are working with IT to provide more accurate data.

Previously Scarborough had an initiation rate of 60% in 2010 and 69% 2013 (A rise of 9%)

Peer supporters;
The breastfeeding Peer Support Team held a 'big latch on' fun day on the 1st August and raised £ 950 to assist in training sessions and a further £50 was raised towards the training of more peer supporters. A further 15 mothers have been recruited for training.

A 'sticker scheme' was launched this year (for businesses to advertise they welcome breast feeding mothers on their premises) This introduces businesses to the equal opportunities act 2010 and the benefits of breastfeeding and how they can support breastfeeding mothers who are on their premises. This is supported by the inspire award. Once signed up the business is required to allocate a colleague to become the breastfeeding champion to take on the education with their firm and to have a breastfeeding policy.

Scarborough site were shortlisted for the RCM breast feeding grant for improving breast feeding rates through linking with local agencies and employers, by delivering training through peer supporters to local employers in Bridlington, Scarborough, Malton and Whitby to encourage breast support within the work place.

We were not successful in winning the grant however we have been approached to present this work at the national RCM conference.

Tongue tie clinics on Ward G2 have commenced and are midwife led with support from Dr Whitfield (Maxillofacial surgeon). This service has been developed to increase timely intervention for babies with a tongue tie who have having difficulties breast feeding. Tongue tie division is performed by a midwife on Scarborough site too.

Non invasive testing of jaundice levels in newborn infants
Mobile Bilirubinometers are in use on postnatal wards and community which enables us to meet the NICE standards for investigating all jaundice. The benefit is, it is non-invasive and more patient friendly with the benefit if an immediate result.

Extended skills
Some midwives have untaken training to perform fetal presentation scans in York triage unit and one midwife can now perform External Cephalic Version (in breech presentation) following successful completion of a university training module and support from O&G Consultants. A Scarborough midwife has commenced training to perform growth scans for babies suspected of being small for gestational age.

Staff awards
Mentor of the year was awarded by the University of York to a York Midwife. She was nominated by student midwives who said she is an excellent teacher with infinite patience and always supportive. This midwife is also a finalist in the regional NHS leadership awards.

Nursing Leadership award was presented by the Chief nurse to a senior midwife who has provided outstanding leadership, guidance and support to a team and ward going through a difficult period.

Royal College of Midwives 2015 awards. The antenatal and newborn screening team have been shortlisted for their work in reducing avoidable repeat blood spot tests on babies.

Achievements: Service developments and achievements outlined above

Risks and plans to mitigate risks

- Achieving the national target to reduce smoking at time of birth to 11%

Targeted work in Scarborough area on-going with plans to implement 'Baby Clear'.

- Inaccurate data from CPD re initiation of breast feeding

Audited separately to gain assurance. Work with IT to rectify the issue.

2.12 Screening

Quality Assurance Report from visit on 12 March 2015. Report received May 2015 National Antenatal and Newborn Screening Programme.

The aim of quality assurance in the NHS Antenatal and Newborn Screening Programme is the maintenance of minimum standards and the continuous improvement in the performance of all aspects of screening and assessment prior to specific treatment in order to ensure that women & their babies have access to a high quality service wherever they live.

In 2013/14, 6315 women booked for maternity care at YTHFT (York: 3995 bookings, Scarborough: 2320 bookings) with 4954 births (York: 3358 births, Scarborough: 1596 births). The majority of women accessing maternity services at the Trust are of white ethnicity (92.5%), the remainder are Polish (2.4%) or other ethnic groups (3%).

York Trust work with a number of external Laboratories to provide the screening service which include; Leeds, Sheffield, Oxford specialist haematology services and Bristol
The screening programme includes audiology, newborn and infant physical examination, child health records department (Harrogate) and maternity services.

Key findings from the report:

- It was evident that a substantial amount of collaborative work has been undertaken to integrate and improve antenatal and newborn screening provision, particularly during the merger. The provision of this screening programme has been maintained throughout with the Local Screening Coordinator instrumental in this process.
- A good working relationship between staff across the screening programmes, and all staff groups was seen. This was demonstrated by the willingness to work with colleagues across the organisation, wider stakeholders and particularly good communication was reported bi-directionally between the laboratories, NHS England Screening and Immunisation Team (SIT), North Yorkshire and Humberside Locality team, and the regional laboratories based at Leeds and Sheffield.
- The SIT embedded in NHS England, North Yorkshire and Humberside Locality demonstrated good working relationships with Local Authorities, CCGs, and other NHS England Localities. There is a commitment to improve these links further through collaborative working between Scarborough and York sites.

It was reported that staff are enthusiastic and go to great lengths to deliver a quality service with huge personal commitment shown by some staff.

Key Performance Indicators (KPIs):

- **YTHFT is currently unable to identify the screening cohort, which means that the service cannot guarantee that all eligible women and babies have received screening. (This is due to data being collected from more than one IT system)**
- Not all KPIs can be submitted due to the inability to match the cohort on the IT system.
- Completion of information and lab requests requires improvement (KPI is not achieved with a downward trend) **Update Aug 15: Individual training and performance management is being undertaken to address this.**
- The percentage of babies from whom it is necessary to take a repeat blood sample due to an avoidable failure in the sampling process shows non-compliance for the last 18 months. **Update Aug 15:** new national standards have been implemented in the screening lab at Leeds; we now receive a monthly update of insufficient new-born blood spot samples and KPI's. In June and July 2015 it is reported that York Trust have achieved the best rates in the Yorkshire & Humber Region, with a KPI of 1.5% (2% is acceptable). **This is a significant improvement.**
- The proportion of newborn screen negative results for all conditions that are available for communication to parents within 6 weeks of birth consistently demonstrates child health records department exceeding the achievable threshold, ensuring parents are informed of their babies' negative new-born screening results.
- YTHFT consistently exceeds the achievable standard for the proportion of antenatal sickle cell and thalassaemia samples submitted to the laboratory which are supported by a completed Family Origin Questionnaire
- The data for Newborn Hearing Screening programme demonstrates the proportion of babies eligible for newborn hearing screening consistently meets the required standard to complete the screen; however, it is failing to meet the requirement to ensure audiological assessments are completed within the recommended timeframe **Update Aug 2015:** This is now achieved by the provision of extra clinic slots

Recommendations

There are a number of good practice areas identified in the report and 27 recommendations (8 are identified as a priority to be achieved within 3 months) which include;

- **IT action plan to provide data from one IT system (this is the reason for being unable to submit data for some KPIs)**
- Review of screening guidelines
- KPIs to be added to Trust risk register
- Formalise process to sign off KPIs and reports
- Develop robust process for notification of child death to all key stakeholders (Child health action with standard operating procedure in Maternity)
- Review of access to combined screening at Bridlington and Whitby Hospitals

Action plan: Has been developed with input from the NSC and submitted in July 2015

Achievements: Collaborative work undertaken to integrate and improve antenatal and newborn screening provision, particularly during the merger with the screening programme maintained throughout. A good working relationship between staff across the screening programmes.

Risks and plans to mitigate risks

- **Unable to submit all screening KPIs:** IT are working towards achieving this.
- **Not achieving KPIs:** Action plans in place and work with the National Screening Committee to aim to achieve this.
- **Achieve the action plan following QA report:** Action plan submitted to National screening committee with regular follow up meetings.

2.13 Research

BaBY (Born and Bred in Yorkshire) study
The last baby for this study has been born. This study has been ongoing since June 2011, we have managed to recruit 5961 persons in York – which is a great achievement.

The data provided from their healthcare records will help the research team at the University of York to monitor the health of our local population. The cord blood samples donated will help to identify which illnesses now and of the future can be detected at birth.

Maternity services are proud to have been a part of this study which will benefit our region for generations to come.

Other current studies are;

- UKOSS (UK Obstetric Surveillance Study) looking at specific adverse conditions nationally such as pulmonary embolism, gastric bypass and placenta praevia
- Minding the Baby (comparison study using routine midwifery care versus NSPCC guided intervention for first time parents under 25 years of age)
- MiNESS (Study into causes of stillbirth) looking at demographic and lifestyle info
- RESPITE (a comparison study using pethidine versus remifentanyl in labour)
- Baby & Me (parenting app to use via smartphones using ‘mind-mindfulness approach)
- NAME (Neurodevelopment of Babies Born to Mothers with Epilepsy Study) Babies are followed up for 2 years following birth.

Achievement: We continue to support a wide range of research projects in relation to Maternity services and neonates

3. Conclusion

A lot of work has taken place in maternity services during the last year with great

achievement, however, it is recognised there are challenges and work continues with the aim to continually improve and deliver high quality, safe and effective services across sites.
4. Recommendation
The Board are asked to note the report

Author	**Liz Ross, Head of Midwifery**
Owner	**Bev Geary, Chief Nurse**
Date	**6 November 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 17 November 2015 – Boardroom, York Hospital

Attendance: Mike Keaney, Chairman; Steve Kitching; Gordon Cooney; Michael Sweet; Lucy Turner; Sue Rushbrook; Andrew Bertram; Graham Lamb; Lisa Gray, Minutes; Juliet Walters; Amanda McGale

Apologies: Anna Pridmore

Observing the meeting as part of the Well Led Review was Grant Thornton's Mark Fletcher and Wendy Cookson

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes Dated 20 October 2015**	The agenda covered the following AFW and CRR items AFW EF1 DoF1,2, 4,7 CRR CE1 DoF 1-3	The notes of the last meeting have been approved with the following corrections: Under the 18 weeks admitted the minute should read – LT advised that on the York site CESP will undertake an additional 75 cases to help reduce the backlog. It is now predicted the target will be achieved in Ophthalmology in February 2016. Under the ED section the minute should be amended to say Yorkshire Doctors, instead of Northern Doctors to be consistent with previous discussions. Under Work Stream 3: Efficiency report, the initials should be amended to SK. Under the Contract and Tender report development the minute should read – MS presented the paper and explained his		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			proposal. It was agreed that this would fall under the remit of the new Business Manager when they are appointed later in the week and they would see part of their role as developing this register.		
2.	**Matters arising**		MS requested an update on the equipment which was noted under the ED minute which may be causing a delay in diagnosis and financial implications. LT confirmed that it is not equipment failure but how the procedure is completed, and confirmed consultants are currently looking at the clinical pathway, as the implications mean a longer ED wait.	The committee were assured that the consultants were looking at the clinical pathway to reduce the ED wait.	
3.	**Risk Register**		MK advised the committee the risk register needed to be amended, as it currently states that the 4 hour ED target has not been delivered for a year and MK believes it is longer than this. LT confirmed the target has not been delivered for 19 months. JW confirmed that the Chief Operating Officer risks required updates, and would ensure these are completed for the next meeting. MK confirmed that Fiona Jamieson would also be including the Yorkshire Doctors on the risk register moving forwards.	The committee were assured that the risks included in the register were being discussed at the meeting, and that the register would be updated for the next meeting.	
4.	**Overview of TAP**		The Trust is continuing to push the key message with staff that TAP is everything we do, and a formal programme and structure has been put in place. GC referred to the TAP Plan, and clarified following a request from MK that the value and RAG rating headings were not TAP ratings but what was already listed elsewhere, e.g. the RAG rating is	The committee were assured that work was in progress around the Trust but noted that the Trust needed to start seeing results soon.	AB to brief the Board on the developments of TAP.

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			based on efficiency report and values on the performance report. This is to stop any duplication throughout the Trust, and AB confirmed the Trust was looking at better ways to report on this information. The business case progress is currently under review, and a panel is being trialled on 20 November 2015. MS queried whether the panel would turnaround cases quicker, as some cases can go on for a length of time. AB confirmed that the issue of a quick turnaround did not sit at director level, as these were turned around quickly in the weekly Corporate Directors meetings, but sat with Directorates. This is due to the complexity of some of the cases, and also looking at different income lines before the case can be finalised, or cases can be delayed due to capital planning. MK queried the plans completion dates, with GC informing the committee these were in line with the TAP programme end date of March 2016. MK enquired whether the Trust expected to receive no further fines following this point but GC confirmed this would not be the case, as the fines will be different then and the performance team would keep working on these to try achieve no further financial penalties. MK noted that the fines were currently more than they were a few months ago, and asked for assurance that the plan was working. AB advised the committee October had been a difficult month due to the 4 hour ED target, but there was a big spike due to the C.Diff fines being added in. GC confirmed C.Diff has only been added in during October, which has increased the fines by £0.12m,		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			therefore there was only a marginal difference in fines, and that C.Diff would only be confirmed officially at year end. AB believes the £0.12m will be reduced as up to 14 cases are being formalised through the CCGs as it is believed there was no lapse in care so it is hoped these fines will be removed. LT asked the committee to note that fines individually have reduced but that it was not clear when added together due to the C.Diff figure. MK was concerned that the overall level of fines is not reducing and queried when we can expect to see improvements MS requested that the committee see an income generation table each month, showing new initiatives coming in to see how the plan is processing. GC confirmed that although there was no current data for optimising elective income there operations team were working on this and theatres have some really good ideas and Directorates are starting to realise that there is more that they can do. JW agreed, and confirmed that growth opportunities needed to be looked at but they also needed to be done in a planned way. Coding and Counting is being looked at carefully as changing how we count or code can have implications on the Trust being paid, as if the CCG disagree with the change they can withhold the payment. Currently the Trust has to give the CCG 6 month's formal notification of any changes.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
5.	**Work Stream 1: Operational Reports**		**Diagnostics –** The target has been achieved for October 2015 (as it did September 2015), and Radiology achieved 99% in its own right. The month of October saw a reduction in waiting times, reporting turnaround times also continued to improve against the 21 day standard. Unusually there were 8 sleep study breaches, due to equipment issues. The committee asked why this happened and LT explained the issues were out the Trust's control. One patient broke a piece of equipment, one patient lost one, and the Trust's supplier was also unable to deliver any replacements in a timely manner. LT confirmed to the committee that new replacement equipment had now been delivered, however it was anticipated there would be further breaches in November, due to the knock on effect. The committee agreed that breast symptomatic could be moved back to monthly monitoring from January 2016. **Cancer –** The Trust achieved breast symptomatic and 62 day 1st treatment targets for Q2. The 14 day fast track target was failed in September and Q2, however LT confirmed to the committee that the target was on track to achieve at Q3. Early analysis for September shows that over 60% of breaches overall were due to patient choice. LT assured the committee that discussions were ongoing with the CCGs in regards to rewriting the cancer fast track proformas to ensure this is taken into account when patients are referred from GPs. LT advised the committee that the 62 day 1st	The committee was assured on all performance issues, but remain concerned about the ED performance and will closely monitor the process of on-going initiatives.	JW to update the Board on the positive and negatives of this month's performance.

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			treatment target was at risk for Q3, but the operations team were continually monitoring the situation. One of the issues is that Head and Neck have a large amount of complex cases, and it is not been helped that there has been a delay in some referrals from Harrogate. MK noted that the fines charts for Diagnostics and Cancer showed a great improvement, due to the hard work of the operations team. The committee confirmed that breast symptomatic could be moved back to monthly monitoring from January 2016. **18 week admitted –** The Trust achieved the incomplete target in October 2015 (validation ongoing), with only one specialty fail in Anaesthetics being fined. The Operational Performance Recovery Plan had outlined that the Trust would be delivering a sustainable backlog by December 2015. The admitted backlog has been reduced by 15% in October 2015, but despite this progress it is predicted by the end of the month that the sustainable backlog would now not be achieved until February 2016. The sustainable backlog is behind plan due to a cancellation of 68 elective patients on an 18 week pathway, this was through bed shortages. The Trust suffered from bed shortages due to infection issues in both York and Scarborough, and non-elective demand. Theatre lists have also been cancelled due to staff shortages on the York site, which has affected the routine capacity rather than the additional capacity which has been put in place to		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			help reduce the backlog. MK enquired how long the additional Ophthalmology capacity would continue for, and LT confirmed this was planned for a year. MK queried whether the Trust was receiving extra income from the additional work. AB informed the committee that the Trust was not receiving additional income as New Medica was delivering the additional capacity due to the Trust being unable to staff the additional capacity. AB assured MS that the Trust was not losing money from outsourcing the additional capacity, and it was improving the fines the Trust received. However the committee were informed that the Trust was making an income from Max Fax as this was being delivered out of Bridlington, and this would continue for as long as necessary. MK questioned whether York Orthopaedics could be moved to Bridlington due to its current success, and LT assured the committee the Trust was looking at this, but there were underlying issues that needed to be worked through first, and another consideration was renting theatre space from Nuffield. MK expressed that this was an income opportunity that the Trust could not afford to lose. Max Fax has continued to progress with their backlog, as they are continuing to work out of Bridlington, but Orthopaedics has increased due to being closed for 2.5 weeks. LT advised the committee to expect a difficult November due to the yearly winter pressures. **ED –** JW reported that performance deteriorated in October 2015 to 87.30% from 89.74% in September 2015. On comparison with October 2014, October		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			2015 saw an increase of attendance by 7.35%, non-elective admissions increased by 2.94% on the York site and by 8.1% on the Scarborough site with overall admissions increasing by 4.6%. Most significantly the Scarborough site saw an increase of 51.5% in GP admissions. JW informed the committee that adding to these pressures has been the bed closures on both sites due to infection. Scarborough saw a significant amount of bed closures over 12 days, with York having more than 37 beds being closed for 14 days, which peaked at 124 bed closures. This has therefore had a negative impact on patient flow, which resulted in 13 x 12hr trolley waits. Bed occupancy has been over 90% for Scarborough (19 days) and York (27 days) for the month. Additional pressures are coming from workforce pressures. JW assured the committee a plan was on-going and a new ED workforce model was being drawn up and although it was in its infancy it is seen as a way forward to modernising emergency care. All of these issues were replicated in other Trusts. Plans are on-going for a discharge to assess model. It is noted that there is a gap in intermediate care, as a large proportion of patients treated would have been better treated outside of the hospital (accounting to approximately 575 bed days). The committee discussed the Older Peoples Assessment Lounge which is due to open on 2 December in York, subject to business case approval, and the one in Scarborough has completed its trial and is also subject to approval. Short stay elderly wards are also due to open in December with both schemes helping improve		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			patient care and experience. JW confirmed daily walk rounds were taking place and staff were being encouraged to be pro-actively discussing time of discharge to help with patient flow. Discussions are still on-going with Yorkshire Doctors who say they cannot cover overnight (10pm – 8am), which is posing a risk to the Trust, despite the Trust being flexible with them. MK queried when the Trust expected to see a reverse in trends. JW explained the Trust saw a reverse in trends up to August, and the Trust did not expect the difficulties in October with norovirus. The different schemes put in place should put the Trust on the road to recovery. This includes developing a primary care front door model in collaboration with the CCG to redirect people away from ED with minor injuries/ailments which should hugely reduce the pressure on ED and reduce fines received. Direct admission rights will be discussed at the Executive Board on 18 November, which is hoped will ease the pressure on ED. MS noted that it was clear GPs would not help the situation over Christmas due to their breaks in service, meaning more people would present at ED. JW was raising this at a meeting later in the week with the CCGs, as an additional issue is patients not being able to get GP appointments generally so they present themselves at ED instead. In the past the Trust has suggested GP hours are extended, but have been informed that this is not financially viable.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			SR updated the committee on working with Bradford University, on researching data from the Trust compared to others and it shows compared to neighbouring hospitals that the patients coming to the Trust were much older and sicker. This poses a risk to the Trust for our mortality rates, which is not clear in data currently released. Work is on-going to get the paper officially published.		
6.	**Work Stream 2: CQUIN Delivery**		MK and MS commended the committee on their efforts to turn all but one CQUIN around.	The committee were assured that work put in place to improve the CQUINs is working as all but one are an amber/green rating.	
7.	**Work Stream 3: Finance Report**		The Trust has seen a further deterioration in October 2015, with the overall income and expenditure position moving from a £6.4m deficit to a £7.3m deficit. The variance from plan is £5.2m which has increased from £3.0m. GL informed the committee there were essentially three issues behind the movement, which were: 1 – Expenditure remained fairly flat over the 2 months, with pay being the main driver as it reduced, displaying the controls on temporary staffing is having an effect, but more was spent on drugs. 2 – Following additional rework of the readmission adjustment made last month an additional £0.4m was added. 3 – There was a large amount of elective activity cancellations in York, due to lack of beds and staff shortages. Provisionally this lost the Trust an additional income of between £0.5m and £0.75m, which the majority would have gone to the Trust's	The committee were disappointed to see there had been a further deterioration in October, but felt assured that plans were being put in place to help alleviate the problem.	AB to update the Board on the positive and negative factors of the financial position.

Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
		bottom line as most associated costs have been incurred. MK was happy to see temporary staffing had been pulled back, however it is still higher than in June 2015, and it remains above Monitors trajectory. MK requested the Chief Nurse updates the Board on workforce spend. MS queried whether there was a risk that Staff Nurses were leaving to join agencies as rates were higher, and AB confirmed that a small amount of Staff Nurses have but the Trust was going live with a 20% advance premium throughout the winter months to help retain staff, and confirmed the Chief Nurse would be updating Board on this. AB confirmed to the committee that as an incentive the Trust has also implemented weekly pay, and that it is on its 6th weekly payment run, which is proving a good driver for staff members including Locum Doctors. The Cash position at the end of October was below plan at £15.2m, partly due to £3m of capital loan not being drawn down due to movements in the capital plan. NHS England didn't pay £4m in September but it was paid in October. AB has concerns that payment terms appear to be becoming a risk as Doncaster wrote to the Trust to request their payment terms were amended to 90 days payment. AB assured the committee the Trust had responded saying this was not possible as it would only accelerate the Trust's problems. AB's main concern is the Trust is sat on £10m strategic capital in Scarborough, and he informed the committee that the Department of Health (DoH) had written to the Trust on behalf of Monitor to ask		Beverley Geary to update the Board on workforce spend, and advance premium rates.

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			Trust's nationally to defer their capital programmes. The Trust responded to the DoH to confirm it is not in a position to defer schemes as they are in process already and it would cause the Trust significant long term problems if we stopped the process now. SK and AB met last week with each finance manager to go through line by line each invoice and income line and agreed an action plan on cash management going forwards as it needs to remain high on the agenda. The cash flow management charts will continue to be updated to keep a tighter control on the Trust's cash flow.		
8.	**Work Stream 3: Efficiency Report**		Overall delivery in October 2015 is £17.9m which is 69% of the £25.8m target, with a £1.3m improvement in the month. The part year adverse variance is £1.0m which has declined by £0.3m in the month, however this is ahead of last year's position which was £2.7m adverse. The in-year planning gap at October 2015 was £2.6m, which has seen a decline in the month by £3.1m. SK confirmed to the committee that this was due to all high risks plans being removed, and that the team is continuing to work with Directorates to develop low risk plans. Efficiency panels have taken place with Directorates and 8 are committed to closing their gaps with the exception of Women's Health. MS queried whether there was any indication the 4 year gap was reducing, AB and SK both confirmed it was too early to tell.	The committee were assured with the on-going work by the efficiency team with directorates to achieve the targets set.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			MK noted to the committee he felt that this was one area the Trust could feel confident in achieving.		
9.	**Work Stream 4: Workforce**		The committee noted the paper, but has no more comments to add following the finance discussion.	The committee were assured the temporary workforce spend controls put in place were helping to ease the financial pressures.	Beverley Geary to update the Board on workforce spend, and advance premium rates.
10.	**Times and dates of meetings for 2016/17**		The committee noted the meeting dates and times for 2016/17.		
11.	**Any other business**		AB updated the committee following the Q2 call with Monitor on Monday 16 November. Monitor appeared satisfied that the Trust was being pro-active in its plans around Nursing and Consultant spend, the Well Led Review, Turnaround Avoidance Programme plans and that the Trust was engaging with Monitor's turnaround team. MK enquired how long it would be before Monitor intervened. AB and JW confirmed that was difficult to say but hoped the Trust's pro-active planning, and with some results starting to deliver that Monitor would feel the Trust was going the right way. Due to the current position of the Trust MK requested an additional meeting to take place in December 2015.		
12.	**Next Meeting**		The next meeting is arranged for 15 December 2015.		

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

Finance Report

Action requested/recommendation

The Board is asked to note the contents of this report.

Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 31 October 2015.

At the end of September the Trust is reporting an Income and Expenditure (I&E) deficit of £7.3m against a planned deficit of £2.1m for the period. The Income & Expenditure position places the Trust behind its Operational plan.

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

Implications for equality and diversity

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

This report is for noting only and contains no recommendations. It is therefore not expected to have any particular impact upon the requirements of, or on the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	November 2015
Version number	Version 1

Briefing Note for the Finance & Performance Committee Meeting 17 November 2015
Briefing Note for the Board of Directors Meeting 25 November 2015

Subject: October 2015 (Month 7) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for the Period to October 2015

Unfortunately we have seen a further deterioration in the reported position for October. The overall income and expenditure position has moved from a £6.4m deficit to a £7.3m deficit. Our variance from plan has increased from £3.0m to £5.2m.

There are essentially three specific issues behind the movement. Firstly, expenditure has remained relatively flat between months with October expenditure only very marginally higher (£0.2m) than September. I would suggest our expenditure controls are holding the position. Secondly, following significant work, we have had to extend the readmission adjustment made last month by a further £0.4m. And, thirdly, we have seen significant levels of elective activity cancelled in the month on the York site. The performance report confirms 80 elective cancellations due to lack of beds but in addition to this around 20 elective surgery lists [number still to be confirmed] have been cancelled due to theatre staffing difficulties. A provisional estimate suggests this lost work would have had a value of between £0.5m and £0.75m with almost all of this going to improve the Trust's bottom line as most of the associated costs have been incurred.

Of concern is that the weekly performance data shows the trend of cancelling elective patients due to lack of beds has continued into November. Elective income is likely to be suppressed again during November.

At £38.9m, expenditure levels for October have been broadly in line with August and September levels and, importantly, have remained well below the peak of £40.4m experienced in July.

Contract penalties continue to impact on the Trust's position but in-month levels remain lower than previously reported. Continuation of this work under the TAP programme is a clear priority for the Trust. The performance report summarises the full implications of the penalties.

The income position reflects the national withdrawal of the 18-week admitted and non-admitted penalties. The Board should also be aware that the reported income position continues to assume a degree of success with our claim to the CCGs for re-investment of ED 4-hour penalties and ambulance turnaround penalties. This is an area with some degree of uncertainty but discussions continue. The Board will be kept informed of progress with these claims.

As part of our routine submissions we are discussing this position with Monitor. I will keep the Board updated in this regard. At this stage, whilst formal investigation is an option for Monitor, the regulatory framework does not mandate Monitor takes this action. However,

Monitor have indicated that following our Q2 submission this is now a serious consideration.

Expenditure Analysis

Pay expenditure is a major pressure on the Trust but at £26.3m for October is lower than £26.7m reported for the months of both August and September.

All our control measures remain in place in regard to the use of temporary agency staff and Monitor continue to escalate central control initiatives. Of note is that from 19 October Monitor require full compliance with on-framework agencies only, except in exceptional and documented instances. We are currently working with all national initiatives as well as our own local controls.

Drug expenditure in month is slightly up on average levels at £4.3m. It currently stands at £3.7m ahead of plan but this largely relates to high cost out of tariff drug costs for which direct recharges are made to commissioners.

Clinical supplies and services expenditure is in line with average levels at £3.8m for the month. And similarly other costs are broadly in line with averages at £4.3m for the month. Investigations continue to identify pressure areas and any necessary supplementary actions.

CIP delivery has continued with good progress in month. There is an adverse impact of £1.0m on the financial position to date but delivery remains on track. More detail of progress to date is provided in the efficiency report.

Contracting Matters

In relation to our community contract with NHS Hambleton and Richmond CCG I can confirm that Whitby Hospital has formally transferred to NHSPropCo in anticipation of the Trust ceasing to provide community services in that locality. This position is not reflected in the October position as the asset transferred on 1 November. Next month's reported position will reflect the technical (non-cash) loss on transfer included in our annual plan.

There are no further contractual issues I would wish to bring to the Board's attention.

Finance Performance Report

November 2015

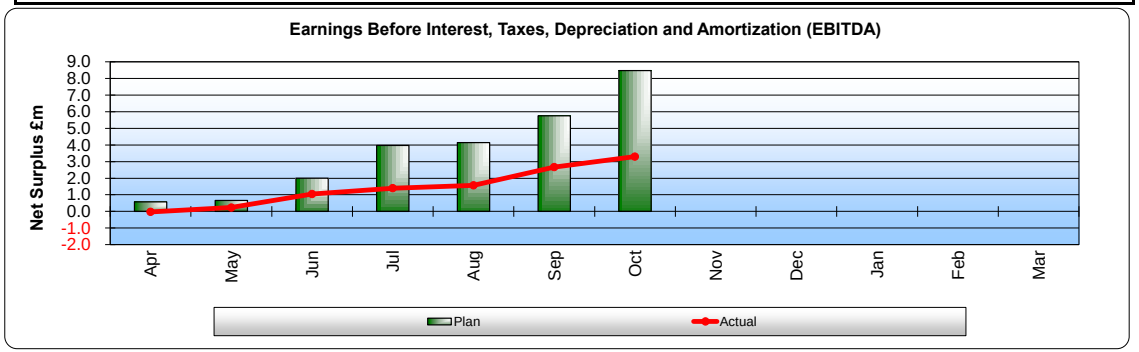
Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

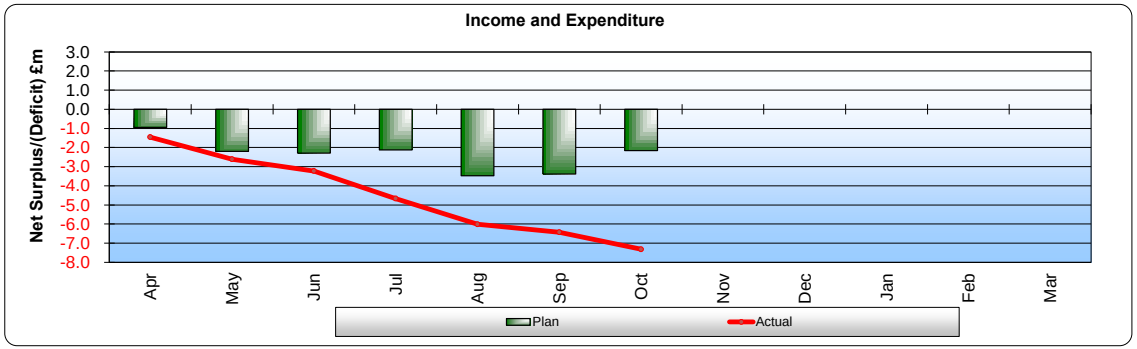
Summary Income and Expenditure Position
Month 7 - The Period 1st April 2015 to 31st October 2015

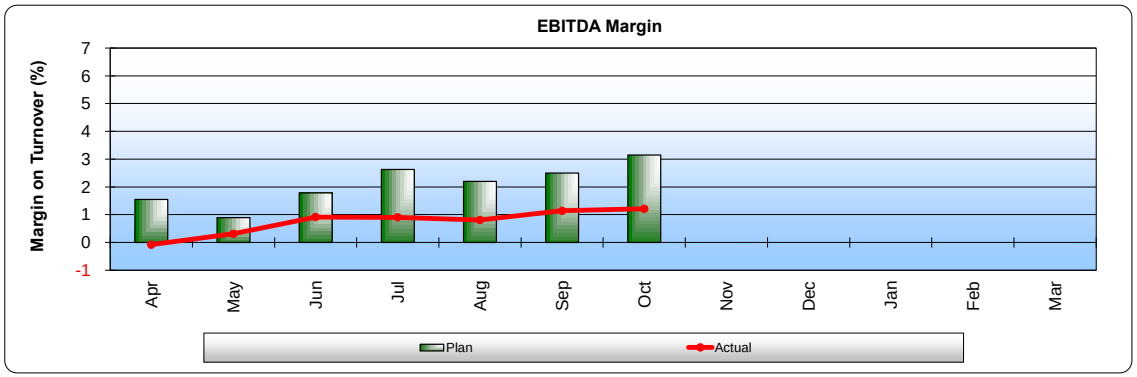
York Teaching Hospital NHS
NHS Foundation Trust

Summary Position:

* The Trust is reporting an I&E deficit of £7.3m, placing it £5.2m behind the operational plan.
* Income is £4.5m ahead of plan, with clinical income being £2.3m ahead of plan and non-clinical income being £2.2m ahead of plan.
* Operational expenditure is ahead of plan by £9.6m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £3.3m (1.21%) compared to plan of £8.5m (3.15%), and is reflective of the reported net I&E performance.
* Due to the timing of the Board meeting the forecast is the one reported to Monitor the previous month.







	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	24,947	14,496	14,849	353	25,963	1,016
Planned same day (Day cases)	33,817	19,714	21,109	1,395	36,307	2,490
Non-Elective Income	104,654	61,384	62,503	1,119	108,617	3,963
Outpatients	66,438	38,349	35,884	-2,465	64,622	-1,816
A&E	14,883	8,570	8,994	424	15,994	1,111
Community	33,046	20,115	21,767	1,652	36,969	3,923
Other	131,877	76,464	76,331	-133	128,524	-3,353
	409,662	**239,092**	**241,437**	**2,345**	**416,996**	**7,334**
Non-NHS Clinical Income						
Private Patient Income	1,036	605	519	-86	899	-138
Other Non-protected Clinical Income	1,890	1,102	1,068	-35	1,802	-88
	2,926	**1,707**	**1,586**	**-121**	**2,700**	**-226**
Other Income						
Education & Training	14,333	8,361	8,892	531	15,154	821
Research & Development	4,156	2,424	2,968	544	4,515	359
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	600	350	431	81	739	139
Other Income	17,601	10,414	11,484	1,070	19,324	1,723
Transition support	10,907	6,362	6,362	-1	10,906	-1
	47,597	**27,912**	**30,138**	**2,226**	**50,638**	**3,041**
Total Income	**460,186**	**268,711**	**273,161**	**4,451**	**470,334**	**10,148**
Expenditure						
Pay costs	-315,045	-181,567	-186,143	-4,576	-314,561	484
Drug costs	-43,497	-25,154	-28,831	-3,677	-46,060	-2,563
Clinical Supplies & Services	-46,416	-26,891	-26,496	395	-42,827	3,589
Other costs (excluding Depreciation)	-47,418	-27,673	-28,338	-665	-53,085	-5,667
Restructuring Costs	0	0	-59	-59	-400	-400
CIP	7,855	1,048	0	-1,048	0	-7,855
Total Expenditure	**-444,521**	**-260,237**	**-269,867**	**-9,630**	**-456,933**	**-12,412**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**15,665**	**8,474**	**3,294**	**-5,179**	**13,401**	**-2,264**
Profit/ Loss on Asset Disposals	-4,500	0	3	3	-4,497	4
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation	-11,000	-6,417	-6,417	0	-11,000	0
Interest Receivable/ Payable	100	58	89	31	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	-335	-167	-175	-8	-303	33
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	-9	-9	-19	-19
PDC Dividend	-7,040	-4,107	-4,107	0	-7,040	1
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**-7,410**	**-2,159**	**-7,322**	**-5,163**	**-9,656**	**-2,246**

Contract Performance

Month 7 - The Period 1st April 2015 to 31st October 2015

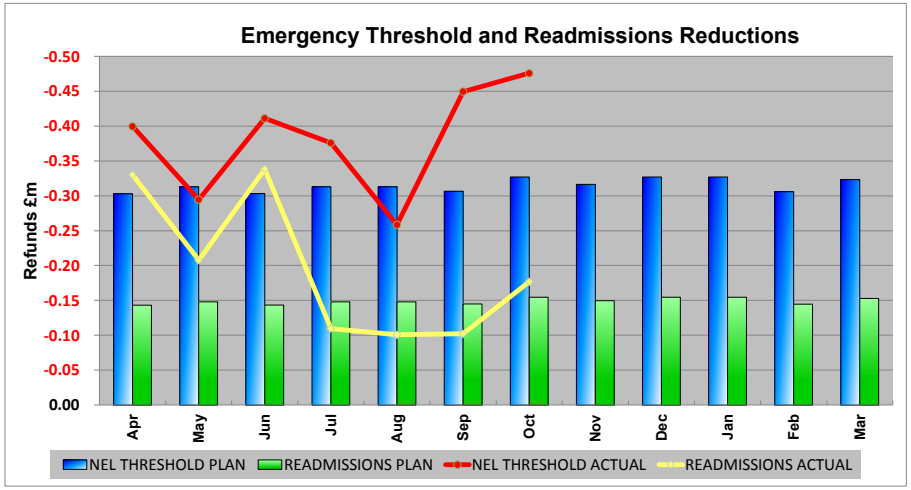
York Teaching Hospital NHS
NHS Foundation Trust

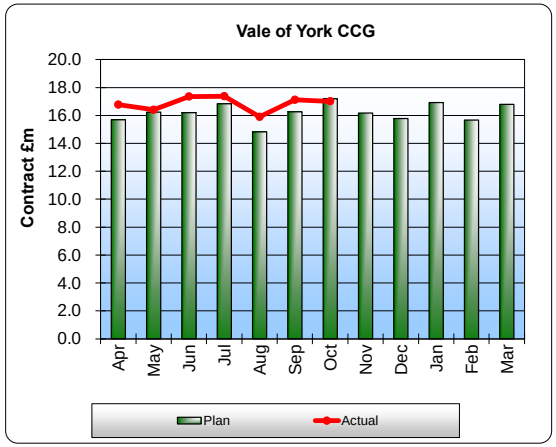
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	194,548	113,222	117,947	4,725
Scarborough & Ryedale CCG	74,959	43,019	46,172	3,153
East Riding CCG	37,600	21,430	24,079	2,649
Other Contracted CCGs	23,761	13,686	13,852	166
NHSE - Specialised Commissioning	35,241	20,628	19,984	-644
NHSE - Public Health	14,466	8,856	8,714	-142
Local Authorities	7,043	3,500	3,347	-153
Total NHS Contract Clinical Income	**387,618**	**224,341**	**234,095**	**9,754**

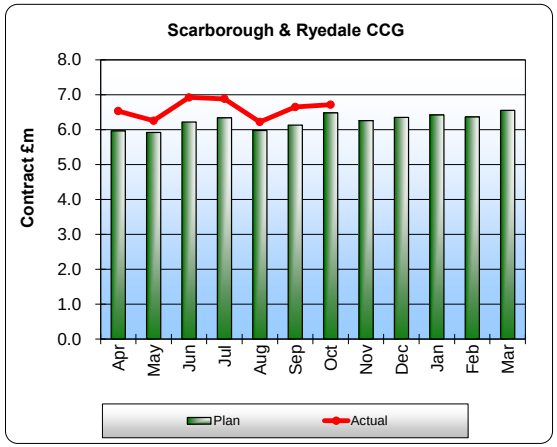
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	9,899	5,792	6,777	985
Risk Income	12,145	8,959	763	-8,196
Total Other NHS Clinical Income	**22,044**	**14,751**	**7,540**	**-7,211**

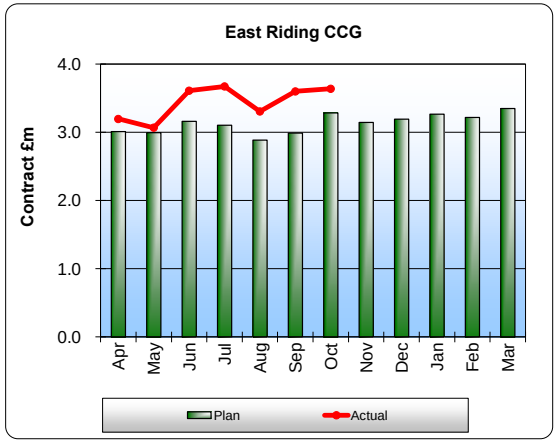
Total NHS Clinical Income	**409,662**	**239,092**	**241,635**	**2,543**

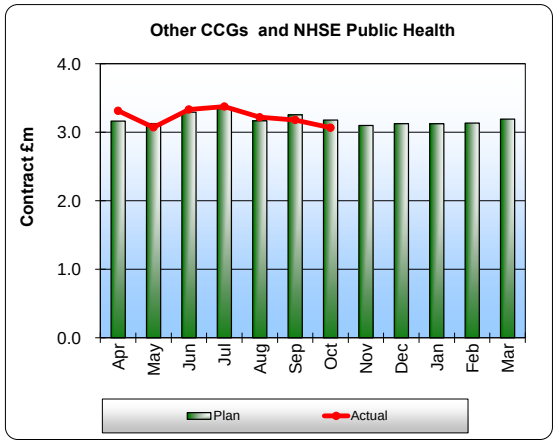
Specialist registrar income moved to other income non clinical	-809
Winter resilience monies in addition to contract	611
Agrees to Clincial Income reported to board	**241,437**

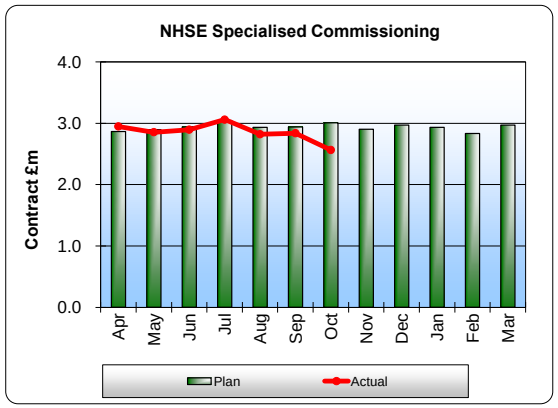


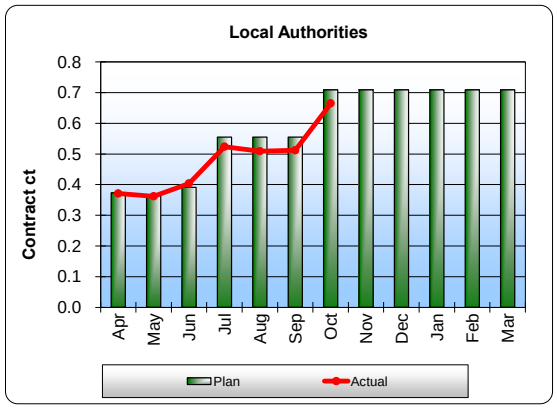












Expenditure Analysis
Month 7 - The Period 1st April 2015 to 31st October 2015

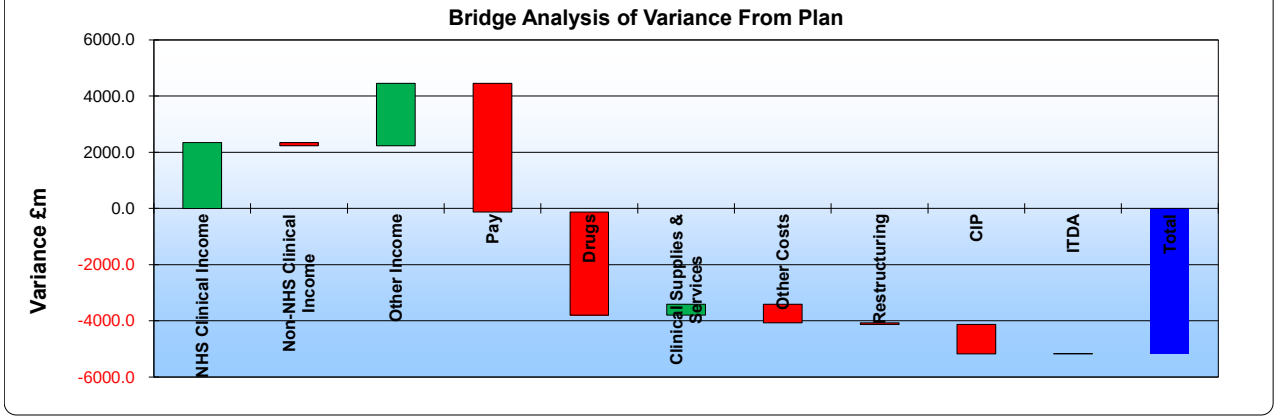
York Teaching Hospital NHS
NHS Foundation Trust

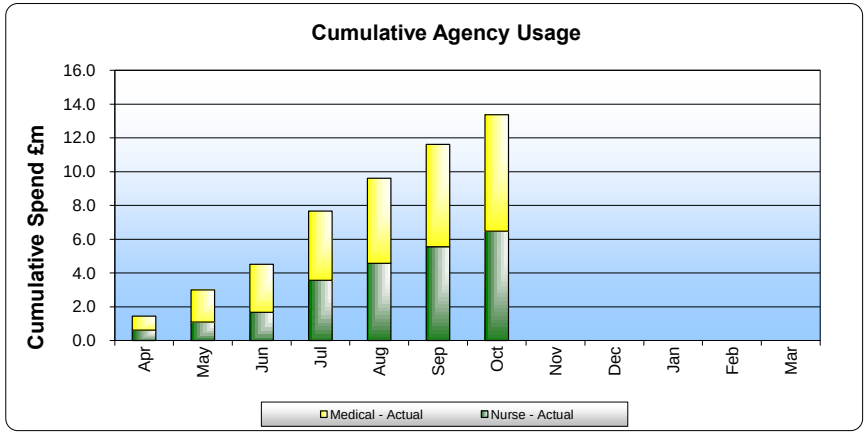
Key Messages:

There is an adverse expenditure variance of £9.6m at the end of October 2015. This comprises:

* Pay budgets are £4.6m adverse, linked to continued high locum and agency costs.
* Drugs budgets are £3.7m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £1.0m behind plan.
* Other budgets are £0.3m adverse.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	54,566	31,645	27,878	0	1,095	0	3,122	32,095	-449	-572	
Medical & Dental	29,473	17,113	15,171	0	126	0	3,772	19,069	-1,957	-1,909	
Nursing, Midwifery & Health Visting	94,334	54,829	47,188	292	200	1,847	6,472	55,998	-1,169	-1,011	
Professional & Technical	9,815	5,691	4,606	72	94	0	361	5,133	558	347	
Scientific & Professional	17,187	9,930	9,017	54	19	0	181	9,271	658	566	
P.A.M.s	22,346	13,069	11,478	30	166	0	236	11,911	1,159	988	
Healthcare Assistants & Other Support Staff	43,768	25,578	25,004	391	76	21	116	25,609	-31	-31	
Chairman and Non-Executives	161	94	94	0	0	0	0	94	0	0	
Executive Board and Senior Managers	14,510	8,432	7,804	3	0	0	34	7,841	591	592	
Administrative & Clerical	34,161	19,759	18,678	120	103	0	221	19,122	637	594	
Agency Premium Provision	4,000	2,333	0	0	0	0	0	0	2,333	2,000	
Vacancy Factor	-9,278	-6,906	0	0	0	0	0	0	-6,906	-6,144	
TOTAL	**315,045**	**181,567**	**166,918**	**962**	**1,881**	**1,868**	**14,514**	**186,143**	**-4,576**	**-4,581**	



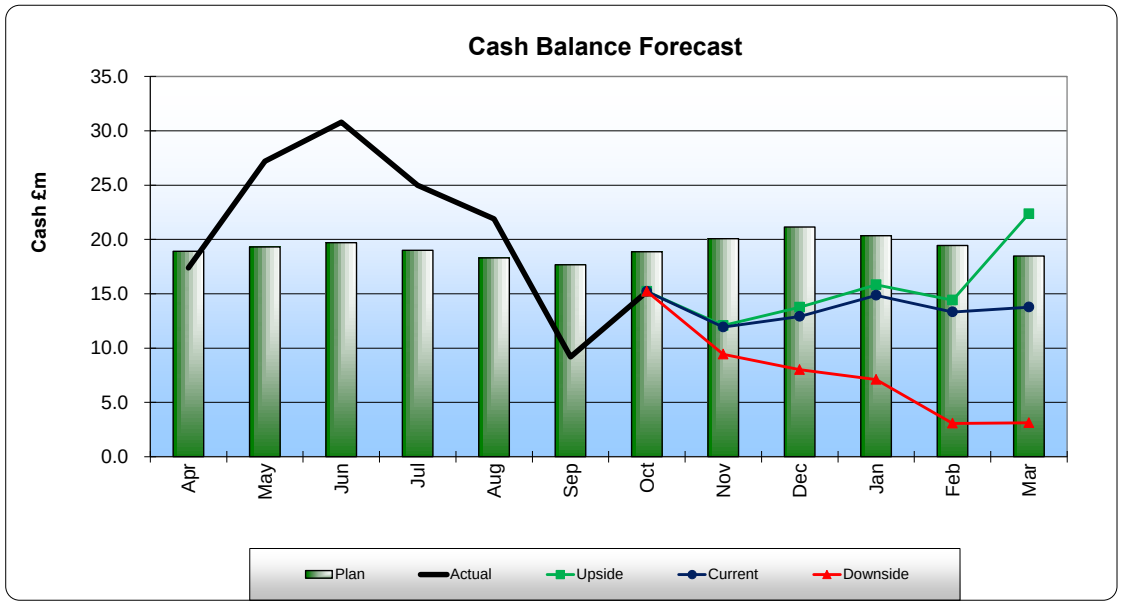


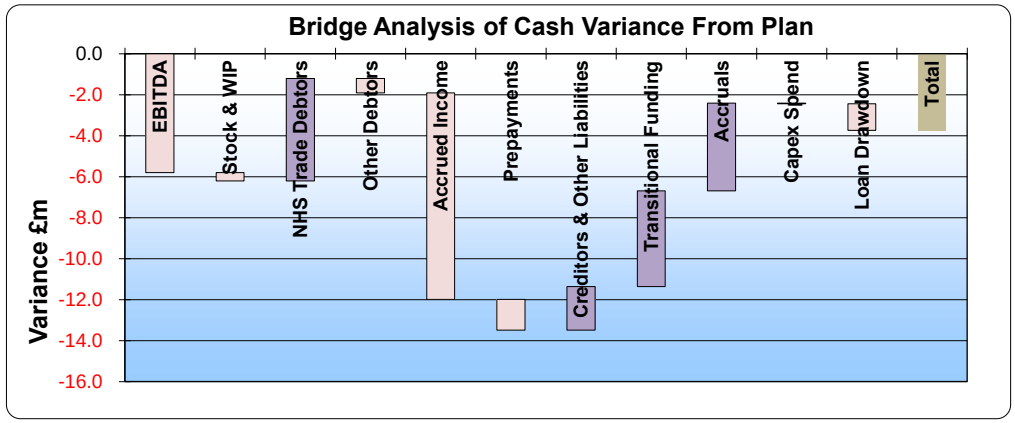
Cash Flow Management
Month 7 - The Period 1st April 2015 to 31st October 2015

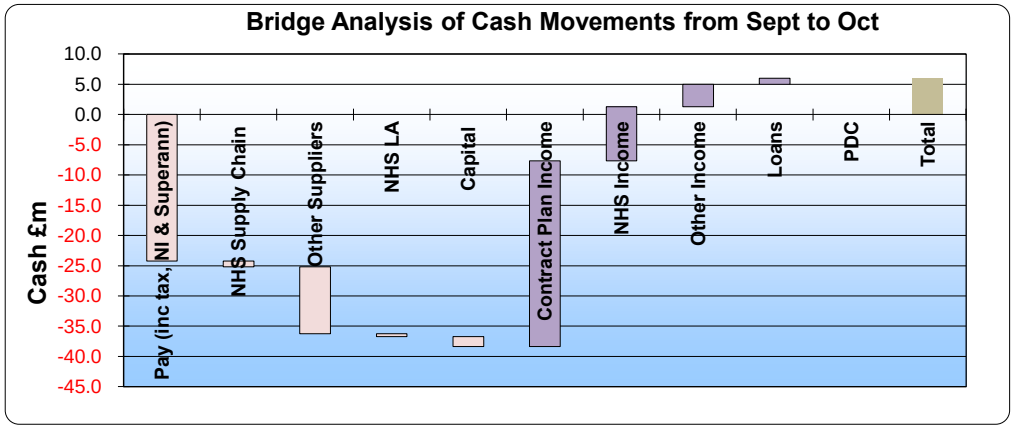
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The cash position at the end of October was £15.2m. This is below plan partly due to £1m of capital loan not drawn down due to movement in the capital plan.
* The cash balance graph now contains a forecast to year end. Using the current forecast and sensitivity analysis, 2 scenario's are presented in terms of upside and downside.
* The introduction of 2 new bridge analysis graphs allow the presentation of the variance from plan and the actual 'in month' cash movements.
* Currently, accrued income and prepayments are under review to ensure working capital is maximised.







Cash Flow Management
Month 7 - The Period 1st April 2015 to 31st October 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

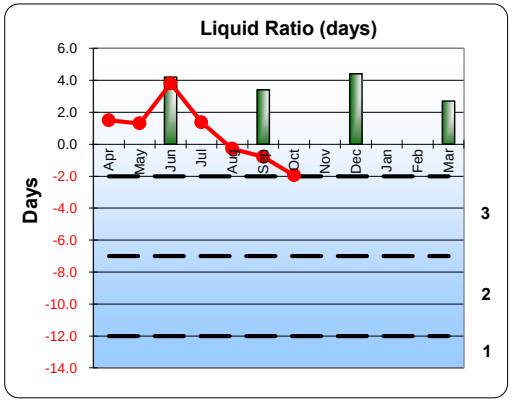
* The receivables balance at the end of October was £8.56m which is below plan due to improved debt collection procedures.
* The payables balance at the end of October was £12.56m which is slightly below plan due to paying more invoices due to increased expenditure levels.
* The Financial Sustainability Risk Rating (FSRR), which is assessed as a score of 2 in October, and is reflective of the I&E position.

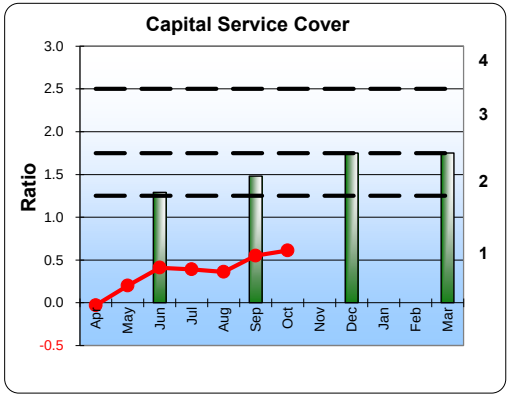
Significant Aged Debtors (+6mths)

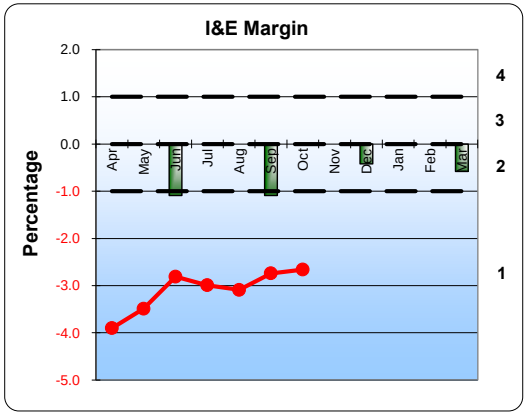
Harrogate and District NHS FT	**£603K**
Depuy of Ireland	**£413K**
NHS Vale of York CCG	**£151K**

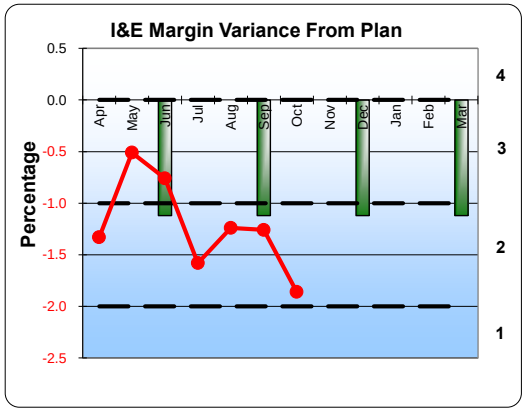
	Under 3 mths £m	3-6 mths £m	6-12 mths £m	12 mths + £m	Total £m
Payables	10.51	1.23	0.61	0.20	12.56
Receivables	6.25	0.64	1.01	0.66	8.56

FSRR Area of Review	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (25%)	4	4	3	3
Capital Service Cover (25%)	2	1	1	2
I&E Margin (25%)	2	1	1	2
I&E Margin Variance From Plan (25%)	2	2	2	3
Overall Financial Sustainability Risk Rating	3	2	2	3









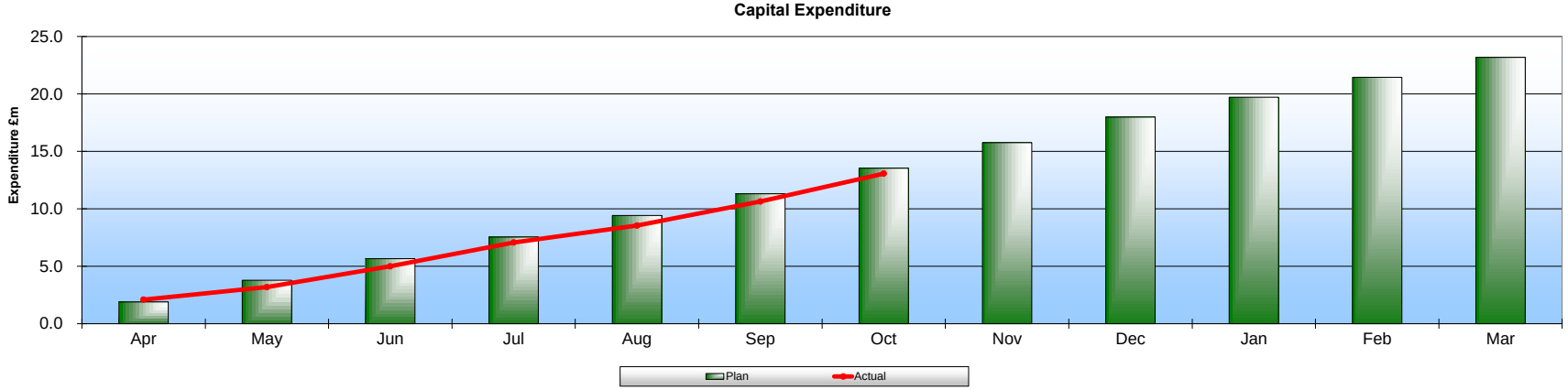
Capital Programme

Month 7 - The Period 1st April 2015 to 31st October 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The Capital Programme for October is running in line with plan.
* Strategic funding has been allocated to existing projects across the Scarborough site, including the Fire Alarm and Lift replacement projects and the upgrade of the IT network.
* The Scarborough and Bridlington Carbon Energy Scheme has the largest projected in year spend at £5.187m
* The overall plan has reduced by £1.5m mainly due to part of the Radiology equipment replacement plan moving into next year, therefore the loan funding has moved with it.



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
CT Scanner replacement- York (Owned)	2,015	1,703	1,715	300	
Fire Alarm System SGH	440	122	440	0	
York ED Phase 2	1,264	171	1,114	150	
SGH/ Brid Carbon & Energy Project	5,087	4,298	5,187	-100	
Radiology Equipment Upgrade	3,085	-	1,080	2,005	£900k funded by loan and remainder funded through depreciation/strategic funding
IT Wireless Upgrade - Trustwide	1,400	381	1,400	0	
Other Capital Schemes	3,655	2,651	4,455	-800	
SGH Estates Backlog Maintenance	1,000	510	900	100	
York Estates Backlog Maintenance - York	1,000	979	1,000	0	
Medical Equipment	650	362	650	0	
IT Capital Programme	1,500	694	1,160	340	
Capital Programme Management	1,150	878	1,350	-200	
Radiology Lift Replacement SGH	440	18	440	0	
York Endoscopy Phase 2	-	138	270	-270	
Urology Facilities Malton	-	167	500	-500	
Contingency	500	-	-	500	Contingency funding has been allocated to specific projects
TOTAL CAPITAL PROGRAMME	**23,186**	**13,072**	**21,661**	**1,525**	

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£	£	£	£	
Depreciation	9,614	5,619	9,614	-	
Loan Funding b/fwd	1,386	1,386	1,386	-	
Loan Funding	9,577	4,615	7,701	1,876	
Charitable Funding	739	180	739	-	
Strategic Capital Funding	1,870	1,272	2,221	- 351	
TOTAL FUNDING	**23,186**	**13,072**	**21,661**	**1,525**	

Efficiency Programme

Month 7 - The Period 1st April 2015 to 31st October 2015

York Teaching Hospital NHS
NHS Foundation Trust

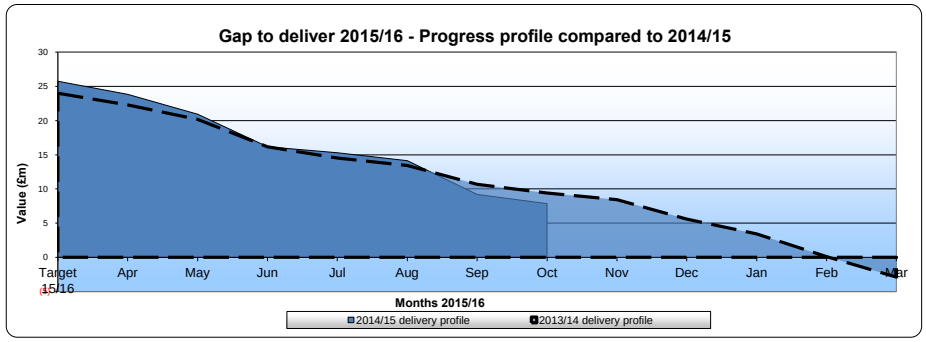
Key Messages:

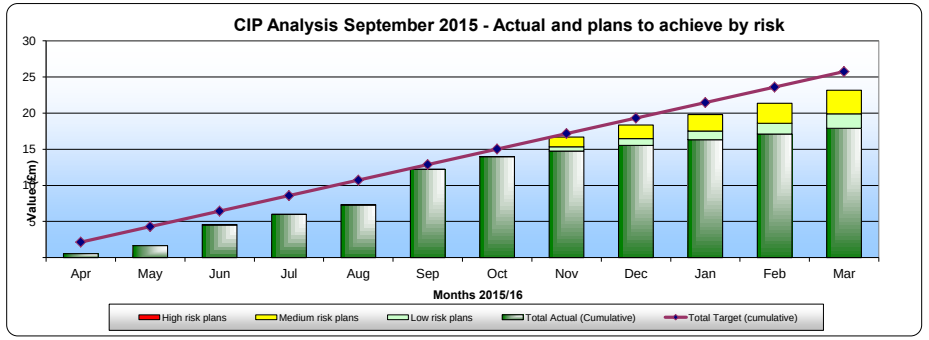
* Delivery - £17.9m has been delivered against the Trust annual target of £25.8m, giving a shortfall of (£7.9m).
* Part year Monitor variance - The part year Monitor variance has a shortfall of (£1m).
* In year planning - The in year planning gap is currently (£2.6m). In Q3 we exclude all in year high risk plans.
* Four year planning - The four year planning gap is (£15.8m). This has improved by £1.1m in month as work continues to develop plans.
* Recurrent delivery - Recurrent delivery is £8.1m, which is 32% of the 2015/16 CIP target.

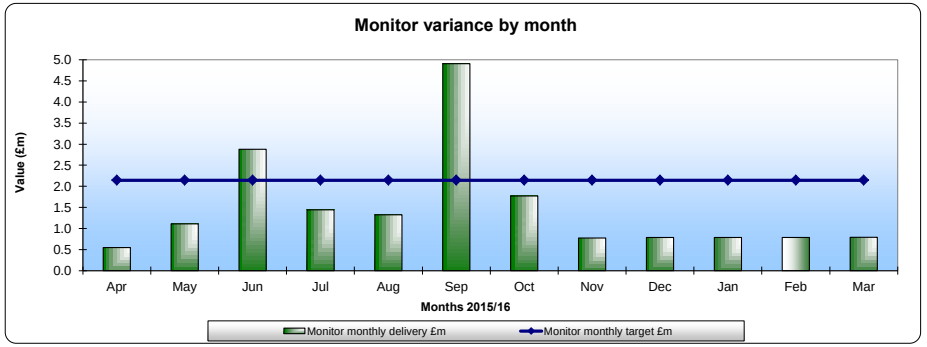
Executive Summary - October 2015	Total £m
TARGET	
In year target	25.8
DELIVERY	
In year delivery	17.9
In year delivery (shortfall)/Surplus	-7.9
Part year delivery (shortfall)/surplus - monitor variance	-1.0
PLANNING	
In year planning surplus/(gap)	-2.6
FINANCIAL RISK SCORE	
Overall trust financial risk score	(1 - RED)

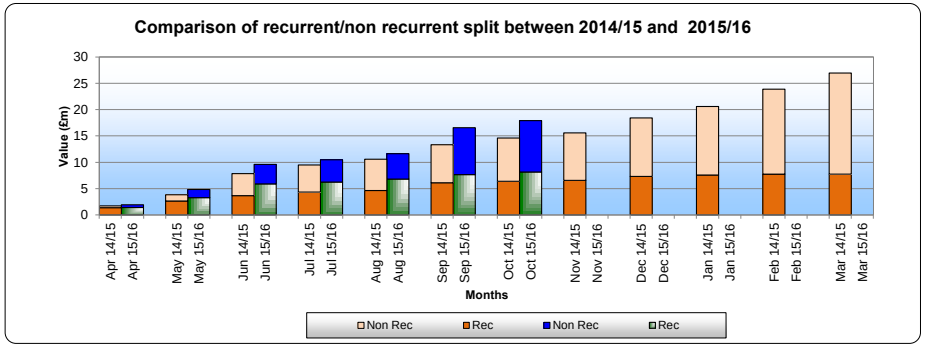
4 Year Efficiency Plan - October 2015					
Year	2015/16	2016/17	2017/18	2018/19	**Total**
	£m	£m	£m	£m	**£m**
Base Target	25.8	15.3	15.2	15.2	**71.4**
Plans	23.2	20.1	8.1	4.2	**55.6**
Variance	-2.6	4.8	-7.1	-11.0	**-15.8**
%	**90%**	**132%**	**53%**	**28%**	**78%**

Risk Ratings			
Financial			
Score	September	October	Trend
1	14	18	↑
2	3	1	↓
3	3	3	→
4	5	3	↓
5	1	1	→
Governance			
Score	September	October	Trend
Red	0	0	→
Green	26	26	→







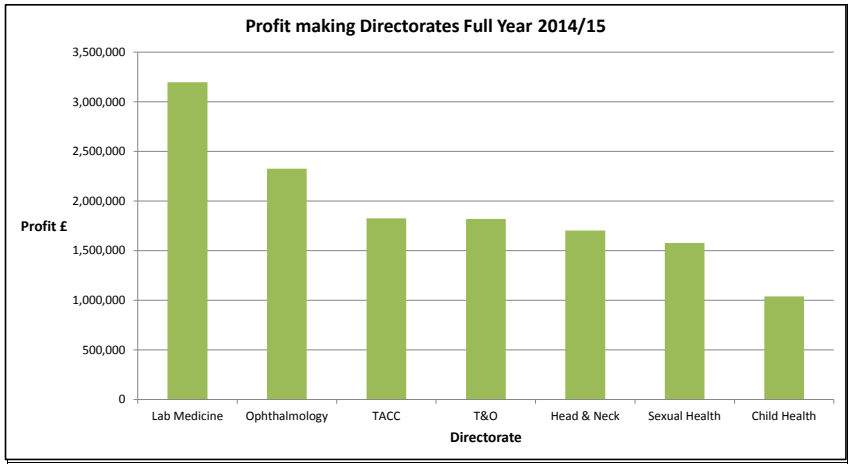


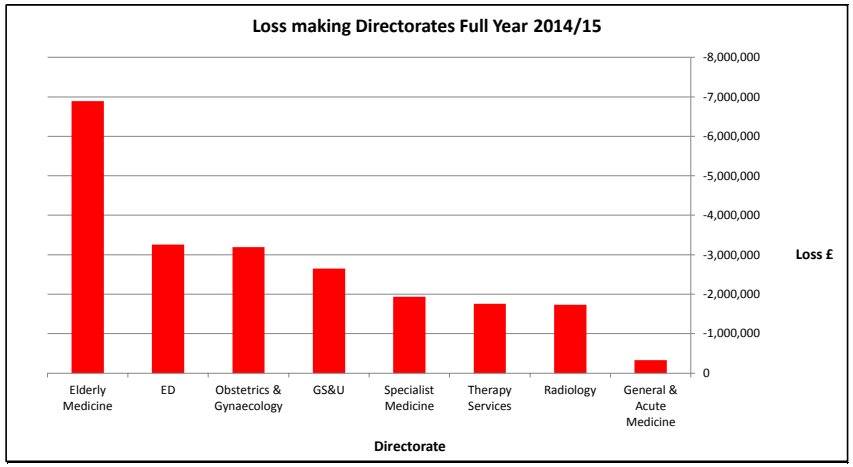
Service Line Reporting
Month 7 - The Period 1st April 2015 to 31st October 2015

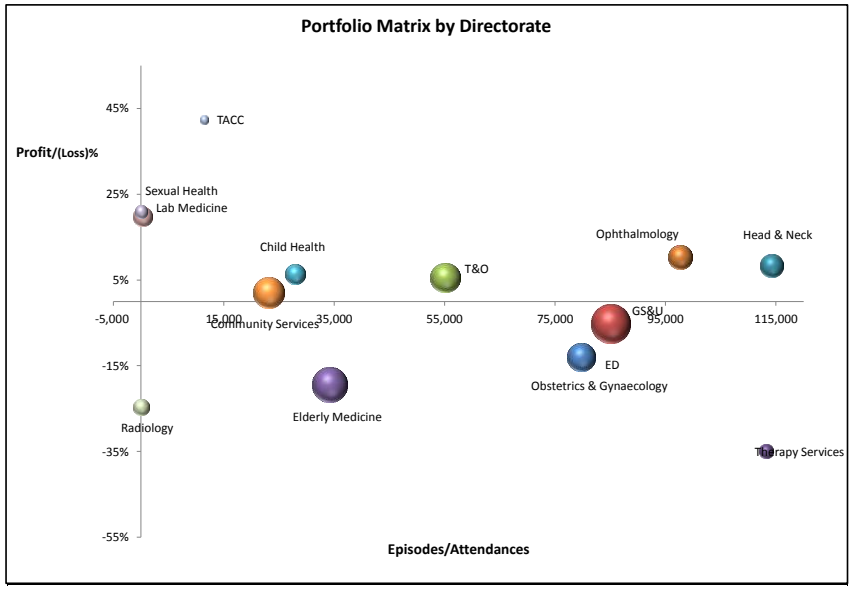
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Current data is based on full year 2014/15
* It is expected Q1 2015/16 will be completed towards the end of November 2015
* Directorate teams are being asked to confirm that the correct consultant job plan allocations are used within the SLR system
* Deep dive work has started within a number of Directorates
* 2 staff have been appointed to the team - 1 started in September 2015 and the other begins January 2016







DATA PERIOD	FULL YEAR 2014/15
CURRENT WORK	* Q1 2015/16 SLR data is now the key focus following the publication of Q4 2014/15 data. Q1 is expected to be completed towards the end of November 2015 * A detailed deep dive piece of work is currently in progress for Women's Health with the aim of identifying what the true underlying financial position of the service is and to improve the quality of the data presentation in Qlikview * Deep dive work for Child Health, Elderly Medicine, General & Acute Medicine and TACC is also underway to agree the income and expenditure allocation methods * Work with Directorate teams is currently on-going to improve the quality of consultant job plan allocations used within the SLR system for each quarterly reporting period
FUTURE WORK	* Q2 2015/16 SLR data will be the priority following the completion of Q1 * The SLR team are continuing to work with Directorate teams to improve the quality of outpatient staffing group costs within SLR * Deep dive work with Emergency Medicine and Trauma & Orthopaedics will commence in the near future to agree allocation methods * Future work around junior doctor job plans will become a key focus to improve the quality of the SLR data and also to inform the annual mandatory Education and Training Cost Collection exercise

BENEFITS TAKEN SINCE SYSTEM INTRODUCTION	**£2.6m**

Executive Pack

October 2015

York Teaching Hospital NHS
NHS Foundation Trust

Executive Summary	Inpatient Elective				Inpatient Non-Elective				Inpatient Day Case				Outpatient (1st Att)				Outpatient (Sub Att)				Non Face-To-Face				Outpatient Procedures			
Specialty	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var
Accident And Emergency	0	0	0	0	2910	1678	1940	262	0	0	12	12	945	549	171	-378	818	475	71	-404	0	0	0	0	0	0	0	0
Acute Medicine	0	0	3	3	219	126	607	481	92	53	125	72	774	450	709	259	1004	583	674	91	94	55	15	-40	0	0	0	0
Anaesthetics	54	31	27	-4	17	10	15	5	1750	1017	1121	104	1650	959	1144	185	2466	1433	1727	294	0	0	0	0	24	14	75	61
Cardiology	670	389	167	-222	2841	1638	1383	-255	1098	638	734	96	12125	7045	7787	742	19537	11352	8992	-2360	155	90	190	100	5627	3270	3093	-177
Chemical Pathology	0	0	0	0	0	0	0	0	54	31	33	2	50	29	77	48	82	48	172	124	0	0	0	0	0	0	0	0
Clinical Neuro-Physiology	0	0	0	0	0	0	0	0	0	0	0	0	1254	729	729	0	70	41	59	18	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	8	5	4	-1	365	212	51	-161	7292	4237	3242	-995	16299	9470	8523	-947	424	246	26	-220	15441	8972	11716	2744
Ear, Nose And Throat	748	435	449	14	998	575	598	23	952	553	723	170	7810	4538	4466	-72	8307	4827	5649	822	12	7	13	6	8987	5222	5274	52
Endocrinology	8	5	4	-1	3698	2132	1713	-419	482	280	286	6	2203	1280	1224	-56	7137	4147	4344	197	506	294	19	-275	0	0	1	1
Gastroenterology	229	133	135	2	4581	2641	3145	504	9602	5579	5294	-285	6261	3638	2777	-861	11532	6701	4968	-1733	1026	596	638	42	60	35	38	3
General Medicine	5	3	6	3	474	250	380	130	2921	1666	1545	-121	92	53	48	-5	133	77	15	-62	18	10	8	-2	79	46	22	-24
General Surgery	2885	1676	1601	-75	7258	4185	4182	-3	10703	6219	6023	-196	15231	8842	8875	33	23104	13386	11877	-1509	794	461	436	-25	3999	2324	1795	-529
Genito-Urinary Medicine	0	0	0	0	0	0	0	0	0	0	0	0	25550	13493	10024	-3469	11980	6322	5650	-672	0	0	0	0	0	0	0	0
Geriatric Medicine	6	3	10	7	9421	5432	6083	651	172	100	96	-4	3844	2234	2311	77	3851	2238	2054	-184	941	547	147	-400	46	27	37	10
Gynaecology	822	478	519	41	980	565	687	122	1474	856	876	20	7670	4457	4310	-147	5650	3283	3627	344	0	0	1	1	4761	2766	2485	-281
Haematology (Clinical)	42	24	23	-1	156	90	133	43	3672	2134	2353	219	1898	1103	1121	18	12610	7327	7619	292	668	388	346	-42	126	73	21	-52
Maxillofacial Surgery	352	205	185	-20	378	218	243	25	1951	1134	1439	305	7009	4073	4113	40	8372	4865	4999	134	0	0	0	0	1846	1073	1556	483
Medical Oncology	58	34	25	-9	148	85	84	-1	6952	4039	4633	594	4186	2432	2487	55	22970	13347	14593	1246	25582	14864	11797	-3067	90	52	73	21
Nephrology	72	42	64	22	1606	926	660	-266	784	456	480	24	791	460	415	-45	8311	4829	3992	-837	3714	2158	2142	-16	0	0	0	0
Neurology	14	8	3	-5	132	76	112	36	746	433	499	66	3286	1909	1726	-183	6115	3553	3083	-470	910	529	473	-56	56	33	0	-33
Obstetrics & Midwifery	24	14	27	13	5338	3078	3416	338	0	0	0	0	46	27	29	2	1166	678	757	79	0	0	0	0	168	98	62	-36
Ophthalmology	251	146	170	24	86	50	37	-13	5385	3129	3575	446	16145	9381	8809	-572	57783	33575	29848	-3727	0	0	0	0	12929	7512	6763	-749
Orthodontics	0	0	0	0	0	0	0	0	0	0	0	0	1491	866	725	-141	1886	1096	975	-121	0	0	0	0	9636	5599	5068	-531
Paediatrics	65	38	36	-2	7156	4126	4381	255	214	124	183	59	5217	3031	2906	-125	10180	5908	5626	-282	424	246	211	-35	670	389	384	-5
Palliative Medicine	0	0	0	0	0	0	0	0	0	0	0	0	1048	609	327	-282	3938	2288	1443	-845	418	243	161	-82	0	0	0	0
Plastic Surgery	34	20	19	-1	8	5	4	-1	338	196	261	65	407	236	358	122	512	297	345	48	0	0	0	0	29	17	6	-11
Restorative Dentistry	0	0	0	0	0	0	0	0	0	0	0	0	629	365	448	83	441	256	208	-48	0	0	0	0	1619	941	731	-210
Rheumatology	6	3	1	-2	14	8	3	-5	2160	1255	1369	114	2732	1587	1569	-18	13097	7610	8509	899	1254	729	869	140	0	0	0	0
Thoracic Medicine	86	50	34	-16	3611	2082	2116	34	498	289	304	15	3859	2242	1839	-403	10544	6127	5408	-719	134	78	51	-27	296	172	129	-43
Trauma And Orthopaedic Surgery	1824	1060	1173	113	3258	1879	1976	97	2283	1327	1456	129	18700	10866	11036	170	27248	15832	16588	756	0	0	0	0	1460	848	815	-33
Urology	1566	910	974	64	1598	921	934	13	5844	3396	5410	2014	2662	1547	3012	1465	4243	2465	5460	2995	14	8	27	19	3788	2201	169	-2032
Obstetrics & Midwifery Zero Tariff	0	0	0	0	6332	3651	3937	286	0	0	0	0	8090	4701	5248	547	35308	20516	16042	-4474	0	0	0	0	9460	5497	5788	291
Gynaecology Zero Tariff	4	2	0	-2	362	209	202	-7	2	1	2	1	4	2	1	-1	42	24	23	-1	0	0	0	0	20	12	12	0
Total	**9825**	**5709**	**5655**	**-54**	**63588**	**36642**	**38975**	**2333**	**60494**	**35119**	**38883**	**3764**	**170951**	**97969**	**94063**	**-3906**	**336736**	**194975**	**183920**	**-11055**	**37088**	**21550**	**17570**	**-3980**	**81217**	**47191**	**46113**	**-1078**

G2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

Efficiency Programme Update – October 2015

Action requested/recommendation

The Committee is asked to note the October 2015 position.

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2015/16 target is £25.8m and year to date delivery, as at October 2015, is £17.9m.

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	This report is presented to the Board of Directors and Finance & Performance Committee.

Risk	The Efficiency Programme presents a significant financial risk to the organisation.
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Andrew Bertram, Director of Finance
Author	Steve Kitching, Head of Corporate Finance & Resource Management
Date of paper	November 2015
Version number	Version 1

Briefing note for the Finance & Performance Committee Meeting 17th November 2015
Briefing note for the Board of Directors Meeting 25th November 2015

Subject: September 2015 - Efficiency Position
From: Steven Kitching, Head of Corporate Finance & Resource Management

Summary reported position for October 2015

Current position – highlights

Delivery - Overall delivery is £17.9m in October 2015 which is (69%) of the £25.8m annual target; there has been a £1.3m improvement in the position in month. This position compares to a delivery position of £14.6m (61%) in October 2014.

The month 7 part year adverse variance is (£1.0m) which has declined marginally in the month by (£0.3m). This position is ahead of the 2014/15 position which was (£2.7m) adverse.

The relative Directorate positions are shown in Appendix 1 & 2 attached.

In year planning – There is an in-year planning gap of (£2.6m) at October 2015, this has declined in the month by (£3.1m) this is due to all high risk plans having been removed. This position is behind 2014/15 position by (£0.6m). Work is continuing with Directorate teams to develop low risk plans.

Four year planning – The four year planning gap is (£15.8m); this position has improved in the month by £1.1m. The comparative position in October 2014 was a gap of (£18.9m). We have a strong planning position for years 1&2 of the plan with £43.3m (105%) worth of plans identified against a target of £41.1m.

Recurrent vs. Non recurrent – Of the £17.9m delivery, £8.1m (45%) has been delivered recurrently, in October 2015. Recurrent delivery is £1.7m ahead of the same position in October 2014, which remains encouraging at this stage. The work continues to identify recurrent schemes.

Quality Impact Assessments (QIA) – All schemes have been sent out to Directorate teams to self assess for their safety impact and all have now been completed. It should be noted that 22 schemes, of the total 909 schemes, were self-assessed as extreme or high risk, following the review process with Helen Hey, Deputy Chief Nurse, 5 of these schemes have been reduced to below high risk. Clinical review continues. Mr Khafagy, Consultant Urologist, has also agreed to provide a medical overview of the process.

Overview

The delivery position remains positive with delivery ahead of last year by £3.3m, at £17.9m. The in-year planning position has declined significantly by (£3.1m); this is due to the removal of all high risk plans at the beginning of Q3. The 4 year planning position has improved in month by £1.1m. We currently have plans for 105% of the combined year 1&2 target.

This would indicate a stable planning position at this stage in the year.

Recurrent delivery remains relatively strong, with the percentage recurrent delivery at 45% of overall delivery which is positive, this percentage has declined marginally in the month and work is on-going to identify recurrent savings.

All Directorates have self assessed their schemes as part of the QIA self-assessment process, and clinical reviews are well underway.

Efficiency panels meetings have started with Directorate teams and 8 have been completed at the time of this report. The panels are focusing on in year planning and delivery gaps.

Risks

Given the positive start in the first 7 months, there remain key risks in the programme.

- There is an in-year planning gap of (£2.6m), work continues to close this gap; there is a 4 year planning gap of (£15.8m).
- Recurrent delivery remains a key focus.
- There are 17 schemes which have been rated as extreme or high risk following the self-assessment process; however the senior nursing review continues. Following final reviews a report is to be prepared for the Resource Management Executive Group.

RISK SCORES - OCTOBER 2015 -APPENDIX 1

DIRECTORATE	FINANCE						GOVERNANCE	
	R	RA	A	AG	G	Trend	R	G
WOMENS HEALTH	1	2	3	4	5	→	○	●
TACC	1	2	3	4	5	→	○	●
MEDICINE FOR THE ELDERLY	1	2	3	4	5	→	○	●
HEAD AND NECK	1	2	3	4	5	→	○	●
SPECIALIST MEDICINE	1	2	3	4	5	→	○	●
GEN MED SCARBOROUGH	1	2	3	4	5	→	○	●
RADIOLOGY	1	2	3	4	5	→	○	●
EMERGENCY MEDICINE	1	2	3	4	5	↓	○	●
GS&U	1	2	3	4	5	→	○	●
SEXUAL HEALTH	1	2	3	4	5	→	○	●
COMMUNITY	1	2	3	4	5	→	○	●
OPHTHALMOLOGY	1	2	3	4	5	→	○	●
CHILD HEALTH	1	2	3	4	5	↓	○	●
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1	2	3	4	5	↓	○	●
GEN MED YORK	1	2	3	4	5	↓	○	●
LAB MED	1	2	3	4	5	↓	○	●
ORTHOPAEDICS	1	2	3	4	5	→	○	●
PHARMACY	1	2	3	4	5	→	○	●
CORPORATE								
OPS MANAGEMENT YORK	1	2	3	4	5	→	○	●
CHIEF NURSE TEAM DIRECTORATE	1	2	3	4	5	→	○	●
SNS	1	2	3	4	5	→	○	●
WORKFORCE AND ORGANISATIONAL DEVELOPMENT	1	2	3	4	5	↓	○	●
ESTATES AND FACILITIES	1	2	3	4	5	↓	○	●
MEDICAL GOVERNANCE	1	2	3	4	5	→	○	●
FINANCE	1	2	3	4	5	→	○	●
CHAIRMAN & CHIEF EXECUTIVES OFFICE	1	2	3	4	5	→	○	●
TRUST SCORE	1	2	3	4	5	↓		

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
WOMENS HEALTH	2,238	4,033	47%	1	16%	1	7%	1	74%	1	4	1
TACC	2,956	7,149	34%	1	19%	1	17%	1	33%	1	4	1
MEDICINE FOR THE ELDERLY	1,423	3,715	24%	1	20%	1	15%	1	82%	1	4	1
HEAD AND NECK	625	1,833	51%	1	28%	1	10%	1	31%	1	4	1
SPECIALIST MEDICINE	2,883	6,700	60%	1	30%	1	20%	1	64%	1	4	1
GEN MED SCARBOROUGH	1,148	2,457	38%	1	36%	1	30%	1	67%	1	4	1
RADIOLOGY	2,410	4,020	47%	1	39%	1	24%	1	52%	1	4	1
EMERGENCY MEDICINE	1,126	2,463	66%	1	41%	1	40%	1	63%	1	4	1
GS&U	2,087	5,273	76%	1	49%	1	30%	1	62%	1	4	1
SEXUAL HEALTH	470	1,040	79%	1	56%	1	9%	1	73%	1	4	1
COMMUNITY	1,562	4,007	44%	1	34%	1	22%	1	106%	3	6	1
OPHTHALMOLOGY	870	2,438	95%	2	60%	1	46%	2	53%	1	6	1
CHILD HEALTH	1,335	2,866	87%	1	69%	2	47%	2	73%	1	6	1
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1,612	3,700	107%	3	80%	3	38%	1	76%	1	8	2
GEN MED YORK	1,949	5,235	100%	3	73%	3	50%	3	118%	4	13	3
LAB MED	1,144	3,247	114%	4	103%	5	69%	5	90%	1	15	3
ORTHOPAEDICS	1,353	3,632	136%	5	114%	5	55%	3	106%	3	16	4
PHARMACY	-189	503	140%	5	101%	5	101%	5	274%	5	20	5
CORPORATE												
OPS MANAGEMENT YORK	695	1,090	73%	1	13%	1	0%	1	76%	1	4	1
CHIEF NURSE TEAM DIRECTORATE	378	695	52%	1	51%	1	15%	1	28%	1	4	1
SNS	1,127	2,220	91%	2	53%	1	31%	1	52%	1	5	1
WORKFORCE AND ORGANISATIONAL DEVELOPMENT	768	1,536	79%	1	59%	1	34%	1	95%	2	5	1
ESTATES AND FACILITIES	3,088	7,650	81%	1	59%	1	48%	2	94%	2	6	1
MEDICAL GOVERNANCE	103	222	150%	5	150%	5	16%	1	70%	1	12	3
FINANCE	151	890	233%	5	233%	5	116%	5	40%	1	16	4
CHAIRMAN & CHIEF EXECUTIVES OFFICE	18	407	1584%	5	1584%	5	965%	5	71%	1	16	4
TRUST SCORE	**33,331**	**79,022**	**90%**	**1**	**70%**	**2**	**32%**	**1**	**78%**	**1**	**5**	**1**

G3

Providing care together in York, Scarborough, Bridlington, Malton, Whitby, Selby and Easingwold communities.

York Teaching Hospital NHS
NHS Foundation Trust

Public Performance Report

November 2015

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	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	**Specialty fail:** £300 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**92%**	93.0%	92.5%	92.8%	93.8%	93.0%	93.8%	94.2%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	0	2	3	0	0	0	0
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	Nil	**Not a 2015/16 target**	82.0%	80.7%	75.6%	76.3%	78.2%	75.3%	75.1%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	Nil	**Not a 2015/16 target**	95.5%	95.4%	95.2%	95.1%	95.2%	95.2%	95.3%

Access Targets: Cancer

NB: Cancer Figures Run One Month Behind Due to National Reporting Timescales

Indicator	Consequence of Breach	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	85.4%	89.8%	93.9%	91.9%	93.0%	91.1%	91.5%
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	90.5%	91.0%	91.4%	94.0%	93.3%	93.4%	95.2%
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	98.4%	96.1%	96.2%	99.3%	98.2%	99.2%	100.0%
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	95.3%	95.6%	94.4%	97.3%	97.5%	96.4%	97.6%
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	100.0%	98.5%	99.6%	100.0%	100.0%	100.0%	100.0%
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	85.0%	76.5%	87.8%	85.1%	85.8%	84.6%	85.4%
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	92.5%	92.2%	98.4%	92.0%	86.2%	97.1%	92.3%
62 Day Consultant Upgrade	General Condition 9	**85%**	50.0%	-	-	-	-	-	-

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£120 fine per patient below performance tolerance (maximum 10% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	89.1%	89.1%	88.3%	91.5%	91.8%	89.7%	87.3%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**0 > 30min**	514	520	539	315	163	70	102
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**0 > 60min**	371	383	415	139	78	30	63
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q3 14/15**	**Q4 14/15**	**Q1 15/16**	**Q2 15/16**	**Aug**	**Sep**	**Oct**
	NHS VALE OF YORK CCG	30mins - 1hr	154	161	163	88	53	9	24
		1hr 2 hours	109	109	114	47	23	12	19
		2 hours +	54	44	26	19	13	0	8
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	176	177	152	94	49	20	41
		1hr 2 hours	77	83	101	28	15	4	18
		2 hours +	25	25	28	1	1	0	3
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	127	134	146	82	36	26	24
		1hr 2 hours	54	70	76	23	11	10	11
		2 hours +	13	17	22	1	1	0	0
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	17	20	27	13	6	4	6
		1hr 2 hours	13	15	14	6	4	1	2
		2 hours +	1	2	3	0	0	0	0
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	2	6	1	1	1	0	0
		1hr 2 hours	1	0	0	1	1	0	0
		2 hours +	0	0	0	0	0	0	0
	OTHER	30mins - 1hr	38	22	50	37	18	11	7
		1hr 2 hours	16	12	27	12	8	3	2
		2 hours +	8	6	4	1	1	0	0
Total number of patients waiting over 8hrs in A&E	General Condition 9	Q1 - Establish baseline	819	944	734	431	140	201	354
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**0 > 12 hrs**	2	11	0	1	0	0	13
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%**	97.0%	97.6%	97.5%	To follow	97.2%	To follow	To follow

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	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
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**	93	93	95	98	99	97	96
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9		104	105	107	108	109	107	108

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**48**	16	21	21	14	8	3	5
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	**108 (TBC)**	28	27	24	16	6	6	6
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases	**Quarterly:** General Condition 9 (identified in 15/16 contract as HPA MESS monthly)	**30**	19	13	11	9	2	3	6
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	1	6	0	0	0	0
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%**	88.5%	86.0%	85.1%	85.6%	88.2%	82.6%	82.3%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95%**	70.1%	66.2%	72.2%	75.1%	76.4%	74.3%	71.5%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 fine per patient below performance tolerance	**99%**	97.9%	95.9%	95.2%	99.4%	98.6%	99.4%	99.0%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	2	0	0	0	0
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	3	15	9	0	0	0	0
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**	229	548	205	40	17	8	77
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%	96.9%	97.1%	97.4%	97.1%	97.6%	97.2%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.7%	99.9%	99.8%	To follow	99.6%	To follow	To follow
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	5.1%	4.3%	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%**	86.3%	92.0%	89.1%	89.7%	91.3%	87.7%	88.3%
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%**	1612	1160	1476	1459	539	485	560
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**	563	514	452	486	150	168	164
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**	2381	2375	2365	2509	792	833	876
% 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**	392	388	419	460	146	141	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**	1391	1420	1434	1431	503	424	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)**	353	374	302	258	82	84	107

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	98.3%	99.3%	99.7%	99.1%	99.5%	99.3%	99.1%
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 01/04/2015	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 01/04/2015	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**	86.3%	85.9%	87.0%	87.4%	87.4%	87.3%	86.3%

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Never Events	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	0	0	1	0	0	0	0

District Nursing Activity Summary

Indicator	Source	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Aug	Sep	Oct
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	-	1366	1638	2637	3678	970	940	1768
	Community nurse/service	-	250	390	735	892	229	294	369
	Acute services	-	599	623	1340	1330	348	334	648
	Self / Carer/family	-	228	348	580	1190	238	251	701
	Other	-	133	176	351	412	96	104	212
	Grand Total	-	2576	3175	5643	7502	1881	1923	3698
Community Adult Nursing Contacts	First	-	3008	3170	4875	4566	1355	1494	1717
	Follow up	-	32314	36266	44663	50099	15044	16238	18817
	Total	-	35322	39436	49538	54665	16399	17732	20534
	First to Follow Up Ratio	-	32.3	34.3	27.8	32.9	11.1	10.9	11.0
Community Hospitals average length of stay (days)	Archways	-	20.6	26.8	21.1	23.0	22.1	19.6	20.7
	Malton Community Hospital	-	17.1	16.0	19.9	16.1	17.3	18.0	14.2
	St Monicas Hospital	-	22.0	24.0	15.5	15.5	14.7	14.0	16.6
	The New Selby War Memorial Hospital	-	13.7	17.6	15.3	14.2	14.2	15.6	12.1
	Whitby Community Hospital	-	20.9	21.9	20.0	19.5	19.9	22.8	12.3
	Total	-	18.1	20.2	18.5	17.4	18.0	18.3	14.1
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	5	8	11	0	8	1
		Emergency	77	71	73	79	34	23	28
	Malton Community Hospital	Elective	21	48	19	37	4	6	2
		Emergency	121	110	101	115	33	44	54
	St Monicas Hospital	Elective	9	16	17	14	4	5	4
		Emergency	27	27	43	41	14	16	18
	The New Selby War Memorial	Elective	69	57	59	69	13	28	30
		Emergency	69	55	68	68	25	16	27
	Whitby Community Hospital	Elective	4	0	0	1	1	0	0
		Emergency	142	140	136	133	39	40	81
	Total	Elective	111	126	129	106	22	47	37
		Emergency	436	403	441	492	145	139	208

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Complaints and PALS												
New complaints this month	60	31	39	37	47	43	41	33	41	37	58	n/a
Complaints at same month last year	45	27	52	16	16	50	38	58	38	0	47	0
Number of Ombudsman complaint reviews	0	0	3	4	7	2	4	1	1	3	1	n/a
Number of Ombudsman complaint reviews upheld	0	0	0	0	0	0	0	0	0	0	0	n/a
Number of Ombudsman complaint reviews partly upheld	0	0	1	1	2	0	0	0	0	0	0	n/a
Late responses this month (at the time of writing)***	5	5	4	1	0	3	2	10	7	4	6	n/a
Top complaint issues												
Aspects of clinical treatment	44	18	21	20	32	30	27	21	29	27	30	n/a
Admission/discharge/transfer arrangements	4	0	2	3	2	1	3	1	1	1	5	n/a
Appointment delay/cancellation - outpatient	0	4	1	2	2	2	2	0	1	1	0	n/a
Staff attitude	5	5	10	7	5	3	7	3	3	3	0	n/a
Communications	0	0	2	2	4	4	1	3	2	2	8	n/a
Other	0	0	0	1	0	0	1	1	0	2	0	n/a
New PALS queries this month	552	443	620	559	478	430	416	498	643	530	631	682
PALS queries at same time last year	419	385	503	470	367	378	369	406	442	488	426	463
Top PALS issues												
Information & advice	150	136	189	173	126	158	155	171	237	233	296	309
Staff attitude	0	17	19	14	12	19	14	23	24	14	19	17
Aspects of clinical treatment	105	66	77	47	84	69	63	72	101	64	76	75
Appointment delay/cancellation - outpatient	63	41	47	28	52	29	35	46	59	39	60	55

**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	13	24	17	16	18	12	14	12	20	11	16	22
% SI's notified within 48 hours of SI being identified*	92%	96%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%
% SI's closed on STEIS within 6 months of SI being reported	8%	0%	0%	0%	66%	100%	TBC	TBC	TBC	TBC	TBC	TBC
Number of Negligence Claims	8	8	12	17	15	15	15	12	14	8	14	21
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)						0	2	0	1	0	0	0
Duty of Candour demonstrated within SI Reports (Threshold 100%)						100%	100%	100%	100%	100%	100%	100%
Percentage of reported SI's, investigated and closed as per agreed timescales**** (Threshold (90%)						83%	85%	83%	93%	100%	92%	100%
Percentage of reported SI's with extension requested.						0.0%	13.3%	0.0%	6.3%	0.0%	0.0%	0.0%

* this is currently under discussion via the 'exceptions log'

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Pressure Ulcers**												
Number of Category 2	42	36	51	35	44	37	49	35	38	44	35	28
Number of Category 3	7	5	4	3	6	4	8	8	3	6	3	8
Number of Category 4	2		1		1		1	1			1	3
Total number developed/deteriorated while in our care (care of the organisation) - acute	42	47	50	30	41	31	38	35	34	36	27	27
Total number developed/deteriorated while in our care (care of the organisation) - community	43	43	43	43	43	43	43	43	43	43	43	43
Falls***												
Number of falls with moderate harm	1	6	2	2	3	1	3	5	1	2	2	4
Number of falls with severe harm	2	6	2	5	4	3	6	4	4	1	5	2
Number of falls resulting in death				1					1		1	1
Safeguarding												
% of staff compliant with training (children)	54%	53%	55%	58%	59%	62%	65%	68%	74%	80%	80%	
% of staff compliant with training (adult)	42%	43%	45%	56%	59%	62%	64%	69%	74%	80%	81%	
% 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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Workforce Strategy Committee Meeting
13th October 2015

York Teaching Hospital NHS
NHS Foundation Trust

Attendance:

Dianne Willcocks, Non Executive Director (Chair)
Libby Raper, Non Executive Director (Vice Chair)
Pat Crowley, Chief Executive
Polly McMeekin, Deputy Director of Workforce
Mike Proctor, Deputy Chief Executive
Gail Dunning, Head of Corporate Development
Jonathan Thow, Deputy Medical Director (Education)
Anne Devaney, Head of Corporate Learning
Beverley Geary, Chief Nurse
Wendy Scott, Head of Community Services
Bev Proctor, Assistant Director of Nursing
Brian Golding, Director of Estates & Facilities

Apologies:
Melanie Liley, Head of AHP Services and Psychological Medicine
Sian Longhorne, Senior HR Lead, Workforce Utilisation

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1.0	**Last Meeting Notes Minutes Dated** **Matters arising from July minutes**		The change of time and venue for the WSC meeting on 26th January 2016 was noted. **Draft WSC Terms of Reference** DW requested that the amended ToR be brought to the December meeting.	Draft ToR to be brought to next meeting for review.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
2.0	**Turnaround Avoidance Programme**		**Paper 2** PC presented a paper highlighting and summarising the eleven workforce related work streams originally identified by Sue Holden in relation to the Turnaround Avoidance Programme (TAP). <u>Job Planning Review</u> – PC commented on the need to return to a culture of trust and regulation and this serves as a vehicle for reinforcing accountability to the organisation. Currently there is varied application. DW noted it was important to reapply professionalism by redefining the principles. <u>Centralised Recruitment</u> – PC noted centralised generic nurse recruitment commenced on 1st October 2015 and this indicated the pace in which he wanted to move at for key projects. <u>Retaining and Developing Clinical Bands 1 to 4 support staff</u>. MP commented on the need to focus how we retain these staff once they have completed their training and for career progression. BG commented on the need to look at offering different kinds of placements and to negotiate what we want from the universities. DW suggested that a stakeholder summit may be required to achieve this to collectively achieve one single voice. This is a priority for the organisation and should be updated on in future meetings. <u>Advanced Clinical Practitioner (ACP) Development.</u> AD advised that there would be a pause for reflection and feedback following the completion of the 2nd cohort in July 2016. A new approach is required for future programmes. It was agreed to consolidate and condense the number of work streams and DW proposed that a progress table be created on the developments with 'deep dives' into work streams as and when	To consolidate and condense and to present matrix table with updates for future meetings.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			appropriate.		
3.0	**Workforce of the Future**		**Paper 3** This paper was helpful as a statement of fact. PC felt it was very useful to determine if the workforce shape reflects the Trust's strategy. This should be reviewed regularly.		
4.0	**Update on Stat / Mandatory Training Compliance Trust wide**		**Paper 4** AD summarised the position one year post implementation of the Learning Hub. Capacity to deliver face to face training remains a concern as does poor attendance. Long lead times may be a factor. PM stated that the new pay progression process should address the issue. Plans are required to address non-compliance and for the Board of Directors to be sighted on this issue. Courses need to be relevant and delivered in a concise mode. AD confirmed that courses are systematically reviewed. PM confirmed that Bank staff are paid for training provided they subsequently work at least two further shifts for the Trust. Helen Hey is currently looking into what stat / mandatory training is required for bank nurses. AD confirmed plans to deliver remote access to the Learning Hub.		Plans to address serial non-compliance with training. AD
5.0	**Temporary Nurse Staffing**		**Paper 5** PM summarised initiatives to grow the Nurse Bank. This included introducing weekly pay; paying for experience plus 5% and specifically for substantive staff paying an additional 15% over the winter period. The Nurse Bank team were also going to trial providing a seven day service.	Temporary Staffing to remain a standing	Board to be made aware of the barriers to what needs to be achieved to

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			The group welcomed these initiatives. DW and LR expressed the need to clear and effective communication to maximise these initiatives.	agenda item.	reduce agency use.
6.0	**Community Workforce Development Programme**		**Paper 6** WS and BP presented the challenges currently facing the community nursing workforce and discussed how they could develop an appropriately trained and skilled workforce along with the wider support this would require. Issues comprised an ageing workforce and a continuously changing demography. The legacy of integration remains and the existing models require updating. WC proposed a working group to address these issues.	WS and BG to develop a working group and provide an update on their actions for the December meeting.	
7.0	**Pilot Site for the Health & Wellbeing Programme**		PM advised that the Trust has been identified as 1 of 12 Trusts nationally to pilot a new Health & Wellbeing programme. This stems from the 5 Year Forward review with the Department of Health and NHS England as co-ordinators and NHS Employers taking a supportive role. The Pilot will last 12 months. Action plans have been agreed and best practise will be shared. These include offering healthy food and health checks for the over 40s. Some funding will be provided but the amount has not yet been confirmed. Measures will include, for example, a reduction in sickness absence. LR and PM acknowledged the need for clear communication around this programme.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
8.0	**Staff Survey – "You said, We did" and 2015 Survey**		PM summarised the outcomes of the 2014 Staff Survey and actions for the 2015 survey. The response rate for the 2014 staff was 47% which is low and the Trust wants to improve on this for the 2015 survey. Outcomes from the 2014 staff survey include: the Staff Brief video; Staff surgeries and the Recommend a Friend campaign. The 2015 staff survey is a mixed mode survey and will target all staff with the majority receiving their survey via email. 1400 staff have received paper questionnaires. There will be 3 reminders on16th October, 6th November and 20th November and the closing date for responses is 20th November. There will be greater links this year with HRMs and Managers to target those areas with low completion rates. DW expressed interest in viewing the final written report of what worked well and what didn't.		
9.0	**Workforce Risks Matrix Review**		**Paper 7** PC commented on the usefulness of the matrix and wanted to make sure it is thread through all of our workforce priorities.	Risk Matrix to be a standing item for future meetings.	
10.0	**Junior Doctor Induction / Junior Doctor Experience**		**Paper 8** – <u>Junior Doctor Induction</u> AD summarised the current Junior Doctor induction process. Following an audit of the induction process there is now a more robust process in place. Corporate induction handbooks have been developed which are also available on the Learning Hub. A 'trackable' checklist has also been introduced to ensure compliance. They are tracked for the full 12 months. Non-compliance results in them not being signed off for ARCP		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Panels. It is a huge resource requirement to keep on top of tracking this. <u>Junior Doctor Experience</u> JT summarised where the Trust was in terms of benchmarking. The Trust is in the top quarter for beds per consultant but the bottom quarter for beds per registrar and it would involve £2 million investment to get to the mid-point. There are specific areas where we need more doctors and this could potentially incur an approximate cost of £500,000 to get to that position. Areas such as ED and Acute Medicine are suffering from large gaps and this is a significant problem. Although there have been efforts to plug these gaps more investment is still required. DW commented there needed to be a plan for where we want to be and by when and it was agreed that this would be discussed in more detail at the next meeting in December.	JT to provide a paper detailing key issues in medical establishment – to include, in particular, the non-consultant, non-training grade.	
	Next meeting dates		**8th December, 2015, 10.00 – 12.00** Classroom 4, Post Grad Medical Education Centre, 5th Floor **26th January 2016, 08:30 – 10:30** Mtg Room1, 2nd Floor, Park House **15th March 2016, 13:00 – 15:00**, Classroom 4, Post Grad Medical Education Centre, 5th Floor		

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

Workforce Metrics and HR Update Report

Action requested/recommendation

The Board of Directors is asked to read the report and discuss.

Summary

The attached document provides information up to October 2015, relating to key Human Resources indicators including; sickness, recruitment & retention and workforce expenditure.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Improve our effectiveness, capacity and capability	☒
3. Develop stronger citizenship through our working with partners	☐
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	November 2015
Version number	Version 1

Board of Directors – 25 November 2015

Workforce Metrics and HR Update Report

1. Introduction and key messages

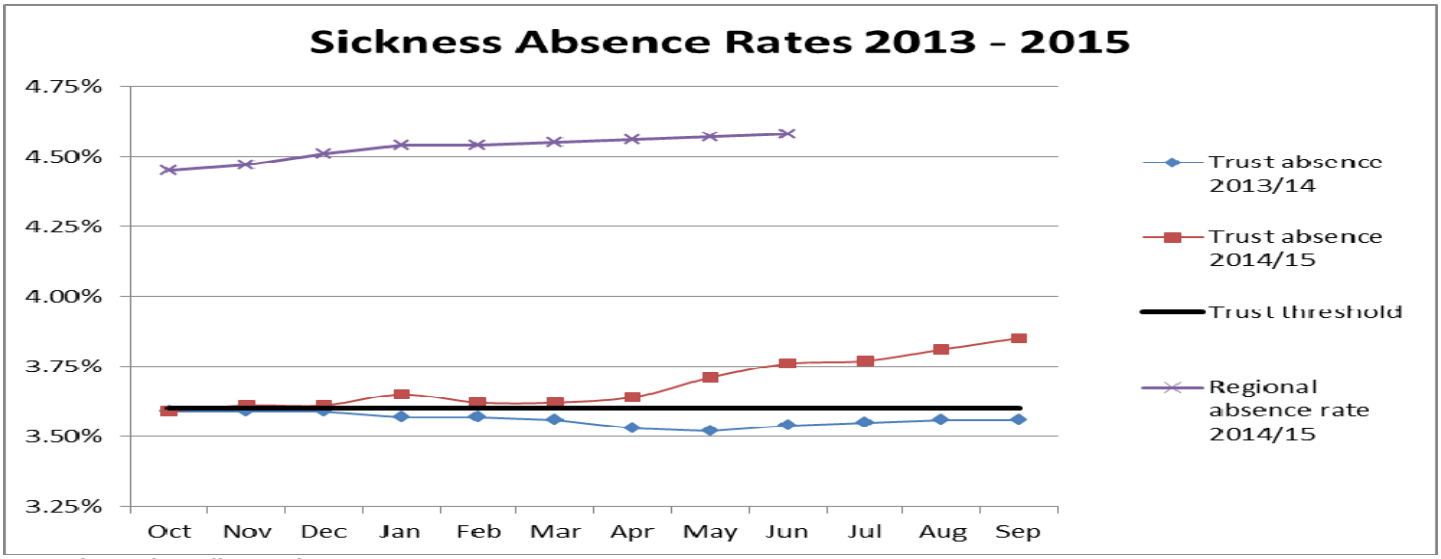
This paper presents key workforce metrics up to October 2015 (where available). The narrative will detail trends and any actions which are being taken to address specific issues. Of particular note:

- Annual sickness absence rates have increased slightly again this month although the Trust's rates continue to compare favourably to rates across the region
- Turnover rates have also increased again, of particular note is the continuing increase in turnover amongst registered nursing staff.
- Overall there has been a small reduction in pay expenditure, within that there has been a small reduction in temporary staffing expenditure and an increase in pay for contracted hours.

2. Human Resources Report

2.1 Sickness Absence

Graph 1 – Sickness absence rates



Source: Electronic Staff Record

The above graph compares the rolling 12 month absence rates to the Trust's locally agreed threshold and to the regional (Yorkshire and Humber) sickness absence rates.

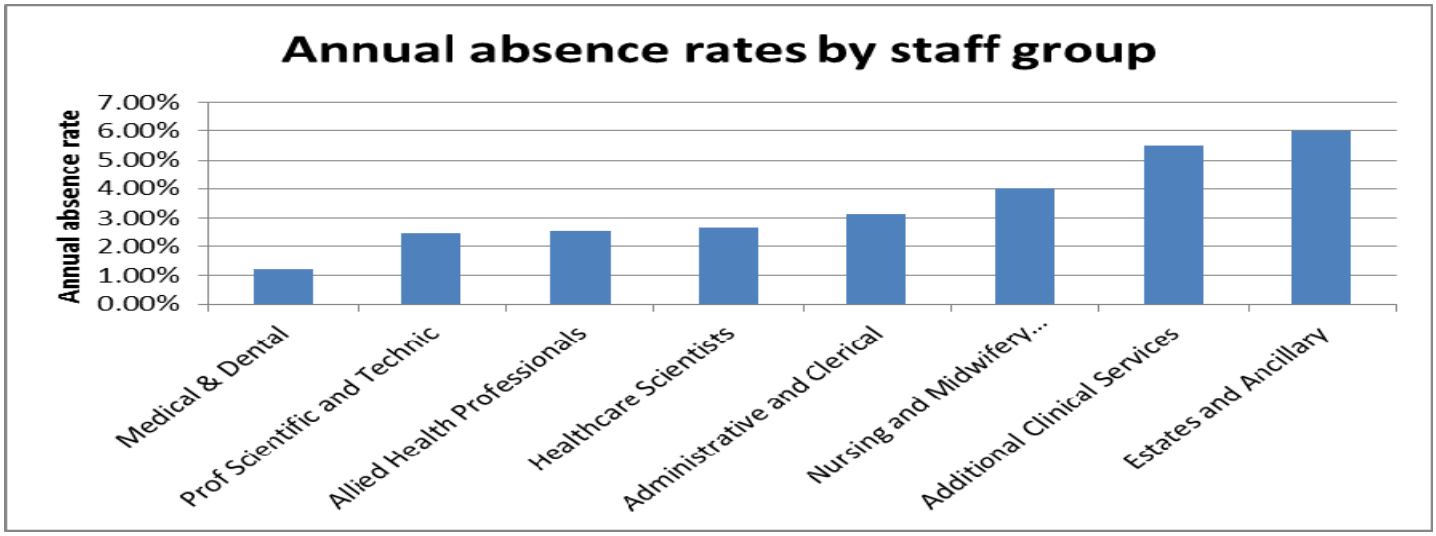
Regional benchmarking data is currently only available up to June 2015. As has been previously reported, Trust absence rates are consistently lower than absence rates across the Yorkshire and Humber region. In the quarter April – June the Yorkshire and Humber region had the third highest regional absence rate of all regions.

There has been a further, slight increase in the annual absence rate this month. As reported last month

much of this increase is the result of work which has been undertaken to improve the reporting of doctors' sickness which has seen the annual absence rate for this staff group increase from 0.84% in August 2014 to 1.21% in September 2015.

Absence rates do vary significantly between staff groups as shown in the graph below. Data published by the Health and Social Care Information Centre (HSCIC) shows that this is also the case across the whole of the NHS.

Graph 2 – Sickness absence rates by staff group across the Trust



The data published by the HSCIC shows that Medical and Dental absence rates are the lowest of any staff group in the NHS whilst absence rates for Healthcare Assistants and Other Support staff (this includes those in the Additional Clinical Services group in the graph above) are the highest.

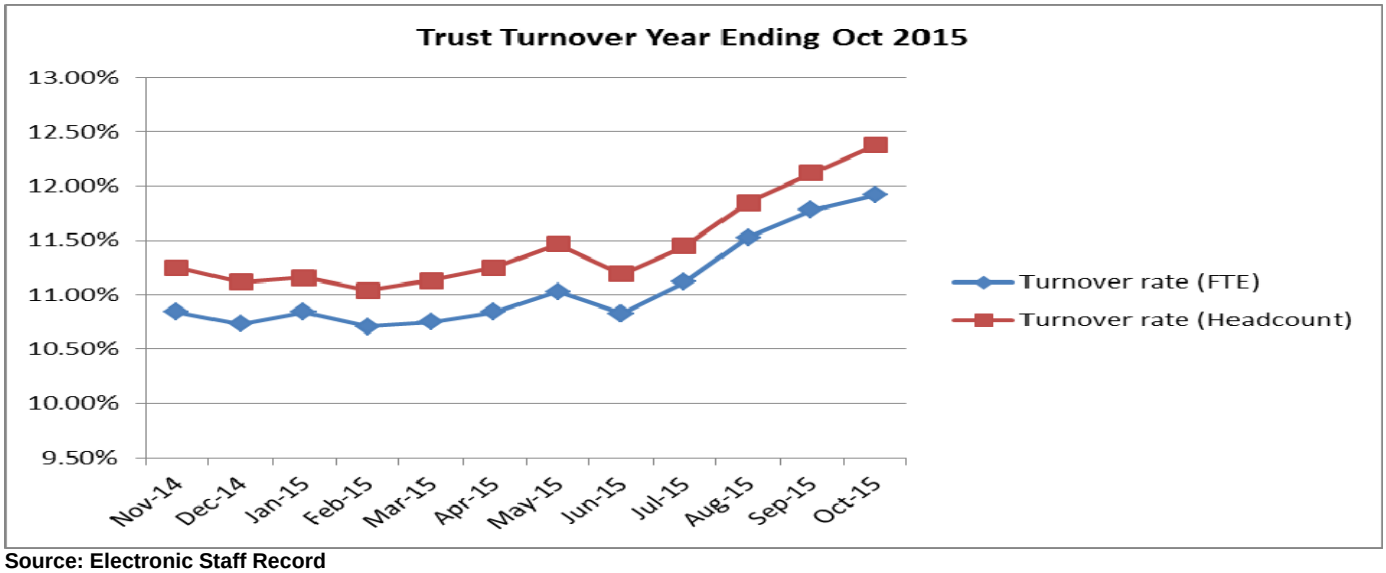
The top three reasons for sickness absence as days lost in the year to September 2015; were anxiety/stress/depression accounting for 19%; musculoskeletal (MSK) problems accounting for 11% and gastrointestinal problems accounting for 8.5%.

2.2 Turnover

Turnover

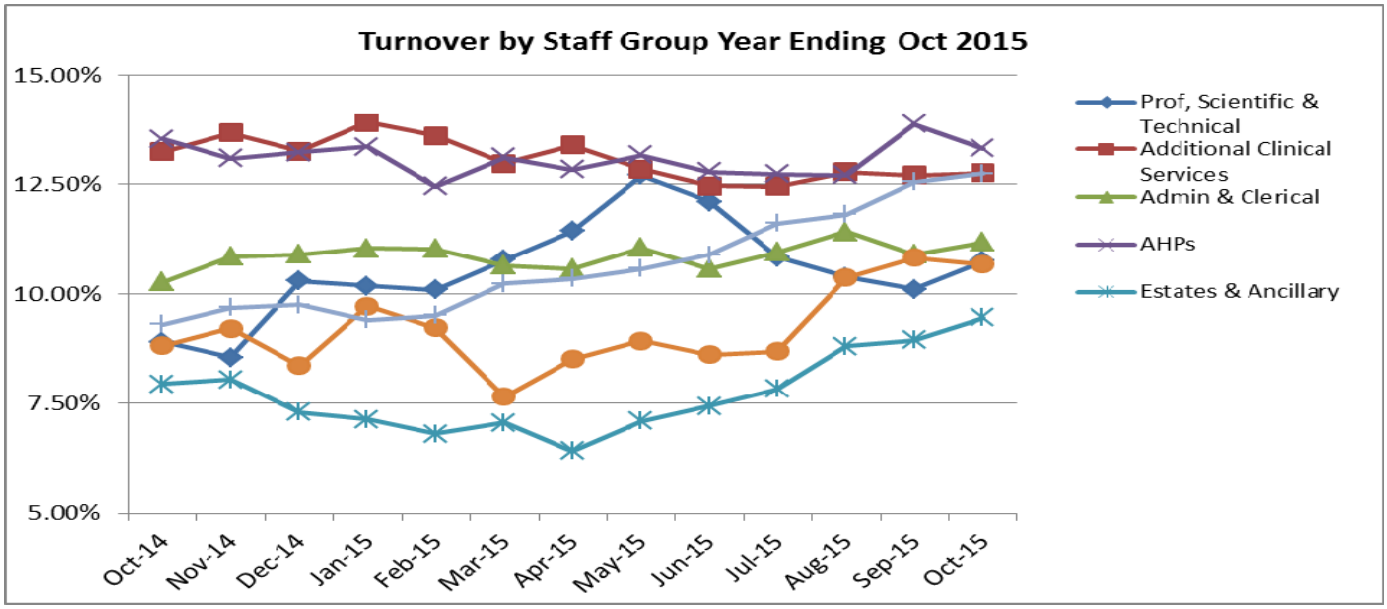
Turnover is continuing to show an upward trend with the annual turnover rate increasing from 12.12% in September 2015 to 12.38% in October 2015.This represents more than 1,000 leavers in the year to October 2015. Voluntary resignations accounted for more than 60% of turnover and retirements accounted for more than 26%.

Graph 3 – Overall Turnover Rates



Source: Electronic Staff Record

Graph 4 – Turnover rates by staff group



It was reported last month that in the last year turnover amongst registered nursing and midwives has increased by more than 3%. There has been a further increase this month from 12.55% to 12.75%. Much of this can be attributed to retirements; some of whom have subsequently returned to our employment. Turnover rates for Additional Clinical Services (12.76%) and Allied Health Professional (13.32%) are the other two groups which are higher than the overall Trust turnover rate.

Turnover also varies significantly between directorates, ranging from 7.27% in Systems and Networks Services to 29.63% in the Operations Management (Scarborough) Directorate, albeit this is a small directorate of only 27 staff and this rate of turnover only equates to eight leavers.

As reported last month 'Healthcare Scientists' is not included in the graph. This is because a recoding exercise has been undertaken which distorts the pattern of behaviour. The average turnover of Healthcare Scientists since October 2014 is 15%.

Please note that when calculating turnover both junior doctors on rotational contracts and bank staff are excluded to prevent distorting the turnover figure. This is a common approach used across the NHS for calculating turnover.

2.3 Pay Expenditure

It was reported last month that Monitor has introduced new rules around agency usage and whilst this is not mandated for this Trust we are encouraged to engage with the rules imposed on others to assist with our reduction in usage, specifically when the need arises to utilise agency staff; this should be from a 'Framework' agency from 19th October 2015.

Trusts are required to report to Monitor any 'off framework' agency usage including the reasons for usage. Trusts are required to seek approval from Monitor where they wish to engage with 'off framework' agencies – this may be where such agencies have been able to provide a reliable supply of temporary staffing, particularly for certain hard to fill specialties.

Proposed caps on agency rates

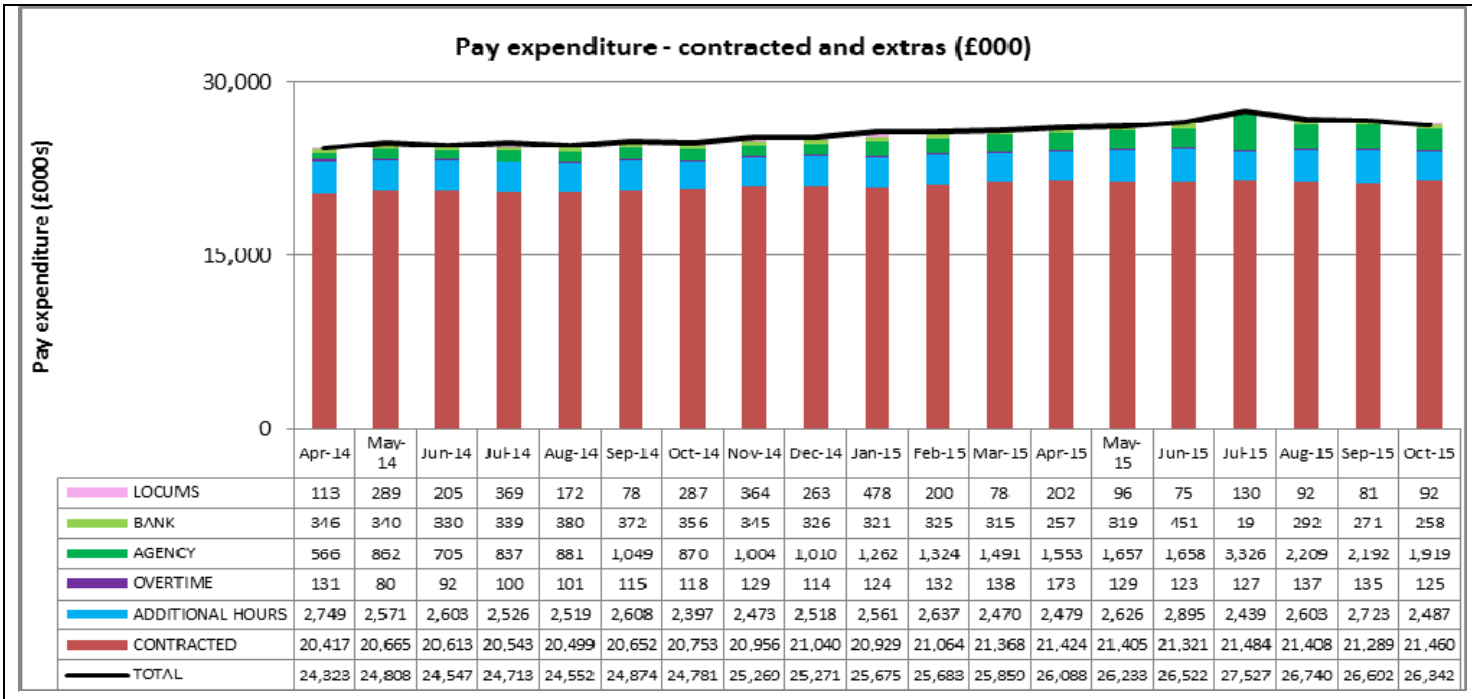
Monitor has also proposed caps on agency rates for nurses and medics. These proposals are being consulted on and the Trust has provided a response but if the proposals are accepted, Trusts will be expected to follow the new rules from 23 November 2015. These proposed caps are in some cases a significant reduction on the rates currently charged by Framework agencies. For example; A Foundation Year 2 medic rate will reduce by 25% on 23rd November; reducing further by a total of 54% on 1st April 2016. Specialty Doctor rates will reduce by 28% and Consultant rates by 25% by 1st April 2016.

Locum / agency rates are significantly higher than NHS pay. Monitor's plans to tackle these escalating rates are welcome. However, operationally these plans will be difficult to implement. Framework agencies have successfully navigated NHS procurement regulations to secure their position and future income. These proposals are therefore at odds with the contractual regulations.

Bank

New rates of pay for bank nurses and weekly pay for bank nurses and medics were introduced in November. The teams responsible for the co-ordination of temporary staffing will monitor the impact of these incentives and report on this in future papers.

Graph 5 – Pay Expenditure

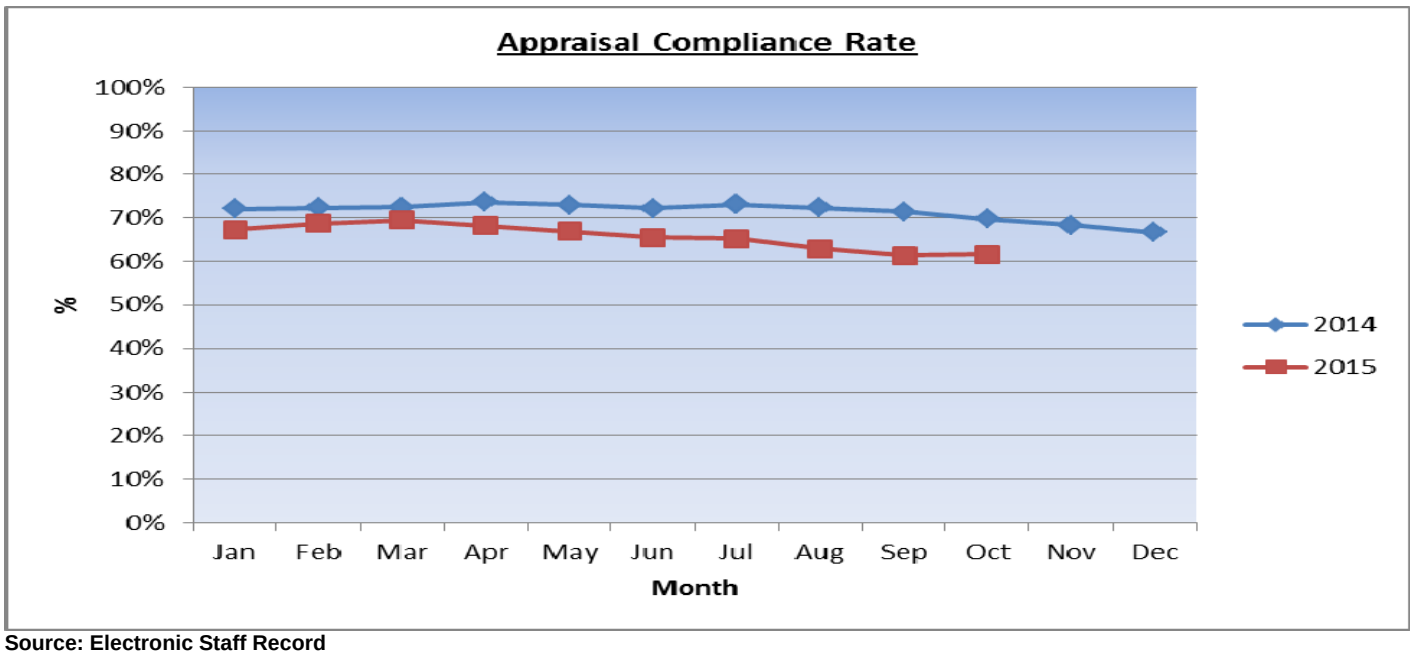


	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
LOCUMS	113	289	205	369	172	78	287	364	263	478	200	78	202	96	75	130	92	81	92
BANK	316	310	330	339	380	372	356	345	326	321	325	315	257	319	451	19	292	271	258
AGENCY	566	862	705	837	881	1,049	870	1,004	1,010	1,262	1,324	1,491	1,553	1,657	1,658	3,326	2,209	2,192	1,919
OVERTIME	131	80	92	100	101	115	118	129	114	124	132	138	173	129	123	127	137	135	125
ADDITIONAL HOURS	2,749	2,571	2,603	2,526	2,519	2,608	2,397	2,473	2,518	2,561	2,637	2,470	2,479	2,626	2,895	2,439	2,603	2,723	2,487
CONTRACTED	20,417	20,665	20,613	20,543	20,499	20,652	20,753	20,956	21,040	20,929	21,064	21,368	21,424	21,405	21,321	21,484	21,408	21,289	21,460
TOTAL	24,323	24,808	24,547	24,713	24,552	24,874	24,781	25,260	25,271	25,675	25,683	25,850	26,088	26,233	26,522	27,527	26,740	26,602	26,342

2.3 Appraisal

Appraisal activity

Graph 4 – Appraisal Compliance



Source: Electronic Staff Record

The appraisal compliance rate was 61.68% for the year ending 31 October 2015. The Trust's local target remains at 95%. This is the first month in which the appraisal data for permanent medical staff has been included in the figures as these have historically been recorded separately. 51.6% of medical staff have had an appraisal within the past 12-months and this compares with 62.4% for non-medical staff.

Detail was provided in last month's report about the work that has been undertaken in relation to the Trust's appraisal process including improved documentation and development of an e-learning package

from staff and managers. Further updates will be provided in future reports.

2.4 Employee Relations Activity

The table below describes the number and type of employee relations activity during October 2015.
* denotes staff on medical and dental terms and conditions are excluded from the figures as these are reported by the Maintaining High Professional Standards Team (MHPS).

Employee Relations Activity	Last month (September 2015)	This month (October 2015)
Number of Disciplinaries (including investigations)*	18	15
Number of Grievances	6	7
Number of Formal Performance Management Cases (Stage 2 and 3)*	3	4
Number of Employment Tribunal Cases*	4	6
Number of Active Organisational Changes (including TUPE)	18	12
Number of long term sick cases ongoing	Not previously reported	142
Number of short term sick cases (Stage 2 and 3)	Not previously reported	123

2.5 National Staff Survey

The annual National Staff Survey opened in September and will closes 27th November 2015. The Staff Survey includes the Staff Friends and Family Test for quarter 3. This year all staff have been invited to participate in the survey and the Trust has taken a 'mixed mode' approach to the methodology, offering completion of the survey electronically to the majority of staff and a paper survey to those without an active e-mail address.

As at 12 November 2015, the response rate to the survey was 40%. The final response rate in last year's survey was 47%. The Trust is publicising the survey to increase the uptake as much as possible.

Results of the survey will be presented to Board when they are published early in 2016.

2.6 ECJ Ruling on Travel Time to Work

The European Court of Justice (ECJ) has ruled that in the case 'Federacion de Servicios Privados del sindicato Comisiones obreras v Tyco Integrated Security SL', where workers have no fixed place of work, the time the workers spend travelling between home and their first and last client is considered working time under the Working Time Directive.

Although the Trust do have employees, especially in the Community, who travel to and from a patient's home sometimes directly from their home; this ruling is not applicable to any Trust employees. This is because all our employees have a designated base of work which is within reasonable distance.

2.7 Junior Doctor Contract Negotiations and Associated Industrial Action

Since 2008, employers and the British Medical Association (BMA) have agreed that the current contract needs to be modernised. They also agree that the current banding system (introduced in 2000) is outdated, unfair and operates with unintentional consequences.

A fairer system that rewards those who work the most unsocial hours is needed. For example, under the current contract, some doctors who work 41 hours could be paid the same as some who work 48 hours, and a doctor working 9am-6pm, Monday-Friday can be paid the same as a doctor working shifts 24/7.

The government also wants an end to the current system where NHS employees receive pay increases every year for time served. Some doctors continue to receive an incremental increase each year even though they are not progressing to an increased level of responsibility.

In October 2013 NHS Employers were mandated by all four UK health departments to begin negotiations with the BMA on a new contract for doctors and dentists in training; negotiations were to be completed by October 2014 and implementation to begin in April 2015.

In February 2014 an interim joint report submitted on the negotiations to Health Ministers confirmed that both sides had agreed that the new contract must be cost neutral, that high-level definitions of pay had been agreed and discussions to develop a set of pay principles were continuing.

In October 2014 the BMA withdrew from negotiations. In response the Government has proposed a new contract with the intention of imposing this contract from 3rd August 2016 should the BMA not re-enter negotiations.

The current contract value comprises basic pay with banding allocation. The new offer suggests the basic pay will increase on average by 11% but may also include flexible pay premia (recruitment and retention premia); unsocial hours enhancements to be paid for work done between 10pm and 7am or on a Sunday and on-call availability allowance. Basic hours will remain at 40. Additional hours could be agreed up to 48 (on average) or up to 56 hours for those who opt out of Working Time Regulations. There would be a new absolute limit of 72 hours in seven consecutive days which is considerably less than the 91 hours that the current contract allows. Detailed below are a couple of examples as to how this might apply:

Example 1: F1 with Band 1B moving to F2 Full shift 8 week rota

	Current Grade	New offer (New Grade)	Change	% Change	Old TCS (New Grade)	Change	% Change under new offer
Grade	F1	F2			F2		
Basic pay	£22,862	£31,600	£8,738	38.2	£28,357	£3,243	11.4
Banding supplement	£9,145	n/a			£14,178		
Rostered hours above 40	n/a	£4,148			n/a		
Saturday premium	n/a	£132			n/a		
Sunday premium	n/a	£461			n/a		
Night premium	n/a	£3,111			n/a		
Availability	n/a	£0			n/a		
Programme premium	n/a	£0			n/a		
Flexible pay premium	n/a	£0			n/a		
Pay protection	n/a	£0			n/a		
Total	**£32,007**	**£39,451**	**£7,444**	**23.3**	**£42,535**	**-£3,084**	**-7.3**

***Basic pay uplifted by an assumed 1% to reflect April 2016 pay award**

Example 2: F2 with Band 1A moving to ST1 Full shift 6 week rota

	Current Grade	New offer (New Grade)	Change	% Change	Old TCS (New Grade)	Change	% Change under new offer
Grade	F2	ST1			ST1		
Basic pay	£28,357	£37,400	£9,043	31.9	£30,302	7098	23.4
Banding supplement	£14,178	n/a			£15,151		
Rostered hours above 40		£4,987					
Saturday premium		£208					
Sunday premium		£727					
Night premium		£4,909					
Availability		£0					
Programme premium		£0					
Flexible pay premium		£0					
Pay protection		£0					
Total	**£42,535**	**£48,231**	**£5,696**	**13.4**	**£45,453**	**2778**	**6.1**
***Basic pay uplifted by an assumed 1% to reflect April 2016 pay award**							

On 28th October 2015 the BMA notified the Trust of their intention to ballot their members. The ballot asks whether they support taking strike action and / or action short of strike. The ballot opened on 5th November and closes on 18th November 2015.

The BMA has taken the unusual step of announcing their dates of industrial action prior to the ballot closing.

Should the ballot be in favour of both strike action and action short of strike the BMA's proposal is:

In the first of three events, junior doctors will provide emergency care only, which is the same as they would provide in their specialty on Christmas Day on Tuesday 1 December (from 8am until 8am Wednesday 2 December). They then intend to escalate their industrial action over the following weeks and have two full walk-outs on Tuesday 8 December (from 8am to 5pm) and Wednesday 16 December (from 8am to 5pm).

The Trust currently employs 224 junior doctors who are members of the BMA. The majority of them are based on the York hospital site, 155 with 57 based on at Scarborough hospital.

2.8 The Living Wage as determined by the Living Wage Foundation

During the first week in November each year The Living Wage Foundation announces the new Living Wage. This is separate to the national living wage referenced by the Chancellor of the Exchequer in the Budget earlier this year. This November there has been an increase of 40p from £7.85 to £8.25 per hour.

This increase equates to an annual salary of £16,131; this engulfs the bottom three spine points of the Agenda for Change payscale and is applicable to 1,100 Trust employees. The full year cost would be £875,000 although £183,000 of this would be off-set by the 1% cost of living uplift from April 2016. This is a significantly higher cost than the previous year which only required a 13p per hour uplift from the minimum point on the Agenda for Change payscale.

These calculations do not take into account the reduction in this cost from incremental drift or the costs associated with natural turnover. Although it is recognised that paying the Living Wage will improve staff

engagement and reduce turnover amongst the affected staff.

To remain a Living Wage employer the Living Wage Foundation allows up to six-months for implementation. The Trust will keep this under review with the objective to implement this uplift as soon the financial position offers us the opportunity to do so.

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	**November 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 November 2015

Procurement Annual Report

Action requested

The Board of Directors is asked to note the progress with regard to implementation of national and local procurement strategies.

Summary

This report provides details of the Purchasing Department progress in the last 12 months in their own strategic aims and also the national strategy.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Improve our effectiveness, capacity and capability	☒
3. Develop stronger citizenship through our working with partners	☒
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 is no direct reference to CQC outcomes

Progress of report	Board of Directors
Risk	No risk.
Resource implications	Resource implications identified in the report.

Author	Ian Willis, Head of Procurement
Owner	Andrew Bertram, Director of Finance
Date of paper	November 2015
Version number	Version V.1

Board of Directors – 25 November 2015

Procurement Annual Report

1. Introduction & Background

In the Autumn of 2013 the Board of Directors received a presentation on the Trust's procurement strategy from Ian Willis, Head of Procurement and in November 2014 received an update. This is the 3rd annual report on matters of Trust procurement.

The department is split into two distinct functions; those of Buying (or procurement) and Materials Management (or 'top-up'). Both functions are supported by Receipt and Distribution teams (often referred to as 'Stores'). The buying function is primarily concerned with higher value non-stock procurements whereas Materials Management deals with the day-to-day needs of wards and departments. Buying is further split into two work-streams; Medical and Surgical, and Estates, Facilities and Corporate Services. Teams are led by qualified (MCIPS) staff with the aim to guide clinical staff through the regulatory regimen helping them make informed or enforced choices (e.g. e-Catalogue).

The purpose of this report is to provide an annual update to the Board of Directors on the work of the Trust's Procurement Team over the preceding financial year, an overview of assurance level of the function and details of progress made against local and national procurement strategies.

Philip Ashton is the Non-executive Director linked to Procurement and has taken an active interest in this area. This paper has been prepared with Philip's oversight.

2.1 Expenditure Levels

2013/14	Area	Sum of Invoice Amounts	% of Invoice Amounts	Invoice Count	% of Invoice Count
Procurement' Controlled	Purchase Orders (inc York Catering)	£ 58,236,405	37.17	46,367	43.04
	NHS Supply Chain	£ 13,560,262	8.65	114	0.11
	Agency Staff	£ 10,977,755	7.01	7,531	6.99
Active Support	Pharmacy	£ 33,014,481	21.07	31,046	28.82
	Catering (Scar & Brid)	£ 679,491	0.43	2,690	2.50
	Estates	£ 589,452	0.38	2,561	2.38
	Other (Capital etc)	£ 24,022,836	15.33	14,009	13.00
Advice (if required)	Utilities	£ 5,256,727	3.35	1,122	1.04
	Other NHS Trusts (Services, Tests etc)	£ 10,348,864	6.60	2,296	2.13
		£ 156,686,272	**100.00**	**107,736**	**100.00**

2014/15	Area	Sum of Invoice Amounts	% of Invoice Amounts	Invoice Count	% of Invoice Count
Procurement' Controlled	Purchase Orders (inc York Catering)	£ 61,606,383	36.06	47,704	42.03
	NHS Supply Chain	£ 15,568,636	9.11	368	0.32
	Agency Staff	£ 16,980,080	9.94	9,504	8.38
Active Support	Pharmacy	£ 36,894,854	21.60	31,907	28.12
	Catering (SGH / Brid)	£ 507,573	0.30	1,997	1.76
	Estates	£ 744,737	0.44	3,023	2.66
	Other (inc Capital)	£ 24,838,252	14.54	14,313	12.61
Advice (if required)	Utilities	£ 4,379,948	2.56	626	0.55
	Other NHS Trusts (Services, Tests etc)	£ 9,324,264	5.46	4,038	3.56
		£ 170,844,727	**100.00**	**113,480**	**100.00**

Key variables.

Agency Staff

- NHS Professionals Ltd and Medacs Healthcare Plc rose by nearly £1M each
- 7 others have increased by more than 1000% (one was 9000+%).

Pharmacy

- Higher cost drugs with greater patient numbers in 3 main areas.
  - Ophthalmology: Lucentis and Eylea account for around £2M (macular degeneration).
  - Biologics: Drugs used to treat R. Arthritis, Irritable Bowel Disease and Psoriasis
  - Cancer drug fund: Increasing numbers of high cost cancer drugs have been made available via the cancer drug fund. (Direct pass-through to CCG/NHSE).

Utilities

Down almost £1M due to a mixture of Carbon Fund initiatives (such as the CHP plant and low energy lighting) and a reduction in wholesale gas prices.

2.2 National Strategy: DH Procurement Better Procurement, Better Value, Better Care

Published in August 2013 the DH Procurement Strategy outlined the NHS as needing to deliver £1.5bn of savings from £20bn of spending. (It rose to £2bn shortly after publication).

The 4 strategic objectives were:

1. Delivering immediate efficiency and productivity gains
2. Improve data, information and transparency
3. Improving outcomes at reduced cost through clinical procurement review partnerships
4. Improve leadership and capability

Lord Carter of Coles was appointed in June 2014 as the NHS Procurement Champion. The aim of his role is to drive the modernisation and accountability of procurement across the NHS and help hospitals to cut waste, save money and drive efficiencies which can then be reinvested into frontline patient care by improving workflow, containing workforce costs, and improved hospital pharmacy and medicines optimisation.

The review's interim report was published in June 2015. It places increasing pressure on the NHS to identify efficiency savings and deliver £22 billion in productivity improvements by 2020.

The Carter review identifies *only* £5 billion to be made from savings, underlining the scale of the productivity challenge facing the NHS and the need to deliver better value by taking action at all levels of the NHS to change clinical practice.

The departmental response to the strategy and the changing emphasis in the Cole review is as follows;

- Evolve/develop the Trust's Procurement Strategy (including periodic reviews),
- Provide greater support for directorates and departments,
- Using targeted projects: Project 100 (looking at the top 100 products), Project 321 (looking at duplication across departments/sites) and Freight Project (reduced charges)
- Implementing key actions; the department has implemented the 10 key actions for NHS Provider organisations outlined in the DH Procurement Transparency Paper (a sub-paper aligned to the DH strategy and drafted to support objective 2).

2.3 Local York Trust Procurement Strategy

The Trust Procurement Strategy was drafted with the Trust's Strategic Plan Objectives in mind; to improve quality and safety, developing and enabling strong partnerships, continuous improvement, and improve facilities and protect the environment.

The Procurement Strategy objectives are;

1. Increasing contract coverage (to continually improve quality & patient safety)
2. Managing cost through control (by limiting approved choices & releasing cash savings)
3. Be a good corporate citizen (to protect our environment & support SME's & BME's)
4. Improve the Standards of Procurement (across the Trust to improve quality& patient safety)

We have been making good progress in all areas of the strategic action plan.

- Contract coverage. Target: To increase spend under contract from £12M to £20M over 3 years. It is up to (around) £67M and continues to grow. This has been done by partnering more closely with Crown Commercial, NHS Supply Chain and the North of England CPC.
- Controlled buying through the use of an electronic catalogue. In 2013 'off-catalogue' buys were trending upwards towards 40%. Target: To reduce to 35% by 2015, 30% by 2016 and 20% by 2017 the percentage of non-catalogue requests. In October it was 22.78%.
- Managing costs: We have achieved the COINS (Clinical, Orthopaedic & Indirect Spend) Project target of saving an extra £1M over 3 years and continue to increase in-year savings.
- Cost through control: The available stationery list has shrunk from 8,500 lines to 159 using NHS Supply Chain's core list. (We were already using a core list of 258). Spend has decreased over the first 6 months of this year by almost £50,000 and the number of ordered lines has reduced by nearly 1,500 when compared to the same period last year.
- Supporting local enterprises. In 2014/15 the Trust spent £10.5m (6.2%) in the North Yorkshire YO region. The target is to increase this as far as possible within EU rules.
- Good Corporate Citizenship: In our submission for the aassessment the Purchasing

Department was ahead of the 40 other cohort organisations. The GCC has 3 Levels (Getting Started, Getting There and Excellent) covering 6 domains (Policies and Performance, Procurement Skills, Procurement Process, Engaging Suppliers, Procuring for Resource Efficiency, and Ethical Procurement.

- Improving Standards: Medical & Surgical Team leader Nicola Cockerill won a national award (Emerging Talent Award) from the Health Care Supply Association.
- Standards: Department was a finalists at the Celebration of Achievement Award in the Efficiency Category and team members have been nominated for the monthly Star Award.
- Improving Quality: Representative on the NOECPC Customer Board and the NHS Supply Chain Northern Customer Board

<u>Business Case Developments - (Unpacking - Materials Management/Stores/Wards).</u>

In August 2013 the department submitted a business case to expand the Materials Management Service into 40 additional areas by introducing an unpacking service.

This was to allow stock to be unpacked in a controlled and timely manner, making the wards tidier and safer places to work and treat patients. It also gave back valuable time to care so, already busy, medical staff could treat patients by not having to order or unpack stock.

The team now visits 62 Wards & Departments on a weekly or twice weekly basis reviewing usage and agreeing safe stock levels. The cages are delivered, unpacked and removed the same morning and stock is rotated by use by date and storage areas tidied.

<u>Results</u>

- Returns have halved
  - Getting it right first time (reducing wasted time & effort. Improving patient safety).
- Discrepancies have doubled.
  - We have captured and recorded more missing deliveries.
- Rebates have doubled.
  - Through standardisation and consolidated supply (improved price banding).

Period / Metric ***(NHS Average)***	Returns (***£1,889***)	Discrepancies (***£3,103***)	Rebates (***£1,016***)	Total
1st 6 months of 2013/14 (before unpacking)	£33,754	£24,177	£26,764	£85,087
1st 6 months of 2015/16 (with unpacking)	£16,848	£47,325	£51,329	£115,803

A pilot has been completed in SBCU at Scarborough to affirm that what we do in York could be replicated on the East Coast. During the initial tidy we found £400 of stock out of date with some items as old as five years out of date. We also found out that two different people were ordering the same items for the ward each week. The picture clearly demonstrates what we achieved in a short period of time. As SCBU is only a small ward (and possibly not statistically significant) we will be moving into ICU at SGH to see what we can achieve there during a month long pilot/project.	

Nursing Agency

- Nursing Temporary Staffing – Procurement have been working with the Trust Nurse Bank Manager to increase the number framework agencies used by the Trust –to reduce the use of non-framework agencies, and have also provided support on the introduction of the Nurse Bank at York hospital site. We have recently supported a tendering exercise in the recruitment of international nurse's, which also aims to reduce agency spend.
- Medical Locums – We brokered a procurement project and have just signed up to a new 2 year agreement for a master vendor arrangement using the CPC framework which started 10th June 2015.
- AHP/HSS Temporary Staffing – We are signed up to the master vendor agreement using the CPC Framework

Sustainable Food & Drink Procurement

In response to the DH "Hospital Food Standards", Procurement is actively working with our Catering colleagues to achieve the sustainable procurement of food to support the Trust's Food & Drink Strategy. The aim is to implement higher environmental and ethical standards in the procurement/sourcing of food and drink our staff, patients and visitors consume by encouraging suppliers to go further than industry standards in the welfare of animals or soil protection. We are also looking at how we might also support communities by asking suppliers to consider social benefit.

Capital, Estates and Facilities

We have developed and tendered our own contracts for both architect design services and construction work, this promotes compliancy, supports local SME's and promotes partnership with the suppliers, whilst delivering efficiency of process internally and saves resources. Design and construction work is called-off at the tendered rates without the need to conduct a tender exercise each time.

The number of contracts under the care and management of the Procurement team on behalf of the Estates and Facilities departments across the Trust have increased by 30%. This is due to the increased number of contracts not previous handled by the department and the creation of new ones. Where possible Trustwide multi-year contracts have been initiated and the Trust is seeing the benefits of this; for example one particular combined contract saves the Trust

circa. £100,000 over a three year period.

Through increased engagement with the E&F the number of tenders has increased leading to an 80% reduction in the number of Single Tender Action forms being submitted.

Local Projects

Local initiative - Project 100: Working with CET/CIT to further standardise and work through the top 100 items. This equates to 31% of NHSSC spending and includes many higher profile / risk of change products such advanced dressings. As an example we have switched from a nationally supplied waste sack to one supplied by a local firm in Sherburn-in-Elmet. We have received positive feedback from users and secured £22K in savings so far. We expect to reach £35K before the end of the financial year for this product.

Hearing aids
Working with Audiology and Harrogate Trust we have combined volumes (Harrogate being larger users a particular brand) and negotiated a rebate on top of national pricing. The forecast rebate is £97k this financial year.

2.4 Procurement Assurance

Title	**2012/2013**	**2013/2014**	**2014/2015**
Non Pay Expenditure	Significant (Y1364)	Significant (Y1465)	Limited (Y1529)
Although the overall assurance level was Limited, Control Objective No1 (Orders for goods and services are placed with the most appropriate suppliers in terms of cost, quantity, and delivery and only after costs have been ascertained) received Significant Assurance.			
Single Tender Actions	~	Limited (Y1431)	Significant (Y1507)
Non Tender Procurement	Significant (Y1359)	~	~
E Tendering System	~	Significant (Y1432)	~
Credit Card Spending	~	~	Significant (Y1555)
Freight Charges	~	~	Low (Y1558)

The Audit Objectives for Freight were: The Trust being aware of the freight charges which will be incurred prior to an order being placed with a supplier, Establishing systems to capture freight charges and Having monitoring mechanisms to ensure the Trust is not incurring 'avoidable' freight charges

To ensure significant assurance the next time this is audited we have implemented six of the nine IA recommendations. We are working towards the other three (R5, 6 & 9 – see appendix) with these expected to be completed by end of the year.

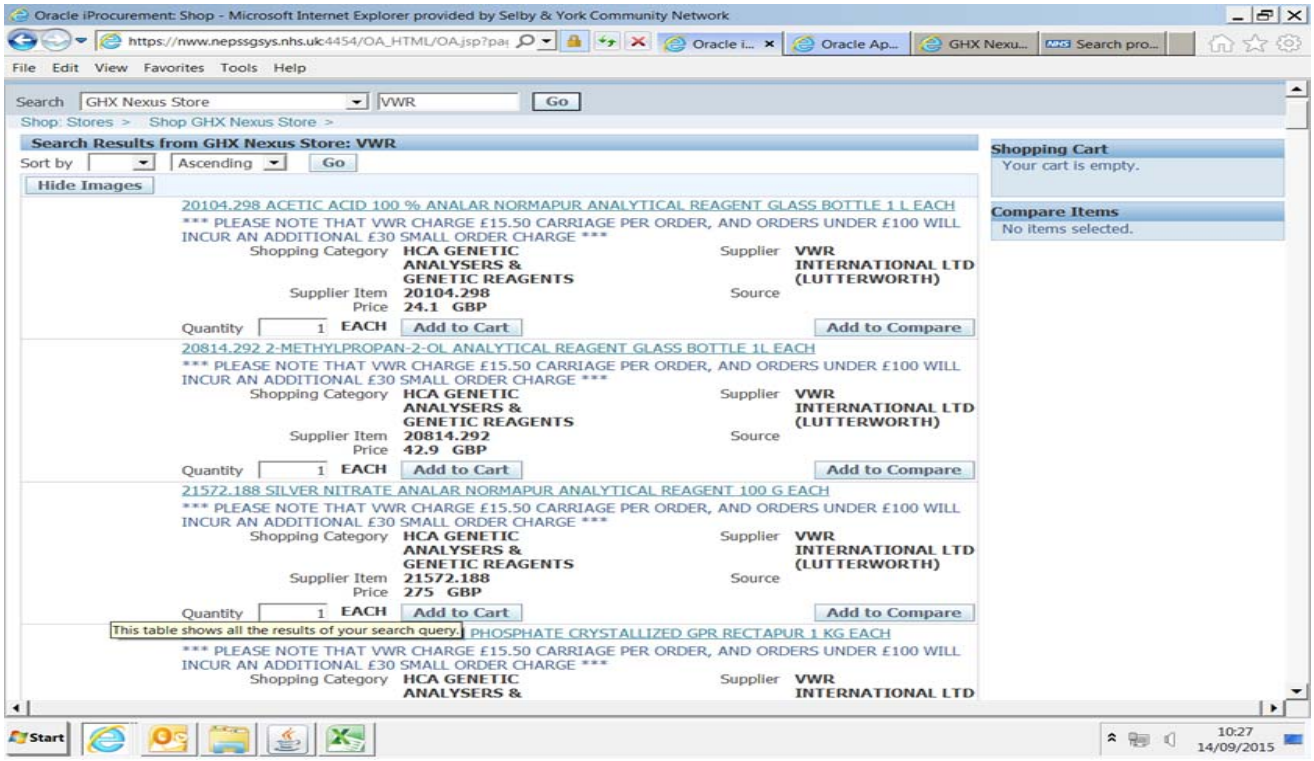
Oracle is not sophisticated enough to auto-populate the freight charges of suppliers onto each order but they can be added as separate lines. Buyers have been re-educated to consider freight charges as part of the total costs of acquisition and to use their skills to consolidate, negotiate and switch suppliers to avoid charges.

We have included information notes within the item description on the Oracle e-catalogue (see appendix) to show where charges could be incurred, aiding end users and buyers to make

more informed choices.	
2. Conclusion	
Progress is being made to improve procurement across the Trust.	
3. Recommendation	
The Board of Directors is asked to endorse the progress made by the Purchasing Department during the last financial year.	
Author	**Ian Willis, Head of Procurement**
Owner	**Andrew Bertram, Director of Finance**
Date	**November 2015**

5: Appendix (Audit Recommendations and Oracle Screenshot)

Recommendation	Completed
R1. The 'long description' field within Oracle should be populated with the supplier freight charge information. This can then be viewed by the requistioner when placing an order.	Yes
R2. Suppliers should be contacted on a periodic basis to ensure the Trust has an up-to-date record of charges	Yes
R3. Buyers should be aware of the freight charged by suppliers. When necessary, the freight charge should be recorded on the purchase order.	Yes
R4. Point five within the 'Important Information' section of the Trust purchase order template should be amended to read: 'Any alternative in quantity or price (including freight charges) must be confirmed in writing by the ordering officer.'	Yes
R5. The Procurement team should establish and validate the reasons for using Air Liquide as a supplier of medical gases for some of the community sites.	On-going
R6. If there is no satisfactory rationale for the use of Air Liquide as a supplier a new supplier should be sourced with a view to a reduction in freight charges.	On-going
R7. Guidance should be provided to procurement staff regarding the review of freight charges during the procurement process. This should include the action that should be taken in the event of the costs appearing excessive.	Yes
R8. Regular monitoring of the freight charges incurred should be undertaken. This should include an analysis by supplier and by Directorate.	Yes
R9. Those suppliers used frequently by the Trust should be contacted and the possibility of bulk order discounts and/or the consolidation of freight charges should be discussed.	On-going



York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the Corporate Risk Committee held in the Chief Executive's Office, York Hospital on 3rd November 2015
Present:

Patrick Crowley	Chief Executive
Sue Symington	Chairman
Fiona Jamieson	Deputy Director for Healthcare Governance
Anna Pridmore	Foundation Trust Secretary
Philip Ashton	Non-executive Director
Polly McMeekin	Deputy Director for Human Resources

Apologies: Anna Pridmore: Foundation Trust Secretary, Philip Ashton, Non Executive Director

Subject/ title	Discussion	Conclusion and action	Evidence /Paper
Minutes of 3rd March 2015	The Minutes were agreed as a true record of the meeting. A discussion took place around the meeting having been missed In June, and postponed (due to attendee availability) in September. It was agreed an additional meeting would held in January 2016 (confirmed as January 14th) Other meetings for the year were scheduled for 4 February 2016 and 5th April 2016. It was agreed that going forward meetings would be every 2		**Enclosure A**

	months. Papers would be circulated to the group both electronically (to SS/PA personal email accounts) and in hard copy.	**FJ to action additional dates**	
3. Matters Arising	There were no matters arising		**Verbal**
4. Risk Management	FJ talked the group through Enclosure B, Risk Management. The paper outlined the significant amount of work that had been undertaken to further improve risk management systems since the group last met. These are summarised below. **Improvements to Datix:** FJ reported on the work undertaken to improve the Datix system of reporting adverse incidents within the Trust. This included a re – development of the reporting tool to make the system more intuitive to use, the collection of the right information to inform decision making, and the use of one matrix to record levels of harm accurately. Both SS and PA asked about the impact of this on attribution of harm reported via the NRLS nationally. FJ asked the group to recall previous internal audit reports that indicated that levels of harm were being incorrectly attributed to incidents, and on scrutiny this was because 1) staff were using a risk (and not a harm) matrix to determine a level of harm ..thus the risk may be high, but the harm might be low or non existent. As a result the organisation was reporting levels of harm that did not reflect the incident. 2) Non of the data uplifted to the NRLS had been previously reviewed for		**Enclosure B**

	accuracy. As a result of internal audit opinion work has been undertaken to 1) revise the reporting system, and 2) to ensure that the data is reviewed prior to upload. On the second item, a process was put in place where all incidents with a moderate, serious or death attribution were reviewed by the Deputy Director of Healthcare Governance, Deputy Director of Patient Safety and where necessary with the Medical Director. This provided a level of assurance to Internal Audit that the process had improved. FJ advised that as a result, our data had showed a significant shift, from being an outlier in the number of moderate incidents of harm, to being at the bottom end of the middle range. FJ advised that as a result of the improvements made, the number of incidents reported were increasing, but there remained some concern around areas where it is known that there is under reporting. As an example, FJ explained that approximately 9-15 insulin errors were reported monthly, but anecdotally this was felt to be the tip of the iceberg. FJ also advised that in terms of staff groups, the highest reporter of incidents was the nursing group, with the smallest reporting group being the medical staff. FJ advised that the Deputy Medical Director recognised the need to raise the profile of this , and that work was being undertaken with Junior Doctors (through the Junior Doctors Working Group) to raise the profile of reporting also. PJC suggested that the CRC document that their position was that the reporting of adverse incidents was not discretionary. FJ also advised that Claims and Complaints had now been migrated onto Datix Web from Datix Rich Client. This would		

	facilitate the better triangulation of risk within the organisation. FJ was asked to make reporting trends a regular feature of her report to the CRC. PA asked that Datix Reporting should be audited in the next annual programme (Note, FJ advised this is now currently being audited alongside other risk management processes within the Trust.) FJ talked through the summary information surrounding incidents reported in the period April to September 2015, noting the top 5 categories of reported incidents, and breaking down the 'clinical' category to provide greater information on the type of incident this included. FJ also indicated the current levels of harm which currently stood at Serious 1% Moderate 2% Low Harm 26% No harm 71% FJ advised that these figures were subject to change as not all levels of harm had yet been assessed or reviewed. FJ also advised that the NRLS always gave caution in terms of the use of benchmark data, given different organisations have different approaches to reporting. She advised that the NRLS within the past two weeks had issued guidance to Trust's that aimed to address this and that this would be built into the Datix Form.	**FJ to include this in future reports**	

	Serious Incidents FJ talked through the work that had been undertaken to clear the backlog of actions pertaining to recommendations made in each investigation. She advised that the SI Group now receive a monthly report on outstanding recommendations, this includes any changes to previously agreed actions (for example when the original action may no longer be relevant). To ensure that commissioners are always involved in the process the Deputy Director of Healthcare Governance now meets with the CSU SI co-ordinator to review the status on ongoing SI's and the status of any actions. This has proved to be a successful meeting. The SI Policy is currently in the process of being re drafted to reflect recent guidance including the new approach to Never Events. The Patient Safety Team have led on the development of NEVERMORE, a publication on learning coming out of Serious Incident Investigations. Learning newsletters detailing the learning from Falls and Pressure Ulcers are also being produced. A discussion then took place around the reporting of SI information to the Board. The Group were keen to see the trending information contained within the report being reported to the Board, rather than the brief summary of SI's declared over the previous month. **Risk Registers** FJ advised that work has been on going on the continuous		

	development and review of directorate risk registers. The CQC Quality Report noted that risk registers were in place at divisional level and that there was a clear correlation between the most significant risks at directorate level and those contained within the Corporate Risk Register. Whilst this is good news, there is still work to be done on the continued development of risk registers. For example, scrutiny of risk registers indicates there needs to be a better reflection of risks being identified via incidents, complaints, failure to comply with NICE Guidelines , SI's and clinical audit. We are now actively seeking to close some of those loops through better sharing of information. Governance Facilitators work with a portfolio of directorates to review risk registers on a regular basis, highlighting those issues for potential escalation to the Corporate Risk register to the Deputy Director of Healthcare Governance. An example of this may be that a directorate identifies an issue with a repeater panel (fire safety) that is yet to be replaced, acknowledging the potential seriousness of the risk and scoring it 15 (5x3). The Deputy Director of Healthcare Governance will then take the advice of the fire safety officer, asking for a view on the assessed level of risk and whether it is appropriate for the Corporate Risk Register. Each Director has their own page on the Corporate Risk Register and a regular review of these high level organisational risks is undertaken with each director and the Deputy Director of Healthcare Governance. At this meeting they review the level of risk, identifying whether the risk has escalated, been mitigated and can be removed from the CRR to the Directorate Risk Register.		

Corporate Risk Register	**FJ talked the group through the Corporate Risk Register paper. She explained that it was a new paper formatted to provide information on** • Risks to be considered for removal from the CRR • Risks to be considered for escalation to the CRR • Risks where there had been some movement in level of severity FJ presented the case for the inclusion of a new corporate risk around the event of failing to comply with CQC improvement notices. This may be a fairly short term risk, but nevertheless should be a feature of the CRR. A further risk had been added around the delay in the transfer of the MSK Service to Healthshare (now January 2016) . The particular risk being around the continued delivery of the service against the reduction in staff due to resignations. The group agreed these were new corporate risks. FJ presented the remainder of the paper , with agreement for the removal of the corporate risks that had been proposed for removal. FJ advised that some risks were being re –distributed as Directors took on additions to their portfolios (for example Infection Control Risks to the Chief Nurse from the Medical Director)		**Enclosure C**

	The Group welcomed the introduction of this paper and requested that it be forwarded on a regular basis to the Board of Directors. AP talked through the work currently ongoing on the continued development of the Assurance Framework, and advised that she is currently meeting with Directors to further refine this. A further update will be provided to the next meeting of the Corporate Risk Committee.	**FJ to ensure the paper is a quarterly feature of the Board Agenda**	
HR Risks – Polly McMeekin	**HR Risks** The group thanked Ms McMeekin for attending the Committee and asked her to present the HR Risks. Ms McMeekin described the following risks • The delivery of seven day services • Shortage in Medical workforce • Safer Staffing A discussion on these risks took place with a consensus that there needed to be a re articulation of the risks. For example, the delivery of seven day services should also be reflected in the COO and MD risks, with the HR articulation of the risk being around how the gaps in 7 day services might be filled and how HR might support this process. It was agreed that medical and nurse staffing belonged in the CN and MD risk portfolio, and therefore any HR risk should be around how the HR risk correlates. For example,are we confident that there		

	are enough staff on the nursing bank? FJ and PM to review and recast risks in the CRR, but also in the AF. PM advised of an emerging risk that had been established around pre employment checks. A review exercise was currently underway to ascertain the size of the problem and would report back at the end of November 2015.	**FJ/PM/AP**	
AOB	**FJ was asked to confirm the dates of future meetings in the current year. (included in these minutes).**	**FJ**	
Date and Time of next meeting	14 January 2016, 0800 -0930 CEO OFFICE Deputy Chief Executive to present risk portfolio Director of Estates and Facilities	**Both have been invited**	

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 25 November 2015

Review of Using Electronic Papers

Action requested/recommendation

- The Board is asked to note the report.
- The Board is asked to provide their feedback on the first trial of the paperless board meetings

Summary

The Chief Executive's Office is looking into the adoption of a paperless boardroom which is steadily increasing with the move from paper board packs to electronic. Tablet devices such as the iPad have increased the adoption of electronic papers since more and more board members are using them. To name but some of the advantages of using electronic papers versus the status quo:

- Collation – the process of collating a paper board pack is laborious and time consuming with multiple individual packs need to be assembled manually. A paperless boardroom lets meeting organisers digitally create copies as they do now only this is the point that the process ends as opposed to an additional day of printing, collating and posting.

- Distribution – The process of distributing paper board packs can be very costly, depending on the number of packs that are needed to reach the directors. A paperless boardroom allows for courier costs to be completely eliminated. For example, the amount paid in postage over the last 12 months is £873.64.

- Revisions – Making amendments to a board paper pack is costly and awkward as directors can potentially be working from different versions. A paperless boardroom can enforce amendments automatically, allowing for more control over the information directors receive and use

- Security risks/theft/loss – When a board pack is lost or stolen, it is unlikely that it can be recovered quickly without potentially the organisation in a compromising position. A tablet or iPad with the documentation saved or accessible, with password protected access to the device and the website, can work towards eliminating this security risk. The more complicated the password for access is, the harder it is to work out.

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	This report has been written to be submitted to the Board of Directors only.
Risk	No risk.
Resource implications	Minor cost implications identified in the report
Owner	Sue Symington, Chair
Author	Cheryl Gaynor, Chief Executive's Office Manager
Date of paper	November, 2015
Version number	Version 1

Review of Using Electronic Papers

1. Introduction and background

The Chief Executive's Office is looking into the adoption of a paperless boardroom which is steadily increasing with the move from paper board packs to electronic. Tablet devices such as the iPad have increased the adoption of electronic papers since more and more board members are using them. To name but some of the advantages of using electronic papers versus the status quo:

- Collation – the process of collating a paper board pack is laborious and time consuming with multiple individual packs need to be assembled manually. A paperless boardroom lets meeting organisers digitally create copies as they do now only this is the point that the process ends as opposed to an additional day of printing, collating and posting.

- Distribution – The process of distributing paper board packs can be very costly, depending on the number of packs that are needed to reach the directors. A paperless boardroom allows for courier costs to be completely eliminated. For example, the amount paid in postage over the last 12 months is £873.64

- Revisions – Making amendments to a board paper pack is costly and awkward as directors can potentially be working from different versions. A paperless boardroom can enforce amendments automatically, allowing for more control over the information directors receive and use

- Security risks/theft/loss – When a board pack is lost or stolen, it is unlikely that it can be recovered quickly without potentially the organisation in a compromising position. A tablet or iPad with the documentation saved or accessible, with password protected access to the device and the website, can work towards eliminating this security risk. The more complicated the password for access is, the harder it is to work out.

2. The Paperless Meetings Project

Using the six-stage project management guide (NHSi, 2010) as a framework for this improvement idea within the Trust, it shows that there are certain critical elements for success which should be continually considered throughout the duration of a project:

- Stakeholder engagement and involvement
- Sustainability
- Measurement
- Risk and Issues management
- Project documentation and gateway criteria

2.1 Stage 1 - Start Out

Given the size of the organisation and the impact that a change to the current board administration system would have, it was important to carry out a stakeholder analysis (Appendix A) to ensure the involvement of the right people as understanding them and acting on their perspectives helps to ensure a strong product and the best results (NHSi, 2010). Stakeholders of this project include:

- Executive Directors
- Non-executive Directors
- Communications Team (Website)
- Board Administrators
- Foundation Trust Secretary
- Governors
- Directorate Managers
- Internal Audit
- External Audit
- Senior Managers
- Post Room
- Systems and Network Services
- Information Governance
- Secretaries
- Patients
- Clinical Directors
- Finance

In carrying out a stakeholder analysis, it was agreed that it would be beneficial to have a discussion and trial with a few key stakeholders from the analysis; Communications Team, Executive Directors, Non-executive Directors, Board Administrators. The Board Administrators had identified that it was important to consider the use of systems/software already available within the Trust to stand in good stead in the possible purchase of a software in the future. This was a useful piece of information that steered the direction of the project.

The stakeholder analysis helped design a membership for the project group. In the early stages, the analysis gives a clear direction for communication to keep all involved and informed at all stages of the project, particularly when it came to the trial. The four categories show the style of communication required; monitor, inform, satisfy and manage.

The initial idea of paperless meetings has already been considered however, it was beneficial to obtain the views of others to see if there was any opportunity to improve the idea or stretch it further. To obtain this information, a trial has been designed and targeted at the majority of key stakeholders identified in Appendix A with a high impact and are high powered to this particular project. The aim of targeting and trialling with these key stakeholders is to gain more of an insight into how they feel about the change idea, how it works or doesn't work and initial reaction to it. It will also aim to determine at an early stage, how worthwhile paperless meetings are.

2.2 Stage 2 – Pilot and Implement

At the last meeting of the Board of Directors (October 2015), views were sought on the initial idea of electronic board papers. Following this, directors agreed to a trial to receive their papers electronically for the November meeting with the exception of the performance report due to its complexity.

Subsequent to this, a trial has been designed and tailored to help the improvement idea of paperless board meetings and sets out measurable targets of improvement. An example of this is measurement is the time and cost of the production of hard copy papers.

It is important to carry out a trial of the idea and it is anticipated that there may be some fine

tuning along the way before it is something that can confidently be implemented across the Board.

The basis of the trial is a cycle of plan, do, study and act (PDSA) (NHSi, 2008) giving a continuous cycle until the project is at its final point of implementation.

Plan

- Request interest from key stakeholders for trial
- Request a webpage with login requirements (£120.00)
- Set up a Board of Directors page
- Provide individual training if required
- Take notes of feedback throughout (i.e. issues faced, system problems etc)
- Request ratings for feedback

Do

- Set web pages up and send electronic documents to the SeeGreen site
- Document any problems and unexpected observations
- Begin to look at ratings and SPC plot them
- Email out a link to the webpage
- Email out the password for access

Study

- Analyse all the data feedback collected
- Compare results with predictions
- Summarise and reflect on anything learnt

Act

- Modifications

At this moment in time we are at the do/study point of the first cycle test for the trial.

2.3 – Sustain and Share

Following a rigorous trial, it is hoped that the paperless board meetings would be fully implemented across the Trust. It is also hoped that the initial project develops further into looking at alternative ways to streamline the website area.

3. Conclusion

The is a flavour for the movement to electronic board papers and the benefits of this type of reporting are expressed regularly. Some of these benefits to consider are:

- Direct access to previous papers
- Quicker access to the agendas and papers
- Securer delivery of papers
- A central record for all members of the board

However, this system does not come without its challenges. These could include distraction to their applications on electronic devises (i.e. emails), there is a website shutdown, the password is accidently slipped out.

Ultimately, this evolutionary migration towards electronic board papers is seen to be an excellent start to an overall move going forwards.

4. Recommendation

- The Board is asked to note the report.
- The Board is asked to provide their feedback on the first trial of the paperless board meetings

5. References and further reading

NHS Institute for Innovation and Improvement (2008) ***Plan, do, study, act*** [Internet]. Available from: http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html [Accessed 17 November 2015].

NHS Institute for Innovation and Improvement (2010) ***The Handbook of Quality and Service Improvement.*** Aldridge, New Audience Limited.

Author	**Cheryl Gaynor, Chief Executive's Office Manager**
Owner	**Sue Symington, Chair**
Date	**November 2015**

Appendix A
Stakeholder Analysis

High Power	**Satisfy** • Directorate Managers • Internal Audit • External Audit • Senior Managers	**Manage** • Executive Directors • Non-executive Directors • Communications Team (Website) • Board Administrators • Foundation Trust Secretary •
Low Power	**Monitor** • Patients • Clinical Directors • Finance • Governors	**Inform** • Post Room • Systems and Network Services • Information Governance • Secretaries
	Low impact/stake holding	High impact/stake holding