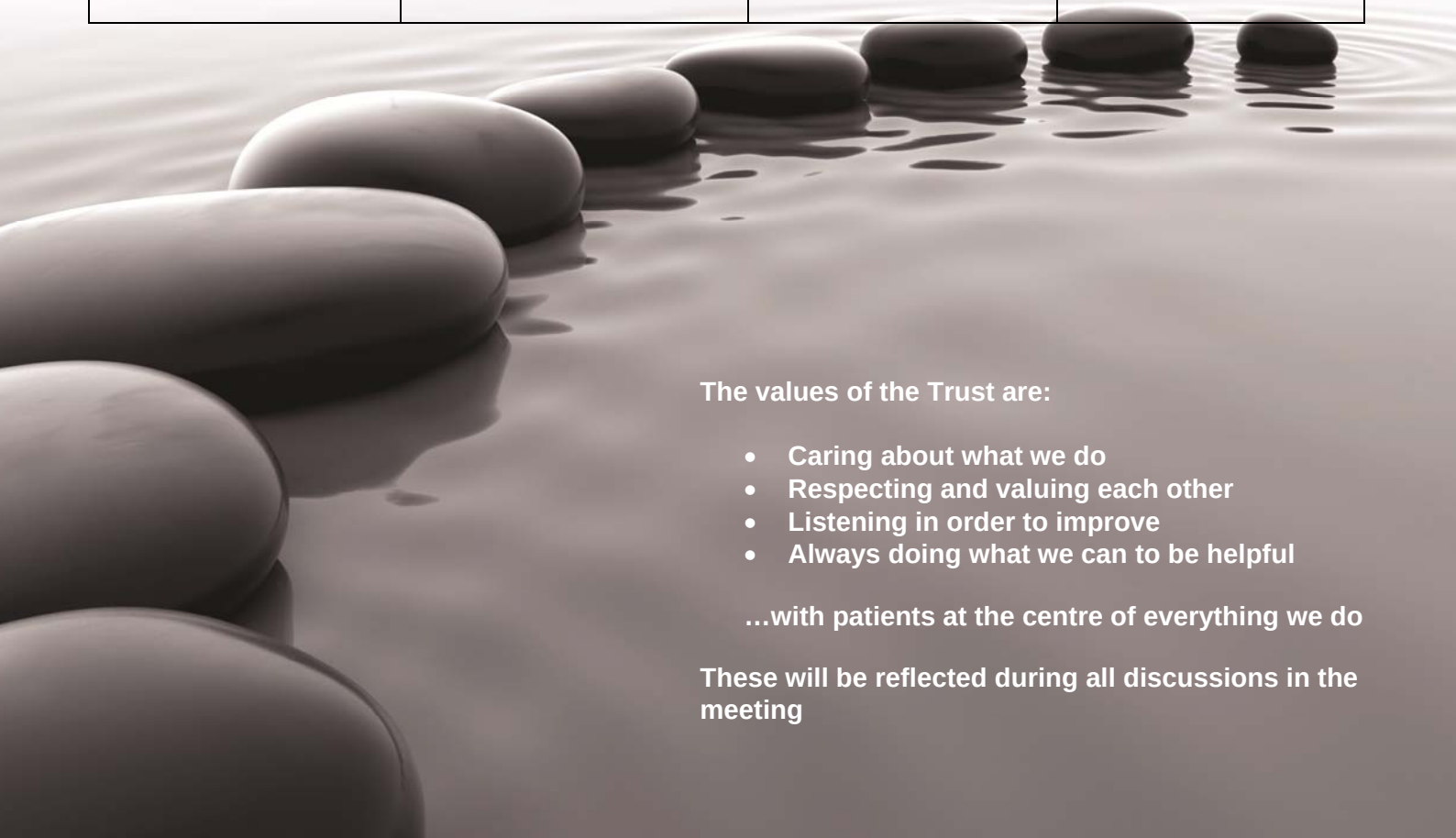
York Teaching Hospital NHS
NHS Foundation Trust

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

on: **Wednesday 29 June 2016**

in: The Conference Room, St Catherine's Hospice, Scarborough

Time	Meeting	Location	Attendees
8.15am – 8.55am	Non-Executive Director Meeting with Chair	Room 1, Conference Centre, St Catherine's Hospice, Scarborough	Non-executive Directors
9.00am – 10.00am	Board of Directors meeting held in private	The Conference Room, St Catherine's Hospice, Scarborough	Board of Directors
10.10am – 11.30am	Discussion on Capital Programme Led by B Golding	The Conference Room, St Catherine's Hospice, Scarborough	Board of Directors
11.30am – 12.45pm	Walkround Scarborough development site and Emergency Department at Scarborough Led by B Golding	Scarborough Hospital	Board of Directors
12.45pm – 1.30pm	Lunch	The Conference Room, St Catherine's Hospice, Scarborough	Board of Directors
1.30pm – 4.00pm	**Board of Directors meeting held in public**	**The Conference Room, St Catherine's Hospice, Scarborough**	**Board of Directors and the general public**



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

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

On: **Wednesday 29 June 2016**

At: **1.30pm – 4.00pm**

In: **The Conference Room, St Catherine's Hospice, Scarborough**

A G E N D A					
No	***Time***	***Item***	***Lead***	***Paper***	***Page***
General					
1.	1.30-1.40	**Welcome from the Chairman** The Chair will welcome observers to the Board meeting.	Chair		
2.		**Apologies for Absence and Quorum** • Sue Rushbrook	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 25 May 2016** To review and approve the minutes of the meeting held on 25 May 2016.	Chair	B	11
5.		**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chair		
6.	1.40-1.55	**Patient Story** Inpatient Survey – a presentation on the results of the inpatient survey given by Hester Rowell	Chief Nurse Hester Rowell (Patient Experience Lead)	Verbal	

No	Time	Item	Lead	Paper	Page
Our Quality and Safety Ambition: Out patients must trust us to deliver safe and effective healthcare					
7.	1.55 – 2.15	**Chief Executive Report** To receive an update on matters relating to general management in the Trust.	Chief Executive	C	27
8.		**Sustainable Transformation Plan update** To receive and update on the development of the Sustainable and Transformation Plan	Chief Executive	Verbal	
9.	2.15 - 2.40	**Quality and Safety Performance issues** To receive the minutes from the last meeting of the Committee and key reports • Patient and Quality Safety Report • Medical Director Report • Chief Nurse Report • Safer Staffing	Chair of the Committee	D D1 D2 D3 D4	35 49 93 99 117
10.		**In patient Survey** To receive a report on the Inpatient survey (this is linked to the Patient Story presentation)	Chief Nurse	E	127
2.40 - 2.50		**Tea break**			
Our Finance and Performance ambitions: Our Sustainable future depends on providing the highest standards of care within our resources					
11.	2.50 - 3.10	**Finance and Performance issues** To receive the minutes from the last meeting of the Committee and key reports: • Finance Report • Efficiency Report • Performance Report	Chair of the Committee	F F1 F2 F3	135 149 167 175

No	Time	Item	Lead	Paper	Page
12.	3.10 - 3.20	**Corporate Governance Statement** To consider and approval the Corporate Governance Statement prior to submission to Monitor.	Foundation Trust Secretary	G	183
13.		**Amendment to the Constitution** The Board is asked to confirm the proposed amendment to the Constitution.	Chairman	H	197
Our People and Capability Ambition: The quality of our services is wholly dependent on our teams of staff					
14.	3.20-3.30	**Workforce Metrics and Update Report** To receive a report updating the Board on HR issues.	Chief Executive	I	201
Our Facilities and Environment Ambitions: We must continually strive to ensure that our environment is fit for our future					
15.	3.30-3.55	**Environment and Estates Committee** To receive an update from the Chair of the Committee and to receive the following reports: • Health and Safety Annual Report • Fire Safety Annual Report • RIDDOR Annual Report	Chair of the Committee	J J1 J2 J3	213 215 239 245
Any Other Business					
16.	3.55-4.00	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 27 July 2016 in Bridlington Hospital. There will be no public Board held in August, but the Board will meet to discuss Dementia issues at Joseph Rowntree on 24 August 2016. The AGM is arranged for 7 September 2016 in York at 5pm. This will be followed by the AGM being held in Scarborough on 8 September 2016 at 10am.			
17.		**Any other business** To consider any other matters of business.			

Items for decision in the private meeting:

- The draft five year financial model projections
- Business cases related to service developments

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.

York Teaching Hospital NHS
NHS Foundation Trust

Additions: Susan Symington—member of the Court of University of York

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	**Member—**the Court of University of York	Nil
Jennifer Adams (Non-Executive Director)	**Non-executive Director** Finance Yorkshire PLC	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Philip Ashton (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Member of the Board of Directors—** Diocese of York Education Trust **Member of the Board of Directors—**William Temple Academy Trust	Nil	Nil
Ms Libby Raper (Non-Executive Director)	**Director—**Yellowmead Ltd	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Governor** —Leeds City College **Chairman and Director** - Leeds College of Music **Member—**The University of Leeds Court	Nil
Michael Keaney (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

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

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

B

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Boardroom York Hospital on 25 May 2016

Present:

Non-executive Directors:

Ms S Symington	Chair
Mrs J Adams	Non-executive Director
Mr P Ashton	Non-executive Director
Mr M Keaney	Non-executive Director
Ms L Raper	Non-executive Director
Mr M Sweet	Non-executive Director
Professor D Willcocks	Non-executive Director

Executive Directors:

Mr P Crowley	Chief Executive
Mr A Bertram	Director of Finance
Mrs B Geary	Chief Nurse
Mr M Proctor	Deputy Chief Executive
Mr J Taylor	Medical Director
Mrs J Walters	Chief Operating Officer

Corporate Directors:

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

In Attendance:

Mr M McGale	Deputy Chief Operating Officer
Mrs A Pridmore	Foundation Trust Secretary

Observers:

Mrs A Bolland	Public Governor – Selby
Mrs M Jackson	Public Governor – York
Mrs M Liley	Member of staff (
Mrs L Pratt	Healthwatch – York
Mr J Todd	Member of staff (Directorate Manager for the Elderly Directorate)
Mrs L Fry	Member of staff (Matron for the Elderly Directorate)
Ms S Plant	Member of staff (Specialist Nurse for Organ Donation)
Mr J Berridge	Member of staff (Clinical Lead Organ Donation)
Mr N Wilson	Member of staff (Deputy Director of Strategy)

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

16/066 Apologies for absence

Apologies were received from Mr M Proctor, Deputy Chief Executive and Mrs J Walters, Chief Operating Officer

Ms Symington asked Mrs Pridmore to confirm that the meeting was quorate. Mrs Pridmore confirmed that the meeting was quorate.

16/067 Declarations of interest

The Board noted the declarations of interest. Mrs Symington declared she had been appointed a member of the Court of the University of York. It was agreed the declaration would be included in the next version of the document.

Action: Mrs Pridmore to update the Declarations of Interest document with the recent declaration from Ms Symington.

16/068 Minutes of the meeting held on the 27 April 2016

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

16/069 Matters arising from the minutes

There were no additional matters arising from the minutes.

Mrs Symington advised that the Board had had the pleasure of having lunch in Elerby's Restaurant and tasting the food provided to the patients at lunchtime. Mr Golding explained that he would like to receive some feedback and suggested that Board members complete the back of the menu list with any comments and forward them to him.

Action: Board members to complete the information on the back of the menu and provide any comments to Mr Golding.

16/070 Patient Story

Ms Symington advised that this month there were two patient stories. The first was supported by Mrs Geary and the second was supported by Mr Keaney.

Mrs Geary welcomed Mr Todd (Directorate Manager for Elderly) and Mrs Fry (Matron to the Elderly Directorate) to present their story. Mr Todd reminded the Board of some of the challenges in the system relating to the access to appropriate care for patients who do not need to continue to stay in hospital. He explained that, particularly over the winter period, the Trust struggled to access appropriate and timely on-going care, some of the most critical being packages of care for patients with a mental health problem.

Mrs Fry presented the story of a patient (Martin) who died in hospital 338 days after being admitted to hospital.

Mrs Fry explained how and why Martin had been admitted to hospital. She outlined Martin's behaviour following the onset of his illness and described the level of frustration being felt by Martin.

Mrs Fry explained that the medical team supporting Martin asked for a mental health assessment, so he was transferred to Ward 37. The assessment showed that Martin would not be able to return home and a placement in alternative accommodation was sought. Martin was assessed as being eligible for continuing health care (CHC) funding due to his condition. Unfortunately as Martin's needs were complex, no one was immediately identified as able to provide the level of care needed, so Martin remained on the ward. The Discharge Liaison Team contracted a local nursing home that had experience of looking after patients with complex needs, but there was no immediate room and Martin was placed on the nursing home's waiting list. When the local Mental Health Community Unit closed any available beds at the home were prioritised for those patients who had been in the Mental Health Community Unit, so Martin remained in hospital. The only time Martin left the ward during his 338 days in hospital was to attend an ENT clinic. Martin died on day 338.

Mr Todd explained that sadly, the case described was not an isolated case. There were challenges in the system which regularly delayed patients moving out of hospital. Mr Todd added that the Commissioners had been made aware of the issues. Mr Todd explained that to progress a resolution to the challenges a multi-stakeholder meeting and review of some of the delays had been arranged.

Mrs Rushbrook added that currently 13 patients had been on ward 37 for more than 28 days and that the average length of stay on the ward was more than 50 days. 50% of those patients were deemed medically fit to be discharged.

Mrs Adams asked if Mrs Fry would tell the Board about the work the ward had been involved with in reducing falls. Mrs Fry outlined the initiatives that had been introduced by the ward which included:

- Checks being undertaken every 15 minutes which were incorporated in to the comfort rounds.
- Patients were being nursed in cohorts so that staff made sure that the patients who were at the greatest risk of falling were closest to the nurses station.

Professor Willcocks asked how the ward worked with the volunteers. Mrs Fry explained that the ward used the volunteers to help with distraction therapy. The volunteers talked to patients and encouraged people to talk about their memories.

The Board thanked Mr Todd and Mrs Fry for the patient story.

Mr Keaney was invited to present his patient story. Mr Keaney explained that this was about the family of a patient whose experience was as a result of some dedicated staff and unusual circumstances. Mr Keaney invited Ms Plant and Mr Berridge to present the story.

Ms Plant explained that the story related to a patient who had arrived in the Emergency Department in March 2016 with an untreatable terminal condition. The Emergency Department Consultant in charge of the patient's care explained to the family that the

patient's condition was an untreatable terminal condition and started discussions with the family about organ donation. The Specialist Nurse was asked to attend the department and support the family and patient. Normally where a patient's family has confirmed that the patient would want to donate their organs the patient is treated in the Intensive Care Unit, Emergency Department or Post Anaesthetic Care Unit. On this occasion, the Post Anaesthetic Care Unit did not have capacity to take another patient; the Emergency Department and the Intensive Care Unit were also very busy with no spare capacity. The patient's family was advised and understood the challenges, but were keen if possible for the patient's organs to be used. The Theatre Coordinator became involved and found a theatre that was not being used, which would be private and would be a clinically appropriate area. Appropriate nursing staff to support the patient and the family was arranged. The family were kept informed about the plans and were part of the decision making process. When the patient passed away it was peaceful and dignified for the patient and the family. As the patient was already in a theatre the staff could retrieve the organs more quickly than would be have been the case if the patient had been in another area of the hospital.

Ms Plant advised that last financial year 19 organs were retrieved, 18 of which were working well and had saved lives. Mr Berridge added that as a result of the arrangements being made for this patient, the Trust was in the process of changing its standard operating procedure.

Mr Crowley asked where the Trust stood when compared with other Trusts. Ms Plant advised that the Trust was average in terms of organ donation, but new procedures were being set up to increase the identification of organ donors.

Mrs Symington thanked all contributors to this section of the agenda and reminded the Board that those stories set tone for the Board.

16/071 Report from the Chief Executive

Mr Crowley advised that his time recently had been dominated by the Sustainability Transformation Plan (STP). He explained that he had spent time promoting the importance of the STP in the wider patch.

Mr Crowley referred to the Board Assurance Framework at a Glance document that was appended to his report and reminded the Board that the document would be part of the Board papers on a monthly basis to support the Board in ensuring that it concentrated on the key risks and issues the Trust was managing.

Mr Crowley referred to the energy centre that had been opened in Bridlington and advised that the sustainability processes in place in the Trust were now leading edge and ahead of other organisations. He confirmed that the Trust would open a similar centre in Scarborough in the near future.

Mr Crowley referred to the general news section of his report and highlighted that the Junior Doctor's dispute seemed to be coming to a conclusion. Discussions were now being held about the Consultant's contract and GPs were starting their discussions around their contracts.

Mr Crowley commented that the removal of the Bridlington shuttle bus would not affect the Trust financially, but had created some unrest with the general public. He advised that the Trust was responding to the situation. He added that it should be noted that removal of the service was the decision of the Commissioners and not the Trust.

Ms Raper asked Mr Crowley to comment on the information around John's Campaign and how volunteers were being involved in the campaign. Mrs Geary explained that a member of the patient experience team (Kay Gamble) was leading the work with staff and would be linking into the volunteers; at this point the initiative was early in the development stage.

Mrs Adams asked about the CHKS top 40 awards and what the categories were. Mr Crowley advised that the Trust had received a top 40 award for the last 14 out of 15 years, since it became a member of CHKS. He advised the CHKS had offered a free presentation on how the awards are scored and the importance of being in the top 40. It was agreed Mr Crowley would circulate some information on the awards to Board members.

Action: Mr Crowley to circulate some information about the CHKS awards to Board members outside the Board meeting.

Mr Crowley asked Mrs Rushbrook to update the Board on a number of system and network issues.

Mrs Rushbrook updated the Board on the announcement by NHS England and Public Health England that they would no longer be collecting data centrally. She talked about the sharing of information protocols and explained that sharing information on a number of different applications created a number of challenges, but she acknowledged that it should not prevent information from being shared. She added that the CCG were keen to work with the Trust on sharing information using a commercial provider.

Mrs Rushbrook updated the Board on the development of the introduction of a public wi-fi in the Trust. She advised that a tender document had been prepared and the Trust would go out to tender soon. Mrs Rushbrook was concerned about the costs associated with the introduction of a free public wi-fi and advised that when Leeds introduced the free public wi-fi it had cost the organisation £80,000 per annum.

Mrs Rushbrook also updated the Board on the introduction of the Electronic Prescribing and Medicine Administration (EPMA) project. She reminded the Board that the system had been developed in house and had received scrutiny from NHS England. They had recently reviewed the whole package and were very impressed with the system. Mrs Rushbrook confirmed that there would be a short delay to the 'go live' date because there were some final adjustments to the system following comments that were received during the pilot stage.

The Board noted the updates form Mrs Rushbrook.

16/072 Quality and Safety Committee

Mrs Adams presented the minutes from the Quality and Safety Committee. She advised that the Committee had, as usual, reviewed the corporate risk registers of the Chief Nurse and the Medical Director and had tried to focus the Committee's agenda around these key risks. Mrs Adams reminded the Board that a number of reviews (CQC, Internal Governance, Well Led reviews) had highlighted some concerns around the process for identifying risks and their escalation to the corporate level. She was pleased to note from the Annual Governance statement that during the year work had been completed around addressing the concerns about risk management including improving the robustness of these important processes. Mrs Adams added that the Quality and Safety Committee had heard about the new Performance Management Meetings approach. Mrs Adams asked Mrs Geary to provide an overview for the Board on the process. Mrs Geary explained that the process took two full days. A number of executive directors were involved and the focus of the meetings was on all aspects of quality and performance of each directorate. She added that risk was a regular feature of the meetings and risk scores were challenged.

Mrs Adams asked Mrs Geary to comment on Nurse staffing matters. Mrs Geary updated the Board on Nurse Revalidation. She reminded the Board that Nurses were required to revalidate from 1 April 2016. The Trust had now put in place a support programme through the Learning Hub and was working in collaboration with the Royal College of Nursing (RCN) and the Royal College of Midwives (RCM). She advised that the feedback received from nurses who had been through the process had been very positive. They had found the process easy Mrs Geary confirmed the Trust would continue to provide support.

Mrs Adams added that last month the Board had heard about work around nurse and HCA recruitment. That work had continued and the Quality and Safety Committee was very pleased to have heard about the effort being put into this key area of risk for the Trust, both from a safety and a finance point of view. Mrs Adams added that there was a large amount of information about nurse staffing included in the Chief Nurse's report starting on page 102 of the Board pack and within the Nursing dashboards on page 110 and the Safer staffing return on page 129.

Mrs Adams highlighted that the Committee had understood that the escalation wards had not been closed. Mrs Adams advised that she first became aware of the issue when she took part in a Patient safety walk round the medical wards on the Scarborough site. On speaking to staff she had been made aware of the 'stress' it was creating for staff. She added that she believed that the same impact is being felt in York. Mrs Geary advised that two escalation wards were still open and staff were being redeployed as required on a shift by shift basis. Mrs Geary added that other than having an impact on staff on the ward the escalation wards remaining open was also affecting the Trust's ability to deep clean an area. Mrs Geary advised that the plan was that ward 24 would close in the near future, following which the Trust would be able to implement the deep clean plan, using ward 24 as the decant ward.

Mrs Adams commented on the Hospital Acquired Infections data. Mrs Adams advised that the Committee's attention was concentrated on the plans to refresh the work of the IPC team to integrate infection prevention more thoroughly into the day to day operation of the wards. Mrs Geary commented on the new governance structure that had been put in place and confirmed it was working well. Mrs Geary advised that the Trust was no longer an outlier for MSSA and good practice was being shared across the organisation. Mr Taylor commented on the additional work that was taking place to address the specific

issue related to ISSA – an infection that was linked to invasive devices like cannulas and catheters. He talked about the impact of devices and the introduction of new cannula and catheter devices.

Mrs Geary spoke about the prolonged outbreak of Norovirus in Scarborough and advised that it had been agreed that a look back exercise would be undertaken which would be led by the CCG. It was anticipated that the work would be completed by 30 June. In the interim, Mrs Geary assured the Board that internal practices had been reviewed and improvements had been made.

Mrs Adams commented about the safety items included in the Medical Director's report and in particular the subject of incident reporting. Mr Taylor confirmed that there was a low level of reporting amongst medical staff. He advised that work was underway to identify the blocks. He added that a temporary paper based system was being used to support and encourage more reporting. Mr Taylor advised that on discussion with the clinicians it had become evident that the main concern about the current DATIX system was the lack of feedback. Mr Taylor added that Adrian Evans (Associate Medical Director) was currently reviewing the systems and processes and discussing possible changes with clinicians.

Mrs Adams added that the Quality and Safety Committee was still concerned that it took between 6 and 9 months for the Executive Board and the Quality and Safety Committee to receive completed Serious Incident reports She added that the Committee was also concerned that the absolute number of incidents reported via our DATIX system seems to be low compared to peer organisations and had dropped off over the last few months. She advised that the Committee's final concern was about how DATIX incidents were allocated a level of harm and the lack of feedback to those that reported the incidents.

Mrs Adams referred to the quality priorities and advised that good progress had been made in some areas such as reducing falls that result in serious harm, compliance with protocols for acute kidney injury, and reducing the number of missed medications. She advised that key challenges remained around the achievement of timely senior reviews of patients, especially on the Scarborough site, and around how patients viewed the service they received within the Emergency Departments.

Mrs Adams commented that the Committee had received very positive updates on the work of the Child Safeguarding Team, particularly around raising awareness of safeguarding issues within the Emergency Department and on the wards, and also on the continued improvement in compliance with safeguarding training.

The Board thanked Mrs Adams for her report.

16/073 Trust Complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulation 2009

Mrs Adams advised that the Quality and Safety Committee had reviewed the annual complaints report, which showed a growing focus on analysis and learning from complaints, rather than simply improving the handling process.

The Board discussed the paper and noted the comments from the Quality and Safety Committee. The Board noted the report.

16/074 Out of Hospital Care Strategy

Mrs Scott presented the strategy and explained that it was presented for comment and approval. She advised that the strategy set out the aspirations of the Out of Hospital Care Directorate and the Trust's ambition to be an active partner in leading the development of systems across the health and social care sector. She advised that the strategy included the key priorities for the staff and stakeholders and how those would be taken forward during the current financial year and beyond.

Mrs Scott added that planning work to implement the strategy was being undertaken with the Provider Alliance Board. She added that the strategic expectation was that the way services were delivered would change.

Professor Willcocks commented that she was pleased to see the link between STP and the working model that had been included in the document.

Mr Sweet explained that he had been involved in some of the development of the strategy. He believed that the strategy reflected what the Trust and stakeholders were trying to achieve and that it fitted well with the national agenda.

It was recognised that for the strategy to be successful there would need to investment into the system.

Mrs Scott advised that before the strategy could be implemented, it would need to be shared with the Provider Alliance Board.

Mrs Adams was pleased to see that the strategy sought to ensure that the patient only had to tell their story once to staff.

Ms Symington felt the strategy was well written and provided a very good vision for how out of hospital services would be provided. She added that there would of course always be patients who need the service and care of the hospital.

16/075 Workforce and Organisational Development Committee

Professor Willcocks advised that the Workforce and Organisational Development Committee had undertaken a fundamental review of the work the Committee was engaged with and attached to the papers was a revised set of terms of reference and work programme for the Committee. Professor Willcocks highlighted the relationship of the duties of the Committee to both the 'Our Shared Commitment document and the Workforce and Organisational Development Strategy. The Board noted the changes and approved the terms of reference.

Professor Willcocks summarised the discussions from the last meeting of the Workforce and Organisational Development Committee. She advised that the Committee had agreed that at its next meeting in July it would receive a detailed paper on clinical appointments and medical workforce issues. Professor Willcocks advised that work was progressing well around e-rostering and Mrs Geary now had a senior nurse working with HR. Mrs Geary added that Mrs Hoskins (the senior nurse undertaking the e-rostering work with HR), would be holding a listening exercise with staff in the near future.

The Board discussed the importance of ensuring that e-rostering was working properly and recognised that some of the changes required were around culture.

Professor Willcocks highlighted that the Committee had reviewed two internal audit reports. She advised that progress had been made since the reports had been written, but it was recognised that there was still further work to complete.

The Board thanked Professor Willcocks and noted her report.

16/076 Workforce Report

Mr Crowley presented the Workforce Report. He highlighted that sickness absence rates were continuing to deteriorate. He advised that he had written to all Directorate Managers and Heads of Department about the deteriorating sickness rates across the organisation. He added that work was also underway to revise the sickness absence policy.

Mrs Scott commented that on analysis of her staff it had been noted that the AHP staff, who tended to be younger, had fewer occasions of sickness, but community staff, who were an older group of staff, had a higher rate of sickness. She suggested that there may be an issue relating to an ageing workforce and suggested that the Trust should be looking at more flexible ways of working. Mr Golding added that he had found a similar position.

Professor Willcocks commented that a significant amount of time was lost to anxiety and stress. The Trust had the Healthy Work Place initiative in place that was led by HR, which can support staff who were suffering from anxiety and stress.

Mr Crowley added that he had noted the discussion the Workforce and Organisational Development Committee had had around staff turnover rates at its last meeting. He noted that the Trust continued to be below industry rates for staff turnover. Mr Crowley referred to a recent conversation that he had had with a senior manager around staff retention and some of the difficulties he had experienced in retaining staff. Mr Crowley advised that the HR department were reviewing the retention and suspension policies. Ms Symington reminded the Board of how expensive it was to recruit staff and asked if that information was used in the organisation. Mr Crowley confirmed that it was.

Mrs Adams asked about the effect the agency cap had had on recruitment and vacant shifts. Mrs Geary explained that, as a result of the introduction of the cap, a five stages process had been introduced for the recruitment of temporary staff. The final stage or option was to use “off framework” recruitment, but this would only be used where all other options had failed. She confirmed that the process was very robust and extensive. Mrs Geary further confirmed that shifts are not being held to deliver the agency cap.

Mr Crowley updated the Board on the recruitment of the Safer Working Guardian. He reminded the Board that it was a new role which would develop. He advised that three candidates had been shortlisted and the first interviews had been held. It had been agreed that second interviews should be held in June with a broader panel and all three candidates. Mr Crowley confirmed that Junior Doctors had been involved in the process.

Professor Willcocks asked about the key areas of improvement from the staff survey and asked if a fuller example of the plan could be presented to the July Workforce and Organisational Development Committee.

Action: A fuller report on the staff survey key areas for improvement to be presented to the Workforce and Organisational Development Committee

The Board thanked Mr Crowley for his report.

16/077 Workforce and Organisational Development Strategy

Mr Crowley presented the document and outlined how it had been put together. He advised that the Workforce and Organisational Development Committee had considered the document at its recent meeting. Professor Willcocks added that the Committee were most impressed with the strategy and its clear thinking and advised that the Workforce and Organisational Development Committee would undertake an early review of the implementation of the strategy.

Mr Crowley added that once the Head of Research had been appointed some further work would be undertaken on the research section of the strategy.

The Board approved the strategy.

16/078 The Golden Thread

Ms Symington presented the paper. She reminded the Board of the work that had been undertaken in January around reviewing the Trust's organisational strategy. This led to a review of the 'Our Commitment to You' document, now named 'Our Shared Commitment' Ms Symington tabled a newly printed version of the document. She advised that the values of the organisation had stayed the same but the ambitions had changed. Referring to the Well Led Review, Ms Symington explained that there were four clear actions that had been progressed, including review of the Trust's Board Assurance Framework. Ms Symington explained how the ambitions approach had been extended to the appraisal system. She advised that she had completed the appraisal of the Chief Executive and the Non-executive Directors and their objectives had been arranged under the four key headings of the Our Shared Commitment document. The high level objectives of the Chair, the Chief Executive and the NEDs were included in the Board papers. Ms Symington added that she felt the arrangements provided a more transparent and open process.

The Board noted the report and supported the approach being adopted.

16/079 Finance and Performance Committee

Mr Keaney presented the minutes from the Finance and Performance Committee that was held on 17 May 2016. He advised that the Committee had had a robust discussion about the current issues. He explained that he believed this financial year would be a year of uncertainty with and a degree of confusion. He reminded the Board that although the Trust was now in month two of the new financial year there was still no information

about the business rules the Trust was required to comply with. He added that £13.6m funding had been allocated on a quarterly in arrears basis, but payment was only made when certain conditions had been achieved, including achieving the £10m control total. Mr Keaney advised that the Trust had been asked to revise the Emergency Department trajectory for the year and had achieved the April trajectory target.

Mr Keaney advised that the Turnaround Avoidance Programme (TAP) project had now been incorporated into the Carter requirements and the Cost Improvement Programme to create an integrated approach to these 3 initiatives. He added that there was currently a Cost Improvement Programme planning gap of £8.5m.

Mr Keaney asked Mrs McGale to comment on the Trust performance.

Mrs McGale reported on the Trust's performance as follows:

Cancer – The Trust achieved all cancer targets in quarter 4. She advised that all Directorates were continuing to work on timed clinical pathways to improve compliance with the national standards, specifically for Breast, Colorectal, Lung and Prostate.

18-weeks – The Trust achieved the incomplete target in April, performance was 92.64%, and the target was 92%. She added that the Trust had complied with the target every month since September 2015.

Mrs McGale added that the Trust's admitted backlog had increased by 66 patients in the last month. There were still some issues around theatre capacity, which was severely reduced during April. This was caused by the restrictions on off-framework, over cap agency staff and the two day Junior Doctor's strike, which included 18 hours withdrawal of emergency care on 26th and 27th April.

Diagnostics – The Trust's performance in April was 99.19% against a target 99%. The Trust had complied with the target every month since September 2015.

Emergency Care Standards (Scarborough) – Mrs McGale advised that there had been some significant concerns around Norovirus in recent months. It had therefore been agreed that a look back exercise would be undertaken. Mrs McGale added that the site continued to implement Visual Hospital. The Trust had also been invited to present Visual Hospital in June 2016 at an Emergency Care National Learning Event hosted by the Emergency Care Improvement Programme (ECIP).

The recent bed modelling exercise identified a shortfall of medical elderly beds in Scarborough. This was being addressed in the short term by extending the opening of Graham Ward beyond the winter period. The medical management of frail elderly patients remained a priority across the Trust and through recent job planning discussions it had been agreed that a Geriatrician would be re-directed to work in the Emergency Department.

Emergency Care Standards (York) – Mrs McGale advised that the Emergency Department in York continued to struggle to achieve the Emergency Care Standards and bed occupancy levels remained high. She reminded the Board that there continued to be staffing issues and the work being undertaken around e-rostering in AMU and the Emergency Department would eventually help resolve the issues. Mrs McGale advised that Dr Stephen Lord had been appointed Clinical Director of the Emergency Department from July 2016. She advised that he was already working with the Directorate Manager to review the model of care in the Emergency Department.

Mrs McGale advised that the trajectory for May for the Emergency Department was 86%. She advised that currently the performance would suggest that the trajectory would be achieved.

Mrs McGale added that the appointment of the Discharge Liaison Officers was now complete and the cohort was currently undertaking their induction programme. They will start work on the wards in the last week of May.

Mr Keaney thanked Mrs McGale for her presentation. Mr Keaney asked Mr Bertram to comment from a finance perspective.

Finance - Mr Bertram confirmed that there was still considerable uncertainty around the Sustainability and Transformation Fund (STF) rules. The April position assumed full receipt of the funding. The Trust had anticipated a larger deficit in month one than has been seen. He advised that the Trust's Income and Expenditure account showed a deficit of £0.8m at the end of month against a planned deficit of £1.1m. He added that he was encouraged by this start to the financial year.

Mr Bertram referred the Board to the charts included in his report. He reminded the Board that NHSI had set the Trust an upper cap limit of £17.2m for its 2016/17 agency expenditure. Mr Bertram advised that the charts provided the Board with detail around the indicative targets for agency expenditure. He asked the Board to note that in April the expenditure on agency staff was £19,000 less than planned. The Board noted the results and asked if there would be peaks in spend around holiday time. The Board understood that through careful planning and use of the e-rostering system holiday time peaks will be kept to a minimum.

Mr Bertram referred the Board to the cash profile included in the Board pack. He reminded the Board that it had been agreed the CCG would make payments to the Trust on a 10 month profile basis. This meant that the final payment for the year from the CCG would be in January 2017, after which the payments from the CCG would fall away. He confirmed that in May the CCG had paid 1/10th of the contract value. He advised that it remained important for the Trust to continue with timely reconciliation with the CCG to avoid any arbitration.

Cost Improvement Programme - Mr Bertram confirmed that the Cost Improvement Programme results were disappointing. He advised that there was considerable work to complete including drawing on the Carter work.

Reference Cost Paper - Mr Bertram referred the Board to the reference cost paper that had been discussed at the Finance and Performance Committee. He advised that the profile of reference costs was increasing nationally. He advised that it was a requirement for the Board or a Board Committee to be aware of them. He advised that the Finance and Performance Committee had considered the paper in detail and had agreed that Mr Bertram should be provided with delegated authority to manage the submission. The Board considered the proposal and agreed that Mr Bertram should be delegated with the appropriate authority.

Quarterly submissions – Mr Bertram advised that NHSI had written to all Trusts to advise that the timetable for submission of returns each month had been changed. He explained that submission would now be required by 15th of the month. This would be ahead of any discussion at Board or Board Committees. The Board noted the change, but were concerned that this would mean that the regulator would have access to the results before the Board or the Board Committees had had an opportunity to review the results.

Mrs Adams asked Mr Bertram to comment on the Carter saving around workforce and if there was a reduction in the budget for administration costs. Mr Bertram advised that it was early days in the development of the actions from the Carter recommendations. There was still a lack of definitions and there were complexities that needed to be considered before adjustments could be made to budgets. He reminded Mrs Adams that all Directorates had individual saving targets that they were expected to achieve during the year.

The Board noted the report.

16/080 Minutes of the Corporate Risk Committee

The Committee noted the minutes from the Corporate Risk Committee.

16/081 Self Assessment against condition G6 of the Licence

Mrs Pridmore presented the prepared document for submission to NHSI and asked the Board to confirm approval of the submission.

The Board approved the submission to NHSI.

16/082 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 29 June 2016, in the Lecture Room at St Catherine's Hospice.

16/083 Any Other Business

Ms Symington commented that she would like to see more patient stories coming from the wards and she encouraged all Executive Directors to ask Directorate Managers, Matrons and Clinical Directors to identify such stories.

Ms Symington advised that she had been considering the Board Assurance Framework during the Board meeting and suggested the only element not covered in the Board

meeting was around learning and development. It was agreed that might be as Mr Proctor was not at the Board meeting.

Mr Golding updated the Board on some property issues.

Groves Chapel – Mr Golding advised that the Planners Area Committee had given planning permission to Groves Chapel, but there had been some opposition from local residents. The panel that had given permission was chaired by a current governor of the Trust. Mr Golding confirmed that the Chair of the Panel had declared he was a governor of the Trust at the start of the panel meeting. Mr Golding added that at the end of the panel deliberation a further decision was made to adjust the times that the supermarket could receive deliveries. As a result the supermarket had now appealed that decision.

Mental Health facilities – Following the closure of Bootham Park Hospital, it was noted that the City of York was struggling with the number of people with mental health issues. Mr Golding had been in discussion with Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) who provided mental health services to York and had shared the Trust's development plans. TEWV have advised that they will open a new Mental Health facility in January 2019.

Tampit Lodge Eastingwold – Mr Golding advised that North Yorkshire County Council, who own Tampit Lodge, had given notice to the Trust to vacate the building. The Trust provided a renal dialysis service from the site. Since receiving the notice from the Council the Trust had investigated the possibility of providing the service from another site, but had not found anywhere suitable. The Trust had recently suggested to the Council that it would purchase Tampit Lodge. This would allow the Trust to continue to provide the renal dialysis service without any interruption and provide some extra space to locate some additional services to the site.

Mr Taylor reminded the Board of the Patient Safety Conference on 21st June at the University of York.

Action list from the minutes of the 25 May 2016

Minute number	Action	Responsible office	Due date
16/067 Declaration of Interests	Update the Declarations of Interest document with the recent declaration from Ms Symington.	Mrs Pridmore	Immediate
16/069 Matters arising from the minutes	Board members were asked to complete the information on the back of the menu and provide any comments to	Mr Golding	Immediate

16/076 Workforce Report	A fuller report on the staff survey key areas for improvement to be presented to the Workforce and Organisational Development Committee	Ms McMeekin	July 2016

Outstanding actions from previous minutes

Minute number and month	**Action**	**Responsible officer**	**Due date**
15/087 Diverse Workforce	A proposal around investment in training for specialist and middle grade doctors in the future to be presented to the Board when developed	Mr Crowley	future
15/117 Community Care update	Provide further detail on the re-ablement discussions when available.	Mrs Scott	When available
16/057 Communications Strategy Update	Present a further update on the Communications strategy at the November Board meeting.	Mrs Brown	November 2016
16/047 NHS Staff Survey	Provide an update report on the progress against the action plan from the Staff Survey to the Board**.**	Mr Crowley	September 2016
16/048 Environment and Estates Committee	Programme in a session on health and safety into the Board day	Mrs Pridmore	To plan

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 June 2016

Chief Executive's Report

Action requested/recommendation

The Board is asked to note the report.

Executive Summary

This report provides an overview from the Chief Executive.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC outcomes.

Progress of report	Board of Directors
Risk	No risk.

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

Board of Directors – 29 June 2016

Chief Executive's Report

1. Chief Executive's Overview

Life continues to be extremely busy in the health service!

- The STP deadline at the end of June is now upon us and we will be able to consider its development to date, potential implications and our contribution to the process later in the agenda.
- We continue to be challenged operationally and our Emergency Department performance remains a concern. The Finance Director will report a good start to the year however, our financial performance continues to be fragile as the increasing impact of the "efficiencies" applied through tariff bites ever deeper and compromises not just on our ability to manage in year but even more importantly, provide for the future.
- In addition (as I write), is the continued uncertainty over the rules associated with accessing the transformation fund.

This presents a difficult context overall but in this light we must continue to focus on doing the right things for our patients and where choices need to be made to both protect and develop services now, and in the future, we must be prepared to make them. For example, operationally we are constantly juggling with the dilemma presented to us by the cap on our agency and locum spend and the need to sustain services that protect both our patients and staff from the difficulties presented by a challenging recruitment market.

The highlights of the last few weeks include another successful Patient Safety Conference and my thanks go to everyone who has contributed. The feedback has once again been excellent and I know how motivating the conference is for our staff. An event of this size certainly differentiates us from the majority of other Trusts and has now become a fixture in our annual calendar.

A couple of weeks ago we hosted a small delegation of CEO's from China who were visiting to further explore their interest in partnering us as a result of the work we are doing with UKIHMA and following my visit to Harbin shortly before Christmas. The early feedback is positive and we await a proposal.

The Deputy Chief Executive and I spent a short time in Toronto sharing our approach to developing clinical leadership, some insights into the nursing and operational agenda and how we manage our efficiency agenda – an agenda that is now becoming a growing reality in Canada. We were well received and there is a growing interest in developing a formal partnership with our hosts to share practice and perhaps support an exchange programme for our staff.

<u>BAF at a glance</u>

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

NHS Improvement's quarterly report

In line with normal practice NHSI has written to us confirming the outcome of our Q4 submissions.

Our current ratings are:

- Financial sustainability risk rating: 2
- Governance rating: Under review

These ratings will be published on NHSI's website later in June.
NHSI is developing the new Oversight Framework, which will be consulted on and will replace the Risk Assessment Framework in due course.

Ward configuration changes at York Hospital

As we will all recognise, the needs of our patients have changed, and over time we have seen an increase in the number of patients we admit who are elderly, many with complex medical conditions. At the same time, advances in surgical techniques mean shorter stays for many patients, and more day cases. This means that the current configuration of wards, which has been largely unchanged for well over ten years, is no longer best suited to our patients' needs or the pattern of admissions.

The impact of this is that when we are busy (and this happens regularly throughout the year, not just in winter) we have more elderly and medical patients than we have beds on dedicated wards. This means that patients are admitted to other areas, usually surgical, where there are beds available, often leading to cancelled operations. This is not ideal for patients, or indeed you as staff, who are often looking after patients with conditions outside of your specialist skills, and you have told us that you find this difficult and frustrating.

We are also facing difficulties in maintaining some areas of performance and there are opportunities to improve patient flow, which will both release efficiencies and better protect our patients from outbreaks of infection. This all contributes to improving patient experience.

All of these factors have led us to agree that we need to look at how we can better organise the way we work to improve patient care and address some of these longstanding issues.

Over recent months the clinical directorates have been working hard with colleagues in our information team to develop a bed modelling tool. This is to support our understanding of the current occupancy of the wards, to identify opportunities to make changes to support clinical need and hopefully address some concerns relating to both the clinical environment and patient case mix.

The model has evolved with clinical input and the work has now been completed, giving us the opportunity to support some priority areas for development.

These priorities have been proposed by the clinical teams, all with the aim of improving quality, safety and patient experience, and include:

- Supporting flow out of our emergency department
- Minimising cancellation on the day of surgery
- Improving capacity for medicine to reduce medical outliers
- Improving accommodation for same day surgical patients (currently on ward 27)
- Developing acute assessment areas for both medicine and surgery
- Addressing the need to support multiple surgical specialties admitted to ward 15

A number of moves have now been agreed, and the ambition is to make these changes before next winter. Clearly there is much work to do, and project teams are being established across directorates to lead and implement the changes.

A clinician, directorate manager and matron from each of the effected directorates, supported by colleagues from radiology, pathology, pharmacy, therapy and administration will all now progress this work.
These changes will help us to improve the care that we offer our patients by having the right staff on the right wards with the right skills to care for them.

Apprenticeships

The Government is currently developing a new policy initiative which will have significant implications for the way our organisation plans and delivers training for our staff. The policy 're-invents' the apprenticeship route for training and this new pathway will encompass not only traditional apprenticeship roles, but increasingly administration, clinical (care, therapy pharmacy) and many others.

In April 2017 our organisation will be required to pay approximately £1.2m into an Apprenticeship Levy Pot via PAYE (i.e. a 'top slice'). This is a new payment and is non-negotiable. We will only be able to use this money by 'buying' apprenticeship training from training providers. If we do not use the money it will be passed on to other organisations to spend.

As we work through the changes we are bringing key members of our staff up to speed with the new arrangements and their implications, and a workshop is planned in July.

In the news

New home for cardio-respiratory unit:

Finally, I am delighted to note the opening of our new cardio-respiratory unit at Scarborough Hospital.

Former offices have been transformed into a modern clinical unit which now provides a purpose built environment to deliver diagnostic tests and therapies for 9,500 patients with heart and lung disorders.

The completed unit now boasts purpose built heart scanning rooms, a clinical exercise laboratory, pacemaker and consultation rooms.

The project was made possible thanks to £50,000 of funding from York Teaching Hospital Charity and £10,000 from the Scarborough League of Friends. The work was done completely in-house by the Trust's Estates and Facilities Team.

The new unit provides a much improved experience for patients and relatives attending the department as well as for staff delivering the care, enabling them to provide treatment in a comfortable and spacious environment with improved privacy and dignity.

I would like to thank the Scarborough Hospital League of Friends and our charity supporters for their input.

2. Recommendation
The Board is asked to note the report.

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

York Teaching Hospital NHS
NHS Foundation Trust

Board Assurance Framework – At a glance.

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

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 June 2016

Quality & Safety Committee Minutes – 21 June 2016

Action requested/recommendation

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

Executive Summary

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

Review of Chief Nurse and Medical Directors Risk Registers.

- Patient Safety items for this month
- Nurse Staffing
- Infection Prevention
- Serious Incident Reporting, Datix reporting and Never Events
- Quarterly Report from Patient Safety Group
- Maternity Services

Clinical Effectiveness items for this month

- Internal Audit Programme for 2016/17
- The deteriorating patient and senior review

Patient Experience items for this month

- Mental Health Act review

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

1. Infection Prevention – since the beginning of 2016 there have been a number of infection related items of a serious nature presented to the committee which continued this month. The committee wished the DIPC to report this concern to Board and give her evaluation of causes and actions.
2. Safety best practice –in the light of the patient safety conference the committee wished to highlight areas of excellence in patient care around the trust and raise awareness of the need to share and expand these – including use of safety huddles, electronic ward information

and daily senior ward rounds.

3. Radiology issues at SGH – a series of SI reports this month together with information contained in a new SI lookback exercise have drawn attention to an issue around radiology services – particularly the out of hours service at SGH. Given the longstanding nature of this concern and the risk to patients the committee wishes to escalate this to the Board and to Workforce and Organisational Development Committee.
4. Wrong site surgery Never Events. The committee have noted three Never Events relating to wrong site surgery since June 2015. They felt that this warranted escalation to Board with a view to a wider review of surgical consent, theatre checklist practice and other safeguards.
5. Maternity service improvements – the committee received a number of reports relating to maternity services and wished to highlight positive trends in stillbirth rates and commend the work that has been undertaken to improve staff training and patient care.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

No references to CQC outcomes.

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

Progress of report	These minutes have only been submitted for the Board.
Risk	No risk.

Resource implications	Resources implication detailed in the report
Owner	Jennie Adams, Non-Executive Director
Author	Liz Jackson, Patient Safety Project Support
Date of paper	June 2016
Version number	Version 1

Quality & Safety Committee – 21 June 2016 Room PT003, Exhibition Centre, University of York

Attendance: Jennie Adams, Libby Raper, Philip Ashton, Ed Smith, Helen Hey, Liz Jackson

Observing: Tara Wickramasekera - Leeds Institute of Health Sciences

Apologies: James Taylor, Beverley Geary and Anna Pridmore

	Agenda Item	Comments	Assurance	Attention to Board
	Last meeting notes dated 17 May 2016	The Committee welcomed Ed Smith and Helen Hey who were in attendance in the absence of James Taylor and Beverley Geary. The minutes were approved as a true and accurate record.		
	Matters arising • Clinical Effectiveness benchmarking project • Incident reporting best practice • Critical care action plan	The Committee queried the absence of the report from the external review and the internal action plan for the Critical Care Review, as these were identified in the actions from the CQC. The Committee were keen to monitor the progress of the action plan that has been put in place. ES agreed to discuss this with JT. **Action: JT to present action plan at next meeting** The Committee discussed the potential sources for Clinical Effectiveness benchmarking, which links with the Lord Carter work. JT agreed at the May meeting to assess what comparative data was available. ES agreed to raise this with JT. **Action: JT to present progress on devising some appropriate information and a format for presenting it to the committee** The Committee discussed incident reporting and that the NLRS data shows that the Trust remains a low reporter nationally. The Committee asked if JT could liaise with exemplar organisations to share and learn best practice. The committee agreed that the Junior Doctors Safety Improvement Group project around paper incident reporting was a good initiative that has explored the barriers to reporting, such as whistle blowing risks. ES advised		

	Agenda Item	Comments	Assurance	Attention to Board
		the Committee that many of the junior doctors have expressed that training around incident reporting should take place at induction and added that the senior doctors should also be targeted for this training. HH explained the further work could be undertaken with the Datix reporting system to improve and simplify its use. The Committee queried if there were better alternatives available to Datix as mobile technology and wi-fi availability improves. Sue Rushbrook has explained the difficulties in finding a solution. Staff have also advised that feedback is not received when an incident has been reported, the committee agreed that organising feedback could be an improvement project which can be discussed with Adrian Evans who is now the lead for serious incident (SI) reporting. **Action: JT to investigate and report on best practice by September meeting and evaluate possible options to improve feedback.** The Committee discussed feedback to Sue Rushbrook regarding the contents of the integrated dashboard and agreed that that this should be co-ordinated by the executive directors. The Committee agreed to extend one of the future meetings so a discussion could take place to come up with an agreed number of editorial suggestions across NEDs and Execs. EJ will co-ordinate diaries. **Action: Committee to arrange additional slot for review of dashboard in July or August**		
	Risk Register for the Medical Director and Chief Nurse CRR Ref: MD7	The Committee were pleased that, as advised by BG at the May meeting, reviews of directorate risk registers are now taking place at PMMs, opening up the opportunity for the risks to be actively identified and resolved. HH explained the new structure of the PMMs to the Committee advising that the focus of the meetings will alternate on a monthly basis between operational and CIP and finance. The Committee queried if Quality and Safety (Q&S) remained at the top of the agenda and HH confirmed that there will be an opportunity to raise Q&S issues every month. The Committee noted the new risk on the Medical Directors Risk Register	The Committee were assured by the inclusion of up to date risk registers.	

	Agenda Item	Comments	Assurance	Attention to Board
	CRR Ref: MD2 & MD4	(MD7) in relation to Critical Care and were pleased to see that risks are being escalated from the Directorate Risk registers. ES advised that this risk is due to the non-clinical transfer of stable patients out of ICU and this is being managed by the Clinical Care action plan (see above). The Committee discussed the Deteriorating Patient and senior reviews not being undertaken in a timely way in certain areas. ES explained the staffing shortages on the Scarborough site and the plan to work on a shift basis. Post take is undertaken up to 10pm in AMU on the York site and this is not currently the case in Scarborough. JT is in discussions with David Humphriss (Clinical Director in Scarborough) to move to more productive senior review with more capacity in place at weekends assisted by a review of job plans. There is a national shortage around recruitment in this specialty and the Scarborough site currently has a large number of locums in place, which is also a quality concern. Given the long standing nature of this issue, the high priority for the D of H and the severe difficulties around recruitment the Committee queried if this were an area that might benefit from use of new technology such as cross-site telemedicine. ES advised that he had been impressed with the technology being used in this way within the stroke service. Adoption of electronic observations and the electronic visual hospital are helping patients to be prioritised. The Elderly Directorate are sharing learning around good practice for daily board rounds and ward rounds. JA observed from recent walkrounds that staff on Ward 35 in York had seen excellent results in terms of reducing patient length of stay from more regular senior review – soon to be twice daily. Use of safety huddles on Chestnut Ward in SGH was also proving valuable in identifying patients at risk. **Action: JT to report back to committee on outcome of discussions with CD in medicine in Scarborough with a view to development of an action plan.**		JT to give an overview of this issue and to highlight areas of good practice and ongoing work.
	Patient Safety			
	Nurse Staffing	The Committee noted the comprehensive information provided in the Chief Nurse report around nurse staffing and focussed its attention on the Safe	The Committee were assured by	

	Agenda Item	Comments	Assurance	Attention to Board
	CRR Ref: CN2	Nurse and Midwifery Staffing Report. HH advised that there is no concern around the crude data on care hours per patient day and the Committee agreed that until there was a better understanding of these numbers they would continue to monitor the Safer Staffing returns and nursing dashboards. The data this month remained fairly steady in comparison to previous months, although the committee expressed some concern about low fill rates on the acute medical wards on both sites – areas of high patient risk. HH advised that York AMU is of high priority due to the recently announced reconfiguration of the wards on this site. The area will now be split in to three sections, a 72 hour AMU, an acute assessment unit and an acute frailty unit. Also ward 15 will be moved to G1 with only seven gynaecology beds remaining. Individuals, including newly qualified nurses commencing in September, have been allocated to the affected wards prior to the reconfiguration decisions, which may impact on their willingness to take up the post. Discussions with these individuals are planned to take place. **Action: The committee would monitor this developing situation in this high risk area - including the added complexity it would bring to Safer Staffing returns.**	the continued focussed attention on nurse staffing and timely submission of new CHPPD data.	
	Infection Prevention CRR Ref: CN7 & CN8	HH focussed the Committee's attention on the MRSA screening data in the Nursing dashboard and advised that Vicki Parkin is working with Systems and Network Services to improve the quality of the data. The Trust remains an outlier for MRSA incidents and compliance with ANTT appears low. A train the trainer approach was originally taken and this now needs to be refreshed due to staff turnover. However HH added that the training data provided by Corporate Learning and Development does not match that held by the wards and more staff have received the training than have been reported. The Committee discussed recent incidences of MRSA and expressed some concern.		BG to highlight a number of IPC related issues to Board BG to update the Board in

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee discussed the Norovirus look back exercise. HH explained that a multiagency meeting has taken place, chaired by the CCG, however the actions and minutes are not yet available. HH advised the Committee that a further four joint infections have been identified in Bridlington. These further cases take the infection rate up to 1.7% against a national average of 0.7% which was felt to be too high. Two patients were of high risk, different infections were identified and different surgeons were involved. Cleaning has now been increased to seven days a week and patient care pathways have been brought into line with those used on the York site. Hand hygiene in this area is good, IPC presence in Bridlington will be increased and the team will be visiting the ward to conduct ANTT training. A capital project to introduce a separate dressings room is being considered. HH advised that a further update will be available in August. The Committee recognised that there continued to be concerns around the management and leadership of the Bridlington site. The committee understood a capital paper and a business case regarding surgical activity, directorate structure and the management structure for Bridlington will be coming to board in July. An incident regarding the superbug CPE (*carbapenemase producing enterobacteriaceae*) has been declared. An early investigation suggests there were lapse in care which involves transfer to another patient. The Committee discussed the work being undertaken by Vicki Parkin around un-ported cannulas with the evidence suggesting that they should reduce instances of MRSA. **Action: Committee and IPC team to receive summary of external Norovirus review and will continue to closely monitor the results of**	The committee were assured by the actions being taken	private session To be raised with the Executive Directors at Private Board .

	Agenda Item	Comments	Assurance	Attention to Board
		actions taken around other IPC incidents.		
	Serious incidents (SIs) & incident reporting CRR:MD2, MD4, MD6, CN8, CN7	The Committee discussed the declared never event of wrong site surgery and raised concern around the fact that this was the third such case in 12 months. They queried the consistency of the use of the WHO theatre safety checklist, consent procedures and other safeguards. ES explained that this was a wrong site surgery for varicose veins caused by a duplication of documentation between electronic and paper records and ambiguous wording, an investigation is taking place. The Committee felt that the number of repeat events warranted a wider review of surgical protocols in order to ensure this does not reoccur. The Committee discussed the clinical SIs in the Medical Director's report and queried if the overall theme was that of investigation failure. ES advised that the case of the aortic aneurism showed symptoms of kidney stones and the misdiagnosis meant that the patient didn't get the right treatment at the right time. In the further discussion of radiology investigations ES explained that Radiology is run on a weekly rota on the Scarborough site and some CT requests are refused – possibly due to fatigue. The Consultant on call interprets scans performed out of hours at SGH, however out of hours CT scanning from York is interpreted in Australia. There are not enough Radiographers to operate the shift system in Scarborough – so technicians are on call from home. This was cited as a possible reason that the Australian option was not viable at SGH. The Committee raised concern around the series of misreported scans and radiology related SIs and highlighted a sense of urgency that this be escalated both to Workforce Strategy Committee and to the Corporate Risk Register of the Medical Director. The Committee noted that the Medical Director's report contained several		JT to highlight wrong site surgery Never Event and feedback wider concerns of Committee

	Agenda Item	Comments	Assurance	Attention to Board
		SIs from November that related to admissions and waits in the Emergency Department. The Committee had been assured in the moment that operational pressures had not affected safety however following investigation harm has been reported. HH added that there have been some SI falls reported at Archways. Following a look back exercise it was identified that some structures were not in place. Benchmarking and comparisons with previous years is being undertaken over the next few months. The Committee welcomed the first analytical report on SIs and noted that it would be developed and improved over time to provide a useful overview of SI trends, themes and learning. The committee queried that some falls and pressure ulcer Sis are classified to NRLS as moderate harm when they appear to be severe harm. HH advised that all falls and pressure ulcers are discussed at panels and are categorised following feedback on the patient and their care. **Action: Committee to raise the radiology issue with Workforce and Organisational Development Committee and Board. JT to consider reviewing both the DRR and CRR to ensure this risk is adequately reflected and report back to committee.** **Action: JT to consider if wider review of theatre/surgery protocols/safeguards is required in light of repeat wrong site surgery Never Events and report back to committee.** **Action: ES to liaise with DP in order to clarify who will produce the quarterly update on Patient Safety Group.**		
	Quarterly Report from Patient Safety	ES advised the Committee that the Sepsis CQUIN remains challenging and has now been extended to include all inpatient areas as well as the admitting areas. Acute identification and prescribing has plateaued and an		

	Agenda Item	Comments	Assurance	Attention to Board
	Group CRR: MD4	Improvement Fellow, Dominic Carroll, is working on implementation. Patients presenting in the admitting areas should be assessed and given antibiotics within an hour and inpatients should be given antibiotics within an hour of identification. The Committee noted the feedback from the Deteriorating Patient Group and agreed that the National Cardiac Arrest Audit was a good measure of care of the deteriorating patient and could be a useful benchmark in this regard. ES confirmed that individuals on each site are checking the accuracy of the data and noted the committee's request to review the data once validated as an initial step towards developing a suite of clinical effectiveness measures. DNACPR could also be used to measure senior decision making and the Committee queried if this could be incorporated in to Safety Huddles on the wards. **Action: JT to report results of national cardiac arrest audit to the committee.**		
	Additional Patient Safety Items	Maternity Services The committee noted the range of information presented on Maternity services. The Committee were pleased to see the regional maternity benchmark information and noted the reduction in the rates of still birth for York Trust in 2015 to below the regional average. In reference to the Saving Babies Lives piece and the action plan update for the SGH unit - HH advised that there is training in place around CTG interpretations. There is a shortage of sonographer support for scans and a model used by Birmingham Hospital is being pursued where midwives receive maternity sonography training. Demand for these services is growing rapidly and continues to exceed supply. A business case has been submitted for an additional sonographer on the York site. HH explained that Maternity triangulate data through risks and complaints and conduct a very robust approach including the transferring of learning	The Committee were assured by the robust approach in Maternity Services.	BG to highlight positive benchmark report and actions taken to improve training and patient care.

	Agenda Item	Comments	Assurance	Attention to Board
		and the completion of actions. Mental Health Act annual review The Committee reviewed the report around mental health activity on the Scarborough site and agreed that a narrative may have been more helpful. This paper will not be submitted to board.		
	Clinical Effectiveness			
	Internal Audit Report Internal Audit Programme for 2016/17	The Committee reviewed the 2016/17 Internal audit plan and agreed that audits of interest to the committee – particularly those receiving limited assurance would be reported to the committee via the Monthly reports of the Executive sponsors – using an executive summary format to highlight actions required and progress made. The Chair of the Audit Committee (PA) was comfortable with this approach. **Action: Execs to add summary of internal audits received to their committee reports focussing on limited assurance reports and actions required/undertaken**		
	Patient Experience			
	Additional Patient Experience Items	The Committee noted the contents of the Chief Nurse report in relation to Patient Experience and agreed to focus its attention on other elements of the agenda at this meeting.		
	Additional items			
	Risk Register round up	The Committee reviewed the Risk Registers and focussed its attention on the risks that had not been discussed under agenda items. CRR Ref: CN9 – The work around mental health liaison for young people is ongoing. HH advised that BG will update the Committee next month. ES added that dialogue has been opened with Tees and Esk Valley NHS Trust to work on the ongoing issues around child mental health.		

	Agenda Item	Comments	Assurance	Attention to Board
		CRR Ref: MD1 – The Committee did not discuss drug errors in details but look forward to receiving feedback from the trial of the EPMA system. CRR Ref: MD3 - The Committee agreed that Information Governance has received focussed attention from the Committee in the preceding months and did not require further attention this month. CRR Ref: MD5 – The Committee agreed that Ophthalmology Outpatients was receiving focussed attention by the Medical Director Team and the Department, as discussed at the May meeting.		
	Next meeting of the Quality and Safety Committee: 19 July 2016 LaRC Conference Room, 2nd Floor Junction 1a, York Hospital at 1.30pm.			

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Patient Safety and Quality Performance Report

June 2016

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

Patient Safety & Quality Performance Report

Chapter Index

Quality and Safety Summary: Trust

Patient Experience	Target/ Threshold 2016/17	Monthly Target/ Threshold	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Litigation - Clinical Claims Settled	-	-	3	4	8	6	4	5	10	4	5	1	2	3	6
Complaints	-	-	41	33	41	37	58	42	38	28	25	40	46	36	30

Care of the Deteriorating Patient	Target/ Threshold 2016/17	Monthly Target/ Threshold	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
12 hour Post Take - York	85%	85%	87%	85%	82%	85%	83%	86%	85%	84%	85%	85%	87%	90%	84%
12 hour Post Take - Scarborough	80%	80%	60%	60%	68%	56%	56%	59%	56%	56%	55%	53%	64%	63%	60%
14 hour Post Take - Trust	100%	100%	84%	82%	85%	81%	81%	83%	80%	82%	81%	80%	86%	85%	83%
Acute Admissions seen within 4 hours	80%	80%	89%	90%	90%	76%	74%	85%	83%	77%	84%	85%	84%	87%	83%
NEWS within 1 hour of prescribed time	90%	90%	87.0%	87.3%	87.5%	87.4%	87.3%	86.3%	87.1%	87.3%	87.2%	85.6%	85.2%	86.8%	87.6%
All Elective patients to have an Expected Discharge Date (EDD) recorded within 24 hours of admission	Q1 91% Q2 91% Q3 93% Q4 93%	87%	87%	89%	90%	91%	88%	88%	90%	88%	93%	94%	89%	87%	86%

Measures of Harm	Target/ Threshold 2016/17	Monthly Target/ Threshold	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Serious Incidents	-	-	14	12	20	11	16	22	19	13	11	27	21	17	12
Incidents Reported	-	-	1261	1218	1253	1294	1280	1278	1358	1269	1313	1366	1311	1280	1165
Incidents Awaiting Sign Off	-	-	863	947	1178	1229	1183	839	889	1149	1344	1389	1348	987	780
Patient Falls	-	-	304	283	267	296	323	287	308	281	315	315	274	274	235
Pressure Ulcers - Newly Developed	-	-	85	62	62	62	54	62	82	59	61	70	87	70	72
Pressure Ulcers - Transferred into our care	-	-	153	157	124	132	124	119	147	159	145	132	127	125	120
Degree of harm: serious or death	-	-	11	7	11	4	9	9	12	5	8	7	7	6	5
Degree of harm: medication related	-	-	115	107	114	120	98	121	112	102	105	96	132	127	114
VTE risk assessments	95%	95%	97.1%	97.2%	97.3%	97.1%	97.6%	97.2%	98.5%	97.9%	98.2%	98.4%	98.5%	98.6%	98.9%
Never Events	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0

Drug Administration	Target/ Threshold 2016/17	Monthly Target/ Threshold	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Insulin Errors	-	-	15	8	12	6	13	11	8	9	6	6	16	6	9
Omitted Critical Medicines	-	-	14	7	17	14	15	9	12	11	16	17	11	19	13
Prescribing Errors	-	-	26	16	32	26	23	29	21	23	21	23	27	24	25
Preparation and Dispensing Errors	-	-	13	9	19	16	11	14	10	9	17	10	10	18	21
Administrating and Supply Errors	-	-	45	49	37	52	42	56	51	50	45	39	68	57	47

Safety Thermometer	Target/ Threshold 2016/17	Monthly Target/ Threshold	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
% Harm Free Care - York	-	-	94.3%	94.3%	95.0%	95.8%	95.1%	95.2%	96.1%	92.7%	96.7%	96.3%	96.4%	95.3%	97.5%
% Harm Free Care - Scarborough	-	-	92.6%	94.8%	90.8%	90.7%	93.9%	93.1%	91.0%	90.2%	93.3%	95.5%	91.7%	93.3%	95.6%
% Harm Free Care - Community	-	-	89.0%	85.7%	94.1%	93.5%	87.1%	94.5%	88.8%	83.5%	83.3%	88.1%	92.1%	93.1%	90.5%
% Harm Free Care - District Nurses	-	-	92.8%	96.2%	93.9%	94.4%	94.7%	96.2%	95.4%	97.2%	94.2%	97.8%	95.0%	97.7%	93.8%

Mortality Information	Target/ Threshold 2016/17	Monthly Target/ Threshold	Oct 11 - Sep 12	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15
Summary Hospital Level Mortality Indicator (SHMI)	100	100	107	104	102	101	97	98	99	102	103	101	101	99	99

Infection Prevention	Target/ Threshold 2016/17	Monthly Target/ Threshold	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Clostridium Difficile - meeting the C.Diff objective	48 (year)	48 (year)	8	6	3	8	3	5	3	7	7	5	3	3	1
Clostridium Difficile -meeting the C.Diff objective - cumulative	48 (year)	48 (year)	15	21	24	32	35	40	43	50	57	62	65	3	4
MRSA - meeting the MRSA objective	0	0	2	2	0	0	0	0	0	0	1	1	0	1	0
MSSA	30 (year)	30 (year)	5	3	4	2	3	6	2	2	2	2	3	9	2
MSSA - cumulative	30 (year)	30 (year)	8	11	15	17	20	26	28	30	32	34	37	9	11
ECOLI			8	8	4	6	6	7	8	8	11	15	7	5	5
ECOLI - cumulative			16	24	28	34	40	47	55	63	74	89	96	5	10
MRSA Screening - Elective	95%	95%	85.54%	85.73%	86.30%	88.19%	82.64%	82.33%	79.90%	89.87%	78.23%	69.17%	74.05%	68.13%	62.50%
MRSA Screening - Non Elective	95%	95%	73.56%	70.28%	74.48%	76.37%	74.33%	71.47%	72.71%	79.71%	75.59%	73.88%	75.57%	82.21%	83.61%

Stroke (one month behind due to coding)	Target/ Threshold 2016/17	Monthly Target/ Threshold	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Proportion of patients spending >90% on their time on stroke unit	80%	80%	78.9%	79.7%	90.0%	91.0%	93.8%	92.2%	89.0%	92.4%	88.2%	82.4%	82.4%	84.9%	1 month behind
Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%	75%	87.0%	81.3%	82.1%	96.2%	80.0%	76.5%	76.9%	81.8%	87.5%	100.0%	100.0%	n/a	1 month behind
Scanned within 1 hour of arrival	50%	50%	53.1%	68.0%	83.3%	80.0%	69.2%	44.4%	77.8%	75.0%	82.4%	72.2%	72.2%	73.3%	1 month behind
Scanned within 24 hours of hospital arrival	90%	90%	90.0%	80.6%	91.8%	93.3%	94.0%	96.7%	90.4%	97.1%	92.6%	90.8%	90.8%	93.4%	1 month behind

AMTS	Target/ Threshold 2016/17	Monthly Target/ Threshold	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
AMTS Screening	90.0%	90.0%	90.9%	97.1%	94.8%	95.1%	96.7%	96.2%	92.0%	88.6%	94.2%	90.1%	89.7%	92.1%	91.3%

Patient Experience

407 PALs contacts were recorded across the Trust in May, 45.9% of these were related to requests for information and advice (187). There were 18 complaints at York and 12 at Scarborough in May; a decrease of 6 for the Trust compared to April.

The Friends & Family Test (FFT) is no longer a CQUIN but forms part of the Trust's Commissioner contracts.
The Trust achieved a 29.4% response rate to the Inpatient FFT in May, the highest response rate since the CQUIN was removed. A total of 3,023 responses were received from Inpatients across the Trust. The 90% target for the % of respondents recomending the Trust was achieved across all sites.
The Trust achieved a 14.8% response rate to the ED FFT in May, a slight decrease on April. The Trust is yet to achieve the 90% target for the % of respondents recommending the Trust, however there was an improvement across both sites; York 81.0% and Scarborough 81.6%..
The Trust achieved a 1.3% response rate to the Community FFT (April 1.3%). The 90% target for the % of respondents recommending the Trust has been consistantly achieved.
Response rates to the Maternity FFT have seen an increase in all 4 stages of the pathway and are the highest seen in the last 12 months. Of note, the response rate to the Labour stage of the Maternity FFT rose from 4.7% in April to 45.9% in May.

Measures of Harm

No Never Events were declared in May.

12 Serious Incidents were declared in May (8 x York, 0 x Scarborough & 4 x Community).
2 of the SIs were attributed to 'clinical incident', 6 were attributed to 'slips, trips and falls' and 4 to pressure ulcers.

Infection Prevention

No cases of healthcare associated MRSA bacteraemia were identifed during May.

1 case of Cdiff was identified in May under Medicine at York. The yearly threshold for 2016/17 remains at 48 cases however monthly allocation allows for more cases during the winter months. The monthly allocation for May is 3, therefore the Trust is currently within threshold.

2 MSSA cases were identified during May; 1 at York (Surgery) and 1 at Scarborough (Elderly).

5 cases of E-Coli were identified during May; 3 at York (Elderly, Medicine & Surgery) and 2 at Scarborough (both Elderly).

Quality and Safety - Miscellaneous

Stroke
All Stroke targets were achieved for the Trust in April.

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

Cancelled Clinics/Outpatient Appointments
153 clinics were cancelled with less than 14 days notice across the Trust in May; 102 at York and 51 at Scarborough. 881 outpatient appointments were cancelled for non clinical reasons; this exceeds the monthly maximum of 721 and will result in General Condition 9 which is initially a Performance Notice.

Ward Transfers between 10pm and 6am
The number of inappropriate ward transfers in May was within the monthly maximum threshold of 100 - 76 across the Trust.

Care of the Deteriorating Patient

The Trust achieved 75% in the proportion of Medicine and Elderly patients receiving a senior review within 12 hours of admission in May. York achieved 84% (against the 85% target) and Scarborough achieved 60% (against the 80% target).

The Trust achieved 82.8% in the proportion of Medicine and Elderly patients seen by a doctor within 4 hours of admission against the 80% target. The target was also achieved across both sites; York - 80.6% and Scarborough 86.4%.

The Trust has an internal target of 90% of routine observations being undertaken within 1 hour of the prescribed time. The Trust has continually failed to achieve target throughout 2015/16 and achieved 87.6% in May.

Drug Administration

There were 9 insulin errors reported in May; 6 at York, 2 at Scarborough and 1 Community. A total of 110 have reported in the last 12 months.

25 Prescribing errors were reported in May; 16 at York, 8 at Scarborough and 1 Community.

Mortality

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

There were 172 Inpatient deaths across the Trust in May; 108 at York and 55 at Scarborough.

11 ED deaths were reported in May at York and 12 at Scarborough.

CQUINS update

Q4 2015/16 Complete.

Litigation

Indicator	Site	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Clinical Claims Settled	York	2	3	3	3	3	1	1	1	4
	Scarborough	2	2	7	1	2	0	1	2	2

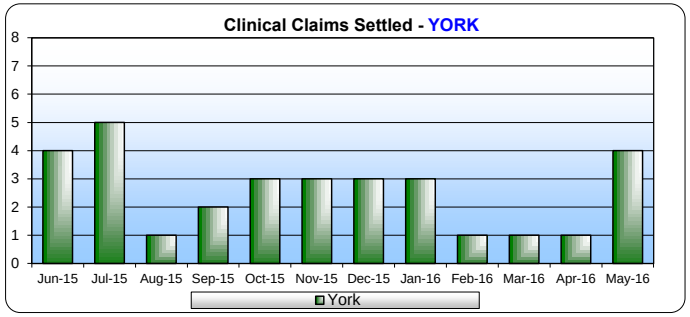
6 clinical claims were settled in May; 4 attributed to York and 2 attributed to Scarborough.

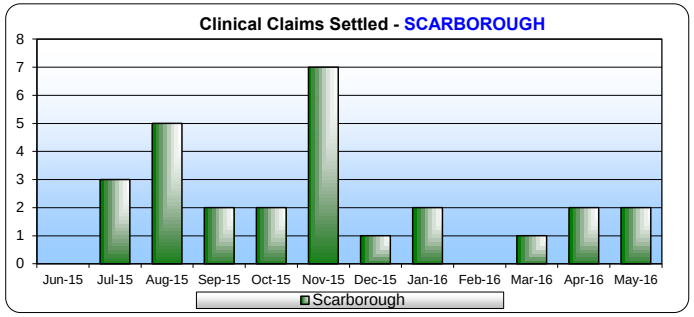
9 clinical negligence claims were received for York site and 7 were received for Scarborough. York had 2 withdrawn/closed claims and Scarborough had 3.

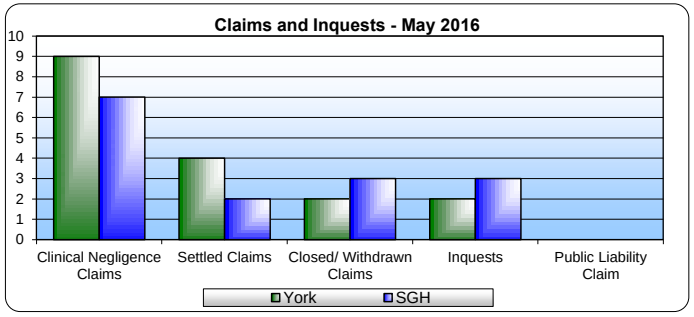
There were 5 Coroner's Inquests heard in May; 2 York & 3 Scarborough.

Litigation

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







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

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

Patient Experience

PALS Contacts
There were 407 PALS contacts in May.

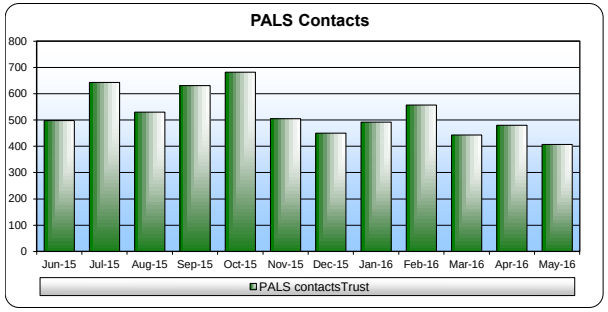
Complaints
There were 30 complaints in May; 18 attributed to York and 12 attributed to Scarborough.

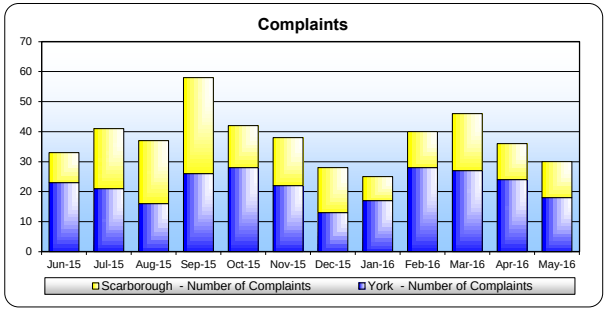
New Ombusman Cases
There were 3 New Ombusman Cases in May – 1 at York and 2 at Scarborough.

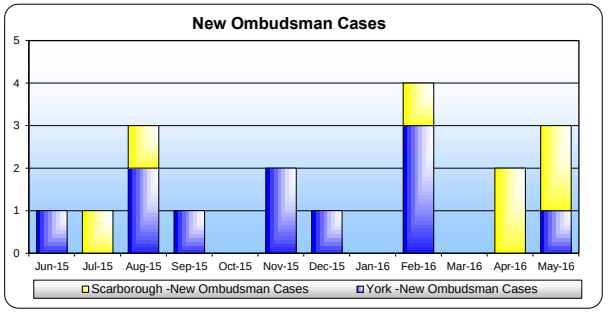
Compliments
34 compliments were received by the Chief Executive in May 2016.

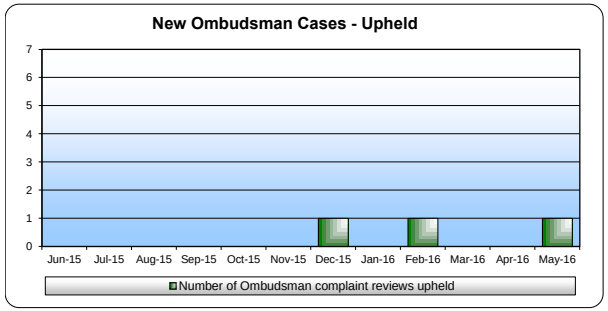
Patient Experience

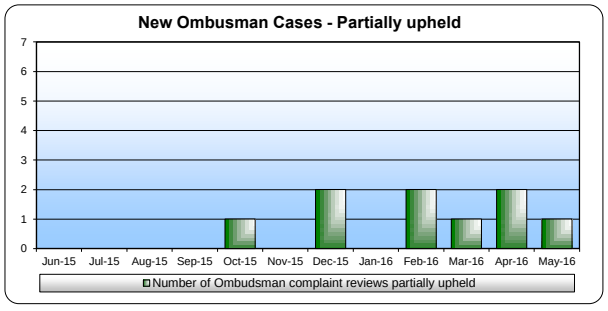
Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
PALS contacts	Trust	498	643	530	631	682	505	450	492	557	443	480	407
Complaints	Trust	33	41	37	58	42	38	28	25	40	46	36	30
New Ombudsman Cases	Trust	1	1	3	1	0	2	1	0	4	0	2	3
New Ombudsman Cases - Upheld	Trust	0	0	0	0	0	0	1	0	1	0	0	1
New Ombudsman Cases - Partially upheld	Trust	0	0	0	0	1	0	2	0	2	1	2	1
New Ombudsman Cases - Not upheld	Trust	2	1	1	1	1	0	6	0	2	4	2	1

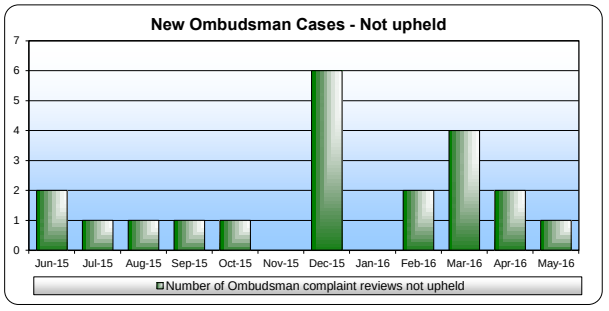












Compliments received by Chief Executive

Directorate	Q3 2015/16	Q4 2015/16	Apr-16	May-16
Acute & General Medicine	10	5	10	2
AHP	2	1	1	1
Anaesthetics/Theatres & Critical Care	2	3	1	4
Child Health	0	0	1	0
Community Services	0	1	0	0
Elderly Medicine	2	7	4	4
Emergency Medicine	9	15	7	4
Estates and Facilities	0	0	1	2
General Surgery & Urology	7	14	5	5
Gynaecology/Obstetrics	1	3	2	1
Head & Neck	2	1	0	3
Human Resources	0	0	0	1
Ophthalmology	3	5	4	0
Radiology	0	0	1	2
Specialist Medicine	10	3	5	4
Trauma & Orthopaedics	4	5	5	1
Unknown/no directorate given	13	1	0	0
Total	**65**	**64**	**47**	**34**

Patient Experience

Complaints and PALs contacts breakdown - May 2016

Complaints by directorate/division (Datix)	All Sites
Allied Health Professionals	1
Acute & General Medicine	8
Child Health	1
Community Services	0
Elderly Medicine	6
Emergency Medicine	3
Estates and Facilities	0
General Surgery & Urology	3
Head and Neck and Ophthalmology	3
Laboratory Medicine	1
Obstetrics & Gynaecology	0
Orthopaedics and Trauma	0
Pharmacy	0
Radiology	1
Specialist Medicine	3
Theatres, Anaesthetics & Critical Care	0
Other	0
TOTAL	**30**

Complaints by subject (Datix)	All Sites
Access to treatment or drugs	1
Admissions, Discharge and Transfer Arrangements	8
Appointments, Delay/Cancellation	0
All aspects of Clinical Treatment	26
Communications/information to patients (written and oral)	6
Facilities	0
Privacy and Dignity	1
End of Life Care	2
Patient Care	11
Prescribing	2
Restraint	0
Staff Numbers	0
Transport	0
Trust Admin/Policies/Procedures inc pt record management	0
Values and Behaviours (Staff)	7
Waiting times	0
Patient Concerns	0
TOTAL	**64**

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

PALS Contacts by Subject	All Sites
Action Plan	2
Admissions, discharge, transfer arrangements	10
Aids / appliances / equipment	2
Appointments, delay/cancellation (inpatient)	8
Appointments, delay/cancellation (outpatient)	29
Staff attitude	9
Any aspect of clinical care/treatment	55
Communication issues	25
Compliment / thanks	38
Alleged discrimination (e.g. racial, gender, age)	1
Environment / premises / estates	2
Foreign language	0
Failure to follow agreed procedure (including consent)	1
Hotel services (including cleanliness, food)	1
Requests for information and advice	187
Medication	1
Mortuary/Post Morten Arrangements	2
Other	8
Car parking	2
Privacy and dignity	1
Property and expenses	4
Personal records / Medical records	11
Safeguarding issues	0
Signer	3
Support (e.g. benefits, social care, vol agencies)	1
Patient transport	4
TOTAL	**407**

Friends and Family

Indicator		Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Inpatients – York	York IP Response Rate	Monitoring Only	18.3%	20.6%	17.4%	18.9%	18.6%	13.8%	11.9%	22.3%	19.9%	21.2%	25.2%	29.8%
Inpatients – Scarborough	Scarborough IP Response Rate		15.3%	21.3%	18.2%	18.0%	18.2%	17.5%	15.1%	19.9%	19.0%	24.0%	25.4%	25.1%
Inpatients - Bridlington	Bridlington IP Response Rate		46.0%	51.6%	69.0%	62.0%	50.2%	24.6%	32.3%	52.6%	47.7%	53.7%	52.4%	45.1%
Inpatients – Combined	**Trust IP Response Rate**		**19.4%**	**22.6%**	**20.3%**	**21.2%**	**20.3%**	**15.6%**	**14.0%**	**23.6%**	**21.5%**	**24.2%**	**27.0%**	**29.4%**
ED – York	York ED Response Rate	Monitoring Only	8.3%	10.0%	9.2%	7.4%	9.6%	10.0%	10.7%	16.0%	19.2%	15.6%	17.1%	15.7%
ED - Scarborough	Scarborough ED Response Rate		6.1%	6.3%	5.8%	4.9%	3.0%	3.6%	7.0%	10.1%	12.8%	11.1%	11.8%	11.6%
ED – Combined	**Trust ED Response Rate**		**7.6%**	**8.8%**	**8.0%**	**6.5%**	**7.4%**	**7.9%**	**9.9%**	**14.7%**	**18.0%**	**14.7%**	**16.0%**	**14.8%**
Maternity – Antenatal		None	31.7%	29.1%	23.7%	29.3%	22.9%	1.9%	9.8%	27.0%	12.8%	26.8%	21.8%	34.2%
Maternity – Labour and Birth			26.7%	28.5%	23.3%	36.2%	26.1%	3.9%	25.1%	20.2%	5.5%	5.6%	4.7%	45.9%
Maternity – Post Natal			29.3%	27.3%	25.5%	40.5%	27.3%	3.8%	0.0%	17.1%	29.3%	35.0%	38.1%	49.3%
Maternity – Community			20.3%	18.7%	19.8%	20.9%	26.2%	2.8%	5.1%	16.0%	16.7%	24.7%	17.4%	32.6%

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

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

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

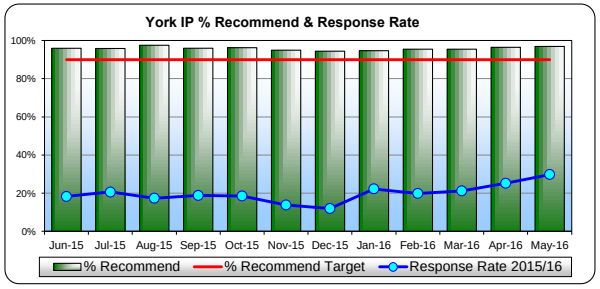
The focus for the Trust is to gain and understand patient feedback and encourage Directorates to use that feedback to drive improvements. Each ward displays a 'Knowing How We're Doing' board which is a giant poster sharing FFT data and comments from that particular ward, along with news and improvements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

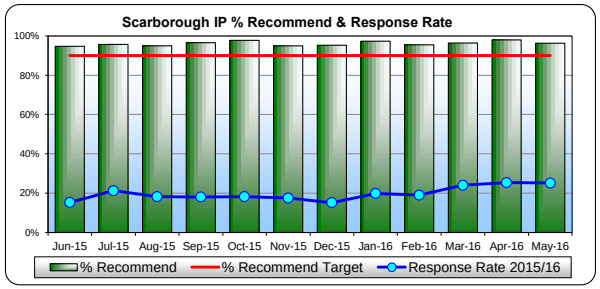
Friends & Family: Inpatients & ED

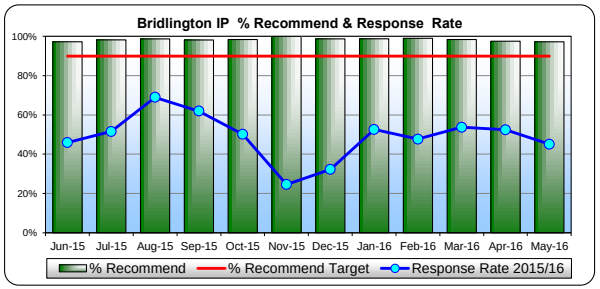
The Friends & Family Test (FFT) has now been rolled out across the Trust, including all Inpatients and Daycases, (previously daycase s and patients <16 were excluded) those attending ED, Community patients and women accessing maternity services being asked the question; "would you recommend this ward/ED/antenatal/labour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

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar-16	Apr-16	May-16
Trust Inpatient Response Rate (including daycases)	None - Monitoring Only	none	19.1%	21.4%	16.7%	23.1%	24.2%	27.0%	29.4%
York Inpatient Response Rate (including daycases)	None - Monitoring Only	none	17.3%	19.0%	14.8%	21.1%	21.2%	25.2%	29.8%
York Inpatient % Recommend	None - Monitoring Only	none					95.5%	96.5%	96.9%
York Inpatient % Not Recommend	None - Monitoring Only	none					1.3%	1.0%	0.7%
Scarborough Inpatient Response Rate (including daycases)	None - Monitoring Only	none	16.0%	19.2%	17.0%	21.0%	24.0%	25.4%	25.1%
Scarborough Inpatient % Recommend	None - Monitoring Only	none					96.5%	98.0%	96.4%
Scarborough Inpatient % Not Recommend	None - Monitoring Only	none					1.6%	0.5%	0.4%
Bridlington Inpatient Response Rate (including daycases)	None - Monitoring Only	none	49.4%	60.3%	35.5%	51.4%	53.7%	52.4%	45.1%
Bridlington Inpatient % Recommend	None - Monitoring Only	none					98.4%	97.5%	97.2%
Bridlington Inpatient % Not Recommend	None - Monitoring Only	none					0.0%	0.6%	0.8%

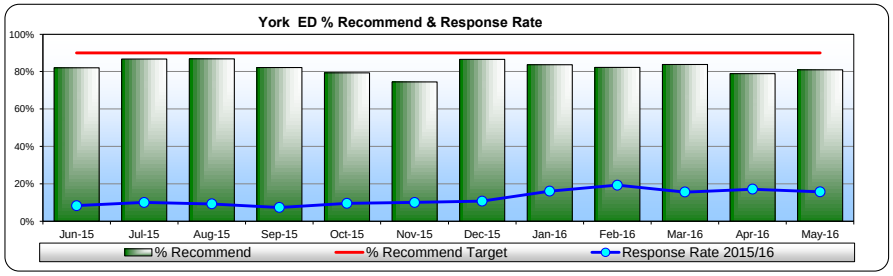
Daycase patients and young people (<16 years) included in FFT April 2015

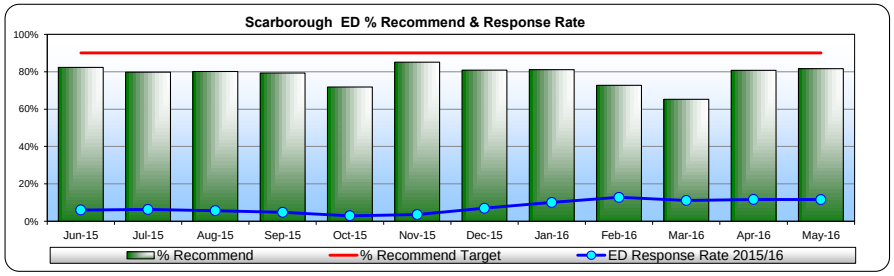






Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar-16	Apr-16	May-16
Trust Emergency Department Response Rate	None - Monitoring Only	none	7.8%	7.8%	8.3%	15.8%	14.7%	16.0%	14.8%
York Emergency Department Response Rate	None - Monitoring Only	none	8.4%	8.9%	10.1%	17.0%	15.6%	17.1%	15.7%
York Emergency Department % Recommend	None - Monitoring Only	none					83.8%	78.9%	81.0%
York Emergency Department % Not Recommend	None - Monitoring Only	none					10.9%	12.9%	11.6%
Scarborough Emergency Department Response Rate	None - Monitoring Only	none	6.7%	5.7%	4.1%	11.3%	11.1%	11.8%	11.6%
Scarborough Emergency Department % Recommend	None - Monitoring Only	none					65.3%	80.7%	81.6%
Scarborough Emergency Department % Not Recommend	None - Monitoring Only	none					24.1%	11.9%	8.8%





Headline Scores

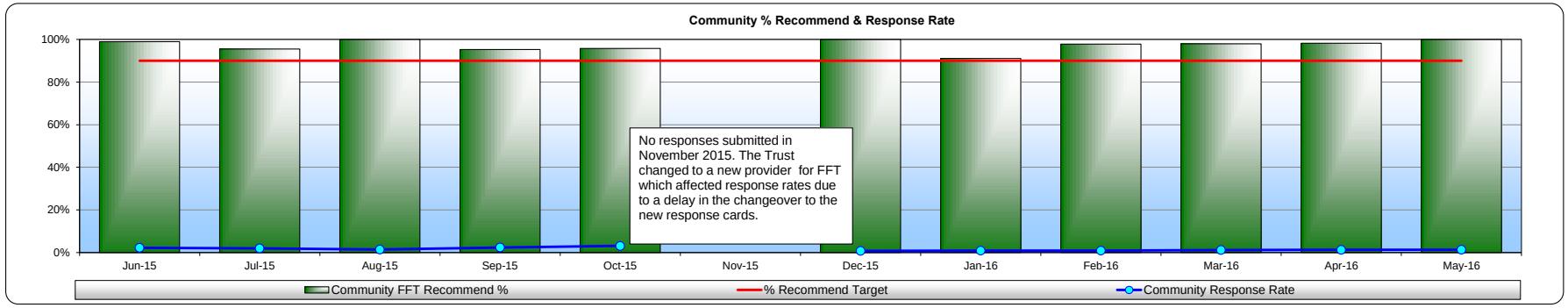
Recommend (%) $\dfrac{\text{Extremely Likely + Likely}}{\text{Extremely Likely + Likely + Neither + Unlikely + Extremely Unlikely + Don't know}} \times 100$

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

Friends & Family: Community

FFT Implemented in Community since January 2015

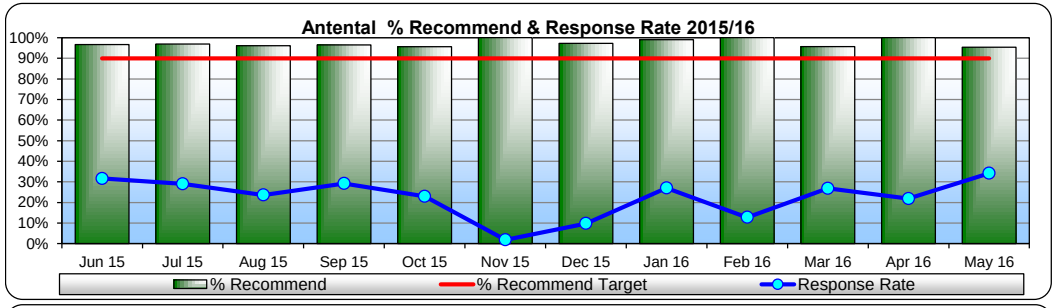
Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar-16	Apr-16	May-16
Community Response Rate	None - Monitoring Only	none	2.5%	1.9%	1.2%	1.0%	1.1%	1.3%	1.3%
Community FFT % Recommend	None - Monitoring Only	none					98.0%	98.3%	100.0%
Community FFT % Not Recommend	None - Monitoring Only	none					0.0%	0.0%	0.0%

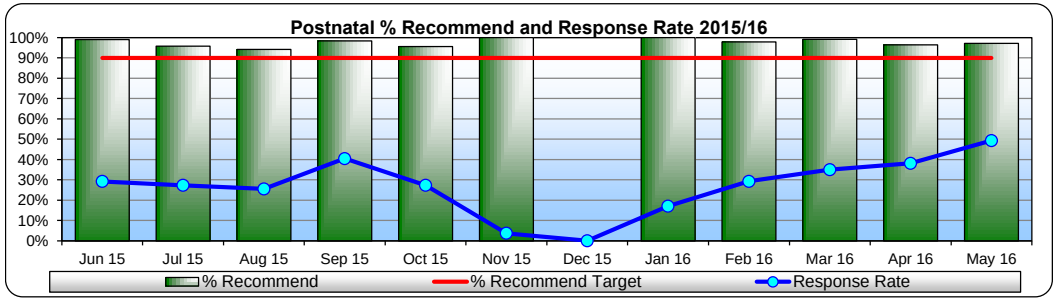


Service/Area	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar-16	Apr-16	May-16
Community Inpatient Services	None - Monitoring only	None	121	153	148	106	37	33	24
Community Nursing Services	None - Monitoring only	None	72	41	5	35	2	4	0
Specialist Services	None - Monitoring only	None	73	58	34	23	10	4	8
Children & Family Services	None - Monitoring only	None	2	11	8	2	0	0	0
Community Healthcare Other	None - Monitoring only	None	60	54	63	13	1	17	30

Friends & Family: Maternity

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Antenatal Response Rate	None - Monitoring only	none	28.5%	27.3%	12.2%	21.8%	26.8%	21.8%	34.2%
Antental % Recommend	None - Monitoring only	none					95.7%	100.0%	95.4%
Antental % Not Recommend	None - Monitoring only	none					1.1%	0.0%	0.0%
Labour and Birth Response Rate	None - Monitoring only	none	27.8%	29.5%	18.3%	10.4%	5.6%	4.7%	45.9%
Labour and Birth % Recommend	None - Monitoring only	none					95.7%	100.0%	99.0%
Labour and Birth % Not Recommend	None - Monitoring only	none					4.4%	0.0%	0.5%
Postnatal Response Rate	None - Monitoring only	none	29.5%	30.7%	11.0%	27.1%	35.0%	38.1%	49.3%
Postnatal % Recommend	None - Monitoring only	none					99.2%	96.4%	97.2%
Postnatal % Not Recommend	None - Monitoring only	none					0.0%	0.0%	0.6%
Postnatal Community Response Rate	None - Monitoring only	none	21.1%	19.8%	12.2%	19.2%	24.7%	17.4%	32.6%
Postnatal Community % Recommend	None - Monitoring only	none					94.9%	100.0%	99.2%
Postnatal Community % Not Recommend	None - Monitoring only	none					1.0%	0.0%	0.0%





2014/15 Performance

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

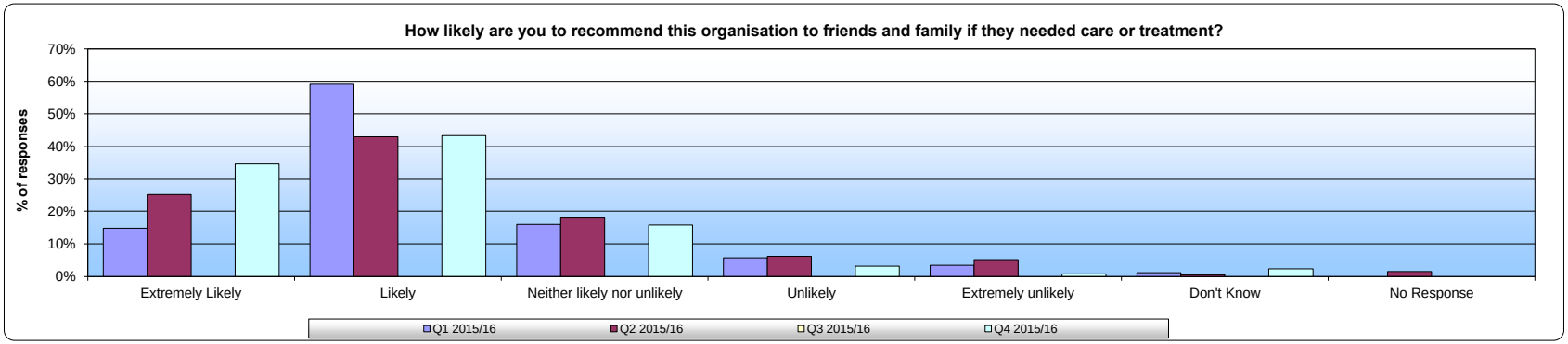
Friends and Family: Staff

York Teaching Hospital NHS
NHS Foundation Trust

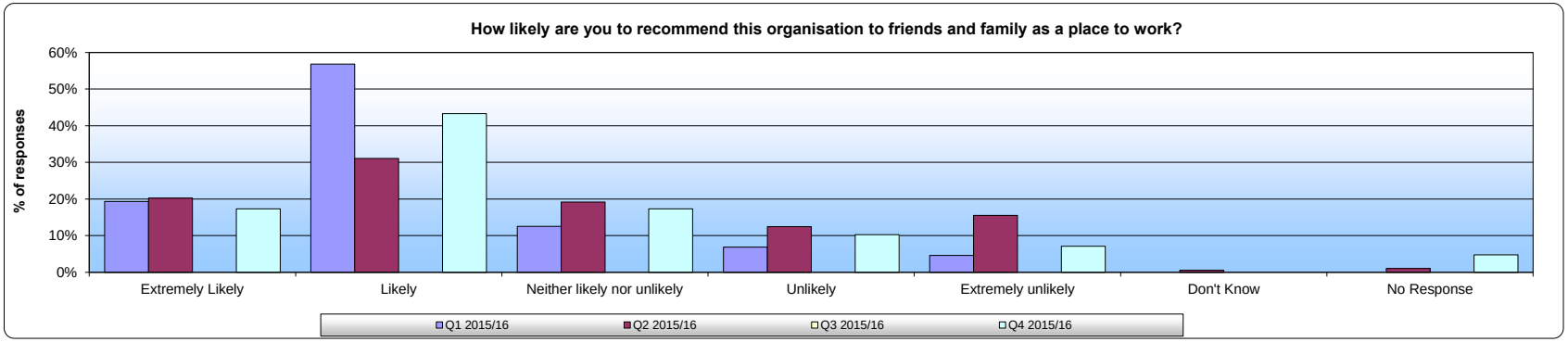
As part of the National Friends and Family CQUIN 2014/15, the Trust was required to submit evidence which demonstrates implementation of staff FFT across all Acute and Community areas.

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

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



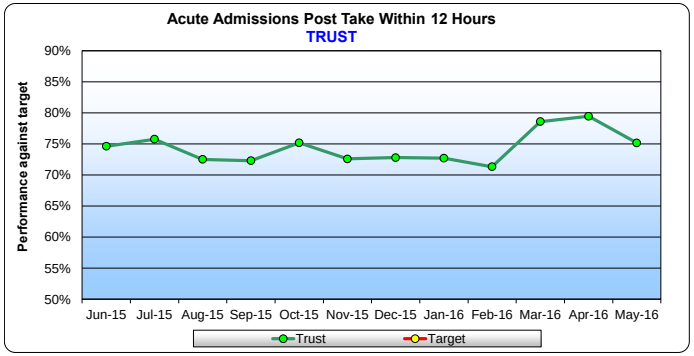
How likely are you to recommend this organisation to friends and family if they needed care or treatment?							
Quarter	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't Know	No Response
Q1 2015/16	14.8%	59.1%	15.9%	5.7%	3.4%	1.1%	0.0%
Q2 2015/16	25.4%	43.0%	18.1%	6.2%	5.2%	0.5%	1.6%
Q3 2015/16	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Q4 2015/16	34.6%	43.3%	15.7%	3.1%	0.8%	2.4%	0.0%

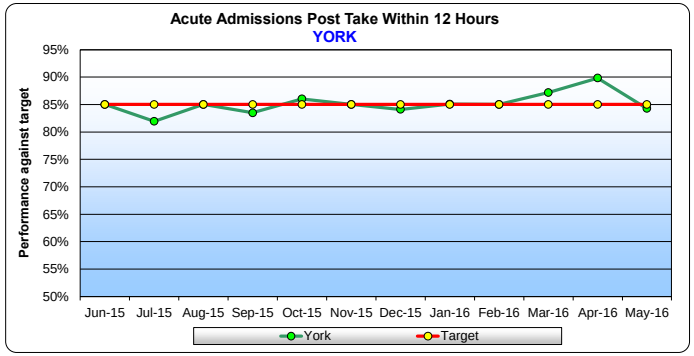


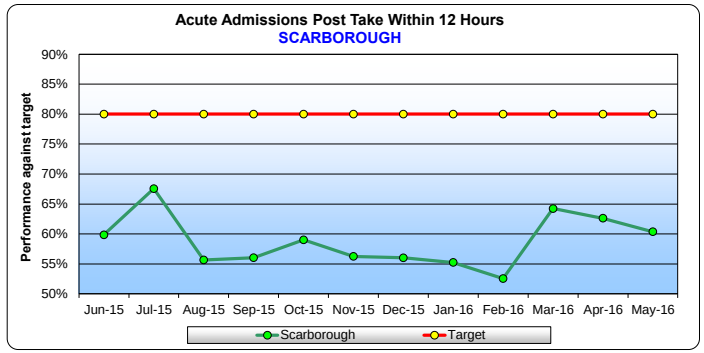
How likely are you to recommend this organisation to friends and family as a place to work?							
Quarter	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't Know	No Response
Q1 2015/16	19.3%	56.8%	12.5%	6.8%	4.5%	0.0%	0.0%
Q2 2015/16	20.2%	31.1%	19.2%	12.4%	15.5%	0.5%	1.0%
Q3 2015/16	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Q4 2015/16	17.3%	43.3%	17.3%	10.2%	7.1%	0.0%	4.7%

Quality and Safety: Care of the Deteriorating Patient

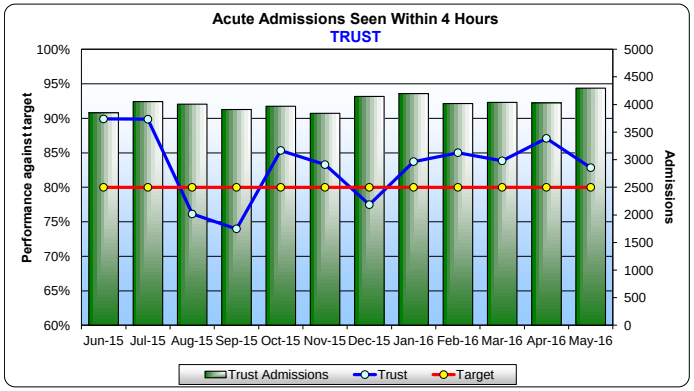
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (SCARBOROUGH)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	80%	61%	60%	57%	57%	64%	63%	60%
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (YORK)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	85%	86%	83%	85%	86%	87%	90%	84%

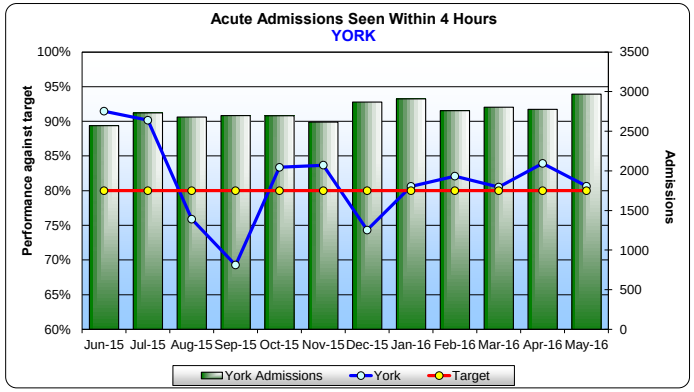


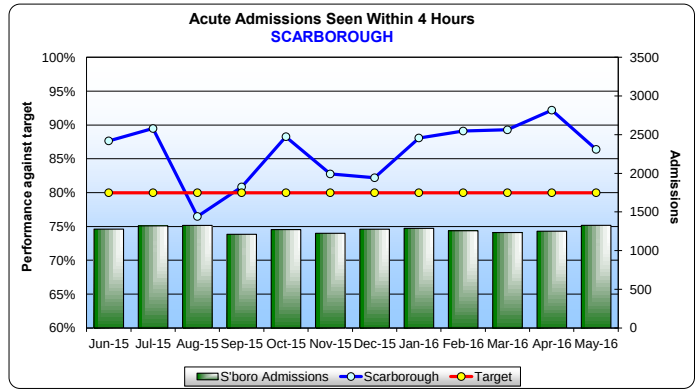




Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	**80% by site**	87.5%	80.1%	82.0%	84.2%	83.8%	87.1%	82.8%

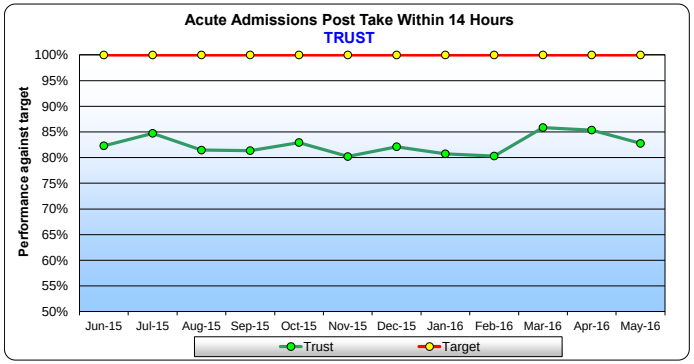


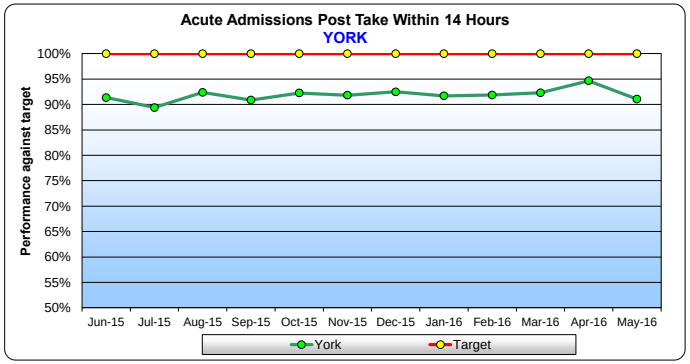


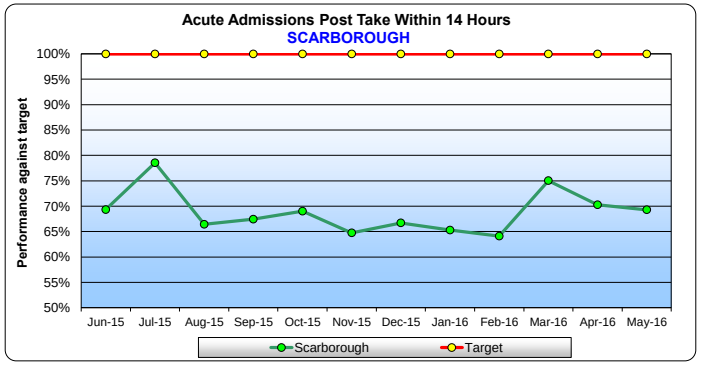


Quality and Safety: Care of the Deteriorating Patient

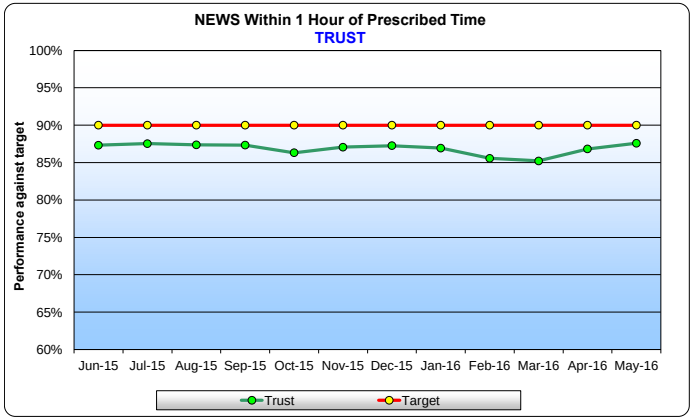
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI		83.9%	82.5%	81.8%	82.3%	85.9%	85.4%	82.8%

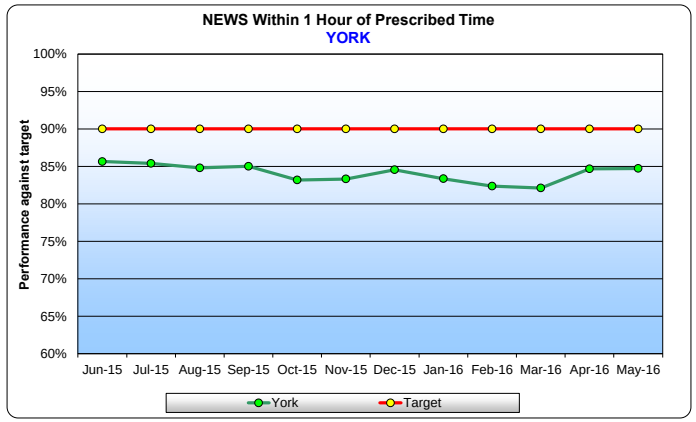


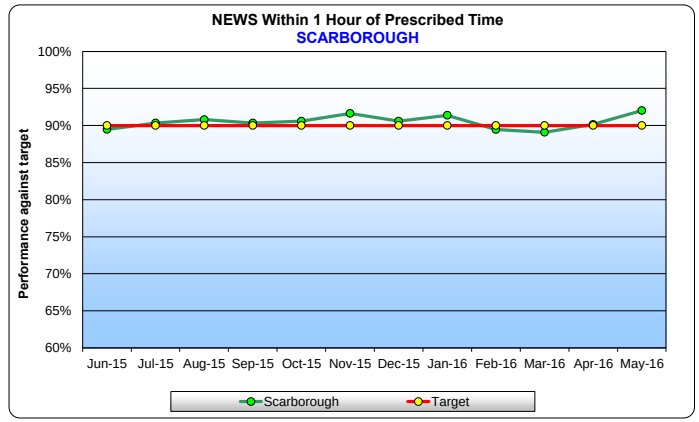




NEWS within 1 hour of prescribed time	None - Monitoring Only		87.0%	87.4%	86.9%	85.9%	85.2%	86.8%	87.6%







Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 12 SIs reported in May; York 8, Scarborough 0 & Community 4.
Clinical Incidents: 2; Both at York.
Slips Trips & Falls: 6; York 4 & Community 2.
Pressure Ulcers: 4; York 2 & Community 2.

Patients Falls and Found on Floor (source: Datix)
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During May there were 113 reports of patients falling at York Hospital, 74 patients at Scarborough and 48 patients within the Community Services. This is a slight reduction on the number reported in April (274), however figures may increase as more investigations are completed.

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during May was 1,165; 651 incidents were reported on the York site, 389 on the Scarborough site and 125 from Community Services.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 780 incidents awaiting sign-off by the Directorate Management Teams.

Pressure Ulcers (source: Datix)
During May 34 pressure ulcers were reported to have developed on patients since admission to York Hospital, 21 pressure ulcers were reported to have developed on patients since admission to Scarborough and 17 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.

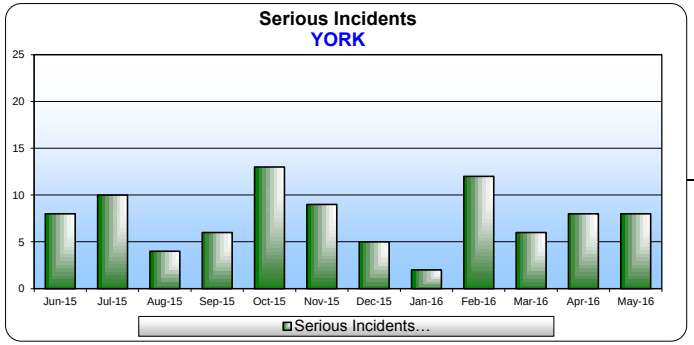
Degree of Harm: Serious/Severe or Death (source: Datix)
During May 5 patient incidents were reported which resulted in serious or severe harm or death. Numbers are subject to change as levels of harm are reviewed and investigations are completed.

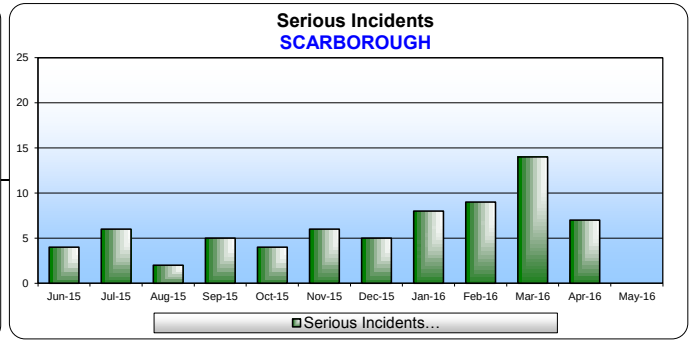
Medication Related Issues (source: Datix)
During May there was a total of 114 medication related incidents reported although this figure may change following validation.

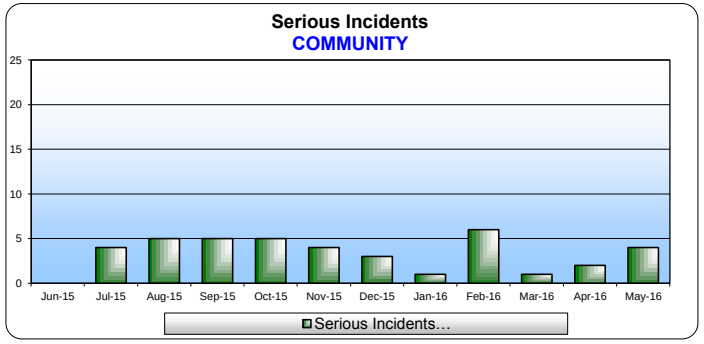
Never Events – No Never events were declared during May.

Measures of Harm

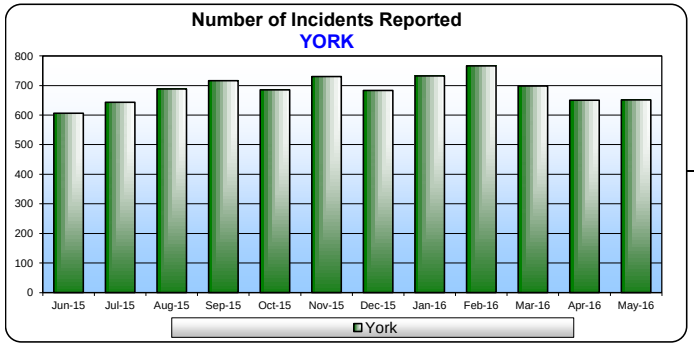
Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Serious Incidents source: Risk and Legal	York	8	10	4	6	13	9	5	2	12	6	8	8
	Scarborough	4	6	2	5	4	6	5	8	9	14	7	0
	Community	0	4	5	5	5	4	3	1	6	1	2	4
Serious Incidents Delogged source: Risk and Legal (Trust)		0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

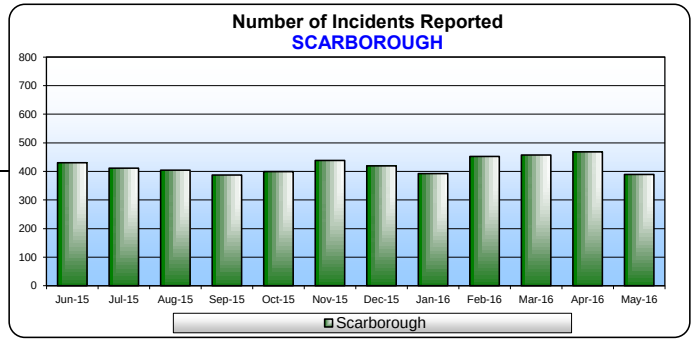


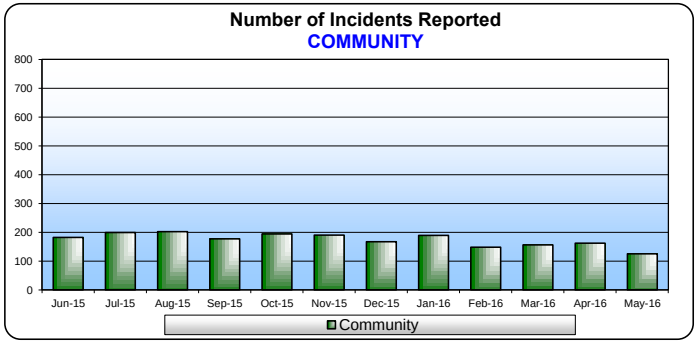




Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Number of Incidents Reported source: Risk and Legal	York	606	643	688	716	685	730	683	732	766	698	650	651
	Scarborough	430	411	404	387	399	438	419	392	452	457	468	389
	Community	182	199	202	177	194	190	167	189	148	156	162	125
Number of Incidents Awaiting sign off at Directorate level		947	1178	1229	1183	839	889	1149	1344	1389	1348	987	780

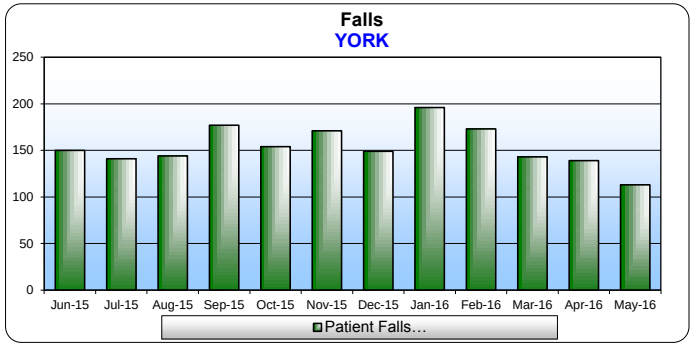


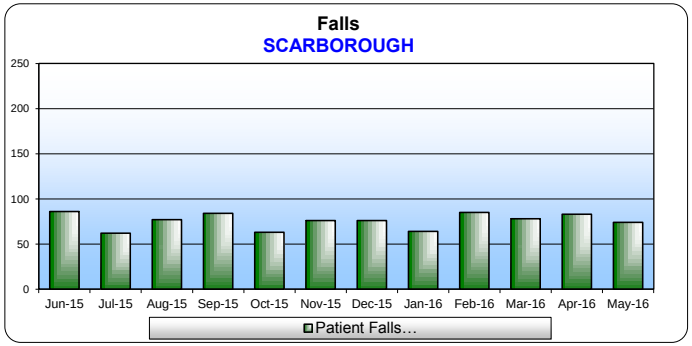


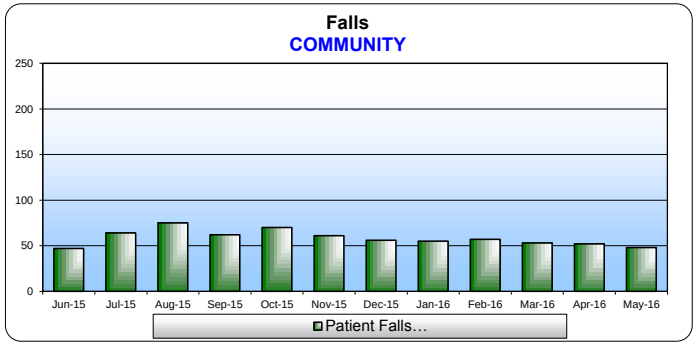


Measures of Harm

Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Patient Falls source: DATIX	York	150	141	144	177	154	171	149	196	173	143	139	113
	Scarborough	86	62	77	84	63	76	76	64	85	78	83	74
	Community	47	64	75	62	70	61	56	55	57	53	52	48

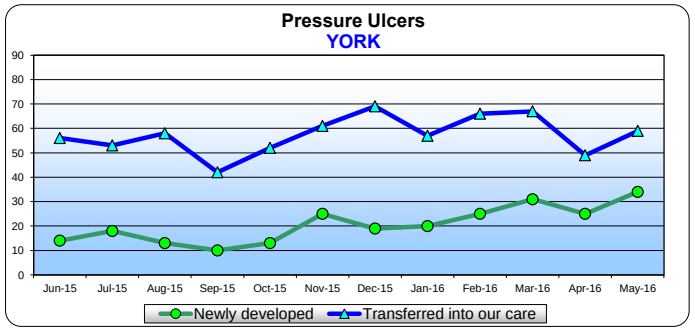


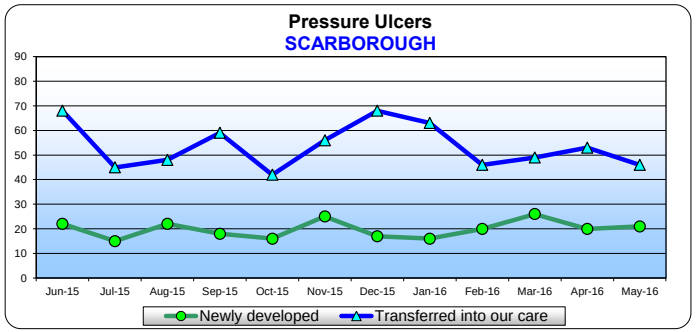


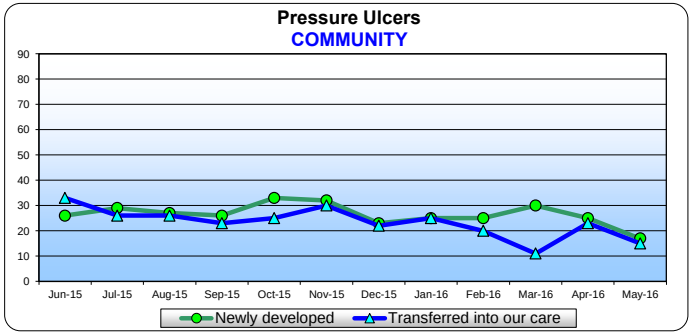


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Indicator			Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Pressure Ulcers source: DATIX	York	Newly developed	14	18	13	10	13	25	19	20	25	31	25	34
		Transferred into our care	56	53	58	42	52	61	69	57	66	67	49	59
	Scarborough	Newly developed	22	15	22	18	16	25	17	16	20	26	20	21
		Transferred into our care	68	45	48	59	42	56	68	63	46	49	53	46
	Community	Newly developed	26	29	27	26	33	32	23	25	25	30	25	17
		Transferred into our care	33	26	26	23	25	30	22	25	20	11	23	15



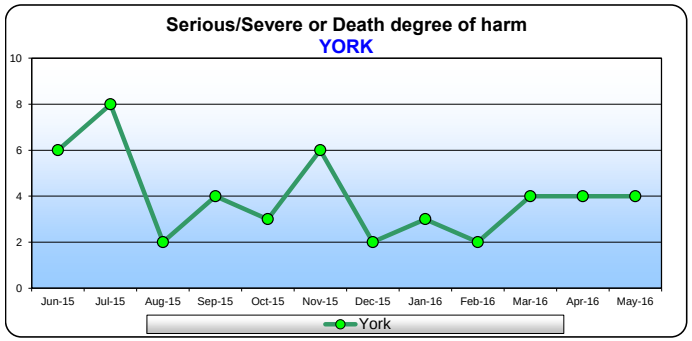


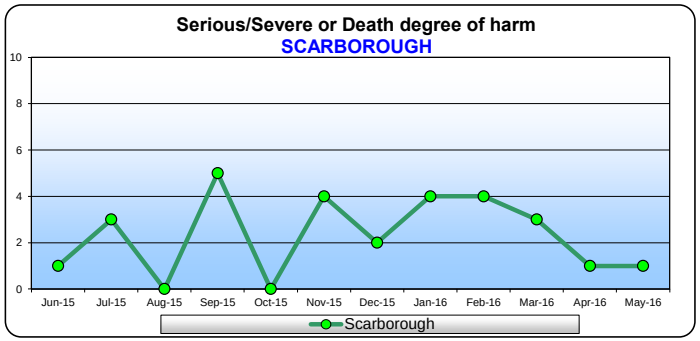


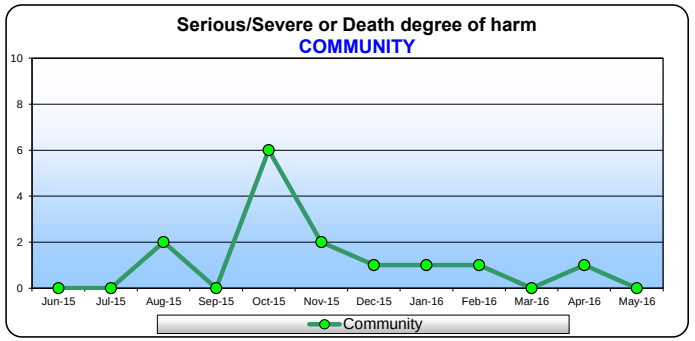
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised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

Measures of Harm

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

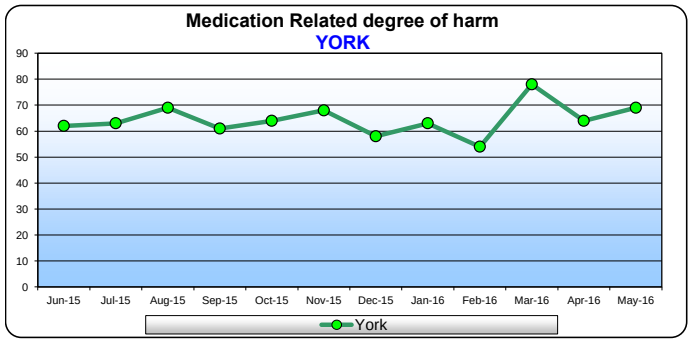


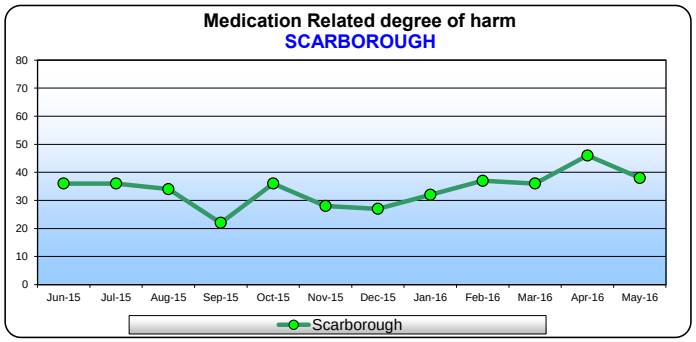


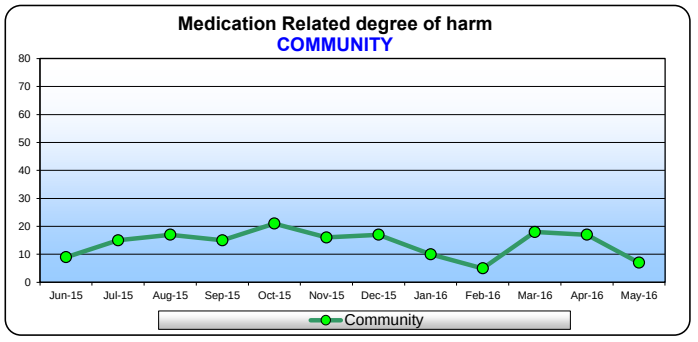


Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Degree of harm: Medication Related Issues source: Datix	York	62	63	69	61	64	68	58	63	54	78	64	69
	Scarborough	36	36	34	22	36	28	27	32	37	36	46	38
	Community	9	15	17	15	21	16	17	10	5	18	17	7

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

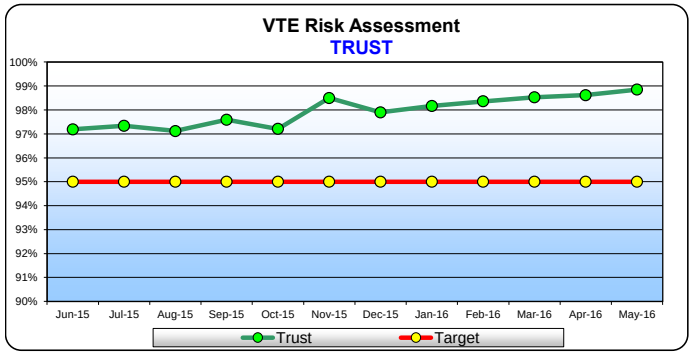


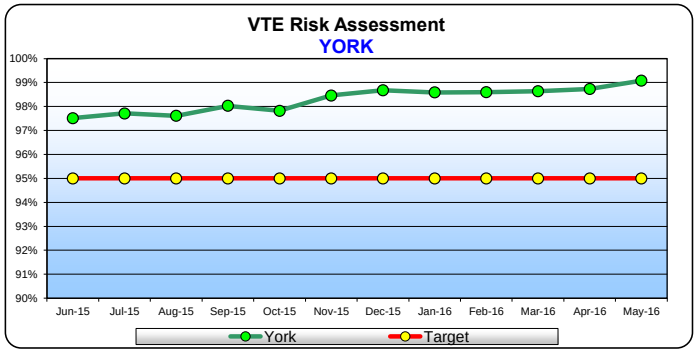


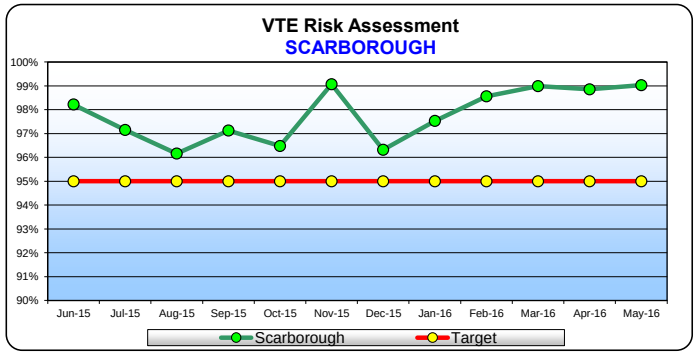


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance source: CPD	£200 in respect of each excess breach above threshold	Trust	95%	97.1%	97.4%	97.9%	98.4%	98.5%	98.6%	98.9%
		York	95%	97.5%	97.8%	98.3%	98.6%	98.6%	98.7%	99.1%
		Scarborough	95%	97.7%	96.8%	97.3%	98.3%	99.0%	98.9%	99.0%







Never Events

Indicator	Consequence of Breach	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
SURGICAL									
Wrong site surgery	As below	**>0**	**1**	**0**	**0**	**0**	0	1	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**	**1**	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 May indicated 1.43% for York and 1.53% for Scarborough.

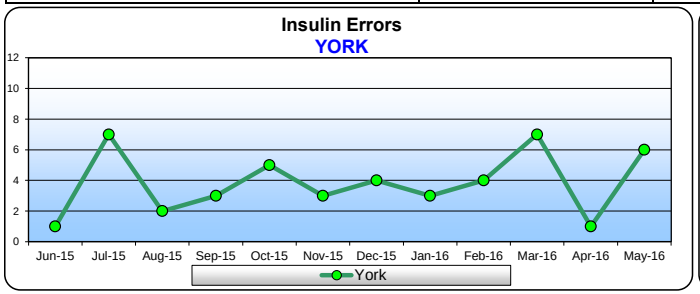
Prescribing Errors
There were 25 prescribing related errors in May; 16 from York, 8 from Scarborough and 1 from Community.

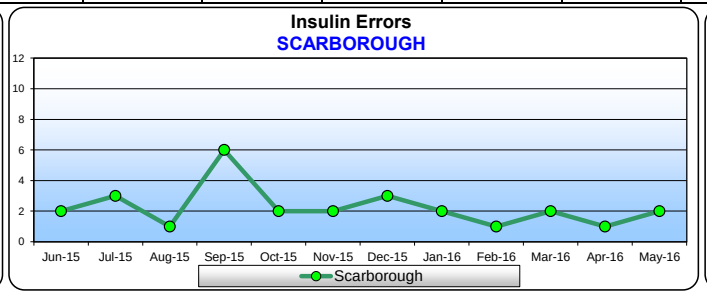
Preparation and Dispensing Errors
There were 21 preparation/dispensing errors in May; 12 from York, 9 from Scarborough and 0 from Community.

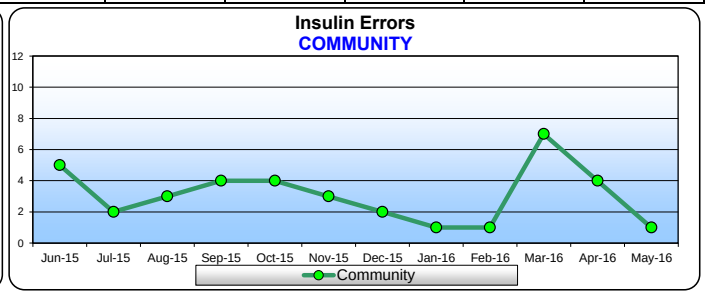
Administrating and Supply Errors
There were 47 administrating/supplying errors in May; 27 were from York, 16 from Scarborough and 4 from Community.

Drug Administration

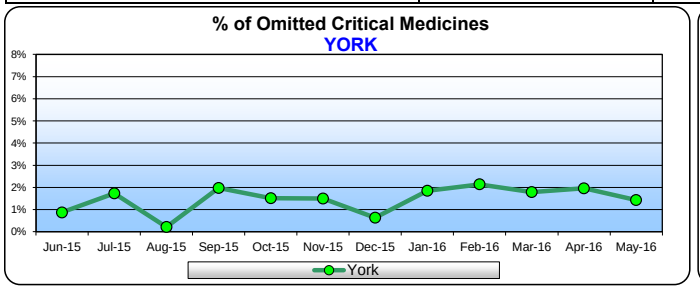
Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Insulin Errors source: Datix	York	1	7	2	3	5	3	4	3	4	7	1	6
	Scarborough	2	3	1	6	2	2	3	2	1	2	1	2
	Community	5	2	3	4	4	3	2	1	1	7	4	1

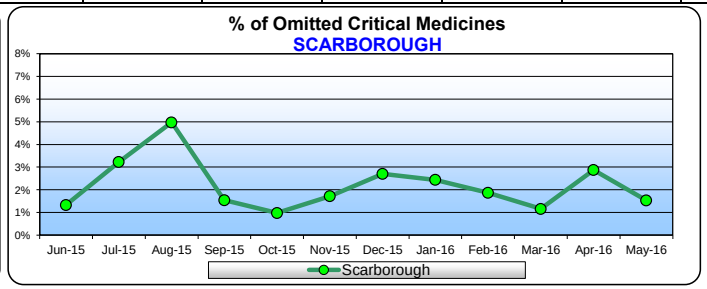


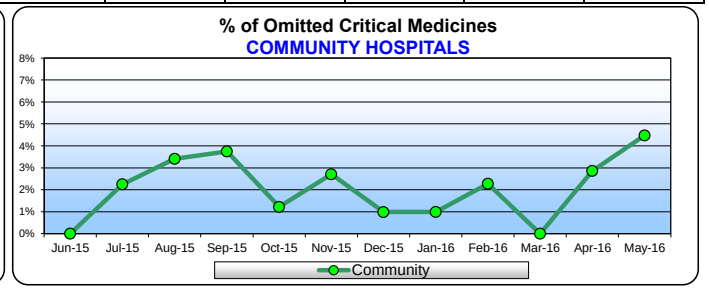




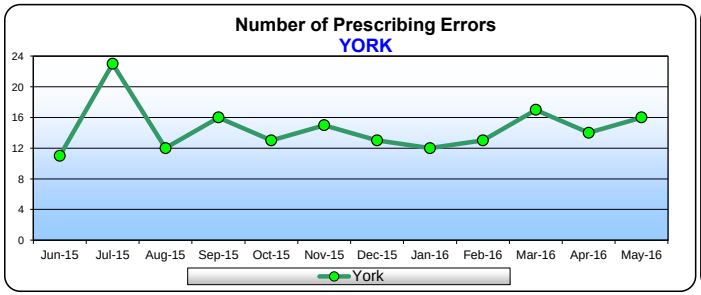
Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Number of Omitted Critical Medicines source: Datix	York	4	8	1	9	6	6	3	9	10	8	9	6
	Scarborough	3	7	10	3	2	4	7	6	5	3	8	4
	Community Hospitals	0	2	3	3	1	2	1	1	2	0	2	3

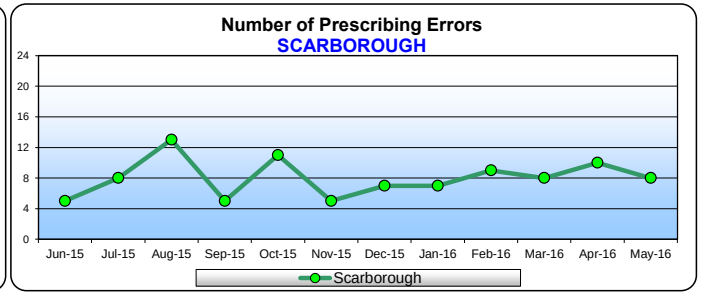


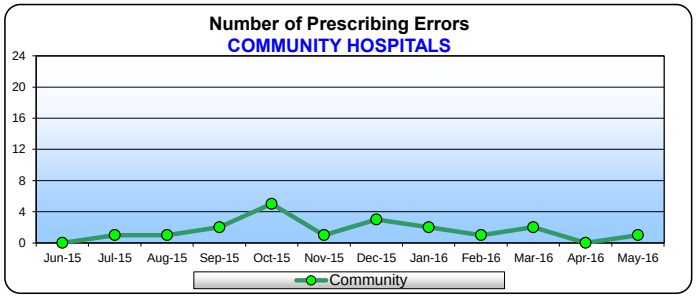




Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Number of Prescribing Errors source: Datix	York	11	23	12	16	13	15	13	12	13	17	14	16
	Scarborough	5	8	13	5	11	5	7	7	9	8	10	8
	Community Hospitals	0	1	1	2	5	1	3	2	1	2	0	1

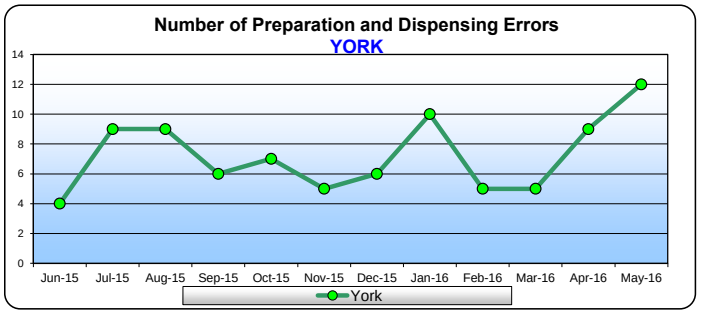


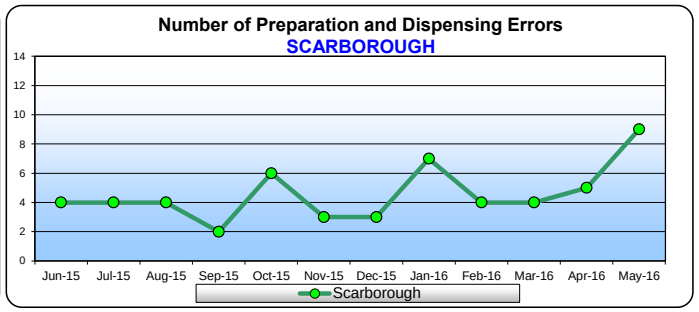


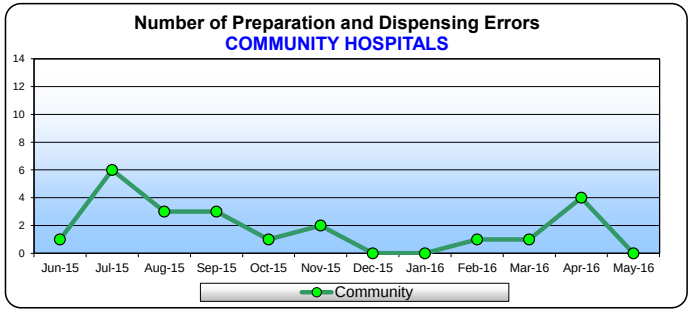


Drug Administration

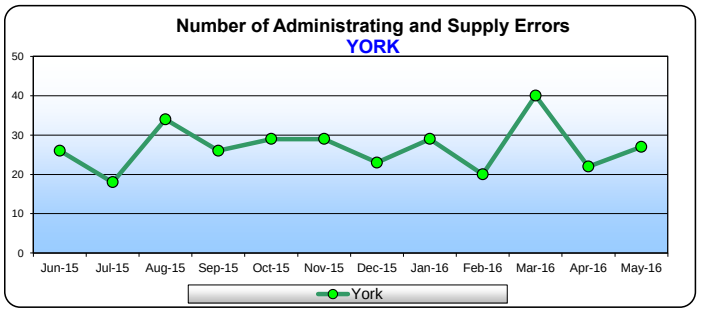
Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Number of Preparation and Dispensing Errors source: Datix	York	4	9	9	6	7	5	6	10	5	5	9	12
	Scarborough	4	4	4	2	6	3	3	7	4	4	5	9
	Community Hospitals	1	6	3	3	1	2	0	0	1	1	4	0

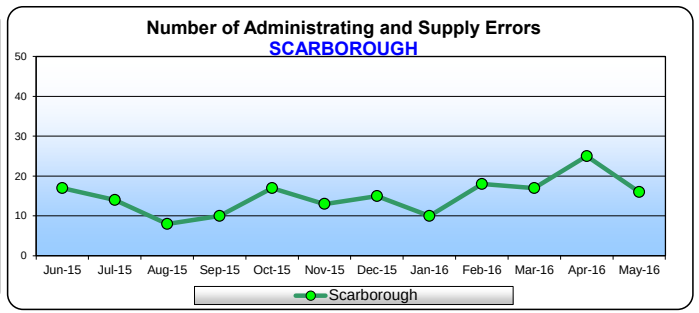


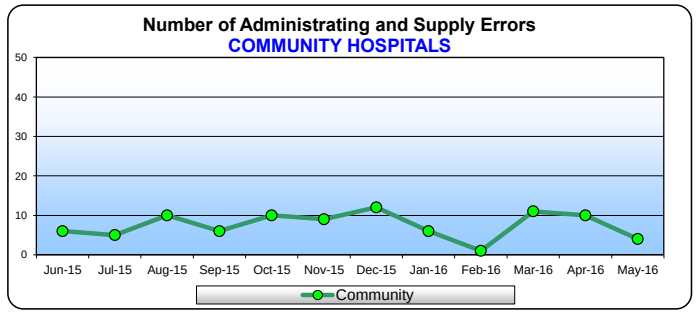




Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Administrating and Supply Errors source: Datix	York	26	18	34	26	29	29	23	29	20	40	22	27
	Scarborough	17	14	8	10	17	13	15	10	18	17	25	16
	Community Hospitals	6	5	10	6	10	9	12	6	1	11	10	4







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

·York: 97.5%
·Scarborough: 95.6%
·Community Hospitals: 90.5%
·Community care: 93.8%

Harm from Catheter Associated Urinary Tract Infection

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

·York: 0.7%
·Scarborough: 1.4%
·Community Hospitals: 0.0%
·Community Care: 0.7%

VTE

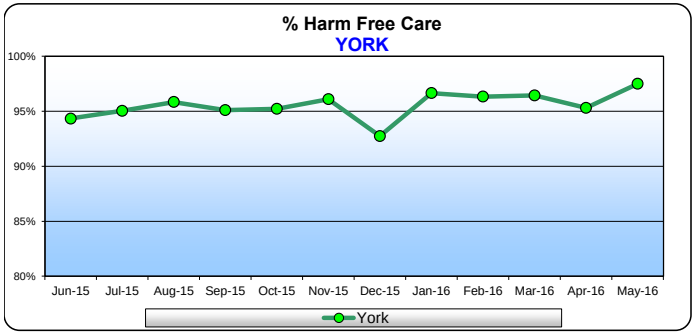
The percentage of patients affected by VTE as measured by the Department of Health definition, monthly measurement of prevalence:

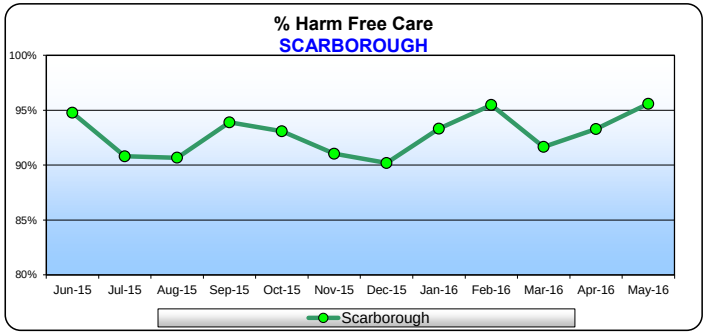
·York: 0.2%
·Scarborough: 0.0%
·Community Hospitals: 0.0%
·Community Care: 0.2%

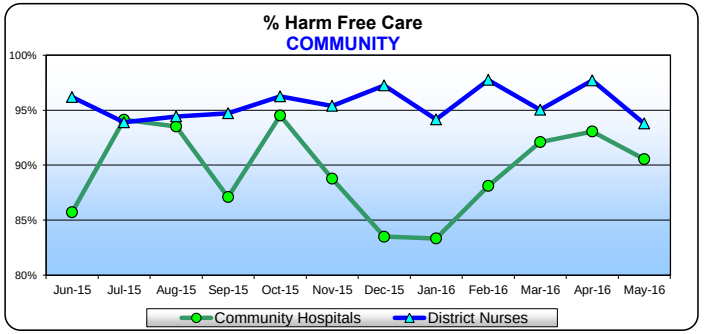
Safety Thermometer

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

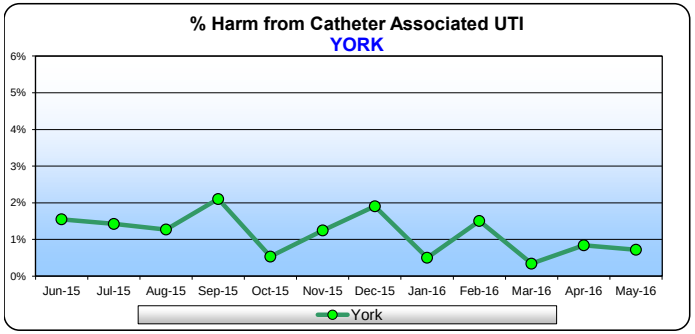
Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
% of Harm Free Care source: Safety Thermometer	York	94.3%	95.0%	95.8%	95.1%	95.2%	96.1%	92.7%	96.7%	96.3%	96.4%	95.3%	97.5%
	Scarborough	94.8%	90.8%	90.7%	93.9%	93.1%	91.0%	90.2%	93.3%	95.5%	91.7%	93.3%	95.6%
	Community Hospitals	85.7%	94.1%	93.5%	87.1%	94.5%	88.8%	83.5%	83.3%	88.1%	92.1%	93.1%	90.5%
	District Nurses	96.2%	93.9%	94.4%	94.7%	96.2%	95.4%	97.2%	94.2%	97.8%	95.0%	97.7%	93.8%

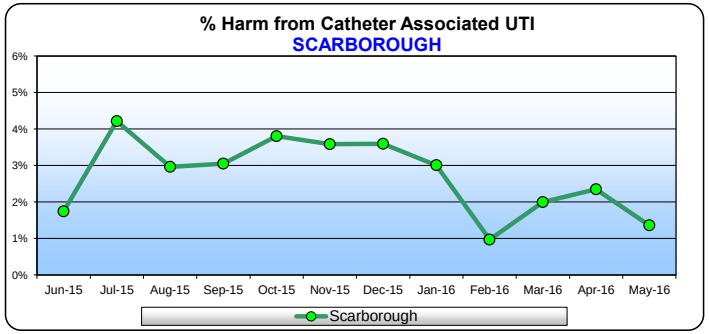


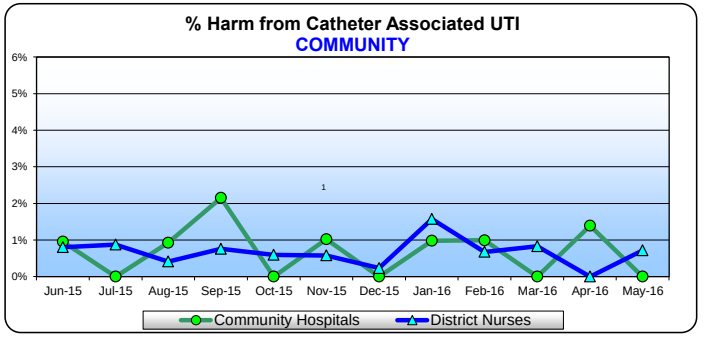




Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	1.5%	1.4%	1.3%	2.1%	0.5%	1.2%	1.9%	0.5%	1.5%	0.3%	0.8%	0.7%
	Scarborough	1.7%	4.2%	3.0%	3.1%	3.8%	3.6%	3.6%	3.0%	1.0%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



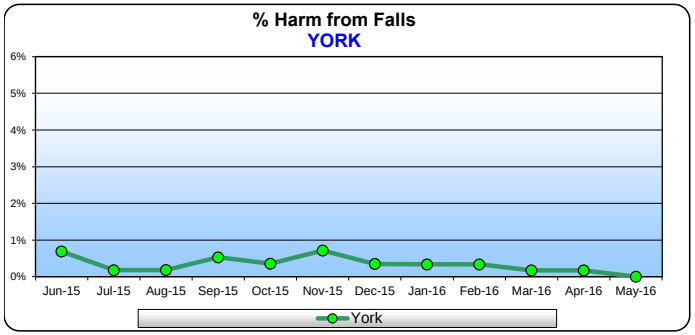


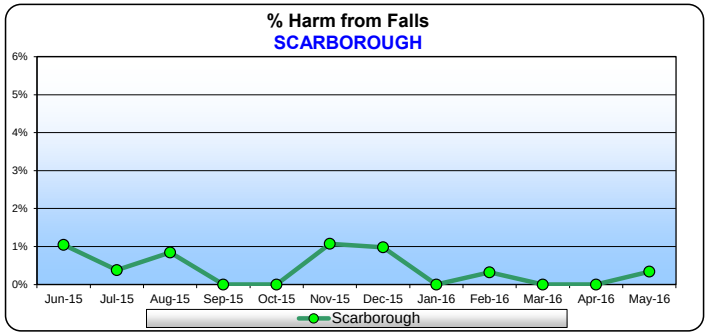


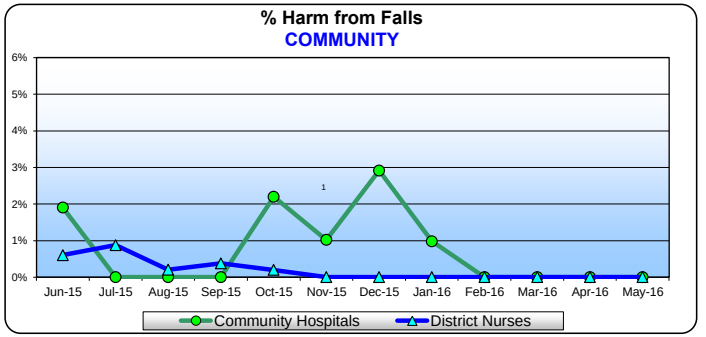
Safety Thermometer

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

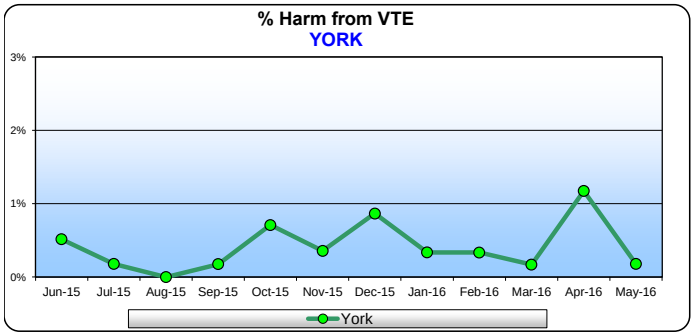
Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
% of Harm from Falls source: Safety Thermometer	York	0.7%	0.2%	0.2%	0.5%	0.4%	0.7%	0.3%	0.3%	0.3%	0.2%	0.2%	0.0%
	Scarborough	1.0%	0.4%	0.8%	0.0%	0.0%	1.1%	1.0%	0.0%	0.3%	0.0%	0.0%	0.3%
	Community Hospitals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

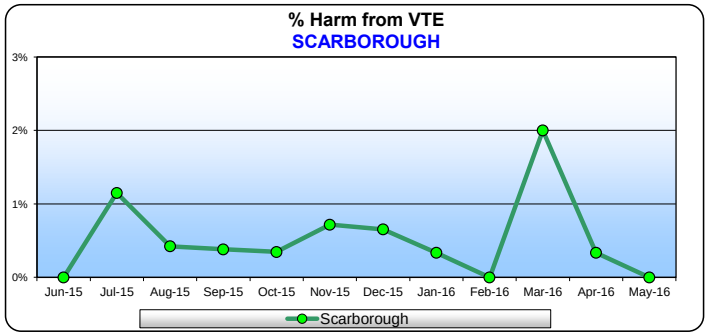


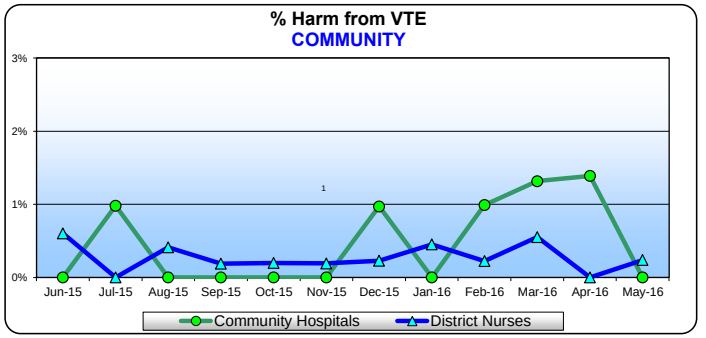




Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
% of VTE source: Safety Thermometer	York	0.5%	0.2%	0.0%	0.2%	0.7%	0.4%	0.9%	0.3%	0.3%	0.2%	1.2%	0.2%
	Scarborough	0.0%	1.1%	0.4%	0.4%	0.3%	0.7%	0.7%	0.3%	0.0%	2.0%	0.3%	0.0%
	Community Hospitals	0.0%	1.0%	0.0%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



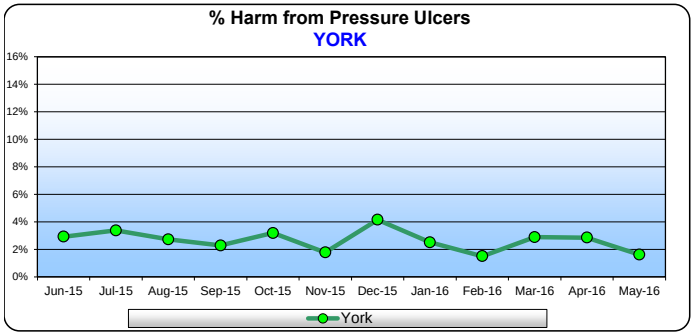


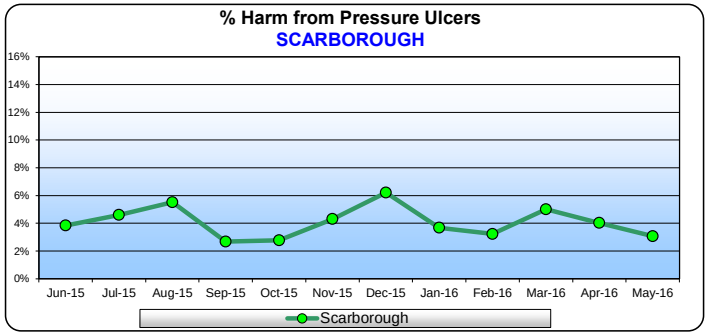


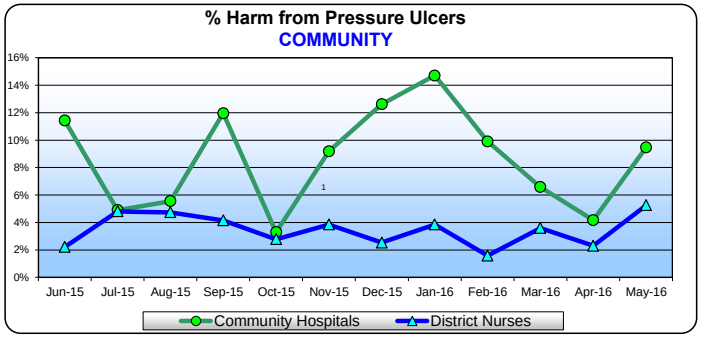
Safety Thermometer

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

Indicator		Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
% of Pressure Ulcers source: Safety Thermometer	York	2.9%	3.4%	2.7%	2.3%	3.2%	1.8%	4.2%	2.5%	1.5%	2.9%	2.9%	1.6%
	Scarborough	3.8%	4.6%	5.5%	2.7%	2.8%	4.3%	6.2%	3.7%	3.2%	5.0%	4.0%	3.1%
	Community Hospitals	11.4%	4.9%	5.6%	12.0%	3.3%	9.2%	12.6%	14.7%	9.9%	6.6%	4.2%	9.5%
	District Nurses	2.2%	4.8%	4.7%	4.2%	2.8%	3.8%	2.5%	3.8%	1.6%	3.6%	2.3%	5.3%







Mortality

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

Definition

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

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

Analysis of Performance

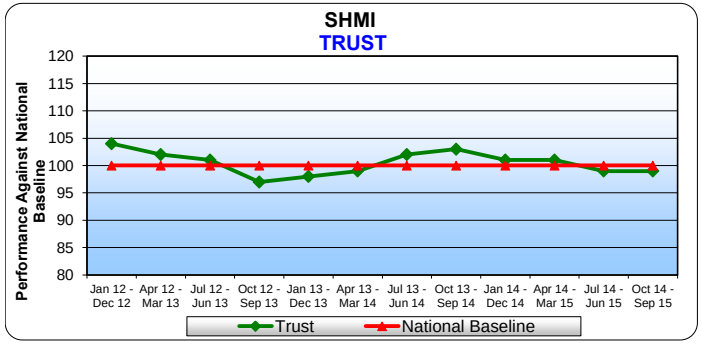
The latest SHMI report indicates the Trust to be in the 'as expected' range. The Oct 2014 - Sep 2015 SHMI saw a 2 point reduction at York and no change for the Trust or Scarborough. Trust - 99, York 93 and Scarborough 107.

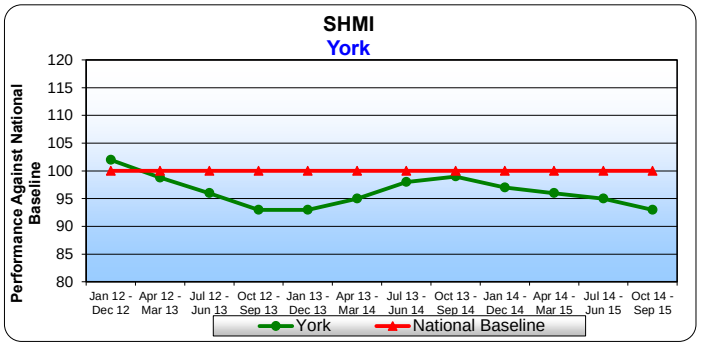
A total of 172 inpatient deaths were reported for the Trust in May; 108 at York and 55 at Scarborough. For the same period last year a total of 197 inpatient deaths were reported for the Trust, therefore there has been a 12.7% decrease. 89 of the inpatient deaths reported in May 2016 were under Geriatric Medicine (51.7%).

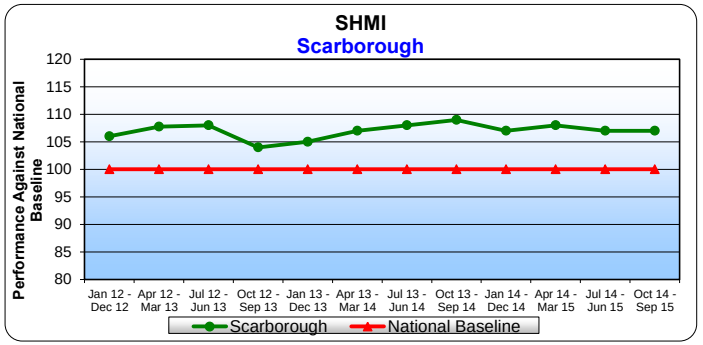
23 deaths in ED were reported in May for the Trust, this is second highest number reported since April 2013 (August 2015 – 26).
The number of ED deaths at York decreased from 13 in April to 11 in May. A total of 140 have been reported in the last 12 months (June 2015 – May 2016) which equates to 12 per month on average.
There were 12 ED deaths at Scarborough in May, an increase from 4 in April. A total of 91 have been reported in the last 12 months (June 2015 – May 2016) which equates to 8 per month on average.

Mortality

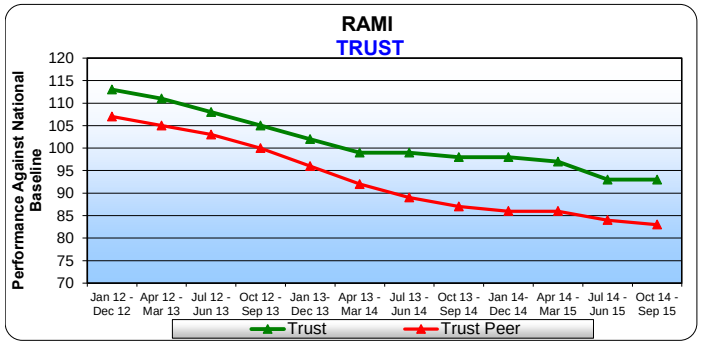
Indicator	Consequence of Breach (Monthly unless specified)	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	99	102	103	101	101	99	99
Mortality – SHMI (YORK)	**Quarterly:** General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

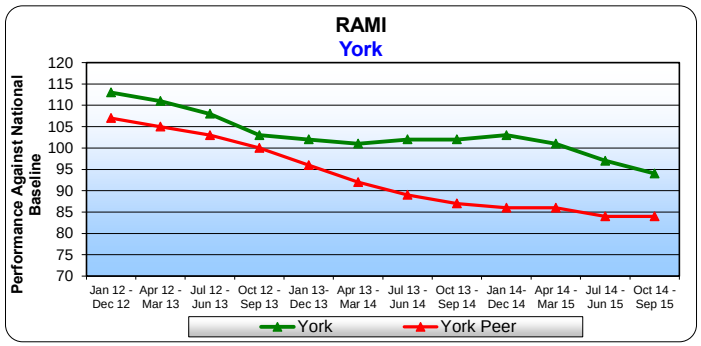


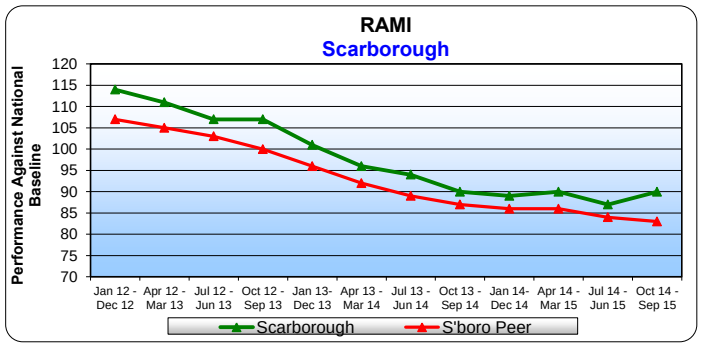




Indicator	Consequence of Breach (Monthly unless specified)	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15
Mortality – RAMI (TRUST)	**none - monitoring only**	99	99	98	98	97	93	93
Mortality – RAMI (YORK)	**none - monitoring only**	101	102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



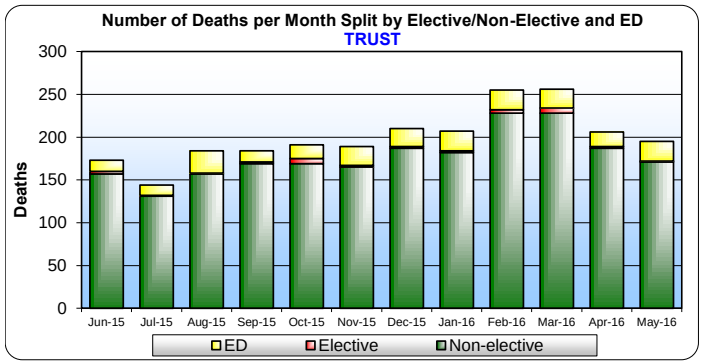


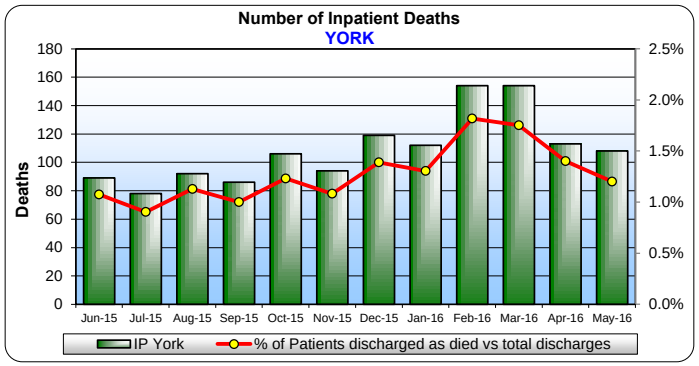


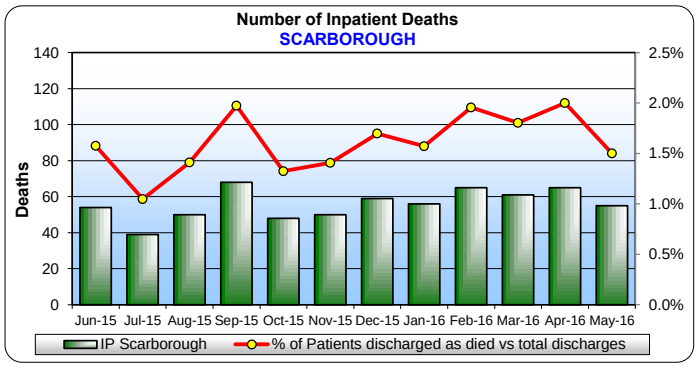
Mortality

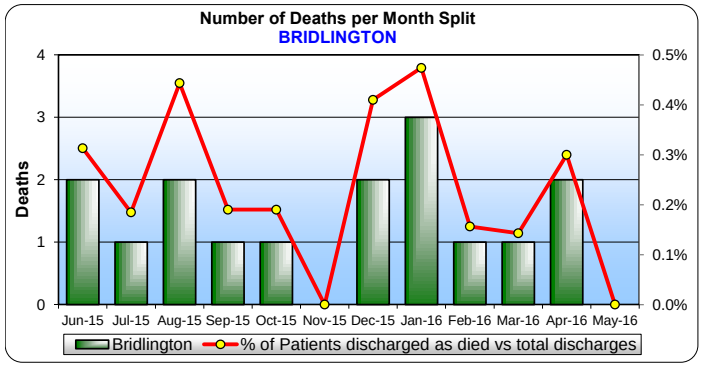
York Teaching Hospital NHS
NHS Foundation Trust

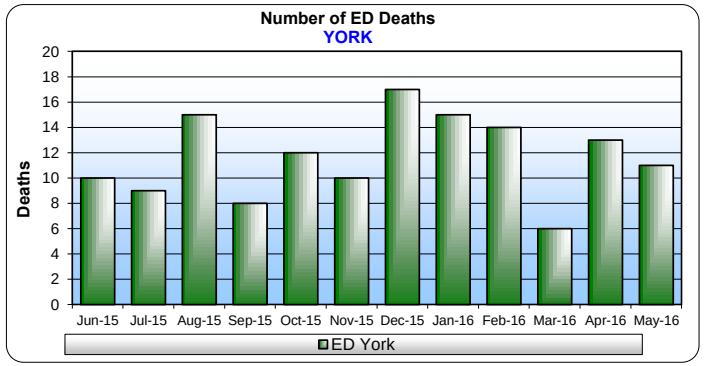
Indicator	Consequence of Breach (Monthly unless specified)	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Number of Inpatient Deaths	None - Monitoring Only	525	461	531	650	234	189	172
Number of ED Deaths	None - Monitoring Only	37	51	59	68	22	17	23

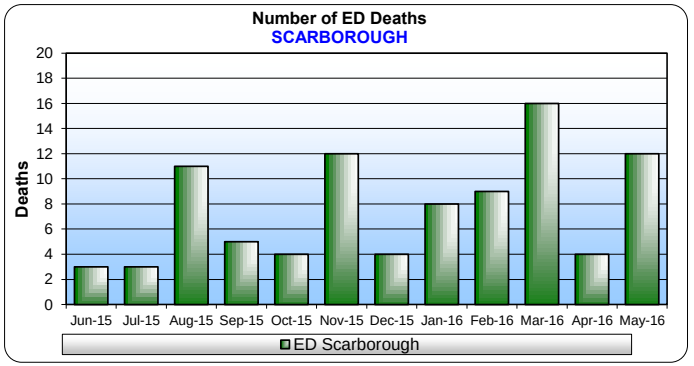


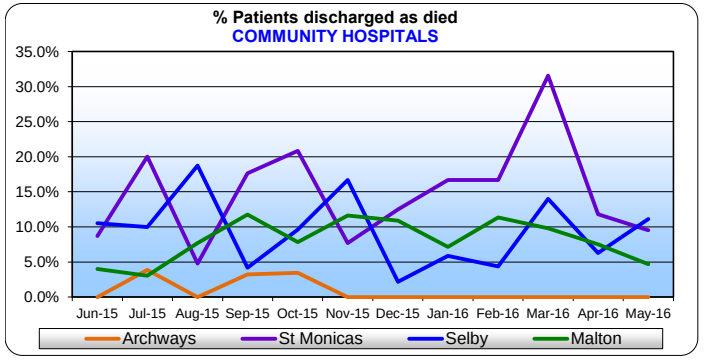


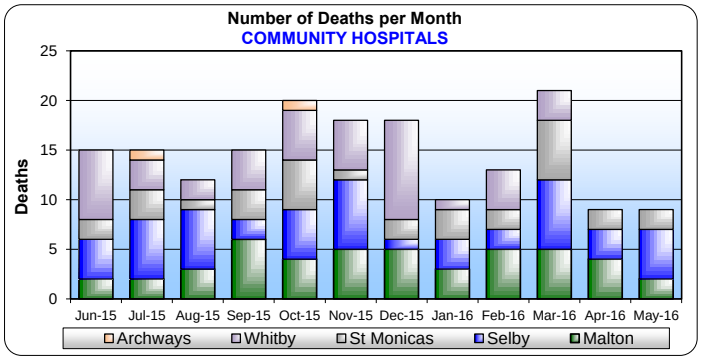












Month	Malton	Selby	St Monicas	Archways	Brid
Jun-15	2	4	2	0	2
Jul-15	2	6	3	1	1
Aug-15	3	6	1	0	2
Sep-15	6	2	3	0	1
Oct-15	4	5	5	1	1
Nov-15	5	7	1	0	0
Dec-15	5	1	2	0	2
Jan-16	3	3	3	0	3
Feb-16	5	2	2	0	1
Mar-16	5	7	6	0	1
Apr-16	4	3	2	0	2
May-16	2	5	2	0	0

Patient Safety Walkrounds – May 2016

Date	Location	Participants	Actions & Recommendations
13/05/2016	Ward 36 & Ward 39	Diane Palmer – Deputy Director Darren Fletcher – Patient Safety Manager Karen Goodman – Clinical Director Jamie Todd – Directorate Manager Lee Fry – Matron Sandra Hindmarsh – Ward Sister Sally Tutill – Ward Sister Michael Keeling – Stroke Specialist Nurse Libby Raper - NED	Ward 39 Three clostridium difficile infections occurred during December / January 2016. Following investigation IPC recommended that Ward 39 should have a refurbishment. Lack of storage results in equipment and chairs being stored on the ward corridor. Action -JT to liaise with Estates for start date of refurbishment. 'Door to Needle' times for stroke patients are improving although access to computers within the ED sometimes causes delays in organising scans and reviewing results. Action –MK to discuss provision of hand-held device for HASU nurse. Ward 36 There are a significant number of RN vacancies on the ward and retention is a problem. Action –DP, LF & ST to agree a development programme for RNs. There have been 3 incidents of severe harm from patient falls in the last 6 months, learning has identified that support around mealtimes is crucial. Action –LF to consider greater use of volunteers. Shelves above the beds in the gym could pose a hazard. Action –LF to arrange for removal.
16/05/2016	Beech, Chestnut & Graham	Ed Smith – Deputy Medical Director Jennie Adams - NED	Beech Ward Nurse staffing remains the primary safety concern, there is some confusion regarding the ratio of budget to establishment. Last month 12% of vacancy shifts were unfilled and the ward vacancy rate is 11%. Medical staffing remains a challenge with one permanent respiratory consultant vacancy and very few non-locum junior doctors. This ward cares for patients with NIV, tracheostomies and chest drains and is a "step down" ward for ITU, therefore acuity is often high. Lack of side rooms/isolation facilities is also a concern. Bed 31 does not have a functioning call bell. Chestnut Ward Nurse staffing is a concern as the RN establishment is below what is required for the acuity of the patients. There are significant concerns with regard to nurses being moved to other wards at night leaving only 2 nurses on the ward, this occurs frequently at the weekend. Some patients do not have a daily senior medical review and junior doctors often have to spend a considerable amount of time on other wards due to the volume of patients outlying on other wards. Caring on a 1:1 with patients with alcohol related issues is particularly challenging. Mental health support needs to be better. The floor in bay 1 is badly pitted and requires replacement. There is no oxygen piped to 5 of the beds on the ward. Graham Ward Nursing staffing is a concern if the dependency is high or when nurses are moved to help on other wards. Patient falls do happen but there is evidence of learning from SI investigations. The position of the nurse's station means that patients are out of sight when nurses are at the desk.
16/05/2016	Labour Ward, G2, G3, G3 and Antenatal Services	Helen Noble – Head of Patient Safety Nicola Dean – Clinical Director Kim Hinton – Directorate Manager A/L DP aware Chris Foster – Matron Liz Ross – Head of Midwifery Mike Sweet - NED	Labour Ward The main corridor floor is patched. Highlighted as a risk 11/02/14.There are two different shades of flooring which has been highlighted as a trip hazard for visually impaired patients. Action - Mike Sweet will raise concerns with Brian Golding and Trish Fowler to contact Estates. Leakage through ceiling from blocked sluices in wards above. Highlighted as a risk 21/05/15. Action – Mike Sweet to discuss with Brian Golding. Antenatal Clinic The main corridor floor to ADU is taped and patched and appears a trip hazard. Action - Mike Sweet will raise concerns with Brian Golding and Debbie Scott to contact Estates.
17/05/2016	Critical Care Unit (ICU & HDU)	Brian Golding – Director Tariq Hoth – Clinical Director Tracey Richardson - Deputy Directorate Manager Elaine Hunter - Lead Sister Wendy Brown – Matron Diane Willcocks - NED	There are 17 beds in total; we are currently funded for 11 level 3, (ICU), beds which are currently under review and may increase to 12. The most recent SI related to an incorrectly operated infusion pump which resulted in a patient receiving an over dose of potassium. The unit is operating a paper based health record system, and are considering developing a business case to deliver an electronic solution. Patients requiring long term ventilation go to third party providers and don't always get best care - Consider case for provision of a long term ventilation unit and discuss at PMM.
27/05/2016	Ward 17, 18, SCBU and Child Development Centre	Andy Bertram – Director Jo Mannion – Clinical Director Liz Vincent – Directorate manager Nicola Lockwood – Matron Libby Raper - NED	A notable increase in teenage self-harm cases and associated difficulties with paed/MH interface was reported the directorate are addressing many of the issues, including training, appointment of a dual trained nurse, environmental audits, and business case for mental health liaison service Ward 17 - No en-suite facilities, which means that the area is non-compliant for oncology patients and cystic fibrosis admission. To obtain costings for installation of this work. Patient request for Wi-Fi – To discuss at PAM.

Infection Prevention - MRSA Incidence

York Teaching Hospital NHS
NHS Foundation Trust

MRSA bacteraemia

Cases by Directorate from April 16 to March 17

YORK HOSPITAL	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Anaesthetics													0
Elderly													0
Head and Neck													0
Haematology													0
Medical													0
Obs and Gynae													0
Orthopaedics													0
Paediatrics													0
Specialist Medicine	1												1
Surgical													0
York	1	0	0	0	0	0	0	0	0	0	0	0	1

Scarborough and Bridlington Hospitals	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Acute Medicine													0
Anaesthetics													0
Elderly Medicine													0
Medical													0
Obs and Gynae													0
Orthopaedics													0
Surgical													0
Paediatrics													0
Scarborough and Bridlington	0	0	0	0	0	0	0	0	0	0	0	0	0

COMMUNITY	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Archways													0
Rehabilitation Units													0
St Helens													0
Whitecross Court													0
Malton													0
Selby													0
St Monicas													0
Whitby													0
Community	0	0	0	0	0	0	0	0	0	0	0	0	0

Infection Prevention - CDIFF Incidence

York Teaching Hospital NHS
NHS Foundation Trust

Clostridium difficile (toxin positive only) - Toxin positive by EIA only - as per mandatory reporting

Post 3 day cases by Directorate from April 16 to March 17

YORK HOSPITAL	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Anaesthetics													0
Elderly													0
Haematology													0
Medical		1											1
Neurology													0
Surgical													0
Specialist Medicine													0
Head and Neck													0
Orthopaedics													0
Obs and Gynae													0
Paediatrics													0
York	0	1	0	0	0	0	0	0	0	0	0	0	1

Scarborough and Bridlington Hospitals	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Acute Medicine													0
Anaesthetics													0
Elderly Medical	2												2
Medical													0
Obstetrics													0
Orthopaedics													0
Paediatrics													0
Surgical	1												1
Scarborough and Bridlington	3	0	0	0	0	0	0	0	0	0	0	0	3

COMMUNITY	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Archways													0
Rehabilitation Units													0
St Helens													0
Whitecross Court													0
Malton													0
Selby													0
St Monicas													0
Whitby													0
Community	0	0	0	0	0	0	0	0	0	0	0	0	0

Infection Prevention - ECOLI Incidence

York Teaching Hospital NHS
NHS Foundation Trust

E coli bacteraemia

Post 2 day cases by Directorate from April 16 to March 17

YORK HOSPITAL	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Anaesthetics													0
Elderly		1											1
Haematology	2												2
Head and Neck													0
Medical		1											1
Neurology													0
Obs and Gynae													0
Oncology													0
Paediatrics													0
Specialist Medicine													0
Surgical		1											1
York	2	3	0	0	0	0	0	0	0	0	0	0	5

Scarborough and Bridlington Hospitals	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Acute Medicine													0
Anaesthetics													0
Elderly Medicine		2											2
Medical													0
Obstetrics													0
Orthopaedics													0
Paediatrics													0
Surgical	2												2
Scarborough and Bridlington	2	2	0	0	0	0	0	0	0	0	0	0	4

COMMUNITY	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Archways													0
Rehabilitation Units													0
Malton	1												1
Selby													0
St Monicas													0
Whitby													0
Community	1	0	0	0	0	0	0	0	0	0	0	0	1

Infection Prevention - MSSA Incidence

York Teaching Hospital NHS
NHS Foundation Trust

MSSA bacteraemia

Post 2 day cases by Directorate from April 16 to March 17

YORK HOSPITAL	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Anaesthetics													0
Elderly													0
Head and Neck													0
Haematology													0
Medical	1												1
Obs and Gynae													0
Orthopaedics													0
Paediatrics													0
Specialist Medicine													0
Surgical	3	1											4
York	4	1	0	0	0	0	0	0	0	0	0	0	5

Scarborough and Bridlington Hospitals	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Acute Medicine													0
Anaesthetics													0
Elderly Medicine	2	1											3
Medical	2												2
Obs and Gynae													0
Orthopaedics	1												1
Surgical													0
Paediatrics													0
Scarborough and Bridlington	5	1	0	0	0	0	0	0	0	0	0	0	6

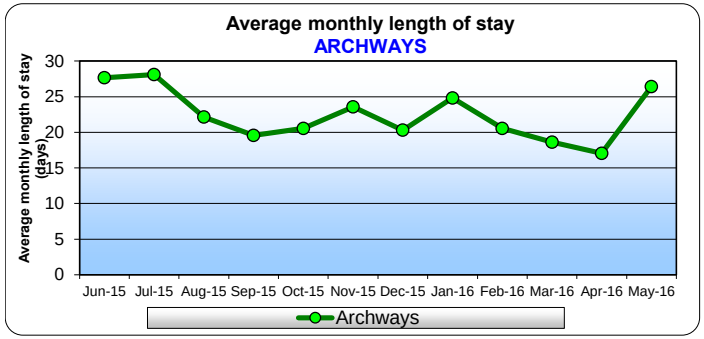
COMMUNITY	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Archways													0
Rehabilitation Units													0
St Helens													0
Whitecross Court													0
Malton													0
Selby													0
St Monicas													0
Whitby													0
Community	0	0	0	0	0	0	0	0	0	0	0	0	0

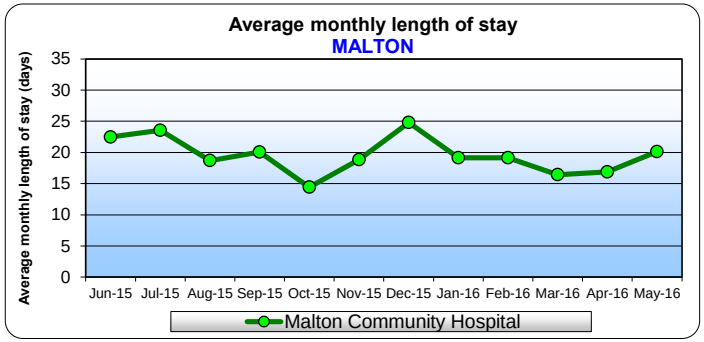
YORK - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Activity	Births	Bookings	1st m/w visit	CPD	≤302	303-329	≥330	298	281	296	281	294	305	301	254	271	311	246	273
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	82.9%	87.2%	89.2%	85.4%	87.1%	87.9%	85.7%	86.2%	87.5%	82.6%	90.2%	89.4%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	6.0%	5.0%	5.7%	7.5%	6.5%	7.2%	4.7%	3.9%	4.8%	7.7%	2.4%	7.7%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	33.3%	28.6%	76.5%	95.2%	73.7%	86.4%	64.3%	90.0%	76.9%	79.2%	33.3%	61.9%
		Births	No. of babies	CPD	≤295	296-309	≥310	276	285	291	310	287	316	290	291	270	276	246	304
		No. of women delivered	No. of mothers	CPD	≤295	296-310	≥311	272	284	288	304	282	311	286	287	269	274	245	294
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	3	0	0	0	0	0	0	0	0	0	0	0
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	0	0	0	0	0	0	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	5	2	8	6	6	5	5
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	1	0	0	0	0	0	0
		SCBU at capacity of intensive cots	No. of times	SCBU	0	1	2 or more	0	0	0	1	0	1	0	1	1	0	0	1
		SCBU no of babies affected	No. of babies affected	SCBU	0		1 or more	0	0	0	1	0	0	0	0	0	0	0	0
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	35-31	≤31.0	30.0	32.0		32.0	29.8	28.5	29.3	30.1				
		1 to 1 care in Labour	CPD	CPD	≥100%		<100%	63.2%	67.3%	64.2%	70.4%	61.3%	63.0%	70.3%	69.0%	65.8%	63.3%	62.0%	57.1%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%		<100%	50.0%	53.0%	56.0%	58.0%	37.1%	50.0%	60.0%	50.0%	56.0%	64.0%	50.0%	48.0%
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	76	76	76	76	76	76	76	76	76	76	76	76
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10		≤9	10	10	10	10	10	10	10	10	10	10	10	10
		Supervisor : M/w ratio 1 :	Ratio	Rota - Contact SOM	15	16-18	≥17	14	14	14	14	14	14	14	14	14	14	14	14
Clinical Indicators	Neonatal/Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%	55.1%	61.1%	55.0%	63.2%	57.8%	62.3%	63.1%	60.1%	58.9%	58.7%	56.1%	63.2%
	Morbidity	Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17%	≥18%	15.2%	11.9%	13.4%	10.0%	12.9%	12.7%	14.1%	15.5%	15.9%	14.9%	11.8%	13.8%
		C/S Births	Em & elect - %	CPD	≤26%	26-28%	>28%	29.3%	25.6%	28.5%	25.5%	27.9%	24.4%	22.4%	23.7%	25.2%	25.4%	31.3%	23.0%
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	1	2	2	2	3	1	1	2	0	0	0	0
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	16	8	19	18	21	11	17	16	31	24	17	12
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	1	3	7	1	2	1	5	3	2	2	3	1
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	0	0	0	0	0	0	1	0	0	0	0	0
		Neonatal Death	No of babies	Risk team- EBC	0		1 or more	0	0	0	0	0	0	0	0	1	0	0	0
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	0	1	1	0	1	1	0	0	1	1	2	0
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70%	>70%	71.0%	69.7%	74.0%	76.3%	72.3%	72.7%	74.5%	79.1%	71.0%	73.4%	74.3%	75.2%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	14.3%	12.7%	10.8%	9.9%	13.1%	9.6%	12.2%	9.4%	14.5%	9.9%	13.1%	11.9%
	Risk Management	SI's	No. of SI's declared	Risk Team	0		1 or more	0	0	0	0	0	0	0	0	0	0	1	1
		CI's	No. of CI's declared	Risk Team	0		1 or more	1	0	0	0	0	0	0	0	0			
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	6	7	8	10	12	6	7	7	13	14	6	9
		PPH > 1.5L as % of all women	% of births	CPD				2.2%	2.5%	2.7%	3.2%	4.2%	1.9%	2.4%	2.4%	4.8%	5.1%	2.4%	3.0%
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	7	3	4	2	3	4	7	6	2	0	2	3
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.5- 4%	≥4%	4.6%	1.4%	3.5%	2.2%	3.4%	3.4%	4.0%	2.7%	1.0%	0.5%	1.8%	0.9%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	0	1	1	2	2	0	0	0	2	0	0	1
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	0	3	0	0	1	0	1	1	0	0	2	1

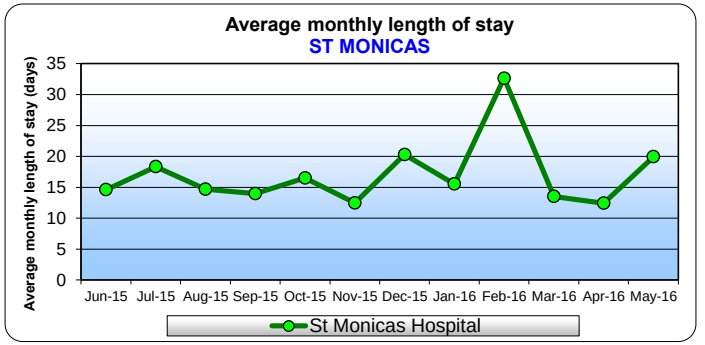
SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Activity	Births	Bookings	1st m/w visit	CPD	≤210	211-259	≥260	196	160	205	194	155	186	200	138	202	178	154	151
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	92.3%	91.3%	84.9%	8140.0%	92..3%	83.9%	86.5%	89.9%	90.6%	93.3%	90.9%	86.1%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	6..1%	5..6%	10.7%	15.5%	7.1%	8.6%	6.5%	8.7%	6.4%	3.4%	8.4%	9.3%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	100.0%	100.0%	77.3%	86.7%	100.0%	100.0%	76.9%	100.0%	100.0%	100.0%	92.3%	78.6%
		Births	No. of babies	CPD	≤170	171-189	≥190	131	118	134	134	139	133	139	121	107	123	142	113
		No. of women delivered	No. of mothers	CPD	≤170	171-189	≥190	131	114	133	134	139	132	139	120	106	120	139	113
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	0	0	0	0	0	0	0	0	0	0	1	
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	0	0	0	0	0	0	0	0	1	
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	1	0	0	0	0	0	0	0	0	0	0	0
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		SCBU at capacity	No. of times	SCBU	0	1	2 or more	12	4	7	4	6	1	2	10	2	0	1	1
		SCBU no of babies affected	No. of babies affected	SCBU	0		1 or more	1	0	0	0	0	0	0	1	0	0	0	0
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	35-31	≤31.0	41.2	42.2	36.6	39.1	36.8	37.0	38.8	39.4	40.2	40.4	43.0	40.2
		1 to 1 care in Labour	CPD	CPD	≥100%		<100%	95.4%	88.6%	85.0%	86.6%	83.5%	85.6%	91.4%	82.5%	84.9%	84.2%	82.7%	85.0%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%		<100%	56.0%	81.0%	80.0%	84.7%	75.4%	83.0%	82.2%	85.0%	81.0%	74.0%	62.0%	82.2%
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	40	40	40	40	40	40	40	40	40	40	40	40
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10		≤9	3	3	3	3	3	3	3	3	3	3	3	3
		Supervisor : M/w ratio 1 :	Ratio	Rota - Contact SOM	15	16-18	≥17	14	14	14	14	14	14	14	14	14	14	14	14
Clinical Indicators	Neonatal/Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%	67.2%	68.6%	64.2%	62.7%	71.2%	75.2%	73.4%	61.2%	66.4%	66.7%	69.0%	69.9%
	Morbidity	Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17%	≥18%	9.2%	6.8%	6.0%	11.2%	10.1%	3.8%	10.1%	11.6%	6.5%	10.6%	4.9%	7.1%
		C/S Births	Em & elect - %	CPD	≤26%	26-28%	>28%	23.7%	23.7%	29.1%	26.1%	18.7%	20.3%	16.5%	26.4%	27.1%	22.8%	26.1%	23.0%
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	0	1	0	0	0	0	0	0	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	4	5	3	4	7	3
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	0	1	1	3	1	1	2	2	0	1	2	1
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	0	1	0	0	0	0	0	0	0	1	0	
		Neonatal Death	No of babies	Risk team- EBC	0		1 or more	0	2	0	0	0	0	0	0	0	0	0	0
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	0	0	0	0	0	0	1	1	0	0	0	0
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70%	>70%	46.6%	54.4%	51.1%	55.2%	59.0%	53.0%	58.3%	65.0%	59.4%	62.5%	57.6%	62.8%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	18.3%	20.2%	24.8%	23.9%	15.1%	30.3%	20.1%	22.5%	22.6%	15.8%	19.4%	14.2%
	Risk Management	SI's	No. of SI's declared	Risk Team	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		CI's	No. of CI's declared	Risk Team	0		1 or more	1	0	0	0	0	0	0	0	0			
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	1	1	2	2	0	1	0	3	1	4	3	2
		PPH > 1.5L as % of all women	% of births	CPD				0.8%	0.9%	1.5%	1.5%	0.0%	0.8%	0.0%	2.5%	0.9%	3.3%	2.2%	1.8%
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	0	3	4	2	2	2	0	0	0	2	0	2
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.5- 4%	≥4%	1.0%	1.1%	2.1%	4.0%	0.9%	0.0%	3.4%	3.4%	1.3%	0.0%	0.0%	1.1%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	0	0	0	1	1	1	0	0	1	0	1	1
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	1	0	0	0	1	2	0	0	0	0	0	0

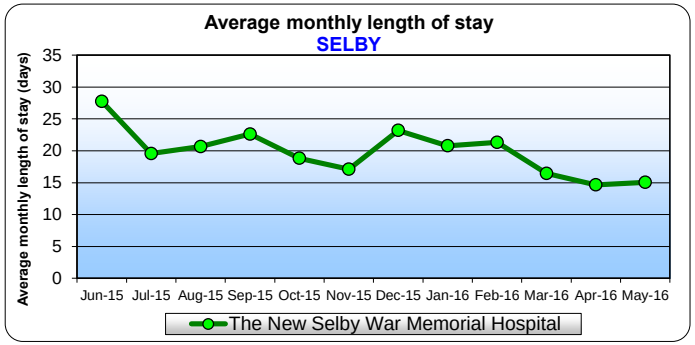
Community Hospitals

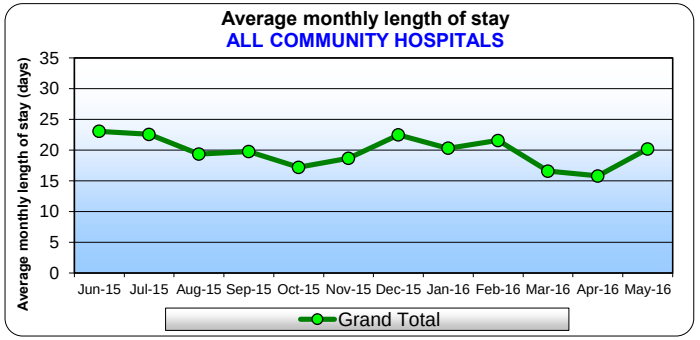
Indicator	Hospital	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Community Hospitals average length of stay (days) Excluding Daycases	**Archways**	22.5	22.0	22.5	20.9	18.6	17.0	26.4
	Malton Community Hospital	20.0	24.3	20.5	19.4	16.4	16.9	20.1
	St Monicas Hospital	21.4	19.3	19.3	18.8	13.5	12.4	19.9
	The New Selby War Memorial Hospital	24.0	23.6	23.0	20.4	16.4	14.7	15.1
	Total	21.9	22.7	21.5	20.0	16.6	15.8	20.2





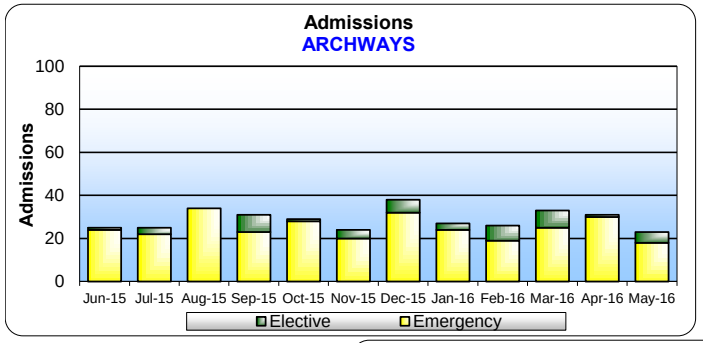


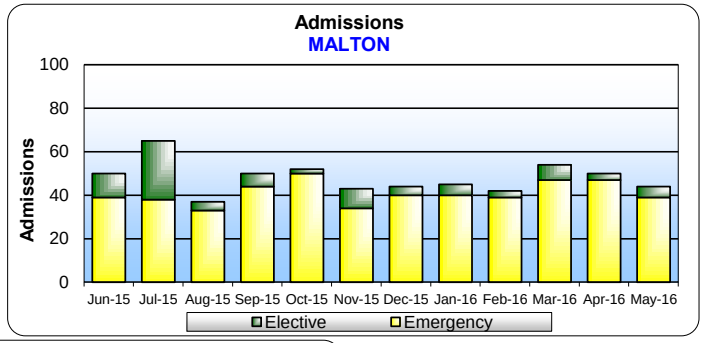


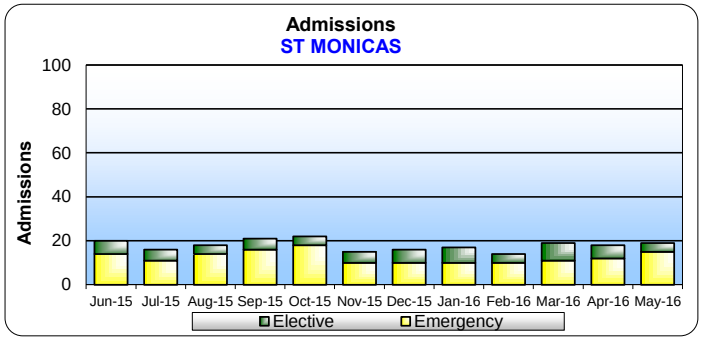


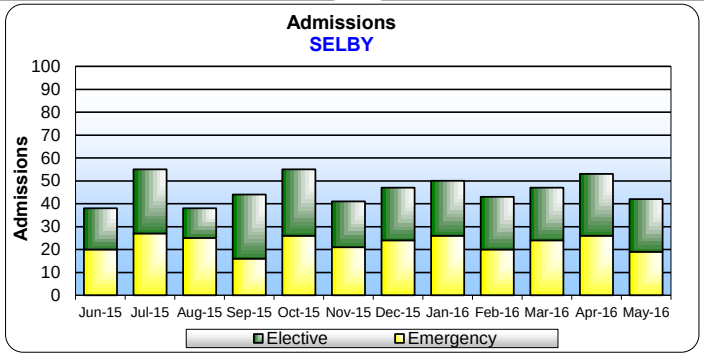
Community Hospitals

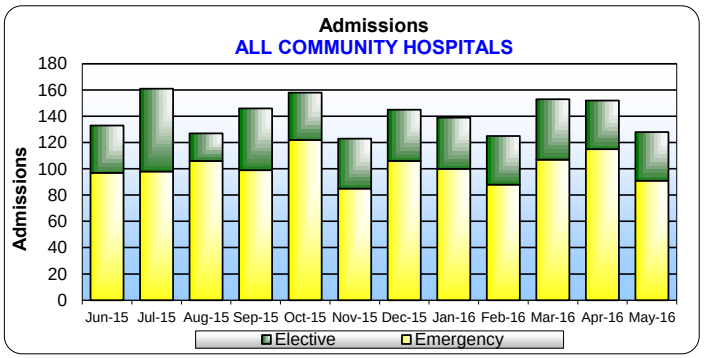
Indicator	Hospital		Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	**Archways**	**Elective**	8	11	11	18	8	1	5
		Emergency	75	79	80	68	25	30	18
	Malton Community Hospital	**Elective**	20	37	15	15	7	3	5
		Emergency	100	115	124	126	47	47	39
	St Monicas Hospital	**Elective**	16	14	15	19	8	6	4
		Emergency	44	41	38	31	11	12	15
	The New Selby War Memorial	**Elective**	58	69	72	70	23	27	23
		Emergency	68	68	71	70	24	26	19
	Total	**Elective**	102	131	113	122	46	37	37
		Emergency	423	436	504	295	107	115	91











Quality and Safety: Misc

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	9	0	8	4	1	8	3
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	0	3	0	0	0
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	100%	100%	100%	100%	100%	100%	100%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.8%	99.7%	99.8%	99.9%	99.9%	To follow	To follow
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	97.5%	97.1%	98.4%	99.0%	99.1%	To follow	To follow
Delayed Transfer of Care – All patients medically fit for discharge and issued a 'notification notice' as per joint protocol for the transfer of care	As set out in Service Condition 3 and General Condition 9	**Set baseline in Q1 and agree trajectory**	Monthly Provider Report						
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	As set out in Service Condition 3 and General Condition 9	**Best Practice Standards**	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced and tabled at sub CMB quarterly.						
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	99.7%	99.1%	99.7%	99.2%	98.1%	99.5%	100.0%
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
All Red Drugs to be prescribed by provider effective from 01/04/15, subject to agreement on list	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
All Amber Drugs to be prescribed as per shared care guidelines from 01/04/15	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 29 June 2016

Medical Director's Report

Action requested/recommendation

Board of Directors are asked to:

Patient Safety
Consider the latest release of PROMs participation rates
Consider recent report from Nutrition Steering Group

Clinical Effectiveness
Note consultants new to the Trust

Patient Experience
Note Patient Safety Conference scheduled for 21st June
Consider recent report from Patient Safety Group.

Executive Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	This report has been discussed at Executive Board.
Risk	No additional risks have been identified other than those specifically referenced in the paper.
Resource implications	None identified.
Owner	James Taylor, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	June 2016
Version number	1

Board of Directors - 29 June 2016

Medical Director's Report

1. Introduction and background

In the report this month:

Patient Safety
PROMs
Update from Nutrition Steering Group
Patient Safety Conference/Sign up to Safety
Clinical Effectiveness
Consultants new to the Trust
Patient Experience
Update from Patient Safety Group

2. Patient Safety

2.1 Patient Reported Outcome Measures - participation rates

This report covers the period April 2014 to May 2015 and was published May 2016.
Participation rates were as follows:

Participation Rate Hernia	Participation Rate Hip	Participation Rate Knee	Participation Rate Vein
49%	104%	121%	24%

In some cases the participation rate figure may be over 100%. If this is the case, it may reflect an increase in clinical activity over and above that recorded by HES. There could be a variety of reasons for this, e.g. an increase in referrals; or bringing activity that was formerly attributed to Independent Hospitals in-house.

2.1 Nutrition Steering Group

Update from the Nutrition Steering Group:

Following the successful trial of the new naso-gastric (NG) tube pathway on the Stroke Unit we now wish to roll this out across the Trust. Whilst we have intranet resources (and are obtaining more), this will need relatively intense face to face work with a number of key stakeholders (predominantly nurses on most adult wards). The current NG tube pathway, although in use for a while does seem to carry a very small but definite risk, and misplacement of an NG tube as well as being potentially catastrophic for the patient is a "never" event. There is also to be a worldwide industry change to a new standard fitting for feeds (called ENFIT) starting in July and on the back of this we have secured significant help from NG manufacturers to help resource this rollout. However, due to illness and a

reconfiguration in the Directorate Nursing we are struggling to support this within the Trust. Helen Hey is aware of the issues and assures us an ADN will be assigned to the Nutrition Steering Group imminently.

The above is another example where a Nutrition Nurse on the York site would be of great value.

2.2 Sign up to Safety Campaign - update

The Trust joined the Sign up to Safety Campaign in July 2014 and as part of the campaign we pledged to host an annual patient safety conference. Our conference this year 'Enhancing Patient Safety through Learning and Improving' will be held at the University of York on 21st June. Over 300 delegates have registered to attend and 60 abstracts have been submitted for the poster presentation so we're destined to be a lively, interesting and informative conference. The keynote address will be given by Professor Sue Hignett from Loughborough University and we're also fortunate to have Professor Allen Hutchinson coming to talk about the national reducing avoidable harm work and the case note review requirements in addition to Stephen Evans from Hempsons Solicitors who will provide some guidance on DNACPR discussions as a result of the Winspear case.

3. Clinical Effectiveness

3.1 Consultants new to the Trust

Manish Jain
York
Haematology
Start date: 09/05/2016

4. Patient Experience

4.1 Patient Safety Group

A summary from the Patient Safety Group meeting of 20th May is provided below:
The Junior Doctor Safety Improvement Group in addition to the Patient Safety Matters newsletter have now set up a Twitter account (@PtSafetyMatters) as an additional form of communication with junior doctors. The trail of using paper incident forms has brought some interesting learning and Will Lea is working with the Risk and Legal Team to suggests some minor alterations to the incident reporting form and then there will be some extensive work focussing on training and culture. The draft proposal for structured patient safety learning was discussed and fully supported.

Jonathan Redman and Clare Scott gave an update on the work of the Deteriorating Patient Group. The group review the national cardiac arrest data, produce a dashboard of mortality measures which are reviewed and they monitor the care of patients with tracheostomies. Training is provided every 6 weeks. They reported a concern that patients with a significantly high NEWS score are not always being escalated promptly and that ceiling of care and DNACPR decisions should be more timely.

A review of the Quality Report Priorities was presented and it was acknowledged that with a small number of exceptions the priorities had been achieved.
The 'Harm Free Care' reports were reviewed and discussed and the continued progress with reduction of falls and pressure ulcers was acknowledged.

A discussion on the use of unported IV cannula resulted in support of a trail on AMU, ED and Elderly care wards.

A report on the use of the post0take ward round was reviewed and good progress was acknowledged.

The revised Delirium Pathway was discussed and some slight modifications proposed.
The review of the Admissions Proforma was reported and good progress was acknowledged.

The WHO surgical checklist audit report was presented. Compliance is good in acute theatres and it was agreed that future audits should consider lower risk areas such as day surgery and out-patients.

A leaflet relating to the consent process was circulated for consideration by the PSG.

5. Recommendations

The Board of Directors are asked to:

Patient Safety
Consider the latest release of PROMs participation rates
Consider recent report from Nutrition Steering Group
Clinical Effectiveness
Note consultants new to the Trust
Patient Experience
Note Patient Safety Conference scheduled for 21st June
Consider recent report from Patient Safety Group.

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**James Taylor, Medical Director**
Date	**June 2016**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 June 2016

Chief Nurse Report – June 2016

Action requested/recommendation

The Committee is asked to note the Chief Nurse Report for June 2016.

Executive Summary

Patient Safety
At the end of May 2016, the vacancy position for adult inpatient areas was 133.76 Registered Nurses (RN) and 59.11fte Healthcare Assistants (HCA). Of these, 96.14fte RN posts and 63.78fte HCA posts have been recruited to and the individuals will commence in post over the coming months. The remaining RN vacancy position is 37.62fte and -2.39fte HCAs.

The Trust's progress towards **Saving Babies' Lives - *A care bundle for reducing stillbirth*** *against the four key elements of care.*

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

Internal Audit reviewed the Maternity Risk Management in May 2016 and provided significant assurance. Key areas for action related to the update of the progress of the maternity review in Scarborough as well as ensuring staff training records are maintained on the Trust's Learning Hub.

Healthcare Associated Infection (HCAI) incidence continues on a downward trend towards national and regional mean.

Effectiveness
The Nurse Rostering Project continues, with focus now turning towards detailed examination of ward based rosters to identify best practice as well as those areas that require improvement and support.

The audit of Midwifery and Obstetrics Risk Management was undertaken in May 2016. The audit provided significant assurance and areas of good practice were identified. Areas for improvement concerned staff training and recording on the learning hub.

The second cohort of ACPS had their OSCE this month. The success rate was excellent, Of the 99 examinations 94 Received pass marks, in total 43 passed with 'Excellent' classification 51 passed with 'Satisfactory' classification.5 stations defer fail marks. In total 4 received 'Borderline'

classification. 1 received 'Unsatisfactory' classification. These will be reassessed in the next 8 weeks.

Patient Experience
The Trust continues to meet its target for 90% of patients to recommend the Trust. The inpatient recommend rate was 98.9%, which is the highest for the last year. The Emergency Department recommend rate is 79.21% and has shown a downward trend since December.

National Volunteers' week took place between the 1st and 12th June. The Trust had a volunteer stand during the week at both York and Scarborough Hospital. Through social medial, volunteers described the reason they volunteer and volunteer supervisors described how much they value their volunteers in their wards and departments.

Work is taking place to commence the implementation of John's Campaign across the Trust, as part of the CQUIN target for 2016-17. A report will be presented to Trust Board in August 2016 as part of the focus on dementia. The Trust's campaign began in May 2016 as part of dementia awareness week and the following pledge was submitted to the Campaign by the Trust

"Our Trust is committed to providing patient centred care, in partnership with carers. We recognise the important role that carers play in providing continuity of support for patients with dementia during their hospital stay. We pledge to introduce John's Campaign this year so that everyone can play their part."

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 has only been submitted for the Quality and Safety Committee.
Risk	No risk.
Resource implications	Resources implication detailed in the report.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	June 2016
Version number	Version 1

Board of Directors – 29 June 2016

Chief Nurse Report – Quality of Care

1. Background

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

The nursing and midwifery strategy has four main focus areas:

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

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

2. Patient Safety

2.1 Nursing and Midwifery Staffing

At the end of May 2016, the vacancy position for adult inpatient areas was 133.76 Registered Nurses (RN) and 59.11fte Healthcare Assistants (HCA). Of these, 96.14fte RN posts and 63.78fte HCA posts have been recruited to and the individuals will commence in post over the coming months. The remaining RN vacancy position is 37.62fte and -2.39fte HCAs.

Recruitment of Nurses, Midwives and Healthcare Assistants is continuing through the Trust. 50 European nurses will have commenced in employment on the York site with 1 also at Scarborough by the end of June 2016. 2 European nurses have resigned from the Trust due to personal circumstances unrelated to their employment with the Trust. A further 12 European nurses are expected to commence during July and August 2016. The Trust continues to support these nurses with their arrival and induction into the Trust.

In addition, a campaign to attract final year nursing students to apply for staff nurse positions with the Trust, with a view to commencing employment in August/September 2016 is underway. Since January 2016, the Trust has offered posts to 105 final year nursing students. 19 of these have subsequently withdrawn from their offers of employment, choosing to take alternative jobs with other organisations.. Significant work is being undertaken to try and retain those who have been offered positions,. In addition 5 nurses who have returned to nursing practice following a career break have also been appointed. Further interviews are taking place during June and July 2016

Healthcare Assistant recruitment took place during May 2016 and this has resulted in 32 candidates being offered positions within the Trust and it is anticipated that they will commence in post between now and September 2016. Further HCA recruitment will be taking place in July, in preparation for winter planning.

The Safer Staffing return for May 2016 is detailed in a separate paper and for the first time provides information on Care Hours per Patient Day, a new metric introduced in the Lord Carter Report.

2.2 Saving Babies' Lives - *A care bundle for reducing stillbirth*

Saving Babies' Lives is a care bundle designed to support providers, commissioners and professionals to take action to reduce stillbirths. It supports the delivery of safer maternity care, as described by the National Maternity Review, in Better Births.

Last November, the Secretary of State for Health announced a new ambition to reduce the rate of stillbirths by 50% in England by 2030, with a 20% reduction by 2020. 'Saving babies' Lives' will help maternity services meet this aspiration.

The RCOG (Royal College of Obstetricians and Gynaecologist) 'Each Baby Counts' project collects data on all intrapartum term stillbirths and will be one of many ways to monitor the effects of all the elements of the care bundle.

York submit data to the RCOG Each baby Counts and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) and became an early implementer/pilot site of the stillbirth care bundles.

Update May 2016;

Stillbirth number/rates	York	Scarborough	Trust
2014/15	14 4.1:1000	8 4.9:1000	22 4.4:1000 births
2015/16	8 2.3:1000	2 1.3:1000	10 2.0:1000 birth

All stillbirth cases are reviewed using the National Patient Safety tool for case review (in line with practise across the region) and discussed at the weekly risk meetings and monthly perinatal mortality meetings.

Peer MDT review of all stillbirth cases from 2015 has taken place (between York and Scarborough) and will be continued (as recommended by MBRRACE)

Serious incident investigations are triggered for all stillbirths where the baby was alive at the onset of labour or with any concern found regarding care provided (in line with regional practise)

Cases of severe brain damage to be an SI will be tabled and discussed at the next Directorate Clinical Governance meeting (as recommended in the national maternity review 'Better births')

There are four elements of care that are recognised as evidence-based and/or best practice which we have already or have plans to implement:

Reducing smoking in pregnancy by carrying out Carbon Monoxide (CO) test at antenatal booking appointment to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate

There is strong evidence that reducing smoking in pregnancy reduces the likelihood of stillbirth.

- Implemented Carbon Monoxide testing for all women at booking and repeat for smokers at 28 weeks

- Provide ‘opt out’ referral to smoking cessation services for all smokers
- Midwives all trained in very brief interventions- raise at every appointment
- ‘Baby clear’ pilot ‘risk perception intervention’ at Scarborough- hard hitting 1:1 appointment immediately after 12 week scan to arrange ‘treatment’ for smoking. This is delivered by a Midwife with extended training.
- Using specific software to link the CO monitor to trigger discussion about harms caused to babies by smoking.

Risk assessment and surveillance of pregnancies for fetal growth restriction.

Currently, the only way to manage growth restriction is to deliver the baby. Therefore, antenatal detection of growth restricted babies is vital and has been shown to reduce stillbirth risk significantly because it gives the option to consider timely delivery of the baby at risk.

- Introduced Customised growth charts in all Trust areas
- Intensive training and assessments for staff
- Women referred in for scans when growth noted to be tailing off
- Auditing all cases of growth restricted babies not diagnosed in pregnancy
- Audit and monitoring of detection rates of growth restriction all Trust sites

Raising awareness amongst pregnant women of the importance of **detecting and reporting reduced fetal movement (RFM),** and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Confidential enquiries into stillbirth have consistently described a relationship between episodes of reduced fetal movement (RFM) and stillbirth incidences.

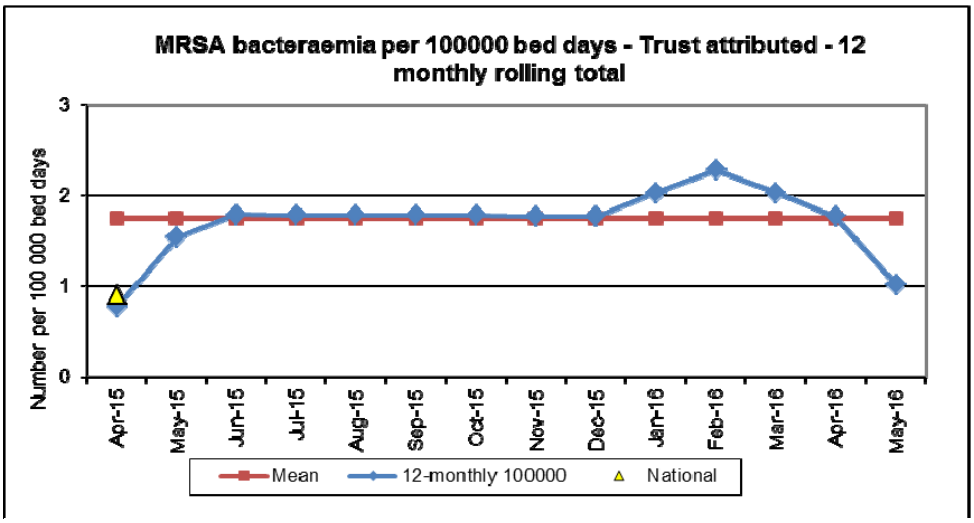
- All women are given a leaflet highlighting the importance of fetal movements between booking and 24 weeks of pregnancy. Movements are then discussed at every midwife appointment after 24 weeks. Women can self-refer to the maternity unit with any concern.
- A standard checklist is being developed to manage the care of women who report reduced movements.

Effective fetal monitoring during labour.

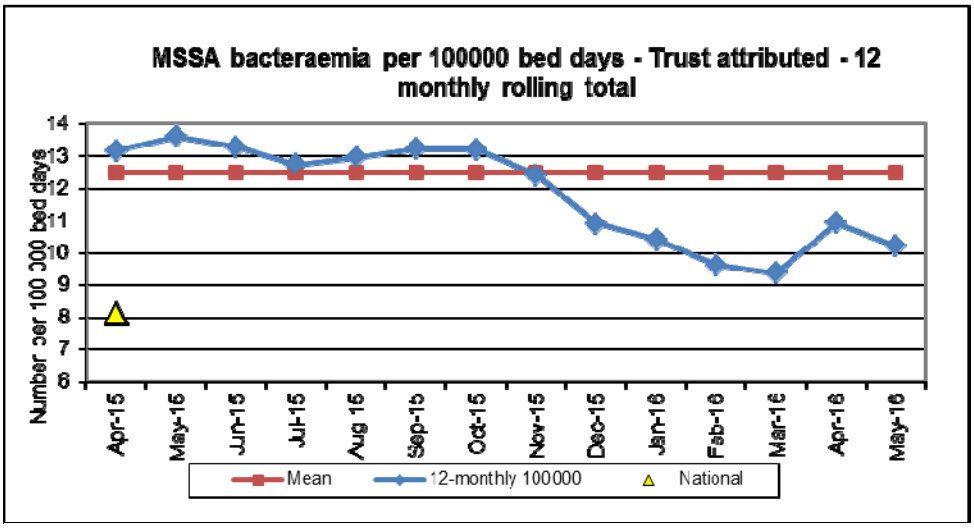
- All staff who are involved in labour care attend annual mandatory training face to face with case discussions and competency assessment.
- All staff must complete an e-learning package about monitoring annually.
- A ‘Fresh Eyes ‘ buddy system is in place when every hour for women who are being continuously monitored a second registered professional must make an assessment of the monitoring and classify it using NICE guidance. This is documented in maternity records using a standard sticker.
- Weekly case discussions in place on both sites for staff to attend.

2.3 Infection Prevention & Control

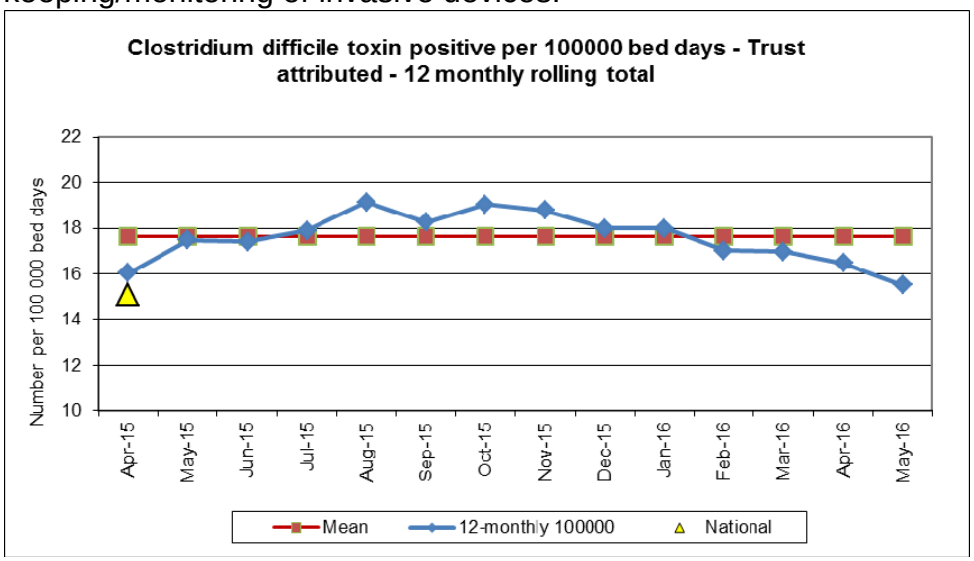
Healthcare Associated Infection (HCAI) incidence continues on a downward trend towards national and regional mean.



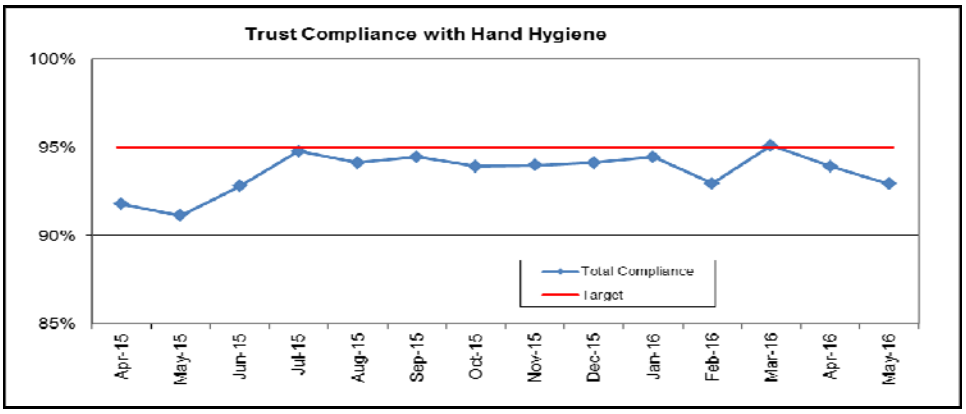
An initiative is in place to improve emergency admission screening to ensure prompt identification of MRSA carriers and treatment of cases



Infection Prevention Nurses are working collaboratively with Patient Safety, Clinical Skills and the Sepsis Team to develop a multi-faceted approach to reduce incidence of all bloodstream infections by improving timing of BC collections, Aseptic Non Touch Technique and record keeping/monitoring of invasive devices.



Hand hygiene compliance across the Trust shows a 93% average.
Isolation Practice Standard in place
Ward based teaching continues with emphasis on appropriate faecal sampling and timely isolation of symptomatic patients
Promotion of timely review of all antimicrobials – 'everybody's responsibility'.



3. Effectiveness

3.1 Nursing Dashboards

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

3.2 Nurse Rostering project

Phase 1 of the project is nearing completion. This will provide high level information on the organisational position in terms of rostering practice and compliance with a number of metrics. A listening exercise is currently underway.

A recent upgrade to the e-rostering software has been completed and final adjustments are being made so staff can access the 'employee on line' functionality from home.

The next phase will include local area 'deep dives' which will allow for a detailed examination of how rosters are being managed , enabling identification of areas of best practice and those that require improvement and support.

The projected impacts and benefits of the project include;

- A better understanding of the challenges faced by roster creators in using the system and therefore as an organisation being better equipped to reconsider whether, for example, system rules are fit for purpose.
- Increased compliance with rules which are determined to be appropriate and fit for purpose.
- Roster creators that are confident in taking ownership and being accountable for using the system and that are competent in creating safe, fair, cost effective rosters.
- There may be some requirement to review and alter currently agreed flexible working patterns.
- Reduced reliance on temporary staffing due to better utilisation of the substantive workforce.
- Potential savings on nursing workforce paybill through better utilisation of the substantive workforce.
- Improved use of the auto roster functionality, making more efficient use of time for roster creators.

- Improved management information.
- A plan for the most effective model for roster creation and management for the future

3.3 Internal Audit Report: Midwifery and Obstetrics Risk Management

This audit was carried out by internal audit in May 2016;

The aim of this audit is to review the risk management processes in place within Midwifery and Obstetrics and gain assurance that risk are identified, recorded, monitored and effectively mitigated

The outcome of the audit report outcome is detailed below:

Opinion: Significant Assurance				
Control Objective	**Assurance Level**	**Number of Recommendations**		
		High	**Medium**	**Low**
1	**Significant Assurance**	**0**	**0**	**1**
2	**Significant Assurance**	**0**	**0**	**0**
3	**Significant Assurance**	**0**	**0**	**0**
4	**Significant Assurance**	**0**	**0**	**0**
5	**Limited Assurance**	**1**	**0**	**0**
Total		**1**	**0**	**1**

Control Objectives

1. There are systems in place to identify, monitor and escalate risks to the Board of Directors.
2. A risk register is maintained which lists identified risks and their management, and is subject to regular reviews.
3. There are systems and processes in place to report, record and investigate incidents and complaints.
4. Recommendations made following investigations of incidents or complaints are disseminated and implemented by all relevant staff in a timely manner.
5. Clinical staff attend mandatory training and their individual training needs are addressed.

Areas of Good Practice

There are robust risk management and review processes in place to support staff at an operational level.

- Staff are engaged with the development of guidelines.
- Serious Incidents are reviewed and evidence is retained of the outcomes of investigations.

Key Areas for Improvement

Actions recorded on the Maternity Review, Project Scarborough that are past their start date but noted as not started should have additional narrative to explain the reasons for the delays.

- A year on report has been completed and will address this.
- An improved data collection process is required in the Trust learning hub to monitor Maternity specific staff training.

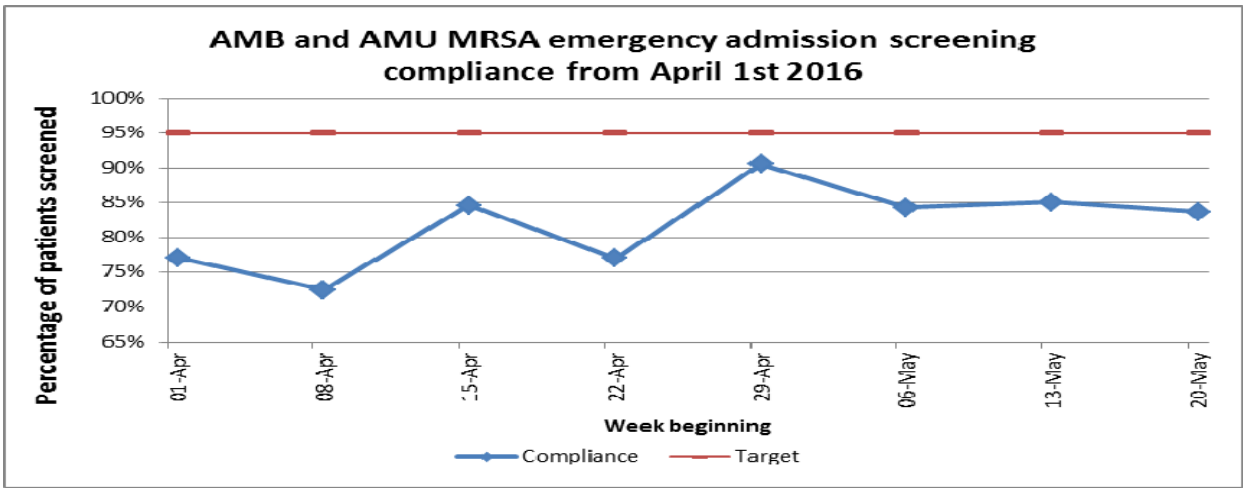
Staff training is currently recorded on the in-house data The local spread sheet for training in 2015 showed compliance with training in Maternity as exceeding the current Trust expectations of 80% and meeting the new higher requirement of 85%.

The service is moving towards the use of the Learning Hub to record training and as yet full annual training records have not been captured

3.4 Infection Prevention & Control

Development and implementation of initiatives to learn from, improve practice and patient safety from Post Infection Review (PIR) and HCAI incident outcomes:

MRSA emergency screening pilot on AMU (York) shows an improvement but compliance remains below the 95% target



Blood Culture closed system specimen collection introduced on York site to match current practice at Scarborough

Commissioning and Local Authority Partnership collaboration to look back at lessons learnt from recent Norovirus outbreak in order to improve. Internal report completed and ward closure data circulated.

3.5 Advanced Clinical Practitioners

The committee are aware that a second cohort of 11 ACPs is currently in training. The final OSCES were undertaken in June.

The trainees are an existing registered practitioner from either Nursing or AHP background who has undertaken Masters level education and training in assessment, diagnostics and treatment of acute and chronic illness. It is a multi-faceted role including clinical, teaching, audit and contribution to service improvement. Typically they will have held a senior position (Band 6 or above) in their professional field and a minimum of 6 years experience prior to advanced practice training.

The OSCES consisted of 9 Stations – candidates assessed by Consultant Physicians or Specialist Practitioners.
The stations were as follows:

- Respiratory
- Cardiovascular
- Abdominal

- Cranial Nerves
- Assessment of the deteriorating patient
- Chest X-ray interpretation
- Prescribing in context
- ECG Analysis
- ABG Analysis

Of the 99 examinations, in total, over 2.5 days, 94 Received pass marks in total, 43 passed with 'Excellent' classification, 51 passed with 'Satisfactory' classification.
This excellent pass rate is due to the hard work of the candidates and the facilitators, who have worked to ensure that we have a safe and clinically competent group of practitioners. The newly qualified ACP's will have a period of pre-ceptorship and on-going clinical supervision and being in role on 1st July.

A third cohort is planned for later this year, however there is some ambiguity around PBR funding.

4. Caring

4.1 Friend and Family Test Latest Results – April 2016

The Trust continues to meet its target for 90% of patients to recommend the Trust. The inpatient recommend rate was 98.9%, which is the highest for the last year. The Emergency Department recommend rate is 79.21% and has shown a downward trend since December.

The response rate for inpatients in April 2016 has continued with an upward trend to 27.0% (national average 24.1%). The ED response rate has dropped slightly to 15.9% (national average 13.3%).

The greatest number of narrative comments are thank you's for staff. Noise at night is also a theme across both York and Scarborough. Following the national inpatient survey workshop a noise at night, Night Owl, campaign will be introduced, led by nursing staff.

4.2 Complaints

The review of the Complaints and Concerns Policy is underway. The aim is to make it person-focused rather than process-focused: so we listen to the issues being raised and the outcome desired and select the best process to achieve this outcome. The revised process will increase ownership for quality and timeliness within directorates. The Patient Experience Team's role will increase its focus on training, support and audit.

4.3 PALS

The PALS team is currently working with reduced staffing, so capacity to handle patient contacts is reduced. Admin support is being provided by a patient experience volunteer to free up time for the PALS advisers to spend on resolving patient issues. The full time Scarborough PALS adviser role is currently out to advertisement on NHS Jobs and there has been much interest.

4.4 Volunteering

National Volunteers' week took place between the 1st and 12th of June. The Trust had a volunteer stand during the week at both York and Scarborough Hospital. Through social medial, volunteers described the reason they volunteer and volunteer supervisors described how much they value their volunteers in their wards and departments.

A volunteer induction day has now been developed which will commence in September at York

and Scarborough and be delivered every 6-8 weeks on each main site. Key speakers will provide volunteers with information on Safeguarding, Infection Control and Prevention, Dementia Awareness, Fire Safety along with information on the Trust's values and Patient Experience. Existing volunteers will also be invited over the next few months to attend the induction.

4.5 John's Campaign

John's Campaign is:

- The right of carers to stay with people with dementia in hospital
- The right of people with dementia to have their carers with them in hospital.
- For carers to not just be allowed on the wards, but to be welcomed.

Rolling out the campaign across the Trust is a CQUIN target for 2016-17. An in depth report will be presented at the August Board of Directors meeting, as part of the focus on dementia. The Trust's campaign began in May as part of dementia awareness week. The following 50 word pledge was submitted to the campaign and launched in internal and media communications. Information about John's campaign will be included in dementia awareness training and is part of e-learning.

"Our Trust is committed to providing patient centred care, in partnership with carers. We recognise the important role that carers play in providing continuity of support for patients with dementia during their hospital stay. We pledge to introduce John's Campaign this year so that everyone can play their part."

The next steps are to consult on a new visitors code with patients and carers before presenting to the Board of Directors for approval.

4.6 Infection Prevention & Control

The Infection Prevention Nurses are carrying out patient reviews during visiting time to answer service user questions and support staff in caring for patients with 'alert' organisms.

5. Recommendation

The Committee is asked to note the Chief Nurse Report for June 2016.

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

Nursing Dashboard - York

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Cum.Total	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU				2	3	1	2	3	1	8	2	4	4	2	1
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	1	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	1	0	0	1	2	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU				2	2	1	2	0	1	5	1	3	3	0	0
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU				0	1	0	0	2	0	2	1	1	0	0	1
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				10	11	18	18	15	18	23	18	18	21	9	12
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				1	0	0	0	1	2	0	0	0	0	1	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%			94.33	95.03	95.83	95.1	95.22%	96.09%	92.73%	96.66%	96.33%	96.44%	95.30%	97.50%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS				9	8	7	11	3	7	11	3	9	2	5	4
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				4	8	1	9	6	6	3	9	10	8	9	6
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				1	1	0	1	3	2	3	0	0	1	6	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				1	0	0	0	1	0	2	2	2	0	1	1
	VTE Other	VTE Other		Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team				96.52	86.24	105.30	104.66	87.43	85.39	98.15	68.51	68.75	86.14	70.2	74.63
		Inpatient area vacancies - HCA	Number	CN Team				17.59	15.99	25.92	30.91	40.81	34.15	31.05	55.87	58.53	34.83	24.8	41.43
	Sickness	Sickness (In Patient Areas)	%	Workforce Info				3.28%	2.56%	3.11%	3.43%	4.47%	3.96%	3.74%	3.99%	4.36%	3.56%	4.27%	
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%			88.90	90.80	87.60	85.4	85.8	90.3	88	88.9	86.7	86.9%	89.55%	86.30%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%			97.00	95.60	93.70	94.3	94.3	96.6	94.5	93.7	94.2	95.1%	96.43%	95.90%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%			119.50	116.30	104.90	99.5	100	95.4	93.6	95.6	92.4	93.1%	98.06%	102.10%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%			119.70	120.10	109.00	106.7	109.1	108.5	103.1	105.1	103.7	104.3%	106.28%	106.50%
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info				27.70	25.90	28.62	29.2	27.94	31.9	32.55	33.7	39.2	38.1	41.70%	42.80%
	Agency Fill Rate	Fill Rate	%	Workforce Info				57.00	62.70	53.11	44.9	43.31	43.1	36.69	42.4	33.9	36.8	30.40%	33.40%
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0		1	0	0	0	0	0	0	0	0	1	0	1	0
		MRSA Screening - Elective	Compliance %	Signal	95%			96.71%	95.10%	97.00%	97.20%	96.61%	97.85%	94.63%	75.64%	70.54%	74.41%	71.79%	61.48%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%			77.19%	76.36%	78.67%	78.21%	74.49%	79.69%	76.26%	79.09%	74.85%	78.53%	79.41%	34.89%
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	48		1	2	0	3	2	4	3	5	5	4	1	0	1
	MSSA	MSSA Bacteraemia	Cummulative	IC Team			5	2	3	0	1	5	0	1	0	2	3	4	1
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team			5	4	1	4	2	3	4	4	4	10	6	2	3
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Governance				9	10	4	6	13	9	5	2	12	6	7	8
	Critical Incidents	CI's reported	Number	Datix - Healthcare Governance				1	4	6	0	0	0	0	0	0	0	0	0
	Never Events	Never Events declared	Number	Datix - Healthcare Governance				1	0	0	0	0	0	0	0	1	0	1	0
Patient Experience	Friends and Family	Inpatient Friends & Family Test	%Recommend	Signal				95.95	95.84	97.53	95.98	96.25	94.96	94.43	94.68	95.48	95.48	96.46%	96.92%
			%Not Recommend	Signal				1.79	0.93	0.75	1.00	1.12	1.60	2.46	1.53	1.92	1.34	1.04%	0.73%
		A&E Friends and Family Test	% Recommend	Signal				82.06	86.76	86.84	82.20	79.35	74.50	86.57	83.70	82.27	83.83	78.93%	80.98%
			% Not Recommend	Signal				12.92	8.06	8.92	12.43	12.83	18.30	7.89	11.28	10.44	10.92	12.86%	11.63%
		Maternity (Ante Natal)	% Recommend	Signal				95.18	97.67	93.93	95.24	86.79	100.00	93.75	97.80	100.00	91.00	100.00	95%
			% Not Recommend	Signal				0.00	0.00	0.00	3.17	1.89	0.00	0.00	0.00	0.00	0.02	0.00	0%
		Birth	% Recommend	Signal				21.10	96.00	96.00	98.50	95.50	91.67	98.50	96.80	100.00	100.00	100.00	99%
			% Not Recommend	Signal				0.00	0.00	0.00	0.00	0.90	8.30	0.00	0.00	0.00	0.00	0.00	0%
		Maternity (Post Natal)	% Recommend	Signal				20.08	100.00	100.00	97.06	95.60	100.00	100.00	100.00	97.10	99.00	100.00	98%
			% Not Recommend	Signal				0.00	0.00	0.00	1.47	1.09	0.00	0.00	0.00	0.00	0.00	0.00	0%
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team				10	6	5	8	24	not available	not available	18	22	28	23	20
		Staff Attitude	Number	PE Team				1	1	1	3	2	not available	not available	1	2	3	3	2
		Patient Care	Number	PE Team				5	2	2	2	4	not available	not available	5	1	3	1	4
		Communication	Number	PE Team				4	3	2	3	5	not available	not available	2	3	5	3	1

Nursing Dashboard - Scarborough

York Teaching Hospital NHS
NHS Foundation Trust

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Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU			4	3	4	4	1	3	5	1	2	7	2	4
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	1	0	0	0	0	0	1	0	0	1
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU			2	2	2	2	1	3	3	1	1	5	1	2
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU			2	1	1	2	0	0	2	0	0	2	1	1
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS			2	1	2	4	8	8	8	4	11	6	7	10
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS			0	0	0	0	0	2	0	0	0	0	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%		0.95	0.91	0.91	93.89%	93.08%	91.04%	90.20%	93.31%	95.48%	91.67%	93.29%	95.58%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS			5	11	7	8	11	10	11	9	3	6	7	4
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS			3	7	10	3	2	4	7	6	10	3	8	4
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			0	1	1	0	0	1	0	1	0	2	0	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			0	1	0	1	1	1	1	0	0	0	1	0
	VTE Other	VTE Other	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			0	1	0	0	0	0	1	0	0	4	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team			41.70	44.25	44.65	43.75	40.37	29.89	37.93	36.93	42.83	41.67	38.59	38.4
		Inpatient area vacancies - HCA	Number	CN Team			9.52	-0.17	-0.38	-7.56	-3.86	1.85	1.35	5.95	2.65	4.24	7.88	7.94
	Sickness	Sickness (In Patient Areas)	%	Workforce Info			4.58%	5.15%	4.98%	5.16%	4.61%	5.08%	6.67%	6.46%	6.63%	3.43%	4.11%	
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%		85.70%	86.80%	81.50	80.5	81.7	83.8	87.5	86.6	83.7	80.8%	85.27%	86.20%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%		93.30%	93.50%	90.00	89.8	92.3	104.6	102.5	92.6	91.8	88.2%	89.92%	89.70%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%		109.80%	112.00%	113.20	109.4	109.2	94.1	90.8	104.9	100.5	100.5%	99.61%	99.90%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%		120.20%	115.40%	119.50	105.9	108.8	108.4	108.8	113.5	118.9	114.0%	115.87%	111.70%
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info			52.60%	51.00%	48.64%	51.80%	59.40%	62.00%	57.17%	73.70%	65.80%	58.60%	61.90%	74.90%
	Agency Fill Rate	Fill Rate	%	Workforce Info			30.00%	33.30%	27.72%	22.70%	19.40%	18.70%	14.63%	11.30%	11.20%	12.40%	10%	5.90%
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0	3	2	0	0	0	0	0	0	0	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%		84.42	91.18	95.31	88.89	95.92	92.36	74.38	66.67	50	50.56	45.71	31.22
		MRSA Screening - Non-Elective	Compliance %	Signal	95%		84.30	89.44	89.93	85.76	90.32	91.55	86.69	87.48	86.47	84.13	87.62	38.02
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	48	16	3	2	0	1	0	0	2	1	0	1	2	0
	MSSA	MSSA Bacteraemia	Cummulative	IC Team	<30	14	1	1	0	2	1	2	1	2	0	0	4	0
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team		38	3	3	0	4	3	4	3	6	3	1	1	2
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Governance			3	6	2	4	4	6	4	6	9	12	7	0
	Critical Incidents	CI's reported	Number	Datix - Healthcare Governance			1	5	1	0	0	0	0	0	0	0	0	0
	Never Events	Never Events declared	Number	Datix - Healthcare Governance			0	0	0	0	0	0	0	0	0	0	0	0
Patient Experience	Friends and Family Test	Inpatient Friends and Family Test	%Recommend	Signal			94.78	95.74	95.02	96.61	97.81	95.00	95.32	97.38	95.52	96.45	98.02%	96.35%
			%Not Recommend	Signal			0.26	1.26	1.39	0.85	0.40	1.00	1.10	0.56	1.07	1.62	0.46%	0.42%
		A&E Friends and Family Test	% Recommend	Signal			82.31	79.76	80.12	79.31	71.83	85.10	80.85	81.10	72.73	65.25	80.74%	81.63%
			% Not Recommend	Signal			9.52	13.69	16.27	13.79	19.72	9.20	12.77	11.81	17.48	24.11	11.85%	8.84%
		Maternity (Ante Natal)	% Recommend	Signal			21.82	95.34	21.18	98.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	96%
			% Not Recommend	Signal			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%
		Birth	% Recommend	Signal			38.80	96.00	93.75	100.00	100.00	100.00	100.00	98.00	100.00	92.30	100.00	99%
			% Not Recommend	Signal			0.00	0.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1%
		Maternity (Post Natal)	% Recommend	Signal			20.10	100.00	100.00	100.00	96.20	100.00	90.90	97.10	100.00	100.00	100.00	100%
			% Not Recommend	Signal			0.00	0.00	0.00	0.00	0.00	0.00	9.10	2.90	0.00	0.00	0.00	0%
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team			1	11	3	11	13	Not Available	Not Available	1	5	7	4	2
		Staff Attitude	Number	PE Team			0	2	1	3	0	Not Available	Not Available	0	0	0	0	0
		Patient Care	Number	PE Team			1	5	1	4	2	Not Available	Not Available	0	1	2	0	1
		Communication	Number	PE Team			0	4	1	4	5	Not Available	Not Available	0	0	2	1	1

Nursing Dashboard - Bridlington

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	CummTotal	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	1	2	2	0	0	2	0	2
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	1	1	0	0	0	0	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	1	1	0	0	2	0	2
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	1	0	0	0	0	0	0	0
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				11	0	2	3	0	1	0	0	0	2	3	0
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				0	0	0	0	0	0	0	0	0	0	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%			0.91	0.90	0.91	91.84%	95.65%	92.45%	91.49%	96.30%	93.88%	85.11%	94.64%	90.00%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS				3.00	1.00	0.00	1	1	1	1	0	1	1	0	0
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				0.00	1.00	0.00	2	0	0	0	3	0	1	0	3
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				1.00	0.00	0.00	0	0	0	0	0	0	1	1	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				1.00	0.00	0.00	0	0	0	0	0	0	0	0	0
	VTE Other	VTE Other		Safety Thermometer - VTE TREATMENT TYPE				0.00	0.00	0.00	0	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team				6.74	8.18	8.06	6.4	6.52	5.52	7.08	6.28	6.78	11.68	5.78	7.4
		Inpatient area vacancies - HCA	Number	CN Team				1.00	2.07	1.42	-0.2	0.08	0.08	1.68	2.68	2.68	3.3	1.68	3.44
	Sickness	Sickness (In Patient Areas)	%	Workforce Info				8.70%	3.16%	11.39%	8.05%	6.06%	6.36%	6.99%	8.65%	6.46%	7.89%		
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%			100.70	96.80	90.20	89	89.8	94.7	86.9	92.6	93.4	90.3%	93.42%	88.90%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%			84.30	95.50	79.80	75.8	73.9	93.2	90.7	76.7	80.1	76.6%	84.69%	79.40%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%			95.60	81.40	85.80	82.3	85.2	73.8	67.9	94.9	92.2	88.9%	93.82%	85.80%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%			129.50	121.30	121.50	106.4	112.7	145	166.1	161.3	153.4	140.3%	150.00%	133.90%
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info				56.30%	70.70%	49.24%	61.40%	82.80%	83.50%	70.95%	81.40%	81.80%	83.30%	80%	84.70%
	Agency Fill Rate	Fill Rate	%	Workforce Info				26.80%	20.20%	37.39%	19.50%	6.50%	7.78%	3.39%	1.20%	2.80%	2.00%	1.90%	0.80%
Infection Prevention	MRSA	MRSA Bacteraemia	Accumulated number of patients	IC Team	0	Green	3	0	0	0	0	0	0	0	0	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%			92.83	88.00	90.55	93.33	94.06	91.1	90.78	82.11	79.67	80.92	75.92	94.44
		MRSA Screening - Non-Elective	Compliance %	Signal	95%			83.33	100.00	88.89	66.67	100	83.33	100	100	--	66.67	100	0
	C.Difficile	C DIF Toxin Trust Attributed	Accumulated number of patients	IC Team	48	Green	3	1	0	1	0	1	0	0	0	0	0	1	0
	MSSA	MSSA Bacteraemia	Accumulated number of patients	IC Team	<30	Red	0	0	0	0	0	0	0	0	0	0	0	1	1
	E-Coli	E-Coli Bacteraemia	Accumulated number of patients	IC Team			4	1	0	0	0	1	0	0	0	2	0	0	0
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - healthcare governance				1	0	0	0	0	0	0	2	0	0	0	0
	Critical Incidents	CI's reported	Number	Datix - healthcare governance				0	0	0	0	0	0	0	0	0	0	0	0
	Never Events	Never Events declared	Number	Datix - healthcare governance				0	0	0	0	0	0	0	0	0	0	0	0
Patient Experience	Friends and Family	Inpatient Friends and Family Test	%Recommend	Signal				97.25%	98.21%	98.71%	98.16%	98.39%	100.00%	98.73%	98.77%	99.02%	98.40%	97.54%	97.23%
			%Not Recommend	Signal				1.37%	0.36%	0.32%	0.61%	0.81%	0.00%	0.00%	0.92%	0.00	0.00	0.62%	0.79%
		A&E Friends and Family Test	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
		Maternity (Ante Natal)	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
		Birth	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
		Maternity (Post Natal)	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team				1	0	0	0	1	not available	not available	0	1	0	0	0
		Staff Attitude	Number	PE Team				1	0	0	0	0	not available	not available	0	0	0	0	0
		Patient Care	Number	PE Team				0	0	0	0	0	not available	not available	0	1	0	0	0
		Communication	Number	PE Team				0	0	0	0	0	not available	not available	0	0	0	0	0

Nursing Dashboard - Trustwide

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Cumm. Total (Financi	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - New PU				15	16	19	19	13	18	16	15	16	21	8	17
		Cat 4	No. of Patients (PP)	Safety Thermometer - New PU				0	0	2	0	1	0	0	0	2	0	1	1
		Cat 3	No. of Patients (PP)	Safety Thermometer - New PU				2	1	3	2	2	4	3	1	5	1	2	3
		Cat 2	No. of Patients (PP)	Safety Thermometer - New PU				10	12	11	9	4	12	9	8	7	17	3	10
		Unstageable	No. of Patients (PP)	Safety Thermometer - New PU				3	3	3	8	6	2	4	6	2	3	2	3
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - New PU				0	0	0	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				33	41	33	36	31	33	31	28	36	35	21	31
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				2	0	0	1	1	4	0	0	0	0	1	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer -CQUIN HARM FREE %	**95%**	Red		94.37	93.73	94.06	94.23	95	94.28	92.79	94.4	95.99	94.13	95.52	95.33%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - UTI - NEW UTI				26	20	20	24	23	17	21	20	17	19	19	19
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	fety Thermometer - OMITTED CRITICAL MEDS				7	18	16	17	9	12	10	19	18	14	21	16
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type				5	3	2	1	4	3	3	1	0	6	8	1
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type				3	2	1	1	2	2	3	2	3	1	2	1
	VTE Other	VTE Other	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type				1	1	3	1	0	0	1	0	1	4	0	0
Workforce	**Vacancies**	Inpatient area vacancies -RN (month end)	Number	CN Team				142.44	148.57	168.94	167.67	148.05	127.31	158.87	125.36	128.13	147.27	120.72	133.76
		Inpatient area vacancies - HCA (month end)	Number	CN Team				30.51	18.47	30.29	26.08	39.05	34.15	31.05	55.57	58.53	34.83	54.54	59.11
	Turnover	Registered Nurses	%	Workforce Info				11.10%	11.21%	11.63%	12.33%	11.53%	12.24%	11.68%	11.83%	14.10%	15.04%	11.10%	11.32%
		Healthcare Assistants	%	Workforce Info				10.89%	11.78%	12.31%	12.15%	12.23%	12.01%	12.24%	10.06%	13.23%	12.81%	9.26%	9.22%
	Sickness	Trustwide nursing / HCA sickness	%	Workforce Info				4.01%	4.35%	3.76%	3.82%	5.17%	4.37%	4.64%	4.64%	4.45%	4.31%	3.87%	
	Safer Staffing Return	**Qualified** Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%	Green		93.39%	93.95%	91.31%	91.70%	92.80%	92.00%	91.20%	90.40%	92.80%	88.80%	91.74%	92.80%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%	Red		95.96%	95.93%	96.67%	88.60%	93.50%	95.40%	88.90%	89.70%	91.10%	91.60%	87.89%	92.00%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%	Green		103.03%	100.85%	100.10%	98.50%	96.70%	100.70%	93.70%	98.00%	96.30%	97.84%	97.02%	97.80%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%	Red		107.16%	105.51%	104.03%	100.60%	109.30%	104.50%	114.20%	115.00%	110.70%	108.48%	119.50%	111.50%
	Bank & Agency	**Overall** Fill Rate	%	Workforce Info				82.24%	87.38%	80.29%	74.26%	77.55%	77.04%	70.76%	79.40%	75.30%	74.67%	73.19%	78.55%
		Bank Fill Rate RN	%	Workforce Info				31.93%	29.66%	28.35%	29.14%	43.74%	36.98%	36.20%	46.38%	42.94%	34.71%	45.41%	50.67%
		Bank Fill Rate HCA	%	Workforce Info				39.74%	43.07%	51.09%	56.02%	51.13%	53.85%	52.56%	67.07%	60.31%	60.18%	58.63%	60.76%
		Bank - RN Hours filled	Number of Hours	Workforce Info				8,192	8,167	8,480	8,868	9,458	10,100	10,499	14,508	14,266	15,115	14,122	15,569
		Bank - HCA Hours filled	Number of Hours	Workforce Info				9,178	10,372	9,616	9,089	9,508	10,711	11,161	13,716	13,879	15,494	14,286	14,273
		Agency Fill Rate RN	%	Workforce Info				43.64%	54.73%	48.66%	42.01%	34.12%	40.36%	32.56%	30.26%	29.82%	31.09%	23.05%	22.48%
		Agency Fill Rate HCA	%	Workforce Info				49.73%	47.72%	34.40%	23.35%	26.06%	22.78%	20.93%	16.55%	18.66%	20.17%	20.61%	24.84%
		Agency - RN Hours filled	Number of Hours	Workforce Info				11,199	15,068	14,553	12,783	7,379	11,021	9,444	9,465	9,905	11,824	7,168	6,908
		Agency - HCA Hours filled	Number of Hours	Workforce Info				11,419	11,494	6,476	3,789	4,847	4,530	4,444	3,385	4,295	5,193	5,022	5,835
Infection Prevention	**MRSA**	MRSA Bacteraemia	Cummulative	IC Team	**0**	Red	1.00	2	0	0	0	0	0	0	1	1	0	1	0
		MRSA Screening - Elective	Compliance %	Signal	**95%**	Red		93.21	92.11	94.72	94.48	95.69	94.32	89.85	78.4	70.83	73.81	68.21	58.79
		MRSA Screening - Non-Elective	Compliance %	Signal	**95%**	Red		76.69	81.11	82.55	80.52	79.71	83.55	83.58	79.94	79.62	80.28	82.21	35.9
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	**48**	Amber	3.00	6	3	8	3	5	2	8	7	5	3	3	1
	MSSA	MSSA Bacteraemia	Cummulative	IC Team	**<30**	Red	9.00	3	4	2	3	6	2	2	2	2	3	9	2
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team			5.00	8	4	6	6	6	3	14	11	15	7	5	5
	Hand Hygiene	Hand Hygiene Compliance 95%	Compliance %	IC Team	**95%**	Green		93%	94.6	94%	94%	94%	94.93%	94%	94%	94%	97%	95%	93%

		Metric	Measure	Data Source	Trajectory	RAG	Cumm. Total (Financi	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May
Risk Management (Trust wide)	**Serious Incidents**	SI's declared	Number	Datix - Healthcare Goverance Team				12	20	11	16	21	19	12	11	27	21	17	12
	Critical Incidents	CI's reported	Number	Datix - Healthcare Goverance Team				2	10	7	0	0	0	0	0	0	0	0	0
	Never Events	Never Events declared	Number	Datix - Healthcare Goverance Team				1	0	0	0	0	0	0	0	1	0	1	0
Patient Experience	**Friends and Family**	Inpatient Friends and Family Test	%Recommend	Signal				95.91%	96.14%	97.01%	96.51%	96.98%	95.46%	95.26%	96%	96.01%	96.19%	98.89%	96.92%
			%Not Recommend	Signal				1.38%	0.92%	0.75%	0.90%	0.88%	1.26%	1.83%	1.19%	1.44%	1.20%	0.83%	0.73%
		A&E Friends and Family Test	% Recommend	Signal				82.12%	85.05%	85.09%	81.49%	78.34%	76.10%	85.61%	83.31%	80.95%	80.86%	79.21%	81.09%
			% Not Recommend	Signal				12.04%	9.43%	10.83%	12.77%	13.75%	16.90%	8.70%	11.36%	11.41%	13.02%	12.70%	11.16%
		Maternity (Ante Natal)	% Recommend	Signal				96.64%	96.90%	96.08%	96.46%	95.60%	100%	97.22%	99.01%	100%	95.65%	100%	95.35%
			% Not Recommend	Signal				0.00%	0.00%	0.00%	1.70%	1.10%	0	0	0	0	1.09%	0%	0%
		Labour & Birth	% Recommend	Signal				100.00%	97.60%	94.90%	98.76%	95.50%	93.75%	98.97%	98.75%	100%	95.65%	100%	98.99%
			% Not Recommend	Signal				0.00%	0.80%	1.02%	0	0.90%	6.25%	0	0	0	4.35%	0%	0%
		Maternity (Post Natal)	% Recommend	Signal				99.03%	95.79%	94.09%	98.37%	95.60%	100%	0	100%	97.87%	99.15%	96.43%	97.16%
			% Not Recommend	Signal				0.00%	0.00%	2.33%	1.62%	1.10%	0	0	0	1.06%	0%	0%	0.57%
		Community Post Natal	% Recommend	Signal				98.82%	100.00%	98.44%	100%	95.66%	100%	94.44%	98.31%	98.41%	94.85%	100%	99.15%
			% Not Recommend	Signal				0.00%	0.00%	0.00%	0	2.59%	0	5.56%	1.69%	0	1.03%	0%	0%
	Complaints	Complaints Total	Number	PE Team				12	17	8	20	42	Not Available	Not Available	19	31	36	27	30
		Staff Attitude	Number	PE Team				2	3	2	6	7	Not Available	Not Available	1	3	3	3	2
		Patient Care	Number	PE Team				6	7	3	6	6	Not Available	Not Available	5	3	5	1	5
		Communication	Number	PE Team				4	7	3	8	5	Not Available	Not Available	2	3	8	4	2

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 June 2016

Safe Nurse and Midwifery Staffing Report

Action requested/recommendation

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

Executive Summary

This is the twenty-fifth submission to NHS Choices of actual against planned staffing data for day and night duty in hours and by ward.

A detailed breakdown for May 2016 staffing levels is contained within the main report.

	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	96.0%	100.0%	90.3%	116.1%
Bridlington and District Hospital	88.9%	85.8%	79.4%	133.9%
Malton Community Hospital	87.1%	111.5%	100.0%	100.0%
Scarborough General Hospital	86.2%	99.9%	89.7%	111.7%
Selby And District War Memorial Hospital	95.5%	94.2%	83.9%	135.5%
St Helens Rehabilitation Hospital	96.8%	96.8%	93.5%	100.0%
St Monicas Hospital	96.4%	98.1%	100.0%	100.0%
White Cross Rehabilitation Hospital	102.4%	91.6%	95.2%	100.0%
York Hospital	86.3%	102.1%	95.9%	106.5%

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

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

From May 2016 CHPPD became the principle measure of nursing and care support with the expectation that it will form part of an integrated quality framework / dashboard. The first return of CHPPD taking place in June 2016. The CHPPD based on the actual staffing provided across the inpatient wards during May 2016 is detailed below:

	Care Hours Per Patient Day (CHPPD)			
	Cumulative count over the month of patients at 23:59 each day	**Registered midwives/ nurses**	**Care Staff**	**Overall**
Archways Intermediate Care Unit	652	2.0	2.0	4.1
Bridlington and District Hospital	1218	4.2	3.4	7.6
Malton Community Hospital	778	2.2	3.2	5.4
Scarborough General Hospital	8049	3.9	2.8	6.8
Selby and District War Memorial Hospital	526	3.2	3.0	6.2
St Helen's Rehabilitation Hospital	593	2.6	2.5	5.1
St Monica's Hospital	294	3.2	3.8	7.0
White Cross Rehabilitation Hospital	651	2.5	2.2	4.6
York Hospital	16435	3.8	2.8	6.6

Vacancies and Sickness continued to be a factor in the staffing of wards during May 2016; as in previous months, this is monitored by the senior nursing team and staff are moved across the wards as appropriate.

Significant recruitment to RN vacancies is underway, however the impact of some of these appointments will not be realised until around September /October 2016 when the newly qualified nurses commence in post.

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

Implications for equality and diversity

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

orientation).

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	First presentation
Risk	No risk
Resource implications	Resources implication detailed in the report
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	June 2016
Version number	Version 1

Board of Directors – 29 June 2016

Safe Nurse and Midwifery Staffing Report

1. Introduction and background

This is the twenty-fifth submission to NHS Choices of actual against planned staffing data for day and night duty in hours and by ward.

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

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

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

From May 2016 CHPPD became the principle measure of nursing and care support with the expectation that it will form part of an integrated quality framework / dashboard. The first return of CHPPD taking place in June 2016. This report, at section 3, provides details of the CHPPD based on the actual staffing provided across the inpatient wards during May 2016.

The Carter review looked at methods for setting appropriate staffing levels. It determined that a new approach was required in order to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards.

Lord Carter suggests that CHPPD gives a more accurate view of the availability of staff and overcomes the limitations of the previous formulae for assessing staffing ratios.

Over the coming months, CHPPD data will be used to benchmark wards against their peers, in addition to benchmarking against comparative organisations. It will provide opportunity to identify potential outliers and ameliorate as required.

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	96.0%	100.0%	90.3%	116.1%
Bridlington and District Hospital	88.9%	85.8%	79.4%	133.9%

Malton Community Hospital	87.1%	111.5%	100.0%	100.0%
Scarborough General Hospital	86.2%	99.9%	89.7%	111.7%
Selby And District War Memorial Hospital	95.5%	94.2%	83.9%	135.5%
St Helens Rehabilitation Hospital	96.8%	96.8%	93.5%	100.0%
St Monicas Hospital	96.4%	98.1%	100.0%	100.0%
White Cross Rehabilitation Hospital	102.4%	91.6%	95.2%	100.0%
York Hospital	86.3%	102.1%	95.9%	106.5%

3. Care Hours per Patient Day

	Care Hours Per Patient Day (CHPPD)			
	Cumulative count over the month of patients at 23:59 each day	**Registered midwives/ nurses**	**Care Staff**	**Overall**
Archways Intermediate Care Unit	652	2.0	2.0	4.1
Bridlington and District Hospital	1218	4.2	3.4	7.6
Malton Community Hospital	778	2.2	3.2	5.4
Scarborough General Hospital	8049	3.9	2.8	6.8
Selby and District War Memorial Hospital	526	3.2	3.0	6.2
St Helen's Rehabilitation Hospital	593	2.6	2.5	5.1
St Monica's Hospital	294	3.2	3.8	7.0
White Cross Rehabilitation Hospital	651	2.5	2.2	4.6
York Hospital	16435	3.8	2.8	6.6

4. Exceptions

There are six wards where RN staffing during the day has fallen below 80% during May. These wards were Ann Wright and Chestnut in Scarborough and, the Acute Medical Unit and Wards 28, 33, 39 in York. The reasons for this were largely due to RN vacancies and sickness. In all cases where planned staffing levels for RNs were not met, additional healthcare assistants were rostered to work. For wards 29 and 33 in York, staff were redeployed from these wards to provide support to wards with higher acuity or dependency.

There are four wards where RN planned staffing levels fell below 80% during night shifts. On Stroke ward in Scarborough this was due to vacancies and on Cherry Ward in Scarborough and Kent and Lloyd wards in Bridlington, due to low bed occupancy levels resulting in staff being redeployed to other wards.

A detailed exception breakdown is detailed below.

<u>Enhanced Supervision</u>

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

Scarborough	York	
Ann Wright	Ward 23	Ward 28
Ash	Ward 29	Ward 33
Chestnut	Ward 34	Ward 35
Oak	Ward 39	

Ward 28 care staff levels are particularly high at 189.7% day and 159.7% night due to a very complex patient who requires enhanced supervision from 2 members of staff permanently.

Provision of Safe Ward Cover

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

Community	Scarborough		York	
Archways	Ann Wright	Beech	AMU	CCU
Fitzwilliam	Cherry	CCU	Ward 14	Ward 25
Selby IPU	Chestnut	Duke of Kent	Ward 33	Ward 39
	Holly	ICU		
	Maple	Stroke		

Bed Occupancy

Lloyd and Kent Wards at Bridlington change their ratio of registered and unregistered staff dependent on bed occupancy with staff being deployed to other ward areas. Waters Ward currently has additional capacity open . G2 and G3 share a healthcare assistant, the healthcare assistant was predominantly on G2 during May 2016.

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

Actions and Mitigation of risk
On a daily basis, matrons and members of the Chief Nurse team deploy staff across the Trust based on risk assessments.

5. Vacancies by Site

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

	Reported vacancies	Vacancies filled	Unfilled Vacancies

			pending start			
	RN	**HCA**	**RN**	**HCA**	**RN**	**HCA**
Bridlington	7.4	3.55	2.6	1.00	4.8	2.44
Community	13.36	6.3	0.54	3.2	12.82	3.58
Scarborough	38.4	7.94	17.4	13.2	21.0	-3.46
York	74.60	41.43	75.60	46.38	-1.00	-4.95
Total	**133.76**	**59.11**	**96.14**	**63.78**	**37.62**	**-2.39**

Of the 96.14fte vacancies pending start, this includes individuals who have been recruited through local generic recruitment, 70.93fte who have been recruited through the Newly Qualified campaign and a further 12fte who have been recruited through the European recruitment campaign. Some offers of posts have been subsequently declined, in the main due to accepting jobs closer to home. The attrition rate is being monitored by the Chief Nurse team.

As shared at the last Board meeting, approval has been given for the Trust to continue to over-recruit to nursing posts to help manage the predicted turnover of nurses during the remainder of the year.

The Newly Qualified campaign continues and interviews are being held during June and July 2016.

The Trust will be undertaking further Healthcare Assistant interviews in July, preparing for the winter period, with start dates expected between September and November 2016.

6. Recommendation

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

7. References and further reading

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

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

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

Appendix 1

Fill rate indicator return

Org: RCB York Teaching Hospital NHS Foundation Trust

Staffing: Nursing, midwifery and care staff

Period: May_2016-17

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

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

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

Comments

Whitby Hospital is not longer under the management of York Teaching Hospital NHS Foundation Trust.

Only complete sites your organisation is accountable for

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Site code *The Site code is	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1116	846	930	1146	682	682	341	594	75.8%	123.2%	100.0%	174.2%	510	3.0	3.4	6.4
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ash	100 - GENERAL SURGERY		930	930	930	945	682	682	0	11	100.0%	101.6%	100.0%	-	429	3.8	2.2	6.0
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Beech	300 - GENERAL MEDICINE		1488	1224	1302	1362	1023	836	682	814	82.3%	104.6%	68.7%	119.4%	946	2.2	2.3	4.5
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Cherry	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1860	1584	1488	1512	1705	1320	1364	1287	85.2%	101.6%	77.4%	94.4%	632	4.6	4.4	9.0
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1488	1140	1116	1134	682	682	682	704	76.6%	101.6%	100.0%	103.2%	843	2.2	2.2	4.3
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2325	1972.5	930	727.5	1364	1122	341	561	84.8%	78.2%	82.3%	164.5%	589	5.3	2.2	7.4
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Duke of Kent	420 - PAEDIATRICS		1627.5	1440	465	495	682	726	341	275	88.5%	106.5%	106.5%	80.6%	330	6.6	2.3	8.9
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Hawthorn	501 - OBSTETRICS		744	726	372	372	682	682	0	0	97.6%	100.0%	100.0%	-	327	4.3	1.1	5.4
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1116	954	930	1038	682	682	682	682	85.5%	111.6%	100.0%	100.0%	538	3.0	3.2	6.2
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE		2790	2295	465	382.5	1705	1584	0	0	82.3%	82.3%	92.9%	-	149	26.0	2.6	28.6
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Lilac	101 - UROLOGY	100 - GENERAL SURGERY	1860	1687.5	1860	1710	682	737	682	660	90.7%	91.9%	108.1%	96.8%	641	3.8	3.7	7.5
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Maple	100 - GENERAL SURGERY		2325	2077.5	1162.5	1192.5	1364	1177	682	671	89.4%	102.6%	86.3%	98.4%	617	5.3	3.0	8.3
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Oak	430 - GERIATRIC MEDICINE		1488	1284	2046	2058	1023	891	1023	1221	86.3%	100.6%	87.1%	119.4%	1025	2.1	3.2	5.3
	RCBCA	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Stroke	430 - GERIATRIC MEDICINE		1116	1044	744	648	1023	737	341	517	93.5%	87.1%	72.0%	151.6%	473	3.8	2.5	6.2
	RCBNH	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Johnson	430 - GERIATRIC MEDICINE		930	858	1302	1254	682	682	341	341	92.3%	96.3%	100.0%	100.0%	658	2.3	2.4	4.8
	RCBNH	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		1162.5	930	930	795	682	363	0	220	80.0%	85.5%	53.2%	-	133	9.7	7.6	17.4
	RCBNH	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Lloyd	100 - GENERAL SURGERY		660	540	660	217.5	198	66	0	0	81.8%	33.0%	33.3%	-	11	55.1	19.8	74.9
	RCBNH	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Waters	430 - GERIATRIC MEDICINE		930	945	930	1012.5	682	671	341	352	101.6%	108.9%	98.4%	103.2%	416	3.9	3.3	7.2
	RCB55	YORK HOSPITAL - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1518	1482	906	804	682	693	682	660	97.6%	88.7%	101.6%	96.8%	839	2.6	1.7	4.3
	RCB55	YORK HOSPITAL - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1674	1440	1116	1194	1023	1001	583	671	86.0%	107.0%	97.8%	115.1%	740	3.3	2.5	5.8
	RCB55	YORK HOSPITAL - RCB55	15	120 - ENT	101 - UROLOGY	1860	1687.5	1395	1260	1023	1023	341	319	90.7%	90.3%	100.0%	93.5%	800	3.4	2.0	5.4
	RCB55	YORK HOSPITAL - RCB55	16	100 - GENERAL SURGERY		2418	2295	1020	997.5	1265	1177	583	506	95.0%	97.8%	93.0%	86.8%	603	5.8	2.5	8.3
	RCB55	YORK HOSPITAL - RCB55	17	420 - PAEDIATRICS		1488	1224	372	336	1023	1012	341	319	82.3%	90.3%	98.9%	93.5%	505	4.4	1.3	5.7
	RCB55	YORK HOSPITAL - RCB55	23	430 - GERIATRIC MEDICINE		1627.5	1357.5	1395	1612.5	682	682	1023	1023	83.4%	115.6%	100.0%	100.0%	897	2.3	2.9	5.2
	RCB55	YORK HOSPITAL - RCB55	25	430 - GERIATRIC MEDICINE		1302	1152	1116	1146	682	682	1023	1001	88.5%	102.7%	100.0%	97.8%	715	2.6	3.0	5.6
	RCB55	YORK HOSPITAL - RCB55	26	430 - GERIATRIC MEDICINE		1627.5	1402.5	1395	1492.5	682	682	1023	1023	86.2%	107.0%	100.0%	100.0%	908	2.3	2.8	5.1
	RCB55	YORK HOSPITAL - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1674	1416	930	1764	682	682	682	1089	84.6%	189.7%	100.0%	159.7%	908	2.3	3.1	5.5
	RCB55	YORK HOSPITAL - RCB55	29	110 - TRAUMA & ORTHOPAEDICS		1488	1002	744	750	682	682	341	396	67.3%	100.8%	100.0%	116.1%	578	2.9	2.0	4.9
	RCB55	YORK HOSPITAL - RCB55	31	370 - MEDICAL ONCOLOGY		2092.5	1920	930	922.5	682	682	341	341	91.8%	99.2%	100.0%	100.0%	531	4.9	2.4	7.3
	RCB55	YORK HOSPITAL - RCB55	32	320 - CARDIOLOGY		1518	1260	1116	1068	682	660	1023	990	83.0%	95.7%	96.8%	96.8%	847	2.3	2.4	4.7
	RCB55	YORK HOSPITAL - RCB55	33	301 - GASTROENTEROLOGY	361 - NEPHROLOGY	1488	1110	1116	1146	682	682	1023	1067	74.6%	102.7%	100.0%	104.3%	914	2.0	2.4	4.4
	RCB55	YORK HOSPITAL - RCB55	34	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1488	1344	1116	1020	682	682	1023	1034	90.3%	91.4%	100.0%	101.1%	887	2.3	2.3	4.6
	RCB55	YORK HOSPITAL - RCB55	35	430 - GERIATRIC MEDICINE		1302	1176	1116	1308	682	682	1023	1144	90.3%	117.2%	100.0%	111.8%	888	2.1	2.8	4.9
	RCB55	YORK HOSPITAL - RCB55	37	430 - GERIATRIC MEDICINE		1095	1050	1927.5	1710	682	682	682	682	95.9%	88.7%	100.0%	100.0%	635	2.7	3.8	6.5
	RCB55	YORK HOSPITAL - RCB55	39	430 - GERIATRIC MEDICINE		1302	972	1116	1434	682	671	682	869	74.7%	128.5%	98.4%	127.4%	687	2.4	3.4	5.7
	RCB55	YORK HOSPITAL - RCB55	36 - Acute Stroke Unit	430 - GERIATRIC MEDICINE		1488	1410	1302	1242	1023	1023	1023	990	94.8%	95.4%	100.0%	96.8%	608	4.0	3.7	7.7
	RCB55	YORK HOSPITAL - RCB55	Acute Medical Unit	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	4650	3517.5	3720	3525	2728	2530	2046	2277	75.6%	94.8%	92.7%	111.3%	815	7.4	7.1	14.5
	RCB55	YORK HOSPITAL - RCB55	Coronary Care Unit	320 - CARDIOLOGY		1860	1620	330	195	1364	1188	0	0	87.1%	59.1%	87.1%	-	191	14.7	1.0	15.7
	RCB55	YORK HOSPITAL - RCB55	Extended Stay Area	100 - GENERAL SURGERY	120 - ENT	990	915	495	420	396	352	0	0	92.4%	84.8%	88.9%	-	142	8.9	3.0	11.9
	RCB55	YORK HOSPITAL - RCB55	G1	430 - GERIATRIC MEDICINE		1488	1206	744	690	682	682	682	671	81.0%	92.7%	100.0%	98.4%	572	3.3	2.4	5.7

Validation alerts (see control panel)	Hospital Site Details		Only complete sites your organisation is accountable for: Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Site code "The Site code is	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
	RCB55	YORK HOSPITAL - RCB55	62	501 - OBSTETRICS		1116	1080	558	522	682	671	341	589	96.8%	93.5%	98.4%	158.1%	662	2.6	1.6	4.2
	RCB55	YORK HOSPITAL - RCB55	63	501 - OBSTETRICS		744	690	372	318	682	638	0	0	92.7%	85.5%	93.5%	-	177	7.5	1.8	9.3
	RCB55	YORK HOSPITAL - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5580	4980	465	487.5	4092	3685	341	330	89.2%	104.8%	90.1%	96.8%	386	22.4	2.1	24.6
	RCBAW	ARCHWAYS INTERMEDIATE CARE UNIT	Archways	925 - COMMUNITY CARE SERVICES		744	714	930	930	682	616	341	396	96.0%	100.0%	90.3%	116.1%	652	2.0	2.0	4.1
	RCBL8	MALTON COMMUNITY HOSPITAL - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		1162.5	1012.5	1627.5	1815	682	682	682	682	87.1%	111.5%	100.0%	100.0%	778	2.2	3.2	5.4
	RCB07	SELBY AND DISTRICT WAR MEMORIAL HOSPITAL - RCB07	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1162.5	1110	1162.5	1095	682	572	341	462	95.5%	94.2%	83.9%	135.5%	526	3.2	3.0	6.2
	RCBTV	ST HELENS REHABILITATION HOSPITAL - RCBTV	St Helens	430 - GERIATRIC MEDICINE		930	900	1162.5	1125	682	638	341	341	96.8%	96.8%	93.5%	100.0%	593	2.6	2.5	5.1
	RCB05	ST MONICAS HOSPITAL - RCB05	St Monicas	925 - COMMUNITY CARE SERVICES		630	607.5	795	780	341	341	341	341	96.4%	98.1%	100.0%	100.0%	294	3.2	3.8	7.0
	RCBP9	WHITE CROSS REHABILITATION HOSPITAL - RCBP9	Whitecross Court	430 - GERIATRIC MEDICINE		930	952.5	1162.5	1065	682	649	341	341	102.4%	91.6%	95.2%	100.0%	651	2.5	2.2	4.6
			Total			76390.5	66483	52215	52176	44825	41646	27082	29414					29196			

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Board of Directors - 29 June 2016

Results of National Inpatient Survey 2015

Action requested/recommendation

The Board is asked to consider and accept the positive assurance about the quality of patient experience in the Trust evidenced by the results of the 2015 national inpatient survey.

The Board is asked to note the action plan proposed by the Patient Experience Steering Group to continue to improve the experience of our patients.

Executive Summary

The CQC mandates all acute trusts to carry out the National Inpatient Survey every year, which evaluates what patients think about the healthcare services provided by the Trust. It is designed to reflect what matters most to patients.

Overall, York Teaching Hospitals NHSFT has improved since 2014 and the Trust compares well with other acute trusts. This is a notable achievement for our staff given the performance and staffing challenges experienced by the Trust.

Internally, patient satisfaction is significantly higher for Bridlington Hospital (which delivers a higher proportion of elective care) compared to York and Scarborough.

Patient Experience Steering Group held a special workshop to review the results of the survey and develop an action plan. Five key areas for action were agreed:

1. Celebrating and recognising success
2. Reducing noise at night
3. Welcoming and encouraging feedback
4. Empowering patients
5. Improving patient experience of discharge

Each area has an action plan with action owners. Patient Experience Steering Group will be overseeing delivery. The success of the action plans will be monitored through future National Inpatient Survey results and, more immediately, the Friends and Family Test results.

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

Implications for equality and diversity

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

Reference to CQC regulations

There are no specific references to CQC outcomes, although the report informs the Trust about performance against standard 1: respecting and involving people who use services

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

Progress of report	Patient Experience Steering Group 4.5.16 Quality & Safety Committee 17.5.16
Risk	No risk
Resource implications	Detailed in report
Owner	Beverley Geary, Chief Nurse
Author	Hester Rowell, Lead for Patient Experience
Date of paper	June 2016
Version number	2

Board of Directors - 29 June 2016

Results of National Inpatient Survey 2015

1. Introduction and background

The Care Quality Commission requires all NHS acute trusts to carry out the national inpatient survey every year.

The survey is designed to focus on what is most important from the perspective of the patient.

The 2015 survey sample was taken from discharged inpatients who attended York Teaching Hospital NHS Foundation Trust (YTHFT) in July 2015. Patients received a paper survey form along with a covering letter and a freepost return envelope. Information was provided about how to access the survey in other languages or formats.

The survey was carried out on the Trust's behalf by the Picker Institute.

The results in this paper show the Trust's performance compared to previous years and compared to other NHS acute Trusts.

2. Results

2.1 Historical comparison

There are 65 questions in the survey. These are grouped into eight categories:

- Admission to hospital
- The hospital and ward
- Doctors
- Nurses
- Your care and treatment
- Operations and procedures
- Leaving hospital
- Overall.

The Picker Institute uses a system of 'problem scores' - this means that lower scores are better.

There are two significant differences since the 2014 survey. The Trust has scored significantly better in two questions. All other scores are in line with previous years' scores.

	2014	2015
Hospital toilets not very or not at all clean	6%	3%
Hospital food was fair or poor	38%	31%

2.2 High levels of reported patient satisfaction

Patients expressed few concerns about cleanliness of rooms and toilets, mixed-sex

accommodation and privacy whilst being examined or treated.

2.3 Low levels of reported patient satisfaction

The areas where patients reported least satisfaction included aspects of the management of discharge (delayed by over an hour, not fully told about the side-effects of medicines, not fully told the danger signals to look for, family not given enough information to help) and the opportunity to discuss concerns with a member of staff or give feedback about the quality of care.

2.4 External Benchmark - Comparison with other NHS Trusts

The CQC published our Trust's benchmark report on 8 June 2016. This compares our Trust to all other acute trusts. For each measure, scores are placed into one of three brackets: best performing, about the same and worst performing.

For our Trust one measure is in the 'better' bracket:

- Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?

All other measures are in the 'about the same' bracket. This covers a relatively wide range, and areas where we are close to top of the range include:

- How do you feel about the length of time you were on the waiting list?
- Did a member of staff answer your questions about the operation or procedure?
- Afterwards, did a member of staff explain how the operation or procedure had gone?
- Did you get enough help from staff to eat your meals?
- Did you ever share a sleeping area with patients of the opposite sex?
- Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?

2.5 Internal Benchmark - Comparison between York, Scarborough and Bridlington

a) Bridlington compared to York and Scarborough

45 out of 65 indicators, levels of satisfaction were greatest at Bridlington Hospital compared to York and Scarborough hospitals. This is significant.

Areas where Bridlington Hospital achieved significantly higher satisfaction levels (fewer reported concerns) compared to York and Scarborough were:

- Bothered by noise at night from other patients
- Did not always get enough help from staff to eat meals
- All questions relating to nurses and doctors
- Not always enough privacy when being examined or treated
- Overall not treated with respect or dignity.

One area where Bridlington patients were less satisfied than York or Scarborough was:

- Planned admission date changed by hospital.

b) Comparison between York and Scarborough

Patients reported significantly more concerns with care at Scarborough compared to York against the following indicators:

- Admission: had to wait a long time to get to bed on ward
- Doctors: did not always get clear answers to questions
- Doctors: talked in front of patients as if they were not there
- Surgery: questions not fully answered
- Surgery: results not explained in a clear way
- Discharge: not fully told of danger signals to look for.

Patients reported significantly more concerns with care at York compared to Scarborough against the following indicators:

- Planned admission: should have been admitted sooner
- Food was fair or poor
- Care: could not always find staff member to discuss concerns with.

2.6 Narrative comments

There are three opportunities to provide narrative comments in the survey. All comments are provided to the Trust. A sample is shown below:

The question asked: *Was there anything particularly good about your hospital care?*

"Everyone in A&E and resus were excellent and reassured me as I was very frightened. This excellent care was continued on high dependency ward with the consultant doctors and nurses. And I feel safe in their care."

"I was in hospital for issues relating to my mental health and even though I had caused myself to be ill I was treated with respect and did not feel I was being judged or receiving a lower standard of care."

"I had a good experience on both wards whist I was in hospital, I especially thought Ward 16 staff team worked really well together, were very caring and helpful."

"The food has improved drastically."

The question asked: *Was there anything that could have been improved?*

"Sleeping at night - noise from staff as well as other patients. Example - metal bin in my ward and people in and out using it again and again."

"Nurses always seemed rushed even though there was hardly anyone on the ward. My discharge was delayed due to waiting for doctors and results, however when it came to my discharge the nurse couldn't get rid of me quick enough so tablets and paperwork was incorrectly filled in and rushed."

"For doctors to speak to you more about your condition".

The question asked: *Any other comments?*

"On recent short says in hospital (to investigate heart problems etc) the biggest problem was boredom and uncertainty of what was happening. It was not often practical to ask a nurse for non-urgent help as they we're busy with ill patients. A new medical (voluntary care assistant?) who could find out things and possibly visit the shop for a patient unable to walk far would help."

"I fall quite a lot and have been in and out of hospital frequently over the years and have found the care and cleanliness over the last few years has greatly improved."

3. Conclusion

Overall, the survey provides a positive picture about care at York Teaching Hospitals.

The achievement of staff across the Trust to achieve improved satisfaction since 2014 can be recognised and celebrated internally with staff and externally with other NHS organisations and the public. This is a particularly notable achievement in year where the Trust has been subject to performance and staffing pressures.

As well as recognising improvement and positive comparison with other NHS Trusts, the results provide insight into areas for improvement. In particular, the narrative comments can be used to inform achievable actions for further improvements.

In particular, areas for improvement include greater publicity and visibility in our hospitals for opportunities to give feedback, reducing noise at night, and sharing good practice from York doctors regarding communication with patients with Scarborough colleagues.

4. Next Steps

The Patient Experience Steering Group held a special workshop meeting on 4 May 2016 to review the results of the National Inpatient Survey and develop an action plan.

There was a wide-ranging group discussion about the key themes and areas for action. These were agreed to be:

4.1 Celebrating and recognising success

The Communications Team will support internal and external communications celebrating the positive outcome of the survey. Matrons and directorate management will support the cascade through to front line staff.

4.2 Reducing noise at night

The Communications Team have designed Night Owl Pledge cards and matrons/sisters will lead the roll out.

The Patient Experience Team are sourcing eye masks/ear plug packs in order to trial offering these to inpatients.
The Estates Team will ensure that noisy bins are identified and replacements arranged as part of PLACE assessment process.

4.3 Welcoming and encouraging feedback

The Patient Experience Team will support matrons to produce a new poster for ward

entrances, encouraging people to give feedback and explaining who to contact with any concerns.

The 'Your Experiences Matter' leaflet will be made more available within the hospital. The Patient Experience Team will replenish leaflets as they go round the wards for Friends and Family Test collections at York and Scarborough.

The 'Knowing How We are Doing Boards' will be reviewed. This will include looking at whether all patient experience information could be displayed in a single area.

A PALS review is currently being undertaken and part of its associated action plan is to make the service more visible and accessible in the hospital. PALS will move to a new office with a space for people who wish to talk face-to-face with a PALS adviser.

A new role for patient experience volunteers will be piloted where they spend time on wards talking to patients and proactively asking for feedback. Healthwatch York has been involved in such a scheme for care homes with City of York Council and will share their learning and best practice.

4.4 Empowering patients

John's Campaign, supported by a new visitors' code, is being launched in the Trust in 2016-17.

The Medical Director has committed to write to all medical staff with key findings from the survey and points for reflection.

4.5 Improving patient experience of discharge

Improving the management of discharge is a wider priority for the Trust. The Patient Experience Steering Group will request that patient experience is formally considered, alongside patient flow, in any service improvement projects relating to discharge.

5. Recommendation

The Board is asked to consider and accept the positive assurance about the quality of patient experience in the Trust evidenced by the results of the 2015 national inpatient survey.

The Board is asked to note the action plan proposed by the Patient Experience Steering Group to continue to improve the experience of our patients.

6. References and further reading

National Inpatient Survey 2015 – Final Report

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 June 2016

Finance and Performance Committee Minutes – 21 June 2016

Action requested/recommendation

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

Executive Summary

The Finance and Performance Committee met on 21 June 2016.

The minutes of the committee meeting are attached, together with the Finance, Efficiency, and Performance Reports.

The committee wishes to draw the following to the attention of the Board:

- How the Carter Recommendations, Turnaround Avoidance Programme & Corporate Improvement Programme link in with one another.
- An update on the Trust's operational performance and the on-going work, particularly with the Emergency Department.
- To update on the Trust's Income and Expenditure position and the concerns the committee has on agency funding and having no business rules through for the sustainability funding.

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

Implications for equality and diversity

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

marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

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

Reference to CQC regulations

No references to CQC outcomes.

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

Progress of report	Board of Directors
Risk	Any risks are outlined in the minutes or reports.
Resource implications	Resource implications are outlined in the minutes or reports.
Owner	Michael Keaney, Non-Executive Director
Author	Lisa Gray, Chief Executive's Office Manager
Date of paper	June 2016
Version number	Version 1

Finance and Performance Committee – 21 June 2016 - Boardroom, York Hospital

Attendance: Mike Keaney, Chairman, Michael Sweet, Andrew Bertram, Lucy Turner, Juliet Walters, Sue Rushbrook, Graham Lamb, Wendy Pollard, Lisa Gray (minutes)

Apologies: Anna Pridmore, Steven Kitching, Gordon Cooney

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes 17 May 2016**	The agenda covered the following AFW and CRR items AFW EF1 DoF1,2, 4,7 CRR CE1 DoF 1-3	The committee asked for two typographical errors to be corrected. The 16/17 contract issues should have stated that the contracts had not been 'signed' rather than 'sighed', and that Sarah's surname is Barrow not Barrows. The remainder of the minutes were approved as a true record of the meeting.		
2.	**Matters arising**		MS expressed to the committee how impressed he was with the updated performance report, and thanked SR and her team for all their hard work with creating the updated report format. There were no further matters arising.		
3	**Risk Register**		The committee noted the risk registers. JW informed the committee that further work is being completed on the Ambulance Handover Time risk, and this would show on the next month's register. MK & MS voiced to the committee that they were happy with the risk registers as they now contain the correct level of detail required.	The committee were assured by the risk register, and the work that has been put in to ensure all risks are included.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
4.	**TAP Monthly Summary**		MK questioned what the Carter Recommendations meant to the Trust and AB confirmed that the Trust was starting to work through the recommendations to enable us to achieve each recommendation, however AB was clear that Carter was not enough in terms of the savings the Trust needs to make. AB drew the committee to two things: 1. The updated Corporate Improvement Team (CIT) project status report. AB confirmed he had met with the CIT to discuss the risks and issues associated with this work, and that these were now being picked up and dealt with. 2. The additional information around Carter which is now included in the performance report. This begins to show what Carter means for the Trust using real data, however AB noted that this was a work in progress and more detail would be added in the coming months. The charts show what the Trust is expected to deliver in terms of Carter against what the Trust has delivered YTD, which is showing an encouraging position already. MK questioned how the Trust had found savings of over £2m in workforce already, and whether this had reduced the workforce the Trust has. AB confirmed the savings had come from fixed directorate budgets where posts had been vacant and added to the non-recurrent CIP each year within the last 3 years or more. These savings have		AB to update the Board on how Carter, TAP & CIP link in with one another.

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			now become recurrent. The Trust has therefore reduced its workforce, but only where the vacant posts were no longer required, therefore the active workforce & current vacant posts remain the same meaning the active workforce has not reduced. Both MK & MS questioned which plan the Trust is working towards, as there is now TAP, CIP & Carter. AB explained that the Trust was working towards each scheme but they all interlink and complement one another. The Trust is continuing with TAP to help avoid turnaround, as well as work towards its £26m CIP target which is project managed by the CET. The Carter Recommendations will also be worked towards, however the Trust is required to deliver much more than Carter requires, as outlined in the CIP target. AB believes Carter is a real opportunity to help the Trust work towards reaching its CIP with the refreshed ideas coming through and therefore it is a welcome addition. MK enquired how the project status report would look each month going forward. The committee agreed that this report would come periodically as the data required will be contained in the monthly performance report. This enables the committee to receive one document with all the data in they need each month to seek assurance, or to assist the non-executive directors raising concerns at committee meetings. The periodic report would then include an overview of what each of the project managers where completing in a higher level format.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			AB confirmed to the committee, following concerns from MK that he is happy that monitor on progress can be managed through the Finance & Performance Committee. There are two main national objectives emerging for 2016/17; these are delivery of the Emergency Care Standard and delivery of financial control totals. The Trust must focus its effort in these main areas. Notwithstanding this prioritisation the Trust must maintain delivery of CQUINS, CIP, 18-weeks, etc. Senior staff are kept fully briefed (through Staff Brief, Performance Assurance, and Executive Board meetings) on what the Trust needs to achieve and this is being fed to each of their staff areas so the Trust can be a successful one. The committee agreed that AB would work with AP to re-work parts of the agenda, to ensure the committee is focussing on the right areas within the meeting to make best use of its time.		
5.	**Work Stream 1: Operational Reports**		JW and LT presented the operational report to the committee. **ED -** The Trust has agreed in terms of the Emergency Care Standard (ECS) to achieve 91.5% by the end of March 2017. JT confirmed the trajectory for May 2016 (86%) was achieved at 87.9%. Pressure remains around triage, with non-elective admissions increasing. JW confirmed the Trust was working with CCG's to help decrease the amount of patients GP's send as the default should not to be	The committee were assured by the work on-going but remain concerned about the current performance in ED.	JW to update the Board on Operational Performance and the on-going work.

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			to admit them. Bed occupancy also remained high throughout May 2016. JW confirmed the operational team are continuing to work with the Executive Board and ED on how the Trust can improve performance. This includes: • Communicating openly and continuously with all staff members so they understand they have a part to play in the Trusts performance. • Bed modelling work is on-going. • A planned 16 day focus on no delays will commence on 11 July 2016 to engage staff, and bring all of the pathways together. • The ED front door model discussions are on-going and there is agreement that the medical model and concept are correct, but concern remains as it may mean a loss of income to the Trust. Discussion with NHSI on how they can support the Trust with this model is required. MS raised concerns around the front door model as Scarborough have had staffing issues, but JW assured the committee that learning from this was taking place. The nursing co-ordinator in place is helping to assess people in the first instance and re-directing them to the correct area which is deflecting people away from ED who do not need to be in attendance. This with the model should reduce the Trust's non admitted breaches, which is		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			one of the Trust's biggest. MK didn't believe the figures were starting to show a reduction, and questioned whether the Trust still has a shortage of ED specialists. JW confirmed there was a shortfall of specialists in York and Scarborough however this has always been the case. The plan is to outline a different workforce around the model by potentially using nurses, HCA's, paramedics and pharmacists to filter patients quicker, and to direct them to the right area which would relieve pressure on ED. MK raised concerns that the model is not going to be a quick fix, so concern grows over improving and sustaining the Trust targets and receiving its sustainability funding. JW informed the committee that the Junior Doctor strike action had not helped with SR noting the knock on effect with no longer having Whitby Hospital as well. In the interim to staff shortages will need to be filled with locums which does have a knock on effect to the agency spend but patient safety is the Trust's priority, and she confirmed that ECS is a national issue. LT brought to the attention of the committee that there is a high risk that ECS will not be met in June, and that the target would become harder to achieve with a 1% increase each move. **Cancer –** The Trust did not achieve the 14 Day Fast Track target (93%) for April 2016, achieving 92.6%.	The committee were assured that corrective action has taken place to improve the fast track performance.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			LT confirmed the contributing factors was patient choice, and staffing/capacity issues in Skin on the East Coast, however staff are now in place so this should improve. **18 weeks –** The Trust achieved 92.1% performance against 92% for May, however 3 specialties failed the 92% target. MS noted there was a continuing increase in some of the back logs and asked whether the committee envisaged a problem. LT confirmed there were concerns around Max Fax but the team were working with them on options available including scheduling increased weekend working and utilising core ENT lists for Max Fax patients. General Surgery had 13 lists cancelled due to theatre staff shortages, and are also looking at weekend working. Newly recruited theatre staff will be in post by October 2016, which will reduce the amount of cancellations. LT informed the committee there had been one 52 week breach due to an admin error, and there was no concern that this was happened regularly. The patient in question when picked up could have been seen in time but unfortunately the patient was deemed medically unfit.	The committee were assured work was being undertaken to stop the back logs getting worse.	
6.	**Work Stream 2: CQUIN delivery**		LT presented the CQUIN report to the committee confirming that Sepsis in ED was the one red flag the Trust received in Q1, and noted that the paper should have read that if the Trust receives 50-89.9% it would receive 50% payment not 5%, and if	The committee were assured by the work being completed on improving the one red flagged CQUIN, and by the near agreement of the local CQUINs	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			it achieved over 90% it would receive 100% payment not 10%. The Trust performance is currently 60% so it is expected to receive 50% payment. Diane Palmer, Deputy Director of Patient Safety is currently working on improving the performance of this CQUIN. LT noted that following her note on local schemes not yet being agreed with the VoY CCG she can confirm that both parties agree with the schemes in principle, there is just the matter of agreeing the wording. A meeting is scheduled however, with the VoY CCG on 23 June 2016 to agree the wording. There will be a full report presented to the committee in July 2016, as all CQUINs will be agreed by this point.	with the VoY CCG.	
7.	**Work Stream 3: Finance Report**		GL informed the committee that the Trusts I&E position is £0.2m ahead of a planned deficit of £0.9m at the end of May 2016, with the Trusts FSRR reporting as a 3. AB noted that the position after month 2 was encouraging following the extreme expenditure controls put in place throughout Q4. GL noted that the main concern currently was the upper cap limits for agency spend as despite the Trust doing reasonably well in April, the Trust exceeded the allowable trajectory by over £0.5m. MK questioned why the corrective action put in place at the end of the previous financial year was no longer working. AB informed the committee that	The committee were assured by the I&E position being ahead of plan. The committee remains concerned over agency spend, but the committee were assured work is on-going to reduce this.	AB to update the Board on the I&E position and around the concerns about agency funding and having no business rules for the sustainability funding.

Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
		following May's increase in agency spend further levels of challenge to teams requesting agency cover have now been put in place by himself, JW, Polly McMeekin (Deputy Director of Workforce), and Jim Taylor (Medical Director), and it is expected that this would improve agency spend. MK enquired as to how much agency spend is covering vacant posts, especially at Scarborough Hospital and AB confirmed that a large majority of overspend was due to vacant posts. MK queried whether the Trust needed to spend this money to ensure patient safety, and whether this would remain the same throughout the year. AB informed the committee that this is constantly changing, so it would not remain the same throughout the year as the Trust continues to actively recruit into the vacant posts, and several locums are coming on board to do NHS work as well. GL confirmed that since the report had been written the contract with the Vale of York CCG had now been signed. The Trust, GL confirmed, is still also awaiting the business rules from NHSI in association with securing sustainability funding. AB hopes these will be received before the Board of Directors meeting on 29 June 2016, to enable him to update the Board and give assurance on where the Trust currently stands in terms of the funding. MK raised his concerns to the committee over the £1.8m owed from debtors over 3 months and	The committee were assured by the contract now being completed. The committee remained concerned that the business rules have yet to be published. The committee were assured by the level of debt collection work that was on-going,	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			whether the Trust would receive payment. AB assured MK that this should significantly reduce as a large amount of this is owed from Harrogate Hospital, and that he had recently met with their Finance Director and agreed payment. Further debt was also being recovered through increased debt collection activity, which now has a more robust system, which has recently helped with two non-paying councils within the country.		
8.	**Work Stream 3: Efficiency Report**		Overall delivery is £5.1m in May 2016 which is 19% of the overall annual target. Part year delivery is £1.1m behind the plan submitted to NHSI but WP informed the committee that the Trust had seen a positive increase in the last month which was helping to close this gap. WP explained that there is currently a push within the Trust to alter some of the non recurrent savings to recurrent, and as a result of this 90% of Mays delivery was recurrent. This has been achieved by speaking with Directorates who have claimed the same non recurrent savings over the last few years and getting to commit to them as recurrent savings. MS raised his concerns that the Trust had therefore only made a saving of £0.5m throughout May, but AB explained this was not the case as the £4.6m would have still been noted as a saving whether it was recurrent or non recurrent. Both MS & MK were pleased to see the Corporate Efficiency Team (CET) were increasing the pressure to make further savings, but MK did question whether there were enough schemes in	The committee were assured by the work that was on-going to find additional savings within the Trust, and the move in some non recurrent savings to recurrent.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			the pipeline to achieve this year's target. AB informed the committee that he was optimistic that the target would be met due to the strength of the CET and the schemes coming up, with Carter Recommendations will also helping. MK queried how the Trust could have savings in workforce, yet the Trust was overspending on agency and questioned whether this saving should be off set against the agency spend. AB confirmed that although they are workforce they need tracking as two separate things.		
9.	**Work Stream 4: Workforce**		The committee noted the supplementary temporary staffing report.		
10.	**Internal Audit Plan for 2016/17**		The committee reviewed the Internal Audit Plan for 2016/17 and confirmed there were no concerns.		
11.	**Any other business**		No other business was discussed.		
12.	**Next Meeting**		The next meeting is arranged for 19 July 2016.		

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York Teaching Hospital NHS

NHS Foundation Trust

Board of Directors – 29 June 2016

Finance Report

Action requested/recommendation

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

Executive Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 31 May 2016.

At the end of May the Trust is reporting an Income and Expenditure (I&E) deficit of £0.7m against a planned deficit of £0.9m for the period. The Income & Expenditure position places the Trust ahead of its Operational plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Finance and Performance Committee
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	June 2016
Version number	Version 1

Briefing Note for the Finance & Performance Committee Meeting 21 June 2016
Briefing Note for the Board of Directors Meeting 29 June 2016

Subject: May 2016 (Month 2) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for May 2016

The Trust's I&E account shows a month 2 deficit of £0.7m against a planned deficit of £0.9m. The Trust is therefore currently reported as £0.2m ahead of plan and has maintained the opening month's favourable variance. This continues to be an encouraging start to the financial year given the current and well documented risks to our plan and the bounce back concern following the quarter four extreme expenditure control measures.

The position includes a fully comprehensive expenditure position, sourced in the usual way through all normal expenditure feed systems. The estimated level of income reported in April has proved to be accurate with no significant movement impacting the May position. Income for May has been assessed using the usual estimation process where coded data is unavailable.

There continues to be no evidence that expenditure trends have surged forward in the first two months of the new financial year with good grip and control measures remaining in place. Some expenditure categories have seen intentionally delayed or postponed requisitions coming through but these have all been manageable to date from within the planned provisions made.

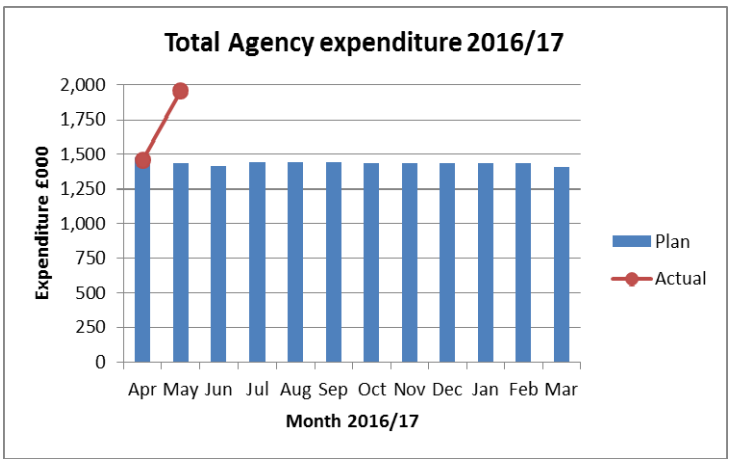
The month two CIP position is more encouraging with in excess of £5m removed from budget, representing some 19% of the target requirement and moving the delivery position into line with that reported at month two last year. The planning gap for the year is still concerning but is starting to close with identification of corporate schemes on the back of the Carter efficiency agenda.

Enhanced Agency Expenditure Analysis

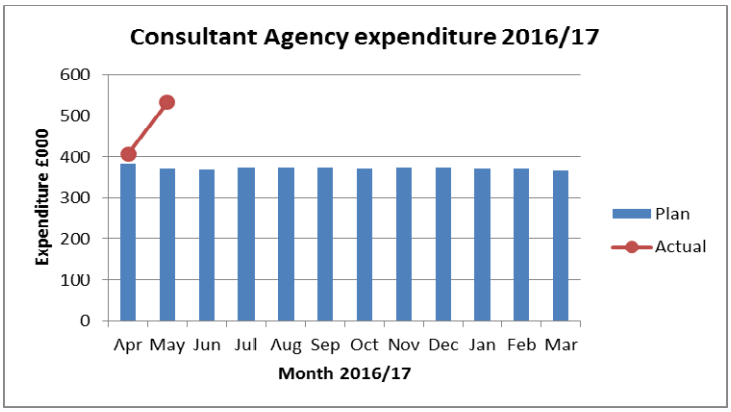
As discussed previously at the Board we have developed our agency staff cost reporting to ensure full visibility against the Trust's overall improvement trajectory. The Board are aware that NHSI has set the Trust an upper cap limit of £17.2m for its 2016/17 agency expenditure. As a reminder the agency spend for 2015/16 totalled £24m.

We have developed a suite of charts that set indicative targets for agency expenditure in the categories of Consultant, Other Medical, Nursing and Other Staff. The sum of each of these targets reconciles back to our capped plan of £17.2m.

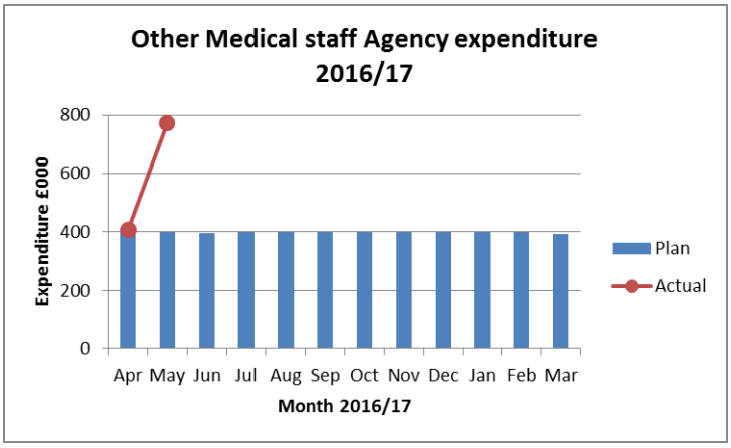
May expenditure has significantly exceeded our allowable trajectory (by over £0.5m). Corrective action is now necessary to ensure this does not become the norm.



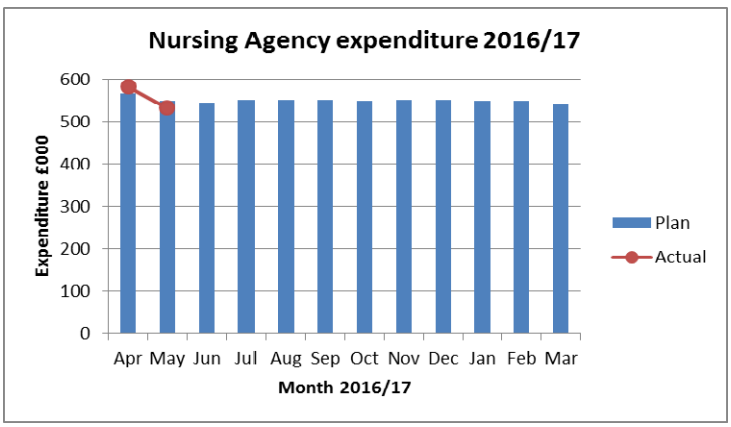
This first chart shows the monthly overall agency target; set at approximately £1.4m per month. The plan is illustrated by the bars. Whilst April spend was £19k less than plan, May has exceeded trajectory by over £0.5m. Corrective action is necessary to ensure this expenditure level is not repeated and indeed action is necessary to recover the position overall.



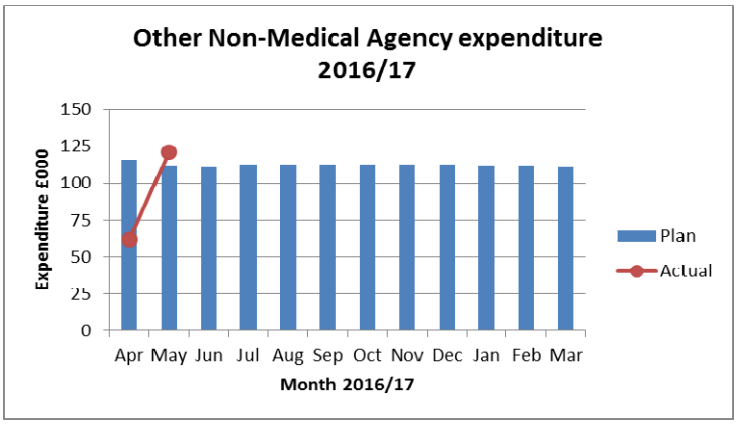
Consultant medical staff agency expenditure has exceeded the monthly target by £130k. This is an area where corrective action is necessary if we are to ensure delivery against our capped expenditure level.



The main pressure this month is in the category of other medical staff (junior staff) agency expenditure. This has exceeded plan by £0.4m. This is the area of greatest risk to the overall delivery of our capped trajectory expenditure level. Corrective action is extremely important.



Nursing staff agency expenditure has remained in line with planned levels and, based on current spend levels, is set to deliver against the capped trajectory level.



The final chart shows non-medical and non-nursing agency staff expenditure. In relative terms this is low level agency usage and whilst we have marginally exceeded the monthly allowable level, the position overall is within trajectory.

2016/17 Contract Issues

All contracts have been signed with the exception of Vale of York CCG. All paperwork and schedules have been agreed (including activity and finance) but the CCG have been holding out for the Trust to agree a risk share in relation to CCG QIPP schemes. At the time of writing this report agreement has just been reached that binds the Trust into a commitment to support delivery of the necessary QIPP for the local health economy. This does not expose the Trust to any significant financial risk but rather seeks to ensure a commitment to prioritise work and release clinical teams to work on QIPP improvement initiatives. It is important the Trust fully supports this agenda to ensure a long term financially and clinically sustainable local health economy.

Sustainability Funding

At the time of writing this report no details have been released regarding the business rules associated with securing this funding. According to NHSI we should expect final confirmation within the next couple of weeks. Our month two position assumes receipt of most of the proportionate element of this funding.

Finance Performance Report

June 2016

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

Finance Report
Chapter Index

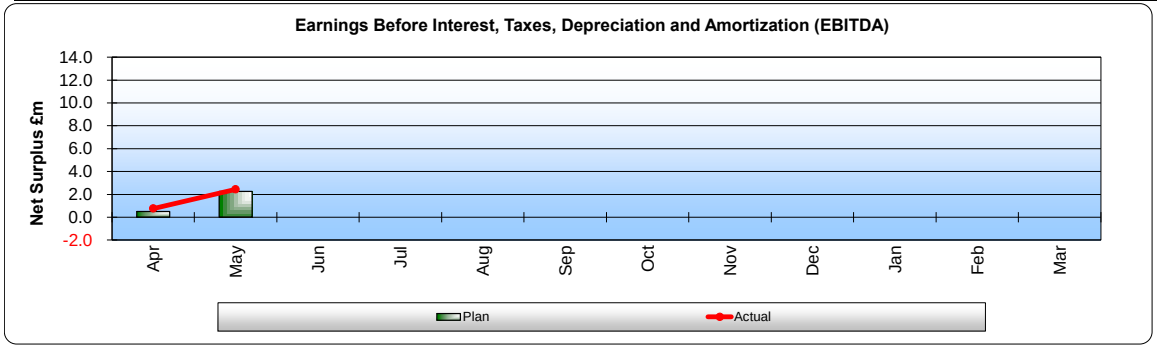
Chapter	Sub-Section
Finance	Summary Income and Expenditure Position
	Contract Performance
	Expenditure Analysis
	Summary Income and Expenditure Position - Cash
	Debtor Analysis
	Summary Income and Expenditure Position - Capital
	Efficiency Programme
	Carter
	SLR

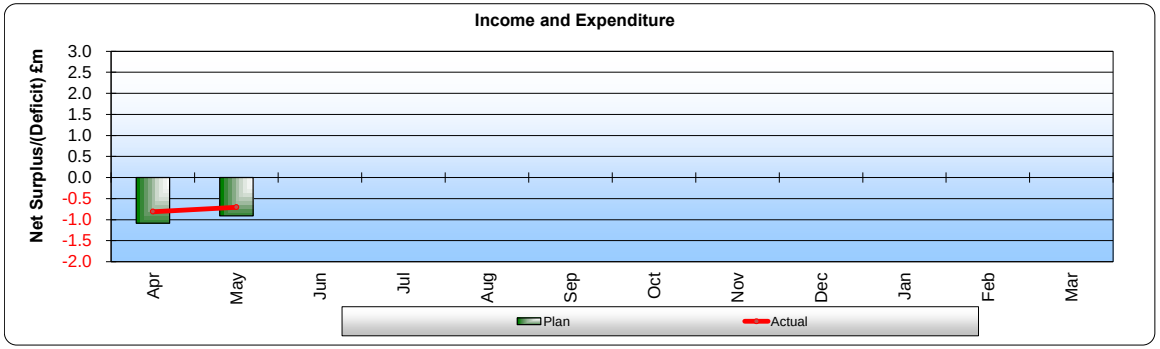
Summary Income and Expenditure Position
Month 2 - The Period 1st April 2016 to 31st May 2016

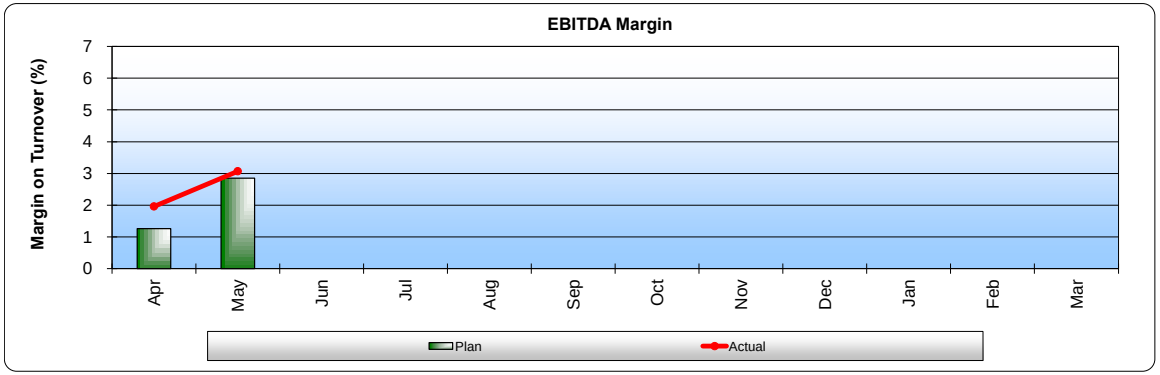
York Teaching Hospital NHS
NHS Foundation Trust

Summary Position:

* The Trust is reporting an I&E deficit of £0.7m, placing it £0.2m ahead of the operational plan.
* Income is £0.5m ahead of plan, with clinical income being £0.2m ahead of plan and non-clinical income being £0.3m ahead of plan.
* Operational expenditure is ahead of plan by £0.3m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £2.4m (3.07%) compared to plan of £2.3m (2.85%), and is reflective of the reported net I&E performance.







	Annual Plan	Plan for Year to Date	Actual for Year to Date	Variance for Year to Date	Forecast Outturn	Annual Plan Variance
	£000	£000	£000	£000	£000	£000
NHS Clinical Income						
Elective Income	26,596	4,373	3,852	-521	26,596	0
Planned same day (Day cases)	38,750	6,346	6,113	-233	38,750	0
Non-Elective Income	109,502	17,936	18,125	189	109,502	0
Outpatients	65,547	10,409	10,749	340	65,547	0
A&E	14,522	2,353	2,341	-12	14,522	0
Community	30,174	4,942	5,137	195	30,174	0
Other	149,945	24,417	24,569	152	149,945	0
	435,036	**70,776**	**70,886**	**110**	**435,036**	**0**
Non-NHS Clinical Income						
Private Patient Income	976	163	181	18	976	0
Other Non-protected Clinical Income	1,827	305	380	75	1,827	0
	2,804	**467**	**561**	**94**	**2,804**	**0**
Other Income						
Education & Training	15,049	2,508	2,398	-110	15,049	0
Research & Development	3,167	528	550	22	3,167	0
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	739	123	157	34	739	0
Other Income	17,171	2,862	3,186	324	17,171	0
Transition support	10,045	1,674	1,674	0	10,045	0
	46,172	**7,695**	**7,965**	**270**	**46,172**	**0**
Total Income	**484,011**	**78,939**	**79,412**	**473**	**484,011**	**0**
Expenditure						
Pay costs	-327,497	-53,282	-52,709	573	-327,497	0
Drug costs	-50,482	-8,348	-8,971	-623	-50,482	0
Clinical Supplies & Services	-46,971	-7,752	-7,110	642	-46,971	0
Other costs (excluding Depreciation)	-50,849	-8,436	-8,111	325	-50,849	0
Restructuring Costs	0	0	-72	-72	0	0
CIP	21,271	1,132	0	-1,132	21,271	0
Total Expenditure	**-454,528**	**-76,686**	**-76,973**	**-287**	**-454,528**	**0**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**29,483**	**2,253**	**2,439**	**186**	**29,483**	**0**
Profit/ Loss on Asset Disposals	0	0	-0	-0	0	0
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation	-12,000	-2,000	-2,000	0	-12,000	0
Interest Receivable/ Payable	100	17	31	15	100	0
Interest Expense on Overdrafts and WCF	0	0	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0	0	0
Interest Expense on Non-commercial borrowings	0	0	0	0	0	0
Interest Expense on Commercial borrowings	-487	-75	-72	4	-487	0
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	0	0	0	0
PDC Dividend	-6,627	-1,105	-1,105	0	-6,627	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**10,169**	**-911**	**-706**	**204**	**10,169**	**0**

Contract Performance
Month 2 - The Period 1st April 2016 to 31st May 2016

York Teaching Hospital NHS
NHS Foundation Trust

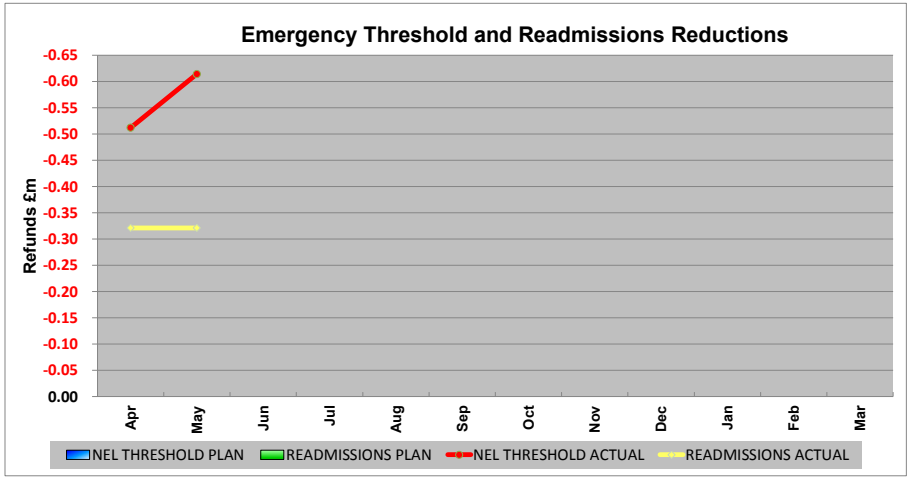
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	0	0	37,548	37,548
Scarborough & Ryedale CCG	0	0	13,359	13,359
East Riding CCG	0	0	6,950	6,950
Other Contracted CCGs	0	0	2,805	2,805
NHSE - Specialised Commissioning	0	0	5,456	5,456
NHSE - Public Health	0	0	2,366	2,366
Local Authorities	0	0	802	802
Total NHS Contract Clinical Income	**0**	**0**	**69,286**	**69,286**

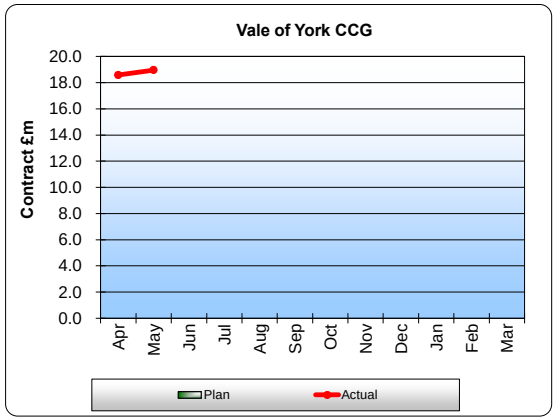
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	0	0	2,116	2,116
Risk Income	0	0	-290	-290
Total Other NHS Clinical Income	**0**	**0**	**1,826**	**1,826**

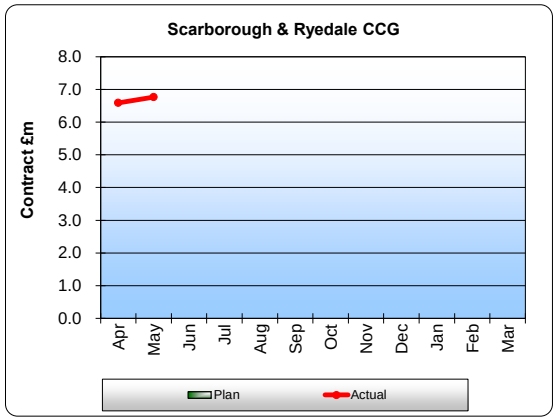
Specialist registrar income moved to other income non clinical	-226
Winter resilience monies in addition to contract	0

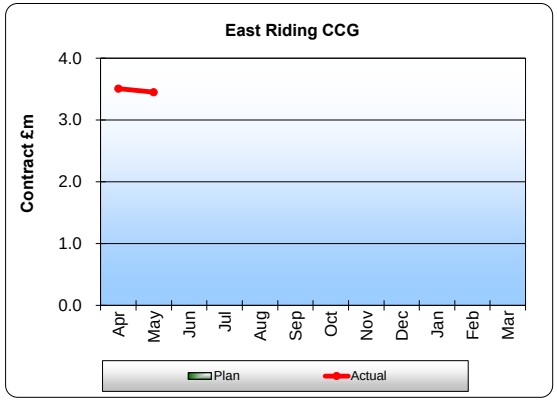
Total NHS Clinical Income	**0**	**0**	**70,886**	**70,886**

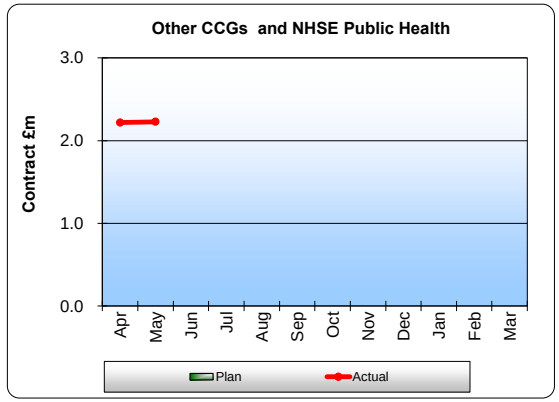
Activity data for May is partially coded (59.09%) and April is 90.18% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.

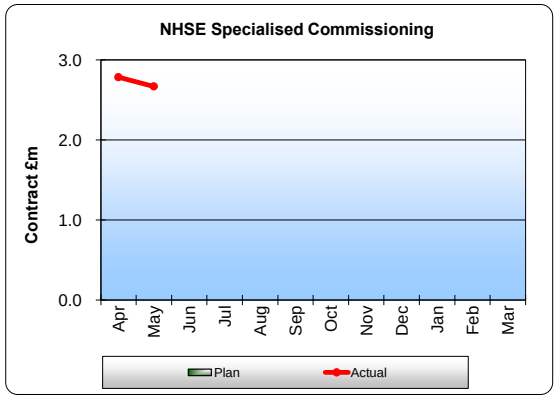


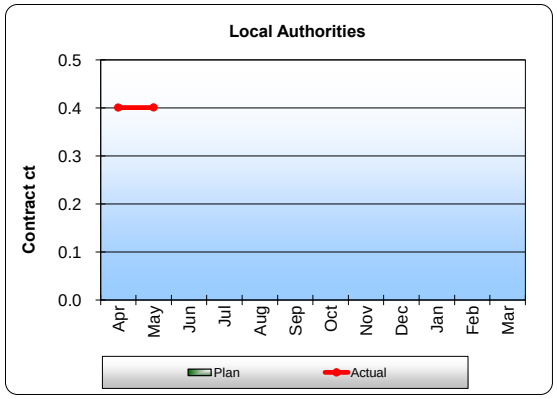












Expenditure Analysis
Month 2 - The Period 1st April 2016 to 31st May 2016

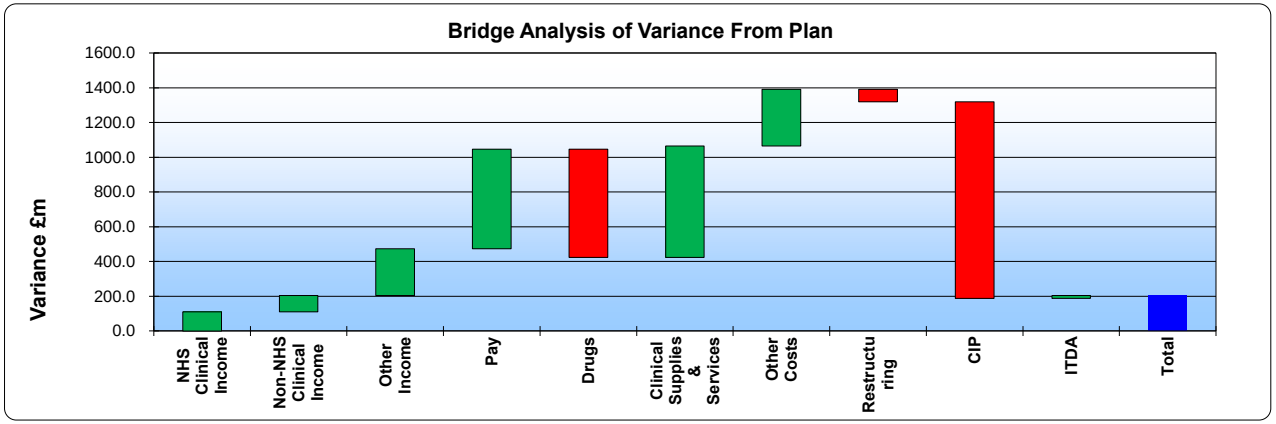
York Teaching Hospital NHS
NHS Foundation Trust

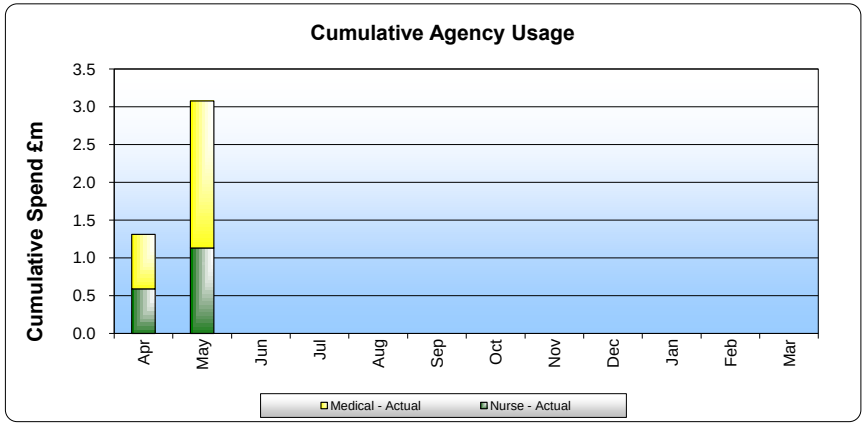
Key Messages:

There is an adverse expenditure variance of £0.3m at the end of May 2016. This comprises:

* Pay budgets are £0.6m favourable, linked to vacant posts. Agency expenditure is £0.5m ahead of the Monitor Plan
* Drugs budgets are £0.6m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £1.1m behind plan.
* Other budgets are £0.9m favourable.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	58,612	9,544	8,168	0	279	0	812	9,259	285	264	
Medical and Dental	30,250	4,975	4,347	0	43	0	1,134	5,524	-548	-21	
Nursing	98,238	16,389	13,128	80	64	1,027	1,132	15,431	958	213	
Healthcare Scientists	11,195	1,823	1,510	38	40	0	69	1,658	165	97	
Scientific, Therapeutic and technical	15,401	2,540	2,332	10	0	2	15	2,359	181	95	
Allied Health Professionals	25,215	4,170	3,652	16	54	3	30	3,755	415	251	
HCAs and Support Staff	43,650	7,276	6,757	107	20	14	32	6,930	346	207	
Chairman and Non Executives	161	27	27	0	0	0	0	27	0	0	
Exec Board and Senior managers	12,393	2,043	2,210	1	0	0	5	2,216	-173	33	
Admin & Clerical	36,354	5,973	5,442	45	17	33	14	5,551	422	188	
Agency Premium Provision	5,816	969	0	0	0	0	0	0	969	485	
Vacancy Factor	-9,787	-2,447	0	0	0	0	0	0	-2,447	-1,066	
TOTAL	**327,497**	**53,282**	**47,573**	**297**	**517**	**1,080**	**3,244**	**52,710**	**572**	**747**	



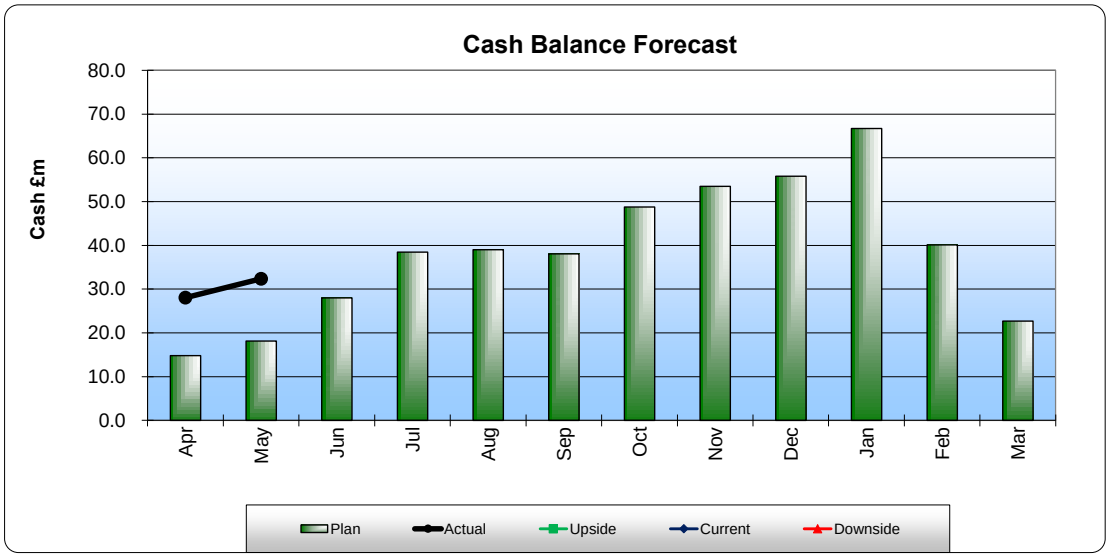


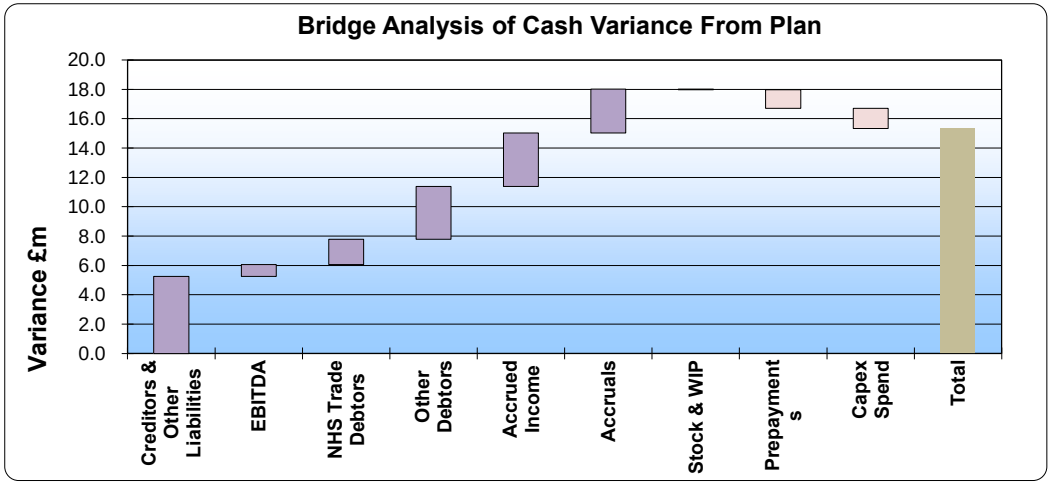
Cash Flow Management
Month 2 - The Period 1st April 2016 to 31st May 2016

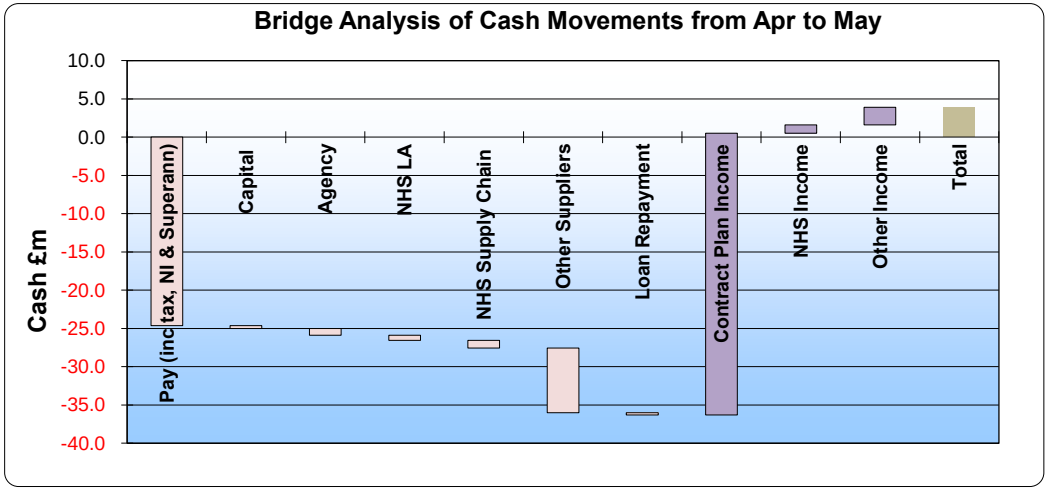
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The cash position at the end of May was £32m.
* The early receipt of the £10m transitional funding last month still influences the position.
* This has resulted in a postion £15m above the monitor plan.







Cash Flow Management
Month 2 - The Period 1st April 2016 to 31st May 2016

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

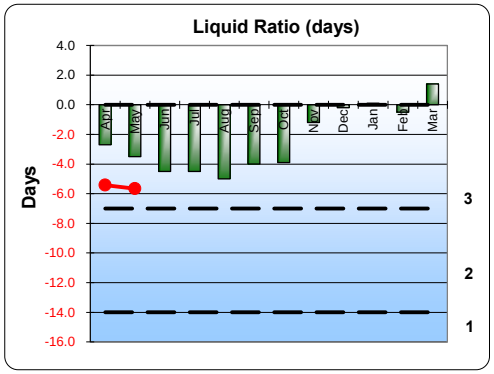
* The receivables balance at the end of May was £6.5m, which is below plan.
* The payables balance at the end of May was £10.2m, which is below plan.
* The Financial Sustainability Risk Rating (FSRR), which is assessed as a score of 3 in May, and is reflective of the I&E position.

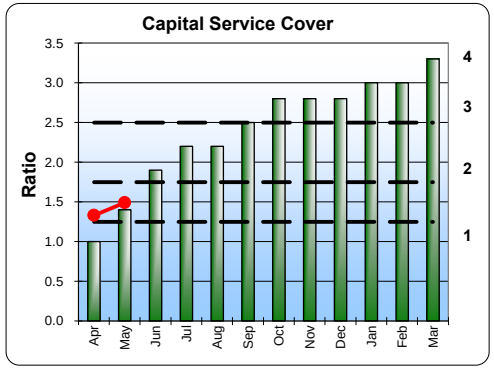
Significant Aged Debtors (+6mths)

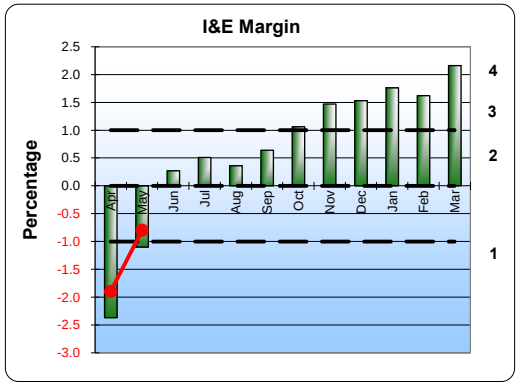
Harrogate and District NHS FT	**£512K**
Depuy Ireland	**£257K**
NHS Vale of York CCG	**£131K**

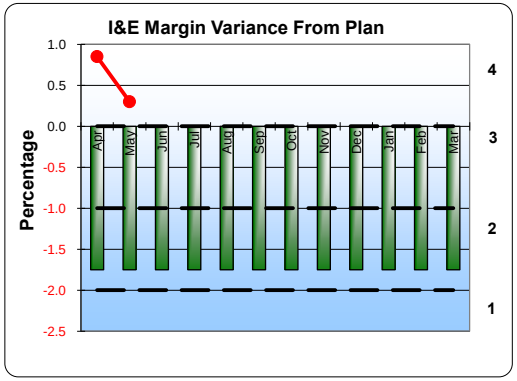
	Under 3 mths	3-6 mths	6-12 mths	12 mths +	Total
	£m	£m	£m	£m	£m
Payables	7.91	0.84	0.75	0.70	10.20
Receivables	4.72	0.63	0.40	0.83	6.58

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







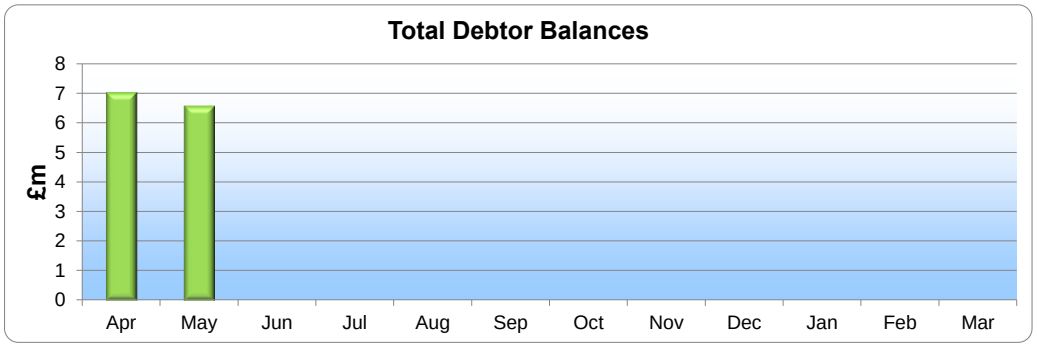


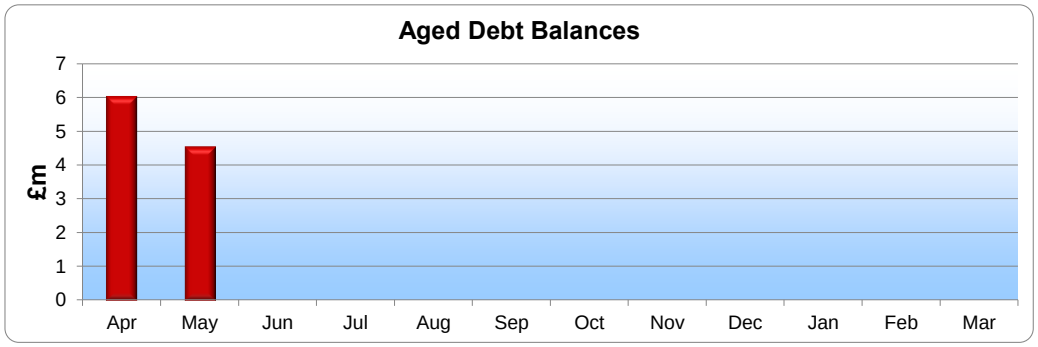
Debtor Analysis
Month 2 - The Period 1st April 2016 to 31st May 2016

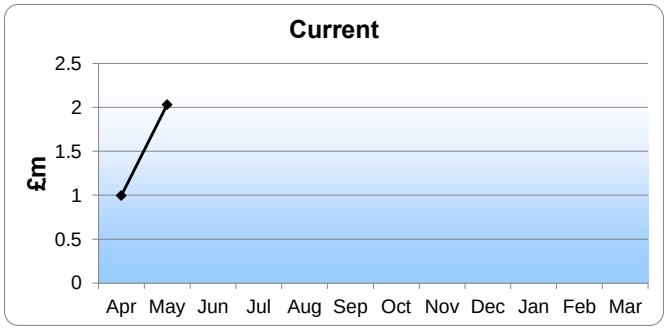
York Teaching Hospital NHS
NHS Foundation Trust

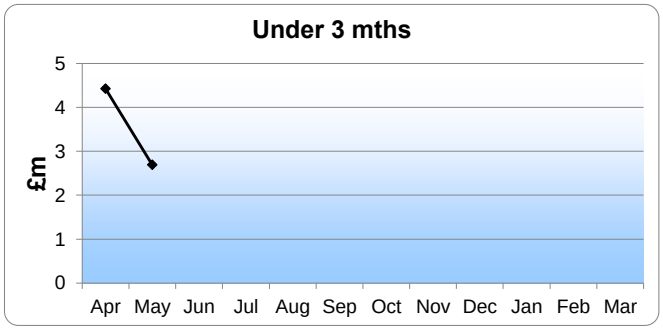
Key Messages:

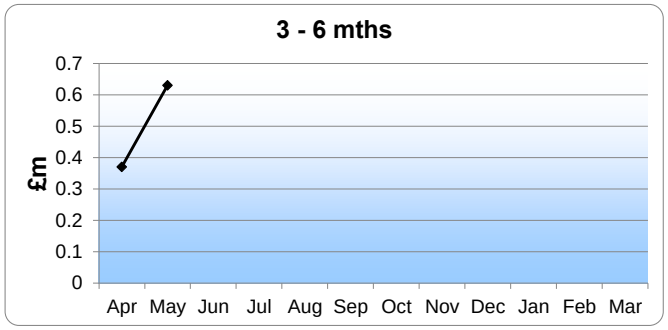
* At the end of May, the total debtor balance was £6.5m.
* Aged Debt was £4.5m, however £2.7m of this is under 3 months old.
* Debtors over 6 months have reduced from the closing position of 15/16 as debt collection activity continues to progress.

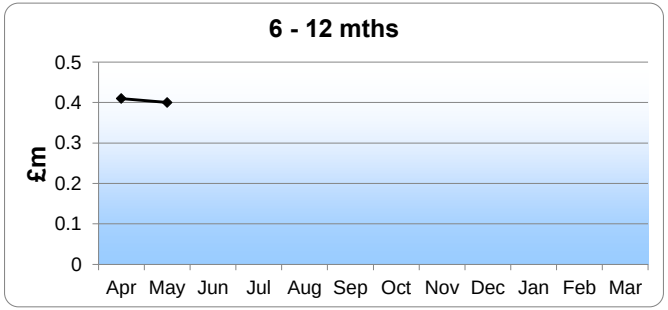


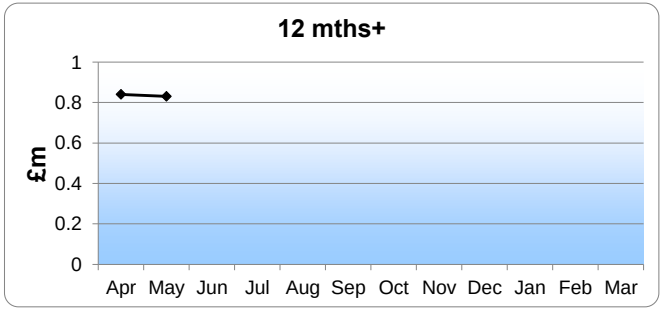












Capital Programme
Month 2 - The Period 1st April 2016 to 31st May 2016

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

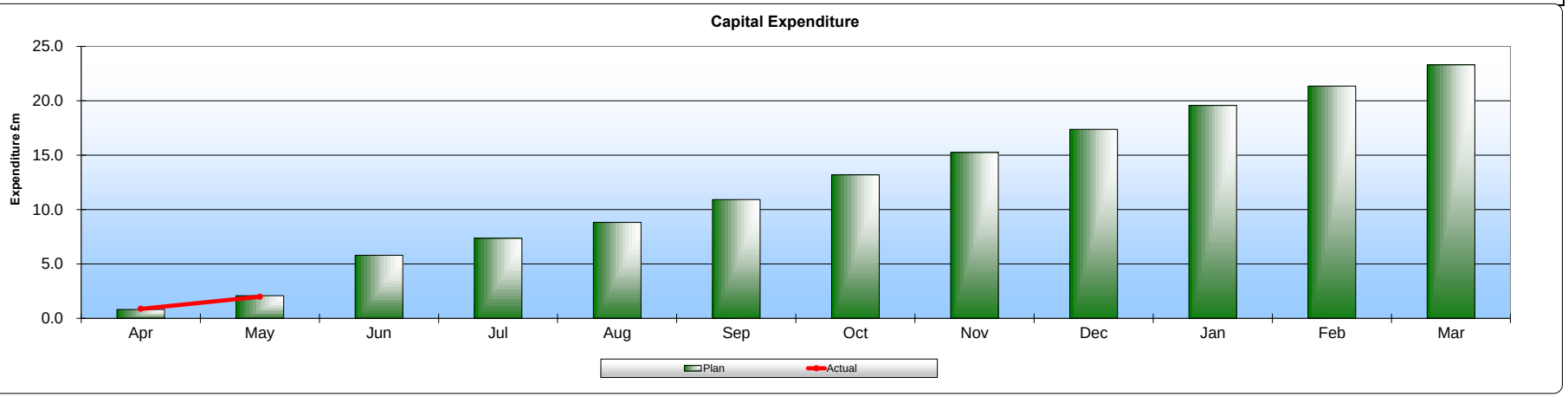
*This years capital programme funding is £23.3m.

* This includes the purchase of Tampit Lodge for £1m

* Schemes to be completed this year include the Malton Urology Scheme for £1.6m, the convertion of Theatre 10 at a cost of £1.1m and York ED improvements phase 2 costing £615k this financial year.

* Strategic funding will be spent on the replacement of the Scarborough Estates and Facilities Portakabins plus completion of the Fire Alarm Scheme, the Lift Replacement scheme and the Ambulance Handover project

* Loan Funding will be spent on Radiology Replacement equipment across both York and Scarborough sites and the Endoscopy Development scheme.



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
Urology Facilities Malton	1,600	394	1,737	-137	
Purchase of Tenpit Lodge Easingwold	1,000	-	1,000	0	
Theatre 10 to cardiac/vascular	1,100	-	1,100	0	
Radiology Replacement	4,450	-	4,450	0	
Radiology Lift Replacement SGH	640	2	840	-200	
Fire Alarm System SGH	640	1	890	-250	
Other Capital Schemes	3,913	584	5,248	-1,335	
SGH Estates Backlog Maintenance	750	35	750	0	
York Estates Backlog Maintenance - York	750	10	750	0	
Medical Equipment	450	100	450	0	
IT Capital Programme	1,600	238	1,600	0	
Capital Programme Management	1,350	239	1,350	0	
Star Appeal	243	7	310	-67	
SGH replacement of estates portakabins	732	-	1,132	-400	
Endoscopy Development	3,500	-	3,500	0	
Contingency	500	-	-	500	
TOTAL CAPITAL PROGRAMME	**23,304**	**1,986**	**25,193**	**- 1,889**	A level of capital creditors is included in the total spend figure.

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£	£	£	£	
Depreciation	12,000	1,976	12,000	-	
Loan Funding b/fwd	-	-	-	-	
Loan Funding	7,950	-	7,950	-	
Charitable Funding	755	7	755	-	
Strategic Capital Funding	3,566	3	3,566	-	
TOTAL FUNDING	**24,271**	**1,986**	**24,271**	**0**	

Efficiency Programme

Month 2 - The Period 1st April 2016 to 31st May 2016

York Teaching Hospital NHS
NHS Foundation Trust

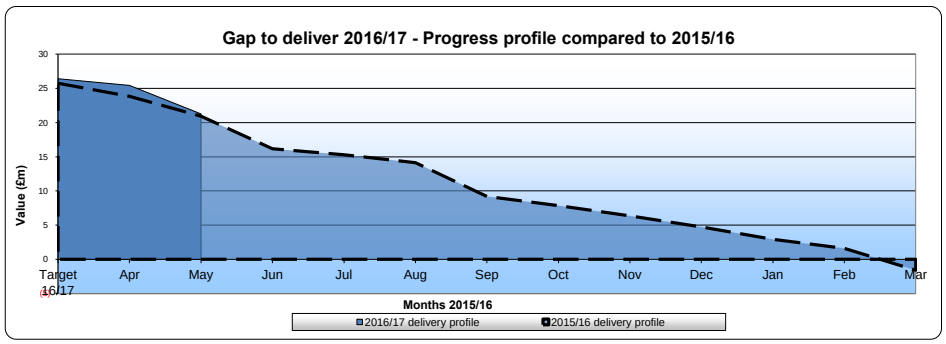
Key Messages:

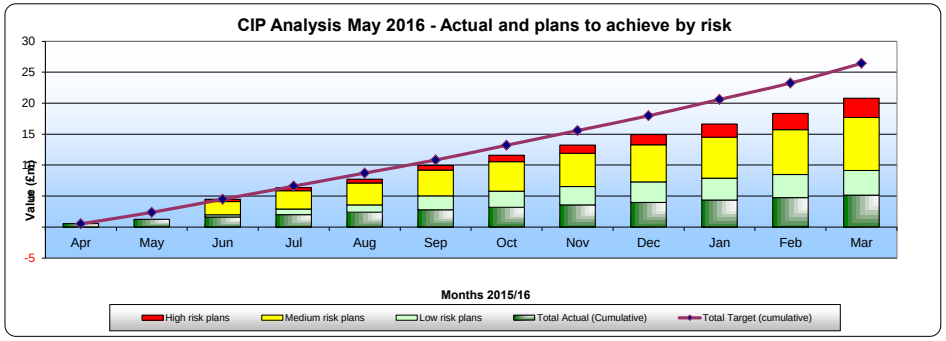
* Delivery - £5.1m has been delivered against the Trust annual target of £26.4m, giving a shortfall of (£21.3m)
* Part year NHSI variance - The part year NHSI variance is (1.1m).
* In year planning - The 2016/17 planning gap is currently (£5.6m)
* Four year planning - The four year planning gap is (£32.1m).
* Recurrent delivery - Recurrent delivery is £4.6m, which is 17% of the 2016/17 CIP target.

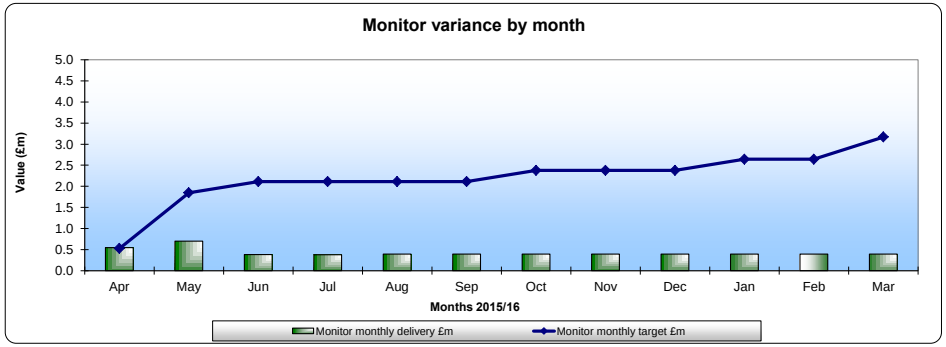
Executive Summary - May 2016	
	Total £m
TARGET	
In year target	26.4
DELIVERY	
In year delivery	5.1
In year delivery (shortfall)/Surplus	-21.3
Part year delivery (shortfall)/surplus - NHSI variance	-1.1
PLANNING	
In year planning surplus/(gap)	-5.6
FINANCIAL RISK SCORE	
Overall trust financial risk score	(2 - RED/AMBER)

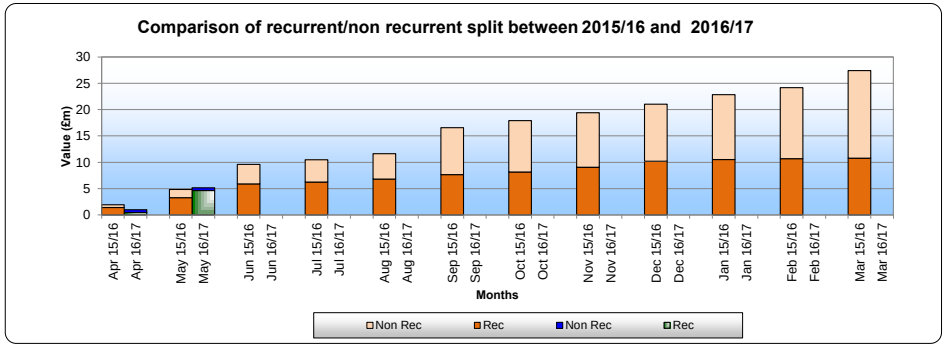
4 Year Efficiency Plan - May 2016					
Year	2016/17	2017/18	2018/19	2019/20	**Total**
	£m	£m	£m	£m	**£m**
Base Target	26.4	15.5	15.5	15.5	**73.0**
Plans	20.8	13.6	5.3	4.4	**44.1**
Variance	-5.6	-1.9	-10.3	-11.1	**-28.9**
%	**79%**	**88%**	**34%**	**29%**	**60%**

Risk Ratings			
Financial			
Score	April	May	Trend
1	25	14	↓
2	2	5	↑
3	0	6	↑
4	0	2	↑
5	0	0	→
Governance			
Score	April	May	Trend
Red	24	6	↓
Green	3	21	↑





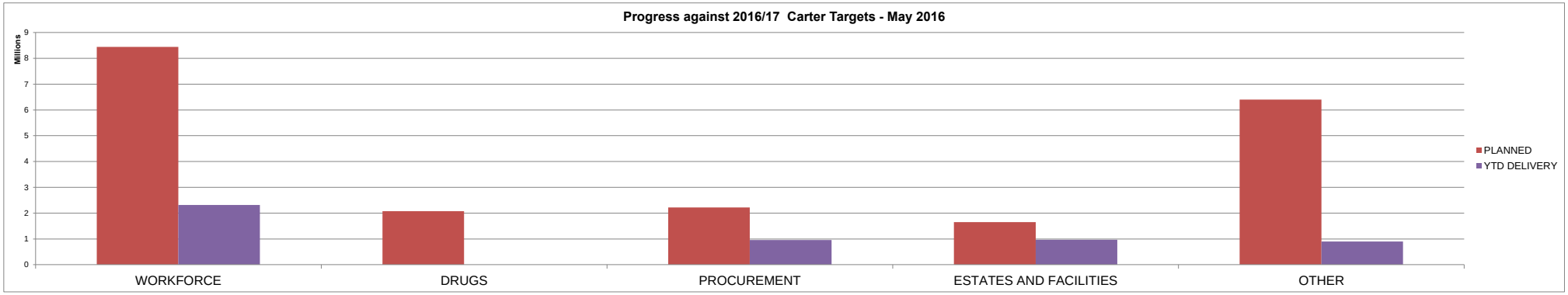




Key Messages:

*
*

EFFICIENCY PROGRAM - CARTER WORKSTREAM PERFORMANCE MAY 2016						
CATEGORY	**WORKFORCE**	**DRUGS**	**PROCUREMENT**	**ESTATES AND FACILITIES**	**OTHER**	**TOTAL**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
2016/17 OVERALL TARGET						26,416
PLANNED	8,440	2,075	2,222	1,648	6,404	20,789
YTD TARGET						2,377
YTD DELIVERY	2,317	0	957	970	901	5,146
YTD VARIANCE	791	-241	696	757	766	2,768
4 YEAR TARGET						0
4 YEAR PLANS	8,833	2,324	2,474	1,961	23,505	39,097
4 YEAR VARIANCE	0	0	0	0	0	0



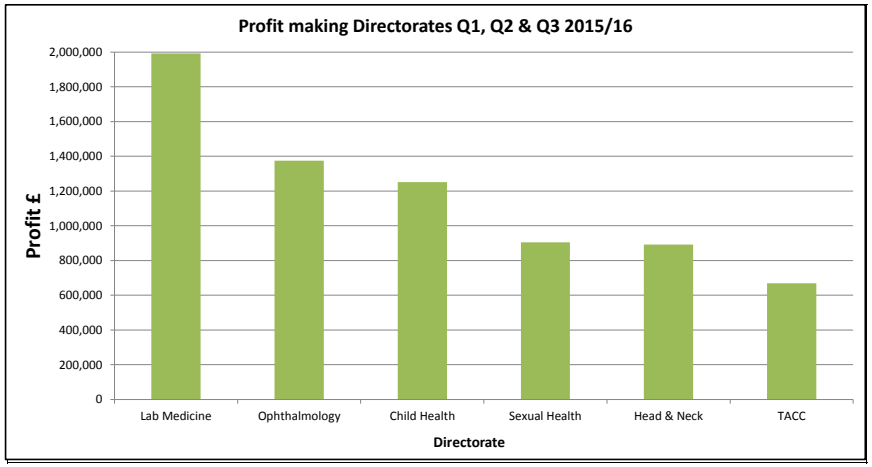
WORKFORCE	DRUGS
PROCUREMENT	**ESTATES AND FACILITIES**

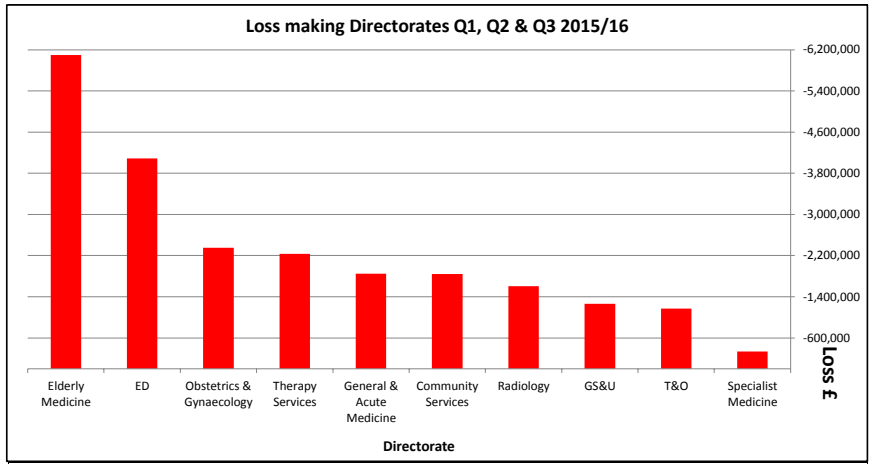
Service Line Reporting
Month 2 - The Period 1st April 2016 to 31st May 2016

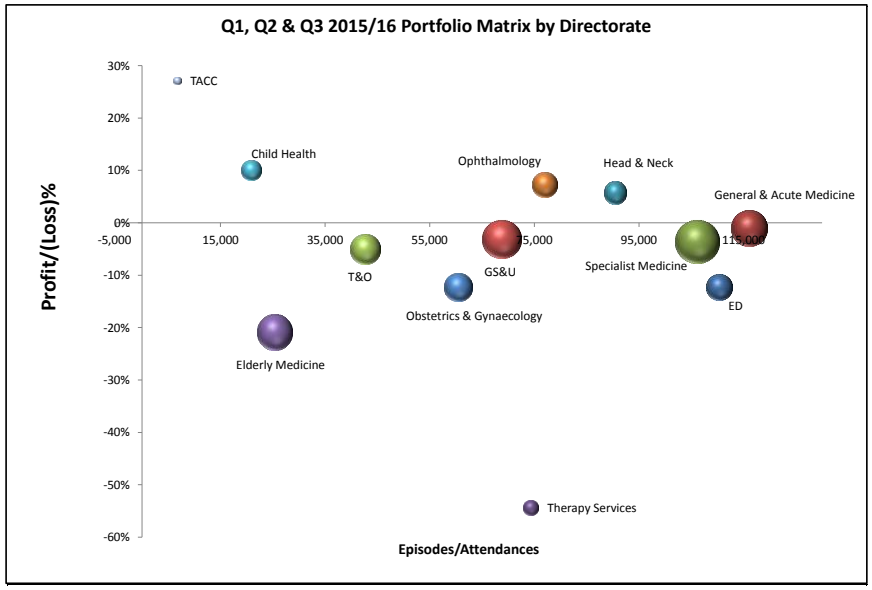
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Current data is based on Q1, Q2 & Q3 2015/16
* It is expected Q4 2015/16 will be completed towards the end of June 2016
* Directorate teams are being asked, on a quarterly basis, to confirm that the consultant PA's allocations used within the SLR system are correct
* Deep dive work is continuing within a number of Directorates







DATA PERIOD	Q1 , Q2 & Q3 2015/16
CURRENT WORK	* Q4 2015/16 SLR data is now the key focus following the publication of Q3 data. Q4 2015/16 is expected to be completed towards the end of June 2016 * The annual Reference Cost calculation is also a key focus for the team ahead of the final submission date of July 28th * Deep dive work for TACC, Womens Health, Specialist Medicine and General & Acute Medicine is underway to agree the income and expenditure allocation methods * Work with Directorate teams is currently on-going to improve the quality of consultant PA allocations used within the SLR system for each quarterly reporting period
FUTURE WORK	* The SLR team are continuing to work with Directorate teams to improve the quality of outpatient staffing group costs within SLR * Future work around junior doctor PA allocations will improve the quality of the SLR data and also to inform the annual mandatory Education & Training cost collection exercise *Preparatory work for the Education & Training mandatory submission will soon begin ahead of the August deadline

BENEFITS TAKEN SINCE SYSTEM INTRODUCTION	**£2.7m**

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F2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 June 2016

Efficiency Programme Update – May 2016

Action requested/recommendation

The Committee is asked to note the May 2016 position.

Executive Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2016/17 target is £26.4m and delivery, as at May 2016, is £5.1m.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report Finance & Performance Committee

Risk	The Efficiency Programme presents a significant financial risk to the organisation.
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Andrew Bertram, Finance Director
Author	Steve Kitching, Head of Corporate Finance & Resource Management
Date of paper	June 2016
Version number	Version 1

Briefing note for the Finance & Performance Committee Meeting 21 June 2016 and Board of Directors meeting 29 June 2016

Subject: May 2016 - Efficiency and Carter update

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

Summary reported position for May 2016

Current position – highlights

Delivery - Overall delivery is £5.1m in May 2016 which is (19%) of the £26.4m annual target. This position compares to a delivery position of £4.8m (18.6%) in May 2015.

Part year delivery is (£1.1m) behind the profiled plan submitted to NHSI.

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

In year planning – There is an in year planning gap of (£5.6m) at May 2016, the comparative position in May 2015, was a gap of (£5.0m).

Four year planning – The four year planning gap is (£28.9m). The position in May 2015 was a gap of (£29.9m). We have a relatively strong planning position for years 1&2 of the plan with £34.4m (82%) worth of plans identified against a target of £42m.

Recurrent vs. Non recurrent – Of the £5.1m delivery, £4.6m (90%) has been delivered recurrently.

Quality Impact Assessments (QIA) – All schemes have been sent out to Directorate teams to self-assess for their safety impact. We are currently working with Mr Khafagy to review the QIA process.

Overview

After a slow start in April 2016 the May 2016 position is extremely encouraging, with a £4.1m delivery improvement reported in the month. The in-year planning position has also moved on in the month from an (£8.5m) gap in April to a (£5.6m) gap in May; a £2.9m improvement.

The recurrent delivery position at 90%, of total delivery to date, is extremely positive, and has been driven predominately by the focus on non-recurrent to recurrent conversion. Of the targeted £6m, £3.2m has been delivered at the end of month 2. Full details by Directorate will be provided for the July 2016 Finance & Performance Committee as part of the June 2016 Efficiency and Carter update. The end of Q1 2016/17 was the targeted delivery date.

The Trust is (£1.1m) behind the NHSI delivery profile at month 2, however it should be noted this does not reflect the significant improvement in overall delivery in Month 2 and

does not offer me any great concern at this stage. We are currently in line with our 2015/16 delivery profile.

Carter

The first Carter Steering Group was held on 8th June 2016 and was chaired by the Chief Executive. The Carter Steering group brings together the Resource Management Executive Group and the Tap Steering Group into one meeting, and aligns the focus of the programmes.

Attached, ***as appendix 3***, is an overview document which intends to provide a summary of the main work streams currently on-going linked to the Carter programme.

Also the Patient Safety, Quality, Workforce, Finance and Performance report has a new Carter page incorporated as part of the Finance & Efficiency section; this will capture overall financial planning & delivery against each of the Carter themes.

The new items described above will be developed in the coming months as the Carter programme evolves and becomes embedded within the organisation.

RISK SCORES - MAY 2016 -APPENDIX 1

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

RISK SCORES - MAY 2016 - APPENDIX 2

DIRECTORATE	Yr1 Target (£000)	4Yr Target (£000)	Yr 1 Plan v Target		Yr 1 Delivery v Target		Y1 Recurrent Delivery v target		4 Yr Plan v Target		Risk Score	
			%	Score	%	Score	%	Score	%	Score	Total Score	Monitor Rating
OPHTHALMOLOGY	763	2,795	45%	1	0%	1	0%	1	14%	1	4	1
HEAD AND NECK	850	2,050	97%	2	0%	1	0%	1	48%	1	5	1
GEN MED SCARBOROUGH	959	2,399	35%	1	2%	1	2%	2	29%	1	5	1
SEXUAL HEALTH	635	1,329	33%	1	11%	2	0%	1	76%	1	5	1
EMERGENCY MEDICINE	434	1,842	33%	1	3%	2	3%	2	31%	1	6	1
CHILD HEALTH	1,072	2,374	98%	2	3%	2	0%	1	52%	1	6	1
TACC	2,248	6,274	43%	1	12%	2	8%	2	44%	1	6	1
RADIOLOGY	1,693	3,295	25%	1	9%	2	9%	3	19%	1	7	1
WOMENS HEALTH	1,683	3,430	31%	1	9%	2	9%	3	50%	1	7	1
SPECIALIST MEDICINE	2,930	6,947	63%	1	11%	2	11%	3	33%	1	7	1
MEDICINE FOR THE ELDERLY	1,513	3,774	176%	5	1%	1	1%	1	84%	1	8	2
GEN MED YORK	1,846	5,686	59%	1	16%	3	15%	4	86%	1	9	2
GS&U	1,964	5,109	61%	1	21%	3	20%	4	81%	1	9	2
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1,280	3,462	52%	1	39%	5	39%	5	39%	1	12	3
ORTHOPAEDICS	1,228	3,521	105%	3	30%	4	23%	5	78%	1	13	3
LAB MED	794	2,881	106%	3	63%	5	58%	5	57%	1	14	3
PHARMACY	374	1,065	102%	3	37%	5	37%	5	90%	2	15	3
COMMUNITY	1,099	2,281	148%	5	15%	3	14%	3	137%	5	16	4
CORPORATE												
SNS	750	1,772	93%	2	2%	1	0%	1	39%	1	5	1
CHIEF NURSE TEAM DIRECTORATE	389	730	34%	1	4%	2	1%	2	18%	1	6	1
HR	376	1,007	53%	1	7%	2	7%	2	42%	1	6	1
OPS MANAGEMENT YORK	205	568	104%	3	11%	2	0%	1	46%	1	7	1
MEDICAL GOVERNANCE	195	533	26%	1	26%	4	16%	4	9%	1	10	2
CHAIRMAN & CHIEF EXECUTIVES OFFICE	74	186	39%	1	39%	5	18%	4	16%	1	11	2
FINANCE	417	1,203	35%	1	35%	5	22%	5	12%	1	12	3
ESTATES AND FACILITIES	2,701	7,099	89%	1	36%	5	36%	5	81%	1	12	3
LEARNING ORGANISATIONAL DEVELOPMENT & RESEAR	217	627	131%	5	25%	4	18%	4	192%	5	18	4
TRUST SCORE	**28,687**	**74,239**	**70%**	**1**	**19%**	**3**	**17%**	**4**	**56%**	**1**	**9**	**2**

Appendix 3

Resource Management Carter Update

Carter Live Projects	Procurement (£3M Target)
Activities – May 2016 onwards	Workshop planned and delivered to senior buyers within Procurement.
	This workshop identified a further £0.5M+ re-current savings opportunities through improved procurement opportunities.
	Key areas to target in the short term • Standardisation of continence products (£0.4M)(Tbc) • Extending use of bulk buying for fast moving consumables (£0.1M) • Accelerating Dressings project (£0.1M)(£0.1M already recorded as CIP) • Standardisation of Tourniquets (£0.075M) • Catering consumables via e-auction (£0.04M)
Future Work plans	Standardisation of ward based consumables (£0.1M)
16/17	Standardisation of procedure packs (Saving TBC)
	Assessing pricing opportunities via NHS Supply Chain (Saving TBC)
	The Procurement team have already developed savings plans that approximate to £2M per year. Therefore, revised three year target is £3M recurrently providing £10M saving over three years.
	Developing plans for producing a Procurement Carter efficiency dashboard

Carter Live Projects	Accounts Payable
May / June 2016 Improving Back Office Efficiency	Implementation of e-invoicing with key suppliers via our GHX procurement business to business exchange – reducing paper, reducing manual handling, improving accuracy.

CET Future Projects	Human Resources (£21M Target)
May/ June 2016	Working with nurse e-roster project team to help establish reporting measures and assist with development of nurse e-rostering dashboard.

Carter Live Projects	Pharmacy (£5M Target)
June 2016	Planning workshop with Pharmacy team to identify Carter Efficiency opportunities.

Carter Live Projects	Estates & Facilities (£5M)
June 2016	Planning workshop with Estates & Facilities team to identify Carter Efficiency opportunities.
	Working with Estates & Facilities to help them develop their Carter reporting capabilities.

Carter Planned Projects	Other (TBC)
June 2016 onwards	Revisiting staffing skills mix within the Outpatients Services across York, Scarborough and Bridlington.

Public Performance Report

June 2016

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

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**92%**	92.8%	93.8%	94.0%	93.0%	93.0%	92.6%	92.9%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**0**	3	0	0	0	0	0	1
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	Not applicable	**Not applicable**	75.6%	76.3%	77.8%	74.2%	73.3%	69.6%	71.6%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	Not applicable	**Not applicable**	95.2%	95.1%	95.3%	95.3%	95.6%	95.3%	96.4%

Access Targets: Cancer

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

Indicator	Consequence of Breach	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Feb	Mar	Apr
14 Day Fast Track	Not applicable	**93%**	93.9%	91.9%	95.2%	93.5%	94.5%	94.1%	92.6%
14 Day Breast Symptomatic	Not applicable	**93%**	91.4%	94.0%	94.8%	95.1%	98.5%	94.0%	94.4%
31 Day 1st Treatment	Not applicable	**96%**	96.2%	99.3%	99.5%	98.6%	98.7%	97.9%	99.2%
31 Day Subsequent Treatment (surgery)	Not applicable	**94%**	94.4%	97.3%	95.5%	96.2%	94.9%	100.0%	100.0%
31 Day Subsequent Treatment (anti cancer drug)	Not applicable	**98%**	99.6%	100.0%	100.0%	99.2%	98.8%	100.0%	100.0%
62 day 1st Treatment	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**85%**	87.8%	85.1%	84.5%	85.8%	84.1%	89.3%	86.6%
62 day Screening	Not applicable	**90%**	98.4%	92.0%	97.0%	90.4%	90.6%	87.5%	90.0%
62 Day Consultant Upgrade	Not applicable	**85%**	50.0%	-	-	-	-	-	-

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**95%**	88.3%	91.5%	87.1%	85.0%	83.4%	86.7%	87.9%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**0 > 30min**	539	315	336	566	223	154	189
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**0 > 60min**	415	139	190	596	224	170	202
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q1 15/16**	**Q2 15/16**	**Q3 15/16**	**Q4 15/16**	**Mar**	**Apr**	**May**
	NHS VALE OF YORK CCG	30mins - 1hr	163	88	91	183	73	55	84
		1hr 2 hours	114	47	74	122	47	65	95
		2 hours +	26	19	18	69	13	15	30
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	152	94	127	184	80	51	44
		1hr 2 hours	101	28	42	128	54	30	32
		2 hours +	28	1	7	40	20	12	7
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	146	82	86	135	48	28	38
		1hr 2 hours	76	23	36	96	39	19	23
		2 hours +	22	1	4	35	19	13	4
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	27	13	10	19	7	5	10
		1hr 2 hours	14	6	2	21	8	2	3
		2 hours +	3	0	0	9	4	0	0
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	1	1	0	2	0	1	0
		1hr 2 hours	0	1	0	2	0	0	1
		2 hours +	0	0	0	1	1	0	0
	OTHER	30mins - 1hr	50	37	22	25	15	14	13
		1hr 2 hours	27	12	6	20	8	9	6
		2 hours +	4	1	1	12	11	5	1
Total number of patients waiting over 8hrs in A&E	General Condition 9	Q1 - Establish baseline	732	431	1060	1656	657	390	320
Trolley waits in A&E not longer than 12 hours	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**0 > 12 hrs**	0	1	18	32	12	7	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%**	97.5%	97.1%	98.4%	99.0%	99.1%	To follow	To follow

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**A banding of "Significantly higher that expected" in SHMI using the "Extract Poisson Distribution" method for deriving upper and lower confidence limits, applied to each sub-group reported**	95	98	99	97	96	95	93
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9		107	108	109	107	108	107	107

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**48**	21	14	15	15	3	3	1
Number of Clostridium difficile due to "lapse in care"	Establish baseline and set trajectory	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**(TBC)**	24	16	23	33	7	5	5
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases	**Quarterly:** General Condition 9	**30**	11	9	10	7	3	9	2
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	6	0	0	2	0	1	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%**	85.1%	85.6%	83.1%	74.0%	74.1%	68.1%	62.5%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95%**	72.2%	75.1%	74.5%	75.0%	75.6%	82.2%	83.6%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	Not applicable for 2016/17 - part of NHS England Sustainability and Transformation Plan (STP)	**99%**	95.2%	99.4%	99.1%	99.6%	99.6%	99.2%	99.4%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	0	3	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**	9	0	8	4	1	8	3
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	General Condition 9	**95%**	97.1%	97.4%	97.9%	98.4%	98.5%	98.6%	98.9%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.8%	99.7%	99.8%	99.9%	99.9%	To follow	To follow
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 - 91% Q2 - 91% Q3 - 93% Q4 - 93%**	89%	90%	89%	92%	89%	87%	86%
Delayed Transfer of Care – All patients medically fit for discharge and issued a 'notification notice' as per joint protocol for the transfer of care	As set out in General Condition 9 - Trust only to be accountable for Health delays.	**Set baseline in Q1 and agree trajectory**	Monthly Provider Report						
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	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	**180 per month**	452	486	448	482	178	189	153
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	**Not applicable**	2365	2509	2492	2599	883	1001	881
% Compliance with WHO safer surgery checklist	General Condition 9	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	419	476	489	466	138	2 month coding lag	2 month coding lag
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	1435	1491	1551	1530	435	2 month coding lag	2 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	**300 per Quarter**	302	258	308	317	104	78	76
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	99.7%	99.1%	99.7%	99.2%	98.1%	99.5%	100.0%
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 .						
All Red Drugs to be prescribed by provider effective from 01/04/2016	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
All Amber Drugs to be prescribed by provider effective from 01/04/2016	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	87.0%	87.4%	86.9%	85.9%	85.2%	86.8%	87.6%

Never Events

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

District Nursing Activity Summary

Indicator	Source	Threshold	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Mar	Apr	May
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	-	2962	2719	3660	3160	950	1025	934
	Community nurse/service	-	976	934	1119	1285	498	458	470
	Acute services	-	1159	1041	1296	1254	392	381	360
	Self / Carer/family	-	498	709	938	849	268	252	265
	Other	-	356	310	424	395	86	149	147
	Grand Total	-	5951	5713	7437	6943	2194	2265	2176
Community Adult Nursing Contacts	First	-	4302	4417	5068	5083	1667	1771	1790
	Follow up	-	41155	46436	55322	61640	22376	22902	24793
	Total	-	45457	50853	60390	66723	24043	24673	26583
	First to Follow Up Ratio	-	9.5	10.5	10.9	12.1	13.4	12.9	13.8
Community Hospitals average length of stay (days)	Archways	-	22.5	22.0	22.5	20.9	18.6	17.0	26.4
	Malton Community Hospital	-	20.0	24.3	20.5	19.4	16.4	16.9	20.1
	St Monicas Hospital	-	21.4	19.3	19.3	18.8	13.5	12.4	19.9
	The New Selby War Memorial Hospital	-	24.0	23.6	23.0	20.4	16.4	14.7	15.1
	Whitby Community Hospital	-	20.0	19.2	12.8	0.0	0.0	0.0	0.0
	Total	-	21.9	22.7	21.5	20.0	16.6	15.8	20.2
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	11	11	18	8	1	5
		Emergency	75	79	80	68	25	30	18
	Malton Community Hospital	Elective	20	37	15	15	7	3	5
		Emergency	100	115	124	126	47	47	39
	St Monicas Hospital	Elective	16	14	15	19	8	6	4
		Emergency	44	41	38	31	11	12	15
	The New Selby War Memorial	Elective	58	69	72	70	23	27	23
		Emergency	68	68	71	70	24	26	19
	Total	Elective	102	131	113	122	46	37	37
		Emergency	423	436	504	295	107	115	91

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Complaints and PALS												
New complaints this month	33	41	37	58	42	38	28	25	40	46	36	30
Number of Ombudsman complaint reviews	1	1	3	1	0	2	1	0	4	0	2	3
Number of Ombudsman complaint reviews upheld	0	0	0	0	0	0	1	0	1	0	0	1
Number of Ombudsman complaint reviews partly upheld	0	0	0	0	1	0	2	0	2	1	2	1
Late responses this month (at the time of writing)***	10	7	4	6	0	8	0	0	0	0	0	0
Top complaint issues												
Aspects of clinical treatment	21	27	29	30	15	30	24	21	39	49	21	26
Admission/discharge/transfer arrangements	1	1	0	5	5	2	3	4	7	10	10	8
Appointment delay/cancellation - outpatient	0	0	2	0	2	3	1	2	1	6	4	0
Staff attitude	3	3	3	6	-	-	-	-	-	-	-	-
Communications	3	2	2	8	5	7	9	13	24	21	14	6
New PALS queries this month	498	643	530	631	682	505	450	492	557	443	480	407
Top PALS issues												
Information & advice	171	237	233	296	309	202	171	196	211	191	200	187
Staff attitude	23	24	14	19	17	18	13	21	16	9	17	9
Aspects of clinical treatment	72	101	64	76	75	66	53	68	91	48	59	55
Appointment delay/cancellation - outpatient	46	59	39	60	55	49	40	37	28	30	42	29

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

Serious Incidents												
Number of SI's reported	12	20	11	16	22	19	13	11	28	21	19	12
% SI's notified within 48 hours of SI being identified*	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% SI's closed on STEIS within 6 months of SI being reported	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of Negligence Claims	12	14	8	14	21	21	15	12	12	12	18	16
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	1	0	1	2	3	1	6	0	1	1	0
Duty of Candour demonstrated within SI Reports (Threshold 100%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of reported SI's, investigated and closed as per agreed timescales**** (Threshold (90%)	83%	93%	100%	92%	94%	75%	100%	71%	100%	100%	100%	100%

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

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Pressure Ulcers**												
Number of Category 2	34	37	44	34	29	47	36	33	42	52	49	45
Number of Category 3	10	4	3	3	7	4	3	4	3	3	2	5
Number of Category 4	0	0	1	1	3	1	1	1	1	0	2	0
Total number developed/deteriorated while in our care (care of the organisation) - acute	35	33	35	27	28	49	38	37	44	57	44	53
Total number developed/deteriorated while in our care (care of the organisation) - community	27	29	27	27	34	33	21	24	26	30	26	19
Falls***												
Number of falls with moderate harm	5	0	3	3	4	4	2	3	7	4	2	3
Number of falls with severe harm	4	5	1	5	3	10	1	4	5	5	4	4
Number of falls resulting in death	0	1	0	0	1	0	1	0	0	0	0	0
Safeguarding												
% of staff compliant with training (children)	68%	74%	80%	80%	81%	82%	82%	82%	84%	85%	86%	86%
% of staff compliant with training (adult)	69%	74%	80%	81%	82%	82%	82%	83%	83%	84%	85%	85%
% of staff working with children who have review CRB checks												

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 June 2016

Corporate Governance Statement and other returns to Monitor

Action requested/recommendation

The Board is asked to consider and approve the attached statements prior to their submission to Monitor.

Executive Summary

As the Board is aware, following the introduction of the Health and Social Care Act 2012, Monitor (now NHSI) changed their regulatory arrangements. Monitor moved away from Terms of Authorisation and released a provider licence; Monitor also introduced the Risk Assessment Framework which replaced the Compliance Framework.

The additional regulatory arrangements are to provide a number of additional statements during the year. Last month the Board was asked to approve a statement related to systems of compliance with license conditions and the availability of resources.

This month the Board is asked to consider and approve

- Corporate Governance Statement – confirming compliance with condition FT (4) of the provider licence
- Certification of AHSCs and governance – as required by Appendix E of the Risk Assessment Framework
- Training of governors' statement – as required by s.151 (5) of the 2012 Act.

There are six questions to address in the submission and the Trust is required to comply or explain against each statement. This year the Trust has developed a narrative.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	The information included in the report has been consulted on prior to the Board meeting
Risk	No risk
Resource implications	There are no resource implications
Owner	Susan Symington, Chair
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	June 2015
Version number	Version 1

Board of Directors – 29 June 2015

Corporate Governance Statement and other Certificates to be submitted to Monitor

1. Introduction and background

As the Board is aware following the introduction of the Health and Social Care Act 2012, Monitor (Now NHSI) changed their regulatory arrangements. Monitor moved away from Terms of Authorisation and released a Provider Licence; Monitor also introduced the Risk Assessment Framework which replaced the Compliance Framework.

The additional regulatory requirements are to provide a number of statements during the year. Last month the Board was asked to approve a statement related to systems of compliance with license conditions and the availability of resources.

This month the Board is asked to consider and approve

- Corporate Governance Statement – confirming compliance with condition FT 4 of the provider licence
- Certification of AHSCs and governance – as required by Appendix E of the Risk Assessment Framework
- Training of governors' statement – as required by s.151 (5) of the 2012 Act.

2. Corporate Governance Statement

Monitor has provided a framework for this statement based condition FT4 of the provider licence. This framework includes a number of key statements which the Trust is required to respond to.

The Board of Directors is required to approve the statement before it is submitted to NHSI at the end of the Month.

1 The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Response

The Board has reviewed the Code of Governance published by Monitor in 2014 and confirms compliance with all requirements, except for:

- One Non-executive Director has a spouse who works as a senior clinician in the organisation.
- One Executive Director's spouse is a senior member of staff.
- Three Non-executive Directors were reappointed by the Council of Governors to serve a third-three year term.
- The Council of Governors has chosen not to make an appointment from the university medical or dental schools to the Board of Directors.
- The composition of the Board of Directors is the Chairman and 6 Non-executive

Directors and 6 voting Executive Directors. There are three additional Directors who are members of the Board, but are not voting Directors.

The Board continues to keep the Corporate Governance arrangements under review as part of its approach to good governance.

As Accountable Officer, the Chief Executive has overall responsibility for the management of risk. The Chief Executive delegates responsibility to other Executive Directors where they are the lead Director for the area as follows:

Clinical risks	Medical Director and Chief Nurse
Quality risks	Chief Nurse
Financial risks	Finance Director
Environmental, Non-clinical risks	Director of Estates and Facilities
Operational risks	Chief Operating Officer
Corporate Learning and Development risks	Deputy Chief Executive
IT risks	Director of Systems and Network
Strategy risks	Chief Executive
Workforce and staffing risks	Chief Executive

During the year the Risk Management Department have continued to develop and improve our systems and processes.

The internal Audit Review undertaken at the end of the financial year confirmed that there was significant assurance about the systems and processes being used. Internal Audit did identify on-going work that was required to ensure the embedding the systems and processes. Over the next year the Risk Management Department will continue this work to ensure all systems and processes for risk management are fully embed.

During 2014/15 the Trust conducted a review of governance that concentrated on four key areas as follows:

- Clarification of reporting lines and review of meetings
- Maximising the performance contribution from Directors and Senior Managers by setting clear expectations
- Expedient decision making, delegated to the lowest appropriate level to support effective operational performance
- Meaningful assurance on the business of the organisation, where key issues are escalated appropriately.

The review was designed to improve the governance around connections and alignment in a number of areas including actions relating to the Integrated Business Plans; Internal Audit Report “Strengthening Corporate Accountability through Staff Conduct and Competence” and guidance from the CQC on the “Fit and Proper Persons Test” requirements.

Following that review the Board of Directors commissioned Grant Thornton LLP to undertake a Well Led Review as prescribed by Monitor.

The review started in November 2015 and the final report was received by the Board in January 2016. Overall:

- The review provided two green scores for the linked areas of information and data quality. The Trust is rightly proud about the information which is provided across the organisation, and specifically to board which supports the monitoring and scrutiny of decision making

and performance management.

- The review produced 6 amber green scores, where Grant Thornton's analysis revealed elements of good practice with no major omissions, and where the review team have confidence in our action plans to continue work and develop these areas.
- The review provided two amber red scores for subset 2 of domain 1: *Is the board sufficiently aware of potential risks to the quality and sustainability and delivery of current and future services"* and subset 6 from Domain 3, "*Are there clear roles and accountabilities in relation to board governance including quality governance?"*

Domain 1- Is the Trust sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

Since the review the Trust has refreshed and rewritten the 'Our Commitment to You' , now called Our Shared Commitment, which describes, at a high level, the key strategic aims of the Trust. The revised iteration clearly states the Trusts strategic objectives, which link in turn to the ambitions of the Sustainability and Transformation Plan currently being produced with partners.

As a result of the new Our Shared Commitment document, the Board has developed and articulated a clear vision for the organisation which is supported by key strategies and underpinned by the ambitions of the Trust. The ambitions have been arranged into the four key assurance committees of the Board, Quality and Safety, Finance and Performance, People and Capability and Facilities and Estates.

Domain 3- Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?

As outlined above, the Trust initiated a governance review more than a year ago. The outcome of the internal review and the Well Led Review both suggested that the Trust should consider restructuring the quality and healthcare governance arrangements. This will include a review of key staff and their roles and contributions to our quality governance framework, the on-going review of our corporate risk register and the directorate risk registers, as well as the support provided to the directorates in the design and use of their own registers. With this goes a renewed commitment to increasing the number of doctors reporting incidents, inviting staff who have submitted incident reports to attend relevant review meetings to observe how their reports are used and the resultant outcomes with the purpose of closing the feedback loop.

The Trust confirms that there are no material inconsistencies between the annual governance statement, the annual and quarterly board statements and the Care Quality Commission action plan.

An Annual Plan is produced each year which underpins the Strategic Plan that covers 5 years. The Board has reviewed both the Annual Plan and the Strategic Plan. The development of these Plans has involved consultation with the Governors and the key stakeholders of the Trust.

The Board has in place a number of Board Committees that support the Board in the discharge of its duties. These include Quality and Safety, Finance and Performance, Corporate Risk, Audit Committee, Workforce and Organisational Development Committee, Environment and Estates Committee and Remuneration Committee.

During the year the Board reviewed the activities of the Workforce and Organisational Development Committee and re-launched the Committee with an overarching remit to review

and support the implementation of the Workforce and Organisational Development Strategy.

The Quality and Safety Committee receives a Patient Safety and Quality Report at each meeting. This report provides detailed information about patient safety issues such as mortality; harm events, infection control issues, drugs administration and patient safety walk rounds. It provides information on clinical effectiveness and patient experience. The Medical Director Report supports this information and provides more detail around key topics such as SHMI, PROMS and the Patient Safety Strategy.

The Finance and Performance Committee receives performance management report at each meeting. The report provides detailed information on the operational performance of the Trust. The Finance Director, Chief Operating Officer and Director of Systems and Network provide assurance to the Committee on the performance of the Trust during the previous month.

The Workforce and Organisational Development Committee meet every two months to discuss workforce issues, oversee the strategic management of workforce and gain assurance about the systems and processes which is shared with the Board of Directors. The workforce in the organisation is a key element of expenditure and impacts on the quality and safety of care the organisation delivers. The Committee also oversees the implementation of the Workforce and Organisational Development Strategy which links directly to the Trust's ambitions.

The Environment and Estates Committee meets on a quarterly basis and issues are considered in detail and assurance is reported back to the Board.

On a quarterly basis the Board reviews the draft statement submission to NHSI and confirms that the information included is consistent with the information received by the Board during the quarter.

The Board reviews performance monthly through the Performance Report, Chief Nurse Report and Medical Director Report, Finance Director Report and Chief Executive Report and the minutes from the Committees that have met in advance of the Board meeting.

The Board receives a quarterly update from the Director of Infection Prevention and Control on the performance of infection control and the actions being undertaken to improve performance. This quarterly report is underpinned by the monthly update the Board receives as part of the monthly performance reporting presented by the Medical Director.

The Board agenda is designed so the Board begins with a Patient Story to set the tone for the meeting, and considers patient safety and quality issues first on the agenda in order that all other agenda items can be related back to patient safety and quality.

The Trust produces an annual Quality Report. It identifies the priorities for patient safety, clinical effectiveness and patient experience for the coming year. These are aligned to the CQUIN targets and the Patient Safety Strategy.

All members of the Board of Directors have received an appraisal in the last 12 months; the Executive Directors are appraised by the Chief Executive, and the Chief Executive is appraised by Chair. The Non-executive Directors are appraised annually by the Chair on behalf of the Council of Governors.. The Chair is appraised annually by the Senior Independent Director and the Lead Governor on behalf of the Council of Governors.

The Trust has in place a fully developed clinical audit programme which is led by the Medical

Director. The programme includes national audits and confidential enquires, along with local clinical audits designed to improve the quality of healthcare provided.

The Trust implements a programme of patient safety walk rounds that involve all Board members. The output from these walk rounds is reviewed and actioned by the Executive Directors and reviewed by the Quality and Safety Committee and reported monthly to the Board.

The Trust has in place a Nursing & Midwifery Strategy and a Patient Safety Strategy. These strategies underpin the approach the Trust adopts to quality and safety.

In common with other Trusts, the organisation has experienced significant issues recruiting staff. The Trust has completed a programme of recruitment of nursing staff from Europe and is working closely with the local universities and colleges to develop supportive programmes of training for students. The Board has put in place a robust programme for the recruitment of temporary staff specifically using the internal bank arrangements where ever possible and only using external agencies if necessary.

During the year, the Board introduced the Turnaround Avoidance Programme (TAP). This programme manages the organisation's approach to delivering a sustainable financial future. TAP does this by bringing structure, process and discipline in to management efforts, for example the alignment of the Corporate Improvement Team with the delivery of Trust priorities, the design and introduction of a new business case process and approach to ensuring return on investment, an improved vacancy control process, and the introduction of a new performance assurance framework.

The principles that have been embedded and reinforced through the Turnaround Avoidance Programme are to see a reduction in costs, an increase in income and performance delivery. These principles were underpinned by a number of work streams.

We know that successful programmes of this nature share a number of characteristics, including:

- Visibility – both in terms of what needs to be done and in terms of leadership and ownership of the programme.
- Transparency – using appropriate documentation and communication so that the broader organisation (our staff) feel engaged and can contribute and challenge.
- "Evidence over anecdote": the programme relies heavily on information and analysis to make decisions and to demonstrate progress.
- Active workforce engagement (including representative of stakeholder organisations).

The programme includes four key work streams:

- Fines Avoidance
- Delivering CQUINs
- Productive workforce
- Better financial management

The Board of Directors have sought to ensure that effective financial decision making, management and control have been in place throughout the year.

The Trust successfully delivered the Cost Improvement Programme (CIP) in 2015/16; this is the sixth consistent year the Trust has delivered the programme. The TAP and the CIP work together to achieve efficiency and economy..

During 2015/16 Lord Carter completed his report into efficiencies and published a set of recommendations. The Trust has started to implement the Carter recommendations and adjusted the governance so that the CIP and the TAP link directly to the recommendations in the Carter Review with the aim of creating an integrated approach to efficiency and economy.

2 The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time

Response

The Board has put in place a system where all guidance on good corporate governance is reviewed and any areas of non-compliance are reported to the board on a 'comply or explain' basis.

3 The Board is satisfied that the Trust implements:

(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation.

Response

The Board has considered the effectiveness of the Board and the committee structure during the year by commissioning Grant Thornton LLP to undertake an independent Well Led Review. Details of the review are included in the response to question 1.

The accountability arrangements in place at Board and at committee level are clearly understood and acted upon. Each committee is chaired by a Non-executive Director. The Chairs of the Committees report monthly to the Board of Directors on the progress of work in "their" Committee.

The key committees associated with performance in the Trust include Quality and Safety, Finance and Performance. The meet monthly and report monthly to the Board and provide assurance around the previous month's reports.

The Workforce and Organisational Development Committee reports meets bi-monthly and reports every two months and provides the Board with an update on the on-going workforce challenges and the actions being taken to address the issues.

The Environment and Estates Committee meets quarterly and reports to the Board following each meeting on the key assurances and concerns being discussed by the Committee.

Each of the four committees reflects a key area of ambition for the trust and meetings are designed to provide a forum for more detailed discussion of issues outside the Board meeting .

The reporting lines throughout the organisation are understood and link back to the Corporate Directors. There is a hierarchy of management that ensures every member of staff has a line manager.

4 The Board is satisfied that the Trust effectively implements systems and/or processes:

a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h) To ensure compliance with all applicable legal requirements.

Response

The Board is satisfied that the Trust has effectively implemented systems and processes that ensure compliance with the Licensee's duty to operate efficiently, economically and effectively. As part of the year-end process, the Trust undergoes an independent audit which includes a review of the use of resources. The External Auditors gave an unqualified opinion on the use of resources in the Trust. The Trust's Audit Committee reviews the systems and processes (including clinical audit) in place, which includes those parts of the Licensee duty and reports regularly to the Board of Directors on the findings and assurances the committee has received. The Trust has in place a robust internal audit service provided by an independent organisation and an agreed work programme of audits that are undertaken during the year. These audits are reported directly to the Audit Committee.

As a result of the financial pressure the organisation experienced during 2015/16 the Audit Committee reviewed the extended going concern statement in detail. The Committee assured itself that the Trust would continue as a going concern over the next 12 months. The Committee also made a distinction between the immediate going concern considerations and the future sustainability of services. The Audit Committee provided assurance to the Board on the issue of going concern.

During the external audit of the Trust's Annual Report and Accounts for 2015/16, the Trust was challenged by its External Auditors to demonstrate that it had achieved value for money in the provision of healthcare services. Following the presentation of considerable evidence and subsequent detailed discussions, Grant Thornton LLP confirmed there was no evidence to support the qualification of the Trust's accounts in relation to value for money. Grant Thornton LLP subsequently issued an unqualified audit opinion.

The Trust's Audit Committee reviews the systems and processes (including clinical audit) in place, which includes compliance with the Licensee duty and reports regularly to the Board of Directors on the findings and assurances the Committee has received.

The Trust has in place a robust internal audit service provided by an independent organisation and an agreed work programme of audits that are undertaken during the year. These audits are reported directly to the Audit Committee.

The Board has received information on the requirements of the licence and during the year has reviewed the quarterly compliance of the Trust with the expected targets and trajectories.

The Board maintains awareness of the regulatory, legal and standard requirements that are placed on Trusts and raises them at the Board as they become known and as they come into effect. The most recent example of this is the introduction of sustainability and transformational fund requirements and the agency cap requirements.

The Board received assurance from the External Auditors on the effectiveness of the systems and processes in place around effective financial decision making, management and control. This formed part of the year end assurances received by the Board. This is also underpinned by the Internal Audit programme of audits undertaken during the year. Reports are submitted for review to the Audit Committee. The Audit Committee raises any concerns with the Board of Directors.

During the year the Board sought additional assurance around the CIP and TAP plans and invited Monitor to review our organisational approach and programmes. Monitor provided helpful feedback and advice to the Board. The Board has sought to implement the suggestions.

The Board has a robust work programme which ensures that information required at the Board is received in a timely manner. The Committees supporting the Board meet on a regular basis (as detailed above) and have a detailed forward work programme which is fed from the Board and other more operational groups and which in turn feeds information back to the Board. Between meetings there is ongoing debate between the Chairman, Chief Executive, other Directors, Non-executive Directors and Foundation Trust Secretary to ensure any adjustments to programmes or agendas are addressed. The Trust has in place an action plan following each meeting which is implemented within the agreed timelines.

The Board receives monthly information on the performance of the Trust and reviews any potential breach of the terms of the licence. During the year the Trust has been in breach of a number of key targets the most significant on-going breach being performance against the Emergency Care Standards. During the year the Trust was able to achieve all key targets with the exception of the Emergency Care Standard. Monitor and subsequently NHSI has kept the Trust under review for governance during the year. The Trust developed a Performance Recovery Plan which reported on a weekly basis internally and quarterly to Monitor. The Trust continues to have a dialogue with Monitor on achievement of the Emergency Care Standards and is part of the national initiative looking at small rural hospitals.

The Trust is reviewing the model of care in the Emergency Department.

The Trust keeps the annual plan under review during the year. The Chief Executive provides a six month summary of performance against the annual plan in his Board report. The Trust involves the Governors in the development of the annual plan and strategic plan. A Board to Board meeting was held with Governors in November 2015. The meeting discussed the half year position and the development of the plan for 2016/17.

5 The Board is satisfied that the systems and/or processes referred to in

paragraph 5 should include, but not be restricted to, systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Response

The Board considers the capabilities of the Board members during the year.

In September 2015 Mrs Holden Director of Workforce and Organisational Development undertook a one year secondment opportunity with NHS Development Agency as an Improvement Director.

During her secondment responsibility for Mrs Holden's portfolio was taken by the Chief Executive including operational workforce issues and the Deputy Chief Executive assumed responsibility for organisational development, research, education and training.

In June 2015 Dr Turnbull, Medical Director retired from the Trust. Mr Taylor was appointed substantively to the post of Medical Director in October 2015 following a short interim period of office.

To strengthen the Board and to reflect the changing external environment, the Board agreed to the appointment of a Director of Out-of-Hospital Care This is a non-voting director role.

The Board makes collective decisions and takes into account the quality aspects of any decision made. During discussions in the Board meeting, the Chairman actively seeks the views of the Medical Director and Chief Nurse in terms of the implications on the quality of care of a decision. The Quality and Safety Committee also provides an additional opportunity for the Board to receive assurance on the impact changes to services have on the quality of care. The Quality and Safety Committee reviews papers in advance of the Board and provides the Board with the assurance it needs around the accurate and comprehensive nature of the papers.

The Board receives updated information from the Workforce and Organisational Development Committee outlining work being undertaken to ensure quality is being maintained from a workforce perspective. The Committee also provides the Board with oversight of initiatives being developed to address workforce risks identified on the risk register.

Each Board meeting receives a patient experience item as an early item on the agenda. This sets the context of the Board meeting and helps to ensure that the rest of the meeting is

linked to quality and safety of services and patients. The Board has, through the Quality and Safety Committee, reviewed the Quality Report and will undertake a further review later in the year.

The Trust engages the Governors and service users in the development of the quality of services provided. The Trust has a Patient Experience Team who actively encourage patients and carers and service users to contribute to the development of services.

Executive members of the Board have a weekly meeting, including the Chief Executive and Chief Nurse where complaints received by the organisation during the previous week are reviewed and an understanding of the scale and trend of the complaints is appreciated at a senior level. On a selective basis, the Chief Executive requests directors to personally supervise particularly sensitive or important complaints.

The Trust has a Patient Experience Steering Group which includes Healthwatch as part of its membership. This meeting collates information about patient experience and interprets it into future actions and ideas for strategy development.

The Medical Director and Chief Nurse meet weekly with the patient safety and risk and legal teams to review all infection control, mortality and serious incidents and other matters pertaining to patient safety and a summary of this meeting is presented weekly at the meeting of Executive Directors to ensure timely reporting and where required, immediate action.

Where there are issues or concerns raised by staff or patients there are a number of routes that can be used to ensure the Board is made aware of the issue when appropriate. An example of this would be the patient safety walk rounds where the Directors, including the Non-executive Directors, undertake regular patient safety walk rounds and speak to staff about their work place and their achievements and concerns. The walk rounds at night are currently being planned.

The Trust has enhanced the performance management system during the year. A number of Executive Directors meet with each senior directorate team on a monthly basis to discuss all issues related to performance, business development, sustainability of services, risk, finance and any other key concern the directorate or the Director may have.

Staff are encouraged to raise concerns with their immediate managers or with a Director. The Chief Executive encourages staff to write to him directly on any matter they wish to raise and he aims to respond to any enquiry within 24 hours.

6 The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.
Response

The Trust continues to undertake nursing staff establishment audits and acuity audits and has increased the number of nurses in the organisation. The Workforce and Organisational Development Committee reviews the detail in advance of the Board and provides support to the Board on the future development of staffing in the organisation.

The Board reviews its membership regularly, both executive and Non-executive. The board is proactive in considering Succession Planning issues both informally and formally through the Remuneration Committee.

2.1 Certification on AHSCs and governance

The Board is asked to approve the statement associated with this certificate. Again this is required to be submitted to Monitor by the end of the month.

For NHS foundation trusts:

- **that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or**
- **whose Boards are considering entering into either a major Joint Venture or an AHSC.**

The Board is satisfied it has or continues to:

• ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence;
• have appropriate governance structures in place to maintain the decision making autonomy of the trust;
• conduct an appropriate level of due diligence relating to the partners when required;
• consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities;
• consider implications of the partnership on the trust's governance processes;
• conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk;
• comply with any consultation requirements;
• have in place the organisational and management capacity to deliver the benefits of the partnership;
• involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services;
• address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework);
• ensure appropriate commercial risks are reviewed;
• maintain the register of interests and no residual material conflicts identified; and
• engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.

Response
Confirmed.

2.2 Training of Governors

For this declaration the proforma does not give the option of a written response, it is purely a confirm statement.

The Trust has provided training to governors through a number of forums including: within the Council of Governors meetings including regular presentations from the Chief Executive to support the Governors development and understanding of the Trust. The Governors have been provided with training specifically around the Electronic Prescribing and Medicine Administration System, the cost improvement programme and Lord Carter recommendations

and Information Governance. The Trust holds six monthly Board to Board meetings with the Council of Governors to discuss current strategic and operational issues.

There have also been specific sessions held for Governors on finance, nursing and estates

The statement included in the proforma is as follows:

The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Response

Confirmed.

3. Recommendation

The Board is asked to consider and approve the attached statements prior to their submission to NHSI.

Author	**Anna Pridmore, Foundation Trust Secretary**
Owner	**Patrick Crowley, Chief Executive**
Date	**June 2016**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 June 2016

Amendment to the Constitution

Action requested/recommendation

The Board is asked to confirm their agreement to the changes made to the Constitution.

Executive Summary

The Trust Constitution is the document in which we articulate our basic governance arrangements including the membership of the Board. This paper asks the Board to confirm their agreement to increasing the Board membership by one Non-executive Director. The final decision on the approval of the amendment to the Constitution lies with the Council of Governors, but under the governance rules the Board is required to confirm agreement to the change.

Due to some timing issues, the Council of Governors on 16 June 2016 considered the issue and in principle agreed that it would be appropriate for an increase to Board Non-executive Director membership would be appropriate. The Council of Governors was made aware that the Board had not formally confirmed their agreement, but the Council of Governors were also advised that the Board had discussed the point outside any formal meeting.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC outcomes (replace this text if necessary).

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

Progress of report	The Report has been written for the Board, but reflects a report prepared for the Council of Governors
Risk	No risk
Resource implications	The additional cost of a 7th Non-executive Director
Owner	Sue Symington, Chair
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	June 2016

Board of Directors – 29 June 2016

Amendment to the Constitution

1. Introduction and Background

The Board is aware that the Constitution of the Trust is the document based on the National Health Service Act 2006 as amended. The Constitution outlines some of the regulations by which the Trust operates. It includes details about the makeup of the Council of Governors and the Board of Directors. The Council of Governors, through the Constitution Review Group undertake a review of the Constitution on a regular basis.

The governance associated with the approval of changes to the Constitution sits with the Council of Governors. The Board of Directors is asked to note the changes and advise the Council of Governors of any concerns they may have.

2. Intermediate change

Currently the Constitution Review Group (a group of the Council of Governors) are undertaking a more wholesale review of the Constitution and will seek to discuss with the Board some possible additional changes later in the year. At present an urgent change has been identified around the membership of the Board of Directors which would be beneficial to address in advance of any other changes.

Following the Well Led Review and a review of a number of best practice guidance documents it has been noted that the Board could benefit from having a clinically based Non-executive Director. It has therefore been proposed that the membership of the Non-executive Director cohort increases from 6 to 7.

To this end, recently the Constitution Review Group met to consider the necessary change to the Constitution to facilitate the Trust to have the ability to increase the Non-executive Director complement from 6 to 7.

The Constitution Review Group noted that the number of Non-executive Directors included in the Board membership had not changed since the Trust became a Foundation Trust in 2007. Although the number of voting directors had increased when Sue Holden joined the Board as an Executive Director in 2013.

As part of their assurance, the Group asked for confirmation that by adding a 7th Non-executive Director role to the Constitution, this did not oblige the Trust to appoint to the role if the need was not there. Enquires have been made with the lawyers to clarify the position and it has been confirmed that the Trust does not need to put in place a 7th NED, if it is not required.

The Constitution Review Group discussed the proposed amendment and was satisfied with the proposal. The Group recommend the change to be approved by the Council of Governors.

The Council of Governors considered the proposed change and was in principle satisfied that the change should occur. The Council of Governors was concerned that the Board of Directors had not had an opportunity to discuss the change in advance of the Council of Governors, but understood that members of the Board had had an opportunity to discuss the proposal outside the Board with the Chair.
3. Recommendation
The Board is asked to note the immediate change to the Constitution which ensures that the Trust can appoint a 7th Non-executive Director if needed.
4. References and further reading
Well Led Review Code of Governance

Author	**Anna Pridmore, Foundation Trust Secretary**
Owner	**Sue Symington, Chair**
Date	**June 2016**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 June 2016

Workforce Report – June 2016

Action requested/recommendation

The Board of Directors is asked to read the report and discuss.

Summary

The attached document provides information up to May 2016, relating to key Human Resources indicators including; sickness and recruitment and retention.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Outcomes 12, 13 & 14

Progress of report	Board of Directors
Risk	No risk

Resource implications	There are Human Resources implications identified throughout this report.
Owner	Patrick Crowley, Chief Executive
Author	Polly McMeekin, Deputy Director of Workforce
Date of paper	June 2016
Version number	Version 1

Board of Directors – 29 June 2016

Workforce Report – June 2016

1. Introduction and background

This paper presents key workforce metrics up to May 2016 (where available). The narrative will detail trends and any actions which are being taken to address specific issues. Of particular note:

- The Trust's annual absence rate remains above 4%.
- There was a small increase in the Trust's annual turnover rate in the year ending May 2016.
- The Trust has made a successful appointment to the Freedom to Speak Up and Safer Working Guardian role.
- Terms and conditions relating to the new Junior Doctor contract have been published but are still subject to the outcome of the BMA referendum expected at the beginning of July.
- Agency usage which is non-compliant with NHS Improvement's rules appears to have plateaued and work is underway to identify further actions to address this.

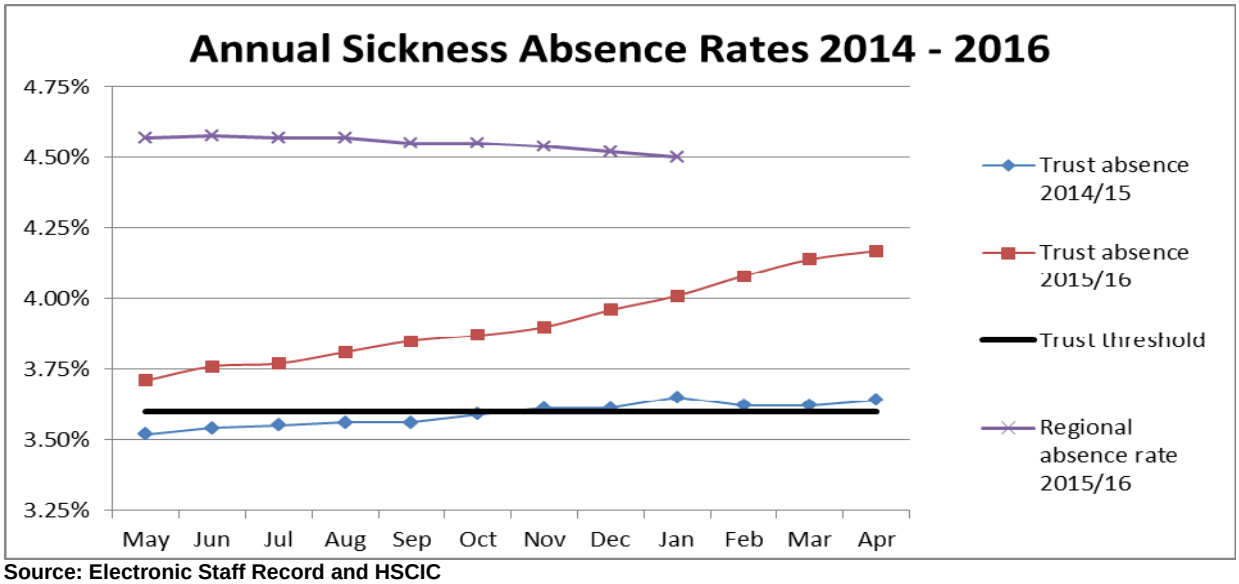
2. Workforce Report

2.1 Sickness Absence

Sickness absence rates

The graph below compares the rolling 12 month absence rates to the Trust's locally agreed threshold and to the regional (Yorkshire and Humber) sickness absence rates. Although the Trust's absence rate continues to be below the regional absence rate, over the past year the Trust's absence rate has shown an upward trend whilst the regional absence rates have reduced slightly. The graph below therefore shows that the gap between these rates has narrowed. The Trust's annual absence rates for the year ending April 2016 was 4.17%.

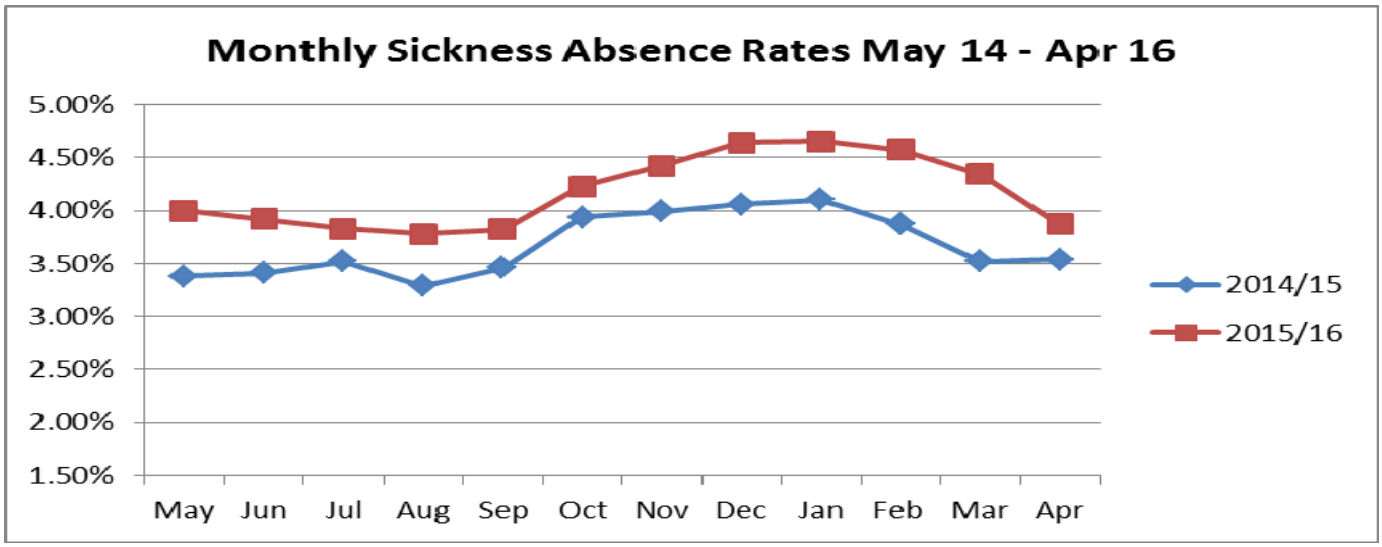
Graph 1 – Annual sickness absence rates



Source: Electronic Staff Record and HSCIC

The graph below shows the monthly absence rates from May 2014 to April 2016. Whilst this demonstrates similar patterns (i.e. seasonal variations) in both years, it also shows that in every month of the last year, the absence rate is higher than it was in the same month of the previous year. However, the monthly absence rate in April 2016 (3.87%) was lower than in March 2016 (4.34%) whereas in 2015 the absence rate increased slightly in April from the previous month. The monthly absence rate in April 2016 is also the first time the rate has been below 4% since September 2015.

Graph 2 – Monthly sickness absence rates



Source: Electronic Staff Record

Sickness absence reasons

The top three reasons for sickness absence based on both days lost (as FTE) and number of episodes are shown in the table below:

Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
Anxiety/stress/depression – 20.52% of all absence days lost	Gastrointestinal – 19.78% of all absence episodes
MSK problems, inc. back problems –18.52% of all absence days lost	Cold, cough, flu – 15.74% of all absence episodes
Gastrointestinal –8.76% of all absence days lost	Anxiety/stress/depression –9.43% of all absence episodes

Trust interventions

As shown above mental health and musculoskeletal problems account for a significant proportion of time lost due to sickness absence. The Trust is implementing a range of interventions to proactively address these areas of concern:

HR support:

- Meeting line managers regularly to review absence levels within their teams; to ensure prompt management and also identification of appropriate support for individuals in a timely manner.
- Existing sickness absence training is being targeted to managers in those departments with higher levels of absence, and/or the departments that are less likely to engage with HR in the prompt management of sickness. From late Summer / Autumn this training will be supplemented

by ‘Leading A Healthy Workforce’ training supported by NHS England.
- The development of further support materials for managers and individuals e.g. the online Mental Wellbeing Toolkit is already on Staff Room (Occupational Health/ Mental Health & Wellbeing); a further booklet is in development ‘Five Ways to Wellbeing’ that suggests simple activities that individuals can undertake to improve/support both mental and physical health.

Improved access to services:
- A part-time Physiotherapist commences employment with the Trust this month to extend the existing service offered to staff with musculoskeletal concerns. In addition to providing treatment they will provide training to prevent musculoskeletal issues arising. Staff can self-refer in York, in Scarborough the access route is via Occupational Health currently with options being considered to harmonise the process with York.
- A part-time Psychologist commences employment with the Trust in July to extend the current service offered by Occupational Health for staff with mental health illnesses that require specialist support. Individuals are referred to this service via an Occupational Health practitioner.

Increasing publicity to improve awareness of the support services already available by:
- Offering fortnightly HR Drop In sessions at both Scarborough and York Hospitals.
- Use of awareness days/weeks e.g. Mental Health Awareness week in May.
- Staff Benefits Fairs at Scarborough and York Hospitals – signposting to services, training, benefits & discounts that support mental and physical health.
- Articles in Staff Matters – the existence of the mental health and musculoskeletal working groups, and raising the profile of these health issues
- Information on Staff Room / use of the weekly Communication bulletin.

Other aspects related to (but not exclusive to) the NHS England Healthy Workforce project:
- A Healthy Workforce Survey was undertaken in June as part of the Trust’s participation in the project. As well as informing national strategy around supporting the health of the workforce, the survey produced a free personal health report for each individual completing it. The report contains recommendations on actions individuals can take to improve their health.
- The Headspace App for mobile phones has been made available free of charge to the Trust for a year. This promotes guided 10-minute meditation sessions, ideal for busy people who are looking for a support mechanism.
- One hour healthchecks are being offered to all staff aged 40+ which explore various aspects of health and signposts individuals to relevant support services; the Trust is also delivering a range of initiatives relating to healthy eating and weight management.
- There is already significant provision of options to encourage increased physical activity (on site classes/gym, discounts with private/council providers etc). As part of the project the Trust is required to increase uptake by 20% by March 2017; the Staff Benefits Team are exploring how to expand existing provision. This has already been achieved on the Scarborough Hospital site.

Sickness absence by age profile

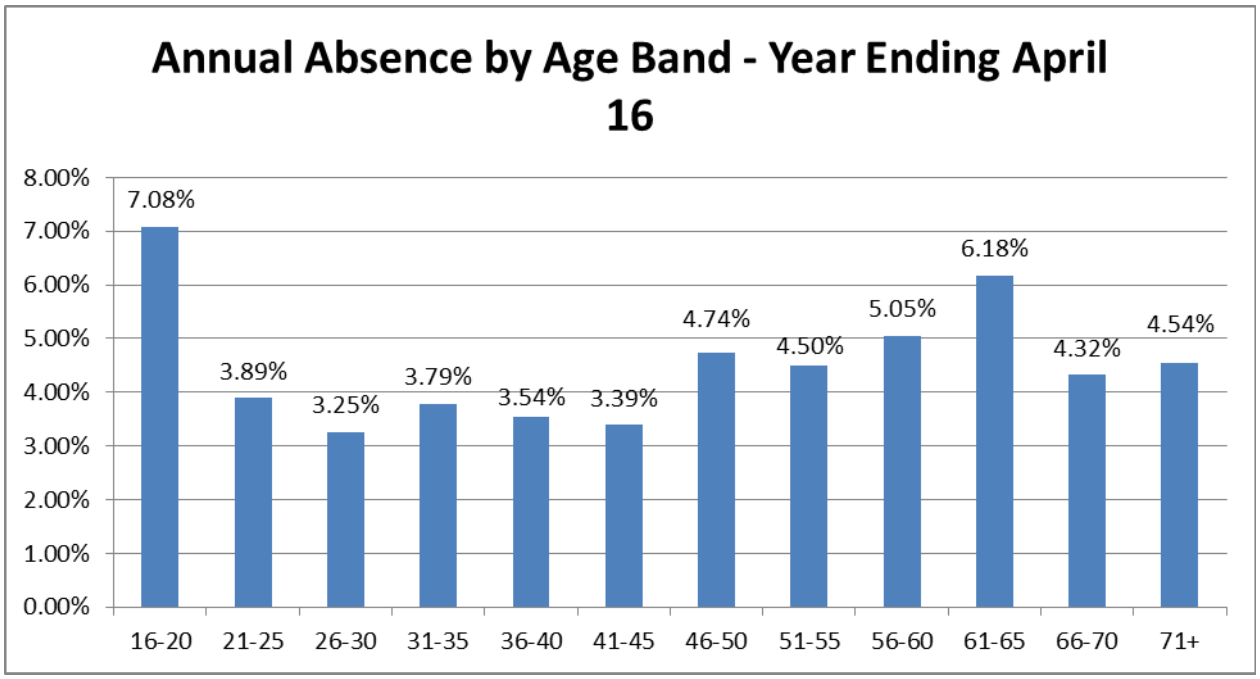
The range in sickness absence rates between directorates and across staff groups have previously been presented in this report. This month an analysis of sickness absence by age has been produced and this is shown in the graph below.

This analysis indicates that with the exception of 16-20 year olds absence increases gradually with age. With the exclusion of absence amongst those within the 16-20 age bracket, absence amongst staff 45 years and under is on average 3.57%, whilst amongst those in the age brackets from 46 years upwards, average absence is 4.89%.

However, within each age band from 21-25 to 41-45, there is a lower proportion of staff with no

absence (36.80%) than the proportion within each age band from 46-50 to 71+ (42.47%). This suggests that those in the older age brackets are less likely to have an episode of absence from work but when they are absent this is for a longer period of time.

Graph 3 – Sickness absence rates by age band



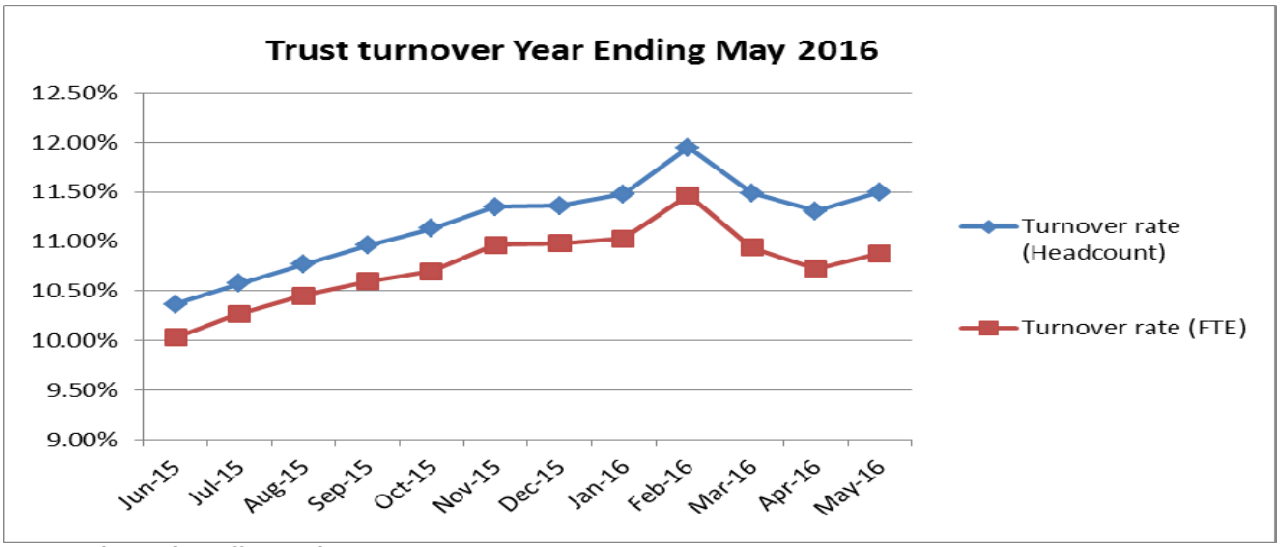
2.2 Turnover

The turnover rates shown below exclude all staff on fixed term contracts, including all junior doctors on rotational contracts. This is a common convention used across the NHS for calculating turnover. The figures also exclude staff subject to TUPE.

There was a small increase in the annual turnover rate in the year to the end of May 2016. Based on full time equivalent leavers the annual turnover rate in April 2016 was 10.88%; based on headcount the rate was 11.50%. This equates to 900 leavers in the 12 month period.

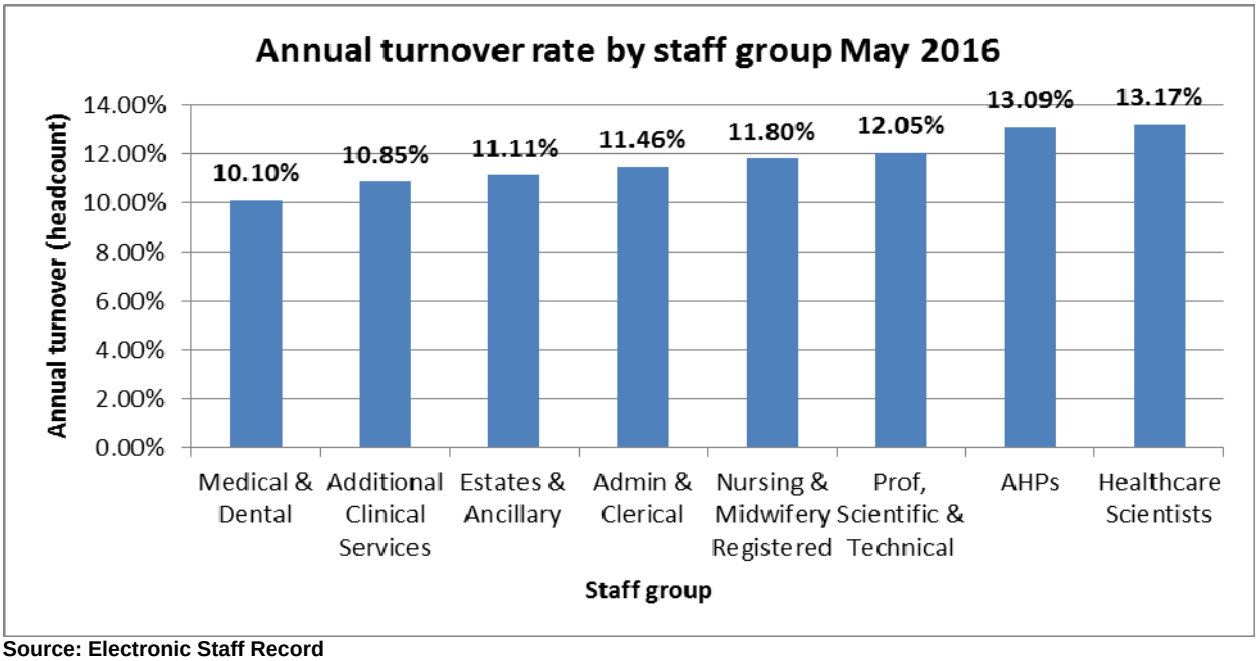
Reasons for leaving are similar to those reported previously with around 68% of leavers having voluntarily resigned for a variety of reasons including promotion, relocation and to undertake further education or training. Around a quarter of leavers retired, including those taking advantage of flexible retirement opportunities. The remainder of leavers were staff who were dismissed, died in service, left through the mutually agreed resignation scheme (MARS) or redundancy.

Graph 4 – Overall Turnover Rates



Source: Electronic Staff Record

Graph 5 – Turnover by staff group



Source: Electronic Staff Record

The two staff groups with the highest rates of turnover are Allied Health Professionals and Healthcare Scientists. This is the same two groups as reported last month but the rates for both staff groups have slightly reduced this month compared to last.

2.3 Freedom to Speak Up/Safer Working Guardian appointment

The Trust's appointment of a Freedom to Speak Up Guardian, incorporating the Safer Working Guardian for Junior Doctors was made in June. Seven applicants were shortlisted from a total of fourteen applications for the full time, band 8A role. The Assessment Centre was conducted on 17th May with three applicants brought forward for two stages of interview. The Trust has now successfully appointed to the role. As specified in the Junior Doctor contract, junior doctors were involved throughout each stage of the recruitment process, as well as involvement from a Clinical Director and the Deputy Chief Nurse.

2.4 Medical Workforce

New Junior Doctor contract

Following ACAS led negotiations with the British Medical Association (BMA), on 27 May NHS Employers published the terms and conditions of service and indicative pay summary that, subject to the outcome of the upcoming BMA referendum, would form the basis for a new junior doctor contract in 2016.

The updated terms and conditions reflect the outcome of the negotiations between NHS Employers' and the BMA. Some of the key changes that have been made to the March 2016 contract offer, include:

- amendments to pay and reward;
- actions to support equality dimensions of the contract;
- refinements to previous rota rules;
- improvements to flexible pay premia (FPP) and other terms;
- clarification of the role of the guardian;
- commitments from HEE including on deployment, governance and period of grace;
- commitment from the General Medical Council to develop mutual recognition of curricula.

The result of the BMA's referendum is due on 6 July and until this point, Trusts are instructed to suspend work on preparing for the introduction of the new contract.

NHS Employers has published Frequently Asked Questions for employers relating to the new contract.

CESR (Certificate of Eligibility for Specialist Registration)

The Trust currently relies heavily on locums for service provision in both Emergency Departments. A significant proportion of this reliance is due to gaps within the Middle Grade rotas. Intelligence from other Trusts supports implementation of the CESR programme to reduce vacancies.

The CESR programme is a rotational training programme into Anaesthetics / ITU, Paediatrics and Acute Medicine with their host being Emergency Medicine. Completion of the programme supports the employee in obtaining their Article 14 which enables them to join the General Medical Council's Specialist Register to become a consultant. This programme therefore facilitates growing our own consultants within Emergency Medicine.

To consider implementation of the CESR programme at this Trust the Clinical Director for Emergency Medicine at Derby Teaching Hospitals is meeting the Emergency Department Directorate on 23rd June. Derby currently has a waiting list of eight middle grade doctors for their established programme.

To ensure the success of the CESR programme requires engagement from directorates, including a commitment from each speciality to providing additional education and clinical supervision.

2.5 New nursing role – Nursing Associate

At the end of May, Health Education England (HEE) launched their response to a consultation on a new support role for nursing in England – the Nursing Associate role.

This new role is expected to sit alongside existing nursing care support workers and fully qualified registered nurses to deliver hands on care.

HEE's consultation attracted more than 1,000 responses from individuals including patients, members of the public and a wide range of organisations including professional bodies, trade unions, health care and social care providers and commissioners of healthcare.

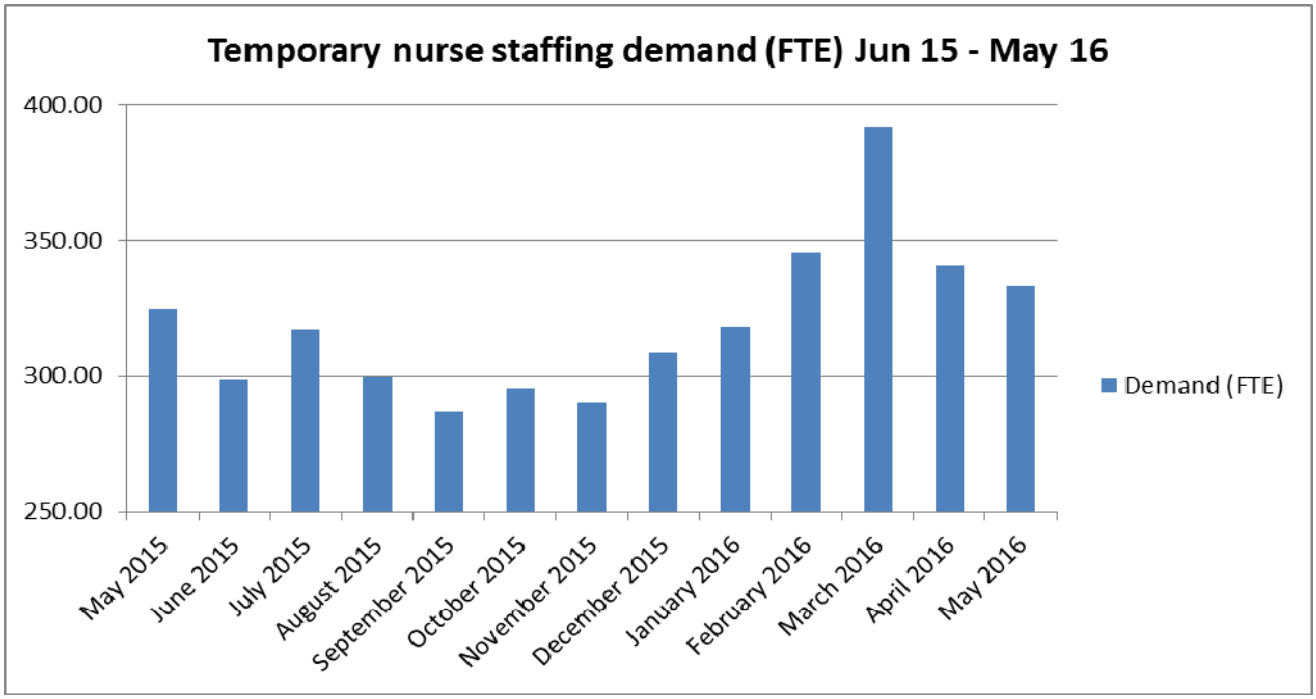
As part of the implementation of the Nursing Associate role, HEE will appoint 'test' sites' to recruit 1,000 students to start training for the role in 2017.

2.6 Temporary staffing

Temporary nurse staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has on average equated to around 319 FTE staff per month. In May there was a small reduction in demand for the second month in a row to 333 FTE from 392 FTE in March and 341 FTE in April. This is to be expected in line with seasonal variations.

Graph 6 – Temporary nurse staffing demand

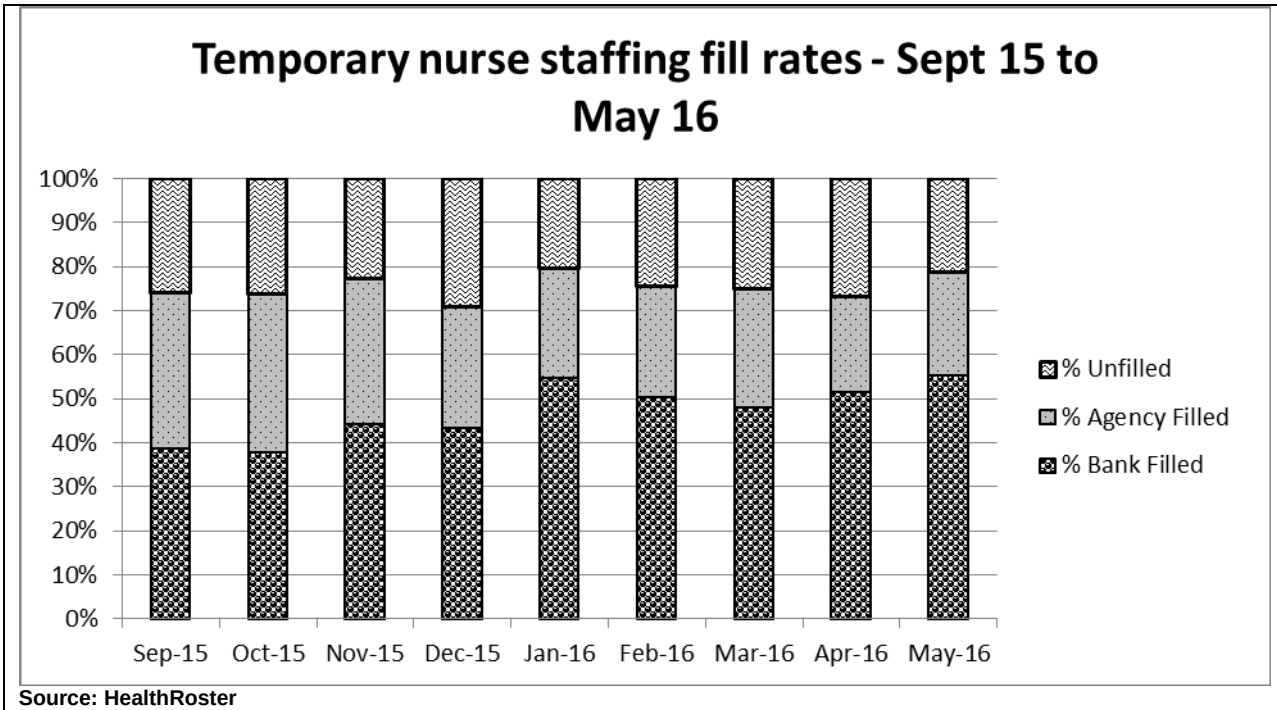


Source: HealthRoster

In November 2015 new incentives were introduced for undertaking work on the internal nurse bank. This included an additional 5% on top of individual's incremental pay point. For the period from 1 December an additional incentive of an extra 15% on top of the basic bank rate was offered for the winter period. This was originally planned to be offered until the end of March and later extended to the end of May. This had an immediate positive impact on the proportion of temporary staffing requirements filled by bank and over the last six months average bank fill for temporary staffing demand has been in excess of 50%.

Agency fill rates increased slightly between April and May 2016 from 21.98% to 23.51%. However, this continues to be well below the average agency fill rates of 33% in the last four months of 2015.

Graph 7 – Nursing Temporary Staffing Fill Rates



Source: HealthRoster

Agency usage reporting to NHS Improvement

There continues to be a requirement to report on a weekly basis to NHS Improvement all agency usage which is not compliant with the rules that have been introduced in phases since November 2015. The third and final phase was introduced on 1st April 2016. These rules relate to use of off framework agencies and price caps on agency use for all staff groups.

All shifts and bookings which are required to be reported to NHS Improvement are subject to senior level scrutiny and are only approved where there would be a patient safety implication of leaving the shift unfilled in line with the 'break glass' clause included in the rules. Retrospective review of all the shifts breaching the new regulations are considered weekly by the Executive Team. Allocation of the Transformation and Sustainability monies is dependent on demonstrating compliance with the rules.

Teams across HR, senior nursing, procurement, operations and finance continue to work closely to ensure compliance with the rules, including negotiations with agency suppliers.

Although immediately after the introduction of the final phase of the rules in April, there was a significant reduction in usage of off framework agency for supply of temporary staffing, this now seems to be plateauing with no further reductions in non-compliant agency usage for nursing or medical temporary staffing during May. A significant proportion of the non-compliant agency usage for both nursing and medics is within the Emergency Departments at the two main hospital sites.

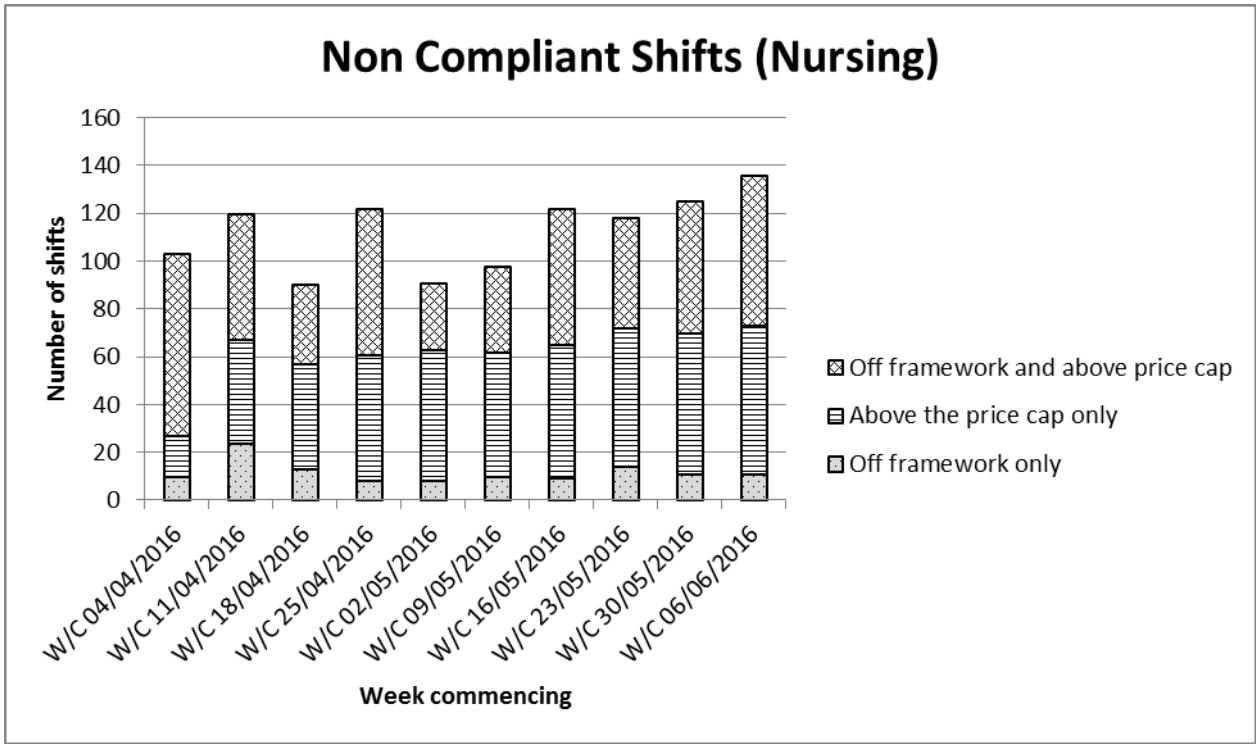
Discussions are taking place on a regional basis with neighbouring trusts and at a local level about what further actions can be taken to address the level of non-compliant agency usage.

Those shifts categorised as 'above the price cap only' are shifts which are booked with agencies on an approved framework but whose rates are still to come in line with the caps. NHS Improvement guidance to agencies is that they must demonstrate plans and actions to come in line with the capped rates by November 2016. However, Trusts are still required to report these shifts in their weekly submission.

Within the agency rules, NHS Improvement will also be setting the maximum amount that an agency worker receives per hour. Whilst Trusts were ***encouraged*** to comply with these rates from 1 April 2016, they are ***required*** to comply with them from 1 July 2016. Any override of this element of the

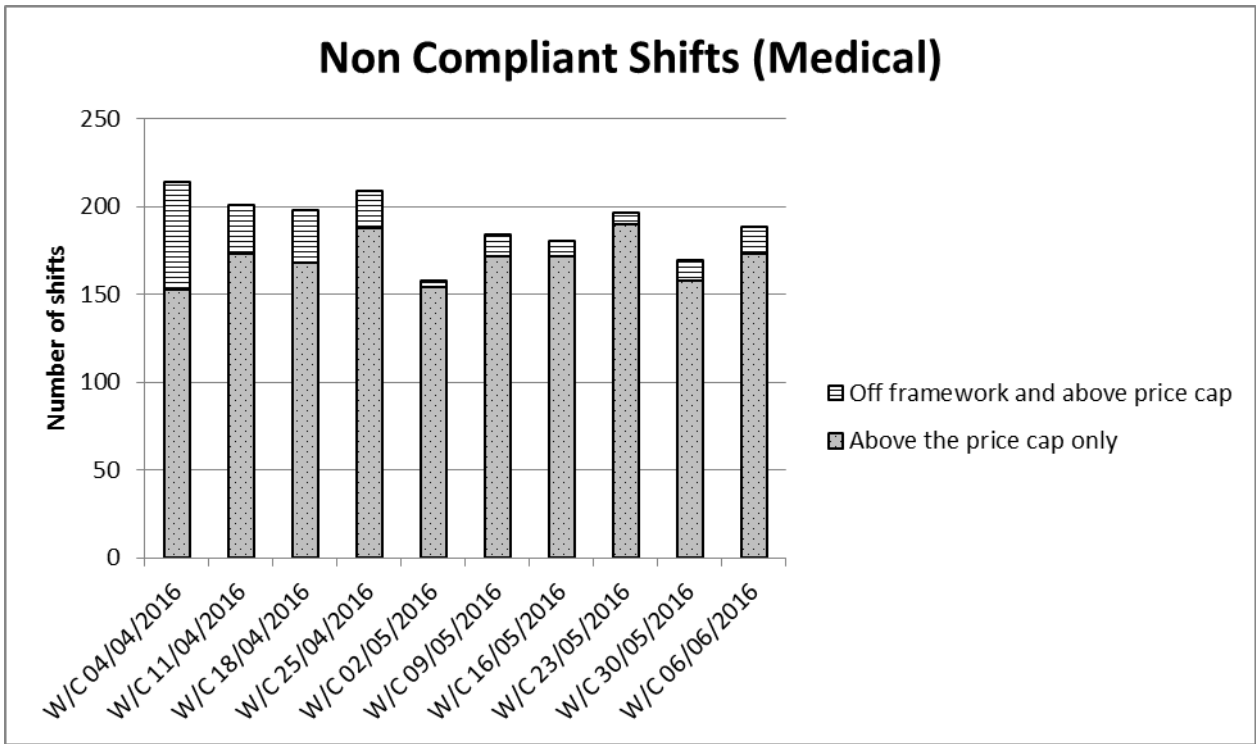
rules must be included on the weekly submission to NHS Improvement. This aim of both the maximum wage rates and the overall price cap is to ensure that agency workers are paid in line with standard NHS terms and conditions.

Graph 8 – Non compliant nursing agency shifts



Source: HealthRoster

Graph 9 – Non compliant medical agency shifts



2.7 Employee Relations Activity

The table below describes the number and type of employee relations activity in each of the last three months.

Employee Relations Activity	Mar 2016	Apr 2016	May 2016
Number of Disciplinaries (including investigations)*	9	13	11
Number of Grievances	11	13	15
Number of Formal Performance Management Cases (Stage 2 and 3)*	6	6	4
Number of Employment Tribunal Cases*	4	3	2
Number of active Organisational Change cases in consultation (including TUPE)	8	8	
Number of long term sick cases ongoing	234	222	190
Number of short term sick cases (Stage 2 and 3)	136	134	170

*denotes staff on medical and dental terms and conditions are excluded from the figures as these are reported by the Professional Standards Team (MHPS).

2.8 Workforce Plan for England

In May 2016 Health Education England (HEE) published the Workforce Plan for England detailing proposed education and training commissions for 2016/17.

HEE is responsible for planning and developing future workforce supply through investing a budget of £5bn on high quality education and training. The recently published plan details an increase in the overall volume of education and training with in excess of 38,000 new training opportunities for nurses, scientists and therapists and over 50,000 doctors and dentists in training.

Increases have been targeted in critical areas such as adult and mental health nursing, paramedics and physician's associates whilst in postgraduate medicine there are increases to training posts in General Practice, Emergency Medicine and Clinical Radiology.

HEE forecasts between 24,000 and 82,000 additional staff could be available to the NHS or other employers by 2020.

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	**June 2016**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 June 2016

Environment & Estates Committee, June 2016

Action requested/recommendation

To receive the annual reports on Health and Safety, Fire Safety and RIDDOR.

Executive Summary

The Environment & Estates Committee met on 08th June 2016 at Selby Hospital.

The minutes from the meeting will be presented to the next meeting of the Board of Directors.

Mr Sweet, the Chairman of the Committee, would like to draw the Board's attention to the following documents included in the Board pack.

- Health & Safety annual report
- Fire Safety Annual Report
- RIDDOR Annual Report

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

Implications for equality and diversity

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

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

identified by the Equality Act.

Reference to CQC regulations

The Environment & Estates Committee is linked to several CQC areas, most significantly:

Regulation 10: Dignity and Respect
Regulation 15: Premises and Equipment

Progress of report	Environment & Estate Committee, June 2016
Risk	None specific to this report.
Resource implications	None specific to this report
Owner	Mike Sweet, Non-Executive Director
Author	Brian Golding, Director of Estates & Facilities
Date of paper	June 2016
Version number	1

J1

York Teaching Hospital NHS
NHS Foundation Trust

Health & Safety in York Hospital NHS Foundation Trust

(Encompassing Fire Safety, Security Management and Non-Clinical Risk Management)

Annual Report 2015/16

Foreword

At York Teaching Hospital NHS Foundation Trust (Trust) we recognise promoting a positive safety culture is vital in protecting the health safety and welfare of our employees, those who use our services and in protecting our environment.

The Trust is committed to promoting an environment which actively supports a safety culture and awareness by recognising health safety and environmental management of risk as being key in the way the Trust operates and critical to the Trust's success.

In achieving this, the Trust has a developed risk strategy, based on risk profiling and assessment of risk to prevent any incidents before they occur, to ensure any residual risk is mitigated to as low as is reasonably practicable and is actively managed.

The report has been produced with the Health & Safety Executive (HSE) guidance managing for health & safety (HSG65) in mind; our aim is to continually improve on what we already have in place, by making the management of safety an integral part of good management and not a stand-alone system.

In the coming year the Trust will continue to take a proportionate and pragmatic approach to management of health safety and non-clinical risk across the organisation, by focusing on what really matters in delivering a safe environment and service for all.

I would like to thank all the various teams involved in the management of risk across the organisation for their efforts in ensuring we have in place robust and effective safety management systems, structures and processes in achieving this aim.

Brian Golding — *Director Health Safety & Non-clinical Risk*

Patrick Crowley — *Chief Executive Officer*

1. Executive Summary

It is a requirement for the Trust's Board of Directors (BoD)[1] to receive an annual Health and Safety (H&S) report covering the Trust's H&S activities; providing assurance on or relating to management of health and safety risks. This report informs the BoD of activity relating to H&S performance from 1 April 2015 to 31 March 2016.

In the year, the Trust continued to meet the requirements of health and safety legislation throughout the year and will continue to progress its management of health safety and environment across the Trust with a continued focus on:

- prevention of injury to patients, staff and visitors;
- maximising the morale, reducing absence levels, improving staff retention and productivity;
- preventing the loss of reputation to the Trust by preventing enforcement action and any resulting criminal or civil action being taken against the Trust or its officers;
- avoiding the damaging effects of financial penalties through uninsured losses;
- providing assurance against NHS and Care Quality Commission standards;
- continued review of existing health and safety arrangements to ensure continued compliance with relevant health safety legislation and applicable safety standards;
- assessing, monitoring and providing assurance all premises are 'so far as is reasonably practicable' fit for purpose;
- review and assurance of the results and addressing issues identified by the self-assessment health and safety audit;
- identification of required health and safety training courses;
- monitoring of policy compliance and addressing any resulting issues related to health safety and the environment;
- effective and safe management of waste and environmental matters and concerns.

Additional arrangements have been put in place to ensure a more robust structure of reporting corporate health safety and non-clinical risk to the Board is in place. This has seen the introduction of a new committee of the BoD with overall responsibility for overseeing the management of Health Safety and non-clinical risk - 'The Environment & Estates Committee' (EEC). The EEC inaugural meeting took place 23 September 2015 bringing together all of the Trust's committees and groups with responsibility for health and safety and non-clinical risk under one executive committee. To date the committee has met on 3 occasions and has been successful in its remit.

Summary of key safety challenges in the year:

1. *Effectiveness of committees and groups in taking lead, responsibility and providing assurance on specific aspects of health and safety and their lines of reporting corporately;*
2. *Clarity in regards to the health and safety function and the links with other risk management functions and agreement on a Trust wide safety strategy;*
3. *Resource availability for continued development of health and safety support systems;*
4. *Clarity in regards to structures, lines of accountability and responsibility for operational / local health and safety management;*
5. *Continued concerns in regards to specific aspects of health and safety training delivery in the Trust.*

[1] *INDG 417 – Leading Health and Safety at Work*

2. Health Safety and Non-Clinical Risk Group

The Health & Safety/Non-Clinical Risk Group (H&S/NCRG) brings together key Trust leads with responsibility for health & safety and non-clinical risk.

The group continued to function in line with the groups Terms of Reference; a summary of key topics discussed by the group in 2015/16 included, needle stick injuries, safety training, safety programmes & plans, non-clinical CAS alerts, non-clinical incidents, review of safety policy and procedures and any specific items brought to the group's attention by direct reports or via sub-committee or group.

As part of the Trust's governance arrangements the group received highlight reports from the Trust's health and safety committees and their sub committees and groups.

Committees & Groups reporting to H&S/NCRG:

- Health & Safety Committees
- Electrical Safety Group
- Fire Safety Group
- Water Safety Committee
- Risk Review Group
- Security Committee
- Medical Equipment Management Committee
- Medical Gases Committee

As part of on-going review of the Trust's governance arrangements, the Terms of Reference of the group and reporting arrangements were amended to include the Environment & Estates Committee as the groups' parent committee.

Meeting dates for 2015/16:

- 19 June 2015
- 11 September 2015
- 15 January 2016

Meeting Attendance Record 2015-16

		19/06/15	11/09/15	15/01/16
Brian Golding (Chair)	Director of Estates and Facilities	√	√	√
Fiona Jamieson	Deputy Director of Healthcare Governance	√	√	√
Andrew Millman	Consultant, Occupational Health	√	A	√
Helen Hey	Nursing	A	A	A
Anne Devaney	Head of Corporate Learning, Workforce & Development	A	√	√
Michelle Wayt	HR Manager	√	√	A*
Colin Weatherill	H&S Manager – Scarborough	√	√	√
Gillian Clarkson	Staff Side Representative	√	A	√
Adam Bassett	Community Services	√	√	√
Kingsley Needham	H&S Manager –York	A	√	√

Directorate Mgr rep		√	√	A

√ - attended, A - provided apologies, * - nominated deputy

1. *As part of on-going work on structures and management of aspects of safety in the Trust further clarification is required on the responsibilities, authority and structure of groups, committees and how they interlink with the corporate management structure.*

Continuing work in the Trust in defining committee reporting and structures is taken place to address any ambiguity in authority and reporting of groups and committees of the Trust.

3. HS&E Interventions, Legislation and Guidance Monitoring

In 2015/16 there were no interventions or concerns raised to the Trust from the UK Health and Safety Executive.

In November 2016 the Trust had an audit from the Environmental Agency against the Hazardous Waste (England & Wales) Regulations 2005 & HTM 07-01 (healthcare technical memorandum – management of waste). The report identified a series of improvements to be made against the HTM, the Trust waste manager developed an action plan to address the identified concerns; the environment agency accepted this plan and closed off the actions to date with on-going monitoring of actions outstanding at the time of this report.

The Trust has kept abreast of new and upcoming Occupational Health and Safety (OH&S) legislation and guidance that will or is likely to impact the Trust. Where an amended or new legislative requirement or guidance has been identified by the Trust the relevant legislation, guidance, audit & inspection reports are reviewed, retained and disseminated to the relevant operational area or across the Trust as required.

In year examples of this review process:

Review of approved codes of practice (L series guidance) reviewed in 2015/16:
- L64 2nd edition – Safety Signs and Signals Regulations 1996;
- L153 3rd edition - Construction (Design & Management) Regulations 2015;
- L138 2nd edition - Dangerous Substances and Explosive Atmospheres Regulations 2002

- Update on the impact on HSE memorandum of understanding on safety management and enforcement post the introduction of the Care Quality Commission (CQC) fundamental standards 01 April 2015;
- Review of the Trust annual fire statement;
- Review of internal audit and findings Y1534.

4. Health and Safety Requirements

Health and Safety legislation requires the Trust has a system in place to proactively manage and control risks. In order to meet these legal requirements the Trust manages its risks based on the revised HSE's model 'Successful Health and Safety Management'

(HSG65[2]). This is a continuous improvement model based on the approach of **Plan, Do, Check, Act**.

2. *It is recognised with the recent and on-going restructure in the organisation, the link and collaborative working with other functions in the Trust needs further consideration and working links forged, providing synergy and efficiency.*

As part of the estates and facilities (health and safety) restructure, a work stream is being developed to identify key stakeholders and functions linked to the management of health safety and non-clinical risk to address this.

3. *For the health and safety department to continue to support the Trust effectively a review of the resource availability within the Trust is advisable to allow for improvements to be made to health and safety systems already in place and to develop additional systems to allow for efficiency at an operational level.*

As part of the estates and facilities restructure, resource availability and requirement in the wider estates and facilities department is being reviewed and from this resource requirements will be defined and as required put into place.

4. *With recent changes in the structure of the management of risk it is not always clear on the operational management structure and responsibilities for directorate management of risk and where this is reported through to the health safety and non-clinical risk function.*

Work is on-going work with the health and safety department and healthcare governance to define this structure and responsibilities.

Plan

During this reporting period, the H&S committees & H&S/NCRG approved or noted the following policies, plans and reports:

- Health and Safety Policy;
- Electrical Safety plan;
- Fire Safety Policy;
- Violence Against Staff Procedure;
- Driving at Work Policy;
- Claims Management Policy;
- Medical Gas Policy;
- Use of Mobile Communication Equipment Policy.

The Trust is currently in the process of developing an overarching health and safety strategy, this strategy is to be aligned with existing corporate risk management strategy and is expected to be developed and approved in 2016.

[2] *HSG65 (Third edition, published 2013)*

Do

Work has continued in many aspects of safety management, with the Trust risk profiling to determine topics which present the greatest health and safety issues for the organisation. These identified risks are captured via the Trust risk assessment processes, recorded and quantified. Risks which are identified as medium or high have specific measures taken to address and effectively manage the risk. By adoption of this approach resource can be identified and prioritised action taken, with less priority given to low risk activities.

The key areas of safety management risk profile established in the Trust against HSE and NHS guidance and standards are:

- Manual handling (patient and non-patient including heavy patient handling);
- Slips Trips & Falls (Patient and non-patient);
- Sharps Injuries;
- Management of Drugs;
- Management of Asbestos;
- Control of Substances (anaesthetic gases, infection prevention, surgical smoke & cleaning agents);
- Decontamination;
- Local Extraction and Ventilation Testing and verification;
- Management of Contractors;
- Working at Height;
- Confined Space Working;
- Medical Gas Management;
- Burns and Scalds Management (Hot water and surfaces);
- Lifting Equipment (including patient and non-patient);
- Window Restrictors;
- Electrical Safety (PAT, HV & LV);
- Fire Safety;
- Driving at Work;
- Workplace Transport (Vehicle and pedestrian segregation);
- Workplace Violence and Aggression;
- Equipment Safety – medical and non-medical;
- Pressure Systems;
- Water Safety (Control of Legionella);
- First Aid Provision.

The above topics have specialist leads and specialist groups or committees to ensure and monitor compliance. Where risks are identified as significant and the control measures in place mitigate the risk to an acceptable level, but further action is deemed required these risks are escalated to directorate and corporate risk registers for risk treatment or acceptance.

In addition to the above work the Trust continued to actively progress the implementation of the NHS Premises Assurance Model (PAM) standards, to bring together compliance with quality, safety and efficiency standards, delivering a central point of monitoring and management, demonstrating assurance in these areas.

Check

Proactive Monitoring - Health & Safety Self-Assessment Audit

Each year in the Trust a health & safety self-assessment audit is undertaken, the audit is shared with operational directorates, directorates are required to complete the audit against prescribed criteria proving assurance of adherence to Trust policy and guidance. The scores from each directorate assessment are aggregated and a final Trust wide score is obtained.

The health and safety self-assessment audit tool is electronic. It is formed in two parts; a mandatory section made up of eight sub sections:

- Safety and Risk Management
- Incident reporting
- Fire Safety
- Slips, Trips and Fall Prevention
- Work related stress
- Infection Prevention (All areas and staff)
- Learning from experience
- Incident investigation

The second part is made up of fifteen risk specific standards:

- Infection Prevention
- Moving and handling people
- Lifting and moving of objects
- Human Tissue Act
- Control of Substances Hazardous to Health (COSHH)
- Violence and Aggression
- Clinical waste handling and disposal
- Display screen equipment
- Laser radiation and artificial optical radiation
- Ionising radiation
- Safety in patient areas
- Safe use and disposal of sharps
- Latex
- Medical equipment
- Resuscitation

Each sub section is awarded marks for a range of key questions asked; when totalled up, they are averaged to produce a mark across all criteria, with the overall percentage mark overtime, providing an indicator by which an area can see its safety performance / compliance develop and improve. Linked to the self-assessment tool are numerous sub departmental audits and inspections to provide assurance and inform the final result.

For the 2015/16 health & safety self-assessment audit an aggregated Trust score of **92% compliance** was returned. Due to resource limitations within the health and safety department the ability to carry out the anticipated face to face audits has not occurred.

Reactive Monitoring - Health and Safety Accident and Incident Reporting System (AIRS) Reports; 2015/16

The Trust has in place a comprehensive system to collect information from accident and incidents which occur in the Trust's (Datix reporting system).

As part of the Datix reporting system the Trust captures significant harm incident (Non-Clinical), the Trust has a duty to report these incident to the HSE under the Reporting of Diseases and Dangerous Occurrence Regulation 2013.

Summary RIDDOR Incidents for year 01 April 2015 – 31 March 2016

Total RIDDOR reports for the year was 18, this represents a 65% reduction in reported incidents compared to the year 2014/15. This significant reduction is due to 14/15 figures being significantly higher than the average reports for the Trust compared to the reported incidents for years 2011 to 2014 and the way RIDDOR incidents were reported in the referenced years.

With this noted, it would be more sensible to compare the RIDDOR reports for the last 5 years across the Trust to give a more realistic longer term comparison on performance, this shows for 2015 an 11.5 % reduction compared to the average for the years 2011 to 2015.

As in previous years, review of RIDDOR reportable incidents has not identified any one area of concern with reportable accidents falling into categories of > 7 day absence, fractures, lacerations and major injuries; with causational factors including slips trips falls, manual handling, contact with and person injury.

(Appendix A –Full summary RIDDOR 15/16)

Act

Health and Safety performance review; working with the Trust legal department routine review of Employee and Public Liability claims are undertaken to identify any significant trends / risks and to identify potential lessons to be learnt to prevent reoccurrence.

It is Trust policy for investigations to be carried out into incidents to identify root causes and put in place measures to either eliminate any potential risk or mitigate the risk so that it is effectively managed; the Trust also has in place a robust policy for the management of serious incidents.

The Trust has in place a Central Safety Alert System managed through the risk department this system collates any alerts which enter into the Trust from an external source or are raised internally. Once an alert has been entered onto the system a process is followed to ensure the alert is addressed and signed off; once this has been completed the alert is closed and advised as appropriate to the informing organisation.

In addition to this the Trust monitors complaints which may have a specific non-clinical safety element, these complaints are reviewed by the operational responsible department and via quarterly reports to the Environment and Estates Committee.

5. Health and Safety Executives key topics in health and social care

The HSE is the national independent regulator for health and safety in the workplace; this includes publicly and private owned health and social care settings, working in partnership

with co-regulators in local authorities to inspect investigate and where necessary take enforcement action.

The HSE leads on employee health and safety and will consider investigation of patient or service user deaths or serious injuries, where there is an indication of a breach of health and safety law was a probable cause or a significant contributory factor and meeting sector specific legislation to secure justice or necessary improvement in standards.

The HSE will take enforcement action in cases where it is considered established standards e.g. NHS safety alerts, internal guidance or systematic management failure e.g. inadequate systems for risk assessment, controls or monitoring, have been identified as a contributing factor.

The HSE will support decisions to allow everyday activities to be undertaken provided a sensible, suitable and sufficient risk assessment has been carried out, documented and reviewed as necessary, to identify and implement any sensible precautions to reduce the risk of significant harm to the individual concerned.

With the introduction of the CQC fundamental standards in April 2015 and supporting memorandums of understanding and agreements between the CQC & HSE the lines of regulatory responsibility in the healthcare sector have been made clearer, with the HSE focus being the regulator for employees, visitor, specific environmental & equipment harm and the CQC being regulator for clinical/ patient safety harm.

(Appendix B – Full Briefing Note CQC Fundamental Standards).

The HSE Health and Social Care Sector identified key topics:
Moving and Handling;
Sharps Injuries;
Slips Trips and Falls;
Workplace Violence;
Equipment Safety (Inc Bedrails, falls from windows);
Dermatitis;
Legionella;
Scalding and Burns.

6. Staff Training

The Trust provides a range of in-house training that contains elements of health & safety. The move to the Learning Hub will allow the organisation to analyse the numbers of staff trained in more detail.

5. *In the terms of specific health and safety training there is still improvement and progress to be made in the areas of Risk Assessment, COSHH Assessment, First Aid and general health and safety qualifications for staff tasked with specific health and safety responsibilities (e.g. IOSH).*

A Trust wide review of training on the organisation in relation to health safety and non-clinical training provision has been identified as a priority in 2016/17.

7. Fire Safety Annual Report

See attached report.

8. Security Management Annual Report

This year our security team have finalised the Trust's Exclusion Policy, working in partnership with the Trust's Safeguarding department; staff can use this as a tool to support them when visitors and patients are consistently being abusive.

The management team successfully reviewed and negotiated the security manned officer contract, the contract went out to tender for the next 3 years with an option for a further 3 years, we secured a current cost saving which included a guaranteed pay increase for the officers on the ground for the next 3 years.

The BoD approved capital expenditure on implementing swipe access control on wards at York Hospital; the works on creating the infrastructure to enable this has commenced.

We have successfully appointed an in-house CCTV programme manager, utilising some of the savings from the re-letting of the manned guarding contract. This enabled the Team to create a Trust wide asset database for all CCTV assets, manage the CCTV control room more closely, providing specific training to operators, producing written Data Protection processes which comply to industry standards and ensuring we regularly audit the system.

We have put together a comprehensive CCTV SLA Tender document for 3 years +2, which will produce recurrent cost savings and ensure value for money whilst providing the Trust with a safer and robust system. This contract is out to tender at the present time. The Programme Manager also produced cost savings and improved service by responding to fault reports on the video management system and cameras and by undertaking corrective action. By managing the video management system and correcting programming faults directly has saved approximately £5000 since July 2015.

Following countrywide thefts of Medical Gases from NHS premises including our own Bridlington Hospital, the Security Department working with Pharmacy and Estates increased the security of Medical Gas stores across the Trust.

We have continued this year to regularly up skill our team of security officers introducing first aid training as a new skill and ensuring they receive regular updates on safeguarding, drug and alcohol awareness, and conflict resolution.

In the coming year we will be working on a 5 year Trust wide CCTV Strategy and creating a CCTV Code of practice in line with the Surveillance commissioner's guidance.

9. Conclusion

2015/16 has seen an improved focus on the wider health and safety risks of the Trust and how the safety function interacts with other aspects of safety management. The Trust continues to work on improving the health and safety systems and processes, striving to embed these systems into the operational management across the organisation.

The recent changes in the Trust's governance arrangements in this area is seen as a positive step in ensuring robust senior management review by the introduction of the Environment & Estates Committee; though in the early stages, the Committee has brought together all key leads and it is anticipated will have a positive impact in the area of safety and non-clinical risk providing further assurance to the BoD.

In the year the H&SNCRG has worked to address operational issues as they have arisen and supported the groups, sub groups and committees in facilitating the operational safety management, working in both non-clinical safety and as required supporting clinical safety functions.

Owner:

Brian Golding, Director of Estates & Facilities

Report authors:

Kingsley Needham, Health and Safety Manager – York
Janet Mason, Head of Security & Accredited Local Security Management Specialist
Mick Lee, Fire Safety Officer – York
Kevin Hudson, Fire Safety Officer - Scarborough
Colin Weatherill, Health and Safety Manager - Scarborough

April 2016

References:

For the purpose of this report the following statutory requirements of the *Health and Safety at Work etc. Act 1974*

The *Management of Health and Safety at Work Regulations 1999*

Control of Substances Hazardous to Health (COSHH) Regulations 2002.

The Regulatory (Fire Safety) Reform Order 2005

HSG 65 third edition - Managing Health and Safety

INDG 417 – Leading Health and Safety at Work

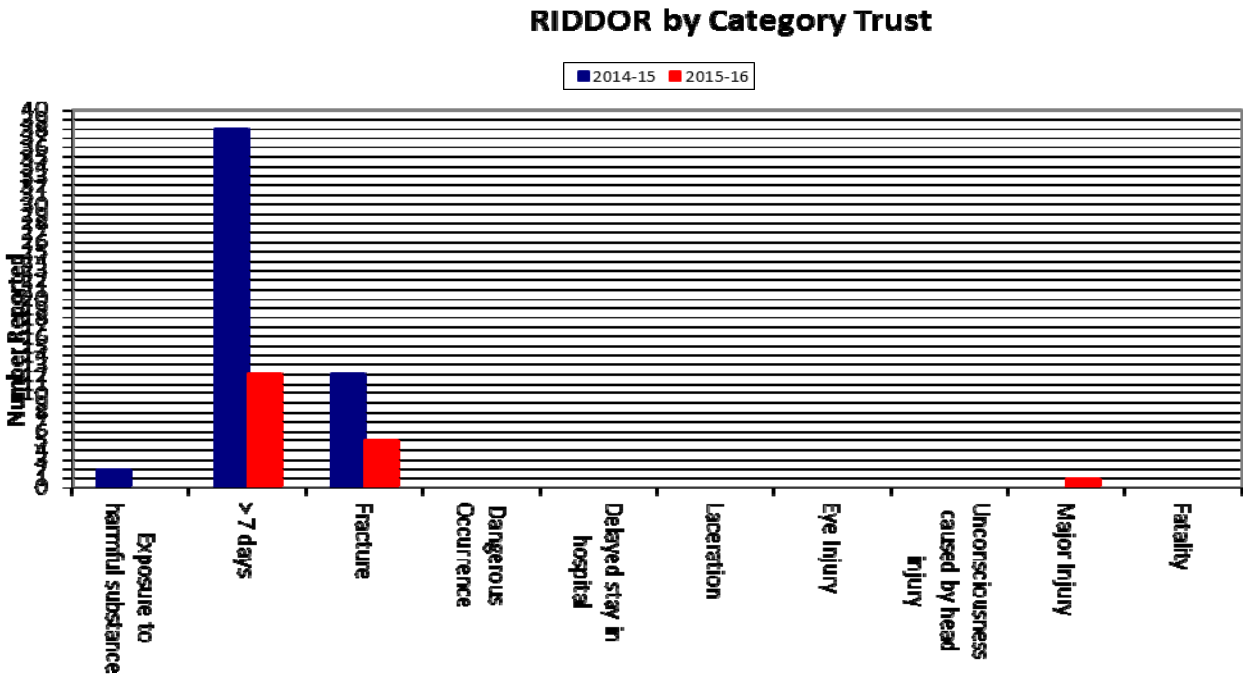
York Teaching Hospital NHS
NHS Foundation Trust

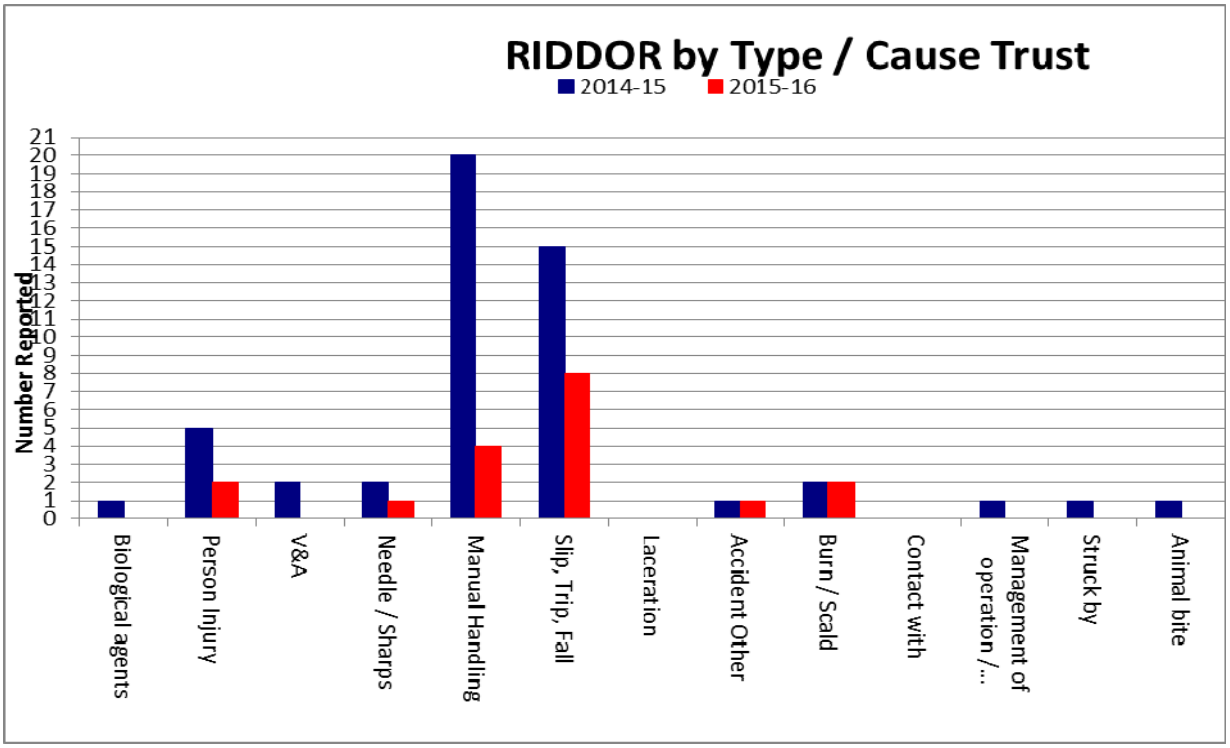
Trust Yearend RIDDOR reports - 2015/2016

For the year ending 31 March 2016, **EIGHTEEN** RIDDOR reportable incidents were confirmed on DATIX.

The total number of RIDDOR reportable incidents for **2015/16** was **EIGHTEEN**, compared to **FIFTY ONE** for the period **2014/15** representing a **65% reduction** of RIDDOR reportable incidents on 2014/15 across the Trust.

Summary of total Trust Reportable Incidents





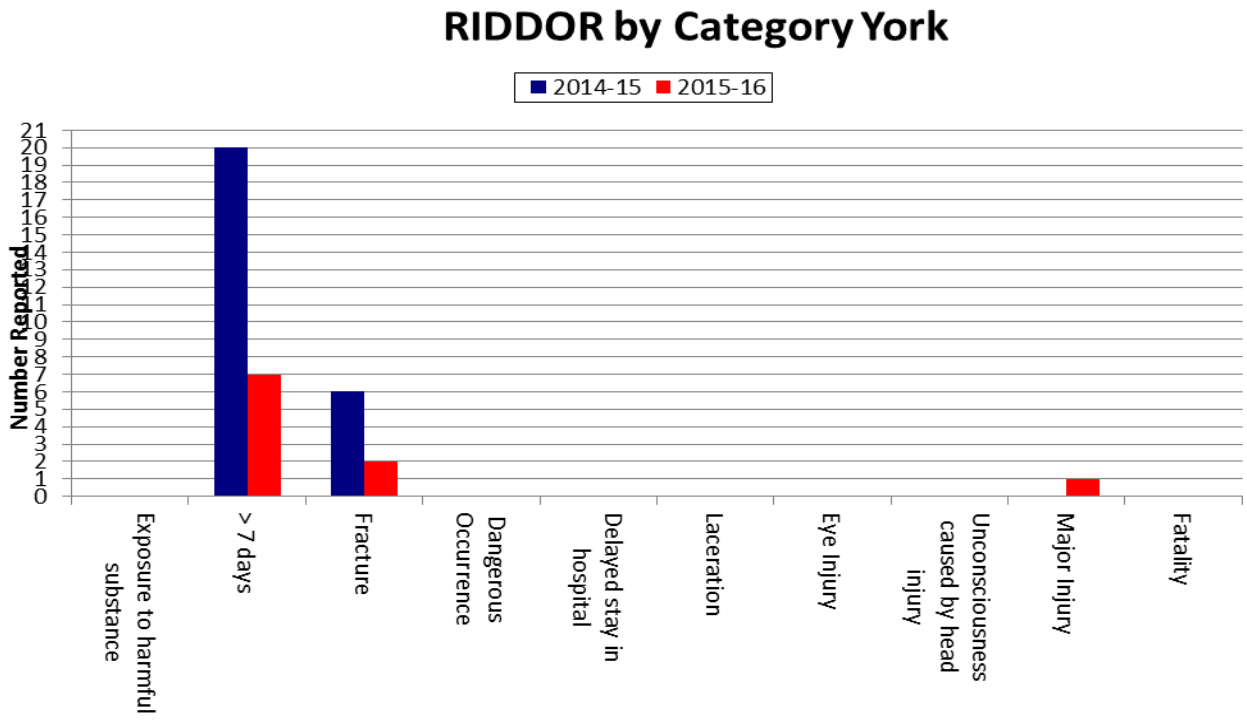
RIDDOR incidents by category & type/cause

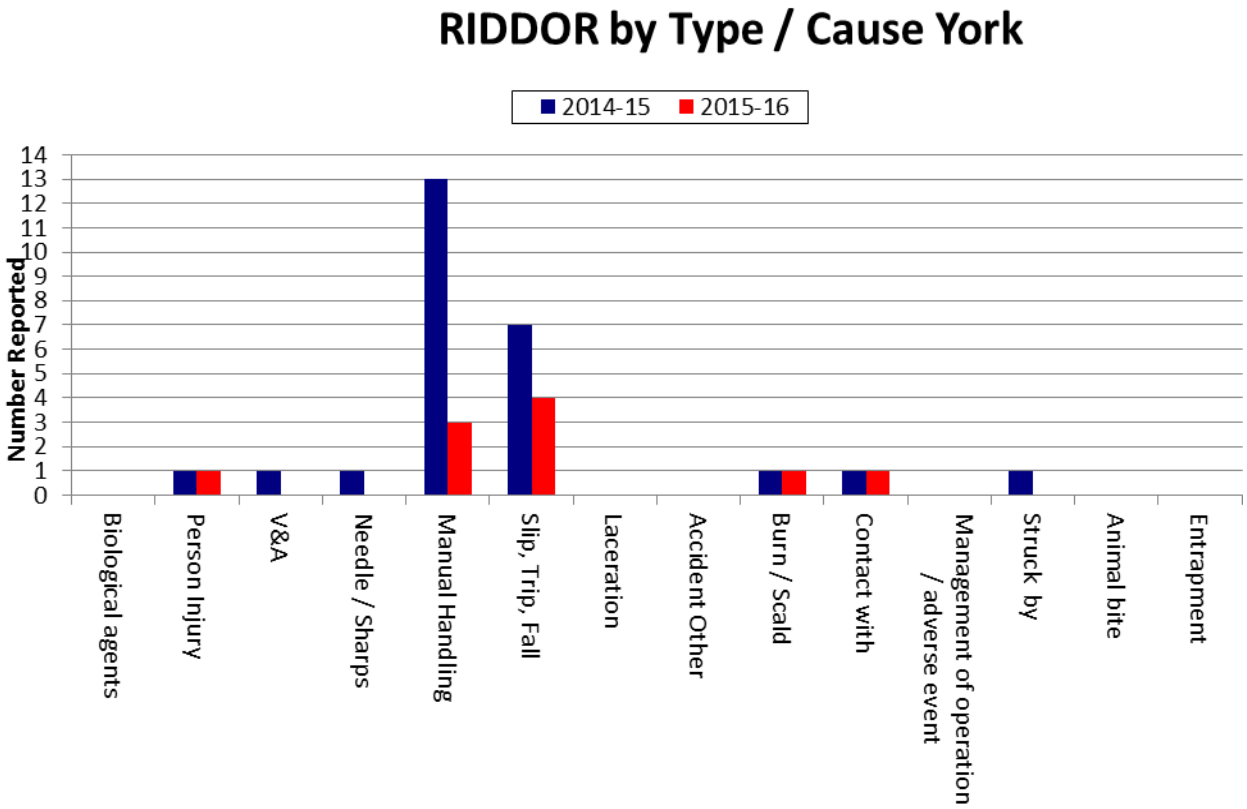
RIDDOR Category to period	2014-15	2015-16
Exposure to harmful substance	2	0
> 7 days	38	12
Fracture	12	5
Dangerous Occurrence	0	0
Delayed stay in hospital	0	0
Laceration	0	0
Eye Injury	0	0
Unconsciousness caused by head injury	0	0
Major Injury	0	1
Fatality	0	0

RIDDOR TYPE / CAUSE	2014-15	2015-16
Biological agents	1	0
Person Injury	5	2
V&A	2	0
Needle / Sharps	2	1
Manual Handling	20	4
Slip, Trip, Fall	15	8
Accident Other	0	0
Burn / Scald	1	1
Contact with	2	2
Management of operation / adverse event	0	0
Struck by	1	0
Animal bite	1	0
Entrapment	1	0

By Operational Region - York

The total number of RIDDOR reportable incidents for **2015/16** was **TEN** compared to **TWENTY SIX** for **2014/15** represents a **61.5% reduction** of RIDDOR reportable incidents on 2014/15 for the York Hospital site.

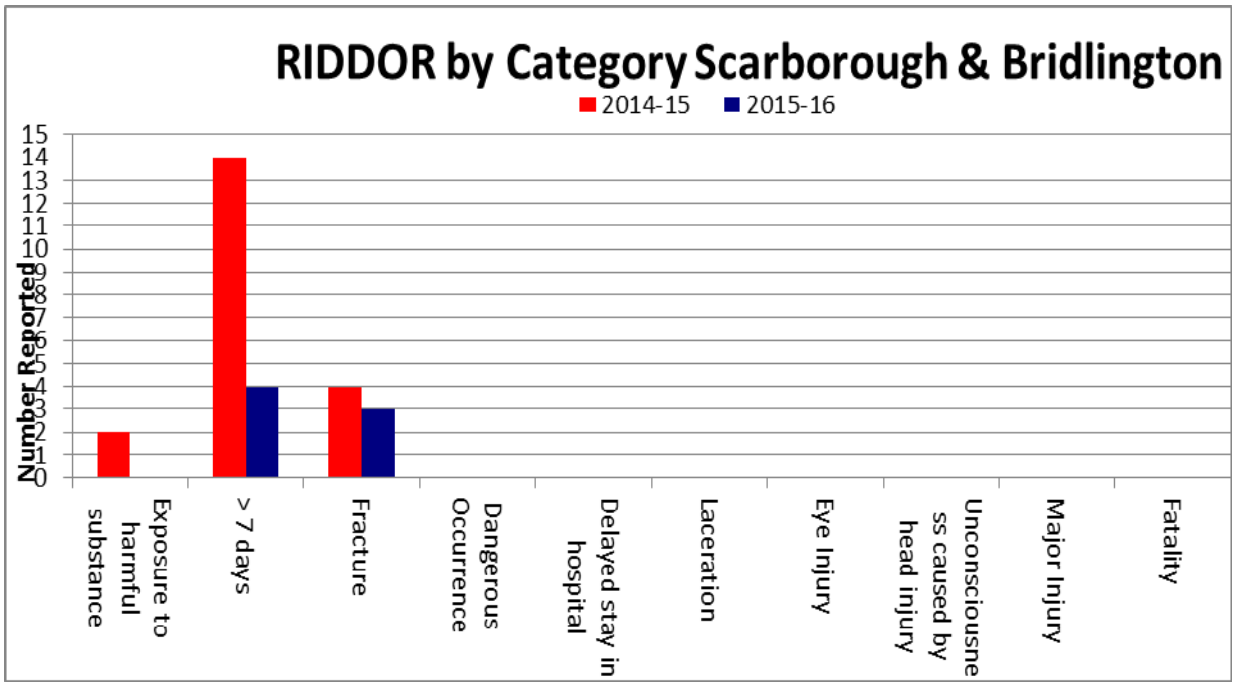


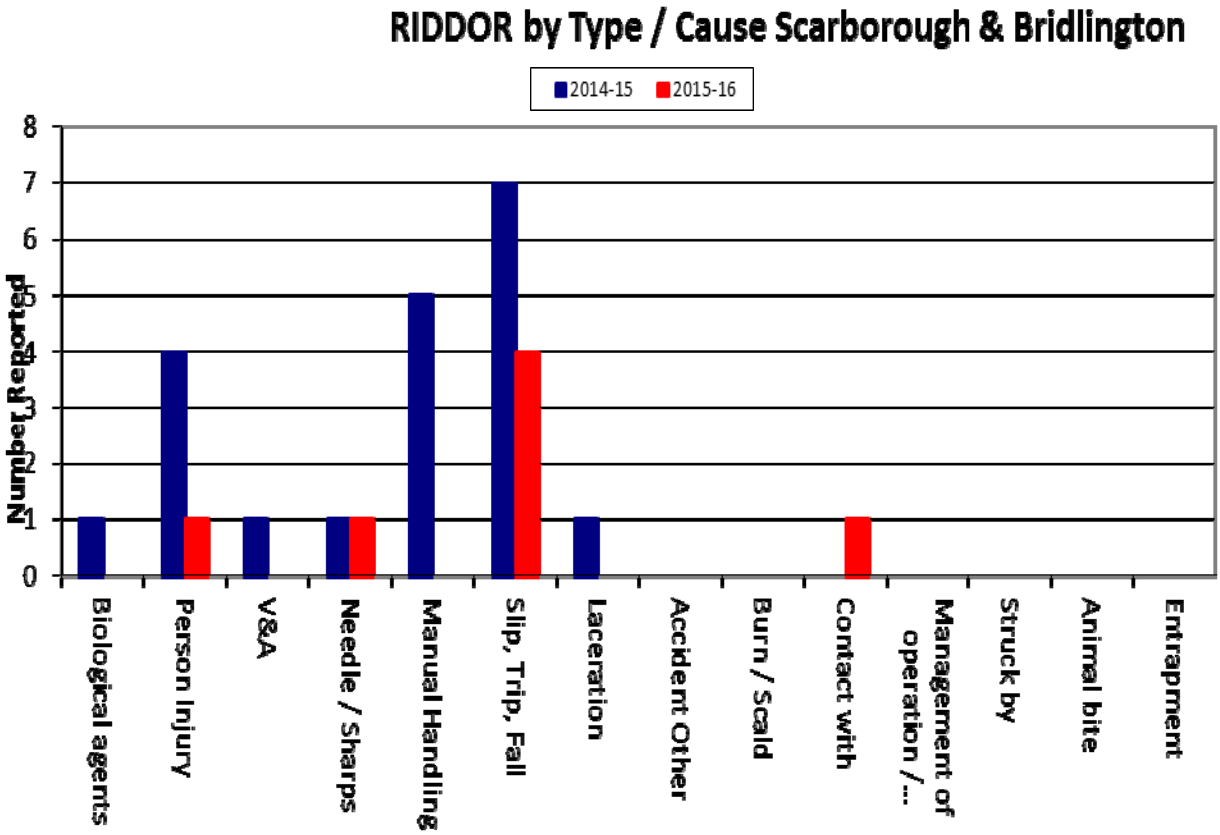


By Operational Region – Scarborough & Bridlington

The total number of RIDDOR reportable incidents for **2015/16** was **SEVEN** compared to **TWENTY** for **2014/15**.

This represents a **65% reduction** of RIDDOR reportable incidents on 2014/15 for the Scarborough & Bridlington Hospitals sites.

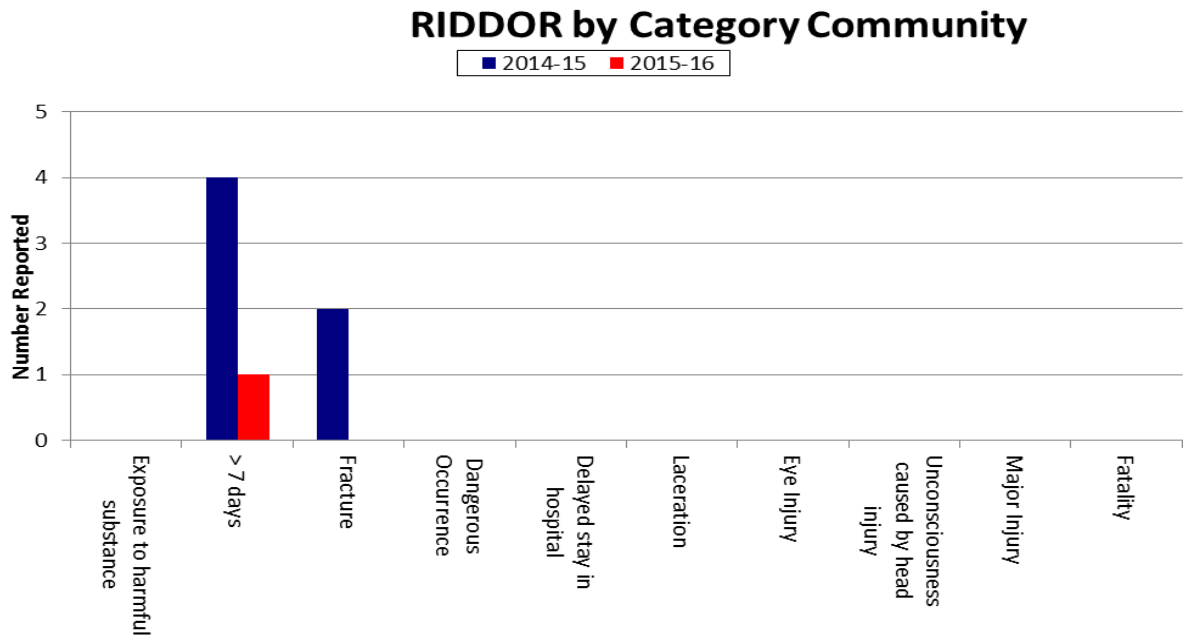


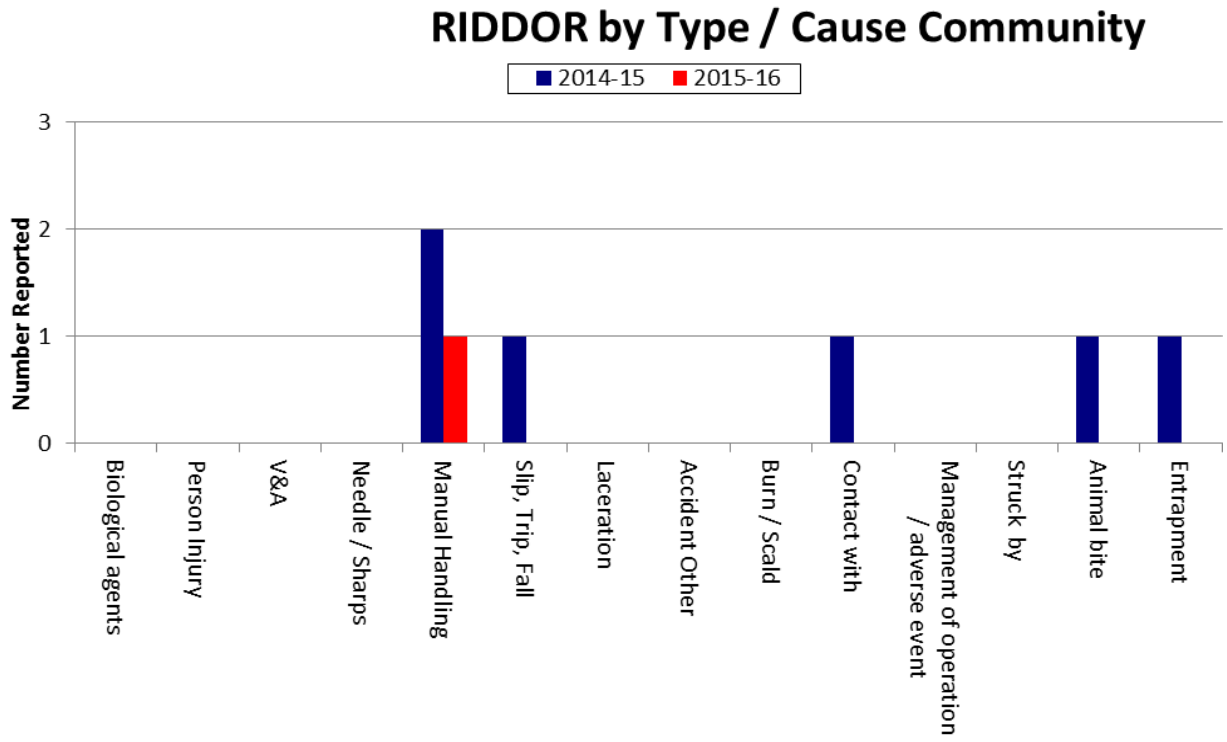


By Operational Region - Community

The total number of RIDDOR reportable incidents for **2015/16** was **ONE** compared to **SIX** for **2014/15**.

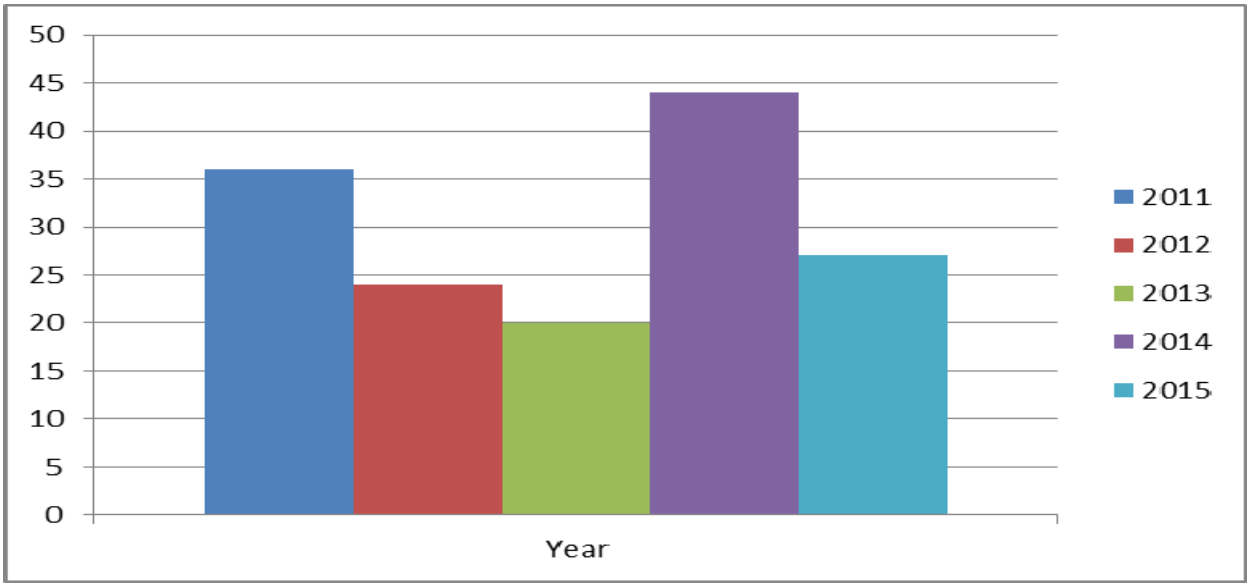
This represents a **83% reduction** of RIDDOR reportable incidents on 2014/15 for the Community Hospitals & Clinics.





As part of improving the Trust H&S management systems; in 2015/16 the review and evaluation of RIDDOR incidents was changed to quartile reporting. It needs to be recognised partly due to this fact and the way in which incidents were reported in the referenced years, this report shows significant reductions in RIDDOR reporting. With this in mind the information below is more reflective of performance as a year on year comparison for the Trust.

RIDDOR reportable Incidents 2011 to 2015 (by calendar year)



The Trust 5 Year average for RIDDOR reported incidents is 30.2 per year ∴for the year 2015 there has been a **11.5% reduction** in RIDDOR reportable incidents.

York Teaching Hospital NHS
NHS Foundation Trust

Purpose
An update on the potential impact of the implementation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) (Part 3), (*HSCR*) and Care Quality Commission (Registration) Regulations 2009 (Part 4) (*CQCR*) its link to and impact on safety legislative framework.

Background
The introduction of the new Care Quality Commission (CQC) - Fundamental Standards was developed from the recommendations from the Francis report following his inquiry into Mid Staffordshire NHS Foundation Trust. The HSCR aim to set out the framework for which care people receive should not fall below the standards.

The introduction of the new fundamental standards and regulations was to close an identified gap[1] in regards to the Heath and Safety Executive (HSE) health and social care enforcement policy and the CQC lacking the necessary powers to secure justice[2].

Detail
The new regulations and fundamental standards set a clear minimum standard that registered providers and managers need to meet. If the standards are not met the CQC will take enforcement action in regards to breach of regulation(s). The CQC now have new enforcement policy[3] and enforcement powers to take, when poor care is identified or regulation beached; allowing the CQC to bring prosecutions for statutory breach or other actions set out in CQC enforcement policy for situations which do not constitute a statutory breach.

The CQC, the (HSE) and Local Authorities (LAs) have in place (as from 1 April 2015) a Memorandum of Understanding (MoU) to reflect the new enforcement powers granted to the CQC. The MoU outlines the responsibilities of the CQC, HSE and LAs when dealing with health and safety incidents in care settings.

The CQC will be the lead for inspection and enforcement for the safety and quality of treatment involving patients and service users from a registered provider.

The HSE / LAs will be the lead for inspection and enforcement of health and safety matters involving patients and service users from non-registered providers and for health and safety matters involving workers, visitors and contractors (this is irrespective of registration).

There will be some cases where more specific criteria may need to be applied; in these cases the most appropriate enforcement body will lead.

The MoU also defines that enforcement bodies will share information across the health and social care sector (i.e RIDDOR and CQC notification requirements).

[1] As identified in the Francis Report
[2] Prior to the introduction of this regulation cases of patient harm fell under Section 3 of Health and Safety at Work etc Act 74 (General duty of care to others than employees)
[3] http://www.cqc.org.uk/content/enforcement-policy

Summary

- The Fundamental Standards replace the existing CQC Essential Standards[4] but are more specifically worded. The standards will form the basis of the CQC inspections allowing for, in some cases, direct enforcement action including taking criminal action. The purpose of enforcement is to "*protect people from harm or the risk of harm'* and '*to hold providers and individuals to account failures in how the service is provided";*
- The introduction of the new regulations and fundamental standards changes the emphasis of the CQC to a role of an enforcement body not just a regulator;
- The 12 new Fundamental Standards are more specific and focussed and set standards of care must not fall below these standards. If so the CQC will take enforcement action;
- Some of the regulations introduce an absolute duty on providers;
- All regulations are potentially subject to prosecution and may involve immediate risk of criminal action;
- Breach of duty may result in prosecution and fines.

Potential Criminal action[5]:

- Direct Prosecution (no need to show harm);
- Fines (now unlimited) – see point ***(1);***
- Penalty notices with fixed fines (to be paid within 28 days).

Other enforcement action at the disposal of the CQC can be:

- Cancel registration;
- Suspend registration;
- Impose, vary or remove conditions of registration;
- Requirement notices;
- Warning notices;
- Special administration for 'Foundation Trusts' following warning notices.

- The CQC and HSE MoU to deal with H&S incidents involving service users. The HSE are currently training the first 40 CQC inspectors in criminal investigations and evidence gathering, currently the CQC inspectors are shadowing HSE Officers.

- CQC Inspections follow Key Lines of Enquiries developed for inspection key questions[6]. Formulation of rating requirements (Outstanding, Good, Requires Improvement and Inadequate) for the 5 key areas.

Compliance with the regulations

- Training for key staff to fully understand the new standards as they apply;
- Review of policy, procedures and supporting documentation and system in line with the new regulations;
- Risk assessment and record keeping at all levels;
- Review the working links between clinical and non-clinical;
- Patient safety leads to understand the focus of the fundamental standards, CQC approach (in particular on incident investigations and evidence gathering).

[4] The Essential Standards were seen as 'insufficiently focused' – Francis Report

[5] Defence for a registered person, or (in the case of regulation 20(2)(a) and (3)) a health service body, to prove that they **took all reasonable steps and exercised all due diligence to prevent the breach of any of those regulations that has occurred**.

[6] Safe, Effective, Caring, Responsive and Well-led.

Summary of new regulations introduced under section 1
Regulation 5[7] – Fit and proper persons: Directors: Directors must meet certain criteria and be of 'good character') be competent to carry out their role taking into account reasonable adjustments. Directors must also be responsible for serious incidents of misconduct or mismanagement in carrying out a regulated activity.

Summary of new fundamental standards under section 2
Regulation 20[8]: Statutory duty of candour: Requires registered persons to open and honest with people when something goes wrong with their care or treatment. Setting out legal duties on when and how to notify people who using their service and notification arrangements to CQC.

Regulation 20A: Requirement to display of performance assessments: Requires care providers to display their CQC rating conspicuously at their premises and on their web site.

(1) Supporting this **Section 85 of other Legal Aid, Sentencing and Punishment of Offenders Act 2012 (into force 12 March 15)** this will apply to H&S and other serious offences. Section 85 removes the limits of fines under the Health and Safety at Work, etc Act 74 (£20,000) and (£5,000) for Regulations made under the Act imposed in Magistrates court; this means magistrates courts can now impose unlimited fines. In the case of a significant charge this will be dealt with an authorised District Judge[9].

The removal of the upper limits of fines is to allow Magistrates and District Judges with a framework to ensure the levels of fines are commensurate with a defendant's culpability.

Section 3 of the Powers of Criminal Courts (Sentencing) Act 2000 can be invoked in order to allocate a case to crown court for sentencing where an organisation has an income in excess of £250 million.

[7] Introduced to NHS bodies November 2014
[8] Introduced to NHS bodies November 2014
[9] As defined in Criminal Practice Direction XIII annex 3 (p49)

Full list of Standards for Reference

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 4: Requirements where the service provider is an individual or partnership

Regulation 5: Fit and proper persons: directors

Regulation 6: Requirement where the service provider is a body other than a partnership

Regulation 7: Requirements relating to registered managers

Regulation 8: General

This regulation is one of the fundamental standards

Regulation 9: Person centered care

This regulation is one of the fundamental standards

Regulation 10: Dignity and respect

This regulation is one of the fundamental standards

Regulation 11: Need for consent

This regulation is one of the fundamental standards

Regulation 12: Safe care and treatment

This regulation is one of the fundamental standards

Regulation 13: Safeguarding service users from abuse and improper treatment

This regulation is one of the fundamental standards

Regulation 14: Meeting nutritional and hydration needs

This regulation is one of the fundamental standards

Regulation 15: Premises and equipment

This regulation is one of the fundamental standards

Regulation 16: Receiving and acting on complaints

This regulation is one of the fundamental standards

Regulation 17: Good governance

This regulation is one of the fundamental standards

Regulation 18: Staffing

This regulation is one of the fundamental standards

Regulation 19: Fit and proper persons employed

This regulation is one of the fundamental standards

Regulation 20: Duty of candour

This regulation is one of the fundamental standards

Regulation 20A: Requirement as to display of performance assessments

This regulation is one of the fundamental standards

Care Quality Commission (Registration) Regulations 2009

Regulation 12: Statement of purpose

Regulation 13: Financial position

Regulation 14: Notice of absence

Regulation 15: Notice of changes

Regulation 16: Notification of death of service user

Regulation 17: Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983

Regulation 18: Notification of other incidents

Regulation 19: Fees

Regulation 20: Requirements relating to termination of pregnancies

Regulation 22A: Form of notifications to the Commission

York Teaching Hospital NHS
NHS Foundation Trust

Trust Fire Safety Report
(For the period 1st Jan 2015 to 31st Mar 2016)

Executive Summary:

During the 2015 calendar year and up to the end of March 2016 the Trust has continued to meet its obligations under all current legislation and remains broadly compliant in maintaining those obligations.

As part of the continuing commitment to make good/upgrade breaches to the structural/passive fire protection across all sites work continued during the above reporting period and this will remain an ongoing commitment. A budget, subject to the normal financial constraints will be made available through business case approvals to continue this work during FY2016/17. The Admin Block at York remains one of the priorities as a possible next phase area. All such work will continue to be carried out by third party accredited contractors, which ensures a standard of work satisfying current legislation and will serve to ensure a robust level of quality assurance and compliance for the Trust.

A comprehensive survey and design initiative took place across the 2 main hospital sites during the early part of 2015 with a view to replacing the fire alarm systems at York & Scarborough. Work was due to commence in Apr 2015 but the project unfortunately had to be deferred with a re-start date during the early part of the 2016/17FY.

Portable fire extinguisher maintenance and annual servicing across all Trust premises continues and will continue into the future to be undertaken by in house maintenance staff operating out of the estates department at Scarborough.

Fire Safety Risk Assessments and reviews continue to be undertaken by the relevant fire advisors across all sites, thereby providing the board with assurances that we meet all current statutory duties placed upon us by current legislation. *(See table below)*

Following on from the internal audit of 2014, fire safety management was again subjected to a **further rigorous audit review during 2015**. This was undertaken as a result of the recommendations made in the 2014 report. We can report/confirm that fire safety across the Trust was awarded a **significant assurance** rating.

York received no audit inspections by the North Yorkshire Fire & Rescue authority during 2015, but has up to the end of March 2016 been subject to 2 inspections (Archways & Ward 14) both of which received a broadly compliant/satisfactory rating.

Fire Safety groups are now well established across both York and Scarborough, with both groups meeting 4 times per year. Transparency is served through accessible folders held on the Trust's Q-Drive facility and is subject to audit/scrutiny.

Training – 1st Jan 2015 to 31st Mar 2016:

Approximate Total manpower figures: 9,200	
York Staff trained (face to face) during 2015 (Calendar Year):	853
York Staff trained (face to face) 1st Jan – 31st Mar 2016	520
Scarborough Staff trained (face to face & Fire Warden) during 2015 (Calendar Year):	* *(25 Fire wardens Trained)*
Scarborough Staff trained (face to face) 1st Jan – 31st Mar 2016	*
E-Learning/Learning Hub **Corporate Induction** **Fire Warden (York)** **Other** *(HCA Induction-York)*	*90* *869* *40* *40*
APPROXIMATE TOTAL TRAINED	*2,437*
Approximately 9,200 Trust personnel will be required to undertake fire safety training over a 3 year period. During 2014 Fire Training was re-organized across the Trust and the requirement for face to face training was changed to a 3 year schedule. Therefore on an annual basis we would now expect to train a third of that total manpower figure (approximately 3000 every year). That annual target was exceeded during 2015. The current CLaD figures as at Mar/Apr 2016 show a rise in compliance of between 81% & 88%	

** Scarborough figures still to be added*

Fire Alarm Activations

Location	Cause of Activation	2015	Up/Down on 2014	Comments
York	Steam Leak	5	Down	
York	Toaster's	4	Up	
York	Unknown Cause	7	Up	
York	Accidental	2	Down	
York	Contractors	6	Up	
York	Aerosols	4	Down	Air Freshener/Deodorants
York	Chemicals	1	Down	Deep cleaning of ward areas
York	Patients	6	Up	Patients on Ward 37
York	Deliberate	1	New 2015	Patient in ED
York	Water Leak	1	New 2015	Ophthalmology (1st Floor)
	Total for York	**35**		

Location	Number of Alarms	Comments
Scarborough	21	
Bridlington	18	
Total for Scarborough area	**39**	

The above figures cover the period include the period 1st Jan 2015 – 31st Mar 2016

Fire Risk Assessments/Reviews

The fire advisors across both York and Scarborough continued to carry out assessments and reviews over this reporting period. The breakdown for which is as follows:

For the calendar year 2015

Region	Number
Scarbrough	65
York	102

For the period 1st Jan to the 31st March 2016 the York fire advisor has completed 10 reviews (off the 2016 schedule).

M R Lee GIFireE, MIFPO, MIFSM
Trust Fire Safety Advisor (York)

K Hudson
Trust Fire Safety Advisor (Scarborough)

Annual Statement of Fire Safety 2015

NHS Organisation Code: RCB	*NHS Organisation Name: YORK TEACHING HOSPITALS NHS FOUNDATION TRUST*	
I confirm that for the period 1st January 2015 to 31st December 2015, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and (please tick the appropriate boxes):		
1	*There are no significant risks arising from the fire risk assessments.*	*√*
OR 2	*The organisation has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment.*	*N/A*
OR 3	*The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks.**	*N/A*
**Where a programme to mitigate significant risks HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk. Date: N/A*		
4	*During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire & Rescue Authority? (Delete as appropriate) If Yes - Please outline details of the enforcement action in Annex A – Part 1.*	*No*
5	*Does the organisation have any unresolved enforcement action pre-dating this Statement? (Delete as appropriate) If Yes Please outline details of unresolved enforcement action in Annex A – Part 2.*	*No*
AND 6	*The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method.*	*√*

Director (Trust Fire Safety)	*Name:*	*B GOLDING Director of Estates & Facilities*
	E-mail:	*brian.golding@york.nhs.uk*
Contact details:	*Telephone:*	*01904 72 5149*
	Mobile:	*N/A*

Chief Executive Name:	***P CROWLEY***
Signature of Chief Executive:	
Date:	***12 January 2016***

Completed Statement to be forwarded to the Health & Social Care Information Centre ***No longer required***

The above certificate is to be attached as an Appendix/Annex to the Annual Fire Safety Report.

(as recommended by the Internal Audit Report 2014)

ANNEX A

Part 1 – Outline details of any enforcement action during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply.
N/A
Part 2 – Outline details of any enforcement action unresolved from previous years, including the original date, and the action the organisation has taken so far. Include any outstanding proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.
N/A

NHS Organisation Code RCB

NHS Organisation Name: YORK TEACHING HOSPITALS NHS FOUNDATION TRUST

Date: 12 January 2016

J3

York Teaching Hospital NHS

NHS Foundation Trust

Health and Safety Summary Report 2014/15

Incident Reporting

As part of the Trust safety management system monthly reporting of non-clinical incidents is undertaken, reports are reviewed for trend analysis and to identify any areas of concern of for potential targeted improvement work. In year there have been no specific areas or topics identified as a significant to cause concern to the Trust and that would require reporting to the Trust Board.

A key performance indicator for non-clinical health and safety is reporting to the UK Health and Safety Executive under the requirements of The Reporting of Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR). Trust review of RIDDOR reports is undertaken on a weekly basis with reported incidents informed to the Trust5 Executive team as they arise. Trend analysis is undertaken to identify any specific topics to inform any specific work stream.

For 2014/15 35 RIDDOR reports were made by the Trust, the type and cause are represented in *Appendix 1*.

Internal Audit Y1534

In year the Trust internal audit function carried out a review of the Trust safety management systems giving limited assurance, the findings of the report were agreed and actions plans developed to address items identified.

Trust Health and Safety Audit Tool

As part of the Trust safety management system the annual self-assessment audit is undertaken across the Trust, the audit contains 8 mandatory standards covering:

- Safety and Risk Management
- Incident Reporting
- Fire Safety
- Slip, Trip and Fall Prevention
- Work Related Stress
- Infection Prevention (All Areas and Staff)
- Learning from Experience
- Incident Investigation

And 15 Risk Specific Standards

- Infection Prevention
- Moving and Handling of People
- Moving and Handling of Objects
- Human Tissue Act
- Substances Hazardous To Health (COSHH)
- Violence and Aggression
- Clinical Waste Handling and Disposal

- Display Screen Equipment
- Laser, Non-ionising Radiation & Artificial Light Sources
- Ionising Radiation
- Safety in Patient Areas
- Safe Use and Disposal of Sharps
- Latex
- Medical Equipment
- Resuscitation

Each year the audit is shared with operational directorates who are asked to complete the self-assessment audit and score against prescribed criteria to provide assurance of adherence to Trust policy and guidance. The scores from each area are aggregated and a final Trust wide score is obtained. For 2014 (audit is currently carried out in line with calendar year) **84% compliance** was achieved across the Trust.

Work of Safety Committees and Groups

Continual improvement of the Trust safety management system has resulted in a full review of the Trust non-clinical committee and groups, as part of this review the decision was made to create a new executive committee (Environment and Estates Committee (EEC)) to oversee all aspects of Trust non-clinical safety performance; reporting directly to and providing assurance to the Trust Board.

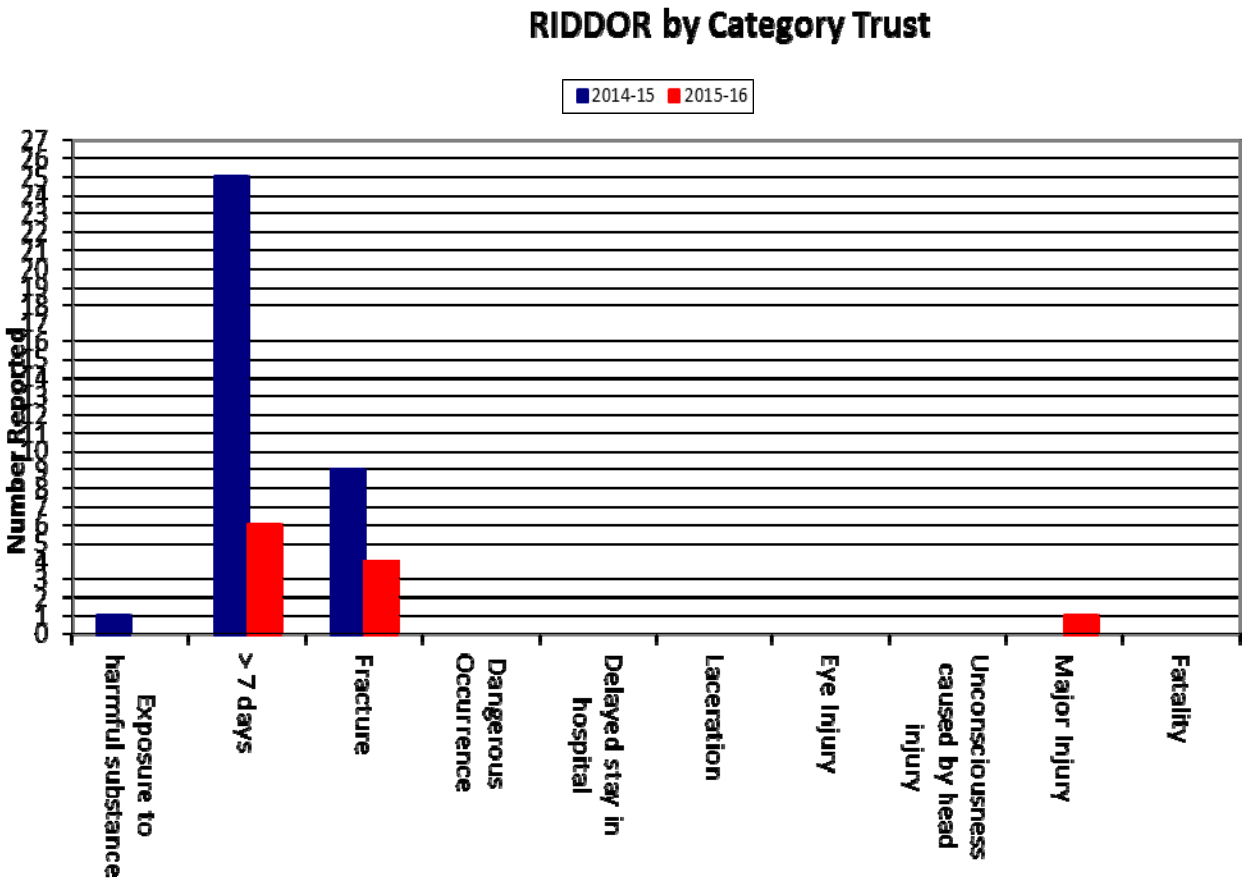
Below the EEC sit the Health Safety and Non-clinical Risk Group and the Trust operational Health and Safety Committees and Groups fulfilling the requirement of consultation with all staff groups within the Trust and key external stakeholders. With these groups having representation from directorates and receiving highlight reports this provides a link to Trust operational non-clinical safety matters.

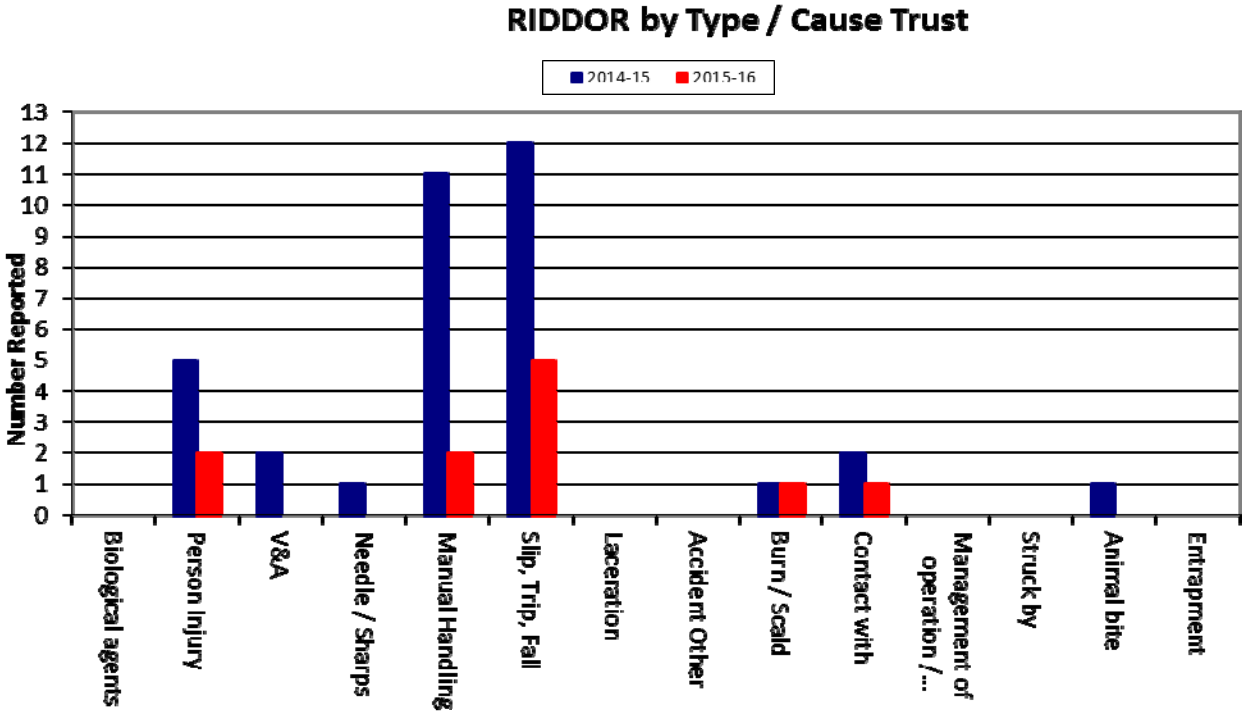
In year the key committees have met at required frequencies undertaking their annual cycles of business.

General

In year the Trust received no inspections or interventions from the UK Health and Safety Executive, Care Quality Commission, Environmental Agency, Environmental Health (with the exception of routine food hygiene inspections of the Trust) or any other relevant regulatory authority.

Appendix 1


RIDDOR by Category Trust
2014-15
2015-16
Number Reported
Exposure to harmful substance
> 7 days
Fracture
Dangerous Occurrence
Delayed stay in hospital
Laceration
Eye Injury
Unconsciousness caused by head injury
Major Injury
Fatality


RIDDOR by Type / Cause Trust
2014-15
2015-16
Number Reported
Biological agents
Person Injury
V&A
Needle / Sharps
Manual Handling
Slip, Trip, Fall
Laceration
Accident Other
Burn / Scald
Contact with
Management of operation /...
Struck by
Animal bite
Entrapment