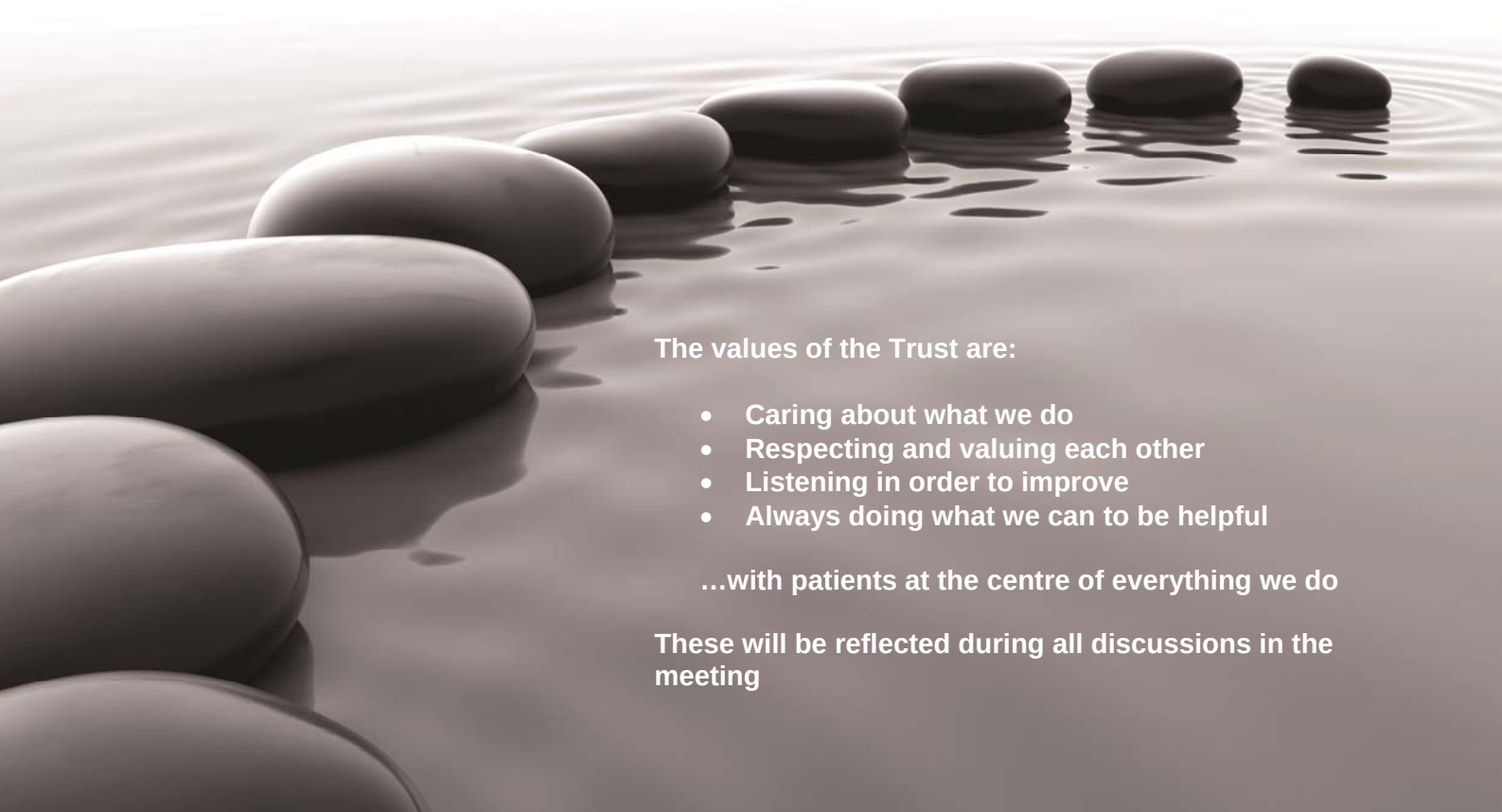
York Teaching Hospital NHS
NHS Foundation Trust

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

on: **Wednesday 28 October 2015**

in: **The Lecture Room, St Catherine's Hospice, Throxenby Lane, Scarborough, YO12 5RE**

Time	Meeting	Location	Attendees
8.15am – 8.55am	Non-executive Director Meeting with Chair	Room 3, St Catherine's Hospice	Non-executive Directors
9.00am – 11.45am	**Board of Directors meeting held in public**	**The Lecture Room, St Catherine's Hospice**	**Board of Directors and observers**
11.50am – 12.35pm	Remuneration Committee	The Lecture Room, St Catherine's Hospice	Non-executive Directors
12.35pm – 1.00pm	Lunch		
1.00pm – 3.45pm	Board of Directors meeting held in private	The Lecture Room, St Catherine's Hospice	Board of Directors



The values of the Trust are:

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

…with patients at the centre of everything we do

These will be reflected during all discussions in the meeting

York Teaching Hospital NHS
NHS Foundation Trust

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

On: **Wednesday 28th October 2015**

At: **9.00am – 11.45am**

In: **The Lecture Room, St Catherine's Hospice, Scarborough, YO12 5RE**

A G E N D A					
No	**Time**	**Item**	**Lead**	**Paper**	**Page**
Part One: General					
1	9.00-9.10	**Welcome from the Chairman** The Chair will welcome observers to the Board meeting.	Chair		
2		**Apologies for Absence and Quorum** • Brian Golding	Chair		
3		**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chair	A	7
4		**Minutes of the Board of Directors meeting held on 30 September 2015** To review and approve the minutes of the meeting held on 30 September 2015.	Chair	B	11
5		**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chair		
6	9.10-9.15	**Patient Story**	Chief Nurse	Verbal	

No	Time	Item	Lead	Paper	Page
7	9.15-9.35	**Chief Executive Report** To receive an update on matters relating to general management in the Trust	Chief Executive	C	25
Part Two: Quality and Safety					
8	9.35-10.05	**Quality and Safety Committee** To be advised by the Chair of the Committee of any specific issues to be discussed. • Patient and Quality Safety Report • Medical Director Report • Chief Nurse Report • Safe Nurse and Midwifery Staffing Report • Patient Experience Quarter 2 Report • Nursing & Midwifery Revalidation	Chair of the Committee	D D1 D2 D3 D4 D5 D6	31 41 75 85 95 103 135
9		**Quarterly Infection Prevention Control Report** To receive the quarterly Infection Prevention Control Report	Director of Infection Prevention and Control	E	147
10	10.05-10.20	**Community Care update** To receive an update on Community Care from the Director of Out of Hospital Care	Director of Out of Hospital Care	F	155
Part Three: Finance and Performance					
11	10.20-10.50	**Finance and Performance Committee** To be advised by the Chair of the Committee of any specific issues to be discussed. • Operational Performance Report • Finance Report • Trust Efficiency Report • Performance Recovery Plan	Chair of the Committee	G G1 G2 G3 G4	161 173 183 197 203

No	Time	Item	Lead	Paper	Page
12	10.50-11.05	**Winter Plan** To discuss and approve the draft winter plan for 2016.	Chief Operating Officer Head of Operational Strategy	H	207
11.05-11.15		Coffee break			
Part Four: Workforce strategy Committee					
13	11.15-11.30	**Workforce Metrics and update report** To receive a report updating the Board on the workforce metrics	Chief Executive	I	229
Part Five: Environment and Estates Committee					
12	11.30-11.40	**Minutes of the meeting held on 23 September and Terms of Reference** To approve the terms of reference for the Committee and note the minutes from the last meeting • Terms of Reference • NHS Protect Report (management Security)	Chairman of the Committee	J J1 J2	237 245 253
Part Six: Governance					
13	11.40-11.45	**Monitor Quarterly Return** To review the quarterly return prior to submission to Monitor	Finance Director	K	269
Any other business					
15		**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 25 November 2015 in the Boardroom, York Teaching Hospital			
16		**Any other business** To consider any other matters of business.			

Items for decision in the private meeting:

MARs scheme

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
October 2015

York Teaching Hospital NHS
NHS Foundation Trust

Additions: No changes

Changes: No changes

Deletions: No changes

A

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

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

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultan-cies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or com-missioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Juliet Walters (Chief Operating Of-ficer)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Andrew Bertram (Executive Director Director of Finance)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member** of the NHS Elect Board as a member representa-tive	Nil
Mr Mike Proctor (Deputy Chief Execu-tive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Spouse a senior member of staff in Community Services	Nil
Beverley Geary (Chief Nurse)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Dr Ed Smith Interim Medical Di-rector	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Jim Taylor Interim Medical Di-rector	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Boardroom, The York Hospital on 30 September 2015.

Present:	**Non-executive Directors**	
	Ms S Symington	Chairman
	Mrs J Adams	Non-executive Director
	Mr P Ashton	Non-executive Director
	Mr M Keaney	Non-executive Director
	Ms L Raper	Non-executive Director
	Mr M Sweet	Non-executive Director
	Professor D Willcocks	Non-executive Director
	Executive Directors	
	Mr P Crowley	Chief Executive
	Mr A Bertram	Director of Finance
	Mrs B Geary	Chief Nurse
	Mr M Proctor	Deputy Chief Executive
	Dr E Smith	Interim Medical Director
	Mrs J Walters	Chief Operating Officer
	Corporate Directors	
	Mr B Golding	Director of Estates and Facilities
	Mrs W Scott	Community Director
In Attendance:		
	Mrs L Brown	Head of Communications
	Mrs A Pridmore	Foundation Trust Secretary
Observers:	Mrs A Bolland	Governor – Selby
	Mrs M Jackson	Public Governor - York
	Ms P McMeekin	York Teaching Hospital
	Mrs S Miller	Public Governor – Ryedale and East Yorkshire
	Ms L Pratt	Healthwatch - York

The Chairman welcomed the Governors and members of the public to the meeting.

15/134 Apologies for absence

Apologies were received from Mrs S Rushbrook, Director of Systems and Networks and Mr J Taylor, Interim Medical Director.

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

15/135 Declaration of Interests

There were no further declarations of interest.

15/136 Minutes of the meeting held on the 19 August 2015

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

15/137 Matters arising from the minutes

There were no matters arising.

15/138 Patient Story

Mrs Geary presented a patient, as told by the patient's wife and long term carer. Mrs Geary summarised the difficulties this long term carer had experienced, in relation to her husband's hospital admission and stays. Mrs Geary outlined the support the Trust seeks to give patients and families.

Mrs Scott added that there was additional support that could be provided by her team in Community. It was agreed that Mrs Scott and Mrs Geary will discuss further outside the meeting.

This was an insightful patient story which reflected not only the patient's perspective, but also that of a close family member and carer. The story challenged the effective use of the 'All about me' form routinely used on wards..

The Chair thanked Mrs Geary for the presentation.

15/139 Report from the Chief Executive

Closure of Bootham Park Hospital – Mr Crowley advised that all inpatients at the hospital run by Leeds and York Partnership NHS Foundation Trust had either been discharged into the community or offered other accommodation. The area of concern for the Trust relates to the impact the closure could have on the psychiatric liaison service. He confirmed he had received assurance from the Chief Executive of Leeds and York Partnership NHS Foundation Trust that the service would not be affected.

Mr Proctor referred to the Chapel that is adjacent to Bootham Park Hospital, which is used by the Trust for some out-patient services. Leeds and York Partnership NHS Foundation Trust, also use the building, but are moving their services to other locations. The environment is adequate for out patient services and the Trust has not been advised by the CQC that the Chapel is included in the closure notice for Bootham Park Hospital. If the CQC wish the building to be closed, as part of the overall closure, a conversation will need to take place with the Trust.

Professor Willcocks referred to a place of safety. Mrs Geary added that as a result of closing Bootham Park Hospital, the 136 Suite has also been closed; this could impact on the Emergency Department.

The Board discussed the recent decision by Virgin Healthcare to not progress the delayed contract with Hambleton and Richmond CCG for the Whitby Hospital. It was confirmed that the Trust would continue to support the CCG and services where ever possible. Mr Sweet asked if Humber MH NHS Foundation Trust had now been awarded the contract. Mr Bertram explained that the Trust had been awarded the contract, but there was a required standstill period of 10 days before any discussions could take place.

Mr Bertram reported to the Board that from 1 July 2015 to 30 October 2015 the Trust was being paid a compromise settlement for any work it undertook for Hambleton and Richmond CCG related to the Whitby contract. From 1 November the recharge would be on an actual cost basis.

The Board expressed their disappointment and noted the comments and assurance given.

CQC report – Mr Crowley reported the Quality Summit was planned for Friday 2nd October. Monitor has invited 24 people including representatives from the CCGs, Healthwatch, Overview and Scrutiny Committee, NHS England, the Trust and Monitor.

The event will include a presentation from CQC on their findings with a response from the Trust. This will be followed by a presentation from Monitor and some work around action planning.

Mr Crowley advised that at this stage the Trust has not received the final reports, although the Trust was promised the reports would be sent during the day.
Post meeting note: The reports were received by the Trust on 30 September 2015.

Visit to Virginia Mason South central Foundation (SCF) Alaska – Mr Crowley explained that he would like to reflect on what he saw on his visit to Alaska. He did feel there were parallels between the two organisations. He agreed he would also share his thoughts with the Council of Governors. It was agreed it would form part of the agenda of the Board to Board meeting to be held on 5 November with the Council of Governors.

Action: Include reflections on the Alaska visit in the Board to Board discussion on 5 November.

Freedom to Speak Up – Mr Crowley confirmed that it had been agreed that Mr Ashton would undertake the role of the Independent Guardian.

Emergency Care Improvement Programme

Mr Crowley reported the Trust had been invited to be part of the Emergency Care Improvement programme. He advised that Mrs Walters was leading the work. He added that he thought this represented a growing recognition of a need for whole system working.

Mrs Walters added that the work has already started and was progressing well.

The Board noted the report.

15/140 Quality and Safety Committee

Ms Raper referred to the Nursing and Midwifery conference. She was very impressed by it and felt it was an excellent event and is looking forward to the next one.

Ms Raper reported that the Committee had a growing focus on risk registers and would now include the practice of reviewing the Medical Director and Chief Nurse risk register at the beginning of every meeting, in addition to the deep dives into individual registers from time to time.

Infection Control

Ms Raper asked Mrs Geary to talk about the annual report and the current performance of infection control. Mrs Geary reflected that last year had been a challenging year with significant pressures being managed. The Trust had reported 59 cases of C-Diff against a trajectory of 59. She added that this year has continued to be challenging, but recently, the incidence of C-Diff had started to reduce.

Mrs Geary added that since taking up the role of Director of Infection Prevention and Control she had introduced a number of key initiatives including a ward accreditation programme.

The Trust has been an outlier for MSSA, as a result she has introduced improvements in cannual care and aseptic techniques. The Trust is slowly seeing a reduction in the number of reported cases.

Care of the deteriorating patient

Ms Raper referred to the deteriorating patient and explained that this had been a focus of the committee for sometime. She invited Dr Smith to update the Board.

Dr Smith referred to post-take12 hour review which was part of a CQUIN in 2014/15, but was not included this year. Measurement has continued and shows that performance can be improved. He explained what the acute and general physician's work practices currently are and outlined the work that needs to be undertaken to improve performance.

The Board discussed the working patterns and understood that some of the challenges were related to the national debates currently being held and changing the working patterns could have some cost implications.

The acute and emergency strategy includes 7 day working and the Trust has established a seven day working group to progress this work and provide momentum.

Ms Raper asked if any specific action was being taken to address the dip in performance in Scarborough. Dr Smith explained it related to historic recruitment issues. He gave an example of some of the challenges- in respiratory medicine there has been a 90% increase in admissions over the last 12 months, but there is only one physician. He confirmed that action is being taken.

The Board acknowledge the significant recruitment challenge that relates to our acute sites.

CIP and Clinical review of quality impact

Ms Raper expressed a concern that there was limited senior medical involvement in the review of CIPs for the impact on quality. Mr Bertram advised that the issue had been discussed at the Finance and Performance Committee and a senior consultant had been identified to fulfill that role.

Mr Crowley reminded the Board that the Clinical Directors all have responsibility for reviewing their CIPs for any impact on quality. The use of the Deputy Director of Nursing and a Senior Clinician for a final review is a further level of assurance.

Ms Raper raised a concern about the patient safety walk rounds. She had noted that a number of walk rounds had been postponed and night walk rounds were not taking place. She expressed how important she felt the walk rounds were in terms of safety and helping the Non-executive Directors to understand the issues.

Mr Crowley commented that safety is paramount to the organisation. The Board discussed the principles around the walk rounds and Mr Crowley added that it was instinctive to broaden the remit, but not move away from the safety principles.

Professor Willcocks endorsed Ms Raper's comments and gave the example of a walk round she had recently been involved with where the ward had put itself into special measures in an effort to change the culture and learn from experience.

Post meeting note: The concern raised will be followed up with the Chief Nurse outside the meeting by the Quality and Safety Committee.

Mrs Adams asked if there was confidence in achieving the CQUIN targets for this year. Mr Bertram advised that CQUIN was included in the discussions at the Finance and Performance Committee and was also a workstream in the Turnaround Avoidance Programme (TAP). He advised that he was not confident all CQUIN would be delivered this year, but he expected the majority to be delivered. Mrs Walters added that there are definitely some risks associated with the CQUIN this year, which were compounded by the delay in agreeing the final CQUIN for the year.

The Board thanked Ms Raper for her report.

15/141 Community services

Mrs Scott presented her paper. She advised that Scarborough and Ryedale CCG and Vale of York CCG have confirmed that community hub funding will continue until end of March 2016; at that stage further evaluation of the services will be undertaken. She referred to the comments of leading academics including Professor Chris Ham, Chief Executive of the Kings Fund who advises that serviced developments like our hubs take time to embed and develop. Demonstrating success is challenging and Mr Crowley added that the view of the executive team is that managing the local growth in referrals should be deemed as a success, even if there has not been an overall reduction in admissions. The Board discussed what criteria could be used to demonstrate success. The Board agreed that managing the growth in the system would be a sensible criterion.

Mrs Scott reported that patient feedback is sought from service users by asking them to complete a patient satisfaction survey. Professor Diane Wilcocks complimented Mrs Scott on the analysis in her paper.

Mr Proctor referred to a recent event held in Selby. Representation from all stakeholders involved in the Selby Hub work attended and patients who have used the service presented their stories. The event was well attended and feedback was excellent.

Ms Raper asked if the staff feedback had been codified so that lessons could be learnt. Mrs Scott advised that this had not happened as yet, but it would be undertaken.

Mr Crowley reinforced Mrs Scotts comments about Professor Ham adding that initiatives need to be given time to demonstrate an impact. The current pressures in the system mean that there is a fine balance between ensuring financial balance and quick results and giving services enough time to mature and develop and demonstrate benefits.

The Board thanked Mrs Scott for her report.

15/142 Finance and Performance Committee

Mr Sweet presented the report. He explained the approach to the meeting had been changed to integrate the Turnaround Avoidance Plans. It had been agreed that Mr Cooney would join the Finance and Performance Committee in future to provide the TAP information.

Operational reports – A&E performance

Mr Sweet referred to the decline in performance in the ED department and asked Mrs Walters to comment. Mrs Walters reminded the Board that the 4 hour target is not just about the ED department, it is about the wider system. She apologised that month on month improvements had not been made. Improvements had been made, but the team is struggling to maintain the changes. The Acute and Emergency Strategy is being implemented, and as expected in August, there was an increase in attendances in Scarborough. This increase was also impacted by workforce challenges currently being addressed and junior doctors starting in the Trust in August.

Mrs Walters explained that people work in a particular way in Scarborough ED, reflecting in specific learnt behaviours. The behaviour has to change to ensure patients are moved out of the ED department swiftly, to an appropriate bed in the hospital if being admitted. Support is being provided through the service improvement team. Dr Smith added in terms of learnt behaviours, two or three years ago the ED department had people in beds in the department. He added that there is a known pressure point in August. There are further developments with the introduction of the Advanced Clinical Practitioner (ACP) role. At present there are three in place and three training.

The Board recognised that August in Scarborough was unique in that the population increases significantly. It was also recognised that in the past the department were able to appoint GP trainees in to the department, this year there have not been any trainees available to appoint.

Mr Crowley added that the Trust must maintain its belief in the changes. There is growth and changing demand in the system and developing a sustainable model takes time and success will be judged on the results of sustainable delivery. He added that there is growing emphasis on the tripartite agreement.

Mr Crowley reflected on what he had seen at Virginia Mason, Seattle and advised that the average wait in the ED department is four and half hours. He added that it is important not to forget the excellent work our staff are doing. The Board agreed that staff are working very hard and providing a comprehensive service to our patients.

Mr Keaney added that 90% bed occupancy in Scarborough is an excellent foundation on which to build on.

Mrs Walters is focused on delivery of the strategy and must maintain confidence. Ms Raper reminded the Board of the importance of the balance of risk and ensuring informed judgments are made.

18-Weeks

Mrs Walters commented that performance is not as strong as was planned. As part of their action plan Maxfax have added extra sessions at Bridlington to address some of the backlog. The expectation is the target will be achieved across the Trust except for two specialties, Maxfax and Ophthalmology and they are continuing to work on their action plans.

In relation to the incomplete target, work continues to reduce the backlog.

Efficiency and finance report

Mr Sweet advised that delivery of CIPs has slowed, but the level of recurrent savings is much higher than has been seen before. At present the part year adverse variance against the Monitor profile is £3.4m which is impacting on the overall financial position. Mr Bertram described the profile approach to the management of CIPs and explained the benefit to the system.

Mr Bertram added the CIP target for this financial year is £25.8m and at present overall delivery is £11.6m; this position is £1m ahead of delivery at the same point last year. Mr Bertram explained that panel discussions have been set up and the directorates continue to be challenged to deliver the target.

Mr Bertram reported on the financial position – he advised that the position has deteriorated to an actual deficit position of £6m against a planned deficit of £3.5m at the end of August. Mr Bertram added that while the overall position has deteriorated by £1.4m during August, this was in line with planned expectations and meant that the Trust had managed to meet its in month plan. He added that he believed that the Trust was seeing the improvements in expenditure control. Elective activity reduced in August as expected, and expenditure has also decreased, particularly of note is the reduction in the agency spend, although it does continue to be a pressure.

Mr Bertram referred to the vacancy levels and agency spend work being undertaken by the Chief Nurse team. He explained that a review, ward-by-ward is being undertaken. The review is looking at the shifts, budget allocation, vacancies and use of agency staffing. The team undertaking the work has completed about 33% of their objective.

Mr Bertram advised that it has been arranged for the TAP team to meet with Monitor's Transformation and Turnaround team and share the Trust's approach to turnaround. He added that the team has been invited by the Treasury Department to demonstrate the Trust's approach to turnaround.

Mr Keaney asked for further clarification on the agency cost position. Mr Bertram explained that before August work had started on a number of pieces of work to address the agency costs including the acuity work and the use of specific agencies.

Mrs Geary referred to the agency rules published by Monitor and advised that the rules suggest the percentage spend on agency for the Trust should be no more than 3% for financial year 2016/17 and 4% for the current financial year. She reported that 73 newly registered nurses will be joining the Trust in the next month and the Trust is recruiting for a further 60 registered nurses to start work in the Trust from December. A review of the skill mix and acuity of patients has been undertaken, including a review of one-to-one nursing with the aim of becoming more effective.

In July the expenditure on agency staff was running at 20%. In August that has dropped to 14%. The allocated budget just under 5%. The Board discussed how to achieve the target and it was agreed it would not be possible if it left unacceptable safety gaps in staffing levels.

Mr Keaney asked about the development of new business. Mr Bertram explained the plan to grow orthopedic work on the east coast by growing market share; he explained that it had been included in the initial business case for Bridlington. Further debate is now being held to consider how to increase the use of the capacity. He gave the example from Bridlington of a cardiologist employed by the Trust who now has proposed undertaking a new procedure in the catheter theatre in York.

Mr Keaney was pleased to hear about the work, but was concerned that the Trust would not be able to get the staff to support the additional work. Mr Crowley reminded Mr Keaney that the developments are medium term.

Mr Keaney was pleased to see that elective cancellations have reduced to 17%.

The Board noted the report.

15/143 Communication and Engagement Strategy

The Chair welcomed Mrs Brown, Head of Communications to the meeting and invited her to give her presentation. Mrs Brown presented the strategy. She outlined the importance of the strategy and highlighted the key strands.

Dr Smith asked Mrs Brown about the future developmental use of Twitter. Mrs Brown explained the intention was to use it is a focused way, the intention being to work with patient experience and be more effective with Twitter and social media generally.

Professor Willcocks asked about the approach to stakeholders and made the suggestion that she would like to have more understanding of what the view of stakeholders was about the Trust. Mrs Brown agreed that at this stage that information is not readily available, but is something that will be developed.

The Board reviewed and approved the strategy.

15/144 HR Report – Workforce of the Future

Mr Crowley presented the report. He explained that the report maps a journey the Trust has been on since the point of merger. He highlighted the challenges and difficulties the Trust managed in addressing the inequities and in bringing the two organisations together. He added the report shows significant movement and determined effort to achieve reduction in the reliance on temporary staff and illustrates a reduction in the number of band 5 nursing staff. The report highlights the changing roles and approaches that have been adopted in the organisation over the last three years. Mr Crowley concluded that the report demonstrated innovative approaches to improve recruitment of staff. By example he highlighted that further incentives being offered to staff who agree to work as part of the bank.

Professor Willcocks commented that the two different christmas tree diagram show a very big change. She added that she felt it was important not to under estimate the ground work that Peta Hayward completed when she was Director of HR and the follow on work that Mrs Holden has been completing in recent months around removing the anomalies and creating new opportunities.

The Chair added that this fits in with her recent comments on the development of leaders. She added that there is a point at which the Trust has to offer jobs that fit with the needs of individuals. Mr Crowley felt that too much flexibility exists in the system to fit with people's lives and there needed to be more discipline and clarity about what the organisation wants.

Mrs Adams was disappointed that more progress had not been made of the economies of scale in support services. Mr Crowley commented that corporate teams had seen investment following integration particularly on the Scarborough site. The consideration is what happens next. Mr Crowley advised that a similar review to that taking place in finance will be undertaken in HR. Work continues to develop a paperless (case notes) system. The Board discussed the introduction of paperless case notes and recognised the challenge that will be to some staff.

Mr Golding added that with in the estates and facilities department management had been tightened up on integration and additional staff had been put into Scarborough. The report masks the reduction in staff that had also been made and continues to be made.

Mr Crowley gave another example of the IT directorate where staff had been rationalised and CIP has always been delivered. The department had also implemented the full CPD system, which would have been very expensive for the Trust to purchase commercially.

Mr Keaney asked what was stopping the organisation from introducing paperless case notes now. Mr Crowley explained that it related to learned behaviours around paper support and ensuring everyone had confidence in the CPD system. He felt the

organisation was well placed for making the change, but the effect of the integration should not be underestimated. Dr Smith supported the comments made and added that it is a big change for a lot of people. There are still some challenges in getting some consultants to use the electronic results system rather than a paper based system.

The Board recognised that the catalyst for this development would be the implementation of the electronic prescribing system.

The Board noted the comments and the report.

15/145 Research and Development Report

Mr Proctor presented the paper. He explained that he was just beginning to work with the department to understand the challenges it is managing. He had recognised that the biggest risk and challenge is the level of income. He explained that the baseline for the number of research projects was set very high and now the Trust was struggling to achieve the number of projects required.

The Board noted the comments.

15/146 Education Report

Mr Proctor presented the report, he outlined that the report was quite narrowly focused and he is working with the department to understand the full breath of the service.

Mr Proctor outlined some of his expectations for future developments in the department and specifically talked about developing the relationship with the universities to encourage them to take people from the local area who would then look to stay in the local area.

Professor Willcocks added that Coventry University in Scarborough will be very important as will St John's University and the Colleges that provide training to the Healthcare Assistants. Mr Proctor agreed with her comments and said he still had to meet with these organisations.

The Board noted the comment.

15/147 Food and Drink Strategy

Mr Golding presented the strategy. He explained that all Trusts are required to produce a strategy that covered three areas - patient nutrition and hydration, healthier eating for patients and staff and sustainable procurement. Mr Golding explained how the strategy addressed these areas. He asked the Board to agree to sample to food on an annual basis as it had done earlier this year.

Mr Sweet asked if there would be specific performance targets monitored as part of the strategy. Mr Golding confirmed that there would be set performance targets including the level of food waste.

Mrs Adams asked how the requirements fit with the requirements of the PLACE assessment for food and hydration. Mr Golding advised that Bridlington now receives

food prepared in York. Mr Golding referred to a pilot introducing catering staff on the wards to provide a beverage service for patients. The pilot had been in one ward and was very successful. The business case for the introduction of the service across the Trust was not supported due to the cost. The Board discussed the trial and the suggested that provision of the service should be reviewed again, perhaps by using volunteers. Mrs Geary confirmed that the number of volunteers and the roles are being reviewed by the Patient Experience Team and she would include this in her review.

Action: The Board agreed to test the food on an annual basis.
Mrs Geary to feedback to the Board on the use of volunteers in the provision of a beverage service of inpatients.

15/148 Environment and Estates Committee

Mr Sweet advised the Committee had held its first meeting during September and would meet on a quarterly basis. The intention was for the Committee to rotate around to different sites and follow the F&P and Q&S model. At the next Board meeting the minutes and the Terms of Reference would be included for the Board to consider.

The Board noted the comments.

15/149 PLACE results 2015

Mr Golding presented the results from the latest Patient Led Assessment of the Care Environment (PLACE). He highlighted the extent of the audit and explained the 5 domains including the domain around dementia that has been introduced this year. Mr Golding outlined the results from the audit and the improvements that had been made since the last audit. Professor Willcocks asked if the dementia domain reflected the Sterling guidelines. Mr Golding confirmed that the domain did not reflect the Sterling guidelines and he would feed that back to the centre.

The Board noted the results of the audit.

15/150 Key Matters arising from the meeting of the Audit Committee held on 14 September 2015 and 13 July 2015 time out meeting

Mr Ashton advised that a further report on the actions from the time out meeting held on 15 July 2015 would be prepared for discussion at the December Board meeting.

Mr Ashton referred to Internal Audit and explained that the Executive Directors commission internal audit from time to time to undertake additional audits where the Executive Directors are aware of existing issues. Currently, this results in a poor level of assurance for the area and although there is no evidence of staff being discouraged from bringing such information to the attention of Directors, it has been identified that this could be a risk. Mr Ashton explained that Internal Audit are looking at how these commissioned reports should be presented.

The Board noted the comments.

15/151 Annual Report of the Audit Committee

Mr Ashton presented the report. He advised that the report had been reviewed by the Audit Committee and presented to the Council of Governors.

The Board noted the report.

15/152 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 28 October 2015, in the Lecture Room, St Catherine's Hospice, Scarborough.

15/152 Any other business

Dates for diaries – Ms Symington reminded Board members that on 5 November it had been arranged that the Board would meet with the Vale of York CCG and in the afternoon the Board would meet with the Council of Governors.

Monitor quarter 1 return – Mr Crowley reported to the Board that the Trust had received confirmation from Monitor on the quarter 1 return. The Trust had a Continuity of services risk rating of 3 and governance rating of under review. Mr Crowley reminded the Board that the governance rating related to the review of the performance of a number of metrics including A&E.

Stroke Group – Botox Clinic – Ms Symington read a letter the Trust had received from a member of the public which enquired about the botox service that has been withdrawn from Scarborough. The Trust has also received a separate email from another member of the public on the same topic.

Ms Symington asked Mrs Walters to comment on the withdrawal of the service. Mrs Walters advised the Botox service ceased following the retirement of the Consultant. This service was supported via a Service Level Agreement (SLA) with Hull CCG for a trained Physiotherapist to work alongside the consultant to undertake the treatment. As the consultant was retiring and the stroke service was transferring to York, Hull withdrew the SLA as they would only support the service at Scarborough Hospital. Scarborough & Ryedale CCG were aware of this decision.

The Trust provides a Botox service at York but this is only for York CCG patients and is fully subscribed. Early discussions have taken place between stroke and neurology (at York) about the potential to extend the current service, although this could only be done if it was commissioned by Scarborough & Ryedale CCG and was adequately resourced.

Outstanding actions from previous minutes

Minute number and month	Action	Responsible officer	Due date
15/114 Quality and Safety Committee	Present a progress paper on the Implementation of the Nursing and Midwifery Strategy	Mrs Geary	January 2016
15/116 Patient Experience Strategy	Present the implementation plan for the Patient Experience Strategy	Mrs Geary	October 2015

15/117 Community Care update	Provide further detail on the re-ablement discussions when available. Include the issue around review of re-ablement service with the system leadership discussions.	Mrs Scott Mrs Walters	When available Report to Board when completed
15/087 Diverse Workforce	A proposal around investment in training for specialist and middle grades in the future to be presented to the Board when developed	Mr Crowley	future

Action list from the minutes of the 30 September 2015

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Chief Executive's Report

Action requested/recommendation

The Board is asked to note the report.

Summary

This report provides an overview from the Chief Executive.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report is only written for the Board of Directors.
Risk	No risk.

Resource implications	No resource implications.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	October 2015
Version number	Version 1

Board of Directors – 28 October 2015

Chief Executive's Report

1. Chief Executive's Overview

I think it is worth setting the scene for the Board by reflecting on a small number of issues that for me illustrate the difficulty the whole service is in as well and the backdrop for our local circumstances.

Firstly, you will have seen recent media coverage of the most up-to-date NHS finance reports. The Finance Director will cover this, and our own performance, in the Finance Report, however the headline is a gross deterioration of the financial position across the NHS. Monitor's latest reported figures for quarter 1 show that of the 83 acute Foundation Trusts, 78 are in deficit. Further figures compiled by NHS Providers show that 132 out of 138 acute providers (both Foundation and non-Foundation Trusts) are in deficit.

The quarter 1 deficit for the NHS provider sector overall is £0.9bn. The projected year end position remains at £2.1bn, however given the sector's current performance this would appear unrealistic and serves to demonstrate the relentless financial pressures facing both the provider sector and the system as a whole.

Secondly, and at a more local level there have been two significant developments over recent weeks regarding local contracts that have been awarded to private sector providers.

Hambleton, Richmondshire and Whitby CCG announced last month that discussions with Virgin Care to provide Community and Out of Hours Services in Whitby had been unsuccessful, and that Virgin Care is unable to proceed. The CCG has made the decision to appoint the reserve bidder, Humber NHS Foundation Trust. Following the standstill period as required by good procurement practice, the CCG will commence work with Humber NHS Foundation Trust to agree a contract and a start date, and we will continue to work with the CCG and the new provider towards a transfer of service.

In relation to the MSK contract in Selby and York we were advised by Vale of York CCG some weeks ago that Healthshare, their chosen provider, was unable to mobilise on 1 November as planned, and we were asked to provide an interim service until 1 February 2016, when Healthshare would start the new contract. Our team undertook extensive capacity and demand analysis based on current referral trends and workforce numbers to determine our options for providing the CCG with some level of service. We concluded that, given our remaining workforce for the MSK service, the number of clinic sessions available, and the volume of patients already in the system, we could offer a reduced service until the end of January 2016 when the new provider could take over.

However, the CCG has subsequently notified Healthshare that they are no longer the provider of the new service, and that the procurement process has been aborted. This unexpected development led to intensive discussions with the CCG in terms of a way forward, and what this means for the future of the MSK service. In the meantime, we are continuing to provide an interim service as agreed.

This has clearly been an unsettling time for our staff in Whitby and in the MSK service, and we are doing our best to support them and keep them informed with regard to their future.

Most recently we experienced significant operational difficulties in York Hospital that resulted in a significant deterioration in our Emergency Department performance and a great deal of media attention.

Taking these together, it is clear that the national financial context is deteriorating at a pace that many observers had not expected and this impact is being felt locally with all partners in some difficulty. This is having a destabilising effect on the whole system. Commissioners are facing difficult decisions and choices and the role of competition as it was originally envisaged is seemingly no longer tenable. The early signs of a growing pressure on the acute system only serve to focus the mind.

This must be the catalyst for closer partnership working as there is no other prospect of a solution to the challenges we face. As a Foundation Trust we must be receptive to this and where necessary and appropriate provide the leadership for it.

Safer staffing
The Trust Development Authority (TDA), Monitor, NICE, CQC and NHS England recently wrote to all Trusts regarding the national line on safe staffing and efficiency.

The letter recognises that Trusts are taking measures to safely staff our services, and acknowledges that "recent messages to the system on safe staffing and on the need to intensify efforts to meet the financial challenge have been seen as contradictory."

The letter also recognises the need for providers to take a risk-based view on staffing, taking into account a number of factors, and that it is therefore "important to look at staffing in a flexible way which is focused on the quality of care, patient safety and efficiency rather than just numbers and ratios of staff."

This places the responsibility for getting the balance right between efficiency and safety back in the hands of individual organisations, with the requirements set out previously by NICE and others acting as guidelines rather than explicit standards. This is a positive development as it enables us to make our own decisions about where to deploy staff.

As I reported last month, we have implemented Monitor's requirement for all nursing agency spend to be through approved frameworks. We have also applied this approach to temporary medical staff, although this is yet to be mandated by Monitor. The letter suggests that we can expect a national rate cap for agency staff to be introduced later in the autumn.

Junior doctors' contract
The high profile debate between Health Secretary Jeremy Hunt and junior doctors over proposed changes to contracts continues, with protests taking place over terms and conditions.

The Health Secretary has written to the Chair of British Medical Association's Junior Doctors' Committee to clarify the Department of Health's position following a recent meeting between the two.

The letter restates his claim that the new contract should improve patient safety by better supporting a seven day service, and that for junior doctors, this means some increase in plain time working (backed up with an increase in basic pay) and a move to paying for hours worked, with additional pay for unsocial hours.

He urges the BMA to return to negotiations, and we will be following this closely to report back to the Board the implications of the final contract when it is agreed.

Director portfolios
Sue Holden's secondment has presented an opportunity to re-visit the Executive Director Portfolios.

Polly McMeekin joined us as Deputy Director of HR just as Sue was departing. Polly is reporting directly to me and is taking the lead on HR issues.

The Board will be aware that I have asked Mike Proctor to take the Executive lead on Education, Organisation Development and Research and Brian Golding is taking Executive Lead on Occupational Health. This arrangement will enable us to 'save' a Director's salary for the duration of Sue's absence.

These changes will, inevitably, enable us to refresh and refocus our approach in these areas, and look at some of these issues in new ways, which I hope will be welcomed by Board colleagues.

Many of the current financial and performance difficulties we face are directly or indirectly related to workforce issues. Whether that is recruitment or retention, both lead to the problems we have in managing patient flow, delivering key access targets and spending on agency staff.

Future reports to the board will update on progress on these and other relevant issues which are so vital to our ability to have stable workforce that is fit for the future.

Stroke external review
As Board members will recall changes were made to the acute stroke pathway in the summer as a result of our inability to safely staff a consultant-led service on the Scarborough site. Two options had been considered; either a full divert to York Hospital of all suspected strokes, or a triage and transfer model. The latter was chosen and means that patients are assessed and given immediate treatment (including thrombolysis) in Scarborough's Emergency Department before being transferred to York for hyper-acute stroke care. They are then transferred back to Scarborough after a couple of days for rehabilitation.

The pathway was developed in partnership with the CCGs, and its implementation was approved on an interim basis by an expert external review team which included Professor Tony Rudd, the National Clinical Director for Stroke.

It was agreed that the external review team would carry out a face to face review of this pathway in October, following which discussions about the permanent option would commence, with an ambition to reach a decision before February 2016.

The external reviewers visited on 6 October to review the clinical data and discuss the pathway with the stroke team. The reviewers endorsed the current pathway and the Stroke Working Group is now planning the steps that need to be taken to implement this as a permanent pathway from February.

Executive Board time-out
Earlier this month I hosted a half-day time out session for the executive Board and other senior managers. This was a commitment following the last time out in March, where we first endorsed the introduction of the Turnaround Avoidance Programme. The purpose of this session was to bring people up to speed with the work done so far on the four workstreams

(workforce, fines reduction, CQUIN delivery, and achieving better financial discipline), to reaffirm our priorities and to generate ideas for how we can continue to drive this work forward.

In the news
We enjoyed positive coverage of our Celebration of Achievement Awards event which took place in Scarborough earlier this month. The event continues to grow year on year and as ever it was fantastic to be able to celebrate the efforts of staff from all across our Trust.

Unsurprisingly we faced widespread interest in our CQC reports. We saw extensive print coverage locally, and I gave several interviews to local radio stations and BBC Look North. Aside from the inevitable headlines given our overall rating, coverage was generally balanced and the staff briefings I attended gave people the opportunity to see beyond the rating and recognise that the reports overall demonstrate good progress.

We are also starting to receive queries about our plans for winter. As you will recall this attracted national coverage last winter, and we are agreeing our approach for this year to ensure we are able to give a consistent message throughout the winter period.

2. Recommendation

The Board is asked to note the report.

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

Quality & Safety Committee – 20th October 2015 Boardroom, York Hospital

Attendance: Libby Raper, Philip Ashton, Jennie Adams, Ed Smith, Beverley Geary, Diane Palmer, Anna Pridmore, Liz Jackson,
Observers: Justin Keen, Tara Wickramasekera

	Agenda Item	Comments	Assurance	Attention to Board
1	**Last meeting notes dated 22 September 2015**	The Committee welcomed Professor Justin Keen and Tara Wickramasekera from the Leeds Institute of Health Sciences at Leeds University who were observing the meeting. The Committee approved the minutes from the last meeting as a true and accurate recorded and noted that all matters arising were covered under item 2.		
2	**Matters arising** - Update on the number of women having a post-partum haemorrhage - Update on alternative hardware for the EPMA system - CIP quality risk assessment update from the comments made at Board - Walk rounds update from the comments made at the Board	**Update on the number of women having a post-partum haemorrhage.** BG explained there had been an increase in the acuity of women attending the unit which has resulted in increase in the number of women having a postpartum haemorrhage. **Update on alternative hardware for the EPMA system.** The Committee has gained assurance that the EPMA hardware displayed at the open day was for demonstration purposes only and will not be the design launched on the wards. It was understood that the pilot is due to commence in February although may be delayed slightly. The Committee noted the wireless improvements being put in place by Systems and Network Services this		

	Agenda Item	Comments	Assurance	Attention to Board
		week. **CIP quality risk assessment update from the comments made at Board.** The Committee gained assurance at the September Board meeting that Richard Khafagy, Consultant Urologist, is the nominated Medic for the CIP quality risk assessments. **Walk rounds update from the comments made at the Board.** Assurance was received at Board that safety would remain the key focus of the Patient Safety Walk Rounds.		
3	**Risk Register for the Medical Director and Chief Nurse**	The Committee welcomed the inclusion of the Chief Nurse and Medical Director Risk Registers but noted that the Chief Nurse version was not the latest version. The Committee asked that executive colleagues establish a robust process to ensure a singles source for the trust risk registers. It will be raised at the next Audit Committee. The Committee asked, as part of the assurance process, that CQC required actions and recommendations are incorporated in to the register. The Committee agreed to postpone the review of the Risk Registers until the updated versions are available at the next meeting.		
4	**Quality and Safety Performance Report**	The Committee focussed its attention against the Patient Safety and Quality overview in the Quality and Safety Quality Report.		

	Agenda Item	Comments	Assurance	Attention to Board
		Measures of harm – The Committee noted the information included in the measures of harm section and specific SI in the Supplementary Medical Director Report. **Infection Prevention** – The Committee agreed that Infection Prevention had been covered in great detail with the DIPC Annual Report at the September meeting and felt that any additional issues could be covered under Item 6. **Quality and Safety Miscellaneous** – The Committee noted the increase in the number of cancelled appointments and asked for some commentary regarding exceeding the monthly maximum. ES advised the Committee that focussed work is being undertaken in Directorates to work through issues. BG added that detail is needed from the Operational team regarding the capacity and number of referrals for each area, the potential for harm and the mitigation for this. **Care of the Deteriorating Patient** – The Committee discussed the persistent problem of not achieving the 12 hour senior review. ES confirmed that this is a patient safety priority and there is still a discrepancy in work plans. ES advised the Committee about a plan to trial a senior doctor assessment on arrival in York ED which will add a degree of senior review at the start of the process. **Drug Administration** – the Committee did not raise any specific issues around drug administration. **Mortality** – To be discussed under Item 12.	The Group were assured by the focus on this area and look forward to reviewing this in more detail next month.	BG and ES to give verbal update at Board.

	Agenda Item	Comments	Assurance	Attention to Board
		CQUIN Update – The Committee were delighted to see that all schemes for Quarter 2 of the 2015/16 CQUINs were RAG rated as green and sent congratulations to all involved in this achievement. **Pressure Ulcer Reporting** – The Committee raised concerns over the increase in percentage harm from pressure ulcers in community hospitals and discussed the national variation in reporting. BG advised the Committee that the various methods of reporting are being looked in to and some methodology may be adopted, this will come to the Committee for discussion. The Committee were concerned that if definitions are changed trend lines will be lost and analysis of data will be difficult. BG confirmed that the external reporting may change but all pressure ulcers will be reported internally.		
5	**Key reports** - Chief Nurse Report - Supplementary Medical Director Report	**Chief Nurse Report** **Quality Report** The Committee welcomed the useful timeline and detail around the production of the Quality Report and were pleased to see the structure in place. BG confirmed that the Committee would be included in the initial consultation between November and January with the first draft of the Report being shared in March. The 6 monthly reports from last years' Quality Report will be coming for review at the November Committee meeting. The Committee were pleased that the review of the previous report ties in with the timeline for consultation of the 2016/17 Report, assuring that measures can be discussed and carried over where necessary. **Nursing and Midwifery Conference**		

	Agenda Item	Comments	Assurance	Attention to Board
		BG advised the Committee that 100% of the attendees who completed a feedback form found the day valuable and 98% stated that they had learnt something new. The Committee pleased to hear the positive feedback. **Supplementary Medical Director Report** **Nutrition and Hydration** The Committee were pleased to see the inclusion of nutrition and the re-energised nutrition steering group and asked about the hydration project that took place on Ward 23. BG advised the Committee that the roll out of the project had been costed and further review was being undertaken. BG went on to explain a pilot is taking place on four wards for six months using professional judgement to change the skill mix of staff. This would include additional HCAs who potentially could provide a beverage service. The Committee asked about future opportunities to use volunteers in the organisation and noted the change in leadership for the volunteer service. **National Reporting and Learning System (NRLS)** The Committee raised concerns about the latest report presented. ES explained some of the reporting changes that have taken place. It was agreed that further information would be provided to the next meeting.		
6	**DIPC** - Quarterly Report - Performance and risk	The Committee noted the content of the quarterly report and agreed that infection prevention was looked at in great detail last month. The Committee noted the trajectory for MSSA and C-Diff BG advised the Committee that ward 34 is now closed		

	Agenda Item	Comments	Assurance	Attention to Board
		with norovirus and bays have also been closed at Selby War Memorial, Whitby, St Helens and on G2.		
7	**Patient Experience Quarterly Report**	BG introduced the Patient Experience Quarterly Report and welcomed feedback on the more detailed format. The Committee asked about the low response rate of the friends and family test. BG advised that a meeting has been scheduled to look at how this can be improved. Work will be focussed on the low reporting areas and Governors have been contacted for support. The Patient Experience Team will also be attending the Professional Nurse Leaders Forum to negotiate what can be done differently. The Committee discussed the knowing how we're doing boards, the use of which could be improved. BG agreed to evaluate the use of the boards. The Committee were pleased to see the content of the Patient Experience Strategy implementation plan. BG advised that that Patient Experience Steering Group have an agreed timeline associated with the plan. The Committee re-visited the issues around staffing of the PALs team. BG explained that two members of staff remain on long term sick and that other members of the team are now being deployed differently to reduce the amount of time that the phones are on voicemail. Other alternatives, such as having the matron of the day's phone number available, are being looked in to. An evaluation of the PALs desk is taking place with the possibility of it being reinstated.		

	Agenda Item	Comments	Assurance	Attention to Board
8	**Children's Safeguarding Annual Report**	BG introduced the Children's Safeguarding Annual Report which highlighted the achievements in this area. BG explained that a new lead is now in post and changes to key personnel will soon be taking place. BG highlighted that Safeguarding training is now in a good position which has been a risk for previous years. The Committee queried the lack of data around training in female genital mutilation. BG confirmed that this is not something that previously had to be reported, however, all staff will have completed the training by the end of November.	The Committee were assured by the encouraging report and congratulated the team for the work being undertaken around this issue.	
9	**Midwifery Annual Report**	The Committee asked that the report be structured differently to clarify the huge amount of activity in this area and asked BG to give an executive overview. BG advised the Committee that staffing ratios remain an issue and existing staff are now being used differently. A business case has been put together for additional funding to cover on call payments in York. BG confirmed that the acuity of women is increasing with more mature women having their first pregnancy, gestational onset diabetes and obesity all factoring. Plans are in place to mitigate for the rise in acuity and BG explained that this needs to be looked at as a health community and not just from the hospital. When the patient acuity is high Midwives from the community are redeployed to the unit or the unit is closed with patients being redirected to the closest alternative. The Committee raised that is would be useful to have more consistent staffing reporting in Maternity.	The Committee were assured by the amount of focus on the activity in Maternity and look forward to receiving the updated report.	

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee asked for an updated report to be presented to the November meeting.		
10	**EWTT**	The Committee welcomed the report. The Committee queried the score from AMU on the York site, BG explained that the two wards have recently amalgamated and work is being undertaken with the Sister and Charge Nurse.	The Committee were assured by the improvements illustrated in the report.	
11	**Clinical Governance Proposal**	The Committee welcomed the interesting proposals in the Clinical Governance Paper. ES explained that this is a work in progress; re-engagement with staff needs to take place and reporting processes need to be embedded. A directorate level clinical governance action log will be put in place to provide assurance that each issue is being reviewed. The Committee agreed that the Obstetrics and Gynaecology Clinical Governance model works well with a weekly meeting and issues being escalated as appropriate. The Committee again confirmed its support for Trust wide learning to be embedded from Sis and agreed that learning from clinical audits and SI investigations need to be shared where appropriate through media such as the Nevermore publication.		
12	**SHMI**	ES updated the Committee on the current Mortality Indicators which are embargoed until Wednesday 28th October.		
13	**Nursing and Midwifery Revalidation**	The Committee noted the report.		

	Agenda Item	Comments	Assurance	Attention to Board
14	**Acuity and Dependency Audit**	The Committee raised concern over the reliability of the safer nursing care tool. BG explained that the National Quality Board have issued guidance that professional judgement can be used when assessing the acuity and dependency of an area. BG confirmed that the tool will remain unchanged for the January audit so that two years of data can be compared. Additional training has taken place with the Senior Nursing Team who validate the data. The two Assistant Directors of Nursing have scheduled visits to other Trusts to review their systems. Some Trusts are operating a real time reporting system. Any recommendation will come to the executive team.	The Committee were assured by BGs comments that the method of approach is being reviewed.	BG to take to Board.
15	**Safer Staffing Report**	BG confirmed that the Safer Staffing Report looked at the budgeted establishment for each area. The Committee noted that the vacancies are increasing and the actions in place are not filling the gaps. BG drew the Committees attention to the HR data paper that came for review last month and highlighted the increase in leavers. The Committee agreed that the current staffing numbers, the number of leavers and the new starters should be reviewed for each area every month.		BG to take to Board.
16	**Any other business**	**Operational Pressures** – BG advised the Committee about significant operational pressures with nine 12 hour breaches in the Emergency Department. BG confirmed that the patients were safe, in beds and had comfe rounds in place and commissioners have been made aware. **Change to the Chair of the Committee** – LR advised that JA will be taking over the role of Chair in the new		

	Agenda Item	Comments	Assurance	Attention to Board
		year, however, the members of the Committee will remain unchanged.		

Patient Safety & Quality Report

October 2015

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

Patient Experience

There has been an increase in the number of PALS contacts on the York site to 631, data is not currently available for the Scarborough site.

The number of complaints rose on both main sites, York saw 26 in September compared to 16 in August and Scarborough rose from 21 to 32 (August compared to September).

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

The percentage of inpatients recommending the Trust has continued to exceed the 90% target on all sites, however there was a slight decrease on previous months at York from 97.53% in August to 95.98% in September.

The response rate for York ED has decreased in September to 7.4% (August - 9.2%). September also saw an decrease in the percentage of patients recommending the department.

The response rate for Scarborough ED remains low and has decreased further in September to 4.9% (August - 5.8%). In addition the proportion of patients recommending the department has also decreased to 79.3%.

Measures of Harm

16 Serious Incidents (SIs) were declared in August (6 x York, 5 x Scarborough and 5 x Community). 1 of the SIs were attributed to 'clinical incident', 9 were attributed to 'slips, trips and falls' and 6 to pressure ulcers.

There were no 'Never Events' reported.

Infection Prevention

3 cases of Cdiff were identified in August, (York 2 & Scarborough 1). The YTD total is now 35 against an annual maximum of 48, therefore above trajectory.

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

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

There were also 6 cases of E-Coli.

Quality and Safety - Miscellaneous

Stroke
In August 91% of patients had 90% of their stay on a stroke unit, this is against the local target of 80%. The Trust achieved the Target for the percentage of patient scanned within 1 and 24 hours of hospital arrival and for those patients who experienced a TIA were assessed and treated within 24 hours.

Cancelled Operations
The number of operations cancelled within 48 hours of the TCI due to lack of beds decreased in September to 8from 17 in August. Year to date 245 patients have had their surgery cancelled within 48 hours due to a lack of beds.

Cancelled Clinics/Outpatient Appointments
The number of cancelled clinics with less than 14 days notice increased compared to August (150) to 168, this is still within the maximum of 200 per month. There was a corresponding increase in the number of cancelled appointments - 833 in September. This exceeds the monthly maximum of 745 and will result in General Condition 9 which is initially a Performance Notice. Of note, Urology cancelled 32 appointments in August compared to 81 in September.

Ward Transfers between 10pm and 6am
The number of inappropriate ward transfers remained fairly static in September at 84 against in 82 in August (37 in York and 47 in Scarborough) and is below the monthly maximum of 100.

Care of the Deteriorating Patient

York achieved 83% of Medicine and Elderly patients receiving a senior review within 12 hours of admission, with Scarborough remaining constant at 56%.

74% of Medicine and Elderly patients were seen by a doctor within 4 hours of admission, across both sites.

The Trust has an internal target of 90% of routine observations being undertaken within 1 hour of the prescribed time. Currently achieving 87.3% overall, with Scarborough showing a continual improvement and achieving 90.3% in September.

Drug Administration

The number of insulin errors at York decreased to 1 in September from 2 in August but rose on the Scarborough site (September; 5 from 1 in August).

Prescribing errors at York rose from 10 in August, to 13 in September however Scarborough saw a fall from 10 in August to 6 in September.

Mortality

The Jan 14 - Dec 14 SHMI reduced to 101 from the previous release of 103, with both York and Scarborough seeing a 2 point reduction.

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

The number of deaths in Septemberwas in line with previous months.

CQUINS update

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

Litigation

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

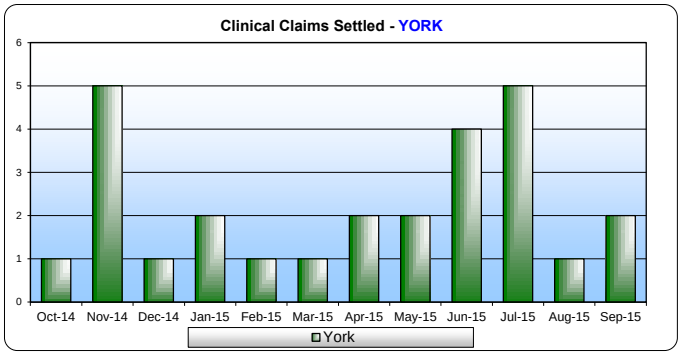
In September, 4 clinical claims were settled; 2 attributed to York & 2 attributed to Scarborough.

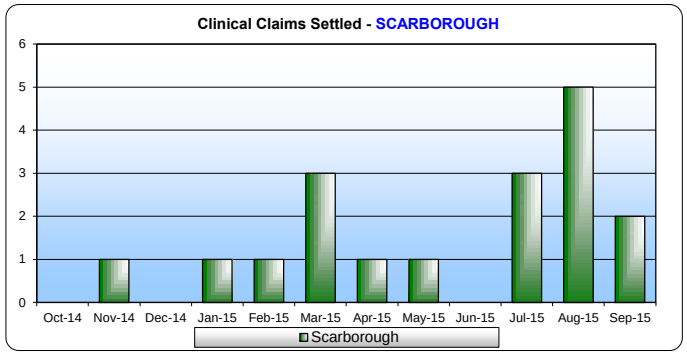
7 clinical negligence claims were received for York site and 7 were received for Scarborough. York had 9 withdrawn/closed claims and Scarborough had 7.

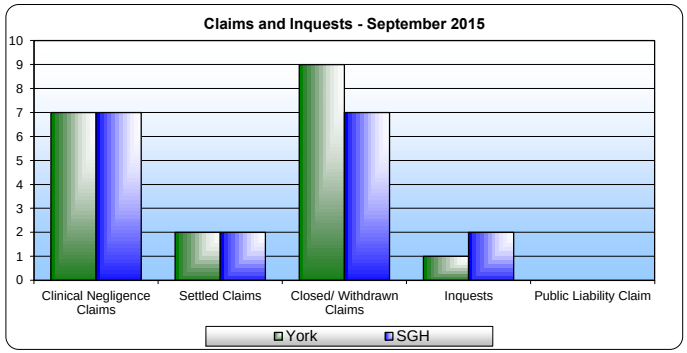
There were 3 Coroner's Inquests heard (1 York & 2 Scarborough).

Litigation

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







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

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

Patient Experience

Complaints
Complaints registered in York relate to York Hospital and Community Services.
Complaints registered in Scarborough relate to Scarborough Hospital and Bridlington Hospital.
There were 26 new complaints registered to the York site and 32 to the Scarborough site in September.

PALS contacts
There were 631 PALS enquiries at York Hospital in September, Scarborough figures are not currently available

New Ombudsman Cases
1 attributable to York & 0 attributable to Scarborough during September.

Complaints – Late Responses
2 recorded at York and 4 in Scarborough in September.
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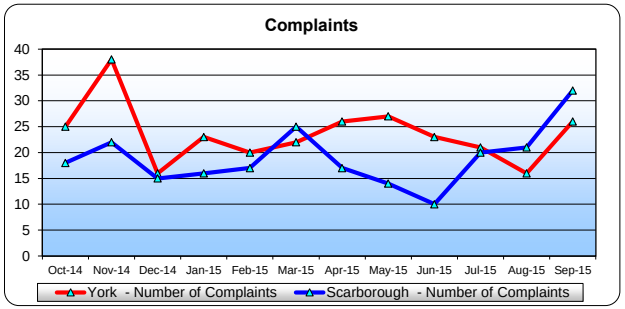
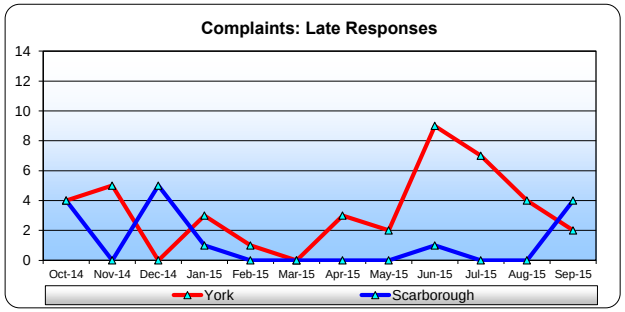
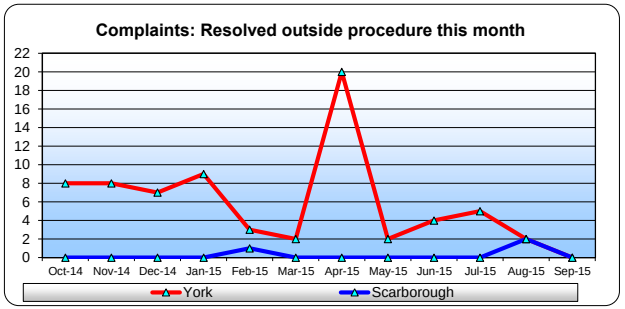
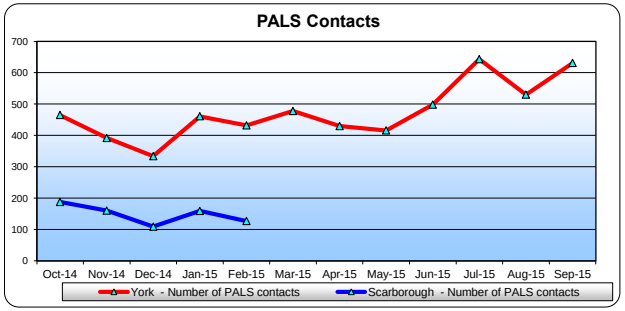
Patient Experience

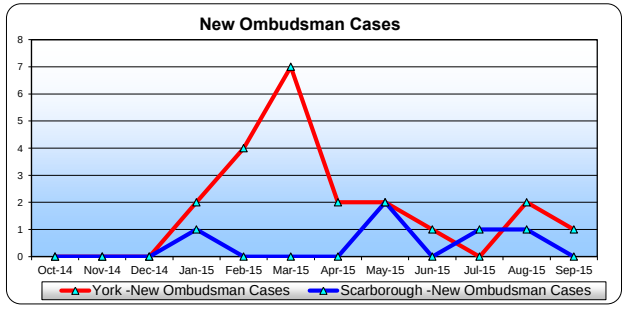
Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Complaints	York	25	38	16	23	20	22	26	27	23	21	16	26
	Scarborough	18	22	15	16	17	25	17	14	10	20	21	32
PALS contacts	York	465	392	334	461	432	478	430	416	498	643	530	631
	Scarborough	188	160	109	159	127	0	0	0	N/A	N/A	N/A	N/A
New Ombudsman Cases	York	0	0	0	2	4	7	2	2	1	0	2	1
	Scarborough	0	0	0	1	0	0	0	2	0	1	1	0
Complaints - Late Responses	York	4	5	0	3	1	0	3	2	9	7	4	2
	Scarborough	4	0	5	1	0	0	0	0	1	N/A	N/A	4
Complaints - Resolved outside procedure this month	York	8	8	7	9	3	2	20	2	4	5	2	0
	Scarborough	0	0	0	0	1	0	0	0	0	0	2	0











Patient Experience

September 2015

Complaints by Directorate/Division (Datix)	Total
Allied Health Professionals	0
Child Health (Y)	1
Clinical Support Services (S)	0
Community Services (Y)	1
Corporate (Y,S)	0
Elderly Medicine (Y)	5
Emergency Medicine (Y)	7
Facilities (Y,S)	2
General Surgery and Urology (Y), Surgery (S)	11
Head and Neck and Ophthalmology (Y)	1
Medicine (General and Acute, Y), Medicine (S)	6
Obstetrics and Gynaecology (Y)	7
Operations (Y)	3
Orthopaedics (Y)	7
Pharmacy (Y)	1
Physiotherapy (Y)	0
Radiology (Y)	3
Sexual Health (Y)	0
Specialist Medicine (Y)	1
Theatres Anaesthetics and CC(Y)	2
Labatory Medicine	0
Total	58

PALS Contact by Subject	York
Action Plan	
Aids / appliances / equipment	1
Admissions, discharge, transfer arrangements	17
Appointments, delay/cancellation (inpatient)	11
Appointments, delay/cancellation (outpatient)	60
Staff attitude	19
Any aspect of clinical care/treatment	76
Communication issues	69
Compliment / thanks	29
Alleged discrimination (eg racial, gender, age)	1
Environment / premises / estates	5
Foreign language	
Failure to follow agreed procedure (including consent)	1
Hotel services (including cleanliness, food)	2
Requests for information and advice	296
Medication	2
Other	1
Car parking	4
Privacy and dignity	2
Property and expenses	13
Personal records / Medical records	12
Safeguarding issues	2
Signer	1
Support (eg benefits, social care, vol agencies)	2
Patient transport	5
Totals:	631

* PALs Scarborough not available

Complaints by Subject (Datix)	Total
Admissions, discharge and transfer arrangements	5
Aids, appliances, equipment, premises	0
All aspect of clinical treatment	30
Appointment delay/cancellation (inpatient)	0
Appointments delay/cancellation (outpatient)	0
Attitude of staff	0
Communication/information to patients (written and oral)	8
Commissioning	1
Complaints handling	0
Consent to treatment	0
Failure to follow agreed procedure	0
Hotel services, including food	0
Mortuary and post mortem arrangements	0
Other	0
Patient Care	4
Patient Concerns	1
Prescribing	2
Patients' privacy and dignity	1
Patients' property and expenses	0
Patients' status, discrimination	0
Personal records	0
Policy and commercial decision of Trust	0
Values and Behaviours (staff)	6
Total	58

Friends and Family

Indicator		Target	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Inpatients – York	York IP Response Rate	Monitoring Only	34.9%	39.4%	35.1%	32.9%	38.4%	45.4%	16.0%	17.4%	18.3%	20.6%	17.4%	18.9%
Inpatients – Scarborough	Scarborough IP Response Rate		39.5%	50.0%	37.9%	41.2%	52.4%	55.8%	16.4%	16.5%	15.3%	21.3%	18.2%	18.0%
Inpatients - Bridlington	Bridlington IP Response Rate		72.3%	77.2%	85.9%	77.0%	90.2%	69.5%	56.0%	47.5%	46.0%	51.6%	69.0%	62.0%
Inpatients – Combined	**Trust IP Response Rate**		**38.2%**	**44.1%**	**38.4%**	**37.7%**	**44.7%**	**49.4%**	**18.6%**	**19.2%**	**19.4%**	**22.6%**	**20.3%**	**21.2%**
ED – York	York ED Response Rate	Monitoring Only	9.6%	15.4%	14.2%	14.8%	14.0%	19.2%	8.3%	8.6%	8.3%	10.0%	9.2%	7.4%
ED - Scarborough	Scarborough ED Response Rate		27.4%	32.7%	19.1%	28.2%	36.8%	29.8%	6.7%	7.3%	6.1%	6.3%	5.8%	4.9%
ED – Combined	**Trust ED Response Rate**		**15.9%**	**21.5%**	**16.0%**	**19.3%**	**21.6%**	**22.8%**	**7.8%**	**8.2%**	**7.6%**	**8.8%**	**8.0%**	**6.5%**
Maternity – Antenatal		None	39.8%	42.8%	32.2%	30.6%	27.6%	36.0%	26.4%	27.5%	31.7%	29.1%	23.7%	29.3%
Maternity – Labour and Birth			17.2%	39.7%	15.8%	19.9%	27.9%	38.5%	31.0%	25.6%	26.7%	28.5%	23.3%	36.2%
Maternity – Post Natal			26.5%	47.1%	19.4%	27.9%	31.9%	32.6%	30.4%	29.0%	29.3%	27.3%	25.5%	40.5%
Maternity – Community			19.5%	18.4%	18.2%	21.3%	14.6%	23.1%	24.3%	18.4%	20.3%	18.7%	19.8%	20.9%

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

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

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

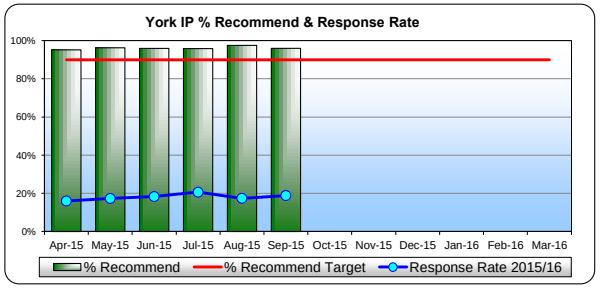
The focus for the Trust is to gain and understand patient feedback and encourage Directorates to use that feedback to drive improvements. Each ward displays a 'Knowing How We're Doing' board which is a giant poster sharing FFT data and comments from that particular ward, along with news and improvements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

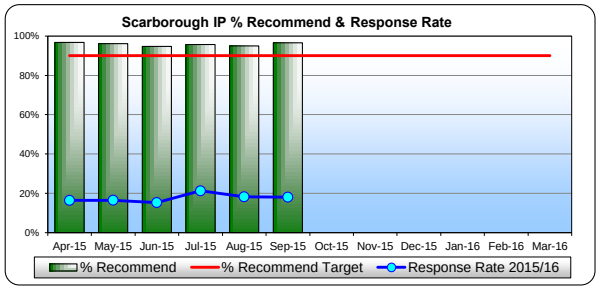
Friends & Family: Inpatients & ED

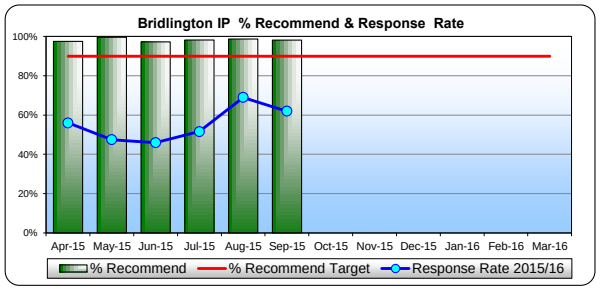
The Friends & Family Test (FFT) has now been rolled out across the Trust, including all Inpatients and Daycases, (previously daycase s and patients <16 were excluded) those attending ED, Community patients and women accessing maternity services being asked the question; "would you recommend this ward/ED/antenatal/labour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

Indicator	Consequence of Breach (Monthly)	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Jul-15	Aug-15	Sep-15
Trust Inpatient Response Rate (including daycases)	None - Monitoring Only	none	39.80%	40.10%	43.90%	21.40%	22.63%	20.33%	21.15%
York Inpatient Response Rate (including daycases)	None - Monitoring Only	none	35.58%	36.39%	39.00%	18.99%	20.61%	17.42%	18.86%
York Inpatient % Recommend	None - Monitoring Only	none					95.84%	97.53%	95.98%
York Inpatient % Not Recommend	None - Monitoring Only	none					0.93%	0.75%	1.00%
Scarborough Inpatient Response Rate (including daycases)	None - Monitoring Only	none	42.52%	42.25%	49.44%	19.22%	21.26%	18.16%	18.02%
Scarborough Inpatient % Recommend	None - Monitoring Only	none					95.74%	95.02%	96.61%
Scarborough Inpatient % Not Recommend	None - Monitoring Only	none					1.26%	1.39%	0.85%
Bridlington Inpatient Response Rate (including daycases)	None - Monitoring Only	none	80.68%	78.19%	78.06%	60.33%	51.57%	68.97%	61.98%
Bridlington Inpatient % Recommend	None - Monitoring Only	none					98.21%	98.71%	98.16%
Bridlington Inpatient % Not Recommend	None - Monitoring Only	none					0.36%	0.32%	0.61%

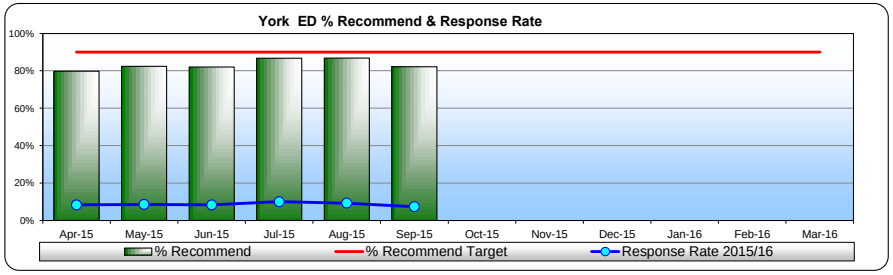
Daycase patients and young people (<16 years) included in FFT April 2015

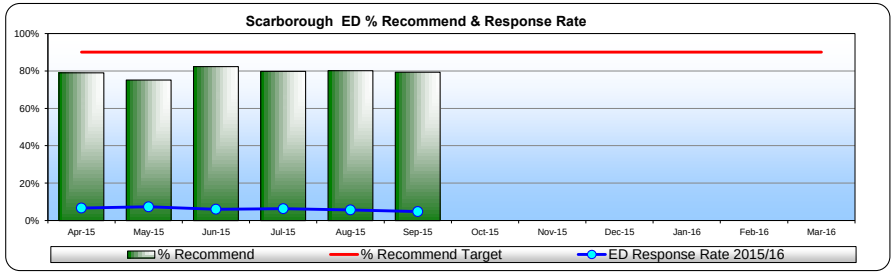






Indicator	Consequence of Breach (Monthly)	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Jul-15	Aug-15	Sep-15
Trust Emergency Department Response Rate	None - Monitoring Only	none	19.90%	17.70%	21.30%	7.78%	8.75%	7.97%	6.52%
York Emergency Department Response Rate	None - Monitoring Only	none	10.85%	13.00%	16.08%	8.90%	9.99%	9.22%	7.36%
York Emergency Department % Recommend	None - Monitoring Only	none					86.76%	86.84%	82.20%
York Emergency Department % Not Recommend	None - Monitoring Only	none					8.06%	8.92%	12.43%
Scarborough Emergency Department Response Rate	None - Monitoring Only	none	34.90%	26.46%	31.44%	5.67%	6.32%	5.75%	4.85%
Scarborough Emergency Department % Recommend	None - Monitoring Only	none					79.76%	80.12%	79.31%
Scarborough Emergency Department 5 Not Recommend	None - Monitoring Only	none					13.69%	16.27%	13.79%





Headline Scores

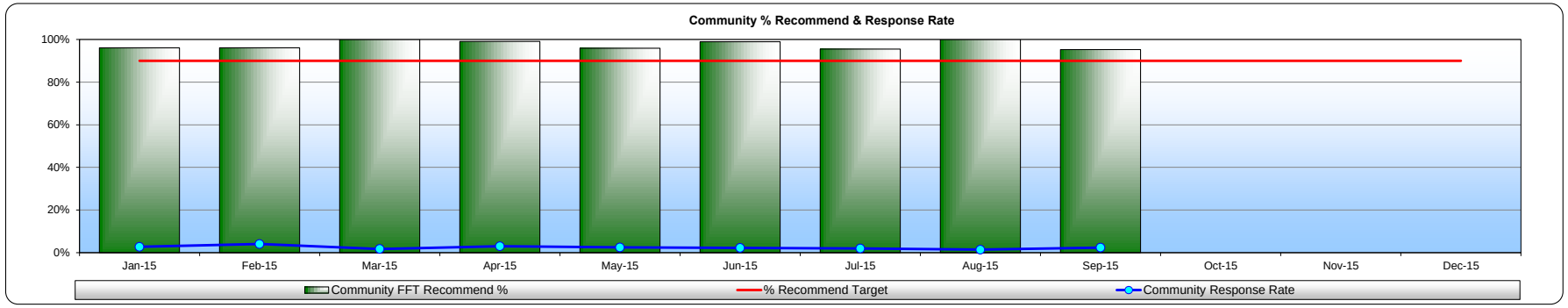
Recommend (%) $\dfrac{\text{Extremely Likely + Likely}}{\text{Extremely Likely + Likely + Neither + Unlikely + Extremely Unlikely + Don't know}} \times 100$

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

Friends & Family: Community

FFT Implemented in Community since January 2015

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Jul-15	Aug-15	Sep-15
Community Response Rate	None - Monitoring Only	none	2.50%	1.86%			1.90%	1.33%	2.35%
Community FFT % Recommend	None - Monitoring Only	none					95.56%	100.00%	95.33%
Community FFT % Not Recommend	None - Monitoring Only	none					2.20%	0.00%	0.00%

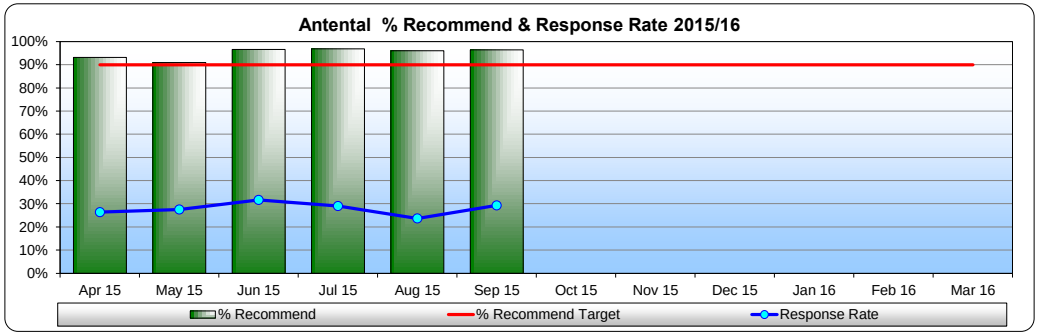


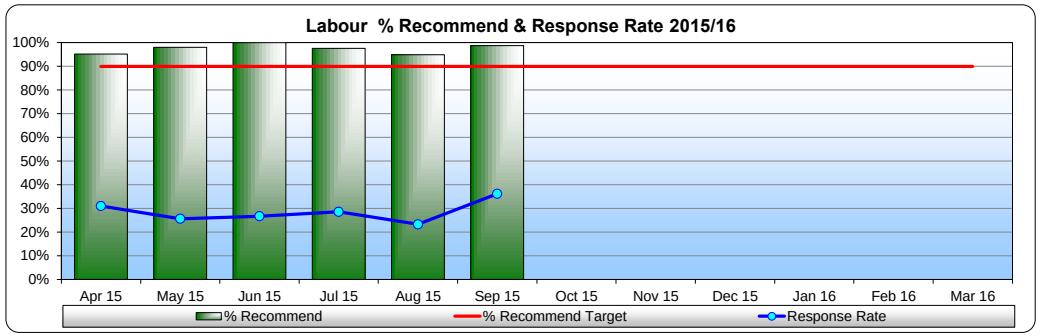
Service/Area	Consequence of Breach (Monthly)	Threshold	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Jul-15	Aug-15	Sep-15
Community Inpatient Services	None - Monitoring only	None	153	148			46	41	61
Community Nursing Services	None - Monitoring only	None	41	5			3	2	0
Specialist Services	None - Monitoring only	None	58	34			11	7	16
Children & Family Services	None - Monitoring only	None	11	8			7	0	1
Community Healthcare Other	None - Monitoring only	None	54	63			23	11	29

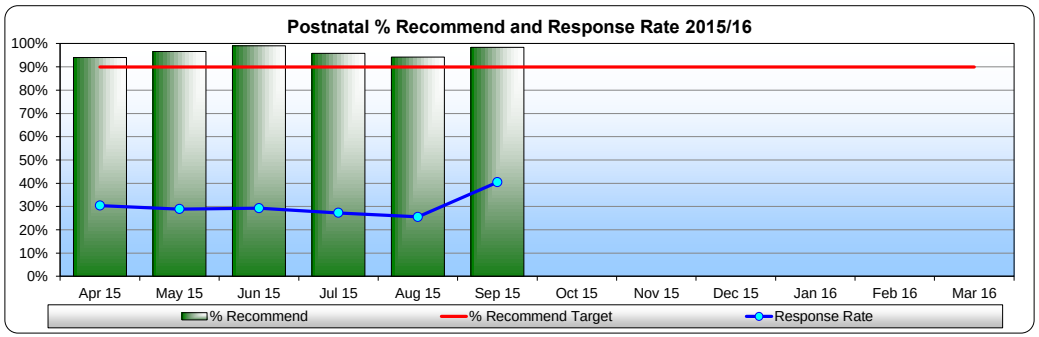
Friends & Family: Maternity

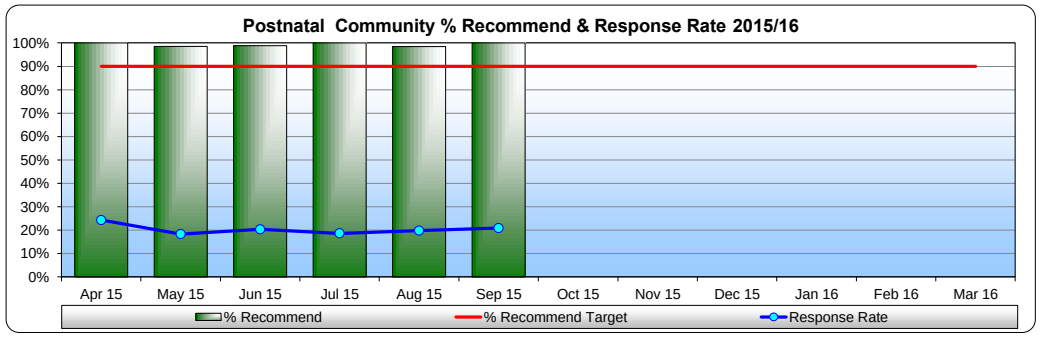
York Teaching Hospital NHS
NHS Foundation Trust

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Antenatal Response Rate	None - Monitoring only	none	32.4%	38.3%	31.4%	27.3%	29.05%	23.67%	29.27%
Antental % Recommend	None - Monitoring only	none					96.90%	96.08%	96.46%
Antental % Not Recommend	None - Monitoring only	none					0.00%	0.00%	0.88%
Labour and Birth Response Rate	None - Monitoring only	none	18.60%	23.50%	28.84%	29.45%	28.54%	23.28%	36.18%
Labour and Birth % Recommend	None - Monitoring only	none					97.60%	94.90%	98.76%
Labour and Birth % Not Recommend	None - Monitoring only	none					0.80%	1.02%	0.00%
Postnatal Response Rate	None - Monitoring only	none	24.8%	30.6%	30.9%	30.7%	27.30%	25.52%	40.46%
Postnatal % Recommend	None - Monitoring only	none					95.79%	94.19%	98.37%
Postnatal % Not Recommend	None - Monitoring only	none					0.00%	2.33%	1.63%
Postnatal Community Response Rate	None - Monitoring only	none	20.00%	18.70%	19.87%	19.78%	18.65%	19.81%	20.88%
Postnatal Community % Recommend	None - Monitoring only	none					100.00%	98.44%	100.00%
Postnatal Community % Not Recommend	None - Monitoring only	none					0.00%	0.00%	0.00%









2014/15 Performance

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

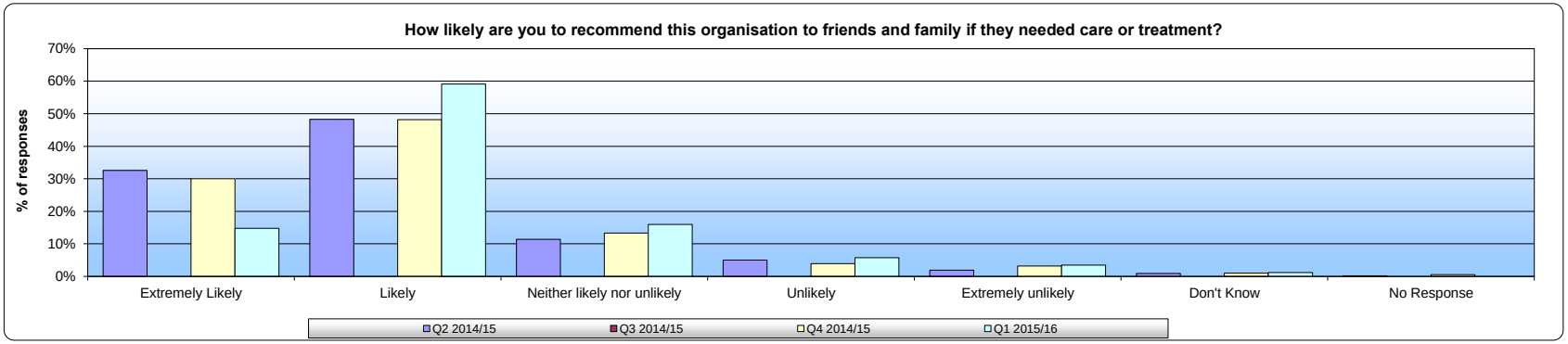
Friends and Family: Staff

York Teaching Hospital NHS
NHS Foundation Trust

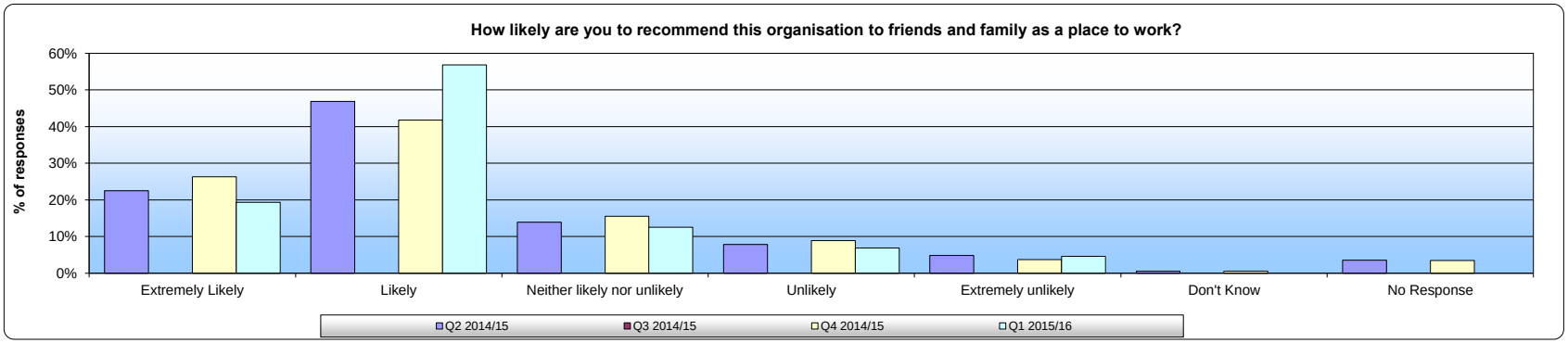
As part of the National Friends and Family CQUIN 2014/15, the Trust was required to submit evidence which demonstrates implementation of staff FFT across all Acute and Community areas.

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

Indicator	Consequence of Breach (Monthly)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16
Response rate - Proportion of Trust employees who responded to the survey	None - Monitoring Only	none	8%	Not Available	38%	49%
Number of Trust employees who responded to the survey	None - Monitoring Only	none	704	Not Available	407	88



How likely are you to recommend this organisation to friends and family if they needed care or treatment?							
Quarter	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't Know	No Response
Q2 2014/15	32.5%	48.3%	11.4%	5.0%	1.8%	0.9%	0.1%
Q3 2014/15	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Q4 2014/15	30.0%	48.2%	13.3%	3.9%	3.2%	1.0%	0.5%
Q1 2015/16	14.8%	59.1%	15.9%	5.7%	3.4%	1.1%	0.0%



How likely are you to recommend this organisation to friends and family as a place to work?							
Quarter	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't Know	No Response
Q2 2014/15	22.4%	46.9%	13.9%	7.8%	4.8%	0.6%	3.6%
Q3 2014/15	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Q4 2014/15	26.3%	41.8%	15.5%	8.8%	3.7%	0.5%	3.4%
Q1 2015/16	19.3%	56.8%	12.5%	6.8%	4.5%	0.0%	0.0%

Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 16 SIs reported in September; York 6, Scarborough 5, Community 5 & Bridlington 0.
Clinical Incidents: 1; York
Slips Trips & Falls: 9; York 5, Scarborough 2 & Community 2.
Pressure Ulcers: 6; York 0, Scarborough 2, Bridlington 1 & Community 3.

Patients Falls and Found on Floor (source: Datix)
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During September there were 179 reports of patients falling at York Hospital, 89 patients at Scarborough and 63 patients within the Community Services. This is an increase from the number reported in August (298), and figures may increase still as more investigations are completed.

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during September was 1,261; 704 incidents were reported on the York site, 380 on the Scarborough site and 177 from Community Services. This is a -0.94% decrease from August.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 1183 (decrease from 1178 at the end of August) incidents awaiting sign-off by the Directorate Management Teams. Risk and Legal are working with the Directorates to facilitate the timely completion of incident investigations.

Pressure Ulcers (source: Datix)
During September 10 pressure ulcers were reported to have developed on patients since admission to York Hospital, 18 pressure ulcers were reported to have developed on patients since admission to Scarborough and 26 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.

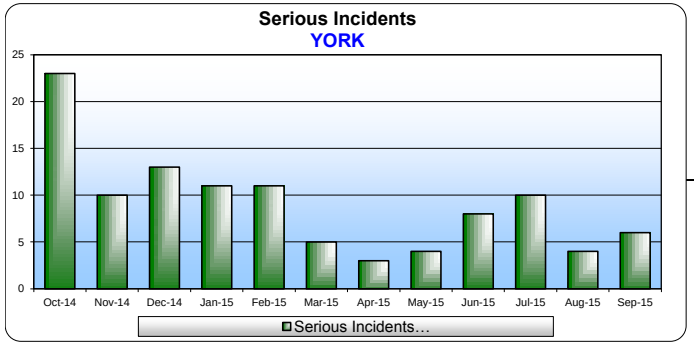
Degree of Harm: Serious/Severe or Death (source: Datix)
During September a total of 6 patient incidents were reported which resulted in serious or severe harm or death (preliminary data subject to validation).

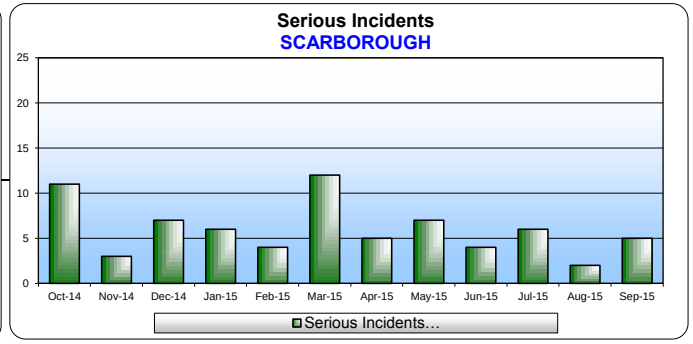
Medication Related Issues (source: Datix)
During September there was a total of 100 medication related incidents reported, although this figure may change following validation.

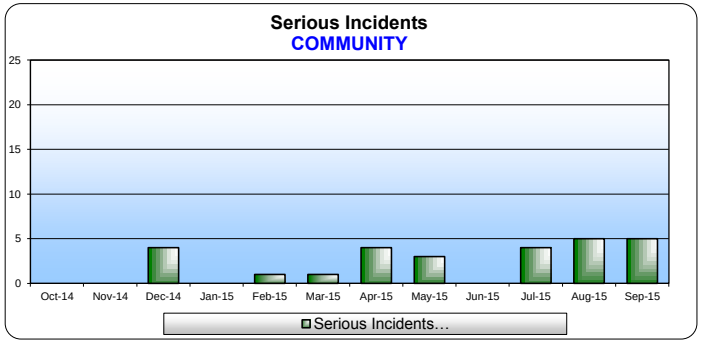
Never Events - There were zero Never Events declared in September.

Measures of Harm

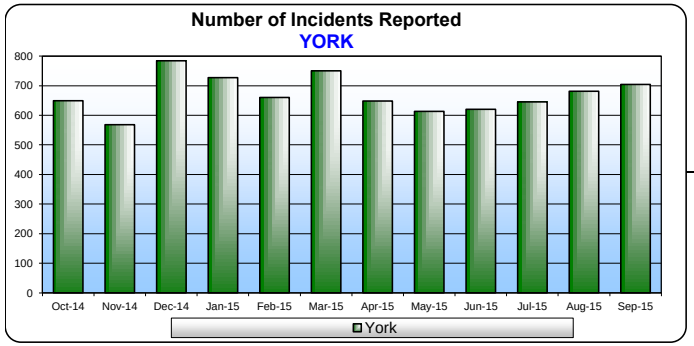
Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Serious Incidents source: Risk and Legal	York	23	10	13	11	11	5	3	4	8	10	4	6
	Scarborough	11	3	7	6	4	12	5	7	4	6	2	5
	Community	0	0	4	0	1	1	4	3	0	4	5	5
Serious Incidents Delogged source: Risk and Legal (Trust)		9	4	2	3	1	2	1	0	0	0	0	0

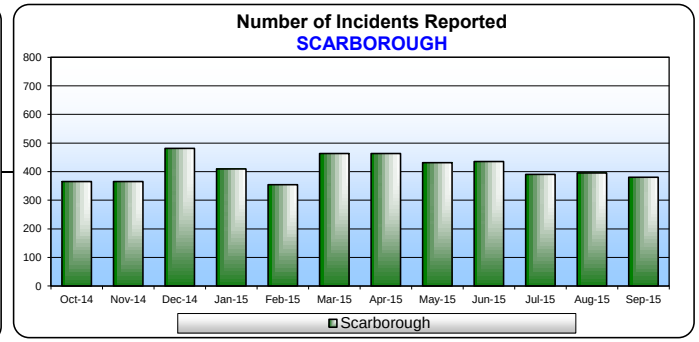


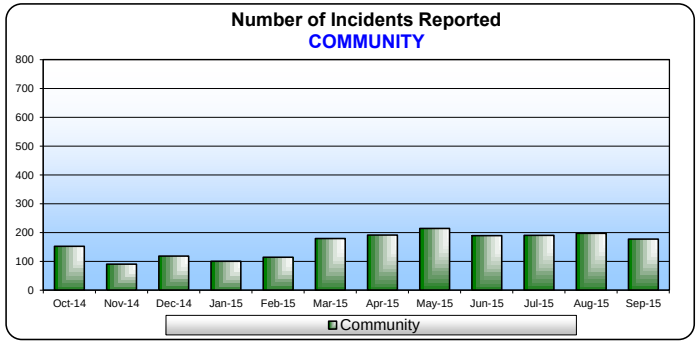




Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Number of Incidents Reported source: Risk and Legal	York	649	568	784	727	660	750	648	613	620	645	681	704
	Scarborough	365	365	481	409	354	463	463	431	435	390	395	380
	Community	152	90	118	100	114	179	191	214	189	190	197	177
Number of Incidents Awaiting sign off at Directorate level		1408	858	272	1444	516	546	1302	863	947	1178	1229	1183

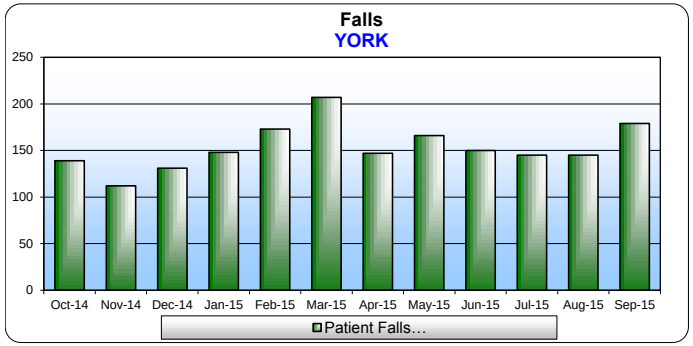


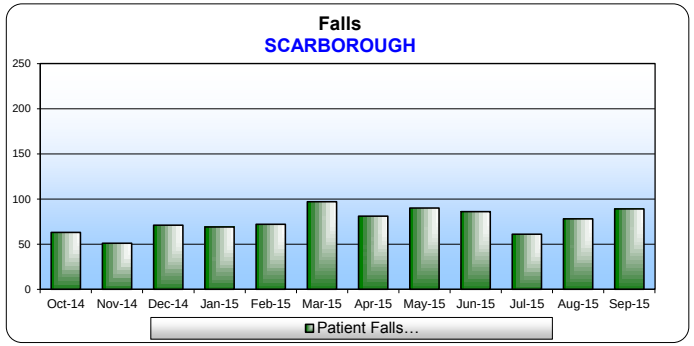


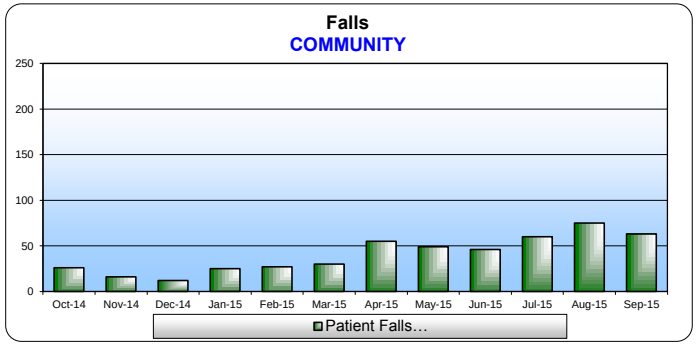


Measures of Harm

Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Patient Falls source: DATIX	York	139	112	131	148	173	207	147	166	150	145	145	179
	Scarborough	63	51	71	69	72	97	81	90	86	61	78	89
	Community	26	16	12	25	27	30	55	49	46	60	75	63

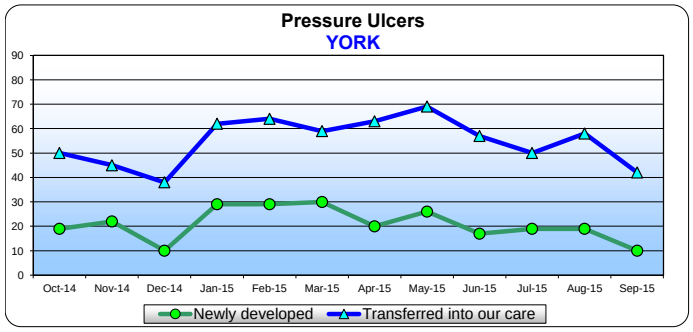


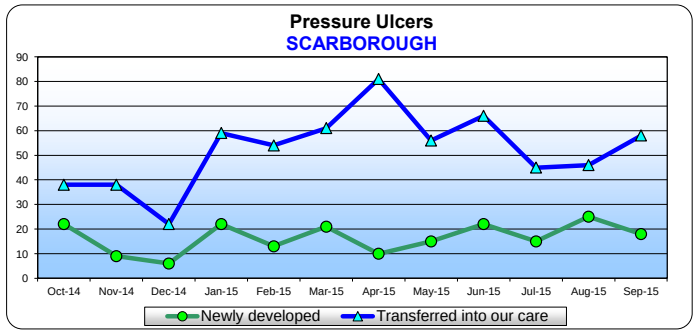


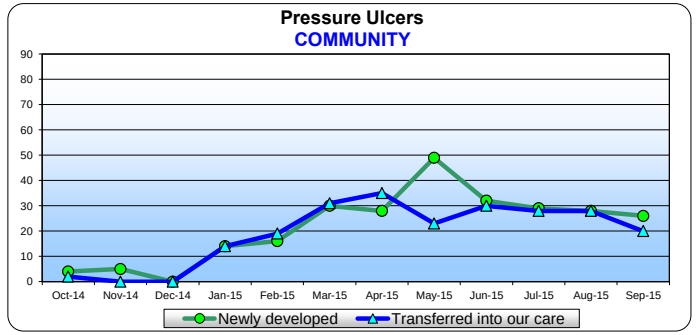


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Indicator			Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Pressure Ulcers source: DATIX	York	Newly developed	19	22	10	29	29	30	20	26	17	19	19	10
		Transferred into our care	50	45	38	62	64	59	63	69	57	50	58	42
	Scarborough	Newly developed	22	9	6	22	13	21	10	15	22	15	25	18
		Transferred into our care	38	38	22	59	54	61	81	56	66	45	46	58
	Community	Newly developed	4	5	0	14	16	30	28	49	32	29	28	26
		Transferred into our care	2	0	0	14	19	31	35	23	30	28	28	20



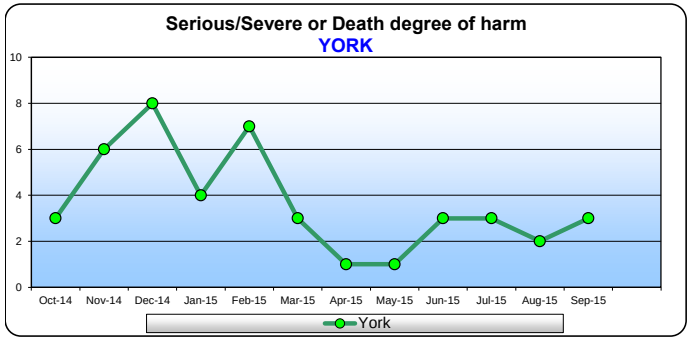


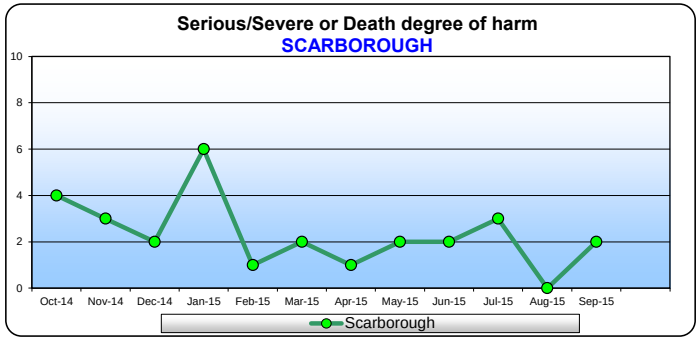


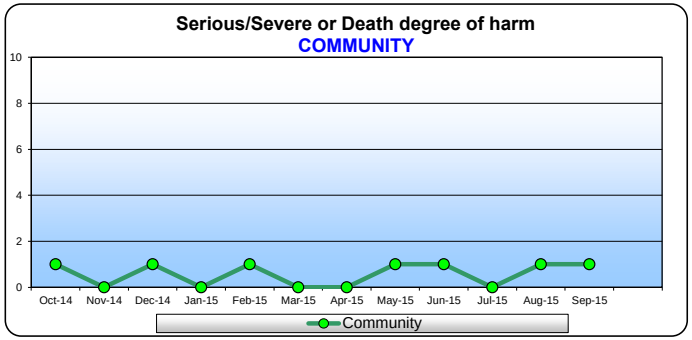
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised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

Measures of Harm

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

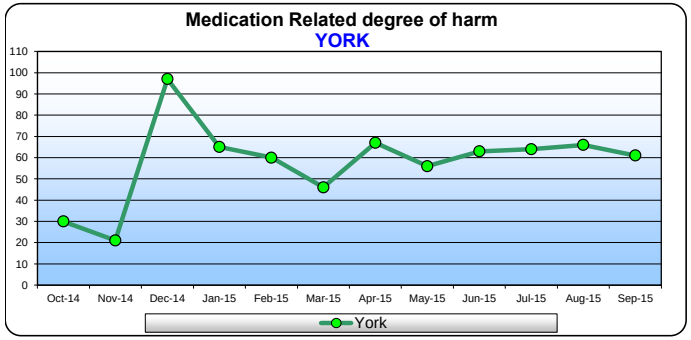


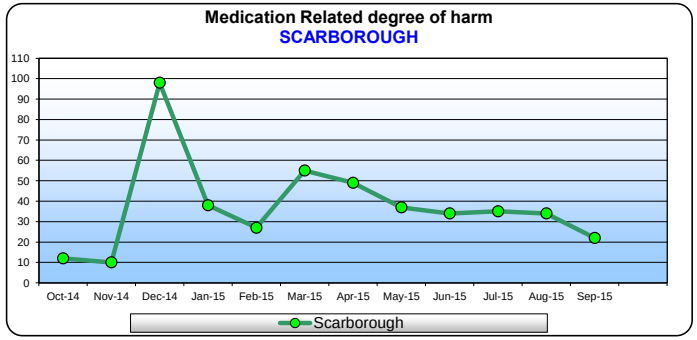


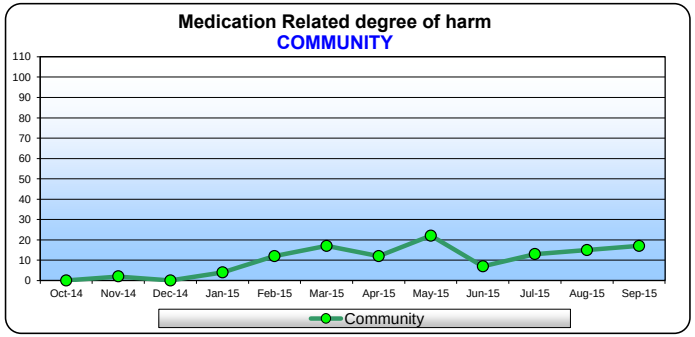


Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Degree of harm: Medication Related Issues source: Datix	York	30	21	97	65	60	46	67	56	63	64	66	61
	Scarborough	12	10	98	38	27	55	49	37	34	35	34	22
	Community	0	2	0	4	12	17	12	22	7	13	15	17

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

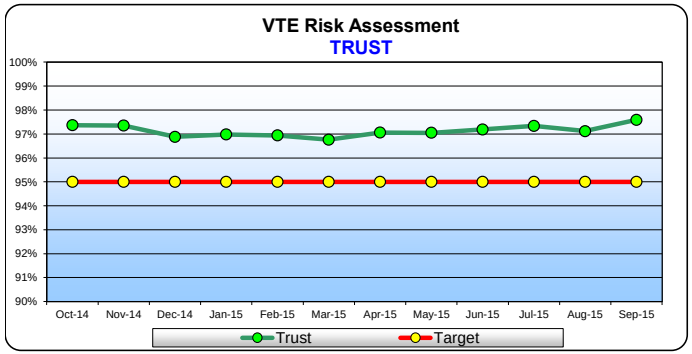


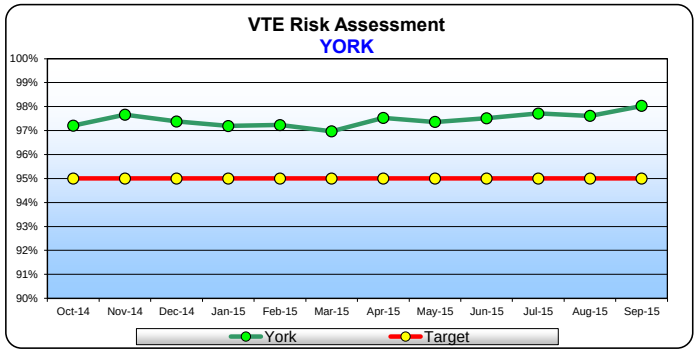


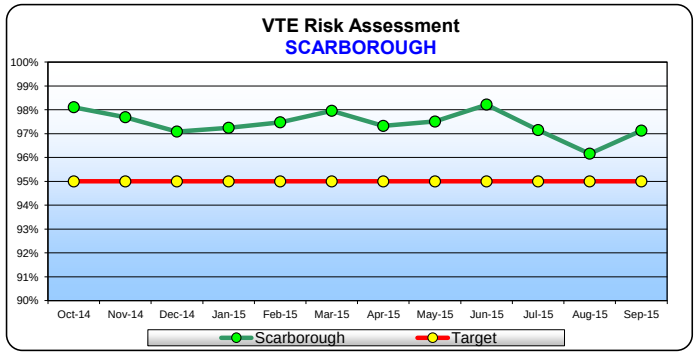


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance source: CPD	£200 in respect of each excess breach above threshold	Trust	95%	97.1%	96.9%	97.1%	97.4%	97.3%	97.1%	97.6%
		York	95%	97.4%	97.1%	97.5%	97.8%	97.7%	97.6%	98.0%
		Scarborough	95%	97.6%	97.6%	97.7%	96.8%	97.2%	96.2%	97.1%







Never Events

Indicator	Consequence of Breach	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
SURGICAL									
Wrong site surgery	As below	**>0**	**0**	**0**	**1**	**0**	0	0	0
Wrong implant/prosthesis		**>0**	**0**	**0**	**0**	**0**	0	0	0
Retained foreign object post-operation		**>0**	**0**	**0**	**0**	**0**	0	0	0
MEDICATION									
Wrongly prepared high-risk injectable medication	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	**0**	**0**	**0**	**0**	0	0	0
Maladministration of potassium-containing solutions		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong route administration of chemotherapy		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong route administration of oral/enteral treatment		**>0**	**0**	**0**	**0**	**0**	0	0	0
Intravenous administration of epidural medication		**>0**	**0**	**0**	**0**	**0**	0	0	0
Maladministration of insulin		**>0**	**0**	**0**	**0**	**0**	0	0	0
Overdose of midazolam during conscious sedation		**>0**	**0**	**0**	**0**	**0**	0	0	0
Opioid overdose of an opioid-naïve Service User		**>0**	**0**	**0**	**0**	**0**	0	0	0
Inappropriate administration of daily oral methotrexate		**>0**	**0**	**0**	**0**	**0**	0	0	0
GENERAL HEALTHCARE									
Falls from unrestricted windows	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	**0**	**0**	**0**	**0**	0	0	0
Entrapment in bedrails		**>0**	**0**	**0**	**0**	**0**	0	0	0
Transfusion of ABO incompatible blood components		**>0**	**0**	**0**	**0**	**0**	0	0	0
Transplantation of ABO incompatible organs as a result of error		**>0**	**0**	**0**	**0**	**0**	0	0	0
Misplaced naso- or oro-gastric tubes		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong gas administered		**>0**	**0**	**0**	**0**	**0**	0	0	0
Failure to monitor and respond to oxygen saturation		**>0**	**0**	**0**	**0**	**0**	0	0	0
Air embolism		**>0**	**0**	**0**	**0**	**0**	0	0	0
Misidentification of Service Users		**>0**	**0**	**0**	**0**	**0**	0	0	0
Severe scalding of Service Users		**>0**	**0**	**0**	**0**	**0**	0	0	0
	MATERNITY								
Maternal death due to post-partum haemorrhage after elective caesarean section	As above	**>0**	**0**	**0**	**0**	**0**	0	0	0

Drug Administration

Omitted Critical Medicines
The audit of critical medicines missed during September indicated 1.98% for York and 1.54% for Scarborough.

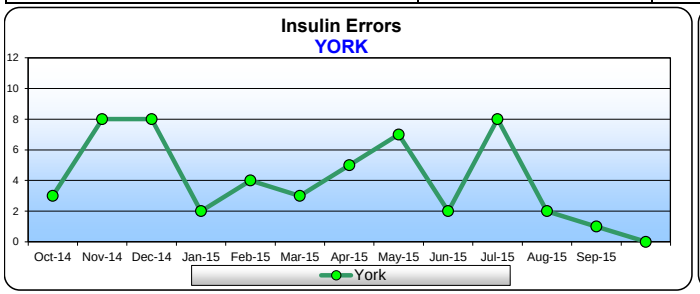
Prescribing Errors
There were 20 prescribing related errors in September; 13 from York, 6 from Scarborough and 1 from Community.

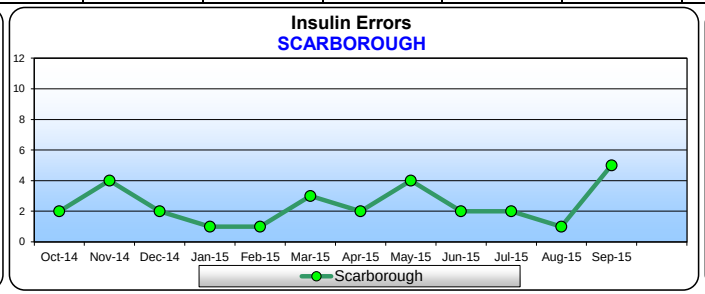
Preparation and Dispensing Errors
There were 16 preparation/dispensing errors in September; 12 from York, 2 from Scarborough and 2 from Community.

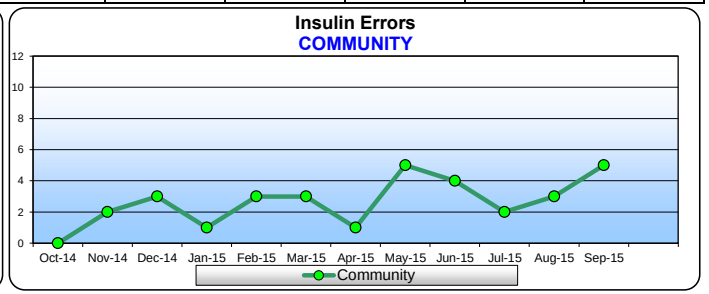
Administrating and Supply Errors
There were 36 administrating/supplying errors in September; 23 from York, 7 from Scarborough and 6 from Community.

Drug Administration

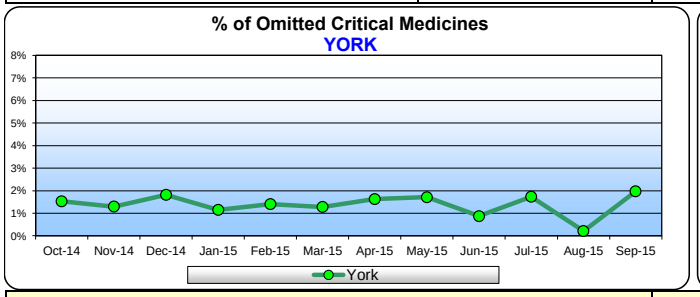
Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Insulin Errors source: Datix	York	3	8	8	2	4	3	5	7	2	8	2	1
	Scarborough	2	4	2	1	1	3	2	4	2	2	1	5
	Community	0	2	3	1	3	3	1	5	4	2	3	5

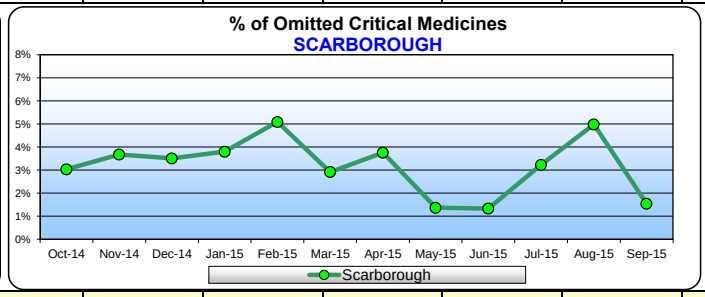


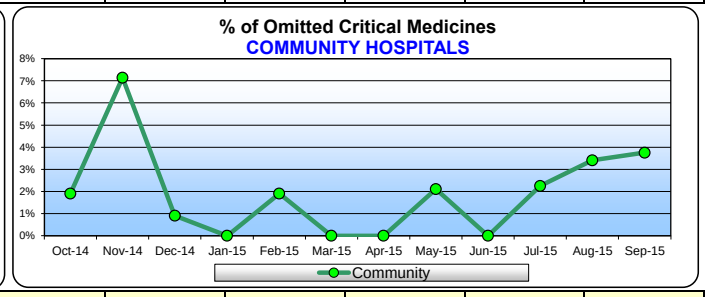




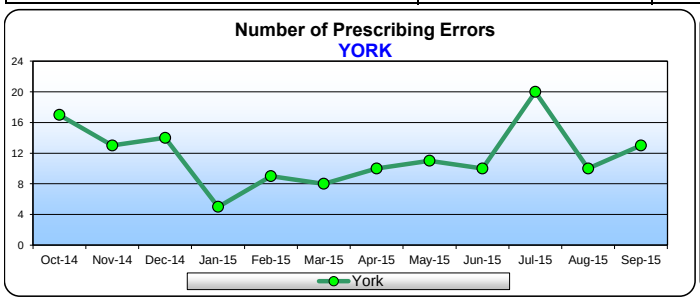
Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Number of Omitted Critical Medicines source: Datix	York	7	6	8	6	6	6	7	9	4	8	1	9
	Scarborough	7	9	9	9	12	7	9	3	3	7	10	3
	Community Hospitals	2	7	1	0	2	0	0	2	0	2	3	3

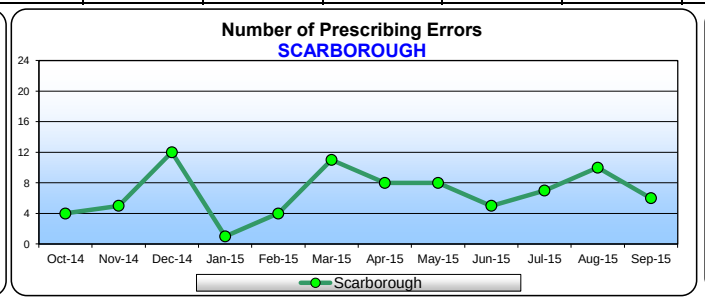


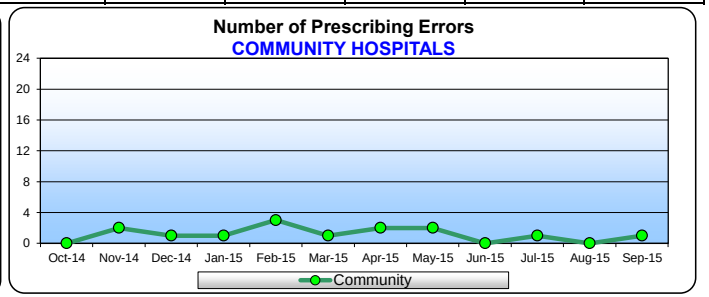




Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Number of Prescribing Errors source: Datix	York	17	13	14	5	9	8	10	11	10	20	10	13
	Scarborough	4	5	12	1	4	11	8	8	5	7	10	6
	Community Hospitals	0	2	1	1	3	1	2	2	0	1	0	1

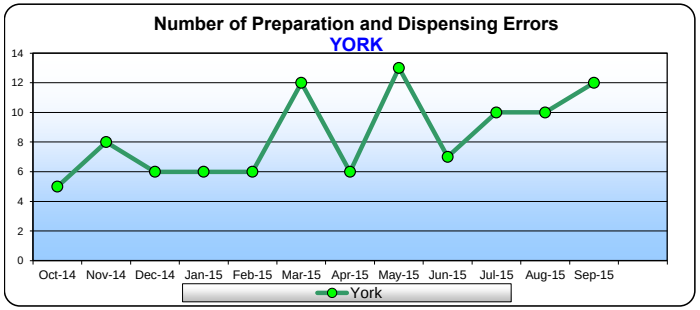


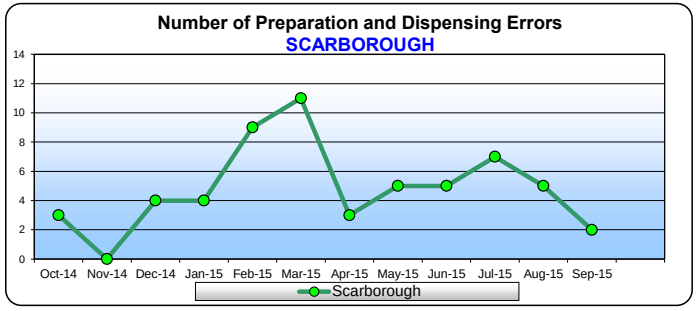


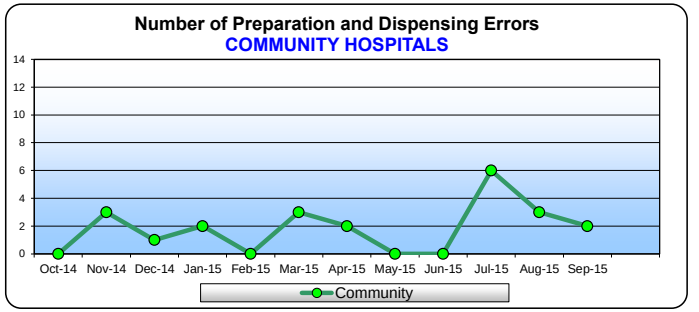


Drug Administration

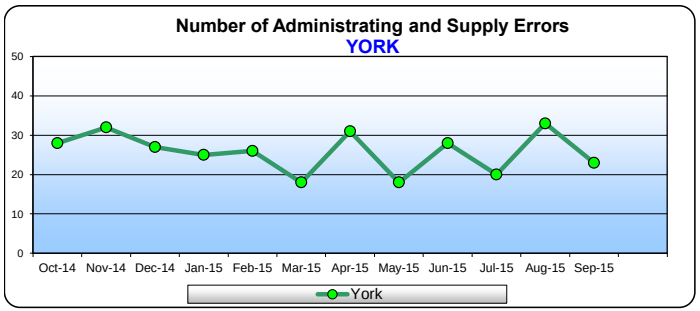
Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Number of Preparation and Dispensing Errors source: Datix	York	5	8	6	6	6	12	6	13	7	10	10	12
	Scarborough	3	0	4	4	9	11	3	5	5	7	5	2
	Community Hospitals	0	3	1	2	0	3	2	0	0	6	3	2

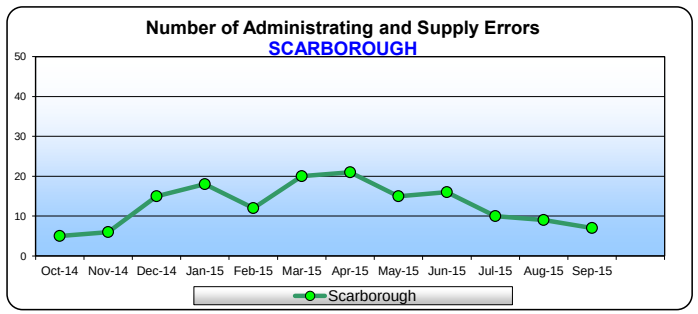


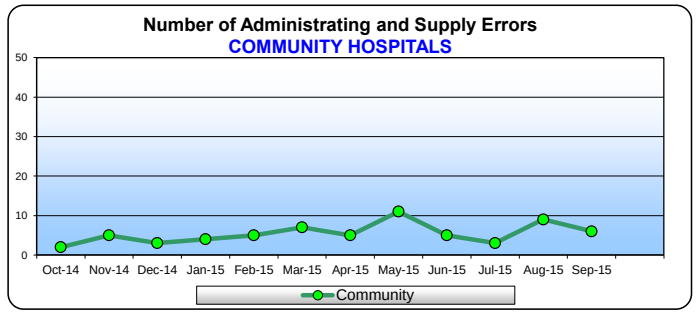




Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Administrating and Supply Errors source: Datix	York	28	32	27	25	26	18	31	18	28	20	33	23
	Scarborough	5	6	15	18	12	20	21	15	16	10	9	7
	Community Hospitals	2	5	3	4	5	7	5	11	5	3	9	6







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: 95.1%
·Scarborough: 93.9%
·Community Hospitals: 87.1%
·Community care: 94.7%

VTE

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

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

Harm from Catheter Associated Urinary Tract Infection

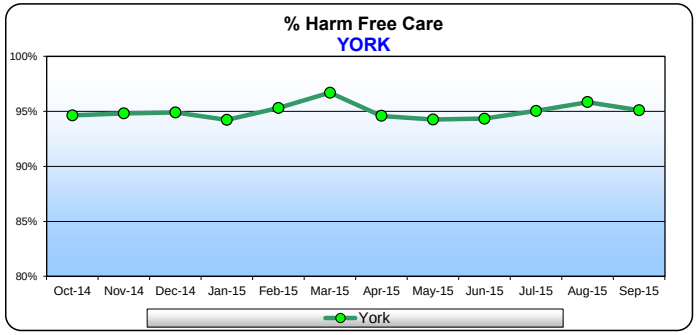
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence:

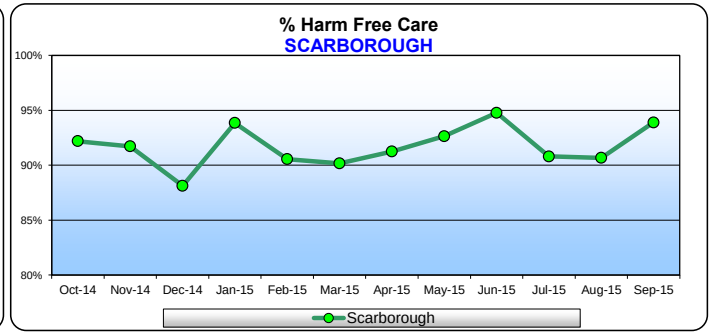
·York: 2.1%
·Scarborough: 3.1%
·Community Hospitals: 2.2%
·Community Care: 0.8%

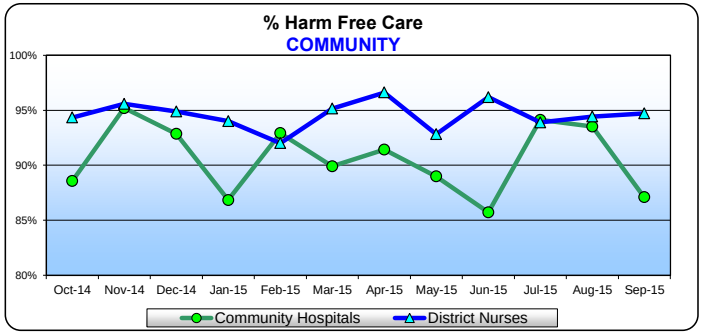
Safety Thermometer

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

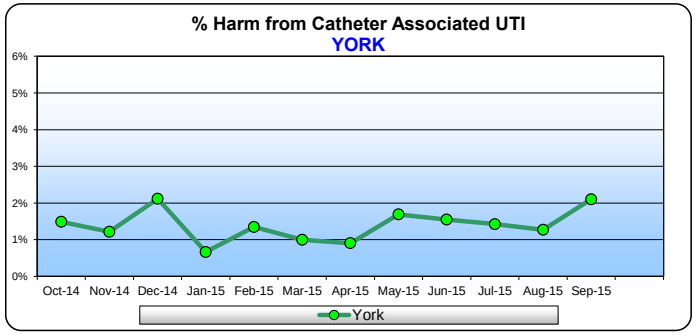
Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
% of Harm Free Care source: Safety Thermometer	York	94.6%	94.8%	94.9%	94.2%	95.3%	96.7%	94.6%	94.3%	94.3%	95.0%	95.8%	95.1%
	Scarborough	92.2%	91.7%	88.1%	93.9%	90.6%	90.2%	91.3%	92.6%	94.8%	90.8%	90.7%	93.9%
	Community Hospitals	88.6%	95.2%	92.9%	86.8%	92.9%	89.9%	91.4%	89.0%	85.7%	94.1%	93.5%	87.1%
	District Nurses	94.3%	95.6%	94.9%	94.0%	92.0%	95.2%	96.6%	92.8%	96.2%	93.9%	94.4%	94.7%

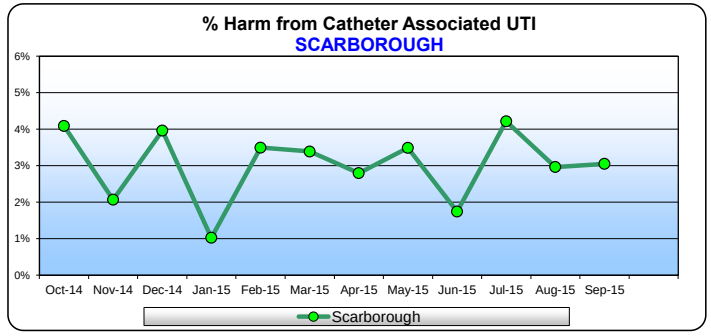


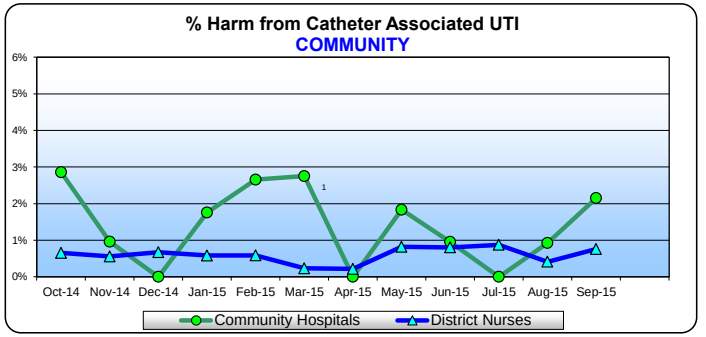




Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	1.5%	1.2%	2.1%	0.7%	1.3%	1.0%	0.9%	1.7%	1.5%	1.4%	1.3%	2.1%
	Scarborough	4.1%	2.1%	4.0%	1.0%	3.5%	3.4%	2.8%	3.5%	1.7%	4.2%	3.0%	3.1%
	Community Hospitals	2.9%	1.0%	0.0%	1.8%	2.7%	2.8%	0.0%	1.8%	1.0%	0.0%	0.9%	2.2%
	District Nurses	0.7%	0.6%	0.7%	0.6%	0.6%	0.2%	0.2%	0.8%	0.8%	0.9%	0.4%	0.8%



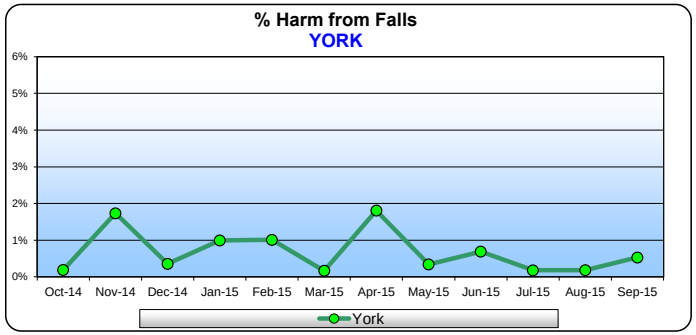


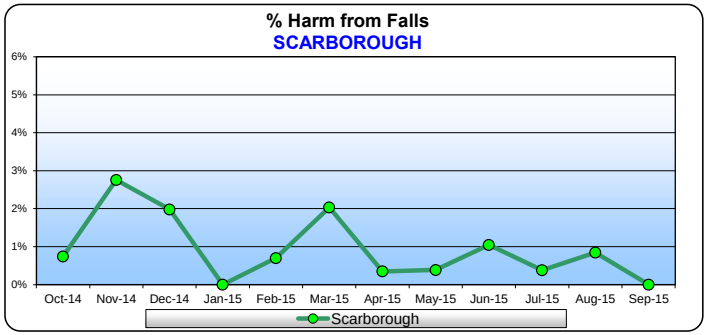


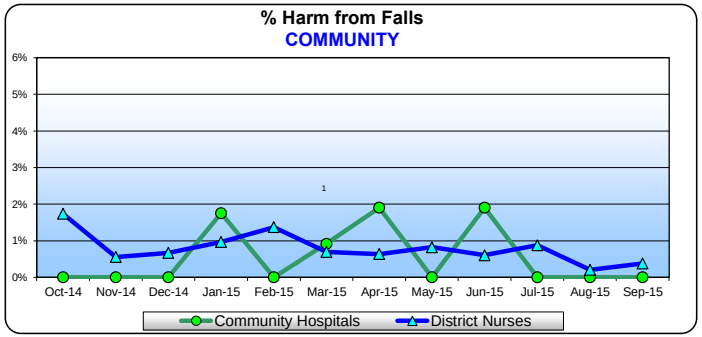
Safety Thermometer

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

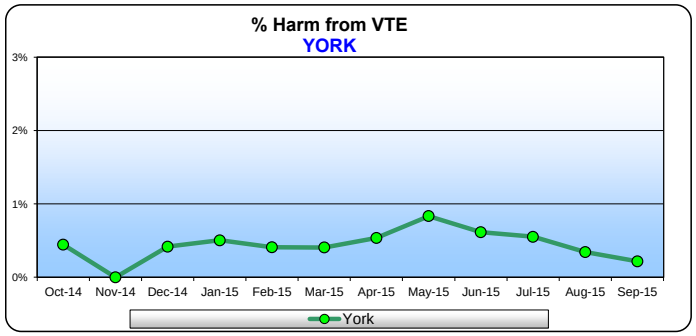
Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
% of Harm from Falls source: Safety Thermometer	York	0.2%	1.7%	0.4%	1.0%	1.0%	0.2%	1.8%	0.3%	0.7%	0.2%	0.2%	0.5%
	Scarborough	0.7%	2.8%	2.0%	0.0%	0.7%	2.0%	0.3%	0.4%	1.0%	0.4%	0.8%	0.0%
	Community Hospitals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

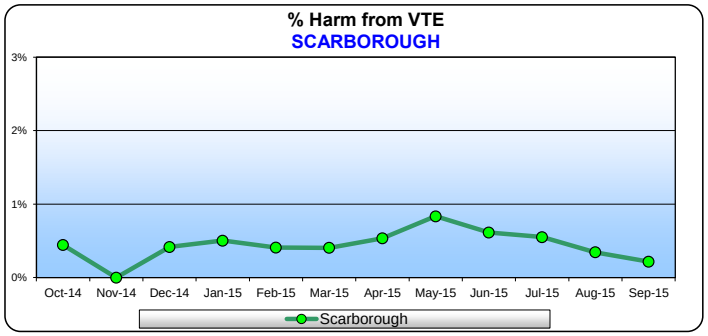


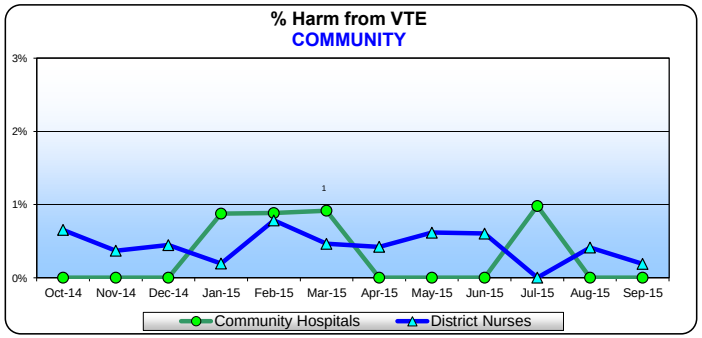




Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
% of VTE source: Safety Thermometer	York	0.4%	0.0%	0.4%	0.5%	0.4%	0.4%	0.5%	0.8%	0.6%	0.6%	0.3%	0.2%
	Scarborough	0.4%	0.0%	0.4%	0.5%	0.4%	0.4%	0.5%	0.8%	0.6%	0.6%	0.3%	0.2%
	Community Hospitals	0.0%	0.0%	0.0%	0.9%	0.9%	0.9%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%
	District Nurses	0.7%	0.4%	0.4%	0.2%	0.8%	0.5%	0.4%	0.6%	0.6%		0.4%	0.2%



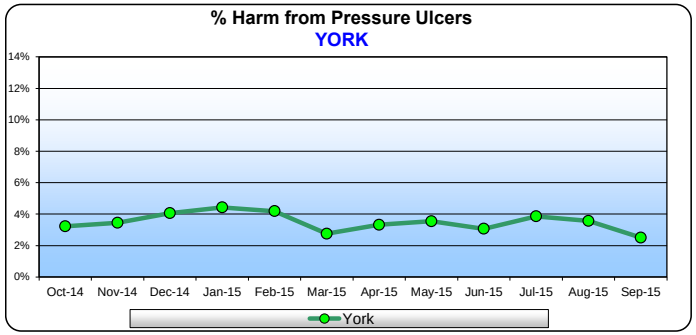


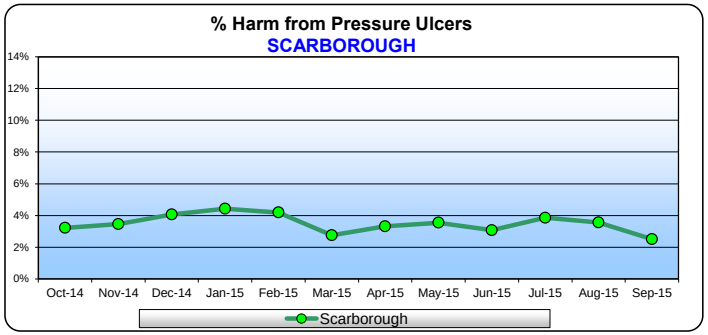


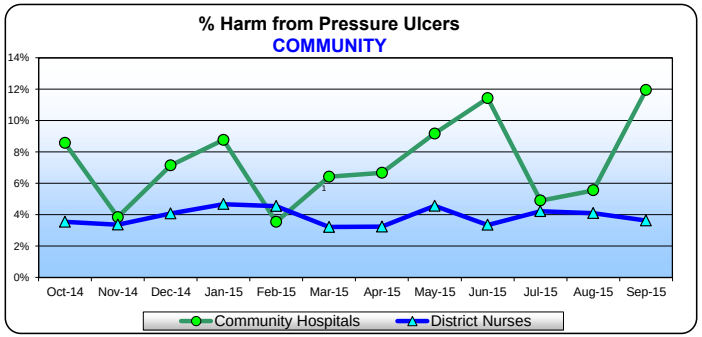
Safety Thermometer

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

Indicator		Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
% of Pressure Ulcers source: Safety Thermometer	York	3.2%	3.4%	4.1%	4.4%	4.2%	2.7%	3.3%	3.5%	3.1%	3.9%	3.6%	2.5%
	Scarborough	3.2%	3.4%	4.1%	4.4%	4.2%	2.7%	3.3%	3.5%	3.1%	3.9%	3.6%	2.5%
	Community Hospitals	8.6%	3.8%	7.1%	8.8%	3.5%	6.4%	6.7%	9.2%	11.4%	4.9%	5.6%	12.0%
	District Nurses	3.5%	3.4%	4.1%	4.7%	4.6%	3.2%	3.2%	4.6%	3.4%	4.2%	4.1%	3.6%







YORK - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Flag Source	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Av. Monthly YtD
Activity	**Births**	Bookings	1st m/w visit	CPD	≤302	303-329	≥330	prev. stats	299	278	248	279	242	303				
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	CQUIN	81.9%	87.1%	89.1%	85.7%	87.4%	87.1%				
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	CQUIN	6.0%	5.0%	6.0%	7.2%	6.1%	7.6%				
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	CQUIN	27.8%	35.7%	33.3%	45.0%	47.1%	47..8%				
		Births	No. of babies	CPD	≤295	296-309	≥310	prev. stats	273	284	289	305	287	316				
		No. of women delivered	No. of mothers	CPD	≤295	296-310	≥311		272	283	288	304	282	311				
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more		3	0	0	0	0					
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more		0	0	0	0	0					
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more		3	4	2	5	11					
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	1				
		SCBU at capacity of intensive cots	No. of times	SCBU	0	1	2 or more		0	0	0	1	0	1				
		SCBU no of babies affected	No. of babies affected	SCBU	0		1 or more		0	0	0	1	0	0				
Workforce	**Staffing**	M/W per 1000 births	Ratio	Matron	≥35.0	35-31	≤31.0	DH	30.0	32.0		32.0	29.8					
		1 to 1 care in Labour	CPD	CPD	≥100%		<100%		63.2%	67.3%	64.2%	70.4%	61.3%	63.0%				
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%		<100%		50.0%	53.0%	56.0%	58.0%	37.1%	50.0%				
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	Safer Childbirth	76	76	76	76	76	76				
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10		≤9		10	10	10	10	10	10				
		Supervisor : M/w ratio 1 :	Ratio	Rota - Contact SOM	15	16-18	≥17	SHA	14	14	14	14	14	14				
Clinical	**Neonatal/Maternal**	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%		55.5%	61.3%	55.2%	62.8%	57.8%	62.7%				
Indicators	**Morbidity**	Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17%	≥18%	prev. stats	15.4%	12.0%	13.2%	10.2%	13.1%	12.9%				
		C/S Births	Em & elect - %	CPD	≤26%	26-28%	>28%	prev. stats	28.7%	25.4%	28.1%	25.0%	27.0%	23.8%				
		Eclampsia	No. of women	CPD	0		1 or more		0	0	0	0	0	0				
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	prev. stats	1	2	2	2	3	1				
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more		16	8	19	18	21	11				
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	prev. stats	1	3	7	1	2	1				
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	0	0	0	0	0	0				
		Neonatal Death	No of babies	Risk team- EBC	0		1 or more		0	0	0	0	0	0				
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more		0	1	1	1	0	1				
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more		0	0	0	0	0	0				
		Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70%	>70%		71.0%	70.0%	74.0%	76.7%	71.8%	72.2%				
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%		14.0%	13.1%	10.1%	10.5%	13.5%	9.6%				
	Risk Management	SI's	No. of SI's declared	Risk Team	0		1 or more		0	0	0	0	0	0				
		CI's	No. of CI's declared	Risk Team	0		1 or more		1	0	0	1	0	0				
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more		2	7	8	10	13	6				
		PPH > 1.5L as % of all women	% of births	CPD					1	3	3	3	5	2				
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	RCOG	7	3	4	2	3	3				
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.5- 4%	≥4%	RCOG	4.7%	1.4%	3.5%	2.3%	3.5%	3.4%				
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more		0	1	1	2	2	0				
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more		0	3	0	0	1	0				

SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Flag Source	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Av. Monthly YtD
Activity	**Births**	Bookings	1st m/w visit	CPD	≤210	211-259	≥260	prev. stats	162	157	157	168	127	122				
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	CQUIN	92.0%	91.1%	87.9%	81.0%	92.9%	78.7%				
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	CQUIN	6.8%	5.7%	8.9%	16.1%	7.1%	9.8%				
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	CQUIN	27.3%	33.3%	42.9%	22.2%	44.4%	50.0%				
		Births	No. of babies	CPD	≤170	171-189	≥190	prev. stats	131	117	134	134	139	131				
		No. of women delivered	No. of mothers	CPD	≤170	171-189	≥190		131	114	133	134	139	130				
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more		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				
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more		1	0	0	0	0	0				
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0				
		SCBU at capacity	No. of times	SCBU	0	1	2 or more		12	4	7	4	6	1				
		SCBU no of babies affected	No. of babies affected	SCBU	0		1 or more		1	0	0	0	0	0				

Workforce	**Staffing**	M/W per 1000 births	Ratio	Matron	≥35.0	35-31	≤31.0	DH	41.2	42.2	36.6	39.1	36.8	37.0				
		1 to 1 care in Labour	CPD	CPD	≥100%		<100%		95.4%	88.6%	85.0%	86.6%	83.5%	86.2%				
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%		<100%		56.0%	81.0%	80.0%	84.7%	75.4%	83.0%				
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	Safer Childbirth	40	40	40	40	40	40				
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10		≤9		3	3	3	3	3	3				
		Supervisor : M/w ratio 1 :	Ratio	Rota - Contact SOM	15	16-18	≥17	SHA	14	14	14	14	14	14				

Clinical	**Neonatal/Maternal**	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%		66.4%	69.3%	63.9%	62.7%	72.1%	75.4%				
Indicators	**Morbidity**	Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17%	≥18%	prev. stats	9.2%	6.1%	6.0%	11.2%	10.1%	3.8%				
		C/S Births	Em & elect - %	CPD	≤26%	26-28%	>28%	prev. stats	23.7%	22.8%	29.3%	26.1%	18.7%	19.2%				
		Eclampsia	No. of women	CPD	0		1 or more		0	0	0	0	0	0				
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	prev. stats	0	1	0	0	0	0				
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more		3	3	2	3	1	2				
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	prev. stats	0	1	1	3	1	1				
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	0	1	0	0	0	0				
		Neonatal Death	No of babies	Risk team- EBC	0		1 or more		0	2	0	0	0	0				
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more		0	0	0	0	0	0				
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more		0	0	0	0	0	0				
		Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70%	>70%		46.6%	51.8%	50.7%	55.2%	43.9%	52.7%				
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%		18.3%	21.1%	25.6%	23.9%	21.0%	30.8%				
	Risk Management	SI's	No. of SI's declared	Risk Team	0		1 or more		0	0	0	0	0	0				
		CI's	No. of CI's declared	Risk Team	0		1 or more		1	0	1	0	0	0				
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more		1	1	2	2	0	1				
		PPH > 1.5L as % of all women	% of births	CPD					1	1	2	2	0	0				
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	RCOG	0	3	4	2	2	3				
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.5- 4%	≥4%	RCOG	0.8%	0.9%	1.5%	2.9%	0.7%	0.0%				
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more		0	0	0	1	1	1				
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more		1	0	0	0	1	2				

Mortality

Indicator	Apr 11 - Mar 12	Jul 11 - Jun 12	Oct 11 - Sep 12	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14
SHMI – York locality	110	105	105	102	99	96	93	93	95	98	99	97
SHMI – Scarborough locality	115	117	112	106	108	108	104	105	107	108	109	107
SHMI – Trust	**112**	**108**	**107**	**104**	**102**	**101**	**97**	**98**	**99**	**102**	**103**	**101**

Definition

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

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

Analysis of Performance

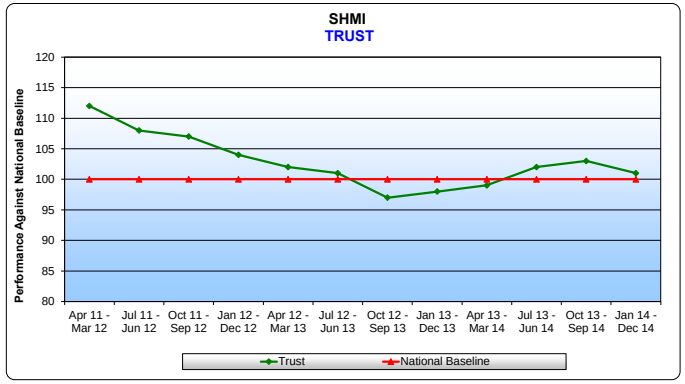
The latest SHMI report for the period January - December 2014 indicates the Trust to be in the 'as expected' range. Both York and Scarborough had a 2 point reduction from the previous release.

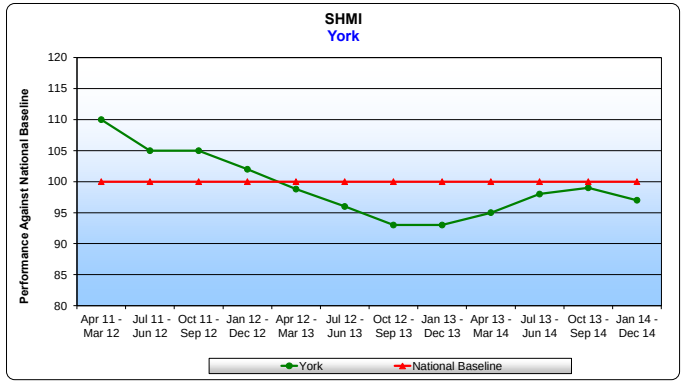
The number of inpatient deaths in September was in line with previous months. The percentage of deaths against all discharges at York has decreased slightly from 1.1% in August to 1% in September (September 2014 was 1.2%). However Scarborough saw an increase from 1.4% in August to 1.9% in September (September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

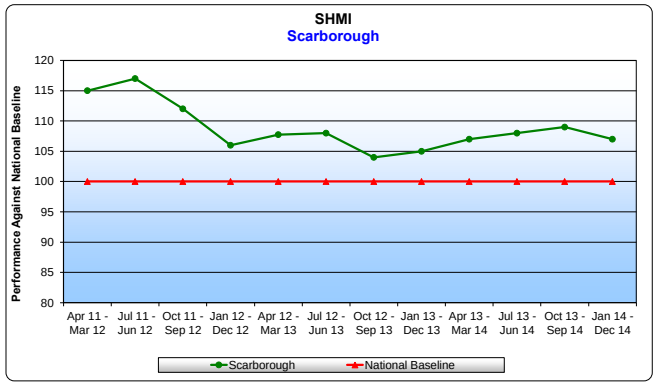
The number of ED deaths in September was also in line with previous months.

Mortality

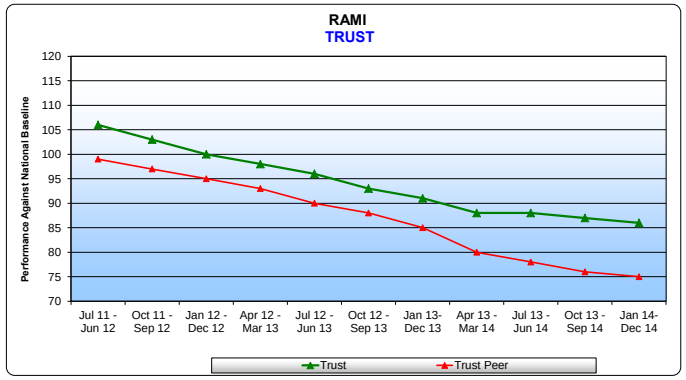
Indicator	Consequence of Breach (Monthly unless specified)	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	101	97	98	99	102	103	101
Mortality – SHMI (YORK)	**Quarterly:** General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

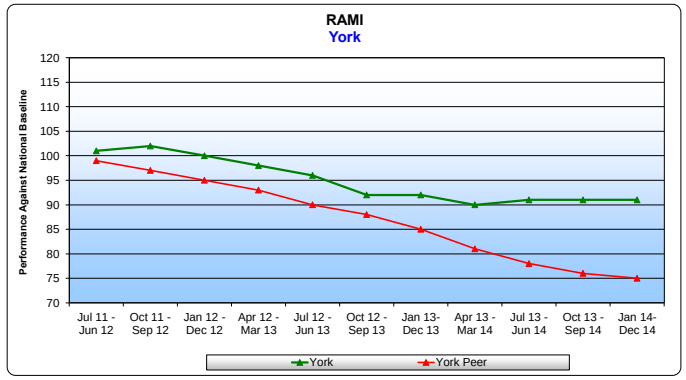


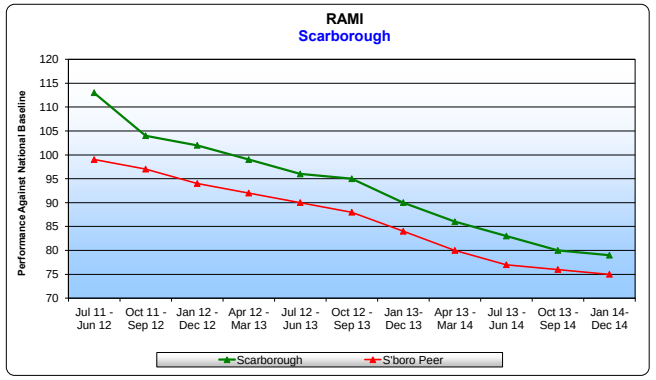




Indicator	Consequence of Breach (Monthly unless specified)	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sept 14	Jan 14 - Dec 14
Mortality – RAMI (TRUST)	**none - monitoring only**	96	93	91	88	88	87	86
Mortality – RAMI (YORK)	**none - monitoring only**	96	92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

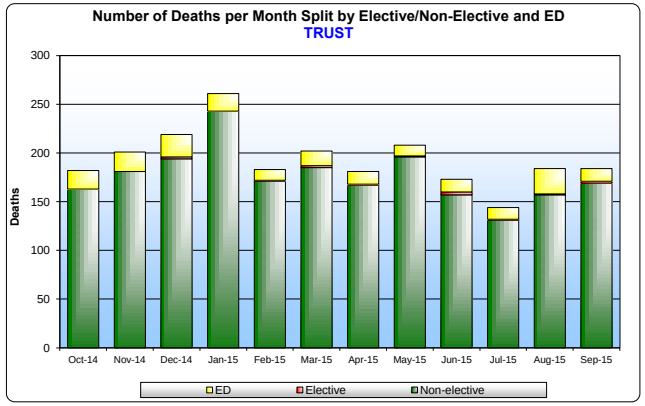


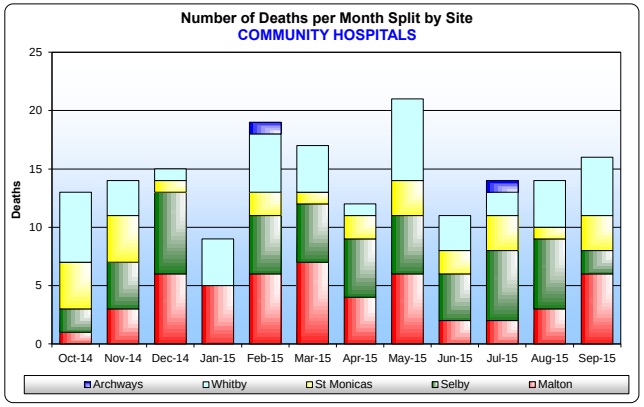




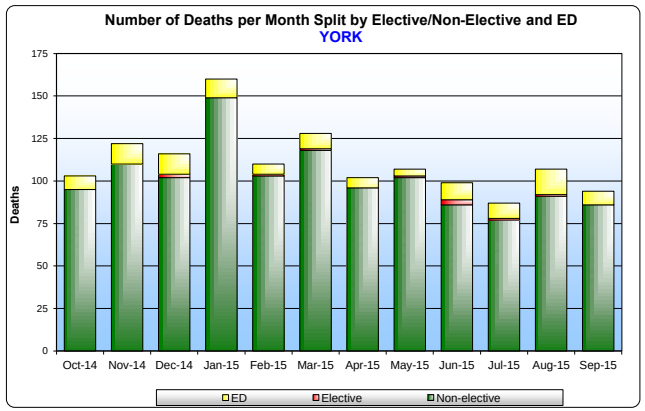
Mortality

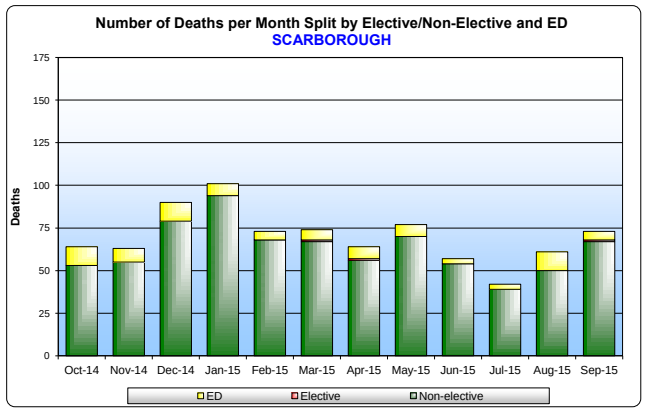
Indicator	Consequence of Breach (Monthly unless specified)	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Number of Inpatient Deaths (excludes deaths in ED)	None - Monitoring Only	540	602	525	461	132	158	171

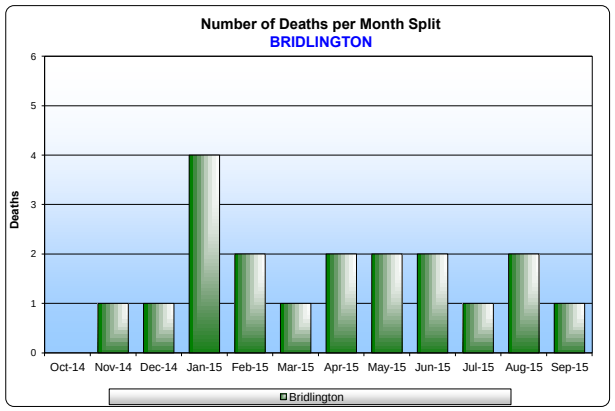




Month	Malton	Selby	St Monicas	Whitby	Archways	Bridlington
Oct-14	1	2	4	6	0	0
Nov-14	3	4	4	3	0	1
Dec-14	6	7	1	1	0	1
Jan-15	5	0	0	4	0	4
Feb-15	6	5	2	5	1	2
Mar-15	7	5	1	4	0	1
Apr-15	4	5	2	1	0	2
May-15	6	5	3	7	0	2
Jun-15	2	4	2	3	0	2
Jul-15	2	6	3	2	1	1
Aug-15	3	6	1	4	0	2
Sep-15	6	2	3	5	0	1





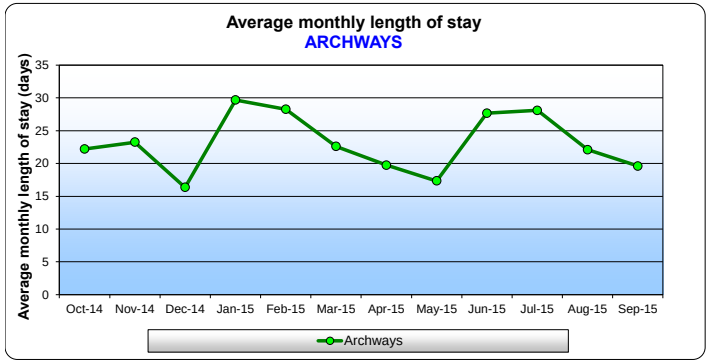


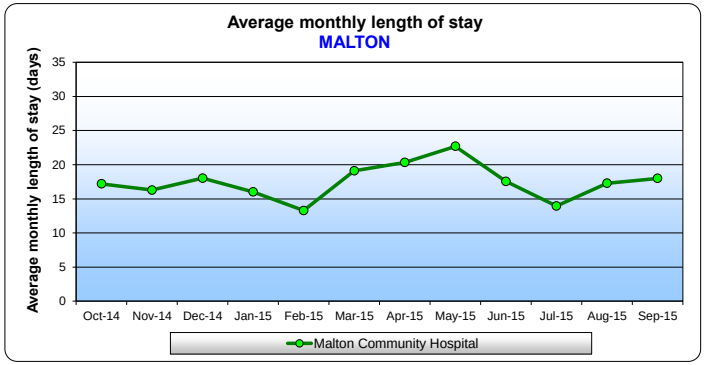
Patient Safety Walkrounds – September 2015

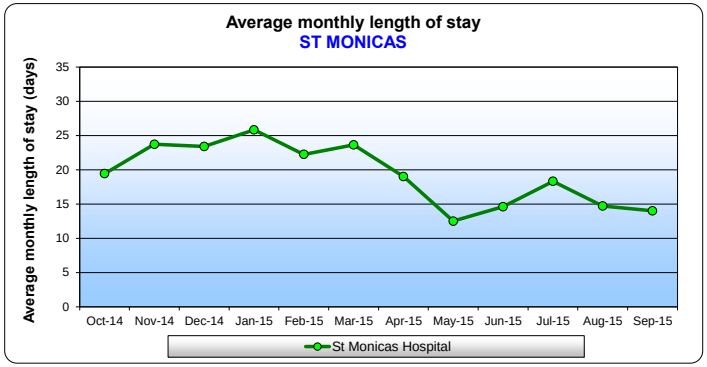
Date	Location	Participants	Actions & Recommendations
26/08/2015	Cardio Respiratory Unit, York Hospital	Bev Geary - Director Nigel Durham – Clinical Director Jane Allen – Head of Department Sharon Lewis – Directorate Manager Chris Morris – Matron Mike Sweet – Non-Executive Director	Report to follow.
02/09/2015	Diabetes Centre, York Hospital	Sue Rushbrook - Director Jonathan Thow – Head of Department Sharon Lewis – Directorate Manager Chris Morris – Matron Mike Keaney – Non-Executive Director	Report to follow.
11/09/2015	Monkgate Health Centre	Brian Golding - Director Ian Fairley – Clinical Director Jen Slaughter – Directorate Manager Tina Ramsey – Lead Nurse Chris Foster – Matron	Although the focus was on Monkgate, issues in the wider service were considered. Vacancies in Sexual Health are being recruited to and temporarily the gaps are being filled by staff working additional hours. Action – Chris Foster to monitor Sample response times are challenging and are missed on some occasions. A contract for remote samples with Airedale is being considered to improve sample turnaround time. Action – Jen Slaughter Some sites report problems with written records and lack of IT infrastructure, and although there is a plan with SNS to resolve the problem there is a time delay. Action - SNS Cleaning only takes place after clinics have finished leading to unacceptable hygiene standards occasionally. Action – Chris Foster to discuss with Carol Birch.
14/09/2015	Wards 11, 14, 16 and Breast Unit, York Hospital	Wards 11, 14, 16 and Breast Unit, York Hospital	Report to follow.
15/09/2015	Therapy Directorate – Main MSK Physio Department, Orthotic Department and Psychological Medicine Department, the Old Chapel Bootham	Mike Proctor - Director Mel Liley – Directorate Manager Liz Anderson – Head of Psychological Medicine Sue Sharp – Head of Orthotics Jennie Adams – Non-Executive Director	There is poor lighting around the department grounds (especially in winter), the paths to and from hospital, and to and from car parks. Paths are slippery in Autumn/winter due to fallen leaves. Action – to ensure Estate Team are contacted when the paths are slippery. There is a capacity challenge with the pain psychology list. Action –referral pathways to be refined. Children's Health Plans have resulted in increased attendance and reporting. Action- Additional resource required to mitigate increased demands. The new operational team manager for Scarborough Childrens SLT will continue to redesign and improve pathway/strategy.
24/09/2015	Archways	Andy Bertram - Director Linda Smith – Locality Manager Jane Farley – Ward Manager Sue Symington - Chair	Three patients were interviewed as part of the walk round. All were extremely complimentary about the staff and the care they were receiving. The current new menu system is resulting in significant waste on the unit. The management team are about to pilot a new way of working in the expectation of improving the position. There are notable issues to be resolved around nurse staffing vacancies, replacement medical cover, replacement for the Sister and Matron. Action – Bev Proctor.
29/09/2015	Duke of Kent Ward, Children's Clinic and SCBU	Diane Palmer - Deputy Director Udupa Venkatesh – Clinical Director Liz Vincent – Directorate Manager Nichola Lockwood – Matron Dianne Willcocks – Non Executive Director	Duke of Kent Ward Bed numbers are planned to increase but this requires an increase in nursing and medical staff. Action – Directorate Management Team. There are challenges in communication/liaison when the orthopaedic team are involved with care of the patients. Action – Clinical Director to monitor and escalate as necessary. SCBU The facilities management system has been very successful but recently withdrawn. Action – to discuss with Brian Golding There are not enough bank staff with skills to work on the unit, this results in extra work for the core team on the unit. Action – to be monitored by Matron. Access to the parents room is via a bay of 2 cots. Action – Matron to seek advice on potential risk from IPC. The baby milk fridge is not locked. Action – Matron to liaise with other units about systems to restrict access to milk fridge.

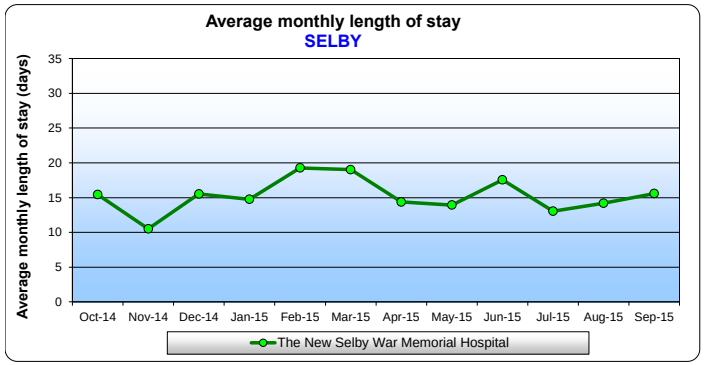
Community Hospitals

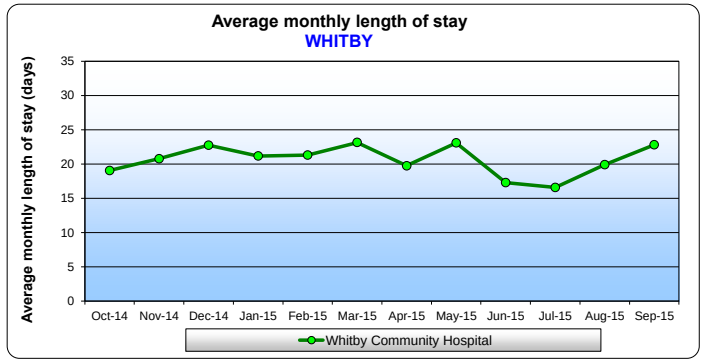
Indicator	Hospital	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Community Hospitals average length of stay (days)	Archways	20.6	26.8	21.1	23.0	28.1	22.1	19.6
	Malton Community Hospital	17.1	16.0	19.9	16.1	13.9	17.3	18.0
	St Monicas Hospital	22.0	24.0	15.5	15.5	18.3	14.7	14.0
	The New Selby War Memorial Hospital	13.7	17.6	15.3	14.2	13.1	14.2	15.6
	Whitby Community Hospital	20.9	21.9	20.0	19.5	16.6	19.9	22.8
	Total	18.1	20.2	18.5	17.4	16.3	18.0	18.3

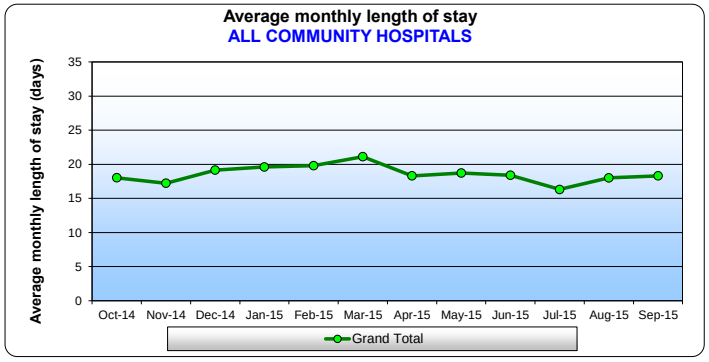






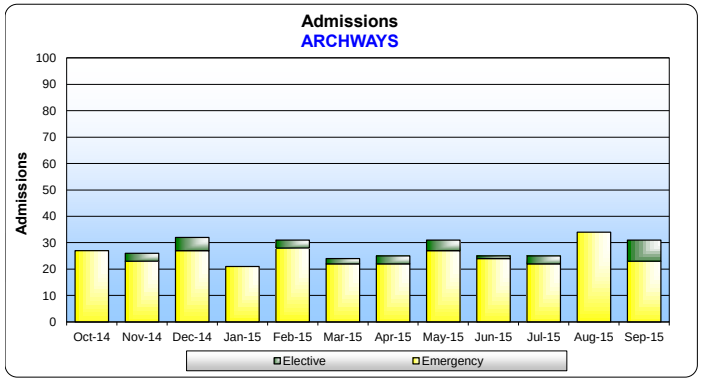


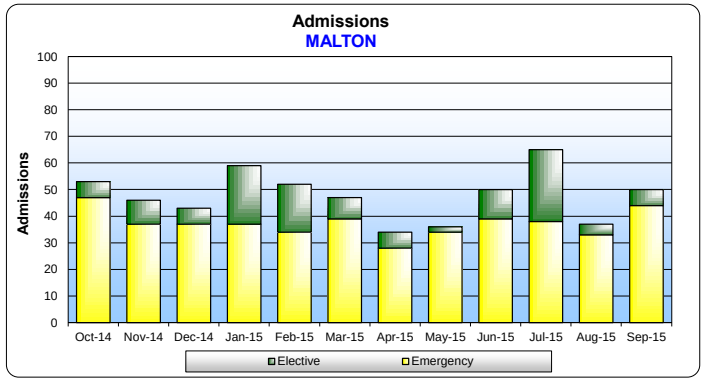


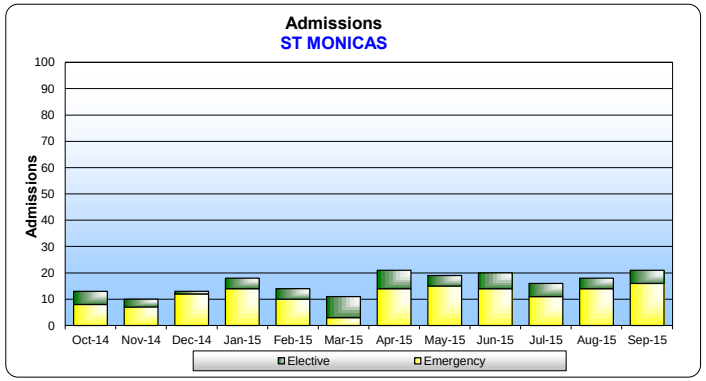


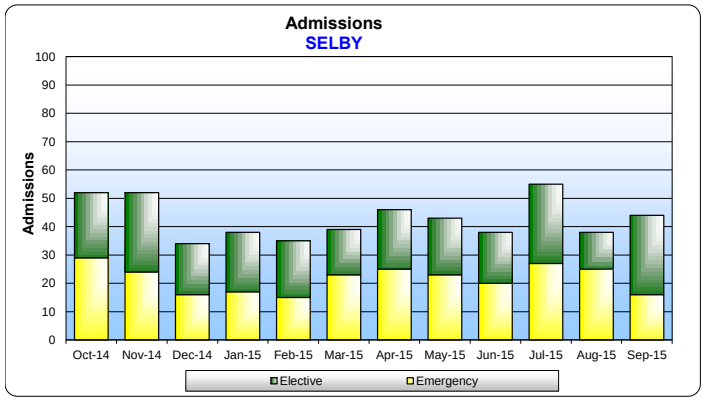
Community Hospitals

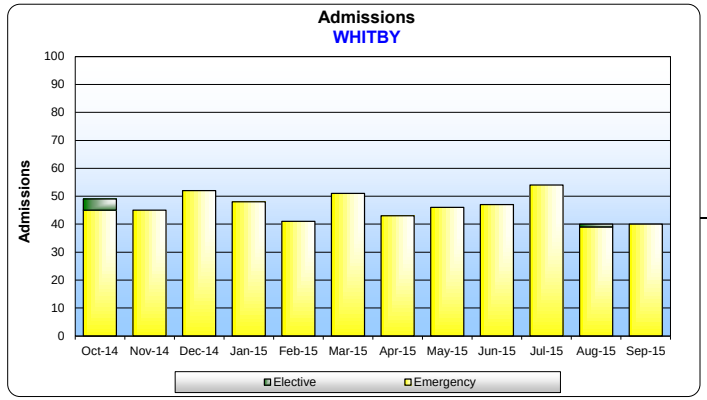
Indicator	Hospital		Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	8	5	8	11	3	0	8
		Emergency	77	71	73	79	22	34	23
	Malton Community Hospital	Elective	21	48	19	37	27	4	6
		Emergency	121	110	101	115	38	33	44
	St Monicas Hospital	Elective	9	16	17	14	5	4	5
		Emergency	27	27	43	41	11	14	16
	The New Selby War Memorial	Elective	69	57	59	69	28	13	28
		Emergency	69	55	68	68	27	25	16
	Whitby Community Hospital	Elective	4	0	0	1	0	1	0
		Emergency	142	140	136	133	54	39	40
	Total	Elective	111	126	103	132	63	22	47
		Emergency	436	403	421	436	152	145	139

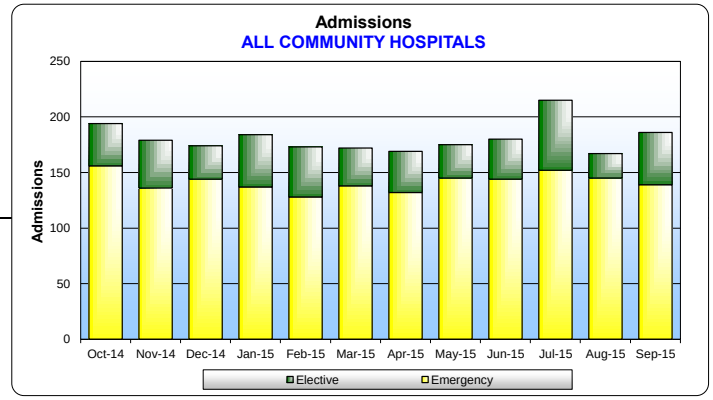












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York Teaching Hospital NHS
NHS Foundation Trust

Board of Director's – 28 October 2015

Medical Director's Report

Action requested/recommendation

Board of Director's should:

- Note consultants new to the Trust
- Consider the results of the antibiotic and probiotic prescribing audit within their Directorates and to ensure that where necessary actions are taken for improvement
- Note the flu update
- Consider the nutrition steering group report
- Consider the NRLS report

Summary

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

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

Implications for equality and diversity

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

This report is for noting only and contains no recommendations. It is therefore not expected to have any particular impact upon the requirements of, or on the protected groups identified by the Equality Act.

Reference to CQC outcomes

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

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

Board of Director's – 28 October 2015

Medical Director's Report

1. Introduction and background

In the report this month:

- Note Consultants new to the Trust
- Consider the Antimicrobial prescribing audit
- Note the Flu Update
- Consider the Nutrition steering group report
- Consider the NRLS report

2. Consultants new to the Trust

Christopher Brewer
Starting as Consultant Obstetrics & Gynaecology
York
Started 1st September 2015

Ed Britton
Consultant Trauma & Orthopaedics
York
Started 1st September 2015

Kevin Falzon
Consultant Ophthalmology (paediatric)
York
Started 16th September 2015

Angela Gruber
Consultant Acute Medicine
Scarborough
Started 21st September 2015

3. Antimicrobial prescribing audit

SUMMARY OF ANTIBIOTIC PRESCRIPTION AUDIT RESULTS
January – September 2015

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

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

% patients >65 years co-prescribed VSL#3 (NB the audit did not investigate if any of the patients >65 years who were not on VSL#3 met any of the exclusion criteria)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
York Hospital	71%	64%	59%	72%	57%	56%	64%	46%	Not reported, supply interruption
Scarborough Hospital	79%	67%	59%	85%	68%	76%	69%	74%	
Trust average	75%	65%	59%	77%	62%	66%	67%	56%	

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

Proportion of iv & oral antibiotics (Trust wide results)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
iv antibiotics	43.9%	43.1%	57.6%	36.2%	50.5%	56.9%	53.4%	53.3%	56.7%
oral antibiotics	56.1%	56.9%	41.5%	63.8%	49.5%	43.1%	46.6%	46.7%	43.3%

Can the prescriber be identified? (legible signature / bleep number)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
% yes	/	/	/	/	/	/	44.3%	54.6%	61.9%
% no	/	/	/	/	/	/	55.7%	45.4%	38.1%

ELDERLY MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of antibiotic prescriptions audited	83	73	44	84	63	58	49	55	49
Antibiotic prescriptions with INDICATION	86%	85%	91%	90%	93%	91%	86%	85%	82%
Antibiotic prescriptions with DURATION / REVIEW	93%	90%	86%	96%	89%	91%	94%	91%	84%
% patients >65 years co-prescribed VSL#3 *^	96%	89%	86%	92%	86%	94%	85%	86%	~

MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of antibiotic prescriptions audited	91	103	83	92	86	87	74	76	101
Antibiotic prescriptions with INDICATION	82%	83%	86%	91%	85%	90%	96%	80%	90%
Antibiotic prescriptions with DURATION / REVIEW	81%	94%	92%	89%	86%	87%	89%	78%	86%
% patients >65 years co-prescribed VSL#3 *^	73%	56%	37%	72%	60%	71%	71%	40%	~

SPECIALIST MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of antibiotic prescriptions audited	2	3	3	5	2	3	2	7	11
Antibiotic prescriptions with INDICATION	100%	67%	67%	80%	50%	100%	100%	71%	64%
Antibiotic prescriptions with DURATION / REVIEW	100%	67%	33%	60%	50%	100%	100%	43%	91%
% patients >65 years co-prescribed VSL#3 *^	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

ORTHO & TRAUMA DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of antibiotic prescriptions audited	11	21	6	11	22	11	11	29	21
Antibiotic prescriptions with INDICATION	73%	71%	83%	82%	77%	55%	91%	93%	81%
Antibiotic prescriptions with DURATION / REVIEW	64%	76%	100%	82%	86%	55%	91%	90%	67%
% patients >65 years co-prescribed VSL#3 *^	60%	78%	40%	75%	56%	43%	25%	75%	~

GENERAL SURGERY & UROLOGY	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of antibiotic prescriptions audited	40	51	61	55	42	48	73	54	61
Antibiotic prescriptions with INDICATION	80%	88%	90%	80%	88%	85%	93%	89%	82%
Antibiotic prescriptions with DURATION / REVIEW	75%	84%	87%	87%	81%	88%	90%	81%	79%
% patients >65 years co-prescribed VSL#3 *^	42%	59%	56%	50%	30%	27%	50%	31%	~

Obs & Gynae DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of antibiotic prescriptions audited	0	8	6	4	7	5	2	4	6
Antibiotic prescriptions with INDICATION	n/a	38%	67%	50%	29%	80%	50%	100%	100%
Antibiotic prescriptions with DURATION / REVIEW	n/a	63%	100%	100%	100%	40%	100%	100%	100%
% patients >65 years co-prescribed VSL#3 *^	100%	50%	0%	0%	n/a	n/a	100%	100%	~

HEAD & NECK DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of antibiotic prescriptions audited	1	4	1	4	2	6	8	1	3
Antibiotic prescriptions with INDICATION	100%	100%	100%	100%	100%	83%	100%	100%	67%
Antibiotic prescriptions with DURATION / REVIEW	100%	100%	100%	50%	50%	100%	82%	100%	33%
% patients >65 years co-prescribed VSL#3 *^	50%	43%	40%	50%	67%	75%	33%	25%	~

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.

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

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

4. Influenza Campaign

Our seasonal influenza vaccination campaign has begun. All frontline staff are being encouraged to have the flu vaccination. Details of drop-in sessions are published on Staffroom.

5. Nutrition Steering Group

The Nutrition Steering Group has been meeting in York for about five years, but has recently re-launched. It sets the Nutrition Strategy for the Trust. There are two new Nutritional Operational Groups (East and West).

Recent initiatives supported by the group include:

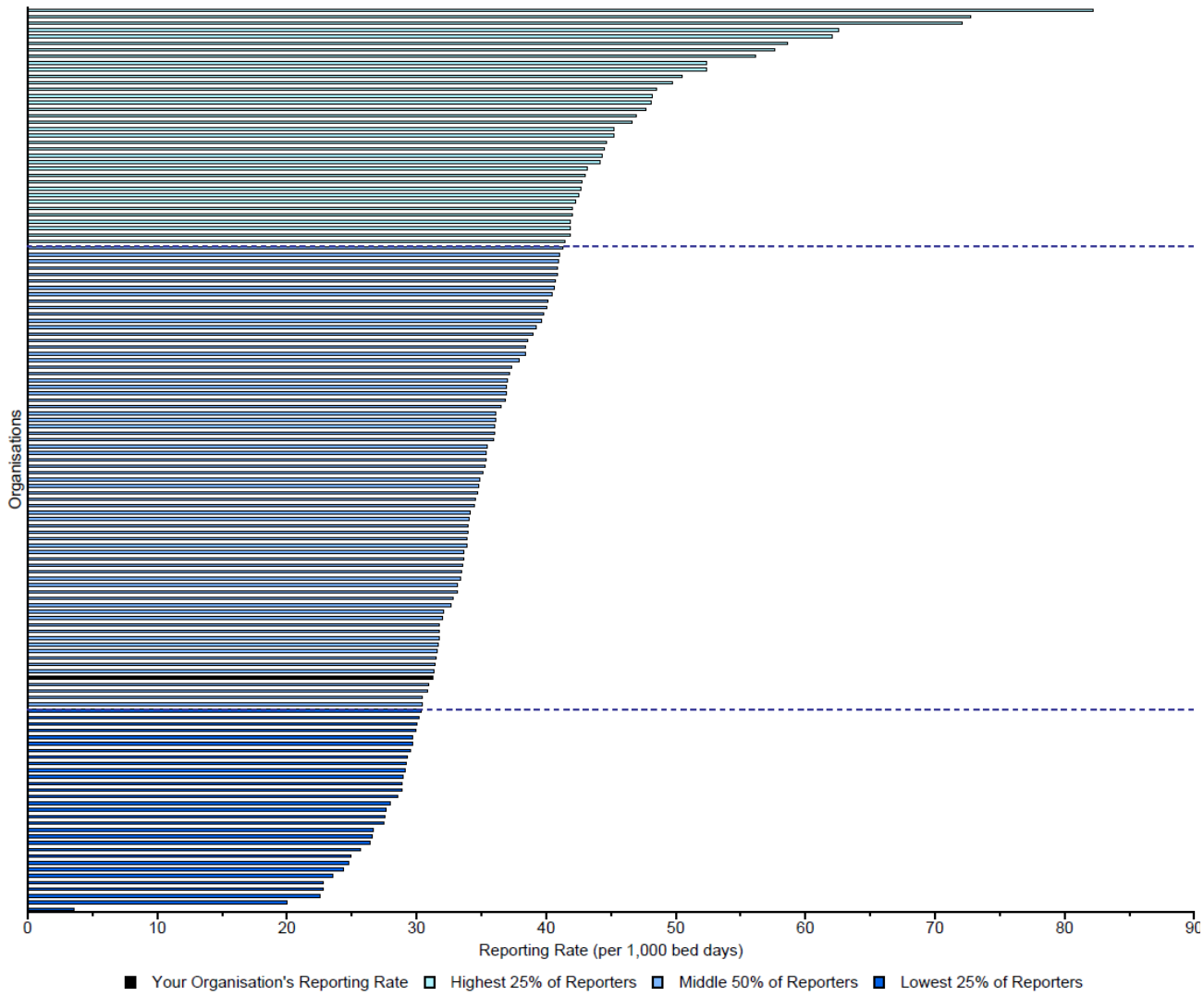
- Development of the Trust Nutrition and Hydration Policy, which is almost complete, and will be an important (but discrete) aspect of helping to deliver the Trust's Food and Drink Strategy.
- Launch of Supported Mealtimes (previously Protected Mealtimes). Adequate nutrition and hydration is vital to delivering good care for all our patients.
- Snapshot audit of naso-gastric feeding tube placement which showed only 3/13 patients had confirmation of position initially attempted by pH testing (as per NPSA Alert 2010).

The Trust currently lacks a robust training program for interpreting chest x-ray after insertion of naso-gastric feeding tubes (normally done if pH fails). Nasogastric feeding into a tube misplaced into the lungs is a NEVER EVENT which can be fatal. An e-learning training programme for interpretation of chest x-ray following insertion of naso-gastric feeding tubes will be launched in the next 2-3 weeks and all medical staff involved with checking placement of these tubes following x-ray will be expected to undertake the training.

6. National Reporting and Learning System (NRLS)

The recently published Patient Safety Incident Report from the NRLS is summarised below.
Reported incidents between 01 October 2014 to 31 March 2015
Organisation type: Acute (non-specialist) organisation
Are you actively encouraging reporting of incidents?
The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 01 October 2014 to 31 March 2015. Your organisation reported 5,458 incidents (rate of 31.29) during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 137 Acute (non-specialist) organisations.



The median reporting rate for this cluster is 35.34 incidents per 1,000 bed days.
Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 1 out of the 6 months between 01 October 2014 to 31 March 2015.
Fifty per cent of all incidents were submitted to the NRLS more than 26 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 184 days after the incident occurred

What types of incidents are reported in your organisation?

Figure 2: Top 10 incident types

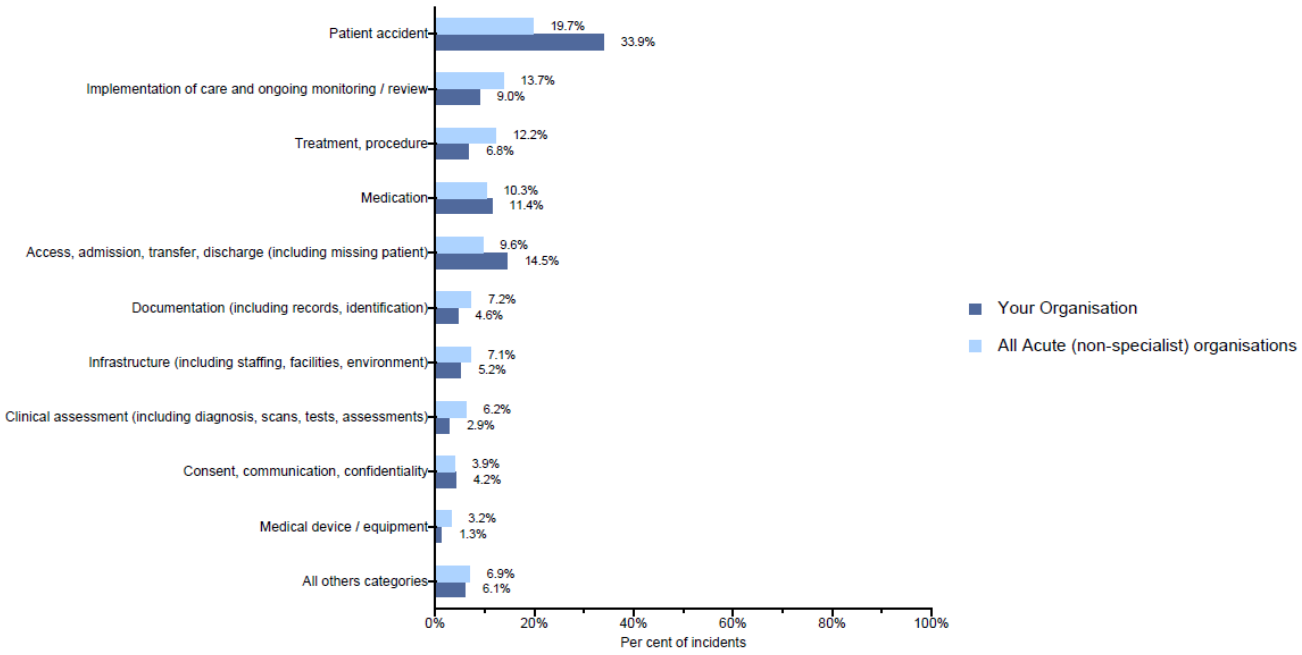
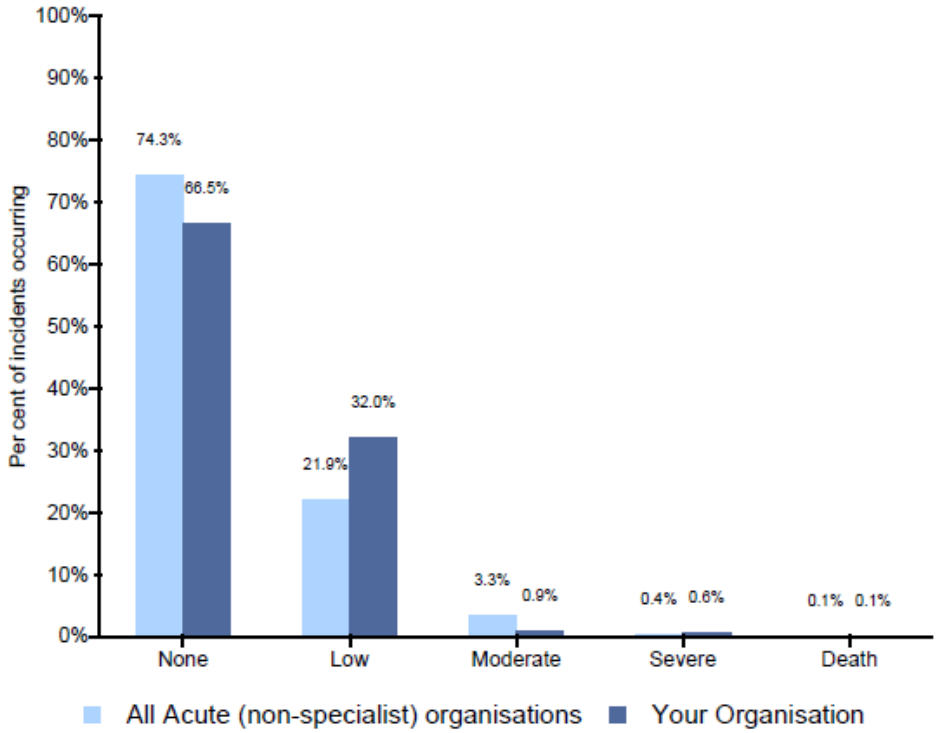


Figure 3: Incidents reported by degree of harm for Acute (non-specialist) Organisations



Degree of harm

	None	Low	Moderate	Severe	Death
Your figures:	3,627	1,746	51	31	3

7. Recommendations	
Board of Director's should: • Note consultants new to the Trust • Consider the most recent results of the monthly antibiotic and probiotic prescribing audit • Note the launch of the influenza campaign • Consider the nutrition steering group report • Consider the NRLS Safety Incident report	
Author	**Diane Palmer, Deputy Director for Patient Safety**
Owner	**Dr Ed Smith, Interim Medical Director** **Mr Jim Taylor, Interim Medical Director**
Date	**October 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Chief Nurse Report – Quality of Care

Action requested/recommendation

The Board are asked to note the Chief Nurse report for October 2015.

Summary

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

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

Implications for equality and diversity

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

This report is for noting only and contains no recommendations. It is therefore not expected to have any particular impact upon the requirements of, or on the protected groups identified by the Equality Act.

Reference to CQC outcomes

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

Progress of report	Executive Board & Quality and Safety Committee
Risk	Associated risks have been assessed.
Resource implications	None identified.

Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	October 2015
Version number	Version 1

Board of Directors – 28 October 2015

Chief Nurse Report – Quality of Care

1. Key priorities

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

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

The strategy is in its final months and an evaluation and assessment of delivery of the objectives initially outlined will be undertaken and presented to the committee early in the new year.

In order to share some of the achievements of the strategy a Nursing and Midwifery conference was held in September for 300 delegates' from across the organisation. Sessions included:

- CQC inspections
- NHS Finance
- Revalidation
- Patient Experience
- Mindfulness
- Measuring Care (patient Safety)

In addition the Assistant Directors of Nursing led a session to give all delegates the opportunity to set priorities for the next strategy which will be written next year.

Feedback from the event was excellent and a summary of some of the responses and commentary from delegates is included at appendix 1.

2. Nurse Staffing

The Cohort of newly qualified nurses are beginning to take up posts across the Trust. Initially they will practice as Healthcare Assistants whilst their NMC professional registration is finalised. These nurses will address some of the nursing shortfalls across the Trust and will be fully supported through a re-designed preceptorship programme.

European Recruitment for further nurses is on-going with interviews commencing at the beginning of October through to January 2016. The plan is for 40 nurses to be recruited for the York site with a further 20 for Scarborough.

The safe nursing and midwifery staffing report for September 2015 is provided as a separate paper.

3. Quality Report

As the Board are aware work has been undertaken to examine our quality priorities and a plan made to consult widely in order to agree quality priorities with key stakeholders at an earlier stage in the year.

A detailed consultation exercise is planned and will begin in November. This will be carried out with both internal and external stakeholders including:

- Quality and Safety Committee
- Patient Experience Steering Group
- Patient Safety Group
- Nutrition Steering Group
- Medicines Management Group
- Executive Board
- Professional Nurse Liaison Forum
- Infection Prevention Control team (via HIPCG)

In addition opinions will be sought from:

- Governors'
- CCG's
- Healthwatch

It is anticipated that this wide consultation will help to determine priorities and drive quality improvement and also inform some of the discussion to agree local CQUINs.

The timetable for completion is below and the final report will be sent for comment to Healthwatch and CCG's in April 2016.

High level aims for the delivery of the quality priorities are at appendix 2.

Activity	**Timing**
Annual report and Quality Report signed off at Board	Wednesday 25 May 2016
The report completed and included in the annual report	Tuesday 10 May 2016
Data collection completed and draft report shared with External Audit	Tuesday 10 May 2016
Expected responses back from external stakeholders	Monday 9 May 2016
Draft shared with Quality and Safety Committee	Tuesday 19 April 2016
Report issued to external stakeholders for a statement	Friday 8 April 2016
Completion of the report and final proof reading	Monday 4 April 2016
Draft shared with Quality and Safety Committee	Tuesday 15 March 2016
Compilation of the document	January – April 2016

Guidance released by Monitor	Estimated as late January or early Feb
Consultation with Governors and Stakeholders	November to January

4. Safeguarding Adults Update

Care Act
The Trust has representation at North Yorkshire County Council (NYCC), East Riding of Yorkshire Council (ERYC) and City of York Council (CYC) safeguarding adults policy review groups. The aim of these groups is to develop a consistent approach to managing safeguarding concerns whilst "Making Safeguarding Personal".

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

Deprivation of Liberty Safeguards (Cheshire West) – Update from March Chief Nurse Report.
The Committee were advised of the progress of implementation of the above ruling in previous reports.

The Law Commission produced a consultation paper on 7th July 2015 and organisations affected have been asked to comment. Representation from the Trust will attend NYCC consultation meeting on 14th October.

The proposed scheme from the Law Commission will be presented to the Trust Safeguarding Adults Governance Group on 13th October.

The proposed scheme is called "Protective Care Arrangements" which outlines plans to allow acute hospitals to self-authorise for a period of 28 days.

The scheme has implications for consultants responsible for the care of patients which may require authorisation under the deprivation of liberty safeguards.

It suggests a specific care plan and full liaison with the patient, carers and family.

This will be discussed and a viewpoint sought in the Safeguarding Adults Governance group next week.

The Safeguarding Adults Team continue to support staff with training, awareness raising, staff forums and any queries regarding Deprivation of Liberty Safeguards can be raised with the team.

Implementation of this ruling has already been highlighted for the Risk Register and this emerging guidance will be included in the next return.

5. Recommendation

The Board are asked to note the Chief Nurse report for October 2015.

6. References
• SAFE Programme http://www.rcpch.ac.uk/safe • NICE palliative and supportive care guidance (2004), National Institute for Health and Care Excellence http://www.nice.org.uk/guidance/csgsp • National End of Life Care Strategy (2008), Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf • National Care of the Dying Audit (2014), Royal College of Physicians London https://www.rcplondon.ac.uk/resources/national-care-dying-audit-hospitals

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

Appendix 1

Nursing and midwifery conference – post-event update

The Trust held its first nursing and midwifery conference on 21 September 2015 at York Racecourse, and over 200 of our nurses and midwives attended. These included colleagues working at all levels from right across the Trust, including community nurses and students. There were an additional 50 colleagues expected, who did not attend on the day. The events team is seeking more information about why they did not attend, and will share this with Matrons.

Attendees all heard from NHS England Chief Nurse (North) Margaret Kitching, the Trust's Chief Nurse Beverley Geary, inspirational speaker and patient Matt King, and the Trust's Deputy Chief Executive Mike Proctor. In addition, attendees each selected three of eight breakout sessions to attend. The topics for these had been suggested by nursing staff and were: finance, CQC, revalidation, ANTT, measuring care, patient experience, mindfulness, and the nursing and midwifery strategy update.

The response to the day has been incredibly positive, both through informal conversations and formal feedback. 140 colleagues completed a feedback form and of those 100% said the day was a valuable use of their time, which is essential when taking staff away from clinical duties. 98% of attendees felt they had learned something new and 95% had the opportunity to contribute as much as they would have liked.

Around 40 cited Matt King's "inspirational" speech as the most useful part of the day, because he reinforced the impact of patient care in a moving and thought-provoking way. The chance to have time away and network with others was also seen as useful.

In terms of future conferences for this group, there is clear feedback that staff would prefer shorter sessions so they can hear about more topics. This is very encouraging as it shows an eagerness to learn more. The role of HCAs and their development would also be a welcome topic for the future, as would something specifically aimed at community nurses.

There has been a suggestion that the mindfulness and revalidation sessions be rolled out across the Trust to help colleagues who could not attend. The practicalities of running face-to-face sessions for all nursing and midwifery staff would not be viable but there could be an action here to create a video or briefing to be shared across the Trust.

"Thank you for making this valuable day possible"

"Time to think about what I do and the organisation I'm part of"

"Good to hear about experiences encountered by community staff"

"Insight into the Trust as a new employee"

Appendix 2

Timelines for the development of the Quality report

Managed through an internal meeting with membership from

- Chief Nurse
- Foundation Trust Secretary
- Head of Patient Experience?
- Head of Patient Safety
- Head of Healthcare Governance

Internal Group meet on a monthly basis during the consultation time.

Activity	**How**	**Timing**
Agree priorities to include in the consultation	Internal meeting of quality group and discussion with Medical Director and Chief Operating Officer Priorities to be discussed a Corporate Directors meeting	Early October 2015
Arrange meetings with Stakeholder – CCG, Council of Governors, Healthwatch and launch consultation exercise NB Do not expect to need a full communications strategy for the consultation, it is limited to key parties. Comms will be involved in supporting the group around the development of the Consultation document	Meeting as a group and one to one basis talking through the consultation information	Early November 2015 Consultation ends mid-January 2016
Analysis of response and agree what priorities for 2016/17 will be included in the report	Internal meeting prep a final summary of the consultation work. Once priorities have been prepared final agreement sought through the Quality and Safety Committee	Internal meeting held mid-January 2016. Final paper work to be presented to the Quality and Safety Committee at the February meeting
Following the publication of the guidance from Monitor – agree with the Corporate Directors and Governors what their key indicators for further auditing will be	Discussion at the Corporate Governance meeting and discussion with the work group of Governors formed to support the production of the Quality Report	February 2016

a) **Production and lay out of the report**

Given the timelines being worked to the report will only have 11 months data from the current year and 1 month from the previous year.

Activity	**How**	**Timing**
Consult with Quality and Safety Committee on the draft report	Through papers presented to meetings	December and January Final draft with priorities agreed February 2016
Attend the Council of Governors meeting to inform them of the work being undertaken to develop the Quality Report	Part of the Council of Governors agenda – presentation led by BG	9 December 2016
Key priorities to be agreed Corporate Directors and Governors	For Directors through Corporate Directors meeting Information taken by BG to meeting For Governors through discussion at group meeting	February 2016 for both
Confirmation given to Internal and External Audit of the key priorities chosen by the Corporate Directors and Governors	Email and meeting	February 2016
Production of the report handled by Fiona Jamieson's team	Management by FJ	January 2016 to April 2016

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Safe Nurse and Midwifery Staffing Report

Action requested/recommendation

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

Summary

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

A detailed breakdown for September 2015 staffing levels is attached at Appendix 1.

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

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Outcome 13

Progress of report	Quality and Safety Committee
Risk	No risks.
Resource implications	Potential resources implications where staffing falls below planned or where acuity or dependency increases due to case mix.
Owner	Beverley Geary, Chief Nurse
Author	Nichola Greenwood, Nursing Workforce Projects Manager
Date of paper	October 2015
Version number	Version 1

Board of Directors – 28 October 2015

Safe Nurse and Midwifery Staffing Report

1. Introduction and background

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

A detailed breakdown for September 2015 staffing levels is attached at Appendix 1.

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

2. High level data by site

	Day		Night	
Site Name	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**
Archways Intermediate Care Unit	100%	95.3%	96.7%	98.3%
Bridlington And District Hospital	89.0%	82.3%	75.8%	106.4%
Malton Community Hospital	87.3%	106.2%	101.7%	91.7%
Scarborough General Hospital	80.5%	109.4%	89.8%	105.9%
Selby And District War Memorial Hospital	95.3%	94%	100%	100%
St Helens Rehabilitation Hospital	81.7%	100%	58.3%	100%
St Monicas Hospital	96.4%	99%	100.0%	100.0%
Whitby Community Hospital	101.0%	99.4%	100.0%	100.0%
White Cross Rehabilitation Hospital	100%	100.0%	70%	96.7%
York Hospital	85.4%	99.5%	94.3%	106.7%

3. Exceptions

<u>Enhanced Supervision</u>

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

Scarborough	York
Ann Wright	Ward 28
Oak	Ward 34
	Ward 36

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

Provision of Safe Ward Cover

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

St Helens

The low fill rate for RNs is due to the recent uplift in RN numbers for the night shift. Historically the unit has been staffed on 1:1 but following a recent review Director's agreed to increase the ratio to 2:1 these are currently out to recruitment

Bed Occupancy

Lloyd and Waters Wards at Bridlington change their ratio of registered and unregistered staff dependent on bed occupancy levels and the effective use of staff with staff being deployed to other ward areas. G2 and G3 share a healthcare assistant and during August, the healthcare assistant was predominantly on G2, which increased its staffing levels.

Activity demands on some wards have resulted in the Surgical Assessment Unit in Scarborough and York remaining open some nights; resulting in increased actual staffing.

Ward 25 in York has adjusted its staffing levels during the latter part of August following their temporary relocation to Ward 24 whilst decoration takes place.

Vacancies, Sickness and Annual Leave

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

Bridlington	Scarborough	Community	York
Lloyd	Ann Wright	Fitzwilliam	AMU
	CCU	St Helens	ICU
	Chestnut	Whitecross Court	Ward 11
	ICU		Ward 16
	Maple		Ward 23
	Oak		Ward 25
	Stroke		Ward 26
			Ward 28
			Ward 35
			Ward 37
			Ward 29

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

4. Sickness, Bank and Agency Fill Rates

Sickness

The overall absence rate for the Trust for the month of August 2015 was **3.76%** By site, sickness within the Nursing and Midwifery workforce across the inpatient areas was, as follows:

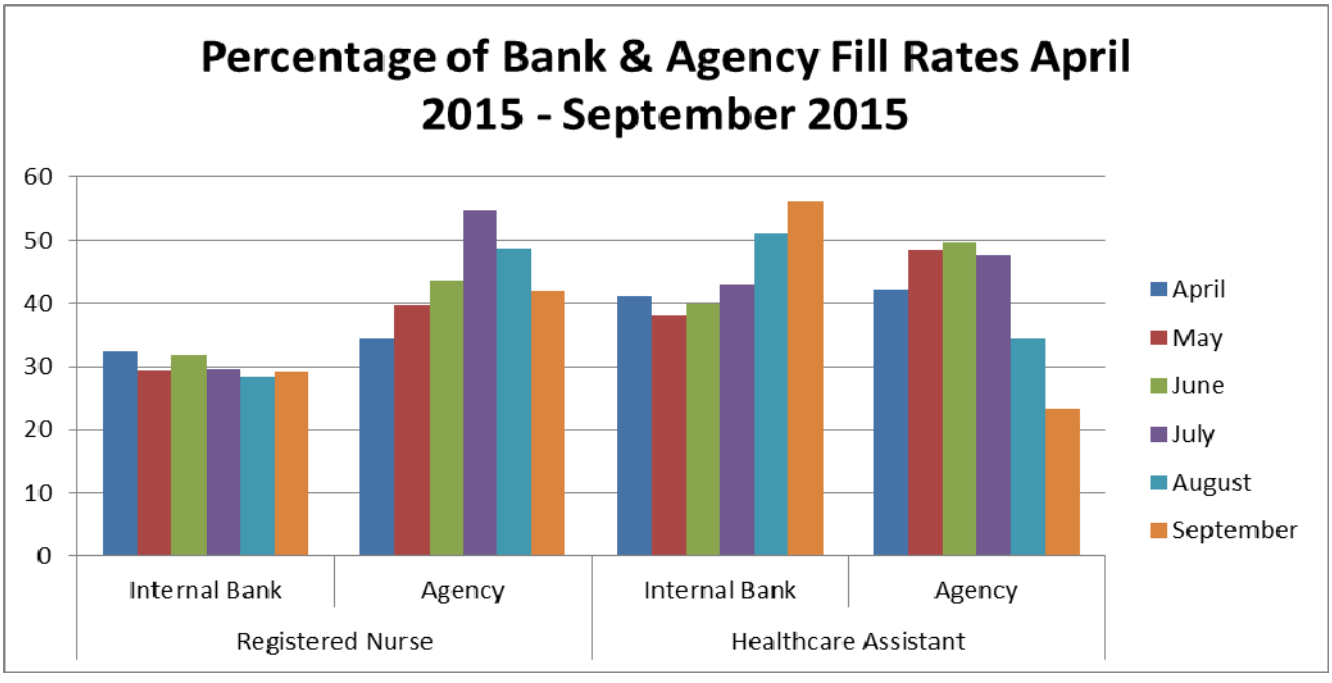
York Acute Hospital – **3.11%**
Scarborough Acute Hospital – **4.98%**
Community Services – **3.98%**

Temporary Staffing

Overall fill rate of bank shifts requested through the internal bank was 37.49% an improvement of 1.36% from August 2015. The fill rate for qualified shifts was 29.14%, a increase of 0.79% on August whilst, the fill rate for unqualified shifts was 56.02%, an improvement of 4.93%.

The percentage of shifts filled by agency reduced this month for both RN shifts and unqualified shifts with 42.01% of shifts being filled by external agency compared with 48.66% in August.

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



5. Recommendation

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

6. References and further reading	
National Quality Board. "*How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability".* 2013	
Author	**Nichola Greenwood, Nursing Workforce Projects Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**October 2015**

	Day				Night							
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Day		Night	
Site Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
ARCHWAYS INTERMEDIATE CARE UNIT	720	720	900	858	330	319	660	649	100.0%	95.3%	96.7%	98.3%
BRIDLINGTON AND DISTRICT HOSPITAL	3585	3190.5	3840	3162	2178	1650	858	913	89.0%	82.3%	75.8%	106.4%
MALTON COMMUNITY HOSPITAL	1125	982.5	1575	1672.5	660	671	660	605	87.3%	106.2%	101.7%	91.7%
SCARBOROUGH GENERAL HOSPITAL	22365	17997	13635	14913	13530	12144	6930	7337	80.5%	109.4%	89.8%	105.9%
SELBY AND DISTRICT WAR MEMORIAL HOSPI	1125	1072.5	1125	1057.5	330	330	660	660	95.3%	94.0%	100.0%	100.0%
ST HELENS REHABILITATION HOSPITAL	900	735	1125	1125	660	385	330	330	81.7%	100.0%	58.3%	100.0%
ST MONICAS HOSPITAL	622.5	600	765	757.5	330	330	330	330	96.4%	99.0%	100.0%	100.0%
WHITBY COMMUNITY HOSPITAL	1575	1590	2475	2460	660	660	990	990	101.0%	99.4%	100.0%	100.0%
WHITE CROSS REHABILITATION HOSPITAL	900	900	1125	1125	660	462	330	319	100.0%	100.0%	70.0%	96.7%
YORK HOSPITAL	44166	37713	24438	24319.5	24398	23012	15004	16005	85.4%	99.5%	94.3%	106.7%

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Patient Experience Quarter 2 Report

Action requested/recommendation

The Quality & Safety Committee is asked to accept assurance on all the management of the Trust's key patient experience measures.

Summary

This report provides a detailed update from the Patient Experience Team for Q2.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

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

Progress of report	Patient Experience Steering Group Quality and Safety Committee

Risk	Risks re complaints handling and PALS are identified in the report along with the mitigation plans.
Resource implications	None identified
Owner	Beverley Geary, Chief Nurse
Author	Hester Rowell, Lead for Patient Experience
Date of paper	October 2015
Version number	Version 1

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Patient Experience Quarter 2 Report

1. Introduction and background

The purpose of this report is to:

- Report on the experiences of patients receiving treatment and care from York Teaching Hospitals NHS Trust

- Report current performance against Trust indicators for collating and responding to patient and carer feedback.

The report provides information from different sources, including:

- Complaints
- Parliamentary and Health Service Ombudsman cases
- Patient Advice and Liaison Service (PALS) activity
- Friends and Family Test
- Family liaison officer activity.

Patient Experience Strategy
The Trust Patient Experience Strategy *Your Experiences Matter* was launched at the Nursing and Midwifery Conference on 21 September 2015. Three Patient Experience workshops, each attended by 40 nurses or midwives, were delivered. The workshops introduced the strategy and challenged participants to ask themselves: "What have I done today to make a difference."

The implementation plan for the strategy is attached at appendix 1.

2. Formal Complaints

Number of complaints received

	York	Scarborough	Bridlington	Community	TOTAL
New complaints July	20	19	1	1	41
New complaints August	15	20	1	1	37
New complaints September	25	30	2	1	58
Dissatisfied July	11	0	0	0	11
Dissatisfied August	0	0	0	0	0
Dissatisfied September	3	1	1	0	5
Resolved outside procedure July	2	2	0	0	4
Resolved outside procedure August	5	0	0	0	5
Resolved outside procedure September	0	0	0	0	0

Complaint handling performance

	July	August	September
Acknowledged in 3 days	41	37	57
Cases closed in month	38	15	42
Cases where response date has been extended in month	37	31	26
Cases open at month end with response time >33 days		36	30
Cases >33 days awaiting meetings		6	3
Cases open at month end		96	118

Repeat/complex contacts
Four repeat/complex cases have been managed in Quarter 2.

One lady is well known to the Trust and to PALS over a period of more than ten years. She has an identified single point of contact and is asked to limit her contact to email. Formal correspondence about this plan now needs repeating, as she is not acting in accordance with the agreement.

Three cases have involved individuals presenting at reception and/or being referred to the Patient Experience Team by directorates. Working in partnership with matrons and directorate managers arrangements have been made to listen to these individuals concerns and take action. Where necessary, single points of contact have been given to limit multiple contacts to people across the Trust which creates confusion for all concerned.

Service developments
In the last two months, some significant changes have been made to team working practices with the aim of improving the quality of responses:

Datix Web Implementation

- The Datix Web case management system went live on 1 September 2015. All new cases received by the Patient Experience Team are now being logged using Datix Web. This new system gives greater functionality for logging complaint subjects and allocating cases to directorates, which will enable the creation of much richer reports.

- The implementation process has involved developing a new system for categorising and coding cases. The system developed by the Health and Social Care Information Centre for national reporting purposes has been used.

- Using Datix Web, the Patient Experience Team will be able to share information with colleagues across the Trust where cases are claims, incidents, serious incidents or safeguarding cases as well as complaints.

- Over the next month key staff across directorates: matrons, directorate managers and deputy directorate managers; will be trained to work directly with the electronic Datix case file. This should reduce the administrative burden of working with paper files and improve joined-up working between directorates and the Patient Experience Team.

- New letter templates have been produced for acknowledgements, covering letters for reports and requesting extensions. The new versions aim to use plain English and avoid the use of stock phrases, promoting tailored communications to individual circumstances.

Complaints resolution process

- A draft good practice document for complaints handling and investigation has been developed and shared with directorates. This is based on guidance from the Patients' Association and Parliamentary and Health Service Ombudsman.

- A trial of a new process has been implemented with Emergency Department and Elderly Medicine. This is focused on making early contact with the complainant – preferably by telephone or face-to-face – to confirm the key points of the complaint and the main issues that they would like investigating. The response letter at the end of the process will be a single letter written to the complainant – rather than a copy of the investigation report. Alternatively complainants can request to receive feedback in the format that they prefer: eg face to face, or a telephone call before the final letter is received.

Complainant survey results – Elderly Medicine

- Eleven complainants who had received a final response letter from us in the last year were contacted by telephone or email to ask about their experience of the process. For those willing to participate, a semi-structured interview took place around six questions:
    1. Did you feel confident to speak up about your concerns.
    2. Did you find it simple to make your complaint?
    3. Once you'd made your complaint, did you feel we listened to you and understood your concerns?
    4. Were you satisfied with the written response you received?
    5. Did you feel your complaint made a difference?
    6. Would you feel confident making a complaint again in the future?

- All respondents said 'yes' to questions 1, 2 and 6.

- The feedback from questions 3-5 was narrative. Comments included:

  Yes [I felt listened to]. I got a letter. It was chapter and verse. I noticed a difference when I visited again.

  I was a bit disappointed [with the written response]. They ran it down into bits. Although they addressed some of the issues, some were not correct. Some information was in the wrong order. Some was undermined/or skirted over. Although they say they apologise – it doesn't seem sincere.

  I don't know [if my complaint made a difference]. I'll never know. I can't see for myself. It just said "I've told Sister and she'll speak to her staff. It's more than just individuals on one ward. It's about the whole hospital."

Complaint case sign off

- The quality checking process for final responses has been reviewed and revised. All responses, once received from directorates, receive a first check by the Patient Experience Team who focus on ensuring that all questions are answered, that the response is clearly explained and laid out and the language is empathetic and appropriate.

- Cases are then sent to the relevant Assistant Chief Nurse (for York, Scarborough, maternity/gynaecology, or community) for checking.

- Final quality checking and approval is given by the Chief Nurse or Deputy Chief Nurse before sign off by the Chief Executive.

3. Formal complaint numbers by directorate & subject

Complaints by Directorate					
	Q1	**July**	**August**	**Sept**	**Q2**
Acute & General Medicine	21	6	7	6	19
Child Health	3	1	0	1	2
Elderly Medicine	12	5	1	5	11
Emergency Medicine	15	7	9	7	23
Estates and Facilities	1	0	1	2	3
Specialist Medicine	3	0	1	1	2
General Surgery & Urology	19	4	4	11	19
Head and Neck and Ophthalmology	11	3	1	1	5
Obstetrics & Gynaecology	9	2	2	7	11
Orthopaedics and Trauma	12	8	5	7	20
Anaesthetics, Theatres & Critical care	5	1	1	2	4
Community Services	7	1	1	1	3
Radiology	1	2	3	3	8
Pharmacy	0	0	0	1	1
Other	0	1	1	3	5

Complaints by Subject	**Q1**	**July**	**August**	**Sept**	**Q2**
Admissions, discharge and transfer arrangements	5	1	0	5	6
Appointments, delay/cancellation (out-patient)	4	0	1	-	1
Appointments, delay/cancellation (in-patient)	3	0	0	-	0
Attitude of staff	13	3	3	6	12
All aspects of clinical treatment	78	27	29	30	86
Commissioning	0	0	0	1	1
Communications/information to patients (written and oral)	8	2	2	8	12
Privacy and dignity	5	2	2	1	5
Complaints handling	0	2	0	0	2
Personal records	0	2	0	-	2
Others	3	2	0	7	9
TOTAL	**119**	**41**	**37**	**58**	**136**

4. Examples of learning and action plans

15/16-048
Pain management for a patient at end of life did not meet his needs. Communication was not effective with the family and he was discharged without his pain control medication. Learning includes: the importance of recording pain scores; use of anticipatory pain control;

and the importance of communicating decisions and next steps with families.

15/16-084
The learning from this complaint included: the need for recording of pain scores; ensuring that basic care needs are acted on swiftly following regular comfort checks; the need to ensure a set of clinical observations are recorded on the day of discharge.

15/16-124
Learning was about the management of consultant appointments: ensuring the administration procedures followed ensured that appointments were not booked before test results were available; ensuring clinical results are only delivered by a clinically qualified member of staff; ensuring that calls from patients receive a timely return.

15/16-077
The Urology Directorate is aware of the inefficiencies in the Prostate Pathway. In particular the lack of a dedicated 'Raised PSA Prostate Clinic'. The directorate reports that it is looking into a way in which such a clinic can be accommodated and run efficiently to allow patients, referred on the two week wait appointment system, access to a dedicated clinic.

15/16-086
Learning included: the need to ensure that patients (particularly those at risk of poor nutrition) should have their weight measured and recorded on admission and before discharge; the importance of good communication with families about the schedule of diagnostic tests, the results, and symptoms to look out for after discharge.

New care plan documentation
With reference to the learning about documentation of patients' observations, a new care plan document has been successfully piloted and is due to be rolled out in September and October. Providing nursing staff with a clear and consistent format will help ensure that observations are well-recorded.

5. Complaints referred to the Parliamentary and Health Service Ombudsman (PHSO)

There are currently 18 cases under investigation with the Parliamentary and Health Service Ombudsman (PHSO). We have received decision letters on six cases since May 2015.

Status of open cases

Status	Number
Notified of investigation – YHFT to send documents	1
PHSO investigation – awaiting decision	14
Draft report received – awaiting final report	1
Upheld/partially upheld cases – action plans outstanding	0

Outcome of cases received in draft/final report

Month	Not upheld	Partially upheld	Upheld
May	1	1	0
June	2	0	0
July	1	0	0
August	1	0	0
September	1	0	0

Examples of the types of actions being taken include:

Continence management: Ward-based continence training for staff from the Continence Specialist Nurse. A new care plan document has been developed, including continence assessment.

Nutritional assessment: The Trust now has Nutrition Organisational Group, chaired by a matron, which oversees Trust policy and practice on hydration and nutrition. The members take responsibility for communicating with staff in their areas. A system of comfort rounds has been introduced where patients are routinely asked about any pain, toilet needs and hydration/nutrition needs.

Referral to Mental Health Assessment and Liaison Team: Daily 'Board Rounds' now take place in all elderly wards where a multi-disciplinary team talk through the patient's care and agree next steps and responsibilities for actions.

Medical issues: Junior doctors have been reminded to seek advice from a radiologist if they have any doubts about the interpretation of x-rays. They have also been reminded about the importance of monitoring kidney function. The new fluid balance charts which are in the process of being rolled out will further support better management of kidney function.

Nursing: The care provided, in the past, by Ward 24 (an escalation ward) has been subject to a full Trust investigation. A standard operation procedure (SOP) has been introduced to ensure that the necessary equipment, staff and documentation are in place to provide high quality care. A full induction for all staff takes place before the ward opens and daily SOP reviews take place.

Complaint management: An apology has been made for sending two letters requesting consent. The new Datix Web case management system will provide a single record of all activity relating to a complaint and avoid such duplication in the future.

6. Positive Feedback

In Q2:

- 71 compliments were sent to the Trust via the Chief Executive's office.
- 129 contacts to say thank you were made via PALS

This is in addition to the many thank yous given directly to ward staff.

Examples include:

Ann Wright Ward, Scarborough
My husband was admitted to Ann Wright Ward at Scarborough Hospital on 10 July and remained there for almost three weeks. I felt I had to write and express our sincere thanks to all staff on every level for their outstanding care and kindness he received during his stay. They are an excellent team who work extremely well together. Nothing was ever too much trouble and my husband's care needs were always met with such a pleasant rapport between patient and staff.

I also noticed whilst visiting my husband how well the staff coped with dementia patients on the ward. They were dealt with sensitively, given reassurance, kindness and caring at the highest level, not an easy task! My husband has been on several wards in Scarborough Hospital, but to all staff on Anne Wright Ward give yourselves a big pat on the back – you

are the best."

Day Unit, York
On 28 August 2015 I attended the Day Unit and underwent surgery. I am pleased to say that, as on a previous operation, I was most impressed by the meticulous care and attention that was given by the team, from reception through to discharge; indeed throughout the entire process.

Another pleasing aspect was the cheerful, friendly and relaxed atmosphere in the theatre itself. Indeed, I was so relaxed myself that I was speaking to the team throughout and was almost oblivious to the operation.

Emergency Department, York
On the morning of Monday 22 June, I walked into A&E at York District Hospital with an uncomfortable sensation of constriction in my chest and shortness of breath. Within 5 minutes I was lying on a bed and hooked up to an ECG. I was discharged from the Coronary Care Unit on Wednesday 24 June having undergone Angioplasty and the fitting of a Stent.

I would like to thank everyone concerned with my care over those few days. Nobody I encountered was anything short of exceptional! Everyone was utterly professional, reassuring and relentlessly cheerful. I wish I could remember the names of everyone and come round to thank them personally. Sadly, I can't - but I'd like to ask you to try and identify those individuals and pass on my thanks and encouragement. There were so many people…

The receptionist at the front desk in A&E who was so friendly, calm and reassuring
All the nurses in A&E who kept checking on me, bringing me sandwiches and making me feel so comfortable
The A&E doctors who took the time to explain everything carefully
The A&E admin team who helped my daughter make arrangements for my car, which I had hastily abandoned in the A&E car park
The X-Ray team
All the staff on the Acute Medical Ward
The kind nurses on the Stroke Ward (to which I was transferred in the middle of the night)
The cleaner who brightened the whole place up with her singing and light-hearted conversation
The catering team - I especially enjoyed the Chilli & Rice!
The Senior Cardio Registrar who explained the Angiogram process to me and overcame my fears - he was right all along!
The male nurse from the Cardio Vascular Imaging Unit who took me down from the ward and helped me completely un-muddle my hospital gown with good humour and dignity
The nurses on the Cardio Vascular Imaging Unit who were so reassuring in the face of abject cowardice
The medical/surgical team - especially Dr Crook - who are simply amazing
Everyone on the Coronary Care Unit - the nurses, student nurses and Cardio Rehabilitation specialist

That's a lot of people and even then I'm sure there are some omissions.

Every single one of those people was at the top of their game and displayed exemplary professionalism and compassion.

My experience of York District Hospital reflected the NHS at its absolute world-beating best.

7. Patient Advice & Liaison Service (PALS)

Contacts by directorate

The table below shows cases logged by directorate. The cases are recorded by the directorate handling the contact.

	Apr	May	Jun	Jul	Aug	Sept
Theatres Anaesthetics and Critical Care	7	9	13	12	10	15
Applied Learning and Research	0	0	0	1	2	3
Chairman and CEO	0	4	1	6	1	4
Child Health	8	2	11	9	13	14
Allied Health Professionals	9	7	11	12	15	15
Community Services	8	7	12	21	16	13
Emergency Medicine	21	19	25	30	21	14
Estates and Facilities	19	23	25	32	22	47
Elderly Medicine	19	18	23	24	14	15
External to Trust	35	28	40	53	36	47
Finance and Performance	24	16	24	36	33	49
Head & Neck	11	17	24	21	13	25
Human Resources	8	1	2	14	14	27
Laboratory Medicine	0	0	1	0	2	2
Specialist Medicine	16	12	26	32	27	21
Medicine (General & Acute)	22	31	35	50	31	40
Nursing and Improvement	120	131	125	142	153	150
Obstetrics and Gynaecology	15	18	12	19	11	13
Ophthalmology	9	14	17	24	12	14
Operations	0	0	4	4	2	2
Orthopaedics & Trauma	26	13	25	25	20	22
Pharmacy	0	1	2	1	0	17
Radiology	10	13	10	21	17	38
General Surgery & Urology	43	31	30	48	42	12
Sexual Health	0	1	0	6	3	1
Totals:	**430**	**416**	**498**	**643**	**530**	**631**

	Apr	May	Jun	Jul	Aug	Sept
Action Plan	2	5	6	6	3	0
Admissions, discharge, transfer arrangements	9	14	13	13	11	17
Aids / appliances / equipment	3	4	5	1	1	1
Appointments, delay/cancellation (inpatient)	17	17	13	15	13	11
Appointments, delay/cancellation (outpatient)	29	35	46	59	39	60
Staff attitude	19	13	23	24	13	19
Any aspect of clinical care/treatment	69	63	72	101	63	76
Communication issues	31	35	37	64	56	69
Compliment / thanks	34	27	63	51	49	29
Alleged discrimination (eg racial, gender, age)	0	2	3	0	0	1
Environment / premises / estates	6	4	4	6	4	5
Foreign language	1	0	0	0	1	0
Failure to follow agreed procedure (including consent)	0	1	2	1	0	1
Hotel services (including cleanliness, food)	0	3	3	3	1	2
Requests for information and advice	158	155	173	236	228	296

Medication	3	2	4	7	4	2
Other	4	5	5	8	12	1
Car parking	1	6	5	1	3	4
Privacy and dignity	2	1	0	2	1	2
Property and expenses	19	12	9	21	16	13
Personal records / Medical records	11	7	7	15	8	12
Safeguarding issues	2	0	1	2	2	2
Signer	2	0	0	0	1	1
Support (eg benefits, social care, vol agencies)	4	1	0	4	1	2
Patient transport	4	4	6	3	0	5
Totals:	**430**	**416**	**500**	**643**	**530**	**631**

PALS has been running with less than half usual staffing levels as the two full time staff members are on long-term sick leave. The efforts of the part-time staff members should be recognised and commended as they have minimised the use of the voicemail and managed increased volumes of calls. They have been supported by other members of the Patient Experience Team to enable core hours to be maintained.

Increase in contacts
There has been a significant increase in contacts in Quarter 2. In part, the lower numbers in April and May were due to reduced capacity due to sickness and annual leave.

Sickness issues have continued, but the support has been provided by the wider Patient Experience Team.

Analysis has been carried out for contacts from the directorates and subjects showing the greatest increase in numbers. The following key points have been identified:

- A letter was sent out in June about neurology services (Specialist Medicine) explaining that all patients would now be treated in York. For patients in the east of our area this is a significant change. The letter had PALS contact details for any queries or concerns.

- The volume logged to Nursing and Improvement are contacts handled directly by the PALS team without allocating to another directorate. When voicemail messages are handled these are logged as contacts, if contact is subsequently made with the caller, this is logged as a new contact. During Quarter 2 the team had to use voicemail on more occasions to manage workload. A significant number of contacts related to queries about the formal complaint process. Some contacts relate to thankyous for the PALS team for resolving an issue.

- The number of cases relating to ‘any aspect of clinical care’ peaked in July. Analysis does not show any clear repeated themes, directorates, wards or individuals within the contacts. At a general level, a significant number of contacts fit into the themes of: issues about care pathways (appointments/test results/next steps) and issues about diagnoses/medical opinion (doesn’t agree with the opinion of the doctor or how it was communicated).

- Support services calls handled increased in September

    - Estates issues: These include: Food issues both positive and negative. Smoking issues – people not happy about being told they can’t smoke at the front of the

hospital or use e-cigarettes. Parking issues – people not happy at the way security staff manage the disabled car park (this has also been raised by Healthwatch today 5.10.15)

- Human Resources: These include: people wanting to find out about employment opportunities, placement opportunities or how to get references.

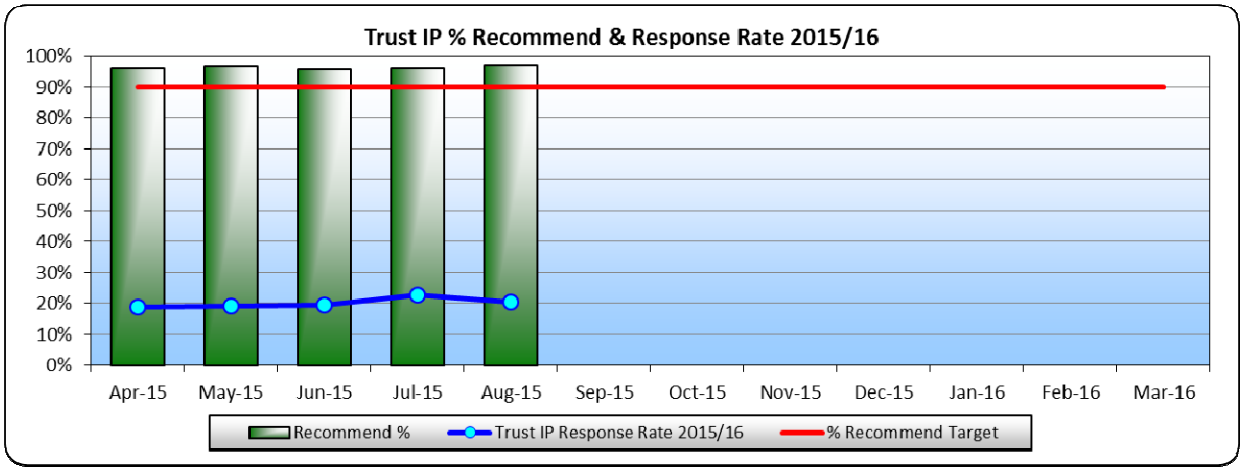
- Finance: These include all issues about funding for oversees patients, handling of subject access request and small claims for lost property.

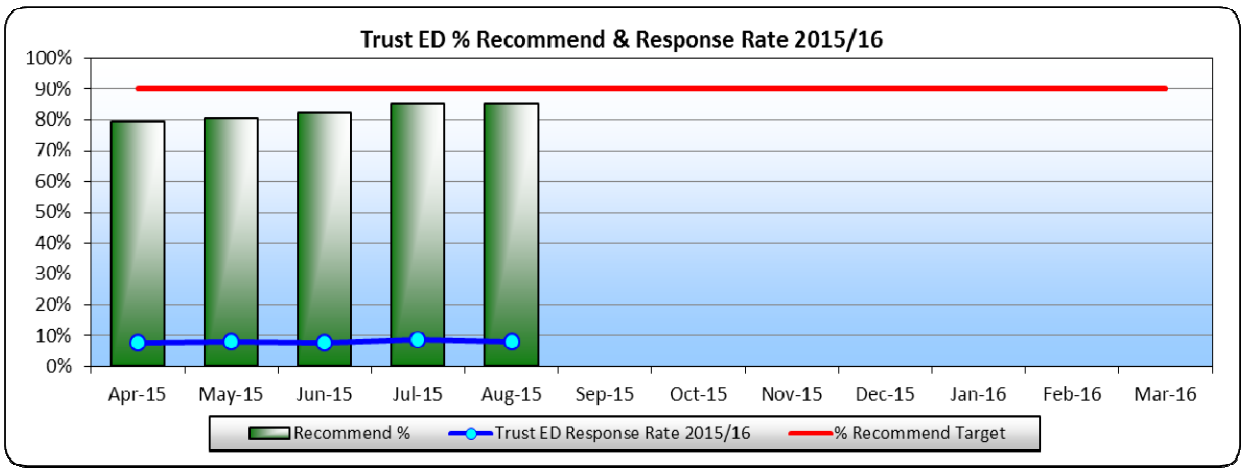
- Sexual Health issues (a low number, but a significant increase in September) include people chasing test results, following up on requests for contact from the YSH team and people asking for clinical advice.

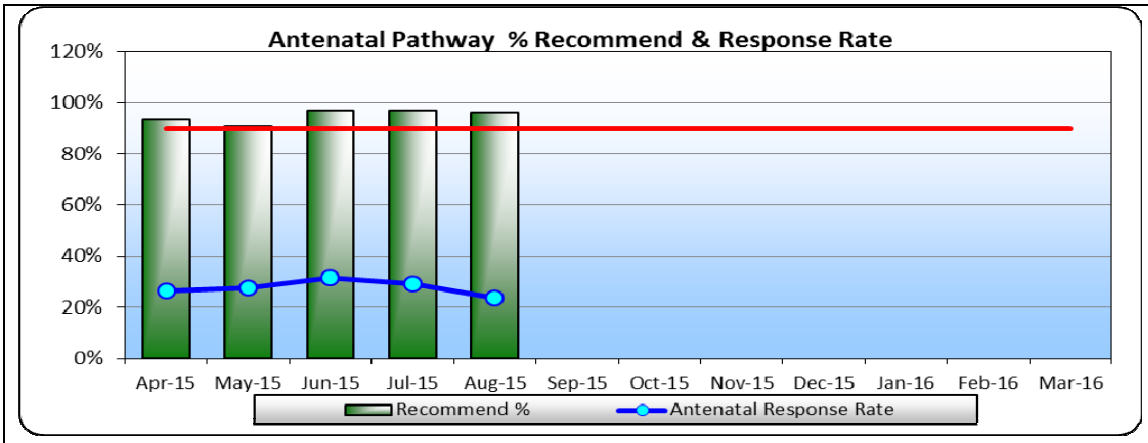
8. Friends and Family Test

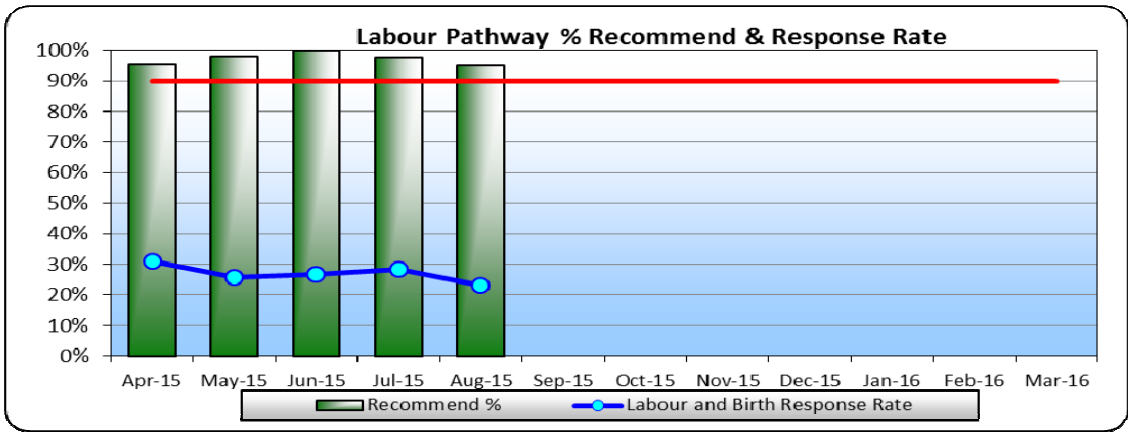
The Friends and Family test results are shown below for Inpatients, Emergency Department (York and Scarborough) and Maternity.

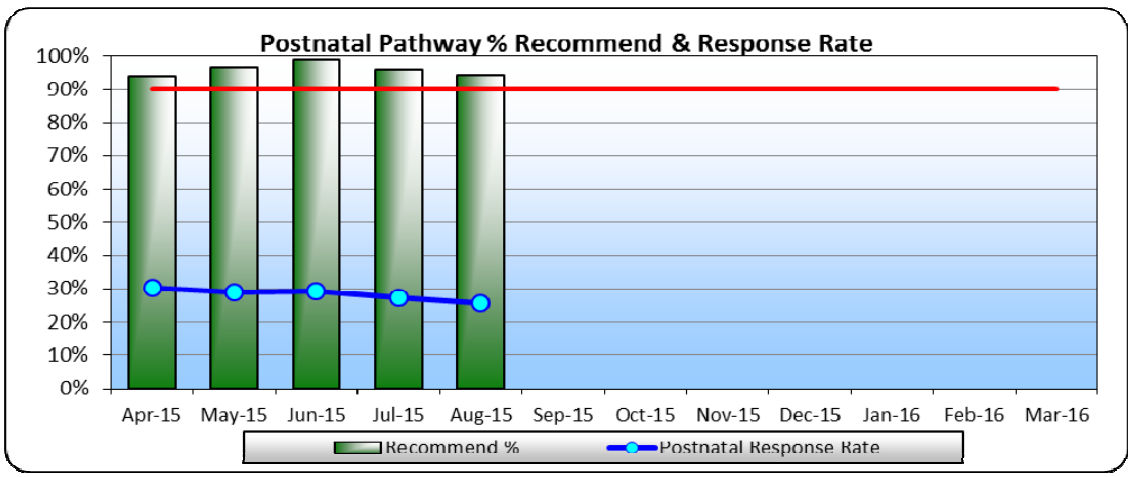
At the time of writing September data is not yet available to complete the Q2 position.

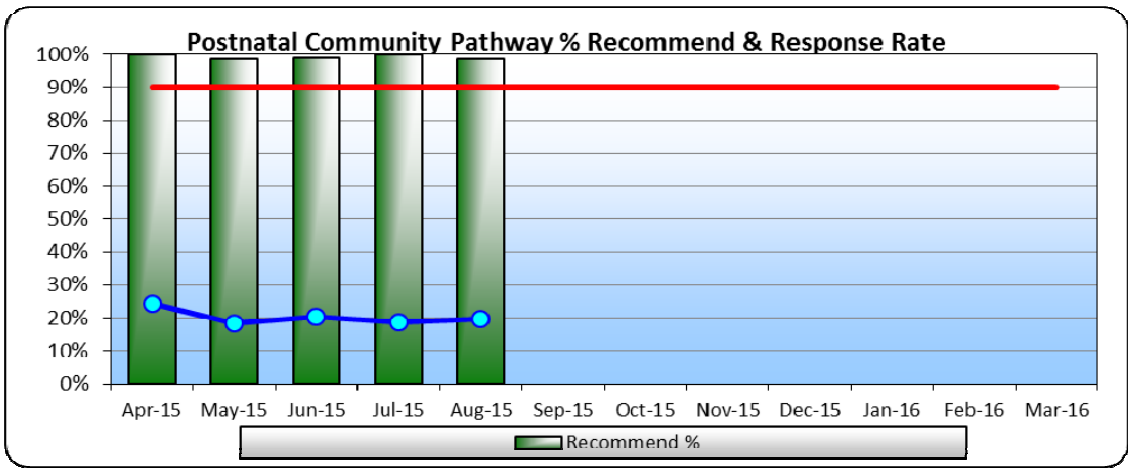





Antenatal Pathway % Recommend & Response Rate
120%
100%
80%
60%
40%
20%
0%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Recommend %
Antenatal Response Rate


Labour Pathway % Recommend & Response Rate
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Recommend %
Labour and Birth Response Rate


Postnatal Pathway % Recommend & Response Rate
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Recommend %
Postnatal Response Rate


Postnatal Community Pathway % Recommend & Response Rate
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Recommend %

Data for community services is also collected.

For community inpatients in July
Response rate: 42.4%
% who would recommend: 100%

For community nursing in July and August five responses were received. The plan in place to be implemented from December 2015 should address this gap.

Response Rates

In 2014-15 response rates were determined by the CQUIN (Commissioning for Quality and Innovation) target. In 2015-16 there is no nationally set response rate target. However, the Trust recognises that it is important to offer patients the opportunity to give feedback on their care at every appropriate contact point, and to ensure that the FFT recommend rates are based on a significant sample of patients.

At the start of 2015-16 day cases became part of the inpatient population. This meant a very significant increase in the number of eligible patients for FFT. Nationally there has been a significant drop in response rates and NHS England acknowledge that 2014-15 cannot be compared like-for-like with 2015-16.

July and August response rate data against national averages

	YTHFT	**National Average**	**National Ranking**
Inpatient	22.6%	27%	128/171
Emergency department	8.75%	15.2%	101/153
Community inpatient	43%	-	
Community nursing	0%	-	
Maternity	28.5%	22%	48/136

The Friends and Family Steering Group was reconvened in August, attended by representatives of nursing staff and directorate management.

Although there is no response rate target for community nursing, a baseline target of 50 responses per month was proposed. The community nursing team has agreed a plan, to take effect from December 2015, where the four localities will take it in turns to have a focus on FFT over a three-month period. This will ensure that patients receiving regular care do not get over-burdened with repeated requests and that the teams are able to review the results and identify learning, before starting the data collection process again.

Actions were agreed for key directorates for improving response rates. Most significantly this includes:

- Receptionists in ESA, Day Unit and Emergency Department explaining the FFT cards and providing a copy (as appropriate) at the point of arrival.

- Commitment from Gastroenterology and Endoscopy to look at how to build FFT into usual working procedures.

- Introducing text messaging for ESA and Day Unit (this went live from 1 October 2015 and early indications are that it has been achieving high response rates)

- Child Health to look at whether the FFT can be linked with the successful *Tops or Pants* initiative.

- Inclusion of providing an FFT card as part of the discharge checklist that is being rolled out Trust-wide.

In addition, Trust Governors have offered their support for handing out cards face-to-face for key areas – in particular the Emergency Department.

% Recommend

For July and August 2015 the proportion of patients who would recommend the service to friends or family are shown below.

	July	**August**	**National Average**
Inpatient	96%	96%	95.9%
Emergency department	85%	85%	88.2%
Community inpatient	93.6%		-
Community nursing	-		-
Maternity	98%	98%	96.8%

Narrative feedback

It is important to recognise that many inpatient areas have consistently strong response rates, and that the vast majority of the FFT feedback across the Trust is very positive. The most frequent comments are praise about “lovely staff” and “kind nurses”.

Specific examples are:

Treated my son with care and dignity went out of their way to make sure he understood what was going to happen.

Always helpful, at the end of the phone, puts mind at ease.

Friendly competent staff made my stay as comfortable and stress-free as possible.

Very friendly and helpful staff. Cannot fault anything.

The midwives were superb providing constant support, encouragement & advice. Thank you so much.

Staff all lovely, food is good.

9. National Maternity Survey

The Trust results from the National Maternity Survey were published on 1 October 2015. Overall, the scores compare positively with national averages and there are no scores highlighting immediate risk or concern.

The Head of Midwifery and Directorate Manager for Obstetrics & Gynaecology, working with the Patient Experience Team, will be leading a full review of the report, including the narrative feedback. This will identify the learning (both positive and negative) to be shared with staff and any necessary actions for improvement.

A full report will be presented to the November Patient Experience Steering Group and Trust Board.

10. Family Liaison Officer Role

Two members of the patient experience team work in the capacity of *family liaison officer (FLO)*. They take responsibility for managing the communication with patients and/or families whose care is subject to a serious incident (SI) investigation.

The responsibility for good communication is closely linked with the Trust's responsibility for being open. It was agreed at the August Serious Incident Group meeting that a flow chart would be produced to ensure all involved were clear about when, how and by whom contact with families should take place.

Learning from handling of recent cases includes:

- Patients and families do not understand the risk scoring matrix used in the SI reports. We have recommended that an explanation is included of the matrix and its meaning.

- Critical incidents (those which do not meet SI criteria but which are identified as requiring full investigation and learning) have not had the same procedure for communicating with families. Further to a bereaved relative receiving a CI report with no supporting communication, it has been recommended that CIs where communication with a family is required should also be considered for FLO involvement.

Active/closed cases

Cases with active FLO involvement: 8

11. Quality Priorities

Trust's Quality Priorities for 2015/16 include the following three aspects for patient experience. The following update on quarter one has be submitted:

- **The Trust will develop and launch a Patient Experience Strategy.**
  This has been approved by the Trust Board of Directors and will be launched at the Nursing and Midwifery Conference on 21 September 2015.

- **Across the Trust the Friends and Family Test will achieve a 90%+ score for patients reporting they would recommend the Trust to their Friends and Family if they needed similar care or treatment.**
  In Q1 2015/16 there were 10,374 responses to FFT and 94% of respondents were extremely likely or likely to recommend the service. 4% were unlikely or extremely unlikely to recommend.

- **'Knowing How We Are Doing Boards' will be rolled out to all wards and departments across the Trust and reviewed on a rolling quarterly basis.**
  54 areas currently have 'knowing how we're doing' boards on display, including all inpatient wards, maternity areas, community hospitals and emergency departments.

  The initiative is now being rolled out to outpatient areas across the Trust. The first eight outpatient boards are now displayed.

Area	KHWDBs displayed	Updated in Q1	Updated in Q2
Inpatient	39	26	7
Maternity	5	3	2
Community inpatients	8	1	1
ED	2	1	1
Outpatient	9	0	7

12. Volunteering

The York Teaching Hospital Volunteering Service has transferred from the Human Resources team to Patient Experience. This is an excellent opportunity to enhance patient experience in the Trust by promoting and developing our volunteering service and raising its profile internally.

There are two 0.5WTE administrator posts (York and Scarborough) supporting the volunteering service. The York post is currently vacant, with a new appointment due to start in post from 1 November.

Detailed actions for volunteering are included in the Patient Experience Strategy Implementation Plan. These will link to the existing current trust volunteering strategy.

The progress towards delivering the implementation plan is overseen by the Patient Experience Steering Group, which will now include looking for assurance of an effective volunteering service within its remit.

13. Recommendation

The Quality & Safety Committee is asked to accept the updates on all the Trust's key patient experience measures.

Author	**Hester Rowell, Lead for Patient Experience**
Owner	**Beverley Geary, Chief Nurse**
Date	**October 2015**

York Teaching Hospital NHS Foundation Trust - Patient Experience Strategy Implementation Plan
Period: September 2015 to September 2016

NS	Not started
IP	In progress
C	Complete

ID	Complete	Required Task	Detailed Actions	Update/Evidence of Delivery
1		**Involving Patients and the Public**		
2	IP	Create a full list of all existing patient involvement, reference, and support groups hosted by the Trust.	List currently exists which details those in York only. Full list will be Trust-wide including contacts for chairs/facilitators and regularity of meetings..	

3	IP	Identify local community groups and communities of interest and ensure they know how to make their views heard to the Trust, ask questions and receive a response.	Create a list of external communities of interest and groups working with CVS, Healthwatch and Trust Equality & Diversity Lead. Make contact to promote Your Experiences Matter and identify any barriers for groups and communities. Agree any necessary actions with the group concerned and the relevant directorate and ensure they are included in directorate patient experience plans. Ensure Patient Experience delivery of Equality Delivery System 2 objectives.	
4	IP	Maintain effective working relationships with other local patient and public involvement leads in health and social care to share learning and identify opportunities for joint working.	Contribute to collaborative working through group hosted by Healthwatch (York) who host a group with representation through Clinical Commissioning Grp, Local Authority, Mental Health Trust & Commissioning Support Unit. Healthwatch (NY) have also brought together Comms and Involvement Leads from Acute Trusts, Ambulance, CCG, CSU, MH Trusts Contribute to Yorkshire & Humber Patient Experience Group hosted by NHS England	Attended NHS England Patient Experience Forum 24.6.15

5	IP	Include updates from user groups eg issues, learning and best practice from patient involvement and support groups in the quarterly Patient Experience Report	Stage 1 - agree schedule/frequency and design format Stage 2 - receive updates and include in PESG reports	Ad-hoc updates provided in PESG during 2015
6	IP	Ensure effective working relationships between the Trust and each of the three Local Healthwatch organisations in our area.	Hold a review meeting with each of the three Healthwatch organisations to confirm points of contact at the Trust, information sharing arrangements and plans for supporting Healthwatch/Trust pieces of work including Healthwatch Enter and Views, response to Healthwatch reports, PLACE assessments. Ensure all three Healthwatch organisations have the opportunity to comment on the Trust Quality Accounts.	Kay Gamble contact for organisational enquiries/enter and view/PLACE/feedback. Lucy Brown contact for communications/press releases Hester Rowell and Helen Hey have held review meetings with HW North Yorks (7.7.15) and York (11.9.15). Quality Account 14/15 feedback requested and received. Chief Exec of HW York is the HW representative on PESG..

7	IP	Supporting our three Local Healthwatch organisations' work associated with their annual workplans. This includes providing information, attending public meetings, facilitating enter-and-view visits and responding to reports.	Make appropriate arrangements to accommodate all HW requests for enter and view visits. Respond on time to all requests for information and requests to comment on draft reports. Provide feedback on delivery of all agreed actions from HW reports.	There is a Patient Experience Action plan detailing agreed actions from three Enter and View reports: - Hospital Discharge, York - Scarborough Hospital Enter and View - Access to Services, York. The delivery of actions is reported to the Patient Experience Steering Group.
8	IP	Deliver patient and public engagement activities required to support the Trust's main service reconfigurations. (Provide advice to directorates on how they can manage smaller scale service changes)	Currently ongoing is the review of the urology diagnostic service. Pt Exp Team work was carried out in 2014 to seek patients' views of one-stop-diagnostic service. Currently the service relocation is with the CCG for investigation of viability. The Trust has moved neurology services from Scarborough to York. A letter was sent out to all affected patients which included the Patient Advice and Liaison Service phone number of anyone wanting to ask questions or raise a concern.	The Patient Experience Team will agree additional projects if required to support Trust need.

9	IP	Work with the Trust Communications Team and Trust Secretary to identify, offer and coordinate opportunities for members and governors to give their views and get involved in Trust initiatives. Ensure that members receive feedback about how their input has been used.	Trust Secretary, Corporate Communications and Patient Experience Team to agree development plan. Patient Experience Team to identify opportunities for members to give views on Trust services and contribute to other patient experience initiatives. Agree and arrange activities where Governors contribute to patient experience work within the Trust.	Governors supported the May 2015 Listening Week.
10	IP	**PRIORITY 1:** Agree and implement a migration plan for the Trust volunteering service from Human Resources to the Patient Experience Team	Meet with HR team who have previously managed volunteering. Move budget to Patient Experience. Introduce staff to wider Patient Experience Team and invite to team meetings. Recruit to 0.5WTE vacancy for volunteering administrator (York) Communicate (email or letter) to existing volunteers to welcome them to the Patient Experience Team	Handover from HR complete. Interviews for volunteering administrator arranged. Volunteering administrator (Scarborough) to attend Sept Pt Exp Team meeting.
11	IP	Develop, gain approval for an implementation plan for the Trust volunteering strategy	Use existing volunteering strategy and create an update on progress to date. Identify gaps in delivery. Devise implementation plan for Patient Experience Steering Group and Board approval.	

12	IP	Deliver the implementation plan for the Trust volunteering strategy		
13	IP	Review and confirm working arrangements with the other volunteering schemes operating in the Trust	Use previously agreed memorandum of understanding between the Friends of York Hospital and York Hospital Volunteers	
14	IP	Develop a role specification for a Patient Experience volunteer and introduce the role into operation and recruit new volunteers to the role.		First draft of role specification produced with input of first Patient Experience Volunteer (previously a Governor).
		Listening, Reporting & Responding		
15	IP	**PRIORITY 1:** Specify and procure a single contract for all (Friends and Family Test) FFT and national patient surveys - linking with HR to include staff FFT and the staff survey	Complete tender specification and assessment criteria. Put out to tender. Review bids. Receive and assess bidder presentation. Let contract with new supplier.	Procurement in final stages - new supplier selected and to be notifed through procurement route. New contract to commence 1st November 2015
16	IP	Develop a Patient Experience Team process for identifying themes and trends from all sources of patient experience feedback, including social media	Review job description for patient experience project manager to include looking across all sources for feedback to identify themes and trends. Establish learning from feedback as a regular team meeting agenda item. Link commentary and learning from themes and trends to new design of patient experience reports.	Revised JD agreed by banding. Will be used when substantive post is advertised (currently fixed term, ending 24.11.15)

17	IP	**PRIORITY 1:** Review the Trust complaints handling process against national best practice, identify gaps and implement improvements	Identify national best practice. Receive monthly updates and best practice from the National NHS Complaints Managers' Forum. Create best practice resources on complaints management for Trust staff and raise awareness through attendance at professional staff meetings. Review YTHFT practice against a framework describing best practice.	National best practice received from NHS England manager reviewing complaints handling. Teleconference held with Nottingham University Hospitals Foundation Trust - identified as a high performing complaints management team by NHS England. Review framework created based on best practice identified. Best practice document produced and shared with directorates. New resolution process trial commenced with Elderly Medicine and Emergency Department.
18	NS	**PRIORITY 1:** Consult on, revise and obtain approval for a new Trust policy for handling enquiries, compliments, comments, concerns and		

19	IP	Migrate the Trust complaints and Patient Advice and Liaison Service onto the Datix Web information management system	Configure Datix Web system to fit with Trust complaint processes. User test new system. Patient Experience Team go live. Investigation officers go live - system of paper complaint files ended. Review fields for PALS usage and make any required changes. Staff training. PALS go live.	Patient Experience Team went live 1.9.15. Directorates start using the system from 19.10.15
20	IP	Respond, on time, to all Parliamentary Health Service Ombudsman (PHSO) information requests in relation to complaint cases they are investigating. Where cases are upheld, provide action plans and evidence of completion within the given timeframe.	Design an internal monitoring system to capture the status and outcome of each case. Report statistics and learning at Patient Experience Steering Group (PESG). Clarify with directorates and matrons roles and responsibilities for developing and providing evidence for action plans.	New format for PHSO information reported to PESG 16.9.15 including learning from upheld cases. Review meeting of Patient Experience Team and directorate handling of a specific action plan to be chaired by Chief Nurse 24.9.15 to identify learning.

21	NS	**PRIORITY 1:** Review the Trust Patient Advice and Liaison Service, agree and implement a service development plan to achieve greater visibility, accessibility and integration with the Patient Experience Team	Identify lead for this piece of work. Establish PALS review group and agree terms of reference for the review. Carry out review and identify actions. Implement action plan.	
22	NS	Encourage directorate and professional groups to use patient stories as part of team meetings/development to support reflection and learning - developing and issuing good practice for using stories in practice	Develop and communicate best practice for using patient stories, building on NHS England report and guidance.	
23	IP	Maintain records of all local patient experience surveys taking place in directorates and report learning via the Patient Experience Steering Group	Transfer log of patient experience surveys to Patient Experience Team from Clinical Effectiveness Team. Incorporate list of current and forthcoming surveys and learning from completed work into PESG reports.	
24	IP	Proactively identify and deliver, in conjunction with directorates, patient experience surveys (up to four per year) to provide greater depth of understanding of issues identified through other feedback sources.	2015/16: Carers' survey currently underway - dementia carers survey is a CQUIN target and all carers is a contract requirement.	Surveying designed in Q1 15/16 with input from Patient Experience Team. Surveys being carried out within nursing teams who have identified appropriate carers.
		Responding and Reporting		

25	IP	Review and revise the Patient Experience section of the Board Quality & Safety report an the Patient Experience Quarterly Report to meet Board of Directors' requirements and enable monitoring of trends	Gather best practice from other Trusts. Design reporting from Datix Web to deliver greater depth of complaints data. Design new template - including both numeric and narrative information - and obtain Quality & Safety committee and Patient Experience Steering Group feedback. Standardise new report format.	Best practice from other Trusts obtained. Datix web live 1.9.15. Reporting formats for complaints being designed for month-end September data. Changes to format of Friends and Family Test section made from August 15 further to Contract Management Board query.
26	IP	Agree patient experience key performance indicators for complaints handling and Friends and Family Test response rate/performance	Propose KPIs for friends and family test response rates and recommend rates. Agree joint working plans with directorates with directorate roles and responsibilities	Patient Experience Steering Group meeting held 17.8.15 and plans agreed to bring outliers on response rate up in line with other areas - with support of Governor Text messaging for day unit went live 1.10.15 with good early results. Next FFT steering group 20.10.15 - review impact of actions agreed at last meeting.
27	NS	Routinely provide an integrated patient experience report to each service area giving numbers of cases and identifying key themes and trends	Design directorate-level patient experience report. Establish standard reporting procedures within the team to populate and distribute the reports.	

28	IP	Produce and display a Knowing How We're Doing Board for each Trust service - ensuring they are reviewed on a rolling quarterly basis.	Roll out boards to all wards. Roll out boards to all out patient areas. Ensure Trust Quality Target is achieved to review all boards on a rolling quarterly basis.	At 1.9.15 54 areas currently have 'Knowing How We're Doing Boards' on display, including all inpatient wards, maternity areas, community hospitals and emergency departments. All boards have been reviewed and 30 have been updated in the last three months.
29	NS	Publish the data from the Knowing How We're Doing Boards on the Trust website	Design new section of the website to explain the Friends and Family Test and the purpose of the boards and enable the public to see copies of the board.	Due to go live November 2015.
30	IP	Provide guidance and good practice to complaint investigating officers about carrying out investigations and documenting findings	Produce good practice document for the Trust. Provide complaint investigation and response training/development sessions through workshops/presentations senior nursing and directorate management meetings.	Good practice document produced and issued in draft for testing and comment July 15. Professional Nurse Leader Forum session on complaints investigation delivered for 14 October 15.
31	IP	Procure specialist writing training for matrons and directorate managers/deputies who write complaint responses	Procure training places from external provider. Identify nominees (all matrons and 1x representative of directorate management) Evaluate training once complete and consider procurement of further places.	30 places procured for 21, 22 and 23 October 2015. All places filled with identified individuals. Venues booked, samples of attendees writing collected for assessment as part of the course.
		Learning and improving		

32	IP	Develop and implement a survey for people who have made a complaint and received a response and share the learning with directorates to support improvement	Develop and test a survey format. Establish surveying as a regular part of the complaints process.	Survey of patients who had a complaint about Elderly Medicine closed in January - July 2015 carried out August 2015 to support the trial of the new resolution process.
33	IP	Work in partnership with the patient safety improvement team to share patient experience learning via established staff communication channels	Identify examples of learning from patient experience sources to be communicated to staff to avoid recurrence or promote best practice. Tailor communications so they are relevant to different professional groups.	Joint working agreed with the patient safety team. First learning example to be included in Autumn 2015 issue of *Nevermore* newsletter
34	NS	Support matrons and directorate managers to create patient experience action plans (either separate or embedded in existing directorate plans) which capture learning points and are subject to regular progress review	Meet with each matron and directorate manager to agree how patient experience actions will be captured and managed. Audit the system for effectiveness.	
35	NS	Develop a bank of patient stories, with learning points and consent to share, which are used in staff training		
36	NS	Review Trust practice against National Institute for Clinical Excellence guidelines: QS015 - Patient experience in generic terms; CG138 - Patient experience in adult NHS services; NS CARERS - Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own	Establish review framework and identify a multidisciplinary team to provide input. Carry out review and report to Patient Experience Steering Group.	

		A culture of learning and responsibility		
37	IP	Ensure that information for patients about how to give feedback is clearly available in wards and public areas	Review how well patients and carers/relatives can find information about how to give feedback as part of PALS review. Patient Experience Team staff collecting Friends and Family Test cards will check patient leaflet displays to ensure that *Your Experiences Matter* leaflets are available and replenish if necessary. Develop new posters for publicising the Friends and Family Test for out patients' areas.	Posters agreed at FFT Steering Group to be completed by 22.10.15. Budget for printing Patient Experience Team leaflets identified.
38	NS	Develop a Trust-wide, multi-disciplinary working group looking specifically at learning and improving from feedback		
39	IP	Attend and present at professional and multi-disciplinary staff forums to promote openness, good communication and best practice for resolving issues in real time as they arise	Identify learning specific to particular patient groups. Identify meetings and forums where learning is discussed and arrange opportunity to present patient experience learning. Review current meetings with directorate management to track complaints case progress to cover wider patient experience agenda.	As at 1.9.15 currently in place for: Head and Neck Directorate meetings and PALS attendance at Ophthalmology meetings. Learning from feedback to be presented at End-of-Life multidisciplinary group.

40	IP	Trial with one directorate and evaluate a staff development session on how to handle situations when concerns are raised with them and avoid complaints	Work in partnership with a directorate to develop a staff development/training session.	Agreed to develop this working with Children's Services Allied Health Professions Clinical Manager

RISK REGISTER - Patient Experience Workplan

Priority Area of Workplan	Risk description	Current Likelihood	Current Impact	Current Risk Rating	Mitigation	Risk Owner

Likelihood	Consequ	Score	Risk Category
1 Rare	1 Negligible/ None	12-25	Red
2 Unlikely	2 Minor/Low	5-11	Amber
3 Possible	3 Moderate	1-4	Green
4 Likely	4 Serious/ Severe		
5 Almost certain	5 Catastrophic / Death		

D6

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Nursing and Midwifery Revalidation

Action requested/recommendation

For information and assurance.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Outcome 14 – Supporting Workers

Progress of report	Quality and Safety Committee
Risk	Nurses and midwives may not comply on date and effectively lose their registration Nurses and midwives may choose to retire earlier than planned due to the introduction of revalidation
Resource implications	Development of system for data collection on learning hub

	Delivery of open events, road shows and other communications Education, training and support for first few cohorts who are required to revalidate Evaluation of system after first three months to ensure the process is as supportive as possible and to monitor the impact revalidation has on attrition
Owner	Beverley Geary, Chief Nurse
Author	Helen Hey, Deputy Chief Nurse
Date of paper	October 2015
Version number	Version 1

Board of Directors – 28 October 2015

Nursing and Midwifery Revalidation

1. Introduction and background

Traditionally nurses and midwives have been expected to renew their registration formally every three years by completing a tick box, paper form, confirming their clinical hours and education and learning achievements and submitting this to the Nursing and Midwifery Council (NMC).

Alongside this process every nurse and midwife has been expected to maintain a hard copy evidence file which could be requested with ten days' notice by the NMC at any time.

The above two processes have been brought into significant question over the past two years and a new process has now been developed and is planned for introduction in April 2016.

This report provides the detail of the new process and describes the work being undertaken in the Trust to support our nurses and midwives to achieve their registration.

The report also outlines some of the associated potential risks and mitigations for the first few months of the process and how the process will be supported in future years.

In addition, a number of the unresolved queries are detailed in the report. The Chief Nurse Team will maintain a focus on resolving some of the queries.

2. Detail

In October 2015, NHS England is scheduled to confirm that a new process for nurses and midwives to maintain their registration will be introduced in April 2016. This date has been deferred on two previous occasions but the expectation is that it will proceed in April 2016.

The main reason for the process to maintain registration is changing is to give greater confidence to the public, employers and fellow professionals that nurses and midwives are up to date with their practice.

The purpose of revalidation is to improve public protection by making sure that nurses and midwives continue to practise safely and effectively throughout their career.

The new process follows similar principles to medical revalidation. Medical revalidation was supported centrally with additional financial resources to support its introduction and maintenance. The process for nursing and midwifery revalidation is not supported by any additional central funding and is potentially much more significant than the introduction of medical revalidation.

The new requirements, detailed on the NMC website, are still provision, but it is expected that they will not undergo significant changes.

Each nurse and midwife will be expected to submit an electronic portfolio to the NMC prior to their revalidation date every three years.

Each electronic portfolio submitted will contain seven sections detailed in Appendix 1, pages 7-10. In this section the Trust Board is provided with the recommendations of how the evidence may be presented.

The NMC are currently not providing an electronic portfolio platform or template. There are a number of private companies developing and marketing example portfolios on the market. The Trust has already taken forward the option of providing our staff with a facility on the learning hub to collate, collect and then submit all their evidence to the NMC directly.

The NMC have expressly stated that Trusts have no responsibility for an individual to maintain their registration. It is a personal, professional responsibility for each individual nurse and midwife. It is evident that many individual nurses, especially in the first months of revalidation will require support to complete the process. Additionally, it would be imprudent for the Trust to assume that the new process will not require some internal support and a level of monitoring, unlike anything that has previously been in place.

In order for the Trust to achieve compliance with revalidation a small team from the Chief Nurses Team, Human Resources, Communications and the Learning Hub have already met and started outlining some of the work required. Work has already commenced on a 'landing platform' for nurses to log and develop their electronic portfolios and Human Resources have ascertained the numbers who will require revalidation each month. In addition, Communications have already started booking venues to run communication events and the high level information has been presented in the brief.

The Chief Nurse Team have made significant progress in relation to revalidation. The landing platform for the development of ePortfolio's is at final review stage in preparation to go live following a systems update on 9 November 2015.

The team are just finalising dates for two specific styles of face to face communication. Firstly, road shows will be delivered on each site to reach as many staff as possible. Currently there are 6 planned, 3 at York, 2 at Scarborough and 1 at Malton Hospital. At York and Scarborough this will include evening sessions.

In addition, the Chief Nurses Team have decided to invite the 139 nurses who are due to revalidate in April, May and June 2016 to specific smaller focussed meetings to support and guide them through the process. When undertaking these sessions the team will assess the requirements of staff and consider putting more sessions on through 2016. However, the plan is that over the next 6 months this will become self-managed and will not require additional resource.

Further consideration is still required in order to give assurance that our 'bank only' staff are supported and to examine options for our colleagues who hold registration but do not work in posts that currently require their registration.

The work required to achieve the best possible process by April 2016 will be further developed over the autumn. The focus will be on those nurses and midwives who are required to submit electronic portfolios in April 2016.

2.1 Potential risks

Capacity

There are two specific areas that related to capacity to ensure and embed this new process.

Firstly, the new process requires new systems, processes and solutions to what is a vastly different way of maintaining registration. The process for each nurse and midwife to record, collate, scan and develop their evidence file will take more time than it has previously. Some of this work will be required in working hours, such as, appraisal, confirmation interviews and 360 degree reviews. Some work, such as, maintaining reflective journals could be maintained out of working hours. In addition, staff will require access to scanners and computers to develop their electronic portfolios.

Secondly, Human Resources have determined that the numbers requiring revalidation in April, May and June 2016 are between 35 and 55 staff each month. However, in October 2016 this rises to 193 staff. This is as a result of universities moving to a one outturn cohort per year and this October number will rise over the coming years. This means a high number of appraisals, confirmation interviews, scanning requirements and access to computers all being required September, October and November each year. This will require additional planning and foresight.

Early Retirement

The new process has been piloted in acute, community and mental health Trusts. Anecdotally both pilot sites and one Trust who has undertaken some scoping work have determined an increase in staff choosing to retire prior to their next revalidation date, which may be slightly earlier than they had planned. This figure has been reported as a 10-20 % higher attrition than would normally be expected.

The NMC has even reported a concern in the nursing press that their income may reduce as older members of the professions; NMC registrants in non-nursing roles and NMC registrants currently overseas choose not to maintain their registration.

This is significant for the Trust. Analysis of the staff requiring revalidation in April, May and June 2016 has been undertaken and demonstrates that 44% of staff are over 50 years and 29% are over 55 year, the oldest person being 68 year. Many of the staff on our Electronic Staff Record aged 60 and above are working ‘bank only’ and may only be supporting the Trust with 1-2 shifts per week and may choose not to revalidate.

It is also expected that this element will impact of our local nursing and residential facilities.

At a time of significant challenges in nurse staffing this may pose and additional risk. This aspect will be monitored during the first three months to determine whether the projected recruitment required in 2016.

Bank Only and Agency Staff

Currently there is an acknowledged overreliance on bank only and agency staff. However, these staff do and will continue to form an important part of our nursing and midwifery workforce.

There is no information on how agency only staff will achieve their sign off confirmation and

collate and submit and electronic portfolio. The only responsibility the Trust has is to check they are working with a framework agency or that prior to the shift the staff member is on the register. With no fixed place of clinical work, clear and consistent line manager and access to a range of facilities to support electronic portfolio development, education and training that some agency staff may struggle to achieve the requirements.

Additionally, for our bank only staff, especially those who only work very few hours. There is a requirement to ensure that they have access to an appropriate appraisal system and confirmation meeting if they want to maintain a bank only contract.

2.2 Unresolved queries

There are a number of areas that have been queried with the NMC but to date the Trust has received limited / no clear direction

Lapses in registration

Currently, unlike medical revalidation which offers a three month amnesty, the NMC are stating that if a member of staff misses their date then they are unregistered. They have not explicitly stated what this mean. For example, will an individual be required to do a return to practice course or are there other routes for them to re-acquire their registrant status.

Dual registration

Many nurses and midwives still hold dual registration and they will be required to demonstrate 450 hours for each part of the registration. If they currently hold a role which does not require one part of their registration how do they fulfil this requirement. The NMC are stating that they could undertake this as voluntary work, but not in their substantive job. This would amount to 12 weeks voluntary work over three years.

Registrants in non-nursing / midwifery roles

If a registrant is in a role that does not require a professional registration then they cannot count any of that role towards registration. Again the NMC have suggested that they evidence 450 hours clinical practice and could undertake voluntary work or an additional job.

The Chief Nurse Team will continue to pursue solutions to some of these outstanding / unresolved queries.

3. Conclusion

The new process for revalidation is welcomed as it will provide greater assurance that nurses and midwives are appropriate for registration and that they maintain up-to-date clinical practice.

The Trust has already undertaken significant work to understand the scope of the requirements and the challenges that may arise as the new process is introduced.

When the announcement is made in October a full schedule of communications and support, specifically for those staff who are due to revalidate in April, May and June 2016 will be launched.

4. Recommendation	
For information and assurance.	
5. References and further reading	
NMC.org.uk	
Author	**Helen Hey, Deputy Chief Nurse**
Owner	**Beverley Geary, Chief Nurse**
Date	**September 2015**

Nurse and Midwifery Revalidation

Appendix 1 – Provisional Revalidation Requirements (September 2015)

Requirement	Descriptor	Electronic portfolio evidence
450 Hours of practice hours	You must practise a minimum of 450 hours (900 hours for those registered as both a nurse and a midwife) over the three years prior to the renewal of your registration. Hours must be carried out in your role as a registered nurse or midwife, which could include: • clinical care, for example in an acute or community setting; • nursing and midwifery education and research; • policy advisory roles; or • management and leadership roles specific to nursing or midwifery.	We recommend that you maintain a record of your practice hours in your portfolio, including: • Dates of practice • Hours undertaken • Details of the organisation • Scope of practice • Work setting • Description of work • Evidence (e.g. timesheets)
40 Hours of Continuing Professional Development	You must undertake 40 hours of Continuing Professional Development (CPD) relevant to your scope of practice as a nurse or midwife, over the three years prior to the renewal of your registration. Of these hours, 20 must be through participatory learning. You will need to maintain accurate records of your CPD and demonstrate how you have used it to reflect on and improve your practice in your written reflections. Participatory learning includes any learning activity which involves interacting with other people, which could include:	You must maintain accurate records of your CPD, including: • CPD method • Description of the topic and how it relates to your practice • Dates and number of hours • Relevance to Code • Evidence that CPD has taken place

	• study day • learning events, such as a conference or workshop • peer review • coaching and mentoring • participation in clinical audit, practice visits and group meetings	
5 Pieces of practice related feedback	You must obtain at least five pieces of practice-related feedback over the three years prior to the renewal of your registration. Feedback can come from a variety of sources, including patients, service users, students and colleagues. Feedback can also be obtained through reviewing complaints, team performance reports and serious event reviews. Feedback can be informal or formal, written or verbal. It could be specific feedback about an individual, or feedback about a whole ward, team or organisation.	We recommend that you keep notes of the content of the feedback. You will not need to record the actual instances of feedback in your portfolio, but you will need to demonstrate how you used feedback to reflect on and improve your practice in your written reflections. Be careful not to record any information that might identify a specific patient or service user.
5 Reflections and discussions	You must record a minimum of five written reflections on the Code, your CPD and practice-related feedback over the three years prior to the renewal of your registration. You must discuss these reflections with another NMC-registered nurse or midwife. Each reflective account can be about an instance of CPD or feedback, or a combination of both. For example, you could create a reflective account on a particular topic which may have arisen through some	• Five written reflective accounts that explain what you learnt, how you changed or improved your work as a result and how it is relevant to the Code. You can use the template provided or your own (see full guidance for criteria) • A completed reflection and discussion form with details of, the person with whom you have had the discussion.

	feedback your team received, such as consent and confidentiality, and identify how that relates to the Code. You must discuss your written reflections with another NMC-registered nurse or midwife as part of a professional development discussion.	
A health character declaration	You must provide a health and character declaration. You must declare if you have been convicted of any criminal offence or issued with a formal caution. Good character is important and is central to the Code because nurses and midwives must be honest and trustworthy. Your good character is based on your conduct, behaviour and attitude. In accordance with the Code, we expect you to declare any cautions and convictions to the NMC immediately, not just at the point of renewal. We expect you to be in a state of health that ensures you are capable of safe and effective practice without supervision, after any reasonable adjustments are made by your employer. This does not mean there must be a total absence of any disability or health condition. Many people with disabilities or health conditions are able to practise effectively with or without adjustments to support their practice.	These declarations will be made as part of your revalidation application. You do not need to keep anything in your portfolio as part of this requirement.
Professional indemnity arrangement	You must declare that you have, or will have when practising, appropriate cover under an **indemnity arrangement**. You must inform us whether this arrangement is through your employer, a membership with a	We recommend that you retain evidence that you have an appropriate arrangement in place.

	professional body, or through a private insurance arrangement.	
Confirmation	You will need to demonstrate that you have met the revalidation requirements. You will need to have a confirmation discussion where you demonstrate how you have met the revalidation requirements. This can form part of an annual appraisal. An appropriate confirmer is your line manager. We recommend that you obtain confirmation from this person wherever possible. A line manager does not have to be an NMC registered nurse or midwife. If you do not have a line manager, we recommend that the person is an NMC-registered nurse or midwife. If that is not possible, you can seek confirmation from another healthcare professional that you work with and who is regulated in the UK.	A confirmation form is available online and we recommend you keep the completed and signed form in your portfolio.

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Quarterly Infection Prevention and Control Report

Action requested/recommendation

The Board of Directors are asked to:

- Receive the Infection Prevention (IP) report for Q2
- Acknowledge actions and interventions for the reduction of Healthcare Associated Infection (HCAI)
- Support the recommendation for improved engagement with the Post Infection Review (PIR) process

Summary

As required by legislative and regulatory requirements, the Trust continues to acknowledge its responsibility to provide safe and effective infection prevention practice with the aim of reducing harm from avoidable infection that occurs either as a direct result of intervention or from contact with the healthcare setting.

This report summarises performance against these requirements and aims to provide assurance of progress against interventions initiated to reduce the increased incidence of healthcare associated infection reported in quarter 1.

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

Implications for equality and diversity

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

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

Reference to CQC

Regulation 12 of the Fundamental Standard – Safe care and treatment: (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Progress of report	Quality and Safety Committee
Risk	Risk to patient safety from healthcare associated infection through variation in compliance with Infection Prevention practice and policy standards
Resource implications	Contractual fines when MRSA bacteraemia and *Clostridium difficile* incidence exceed trajectory and lapses in care identified.
Owner	Beverley Geary, Chief Nurse, Director of Infection Prevention and Control (DIPC)
Author	Vicki Parkin, Deputy DIPC
Date of paper	October 2015
Version number	1

Board of Directors – 28 October 2015

Quarterly Infection Prevention and Control Report

1. Introduction

During Q1 the Trust experienced a period of increased incidence of HCAI for which a series of reduction initiatives were developed focussing on intelligence and outcome from PIR. Recurring themes from PIR identified screening, clinical sampling, variation in compliance with Aseptic Non Touch Technique (ANTT) and isolation practice as significant risks and contributors.

Delivery during Q2 of enhancements to statutory and mandatory IP training to reflect the learning from PIR and case follow up have been made underpinned as reported previously by IP awareness days on both acute sites, ANTT competency based training, ANTT e-learning for nursing and medical staff and ward based training and education specific to these areas of practice.

The impact of these interventions during Q2 demonstrates a downward trend in HCAI and closer to monthly trajectory than in the previous quarter.

2. Update: Incidence and Performance

Information below describes HCAI incidence in Q2 and compares it with that which occurred in Q1:

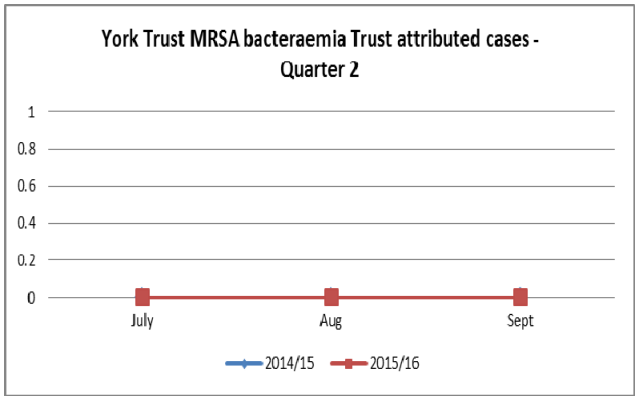
MRSA Bacteraemia:
Q1 – 6 cases. Q2 – 0 cases. National Trajectory – zero tolerance, fines incurred for each case.

MSSA Bacteraemia:
Q1 – 11 cases. Q2 – 9 cases predominantly in medical, elderly and surgical directorates each with reduced incidence this quarter. Local trajectory – less than 30 cases, no financial penalty.

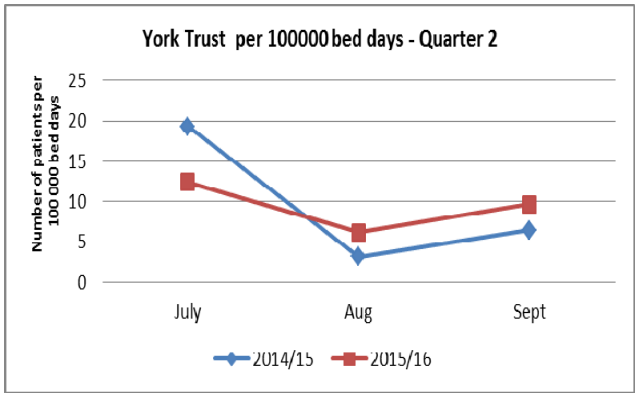
***Clostridium difficile* infection (CDI):** 35 cases against a trajectory of 48.
Q1 – 21 cases. Q2 – 14 cases predominantly in the directorates mentioned above where action plans are agreed at PIR with clinical and nurse leads. Fines incurred if lapses in care are identified and trajectory is exceeded.

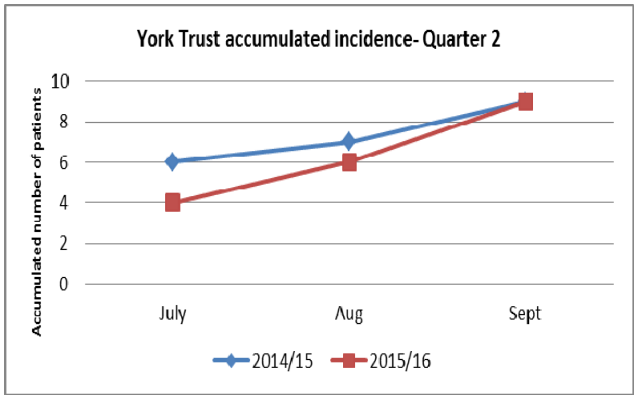
Comparative incidence data below describes 2014/15 and 2015/16 incidence by site for the same time period.

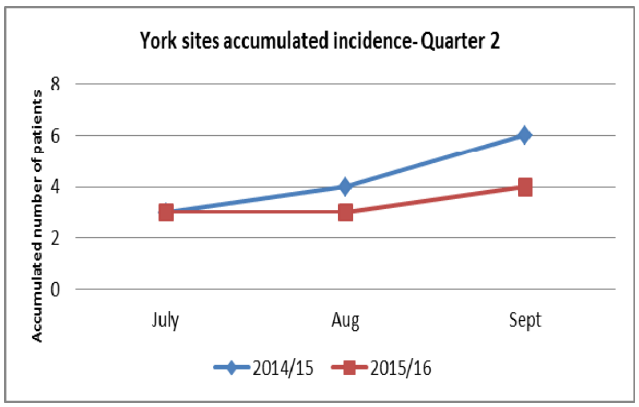
MRSA bacteraemia Trust attributed cases

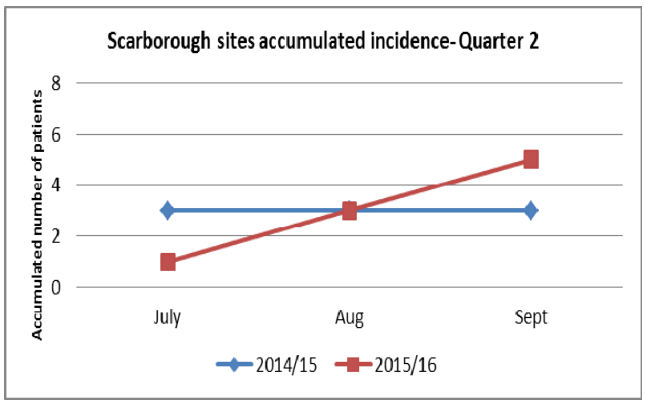


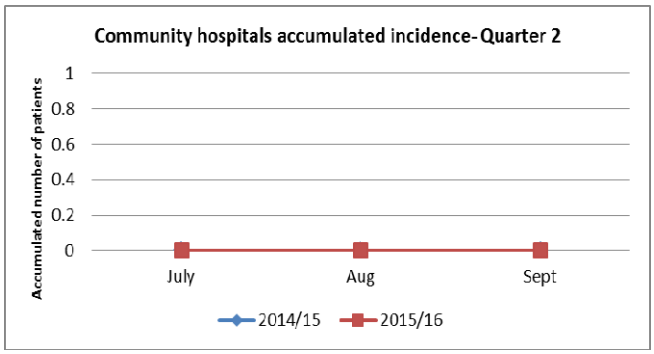
MSSA bacteraemia Trust attributed cases



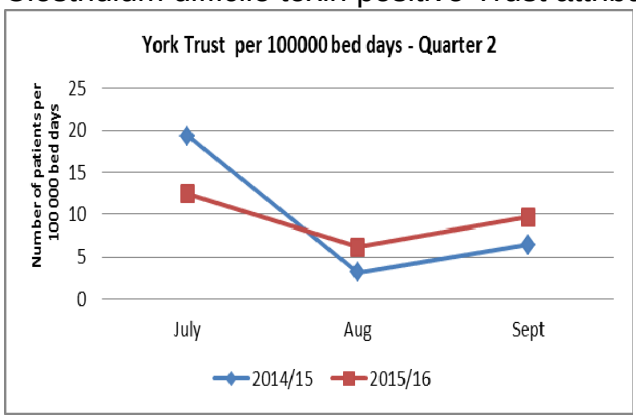


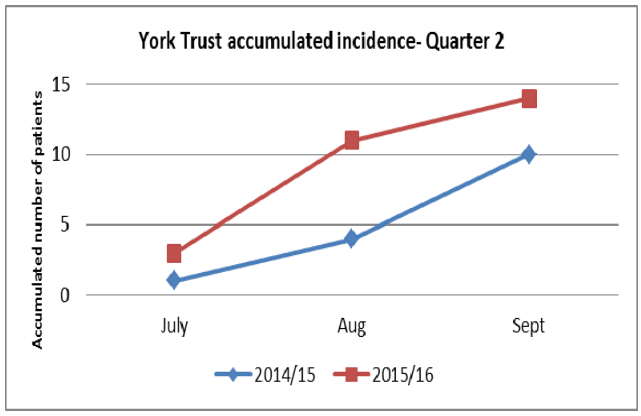


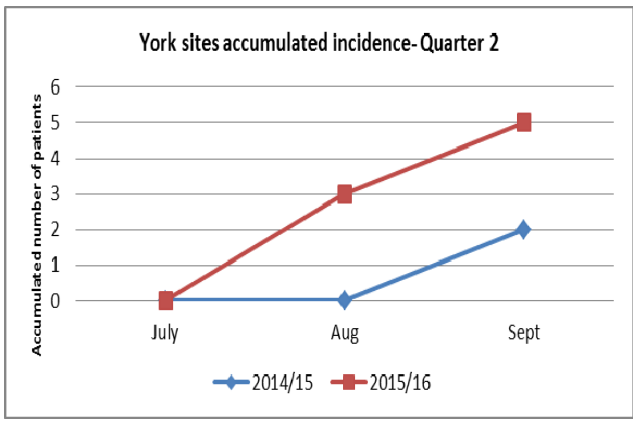


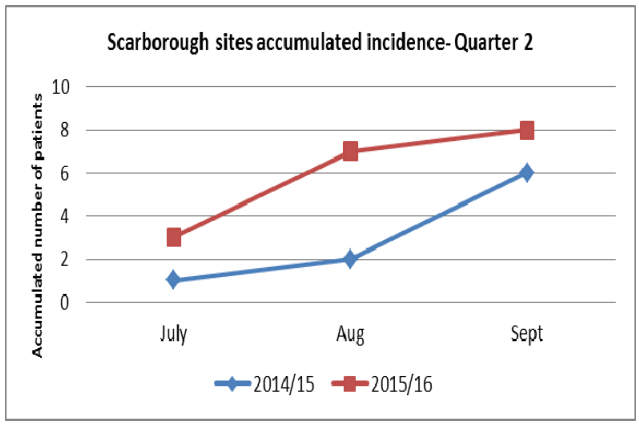


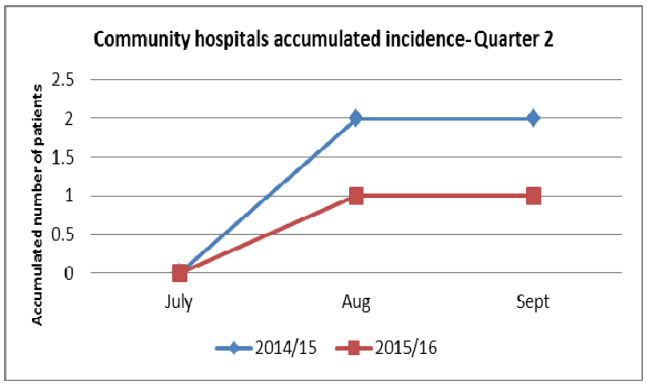
Clostridium difficile toxin positive Trust attributed cases











Ward based training and education sessions are delivered to high inidence areas to address and raise awareness of PIR outcome and best practice in line with Trust IP polices/guidelines. With subsequent dissemination at PNLF, Senior Nurse meetings and Medical staff training.

Post Infection Review:
Work continues to refine this process to ensure effective review and to optimise care learning opportunities. We have attempted to make attendance at PIR meetings as accessible as possible by varying times and locations therefore meeting the requirements of attendees. Whilst engagement from clinical and nursing leads has improved in some areas it remains not so in others, the consequence being significant delay in case review. These issues have been escalated to the Chief Nurse/DIPC and Medical Director.

There were no outbreaks of infection during Q2. The IP Team are developing a multifaceted approach to raising awareness of the management of winter vomiting virus across the Organisation. This includes IP briefings at Senior Nurse and PNLF meetings, communication through staff room/staff brief and IP message of the month.

Antimicrobial Stewardship:
Monthly antimicrobial audits throughout the Trust continue to show improvement in adherence to the prescribing standards which are as follows:

- All antimicrobial prescriptions shall have an indication recorded on the prescription
- All antimicrobial prescriptions shall have a duration or review date recorded on the prescription

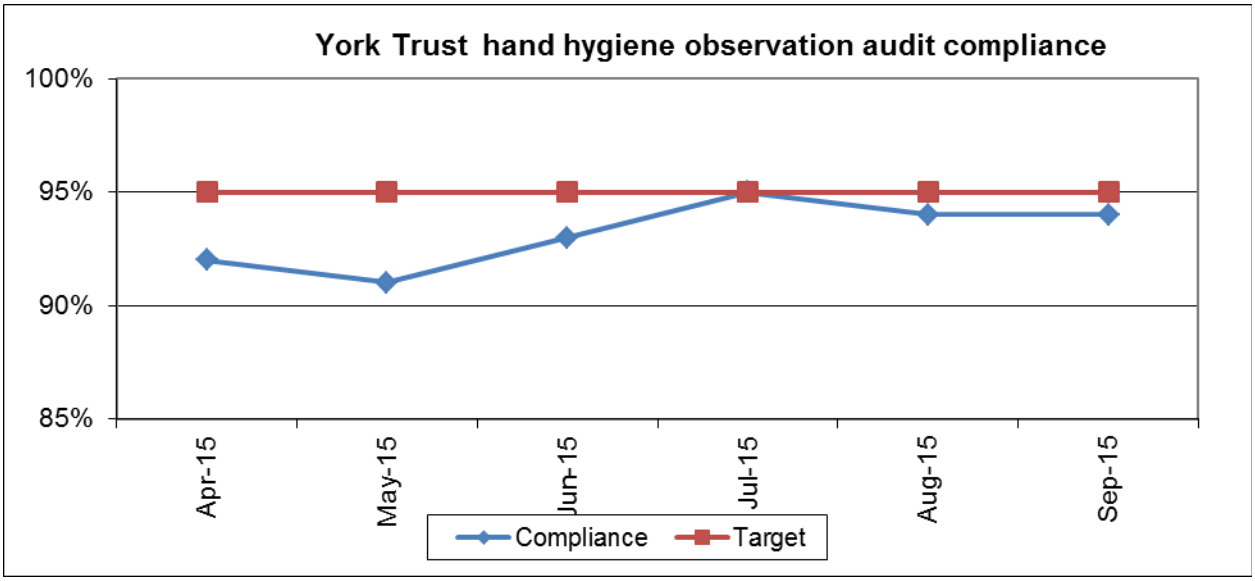
Areas which perform poorly in these audits have had extra input from the antimicrobial pharmacy team to help improve the quality of their prescribing.

The use of probiotics with the aim of reducing CDI is being evaluated by the Antimicrobial Stewardship Team (AST) with a view to withdraw its use that currently shows little clinical benefit, reduction in incidence or health gain vs cost. AST will be presenting a paper to support this change at HIPCG in December.

Weekly antimicrobial stewardship ward rounds on both acute sites which include members of the pharmacy antimicrobial team together with microbiology consultants/registrars have proved very successful in reviewing inpatient antibiotic prescriptions. Data below supports this and describes compliance with prescribing standards demonstrating month by month improvement:

		Q2 2014/15	Jul 15	Aug 15	Sep 15	Q2 2015/16
Antimicrobial pathway compliance with indication (information from Antimicrobial Stewardship Team)	Elderly	89%	86%	85%	82%	84%
	Head + Neck	72%	100%	100%	67%	89%
	Medicine	84%	96%	80%	90%	89%
	Obstetrics + Gynaecology	with surgery	50%	100%	100%	83%
	Specialist Medicine	with medicine	100%	71%	64%	78%
	Surgery + Urology	77%	93%	89%	82%	88%
	Trauma + Orthopaedics	83%	91%	93%	81%	88%
	Trust	81%	88%	88%	81%	86%
Antimicrobial pathway compliance with duration or review date (information from Antimicrobial Stewardship Team)	Elderly	87%	94%	91%	84%	90%
	Head + Neck	81%	82%	100%	33%	72%
	Medicine	83%	89%	78%	86%	84%
	Obstetrics + Gynaecology	with surgery	100%	100%	100%	100%
	Specialist Medicine	with medicine	100%	43%	91%	78%
	Surgery + Urology	73%	90%	81%	79%	83%
	Trauma + Orthopaedics	78%	91%	90%	67%	83%
	Trust	80%	92%	83%	77%	84%
Percentage patients >65 years co-prescribed VSL#3 (information from Antimicrobial Stewardship Team)	Elderly	77%	85%	86%	VSL product not available	86%
	Head + Neck	0%	33%	25%		29%
	Medicine	55%	71%	40%		56%
	Obstetrics + Gynaecology	with surgery	100%	100%		100%
	Surgery + Urology	25%	50%	31%		41%
	Trauma + Orthopaedics	43%	25%	75%		50%
	Trust	56%	67%	56%		62%

Hand Hygiene:
A Trust wide improvement plan implemented late last year following external audit that demonstrated 32% - 60% compliance has led to greater understanding of the World Health Organisation 5 moments for hand hygiene amongst clinical staff. The hand hygiene observation audits have shown consistently improved compliance and less variation in practice across all sites identified through external review



3. Review of Governance

As part of review of governance within the Organisation, an external review of Governance arrangements for Infection Prevention has been undertaken to ensure the Trust continues to deliver assurance and reduces the incidence of HCAI.

Recommendations are currently being reviewed and actions will be agreed at the next HIPCG

4. Conclusion

Interventions to reduce increased HCAI incidence have been developed and implemented with clinical staff and appear to be contributing to a downward trend.

In addition to effective IP practice without variation, PIR is fundamental to the identification of areas of care that may impact on risk, outcome and incidence of infection. To enable this, full engagement with the process is required.

Collective and multidisciplinary responsibility for IP is essential to maintaining a downward trend and enhancing patient safety.

5. Recommendations

The Board of Directors is asked to:
Receive the IP report for Q2
Acknowledge actions and interventions for reduction of HCAI
Support the recommendation for improved engagement with the PIR process.

6. References and further reading

Relevant Legislation and Guidance:

- The Health and Social Care Act 2008:Code of Practice on the prevention and control of infections and related guidance, updated July 2015
- NICE Infection and Prevention Quality Standard 61 April 2014
- Epic 3: National Evidence-Based Guidelines for Preventing Healthcare Associated Infections in NHS Hospitals in England 2014

Author	**Vicki Parkin, Deputy DIPC**
Owner	**Beverley Geary, Chief Nurse, DIPC**
Date	**October 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Community Services Work Programme 2015/16 – Service Improvement Update

Action requested/recommendation

The Board of Directors is asked to note the update on community services improvement projects.

Summary

This paper provides an update on community services improvement projects. These form part of a wider work programme that was presented to the Board of Directors in May 2015.

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

Implications for equality and diversity

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

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	n/a
Risk	Associated risks have been assessed
Resource implications	Any resources implications are detailed in the report
Owner	Wendy Scott, Director of Out of Hospital Care
Author	Steve Reed, Head of Out of Hospital Care Wendy Scott, Director of Out of Hospital Care

Date of paper	October 2015
Version number	Version 1

Board of Directors – 28 October 2015

Community Services Work Programme 2015/16 – Service Improvement Update

1. Introduction

This paper provides an update on community services improvement projects. These form part of a wider work programme that was presented to the Board of Directors in May 2015

2. Background

The Community Services work programme (2015/16) describes a number of work streams, some of these are being delivered jointly with partner organisations including North Yorkshire County Council (NYCC), City of York Council (CYC), GP Practices in Ryedale and the GP Federation in Selby. Voluntary sector organisations are also engaged.

The Community Services Directorate is committed to modernising and developing services. It recognises that services need to adapt to meet increasing demand, changing demographics, workforce challenges and the diverging expectations of patients who want to take advantage of rapid developments in IT and who want to take more responsibility for their own care.

Also, there is recognition at both national and local level that the health and social care system must work together more effectively to deliver a wider range of services in partnership.

3. Overview of Schemes and Progress to Date

- Community Discharge Liaison Service
- Community Mobile Working
- Care Hub Pilots – Phase Two
- Single Point of Access
- Intermediate Care and Reablement Services

Establishing a Community Discharge Liaison Service

All team members have now been recruited; the third and final member will join at the end of October 2015. The team have established a schedule to support Board Rounds on all community wards and will ensure an accurate daily 'sit rep' report.

A project group has been established and this includes representatives from both CYC and NYCC. Key work streams include:

- Introducing new procedures to support the management of delayed transfers of care;
- Introducing a 'ticket home' - this ensures that patients and relatives/carers are aware of their planned discharge date;
- Working with systems and network colleagues to ensure community wards are exploiting the full benefits of developments in CPD such as electronic board rounds.

Key evaluation metrics include a reduction in length of stay for patients in community wards, an increase in the number of patients admitted or transferred into community wards (increased throughput) and a reduction in the number of delayed transfers of care from community units.

Community Mobile Working

The Community Mobile Working project launched with a two day rapid improvement event; frontline staff and IT professionals came together to design how community nursing teams would work differently, assuming an 'ideal state'. As part of this process they considered how mobile technology could support this process. A similar event has also been held for community therapy teams.

Progress to date includes:

- All pilot teams are now using an electronic scheduling tool to plan visits;
- A software supplier review has taken place to consider how the community electronic record is used by community teams;
- Smart Phones have been rolled out to all pilot teams;
- Work has been undertaken with software suppliers to provide a mobile configuration to meet the needs identified in the rapid improvement event and to set up a trial device for teams to test;
- Providing staff with access to other clinical systems (CPD, Summary Care Record) to obtain key clinical information.

Next steps:

- An evaluation of the configuration of the pilot devices and the development of a business case for the associated project costs;
- Reconfiguration of the community electronic record following best practice advice;
- To set up key clinical documentation on the community electronic record;
- To ensure revised referral forms are available via the community electronic record;
- Implement a protocol for the sharing of images between clinical teams;
- Roll out configured lap tops to pilot teams.

Key evaluation metrics include the percentage of time spent by staff on clinical care (as opposed to administration and travel), an increase in the total number of patient contacts and real time updates of clinical information.

Care Hub Pilots

The Trust has delivered, in partnership with NYCC, Coast and Vale Community Action and GP Practices, three new service models to serve the populations of Selby and Ryedale. These include:

- Community Response Teams – integrated health and social care teams supporting people to remain independent in their own homes. This can avoid a hospital admission or emergency respite placement and facilitate the timely discharge of patient's home from hospital.
- Care Home In reach – Care of the Elderly Consultants working in partnership with GPs, specialist nurses and care home management teams to provide holistic reviews of care home residents to support comprehensive care planning.
- Older Person's Clinic – providing Care of the Elderly Consultant led weekly clinics that undertake a comprehensive geriatric assessment of frail older people; this supports complex care planning and provides an alternative (where appropriate) to hospital admission or hospital outpatient attendance..

These pilots are underpinned by a 'one team' approach; bringing together health and social care teams to work in different ways. Phase One has focused on recruiting staff and bringing together health and social care teams, working closely with primary care and the voluntary sector and co locating staff where it makes sense to do so. Phase Two seeks to accelerate integration. Next steps include:

- Defining and developing an integration work programme with partners that can realise the benefits of working together in new and different ways;
- Using the community electronic record to create a shared electronic record between teams;
- Expanding on links with third sector partners;
- Working with mental health teams;
- Creating a model for integrated care in the community.

Key evaluation metrics include reducing, where appropriate non-elective admissions to hospital services and admissions to residential social care. Service user feedback is crucial and measures include service users reporting that their care and support was streamlined and 'joined up'.

Single Point of Access

YHFT currently subcontract with Yorkshire Ambulance Service (YAS) for a Community Single Point of Access (SPA) call handling service. However, work has progressed to repatriate this service 'in house'. This approach is seen as part of a wider initiative to establish a YHFT 24/7 single contact centre solution.

A YHFT Community SPA contact centre will launch on 7th December 2015. This service, based at Monkgate Health Centre will manage all community nursing contacts (currently 80,000 per annum).

A SPA working group meets regularly. Key work areas include:

- Ensuring that referral details are recorded by the contact centre team into the community electronic record; these can then be electronically transmitted to the relevant team (currently this requires duplicate entry as the YAS service operates on a different IT system);
- Creating functionality so that all GP practices can refer directly from their electronic record (rather than necessitating a phone call);
- Creating administrative templates to ensure that all relevant information is taken from referrers before transfer to clinical teams.

Key evaluation metrics include measuring call handling performance, in particular the percentage of calls answered within one minute. Referrer feedback will also be invited so that referrer satisfaction with the system can be evaluated.

Intermediate Care and Reablement Services

The Trust is working with partners at both CYC and NYCC to review current intermediate care and reablement services delivered in Scarborough and Ryedale and York and Selby. This work involves benchmarking existing services against national measures/outcomes and also workshop activities aimed at designing future integrated models (current intermediate care services are provided by YHFT and reablement services are provided by CYC and NYCC). This work will in turn support the health and social care commissioners in designing future service specifications that will deliver integrated health and social care provision.

4. Recommendation	
The Board of Directors is asked to note the update on community services improvement projects.	
Author	**Steve Reed, Head of Strategy for Out of Hospital Services** **Wendy Scott, Director of Out of Hospital Care**
Owner	**Wendy Scott, Director of Out of Hospital Care**
Date	**October 2015**

York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 20 October 2015 – Boardroom, York Hospital

Attendance: Mike Keaney, Mike Sweet, Andrew Bertram, Steve Kitching, Lucy Turner, Anna Pridmore

Apologies: Graham Lamb Juliet Walters Sue Rushbrook

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes Dated 22 September 2015**	The agenda covered the following AFW and CRR items	The notes of the last meeting have been approved with the following correction:		
2.	**Matters arising**		All matters arising were picked up as part of the discussions.		
3.	**Risk Register**	**AFW** DoF2,3,4,7 COO 1&2	It was noted that the registers were updated on a quarterly basis. There were no further comments about the registers at the meeting.	The Committee were assured that the risks included in the registers were being discussed by the meeting.	
5.	**Work Stream 1 Eradication of fines: Operational Reports**	CRR CE 2 DoF1-4 &6 COO 1-4	**Diagnostics –** The target has been achieved for quarter 2. There has also been a significant reduction in fines from £122,000 in May 2015 to zero in September. Significant work has been completed in Radiology including the department having a greater understanding of the start, stop rules. The Committee asked about the scanner in Scarborough and were advised that options are still being reviewed; LT added that she did not expect performance to be affected unless the scanner was down for an extended period of time.	The Committee were pleased to see the improvements that had been achieved and looked forward to continuing to see sustained achievement of the target.	JW to update the Board on Operational Performance generally with a particular focus on ED performance

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			LT advised that work in endoscopy and cystoscopy continues and action plans developed with NHS Elect are being worked through with the Directorate. **Cancer –** The team has continued to work hard to achieve the target at Q2 for breast symptomatic. The Trust failed the Q2 is fast track 2 week waits due to staff sickness and patient choice. In September 67% of the breaches were due to patient choice. It will be reported to Monitor in the quarterly return that at this stage the target for 62 day 1st treatment target has not been achieved. Part of the risk relates to the treatment patients receive at other tertiary centres that have yet to be uploaded onto the national cancer database. Once the figures have been validated this position will be clearer. **18 week admitted –** The achievement of this target is off trajectory. There are concerns regarding the current projections for Ophthalmology and Max Fax to deliver sustainable admitted backlogs. Further work with the 18 week sustainable backlog model is being undertaken to understand why the impact of the slight operational changes made have had such a large impact on the trajectory. The Committee discussed the service on the East Coast provided by New Medica and enquired why this work was not being undertaken in house. LT explained that the Trust does not have the capacity to complete the work in house. She explained that a job has been advertised four times recently without success. LT advised that on the York site CESP will	The Board noted the hard work that had been taking place to achieve the results and was assured by the Ops team using the learning from the breast symptomatic challenges to resolve some of the other challenges now being managed	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			undertake an additional 75 cases to help reduce the backlog. It is now predicated the target will be achieved in Ophthalmology in February 2016 LT reflected that the biggest risk to the 18 week target was winter and cancellations. It is very important that elective work keeps going over the winter. To support that LT described the contingency arrangements being put in place including the use of Nuffield and Ramsey. In terms of fines, LT explained that the fines in September were £10,800 compared to last year when they were over £25,000. She added that the fine per patient will increase to £300 for the incomplete standard in 18 weeks as from November. **ED –** LT reported that ED performance had deteriorated from 91.8% in August to 89.74%. The comparison of September 2015 with September 2014 shows there has been an increase (4.5%) in attendance; non elective admissions in York increased by 13.2% and in Scarborough by 6.7%; overall admissions have increased by 10.8%. The Committee discussed the performance and noted that this was not just about flow, there were other aspects that affected the achievement of the target. LT added that the Minor Injuries Unit run by Northern Doctors closes between 10pm and 8am. As a result patients are being seen in the ED department in Scarborough. Discussions are being held with Northern Doctors about the impact this might have on the ED department in Scarborough and the implications of any fines that might be incurred as a result. LT reported that more	The Committee was disappointed to see performance, but were encouraged by the activity being undertaken to bring the performance back into line and then seek to move forward.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			patients were leaving the department without being seen and work was being undertaken to establish why this was the case. LT outlined the work being undertaken to continue to resolve the issues being experienced in achieving the 4 hour target. She outlined: • The business cases to expand ambulatory care in York and Scarborough have now been agreed. • The DVT pathway will transfer to primary care in October. • Service models for frailty services are agreed and a business case is being developed, and NHS Elect are visiting the Trust in October re to support the development of the service. • Work on the York site continues to develop a primary care 'front door' model in collaboration with the CCG • The winter resilience plan has been finalised and will be discussed at the Board of Directors in October. • The Emergency Care Intensive Support Team are continuing to provide support to the Trust across the emergency care pathway and action plans are being developed following their September site visit. • A trial of senior doctor assessment in ED for patients arriving by ambulance has been introduced.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			LT acknowledged there had been steady improvement in the achievement of the 4 hour target since March 2015. In August there were a number of new doctors and shortages of staff. In September and October there have been a number of locums working out of hours and weekends which has resulted in there being significant challenges at the beginning of the week. The Committee discussed the plans and agreed that the first task was to stabilise the position and then start to move forward. The Committee asked if LT could explain the improvement in the ambulance turn round times. LT advised that a lot of effort has been made to improve the position. Nurses are working in the ambulance turn round area. The Directorate Manager has been working with the Nurses to ensure there is a protected post for the area. The Trust has also challenged the data and has changed to using CPD rather than the ambulance service system. This has given the Trust a better understanding of the patient flow and improved data. LT acknowledged there had been steady improvement in the achievement of the 4 hour target since March 2015. In August there were a number of new doctors and shortages of staff. In September and October there have been a number of locums working out of hours and weekends which has resulted in there being significant challenges at the beginning of the week. The Committee discussed the plans and agreed		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			that the first task was to stabilise the position and then start to move forward. AB updated the Committee on the actions being taken to reduce the penalties. He explained that discussion will be held with the CCG about patient referrals that take place when it is know that the patient will not be able to attend because they are away. AB reflected on the discussions he would be holding with Northern Doctors and confirmed that the Trust would obviously help Northern Doctors if they could not deliver the contract, but there would be a cost attached to that help. AB gave a third example of a challenge to a manufacture on a piece of equipment that might be causing a delay in diagnosis. He confirmed that it can be proved the equipment is causing a delay he will discuss the financial implications for the Trust with the manufacture.		
6.	**Work Stream 2: CQUIN Delivery**		The Committee noted the report and the success in achieving Q2. LT explained that the biggest concern in Q3 was ambulatory care. This was discussed at the Executive Board time out held in October. The event included attendance from all Executive Board members, plus Directorate Managers and other key senior managers. The discussions provided some additional information about how the Directorates would like to with the CQUIN. She added that it is hoped that this will help earlier development of the CQUIN for 16/17. AP linked this to the development of the Quality Report and it was agreed a further discussion would take place outside the meeting.	The Committee were pleased to see the achievements and assured by the work being undertaken to continue to achieve the CQUIN for this year.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
7.	**Work Stream 3: Finance Report**		AB presented the finance report. He outlined that there had been a further deterioration in the position. The overall income and expenditure position has moved from £6.0m deficit to a £6.4m deficit and the variance to plan has increased from £2.5m to £3.0m. He raised that in terms of the actual trading month of September the Trust was able to fully balance its in-month income and expenditure; this is the first month of the financial year that this has been achieved. He added that this is a demonstration of TAP having an effect. AB reported that a new provision of £0.4m has caused the deterioration in the year-to- date position. Following detailed reconciliation work with the CCGs an issue relating to readmissions activity suggests the Trust has assumed too much income. AB reported clinical income in September was £35.1m and last year income was £2m higher. The Committee asked if demand has been managed more by the CCG in September. AB explained that was not the case, it was more related to the date the schools went back and people taking later holidays. He anticipated there would be an increase in October. AB referred to the system wide information included in his report and reflected the staggeringly poor position the NHS was in at Quarter 1. He reflected that this does make our position look more positive. He added that this provides the context for current performance and	The Committee remains disappointed that the Trust is showing a financial deficit, but acknowledges the hard work that is being undertaken to arrest any further deterioration and the impact TAP is starting to have	AB to update the Board

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			sets some realistic expectations, but also makes delivery of the efficiency programme more difficult. MS asked if the CCG will continue to be in a position to pay for the additional work above contract being undertaken. AB confirmed he had no reason to suggest they would not be able to pay. The Committee noted the contracting issues related to MSK and asked what the impact of the recent decision by the CCG to abort their procurement exercise. LT explained that it might have an impact on the organisation from an operational perspective. AB confirmed he did not expect it to impact the organisation financially.		
8.	**Work Stream 3: Efficiency Report**		The Committee were pleased to see the progress that had been made in the CIP position. It was noted that overall delivery was 64% of the annual target and that there has been a £5.0m improvement in the position in month. SH described the work currently being undertaken and confirmed four panels had met to discuss with the directorates how they were going to close the gap on their CIP. SH explained that the Quality Impact Assessment will be reviewing 22 schemes that are considered high risk before they are approved. The Committee discussed the directorates that were low achievers and noted the work being undertaken in the panels was picking up the	The Committee were pleased and reassured by the excellent achievements around the CIP.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			issues.		
9.	**Work Stream 4: Workforce**		The Committee agreed that this element of the work stream sat with the Workforce Strategy Committee. The Committee was keen to see the position, but agreed the detail should not be discussed by the Finance and Performance Committee. The Committee asked AP to ensure the Workforce Strategy Committee received the information provided to the Finance and Performance Committee.		
10.	**Overview information from TAP**		AB provided an overview of further information related to TAP: • Executive Board Time Out – He outlined the agenda for the meeting and explained that each of the TAP work streams was discussed in groups including discussing the progress against each stream and the implementation of TAP. It has been agreed that details from the event are being written up and will be shared with the Executive Board. • AB explained that he and a number of other officers from the Trust had met with Monitor's Transformation/Turn around Team and he was starting to get an understanding of the big picture around future financial sustainability of the Trust. He confirmed he would be preparing a paper to be discussed in the private board. • AB referred to the efficiency matrix which demonstrates where a directorate could be	The Committee were interested to hear the developments in thinking around financial sustainability and were assured that a further discussion would be held with the Board.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			more efficient. He explained that using the developing model from Monitor will help with the discussions with the CCG around service provision and cost of services. For example, If the directorate can demonstrate the service is being provided in the most efficient way through an analysis and it follows the agreed specification, but the service is still not cost effective, Monitor are agreeing to join in the discussions and support any need to rebalance income against the spend. The Committee agreed this was a useful development. AB updated the Committee on the developments at Bridlington and explained the intention was to grow market share. The Committee asked about elective income improvements. It was agreed that GC would be asked to provide a paper to the next meeting. The Committee asked about progress on Whitby. AB confirmed the ownership of the building would be transferred on 1 November 2015 and Humber FT is undertaking their due diligence and it is anticipated the service will transfer at the end of the financial year. In the meantime we will continue to provide the services on a cost basis.		
10.	**Contract and Tender Report Development**		MS presented the paper and explained his proposal. It was agreed that this would fall under the remit of the new Business Manager when he is appointed later in the week and he would see part		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			of his role as developing this register.		
11.	**Any other business**		The Committee discussed the 4% cap on agency costs and asked if it achievable. AB said that the commentators believe it will not work.		
12.	**Next Meeting**		The next meeting is arranged for 17 November 2015		

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Monthly Performance Report

October 2015

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

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	**Specialty fail:** £150 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**92%**	93.0%	92.5%	92.8%	93.8%	92.3%	93.0%	93.8%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	0	2	3	0	0	0	0
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	Nil	**Not a 2015/16 target**	82.0%	80.7%	75.6%	76.3%	75.7%	78.2%	75.3%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	Nil	**Not a 2015/16 target**	95.5%	95.4%	95.2%	95.1%	95.0%	95.2%	95.2%

Access Targets: Cancer

NB: Cancer Figures Run One Month Behind Due to National Reporting Timescales

Indicator	Consequence of Breach	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jun	Jul	Aug
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	85.4%	89.8%	93.9%	one month behind	94.0%	93.0%	91.1%
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	90.5%	91.0%	91.4%	one month behind	93.6%	93.3%	93.4%
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	98.4%	96.1%	96.2%	one month behind	94.8%	98.2%	99.2%
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	95.3%	95.6%	94.4%	one month behind	96.4%	97.5%	96.4%
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	100.0%	98.5%	99.6%	one month behind	100.0%	100.0%	100.0%
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	85.0%	76.5%	87.8%	one month behind	88.7%	85.8%	84.6%
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	92.5%	92.2%	98.4%	one month behind	100.0%	86.2%	97.1%
62 Day Consultant Upgrade	General Condition 9	**85%**	50.0%	-	-	-	-	-	-

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£120 fine per patient below performance tolerance (maximum 10% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	89.1%	89.1%	88.3%	91.5%	92.9%	91.8%	89.7%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**0 > 30min**	514	520	539	315	82	163	70
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**0 > 60min**	371	383	415	139	31	78	30
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q3 14/15**	**Q4 14/15**	**Q1 15/16**	**Q2 15/16**	**Jul**	**Aug**	**Sep**
	NHS VALE OF YORK CCG	30mins - 1hr	154	161	163	88	26	53	9
		1hr 2 hours	109	109	114	47	12	23	12
		2 hours +	54	44	26	19	6	13	0
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	176	177	152	94	25	49	20
		1hr 2 hours	77	83	101	28	9	15	4
		2 hours +	25	25	28	1	0	1	0
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	127	134	146	82	20	36	26
		1hr 2 hours	54	70	76	23	2	11	10
		2 hours +	13	17	22	1	0	1	0
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	17	20	27	13	3	6	4
		1hr 2 hours	13	15	14	6	1	4	1
		2 hours +	1	2	3	0	0	0	0
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	2	6	1	1	0	1	0
		1hr 2 hours	1	0	0	1	0	1	0
		2 hours +	0	0	0	0	0	0	0
	OTHER	30mins - 1hr	38	22	50	37	8	18	11
		1hr 2 hours	16	12	27	12	1	8	3
		2 hours +	8	6	4	1	0	1	0
Total number of patients waiting over 8hrs in A&E	General Condition 9	Q1 - Establish baseline	819	944	734	431	90	140	201
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**0 > 12 hrs**	2	11	0	1	1	0	0
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	97.0%	97.6%	97.5%	To Follow	96.3%	To follow	To follow

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**A banding of "Significantly higher that expected" in SHMI using the "Extract Poisson Distribution" method for deriving upper and lower confidence limits, applied to each sub-group reported**	96	93	93	95	98	99	97
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9		108	104	105	107	108	109	107

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**48**	16	21	21	14	3	8	3
Number of Clostridium difficile due to "lapse in care"	Establish baseline and set trajectory	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**108 (TBC)**	28	27	24	16	4	6	6
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases	**Quarterly:** General Condition 9 (identified in 15/16 contract as HPA MESS monthly)	**30**	19	13	11	9	4	2	3
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	1	6	0	0	0	0
Confirmed cases of MRSA Bacteraemia to be notified to commissioner by next working day	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 21 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
All High Risk (non-day case) Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95%**	88.5%	86.0%	85.1%	85.6%	86.3%	88.2%	82.6%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95%**	70.1%	66.2%	72.2%	75.1%	74.5%	76.4%	74.3%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 fine per patient below performance tolerance	**99%**	97.9%	95.9%	95.2%	99.4%	97.0%	98.6%	99.4%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	2	0	0	0	0
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	3	15	9	0	0	0	0
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	229	548	205	40	15	17	8
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	£200 in respect of each excess breach above threshold	**95%**	97.1%	96.9%	97.1%	97.4%	97.3%	97.1%	97.6%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.7%	99.9%	99.8%	To follow	99.7%	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%**	5.1%	4.3%	Reports currently unavailable from the HSCIC due to a change in system.				
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 87% Q2 - 89% Q3 - 91% Q4 - 93%**	86.3%	92.0%	89.1%	89.7%	90.1%	91.3%	87.7%
Delayed Transfer of Care to be maintained at a minimum level	As set out in General Condition 9 - Trust only to be accountable for Health delays.	**<1%**	1612	1160	1476	1459	435	539	485
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance						
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**200 per month**	563	514	452	486	168	150	168
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**End Q2 745; end Q4 721**	2381	2375	2365	2509	884	792	833
% Compliance with WHO safer surgery checklist	General Condition 9	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	392	386	389	1 month coding lag	172	136	1 month coding lag
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	1391	1419	1341	1 month coding lag	498	479	1 month coding lag
Reduction in avoidable transfers within the Trust after 10pm. Excludes transfers for clinical reasons or for patients transferred to a more appropriate ward	General Condition 9	**100 per month (Baseline 374; Q1;-330; Q2-280;Q3-250;Q4-220)**	353	374	302	258	92	82	84

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	98.3%	99.3%	99.7%	99.1%	98.6%	99.5%	99.3%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	General Condition 9	**Best Practice Standards**	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced quarterly .						
Immediate Discharge letters - 24 hour standard: Overall Trust Position Monthly report and quarterly audit . Action plan to be provided where the target failed in any one month. 25 cases from SR and 25 cases from ERY.	General Condition 9	**>98% for admitted patients discharged and >98% for A&E patients discharged**	Quarterly audit						
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Rydale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology). 25 cases from SR and 25 cases from ERY	General Condition 9	**Q1 - 94% Q2 - 95% Q3 - 96% Q4 - 97%**	Quarterly audit						
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	General Condition 9	**Q1 - 90% Q2 - 92% Q3 - 94% Q4 - 96%**	Quarterly audit						
All Red Drugs to be prescribed by provider effective from 01/04/2015	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
All Amber Drugs to be prescribed by provider effective from 01/04/2015	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	86.3%	85.9%	87.0%	87.4%	87.5%	87.4%	87.3%

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Never Events	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	0	0	1	0	0	0	0

District Nursing Activity Summary

Indicator	Source	Threshold	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Jul	Aug	Sep
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	-	2095	1999	2729	2567	848	881	838
	Community nurse/service	-	744	777	908	835	317	246	272
	Acute services	-	876	907	1080	963	395	285	283
	Self / Carer/family	-	291	413	457	666	240	204	222
	Other	-	201	223	299	277	117	79	81
	Grand Total	-	4207	4319	5473	5308	1917	1695	1696
Community Adult Nursing Contacts	First	-	2833	3179	4351	4464	1621	1355	1488
	Follow up	-	32068	35413	41527	46851	15630	15044	16177
	Total	-	34901	38592	45878	51315	17251	16399	17665
	First to Follow Up Ratio	-	34.0	33.5	29.6	31.6	9.6	11.1	10.9
Community Hospitals average length of stay (days)	Archways	-	20.6	26.8	21.1	23.0	28.1	22.1	19.6
	Malton Community Hospital	-	17.1	16.0	19.9	16.1	13.9	17.3	18.0
	St Monicas Hospital	-	22.0	24.0	15.5	15.5	18.3	14.7	14.0
	The New Selby War Memorial Hospital	-	13.7	17.6	15.3	14.2	13.1	14.2	15.6
	Whitby Community Hospital	-	20.9	21.9	20.0	19.5	16.6	19.9	22.8
	Total	-	18.1	20.2	18.5	17.4	16.3	18.0	18.3
Community Hospitals admissions. Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	8	5	8	11	3	0	8
		Emergency	77	71	73	79	22	34	23
	Malton Community Hospital	Elective	21	48	19	37	27	4	6
		Emergency	121	110	101	115	38	33	44
	St Monicas Hospital	Elective	9	16	17	14	5	4	5
		Emergency	27	27	43	41	11	14	16
	The New Selby War Memorial	Elective	69	57	59	69	28	13	28
		Emergency	69	55	68	68	27	25	16
	Whitby Community Hospital	Elective	4	0	0	1	0	1	0
		Emergency	142	140	136	133	54	39	40
	Total	Elective	111	126	103	132	63	22	47
		Emergency	436	403	421	436	152	145	139

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Complaints and PALS												
New complaints this month	43	60	31	39	37	47	43	41	33	41	37	58
Complaints at same month last year	52	45	27	52	16	16	50	38	58	38	0	47
Number of Ombudsman complaint reviews	0	0	0	3	4	7	2	4	1	1	3	1
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	0	0	0	1	1	2	0	0	0	0	0	0
Late responses this month (at the time of writing)***	8	5	5	4	1	0	3	2	10	7	4	6
Top complaint issues												
Aspects of clinical treatment	31	44	18	21	20	32	30	27	21	29	27	30
Admission/discharge/transfer arrangements	5	4	0	2	3	2	1	3	1	1	1	5
Appointment delay/cancellation - outpatient	0	0	4	1	2	2	2	2	0	1	1	0
Staff attitude	0	5	5	10	7	5	3	7	3	3	3	0
Communications	0	0	0	2	2	4	4	1	3	2	2	8
Other	2	0	0	0	1	0	0	1	1	0	2	0
New PALS queries this month	653	552	443	620	559	478	430	416	498	643	530	631
PALS queries at same time last year	536	419	385	503	470	367	378	369	406	442	488	426
Top PALS issues												
Information & advice	42	150	136	189	173	126	158	155	171	237	233	296
Staff attitude	0	0	17	19	14	12	19	14	23	24	14	19
Aspects of clinical treatment	89	105	66	77	47	84	69	63	72	101	64	76
Appointment delay/cancellation - outpatient	24	63	41	47	28	52	29	35	46	59	39	60

**note: upheld complaints are reported quarterly to allow for investigation timescales*
***note: we do not record partly - if a complaint generates 1 or more actions for improvement then it is reorded as upheld*
****note: if extensions are made in agreement with the complaint, responses are not considered late*

Serious Incidents												
Number of SI's reported	34	13	24	17	16	18	12	14	12	20	11	16
% SI's notified within 48 hours of SI being identified*	100%	92%	96%	100%	100%	100%	100%	100%	100%	95%	100%	100%
% SI's closed on STEIS within 6 months of SI being reported	0%	8%	0%	0%	0%	66%	100%	TBC	TBC	TBC	TBC	TBC
Number of Negligence Claims	16	8	8	12	17	15	15	15	12	14	8	14
Extension requests made at least 4 weeks prior to deadline of report due date, and reason given is acceptable to CCG (Threshold - 90% by Q4)							0	2	0	1	0	0
Duty of Candour demonstrated within SI Reports (Threshold 100%)							100%	100%	100%	100%	100%	100%
Percentage of reported SI's, investigated and closed as per agreed timescales**** (Threshold (90%)							83%	85%	83%	93%	100%	92%
Percentage of reported SI's with extension requested.							0.0%	13.3%	0.0%	6.3%	0.0%	0.0%

* this is currently under discussion via the 'exceptions log'

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Pressure Ulcers**												
Number of Category 2	43	42	36	51	35	44	37	50	35	38	44	34
Number of Category 3	10	7	5	4	3	6	4	8	8	3	6	2
Number of Category 4	1	2	0	1	0	1	0	1	1	0	0	1
Total number developed/deteriorated while in our care (care of the organisation) - acute	52	42	47	50	30	41	31	38	35	34	35	27
Total number developed/deteriorated while in our care (care of the organisation) - community	29	43	25	24	25	32	25	47	27	29	28	27
Falls***												
Number of falls with moderate harm	7	1	6	2	2	3	2	4	6	0	3	1
Number of falls with severe harm	4	2	6	2	5	4	2	7	4	5	1	3
Number of falls resulting in death	0	0	0	0	1	0	0	0	0	1	0	1
Safeguarding												
% of staff compliant with training (children)	51%	54%	53%	55%	58%	59%	62%	65%	68%	74%	80%	80%
% of staff compliant with training (adult)	40%	42%	43%	45%	56%	59%	62%	64%	69%	74%	80%	81%
% of staff working with children who have review CRB checks												

Note ** and *** - falls and pressure ulcers subject to validation. Fall resulting in death currently being investigated as Serious Incident and the degree of harm will be confirmed upon completiion of investigation.
All falls and pressure ulcer data has been refreshed to reflect imrovements in identification, monitoring and reporting of falls and pressure ulcers.
**** - data revised to exclude SIs which have been delogged since declaration

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Finance Report

Action requested/recommendation

The Board is asked to note the contents of this report.

Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 30 September 2015.

At the end of September the Trust is reporting an Income and Expenditure (I&E) deficit of £6.4m against a planned deficit of £3.4m for the period. The Income & Expenditure position places the Trust behind its Operational plan.

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

Implications for equality and diversity

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

This report is for noting only and contains no recommendations. It is therefore not expected to have any particular impact upon the requirements of, or on the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	October 2015
Version number	Version 1

Briefing Note for the Board of Directors Meeting 28 October 2015

Subject: September 2015 (Month 6, Q2) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for the Period to September 2015

Unfortunately we have seen a further deterioration in the reported position for September, when compared to October. The overall income and expenditure position has moved from a £6.0m deficit to a £6.4m deficit. Our variance from plan has increased from £2.5m to £3.0m.

There is a very significant observation that I would wish to bring to the Board's attention. For the actual trading month of September the Trust was able to fully balance its in-month income and expenditure. This is the first month this financial year we have been able to do this. Income levels have been higher than August, as expected, but did not show the same level of gain as we saw between August and September in 2014.

There is a specific issue for which I have created a new provision of £0.4m that has caused the deterioration in the year-to-date position. Following detailed quarter one reconciliation work with the CCGs an issue relating to readmissions activity suggests we have assumed too much income. At the time of writing this report this issue is being investigated and we do not have a conclusion. To be prudent we have revised down our Q1 income assumptions.

Clinical income in September was £35.1m (including a reduction of £0.4m for the Q1 readmissions potential issue). August was £34.1m in comparison. Last year income was some £2m higher in September than August, but levels of marginal rate payment for very high non-elective activity levels have compromised elective activity income levels.

At £38.7m, expenditure levels for September have been broadly in line with August levels and, importantly, have stayed well below the peak of £40.4m experienced in July.

The position in relation to contract penalties shows continued signs of improvement with a continued downward trend in September. Continuation of this work under the TAP programme is a clear priority for the Trust; having said that the accrued position continues to have a material impact on our reported income and expenditure position. The performance report summarises the full implications of the penalties.

The income position reflects the national withdrawal of the 18-week admitted and non-admitted penalties. The Board should also be aware that the reported income position continues to assume a degree of success with our claim to the CCGs for re-investment of ED 4-hour penalties and ambulance turnaround penalties. S&R CCG have initially rejected our request for help but discussions continue about more specific targeted reinvestment support. The recent conversations with Monitor (both with the CCGs and in our internal meetings) have been supportive in this regard. VOY CCG have yet to formally respond to

our letter but have indicated a willingness to support legitimate claims. The Board will be kept informed of progress with these claims.

As part of our routine submissions we are discussing this position with Monitor. I will keep the Board updated in this regard. At this stage, whilst formal investigation is an option for Monitor, the regulatory framework does not mandate Monitor takes this action. To date there are no indications that Monitor are considering taking any further action.

Expenditure Analysis

Pay expenditure is a major pressure on the Trust but has stayed at £26.7m for the month of September, the same level reported for August.

All our control measures remain in place in regard to the use of temporary agency staff and Monitor continue to escalate central control initiatives. Of note is that from 19 October Monitor require full compliance with on-framework agencies only, except in exceptional and documented instances. We are currently working with all national initiatives as well as our own local controls.

Drug expenditure in month is in line with average levels at £4.1m. It currently stands at £2.9m ahead of plan but this largely relates to high cost out of tariff drug costs for which direct recharges are made to commissioners.

Clinical supplies and services expenditure is also in live with average levels at £3.8m for the month. And similarly other costs are broadly in line with averages at £4.1m for the month. Investigations continue to identify pressure areas and any necessary supplementary actions.

CIP delivery has moved significantly forward in month. There is a small adverse impact on the financial position to date but a marked improvement from the position previously reported. More detail of progress to date is provided in the efficiency report.

Contracting Matters

The only contracting issue that I would wish to bring to the Board's attention relates to MSK. The contract was due to expire at the end of October but was initially extended to the end of January given mobilisation difficulties being experienced by the winning bidder following the CCG's recent procurement exercise.

More recently the CCG have aborted their procurement exercise and have requested the Trust continues as the CCG's MSK service provider. Discussions continue in this regard. I will update the Board as to the latest position at the meeting.

System-wide Update

I wanted to take the opportunity in this report to bring the Board up to date with the reported Q1 position for the NHS as a whole. This position is very important context for the current position we find ourselves managing.

Recently, national information has been published for quarter one. Clearly this is aged information but nevertheless it is information that provides a key insight to current performance trends.

The first table I would wish to bring to the Board's attention has been published by Monitor. This relates to FT performance only. The table shows that whilst the overall number of FTs in deficit is 118/151 (78%) there is a real concentration within the Acute sector. Monitor's information confirms 78/83 (94%) of Acute FTs were in deficit in Q1.

Quarter ended 30 June 2015

	Number of trusts[1]	Operating Revenue[2] £m	Net surplus[2] £m	Number of trusts[1] in deficit	EBITDA[2] %	GRR red rated trusts[1]	% red rated[1]
Acute	83	7,919	(437)	78	(0.3%)	33	40%
Mental health	43	2,210	7	25	4.6%	4	9%
Specialist	17	744	(11)	10	2.6%	-	-
Ambulance	5	234	(4)	4	3.3%	-	-
Community	3	139	(0)	1	2.4%	-	-
Total	**151**	**11,246**	**(445)**	**118**	**0.9%**	**37**	**25%**

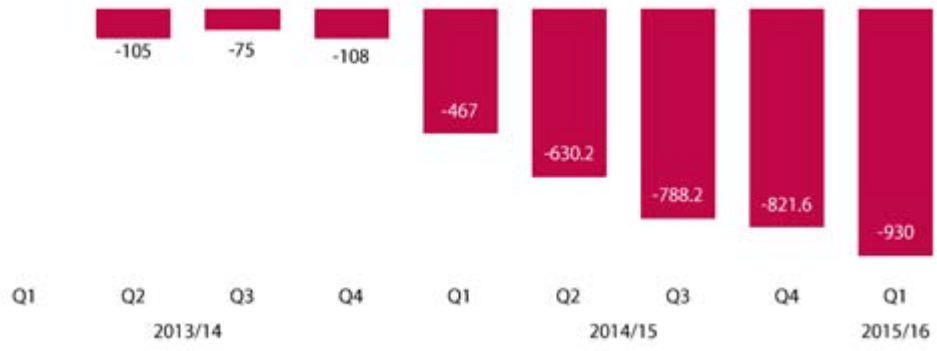
The second table I would wish to bring to the Board's attention has been published by NHS Providers. This shows FT and non-FT performance combined. The analysis confirms that 190/241 (79%) NHS healthcare providers were in deficit at Q1. Again the analysis confirms an extremely high concentration in the acute sector with 132/138 (96%) of Acute providers in deficit.

TABLE 1: PROVIDER FINANCIAL POSITION AT Q1 2015/16

Trust type	Number of providers	Number of providers in deficit	Net position	Proportion of providers in deficit
Acute	138	132	-£912m	96%
Ambulance	10	8	-£7.4m	80%
Community	19	9	-£2.0	47%
Mental Health	57	31	2.1m	54%
Specialist	17	10	-£11m	59%
All	241	190	-£930m	79%

The final chart that I would like to bring to the Board's attention has been prepared by NHS Providers. This shows the quarter-by-quarter deficit position for the NHS over the last two years. The trend is extremely clear and it is of enormous concern that the Q1 deficit for 2015/16 exceeds (already) the final outturn deficit for 2014/15.

FIGURE 1: YEAR TO DATE SURPLUS/DEFICIT FOR THE NHS PROVIDER SECTOR (£M)



Finance Performance Report

October 2015

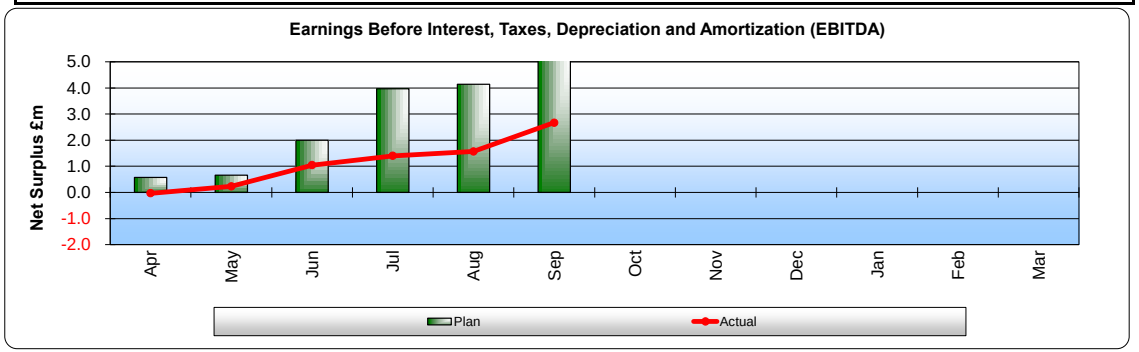
Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

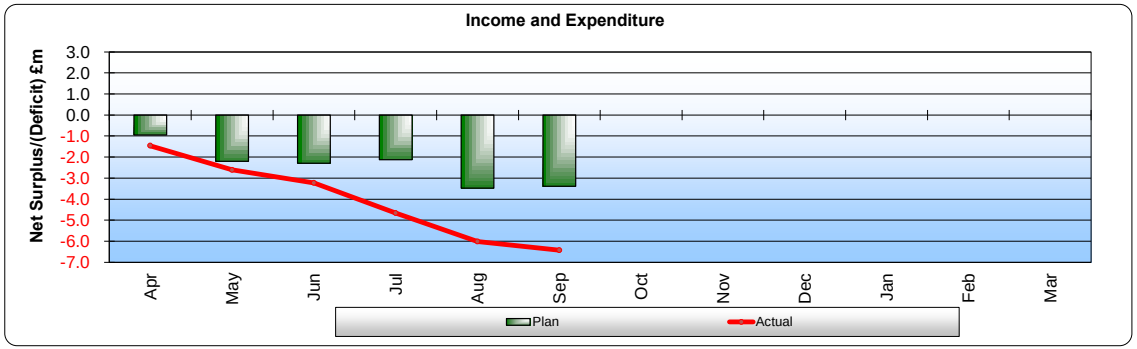
Summary Income and Expenditure Position
Month 6 - The Period 1st April 2015 to 30th September 2015

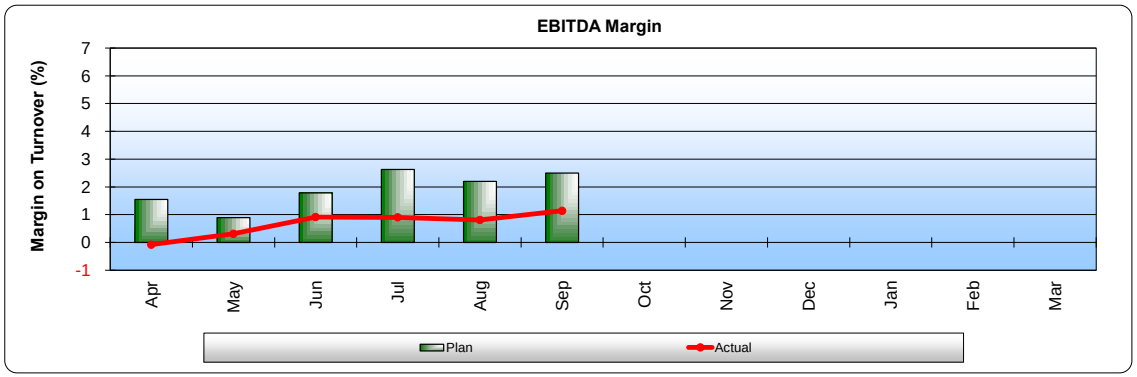
York Teaching Hospital NHS
NHS Foundation Trust

Summary Position:

* The Trust is reporting an I&E deficit of £6.4m, placing it £3.0m behind the operational plan.
* Income is £4.0m ahead of plan, with clinical income being £2.4m ahead of plan and non-clinical income being £1.6m ahead of plan.
* Operational expenditure is ahead of plan by £7.1m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £2.7m (1.14%) compared to plan of £5.8m (2.50%), and is reflective of the reported net I&E performance.
* Due to the timing of the Board meeting the forecast is the one reported to Monitor the previous month.







	Annual Plan	Plan for Year to Date	Actual for Year to Date	Variance for Year to Date	Forecast Outturn	Annual Plan Variance
	£000	£000	£000	£000	£000	£000
NHS Clinical Income						
Elective Income	24,947	12,275	12,661	386	25,346	399
Planned same day (Day cases)	33,817	16,730	17,832	1,102	34,533	716
Non-Elective Income	104,654	52,562	54,004	1,442	110,461	5,807
Outpatients	66,425	32,379	30,465	-1,914	65,928	-497
A&E	14,883	7,281	7,788	507	15,341	458
Community	33,047	17,573	18,730	1,157	34,392	1,345
Other	131,888	65,332	65,075	-257	126,188	-5,700
	409,661	**204,132**	**206,555**	**2,423**	**412,189**	**2,528**
Non-NHS Clinical Income						
Private Patient Income	1,036	518	450	-69	1,036	-0
Other Non-protected Clinical Income	1,890	945	901	-44	1,798	-92
	2,926	**1,463**	**1,351**	**-112**	**2,834**	**-92**
Other Income						
Education & Training	14,333	7,167	7,635	468	15,225	892
Research & Development	4,156	2,078	2,452	374	4,698	542
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	600	300	370	70	739	139
Other Income	17,596	8,972	9,768	796	18,791	1,195
Transition support	10,907	5,454	5,453	-1	10,906	-1
	47,593	**23,970**	**25,677**	**1,707**	**50,359**	**2,766**
Total Income	**460,180**	**229,565**	**233,583**	**4,018**	**465,382**	**5,202**
Expenditure						
Pay costs	-315,361	-155,220	-159,801	-4,581	-310,171	5,190
Drug costs	-43,435	-21,590	-24,485	-2,895	-49,369	-5,934
Clinical Supplies & Services	-46,641	-23,116	-22,624	492	-45,217	1,424
Other costs (excluding Depreciation)	-48,275	-24,557	-23,972	586	-46,859	1,416
Restructuring Costs	0	0	-33	-33	-100	-100
CIP	9,198	670	0	-670	0	-9,198
Total Expenditure	**-444,514**	**-223,813**	**-230,915**	**-7,102**	**-451,716**	**-7,202**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**15,666**	**5,752**	**2,668**	**-3,084**	**13,666**	**-2,000**
Profit/ Loss on Asset Disposals	-4,500	0	3	3	-4,497	3
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation	-11,000	-5,500	-5,500	0	-11,000	0
Interest Receivable/ Payable	100	50	81	31	156	56
Interest Expense on Overdrafts and WCF	0	0	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0	0	0
Interest Expense on Non-commercial borrowings	0	0	0	0	0	0
Interest Expense on Commercial borrowings	-335	-167	-150	17	-303	32
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	-9	-9	-6	-6
PDC Dividend	-7,040	-3,520	-3,520	0	-7,040	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**-7,409**	**-3,385**	**-6,427**	**-3,042**	**-9,324**	**-1,915**

Contract Performance

Month 6 - The Period 1st April 2015 to 30th September 2015

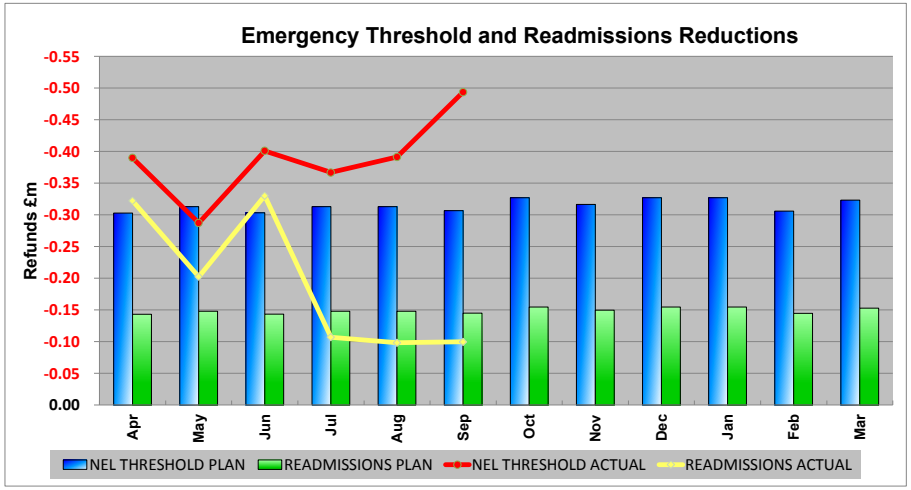
York Teaching Hospital NHS
NHS Foundation Trust

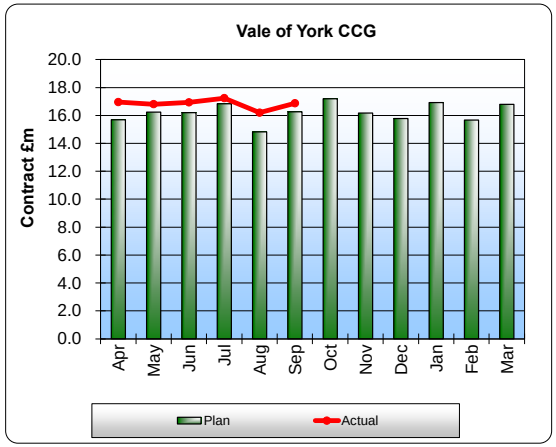
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	194,548	96,031	100,815	4,784
Scarborough & Ryedale CCG	75,075	36,638	39,903	3,265
East Riding CCG	37,600	18,145	20,203	2,058
Other Contracted CCGs	23,761	11,666	11,941	275
NHSE - Specialised Commissioning	35,241	17,621	17,231	-390
NHSE - Public Health	14,465	7,696	7,527	-169
Local Authorities	7,706	3,455	2,693	-762
Total NHS Contract Clinical Income	**388,396**	**191,252**	**200,313**	**9,061**

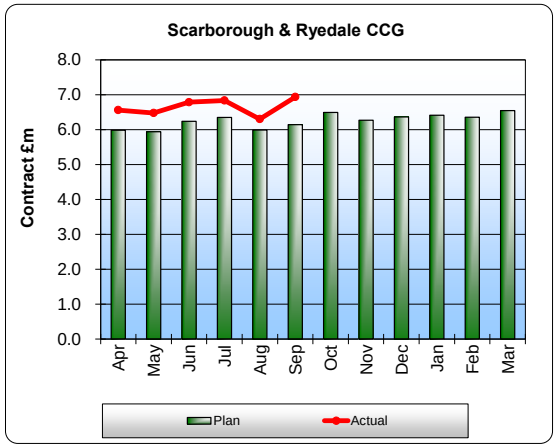
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	9,898	4,131	5,446	1,315
Risk Income	11,367	8,749	763	-7,986
Total Other NHS Clinical Income	**21,265**	**12,880**	**6,209**	**-6,671**

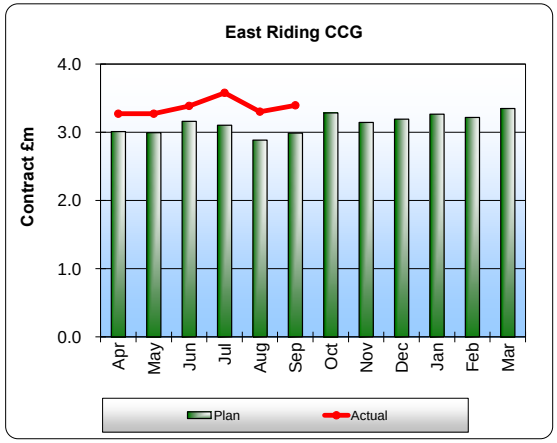
Total NHS Clinical Income	**409,661**	**204,132**	**206,522**	**2,390**

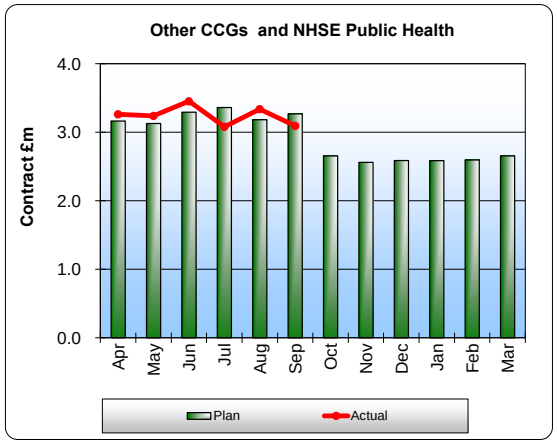
Specialist registrar income moved to other income non clinical	-578
Winter resilience monies in addition to contract	611
Agrees to Clincial Income reported to board	**206,555**

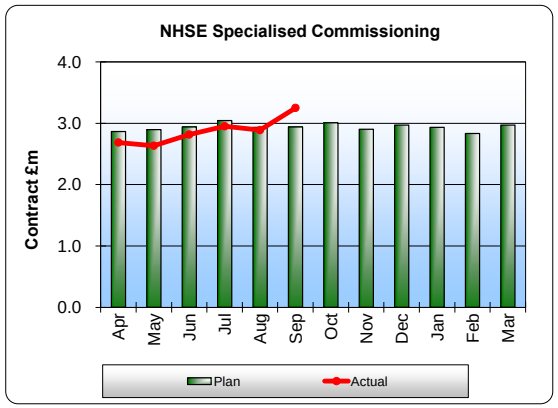


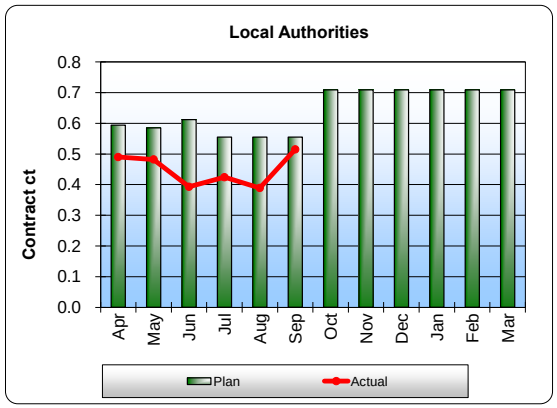












Expenditure Analysis
Month 6 - The Period 1st April 2015 to 30th September 2015

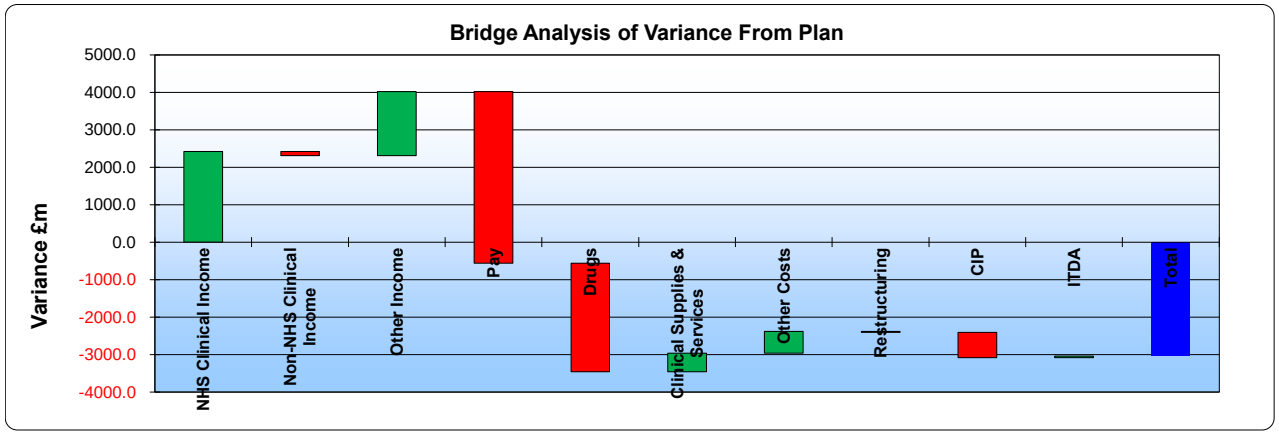
York Teaching Hospital NHS
NHS Foundation Trust

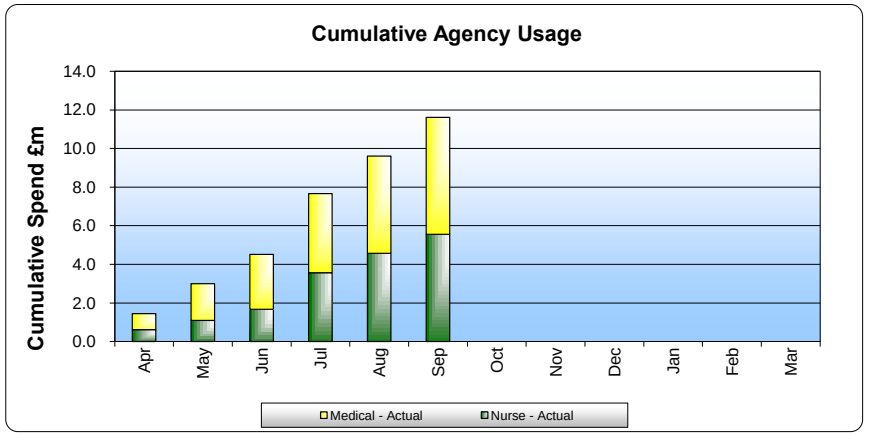
Key Messages:

There is an adverse expenditure variance of £7.1m at the end of September 2015. This comprises:

* Pay budgets are £4.6m adverse, linked to continued high locum and agency costs.
* Drugs budgets are £2.9m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £0.7m behind plan.
* Other budgets are £1.1m favourable.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	54,529	27,018	23,830	0	916	0	2,844	27,590	-572	-533	
Medical & Dental	29,176	14,391	12,985	0	102	0	3,213	16,300	-1,909	-1,498	
Nursing, Midwifery & Health Visting	94,548	47,159	40,601	257	168	1,591	5,553	48,170	-1,011	-928	
Professional & Technical	9,657	4,757	3,938	62	81	0	330	4,410	347	204	
Scientific & Professional	17,225	8,529	7,748	49	19	0	147	7,963	566	548	
P.A.M.s	22,361	11,225	9,836	26	150	0	225	10,238	988	925	
Healthcare Assistants & Other Support Staff	43,960	21,951	21,480	333	66	19	85	21,982	-31	95	
Chairman and Non-Executives	161	80	81	0	0	0	0	81	0	0	
Executive Board and Senior Managers	14,590	7,294	6,672	3	0	0	27	6,703	592	510	
Administrative & Clerical	34,195	16,959	16,007	104	83	0	171	16,365	594	465	
Agency Premium Provision	4,000	2,000	0	0	0	0	0	0	2,000	1,667	
Vacancy Factor	-9,040	-6,144	0	0	0	0	0	0	-6,144	-5,214	
TOTAL	**315,361**	**155,220**	**143,177**	**835**	**1,584**	**1,610**	**12,595**	**159,801**	**-4,581**	**-3,760**	



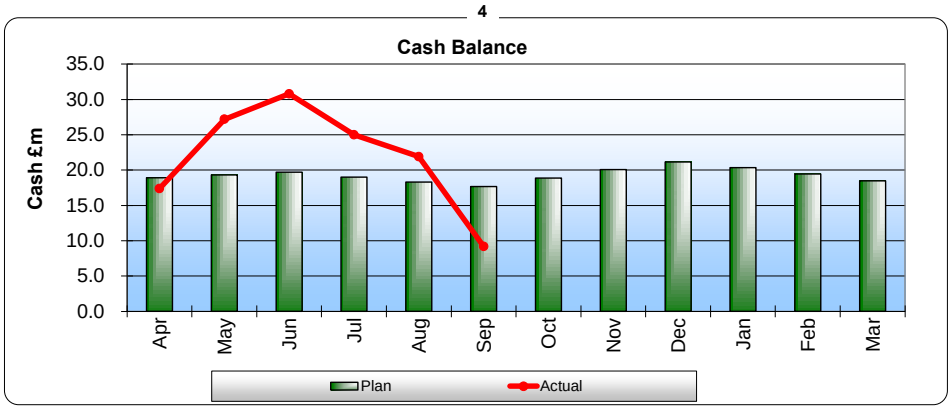


Cash Flow Management
Month 6 - The Period 1st April 2015 to 30th September 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The cash position at the end of September was £9.18m. This is below plan in part due to NHS England not paying the September block payment of £4m, and due to the underlying I&E position.
* The receivables balance at the end of September was £14.66m which is above plan due to the delayed block payment above.
* The payables balance at the end of September was £6.6m which is slightly below plan due to paying more invoices due to increased expenditure levels.
* The Continuity of Service Risk Rating (CoSSR) has now been replaced by the Financial Sustainability Risk Rating (FSRR), which is assessed as a score of 2 in September, and is reflective of the I&E position.

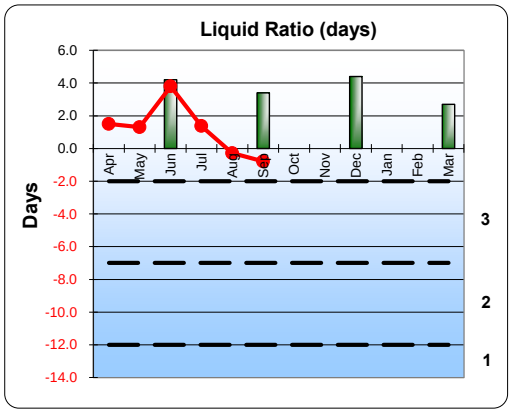


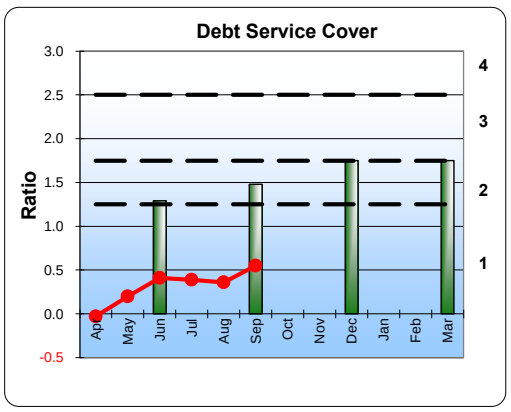
	Under 3 mths £m	3-6 mths £m	6-12 mths £m	12 mths + £m	Total £m
Payables	5.01	0.98	0.40	0.21	6.60
Receivables	11.48	1.99	0.55	0.64	14.66

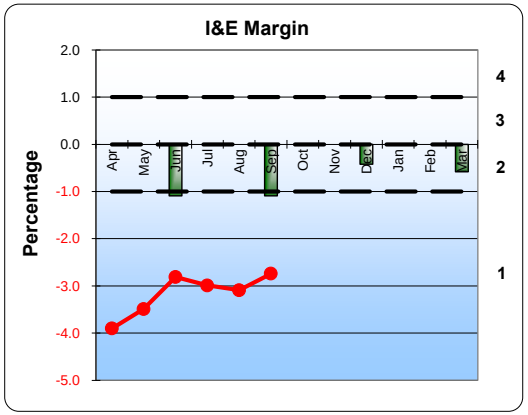
Significant Aged Debtors (+6mths)

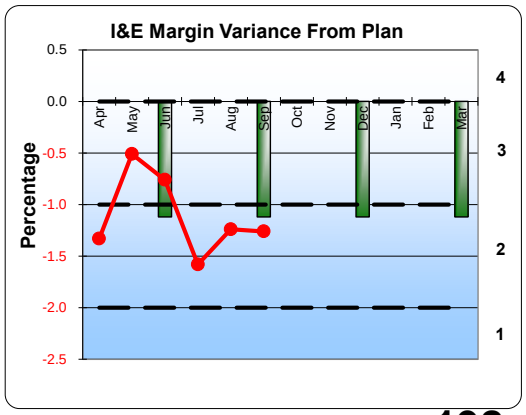
Harrogate and District NHS FT	**£584K**
Selby District Council	**£62K**
Leeds Teaching Hospital	**£62K**

FSRR Area of Review	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (25%)	4	4	4	3
Capital Service (25%)	2	1	1	2
I&E Margin (25%)	2	1	1	2
I&E Margin Variance From Plan (25%)	2	2	2	3
Overall Financial Sustainability Risk Rating	3	2	2	3









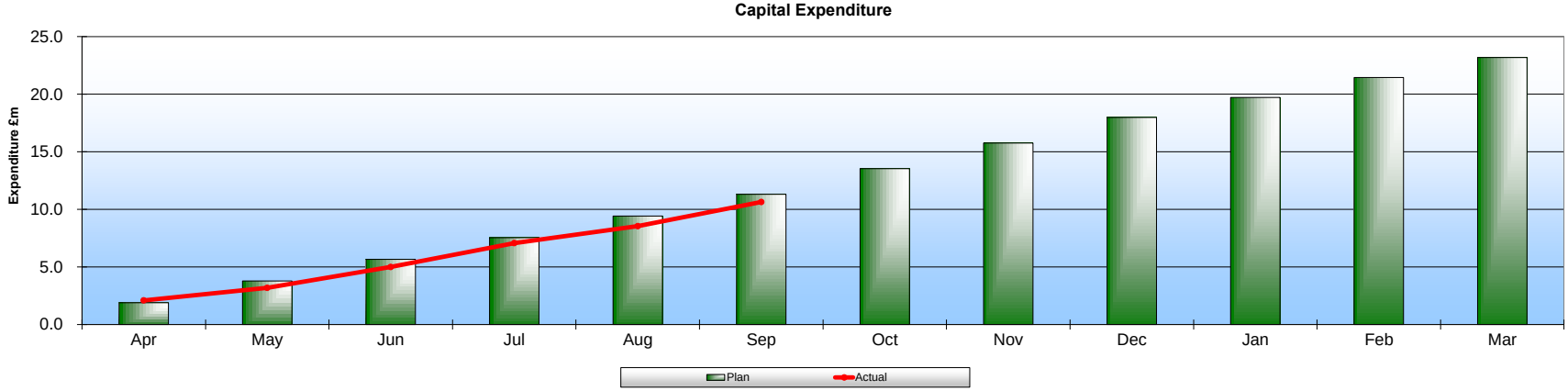
Capital Programme

Month 6 - The Period 1st April 2015 to 30th September 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The Capital Programme for September is running in line with plan.
* Strategic funding has been allocated to existing projects including the Scarbrough Fire Alarm and Lift replacement schemes.
* The Scarborough and Bridlington Carbon Energy Scheme has the largest projected in year spend at £5.087m
* The overall plan has reduced by £1.9m due to part of the Radiology equipment replacement plan moving into next year, therefore the loan funding has moved with it.



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
CT Scanner replacement- York (Owned)	2,015	866	1,714	301	
Fire Alarm System SGH	440	112	440	0	
York ED Phase 2	1,264	157	1,114	150	
SGH/ Brid Carbon & Energy Project	5,087	3,738	5,087	0	
Radiology Equipment Upgrade	3,085	-	1,080	2,005	£1.876m funded by loan and remainder funded through depreciation
IT Wireless Upgrade - Trustwide	1,400	302	1,400	0	
Other Capital Schemes	3,655	2,270	3,735	-80	
SGH Estates Backlog Maintenance	1,000	443	1,000	0	
York Estates Backlog Maintenance - York	1,000	755	1,000	0	
Medical Equipment	650	375	650	0	
IT Capital Programme	1,500	551	1,500	0	
Capital Programme Management	1,150	836	1,250	-100	
Radiology Lift Replacement SGH	440	12	440	0	
York Endoscopy Phase 2	-	101	270	-270	
Urology Facilities Malton	-	123	500	-500	
Contingency	500	-	130	370	
TOTAL CAPITAL PROGRAMME	**23,186**	**10,641**	**21,310**	**1,876**	

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£	£	£	£	
Depreciation	9,614	5,057	9,614	-	
Loan Funding b/fwd	1,386	866	1,386	-	
Loan Funding	9,577	3,738	7,701	1,876	
Charitable Funding	739	185	739	-	
Strategic Capital Funding	1,870	795	1,870	-	
TOTAL FUNDING	**23,186**	**10,641**	**21,310**	**1,876**	

Efficiency Programme

Month 6 - The Period 1st April 2015 to 30th September 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Delivery - £16.6m has been delivered against the Trust annual target of £25.8m, giving a shortfall of (£9.2m).
* Part year Monitor variance - The part year Monitor variance has a shortfall of (£0.7m).
* In year planning - The in year planning surplus is currently £0.5m.
* Four year planning - The four year planning gap is (£16.9m). This has improved by £4.5m in month as work continues to develop plans.
* Recurrent delivery - Recurrent delivery is £7.6m, which is 30% of the 2015/16 CIP target.

Executive Summary - September 2015

	Total £m
TARGET	
In year target	25.8
DELIVERY	
In year delivery	16.6
In year delivery (shortfall)/Surplus	-9.2
Part year delivery (shortfall)/surplus - monitor variance	-0.7
PLANNING	
In year planning surplus/(gap)	0.5
FINANCIAL RISK SCORE	
Overall trust financial risk score	(2 - RED/AMBER)

4 Year Efficiency Plan - September 2015

Year	2015/16	2016/17	2017/18	2018/19	**Total**
	£m	£m	£m	£m	**£m**
Base Target	25.8	15.3	15.2	15.2	**71.4**
Plans	26.2	16.4	7.1	4.8	**54.5**
Variance	0.5	1.1	-8.1	-10.4	**-16.9**
%	**102%**	**107%**	**47%**	**32%**	**76%**

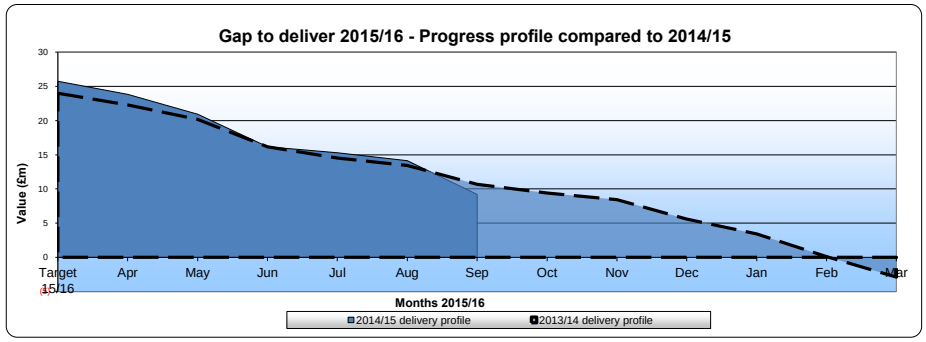
Risk Ratings

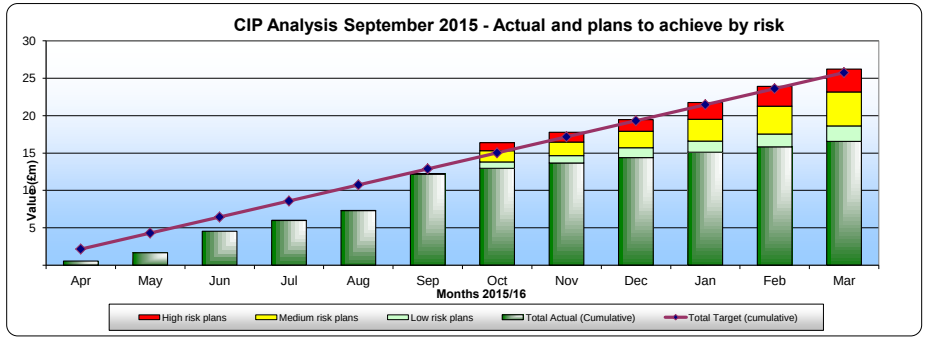
Financial

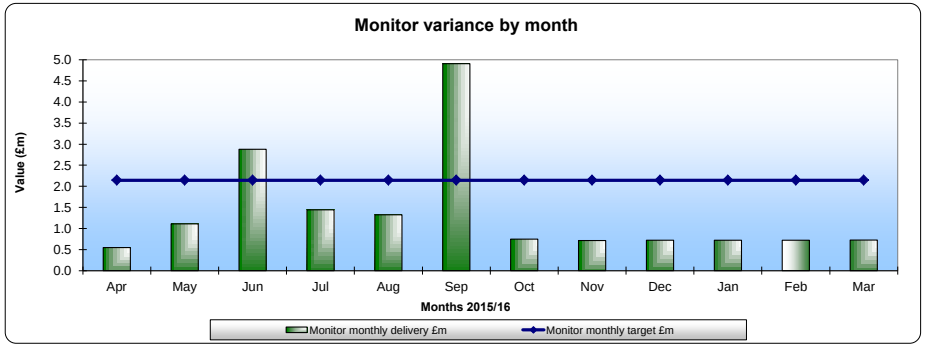
Score	August	September	Trend
1	15	14	↓
2	5	3	↓
3	1	3	↑
4	4	5	↑
5	1	1	→

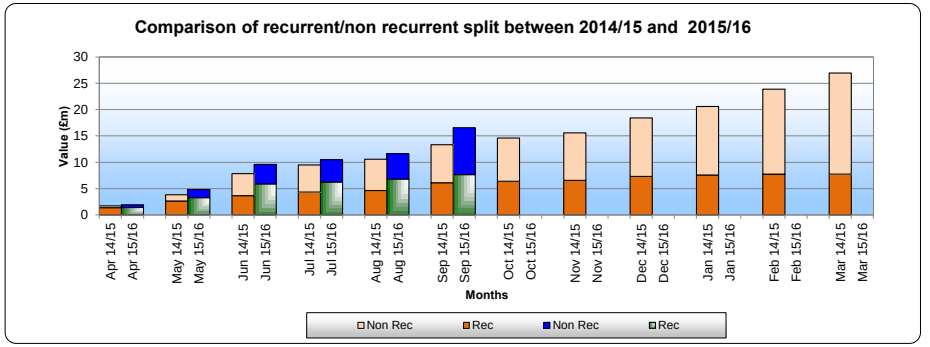
Governance

Score	August	September	Trend
Red	0	0	↑
Green	26	26	↑









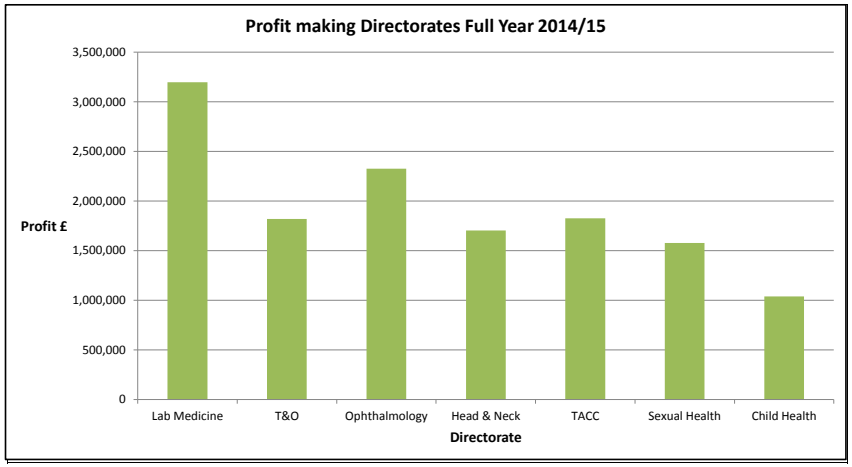
Service Line Reporting

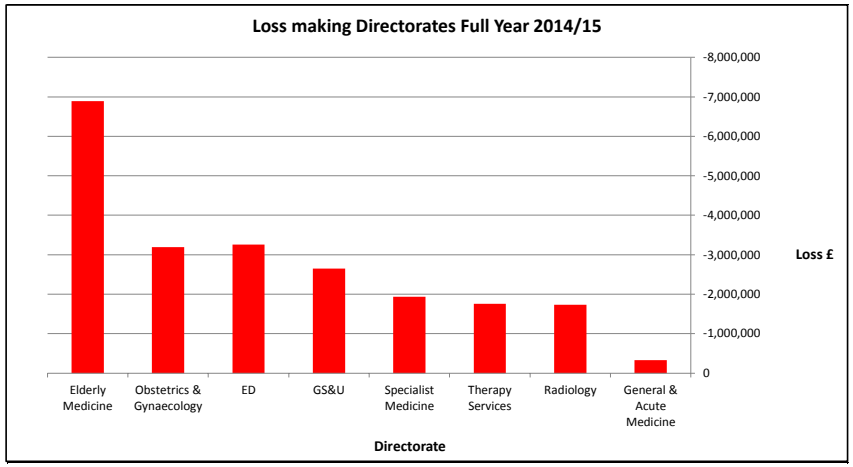
Month 6 - The Period 1st April 2015 to 30th September 2015

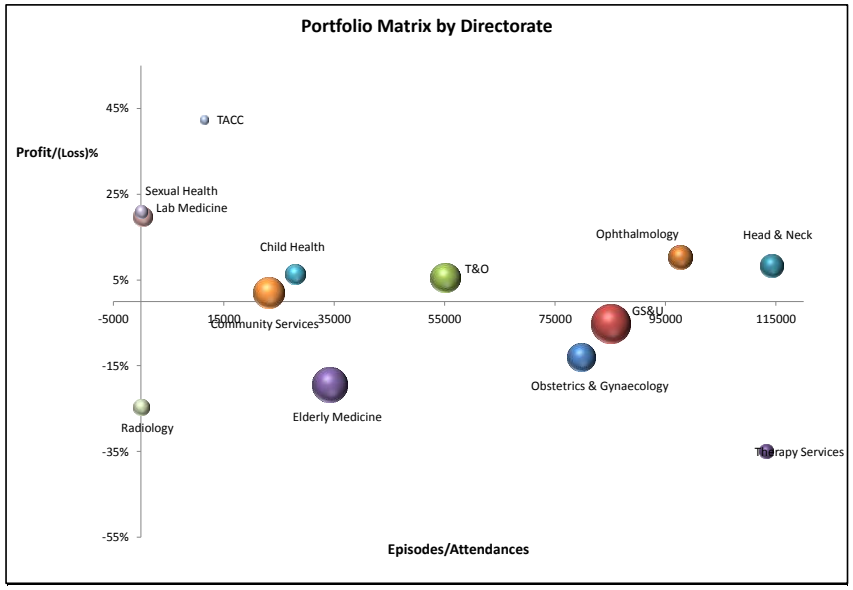
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Current data is based on full year 2014/15
* It is expected Q1 2015/16 will be completed towards the end of November 2015
* Directorate teams are being asked to confirm that the correct consultant job plan allocations are used within the SLR system
* Deep dive work has started within a number of Directorates
* 2 staff have been appointed to the team - start dates are September 2015 and January 2016







DATA PERIOD	FULL YEAR 2014/15
CURRENT WORK	* Q1 2015/16 SLR data is now the key focus following the publication of Q4 2014/15 data. Q1 is expected to be completed towards the end of November 2015 * A detailed deep dive piece of work is currently in progress for Women's Health with the aim of identifying what the true underlying financial position of the service is and to improve the quality of the data presentation in Qlikview * Deep dive work for Child Health, Elderly Medicine, General & Acute Medicine and TACC is also underway to agree the income and expenditure allocation methods * Work with Directorate teams is currently on-going to improve the quality of consultant job plan allocations used within the SLR system for each quarterly reporting period
FUTURE WORK	* Q2 2015/16 SLR data will be the priority following the completion of Q1 * The SLR team are continuing to work with Directorate teams to improve the quality of outpatient staffing group costs within SLR * Deep dive work with Emergency Medicine and Trauma & Orthopaedics will commence in the near future to agree allocation methods * Future work around junior doctor job plans will become a key focus to improve the quality of the SLR data and also to inform the annual mandatory Education and Training Cost Collection exercise

BENEFITS TAKEN SINCE SYSTEM INTRODUCTION	**£2.6m**

Executive Pack

September 2015

York Teaching Hospital NHS
NHS Foundation Trust

Executive Summary	Inpatient Elective				Inpatient Non-Elective				Inpatient Day Case				Outpatient (1st Att)				Outpatient (Sub Att)				Non Face-To-Face				Outpatient Procedures			
Specialty	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var
Accident And Emergency	0	0	0	0	2910	1426	1695	269	0	0	5	5	945	465	160	-305	818	402	70	-332	0	0	0	0	0	0	0	0
Acute Medicine	0	0	3	3	219	107	525	418	92	45	110	65	774	381	589	208	1004	494	529	35	94	46	14	-32	0	0	0	0
Anaesthetics	54	27	23	-4	17	8	14	6	1750	861	909	48	1650	812	984	172	2466	1213	1468	255	0	0	0	0	24	12	60	48
Cardiology	670	330	147	-183	2841	1392	1186	-206	1098	540	625	85	12125	5966	6885	919	19537	9612	7848	-1764	155	76	168	92	5627	2768	2519	-249
Chemical Pathology	0	0	0	0	0	0	0	0	54	27	32	5	50	25	65	40	82	40	125	85	0	0	0	0	0	0	0	0
Clinical Neuro-Physiology	0	0	0	0	0	0	0	0	0	0	0	0	1254	617	621	4	70	34	50	16	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	8	4	4	0	365	180	47	-133	7292	3588	2729	-859	16299	8019	7360	-659	424	209	23	-186	15441	7597	10138	2541
Ear, Nose And Throat	748	368	380	12	998	489	501	12	952	468	631	163	7810	3843	3910	67	8307	4087	4867	780	12	6	9	3	8987	4422	4425	3
Endocrinology	8	4	2	-2	3698	1812	1358	-454	482	237	269	32	2203	1084	1071	-13	7137	3511	3739	228	506	249	18	-231	0	0	1	1
Gastroenterology	229	113	118	5	4581	2245	2765	520	9602	4724	4462	-262	6261	3080	2378	-702	11532	5674	4191	-1483	1026	505	546	41	60	30	33	3
General Medicine	5	2	4	2	434	213	338	125	2867	1411	1322	-89	92	45	40	-5	133	65	11	-54	18	9	6	-3	79	39	18	-21
General Surgery	2880	1417	1353	-64	7253	3554	3541	-13	10460	5146	5141	-5	15012	7386	7559	173	22695	11166	10018	-1148	794	391	390	-1	3999	1968	1579	-389
Genito-Urinary Medicine	0	0	0	0	0	0	0	0	0	0	0	0	25550	10942	7896	-3046	11980	5125	4310	-815	0	0	0	0	0	0	0	0
Geriatric Medicine	6	3	9	6	9421	4617	5238	621	172	85	88	3	3844	1891	2031	140	3851	1895	1795	-100	941	463	115	-348	46	23	31	8
Gynaecology	822	404	449	45	980	480	583	103	1474	725	751	26	7670	3774	3639	-135	5650	2780	3027	247	0	0	1	1	4761	2342	2148	-194
Haematology (Clinical)	42	21	18	-3	156	76	104	28	3672	1807	2018	211	1898	934	918	-16	12610	6204	6463	259	668	329	284	-45	126	62	19	-43
Maxillofacial Surgery	352	173	156	-17	378	185	214	29	1951	960	1200	240	7009	3448	3439	-9	8372	4119	4171	52	0	0	0	0	1846	908	1276	368
Medical Oncology	58	29	21	-8	148	73	70	-3	6952	3420	3932	512	4186	2060	2132	72	22970	11301	12333	1032	25582	12586	9907	-2679	90	44	58	14
Nephrology	72	35	54	19	1606	787	533	-254	784	386	407	21	791	389	362	-27	8311	4089	3483	-606	3714	1827	1831	4	0	0	0	0
Neurology	14	7	3	-4	132	65	89	24	746	367	435	68	3286	1617	1520	-97	6115	3009	2680	-329	910	448	408	-40	56	28	0	-28
Obstetrics & Midwifery	24	12	25	13	5338	2616	2916	300	0	0	0	0	46	23	21	-2	1166	574	633	59	0	0	0	0	168	83	54	-29
Ophthalmology	251	123	135	12	86	42	30	-12	5385	2649	3011	362	16145	7943	7528	-415	57783	28429	25143	-3286	0	0	0	0	12929	6361	5429	-932
Orthodontics	0	0	0	0	0	0	0	0	0	0	0	0	1491	734	615	-119	1886	928	877	-51	0	0	0	0	9636	4741	4269	-472
Paediatrics	65	32	29	-3	7156	3507	3606	99	214	105	150	45	5217	2566	2501	-65	10180	5001	4843	-158	424	209	168	-41	670	330	297	-33
Palliative Medicine	0	0	0	0	0	0	0	0	0	0	0	0	1048	516	320	-196	3938	1937	1428	-509	418	206	140	-66	0	0	0	0
Plastic Surgery	34	17	16	-1	8	4	3	-1	338	166	230	64	407	200	301	101	512	252	296	44	0	0	0	0	29	14	5	-9
Restorative Dentistry	0	0	0	0	0	0	0	0	0	0	0	0	629	309	386	77	441	217	181	-36	0	0	0	0	1619	797	609	-188
Rheumatology	6	3	1	-2	14	7	3	-4	2160	1063	1146	83	2732	1344	1276	-68	13097	6444	7041	597	1254	617	752	135	0	0	0	0
Thoracic Medicine	86	42	27	-15	3611	1770	1829	59	498	245	248	3	3859	1899	1573	-326	10544	5188	4640	-548	134	66	44	-22	296	146	107	-39
Trauma And Orthopaedic Surgery	1824	897	1010	113	3258	1597	1698	101	2283	1123	1234	111	18700	9200	9527	327	27248	13406	14227	821	0	0	0	0	1460	718	656	-62
Urology	1566	770	822	52	1598	783	817	34	5844	2875	4647	1772	2662	1310	2572	1262	4243	2088	4634	2546	14	7	25	18	3788	1864	147	-1717
Obstetrics & Midwifery Zero Tariff	0	0	0	0	6332	3103	3347	244	0	0	0	0	8090	3980	4445	465	35308	17372	13515	-3857	0	0	0	0	9460	4654	5059	405
Gynaecology Zero Tariff	4	2	0	-2	362	177	176	-1	2	1	1	0	4	2	1	-1	42	21	19	-2	0	0	0	0	20	10	10	0
Total	**9820**	**4831**	**4805**	**-26**	**63543**	**31140**	**33183**	**2043**	**60197**	**29617**	**33051**	**3434**	**170732**	**82371**	**79994**	**-2377**	**336327**	**164697**	**156015**	**-8682**	**37088**	**18247**	**14849**	**-3398**	**81217**	**39959**	**38947**	**-1012**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Efficiency Programme Update – September 2015

Action requested/recommendation

The Board is asked to note the September 2015 position.

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2015/16 target is £25.8m and year to date delivery, as at September 2015, is £16.6m.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report Finance & Performance Committee.

Risk	The Efficiency Programme presents a significant financial risk to the organisation.
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Andrew Bertram, Director of Finance
Author	Steve Kitching, Head of Corporate Finance & Resource Management
Date of paper	October 2015
Version number	Version 1

Briefing note for the Board of Directors Meeting 28th October 2015

Subject: September 2015 - Efficiency Position
From: Steven Kitching, Head of Corporate Finance & Resource Management

Summary reported position for September 2015

Current position – highlights

Delivery - Overall delivery is £16.6m in September 2015 which is (64%) of the £25.8m annual target; there has been a £5.0m improvement in the position in month. This position compares to a delivery position of £13.3m (55%) in September 2014.

The month 6 part year adverse variance is (£0.7m) which has improved by £2.7m in the month. This position is ahead of the 2014/15 position which was (£2.4m) adverse.

The relative Directorate positions are shown in Appendix 1 & 2 attached.

In year planning – There is an in-year planning surplus of £0.5m at September 2015, this has improved in the month and is ahead of the 2014/15 position by £2.2m. Work is continuing with Directorate teams to develop low risk plans.

Four year planning – The four year planning gap is (£16.9m), this position has improved in the month by £4.5m. The comparative position in September 2014 was a gap of (£20.3m). We have a strong planning position for years 1&2 of the plan with £42.6m (104%) worth of plans identified against a target of £41.1m.

Recurrent vs. Non recurrent – Of the £16.6m delivery, £7.6m (46%) has been delivered recurrently, in September 2015. Recurrent delivery is £1.5m ahead of the same position in September 2014, which remains encouraging at this stage. The work continues to identify recurrent schemes.

Quality Impact Assessments (QIA) – All schemes have been sent out to Directorate teams to self assess for their safety impact and all have now been completed. It should be noted that 22 schemes, of the total 909 schemes, were self-assessed as extreme or high risk, following the review process with Helen Hey, Deputy Chief Nurse, 5 of these schemes have been reduced to below high risk. Clinical review continues. Mr Khafagy, Consultant Urologist, has also agreed to provide a medical overview of the process.

Overview

The delivery position remains positive with delivery ahead of last year by £3.3m, at £16.6m. There is now a surplus of in year plans of £0.5m, however it should be noted high risk plans (£3m) remain in this position, and these will be removed from the position at the beginning of Q3. The 4 year planning position has improved in month by £4.5m. We currently have plans for 104% of the combined year 1&2 target.

This would indicate a stable planning position at this stage in the year.

Recurrent delivery remains relatively strong, with the percentage recurrent delivery at 46% of overall delivery which is positive, this percentage has declined in the month and work is on-going to identify recurrent savings.

All Directorates have self assessed their schemes as part of the QIA self-assessment process, and clinical reviews are well underway.

Efficiency panels meetings have started with Directorate teams and 4 have been completed at the time of this report. The panels are focusing on in year planning and delivery gaps.

Risks

Given the positive start in the first 6 months, there remain key risks in the programme.

- Although planning is ahead of plan by £0.5m, there remains high risk plans in the system of £3m, which will be removed at the start of Q3; there is a 4 year planning gap of (£16.9m).

- The % of recurrent delivery has fallen and this remains a key focus.

- There are 17 schemes which have been rated as extreme or high risk following the self-assessment process; however the senior nursing review continues.

DIRECTORATE	FINANCE						GOVERNANCE	
	R	RA	A	AG	G	Trend	R	G
WOMENS HEALTH	1	2	3	4	5	→		
TACC	1	2	3	4	5	→		
COMMUNITY	1	2	3	4	5	→		
HEAD AND NECK	1	2	3	4	5	→		
SPECIALIST MEDICINE	1	2	3	4	5	→		
OPHTHALMOLOGY	1	2	3	4	5	→		
GEN MED SCARBOROUGH	1	2	3	4	5	→		
RADIOLOGY	1	2	3	4	5	→		
GS&U	1	2	3	4	5	→		
SEXUAL HEALTH	1	2	3	4	5	→		
MEDICINE FOR THE ELDERLY	1	2	3	4	5	→		
EMERGENCY MEDICINE	1	2	3	4	5	→		
CHILD HEALTH	1	2	3	4	5	→		
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1	2	3	4	5	↑		
GEN MED YORK	1	2	3	4	5	→		
LAB MED	1	2	3	4	5	↑		
ORTHOPAEDICS	1	2	3	4	5	→		
PHARMACY	1	2	3	4	5	→		
CORPORATE								
OPS MANAGEMENT YORK	1	2	3	4	5	→		
CHIEF NURSE TEAM DIRECTORATE	1	2	3	4	5	→		
SNS	1	2	3	4	5	→		
WORKFORCE AND ORGANISATIONAL DEVELOPMENT	1	2	3	4	5	↑		
ESTATES AND FACILITIES	1	2	3	4	5	↑		
MEDICAL GOVERNANCE	1	2	3	4	5	↑		
FINANCE	1	2	3	4	5	→		
CHAIRMAN & CHIEF EXECUTIVES OFFICE	1	2	3	4	5	→		
TRUST SCORE	1	2	3	4	5	↑		

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York Teaching Hospital NHS
NHS Foundation Trust

Operational Performance Recovery Plan

Monthly Status Summary

This monthly summary provides a highlight report detailing progress against the trajectories set out in the April 2015 'Operational Performance Recovery Plan'. It clearly identifies if the Trust is on or off trajectory and provides narrative reasons for this.

The report gives a timely update and is therefore reliant on soft operational intelligence as well as data. Some assumptions have to be made in the development of this report.

It should be noted that any data provided in this report is not validated and could be subject to change.

Produced by: Senior Operations Team

Operational Performance Recovery Plan

Monthly Status Summary: September 2015

ED

Trajectory: Sept 15

- **Performance**: **Off trajectory:** 4hr Perf (all types): 89.62%.
- **Achievements**: Minor Injuries moved to UCC in SGH on 28th September. Work is progressing on the York site to develop a primary care 'front door' model in collaboration with the CCG. ECIST reports rec'd for both sites, actions are linked to the ED Recovery Plan. SGH beds have been available this month, target missed due to other elements of patient flow. Ambulatory Care BCs agreed for both sites; Frailty clinical model agreed, BC to be developed. NHS Elect to visit re. Frailty model on 22/10/15.
- **Risks**: Performance deteriorated from 91.81% in Aug to 89.62% in Sept. There were a total of 1,693 breaches across the Trust; an increase of 241 against August. Of the Type 1 breaches, 56.6% were admitted. York site continues to have siginifcant bed pressures. Comparing September 2015 to September 2014; non elective admissions in York increased by 312 (13.2%) and in Scarborough by 77 (6.7%); Trust overall admissions have increased by 380 (10.8%) for the period.

18 weeks admitted

Trajectory:

Dec 15

- **Performance**: **Off trajectory.**
- **Achievements**: currently projected that the following specialties will achieve in line with Dec trajectory; General Surgery; Gynaecology; Urology; & ENT. T&O have already achieved. Overall trajectory moved forward 5 weeks since last month to early Feb 16. MF backlog reduced by 40%.
- **Risks**: Changes in Opthal plans have a significant impact on overall trust delivery; directorate now projected to achieve sustainable delivery in Feb16. CESP will deliver up to 75 cases on the York site prior to end Dec 15. Currently exploring further avenues of additional capacity for MF. Theatre staffing at York site remains challenging through October and it is likely routine lists will have to be cancelled.

Cancer

(Monitored Quarterly)

Trajectory:

Q1 FT/62 day

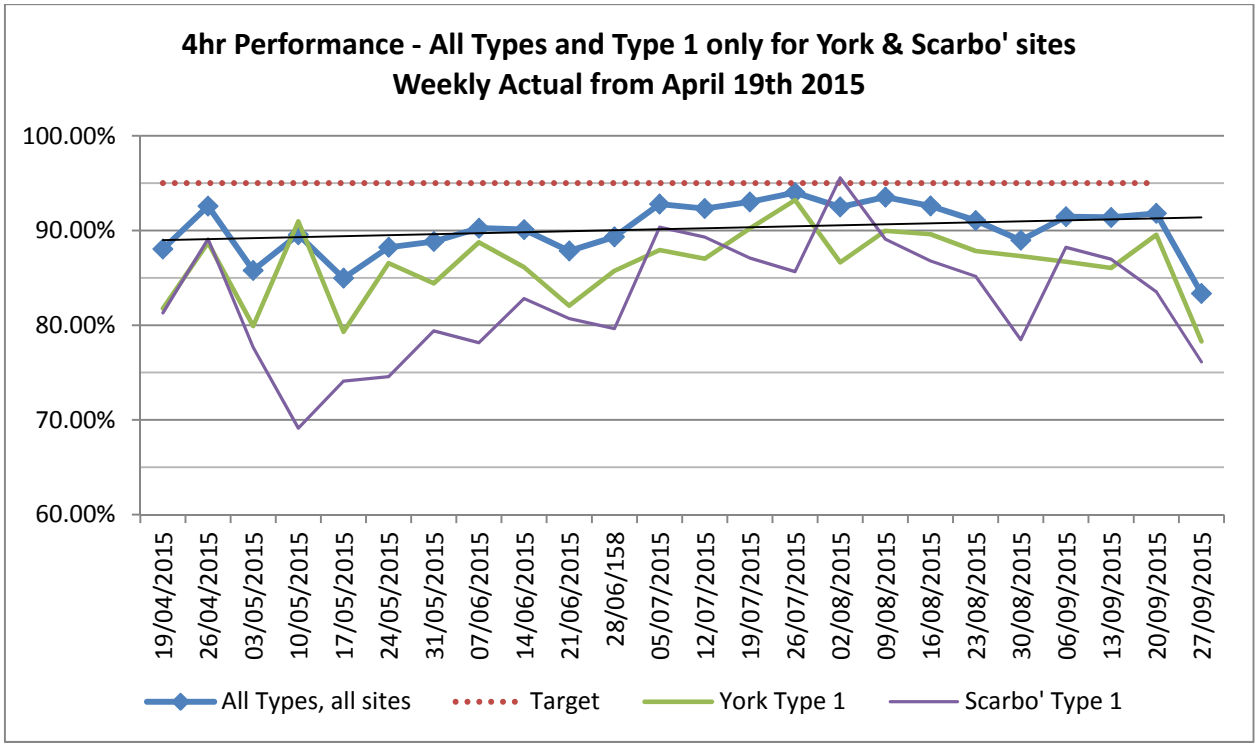
Q2 Breast Sy

- **Performance**: Current postion for the Quarter is UNVALIDATEFD
- **Off trajectory (FT)** Q2: FT: 91.64%; BS **95.24**%; 62: **83.41%**.
- **Achievements**: Achieved BS target QTD. Holding one CT slot per day on York site to minimise delays in lung pathway is working well. Undertaken breach root cause analysis meeting with LTH to explore problem pathways.
- **Risks**: Dermatology has experienced capacity shortfalls due to staff sickness, a new locum has now started in post. Increased patient choice breaches of TWW in Aug and Sept across all sites; September analysis is underway, approx 67% of pts who breaches chose to wait >14days. There are risks concerning 62 day treatments undertaken at tertiary centres that have yet to be uploaded.

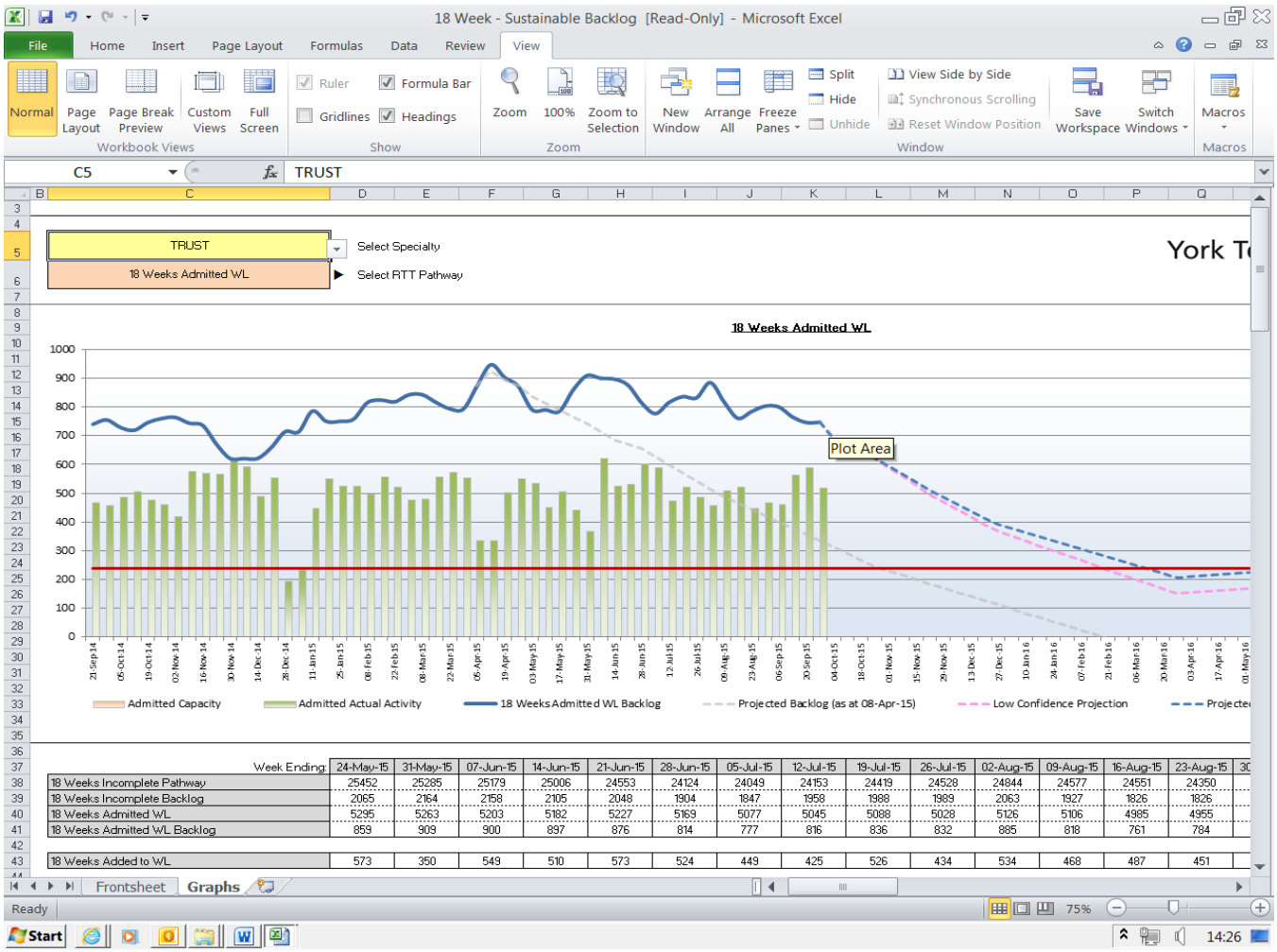
Diagnostics

Trajectory: Oct 15

- **Performance**: **On Trajectory**: Radiology achieved 99% target Sep 15.
- **Achievements**: Trust achieved performance against this target on aggregate for first time since Nov 14. Reduced endoscopy and cystoscopy breaches due to additional capacity. Cover for Echo in Scarbo' for Oct is now agreed and should minimise breaches.
- **Risks**: Cystoscopy breaches still occurring despite additional capacity. NHS Elect event held this week and the department will be implementing the learning from this event in the coming weeks.



18 Week Admitted Backlog Trajectory



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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Internal Trust Winter Resilience Plan 2015/16

Action requested/recommendation

The Board are asked:

- To note the changes and increases in service provision across the Trust
- To note planned changes to the ward allocations at both sites
- To note planned changes to elective service provision over the Winter
- To be aware of the services that will be available outside the Trust over Winter
- To support the next steps as detailed on the final page

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Winter Planning Group, Operational Steering Group, Executive Board

Risk	Winter poses significant operational, clinical and financial risks to the organisation. This paper sets out the Trust's internal response to manage that risk.
Resource implications	Resources implication detailed in the report.
Owner	Juliet Walters, Chief Operating Officer
Author	Mark Hindmarsh, Head of Operational Strategy
Date of paper	October 2015
Version number	Version 1

York Teaching Hospital NHS Foundation Trust

Internal Trust Winter Resilience Plan 2015/16

October 2015

Contents

Introduction

This paper sets out the Trust's internal plans to continue to run an effective service over the coming Winter for both acute and non-acute patients. Following the declaration of a major incident at Scarborough last January, as well as continued pressure and high levels of demand across all sites, this paper sets out how internally we will respond to these challenges.

This plan is not intended to address regional issues (e.g. flu vaccination programmes) or replace regional Winter plans, which are led and coordinated through the local System Resilience Group (SRG), led by the local CCGs. The Trust's plan focuses on what we can do internally to address winter pressures and compliments the other on-going work and service developments within the community.

The paper is split into three sections, one for York Hospital and one for Scarborough Hospital and one looking at Trustwide arrangements. The site specific sections are organised into four sub-headings:

- Acute service provision
- Changes to the wards
- Elective service provision
- Service provision outside the hospital

The development of this plan

Two staff open sessions were held in July 2015 on each site, to listen to staff and to provide a forum for them to express their opinions on what happened last Winter, and to hear their ideas as to what could be done better this year.

A detailed write up of these sessions was presented to the Trust Executive Board at the end of July. Some of the key themes included:

- Tighter controls on annual leave, so more staff were in and working on key days
- Qualified, non-patient facing staff working in clinical areas over peak times
- Cancelling or reducing non-urgent elective (including outpatient) work to ensure clinicians were able to concentrate on acute work
- 7 day working for clinical staff – particularly over the bank holiday period
- Escalation wards will be clearly communicated to staff before the busy Winter period begins.
- Some elective surgical wards should be redesignated to medical wards to cohort "outlying" medical patients in these locations.
- There should be a clear plan for elective services so that staff do not have to cancel large numbers of patients on the day of surgery
- There should be more senior management presence on site, especially out of hours
- Incentivising staff either with days in lieu or with supplementary payments for working unsociable shifts

Following these sessions, two Winter Planning Development meetings have taken place, which have included executive input, along with all directorates, nursing, learning and development and human resources departments.

At these meetings it was agreed that directorates should begin planning for Winter immediately, using a standard template and begin discussions with their teams about how they could work differently to address the pressures that Winter brings.

Each directorate has had the opportunity to review each others plans to help ensure that they are aligned. Where gaps or mis-alignments were found teams are working through these presently. The information in this paper is comprised largely of the returns from directorates.

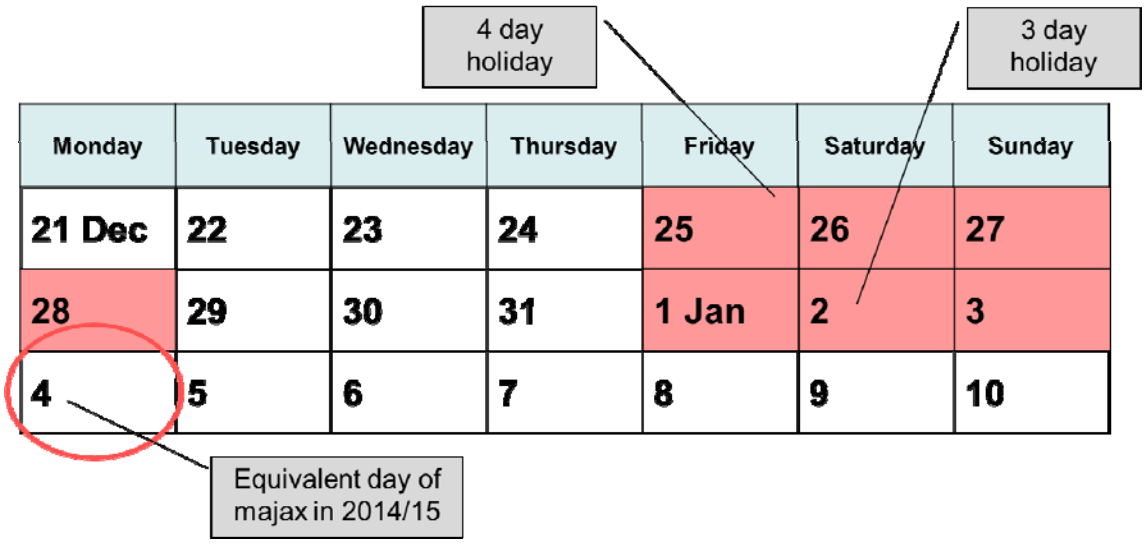
Aims and objectives of this plan

The Winter plan is aimed at ensuring the Trust is able to achieve the following objectives throughout Winter:

- Inpatients who are medically fit and ready for discharge are not delayed in a Trust bed due to the absence of a service run by the Trust.
- The Trust continues to run an effective elective surgical service. This means that:
  - Fewer patients are cancelled at short notice than last year
  - No patients having surgery for cancer or who are deemed urgent or emergency should have their procedure cancelled.
- There is a clearer plan, communicated to staff around the changes to escalation wards. Nursing staff are supported and prepared for these changes.
- The Trust does not need to declare a major incident

Key dates to be aware of

The Board should be clear on key dates over the Winter period this year. There is a four day holiday from the 25th to 28th December and then a further three day holiday from the 1st to the 3rd January. Last year, the Trust declared a major incident on the Monday following this period – this year the corresponding day is the 4th January.



This plan makes explicit reference to this period in particular. However, directorates have completed plans not just for this period, but have planned for the period from mid-December to the end of March 2016.

York and Scarborough Hospital Emergency Departments

Both hospitals already operate a 24/7 emergency service and will continue to do so over the Winter. There will be peaks in demand in both departments over Winter, and it is known that we have gaps in the workforce at times to deal adequately with these peaks. The Emergency Care recovery plan will continue to be worked through to address these and other issues to help support emergency care.

The delivery of this Trustwide Winter plan in its entirety, helping patients flow through the hospitals and ensuring beds are available for ED to admit patients into, will be a huge help to the continued proper functioning of both departments.

Links to other Winter plans

This paper links to but does not describe the other winter related plans that are also in development across the Trust. These include:

- Norovirus plan
- D&V and other ward based infection control plans
- Trust staff flu vaccination programme
- Escalation plan

In addition there is the regional wide escalation plan (REEP), which is being developed by all partners, lead by the local Systems Resilience Group.

YORK HOSPITAL

1. Acute service provision

A set of standards were agreed based on the National "Keogh Standards" for directorates to work against for the purposes of developing their Winter plan. Where these standards weren't directly relevant, directorates were engaged in developing their own set of standards. Below follows a summary of the services directorates propose to run over Weekends and Bank Holidays in Winter.

Acute medicine, general medicine and elderly medicine provision

Consultant review

The aim is to ensure that all patients receive a senior review on a daily basis. The General Internal Medicine (GIM) consultant of the day will be present on the Acute Medical Unit (AMU) every day, ensuring that newly admitted patients will be seen by a consultant following admission within 12 hours. The Elderly consultant on-call will also conduct a post-take ward round on the AMU every day.

The Elderly team will provide an extra consultant on Saturday mornings and on the Bank holiday days over the entire Winter period. They will be focussed on the sickest patients and those patients that can be discharged from the Trust that day. A board round will be undertaken in the afternoon each weekday on the designated short stay ward.

In Cardiology, Renal, Acute Medicine and Gastroenterology funding has been agreed to support a consultant ward round every day (including weekends and bank holiday days), supported by a junior medical team. In diabetes, additional consultant ward rounds will be undertaken on the weekends of the 26th and 27th December and on the 2nd and 3rd January.

All medical specialties have undertaken a review of outpatient clinics to ensure they are fit for Winter. This will do two things:

- ensure that "urgent" slots will be made available for patients to prevent admission or speed discharge
- some clinics will be cancelled, and instead of the clinic the consultant and their team will be ward based for that session to support discharges

On top of this, all specialties will provide an emergency on-call service for medical emergency cases.

Admission avoidance services

Ambulatory Care – this service located on Level 2 (adjacent to AMU) will operate as normal on all weekdays and weekend days, except Christmas Day and New Year's Day. All patients attending the hospital as an emergency will be considered ambulatory until a clinical decision has been made to the contrary.

Rapid Access Therapies Service (RATS) - this service is based in ED and will be available 8am-8pm every day. The RATS service is focuses on frail elderly patients who do not require an admission.

Acute Frailty unit – this service will be operational ready for the Winter. The service will be consultant-led and will work closely with the RATs team. The service will be located on ward 24.

Medical elective procedures
An additional inpatient ERCP endoscopy list has been funded over the long Christmas bank holiday weekend (exact day to be confirmed)

Acute surgical provision

All patients under a surgical specialty will be reviewed daily by a consultant and newly admitted patients will be seen within 12 hours. In addition board rounds will be undertaken daily by a senior doctor. Acute and emergency surgery will be available in the usual way via an on-call system. CEPOD lists and trauma lists will run daily as normal.

Paediatric service provision

The service will run either a consultant on call service over night or a consultant of the week model every day. The consultant will be present on the ward daily to see new admissions and follow up other paediatric inpatients.

York hospital will be working closely with the paediatric team on the Scarborough site in relation to capacity issues to ensure transfers inhouse occur firstly.

Support services provision

Pathology
Haematology – full service, 7-days per week including Bank Holidays
Biochemistry – full service, 7-days per week including Bank Holidays
Microbiology – full service Monday to Friday with an 8.30am-4pm on weekends and Bank Holidays
Histopathology - a full service across will run Monday to Friday with the exception weekends and Bank Holidays.

Radiology
CT, MRI and ultrasound - Monday to Friday service only excluding Bank Holidays. On-call arrangements are in place 24/7 for urgent cases. There is a full service 24/7 for x-ray. Due to some fixed sessions that are already agreed, the on-call Radiographer and Radiology staff will be available at times during weekends in the key areas, such as Ultrasound and CT to support additional requests from inpatient areas. Staff in radiology have been offered a range of shifts on weekend and bank holiday days which can be undertaken in exchange for a day in lieu. The final radiology schedule will be completed once all staff have responded to this request.

There will also be a great emphasis on inpatient scans, with a resulting decrease in outpatient and elective bookings to assist with patient flow at this crucial time.

Therapies
The whole service has cancelled non-urgent clinics and clinics not linked to services that may accrue fines from the 21st December to the 15th January. All staff released will be allocated to inpatient wards and the service will run a prioritisation system which will enable staff to schedule their time appropriately. For the AMU, the plan is to have the ward covered every day, although at time of writing there are still some shifts uncovered pending recruitment and volunteers coming forward for lieu days.

The FREDA (discharge) and stroke teams will be operational every day, except Christmas day. There will be an MSK service on two days out of four on the long weekend, and the respiratory team (including ITU) will have staff in every day.

Pharmacy
An inpatient service supporting admissions and discharges will be available every day on site. On weekend days and Bank Holidays this will be for the six hour period from 10am to 4pm. An on-call service will be available out of hours. In addition, key discharging wards will have their own TTO pharmacy supply that can be accessed at all times.

2. Ward escalation plans

Additional beds will be required on the York site to manage winter pressures. This will include both the opening of extra escalation beds, and the temporary re-allocation of some beds on surgical wards to medical elderly beds. The plan is set out below.

Ward G1 (normally Obstetrics & Gynaecology)

The full 23 beds on the ward will be used to house patients with a Delayed Transfer of Care (DToC). This will help to cohort this group of patients together, improving efficiency and reducing medical "outliers". The medical cover for this ward would be provided in the first instance by a junior doctor and by exception to the consultant team. Cohorting this group of patients together also means the nursing resource for the ward is reduced as this group of patients have fewer acute medical needs. A Standard Operating Policy (SOP) is already in place for how this ward will function and staffing levels have been agreed with corporate nursing.

During this time, the obstetrics, gynaecology and breast surgery services will be re-provided in other locations in the Trust. During December 2015, the plan is:

- Short stay gynaecology and breast surgery – patients to be admitted to ESA post-operatively
- Hyperemesis admissions - In hours patients to be managed on an OP basis through the antenatal day unit (70%). Out of hours patients to be managed on G3 (30%)

In January 2016 the plan is:

- Elective and non-elective gynaecology and breast patients – admitted to ward 15
- Gynaecology ward attenders and early pregnancy – in hours to be seen in gynaecology assessment area. If admission required utilise ward 15.
- Pre-operative clinics and other outpatient clinics – to be provided in the colposcopy suite.

During this time, gynaecology nursing staff will be transferred away from G1 ward onto ward 15 to utilise their skills most effectively.

Ward 24

Ward 24 will be opened as a 20 bedded elderly short stay ward. It will also house the 10 bedded acute frailty unit. The main ward will be staffed and open 7 days a week. The ward will have a specific focus on patients with an EDD of 5 days or less to support their proactive management and early discharge planning.

Ward 29

Due to planned reductions in elective orthopaedic work over this period, approximately 20 beds will be available on this ward. The SOP for accessing them, or where they could be redeployed to, is being worked through at time of writing.

Staffing arrangements

All Winter ward areas have had the nurse staffing establishment signed off and agreed by the corporate nursing teams. Rather than having one or two wards staffed predominantly by agency, some permanent Trust nursing staff will be reallocated and their post on their main ward will need to be backfilled by agency/bank shifts. This may be partially offset by slippage in existing budgets but the estimated cost of this reallocation of staff will be discussed at corporate directors this month.

Between October and the beginning of December, in a phased, planned way, a nursing training needs analysis will be undertaken and training programme delivered to ensure that nurses from a surgical specialities have the competencies and confidence to work in acute medicine /elderly areas.

3. Elective service provision

In order to avoid short-notice cancellations and disruption to elective services, it has been agreed that some specialties will step-down non-urgent procedures and convert some overnight lists to day case lists.

Using Extended Stay Area (ESA) Ward

To house the specialty plans below, it is proposed that ESA is utilised in the following way:

- Beds will be used fully to ensure all day case and overnight surgery cases are located here, with only urgent and cancer cases admitted to the main bed stock.
- The ward is to be open on Friday night and Saturday morning from 1st November - one month earlier than planned.
- Through January to March ESA will be open alternative weekends to allow the elective surgery displaced from the week to take place. This is subject to receiving approval from corporate directors.

Elective surgery plans by specialty

<u>General surgery</u>

Reduce elective work by only operating on cancer patients, clinically urgent patients and those suitable for ESA/day unit during the 6 week period from mid-December to the beginning of February. It is anticipated that this will mean the cancellation of 2 lists per week – 12 theatre sessions in total. These clinical sessions will be converted into endoscopy, outpatient sessions or inpatient ward work were needed.

<u>Trauma and orthopaedics</u>

T&O are proposing a number of changes to their theatre schedules. On a weekly basis at least six main theatre lists will be converted to day case procedures, and at least four lists will be converted from elective work to trauma work. Two to three elective lists per week will be transferred to the Bridlington site and were patients do not want to transfer they will move to the private sector.

<u>ENT, Maxfax and Ophthalmology</u>

Due to the case mix and cancer workload the ENT elective work will need to continue in main theatres, so no changes are planned to their elective schedule. For Maxfax two lists each week will be converted from overnight to non-overnight stay lists to reduce pressure on the main ward base. The majority of ophthalmic surgery is already undertaken as a day case, but between two and three GA lists per week will be converted to LA lists.

Gynaecology
From the period mid-December to Mid-January Gynaecology plan to maintain 14 main theatre lists. Seven lists will be converted from main theatres to the day unit, and there will be an extra four day unit lists run on Saturdays and Sundays over this period to maintain activity lost on bank holiday days.

4. Service provision outside the hospital

Community

Community inpatient bed base
On the weekend and Bank Holiday days across all the community inpatient bed base medical reviews will only be available via the out of hours GP or the hospital urgent on-call system – patients will not be routinely reviewed by a doctor. Discussions are on-going with GPs in Selby and Malton to provide additional cover over weekend and Bank Holiday days.

Community discharge liaison team
The community discharge liaison team work to support discharges from the Trusts community hospital beds. In December the discharge liaison team will only be available on normal week day days and so won't be available on weekends or Bank Holiday days in December. From 4th January the team will pilot a change their working patterns to additionally cover weekend days too.

Single point of access
The single point of access into community services will be available every day over Winter and the community bed base will be staffed to normal nursing levels every day.

Community nursing
Across the teams capacity will be maximised through tight control of annual leave and negotiations with GPs around not undertaking QOF diagnostics over Winter. There is also a range of initiatives to further increase capacity in the team, centred around providing more clinic based care and re-structuring how phlebotomy services operate.

Primary care

The CCG in York have indicated that at the present time there will be no additional GP primary care services available to patients on any of the weekend or Bank Holiday days. This is likely to cause the Trust significant issues. Every patient that wishes to access an appointment in primary care should be able to do so, and should not simply default to the ED or GP out of hours service, as it is unlikely to be able to cope with demand. Discussions with local CCGs are ongoing on this issue.

Social care

The aim is to ensure social care is able to accept and process referrals and support the discharge of patients with complex care needs seven days a week. Discussions are ongoing to ensure these arrangements are fulfilled. There is a need to be specific regarding Bank Holiday provision of care.

Assessments for local authority residential care
In 2013/14 the local authority provided a member of their team to undertake assessments for the residential care home manager for local authority run accommodation in the area. The expectation is that this service should run in 2015/16 and be focussed on ward 24.

Local authority funded care and spot purchasing

The City of York local authority has struggled with providing sufficient capacity in the council run residential care homes and in the provision of home based care for some time. This has led to the so called “spot purchasing” of beds in private residential homes to provide additional capacity for patients waiting for a package of care to commence. These arrangements will need to continue this Winter, and the assessment criteria should be standardised to make the process of referral to these homes simpler and quicker.

Private nursing and residential care

There are a range of private nursing and care homes in the locality, each with their own set of eligibility and referral criteria and assessment arrangements. The Trust will need to clarify what these arrangements are and when assessments can take place to help support discharges.

Discharge to assess

Work is continuing with CYC and NYCC to develop models of discharge to assess. This will allow social care assessments to be undertaken outside of the hospital setting freeing up hospital beds for acutely ill patients.

Mental health

The Chief operating officers from all local providers of social care were written to at the start of July, asking them to engage with us and share plans. The Trust requires that social care is able to accept and process referrals and support discharges of patients with complex care needs seven days a week. We have requested details relation to service provision for the CRISIS service, CAMHs and Liaison Psychiatry.

SCARBOROUGH HOSPITAL

1. Acute service provision

As with York Hospital standards were drafted based on the National "Keogh Standards" for directorates to work against for the purposes of developing their Winter plan. Below follows a summary of the services directorates propose to run over Weekends and Bank Holidays in Winter.

Acute medicine, general medicine and elderly medicine provision

Consultant review

An on-call service will be available for medical emergencies and the General Medical consultant of the day will undertake an evening ward round to see new patients admitted during that day. In addition, funding has been agreed for two additional consultant ward rounds to take place on each day 26th, 28th and 1st January covering all of medicine. These ward rounds will be focussed on sick patients, potential discharges and where possible all other patients.

Funding has also been agreed for more junior medical cover to support the Scarborough site on all the Bank Holiday days and weekend days over the Christmas and New Year period. This will help ensure that the consultant ward rounds are as effective as possible.

In addition to extra focus on acute work on the 24th, 31st December and 4th January, the Gastroenterology service has been funded for additional specialty ward rounds on the 26th, 28th December and 2nd January.

The elderly escalation ward will be staffed by a consultant, with a ward round being undertaken daily, and a board round in the afternoon. There will be an additional middle grade to ensure timely task completion.

The respiratory provision on site remains a serious concern, especially in the week commencing the 4th January, where the plans is to have 0.6WTE consultant available for phone advice and a locum general medical consultant on site only. This has been escalated to the Trust Medical Director.

All specialties are also in the process of reviewing their clinics to identify which clinics can be cancelled to free up consultants for ward rounds. The aim is to ensure that all wards, have daily ward rounds during the week, during this period. Clinics are also being reviewed to identify where the template can be changed so that rapid access slots are provided for so patients to be discharged to come back as an OP.

Admission Avoidance Services

Ambulatory Care – this service located in Dales Unit and will operate as normal on all weekdays, except Christmas Day and New Year's Day. Patients attending the hospital as an emergency should be considered ambulatory until a clinical decision has been made to the contrary.

Rapid Access Therapies Service (RATS) - this service is based in ED and will be available 8am-8pm every day. The RATS service is focuses on frail elderly patients who do not require an admission.

Acute Frailty unit – The service is consultant-led and will work closely with the RATs team. The operating model and opening hours for this service are being agreed at time of writing.

Medical Elective Procedures
An extra ERCP list will run on the 30th December, focussed on acute inpatients.

Acute surgical provision

All patients under a surgical specialty will be reviewed daily by a consultant and newly admitted patients will be seen within 12 hours. In addition board rounds will be undertaken daily by a senior doctor. Acute and emergency surgery will be available in the usual way via an on-call system. CEPOD lists and trauma lists will run daily as normal.

In order for surgery to continue to run effectively and to support ED, the Surgical Assessment Unit (SAU) needs to be protected and should not be used as an escalation area.

Paediatric service provision

The on call consultant will undertake two planned ward rounds daily 9am and 4pm to see all new admissions and follow up all current paediatric inpatients.

Support services provision

Pathology
A full service across haematology, biochemistry, microbiology and histopathology will run on every non-weekend or bank holiday day. Additionally, haematology and biochemistry services will run all day on weekends and bank holiday days. Microbiology will run a morning only service on Bank Holiday and weekend days with on-call outside of these hours. Histopathology will be closed on weekend days and bank holidays.

Radiology
On weekend days and Bank Holidays radiology have in place an on-call service for urgent cases for CT, MRI and ultrasound. X-ray is available 24/7. Due to some fixed sessions that are already agreed, the on-call Radiographer and Radiology staff will be available at times during weekends in the key areas, such as Ultrasound and CT to support additional requests from inpatient areas. Staff in radiology have been offered a range of shifts on weekend and bank holiday days which can be undertaken in exchange for a day in lieu. The final radiology schedule will be completed once all staff have responded to this request.

There will also be a great emphasis on inpatient scans, with a resulting decrease in outpatient and elective bookings to assist with patient flow at this crucial time.

Therapies
The whole service has cancelled non-urgent clinics and clinics not linked to services that may accrue fines from the 21st December to the 15th January. All staff released will be allocated to inpatient wards and the service will run a prioritisation system which will enable staff to schedule their time appropriately.

There will be an inpatient respiratory physiotherapy service, covering inpatient wards and ICU every day. The service continues to work with staff and encourage volunteers to work some of the weekend days and bank holiday days in exchange for lieu days.

Pharmacy

An inpatient service supporting admissions and discharges will be available every day on site except Christmas day. On weekend days and Bank Holidays this will be for the period from 9am to 12.45pm. An on-call service will be available out of hours. In addition, key discharging wards will have their own TTO pharmacy supply that can be accessed at all times.

2. Ward escalation plans

Graham Ward

In Scarborough the plan is to use the 19 beds on Graham Ward as the Winter escalation ward – with a particular focus on elderly patients with an anticipated length of stay of less than 5 days. The plan is to begin functioning in this way from Monday 7th December and it should remain open until 15th April 2016.

The ward will be predominantly staffed with nurses from other ward areas – meaning that it will not be mainly agency staff left running the ward. The costs for running Graham Ward are already in established budgets.

Ash Ward

This 16 bedded surgical ward will be re-allocated to the elderly team to manage from the beginning of December. This will help to reduce the level of "outliers" in the hospital and speed up discharges. This will be implemented from the 1st November and run to the 31st March.

Further additional acute medical capacity at Scarborough

It is not possible to plan to re-allocate a further surgical ward to medicine in a planned way. This is due to the physical availability of side rooms on Maple and Lilac Wards which will inevitably be needed by both medicine and surgery. The plan therefore, is to have any other medical outlying patients across the remaining surgical wards, but to ensure they are reviewed daily by a consultant.

Bridlington wards

Waters Ward at Bridlington Hospital will also be used to support the Scarborough site. It will house patients from Scarborough Hospital and Johnson Ward at Bridlington Hospital that have reached the end of their acute episode of care, and are awaiting the next phase of their care plan to be delivered, for example patients with a fractured neck of femur awaiting rehabilitation physiotherapy.

Staffing arrangements

As in previous years, a multi-disciplinary team will be brought together to cover the ward to include all disciplines. This will need to include strong clinical leadership (nursing and medical) to deliver the best care to this group of patients. Once the ward function is clear, the ward team should be involved in the planning around how the ward will function over Winter.

3. Elective service provision

Elective surgery plans by specialty

Through a mixture of cancelled lists, lists at Bridlington, referral of work to the private section and conversion of lists to day surgery all surgical specialties have

comprehensive plans in place over the intense period of Winter. All 30 sessions at Bridlington will be fully booked. A summary, by specialty is set out below.

General surgery
There are no planned elective lists on weekend or bank holiday days. Other weekday days will have reduced activity. From the first week of January for the following six weeks elective work will be focussed on cancer patients, clinically urgent patients and those suitable for Aspen ward. This will mean the cancellation of 2 lists per week (total of 12 sessions), which will be converted into endoscopy or outpatient sessions.

The directorate are also exploring whether to IPT some of the routine work to Hull Spire during this period. An initial positive response has been received but the directorate is awaiting confirmation of the procedures they would be willing to undertake.

Trauma and orthopaedics
All elective orthopaedics work has already been transferred to the Bridlington site, and this will be maintained over the Winter period.

ENT, Maxfax and Ophthalmology
Maxfax elective services plan to run as normal in December. Come January the weekly Scarborough Hospital main theatre list will switch to Bridlington. ENT propose that they will pause elective surgical lists for the week before Christmas and the first two weeks of January. For Ophthalmology, the three GA lists that are normally run each week will be converted to LA lists reducing the need for overnight beds. This arrangement will be in place until mid-January.

Gynaecology
From mid-December to mid-January, Gynaecology have cancelled a total of 12 main theatre lists. Four of these lists should be re-provided at the Bridlington site, giving a net loss of eight main theatre lists. Eight additional outpatient clinic sessions will run during this time to ensure clinical time isn't completely lost. Over this time period the service will continue to run a total of six theatre lists which should be sufficient to manage non-elective demand that presents during this period.

Elective surgery ward base

Aspen is to be maintained as an Admission Ward and Day Unit for as long as possible. If it is required for use as an acute inpatient ward this must be identified as part of an escalation plan in the 11am Operational Meeting Monday – Friday, with 24 hours notice where possible. The standard protocol for opening an escalation must be followed and authorisation achieved from Deputy COO, Director of Finance and Assistant Chief Nurse.

4. Service provision outside the hospital

Community

Community inpatient bed base
On the weekend and Bank Holiday days across all the community inpatient bed base medical reviews will only be available via the out of hours GP or the hospital urgent on-call system – patients will not be routinely reviewed by a doctor. Discussions are on-going with GPs in Malton to provide additional cover over weekend and Bank Holiday days.

Community discharge liaison team

The discharge liaison team will only be available on normal week day days and so won't be available on weekends or Bank Holiday days in December. The team will pilot a change their working patterns come January, meaning that there will be weekend cover available for all patients in community hospitals.

Single point of access
The single point of access into community services will be available every day over Winter and the community bed base will be staffed to normal nursing levels every day.

Community nursing
Across the teams capacity will be maximised through tight control of annual leave, reductions in training and negotiations with GPs around not undertaking QOF diagnostics over Winter. There is also a range of initiatives to further increase capacity in the team, centred around providing more clinic based care and re-structuring how phlebotomy services operate.

Discharge to assess
Work is continuing with NYCC to develop models of discharge to assess. This will allow social care assessments to be undertaken outside of the hospital setting freeing up hospital beds for acutely ill patients.

Social care

The Chief operating officers from all local providers of social care were written to at the start of July, asking them to engage with us and share plans. The Trust requires that social care is able to accept and process referrals and support discharges of patients with complex care needs seven days a week.

Reablement beds
Step up and step down beds will be available (subject to funding agreements) at 101 Prospect Road in Scarborough. Patients will receive therapies and social care input for blocks of four days to support their reablement or prevent admission. The team are in the process of confirming the inclusion criteria at time of writing.

Private nursing and residential care
There are a range of private nursing and care homes in the locality, each with their own set of eligibility and referral criteria and assessment arrangements. The Trust will need to clarify what these arrangements are and when assessments can take place to help support discharges.

Mental health

The Chief operating officers from all local providers of social care were written to at the start of July, asking them to engage with us and share plans. The Trust requires that social care is able to accept and process referrals and support discharges of patients with complex care needs seven days a week. We have requested details relation to service provision for the CRISIS service, CAMHs and Liaison Psychiatry.

TRUSTWIDE ARRANGMENTS

Operational management

Operations centre and on-site clinical leadership

Trust wide bed and site management will take place from the Operations Centre at York Hospital (level 2, adjacent to ward 21). From this base the Clinical Site managers and operations team will coordinate with each other, transfer patients, identify pressure points and act as the hub for all information about what is happening across our hospitals at any one time. It is also anticipated primary and social care colleagues can dial into meetings when pressure on the hospitals is building.

Senior management presence

There will be a member of the senior operational management team, present on site 7 days every day over the Winter period. This will support swift decision making and the clinical teams on site.

Directorate manager on-call arrangements

The normal directorate manager on-call arrangements will apply, with the on-call manager coming on site to support operations if the need arises.

Additional nursing support for the hospital ward base

In order to increase nursing numbers in ward areas over winter and to support escalation areas, all non-ward based Registered Nurses will be expected to work in a clinical capacity over the peak period of winter pressure. Where possible this will be within their specialist areas of work and shift times will be agreed with the individual. This will not compromise clinic activity or specialist services.

Governance arrangements

The hospital interim medical directors have agreed to chair the Trustwide Winter planning group. The Group will be a multi-disciplinary group that will report into both the Acute and Planned Care Task and Finish Groups. It will provide the forum for decisions to be made, and allow clear communication to follow out to directorate and service areas as needed.

Conclusions and next steps

Services have already undertaken a huge amount of work in planning for Winter and in many cases we are well sighted and clear around what we plan to provide and when. Between now, and the time this plan is put into operation, the following areas should be our priorities for focus and action:

- Confirming that were funding is agreed for additional shifts and sessions that these are completely filled.
- Confirm the exact working arrangements and availability for radiology and therapies services, particularly on key days in the holiday period.
- Confirming the SOP for the medical use of beds on ward 29.
- In York and Scarborough, further clarity is needed around plans in social care, both in terms of assessments of hospital based patients requiring local authority care and confirmation around spot purchasing of additional capacity.

- There are a range of service improvements underway in the Trust's community services that should be in place by Winter – these need to be confirmed.
- The Trust needs to work with local CCGs to ensure that there is primary care available on key bank holiday and weekend days.

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Human Resources Report – October 2015

Action requested/recommendation

The Board of Directors is asked to read the report and discuss.

Summary

The attached document provides information up to September 2015, relating to key Human Resources indicators including; sickness, recruitment & retention and workforce expenditure.

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

Implications for equality and diversity

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

This report is for noting only and contains no recommendations. It is therefore not expected to have any particular impact upon the requirements of, or on the protected groups identified by the Equality Act.

Reference to CQC outcomes

Outcomes 12, 13 & 14

Progress of report Board of Directors

Risk No risk

Resource implications	There are Human Resources implications identified throughout this report
Owner	Patrick Crowley, Chief Executive
Author	Polly McMeekin, Deputy Director of Workforce
Date of paper	October 2015
Version number	Version 1

Board of Directors – 28 October 2015

Human Resources Report – October 2015

1. Introduction and key messages

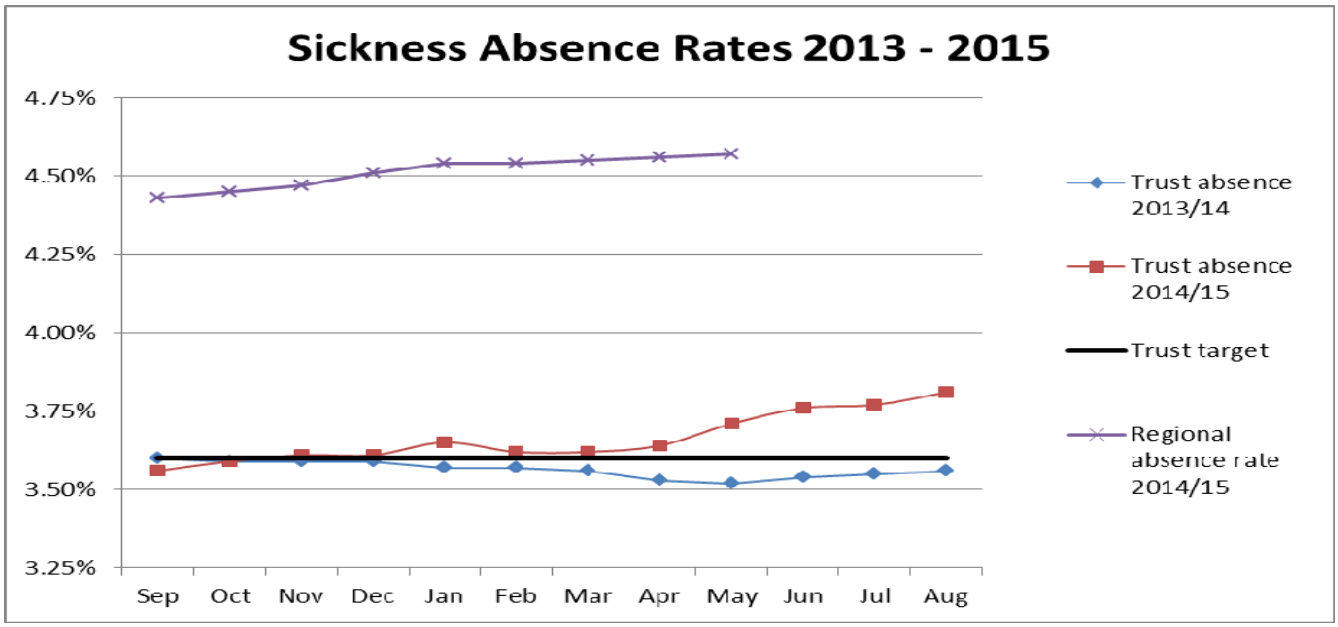
This paper presents key workforce metrics up to September 2015 (where available). The narrative will detail trends and any actions which are being taken to address specific issues. Of particular note:

- Whilst absence rates have increased in the last year, the Trust figure compares favourably against the regional average absence rate.
- Turnover has increased over the last year by 1.2% to 12.2%. This trend is seen across almost all staff groups.
- Appraisal compliance for non-medical staff at the end of September 2015 was 61.44%. This is 10% lower than at the same point in 2014. A phased approach is being taken to embed a revised appraisal framework with an explicit link to Trust values.

2. Human Resources Report

2.1 Sickness Absence

Graph 1 – Sickness absence rates



Source: Electronic Staff Record

The above graph compares the rolling 12 month absence rates to the Trust's locally agreed threshold and to the regional (Yorkshire and Humber) sickness absence rates.

Trust absence rates consistently compare very favourably to average absence rates across the region. In the last six months for which there is data available, the Trust annual absence rate was on average 0.9% lower than the regional average which is 4.57%.

Since March 2015 the absence rate at the Trust has steadily increased to 3.81% in August 2015. This is 0.21% higher than the 3.60% the previous year. Much of this increase is the result of work which has been undertaken to improve the reporting of doctors' sickness which has seen the annual absence rate for this staff group increase from 0.84% in August 2014 to 1.2% in August 2015.

The top three reasons for sickness absence in the year to August 2015; were anxiety/stress/depression accounting for 19%; musculoskeletal (MSK) problems accounting for 11% and gastrointestinal problems accounting for 8.5% of all days lost.

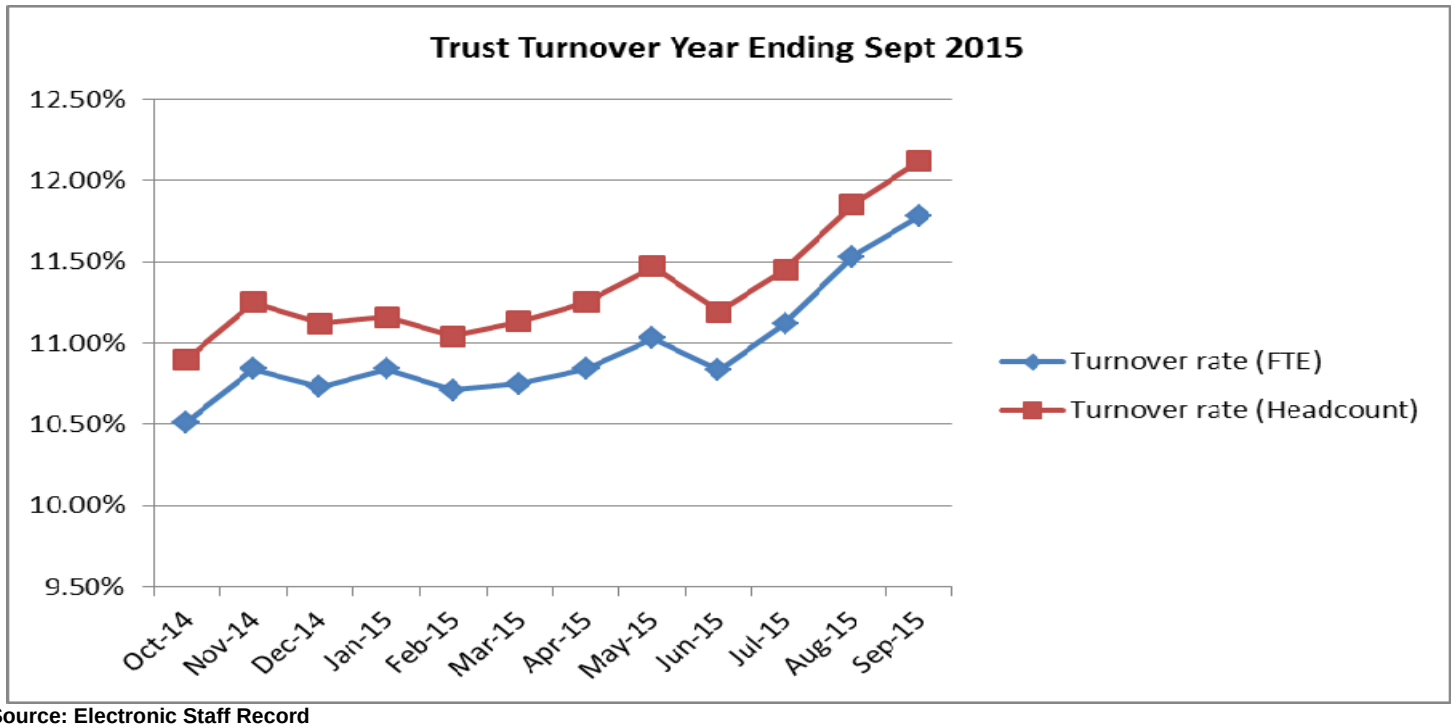
The Trust has been selected as one of twelve NHS Trusts nationally to participate in a 12-month pilot to improve the health and wellbeing of our workforce. We will be working closely with NHS England and the Department of Health to share good practise and adopt strategies which will ultimately reduce our sickness absence further. Initially our focus will be on improving mental health and MSK as our two main reasons contributing to sickness absence.

2.2 Turnover

Turnover

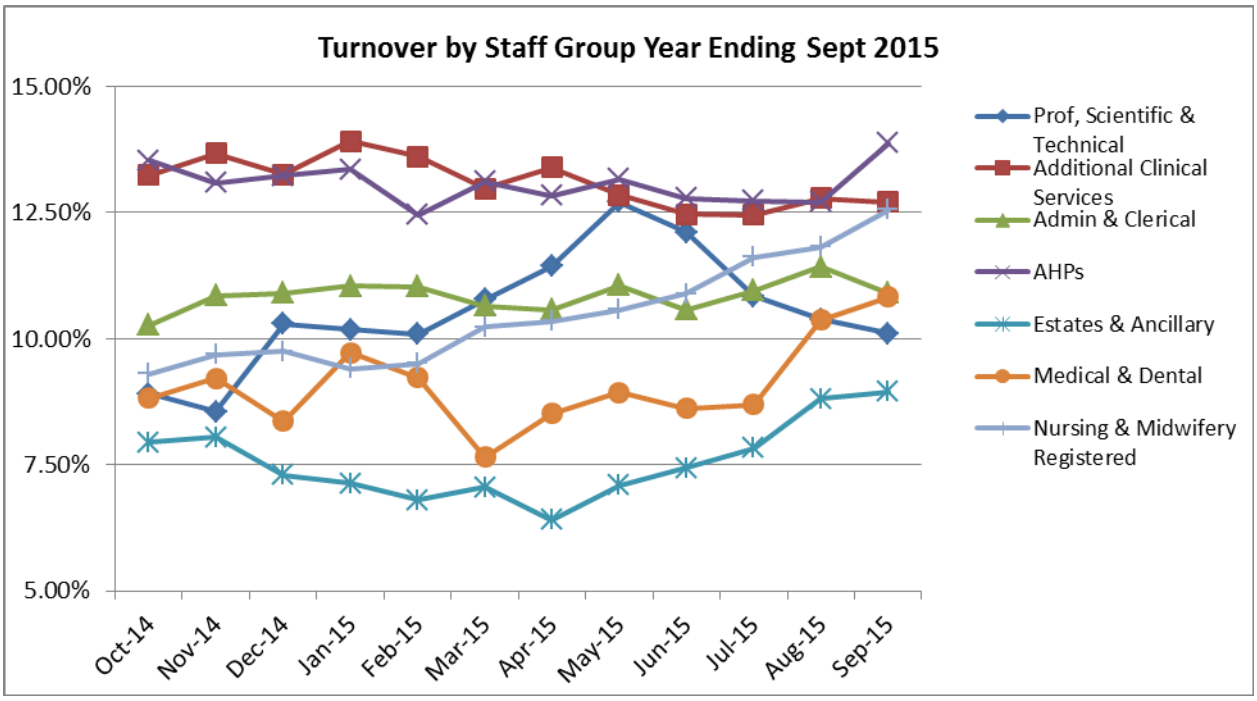
Over the past 12 months the overall Trust turnover rate has increased by over 1.2% based on both FTE and headcount calculations. This represents almost 1,000 leavers in the year to September 2015. Included within this is a small number of staff (17) who TUPE transferred to a different organisation. In September the overall annual turnover percentage by headcount was 12.2%.

Graph 2 – Overall Turnover Rates



Source: Electronic Staff Record

Graph 3 – Turnover rates by staff group



Turnover in a number of staff groups has increased steadily. Specifically turnover amongst registered nursing and midwives has increased by more than 3% from 9.31% in October 2014 to 12.55% in September 2015. Much of this can be attributed to retirements; some of whom have subsequently returned to our employment.

The staff group 'Healthcare Scientists' is not included in the graph. This is because a recoding exercise has been undertaken resulting in 21% joining the Professional, Scientific and Technical staff group. As the Healthcare Scientist staff group is relatively small with approximately 210 staff; this would depict a distorted pattern of behaviour. The average turnover of Healthcare Scientists since October 2014 is 15%.

Please note that when calculating turnover both junior doctors on rotational contracts and bank staff are excluded to prevent distorting the turnover figure. This is a common approach used across the NHS for calculating turnover.

2.3 Pay Expenditure

Nationally the NHS is being encouraged to significantly reduce agency spend. Whilst this is not mandated for this Trust we are encouraged to engage with the rules imposed on others to assist with our reduction in usage. The letter from Monitor in September specifically concerned nursing agency (registered and unregistered) and the need to reduce this spend. When the need arises to utilise agency staff; this should be from a 'Framework' agency from 19th October 2015.

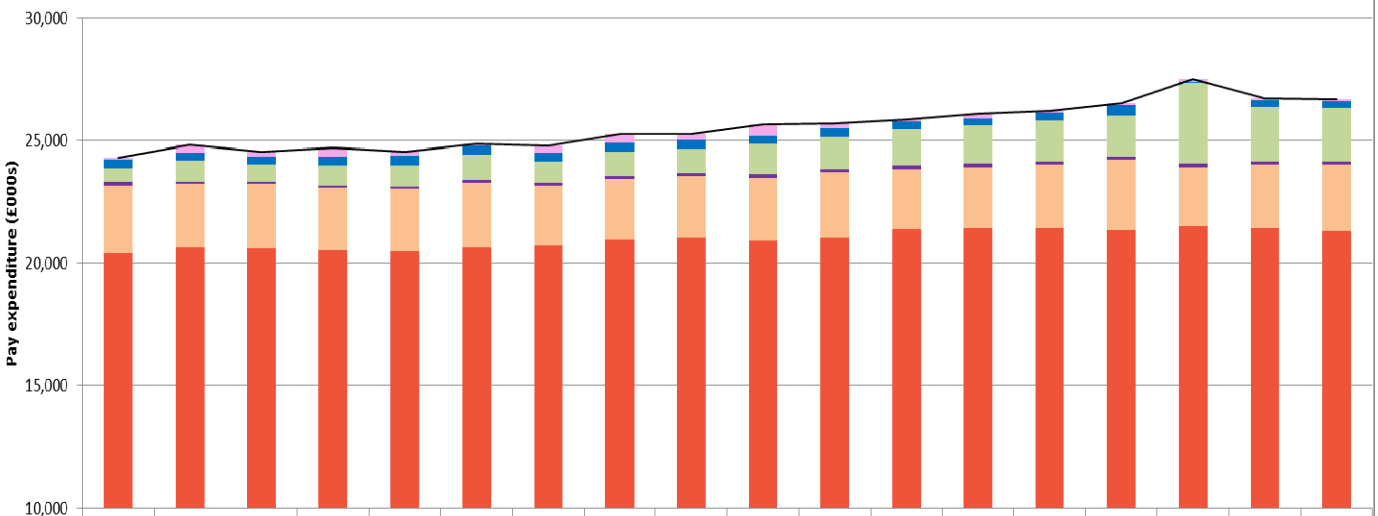
This month our Temporary Staffing Procedure has been reviewed and approved. This Framework details the process to be undertaken to ensure our substantive (contracted) staff are being effectively utilised before we seek external support via an agency.

To achieve this aim significant work is also being undertaken to incentivise our internal Bank. This includes the introduction of weekly pay; currently being piloted with full implementation from 1st November 2015. Pay rates will reflect level of experience with an additional uplift during Winter Pressures offered to our Bank staff who are also substantively employed by the Trust.

In addition the Nurse Bank and Medical Rota teams will be trialing extended service provision during

December and January. The teams will be delivering a service during Saturdays. The driver for this is to ensure that the most cost effective solutions are sought for temporary staffing requirements that arise out of hours.

The graph below details the level and type of pay expenditure Since April 2014.

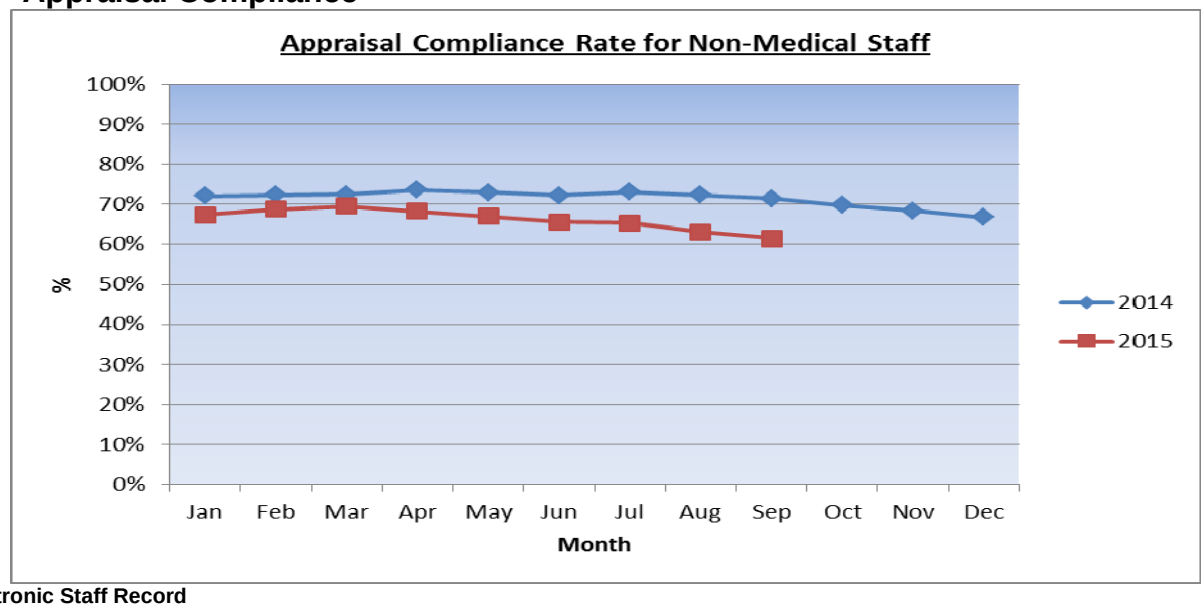


	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
LOCUMS	113	289	205	369	172	78	287	364	263	478	200	78	202	96	75	130	92	81
BANK	346	340	330	339	380	372	356	345	326	321	325	315	257	319	451	19	292	271
AGENCY	566	862	705	837	881	1,049	870	1,004	1,010	1,262	1,324	1,491	1,553	1,657	1,658	3,326	2,209	2,192
OVERTIME	131	80	92	100	101	115	118	129	114	124	132	138	173	129	123	127	137	135
ADDITIONAL HOURS	2,749	2,571	2,603	2,526	2,519	2,608	2,397	2,473	2,518	2,561	2,637	2,470	2,479	2,626	2,895	2,439	2,603	2,723
CONTRACTED	20,417	20,665	20,613	20,543	20,499	20,652	20,753	20,956	21,040	20,929	21,064	21,368	21,424	21,405	21,321	21,484	21,408	21,289
TOTAL	24,323	24,808	24,547	24,713	24,552	24,874	24,781	25,269	25,271	25,675	25,683	25,859	26,088	26,233	26,522	27,527	26,740	26,692

2.3 Appraisal

Appraisal activity

Graph 4 – Appraisal Compliance



Source: Electronic Staff Record

The appraisal compliance rate for non-medical staff was 61.44% for the year ending 30 September 2015. This is a reduction of 10% from the same period the previous year which was 71.46%. The Trust's local target remains at 95%.

Senior medical staff's appraisals have historically been recorded separately. From November 2015 we will be reporting on the combined medical and non-medical appraisal rate.

Significant work has been undertaken this year to improve the documentation and process for non-medical appraisals. The new Appraisal Framework and Performance Development Matrix (PDM) was launched in May 2015. The Framework encourages open and honest conversations about performance. The PDM combines current capability and 'fit' with the organisation's values and expected behaviours. The associated paperwork has been reduced significantly so the focus is on the conversation rather than the completion of forms.

An e-learning package for both staff and managers is being launched this month (October 2015). This provides 'real' examples of how the appraisal framework can be used effectively.

To further improve compliance rates the Trust intends to make it a requirement for an individual to have had an annual appraisal in order for them to obtain their incremental pay progression. This requirement also extends to compliance with mandatory training. The policy is currently being negotiated with our trade union colleagues.

2.4 Employee Relations Activity

The table below describes the number and type of employee relations activity during September 2015.
* denotes staff on medical and dental terms and conditions are excluded from the figures.

Employee Relations Activity	September 2015
Number of Disciplinaries (including investigations)*	18
Number of Grievances	6
Number of Formal Performance Management Cases (Stage 2 and 3)*	3
Number of Employment Tribunal Cases*	5
Number of Active Organisational Changes (including TUPE)	18

2.5 Staff Friends & Family Test

In quarter one of this financial year (2015/16), the Staff Friends and Family Test was undertaken in the Pharmacy directorate and a response rate of 49% was achieved.

74% of staff said that they would be extremely likely or likely and 9% said they were extremely unlikely or unlikely to recommend the organisation to friends and family if they needed care or treatment.

76% said that they would be extremely likely or likely and 11% said they were extremely unlikely or unlikely to recommend the organisation to friends and family as a place to work.

These scores resulted in the Trust being placed 75th out of 238 Trusts for recommending the Trust as a place to receive care or treatment. We ranked 208th out 238 for recommending the Trust as a place to work. We are currently awaiting the results from quarter two; the survey was run in the Emergency Department and Laboratory Medicine.

3. Conclusion

This report has detailed key workforce metrics highlighting any issues or trends. In those areas where there are issues, actions which have already been identified have been detailed. The impact of actions will become apparent in subsequent reports.

4. Recommendation	
The Board of Directors is asked to read the report and discuss.	
Author	**Polly McMeekin, Deputy Director of Workforce**
Owner	**Patrick Crowley, Chief Executive**
Date	**October 2015**

York Teaching Hospital NHS
NHS Foundation Trust

Environment & Estates Committee – 23 September 2015

Attendees: Michael Sweet (MS) (Chair), Jennie Adams (JA), Brian Golding (BG), Andy Fairgrieve (AF), Dave Biggins (DB), Colin Weatherill (CW), Brian Golding2 (BG2), Jane Money (JM), Janet Mason (JMa), Fiona Jamieson (FJ), Carol Birch (CB), Jacqueline Carter (JC)

Apologies: None

	Agenda item	Comments	Assurance	Attention to Board
1.	**Welcome / Introductions.**	MS, Chair, welcomed colleagues to the inaugural meeting of this Committee. To set the context he provided some background on how the meeting had arisen through the governance review and recognised the importance of the Committee with direct reporting into the BoD. The minutes will be seen by the BoD routinely and meetings will happen quarterly at different sites and incorporate site visits from time to time. Brian Golding, Director of Estates & Facilities confirmed he was pleased the Committee had been established. He echoed the Chair's comments and confirmed that it links to one of the Trust's Corporate objectives "Improve our facilities and protect the environment" and is an opportunity to provide assurance to the BoD and give Non-Executive Director colleagues a better understanding of this work. MS said he and JA were here to be assured on behalf of the BoD.		
2.	**Apologies for absence.**	None		
3.	**Terms of Reference.**	The Committee received the Terms of Reference for consideration. Subject to a number of small changes these were endorsed. The Terms of Reference will be submitted to the BoD for approval in October.		Board to receive and approve ToR. Paper attached 1

4.	**Premises Assurance Model (PAM)** • **Introduction to NHS Premises Assurance Model (PAM).** • **YTH PAM compliance report.**	DB presented to the Committee an overview of the NHS Premises Assurance Model (PAM), explaining why the DoH has brought it in and explaining what we as an organisation have done. PAM is a self-assessment tool which allows us to monitor compliance against quality & safety indicators on efficiency, effectiveness and governance. Domain leads identify further evidence and develop action plans to increase compliance against the tool. Any significant risks identified are escalated to the Estates & Facilities Director and the Risk Registers where appropriate. Local and Board level monitoring of progress against the model continues. FJ asked if this information was broken down by site. DB confirmed he was starting to roll the work out, and it will be site specific going forward. JA asked about the patient experience domain and in particular SAQ code PE6, portering services – on which we have been rated red (inadequate evidence). DB confirmed it related to having correct processes and procedures in place and what we do not have is an over-arching policy on how we manage porters. BG confirmed he is seeking to modernise the portering service as part of the efficiency process. MS asked how the scores are calculated. DB confirmed the document automatically scores the tool for you. MS asked if the document could show trends going forward. This was agreed. He also suggested linking up with Internal Audit in terms of how we layout the document and how to chase action plans that are overdue. This was noted. MS thanked DB for the presentation. PAM will be discussed every quarter.		
5.	**PLACE Results 2015**	The Environment & Estates Committee received the published PLACE results and were asked to note the contents. The paper also set out the process of the patient led assessments which took place between 3/3 and 17/4 on all sites with in-patient facilities. It was noted that dementia is now scored and as it is a new area an action plan will be put together. JA asked about the scores given against food. CB explained that food		

		scores are spilt into two components; an organisational part which gives you an overall score and an assessment of ward based practices and quality of food provided on the day. It was noted that the smaller community units generally scored higher, and this was because their environments were better, often having dining rooms. BG commented also that these assessments happened before our new catering facilities were in place and so we are anticipating improvements as this is rolled out. This was noted. JA asked for more detail on the dementia assessment. BG explained that the scores generally relate to the environment. Our design and construction partners have been invited to carry out a PLACE inspection so that we start to design in improvements. MS asked for more detail around privacy & dignity scores - this was provided - BG explained it is very much centred on the built environment. It was noted that feedback sessions have been arranged for October where the action plans will be discussed with Governors and Healthwatch and broken down into more detail. MS asked for feedback at the next meeting. This was agreed. It was agreed that Place results will be seen by the BoD in September in advance of the E&E Committee report as the results have already been made public.		PLACE report to go to Board Sept meeting – completed.
6.	**Health & Safety** • **ToR for H&S/NCRG.** • **H&S/NCRG minutes of last mtng.** • **Quarterly report.**	The Committee received the Terms of Reference for approval. A number of small changes were required. The Chair asked for these to be amended and brought back to the next meeting for ratification. This was agreed. The Committee received the minutes of the Health & Safety/ Non Clinical Risk Group meeting held on 11th September. These were noted. Issues to highlight included: • Issue around reporting of staff needlestick injuries - in hand. • Community services - policies/procedures to be brought in line with rest of Trust.		

		• H&S Action Plan - a question was raised whether the action plan should be seen by this Committee in future (as it includes KPIs, Internal audit recommendations, H&S training et al). • Central Alerting Systems – FJ is currently reviewing this work. MS or JA may attend these meetings on an ad hoc basis in the future. CW presented the first quarterly report on health, safety and security to the Committee reporting on non-clinical risk information through monitoring of data received and complaints, claims, AIRS, Riddors and SIs. The report also included at Appendix 1 potential items for discussion by the Committee at future meetings. Looking at the charts and tables provided in the report MS confirmed he would like to see comparisons against previous quarters and current figures, and highlight those issues that require escalating for discussion. Under section 1.4 of the report on AIRS, CW agreed to provide more detail around slips, trips and falls and spilt the data between patients and staff. CW agreed to contact Diane Palmer. BG agreed to arrange for patient safety walk rounds to include more questions on staff health and safety information. This was noted. BG and CW agreed to meet to discuss the contents of future reports.		
7.	**NHS Protect report.**	JMa presented two reports to the Committee on NHS Protect. The first paper provided information and background on NHS protect which is a national organisation in partnership with the DoH committed to raising the standards in the NHS, by adopting a risk based approach to security management and protecting staff and resources from crime. The Trust is expected to have a security management director (Patrick Crowley (delegated to BG)) and local security management specialist (Janet Mason) in place. An annual work plan is also expected to be submitted, as evidence of compliance. The second paper showed our compliance based on the latest self-		

		review submission against NHS protect standards. Standards 4.1 and 4.4 were raised as we had been rated red which require improvement. JMa explained that these were around developing criteria for when recovery of financial loss is required through prosecutions, and we do not have an overarching policy on this. Therefore, an action plan will be developed accordingly. This was noted. The Committee endorsed the paper and were assured that appropriate action plans were in place to address the issues raised. Report requires to be seen by BoD for overall approval.		Report to go to Board. Paper attached 2.
8.	**Sustainable Development** • **ToR for Sustainable Development Group**. • **SDG minutes of last mtng.** • **Sustainable Development Management Plan – Action Plans.** • **Baseline Carbon footprint data.**	The Committee received the Terms of Reference for approval. To set the context BG provided some background on sustainable development reminding the Committee that the BoD had approved a Sustainable Development Management Plan in January 2015, delegating the action planning to the Sustainable Development Group. The Sustainable Development Action Plans were presented to the Committee for consideration. The management plan contains some core objectives which have been consolidated into an action plan at the back of the document which identified the leads for each objective. This ensures the Trust's plans are clearly laid out and well known. As a Trust we also measure our impact as an organisation on sustainable development through a self assessment tool called the Good Corporate Citizenship which allows us to benchmark ourselves against other Trusts on a number of areas such as Travel, Procurement and Waste. BG2 and JM also provided a number of reports to highlight to the Committee our carbon footprint position in a number of categories - energy, travel, procurement and commissioning. It was noted that our energy consumption targets are well adrift for Selby Hospital – BG2 was aware and agreed to look into it and report back. *Fiona Jamieson left the meeting at this point.*		

		BG2 presented the first draft of the carbon footprint data in the format that had been agreed in the sustainable development management plan. BG2 explained that the figures for procurement and Capital developments were based on our actual expenditure and indices published by SDU and as such could only be regarded as indicative. It was noted that over time we might want to move to a different method, where we can demonstrate the progress that has been made against targeted improvements in particular areas. Meanwhile this provides a starting point. Over time, as the suppliers position improves it is anticipated that the indices will change to reflect that. BG2 confirmed that carbon emissions are reported under 3 categories: Scope 1: Direct emissions from burning fossil fuels. Scope 2: Indirect emissions from bought in energy (eg. electricity). Scope 3: Indirect emissions from all other consumption. The data as presented only included York from 2007, with Community and SNEY being added in 2012 and 13 respectively. For this reason the overall carbon footprint has increased significantly from 2007. BG2 will be exploring the feasibility of identifying and including SNEY data based on ERIC returns and annual reports. The data clearly indicates a reduction in Scope 2 emissions, (electricity bought from the National Grid) as a direct result of the carbon energy fund project at York. We can expect this to further improve once the Scarborough and Bridlington projects come on stream in 2016. The Committee was reminded that in 2009 the BoD adopted reduction targets of: 10% by 2015 26% by 2020 80% by 2050. MS thanked BG2 for this update. It was agreed to discuss in more detail at a future meeting.		

9.	**Travel & Transport Group.**	Deferred until next meeting.		
10.	**Space Utilisation Group.**	Deferred until next meeting.		
11.	**Any Other Business.**	None.		
12.	**Future meeting dates.**	Tuesday 15th December 2015 @ 10am – Scarborough Hospital.		

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J1

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Terms of Reference Environment & Estates Committee

Action requested/recommendation

The Board of Directors is asked to approve the Terms of Reference for the Environment & Estates Committee.

Summary

Following a review of the Trust's governance structure the Environment & Estates Committee has been established. The Terms of Reference have been seen by the Committee at its first meeting and are presented for approval by Board of Directors.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Regulation 9, outcome 4 – safe care and treatment
Regulation 15, outcome 10 – cleanliness, safety & suitability

Progress of report	Prepared for presentation to the Board of Directors.
Risk	None
Resource implications	None
Owner	Michael Sweet, Chair of Environment & Estates Committee
Author	Brian Golding, Director of Estates & Facilities
Date of paper	October 2015
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Environment & Estates Committee:

Summary of Governance

Version 1.2
September 2015

York Teaching Hospital NHS Foundation Trust

ENVIRONMENT & ESTATES COMMITTEE: Summary of Governance

Table of Contents

ENVIRONMENT & ESTATES COMMITTEE

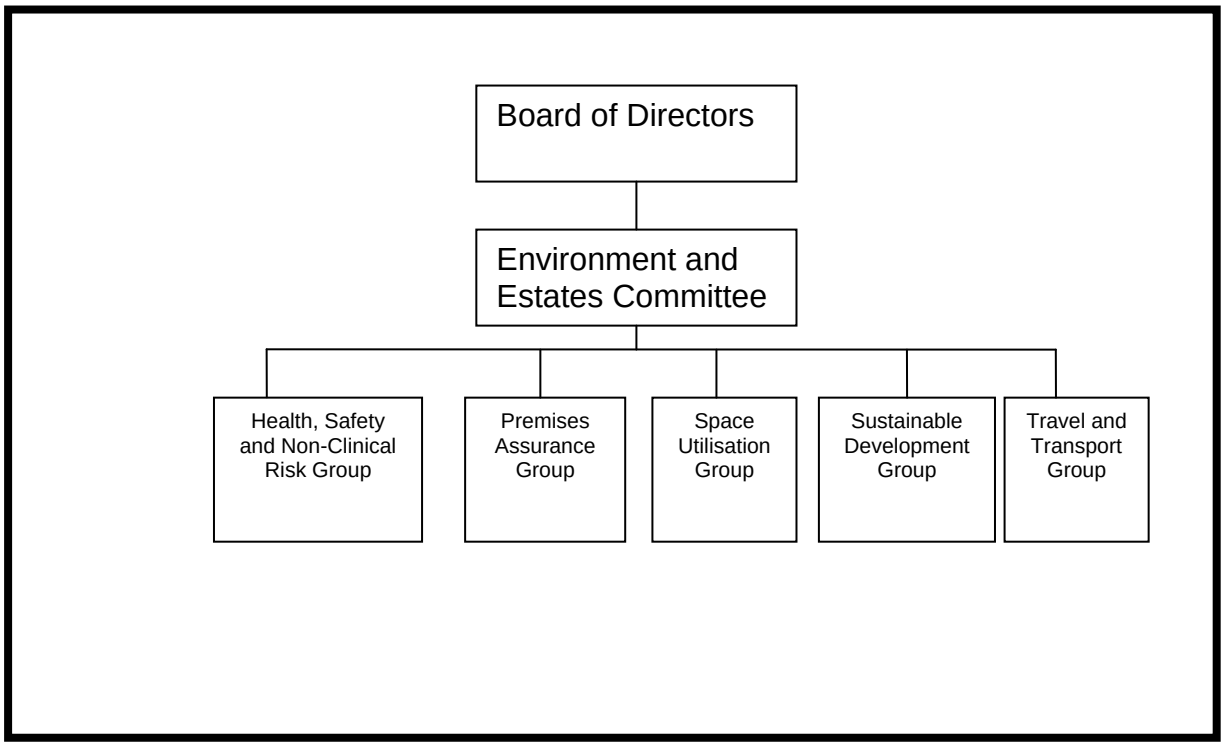
Terms of Reference

1	**Status**
1.1	The Environment & Estates Committee is a committee of the Board of Directors. The minutes of the Environment & Estates Committee will be received by the Board of Directors.
2	**Purpose of the Committee**
2.1	One of the Trust's four key objectives is to "Improve our facilities and protect the environment". The Environment & Estates Committee will monitor progress against this objective and ensure the Board of Directors receives assurance about the Trust's ownership, operation and maintenance of the built environment.
3	**Authority**
3.1	The Board of Directors has provided delegated authority to the Environment & Estates Committee to seek assurance around the suitability and safety of the Trust's assets, in relation to their usage by staff, patients and visitors.
4	**Legal requirements of the Committee**
4.1	There are no specific legal requirements attached to the functioning of the Committee. The Committee will however, be made aware of any legal requirements the Trust is expected to fulfil.
5	**Roles and functions**
5.1	To consider the Trust Premises Assurance Model at each meeting.
5.2	To receive a summary of the workings of the Travel and Transport Group.
5.3	To receive a report from the Health, Safety and Non-Clinical risk management group, including an overview of RIDDOR reportable incidents, new claims and settled claims and security.
5.4	To receive a summary of the workings of the Sustainable Development Group, including progress against the Sustainable Development Management Plan.
5.5	To receive reports from the Trust Space Planning Group.
5.6	To provide assurance to the Board of Directors on the systems and processes used by the Trust to support the Environment & Estates agenda.
5.7	To escalate any areas of concern identified to the Board of Directors for further discussion and resolution.
5.8	The Environment & Estates Committee will submit the minutes to the Board of Directors following each of the Environment & Safety Committee's meetings (at least 4

	times per year), together with an annual report.
6	**Membership**
6.1	The membership of the Environment and Estates Committee will comprise:- • 2 NEDs – Mike Sweet (Chair) and Jennie Adams The following Directors and officers will be in attendance: • Director of Estates and Facilities (Brian Golding) • Deputy Director of Estates and Facilities (Andrew Fairgrieve) • Head of Medical Engineering (David Biggins) • Trust Health, Safety and Security Managers (Colin Weatherill/ Kingsley Needham/Janet Mason) • Trust Sustainable Development Manager, (Jane Money/ Brian Golding2) • Carol Birch, Head of Facilities – Satellite properties (ad hoc) • Fiona Jamieson, Deputy Director of Healthcare Governance • Administrative support (Jacqueline Carter)
7	**Quoracy**
7.1	The Committee will be quorate with 5 members attending, one of whom must be a NED. The Chair of the meeting will ensure that a deputy is appointed to preside over a meeting when the Chair is unavailable or has a conflict of interest.
8	**Meeting arrangements**
8.1	The Environment & Estates Committee will meet prior to the Board of Directors meeting (minimum of 4 times per year) and all supporting papers will be circulated 7 days in advance of the meeting. Copies of all agendas and supplementary papers will be retained by the Director of Estates & Facilities Office in accordance with the Trust's requirements for the retention of documents. The Director of Estates and Facilities Office will supply the secretariat service to the Committee.
8.2	The Chair of the Environment & Estates Committee has the right to convene additional meetings.
8.3	Where members of the Environment & Estates Committee are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the secretary of the committee and provide a deputy; the deputy does not form part of the quorate committee unless agreed with the Chair, and must be fully briefed.
9	**Review and monitoring**
9.1	The Environment & Estates Committee will maintain a register of attendance at the meeting. Attendance of less than 50% will be brought to the attention of the Chair of the Committee to consider the appropriate action to be taken. The attendance record will be reported as part of the annual report. The annual report will be presented to the Board of Directors.
9.2	The Terms of Reference will be reviewed every year.

Author	**Brian Golding, Director of Estates & Facilities**
Owner	**Environment & Estates Committee**
Date of Issue	**October '15**
Version	**1.2**
Approved by	**Board of Directors**
Review date	**October '16**

Governance Structure



Standing Agenda

No.	Agenda item	Comments	Attention to Board
1.	Operational Safety and Risk management, including Fire Safety and Security		
2.	Travel and Transport Group		
3.	Premises Assurance Model		
4.	Space Planning		
5.	Sustainable Development Management Plan		
6.	For attention of BoD		
7.	Any other business		
8.	Next meeting		

J2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Focused quality assessment of compliance against NHS Protect standards for providers (Security Management)

Action requested/recommendation

Following the Trusts annual self-review submission against NHS Protect standards for providers (Security Management) a focused quality assessment of compliance was undertaken in March 2015 by NHS Protects' Quality and Compliance assessor.

The following recommendations were received for areas which required improvement;

Standard 2.5 – Amber
The organisation has an on-going programme of work to raise awareness of security measures and security management in order to create a pro-security culture among all staff, across all sites. This programme of work will be reviewed, evaluated and updated as appropriate to ensure that it is effective.
Action required - Work with Systems and Networks and Communications to develop a security management page on the Trust intranet, this page to include actions to be taken in the event of incidents and the outcome of successful sanctions. A brief summary of the role of the Local Security Management Specialist, Local Security Managers, and the role of the security teams

Standard 4.1 – Red
The organisation is committed to applying all appropriate sanctions against those responsible for acts of violence, security breaches, theft and criminal damage.
Action required - Further develop the current sanctions and redress policy/procedure to detail the criteria for when recovery of financial loss is required, the actions required to recover loss, responsibility and authority to action this.

Standard 4.3 – Amber
Where appropriate, the organisation publicises successful prosecutions of cases relating to a) denying unnecessary access to premises b) the consequences of assaulting NHS staff c) breaching the security of NHS premises and property d) acts of theft and criminal damage.
Action required - Work with Systems and Networks and Communications to develop a security management page on the Trust intranet, this page to include actions to be taken in the event of incidents and the outcome of successful sanctions. A brief summary of the role of the Local Security Management Specialist, Local Security Managers, and the role of the security teams

Standard 4.4 – Red
The organisation has a clear policy on the recovery of financial losses incurred due to any theft of, or criminal damage to, its assets and can demonstrate its effectiveness.
Action required - Further develop the current sanctions and redress policy/procedure to detail the criteria for when recovery of financial loss is required, the actions required to recover loss, responsibility and authority to action this.

Summary

Remedial action was required against standards 2.5, 4.1, 4.3 and 4.4

Two actions are required to address the four standards

1. Create a security page on the Trust intranet to raise awareness of security within the Trust and incorporate any sanctions or redress applied by the Trust
2. Develop and implement Trust Sanctions and Redress Policy

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	Environment and Estates Committee
Risk	Non- compliance against NHS Protect standards

Resource implications	There are no resource implications relating to this.
Owner	Brian Golding, Director of Estates and facilities
Author	Janet Mason, Head of Security and Car Parking/LSMS
Date of paper	September 2015
Version number	Version 1

NHS

Protect

Focused quality assessment of compliance against NHS Protect standards for providers (Security Management)

Final Report

York Teaching Hospitals NHS Foundation Trust

Tackling fraud and managing security

Quality Assessment:

Contact Name	Job Title
Name: Kevin Barnes Contact number: 0191 2046344 Email address: Kevin.barnes@nhsprotect.gsi.gov.uk	Senior Quality and Compliance Inspector

Introduction

York Teaching Hospital NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles.

In April 2011 it took over the management of community-based services in Selby, York, Scarborough, Whitby and Ryedale and in July 2012 it acquired Scarborough and North East Yorkshire Healthcare NHS Trust, bringing Scarborough and Bridlington Hospitals into the organisation.

The organisation has an annual turnover of over £400million. It manages a number of hospital sites, and has a workforce of over 8,500 staff working across its sites.

The information provided for the purposes of this report is based upon the documentation reviewed, the information provided to us during the course of the assessment process, interviews with all relevant personnel and/or third parties and the agreed scope and objectives for this assessment as set out in the assessment rationale. This assessment does not therefore set out all areas of risk in relation to security management work within the organisation and is limited to the areas that have been assessed as set out in the assessment rationale.

Signature – by email	Kevin Barnes
Date	7 April 2015

Ratings The rating system is based on red, amber and green (RAG) ratings and links directly to the NHS Protect standards for providers (security management).	
RED – a risk has been identified but no action has been taken to mitigate the risk, or the action taken is very limited in scope.	**R**
AMBER – a risk has been identified and action has been taken to mitigate the risk. There is evidence of compliance through outputs. However, the effectiveness of the work conducted has not yet been evaluated or there is no reduction of the risk. There is therefore little or no evidence of outcomes.	**A**
GREEN – a risk has been identified, activity has been conducted and there has been measurement undertaken to evaluate the effectiveness of the work conducted. The risk has been mitigated or significant progress has been made in mitigating the risk. Outcomes are therefore present.	**G**

Strategic Governance	
Organisation self review rating	**Green**
Assessment Rating	**Not assessed**
Inform and Involve	
Organisation self review rating	**Amber**
Assessment Rating	**Green**
Prevent and Deter	
Organisation self review rating	**Green**
Assessment Rating	**Not assessed**
Hold to Account	
Organisation self review rating	**Green**
Assessment Rating	**Amber**

Summary of Quality Assessment

There were, at the time of the assessment two accredited Local Security Management Specialists (LSMSs) in post, Janet Mason and Colin Weatherill. Both LSMSs are based at York hospital. In addition the organisation also employed two security managers, based at York and Scarborough.

The organisation was assessed on Tuesday 17 March 2015 with a meeting also held with Mr Patrick Crowley, Chief Executive Officer, the Security Management Director (SMD). A focused assessment was conducted at the organisation covering Inform and Involve and Hold to Account. The organisation was assessed against the 2014/15 Standards for Providers (security management).

Informative meetings and discussions took place with relevant staff and the evidence provided was reviewed prior and during the assessment process.

The Self Review Tool (SRT) was submitted on 14 December 2014. This indicated 19 green standards and 12 amber rated standards. Supporting comments were made in relation to each self assessed standard.

Some of the ratings indicated on the SRT have moved from amber to green (2.1, 2.4 and 2.7). One standard has moved from green to amber (4.3). One standard has moved from amber to red (4.4) and one standard from green to red (4.1). Standard 2.3 is rated neutral.

Appropriate and relevant recommendations are included in this report to improve the organisations security management work going forward.

Many thanks are given to those staff who assisted with the assessment process.

Inform and Involve

York Teaching Hospitals NHS Foundation Trust meets standards; 2.1, 2.2, 2.4, 2.6 and 2.7

York Teaching Hospitals NHS Foundation Trust partially meets standard; 2.5

Standard 2.3 is rated neutral.

Standard

2.1 The organisation undertakes risk assessments in relation to: a) protecting NHS staff and patients b) security of premises c) protecting property and assets d) security preparedness and resilience.
The organisation uses its identified risks to develop inclusive policies in respect of the above (a-d) and can demonstrate implementation of these policies. The policies are monitored, reviewed and communicated across the organisation.

The organisation demonstrated that an annual security risk assessment process was established and working within the organisation. The process was controlled and managed by the LSMSs with support provided by security managers.

Policies and procedures resulting from this process were emailed to those staff who had a responsibility for the implementation of any policy or procedural change.

The LSMS provided an example of such a procedural update with a copy of the Bridlington CCTV Procedure (Sec02 Rev V4 07/12). This procedure was created as an outcome from the security risk assessment process and was monitored and reviewed by the LSMS.

Another example to support this standard were the baby tagging issues at York hospital, which resulted in joint working with other departments (estates). This led to a business case for funding being presented to the Corporate Director. The outcome of this was that the funding was given and installation of a new baby tagging system was underway at the time of the assessment visit.
.

Rating

Green

Standard
2.2 The organisation develops and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property and assets
The organisation demonstrated effective relationships with local and regional anti-crime groups including the police, counter terrorism security advisors, MAPS (the multiagency problem solving panel) and fellow LSMSs. Relationships resulted in regular meetings and minutes of these meetings were provided during and prior to the assessment visit (MAPS agenda 11 November 2014 and Criminal Behaviour Order / Injunction Working group 30 April 2014). The LSMS was due to meet a local North Yorkshire Police Inspector in March this year in order that a police presence can once again be onsite at York Hospital during weekends. The organisation had set aside a dedicated office at York Hospital for police to use as and when required in order to be a visible presence onsite.
Rating
Green

Standard
2.3 The organisation participates in all national and local publicity initiatives, as required by NHS Protect, to raise security awareness.
NHS Protect has not issued any local or national initiatives, as such this standard is rated neutral.
Rating
Neutral

Standard

2.4 The organisation demonstrates effective communication between risk management, capital projects management, estates, security management and external agencies to discuss security weaknesses and to agree a response.

There was effective communication between internal departments and external agencies to discuss security issues. This was clearly demonstrated with the installation of the revised baby tagging system at the maternity wards at York Hospital, which relied on effective communication between Risk, Estates and the LSMSs as well as local clinical staff.

Security management issues were presented by the LSMSs at a number of groups including; Estates and Facilities Team Management meetings, Capital Planning Project Board meetings which were bi-monthly meetings and the Health, Safety and Welfare (HSW) Committee meetings every two months where issues arising are presented to the quarterly Non-clinical Risk Committee meetings (a sub-committee of the trust board).

The organisation was able to provide evidence of meeting minutes prior to and during the assessment visit (HSW agenda for 30/9/14 and minutes from the Estates and Facilities Management team meeting on 25/9/14)

Rating

Green

Standard

2.5 The organisation has an ongoing programme of work to raise awareness of security measures and security management in order to create a pro-security culture among all staff, across all sites. This programme of work will be reviewed, evaluated and updated as appropriate to ensure that it is effective.

The LSMSs presented a monthly security update to all new staff during induction training provided by the Corporate Learning and Development department. A dedicated 30 minute slot was included for the LSMS to provide an overview of security management. This initial introduction to security management was updated annually through e-learning and a face to face refresher event after staff have been in post for 3 years. The LSMSs indicated that feedback was provided but no evidence was seen to support this.

The LSMS worked together with their LCFS colleague to promote an anti-crime week which was held in February 2015, and documentation was seen on site to support this. This is positive, however when we asked the LSMSs what the feedback was in relation to this event they indicated that there was no feedback taken or evaluation conducted. It is important that after such an event that

feedback and evaluation is undertaken in order to assess the effectiveness of the event i.e. what went well, what did not, and what could be improved for future events.

There was evidence of security awareness sessions provided to departments at York and Scarborough hospitals (to bed-managers).

The organisation had an intranet system called 'Horizon' however there was no dedicated security management page. This was an opportunity lost to promote security awareness and to inform staff of the role of the LSMS. The LSMSs indicated that articles were provided in the monthly 'Staff Brief' newsletter which was welcomed, however at the time of the assessment we were not provided with any examples in evidence.

The organisation should consider creating a dedicated security management intranet page, which can provide information on the role of the LSMS, reporting arrangements and links to relevant policies, such as the Security policy, the Lone Workers policy and the Violence and Aggression policy.

The organisation could consider writing monthly articles within the 'Staff Brief' to promote the role of the LSMS.

It should be noted that during the assessment visit we spoke with a number of staff across a number of wards. When asked 'Did they know who the LSMS is and what does the LSMS do?' no staff indicated that they knew the LSMS or the role of the LSMS. This demonstrated that work must be undertaken at local ward level to raise awareness of security management and the LSMS. It was encouraging however that all the staff spoken with, when asked about reporting arrangements knew the process to do so (Datix).

Rating
Amber

Standard	Recommended action	
2.5	The organisation must evaluate the effectiveness of its security management awareness work to ensure resources are being used effectively. Levels of staff awareness should be measured.	
Deadline for completion	**Organisation Response/Action Plan**	**Responsible Officer**

Standard

2.6 All staff know how to report a violent incident, theft, criminal damage or security breach. Their knowledge and understanding in this area is regularly checked and improvements in staff training are made where necessary.

The organisations incident reporting system was DATIX at the time of the assessment. Incident reporting was covered as part of the staff induction, e-learning and refresher training. Since DATIX was first introduced into the organisation in 2010 there was evidence of over 151,000 incident reports logged on the system, this would indicate knowledge and understanding of how to report incidents.

The LSMS interrogated DATIX on a monthly basis and trend analysis reports had been provided as evidence to support this standard. During the assessment visit we spoke with a number of staff across a number of wards and all staff spoken to confirmed that they knew how to report incidents of violence, theft and criminal damage.

The LSMS explained that trend analysis of incident reports following a series of thefts from within Scarborough hospital led to a joint investigation with North Yorkshire Police resulting in the arrest of a member of staff who was, at the time of the assessment on police bail. This was positive and demonstrates the effectiveness of incident reporting.

Rating

Green

Standard

2.7 All staff who have been a victim of a violent incident have access to support services should they require it.

The organisation had an occupational health department which provided a full range of support services to staff, which included counselling.

Support services were covered within a number of policies and procedures which included the Violence and Aggression Policy, Supporting Staff Policy and Responding to Violence staff procedure. Support services through occupational health were used effectively to support a member of staff (LH) following a case of harassment.

We were able to speak with a number of staff during the visit all of which said they knew about the services offered by the occupational health department.

Rating

Green

Hold to Account

York Teaching Hospitals NHS Foundation Trust meets standard; 4.2

York Teaching Hospitals NHS Foundation Trust partially meets standard; 4.3

York Teaching Hospitals NHS Foundation Trust does not meet standards; 4.1 and 4.4

Standard

4.1 The organisation is committed to applying all appropriate sanctions against those responsible for acts of violence, security breaches, theft and criminal damage.

There were a number of policies which reflected security management requirements. These included the Security Policy, Lone Workers Policy and Violence and Aggression Policy. However there was little evidence written within these policies which demonstrated the organisational commitment to applying all appropriate sanctions.

The organisation was able to demonstrate that a number of sanctions had been obtained (incidents involving the following persons; LH, SA and DT), which is encouraging. However the work undertaken had not been systematically applied to all incidents.

It is important that the organisation remembers to record the decision making processes on a case by case basis, as some incidents may not be suitable for sanction action. DATIX can be used to record such decisions made and this will lead to a consistent approach being applied on a case by case basis.

Rating

Red

Standard	Recommended action
4.1	The organisation should reinforce its commitment to applying the full range of appropriate sanctions to those found responsible for acts of violence, theft and criminal damage through policy and procedural documents. The organisation should record its decision making process on a case by case basis to ensure a consistent approach. This could be done via entries made to the DATIX incident reporting

	system. Subsequent publicity (where appropriate) should follow successful outcomes. This will act as deterrence to others, and reinforces the organisations commitment.	
Deadline for completion	Organisation Response / Action Plan	Responsible Officer

Standard
4.2 The organisation has arrangements in place to ensure that allegations of violence, theft and criminal damage are investigated in a timely and proportionate manner and these arrangements are monitored, reviewed and evaluated.
The organisation used the DATIX incident reporting system to record security incidents. All incidents that were tagged as violence and aggression or security were emailed directly to the LSMS for monitoring and action. All incidents reported to the LSMS were reviewed on a weekly basis with a log provided which highlighted incident reports which had not been actioned or progressed. Trend analysis was conducted monthly which supported security risk assessment work and informed future work planning.
Rating
Green

Standard
4.3 Where appropriate, the organisation publicises successful prosecutions of cases relating to a) denying unnecessary access to premises b) the consequences of assaulting NHS staff c) breaching the security of NHS premises and property d) acts of theft and criminal damage.
The organisation was able to evidence successful outcomes being publicised within the local press and online (Whitby Gazette, Daily Mail and Yorkpress.co.uk). However, opportunities to publicise sanctions internally were lost as there was no evidence of successful outcomes recorded in the organisations newsletter 'Staff Brief' or on the Intranet system.

The LSMSs said that there was no dedicated security management page built into the Intranet. This is something the organisation should create and use effectively. A dedicated security management page can support awareness of security management issues, the role of the LSMS and provide staff with relevant information on reporting and sanctions. Effective publicity can act as a deterrence to others and helps to support the organisations commitment to applying all appropriate sanctions.
Rating
Amber

Standard	Recommended action	
4.3	The organisation should have an effective communications strategy which will describe the processes to follow when sanctions are achieved and the publicity methods which could be used to act as a deterrent to others. The effectiveness of this strategy should be monitored and evaluated.	
Deadline for completion	Organisation Response / Action Plan	Responsible Officer

Standard
4.4 The organisation has a clear policy on the recovery of financial losses incurred due to any theft of, or criminal damage to, its assets and can demonstrate its effectiveness.
There was no evidence provided of a clear policy on the recovery of financial losses incurred due to theft and or criminal damage. The organisation was able to demonstrate that there was some activity to recover losses (compensation for criminal damage) however the activity was not conducted in a clear, comprehensive or timely manner. Following the assessment visit the LSMS was provided with an example of a sanctions and redress policy which could be adapted for use within the organisation.
Rating
Red

Standard	Recommended action	
4.4	The organisation should ensure that any money lost is recovered and reinvested for patient care. The organisation must have a clear policy on the recovery of financial losses, and this process should be measured for effectiveness.	
Deadline for completion	Organisation Response / Action Plan	Responsible Officer

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 October 2015

Monitor quarter 2 submission

Action requested/recommendation

The Board is asked to consider the information and approve the submission to Monitor at the end of the month.

Summary

The Trust is required to submit the quarter 2 return at the end of the month.

The position being submitted is as follows:

Continuity of Services rating (CoSR) 3. The finance report and attached appendix confirms the position.

Governance – there are a number of targets that have not been achieved this quarter including:

A&E 4 hour target
Cancer 62 Day for first treatment
Cancer 2 weeks (all cancers)
C-Diff

(Please note that the figures included in the return for Cancer are un-validated and will be confirmed during November.)

Attached are copies of the submission documents.

The Trust continues to comply with the standard licence conditions as required by the Risk Assessment Framework and Monitor Provider Licence.

The Chair and I will review the final supporting letter on behalf of the Board and confirm the letter prior to the submission being made to Monitor.

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

Implications for equality and diversity

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

Reference to CQC outcomes

This paper supports the overall principles of the CQC outcomes.

Progress of report	Board of Directors
Risk	The risks are associated to the financial position and performance.
Resource implications	None identified.
Owner	Patrick Crowley, Chief Executive
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	October 2015
Version number	Version 1

Click to go to index

Summary of Financial Statements for York Teaching Hospital NHS Foundation Trust

	Plan For YTD ending 30-Sep-15	Actual For YTD ending 30-Sep-15	Variance For YTD ending 30-Sep-15	Plan For Year ending 31-Mar-16	Simple Forecast Year ending 31-Mar-16	Adjusted Forecast Year ending 31-Mar-16	Forecast Variance Year ending 31-Mar-16
Summary Income and Expenditure Account							
Operating income (inc in EBITDA)							
NHS Clinical income	200.283	206.556	6.273	404.804	411.076	416.396	11.592
Non-NHS Clinical income	1.388	1.350	(0.038)	2.776	2.738	2.700	(0.076)
Non-Clinical income	22.664	25.308	2.644	45.328	47.972	49.900	4.572
Total	**224.335**	**233.214**	**8.879**	**452.907**	**461.786**	**468.996**	**16.089**
Operating expenses (inc in EBITDA)							
Employee expense	(146.917)	(159.801)	(12.884)	(295.371)	(308.255)	(314.561)	(19.190)
Non-Pay expense	(70.986)	(71.081)	(0.095)	(142.483)	(142.578)	(141.971)	0.512
PFI / LIFT expense	-	-	-	-	-	-	-
Total	**(217.903)**	**(230.882)**	**(12.979)**	**(437.854)**	**(450.833)**	**(456.532)**	**(18.678)**
EBITDA	6.432	2.332	(4.100)	15.053	10.954	12.464	(2.589)
EBITDA Margin %	2.87%	1.00%	(1.87%)	3.32%	2.37%	2.66%	(0.67%)
Operating income (exc from EBITDA)							
Donations and Grants for PPE and intangible assets	0.300	0.370	0.070	0.600	0.670	0.739	0.139
Operating expenses (exc from EBITDA)							
Depreciation & Amortisation	(5.500)	(5.500)	-	(11.000)	(11.000)	(11.000)	-
Impairment (Losses) / Reversals	-	-	-	(0.300)	(0.300)	(0.300)	-
Restructuring costs	-	(0.033)	(0.033)	-	(0.033)	(0.400)	(0.400)
Total	**(5.500)**	**(5.533)**	**(0.033)**	**(11.300)**	**(11.333)**	**(11.700)**	**(0.400)**
Non-operating income							
Finance income	0.050	0.081	0.031	0.100	0.131	0.156	0.056
Gain / (Losses) on asset disposals	-	-	-	-	-	-	-
Gain on transfers by absorption	(4.500)	0.003	4.503	(4.500)	0.003	(4.497)	0.003
Other non - operating income	-	-	-	-	-	-	-
Total	**(4.450)**	**0.084**	**4.534**	**(4.400)**	**0.134**	**(4.341)**	**0.059**
Non-operating expenses							
Interest expense (non-PFI / LIFT)	(0.162)	(0.150)	0.012	(0.323)	(0.312)	(0.303)	0.021
Interest expense (PFI / LIFT)	-	-	-	-	-	-	-
PDC expense	(3.520)	(3.520)	-	(7.040)	(7.040)	(7.040)	-
Other finance costs	-	(0.009)	(0.009)	-	(0.009)	(0.019)	(0.019)
Non-operating PFI costs (e.g. contingent rent)	-	-	-	-	-	-	-
Losses on transfers by absorption	-	-	-	-	-	-	-
Other non-operating expenses (including tax)	-	-	-	-	-	-	-
Total	**(3.682)**	**(3.679)**	**0.003**	**(7.363)**	**(7.361)**	**(7.362)**	**0.002**
Surplus / (Deficit) after tax	**(6.900)**	**(6.427)**	**0.473**	**(7.410)**	**(6.937)**	**(10.200)**	**(2.791)**
Profit/(loss) from discontinued Operations, Net of Tax	-	-	-	-	-	-	-
Surplus / (Deficit) after tax from Continuing Operations	**(6.900)**	**(6.427)**	**0.473**	**(7.410)**	**(6.937)**	**(10.200)**	**(2.791)**

Memorandum Lines:							
Surplus / (Deficit) before impairments and transfers	(2.400)	(6.430)	(4.030)	(2.610)	(6.640)	(5.403)	(2.794)
One off income/costs	(4.500)	(0.030)	4.470	(4.800)	(0.330)	(5.197)	(0.397)
Normalised Surplus / (Deficit)	(2.400)	(6.396)	(3.997)	(2.610)	(6.606)	(5.003)	(2.393)
Normalised Surplus / Deficit Margin %	(1.09%)	(2.74%)	(1.65%)	(0.58%)	(1.43%)	(1.07%)	(0.49%)
Summary Statement of Financial Position							
Non-current Assets							
Intangible assets	2.460	2.121	(0.339)	3.403	3.064	3.064	(0.339)
Property, Plant & Equipment	226.447	230.965	4.518	233.081	237.599	237.599	4.518
On-balance sheet PFI	-	-	-	-	-	-	-
Other	1.087	1.087	-	1.087	1.087	1.087	-
Total	**229.994**	**234.173**	**4.179**	**237.571**	**241.750**	**241.750**	**4.179**
Current Assets							
Cash and cash equivalents	17.659	9.180	(8.479)	18.465	9.986	9.986	(8.479)
Other current assets	27.273	40.012	12.739	27.273	40.012	40.012	12.739
Total	**44.932**	**49.192**	**4.260**	**45.738**	**49.998**	**49.998**	**4.260**
Current Liabilities							
Overdrafts and drawdowns in committed facilities	-	-	-	-	-	-	-
PFI / LIFT leases	-	-	-	-	-	-	-
Other borrowings	(1.434)	(1.434)	-	(2.001)	(2.001)	(2.001)	-
Other current liabilities	(32.492)	(41.505)	(9.013)	(33.657)	(42.670)	(42.670)	(9.013)
Total	**(33.926)**	**(42.939)**	**(9.013)**	**(35.658)**	**(44.671)**	**(44.671)**	**(9.013)**
Non-current Liabilities							
PFI / LIFT leases	-	-	-	-	-	-	-
Other borrowings	(17.934)	(16.834)	1.100	(20.095)	(18.995)	(18.995)	1.100
Other non-current liabilities	(1.115)	(1.169)	(0.054)	(1.115)	(1.169)	(1.169)	(0.054)
Total	**(19.049)**	**(18.003)**	**1.046**	**(21.210)**	**(20.164)**	**(20.164)**	**1.046**
Reserves	221.951	222.424	0.473	226.441	226.914	226.914	0.473
Summary Statement of Cash Flows							
Surplus (Deficit) from Operations	1.232	(2.832)	(4.064)	4.353	0.290	1.502	(2.851)
Operating activities							
Non-operating and non-cash items in operating surplus/(deficit)	5.500	5.500	-	11.300	11.300	11.300	-
Operating Cash flows before movements in working capital	**6.732**	**2.668**	**(4.064)**	**15.653**	**11.590**	**12.802**	**(2.851)**
Movements in working capital	0.060	(4.964)	(5.024)	0.052	(4.972)	(4.972)	(5.024)
Increase/(Decrease) in non-current provisions	-	0.054	0.054	-	0.054	0.054	0.054
Net cash inflow/(outflow) from operating activities	**6.792**	**(2.242)**	**(9.034)**	**15.705**	**6.672**	**7.884**	**(7.821)**
Investing activities							
Capital Expenditure (Accruals basis)	(11.308)	(10.983)	0.325	(23.186)	(22.861)	(22.861)	0.325
Increase/(decrease) in Capital Creditors	-	1.298	1.298	1.173	2.471	2.471	1.298
Proceeds on disposal of PPE, intangible assets and investment property	-	0.237	0.237	0.500	0.737	0.737	0.237
Other cash flows from investing activities	0.050	0.073	0.023	0.100	0.123	0.123	0.023
Net cash inflow/(outflow) from investing activities	**(11.258)**	**(9.375)**	**1.883**	**(21.413)**	**(19.530)**	**(19.530)**	**1.883**

Financing activities							
Public Dividend Capital repaid	-	-	-	-	-	-	-
Repayment of borrowings	(0.630)	(0.630)	-	(1.258)	(1.258)	(1.258)	-
Capital element of finance lease rental payments	(0.054)	(0.054)	-	(0.054)	(0.054)	(0.054)	-
Interest element of finance lease rental payments	-	-	-	-	-	-	-
Interest paid on borrowings	(0.163)	(0.153)	0.010	(0.324)	(0.314)	(0.314)	0.010
Other cash flows from financing activities	4.479	3.142	(1.337)	7.316	5.979	5.979	(1.337)
Net cash inflow/(outflow) from financing activities	**3.632**	**2.305**	**(1.327)**	**5.680**	**4.353**	**4.353**	**(1.327)**
Opening cash and cash equivalents less bank overdraft	18.493	18.493	-	18.493	18.493	18.493	-
Net cash increase / (decrease)	(0.834)	(9.312)	(8.478)	(0.028)	(8.505)	(7.293)	(7.265)
Changes due to transfers by absorption	-	-	-	-	-	-	-
Closing cash and cash equivalents less bank overdraft	**17.659**	**9.181**	**(8.478)**	**18.465**	**9.988**	**11.200**	**(7.265)**

Financial Sustainability Risk Rating

Capital Service Cover

Revenue Available for Capital Service	6.482	2.413	(4.069)	15.153	11.085	12.620	(2.533)
Capital Service	(4.366)	(4.363)	0.003	(8.675)	(8.673)	(8.674)	0.002
Capital Service Cover metric	1.48	0.55	(0.93)	1.75	1.28	1.46	(0.29)
Capital Service Cover rating	**2**	**1**		**2**	**2**	**2**	

Liquidity

Working Capital for FSRR	4.166	(1.019)	(5.185)	3.240	(1.945)	(1.945)	(5.185)
Operating Expenses within EBITDA, Total	(217.903)	(230.882)	(12.979)	(437.854)	(450.833)	(456.532)	(18.678)
Liquidity metric	3.441	(0.794)	(4.236)	2.664	(1.553)	(1.534)	(4.198)
Liquidity rating	**4**	**3**		**4**	**3**	**3**	

I&E Margin

Normalised Surplus/(Deficit)	(2.400)	(6.396)	(3.997)	(2.610)	(6.606)	(5.003)	(2.393)
Adjusted Total Income for FSRR	224.685	233.665	8.980	453.607	462.587	469.890	16.283
I&E Margin	(1.07%)	(2.74%)	(1.67%)	(0.58%)	(1.43%)	(1.06%)	(0.49%)
I&E Margin rating	**1**	**1**		**2**	**1**	**1**	

I&E Margin Variance

I&E Margin	(1.07%)	(2.74%)	(1.67%)	(0.58%)	(1.43%)	(1.06%)	(0.49%)
I&E Margin Variance From Plan	(1.12%)	-1.67%		(1.12%)	(0.85%)	(0.49%)	
I&E Margin Variance From Plan rating	**2**	**2**		**2**	**3**	**3**	

Overall Financial Sustainability Risk Rating	**2**	**2**		**3**	**2**	**2**	

Continuity of Service Risk Rating

CIPs

CIPs as a percentage of opex within EBITDA less PFI expenses	5.58%	5.02%	(0.56%)	5.56%	5.27%	5.21%	(0.35%)
CIPs	12.878	12.207	(0.671)	25.755	25.084	25.084	(0.671)

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Declaration of risks against healthcare targets and indicators for 201516 by York Teaching Hospit

Targets and indicators as set out in the Risk Assessment Framework (RAF) - definitions per RAF Appendix A *NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.*	Threshold or target YTD	Quarter 2 Performance	Quarter 2 Declaration	Quarter 2 Comments / explanations
Target or Indicator (per Risk Assessment Framework)				
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	93.8%	Achieved	
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	91.5%	Not met	
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	84.8%	Not met	These figures are un validated
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	95.0%	Achieved	These figures are un validated
Cancer 31 day wait for second or subsequent treatment - surgery	94%	95.3%	Achieved	These figures are un validated
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	99.6%	Achieved	These figures are un validated
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	0.0%	Not relevant	
Cancer 31 day wait from diagnosis to first treatment	96%	98.9%	Achieved	These figures are un validated
Cancer 2 week (all cancers)	93%	91.9%	Not met	These figures are un validated
Cancer 2 week (breast symptoms)	93%	94.0%	Achieved	These figures are un validated
C.Diff due to lapses in care (YTD)	29.5	14	Not met	
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	N/A	Achieved	
Community care - referral to treatment information completeness	50%	100.0%	Achieved	
Community care - referral information completeness	50%	70.8%	Achieved	
Community care - activity information completeness	50%	95.5%	Achieved	
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A		No	
Date of last CQC inspection	N/A		31/03/2015	
CQC compliance action outstanding (as at time of submission)	N/A		No	
CQC enforcement action within last 12 months (as at time of submission)	N/A		No	
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		Yes	
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No	
Overall rating from CQC inspection (as at time of submission)	N/A		Requires improvement	
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		No	
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No	
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A		N/A	

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In Year Governance Statement from the Board of York Teaching Hospital NHS Foundatior

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (see notes below)

Board Response

For finance, that:

The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months. — **Confirmed**

The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return. — **Confirmed**

For governance, that:

The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards. — **Confirmed**

Otherwise:

The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, Table 3) which have not already been reported. — **Confirmed**

Consolidated subsidiaries:

Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds. — 0

Signed on behalf of the board of directors

Signature	Sign Here.	Signature	Sign Here.
Name	Susan Symington	Name	Patrick Crowley
Capacity	Chairman	Capacity	Chief Executive
Date		Date	

Responses still to complete: 0

Notes:

Monitor will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to Monitor to arrive by the submission deadline.
In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.
This may include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.
Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A

B

C