York Teaching Hospital
NHS Foundation Trust

# Board of Directors (Public Meeting)

Wednesday 27 September 2017

York Teaching Hospital
NHS Foundation Trust

# BOARD OF DIRECTORS MEETING

**The programme for the next meeting of the Board of Directors will take place:**

On: Wednesday 27 September 2017

In: The Boardroom, Foundation Trust Headquarters, 2nd Floor Administration Block, York Hospital, Wigginton Road, York, YO31 8HE

| TIME | MEETING | LOCATION | ATTENDEES |
|---|---|---|---|
| 9.00am – 10.30am | Board of Directors meeting held in private | Boardroom, Foundation Trust Headquarters | Board of Directors |
| **10.45am – 13.15pm** | **Board of Directors meeting held in public** | **Boardroom, Foundation Trust Headquarters** | **Board of Directors** |
| 13.15pm 13.45pm | Lunch | | Board of Directors |
| 13.45pm – 14.45pm | General Data Protection Regulation Seminar - Hempsons | Boardroom, Foundation Trust Headquarters | Board of Directors |

York Teaching Hospital
NHS Foundation Trust

# Board of Directors (Public) Agenda

| | SUBJECT | LEAD | PAPER | PAGE | TIME |
|---|---|---|---|---|---|
| 1. | **Apologies for absence and quorum**<br><br>To receive any apologies for absence | Chair | Verbal | - | 10.45 |
| 2. | **Declaration of Interests**<br><br>To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders. | Chair | A | 7 | |
| 3. | **Minutes of the meeting held on 26 July 2017**<br><br>To receive and approve the minutes from the meeting held on 26 July 2017 | Chair | B | 13 | |
| 4. | **Matters arising from the minutes and any outstanding actions**<br><br>To discuss any matters or actions arising from the minutes | Chair | Verbal | - | |
| 5. | **Patient Story**<br><br>To receive the details of a patient letter. | | Verbal | - | 10.55 |
| 6. | **Chief Executives Update**<br><br>To receive an update from the Chief Executive | Chief Executive | C | 29 | 11.05 |

| | SUBJECT | LEAD | PAPER | PAGE | TIME |
|---|---|---|---|---|---|
| Our Finance and Performance Ambition: Our sustainable future depends on providing the highest standards of care within our resources | | | | | |
| 7. | **Finance and Performance Committee**<br><br>To receive the minutes of the last meeting and be advised by the Chair of the Committee of any specific issues to be discussed. Papers for information.<br><br>• Finance Report<br>• Efficiency Report<br>• Performance Report | Committee Chair | D<br><br>D1<br>D2<br>D3 | 33<br><br>39<br>59<br>69 | 11.20 |
| 8. | **Winter Plan Update**<br><br>To receive a briefing on the work in relation to the system planning for winter | Chief Operating Officer | Verbal | - | 11.40 |
| 9. | **Emergency Planning Report and Annual self-assessment against core standards**<br><br>To receive and approve the self-assessment | Chief Operating Officer | E | 91 | 11.50 |
| 10. | **Out of Hospital Care Quarterly Report**<br><br>To receive the Out of Hospital Care Quarterly Report. | Chief Operating Officer | F | 111 | 12.05 |

| | SUBJECT | LEAD | PAPER | PAGE | TIME |
|---|---|---|---|---|---|
| | Our Quality and Safety Ambition: Our patients must trust us to deliver safe and effective healthcare | | | | |
| **11.** | **Quality and Safety Committee**<br><br>To receive the minutes of the last meeting and be advised by the Chair of the Committee of any specific issues to be discussed. Papers for information. | Committee Chair | G | 137 | 12.15 |
| | • Patient Safety & Quality Report | | G1 | 151 | |
| | • Medical Directors Report | | G2 | 185 | |
| | • Chief Nurse Report | | G3 | 195 | |
| | • Mortality Report | | G4 | 211 | |
| | • End of Life Care Report | | G5 | 225 | |
| | Our Facilities and Environment Ambitions: We must continually strive to ensure that our environment is fit for our future | | | | |
| **12.** | **Environment and Estates Committee**<br><br>To receive the minutes of the last meeting and be advised by the Chair of the Committee of any specific issues to be discussed. Papers for information | Committee Chair | H | 241 | 12.30 |
| | • Committee Annual Report | | H1 | 253 | |
| | • Health & Safety Annual Report | | H2 | 261 | |
| | Our People and Capability Ambition: The quality of our services is wholly dependent on our teams of staff | | | | |

| | SUBJECT | LEAD | PAPER | PAGE | TIME |
|---|---|---|---|---|---|
| **13.** | **Workforce and Organisational Development Committee**<br><br>To receive the minutes of the last meeting and be advised by the Chair of the Committee of any specific issues to be discussed. Papers for information:<br><br>• Workforce Metrics<br>• End of Placement Survey Report | Committee Chair | I<br><br>I1<br>I2 | 293<br><br>301<br>311 | 12.45 |
| **14.** | **Freedom to Speak Up/Safer Working Guardian Report**<br><br>To receive a report detailing the work of the Freedom to Speak Up/Safer Working Guardian. | Chief Executive | J<br>J1 | 321<br>331 | 13.00 |
| **15.** | **Any other business**<br><br>• Reflections on the meeting<br>• BAF Alignment | | Verbal | - | 13.15 |
| **16.** | **Time and Date of next meeting**<br><br>The next meeting will be held on Wednesday 26 October 2017 in the Boardroom, Foundation Trust Headquarters, York Hospital. | | | | |

Items for decision in the private meeting: Financial Recovery Plan, Revalidation Report

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

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

# Register of directors' interests
Sept 2017

York Teaching Hospital
NHS Foundation Trust

**Additions:** No changes

**Changes:** D Willcocks

**Deletions:** P Ashton, J Walters & S Rushbrook

**A**

| Director | Relevant and material interests | | | | | |
|---|---|---|---|---|---|---|
| | Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies). | Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS. | Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS. | A position of authority in a charity or voluntary organisation in the field of health and social care. | Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services | Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders |
| ***Ms Susan Symington (Chair)*** | **Non-executive Director—**Beverley Building Society<br>**Director** - Lodge Cottages Ltd | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | **Member—**the Court of University of York | 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 | Spouse is a Consultant Anaesthetist at the Trust | 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<br>**Chairman and Director -** Leeds College of Music<br>**Member—**The University of Leeds Court<br><br>**Trustee**—York Music Hub | Nil |
| ***Mr Michael Sweet (Non-Executive Director)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |

| Director | Relevant and material interests | | | | | |
|---|---|---|---|---|---|---|
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| ***Professor Dianne Willcocks (Non-Executive Director)*** | **Member—**Great Exhibition of the North (2018) Board | Nil | Nil | **Chair—Charitable Trustee**<br>**Act as Trustee** –on behalf of the York Teaching Hospital Charity<br><br>**Trustee and Vice Chair—**of the Joseph Rowntree Foundation and Joseph Rowntree Housing Trust<br><br>**Chair—**Advisory Board, Centre for Lifelong Learning University of York<br><br>**Member—**Executive Committee YOPA<br>**Patron—**OCAY<br><br>**Chairman** - City of York Fairness and Equalities Board<br><br>**Member –**Without Walls Board | **Director—**London Metropolitan University<br><br>**Board Member**—York Museums Trust<br><br>**Chair of Steering Group** - York Mediale Festival | Nil |

| Director | Relevant and material interests | | | | | |
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| ***Michael Keaney (Non-Executive Director)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |
| ***Jenny McAleese (Non-Executive Director)*** | **Non-Executive Director**—York Science Park Limited<br>**Director**—Jenny & Kevin McAleese Limited | **50% shareholder and Director**—Jenny & Kevin McAleese Limited | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity<br><br>**Trustee**—Graham Burrough Charitable Trust<br><br>**Member**—Audit Committee, Joseph Rowntree Foundation | **Member of Council**—University of York | Nil |
| ***Mr Patrick Crowley (Chief Executive)*** | 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 |

| Director | Relevant and material interests | | | | | |
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| ***Mr Mike Proctor (Deputy Chief Execu-tive)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Spouse a senior member of staff in Community Services | Nil |
| ***Beverley Geary (Chief Nurse)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |
| ***Mr James Taylor (Medical Director)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |
| ***Mrs Wendy Scott (Director of Out of Hospital Care)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Nil | Nil |
| ***Mr Brian Golding (Director of Estates and Facilities)*** | Nil | Nil | Nil | **Act as Trustee** –on behalf of the York Teaching Hospital Charity | Spouse is Director of Strategy and Planning at HEY NHS FT | Spouse is a Director at HEY NHS FT and Trus-tee of St Leonards Hos-pice |

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Board of Directors Public Minutes – 26 July 2017

**Present:** **Non-executive Directors**

| | |
|---|---|
| Ms S Symington | Chair |
| Mrs J Adams | Non-executive Director |
| Mr M Keaney | Non-executive Director |
| Mrs J McAleese | Non-executive Director |
| Ms 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 |
| Mr J Taylor | Medical Director |
| Mrs J Walters | Chief Operating Officer |

**Corporate Directors**

| | |
|---|---|
| Mr B Golding | Director of Estates & Facilities |
| Mrs W Scott | Director of Out of Hospital Care |

**In Attendance:**

| | |
|---|---|
| Mrs L Provins | Foundation Trust Secretary |
| Mrs H Hey | attending on behalf of Mrs Geary |

**Observers:**

Jack Nelson – Pupil Westfield Primary School for item 17/068
Caroline Ralucka – Westfield Primary School for item 17/068
Tracey Ralph – Head Teacher, Westfield Primary School for item 17/068
Vicky Mulvana- Tuohy – Senior AHP Manager for item 17/068
Jo Mannion – Clinical Director, Paediatrics for item 17/068
Lucy Brown – Head of Communications
Jeanette Anness - Public Governor – Ryedale and East Yorkshire

Sheila Miller – Public Governor – Ryedale and East Yorkshire
Mick Lee – Staff Governor – York
Suzanne Morris – Insight Programme
Lesley Pratt – Healthwatch – York
Margaret Jackson – Public Governor - York
Michael Reakes – Public Governor – York
Brandon Hammond – Ethicon J&J
David Griffin – Insight Programme
Philip Mettam – Accountable Officer, Vale of York CCG
John Cooke – Public Governor – York
Karen Porter – Stakeholder Governor
Malcolm Richardson – Unite Representative
Prof. Una MacLeod – Dean of Hull York Medical School for item 17/074

Ms Symington welcomed everyone to the meeting.

## 17/064 Apologies for absence

Apologies were received from Mr Proctor, Deputy Chief Executive, Mrs Geary, Chief Nurse and Mr Ashton, Non-executive Director.

## 17/065 Declarations of interest

No further declarations of interest were raised.

## 17/066 Minutes of the meeting held on the 31 May 2017

The minutes of the meeting held on the 31 May 2017 were approved as a correct record.

## 17/067 Matters arising from the minutes

Page 18 – Minute No 17/054 – Mr Sweet asked if the IT Strategy had been assigned to one of the Board Committees for monitoring. Ms Symington stated that it had not currently been assigned, but noted that an action plan was due back to the Board next month. Mr Crowley stated that he was exploring setting up a separate group which would look at the IT strategy and also provide clinical involvement. Ms Symington stated that it was part of the work of all four Board Committees.

**Action: IT Strategy/Cyber Attack Review to be provided at the August Board Meeting**

## 17/068 Patient Story – Children's Takeover Challenge

Ms Symington welcomed Jack and Caroline to the meeting together with their Head Teacher, Ms Ralph, from Westfield Primary School. The Board received a short video and

presentation which captured the key elements and experiences from the day. Ms Mulvana-Tuohy, APH Senior Manager stated that an action plan had been drafted to capture the key points raised by the day and that the full video would be made available to the Board.

Ms Symington thanked the children for the presentation and Mr Crowley thanked Ms Mulvana-Tuohy and Dr Mannion for organising the event. He stated that the Trust was strongly committed to the work which had taken a lot of organising and reminded the Trust of its core commitment to service users.

Ms Symington highlighted the board papers and stated that having a patient story element at the beginning of the meeting helped to remind the Board of the importance of the balance required between the challenges the Trust faced and the delivery of high quality, safe healthcare.

Ms Raper stated that there was a fantastic set of recommendations, but the Trust needed to consider whether it continued to provide the ED element of the Takeover Challenge visit following the children's feedback.

## 17/069 Chief Executive Report

Mr Crowley stated that the Takeover Challenge presentation set the tone for the meeting, but this was also his opportunity to set the context for the Board. He stated that the Trust was working in difficult changeable times with elements like the capped expenditure process being applied to the system without any notice, adding elements of uncertainty. Mr Crowley stated that a data gathering exercise was in progress for the emerging planned CQC inspection and that the City of York Council had been informed that they were also to be inspected by the CQC in relation to capability and capacity.

**Outcome: Chief Executive to keep the board fully informed of progress and developments in relation to the CQC Inspection likely to take place in the autumn.**

Mr Crowley stated that the financial position was deteriorating and that a freeze had been placed on non-clinical vacancies and a number of other controls were being put in place to arrest the position. He added that despite this difficult backdrop the Trust had to continue to do the right things as an organisation and demonstrate the values consistently. One aspect of this was that the Trust was helping support the breast radiology service at the Friarage Hospital so that this service could continue to be provided.

Mr Crowley briefed the Board on the recent Clinical Summit, the positive feedback for ophthalmology training and that the Trust is supporting the Human Rights City declaration signed up to by the Lord Major of York. Mr Crowley also highlighted that the Trust is working with John Hopkins Hospital in the USA around a proposal to work together, initially, over the development of the Trust's Institute. The last item Mr Crowley raised was

about the mobile chemotherapy unit which had been launched and had received overwhelming support at the launch from the Governors and cancer sufferers who could now receive treatment locally. He noted Calendar had done a fantastic piece on the launch which included the Grounds man at Malton Rugby Club and it was moments like these that reminded staff what service delivery was really about.

Mr Crowley highlighted that in the face of adversity the Trust continues to seek to improve services for the community it serves.

## 17/070 Finance and Performance Issues

Mr Keaney stated that there were two items to raise to the Board. He noted that performance had improved and the STP funding trajectory had been met with improvements being seen from the acute medical model at Scarborough. However, he stated that the ECS, RTT and cancer targets remain challenging and the Trust continues to work under massive pressures.

Mr Keaney highlighted the deteriorating financial position and that the Trust had missed the quarter one STP funding target. He stated that things were getting harder especially in light of the capped expenditure process and QIPP. Mr Keaney highlighted that the Chief Nurse's staffing report to the Quality and Safety Committee highlighted the 25% vacancy problem, but he also noted that medical staffing was of concern.

Mrs Walters briefed the Board on the quarter one ECS position and stated that initiatives put in were starting to come together; however, it was important to see this in context and she noted that although there had been a reduction in type one attendances, type three attendances had seen a significant increase so the hospital remained incredibly busy. Mrs Walters stated that unfortunately, July was seeing a decline in performance as the pressures on workforce continue. Mrs Walters highlighted that patient safety was paramount and the work by the nursing team was exceptional in trying to maintain this; however, there has been an increase in agency spend due to trying to support areas. The focus remained on trying to reduce delayed discharges of care.

Mrs Adams asked whether any particular area was struggling with the 62 day cancer target. Mrs Walters stated that the Trust had achieved five out of the seven cancer targets, with the challenges continuing around the patients who have complex pathways that cross over specialties. There are also delays getting patients into tertiary centres. She noted capacity constraints in diagnostics and said that work was being done across the whole system to address this. In relation to the 14 day fast track, there remain challenges at the east coast in dermatology and the Trust is working with Scarborough and Ryedale CCG to look at the provision of a different sustainable model. Mrs Walters also noted that 25% of breaches were with regard to patient choice.

Ms Raper asked about the 62 day work with Hull and Leeds and it was noted that the Trust continues to link with both areas and that a system wide review is taking place to look at future proofing capacity. Mrs Walters also noted that there are trackers to follow each patient through the pathway.

Prof. Willcocks asked about the issues with the 14 day fast track target and whether it was down to GP referrals. Mrs Walters stated it was due to a myriad of things. A number of patients were being referred and found to be non-cancer so primary care were being asked to do more in relation to vetting the referrals and were also being asked to submit photos of skin lesions so that the referrals which were clearly not cancer could be put in the right category. Capacity is lost when patients do not attend and this could be due to them not being worried as the GP has said it is unlikely to be cancer or that the GP has not told them that they require an urgent appointment.

Mr Keaney stated that the CQUIN targets had been reviewed and 95% were green for the first quarter, but he noted some caution as the Trust had the winter period to go which would inevitably mean higher bed occupancy and ward closures.

Mrs McAleese stated that there were some CQUIN targets which had high financial incentives and the any initiatives like the vacancy freeze should be triangulated to ensure essential non-clinical posts vacancy freezes did not risk achievement of these targets. Mr Crowley stated that freeze was probably the wrong word and it was more of an enhancing of the controls around vacancies.

Mr Keaney noted that a few staff had cost the Trust £350k in the previous year by not having a flu vaccine and having the vaccine would be prioritised again this year.

Mr Bertram stated that the Trust had entered a difficult phase; however, he also noted that this was currently just in relation to one month and asked the Board to hold their nerve as the position was still recoverable as it was early enough in the year to take action. He highlighted that the plan was always risky as there was no contingency built in and this was also the eighth year of delivering an above 4% efficiency. Mr Bertram provided some context and stated that currently the majority of acute providers were in significant financial distress.

Mr Bertram sated that the Trust had a £2.7m variance from plan due to overspend pressures which had resulted in the loss of the STP funding of £1.8m. He noted that there was still an opportunity to recover the STP funding if the Trust can get back on track and hit the control total. Mr Bertram highlighted the comparison with the 2016/17 position and that difficulties had been expected in quarter one, but not to this level. He noted that expenditure was increasing whilst income was reducing. Mr Bertram stated that he will make the income and expenditure position clearer for the following month by stripping out the funding. Mr Bertram also highlighted the move to HRG4+ funding which he would keep an eye on to see how the position developed.

In respect of expenditure, Mr Bertram noted two key variances; the £2m pay pressure and the shortfall in the CIP profile. The pay issue was not all about agency although there was definitely an upward trend in relation to medical staffing as there were significant pressures on consultants. He noted that there was also a pressure caused by the number of elderly patients requiring one to one care due to the significant risk of falls.

The vacancy factor was causing a pressure on expenditure especially in relation to CIP as some areas work with an assumption that they will always be a post down which provides a generic CIP. Analysis is being done to look at the vacancy factor and see if there is anything unusual going on. Mr Bertram also reported that there are pressures in relation to the current levels of maternity leave and sickness some of which do require agency cover.

Mr Bertram stated that the Finance Team were working on a recovery plan to bring back to the Board. The position had been discussed with NHSI on Monday and the various controls being put in place had been touched on including a vacancy freeze, debtor management and a discretionary spend control. NHSI were comfortable with the approach being taken and that the forecast outturn is still to hit the £3m surplus. Mr Bertram stated that there was clearly some risk to delivery of the plan, but that this was not the time to change the plan as it could also be reviewed and changed at the end of quarter two or three.

Mr Bertram highlighted the cash position to the Board which is slightly ahead of plan, but will deteriorate due to the STP funding being missed. Mr Bertram stated that a number of cash flow scenarios have been produced to show what will happen in the worst case which would mean that the Trust has to enter the distressed cash regime.

Mr Bertram explained that currently the CCGs pay the Trust in tenths over the year instead of twelfths. He stated that NHSE have asked what effect it would have on the Trust if it was paid in twelfths. Mr Bertram stated that payment in tenths makes a difference to the cash profile of the Trust and provides cover so that recovery work can be done as well as progressing with the capped expenditure programme. The modelling work will be shared with the CCGs and NHSE

Ms Symington stated that this work provided a very thorough review of the Trust position.

Mr Sweet asked about the use of agency and Mr Bertram stated that any further pressure from NHSI is unlikely to bring the Trust's target of £17.2m down, but will be applied to the agencies and individuals currently trying to exploit the market, so it will help the Trust. Currently in departments like A & E the Trust has to pay above the capped rate to provide cover and ensure patient safety.

Ms Raper asked whether any shift in assumptions would be required with the CCG being put in special measures. Mr Bertram stated that he was not expecting a shift. In relation

to the capped expenditure process nothing had changed and the Trust was only looking to explore projects that were safe and did not have any constitutional implications.

Mrs Adams asked whether Mr Bertram had any intelligence as to whether the wider sector in the NHS was also experiencing difficulties. Mr Bertram stated that the number of trusts in deficit is growing, but he had not seen the quarter one figures as yet.

Mr Keaney stated that the negative quarter one position was very disappointing and that, it is vital that the Trust identify the underlying causes of the financial challenges.

**Outcomes:**

1. **The Trust will focus on delayed discharges of care, and feedback progress to the Board.**
2. **The Board will actively support and promote the flu having the vaccination programme for winter 2017-18.**
3. **Mr Bertram will make the income and expenditure position clearer for Board next month by stripping out the funding element.**
4. **The Board will further discuss the financial challenges at the private Board meeting in August, along with a session to identify the appetite of the Board for radical change.**

Ms Symington stated that the Board needed to hold its nerve and that there would be further discussions at the private meeting in August.

## 17/071 Quality and Safety Performance Issues

Mrs Adams stated that the Quality and Safety Committee had reviewed a number of reports including the Director of Infection Prevention and Control Report, Patient Experience Report, Out of Hospital Care Report and the Midwifery Report. She had welcomed Mrs Scott and Ms Ross to the meeting. The Committee had continued to focus on areas of high risk from the corporate risk register and areas identified in the last CQC report.

Mrs Scott highlighted that an inspection had been triggered by the CQC due to City of York Council receiving a low ranking in relation to 6 national metrics around the better care funding metrics. She stated that this was a new initiative and that the CQC would be on the patch on the 30 October. The Trust is working with all partners to understand the current position and how it can be improved.

Mrs Adams acknowledged the amount of work that had been done, but that there was always more, although most of it was currently not within the Trust's control. Mrs Scott stated that the system needed to work in partnership; however, this was difficult with the capped expenditure process in place, although hopefully this would address some of the issues and drive transformation of services.

Prof. Willcocks asked whether the independent sector and volunteers would be involved in the CQC visit in October especially in light of the issues with their contractual arrangements with the CCG. Mrs Scott stated that data would be submitted first in relation to the services provided and this data would be triangulated by the CQC to see who they would visit which may or may not involve the voluntary sector although she did think that Healthwatch would be involved.

Mrs Adams stated that she had discussed nurse staffing with the Workforce and Organisational Development Committee Chair and it had been agreed that the short term situation in relation to nursing vacancies would be part of the quality and safety agenda. Mrs Hey provided the Board with an overview of the nurse staffing paper including that the fill rate remains positive with the use of bank and agency. There are hot spots in Bridlington, but work is continuing to ensure that the right staff are in the right place at the right time and that the position remains safe.

In relation to recruitment, the Trust currently has 171 registered nurse vacancies and following new starters and leavers being taken into account this will be 118 in the autumn, which will be the pre-winter position. Turnover remains at about 10% to 12% leaving every month, although some of these could be on a retire and return basis. Mrs Hey noted some ambiguities with the way some Trusts collect data, but added that the Trust sticks to figures separated into registered nurse figures and care staff figures and this can make it difficult to bench mark the position.

Mrs Hey stated that the high risk areas are emergency, acute and respiratory on the York site and focus is on recruitment, staff development and ensuring areas have the best possible cover. Mrs Hey highlighted to the Board the number of on-going initiatives including; associate practitioners, the nursing associates programme, the development of rotational posts, the establishment of on-boarding and working with local universities to ensure staff join the Trust following applying for jobs, attending recruitment days and jobs fairs and the current work with Coventry University on their new undergraduate programme. The Trust also continues to generically recruit and grow the nurse bank.

Mrs Adams stated that in relation to medical staffing work is progressing to introduce new working patterns in general medicine at Scarborough to deliver seven day cover and the August changeover figures have improved.

Mr Taylor stated that a new GIM rota start date has been pencilled in for the beginning of September and will provide an increased presence both during the week and at weekends, but this still requires full sign off. In relation to the junior doctor changeover the Trust has improved the fill rate to 90% for York and it is between 50 and 60% for Scarborough. Mr Taylor noted that Scarborough does get a lower fill rate as doctors are allowed to choose where they receive their training. He noted that the team had worked hard to achieve this position.

Mrs Adams stated that the infection control report showed the Trust performing well in relation to C Diff. and provided an update on the joint site infections rates at Bridlington. Deep cleaning and training continues across both sites and the report had not given the Committee any cause for concern.

Mrs Adams stated that the six monthly midwifery update had shown that the stillbirth rate in the Trust had come down in the last couple of years. Mrs Adams was looking forward to hearing more on the regional and national findings from the Each Baby Counts publication as she felt the work was vital to the Trust.

Mrs Adams reported that she had chaired a recent paediatric consultant interview panel and out of the four consultants appointed, two were neonatal paediatricians.

Mrs Adams stated that the Patient Experience Report continued to provide the Committee with more detailed and better information about the feedback from patients, although the Friends and Family Test (FFT) responses rates appeared to be declining again and there was also some deterioration in complaint response times.

Mrs Hey stated that complaint responses had been devolved down to directorate level and some directorates were finding this more challenging than others. The Patient Experience Team had engaged with the new Deputy Director Manager development sessions to help with this process. Mrs Hey highlighted that FFT responses were down nationally and that text messaging was being introduced in some areas to encourage responses.

Mrs Hey stated that the Patient Experience Team continued to work hard to encourage volunteers into the Trust with a focus on governance and introducing new roles.

Mrs Adams stated that the Committee had looked at item 1.6 on the Board Assurance Framework which was about embracing new technology and had recommended that the rating should be revised from Green to Amber. Mrs Provins stated that this recommendation would be discussed at the private Board.

Ms Symington highlighted the enormity of the challenges being faced by the Trust which had been raised from both the Finance and Performance Committee and the Quality and Safety Committee. She stressed that the board must seek a balanced position: understanding and discussing the gravity of the current position along with maintaining a will to innovate and develop services for the benefit of patients and service users. There were no board actions.

## 17/072 Environment and Estate Issues

Mr Sweet highlighted recent erroneous press coverage regarding work being undertaken to set up a private company and he thought it would be useful to get Mr Golding to update the Board as clearly this has worried staff unnecessarily.

Mr Golding stated that some effort was being put in across the STP area to look at external contracts and see whether any savings could be made. A stand-alone company had been discussed and he had shared this discussion with senior members of his team; however, this information had been unfortunately misconstrued by some staff so he had written to the whole team clarifying the position. Mr Golding had also shared it with the unions at the JNCC meeting.

Mr Sweet stated that the minutes of the last Committee meeting were self-explanatory, however he wished to highlight that sustainability remains a major issue for the Committee and he was pleased to report the appointment of WRM as the company who would undertake the baseline assessment to assess the extent of sustainability awareness across the Trust. Once the work is done a business case can be drafted on how the Trust can achieve both cost and carbon savings.

A sustainability section has been included in all business cases and further work is being done to provide more information to directorate managers. Agreement in principle was also obtained at last week's Finance and Performance Committee for Internal Audit to consider sustainability as part of the audit process.

Mr Sweet stated carbon emissions had risen steadily from 2007 to 2016, however, due to the work being done, emissions were now beginning to fall especially those per patient.

Mr Sweet highlighted that Corporate Directors had considered the national policy to make all NHS site smoke free by 2018 and their view was to retain the smoking shelters. The Committee discussed this view in conjunction with the wider BAF ambitions and were in full agreement. Mr Sweet also noted that following the Grenfell fire, fire safety will now appear as a regular item on the Committee's agenda.

Mr Sweet stated that NHS Protect had been disbanded in March and the function taken into Counter Fraud. The Committee has asked for a paper on the implications of this.

Mr Sweet stated that terms of reference had been approved for the Premises Assurance Group and the Sustainability Development Group.

Mr Golding stated that NHS Protect had central security advisors and looked at cases of violence and aggression. The disbanding was part of a central cost saving exercise so the Trust would be looking at what impact there might be.

Prof. Willcocks expressed concern about the continued provision of smoking shelters and would rather this was an interim measure. Mr Crowley took the Board through the history to this and stated that the Trust had no powers of enforcement and that it was better to have the shelters than displace smokers to the periphery of the site near busy roads and junctions. A consultation had initially been held about smoking shelters and staff were in favour of them so once they were in place staff compliance was required. However, the

Trust cannot control non-staff members and it was better to have the smoking shelters which addressed safety issues.

## 17/073 Workforce and Organisational Development Issues

Ms Raper stated the Committee was pleased to welcome Mr Sweet to the Committee last month and were also planning a summer special meeting in September to look at the robustness of data being received. Ms Raper stated that work continues to triangulate information between the committees especially in areas of high risk like nursing and medical staffing and recruitment. She noted that she had agreed with the Chair of the Quality and Safety Committee that they would continue to focus on volunteering as this sat within the Chief Nurse's portfolio and she attended the Quality and Safety Committee.

Ms Raper stated that the work of the Institute will be reported through the Committee who would look at the recommendations and governance.

Mrs Raper stated that the Committee had reviewed the Research and Development Strategy and the apprenticeship reporting and had received a report on nurse on-boarding and the creative streams of recruitment.

Ms Raper wished to raise that the Committee had received assurance around bullying which was an area which the Committee keep a watch on and she asked Mr Golding to provide an update on current work. Mr Golding stated that there had been a lot of press coverage lately and that he had been working with the regional representative from Unite. Mr Golding stressed that the Trust take any allegations of bullying seriously and had engaged a member of the Organisational Development Team to work alongside unit and staff on the ground floor to look at the issues being raised. Poor relationships at supervisor level had been identified and a development programme was currently being developed for domestic staff and supervisors to try to improve relationships. Information was also being triangulated with the Freedom to Speak up Guardian and the staff survey.

Ms Raper stated that the Committee had spent a significant amount of time looking at assurance provided by the Equality and Human Rights Report which was highlighted as an action on the previous Board minutes.

Prof. Willcocks noted that the report was exceptional with much better balanced data being presented than had previously been received which looked at embedding of the values into organisational culture. The report identified areas where the Trust needs to make progress. It was noted that the Fairness Forum is key in moving this agenda forward.

Mrs Adams raised that disciplinaries include a higher proportion of non-white staff and Ms Raper stated that this reinforced the need to maintain vigilant scrutiny on this information.

Ms Raper stated that the Committee had reviewed the recruitment and retention element of the Workforce and Organisational Development Strategy and made some suggestions for improvement.

**Outcome:** Ms Raper stated that the Committee had review the Board Assurance Framework element in relation to staff retention and were recommending that due to pockets of high staff turnover the rating should change to amber. This will be picked up in the private Board when the full Board Assurance Framework is discussed.

## 17/074 Hull York Medical School Update

Ms Symington welcomed Prof. MacLeod, the Dean of Hull York Medical School, to the Trust. Ms MacLeod thanked the Chair for the opportunity to come and talk to the Board and she stated that she had heard some of the earlier conversations about the difficulties recruiting staff and this was why the relationship between the Medical School and the Trust was critical.

Ms MacLeod stated that the Medical School was the sixth smallest in the country, but that they provided an above average number of doctors going into GP training. She noted that it was seen to be hard to get into Medical School, but this was due to the number of schools competing for the best candidates. She advised the Board of some of the changes in staffing and new appointments which had been made including the collaboration with the Trust on the appointment of the MBBS Programme Director so that he was able to continue with his clinical practice. Ms MacLeod stated that the student feedback for the Trust was also very good.

Ms MacLeod highlighted that following a meeting of the joint senate of the school earlier in the day, it had been agreed to revamp the honorary staffing policy which would hopefully make it easier to attract NHS colleagues in particular. She noted that she was working with Mr Taylor and Ms Harris so that there was closer liaison with the Trust especially in relation to research and it was hoped to make joint research appointments an area of strength between the two organisations.

Ms MacLeod stated that the school had moved into a new building in Hull which was state of the art and designed around student experience. She stated that in relation to expansion of student numbers, the school was likely to get 15 extra places and she also mentioned the cap on international students, which was being introduced.

Prof. Willcocks stated that the warm words on working together were well received, but she was keen to know how this would work in relation to research which was currently high profile for the Trust. Ms MacLeod stated that she had recently met Ms Harris the Head of Research for the Trust to discuss collaboration especially in terms of investing in academics which had previously been a stronger link with Hull due to their long standing problems attracting medical staff and that this difficulty in attracting medical staff was now

also affecting York. Ms MacLeod stated that the expansion of medical student numbers was an opportunity for the school and the Trust to invest in academics.

Mr Golding asked if the expansion in medical student numbers would also translate into capital requirements, but Ms MacLeod thought this was unlikely.

Mrs Adams wondered why so many of the students went onto be GPs and Ms MacLeod clarified that it was a high percentage in national terms, but only 25% of the whole, but she also thought that there was good teaching in general practice and social determinants of health at the school.

**Outcome: The Board confirmed its commitment that the Trust should work openly and positively with HYMS.**
Ms Symington thanked Ms MacLeod for her time and stated that this should be a regular update for the Board in July each year.

## 17/075 Any other Business

**Board Question -** Mrs Hey stated that the Board had received a question from a member of the public. The question was: Why can't I access a Parkinson's Nurse?

Mrs Hey stated that the Trust has one whole time equivalent clinical nurse specialist in York for Parkinson's disease who is under the neurology department and therefore can only see patients under care of the elderly if time allows. She highlighted that this is a capacity and funding issue, but the Trust is in the process of making links with other organisations to understand if there is an opportunity to get some funding that will support any future developments, which are sustainable in the long term.

**Board Assurance Framework** – Ms Symington highlighted that discussions on elements of the BAF had taken place in both the Quality and Safety and Workforce and Organisational Development Committees and will be further discussed in the private Board. She stated that in light of the conversations held during this meeting there were a number of areas which needed to be discussed that may require an adjustment of the risk rating.

**Private Board** – Ms Symington stated that the next meeting of the Board will be in private on the 23 August.

**Reflections on the meeting** – Ms Symington asked for reflections on the meeting by Board members.

Mrs Adams expressed concern that Executive colleagues had not really contributed to items other than their own. Mr Crowley stated that this was perhaps to do with the current structure as the full discussions take place at the Board Committees which are held a

week before the Board. He also noted that many of the items like capped expenditure are collectively considered by the Executive team during Corporate Director and operational meetings that happen every week. He stated that it might be worth considering if the structure is right as the Board is set up to invite feedback from the Board Committees.

Ms Symington stated that it could be that the structure either worked very well or was in effect constricting the discussion at Board and it may be that there needed to be some variation.

Mrs McAleese stated that the feedback today was very performance related and that an observer had previously commented that there needed to be more balance between performance and strategy discussion. She noted that the current challenges to the organisation in relation to finance, operational performance and recruitment issues were discussed. She stated that there was also a useful presentation from the Dean of the Hull, York Medical School which highlighted that stronger links were required so it was about how the Board tied all that together and produced some clear actions.

Mr Taylor stated that the Dean had mentioned that she felt the Medical School had made a fresh start and that there was a clear commitment to re-energising the curriculum and the partnership with the Trust.

Ms Symington stated that she will ensure that Mr Proctor is apprised of the conversation.

Ms Raper wondered whether better use could be made of the Board conversations as she thought it would have been useful to tie in the development of the Institute with the HYMS conversation.

Mr Crowley agreed with what was being said and stated that it was about joining up some of the conversations and shaping the agenda to allow this. He also noted that some of the conversations around the BAF provided that strategic context, but he also stressed that there were less and less freedom for the Trust to set its own strategy in respect of the challenges faced and the context of the NHS as a whole.

No further business was discussed.

**Outcome: The Chair and the Trust Secretary will consider the reflections and continue to develop board agendas which focus on key risks and issues effectively.**

## 17/076 Date and Time of next meeting

The next meeting of the Board will be held on Wednesday 27 September 2017 in the Boardroom at York Hospital.

## Outstanding actions from previous minutes

| Minute No. and month | Action | Responsible office | Due date |
|---|---|---|---|
| 17/025 | Provision of a paper on isolation facilities | Mr Golding | May 2017<br>Sept 2017 |
| 17/012 | Parity of other staff groups with junior doctors in relation to exception reporting criteria (20 mins) to be added to the work programme. | Mrs Provins | tbc |
| 16/112 | The Board to receive the refreshed Equality and Diversity objectives | Mr Golding | Changed - July Public Board & WOD |
| 17/54 | Mrs Rushbrook to provide an Action Plan to cover 12 to 18 months of the IT Strategy. | Mrs Rushbrook | August 2017 |

York Teaching Hospital NHS Foundation Trust

## Board Assurance Framework – At a glance.

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

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

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Chief Executive's Overview

Recommendation

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

Current approval route of report

This report was drafted for the Board of Directors.

Purpose of report

This report provides an overview from the Chief Executive.

Key points for discussion

There are no specific points to raise.

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

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

Version number: 1

Author: Patrick Crowley, Chief Executive

Executive sponsor: Patrick Crowley, Chief Executive

Date: September 2017

## 1. Organisational priorities

Earlier this month I wrote to all staff following our AGM, to reflect on the previous year and to look to the future in the context of our organisational strategy and priorities.

Every person in the NHS knows all too well that the environment we are working in is the most challenged it has ever been. Given this context it is clear that our short-term priority must be to consolidate our position.

We need to focus on our finances, on recruiting and retaining staff, and ensuring our services are as safe as they can be. This can only be done by working with our partners, particularly our commissioners, on how we respond as a system.

Managing our resources as effectively as possible is vital to the security and stability of the clinical care we offer as well as allowing us the choice to continue to invest in the services we have all worked so hard to develop.

Directorates have developed detailed and ambitious plans, and it is vital we continue to do so, as this helps us describe our future and is essential for improvement. However, what we now need to do is organise ourselves to get the best possible outcomes we can in the current environment, which is one of contracting resources and growing demand, and we must all recognise the need to set clear priorities and at times set aside our own needs for the greater good.

It is now five years since we merged York and Scarborough Trusts, and six years since we incorporated community services. The next five years will be about how we can move forward in these most challenging circumstances, and this will require us to look dispassionately about how we deliver the best services we can for our patients. This will require your involvement, and potentially compromise. Importantly, it may also mean that some development plans may not be able to proceed in the short to medium term.

Access to services in an area the size of North Yorkshire is clearly important, and this may present opportunities as well as potentially difficult decisions. For example, centralisation of services in Malton (such as urology) has been welcomed, and has enabled the creation of a service that is highly regarded by patients and has improved upon the previous services previously delivered across multiple sites.

It is going to feel very different in the Trust for a period of time and this is going to impact on everyone. I am confident that by keeping these priorities at the forefront of the decisions we make in the coming weeks and months, we can ensure services remain as safe as they can be.

## 2. CQC inspection

The CQC's unannounced inspection into the Trust's core services took place last week. A team of inspectors visited the York, Scarborough and Bridlington sites and spoke to staff and patients.

Members of the Executive team met with the CQC at the end of the inspection to receive high-level feedback. The inspectors were highly complimentary of the way they were

welcomed into the organisation, and wanted us the pass on their thanks to everyone who was involved.

As with previous inspections, they commented on the enthusiasm, commitment and care demonstrated by staff in all parts of the Trust. I will be writing out to staff to thank them for the manner in which they approached the inspection, and to inform them of next steps.

This was the team's first visit under the CQC's new inspection regime, and it the start of the process which will ultimately result in our final report and rating. Focus groups are planned with staff and patients, and these will further inform the CQC's overall conclusions, as well as feeding in to the 'Well led' review, planned for mid-October this year. We expect to receive the final reports in February 2018.

## 3. Finance

As you will all be aware, our financial position is attracting significant attention, and a great deal of work is being done in a bid to arrest the deterioration. A recovery plan has been developed, and will be discussed by Board members in detail. We are looking at how we can best communicate with our staff regarding our finances, in particular our cash position, and there is a difficult balance to be struck between being open and transparent and causing unnecessary concern regarding pay and the provision of services.

## 4. Staffing and bed capacity

As a group of directors we have been considering the possibility, and indeed growing necessity, to reduce our bed capacity in light of the number of concerns regarding nursing staffing levels.

There is a significant national problem regarding registered nurse vacancies, and recruitment is challenging. Substantial effort goes into ensuring that we maintain safe staffing levels at all times and this is based on regular risk assessments of both staffing levels and patient acuity.

We would of course prefer posts to be filled on a substantive basis, but this is not always possible and the continued use of bank and agency staff ensures that we retain our focus on the safety of both patients and staff. This has a significant financial impact.

We have taken steps on the York site, and have also decided to temporarily close Waters Ward at Bridlington Hospital to admissions in order to redeploy staff elsewhere.

These decisions are not taken lightly, and will inevitably cause concern in the community, but in the current recruitment climate we have no alternative and this is absolutely a symptom of the increasing pressures facing us.

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Finance & Performance Committee Minutes – 19 September 2017

**Attendance:** Mike Keaney Chairman, Mike Sweet, Andrew Bertram, Wendy Scott, Wendy Pollard, Lynette Smith, Lynda Provins, Graham Lamb, Louise Parker, Susan Symington, Andrew Bennett, Joanne Best,

## Apologies for Absence

Gordon Cooney Sue Rushbrook Steven Kitching

## Minutes of the meeting held on the 22 August 2017

The minutes of the meeting held on 22 August 2017 were agreed as an accurate record.

## Matters arising from the minutes

MK welcomed Wendy Scott in her new role as COO to the Committee and also welcomed Sue Symington, the Trust Chair who attended as an observer.

MK told the Committee that the Corporate Improvement Team Quarterly Report has been deferred to the next meeting. MS has also asked if the report can provide monetary values.

## Emergency Care Standard Delivery

LS stated that the Emergency Care Standard for August had not been achieved, performance levels were at 88.1% which is 2% less than the trajectory of 90.5%. August has proved to be a difficult month but she stated that workforce challenges rather than bed occupancy was a key factor for the performance this month.

The 2 hour to decision to admit is core focus for work on at the York site and escalation plans have been instigated to manage workforce challenges. Ambulance handover times have increased but are improved on last year and the significant work has been undertaken on reducing bed occupancy rates which has enabled temporary closure of beds to support staffing levels during August. There has been an increase in readmissions during August, which will be monitored closely during September.

MK enquired about the number of doctors on duty during the night and was told that ED had been running with 5 doctors. The Committee discussed the medical establishment and it was noted that

they are running with 2 extra doctors to the establishment and that locum and agency staff are being used to fill these positions which obviously has financial implications.

MK observed that the July and August months have produced poor performance levels and therefore he has real concern for the winter months.

WS stated that performance levels nationally are poor but that the Trust needs to gain a balance and understanding of when to move staff from ED. There is a need to focus on the escalation process.

MS reiterated that the Trust has over and above the establishment of doctors in ED and it is still not delivering the required performance. WS stated there is a shortage of doctors, but the Trust needs to focus on what actually works to support achieving performance and patient safety.

The Committee discussed the establishment advised by the Royal College, however, WS stated that additional staff is not always the answer.

**Assurance:** The Committee were assured that patient safety remains the priority, however expressed concern about achievement of the targets.

**Attention to the Board**: WS to provide an overview to the Board.

## Cancer

Performance was below expected levels for August, with 14 day Fast Track at its lowest ever level of 80.7% in recent years with 234 breaches, 79% of which were diagnosed as not having cancer. Delays in Fast Track skin continue to be a factor in the Trust's low performance. MS enquired about the new cameras and how they are supporting improvement within the service. LS stated that the SR CCG have supported a move to the approach of returning the referral if no photograph is attached from October.

MK asked LS if there had been any serious delays in cancer, LS replied that there had been delays on dermatology fast track but dermatology patients were treated within 62 days. All breaches over 62 days had a root cause analysis and over 104 days had a clinical harm review reported to the Strategic Board.

Colorectal fast track account for 27.4% of fast track breaches with 71.9% of delayed patents diagnosed with no cancer.
It was noted that some of the 14 day fast track breaches where because of patient choice with patients cancelling appointments.

The 62 day wait from GP referral did not meet performance levels and the Trust has received additional money to support this. The implementation of the timed pathways and diagnostic turnaround both internally and at tertiary centres is a core focus of the Cancer Strategic Board to support diagnosis by day 28 as per the 2020 standard and to improve the number of patients transferred by day 38 to tertiary centres.

Following the number of breaches during August a discussion continued with regards to capacity and diagnostic times

The 62 day wait for screening was not achieved in August.

## Diagnostic

LS stated that the diagnostic target was achieved in August at 99.1% and this is the first time since March 17 that it has been achieved due to improvements in sleep study delays. There is no expectation that it will drop in September. The in-depth review of diagnostics will continue.

## Planned Care

LS stated that the 18 week planned care for August was 87.5% which is 3.7% off trajectory and it is unlikely to achieve the 92% national standard by October. LS told the Committee that this is due to several factors and that there is a need to ensure that we maximise utilisation of outpatients and theatre capacity.

The Committee discussed this and AB noted that the CCGs are challenging the fact that there is a reduction in referrals but not a corresponding reduction in procedures.

MK stated that the Board should be notified of deterioration.

A discussion continued between AB / WS with regards to outsourcing and the preference to work in-house.

MK received confirmation that there is no plan for a 'planned failure'l at the current time.

MS enquired about the use of theatres to which LS replied that a Business Case is in the process of being drafted with regards to extending theatre opening times. It will be reviewing activity v costs issues.

WS assured the committee that the Trust is looking at the full utilisation of theatres. LPa explained that her team was involved with this improvement work and that they have linked with Sheffield Hospital who have already done work in this area.

SS emphasised the need for the low achievement levels to be communicated to all staff, patients and Trust stakeholders. LS replied that she is working with the communication team for the emergency care standard. The Committee agreed that this needs to be delivered professionally and sooner rather than later.

A general discussion took place with regards to returning to standard operating procedures and continuous review of services. The Committee also discussed initiative fatigue. LS stated that a full stocktake was in progress of the Return to Operational Standards and MK asked for this to come to the Committee next month. WS stated that they would focus on key elements of the operation to ensure they are able to support sustainability and would seek to minimize the number of initiatives being undertaken at any one time.

MS commented on the use of the discharge lounge and if it was being used to its full potential or surplus to needs. The committee was told that this is also under review as Scarborough and York work differently.

## CQUIN

LS gave a brief update stating that the Health and Wellbeing element remains at amber for September. The Trust had performed highly in the period prior to the CQUIN, which would make it more difficult to achieve the benchmark. In relation to sepsis, the focus has been on ensuring patients are given the right antibiotic rather than general antibiotics. Sepsis also remains at amber.

LS stated that with regards to Improving Services for People with Mental Health needs who present to A&E, it is difficult to have control over this outcome as there is no control over who comes into A & E and the Trust is still in discussion with the CCG over this. With regards to flu vaccinations, the Trust has until February to secure the target rather than December which was the cut off last year.

### Capital Planning

ABen gave a overview of the current position and stated that capital expenditure up to the end of July 17 was below the forecast spending plan notified to NHSI (Monitor). Expenditure was £4.3m which is 25% below from the planned £5.7m. He also noted that during Quarter 2 there will be a need to reduce spending by approximately £2m to repay loans previously received from ITFF.

ABen gave an overview of Planned Capital Expenditure and stated that he is not concerned at the Trust position as there is a plan to manage the funds back to balance and continue to pay back the loans. He noted the risks and actions being taken to ensure delivery.

MK enquired how the deficit will affect capital planning going forward. AB stated that there will need to be some slippage, but this will be limited due to the critical nature of the schemes being taken forward. It was agreed that following the planned discussion at the next Capital Planning Group, a report will be provided to note what schemes can be deferred.

MS enquired why the Trust had both an Improvement Team and an Efficiency Team as there would appear to be common ground between them. AB explained that they both carry out very different tasks and discussions are held between the teams to correlate information.

## Finance

GL reported the Trust has a financial deficit of £17.6m against a planned deficit of £ 2.5m which gives a variance of £15.1m at the end of August. He explained that a significant proportion of this was due to the loss of the STP funding. GL provided the key points from the report highlighting the issues with pay costs which continue to provide a significant pressure due to agency spend in relation to additional staffing requirements and 1 to 1 supervision. He also noted the CIP shortfall of £2.9m.

### Cash

The cash position was discussed. The national decision taken by NHSE for CCGs to pay Trusts in 12th rather than 10th has had a significant impact on the Trust cash profile. It is now forecast that the Trust will run out of cash in November rather than October. AB stated that the Trust has discussed its position fully with NHSI and has commenced its application process into the Distressed Cash Regime.

The Committee discussed initiatives that could help the Trust improve financial performance including initiatives to cohort some services over the STP area, going paperlite and the further extension of e-rostering.

MK asked what it would mean if the Trust had to go into special measures. AB explained that this may mean a turn-around team being appointed to the Trust. He stated that NHSI want to see a recovery plan and implementation of the actions together with assurance that the Board was wholly sighted on the issue. AB stressed that the Trust is not in special measures but is on the verge and that a recovery plan has been formulated.

MK noted that the Audit Committee has asked that the Quality and Safety Committee look at the actions in the draft recovery plan to ensure that any impact is scrutinised at from a safety perspective. MK suggested that the Recovery Plan should be reviewed by the Estates & Workforce Committee and that the Recovery Plan should be a regular item on the agenda of future Board meetings.

AB stated that the corporate team is on board with the recovery plan and it is discussed every week at Corporate Directors to ensure actions are being implemented.

AB explained to the committee what the predicted cash flow model on P61 of the papers showed. The Committee discussed the predictions and AB highlighted each scenario. AB stated that the draft plan will be discussed at the Executive Board tomorrow. AB stated that he will update the Board next week and further values will be added to the draft.

AB assured the committee that actions are being looked at and implemented. The Committee asked that their serious concern be made known to the Executive Board and AB undertook to do this and expressed his appreciation for the stance that the Committee was taking.

**Assurance**: The Committee expressed concern about the financial position and that the recovery actions being put in place are still insufficient.

**Attention to the Board:** AB will provide the Board with a financial update including cash profiling and the draft financial recovery plan.

## Out of Hospital Care Report

This report was received for information.

## Corporate Risk Register and Board Assurance Framework

The Audit Committee asked each of the Board Committees to review any gaps in assurance on the BAF. The Committee noted that for F & P there are no gaps.

## Any other business

No other business was discussed.

## Time and Date of the next meeting

The next meeting is arranged for the 17 October 2017 in the Boardroom, York Hospital

D1

NHS

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Finance Report

## Recommendation

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

## Current approval route of report

This report is drafted for presentation to the Finance and Performance Committee, Executive Board, and Board of Directors.

## Purpose of report

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 31 August 2017.

At the end of August the Trust is reporting an Income and Expenditure (I&E) deficit of £17.6m against a planned deficit of £2.5m for the period. The Income & Expenditure position places the Trust behind its Operational plan.

## Key points for discussion

There are no specific points for discussion.

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

There are no references to CQC outcomes.

Version number: 1

Author: Graham Lamb, Deputy Finance Director

Executive sponsor: Andrew Bertram, Finance Director

Date: September 2017

York Teaching Hospital
NHS Foundation Trust

## Briefing Note for the Board of Directors Meeting 27 September 2017

## Subject: August 2017 (Month 5) Financial Position

## From: Andrew Bertram, Finance Director

### 1. Summary Reported Position for August 2017

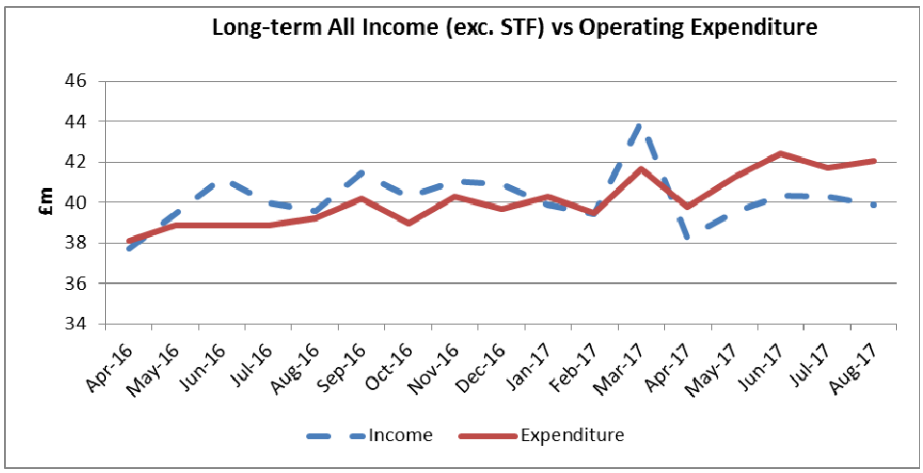
The deterioration in our financial position has continued into August. It is clear there is now an established trend miss-match between our income levels and our expenditure.

As a result we continue to lose out on our available sustainability funding and our reported position continues to exclude this.

The profile of our current plan assumed a year-to-date deficit of £2.5m and we are currently reporting a £17.6m deficit, therefore an adverse variance to plan of £15.1m. The significant components of the variance are the lost sustainability funding of £3.4m and a shortfall against our operational income and expenditure control total of £11.7m.

This continues to be a very worrying position. Corporate Directors have prepared a financial recovery plan that is now the focus of attention. If the position can be corrected then it is possible to recover the lost sustainability funding in subsequent months should our financial control total performance be brought back on track.

The chart below looks at our long term income and operational expenditure (above the EBITDA line) trend. The chart shows income above operational expenditure for Q1, Q2 and Q3 of 2016/17 and shows the difficulty we encountered in Q4 last year with poor performance in months 10 and 11 and some degree of recovery in month 12. During 2017/18 operational expenditure is shown as routinely exceeding income. This position was expected in the early months of the year with a deficit plan but the early indications are that the trend lines are diverging at an unplanned rate. This chart has been adjusted to exclude all sustainability funding. The chart clearly shows the continuing adverse trend.



Operational expenditure in August was high at £42.1m. The monthly average this financial year has been £41.3m and the 2016/17 monthly average was £39.5m.

The month 5 CIP position shows £7.9m removed from budget in full year terms against the £22.8m target. The planning gap for the year has come down and stands at £4.1m. This will continue to need to be carefully monitored as we progress through the financial year. The relentless nature of the efficiency programme delivery requirements does mean that even though progress is comparable to last year the month 5 income and expenditure account is impacted by a profile shortfall of £2.9m. Clearly, if ultimately the Trust's CIP is delivered by the end of the financial year then the in-year adverse variance impact is eventually removed.

## 2. Income Analysis

Overall, income is showing as £4.0m behind plan in September.

£3.4m of this adverse variance relates to lost sustainability funding. The balance of £0.6m relates to shortfalls in expected income levels in non-elective care, outpatients and some areas classified as "other".

We have raised a concern over the impact of HRG4+ with NHSI and have requested that we are considered in any national work in this area. In the meantime we continue our own analysis to understand the impact from the currency change. I have raised with the Board the potential issue associated with non-elective income (currently £0.5m below plan) despite our hospitals being extremely busy with emergency patients. It appears that pathways changes from increased use of ambulatory care, assessment areas and consistently increasing short stay patients has compromised income in an unplanned way. Each of these pathway redesigns has been clinically and operationally necessary and fully supported through the review work by ECIP, ECIST, NHSI, UM and our own internal improvement work. VOY CCG have just raised a formal activity query given the significant increases in activity in these areas and we are ensuring that the review work associated with this query will consider whether the Trust has been disadvantaged from an income perspective. If this is proven then there is a mechanism to provide protection from an unplanned income loss to the Trust and a windfall saving to the CCG.

Excluded from tariff drug income is running ahead of plan and is compensating for most of the expenditure pressure of £2.6m. This income is reported under other clinical income.

Other non-clinical income is showing an artificial shortfall against plan of £1.4m. This relates to an adjustment necessary to align assumptions in relation to a provision for stranded fixed cost recovery in the event of CCG QIPP adversely impacting our underlying expenditure position. This has not happened and the reported deficit is compensated for by a favourable over recovery of elements of clinical income where QIPP has not delivered against planned reductions. The impact is neutralised overall.

## 3. Expenditure Analysis

Pay costs continue to cause a significant spend pressure on the Trust's financial position. At the end of month 5 the reported adverse variance stands at £3.3m. Of note is that the position has deteriorated significantly this month.

In relation to total agency expenditure we have seen significant pressure continue into July, with even higher in month spend. The analysis shows that overall the Trust has spent

year-to-date £8.9m against a £7.2m target. The overspend rate continues to grow and now stands at 23%, compared to 20% in July and 15% in June. The analysis shows that the pressure in the main continues to come from consultant medical staff, although the pressure from junior medical staff is growing. Nursing agency spend reduced in August but remained ahead of plan.

The routine full analysis of pay pressure against individual directorate operational budgets has continues and shows continuing pressure from the provision of unplanned 1:1 supervision, exceptional additional staffing requirements above plan (additional ED doctor cover as the main component), demand driven pressures with additional premium rate Radiology reporting, exceptional sickness and maternity cover effecting consultant and junior medical staffing and pressure from the need for the Trust to operationally maintain escalation beds open at a time in the year when these would not normally be necessary. Junior medical pay expenditure was £0.1m higher in August than the previous monthly average reflecting better rota fill rates with the August changeover but with a catch up of expenditure associated with agency cover for previous gaps. The higher fill rate should see a reduction in agency spend going forward.

Drugs spend has remained higher than plan but this pressure relates almost exclusively to pass through high costs drugs outside of normal tariff arrangements. In this instance the Trust recharges the full additional cost direct to commissioners and therefore this pressure is directly compensated by an over recovery of income.

The non-pay pressure has continued into August. Of note is expenditure of £0.2m for the creation of CCG office space at the Trust's Kettlestring Lane site. This is matched by income from the CCG so has a neutral bottom line impact but is causing a positive income variance and a deficit expenditure variance. Of note is continued spend pressure from subcontracting healthcare arrangements as the Trust continues to source capacity to manage delivery of the RTT standards.

## 4. I&E Forecasting

Whilst there remains no need to formally consider our forecast position in-quarter for the purposes of notifying NHSI; it is still important that the Board consider whether our current financial position impacts on our current year-end forecast outturn (plan) position. It is clear that the August position continues to heighten the risk to the delivery of our plan.

NHSI have a very structured approach to forecasting. Should the Board wish to vary its forecast from plan then a formal submission is required. This should be discussed in advance with the regional NHSI team. The submission should include; the key drivers for the deterioration in forecast, an analysis of causes, confirmation that commissioners have been informed and opportunities for support explored, confirmation that the Trust's key clinical decision making body is aware and are signed up to recovery actions (including working capital actions and capital programme spend reductions) and a formal signed declaration is required to confirm that the Board have agreed the revision to forecast and have agreed corrective action.

The revision can only be made at quarterly reporting intervals so cannot be made this month.
Following the discussion at last month's Board of Directors meeting I have raised the risk issue with NHSI that our current trading position places on delivery of our plan.

The request to the Board, from NHSI, in considering a revision to our forecast outturn is that before making such an adjustment the Board satisfies itself that any and all recovery actions have been exhausted.

My recommendation remains to the Board that we continue discussions with the regional NHSI team regarding the emerging risk to our forecast position, we continue work to understand the financial detail, we complete our recovery plan and we complete our assessment of the recovery potential. We should not yet seek to formally revise our forecast as I do not believe the Board can make the assertion that all recovery actions have been exhausted.

## 5. Cash Forecasting

The Financial Recovery Plan prepared for the Board includes revised cash flow modelling assessing the impact of the loss of STF and our current trading position. It is clear from this work that we will require formal working capital support from November this year. We have now approached NHSI to request access to the distressed cash team, to agree any necessary application paperwork and to ensure all relevant parties are sighted on our emerging position.

There are formal requirements on the Board associated with distressed cash access and I will share details as these emerge.

## 6. Old year Contract Settlements

At the time of writing this report all old year end settlements have been agreed with the exception of VOY CCG. With NHSE's legal direction role this is proving difficult to finalise an agreement. I am keen to stress that significant work is underway by the Trust and CCG teams to bring this matter to a resolution.

## Q1 Provider Sector Performance

| 3 months ended 30 June 2017 by sector | Number of providers | Year to Date - Month 3 2017/18 | | | |
|---|---|---|---|---|---|
| | | Plan | Actual | Variance | Deficit providers |
| | No. | £m | £m | £m | No. |
| Acute | 135 | (742) | (839) | (97) | 117 |
| Ambulance | 10 | (3) | 0 | 3 | 5 |
| Community | 18 | (1) | 4 | 5 | 6 |
| Mental Health | 53 | (4) | (2) | 2 | 25 |
| Specialist | 17 | (18) | (15) | 3 | 9 |
| **Surplus / (deficit) – control total basis (1)** | **233** | **(767)** | **(851)** | **(84)** | **162** |
| Technical adjustments | | (12) | 0 | 12 | |
| Uncommitted STF | | 73 | 116 | 42 | |
| **Reported adjusted financial position surplus/(deficit) include all STF (2)** | | **(706)** | **(736)** | **(30)** | |

Source: NHSI Quarterly Performance Report

# Finance Performance Report

## August 2017

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

# Finance Report
## Chapter Index

# Summary Income and Expenditure Position
## Month 5 - The Period 1st April 2017 to 31st August 2017

York Teaching Hospital NHS Foundation Trust

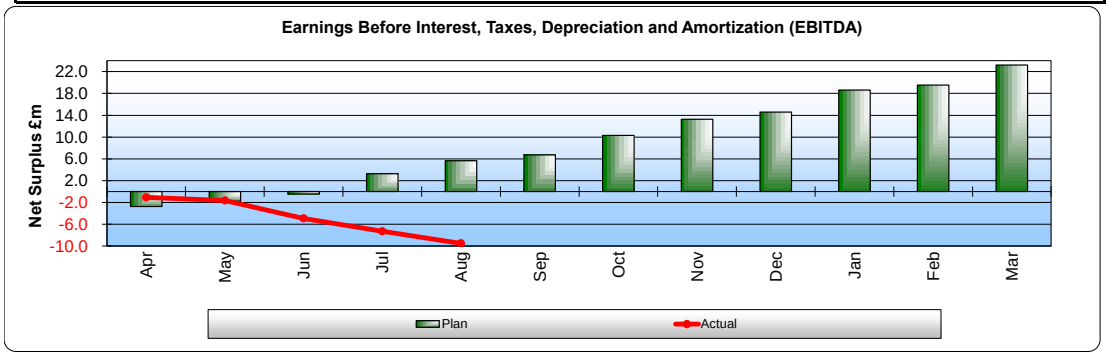
**Summary Position:**

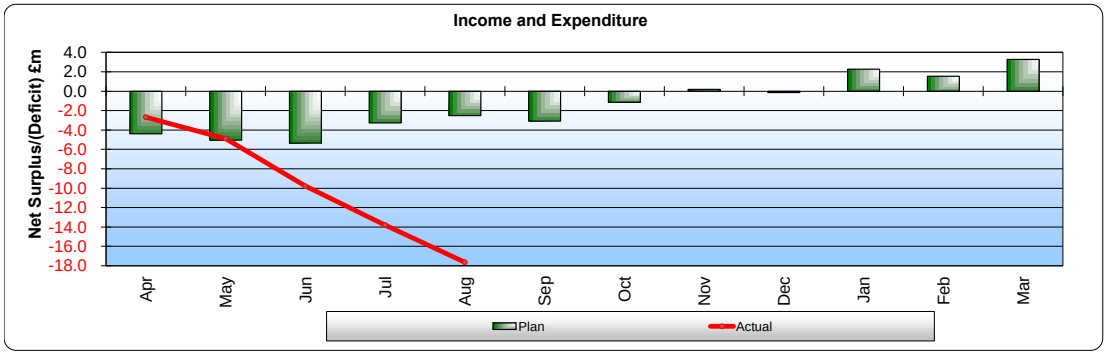
* The Trust is reporting an I&E deficit of £17.6m, placing it £15.1m behind the operational plan.

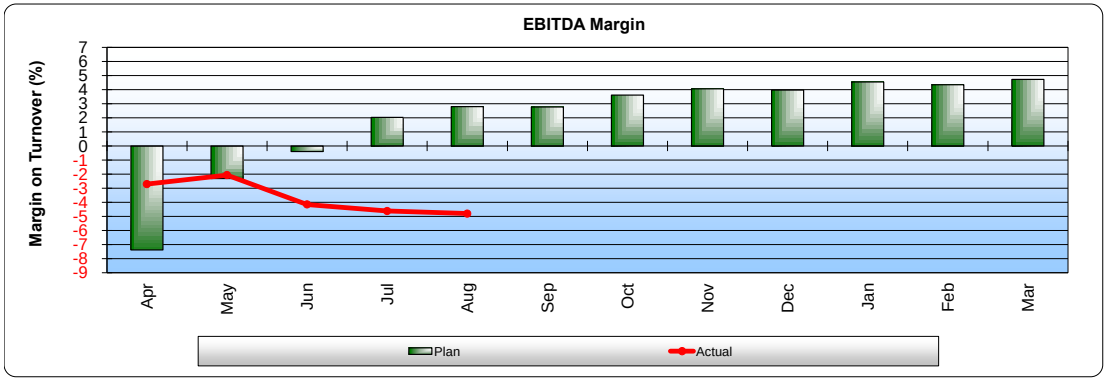
* Income is £4.0m behind plan, with clinical income being £0.6m ahead of plan and non-clinical income being £4.6m behind plan.

* Operational expenditure is ahead of plan by £11.1m, with further explanation given on the 'Expenditure' sheet.

* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is -£9.5m (-4.8%) compared to plan of £5.6m (2.8%), and is reflective of the reported net I&E performance.



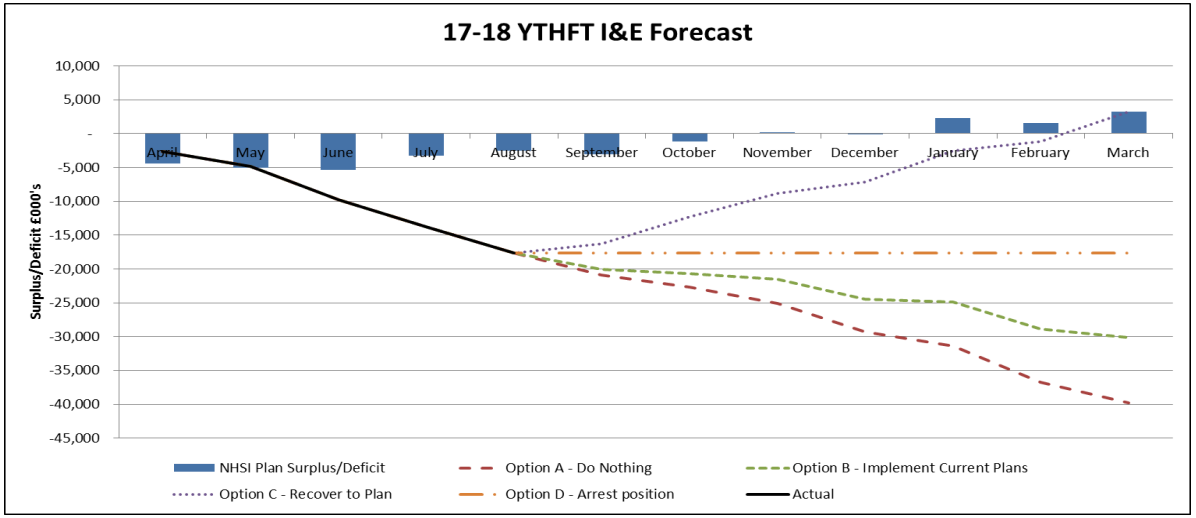




| | Annual Plan | Plan for Year to Date | Actual for Year to Date | Variance for Year to Date | Forecast Outturn | Annual Plan Variance |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **NHS Clinical Income** | | | | | | |
| Elective Income | 23,353 | 9,843 | 10,093 | 250 | 23,353 | 0 |
| Planned same day (Day cases) | 37,689 | 15,734 | 16,440 | 706 | 37,689 | 0 |
| Non-Elective Income | 111,619 | 46,273 | 45,744 | -529 | 111,619 | 0 |
| Outpatients | 59,278 | 24,503 | 23,591 | -912 | 59,278 | 0 |
| A&E | 14,982 | 6,189 | 6,841 | 652 | 14,982 | 0 |
| Community | 31,282 | 13,032 | 13,279 | 247 | 31,282 | 0 |
| Other | 156,173 | 62,239 | 62,334 | 95 | 156,173 | 0 |
| | **434,376** | **177,813** | **178,322** | **509** | **434,376** | **0** |
| **Non-NHS Clinical Income** | | | | | | |
| Private Patient Income | 956 | 398 | 288 | -110 | 956 | 0 |
| Other Non-protected Clinical Income | 1,510 | 629 | 782 | 153 | 1,510 | 0 |
| | **2,466** | **1,027** | **1,070** | **43** | **2,466** | **0** |
| **Other Income** | | | | | | |
| Education & Training | 12,946 | 5,394 | 5,595 | 201 | 12,946 | 0 |
| Research & Development | 3,296 | 1,373 | 1,340 | -33 | 3,296 | 0 |
| Donations & Grants received (Assets) | 0 | 0 | 0 | 0 | 0 | 0 |
| Donations & Grants received (cash to buy Assets) | 623 | 260 | 260 | 0 | 623 | 0 |
| Other Income | 22,632 | 11,429 | 10,049 | -1,379 | 22,632 | 0 |
| Sparsity Funding | 2,600 | 1,083 | 1,083 | 0 | 2,600 | 0 |
| STF | 11,832 | 3,352 | 0 | -3,352 | 11,832 | 0 |
| | **53,929** | **22,891** | **18,328** | **-4,563** | **53,929** | **0** |
| **Total Income** | **490,771** | **201,732** | **197,720** | **-4,012** | **490,771** | **0** |
| **Expenditure** | | | | | | |
| Pay costs | -332,344 | -136,621 | -139,882 | -3,262 | -332,344 | 0 |
| Drug costs | -52,583 | -21,969 | -24,531 | -2,562 | -52,583 | 0 |
| Clinical Supplies & Services | -47,794 | -19,570 | -20,187 | -617 | -47,794 | 0 |
| Other costs (excluding Depreciation) | -49,899 | -20,865 | -22,246 | -1,381 | -49,899 | 0 |
| Restructuring Costs | 0 | 0 | -372 | -372 | 0 | 0 |
| CIP | 14,941 | 2,900 | 0 | -2,900 | 14,941 | 0 |
| **Total Expenditure** | **-467,679** | **-196,125** | **-207,218** | **-11,093** | **-467,679** | **0** |
| **Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)** | **23,092** | **5,607** | **-9,498** | **-15,105** | **23,092** | **0** |
| Profit/ Loss on Asset Disposals | 0 | 0 | 1 | 1 | 0 | 0 |
| Fixed Asset Impairments | -300 | 0 | 0 | 0 | -300 | 0 |
| Depreciation - purchased/constructed assets | -11,604 | -4,835 | -4,835 | 0 | -11,604 | 0 |
| Depreciation - donated/granted assets | -396 | -165 | -165 | 0 | -396 | 0 |
| Interest Receivable/ Payable | 130 | 54 | 33 | -22 | 130 | 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 | -420 | -164 | -164 | -0 | -420 | 0 |
| Interest Expense on Finance leases (non-PFI) | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Finance costs | 0 | 0 | 0 | 0 | 0 | 0 |
| PDC Dividend | -7,216 | -3,007 | -3,007 | 0 | -7,216 | 0 |
| Taxation Payable | 0 | 0 | 0 | 0 | 0 | 0 |
| **NET SURPLUS/ DEFICIT** | **3,286** | **-2,510** | **-17,636** | **-15,126** | **3,286** | **0** |

## Summary Trust Forecast
**Month 5 - The Period 1st April 2017 to 31st August 2017**

York Teaching Hospital NHS
NHS Foundation Trust

Option A: Assumes no change to current trends and therefore assumes current rate of CIP delivery is maintained. Adjustments have been made to reflect the impact of non-recurrent expenditure already incurred.
Option B: Assumes delivery of the CIP plan, the Capped Expenditure Plans and the Financial Recovery plans.
Option C: Assumes recovery of the position, to an end of year surplus of £3.2m.
Option D: Assumes the remaining months of the year deliver neither a surplus nor deficit.




| | Year End Position (£000's) | | | |
|---|---|---|---|---|
| | **Option A** | **Option B** | **Option C** | **Option D** |
| Clinical Income | 432,139 | 433,683 | 434,898 | 427,973 |
| Other Income | 46,553 | 46,553 | 55,183 | 46,553 |
| **Total Income** | **478,692** | **480,236** | **490,081** | **474,525** |
| | | | | |
| Pay Expenditure | -338,988 | -335,206 | -315,486 | -320,938 |
| Drug Expenditure | -59,456 | -57,839 | -56,362 | -56,330 |
| CSS Expenditure | -47,538 | -46,245 | -45,064 | -45,039 |
| Other Expenditure | -52,713 | -51,279 | -49,970 | -49,941 |
| **Total Operating Expenditure** | **-498,695** | **-490,569** | **-466,882** | **-472,247** |
| | | | | |
| Other Expenditure | -19,831 | -19,831 | -19,914 | -19,914 |
| Surplus/Deficit | -39,834 | -30,165 | 3,285 | -17,636 |

# Contract Performance

## Month 5 - The Period 1st April 2017 to 31st August 2017

York Teaching Hospital NHS
NHS Foundation Trust

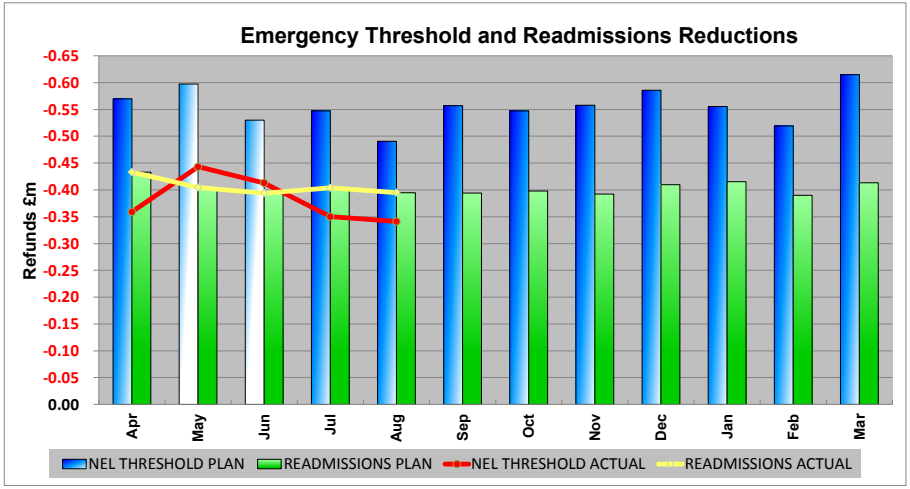
| Contract | Annual Contract Value | Contract Year to Date | Actual Year to Date | Variance |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Vale of York CCG | 217,060 | 89,344 | 89,202 | -142 |
| Scarborough & Ryedale CCG | 81,522 | 34,015 | 34,459 | 444 |
| East Riding CCG | 41,841 | 17,287 | 17,186 | -101 |
| Other Contracted CCGs | 16,823 | 7,008 | 7,187 | 179 |
| NHSE - Specialised Commissioning | 42,428 | 17,641 | 17,259 | -382 |
| NHSE - Public Health | 15,319 | 6,381 | 5,725 | -656 |
| Local Authorities | 4,581 | 1,913 | 1,886 | -27 |
| **Total NHS Contract Clinical Income** | **419,574** | **173,589** | **172,904** | **-685** |

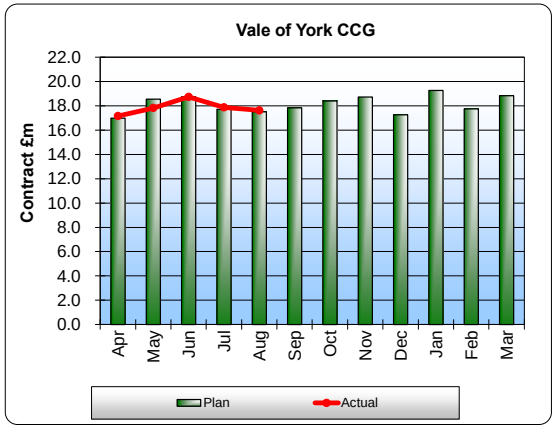
| Plan | Annual Plan | Plan Year to Date | Actual Year to Date | Variance Year to Date |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Non-Contract Activity | 12,417 | 5,199 | 6,525 | 1,326 |
| Risk Income | 2,385 | -975 | 0 | 975 |
| **Total Other NHS Clinical Income** | **14,802** | **4,224** | **6,525** | **2,301** |

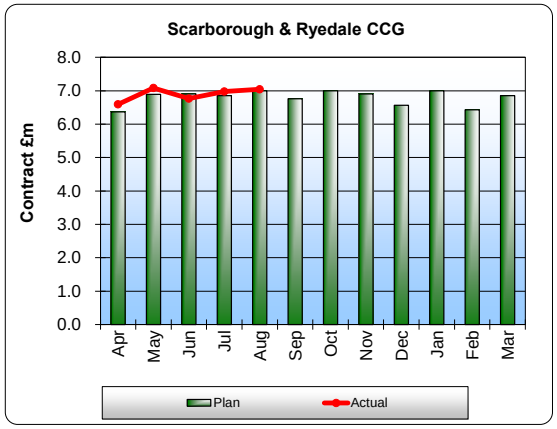
| | |
|---|---|
| Sparsity funding income moved to other income non clinical | -1107 |
| Winter resilience monies in addition to contract | 0 |

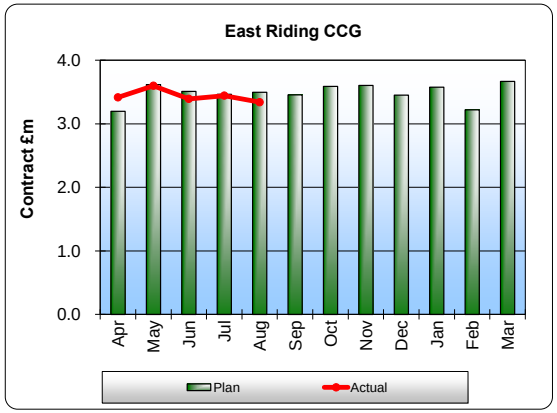
| | | | | |
|---|---|---|---|---|
| **Total NHS Clinical Income** | **434,376** | **177,813** | **178,322** | **509** |

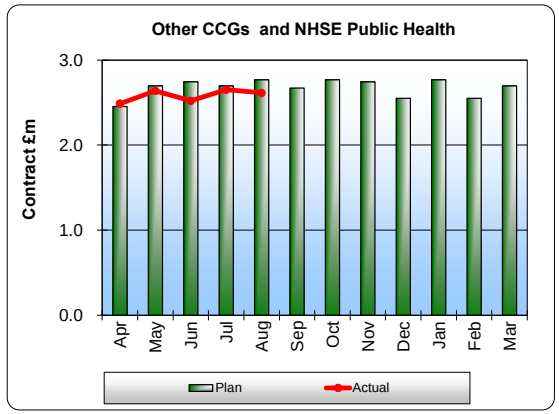
**Activity data for August is partially coded (51.1%) and July data is 90.6% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.**

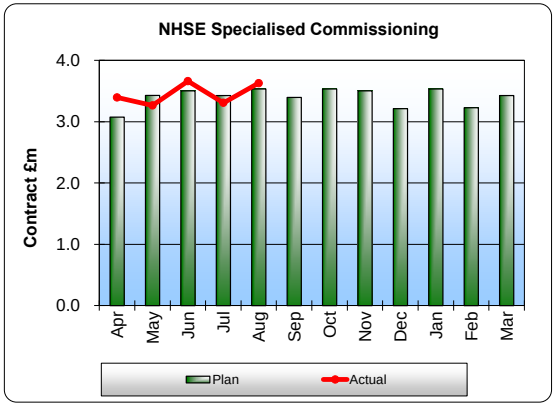


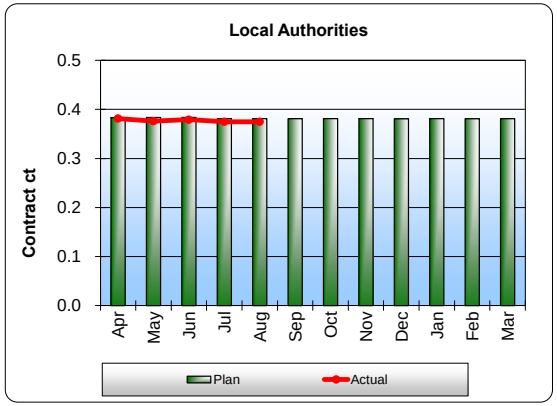



# Agency Expenditure Analysis

## Month 5 - The Period 1st April 2017 to 31st August 2017

York Teaching Hospital NHS
NHS Foundation Trust

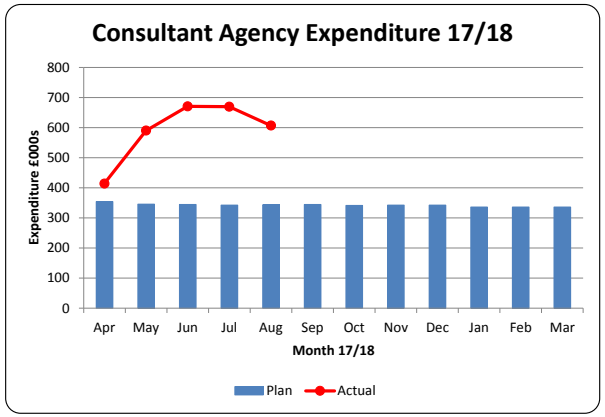
**Key Messages:**

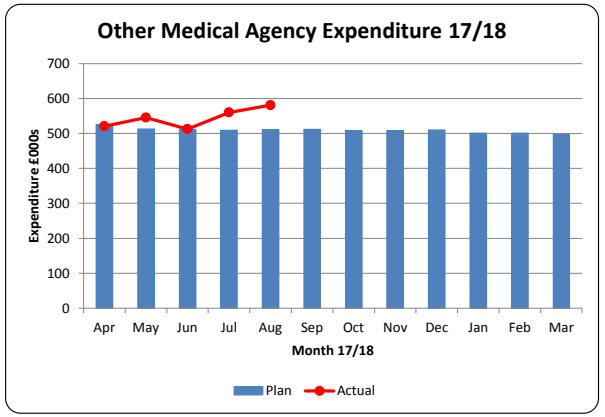
* Total agency spend year to date of £8.9m compared to an NHSI plan of £7.2m.

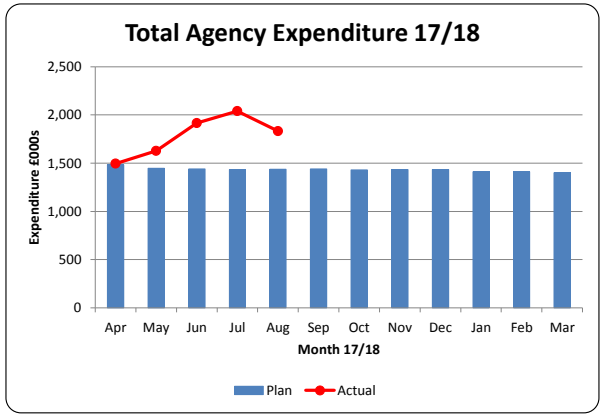
* Consultant Agency spend is ahead of plan by £1.2m.

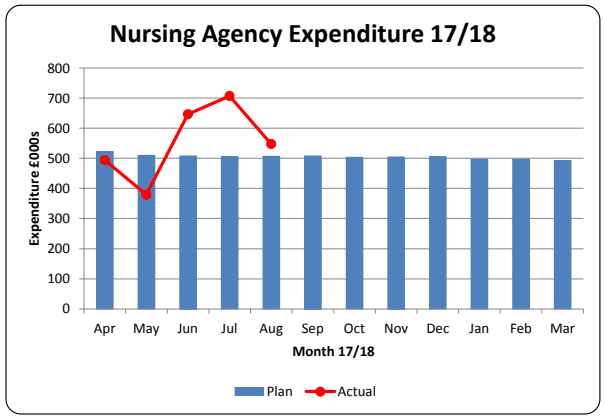
* Nursing Agency is ahead of plan by £0.2m.

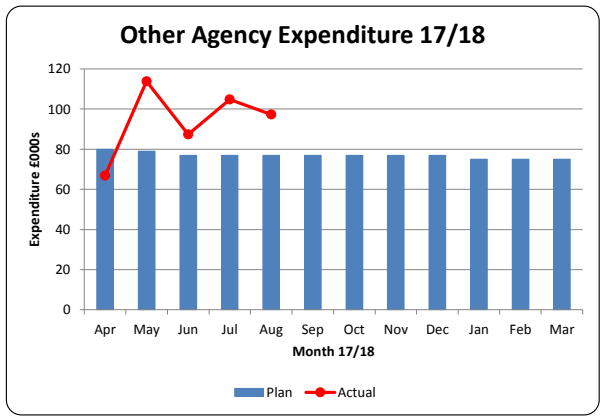
* The Trust is ahead of the Medical Locum Reduction target by £1.2m.

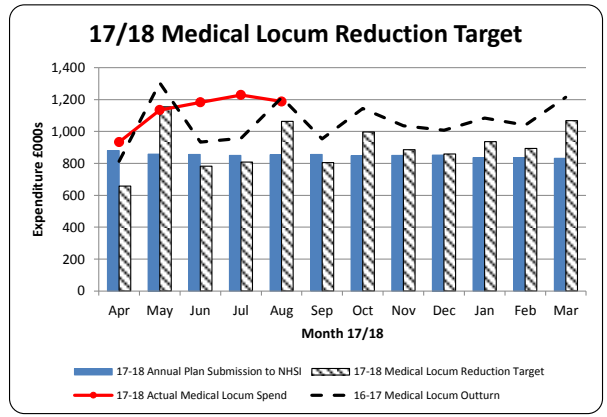


# Expenditure Analysis
## Month 5 - The Period 1st April 2017 to 31st August 2017

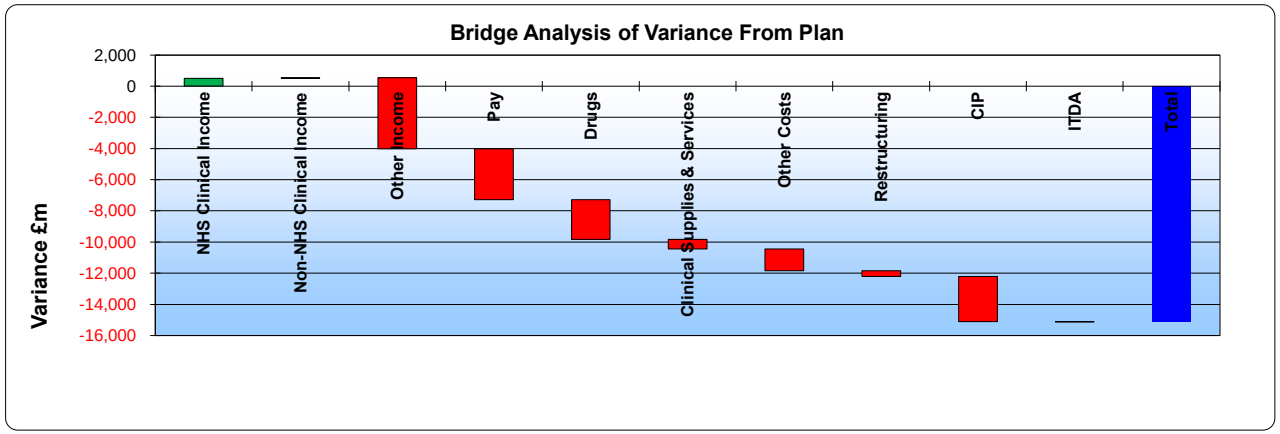
York Teaching Hospital NHS
NHS Foundation Trust

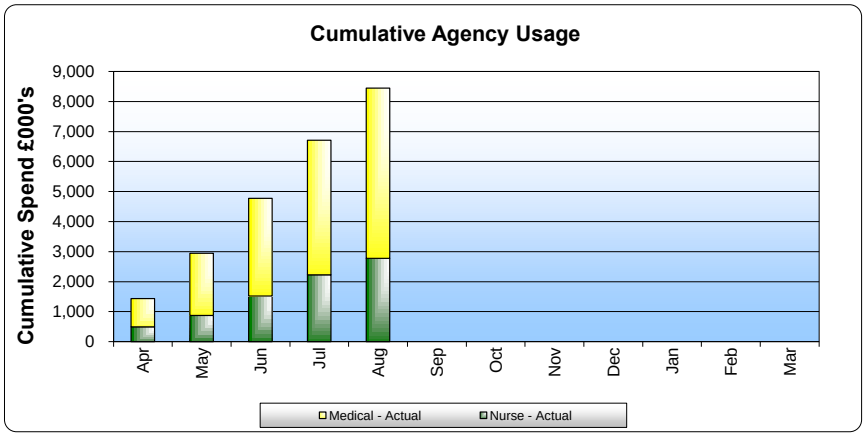
**Key Messages:**

There is an adverse expenditure variance of £11.1m at the end of August 2017. This comprises:

* Pay budgets are £3.2m ahead of plan.
* Drugs budgets are £2.6m ahead of plan, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £2.9m behind plan.
* Other budgets are £2.4m ahead of plan.

| Staff Group | Annual | Year to Date | | | | | | | | Previous | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Plan | Contract | Overtime | WLI | Bank | Agency | Total | Variance | Variance | |
| Consultants | 60,701 | 25,063 | 21,578 | 0 | 578 | 0 | 2,950 | 25,106 | -43 | 150 | |
| Medical and Dental | 29,792 | 12,351 | 12,011 | 0 | 149 | 0 | 2,720 | 14,880 | -2,529 | -1,864 | |
| Nursing | 96,757 | 40,220 | 33,342 | 198 | 191 | 3,681 | 2,774 | 40,186 | 34 | 224 | |
| Healthcare Scientists | 11,379 | 4,583 | 4,081 | 97 | 60 | 30 | 120 | 4,389 | 194 | 312 | |
| Scientific, Therapeutic and technical | 16,428 | 6,751 | 6,056 | 49 | 0 | 19 | 90 | 6,215 | 536 | 450 | |
| Allied Health Professionals | 25,941 | 10,739 | 9,954 | 25 | 114 | 21 | 43 | 10,158 | 581 | 535 | |
| HCAs and Support Staff | 45,403 | 18,900 | 17,069 | 318 | 55 | 35 | 103 | 17,580 | 1,320 | 1,058 | |
| Chairman and Non Executives | 186 | 77 | 77 | 0 | 0 | 0 | 0 | 77 | 0 | 1 | |
| Exec Board and Senior managers | 13,942 | 5,932 | 5,882 | 9 | 0 | 0 | 0 | 5,891 | 41 | 71 | |
| Admin & Clerical | 37,593 | 15,566 | 14,535 | 114 | 48 | 59 | 114 | 14,870 | 696 | 580 | |
| Agency Premium Provision | 5,164 | 2,152 | 0 | 0 | 0 | 0 | 0 | 0 | 2,152 | 1,721 | |
| Vacancy Factor | -12,135 | -6,210 | 0 | 0 | 0 | 0 | 0 | 0 | -6,210 | -5,245 | |
| Apprenticeship Levy | 1,192 | 497 | 531 | 0 | 0 | 0 | 0 | 531 | -34 | -34 | |
| **TOTAL** | **332,344** | **136,621** | **125,116** | **811** | **1,195** | **3,846** | **8,914** | **139,883** | **-3,262** | **-2,040** | |



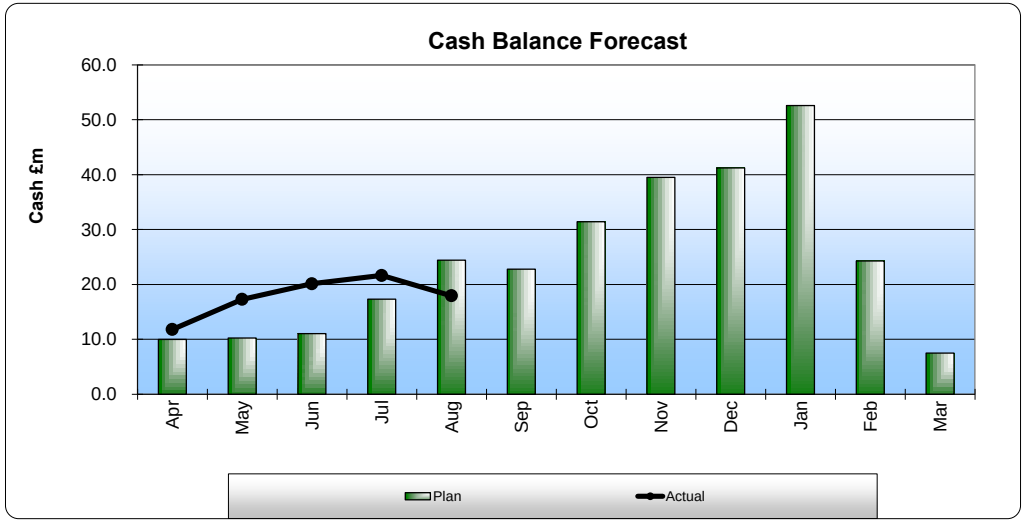
# Cash Flow Management
## Month 5 - The Period 1st April 2017 to 31st August 2017

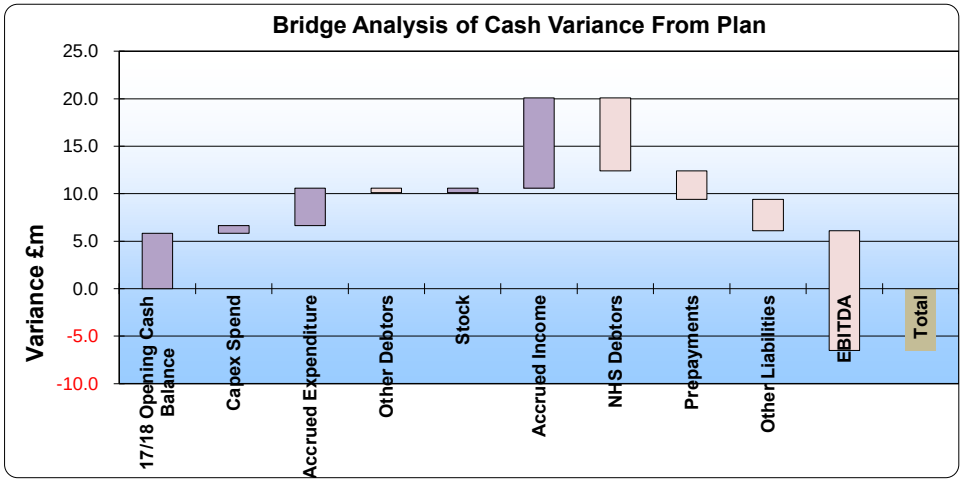
York Teaching Hospital NHS
NHS Foundation Trust

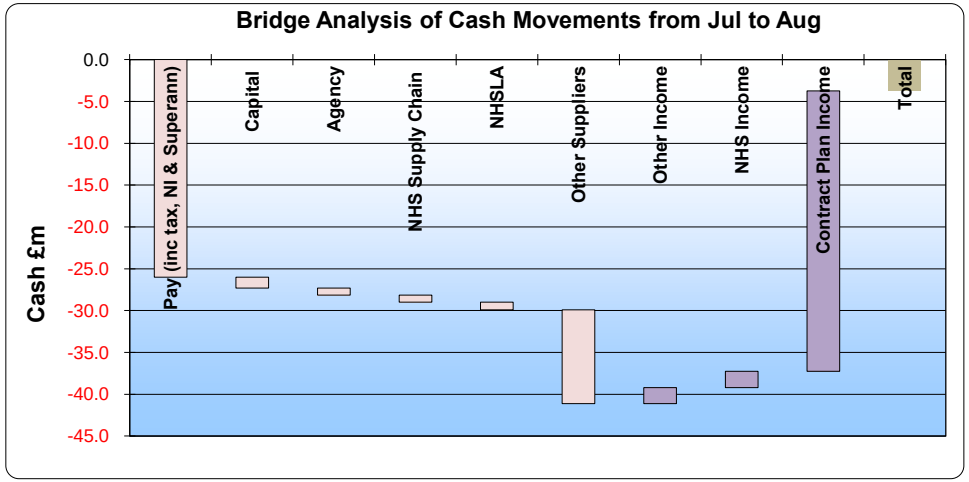
### Key Messages:

* The cash position at the end of August was £17.9m, which is below plan by £6.5m.
* The 17/18 opening cash balance was £5.8m favourable to the planned forecast outturn balance.
* The key factors influencing cash are:

- Negative impact due to the I&E position.
- Negative impact due to changes in payment profiles with our main commissioners.
- Positive impact due to capital expenditure slippage.
- Positive impact from combined accured income & debtors balances lower than planned.



# Cash Flow Management
## Month 5 - The Period 1st April 2017 to 31st August 2017

York Teaching Hospital NHS
NHS Foundation Trust

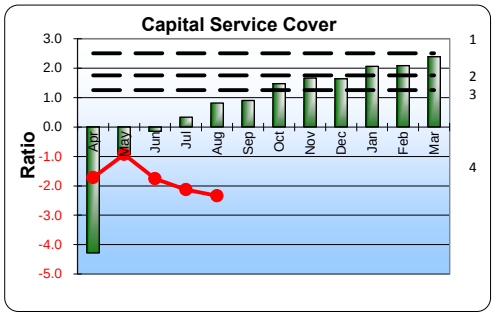
### Key Messages:

* The receivables balance at the end of August was £12m, which is on plan.
* The payables balance at the end of August was £12.8m, which is higher than plan.
* The Use of Resources Rating is assessed as a score of 4 in August, and is reflective of the I&E position.

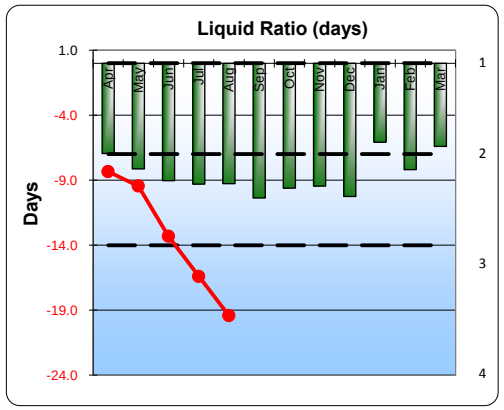
**Significant Aged Debtors (+6mths)**

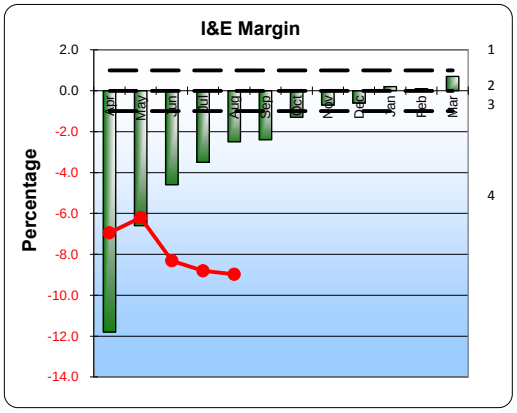
| | |
|---|---|
| **NHS Property Services** | **£366K** |
| **Harrogate & District NHS Foundation Trust** | **£255K** |
| **Depuy** | **£143K** |

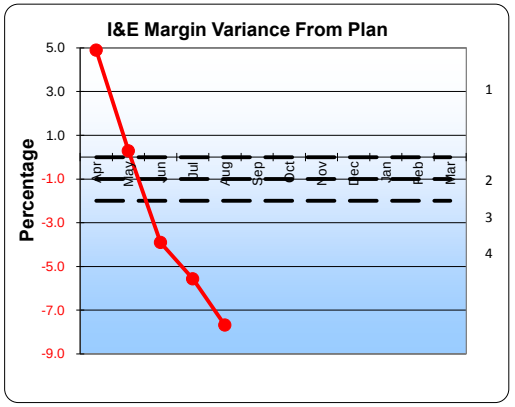
| | Under 3 mths | 3-6 mths | 6-12 mths | 12 mths + | Total |
|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m |
| Payables | 10.54 | 1.03 | 0.75 | 0.50 | 12.81 |
| Receivables | 7.25 | 3.26 | 0.54 | 0.89 | 11.94 |

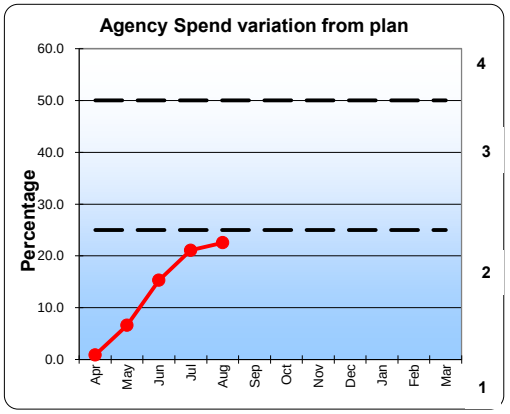



| | Plan for Year | Plan for Year-to-date | Actual Year-to-date | Forecast for Year |
|---|---|---|---|---|
| Liquidity (20%) | 2 | 3 | 4 | 2 |
| Capital Service Cover (20%) | 2 | 3 | 4 | 2 |
| I&E Margin (20%) | 2 | 4 | 4 | 2 |
| I&E Margin Variance From Plan (20%) | 1 | 1 | 4 | 1 |
| Agency variation from Plan (20%) | 1 | 1 | 2 | 1 |
| Overall Use of Resources Rating | **2** | **3** | **4** | **2** |



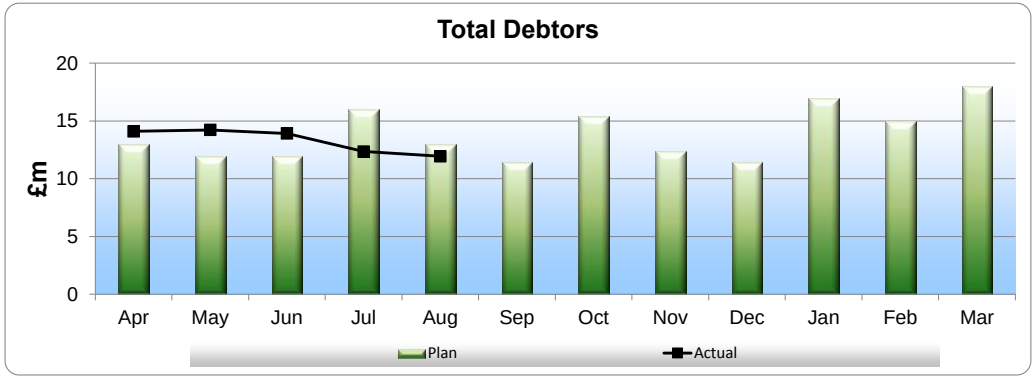
# Debtor Analysis

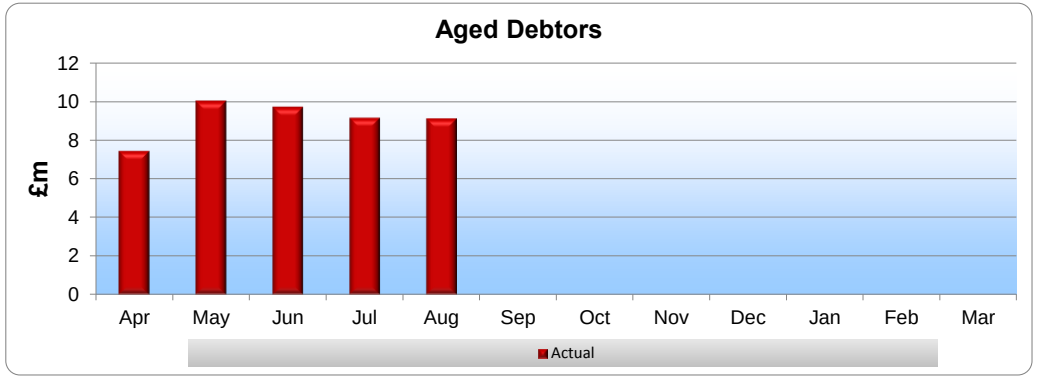
## Month 5 - The Period 1st April 2017 to 31st August 2017

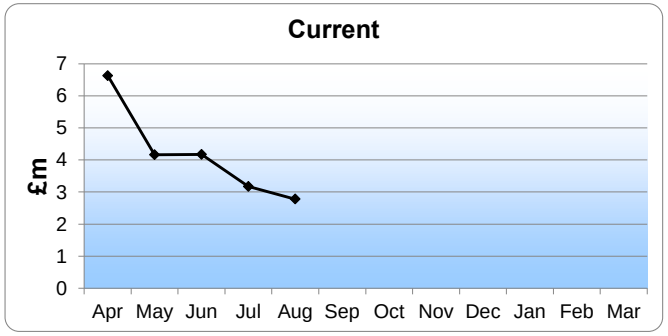
York Teaching Hospital NHS
NHS Foundation Trust

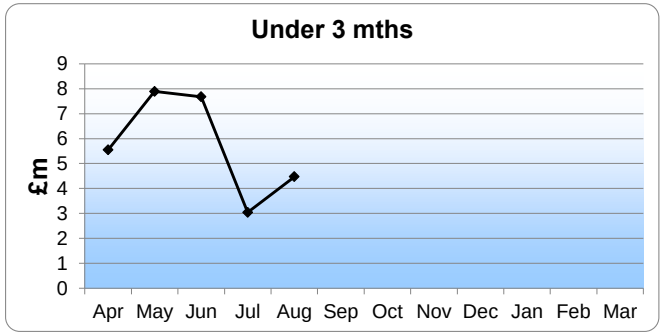
### Key Messages:

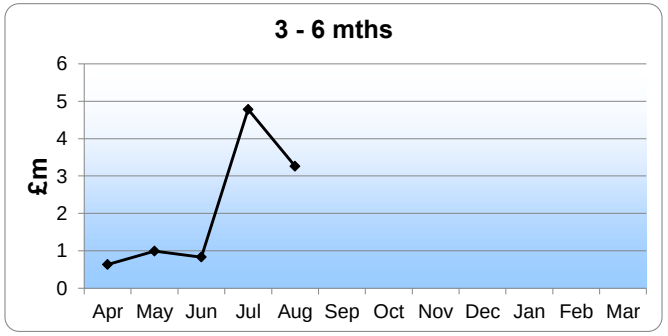
* At the end of August, the total debtor balance was £12m, with £2.7m relating to 'current' invoices not due.
* Aged debt totalled £9m. This is significantly influenced by delays in resolving a number of 16/17 Commissioner agreement invoices.
* Of these agreement invoices, 3 organisations total £2.3m; Vale of York CCG (£821k), Scarborough & Ryedale CCG (£1m) and NHS England (£515k).
* Excluding the 'anomalies' above, the aged debt total would be £7m. This is marginally higher than the position at the same point last year.

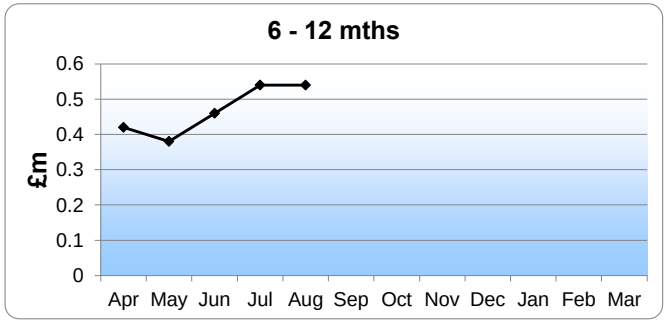


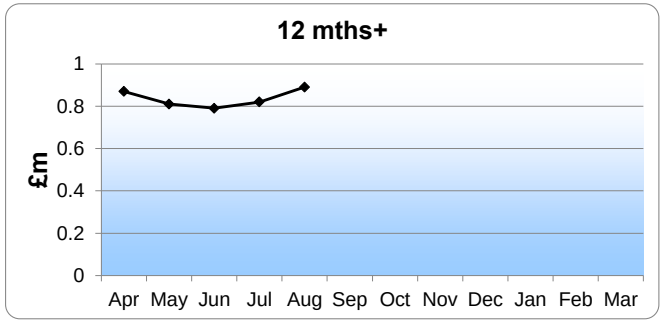



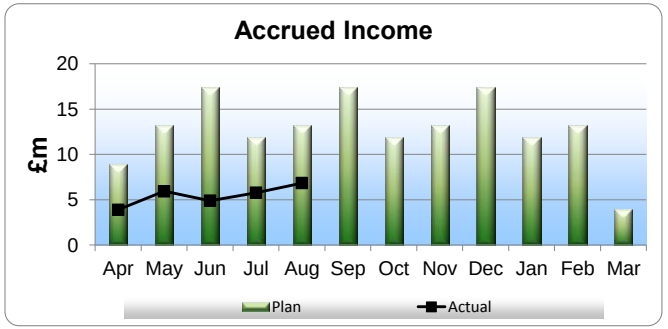



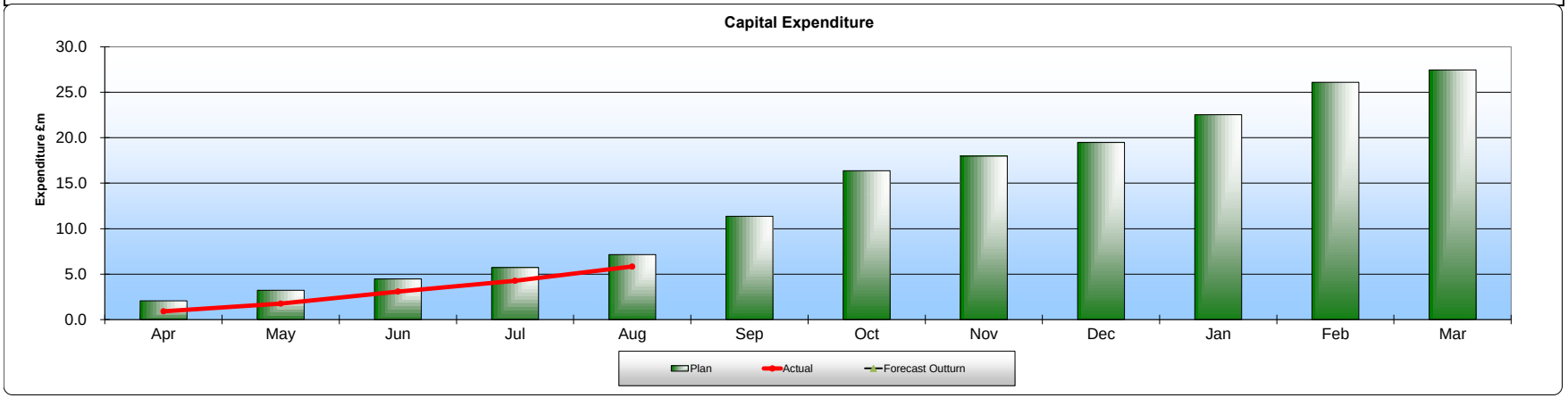



# Capital Programme
## Month 5 - The Period 1st April 2017 to 31st August 2017

York Teaching Hospital NHS
NHS Foundation Trust

**Key Messages:**

* The Capital plan for 2017-18 totals £27.466m.
* Work on the Radiology department across both Scarborough and York totals £5.526m, this is to replace 2 x MRI's, the VIU and Cardiac Labs at York plus X-Ray rooms on both sites and includes enabling works for the 2nd CT Scanner at Scarborough.
* Work on the Endoscopy extension will commence with an expected spend of £5.5m and detailed designs for the VIU/ Cardiac extension will be developed at an expected cost of approx £1m.
* The Pathology reconfiguration across both sites is included in the plan at a cost of £3.662m.




| Scheme | Approved in-year Expenditure | Year-to-date Expenditure | Forecast Outturn Expenditure | Variance | Comments |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | |
| York Micro/ Histology integration | 2411 | 17 | 500 | 1911 | |
| SGH Pathology /Blood Sciences | 1251 | 25 | 600 | 651 | |
| Theatre 10 to cardiac/vascular | 1265 | 603 | 1265 | 0 | |
| Radiology Replacement | 5526 | 0 | 5144 | 382 | |
| Radiology Lift Replacement SGH | 799 | 37 | 1284 | -485 | |
| Fire Alarm System SGH | 940 | 34 | 1027 | -87 | |
| Other Capital Schemes | 985 | 1031 | 3357 | -2372 | |
| SGH Estates Backlog Maintenance | 1300 | 180 | 1300 | 0 | |
| York Estates Backlog Maintenance - York | 1200 | 629 | 1200 | 0 | |
| Cardiac/VIU Extention | 1000 | 24 | 1000 | 0 | |
| Medical Equipment | 500 | 151 | 500 | 0 | |
| IT Capital Programme | 1500 | 322 | 1500 | 0 | |
| Capital Programme Management | 1450 | 690 | 1450 | 0 | |
| SGH replacement of estates portakabins | 1339 | 1332 | 1339 | 0 | |
| Endoscopy Development | 5500 | 0 | 5500 | 0 | |
| Contingency | 500 | 0 | 500 | 0 | |
| Estimated In year work in progress | 0 | 756 | 0 | 0 | |
| **TOTAL CAPITAL PROGRAMME** | **27466** | **5831** | **27466** | **0** | |

| This Years Capital Programme Funding is made up of:- | Approved in-year Funding | Year-to-date Funding | Forecast Outturn | Variance | Comments |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | |
| Depreciation | 10554 | 4177 | 10554 | 0 | |
| Loan Funding b/fwd | 4450 | 25 | 4450 | 0 | |
| Loan Funding | 6500 | 0 | 6500 | 0 | |
| Charitable Funding | 623 | 43 | 623 | 0 | |
| Strategic Capital Funding | 5339 | 1586 | 5339 | 0 | |
| **TOTAL FUNDING** | **27466** | **5831** | **27466** | **0** | |

# Efficiency Programme

**Month 5 - The Period 1st April 2017 to 31st August 2017**

York Teaching Hospital NHS
NHS Foundation Trust

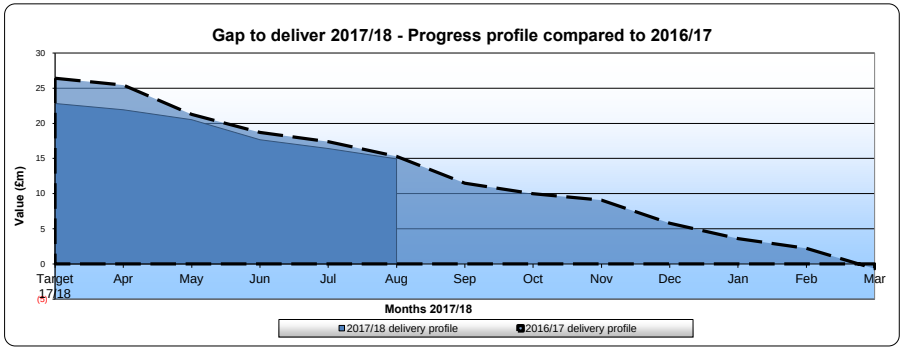
**Key Messages:**

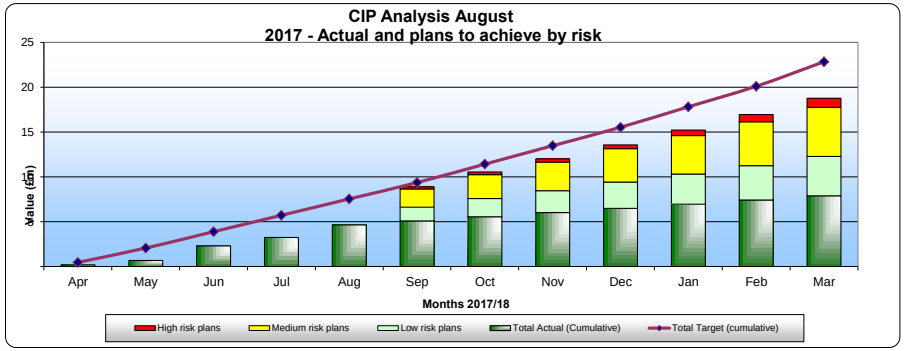
* Delivery - £7.9m has been delivered against the Trust annual target of £22.8m, giving a shortfall of (£14.9m).
* Part year NHSI variance - The part year NHSI variance is (£2.9m).
* In year planning - The 2017/18 planning gap is currently (£4.1m).
* Four year planning - The four year planning gap is (£8.0m).
* Recurrent delivery - Recurrent delivery is £4.4m in-year, which is 19% of the 2017/18 CIP target.

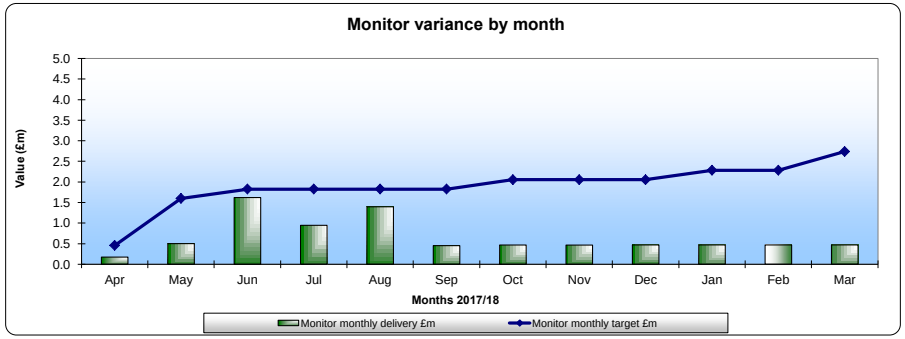
| Executive Summary - August 2017 | |
|---|---|
| | Total £m |
| TARGET | |
| In year target | 22.8 |
| DELIVERY | |
| In year delivery | 7.9 |
| In year delivery (shortfall)/Surplus | -14.9 |
| Part year delivery (shortfall)/surplus - NHSI variance | -2.9 |
| PLANNING | |
| In year planning surplus/(gap) | -4.1 |
| FINANCIAL RISK SCORE | |
| Overall trust financial risk score | HIGH |

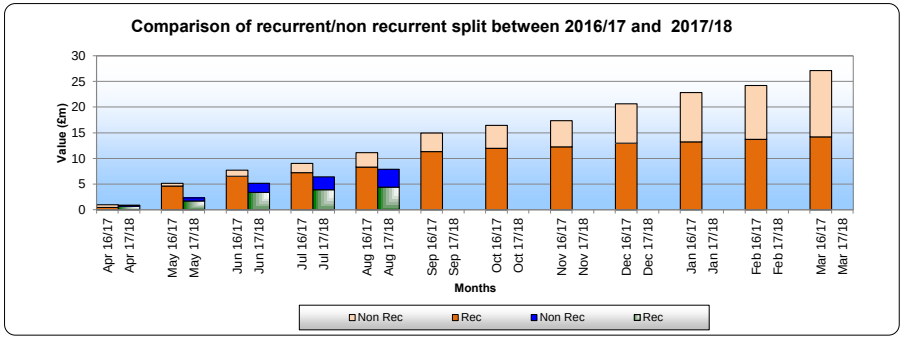
| 4 Year Efficiency Plan - August 2017 | | | | | |
|---|---|---|---|---|---|
| Year | 2017/18 | 2018/19 | 2019/20 | 2020/21 | **Total** |
| | £m | £m | £m | £m | **£m** |
| Base Target | 22.8 | 12.7 | 12.7 | 12.7 | **61.0** |
| Plans | 18.8 | 16.0 | 10.2 | 8.1 | **53.0** |
| Variance | -4.1 | 3.2 | -2.6 | -4.6 | **-8.0** |
| | | | | | |
| **%** | **82%** | **125%** | **80%** | **64%** | **87%** |

| Risk Ratings | | | |
|---|---|---|---|
| Financial | | | |
| Risk | July | August | Trend |
| High | 19 | 16 | ↓ |
| Medium | 6 | 4 | ↓ |
| Low | 2 | 7 | ↑ |
| Governance | | | |
| Risk | July | August | Trend |
| High | 7 | 1 | ↓ |
| Medium | 10 | 2 | ↓ |
| Low | 10 | 24 | ↑ |



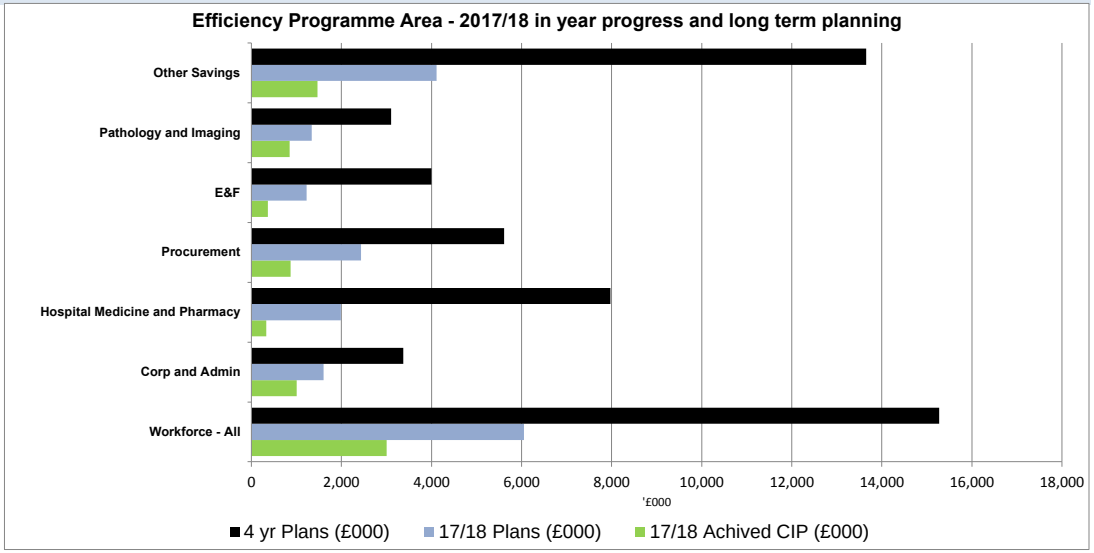



**Key Messages:**

Model Hospital - Working through opportunities identified with Directorates.
Get It Right First Time (GIRFT) - Head and Neck, Max Fax, General Surgery and T&O visits scheduled.
* Procurement - PPIB £400K opportunity to be maximised - work progressing.

## EFFICIENCY PROGRAM - CARTER WORKSTREAM PERFORMANCE AUGUST 2017

| Efficiency Programme Area | 4 yr Plans (£000) | 17/18 Plans (£000) | 17/18 Achived CIP (£000) |
|---|---|---|---|
| Workforce - All | 15,272 | 6,053 | 3,000 |
| Corp and Admin | 3,375 | 1,604 | 1,002 |
| Hospital Medicine and Pharmacy | 7,975 | 1,987 | 331 |
| Procurement | 5,609 | 2,438 | 870 |
| E&F | 3,996 | 1,223 | 364 |
| Pathology and Imaging | 3,099 | 1,339 | 851 |
| Other Savings | 13,653 | 4,115 | 1,465 |
| TOTAL | 52,979 | 18,759 | 7,884 |




### WORKFORCE

1. Review ongoing with Nurse E-Rostering System being led by Senior Nursing Team, E-Roster Team, HR and the Efficiency Team. Work ongoing to identify efficiencies, Benefits realisation document has been issued to Corporate Nursing Team..

2. Expansion of eRostering to wider Trust is in the planning stages with forecast efficiencies of £1.4m over 5 year period after implementation.

3. Workforce Team success with recruitment of substantive Consultants removing the reliance on Agency.

### HOSPITAL PHARMACY AND MEDICINE

1. Electronic Prescribing is being rolled out across the Trust and upon full implementation an efficiency will be realised.

2. The Pharmacy Department continue to work with the switch to Biosimilars with some efficiency being recognised by the Trust within the CIP Programme, however approximately £800K of savings is attached to CQUINs and does not contribute to the delivery of the Programme but it is recognised within the Model Hospital Pharmacy Dashboard.

3. Warehousing project in planning stages.

### PROCUREMENT

1. Procurement Purchasing Price Index (PPIB) Benchmarking Tool (comparison of pricing) - opportunity of approximately £400K.

2. Workshop held with Procurement and a follow-up held in September with schemes being identified and updated on a monthly basis.

### ESTATES AND FACILITIES

1. Work ongoing to improve data collection for ERIC returns.

2. Model Hospital identifies opportunities - working with E&F and Finance Manager.

### CORPORATE AND ADMIN

1. Corporate and Admin review outcome received; leads in areas to comply or explain variation and plans to be developed where appropriate. CET finalising report identifying spend as a % of income.

### PATHOLOGY AND IMAGING

1. Pathology data collection submitted and loaded on to Model Hospital. Directorate assessing and identifying areas of opportunity. The overall position is positive when compared to peers.

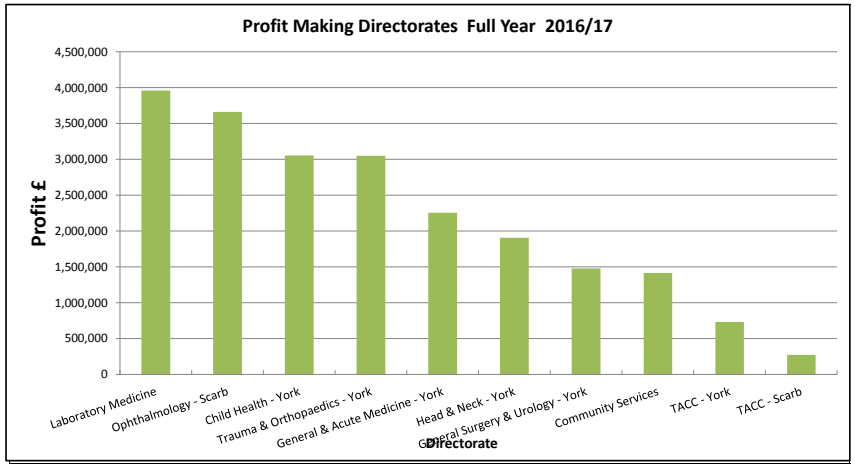
2. Workshop planned for Pathology.

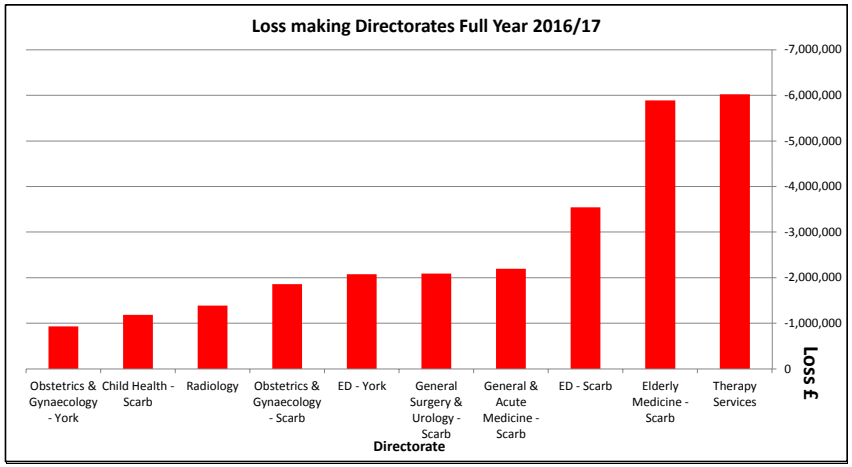
# Service Line Reporting
## Month 5 - The Period 1st April 2017 to 31st August 2017

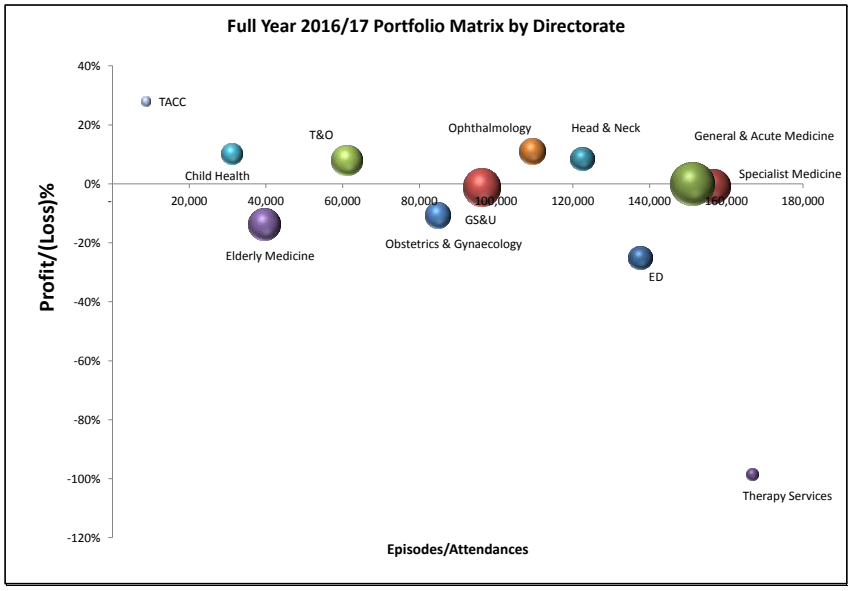
York Teaching Hospital NHS
NHS Foundation Trust

**Key Messages:**

* Current data is based on full year 2016/17
* It is expected that Q1 2017/18 data will be completed towards the end of September 2017
* Qlikview user guides are continued to be developed to help users log in and navigate round the system




| DATA PERIOD | Full Year 2016/17 |
|---|---|
| CURRENT WORK | * The Reference Costs submission to the DoH and NHSI is now the key focus for the team<br><br>*Qlikview user guides have been published to help users log in and navigate round the system. More user guides covering different areas of Qlikview will be released over the coming months<br><br>* Work with Directorate teams is currently on-going to improve the quality of consultant PA allocations used within the SLR PLICS system for each quarterly reporting period<br><br>* The SLR team are continuing to work with Directorate teams to improve the quality of outpatient staffing group costs within SLR PLICS |
| FUTURE WORK | * Work on the Q1 2017/18 SLR PLICS data will commence once the Reference Cost return has been submitted<br><br>* Future work around junior doctor PA allocations will improve the quality of the SLR data and also inform the annual mandatory Education & Training cost collection exercise<br><br>* Planning for the NHSI Costing Transformation Programme will soon begin to ensure that we are prepared for future mandatory reporting requirements |

| | |
|---|---|
| FINANCIAL BENEFITS TAKEN SINCE SYSTEM INTRODUCTION | **£2.93m** |

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Efficiency Programme Update – August 2017

## Recommendation

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

## Current approval route of report

This report is drafted for presentation to the Finance and Performance Committee and Board of Directors.

## Purpose of report

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2017/18 target is £22.8m and delivery, as at August 2017 is £7.9m.

## Key points for discussion

There are no specific points for discussion.

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

## Reference to CQC Regulations

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

Version number: 1

Author: Steven Kitching, Head of Corporate Finance & Resource Management

Executive sponsor: Andrew Bertram, Finance Director

Date: September 2017

## Briefing note for the Board of Directors Meeting 27 September 2017

**Subject:** August 2017 - Efficiency and Carter update

**From:** Steve Kitching, Head of Corporate Finance & Resource Management

## Summary reported position for August 2017

## Current position – highlights

***Delivery*** - Delivery is £7.9m in August 2017 which is (34%) of the £22.8m annual target. This position compares to a delivery position of £11.1m in August 2016.

Part year delivery is £2.9m behind the profiled plan submitted to NHSI.

The relative Directorate positions are shown in ***Appendix 1*** attached.

***In year planning*** – At August 2017 CIP planning is £18.8m (82%) with a gap of £4.1m, the comparative position in August 2016 was a gap of £1.8m.

***Four year planning*** – The four year planning gap is (£8m). The position in August 2016 was a gap of (£17.9m).

***Recurrent vs. Non recurrent*** – Of the £7.9m delivery, £4.4m (55%) in-year has been delivered recurrently. Recurrent delivery is £3.9m behind the same position in August 2016.

***Quality Impact Assessments (QIA)*** –

Directorates are currently assessing their CIP schemes and a review by the Clinical Lead for Efficiency will be commenced at the beginning of September 2017 for schemes identified up to the end of July 2017.

## Overview

The August 2017 delivery position of £7.9m is £2.9m behind the NHSI plan and £3.2m behind the position in August 2016.

The in-year planning position has improved by £1.7m in month to £18.8m with the 4-year planning gap improving by £3.5m, from £11.5m to £8.0m.

There are 16 High Risk Directorates in terms of planning and delivery, 11 of which are Clinical Directorates.

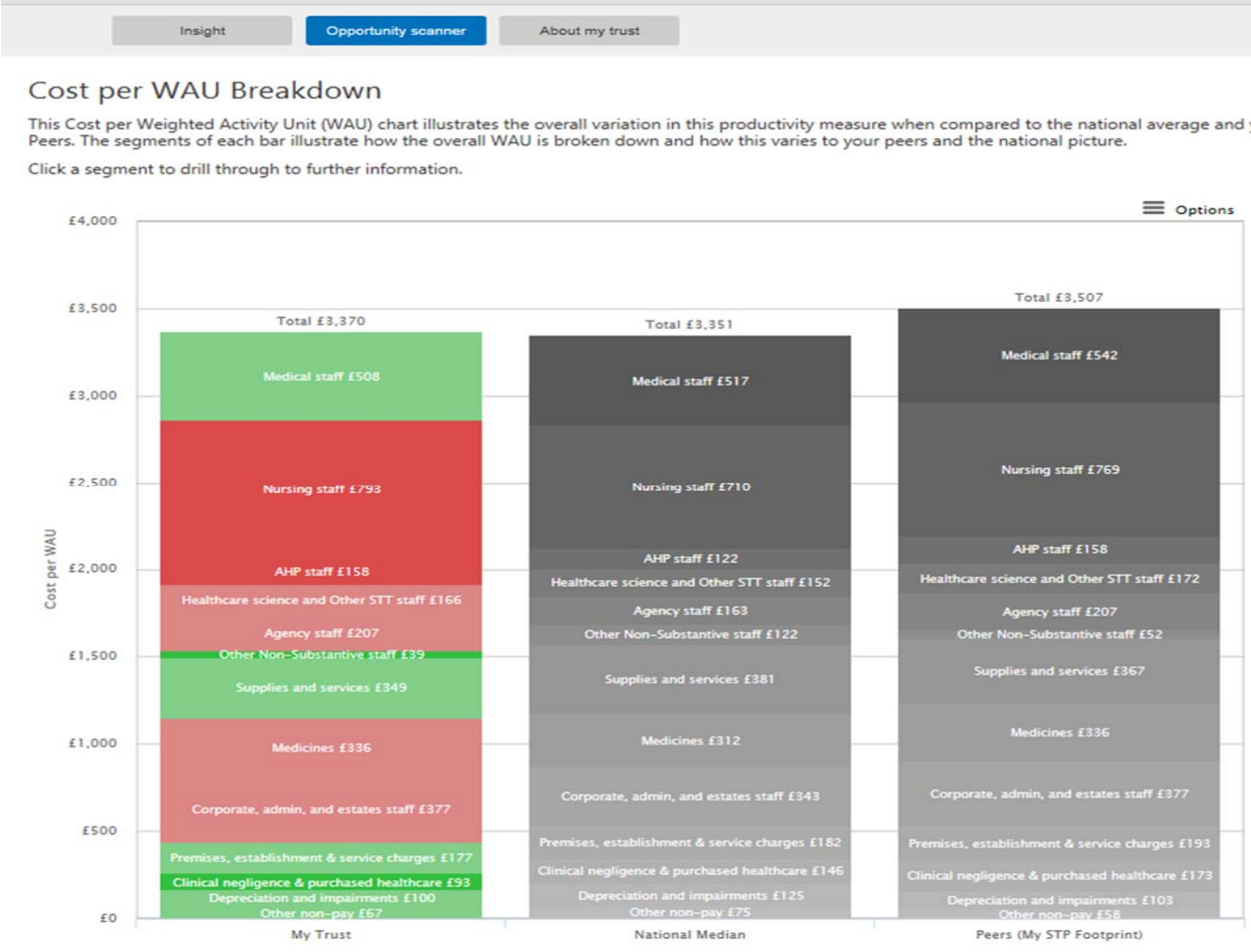
Monthly delivery in August saw a slight decline on the previous month's delivery, down from £1.6m to £1.5m. The relative Directorate positions are shown in ***Appendix 2*** attached.

The Resource Management Team are working with Directorates and Finance Managers to improve the planning and delivery position using the Model Hospital to explore opportunities where presented.

The Team are working with the Service Improvement Team to identify and quantify efficiency opportunities that result from their work streams.

## NHSI Model Hospital

The Opportunity Scanner (See below) provides a high level summary of areas of opportunity at Cost of Weighted Activity Unit (WAU) within the Trust and compares us against the national median and our peers (STP foot print).




The areas in red are the areas with the greatest opportunity, with Nursing presenting the largest opportunity (£793 per WAU) followed by Admin and Back Office function (£377 per WAU).

There are a number of Trust-wide schemes that are being implemented with a view to reducing the cost of nursing, these are:

Nurse Rostering; review of sickness and implementation of SafeCare, the latter presenting an opportunity of £1.5m over 5 years.

## Admin and Back Office function

Recommendation 7 of the CARTER report.

“All Trusts corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020 (or have plans in place for shared service consolidation with, or outsourcing to, other providers by January 2017), so that resources are used in a cost effective manner.

## Current Position

Our current position suggests that we are behind the Carter recommendation, with 2016/17 data showing us at 8.54%. A refresh of data for 2017/18 should be available late autumn 2017.

Table 1 below shows the current split at function level.

**Table 1 - Corporate Functions and Admin as a % of Total Income**

| | 2015/2016 | 2016/2017 |
|---|---|---|
| Overall Trust Level | 8.54% | 8.54% |
| Corporate Functions | 5.14% | 4.99% |
| Support Services | 1.09% | 1.10% |
| Clinical Directorates | 2.27% | 2.42% |

Further analysis of our ESR (Electronic Staff Record) shows that some staff groups have the incorrect Occupational code and further work needs to be done with Workforce to rectify this. This will marginally impact on our current position but does not bring us to the suggested target.

A high level analysis of the admin budgets compared with actual WTE shows we are currently carrying 160.89 WTE vacancies within budgeted establishment equating to an underspend of £308K per month.

A final report will be presented in October 2017.

## Carter

## Get It Right First Time (GIRFT)

"Following the completion of a quality improvement pilot in orthopaedics entitled Getting It Right First Time (GIRFT), the Department of Health has commissioned a programme that will cover an additional ten clinical areas over the next three years to support the NHS in delivering productivity and efficiency improvements across England. Lord Carter is leading this agenda and GIRFT is a key strand of activity within this area which is being led by The National Director of Clinical Quality & Efficiency (Prof Tim Briggs).

The ambition is to identify areas of unwarranted variation in clinical practice and/or divergence from the best evidence. The work will culminate in a report and set of national recommendations aimed at improving quality of care and also reducing expenditure on complications, litigation, procurement and unproven treatment.

This work will also support the development of the Model hospital, which will provide Trusts with a set of numbers to compare all areas of efficiency and productivity alongside their quality indicators and standards. It will allow acute trusts using a number of indicators and benchmarks, to plot productivity by clinical specialty".

## What does this mean for York

The Model Hospital identifies opportunity by Clinical Service Lines, please see Table 2 below.

One approach is to use the GIRFT programme to explore the opportunities presented to reduce cost and produce better outcomes.

## Table 2 - The Model Hospital – Identified opportunity Clinical Service Lines

| Directorate/Speciality | Value | Areas |
|---|---|---|
| Orthopaedic Surgery | £30,502 | Cost per WAU - Medical staff |
| General Surgery | £1,010,000 | Cost per WAU – Other settings, Medical Staff, Nursing Staff, Other Staff |
| Urology | £1,040,000 | Cost per WAU – Outpatients, Day Cases, Medical Staff |
| Obstetrics & Gynaecology | £1,320,000 | Cost per WAU - Day Cases, Medical Staff, Nursing Staff, Other Staff |
| ENT | £90,272 | Cost per WAU – Non Elective Admissions, Other settings, Medical Staff, Nursing Staff, Other Staff |
| Oral & Maxillofacial | £337,870 | Cost per WAU - Non Elective |

| | | |
|---|---|---|
| | | Admissions, Day Cases, Other settings |
| Dentistry | £304,320 | Cost per WAU - Non Elective Admissions, Day Cases, Other settings, Consultants, Other Staff |
| Breast Surgery | £145,610 | Cost per WAU - Other settings, Nursing Staff |
| Paediatrics | £797,690 | Cost per WAU - Non Elective Admissions, Outpatients, Critical Care, Medical Staff, Nursing Staff, Other Staff |
| Ophthalmology | £373,190 | Cost per WAU – Elective Admissions, Other settings, Consultants, Nursing Staff, |
| Plastic Surgery & Burns | £412,890 | Cost per WAU - Non Elective Admissions, Outpatients, Day Cases |
| General Medicine | £123,590 | Cost per WAU – Outpatients, Other Settings, Medical Staff, Nursing Staff, Other Staff |

GIRFT is in the very early stages of development at York and requires a structured approach to realise the potential benefits.

A preliminary meeting was held in August to discuss the formation of a project group, attendees were:

- J Taylor, Medical Director,
- G Miller, Assistant Medical Director,
- D Richardson, Assistant Medical Director,
- G Cooney, Director of Performance,
- S Kitching, Head of Corporate Finance and Resource Management,
- Wendy Pollard, Deputy Head of Resource Management

It was agreed that G Miller would be the lead for Surgical Specialties and D Richardson the Lead for Medical Specialties in the roll out of the national GIRFT programme.

Further discussion is required to identify the resource required to take this forward in a structured way.

The table below details agreed dates for York GIRFT visits.

| **Directorate** | **Scheduled Visit** | **Outcome** |
|---|---|---|
| Vascular | 13.12.16 | Report Received – to be picked up with Directorate |
| ENT | 20.02.17 | Report Received – to be picked up with Directorate |
| Max Fax | 11.10.17 | |
| General Surgery | 10.11.17 | |
| T&O | Dec 17 | |
| Obs & Gynae | TBA | |

## Risk

The key risks in the programme:

- Delivery of the Programme
- The in-year planning gap of £4.1m
- The 4 year planning gap of (£8.0m).
- Reducing the carry forward balance of non-recurrent delivery by 2019.
- QIPP schemes.
- Financial Position.

## RISK SCORES - AUGUST 2017 - APPENDIX 1

| DIRECTORATE | Yr1 Target | 4Yr Target | Yr 1 Plan v Target | | Yr 1 Delivery v Target | | Y1 Recurrent Delivery v target | | 4 Yr Plan v Target | | | Overall Financial Risk | Governance Risk |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | (£000) | (£000) | % | Risk | % | Risk | % | Risk | % | Risk | Total Score | | |
| SPECIALIST MEDICINE | 2,818 | 6,975 | 50% | HIGH | 23% | HIGH | 14% | HIGH | 33% | HIGH | 12 | HIGH | LOW |
| GEN MED YORK | 1,801 | 5,662 | 69% | HIGH | 34% | HIGH | 16% | HIGH | 88% | HIGH | 12 | HIGH | LOW |
| RADIOLOGY | 1,863 | 3,417 | 33% | HIGH | 16% | HIGH | 12% | HIGH | 38% | HIGH | 12 | HIGH | LOW |
| GS&U | 1,952 | 4,939 | 45% | HIGH | 25% | HIGH | 13% | HIGH | 76% | HIGH | 12 | HIGH | MEDIUM |
| WOMENS HEALTH | 1,654 | 3,364 | 41% | HIGH | 18% | HIGH | 17% | HIGH | 40% | HIGH | 12 | HIGH | LOW |
| EMERGENCY MEDICINE | 865 | 2,555 | 87% | HIGH | 33% | HIGH | 32% | MEDIUM | 63% | HIGH | 11 | HIGH | LOW |
| AHP & PSYCHOLOGICAL MEDICINE | 1,257 | 3,439 | 46% | HIGH | 29% | HIGH | 23% | HIGH | 40% | HIGH | 12 | HIGH | LOW |
| MEDICINE FOR THE ELDERLY | 1,225 | 3,424 | 90% | HIGH | 26% | HIGH | 6% | HIGH | 55% | HIGH | 12 | HIGH | LOW |
| CHILD HEALTH | 849 | 2,099 | 79% | HIGH | 39% | MEDIUM | 25% | MEDIUM | 55% | HIGH | 10 | HIGH | LOW |
| TACC | 2,662 | 6,751 | 103% | MEDIUM | 28% | HIGH | 22% | HIGH | 63% | HIGH | 11 | HIGH | LOW |
| GEN MED SCARBOROUGH | 696 | 1,839 | 105% | MEDIUM | 36% | MEDIUM | 30% | MEDIUM | 81% | HIGH | 9 | MEDIUM | LOW |
| COMMUNITY | 438 | 780 | 48% | HIGH | 21% | HIGH | 19% | HIGH | 207% | LOW | 10 | HIGH | LOW |
| OPHTHALMOLOGY | 826 | 2,758 | 139% | LOW | 32% | HIGH | 7% | HIGH | 105% | MEDIUM | 9 | MEDIUM | MEDIUM |
| HEAD AND NECK | 717 | 1,838 | 120% | LOW | 27% | HIGH | 4% | HIGH | 107% | MEDIUM | 9 | MEDIUM | LOW |
| PHARMACY | 431 | 1,027 | 120% | LOW | 51% | LOW | 39% | LOW | 117% | LOW | 4 | LOW | LOW |
| SEXUAL HEALTH | 540 | 1,021 | 101% | MEDIUM | 70% | LOW | 43% | LOW | 103% | MEDIUM | 6 | LOW | LOW |
| LAB MED | 551 | 2,522 | 136% | LOW | 108% | LOW | 92% | LOW | 71% | HIGH | 6 | LOW | LOW |
| ORTHOPAEDICS | 682 | 3,026 | 123% | LOW | 115% | LOW | 88% | LOW | 111% | LOW | 4 | LOW | LOW |
| | | | | | | | | | | | | | |
| **CORPORATE** | | | | | | | | | | | | | |
| MEDICAL GOVERNANCE | 117 | 213 | 26% | HIGH | 26% | HIGH | 0% | HIGH | 15% | HIGH | 12 | HIGH | LOW |
| CHIEF NURSE TEAM DIRECTORATE | 351 | 673 | 47% | HIGH | 13% | HIGH | 0% | HIGH | 24% | HIGH | 12 | HIGH | LOW |
| HR | 256 | 848 | 103% | MEDIUM | 48% | LOW | 3% | HIGH | 107% | 'MEDIUM | 6 | LOW | LOW |
| ESTATES AND FACILITIES | 2,101 | 6,114 | 61% | HIGH | 20% | HIGH | 18% | HIGH | 66% | HIGH | 12 | HIGH | LOW |
| SNS | 433 | 1,408 | 111% | LOW | 25% | HIGH | 6% | HIGH | 93% | HIGH | 10 | HIGH | HIGH |
| FINANCE | 465 | 1,300 | 150% | LOW | 150% | LOW | 73% | LOW | 55% | HIGH | 6 | LOW | LOW |
| OPS MANAGEMENT YORK | 171 | 595 | 64% | HIGH | 64% | LOW | 0% | HIGH | 26% | HIGH | 10 | HIGH | LOW |
| CHAIRMAN & CHIEF EXECUTIVES OFFICE | 192 | 483 | 73% | HIGH | 73% | LOW | 32% | LOW | 30% | HIGH | 8 | MEDIUM | LOW |
| LOD&R | 169 | 527 | 148% | LOW | 130% | LOW | 64% | LOW | 108% | MEDIUM | 5 | LOW | LOW |
| | | | | | | | | | | | | | |
| **TRUST SCORE** | **22,825** | **61,001** | **82%** | **HIGH** | **35%** | **HIGH** | **19%** | **HIGH** | **87%** | **HIGH** | **12** | **HIGH** | **LOW** |

# YTD Directorate CIP Progress - August 2017

| DIRECTORATE | Annual Target | YTD Budget | April Achieved | May Achieved | June Achieved | July Achieved | August Achieved | YTD Achieved | YTD Variance | % YTD Target Achieved |
|---|---|---|---|---|---|---|---|---|---|---|
| | (£000) | (£000) | (£000) | (£000) | (£000) | (£000) | (£000) | (£000) | (£000) | % |
| SPECIALIST MEDICINE | 2,818 | 930 | 1 | 15 | 69 | 117 | 109 | 311 | -619 | 33% |
| TACC | 2,662 | 891 | 1 | 31 | 178 | 175 | 45 | 494 | -396 | 55% |
| GS&U | 1,952 | 701 | 33 | 19 | 51 | 103 | 83 | 250 | -451 | 36% |
| RADIOLOGY | 1,863 | 622 | 3 | 21 | 29 | 74 | 66 | 210 | -411 | 34% |
| GEN MED YORK | 1,801 | 599 | 1 | 11 | 48 | 84 | 245 | 210 | -389 | 35% |
| WOMENS HEALTH | 1,654 | 557 | 4 | 21 | 30 | 63 | 26 | 363 | -194 | 65% |
| AHP & PSYCHOLOGICAL MEDICINE | 1,257 | 447 | 1 | 25 | 28 | 77 | 39 | 157 | -290 | 35% |
| MEDICINE FOR THE ELDERLY | 1,225 | 407 | 11 | 30 | 30 | 33 | 49 | 144 | -263 | 35% |
| EMERGENCY MEDICINE | 865 | 314 | 0 | 6 | 36 | 44 | 44 | 135 | -180 | 43% |
| CHILD HEALTH | 849 | 281 | 4 | 0 | 49 | 61 | 103 | 158 | -123 | 56% |
| OPHTHALMOLOGY | 826 | 274 | 0 | 17 | 190 | 5 | 16 | 314 | 40 | 114% |
| HEAD AND NECK | 717 | 245 | 0 | 55 | 108 | 1 | 10 | 180 | -65 | 73% |
| GEN MED SCARBOROUGH | 696 | 231 | 2 | 5 | 25 | 60 | 34 | 102 | -130 | 44% |
| ORTHOPAEDICS | 682 | 226 | 21 | 37 | 308 | 155 | 68 | 555 | 328 | 245% |
| LAB MED | 551 | 192 | 3 | 40 | 60 | 183 | 54 | 354 | 162 | 184% |
| SEXUAL HEALTH | 540 | 179 | 9 | 19 | 84 | 87 | 45 | 253 | 74 | 141% |
| COMMUNITY | 438 | 153 | 0 | 1 | 4 | 11 | 18 | 60 | -92 | 40% |
| PHARMACY | 431 | 143 | 1 | 7 | 19 | 55 | 58 | 101 | -42 | 71% |
| | | | | | | | | | | |
| **CORPORATE** | | | | | | | | | | |
| ESTATES AND FACILITIES | 2,101 | 525 | 18 | 28 | 28 | 100 | 53 | 174 | -351 | 33% |
| FINANCE | 465 | 284 | 0 | 28 | 52 | 93 | 162 | 227 | -57 | 80% |
| SNS | 433 | 145 | 0 | 7 | 75 | 0 | 5 | 244 | 98 | 168% |
| CHIEF NURSE TEAM DIRECTORATE | 351 | 122 | 0 | 10 | 21 | 0 | 14 | 36 | -86 | 30% |
| HR | 256 | 92 | 18 | 10 | 8 | 13 | 75 | 63 | -30 | 68% |
| CHAIRMAN & CHIEF EXECUTIVES OFF | 192 | 68 | 0 | 0 | 42 | 34 | 14 | 151 | 82 | 220% |
| OPS MANAGEMENT YORK | 171 | 58 | 0 | 0 | 8 | 3 | 1 | 25 | -33 | 43% |
| LOD&R | 169 | 56 | 19 | 14 | 33 | 27 | 59 | 94 | 38 | 168% |
| MEDICAL GOVERNANCE | 117 | 43 | 0 | 22 | -13 | 12 | 1 | 79 | 37 | 185% |
| | | | | | | | | | | |
| **TRUST SCORE** | **26,082** | **8,789** | **151** | **479** | **1,599** | **1,669** | **1,496** | **5,444** | **-3,345** | **62%** |

D3 NHS
York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Operational Performance Headlines

## Recommendation

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

## Current approval route of report

This report is drafted for presentation to the Finance and Performance Committee and Board of Directors.

## Purpose of report

Performance against the STF trajectory is below planned levels for ECS (88.1%), 18 weeks referral to treatment times (87.5%) and Cancer waiting times (80.7%-two week waits; 82.4%-62 days GP, 86.8%-62 day screening).

There has been improvement in August for the ECS target and improvement in July 62 day waits to first treatment from GP referral performance. August has seen a return to operational standards for diagnostic tests within 6 weeks. RTT performance in August and Cancer two week wait performance for July has reduced compared to previous months with performance at unprecedented levels for cancer two week waits. The Trust is engaged on specific work with commissioners on planned care and dermatology two week waits to work towards recovery.

The review of actions supporting performance through the Return to Operational Standards has been completed with a refresh aligned to the national guidance on flow and High Impact Actions for 62 day waits for cancer planned for October.

## Key points for discussion

There are no specific points for discussion.

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

Reference to CQC Regulations

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

There are no references to CQC outcomes.

Version number: 1

Author: Lynette Smith, Head of Operational Performance

Executive sponsor: Wendy Scott, Chief Operating Officer

Date: September 2017

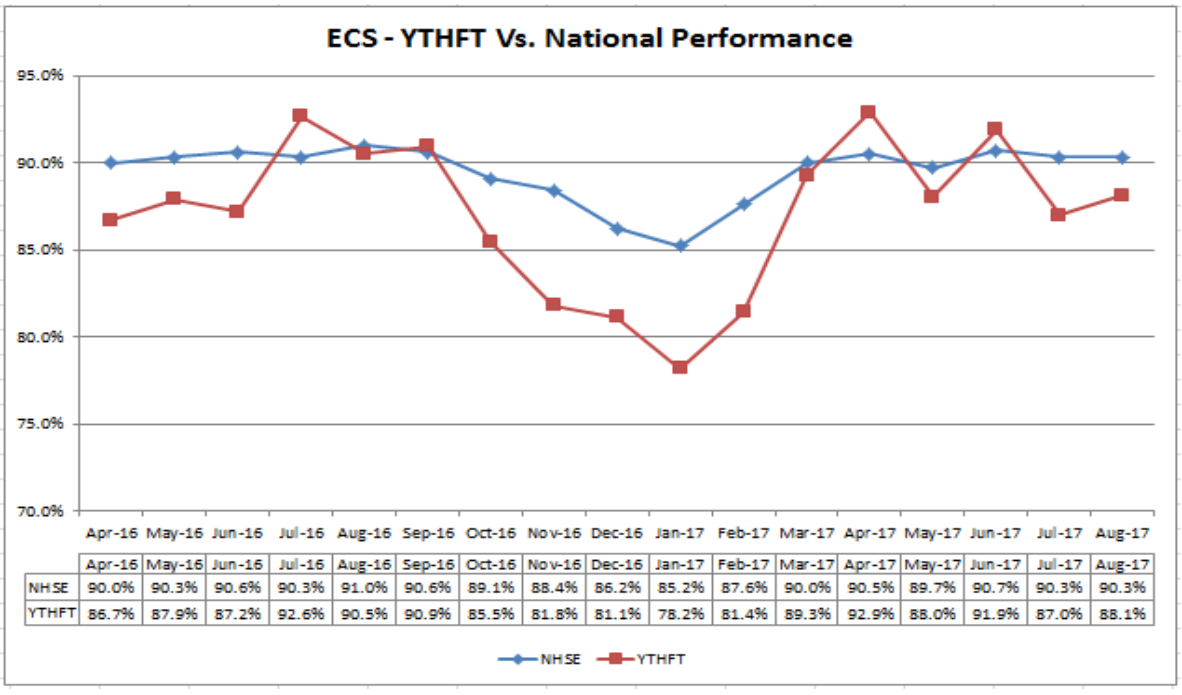
## 1. Introduction and Background

The Trust performance recovery plan 'Return to Operational Standards' (RTOS) sets out the actions to support performance against the Emergency Care Standard, referral to treatment times and cancer waiting times, setting out the revised trajectories for performance recovery. The review of the Return to Operational Standards has been completed with a refresh to be presented in October.

The key metrics are detailed in the performance dashboard and this report provides the operational response to the performance position.

## 2. Performance Headlines: Unplanned Care

Performance against the Emergency Care Standard (ECS) was not achieved in August, with performance at 88.1% against a trajectory of 90.5%. The Trust is currently off trajectory for the Q2 STF at 87.08% and is unlikely to achieve the trajectory at the end of September. The performance for August 17 is improved from July but represents a 2.43% decline on August 16. The performance position is unprecedented for the summer months, and is below the national average of 90.3% for August.

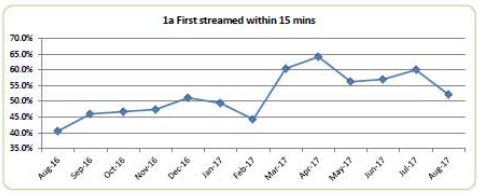


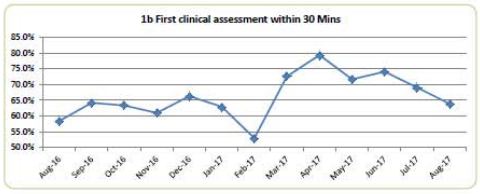

| | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHSE | 90.0% | 90.3% | 90.6% | 90.3% | 91.0% | 90.6% | 89.1% | 88.4% | 86.2% | 85.2% | 87.6% | 90.0% | 90.5% | 89.7% | 90.7% | 90.3% | 90.3% |
| YTHFT | 86.7% | 87.9% | 87.2% | 92.6% | 90.5% | 90.9% | 85.5% | 81.8% | 81.1% | 78.2% | 81.4% | 89.3% | 92.9% | 88.0% | 91.9% | 87.0% | 88.1% |

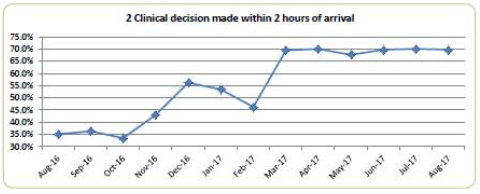
ED attendances were marginally down compared to both July 17 (-1.7% -304) and August 16 (-1.44% - 251). Non-admitted breaches in ED (a focus of the Return to Operational Standards) have remained high, although reduced from July 17 (-194). This has been particularly challenging overnight. Actions to address this include the implementation of Emergency Physician in Charge to provide leadership and oversight across ED. Work is ongoing to embed this and develop effective operational models.

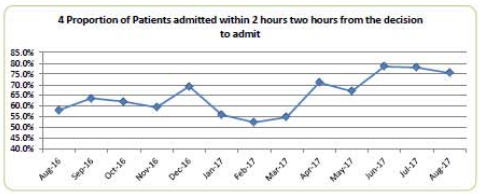
The weekly monitoring of AMM and 4 hour protocol metrics has identified a decline in time to first assessment at Scarborough. Pressures at the start of the pathway can be seen in the increase in ambulance handover times at the Scarborough site, of the 810 total handovers over 15 minutes 69.8% were at Scarborough, with 6 over 2 hours. Staffing

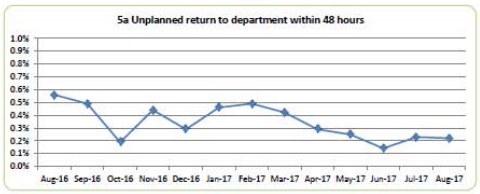
pressures combined with surges in the department at key periods has affected handover times. The Trust is working with YAS on the ambulance concordat to help improve turnaround times. The time to decision within 2 hours has largely remained consistent, however the % patients' ready for transfer by 3 hours into a ward declined in August, contributing to admitted breaches.

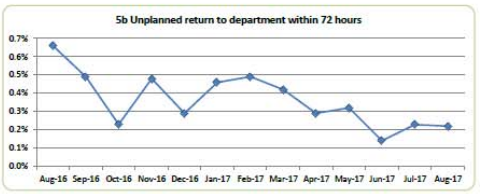



At the York site, the time to decision to admit or not at 2 hours remains lower than SGH and admitted patients ready for transfer at three hours also declined in mid-August. ED York has reported severe pressure for much of August, with escalation plans instigated to manage workforce challenges. Ambulance handovers over 15 minutes marginally increased from August. There was a reduction in long handovers at York site despite the pressures in the department.

The ED OPEL escalation process has been reviewed to ensure the scores reflect the pressure and drive action to de-escalate.

Trust ambulance handovers over 30 minutes remain better August 16 performance by 5.6% (-22), however the recent increase in handovers over 15 and 30 minutes compared with July reflects pressure within ED. The streaming element of the RTOS, including both ambulance turnaround and non-admitted breach work continues. There has been a 15.2% (-49) reduction in long waits in ED from July 17 at Trust level and a significant reduction of 26.7% between July and August at York site. There was one 12 hour trolley wait for the Trust at Scarborough site.

Non-elective admissions have remained comparable to previous months' performance and exactly correlate to August 16. The conversion rate from ED attendances to non-elective admissions has increased 0.6% at the Trust level from July 17 and is 1% higher than August 16. Improvements in streaming are likely to contribute to an increased conversion rate. In August 17 there was a significant increase in the non-elective admissions through ED and in emergency re-admissions (reported in arrears) at Scarborough. The spike in Trauma non-electives seen in July has not continued into August at the York site.

Actions to improve flow across the hospital have included further work to embed the SAFER bundles on both sites and introduction of specific methodology to improve discharges earlier in the day. Bed Occupancy rates at midnight have improved from July, although with significant fluctuations on specific days. York site ranges from 83.21%-97.53% with 14 days under 90% and Scarborough site ranged from 77%-96.34% with 22

days under 90%. For August there is a low correlation between bed occupancy rates and ECS performance.

A comprehensive review of patients staying over 7 days has been undertaken with system partners in August to target delays. There has been an overall marked decrease in the number of patients over 7 days in August, down 14.4% (-145) across the Trust, indicating early impact of this work. This is the lowest number the Trust has seen since 2014-15. Bed days lost due to delayed patients have increased markedly in August in acute sites, and decreased in the community bed base. This may be as a result of the detailed review of patients undertaken in August and will be reviewed through the complex discharge group.

Workforce pressures have been a key factor in delivering the ECS standard in August. To address this, the Trust has approved involvement in the CESA programme to support recruitment of ED medics, and deployed of ACPs at first assessment in Scarborough to target times where non-admitted breaches occur. Significant work is underway to support the nurse staffing establishment with new recruits commencing in October. The work continues to review clinical site management out of hours and to target stranded and delayed patients.

## 3. Performance Headlines: Cancer

The Trust met 4 out of the 7 targets for July 17 and Quarter 1 of 2017/18.

Performance was under expected levels for:
- 14 day Fast Track: 80.7% - 234 breaches, of which 79% were diagnosed as no cancer
- 62 day wait 1st Treatment GP: 82.4% - 23 breaches (30 patients)
- 62 days wait 1st Treatment screening: 86.8% - 3.5 breaches (5 patients)

Nationally all but the 62 day GP target were met. The Trust performed better than the national position on 62 day GP target (Trust 82.4%, England 81.4%).

The 14 day fast track performance has continued to decline. Delays in Dermatology fast tracks continues to be the predominant factor in the low Trust performance, with skin accounting for 57.7% of all fast track breaches in July. Of these 75% were diagnosed as having no cancer and first treatment of dermatology cancers are met within 62 days. The Trust has received confirmation from the commissioners to progress with a new consolidated service model for dermatology to arrest the performance deterioration and move towards recovery. Additional agreements on use of photographs with referrals will be implemented from October to support the triage of suspected skin cancers.

Colorectal fast track accounted for 27.4% of fast track breaches, 71.9% of delayed patients were diagnosed with no cancer. Additional clinics have been implemented through August to address the colorectal fast track position. Recruitment for the consultant vacancy at the east coast is underway. The Trust continues to work with the Cancer Alliance and Commissioners to develop streamlined pathways for colorectal fast tracks supported by additional funding.

Patient cancellations of appointments accounted for 16% of breaches in July. Further work on cancellations by practice is ongoing to support communication to patients on the importance of attending urgent appointments.

There were 23 breaches attributable to the Trust in July for 62 day 1st treatment. These were spread across 8 tumour sites, colorectal had the highest number of attributable breaches (5). Of the Trust beaches 7 of the attributable breaches (10 patients) were due to complex diagnostic pathways or delays due to medical reasons. 11 attributable breaches (15 patients) were delayed due to administrative, capacity or healthcare provider reasons. These are the focus of improvement actions, notably timed pathways for tumour sites and focussing additional funds on diagnostic turnaround times. The Trust is working through the Cancer Alliance on capital funding for regional diagnostics to improve access and turnaround. Cancer reporting has been enhanced for directorates in August and a targeted review of patients no yet diagnosed with cancer has significantly reduced those waiting over 104 days.

There were 3.5 breaches attributable to the Trust in July for 62 days wait from screening, spread across 2 tumour sites with 3 attributable to Lower GI and 0.5 attributable to Breast.

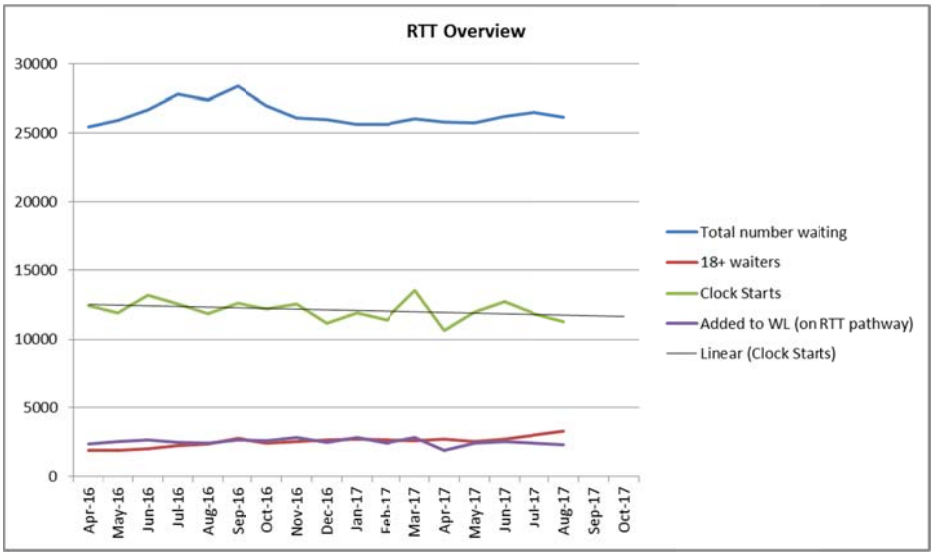
## 4. Performance Headlines: Planned Care

RTT performance for August is 87.5%, this is 3.7% off trajectory and it is unlikely that the planned return to national standard of 92% by October will be achieved.

The Trust RTT position is below the national average for July (Trust 88.2.1%, England 89.9%).

The admitted backlog has improved through August. The admitted position has been supported by increased day case activity; improved utilisation of the lists held and reduced cancellations compared to July 17. However, the non-admitted backlog increased significantly in August, the third month seeing increases of 200 patients tipping into the over 18 week backlog. This will partially be a reflection of the increased referral numbers seen between April-June.

At the time of writing the report 26,359 patients were on the incomplete pathway, with 3500 of those waiting over 18 weeks. The numbers of people on the waiting list and those treated on the admitted pathway has remained fairly constant, despite a year to date reduction in GP referrals of 20.6%.



Outpatient referrals continues to decrease from July 17 across all types and August 17 saw a 5% decrease from August 16 (-897). Within the overall decrease there was a 5.9% increase in GP referrals at Scarborough in August compared with July. There was a 20% increase (+66) in the number of cancelled outpatient appointments for non-clinical reasons at Scarborough in August, and in conjunction with longer polling ranges for some specialities, this is likely to contribute to the increases in the non-admitted backlog.

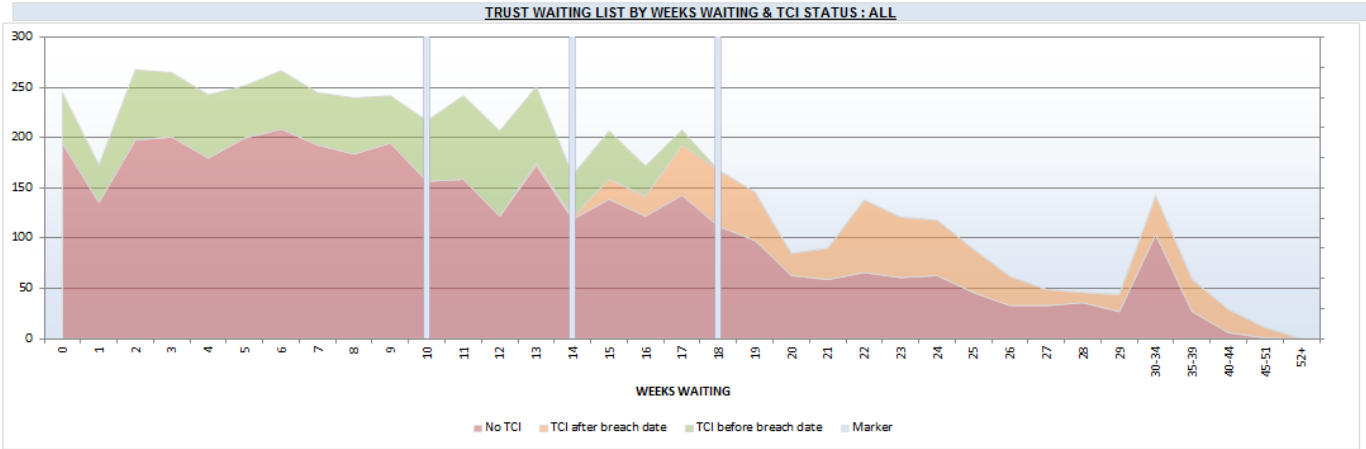
DNA rates have decreased in August to 6.7% following concerted work across directorates, with York site DNA rate down to 5.9%. Overdue follow ups have increased in August. This is a focus of work for the planned care programme.

Specialities with an incomplete backlog of greater than 200 include General Surgery, ENT, Opthalmology, Dermatology, Maxfax and Thoracic Medicine. General Surgery and Dermatology are experiencing higher demand in Cancer pathways and the alignment of resource to support urgent pathways is likely to impact on RTT non-admitted capacity. MaxFax is continuing to run additional ECPs and outsourcing to manage the backlog; however the risk remains high for long waits, with MaxFax comprising 36% of 40+ week waits. Ophthalmology is looking to outsource further work to support the admitted pathway and follow ups to release capacity for new patients.

Higher volume specialities with performance below the national standard or planned STF trajectory of 91.2% include General Surgery, ENT, Urology, MaxFax, Ophthalmology, Gastroenterology, Dermatology, Thoracic Medicine, Gynaecology and Rheumatology.

Improved performance has been seen in Cardiology, Neurology, Gastroenterology and Gynaecology

The profile of patients with open clocks continues to have a peak waiting for more than 30 weeks.




There were 75 patients at the time of writing the report that were waiting over 40 weeks, Patients are reviewed weekly through the PTL and prioritised through theatre planning and bed meetings. There was a declared 52 week breach in MaxFax in August.

Theatre utilisation of planned sessions improved in August compared with July and day case increased from July. 96.2% of requested lists have gone ahead year to date, however the total number remains 20% lower than the lists identified in the service level

agreement to meet planned demand this year. This may be due to a combination of leave, consultant vacancy and staffing. Theatre productivity is a core work programme for the Trust.

## 5. Diagnostics

The diagnostic target has been achieved in August 17 at 99.1% for the first time March. Remedial action has been taken to improve the sleep studies performance through purchase of additional equipment and a revised approach to the pathway. Capacity and demand work is underway for endoscopy, cystoscopy and MR as part of recovery and sustainability plans in Diagnostics.

The Trust performed better than the national average in July (Trust 98.9%; England 98.2%).

## 6. Conclusion

Performance against the STF trajectory is below planned levels for ECS, 18 weeks referral to treatment times and Cancer waiting times. There has been improvement on the ECS target and 62 day waits to first treatment from GP referral in July, and a return to operational standards for diagnostic tests within 6 weeks in August. RTT performance in August and Cancer two week wait performance for July has reduced compared to previous months. The Trust is engaged on specific work with commissioners on planned care and dermatology two week waits to work towards recovery.

The review of actions supporting performance through the Return to Operational Standards has been completed with a refresh aligned to the national guidance on flow and High Impact Actions for 62 day waits for cancer planned for October.

## 7. Recommendation

To note the paper and actions ongoing to improve the performance position.

## 8. References and further reading

September Performance Report

# Public Performance Report

## September 2017

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

# Performance Report
## Chapter Index

| Chapter | Sub-Section |
|---|---|
| **Performance** | Trust Performance Index |
| | STF Trajectory |
| | Trust Unplanned Care - Emergency Care Standard |
| | Trust Unplanned Care - Adult Admissions |
| | Trust Length of Stay & Delayed Transfers of Care |
| | Trust Paediatric Admissions |
| | Trust Planned Care Outpatients |
| | Trust Planned Care - Elective Activity & Theatre Utilisation |
| | Diagnostics & 18 Weeks RTT Incomplete |
| | Cancer |

# Activity Summary: Trust

| Operational Performance: Unplanned Care | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency Care Attendances | | 16371 | 16491 | 14904 | 15414 | 14524 | 13560 | 15695 | 16099 | 16834 | 16330 | 17438 | 17134 |
| Emergency Care Breaches | | 1486 | 2398 | 2711 | 2908 | 3168 | 2519 | 1680 | 1144 | 2018 | 1328 | 2268 | 2033 |
| Emergency Care Standard Performance | 95% | 90.9% | 85.5% | 81.8% | 81.1% | 78.2% | 81.4% | 89.3% | 92.9% | 88.0% | 91.9% | 87.0% | 88.1% |
| ED Conversion Rate: Proportion of ED attendances subsequently admitted | | 35.7% | 36.3% | 36.7% | 37.7% | 39.2% | 38.8% | 38.9% | 37.9% | 37.0% | 36.8% | 35.9% | 36.5% |
| ED Total number of patients waiting over 8 hours in the departments | | 175 | 479 | 666 | 720 | 1076 | 842 | 319 | 136 | 378 | 158 | 323 | 274 |
| ED 12 hour trolley waits | 0 | 0 | 4 | 3 | 11 | 45 | 6 | 9 | 0 | 3 | 0 | 2 | 1 |
| ED: % of attendees assessed within 15 minutes of arrival | | 67.5% | 65.7% | 62.3% | 60.7% | 57.8% | 61.3% | 73.6% | 79.7% | 72.8% | 72.9% | 70.7% | 68.8% |
| ED: % of attendees seen by doctor within 60 minutes of arrival | | 41.2% | 36.0% | 36.7% | 36.0% | 37.5% | 41.9% | 48.2% | 51.8% | 40.1% | 43.3% | 36.6% | 43.6% |
| Ambulance Handovers waiting 15-29 minutes | 0 | 381 | 385 | 413 | 475 | 473 | 448 | 430 | 211 | 272 | 335 | 360 | 446 |
| Ambulance handovers waiting >30 minutes | 0 | 168 | 245 | 302 | 287 | 330 | 289 | 183 | 68 | 164 | 150 | 215 | 258 |
| Ambulance handovers waiting >60 minutes | 0 | 119 | 184 | 250 | 275 | 379 | 303 | 67 | 35 | 92 | 75 | 96 | 106 |
| Non Elective Admissions (excl Paediatrics & Maternity) | | 4401 | 4403 | 4084 | 4271 | 4216 | 3872 | 4574 | 4204 | 4378 | 4482 | 4450 | 4446 |
| Non Elective Admissions - Paediatrics | | 608 | 755 | 819 | 767 | 745 | 659 | 791 | 675 | 664 | 607 | 617 | 496 |
| Delayed Transfers of Care - Acute Hospitals | | 1120 | 857 | 1019 | 882 | 967 | 949 | 1089 | 875 | 908 | 902 | 806 | 1238 |
| Delayed Transfers of Care - Community Hospitals | | 378 | 470 | 326 | 396 | 244 | 401 | 488 | 442 | 313 | 298 | 352 | 234 |
| Patients with LoS >= 7 Midnights (Elective & Non-Elective) | | 1006 | 1007 | 1016 | 1050 | 1175 | 981 | 1079 | 987 | 1048 | 957 | 1006 | 861 |
| Ward Transfers - Non clinical transfers after 10pm | 100 | 93 | 98 | 105 | 97 | 138 | 98 | 111 | 79 | 90 | 60 | 110 | 70 |
| Emergency readmissions within 30 days | | 688 | 719 | 726 | 743 | 721 | 693 | 798 | 707 | 798 | 807 | 2 months behind | 2 months behind |

| Operational Performance: Planned Care | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outpatients: All Referral Types | | 18102 | 17600 | 17930 | 16011 | 17455 | 16415 | 18972 | 15674 | 17567 | 18484 | 16682 | 16592 |
| Outpatients: GP Referrals | | 10388 | 9645 | 9879 | 8728 | 9259 | 9029 | 10707 | 8425 | 9199 | 10077 | 8997 | 8954 |
| Outpatients: Consultant to Consultant Referrals | | 2258 | 2180 | 2259 | 2024 | 2318 | 2134 | 2302 | 1981 | 2200 | 2265 | 2116 | 2143 |
| Outpatients: Other Referrals | | 5456 | 5775 | 5792 | 5259 | 5878 | 5252 | 5963 | 5268 | 6168 | 6142 | 5569 | 5495 |
| Outpatients: 1st Attendances | | 12509 | 12319 | 13486 | 11025 | 12856 | 11296 | 13892 | 10352 | 12318 | 12517 | 12016 | 11723 |
| Outpatients: Follow Up Attendances | | 26537 | 26241 | 28526 | 24376 | 27681 | 24908 | 29563 | 23150 | 27794 | 27820 | 26740 | 26633 |
| Outpatients: 1st to FU Ratio | | 2.12 | 2.13 | 2.12 | 2.21 | 2.15 | 2.21 | 2.13 | 2.24 | 2.26 | 2.22 | 2.23 | 2.27 |
| Outpatients: DNA rates | | 7.2% | 6.8% | 6.7% | 6.8% | 7.1% | 6.8% | 6.6% | 6.8% | 7.1% | 7.2% | 7.0% | 6.7% |
| Outpatients: Cancelled Clinics with less than 14 days notice | 180 | 222 | 218 | 240 | 145 | 185 | 175 | 222 | 151 | 163 | 147 | 147 | 140 |
| Outpatients:Hospital Cancelled Outpatient Appointments for non-clinical reasons | | 909 | 828 | 818 | 682 | 883 | 877 | 912 | 906 | 891 | 942 | 834 | 825 |
| Diagnostics: Patients waiting <6 weeks from referral to test | 99% | 99.4% | 99.2% | 99.2% | 99.0% | 99.0% | 99.0% | 99.0% | 97.2% | 98.1% | 98.8% | 98.9% | 99.1% |
| Elective Admissions | | 771 | 740 | 839 | 619 | 699 | 631 | 787 | 610 | 750 | 758 | 719 | 717 |
| Day Case Admissions | | 5977 | 5973 | 6189 | 5507 | 6154 | 5822 | 6800 | 5448 | 6216 | 6366 | 5896 | 6069 |
| Cancelled Operations within 48 hours - Bed shortages | | 3 | 48 | 101 | 71 | 191 | 117 | 53 | 4 | 57 | 10 | 23 | 12 |
| Cancelled Operations within 48 hours - Non clinical reasons | | 115 | 120 | 180 | 121 | 246 | 169 | 122 | 46 | 154 | 57 | 64 | 57 |
| Theatres: Utilisation of planned sessions | | 91.1% | 88.1% | 89.4% | 86.5% | 85.9% | 85.7% | 90.4% | 90.5% | 86.9% | 89.3% | 88.4% | 89.6% |
| Theatres: number of sessions held | | 575 | 621 | 659 | 545 | 669 | 617 | 706 | 531 | 621 | 633 | 629 | 590 |
| Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc) | | 108 | 85 | 80 | 65 | 30 | 55 | 65 | 70 | 84 | 71 | 72 | 56 |

# Activity Summary: Trust

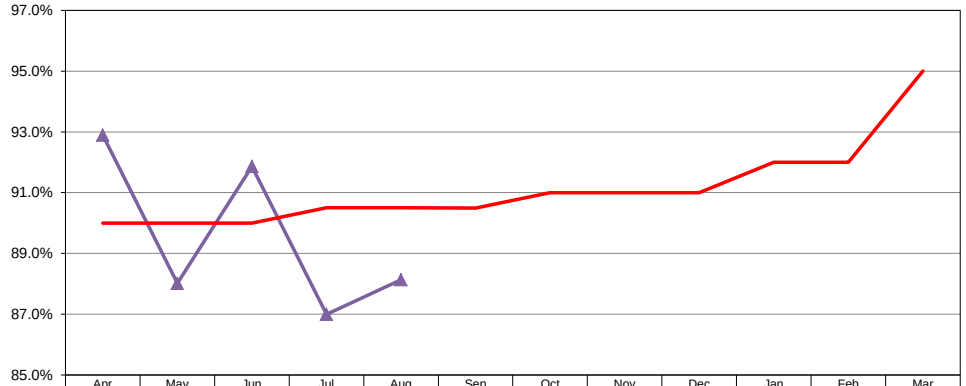
| 18 Weeks Referral To Treatment | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Incomplete Pathways | 92% | 90.8% | 90.9% | 90.0% | 89.4% | 89.0% | 89.2% | 89.5% | 88.9% | 89.6% | 89.1% | 88.2% | 87.5% |
| Waits over 52 weeks for incomplete pathways | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 1 |
| Waits over 36 weeks for incomplete pathways | 0 | 77 | 81 | 94 | 126 | 152 | 172 | 168 | 159 | 165 | 156 | 152 | 197 |
| Number of patients on Admitted Backlog (18+ weeks) | - | 1261 | 1165 | 1205 | 1312 | 1344 | 1296 | 1220 | 1426 | 1357 | 1331 | 1418 | 1353 |
| Number of patients on Non Admitted Backlog (18+ weeks) | - | 1315 | 1238 | 1340 | 1372 | 1441 | 1410 | 1427 | 1380 | 1302 | 1520 | 1720 | 1976 |

| Cancer (one month behind due to national reporting timetable) | Quarterly target | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer 2 week (all cancers) | 93% | 92.7% | 86.2% | 89.8% | 94.0% | 88.7% | 93.9% | 90.9% | 86.4% | 86.2% | 87.0% | 80.7% | 1 month behind |
| Cancer 2 week (breast symptoms) | 93% | 95.8% | 97.6% | 97.8% | 96.0% | 94.3% | 94.7% | 94.9% | 88.0% | 95.0% | 95.1% | 97.1% | 1 month behind |
| Cancer 31 day wait from diagnosis to first treatment | 96% | 98.0% | 98.2% | 97.1% | 98.8% | 96.7% | 97.8% | 96.1% | 96.6% | 96.6% | 98.4% | 98.3% | 1 month behind |
| Cancer 31 day wait for second or subsequent treatment - surgery | 94% | 92.7% | 100.0% | 83.3% | 97.1% | 95.0% | 94.6% | 97.5% | 92.5% | 94.1% | 97.2% | 95.2% | 1 month behind |
| Cancer 31 day wait for second or subsequent treatment - drug treatments | 98% | 100.0% | 100.0% | 99.2% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 1 month behind |
| Cancer 62 Day Waits for first treatment (from urgent GP referral) | 85% | 77.1% | 77.8% | 80.2% | 84.8% | 83.1% | 78.0% | 82.5% | 85.2% | 76.8% | 80.6% | 82.4% | 1 month behind |
| Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) | 90% | 92.6% | 94.9% | 93.4% | 89.8% | 92.2% | 83.3% | 86.0% | 91.7% | 93.5% | 96.4% | 86.8% | 1 month behind |

# Sustainability and Transformation Fund Trajectory (STF) and Performance Recovery Trajectories

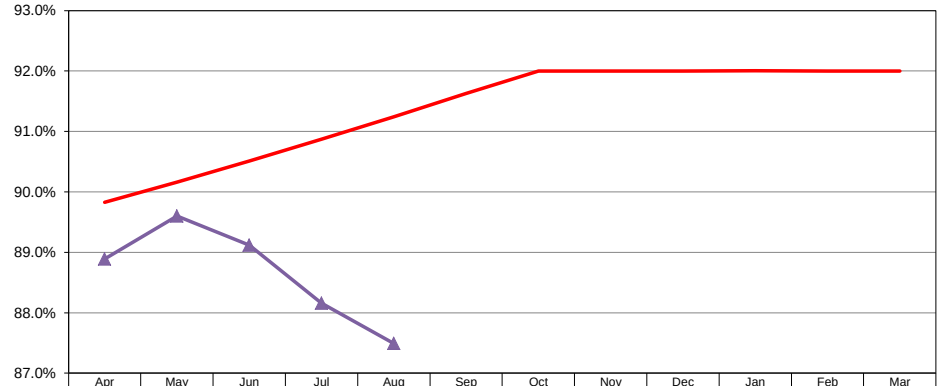
**September 2017**

## Emergency Care Standard Improvement Trajectory




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Performance | 92.9% | 88.0% | 91.9% | 87.0% | 88.1% | | | | | | | |
| STF Trajectory | 90.0% | 90.0% | 90.0% | 90.5% | 90.5% | 90.5% | 91.0% | 91.0% | 91.0% | 92.0% | 92.0% | 95.0% |

## Referral To Treatment Incomplete Pathways

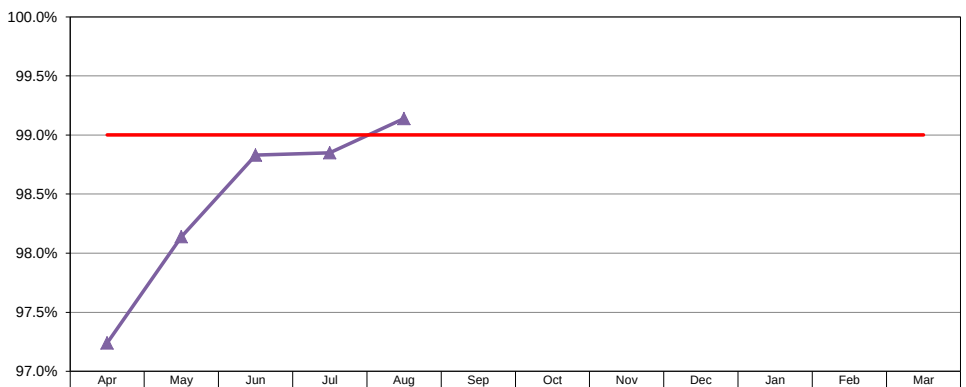



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Incomplete Pathways | 88.9% | 89.6% | 89.1% | 88.2% | 87.5% | | | | | | | |
| Trajectory | 89.8% | 90.2% | 90.5% | 90.9% | 91.2% | 91.6% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% |

## Cancer 62 Day Waits For First Treatment (From Urgent GP Referral)


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer 62 Day Waits | 85.2% | 76.8% | 80.6% | 82.4% | | | | | | | | |
| Trajectory | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% |

## Diagnostics: Patients Waiting < 6 Weeks From Referral to Test

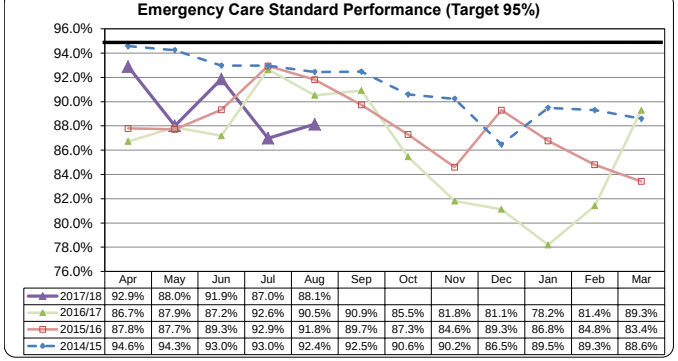



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Performance | 97.2% | 98.1% | 98.8% | 98.9% | 99.1% | | | | | | | |
| Trajectory | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% |

# Trust Unplanned Care
# Emergency Care Standard

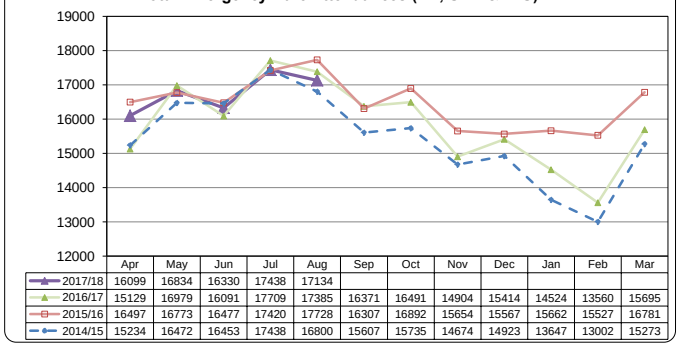
**September 2017**

## Emergency Care Standard Performance (Target 95%)



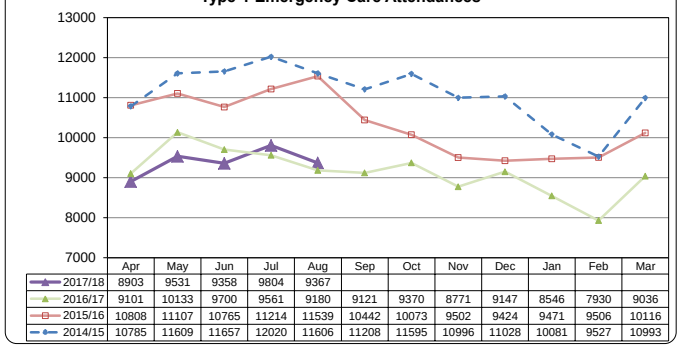
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 92.9% | 88.0% | 91.9% | 87.0% | 88.1% | | | | | | | |
| 2016/17 | 86.7% | 87.9% | 87.2% | 92.6% | 90.5% | 90.9% | 85.5% | 81.8% | 81.1% | 78.2% | 81.4% | 89.3% |
| 2015/16 | 87.8% | 87.7% | 89.3% | 92.9% | 91.8% | 89.7% | 87.3% | 84.6% | 89.3% | 86.8% | 84.8% | 83.4% |
| 2014/15 | 94.6% | 94.3% | 93.0% | 93.0% | 92.4% | 92.5% | 90.6% | 90.2% | 86.5% | 89.5% | 89.3% | 88.6% |

## Total Emergency Care Attendances (ED, UCC & MIU)



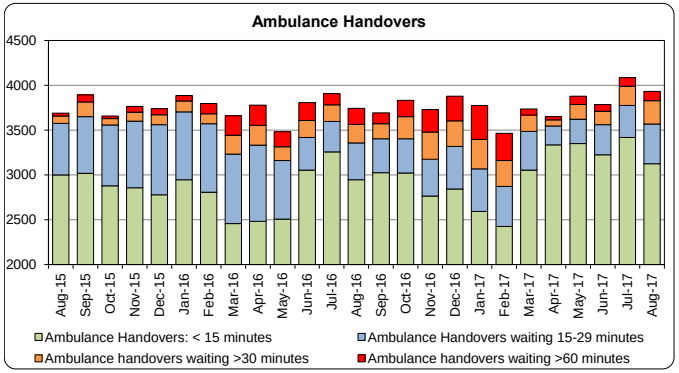
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 16099 | 16834 | 16330 | 17438 | 17134 | | | | | | | |
| 2016/17 | 15129 | 16979 | 16091 | 17709 | 17385 | 16371 | 16491 | 14904 | 15414 | 14524 | 13560 | 15695 |
| 2015/16 | 16497 | 16773 | 16477 | 17420 | 17728 | 16307 | 16892 | 15654 | 15567 | 15662 | 15527 | 16781 |
| 2014/15 | 15234 | 16472 | 16453 | 17438 | 16800 | 15607 | 15735 | 14674 | 14923 | 13647 | 13002 | 15273 |

## Type 1 Emergency Care Attendances

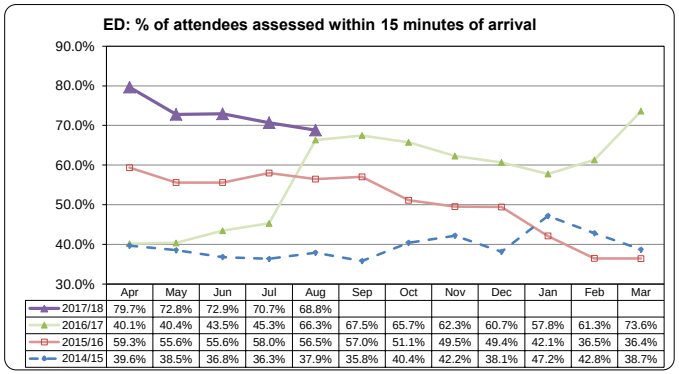


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 8903 | 9531 | 9358 | 9804 | 9367 | | | | | | | |
| 2016/17 | 9101 | 10133 | 9700 | 9561 | 9180 | 9121 | 9370 | 8771 | 9147 | 8546 | 7930 | 9036 |
| 2015/16 | 10808 | 11107 | 10765 | 11214 | 11539 | 10442 | 10073 | 9502 | 9424 | 9471 | 9506 | 10116 |
| 2014/15 | 10785 | 11609 | 11657 | 12020 | 11606 | 11208 | 11595 | 10996 | 11028 | 10081 | 9527 | 10993 |

## Ambulance Handovers

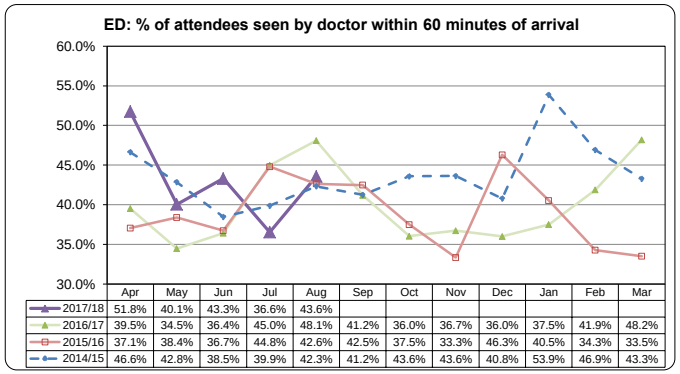



## ED: % of attendees assessed within 15 minutes of arrival



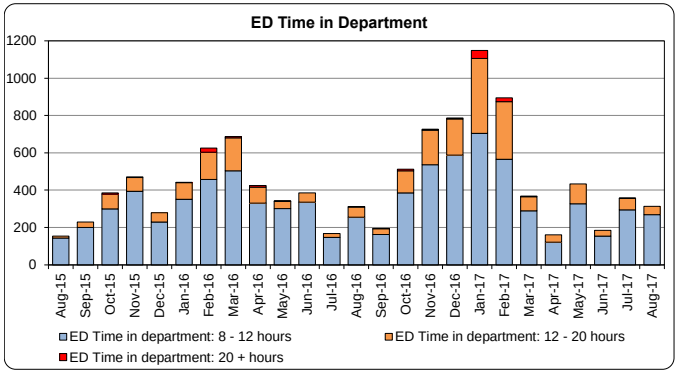
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 79.7% | 72.8% | 72.9% | 70.7% | 68.8% | | | | | | | |
| 2016/17 | 40.1% | 40.4% | 43.5% | 45.3% | 66.3% | 67.5% | 65.7% | 62.3% | 60.7% | 57.8% | 61.3% | 73.6% |
| 2015/16 | 59.3% | 55.6% | 55.6% | 58.0% | 56.5% | 57.0% | 51.1% | 49.5% | 49.4% | 42.1% | 36.5% | 36.4% |
| 2014/15 | 39.6% | 38.5% | 36.8% | 36.3% | 37.9% | 35.8% | 40.4% | 42.2% | 38.1% | 47.2% | 42.8% | 38.7% |

## ED: % of attendees seen by doctor within 60 minutes of arrival

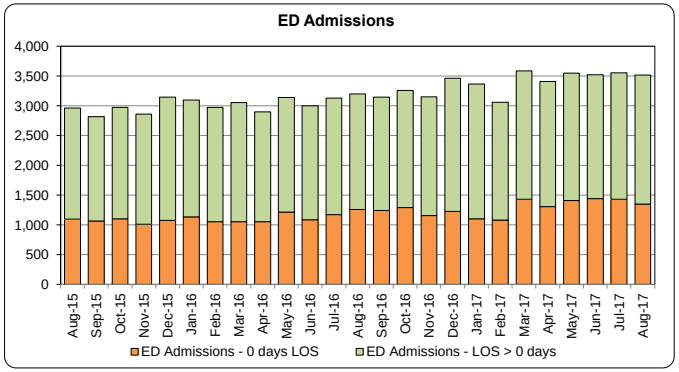


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 51.8% | 40.1% | 43.3% | 36.6% | 43.6% | | | | | | | |
| 2016/17 | 39.5% | 34.5% | 36.4% | 45.0% | 48.1% | 41.2% | 36.0% | 36.7% | 36.0% | 37.5% | 41.9% | 48.2% |
| 2015/16 | 37.1% | 38.4% | 36.7% | 44.8% | 42.6% | 42.5% | 37.5% | 33.3% | 46.3% | 40.5% | 34.3% | 33.5% |
| 2014/15 | 46.6% | 42.8% | 38.5% | 39.9% | 42.3% | 41.2% | 43.6% | 43.6% | 40.8% | 53.9% | 46.9% | 43.3% |

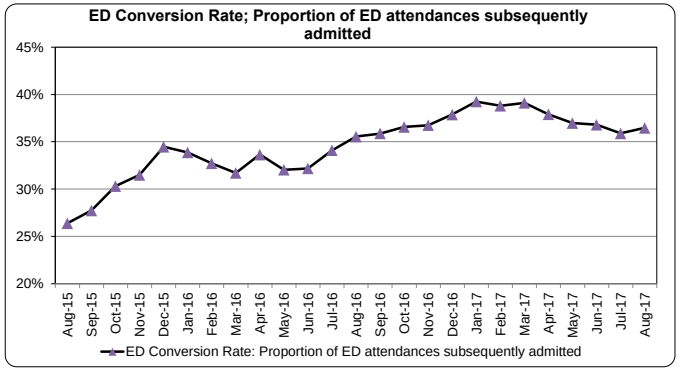
## ED Time in Department




## ED Admissions



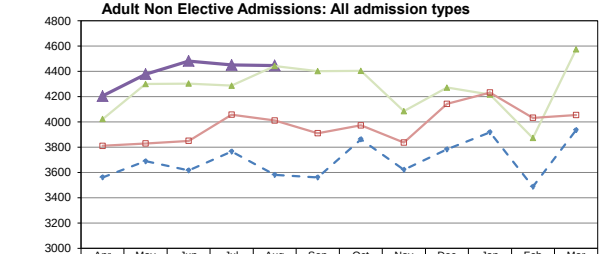

## ED Conversion Rate; Proportion of ED attendances subsequently admitted



# Trust Unplanned Care
# Adult Admissions

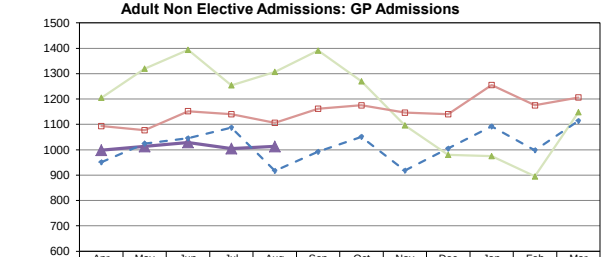
**September 2017**

## Adult Non Elective Admissions: All admission types



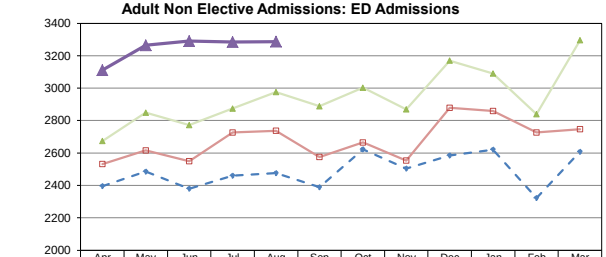
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 4204 | 4378 | 4482 | 4450 | 4446 | | | | | | | |
| 2016/17 | 4022 | 4299 | 4303 | 4286 | 4442 | 4401 | 4403 | 4084 | 4271 | 4216 | 3872 | 4574 |
| 2015/16 | 3810 | 3829 | 3850 | 4057 | 4010 | 3910 | 3972 | 3836 | 4142 | 4232 | 4032 | 4054 |
| 2014/15 | 3561 | 3688 | 3616 | 3765 | 3581 | 3560 | 3862 | 3621 | 3782 | 3918 | 3487 | 3935 |

## Adult Non Elective Admissions: GP Admissions



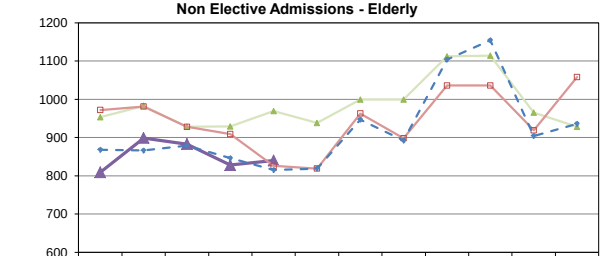
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 998 | 1013 | 1029 | 1005 | 1013 | | | | | | | |
| 2016/17 | 1205 | 1320 | 1394 | 1254 | 1307 | 1391 | 1270 | 1096 | 980 | 975 | 895 | 1148 |
| 2015/16 | 1093 | 1077 | 1152 | 1140 | 1106 | 1162 | 1175 | 1146 | 1140 | 1255 | 1175 | 1206 |
| 2014/15 | 951 | 1024 | 1045 | 1087 | 917 | 992 | 1051 | 918 | 1005 | 1092 | 998 | 1114 |

## Adult Non Elective Admissions: ED Admissions



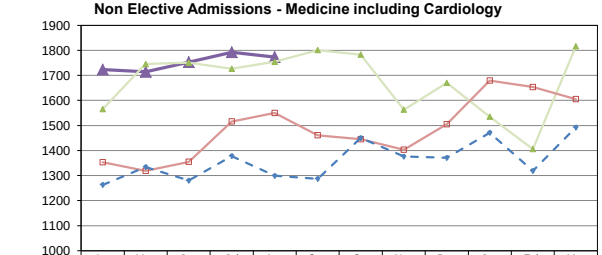
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 3111 | 3264 | 3290 | 3285 | 3287 | | | | | | | |
| 2016/17 | 2674 | 2849 | 2772 | 2874 | 2976 | 2888 | 3003 | 2869 | 3170 | 3090 | 2839 | 3296 |
| 2015/16 | 2532 | 2616 | 2549 | 2726 | 2737 | 2575 | 2665 | 2553 | 2879 | 2859 | 2726 | 2747 |
| 2014/15 | 2396 | 2485 | 2380 | 2460 | 2476 | 2389 | 2623 | 2504 | 2585 | 2621 | 2323 | 2608 |

## Non Elective Admissions - Elderly



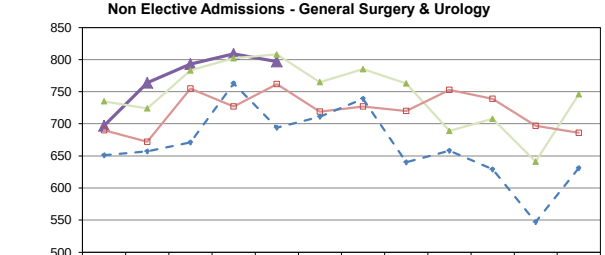
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 809 | 899 | 883 | 828 | 840 | | | | | | | |
| 2016/17 | 953 | 983 | 928 | 929 | 969 | 938 | 999 | 999 | 1112 | 1114 | 965 | 928 |
| 2015/16 | 972 | 981 | 928 | 909 | 826 | 819 | 963 | 898 | 1036 | 1036 | 919 | 1058 |
| 2014/15 | 868 | 866 | 879 | 846 | 815 | 819 | 947 | 892 | 1104 | 1154 | 904 | 936 |

## Non Elective Admissions - Medicine including Cardiology



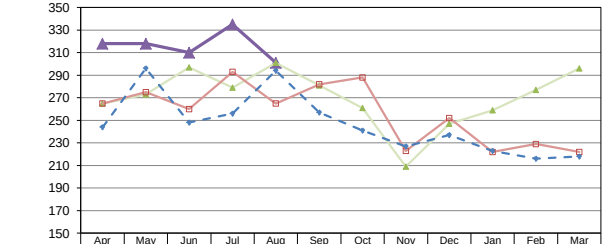
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 1723 | 1714 | 1753 | 1792 | 1773 | | | | | | | |
| 2016/17 | 1565 | 1745 | 1750 | 1726 | 1754 | 1801 | 1783 | 1563 | 1670 | 1535 | 1406 | 1816 |
| 2015/16 | 1353 | 1319 | 1355 | 1516 | 1550 | 1461 | 1445 | 1403 | 1505 | 1679 | 1653 | 1605 |
| 2014/15 | 1263 | 1334 | 1280 | 1378 | 1299 | 1287 | 1450 | 1376 | 1371 | 1471 | 1319 | 1492 |

## Non Elective Admissions - General Surgery & Urology



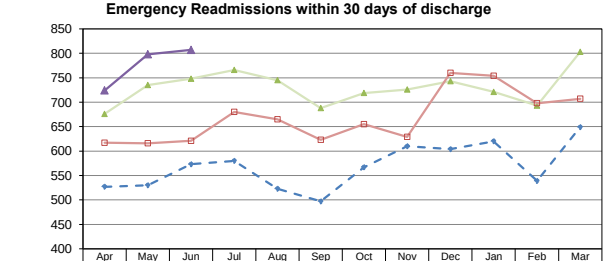
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 697 | 764 | 793 | 809 | 797 | | | | | | | |
| 2016/17 | 735 | 724 | 783 | 802 | 808 | 765 | 785 | 763 | 689 | 708 | 641 | 746 |
| 2015/16 | 690 | 672 | 755 | 727 | 762 | 719 | 727 | 720 | 753 | 739 | 697 | 686 |
| 2014/15 | 651 | 657 | 671 | 763 | 694 | 711 | 739 | 640 | 658 | 629 | 547 | 631 |

## Non Elective Admissions - Trauma & Orthopaedics



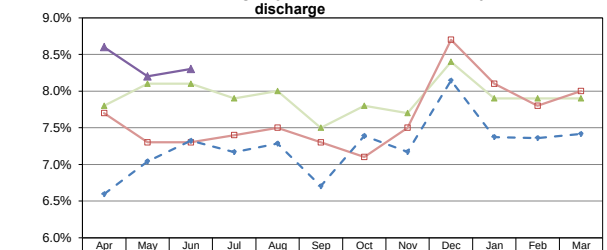
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 318 | 318 | 310 | 335 | 301 | | | | | | | |
| 2016/17 | 265 | 273 | 297 | 279 | 301 | 281 | 261 | 209 | 247 | 259 | 277 | 296 |
| 2015/16 | 265 | 275 | 260 | 293 | 265 | 282 | 288 | 223 | 252 | 222 | 229 | 222 |
| 2014/15 | 244 | 296 | 248 | 256 | 294 | 257 | 241 | 227 | 237 | 223 | 216 | 218 |

## Emergency Readmissions within 30 days of discharge



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 724 | 798 | 807 | | | | | | | | | |
| 2016/17 | 676 | 735 | 748 | 766 | 745 | 688 | 719 | 726 | 743 | 721 | 693 | 803 |
| 2015/16 | 617 | 616 | 621 | 680 | 665 | 623 | 655 | 629 | 760 | 754 | 698 | 707 |
| 2014/15 | 527 | 530 | 573 | 580 | 523 | 497 | 567 | 610 | 604 | 620 | 539 | 649 |

## Readmission Rate: Emergency Readmissions within 30 days of discharge

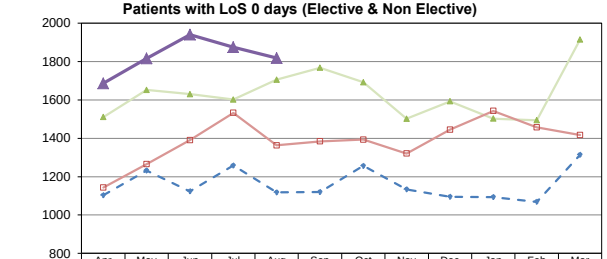


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 8.6% | 8.2% | 8.3% | | | | | | | | | |
| 2016/17 | 7.8% | 8.1% | 8.1% | 7.9% | 8.0% | 7.5% | 7.8% | 7.7% | 8.4% | 7.9% | 7.9% | 7.9% |
| 2015/16 | 7.7% | 7.3% | 7.3% | 7.4% | 7.5% | 7.3% | 7.1% | 7.5% | 8.7% | 8.1% | 7.8% | 8.0% |
| 2014/15 | 6.6% | 7.0% | 7.3% | 7.2% | 7.3% | 6.7% | 7.4% | 7.2% | 8.1% | 7.4% | 7.4% | 7.4% |

# Trust Length of Stay & Delayed Transfers of Care (DTOC)

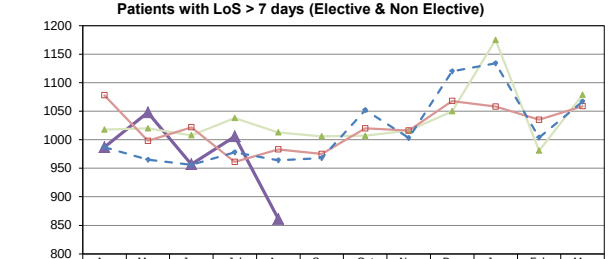
**September 2017**

## Patients with LoS 0 days (Elective & Non Elective)



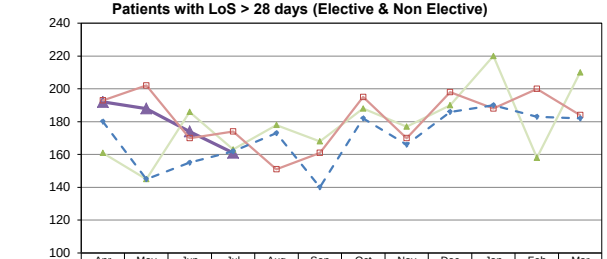
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 1686 | 1816 | 1940 | 1875 | 1818 | | | | | | | |
| 2016/17 | 1511 | 1652 | 1630 | 1602 | 1705 | 1768 | 1692 | 1502 | 1593 | 1503 | 1494 | 1915 |
| 2015/16 | 1143 | 1265 | 1390 | 1533 | 1363 | 1384 | 1393 | 1321 | 1445 | 1543 | 1457 | 1417 |
| 2014/15 | 1103 | 1232 | 1124 | 1258 | 1118 | 1120 | 1256 | 1134 | 1095 | 1094 | 1069 | 1314 |

## Patients with LoS > 7 days (Elective & Non Elective)



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 987 | 1048 | 957 | 1006 | 861 | | | | | | | |
| 2016/17 | 1018 | 1020 | 1008 | 1038 | 1013 | 1006 | 1007 | 1016 | 1050 | 1175 | 981 | 1079 |
| 2015/16 | 1078 | 998 | 1022 | 961 | 983 | 975 | 1020 | 1016 | 1068 | 1058 | 1035 | 1059 |
| 2014/15 | 987 | 965 | 956 | 978 | 964 | 968 | 1052 | 1003 | 1120 | 1134 | 1004 | 1067 |

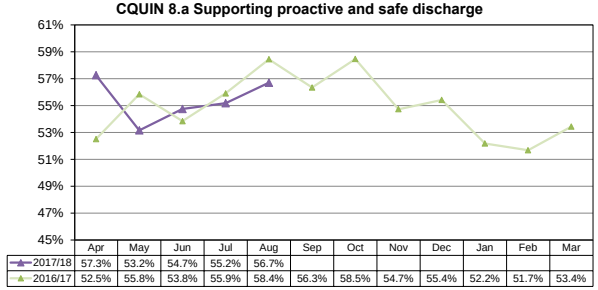
## Patients with LoS > 28 days (Elective & Non Elective)



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 192 | 188 | 174 | 161 | | | | | | | | |
| 2016/17 | 161 | 145 | 186 | 163 | 178 | 168 | 188 | 177 | 190 | 220 | 158 | 210 |
| 2015/16 | 193 | 202 | 170 | 174 | 151 | 161 | 195 | 170 | 198 | 188 | 200 | 184 |
| 2014/15 | 180 | 145 | 155 | 162 | 173 | 140 | 182 | 166 | 186 | 190 | 183 | 182 |

*Updated one month in arrears*

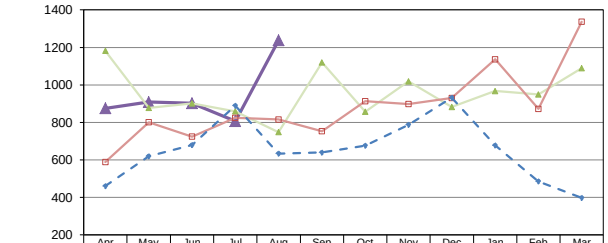
## CQUIN 8.a Supporting proactive and safe discharge



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 57.3% | 53.2% | 54.7% | 55.2% | 56.7% | | | | | | | |
| 2016/17 | 52.5% | 55.8% | 53.8% | 55.9% | 58.4% | 56.3% | 58.5% | 54.7% | 55.4% | 52.2% | 51.7% | 53.4% |

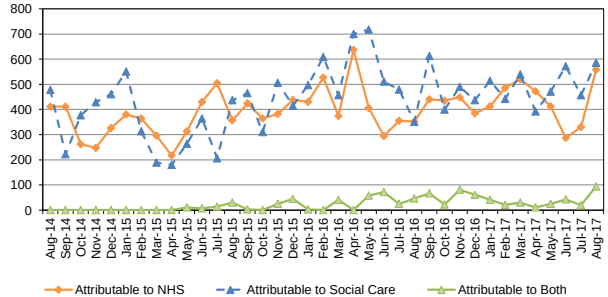
Proportion of patients aged 65+ admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission (excluding those with a LoS < 3 days) over

## Acute Delayed Transfers of Care - Lost Bed Days

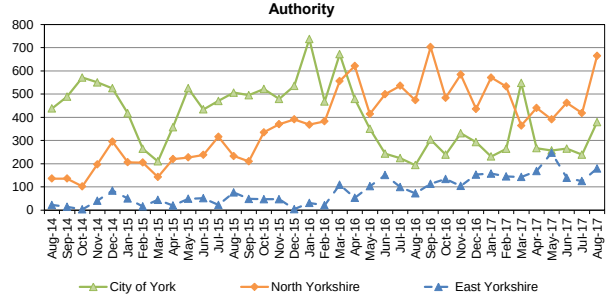


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 875 | 908 | 902 | 806 | 1238 | | | | | | | |
| 2016/17 | 1182 | 877 | 901 | 859 | 748 | 1120 | 857 | 1019 | 882 | 967 | 949 | 1089 |
| 2015/16 | 588 | 801 | 724 | 824 | 815 | 753 | 913 | 898 | 930 | 1136 | 872 | 1337 |
| 2014/15 | 460 | 619 | 679 | 889 | 633 | 639 | 676 | 787 | 931 | 677 | 485 | 397 |

## Acute Delayed Transfers of Care - Lost Bed Day by Type



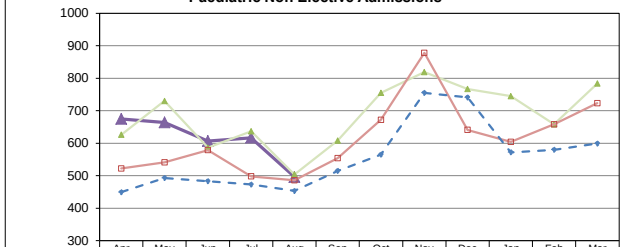

## Acute Delayed Transfers of Care - Lost Bed Day by Type by Local Authority



# Paediatric Admissions

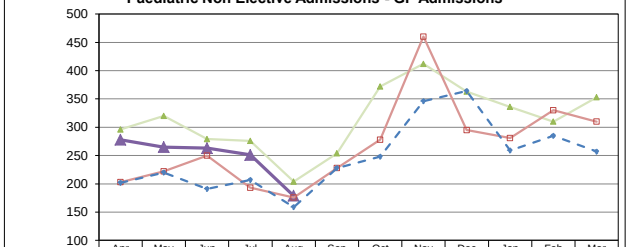
**September 2017**

## Paediatric Non Elective Admissions



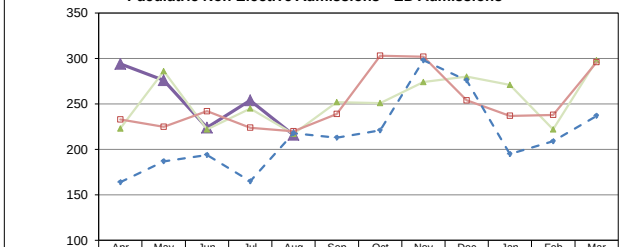
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 675 | 664 | 607 | 617 | 496 | | | | | | | |
| 2016/17 | 626 | 730 | 586 | 637 | 504 | 608 | 755 | 819 | 767 | 745 | 658 | 784 |
| 2015/16 | 522 | 541 | 579 | 498 | 486 | 554 | 672 | 878 | 641 | 604 | 658 | 723 |
| 2014/15 | 449 | 493 | 483 | 473 | 453 | 515 | 565 | 755 | 741 | 572 | 580 | 599 |

## Paediatric Non Elective Admissions - GP Admissions



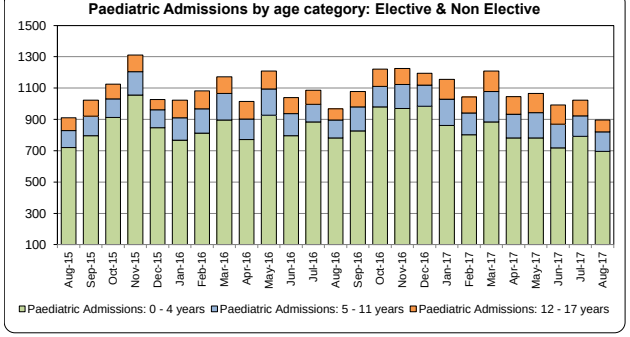
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 278 | 265 | 263 | 251 | 179 | | | | | | | |
| 2016/17 | 296 | 320 | 279 | 276 | 204 | 254 | 372 | 412 | 363 | 336 | 310 | 353 |
| 2015/16 | 203 | 222 | 250 | 193 | 176 | 228 | 278 | 460 | 295 | 281 | 330 | 310 |
| 2014/15 | 202 | 220 | 191 | 207 | 159 | 228 | 248 | 346 | 364 | 259 | 285 | 257 |

## Paediatric Non Elective Admissions - ED Admissions

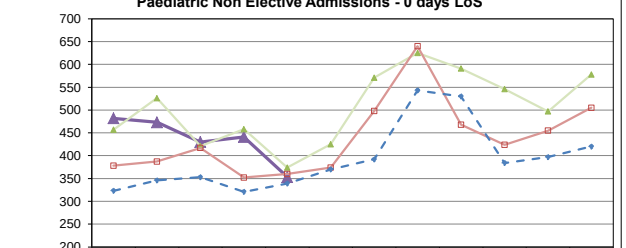


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 294 | 276 | 224 | 254 | 216 | | | | | | | |
| 2016/17 | 223 | 286 | 222 | 245 | 217 | 252 | 251 | 274 | 280 | 271 | 222 | 298 |
| 2015/16 | 233 | 225 | 242 | 224 | 220 | 239 | 303 | 302 | 254 | 237 | 238 | 296 |
| 2014/15 | 164 | 187 | 194 | 165 | 218 | 213 | 221 | 298 | 276 | 195 | 209 | 237 |

## Paediatric Admissions by age category: Elective & Non Elective

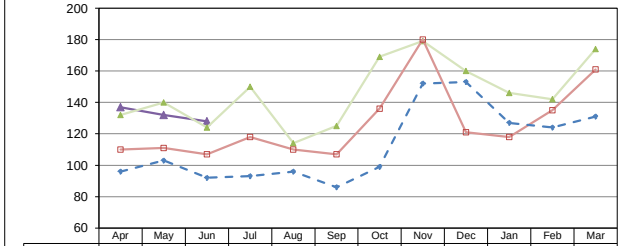



## Paediatric Non Elective Admissions - 0 days LoS



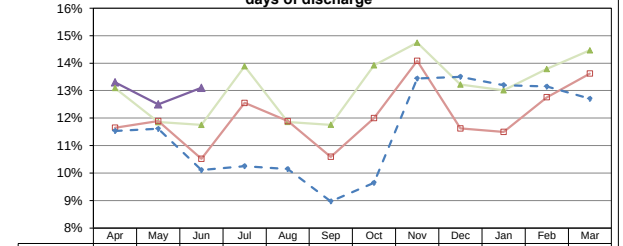
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 482 | 473 | 430 | 441 | 353 | | | | | | | |
| 2016/17 | 457 | 526 | 421 | 458 | 374 | 425 | 571 | 625 | 591 | 546 | 497 | 578 |
| 2015/16 | 378 | 387 | 417 | 352 | 360 | 374 | 498 | 640 | 468 | 424 | 455 | 505 |
| 2014/15 | 323 | 346 | 353 | 321 | 339 | 370 | 392 | 543 | 530 | 384 | 397 | 420 |

## Paediatric Emergency Readmissions within 30 days of discharge



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 137 | 132 | 128 | | | | | | | | | |
| 2016/17 | 132 | 140 | 124 | 150 | 114 | 125 | 169 | 179 | 160 | 146 | 142 | 174 |
| 2015/16 | 110 | 111 | 107 | 118 | 110 | 107 | 136 | 180 | 121 | 118 | 135 | 161 |
| 2014/15 | 96 | 103 | 92 | 93 | 96 | 86 | 99 | 152 | 153 | 127 | 124 | 131 |

## Paediatric Readmission Rate: Emergency Readmissions within 30 days of discharge

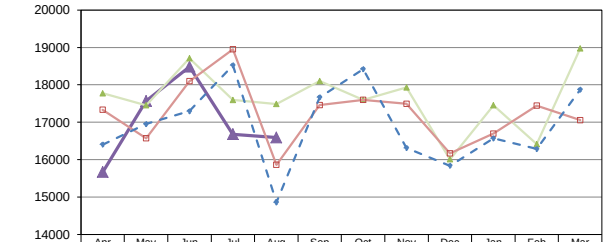


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 13.3% | 12.5% | 13.1% | | | | | | | | | |
| 2016/17 | 13.1% | 11.9% | 11.8% | 13.9% | 11.9% | 11.8% | 13.9% | 14.7% | 13.2% | 13.0% | 13.8% | 14.5% |
| 2015/16 | 11.7% | 11.9% | 10.5% | 12.6% | 11.9% | 10.6% | 12.0% | 14.1% | 11.6% | 11.5% | 12.8% | 13.6% |
| 2014/15 | 11.5% | 11.6% | 10.1% | 10.3% | 10.1% | 9.0% | 9.6% | 13.4% | 13.5% | 13.2% | 13.1% | 12.7% |

# Trust Planned Care
# Outpatients

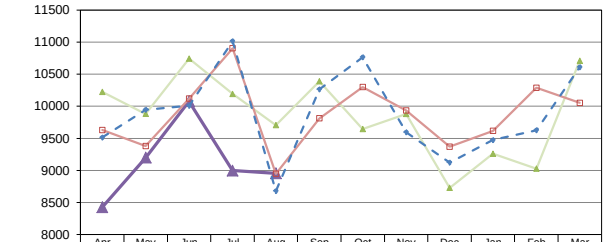
**September 2017**

### Outpatients: All Referral Types (excluding AHPs)



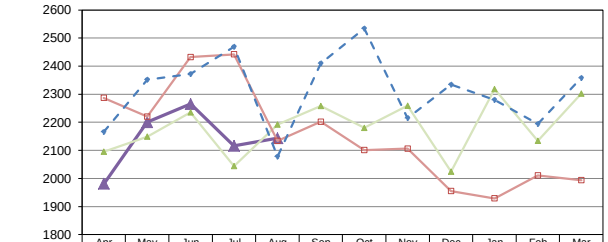
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 15674 | 17567 | 18484 | 16682 | 16592 | | | | | | | |
| 2016/17 | 17774 | 17455 | 18711 | 17594 | 17489 | 18102 | 17600 | 17930 | 16011 | 17455 | 16415 | 18972 |
| 2015/16 | 17337 | 16572 | 18098 | 18950 | 15864 | 17459 | 17599 | 17492 | 16169 | 16696 | 17445 | 17056 |
| 2014/15 | 16404 | 16953 | 17295 | 18522 | 14861 | 17666 | 18420 | 16314 | 15840 | 16571 | 16286 | 17871 |

### Outpatients: GP Referrals (excluding AHPs)



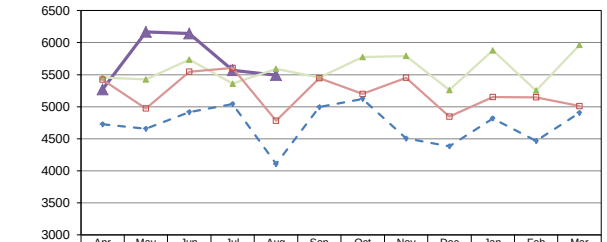
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 8425 | 9199 | 10077 | 8997 | 8954 | | | | | | | |
| 2016/17 | 10223 | 9881 | 10742 | 10192 | 9706 | 10388 | 9645 | 9879 | 8728 | 9259 | 9029 | 10707 |
| 2015/16 | 9628 | 9379 | 10119 | 10903 | 8949 | 9812 | 10299 | 9934 | 9369 | 9616 | 10287 | 10052 |
| 2014/15 | 9513 | 9946 | 10008 | 11012 | 8678 | 10262 | 10763 | 9595 | 9122 | 9473 | 9626 | 10609 |

### Outpatients: Cons to Cons Referrals (excluding AHPs)



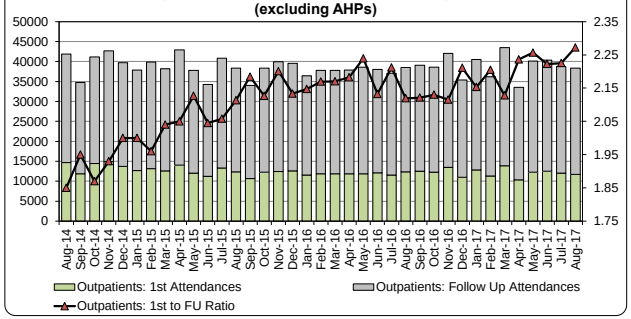
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 1981 | 2200 | 2265 | 2116 | 2143 | | | | | | | |
| 2016/17 | 2095 | 2149 | 2235 | 2044 | 2192 | 2258 | 2180 | 2259 | 2024 | 2318 | 2134 | 2302 |
| 2015/16 | 2287 | 2220 | 2432 | 2442 | 2134 | 2202 | 2101 | 2106 | 1955 | 1929 | 2011 | 1994 |
| 2014/15 | 2166 | 2352 | 2372 | 2469 | 2078 | 2410 | 2534 | 2215 | 2334 | 2280 | 2194 | 2358 |

### Outpatients: Other Referrals (excluding AHPs)

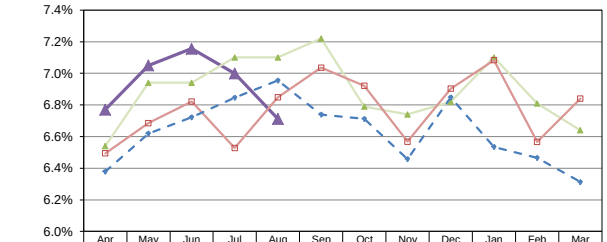


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 5268 | 6168 | 6142 | 5569 | 5495 | | | | | | | |
| 2016/17 | 5456 | 5425 | 5734 | 5358 | 5591 | 5456 | 5775 | 5792 | 5259 | 5878 | 5252 | 5963 |
| 2015/16 | 5422 | 4973 | 5547 | 5605 | 4781 | 5445 | 5199 | 5452 | 4845 | 5151 | 5147 | 5010 |
| 2014/15 | 4725 | 4655 | 4915 | 5041 | 4105 | 4994 | 5123 | 4504 | 4384 | 4818 | 4466 | 4904 |

### Outpatients: Attendances & 1st to Follow Up Ratio (excluding AHPs)

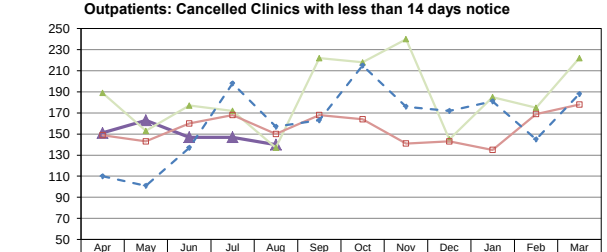



### Outpatients: DNA rates



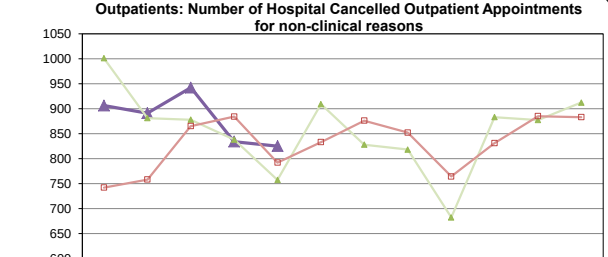
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 6.8% | 7.1% | 7.2% | 7.0% | 6.7% | | | | | | | |
| 2016/17 | 6.5% | 6.9% | 6.9% | 7.1% | 7.1% | 7.2% | 6.8% | 6.7% | 6.8% | 7.1% | 6.8% | 6.6% |
| 2015/16 | 6.5% | 6.7% | 6.8% | 6.5% | 6.8% | 7.0% | 6.9% | 6.6% | 6.9% | 7.1% | 6.6% | 6.8% |
| 2014/15 | 6.4% | 6.6% | 6.7% | 6.8% | 7.0% | 6.7% | 6.7% | 6.5% | 6.8% | 6.5% | 6.5% | 6.3% |

### Outpatients: Cancelled Clinics with less than 14 days notice



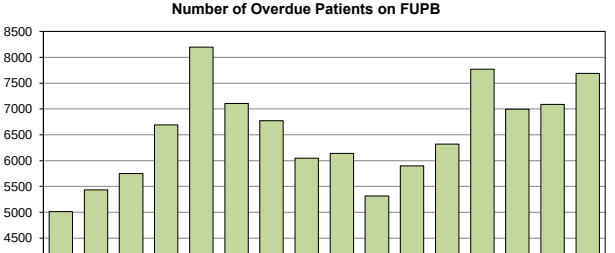
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 151 | 163 | 147 | 147 | 140 | | | | | | | |
| 2016/17 | 189 | 153 | 177 | 172 | 137 | 222 | 218 | 240 | 145 | 185 | 175 | 222 |
| 2015/16 | 149 | 143 | 160 | 168 | 150 | 168 | 164 | 141 | 143 | 135 | 169 | 178 |
| 2014/15 | 110 | 101 | 137 | 198 | 157 | 163 | 215 | 176 | 172 | 181 | 145 | 188 |

### Outpatients: Number of Hospital Cancelled Outpatient Appointments for non-clinical reasons



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 906 | 891 | 942 | 834 | 825 | | | | | | | |
| 2016/17 | 1001 | 881 | 878 | 838 | 757 | 909 | 828 | 818 | 682 | 883 | 877 | 912 |
| 2015/16 | 742 | 758 | 865 | 884 | 792 | 833 | 876 | 852 | 764 | 831 | 885 | 883 |

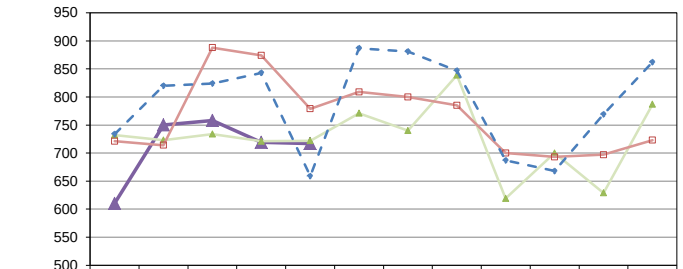
### Number of Overdue Patients on FUPB



# Trust Planned Care
# Elective Activity & Theatre Utilisation

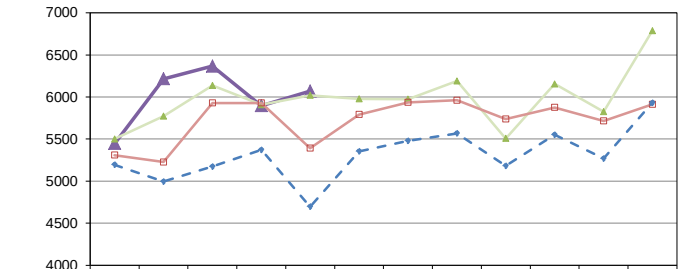
**September 2017**

## Ordinary Elective Admissions



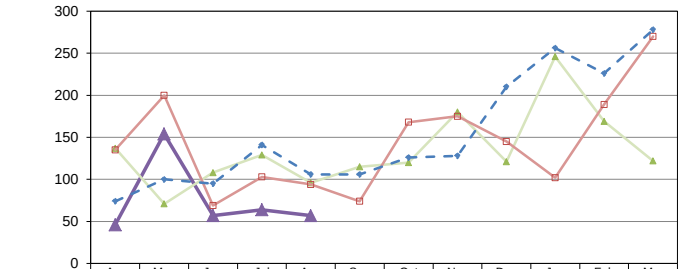

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 610 | 750 | 758 | 719 | 717 | | | | | | | |
| 2016/17 | 732 | 723 | 734 | 721 | 722 | 771 | 740 | 839 | 619 | 700 | 629 | 787 |
| 2015/16 | 721 | 714 | 888 | 874 | 779 | 809 | 800 | 785 | 700 | 693 | 697 | 723 |
| 2014/15 | 734 | 820 | 824 | 843 | 659 | 887 | 881 | 847 | 687 | 668 | 769 | 862 |

## Ordinary Day Case Admissions



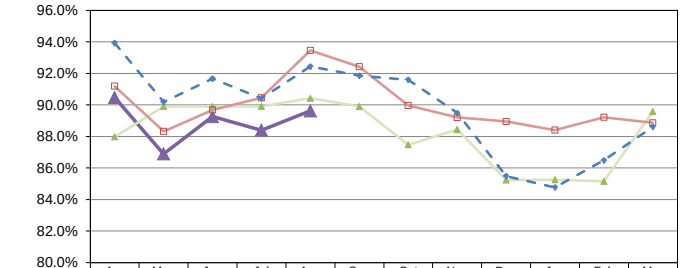

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 5448 | 6216 | 6366 | 5896 | 6069 | | | | | | | |
| 2016/17 | 5500 | 5771 | 6137 | 5907 | 6019 | 5977 | 5973 | 6189 | 5507 | 6154 | 5824 | 6786 |
| 2015/16 | 5309 | 5226 | 5929 | 5929 | 5392 | 5792 | 5936 | 5960 | 5737 | 5876 | 5715 | 5912 |
| 2014/15 | 5194 | 4994 | 5173 | 5371 | 4696 | 5353 | 5478 | 5567 | 5181 | 5551 | 5268 | 5931 |

## Elective operations cancelled within 48 hours - Non clinical reasons



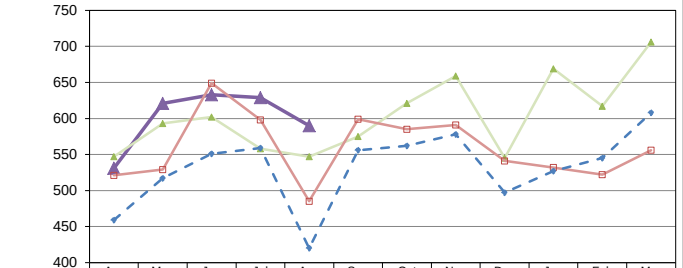

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 46 | 154 | 57 | 64 | 57 | | | | | | | |
| 2016/17 | 137 | 71 | 108 | 129 | 96 | 115 | 120 | 180 | 121 | 246 | 169 | 122 |
| 2015/16 | 135 | 200 | 69 | 103 | 94 | 74 | 168 | 175 | 145 | 102 | 189 | 270 |
| 2014/15 | 74 | 100 | 95 | 141 | 106 | 106 | 126 | 128 | 210 | 256 | 226 | 278 |

## Theatres: Utilisation of planned sessions



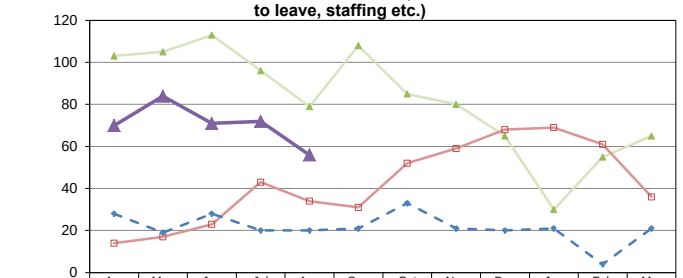

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 90.5% | 86.9% | 89.3% | 88.4% | 89.6% | | | | | | | |
| 2016/17 | 88.0% | 89.9% | 89.9% | 89.9% | 90.4% | 89.9% | 87.5% | 88.4% | 85.2% | 85.3% | 85.2% | 89.6% |
| 2015/16 | 91.2% | 88.3% | 89.7% | 90.5% | 93.5% | 92.4% | 90.0% | 89.2% | 89.0% | 88.4% | 89.2% | 88.9% |
| 2014/15 | 93.9% | 90.2% | 91.7% | 90.4% | 92.4% | 91.8% | 91.6% | 89.5% | 85.5% | 84.8% | 86.5% | 88.6% |

## Theatres: Number of sessions held




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 531 | 621 | 633 | 629 | 590 | | | | | | | |
| 2016/17 | 547 | 593 | 602 | 558 | 547 | 575 | 621 | 659 | 545 | 669 | 617 | 706 |
| 2015/16 | 521 | 529 | 649 | 598 | 485 | 599 | 585 | 591 | 541 | 532 | 522 | 556 |
| 2014/15 | 459 | 517 | 551 | 559 | 420 | 556 | 562 | 578 | 497 | 527 | 545 | 608 |

## Theatres: Lost sessions < 6 weeks notice (list available but lost due to leave, staffing etc.)



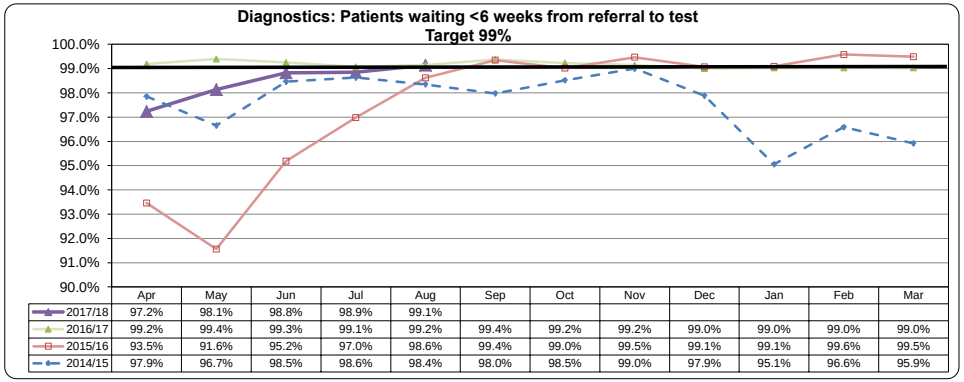

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 70 | 84 | 71 | 72 | 56 | | | | | | | |
| 2016/17 | 103 | 105 | 113 | 96 | 79 | 108 | 85 | 80 | 65 | 30 | 55 | 65 |
| 2015/16 | 14 | 17 | 23 | 43 | 34 | 31 | 52 | 59 | 68 | 69 | 61 | 36 |
| 2014/15 | 28 | 19 | 28 | 20 | 20 | 21 | 33 | 21 | 20 | 21 | 4 | 21 |

All cancellations are within 6 weeks of the planned procedure date. Cancellations exclude lists added in error and those that have been rescheduled.

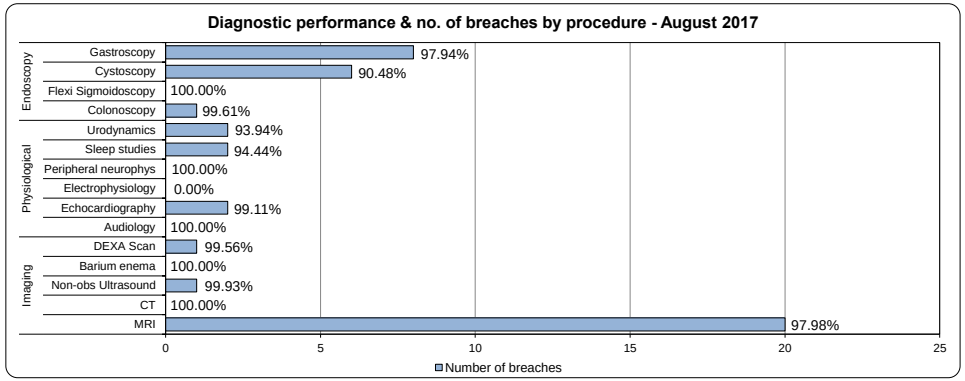
# Diagnostics & Referral To Treatment

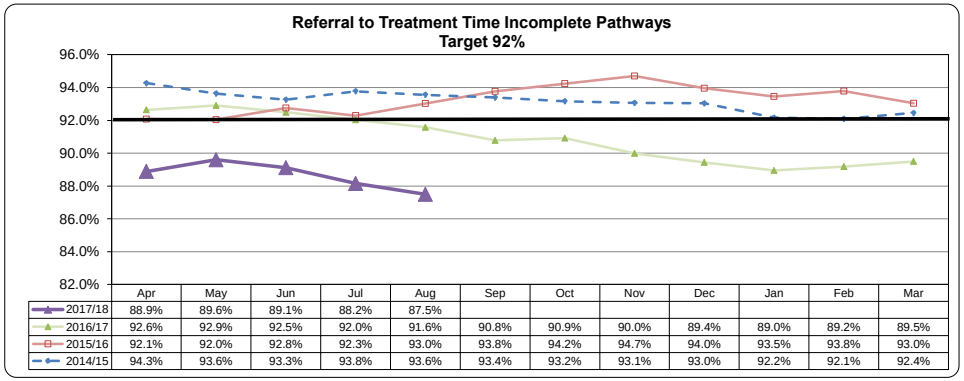
**September 2017**

The Trust is monitored at aggregate level against the Diagnostic & Referral to Treatment Incomplete Targets.

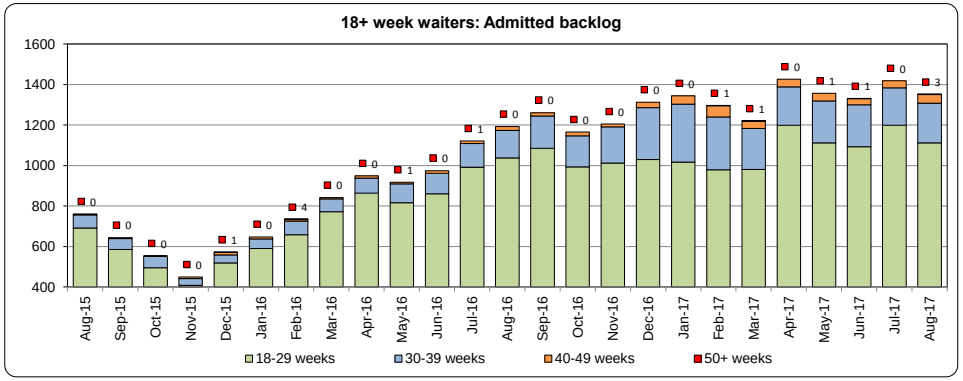


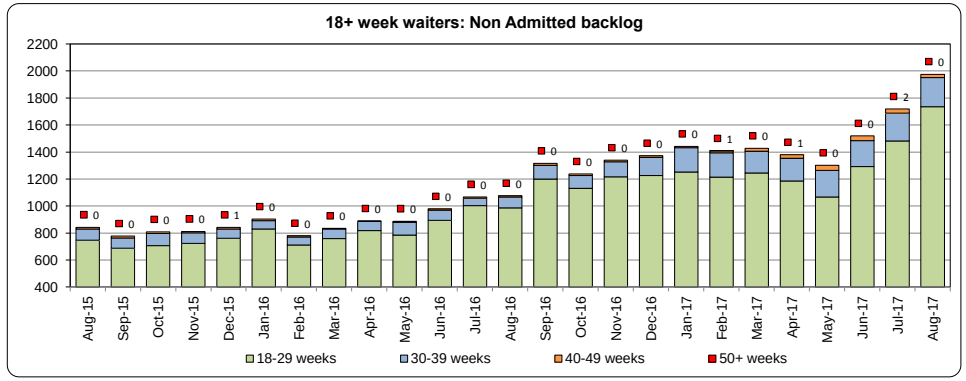

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 97.2% | 98.1% | 98.8% | 98.9% | 99.1% | | | | | | | |
| 2016/17 | 99.2% | 99.4% | 99.3% | 99.1% | 99.2% | 99.4% | 99.2% | 99.2% | 99.0% | 99.0% | 99.0% | 99.0% |
| 2015/16 | 93.5% | 91.6% | 95.2% | 97.0% | 98.6% | 99.4% | 99.0% | 99.5% | 99.1% | 99.1% | 99.6% | 99.5% |
| 2014/15 | 97.9% | 96.7% | 98.5% | 98.6% | 98.4% | 98.0% | 98.5% | 99.0% | 97.9% | 95.1% | 96.6% | 95.9% |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 88.9% | 89.6% | 89.1% | 88.2% | 87.5% | | | | | | | |
| 2016/17 | 92.6% | 92.9% | 92.5% | 92.0% | 91.6% | 90.8% | 90.9% | 90.0% | 89.4% | 89.0% | 89.2% | 89.5% |
| 2015/16 | 92.1% | 92.0% | 92.8% | 92.3% | 93.0% | 93.8% | 94.2% | 94.7% | 94.0% | 93.5% | 93.8% | 93.0% |
| 2014/15 | 94.3% | 93.6% | 93.3% | 93.8% | 93.6% | 93.4% | 93.2% | 93.1% | 93.0% | 92.2% | 92.1% | 92.4% |

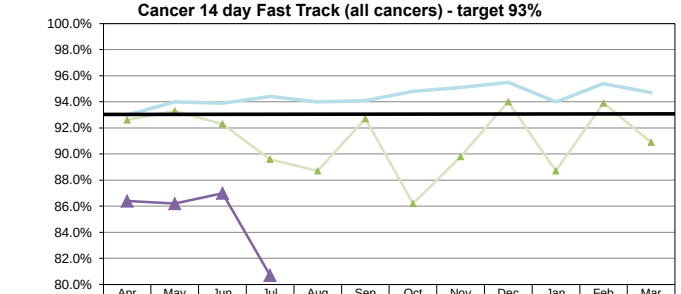


# Trust Cancer

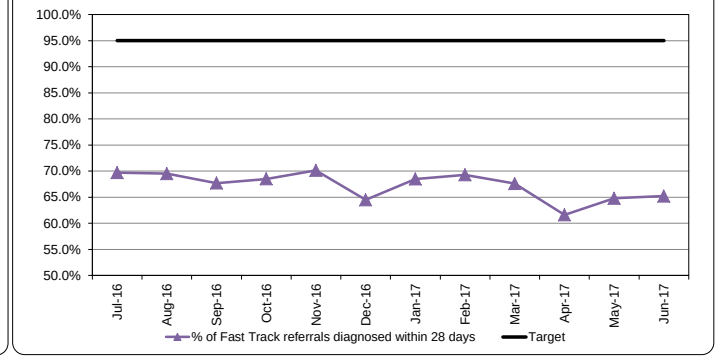
## September 2017

### Cancer 14 day Fast Track (all cancers) - target 93%

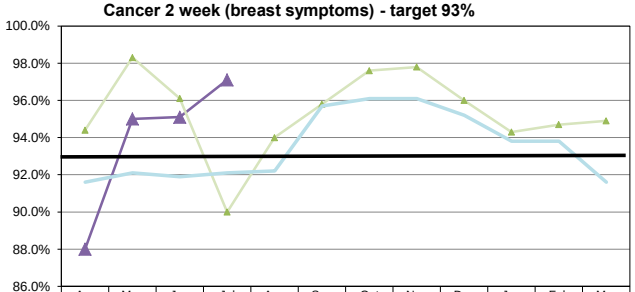



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 86.4% | 86.2% | 87.0% | 80.7% | | | | | | | | |
| 2016/17 | 92.6% | 93.3% | 92.3% | 89.6% | 88.7% | 92.7% | 86.2% | 89.8% | 94.0% | 88.7% | 93.9% | 90.9% |
| NHSE 16/17 | 93.0% | 94.0% | 93.9% | 94.4% | 94.0% | 94.1% | 94.8% | 95.1% | 95.5% | 94.0% | 95.4% | 94.7% |

### % of Fast Track referrals diagnosed within 28 days - target 95%

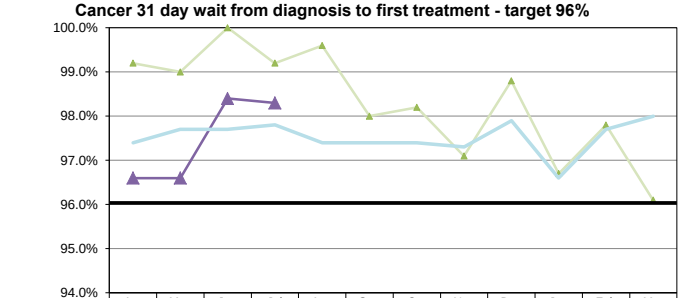



### Cancer 2 week (breast symptoms) - target 93%



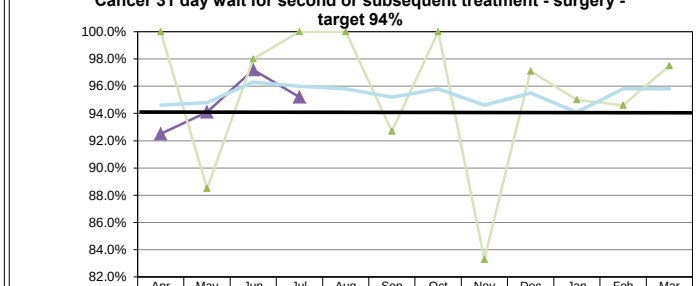

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 88.0% | 95.0% | 95.1% | 97.1% | | | | | | | | |
| 2016/17 | 94.4% | 98.3% | 96.1% | 90.0% | 94.0% | 95.8% | 97.6% | 97.8% | 96.0% | 94.3% | 94.7% | 94.9% |
| NHSE 16/17 | 91.6% | 92.1% | 91.9% | 92.1% | 92.2% | 95.7% | 96.1% | 96.1% | 95.2% | 93.8% | 93.8% | 91.6% |

### Cancer 31 day wait from diagnosis to first treatment - target 96%



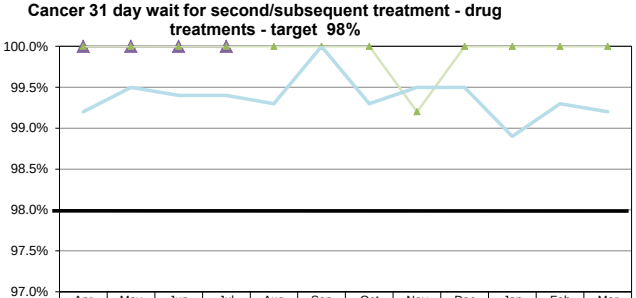

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 96.6% | 96.6% | 98.4% | 98.3% | | | | | | | | |
| 2016/17 | 99.2% | 99.0% | 100.0% | 99.2% | 99.6% | 98.0% | 98.2% | 97.1% | 98.8% | 96.7% | 97.8% | 96.1% |
| NHSE 16/17 | 97.4% | 97.7% | 97.7% | 97.8% | 97.4% | 97.4% | 97.4% | 97.3% | 97.9% | 96.6% | 97.7% | 98.0% |

### Cancer 31 day wait for second or subsequent treatment - surgery - target 94%



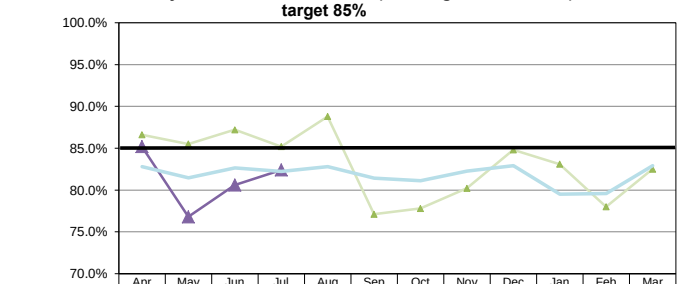

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 92.5% | 94.1% | 97.2% | 95.2% | | | | | | | | |
| 2016/17 | 100.0% | 88.5% | 98.0% | 100.0% | 100.0% | 92.7% | 100.0% | 83.3% | 97.1% | 95.0% | 94.6% | 97.5% |
| NHSE 16/17 | 94.6% | 94.8% | 96.3% | 96.0% | 95.8% | 95.2% | 95.8% | 94.6% | 95.5% | 94.1% | 95.8% | 95.8% |

### Cancer 31 day wait for second/subsequent treatment - drug treatments - target 98%



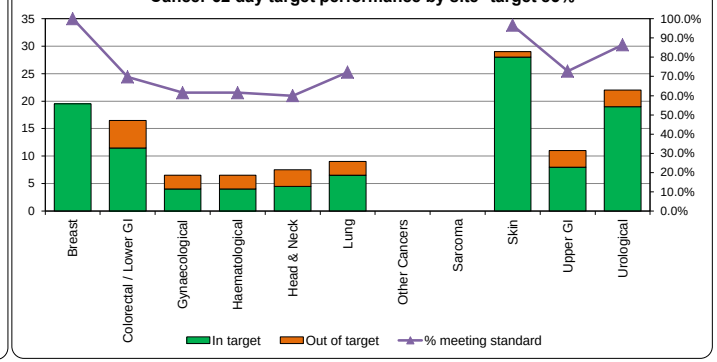

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 100.0% | 100.0% | 100.0% | 100.0% | | | | | | | | |
| 2016/17 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.2% | 100.0% | 100.0% | 100.0% | 100.0% |
| NHSE 16/17 | 99.2% | 99.5% | 99.4% | 99.4% | 99.3% | 100.0% | 99.3% | 99.5% | 99.5% | 98.9% | 99.3% | 99.2% |

### Cancer 62 Day Waits for first treatment (from urgent GP referral) - target 85%

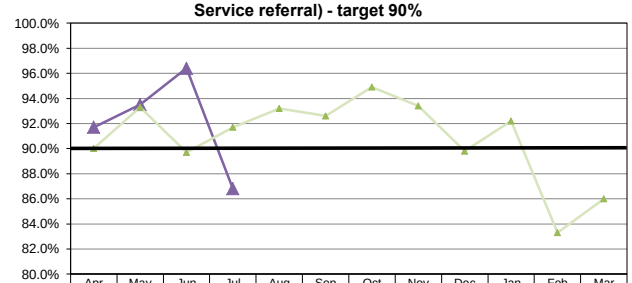



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 85.2% | 76.8% | 80.6% | 82.4% | | | | | | | | |
| 2016/17 | 86.6% | 85.5% | 87.2% | 85.2% | 88.8% | 77.1% | 77.8% | 80.2% | 84.8% | 83.1% | 78.0% | 82.5% |
| NHSE 16/17 | 82.8% | 81.4% | 82.7% | 82.2% | 82.8% | 81.4% | 81.1% | 82.3% | 82.9% | 79.5% | 79.6% | 82.9% |

### Cancer 62 day target performance by site -target 85%




### Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - target 90%




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 91.7% | 93.5% | 96.4% | 86.8% | | | | | | | | |
| 2016/17 | 90.0% | 93.3% | 89.7% | 91.7% | 93.2% | 92.6% | 94.9% | 93.4% | 89.8% | 92.2% | 83.3% | 86.0% |

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Annual Report – Trust Emergency Preparedness, Resilience and Response (EPRR)

## Recommendation

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

## Current approval route of report

This report has been prepared for the Board.

## Purpose of report

The Board are asked to:

- Note that following a self-assessment against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards the Trust has rated itself as "Partially" compliant (i.e. not fully compliant with 10 of 60 applicable standards). This is the same rating as in 2016/17.
- Approve the updated version of the EPRR Action Plan for 2017 (appendix 3).
- Approve the updated and improved governance and reporting arrangements for EPRR in The Trust, including the appointment of a Non-Executive Director to hold the EPRR portfolio and a Board sub-group to received regular EPRR updates.
- Note the key priorities and updated action plan for EPRR in the next 12 months.

## Key points for discussion

There are a range of Statutory Regulation and National Policies that define The Trust's responsibilities around EPRR. Each year, the Trust is expected to undertake a self-assessment against the NHS England Core EPRR Standards, which must be submitted to the Trust Board as part of the assurance process. This year The Trust is reporting "partial" compliance with the NHS England Standards, which is the same as in 2016/17. This continued "partial" compliance rating is largely due to a re-focusing of the EPRR work in response to recent terrorist and cyber incidents.

The Trust has strengthened its partnership working arrangements with the Military, NHS England and other provider NHS organisations. In recent months staff having attended training and events in Hull, Bradford and Selby.

In the last 12 months there have been a series of significant events and incidents that have impacted on the EPRR agenda. Locally, the Cyber-attack of May 2017 highlighted the need to

improve arrangements for updating IT systems and strengthen Business Continuity plans. This is now an area of high priority for improvements in 2017/18 and there is a dedicated action plan to work through in the coming months.

Terrorist incidents, both in the UK (Manchester and London) and abroad (especially in European cities) have served to remind us that the terrorist threat is a real one, and it is crucial that we have robust arrangements in place to respond to these sorts of incidents. With this in mind, the Trust has now agreed with the Army Medical Training Centre in Strensall that they will support us to run a live exercise (LIVEX) in July 2018 to test our arrangements. Delivering this exercise is our main area of focus for 2018. Between then and now, a range of action cards, table top exercises and workshops have begun to take place to prepare our teams for this event and of course in readiness for a real incident.

The Emergency Planning Steering Group, established in 2016 is now running regularly as are it's four main sub-groups. Early significant achievements have included a "prepared" rating from the Yorkshire Ambulance Service around our CBRN preparedness (improved from "unprepared" in 2015), and the development of new Business Continuity plans across the Trust. Detailed plans are in place for each of the four sub-groups to work through in 2017/18.

To continue to strengthen awareness and governance around this agenda, The 2017/18 NHS England EPRR Core Standards request that Acute Trusts should nominate a Non-Executive Director to lead on the EPRR portfolio. The individual should receive regular reports from the Accountable Emergency Officer (AEO), or nominated deputy, and these reports should be fed into The Trust Board.

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Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

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

There is no reference to CQC Outcomes.

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Version number: 1

Author: Mark Hindmarsh, Head of Operational Strategy

Executive sponsor: Wendy Scott, Chief Operating Officer

Date: September 2017

## 1. Purpose

- Inform the Board that following a Self-Assessment against the NHS England Emergency Planning, Resilience and Response (EPRR) Core Standards the Trust has rated itself as "Partially" compliant (i.e. not fully compliant with 10 of 60 applicable standards).
- Request that the Board formally acknowledge this rating as part of the Core Standards compliance submission to NHS England.
- Summarise the main incidents and events of note that have taken place relating to EPRR in the last 12 months
- As part of the 2016 NHS England Core Standards Submission, the Board approved an Action Plan for EPRR. This report will update that plan, and suggest an updated plan to be supported by the Trust Board.
- Request that the Board approve the updated and improved governance and reporting arrangements for EPRR in the Trust, including the appointment of a Non-Executive Director to hold the EPRR portfolio.
- Inform the Board of the key priorities for EPRR in the next 12 months.

## 2. Civil Contingencies Act

Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can plan for and deal with a wide range of incidents and emergencies that could affect health or patient care. This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR). Under this act the Trust is defined as a Category 1 responder and is subject to civil protection duties which are to:

- Assess the risk of emergencies occurring and use this knowledge to inform contingency planning;
- Ensure emergency plans and business continuity management arrangements are in place;
- Communicate with the public to ensure they are warned, informed and advised in the event of an emergency;
- Share information and cooperate with other local responders to enhance coordination and efficiency.

### 2.1 NHS England Core EPRR Standards and other Statutory and National Policy Drivers

In addition to the Civil Contingencies Act (2004), the Trust must also comply with; the Health and Social Care Act (2012), NHS Standard Contracts, NHS England Command and Control Framework, NHS England Business Continuity Management Framework and the NHS England Core Standards for EPRR.

The NHS England Core Standards EPRR Framework contains principles for health emergency planning for the NHS in England at all levels including NHS provider organisations, providers of NHS-funded care, clinical commissioning groups (CCGs), general practices and other primary / community care organisations.

The NHS England Core Standards for EPRR provide the minimum standards that NHS organisations and providers of NHS funded care must meet. The Trust is required to undertake an annual self-assessment against the core standards relating to acute Trusts and provide assurance to NHS England (Yorkshire and the Humber) that robust and resilient EPRR arrangements are in place and maintained within the Trust. Organisations are expected to state overall whether they believe they are fully, substantially, partially or non-compliant with the core standards – and in 2016, the Trust was self-assessed to be "partially" compliant with the standards. As part of this

annual process, it is requested that the Trust Board approves the self-assessment that has been undertaken and the declared rating.

This year, the Statement of Compliance (see appendix 1) is due to be submitted by the 6th October 2017. Following an assessment, the Emergency Planning Steering Group has assessed the Trust to be "partially" compliant with the standards. This means that we have not been able to fully comply with 10 of the 60 key applicable standards and the annual work programme must address these areas of non-compliance. **The Board is requested to note this compliance rating.**

There are two main reasons for reporting "partial" compliance with these standards in consecutive years. Firstly, in response to terrorist and cyber incidents (described in section 4) there has been a need to redirect the EPRR work to focus on preparations for responding to a mass casualty type scenario and business continuity. There are only a handful of the core standards that relate specifically these areas, and so the work that has been undertaken doesn't reflect directly in improved compliance with more of the core standards. Secondly, there are 9 extra standards this year compared to last (51 in 2016/17 and 60 applicable in 2017/18), some of which are entirely new standards, and some of which are a result of splitting some of last year's standards into several new standards. This has meant that as the Trust has turned green some standards that were red 2016/17, extra standards have been added that are red in 2017/18.

The 2017/18 standards are available in full (appendix 2) and updated copy of the action plan that went to the Board in November 2016 is attached as appendix 3 to this paper. All actions have been updated, and there have been some additions made to the action plan to ensure that it remains a live document. These actions will continue to be managed and monitored by the Emergency Planning Steering Group.

## 2.2 Main incidents and EPRR events of note in the last 12 months

**Cyber Attack**
On the 12th May 2017, the Trust was victim of a computer virus that impacted on all Windows Operating Systems. Over 1,800 individual PCs across all Trust sites were infected as well as 22 servers and numerous pieces of equipment that were connected to the Trust IT network. A de-brief report was submitted to Trust Board in August describing the incident in detail, summarising staff feedback (over 300 responses were received) and setting out an action plan to improve the Trust response to this sort of incident in future. Recommendations included strengthening the arrangements for applying patch updates to the Windows Operating Systems and improving business continuity arrangements for the loss of IT systems. The implementation of the action plan will be overseen by the Emergency Planning Steering Group.

The threat to the Trust in this area continues to be significant, and so will continue to be a high priority in 2017/18.

**Manchester Arena Bombing**
The Manchester Arena Bombing on the 23rd May 2017 had a direct impact on our organisation. Firstly, two patients were treated in the York Hospital Emergency Department as a direct result of the incident. The physical injuries sustained by these two individuals were minor and both patients were discharged from the department not requiring further hospital treatment. Their GPs were contacted, to inform them of their attendance and to allow for follow up in primary care for any other support they may need.

Secondly, this attack led to an increase in the national terror threat level to "critical", meaning an attack was expected imminently. For the Trust, this triggered a cascade of communication to staff highlighting the location key policies and documents to be used in the event of an incident and to contact our security teams if they noticed anything suspicious.

**Other Terror Attacks Internationally and in London**
Since the London Westminster Bridge attack of the 22nd March 2017, there have been attacks in Paris and Stockholm in April, Manchester in May, in London again on the 9th and 19th June, in Barcelona on the 17th August and again in London on the 15th September. The combination of these incidents, and in particular the way in which healthcare organisations in the UK have responded to these incidents, serve to remind the Trust that the threat is a real one, and it is crucial that we have robust arrangements in place to respond to these sorts of incidents.

At a conference, held by NHS England (Yorkshire & Humber) in July, provider and commissioning organisations came together to agree how they would work collectively to distribute casualties in the event of a Mass Casualty incident. These arrangements would go above and beyond the normal Major Trauma Network arrangements – as if there were to be an incident on the scale of the Manchester attack the designated Major Trauma centres in Leeds and Hull would be unable to manage alone. As a result of these discussions, it has been agreed that both York and Scarborough Hospitals may be expected to take the most critically ill patients in the event of a serious incident taking place in our region.

We will continue to work with the Yorkshire & Humber Major Trauma network (the Clinical Lead of which is a Consultant Anaesthetist based at Scarborough Hospital) and other provider and commissioning partners on this crucial agenda in 2017/18 as our top priority.

**Other local events**

The Emergency Planning team across both hospital sites also worked well with external partners to ensure the coordination of special measures to maintain safe patient care during a number of large scale events held in both York and Scarborough. These included the Tour de Yorkshire and the York Marathon.

## 2.3 Work of the Emergency Planning Steering Group in 2016/17

The Emergency Planning Steering Group (EPSG) meets quarterly to oversee the development and maintenance of Trust emergency and business continuity arrangements. This group is chaired by the delegated Accountable Emergency Officer (Head of Operational Strategy). The group has four sub-groups reporting to it that meet to focus on a specific area of the EPRR agenda and manage compliance with the NHS England Core Standards that relate to their area. The work of the sub-groups is highlighted below:

**Major Incident / Serious Untoward Incident Sub-Group**
The group is co-chaired by the Directorate Manager for Emergency & Acute Medicine and the Senior Patient Flow Manager. The group is responsible for agreeing the arrangements and developing the capability of both sites to respond to a major incident - including a mass casualty incident. This includes coordinating training and education for clinical and non-clinical staff, updating key procedural documents, running table top exercises, and preparing for a live emergency exercise (LIVEX) in July 2018.

Working with colleagues based in Her Majesty's Armed Forces, the Trust has managed to secure an agreement with the Army Medical Training Centre, based in Strensall, York, to use their

facilities to run a live exercise in July 2018. The exercise will simulate a mass casualty type incident and will involve both front line clinical staff and support staff in testing our preparedness. A detailed plan of work to be undertaken, leading up to the LIVEX in July 2018 is attached to this report in appendix 4.

**Chemical, Biological, Radiological, Nuclear (CBRN) / Hazmat Sub-Group**
The group is co-chaired by the two Deputy Directorate Managers for Acute and Emergency medicine at York and Scarborough. It is now also supported by a designated nurse expert based in the main ED at each main site.

The Trust's preparedness to respond to a Chemical, Biological, Radiological, Nuclear (CBRN) / Hazmat (Hazardous Material) incident is inspected on site bi-annually by Yorkshire Ambulance Service (YAS). The last audit in 2015, uncovered significant failings on both sites, with the Trust rated by YAS as "unprepared". The 2017 inspection took place in July 2017 where teams were commended for their improvement and were given a "prepared" rating (the highest rating possible by a Trust of our size and scale).

In recent months there have been at least three CBRN incidents across our Trust. All of them involved one individual self-presenting at one of our EDs. Patients were correctly identified by staff at the front door and procedures were followed, including in one incident the erection of the decontamination tent at York.

Further training and awareness around CBRN capability will continue this year, including the development of train the trainer roles in both EDs and within the Estates & Facilities and Security teams.

**Business Continuity Sub-Group**
This work is now led by the Deputy Head of Operational Performance. Since coming into post in February 2017 a series of workshops have been held on both main sites with clinical and corporate directorates to develop plans, in the first instance against the core five scenarios; loss of power, loss of IT, restricted access to buildings, loss of staff and loss of communications. All areas have also been supported to develop their Business Impact Analysis – which will help directorates prioritise their activities.

The May Cyber-attack served to re-inforce the importance of these plans, and exposed gaps across the organisation, either where plans were not in place or where they did not work as planned. We aim to have completed business continuity plans for the main five areas by the end of October 2017. Following this plans will be rigorously tested and table top exercises will be held. There will then be a need to develop additional plans specific to certain areas of the Trust.

**Pandemic Flu Sub-Group**
The group is co-chaired by the Senior Patient Flow Manager and the Lead Nurse for Infection Prevention. The group leads on planning the special measures that may be required in response to a major outbreak and to ensure robust plans are in place. The group is currently revising its core policy and procedure document and is planning to run an options appraisal session in the coming months to look at the best location on both sites to manage an infected cohort of patients in the event of an outbreak.

Early media reports have highlighted that Australia and New Zealand have already seen high levels of flu this year, and this is likely to be reflected in the number of flu cases experienced in the UK this winter. Patients are likely to begin to become infected over the next 4-8 weeks. The Trust is preparing and reviewing its plans with this likely increased demand in mind.

## 2.4 Governance and leadership arrangements for EPRR

The Chief Executive is responsible for ensuring that the Trust is compliant with the Civil Contingencies Act 2004, supporting statutory legislation and national guidance. The Chief Operating Officer is the designated Accountable Emergency Officer (AEO) with delegated responsibility for EPRR within the Trust.

In mid-April 2017 the day to day leadership and management of the EPRR portfolio for the Trust transferred from the Deputy Chief Operating Officer to The Head of Operational Strategy, who chairs the internal Emergency Planning Steering Group. Since the decision in December 2015 to not replace the Trust Emergency Planning Officer following their retirement, the Head of Operational Strategy is supported on a day-to-day basis by a range of other individuals who combine Emergency Planning and Business Continuity work with their other operational roles, including in some cases leading one of the Emergency Planning Steering Group sub-groups.

As the EPRR agenda becomes increasingly prominent and the Trust is put under more scrutiny, it is likely that more resources will be needed in the EPRR team. While it is important that Emergency Planning is embedded in the role and responsibilities of key operational staff, this growing agenda is likely to require a dedicated individual to hold the whole portfolio in the near future. Additionally, one of the NHS England Core Standards is to ensure that the Trust lead for EPRR has a qualification in Emergency Planning, and so appointment to this role such as this will also help the Trust compliance rating.

Under the updated NHS England Core EPRR Standards for 2017/18, the Trust should now also nominate a non-Executive Director to formally hold the EPRR portfolio for the organisation. This individual should provide additional scrutiny to the Trust's EPRR work and receive regular updates from the AEO on progress in this area. **The Board is requested to identify a Non-Executive Director to hold the EPRR portfolio.**

In 2016, the Deputy Chief Operating Officer put in place a revised set of internal governance arrangements for EPRR work within the Trust and these are depicted below:


In order to strengthen these internal governance arrangements further, it is requested that following the appointment of a NED to hold the EPRR portfolio that **the Board support the Head of Operational Strategy and the AEO reporting at least quarterly to a relevant Trust Board sub-group on progress with EPRR.** This will insure that EPRR is regularly discussed and remains at the fore of discussion within the Trust. **The Board are also asked to identify which sub-group receives these regular updates.**

## 2.5 Internal Audit Report

Following a request by the Chief Operating Officer, the Trust's Internal Audit team undertook an audit of EPRR arrangements which reported its findings in March 2017. The report gave EPRR arrangements a rating of "limited" assurance.

A 27 point action plan was produced as a result of the audit which was handed over to the Head of Operational Strategy in April 2017, which is being worked through presently. The action plan produced by the Internal Audit was produced using the NHS England Core Standards as their framework, and so completion of the Internal Audit Action plan should translate through to an improved compliance rating.

As a means to demonstrate improvement and progress, a request to repeat the audit in March 2018 has already been made to the Trust Audit Team.

## 2.6 Partnership Working, Training and External Engagement

On a quarterly basis the Head of Operational Strategy attends the Local Health Resilience Forum, hosted by NHS England, that is attended by all local NHS and care providers across the region. Other sub-group chairs also attend forums, hosted by NHS England with their counterparts in other organisations.

In the last six months, the team have proactively engaged with other organisations in the region for training and support. This has culminated in Trust staff being present at live events in Bradford and Hull and a table top event in Selby (run by North Yorkshire Council). Trust staff, from across the EPRR portfolio have also attending training sessions at Winterbourne Gunner, Easingwold and Newcastle. The first wave of training for our 1st and 2nd on-call managers will take place in November 2017, with further dates to be agreed in early 2018 in line with the LIVEX 2018 delivery plan.

The team have worked especially hard in recent months to build relationships with personnel at the Army Medical Training Centre in Strensall. The Trust already has agreement for Army personnel to be seconded into the Trust in a clinical directorate on a rotational basis, but we have been able to agree use of the facilities in Strensall for the LIVEX in July 2018 along with training expertise from the Army team on a two day per month basis, to support the LIVEX, commencing October 2017.

## 3. Conclusion

The enclosed report identifies progress against the 2016 plan and identified further work to be undertaken during 2017/18. There is a high level of commitment to ensure we are in a state of readiness to respond to both planned and unplanned events. The work will continue to be driven and delivered by the four Emergency Planning Sub-groups, with a particular focus on delivering the LIVEX in July 2018 and improving our Business Continuity plans – in line with the actions from the Cyber Attack report.

The attached work plan (appendix 3) sets out the main areas of focus for the next 12 months, and coupled with the improved governance and reporting arrangements recommended in this paper, this should ensure momentum is maintained and we continue to improve our preparedness in this area.

**APPENDIX 1**

## Yorkshire and the Humber Local Health Resilience Partnership (LHRP) Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018

## STATEMENT OF COMPLIANCE

York Teaching Hospital NHS Foundation Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.
Following assessment, the organisation has been self-assessed as demonstrating the Partial compliance level (from the four options in the table below) against the core standards.

| Compliance Level | Evaluation and Testing Conclusion |
|---|---|
| **Full** | **Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.** |
| **Substantial** | **Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.** |
| **Partial** | **Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.** |
| **Non-compliant** | **Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.** |

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.
I confirm that the organisation has undertaken the following exercises on the dates shown below:

| | |
|---|---|
| A live exercise (required at least every three years) | Scheduled for July 2018 |
| A desktop exercise (required at least annually) | Ran July 2017 x 2. Further scheduled for Nov 2017 and April 2018 |
| A communications exercise (required at least every six months) | To be undertaken as part of run up to LIVEX in July 2018 |

I confirm that the relevant teams in my organisation have considered the debrief reports and actions required from the cyber incidents at North Lincolnshire and Goole NHS FT and Leeds Teaching Hospitals NHS Trust. An plan for the identified actions arising is available.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

| | |
|---|---|
| _____ | _____ |
| Date of board / governing body meeting | 27th September 2017 |

## APPENDIX 2

| | Core standard | Self-assessment RAG<br><br>Red = Not compliant and not in work plan.<br><br>Amber = Not compliant but evidence of progress<br><br>Green = fully compliant |
|---|---|---|
| **Governance** | | |
| **1** | Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management) | |
| **2** | Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response. | |
| **3** | Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response. | |
| **4** | The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards. | |
| **Duty to assess risk** | | |
| **5** | Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions. | |
| **6** | There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers. | |
| **7** | There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners. | |

| **Duty to maintain plans – emergency plans and business continuity plans** | | |
|---|---|---|
| | Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive): | |
| **8** | Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan)) | |
| **9** | corporate and service level Business Continuity (aligned to current nationally recognised BC standards) | |
| **10** | HAZMAT/ CBRN - see separate checklist on tab overleaf | |
| **11** | Severe Weather (heatwave, flooding, snow and cold weather) | |
| **12** | Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions) | |
| **13** | Mass Countermeasures (eg mass prophylaxis, or mass vaccination) | |
| **14** | Mass Casualties | |
| **15** | Fuel Disruption | |
| **16** | Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care) | |
| **17** | Infectious Disease Outbreak | |
| **18** | Evacuation | |
| **19** | Lockdown | |
| **20** | Utilities, IT and Telecommunications Failure | |
| **21** | Excess Deaths/ Mass Fatalities | |
| **22** | having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab | |
| **23** | firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab | |
| **24** | Ensure that plans are prepared in line with current guidance and good practice which includes: | |
| **25** | Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources. | |
| **26** | Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical. | |
| **27** | Arrangements explain how VIP and/or high profile patients will be managed. | |
| **28** | Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content | |

| | | |
|---|---|---|
| **29** | Arrangements include a debrief process so as to identify learning and inform future arrangements | |
| **Command and Control (C2)** | | |
| **30** | Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary. | |
| **31** | Those on-call must meet identified competencies and key knowledge and skills for staff. | |
| **32** | Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist. | |
| **33** | Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident. | |
| **34** | Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response. | |
| **35** | Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events. | |
| **36** | Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements; | |
| **Duty to communicate with the public** | | |
| **37** | Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents. | |
| **38** | Arrangements ensure the ability to communicate internally and externally during communication equipment failures | |
| **Information Sharing – mandatory requirements** | | |
| **39** | Arrangements contain information sharing protocols to ensure appropriate communication with partners. | |
| **Co-operation** | | |
| **40** | Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate) | |
| **41** | Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA | |
| **42** | Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained. | |

| | | |
|---|---|---|
| **43** | Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas. | |
| **44** | Arrangements outline the procedure for responding to incidents which affect two or more regions. | |
| **45** | Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties | |
| **46** | Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared | |
| **47** | Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months | |
| **48** | Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level | |
| **Training And Exercising** | | |
| **49** | Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents | |
| **50** | Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work. | |
| **51** | Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises | |
| **52** | Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation. | |
| **Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards** | | |
| **53** | There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex) | |
| **54** | Staff are able to access the organisation HAZMAT/ CBRN management plans. | |
| **55** | HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation. | |
| **56** | Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7. | |
| **57** | Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7. | |
| **Decontamination Equipment** | | |
| **58** | There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. | |
| **59** | The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when | |

| | | |
|---|---|---|
| | applicable) | |
| **60** | There are routine checks carried out on the decontamination equipment including:<br>A) Suits<br>B) Tents<br>C) Pump<br>D) RAM GENE (radiation monitor)<br>E) Other decontamination equipment | |
| **61** | There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for:<br>A) Suits<br>B) Tents<br>C) Pump<br>D) RAM GENE (radiation monitor)<br>E) Other equipment | |
| **62** | There are effective disposal arrangements in place for PPE no longer required. | |
| **Training** | | |
| **63** | The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training | |
| **64** | Internal training is based upon current good practice and uses material that has been supplied as appropriate. | |
| **65** | The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme. | |
| **66** | Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant. | |
| **2017 DEEP DIVE ADDITIONAL STANDARDS (do not contribute to overall rating)** | | |
| **DD1** | The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a pubic Board/Governing Body meeting for sign off within the last 12 months. | |
| **DD2** | The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report. | |
| **DD3** | The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation. | |
| **DD4** | The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function | |

| | | |
|---|---|---|
| **DD5** | The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group | |
| **DD6** | The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings | |

**APPENDIX 3**

# Emergency Preparedness, Resilience and Response Action Plan

**Updated:** September 2017

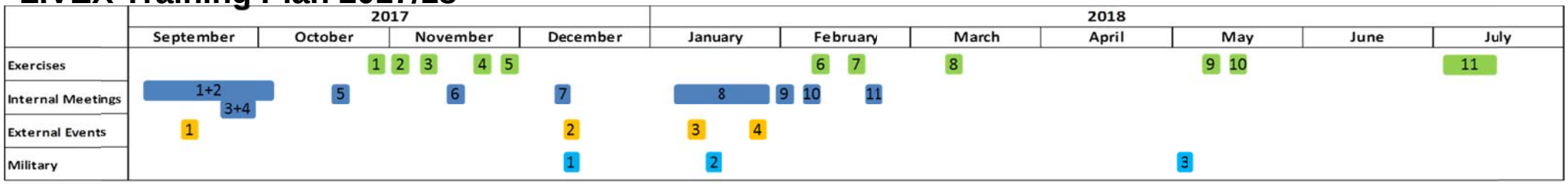
| Date Action Originally Identified | NHS England Core Standard Ref. No. | Core Standard / Action Description | Improvement required to achieve compliance (as of November 2016) | Deadline | September 2017 Update |
|---|---|---|---|---|---|
| Nov 2016 | 2 | Appointing an Emergency Preparedness and Resilience (EPRR) professional(s) who can demonstrate an understanding of EPRR principles | Since the retirement of the designated Trust EPRR officer in December 2015 the trust is developing a team of core individuals to lead on aspects of emergency planning<br><br>The new Senior patient flow manager, alongside DDM's in each ED, have core responsibilities to deliver against the Emergency planning standards.<br><br>Business continuity has also become an identified role within the senior operations team. | Feb 2017 | Complete.<br><br>Arrangements are in place for input from an individual with expert knowledge in emergency planning one day per week.<br><br>Responsibility for Business continuity has been incorporated into the job role of the Deputy Head of Operational Performance. |
| Nov 2016 | 5 & 6 | Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions | Whilst risk assessments are undertaken, work is underway to establish an improved /more comprehensive documentation of risk assessments.<br><br>These are to be piloted October 2016 with an ambition for all to be completed by December 2016. | April 2017 | Partially complete.<br><br>A process is in place for risk assessments (including impact analysis) to be made within directorates for Business Continuity incidents.<br><br>The Trust is yet to undertake formal risk assessments related to Major incidents, CBRN incidents or pandemic flu. |
| Nov 2016 | 8 | Effective arrangements are in | Substantive generic response | April | Partially complete. |

| | | | | | |
|---|---|---|---|---|---|
| | | place to respond to the risks the organisation is exposed to, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on resources & capacity. | arrangements are in place; However, arrangements will always need updating to reflect guidance, lessons, emerging &/or specific risks, etc, therefore on going need for review of suite of incident plans including Majax, Pandemic flu and escalation response to support patient flow | 2017 | Significant updates made to business continuity arrangements, CBRN policy and Major Incident Plans. Significant work still required to update Mass Casualty response plan and Pandemic Flu. |
| Nov 2016 | 34 | Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents | Training plan and training needs analysis for EPRR are in place; However, dependent upon the outcome and roll out for new documentation, it is anticipated additional training requirement will be required | On-going | Partially complete.<br><br>Significant extra members of staff trained in CBRN, business continuity and have attended sessions on managing in a mass casualty incident.<br><br>Training plans will continue to develop as part of LIVEX plan. |
| Nov 2016 | 36 | Demonstrate organisation wide (including on-call personnel) appropriate participation in multiagency exercises | There has been comparatively little opportunity to participate in multi-agency exercises in 2016 to date; whilst staff have participated there would be value in an improved /more comprehensive documentation of participation in multi-agency exercises and a sharing of good practice. | Dec 2016 | Complete.<br><br>Trust staff have attended multi-agency events in Hull, Bradford and Selby within the last 6 months. |
| Nov 2016 | 37 | Preparedness ensures all incident commanders maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation. Those on-call must meet identified competencies and key knowledge and skills for staff | Training plan and training needs analysis for EPRR are in place; All new personnel onto the on call rota receive support, shadowing and mentorship to undertake the role However, additional capacity needs to be identified to enable development and delivery of appropriate EPRR awareness training relevant to a range of staff. | January 2017 on-going thereafter | Partially complete.<br><br>Some 1st and 2nd oncall managers attending training in November 2017. Further in-house training to be arranged for early 2018 as part of LIVEX plan. |

| | | | | | |
|---|---|---|---|---|---|
| Nov 2016 | DD1 | Organisation have updated their pandemic influenza arrangements to reflect changes to the NHS and partner organisations, as well as lessons identified from the 2009/10 pandemic including through local debriefing | The plan has been revised to reflect currently available guidance and organisational chances; Individual directorates / services need to revise business continuity plans to address/implement plan requirements. | April 2017 | Complete.<br><br>The plan has been updated and continues to be refined as per the work of the Pandemic Flu Sub-group. |
| Nov 2016 | DD3 | Organisations have undertaken a pandemic influenza exercise or have one planned in the next six months | The Trust will hold an internal exercise or participate in a multi-organisation exercise since updating their local arrangements in the next six months | Nov 2016 onwards | Not complete.<br><br>The CBRN sub-group have ownership of this action |
| **September 2017 – Additional EPRR Actions** | | | | | |
| Sept 2017 | n/a | Deliver a live emergency exercise (LIVEX), simulating a mass casualty event | This process will be managed by the Major Incident Sub-Group and supported by the military team at Strensall Barracks. | July 2018 | |
| Sept 2017 | n/a | Complete all actions falling out of the Cyber-Attack de-brief of August 2017 | Process to be managed by the Emergency Planning Steering Group. | Dec 2018 | |
| Sept 2017 | n/a | Maintain “prepared” rating for CBRN preparedness achieved in July 2017 | Expand training and awareness in both main EDs | On-going | |
| Sept 2017 | n/a | Finalise all Business Continuity Plans for main 5 scenarios for York and Scarborough sites | | October 2017 | |
| Sept 2017 | n/a | Complete Internal Audit, and demonstrate improved position against March 2017 rating of “limited” assurance | | March 2018 | |

**APPENDIX 4**

# LIVEX Training Plan 2017/18




| | Table Tops / Exercises | Owner | Internal Meetings | Owner | External Events | Owner | Army Deadlines | Owner |
|---|---|---|---|---|---|---|---|---|
| **September** | | | 1 **TBC Sep 17:** Validate Clinical Action Cards. (YTH/SGH)<br>2 **Sep 17:** Clinical Directors Face to Face<br>3 **26 Sep 17:** Brief Snr Nursing Team on LIVEX18 training plan.<br>4 **26 Sep 17:** Brief Jim Taylor on LIVEX18 training plan. | DT/TW<br>MH<br>MH<br>MH | 1 **14 Sep 17:** Emergency Planning Conference | MH | | |
| **October** | 1 **TBC Oct 17:** Dry run through of Table Top Exercises by Internal MAJAX Team. | CW | 5 **18 Oct 17:** Present LIVEX18 training plan to Exec Board. | MH | | | | |
| **November** | 2 **1 Nov 17:** Gp 1 Table Top Exercise (SGH).<br>3 **8 Nov 17:** Gp 1 Table Top Exercise (YTH).<br>4 **22 Nov 17:** Gps 2/3 Table Top Exercises (YTH).<br>5 **29 Nov 17:** Gp 2/3 Table Top Exercises (SGH). | CW<br>CW<br>CW<br>CW | 6 **15 Nov 17:** MAJAX Team Table Top Exercise Coord Conf. | CW | | | | |
| **December** | | | 7 **TBC Dec 17:** Introduce Gp 4 to MAJAX Action Cards. | DT/TW | 2 **12 Dec 17:** NHS E Exercise. | MH | 1 **TBC Dec 17:** Reservist Manpower Required (SOR) to 2 Med Bde. | CW |
| **January** | | | 8 **TBC Jan 17:** Gp 4 write Action Cards (YTH/SGH).<br>9 **TBC Jan/Feb 17:** Validate Supporting Depts Action Cards (YTH/SGH). | CW<br>DT/TW | 3 **TBC Jan 17:** On Call Managers Leadership in Crisis Training Courses (SGH).<br>4 **TBC Jan 17:** On Call Managers Leadership in Crisis Training Courses (YTH). | CW<br>CW | 2 **TBC Jan 17:** Training Objectives to AMSTC. | CW |
| **February** | 6 **TBC Feb 17:** Gp 4 Table Top Exercise (SGH).<br>7 **TBC Feb 17:** Gp 4 Table Top Exercise (YTH). | CW<br>CW | 10 **TBC Feb 17:** On Call Managers walk through of MAJAX Plan (YTH).<br>11 **TBC Feb 17:** On Call Managers walk through of MAJAX Plan (SGH). | CW<br>CW | | | | |
| **March** | 8 **TBC Mar 17:** Gp 5 (Silver/Gold) Table Top Exercise. (YTH/SGH) | CW | | | | | | |
| **April** | | | | | | | | |
| **May** | 9 **TBC May 17:** Extended Table Top Exercise (YTH).<br>10 **TBC May 17:** Extended Table Top Exercise (SGH). | CW<br>CW | | | | | 3 **TBC May 17:** Real Life Support Requirement. | CW |
| **June** | | | | | | | | |
| **July** | 11 **TBC Jul 17:** LIVEX18 (YTH/SGH) | CW | | | | | | |

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Out of Hospital Care Board Strategy Report – September 2017

## Recommendation

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

## Current approval route of report

This draft has been written for the Board of Directors.

## Purpose of report

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

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

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

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

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

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

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

## Key points for discussion

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

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

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

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

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

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

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

There are no direct references to CQC outcomes.

Version number: 1

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

Executive sponsor: Wendy Scott, Chief Operating Officer

Date: September 2017

## 1. Developments

### 1.1 Stranded Patient Review

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

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

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

The recommendations from the review are:

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

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

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

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

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

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

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

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

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

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

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

### 1.3 Community Inpatient Bed Review

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

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

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

The key findings from the audit are:

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

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

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

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

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

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

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

### 1.4 Taking a co-production approach

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

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

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

## 2. Conclusion

The next steps for the developments described are:

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

## 3. Recommendation

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

## 4. Appendices

Appendix 1: Review of Stranded Patients in York Hospital August 2017
Appendix 2: Self-Assessment against High Impact Changes to Reduce DToC
Appendix 3: Overview of the Complex Discharge Programme September 2017
Appendix 4: Update Report on Reconfiguration of Archways September 2017

**Appendix 1**

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

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

## Introduction

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

## Methodology

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

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

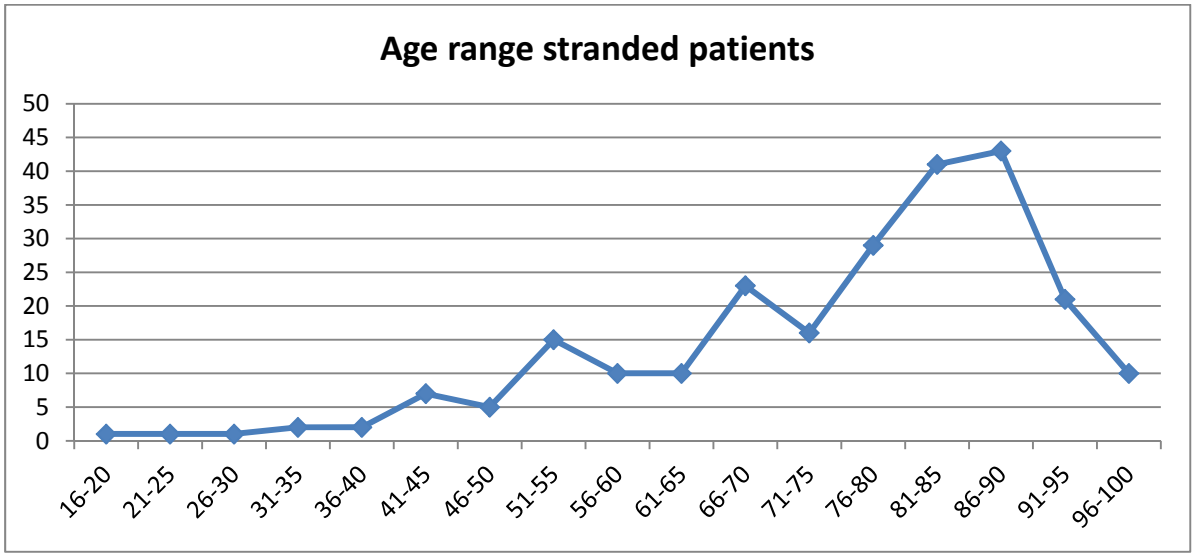
**Findings**

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

**Demographics**

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

Chart 1: Age range



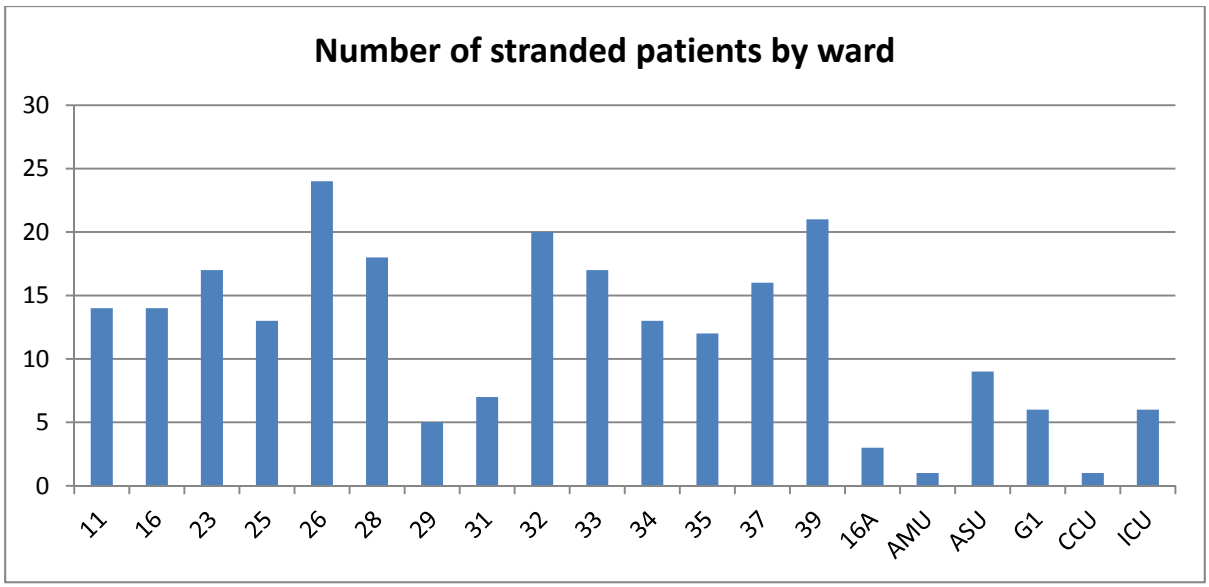

**Specialities:** There were stranded patients in all of the following specialties:

Table 1: Numbers of stranded patients per specialty

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

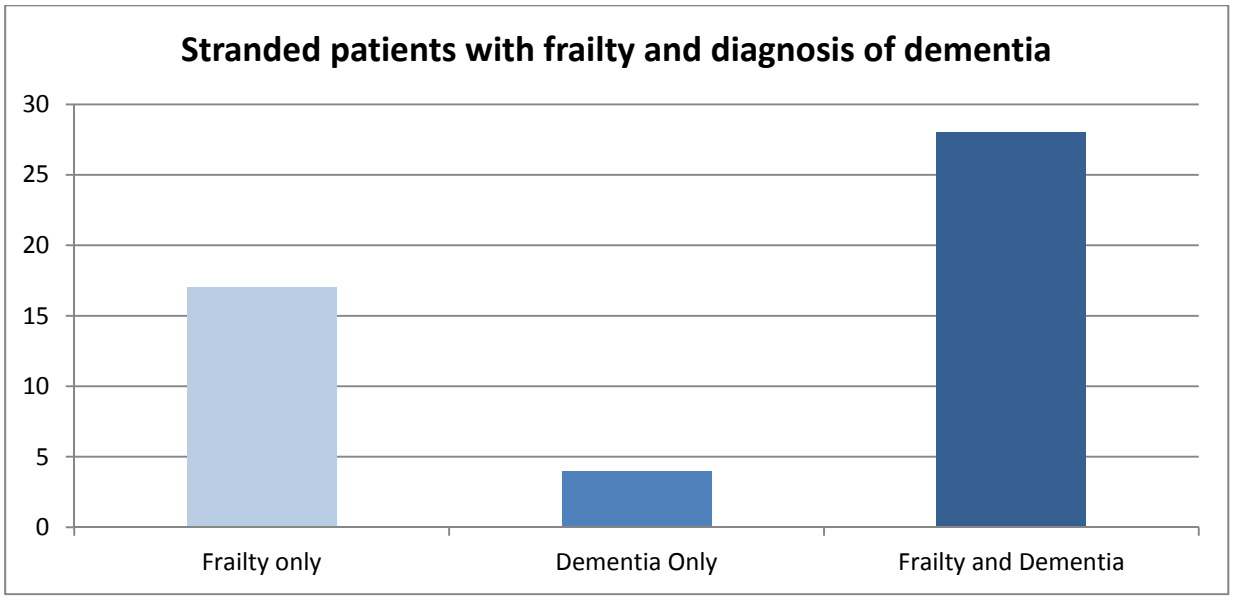
**Location:** The following chart shows the number of stranded patients per ward (appendix 3 for ward descriptors)

Chart 2: Number of stranded patients by ward



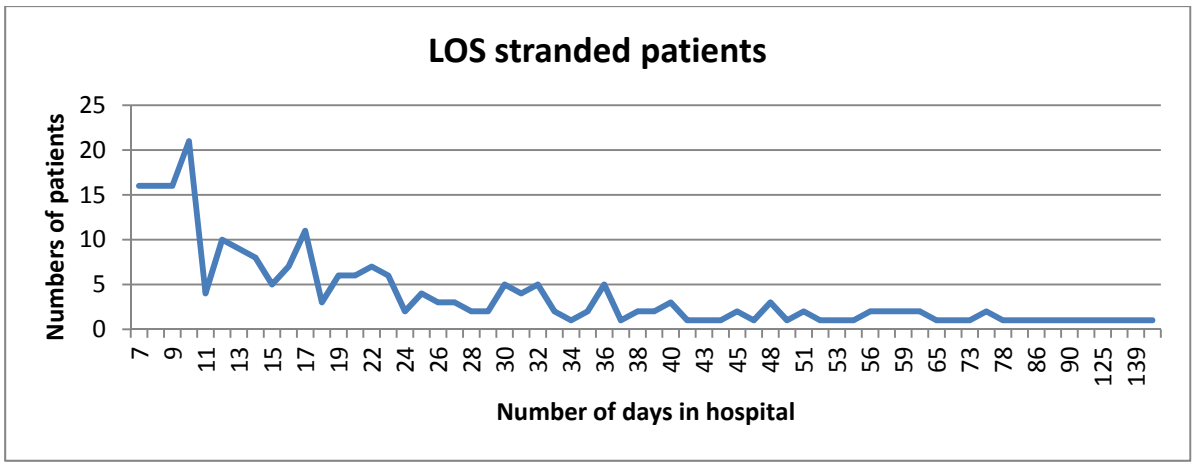

**Frailty and diagnosis of dementia:** Patients' frailty status and diagnosis of dementia were captured from the electronic Whiteboard system; 19% were frail and 14% had a diagnosis of dementia. 28 of the patients with dementia were also frail (88%).

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



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

Chart 4: Length of Stay Stranded Patients




**Analysis**

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

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

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

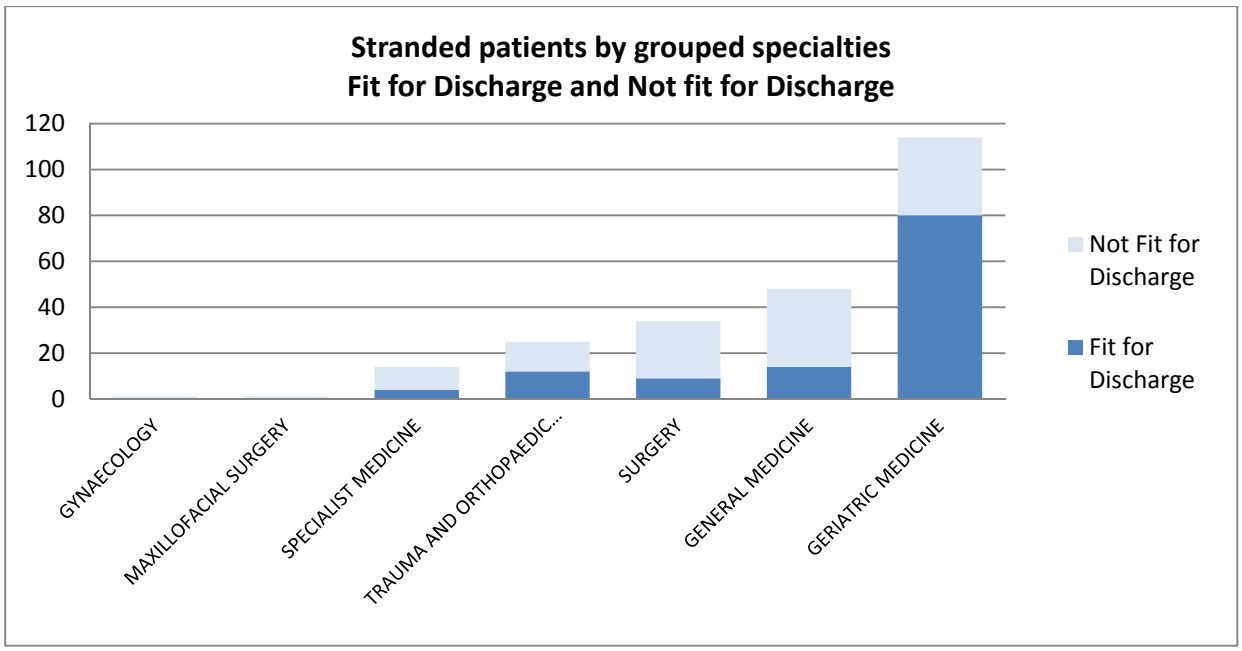
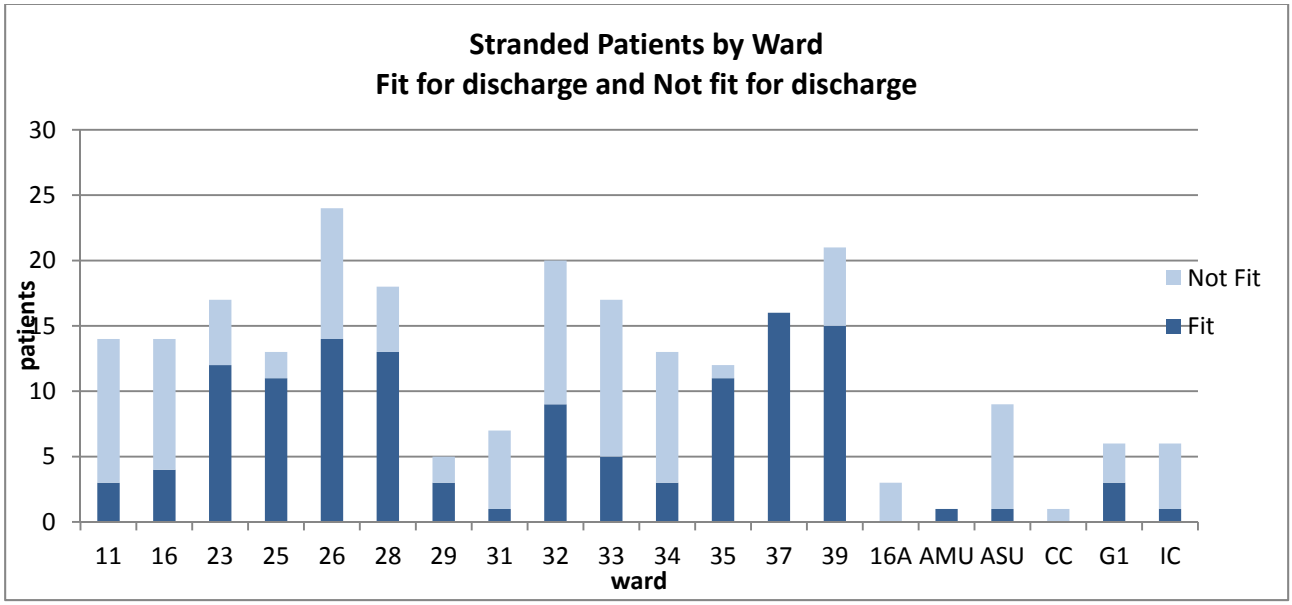


Chart 6: Fit for Discharge / Not fit for Discharge by Ward




**Reasons for being in hospital:**

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

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

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

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

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

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

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

**B: Grouped by themes**

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

Table 4: MDT

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

Table 5: Waiting for assessments

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

Table 6: Waiting for a bedded unit

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

Table 7: Family and Patient

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

Table 8: Continuing Health Care

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

**C: Health and Social Care**

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

Table 9: Services provided by Health

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

Table 10: Services provided by Social Services

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

Table 11: Services provided by Health or Social Services

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

**Conclusions:**

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

**Recommendations:**

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

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

## Appendices

### Appendix 1:

reviewing-stranded-patients-in-hospital-R

### Appendix 2:

Codes for stranded patient review Augus

### Appendix 3:

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

**Appendix 4:**

Specialties Grouped

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

## Appendix 2 - Executive Summary

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

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

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

## Introduction

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

## Programme Overview

### Integrated Complex Discharge Planning Project

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

### Community Bed Review

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

### Integrated Intermediate Care and Reablement

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

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

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

### Improving Discharge into Care Settings

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

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

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

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

## Introduction

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

## Performance Information

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

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

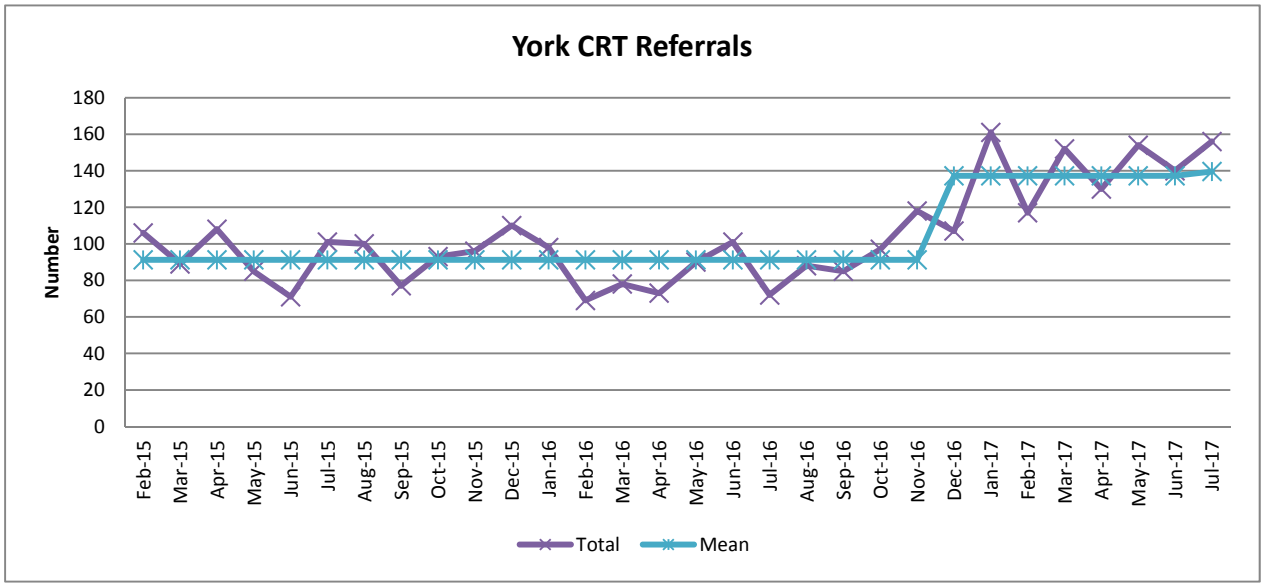



Chart 1 demonstrates that the expansion has continued on and above plan. The team were expected to increase the average monthly referrals from 91 to 120. The team are actually supporting an average of 139 referrals per month. Over the seven month (January – July) this would represent an additional 133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

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

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

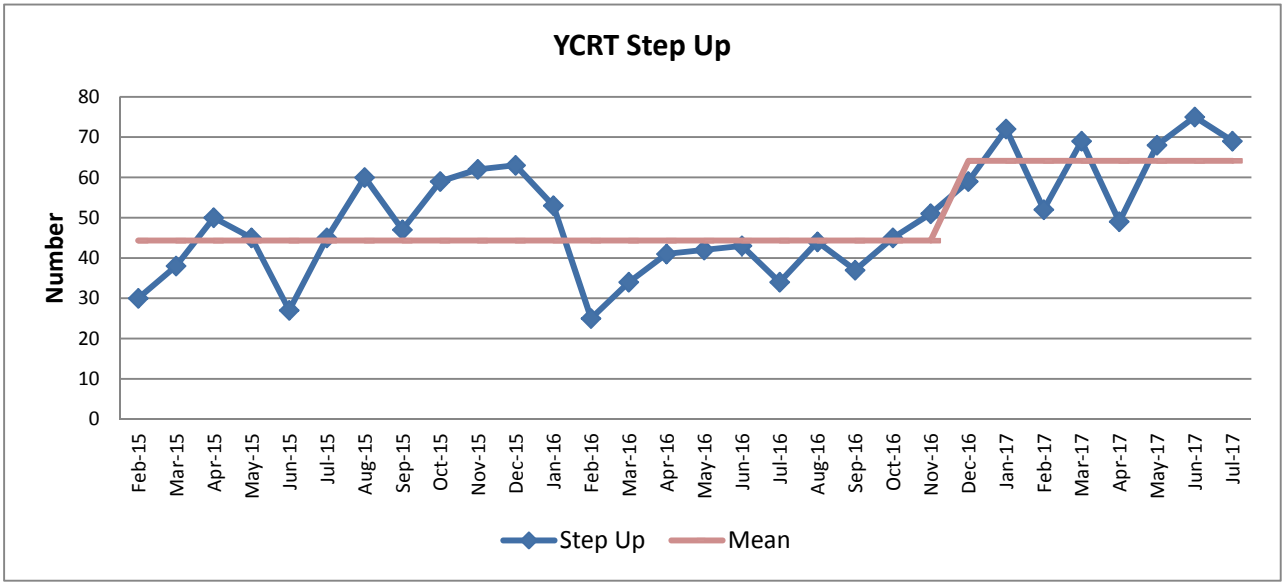



Chart 2 demonstrates that an increased number of patients are being supported in their own homes since the reconfiguration and as a result have not required an admission to hospital or a community unit. The addition of the roles of the advanced clinical practitioner and the outreach pharmacist has also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

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

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

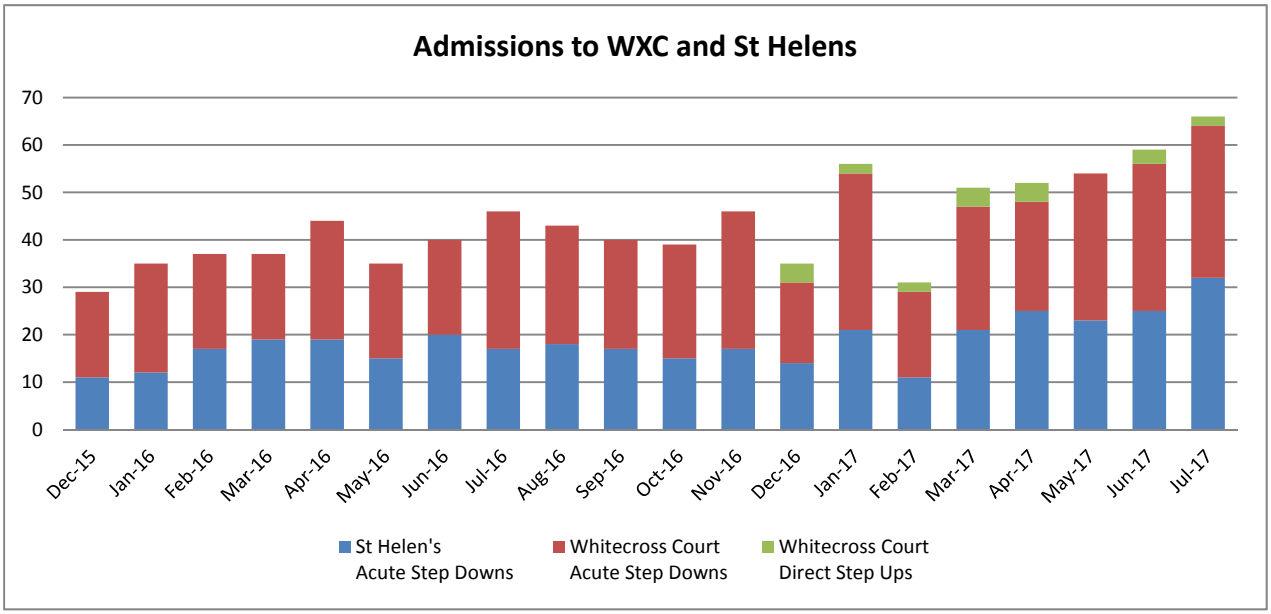



Chart 3 demonstrates that the same number of step up patients who were previously stepped up to Archways (average 3 per month) have been accommodated by the change of admission criteria to White Cross Court.

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

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

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

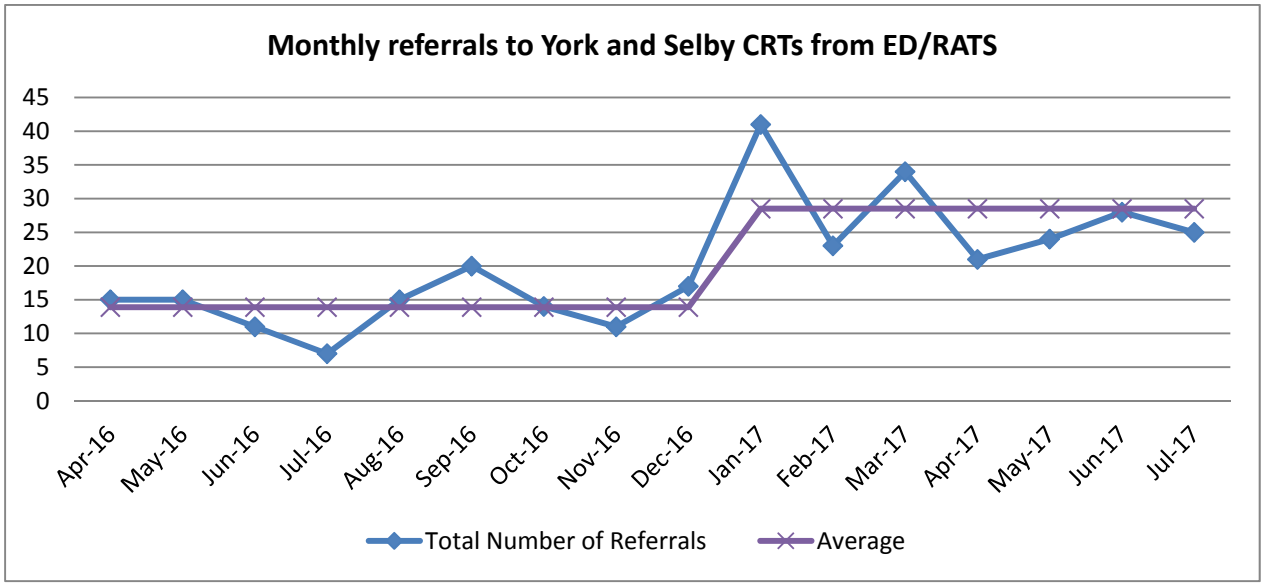



Chart 4 demonstrates a sustained increase in the number of referrals from the Emergency Department directly into Community Response Teams, avoiding the need for an admission to an acute or community hospital bed.

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

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

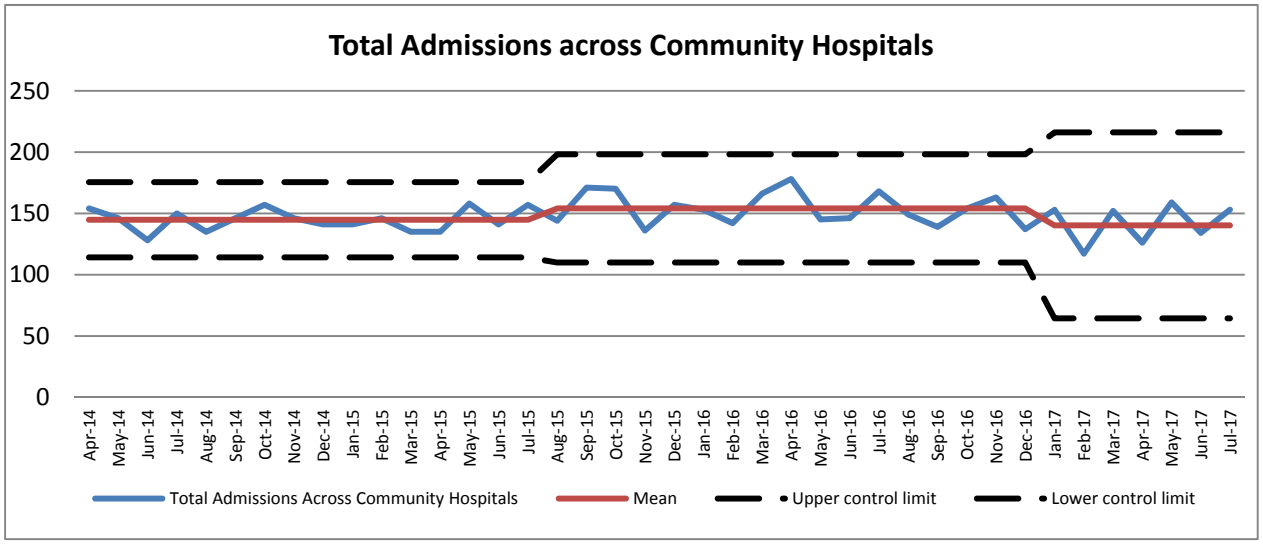



Chart 5 demonstrates that admissions have reduced as we would have expected (with 22 fewer beds and the increased referrals to the Community Response Team). However, the reduction (14 fewer admissions on average) has been smaller than previous activity levels at Archways (29 admission per month on average)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

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

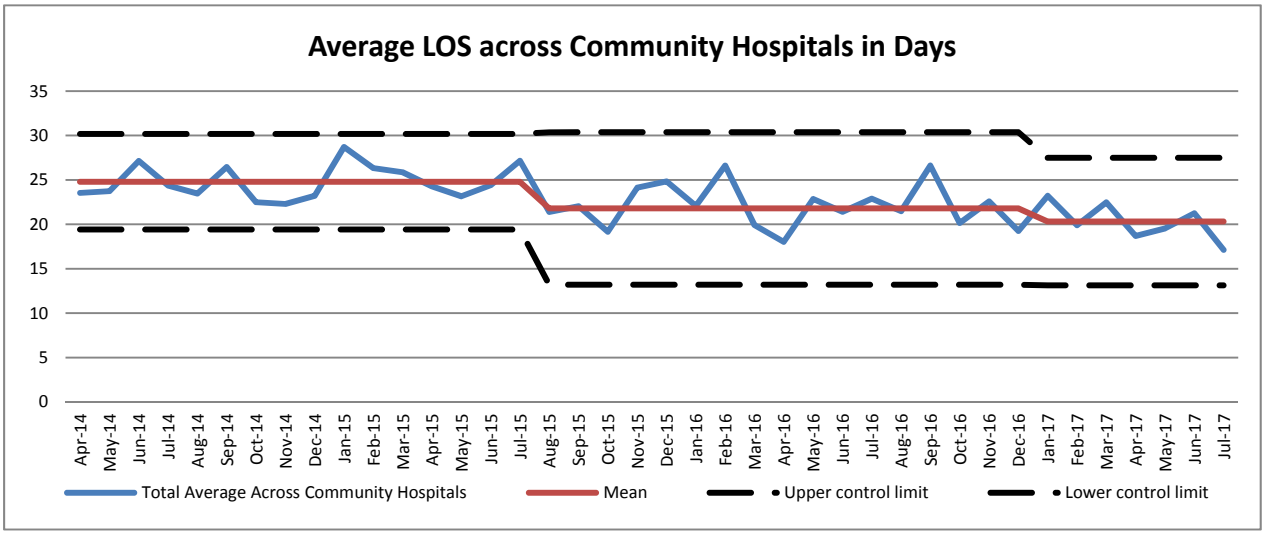



Chart 6 demonstrates that the average length of stay has reduced by 1.5 days following the reconfiguration and the combination of Discharge Liaison, the Acute Clinical Practitioners and the improved access to the Community Response Team. This reduction in length of stay is supporting the increased throughput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

## Conclusion

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

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

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

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

**Author: Steve Reed, Head of Strategy for Out of Hospital Care**
**Owner: Wendy Scott, Chief Operating Officer**
**Date: September 2017**

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Quality and Safety Committee Minutes – 19.09.17

## Recommendation

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

## Current approval route of report

For Quality & Safety Committee

## Purpose of report

The Board is asked to note the items discussed at the Quality and Safety Committee, the assurance taken from these discussions and the key items of interest that have been highlighted for the attention of the Board.

## Key points for discussion

The purpose of the Committee is to receive assurance and to provide challenge and scrutiny around matters of patient safety, patient experience and clinical effectiveness within the Chief Nurse and Medical Director's areas of responsibility. Each month a small number of items will be selected for escalation to the Board of Directors for information and/or debate. The agenda follows an established structure to include:

Review of Chief Nurse and Medical Directors Risk Registers.

Patient Safety items for this month

- Nurse Staffing
- Serious Incidents and Never Events
- Quarterly Falls Report
- Quarterly Pressure Ulcer Report

- Maternity Serious Incident Report

Clinical Effectiveness items for this month

- Quarterly Mortality Report
- Annual Serious Hazards of Transfusion (SHOT) reports
- Antibiotic Prescribing Audit

Patient Experience items for this month

- Complaints and Compliments
- Friends and Family

This month the Committee has selected the following for the particular attention of the Board.

- BG to highlight nurse staffing position
- JA to highlight alignment of external initiatives
- JT to feedback progress on the mortality process
- JT to update on Antibiotic audit and to highlight EPMA rollout date

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

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

Version number: 1

Author: Liz Jackson, Patient Safety Project Support Officer

Executive sponsor: Jennie Adams, Non-executive Director

Date: September 2017

York Teaching Hospital
NHS Foundation Trust

# Quality & Safety Committee Minutes – 19 September 2017

**Attendance:** Jennie Adams, Libby Raper, James Taylor, Diane Palmer, Lynda Provins, Helen Hey and Liz Jackson

## Apologies for Absence: Beverley Geary

## Minutes of the meeting held on the 21 August 2017

The notes from the meeting held on the 21 August were approved as a true and accurate record.

## Matters arising from the minutes

Item 8 – JT confirmed that the new job plans for the Physicians in Scarborough commenced in September. ES has advised that there is some feeling of improvement, especially on weekdays. There remains a voluntary aspect to the rota for weekends. There have been two instances on weekends when there has only been one consultant physician available and the new plan was to move to two. There has been an element of compromise in the new job plans, which has led to not seeing as many improvements as hoped for, however there will be a further review once the current change has embedded.

Item 40 – The Committee noted that the issue of out of hour single registrar physician on-call was discussed in the Patient Safety Group minutes provided in the papers. JT explained that there have been some improvements in the time to senior review on both sites. However there remains the same number or less junior doctors available and the acuity of patients is increasing. Enhancing the out of hours cover remains a challenge and focused work is being undertaken by Mark Hindmarsh to identify options. Escalation of the deteriorating patient is a concern; the escalation policy has been reviewed and consideration given to enhancing the outreach team. JT will meet with Mike Hindmarsh and feedback to the committee on proposed actions. The MD risk register will also be amended to reflect this specific challenge around patient safety.
**Action: JT to report back on outcome of MH work and amend Risk Register of MD for next meeting.**

Item 36 – The Committee agreed to review the Patient Consent audit report in January as FJ was unable to provide this data at this time. JT advised that the previous audit had limited assurance but many of the concerns were relatively minor e.g. patients were not being given a copy of the completed consent form, which is not a high concern. The

Committee need to be sure that this outstanding work around a limited assurance audit is part of Fiona Jamison's teams work plan.
**Action: LP to query with FJ that limited assurance audits in her remit are followed up and reported via the committee.**

Item 37 – The Committee highlighted that the OOH remote radiology service is now up and running at SGH although there remains a backlog on routine reporting. It was believed that the capital project work is still going ahead and LP confirmed that the Finance and Performance Committee have asked for an updated capital report for review which will be helpful in confirming this is the case.

Item 42 – The Patient Safety Group minutes were included in the pack; the Committee asked if items for escalation to the Q&S committee could be provided at the end of the minutes. JA and LR will arrange a physical presence at the meeting and DP agreed to send the dates to them. The Clinical Effectiveness minutes are not yet being seen routinely by the Committee and LP agreed to chase these for the next meeting. HH confirmed that this Group is developing in maturity and that the minutes sit with FJs team.
**Actions: DP to send PSG dates to LR and JA.**
**LP to chase CEG minutes and request items for escalation to committee be highlighted in them.**

Item 43 – JT and JA have reviewed another Trust's approach to gaining assurance around clinical effectiveness. Glenn Miller has also looked in to this and advised that there is a wealth of available material from which the Committee could gain assurance. The Committee queried the Getting it Right First Time initiative, JT advised that this is a national Quality Improvement Project, which originally started with Orthopaedics, then Surgery and now includes Medicine. There is a national lead for each specialty who will visit each Trust in England to work through the framework. Glenn Miller is the Trust Lead for Surgery and Donald Richardson is the Trust lead for Medicine. The project is reported through the Carter Steering Group. JT is liaising with Gordon Cooney regarding this project and the committee asked for the Medical Directors report to capture significant findings within GIRFT relating to quality and safety in his monthly report when appropriate – given that there was no other formal reporting structure in place.

The Committee expressed a view that a plethora of Quality Improvement initiatives are ongoing at any one time without any real oversight, coordination or alignment. HH explained that within nursing work has been undertaken to align operational work for the wards and amalgamate the externally driven initiatives. External initiatives often needed to be interpreted locally for best effect. In terms of the MDs portfolio , DP advised that this issue has also been raised at Patient Safety Group. The new Patient Safety Strategy is overdue and DP is currently in discussions with JT regarding an up to date version which may usefully help to bring a number of initiatives under one umbrella.
**Actions: JT to feedback GIRFT findings to committee.**

**JT to develop with GM a means of providing the committee with assurance around clinical effectiveness.**

**Assurance: Further assurance on clinical effectiveness has been requested**

Item 44 and Item 46 – A paper was submitted to the Group to provide assurance around Maternity SIs.

Item 47 – The Committee queried if the Never Events Report was complete, JT and DP confirmed that comments have been submitted for the first draft and an amended version is awaited. The committee wished to see a final version at the October meeting.
**Action: JT to provide committee with Never Event Report in October**

## Other matters arising

The Committee queried the increase in prevalence for pressure ulcers in community and CAUTIs on the Scarborough site that were identified in the August integrated dashboard. DP explained that the increase in pressure ulcers matches incident reporting and the CAUTI prevalence does rise from time to time and confirmed that at present neither of these increases were significant enough to be of concern.

The Committee noted that the stroke patients being scanned within one hour of arrival had come back in to line, however queried if there were any operational issues in the stroke service leading to the number of TIA patients being assessed in 24 hours dropping. JT did not think that anything had been escalated however vascular colleagues have experienced issues accessing theatre for surgical interventions due to lack of beds.
**Action: Committee will monitor stroke performance data**

## Risk Register for the Medical Director and Chief Nurse

The Committee noted that there had been no changes made to either the Chief Nurse or Medical Director Risk Registers.

CN12 – The risk regarding NIV has decreased slightly from 15 to 12 for the summer period. HH confirmed that this will be closely monitored.

MD2 – The Committee queried if this risk around Medical Staffing was too general and if the physician registrar on call rota should be a separate risk. JT agreed to re-write MD2 to be more specific about this challenge within acute and urgent care.

The Committee noted that the Safeguarding Adults Strategy was approved at the Safeguarding Adults Governance Group and asked that this be brought to the Committee.
**Action – LP to add to the agenda.**

## Patient Safety

### Nurse Staffing
(CRR Ref: CN2, CN11, CN12, CN13 & MD9)

HH advised that 70 newly qualified staff will start this autumn. Capacity has been temporarily removed in challenged areas and this position has been more or less maintained, with some beds being reopened on the York elderly ward at the weekend. The closing of beds has been welcomed by staff however; concerns around staffing levels and redeployment continue to be encountered.. Workshops are being looked into understand the views of staff and improve their understanding of the situation and the safety implications. The decisions can be communicated to staff in a different way and HH advised that staff in Salford have the view that they work for the Trust and not a particular ward. Challenges will continue with Matrons and Assistant Directors of Nursing reviewing staffing daily.

The Committee reviewed the unfilled vacancy data included in the report and noted that there was little improvement on the Scarborough site in prospect even post the new intake. With winter approaching this was a significant concern in terms of patient safety.
The Committee queried the new use of terms “trained” and “untrained” over “registered” and “unregistered” and whether their use reflects an accurate view of staffing - as associate practitioner roles are not registered nurses. JA noted that this topic was receiving considerable attention from NHSE and the RCN. HH advised that the associate practitioners are in place to support the registered nurses and therefore the numbers of band five nurses can be reduced. The Committee agreed that more granularity is necessary for clarity and assurance and this breakdown would also be useful for the Workforce Committee. HH agreed that staffing data could be looked at more dynamically in future.
**Action: HH to discuss with BG possible solutions to issue of new role classification.**

LR queried the ward understanding of enhanced supervision as this is aligned to the Carter work. HH advised that a decision tool is being piloted in the Elderly Medicine Directorate, which is being overseen by Ginni Russell.

### Serious Incidents and Never Events
(CRR Ref: MD8)

JA expressed the view that, despite some work on this area by Adrian Evans, there appeared to continue to be an issue around the timely reporting and quality of SI investigations – and assurance around learning and actions from them. This view was supported by the minuted discussions around the SI process at the July Patient Safety Group. The request to see confirmation that Duty of Candour had been fulfilled has not been met. DP advised that the reports are a summary and a selection are presented to the Committee which can affect the dates. The SI Committee continue to undertake a lot of the work and further training is needed for investigators in order to get more useful reports. A

lot of discussion takes place at the Committee to ensure that they gain assurance from the reports.
JT stated that this was a work in progress and needed further refinement.
JA was not assured by the current arrangements and wished to explore other avenues to provide the assurance that the committee needs to see.
**Action: JA and JT to explore ways to improve committee assurance on this issue**

**Assurance: Further assurance requested around SI process**

## Quarterly Falls Report

The overall number of falls are reducing however there will always be a certain number. Serious harm continues to be measured and still demonstrates an improvement. The safety thermometer prevalence remains below the national data line.

DP queried if the Committee would like to continue receiving the report and the Committee confirmed that a lot of assurance is gained. The Committee reviewed learning from falls, noting that lack of COMFE rounds has become less of a factor in falls investigations and queried if risk assessment training was taking place. DP advised that risk assessment training is on-going and currently falls sensor training is a major focus. NICE recommends that using sensors in isolation does not reduce incidences of falls and a multifaceted approach should be taken. DP felt that falls sensors gave false assurance. They may be of some benefit but not used in isolation.

**Assurance: The Committee took assurance from the positive data in relation to inpatient falls.**

## Quarterly Pressure Ulcer Report

There has been an increase in reporting, which DP was confident would settle. Category 3 and 4 pressure ulcers are reviewed in further detail as Sis. The data identifies where improvements are needed, community remains a challenge due to multi agency care provision. Safety Thermometer had seen a small increase however the data remains below the national data line.

DP explained that the prevalence data has mirrored the incident data for some time and there is a proposal to discontinue the prevalence data, which has not been a national requirement for 18 months. HH added that the ward sisters undertake a lot of audit and they do not use the point prevalence data. The Committee raised some concern that this would lose an element of benchmarking. DP advised that attendance at national conferences enables the view of the national picture. The Committee agreed to have further discussion outside of the meeting.
**Action: For further discussion outside of the meeting.**

## Maternity Serious Incident Report

(AL Items: 44 & 46)

The Committee reviewed the eight maternity SIs reported between April and August. Four have concluded that there were no lapses in care, with one awaiting post mortem report, and three are not yet completed. Liz Ross, Adrian Evans and Nicola Dean have worked closely together on the investigations and report no themes have been identified to date. The Trust is an outlier for neonatal deaths (EMBRACE report June 2017) and currently these are reported as SIs (along with maternal deaths and intrapartum stillbirths). There is a proposal to change the process and conduct a review within 72 hours of any incident, prior to the declaration of an SI. This would align the Trust to others in the region. The Committee raised concern that, considering the Trust is an outlier for Neonatal deaths, and that these cases have to be reported and reviewed externally to comply with the Each Baby Counts recommendations that changing the classification would make little practical difference to the team. However it would mean they were not automatically seen by the Q&S committee. HH explained that the 72 hour review would continue to identify learning and lapses in care. DP explained that a different process could be followed for investigating neonatal deaths, such as that used for falls and pressure ulcers. The Committee agreed that this might make a good template and requested a proposal that would meet the needs of the department, the committee and external bodies.

The Committee queried the Consultant cover on labour ward data included in the integrated dashboard (p.34) as this is blank for August 2017.
**Action: Chief Nurse to liaise with Maternity team to find acceptable way to proceed with incident reporting to the Committee. The outcomes of the four remaining SI reports to be reported to the committee in due course.**

**Assurance: The Committee were assured by the thorough investigations ongoing into these events**

# Clinical Effectiveness

## Quarterly Mortality Report

The Committee were pleased to see that more structured judgement case note reviews (SJCRs) are being undertaken. JT added that with the involvement of the Mortality Steering Group the work on the new process is starting to take shape and advised that the term “avoidable death” is no longer being used. The SJCRs are promoting organisational learning and identifying where improvements are needed with the individual recommendations being debated robustly at Clinical Governance Meetings. 90 Consultants have now received the Mortality review training; however time constraints remain an issue. The Committee were pleased with the format of the quarterly report and noted some concern with the finding that a significant percentage of reviews could not find documentation of time of initial clerking or of senior review of these patients.

**Assurance: The Committee were assured by the progress being made in implementation of the new process.**

## Annual Serious Hazards of Transfusion (SHOT) reports

DP explained that these reports were the national and local annual reports for serious hazards of transfusion. There have been 3000 incidents nationally and 16 locally. These reports will go to Executive Board and Governance Committees for discussion. The Committee asked that highlights of the report are provided following the discussion at these Groups. DP advised that the reports were included to assure the Committee that we do report these instances and the Trust is neither exemplar or of concern in this area.

## Antibiotic Prescribing Audit

The Committee noted that compliance with antibiotic prescribing has slipped in General Medicine, Orthopaedics and Obstetrics and Gynaecology. JA asked about any plans to highlight this deterioration to clinicians. JT noted this concern and agreed to raise the issue at Executive Board and with the Clinical Directors.

HH added that the roll out of EPMA will commence on the 17th October on the York site and the task alerts on the system will aid antibiotic compliance.
**Action: JT to bring slippage in AB prescribing audit results to attention of Exec Board and CDs**

## Patient Experience

## Complaints and Compliments

HH highlighted to the Committee that the number of complaints may seem higher than usual and explained that this may be due to the processes within the PALs Team. The Committee commended the number of compliments received by General Surgery and Urology and JT agreed to feed back to the Directorate.

## Friends and Family

The Committee noted that the inpatient family and friends response rate remains below the national average. HH advised that the Matrons are working to improve this, with focused work taking place on the Scarborough site.

The Safeguarding report, previously received by the Committee, had highlighted the lack of paediatric facilities in the Emergency Departments. HH explained that the report included an action plan, however, significant gaps in the Safeguarding team has led to a delay in the actions being completed. DP advised that following a meeting with the department, paediatric facilitates were not on the directorates agenda as this would require an internal or external rebuild.
**Action: JA to feedback to EE committee query on an interim solution to child facilities at York ED.**

## Additional Items

### Finance Recovery Plan

The Committee queried the effect of removal of the premium for bank staff, HH advised that there would be an element of risk, however was confident that the shifts would continue to be filled. The senior nursing team have signed up to the items in the plan. The Committee were concerned that the recommendations around study leave and annual leave would be demoralising for staff. JT highlighted that carrying annual leave over to the next year increases the difficulty in covering additional capacity. Study leave has always been discretionary and the changes will not affect revalidation. Replacement equipment will progress as planned.

The Financial Recovery Plan will be reviewed in further detail at Executive Board and executive time out but key Q&S executives did not express any specific concerns around any significant risks to patient safety within the plan.

### Board Assurance Framework

The Committee highlighted that the amber risks associated with the Committee all included information in the Gap in control/assurance section of the framework with the exception of risk 1.6. This had been previously discussed and gaps had been shared with LP offline and the BAF will be amended to reflect this.
**Action LP to amend BAF**

### Claims

The Committee noted the inclusion of the claims information and queried where this is reviewed. JT and DP confirmed that this is discussed at Directorate Governance Meetings and has occasionally been included in nevermore if it is of trust wide interest. JA queried if a more thematic Trust wide analysis might be productive – in line with a suggestion from the key note speaker at the patient safety conference.

### Duty of Candour

The committee queried the absence of a report on Duty of candour. JT was unsure about the nature of the report but hoped that DoC data will be included in the integrated dashboard in future.
**Action: JT to speak to FJ.**

### Time and Date of the next meeting

**Next meeting of the Quality and Safety Committee: 17 October 2017, 1.30pm – 3.30pm, Boardroom, York Hospital**

**Quality & Safety Committee – Action Plan – September 2017**

| No. | Month | Action | Responsible Officer | Due date | Completed |
|---|---|---|---|---|---|
| 8 | Jun 16 | Outcome of discussions with CD for Medicine and action plan (Re: Scarborough Physicians time out 27.09.16) | Medical Director | Nov 16<br>Jan 17<br>Monthly updates | |
| 36 | Mar 17 | Foundation Trust Secretary to liaise with Deputy Director of Healthcare Governance for the Patient Consent Audit report<br><br>LP to query with FJ that audit report from internal audit is being followed up. | Foundation Trust Secretary<br><br>Foundation Trust Secretary | May 17, Jun 17, Jul 17, Aug 17, Sept 17, Jan 18<br><br>Oct 17 | |
| 37 | Mar 17 | The Committee requested an update on the actions around the Radiology Risk | Medical Director | Sept 17<br>On-going | |
| 40 | May 17 | Lack of training middle grades in Acute Medicine – JT to report back on the outcome of MH work and amend his risk register | Medical Director | Aug 17<br>Oct 17 | |
| 42 | Jun 17 | Foundation Trust Secretary to liaise with chairs of the Patient Safety Group and Clinical Effectiveness Group minutes to highlight items for escalation to Committee | Foundation Trust Secretary | Sept 17<br>Oct 17 | |
| 43 | Jul 17 | JT and DP to reflect on and develop additional assurance around clinical effectiveness | Medical Director and Deputy Director for Patient Safety | Aug 17<br>Oct 17 | |
| 44 | Jul 17 | BG to share outcome of remaining investigations into recent maternity SIs. LR to include detail in bi annual maternity report. | Chief Nurse and Foundation Trust Secretary | Oct 17 | |
| 45 | Jul 17 | Mike Sweet as Chair of the E&E committee to feedback complaints | Chair | Aug 17<br>Nov 17 | |

| | | | | | |
|---|---|---|---|---|---|
| | | themes around signage in SGH outpatients and York Ambulatory Care areas to the E&E team. Also Safeguarding report on children's ED facilities at York JA to feedback. | | | |
| 47 | Aug 17 | Never Events Report | Medical Director | Sept 17<br>Oct 17 | |
| 48 | Sept 17 | Maternity SI investigation process proposal | Chief Nurse Team | Oct 17 | |
| 49 | Sept 17 | DP to send PSG dates to LR and JA. | Dep Director of Patient Safety | Oct 17 | |
| 50 | Sept 17 | JT to feedback GIRFT findings to committee. JT to develop with GM a means of providing the committee with assurance around clinical effectiveness. | Medical Director | Nov 17 | |
| 51 | Sept 17 | Committee will monitor stroke performance data | Chair | Oct 17 | |
| 52 | Sept 17 | LP to add Safeguarding Adults Strategy to the agenda. | Foundation Trust Secretary | Oct 17 | |
| 53 | Sept 17 | HH to discuss trained and untrained categorisation with BG possible solutions to issue of new role classification. | Chief Nurse Team | Oct 17 | |
| 54 | Sept 17 | JA and JT to explore ways to improve committee assurance on this issue | Chair Medical Director | Oct 17 | |
| 55 | Sept 17 | Provision of pressure ulcer point prevalence data for further discussion outside of the meeting. | Chair - Dep Director of Patient Safety | Oct 17 | |
| 56 | Sept 17 | Chief Nurse to liaise with Maternity team to find acceptable way to proceed with incident reporting to the Committee. The outcomes of the four remaining SI reports to be reported to the committee in due course. | Chief Nurse | Oct 17 | |
| 57 | Sept 17 | JT to bring slippage in antibiotic prescribing audit results to attention of Exec Board and CDs | Medical Director | Oct 17 | |
| 58 | Sept | JA to feedback to EE committee | Chair | Oct 17 | |

| | | | | | |
|---|---|---|---|---|---|
| | 17 | query on an interim solution to child facilities at York ED | | | |
| 59 | Sept 17 | LP to amend BAF | FT Secretary | Oct 17 | |
| 60 | Sept 17 | JT to speak to FJ regarding a Duty of Candour Review | Medical Director | Oct 17 | |

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# Patient Safety and Quality Performance Report

## September 2017

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

# Patient Safety & Quality Performance Report
## Chapter Index

| Chapter | Sub-Section |
|---|---|
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| | Never Events |
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| | Maternity Dashboards |
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| | Quality and Safety Miscellaneous |

# Quality and Safety Summary: Trust

| Patient Experience | Target/ Threshold 2017/18 | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Litigation - Clinical Claims Settled | - | - | 5 | 1 | 8 | 2 | 2 | 3 | 5 | 1 | 10 | 7 | 6 | 2 |
| Complaints | - | - | 44 | 36 | 37 | 33 | 43 | 32 | 38 | 34 | 47 | 36 | 51 | 45 |

| Care of the Deteriorating Patient | Target/ Threshold 2017/18 | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 hour Post Take - York | 85% | 85% | 82% | 82% | 85% | 87% | 84% | 85% | 81% | 82% | 81% | 82% | 84% | 80% |
| 12 hour Post Take - Scarborough | 80% | 80% | 52% | 53% | 61% | 60% | 69% | 62% | 67% | 60% | 54% | 68% | 69% | 64% |
| 14 hour Post Take - York | 82% | Q1 82%<br>Q2 82%<br>Q3 85%<br>Q4 90% | 89% | 89% | 91% | 93% | 89% | 91% | 89% | 90% | 91% | 91% | 91% | 90% |
| 14 hour Post Take - Scarborough | 60% | Q1 52%<br>Q2 60%<br>Q3 70%<br>Q4 80% | 61% | 66% | 72% | 70% | 80% | 72% | 75% | 72% | 63% | 79% | 80% | 74% |
| Acute Admissions seen within 4 hours | 80% | 80% | 74% | 77% | 81% | 88% | 87% | 92% | 87% | 85% | 83% | 86% | 93% | 83% |
| NEWS within 1 hour of prescribed time | 90% | 90% | 88.1% | 87.8% | 87.9% | 87.1% | 86.5% | 87.1% | 87.9% | 89.4% | 87.2% | 89.2% | 89.0% | 89.5% |
| All Elective patients to have an Expected Discharge Date (EDD) recorded within 24 hours of admission | 93% | 93% | 88% | 88% | 88% | 85% | 87% | 89% | 87% | 87% | 86% | 86% | 84% | 88% |

| Measures of Harm | Target/ Threshold 2017/18 | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Serious Incidents | - | - | 12 | 9 | 18 | 14 | 28 | 18 | 10 | 9 | 20 | 19 | 14 | 12 |
| Incidents Reported | - | - | 1064 | 1170 | 1204 | 1226 | 1402 | 1262 | 1380 | 1234 | 1194 | 1240 | 1324 | 1185 |
| Incidents Awaiting Sign Off | - | - | 813 | 752 | 670 | 768 | 963 | 1059 | 1129 | 828 | 698 | 746 | 868 | 832 |
| Patient Falls | - | - | 194 | 226 | 212 | 260 | 271 | 216 | 222 | 225 | 228 | 230 | 218 | 217 |
| Pressure Ulcers - Newly Developed | - | - | 93 | 121 | 125 | 115 | 140 | 111 | 137 | 131 | 135 | 110 | 124 | 109 |
| Pressure Ulcers - Transferred into our care | - | - | 63 | 64 | 65 | 70 | 94 | 64 | 88 | 74 | 66 | 76 | 77 | 56 |
| Degree of harm: serious or death | - | - | 8 | 8 | 5 | 5 | 9 | 8 | 8 | 7 | 3 | 10 | 4 | 3 |
| Degree of harm: medication related | - | - | 115 | 139 | 149 | 153 | 162 | 173 | 174 | 150 | 127 | 157 | 159 | 124 |
| VTE risk assessments | 95% | 95% | 98.5% | 98.7% | 98.3% | 98.3% | 98.3% | 98.4% | 98.6% | 98.5% | 97.9% | 98.3% | 97.6% | 97.9% |
| Never Events | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 |

| Drug Administration | Target/ Threshold 2017/18 | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Insulin Errors | - | - | 10 | 13 | 9 | 8 | 8 | 4 | 6 | 12 | 11 | 10 | 12 | 9 |
| Omitted Critical Medicines | - | - | 17 | 15 | 17 | 18 | 18 | 16 | 13 | 9 | 6 | 16 | 19 | 15 |
| Prescribing Errors | - | - | 33 | 30 | 28 | 26 | 51 | 35 | 36 | 28 | 33 | 33 | 36 | 17 |
| Preparation and Dispensing Errors | - | - | 9 | 22 | 34 | 18 | 11 | 15 | 13 | 20 | 14 | 27 | 28 | 13 |
| Administrating and Supply Errors | - | - | 42 | 61 | 49 | 63 | 57 | 86 | 75 | 66 | 49 | 59 | 56 | 57 |

| Safety Thermometer | Target/ Threshold 2017/18 | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Harm Free Care - York | - | - | 96.7% | 96.5% | 96.8% | 96.9% | 94.6% | 96.3% | 97.0% | 96.3% | 95.5% | 96.9% | 97.4% | 95.5% |
| % Harm Free Care - Scarborough | - | - | 90.9% | 93.2% | 92.6% | 94.2% | 94.2% | 92.6% | 92.7% | 91.9% | 92.8% | 94.9% | 88.4% | 91.0% |
| % Harm Free Care - Community | - | - | 92.3% | 91.0% | 88.1% | 87.9% | 93.1% | 91.7% | 94.4% | 87.5% | 95.7% | 96.4% | 93.6% | 85.1% |
| % Harm Free Care - District Nurses | - | - | 95.6% | 95.4% | 96.1% | 95.4% | 96.2% | 95.1% | 95.7% | 94.5% | 94.9% | 97.9% | 95.3% | 94.2% |

| Mortality Information | Target/ Threshold 2017/18 | Monthly Target/ Threshold | Jan 14 - Dec 14 | Apr 14 - Mar 15 | Jul 14 - Jun 15 | Oct 14 - Sep 15 | Jan 15 - Dec 15 | Apr 15 - Mar 16 | Jul 15 - Jun 16 | Oct 15 - Sep 16 | Jan 16 - Dec 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary Hospital Level Mortality Indicator (SHMI) | 100 | 100 | 101 | 101 | 99 | 99 | 99 | 100 | 99 | 98 | 97 |

| Infection Prevention | Target/ Threshold 2017/18 | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clostridium Difficile - meeting the C.Diff objective | | | 1 | 3 | 2 | 8 | 10 | 5 | 5 | 2 | 2 | 5 | 2 | 3 |
| CDIFF Cumulative Threshold | 48 (year) | 48 (year) | 17 | 22 | 27 | 35 | 40 | 45 | 48 | 4 | 8 | 12 | 16 | 20 |
| Clostridium Difficile -meeting the C.Diff objective - cumulative | | | 13 | 16 | 18 | 26 | 36 | 41 | 46 | 2 | 4 | 9 | 11 | 14 |
| MRSA - meeting the MRSA objective | 0 | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 3 |
| MSSA | 30 | 2 | 0 | 8 | 4 | 5 | 5 | 5 | 5 | 3 | 3 | 7 | 5 | 5 |
| MSSA - cumulative | | | 20 | 28 | 32 | 37 | 42 | 47 | 52 | 3 | 6 | 13 | 18 | 23 |
| ECOLI | | | 10 | 4 | 5 | 5 | 9 | 8 | 5 | 6 | 8 | 9 | 4 | 7 |
| ECOLI - cumulative | | | 49 | 53 | 58 | 63 | 72 | 80 | 85 | 6 | 14 | 23 | 27 | 34 |
| MRSA Screening - Elective | 95% | 95% | 85.0% | 89.8% | 86.3% | 84.7% | 87.7% | 88.4% | 88.1% | 89.1% | 84.7% | 88.3% | 84.4% | 87.6% |
| MRSA Screening - Non Elective | 95% | 95% | 86.4% | 86.0% | 85.9% | 84.8% | 86.0% | 86.7% | 87.4% | 87.4% | 84.3% | 85.9% | 88.2% | 89.2% |

| Stroke (one month behind due to coding) | Target/ Threshold 2017/18 | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of patients spending >90% on their time on stroke unit | 80% | 80% | 93.6% | 90.6% | 87.1% | 89.5% | 90.5% | 89.7% | 83.7% | 85.4% | 89.4% | 80.7% | 92.4% | 1 month behind |
| Proportion of patients who experience a TIA who are assessed & treated within 24 hrs | 75% | 75% | 73.9% | 92.6% | 64.7% | 90.5% | 95.2% | n/a | n/a | 87.5% | 83.3% | 100.0% | 62.5% | 1 month behind |
| Scanned within 1 hour of arrival | 50% | 50% | 63.6% | 75.0% | 68.0% | 79.0% | 60.0% | 55.6% | 69.2% | 52.6% | 50.0% | 35.7% | 81.3% | 1 month behind |
| Scanned within 24 hours of hospital arrival | 90% | 90% | 92.5% | 96.5% | 96.3% | 93.6% | 91.9% | 94.0% | 89.9% | 87.9% | 89.2% | 92.4% | 100.0% | 1 month behind |
| Proportion of stroke patients with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation | n/a | n/a | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 1 month behind |

| AMTS | Target/ Threshold 2017/18 | Monthly Target/ Threshold | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AMTS Screening | 90.0% | 90.0% | 86.5% | 91.2% | 87.8% | 87.8% | 90.1% | 88.3% | 88.9% | 86.7% | 79.3% | 85.1% | 81.7% | 80.5% |

## Patient Experience
**(Patient Experience Team)**

**Friend and Family Test (FFT) Latest Results – July 2017**

**Recommend Rates**
The inpatient recommend rate was above the Trust target of 90% and in line with the national average of 96%. The ED recommend rate was 82%, below the national average of 88%. The main issues identified are waiting, communication around waiting times and facilities/prioritisation for children.

**Response Rates**
The Patient Experience Team continues to proactively engage with the matrons, sisters and directorate managers. Both EDs have seen an improvement in response rates in the last month. The inpatient response rates in Scarborough have been significantly lower than in York. The Scarborough matrons are taking the lead on re-promoting FFT in their wards. Text messaging went live at the end of July for Medical Elective Services in York and Endoscopy on all sites – areas with historically high patient numbers and low response rates.

**Complaints and Concerns**
Acute and General Medicine have received a higher than usual number of contacts for complaints, concerns, comments and enquiries. Within this the main themes are concerns about discharge (too early, delayed or lack of appropriate care package); about waiting times for outpatient appointments; and delays in receiving test results. The top two departments receiving complaints/concerns in August are Acute Medical Unit York (9) and Chestnut Ward Scarborough (5).

Trauma and Orthopaedics have received a higher number of contacts than average. There is a theme of concerns about waiting times for

## Measures of Harm

1 Never Event was declared in August 2017, for Wrong Site Surgery.

12 Serious Incidents were declared; 8 at York, 3 at Scarborough and 1 in Community. 8 of the SIs were attributed to Clinical Incidents and 4 were attributed to Pressure Ulcers. There were no SIs attributed to Slips, Trips and Falls.

## Infection Prevention

The Trust reported 3 cases of MRSA in August. This remains a zero tolerance measure in 2017/18.

In August 2017 the Trust reported 3 cases of CDIFF; all at York. The yearly threshold for 2017/18 remains at 48, monthly allocation allows for 4 cases.

5 cases of MSSA were reported in August. 3 cases were reported at York and 2 at Scarborough.

7 cases of ECOLI were reported in August. 6 cases were reported at York and 1 at Scarborough.

## Quality and Safety - Miscellaneous

**Stroke** (reported 1 month behind due to coding)
In July the Trust achieved target for the proportion of patients spending > 90% of their time on a stroke unit, patients scanned within 1 hour of arrival and within 24 hours of hospital arrival. The Trust failed to achieve target for the proportion of patients who experience a TIA who are assessed & treated within 24 hrs.

**Cancelled Operations**
57 operations were cancelled within 48 hours of the TCI date in July. This is greater than August 2016 when only 12 operations were cancelled.

**Cancelled Clinics/Outpatient Appointments**
140 clinics were cancelled with less than 14 days notice; this figure is comparable with August 2016. 825 outpatient hospital appointments were cancelled for non clinical reasons which is a 9% increase on August 2016.

**Ward Transfers between 10pm and 6am**
70 ward transfers between 10pm and 6am were reported in August 2017 (Scarborough - 29, York - 41). This figure is below the 100 threshold but higher than August 2016 when the Trust reported 62 transfers.

**AMTS**
The Trust failed to achieve the 90% target for AMTS screening in August, performance was 80.5%. The Trust has failed to achieve the target in 10 months of the last 12.

## Care of the Deteriorating Patient

Targets were achieved across both sites for the proportion of Medicine and Elderly patients receiving a senior review within 14 hours in August. York achieved 90% against the 82% target for Q2 and Scarborough achieved 74% against the 60% target for Q2.

89.5% of patients had their NEWS scores completed within 1 hour in August against the Trust's internal target of 90%. Scarborough continue to consistently achieve target with performance of 95.2% in August, York achieved 83.5%.

88% of Elective patients had their Expected Date of Discharge recorded within 24 hours of admission across the Trust in August. The target of 93% was therefore not achieved.

## Drug Administration

9 insulin errors were reported in August, including 3 for York, 4 for Scarborough and 2 for Community.

17 prescribing errors were reported across the Trust in August, 41.2% were attributed to York.

The number of dispensing errors at York have seen a general improvement since the spike in October and November 2016, however another period of increased errors occurred in June and July 2017. Scarborough and Community figures are comparable with previous months.

## Mortality

The latest SHMI report indicates the Trust to be in the 'as expected' range. The July 2015 - June 2016 SHMI saw a 1 point decrease for the Trust and Scarborough, and a 1 point increase for York. Trust - 99, York 96 and Scarborough 106.

161 inpatient deaths were reported across the Trust in August; 95 were reported at York and 60 were reported at Scarborough.

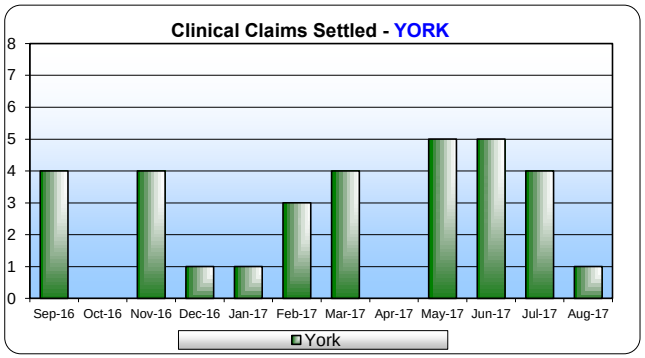
11 deaths in ED were reported in August; 8 at York and 3 at Scarborough.

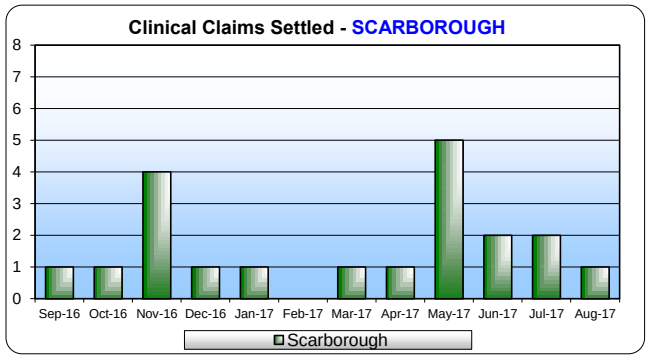
## CQUINS update (Operations Team)

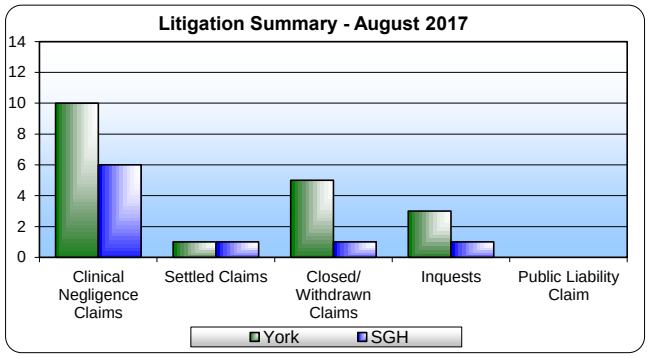
The Trust is currently collating evidence reports to show compliance against 2017/18 Q1 CQUINs, it is envisaged that all CQUINs will be achieved for Q1 bar Timely identification & treatment of patients with sepsis in emergency departments and acute inpatient settings which it is believed will attract partial payment.

## Litigation

| Indicator | Site | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Negligence Claims Received | York | 6 | 7 | 3 | 7 | 7 | 6 | 7 | 12 | 7 | 10 | 8 | 10 |
| | Scarborough | 4 | 6 | 11 | 4 | 4 | 2 | 2 | 2 | 8 | 7 | 5 | 6 |
| Clinical Claims Settled | York | 4 | 0 | 4 | 1 | 1 | 3 | 4 | 0 | 5 | 5 | 4 | 1 |
| | Scarborough | 1 | 1 | 4 | 1 | 1 | 0 | 1 | 1 | 5 | 2 | 2 | 1 |
| Closed/ Withdrawn Claims | York | 6 | 3 | 7 | 6 | 6 | 11 | 7 | 0 | 1 | 5 | 4 | 5 |
| | Scarborough | 7 | 7 | 6 | 2 | 2 | 12 | 3 | 2 | 1 | 4 | 7 | 1 |
| Coroners Inquests Heard | York | 5 | 1 | 4 | 0 | 0 | 1 | 3 | 3 | 2 | 3 | 6 | 3 |
| | Scarborough | 2 | 2 | 5 | 6 | 6 | 2 | 1 | 2 | 1 | 4 | 1 | 1 |



# Patient Experience

**PALS Contacts**
There were 291 PALS contacts in August.

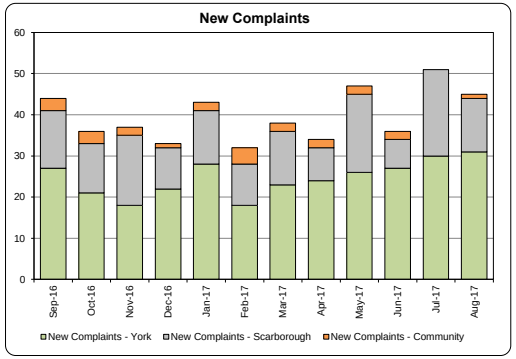
**Complaints**
There were 45 complaints in August; 31 were attributed to York, 12 to Scarborough ,1 to Bridlington and 1 to Community.

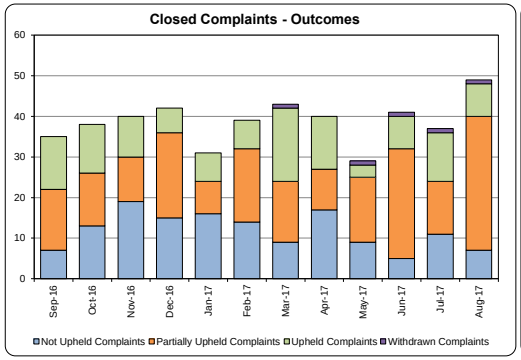
**New Ombudsman Cases**
There were 2 New Ombudsman Cases in August; both attributed to York.

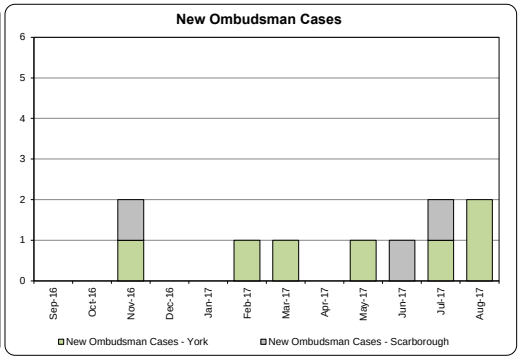
**Compliments**
348 compliments were received in August 2017, a decrease on the high numbers seen in June and July. Up until December 2016 compliments reported were only those received directly by the Chief Executive and PALS. From January 2017 numbers from wards and departments are included.

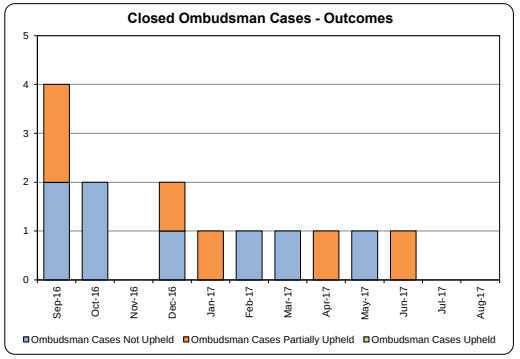
# Patient Experience

## Sep-17



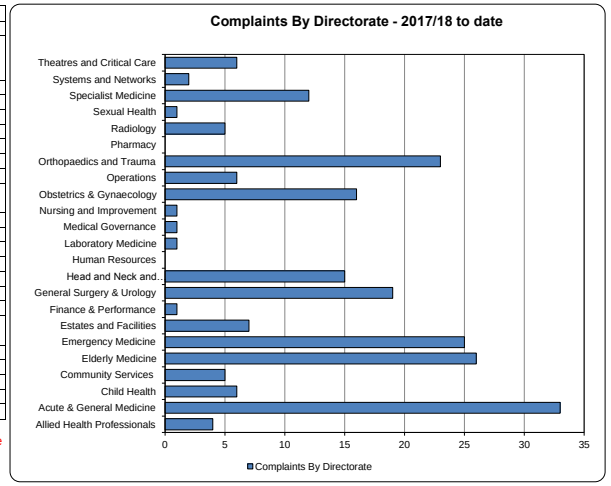



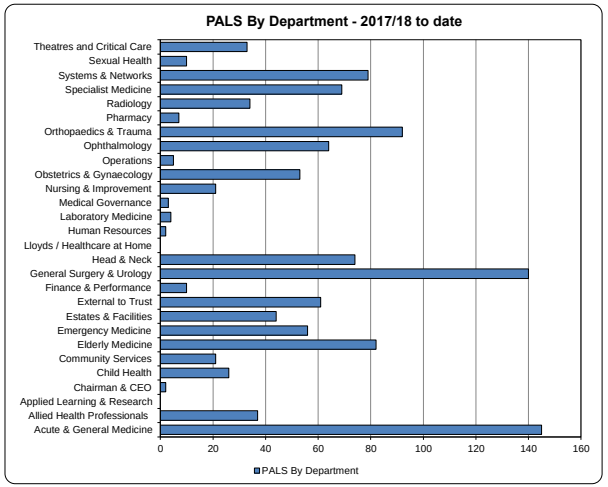

| Complaints By Subject | Aug-17 | YTD |
|---|---|---|
| Access to treatment or drugs | 3 | 4 |
| Admissions, Discharge and Transfer Arrangements | 6 | 37 |
| All aspects of Clinical Treatment | 26 | 141 |
| Appointments, Delay/Cancellation | 3 | 29 |
| Commissioning | 0 | 0 |
| Comms/info to patients (written and oral) | 16 | 65 |
| Complaints Handling | 0 | 0 |
| Consent | 0 | 2 |
| End of Life Care | 0 | 2 |
| Facilities | 1 | 10 |
| Mortuary | 0 | 0 |
| Others | 0 | 0 |
| Patient Care | 17 | 79 |
| Patient Concerns | 0 | 2 |
| Prescribing | 4 | 16 |
| Privacy and Dignity | 6 | 17 |
| Restraint | 0 | 1 |
| Staff Numbers | 0 | 1 |
| Transport | 0 | 0 |
| Trust Admin/Policies/Procedures | 6 | 17 |
| Values and Behaviours (Staff) | 14 | 58 |
| Waiting times | 1 | 5 |
| **TOTAL** | **103** | **486** |

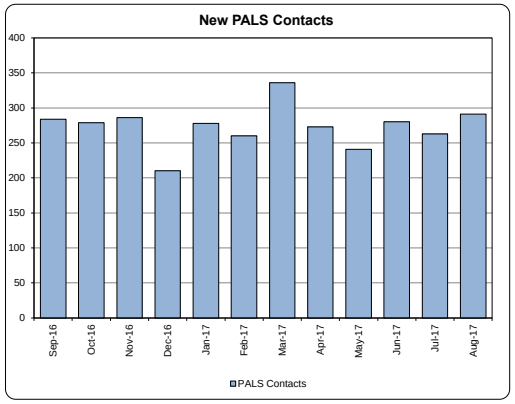
Due to new reporting the number of complaints/PALS contacts by subject is greater than the total number of complaints because each subject within the complaint can be identified as opposed to just the one deemed to be the 'primary'.

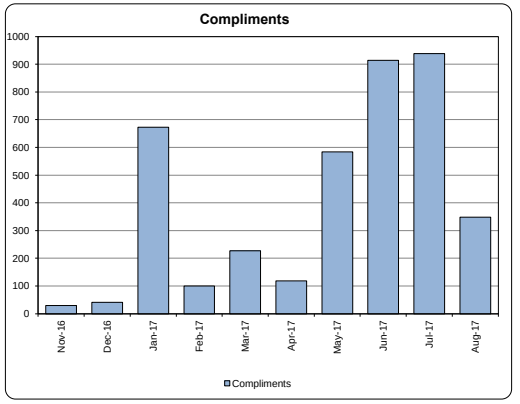



| PALS By Subject | Aug-17 | YTD |
|---|---|---|
| Access to Treatment or Drugs | 11 | 61 |
| Admissions and Discharges (Excluding Delayed Discharge due to absence of care package) | 19 | 73 |
| Appointments | 47 | 254 |
| Clinical Treatment | 19 | 96 |
| Commissioning | 1 | 3 |
| Communication | 60 | 357 |
| Consent | 0 | 3 |
| End of Life Care | 1 | 4 |
| Facilities | 5 | 33 |
| Integrated Care (including Delayed Discharge Due to Absence of a Care Package | 0 | 0 |
| Mortuary | 1 | 1 |
| Patient Care | 30 | 72 |
| Patient Concerns | 10 | 54 |
| Prescribing | 4 | 19 |
| Privacy, Dignity & Respect | 5 | 17 |
| Staff Numbers | 0 | 0 |
| Transport | 3 | 9 |
| Trust Admin/Policies/Procedures Inc. pt. record management | 16 | 58 |
| Values and Behaviours (Staff) | 46 | 161 |
| Waiting Times | 13 | 73 |
| **Total** | **291** | **1348** |

Since July 2016 there was a change in how PALS log cases. Issues such as misplaced calls from switchboard or requests to speak to other departments are no longer logged. The new IT system allows cases to be updated rather than creating new logs.

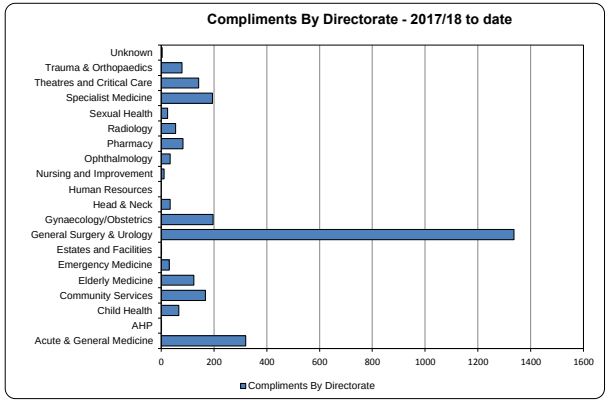


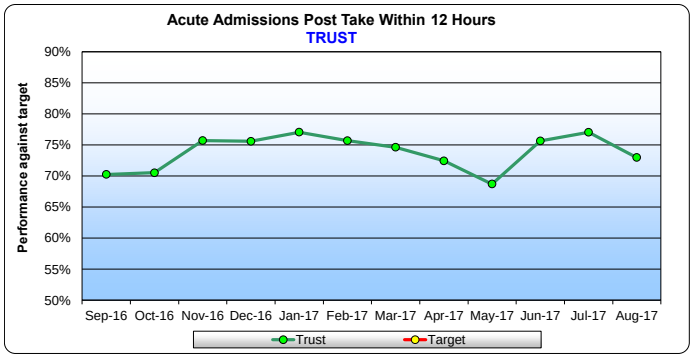

| Compliments By Directorate | Aug-17 | YTD |
|---|---|---|
| Acute & General Medicine | 52 | 320 |
| AHP | 0 | 1 |
| Child Health | 8 | 67 |
| Community Services | 59 | 167 |
| Elderly Medicine | 22 | 124 |
| Emergency Medicine | 0 | 30 |
| Estates and Facilities | 0 | 1 |
| General Surgery & Urology | 38 | 1337 |
| Gynaecology/Obstetrics | 32 | 196 |
| Head & Neck | 1 | 34 |
| Human Resources | 0 | 0 |
| Nursing and Improvement | 0 | 11 |
| Ophthalmology | 14 | 34 |
| Pharmacy | 13 | 82 |
| Radiology | 9 | 55 |
| Sexual Health | 0 | 24 |
| Specialist Medicine | 48 | 194 |
| Theatres and Critical Care | 48 | 142 |
| Trauma & Orthopaedics | 4 | 79 |
| Unknown | 0 | 4 |
| **Total** | **348** | **2902** |

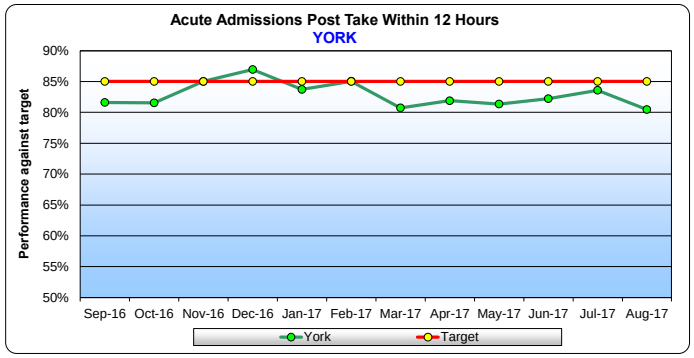
Up until December 2016 compliments reported were only those received directly by the Chief Executive and PALS. From January 2017 numbers from wards and departments are included

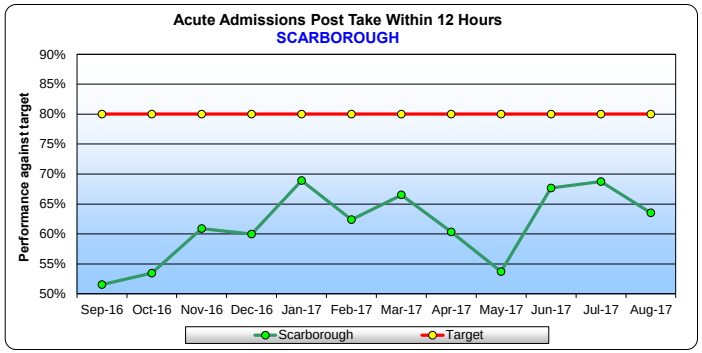


# Quality and Safety: Care of the Deteriorating Patient

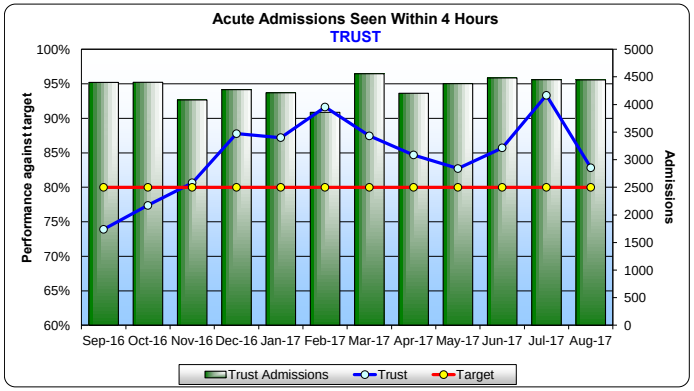
| Indicator | Consequence of Breach (Monthly unless specified) | Threshold | Q2 16/17 | Q3 16/17 | Q4 16/17 | Q1 17/18 | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|
| Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (SCARBOROUGH) | Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI | 80% | 54% | 58% | 66% | 61% | 68% | 69% | 64% |
| Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (YORK) | Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI | 85% | 83% | 84% | 83% | 82% | 82% | 84% | 80% |

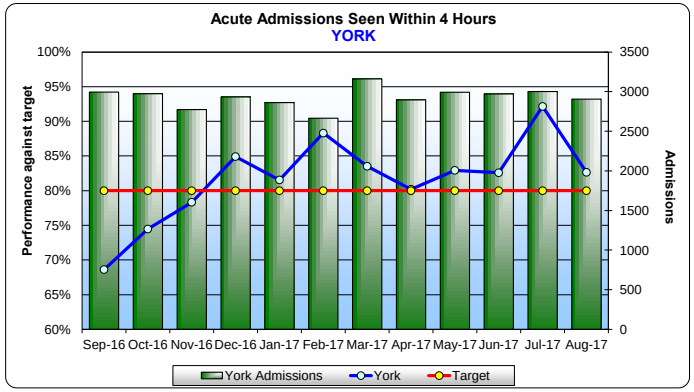


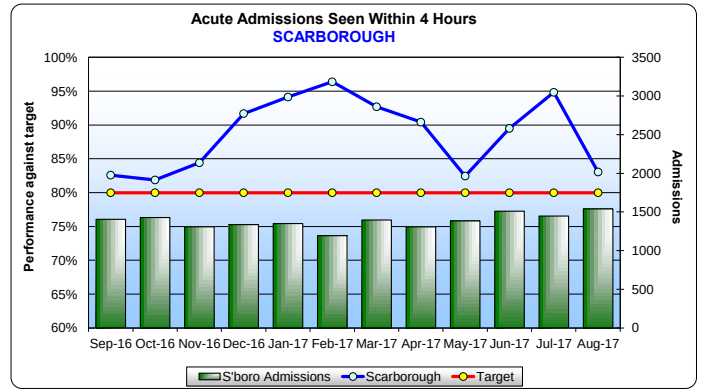




| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Care of the Deteriorating Patient:<br>All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse) | Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI | **80% by site** | 80.4% | 81.7% | 88.7% | 84.4% | 85.7% | 93.3% | 82.8% |

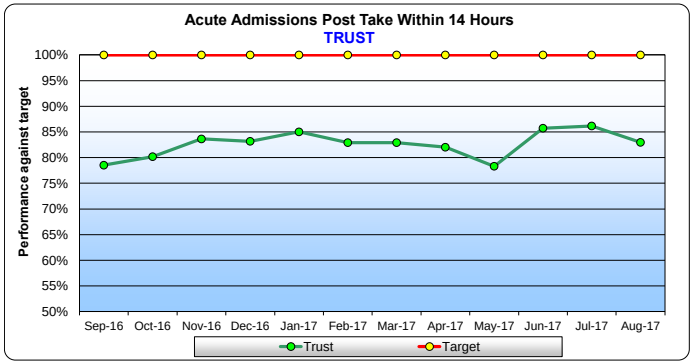


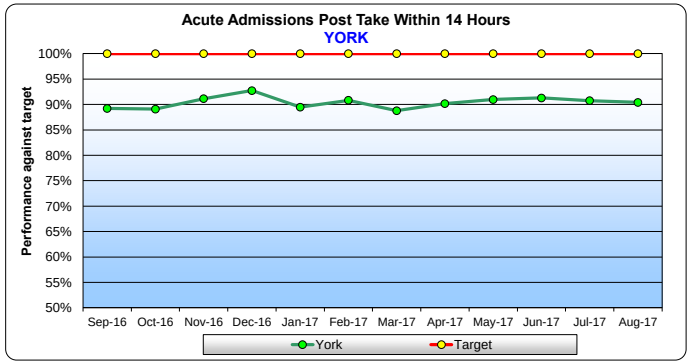



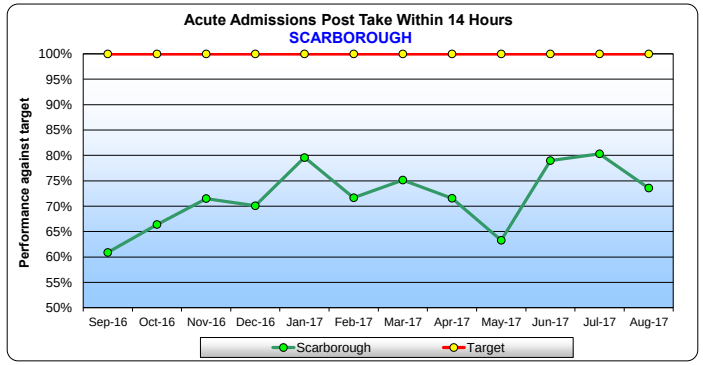



# Quality and Safety: Care of the Deteriorating Patient

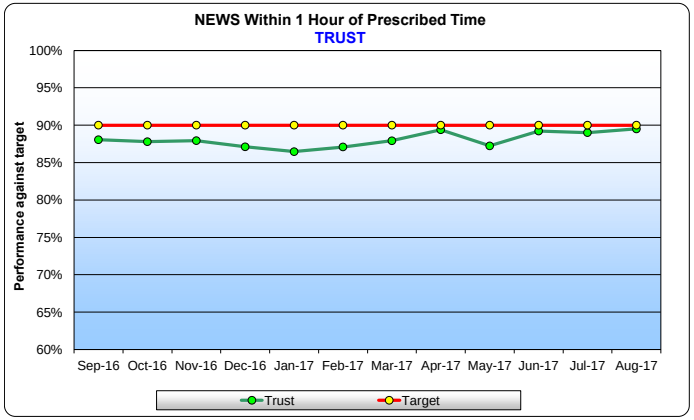
| Indicator | Consequence of Breach (Monthly unless specified) | Threshold | Q2 16/17 | Q3 16/17 | Q4 16/17 | Q1 17/18 | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|
| Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival - Royal College Standard - 100% | Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI | | 80.3% | 82.2% | 83.6% | 82.0% | 85.7% | 86.2% | 83.0% |

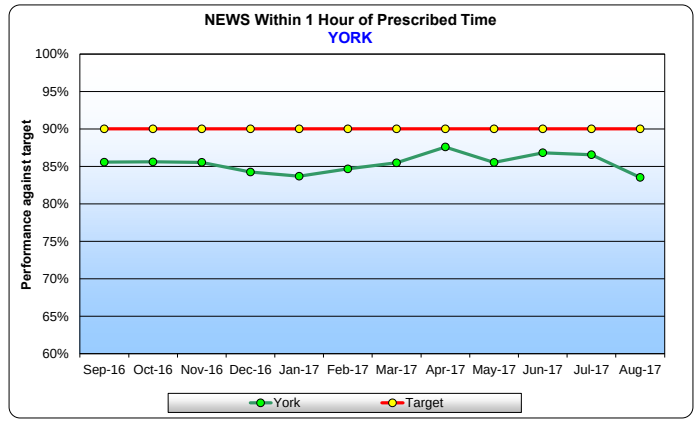


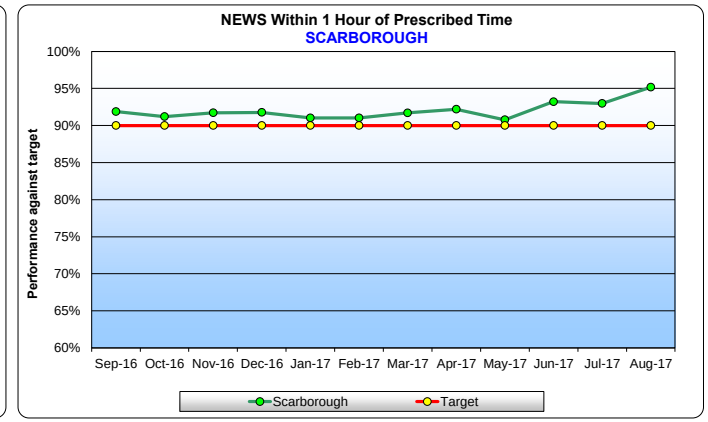




| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| NEWS within 1 hour of prescribed time | None - Monitoring Only | | 87.9% | 87.6% | 87.2% | 88.7% | 89.2% | 89.0% | 89.5% |



# Measures of Harm

**Serious Incidents (SIs) declared** (source: Datix)
There were 12 SIs reported in August; York 8, Scarborough 3, Community 1.
Clinical Incidents: 8; York 5, Scarborough 3
Slips Trips & Falls: None reported
Pressure Ulcers: 4; York 3, Community 1

**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 August there were 123 reports of patients falling at York Hospital, 69 patients at Scarborough and 25 patients within the Community Services (217 in total).

**Number of Incidents Reported** (source: Datix)
The total number of incidents reported in the Trust during August was 1,185; 679 incidents were reported on the York site, 359 on the Scarborough site and 147 from Community Services.

**Number of Incidents Awaiting Sign Off at Directorate Level** (source: Datix)
At the time of reporting there were 832 incidents awaiting sign-off by the Directorate Management Teams.

**Pressure Ulcers** (source: Datix)
During August 36 pressure ulcers were reported to have developed on patients since admission to York Hospital, 34 pressure ulcers were reported to have developed on patients since admission to Scarborough and 39 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.

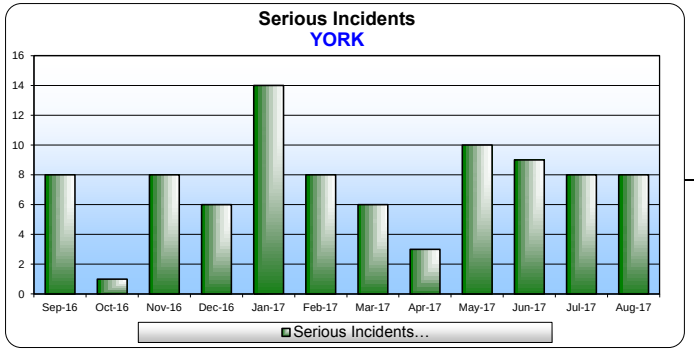
**Degree of Harm: Serious/Severe or Death** (source: Datix)
During August 3 patient incidents were reported which resulted in serious or severe harm or death. Numbers are subject to change as levels of harm are reviewed and investigations are completed.

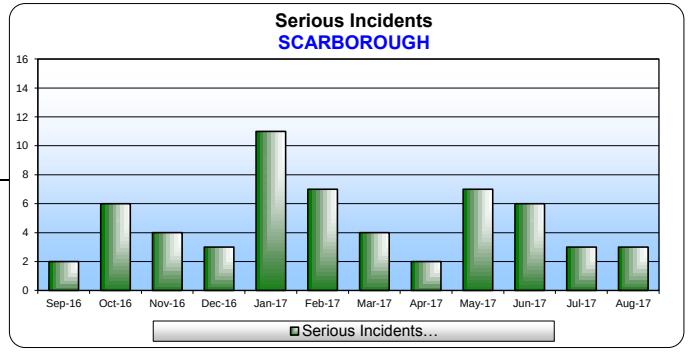
**Medication Related Issues** (source: Datix)
During August there were a total of 124 medication related incidents reported although this figure may change following validation.

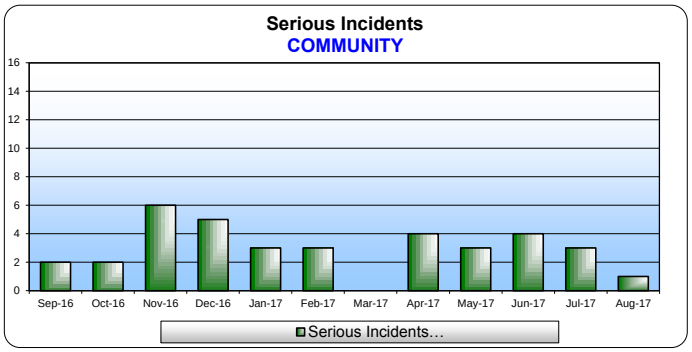
**Never Events** – 1 Never Event was declared during August, categorised under Wrong Site Surgery.

# Measures of Harm

| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Serious Incidents source: Risk and Legal | York | 8 | 1 | 8 | 6 | 14 | 8 | 6 | 3 | 10 | 9 | 8 | 8 |
| | Scarborough | 2 | 6 | 4 | 3 | 11 | 7 | 4 | 2 | 7 | 6 | 3 | 3 |
| | Community | 2 | 2 | 6 | 5 | 3 | 3 | 0 | 4 | 3 | 4 | 3 | 1 |
| Serious Incidents Delogged source: Risk and Legal (Trust) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 |

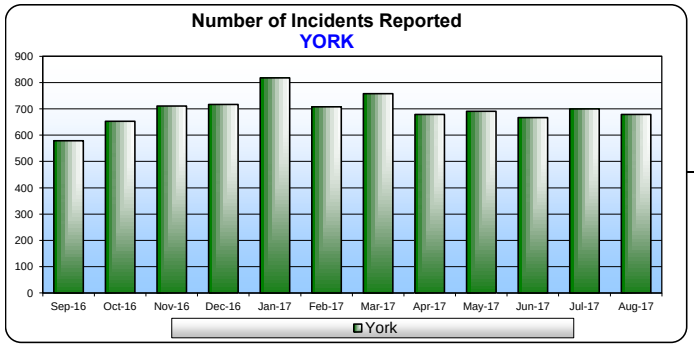


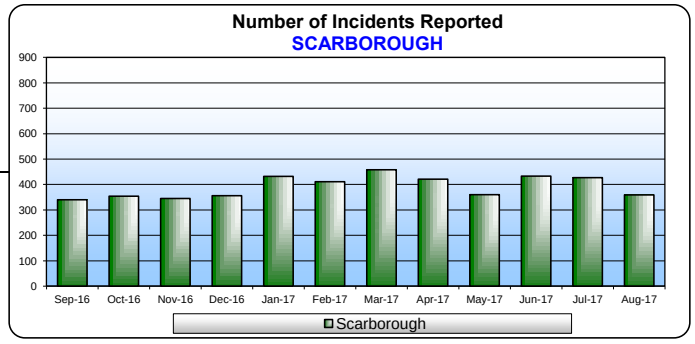



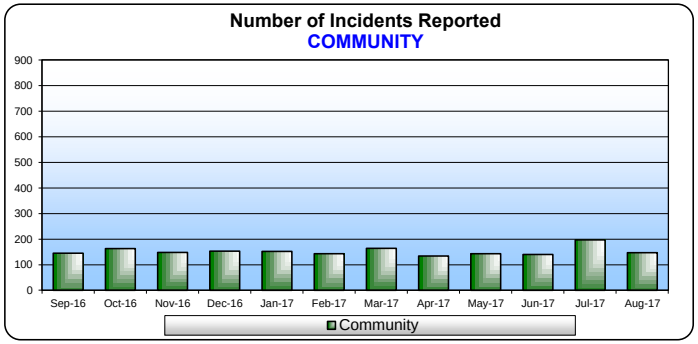




Note - 12 Hour breaches are listed as Operations for the Directorate Investigating (although the location is ED).

| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Incidents Reported source: Risk and Legal | York | 579 | 653 | 711 | 717 | 818 | 708 | 758 | 679 | 691 | 667 | 700 | 679 |
| | Scarborough | 340 | 354 | 345 | 356 | 432 | 411 | 458 | 421 | 360 | 433 | 427 | 359 |
| | Community | 145 | 163 | 148 | 153 | 152 | 143 | 164 | 134 | 143 | 140 | 197 | 147 |
| Number of Incidents Awaiting sign off at Directorate level | | 813 | 752 | 670 | 768 | 963 | 1059 | 1129 | 828 | 698 | 746 | 868 | 832 |

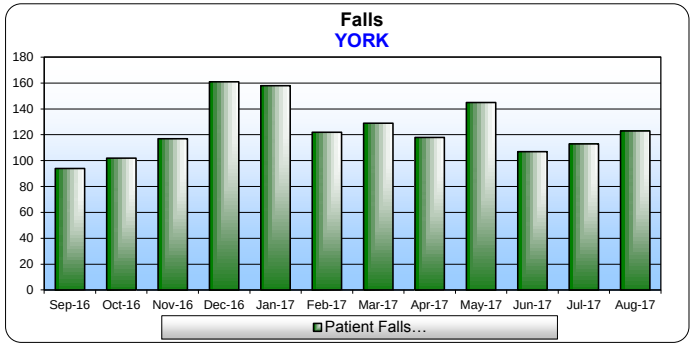


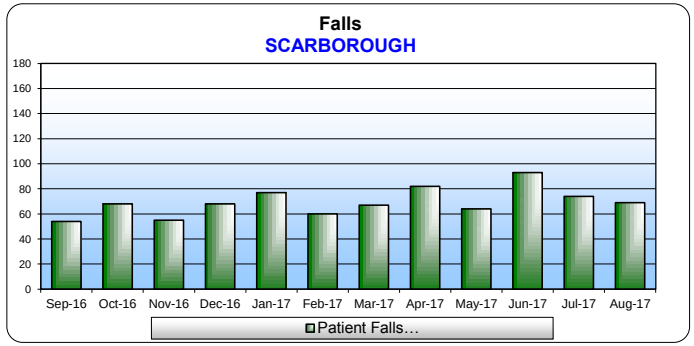



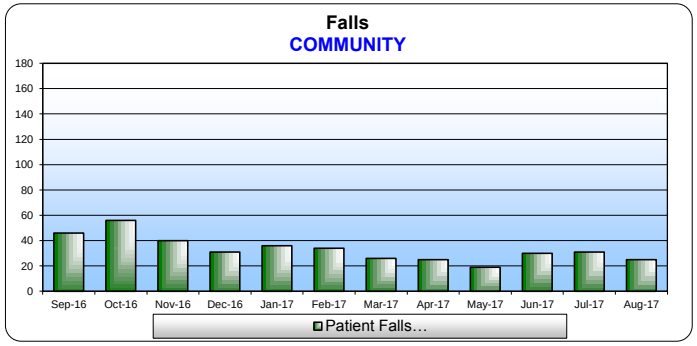



# Measures of Harm

| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient Falls source: DATIX | York | 94 | 102 | 117 | 161 | 158 | 122 | 129 | 118 | 145 | 107 | 113 | 123 |
| | Scarborough | 54 | 68 | 55 | 68 | 77 | 60 | 67 | 82 | 64 | 93 | 74 | 69 |
| | Community | 46 | 56 | 40 | 31 | 36 | 34 | 26 | 25 | 19 | 30 | 31 | 25 |

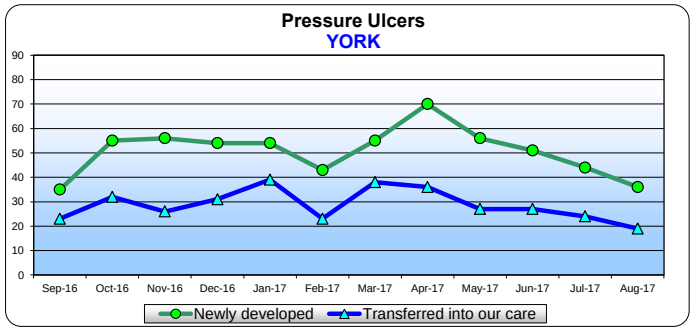


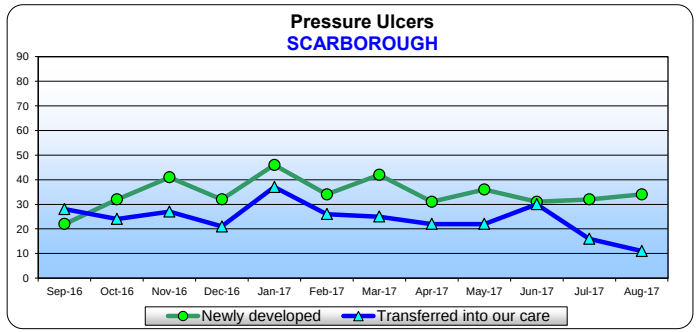



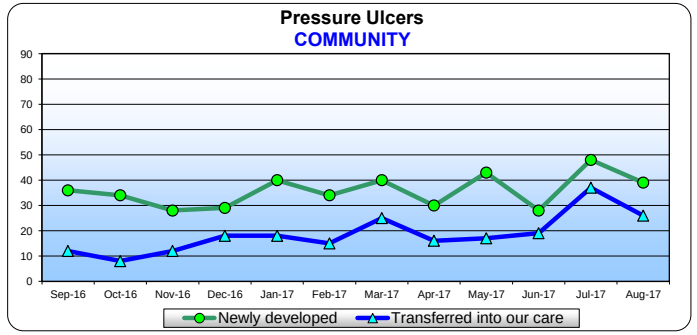




Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.
Increases in December and January reflect the increase in the number of frail and elderly patients in hospital.

| Indicator | | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pressure Ulcers source: DATIX | York | Newly developed | 35 | 55 | 56 | 54 | 54 | 43 | 55 | 70 | 56 | 51 | 44 | 36 |
| | | Transferred into our care | 23 | 32 | 26 | 31 | 39 | 23 | 38 | 36 | 27 | 27 | 24 | 19 |
| | Scarborough | Newly developed | 22 | 32 | 41 | 32 | 46 | 34 | 42 | 31 | 36 | 31 | 32 | 34 |
| | | Transferred into our care | 28 | 24 | 27 | 21 | 37 | 26 | 25 | 22 | 22 | 30 | 16 | 11 |
| | Community | Newly developed | 36 | 34 | 28 | 29 | 40 | 34 | 40 | 30 | 43 | 28 | 48 | 39 |
| | | Transferred into our care | 12 | 8 | 12 | 18 | 18 | 15 | 25 | 16 | 17 | 19 | 37 | 26 |



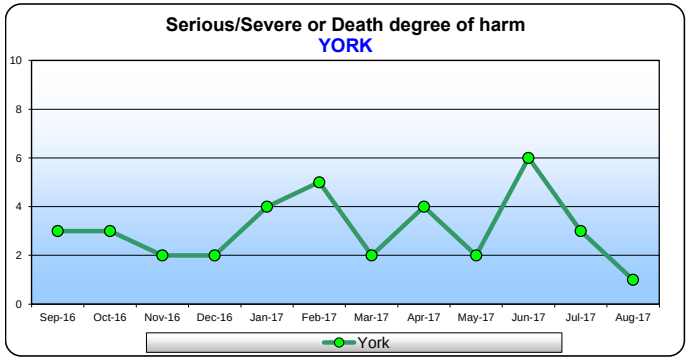



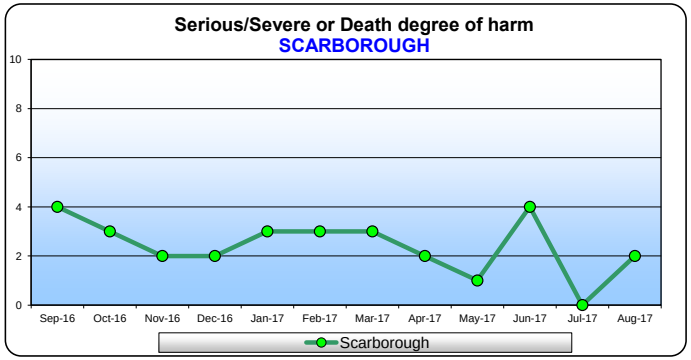



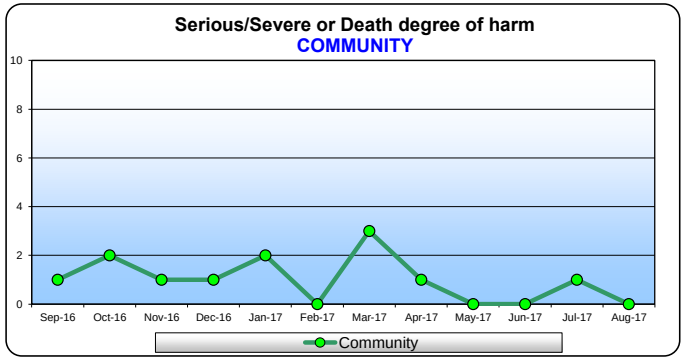

Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised as a 'Deterioration of a previously reported ulcer'.
The increase in newly developed or deteriorated under our care is thought to be attributable to a re-classification of the data on the Datix system implemented on 01/09/16, recognising more accurately our responsibility for patients in the community.

# Measures of Harm

| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Degree of harm: serious/severe or death source: Datix | York | 3 | 3 | 2 | 2 | 4 | 5 | 2 | 4 | 2 | 6 | 3 | 1 |
| | Scarborough | 4 | 3 | 2 | 2 | 3 | 3 | 3 | 2 | 1 | 4 | 0 | 2 |
| | Community | 1 | 2 | 1 | 1 | 2 | 0 | 3 | 1 | 0 | 0 | 1 | 0 |



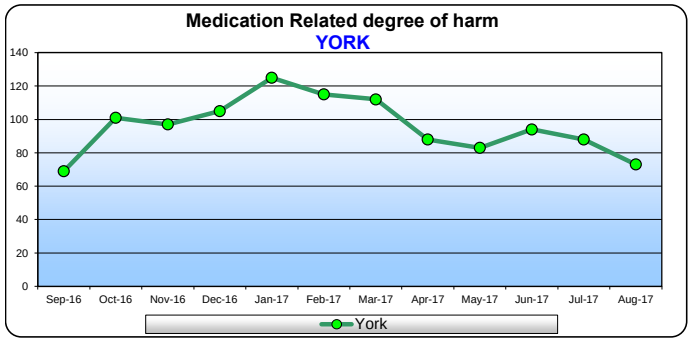



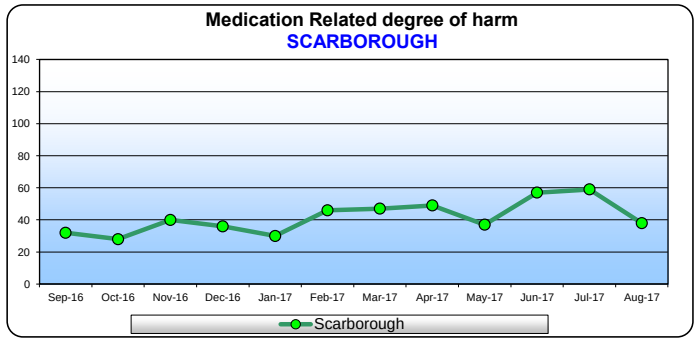



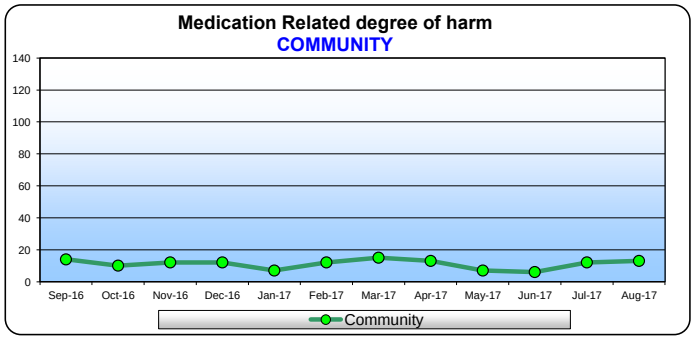

Note: data from October 2016 onwards all subject to ongoing validation

| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Degree of harm: Medication Related Issues source: Datix | York | 69 | 101 | 97 | 105 | 125 | 115 | 112 | 88 | 83 | 94 | 88 | 73 |
| | Scarborough | 32 | 28 | 40 | 36 | 30 | 46 | 47 | 49 | 37 | 57 | 59 | 38 |
| | Community | 14 | 10 | 12 | 12 | 7 | 12 | 15 | 13 | 7 | 6 | 12 | 13 |

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.

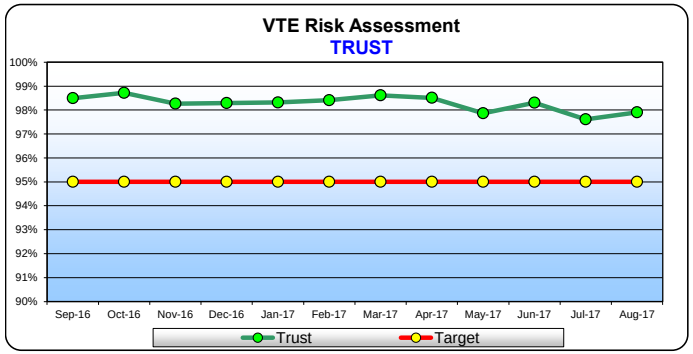


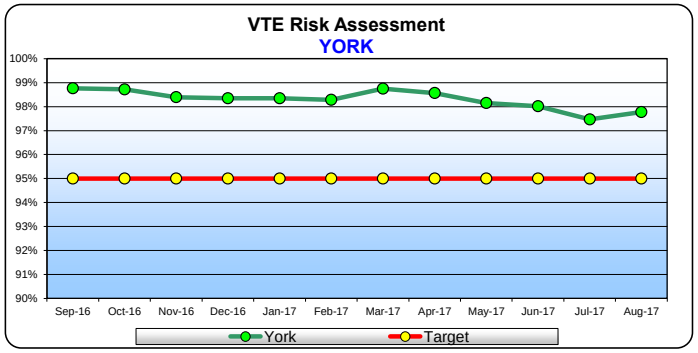



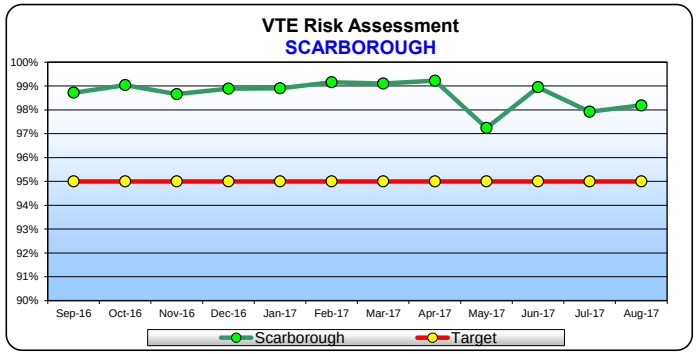



# Measures of Harm

| Indicator | Consequence of Breach | Site | Threshold | Q2 16/17 | Q3 16/17 | Q4 16/17 | Q1 17/18 | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|---|
| VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance<br>source: CPD | Issue of Contract Performance Notice and subsequent process in accordance with GC9 | Trust | 95% | 98.5% | 98.4% | 98.5% | 98.2% | 98.3% | 97.6% | 97.9% |
| | | York | 95% | 98.7% | 98.5% | 98.5% | 98.2% | 98.0% | 97.5% | 97.8% |
| | | Scarborough | 95% | 98.8% | 98.9% | 99.1% | 98.1% | 98.9% | 97.9% | 98.2% |



# Never Events

| Indicator | Consequence of Breach | Threshold | Q2 16/17 | Q3 16/17 | Q4 16/17 | Q1 17/18 | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|
| **SURGICAL** | | | | | | | | | |
| Wrong site surgery | As below | >0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 |
| Wrong implant/prosthesis | | >0 | 0 | 0 | 0 | 1 | 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 | 1 | 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 August indicated 1.78% for York, 2.57% for Scarborough and 0.00% for Community.

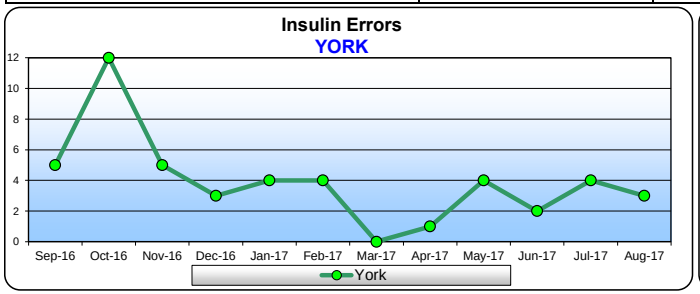
**Prescribing Errors**
There were 17 prescribing related errors in August; 7 from York, 9 from Scarborough and 1 from Community.

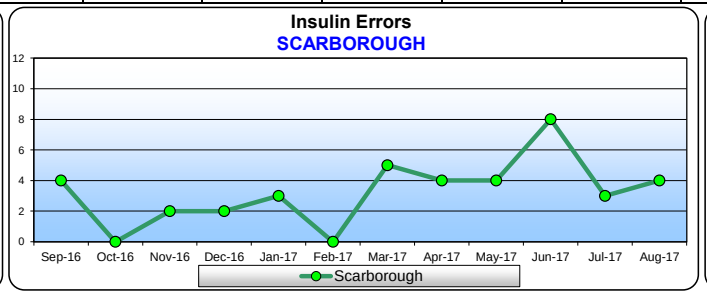
**Preparation and Dispensing Errors**
There were 13 preparation/dispensing errors in August; 6 from York, 4 from Scarborough and 3 from Community.

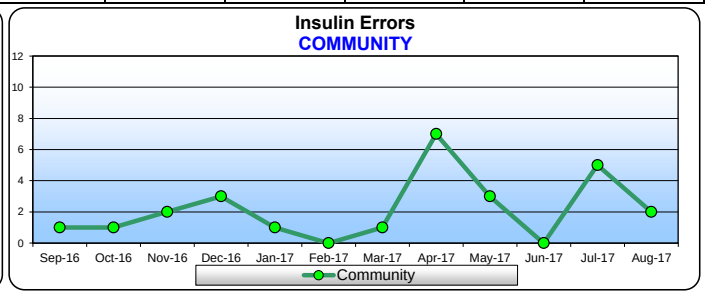
**Administrating and Supply Errors**
There were 57 administrating/supplying errors in August; 35 were from York, 15 from Scarborough and 7 from Community. Audit work on missed doses has raised the awareness of the importance of reporting medication errors, and this is thought to have contributed to the increase in administration errors from December .

# Drug Administration

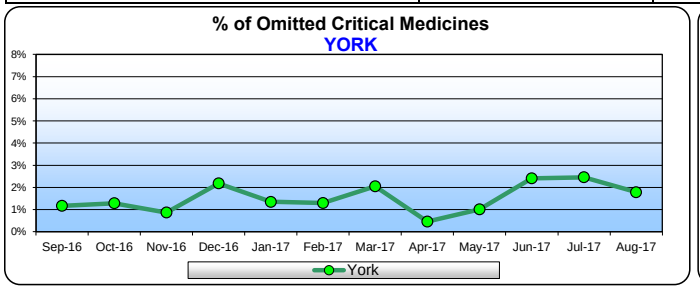
| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Insulin Errors<br>source: Datix | York | 5 | 12 | 5 | 3 | 4 | 4 | 0 | 1 | 4 | 2 | 4 | 3 |
| | Scarborough | 4 | 0 | 2 | 2 | 3 | 0 | 5 | 4 | 4 | 8 | 3 | 4 |
| | Community | 1 | 1 | 2 | 3 | 1 | 0 | 1 | 7 | 3 | 0 | 5 | 2 |

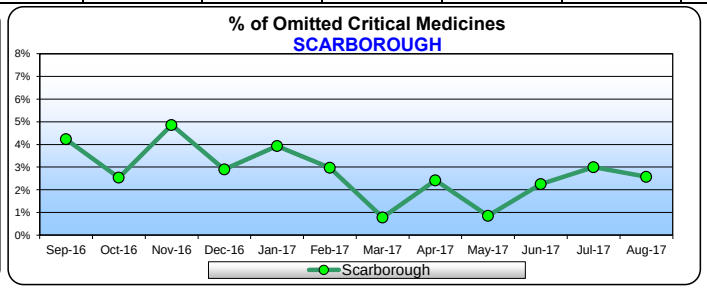


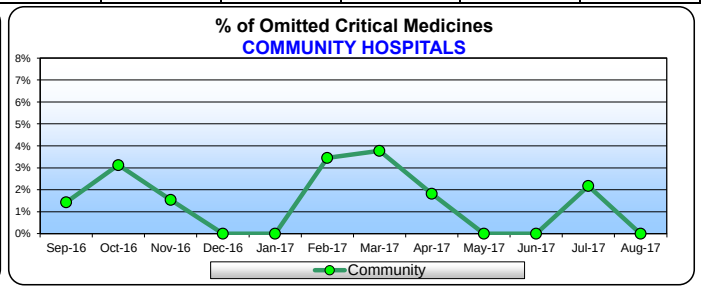



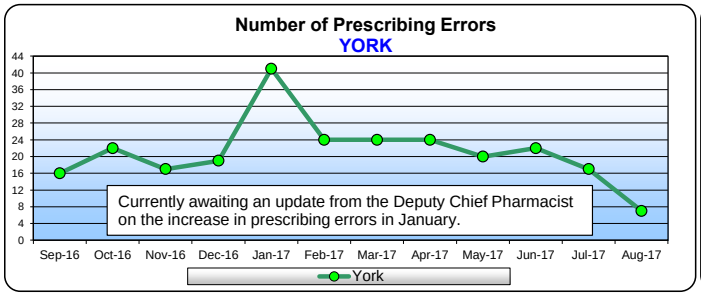

| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Omitted Critical Medicines<br>source: Datix | York | 5 | 6 | 4 | 10 | 7 | 6 | 9 | 2 | 4 | 10 | 11 | 8 |
| | Scarborough | 11 | 7 | 12 | 8 | 11 | 8 | 2 | 6 | 2 | 6 | 7 | 7 |
| | Community Hospitals | 1 | 2 | 1 | 0 | 0 | 2 | 2 | 1 | 0 | 0 | 1 | 0 |

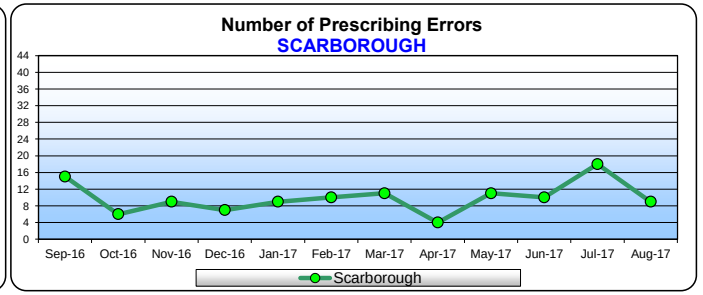


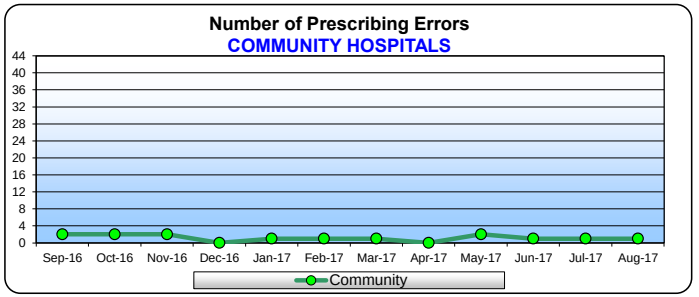




| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Prescribing Errors<br>source: Datix | York | 16 | 22 | 17 | 19 | 41 | 24 | 24 | 24 | 20 | 22 | 17 | 7 |
| | Scarborough | 15 | 6 | 9 | 7 | 9 | 10 | 11 | 4 | 11 | 10 | 18 | 9 |
| | Community Hospitals | 2 | 2 | 2 | 0 | 1 | 1 | 1 | 0 | 2 | 1 | 1 | 1 |

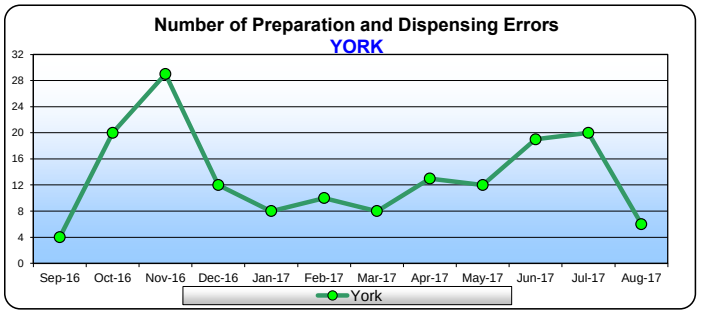


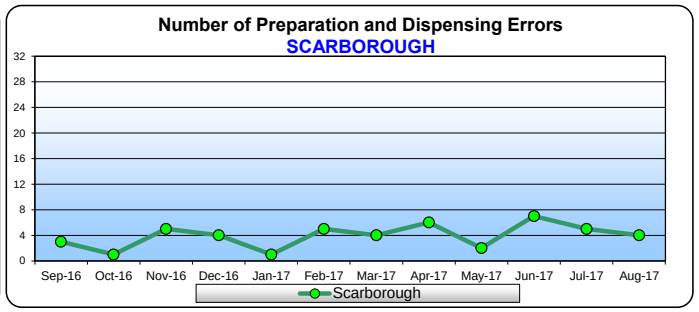



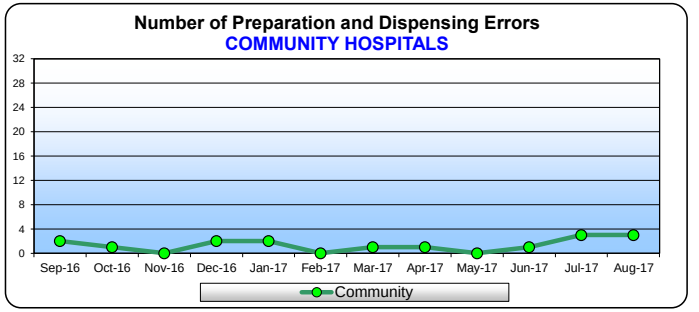



# Drug Administration

| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Preparation and Dispensing Errors<br>source: Datix | York | 4 | 20 | 29 | 12 | 8 | 10 | 8 | 13 | 12 | 19 | 20 | 6 |
| | Scarborough | 3 | 1 | 5 | 4 | 1 | 5 | 4 | 6 | 2 | 7 | 5 | 4 |
| | Community Hospitals | 2 | 1 | 0 | 2 | 2 | 0 | 1 | 1 | 0 | 1 | 3 | 3 |

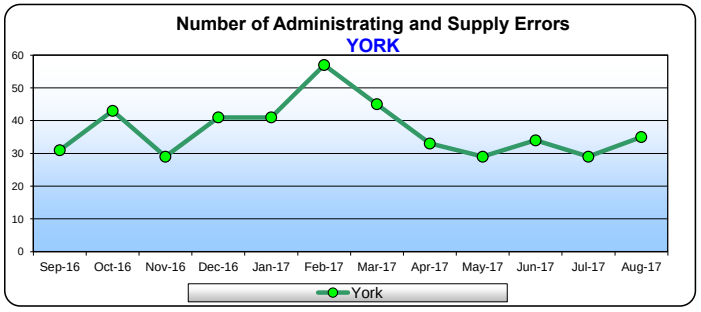


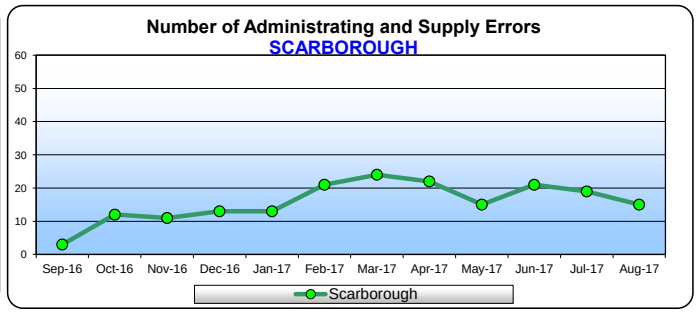



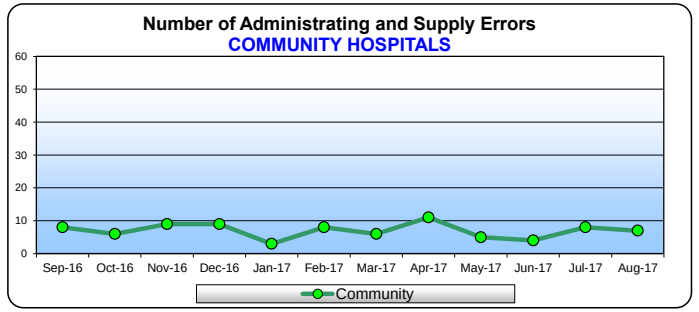




Note re increase in Dispensing Errors - Healthcare at Home have recently experienced a high turnover of staff which has contributed to the increase in errors as the service has mostly been delivered by locums. The vacancies are currently being recruited to and a new manager has been appointed. Trust Senior Pharmacy staff are also meeting with the Chief Pharmacist from Healthcare at Home on a weekly basis and they have provided an action plan that includes the review of all policies and processes. Trust Pharmacy staff are in the process of delivering training to their old and new staff to help to improve the situation.

| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Administrating and Supply Errors<br>source: Datix | York | 31 | 43 | 29 | 41 | 41 | 57 | 45 | 33 | 29 | 34 | 29 | 35 |
| | Scarborough | 3 | 12 | 11 | 13 | 13 | 21 | 24 | 22 | 15 | 21 | 19 | 15 |
| | Community Hospitals | 8 | 6 | 9 | 9 | 3 | 8 | 6 | 11 | 5 | 4 | 8 | 7 |




Note re increase in medication error reporting - audit work on missed doses has raised the awareness of the importance of reporting medication errors, and this is thought to have contributed to the increase in administration errors from December onwards.

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

·York: 95.5%
·Scarborough: 91.0%
·Community Hospitals: 85.1%
·Community care: 94.2%

**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: 1.2%
·Scarborough: 4.0%
·Community Hospitals: 2.1%
·Community Care: 0.8%

**VTE**

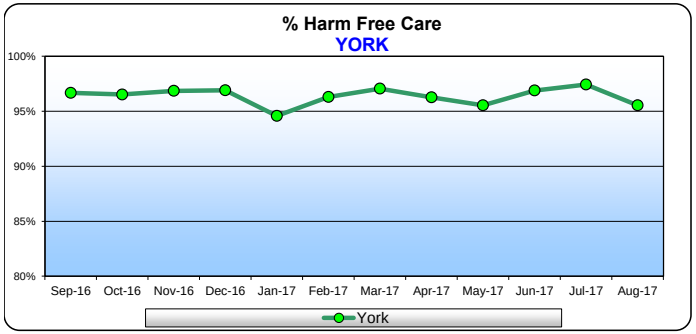
The percentage of patients affected by VTE as measured by the Department of Health definition, monthly measurement of prevalence:

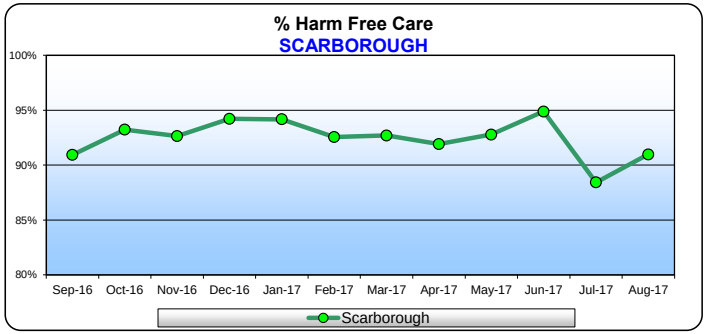
·York: 0.0%
·Scarborough: 0.0%
·Community Hospitals: 2.1%
·Community Care: 0.0%

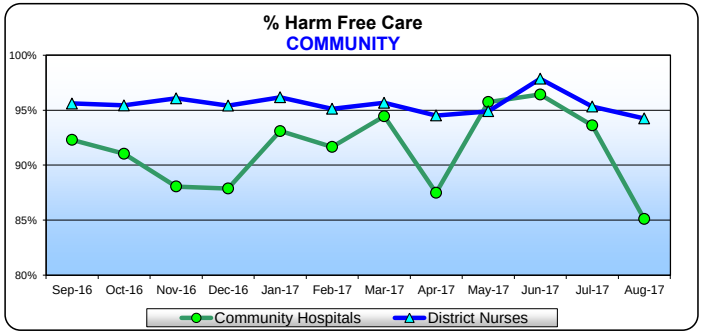
# Safety Thermometer

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

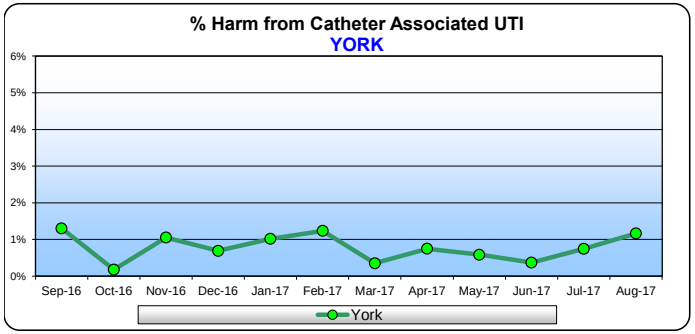
| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Harm Free Care<br>source: Safety Thermometer | York | 96.7% | 96.5% | 96.8% | 96.9% | 94.6% | 96.3% | 97.0% | 96.3% | 95.5% | 96.9% | 97.4% | 95.5% |
| | Scarborough | 90.9% | 93.2% | 92.6% | 94.2% | 94.2% | 92.6% | 92.7% | 91.9% | 92.8% | 94.9% | 88.4% | 91.0% |
| | Community Hospitals | 92.3% | 91.0% | 88.1% | 87.9% | 93.1% | 91.7% | 94.4% | 87.5% | 95.7% | 96.4% | 93.6% | 85.1% |
| | District Nurses | 95.6% | 95.4% | 96.1% | 95.4% | 96.2% | 95.1% | 95.7% | 94.5% | 94.9% | 97.9% | 95.3% | 94.2% |

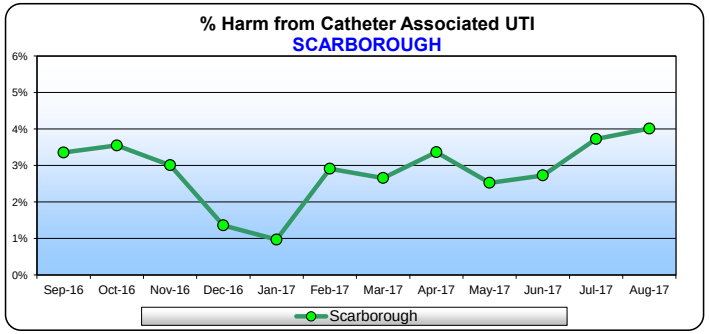


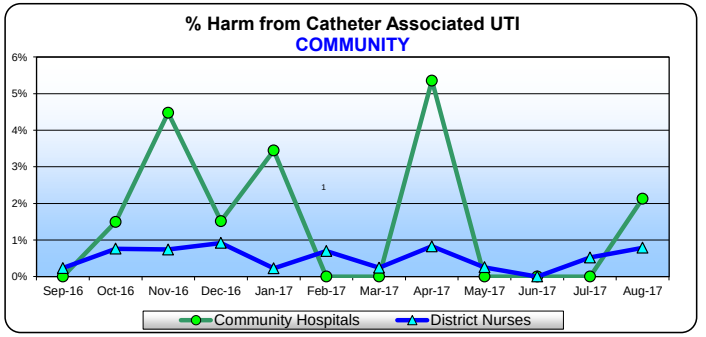




| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Harm from Catheter Associated Urinary Tract Infection<br>source: Safety Thermometer | York | 1.3% | 0.2% | 1.1% | 0.7% | 1.0% | 1.2% | 0.3% | 0.7% | 0.6% | 0.4% | 0.7% | 1.2% |
| | Scarborough | 3.4% | 3.5% | 3.0% | 1.4% | 1.0% | 2.9% | 2.7% | 3.4% | 2.5% | 2.7% | 3.7% | 4.0% |
| | Community Hospitals | 0.0% | 1.5% | 4.5% | 1.5% | 3.4% | 0.0% | 0.0% | 5.4% | 0.0% | 0.0% | 0.0% | 2.1% |
| | District Nurses | 0.2% | 0.8% | 0.7% | 0.9% | 0.2% | 0.7% | 0.2% | 0.8% | 0.3% | 0.0% | 0.5% | 0.8% |



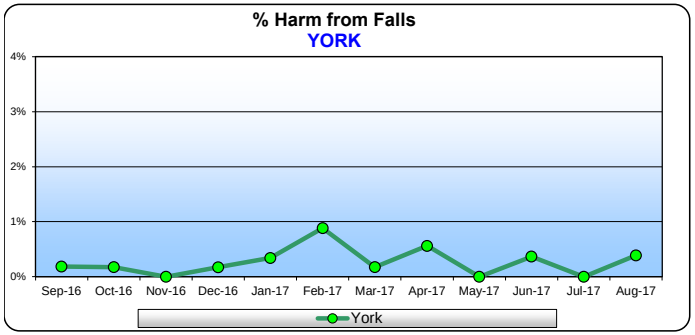



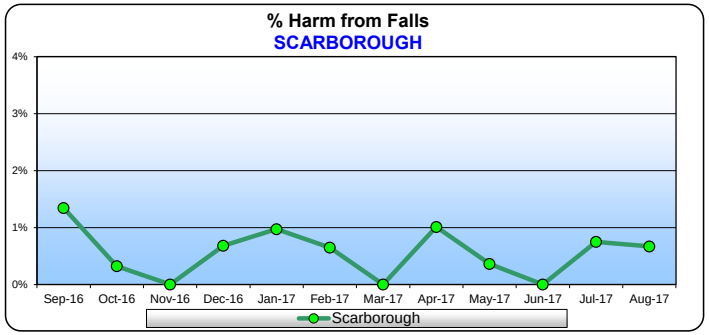



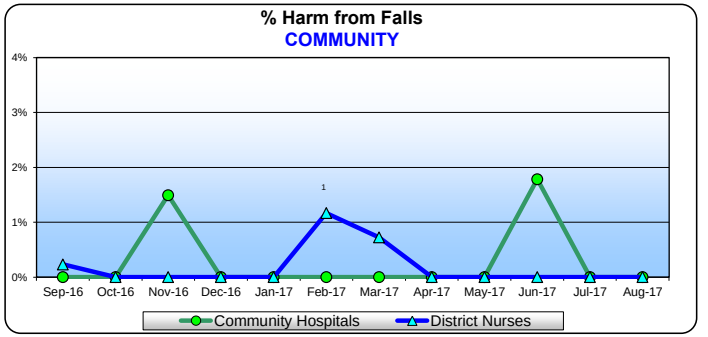
# Safety Thermometer

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.

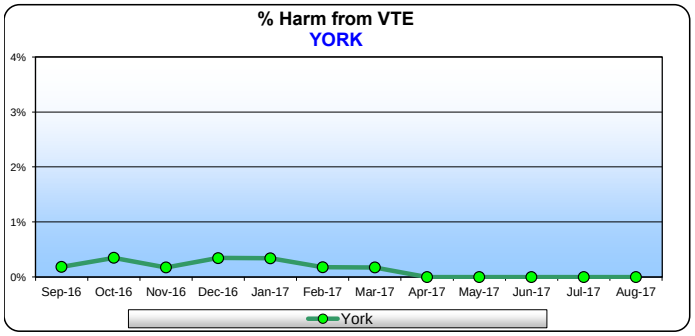
| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Harm from Falls<br>source: Safety Thermometer | York | 0.2% | 0.2% | 0.0% | 0.2% | 0.3% | 0.9% | 0.2% | 0.6% | 0.0% | 0.4% | 0.0% | 0.4% |
| | Scarborough | 1.3% | 0.3% | 0.0% | 0.7% | 1.0% | 0.6% | 0.0% | 1.0% | 0.4% | 0.0% | 0.8% | 0.7% |
| | Community Hospitals | 0.0% | 0.0% | 1.5% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 1.8% | 0.0% | 0.0% |
| | District Nurses | 0.2% | 0.0% | 0.0% | 0.0% | 0.0% | 1.2% | 0.7% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

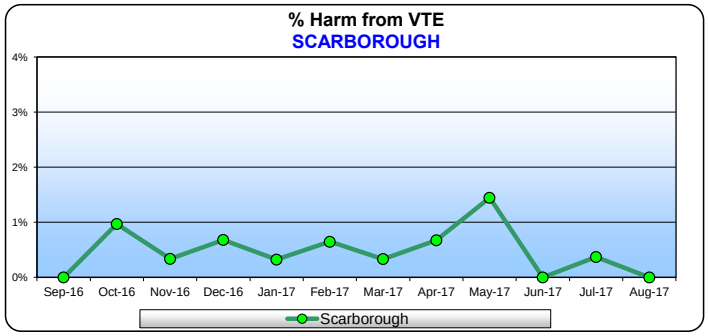


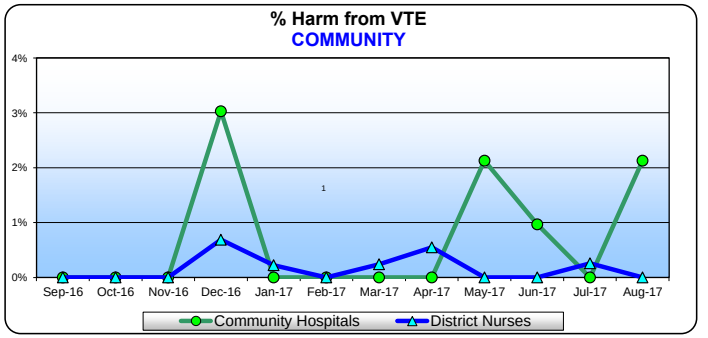




| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of VTE<br>source: Safety Thermometer | York | 0.2% | 0.3% | 0.2% | 0.3% | 0.3% | 0.2% | 0.2% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| | Scarborough | 0.0% | 1.0% | 0.3% | 0.7% | 0.3% | 0.6% | 0.3% | 0.7% | 1.4% | 0.0% | 0.4% | 0.0% |
| | Community Hospitals | 0.0% | 0.0% | 0.0% | 3.0% | 0.0% | 0.0% | 0.0% | 0.0% | 2.1% | 1.0% | 0.0% | 2.1% |
| | District Nurses | 0.0% | 0.0% | 0.0% | 0.7% | 0.2% | 0.0% | 0.2% | 0.5% | 0.0% | 0.0% | 0.3% | 0.0% |



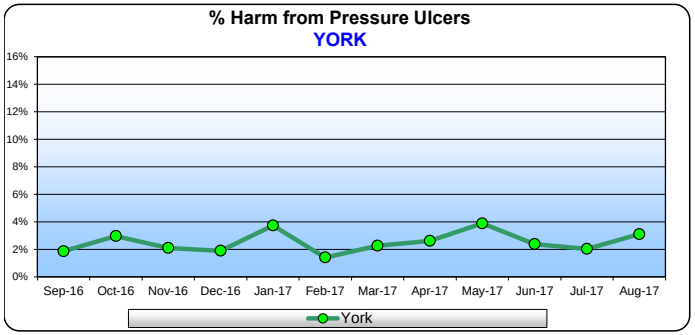



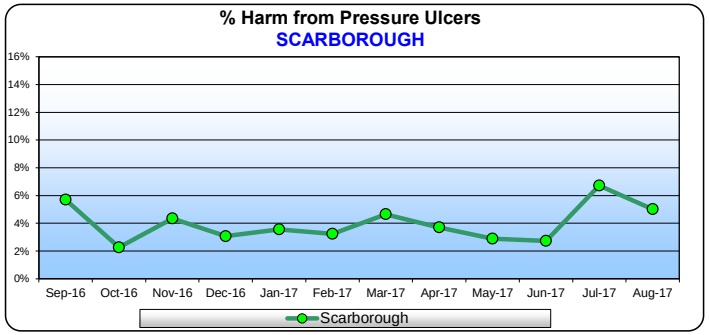



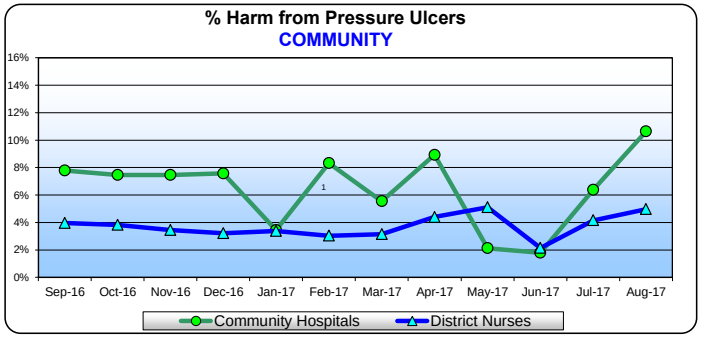
# Safety Thermometer

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

| Indicator | | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Pressure Ulcers source: Safety Thermometer | York | 1.9% | 3.0% | 2.1% | 1.9% | 3.7% | 1.4% | 2.3% | 2.6% | 3.9% | 2.4% | 2.0% | 3.1% |
| | Scarborough | 5.7% | 2.3% | 4.3% | 3.1% | 3.6% | 3.2% | 4.7% | 3.7% | 2.9% | 2.7% | 6.7% | 5.0% |
| | Community Hospitals | 7.8% | 7.5% | 7.5% | 7.6% | 3.4% | 8.3% | 5.6% | 8.9% | 2.1% | 1.8% | 6.4% | 10.6% |
| | District Nurses | 4.0% | 3.8% | 3.4% | 3.2% | 3.4% | 3.0% | 3.1% | 4.4% | 5.1% | 2.1% | 4.2% | 5.0% |



# Mortality

| Indicator | Oct 12 - Sep 13 | Jan 13 - Dec 13 | Apr 13 - Mar 14 | Jul 13 - Jun 14 | Oct 13 - Sep 14 | Jan 14 - Dec 14 | Apr 14 - Mar 15 | Jul 14 - Jun 15 | Oct 14 - Sep 15 | Jan 15 - Dec 15 | Apr 15 - Mar 16 | Jul 15 - Jun 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SHMI – York locality | 93 | 93 | 95 | 98 | 99 | 97 | 96 | 95 | 93 | 94 | 95 | 96 |
| SHMI – Scarborough locality | 104 | 105 | 107 | 108 | 109 | 107 | 108 | 107 | 107 | 108 | 107 | 106 |
| **SHMI – Trust** | **97** | **98** | **99** | **102** | **103** | **101** | **101** | **99** | **99** | **99** | **100** | **99** |

**Definition**

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

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

**Analysis of Performance**

The latest SHMI report indicates the Trust to be in the 'as expected' range. The July 2015 - June 2016 SHMI saw a 1 point decrease for the Trust and Scarborough, and a 1 point increase for York. Trust - 99, York 96 and Scarborough 106.

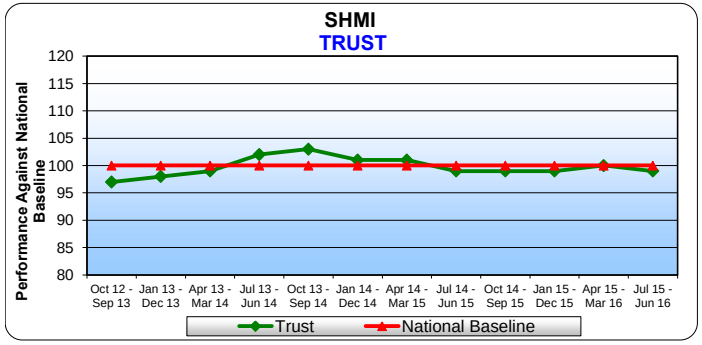
161 inpatient deaths were reported across the Trust in August. 95 deaths were reported at York Hospital, this is comparable with August 2016 (4.4% increase). 60 deaths were reported at Scarborough, a 20% increase on August 2016. The Trust saw a total of 6 deaths across the Community sites in August 2017.

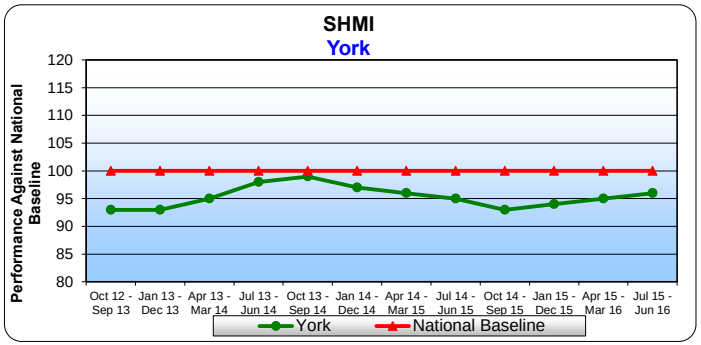
11 deaths in ED were reported in August; 8 at York and 3 at Scarborough. This is a slight decrease on August 2016 (14 deaths in total; 4 at York and 10 at Scarborough) and remains comparable with the last quarter.

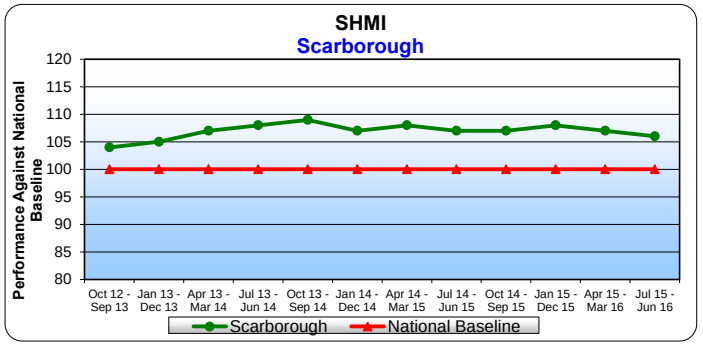
# Mortality

York Teaching Hospital NHS
NHS Foundation Trust

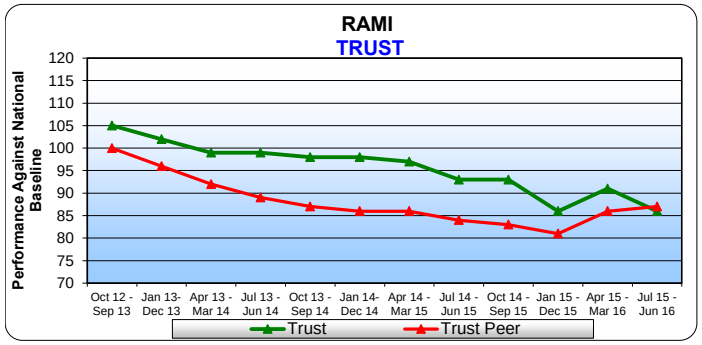
| Indicator | Consequence of Breach (Monthly unless specified) | Jan 14 - Dec 14 | Apr 14 - Mar 15 | Jul 14 - Jun 15 | Oct 14 - Sep 15 | Jan 15 - Dec 15 | Apr 15 - Mar 16 | Jul 15 - Jun 16 |
|---|---|---|---|---|---|---|---|---|
| Mortality – SHMI (TRUST) | **Quarterly:** General Condition 9 | 101 | 101 | 99 | 99 | 99 | 100 | 99 |
| Mortality – SHMI (YORK) | **Quarterly:** General Condition 9 | 97 | 96 | 95 | 93 | 94 | 95 | 96 |
| Mortality – SHMI (SCARBOROUGH) | **Quarterly:** General Condition 9 | 107 | 108 | 107 | 107 | 108 | 107 | 106 |

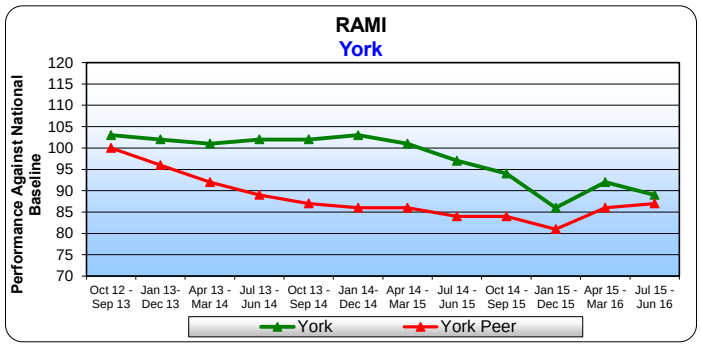


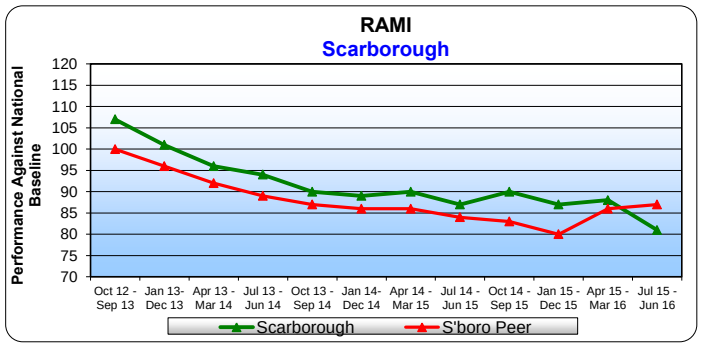




| Indicator | Consequence of Breach (Monthly unless specified) | Jan 14 - Dec 14 | Apr 14 - Mar 15 | Jul 14 - Jun 15 | Oct 14 - Sep 15 | Jan 15 - Dec 15 | Apr 15 - Mar 16 | Jul 15 - Jun 16 |
|---|---|---|---|---|---|---|---|---|
| Mortality – RAMI (TRUST) | **none - monitoring only** | 98 | 97 | 93 | 93 | 86 | 91 | 86 |
| Mortality – RAMI (YORK) | **none - monitoring only** | 103 | 101 | 97 | 94 | 86 | 92 | 89 |
| Mortality – RAMI (SCARBOROUGH) | **none - monitoring only** | 89 | 90 | 87 | 90 | 87 | 88 | 81 |



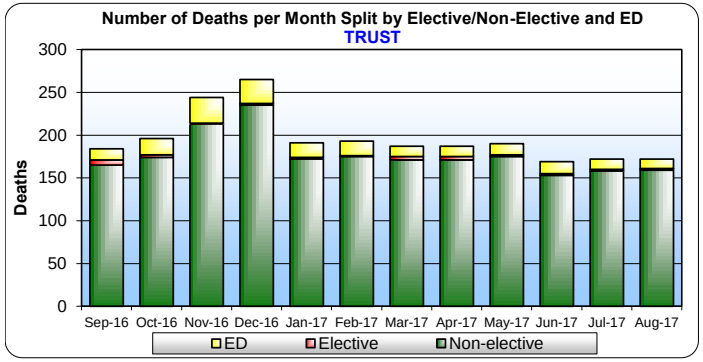



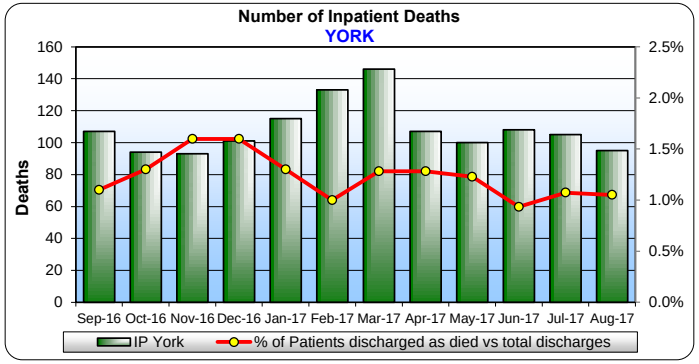



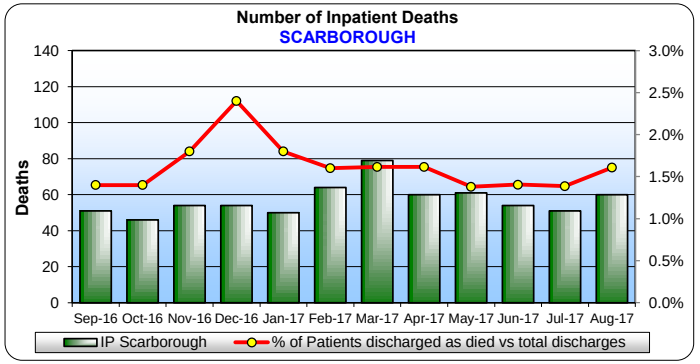
# Mortality

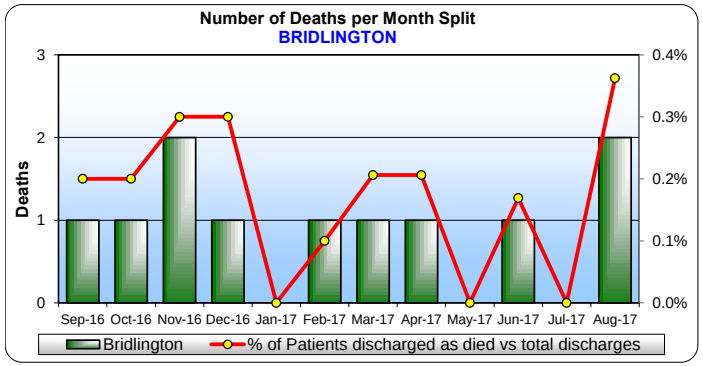
York Teaching Hospital NHS
NHS Foundation Trust

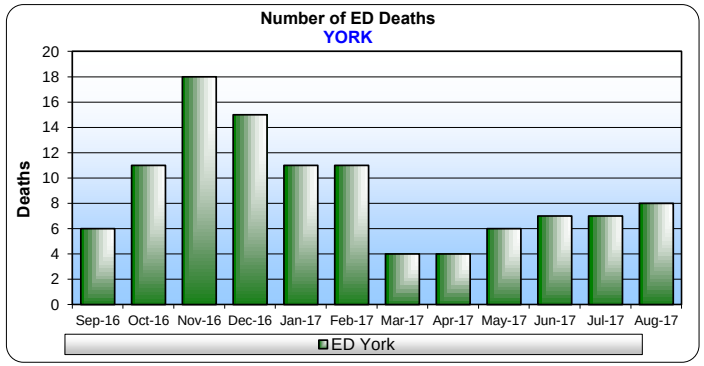
| Indicator | Consequence of Breach (Monthly unless specified) | Q2 16/17 | Q3 16/17 | Q4 16/17 | Q1 17/18 | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|
| Number of Inpatient Deaths | None - Monitoring Only | 486 | 628 | 525 | 507 | 155 | 160 | 161 |
| Number of ED Deaths | None - Monitoring Only | 37 | 77 | 46 | 39 | 14 | 12 | 11 |

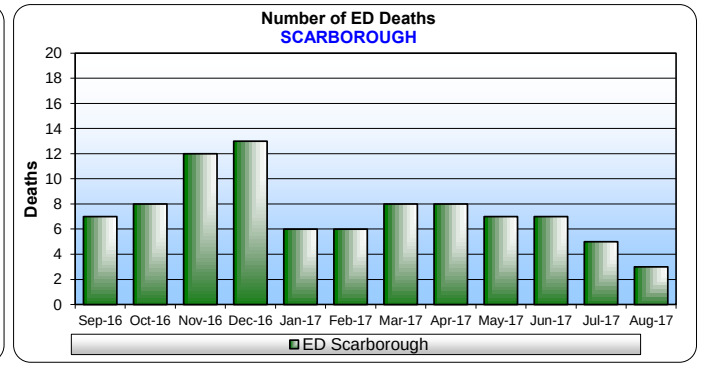


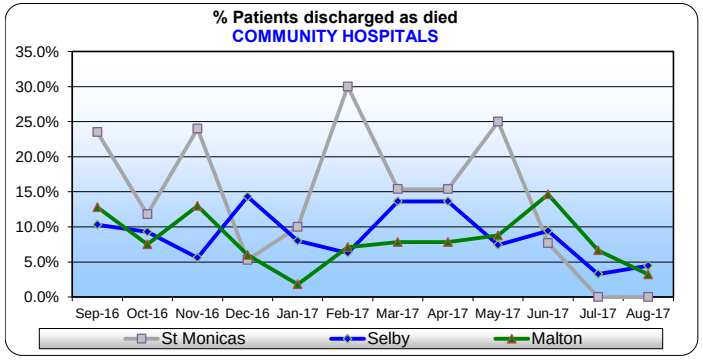



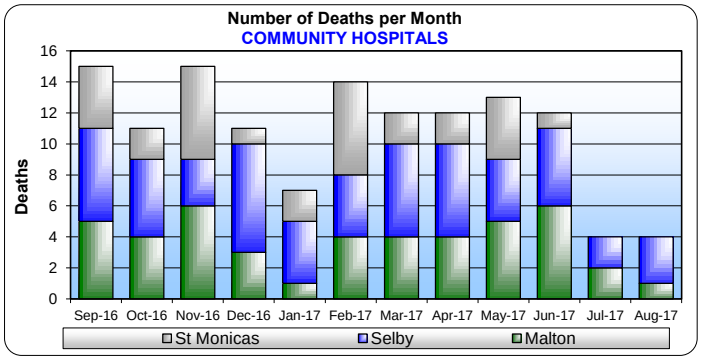




| Month | Malton | Selby | St Monicas | Brid |
|---|---|---|---|---|
| Sep-16 | 5 | 6 | 4 | 1 |
| Oct-16 | 4 | 5 | 2 | 1 |
| Nov-16 | 6 | 3 | 6 | 2 |
| Dec-16 | 3 | 7 | 1 | 1 |
| Jan-17 | 1 | 4 | 2 | 0 |
| Feb-17 | 4 | 4 | 6 | 1 |
| Mar-17 | 4 | 6 | 2 | 1 |
| Apr-17 | 4 | 6 | 2 | 1 |
| May-17 | 5 | 4 | 4 | 0 |
| Jun-17 | 6 | 5 | 1 | 1 |
| Jul-17 | 2 | 2 | 0 | 0 |
| Aug-17 | 1 | 3 | 0 | 2 |

## Patient Safety Walkrounds – August 2017

York Teaching Hospital NHS
NHS Foundation Trust

| Date | Location | Participants | Actions & Recommendations |
|---|---|---|---|
| 01/08/2017 | Ward 31 | Juliet Walters - Director<br>Karen Cowley – Directorate Manager<br>Mark Quinn – Clinical Director<br>Tracey Ward - Matron<br>Emily Hemmings - Sister<br>Jenny Macaleese – Non-Executive Director | No issues raised and previous actions completed. |
| 10/08/2017 | Theatres, Outpatients & Pain Clinic, Scarborough | Ed Smith – Deputy Medical Director<br>Tracey Richardson – Directorate Manager<br>Phil Dickinson – Consultant<br>Pauline Guyan – Matron | PCA/Epidural Training needs to be done by PACU staff. **Action** - Matron to address with PACU lead re competency training of staff.<br><br>Acute Pain Service –need decision on which infusion pumps are to be used in Scarborough. **Action** – Matron to speak to Pain Lead Nurse and CD. PD to discuss medical support with CD.<br><br>Out of Hours Scrub Nurse often supports Emergency Sections due to unexpected staffing issues, resulting in closing Acute Theatre. **Action** – DM to contact Obs & Gynae DM re alternative plan.<br><br>Set of doors in old PACU are old and may need replacing. **Action** – DM to check if they are in the capital plan programme work.<br><br>Outpatients' environment, split site, no sisters' office, no staff accommodation, room for patient observation facilities in area c. **Action** – consider options. |
| 24/08/2017 | ED and Urgent Care Centre, York | Sue Symington – Chair<br>Diane Palmer – Deputy Director<br>Steve Lord – Clinical Director<br>David Thomas – Directorate Manager<br>Jill Wilford - Matron | ED Front Door has multiple services operating which means Reception is extremely busy and the foyer is confusing for patients. Services are: Walk-in arrivals for Emergency Dept., Walk-in arrivals for UCC, Orthopaedic OP Clinic, GP Out of Hours Service. **Action** – additional Capital Funds have been secured from NHS(E) to make improvements in ED Front Door for Primary Care Service. This will include significant changes to the waiting and streaming area. NB: the changes being proposed will be in place by Dec 17. Streaming cubicles will be built in current void space that is used as an ambulance overflow area which means there will be no Ambulance overflow.<br><br>Confidentiality of patients discussing presentation with Clinical Navigator. **Action** – Remains an ongoing issue but is to be rectified as part of the infrastructure work planned (see above).<br><br>Shortfalls in staffing numbers. **Action** – Nursing: revised nursing model in place but still has shortfalls due to inability to recruit in totality. In addition, ED staff are being moved into other ward areas. Doctors: reviewing medical staff workforce in ED. CESR programme for ED Specialty Doctors is being advertised, also exploring Portfolio GP roles within ED. In addition to expanding the ACP workforce.<br><br>Some cubicles not in view of main nurses' station. **Action** – there is guidance now on cubicle allocation (following of 2 SIs). Looking at "fit to sit" concept so that those who are safe to sit out of cubicles can do so and free-up valuable cubicle space.<br><br>The all-up training requirement for an ED nurse requires a very significant amount of study time to be allocated in the rota, which cannot be accommodated. **Action** – highlighted on the Risk Register. |

| YORK - MATERNITY DASHBOARD | | | Measure | Data source | No Concerns (Green) | Of Concern (Amber) | Concerns (Red) | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Activity | Births | Bookings | 1st m/w visit | CPD | ≤302 | 303-329 | ≥330 | 326 | 303 | 366 | 248 | 288 | 301 | 286 | 259 | | | | |
| | | Bookings <13 weeks | No. of mothers | CPD | ≥90% | 76%-89% | ≤75% | 86.2% | 90.1% | 91.8% | 90.9% | 88.9% | 88.0% | 87.8% | 84.9% | | | | |
| | | Bookings ≥13 weeks (exc transfers etc) | No. of mothers | CPD | < 10% | 10.1%-19.9% | >20% | 5.8% | 5.0% | 4.1% | 4.3% | 5.9% | 7.3% | 4.5% | 4.2% | | | | |
| | | Bookings ≥ 13wks seen within 2 wks | No. of mothers | CPD | ≥90% | 76%-89% | ≤75% | 94.70% | 60.00% | 86.70% | 54.50% | 64.70% | 81.80% | 76.90% | 63.60% | | | | |
| | | Births | No. of babies | CPD | ≤295 | 296-309 | ≥310 | 269 | 244 | 264 | 244 | 267 | 259 | 273 | 269 | | | | |
| | | No. of women delivered | No. of mothers | CPD | ≤295 | 296-310 | ≥311 | 264 | 240 | 261 | 237 | 263 | 253 | 269 | 262 | | | | |
| | Closures | Homebirth service suspended | No. of suspensions | Comm. Manager | 0-3 | 4-6 | 7 or more | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | | Women affected by suspension | No. of women | Comm. Manager | 0 | 1 | 2 or more | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | | Community midwife called in to unit | No. of times | Comm. Manager | 3 | 4-5 | 6 or more | 5 | 3 | 3 | 0 | 0 | 3 | 2 | 1 | | | | |
| | | Maternity Unit Closure | No. of closures | Matron | 0 | | 1 or more | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | | SCBU at capacity (**since May 2017**) | No of times | SCBU | | | | | | | | 0 | 0 | 0 | 2 | | | | |
| | | SCBU at capacity of intensive cots | No. of times | SCBU | | | | 9 | 15 | 7 | 2 | 2 | 0 | 1 | 3 | | | | |
| | | SCBU no of babies affected | No. of babies affected | SCBU | 0 | 1 | 2 or more | 0 | 0 | 6 | 0 | 0 | 0 | 0 | 0 | | | | |
| Workforce | Staffing | MW to birth ratio | Ratio | Matron | ≤29.5 | 29.6 - 30.9 | >31 | 29 | 29 | 28 | 35 | 35 | 34 | 34 | 30 | | | | |
| | | 1 to 1 care in Labour | CPD | CPD | 100% | 80% - 99.9% | ≤79.9% | 78.8% | 81.3% | 78.9% | 71.7% | 76.0% | 77.5% | 72.5% | 73.7% | | | | |
| | | L/W Co-ordinator supernumary % | Shift Handover Sheets | Risk Team | 100% | 80% - 99.9% | ≤79.9% | 61.0% | 78.0% | 74.0% | 63.0% | 69.0% | 65.0% | 62.0% | 51.0% | | | | |
| | | Consultant cover on L/W | av. hours/week | DM / CD | 40 | | ≤39 | 76 | 76 | 76 | 76 | 76 | 76 | 76 | | | | | |
| | | Anaesthetic cover on L/W | av.sessions/week | DM / CD | 10 | 4-9 | ≤3 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | | | | |
| Clinical Indicators | Neonatal/ Maternal | Normal Births | No. of svd - % | CPD | ≥60.6% | 60.5-55% | <55% | 56.7% | 61.8% | 62.6% | 58.7% | 61.9% | 58.9% | 63.2% | 57.7% | | | | |
| | | Assisted Vaginal Births | No. of instr. Births - % | CPD | ≤13.2 | 13.3-17.9% | ≥18% | 17.4% | 10.0% | 11.9% | 11.4% | 9.9% | 14.6% | 11.2% | 10.7% | | | | |
| | | C/S Births | Em & elect - % | CPD | ≤26% | 26.1-27.9% | >28% | 26.5% | 28.3% | 25.7% | 30.4% | 28.1% | 26.1% | 25.3% | 29.0% | | | | |
| | | Eclampsia | No. of women | CPD | 0 | | 1 or more | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | | | | |
| | | Undiagnosed Breech in Labour | No. of women | CPD | 2 or less | 3-4 | 5 or more | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 1 | | | | |
| | | HDU on L/W | No. of women | LW Activity Sheet | 3 or less | 4 | 5 or more | 11 | 18 | 4 | 21 | 11 | 23 | 12 | 14 | | | | |
| | | BBA | No. of women | Risk Team - Datix | 2 or less | 3-4 | 5 or more | 1 | 4 | 1 | 5 | 1 | 5 | 4 | 3 | | | | |
| | | Diagnosis of HIE | No. of babies | SCBU Paed | 0 | 1 | 2 or more | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | | | | |
| | | NHS Resolution cases | No of cases | | 0 | 1 | 2 or more | | | | 0 | 2 | 0 | 0 | 0 | | | | |
| | Morbidity | Neonatal Death | No of babies | Risk team- EBC | 0 | | 1 or more | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | | | | |
| | | Antepartum Stillbirth | No. of babies | Risk Team | 0 | 1 | 2 or more | 2 | 0 | 0 | 0 | 1 | 0 | 3 | 1 | | | | |
| | | Intrapartum Stillbirths | No. of babies | Risk Team | 0 | | 1 or more | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | | | |
| | Risk Management | Breastfeeding Initiation rate | % of babies feeding at birth | CPD | >74.4% | 74.3-70.1% | <70% | 74.2% | 72.5% | 73.6% | 71.7% | 77.6% | 75.5% | 73.6% | 76.3% | | | | |
| | | Smoking at time of delivery | % of women smoking at del. | CPD | <11% | 12-14% | >15% | 11.4% | 12.5% | 14.6% | 11.0% | 9.1% | 6.7% | 12.6% | 11.5% | | | | |
| | | SI's | No. of Si's declared | Risk Team | 0 | | 1 or more | 0 | 0 | 0 | 2 | 4 | 1 | 0 | 0 | | | | |
| | | PPH > 1.5L | No. of women | CPD | 2 or less | 3-4 | 5 or more | 4 | 12 | 3 | 8 | 4 | 8 | 9 | 8 | | | | |
| | | PPH > 1.5L as % of all women | % of births | CPD | | | | 1.5% | 5.0% | 0.8% | 3.4% | 1.5% | 3.6% | 2.6% | 3.1% | | | | |
| | | Shoulder Dystocia | No. of women | CPD | 2 or less | 3-4 | 5 or more | 0 | 0 | 3 | 6 | 2 | 2 | 3 | 6 | | | | |
| | | 3rd/4th Degree Tear | % of tears (vaginal births) | CPD | ≤2.5% | 2.6- 3.9% | ≥4% | 2.0% | 2.8% | 5.1% | 1.2% | 1.6% | 4.2% | 2.9% | 2.7% | | | | |
| | New Complaints | Informal | No. of Informal complaints | Risk Matrix | 0 | 1-4 | 5 or more | 0 | 0 | 1 | 1 | 3 | 2 | 0 | 3 | | | | |
| | | Formal | No. of Formal complaints | Risk Matrix | 0 | 1-4 | 5 or more | 5 | 0 | 2 | 3 | 2 | 2 | 2 | 1 | | | | |

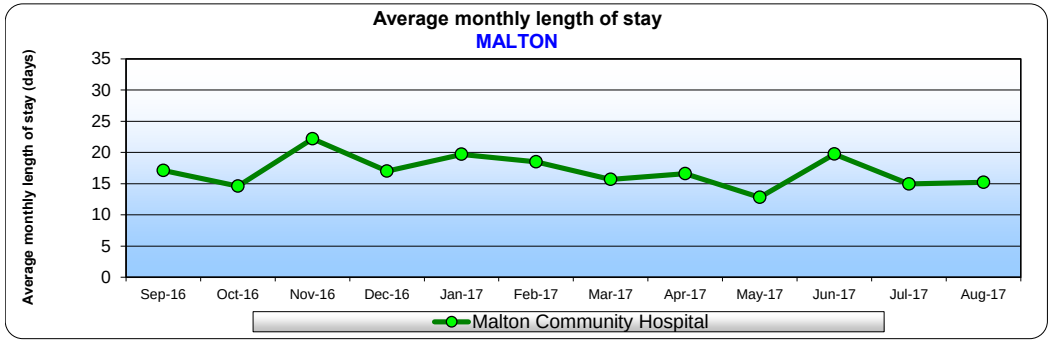
***Maternity Dashboard metrics were reviewed on 01.08.2017***

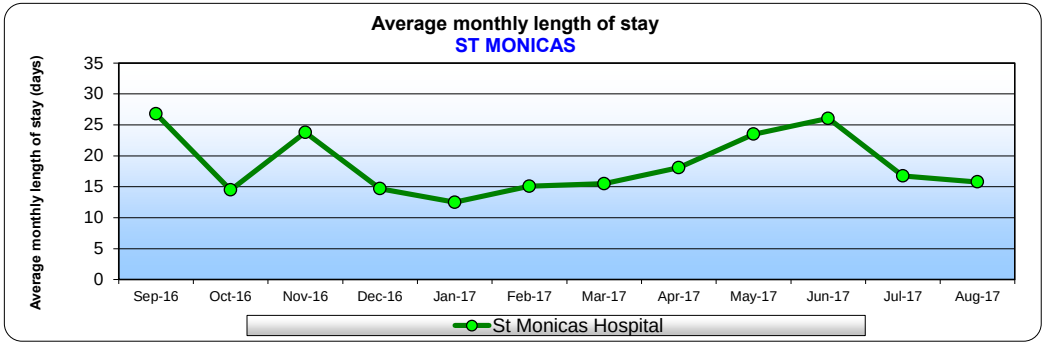
| SCARBOROUGH - MATERNITY DASHBOARD | | | Measure | Data source | No Concerns (Green) | Of Concern (Amber) | Concerns (Red) | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Activity | Births | Bookings | 1st m/w visit | CPD | ≤210 | 211-259 | ≥260 | 217 | 194 | 217 | 154 | 206 | 171 | 177 | 153 | | | | |
| | | Bookings <13 weeks | No. of mothers | CPD | ≥90% | 76%-89% | ≤75% | 93.1% | 91.2% | 91.2% | 92.2% | 90.8% | 89.5% | 91.0% | 91.5% | | | | |
| | | Bookings ≥13 weeks (exc transfers etc) | No. of mothers | CPD | < 10% | 10%-20% | >20% | 5.1% | 6.2% | 4.6% | 7.8% | 8.3% | 9.9% | 6.8% | 5.2% | | | | |
| | | Bookings ≥ 13wks seen within 2 wks | No. of mothers | CPD | ≥90% | 76%-89% | ≤75% | 73% | 83% | 100% | 100% | 82% | 82% | 75% | 100% | | | | |
| | | Births | No. of babies | CPD | ≤170 | 171-189 | ≥190 | 124 | 138 | 128 | 112 | 121 | 108 | 127 | 118 | | | | |
| | | No. of women delivered | No. of mothers | CPD | ≤170 | 171-189 | ≥190 | 122 | 137 | 127 | 111 | 120 | 108 | 127 | 116 | | | | |
| | Closures | Homebirth service suspended | No. of suspensions | Comm. Manager | 0-3 | 4-6 | 7 or more | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | | Women affected by suspension | No. of women | Comm. Manager | 0 | 1 | 2 or more | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | | Community midwife called in to unit | No. of times | Comm. Manager | 3 | 4-5 | 6 or more | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | | Maternity Unit Closure | No. of closures | Matron | 0 | | 1 or more | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | | SCBU at capacity (**since May 2017**) | No of times | SCBU | | | | | | | | 1 | 1 | 0 | 0 | | | | |
| | | SCBU at capacity of intensive care cots | No. of times | SCBU | | | | 0 | 0 | 0 | 1 | 4 | 1 | 5 | 2 | | | | |
| | | SCBU no of babies affected | No. of babies affected | SCBU | 0 | 1 | 2 or more | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 1 | | | | |
| Workforce | Staffing | M/W to birth ratio | Ratio | Matron | ≤29.5 | 29.6-30.9 | >31 | 41.0 | 40.8 | 40.2 | 23 | 24 | 24 | 24 | 24 | | | | |
| | | 1 to 1 care in Labour | CPD | CPD | ≥100% | 80% - 99.9% | ≤79.9% | 88.5% | 89.8% | 89.8% | 86.5% | 80.8% | 88.8% | 82.7% | 90.5% | | | | |
| | | L/W Co-ordinator supernumary % | Shift Handover Sheets | Risk Team | ≥100% | 80% - 99.9% | ≤79.9% | 80.6% | 78.6% | 85.5% | 91.6% | 88.3% | 80.0% | 75.8% | 80.6% | | | | |
| | | Consultant cover on L/W | av. hours/week | DM / CD | 40 | | ≤39 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | | | | | |
| | | Anaesthetic cover on L/W | av.sessions/week | DM / CD | 5 | 3-4 | <3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | | | | |
| Clinical Indicators | Neonatal/ Maternal | Normal Births | No. of svd - % | CPD | ≥60.6% | 60.5-55% | <55% | 70.2% | 72.5% | 66.9% | 64.9% | 66.9% | 63.6% | 63.6% | 68.9% | | | | |
| | | Assisted Vaginal Births | No. of instr. Births - % | CPD | ≤13.2 | 13.3-17.9% | ≥18% | 13.9% | 6.6% | 5.5% | 14.4% | 5.8% | 12.0% | 7.1% | 7.8% | | | | |
| | | C/S Births | Em & elect - % | CPD | ≤26% | 26.1-27.9% | >28% | 16.4% | 21.2% | 26.8% | 19.8% | 27.5% | 23.1% | 27.6% | 21.6% | | | | |
| | | Eclampsia | No. of women | CPD | 0 | | 1 or more | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | | Undiagnosed Breech in Labour | No. of women | CPD | 2 or less | 3-4 | 5 or more | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | | | | |
| | | HDU on L/W | No. of women | LW Activity Sheet | 3 or less | 4 | 5 or more | 3 | 4 | 4 | 7 | 2 | 4 | 5 | 1 | | | | |
| | | BBA | No. of women | Risk Team - Datix | 2 or less | 3-4 | 5 or more | 2 | 2 | 3 | 1 | 5 | 3 | 2 | 1 | | | | |
| | | Diagnosis of HIE | No. of babies | SCBU Paed | 0 | 1 | 2 or more | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | | | |
| | | NHS Resolution cases | No of cases | | 0 | 1 | 2 or more | | | | 0 | 0 | 1 | 0 | 0 | | | | |
| | Morbidity | Neonatal Death | No of babies | Risk team- EBC | 0 | | 1 or more | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | | Antepartum Stillbirth | No. of babies | Risk Team | 0 | 1 | 2 or more | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | | | | |
| | | Intrapartum Stillbirths | No. of babies | Risk Team | 0 | | 1 or more | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | Risk Management | Breastfeeding Initiation rate | % of babies feeding at birth | CPD | >74.4% | 74.3-70.1% | <70% | 58.2% | 58.4% | 51.2% | 56.8% | 54.2% | 59.3% | 57.5% | 63.8% | | | | |
| | | Smoking at time of delivery | % of women smoking at del. | CPD | <11% | 12-14% | >15% | 19% | 18% | 24% | 23% | 18% | 19% | 17% | 25% | | | | |
| | | SI's | No. of Si's declared | Risk Team | 0 | | 1 or more | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | | | | |
| | | PPH > 1.5L | No. of women | CPD | 2 or less | 3-4 | 5 or more | 3 | 3 | 5 | 5 | 2 | 3 | 4 | 0 | | | | |
| | | PPH > 1.5L as % of all women | % of births | CPD | | | | 3 | 2 | 4 | 5 | 2 | 3 | 3 | 0 | | | | |
| | | Shoulder Dystocia | No. of women | CPD | 2 or less | 3-4 | 5 or more | 2 | 1 | 2 | 1 | 0 | 2 | 1 | 1 | | | | |
| | | 3rd/4th Degree Tear | % of tears (vaginal births) | CPD | ≤2.5% | 2.6- 3.9% | ≥4% | 2.9% | 2.8% | 1.1% | 1.1% | 0.0% | 1.2% | 0.0% | 1.1% | | | | |
| | New Complaints | Informal | No. of Informal complaints | Risk Matrix | 0 | 1-4 | 5 or more | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | | | |
| | | Formal | No. of Formal complaints | Risk Matrix | 0 | 1-4 | 5 or more | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 1 | | | | |

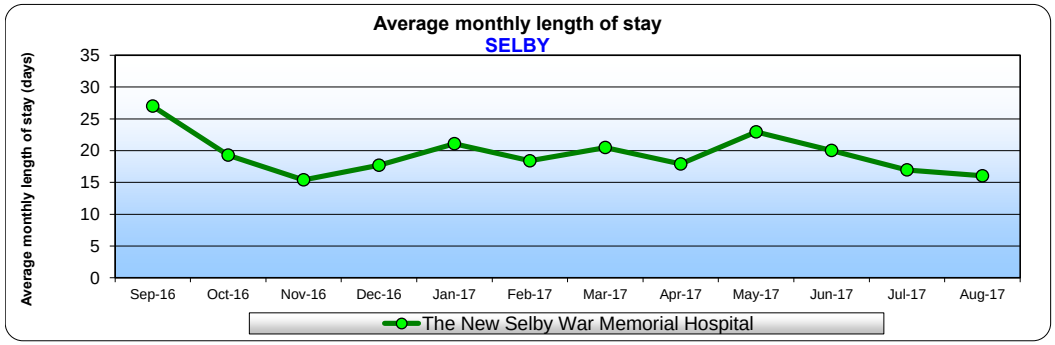
***Maternity Dashboard metrics were reviewed on 01.08.2017***

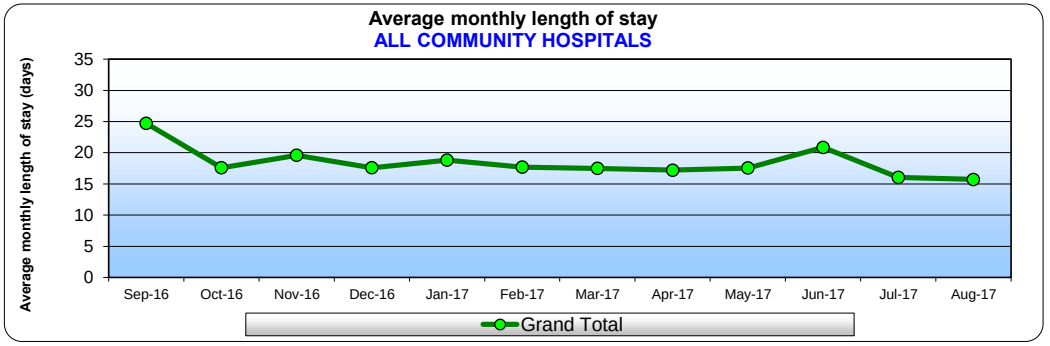
## Community Hospitals

| Indicator | Hospital | Q2 16/17 | Q3 16/17 | Q4 16/17 | Q1 17/18 | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|
| **Community Hospitals average length of stay (days)** Excluding Daycases | **Malton Community Hospital** | 18.5 | 18.6 | 17.9 | 16.0 | 19.8 | 14.9 | 15.2 |
| | **St Monicas Hospital** | 22.7 | 17.2 | 14.4 | 22.6 | 26.1 | 16.8 | 15.8 |
| | **The New Selby War Memorial Hospital** | 23.0 | 17.7 | 20.2 | 20.4 | 20.0 | 17.0 | 16.1 |
| | **Total** | 21.9 | 18.3 | 18.0 | 18.5 | 20.9 | 16.0 | 15.7 |



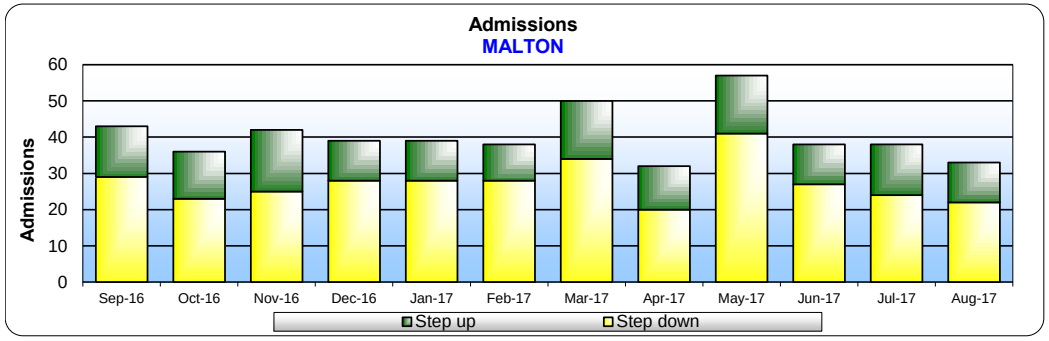



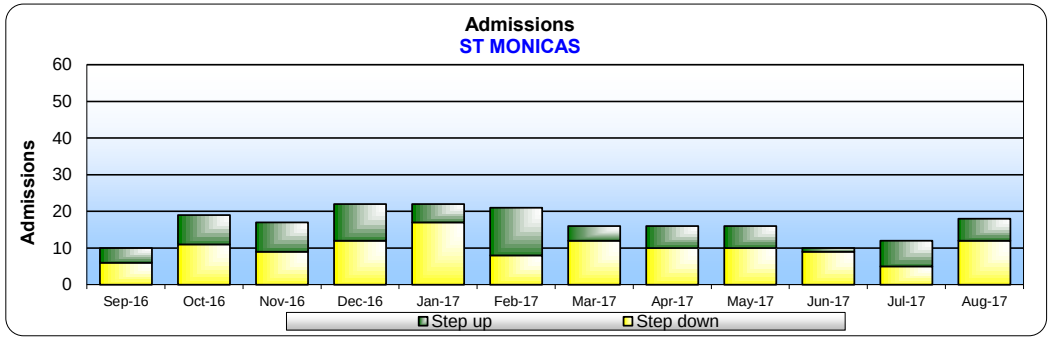



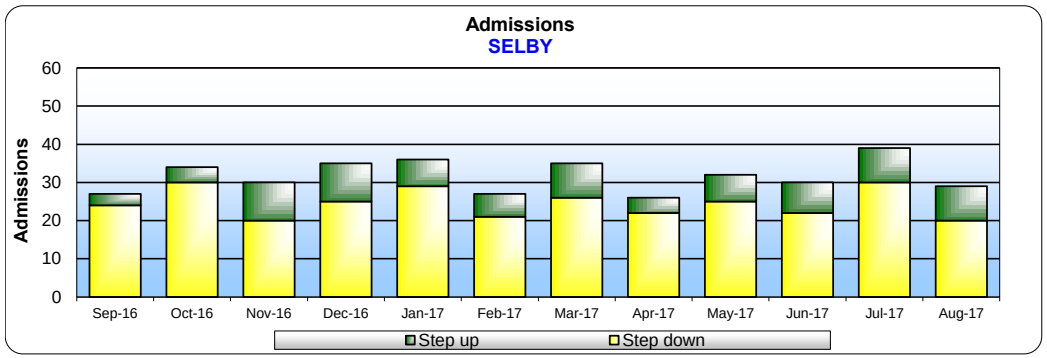



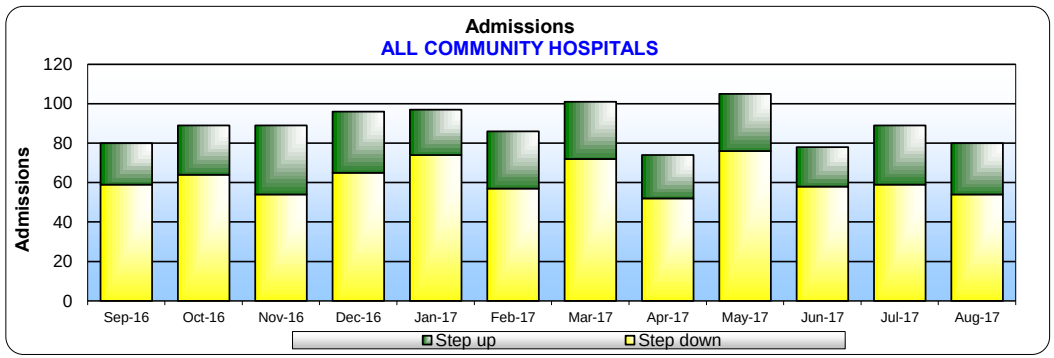
## Community Hospitals

| Indicator | Hospital | | Q2 16/17 | Q3 16/17 | Q4 16/17 | Q1 17/18 | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|
| **Community Hospitals admissions**<br><br>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. | **Malton Community Hospital** | **Step up** | 39 | 41 | 37 | 39 | 11 | 14 | 11 |
| | | **Step down** | 93 | 76 | 90 | 88 | 27 | 24 | 22 |
| | **St Monicas Hospital** | **Step up** | 14 | 26 | 22 | 13 | 1 | 7 | 6 |
| | | **Step down** | 23 | 32 | 37 | 29 | 9 | 5 | 12 |
| | **The New Selby War Memorial** | **Step up** | 24 | 24 | 22 | 19 | 8 | 9 | 9 |
| | | **Step down** | 66 | 75 | 76 | 69 | 22 | 30 | 20 |
| | **Total** | **Step up** | 81 | 100 | 81 | 71 | 20 | 30 | 26 |
| | | **Step down** | 246 | 234 | 203 | 186 | 58 | 59 | 54 |



# Quality and Safety: Misc

| Indicator | Consequence of Breach (Monthly unless specified) | Threshold | Q2 16/17 | Q3 16/17 | Q4 16/17 | Q1 17/18 | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|
| 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** | 2 | 2 | 18 | 4 | 2 | 1 | 3 |
| 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 |
| Sleeping Accommodation Breach | £250 per day per Service User affected | **0** | 0 | 0 | 5 | 0 | 0 | 0 | 0 |
| % Compliance with WHO safer surgery checklist | No financial penalty | **100%** | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| 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%** | 99.9% | 99.6% | 99.8% | 99.7% | 99.7% | To follow | To follow |
| 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%** | 98.8% | 98.2% | 98.2% | 97.9% | 97.7% | 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%** | 5.8% | 3.3% | 3.9% | 7.1% | 7.1% | n/a | n/a |
| Delayed Transfer of Care – All patients medically fit for discharge and issued a 'notification notice' as per joint protocol for the transfer of care | As set out in Service Condition 3 and General Condition 9 | **Set baseline in Q1 and agree trajectory** | Monthly Provider Report | | | | | | |
| Trust waiting time for Rapid Access Chest Pain Clinic | General Condition 9 | **99%** | 100.0% | 94.9% | 100.0% | 100.0% | 100.0% | 100.0% | To follow |
| Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP) | As set out in Service Condition 3 and 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 and tabled at sub CMB quarterly. | | | | | | |
| Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition) | General Condition 9 | **90%** | 99.8% | 99.8% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent | General Condition 9 | **95%** | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| All Red Drugs to be prescribed by provider effective from 01/04/15, subject to agreement on list | Recovery of costs for any breach to be agreed via medicines management committee | **0** | CCG to audit for breaches | | | | | | |
| All Amber Drugs to be prescribed as per shared care guidelines from 01/04/15 | Recovery of costs for any breach to be agreed via medicines management committee | **0** | CCG to audit for breaches | | | | | | |

## Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

| | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Complaints and PALS** | | | | | | | | | | | | |
| New complaints this month | 44 | 36 | 37 | 33 | 43 | 32 | 38 | 34 | 47 | 36 | 51 | 45 |
| Top 3 complaint subjects | | | | | | | | | | | | |
| All aspects of Clinical Treatment | 71 | 40 | 36 | 18 | 32 | 16 | 39 | 26 | 34 | 21 | 34 | 26 |
| Communications/information to patients (written and oral) | 72 | 19 | 17 | 12 | 16 | 2 | 16 | 6 | 11 | 17 | 15 | 16 |
| Patient Care | 26 | 13 | 36 | 10 | 35 | 17 | 23 | 15 | 10 | 18 | 19 | 17 |
| Top 3 directorates receiving complaints | | | | | | | | | | | | |
| Acute & General Medicine | 6 | 3 | 5 | 4 | 8 | 4 | 7 | 8 | 7 | 3 | 4 | 11 |
| Emergency Medicine | 6 | 10 | 5 | 7 | 8 | 1 | 6 | 5 | 3 | 5 | 6 | 6 |
| General Surgery & Urology | 3 | 3 | 7 | 4 | 6 | 5 | 4 | 1 | 7 | 3 | 7 | 1 |
| Number of Ombudsman complaint reviews (new) | 0 | 0 | 2 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 2 | 2 |
| Number of Ombudsman complaint reviews upheld | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Number of Ombudsman complaint reviews partly upheld | 2 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 |
| New PALS queries this month | 284 | 279 | 286 | 210 | 278 | 260 | 336 | 273 | 241 | 280 | 263 | 291 |
| Top 3 PALS subjects | | | | | | | | | | | | |
| Communication issues | 51 | 51 | 76 | 52 | 50 | 56 | 62 | 62 | 56 | 87 | 92 | 60 |
| Any aspect of clinical care/treatment | 28 | 23 | 20 | 22 | 24 | 28 | 30 | 26 | 17 | 18 | 16 | 19 |
| Appointments | 60 | 50 | 44 | 43 | 40 | 29 | 46 | 57 | 53 | 55 | 42 | 47 |
| | | | | | | | | | | | | |
| **Serious Incidents** | | | | | | | | | | | | |
| Number of SI's reported | 12 | 9 | 18 | 14 | 28 | 18 | 10 | 9 | 20 | 19 | 14 | 12 |
| % SI's notified within 2 working days of SI being identified | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| * this is currently under discussion via the 'exceptions log' | | | | | | | | | | | | |
| **Compliance with Duty of Candour for Serious Incidents*:** | | | | | | | | | | | | |
| -Verbal Apology Given | | | | | | | | | | | | |
| -Written Apology Given * | | | | | | | | | | | | |
| -Invitation to be involved in Investigation | 3 | 1 | 9 | 3 | 2 | 2 | 5 | 0 | 6 | 4 | 4 | 1 |
| -Given Final Report (If Requested) | 1 | 2 | 0 | 1 | 2 | 1 | 2 | 0 | 2 | 1 | 0 | 1 |
| | | | | | | | | | | | | |
| **Pressure Ulcers**** | | | | | | | | | | | | |
| Number of Category 2 | 63 | 77 | 81 | 74 | 91 | 67 | 94 | 90 | 78 | 69 | 69 | 61 |
| Number of Category 3 | 3 | 4 | 6 | 6 | 4 | 6 | 2 | 5 | 11 | 5 | 6 | 6 |
| Number of Category 4 | 0 | 1 | 1 | 1 | 0 | 0 | 2 | 2 | 2 | 1 | 1 | 3 |
| Total number developed/deteriorated while in our care (care of the organisation) - acute | 57 | 85 | 99 | 86 | 99 | 74 | 97 | 101 | 91 | 82 | 84 | 70 |
| Total number developed/deteriorated while in our care (care of the organisation) - community | 36 | 36 | 26 | 29 | 41 | 37 | 40 | 30 | 44 | 28 | 40 | 39 |
| | | | | | | | | | | | | |
| **Falls***** | | | | | | | | | | | | |
| Number of falls with moderate harm | 3 | 0 | 0 | 2 | 4 | 0 | 3 | 7 | 2 | 2 | 0 | 1 |
| Number of falls with severe harm | 4 | 3 | 2 | 2 | 4 | 3 | 2 | 1 | 1 | 2 | 2 | 0 |
| Number of falls resulting in death | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

| | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Safeguarding** | | | | | | | | | | | | |
| % of staff compliant with training (children) | 86% | 86% | 86% | 87% | 87% | 85% | 85% | 85% | 85% | 84% | 84% | 83% |
| % of staff compliant with training (adult) | 86% | 85% | 86% | 88% | 87% | 85% | 86% | 86% | 86% | 86% | 86% | 85% |
| % of staff working with children who have review CRB checks | | | | | | | | | | | | |
| **Prevent Strategy** | | | | | | | | | | | | |
| Attendance at the HealthWRAP training session | | | | | | | | | | | | |
| Number of concerns raised via the incident reporting system | | | | | | | | | | | | |
| **Claims** | | | | | | | | | | | | |
| Number of Negligence Claims | 10 | 13 | 14 | 11 | 10 | 8 | 9 | 14 | 15 | 17 | 13 | 16 |
| Number of Claims settled per Month | 5 | 1 | 8 | 2 | 7 | 3 | 5 | 1 | 10 | 9 | 6 | 2 |
| Amount paid out per month **** | £262,750 | £35,000 | £780,500 | £250,000 | £128,226 | £75,000 | £3,338,000 | £1,200,000 | £674,869 | £6,382,000 | £83,500 | £105,000 |
| Reasons for the payment | Accepted Liability | Accepted Liability | Accepted Liability | Accepted Liability | Accepted Liability | Accepted Liability | Accepted Liability | Accepted Liability | Accepted Liability | Accepted Liability | Accepted Liability | Accepted Liability |

* The Trust is currently developing its processes for recording Duty of Candour and reporting has been temporarily suspended until this has been implemented.

Note ** and *** - falls and pressure ulcers subject to validation. Falls resulting in deaths are investigated as Serious Incidents and the degree of harm will be confirmed upon completion of investigation.

All falls and pressure ulcer data is refreshed monthly to reflect ongoing monitoring and reporting of falls and pressure ulcers. A change on the way the Trust reports pressure ulcers was implemented on 01/09/16 resulting in a slight increase in the pressure ulcers reported as developing under our care. Category 3 & 4 pressure ulcer data excludes Category 3 ulcers which are recorded as having developed within 72 hours of admission to inpatient.

**** one claim in April was settled for a lump sum payment of £450,000 (included in the data) with yearly payments of £145,000 to fund care needs, with the Claimant's life expectancy being between 3 and 5 years. The ongoing care costs are excluded from the above data as they cannot be quantified at present. Amount paid shows the damages. One claim settled in March was settled for a £3,000,000 lump sum plus £59,000 per annum for life. Only the lump sum is reflected in the amount paid out. A claim was settled in June for £6m lump sum with annual payments for life which all totals approximately £14,999,999. Only the lump sum is reflected in the amount paid as the the remainder of the payment is approximate.

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Medical Director's Report

## Recommendation

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

## Current approval route of report

This draft has been written for the Board of Directors only.

## Purpose of report

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

## Key points for discussion

- Review end of placement survey summary
- Note consultants new to the Trust
- Be aware of antibiotic resistance national campaign
- Consider anti-microbial prescribing audit results.
- Note planned 7 day services self-assessment.

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

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

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

Version number: 1

Author: Diane Palmer, Deputy Director of Patient Safety

Executive sponsor: Mr James Taylor, Medical Director

Date: September 2017

## 1. Introduction and Background

In the report this month:

Clinical Effectiveness:

- end of placement survey summary
- consultants new to the Trust

Patient Experience:

- antibiotic resistance national campaign
- anti-microbial prescribing audit results
- 7 day services self-assessment.

## 2. Clinical Effectiveness

### 2.1 End of Placement Survey Summary Report

The Hull York Medical School, End of Placement Survey Report for 2016/17 is summarised and presented at paper I2.

### 2.2 Consultants new to the Trust

The following consultants joined the Trust in June:

Ismail Abdul Kadir
Locum Consultant Elderly
Scarborough

Stamatios Oikonomou
Locum Consultant Dermatology
York

Peter Strandring
Consultant Paediatrics
Scarborough

Udupa Venkatesh
Consultant Paediatrics
Scarborough

The following consultants joined the Trust in July:

Shahnawaz Ali
Consultant Anaesthetics
Scarborough

Sayanti Ghosh
Consultant Obstetrics and Gynaecology
York

# 3. Patient Experience

## 3.1 Antibiotic resistance national campaign

| | |
|---|---|
| Campaign name | Antibiotic resistance national campaign (October 2017) |
| Activity dates | 23 October –December 2017 |
| Topline | In October 2017 Public Health England (PHE) will launch a national campaign across England to support the government's efforts to reduce inappropriate prescriptions for antibiotics by raising awareness of the issue of antibiotic resistance and reducing demand from the public. |
| Policy objective | Antibiotic resistance is a complex problem – overuse and misuse of antibiotics is creating antibiotic-resistant strains of bacteria against which none of our current antibiotics work. The race is on to develop new antibiotics to kill these resistant strains but, if we don't win that race, we could face a future in which antibiotics no longer work. That could mean a return to the pre-antibiotic age, where people with compromised immune systems may not recover from common infections and deaths in childbirth, or from infected wounds, or pneumonia were commonplace.<br><br>The inappropriate use of antibiotics drives antibiotic resistance and means antibiotics may become less likely to work in the future. The campaign will support the government 's ambition to halve inappropriate prescribing of antibiotics in the UK by 2020. |
| Aim, key message and evaluation | The public have little understanding of the concept of antibiotic resistance and what it means for them. Research shows that inappropriate prescribing is, in part, due to patients expecting or demanding antibiotics, without understanding whether that they may not be effective for their illness. The focus of this campaign will be on tackling this lack of understanding and thereby reducing patient pressure for antibiotics.<br><br>The campaigns key aims are to:<br>• Alert and inform the public to the issue of AMR in a way that they understand in a manner which they understand and increase recognition of personal risk of inappropriate usage<br>• Reduce public expectation for antibiotics by increasing understanding amongst patients about why they might not be given antibiotics, so reducing demand<br>• Support healthcare professional (HCP) change by boosting support for alternatives to prescription<br><br>The messaging for the national campaign aims to move patients to a better understanding that taking antibiotics when you don't need them means they are less likely to work for you in the future and to trust their doctors' advice regarding the best appropriate treatment for them.<br><br>The national campaign builds upon learnings from the pilot in the North West in February 2017. Research findings from the pilot campaign showed positive results:<br>• 49% of consumers and 60% of GPs in the North West were aware of the campaign<br>• The memorable creative drew our audience's attention, with many spontaneously recalling elements of the ads<br>• The campaign appears to have had a positive impact, with people in the region less likely to ask their GP for antibiotics after the campaign (a 6ppt shift)<br>• GPs were less likely to report being asked to prescribe antibiotics frequently when they are not needed (a decrease of 9ppt)<br>• Impact on prescribing data is being analysed and we expect to be able to update on this in Autumn 2017.<br><br>Following the national roll-out, pre and post national evaluation will be conducted to assess:<br>• Reach<br>• Understanding of key messages<br>• Attitudes towards antibiotics<br>• Expectation for antibiotics<br>• Changes in prescribing rate |
| Campaign target audience? | The campaign is aimed at all adults with a particular focus on groups most likely to use antibiotics:<br>• Women aged 20-45 who tend to have primary responsibility for family health across SEG groups<br>• Older men and women aged 50+, with a focus on those with recurrent conditions and high levels of contact with GPs.[1] |
| Key facts, the issue and the importance of running a national campaign | • The World Health Organisation (WHO) fears that we are heading for a post-antibiotic era where common infections and minor injuries which have been treatable for decades can once again kill.[2]<br>• Whilst antibiotics are vital for treating many infections, there is evidence that antibiotics are being taken for viral infections such as colds or flu where they are not effective.[3]<br>• Patients have little knowledge about how long common infections usually last.<br>• The costs of AMR are enormous, both in financial terms and in lives lost and disability years. By 2050, deaths attributable to AMR resistance could be as high as 10 million a year alongside a reduction of 2% to 3.5% in Gross Domestic Product (GDP).[4]<br>• It is estimated it could cost the world up to 100 trillion USD.[5]<br>• Despite the severity of the problem, public understanding of the issue is low: there is not wide understanding of the difference between viral infections (which are not treatable with antibiotics) and bacterial infections (which may be). 40% of people surveyed thought that viral infections could be treated with antibiotics (Ipsos Mori 2014). This lack of understanding may be driving negative behaviours around antibiotics, including inappropriate pressure on prescribers to prescribe them and sharing antibiotics. |
| How this | AMR public and partner engagement to improve clinical practice and promote wider understanding of the need to |

| | |
|---|---|
| campaign supports other AMR work? | reduce inappropriate prescribing[5] is on-going and this campaign will:<br><br>• Align itself with the Antibiotic Guardian programme (http://antibioticguardian.com) which encourages healthcare professionals and engaged members of the public to take a pledge to help preserve antibiotics. Antibiotic Guardians will be encouraged to promote the national AMR campaign to members of the public and a toolkit which will include posters and leaflets will be made available for their use<br><br>• Incorporate TARGET materials (Treat Antibiotics Responsibly = Guidance, Education, Tools) specifically the Back-up prescription which allows prescribers to provide a note to their patient to explain why they are not prescribing antibiotics https://www.nice.org.uk/guidance/ng15<br><br>• Use behavioural Insights collected by the team at PHE to explore how messaging can further influence patient expectation and demands for antibiotics https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405031/Behaviour_Change_for_Antibiotic_Prescribing_-_FINAL.pdf<br><br>• Be shared with the European Antibiotic Awareness Day (EAAD) a Europe-wide initiative led by the European Centre for Disease Prevention and Control (ECDC). http://ecdc.europa.eu/en/eaad/Pages/Home.aspx<br><br>Ongoing evaluation of these efforts has shown some success and antibiotic prescribing rates are reducing, although there is variation in this across England. A key area for focus now is public engagement, as we need to reduce the number of patients who are expecting or demanding antibiotics from their prescriber/healthcare professional[7]. |
| What activities will be taking place? | Antibiotic resistance is a complex problem that requires a high profile campaign to land an impactful message around personal risk which motivates the audience to change their behaviour without deterring those who do need antibiotics.<br><br>The campaign needs to reach a large audience – mass advertising on TV, radio, press and billboards, and PR are viewed as key channels to achieve this. Engaging the support of partners in the community with direct lines of communication to the target audience is also vital to the success of the campaign. |
| Getting involved | Brief colleagues and help cascade information<br>The Chief Medical Officer is supporting the launch of this campaign and is committed to the strengthening of resources available to support health professionals, their patients, and the public, so that all understand the value and importance of antibiotics and the shared responsibility for reducing inappropriate use.[8]<br><br>Please share and brief relevant colleagues encouraging them to:<br>• Act order campaign resources and make a pledge to become an Antibiotic Guardian (http://antibioticguardian.com)<br>• Display toolkit assets like posters, digital content and leaflets so information is accessible by patients.<br>• Share the campaign with colleagues and the public on websites and intranets, social media and internal and external newsletters<br><br>Campaign resources<br>There will be free campaign resources for healthcare practitioners engaging with patients who are asking for antibiotics including (but not limited to) GP practices, dentists, nurses, pharmacists and those with responsibility for prescribing antibiotics as well as local communication teams in the NHS and in local authorities. 60% of GPs and 250 hospitals in England will automatically have resources delivered to them but we are keen to "gap fill" those remaining who are not already captured in our delivery system. The list of hospitals and GPs currently covered can be found on the PHE campaign resource centre AMR Getting Involved page.<br><br>Whilst GPs and hospitals are our priority setting for the materials we are also keen to have a wide range of locations display the campaign where our target audience are likely to see them (e.g. other NHS settings, libraries, children's centres, care settings etc.). We would still be keen to bulk order these groups but individual orders can also be made on the PHE Campaign Resource Centre. The resources will be available to pre-order in August and will include leaflets, posters, briefing sheets, waiting rooms screens and an engagement tool for prescribers.<br><br>To be notified about the campaign and be informed when resources are available to pre-order, register with the Campaign Resource Centre and select to receive Antimicrobial Resistance communications. If you are already registered, update your email subscription preferences in Your Account area.<br>To register for updates: https://campaignresources.phe.gov.uk/resources/user/new<br>To order resources : https://campaignresources.phe.gov.uk/resources/campaigns/58 |
| For enquiries | Email: partnerships@phe.gov.uk |

## 3.2 Antibiotic prescription audit results

**SUMMARY OF ANTIBIOTIC PRESCRIPTION AUDIT RESULTS**
**January – December 2017**

| indication on antibiotic prescription | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| York Hospital | 90% | 91% | 92% | 90% | 94% | 96% | 91% | 84% | | | | |
| Scarborough Hospital | 76% | 84% | 86% | 89% | 83% | 88% | 89% | 71% | | | | |
| Trust average | 84% | 88% | 89% | 90% | 90% | 93% | 91% | 79% | | | | |

| duration / course length on antibiotic prescription | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| York Hospital | 89% | 87% | 89% | 84% | 79% | 82% | 89% | 85% | | | | |
| Scarborough Hospital | 85% | 86% | 90% | 85% | 81% | 76% | 83% | 69% | | | | |
| Trust average | 87% | 86% | 90% | 84% | 80% | 80% | 86% | 78% | | | | |

| % of in-patients prescribed antibiotics | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| York Hospital | 28% | 28% | 25% | 26% | 26% | 26% | 30% | 26% | | | | |
| Scarborough Hospital | 36% | 33% | 31% | 29% | 32% | 29% | 37% | 38% | | | | |

| Proportion of iv & oral antibiotics (Trust wide results) | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| iv antibiotics | 47.7% | 49.3% | 45.8% | 45.8% | 52.2% | 54.7% | 54.4% | 55.3% | | | | |
| oral antibiotics | 52.3% | 50.7% | 54.2% | 54.2% | 47.8% | 45.3% | 45.6% | 44.7% | | | | |

| Evidence of clinical review within 72 hours of prescribing | Jan; Feb; Mar. target 90% | | |
|---|---|---|---|
| CQUIN data determined from a random sample of 50 prescriptions Trust wide. Evidence looked for in medical notes / recorded on antibiotic prescription | 88% 44/50 | 94% 47/50 | 98% 49/50 |

| ELDERLY MEDICINE DIRECTORATE | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of antibiotic prescriptions audited | 108 | 84 | 67 | 49 | 62 | 67 | 62 | 65 | | | | |
| Antibiotic prescriptions with INDICATION | 87% | 95% | 93% | 90% | 89% | 84% | 95% | 91% | | | | |
| Antibiotic prescriptions with DURATION / REVIEW | 93% | 99% | 96% | 90% | 90% | 84% | 98% | 91% | | | | |

| MEDICINE DIRECTORATE | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of antibiotic prescriptions audited | 120 | 106 | 110 | 110 | 119 | 104 | 102 | 111 | | | | |
| Antibiotic prescriptions with INDICATION | 83% | 86% | 89% | 89% | 87% | 90% | 91% | 78% | | | | |
| Antibiotic prescriptions with DURATION / REVIEW | 87% | 82% | 93% | 80% | 76% | 83% | 88% | 77% | | | | |

| SPECIALIST MEDICINE DIRECTORATE | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of antibiotic prescriptions audited | 10 | 13 | 7 | 10 | 6 | 4 | 5 | 9 | | | | |
| Antibiotic prescriptions with INDICATION | 90% | 100% | 100% | 90% | 100% | 100% | 100% | 100% | | | | |
| Antibiotic prescriptions with DURATION / REVIEW | 90% | 92% | 100% | 90% | 83% | 100% | 100% | 89% | | | | |

| ORTHOPAEDICS & TRAUMA DIRECTORATE | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of antibiotic prescriptions audited | 12 | 21 | 19 | 16 | 21 | 19 | 28 | 20 | | | | |
| Antibiotic prescriptions with INDICATION | 83% | 67% | 79% | 100% | 100% | 95% | 89% | 65% | | | | |
| Antibiotic prescriptions with DURATION / REVIEW | 75% | 71% | 74% | 88% | 95% | 84% | 86% | 65% | | | | |

| GENERAL SURGERY & UROLOGY | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of antibiotic prescriptions audited | 64 | 52 | 54 | 68 | 73 | 68 | 91 | 61 | | | | |
| Antibiotic prescriptions with INDICATION | 86% | 92% | 89% | 90% | 96% | 100% | 93% | 77% | | | | |
| Antibiotic prescriptions with DURATION / REVIEW | 88% | 87% | 89% | 88% | 73% | 76% | 79% | 69% | | | | |

| Obs & Gynae DIRECTORATE | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of antibiotic prescriptions audited | 7 | 5 | 1 | 2 | 6 | 5 | 4 | 8 | | | | |
| Antibiotic prescriptions with INDICATION | 0% | 100% | 100% | 100% | 50% | 100% | 0% | 38% | | | | |
| Antibiotic prescriptions with DURATION / REVIEW | 0% | 80% | 100% | 100% | 100% | 0% | 50% | 38% | | | | |

| HEAD & NECK DIRECTORATE | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of antibiotic prescriptions audited | 5 | 9 | 6 | 4 | 4 | 7 | 4 | 1 | | | | |
| Antibiotic prescriptions with INDICATION | 100% | 56% | 100% | 75% | 100% | 86% | 75% | 100% | | | | |
| Antibiotic prescriptions with DURATION / REVIEW | 60% | 44% | 33% | 50% | 50% | 71% | 50% | 100% | | | | |

NB With effect from January 2015, Directorate results are derived from the consultant assigned to each patient on CPD on audit day, and may therefore differ slightly from ward results.

## 3.3 Seven day services self-assessment

The autumn 2017 seven day services survey will focus on clinical standard 2- time to first consultant review, as this is the standard that is the least well achieved nationally. The 7 day services survey will return to full data collection for all four priority clinical standards in the spring of March 2018.

There are two types of questions to be answered in the survey:

1. Proportion of patients reviewed by a consultant within 14 hours of admission to hospital (clinical standard 2)
2. Dates and times patients and their families were informed of the diagnosis, plan and prognosis.

The definition of a consultant for clinical standard 2 includes doctors on the General Medical Council Specialist Register who are eligible to become consultants, but not doctors who have yet to complete training.

Our data submission will cover the seven days from 20th September onwards and we will require the audit data to be submitted by 17th November 2017.

The last audit which was completed in March 2017 indicated that the overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission was 81%. The table below indicates compliance with the standard by day of the week (based on day of admission).

| | Day of admission | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Mon | Tue | Wed | Thu | Fri | Sat | Sun | Weekday | Weekend | Total |
| Proportion of patient reviewed by a consultant within 14 hours of admission to hospital | 57% | 100% | 75% | 91% | 73% | 92% | 60% | 80% | 83% | 81% |

Where the patient has been reviewed within 14 hours of admission, colleagues will not need to provide any additional information locally as the data will be provided from SNS however where there is no record on CPD of the review, colleagues will be sent a proforma to complete retrospectively indicating why there was failure to comply or to record electronically compliance with the standard.

Where there is no record of patients and/or families being advised of diagnosis or plan or prognosis, this will be recorded as not taking place.

All consultants are asked to complete the audit as requested and to send completed proformas to Diane Palmer, Deputy Director of Patient Safety.

## 4. Recommendations

Board of Directors are requested to:

- Review end of placement survey summary
- Note consultants new to the Trust
- Be aware of antibiotic resistance national campaign

- Consider anti-microbial prescribing audit results
- Note 7 days service self-assessment.

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Chief Nurse Report

## Recommendation

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

## Current approval route of report

This draft has been written for the Executive Board and Quality & Safety Committee.

## Purpose of report

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

## Key points for discussion

The adult inpatient vacancy position across the Trust at the end of August 2017 is detailed below. For the first time, we have re-classified our nursing workforce into trained and untrained following the development of the role of Associate Practitioner, whilst not holding a registration, will be a trained role providing care over and above that of a healthcare assistant.

There are a number of workforce initiatives that are continuing to progress in developing new nursing roles, new ways of attracting nurses to the Trust through the development of rotational posts and the plans for SafeCare, a new tool purchased by the Trust to support professional decision making in relation to safe staffing.

The Infection Prevention team has recently completed a restructure, it is anticipated that this structure will become operational on 1st November.

The Trust Safeguarding Adults Strategy was reviewed for 2017 -2020 and approved at the February Safeguarding Adults Governance Group.

The Multi-Agency Safeguarding Adults Policy has been reviewed and is currently out at consultation. Expected finalisation will be December 2017.

The Trust has been successful in becoming a pilot site for the introduction of the National Bereavement Care Pathway (NBCP), aimed at to improving the quality of bereavement care experienced by parents and families at all stages of pregnancy and baby loss up to 12 months. The pilot will commence in October 2017.

The Trust has achieved 97% patient satisfaction in the Friends and Family test during July 2017. However whilst both emergency departments have had an improvement in response rates during July, their satisfaction was at 82%, lower than the national target rate of 90%. Themes reported through the test are continuing to be assessed and discussed with Matrons to identify where improvements can be achieved.

32 volunteers were recruited in the last cohort. The focus is now on supporting successful placement in wards and departments

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

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

The CQC fundamental standards are integral to all aspects of the report.

Version number: 1

Author: Beverley Geary, Chief Nurse

Executive sponsor: Beverley Geary, Chief Nurse

Date: September 2017

## 1. Introduction and Background

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

The nursing and midwifery strategy has four main focus areas:

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

The New nursing strategy has been written and will be launched at the Nursing and Midwifery conference in October. The main focus areas are:

- Experience and Communication
- Workforce
- Safe, quality care
- Partnerships and efficiency

The themes triangulate with the Patient Experience and Patient Safety strategies in order that priorities are aligned across disciplines to ensure delivery of the key objectives.

## 2. Patient Safety

### 2.1 Nurse Staffing

The adult inpatient vacancy position across the Trust at the end of August 2017 is detailed in the separate paper. For the first time, we have re-classified our nursing workforce into trained and untrained following the development of the role of Associate Practitioner and in anticipation of the Nursing associate role. Whilst these staff will not hold a registration they will be trained in agreed competencies; with robust assessments undertaken. In addition, the Nursing Associate role will be regulated and the Chief Nurse Team are participating in workshops at a national level to influence this.

In the coming weeks and months, Associate Practitioners within AMU & AMB will complete their training and will offset a number of trained staff vacancies. Further recruitment of 13fte Associate Practitioners has taken place, these will fill positions on inpatient wards on the York site with the expectation that these individuals commencing in post in November 2017. Further recruitment is ongoing for a further cohort to begin in January 2018 for inpatient and other clinical services, mainly on the Scarborough site.

The Trust is holding a recruitment fair on 30th September 2017 and there will be a significant nursing presence at this event looking to recruit both experienced nurses as well as nursing who are due to qualify during 2018. The Chief Nurse Team will also be attending a recruitment fair in Preston in early October with a view to attracting further recruits.

### 2.1.2 Nursing Associate - National pilot programme

The Trainee Nursing Associates have now completed their first placement and academic assessment. With support from the communications team, their early reflections are being captured on video and are being shared with Health Education England and on social media. The Chief Nurse team continue to provide professional mentorship to each of the trainees with the additional support of a Nursing Associate forum each quarter. Consideration is now being given to future cohorts.

### 2.1.3 Associate practitioners

The first cohort of associate practitioners in the Emergency Department is nearing the end of their training by completing the agreed core competencies. The second cohort, based in acute medicine is also progressing well and aiming to complete training within the coming months. A recruitment plan is in development to support staff who have an existing foundation degree in health and social care or who are registered nurses without NMC registration, who may be eligible and willing to participate in cohort three. This will be across directorates where workforce transformation activities have been completed and where new roles have been identified. This will support the Trust to bridge the gap between the Health Care Assistant and Registered Nurses and address the workforce challenges facing the profession locally and nationally.

### 2.1.4 Rotational posts

A working group has been established to plan for the implementation of rotational posts for registered nurses across the Trust. This offers a development opportunity for both newly qualified and experienced nurses, enabling them to gain experience in 2-3 wards / units across a number of specialties before deciding on preferred place of work. It is hoped that this will contribute to the organisation's retention plans.

### 2.1.5 On-Boarding

Work is underway to prepare to welcome our newly registered nurses arriving in autumn. The purpose of on-boarding is for the Trust to remain connected to new staff and facilitate them to begin to make work relationships prior to commencement. On-boarding days will take place in the coming months where the new registrants will be invited to meet members of the Chief Nurse team and begin to understand our values and how they will be supported through the preceptorship programme.

### 2.1.6 SafeCare

SafeCare is a software solution that supports professional decision making in relation to safe staffing. By entering acuity and dependency data at several intervals throughout the day, senior nurses are able to visualise the true staffing risks across the trust and make decisions to move staff accordingly. A project team is being established and implementation will be led by the Chief Nurse team and is expected to take six months.

## 2.2 Nursing Dashboards

The nursing dashboards continue to be populated on a monthly basis across all inpatients wards and are used through performance management meetings, as well as by the Chief Nurse Team in 1:1 catch ups with Assistant Directors of Nursing and Matrons.

We are continuing to develop the ward level dashboards as a means to identify trends and RAG assurances on key workforce metrics.

The Trust-wide and site level dashboards are attached at appendix 1.

## 2.3 Electronic Rostering – Internal Audit report

The internal audit team have recently completed a review of a previous audit undertaken in 2015 in relation to E-Rostering. The purpose being to establish progress of a Trust wide project commissioned to lead improvements in rostering best practice. The project to date has resulted in 27 deep dive processes being facilitated, reducing unwarranted variation across 5 themes; leadership, competence & capability, culture & behaviour, technical & system, policy & procedure. This has resulted in the audit reporting significant assurance.

## 2.4 Infection Prevention

The IPC team have recently undergone a full change management process in order the restructure the team to create new roles and provide equity of service across all areas of the organisation. The DDIPC strategic planning role will sit with a Consultant Microbiologist and a full time specialist IPN will be recruited to manage the nursing team. In the interim; to reduce risks associated with reduced team numbers an ADN will have a leadership role and Matrons will become more involved in day to day IPC management.

## 2.5 Adult Safeguarding

### 2.5.1 DoLS

The administration of the DoLS process has recently been affected by sickness absence and as a result was not meeting the required follow up which potentially poses risks to the Trust. The risk register is being updated and contingency plans are being explored. A solution has been identified and the staff member will be trained to administer the process, this will address the backlog and reduce the risk.

The Law Commission Proposals to change the Cheshire West Ruling in respect of Deprivation of Liberty had been submitted to Government but it is reported that this is on hold due to the Brexit negotiations.

### 2.5.2 Safeguarding Adults Trends

The Safeguarding Adults Team have received four safeguarding concerns raised against Oak since 1st July. Findings indicate 3 common themes:

1) Gaps in documentation
2) Little evidence of communication with care home
3) Discharge planning and information

Previous experience suggests that this will be noted by the NYCC Safeguarding Manager and we may be subject to a low level concerns discussion which usually involves CCGs and CQC. Historically Oak ward was subject to similar discussions in 2015 with Chief Nurse involvement.

Matron and Assistant Director of Nursing are aware and have been asked for comment to prepare support/action planning and mitigation.

### 2.5.3 Strategy

The Trust Safeguarding Adults Strategy was reviewed for 2017 -2020 and approved at the February Safeguarding Adults Governance Group. Making Safeguarding Personal underpins the strategy in line with Local Authority Safeguarding Adults Boards. As a result of the development a work plan is in place to ensure outcomes are met. Progress is reportable to the Safeguarding Adults Governance Group quarterly.

The Multi-Agency Safeguarding Adults Policy has been reviewed and is currently out at consultation. Expected finalisation will be December 2017. On review of the draft policy, safeguarding systems will be made more accessible, more person centred and will place more responsibility on providers for investigations. As the Trust Safeguarding Adults Team currently contribute to and, on some occasions, lead on investigations into care delivered by the Trust there will be little impact operationally. It will however require policy and training review and amendment.

## 3. Patient Experience

### 3.1 National Bereavement care pathway

The National Bereavement Care Pathway (NBCP), which has the support of the Department of Health, has been developed to improve the quality of bereavement care experienced by parents and families at all stages of pregnancy and baby loss up to 12 months.

A Core Group of charities and professional bodies, who are leading the NBCP, announced 11 sites in England who will trial the use of new materials, guidelines and training for professionals to help improve the care bereaved parents receive. York Trust applied to be one of the pilot sites and was successful. Pilot sites were chosen as representative of geography, capacity and specialism. The 11 pilot sites will work with the project team from October 2017 to understand the impact and the effectiveness of the pathway on improving bereavement care for parents. We are currently waiting for the NMCP lead to meet with us to discuss next steps and date for the pilot to commence.

## 3.2 Patient Experience

### 3.2.1 Friend and Family Test (FFT) Latest Results (July 2017)

| | % Patients Satisfied July | National Average % (Jun 17) | % Response Rate July | National Average % (Jun 17) |
|---|---|---|---|---|
| Inpatient | **97** | **96** | **19** | **26** |
| Emergency Department | **82** | **88** | **14** | **13** |
| Maternity | **97** | **97** | **33** | **24** |

### 3.2.2 Themes and Trends from FFT

The Patient Experience Team continues to proactively engage with the matrons, sisters and directorate managers. Both EDs have seen an improvement in response rates in the last month. The inpatient response rates in Scarborough have been significantly lower than in York and work is ongoing with the Scarborough matrons who are taking the lead on re-promoting FFT in their ward areas.

Text messaging went live at the end of July for Medical Elective Services in York and Endoscopy on all sites – areas with historically high patient numbers and low response rates.

Themes for the FFT feedback include:

- ED: appreciation of staff; dissatisfaction with waiting times, triage and communication while waiting; and concern about waiting times/priority given to children. An action plan has been developed linking with the results of the National Emergency Department Survey 2016 and is being taken forward by the matrons at York and Scarborough.
- Inpatient: appreciation of staff; waiting times for day surgery – coming in to the unit in the morning, but being scheduled later down the list; comments about lack of nursing staff. The matron for Theatres, Anaesthetics and Critical Care engaged the directorate's clinicians in a discussion about minimising waiting times, and nil-by-mouth in particular. The feedback is that they are continuing to look at how they communicate with patients around food and fluid before their procedure, but that they continue to prepare patients in time for the start of the list as it supports best use of theatre time and the ability to be flexible around last minute changes.

### 3.2.3 Complaints and Concerns

Acute and General Medicine have received a higher than usual number of contacts for complaints, concerns, comments and enquiries. Within this the main themes are concerns about discharge (too early, delayed or lack of appropriate care package); about waiting times for outpatient appointments; and delays in receiving test results. The top two departments receiving complaints/concerns in August are Acute Medical Unit York (9) and Chestnut Ward Scarborough (5).

Trauma and Orthopaedics have received a higher number of contacts than average. There is a theme of concerns about waiting times for appointments.

### 3.2.4 Volunteering

32 volunteers were recruited in the last cohort. The focus is now on supporting successful placement in wards and departments. Feedback from volunteers demonstrates the necessity of knowing their supervisor, having an early local induction to the ward/department and being made to feel a welcome and valued part of the team. Areas were volunteers are successfully supporting staff are: York Outpatients, Ward 39, Ward 26, Ward 35 (linking with the dementia champion). In some other areas the volunteering team are working with matrons and sisters to increase the support and communication they are providing to their volunteers.

## 4. Recommendation

The Committee is asked to note the Chief Nurse Report for September 2017.

# Nursing Dashboard - York

York Teaching Hospital NHS
NHS Foundation Trust

| | | Metric | Measure | Data Source | Trajectory | RAG | Cum.Total | September | October | November | December | January | February | March | April | May | June | July | August |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient Safety | Pressure Ulcers | PURP Overall | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 4 | 4 | 4 | 3 | 7 | 1 | 3 | 9 | 2 | 3 | 6 | 4 |
| | | Cat 4 | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| | | Cat 3 | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Cat 2 | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 3 | 3 | 3 | 2 | 4 | 0 | 2 | 6 | 1 | 1 | 2 | 2 |
| | | Unstageable | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 1 | 1 | 1 | 1 | 3 | 1 | 1 | 3 | 1 | 2 | 3 | 2 |
| | | Deep Tissue Injury | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Falls | Falls | No. of Patients (PP) | Safety Thermometer - FALLS | | | | 9 | 6 | 14 | 9 | 13 | 15 | 7 | 16 | 7 | 8 | 7 | 13 |
| | | Falls With Harm (Moderate/Severe) | No. of Patients (PP) | Safety Thermometer - FALLS | | | | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Safety Thermometer | Safety Thermometer Overall (Harm Free Care) | % | Safety Thermometer - CQUIN HARM FREE % | 95% | | | 96.66% | 96.52% | 96.85% | 96.90% | 94.58% | 96.30% | 97.05% | 96.27% | 95.53% | 96.88% | 97.42% | 95.54% |
| | Catheter acquired UTI | New UTI | No. of Patients (PP) | Safety Thermometer - CQUIN HARMS | | | | 7 | 6 | 7 | 4 | 6 | 3 | 4 | 0 | 4 | 3 | 4 | 6 |
| | Critical Missed Meds | Critical Missed Meds | No. of Patients (PP) | Safety Thermometer - OMITTED CRITICAL MEDS | | | | 5 | 6 | 4 | 10 | 7 | 6 | 9 | 2 | 4 | 10 | 11 | 8 |
| | Drug Errors | Drug Errors (inpatient wards only) | | Datix | | | | 62 | 95 | 90 | 106 | 121 | 112 | 106 | 82 | 80 | 91 | 86 | 74 |
| | NEWS | Compliance with NEWs (inpatient wards only) | | Signal | | | | 77.31% | 77.88% | 77.79% | 80.10% | 78.78% | 84.49% | 85.70% | 85.54% | 84.17% | 86.38% | 87.89% | 88% |
| | Deep Vein Thrombosis | New DVT | No. of Patients (PP) | Safety Thermometer - VTE TREATMENT TYPE | | | | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Pulmonary Embolism | New PE | No. of Patients (PP) | Safety Thermometer - VTE TREATMENT TYPE | | | | 1 | 2 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 |
| | VTE Other | VTE Other | | Safety Thermometer - VTE TREATMENT TYPE | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Workforce | Vacancies | Inpatient area vacancies -RN | Number | CN Team | | | | 73.81 | 51.9 | 60.92 | 53.54 | 68.28 | 79.96 | 86 | 86.58 | 92.95 | 96.13 | 109.43 | 120.39 |
| | | Inpatient area vacancies - HCA | Number | CN Team | | | | 47.8 | 53.07 | 35.63 | 42.17 | 26.86 | 27.68 | 13.87 | 34.05 | 22.7* | 21.52% | 20.01 | 27.49 |
| | Vacancy Rate | Inpatient area -RN | % | CN Team | | | | | | | | | | | 17.89% | 18.80% | 19.86% | 22.55% | 24.34% |
| | | Inpatient area- HCA | % | CN Team | | | | | | | | | | | 10.96% | 7.39% | 6.97% | 6.46% | 9.15% |
| | Sickness | Sickness (In Patient Areas) | % | Workforce Info | | | | 3.46% | 4.32% | 4.69% | 3.97% | 4.24% | 4.40% | 4.25% | 4.44% | 4.27% | 4.26% | 4.54% | |
| | Maternity Leave | Inpatient nursing / HCA | % | Workforce Info | | | | 3.28% | 3.18% | 3.04% | 3.20% | 3.46% | 3.59% | 3.63% | 3.62% | 3.27% | 2.90% | 3.09% | 3.07% |
| | Appraisals | Registered Nurses (Ward Areas) | % | Workforce Info | 95% | | | 67.19% | 67% | 70.03% | 70.53% | 69.01% | 65.28% | 64.15% | 61.46% | 63.14% | 63.31% | 63.14% | 66.16% |
| | | Healthcare Assistants (Ward Areas) | % | Workforce Info | 95% | | | 75.29% | 74.68% | 77.72% | 78.54% | 74.09% | 73.67% | 71.96% | 70.87% | 68.83% | 66.50% | 60.76% | 63.67% |
| | Safer Staffing Return | Qualified Fill Rated - Day | % | Safer Staffing Return | Between 80 - 100% | | | 89.80% | 91.00% | 93.70% | 92.40% | 93.30% | 93.80% | 91.20% | 91.0% | 91.50% | 90.8% | 89.10% | 85.20% |
| | | Qualified Fill Rated - Night | % | Safer Staffing Return | Between 80 - 100% | | | 106.10% | 98% | 98.30% | 97.30% | 99.50% | 96.40% | 94.90% | 92.6% | 96.35 | 96.3% | 95.50% | 94.60% |
| | | Unqualified Fill Rates - Day | % | Safer Staffing Return | Between 80 - 100% | | | 96.20% | 107.30% | 110.30% | 108.30% | 104.80% | 106.70% | 108.40% | 110.8% | 109.90% | 113.1% | 112% | 109.10% |
| | | Unqualified Fill Rates - Night | % | Safer Staffing Return | Between 80 - 100% | | | 115.80% | 114.80% | 119.50% | 113.70% | 118.80% | 118.60% | 117.10% | 119.6% | 117.60% | 116.5% | 118.80% | 115.90% |
| | Care Hours per patient Day | Registered Nurses | | Safer Staffing Return | | | | 4.1 | 4 | 3.7 | 3.8 | 3.7 | 3.8 | 3.8 | 3.8 | 3.7 | 3.7 | 3.6 | 3.6 |
| | | Healthcare Assistants | | Safer Staffing Return | | | | 3.1 | 2.9 | 2.8 | 2.8 | 2.6 | 2.7 | 2.9 | 3.0 | 2.8 | 2.9 | 2.8 | 2.9 |
| | | Total | | Safer Staffing Return | | | | 7.3 | 6.9 | 6.5 | 6.6 | 6.3 | 6.5 | 6.7 | 6.8 | 6.5 | 6.6 | 6.4 | 6.6 |
| | Internal Bank Fill Rate | Fill Rate | % | Workforce Info | | | | 40.30% | 39.40% | 43.10% | 40.80% | 42.10% | 43.50% | 46.80% | 46.40% | 46.50% | 47.30% | 46.00% | 46% |
| | Agency Fill Rate | Fill Rate | % | Workforce Info | | | | 40.60% | 43.30% | 41.40% | 39.60% | 37.10% | 39.10% | 36.80% | 33.80% | 33.80% | 33.60% | 33.20% | 30.90% |
| Infection Prevention | MRSA | MRSA Bacteraemia | Cummulative | IC Team | 0 | | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| | | MRSA Screening - Elective | Compliance % | Signal | 95% | | | 52.17% | 53.74% | 78.70% | 73.48% | 66.83% | 62.11% | 65.97% | 61.52% | 86.78% | 92.15% | 86.22% | 91.10% |
| | | MRSA Screening - Non-Elective | Compliance % | Signal | 95% | | | 79.34% | 78.63% | 58.65% | 59.31% | 77.57% | 78.44% | 78.53% | 78% | 79.43% | 82.41% | 86.24% | 88.02% |
| | C.Difficile | C DIF Toxin Trust Attributed | Cummulative | IC Team | 48 | | 3 | 0 | 2 | 1 | 6 | 5 | 4 | 2 | 0 | 2 | 0 | 0 | 1 |
| | MSSA | MSSA Bacteraemia | Cummulative | IC Team | | | 11 | 0 | 7 | 0 | 2 | 3 | 3 | 3 | 2 | 5 | 0 | 4 | 0 |
| | E-Coli | E-Coli Bacteraemia | Cummulative | IC Team | | | 8 | 6 | 1 | 4 | 4 | 4 | 4 | 2 | 5 | 0 | 0 | 3 | 0 |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Risk Management (Trust wide) | **Serious Incidents** | SI's declared | Number | Datix - Healthcare Governance | | | | 4 | 1 | 8 | 6 | 14 | 8 | 6 | 3 | 10 | 9 | 8 | 8 |
| | **Clinical Incidents** | CI's reported | Number | Datix - Healthcare Governance | | | | 4 | 1 | 7 | 5 | 10 | 3 | 3 | 1 | 5 | 6 | 4 | 5 |
| | **Never Events** | Never Events declared | Number | Datix - Healthcare Governance | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |

| | | **Metric** | **Measure** | **Data Source** | **Trajectory** | **RAG** | **Cum.Total** | **September** | **October** | **November** | **December** | **January** | **February** | **March** | **April** | **May** | **June** | **July** | **August** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient Experience | **Friends and Family** | Inpatient Friends & Family Test | %Recommend | Signal | | | | 95.88% | 95.88% | 95.60% | 95.62% | 95.17% | 96.16% | 95.70% | 95.30% | 96.23% | 96.27% | 96.26% | |
| | | | %Not Recommend | Signal | | | | 1.26% | 1.26% | 1.43% | 1.34% | 1.18% | 0.60% | 1.25% | 1.04% | 1.15% | 0.79% | 0.98% | |
| | | A&E Friends and Family Test | % Recommend | Signal | | | | 83.52% | 83.52% | 84.64% | 84.32% | 84.90% | 81.84% | 85.75% | 85.40% | 85.89% | 84.71% | 82.39% | |
| | | | % Not Recommend | Signal | | | | 9.74% | 9.74% | 10% | 10.45% | 9.38% | 10.34% | 7.48% | 7.20% | 7.18% | 7.28% | 10.41% | |
| | | Maternity (Ante Natal) | % Recommend | Signal | | | | 100% | 100% | 98.70% | 96.29% | 93% | 100% | 94.34% | 95.30% | 96.85% | 98.47% | 96.90% | |
| | | | % Not Recommend | Signal | | | | 0% | 0% | 0% | 1.85% | 0% | 5 | 3.78% | 0% | 0% | 0% | 0.78% | |
| | | Birth | % Recommend | Signal | | | | 100% | 100% | 96.93% | 97.54% | 99% | 98.80% | 94.45% | 98.50% | 100% | 97.67% | 97.28% | |
| | | | % Not Recommend | Signal | | | | 0% | 0% | 0.61% | 0% | 0% | 1.20% | 1.12% | 0% | 0% | 0.58% | 1.82% | |
| | | Maternity (Post Natal) | % Recommend | Signal | | | | 100% | 100% | 97.67% | 100% | 95% | 94.74% | 94.29% | 96.60% | 97.20% | 97% | 95.37% | |
| | | | % Not Recommend | Signal | | | | 0% | 0% | 0% | 0% | 0% | 1.68% | 3% | 2.38% | 2.77% | 0% | 3.71% | |
| | **Complaints *new DATIX system reporting not yet available. Will be populated asap.** | Complaints Total | Number | PE Team | | | | 21 | 19 | 13 | 17 | 26 | 15 | 20 | 11 | 15 | 15 | 18 | 21 |
| | | Staff Attitude | Number | PE Team | | | | 1 | 0 | 1 | 4 | 2 | 2 | 3 | 20 | 1 | 3 | 4 | 1 |
| | | Patient Care | Number | PE Team | | | | 0 | 2 | 3 | 1 | 5 | 5 | 3 | 0 | 3 | 6 | 1 | 1 |
| | | Privacy & Dignity | Number | PE Team | | | | | | | | | | | 0 | 0 | 0 | 2 | 4 |
| | | Communication | Number | PE Team | | | | 2 | 4 | 0 | 3 | 2 | 0 | 1 | 0 | 2 | 0 | 0 | 3 |

**Assistant Director Narrative - Emma George & Virginia Russell**

- Increased number of reported falls over last quarter but non with harm in August
- Reduction in drug error incidents and incidents relating to omitted critical medicines
- MRSA screening data relating to both elective and non-elective admissions< 95% but may be an anomaly with the data which may show an improved position. IP and SNS in discussion regarding this.
- 1 case of toxin positive C diff making a total of 3 cases on a target of 48 for the year. PIR process underway.
- 8 SI's in total of which 5 are clinical incidents and one a never event of wrong site surgery in vascular.
- 3 Category 3 Pressure Ulcers were declared and are undergoing RCA process currently prior to presentation at internal panel.

# Nursing Dashboard - Scarborough

York Teaching Hospital NHS
NHS Foundation Trust

| | | Metric | Measure | Data Source | Trust Trajectory | Cum Total | September | October | November | December | January | February | March | April | May | June | July | August |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient Safety | Pressure Ulcers | PURP Overall | No. of Patients (PP) | Safety Thermometer - NEW PU | | | 2 | 4 | 4 | 3 | 3 | 0 | 5 | 3 | 2 | 1 | 7 | 0 |
| | | Cat 4 | No. of Patients (PP) | Safety Thermometer - NEW PU | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Cat 3 | No. of Patients (PP) | Safety Thermometer - NEW PU | | | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 |
| | | Cat 2 | No. of Patients (PP) | Safety Thermometer - NEW PU | | | 0 | 3 | 3 | 2 | 3 | 0 | 0 | 2 | 2 | 0 | 5 | 0 |
| | | Unstageable | No. of Patients (PP) | Safety Thermometer - NEW PU | | | 0 | 1 | 1 | 1 | 0 | 0 | 4 | 1 | 0 | 0 | 0 | 0 |
| | | Deep Tissue Injury | No. of Patients (PP) | Safety Thermometer - NEW PU | | | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Falls | Falls | No. of Patients (PP) | Safety Thermometer - FALLS | | | 15 | 7 | 18 | 15 | 13 | 10 | 3 | 5 | 6 | 11 | 6 | 11 |
| | | Falls With Harm (Moderate/Severe) | No. of Patients (PP) | Safety Thermometer - FALLS | | | 2 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| | Safety Thermometer | Safety Thermometer Overall (Harm Free Care) | % | Safety Thermometer - CQUIN HARM FREE % | 95% | | 90.94% | 93.23% | 92.64% | 94.22% | 94.17% | 92.56% | 92.69% | 91.92% | 92.78% | 94.88% | 88.43% | 90.97% |
| | Catheter acquired UTI | New UTI | No. of Patients (PP) | Safety Thermometer - CQUIN HARMS | | | 10 | 11 | 7 | 4 | 10 | 4 | 3 | 4 | 9 | 3 | 8 | 3 |
| | Critical Missed Meds | Critical Missed Meds | No. of Patients (PP) | Safety Thermometer - OMITTED CRITICAL MEDS | | | 11 | 7 | 12 | 8 | 11 | 8 | 2 | 6 | 2 | 6 | 7 | 7 |
| | Drug Errors | Drug Errors (inpatient wards only) | | Datix | | | 25 | 27 | 33 | 34 | 26 | 40 | 40 | 41 | 34 | 51 | 53 | 37 |
| | NEWS | Compliance with NEWs (inpatient wards only) | | Signal | | | 85.53% | 84.78% | 90.80% | 90.60% | 83.46% | 83.47% | 84.62% | 86.48% | 85.25% | 87.30% | 87.23% | 87.75% |
| | Deep Vein Thrombosis | New DVT | No. of Patients (PP) | Safety Thermometer - VTE TREATMENT TYPE | | | 0 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 |
| | Pulmonary Embolism | New PE | No. of Patients (PP) | Safety Thermometer - VTE TREATMENT TYPE | | | 0 | 1 | 0 | 2 | 1 | 1 | 1 | 1 | 2 | 0 | 1 | 0 |
| | VTE Other | VTE Other | No. of Patients (PP) | Safety Thermometer - VTE TREATMENT TYPE | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Workforce | Vacancies | Inpatient area vacancies -RN | Number | CN Team | | | 43.01 | 37.86 | 42.06 | 40.46 | 47.84 | 52.61 | 57.54 | 58.46 | 62.92 | 65.14 | 67.14 | 69.21 |
| | | Inpatient area vacancies - HCA | Number | CN Team | | | 17.8 | 16.7 | 10.03 | 6.84 | 8.98 | 3.68 | 0.88 | 7.16 | 8.06 | 9.47 | 5.26 | 7383 |
| | Vacancy Rate | Inpatient area -RN | | | | | | | | | | | | 22.19% | 24.30% | 25.16% | 25.98% | 26.78% |
| | | Inpatient area - HCA | | | | | | | | | | | | 4.26% | 4.76% | 5.58% | 3.10% | 4.64% |
| | Sickness | Sickness (In Patient Areas) | % | Workforce Info | | | 4.54% | 4.72% | 4.57% | 4.92% | 5.27% | 4.42% | 4.17% | 3.98% | 5.21% | 5.21% | 4.88% | |
| | Maternity Leave | Inpatient nursing / HCA | % | Workforce Info | | | 1.92% | 1.60% | 2.10% | 2.21% | 2.77% | 3.16% | 3.24% | 3.17 | 3.39% | 3.05% | 3.21% | 3.15% |
| | Appraisals | Registered Nurses (Ward Areas) | % | Workforce Info | 95% | | 66.97% | 63.91% | 68.28% | 70.13% | 71.10% | 72.85% | 74.94% | 74.79% | 75.61% | 76.8% | 72.39% | 77.33% |
| | | Healthcare Assistants (Ward Areas) | % | Workforce Info | 95% | | 59.88% | 69.90% | 65.10% | 81.73% | 64.91% | 69.81% | 71.96% | 75.79% | 76.35% | 82.3% | 81.22% | 84.85% |
| | Safer Staffing Return | Qualified Fill Rated - Day | % | Safer Staffing Return | Between 80 - 100% | | 86% | 88.70% | 90.40% | 89.50% | 86% | 83.30% | 81.40% | 82.7% | 83.90% | 82.8% | 81.40% | 77.90% |
| | | Qualified Fill Rated - Night | % | Safer Staffing Return | Between 80 - 100% | | 98.20% | 95.10% | 99.10% | 96.30% | 93.50% | 91.10% | 92.40% | 88.1% | 90.30% | 82.8% | 88.80% | 83.90% |
| | | Unqualified Fill Rates - Day | % | Safer Staffing Return | Between 80 - 100% | | 93.40% | 97.10% | 102.40% | 100.10% | 98% | 99.20% | 103.50% | 106.7% | 102.60% | 102.2% | 103.90% | 101.30% |
| | | Unqualified Fill Rates - Night | % | Safer Staffing Return | Between 80 - 100% | | 118.60% | 110.10% | 114.80% | 109% | 104.30% | 102.80% | 104.50% | 105.5% | 105.10% | 106.7% | 111.50% | 106.90% |
| | Care Hours per patient Day | Registered Nurses | | Safer Staffing Return | | | 3.9 | 3.9 | 4 | 4.1 | 3.8 | 3.7 | 3.7 | 3.8 | 3.8 | 3.9 | 3.8 | 3.8 |
| | | Healthcare Assistants | | Safer Staffing Return | | | 2.8 | 2.7 | 2.8 | 2.8 | 2.6 | 2.7 | 2.7 | 2.9 | 2.9 | 3 | 3.1 | 3.2 |
| | | Total | | Safer Staffing Return | | | 6.6 | 6.6 | 6.8 | 6.9 | 6.4 | 6.4 | 6.4 | 6.7 | 6.7 | 6.9 | 6.9 | 6.9 |
| | Internal Bank Fill Rate | Fill Rate | % | Workforce Info | | | 59.90% | 57.30% | 59.20% | 57% | 66% | 62.30% | 61.30% | 58.80% | 58.70% | 53.90% | 52.90% | 50.10% |
| | Agency Fill Rate | Fill Rate | % | Workforce Info | | | 14.80% | 18.20% | 18.20% | 16.40% | 13.60% | 14.70% | 15.30% | 17.70% | 17.70% | 16.70% | 18.60% | 14.60% |
| Infection Prevention | MRSA | MRSA Bacteraemia | Cummulative | IC Team | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | MRSA Screening - Elective | Compliance % | Signal | 95% | | 38.51% | 42.37% | 44.23% | 42.98% | 42.86% | 40.20% | 43.09% | 30.58% | 75.81% | 65.69% | 78% | 75.86% |
| | | MRSA Screening - Non-Elective | Compliance % | Signal | 95% | | 88.08% | 90.12% | 82.52% | 78.46% | 87.50% | 88.95% | 90.73% | 88.55% | 92.36% | 90.50% | 90.23% | 90.96% |
| | C.Difficile | C DIF Toxin Trust Attributed | Cummulative | IC Team | 48 | 3 | 0 | 0 | 3 | 2 | 3 | 1 | 2 | 2 | 1 | 0 | 0 | 0 |
| | MSSA | MSSA Bacteraemia | Cummulative | IC Team | <30 | 5 | 0 | 1 | 1 | 0 | 1 | 4 | 2 | 1 | 3 | 0 | 1 | 0 |
| | E-Coli | E-Coli Bacteraemia | Cummulative | IC Team | | 0 | 2 | 2 | 1 | 1 | 5 | 1 | 3 | 0 | 0 | 0 | 0 | 0 |
| Risk Management (Trust wide) | Serious Incidents | SI's declared | Number | Datix - Healthcare Governance | | | 1 | 6 | 4 | 1 | 10 | 7 | 4 | 1 | 3 | 5 | 3 | 3 |
| | Critical Incidents | CI's reported | Number | Datix - Healthcare Governance | | | 0 | 2 | 4 | 3 | 7 | 5 | 3 | 0 | 3 | 4 | 2 | 3 |
| | Never Events | Never Events declared | Number | Datix - Healthcare Governance | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | | Metric | Measure | Data Source | Trust Trajectory | Cum Total | September | October | November | December | January | February | March | April | May | June | July | August |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Metric** | **Measure** | **Data Source** | **Trajectory** | **Mar** | **September** | **October** | **November** | **December** | **January** | **February** | **March** | **April** | **May** | **June** | **July** | **August** |
| **Patient Experience** | **Friends and Family Test** | Inpatient Friends and Family Test | %Recommend | Signal | | | 97.94% | 97.40% | 97.55% | 97.51% | 98.23% | 97.40% | 97.75% | 98.04% | 80.82% | 98.32% | 97.44% | |
| | | | %Not Recommend | Signal | | | 0.74% | 0.78% | 0.53% | 0.52% | 0.18% | 1.04% | 0.75% | 0.30% | 5.48% | 0.79% | 0.51% | |
| | | A&E Friends and Family Test | % Recommend | Signal | | | 75.97% | 78.20% | 66.06% | 84.62% | 80.82% | 79.31% | 76.19% | 85.23% | 97.37% | 83.70% | 80.35% | |
| | | | % Not Recommend | Signal | | | 17.53% | 17.29% | 17.43% | 7.69% | 10.96% | 15.52% | 13.10% | 0% | 0.72% | 12.37% | 13.29% | |
| | | Maternity (Ante Natal) | % Recommend | Signal | | | 97.44% | 98.65% | 99.17% | 96% | 96% | 100% | 97.00% | 98.76% | 100% | 100% | 100% | |
| | | | % Not Recommend | Signal | | | 0% | 0.00% | 0.00% | 0% | 0% | 0% | 2.36% | 0% | 0% | 0% | 0% | |
| | | Birth | % Recommend | Signal | | | 97.96% | 99.09% | 98.54% | 100% | 92% | 100% | 100% | 100% | 100% | 100% | 100% | |
| | | | % Not Recommend | Signal | | | 0% | 0.00% | 0.00% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | |
| | | Maternity (Post Natal) | % Recommend | Signal | | | 100% | 97.80% | 96.95% | 100% | 98% | 100% | 100% | 100% | 98.90% | 100% | 96% | |
| | | | % Not Recommend | Signal | | | 0% | 0.00% | 0.00% | 0% | 1.96% | 0% | 0% | 0% | 0% | 0% | 0.80% | |
| | **Complaints *new DATIX system reporting not yet available. Will be populated asap.** | Complaints Total | Number | PE Team | | | 8 | 10 | 14 | 17 | 10 | 9 | 8 | 9 | 11 | 5 | 10 | 8 |
| | | Staff Attitude | Number | PE Team | | | 1 | 1 | 1 | 4 | 1 | 2 | 3 | 3 | 1 | 0 | 1 | 1 |
| | | Privacy & Dignity | Number | PE Team | | | | | | | | | | 0 | 0 | 0 | 1 | 0 |
| | | Patient Care | Number | PE Team | | | 1 | 1 | 1 | 2 | 3 | 2 | 0 | 0 | 0 | 0 | 0 | 1 |
| | | Communication | Number | PE Team | | | 3 | 1 | 1 | 3 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 0 |

**Assistant Director Narrative - Sarah Clarke**

**MRSA Screening** – Elective 75.86% - 2.14% decline from last month. MRSA Screening - Non Elective 90.96% - 0.73% improvement from last month. Discussions held with matrons in matron assurance meetings regarding the importance of screening patients within 24 hours of admission. Ward managers briefed at PNLF regarding the importance of screening patients within 24 hours of admission.
**Appraisals** Healthcare Assistants (Ward Areas) 77.3% which is a 3.36% improvement on last month. Appraisals registered Nurses (Ward Areas) 84.8%, which is a 4.94% improvement on last month. Discussion with matrons regarding the on-going plans in place to conduct and complete appraisals
**F&F Inpatient areas** - This is a 0.88% decline in persons who would recommend the service. F&F ED - This is a 3.35% decline in persons who would recommend the service. Discussion with matrons regarding the importance of the F&FT in gaining valuable ward/department feedback

# Nursing Dashboard - Bridlington

York Teaching Hospital NHS
NHS Foundation Trust

| | | Metric | Measure | Data Source | Trajectory | RAG | CummTotal | September | October | November | December | January | February | March | April | May | June | July | August |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | |
| | Pressure Ulcers | PURP Overall | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 0 | 0 | 0 | 3 | 0 | 1 | 1 | 2 | 1 | 1 | 1 | 1 |
| | | Cat 4 | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Cat 3 | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | | Cat 2 | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 2 | 0 | 1 | 1 | 0 |
| | | Unstageable | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| | | Deep Tissue Injury | No. of Patients (PP) | Safety Thermometer - NEW PU | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Falls | Falls | No. of Patients (PP) | Safety Thermometer - FALLS | | | | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 6 | 2 | 4 | 3 | 3 |
| | | Falls With Harm (Moderate/Severe) | No. of Patients (PP) | Safety Thermometer - FALLS | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Safety Thermometer | Safety Thermometer Overall (Harm Free Care) | % | Safety Thermometer - CQUIN HARM FREE % | 95% | | | 91.84% | 92.11% | 100% | 87.50% | 90.57% | 88.46% | 93.10% | 78.57% | 87.50% | 87.23% | 87.50% | 83.78% |
| | Catheter acquired UTI | New UTI | No. of Patients (PP) | Safety Thermometer - CQUIN HARMS | | | | 1 | 1 | 7 | 4 | 3 | 4 | 2 | 3 | 9 | 5 | 6 | 3 |
| | Critical Missed Meds | Critical Missed Meds | No. of Patients (PP) | Safety Thermometer - OMITTED CRITICAL MEDS | | | | 0 | 0 | 1 | 0 | 4 | 0 | 1 | 0 | 4 | 0 | 0 | 2 |
| | Drug Errors | Drug Errors (inpatient wards only) | | Datix | | | | 0 | 1 | 2 | 1 | 4 | 4 | 1 | 7 | 1 | 3 | 4 | 3 |
| | NEWS | Compliance with NEWs (inpatient wards only) | | Signal | | | | 92.88% | 91.21% | 91.80% | 93% | 90.77% | 82.55% | 83.20% | 84.51% | 82.59% | 84.74% | 86.17% | 86.10% |
| | Deep Vein Thrombosis | New DVT | No. of Patients (PP) | Safety Thermometer - VTE TREATMENT TYPE | | | | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Pulmonary Embolism | New PE | No. of Patients (PP) | Safety Thermometer - VTE TREATMENT TYPE | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| | VTE Other | VTE Other | | Safety Thermometer - VTE TREATMENT TYPE | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | | | | | | | | | | | | |
| Workforce | Vacancies | Inpatient area vacancies -RN | Number | CN Team | | | | 5 | 7 | 6.15 | 7.36 | 5.33 | -0.33 | 0.44 | 0.6 | 1.4 | 1.33 | 2.13 | 2.33 |
| | | Inpatient area vacancies - HCA | Number | CN Team | | | | 4.84 | 5.6 | 4.19 | 6.5 | 8.43 | 7.63 | 7.83 | 7.03 | 7.03 | 6.36 | 4.9 | 6.13 |
| | Vacancy Rate | Inpatient area -RN | | | | | | | | | | | | | 1.49% | 3.48% | 3.30% | 5.28% | 5.78% |
| | | Inpatient area - HCA | | | | | | | | | | | | | 18.41% | 18.41% | 16.60% | 12.77% | 15.40% |
| | Sickness (In Patient Areas) | Sickness | % | Workforce Info | | | | 15.55% | 12.58% | 10.15% | 8.61% | 12.24% | 13.02% | 8.83% | 9.92% | 12.23% | 10.20% | 10.73% | 8.26% |
| | Maternity Leave | inpatient nursing / HCA | % | Workforce Info | | | | 1.43% | 1.56% | 2.69% | 3.48% | 3.46% | 3.46% | 3.46% | 3.47% | 3.53% | 3.72 | 3.86% | 2.51% |
| | Appraisals | Registered Nurses (Ward Areas) | % | Workforce Info | 95% | | | 53.66% | 57.16% | 67.71% | 76.19% | 79.76% | 77.68% | 78.16% | 78.16% | 79.30% | 72.87% | 56.73% | 65.55% |
| | | Healthcare Assistants (Ward Areas) | % | Workforce Info | 95% | | | 52.78% | 70.83% | 81.73% | 96.15% | 95.83% | 95.83% | 93.75% | 87.50% | 86.93% | 86.93% | 72.16% | 74.78% |
| | Safer Staffing Return | Qualified Fill Rated - Day | % | Safer Staffing Return | Between 80 - 100% | | | 83.10% | 97.90% | 80.50% | 78.60% | 89.20% | 85.20% | 87.60% | 80.1% | 75% | 74.4% | 72.30% | 49.10% |
| | | Qualified Fill Rated - Night | % | Safer Staffing Return | Between 80 - 100% | | | 92.10% | 74.40% | 63.60% | 88.10% | 76% | 79.90% | 76.10% | 95.5% | 71.70% | 61.9% | 65% | 57.60% |
| | | Unqualified Fill Rates - Day | % | Safer Staffing Return | Between 80 - 100% | | | 64.50% | 84.90% | 93.10% | 88.10% | 93.80% | 84.30% | 99.90% | 74.5% | 91.30% | 85.6% | 90.10% | 83.30% |
| | | Unqualified Fill Rates - Night | % | Safer Staffing Return | Between 80 - 100% | | | 191.70% | 132.30% | 201.70% | 204.80% | 164.50% | 158.90% | 140.30% | 175.0% | 146.80% | 156.7% | 188.70% | 195.20% |
| | Care Hours per patient Day | Registered Nurses | | Safer Staffing Return | | | | 3.5 | 3.4 | 3.4 | 3.6 | 3.1 | 3 | 3.2 | 2.9 | 3.4 | 3.3 | 3.5 | 2.8 |
| | | Healthcare Assistants | | Safer Staffing Return | | | | 3.9 | 3.7 | 3.9 | 4.1 | 3 | 2.9 | 3.2 | 3.1 | 3.6 | 3.6 | 4.1 | 2.4 |
| | | Total | | Safer Staffing Return | | | | 7.5 | 7.1 | 7.3 | 7.7 | 6.2 | 5.6 | 6.5 | 6.1 | 7 | 6.9 | 7.6 | 7.1 |
| | Internal Bank Fill Rate | Fill Rate | % | Workforce Info | | | | 85.50% | 82.20% | 84.20% | 74.90% | 74.20% | 82.60% | 81.50% | 75.50% | 75.60% | 71.30% | 73.47% | 78.82% |
| | Agency Fill Rate | Fill Rate | % | Workforce Info | | | | 0.60% | 0.30% | 1.70% | 5.80% | 9.40% | 4.20% | 3.30% | 10% | 10% | 4.60% | 1.40% | 1.52% |
| | | | | | | | | | | | | | | | | | | | |
| Infection Prevention | MRSA | MRSA Bacteraemia | Accumulated number of patients | IC Team | 0 | Green | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | MRSA Screening - Elective | Compliance % | Signal | 95% | | | 97.99% | 99.34% | 97.56% | 97.66% | 100.00% | 67.89% | 99.40% | 100% | 100% | 95% | 90.63% | 96.77% |
| | | MRSA Screening - Non-Elective | Compliance % | Signal | 95% | | | 100% | 100% | 100% | 100% | 100% | 75% | 100% | 100% | 100% | 100% | 100% | 75% |
| | C.Difficile | C DIF Toxin Trust Attributed | Accumulated number of patients | IC Team | 48 | Green | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | MSSA | MSSA Bacteraemia | Accumulated number of patients | IC Team | <30 | Red | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | E-Coli | E-Coli Bacteraemia | Accumulated number of patients | IC Team | | | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | | | | | | | | | | | | |
| Risk Management (Trust wide) | Serious Incidents | SI's declared | Number | Datix - healthcare governance | | | | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 4 | 1 | 0 | 0 |
| | Critical Incidents | CI's reported | Number | Datix - healthcare governance | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 |
| | Never Events | Never Events declared | Number | Datix - healthcare governance | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |

| | | Metric | Measure | Data Source | Trajectory | RAG | CummTotal | September | October | November | December | January | February | March | April | May | June | July | August |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Metric** | **Measure** | **Data Source** | **Trajectory** | **RAG** | **Cum.Total** | **September** | **October** | **November** | **December** | **January** | **February** | **March** | **April** | **May** | **June** | **July** | **August** |
| **Patient Experience** | **Friends and Family** | Inpatient Friends and Family Test | %Recommend | Signal | | | | 98.74% | 98.74% | 98.90% | 99.73% | 100% | 98.60% | 98.01% | 98.14% | 99.66% | 99.34% | 98.72% | |
| | | | %Not Recommend | Signal | | | | 0.32% | 0.32% | 0% | 0% | 0% | 0% | 0.00% | 0% | 0% | 0% | 0.64% | |
| | | A&E Friends and Family Test | % Recommend | Signal | | | | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| | | | % Not Recommend | Signal | | | | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| | | Maternity (Ante Natal) | % Recommend | Signal | | | | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| | | | % Not Recommend | Signal | | | | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| | | Birth | % Recommend | Signal | | | | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| | | | % Not Recommend | Signal | | | | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| | | Maternity (Post Natal) | % Recommend | Signal | | | | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| | | | % Not Recommend | Signal | | | | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| | **Complaints** | Complaints Total | Number | PE Team | | | | 1 | 0 | 2 | 0 | 2 | 0 | 1 | 0 | 1 | 0 | 1 | 1 |
| | | Staff Attitude | Number | PE Team | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Privacy & Dignity | Number | PE Team | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 |
| | | Patient Care | Number | PE Team | | | | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Communication | Number | PE Team | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Assistant Director Narrative - Sarah Clarke**

**Pressure Ulcers -** CAT 3 RCA in progress
**Appraisals** - Registered Nurses (Ward Areas) 65.55% which is an 8.82% improvement on last month. Healthcare Assistants (Ward Areas) 74.78 % which is a 2.62 % improvement on last month. Discussion with matrons regarding the on-going plans in place to conduct and complete appraisals
**MRSA Screening** 25% decline from last month. Discussions held with matrons in matron assurance meetings regarding the importance of screening patients within 24 hours of admission. Ward managers briefed at PNLF regarding the importance of screening patients within 24 hours of admission

# Nursing Dashboard - Trustwide

York Teaching Hospital NHS
NHS Foundation Trust

| | | Metric | Measure | Data Source | Trajectory | RAG | Cumm. Total (Financial Year | September | October | November | December | January | February | March | April | May | June | July | August |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient Safety | Pressure Ulcers | PURP Overall | No. of Patients (PP) | Safety Thermometer - New PU | | | | 15 | 17 | 17 | 20 | 18 | 9 | 18 | 21 | 12 | 14 | 32 | 16 |
| | | Cat 4 | No. of Patients (PP) | Safety Thermometer - New PU | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 |
| | | Cat 3 | No. of Patients (PP) | Safety Thermometer - New PU | | | | 2 | 3 | 3 | 2 | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 1 |
| | | Cat 2 | No. of Patients (PP) | Safety Thermometer - New PU | | | | 11 | 7 | 7 | 11 | 10 | 5 | 8 | 13 | 7 | 4 | 12 | 8 |
| | | Unstageable | No. of Patients (PP) | Safety Thermometer - New PU | | | | 1 | 7 | 7 | 7 | 8 | 4 | 8 | 8 | 5 | 7 | 9 | 6 |
| | | Deep Tissue Injury | No. of Patients (PP) | Safety Thermometer - New PU | | | | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Falls | Falls | No. of Patients (PP) | Safety Thermometer - FALLS | | | | 28 | 23 | 40 | 28 | 31 | 36 | 20 | 30 | 16 | 27 | 19 | 30 |
| | | Falls With Harm (Moderate/Severe) | No. of Patients (PP) | Safety Thermometer - FALLS | | | | 3 | 0 | 0 | 1 | 1 | 4 | 0 | 0 | 0 | 0 | 1 | 0 |
| | Safety Thermometer | Safety Thermometer Overall (Harm Free Care) | % | Safety Thermometer -CQUIN HARM FREE % | 95% | Red | | 94.71% | 95.15% | 95.27% | 95.33% | 94.90% | 94.45% | 94.89% | 93.87% | 94.32% | 96.36% | 94.26% | 93.58% |
| | Catheter acquired UTI | New UTI | No. of Patients (PP) | Safety Thermometer - UTI - NEW UTI | | | | 15 | 19 | 34 | 18 | 26 | 17 | 11 | 21 | 29 | 15 | 26 | 16 |
| | Critical Missed Meds | Critical Missed Meds | No. of Patients (PP) | Safety Thermometer - OMITTED CRITICAL MEDS | | | | 17 | 15 | 19 | 20 | 23 | 17 | 17 | 9 | 11 | 17 | 19 | 17 |
| | Drug Errors | | | Datix | | | | 101 | 133 | 138 | 152 | 159 | 168 | 163 | 141 | 121 | 152 | 155 | 127 |
| | NEWS | | | Signal | | | | 88.10% | 87.90% | 87.90% | 87% | 86.30% | 86.72% | 87.90% | 98.40% | 87.20% | 89.20% | 89% | 88.80% |
| | Deep Vein Thrombosis | New DVT | No. of Patients (PP) | Safety Thermometer - VTE Treatment Type | | | | 0 | 2 | 2 | 5 | 1 | 2 | 1 | 1 | 1 | 0 | 0 | 1 |
| | Pulmonary Embolism | New PE | No. of Patients (PP) | Safety Thermometer - VTE Treatment Type | | | | 1 | 3 | 0 | 4 | 3 | 2 | 2 | 3 | 4 | 1 | 0 | 0 |
| | VTE Other | VTE Other | No. of Patients (PP) | Safety Thermometer - VTE Treatment Type | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Workforce | Vacancies | Inpatient area vacancies -RN (month end) | Number | CN Team | | | | 141.91 | 105.5 | 117.26 | 109.42 | 125.88 | 138.05 | 149.79 | 152.05 | 162.81 | 171.34 | 185.05 | 198.99 |
| | | Inpatient area vacancies - HCA (month end) | Number | CN Team | | | | 80.38 | 75.65 | 59.37 | 59.86 | 47.56 | 42.78 | 26.97 | 51.99 | 41.37 | 41.83 | 34.66 | 45.97 |
| | Vacancy Rate | Inpatient area -RN (month end) | % | CN Team | | | | | | | | | | | 18.03% | 18.78% | 20.39% | 22.01% | 23.40% |
| | | Inpatient area - HCA (month end) | % | CN Team | | | | | | | | | | | -- | 8.21% | 7.29% | 6.03% | 7.72% |
| | Turnover | Registered Nurses & midwives | % | Workforce Info | | | | 10.70% | 10.03% | 9.77% | 9.91% | 9.65% | 11.07% | 9.03% | 9.72% | 9.59% | 9.40% | 9.24% | 9.12% |
| | | Healthcare Assistants | % | Workforce Info | | | | 9.84% | 8.22% | 8.31% | 7.55% | 7.40% | 7.11% | 8.12% | 8.47% | 8.36% | 8.10% | 8.24% | 8.11% |
| | Sickness | Trustwide nursing / HCA sickness | % | Workforce Info | | | | 5.01% | 4.40% | 4.15% | 4.52% | 4.76% | 4.43% | 4.08% | 4.13% | 4.31% | 4.41% | 4.54% | |
| | Maternity Leave | Trustwide nursing / HCA | % | Workforce Info | | | | 2.84% | 2.65% | 2.75% | 2.89% | 2.82% | 2.79% | 2.76% | 2.79% | 2.82% | 2.68% | 2.75% | 2.83% |
| | Appraisals | Registered Nurses | % | Workforce Info | | 95% | | 70.99% | 71.53% | 73.33% | 73.88% | 71.16% | 74.50% | 73.22% | 72.07% | 74.27% | 75.44% | 75.09% | 82.94% |
| | | Healthcare Assistants | % | Workforce Info | | 95% | | 71.63% | 71.27% | 75.34% | 77.45% | 77.93% | 78.49% | 77.52% | 76.03% | 76.21% | 74.85% | 72.78% | 78.31% |
| | Safer Staffing Return | **Qualified** Fill Rated - Day | % | Safer Staffing Return | Between 80 - 100% | Green | | 88.61% | 90.82% | 92.12% | 90.90% | 90.84% | 90.00% | 88.20% | 88.21% | 88.61% | 87.67% | 86.19% | 82.94% |
| | | **Qualified** Fill Rated - Night | % | Safer Staffing Return | Between 80 - 100% | Red | | 93.58% | 95.98% | 96.80% | 95.20% | 88.45% | 93.78% | 93.14% | 90.41% | 93.00% | 92.38% | 91.83% | 89.08% |
| | | **Unqualified** Fill Rates - Day | % | Safer Staffing Return | Between 80 - 100% | Green | | 101.56% | 101.79% | 105.53% | 103.44% | 101.19% | 102.08% | 105.59% | 106.95% | 105.25% | 106.44% | 106.45% | 103.69% |
| | | **Unqualified** Fill Rates - Night | % | Safer Staffing Return | Between 80 - 100% | Red | | 117.41% | 113.11% | 119.19% | 113.69% | 11452.00% | 114.04% | 113.65% | 115.29*% | 113.68% | 113.56% | 117.08% | 114.58% |
| | Care Hours per patient Day | Registered Nurses | | Safer Staffing Return | | | | 3.8 | 3.8 | 3.7 | 3.8 | 3.6 | 3.6 | 3.6 | 3.7 | 3.6 | 3.7 | 3.3 | 3.6 |
| | | Healthcare Assistants | | Safer Staffing Return | | | | 3.0 | 2.9 | 2.8 | 2.8 | 2.7 | 2.7 | 2.9 | 3 | 2.9 | 3 | 3 | 3 |
| | | Total | | Safer Staffing Return | | | | 6.8 | 6.7 | 6.5 | 6.6 | 6.2 | 6.3 | 6.5 | 6.7 | 6.5 | 6.7 | 6.3 | 6.6 |
| | Bank & Agency | **Overall** Fill Rate | % | Workforce Info | | | | 79.86% | 81.33% | 83.19% | 78.18% | 80.36% | 82.02% | 82.16% | 80.05% | 79.20% | 78.36% | 77.68% | 74.11% |
| | | **Bank** Fill Rate RN | % | Workforce Info | | | | 47.60% | 46.28% | 51.94% | 48.66% | 50.10% | 49.13% | 49.63% | 48.25% | 49.57% | 44.57% | 42.79% | 40.08% |
| | | **Bank** Fill Rate HCA | % | Workforce Info | | | | 51.78% | 51.35% | 51.77% | 49.97% | 54.60% | 56.25% | 60.13% | 57.80% | 59.04% | 62.16% | 61.77% | 62.60% |
| | | **Bank** - RN FTE filled | Number of Hours | Workforce Info | | | | 195.91 | 199.53 | 188.43 | 183.04 | 215.00 | 213.39 | 242.68 | 211.23 | 213.16 | 221.77 | 244.56 | 263.95 |
| | | **Bank** - HCA FTEfilled | Number of Hours | Workforce Info | | | | 199.96 | 1946.00 | 209.22 | 206.50 | 195.99 | 198.30 | 212.12 | 208.89 | 209.35 | 193.24 | 223.05 | 215.77 |
| | | **Agency** Fill Rate RN | % | Workforce Info | | | | 30.82% | 33.90% | 31.24% | 29.52% | 28.31% | 30.98% | 28.54% | 26.31% | 26.39% | 27.14% | 27.85% | 25.48% |
| | | **Agency** Fill Rate HCA | % | Workforce Info | | | | 29.49% | 31.16% | 31.02% | 30.13% | 27.91% | 27.92% | 26.60% | 27.80% | 23.46% | 23.53% | 23.40% | 21.97% |
| | | **Agency** - RN FTE filled | Number of Hours | Workforce Info | | | | 60.38 | 67.64 | 58.87 | 54.03 | 60.86 | 66.11 | 69.27 | 55.58 | 56.25 | 60.78 | 68.10 | 67.26 |
| | | **Agency** - HCA FTE filled | Number of Hours | Workforce Info | | | | 583.97 | 60.64 | 64.90 | 62.21 | 54.70 | 55.17 | 56.43 | 58.07 | 49.12 | 45.46 | 52.72 | 47.40 |

| | | Metric | Measure | Data Source | Trajectory | RAG | Cumm. Total (Financial Year | September | October | November | December | January | February | March | April | May | June | July | August |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Stat & Mand Training | Statutory & Mandatory Training | Statutory Training | | CLAD | 75% | | | 69.78% | 70.21% | 84.35% | 69.84% | 59.72% | 84.73% | 89.05% | 87.68% | 88.39% | 89.96% | 88.57% | 88.92% |
| | | Mandatory Traiing | | CLAD | 75% | | | 78.61% | 79.24% | 83.75% | 77.79% | 73.12% | 85.11% | 85.55% | 89.78% | 90.10% | 88.42% | 88.54% | 88.90% |
| Infection Prevention | MRSA | MRSA Bacteraemia | Cummulative | IC Team | | Red | 4 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 3 |
| | | MRSA Screening - Elective | Compliance % | Signal | 95% | Red | | 58.77% | 61.75% | 82.48% | 78.51% | 71.77% | 67.89% | 69.36% | 62.56% | 85.98% | 81.69% | 85.34% | 88.57% |
| | | MRSA Screening - Non-Elective | Compliance % | Signal | 95% | Red | | 82.29% | 82.62% | 65.89% | 64.81% | 81.11% | 82.01% | 82.62% | 81.59% | 84.12% | 81.63% | 87.74% | 89.16% |
| | C.Difficile | C DIF Toxin Trust Attributed | Cummulative | IC Team | | Green | 14 | 1 | 3 | 2 | 8 | 10 | 5 | 5 | 2 | 2 | 5 | 2 | 3 |
| | MSSA | MSSA Bacteraemia | Cummulative | IC Team | | Red | 23 | 0 | 8 | 4 | 5 | 5 | 6 | 4 | 3 | 3 | 7 | 5 | 5 |
| | E-Coli | E-Coli Bacteraemia | Cummulative | IC Team | | | 34 | 10 | 4 | 5 | 5 | 9 | 8 | 5 | 6 | 8 | 9 | 4 | 7 |
| | Hand Hygiene | Hand Hygiene Compliance 95% | Compliance % | IC Team | 95% | Amber | | 94% | 94% | 94% | 93% | 94% | 95% | 94% | 94% | 95% | 93% | 93% | 97% |
| Risk Management (Trust wide) | Serious Incidents | SI's declared | Number | Datix - Healthcare Governance Team | | | | 12 | 9 | 18 | 14 | 28 | 18 | 10 | 9 | 20 | 19 | 14 | 12 |
| | Critical Incidents | CI's reported | Number | Datix - Healthcare Governance Team | | | | 4 | 3 | 11 | 7 | 17 | 10 | 6 | 1 | 11 | 11 | 7 | 8 |
| | Never Events | Never Events declared | Number | Datix - Healthcare Governance Team | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 |
| Patient Experience | Friends and Family | Inpatient Friends and Family Test | %Recommend | Signal | | | | 96.70% | 96.70% | 96.21% | 96.79% | 96.51% | 96.81% | 96.40% | 93.34% | 94.96% | 95.05% | 96.63% | |
| | | | %Not Recommend | Signal | | | | 1.03% | 1.03% | 1.15% | 0.97% | 0.79% | 0.60% | 1.00% | 0.72% | 1.89% | 1.78% | 0.88% | |
| | | A&E Friends and Family Test | % Recommend | Signal | | | | 82.76% | 83.52% | 81.61% | 84.37% | 84.25% | 81.49% | 84.18% | 85.37% | 85.13% | 84.48% | 81.96% | |
| | | | % Not Recommend | Signal | | | | 10.81% | 9.74% | 11.21% | 10.02% | 9.63% | 11.06% | 8.40% | 7.65% | 6.92% | 8.25% | 11.02% | |
| | | Maternity (Ante Natal) | % Recommend | Signal | | | | 98.65% | 98.65% | 99.17% | 96.12% | 94.45% | 100% | 95.65% | 97.58% | 97.53% | 98.60% | 98% | |
| | | | % Not Recommend | Signal | | | | 0% | 0% | 0% | 0% | 1.82% | 0% | 2.90% | 0% | 0% | 0% | 0.68% | |
| | | Labour & Birth | % Recommend | Signal | | | | 99.09% | 99.09% | 98.54% | 98.34% | 97.56% | 99.19% | 98.61% | 98.97% | 100% | 97.80% | 97.64% | |
| | | | % Not Recommend | Signal | | | | 0% | 0% | 0% | 0% | 0% | 0.81% | 0.00% | 0% | 0% | 0.54% | 1.58% | |
| | | Maternity (Post Natal) | % Recommend | Signal | | | | 97.80% | 97.80% | 96.95% | 98.21% | 99.11% | 99.13% | 96.03% | 97.62% | 98.94% | 97.26% | 96^ | |
| | | | % Not Recommend | Signal | | | | 0% | 0% | 0% | 0% | 0% | 0% | 0.79% | 2.38% | 0% | 0% | 3.20% | |
| | | Community Post Natal | % Recommend | Signal | | | | 100% | 100% | 98.18% | 100% | 97.17% | 96.72% | 98.15% | 97.83% | 98.72% | 100% | 98.92% | |
| | | | % Not Recommend | Signal | | | | 0% | 0 | 0% | 0% | 0% | 1.64% | 0.93% | 0% | 1.28% | 0% | 0% | |
| | Complaints | Complaints Total | Number | PE Team | | | | 33 | 31 | 30 | 26 | 39 | 27 | 30 | 31 | 29 | 21 | 29 | 31 |
| | | Staff Attitude | Number | PE Team | | | | 2 | 1 | 2 | 4 | 3 | 5 | 6 | 5 | 4 | 4 | 5 | 2 |
| | | Privacy & Dignity | Number | PE Team | | | | | | | | | | | 0 | 0 | 0 | 2 | 1 |
| | | Patient Care | Number | PE Team | | | | 1 | 3 | 5 | 2 | 9 | 8 | 4 | 0 | 3 | 6 | 2 | 5 |
| | | Communication | Number | PE Team | | | | 5 | 5 | 1 | 4 | 2 | 0 | 2 | 1 | 3 | 0 | 1 | 3 |

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Mortality Report

## Recommendation

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

## Current approval route of report

This report is drafted for presentation to the Quality and Safety Committee and Board of Directors.

## Purpose of report

The Board of Directors is asked to consider the Mortality Report.

## Key points for discussion

There are no specific points for discussion.

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

## Reference to CQC Regulations

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

Version number: 1

Author: Diane Palmer, Deputy Director of Patient Safety

Executive sponsor: James Taylor, Medical Director

Date: September 2017

York Teaching Hospital NHS
NHS Foundation Trust

# Trust Mortality Review Report

**August 2017**
**Reporting period: Quarter 1 2017 - 2018**

## Contents



## Executive Summary


- Percentage of deaths for Q1 2017-2018 in relation to the total number of admissions during this period; 1.2% for Q1(2016/17 Q1= 1.3%, Q2=1.2%, Q3 = 1.4%, Q4 = 1.4%) The number of admissions reduced during Q1 compared to Q4.
- The most common cause of death identified by mortality reviews during Q1 remains as pneumonia, followed by heart failure, cancer and sepsis.
- Of the total number of deaths during Q1, 75% had a completed Mortality Review Proforma as opposed to 77% in Q4.
- 57 of the 379 Mortality Reviews completed (16%) were cases which were reported to HM Coroner.
- 4 Mortality Review reports (1%) indicated a disparity between the certified cause of death and that given after the review.
- Day of admission appears to have little impact on mortality in the acute hospitals, however there remains a significant difference in the Community Hospitals for Q1, showing most deaths occurring for patients admitted on a Tuesday.
- The percentage of patients noted to be on an inappropriate ward were 1.7% in April, 1.9% in May and 1.6% in June.

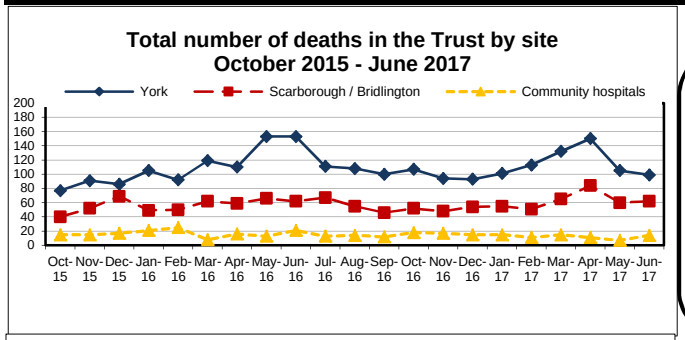
## Number of Deaths

Total number of deaths by month, site and directorate (as provided from Signal) and Mortality Review Proformas received.

| Total number of admissions, deaths and Mortality Reviews undertaken by site | | | | |
|---|---|---|---|---|
| | | Apr-17 | May-17 | Jun-17 |
| York | Admissions | 8440 | 9401 | 9353 |
| | Deaths | 108 | 114 | 88 |
| | Mortality Reviews | 96 | 89 | 66 |
| Scarborough / Bridlington | Admissions | 3838 | 4062 | 4210 |
| | Deaths | 55 | 49 | 53 |
| | Mortality Reviews | 39 | 33 | 21 |
| Community Hospitals | Admissions | 99 | 135 | 103 |
| | Deaths | 12 | 13 | 12 |
| | Mortality Reviews | 11 | 10 | 14 |
| Trust Total | Admissions | 12377 | 13598 | 13666 |
| | Deaths | 175 | 176 | 153 |
| | Mortality Reviews | 146 | 132 | 101 |
| | % of Mortality Reviews | 83.4% | 75.0% | 66.0% |

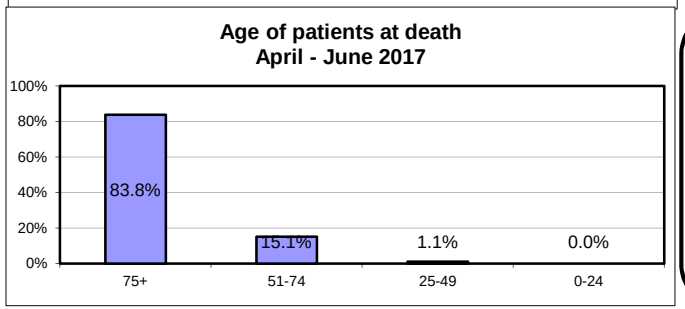
75% of the total deaths from April - June 2017 had a mortality proforma completed.

Q1: 2016/17 - 411 proformas were completed during Q1 and 525 deaths (78%)
Q2: 2016/17 - 372 proformas were completed during Q2 and 482 deaths (77%)
Q3: 2016/17 - 500 proformas were completed during Q3 and 558 deaths (90%)
Q4: 2016/17 - 455 proformas were completed during Q4 and 592 deaths (77%)
Q1: 2017/18 - 379 proformas were completed during Q1 and 504 deaths (75%)




The chart shows a decrease in the number of deaths at York and Scarborough during April to June 2017.

Numbers of deaths at the Community Hospitals remain consistent.




The majority of deaths reviewed are inpatients aged over 75 years.

3 Mortality Reviews were received for patients under the age of 49 during Q1, a decrease from 7 during Q4.

| Total number of admissions, deaths and Mortality Reviews undertaken by speciality | | | | |
|---|---|---|---|---|
| | | Apr-17 | May-17 | Jun-17 |
| Elderly Medicine | Admission | 835 | 949 | 911 |
| | Deaths | 87 | 79 | 66 |
| | Mortality Reviews | 79 | 73 | 57 |
| General Medicine | Admission | 2551 | 2801 | 2728 |
| | Deaths | 52 | 52 | 60 |
| | Mortality Reviews | 38 | 28 | 28 |
| Orthopaedics | Admission | 658 | 744 | 804 |
| | Deaths | 5 | 3 | 3 |
| | Mortality Reviews | 1 | 3 | 0 |
| Paediatrics | Admission | 1043 | 1067 | 995 |
| | Deaths | 2 | 3 | 0 |
| | Mortality Reviews | Child death reports completed | | |
| Specialist Medicine | Admission | 1477 | 1663 | 1630 |
| | Deaths | 4 | 5 | 3 |
| | Mortality Reviews | 4 | 3 | 2 |
| Surgery | Admission | 2540 | 2837 | 2876 |
| | Deaths | 12 | 20 | 8 |
| | Mortality Reviews | 9 | 1 | 1 |

## Cause of Death

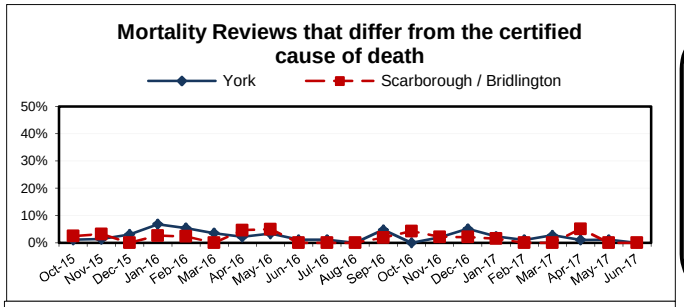
The tables and graphs below show the most common causes of death and data recorded on the Mortality Review Proforma.

| 10 most common causes of death as identified by Mortality Reviews | | | | |
|---|---|---|---|---|
| | Apr-17 | May-17 | Jun-17 | Total |
| Pneumonia | 32 | 30 | 26 | 88 |
| Heart Failure | 16 | 17 | 9 | 42 |
| Cancer | 10 | 11 | 8 | 29 |
| Sepsis | 10 | 8 | 8 | 26 |
| Stroke | 8 | 4 | 6 | 18 |
| GI | 7 | 6 | 3 | 16 |
| Old age | 3 | 6 | 3 | 12 |
| COPD | 4 | 0 | 3 | 7 |
| Dementia /Alzheimer's | 3 | 3 | 1 | 7 |
| Renal failure /AKI | 2 | 3 | 0 | 5 |
| Total | 95 | 88 | 67 | 250 |

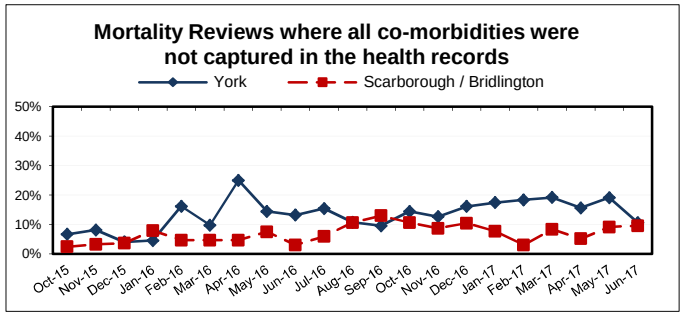
Pneumonia still remains the most common cause of death identified from the Mortality Reviews.

Heart failure remains high but is showing a reduction from 74 deaths in Q4 to 42 during Q1.

There remains a strong focus on sepsis and this is reflected in the table. The number of deaths has reduced from 33 deaths in Q4 to 26 during Q1.

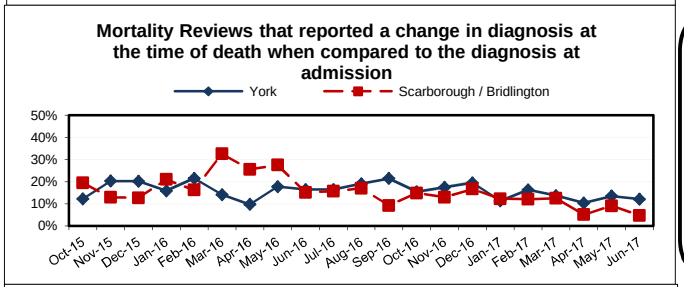



Of the 379 Mortality reviews received during Q1, 1% identified the cause of death to be different to that reported on the death certificate. Of the 1% identified, 50% of these deaths occurred at York Hospital and 50% at Scarborough Hospital.

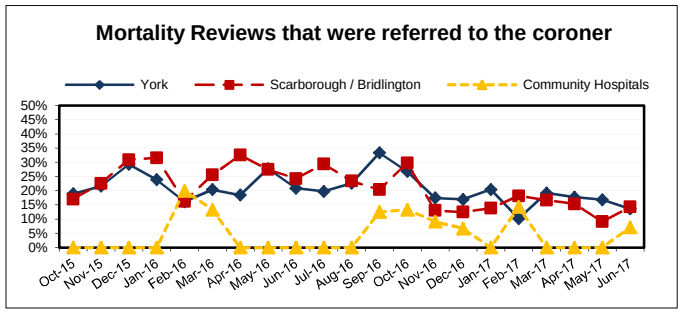



Where there were pre-existing co-morbidities, these had not been captured on 14% of admissions during Q1, this remains the same as Q4.

Scarborough Hospital has shown an increase during Q1.

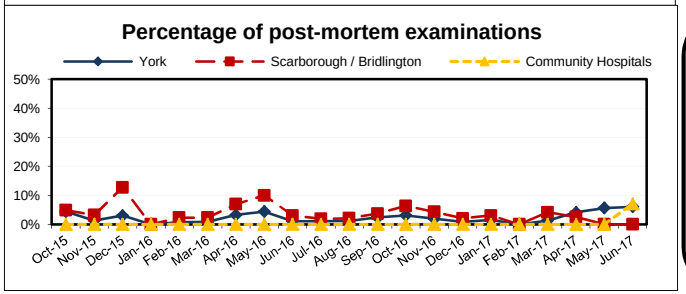



In 10% of cases, the diagnosis at the time of death is different to that on admission during Q1. This is a slight decrease from Q4.




Primary reason for referral to coroner:

- Unknown cause of death
- Inconclusive cause of death
- Died within 24 hours of admission.



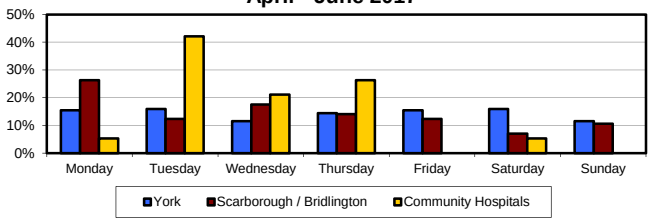

Primary reason for post mortem examination:

- Unknown cause of death
- Inconclusive cause of death.

## Admission

The charts below provide data in relation to day, admission route, time to initial clerking and senior review.

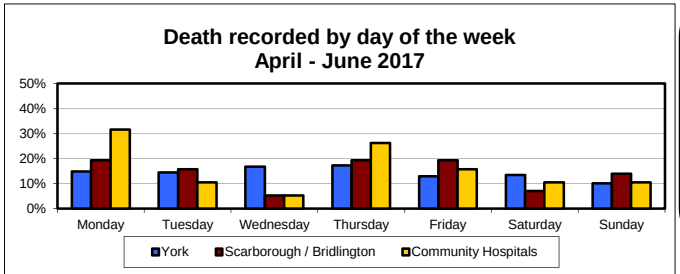
### Deaths by day of admission April - June 2017




Community Hospitals indicate an increased percentage of deaths for patients admitted on a Tuesday and Thursday.

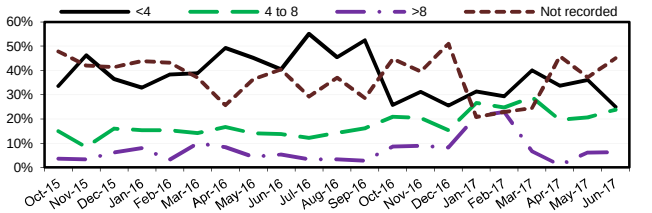
Scarborough and York Hospitals indicate consistency throughout the week with at slight increase at Scarborough on a Monday.

### Death recorded by day of the week April - June 2017




Reports from Community Hospitals indicate during Q1, 31% of deaths occur on a Monday and 26% on a Thursday. Scarborough reports most deaths on a Monday, Thursday and Friday at 19% and York reports most deaths on a Wednesday and Thursday at 17%.

### Time from admission to clerking

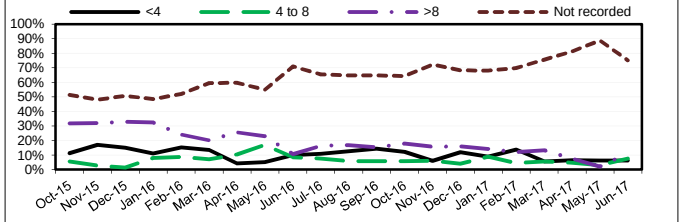



The time from admission to clerking was greater than eight hours for some patients however this has shown a decrease during Q1 compared to Q4.

The number of patients waiting over four hours to be clerked has remained the same for Q1 as Q4, around 20 - 25% .

A large number of reports do not

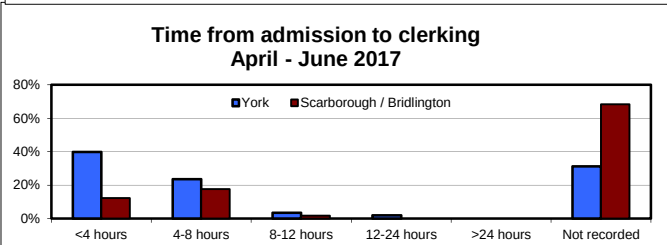
### Time from admission to consultant review




Q1 remained consistent for the time from admission to consultant review within eight hours.

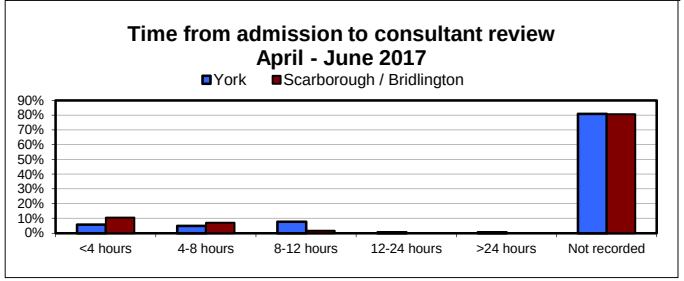
There are a large number of cases where this is not recorded on the proforma. 5% of patients waited longer than eight hours from admission to consultant review.

### Time from admission to clerking April - June 2017



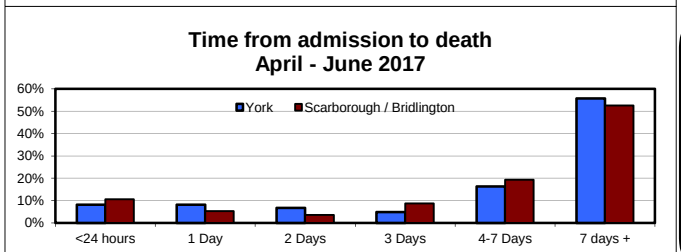

Of the 379 Mortality Reviews completed during Q1 from York and Scarborough, the time from admission to clerking was greater than four hours for 20% of patients. 30% of the reports did not record this information.

### Time from admission to consultant review April - June 2017




From the Mortality Reviews, 14% of patients were seen within 12 hours of admission by a Consultant. However,64% of Mortality Reviews did not document the time from admission to consultant review.

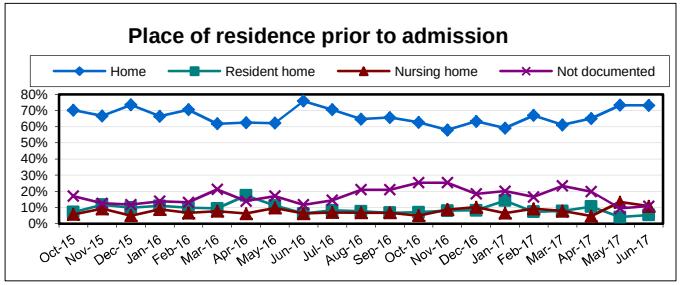
### Time from admission to death April - June 2017




During Q1, 41% of admitted patients reviewed were inpatients for greater than seven days this is a slight increase from 37% patients during Q4.

21% of patients were in up to four days this is a decrease from Q4 and 13% were inpatients for between four and seven days a

### Place of residence prior to admission

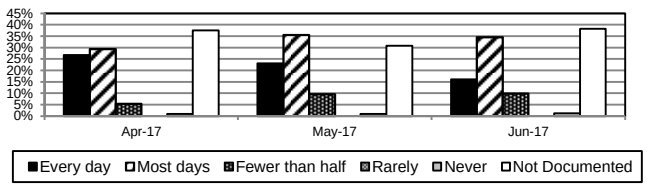



43% of patients admitted to the Acute Trust came in from their own home during Q1.

## Appropriate Care / Treatment

The charts below summarise consultant review frequency and end of life care.

**Did the patient have daily consultant reviews**

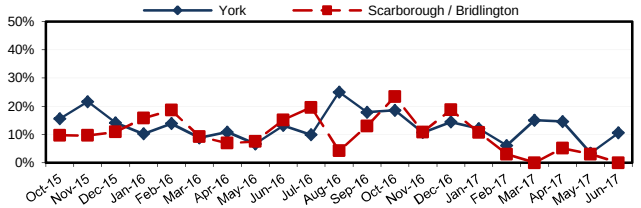



0.8% of patients during Q1 did not have a consultant review.

19% of patients were seen every day, a further 28% of patients were seen most days.

26 patients died within 24 hours of admission. Of the 26 patients: 18 died at York, 7 at Scarborough and 1 at Malton.

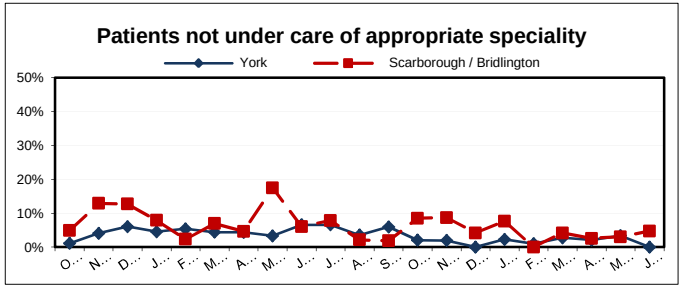
**Patients transferred to a higher level of care**




This demonstrates the percentage of patients transferred to a higher level of care unexpectedly due to change in condition. E.g. HDU,ICU,Theatre.

This has shown an increase at York with 11% of cases noted in June. A slight increase during April and then a decrease at

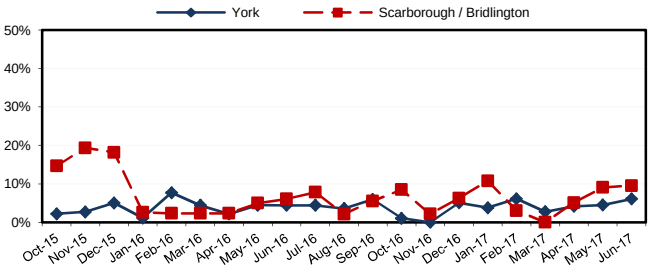
**Patients not under care of appropriate speciality**




This data includes patients with a diagnosis which may require surgical opinion and therefore in some cases remain under the wrong speciality.

There were five cases in York and three cases in Scarborough during Q1.

**Patients not on appropriate ward**

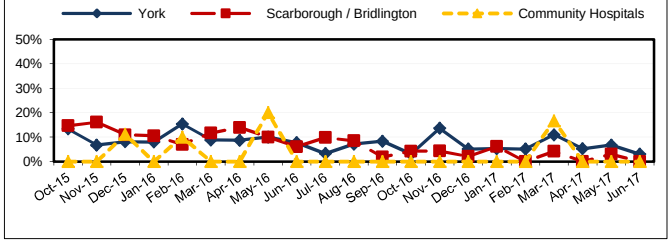



This data shows the percentage of patients on an inappropriate ward by diagnosis/speciality. E.g Medical patient being cared for on a Surgical ward and vice versa.

There has been a slight increase in the number of patients on an inappropriate ward from 1.7% in Q4 to 1.9% in Q1 on the Scarborough site.

On the York site there is an increase from 2.8% in Q4 to

**Trust is recorded as an inappropriate place to die following review**



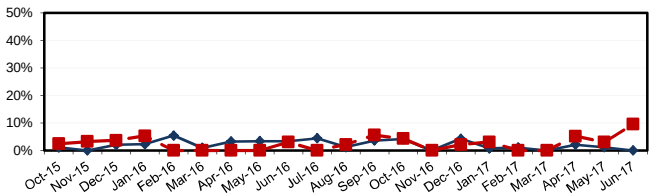

Primary reasons given for inappropriate place to die were:

- Delayed discharge, awaiting care packages
- Lack of advanced care planning.

## Failure to treat Appropriately

The graphs below summarise end of life decision making.

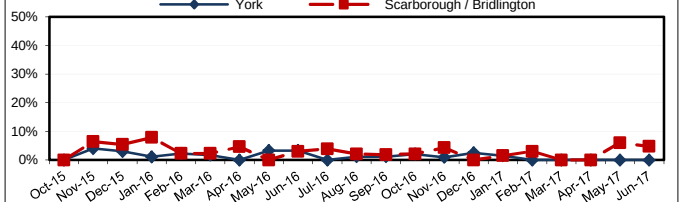
### Deaths where ceiling of care is not defined




2.2% of cases have been identified at Scarborough and York Hospital during Q1.

Work is on-going to improve the documentation of ceiling of care as part of the review of the admission proforma.

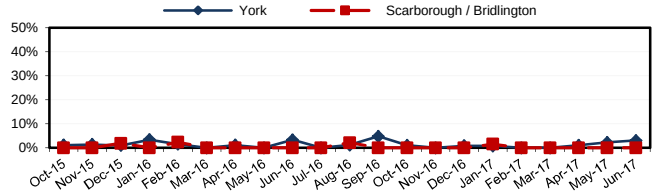
### Deaths with incorrect DNACPR decision making




There were 0.8% of the cases reported at Scarborough. 0 cases were reported at York and in the community during Q1.

There are no details on the reviews to indicate why these were thought to be incorrect.

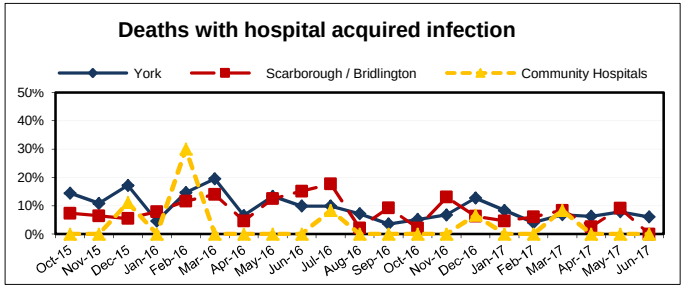
### Deaths where failure to define a clear plan is identified




1.4% of cases reported failed to define a clear plan during Q1.

Five cases at York and zero cases at Scarborough.

### Deaths with hospital acquired infection

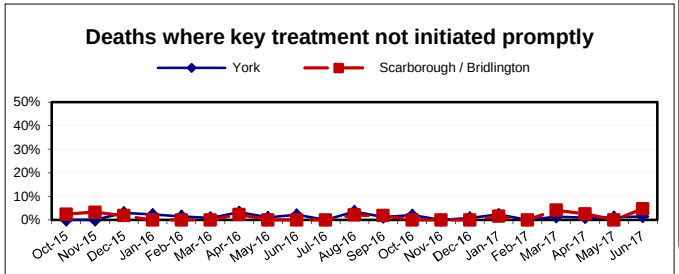



**Hospital Acquired Infection:**
21 patients were noted to have developed a HAI during Q1.

5% of patients were noted to have developed a HAI at York.

1% of patients were noted to have developed a HAI at Scarborough.

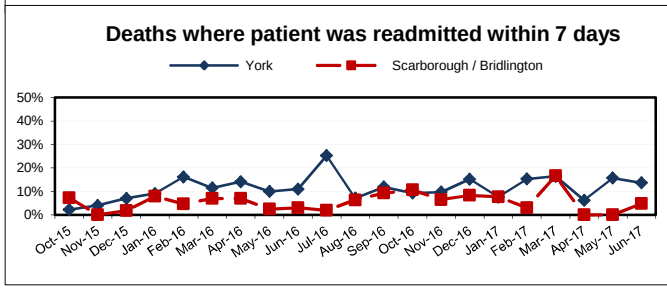
### Deaths where key treatment not initiated promptly




Mortality Reviews have identified that key treatment was not initiated promptly in 1.4% of the cases during Q1.

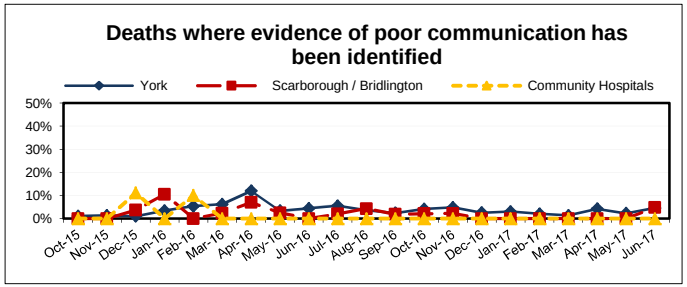
The reasons given for the delay in treatment for these cases were as follows:
- 2 x delay in medical review
- 1 x communication with staff
- 3 x reason not given.

### Deaths where patient was readmitted within 7 days




**No: of pts**
April 17- 6% of patients
May 17 - 3.9% of patients
June 17 - 3.1% of patients
**re-admission related to previous admission:**
April 17 - 0.2% of patients
May 17 - 0.2% of patients
June17 - 1.1% of patients

### Deaths where evidence of poor communication has been identified




In most cases in the acute setting, Mortality Reviews have identified that communication was completed well. Poor communication was reported in ten reviews during Q1.

## Appendix A - Learning from in-depth casenote reviews

**Structured judgement review**

Structured judgement review can be used for a wide range of hospital based safety and quality reviews across services and specialities and not only for those cases where people die in hospital. The purpose of the review is to provide information from which teams or the organisation can learn. On completion of the mortality review proforma if the care overall is deemed to be poor or very poor, (score 1 or 2) or when harms have been identified, or if concerns have been raised about a case this would require a more in depth case note review. Other criteria also include, Learning disabilities, elective admissions  those declared an SI and those requiring an inquest.

Judging the level of the avoidability of a death is a complex assessment that can be challenging to undertake. This is because the assessment goes beyond judging quality and safety of care by also taking account of such issues as co morbidities and estimated life expectancy. The judgement is framed by a six point scale (6 –no evidence of avoidability, to 1-definetly avoidable).

In Quarter 1, nine structured judgement reviews were undertaken. Six from Elderly, one from medicine and two from ICU.

| Overall Care Score | |
|---|---|
| **1** | Very poor care – may have led to severe harm(s) or even death |
| **2** | Poor care – may have caused moderate or minor harm(s) or led to patient / family distress |
| **3** | Adequate care |
| **4** | Good care |
| **5** | Excellent |

| Avoidability Score | |
|---|---|
| **1** | Definitely avoidable |
| **2** | Strong avoidabilty |
| **3** | Probably avoidable >50/50 |
| **4** | Possibly avoidable <50/50 |
| **5** | Slight evidence of avoidability |
| **6** | Definitely not avoidable |

| | Elderly | | | | | | Medicine | ICU | |
|---|---|---|---|---|---|---|---|---|---|
| **Overall care score** | 2 | 3 | 2 | 2 | 4 | 5 | 2 | 2 | 2 |
| **Avoidability score** | 3 | 6 | 3 | 6 | 5 | 5 | 3 | 3 | 6 |

There were two SJCRs declared as an SI, they are:

- Apr17 4369104378
- Jun17 4065528941

## Appendix A

**Apr17 4369104378**

**Overall care score:2 Avoidability score:3**

**The key issues highlighted from this case were:**
Initial good leadership however on a Saturday the patient deteriorated and care was inadequate
Assessment was limited and escalation was not rapid enough to SpR and CCOT.
**Action plan:**
There were no outreach on site at the time so this case will be discussed at the deteriorating patient group.
There is evidence that the escalation process needs to be looked at on both sites.

**Mortality Steering Group discussion:**
Recommend a SI investigation. Dr Blackmore has produced a clear plan regarding infection control issues identified.

**Apr17 4386978216**

**Overall care score: 3 Avoidability score: 6**

**The key issues highlighted from this case were:**
The patient arrived at Scarborough ED at 0640hours with symptoms of a stroke. The stroke consultant decided to transfer the patient to ward 36 at York Hospital. During this time the respiratory rate was 40 but other observations were normal. The patient was reviewed again at 1355 by an ST3 and declared suitable for transfer. The ambulance was ordered at 17.10. 3 hour delay to order transport.
The patient was reviewed at York by the FY1 at 19.35. Respiratory failure had developed so support was requested from CCOT and a senior doctor. Asked for the ICU registrars help with management around 2000 hours, the registrar attended at 0015.
Delay in non-invasive ventilation.

**Action plan:**
Ensure patients are stable for transfer between sites.
Discuss in stroke service meetings-completed.

**Mortality Steering Group discussion:**
There was discussion about the delay in non-invasive respiratory support. This should be monitored to see if recurs.

The reviewer felt the transfer was appropriate due to the policy for stroke transfers. However, the patient must be stable and a detailed assessment should be made if necessary.

**May17 4367512045**

**Overall care score: 2 Avoidability score: 6**

**The key issues highlighted from this case were:**
Delay in initial assessment on stroke unit
No advanced care planning despite very poor prognosis leading to inappropriate resuscitation event when deteriorate shortly after admission
Communication failure.

**Action plan:**
Both the transferring team and the accepting team should communicate clearly using SBARR.
Ensure comprehensive evaluation with appropriate ACP decisions in ED if needed
Comply with Trusts escalation and CPR policy.

**Mortality Steering Group discussion:**
This case related to poor end of life care and poor communication on admission.
This has been fed back to both ED and the stroke team.
Will consider auditting use of NEWS in stroke patients in ED.

**Jun17 4065528941**

**Overall care score: 2 Avoidability score: 3**

**The key issues highlighted from this case were:**
- Documentation of discussions
- Received antibiotics after 5 hours from admission, despite being prescribed 3.5 hours earlier
- Failure to escalate to CCOT on PTWR despite NEWS 7.

**Action plan:**
- This is a system wide process problem, failure to manage sepsis as per Sepsis 6 guidelines
- Failure to escalate early
- Involvement of Sepsis group and Deteriorating patient group as an example of poor care
- More robust Education.

**Mortality Steering Group discussion:**
This is the first SJCR received with an avoidability score of 3, the care was very poor and the group feel it was generous giving an overall care score 2.

**Jun17 4387633468**

**Overall care score: 2 Avoidability score: 3**

**The key issues highlighted from this case were:**
Lack of appreciation of rising sodium
Lack of hand over arrangements before the weekend to ensure continuity of care-not seen over weekend
Documentation poor in places
In ED for 13 hours

**Action plan:**
Review hand over arrangements on the wards especially before the weekends / bank holidays.

**Mortality Steering Group discussion:**
This patient had learning disabilities therefore it is a requirement to complete a review. The initial care was good however the care declined over the weekend, re: fluids, lack of leadership, failure to handover.
The report highlights key themes such as: failed handover on a Friday afternoon.
The group agree this case requires:
A SI investigation.
Cross referencing with safeguarding due to the learning disability process.

Put forward as SI-pending

**Jun17 6518254629**

**Overall care score: 5 Avoidability score: 5**

**The key issues highlighted from this case were:**
Concerns raised by the family that more treatment could have been done to prevent death
Took 7 hours to get to York ASU (target <4) and only received first dose of aspirin 8 hours after this (no effect on outcome)

**Action plan:**
This man had evidence of stroke prior to this admission and was not on secondary prevention. Nothing further could have been done for him as an in-patient hence care scores good above.
GP has been asked to investigate .

**Mortality Steering Group discussion:**
This was a tragic case where a young patient died. The patient was seen in ED 2 months prior to death due to a minor accident and had a CT head later. The GP did not act upon the finding of an ischaemic stroke.
The patient's GP has responded to the feedback.

These actions are to be discussed at the directorate Clinical Governance meeting with an agreed lead and timescales. A quarterly outcome report will be receirved from each of the directorates with clear action plans and duty of candour where appropriate.

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# Board of Directors – 27 September 2017
# Annual report for End of Life Care 2016/17

## Recommendation

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

## Current approval route of report

This report was drafted for the Board of Directors.

## Purpose of report

The End of Life Care annual report reflects the improvements and challenges for end of life care delivery across the Trust settings. The report compares the organisational key performance indicators (KPI's) from the National Care of the Dying Audit reported in 2016, and self- assessment data to date.

The report reflects the achievements, challenges, risks and gives recommendations to improve care at the end of life.

## Key points for discussion

There are no key points for discussion.

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Regulation 10 Dignity and Respect

Version number: 1

Author: Kath Sartain, Lead Nurse (End of Life Care)

Executive sponsor: Beverley Geary, Chief Nurse

Date: June 2017

York Teaching Hospital
NHS Foundation Trust

# End of Life Care Annual Report 2016/2017

**Kath Sartain, Lead Nurse for End of Life Care**

# INDEX

# Executive Summary

End of Life Care affects us all, at all ages, the living, the dying and the bereaved. It is not a response to a particular illness or condition; it is not the parochial concern of a particular group or section of society. We cannot defeat death, but, we can change the way we talk about dying, death and bereavement. We can prepare, plan, care and support those who are dying and the people who are close to them. (Ambitions for Care 2015, National Palliative and End of Life Care Partnership).

York Teaching Hospital NHSFT appointed a Non-Executive Director to work with the senior medical and nursing staff leading on End of Life Care. This has provided valuable links between Trust Board and the clinical team. It has been agreed that this team will provide annual and regular reports on key organisational issues affecting End of Life Care to the Quality and Safety Committee and the Trust Board.

The Trust's outcomes are measured using the National Care of the Dying audit, benchmarking the Trust's position against other care providers on issues relating to End of Life Care, (appendix A).

The National Care of the Dying Audit for Hospitals (NCDAH), England, found significant variations in care across hospitals in England. The audit showed that major improvements need to be made to ensure better care for dying people and better support for their families, carers, friends and those important to them. The audit, led by the Royal College of Physicians and Marie Curie Cancer Care, reports on organisational and clinical Key Performance Indicator's (KPIs).

York Teaching Hospital NHSFT organisational KPI's are compared in appendix A, demonstrating significant organisational improvement over the past 2 years. If the parameters are the same in the next NCDAH; the Trust position will be that all 7 measures will be achieved and sustained.

Key achievements last year:

- transfer from a pilot 7 day specialist palliative care service, to a permanent 7 day service
- education strategy for End of Life Care training for all staff: delivery plan for all staff to access EOLC mandatory training. Over 80% of non-medical staff have attended
- improvements in information sharing from specialist palliative care at discharge through the electronic discharge letter
- fast track process and protocols are in place completely on Scarborough site, and partially on York site
- volunteers in End of Life Care sitting and bereavement services have been recruited and trained
- ceiling of care work / goals of care are now available and started to be used on the IT system
- bereavement service and improved environment in Scarborough hospital is in place

Definition: Palliative and end of life involves care to all those with any advanced progressive incurable illness. The aim of palliative and end of life care is to enable each individual to live as well as possible until they die; ensuring that the patient and family have their needs identified and met throughout the last phase of life and into bereavement. It includes management of all symptoms. (WHO definition for Specialist Palliative Care

## Introduction

"Death and dying are inevitable. Palliative and End of Life Care must be a priority. The quality and accessibility of this care will affect all of us and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes." (National Council of Palliative Care 2015).

In the recent period, there has been guidance from NHS England including a framework for excellence in End of Life Care; Ambitions for Palliative and End of Life Care (2015), NICE guidance (2015) and Five Year Forward (2015). Each document emphasises the importance of local decision making in the delivery of palliative and End of Life Care.

As a Trust we are endeavouring to achieve these ambitions; build on the good care being provided currently within the Trust and aim for outstanding care, for every patient, every time. The Trust's End of Life Care (EOLC) Strategy provides clear direction to help achieve this with an action plan to achieve effective outcomes.

The previous CQC EOLC report (2015) recorded 'Good', with areas of outstanding practice across all areas.

Part of the focus for 2017 is to develop and improve EOLC for the Trust, this will be done by:

- increase access to generalist EOLC education
- build on the Last Days of Life Care Plan developing an electronic simple version
- improve EOLC packages that recognise all areas of diversity
- improve collaboration for EOLC with primary and third sector care

All the objectives are listed in the EOLC strategy (appendix B)

This report will focus on the achievements, challenges, risks and the recommendations for the Trust Board.

## Achievements in the past year

The Trust End of Life Care Strategy (appendix B) has been revised through the senior leads meeting and now has goals set for the forthcoming years. This provides assurance for the chief nursing team and for the Quality and Safety Committee. The majority of the priorities for 2016 have been met and are listed below. Those not achieved are either being carried over or have been reviewed and revised.

1. Projects commenced in 2015 continue, and evolve ensuring the Five Priorities of Care are embedded within the Trust's care

- Care plan for the last days of life – plan to seek an electronic version in 2017/18
- Pharmacy group work continues
- Nurse led beds agreement with St Catherine's Hospice, Scarborough, continues
- Comfort packs: embedded and assurance through the Trust ward accreditation process
- Research engagement: links build with York University and Trust Research department
- CQC report has guided work plan and strategy (Appendix B)
- Incident and complaint reporting for EOLC is embedded
- Audit programme (available Q/yorkhospitals/effectiveteam/palliativecare)

## 2. 7 day specialist palliative care

NICE palliative and supportive care guidance (2004), stated that 'SPC should be staffed to a sufficient level to undertake face to face assessment at home or in hospital during normal hours, 7 days a week'. This has been further endorsed by National End of Life Care Strategy (2008), the National Care of the Dying Audit (2016), specialist palliative care commissioners report (2016) and is a CQC requirement.

York Teaching Hospital NHSFT launched a pilot 7 day SPC service across York and Scarborough acute hospitals, and York community with the of aim having a clinical nurse specialist available for all three areas from November 2015 between the hours of 8am and 4 pm. The pilot was achieved within current establishment, putting the educational component of the role at risk to achieve this. The risk was a reduction in the frequency of the one day teaching session on each site. It did not affect the mandatory training frequency. Without the facilitators increasing their clinical activity, the 7 day service would not have been successful.

All clinical 7 day activity was recorded and examples of earlier discharge, transfer to a hospice/care home bed, prevention of admission and support in the emergency department are identified in the report (appendix E). In quarter 3 of 2016, due to significant sickness within the community team, the community service was temporarily put on hold. The acute sites continued to provide a 7 day service.

From the pilot, a business case identified further staff requirements to ensure sustainability. The teams have increased their workforce through Macmillan Cancer Support funding, to enable continuity of providing specialist palliative care over 7 days.

The full 7 day specialist palliative care report is available in appendix (E).

## 2. Bereavement services

Since January 2016, the Scarborough bereavement services have a designated room which has been refurbished. This now provides an appropriate environment for the bereaved on the Scarborough hospital site. The bereavement officer post has been supported initially by York Charitable Funds and, through a successful business case, the post has become substantive.

On the York site the bereavement service continues to go from strength to strength, working closely with external agencies Cruse and Sands, to provide an extended support for our relatives.

During 2016 a bereavement survey was undertaken across both Scarborough and York seeking feedback from relatives. It is extremely difficult to access feedback at this challenging time for relatives, however; approximately 20% of all the relatives who experienced the service provided a response and reported significantly positive comments about their experiences. Key improvements identified were to offer better signage, a map to the registrars and wider URL information in the booklet. The full report is attached in appendix C.

## 3. Improved Communications

Working together with systems and networks, the assistant medical director and chief nursing team a key piece of work has been to provide an identifier within the IT system to encourage goals of care or ceiling of care decisions (COC) to be documented by the medical teams. This is not to force decisions but to encourage all clinicians to consider the best plan of care at 'post

take round' and continually during the patient care episode. There is increasingly more uptake of the electronic COC, although, this needs to continue to be part of the work programme to ensure the practice is embedded.

Key EOLC information is now transferred into the electronic discharge letter; helping to improve communication across settings.

A fast track process has been developed this year, based on learning from end of life care poor discharge incidents. Fast track is offered to those patients who may be in their last weeks of life. The fast track process provides all wards with a check list and direction on what is required to achieve an excellent discharge quickly.

Since undertaking this, an audit at Scarborough has shown that 90% of all fast track discharges have appropriate medication, information and communication is shared. York site will have an audit undertaken in 2017.

**4. Joint working across localities**

The specialist palliative and EOLC team, bereavement services and senior End of Life Care leads (EOLC Leads: Non-executive director, Lead Nurse, consultants and directorate manager) have joined together to ensure that the leadership, skills and care delivery are guided by the same strategy, whilst embracing the unique differences each site holds. There has been a quarterly joint EOLC Business Meeting, focusing on key components resulting in a work plan (Appendix B) which focuses on improved care, performance and finance.

The End of Life Strategic board which embraced all localities was disbanded this year; however, each locality has a specific operational group, to address the needs of each community. The locality groups work together to ensure operational problems are resolved. The Trust plays an active role within the memberships.

Between the locality and the Yorkshire and Humber regional groups there is a strong desire to work with Humber, Coast and Vale Sustainability and Transformation Plan (STP) to ensure the EOLC agenda is promoted and embedded across the STP. The Network leads are currently seeking ways to identify common themes at STP and through the EOLC agenda.

The senior hospital EOLC leads meet regularly with the Non-Executive Director; to discuss national and regional directives and review the position of the Trust's performance.

**5. Care homes**

Since the introduction of the T34 syringe drivers across the Trust, a loan service for care homes has been in existence. The primary aim of this, has been to ensure those patients dying in their care homes, could gain access to equipment readily. All nursing homes in the localities can access this service; in Scarborough all care homes are participating and 2/3 of York care homes have signed the agreement.

In 2016, this project was improved by the introduction of a more robust service which resulted in all homes in the scheme having a syringe driver on permanent loan. The Trust provides free education related use of the syringe driver. This means all patients have immediate access to a syringe driver on transfer to a care home or if their condition deteriorates.

An audit was undertaken to understand how many care homes admitted patients in the last 72 hours of life. Some of the reasons for admission were due to staff not recognising the patient

was in the last days of life and no recording of advance care planning. With the improved access to education and the equipment, this audit will be repeated in 2017. We aim for a 20% reduction of patients admitted unnecessarily to care homes in the last 72 hours of life.

## 6. Volunteers

Ambitions for palliative care and end of life care (2015) highlights in ambition 6; '*each community is prepared to help'* and that volunteers are a significant resource in creating good EOLC and must be valued more highly and used more effectively.

Working together with the Trust volunteering department, two exciting volunteer roles have been developed this year; bereavement volunteer and end of life care sitter.

Within the bereavement department the volunteers offer support and a welcome to the relatives, and the end of life sitters will sit with those patients in the last days of life so they are not alone. There have been a total of 9 volunteers across both sites, however the number fluctuates depending on volunteer commitments.

There is a clear support for the volunteers and education is offered as an additional support.

## 7. Education

Ambition 5 in 'Ambitions for palliative care and end of life care' (2015) states that '*all staff are prepared to care'*, and that staff are able to bring empathy skills and expertise to ensure competent, confident and compassionate care.

Education is essential and this year, the education strategy (appendix D) has been refreshed linking all our education to Health Education England's 'End of Life Care Core Skills Education and Training Framework' (2016) and specifically working with the learning outcomes produced by Health Education Yorkshire and Humber.

The education strategy's overall aim is to provide a co-ordinated and collaborative approach to EOLC across health and social care settings enabling staff to have skills and confidence in delivering compassionate care at end of life.

The National Framework describes core knowledge and skills for staff and this is identified in 3 Tiers:

- Tier 1 – those staff who require general end of life awareness
- Tier 2 – those staff who have regular contact with people receiving end of life care
- Tier 3 – those staff in roles which frequently provide end of life care

During 2016, the full day education has continued, but has been limited by 50% due to the pilot of providing a 7 day service. From 2017, the education plan will deliver education on all sites every month. We will work in partnership with other local stakeholders to ensure End of Life Care education delivery improves across the locality.

A key education achievement has been the delivery of the e-learning programme End of Life Care for All (e-ELCA), recommended by NICE (2015) on the Trust's Leanring Hub. In addition, key end of life care modules are now mandatory for all medical staff. This has achieved a quality report requirement.

The e-ELCA aims to enhance the training and education of the health and social care workforce so that well-informed high quality care can be delivered by confident and competent staff and volunteers, to support people wherever they happen to be. All staff are required to attend mandatory end of life care education every 3 years (Tier 1).

In addition, there are a variety of other educational initiatives (appendix F) which highlights the education delivered this year.

A real success is the Ward Champion Programme, which offers bespoke training for the ward champion. This ensures all wards have a champion who has received the full day education and shadowing opportunity with the hospice or palliative care team. The learning from this is then disseminated throughout the ward area through an identified ward specific project. Individual areas are identifying specific issues and changing ward practice.

Table 1highlights the training delivered in 2016.

Table 1

| Educational training April 2016- March 2017 | York numbers of staff | Scarborough numbers of staff | Total staff number trained | Total staff % trained |
|---|---|---|---|---|
| EOLC mandatory sessions (not medical staff ) | 578 | 253 | 831 | 83% |
| Full day educational training | 75 | 50 | 125 | - |
| Preceptorship end of life care days | 70 | 16 | 86 | - |
| Medical e- learning (e-ELCA) | | | 144 | 43% |

Advanced Communication Skills and Nurse Led, Do Not Resuscitate cardio pulmonary resuscitation (DNACPR) training are being provided for staff identified at their appraisal. These courses are delivered in partnership with St Leonard's and St Catherine's hospices. The learning from the courses will be shared with the nurse/medical manager and the impact recorded through appraisal.

**Challenges and Risks**

**1. Improved access to information sharing**

The team are keen to explore the feasibility of different ways using mobile technology for the community specialist palliative care team. The belief is that the use of mobile IT devices will improve the speed and effectiveness of communication and the ability to provide care significantly at admission to and discharge from the hospital.

The interoperability of IT systems is a challenge in some of our localities. If interoperability is improved then specific information sharing of advance care plans, adhering to patient's preferences and wishes should reduce inappropriate admission and treatment and enable clearer decision making. National guidance suggests that EPaCCS (electronic palliative care coordination system) should be available by 2018. (What's important to me: A Review of choice in EOLC 2015). However, the key objective for the Trust is to find a route for key messages to be shared electronically which will benefit the patient experience.

## 2. Mortuary Services

The Mortuary environment on the Scarborough site is unsatisfactory and has been identified as an essential work through the Capital Build scheme. To achieve a good standard of environment and service, a business case is required that will need consideration in 2017. The case will include an additional corridor for transportation of bodies from the main hospital to the mortuary.

## 3. Embedding the Five Priorities, including the Care Plan

There are recognised challenges in embedding the care plan for the last days of life in York hospital and the community settings. There is a clear support structure from the corporate team supporting the use of the plan, the structure will be reviewed in order to ensure the clinical areas are enabled to access support easily and effectively.

A key piece of work this year is to explore recording the care plan electronically, linking it to the National Early Warning System. This is a key work programme for 2017 and will be piloted in paper format first, prior to introducing onto IT. Engagement with wider stakeholders will be undertaken in 2017.

Working with the Macmillan GP Facilitators across both CCG's, there is an aim to link the care plan to primary care IT and explore the benefits for this. This will be a large piece of work which will take time to mature and embed over the 2017/18 period.

## 4. Education Programme

The plan for 2017 is to revise the education programme, in order to ensure education is accessible and has impact new; more innovative ways need to be explored and introduced in order to ensure all wards across the organisation can access training.

A full education programme is available in the education strategy (appendix D). Key aims are:

- all wards have EOLC champions
- all medial teams have EOLC champions
- community setting provides education including access for wider stakeholders
- bereavement care for ancillary staff
- communication skills training will be a key piece of work in 2017, building on the current trainers' expertise and expanding the number of trainers. The goal is to run additional advanced communications skills within the hospital, as well as working in partnership with our local hospices.

The proposed reduction in Health Education England funding for the level 6 and 7 courses designed for specialist staff (Tier 3) will create an additional challenge. As the funding has been altered, the availability of courses is reduced and potentially this will have an impact on the specialist workforce. The details of the changes to funding remain uncertain and we are working closely with higher education provider to best use the limited funding available.

## 5. Patient outcomes measures

Currently the specialist palliative care teams do not routinely identify patient related outcomes. The national specialist palliative care commissioning document (2016) recommended measurement of patient outcomes for all of specialist palliative care.

The teams are currently looking at how this can occur, and then the challenge will be to record this electronically to begin to measure and demonstrate impact of care. This work will be undertaken across all sites.

## 6. Research

Professor Miriam Johnson, who works in the Trust, is leading on international palliative care studies. Opportunities for the Trust to participate in some of this research will be challenging without a specific research nurse. A number of clinicians have expressed an interest in becoming principle investigators; however, in order to participate fully, additional resources will be required.

Both acute sites will participate in a study with University of Southampton examining how we communicate with relatives during End of Life Care. This study will be completed 2017.

Participation in research is important to continue improving the quality of EOLC; however, due to limited research staffing resource on the York site, research activity is limited. Addressing this in 2017 will be considered along with other priorities of the team.

## Conclusion

There have been a number of ‘end of life care’ improvements across the Trust since 2014. The CQC reported ‘good’, with areas of outstanding, across the key lines of enquiry and now there is opportunity to build on this and aim for an outstanding service.

The teams have worked hard and have been positive in embracing changes and challenges this year. The desire to work cohesively and find new ways of improving should be commended.

## Recommendations

1. To embed the care plan for the last days of life into each clinical setting
2. To ensure access for all patients with identified health inequalities is available in the Trust
3. To continue with the IT development and aim for interoperability between services
4. To work with the STP ensuring clear direction and delivery of end of life care
5. To increase activity in end of life care research
6. Mortuary business cases to be developed and presented
7. To scope advance care planning within the Trust

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**APPENDIX A**
**National Care of the Dying Audit Results – York**

| Description | National % of Trusts that achieved KPI | Achieved Yes/No York 2014 | 2017 Self assessment | Current position March 2017 |
|---|---|---|---|---|
| Access to information relating to death and dying | 41% | No | YES | The DWP Bereavement Booklet referenced in the NCDAH is now displayed in the York Bereavement Suite using the CQC driven service headings of "Safe, Caring, Effective, Responsive, and Well Lead" have identified key areas to address. Action plans are being developed. The palliative care teams and end of life care facilitators will be actively involved in the dissemination of this information to all clinical staff caring for patients at the end of life using ward visits and formal/informal education programmes |
| Access to specialist support for care in the last days of life | 21% | No | YES | National recommendations are that patients should have access to Nurse Specialist Palliative Care face to face assessments 7 days a week 9-5 and 24/7 telephone support advice is provided by the palliative care consultants across the region.<br>The acute services continue to provide a 7 day service. The community is currently suspended due to staffing issues. There is a plan to recommence this through the additional staffing resource. |
| Care of the dying: continuing education, training and audit | 40% | No | YES | We now have End of Life Care Educators in post in the community and both acute sites. Monthly full day education sessions on End of Life Care.<br>Specialist Palliative Care Team provides the mandatory training for End of Life Care for all disciplines apart from the medics.<br>Kath Sartain and Anne Garry are reviewing the medical staffing training along with the Yorkshire and Humber regional group for End of Life Care<br>Karen Cowley and Kath Sartain have successfully addressed permanent funding for the temporary post with initial finance from Macmillan Cancer Support |
| Trust Board representation and planning for care of the dying | 28% | No | YES | Chief Nurse, Bev Geary, is the executive lead for end of life care. Prof Dianne Willcocks is NED lead on Trust Board attending End of Life Care Leads meetings. An annual report from these meetings submitted to Q+S committee and to Trust Board through the chief nurse board report. |
| Clinical Protocols for the prescription of medications at the end of life | 98% | Yes | YES | Protocols continue to be available on ward or as part of individual Last Days of Life care plan |
| Clinical provision/protocols promoting privacy, dignity and respect up to and including after | 34% | No | YES | The Trust provides this through the last days of life care plan |

| | | | | |
|---|---|---|---|---|
| death of patient | | | | |
| Formal feedback processes regarding bereaved relatives views of care delivery | 34% | No | YES | The bereavement team have sought feedback from relatives between August-October 2016. The report is attached in the appendices |

**Appendix B**

## END OF LIFE STRATEGY
## YORK TEACHING HOSPITAL NHSFT 2015-2019

Microsoft Word 97 - 2003 Document

**Appendix C**

## BEREAVEMENT SERVICES FEEDBACK AUDIT 2016

Microsoft Word 97 - 2003 Document

**Appendix D**

## YORK/SCARBOROUGH HOSPITAL EDUCATION SUMMARY
## APRIL 2016 – MARCH 2017

Microsoft Word 97 - 2003 Document

Training undertaken for the End of Life Ca

educational strategy 25_1_2017 v3.pdf

**Appendix E**

## PILOT STUDY FOR PROVIDING A 7 DAY SPECIALIST PALLIATIVE CARE SERVICE

Adobe Acrobat Document

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Environment and Estates Committee Minutes

## Recommendation

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

## Current approval route of report

This report is drafted for presentation to the Board of Directors.

## Purpose of report

The purpose of the Committee is to receive assurance and to provide challenge and scrutiny around environment and estates matters within the Director of Estates & Facilities areas of responsibility.

## Key points for discussion

The Board of Directors is asked to approve the following items:

i) Trust H&S Annual Report for 2016/17; and
ii) ii) EEC Committee Annual Report.

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

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

There are no references to CQC outcomes.

Version number: 1

Author: Michael Sweet, Non-executive Director

Executive sponsor: Brian Golding, Director of Estates and Facilities

Date: September 2017

York Teaching Hospital
NHS Foundation Trust

# Environment & Estates Committee Minutes – 16 August 2017

**Attendance:** Michael Sweet (MS) (Chair), Jennie Adams (JA), Andrew Bennett (AB), David Biggins (DB), Lynda Provins (LP), Jane Money (JM), Janet Mason (JMa), Steve Reed (SR) (part meeting), Jacqueline Carter (JC)

1. **Apologies for Absence:** Brian Golding, Director of Estates & Facilities and Colin Weatherill, Head of Health, Safety & Security.

2. **Welcome / Introductions**: MS welcomed Janet Mason, Head of Security & Car Parking, to the meeting who was attending on behalf of Colin Weatherill.

## 3. Minutes of the meeting held on the 7 June 2017

The minutes of the last meeting held on 7th June 2017 were agreed as a correct record.

## 4. Matters arising from the minutes

**Charitable Rate Exemption –** AB confirmed the Trust has signed up to a landmark legal case with at least 20 other Trusts being invited to join to achieve charitable rate exemption. Legal papers will be issued to each Trust's principal billing authority this month and subject to the response proceedings are tentatively scheduled for September. There is a further piece of work that BG has asked AB to pick up with GVA our ratings advisers and the solicitors regarding the impact on our relationship with the Local Authority if the test case is successful and Trusts are proved to be exempt. JA asked what the cost implications are to the Trust. AB assured the EEC that the bulk of costs are being met by GVA and is deemed a low financial risk to the Trust at this stage.
**Action: AB.**

**H&S training –** the new training post has been matched to an AFC salary band and will be tabled through Vacancy Control in September. Due to Trust wide financial constraints the post will however, automatically be frozen. Item to remain on the minutes.
**Action: CW.**

**Legislation –** CW met with the Trust Chair on 18th July when they discussed various topics in regards to health and safety in the Trust and the various statutory requirements including Board information and training. The chair noted the complexity of the current reports coming to the Board regarding risk and safety and currently was happy for the Board to receive health and safety updates on legislation as they arose via the Environment and Estates Committee. The Chair was aware of the Trust's Health and

Safety Strategy and acknowledged that via its implementation the type and scope of health and safety training for the Board will be identified.

**Estates Condition Survey** (DRR EF01) – AB has received fee proposals for 2 radically different approaches regarding the undertaking of the survey. This was noted.
**Action: AB to discuss further with BG.**

**Heat Wave Policy** – *action carried forward from previous meeting and this item remains in matters arising for action* - MS confirmed the BoD had noted that the EEC had approved the Heat wave Policy at its last meeting.

At the last meeting BG referred to a recent BoD Leadership Walk round at York Hospital (YH) where it was noted that some areas did not have the appropriate equipment available to allow staff to routinely measure temperatures in the ward areas so as to be able to assess when to implement the Heat wave Policy locally. This Policy is a different approach as to how it was managed previously in terms of equipment and communication and it is now the responsibility of the individual ward areas to implement. The Policy is very much about preparedness but will also trigger a response as to when to take further measures but acknowledged that further work was required to ensure the process was understood. This was noted.
**Action: BG/CW to discuss further.**

**Datix Reporting** – LP confirmed she had met with Fiona Jamieson since the last meeting. She said there have been a number of articles posted in Staff Matters detailing what happens behind the scenes around the reporting process and that an "action from learning" strategy will be developed to aid understanding of claims and complaints. In the main this topic will be reported back through the Q&S Committee.
**Action: LP to keep EEC informed of progress.**

**Space Audit** – since the last meeting the space audit work has been completed in York and over 90% completed in Scarborough. Two items to note: i) the gross internal floor area at Scarborough has increased whilst York's has decreased and ii) internal validation of the change in the York data has indicated that previously the hospital's gross internal floor area included data for Groves Chapel, Bootham Park Court and Park House. So, through Tony Burns' (Space Manager) work and other discussions we now have a lot more clarity about how the floor area data is built up. There is still work to be done to drive down the amount of non-clinical space across the estate, which is currently at 38%. JA asked whether this information is included in any Estates Return Information Collection (ERIC) return; AB confirmed it is included and it also feeds the Carter dashboard information. This was noted. AB will set out the report for the October EEC meeting.
**Action: AB.**

**SDG ToR –** JM to discuss with BG.

The Action Log was considered by the EEC and will be updated in line with the meeting discussion.

Following discussion at the last meeting JM presented the draft Trust Travel Plan to the EEC for comment. A very constructive discussion then took place.

The idea of presenting the Travel Plan to the EEC was to invite feedback on its content and direction of planning. It should however, be noted that it is a draft document and a live planning tool and, therefore, it will be updated regularly. The Plan aims to address issues such as the growing numbers of cars coming to the Trust's sites which increased Co2, air pollution and congestion. JM had summarised the plan's objectives in the covering sheet for ease of reference for the EEC. Pages 28-31 also identified some targets and initiatives.

One matter that JM felt was missing from the Plan was a target for reducing pollution caused by Trust travel.

MS thanked JM for introducing the document and opened the meeting to comments.
The EEC felt that there was a lot of information in the Travel Plan but expressed concern that the data seemed skewed in favour of non-clinical staff who work normal "office" hours. Also the action plan seemed to focus on issues around how we stop people doing things rather than putting it in a sustainable travel planning context which should offer a more positive approach to solutions.
JA felt the document was not ambitious enough and was concerned that it did not understand or reflect clinical care pathways. The plan of what, when, how and why seemed to be lost and the EEC felt that there was a lack of focus on what a sustainable health service needed to consider - the implementation of new models of care by developing care in the community, telemedicine, and where travel was necessary this should be through using low Co2 and low emission vehicles.
The EEC felt a clear position statement was required as to where we are now and where we want to be, while at the same time ensuring that we comply with the relevant Health Technical Memorandum (HTM) 07-03 car parking management : environment & sustainability. This would then be followed by a set of actions that led to the achievement of this position.

It was noted that this version of the Travel Plan was too heavily focussed on the main York site whereas it should be focussing on all key sites Trust wide and the priorities should include the experience of the lift share scheme and patient transfer at Malton/SGH.

The EEC asked for some further analysis work to be undertaken prior to speaking to the management consultants who had produced the Travel Plan for the Trust, and this should include: information on compliance with HTM 07-03, an input from JMa on car parking and JM on sustainability, together with an input from clinical staff as the EEC felt the Plan missed the focus on NHS key issues, e.g. how we might help staff who are not working 9-5 as there appeared to be too much of a focus on those working 9-5.

It was noted that the Travel & Transport Group were due to meet in August where this can be discussed further. JA asked that a senior nurse and consultant are involved in any decision making reporting through to the T&T Group. MS asked that a Steering Group be formed comprising JM (lead), Dan Braidley, Zara Ridge and JMa to take this work forward.
**Action: JM.**

The EEC supported the idea of a Healthy Travel Plan but did not endorse the document in its present form. The EEC asked for the Travel Plan to be reviewed and developed before it is brought back to the Committee for approval.
**Action: JM.**

## 5. Work Programme

The Work Programme was considered by the EEC and will be updated in line with the meeting discussion.

## 6. Board Assurance Framework

LP presented the Board Assurance Framework document (BAF) to the EEC which is a standing item on the Committee's agenda.

It was agreed at the last meeting that where we are able to, measures are put in place against the BAF ambitions to allow for a more consistent and evidence based approach when assessing whether any items require a revision of their RAG rating and escalation to the BoD. The Board Assurance Framework (BAF) is comprised of 4 key ambitions of the Trust that each sub-committee of the BoD assess themselves against.

LP confirmed that since the last meeting she had met with DB and CW to specifically discuss the privacy & dignity section (the 2nd E&F ambition on the BAF schedule) although she had done a very brief overview of each area. For privacy & dignity evidence gathering and emerging themes, the PLACE report is the main source with a score of 79.8% for York. She has considered the PALS Board report but it does not identify any emerging themes.

JA asked whether the national in-patient survey could also be used as a source of information and indeed a scoring mechanism. The latest report was published in July for 2016 and asks a number of privacy & dignity questions and scores you in relation to the whole of NHS England and provides benchmark material. This was noted and will be considered as an additional source.

Subject to looking at this survey LP recommended to the EEC that the score remains green in light of PLACE assessments. This was agreed. DB suggested that it would be beneficial to take into account all sites not just York scores. This was noted.
**Action: LP.**

LP assured the EEC she will commence work on the other 3 BAF items with a view to rolling that out following the October meeting.

The Committee noted and approved the recommendation in the report.

## 7. Directorate Risk Register

The EEC reviewed the red and amber risks on the Directorate Risk Register in line with agreed arrangements.

The following items were noted:

EF01 - Estates YH/SGH - Capital - Condition Survey – there was general consensus that this item is re-scored to 25 and be reviewed at the next meeting. Also, see matters arising.

**Action: CW.**

EF02 – Estates YH/SGH - SGH Fire Alarm – awaiting BoD BC approval in August. York is approved. The Trust is committed to delivering both of these projects that are aimed at eliminating high-risk items.

EF17 – Estates all sites – Fire Safety – item to be reviewed through Fire Safety Group.

EF04 – PAM compliance – work is on-going to increase evidence to support compliance which should result in this rating being reduced.

EF09 – Estates SGH – inadequate ventilation ICU – commission a new ICU in SGH. DB is concerned that this item is being managed by the Ventilation Steering Group (VSG) who have not met for 6 months. This was noted.

EF10 – Estates York – air handling units required to be updated. The VSG will be asked to consider this risk and report back.

At this point DB made reference to the Site Facilities Operational Group that has been set up in York and is in the process of being set up for Scarborough. These will provide an assurance route for items such as EF9 and EF10 above and will provide for more of the risks within the directorate to emerge as a means of broadening the cover of the RR.

EF44 – Estates York – RRO plant at renal unit – the project is being developed to replace the RRO plant but it was noted there is a larger piece of work to be undertaken as well around the Renal unit itself. This was noted.

MS noted these updates and drew attention to EF01 rating and EF09 and 10 which required to be considered by the Ventilation Steering Group (VSG). With regard to the appended action log, whilst it has been reduced in length and content, it was unclear what benefit it provided to the EEC and the RR.
**Action: CW - Log to be discussed at the next meeting.**

## 8. E&F Policy & Procedure programme

The Policy & Procedure schedule was considered by the EEC.
The following items were noted:

Portering procedure – approved by the Premises Assurance Group (PAG).

Asbestos Management – DB assured the EEC there is an existing policy in place however, he acknowledged it required updating prior to the CQC visit.
**Action: CW.**

LOLER and Lifts – alludes to the fact that there is no designated Steering Group that these would feed into however, A.Betts has provided assurance that his team is working on both procedures.
Cleaning policy – to be presented at the next EEC.
**Action: DB.**

It was asked that for the next meeting a colour table be added to the end of the schedule to allow members to see "at a glance" what was in date or outstanding.
**Action: DB**

It was asked that a Capital Projects Policy be added to the schedule list.
**Action: AB/DB.**

The Committee noted the schedule which will be updated in line with the meeting discussion.

## 9. Committee Annual Report

The EEC received the Committee Annual Report for noting and endorsement.

MS asked that the report highlights that meetings are held Trust wide which allows for local governors to be invited to attend. He also asked for PLACE to be added to the 2017/18 Work Programme and for the committees below the PAG, SDG and H&S Non-Clinical Risk Group to be added to the Governance Structure.

Although it was considered that the documentation was light on content as it did cover the key points the Committee approved the Report and asked for it to be tabled at the BoD in September. However, it will be expected that the 2017/18 report will be more expansive and detailed.

## 10. Internal Audit Reports

None.

## 11. Property and Capital: Estates Strategy

See item 14.

## 12. Health, Safety & Security: Quarterly Report (Q1)

The EEC received the quarterly report for the period quarter 1 ending June '17. The report was noted by the EEC.

## 13. Health, Safety & Security: H&S Annual Report (incorporating the Annual Fire Report/Statement and H&S/NCRG Committee Annual Report.

The EEC received the H&S Trust wide annual report for noting and comment.
MS highlighted there had been a significant drop in RIDDOR reporting but incidents of violence and aggression had increased.

The EEC received the H&S/NCRG Committee Annual Report for approval. MS highlighted his concern at the low attendance record which needed to be improved. The Committee approved the Committee Annual Report.

The Committee endorsed the Trust Health & Safety Annual Report which will be forwarded to the BoD for approval in September.

## 14. Health, Safety & Security: Briefing Paper on NHS Protect position

Following discussion at the last meeting JM briefed the EEC on how the Trust was addressing any gaps in reporting processes following the disbandment of NHS Protect and the need for any national reporting. The following was highlighted to the Committee:

To partly address this a new "Health Authority" has been created to pick up NHS Counter Fraud.

Requirement remains for the Trust to have access to the Local Security Management Specialist (LSMS) functions and complies with this requirement through having an LSMS nominated person.

The Trust's security function will still collect and review local V&A data for validation.

The Trust's Head of Security and the nominated LSMS committed at the end of 2016 to lead, together with the support of the LSMSs from other Trusts in the region, the development of an NHS security managers meeting for the Yorkshire and Humber region. This has been well attended with agreement to further development of the information sharing processes in order to mitigate the risk posed by the ending of NHS Protect central alert system.

MS thanked JMa for this update. The EEC noted the recommendation in the report, welcomed the creation of the Yorkshire & Humber group and looked forward to receiving regular updates through the H&S Quarterly reports.

## 15. Health, Safety & Security: Any new legislation, CWC, HSE reporting information.

No update.

## 16. Health, Safety & Security: Fire Protection briefing

JM provided a Trust position statement post the Grenfell tower fire regarding cladding on Trust buildings. She reported that CW had been asked to provide a list of the Trust's clad buildings along with the results of the required cladding test to NHSI who have since informed us the Trust is classed as low risk.

It was noted that CW had queried the methodology of the current tests to try and understand why the Government was reporting 100% failure rate of cladding already tested since Grenfell. The new method of testing is a very different to the test that used to be undertaken which was more relevant to fire spread. This was noted.

## 17. Premises Assurance Model (PAM): Quarterly report

DB presented the PAM quarterly report to the Committee which highlighted the overall compliance position against PAM at Appendix 1. Highlights from the report are as follows:

- Lack of assurance around design and layout of premises.

- Significant improvements against the patient experience and safety domains at Bridlington.
- Working with multi-disciplinary teams to introduce a signage strategy focussing on access and disability requirements.
- SGH Site Facilities Operational Group to be set up as soon as possible.
- PLACE assessments – assessor profile to be reviewed.
- The NHS PAM monthly dashboard is widely disseminated and reviewed amongst E&F teams and they are given protected time to undertake the assessments.

JA was pleased to note the access and signage strategy being developed.
MS asked whether deadline dates could be added to the tracker as a means to eliminating the red ratings in a timely manner. This was noted.
**Action: DB to consider.**

The Committee noted the recommendations in the report and took considerable assurance to the work that has already been done.

### 18. Carter Report – E&F efficiencies: Quarterly report

Item deferred.

### 19. Sustainable Development: SDMP + Action Plan

This item was deferred except for discussion on the Trust's SDMP Mission Statement. JM explained the revised NHS SDU templates ask for a mission statement and she had provided a form of words which perhaps could be adopted as the Trust's statement. Following discussion it was agreed that the draft statement would be circulated to EEC members seeking comment with an agreed deadline so as to assist JM in providing a final draft.
**Action: JM.**

### 20. Sustainable Development: SDG 11th May minutes

Item deferred.

At this point in the meeting JM made reference to Internal Audit reports and asked whether if there is any reference or link to sustainable development that colleagues flag it up to her or to this meeting. JA commented whether JM was able to influence the setting of future audit programmes. **Action: JM to discussion further with BG around mapping of future audits.**

### 21. Out of Hospital Care: York Care Collaborative work / Estates Strategy

**York Care Collaborative**
SR updated the group on the York Care Collaborative work underway which is centred around a group of independent practitioners who have agreed to work together as an aim to achieving efficiencies and/or creating better joint working in some areas.
Of the 3 GP Federations in York the Trust is currently working with CAVA (City & Vale Alliance) who have expressed an interest in working more closely with the Trust and in a more formal way. Formal collaboration has been achieved through a Memorandum of

Understanding signed by the Trust and CAVA. Both organisations have agreed to explore areas of joint working such as a clinical project to review the design pathway for end of life care within the community; an organisational project for sharing and supporting finance resources; and access to Statutory & Mandatory training. There is also an Estates project being developed for Easingwold (see below) that will involve the York Care Collaborative. At the moment the Trust's Out Of Hospital team operates out of 44 different sites and provides over 300 different services. Some of these might be suitable for consideration as part of the wider Estates Strategy.

MS thanked SR for this update.

**Bootham Park Court / Easingwold developments**
Linked to the above, AB updated the Committee on the Bootham Park Court Development Project, which is examining the potential for creating a well-being village/health campus on land adjacent to York Hospital. AB explained that his facility could offer a solution to current challenges that are faced by the Trust and its GP Collaborative partners.

There will be opportunity for this project to be broadened out to include organisations such as CYC and TEWV along with the voluntary sector. For example, challenges that are currently being experienced by local health and social care organisations are the delayed discharge of in-patients, length of stay, access to primary care services and avoidable A&E attendances and the proposed development will possibly offer, or facilitate, solutions to these problems.

MS asked whether this project impacts on any Carter recommendations for space utilisation, reducing Trust footprints and the pressure on Trusts to release surplus land for affordable housing. AB assured the Committee that whilst there was pressure on the Trust to release surplus land, this development zone was too critical to the Trust's Estate Strategy to be disposed of without very careful consideration because it offered an extremely important opportunity to create a facility that could benefit the Trust's services and the wider health system and also be a source for income generation.

In terms of timetable it was hoped, that subject to approval, it would be possible to have an outline Business Case and detailed design available during 2018. If the development did go ahead it was noted there is some scope for private finance to provide funds rather than the NHS.

With regard to the Easingwold project the work to date has focussed on the properties that are located in Easingwold, the opportunities to re-develop them to support current and future clinical services in this locality, and the options for releasing parts of the estate. A piece of work has been undertaken which identifies a preferred development site in Easingwold to develop into a health campus and bring the current fragmented services together and part fund it from property disposal. AB assured the EEC that although we need to be realistic about what we can achieve the utilisation of this site development zone for the benefit of the Trust and the wider health community is considered to be the right direction in which to proceed. Furthermore, a minimum amount of capital will be invested, initially, to prepare the outline business case for investment and AB confirmed that there would be opportunities to draw upon external finances for this project.

MS thanked AB for this update. The Committee noted the potential around future developments at Bootham Park Court and Easingwold in conjunction with the York Care Collaborative.

## 22. Any Other Business

**PLACE Report**

DB confirmed to the EEC that the PLACE results had been received for 2016/17. He highlighted to the Committee that there had been reduced scores received for ward food on the main sites, and he would be looking to expand work on access and disability aspects of the Trust's facilities. The PLACE results would be seen by the BoD at its meeting in September and the EEC in October. **Action: DB.**

**Items for progression to BoD:**

- PLACE Results.
- Board Assurance Framework work.
- H&S Annual Report.
- Fire Protection – Post Grenfell update.
- EEC Annual Report.
- NHS Protect update
- Site developments – Bootham Park and Easingwold

## 23. Time and Date of the next meeting

**Next meeting of the Environment and Estates Committee: 4th October 2017 @ 10.30am. Venue – Scarborough Hospital**

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Environment and Estates Committee Annual Report 2016/17

## Recommendation

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

## Current approval route of report

This report is drafted for presentation to the Board of Directors.

## Purpose of report

The Environment & Estates Committee is a sub-committee of the Board of Directors. The EEC ensures the BoD receives assurance about the Trust's ownership, operation and maintenance of the built environment and associated services. The EEC has delegated authority to seek assurance around the suitability and safety of the Trust's assets and services provided by the Estates & Facilities Directorate.

## Key points for discussion

The Board of Directors (BoD) is asked to receive the Environment & Estates Committee Annual Report for 2016/17 for noting and approval in line with governance arrangements.

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

CQC outcome regulation 15: premises and equipment.

Version number: 1

Author: Michael Sweet, Non-executive Director

Executive sponsor: Brian Golding, Director of Estates and Facilities

Date: September 2017

York Teaching Hospital NHS
NHS Foundation Trust

# Annual Report of the Environment & Estates Committee 2016/17

## Introduction

The Environment & Estates Committee is a sub-committee of the Board of Directors. The EEC ensures the BoD receives assurance about the Trust's ownership, operation and maintenance of the built environment and associated services. The EEC has delegated authority to seek assurance around the suitability and safety of the Trust's assets and services provided by the Estates & Facilities Directorate.

The Group receives highlight reports from other committees:
H&S (Health & Safety) /NCRG (Non Clinical Risk Group),
Sustainable Development Group,
Premises Assurance Group,
in line with the governance structure, copy attached. **(Appendix 1).**

## Overview of the year 2016/17

The Committee is continuing to function well and is well attended.

A table of attendance is attached. (**Appendix 2**).

## Work of the group

During this reporting period, the Group approved, endorsed or noted the following policies, plans and reports:

- H&S Annual Report (including Fire Safety)
- Sustainable Development Management Plan (SDMP)
- Security Policy
- H&S Policy
- Fire Policy
- Premises Assurance Model (PAM) Annual Report

and routinely received information on:

- RIDDOR reportable incidents, new claims and settled claims, incidents, complaints and PALS information
- Estates Strategy
- Space utilisation (Lord Carter review)
- Risk Register Assurance (introducing a routine review of red/amber risks and all risks)
- Internal Audit Reports
- New Legislation

- Progress on the SDMP

Following a review of Trust wide governance the Terms of Reference and reporting arrangements have been amended resulting in a streamlined membership.

**Update on audit work**

During the reporting period the Committee were assured that the following audits received a "high or significant assurance" rating:

- Y1721 - Carbon Reduction Commitment (CRC) Scheme Nov '16 – (high)
- Y1703 - Decontamination,
- Y1740 - Estates Strategy,
- Y1725 - Infrastructure repairs and maintenance,
- Y1741 - Non-Medical Equipment focussing on Portable Appliance Testing

The Committee also discussed the action plans arising from those reports that received a "limited assurance" rating:

- Y1713 - Compliance with statutory regulations through use of PAM,
- Y1663 Doctors Accommodation May '16,
- IA Y1638 – Occupational Health Performance Indicators – Data Quality- *(referred to Workforce Committee),*
- IA Y1621 – H&S Report

**New legislation**

Due to BREXIT the current approach is to look at adoption of EU statute into UK legislation and as such there has been no significant changes which require attention of the Committee. Going forward the Committee will be notified of any relevant environmental legislation and Statutory Instruments.

**2017/18 Work Programme**

Work for the forthcoming year will include:

Monitoring progress towards the Carter targets
Continuing to review risks and BAF
Monitoring improvements in PAM compliance
Building a comprehensive Estates and Facilities Risk Register
Promote sustainable development throughout the Trust
PLACE Results

**Meetings**

During 2016/17 the Committee met on the following dates:

8th June
15th September
6th December
7th February 2017

Meetings are now held bi-monthly in 2017/18 and are planned for:

11th April
7th June
16th August
4th October
6th December
February 2018

**Conclusion**

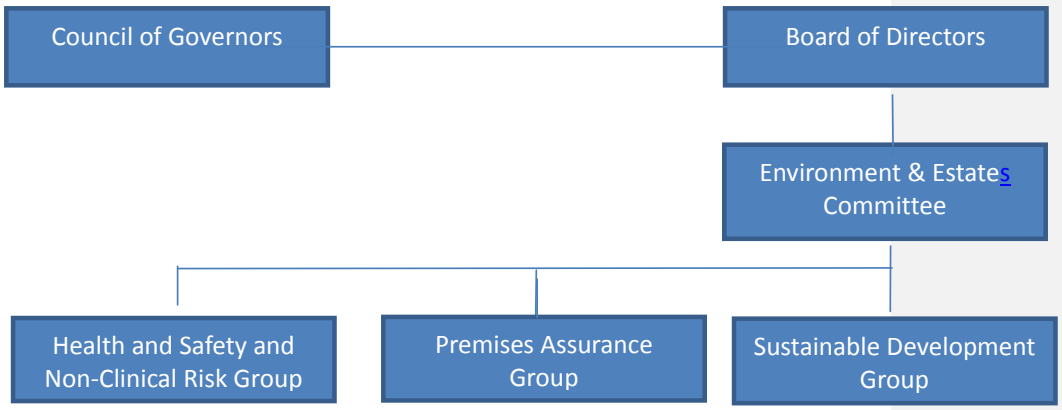
Over the last 12 months the Committee has developed an understanding of the key issues and risks across the breadth of services that support the Trust's property and infrastructure.

Brian Golding,
Director of Estates & Facilities
Michael Sweet
Chair – Environment & Estates Committee

**Appendix 1**

# Governance Structure

## Environment and Estates Committee



**Appendix 2**

**Environment & Estates Committee**

**Attendance record from April '16 to March '17 by current members**

| | 8.6.16 | 15.9.16 | 6.12.16 | 7.2.17 | Total (4) |
|---|---|---|---|---|---|
| Mike Sweet, Chair (NED) | √ | √ | √ | √ | 4 |
| Jennie Adams (NED) | √ | √ | √ | √ | 4 |
| Brian Golding, Director of E&F | √ | √ | √ | √ | 4 |
| Lynda Provins, Trust Secretary | √ | √ | X | √ | 3 |
| Colin Weatherill, Head of Health, Safety & Security | √ | √ | √ | √ | 4 |
| David Biggins, Head of Medical Engineering | √ | √ | √ | √ | 4 |
| Jane Money, Head of Sustainability | √ | √ | √ | √ | 4 |
| Andrew Bennett, Head of Capital Projects *(became full member April'17)* | √ | n/a | n/a | n/a | 1 |
| Jacqueline Carter – minutes | √ | √ | √ | √ | 4 |
| | | | | | |
| ~~*Janet Mason, Security Manager *(no longer attends EEC)*~~ | ~~√~~ | ~~n/a~~ | ~~n/a~~ | ~~n/a~~ | ~~1~~ |
| ~~*Carol Birch, Head of E&F Community *(no longer attends EEC)*~~ | ~~√~~ | ~~√~~ | ~~√~~ | ~~n/a~~ | ~~3~~ |
| ~~*Paul Bishop, Head of E&F York *(no longer attends EEC)*~~ | ~~√~~ | ~~n/a~~ | ~~n/a~~ | ~~n/a~~ | ~~1~~ |
| ~~*Andy Betts, Head of E&F, SGH *(no longer attends EEC)*~~ | ~~X~~ | ~~n/a~~ | ~~n/a~~ | ~~n/a~~ | ~~0~~ |
| ~~*Fiona Jamieson, Head of Healthcare Governance *(no longer attends EEC)*~~ | ~~X~~ | ~~n/a~~ | ~~n/a~~ | ~~n/a~~ | ~~0~~ |

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*no longer attends EEC following review of Terms of Reference (ToR).

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Health and Safety Annual Report 2016/17

## Recommendation

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

## Current approval route of report

Health Safety Non-Clinical Risk Group
Environment & Estates Committee
Summary Board of Director for information

## Purpose of report

It is a requirement for the Trust's Board of Directors (BoD) to have in place formal procedures for auditing and reporting on health and safety performance. This annual Health and Safety (H&S) report covers the Trust's H&S activities from 1 April 2016 to 31 March 2017; providing assurance on the H&S performance and management of risks. The Report was seen and noted by the Environment & Estates Committee in August 2017.

## Key points for discussion

There are no key points for discussion.

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended):

- Regulation 12 - Safe Care & treatment;
- Regulation 13 - Safeguarding service users from abuse and improper treatment;
- Regulation 15 – Premises & equipment;
- Regulation 17 – Good governance.

Version number: 1

Author: Colin Weatherill, Head of Health, Safety and Security

Executive sponsor: Brian Golding, Director of Estates and Facilities

Date: September 2017

York Teaching Hospital NHS
NHS Foundation Trust

# Health Safety & Security in York Hospital NHS Foundation Trust

**(Encompassing Fire Safety, Security Management and Non-Clinical Risk Management)**

# Annual Report 2016/17

## Foreword

At York Teaching Hospital NHS Foundation Trust (Trust) we recognise promoting a positive safety culture is vital in protecting the health safety and welfare of our employees, those who use our services and in protecting our environment.

The Trust is committed to promoting an environment which actively supports a safety culture and awareness by recognising health safety and environmental management of risk as being key in the way the Trust operates and critical to the Trust's success.

In achieving this, the Trust has a developed risk strategy, based on risk profiling and assessment of risk to prevent any incidents before they occur, to ensure any residual risk is mitigated to as low as is reasonably practicable and is actively managed.

The report has been produced with the Health & Safety Executive (HSE) guidance managing for health & safety (HSG65) in mind; our aim is to continually improve on what we already have in place, by making the management of safety an integral part of good management and not a stand-alone system.

In the coming year the Trust will continue to take a proportionate and pragmatic approach to management of health safety and non-clinical risk across the organisation, by focusing on what really matters in delivering a safe environment and service for all.

I would like to thank all the various teams involved in the management of risk across the organisation for their efforts in ensuring we have in place robust and effective safety management systems, structures and processes in achieving this aim.

Brian Golding — *Director Health Safety & Non-clinical Risk*

Patrick Crowley — *Chief Executive Officer*

## 1. Executive Summary

It is a requirement the Trust's Board of Directors (BoD)[1] to have in place formal procedures for auditing and reporting on health and safety performance. This annual Health and Safety (H&S) report covers the Trust's H&S activities from 1 April 2016 to 31 March 2017; providing assurance on the H&S performance and management of risks.

The Trust continued to meet the requirements of health and safety legislation throughout the year and will continue to progress its management of health safety and environment across the Trust with a continued focus on:

- prevention of injury to patients, staff and visitors;
- maximising the morale, reducing absence levels, improving staff retention and productivity;
- mitigation of reputational damage to the Trust by preventing enforcement action and any resulting criminal or civil action being taken against the Trust or its officers;
- avoiding the damaging effects of financial penalties through uninsured losses;
- providing assurance against NHS and Care Quality Commission standards;
- continued review of existing health and safety arrangements to ensure continued compliance with relevant health safety legislation and applicable safety standards;
- assessing, monitoring and providing assurance all premises are 'so far as is reasonably practicable' fit for purpose;
- review and assurance of the results and addressing issues identified by the self-assessment health and safety audit;
- identification of required health and safety training courses;
- monitoring of policy compliance and addressing any resulting issues related to health safety and the environment;
- effective and safe management of waste and environmental matters and concerns.

## 2. Environment and Estates Committee

Work has continued to embed a robust structure of reporting corporate health safety and non-clinical risk to the Board, building on the introduction of the Environment and Estates Committee with overall responsibility for overseeing the management of Health Safety and non-clinical risk.

This year the Committee has overseen:

- the introduction Estates and Facilities Premises Assurance Arrangements; defining the structure and compliance monitoring of the physical environment in the Trust, detailing a structure of individual responsibilities and sub committees and groups for management of specific H&S and Environmental key areas set against the NHS Premises Assurance Model (PAM'S) framework;
- Further development of quarterly reporting on H&S, Non-Clinical risk, claims, environmental/sustainability, non-clinical claims, SI's, Incident reports and complaints.

The committee has met on 3[2] occasions (June, September 16 and January 17) in the report period and has been successful in its remit.

[1] *INDG 417 – Leading Health and Safety at Work*
[2] *EEC 1/4ly meeting March 17 meeting took place in April 17*

Summary of key safety challenges in the year:

1. *Continued work on effectiveness of committees and groups in taking lead, responsibility and providing assurance on specific aspects of health and safety and their lines of reporting corporately;*
2. *Clarity in regards to the health and safety function and the links with other risk management functions development and approval of a Trust wide safety strategy;*
3. *Resource availability for continued development of health and safety support systems;*
4. *Clarity in regards to structures, lines of accountability and responsibility for operational / local health and safety management;*
5. *Continued concerns in regards to specific aspects of health and safety training delivery in the Trust.*

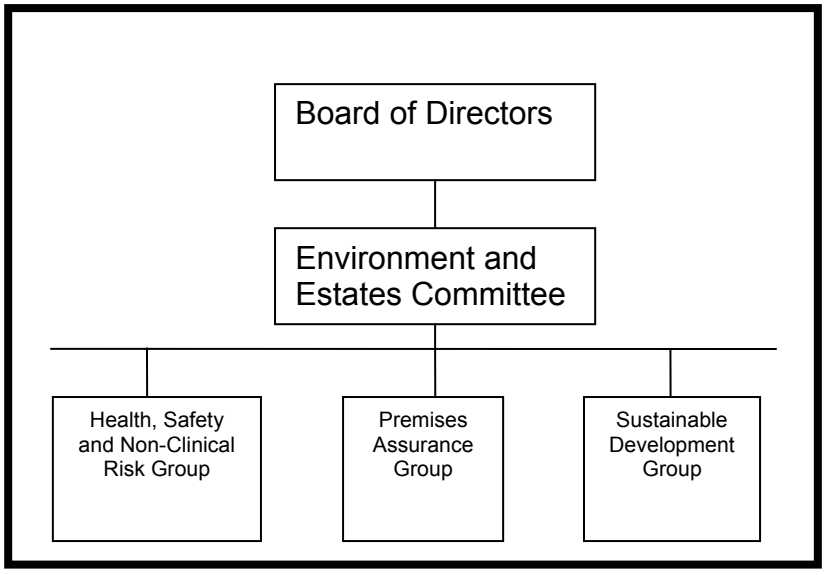
**3. Health Safety and Non-Clinical Risk Group (Committee Annual Report)**

The Health & Safety/Non-Clinical Risk Group (H&S/NCRG) brings together key Trust leads with responsibility for health & safety and non-clinical risk.

The group continued to function in line with the group's Terms of Reference; a summary of key topics discussed by the group in 2016/17 included, needle stick injuries, safety training, safety programmes & plans, non-clinical CAS alerts, non-clinical incidents, review of safety policy and procedures and any specific items brought to the group's attention by direct reports or via sub-committee or group.

As part of the Trust's governance arrangements the group received highlight reports from the Trust's health and safety committees and their sub committees and groups.

As part of on-going review of the Trust's governance arrangements, the Terms of Reference of the group and reporting arrangements were amended to include the Environment & Estates Committee as the groups' parent committee:




Meeting dates for 2016/17 were:

- 29th April '16
- 23rd August '16

- 14th October '16
- 10th February '17

**Meeting Attendance Record 2016-17:**

**H&S/NCRG Attendance record from April '16 to March '17 by current members**

| | 29.4.16 | 23.8.16 | 14.10.16 | 10.2.17 | Total (4) |
|---|---|---|---|---|---|
| Brian Golding, Chair | √ | √ | X | √ | 3 |
| Adam Bassett, Community | √ | √ | √ | √ | 4 |
| Staff Side rep | √ | √ | X | √ | 3 |
| Anne Devaney, Corporate Learning | X | √ | √ | X | 2 |
| Andrew Millman, OH | √ | X | X | X | 1 |
| Kingsley Needham, H&S | √ | √ | √ | √ | 4 |
| HR Manager | √ | √ | √ | X | 3 |
| C Weatherill H&S | √ | √ | √ | √ | 4 |
| Helen Hey, Nursing | X | √ | X | X | 1 |
| Fiona Jamieson, Healthcare Governance | X | √ | √ | X | 2 |
| DM rep | | | | | 0 |
| Jacqueline Carter - Minutes | √ | √ | √ | √ | 4 |

**4. Specific Topic Areas and Reporting Committees & Groups reporting to Environment and Estates Committee Assurance/Compliance Structure**

**Appendices 1,2** attached at the back of the Report identifies those groups that report into the H&S&NCRG and specific topic areas they cover to support the EEC assurance/compliance structure.

Meeting dates for 2017/18 have been agreed. A Work Programme will be developed and the following topics will be included for discussion for the forthcoming year:

- H&S Directorate Self Assessment Internal Audits commencing August '17,
- The development of a H&S training needs programme,
- Water Safety & Legionella Policy,
- Medical Devices Management Policy,
- Pest Control Policy,
- Waste Management.

**5. HS&E Interventions, Legislation and Guidance Monitoring**

In 2016/17 there were no interventions raised to the Trust from the UK Health and Safety Executive.

In July 2016 the Trust received a letter from the HSE in response to an identified defect following a thorough examination report of a passenger/goods lift at Scarborough Hospital. This was dealt with on the day the competent inspectors reported the defect with the action taken reported to the HSE to address their letter of concern.

Occupational Health and Safety (OH&S) legislation and guidance that will or is likely to impact the Trust are reported via the health safety & security department and Estates competent persons. Where an amended or new legislative requirement or guidance has been identified by the Trust the relevant legislation, guidance, audit & inspection reports are reviewed, retained, disseminated to the relevant operational area or across the Trust as required with summary of applicable changes reported to the Environment and Estates Committee.

In year examples of this review process:

- New sentencing guidelines applicable to health & safety, corporate manslaughter and food safety legislation;
- Internal Audit Y1745 health and Safety;
- Yearend review of Reported Incidents under the Reporting of Diseases and Dangerous Occurrence Regulations 2013;
- Update on the potential impact of the implementation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) (Part 3), (HSCR) and Care Quality Commission (Registration) Regulations 2009 (Part 4) (CQCR) its link to and impact on safety legislative framework;
- Health and Safety Self-assessment Audit 2015 results;
- Trust security reported physical assaults 2015/16;
- Estates and Facilities (Environment) Risk Register review.

## 6. Health and Safety Requirements

Health and Safety legislation requires the Trust has a system in place to proactively manage and control risks. In order to meet these legal requirements the Trust manages its risks based on the revised HSE's model 'Successful Health and Safety Management' (HSG65[3]). This is a continuous improvement model based on the approach of **Plan, Do, Check, Act**.

1. *The link and collaborative working with other risk and safety functions continues to be a challenge in forging closer working links, providing synergy and efficiency.*

Work in year continued in developing a health and safety strategy and key stakeholders and functions linked to the management of health safety and non-clinical risk to further address this.

2. *For the health and safety department to continue to support the Trust effectively a review of the resource availability within the Trust is advisable to allow for*

[3] *HSG65 (Third edition, published 2013)*

*improvements to be made to health and safety systems already in place and to develop additional systems to allow for efficiency at an operational level.*

As part of the development of a wider health and safety strategy, resource availability and requirement in the wider safety functions are being reviewed and from this resource requirements will be defined and as required put into place.

3. *The Trust structures for management of risk it is not always clear as part of the operational management structure and responsibilities for directorate management of risk and where this is reported through to the health safety and non-clinical risk function.*

On-going work with the various Trust functions is underway to define this structure and responsibilities.

**Plan**

During this reporting period, the H&S and Risk Committees and groups have approved or noted policies, procedures plans and reports. As part of this governance structure specialist groups and committees review, provide specialist advice and oversee policy and procedure development. Once approved at each specialist group policies and procedures are promulgated through the appropriate parent group or committee with final oversight by the Environment and Estates Committee acting on behalf of the Board.

In year the Trust has developed an overarching health and safety strategy, this strategy is to be aligned with existing corporate risk management strategy and was due to be presented in the Environment and Estates Committee March 2017[4].

**Do**

Work has continued in many aspects of safety management, with the Trust risk profiling to determine topics which present the greatest health and safety issues for the organisation. These identified risks are captured via the Trust risk assessment processes, recorded and quantified. Risks which are identified as medium or high have specific measures taken to address and effectively manage the risk. By adoption of this approach resource can be identified and prioritised action taken, with less priority given to low risk activities.

H&S and Non-Clinical risk topics have identified specialist leads and specialist committees/groups to ensure and monitor compliance. Where risks are identified as significant and the control measures in place mitigate the risk to an acceptable level, but further action is deemed required these risks are escalated to directorate and corporate risk registers for risk treatment or acceptance.

The Trust has focused and actively progressed the implementation of the NHS Premises Assurance Model (PAM) standards, to bring together compliance with quality, safety and efficiency standards, delivering a central point of monitoring and management, demonstrating assurance in these areas.

**Check**

[4] *Presented to EEC April 2017*

Proactive Monitoring - Health & Safety Self-Assessment Audit & EEC Quarterly Reporting

Each year in the Trust a health & safety self-assessment audit is undertaken, the audit is shared with operational directorates, directorates are required to complete the audit against prescribed criteria proving assurance of adherence to Trust policy and guidance. The scores from each directorate assessment are aggregated and a final Trust wide score is obtained.

The health and safety self-assessment audit tool is electronic. It is formed in two parts; a mandatory section made up of eight sub sections:

- Safety and Risk Management
- Incident reporting
- Fire Safety
- Slips, Trips and Fall Prevention
- Work related stress
- Infection Prevention (All areas and staff)
- Learning from experience
- Incident investigation

The second part is made up of fifteen risk specific standards:

- Infection Prevention
- Moving and handling people
- Lifting and moving of objects
- Human Tissue Act
- Control of Substances Hazardous to Health (COSHH)
- Violence and Aggression
- Clinical waste handling and disposal
- Display screen equipment
- Laser radiation and artificial optical radiation
- Ionising radiation
- Safety in patient areas
- Safe use and disposal of sharps
- Latex
- Medical equipment
- Resuscitation

Each sub section is awarded marks for a range of key questions asked; when totalled up, they are averaged to produce a mark across all criteria, with the overall percentage mark overtime, providing an indicator by which an area can see its safety performance / compliance develop and improve. Linked to the self-assessment tool are numerous sub departmental audits and inspections to provide assurance and inform the final result.

For the 2016/17 health & safety self-assessment audit was delayed to reduce the burden of audit and inspection work at an operational level at the end of the financial year, it is planned for this audit to be undertaken in the summer of 2017.

Health Safety and Non-Clinical risk performance has been reported on a quarterly basis to the Environment and Estates Committee.

Reactive Monitoring - Health and Safety Accident and Incident Reporting System (AIRS) Reports; 2016/17

The Trust has in place a comprehensive system to collect information from accident and incidents which occur in the Trust's (Datix reporting system).

As part of the Datix reporting system the Trust captures significant harm incident (Non-Clinical), the Trust has a duty to report these incident to the HSE under the Reporting of Diseases and Dangerous Occurrence Regulation 2013.

Summary RIDDOR Incidents for year 01 April 2016 – 31 March 2017

Total RIDDOR reports for the year was 18, this figure is the same as the Trust reported in 2015/16.

RIDDOR reports for the last 5 years[5] across the Trust giving a longer term comparison on performance, this shows for 2016 a 26.74 % reduction compared to the average for the years 2011 to 2016.

Review of RIDDOR reportable incidents has identified a rising trend in incidents involving violence and aggression (clinical related) with reportable accidents falling into categories of > 7 day absence, fractures and contact with; with causational factors including slips trips falls, violence and aggression, manual handling, exposure to and entrapment.

***(Appendix 3 –Full summary RIDDOR 16/17)***

**Act**

Health and Safety performance review; working with the Trust legal department routine review of Employee and Public Liability claims are undertaken to identify any significant trends / risks and to identify potential lessons to be learnt to prevent reoccurrence.

It is Trust policy for investigations to be carried out into incidents to identify root causes and put in place measures to either eliminate any potential risk or mitigate the risk so that it is effectively managed; the Trust also has in place a robust policy for the management of serious incidents.

The Trust has in place a Central Safety Alert System managed through the risk department this system collates any alerts which enter into the Trust from an external source or are raised internally. Once an alert has been entered onto the system a process is followed to ensure the alert is addressed and signed off; once this has been completed the alert is closed and advised as appropriate to the informing organisation.

In addition to this the Trust monitors complaints which may have a specific non-clinical safety element, these complaints are reviewed by the operational responsible department and via quarterly reports to the Environment and Estates Committee.

## 7. Health and Safety Executives key topics in health and social care

The HSE is the national independent regulator for health and safety in the workplace; this includes publicly and private owned health and social care settings, working in partnership with co-regulators in local authorities to inspect investigate and where necessary take enforcement action.

[5] *Calendar year*

The HSE leads on employee health and safety and will consider investigation of patient or service user deaths or serious injuries, where there is an indication of a breach of health and safety law was a probable cause or a significant contributory factor and meeting sector specific legislation to secure justice or necessary improvement in standards.

With the introduction of the CQC fundamental standards supporting memorandums of understanding and agreements between the CQC & HSE on the lines of regulatory responsibility in the healthcare, with the HSE focus being the regulator for employees, visitor, specific environmental & equipment harm and the CQC being regulator for clinical/ patient safety harm.

The HSE Health and Social Care Sector identified key topics:
Moving and Handling;
Sharps Injuries;
Slips Trips and Falls;
Workplace Violence;
Equipment Safety;
Dermatitis;
Legionella;
Falls from Windows;
Bedrails;
Scalding and Burns.

## 6. Staff Training

The Trust provides a range of in-house training that contains elements of health & safety. The move to the Learning Hub will allow the organisation to analyse the numbers of staff trained in more detail.

4. *In the terms of specific health and safety training there is still improvement and progress to be made in the areas of Risk Assessment, COSHH Assessment, First Aid and general health and safety qualifications for staff tasked with specific health and safety responsibilities (e.g. IOSH).*

A Trust wide review of training on the organisation in relation to health safety and non-clinical training provision has been identified as part of the development of the trust Health and Safety Strategy.

## 8. Fire Safety Annual Report

See attached report. **Appendix 4.**

## 9. Security Management Annual Report

This year our security team won the Trust annual celebration of achievement award in the category of; ‘Excellence in Patient Care’ and were finalists in the category of; ‘Outstanding In House Security Team’ at the national OSPA’s awards. We continue to extend and refresh their training to ensure they provide the best care to our patients and staff.

Our two security/car parking managers successfully completed the professional training from NHS protect to qualify as accredited security management specialists. This brings the

Trust into the healthy position of having four fully qualified Local Security Management Specialists.

The implementation of swipe access control on wards at York Hospital has been installed and completed and working with Clinical colleagues we now have the ability to lockdown wards and restrict access when required.

The in-house CCTV programme manager has proved a vital role, introducing strict guidelines on the management of our CCTV to comply with legislation and saving £18,000 on undertaking basic video system management and correcting faults, this also allowed for the maintenance contract for the system to be re-tendered and awarded at half the previous annual cost, saving a further £10,000 on a recurring basis.

Our central CCTV control room processed 130 CCTV data requests the majority of which have been crucial as police evidence. In line with our Strategy, in addition to York and Scarborough we now have the capability to live view cameras from Bridlington and Malton sites via our central control room,

The 2015 gas thefts (Operation Leopard) from various Hospitals across the country including Bridlington concluded in March of this year with combined prison sentences of 10 years, the Security Management Team and Police worked in partnership to bring these sanctions.

Following concerns raised on ward 37 in relation to staff injuries from patients, clinical staff, safeguarding and security formed a task and finish group to look at the issues and address staffs concerns. New systems were introduced by clinical staff and enhanced conflict resolution training and breakaway techniques were given to staff.

The Security Department has become more actively involved in and around Emergency Planning, CBRN, Majax, Disaster Management and Counter Terrorism and will continue to have a key in ensuring we have robust systems in place.

In the coming year we will be applying for the Surveillance Commissioners certification for our CCTV systems and will look to the feasibility of introducing Body Worn Cameras for the officers.

## 10. Conclusion

2016/17 has a continued focus on the wider health safety and security risks of the Trust and how the safety function interacts with other aspects of safety management, with on-going work on improving the health and safety systems and processes, striving to embed these systems into the operational management across the organisation.

Changes in the Trust's governance arrangements in this area and link to the NHS PAM's model is seen as a positive step in ensuring robust senior management review by the introduction of the Environment & Estates Committee and is having a positive impact in the area of safety and non-clinical risk providing further assurance to the BoD.

**Owner:**

Brian Golding, Director of Estates & Facilities

**Report authors:**

Kingsley Needham, Health and Safety Manager – York
Janet Mason, Head of Security & Accredited Local Security Management Specialist
Mick Lee, Fire Safety Officer – York
Kevin Hudson, Fire Safety Officer - Scarborough
Colin Weatherill, Head of Safety and Security
May 2017

**References:**

For the purpose of this report the following primary statutory requirements and supporting guidance:

The Health and Safety at Work etc. Act 1974

The Regulatory (Fire Safety) Reform Order 2005

HSG 65 third edition - Managing Health and Safety

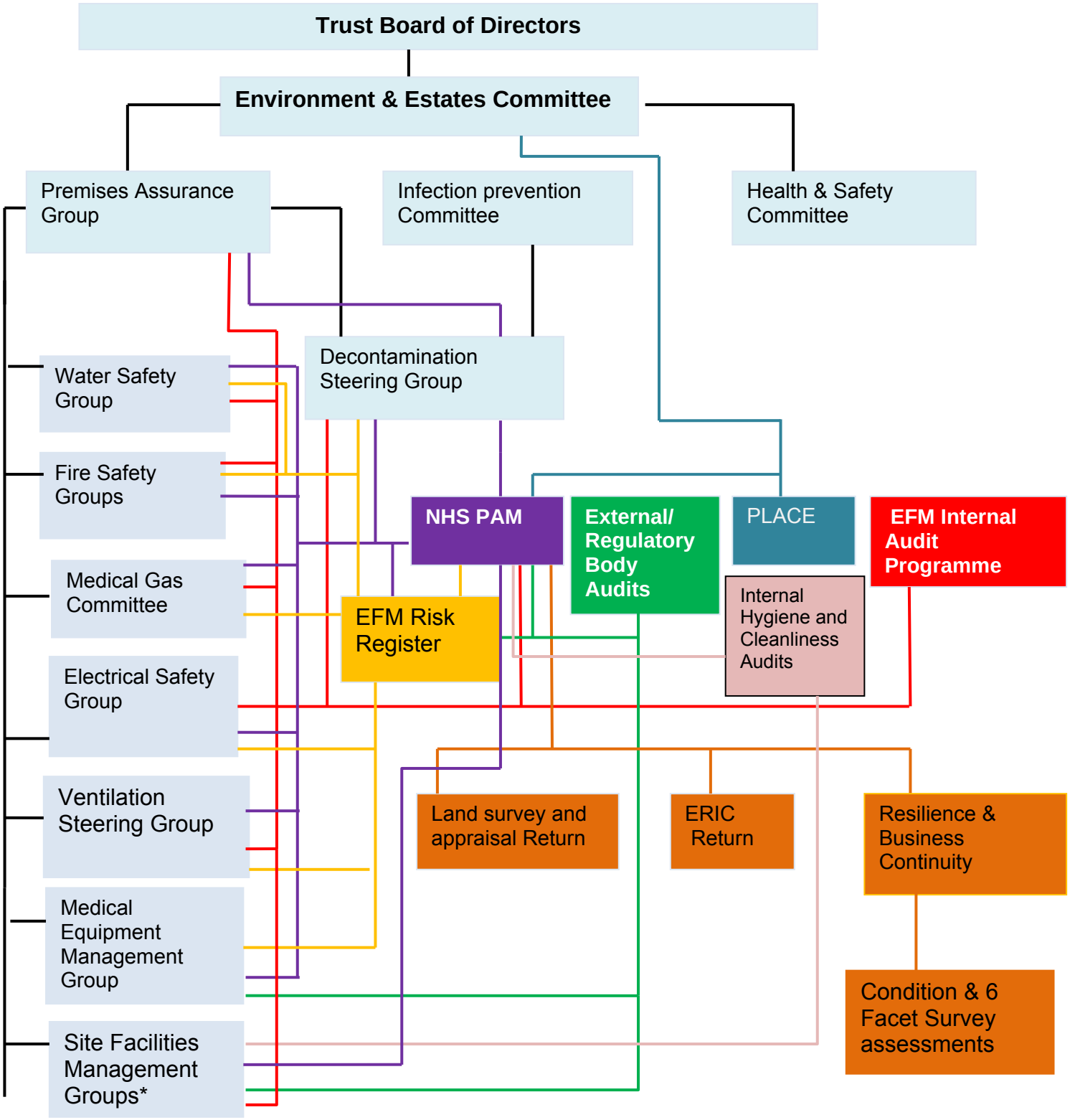
INDG 417 – Leading Health and Safety at Work

**Appendix 1**

## Estates & Facilities Systems & Functions- Compliance Monitoring Requirements

| EF Function | Minimum Compliance Requirement | Compliance Assurance Source(s) | Frequency | Responsible Person | Responsible group for monitoring any action plans |
|---|---|---|---|---|---|
| Asbestos | Trust Procedure<br>Control of Asbestos Regulations 2012 | NHS PAM<br>Internal Audit Schedule | Quarterly | Health and Safety Manager | Premises Assurance Group |
| Pressure Systems | Trust Procedure<br>Pressure Systems Safety Regulations | NHS PAM<br>Internal Audit Schedule<br>AE Reports | Quarterly | Head of E&F | Health & Safety Committee |
| Health, Safety & Welfare | Trust Policy<br>Health & Safety At Work etc Act 1974 | NHS PAM<br>Internal Audit Schedule | Quarterly | Health & Safety Manager | Health & Safety Committee |
| Medical Gases | Trust Policy<br>HTM 02 | NHS PAM<br>Internal Audit Schedule<br>AE Reports | Quarterly | APs | Medical Gas Management Group |
| Natural & Specialist Piped Gas | Trust Procedure<br>Gas Appliances safety Regulations 1995 | NHS PAM<br>Internal Audit Schedule | Quarterly | APs | Medical Gas Management Group |
| Water Systems | Trust Policy<br>HTM 04 & L8 | NHS PAM<br>Appointed Advisor Reports<br>Internal Audit Schedule | Quarterly | RPs | Water Safety Group |
| Mechanical and lifting equipment | Trust Procedure<br>LOLER Regulations 1998 | NHS PAM<br>Internal Audit Schedule | Quarterly | Head of E&F | Health & Safety Committee |
| Fire safety | Trust Policy<br>Regulatory Reform (Fire Safety) Order 2005 | NHS PAM<br>Internal Audit Schedule | Quarterly | Fire Safety Officer | Health & Safety Committee |
| Medical Devices and equipment | Trust Policy<br>MHRA Guidance- April 2014 | NHS PAM<br>ISO 9001;2015 Accreditation and Internal audit schedule | Quarterly | Medical Device Manager | Medical Device Management Group |
| Waste Management | Trust Policy<br>HTM 07 | NHS PAM<br>Internal audit schedule<br>External Annual Audit | Quarterly | Waste Manager | Site Facilities Management Group |
| Catering | Trust Policy<br>Food Hygiene Regulations 2006 | NHS PAM<br>PLACE Assessment<br>EHO Annual Audit | Quarterly | Head of E&F | Site facilities Management Group |
| Cleanliness | Trust Policy<br>Health & Social Care Act COP | NHS PAM<br>PLACE Assessment | Quarterly | Site Facilities Managers | Environmental Steering Group |
| Decontamination | Trust Policy<br>HTM 01 & HTM 06 | NHS PAM<br>Internal Audit Schedule<br>ISO Accreditation<br>AE Reports | Quarterly | Deputy Decontamination Lead | Decontamination Steering Group |
| Lifts | Trust Procedure<br>Lifts Regulations 1997 | NHS PAM<br>Internal Audit Schedule | Quarterly | AP | TBC |
| Contractor Management | Trust Procedure<br>Health & Safety At Work etc Act 1974<br>HSE INDG368 | NHS PAM<br>Internal Audit Schedule | Quarterly | Head of E&F | Health & Safety Committee |
| Electricity | Trust Policy<br>Electricity at Work Regulations<br>HTM 06 | NHS PAM<br>Internal Audit Schedule<br>AE Reports | Quarterly | AP | Electrical Safety Group |
| Ventilation | Trust Procedure<br>HTM 03 | | | AP | Ventilation Steering Group |
| Laundry & linen | Trust Procedure<br>CFPP 04-01 | NHS PAM<br>Internal Audit Schedule | Quarterly | Facilities Managers | Site Facilities Management Group |
| Security Management | Trust Policy<br>NHS Protect Risk Standards | NHS PAM | Quarterly | Security Manager | Health & Safety Committee |
| Pest Control | Trust procedure<br>Public Health Act | NHS PAM | Quarterly | Facilities Managers | Health & Safety Committee |

## Estates & Facilities Governance Structure




*York & Community and SGH/BDH

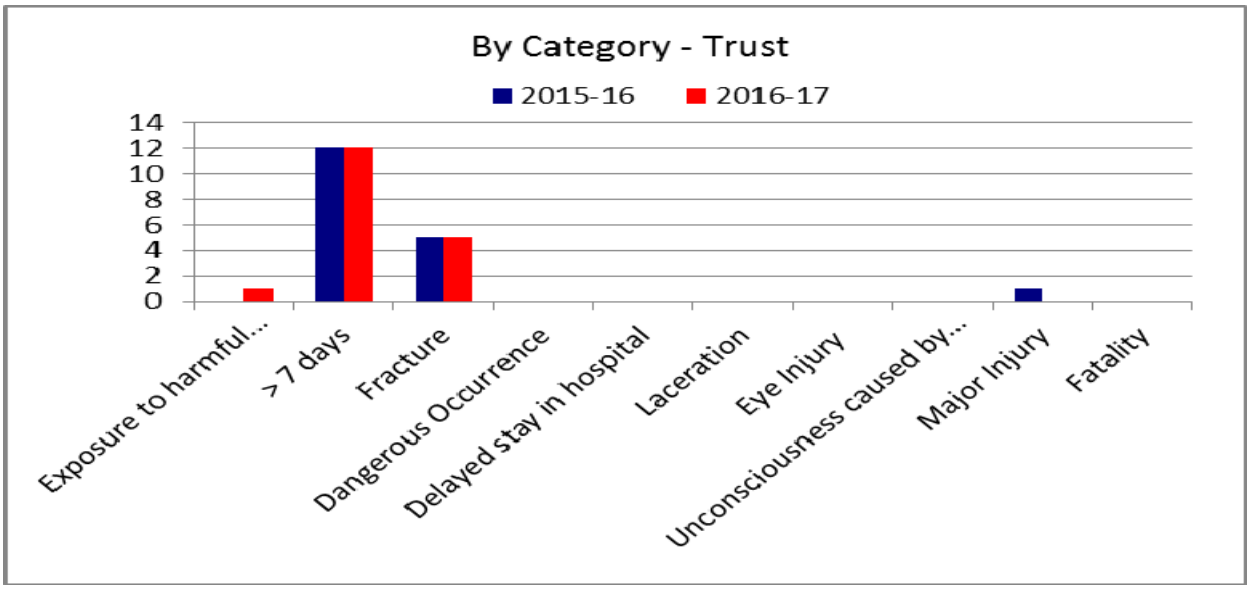
**Appendix 3**

# Year end Summary RIDDOR report - 2016/2017

For the period 01 April 2016 to 31 March 2017, **EIGHTEEN**[1] RIDDOR reportable incidents were confirmed on Datix across the Trust.

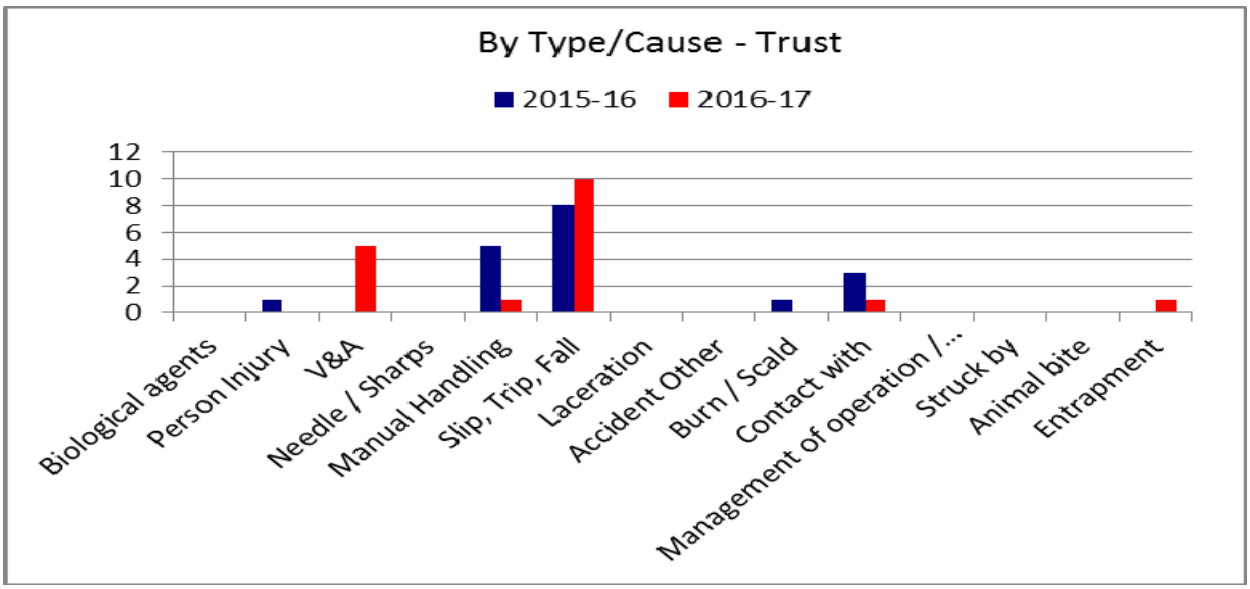
The total number of RIDDOR reportable incidents for **2016/17** was **EIGHTEEN**, compared to **EIGHTEEN** for the period **2015/16** representing no change in the number of RIDDOR's reported across the Trust.

**Summary of total Trust Reportable Incidents**




| RIDDOR Category | 2015-16 | 2016-17 |
|---|---|---|
| **Exposure to harmful substance** | 0 | 1 |
| **> 7 days** | 12 | 12 |
| **Fracture** | 5 | 5 |
| **Dangerous Occurrence** | 0 | 0 |
| **Delayed stay in hospital** | 0 | 0 |
| **Laceration** | 0 | 0 |
| **Eye Injury** | 0 | 0 |
| **Unconsciousness caused by head injury** | 0 | 0 |
| **Major Injury** | 1 | 0 |
| **Fatality** | 0 | 0 |

[1] This figure included 1 late report from 2015/16 from 22 March 2016

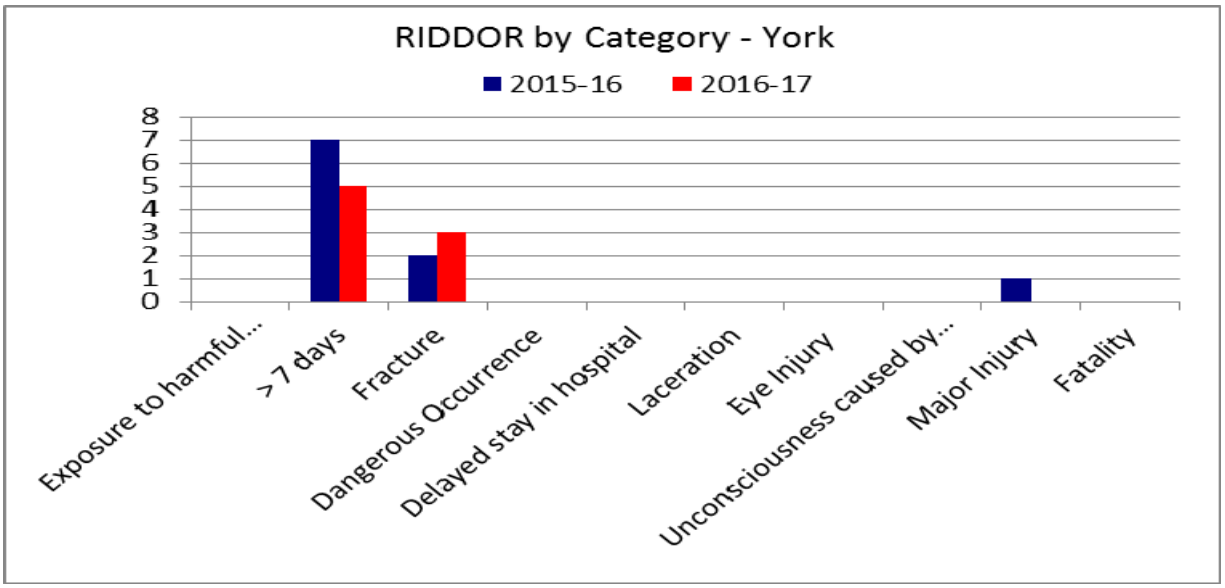


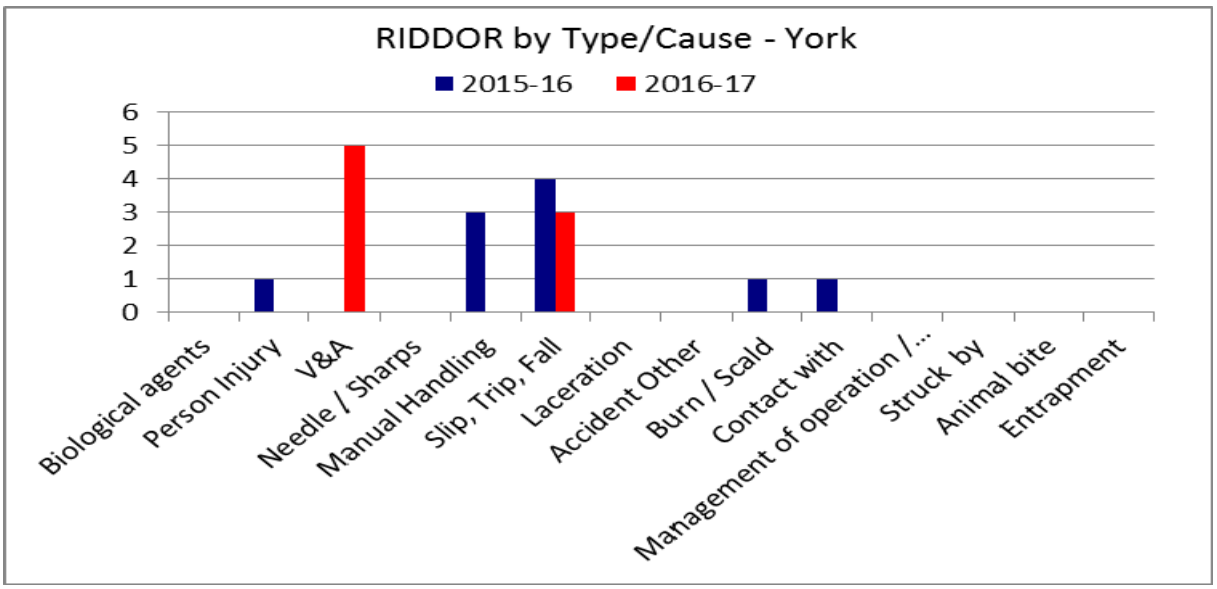

| RIDDOR TYPE / CAUSE | 2015-16 | 2016-17 |
|---|---|---|
| **Biological agents** | 0 | 0 |
| **Person Injury** | 1 | 0 |
| **V&A** | 0 | 5 |
| **Needle / Sharps** | 0 | 0 |
| **Manual Handling** | 5 | 1 |
| **Slip, Trip, Fall** | 8 | 10 |
| **Laceration** | 0 | 0 |
| **Accident Other** | 0 | 0 |
| **Burn / Scald** | 1 | 0 |
| **Contact with** | 3 | 1 |
| **Management of operation / adverse event** | 0 | 0 |
| **Struck by** | 0 | 0 |
| **Animal bite** | 0 | 0 |
| **Entrapment** | 0 | 1 |

The most significant difference between 2015-16 and 2016-17 was a change in causation, with the number of RIDDOR incidents involving manual handling dropping and being replaced by a significant increase of incidents involving violence and aggression with 5 incidents being reported from the YORK site.

## By Site - York

The total number of RIDDOR reportable incidents for **2016/17** was **EIGHT** compared to **TEN** for **2015/16** representing a 20% reduction of RIDDOR reportable incidents on 2015/16 for the York Hospital site.

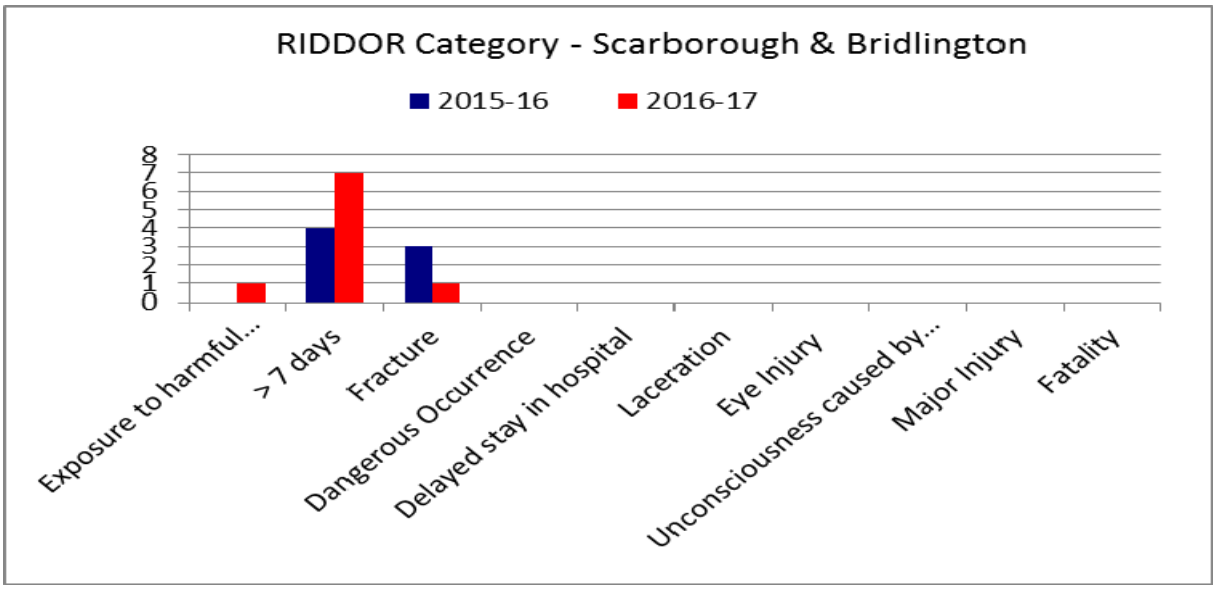


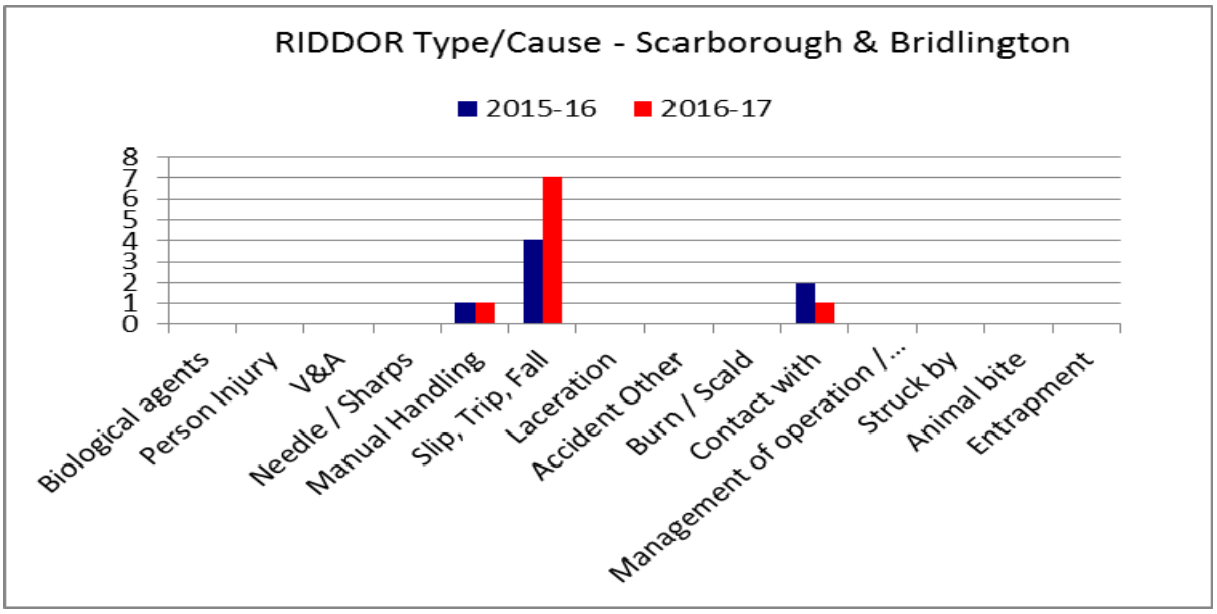



## By Site – Scarborough & Bridlington

The total number of RIDDOR reportable incidents for **2016/17** was **NINE** compared to **SEVEN** for **2015/16**.

This represents a 22% increase of RIDDOR reportable incidents on 2015/16 for the Scarborough & Bridlington Hospitals sites.

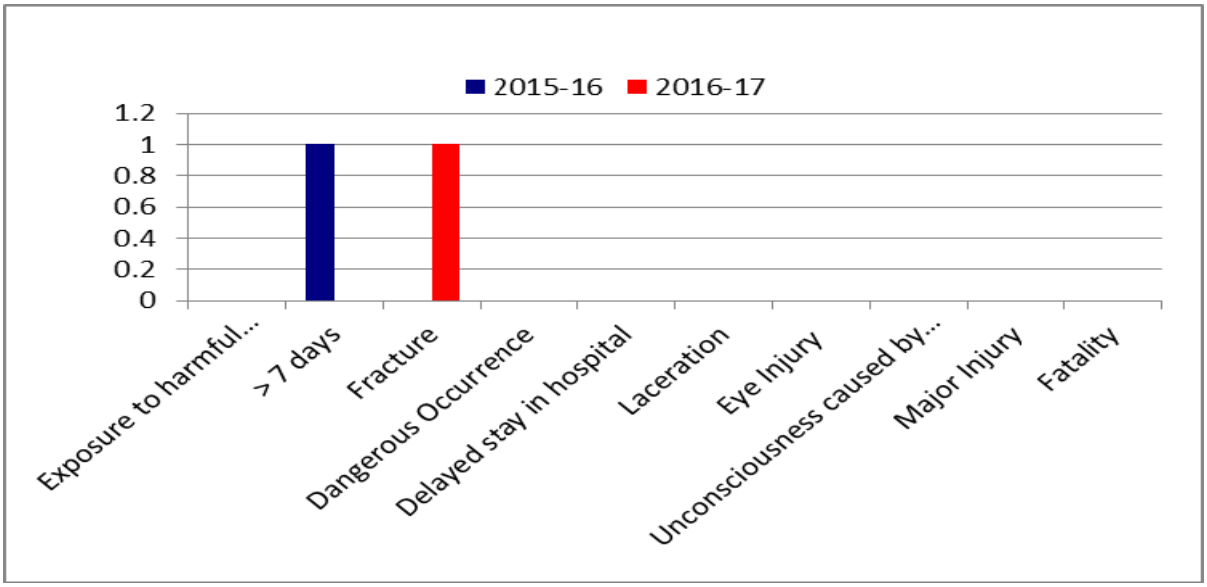


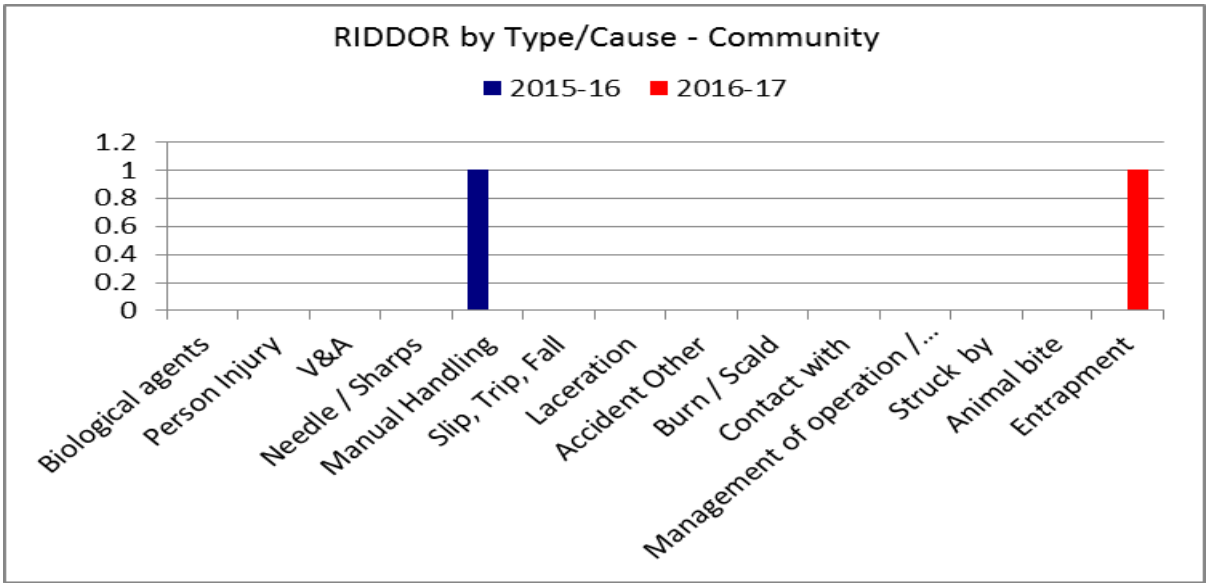



## By Sites - Community

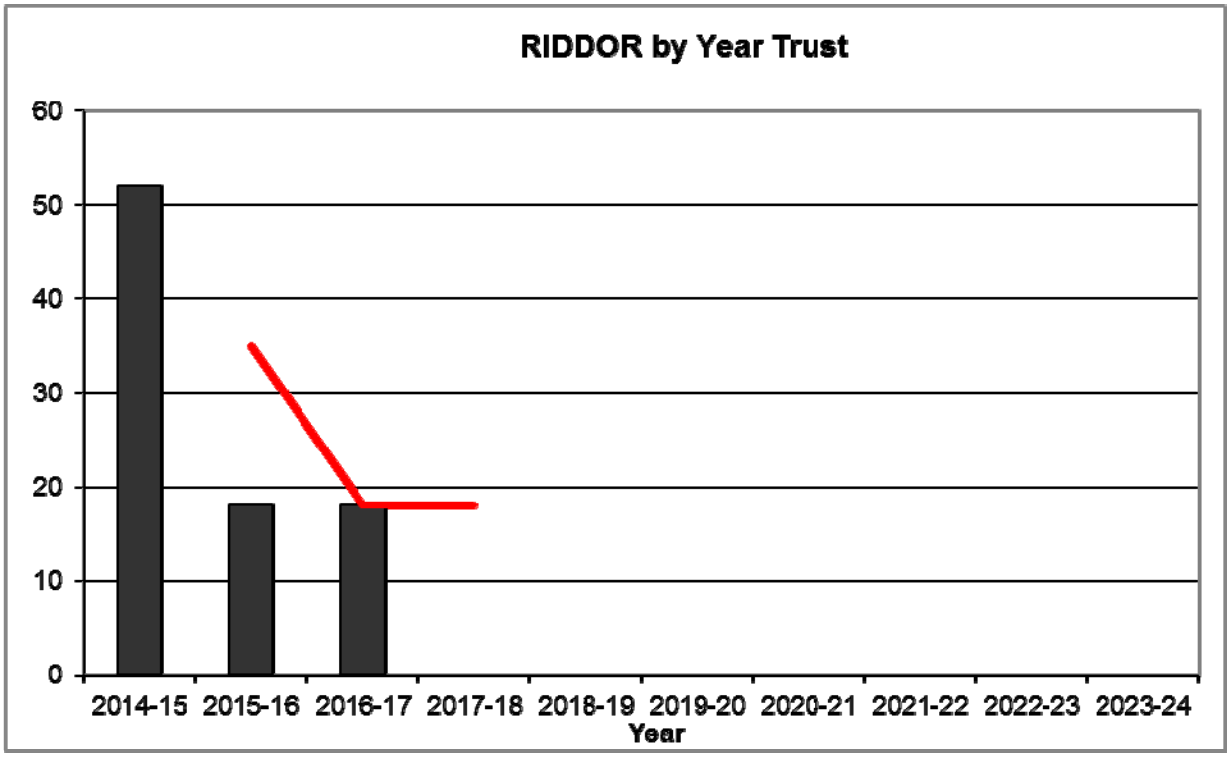
The total number of RIDDOR reportable incidents for **2016/17** was **ONE** compared to **ONE** for **2015/16**.

This represents no change in the number of RIDDOR reportable incidents on 2015/16 for the Community Hospitals & Clinics.



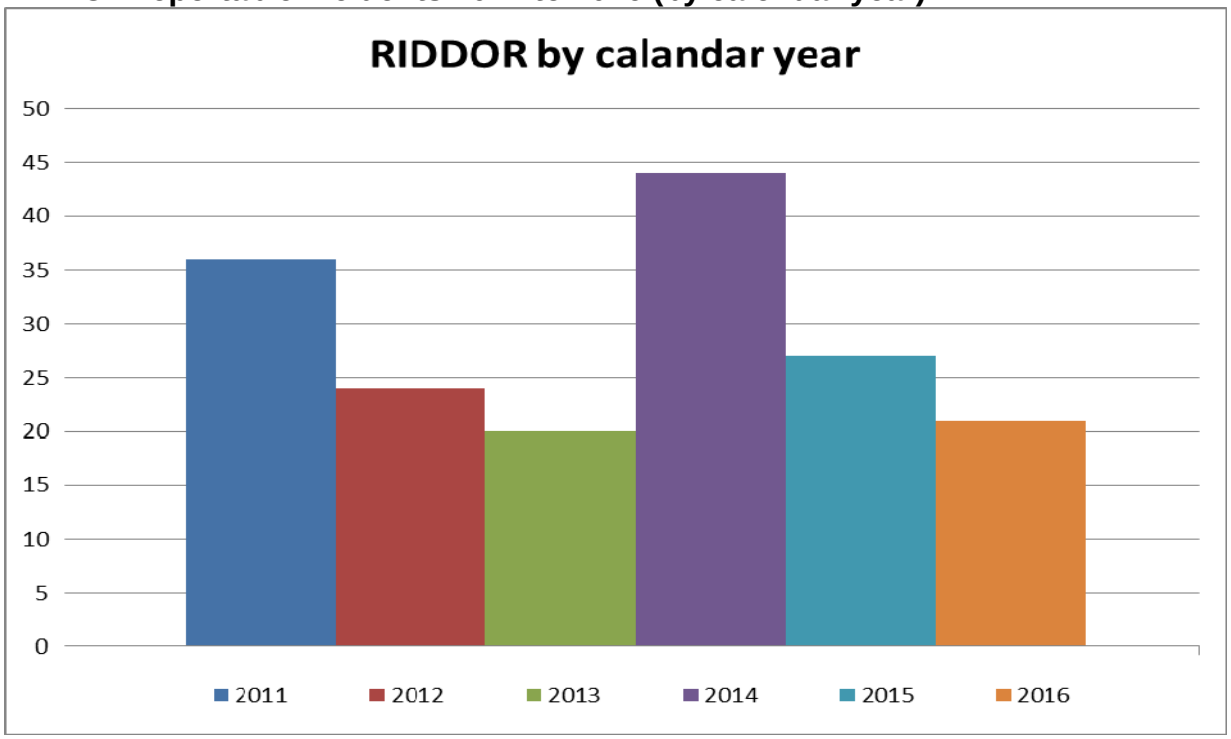



**RIDDOR reportable Incidents 2014/15 to 2016/17 (Financial year)**




RIDDOR reported for the last 3 financial years show a significant drop in reported incidents from 2014/15 but a levelling trend for 15/16 to 16/17.

**RIDDOR reportable Incidents 2011 to 2016 (by calendar year)**




The Trust 6 Year average for RIDDOR reported incidents is 28.7 per year ∴for the number of incidents reported for 2016 is 26.74% less than the 6 year average.

**END**

# Trust Fire Safety Report - 2016

**Executive Summary**

During the 2016 calendar year and continuing into and throughout 2017, the Trust will continue to meet its obligations under all current legislation and remain broadly compliant in maintaining those standards.

As part of the continuing commitment to make good/upgrade breaches to the structural/passive fire protection across all sites, work continued during the above reporting period and this will remain an ongoing commitment during the FY2017/18. All work will continue to be carried out by third party accredited contractors, which ensures a standard of work satisfying current legislation and will serve to ensure a robust level of quality assurance and compliance for the Trust.

In year remediation work for fire safety continues across the Trust estate with on-going work planned for 2017/18 across all Trust sites.

**Fire Alarm Replacement** (York/Scarborough)
A comprehensive survey and design initiative took place across the 2 main hospital sites during the early part of 2015 with a view to replacing the fire alarm systems at York & Scarborough. Work is now due to commence across both main hospital sites during the FY17/18.

**Portable Fire Extinguishers**
Annual servicing of these items across all premises will be undertaken by a suitably trained individual employed by the Trust. Historically this has been a member of the estates maintenance team based out of Scarborough.

**Fire Safety Training**
This continues to be delivered across all sites by the relevant fire safety advisors. Face to face sessions are delivered as required with no Trust employee going more than 3 years without this type of training. There remains in place a requirement under the Statutory & Mandatory training policy, for fire training to be undertaken annually, on induction and through face to face or e-learning via the learning Hub as applicable.
*(See Table 1)*

**Fire Alarm Activations**
There were a number of false alarm activations across all sites, but in total they have reflected a pleasing reduction in overall numbers, compared with previous years. It is likely that on completion of the planned/proposed fire alarm replacement across the two main hospital sites that these figures will continue to decline.
*(See Table 2)*

**Fire Safety Risk Assessments**
Regular reviews continue to be undertaken by the relevant fire advisors across all sites, thereby providing the board with assurances that we meet all current statutory duties placed upon us by current legislation.
*(See Table 3)*

**Fire Service Audits**
The Trust was subject to local authority fire safety audits, carried out by officers of the North Yorkshire Fire & Rescue Services. In all case premises which were subject to the NYFRS audits received the broadly compliant/satisfactory rating.

**Trust Fire Safety Group(s)**
The Fire Safety groups are now well established across both Eastern & Western regions, with both groups meeting 4 times per year. Transparency is served through accessible folders held on the Trust's Q-Drive facility which are then subject to audit/scrutiny upon request. The Trust Fire Safety Manager (Kingsley Needham) has taken on the chair responsibilities for both groups.

**Training** ***(Table 1)***

| **Approximate Total manpower figures: 9,200** | |
|---|---|
| **York Staff** trained Stat/Mand (face to face)<br>Jan – Jun 2016 | **907** |
| **York Staff** trained Stat/Mand (face to face)<br>Jul – Dec 2016 | **451** |
| **Fire Wardens Trained (York) - 2016** | **21** |
| **Total York Staff Trained Over Calendar Year 2016** | **1,379** |
| ***Scarborough Staff** trained Stat/Mand (face to face)<br>Jan - Jun 2016 | **304** |
| ***Scarborough Staff** trained Stat/Mand (face to face)<br>Jul - Dec 2016 | **468** |
| **Fire Wardens Trained (S'Boro) - 2016** | **30** |
| **Total S'Boro Staff Trained Over Calendar Year 2016** | **802** |
| ***E-Learning/Learning Hub**<br>***Corporate Induction** *(Delivered at York Post Grad Centre)*<br>***Stat/Mand Refresher** *(York Based at Social Club)*<br>***HCA Induction - York** | **41**<br>**981**<br>**979**<br>**166** |
| **APPROXIMATE TOTAL TRAINED** | **4,348** |
| *Approximately 9,200 Trust personnel are required to undertake fire safety training over a 3 year period. With face to face training changed to a 3 year cycle we would expect to train approximately 3000 every year (face to face). That annual target was exceeded during 2016. The current CLaD compliance figure as at 30th Jan 2017 shows a compliance of between 80% & 82%.* | |

*** - Figures Supplied by Corporate Learning and Development**

***Fire Alarm Activations 2016 (Table 2)***

| Location | Cause of Activation | 2016 | Up/Down on 2015 | Comments |
|---|---|---|---|---|
| York | Steam Leak | 1 | Down by 4 | |
| York | Toaster's | 3 | Down by 1 | W24, W37, W26 |
| York | Unknown Cause | 8 | Up by 1 | |
| York | Accidental | 7 | Up by 5 | |
| York | Contractors | 4 | Down by 2 | |
| York | Aerosols | 3 | Down by 1 | Air Freshener/Deodorants |
| York | Electrical Faults | 2 | New 2016 | |
| York | Smell of Burning | 1 | New 2016 | WXC Gym |
| York | Smoking | 2 | New 2016 | Maternity & W26 Toilet Areas |
| | **Total for Western Region** | **31** | **Down 4 on 2015** | |

| Location | Number of Alarms | Comments |
|---|---|---|
| Scarborough | 16 | Down by 5 on 2015 |
| Bridlington | 10 | Down by 8 on 2015 |
| **Total for Eastern Region** | **26** | Down by 13 on 2015 |

The above figures cover the period 1st Jan 2016 – 31st Dec 2016

**Fire Risk Assessments/Reviews (Table 3)**

The fire advisors across both Eastern & Western regions continued to carry out assessments and reviews over this reporting period. The breakdown for which is as follows:

**For the Calendar year 2016**

| Region | Number |
|---|---|
| Eastern | 42 |
| Western | 118 |
| Bridlington Hospital | 18 (Carried out by the Western Region Fire Advisor) |

M R Lee GIFireE, MIFPO, MIFSM
Trust Fire Safety Advisor
(Western Region)

K Needham
Trust Fire Safety Manager

*Annual Statement of Fire Safety 2016*

| | | |
|---|---|---|
| ***NHS Organisation Code: RCB*** | ***NHS Organisation Name: YORK TEACHING HOSPITALS NHS FOUNDATION TRUST*** | |
| ***I confirm that for the period 1st January 2016 to 31st December 2016, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and (please tick the appropriate boxes):*** | | |
| ***1*** | ***There are no significant risks arising from the fire risk assessments.*** | ***N/A*** |
| ***OR 2*** | ***The organisation has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessments. (Fire Alarm Replacement across York & Scarborough sites)*** | √ |
| ***OR 3*** | ***The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks.**** | ***N/A*** |
| ****Where a programme to mitigate significant risks HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk. Date: N/A*** | | |
| ***4*** | ***During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire & Rescue Authority? (Delete as appropriate) If Yes - Please outline details of the enforcement action in Annex A – Part 1.*** | ***No*** |
| ***5*** | ***Does the organisation have any unresolved enforcement action pre-dating this Statement? (Delete as appropriate) If Yes Please outline details of unresolved enforcement action in Annex A – Part 2.*** | ***No*** |
| ***AND 6*** | ***The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method.*** | √ |
| ***Director (Trust Fire Safety)*** | ***Name: B GOLDING Director of Estates & Facilities*** | |

*/*

| | | |
|---|---|---|
| | ***E-mail:*** | ***brian.golding@york.nhs.uk*** |
| ***Contact details:*** | ***Telephone:*** | ***01904 72 5149*** |
| | ***Mobile:*** | ***N/A*** |
| ***Chief Executive*** | ***Name:*** | ***P CROWLEY*** |
| ***Signature of Chief Executive:*** | | |
| ***Date:*** | ***31 January 2017*** | |
| ***Completed Statement to be forwarded to the Health & Social Care Information Centre No longer required*** <br> ***The above certificate is to be attached as an Appendix/Annex to the Annual Fire Safety Report.*** <br> ***(as recommended by the Internal Audit Report 2014)*** | | |

***ANNEX A***

| ***Part 1 – Outline details of any enforcement action during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply.*** |
|---|
| ***N/A*** |
| ***Part 2 – Outline details of any enforcement action unresolved from previous years, including the original date, and the action the organisation has taken so far. Include any outstanding proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.*** |
| ***N/A*** |

***NHS Organisation Code RCB***

***NHS Organisation Name: YORK TEACHING HOSPITALS NHS FOUNDATION TRUST***

***3***

***Date: 31 January 2017***

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York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Workforce & Organisational Development Committee minutes – 19 September 2017

**Present:**

Libby Raper, Non-executive Director (Chair)
Dianne Willcocks, Non-executive Director
Jenny McAleese, Non-executive Director
Michael Proctor, Deputy Chief Executive
Brian Golding, Director of Estates & Facilities
Polly McMeekin, Deputy Director of Workforce
Melanie Liley, Deputy Director of Out of Hospital Care
Lynda Provins, Foundation Trust Secretary
Tracy Astley, Workforce PA (Minutes)

## Apologies for absence

No apologies were received.

## 1. Last Meeting Notes – 18 July 2017

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

## 2. Matters Arising and Action Log

Action log ratified. No matters arising.

## 3. Risk Registers

Corporate Development Risk Register

MP agreed that the register needs updating to reflect current status.

HR Risk Register

HR4 - mitigation needs updating.
HR8 – add Champions role and FTSU.
HR11 – update re business case status.
HR12 – update to current status.
HR13 – update to current status.

In line with the Risk Management Framework it was agreed that the committee would only review risks rated 10+ and those with a risk factor of 15+ should be seen by the Board.

## 4. Workforce Board Report

PM gave succinct points from the report:-

- Sickness absence tracking at 4.43% cumulative. Main reason is stress, anxiety and depression with 70% of staff coming from Estates and Ancillary (mainly within Band 1 group) Additional Clinical Services and Nursing & Midwifery staff groups. Work undertaken to address these issues include: line management training, recruitment of 41 Fairness Champions, and holding Bullying/Harassment drop in sessions as well as HR/ODIL work with Facilities on York site. This is in partnership with our TU reps. The HSE Stress Risk Assessment is being used and Elaine Middleton, Clinical Psychologist, is analysing the results and giving feedback.
Incentives have been put forward to Trade Unions to help the recruiting and retention of Band 1 cleaners.

- 78 newly qualified nurses are due to join the Trust from 15 different universities. To support with onboarding a Welcome Day was held on the 14th August where the nurses met with key people within the organisation. An additional challenge to recruitment above Brexit is the MNC requirement for nurses to pass International English Language Testing System (IELTS). This took effect for nurses with the EEA in June 2016. The NMC are currently consulting on whether these standards should be relaxed in some circumstances.

LR suggested that the issue with line management be looked at in a future meeting.

**Action:** Line management issues to be included in the discussion around People Development.

DW highlighted the shift from short term to long term sickness is increasing. PM advised that this was due to stress/anxiety/depression typically causing long term illness.

JM enquired about Occupational Health's (O.H.) involvement. PM advised that O.H. is consultant led. There is generally a slight delay in individuals seeing them. Better communication from the line manager could assist with this by providing a concise overview on the individual to the O.H. practitioner prior to the appointment.

It was decided by the committee that issues regarding Occupational Health should be brought under the WFODC governance.

**Assurance:** The Committee took assurance from the ongoing work to address the identified issues.

## 5. Monthly Information Pack

It was agreed that the monthly information pack be sent in colour to the Committee.

**Action:** LP to facilitate this with Cheryl Gaynor.

On further development of the workforce section, the Committee agreed to more clearly adopt the approach of triangulation of issues ahead of raising specific items through Committee meetings.

## 6. End of Placement Survey Report 2016-17

MP advised that the report was for information only but wanted to highlight the student satisfaction rates through the achievement by the Trust to provide a good educational experience.

**Action:** Chair to share with the Board of Directors.

## 7. Medical Workforce Report

PM gave succinct points from the report:-

- In August there were 177 new starters and 134 leavers.
- There were 26 Trust grade posts recruited to across all specialities to mitigate trainee gaps.
- August/Sept 63 trainees are to join the Trust.
- Appointed 4 Paediatric consultants.
- CESR business case has been agreed within ED and now being implemented.
- Two long term locum agency workers have been recruited to fixed term positions in Specialist Med.

LR enquired that in terms of the risk to the safety of the organisation where should the focus be. PM replied that the focus has been on Emergency Medicine and Acute Medicine at Scarborough. However, after a successful recruitment campaign a Consultant has been appointed to work at Scarborough Hospital ED and two Consultants have commenced in fixed term posts in Acute Medicine. PM did highlight that it is a struggle to appoint Consultants to the Scarborough site as most of them want to work at York Hospital but there has been some inroads in persuading Consultants to work between sites.

MP suggested offering an incentive to leavers to return within three months of leaving the Trust either:-

- by having exit interviews and informing individuals then
- or before the three months deadline for the Line Manager to telephone the individual to enquire if they would like to return to the Trust.

The Committee agreed with the spirit of the incentive but agreed it should be rolled out at directorate level and guidance should be created around this.

**Action:** PM to create a framework around incentivising leavers to return to the Trust.

## 8. Nurse Rostering Project Update

PM gave succinct points from the report:-

- Out of the 19 actions, 13 are complete, 4 are ongoing with each deep dive.

- Roster Policy has been re-negotiated and has been ratified with the first roster cycle being actioned. Any individuals with a Flexible Working arrangement in place cannot additionally request shift preference.

- 28 deep dives have been completed equating to 68% overall. 10 have been handed back to the matron/Associate Chief Nurse.

- Bank/agency rates do not correspond with sickness absence and leaver rates due to increased demand for enhanced care, specifically 1:1 care in the elderly directorate. DW suggested looking at alternatives such as the recruitment of volunteers to help with the elderly depending on their level of care. ML suggested revisiting the principles of de-conditioning to reduce unnecessary delays in discharge.
Action: ML to discuss with nursing workforce their requirement for one to one care.

- Business case has been approved to introduce Safecare, with a November timeline. Tablets are to be purchased through IT within the next week or so. The Committee was encouraged by this development and looked forward to hearing further as implementation takes place.

## 9. Apprenticeship Update

BG gave an update and advised that £1.3m had been put into the Trust's Apprenticeship levy. The contract is to have 2.3% of the Trust's workforce made up of apprentices, which equates to 200 in post.

There are firm plans for 122 apprentices to start with the Trust by the end of November with 27 starting next month. Assessment of gaps will take place for the next round.

BG met with Lucy Brown, Head of Communications, to promote awareness of the apprenticeship strategy across the organisation.

By April 2018 the Trust will be able to offer in-house training in the unregistered health care group. The Committee was very encouraged by this and looked forward to seeing significant growth in this section of the apprenticeship workforce.

DW enquired if there were any higher apprenticeships available. BG replied that there are 5 AHPs in post that are on a higher apprenticeship. He advised that there was not a problem with graduate grades but more of an issue with general workers not meeting the criteria. DW suggested linking with York College to enquire what they can offer.

## 10. ACP Update

MP gave an update and advised that there is a massive demand through primary care for ACPs. The Trust has three cohorts of ACPs that are being used as additional staffing. There is a value for investment challenge for the Trust and Directorates need to consider the ACP role in the context of the overall skill mix and budget.

Regarding the STP, there is very little to report back at the moment.

**Action:** Chair to outline the challenge re ACPs at Private Board.

## 11. Workforce Race Equality Standard (WRES) Report

PM advised that the WRES goes to the Fairness Forum and was submitted to NHS England at the end of August. It is a to-do list and action log with the Fairness Forum having oversight of it.

DW advised that the Trust has now signed up the York Human Rights City Charter and also through Lydia the Fairness & Equality Board.

**Assurance:** The Committee took assurance from the integration of this information into the intelligence available to the Fairness Forum.

## 12. Internal Audit Report

### Y1803 – Recruitment & Retention Premia Policy
### Y1821 – Follow up Use of Locums & Agency Staff

PM reported that both audits had received Significant Assurance.

Y1803 had received three recommendations and all have been actioned.
Y1821 had received four recommendations, two have been completed and two have been partially implemented.

PM advised that the Bank business case is being finalised ready to go to panel and communication has been sent out to directorates on how to make the bookings. It was work in progress but one that will be closed down soon.

The Committee agreed that only those audits that had received Limited Assurance should be presented at the meeting.

**Assurance:** The Committee noted the conclusions of Significant Assurance.

## 13. Action points from Extraordinary WFODC meeting 04/09/17

LR advised that she had been discussing with members of the Quality & Safety Committee the situation regarding nurse/medical staffing. It was agreed that this committee should maintain a good focus on these areas.

LR advised that she would like to focus the December meeting on one subject – People Development. This will build on the discussions at the Sept 4th special session. The committee agreed.

**Action:** Construct an agenda on People Development for the December meeting.

## 14. ERG Minutes

The Committee noted the minutes fell below the standard required for WFODC.

**Action:** Add ERG TOR to the November agenda.

**Action:** Chair to discuss with Board the governance around minutes fit for purpose.

## 15. BAF Action Plans

LR was pleased to note that the BAF had been updated and highlighted the work still to do, including:-

- Focus on boxes that are not green.
- Focus on the workforce issues where there are gaps in the control/assurance column.
- Research points need to be kept up to date.

## 16. Any Other Business

DW enquired over the current situation regarding staff and potential change of employer.

**Action:** ML to keep the Committee briefed on this.

Out of Hospital Care report – The Committee asked for the quarterly report and to always be included in the agenda ahead of any Board discussion.

**Action:** LP to circulate to members of the committee.

## 17. Escalated to Board

Public Board

- Share the End of Placement Survey Report 2016-2017.
- Discuss the governance around minutes fit for purpose.

Private Board

- Role of the ACP and its best application for the Trust.

## 18. Time and Date of next meeting

The next meeting is arranged for 17th October 2017, 16:00 – 17:30, YH HQ Board Room.

## Action Log: Workforce & Organisational Development

| Month | No. | Action | Responsible Officer | Due date | Completed |
|---|---|---|---|---|---|
| May | 1 | Invite Glenn Miller to the October meeting to discuss job planning. | PM | Oct meeting | Glenn Miller to attend. |
| June | 2 | Send Education Review Group TOR to MP. Invite Anne Devaney to meeting. | PM | Nov meeting | Anne Devaney to attend |
| June | 3 | Invite Gail Dunning to meeting to discuss staff development | PM | Oct meeting | Gail Dunning to attend. |
| July | 4 | Discuss Leadership Strategy at a future date. | MP | Nov meeting | |
| Sept | 5 | Give apprenticeship update on a quarterly basis including statistics. | BG | December meeting | |
| Sept | 6 | Monthly Information Pack to be sent to JM/DW/PM in colour. Arrange with Cheryl Gaynor. | LP | Oct meeting | |
| Sept | 7 | Create a framework around incentivising leavers to return to the Trust within 3 months. | PM | Oct meeting | |
| Sept | 8 | Discuss with nursing workforce their requirement for one to one care. | ML | Oct meeting | |

| | | | | | |
|---|---|---|---|---|---|
| Sept | 9 | Construct an agenda on People Development for December meeting incl. line management issues, picking up on the 4th September development session discussion. | PM | Dec meeting | |
| Sept | 10 | Add ERG TOR to the November agenda. | PM | Nov meeting | |
| Sept | 11 | Circulate OHC report to members and ensure a schedule of review through the Committee. | LP | Immediately | |
| Sept | 12 | Keep the Committee briefed on the current situation regarding staff and potential change of employer. | ML | | |

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Workforce Report

## Recommendation

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

## Current approval route of report

This draft has been written for the Board of Directors.

## Purpose of report

The report provides information up to August 2017, relating to key Human Resources indicators including; sickness and appraisals.

## Key points for discussion

This paper provides an overview of work being undertaken to address workforce challenges, and key workforce metrics (data up to August 2017). Of particular note:

- The monthly sickness absence rate in July was 4.74%, an increase from 4.43% in June. This contributed to an increase in the Trust's cumulative annual absence rate which currently stands at 4.36%
- Demand for temporary medical staff equated to 99 FTE in June, with 97% of these shifts being filled via bank or agency. The report provides an update on the progress of the SAS Doctor Recruitment and Retention Strategy which is one measure designed to help reduce demand
- Time to hire at the Trust compares favourably in respect of the completion of employment checks; however, time to shortlist candidates is longer than in most comparable organisations
- An update on the progress of the 2016 Staff Survey Action Plan and plans for the 2017 Staff Survey

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

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

There are no direct references to CQC outcomes.

Version number: 1

Author: Polly McMeekin, Deputy Director of Workforce

Executive sponsor: Patrick Crowley, Chief Executive

Date: September 2017

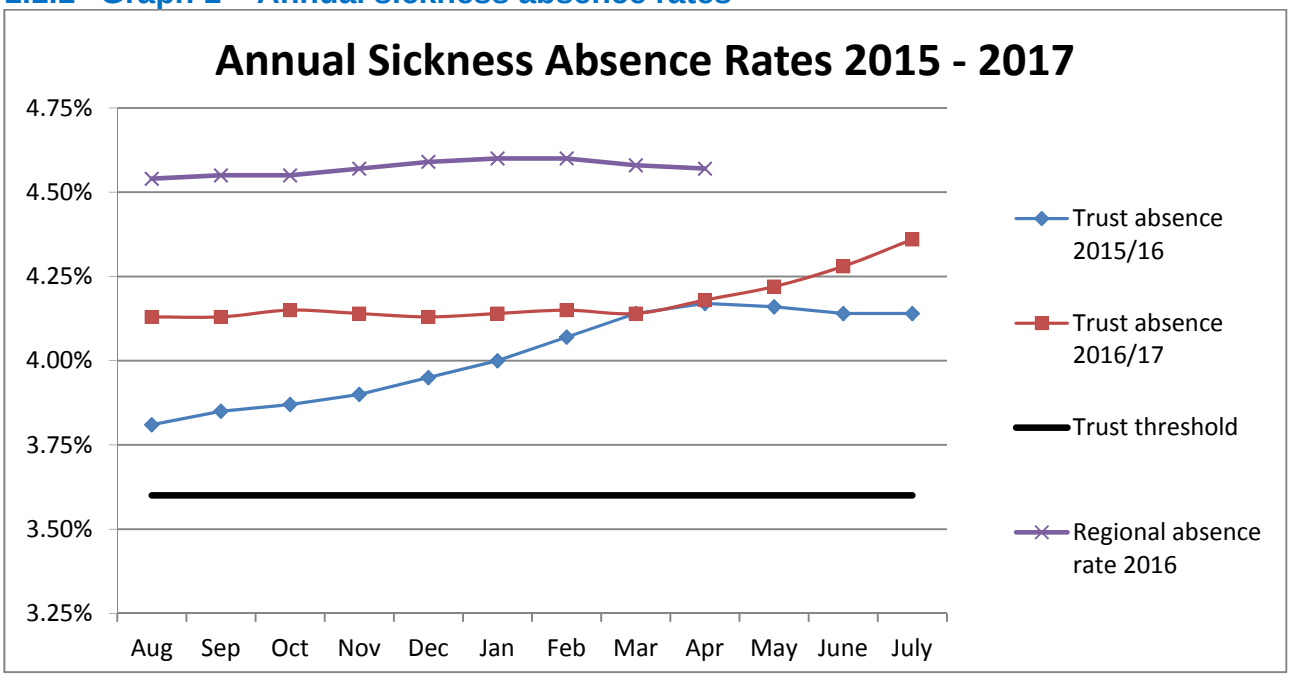
# 1. Sickness and Absence

## 1.1 Sickness absence rates

Graph 1 compares the rolling 12 month absence rates to the Trust's locally agreed threshold and to the regional (Yorkshire and Humber) sickness absence rates. In July 2017 the cumulative annual absence rate was 4.43%.

The Trust absence rate has compared favourably with sickness absence across the region; however, the Trust absence rate has increased since the start of the new Financial Year and because of the lead-times for the publication of regional data, a recent comparison is not possible. In the year to April 2017, the regional annual absence rate was 4.57%.

### 1.1.1 Graph 1 – Annual sickness absence rates

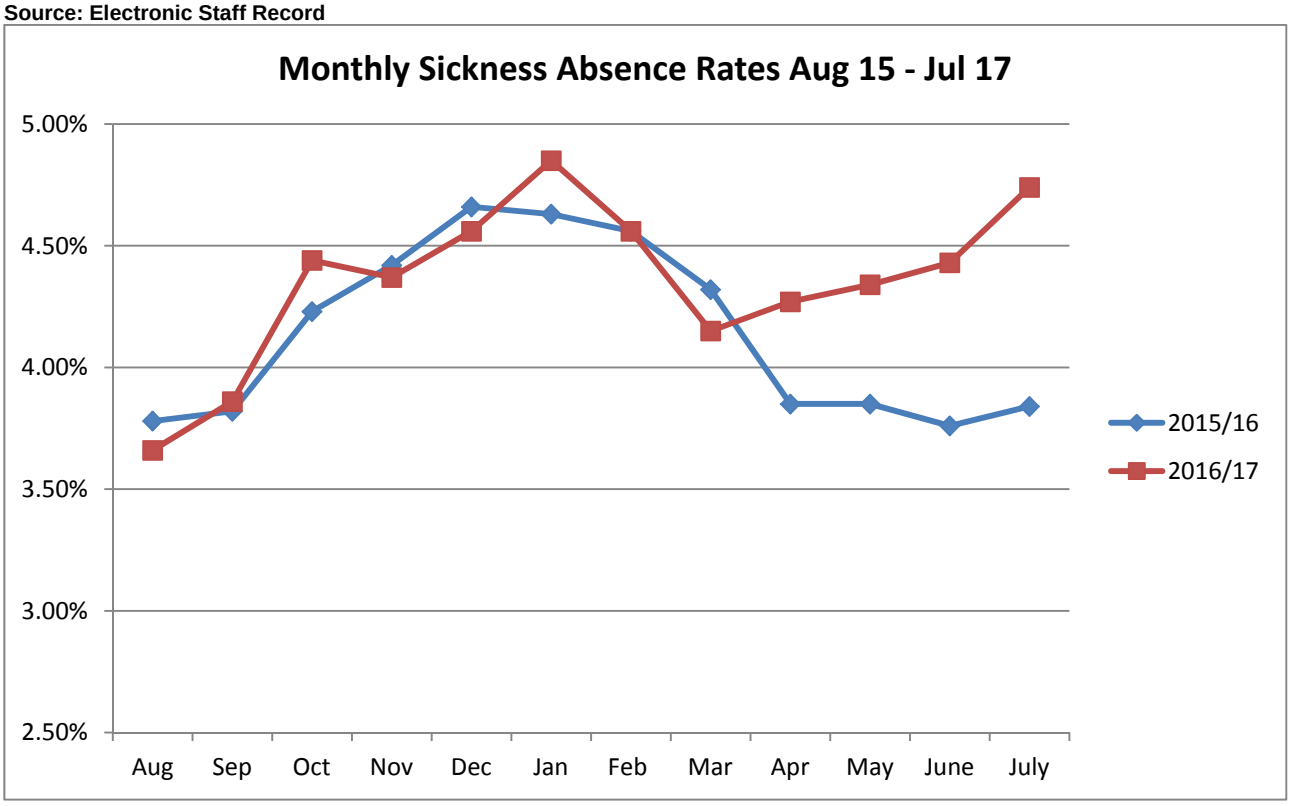



**Source: Electronic Staff Record and NHS Digital**

Graph 2 shows the monthly absence rates from August 2015 to July 2017. The monthly absence rate of 4.74% in July 2017 was a notable increase from the previous month's absence rate of 4.43% and absences since April have been considerably higher than in the corresponding months in 2016 (the absence rate in July 2016 was 3.84%).

### 1.1.2 Graph 2 – Monthly sickness absence rates

**Source: Electronic Staff Record**




## 1.2 Sickness absence reasons

The top three reasons for sickness absence in the year ending July 2017, based on both days lost (as FTE) and number of episodes are shown in the table below:

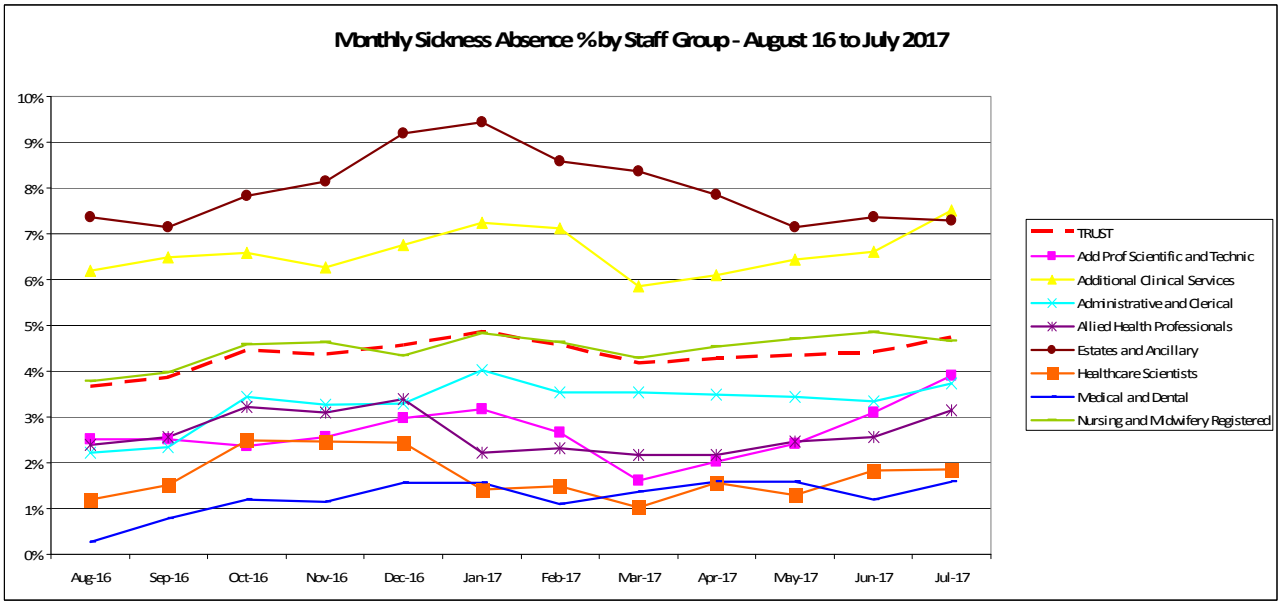
### 1.2.1 Table 1 – Sickness absence reasons for July 2017

| Top three reasons (days/FTE lost) | Top three reasons (episodes of absence) |
|---|---|
| Anxiety/stress/depression – 20.80% of all absence days lost | Gastrointestinal – 20.47% of all absence episodes |
| MSK problems, inc. back problems – 18.80% of all absence days lost | Cold, cough, flu – 18.02% of all absence episodes |
| Gastrointestinal – 10.02% of all absence days lost | MSK problems, inc. back problems – 11.15% of all absence episodes |

The sickness reason of Anxiety / Stress / Depression is now the top sickness reason based on FTE days lost and, compared with the same month of the previous year, the number of FTE Days lost due to this reason has increased by almost two-thirds (the number of FTE Days lost in July 2017 was 2766.59 FTE compared to 1679.48 FTE Days lost in July 2016).

By staff group, the Estates and Ancillary, Additional Clinical Services and Nursing and Midwifery staff groups have the highest sickness absence rates (see Graph 3). Collectively, these staff groups accounted for 70% of sickness absences due to Anxiety / Stress / Depression in the last 12-months.

### 1.2.2 Graph 3 – Monthly Sickness Absence Rates by Staff Group




By directorate, Theatres, Anaesthetics and Critical Care, General and Acute Medicine, Estates and Facilities and Community made up 41.7% of all the FTE days lost in July due to Anxiety / Stress / Depression. These directorates also have the highest proportion of Long Term Sickness cases (of which Anxiety / Stress / Depression is the main LTS sickness reason for each of them). This therefore suggests that Long Term Sickness cases are a big contributory factor to the overall increase in the organisations sickness absence rates.

## 2. Medical Staffing Update

The levels of locum usage typically show a reduction in August following Junior Doctors In July, 99 Full Time Equivalent (FTE) medical locums were requested at the Trust across both York and Scarborough Hospital. In total, 97% of the shifts were filled (96 FTE). Approximately a third of the shifts (31 FTE) were filled via Bank. The highest concentration of requests continues to be in Emergency Medicine, Elderly Medicine and General Medicine, where the Trust is experiencing its most acute shortages. changeover. This August, the Trust welcomed 132 new doctors to the organisation. As part of the cohort, 60 Foundation Year 1 doctors have begun their medical training, while a further 115 doctors across a number of different grades and specialties will be undertaking the next stage in their training at one of the Trust's hospitals (72 of the doctors are new to the organisation). 134 doctors have left the organisation to undertake their next training rotation in another organisation.

Another significant contributor to the Trust's locum usage is its number of Consultant and Middle Grade vacancies. The Trust is taking a number of approaches to try and help address these shortages, including through the delivery of the Specialty and Associate Specialist (SAS) Doctors Recruitment and Retention Strategy. As part of this strategy:

- A business case has been agreed for the introduction of a local CESR Training Programme in the Emergency Department, and a campaign to recruit to the Programme is now in development.
- A corporate approach which provides an option for Specialty Doctors to apply to be re-graded as Associate Specialists has been agreed and is open to applications. The General Surgery & Urology directorate is already developing a business case to support a re-grading application for one of its Specialty Doctors, while other specialties have expressed strong interest.
- An additional two days has been added to the annual leave entitlement for SAS doctors who have completed seven years' service in the grade.

## 3. Recruitment Update

### 3.1 Time to hire and compliance

A recent survey undertaken by the organisation's recruitment system supplier Trac has shown that the Trust's time to hire compares favourably with other organisations. In a survey completed by 73 participating organisations – the majority of which were NHS Trusts – the Trust was ranked 20th for the overall speed of its employment checking processes, with only two of the 19 organisations which ranked higher dealing with a comparable volume of candidate checks. The survey has, however, shown that there is scope for further efficiency in regard to the speed of applicant shortlisting, as the Trust's managers take an average of 9.5 days to shortlist, compared with a median of 8 days in other organisations and a best in class of 3.1 days (notably, in an organisation which deals with a higher volume of applicants than the Trust). The Recruitment Team have planned a number of training events in October and November which are designed to help managers reduce the time they spend completing shortlisting for their vacancies.

The Trust's time-to-hire measures for the six-months to 1 August 2017 are as follows:

#### 3.1.1 Table 2 – Time to hire measures, February – July 2017

| Metric | Trust average (working days) |
|---|---|
| Time taken to authorise vacancy from first requisition | 10.6 |
| Time taken to shortlist | 9.5 |
| Time lapse between invitation to interview and interview date | 9.8 |
| Time taken to complete employment checks | 20.7 |
| Time lapse from vacancy authorisation to candidate start date | 76.7 |

In addition to hire times, the team has recently undertaken an audit of its employment checks compliance, using a sample of eleven files for new starters with the Trust in July and August 2017. The sample showed full compliance with mandatory checks (ID, right to work in UK, criminal records, reference, health and professional registration checks). An area for further action was qualification checks, where the audit highlighted ambiguities in some job specifications which made the specified requirements difficult to validate. This finding will help to inform a review of corporate job descriptions used by the Trust.

### 3.2 Newly qualified nurses

Preparations are continuing for the arrival of 78 newly qualified nurses who will join the Trust throughout September, October and November. The rolling programme of student nurse recruitment has been the result of a collaboration between the Human Resources and Chief Nurses Teams, and has seen the appointment of nurses from universities across the country. In total, the cohort is made up of students from fifteen different universities, with the majority due to graduate from the University of York (60%) and the University of Hull (12%) in the coming weeks. 34 of the cohort attended a welcome day at York Teaching Hospital Social Club on 14 August 2017. This was designed to introduce the students to key staff at the Trust, and help them prepare for their new roles.

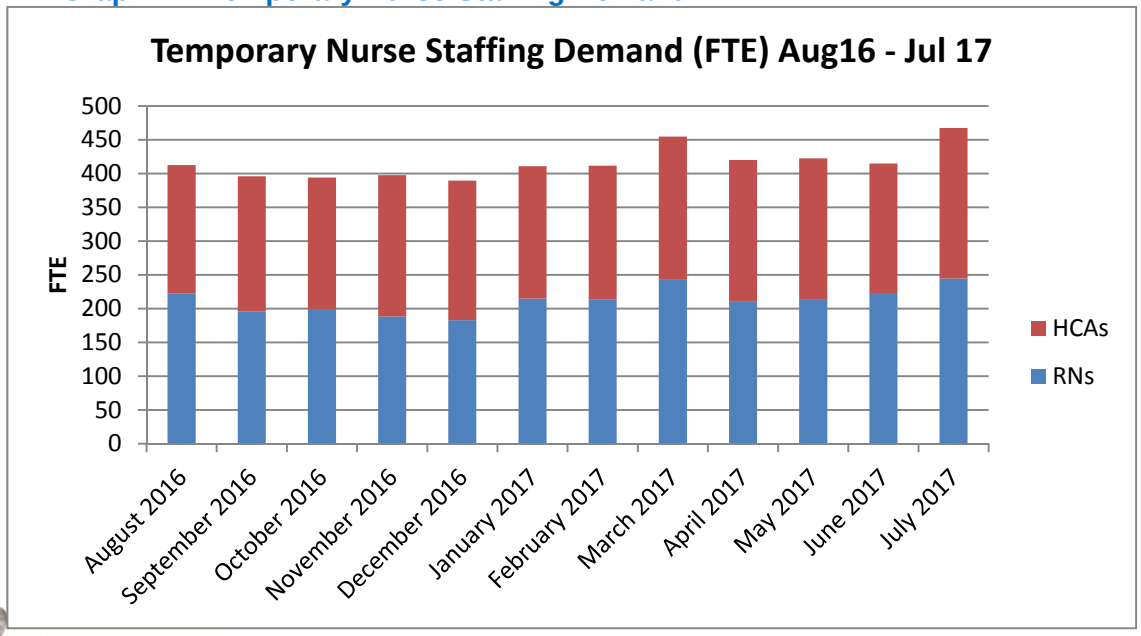
### 3.3 Recruitment Open Event

Following on from the success of previous events, a further Recruitment Event is taking place on Saturday 30th September from 10am to 2pm in the Main Entrance of York Teaching Hospital. The event will focus on opportunities to join the Trust as a nurse – in both qualified and unqualified roles – as well as marketing the availability of apprenticeships and other vacancies. Once again, staff from the Trust will be joined by representatives from City of York Council, who will promote the availability of jobs in Adult Social Care. Previous events at both York and Scarborough have consistently attracted the interest of hundreds of people all wanting a career in the NHS and following extensive coverage on social media the latest event is expected to be well-attended. An update on the event will be provided in the November Board Report.

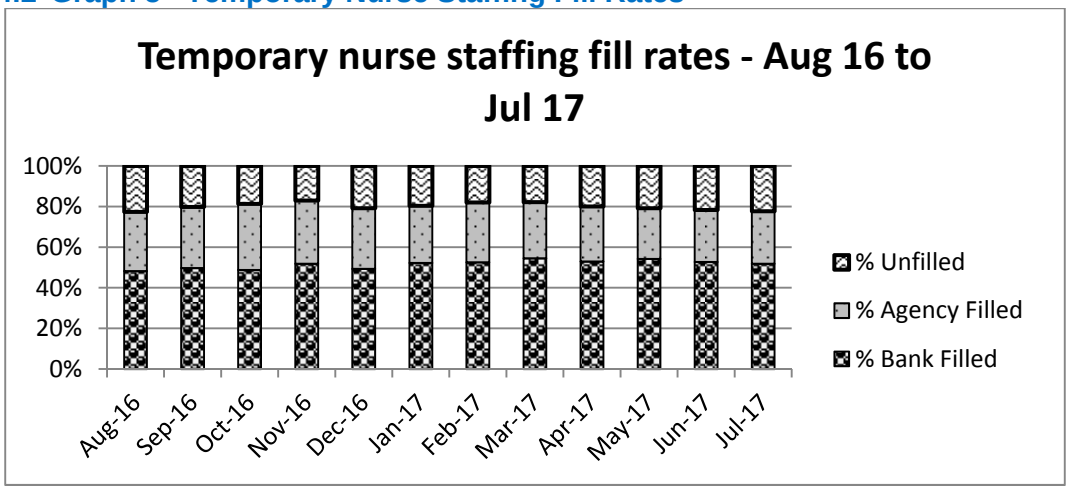
## 4. Temporary Nurse staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has equated to an average of around 416 FTE staff per month. Demand in July equated to 467.61 FTE - the highest level of demand recorded in the last twelve months and more than 22% higher than demand in the same month of the previous year (demand in July 2016 was 382.82 FTE). This was made up of 244.56 FTE demand for RNs and 223.05 FTE HCAs, both notably higher than in the previous month.

### 4.1 Graph 4 – Temporary Nurse Staffing Demand



### 4.2 Graph 5 –Temporary Nurse Staffing Fill Rates




Source: HealthRoster

Graph 5 above shows the proportion of all shifts requested that were either filled by bank, agency or were unfilled. Overall, bank fill rates made up 51.85% of all requests in July (a small reduction from the previous month's bank fill rate of 52.76%). Agency fill rates increased marginally from 25.60% in June to 25.84% in July. The small drop in the bank fill rates is most likely attributable to the beginning of the summer holiday period.

## 5. Development of NMC proposals around IELTS

The International English Language Testing System (IELTS) is one of the main English language tests in the world and is used to assess the language competency of individuals from overseas applying for professional registration with a UK health regulator.

In January 2016, the Nursing and Midwifery Council (NMC) extended the application of its IELTS standards to European nurses applying to work in a registered role in the UK. The standards had previously only applied to nurses seeking to relocate to the UK from outside of the European Economic Area (EEA). The NMC advised that the changes would help to raise standards and protect public safely; however, the decision was controversial, both due to the academic form of the test and what most consider to be the exceptionally high standards it sets for applicants. As a consequence, since January, high numbers of European nurses have had difficulty demonstrating the required level of language competency which has resulted in a significant reduction in nursing workforce supply to the UK.

Following lobbying from NHS Employers, the NMC have agreed to a review of its approach to language testing, and are considering an easement whereby non-UK trained nurses are able to demonstrate equivalence to IELTS if they can show that they have practiced or been taught mainly in English. The NMC are also reviewing the most controversial part of the test: the written element of IELTS; and will explore alternatives alongside the potential for a form of testing which incorporates a greater clinical component.

Elements of the proposals are likely to require public consultation and would take effect towards the end of the 2017 calendar year, or in early 2018.

## 6. Staff Survey

Following the results of the 2016 Staff Survey, work has been undertaken to try and address some of the key themes of the survey. There has been a strong focus on the findings related to violence, harassment and bullying, and one of the key initiatives to try and improve the Trust's response to feedback via the survey has been the development of the 'Fairness Champion' role. This is a voluntary position that will be undertaken by Trust staff and will champion fairness, raise concerns and challenge inappropriate behaviour across the organisation.

On the back of a recent advertising campaign within the Trust, the Freedom to Speak Up Guardian received 43 applications for the role from a range of staff across all sites, grades and professions (from Catering Assistants to Consultants). All of those who applied were interviewed on 7th and 8th September. The new cohort of Champions will then be provided with some initial training for the role in September and October.

While the 2016 Staff Survey Action Plan is still the subject of ongoing work, plans for the 2017 Staff Survey are being finalised ahead of its launch at the end of September. As in 2016, the Trust will undertake a full census paper survey of all staff who were in post on or before 1 September 2017. The survey will run until 1 December 2017 and will include additional questions developed for the Trust in connection with the previous year's findings.

## 7. Non-medical non-nursing agency audit

An audit of the Trust's process for the authorisation and deployment of non-medical non-nursing agency staff was completed by Internal Audit in August. The audit sought to establish that effective systems and processes were in place to regulate the use of agency staff and ensure compliance with NHS Improvement's rules. Following conversations with key staff, a review of Trust policies and procedures, and the study of materials developed on the back of a previous audit, Internal Audit determined that the systems and processes provided significant assurance. This represents a clear improvement from the previous audit conducted 12-months earlier which offered an opinion of limited assurance on the Trust's procedures.

## 8. Employee Relations Update

The table below describes the number and type of employee relations activity in each of the last four months up to and including July 2017.

| Employee Relations Activity | April 2017 | May 2017 | June 2017 | July 2017 |
|---|---|---|---|---|
| Number of Disciplinaries (including investigations)* | 29 | 18 | 24 | 22 |
| Number of Grievances | 9 | 9 | 11 | 1 |
| Number of Formal Performance Management Cases (Stage 2 and 3)* | 3 | 1 | 1 | 3 |
| Number of Employment Tribunal Cases* | 0 | 2 | 1 | 1 |

| | | | | |
|---|---|---|---|---|
| Number of active Organisational Change cases in consultation (including TUPE) | 7 | 9 | 12 | 10 |
| Number of long term sick cases ongoing | 156 | 156 | 160 | 196 |
| Number of short term sick cases (Stage 2 and 3) | 127 | 117 | 124 | 83 |

*staff on medical and dental terms and conditions are excluded from the figures as these are reported by the Professional Standards Team (MHPS).

## 9. 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.

## 10. Recommendation

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

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# End of Placement Survey Report 2016-17

## Recommendation

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

## Current approval route of report

This report is drafted for presentation to the Workforce & Organisational Development.

## Purpose of report

This report provides an overview of student feedback gathered via the End of Placement Survey since 2014-15 from students on placement in Years 3, 4 and 5 across 'All HYMS'* and at Scarborough and York. The majority of activity takes place within York Teaching Hospital NHS Foundation Trust hospitals with feedback from students on placement at Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), in hospices and in primary care also included due to the integrated nature of placements. Responses from students on placement at TEWV account for just under 10% of the Scarborough and York scores with the primary care experience also integrated into the placement.

Response rates have been lower in the last two years compared to 2014-15 with approximately 62% of the population responding in 2016-17.

*'All HYMS' refers to all placement providers linked to the Grimsby, Hull, Scarborough, Scunthorpe and York HYMS Education Centres including hospital trusts, mental health trusts, community interest companies, private healthcare providers and general practices.

## Key points for discussion

There are no specific points for discussion.

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

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

Version number: 1

Author: Alison Evans, Clinical Programmes Officer

Executive sponsor: Michael Proctor, Deputy Chief Executive

Date: September 2017

# Hull York Medical School

## End of Placement Survey Report 2016-17

## York and Coast

### 1. Introduction

This report provides an overview of student feedback gathered via the End of Placement Survey since 2014-15 from students on placement in Years 3, 4 and 5 across 'All HYMS'* and at Scarborough and York. The majority of activity takes place within York Teaching Hospital NHS Foundation Trust hospitals with feedback from students on placement at Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), in hospices and in primary care also included due to the integrated nature of placements. Responses from students on placement at TEWV account for just under 10% of the Scarborough and York scores with the primary care experience also integrated into the placement.

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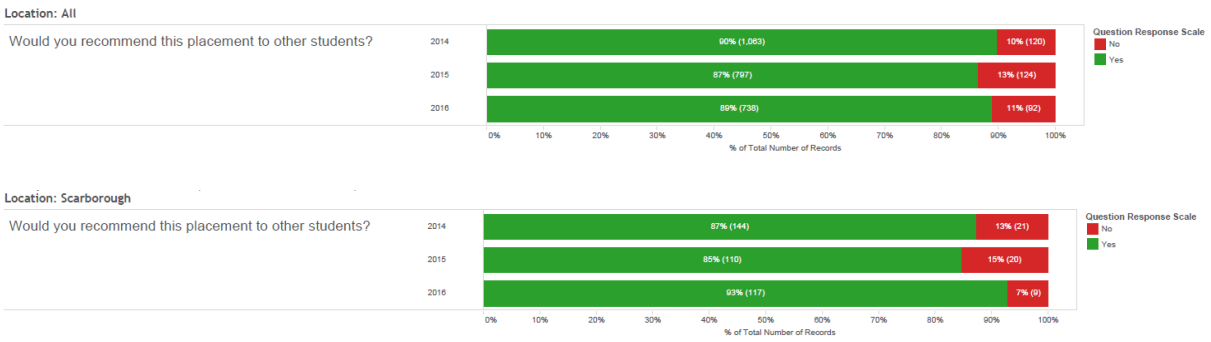
### 2. End of Placement Survey responses

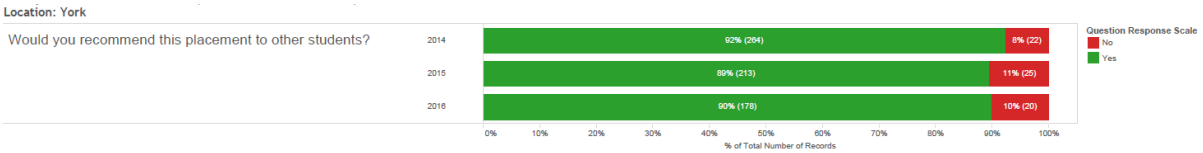
Question responses in this section of the report have been mapped as closely as possible to the question categories used in the National Student Survey (NSS) 2017 (these are shown in Appendix 1).

<u>2.1 Overall satisfaction</u>

A slightly higher percentage of students on placement in Scarborough and York would recommend their placement to other students compared to the 'All HYMS' figure in 2016-17 (figure 1). The 2016-17 figure for 'All HYMS' is 89%, 93% in Scarborough and 90% in York. The scores dipped for 'All HYMS', Scarborough and York in 2015-16 with Scarborough scores making the strongest recovery in 2016-17, jumping from 85% to 93%.

**Figure 1**

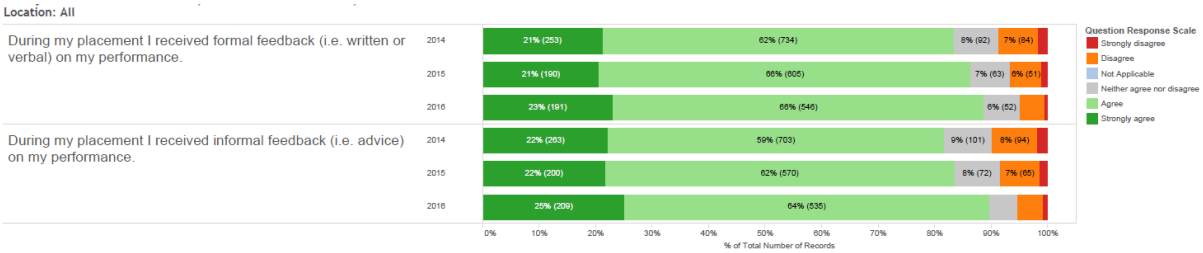




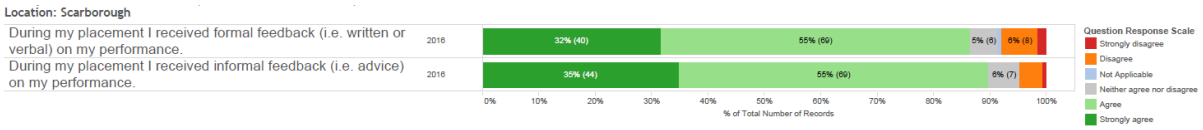

## 2.2 Assessment and feedback

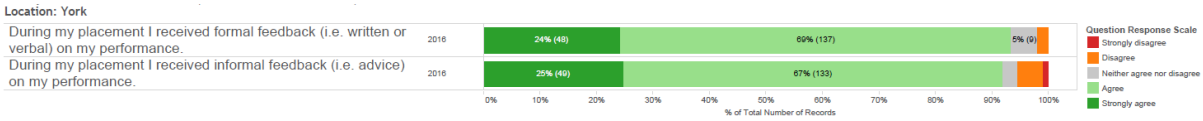
In relation to 'Assessment and feedback', scores in response to questions about students receiving 'formal' and 'informal' feedback have steadily improved with 89% of students agreeing or strongly agreeing with each statement across 'All HYMS' in 2016-17 (figure 2). In York, scores for 'formal feedback' are above those for 'All HYMS' at 93% 'agree' or 'strongly agree' and at 92% for 'informal feedback'. Scores for 'informal feedback' at Scarborough also exceed the 'All HYMS' score at 90% and the score for 'formal feedback' is very close to the 'All HYMS' figure at 87%. When describing a good or excellent tutor, free text comments gathered from across the patch often mention tutors who provide clear, constructive and timely feedback as well as the teaching they have provided, the planning they have undertaken and the support they provide to the students. The overall NSS 2016 'Assessment and feedback' score showed 67% satisfaction. The results from the 2016-17 End of Placement Surveys, below, indicate that some improvement in this area has been made.

**Figure 2**




2016-17 scores only:



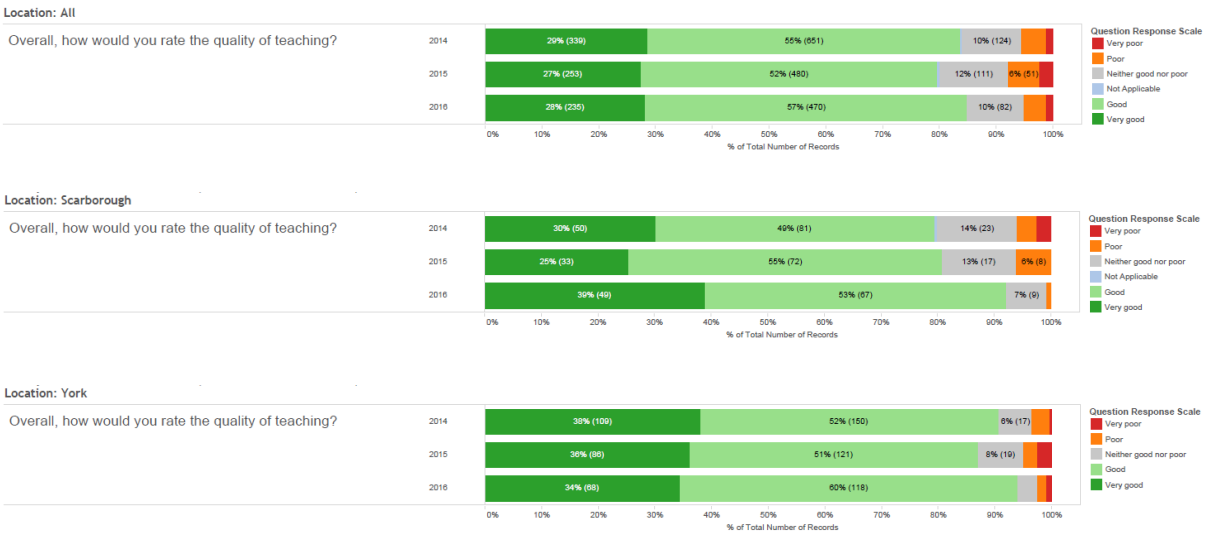

## 2.3 The teaching on my course and learning opportunities

Whilst scoring slightly lower than the scores relating to assessment and feedback, the quality of teaching overall is rated at 85% 'good' or 'very good' across 'All HYMS' in 2016-17 (figure 3). This figure is higher in both Scarborough and York at 92% and 94% respectively. Whilst scores in York dipped in 2015-16, they have recovered well in 2016-17. Free text comments relate favourably to individual secondary care tutors particularly in relation to those teaching in York on the Cardiology, Respiratory and Dermatology block and tutors teaching in the Women's health block in Scarborough with the following examples of this: 'Sessions with Dr A and Dr B were particularly helpful - well planned, and had a good mixture of lecture-style tutorial sessions and bedside teaching,

with the opportunity to take supervised histories/examinations from patients on the wards and receive individual feedback every single week. Teaching in this style, with recurring tutors every week, would have been extremely helpful in the other blocks as well' and 'O&G tutors / dept fantastic, interactive sessions, valuable feedback..'

Whilst the quality of teaching generally scores well, free text comments also show that in some areas students feel there is a lack of both seminar and bedside teaching.

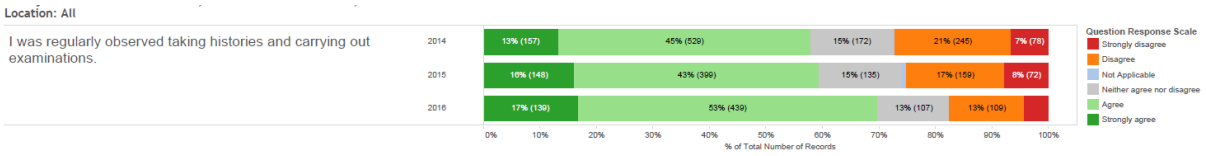
**Figure 3**

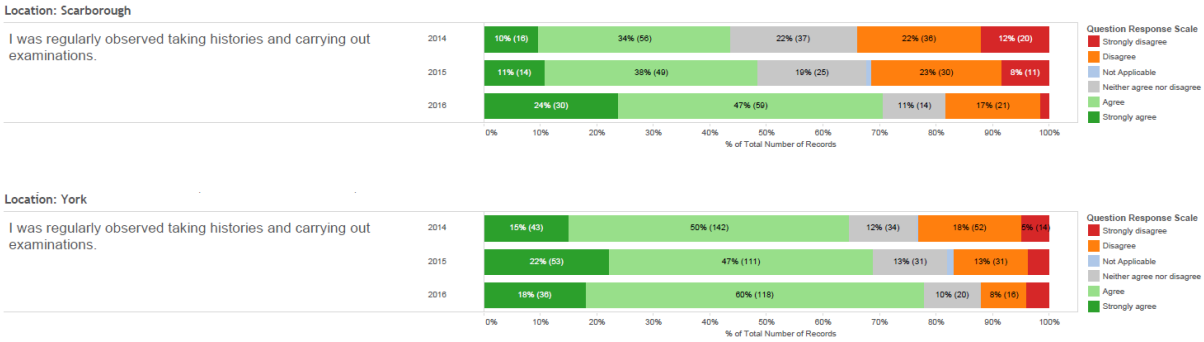



Free text comments also reveal that students in Scarborough feel that they miss out on opportunities during the Cancer block as there is no specific cancer ward at the hospital. One student suggests that 'more cross site lectures' would be useful as would 'enabling students to attend cancer clinics in York'. Comments of a similar nature arise in relation to neurology across sites at HYMS where there isn't a neurology ward or department which is also noted in the NSS 2016 qualitative data. However, students in Scarborough also made positive comments in 2016-17 about the neurology teaching which had been arranged for them.

Notable improvement can be seen across 'All HYMS' in response to the statement 'I was regularly observed taking histories and carrying out examinations' from approximately 58% of students agreeing or strongly agreeing with the statement in 2014 to 70% of students agreeing or strongly agreeing in 2016 (figure 4). Significant improvement was made to the score at Scarborough from 44% satisfaction in 2014 to 71% in 2016. In York, steady improvement over the three year time period saw the score improve from 65% to 78%.

**Figure 4**





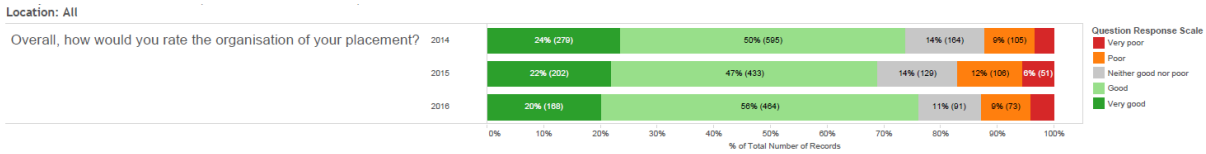


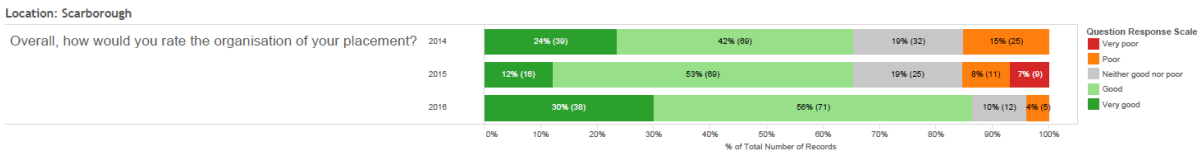


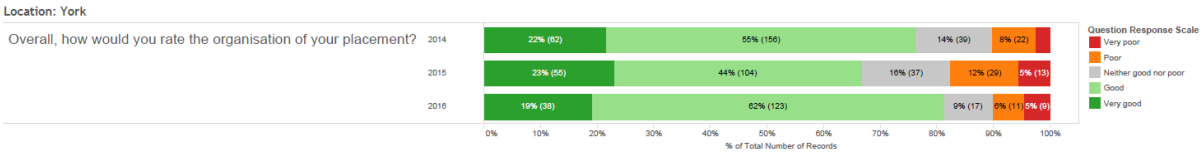
## 2.4 Organisation and management

Scores relating to the organisation of the course and its placements have traditionally been lower than desired in the NSS and incurred a significant drop in satisfaction of 15 percentage points from 2015 to 2016 with a satisfaction score of 67%. The End of Placement Survey scores have improved however from 2015-16 with 76% of students rating the organisation of their placement as 'good' or 'very good' in 2016-17 for 'All HYMS' (figure 5). Scores at Scarborough and York were above the 'All HYMS' score in 2016-17 at 86% and 81% respectively.

**Figure 5**




- The score for 'All HYMS' in response to the statement 'While on placement, timetabled formal teaching sessions took place as planned' have declined slightly from 71% to 68% satisfaction over three years.
- Scores for Scarborough have significantly improved over three years from 71% satisfaction in 2014-15 to 84% in 2016-17 in relation to the same statement.
- The York score is higher than that of 'All HYMS' at 80% satisfaction in 2016-17 which was the same as its 2014-15 score having recovered from a dip to 75% in 2015-16.

Scores relating to the staff who coordinate placements at Scarborough and York are above the 'All HYMS' scores for 2016-17 following significant improvements in this area from 2015-16 (table 1).

**Table 1**

| Staff responsible for the coordination of the placement were helpful (2016-17) |
|---|

| (strongly agree and agree responses) | | | |
|---|---|---|---|
| | 2016-17 | 2015-16 | 2014-15 |
| All HYMS | 87% | 79% | 85% |
| Scarborough | 92% | 67% | 76% |
| York | 92% | 78% | 89% |

2.5 Learning resources

- The quality of facilities** overall scores well in the End of Placement Survey at around 90% satisfaction over the last three years for 'All HYMS'.
- The overall satisfaction with the facilities at Scarborough was 95% and 91% in York, both had improved from the previous year.
- This area in the NSS 2016 gained the highest overall score for HYMS (97% satisfaction) having steadily risen for the previous three years.
- Access to the internet scores the lowest in this section at 65% satisfaction across 'All HYMS'. Students appear to be more satisfied with internet access at Scarborough (76%) and at York (77%) whose scores had both increased from the previous year.

**The areas which make up the 'facilities' section of questions include: access to clinical areas, access to rooms for teaching, access to clinical skills labs, library resources, access to IT facilities and access to the internet.

2.6 Learning community

- 59% of students reported feeling part of the clinical team across 'All HYMS'.
- Students on placement in Scarborough and York have given scores roughly in-line with 'All HYMS' (60% and 56% respectively).
- The 'All HYMS' 2016-17 score was in-line with the 2014-15 score but had dipped in 2015-16. Scarborough and York scores followed the same pattern.
- Examples of free text comments include '…. extremely lovely and helpful staff who enabled you to practice history and examination and become a part of the clinical team' at York and 'Overall I felt part of the clinical team and gained a lot from this placement' at Scarborough provide evidence of clinical areas in which students clearly feel part of the team.

## 3. End of Assistantship Survey responses

The overall satisfaction score gauged by responses to the question 'Would you recommend this placement to other students?' is 97% for 'All HYMS' following the most recent Assistantship which concluded in June 2017 (figure 6). In Scarborough, the score for this question has been 100% for the past two years. The score in York increased from 83% in 2015-16 to 96% in 2016-17. The 4% who responded that they would not recommend the Assistantship equated to one student.

Assistantship population academic year 2016/17: 120 students

**Figure 6**


When considering how prepared students feel after their Assistantship, the feedback shows that a slightly lower proportion of students in Scarborough and York feel prepared compared to the 'All HYMS' figure (table 2) with improvement shown from 2015-16 in York.

**Table 2**

| **Overall I feel prepared to take up my first Foundation post** | | | |
|---|---|---|---|
| | 2016-17 (agree/strongly agree) | 2015-16 (agree/strongly agree) | 2014-15 (agree/strongly agree) |
| All HYMS | **87%** | **77%** | **90%** |
| Scarborough | **82%** | **83%** | **84%** |
| York | **84%** | **76%** | **92%** |

When looking at the free text data, the majority of responses to the question 'What were the best aspects of the placement?' from students in Scarborough and York included a reference to 'feeling part of the team'.

## 4. Conclusion

When considering the End of Placement Survey and End of Assistantship Survey results over the past three years:

- Overall satisfaction with clinical placements gauged by the response to 'Would you recommend this placement to other students?' is slightly above that of 'All HYMS' for 2016-17 for placements taking place in Scarborough and York.
- Scores relating to the 'quality of teaching' are noticeably higher than the 'All HYMS' score in Scarborough and York and free text comments highlight two tutors in particular who teach in Year 3 at York and a Year 4 teaching team at Scarborough.
- Significant improvement has been made in Scarborough in relation to the 'observation of history taking and examination' and steady improvement has also been made in York. Both areas exceed the 2016-17 'All HYMS' score.

- Scores from students on placement in Scarborough are either in-line with, or slightly below, the satisfaction scores for 'All HYMS' in relation to formal and informal feedback. In York, both of these scores are higher than the 'All HYMS' scores.
- The scores for the 'organisation of placements' at Scarborough and York exceed those of 'All HYMS', particularly for placements in the Scarborough area.
- The satisfaction score relating to staff who coordinate placements is higher in both the Scarborough and York areas than the 'All HYMS' score as is the score relating to 'timetabled teaching sessions took place as planned'.
- Scores from students on placement in Scarborough and York are in-line with the 'All HYMS' scores for 'feeling part of the team'.
- Responses in relation to 'access to the internet' made little change from 2015 to 2016 for 'All HYMS' but improved in both Scarborough and York.

The majority of scores relating to placements in Scarborough and York have generally improved over the last three years. Scores which dipped in 2015-16 were in-line with the same pattern seen for 'All HYMS'.

When looking at 'overall' satisfaction with the Year 3, 4 and 5 clinical placement experience at Scarborough and York, both sites exceed the score for 'All HYMS' at 90% or above.

Scarborough exceeds the 'All HYMS' score for the Assistantship in terms of students recommending the Assistantship at this site and has a 100% track record for the last two years. The overall satisfaction rate for the Assistantship at York is in-line with that of 'All HYMS'. Scores relating to how prepared students feel for their F1 post at both sites are very slightly below those of 'All HYMS'.

**Student feedback in 2017-18**

Plans to gather student feedback in 2017-18 include:

- the deployment of separate primary and secondary care surveys to enable clearer reporting of data
- a reduction in the overall amount of survey questions which students are required to answer at the end of a placement
- more targeted questioning in Year 5

Students will also continue to provide feedback: locally whilst on placement; through student representation on committees; through the Student Staff Committee and through focus groups.

Alison Evans, Clinical Programmes Officer

July 2017

**Appendix 1:** NSS question categories

| **NSS category** |
|---|
| The teaching on my course |
| Learning opportunities |
| Assessment and feedback |
| Academic support |
| Organisation and management |
| Learning resources |
| Learning community |
| Student voice |
| Overall satisfaction |

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Freedom to Speak Up report (September 2017)

## Recommendation

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

## Current approval route of report

This draft has been written for the Board of Directors.

## Purpose of report

This is the third report of the Freedom to Speak Up Guardian (FTSUG) which summarises the number and nature of concerns being raised to the FTSUG, the continued development of the role over the last twelve months and the impact it has had within the organisation.

## Key points for discussion

There are no specific key points to raise.

## Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

## Reference to CQC Regulations

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

There are no direct references to CQC outcomes.

Version number: 1

Author: Lisa Smith, Freedom to Speak Up Guardian

Executive sponsor: Patrick Crowley, Chief Executive

Date: September 2017

## 1. National Update

The National Guardian Office (NGO) has recently published the first quarter dataset on speaking up information. All Trust Guardians were asked to submit data from April-June 2017 and 129 Trusts responded. Below is a summary of the national information:

- **936** cases were raised to Freedom to Speak Up Guardians / ambassadors / champions
- **308** of these cases included an element of patient safety / quality of care
- **351** included elements of bullying and harassment
- **65** related to incidents where the person speaking up may have suffered some form of detriment
- **170** anonymous cases were received
- **13** trusts did not receive any cases through their Freedom to Speak Up Guardian

Of the 129 Trusts that submitted data, only 2 Trusts recorded higher contact numbers than our Trust during Q1.

Trust data compared with national data

| | | | | | |
|---|---|---|---|---|---|
| Trust Data | 11 | None | 49% | 24% | 18% |
| National Data | 2.5 | 170 | 37% | 33% | 8% |

### 1.1 Pan Sector event

The first Pan Sector network meeting hosted by the National Guardian for the NHS, Dr Henrietta Hughes, took place on 17 July 2017. There were representatives from KPMG, Clinical Human Factors Group, NHS Improvement, CQC, and Freedom to Speak Up Guardians from Brighton and Sussex NHS Trust, York Teaching Hospital NHS Foundation Trust and Nottingham NHS Trust, Parliamentary and Health Service Ombudsman (PHSO), The Civil Aviation Authority, NHS Providers, The Healthcare Safety Investigation Board and The Institute of Business Ethics.

The purpose of the network was primarily to influence the attitude of organisations, the media and the public about whistle-blowers to reduce the stigma and to enhance the reputation of people who speak up for the benefit of their patients, customers and the public. It shares best practice and encourage consistency, for insight and education and to develop standards. There is also the impact on the bottom line, both financial and altruistic. The network will lead to shared learning and new perspectives, with narratives around positive outcomes and business values. It will foster a positive open culture where workers feel safe and supported to speak up. The network also allows bench-marking across different industries, triangulation of information and consistency. There is the possibility that the network could operate like a think-tank.

### 1.2 NGO national event

The next national Freedom to Speak Up Guardian Day event on Thursday 19 October in London. The event will feature the first national Freedom to Speak Up Awards. They

have received 60 nominations across four categories. The day includes workshops for Guardians. One of those topics is 'Working with the Board' and the NGO have asked the Trust Guardian to lead this workshop as they recognise York as having done some great work on this with a good deal of Board support.

### 1.3 Developing an employment (Whistleblower's) Support Scheme for secondary care

The Freedom to Speak Up report also recommended that staff that have raised concerns and suffered detriment as a result, should be supported to find alternative employment within the NHS. A proposal is under development to deliver a Whistleblower's Support Scheme. The key aim of the scheme will be to support individuals who have raised concerns in the public interest about risk, malpractice or wrong doing in the NHS and have experienced employment difficulties as a result. NHS England is responsible for the delivery of the scheme for primary care with NHS Improvement leading implementation of the scheme for secondary care.

### 1.4 NHS Employers

In July NHS Employers published a 'Share and Learn' case study written by the Trust Guardian. This article attracted international attention, as far away as Australia and some further requests to write articles for other national journals.

### 1.5 Royal College of Nursing

In July the Trust Guardian and Chief Nurse were invited to speak at the national Nursing Times Deputy Chief Nurse Conference in Leeds. They were joined by Dr Henrietta Hughes, National Freedom to Speak Up Guardian to deliver a presentation on 'Whistle blowing: Learning from the past and planning for the future'.

This provided an opportunity for senior nurse leaders from across the country to hear about the Trust's approach to 'speaking up'. The presentation highlighted how organisations can support creating an environment for people to speak out and how to develop and implement a 'freedom to speak up' strategy and a case study was presented.

## 2. Freedom to Speak Up

### 2.1 Promoting the FTSUG role

The Trust has continued to promote the role; new postcards have been printed specific to the FTSU Guardian, as well as the role being signposted in a number of other Trust materials and documents including the revised Personal Responsibility Framework and the staff well-being services.

### 2.2 Training and development

Work is underway with ODIL to produce a bespoke training video on 'handling concerns' as part of all the leadership programmes.

### 2.3 Trust culture

The culture of an organisation has a huge impact on its ability to improve quality and safety. Being free to speak up requires a significant culture change in the NHS, culture change comes from leadership at all levels in the organisation and living the Trust

values and developing our staff makes a huge contribution to this culture.

The FTSU Guardian, supported by the CEO is working in partnership with the senior HR engagement lead to develop an 'Engagement and Leadership Strategy' by the end of the year which will incorporate elements of the national framework launched by NHS Improvement in December 2016 called '**Developing People – Improving Care'.** This will build on the existing OD leadership approaches and initiatives, acknowledging the progress already made, with the aim to further develop current and future leaders with the compassionate, inclusive leadership qualities as well as the specific management skills required to meet today's challenges. A small working group from HR and OD has already been established and scoping work is already underway to provide a gap analysis.

The strategy will include:

- Ways to communicate the strong strategic narrative
- Implementing a Culture of Care Barometer survey
- Creating newly aligned HR policies and procedures
- Developing competent managers through the development of a new training programme
- The employees voice
- The introduction of Swartz Rounds
- The role of the Fairness Champions.

## 2.4 Fairness Champions

Throughout the summer the Guardian and the Equality and Diversity Lead, supported by the CEO, led a Trust-wide recruitment campaign to develop a network of volunteer 'champions'. The role of a 'champion' will support the freedom to speak up agenda, help us to promote fairness, raise concerns and challenge behaviour which is inconsistent with the Trust values. It is hoped these roles will play a key part in tackling the issues highlighted in the last staff survey.

43 applications were received from a wide range of diverse staff from across the whole organisation from all grades and professions from catering to consultants. Following two, full days of interviews, we successfully appointed 28 new champions and have further interviews planned for those unable to attend the initial round of interviews. A robust induction programme is planned for all the new champions.

## 2.5 Internal audit

In July Internal Audit completed the review of raising concerns and whistle blowing. The conclusion was as follows:

There are clearly defined lines of accountability relating to raising concerns and whistle blowing. A Freedom to Speak Up Guardian, Designated Senior Officer and Designated Independent Director are all in place at the Trust.

The Trust's Whistle blowing Policy was found to be consistent with the key elements of NHS Improvement's national standard and to go beyond minimum requirements in areas. The Policy is available to staff via the intranet and is scheduled to be distributed via Staff Matters, although this has not yet taken place. It was noted that raising

concerns and whistle blowing is not currently included within any statutory and mandatory training module provided by the Trust.

Audit testing included the walkthrough of an anonymised case where a concern had been raised. We were able to confirm that the Trust's Freedom to Speak Up Guardian had appropriately recorded the concern and relevant dates as well as updates being fed back to the individual. We also confirmed a three month well-being check was scheduled to be carried out. The on-going investigation was being undertaken by an appropriate, independent individual.

Through our fieldwork we were also able to confirm for instances where an individual had raised a concern, through the Freedom to Speak Up Guardian that would have been more appropriately escalated through another Trust Policy, such as Bullying and Harassment, reasonable action had been taken.

We therefore offer an opinion of Significant Assurance on the effectiveness of the processes in place to enable staff to raise concerns and whistle blow.

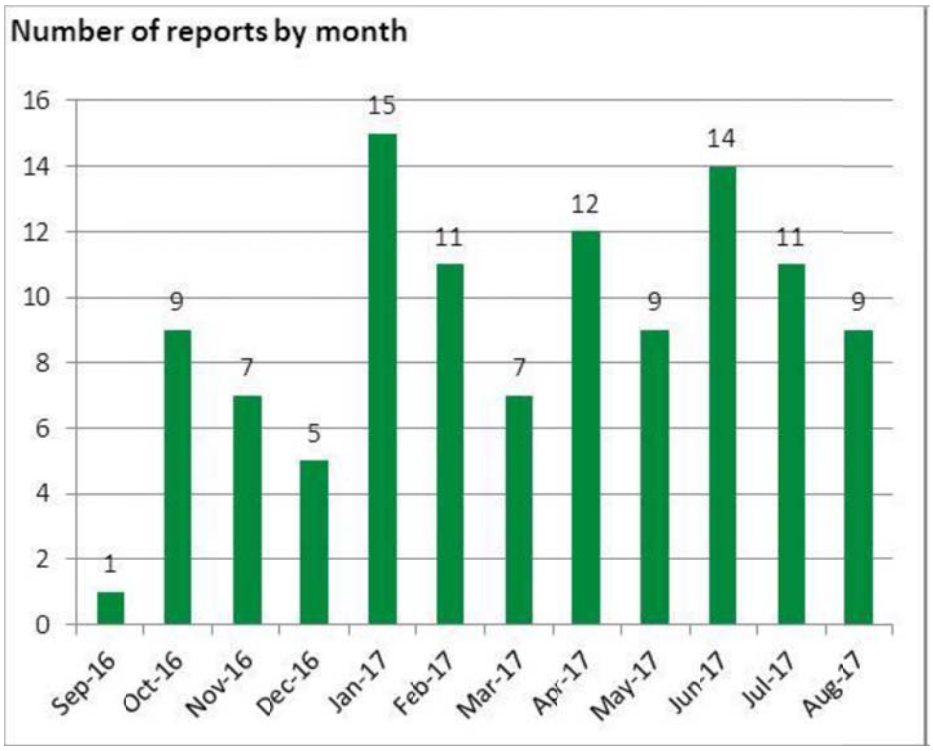
## 3. Concerns Raised

Since the launch of the role at the end of September 2016 to the end of August 2017 the total number of individual 'speak up' contacts has been 110. The average number of 11 new concerns per month remains consistent. The current number of 'open' cases is 17. Trust site breakdown is as follows:

- 70 York
- 31 Scarborough
- 8 Bridlington
- 1 Community.

The charts below detail numbers of concerns received for each month, the job roles of the individuals contacting the FTSU and the main themes. The wide range of individuals who are raising concerns indicates that the role has reached all parts of the organisation.

There have been no immediate patient safety concerns raised.


Number of reports by month
16
14
12
10
8
6
4
2
0
1
9
7
5
15
11
7
12
9
14
11
9
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Oct-16
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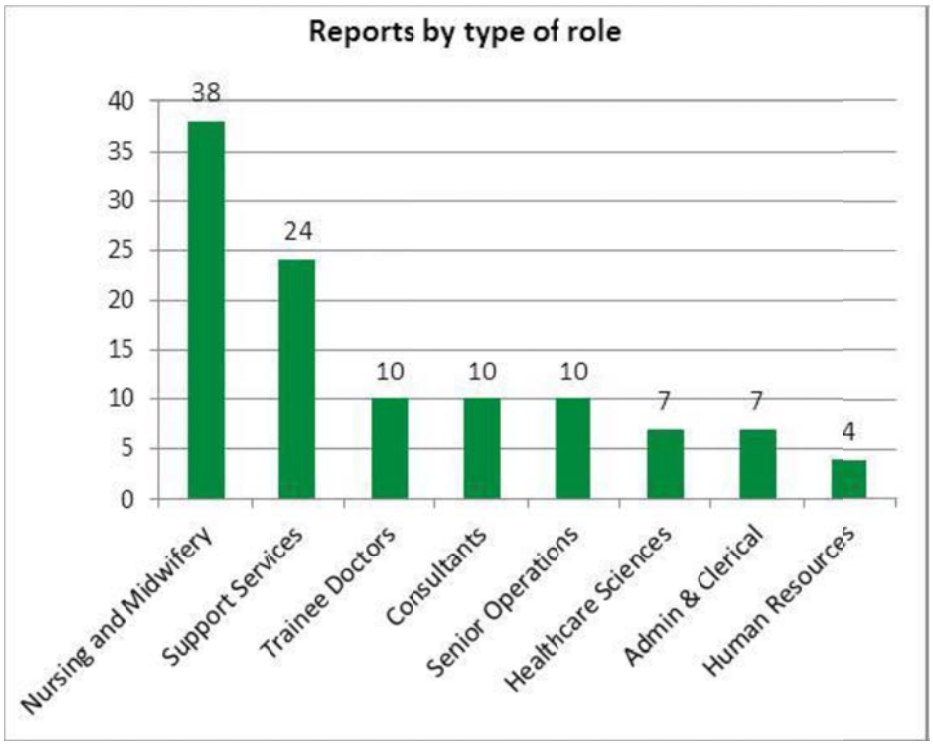
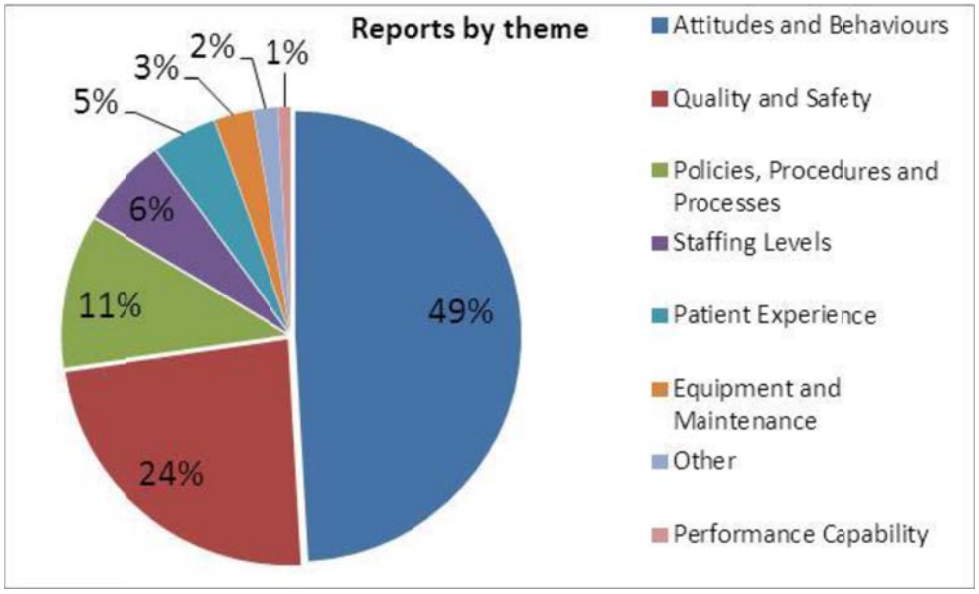
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17


Reports by type of role
40
35
30
25
20
15
10
5
0
38
24
10
10
10
7
7
4
Nursing and Midwifery
Support Services
Trainee Doctors
Consultants
Senior Operations
Healthcare Sciences
Admin & Clerical
Human Resources

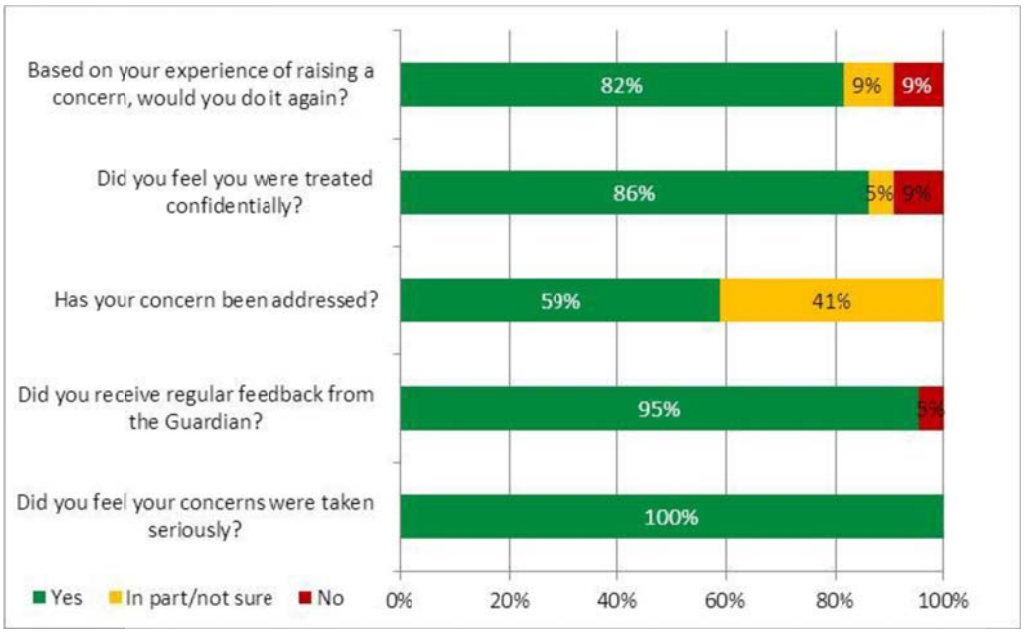


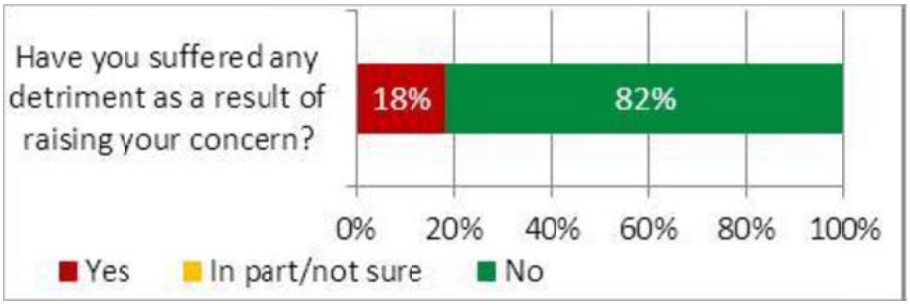

## 3.1 Themes : learning not blaming

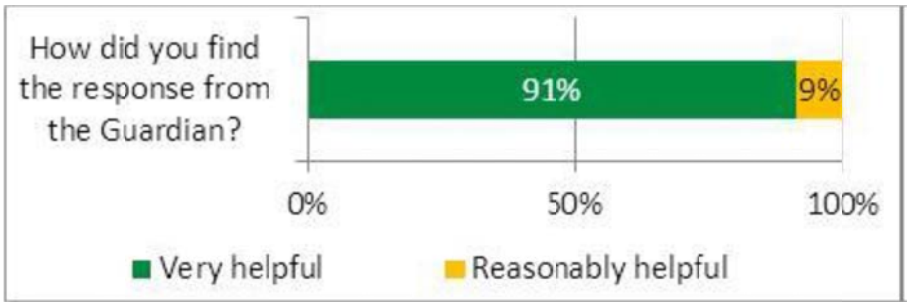
- Investigations taking too long
- Pessimism that anything would change as a result of speaking up
- Worries about repercussions
- The important of responding to issues as soon as possible after they are raised – this gives confidence to workers that they are being listened to and taken seriously
- Giving and receiving feedback is crucial and usually appreciated by all involved
- Good working relationships with HR and communications colleagues are essential.

## 3.2 Survey results following closure of a concern

Following the closure of a concern, where appropriate, staff are followed up by the Guardian and asked the following questions:




## 4. Conclusion

Whilst the FTSU Guardian role is to respond to and support staff who wish to raise concerns, it is also key to supporting and influencing an open culture where speaking up becomes business as normal and this requires a pro-active approach to culture change.

The expectation is that implementation of all the above actions and developments will help improve the experience of all of our staff and therefore our patients.

## 5. Recommendation

The Board of Directors are asked to:

1. read and note this report; and
2. endorse the development of an 'Engagement and Leadership Strategy'.

York Teaching Hospital
NHS Foundation Trust

# Board of Directors – 27 September 2017
# Guardian of Safe Working report (September 2017)

## Recommendation

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

## Current approval route of report

This draft has been written for the Board of Directors.

## Purpose of report

This paper sets outs the background and context around the introduction of the Guardian of Safer Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust.

## Key points for discussion

This paper sets out to execute the responsibilities of the Guardian of Safe Working (GSW) by giving assurance to the Board that doctors are working safe hours. The report includes aggregated data on exception reporting, broken down by categories such as speciality, directorate and grade and where appropriate, and will give details of any fines levied against departments for breach of terms and conditions relating to safety.

It aims to:

- Identify to the Board any areas where there are current difficulties maintaining safe working hours, including rota gaps / staff vacancies and locum usage
- Outline to the Board any plans already in place to address these
- Highlight to the Board any areas of good practice and/or persistent concern which may require a wider, system solution.

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

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

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

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

There are no direct references to CQC outcomes.

Version number: 1

Author: Lisa Smith, Guardian of Safe Working

Executive sponsor: Patrick Crowley, Chief Executive

Date: September 2017

## 1. Update from the Guardian of Safe Working

Currently 272 junior doctors working under the 2016 terms and conditions. By the end of October 2017 all of the Trust's doctors in training posts will have transitioned to the 2016 terms and conditions. Additionally, all 'Trust Grade' doctors being contracted from August 2017 onwards will fall under the new 2017 Trust terms which include the provision to exception report and receive work schedules.

### 1.1 Junior Doctors' forum

Having established a reasonably successful forum (with a junior doctor as the Vice-Chair) and produced our first newsletter at the end of July (before the main August rotation of trainees), membership and momentum had to be re-established and this will take some time. The GSW attended all junior doctor induction days and promoted the forum as well as discussing the desired Trust culture around exception reporting – which is to have an open culture where trainees feel safe to raise exception reports without fear of reprisals.

### 1.2 Exception reporting and Guardian fines

Dr Steven Lord joined the team as the 'exception reporting champion' as a way of addressing safe working practices and is helping facilitate clinical discussions between trainee and supervisor where appropriate and helping the GSW develop recommendations as a result of exception reporting.

Exception reporting must be seen throughout the Trust as a positive thing which keeps staff and patients safe by highlighting problems that the Trust can then address. Trainees must not be fearful of submitting them.

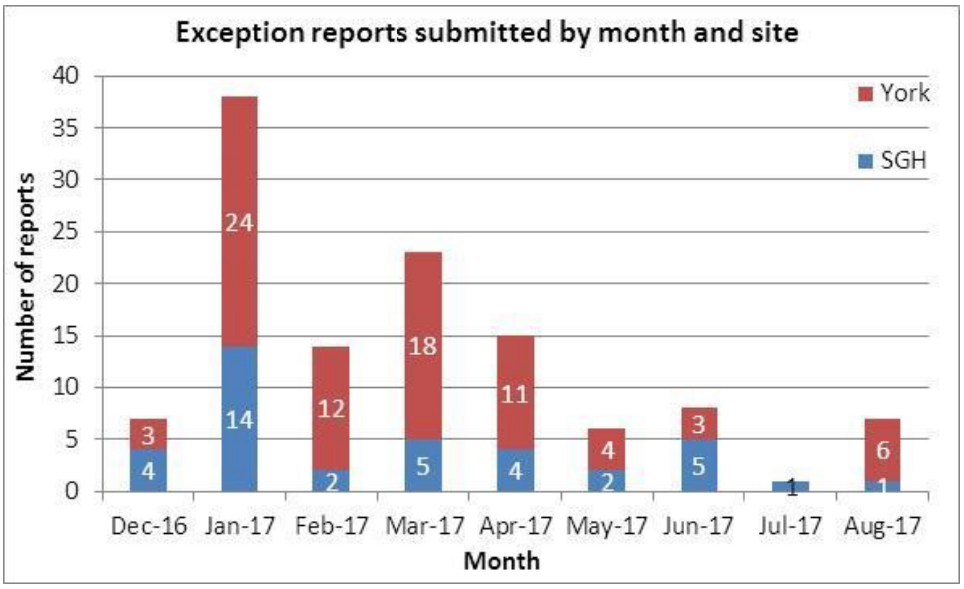
Training and raising awareness of this with consultants is vital to the culture change. Despite a significant push and several reminders from the DME and the Medical Director, records indicate that only 28 Educational Supervisors have undertaken the HEE training on dealing with exception reports.

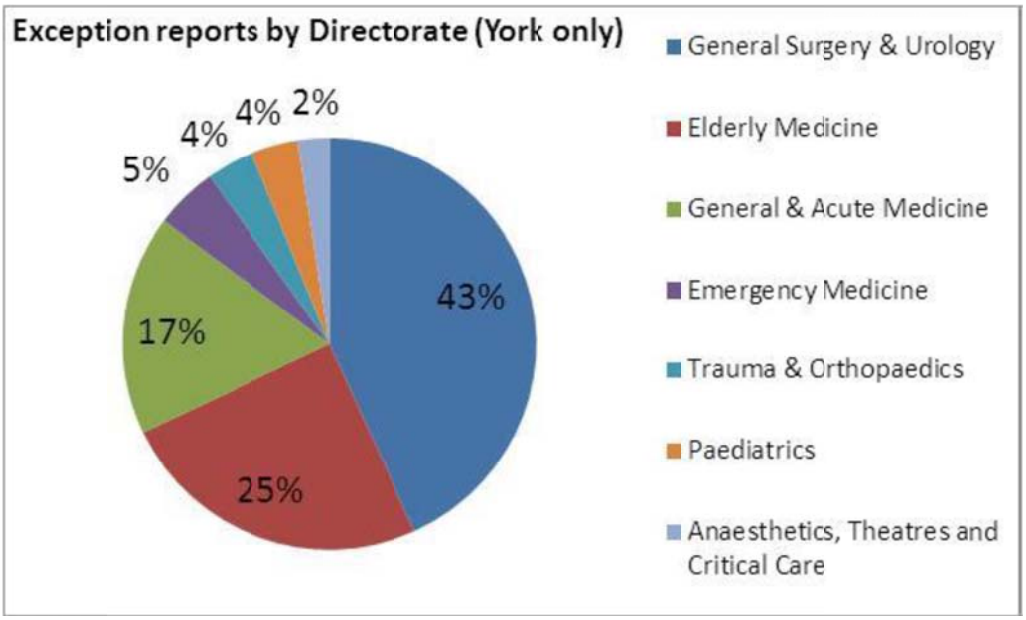
- Overall 71.43% of exception reports were closed within timescales.
- 32% of reports came from Scarborough Hospital and 68% came from York Hospital
- 95.80% came from FY1 doctors, 0.84% came from ST1 doctors, 2.52% came from ST3 doctors, 0.84% came from CT1 doctors
- The 119 reports came from 22 doctors
- 58 have resulted in payment to the Trainee for additional hours worked (total of 75.75 hours claimed with a value of £963.54)
- 42 have resulted in TOIL being approved (total of 50 hours claimed)
- 117 are concerning Hours & Rest
- 2 are for Education & Training.

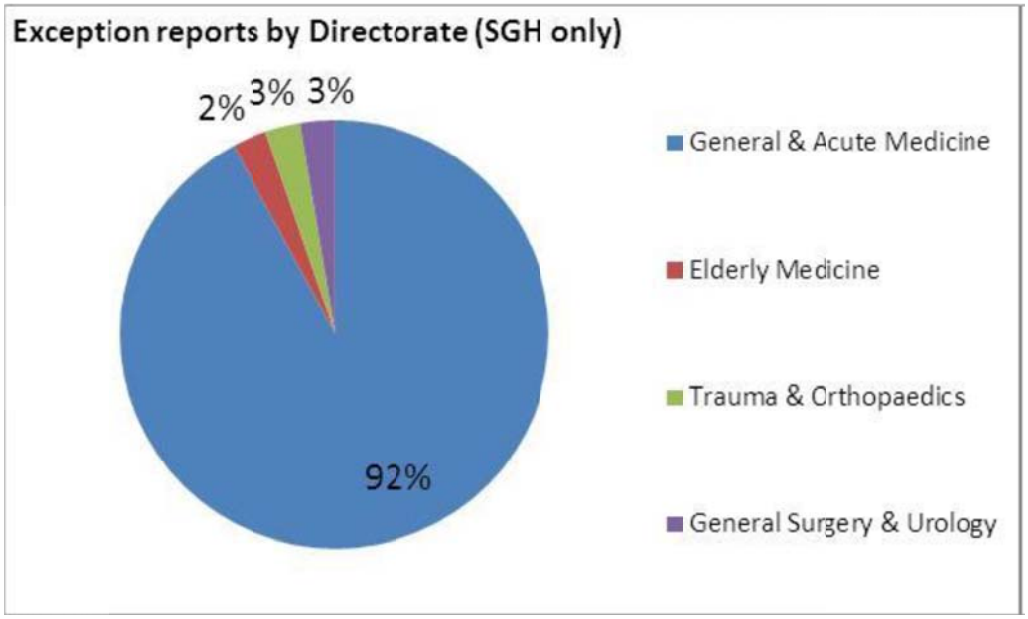
## 1.3 Guardian fines

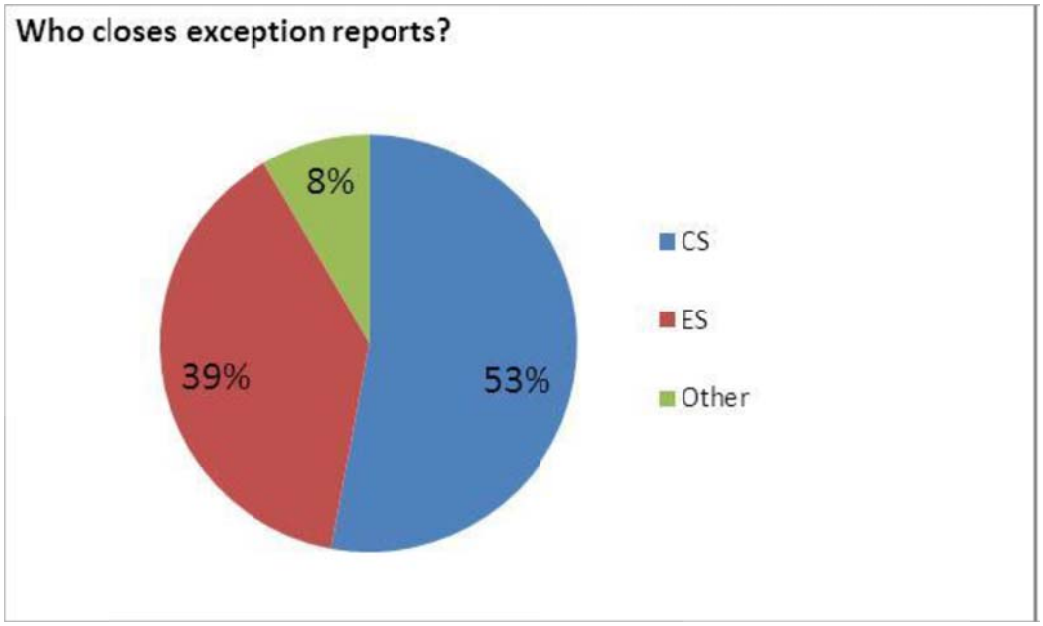
1 fine has been levied against the Elderly Medicine Directorate. This is because one trainee was unable to achieve more than 75% of their breaks over two, four week reference periods. The fine is calculated by multiplying the applicable hourly rate at the time each break was missed by two. Note this is done only once per missed break, regardless of how many 4-week reference periods that the missed breaks/s fall within. This resulted in a total fine of £ 147.18. The Guardian receives the whole amount of the fine (no proportion is paid to the trainee) and the Junior Doctor Forum will decide how the monies will be spent.

Below are the charts using aggregated data from exception reporting.






## 1.4 Positive outcomes from exception reports / Guardian interventions

- Chestnut Ward case study: the concerns on Chestnut continue to be monitored and support offered to the staff. Below is some feedback recently received from NHS choices which has been shared with all staff involved with Chestnut.

> *"Outstanding care from all staff in Chestnut Ward - I was admitted to Chestnut Ward on Monday 7th August and discharged on Monday 14th of August. I would like to thank all the staff in Chestnut Ward for their amazing care and attention which made my stay in hospital completely stress free and comfortable. I would like this opportunity to say a massive thank you to you all."*

- Change of ward (and therefore Clinical Supervisor) for one trainee due to relationship issues

- Avoiding a breach: time off in lieu (TOIL) arranged directly by Guardian for one Trainee to ensure adequate rest before a breach of the 72 hour in 7-day period rule

- Rota Changes: FY1 surgery rotas in York did not allow for attendance at mandatory FY1 teaching meaning that each week they FY1 doing 1pm until midnight shift from Monday to Thursday was always working 30 minutes to one hour minutes uncompensated, and mandated, before their shift begins. Rota change in progress.

## 1.5 Challenges

### 1.5.1 Medical Ward SGH

Trainees working consistently outside of work schedules: Beech ward at SGH is a very busy large medical ward with effective nursing leadership and a total of five Consultant Physicians providing patient care. As such it can be a challenging environment in which to work and tends to accommodate the sickest patients in the hospital including those stepping down from Intensive Care, and others undergoing non-invasive ventilation therapy. One of the particular challenges on the medical wards at Scarborough is the provision of adequate supervision of the junior medical team in an environment in which middle grade posts are hard to recruit to. In addition, the Core and Higher Trainees in Medicine have extensive commitments away from the ward in order to fulfil their training requirements (e.g. clinics and procedure lists), and this can impact on their ability to support the junior medical team in managing the patients on the ward.

In response to potential safety concerns in August, it was decided to temporarily reduce the capacity on Beech ward by one bay. This allowed consolidation of the junior medical and nursing resource over a smaller bed base. In addition there was re-allocation of middle grade medical support from other areas to cover the rota gaps generated by the difficulty in recruiting appropriate staff to cover. All members of the team have been encouraged to report ongoing concerns and the medical staffing situation (at all grades) is being closely monitored going forward and the GSW is working closely with the deputy medical director.

### 1.5.2 Culture and engagement

Engagement remains a challenge in terms of junior doctors themselves, educational and clinical supervisors and wider management teams in respect of their responsibilities around exception reporting. Some of this is being addressed through attending each junior doctor induction and training events for consultants (such as clinical governance meetings, grand round, etc) plus meetings with management teams. A new link to resources has been established on the Learning Hub for all supervisors. Concerns remain from junior doctors about reprisals.

## 1.6 Rota gaps for doctors currently on 2016 (new) terms and conditions

A rota gap is a post in a rota pattern that is vacant and not filled with a doctor (training or non-training) and therefore a department is essentially one person (or potentially more) down in numbers. This doesn't mean that the burden falls to the other doctors, (if this was the case then a rota change would be applied) as either a full time locum or where deemed manageable the out-of-hours element of the rota would cover the rota.

## 1.7 York vacancies

| Post type | Comments |
|---|---|
| Elderly GPSTR x1 | Covered with full-time locum until February 2018 |
| Elderly CT x1 | Post vacant until February 18, covered with Full time locum, not being currently advertised as the F3 post may occupy this slot |
| ENT GPSTR x1 | Out of hours only being covered by Bank Locums, not being advertised |
| AMU ACCS x1 | Post vacant for 6 months, full-time locum occupying slot, being advertised at the moment |
| ED ACCS x1 | Post vacant for 6 months covering ad-hoc shifts only, being advertised at present |
| M/G/P FY2 x1 | Post vacant for 4 months only on call shift being covered |
| GP FY2 x1 | Post vacant due to Maternity leave, post not being covered |
| T&O CT x2 | Both post being covered by full time locum, post out to advert |
| T&O F2 x3 | All posts being filled by fulltime locums, posts out to advert |
| Vascular CT x1 | Only on calls being covered, the post will be filled by an MTI Doctor however no start date is available at present |
| Respiratory CT x1 | Fulltime locum occupying slot until December 17 |
| Stroke Registrar x1 | Post not being filled, as the rota had a doubled up slot on it |
| Cardiology Registrar x1 | Post not being filled |
| Neurology Registrar x1 | Long term vacant post not being filled |
| Chemical Pathology Registrar x1 | No Locum cover required, post not being backfilled or advertised |
| Microbiology Registrar x1 | No Locum required, post not being backfilled or advertised |
| Histopathology Registrar x1 | No Locum cover required, post not being backfilled or advertised |

## 1.8 Scarborough vacancies

| Post type | Comments |
|---|---|
| Elderly CT x4 | Currently all these posts are being covered with full-time locums. The posts have been advertised and 2 x new starters have been recruited commencing in December and the remaining posts will be filled with Bank, not Agency Locums going forward |
| Elderly GPSTR x1 | |
| Bridlington CT x1 | |
| Respiratory CT x1 | All posts filled with full-time locums at present, this will change to Trust grade FY2 occupying from December |
| Gastro CT x2 | |
| Gastro Registrar x1 | Filled with Full time locum, adverts going out |
| Respiratory Registrar x1 | Filled with Full time locum, adverts going out |
| Cardiology Registrar x2 | Filled with Full time locum, adverts going out |
| O&G FY2 x1 | Being covered by a Bank Locum, advertised, but didn't recruit |
| O&G FY2 Trust Grade x1 | Being covered by a full-time Agency locum. Post was offered to a candidate but they turned down the post |
| O&G Registrar x1 | Being covered by a full-time Agency locum, post advertised by no suitable candidates, post back out to advert |
| Paediatrics FY2 x1 | Covering On call only, recruitment has taken place however no-one wanted a post in Paediatrics |
| Paediatrics STR x1 | Fill time locum covering at the moment, but post has been recruited too with an anticipated Mid-October start date |
| Paediatrics Registrar x1 | Full time locum covering vacancy, recruitment has taken place, but no suitable candidates |
| Surgery FY1 x1 | Covering On call shift only |
| T&O FY1 x1 | Covered by a full-time locum, post out to advert |
| Surgery CT x2 | Covered by 1 x full-time locum and 1 x On call shifts only. Recruitment is ongoing |
| Surgery Registrars x4 | Covered by 3 x full-time locums and 1 x covering On calls only |
| ED CT x2 | All covered by full time locums |
| ED ACCS x1 | |
| GP FY2 x1 | Post vacant until December, post not being backfilled |
| Anaesthetics ST x1 | Covering On calls only |
| Anaesthetics Trust grade x1 | Covering On calls only |

## 1.9 Feedback on GSW role

As part of the 2016 TCS it is recognised as good practice for the GSW to gain feedback on the role from both junior doctors and consultant supervisors. Although the role had only been in place for eight months before the end of the 2016 junior doctor rotation, the GSW felt it was important to gain feedback from this first cohort of trainees on their experience of working with the GSW.

During July the GSW sent out an anonymous survey to all members of the JDF and LNC, with a response rate of 80%

***Respondents:***

| | |
|---|---|
| Junior Doctors | 28% |
| Supervisors | 32% |
| Other | 40% |

***The GSW is:***

Independent in the role

| | |
|---|---|
| Strongly agree | 50% |
| Agree | 50% |

Visible within the Trust

| | |
|---|---|
| Strongly agree | 64% |
| Agree | 32% |
| Disagree | 4% |

Successfully engaging with supervisors

| | |
|---|---|
| Strongly agree | 64% |
| Agree | 23% |
| Neither agree or disagree | 13% |

Advocating on behalf of junior doctors Strongly agree 82%
Agree 18%

Making a difference to the safe working environment for junior doctors Strongly agree 46%
Agree 54%

The GSW has credibility within the Trust Strongly agree 48%
Agree 52%

Comments received by respondents:

1. Lisa works very hard and has formed good working relationships locally,

regionally and nationally and improved the training experience for junior doctors.

2. GSW has excelled at her role, and I believe that other Trusts look to York as the benchmark of how the role should work within their organisations too.

3. Extending the role to doctors not in training posts would be a huge 'added-value' action.

4. Having attended some of the Junior Doctor Forum meetings, I know that Lisa is making a real difference to the working lives of juniors. I think it was a very forward thinking move by the Trust to have the same post holder carrying out both Guardian roles as the potential for linking issues across different areas of the Trust is maximised. However, as the culture within the organisation shifts towards safer working hours and more as more individuals feel empowered to raise concerns and 'blow the whistle', I think it unlikely that a single post holder will be able to manage the increasing demands of the role. As the pressures on the Guardians time increases, there may be more need for the roles to be split or for a role put in place to provide her with permanent support rather than the temporary support currently available.

5. The combination of 2 roles that both have the potential to expand could limit what is achievable.

6. I think the dual role could be confusing for staff. It would be easy for non-medical staff to assume that you are representing/associated with the junior doctors only.

7. Our guardian is excellent in her role. She is fair minded, persistent, consistent and able to engage with staff from all levels in the organisation effectively. How did we manage without her!

8. Needs to be listened to and action taken for any concerns raised by her.

9. I think that as the roles of GSW and FSU have become embedded in the organisation, and become visible and used by all staff groups that the role being combined might at some point become unmanageable and the role might need to be split. I think we have seen the GSW role gain real credibility and make a difference to Junior Doctors in training. I believe that we have also started to change perceptions across the Trust of the role that both the Guardian, that she really does make a difference.

## 2. Conclusion

Exception reporting has been active for nine months now. We have made some initial progress and had some good outcomes. We have also encountered some problems. We now have 272 doctors on the 2016 contract which as the new terms and conditions embed we will be able to see the impact exception reporting is having. The key to making this a positive change where both staff and patients benefit is engagement from the junior doctors themselves and support from the educational and clinical supervisors.

## 3. Recommendation

The Board of Directors are asked to:

1. read and note this report; and

2. encourage clinical directors, directorate managers and educational and clinical supervisors to be aware of their responsibilities within the new contract and continue to support junior doctors to work safely.