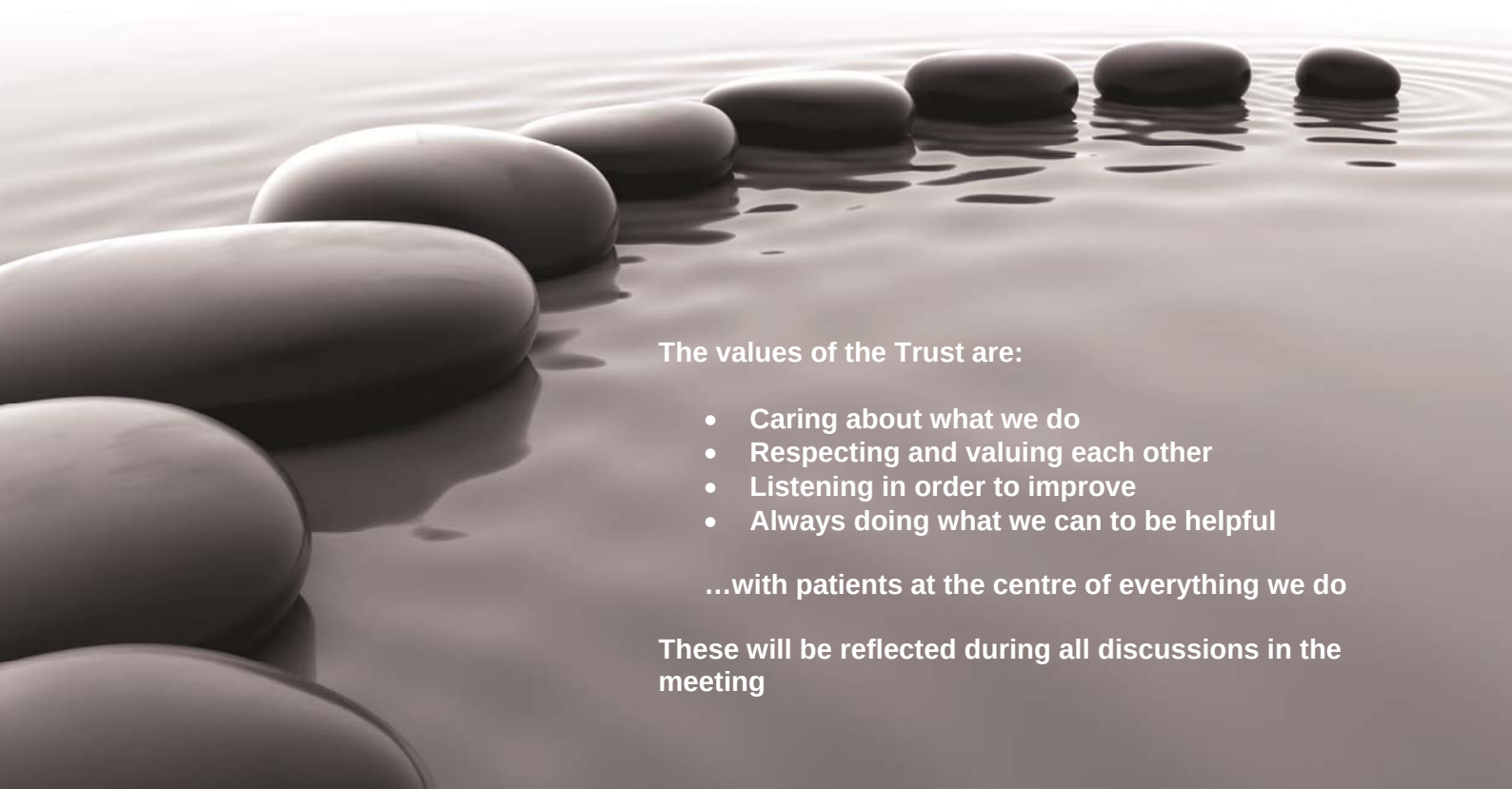
York Teaching Hospital NHS
NHS Foundation Trust

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

on: **Wednesday 29 July 2015**

in: **The Boardroom, The York Hospital**

Time	Meeting	Location	Attendees
8.15am – 8.55am	Non-Executive Director Meeting with Chair	Susan Symington's Office	Non-executive Directors
9.00am – 11.30am	**Board of Directors meeting held in public**	**Boardroom, York Hospital**	**Board of Directors and observers**
11.30am – 12.00 Noon	Charitable funds Committee	Boardroom, York Hospital	Board of Directors
12.00 Noon – 12.30pm	Lunch		
12.30pm – 2.30pm	Board of Directors to consider confidential information held in private	Boardroom, York Hospital	Board of Directors



The values of the Trust are:

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

…with patients at the centre of everything we do

These will be reflected during all discussions in the meeting

York Teaching Hospital NHS
NHS Foundation Trust

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

On: **Wednesday 29 July 2015**

At: **9.00am – 11.30am**

In: **The Boardroom York Hospital**

A G E N D A					
No	**Time**	**Item**	**Lead**	**Paper**	**Page**
Part One: General					
1	9.00-9.10	**Welcome from the Chairman** The Chair will welcome observers to the Board meeting.	Chair		
2		**Apologies for Absence and Quorum** Philip Ashton, Non-executive Director Mike Proctor, Deputy Chief Executive Andy Bertram, Director of Finance	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 24 June 2015** To review and approve the minutes of the meeting held on 24 June 2015	Chair	B	13
5		**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chair		

No	Time	Item	Lead	Paper	Page
6	9.10-9.15	**Patient Story** To hear a patient story from Scarborough	Chief Nurse	Verbal	
7	9.15-9.35	**Chief Executive Report** To receive an update on matters relating to general management in the Trust	Chief Executive	C	25
Part Two: Quality and Safety					
8	9.35-10.05	**Quality and Safety Performance issues** To be advised by the Chair of the Committee of any specific issues to be discussed. • Patient and Quality Safety Report • Medical Director Report • Falls Report • Pressure Ulcer Report • Chief Nurse Report • Safer Staffing	Chair of the Committee	D D1 D2 D3 D4 D5 D6	57 67 101 111 123 131 155
9		**Quarterly DIPC report** To consider and approve the quarterly DIPC report		E	163
10		**Patient Experience Strategy** To consider and approve the Patient Experience Strategy		F	173
11	10.05-10.20	**Community Care update** To receive an update on Community Care from the Community Director	Community Director	Verbal	

No	Time	Item	Lead	Paper	Page
Part Three: Finance and Performance					
12	10.20-10.55	**Finance and Performance issues** To be advised by the Chair of the Committee of any specific issues to be discussed. • Operational Performance Report • Finance Report • Trust Efficiency Report • Performance Recovery Plan	Chair of the Committee	G G1 G2 G3 G4	181 191 201 215 221
13		**Emergency Care Standards** To receive a briefing on the Emergency Department performance	Chief Operating Officer	H	225
Part Four: HR and OD information					
14	10.55-11.25	**Equality and Diversity report including** • Annual E&D report to demonstrate our compliance with the Equality Act • EDS2 Summary Report • Workforce Race Equality Standard Report • Equality Objectives To approve the report	Director of Workforce and Organisational Development	I I1 I2 I3	265 385 395 401
15		**Staff Survey update report** To receive an update on the Staff Survey	Director of Workforce and Organisational Development	J	415
16		**Workforce Strategy Committee** To receive the draft minutes from the meeting held on 20 July 2015	Chairman of the Committee	K	419

No	Time	Item	Lead	Paper	Page
Part Five – Monitor submission					
17	11.25-11.30	**Monitor quarterly return** To approve the quarterly return to be submitted to Monitor	Chief Executive	L	429
Any other business					
18		**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 19 August 2015 in the Boardroom York Hospital			
19		**Any other business** To consider any other matters of business.			

Items for decision in the private meeting:

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

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

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

Register of directors' interests
July 2015

York Teaching Hospital NHS
NHS Foundation Trust

Additions: Dr Ed Smith, Interim Medical Director
Mr J Taylor, Interim Medical Director

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Changes: No changes

Deletions: Dr Alastair Turnbull has retired from the Trust

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

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

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	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or 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
Mrs Sue Holden (Executive Director of Workforce and Organisational De-velopment)		**Director –** SSHCoaching Ltd		**Member -**Conduct and Standards Committee – York University Health Sciences **Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
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

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	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or 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
Dr Ed Smith Interim Medical Di-rector	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Jim Taylor Interim Medical Di-rector	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

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Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Boardroom, The York Hospital on 24 June 2015.

Present:	**Non-executive Directors**	
	Ms S Symington	Chairman
	Mrs J Adams	Non-executive Director
	Mr P Ashton	Non-executive Director
	Mr M Keaney	Non-executive Director
	Ms L Raper	Non-executive Director
	Mr M Sweet	Non-executive Director
	Professor D Willcocks	Non-executive Director
	Executive Directors	
	Mr P Crowley	Chief Executive
	Mr A Bertram	Director of Finance
	Mrs B Geary	Chief Nurse
	Mrs S Holden	Director of Workforce and Organisational Development
	Mr M Proctor	Deputy Chief Executive
	Dr E Smith	Interim Medical Director
	Mr J Taylor	Interim Medical Director
	Mrs J Walters	Chief Operating Officer
	Corporate Directors	
	Mr B Golding	Director of Estates and Facilities
	Mrs S Rushbrook	Director of Systems and Networks
Attendance:	Mrs A Pridmore	Foundation Trust Secretary
Observers:	Mrs A Bolland	Public Governor – Selby
	Mrs S Miller	Public Governor – Ryedale and East Yorkshire
	Mr P Baines	Public Governor – York
	Mrs M Jackson	Public Governor - York

The Chairman welcomed the Governors and the two Interim Medical Directors - Dr Ed Smith and Mr Jim Taylor to the meeting. She asked Mrs Pridmore to confirm the meeting was quorate. Mrs Pridmore confirmed the meeting was quorate

15/094 Apologies for absence

Apologies were received from Mrs S Holden, Director of Workforce and Organisational Development. Ms Symington explained that Mrs Holden was attending a meeting in London as part of a workshop hosted by Dame Carol Black. The Trust had been invited to attend as an exemplar organisation around Workforce wellbeing and engagement.
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15/095 Declarations of Interests

The Board of Directors noted the current list of interests declared. The Board were reminded that if there were any changes to interests declared they should advise Mrs Pridmore.

It was noted that the document should be adjusted to remove Dr Turnbull and include Dr Smith and Mr Taylor.

15/096 Minutes of the meeting held on the 26 May 2015

The minutes were approved as a true record of the meeting

15/097 Matters arising from the minutes

15/084 Quality and Safety Committee – Family and Friends Test

At the last meeting the Board asked for a further Family and Friends Test update to be given by Mrs Geary. Mrs Geary advised that the Quality and Safety Committee had noticed a reduction in responses being received. She explained there had been a change in how the numbers were calculated. The calculation now takes into account all day-case patients and includes them in the inpatient numbers, so the denominator has increased resulting in a reduction in the response. This has been seen nationally and noted by NHSE.

The Board noted the change and the impact of the change and will continue to monitor the Family and Friends Test score.

15/098 Patient Story

Mrs Geary presented a patient complaint. She provided an overview of the complaint and explained how it reflected the complexity of our systems. Mrs Geary explained that the complaint had been followed up by a Matron. One of the key issues identified from the investigation was the importance of the patient and relative receiving all the information they need in a way that is accessible and easy to understand. In this case the complainant had been provided with a wealth of information, but this had resulted in the complainant being confused about how best to access care for the patient.

Ms Symington commented that we should put ourselves 'in the patients' shoes' and treating people as individuals.

Professor Willcocks commented about work being undertaken in the community that she had been impressed with, particularly around staff never saying no and not passing patients on to another person without responsibly making sure everything is understood.

Mr Crowley reflected on a recent meeting with a research organisation. He had been asked for his views about healthcare reform. In the meeting he had discussed the different types of reform – political, motivation and quality. He talked about tapping into the vocational spirit of those providing services and putting patients at the centre of everything the Trust does.

15/099 Report from the Chief Executive

Mr Crowley talked about the Chief Executive's meeting he had attended with NHS Providers. He reflected on the presentations and their familiar themes.

At the event the Chief Executive of NHS Providers, Chris Hopson had spoken about the political climate hardening and explained there were three options:

- Putting more money in the system – that was not expected to happen
- Changing what can be provided – it was not anticipated such a debate would take place
- Managing resources more effectively on the provider side which is the option Trusts are working with.

Additionally Lord Carter had reviewed procurement across the NHS and had reluctantly identified a savings figure of £5bn to be realised by 2019/20.

This summary of the meeting reaffirmed the Trusts understanding of the direction the Trust needs to take. Mr Crowley added that he has no doubt that future discussions centrally will be led by financial concerns. Mr Crowley observed that some of the requirements of the Francis Report were changing. Mrs Geary supported this observation including the announcement of the suspension of safer staffing information collection.

Mrs Geary attended the Deputy Chief Nurse meeting recently with the Chief Nursing Officer for England where there were comments about the safer staffing initiative and nurse staffing numbers.

The Emergency Department guidance has not been launched as planned and it has been understood the guidance around staffing levels is unaffordable. Historically this guidance has not involved senior nurses, but the Chief Nursing Officer for England had been asked to look at the safer staffing issues, so it is hoped nursing staff can now influence any guidance development. Mrs Geary also reflected on some good practice being seen at a Trust in Manchester where they have 80 Band 4 highly trained staff and has one of the best skill compliments in the country.

CQC reports - Mr Crowley reminded the Board the CQC had intended on holding their internal meeting on 12 June and the Trust had been asked to hold the 21 July for the Quality Summit. The Trust had still not received the reports for comment, so he now suspected that the date for the Quality Summit would slip. Mr Crowley confirmed when the reports are received the organisation will be briefed. He expects the Trust to be required to make a quick assessment of the reports and provide any challenge on detail back to the CQC quickly.

Mr Crowley confirmed he would advise the Board at the next meeting of any progress during the month.

Agency working – Mr Crowley talked about the importance of agency staff and the value they add to the organisation. He explained that the suggestion that agency staff cost are two or three times more than a substantive member of staff is misleading, although it is

recognised there is a premium. Agency staff have chosen to work flexibly, to suit their particular circumstances, and are no less valued than substantive staff.

Medical Director – Mr Crowley warmly welcomed Dr Smith and Mr Taylor to the meeting as Interim Medical Directors who will assume the role until a substantive appointment is made. He outlined the timetable for the recruitment process.

The role will be advertised on 17 August 2015 and will be open for 28 days, closing on 14 September 2015. The short listing will take place between 15 and 21 September 2015. The Assessment Centre will take place on 20 October and interviews will be held some time between 21 and 23 October dependent on panel availability.

Lessons Learnt – Mr Crowley thanked those who had been involved in the recent research meeting on the Scarborough acquisition. He was pleased Monitor and the CASS Business School had sought the Trust out to be part of the study. He reminded the Board it had always been his view that where ever possible, the Trust would share its knowledge and experience of the Scarborough acquisition.

Media coverage – Mr Crowley talked about the arrangements for the stroke service and explained that Mrs Walters had attended a public session with Mr Cox (Chief Officer for Scarborough and Ryedale CCG) to present the changes and outline the difficulties around recruitment. He explained that the Trust will always deploy services on the east coast that are appropriate and financially viable.

External awards – Mr Crowley congratulated Mr Golding and his team on being shortlisted for 'Client of the year' and 'Integration and collaborative working'.

Celebration of achievement award – Mr Crowley advised the Board the nominations were open, closing on 24 July 2015. He advised the event would be held on 1 October in Scarborough. All Board members are encouraged to attend this celebration.

The Chair thanked Mr Crowley for his report and acknowledged the challenges faced by the executive team, and the balance required at Board between challenge and support.

15/100 Quality and Safety Committee

Ms Raper advised that the Committee had welcomed Dr Smith to the Committee and looked forward to his contribution.

She expressed frustration at the amount of information being received by the Committee and asked if it would be possible to have more trend-based information. Mrs Rushbrook agreed she would discuss in more detail outside the meeting.

Action: Mrs Rushbrook to discuss more trend-based information with Ms Raper outside the Board meeting.

Referring to the notes of the meeting Ms Raper highlighted following topics:

Cold babies – this continues to be an issue which continues to be discussed, although there were no specific actions to be discussed.

Family and Friends Test – The Committee is looking forward to working with the new lead for patient experience.

Infection Control – The Committee received assurance of the continued application of control measures. Ms Raper asked Mrs Geary as Interim Director of Infection Prevention Control, to comment on any other actions the Trust could take.

Mrs Geary reported to the Board there had now been five cases of MRSA, 20 C-Diff cases and 10 MSSA cases.

A root and branch review of the infection control from ward to Board was being undertaken, which includes a review of the membership of the Hospital Infection Prevention Control Group. Lots of actions have been taken around cannulisation practice and Public Health England had been invited to come and provide some advice to the Trust. Since taking on responsibility for infection control Mrs Geary has met with the team and sought to involve Dr Smith and Mr Taylor.

Mrs Geary advised, of the cases declared, there had been no cross contamination in the C-Diff or MSSA.

There is a focus around MSSA as the Trust was an outlier last year. As reported to Board before, new training in Aseptic techniques has been taking place for medical staff which should result in a reduction in the number of cases being reported.

Mrs Adams was concerned about the financial implications of the increase in health associated infections and asked what progress had been made against the proposal to reconfigure beds. Mr Golding advised there were a range of plans in place. The amalgamation of short stay ward and the acute medical unit was complete. He explained there had been some challenges progressing the work further because the wards had been busy.

Mr Golding described the newly installed card access system used on the wards, and he explained the wards can adjust access during the day and limit access when needed for example if there is an outbreak of health associated infection.

Mrs Walters added that the bed configuration modelling has been completed, Mrs Rushbrook explained her department was involved in a piece of work looking at length of stay. Specifically looking at what that information can tell the Trust and how it could support decision making about any bed reconfiguration. She explained the her team had reviewed five years of data including spells and procedures for each patient in the General Surgery and Urology Directorate and had met with the Directorate recently to discuss the data and ensure the Directorate understood the information and recognised their ownership of it.

The Board noted the comments and the work being undertaken by Mrs Geary.

Waits in the Emergency Department – The Committee were concerned that there were now 8 hour waits in the Emergency Department and had asked for assurance that safety of patients was not being compromised.

Dr Smith echoed the Committees concern that patients were waiting 8 hours for a bed. He reflected that it was a symptom of the problems being experienced in the Trust. He added that he could assure the Board and the Committee that safety was not compromised. COMFE rounds had been introduced in the Emergency Department and had been supported by the use of Healthcare workers.

The Board expressed on-going concern at the challenges faced in both Emergency Departments.

Child Safeguarding – The Committee had noted the improvements reflected in the report provided to the Committee.

End of Life Care – Ms Raper reported the Committee was concerned about the funding of the education post. It was proposed that the funding might be through the Charitable Funds.

Professor Willcocks added her appreciation of the work being undertaken and the support from the Executive Directors.

Safer Staffing report – The Committee noted a reduction in vacancy levels. Ms Raper invited Mrs Geary to comment further on the report. Mrs Geary explained the 142.1% staffing at St Monica's was based on 12 midnight and 12 midday occupancy level. As a result of the recent national discussion and announcement, these measures of reporting are unlikely to continue, it is expected future reports will be based on reporting over 3 shifts.

Ms Symington asked Mr Proctor to comment on the recent event at St Monica's. Mr Proctor explained this was a public meeting and currently there was more work to complete on the outcome in collaboration with the CCG.

Successful recruitment – Mrs Geary advised 72 offers have been made to nurses studying at York University. She expected them to join the Trust is September 2015. 65 had already accepted offers.

It is hoped that, following discussions with the University, the nurses will be able to work for the Trust before September allowing them to integrate into their teams earlier. Mrs Geary added 'Get On Board Days' have been arranged to be held in York and Scarborough which will allow the nurses to start their preceptorship early.

In terms of EU recruitment, Mrs Geary advised she was waiting for some final costings, and that the intention is to have a blended approach to recruitment.

In terms of international recruitment, she reflected recent announcements by the Government have created ambiguity around this option. International recruitment is currently on hold.

Mr Keaney commented it was excellent news on the recruitment of nurses, but asked about the progress made on the recruitment of doctors. Dr Smith outlined some of the approaches being taken, particularly around specialisms to which it is difficult to recruit

doctors to. He explained other models of care are being put in place for those areas including introducing the Advanced Clinical Practitioners who are in their final stages of training. He added medical workforce non training grade doctors are a committed group of staff who are also being invested in to support their development.

Mrs Geary added that HCA recruitment continues and the Trust recruits above the vacancy level so that it has staff available who can up-skill to Band 3.

Mrs Adams asked about senior review. She was concerned that only 60% acute admissions receive a senior review within 12 hours. Dr Smith explained there were multiple issues related to senior review including a challenge around resources. Electronic prompts are useful and are used. 7 day working is part of the solution along with understanding how to get the most senior person to review the patient as soon as possible. A significant amount of work needs to be completed before the review can be delivered consistently.

The Board thanked Ms Raper for her summary of the meeting and for the additional comments made by Mrs Geary and Dr Smith.

15/101 Community Care update

Mr Proctor explained he would report on each area individually.

Whitby – The process for handover to Virgin Health on 1 July and the final TUPE arrangements were discussed.

Ms Symington asked if the Board would see any difference in the finance report. Mr Bertram explained not because it had already all been planned for.

Scarborough/Ryedale – Mr Proctor reminded the Board that currently the CCG has served notice on the Trust for the services in the Community. The CCG have advised they will make a decision on the future of the services following their Governors meeting.

He added there are three themes being considered:

- Acute Services
- Wellbeing
- Out of hospital care

Mr Proctor added a further Vanguard bid will be progressed by Mrs Walters.

Selby/ York – the provider alliance is progressing well. A whole system meeting has taken place that included Harrogate and Humber where a vision and principles were agreed. There are now teams of people to support patient progress in the localities. The next meeting will be held mid July.

The Board thanked Mr Proctor for his update.

15/102 Finance and Performance Committee

Mr Keaney presented the minutes from the Committee meeting. The Committee recognises staff are working very hard to deliver a good service and is very conscious that areas of poor performance should not become normalised, for example performance in ED. The Committee is aware of the interrelationship of the issues and challenges, and the of work programmes developed to reduce these challenges. Mr Keaney asked if there was a way to pull all this work together and arrange a special half day meeting to look at all the issues.

Mr Keaney explained the Committee had spent a considerable amount of time discussing the performance issues and the Committee was assured by the improvement in delivery around the Cancer targets, but the level of cancelled operations was concerning. He invited Mrs Walters to comment.

Mrs Walters assured the Board the 18 week performance was ahead of plan for recovery. The Team has worked hard to achieve the results. Delivery against the three Cancer targets has also progressed well. Breast surgery is the only Cancer target that has not been achieved, mainly due to patient choice. Further work with the CCG is being carried out.

Mrs Adams asked if the long term solution to the 18 week issue was to use external providers, which would have a financial impact on the organisation. Mrs Walters confirmed it was a short term solution.

Diagnostics saw a reduction in the number of breaches in the last month. A business case, supported by the Corporate Directors has allowed for additional investment to be made to support delivery and some work has been passed to the private sector to undertake.

The Emergency Department issues are different on both sites.

York – the non admitted patient element is affecting the delivery in York, work continues to review other actions that can be taken. Mr Ashton asked about the changes in the department. Mrs Walters confirmed there were workforce and process issues that were being addressed.

Mr Ashton recognised the acuity profile of patients was a major issue, but was seeking assurance about the completion of the physical and environmental projects that are still on-going in the department. Mr Golding confirmed the work would be finished by the end of this year. Mrs Walters added there was work being completed around acuity.

Scarborough – the patient flow is an issue in Scarborough. To support the department a geriatrician has been added to the clinical team in the department. This is a new initiative and an update will be given at the next Board.

Action: Mrs Walters to update the Board on the inclusion of a geriatrician in the Emergency Department at the next meeting.

Mrs Walters added there is a lack of access to intermediate care beds in Scarborough. A ward has been created in the hospital for patients whose discharge has been delayed. She added currently it can take seven days for an assessment to take place and this is too long.

Ms Raper asked if the 4-hour target in the operational performance plan would be reassessed. Mrs Walters agreed the target would need to be reviewed and a discussion would be held with the Executive Team.

Dr Smith added the Emergency Department target is challenging and there are different difficulties in each department, but overall the patients coming through the doors in Scarborough and York are the same, and in theory the solution in the long term should be the same, but as has been demonstrated the interim solution is different. Different solutions are being tested on both sites.

Mr Sweet asked about the new guidance from NICE around Cancer referrals and how that would affect the Trust. Mrs Walter explained the guidance would need to be mapped across the organisation and the Cancer Board are sighted on it. The introduction will start with a pilot which will give the system intelligence about the number of referrals that can be expected and allow time to plan. Mr Bertram added that such guidance does have the potential for disruption, but it is helpful to have notice around the changes.

Mr Keaney asked Mr Bertram to comment on the finance report for month two and the Cost Improvement Programme.

Mr Bertram outlined the income and expenditure position reported for May. It represents a slight improvement in terms of variance from plan when compared to month one. The variance at month one was £500k and for month two it is £400k, although the actual reported position has worsened by £1.1m from £1.5m to £2.6m. He believed this did not reflect a structural deficit position in the organisation.

The position in relation to contract penalties is very disappointing. After two months the penalties incurred are £1.1m. On the strength of the developing RTT national picture and the agreement by Commissioners to the Trust's improvement trajectory, the reported penalties do not include £0.25m related to 18 week delays

Mr Bertram highlighted pay expenditure. Spend in May was £26.2m compared to April at £26.1m. The increase was influenced by the recent pay awards and agency and locum costs. The Trust continues to draw heavily on the planned contingencies to cover the premium agency costs. Mr Bertram added the under spend of £0.45m on pay related to the return of non-recurrent CIP from 2014/15 and was somewhat artificial whilst directorates considered their position.

Efficiency report

Mr Bertram advised he was pleased with the CIP progress this month. He reminded the Board the annual target is £26m. To date £4.8m has been achieved which is 19% of the annual target, (last year at this time the Trust had achieved 16%). £3.3m is recurrent which is untypically high. Mr Bertram expects the Trust to return to more normal levels of recurrent v non-recurrent delivery as we progress through the year.

Ms Raper asked about the Quality impact assessment for CIPs, enquiring who was undertaking the assessment of schemes from a clinical perspective. Mr Bertram advised that Mrs Geary has identified a member of her team, Ms Helen Hey, Deputy Chief Nurse, to undertake the assessments and Mr Martin Telfer, Assistant MD, to also assess the schemes.

Mr Bertram drew the Board's attention to the new information included in the report that related to Service Line Reporting. He explained the information would be developed over the next few months but would feature as part of the standard pack.

Mr Golding asked if the information could be used to support any bidding the Trust undertakes. Mr Bertram confirmed it could. He used the MSK Service as an example.

Mrs Adams asked how useful it was to know what services were loss making. Mr Bertram explained it was useful and described work being undertaken to reduce the losses made by those services. Specific examples were discussed where corrective action has been possible.

Professor Willcocks added that looking at the elderly medicine it becomes a compelling case for people to be treated in the community.

Ms Symington thanked Mr Bertram for his report.

15/103 Workforce Strategy Committee

Professor Willcocks summarised the information included in the minutes. Professor Willcocks highlighted a number of areas including the discussion the Committee had about junior doctors and the Committee's disappointment about the progress of the work around volunteers.

Professor Willcocks advised the Committee would be holding an extra meeting in July.

The Board noted the content of the minutes and work being undertaken by the Committee.

15/104 Corporate Governance Statement

The Board reviewed the statement, recognising that all members of the Board had had an opportunity to comment on the statement in advance of the Board meeting. There were no additional comments from members of the Board. The Chair mentioned she would like to review the statement one final time before it is submitted to Monitor and she may have some minor amendments she would like made.

The Board approved the statement subject to a final review by the Chair.

Post meeting note: Following a further review by the chair no changes were made and the document was submitted to Monitor as expected.

15/105 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 29 July 2015, Boardroom, York Hospital.

15/106 Any other business

Ms Symington reminded the Board the celebration of achievement award would be held on 1 October 2015 in Scarborough. She understood attendance by the Executive was mandatory and encouraging Non-executive Directors to attend if possible.

Ms Raper advised she would not be able to attend.

15/107 After the Private Board meeting

Following the private Board meeting the Board was invited to sample meals from the new patient menu prepared by the kitchen in Ellerby's Restaurant.

Post meeting note: The Board members were delighted with the quality of the food and the environment in Ellerby's Restaurant.

Outstanding actions from previous minutes

Minute number and month	Action	Responsible officer	Due date
14/174 Procurement update	Develop and bring to the Board a food and drink strategy.	Mr Golding	During 2015
15/087 Diverse Workforce	A proposal around investment in training for specialist and middle grades in the future to be presented to the Board when developed	Mrs Holden	future

Action list from the minutes of the 24 June 2015

Minute number	Action	Responsible office	Due date
15/100 Quality and Safety Committee	Discuss more trend based information with Ms Raper outside the Board meeting.	Mrs Rushbrook	Immediate outside the Board meeting
15/102 Finance and Performance Committee	Update the Board on the inclusion of a geriatrician in the Emergency Department at the next meeting.	Mrs Walters	July 15

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Chief Executive Report

Action requested/recommendation

The Board is asked to note the content of the report.

Summary

This report is designed to provide a summary of the operational issues the Chief Executive would like to draw to the attention of the Board of Directors.

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

Implications for equality and diversity

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

It is anticipated that the comments in 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	Report developed for the Board of Directors.
Risk	No specific risks have been identified in this document.

Resource implications	The paper does not identify resource implications.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	July 2015
Version number	Version 1

Board of Directors – 29 July 2015

Chief Executive Report

Turnaround Avoidance Programme: Delivering Success

Further to previous Board discussions regarding our plans to develop a work programme to arrest the deterioration of our performance and our financial position, the programme has now been officially launched with a briefing that has been shared within the organisation.

We will be increasing the communication around this programme over the coming weeks and months, and there will be a number of involvement sessions for staff at our main sites.

The Turnaround Avoidance Programme: Delivering Success is designed to provide structured support and governance to a number of initiatives intended to restore performance and improve finance. The Programme Director will be Gordon Cooney and the Trust's Corporate Improvement Team will move across to support the work.

The Team will work in a similar way to that of the Corporate Efficiency Team in that responsibility and accountability for delivery of the key turnaround avoidance initiatives are firmly placed with Executives, Senior Managers and Clinical Directorate Management Teams with the Turnaround Avoidance Team ensuring overarching governance, pace, and reporting are in place and will provide additional support to project delivery.

The team will be focussing on the following work streams:

- Performance improvement
- Fine eradication programme
- Expenditure control and discipline (including business case evaluation)
- Staffing and productivity
- Opportunities for income maximisation

As the Trust moves into its Turnaround Avoidance Programme there will be a number of immediate changes to the way we operate. These are all designed to ensure we focus relentlessly on delivering a quality service to our patients, comply fully with the required national and local standards and that we move quickly to once again living within our financial means.

These actions include a senior staff vacancy freeze (band 7 or above), increased elective activity delivery, tighter control of discretionary expenditure, post-implementation reviews of business cases, reinforcement of the Trust's scheme of delegation, and a requirement for all improvement initiatives to align their objectives to the Turnaround Avoidance Programme.

Each of these actions is designed to secure performance improvement or to bring our financial position back under control. These actions are representative of those that would feature as part of a formal turnaround process should the Trust find itself in breach of the terms of its operating license and ultimately be placed in special measures.

Every effort will be made to engage all staff in the organisation with the principles of the

programme, and open dialogue will be encouraged to enable staff to contribute their ideas for improvement.

The briefing that has been shared with staff is attached to this paper.

Seven day working and the consultant contract

Board members will no doubt have seen the widespread coverage resulting from the Health Secretary's recent announcement regarding seven day working and doctors' contracts.

Jeremy Hunt announced his intention to negotiate with the BMA to reform the current consultant contract, removing the opt-out from weekend working. The new contract would apply to all new doctors, and whilst existing doctors would not be moved on to the new contracts, the Health Secretary has committed to removing "extortionate off-contract payments" for those who work additional shifts at weekends despite having opted out of weekend working.

He has stated that there will now be a six week negotiation period with the BMA, however he intends to impose a new contract should the negotiations fail to reach a satisfactory outcome. He anticipates that by the end of this Parliament, the majority of doctors will be on seven day contracts.

I will be watching these negotiations with interest as they unfold, and depending on the outcome, we will need to consider the implications for our own staff and the expectations around future delivery of our services. However, I would like to reassure the Board that I do not consider the current level of remuneration, paid by prior agreement to medical staff working extra to contract, to be "extortion" and confirm that it is subject to an open and transparent approval process.

Of more importance, in my opinion, is the work we are doing to assess and address any deficit in our current provision when set against the ambition to provide effective and appropriate services on a 7 day basis, particularly for our most acutely ill patients. Our priorities for investment will include growing our medical workforce, improved access to diagnostics, and developing the infrastructure (including management) to support this. It will be equally important to see a commensurate growth in provision across the whole health and social care system to make this more meaningful. The challenge for us all will be to manage this progressively at a time of austerity.

The Health Secretary also alluded to a move to fewer targets in his speech, in exchange for greater transparency in the Health Service. Whilst there is every indication that the focus will continue to be strongly placed on finance, a shift away from targets might offer the necessary 'escape valve' for some of the pressures we are facing and is therefore encouraging, however we need to understand exactly what this means in practice.

Financial Position

Our month three financial position (April to June 2015) shows that we are some £1m worse than our planned deficit of £2.2m. The impact of this deficit directly reduces the organisation's cash levels. Most organisations that fail (in both the public and private sectors) do so because of pressure on their underlying cash levels. We are not immune or protected from this pressure and our ability to make investment choices, both capital and revenue, are immediately affected by our current position.

Under the Monitor regulatory framework, our current financial position means we will potentially be subject to an investigation. To put this in context, of the other provider Foundation Trusts in our region, at least four are also facing investigations as a result of their current position, and at least one of the non-Foundation Trusts is also showing a deficit over planned levels. Whilst this shows that we are by no means alone in wrestling with these challenges, our regulators have an obligation to challenge our performance if they see fit, and this serves to underline the importance of our Turnaround Avoidance Programme and the need to arrest the deterioration of our financial performance as a matter of urgency.

An interesting example of where we are feeling the effects locally of changes to national policy is in relation to specialist commissioning tariffs. We have approved a business case at the Executive Board to develop our cancer services that also sets out a funding gap brought about by a decision for specialist commissioners to only pay for 70% of the growth in high cost cancer drugs. This means that we have to meet the shortfall that is created through this tariff rule before we can consider other investments. However we have little choice but to manage the gap and effectively invest resources to continue to provide these treatments that are so vital to the community. Whilst the rationale behind this is to put the onus on providers to find efficiencies in this part of the system and to help manage the spiralling costs to the commissioners, it nonetheless has a tangible impact on our financial position and our ability to make choices about how we make investments and support business cases.

In the news

Staff at Scarborough Hospital were delighted to welcome Alzheimer's Society Chief Executive Jeremy Hughes when he visited the Hospital last month.

In partnership with the Alzheimer's Society a dementia support worker was introduced at Scarborough Hospital in December 2014, providing invaluable in-house support to patients with dementia, their carers and staff.

Mr Hughes visited to see first hand the work that is taking place and the impact it is having on staff, patients and carers.

The visit gained extensive local media coverage, drawing positive attention to many of the excellent dementia initiatives taking place across the organisation and in particular at Scarborough Hospital.

The Trust also gained positive coverage from the announcement of our Summer placement scheme. Pupils from local schools were invited to apply for a four week placement to get real work experience with pay. Sixteen students have been successful and will be working in a range of roles in areas including therapies, estates, and human resources as well as on the wards.

Other media handling issues over the last month include responding to stories regarding terms and conditions for our cleaning staff, the withdrawal nationally of recruitment and retention premia (RRP) for maintenance staff, and the cost of uneaten meals in hospitals.

Director of Estates and Facilities Brian Golding has written a letter for publication in the Bridlington Free Press regarding union comments on our review of domestic services.

Orthopaedic surgery at Bridlington Hospital: one year on

Bridlington Hospital has celebrated its first anniversary since elective orthopaedic surgery relocated from Scarborough Hospital.

The first orthopaedic procedure was performed at Bridlington Hospital on 28 April 2014, and the first year of operating almost 2000 operations were performed.

Over 40 percent of these patients were discharged and back at home just 24 hours after their operation, and patient feedback continues to be excellent.

All elective orthopaedic surgery is now delivered at Bridlington, with only trauma (emergency) cases taking place at Scarborough Hospital and since relocating to Bridlington, not a single operation has had to be cancelled. This is not only positive for patients, it is an excellent illustration of how we can protect our elective income through the separation of elective and acute capacity, and provides a model for some of our other surgical services to follow.

The Trust has also just found out that it is one of four Trusts in the Yorkshire and Humber region chosen to take part in a research project which will look at why Bridlington Hospital performs so exceptionally well in terms of hip and knee replacements.

The study is being led by Professor Rebecca Lawton who heads the Quality and Safety research team at Bradford Institute for Health Research based at Bradford Teaching Hospitals and is being funded by the CLAHRC (Collaboration for Leadership in Applied Health Research and Care) Yorkshire and Humber.

Patient Safety

The latest Summary Hospital Level Mortality Indicator (SHMI) figures will be published on 29 July 2015. The SHMI is an indicator of mortality and is regarded as one of a number of measures of an organisation's safety. Our overall figure has continued to improve from 112 in March 2012 (pre-merger) to 103 in the last published figures (September 2014), with Scarborough's SHMI moving in the same time period from 115 to 109 and York's moving from 110 to 99. These figures place us well within the normal levels and whilst we would clearly wish to see this reduce again this time, it is a good illustration of the sustainable improvements to safety that have been made on both main sites, and we would be positive about this.

External awards

I am really pleased to report that we have won the 'Integration and Collaborative Working' award at the Yorkshire and Humber Constructing Excellence awards, for our work with Kier on the capital developments delivered through our framework agreement with them. These awards represent a broad cross section of the construction industry, and the winners then go on to compete at the National Constructing Excellence Awards held in London in the Autumn.

Equality and diversity

As part of our meeting today we will be reviewing our organisational returns related to equality and diversity issues. The reports highlight that we still have much room for improvement in understanding how our staff and patients experience our services and, more importantly, how we use the information we have regarding protected characteristics to inform how we plan and deliver these services. This agenda is central to our values in demonstrating how we respect difference and increasingly ensure that we reflect our community and provide fair and equal opportunities for patients and staff. I look forward to the discussion and expect we will all identify things we can personally take a lead in doing to improve our awareness of issues which create barriers to having an inclusive approach to all

staff and users of our services.

Changes to the Board of Directors

Finally I wish to announce that Sue Holden, Director of Workforce and Organisational Development, will be leaving the Trust in September to take up a 15 month secondment with the NHS Trust Development Authority.

Sue will be working as Improvement Director for Hinchingbrooke Healthcare NHS Trust, to help them sustain improvements to services and care quality.

Sue's leadership of the Trust's development programme, particularly in relation to our clinical leadership capability and effectiveness, has made a significant impact on this organisation and her appointment into this new role is a high level recognition of the work she has done over many years in the field of organisational development. Her contribution to our Board will be missed.

Arrangements for covering Sue's role during the secondment period will be shared in due course.

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

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22 July 2015

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Briefing Note

For the Attention of: **Executive Board, York and Scarborough Hospital & Community Boards, Directorate Managers, Matrons, Finance Managers, Deputy Directorate Managers, Operations Management Team, Senior Managers**

From: **Patrick Crowley, Chief Executive**

Turnaround Avoidance Programme – Delivering Success

Through recent Executive and Hospital Board presentations, and through Team Brief sessions, you will be aware of the Trust's declining performance against some of the national standards and of our weakening financial position and deficit plan for 2015/16.You will also be aware of the developing work programme, designed to arrest the deterioration in these areas. The purpose of this briefing is to mark the formal launch of this programme.

Our financial position (April to June 2015) shows that we are some £1m worse than our planned deficit of £2.2m. The impact of this deficit directly reduces the organisation's cash levels. Most organisations that fail (in both the public and private sectors) do so because of pressure on their underlying cash levels. We are not immune or protected from this pressure and our ability to make investment choices, both capital and revenue, are immediately affected by our current position.

We are actively seeking additional financial support to help deal with the costs associated with unplanned escalation activity, premium locum and agency costs and other unplanned operational pressures. However, irrespective of whether this is successful or not it is vital that as an organisation we play our part in full in addressing the underlying pressures facing the health service overall and importantly health services for our community that are so important to us all.

We must, individually and collectively, accept the responsibility to ensure the Trust lives within its means and lives up to its obligations in terms of both quality and performance. It is essential we all work with vigilance, appropriate compliance and discipline to ensure we get the very best out of our resources at all times.

Under the Monitor regulatory framework our current financial position means we will potentially be subject to an investigation. To put this in context, of the other provider Foundation Trusts in our region, at least four are also facing investigations as a result of their current position and at least one of the non-Foundation Trusts is also showing a deficit over planned levels. Whilst this shows that we are by no means alone in wrestling with these challenges, our regulators have an obligation to challenge our performance if they see fit, and this serves to underline the importance of our Turnaround Avoidance Programme and the need to arrest the deterioration of our financial performance as a matter of urgency.

Any regulatory intervention will significantly reduce our freedom to set our own priorities and make our own choices and a further deterioration in our finances will similarly affect our freedom to act. Losing this freedom will not only damage the "present" for our services but will also affect our future development and aspirations. I believe it is essential to avoid this if we can. If we fail then we will fail our patients who must remain the centre of all our considerations at all times.

There are a number of important areas where we need to see a significant improvement in our performance:

- Our performance against the 4-hour emergency access target should be at least 95% but we recorded 87.8% for April, 87.7% for May and 89.3% for June. This is a symptom of how we manage acute flow collectively and must be addressed. Performance is assessed quarterly and it is now 15 months since we last achieved this standard.

- Ambulance turnaround performance is measured by the time it takes to hand a patient over to ED staff. This is expected to take place within 30 minutes, and we are fined £200 for every patient waiting over 30 minutes and £1,000 for every patient waiting more than 60 minutes. We have repeatedly failed to manage all patients within these time requirements with significant numbers of breaches throughout all last year on both main sites.

- Diagnostic performance is assessed against a target of 99% of patients referred for a diagnostic test to have had the test within six weeks. We continue to see breaches in radiology and other diagnostics, and fines are set at £200 per breach.

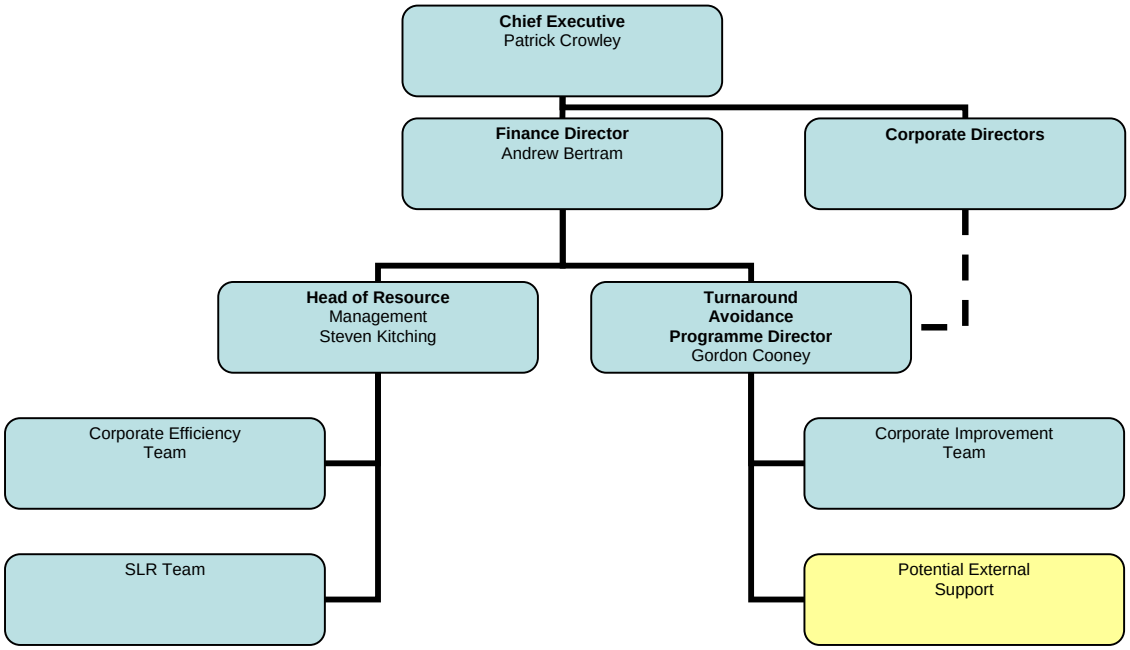
- We have seen a number of cases of C diff and MRSA this year, placing us at significant risk of being over our allowed trajectory. We are fined £10k per case over trajectory and this is particularly disappointing as it is not an area where we incurred penalties during 2014/15.

- We have 16 CQUINs worth a total of £9m this financial year. The CQUINs require performance delivery in a number of areas assessed either nationally or locally as important improvements in the quality of care we provide. We are struggling to deliver in some of these areas and are risking reputational and financial implications that will have serious consequences in both the short and longer term.

- In terms of our financial position, we are being adversely impacted by three key issues: staffing costs (specifically agency and locum costs), CIP delivery running behind the profiled plan and contract penalties.

The Turnaround Avoidance Programme – Delivering Success - is designed to provide structured support and governance to a number of initiatives intended to restore performance and improve finance. Andrew Bertram, Finance Director, will be the Programme Executive and accountable to myself and the Board of Directors for its delivery. The Programme Director will be Gordon Cooney who will lead the Trust's Corporate Improvement Team to support this work.

The team will work in a similar way to that of the Corporate Efficiency Team in that responsibility and accountability for delivery of the key turnaround avoidance initiatives are firmly placed with Executives, Senior Managers and Clinical Directorate Management Teams. The Turnaround Avoidance Team will ensure overarching governance, pace, reporting and will provide additional support to project delivery. The chart below illustrates the management arrangements.



The team will be focussing on the following key work streams:

- Performance improvement
- Fine eradication programme
- Expenditure control and discipline (including business case evaluation)
- Staffing and productivity
- Opportunities for income maximisation

The purpose of this briefing is to support Directorate Management Teams, in subsequent discussions with their wider teams, to ensure there is a common understanding of the actions being taken to Deliver Success for the Trust and recognise why this approach is necessary.

The Turnaround Avoidance Team launched formally on 6 July and will be meeting all Directorate Management Teams to ensure coordination of effort.

As the Trust moves into its Turnaround Avoidance Programme there will be a number of immediate changes to the way we operate. These are all designed to ensure we focus relentlessly on delivering a quality service to our patients, comply fully with the required national and local standards and that we move quickly to live within our financial means. Details of these requirements are provided at Appendix A.

Each of these actions is designed to secure performance improvement or to bring our financial position back under control. These actions are representative of those that would feature as part of a formal turnaround process should the Trust find itself in breach of the terms of its operating license and ultimately be placed in special measures.

Your full cooperation is required to ensure the Trust has a chance of surviving the current nationally driven financial pressures but also to recover its performance delivery and restore our reputation for delivering safe and effective healthcare to our community.

We will be sharing regular updates as the work programme progresses, and staff briefing sessions are being planned to share further detail about the on-going work and to give staff the opportunity to ask questions and contribute ideas.

All Clinical Directors, Directorate Managers and Service Managers are required to confirm by email to myself that they have briefed their full teams on the content of this email and the actions being taken. Your email should include details of how the briefing was undertaken and how you have ensured onward dissemination to all staff working at all levels.

I am confident, with your commitment and support, that we can achieve what we need to. Please encourage everyone to embrace what is required and fully contribute where they can. It is vital we listen to each other and provide support and help to others at all times. Placing our patients at the centre of all our considerations and working openly and honestly in doing this, living up to our values, can be our only response and if we do that we will achieve all that we need to.

We must retain control of our own destiny. We must deliver success.

Yours sincerely

Patrick Crowley
Chief Executive

Attachments:
Appendix A: Operational Changes under the Turnaround Avoidance Programme – Delivering Success: immediate actions
Appendix B: Reservation of Powers and Scheme of Delegation

Appendix A.

Operational Changes under the Turnaround Avoidance Programme – Delivering Success: immediate actions

Current action being taken:

1. Increased elective activity will be targeted. The recent sustained non-elective operational pressures have led to a reduction in elective activity and an increased level of patient cancellations. This reduced level of elective activity directly compromises patient experience of our services, compromises 18-week delivery and reduces Trust income levels. All Directorates have agreed improvement trajectories designed to deliver 18-week standards and formal monitoring against these trajectories is now in place. Action will be taken to increase elective activity still further.

2. CIP delivery. Directorates are asked to focus effort on taking urgent, safe and sensible action to ensure delivery of their nationally required savings programme. A small number of Directorates have made poor progress in this regard and this is compromising the financial stability of the organisation. Directorates will be expected to provide plans through their PMMs showing their trajectory to full delivery.

3. A number of Business Cases have been submitted recently where the costs of implementation exceed the income expected to be recovered. Indeed a number of cases have been received where no income has been referenced at all. Were we to progress these cases we will simply cause further deterioration of the Trust's financial position. Under the Turnaround Avoidance Programme, Directorates should not expect support to be forthcoming as the Trust does not have contingent resources for investment. Cases for investment will need to describe income sources. The Trust's Commissioning and Finance Teams will work with Directorates on these solutions and early engagement from Directorates is crucial.

4. Recent post-implementation reviews of a number of business cases have suggested difficulties in meeting stated objectives. The Turnaround Avoidance Team will be working with Directorates with Business Cases in this position to discuss the practicalities of re-energising the case, re-specifying KPIs or (ultimately) withdrawal of the case funding.

5. All improvement initiatives will require reconciliation of their objectives to the Turnaround Avoidance Programme and will require clearly articulated KPIs to measure progress and improvement. The Turnaround Avoidance Team will be working with Directorates in this regard. Improvement initiatives to reduce penalties, secure contractual performance compliance or improve our finances will take priority in support and development.

6. Arrangements will be made to repeat the MARS exercise (Mutually Agreed Resignation Scheme). Terms and conditions apply but under this national scheme

staff can apply to leave the Trust for enhanced financial compensation providing their post can be removed from the department's core establishment. This action is designed to reduce payroll costs whilst protecting existing staff.

7. The Trust's job planning committee will be reconstituted with direction on planning principles agreed by the Executive Board. An exercise will be undertaken to review all job plans in line with these principles.

Additional operational changes to be implemented with immediate effect:

8. Attached to this briefing is a copy of the Trust's current Scheme of Delegation (Appendix B). This is an important governance document and sits as part of the Board of Directors' approved Standing Orders. It is essential that all staff should understand their responsibilities and their level of responsibility regarding the Scheme of Delegation. Full compliance with the Scheme is required and no investment decisions must be taken outside of the Scheme. Breaches of the Scheme of Delegation will be considered as potential disciplinary matters.

9. Discretionary expenditure. This action is normally retained for implementation in the final months of the financial year but with continued and sustained pressure on our finances we must now take action to defer, delay or remove all discretionary expenditure where it is safe to do so. There is no prescriptive list of discretionary expenditure but Directorates are asked to consider all requisitions and to question the absolute need. Examples of discretionary expenditure may include; office equipment, conference attendance, travel, hospitality, training and development, etc. For the avoidance of doubt discretionary expenditure does not include mandatory CPD and other mandatory training or accreditation activity. We will be monitoring this position extremely closely on a week-by-week basis and will be discussing specific directorate issues and overspend pressures through operational and executive PMMs. Questionable requisitions will be returned to the Directorate Manager by the Purchasing Team for a discussion as to need.

10. In relation to CQUINS, and other contractual requirements, the Executive Board has confirmed compliance is mandatory for all staff working at all levels on all sites. Non-compliance will be escalated to the Medical Director, Chief Nurse or Chief Executive (as appropriate) and may ultimately result in disciplinary action. Details of CQUINS and all contractual requirements feature on directorate performance dashboards and the Trust's Performance Booklet. Directorate Management Teams should ensure all staff are aware of applicable requirements.

11. Under the Fine Eradication Programme, with immediate effect, any information leaving the organisation for the purpose of reporting contractual KPIs (where the possibility of a fine or penalty exists) will move to be managed through the Chief Executive's Office. This includes all RTT, ED, Cancer, Diagnostic, CQUIN and Infection Control reporting. No reportable contractual information is to be reported direct from any department without express permission from the Chief Executive. Full compliance is expected by all staff.

12. A senior staff vacancy freeze has been implemented. All vacancies at band 7 or above (arising for whatever reason) will be subject to an immediate vacancy freeze.

Consideration will be given to lifting the freeze on a case-by-case basis and any requests should be made in writing to the Chief Executive. This vacancy freeze has also been applied to all vacant roles currently in the recruitment process where a job offer has not yet been made. This action is designed to reduce payroll costs whilst protecting existing staff.

13. Directorates are required to review current spending levels and assure themselves of their understanding of their budgetary pressure areas. No directorate has prior authorisation to overspend and any pressure areas causing overspends should be documented and submitted for formal approval through the Directorate PMM process.

York Teaching Hospital NHS
NHS Foundation Trust

RESERVATION OF POWERS

AND

SCHEME OF DELEGATION

Author: Foundation Trust Secretary
Owner: Chief Executive
Publisher: Compliance Unit
Date of Issue: September 2014
Version: 7
Approved By: Audit Committee and Board of Directors
Review date: September 2015

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS AND DELEGATION OF POWERS

Introduction

The Code of Accountability for NHS Boards and Monitor's Code of Governance requires the Board of Directors to draw up a schedule of decisions reserved to it and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

GOVERNORS' LEGAL RESPONSIBLITIES

Introduction

The Trust has a body of elected individuals that make up the Council of Governors. Governors have a number of legal rights and responsibilities. These include:

- The appointment or dismissal of the Chairman and Non-executive Directors
- The approval of the appointment of the Chief Executive
- At a general meeting the Council of Governors will:
    - receive the annual accounts annual report and Quality Report and annual audit letter from the external auditors
    - approve the remuneration and allowances and other terms and conditions of the office of the Chairman and Non-executive Directors
    - appoint or replace the Trust's auditor at a general meeting
- Providing the views of the Council of Governors to the Board of Directors for the purposes of the preparation by the Board of Directors of the document containing information as to the Trust's forward planning in respect of each Financial Year to be given to Monitor
- Receiving and considering the views of the Members on matters of significance to the future plans of the Trust
- Approval of the amended of the constitution
- Hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors
- Represent the interests of the NHS Foundation Trust members and the public served by the Trust
- Approving significant transactions that fall within the definition
- Appointment and removal of the External Auditors
- Approval of the increase of non- NHS income where it is 5% or more in any one year

FUNCTIONS WHICH ARE RESERVED FOR DECISION BY THE BOARD

1.1 General enabling provision

The Board may determine any matter (for which it has delegated or statutory authority) it wishes in full session within its statutory powers.

1.2 Regulation and controls

- Approval, suspension, variation or amendment of Standing Orders, Reservation of Powers and Scheme of Delegation and Standing Financial Instructions for the regulation of its proceedings and business

- Approval of the Reservation of Powers and Scheme of Delegation from the Board to officers

- Requiring and receiving the Declaration of Directors' Interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration

- Requiring and receiving declaration of interest from officers which may conflict with those of the Trust.

- Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property

- Approval of the arrangements for dealing with complaints

- Adoption of the organisational structure, processes and procedures to facilitate the discharge of business by the Trust and to agree any modification there to

- To receive reports from committees including those which the Trust is required to provide by the Secretary of State, Monitor or other regulatory body or regulation to establish and to take appropriate action thereon

- To confirm recommendations presented to the Board of Directors by the Trust's Committees

- To establish terms of reference and reporting arrangements of all sub-committees of the Board of Directors

- Ratification of any urgent decisions taken by the Chairman in accordance with Standing Orders

- Approve the Trust's Major Incident Plan

- Prescribe the Financial and Performance reporting arrangement required by the Board of Directors

1.3 Appointments

- The appointment and dismissal of Board Committees
- The appointment of the Vice Chairman
- The appointment of the Senior Independent Director in consultation with the Council of Governors
- Through the Remuneration Committee the appointment and appraisal of Executive Directors and the disciplinary procedures of the Trust
- Ratification of the appointment of senior medical staff
- Approval of all new consultant appointments related to a business case
- The appointment of membership of the Board sub-committees
- The appointment of any representative body outside the organisation

1.4 Policy Determination

- The Board of Directors will approve policies that require specific Board approval including:
  - Management of Risk
  - Fire Safety Policy
  - Health and Safety Policy
  - Security Policy

This is not an exhaustive list.

1.5 Strategy and plans

- Define and approve the strategic aims and objectives of the Trust
- Approve strategic business plans incorporating a programme of investment in respect of the application of available financial resources
- Approve proposals for ensuring quality and safety and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State
- Approve proposals for action on litigation against or on behalf of the Trust
- Review use of NHSLA risk pooling schemes

1.6 General matters

- Acquisition, disposal of land/ or buildings above a value of £1m.
- Change of use of land
- Joint ventures
- To agree actions on litigation against or on behalf of the Trust
- Any investment regardless of size of new activity or any disinvestment

1.7 Financial and performance reporting arrangements

- Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust
- Consideration and approval of the Trust's Annual Report and Annual Accounts prior to submission to Parliament
- Receive the annual management letter from the external auditor and agree proposed action taking account of the advice, where appropriate, of the Audit Committee

SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

	Delegated Matter	Authority delegated to	Reference document
1	**Accountability**		
1a	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources	Chief Executive	Accounting Officer Memorandum
1b	Ensure that expenditure by the Trust complies with Parliamentary requirements	Chief Executive	
1c	To ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness	Chief Executive Finance Director Foundation Trust Secretary	
2	**Planning & Budgetary Control**		
2a	Prepare and submit an Annual Plan	Finance Director/ Director of Corporate Development and Research	SFI 3.1
2b	Management of budgets for the totality of services	Chief Executive	SFI 3.2
	• At Directorate level Prime budget holders are clinical directors and directors who hold all operating budgets for the Directorate's they manage including, where appropriate, income, activity and expenditure. Directorate Managers who provide professional support to practising Clinical Directors have also been granted Prime budget holder status.	Prime budget holder	Trust Finance Manual section 8
	• At individual budget unit level (pay and non pay) Prime budgets holders can delegate budgetary authority to delegated budget holders. These are typically lead clinicians, senior and other operational managers who control budgets on a day to day basis.	Delegated budget holder	Trust Finance Manual section 8
2c	Virement (planned transfer) of resources between directorate or specialty/department budgets (per	Finance Director	SFI 3.2.3, 3.3.2

	annum):		Trust Finance Manual. Section 8.2.3.
2d	Non pay requisitions - Decisions to rent or lease in preference to outright purchase	Head of Corporate Finance	SFI10.2
2e	Authority to change clinical template activity	Director of Operations/ Finance Director	
2f	Non-pay revenue expenditure within budgets (Note: over £50K the Business Case procedure shall apply)		SFI 9 Trust Finance Manual - section 5.2
	• Orders up to £1,000, except with explicit agreement to a higher limit set by FD	Delegated budget holder (If within available budget resources as agreed with Finance Director)	
	• Orders up to £50K (Except medical equipment – see below)	Prime budget holder (If within available budget resources as agreed with Finance Director)	
	• Medical equipment (i.e. medical, scientific, technical and x-ray equipment) - individual items over £1k and up to £100K	Medical Equipment Resource Group (MERG)	Trust Finance Manual; section 8.2.1
	• Orders over £50k (medical equipment over £100k) up to £500k	Executive Board	
	• Orders over £500K	Board of Directors	
	• Establishment of escalation facilities at short notice and associate costs	Deputy Chief Executive	
2g	Non-pay expenditure for which no specific budget has been established and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above).	Finance Director	SFI 9
2h	Purchasing Cards: Authority to issue purchasing cards and setting of limits	Prime budget holder	
3	**Bank accounts and loans**		
3a	Loan arrangements	Director of Finance	SFI 5
4	**Business Cases**		

4a	Delegated limits relate to capital schemes within the agreed annual programme, annual revenue costs or the combination of capital and revenue cost in the first full year and relates to approval of a business case **Capital only** • up to £100k	Capital Programme Management Group	SFI 10
	• £100k-£500K-	Chief Executive / Finance Director through Capital Planning Board	
	• £500k-£1m	Executive Board	
	• Over £1m (and all PFI proposals)	Board of Directors	
	Capital and revenue, and revenue only		
	• Up to £50k	Prime Budget Holder	
	• £50k - £300k	Chief Executive	
	• £300k - £1m	Executive Board	
	• Over £1m (and all PFI proposals)	Board of Directors	
	• Consider all new consultant appointments and recommend to Board of Directors	Executive Board	
5	**Asset Register**		
5a	Maintenance of the asset register	Chief Accountant	SFI 10.3
6	**Quotations, Tendering and Contracts**		
6a	Obtaining a minimum of 3 written competitive tenders for goods/services over £25K	Head of Procurement	SFI 9
6b	Waiving of quotations and tenders subject to SFIs and SOs (including approval of single tenders)	Chief Executive	SFI 9.5
6c	Opening tenders – manual	An Executive Director and the Foundation Trust Secretary	SFI 9.5

6d	Opening tenders – electronically the system prevents quotes/tenders from being opened before the deadline	Head of Procurement	
6e	Acceptance of quotations/permission to consider late quotations	Head of Procurement	SFI 9.5.4
6f	Acceptance of tenders/permission to consider late tenders – over £25K	Chief Executive	SFI 9.5.4
6g	Accepting contracts and signing relevant documentation up to £25k	Head of Procurement	
6h	Accepting contracts and signing relevant documentation over £25k	Chief Executive / Finance Director	
7	**Expenditure variations on capital schemes**		SFI 10.1
	• Variations up to a value £10k		
	• Variations up to a value of £300k	Capital Programme Management Group Chief Executive / Finance Director through Capital Planning Board	
	• Variations up to the value of £500K	Executive Board	
	• Unlimited	Board of Directors	
8	**Setting of fees and charges**		SFI 6.2
8a	Private patient, overseas visitors, income generation and other patient related services	Finance Director	Provider Licence
8b	Financing content of NHS contracts	Finance Director	
8c	Approval of healthcare contracts and other agreements resulting in income to the Trust	Finance Director	
8d	Approval of variations of healthcare contracts:		
	• Up to £200K	Finance Director	
	• Over £200K	Executive Board	
9	**Property transactions**		SFI 12.1
9a	Disposal and acquisition of land and buildings		
	• Up to £300K	Chief Executive	
	• £300k-£1m	Executive Board	

	• Above £1m	Board of Directors	
9b	Lets and leases:		SFI 10.2
	• preparation and signature of all tenancy agreements/ licenses for all staff subject to Trust Policy on accommodation for staff	Director of Estates and Facilities	
	• extensions to existing leases	Director of Estates and Facilities	
	• Letting of premises to outside organisations, subject to business case limits	Director of Estates and Facilities	
	• Approval of rent based on professional assessment	Director of Estates and Facilities	
10	**Condemning and disposal - Equipment**		
10a	Items obsolete, obsolescent, redundant, and irreparable or cannot be repaired cost effectively (note: For disposal including those for sale the tendering and quotation limits shall apply)	Executive Director responsible for the area	SFI 12.1 Disposal policy
11	**Losses and compensation**		
11a	All losses, compensation and special payments shall be in accordance with current DOH guidance & details of all such payments shall be presented to the Audit Committee		SFI 12.2
11b	Maintain a losses and special payments register	Finance Director	SFI 12
11c	Clinical cases	Settled by NHS Litigation Authority	
11d	Non clinical cases		
	• Up to £50K	Finance Director	
	• £50K-£300k	Chief Executive	
	• £300k-£500k	Executive Board	
	• Over £500K	Board of Directors	
11e	Review schedules of losses and compensations and make recommendations to the Board	Audit Committee	
11f	Special payments	Treasury approval	
12	**Petty cash disbursements**		SFI 9.3

12a	Expenditure up to £50 per item	Petty cash holder	
12b	Expenditure over £50 per item	Finance Director	
12c	Reimbursement of patients monies up to £250	Delegated budget holder	
12d	Reimbursement of patients monies over £250	Prime budget holder	
13	**Maintenance and update of Trust accounting policies**	Finance Director	FRM and Monitor guidance
13a	Approval of updated Trust accounting policies	Audit Committee	
14	**Investment of funds**		SFI 5.4 Treasury Management Policy
14a	Investment of funds	Finance Director	
15	**Provision of services to other organisations**		
15a	Legal and financial arrangements for the provision of services to other organisations	Finance Director	
15b	Signing agreement with other organisations	Finance Director	
16	**Audit and Accounts**		SFI 2.5.1 SFI 4
16a	Approve the appointment and where necessary dismissal of the External Auditors	Council of Governors	
16b	Receive the annual management letter from the External Auditor.	Council of Governors	
16c	Receive the annual management letter from the external auditor and agree proposed action, taking account of the advice, where appropriate, of the Audit Committee	Board of Directors	
16d	Receive an annual report from the Internal Auditors and agree action	Audit Committee	
17	**Annual Report and Accounts**		
17a	Receive and approve the Annual Report and Accounts and Quality Report	Board of Directors	SFI 4
17b	Receive the Annual Report and Accounts and Quality Report and any comments on them at the Annual General Meeting	Council of Governors	
17c	Sign the annual statements including the annual accounts on behalf of the Board of Directors	Chairman, Chief Executive and	

		Finance Director	
17d	Implementation of internal and external audit recommendations	Finance Director	SFI 2.1
18	**Retention of Records**		
18a	Maintaining archives of records to be retained	Chief Executive	SFI 17
19	**Declaration of Interests**		SO 6
19a	The keeping of a declaration of board members and officers' interests	Foundation Trust Secretary	
20	**Receipt or provision of hospitality and gifts**	All Trust employees have a duty to declare	SFI 16
20a	Approve procedures for declaration of hospitality and sponsorship	Board of Directors	Standards of Business Conduct
20b	Maintenance of gifts and hospitality register	Foundation Trust Secretary	
20c	Approval of receipt of both individual and collective hospitality	Prime budget holder	
21	**Attestation of sealings in accordance with Standing Orders**		
21a	Attestation of sealings in accordance with Standing Orders	Chairman or Designated NED and Chief Executive or Designated ED	SO 10
21b	The keeping of the sealings	Foundation Trust Secretary	SO 10
22	**Research and development**		
22a	Approval of research and development contracts (including variations or extensions):		
	• Up to £300K	Medical Director or Director of Finance or Chief Executive	
	• £300k -£1m	Executive Board	
	• £1m and over	Board of Directors	
23	**Personnel and Pay**		SFI 8
23a	Approve management policies including personnel policies incorporating arrangements for the appointment, removal and remuneration of	JMSC/LNC and Executive Board	

	staff		
23b	Authorisation of timesheets (including agency timesheets)	Delegated budget holder	
23c	Authority to fill funded post on the establishment with permanent staff	Chief Executive	SFI 8
23d	Authority to appoint staff to post not on the formal establishment	Chief Executive	SFI 3/8
23e	Granting of additional increments to staff:	All subject to compliance with A4C regulations	SFI 8
	• within budget	Director of Human Resources	
	• in excess of budget	Director of Finance	
	• for Chief Executive and Director posts	Remuneration Committee	
	• for Non-executive Directors and Chairman	Council of Governors	SO 2.3
23f	Upgrading and regarding	Director of Human Resources	SFI 8
23g	Variation to existing Consultant Contracts/job plans	Medical Director Both subject to compliance with regulations	
23h	Authority to authorise overtime	Delegated Budget Holder	SFI 8
23i	Authority to authorise travel and subsistence expenses	Delegated Budget Holder	
23j	Authority to pay clinical excellence awards to Consultants	Board of Directors endorse decision of Committee chaired by the Chief Executive or Director of HR	
23k	Authority to pay discretionary points to staff grade and associate specialist doctors	Medical Director	
23l	Consider and approve recommendations on behalf of the Board on the remuneration and terms of service of corporate directors to ensure they are fairly rewarded for their individual	Remuneration Committee	

	contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff		
23m	Approval of annual leave	Delegated budget holder	Annual Leave Policy
23n	Annual leave – approval of carry forward		
	• Up to a maximum of 5 days:	Delegated budget holder	
	• Over 5 days		
	(i) Medical Staff	Medical Director	
	(ii) Other Staff	Prime budget holder	
23o	Approval of compassionate leave		Special Leave Policy
	• Up to 5 days	Delegated budget holder	
	• Up to 10 days	Prime budget holder in consultation with HR	
23p	Special leave		Special Leave Policy
	• Paternity	Delegated budget holder	Paternity leave Policy
	• Other	Delegated budget holder	
	• Maternity leave		Maternity Leave Policy
	• Leave without pay	Delegated budget holder	
	• Medical staff leave of absence – paid and unpaid	Chief Executive	Special Leave Policy
	• Time off in lieu	Prime budget holder	Special Leave Policy
	• Flexible working arrangements	Delegated budgeted budget	Flexible Working Policy
	• Extension of sick leave on half pay up to three months	Director of HR delegated where appropriate to Prime budget holder	Managing Sickness Absence Policy
	• Return to work part time on full pay to assist		

	recovery		
	• Extension of sick leave on full pay		
23q	Study leave		
	• Study leave outside the UK – medical	Clinical Director	Policy on Learning Leave
	• Study leave outside the UK – other	Prime budget holder	
	• Medical staff study leave (UK)	Clinical Director Delegated budget holder	
	All other study leave (UK)	Delegated budget holder	
23r	Rent and House Purchases: Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		Relocation Expenses Policy
	• up to £6,000 (non-medical staff)	Prime Budget Holder	
	up to £6,000 (medical staff)	Director of Human Resources or Medical Director	
	• £6,000 - £8,000	Director of Human Resources or Medical Director	
	• Over £8,000	Chief Executive	
23s	Requests for new posts to be authorised as car users or mobile phone users	Prime budget holder	Lease Car and Mobile Phone Policies
23t	Renewal of fixed term contracts	Delegated budget holder	
23u	Authorisation of retirement on the grounds of ill health.	Via the Director of Human Resources (the decision can only be made by the NHS Pensions Agency)	
23v	Authorisation of staff redundancy	Finance Director and Director of Human Resources	Redundancy Policy
23w	Any termination settlement	Finance Director (with HM Treasury approval where	

		required)	
23x	Authorisation of staff dismissal	Director of Human Resources	Disciplinary Policy
23y	Engagement of staff not on the establishment	Corporate Directors	
23z	Booking of Bank or Agency Staff		
	• Medical Locums	Prime Budget Holder	
	• Nursing	Prime Budget Holder	
	• Clerical	Prime Budget Holder	
24	**Facilities for staff not employed by the Trust to gain practical experience** Professional recognition, honorary contracts and insurance of medical staff, work experience students	Director of Human Resources or Medical Director	
25	**Security and risk management**		
25a	Corporate responsibility for implementation of the Security Policy	Director of Estates and Facilities	Security Policy
25b	Overall statutory responsibility for security management within the Trust	Chief Executive	
25c	Where an offence is suspected		
	• Criminal offence of a violent or clinical nature	Head of Security	
	• Where a fraud or theft is involved	Head of Security (theft)/ Local Counter-Fraud Specialist (fraud)	
25d	Authority for the issue of ID and security badges and car park passes	Delegated budget Holder	Security Policy ID Badge policy
26	**Insurance policies**		
26a	Insurance	Head of Corporate Finance	SFI 18/ Claims Handling Policy
26b	Review of all statutory compliance legislation and Health and Safety requirements including Control of Substances Hazardous to Health Regulations	Health and Safety Manager	Health and Safety Policy
27	**Authorisation of new drugs**		

27a	Yearly cost of drugs		
	• Estimated total yearly cost per individual drug up to £25,000	Directorate managers	Pharmaceutical Procurement Policy
	• Estimated total yearly cost per individual drug above £25,000	DTC recommendation, subject to business case procedure and Executive Board approval	Pharmaceutical Procurement Policy
27b	Authority to purchase/contract:		
	• Up to £5K	Senior Technician	
	• £5K - £50K	Countersigned by Principal Pharmacist	
	• £50K - £100K	Countersigned by Chief Pharmacist	
	• £100K to £150K	Director of Finance or Chief Executive	
	• £150K to £300K	Chief Executive	
	• £300K - £1m	Executive Board	
	• Over £1m	Board of Directors	
27c	Approval of nurses and others to administer and prescribe medication beyond the normal scope of practice	Director of Nursing or Medical Director or Chief Pharmacist	Nurse, Midwives, HV Act, Midwives Rules/Codes of Practice, NMC Code of professional Conduct/CSP Rules of Professional Conduct
28	**Patients and relatives' complaints**		
28a	Overall responsibility for ensuring that all complaints are dealt with effectively	Head of Patient Experience	Complaints Policy PALS policy
28b	Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly	Head of Patient Experience	Complaints Policy PALS policy
28c	Agreement of financial compensation	Director of Finance	Losses procedure
29	**Extra Contractual Payment**		
	Authority to undertake and approval to pay	Director of Finance	

	waiting list initiatives	or Deputy Chief Executive	
30	**Engagement of Trust's Solicitors**	Chief Executive, Foundation Trust Secretary, Finance Director, Head of Corporate Finance, Director of Estates and Facilities, Director of Human Resources, Head of Risk and Legal Services	

Quality & Safety Committee – 21st July 2015 Boardroom, York Hospital

Attendance: Libby Raper, Ed Smith, Beverley Geary, Anna Pridmore, Brian Golding, Liz Jackson, Emma Ferguson

Apologies: Diane Palmer, Philip Ashton, Jennie Adams

	Agenda Item	Comments	Assurance	Attention to Board
1	**Last meeting notes dated 19 May 2015**	The Committee noted that the meeting was not quorate and would therefore be unable to confirm any decisions; however discussions around all items would still take place with items being highlighted to board. The Committee welcomed Brian Golding who was presenting the Estates information relating to quality and Emma Ferguson who is part of the Faculty of Medicine and Health at Leeds University and was observing the meeting. The minutes were approved as a true and accurate record.		
2	**Matters arising** - Early Warning Trigger Tool	**Mortality** – ES confirmed that the meeting with CHKS is scheduled to take place in the coming weeks. The Committee revisited the conversation regarding the amount of supplementary papers provided and were pleased to note that Sue Rushbrook is looking in to this. The Committee noted the changes to the integrated dashboard, which now includes a page which specifically highlights the interests of the Committee.		

	Agenda Item	Comments	Assurance	Attention to Board
		Cold Babies – BG confirmed that action had been taken to address the cold babies issue with the position of the cot being changed. This issue will not be included on the Maternity dashboard **Ward reconfiguration** – Brian G confirmed that an analysis of activity data is taking place with regard to the long term plan of ward reconfiguration. AMU and SSW have now merged and there is still some finer detail to complete. Security has been increased on all wards, main doors can now be locked and are controlled by the nurse in charge. **SI Quarterly Report** – The Committee confirmed that no further comments have been received and the item can now be closed. **End of life Care** – BG confirmed that the Committees suggestion regarding the funding of the educator post had been passed on to Kath Sartain, Lead Nurse for End of Life Care. **Early Warning Trigger Tool** – The Committee welcomed this helpful report and focused its attention to specific items. **Appraisal compliance** – The Committee noted the challenge of achieving compliance with nursing appraisals. BG explained that monthly red flags are now received by email to flag up any outstanding appraisals. The revalidation requirements come into effect in April 2016 and will address compliance as a completed appraisal will be part of the revalidation process. If a nurse is unable to revalidate they will lose their registration.	The Committee were assured by BG and ES's comments that this issue has been rectified and does not require monitoring.	

	Agenda Item	Comments	Assurance	Attention to Board
		Hand Hygiene – The Committee showed concern over the conflicting data. The Trust was previously reporting 100% compliance with an external audit by Go-Jo showing 33%. BG explained that hand hygiene compliance has increased, but remains a concern. BG explained plans that are being put in place to provide assurance.	The Committee took assurance from actions to review and re calibrate the data and by its inclusion on the Nursing Dashboard going forward.	
3	**Quality and Safety Performance Report**	The Committee focussed its attention on the additional Patient Safety and Quality page in the integrated dashboard. **Patient Experience** – The Committee noted the reduction of complaints on the Scarborough site. BG explained that ward level staff are now being empowered to resolve issues as they happen. A Matron of the day has been put in place to support staff and is available to visit the ward if needed. This initiative has been well received by patients and relatives. A new way of dealing with complaints is being piloted in the Emergency Department and Elderly Medicine. This has highlighted that staff in directorates dealing with complaints have not had any training in the writing of the report. Training will now take place in September and October. The initiative will be refined and rolled out to the rest of the Trust. The Committee queried the Patient Experience quarterly report and if the paying of compensation was appropriate. BG explained this this is common practice when a complaint has been upheld by the Health Service Ombudsman. **Infection Prevention –** BG advised the committee that an urgent meeting had been held to discuss the 6 cases of bacteraemia on the Scarborough site. This	The Committee welcomed the assurance provided regarding the process to create the additional overview page. The Committee acknowledged the on-going	BG to update Board

	Agenda Item	Comments	Assurance	Attention to Board
		meeting included BG, ES, Emma Day, Vicki Parkin and Katrina Blackmore. A list of agreed actions has been put in place. The Trust remains in line with other organisations in relation to Clostridium Difficile. In terms of MSSA, the Trust remains an outlier. Focus will be on the IPC agenda and re-launch of the IPC strategy. All governance structures are being reviewed. BG will meet weekly with Katrina Blackmore to streamline and clarify the organisational plan. **Quality and Safety Miscellaneous** **Stroke** – The Committee showed concern over the drop in patients receiving an urgent scan within an hour of arrival. ES explained that data is being looked at each week and monitoring is taking place to understand the impact the system change is having on the York Site. It is hoped that the scans take place faster on the Scarborough site due to the time it takes to make the decision to transfer the patient to York. The Committee look forward to reviewing the three month formal report at a later date. Cancelled Operations – The Committee noted the reduction in cancelled operations. ES explained that this indicated some release on the pressure on the system. Ward Transfers – ES explained to the Committee that there is some confusion over the definition of an inappropriate transfer. BG will action with the Matron	level of concern.	

	Agenda Item	Comments	Assurance	Attention to Board
		team. **Deteriorating Patient** – ES explained that there is a struggle to provide ward care on the Scarborough site due to a lack of Consultants on the on call rota. Juliet Walters is currently looking at 7 day working and how resources are spread adequately to provide safe care. **Mortality** – The Committee discussed the SHMI figure which will be released next week. ES will look in to the mortality indicators in more detail. **CQUIN Update** – The Committee were pleased to note the dementia results and congratulated the team in achieving the quarter 1 target. ES explained that this work is not currently sustainable; changes will need to be made to make the system sustainable.	The Committee were assured by the fact that this work is incorporated in to the Turn Around Project.	ES to update Board
4	**Estate information related to quality**	Brian G introduced the Estates and Facilities Directorate 5 year strategy and focused the discussion on three key areas relating to Patient Safety and Quality. **Domestics** - £8million a year is currently spent on cleaning and there are different processes on each site. An external company, I-Clean, was commissioned to undertake a comprehensive review of the cleaning services. A set of rotas have been agreed to harmonise the processes and procedures across all sites. Brian G confirmed that standards were not at risk and this initiative delivers part of the Cost Improvement Programme. Cleaning is monitored daily and if standards fall then an action plan is prepared in agreement with the ward sister. **Catering** – Bran G explained that before the merger		Brian G to update Board

	Agenda Item	Comments	Assurance	Attention to Board
		the in house catering team at York had won the catering contract. Since the introduction of the new catering system the options available for patients had increased from 3 main courses to 40 main course options every day. The strategy is to gradually ensure the same standards of food are served at each site which will eventually result in reduce costs and improved quality. The Food Strategy will come to Board in September. **Patient Entertainment** - Scarborough Hospital does not have an entertainment system and York uses the 'Hospedia' service which consists of a television and a phone; however negative feedback has been received about the cost of this service. The contract with 'Hospedia' comes to an end in 3 years and a plan will be put in place for the future. The Committee asked that learning from other Trusts regarding the provision of WiFi be incorporated into this plan. **Space Audit** – Brian G introduced the space audit to the Committee which shows all areas occupied by the Trust and whether it is leased or owned. The Committee were interested to understand the footprint of the Organisation. The Committee queried the additional on-going learning from the improvement of the Maternity Theatres in Scarborough. Brian G explained that the project plan is currently being completed and will go to the Finance and Performance Committee for review. The Committee asked that, with the creation of the new Board sub-committee for Health and Safety, the Terms of Reference be reviewed.		

	Agenda Item	Comments	Assurance	Attention to Board
5	**Supplementary Medical Director Report** - Information Governance - SHMI - Grand Rounds	**Grand Round** – The Committee noted that the Grand Round is a Medical Meeting for education and reflection by Doctors. This was unclear from the last meetings minutes. The Committee noted the work being undertaken around end of life care and the on-going work around infection prevention and control. **Serious Incidents** - The Committee focussed its attention on a Serious incident relating to the mismanagement of Insulin sliding scale. ES explained that there has been a renewed focus on diabetes management and will be discussed in detail at the Patient Safety Group. **Sepsis –** ES introduced the concept of rapid feedback, the model for which is currently being rolled out. The Sepsis Steering Group meets monthly to deliver objectives and efforts are being refocused.	The Committee welcomed the higher profile that Diabetes Management was being given by the Patient Safety Group.	
6	**Patient Experience Quarterly Report**	The Committee had no further comment to that discussed under item 3. BG advised the Committee that there may be changes to the way in which Patient Experience report and a proposal will come from the new Patient Experience Lead.		
7	**Patient Experience Strategy**	BG confirmed to the Committee that the Patient Experience Strategy is now complete and will be officially launched at the Trust Open Day and the Nursing and Midwifery Conference. LR reviewed the document and noted that it would be approved by the Board meeting in July.	The Committee were pleased with this progress and look forward to reviewing the implementation plan at a later date.	BG to take to Board
8	**Maternity Services**	BG agreed to circulate the revised risk register to the		

	Agenda Item	Comments	Assurance	Attention to Board
	– Scarborough - Risk Register	Committee members and any issues will be discussed at next month's Committee meeting.		
9	**Supplementary Chief Nurse Report** - Nursing and Midwifery strategy update - Quality report plan	**Quality Report** – the Committee welcomed the very detailed plan and asked that the upcoming dates be more specific. **Nursing and Midwifery Strategy** – Key issues will be identified and priorities for the next three years will be set at the Nursing and Midwifery Conference. The new plan is to have consultation with all nurses with Lead Nurses and Matrons receiving feedback from ward teams. **Nursing Recruitment** – BG advised the Committee that 84 posts have been offered to commence in October, this leaves 0 vacancies. Approval has just been given to recruit to 60 European nurses to cover the winter pressures. **Infection Prevention Update** – The Committee agreed that the information presented in the format submitted did not provide assurance. BG to reformat prior to Board.	The Committee were assured by the continuing work in this area.	BG to take to Board
10	**Quarterly Pressure Ulcer Update**	The Committee showed concern over the number of unstageable pressure ulcers being reported. BG explained that this is down to training and culture. BG highlighted that the trend continues to go down.		
11	**Quarterly Fall Report**	The Committee noted the increase in reporting and the significant reduction in the severity of falls.		
12	**DIPC quarterly report**	As discussed under other items throughout the agenda.		BG to take to private Board
13	**Safer Staffing**	BG explained the changes to the safer staffing report.		

	Agenda Item	Comments	Assurance	Attention to Board
	Report	The information was not as consistent as it could be. 12 hour shifts have now been incorporated and the new report projects realistic figures. NHS England has discussed this with the Trust and confirmed its comfort with the revised approach. The Committee noted the increased sickness rate in Scarborough Hospital and BG confirmed that attention is being given to the issue.		
14	**Any other business** Quality Governance Framework	The Governance Review is being undertaken and the plan has been circulated to Directors.		
15	**Other** **Work Programme**	No other business was discussed.		

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Patient Safety & Quality Report

July 2015

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

Patient Safety and Quality
Executive Summary

12 Serious Incidents (SIs) were declared in June. One was a Never Event due to a wrong site dental extraction, nine of the SIs were attributed to patient falls incidents, one was related to a Category 3 pressure ulcer and one a Category 4 pressure.

Patient falls remains the most frequently reported incident and reduction of falls with harm is a priority for the Trust.

Six cases of toxin positive C. difficile were identified in June.

Three cases of MSSA bacteraemia were identified.

Two cases of MRSA were identified.

One complaint was reported to the Ombudsman.

The overall % of patients who spend >90% of their time on a stroke unit reduced slightly to 78.9% in May.

Overall performance with the Emergency Department four hour standard was 89.3% in June.

Diane Palmer
Deputy Director of Patient Safety

Mortality

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

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

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

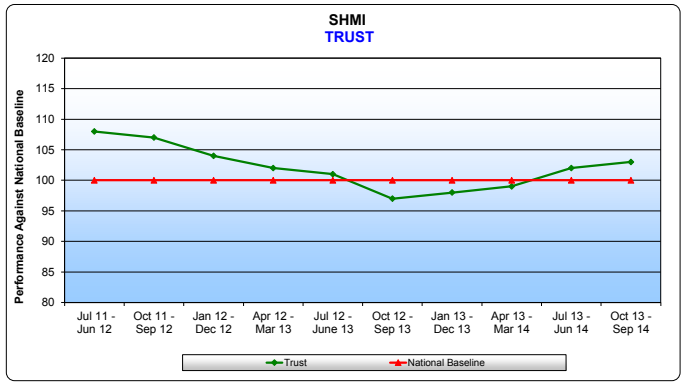
Analysis of Performance
The latest SHMI report for the period October 2013 to September 2014 indicates the Trust to be in the 'as expected' range. In January 2014 the York site saw a spike in the number of patient deaths which was outside normal range, this time period is contained in the latest SHMI release.

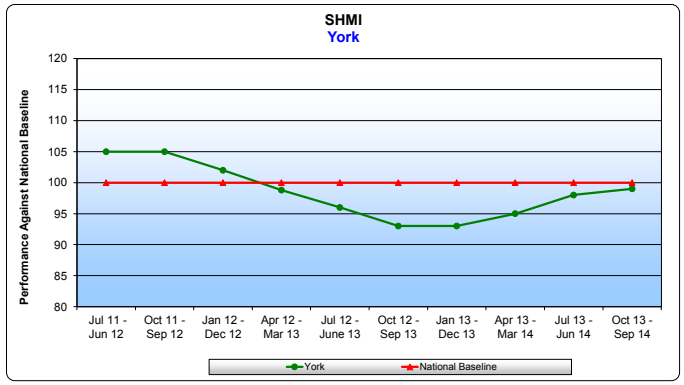
Analysis of SHMI categories is ongoing to identify differences between the York and Scarborough sites, together with any areas of ‘excess deaths’ where audits will be undertaken.

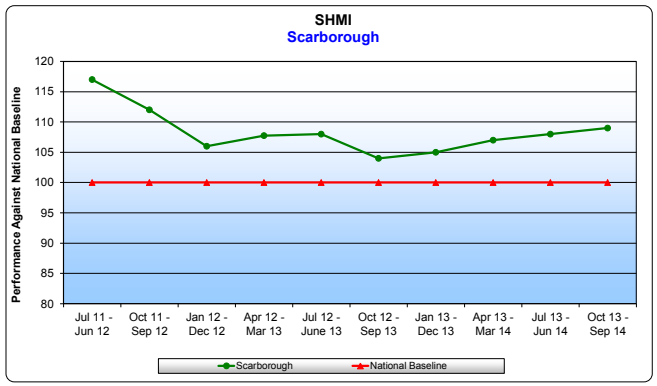
Following a spike in deaths during January 2015, the subsequent five months have seen deaths fall within expected range. Overall inpatient deaths are up 8.8% (2015-16) compared to 2014-15 with the highest percentage increase occurring on the Scarborough site, up over 26% on 2014-15 year-to-date.

Mortality

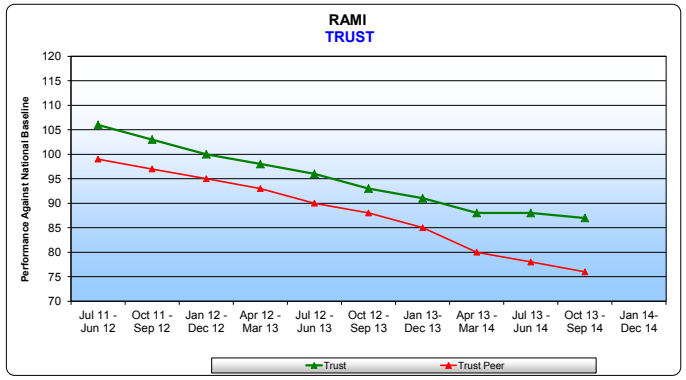
Indicator	Consequence of Breach (Monthly unless specified)	Apr 12 - Mar 13	July 12 - June 13	Oct 12 - Sept 13	Jan 13 - Dec 13	Apr 13 - Mar 14	July 13 - June 14	Oct 13 - Sept 14
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	102	101	97	98	99	102	103
Mortality – SHMI (YORK)	**Quarterly:**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

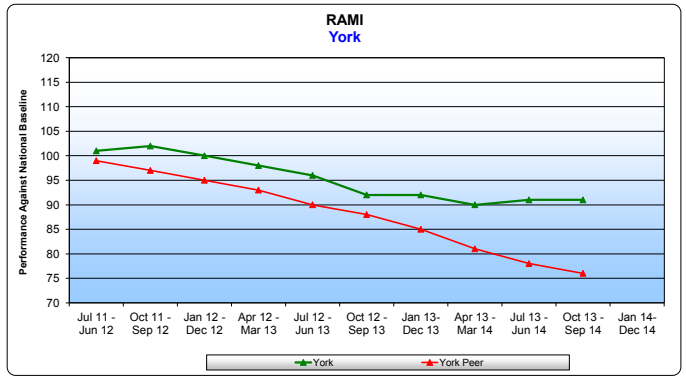


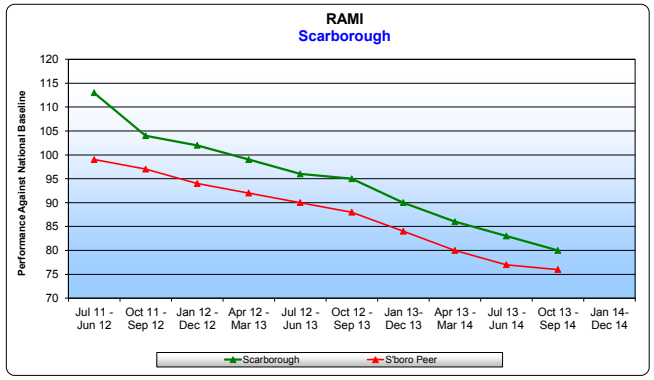




Indicator	Consequence of Breach (Monthly unless specified)	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sept 14
Mortality – RAMI (TRUST)	**none - monitoring only**	98	96	93	91	88	88	87
Mortality – RAMI (YORK)	**none - monitoring only**	98	96	92	92	90	91	91
Mortality – RAMI (SCARBOROUGH)	**none - monitoring only**	99	96	95	90	86	83	80

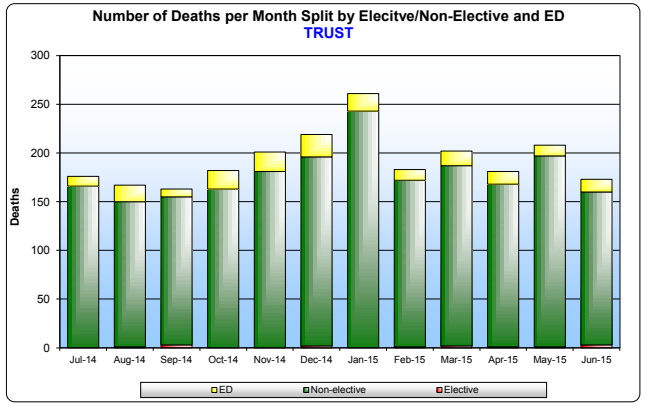


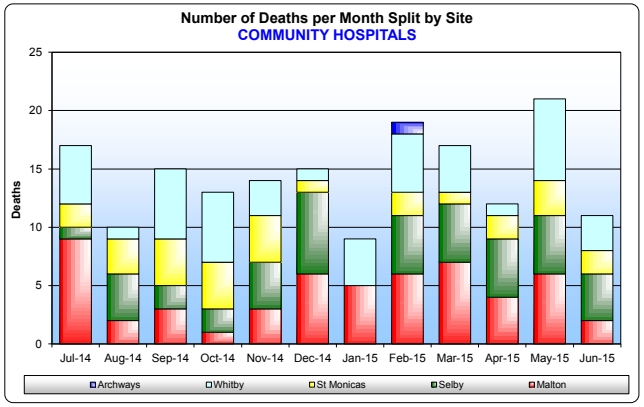




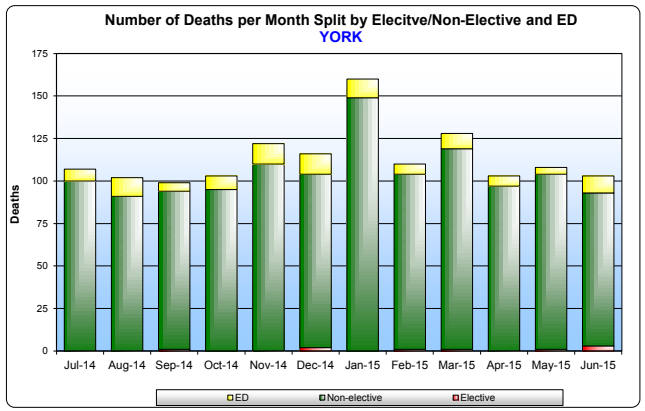
Mortality

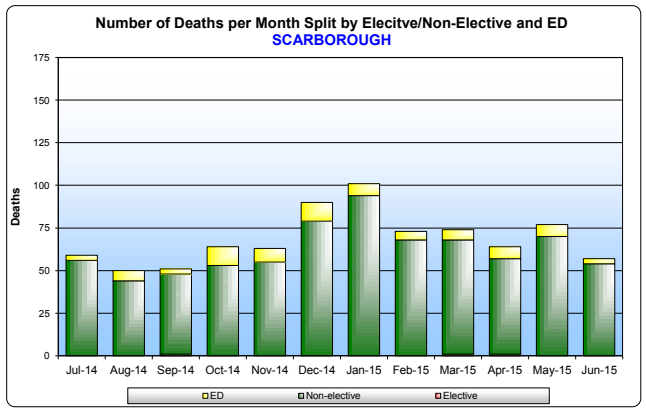
Indicator	Consequence of Breach (Monthly unless specified)	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Apr	May	Jun
Number of Inpatient Deaths (excludes deaths in ED)	None - Monitoring Only	471	540	602	525	168	197	160

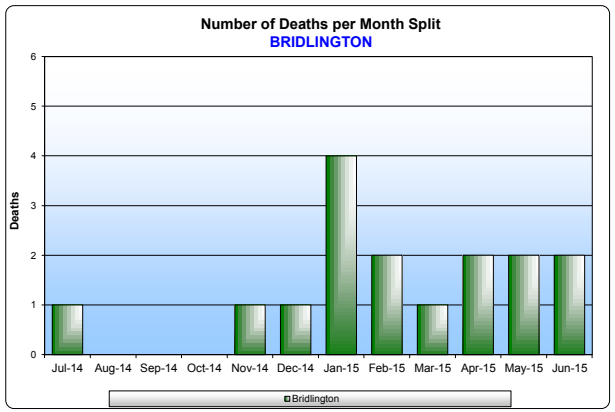




Month	Malton	Selby	St Monicas	Whitby	Archways	Bridlington
Jul-14	9	1	2	5	0	1
Aug-14	2	4	3	1	0	0
Sep-14	3	2	4	6	0	0
Oct-14	1	2	4	6	0	0
Nov-14	3	4	4	3	0	1
Dec-14	6	7	1	1	0	1
Jan-15	5	0	0	4	0	4
Feb-15	6	5	2	5	1	2
Mar-15	7	5	1	4	0	1
Apr-15	4	5	2	1	0	2
May-15	6	5	3	7	0	2
Jun-15	2	4	2	3	0	2







Litigation

Indicator	Site	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Clinical Claims Settled	York	1	5	1	2	1	1	2	2	4
	Scarborough	0	1	0	1	1	3	1	1	0

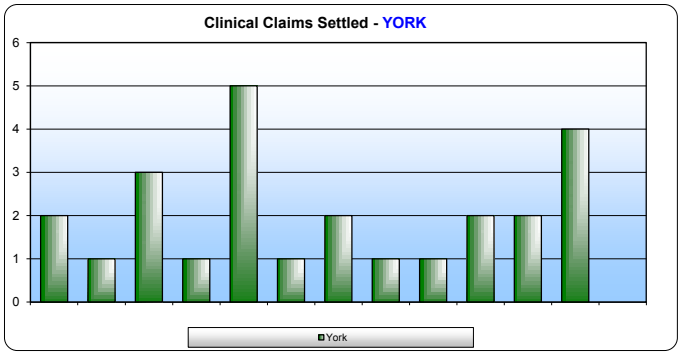
Four clinical claims attributed to York were settled in June.

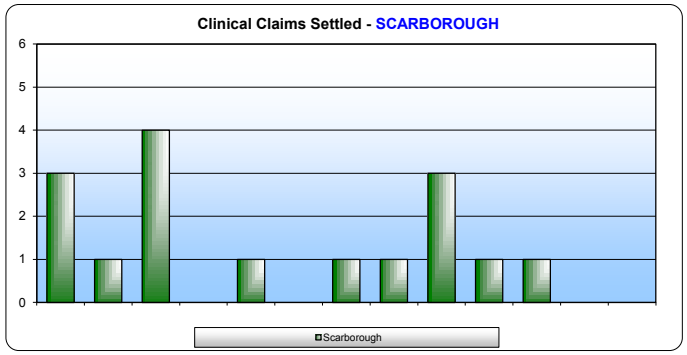
In June, seven clinical negligence claims for York site were received and five were received for Scarborough. York & Scarboro ugh had eight and one withdrawn/closed claims respectively.

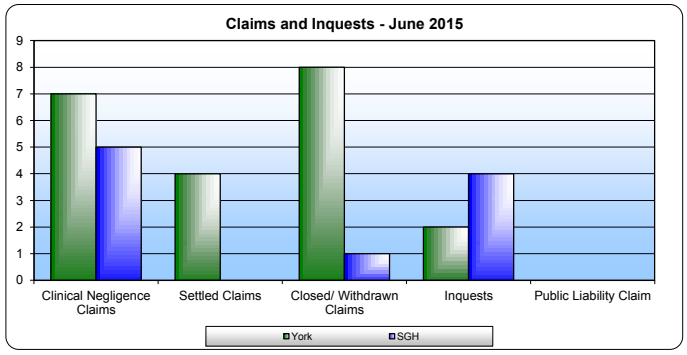
There were six Coroner's Inquests heard in June (two York & four Scarborough).

Litigation

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







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

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

Patient Experience

Complaints
Complaints registered in York relate to York Hospital and Community Services.
Complaints registered in Scarborough relate to Scarborough Hospital and Bridlington Hospital.
There were 23 new complaints registered to the York site and 10 to the Scarborough site in June.

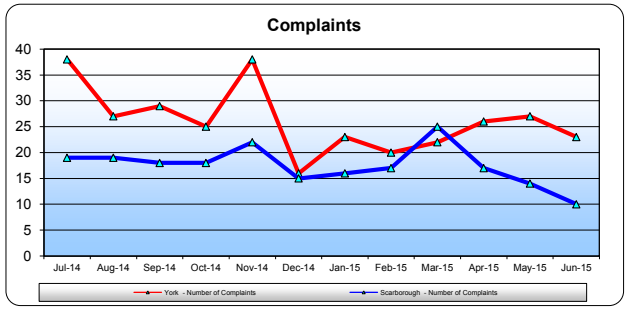
PALS contacts
There were 498 PALS enquiries at York Hospital in June, Scarborough figures are not currently available

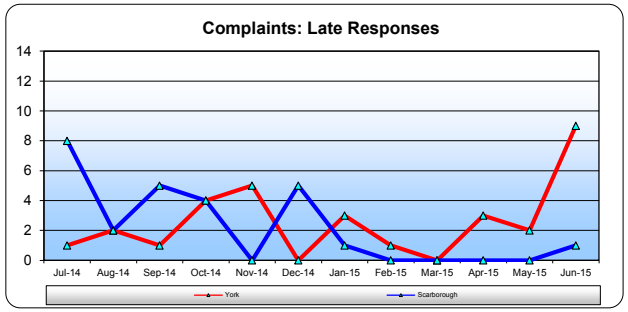
New Ombudsman Cases
One attributable to York & nil attributable to Scarborough during June.

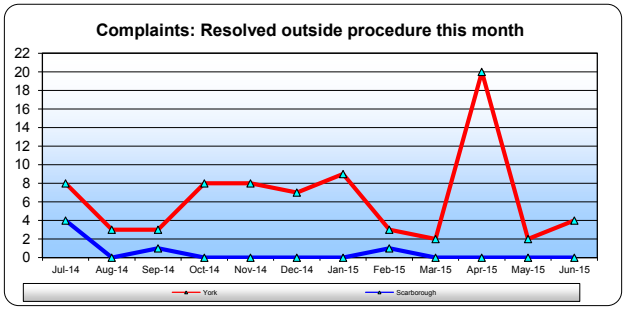
Complaints – Late Responses
9 recorded at York and 1 at Scarborough in June.

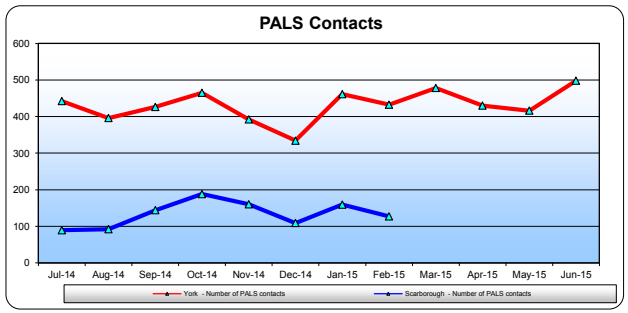
Patient Experience

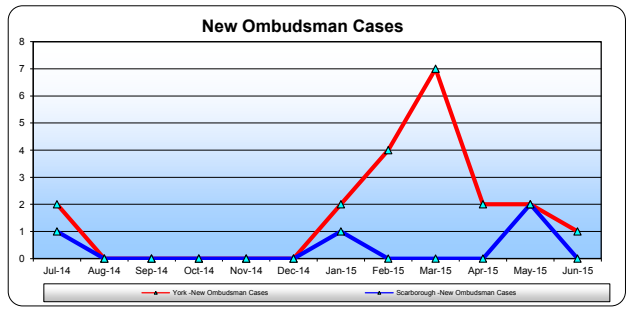
Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Complaints	York	38	27	29	25	38	16	23	20	22	26	27	23
	Scarborough	19	19	18	18	22	15	16	17	25	17	14	10
PALS contacts	York	442	396	426	465	392	334	461	432	478	430	416	498
	Scarborough	89	92	144	188	160	109	159	127	N/A	N/A	N/A	N/A
New Ombudsman Cases	York	2	0	0	0	0	0	2	4	7	2	2	1
	Scarborough	1	0	0	0	0	0	1	0	0	0	2	0
Complaints - Late Responses	York	1	2	1	4	5	0	3	1	0	3	2	9
	Scarborough	8	2	5	4	0	5	1	0	0	0	0	1
Complaints - Resolved outside procedure this month	York	8	3	3	8	8	7	9	3	2	20	2	4
	Scarborough	4	0	1	0	0	0	0	1	0	0	0	0











Patient Experience

June 2015

Complaints by Directorate/Division (Datix)	York	S'boro	Total
Allied Health Professionals	0	0	0
Child Health (Y)	0	0	0
Clinical Support Services (S)	0	0	0
Community Services (Y)	1	0	1
Corporate (Y,S)	0	0	0
Elderly Medicine (Y)	4	1	5
Emergency Medicine (Y)	2	3	5
Facilities (Y,S)	1	0	1
General Surgery and Urology (Y), Surgery (S)	1	3	4
Head and Neck and Ophthalmology (Y)	2	1	3
Medicine (General and Acute, Y), Medicine (S)	4	0	4
Obstetrics and Gynaecology (Y)	3	0	3
Operations (Y)	0	0	0
Orthopaedics (Y)	2	2	4
Pharmacy (Y)	0	0	0
Physiotherapy (Y)	0	0	0
Radiology (Y)	0	1	1
Sexual Health (Y)	0	0	0
Specialist Medicine (Y)	1	0	1
Theatres Anaesthetics and CC(Y)	1	0	1
Total	22	11	33

Complaints by Subject (Datix)	York	S'boro	Total
Admissions, discharge and transfer arrangements	1	0	1
Aids, appliances, equipment, premises	0	0	0
All aspect of clinical treatment	14	7	21
Appointment delay/cancellation (inpatient)	0	1	1
Appointments delay/cancellation (outpatient)	0	0	0
Attitude of staff	2	1	3
Communication/information to patients (written and oral)	3	0	3
Complaints handling	0	0	0
Consent to treatment	0	0	0
Failure to follow agreed procedure	0	0	0
Hotel services, including food	0	0	0
Mortuary and post mortem arrangements	0	0	0
Other	1	0	1
Patients' privacy and dignity	2	1	3
Patients' property and expenses	0	0	0
Patients' status, discrimination	0	0	0
Personal records	0	0	0
Policy and commercial decision of Trust	0	0	0
Total	23	10	33

PALS Contact by Subject	York	S'boro	Total
Action Plan	6	n/a	n/a
Aids / appliances / equipment	5	n/a	n/a
Admissions, discharge, transfer arrangements	13	n/a	n/a
Appointments, delay/cancellation (inpatient)	13	n/a	n/a
Appointments, delay/cancellation (outpatient)	46	n/a	n/a
Staff attitude	23	n/a	n/a
Any aspect of clinical care/treatment	72	n/a	n/a
Communication issues	37	n/a	n/a
Compliment / thanks	63	n/a	n/a
Alleged discrimination (eg racial, gender, age)	3	n/a	n/a
Environment / premises / estates	4	n/a	n/a
Foreign language	0	n/a	n/a
Failure to follow agreed procedure (including consent)	2	n/a	n/a
Hotel services (including cleanliness, food)	3	n/a	n/a
Requests for information and advice	171	n/a	n/a
Medication	4	n/a	n/a
Other	5	n/a	n/a
Car parking	5	n/a	n/a
Privacy and dignity	0	n/a	n/a
Property and expenses	9	n/a	n/a
Personal records / Medical records	7	n/a	n/a
Safeguarding issues	1	n/a	n/a
Signer	0	n/a	n/a
Support (eg benefits, social care, vol agencies)	0	n/a	n/a
Patient transport	6	n/a	n/a
Totals:	498	n/a	n/a

Friends and Family

Indicator		Target	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Inpatients – York	York IP Response Rate	Monitoring Only	39.0%	36.1%	31.7%	34.9%	39.4%	35.1%	32.9%	38.4%	45.4%	16.0%	17.4%	18.3%
Inpatients – Scarborough	Scarborough IP Response Rate		40.1%	44.4%	43.1%	39.5%	50.0%	37.9%	41.2%	52.4%	55.8%	16.4%	16.5%	15.3%
Inpatients - Bridlington	Bridlington IP Response Rate		86.0%	71.1%	83.6%	72.3%	77.2%	85.9%	77.0%	90.2%	69.5%	56.0%	47.5%	46.0%
Inpatients – Combined	**Trust IP Response Rate**		**41.7%**	**40.2%**	**37.6%**	**38.2%**	**44.1%**	**38.4%**	**37.7%**	**44.7%**	**49.4%**	**18.6%**	**19.2%**	**19.4%**
ED – York	York ED Response Rate	Monitoring Only	14.5%	9.4%	8.5%	9.6%	15.4%	14.2%	14.8%	14.0%	19.2%	8.3%	8.6%	8.3%
ED - Scarborough	Scarborough ED Response Rate		35.9%	36.8%	31.5%	27.4%	32.7%	19.1%	28.2%	36.8%	29.8%	6.7%	7.3%	6.1%
ED – Combined	**Trust ED Response Rate**		**22.8%**	**20.0%**	**16.7%**	**15.9%**	**21.5%**	**16.0%**	**19.3%**	**21.6%**	**22.8%**	**7.8%**	**8.2%**	**7.6%**
Maternity – Antenatal		None	27.7%	33.1%	37.2%	39.8%	42.8%	32.2%	30.6%	27.6%	36.0%	26.4%	27.5%	31.7%
Maternity – Labour and Birth			19.4%	16.2%	20.4%	17.2%	39.7%	15.8%	19.9%	27.9%	38.5%	31.0%	25.6%	26.7%
Maternity – Post Natal			24.8%	20.9%	29.4%	26.5%	47.1%	19.4%	27.9%	31.9%	32.6%	30.4%	29.0%	29.3%
Maternity – Community			21.1%	22.7%	17.2%	19.5%	18.4%	18.2%	21.3%	14.6%	23.1%	24.3%	18.4%	20.3%

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 are included in the Inpatient performance, this is as per national guidelines.

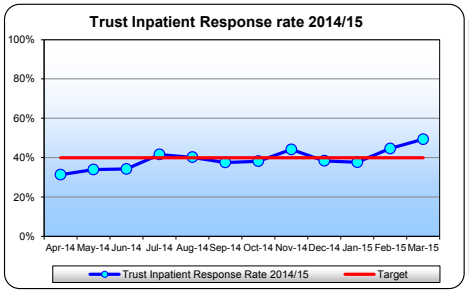
The focus for the Trust is to gain and understand patient feedback and encourage Directorates to use that feedback to drive improvements. Each ward displays a 'Knowing How We're Doing' board which is a giant poster sharing FFT data and comments from that particular ward, along with news and improvements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

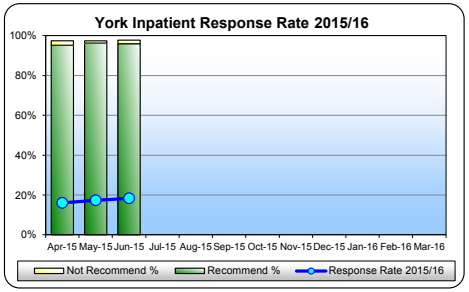
Friends & Family: Inpatients & ED

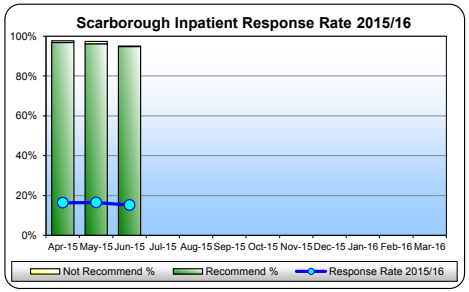
The Friends & Family Test (FFT) has now been rolled out across the Trust, including all Inpatients and Daycases, (previously daycase s and patients <16 were excluded) those attending ED, Community patients and women accessing maternity services being asked the question; "would you recommend this ward/ED/antenatal/labour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

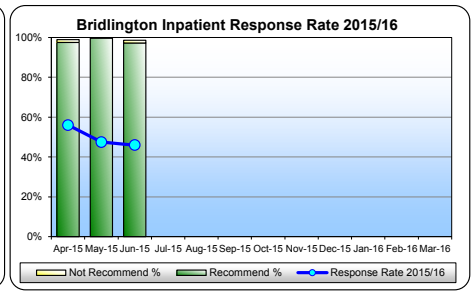
Indicator	Consequence of Breach (Monthly)	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Apr-15	May-15	Jun-15
Combined Inpatient Response Rate (including daycases)	None - Monitoring Only	none	39.80%	40.10%	43.90%	19.09%	18.64%	19.19%	19.41%
York Inpatient Response Rate (including daycases)	None - Monitoring Only	none	35.58%	36.39%	39.00%	17.25%	16.01%	17.35%	18.31%
York Inpatient Recommend %	None - Monitoring Only	none					95.17%	96.26%	95.95%
Scarborough Inpatient Response Rate (including daycases)	None - Monitoring Only	none	42.52%	42.25%	49.44%	15.98%	16.37%	16.46%	15.25%
Scarborough Inpatient Recommend %	None - Monitoring Only	none					96.81%	96.18%	94.78%
Bridlington Inpatient Response Rate (including daycases)	None - Monitoring Only	none	80.68%	78.19%	78.06%	49.43%	55.98%	47.46%	45.97%
Bridlington Inpatient Recommend %	None - Monitoring Only	none					97.51%	99.60%	97.25%

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

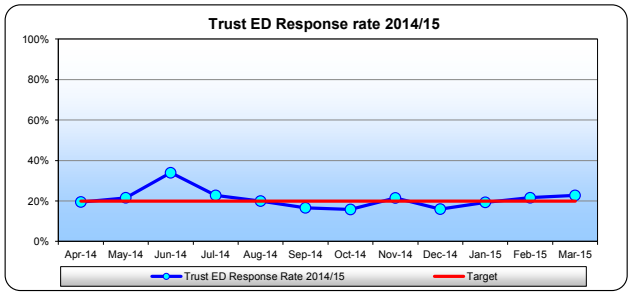


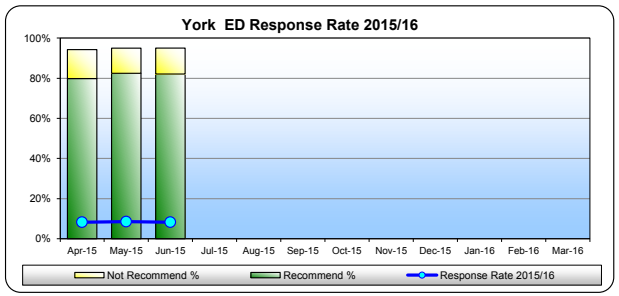


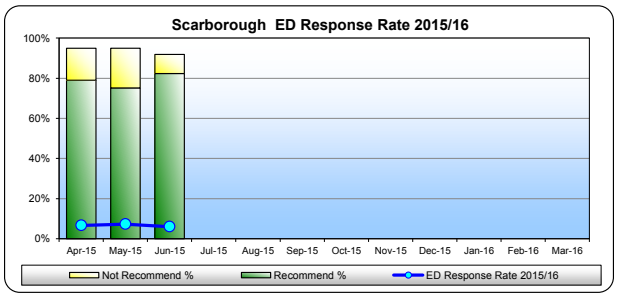




Indicator	Consequence of Breach (Monthly)	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Apr-15	May-15	Jun-15
Combined Emergency Department Response Rate	None - Monitoring Only	none	19.90%	17.70%	21.30%	7.84%	7.78%	8.17%	7.56%
York Emergency Department Response Rate	None - Monitoring Only	none	10.85%	13.00%	16.08%	8.38%	8.29%	8.56%	8.29%
York Emergency Department Recommend %	None - Monitoring Only	none					79.81%	82.42%	82.06%
Scarborough Emergency Department Response Rate	None - Monitoring Only	none	34.90%	26.46%	31.44%	6.69%	6.68%	7.33%	6.05%
Scarborough Emergency Department Recommend %	None - Monitoring Only	none					78.98%	75.14%	82.31%







Headline Scores

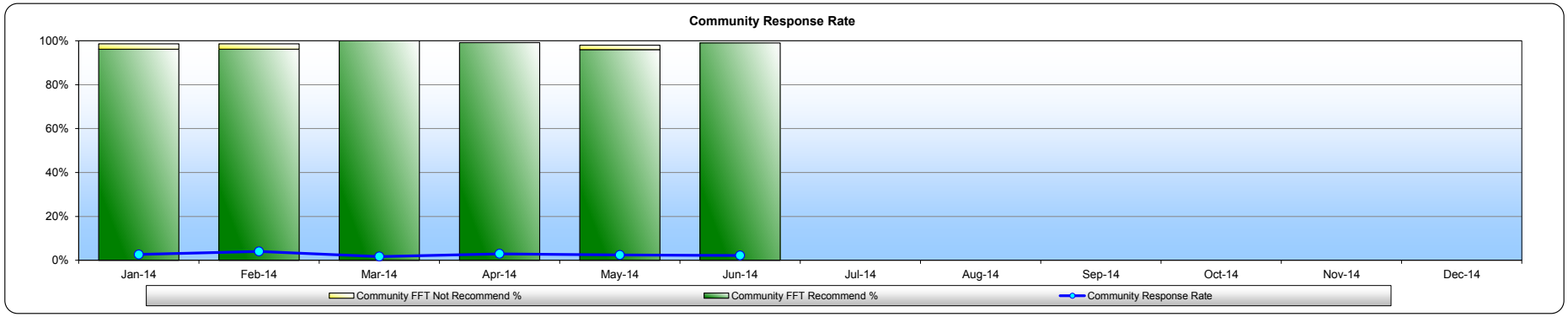
Recommend (%) $\dfrac{\text{Extremely Likely + Likely}}{\text{Extremely Likely + Likely + Neither + Unlikely + Extremely Unlikely + Don't know}} \times 100$

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

Friends & Family: Community

FFT Implemented in Community since January 2015

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Apr-15	May-15	Jun-15
Community Response Rate	None - Monitoring Only	none	2.50%				2.95%	2.39%	2.20%
Community FFT Recommend %	None - Monitoring Only	none					99.15%	95.96%	99.01%
Community FFT Not Recommend %	None - Monitoring Only	none					0.00%	2.02%	0.00%

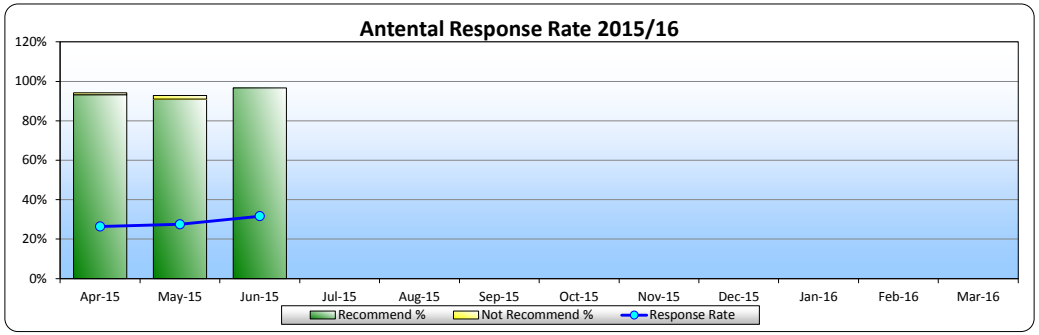


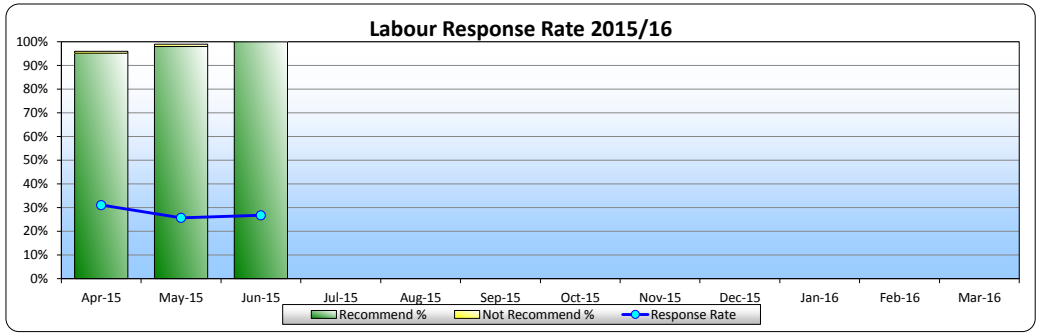
Service/Area	Consequence of Breach (Monthly)	Threshold	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Apr-15	May-15	Jun-15
Community Inpatient Services	None - Monitoring only	None	153				53	45	55
Community Nursing Services	None - Monitoring only	None	41				22	12	7
Rehabilitation & Therapy Services	None - Monitoring only	None	0				0	0	0
Specialist Services	None - Monitoring only	None	58				19	17	22
Children & Family Services	None - Monitoring only	None	11				4	5	2
Community Healthcare Other	None - Monitoring only	None	54				19	20	15

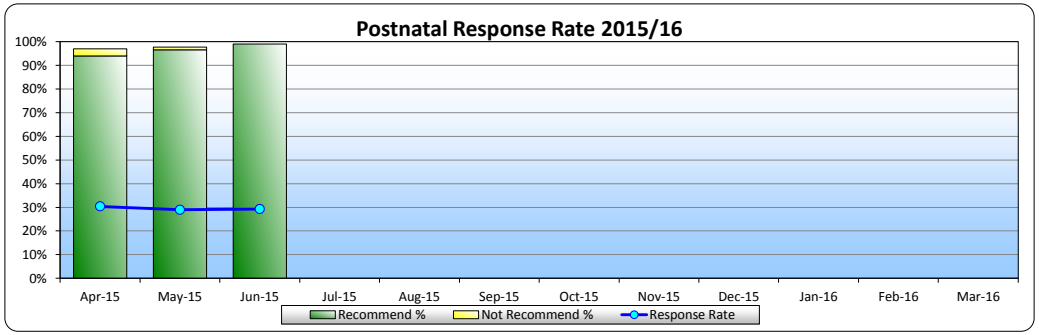
Friends & Family: Maternity

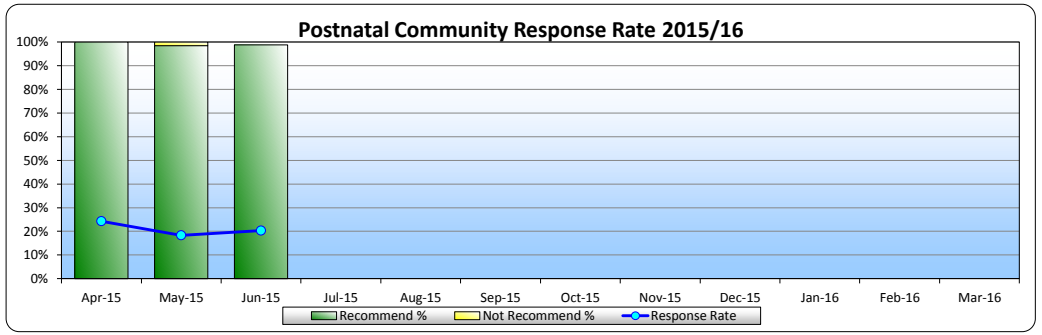
York Teaching Hospital NHS
NHS Foundation Trust

Indicator	Consequence of Breach (Monthly)	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Apr	May	Jun
Antenatal Response Rate	None - Monitoring only	none	32.4%	38.3%	31.4%	28.5%	26.41%	27.54%	31.65%
Antental % Recommend	None - Monitoring only	none					93.20%	90.99%	96.64%
Labour and Birth Response Rate	None - Monitoring only	none	18.60%	23.50%	28.84%	27.78%	31.02%	25.63%	26.71%
Labour and Birth % Recommend	None - Monitoring only	none					95.20%	98.04%	100.00%
Postnatal Response Rate	None - Monitoring only	none	24.8%	30.6%	30.9%	29.5%	30.40%	28.95%	29.26%
Postnatal % Recommend	None - Monitoring only	none					94.00%	96.59%	99.03%
Postnatal Community Response Rate	None - Monitoring only	none	20.00%	18.70%	19.87%	21.09%	24.32%	18.36%	20.33%
Postnatal Community % Recommend	None - Monitoring only	none					100.00%	98.51%	98.82%









2014/15 Performance

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

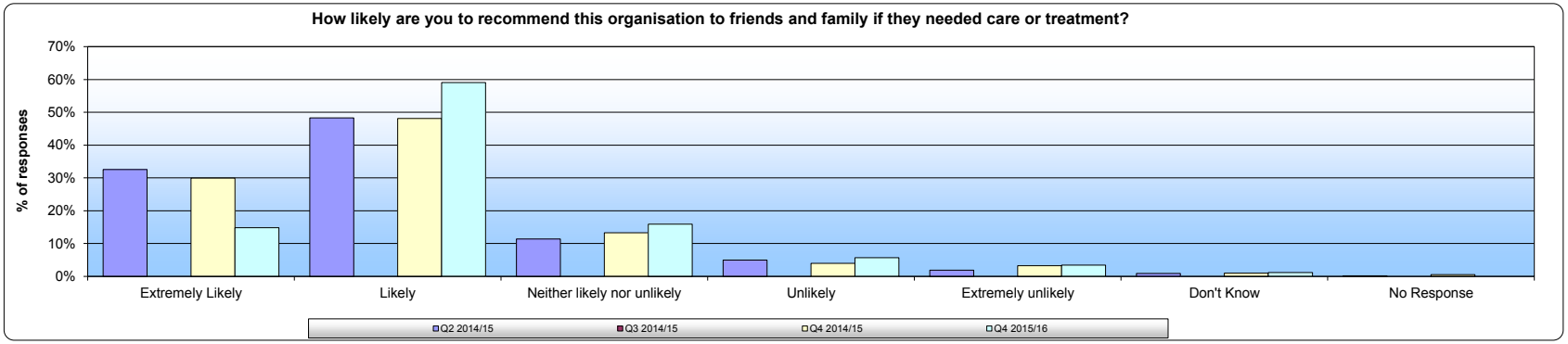
Friends and Family: Staff

York Teaching Hospital NHS
NHS Foundation Trust

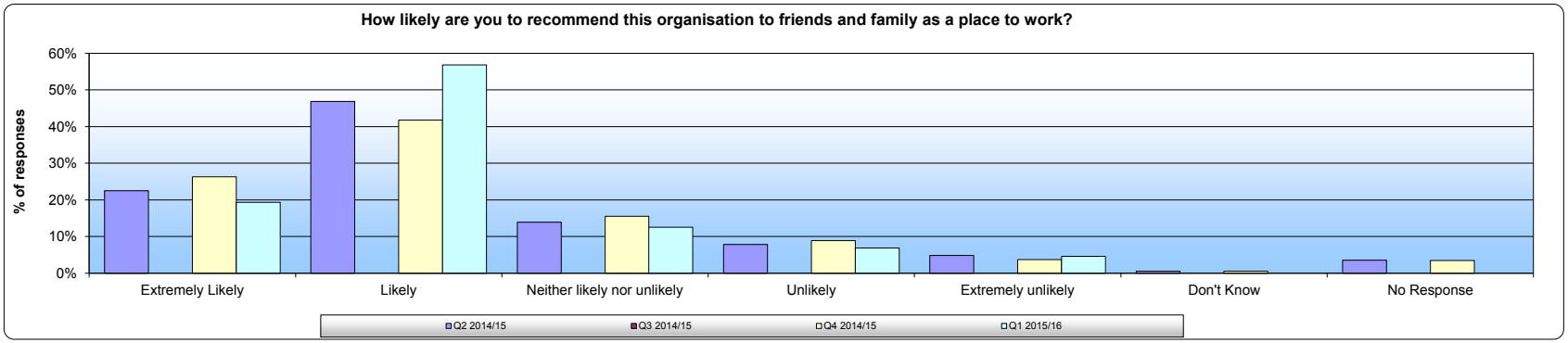
As part of the National Friends and Family CQUIN 2014/15, the Trust was required to submit evidence which demonstrates implementation of staff FFT across all Acute and Community areas.

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

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



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



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

Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 12 SIs reported in June:
Clinical 1; York
Slips Trips Falls 9; 5 York , 3 Scarborough & 1 Bridlington
Pressure Ulcers 2; York

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 June there were 150 reports of patients falling at York Hospital, 86 patients at Scarborough and 46 patients within the Community Services. This is a decrease from the number reported in May, 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 June was 1,244, 620 incidents were reported on the York site, 435 on the Scarborough site and 189 from Community Services. This is a 1.1% decrease from May.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 947 (increase from 863 at the end of May) incidents awaiting sign-off by the Directorate Management Teams. Risk and Legal are working with the Directorates to facilitate the timely completion of incident investigations.

Pressure Ulcers (source: Datix)
During June 17 pressure ulcers were reported to have developed on patients since admission to York Hospital, 22 pressure ulcers were reported to have developed on patients since admission to Scarborough and 32 pressure ulcers were reported as having developed on patients in our community hospitals or community care.
These figures should be considered as approximations as not all investigations have been completed.

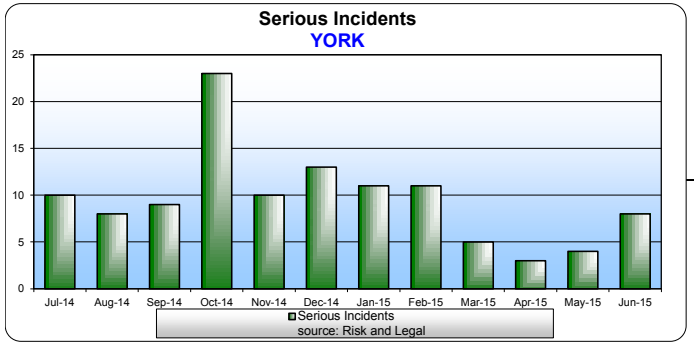
Degree of Harm: Serious/Severe or Death (source: Datix)
During June a total of 6 patient incidents were reported which resulted in serious or severe harm with zero resulting in death.

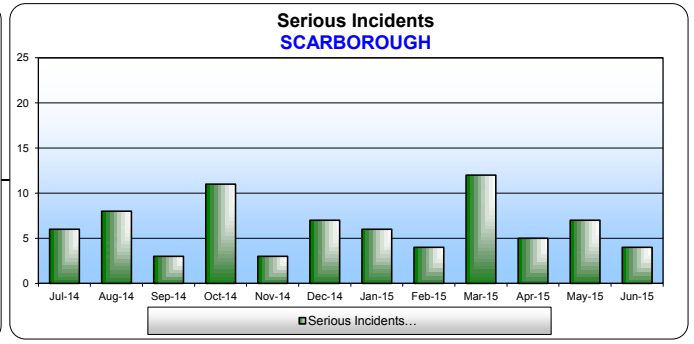
Medication Related Issues (source: Datix)
During June there was a total of 104 medication related incidents reported, although this figure may change following validation. A change of recording was made in December 2014 to improve capture of Medication Related Issues.

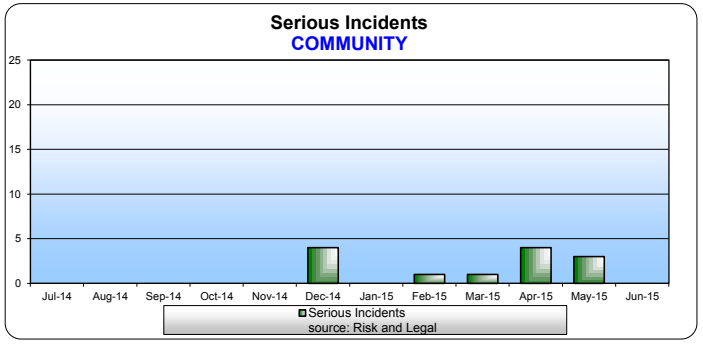
Never Events - one at York (Head and Neck), wrong site of surgery.

Measures of Harm

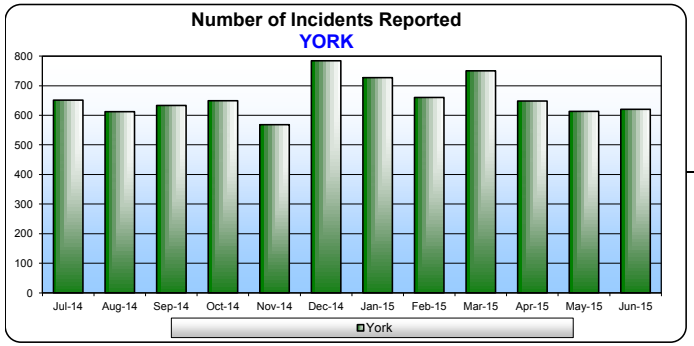
Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Serious Incidents source: Risk and Legal	York	10	8	9	23	10	13	11	11	5	3	4	8
	Scarborough	6	8	3	11	3	7	6	4	12	5	7	4
	Community	0	0	0	0	0	4	0	1	1	4	3	0
Serious Incidents Delogged source: Risk and Legal (Trust)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

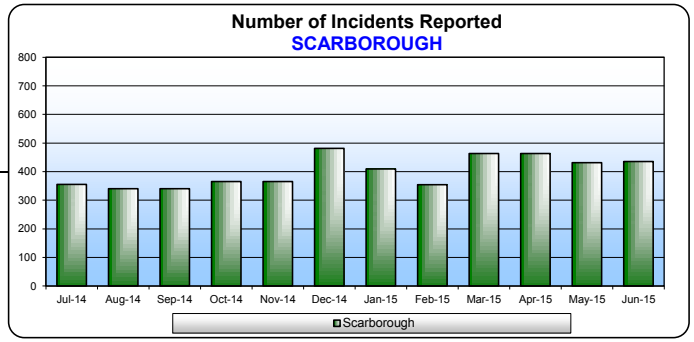


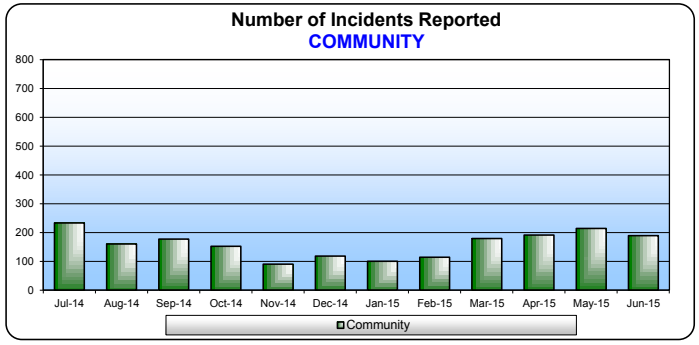




Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Number of Incidents Reported source: Risk and Legal	York	651	612	633	649	568	784	727	660	750	648	613	620
	Scarborough	355	340	340	365	365	481	409	354	463	463	431	435
	Community	233	160	177	152	90	118	100	114	179	191	214	189
Number of Incidents Awaiting sign off at Directorate level		-	1870	1497	1408	858	272	1444	516	546	1302	863	947

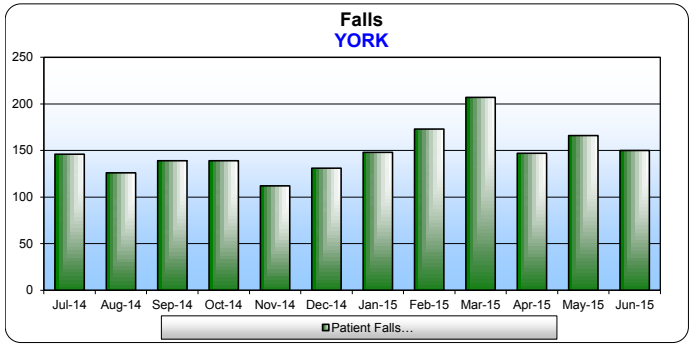


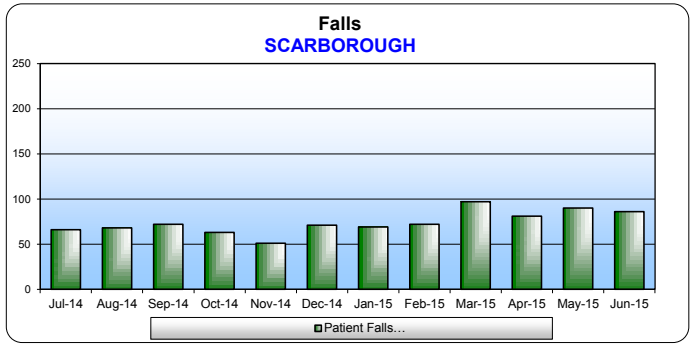


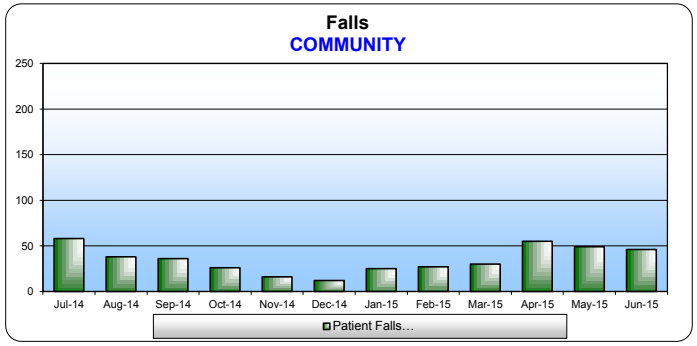


Measures of Harm

Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Patient Falls source: DATIX	York	146	126	139	139	112	131	148	173	207	147	166	150
	Scarborough	66	68	72	63	51	71	69	72	97	81	90	86
	Community	58	38	36	26	16	12	25	27	30	55	49	46

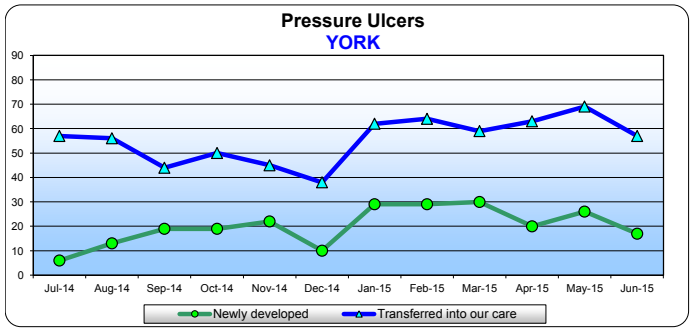


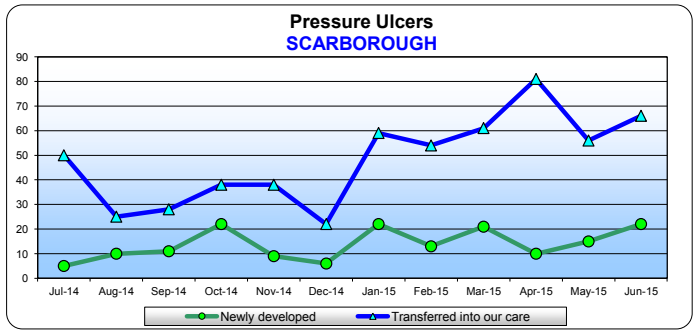


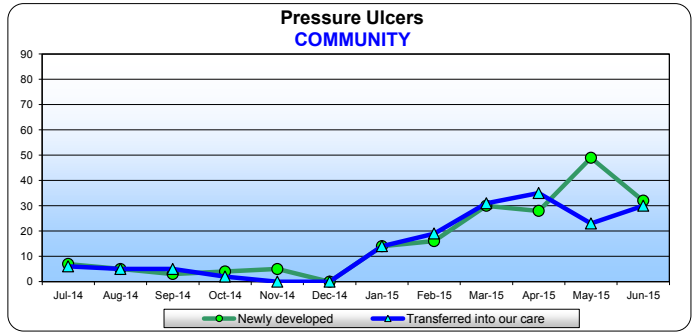


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Indicator			Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Pressure Ulcers source: DATIX	York	Newly developed	6	13	19	19	22	10	29	29	30	20	26	17
		Transferred into our care	57	56	44	50	45	38	62	64	59	63	69	57
	Scarborough	Newly developed	5	10	11	22	9	6	22	13	21	10	15	22
		Transferred into our care	50	25	28	38	38	22	59	54	61	81	56	66
	Community	Newly developed	7	5	3	4	5	0	14	16	30	28	49	32
		Transferred into our care	6	5	5	2	0	0	14	19	31	35	23	30



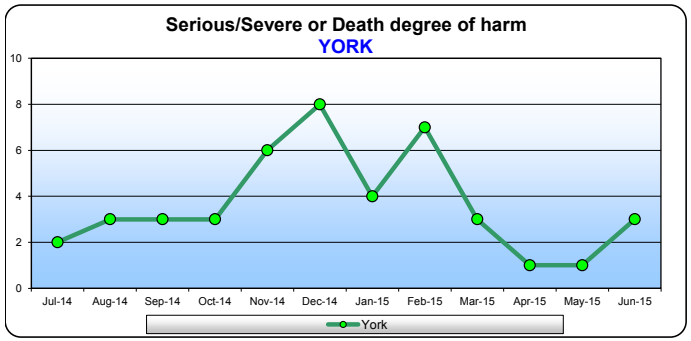


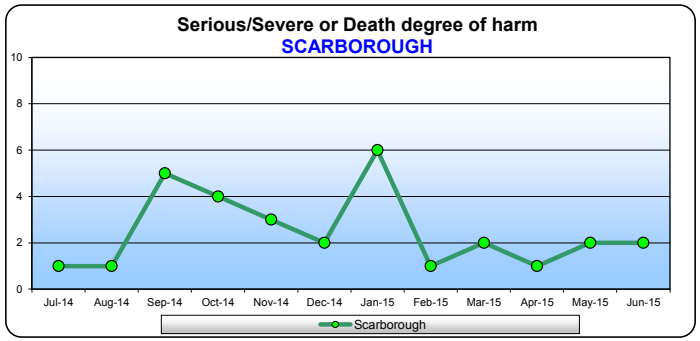


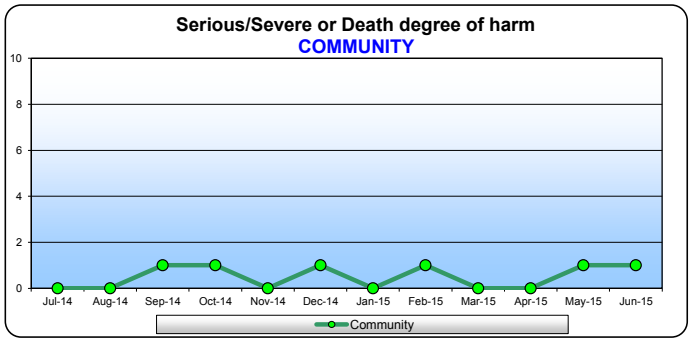
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised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

Measures of Harm

Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Degree of harm: serious/severe or death source: Datix	York	2	3	3	3	6	8	4	7	3	1	1	3
	Scarborough	1	1	5	4	3	2	6	1	2	1	2	2
	Community	0	0	1	1	0	1	0	1	0	0	1	1

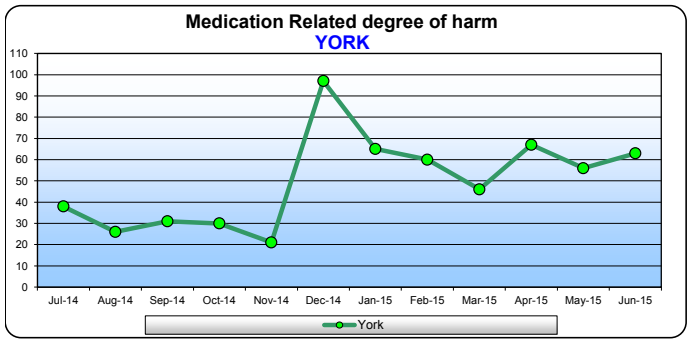


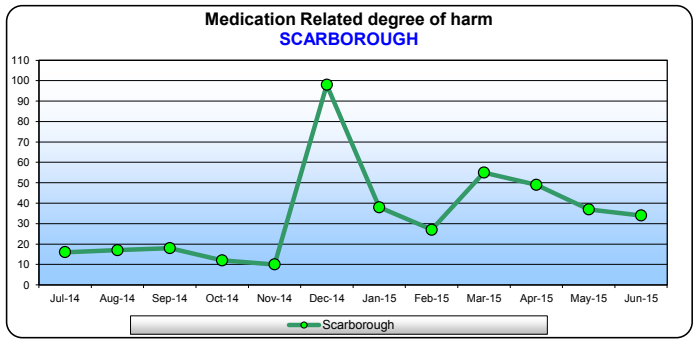


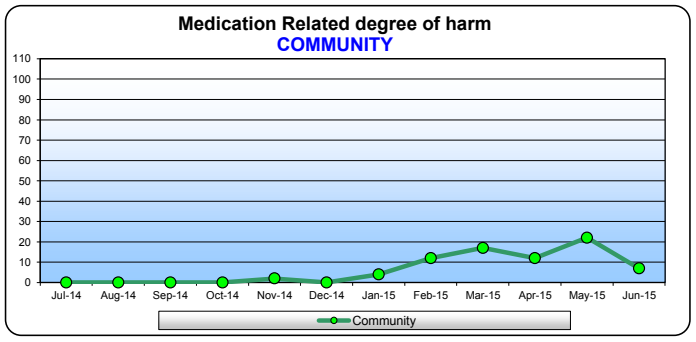


Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Degree of harm: Medication Related Issues source: Datix	York	38	26	31	30	21	97	65	60	46	67	56	63
	Scarborough	16	17	18	12	10	98	38	27	55	49	37	34
	Community	0	0	0	0	2	0	4	12	17	12	22	7

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.

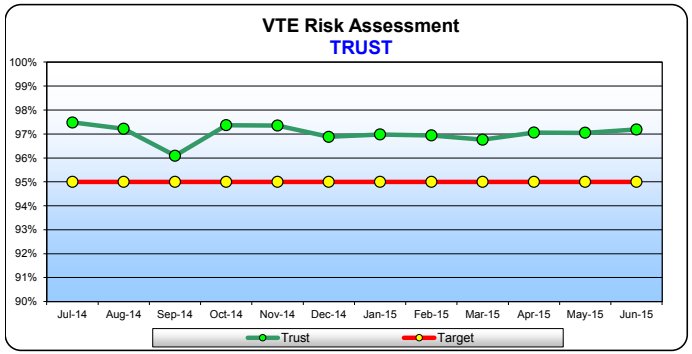


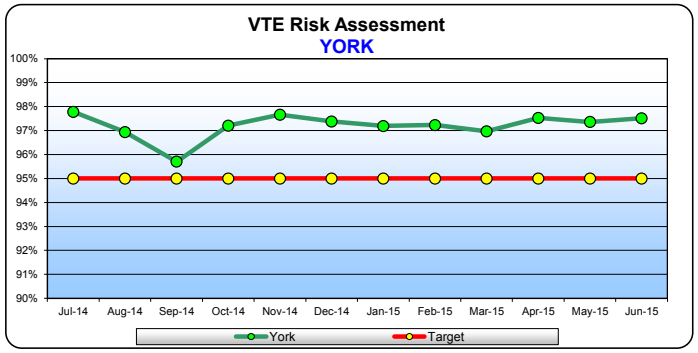


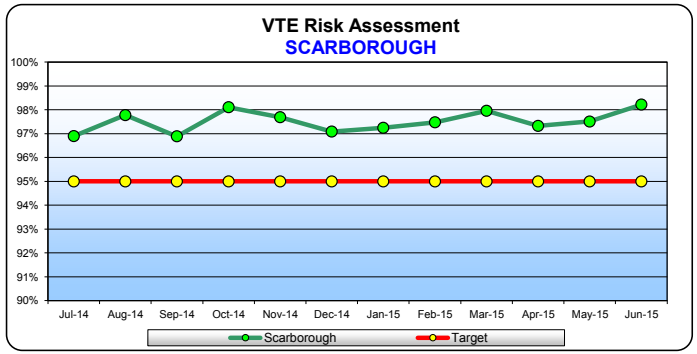


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Apr	May	Jun
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%	96.9%	97.1%	96.9%	97.1%	97.1%	97.1%	97.2%
		York	95%	96.8%	97.4%	97.1%	97.5%	97.5%	97.4%	97.5%
		Scarborough	95%	97.2%	97.6%	97.6%	97.7%	97.3%	97.5%	98.2%







Drug Administration

Omitted Critical Medicines
The audit of critical medicines missed during June indicated 0.87% for York and 1.33% for Scarborough .

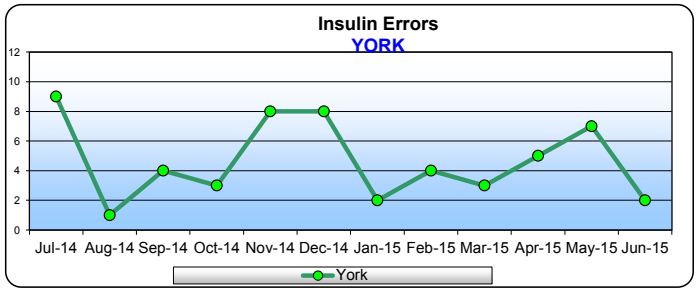
Prescribing Errors
There were 15 prescribing related errors in June; 10 from York, 5 from Scarborough and 0 from Community.

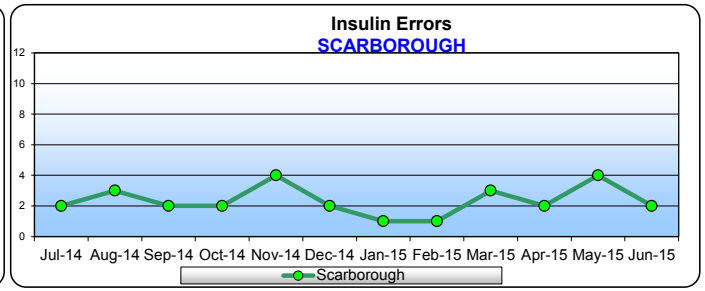
Preparation and Dispensing Errors
There were 12 preparation/dispensing errors in June; 7 from York and 5 from Scarborough.

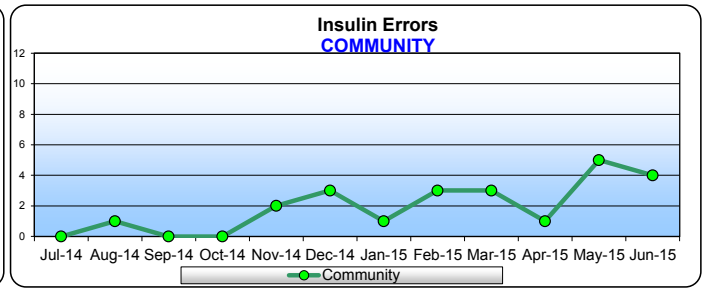
Administrating and Supply Errors
There were 49 administrating/supplying errors in June; 28 from York, 16 from Scarborough and 5 from Community.

Drug Administration

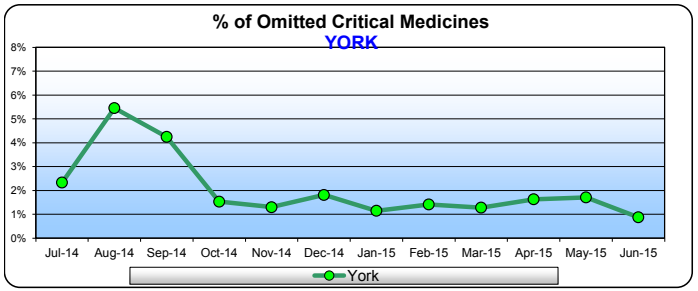
Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Insulin Errors source: Datix	York	9	1	4	3	8	8	2	4	3	5	7	2
	Scarborough	2	3	2	2	4	2	1	1	3	2	4	2
	Community	0	1	0	0	2	3	1	3	3	1	5	4

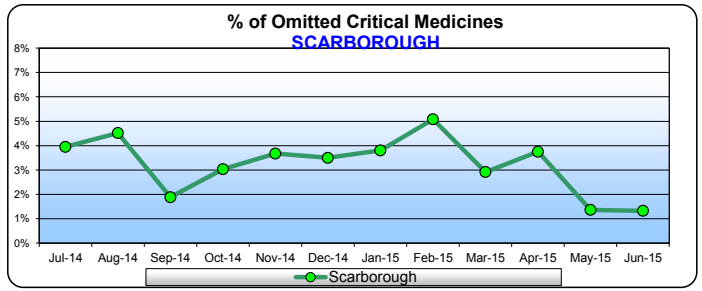


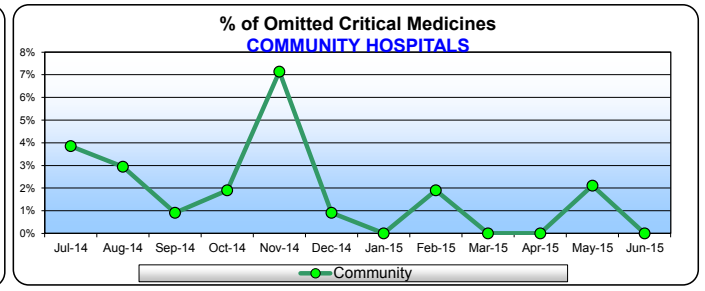




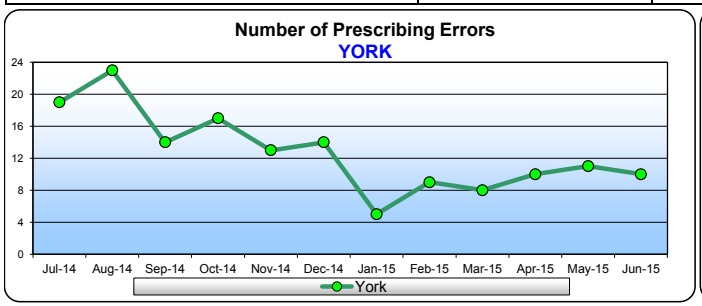
Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Number of Omitted Critical Medicines source: Datix	York	10	20	18	7	6	8	6	6	6	7	9	4
	Scarborough	9	9	4	7	9	9	9	12	7	9	3	3
	Community Hospitals	4	3	1	2	7	1	0	2	0	0	2	0

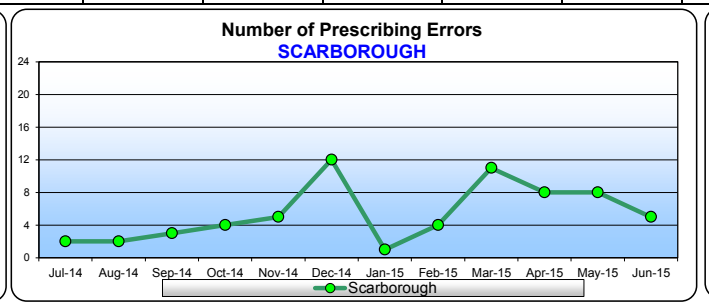


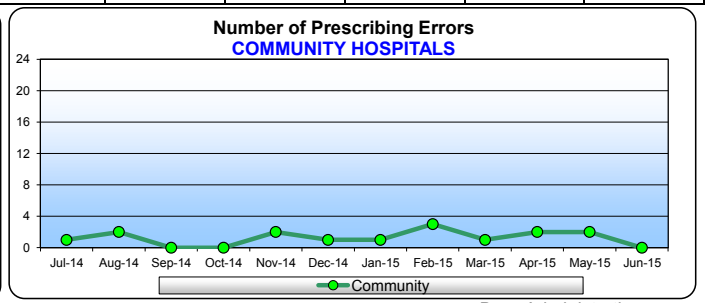




Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Number of Prescribing Errors source: Datix	York	19	23	14	17	13	14	5	9	8	10	11	10
	Scarborough	2	2	3	4	5	12	1	4	11	8	8	5
	Community Hospitals	1	2	0	0	2	1	1	3	1	2	2	0

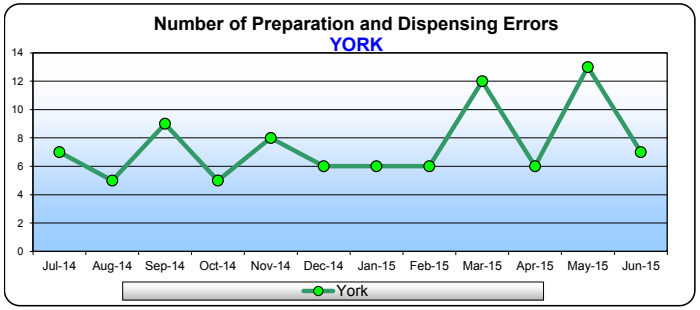


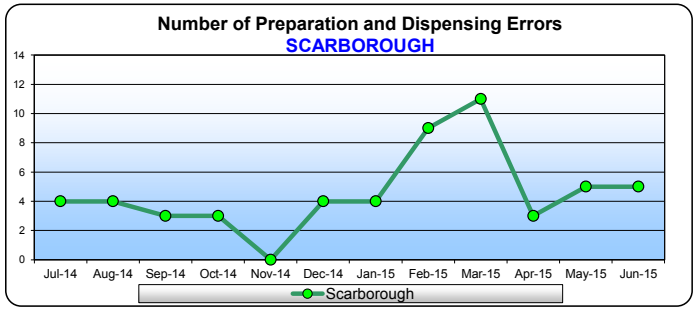


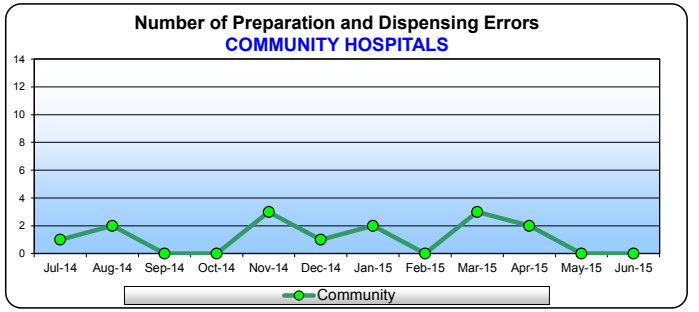


Drug Administration

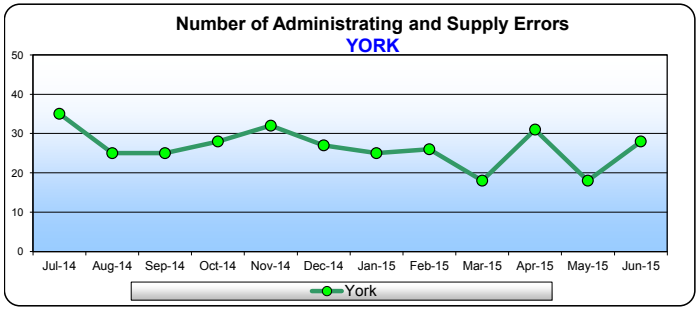
Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Number of Preparation and Dispensing Errors source: Datix	York	7	5	9	5	8	6	6	6	12	6	13	7
	Scarborough	4	4	3	3	0	4	4	9	11	3	5	5
	Community Hospitals	1	2	0	0	3	1	2	0	3	2	0	0

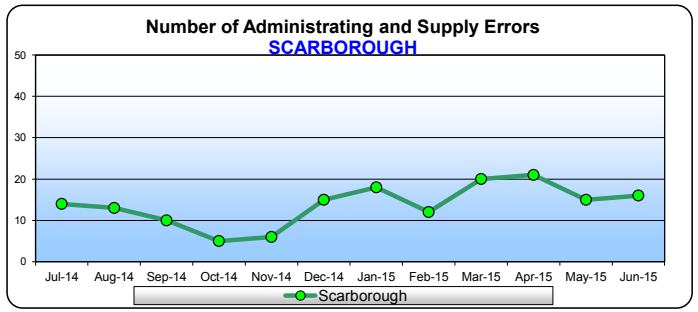


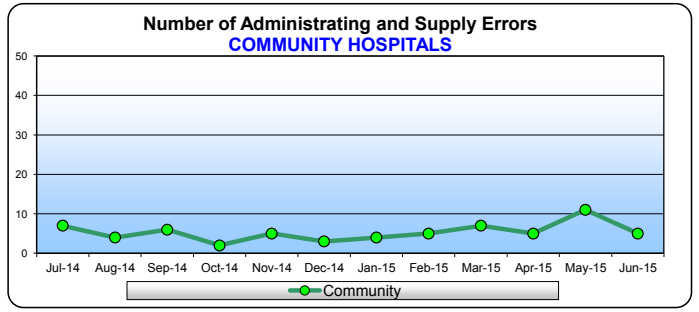




Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Administrating and Supply Errors source: Datix	York	35	25	25	28	32	27	25	26	18	31	18	28
	Scarborough	14	13	10	5	6	15	18	12	20	21	15	16
	Community Hospitals	7	4	6	2	5	3	4	5	7	5	11	5







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

·York: 94.3%
·Scarborough: 94.8%
·Community Hospitals: 85.7%
·Community care: 96.2%

VTE

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

·York: 0.5%
·Scarborough: 0%

Harm from Catheter Associated Urinary Track Infection

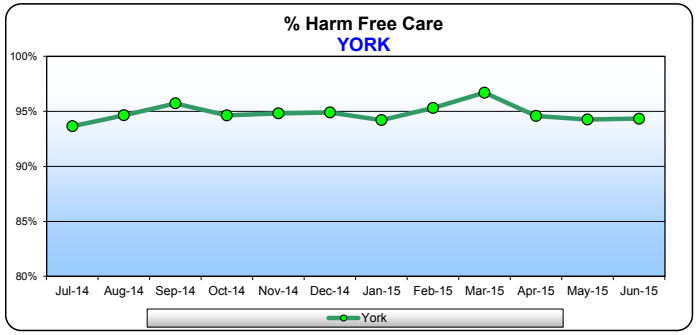
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence:

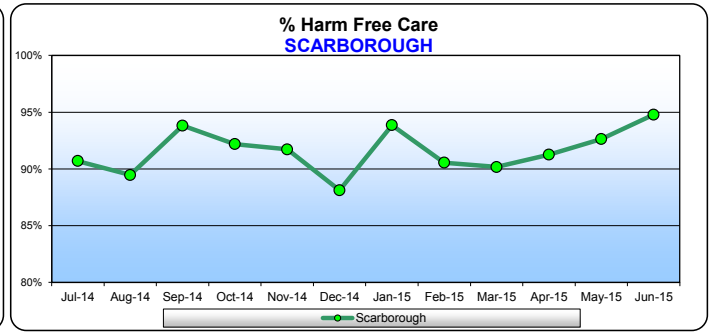
·York: 1.5%
·Scarborough: 1.7%
·Community Hospitals: 1.0%
·Community Care: 0.8%

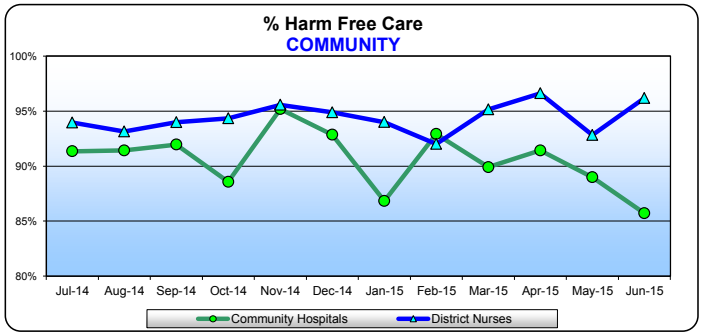
Safety Thermometer

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

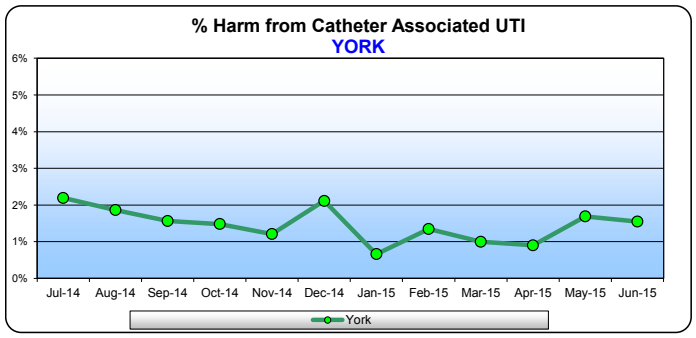
Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
% of Harm Free Care source: Safety Thermometer	York	93.6%	94.6%	95.7%	94.6%	94.8%	94.9%	94.2%	95.3%	96.7%	94.6%	94.3%	94.3%
	Scarborough	90.7%	89.5%	93.8%	92.2%	91.7%	88.1%	93.9%	90.6%	90.2%	91.3%	92.6%	94.8%
	Community Hospitals	91.4%	91.4%	92.0%	88.6%	95.2%	92.9%	86.8%	92.9%	89.9%	91.4%	89.0%	85.7%
	District Nurses	94.0%	93.1%	94.0%	94.4%	95.6%	94.9%	94.0%	92.0%	95.2%	96.6%	92.8%	96.2%

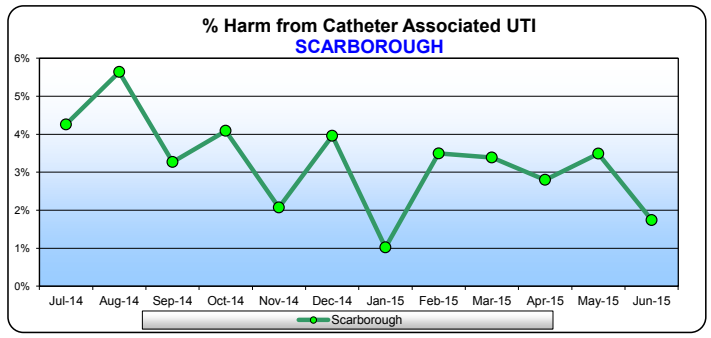


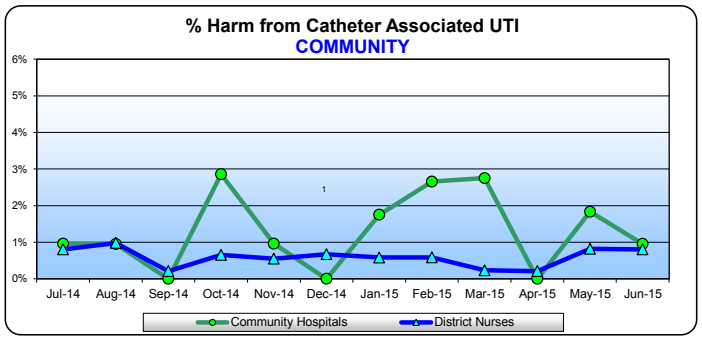




Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	2.2%	1.9%	1.6%	1.5%	1.2%	2.1%	0.7%	1.3%	1.0%	0.9%	1.7%	1.5%
	Scarborough	4.3%	5.6%	3.3%	4.1%	2.1%	4.0%	1.0%	3.5%	3.4%	2.8%	3.5%	1.7%
	Community Hospitals	1.0%	1.0%	0.0%	2.9%	1.0%	0.0%	1.8%	2.7%	2.8%	0.0%	1.8%	1.0%
	District Nurses	0.8%	1.0%	0.2%	0.7%	0.6%	0.7%	0.6%	0.6%	0.2%	0.2%	0.8%	0.8%



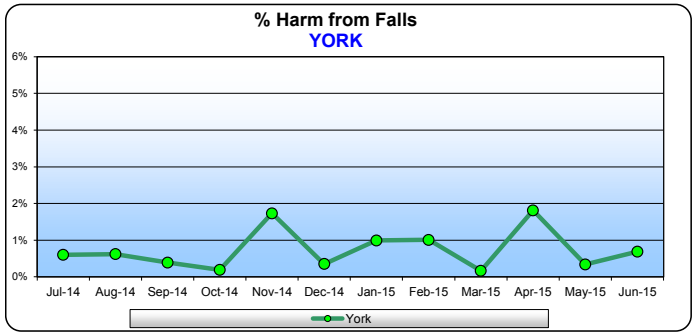


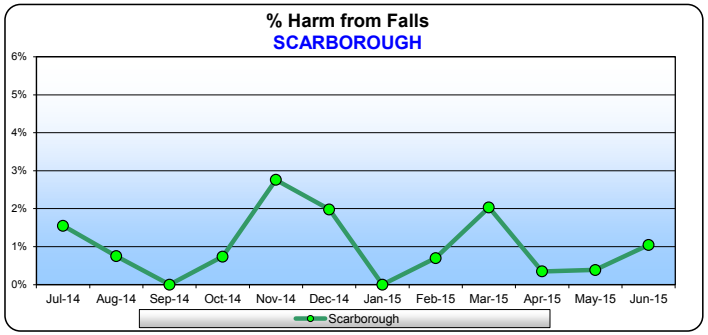


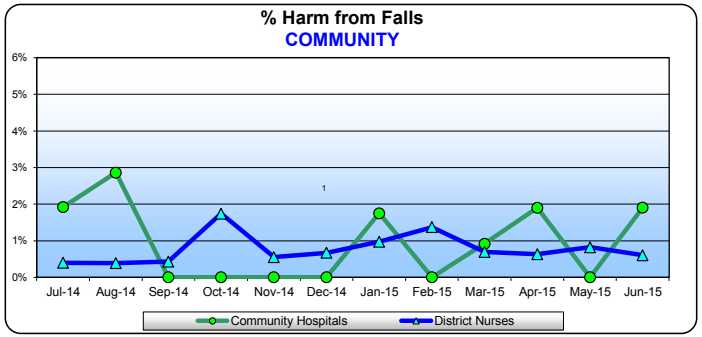
Safety Thermometer

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

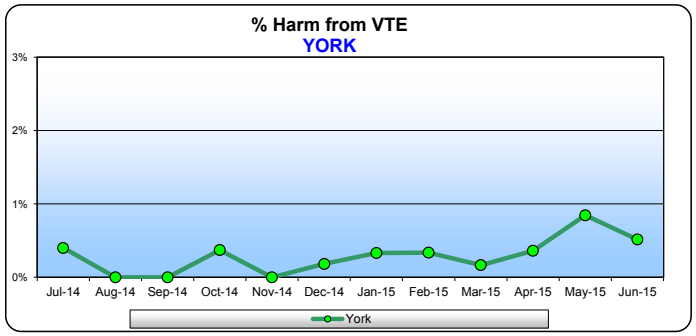
Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
% of Harm from Falls source: Safety Thermometer	York	0.6%	0.6%	0.4%	0.2%	1.7%	0.4%	1.0%	1.0%	0.2%	1.8%	0.3%	0.7%
	Scarborough	1.6%	0.8%	0.0%	0.7%	2.8%	2.0%	0.0%	0.7%	2.0%	0.4%	0.4%	1.0%
	Community Hospitals	1.9%	2.9%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.9%	1.9%	0.0%	1.9%
	District Nurses	0.4%	0.4%	0.4%	1.7%	0.6%	0.7%	1.0%	1.4%	0.7%	0.6%	0.8%	0.6%

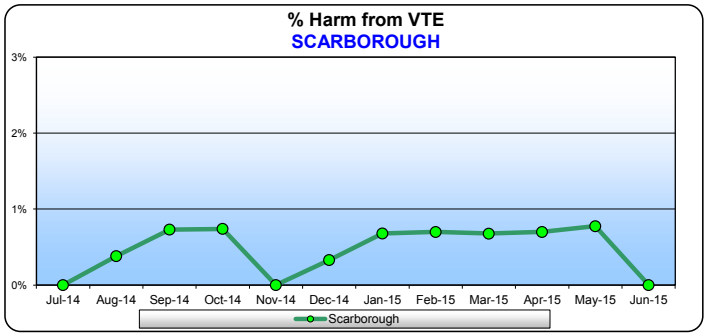


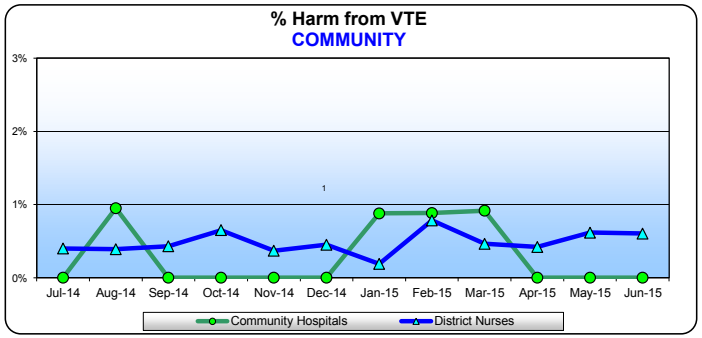




Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
% of VTE source: Safety Thermometer	York	0.4%	0.0%	0.0%	0.4%	0.0%	0.2%	0.3%	0.3%	0.2%	0.4%	0.8%	0.5%
	Scarborough	0.0%	0.4%	0.7%	0.7%	0.0%	0.3%	0.7%	0.7%	0.7%	0.7%	0.8%	0.0%
	Community Hospitals	0.0%	1.0%	0.0%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



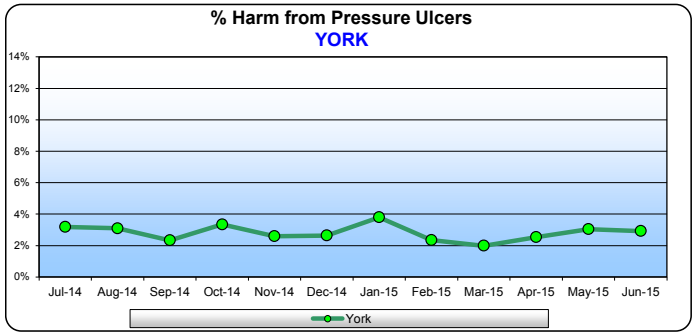


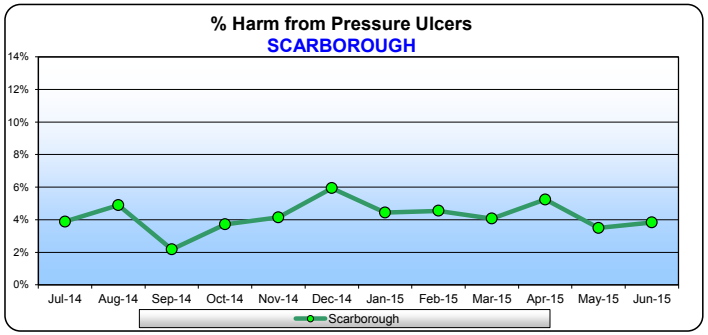


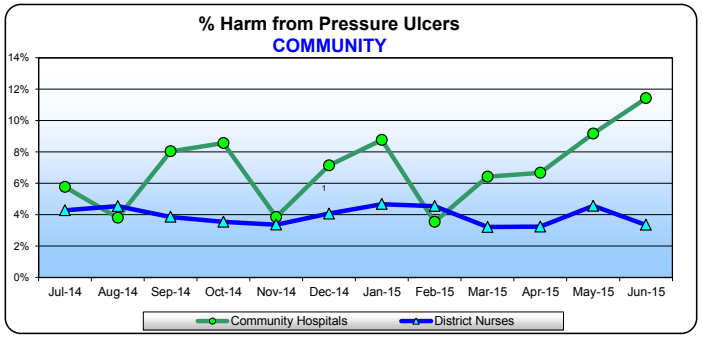
Safety Thermometer

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

Indicator		Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
% of Pressure Ulcers source: Safety Thermometer	York	3.2%	3.1%	2.3%	3.3%	2.6%	2.6%	3.8%	2.3%	2.0%	2.5%	3.0%	2.9%
	Scarborough	3.9%	4.9%	2.2%	3.7%	4.1%	5.9%	4.4%	4.5%	4.1%	5.2%	3.5%	3.8%
	Community Hospitals	5.8%	3.8%	8.0%	8.6%	3.9%	7.1%	8.8%	3.5%	6.4%	6.7%	9.2%	11.4%
	District Nurses	4.3%	4.5%	3.9%	3.6%	3.4%	4.1%	4.7%	4.6%	3.2%	3.2%	4.6%	3.4%







Never Events

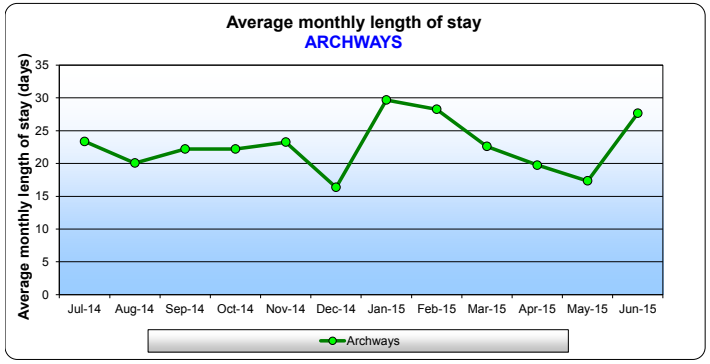
Indicator	Consequence of Breach	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Apr	May	Jun
SURGICAL									
Wrong site surgery	As below	>0	0	0	0	1	0	0	1
Wrong implant/prosthesis		>0	0	0	0	0	0	0	0
Retained foreign object post-operation		>0	0	0	0	0	0	0	0
MEDICATION									
Wrongly prepared high-risk injectable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

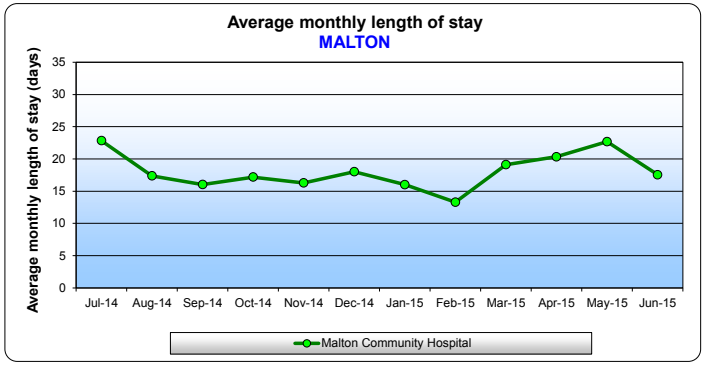
Patient Safety Walkrounds – June 2015

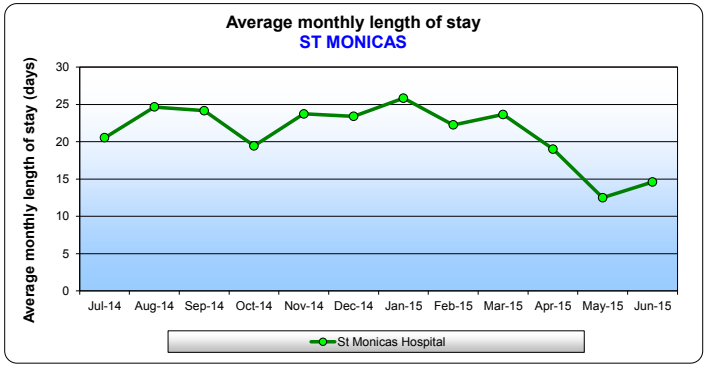
Date	Location	Participants	Actions & Recommendations
04/06/2015	Ward 32 and CCU	Brian Golding – Director Nigel Durham – Clinical Director Sharon Lewis – Directorate manager Chris Morris/Tracey Ward – Matron Mike Sweet - NED	Neuro patients on 32 often need additional support, which if not filled by NHSP draws staff from elsewhere- although additional shifts generally being filled. Biggest cause of delayed discharges is untimely completion of EDNs - it was suggested that a small working group, involving medical, nursing and pharmacy could look into an improved system, that could be piloted in the directorate. BG agreed to raise at Corporate directors as this is a trustwide issue. There had been a near miss caused by a perceived design fault with a bathroom door – ensure that there is adequate training post-handover for new projects. Records could be improved if Phillips monitoring system could interface with CPD - Philips are working on this but progress towards integration is slow. There are currently two ward sister vacancies, and one extended sickness – this is on directorate risk register and corporate nursing team have been advised. Discussed a case where a patient had to wait 2.5 hrs in ED for a bed in CCU. CCU has seen an increase in drug related errors – under investigation. Bay 1 in CCU doesn't have a door, and so patients can't be properly isolated – AB to contact Estates.
10/06/2015	Ward 17, 18 (CAU), Special Care Baby Unit and Child Development Centre	Andy Bertram - Director Rob Smith – Consultant Liz Vincent – Directorate Manager Libby Raper - NED	Notable increase in teenage self-harm cases and associated difficulties with paed/MH interface - Continued representation of Trust issues and concerns through Liz Vincent at the CAMHS interface group. Uncertainty over the contractual position with the CCG still running their procurement exercise – and the potential for significant backwards steps if the provider is changed - Directorate to ensure risk issues are identified on the directorate's risk register and for potential escalation to the corporate risk register through PMM discussions. Controlled access to SCBU is not working. Staff regularly switch this system off as the panel is faulty and access cannot be properly controlled - AB to raise with BG.
18/06/2015	Emergency Department and Urgent Care Centre	Juliet Walters –Director Stephen Lord – ED Consultant Richard Morris – Directorate Manager Jill Wilford – Lead Nurse Philip Ashton - NED	There are insufficient permanent staff in the resus area and increased demand in the dept- increased capacity to be addressed as part of the plans for the new ED build, staffing to be addressed as part of the review of workforce. Observation Bays – increased capacity planned but unclear whether additional staffing has been included - RM to check workforce and estates plans to ensure staffing has been included. RM to check with B G re timeline for the build. There is no paediatric mental health provision in ED, patients have to be admitted in order to be reviewed by CAMHS - RM to discuss with Child Health Directorate and with TEWV. Radiology handover between 08.00 – 09.00 and 22.00 – 23.00 is an issue when reporting transfers to Australia as it causes delays - RM to discuss with Steve Mackell.
23/06/2015	CCU and Cardio-Respiratory Unit (SH)	Patrick Crowley – Chief Executive David Humphriss – Clinical Director Sharon Lewis – Directorate Manager Tracey Wright – Matron Jennie Adams - NED	CCU There are several RN vacancies in the CCU, including the lead nurse role and a vacancy for a Consultant - recruitment plans are in place but there is a shortage in this specialty. At times of high hospital activity and especially at night, nurses from this area are sometimes moved to cover other areas which prevents CCU staff from attending cardiac arrests on other wards/ED. The unit is part of the general consultant on call rota so there is often no consultant cardiologist on call. Designated angiography beds are often used as additional general medical beds and siderooms for non-cardiac patients with infections. The CCU is frequently used as additional bed capacity for outlying medical patients which results in cardiology procedures being cancelled due to lack of beds. The most recent SI was a fatal fall- use of low level beds to be reinforced. A review is being undertaken to identify patient who may have been missed off waiting lists. Issue appears to have been result of parallel use of manual system with introduction of CPD. A service-wide SI was declared around the accuracy of recent echocardiogram reports and a number of issues identified around training and capability of staff. The service was suspended for a time while a solution was found. The service has now resumed with support from York staff. Waiting times have recovered but additional staff will be required to prevent build up in the future and a new echo machine.
30/06/2015	Ward 35 & 37	Andy Bertram - Director Karen Goodman – Clinical Director Jamie Todd – Directorate Manager Hilary Woodward – Matron (37) Katie Holgate – Matron Philip Ashton - NED	High temperature on the wards in Summer still remains an issue but is being managed through the Trust's heat escalation process. AB will escalate to Brian Golding to install aircon ASAP in side rooms currently out of action due to maintenance works. The extra HCA on night duty on Ward 37 has made a big difference to the number of patients falling, bays 4 and 5 designated at high falls risk and cohorting of patients helps with visibility and risk management. The last fall with harm was before Christmas on ward 35. Typical AIRS forms for the wards relate to difficulties getting doctors to come to the ward and difficulties in patient transfers from AMU. The directorate is engaged in work to improve these processes. Trial of comfort boxes for relatives of patients in elderly at the end of their life. Comfort boxes include 3 bags with a blanket, bottle of water, wipes, toiletries, tissues, boiled sweets and a token for a meal in Ellerby's café. In addition for each ward a low lamp to give subdued lighting around patient's bed space. Staff vacancies - the directorate is developing a rotation programme to provide training in elderly, stroke and dementia care. Dementia café Ward 37 - Sister Clark to consider Trust's Charity Committee to seek funding.

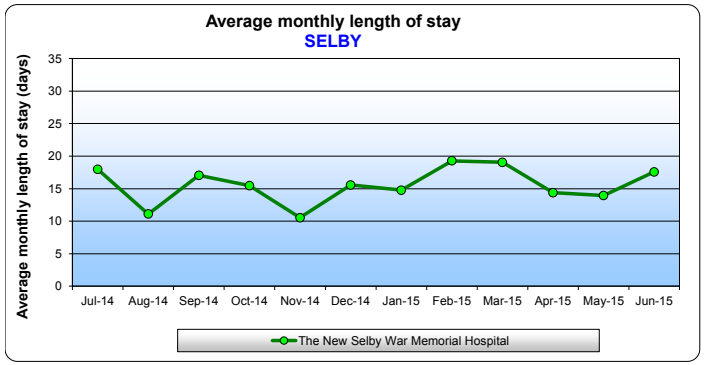
Community Hospitals

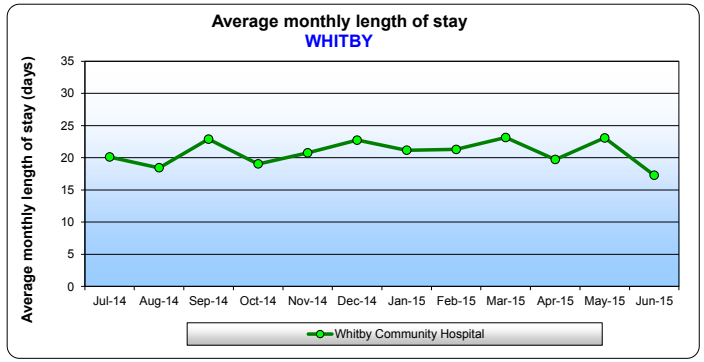
Indicator	Hospital	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Apr	May	Jun
Community Hospitals average length of stay (days)	Archways	22.1	20.6	26.8	21.1	19.7	17.3	27.7
	Malton Community Hospital	18.6	17.1	16.0	19.9	20.3	22.7	17.6
	St Monicas Hospital	23.2	22.0	24.0	15.5	19.0	12.5	14.6
	The New Selby War Memorial Hospital	15.6	13.7	17.6	15.3	14.4	13.9	17.6
	Whitby Community Hospital	20.3	20.9	21.9	20.0	19.7	23.1	17.3
	Total	19.4	18.1	20.2	18.5	18.3	18.7	18.4

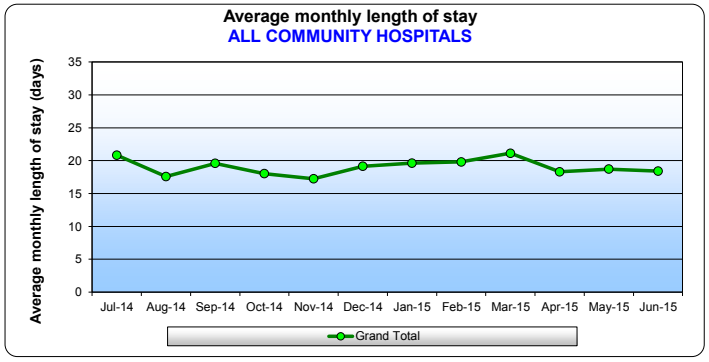






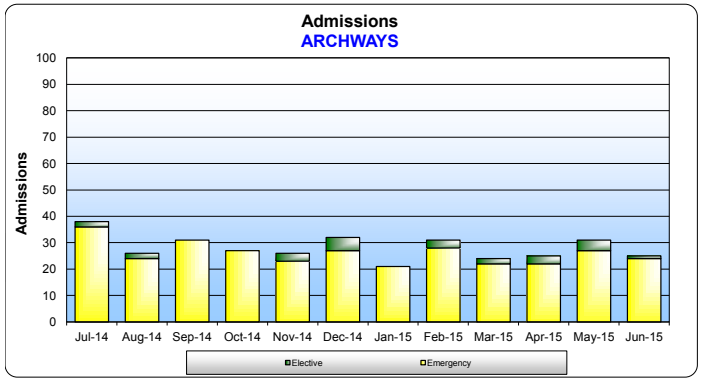


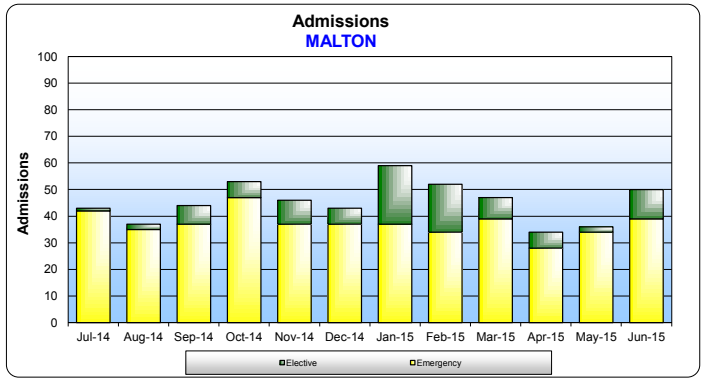


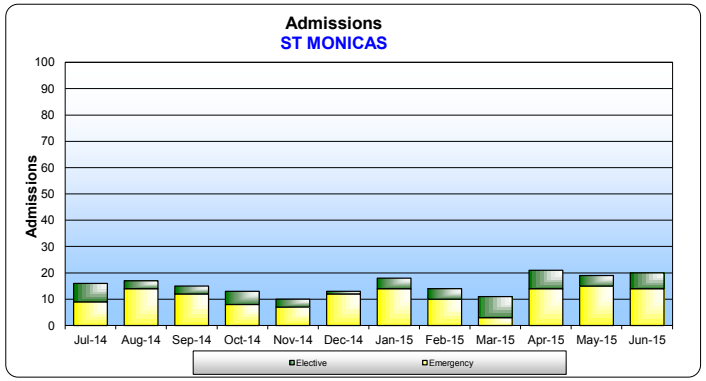


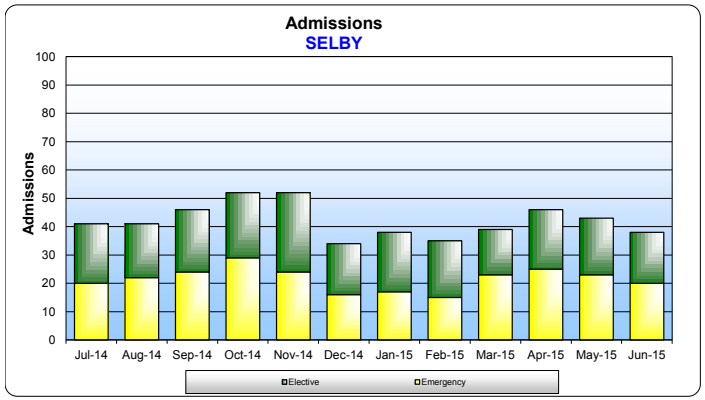
Community Hospitals

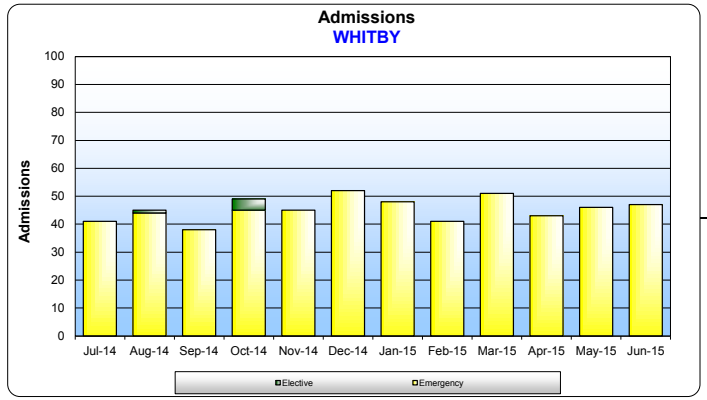
Indicator	Hospital		Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Apr	May	Jun
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	4	8	5	8	3	4	1
		Emergency	91	77	71	73	22	27	24
	Malton Community Hospital	Elective	10	21	48	19	6	2	11
		Emergency	114	121	110	101	28	34	39
	St Monicas Hospital	Elective	13	9	16	17	7	4	6
		Emergency	35	27	27	43	14	15	14
	The New Selby War Memorial	Elective	62	69	57	59	21	20	18
		Emergency	66	69	55	68	25	23	20
	Whitby Community Hospital	Elective	1	4	0	0	0	0	0
		Emergency	123	142	140	136	43	46	47
	Total	Elective	90	111	126	103	37	30	36
		Emergency	429	436	403	421	132	145	144

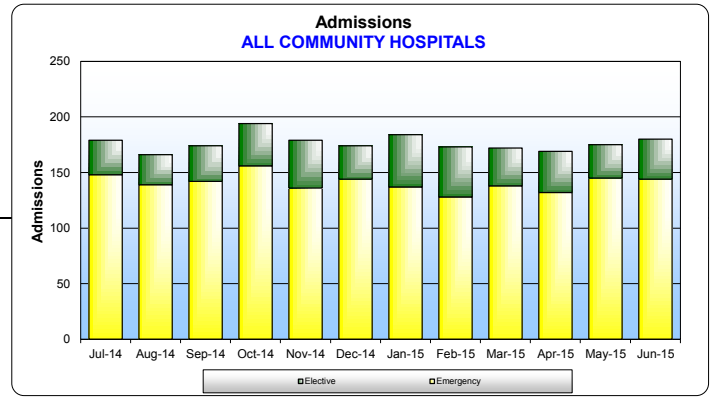












YORK - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Flag Source	April	May	June	July	August	September	October	November	December	January	February	March	Av. Monthly YtD
Activity	Births	Bookings	1st m/w visit	CMIS from Jan CPD	≤302	302-329	≥330	prev. stats	276	297	253	302	254	325	314	296	246	311	300	266	286.7
		Bookings <13 weeks	No. of mothers	CMIS from Jan CPD	≥90%	76%-89%	≤75%	CQUIN	84.1%	82.8%	88.4%	89.7%	86.6%	86.3%	86.6%	88.0%	87.0%	88.0%	90.0%	96.2%	87.8%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	CQUIN	8.0%	4.7%	5.5%	3.0%	6.3%	7.1%	8.3%	6.4%	5.3%	6.0%	5.0%	2.3%	5.7%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	CQUIN	-	-	-	-	-	-	-	-	-	-	-		-
		Births	No. of babies	CPD	≤295	296-309	≥310	prev. stats	250	292	289	308	317	308	319	244	264	269	228	273	280.1
		No. of women delivered	No. of mothers	CPD	≤296	296-310	≥311		243	290	289	302	311	303	316	239	261	265	224	272	276.3
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more		0	2	0	0	0	1	1	3	1	3	1	4	1.3
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more		0	0	0	0	0	0	1	0	0	1	0	0	0.2
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more		1	2	4	4	2	1	5	1	1	3	1	4	2.4
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	1	1	0	0	0	0	0	0	0	0		0.2
		SCBU at capacity	number of times	SCBU	0	1	2 or more		0	5	0	1	1	0	0	0	0	1	0		0.7
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	29.0	29.0	29.0	29.8	30.5	31.4	31.3	31.9	33.2	32.5	32.5		30.9
		1 to 1 care in Labour	CPD	CPD	≥75%	61%-74%	≤60%		79.4%	76.2%	77.9%	79.8%	83.6%	78.5%	79.0%	86.6%	83.9%	82.3%	80.8%	76.8%	0.8
		L/W Co-ordinator supernumary %		Risk Team					71	51	50	45	61	48	43	56	55	70	63	42	5450.8%
		Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	76	76	76	76	76	76	76	76	76	76	76	76	76.0
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10		10	10	10	10	10	10	10	10	10	10	10	10	10.0
		Supervisor : M/w ratio 1 :	Ratio	Rota	12	13-15	15	SHA	14	14	14	14	14	14	14	14	14	14	14	14	14.0
Clinical	Neonatal/Maternal	Normal birth	No. of svd	CPD	≥65%	64%	≤63%		58.0%	58.5%	65.6%	62.7%	61.4%	64.4%	58.2%	58.2%	57.5%	61.9%	62.1%	59.2%	60.6%
Indicators	Morbidity	Assisted Vaginal Births	No. of instr. births	CPD	≤15%	16-19%	≥20%	prev. stats	22.4%	19.9%	14.6%	12.7%	13.2%	11.2%	14.9%	15.9%	18.0%	17.4%	12.5%	13.6%	15.5%
		C/S Deliveries	Em & elect	CPD	≤24%	24.1-25.9	≥26%	prev. stats	25.8%	26.0%	23.3%	27.3%	22.8%	21.1%	25.6%	24.3%	22.2%	19.2%	24.6%	26.5%	24.1%
		Eclampsia	No. of women	CPD	0		1 or more		0	1	0	0	0	0	1	0	0	0	0	0	0.2
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	prev. stats	0	2	1	3	0	0	1	1	1	2	1	0	1.0
		ICU transfers	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	0	2	0	0	0	0	0	1	1	0	0	0.3
		HDU on L/W	No. of days	Handover Sheet					10	30	30	20	20	15	25	15	28	15	14	14	19.7
		Uterine Rupture from Jan 14	No of women	CPD	0	1	2 or more		0	0	0	0	0	0	0	0	0	0	0	0	0.0
		BBA	No. of women	Risk Team - Datix	1	2-3	4 or more	prev. stats	4	5	3	4	3	7	4	2	8	4	4	2	4.2
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	0	0	0	1	0	0	1	0	1	1	1	1	0.5
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more		-	-	-	-	-	-	-	-	-	1	1	0	0.7
		Intrapartum Stillbirths	No. of babies	Risk Team	0	0	1 or more		-	-	-	-	-	-	-	-	-	0	0	0	0.0
	Risk Management	SI's	Total	Risk Team	0	1	1 or more		0	1	0	0	0	0	0	0	0	0	0	0	0.1
		PPH > 2L	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		1	5	4	4	1	2	2	0	2	1	2	2	2.2
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	RCOG	1	3	5	2	3	7	5	1	6	4	1	3	3.4
		3rd/4th Degree Tear	% of tears (vaginal b	CPD	≤1.5%	1.6-6.1%	≥6.2%	RCOG	5.4%	5.3%	6.4%	6.3%	2.3%	3.5%	2.2%	2.2%	3.0%	1.5%	5.4%	2.9%	3.9%
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		96.0%	94.0%	92.0%	91.0%	91.0%	91.0%	89.0%	91.0%	92.0%	86.0%	89.0%	77.0%	89.9%
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		78.0%	83.0%	74.0%	71.0%	71.0%	46.0%	46.0%	50.0%	50.0%	79.0%	76.0%	58.0%	65.2%
		Training cancelled	No. of staff affected	Risk Team	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0	0.0
	New Complaints	Informal	Total		0	1-4	5 or more		3	0	3	3	1	1	1	2	0	0	1	0	1.3
		Formal	Total		0	1-4	5 or more		2	0	0	1	0	2	0	4	0	0	2	1	1.0

SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Flag Source	April	May	June	July	August	September	October	November	December	January	February	March	Av. Monthly YtD
Activity	Births	Bookings	1st m/w visit	Evolution from Jan CPD	≤200	201-249	≥250	prev. stats	193	183	185	187	176	192	193	139	136	151	131	266	184
		Bookings <13 weeks	No. of mothers	Evolution from Jan CPD	≥90%	76%-89%	≤75%	CQUIN	94.3%	88.1%	94.6%	87.1%	84.7%	87.4%	87.2%	92.4%	90.4%	87.0%	91.6%	96.2%	90.1%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	CQUIN	4.1%	9.7%	3.8%	9.8%	11.9%	9.9%	11.7%	6.5%	8.8%	9.8%	7.6%	2.3%	8.0%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	CQUIN	-	-	-	-	-	-	-	-	-	-	-		
		Births	No. of babies	CPD	≤170	171-189	≥190	prev. stats	119	119	125	134	158	146	148	129	138	142	125	125	134
		No. of women delivered	No. of mothers	CPD	≤170	171-189	≥190		116	119	124	132	158	146	145	127	136	138	125	127	133
	Closures	Homebirth service suspended	No. of closures	Comm. Manager	0-3	4-6	7 or more		0	0	1	0	0	0	0	0	1	0	0	1	0
		Homebirth service suspended	No. of women	Comm. Manager	0	1	2 or more		0	0	1	0	0	0	0	0	1	0	0	1	0
		Escalation Policy implemented	No. of times	Comm. Manager	3	4-5	6 or more		0	0	1	0	0	0	0	1	1	0	0	0	0
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	1	0	0	0	0	0	1	0	0	0	0
		SCBU at capacity	no of times	SCBU	0	1	2 or more		7	26	10	4	21	10	8	8	20	26	5	14	12
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	43.3	43.5	42.5	43.7	40.1	38.2	38.0	39.9	38.6	42.0	42.3	41.1	41.5
		HCA's	Ratio	Matron				staffing paper	15.7	15.3	15.7	14.5	14.5	15.9	15.9	15.3	15.8	16.3	16.3	16.3	16.0
		1 to 1 care in Labour		Risk Team	≥75%	61%-74%	≤60%		88.0%	86.0%	87.0%	88.0%	88.0%	92.0%	93.0%	91.3%	91.3%	90.6%	93.6%	76.8%	89.9%
				Risk Team					64.5%	70.9%	75%	58%	50%	50%	58%	50%	59%	55%	64%	62.0%	63.3%
		Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	40	40	40	40	40	40	40	40	40	40	40	40	40
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10		3	3	3	3	3	3	3	3	3	3	3	3	3
		Supervisor : M/w ratio 1 :	Ratio	Rota	15	16-19	20	SHA	14	14	14	14	14	14	14	14	14	14	14	14	14
Clinical	Neonatal/Maternal	Normal birth	No. of svd	CPD	≥65%	64%	≤63%		76.7%	68.9%	64.0%	76.5%	70.3%	76.0%	71.0%	72.4%	69.9%	77.5%	75.2%	68.0%	71.9%
Indicators	Morbidity	Assisted Vaginal Births	No. of instr. births	CPD	≤15%	16-19%	≥20%	prev. stats	3.4%	6.7%	6.5%	3.8%	9.5%	9.0%	5.5%	4.7%	7.4%	5.8%	9.6%	8.8%	6.3%
		C/S Deliveries	Em & elect	CPD	≤24%	24.1-25.9	≥26%	prev. stats	19.8%	23.5%	29.0%	18.9%	20.9%	15.2%	22.8%	22.8%	22.8%	22.5%	24.8%	23.2%	22.5%
		Eclampsia	No. of women	CPD	0		1 or more		0	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	prev. stats	1	1	0	0	0	0	0	0	1	0	0	0	0
		ICU transfers	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	0	0
		HDU on L/W	No. of days	Handover Sheet					3	0	0	2	2	2	2	3	2	4	0	1	2
		P/N Hysterectomies < 7days p/n	No of women	Risk Team	0	1	2 or more		0	0	0	0	0	0	0	0	0	0	0	0	0
		BBA	No. of women	Risk Team - Datix	1	2-3	4 or more	prev. stats	0	0	0	3	2	0	2	1	1	3	0	1	1
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	0	1	0	0	0	0	0	0	0	0	0	0	0
		Stillbirths Antepartum	No of babies	Risk Team	0	1	2 or more	prev. stats	-	-	-	-	-	-	-	-	-	1	0	0	0
		Stillbirths Intrapartun	No. of babies	Risk Team	0	0	1 or more	prev. stats	-	-	-	-	-	-	-	-	-	1	0	0	0
	Risk Management	SI's	Total	Risk Team	0	1	2 or more		1	0	0	0	0	1	1	0	0	0	1	0	0
		PPH > 2L	No. of women	Risk Team - Datix	1 or less	2-3	3 or more		2	0	0	2	0	1	3	0	0	1	0	1	1
		Shoulder Dystocia	No. of women	Risk Team - Datix	1 or less	2-3	3 or more	RCOG	0	1	1	0	1	0	0	0	0	1	1	2	1
		3rd/4th Degree Tear	% of tears (vaginal b	CPD	≤1.5%	1.6-6.1%	≥6.2%	RCOG	0.4%	0.7%	1.6%	0.0%	1.3%	0.7%	2.1%	0.0%	3.7%	1.4%	1.1%	0.9%	1.6%
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		91.0%	90.0%	94.0%	93.0%	93.0%	93.0%	94.0%	84.0%	89.0%	66.0%	80.0%	80.0%	87.9%
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		0.0%	0.0%	77.0%	92.0%	92.0%	92.0%	92.0%	100.0%	92.0%	93.0%	86.0%	86.0%	73.6%
		Training cancelled	No. of staff affected	Risk Team	0		≥1		0	0	0	0	0	8	0	0	0	0	0	0	1
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		0	1	0	1	2	3	1	1	0	0	1	0	1
		Formal	Total	Matron	0	1-4	5 or more		2	0	0	0	1	4	0	0	0	0	0	0	1

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D2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Director's – 29 July 2015

Medical Director's Report

Action requested/recommendation

Board of Director's should:

- Note the consultants joining the Trust
- Be aware of the compliance audit with the antimicrobial guidelines
- Note the update/progress with the Patient Safety Strategy/Sign up to Safety Campaign
- Note the Severe Sepsis Rapid Feedback Process.

Summary

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

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

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

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

Board of Director's – 29 July 2015

Medical Director's Report

1. Introduction and background

In the report this month:

- **Consultants new to the Trust**
- **Summary of Antibiotic Prescription Audit Results**
- **Patient Safety Strategy/ Sign up to Safety Campaign Update**
- **Sepsis Rapid Feedback Process.**

2. Consultants new to the Trust

Dr Peter Wanklyn
Consultant in Stroke - York Hospital
Commenced 08/06/2015

3. Antimicrobial prescribing audit

January – June 2015

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

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

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

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

Proportion of iv & oral antibiotics (Trust wide results)	Jan	Feb	Mar	Apr	May	Jun
iv antibiotics	43.9%	43.1%	57.6%	36.2%	50.5%	56.9%
oral antibiotics	56.1%	56.9%	41.5%	63.8%	49.5%	43.1%

Can the prescriber be identified? (legible signature / personal bleep number)	Jan	Feb	Mar	Apr	May	Jun
% yes	/	/	/	/	/	/
% no	/	/	/	/	/	/

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

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

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

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

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

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

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

NB With effect from January 2015, Directorate results are derived from the consultant assigned to each patient on CPD on audit day, and may therefore differ slightly from ward results.

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

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

4. Patient Safety Strategy/ Sign up to Safety Campaign Update

Ensuring consistency of care, 24 hours a day, 7 days a week

To ensure that patients who are admitted to hospital for urgent treatment are assessed promptly we aim for 80% of all acute medical, elderly medical and orthogeriatric patients to be reviewed by a consultant within 12 hours of admission, with a view to continuous improvement aligned with the Royal College of Physicians guidance. Currently we are achieving this standard on the York Hospital site but not at Scarborough Hospital.

We continue to promote multidisciplinary ward and board rounds and are developing the Safety Briefings (Scarborough site only) in collaboration with the Improvement Academy.

To ensure consistency in ward round practices we have mandated the use of the Post-take Ward Round Check List on Acute Assessment Units and agreed a local CQUIN to support this work. Currently we are reviewing the checklist to ensure that it is fit for purpose and developing standards for use. We anticipate that we will achieve the Q1 CQUIN requirements.

We consistently achieve good rates of compliance on all sites with the WHO surgical safety checklist, however recent audits of practice have identified some quality improvements necessary to enhance the process. Additional work to consider the effectiveness of the post procedure briefing is required. We recently participated in the NHS QUEST Theatre Safety Culture Learning Exchange event.

Patients admitted acutely with delirium or dementia aged 75 years or over should have a dementia specific assessment and where necessary be referred for advice or treatment. The national target is that 90% of our patients should have these assessments and we continue to see improvement, particularly at the Scarborough site.

Reducing Mortality and Improving Mortality Indicators
We aim to learn as much as possible by critically examining the care we have provided prior to a patient dying in our hospital. All in-patient deaths are reviewed by a consultant and reports collated by the Patient Safety Team for review at the Trust Mortality Review Group. The Mortality Review Group provides a 6 monthly composite report of all reviews for dissemination of learning.

We continue to monitor our depth of coding.

The Trust Summary Hospital-level Mortality Indicator (SHMI) for the period of October 2013-September 2014 was 102.9 and remains within the 'as expected' range, although higher than our target of 95.

The Trust overall Hospital Standardised Mortality Ratio (HSMR) for the period July 2013-June 2014 was 102, which is within the 'as expected' range, although higher than our target of 100 or less.

Reducing harm from avoidable physiological deterioration
Problems surrounding the management of the deteriorating patient are often multi-factorial.

We are developing a robust plan to support safer medicines management in conjunction with the Medicines Management Review Group. We are also developing a system for electronic prescribing and medicines administration (EPMA) which is led by the EPMA Project team.

We continue to promote better management of patients with diabetes, this work is being led by the Think Glucose Group.

A Clinical Guideline for Management of Sepsis has been developed which includes a screening tool to aid recognition and treatment of patients. These have been piloted on the Emergency Departments and Acute Medical Units in both acute hospital sites and Ward 14. A recent audit of these wards has given us a baseline of compliance with the sepsis screening tool and the Sepsis Steering Group is currently developing an action plan for improvement. We plan to implement the Sepsis Guideline over the next 12 months. The national sepsis CQUIN poses an additional challenge for us in that we need to develop tools

for use in paediatrics and woman's services and to have them ready to use at the end of Q1 2015/16. We anticipate that we will achieve the Q1 CQUIN target related to management of the patient with severe sepsis. To support achievement of the national CQUIN to the end of March 2016 we propose to implement a system of rapid feedback (see Sepsis Rapid Review paper).

We aim to reduce the number of in-hospital cardiac arrests and a further cardiac arrest audit is planned to take place in July 2015. The audit results will be reported to the Deteriorating Patient Group and the Patient Safety Group so that consideration can be given to introduction of a continuous cardiac arrest audit.

Currently, all new doctors who come to the Trust as FY2 or above on the York site, have induction training which includes a lecture by an Intensive Care doctor on the management of the deteriorating patient. We are striving to ensure the same induction is delivered on the Scarborough site. Additionally the Deteriorating Patient Group is considering whether it would be possible to have regional deanery study time allocated to the management of the deteriorating patient so that registrar level doctors could receive training collectively.

We have introduced a modified version of the National Early Warning System (NEWS) in our community hospitals.

Excellence in end of life care

Our aims are that for patients who are at the end of life:

- they will have appropriate, inclusive and well documented DNACPR decision making
- appropriate and agreed ceiling of care decision making will be recorded and acted upon, detailing treatment options as relevant to the patient including whether or not to transfer to a higher level of care or the application of a DNACPR order.

Progress with achieving these aims is monitored by the DNACPR Group. Compliance with completion of the DNACPR form has improved but there is much more to be done. We plan to focus on communication with our clinical staff via screen shots and posters clearly indicating best practice relating to DNACPR. Additionally a new training programme will shortly be available.

We know that some of our senior clinical nurses are best placed to aid DNACPR decision making and we plan to train and support these staff to develop the necessary skills and competencies.

To support better recording of DNACPR decision making we will include specific questions in the Post-take Ward Round Checklist.

Infection prevention and control
Our aim is to reduce the incidence of healthcare associated infections. An update on IPC is reported separately.

Areas of identified concern
Analysis of harm events in the Trust has identified recurrent themes.

We aimed to reduce the development of pressure ulcers (as measured by the Safety Thermometer audit) by 20% - this was achieved as a CQUIN in 2014/15. We are now aiming to reduce the incidence of pressure ulcers by 20% (within the period April 2015-March 2016). The Pressure Ulcer Reduction Plan will continue to be monitored by the Pressure Ulcer

Steering Group.

We have established a standardised approach to assessment and interventions for patients at risk of falling in hospital – this was achieved as a CQUIN in 2014/15. This has been tested and implemented (paper version) successfully in our community hospitals and we aim to introduce the electronic version to our acute hospitals during August-September 2015. We aimed to reduce the number of patients who experienced severe harm as a result of a fall in hospital by 30% - this was achieved in 2014/15. We are now aiming to reduce the incidence of severe harm from falls by an additional 20% (within the period April2015-March2016).

We continue to have a focus on maternity care and reduction of SIs and incidents which result in clinical claims.

We plan to focus on the Emergency Departments to reduce incidents which result in clinical claims.

Continually Learn
Following the move to Datix web for recording complaints (expected to be complete September 2015), the Patient Experience Report will be developed to summarise information from multiple sources including complaints, friends and family, PALS and formal and informal feedback.

We strive to ensure that wherever possible a Patient Safety Walkround is held every week with a monthly summary report received by Executive Board and Trust Board of Directors. During the period April 2014-March 2015, 47 Patient Safety Walkrounds were completed.

Dissemination of learning from Serious Incident Patient Falls and Pressure Ulcers Panels is circulated monthly to all clinical staff. The first of our 'Nevermore' publications for acute services and the community, aiming to focus on learning from serious incidents and to report on recent patient safety related matters, have been well received.

Honesty
We launched our Being Open Policy last year and training on Duty of Candour in March 2015.

We plan to pilot an initiative to involve patients in safety through the use of briefings and SI investigations.

We are enhancing the processes of informed consent by ensuring that patients understand what we are planning to do before consenting for treatment.

We have a Patient Safety internet page (public facing) but this needs additional development.

Collaborate
We continue to work with our partners including NHS QUEST, The Improvement Academy, York University and the Global Sepsis Alliance.

Last year a group of doctors in training led by a CT2 in Medicine developed the Junior Doctors Improvement Group (JDIG). This group which was endorsed by the Medical Director and Chief Executive and chaired by a junior doctor has provided a responsive forum for consultation in addition to starting some useful projects including better use of the Datix system by junior doctors and more effective handover.

Support
We continue to work with our staff to recognise why things go wrong and how to put them

right. Specifically we are reviewing the Patient Safety mandatory training to ensure that it is responsive and effective.

We continue to encourage the reporting of errors and incidents and are developing better systems to provide feedback to reporters.

We continue to promote The Patient Safety Award which is part of the Celebration of Achievement Award to ensure that patient safety initiatives are supported.

Our Patient Safety Conference held in May 2015 was a huge success, giving staff time to discuss and present local initiatives and to celebrate progress. A conference planning group has been developed to ensure that this becomes an annual event and that we prepare our staff for even greater participation.

5. Sepsis Rapid Feedback

Background

Sepsis is a complex disease process associated with high mortality rates. Sepsis causes about 37,000 deaths per year in the United Kingdom accounting for more deaths than lung cancer alone, or breast and bowel cancer combined (Survive Sepsis, 2010).

In recent years international consensus has been reached about the management of sepsis, both in terms of identification, through standardised screening criteria, and management utilising the Sepsis 6 Care Bundle (Survive Sepsis 2010).

A recent audit of the Emergency Departments, Acute Medical Units and on a Surgical admitting Ward at York Hospital demonstrated 22% compliance with delivery of the Sepsis 6 Care Bundle within 1 hour. Although this is an improvement from the previous year (14%) the focus is now driven by the National CQUIN target which is to improve screening of directly admitted patients for severe sepsis with an added requirement to administer antibiotics to those patients who meet the severe sepsis criteria within 1 hour of presentation. The CQUIN target is that we will be appropriately screening and administering antibiotics to patients within one hour of presentation.

Rapid Feedback

In order to focus improvement in the early identification and treatment of patients with severe sepsis we propose to introduce rapid feedback to Medical teams on the timeliness of recognition of severe sepsis and delivery of the Sepsis 6 Care Bundle. This approach has been adopted by Nottingham University Hospitals NHS Trust and has supported an increase in bundle compliance from 25% to 70% and specifically antibiotic delivery within 1 hour from 40% to 80%. Additionally this has contributed to a reduction in crude critical care sepsis mortality from 42% to 28%.

Feedback would be provided to clinicians on any patients reviewed by the critical care outreach teams with severe sepsis. The Outreach Nurse would complete an audit form which would determine compliance with the care bundle and timeline the response to severe sepsis. This would be reviewed by the Patient Safety Team and an email be sent to the consultant responsible for the patient (Appendix 1). Additionally, a monthly composite report would be sent to the Directorate Management Team.

Appendix 1

Feedback to Clinicians

Intervention	Target	Achieved
Screening tool used	yes	yes
Patient escalated appropriately by Nurse	10 mins	immediate
Patient seen by Doctor	30 mins	45mins
Sepsis 6 interventions		
Appropriate oxygen administered	1 hour	30 mins
Blood Cultures Taken	1 hour	30 mins
Lactate Measured	1 hour	2 hours
Fluid Resuscitation	1 hour	1.5 hours
Fluid Balance/ Urine Output Measured	1 hour	30 mins
IV Antibiotics Administered	1 hour	45 mins
No of interventions within 1 hour	6 interventions	3 interventions

6.Recommendations

Board of Director's should:

- note the consultant new to the Trust
- consider the compliance audit with the antimicrobial guidelines
- note the update/progress with the Patient Safety Strategy/Sign up to Safety Campaign
- note the Severe Sepsis Rapid Feedback Process.

Author	**Diane Palmer, Deputy Director for Patient Safety**
Owner	**Dr Ed Smith, Interim Medical Director** **Mr Jim Taylor, Interim Medical Director**
Date	**July 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Patient Falls Reduction – Quarterly update

Action requested/recommendation

To consider the progress with reduction of patient falls incidents.

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

Implications for equality and diversity

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

Reference to CQC outcomes

This paper supports the overall principles of the CQC outcomes.

Progress of report	Organisational Falls Steering Group Quality and Safety Committee
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse.
Author	Diane Palmer, Deputy Director of Patient Safety Darren Fletcher, Patient Safety Manager
Date of paper	July 2015
Version number	Version 1

Board of Directors – 29 July 2015

Trends, actions and learning from Serious Incident (SI) Reports and a review of all incidents reported relating to inpatient falls – July 2015.

1. Introduction and background

A reduction in the number of patient falls incidents and specifically serious injury from falls remains a priority for the Trust. A target of reducing falls resulting in moderate or severe injury by 30% was an agreed target for 2014 – 2015 and the Trust achieved a 55% reduction by March 2015. We are aiming to achieve a further 20% reduction in falls resulting in moderate or severe harm by March 2016.

2. Total number of fall incidents reported April – June 2015

The total number of patient fall incidents reported on the Trust incident reporting system (Datix) for the period April 2014 – March 2015 are outlined in Table 1. Data are broken down by level of harm resulting from the fall and displayed by Trust site. Whilst during the year there was an increase in the overall number of falls reported for three sites, there is a reduction overall in the number of falls reported from community hospitals.

Table 1. Total number of fall incidents reported 2014 - 2015. Data source: Datix

	York Acute				Scarborough (including Bridlington)				Community Hospitals				Community Care			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
No harm	247	283	325	392	127	133	166	170	102	100	68	66	5	3	7	9
Low harm	151	122	107	133	62	73	80	71	30	34	19	32	3	2	3	12
Moderate harm	4	4	8	2	2	3	2	4	7	5	2	1	0	1	0	2
Severe / Death	7	2	3	7	6	1	7	4	3	1	2	0	0	1	0	0
Pending	0	0	2	0	0	0	1	0	0	0	0	0	0	1	1	0
TOTAL	**409**	**411**	**445**	**534**	**197**	**210**	**256**	**249**	**142**	**140**	**91**	**99**	**8**	**8**	**11**	**23**

The number of patient falls reported in 2013-2014 and 2014-2015 are displayed by Trust site and severity of harm in Table 2. Although the overall number of patient falls incidents remains high, there has been a significant reduction in the number which resulted in moderate or severe harm or death.

Table 2. The number of falls reported by site and severity of harm 2013-2014 and 2014-2015

	Trust Total		York Acute		Scarborough Acute		Community Services	
	Year 2013 – 2014	Year 2014 - 2015	Year 2013 – 2014	Year 2014 - 2015	Year 2013 – 2014	Year 2014 - 2015	Year 2013 – 2014	Year 2014 - 2015
All falls	3437	3233	1919	1799	874	912	644	522
No harm	2255	2203	1277	1247	562	596	416	360
Low harm	963	934	558	513	220	286	185	135
Moderate harm	149	47	55	18	59	11	35	18
Severe harm / death	46	44	28	19	11	18	7	7
Uncoded	24	5	1	2	22	1	1	2

The following tables (3 – 6) outline the number of falls reported during Q1 of 2015. It should be noted that information is from Datix and that numbers may alter and severity of harm be modified as investigations are completed and processed.

Table 3 shows the number of falls reported during Q1 in 2015 – 2016 at York Acute site. The table indicates that there has been an increased number of falls reported when compared with Q1 in 2014 – 2015, however, the number of falls resulting in severe harm has reduced. A significant number of reports are awaiting validation and therefore data may change slightly as these are processed.

Table 3. Total number of fall incidents reported at York Hospital site during Q1 2015 - 2016. Data source: Datix

	York Acute				
	Q1 total 2014-2015	Q1 total 2015-2016	Q1 2015 - 2016		
			Apr-15	May-15	June-15
No harm	247	281	113	116	52
Low harm	151	73	28	26	19
Moderate harm	4	4	0	2	2
Severe / Death	7	4	1	1	2
Pending	0	75	2	20	53
TOTAL	**409**	**437**	**144**	**165**	**128**

Table 4 shows the number of falls reported during Q1 in 2015 – 2016 at Scarborough acute site (including Bridlington Hospital). An increase in the number of falls reported when compared with Q1 in 2014 – 2015 is noted however, the number of falls resulting in severe harm has reduced. A significant number of reports are awaiting validation and therefore data may change slightly as these are processed.

Table 4. Total number of fall incidents reported at Scarborough acute site during Q1 2015 - 2016. Data source: Datix

	Scarborough Acute (including Bridlington)				
	Q1 total 2014-2015	Q1 total 2015-2016	Q1 2015 - 2016		
			Apr-15	May-15	June-15
No harm	127	143	53	59	31
Low harm	62	43	18	13	12
Moderate harm	2	4	2	1	1
Severe / Death	6	3	1	1	1
Pending	0	50	5	16	29
TOTAL	**197**	**243**	**79**	**90**	**74**

The number of falls reported during Q1 in 2015 – 2016 at Community Hospitals is shown in Table 5. The total number of falls has decreased compared with the same period last year and also the number of falls that result in moderate and severe harm. Community Hospitals implemented a revised risk assessment and intervention process during 2014- 2015 with focused training sessions around falls prevention delivered to Nurses and Health Care Assistants which may account for some of this improved position.

Table 5. Total number of fall incidents reported at Community Hospitals during Q1 2015 - 2016. Data source: Datix

	Community Hospitals				
	Q1 total 2014-2015	Q1 total 2015-2016	Q1 2015 - 2016		
			Apr-15	May-15	June-15
No harm	102	53	26	17	10
Low harm	30	36	23	11	2
Moderate harm	7	1	0	1	0
Severe / Death	3	2	0	2	0
Pending	0	34	1	9	24
TOTAL	**142**	**126**	**50**	**40**	**36**

Table 6 shows the number of falls reported during Q1 in 2015 – 2016 by District Nursing Teams. The number of reports remains low, although the numbers have increased compared with the same period last year.

Table 6. Total number of fall incidents reported within Community Care during Q1 2015 - 2016. Data source: Datix

	Community Care				
	Q1 total 2014-2015	Q1 total 2015-2016	Q1 2015 - 2016		
			Apr-15	May-15	June-15
No harm	5	9	4	4	1
Low harm	3	4	1	2	1
Moderate harm	0	0	0	0	0
Severe / Death	0	0	0	0	0
Pending	0	4	0	3	1
TOTAL	**8**	**17**	**5**	**9**	**3**

The total number of patient fall incidents for Q1 are displayed in Table 7 alongside data from Q1, Q2, Q3 and Q4 in 2014 - 2015 for comparison and shows an increase in the number of incidents reported in comparison with Q1 of 2014-2015, although there is a decrease in the number of incidents resulting in moderate/severe harm or death.

Table 7. Total number of falls reported across the organisation each quarter. Data source: Datix

	2014 - 2015				2015 - 2016
	Q1	Q2	Q3	Q4	Q1
No harm	481	520	564	635	486
Low harm	246	231	209	248	156
Moderate harm	13	13	12	9	9
Severe / Death	16	5	12	11	9
Pending	0	2	6	2	163
TOTAL	756	771	803	905	823

3. Wards reporting 20 or more patient falls (April – June 2015)

At the time of reporting, 13 wards/areas have identified 20 or more patient falls during Q1 of 2015 - 2016. The number of falls for those 13 wards, and a summary breakdown by severity are illustrated in Table 8. The number reported during Q1 2014 – 2015 are also shown for comparison. Several wards which reported a high number of falls in 2014 have continued to report high numbers in the same period of 2015. York Acute Medical Unit and Ward 24 have shown a significant increase in the number of falls reported in Q1 2015 when compared with the same period in 2014.

Table 8. Wards reporting 20 or more falls during Q1 2014 and 2015

Ward / Area	Number of falls reported during Q1 2014 – 2015	Number of falls reported during Q1 2015 - 2016
Ward 37	57	60
Ward 26	34	39
Ward 23	41	38
Oak Ward	34	33
AMU (York)	13	32
Ward 35	41	30
Waters Ward	22	28
Whitecross Court	26	27
Ward 24	17	26
Archways	22	25
Johnson Ward	24	24
Whitby Ward	17	23
Ward 34	19	22

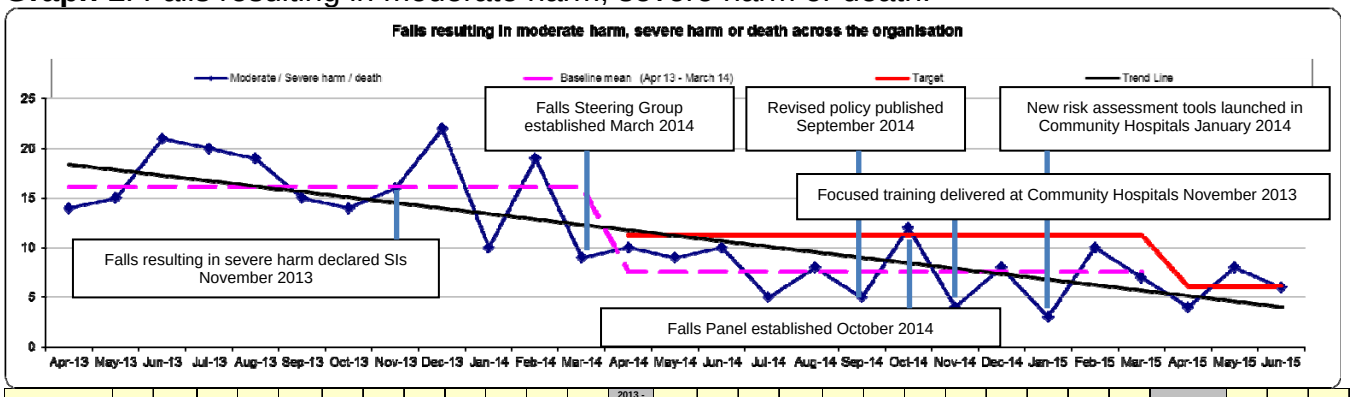
4. Falls resulting in harm

Graph 1 shows the total number of falls resulting in moderate harm, severe harm or death identified on the incident reporting system (Datix) from April 2013 – June 2015. Validation and review of Datix incident reports has taken place during 2014 - 2015 and as a result, the level of harm may have been re-categorised. Whilst this would impact on the categorisation of falls resulting in harm, it is also recognised that a revision of the policy, improved assessment tools, learning from investigations and focused staff training may also have contributed to a reduction in harm.

The average number of falls resulting in moderate or severe harm from April 13 – March 14 was 16.2 per month. A 30% reduction by March 2014 would therefore provide a target of no more than 11.3 falls per month. Calculating the average number of falls resulting in moderate or severe harm for 2014 – 2015 shows that the Trust had an average of 7.6 falls per month resulting in moderate of severe harm.

The Trust is aiming for a further reduction in moderate or severe harm of 20% for 2015 – 2016. This translates to an average of 6 falls per month (18/quarter) resulting in moderate or severe harm by March 2016. For Q1 we have identified a total of 18 falls which have resulted in moderate/sever harm or death, however this figure may alter as incident investigations are completed.

Graph 1. Falls resulting in moderate harm, severe harm or death.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013 - 2014 Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014 - 2015 Total	Apr-15	May-15	Jun-15
Number of falls resulting in moderate harm, severe harm or death	14	15	21	20	19	15	14	16	22	10	19	9	194	10	9	10	5	8	5	12	4	8	3	10	7	Cumulative total to date: 91	4	8	6

Eight incidents resulting in severe harm have been reported during Q1 2015-2016. The wards reporting these incidents are shown in Table 9. Incident reports from the same period during 2014 – 2015 are also shown for comparison. It is noted that all of the wards reporting a fall that resulted in severe harm during Q1 of 2015-2016 also reported similar incidents during Q1 of 2014 – 2015 although a reduction in the number of incidents is recognised in most wards. Three wards (26, 37 and Johnson) listed in Table 9 are also noted to be in Table 8, reporting 20 or more falls during Q1.

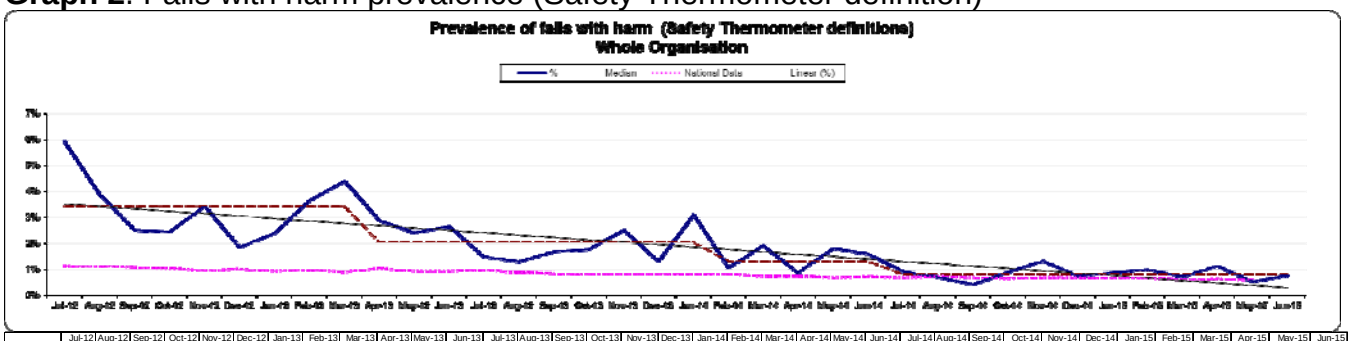
Table 9. Wards reporting falls that resulted in severe harm during Q1 2015 - 2016

		2014 – 2015 total	2015 – 2016 Q1
Ward 26	Total Falls	174	39
	Severe Harm	2	2
AMU (SH)	Total Falls	45	16
	Severe Harm	4	1
Beech	Total Falls	73	13
	Severe Harm	2	1
Johnson	Total Falls	108	24
	Severe Harm	3	1
Malton	Total Falls	76	15
	Severe Harm	1	1
St Helens	Total Falls	59	19
	Severe Harm	1	1
Ward 36	Total Falls	91	13
	Severe Harm	2	1
Ward 37	Total Falls	222	60
	Severe Harm	4	1

5. Falls Prevalence

Graph 2 shows the prevalence of falls with harm as identified through the Safety Thermometer surveys from July 2012 to June 2015. A reduction in the prevalence of falls is noted and has been sustained since July 2014 and now shows our current position in line with national data.

Graph 2. Falls with harm prevalence (Safety Thermometer definition)



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Denominator	1473	1396	1396	1519	1493	1414	1477	1513	1500	1529	1416	1543	1413	1476	1440	1423	1442	1460	1520	1524	1462	1512	1508	1517	1448	1456	1452	1466	1603	1522	1625	1605	1527	1513	1556	1581
Numerator	87	54	35	37	51	26	35	55	66	44	34	41	21	19	24	25	36	19	47	16	28	13	27	24	13	10	6	13	21	11	14	16	11	17	8	12
%	5.91%	3.87%	2.51%	2.44%	3.42%	1.84%	2.37%	3.64%	4.40%	2.88%	2.40%	2.66%	1.49%	1.29%	1.67%	1.76%	2.50%	1.30%	3.09%	1.05%	1.92%	0.86%	1.79%	1.58%	0.90%	0.69%	0.41%	0.89%	1.31%	0.72%	0.86%	1.00%	0.72%	1.12%	0.51%	0.76%

6. Actions and Learning from SIs

A total of 13 SI investigation reports have been completed since the previous report in April 2015. Analysis of these incidents indicate that:

- 100% of patients had a falls risk assessment completed prior to the incident occurring
- 85% of patients had a falls risk assessment completed within 6 hours of admission
- 46% of patients had their falls risk reassessed every 7 days
- 46% of patients had a target COMFE (intentional rounding) frequency of 2 hours or more prior to the fall
- 91% of patients had a COMFE (intentional rounding) visit in the two hours preceding the fall
- 100% of patients had a Bedrail Assessment completed
- 15% of patients had bedrails in use that may have contributed to the fall
- 54% of patients had a fall going to or from the toilet
- 38% of falls occurred during the night (between midnight and 6.30am).

The initial falls risk assessments indicated;

- 38% of patients were assessed at high risk
- 31% of patients were assessed at medium risk
- 31% of patients were assessed at low risk.

The most recent falls risk assessment completed prior to the incident occurring showed;

- 38% of patients were assessed at high risk
- 46% of patients were assessed at medium risk
- 16% of patients were assessed at low risk.

A review of the completed investigation reports highlights the possible contributory factors shown in Table 10. Historic results are shown for comparison.

Table 10. List of possible contributory factors identified

	2014 - 2015			2015 - 2016
	Q2	Q3	Q4	Q1
Confusion prior to fall incident	54%	62%	60%	46%
Not wearing glasses if usually worn	43%	29%	45%	23%
Evidence of sepsis	31%	25%	20%	23%
Recent administration of sedative medication	15%	8%	8%	8%
High levels of ward dependency	15%	58%	12%	0
Lying and standing blood pressure not measured	77%	67%	83%	85%

Inaccurate risk assessments	15%	33%	30%	46%
Patient not following advice (no cognitive impairment)	46%	60%	12%	23%
Bed rails	8%	0	24%	15%
Patients taking medications that increase the risk of falls	46%	9%	32%	31%

Table 11 shows the preventative measures that were noted to have been actioned on reviewing the 13 investigation reports.

Table 11. List of preventative measures

	2014 - 2015			2015 - 2016
	Q2	Q3	Q4	Q1
Outcome of assessment discussed with patient / carer	64%	64%	65%	62%
Bed at lowest level (unless receiving clinical care)	100%	90%	100%	80%
Chair at appropriate height	100%	100%	100%	100%
Environment de-cluttered	100%	92%	100%	100%
Adequate footwear available	77%	92%	92%	100%
Communication problems managed	100%	92%	100%	100%
Falls Patient Information Leaflet given to patient / carers	15%	8%	61%	62%
Medication review undertaken where appropriate	88%	100%	96%	100%
Nursed in an easily observable area when identified at high risk	63%	50%	74%	77%
Falls risk sign placed above the head of the bed when identified high risk	43%	71%	60%	80%
Enhanced nursing considered if high risk	33%	33%	89%	50%

It was noted that one patient did have enhanced nursing in place, however, this was removed due to staffing difficulties at the time of the incident.

Summary of fall incidents

Of the 13 SI reports reviewed;

- Seven patients sustained a fractured neck of femur
- One patient sustained a fractured humerus
- One patient sustained a fractured clavical
- One patient sustained a fractured wrist
- One patient sustained a fractured ankle
- One patient sustained a subdural bleed
- One patient sustained a fractured neck of femur and a fractured humerus.

A patient identified at high risk of falling was sitting on a chair opposite the nurse's station to facilitate maximum observation by nursing staff. The ward phone was ringing and the patient got out of the chair to answer it. The patient fell and sustained a fractured neck of femur.

A patient was mobilising around the bed area after using a commode. The patient lost balance and put their hands out to steady themselves on what they thought was a wall but was in fact the curtain. The patient fell and sustained a fractured neck of femur. Previous history of falls had not been recognised by staff completing assessments and changes in the patient's condition and medication did not prompt re-assessments.

A patient collapsed whilst being assisted to mobilise by a nurse. The nurse controlled the fall however the patient hit their arm against the door frame during the descent. The patient

sustained a fractured humerus.

A patient had an unwitnessed fall from the chair, staff were alerted by a visitor that the patient was on the floor. The patient sustained a fractured neck of femur.

A patient with cognitive impairment attempted to mobilise from the bed as staff left the bay to carry out other duties. The patient fell and sustained a fractured neck of femur. It was noted as part of the investigation that a low profiling bed, crash mats and falls sensors could have been utilised to manage the risks for this patient but were not in place at the time of the incident.

A patient had suffered a possible ischaemic event causing confusion and disorientation. The patient was mobilising independently on advice from therapists. The patient was found on the floor in a different bay to where their bed was located. It was noted that the patient often left their frame behind when turning. The patient sustained a fractured neck of femur and a fractured humerus.

A patient was noted to be at high risk of falls and enhanced supervision had been requested to manage the risks however, staff were not available on the day of the incident. Staff were alerted to the patient by a visitor after they saw the patient fall from the chair. The patient sustained a fractured wrist.

A patient had an unwitnessed fall from the bed with full length bedrails raised. The patient was found in a position that would suggest that the patient had shuffled to the end of the bed and attempted to get out of the gap between the bed rail and foot board. The patient sustained a fractured clavical.

Two patients went against advice of nursing staff to ask for assistance before mobilising to the bathroom. Whilst in the bathroom, one patient attempted to pick up a can of deodorant from the floor and lost their balance causing them to fall sustaining a fractured neck of femur. The second patient's legs gave way on the way to the bathroom causing a fall that resulted in a fractured ankle.

A patient was admitted with a history of reduced mobility and had no signs of cognitive impairment and no history of previous falls. The patient had an unwitnessed fall from their bed and was unable to recollect the events surrounding the incident. The patient sustained a fractured neck of femur.

A patient with cognitive impairment attempted to climb out of bed with bed rails in situ. This was witnessed by staff, however, they were unable to reach the patient in time before they fell from the bed. The patient sustained a subdural bleed.

A patient had been assessed as able to mobilise independently. The patient's medical condition had changed and new opioid medications had been administered. Although the patient was informed of the side effects and advised to call for help before mobilising, re-assessments of the falls risk were not undertaken. The patient mobilised from their bed independently and used a walking frame issued to another patient. They took a few steps and fell to the floor. The patient sustained a trochanteric fracture of the left femur.

7. Conclusions / Recommendations

The number of falls reported remains high across the Trust although it is recognised that the number of falls resulting in moderate or severe harm have reduced. The Trust achieved the 30% reduction in falls resulting in moderate or severe harm for 2014-2015 and aims to reduce this number by a further 20% during 2015 – 2016. Figures for April to June 2015 indicate that

the quarterly target (18) has been achieved. A continued focus on falls prevention and implementation of revised policies and processes is necessary.

Analysis of the patient falls SI investigations has identified that there has been sustained improvement in the timing for the initial risk assessment however; there remains a lack of understanding with the process of assessment of patients at risk of falls and the associated interventions.

The following actions are recommended;

- Move to electronic process of risk assessment in acute hospitals during August 2015
- Development of a training package for undertaking lying and standing blood pressure
- Reminder of the requirement for falls risk assessments to be reviewed every seven days as a minimum and when patient's condition changes or deteriorates
- Reminder to provide patient information leaflets to patients or relatives where risks are identified and discuss the outcomes of falls assessments.
- Reminder of the correct use of bed rails.

8. References and further reading

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

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Pressure ulcer reduction plan – update on progress

Action requested/recommendation

To consider report on progress with the pressure ulcer reduction plan, and note the progress.

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

Implications for equality and diversity

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

Reference to CQC outcomes

This paper supports the overall principles of the CQC outcomes.

Progress of report	Quality and Safety Committee
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse.
Author	Diane Palmer, Deputy Director of Patient Safety Lisa Pinkey, Patient Safety Manager
Date of paper	July 2015
Version number	Version 1

Board of Directors – 29 July 2015

Pressure Ulcer Reduction Plan – update report July 2015

1. Background

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

This report is a quarterly review (Q1 2015-16) of pressure ulcer incidence and prevalence data measured from the Trust incident reporting system (Datix) and the Safety Thermometer, and results are compared to 2014-15 data. Also presented is a review of the pressure ulcer related Serious Incident (SI) investigations which have been completed in Q1 of 2015-16.

2. Number of pressure ulcer incidents reported in 2014-15 (developed *or* deteriorated in our care)

Table 1 (below) summarises the number of unstageable, category 2, 3 and 4 pressure ulcer incidents reported during 2014-15 that developed or deteriorated in our care.

The number of pressure ulcers developed or deteriorated in our care remained high last year, despite a fall in prevalence (old and new ulcers).

The number of unstageable pressure ulcers was higher than expected, particularly in community settings. The reason these ulcers remained as unstageable related mainly to how they are reported on Datix and that the reports are not updated once the ulcers can be categorised or in some instances the patient has died before the ulcer can be categorised. This failure to categorise a large number of pressure ulcers may result in failure to recognise serious deterioration and whilst the patients may have received appropriate treatment the opportunity for learning and trend analysis is missed.

Table 1. *Total number of pressure ulcers reported by site each Quarter 2014 -2015.*
Data source: Datix

	York Acute				Scarborough Acute				Community Hospitals				Community Care			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cat 2	32	21	36	36	28	16	32	42	41	18	9	17	51	35	46	40
Cat 3	8	5	9	4	10	2	9	3	5	0	0	1	22	11	7	5
Cat 4	1	0	0	2	0	0	0	0	0	0	0	7	1	0	3	0
Unstageable	11	7	18	16	7	6	19	11	2	5	4	25	13	13	24	17
Total	**56**	**34**	**62**	**58**	**45**	**24**	**58**	**56**	**43**	**22**	**15**	**50**	**78**	**52**	**78**	**62**

3. Report of the number of new category 2, 3 and 4 pressure ulcer incidents reported in Quarter 1, 2015-16 (developed *or* deteriorated in our care)

Table 2 (below) displays the number of pressure ulcers reported by site during Quarter 1 of 2015 – 2016. Again, it is clear that the number of unstageable ulcers is more prevalent in the community, and that we must consider how these can be re-categorised to ensure appropriate treatment and care is given and learning identified.

Comparing the same reporting period in 2014-15, the Community Hospitals are reporting a significantly lower number of incidents overall in Q1 2015/16. In considering Category 3 and 4 pressure ulcers there is a reduction on all sites when compared with the same reporting period in 2014-15 and a significant reduction in Community Care.

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

	York Acute	Scarborough Acute	Community Hospitals	Community Care
	Q1	Q1	Q1	Q1
Cat 2	30	36	13	35
Cat 3	6	4	4	11
Cat 4	1	0	0	1
Unstageable	10	7	1	26
Total	47	47	18	73

Table 3 (below) shows the total number of ulcers across the Trust reported during Quarter 1, with results from 2014 – 2015 for comparison. It should be noted that although the numbers are lower for Q1 than for last year's Q1, numbers may increase as Datix investigations are validated and pressure ulcers may be re-categorised as a result of validation.

Table 3. *Total number of ulcers reported in the Trust each Quarter.*
Data source: Datix

	2014 – 2015					**2015 - 2016**
	Q1	Q2	Q3	Q4	**Total 2014 - 2015**	**Q1**
Cat 2	152	90	123	135	**500**	**114**
Cat 3	45	18	25	13	**101**	**25**
Cat 4	2	0	3	9	**14**	**2**
Unstageable	33	31	65	69	**198**	**44**
Total	222	132	213	226	**813**	**185**

4. Report of wards reporting 5 or more pressure ulcers in Quarter 1, 2015-2016 (developed or deteriorated in our care)

At the time of reporting, seven wards have reported 5 or more ulcers during Quarter 1. These are all newly developed or deteriorated whilst in our care. Details for these areas are shown in Table 4 below.

Table 4. *Wards reporting 5 or more pressure ulcers in Quarter 1 2015-2016 (developed or deteriorated in our care)*

		Q1 total	Q2 total	Q3 total	Q4 total	**Total 2014-15**	April 15	May 15	June 15	**Total Q1 2015-16**
Chestnut	Category 2	1	3	3	3	**10**	2	4	1	**7**
	Category 3	1	0	0	1	**2**	1	1	0	**2**
	Category 4	0	0	0	0	**0**	0	0	0	**0**
	Unstageable	0	0	3	0	**3**	0	1	0	**1**
ICU/HDU (York)	Category 2	4	3	8	5	**20**	0	4	1	**5**
	Category 3	1	0	0	0	**1**	0	0	2	**2**
	Category 4	1	0	0	0	**1**	0	0	0	**0**

	Unstageable	0	0	0	0	**0**	0	0	0	**0**
Johnson	Category 2	2	1	5	4	**12**	1	1	4	**6**
	Category 3	0	0	0	0	**0**	0	0	0	**0**
	Category 4	0	0	0	0	**0**	0	0	0	**0**
	Unstageable	0	1	0	0	**1**	0	0	0	**0**
Malton	Category 2	6	7	7	6	**26**	2	3	1	**6**
	Category 3	1	0	0	0	**1**	0	0	0	**0**
	Category 4	0	0	0	0	**0**	0	0	0	**0**
	Unstageable	1	1	2	3	**7**	0	0	0	**0**
Oak	Category 2	5	6	1	3	**15**	3	1	0	**4**
	Category 3	2	3	2	1	**8**	0	0	1	**1**
	Category 4	0	0	0	0	**0**	0	0	0	**0**
	Unstageable	2	1	2	0	**5**	0	0	2	**2**
Ward 26	Category 2	3	3	2	3	**11**	3	0	0	**3**
	Category 3	0	0	1	1	**2**	0	0	0	**0**
	Category 4	0	0	0	0	**0**	0	0	0	**0**
	Unstageable	2	1	3	1	**7**	0	3	0	**3**
Ward 35	Category 2	2	4	2	5	**13**	3	1	0	**4**
	Category 3	0	0	0	0	**0**	0	0	1	**1**
	Category 4	0	0	0	0	**0**	0	0	0	**0**
	Unstageable	1	3	7	2	**13**	0	0	0	**0**

5. Safety Thermometer Pressure Ulcer Prevalence Report

The charts below illustrate the pressure ulcer prevalence in accordance with the Safety Thermometer definition.

Chart 1 shows percentages of patients with pressure ulcers (old and new), and across the whole organisation. Trust prevalence has remained below the national data since July 2014.

Chart 1.

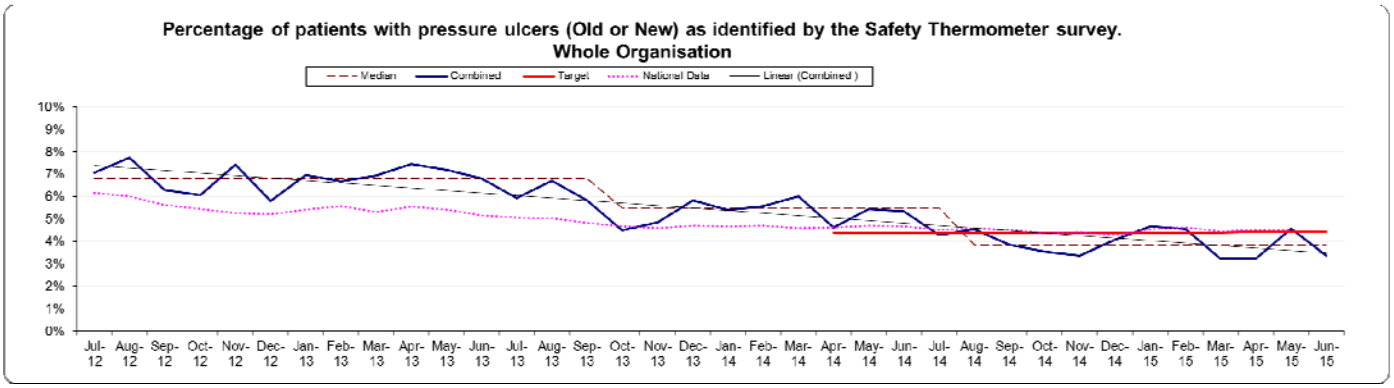


Chart 2 shows that, for acute sites within the Trust, the median pressure ulcer prevalence is below target rates since April 2014, with prevalence much lower during September 2014 and March 2015.

Chart 2.

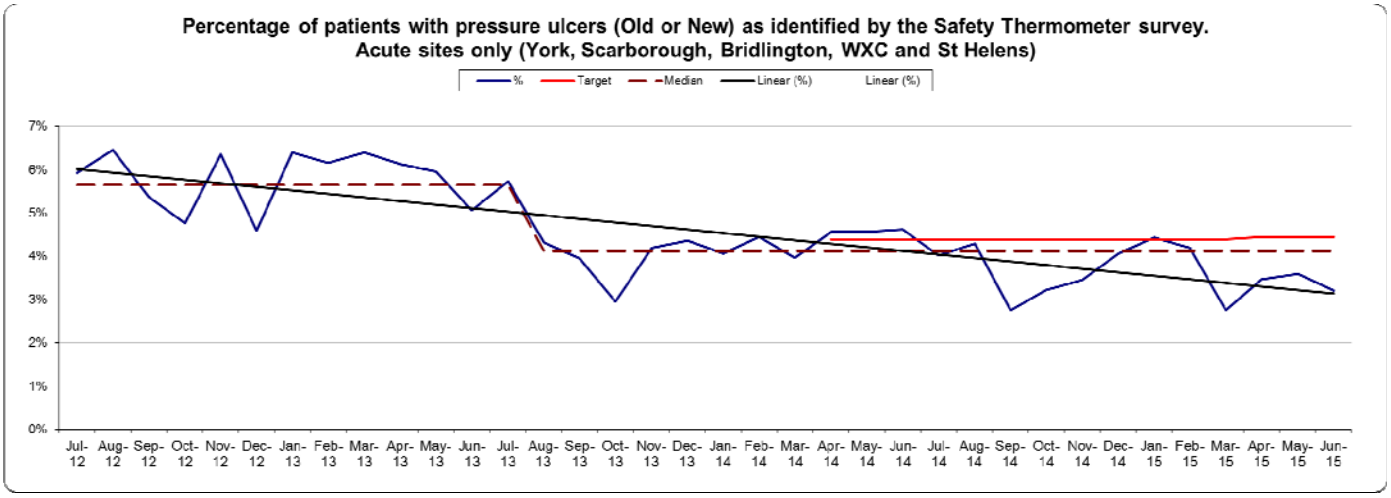


Chart 3 illustrates that, in community hospitals, the median prevalence of patients with pressure ulcers are still higher than the target rates.

Chart 3.

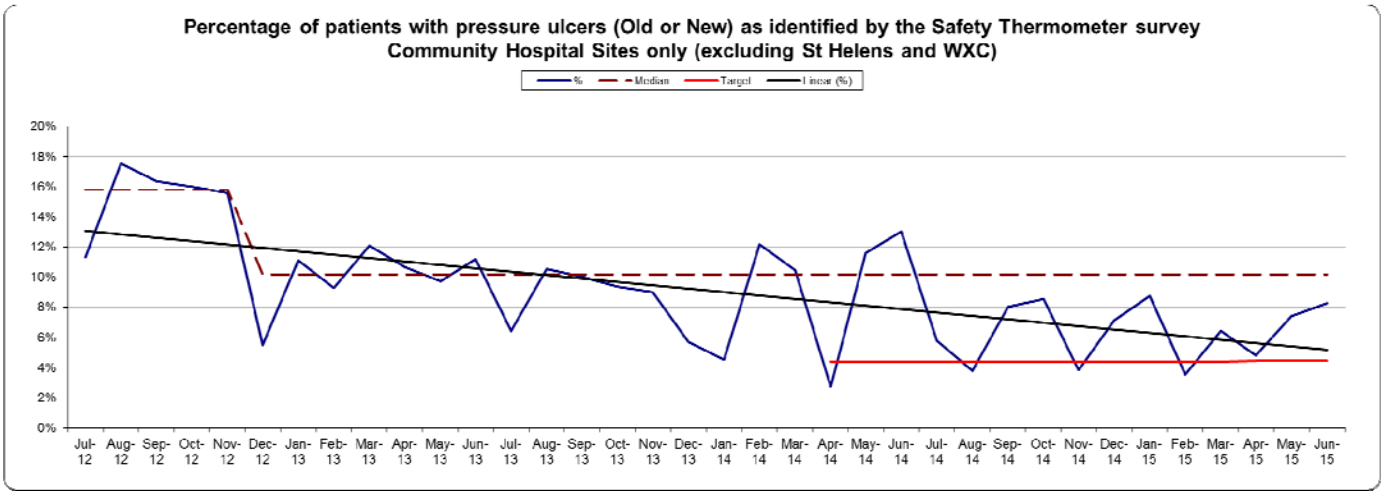
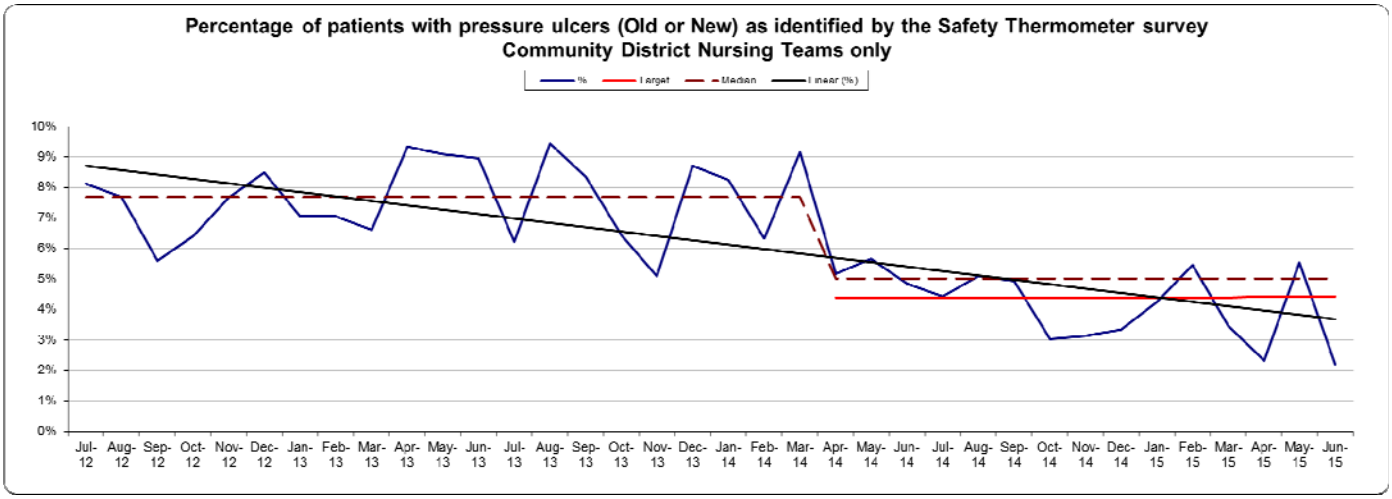


Chart 4 shows that, for community district nursing teams, pressure ulcer prevalence is lower than in previous years (around a 5% median rather than 7.8%).

Chart 4.



All the charts show an overall trend in reduction of prevalence of pressure ulcers since 2013. However, this is reflected more prominently in prevalence data across acute sites than within community areas.

More work is needed to reduce levels in community sites to remain on target.

6. Learning from SIs

A total of 10 SI investigation reports have been completed in the Q1 2015-16 reporting period. Of these;

- 2 patients had ulcers to the sacrum
- 2 patients had ulcers to the buttock
- 1 patient had an ulcer in the gluteal crease
- 1 patient had ulcers to both ears
- 2 patients had ulcer to the coccyx
- 2 patients had multiple ulcers, of these:
  -1 had ulcer to left hip, and 2 sacral ulcers
  -1 had 2 heel ulcers below both ankles.

Of the 10 reports above, one related to a Category 4 pressure ulcer, with the remainder being all Category 3 pressure ulcers.
Analysis of these reports shows that;

- 70% of the incidents relate to the deterioration of a previously known pressure ulcer
- 90% of the incidents had a risk assessment completed as per policy
- 70% of the incidents had the risk assessment reviewed as per policy
- 40% of the incidents were not initially assessed correctly
- 30% of the incidents were not reassessed correctly
- 30% of the investigations identified issues with pressure relieving equipment
- 50% of the investigations identified issues with staff competence
- Staff had access to a Tissue Viability Link Nurse in 90% of the incidents.

Table 5. List of possible contributory factors identified

Patient or family not accepting advice	20%
Poor communication between teams	10%
Disease progression	40%
Poor choice or lack of dressing review	10%
Patient's behaviour	20%
Lack of assessments / re-assessments	40%
Oxygen therapy equipment	10%
Lack of staff education	40%
Use of TED stockings	10%
Poor documentation	30%

Summary of learning

One patient developed ulcers to both ears as a result of wearing an oxygen mask. The patient continuously pulled the mask down to speak, resulting in skin trauma.

One patient developed heel ulcers at both ankles as a result of TED stockings. There were gaps in documentation around staff monitoring the patient's heels.

One patient was frail and malnourished and their initial Waterlow score was inaccurate. This was reported in the significant findings, and, If this had been accurate, the patient may have received a suitable mattress earlier.

Although risk assessments were carried out according to policy in 90% of cases, three more patients were assessed wrongly using the Waterlow risk assessment, and of these, two were not reassessed on ward transfers. Only 56% of ward staff on AMU have received pressure ulcer prevention training.

One patient was given a T Bar to elevate their feet, but the redistribution of pressure led to pressure ulcer development on the patient's coccyx. Once the T Bar was removed, the patient recovered.

One patient preferred to spend a lengthy amount time in their wheelchair (12 hours), and was reluctant to spend time in bed to alleviate pressure. Earlier clarification of management was reported as an area of learning.

One spinally injured patient refused to comply with pressure ulcer treatment. Although the patient had input from district nurses and TVNs, they had a history of non-compliance with advice. This case has been escalated as requires a more senior approach and possibly a multi-disciplinary management approach.

One patient's RCA is awaiting decisions over possible de-logging of the case. This patient developed a pressure ulcer while using a slide sheet. There was a difficult relationship between the patient and the DN team, which was seen as a significant finding, as the patient replaced the pressure relieving mattress with their own for comfort, and declined a hoist for transferring.

Despite the 'Being Open Policy' being revised and implemented in 2014 as part of the Duty of Candour, for two of the patients above, an apology was not given at the time of identifying the incident. This was delayed on one occasion, and due to lack of staff awareness on another occasion.

7. Conclusions and recommendations

Based on analysis of the data arising from the report above, there a several concluding comments:

- Pressure ulcers have reduced significantly overall in Quarter 1 2015-16 compared with the previous year, however, regarding community hospitals the reduction in incidence is less encouraging, remaining higher than target rates.
- Reporting a large number of unstageable ulcers may cause data to be skewed and category 3 and 4 pressure ulcers to be unrecognised.
- Seven wards have reported five or more pressure ulcers which have developed or deteriorated in our care in the last 3 months and these wards should be considered for additional support.
- The prevalence of pressure ulcers remains below the national data point.
- Following analysis of the 10 SI reports, issues are highlighted around initial and repeat assessments of patients, lack of equipment and competency of staff.
- Non-compliance with pressure ulcer regimes is an issue and highlights communication problems between clinical staff and patients or carers.
- Patients were not apologised to in a timely manner, despite the Duty of Candour implementation within the Trust.

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

- The overall incidence of unstageable pressure ulcers should be an area of focus, particularly in regard to reporting via Datix.
- Training in pressure ulcer prevention and in particular earlier detection of high risk patients through accurate use of tools, including the Waterlow assessment and the COMFE tool.
- Management plans specifically targeting spinal and neurologically injured patients.
- More effective use and documentation of Duty of Candour.

Author	**Diane Palmer, Deputy Director for Patient Safety** **Lisa Pinkney, Patient Safety Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**July 2015**

D5

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Chief Nurse Report – Quality of Care

Action requested/recommendation

The Board is asked to note the Chief Nurse report for July 2015.

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	Quality & Safety Committee
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	July 2015
Version number	Version 2

Board of Directors – 29 July 2015

Chief Nurse Report – Quality of Care

1. Key priorities

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

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

A quarterly update of the implementation plan is attached at appendix 1and illustrates progress toward delivering the objectives. A Nursing and Midwifery conference is planned for September this year where the delegates will participate in an exercise to identify priorities for the next 3 years.

The Early Warning Trigger Tool is now widely used to identify potential risks to quality of care delivered in the ward areas, a review of the tool is underway and some refinements are anticipated in order to ensure that any potential risk are identified early and mitigations put in place.

The nursing quality dashboard has been developed and refined. A data collection exercise is on-going, the report will be submitted to Quality and Safety Committee in September.

2. Nurse Staffing

Safer Staffing
The Trust introduced a revised tool to capture the ward staffing levels to simplify the return at the beginning of June, following feedback from ward sisters and Matrons. Feedback from ward sisters, Matrons and Community Locality Managers on the tool has been very positive, it is anticipated that the data will be more accurate as a result of the revisions.
The safer staffing report, which is detailed in a separate paper provides the first return using this new tool.

Nurse Recruitment
The Board are aware of the efforts to recruit to vacant post and to reduce the vacancy gaps.
To date we have offered 84 posts to Registered Nurses, 72 of these are to final year students who will qualify in the autumn and begin in York and Scarborough towards the end of October. If all of the registrants recruited take up posts the vacancies in ward areas will be filled. Work is continuing to keep in touch with the new starters and a new induction programme is planned.

In order to ensure a sustainable workforce with capacity to flex in order to address

additional demand during the winter months approval to recruit additional Registered nurses via a European campaign has been agreed.
In order to achieve the best return the Trust will be marketed across a number of countries from mid July to mid August with interviews planned for September. The Committee will receive updates in future reports.

The Recruitment, Retention and Nursing and Midwifery Staffing group met for its first meeting at the end of June. The remit of this group is to ensure a co-ordinated approach to the nursing workforce agenda across all sites, ensuring the key links with e-rostering, recruitment, workforce information. An action plan outlining the key milestones has been developed.

3. Quality Report

The quality and safety committee have previously expressed some concern regarding coordination and timelines to agree quality priorities. Discussions on future planning and consultation have resulted in clear objectives and timelines.
The proposed planning and governance is detailed below:

Timeline

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

Detailed work to identify priorities

Consultation exercise
Consultation exercise -3 months between November and January

Groups to be consulted –
- Quality and Safety Committee
- CCGs
- Healthwatch
- Governors

Managed through an internal meeting with membership from

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

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

Activity	How	Timing
Agree priorities to include in the consultation	Internal meeting of quality group and discussion with Medical Director and Chief Operating Officer Priorities to be discussed a Corporate Directors meeting	Early October 2015
Arrange meetings with Stakeholder – CCG, CoG, Healthwatch and launch consultation exercise	Meeting as a group and one to one basis talking through the consultation information	Early November 2015 Consultation ends mid-January 2016
Analysis of response and agree what priorities for 2016/17 will be included in the report	Internal meeting prep a final summary of the consultation work. Once priorities have been prepared final agreement sought through the Quality and Safety Committee	Internal meeting held mid-January 2016. Final paper work to be presented to the Quality and Safety Committee at the February meeting
Following the publication of the guidance from Monitor – agree with the Corporate Directors and Governors what their key indicators for further auditing will be	Discussion at the Corporate Governance meeting and discussion with the work group of Governors formed to support the production of the Quality Report	February 2016

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

Activity	How	Timing
Consult with Quality and Safety Committee on the draft report	Through papers presented to meetings	December and January Final draft with priorities agreed February 2016
Attend the Council of Governors meeting to inform them of the work being	Part of the Council of Governors agenda – presentation led by BG	9 December 2016

undertaken to develop the Quality Report		
Key priorities to be agreed Corporate Directors and Governors	For Directors through Corporate Directors meeting Information taken by BG to meeting For Governors through discussion at group meeting	February 2016 for both
Confirmation given to Internal and External Audit of the key priorities chosen by the Corporate Directors and Governors	Email and meeting	February 2016
Production of the final report		January 2016 to April 2016

4. Early Warning Trigger Tool

The April to June quarterly report is available as a separate paper. Nine months have now passed since the tool was launched and to date no ward has triggered a red flag on their monthly submissions.

As previously reported, a review of the trigger tool will be taking place during July, the outcome of which will be shared with the Committee at a further meeting.

5. Patient Experience

I am pleased to report that Hester Rowell has now commenced in post at the Lead for Patient Experience. Hester will lead on the development of the Trust's Patient Experience strategy.

The Board are aware of the work that has been undertaken to develop a Trust Patient Experience Strategy, final amendments were agreed at the July meeting of the Patient Experience group which will be launched in September 2015.

Friends and Family Test
As highlighted at Board in June from 1 April 2015 day cases, walk-in activity and paediatrics have all been included in the Inpatient Friends and Family Testing. Prior to this they were excluded.
This means that the denominator for calculating the response rate has increased significantly. In April and May 2014 the inpatient response numbers were 936 and 1088. In 2015 they have been 1218 and 1198 but despite this the response *rate* has more than halved.

We are now revisiting work previously undertaken to improve our response rates with a particular focus upon day cases. The FFT Steering Group will be reconvened and plan to look at alternative methods available which may be more suitable for day-case patients, in particular text messaging.

The quarterly report updating the Board on all aspects of the Patient Experience is detailed in a separate paper.

6. Safeguarding adults

Deprivation of Liberty Safeguards (Cheshire West)
The Committee were advised of the progress of implementation of the above ruling in June 2015.

There are further updates as to the actions as follows:

1) Presentation of the proposed implementation plans following the Law Society
2) Guidance to the Safeguarding Adults Governance Group 2nd July 2015.
3) Briefing paper to be submitted to the Trust Board with the following information:
    a. Evidence to support the proposed "non-negligible" time frame
    b. Evidence of research of other Trust Practice
    c. Applications statistics.

The impact of this emerging guidance is far reaching for all clinical staff. Whilst it is good practice to establish capacity at the onset of a patient's journey, if the patient appears to lack capacity then under this guidance a DoLs should be considered. The use of "**non-neglible period time"** appears to be the most pragmatic way forward however is open to interpretation and carries risk associated with enabling staff to be aware of this and to make decisions.
Implementation of this ruling has already been highlighted for the Risk Register and this emerging guidance will be included in the next return.

The City of York Safeguarding Adults Board asked the CCG Designated Lead for Safeguarding Adults to lead on a Lessons Learned Process following an incident at York Hospital in 2013. The recommendations have recently been agreed and the Trust has been asked to respond with on-going actions and evidence of actions to mitigate future risks. The response (in the format of a working action plan) has been submitted to the Trust Safeguarding Adults Governance Group for approval (by 10th July). On receipt of this approval the response was submitted to the Lessons Learned Lead who will report to the City of York Safeguarding Adults Board in September.

8. Recommendation

The Board is asked to note the Chief Nurse report for July 2015

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

July 2015 update:

York Teaching Hospital NHS
NHS Foundation Trust

Nursing and Midwifery Strategy Implementation Plan: Year 2

The Nursing and Midwifery strategy sets out priorities to achieve high quality nursing care over the next 3 years and was approved at Board in May 2013.The implementation plan outlines current work streams and priorities and demonstrates progress to date. The strategy has been aligned to the Chief Nursing Officers 6 C's in order to ensure compassion in care and to embed these values and behaviours in all Nursing and Midwifery practice.

C1 -Care
C2 -Compassion
C3 -Competence
C4 -Communication
C5 -Courage
C6 -Commitment

Priority 1	**Improve Patient Experience**

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
1a	C1 C4	Develop Patient Public Involvement (PPI) strategy.	Revised Dec 2014	• Work plan agreed in Patient Experience Committee. • Delay in the development of a strategy due to the in-depth review of PPI activity in order to inform the new strategy. • Service users being involved in development of maternity bereavement service Scarborough site. • MSLC chair being involved in Friends & Family Test (FFT) action plan written by Head of Midwifery • Recommendations for in-depth review approved at Executive Board. • New appointment to lead PPI agenda and the integration of Patient Experience	• Strategy document developed. Final comments being received by 24 July 2015. To present to Trust Board August 2015. • PE implementation plan developed to take forward recommendations from the PE Review. The plan will be undergo a full review following ratification of the strategy to ensure it is relevant • PE Strategy will be launched at Nursing Conference on 21	Lead Patient Experience/ Chief Nurse	Green

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
				team (Kay Gamble) • New lead to start writing the strategy • Kay Gamble has stepped down from Patient Experience Lead role and new Lead appointed (Hester Rowel)	September 2015		
1b	C2 C4	Undertake a review of the Patient Experience service, function and capacity and make recommendations to the Nursing Board.	June 2014	• Questionnaires re: training circulated. • Review of processes completed. • Review of the Patient Experience Team (PET) completed • Results of training questionnaire presented at the Patient Experience Steering Group. • Outcome of review of PET agreed at PPI Steering Group • Board of Directors agreed recommendations. • New job description Agenda for Change (AFC) matched. New Lead in Post	• Completed	Chief Nurse Team	Green
1c	C4 C5	Strengthen the role of ward sister and district nursing sister in the management of and learning from complaints in their areas	July 2014	• Afternoon of discussion and presentations planned on Patient experience and complaints management for Professional Nurse Leadership Forum (PNLF). • NHS Elect training commenced. • Midwifery Ward sisters involved in the management of complaints with support from the Matron • Complaints and patient experience included in Maternity mandatory training for all staff • Discussions took place at PNLF. • NHS Elect training completed.	• Community update: • Datix to include lessons learnt box • Development of Datix Dashboard • Development of Incident tracker to feedback lessons learnt at PNLF (Community) • Clinical Governance Lead to be appointed for community services	Matrons, PPI team and Community Safety & Performanc e Manger	Green
1d	C1	Continue to develop the	Dec 2014	• The dementia delivery group is reviewing	• Emma Day will pick up the	Chief Nurse	Amber

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
	C4	patient experience steering group to include further work around PPI. Undertake a benchmarking exercise as to what groups are the Trust involved in and what are we doing in house, (i.e. older peoples forum on York site)		what PPI activity is undertaken across sites and is developing a plan to further build on the work to date. • Healthwatch presented at the Patient Experience PNLF, which was well attended by ward sisters and clinical nurse specialists. The ward sisters worked in groups, reviewing complaints and best practice. Pledges were made to improve the patient experience and will be reviewed in 6 months. • MSLC group. Communication sub group attended by Maternity Matron looking at FFT processes and staff experience. • Home birth support group has been set up to involve users also. • Dementia delivery group developed an action plan • Dementia Lead changed to Emma Day	work of the dementia delivery group and continue to develop the PPI activity associated with this group • Emma welcomed the CEO of Alzheimer Society to Scarborough for a visit in June 2015 • Healthwatch have undertaken Enter and View. Specifically in ED at York. Formal report awaited	Team / PPI team	
1e	C5 C6	Explore and agree the priorities of the new Matron group in the delivery of the PPI agenda	Sept 2014	• Development programme planned for April 2014, started working with Organisational Development Integrated Learning (ODIL) team re: on-going programme • Development plan in place • Coaching taking place. • Matrons are now having a quarterly time out and PPI forms a significant part of this agenda	• Matrons Time Out July 2015. Priorities agreed • Matrons Review (following restructure in 2014) undertaken and presented to relevant meetings	Matrons/ Chief Nurse Team/ Lead for Patient Experience	Green
1f	C2 C4	Review of Trust visiting policy in order to meet the needs of patients and relatives.	Revised Sept 2014	• New Matron group to review and revise policy in conjunction with the protected meal time policy and present recommendations to Matrons meeting /	• Policy complete and will be ratified and nursing policy review group 31 July 2015	Matrons	Green

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
				Nursing Board • Nursing Board dates timetabled. • Review visitors code integrated across all directorates/services. • Policy written to be ratified			
1g	C6	Introduce Friends and Family Test for OPD, Community services and community inpatient areas.	Oct 2014	• FFT commenced in community hospitals ahead of roll out, data report will be produced June 2014 • Up and running in community services inpatient units. Work progressing to roll out in community nursing teams (patients seen at home)	• FFT roll out completed • CQUIN achieved • Opportunity to review FFT / options for future to be considered as part of the next FFT procurement process	Patient Experience Team	Green
1h	C1 C2 C4	Improve Patient involvement in the Safeguarding Adults Process Early identification (at start of hospital journey) of vulnerable adults and embed prevention of and protection from abuse in care planning	Revised Dec 2014	• Generic patient information Leaflet development – awaiting approval and publication. Cost scoping exercise delayed publication – revised target date Dec 2014 • Family/patient specifically involved in Safeguarding Adults Process leaflet – awaiting approval and publication. PPI to be included in membership of Safeguarding Adults Governance Group completed. • PPI to be included in membership of Safeguarding Adults Governance Group • Vulnerable adult recognition on ED admission proforma (Scarborough Acute). Vulnerable adult recognition on ED admission proforma completed at both York and Scarborough. Revised action – Audit after 3 months for value.	• Suspension Policy Pilot Underway	Lead Nurse for Safeguarding Adults	Green
1i	C1 C2	Develop guidance for Mental Health Support	April 2015 (complete)	Phase 1 1) Task and Finish Group - established	• Membership of Mental Health Multi-Agency	Lead Nurse for	Green

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
	C3	in acute setting to support patients who have develop Mental ill-health in acute settings		2) Policy Development – on-going 3) Staff Training (MH First Aid) – partial completed 4) Service Level agreement with MH Provider – on-going Phase 2 1) Business case for MH support Team 2) Recruitment	concordat • Mental health first aid training delivered to key staff • Mental health first aid training in other high risk areas identified	Safeguarding Adults	
1j		Maternity Friends and Family Test Feedback	Ongoing	• Quarterly action plans developed in Maternity from qualitative FFT feedback with user representatives input • Quarter one report tabled at Maternity Services Liaison Committee 02.10.2014. • Confirmed user input into the action plan • Confirmed involvement from the Clinical Commissioning Group (CCG)	• Knowing How We're Doing Boards have been rolled out to Maternity wards • FFT results are reported at the Maternity Services Liaison Committee (now chaired by the Patient Experience Lead from the CCG) • The work on Maternity FFT was shortlisted for a Patient Experience Award in the Listening, Reporting, Acting category. This focused achieving senior buy-in; engaging all senior nurses and sisters, routinely reviewing qualitative feedback, taking action on the results and engaging all staff in why FFT matters.	Head of Midwifery	Amber

Priority 2	Delivering High Quality Safe Patient Care

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
2a	C5 C6	Strengthen nursing leadership by empowering ward sisters, charge nurses & district nursing sisters to ensure all care is of a high standard and meets values of the organisation	Ongoing	• Reviewed the It's My Ward Programme with skills days on-going. • Ward Sisters meeting commenced, Director of Nursing Q&A session at each. • Increased attendance and input at PNLF • Consultation with Ward Sister planned re: reporting structures. • Plan to work with ODIL to review and evaluate the IMW programme. • Plans to further develop the philosophy behind 'It's my ward' programme to develop 'It's my well run ward'. • Band 6 leadership programme delivered	• Leadership programmes delivered • Programme has evaluated well • Drop in sessions for Band 6's planned for both acute hospital sites • Senior Nurses accessing UK Leadership Academy development programmes	ODIL Chief Nurse Team	Green
2b	C1 C6	Ensure the right staff are in the right place at the right time.	Ongoing (planned April & Oct)	• Safer Staffing Project commenced • Meeting with Keith Hurst took place in April 2014, Matrons trained in the awareness of the AUKUH tool, presentation to Ward Sisters during May 2014. • Acuity Audit commenced for 2 weeks in June. • Staffing SOP reviewed and daily staffing meetings in place. • Publishing of daily staffing at ward level commenced • Submission of staffing data via UNIFY commencing June 2014 • Acuity and dependency audit repeated in September 2014. Waiting results. • Safer staffing declared data discussed at the September Board. Agreed to explore	• New systems to collect actual versus planned staffing develop and operational • Unify return continues. No national feedback about how this data will be used • Matrons have revised their daily staffing work to be more efficient • Acuity and dependency audit data being collected in July 2015 • Significant recruitment effort has resulted in 86 RN offers being made for September / October 2015 start	Chief Nurse Team	Green

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
				a more meaningful way of presenting the staffing information that will provide the NEDs with the assurance that they need regarding staffing. • Need accurate up to date information re: use of temporary workforce and ratio. • Additional paper completed reviewing issues around Scarborough - vacancies by area, including Bank / Agency activity and the recruitment. • Looking at worst case scenario for winter and contingency plan (keeping 1:8 ratio) • Complex national picture as NICE have discontinued their work. NHS England do not support the A & E work which NICE will publish • Very limited evidence base for the NICE Guidelines • Awaiting direction from national CNO but until this is received Trust is continuing to operate within current guidelines and recommendations	• Plan for EU recruitment being implemented		
2c	C1 C2 C6	Work with patient safety and compliance teams to ensure delivery of patient safety strategy.	April 2014 and ongoing	• Pressure Ulcer Reduction Plan updated and action plan for 2014/15 developed – update to Board June 2014. • Business case developed to identify nursing resource required to support Electronic Prescribing. • Supervisors of midwives will be undertaking work around medication errors and missed meds • Pressure Ulcer Panel in place to assure learning.	• All work on pressure ulcer continues • New lessons learned from falls and pressure ulcer document developed monthly release implemented • New Nursing and Midwifery Medicines Management Group developed to examine safety issues specifically for nurses and	Patient Safety Team & Chief Nurse Team	Amber

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
				• Work to reduce missed medications continues. • EPMA (Electronic Prescribing and medicines administration) project gives us a great opportunity to iron all of the issues before full implementation. Jennie Booth Lead Nurse Medicines Management is setting up a forum of clinicians to take forward. • September 2014 - introduction of Falls Panel. This is based on the philosophy of the pressure ulcer Panel. To assure the Trust of actions taken, change in practice and dissemination of learning. • Reduction in falls resulting in serious harm. December 2014 launched new inpatient falls policy. • New resources and training package launched for inpatients falls reduction.	midwives. First meeting 21 July 2015 • New electronic Falls Assessment tool awaited from Systems and Networks which will be linked to the CNT's next set of planned training on falls prevention		
2d	**C5** **C6**	Continue to review nursing documentation in order to reduce paperwork and to have consistent records across the organisation	ongoing	**3** work streams full established that focus upon: 1. Pathways - This work is significant as there are over 26 pathways. Work has taken place to review all new pathways to ensure that there is no duplication and the documentation is fit for purpose. The next stage is to work with IT to develop the existing pathways electronically. Work is on-going and progressing as planned. Next stage is link to IT systems. 2. Single record of care – The single record	Community update: • A significant amount of paperwork has been reduced with assessments electronic • Community Documentation Group is established. Acute Inpatient update: • Combined nursing documentation being piloted	**Chief Nurse Team**	**Amber**

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
				of care and revised COMFE tool has been piloted on 3 wards, Ann Wright, White Cross Court and ward 26. This has been well evaluated by the users and will rolled out across care of the elderly at Scarborough and York. 3. Discharge- Electronic discharge nursing document has been written in draft and is planned for approval in June. This will then require a pilot and implementation plan.	• The electronic discharge document is ongoing. The group has agreed to develop this as a paper document in the short term. The documentation group has recently agreed to revise the membership and refocus. The priorities for the next 6 months are development of the discharge check list and roll out of the COMFE tool and single record of care. The revised fluid balance chart has been piloted and will now replace the existing 8 versions. The rollout will take place in September 2015		
2e	C1 C3	Lead the work on falls reduction across the organisation, review the documentation and assessment process in order to streamline and	Sept 2014	• Falls Steering Group set up, membership agreed. • Terms of reference approved. • Delivery groups at both main sites and community. • Strategy to be developed.	• Awaiting electronic Falls Assessment tool to complete this work. • When tool is available the revised education programme will be rolled	Chief Nurse Team	Amber

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
		ensure a consistent approach across the organisation		• Revised risk assessment and implementation plan in draft. To be shared with ward sisters via the documentation steering group in June 2014. • New Inpatient Falls policy ready to be launch. Postponed as electronic tool not finalised for implementation. To be launched during Blue Thursday. • New resources in place to support staff (patient information leaflet, patient poster, falls sticker, staff poster) • New Falls training package for inpatient staff ready for roll out. • September 2014 – first Falls Panel held (review of RCA to assure learning disseminated).	out • Falls panels continue • Learning from falls report produced and disseminated monthly • Review of equipment to prevent falls completed. Trust wide procurement options to be considered		
2f	C1 C2	Introduce Advanced Clinical Practitioner's to facilitate early decision making and timely access to treatment.	May 2014 And ongoing	• Second cohort of trainees recruited to development of the ACP role continues in collaboration with clinical and educational teams	• Work continues. • ACPs entering final year training being supported by current ACPs. Good engagement from Clinicians to support their development and sign off	CLAD, Chief Nurse Team	Green
2g	C1	Infection Prevention (IP) Improve and sustain competency in IP clinical practice and invasive device management that ensures the prevention of avoidable harm from	Permanent Objective	• Weekly feedback of IP performance data to Quality and Safety Group and Directorate Leads. • Quarterly performance data presented to Board of Directors via DIPC report Trust Performance Framework and meetings (PIM`s) • IV specialist role appointed to the IPT. • Proactive programme of high level HPV	• CDI, MSSA and MRSA are all over target or trajectory • Full review of IPC Team and all Governance structures underway • CN has assumed role of DIPC • External review	IPT, Chief Nurse Team Matrons	Red

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
		Healthcare Associated Infection (HCAI) through: Implementation and audit of the IP Annual Plan, policies and guidelines that reflect regulatory and legislative requirements and IP risks/priorities. Effective use of IP performance data and the Trust performance framework to ensure accountability and responsibility for the prevention and control of HCAI and patient safety from Ward to Board. E-Learning packages that facilitate education and understanding Develop a Directorate Assurance Framework New Matron team to devise an approach to prioritise this agenda and raise awareness in		disinfection delivered to high risk areas during Aug/Sept. • Directorate Risk Registers • IP and Internal Audit reports • PIR/RCA reports • E-Learning packages implemented via CLAD learning Hub	commissioned • New draft action plan developed • New Accreditation Tool and process developed • ANNT training delivered July 2015		

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
		their clinical areas					
2h	C3 C4 C6	Formalise Trust wide approach to shared learning from Safeguarding Adults Investigations where actions are identified.	Ongoing	• Full Matron/ward sister involvement in Safeguarding Adults Investigation • Completed – matron consultation and involvement in Safeguarding Adults Investigations. • Evidence can be provided as part of anonymised case studies.	• Work continues to embed in practice.	Matrons / Lead Nurse for Safeguarding Adults	Green
2i		Third and fourth degree tear rate	Ongoing	• Multidisciplinary working group to audit, review practise and recommend actions to reduce rates • Work progressing on schedule • This is not unique to York Trust. There is new National work underway. York Trust will take an active role in this piece of work.	• Work continues. Specialist equipment ordered. Rates have decreased since this work commenced.	Head of Midwifery	Green

Priority 3	Measuring the impact of care

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
3a	C5 C6	Introduce Early Warning Trigger Tool to highlight potential problem areas and to ensure nurses and midwives have meaningful data to influence the delivery of care.	Sept 2014	• Testing phase on-going, pilot commenced • Early warning trigger tool being trialled on Hawthorn ward • The Trust has been using the National Early Warning Score and deteriorating patient escalation policy for 12 months. The policy is currently under review by the deteriorating patient group. • Over the past year we have seen an overall improvement in hospital mortality and a reduction in cardiac arrests.	• EWTT implemented and data collected for 9 months • Quarterly EWTT reporting to Board commenced January 2015 • EWTT will be reviewed (use and impact) by CNT August / September 2015	Chief Nurse Team	Green
3b	C3	Introduce Nursing	May 2014	• Draft Dashboard developed, project team	• Dashboard fully developed.	Chief Nurse	Green

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
	C5	Dashboard to give an overview of key quality indicators for all areas	and ongoing	identified to work in conjunction with the EWTT • This has been developed as a stand alone dashboard and is complete other than the background ward specific information. • Maternity dashboard established and reviewed at Directorate Clinical Governance meetings • Dashboard presented at the June Professional Nurse Leadership Forum (PNLF). More work re: data collection needed • The Dashboard is working progress. • Further support is required from IT (relating to populating and drawing of data) • Dashboard development complete	First set of data will be presented to CNT week commencing 20 July 2015 • CNT to ensure Dashboard dovetails with EWTT and avoid duplication of effort • In addition to the dashboard and EWTT the CNT have presented an Accreditation model in direct response to the Trusts current infection rate	Team	
y	C1 C3	Explore feasibility of IT solutions to documentation	Ongoing	• Assessment documents now electronic • A business case has been written to support a band 7 project role for a senior nurse to support the development, training and education at ward level and to provide the clinical expertise (workforce). • Further work is being undertaken to move more nursing documentation using the IT system.	• Work on electronic solutions for nursing assessments continues. Next tool to be delivered will be the Falls Assessment Tool	Chief Nurse Team /IT	Amber
3d	C1 C6	Develop a Nursing Policy and procedures' Group in order to ensure all polices are up to date and reflect	June 2014 and ongoing	• Initial meeting to plan TOR, wider meeting to involve all key stake holders planned for April 2014. • Maternity guidelines groups established cross site	• Following changes to both the central policy team and the CNT this group has been refreshed. The first revised meeting is on 31	Chief Nurse Team	Amber

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
		current best practice		• Meeting refreshed and rearranged	July and will be chaired by Deputy Chief Nurse		
3e	C3 C6	Evaluate the Productive Ward programme and agree next steps	April 2014	• Evaluation of impact of targeted work at Scarborough site very positive for most areas. • Meeting planned to consider future approach – evaluation undertaken – project suspended due to project support needed for safer staffing initiative. • Work is progressing to ensure 'It's My Ward' programme with an additional module called 'It's my well run ward'. • An accelerated leadership programme is being developed for band 6 nurses. This is an exciting development for aspiring nurse leaders to develop and enhance their leadership skills. • Band 6 leadership course developed • Drop in sessions for aspirant Band 6's being held on both acute Trust sites	• It's My Ward aspirant Band 6 programme delivered to 2 cohorts	Chief Nurse Team	Green
3f	C2 C3 C4	Work with the compliance unit to review delivery of actions from visits to clinical areas in order to provide assurance to the Nursing Board re: quality of care	Dec 2014	• A review of all audits undertaken at ward and department level will start in June. This will link to the CQC 5 questions. The plan is to streamline and reduce repetition and develop achievable actions plans. The group will process map in June and develop recommendations and subsequent implementation plan. • Patient safety walk a rounds planned, undertaken on G1 • Process mapping completed and all clinical audits reviewed. An up dated plan to be developed.	• Care Quality Commission visited the Trust in March 2015. The CNT await the report and will respond accordingly • New model of Ward Accreditation to be considered to provide greater assurance with a specific focus on infection prevention	Chief Nurse Team / Compliance Unit	Green

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
				• Audit schedule linked into the CQC 5 questions.			
3g	Ci C2 C4 C6	Open and Honest	Review to Sept 2015	• Introduce this initiative to publish patient safety and experience data. • Task and finish group set up. Pilot begun on both acute sites	• EWTT embedded in practice – agenda nationally no longer a priority to review	Chief Nurse Team	Green
3h	C3 C4 C6	Safeguarding Adults Team to report quarterly Safeguarding Adults Activity to Matrons and ward Sisters at relevant meetings.	Sept 2014 Completed	• Quarterly reporting of activity to Safeguarding Adults Governance Group • Board reporting • Quarter report to be circulated to matrons following approval at Safeguarding Adults Governance Group (standing agenda item)	Actions completed. • Quarterly reporting of activity to Safeguarding Adults Governance Group continues • Board reporting - next due March 2015 Board. • Quarter report to be circulated to matrons - commenced	Lead Nurse for Safeguarding Adults	Green

Priority 4	Staff experience

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
4a	C2 C4	Utilise staff survey feedback to understand key themes and identify priorities.	April 2014 and ongoing	• Family and Friends staff questionnaire was undertaken in June. The results shared with matrons. • Staff 'listening exercises' considered in Maternity following staff survey results. Multidisciplinary group arranged to develop action plan. • Maternity newsletter developed for staff to help improve communication • From September all nurses will be able to speak to the Chief Nurse on a one to one basis at a series of new monthly surgeries planned to take place across	• Work on Cultural Barometer reported. This way of collecting information from staff is under review. • Patient Experience Team working with Human Resources on service specification for surveys and friends and family test questions to examine the opportunities greater triangulation across all feedback (staff and service	Chief Nurse Team with HR Workforce team	Green

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
				the Trust. • A Culture Barometer has been developed and to be piloted December 2014.	users) will present.		
4b	C4 C6	Ensure all Nurses and Midwives receive a valid appraisal which includes an agreed development plan	Ongoing	• Ongoing work in all Directorates' to achieve annual appraisal. • Chief Nurse Team meeting with external partners to explore electronic solutions to include revalidation – meeting taken place. • Attendance at NMC Re-validation event June 2014. • HR is working on an IT solution for appraisal and is currently in the early stages, with a steering group set up. The IT Company is showcasing the example in June. • On-going monitoring of appraisal rates by matrons	• Nurse revalidation deferred until April 2015. Waiting for national confirmation of date. • Preparation commenced to achieve revalidation • Human Resources has linked ESR to NMC to ensure Trust has sight of revalidation dates • Learning Hub will develop a 'landing platform specifically for revalidation • Communications Team will support comprehensive approach to dissemination • Work plan and progress will be presented in a separate paper at September 2015 Board	Matrons, Ward Sisters	Amber
4c	C3	Explore and consider the training requirements of nurses and midwives and identify alternative methods of delivery.	Ongoing April 2015	• Review of Statutory & Mandatory training requirements for Nursing & Midwifery staff commenced, task and finish group set up to conduct this work and report to nursing Board • Mandatory maternity specific training reviewed annually in line with current guidance	• Statutory and Mandatory training review completed. This will however remain under review and responsive to any emergent clinical risks or concerns • New starter induction and preceptorhsip model being developed and will be implemented for newly	Chief Nurse Team/ ODIL	Green

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
					qualified staff who start in September / October 2015		
4d	C4 C6	Develop the knowing how we are doing boards to reflect what patients and relatives and staff want to see and include positive patient feedback and also work that we have done to reflect patient feedback and measure the effectiveness of this change	September 2014	• Sisters and Matrons discussion and suggestions have begun. Recommendations made May 2014. • The ward sisters have met with one ADN and their opinions have been acknowledged. It has been agreed that the laminate will be removed form the boards, which will leave them blank. The boards will then be converted in July to include daily safer staffing and patient experiences, using family and friends and patient feedback. "Use said, we did". • Positive patient feedback given on monthly mandatory maternity training, at staff meetings with Matron and sent out to staff via e-mail.	• Knowing how we're doing boards really well established • Audit of their impact / effect was agreed at Patient Experience Steering Group, July 2015	Chief Nurse Team with HR Workforce team	Green
4e	C5 C6	Consider centrally supported recruitment process to reduce duplication, ensure recruitment in a timely fashion.	April 2014 and ongoing	• Work continues with an aim to reduce vacancies • One stop shop recruitment is working well, as did the city tour to Glasgow with a number of registered nurses recruited. The recruitment process is working well, with changes to the VC process and DBS. • Cross site recruitment for midwives at Band 5 commenced in Maternity • Fast Track recruitment process for Band 5 and Health Care Assistants (HCA's)	• Some generic recruitment has been supported by Human Resources • Requests for further generic recruitment from Human Resources declined in June 2015 due to capacity issues • Matrons and DMs advised to advertise all vacancies through their directorate structures until Human Resources develops capacity to support	Chief Nurse Team with HR Workforce team	Green
4f	C4 C6	Continue to work with HR to utilise e-rostering to make the most	Sept 2014	• Principles of e-roster commenced on paper roster at Scarborough site	• Roll out of e-roster across Bridlington and Scarborough continues	Chief Nurse Team with HR	Green

NO	6C's	Action	Target	Evidence	July 2015 update	Lead	Status
		efficient use of resources. Introduce e-rostering at Scarborough site		• Maternity in preparation for e-roster implementation • Community inpatients have implemented a process for Admin team to input the rota with support from e-rostering manager and HR.	• KPIs developed and have been reported for 2 months in order to manager individuals against their effective use of e-roster	Workforce team	
4g	C4 C6	Conduct an evaluation of the local induction arrangements for Nurses and Midwives	Dec 2014	• New Matrons group to work with Ward Sisters to introduce a robust system across the organisation that represents local priorities. • Induction packages reviewed and in place for band 5&6 midwives. Band 7 development package commenced.	• New induction process to commence in September 2015 for newly qualified nurses	Matrons	Green
4h	C1 C4 C6	Development of Supervision model and implementation	Revised Dec 2014	• A task and Finish group set up to develop a Supervision of patients Guidance following incidents across sites.	• Policy Completed	Lead Nurse for Safeguarding Adults / Director of Nursing	Green

Assurance Processes

- Nursing Board for approval, monitoring, identifying risks and progress
- Exceptions discussed at Matrons 1:1's and NMT
- Quarterly update to Board of Directors via Chief Nurse report

Beverley Geary
Chief Nurse

D6

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Safe Nurse and Midwifery Staffing Report

Action requested/recommendation

The Board is asked to receive the exception report for information and note the current recruitment campaigns which are on-going.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Outcome 13

Progress of report	Quality & Safety Committee
Risk	Any risks are identified in the report
Resource implications	Potential resources implications where staffing falls below planned or where acuity or dependency increases due to case mix.
Owner	Beverley Geary, Chief Nurse

Author	Nichola Greenwood, Nursing Workforce Projects Manager
Date of paper	July 2015
Version number	Version 1

Board of Directors – 29 July 2015

Safe Nurse and Midwifery Staffing Report

1. Introduction and background

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

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

As reported last month; following feedback from ward sisters and matrons; a revised safer staffing tool was introduced in June 2015. The new tool has received a positive response and will continue to be used for ward staffing level reporting moving forward.

In order to give a more accurate reflection of the staffing levels on ward areas a review of shifts patterns was undertaken against each of the three shifts patterns. In addition, bed occupancy level calculations have also now been removed.

We are now more confident that the fill rates reflect the numbers of Registered nurses and care staff by ward per shift.

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	100.0%	97.3%	100.0%	100.0%
Bridlington & District Hospital	100.7%	95.6%	84.3%	129.5%
Malton Community Hospital	94.7%	110.5%	96.7%	100.0%
Scarborough General Hospital	85.7%	109.8%	93.3%	120.2%
Selby War Memorial Hospital	91.3%	101.3%	100.0%	100.0%
St Helen's	90.8%	100.0%	100.0%	100.0%
St Monica's	93.9%	98.1%	100.0%	100.0%
Whitby Community Hospital	100.5%	98.2%	100.0%	98.9%
White Cross Court	87.5%	100.0%	88.3%	103.3%
York Hospital	88.9%	119.5%	97.0%	119.7%

3. Exceptions

Enhanced Supervision

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

Bridlington	Scarborough	York	
Waters	Ann Wright	AMU	Ward 11
	Chestnut	Ward 14	Ward 23
	Oak	Ward 26	Ward 28
		Ward 31	Ward 32
		Ward 33	Ward 34
		Ward 35	Ward 36-ASU
		Ward 37	Ward 39

Whilst some work has been undertaken to understand why there is a significant variation in requests for enhanced supervision the practice continues and a detailed analysis has now been requested by the Chief Nurse to target education or changes to staffing models if required.

Changes in staffing models

Some wards have planned over establishment following accelerated improvement work and the development of new roles.

Community	Scarborough	York
	Cherry	Ward 28

Provision of Safe Ward Cover

A number of areas change the ratio of registered and unregistered staff to ensure basic care needs are delivered due to vacancies, sickness or variations of operative procedures. This has resulted at times in change in skill mix or staff moved to other wards to ensure safe patient care.
These ward areas are:

Bridlington	Scarborough		York
Kent	Ann Wright	Beech	G1
	Coronary Care Unit	Hawthorn	G2
	Holly	Maple	ICU
	Oak	Stroke	Ward 15
			Ward 16
			Ward 25

Bed Occupancy

A number of areas change the ratio of registered and unregistered staff dependent on bed occupancy levels and the effective use of staff with staff being deployed to other ward areas. These ward areas are:

Bridlington	York
Kent	Ward 17
Lloyd	

Activity demands on some wards have resulted in units which would typically close overnight, remaining open. This has resulted in increased staffing on these wards:

Scarborough	York
Lilac	Extended Stay

Vacancies, Sickness and the Trust's ability to fill shifts can reduce the average percentage staffing levels each month

Vacancies

Scarborough	York
Chestnut	Ward 23
Maple	Ward 25
Oak	Ward 26
	Ward 35

The implementation of the revised safer staffing tool and the removal of the bed occupancy calculation has highlighted difficulties in implementing the annual leave algorithm on Waters ward in Bridlington. This is being addressed by the Matron as an urgent priority.

Actions and Mitigation of risk
At least daily staffing meeting are taking place to deploy staff to high risk areas. Where there is low activity these staff are moved to other wards in order to improve levels.

4. Vacancies by Site

The vacancies reported below, for adult inpatient areas, are based on information provided on a weekly basis by Matrons as part of their weekly vacancy reporting. The information below shows the position as at 3rd July 2015.

	Bridlington		Community		Scarborough		York	
	RN	HCA	RN	HCA	RN	HCA	RN	HCA
Actual Vacancies	6.74	1.00	2.48	2.40	41.70	9.52	91.52	17.59
Pending Start	1.00	0.00	0.00	0.60	21.40	3.69*	51.8	10.67
Outstanding Posts	**5.74**	**1.00**	**2.48**	**1.80**	**20.30**	**5.83**	**39.72**	**6.92**

*3.25 Band 3 posts

Of the outstanding registered nurses vacancies within the inpatient areas, 12.16wte are for Band 6 or Band 7 nurse positions across the Trust, broken down as follows: York- 8.16wte , Scarborough-4wte

Registered nurse Band 5 vacancies continue to reduce across the Trust following significant generic and departmental recruitment over the last few months. Recent generic registered nurse recruitment campaigns have now been concluded and consideration is now being given

to further recruitment initiatives to address the remaining vacancy position. It is anticipate that following the successful recruitment of the newly qualified nurses ward areas vacancies will reduce to near nil.

As detailed in the Chief Nurse report European recruitment will begin in August to over recruit for winter pressures and to ensure that there is flexibility in the system to address shortfalls and reduce the reliance on Agency and Bank.

Healthcare assistant Band 2 vacancies are in the process of being filled following the recent recruitment campaigns across the Trust. A recruitment campaign for Band 3 Senior Healthcare Assistants will commence in the autumn.

5. Sickness, Bank and Agency Fill Rates

Sickness

The overall absence rate for the Trust for the month of May 2015 was 4.01% By site, sickness within the Nursing and Midwifery workforce across the inpatient areas was, as follows:

York Acute Hospital – 3.7 %
Scarborough Acute Hospital – 5.55%
Community Services – 4.24%

Temporary Staffing (Scarborough) - June

Overall fill rate of bank shifts requested through the internal bank was 78.32%, an improvement of 2.36% from May 2015. The fill rate for qualified shifts was 71.03%, an improvement of 2.87% on May and, the fill rate for unqualified shifts was 89.69%, an improvement of 4.61%.

The percentage of shifts filled by agency increased this month for both RN shifts and unqualified shifts with 47.19% of shifts being filled by external agency compared with 43.75% in May 38.02% in April, 30% in March, 34% in February and 37% in January 2015.

The percentage of shifts filled by agency increased this month for both RN shifts and unqualified shifts with 35.9% of shifts being filled by the internal Nurse bank, compared with 33.42% in May, but a slight decrease against our end of April 2015 position at 36.51%

6. Recommendation

The Board is asked to receive the exception report for information and note the current recruitment campaigns which are on-going.

7. References and further reading

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

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

Fill rate indicator return

Staffing: Nursing, midwifery and care staff

Please provide the URL to the page on your trust website where your staffing information is available
(Please can you ensure 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

Only complete sites your organisation is accountable for		Main 2 Specialties on each ward		Day				Night				Day		Night	
				Registered		Care Staff		Registered		Care Staff					
Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Johnson	430 - GERIATRIC MEDICINE		900	858	1260	1236	660	660	330	330	95.3%	98.1%	100.0%	100.0%
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		1125	1087.5	900	750	660	385	0	275	96.7%	83.3%	58.3%	-
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Lloyd	100 - GENERAL SURGERY		660	720	330	180	198	132	198	110	109.1%	54.5%	66.7%	55.6%
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Waters	430 - GERIATRIC MEDICINE		1125	1170	1125	1290	660	660	330	396	104.0%	114.7%	100.0%	120.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1080	894	900	1170	660	660	330	616	82.8%	130.0%	100.0%	186.7%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ash	100 - GENERAL SURGERY		1125	952.5	900	922.5	660	638	0	220	84.7%	102.5%	96.7%	-
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Beech	300 - GENERAL MEDICINE		1440	1410	1260	1314	990	803	660	825	97.9%	104.3%	81.1%	125.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Cherry	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1800	1602	1440	1464	1650	1386	1320	1386	89.0%	101.7%	84.0%	105.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1440	1128	1080	1074	660	671	660	759	78.3%	99.4%	101.7%	115.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2475	2032.5	450	847.5	1320	1221	330	451	82.1%	188.3%	92.5%	136.7%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Duke of Kent	420 - PAEDIATRICS		1575	1372.5	450	442.5	660	660	330	330	87.1%	98.3%	100.0%	100.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Hawthorn	501 - OBSTETRICS		720	732	360	360	660	660	0	0	101.7%	100.0%	100.0%	-
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1080	966	1080	1128	660	660	660	660	89.4%	104.4%	100.0%	100.0%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE		2700	2257.5	450	390	1650	1628	0	0	83.6%	86.7%	98.7%	-
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Lilac	101 - UROLOGY	100 - GENERAL SURGERY	1800	1605	1800	1740	660	693	660	715	89.2%	96.7%	105.0%	108.3%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Maple	100 - GENERAL SURGERY		2250	1972.5	1125	1657.5	1320	1210	660	836	87.7%	147.3%	91.7%	126.7%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Oak	430 - GERIATRIC MEDICINE		1800	1398	1620	1764	990	946	990	1166	77.7%	108.9%	95.6%	117.8%
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Stroke	430 - GERIATRIC MEDICINE		1440	1152	720	696	990	781	330	363	80.0%	96.7%	78.9%	110.0%
YORK HOSPITAL - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1470	1422	882	942	660	660	660	660	96.7%	106.8%	100.0%	100.0%
YORK HOSPITAL - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1620	1482	1080	1038	990	990	572	682	91.5%	96.1%	100.0%	119.2%
YORK HOSPITAL - RCB55	15	120 - ENT	101 - UROLOGY	1800	1755	1350	1335	990	957	330	352	97.5%	98.9%	96.7%	106.7%
YORK HOSPITAL - RCB55	16	100 - GENERAL SURGERY		2347.5	2070	997.5	1080	1232	1177	572	561	88.2%	108.3%	95.5%	98.1%
YORK HOSPITAL - RCB55	17	420 - PAEDIATRICS		1440	1188	360	300	990	990	330	198	82.5%	83.3%	100.0%	60.0%
YORK HOSPITAL - RCB55	23	430 - GERIATRIC MEDICINE		1800	1432.5	1125	1850	660	660	990	1089	79.6%	165.3%	100.0%	110.0%
YORK HOSPITAL - RCB55	25	430 - GERIATRIC MEDICINE		1440	1146	900	1170	660	660	990	990	79.6%	130.0%	100.0%	100.0%
YORK HOSPITAL - RCB55	26	430 - GERIATRIC MEDICINE		1800	1395	1125	1545	660	660	990	1001	77.5%	137.3%	100.0%	101.1%
YORK HOSPITAL - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1620	1380	900	1116	660	715	660	726	85.2%	124.0%	108.3%	110.0%
YORK HOSPITAL - RCB55	29	110 - TRAUMA & ORTHOPAEDICS		1440	1212	720	672	660	649	330	330	84.2%	93.3%	98.3%	100.0%
YORK HOSPITAL - RCB55	31	370 - MEDICAL ONCOLOGY		2025	1852.5	900	892.5	660	671	330	352	91.5%	99.2%	101.7%	106.7%
YORK HOSPITAL - RCB55	32	320 - CARDIOLOGY		1476	1266	1080	1776	660	638	990	1672	85.8%	164.4%	96.7%	168.9%
YORK HOSPITAL - RCB55	33	301 - GASTROENTEROLOGY	361 - NEPHROLOGY	1440	1242	1080	1548	660	660	990	1408	86.3%	143.3%	100.0%	142.2%
YORK HOSPITAL - RCB55	34	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1440	1362	1080	1680	660	660	990	1496	94.6%	155.6%	100.0%	151.1%
YORK HOSPITAL - RCB55	35	430 - GERIATRIC MEDICINE		1440	1134	900	1404	660	660	990	1045	78.8%	156.0%	100.0%	105.6%
YORK HOSPITAL - RCB55	37	430 - GERIATRIC MEDICINE		1080	954	1260	1356	660	660	660	737	88.3%	107.6%	100.0%	111.7%
YORK HOSPITAL - RCB55	39	430 - GERIATRIC MEDICINE		1080	924	900	1008	660	649	330	451	85.6%	112.0%	98.3%	136.7%
YORK HOSPITAL - RCB55	36 - Acute Stroke Unit	430 - GERIATRIC MEDICINE		1440	1344	900	996	990	990	660	682	93.3%	110.7%	100.0%	103.3%

Only complete sites your organisation is accountable for				Day				Night				Day		Night	
		Main 2 Specialties on each ward		Registered		Care Staff		Registered		Care Staff					
Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
YORK HOSPITAL - RCB55	Acute Medical Unit	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	4500	4260	3600	4065	2640	2585	1980	2695	94.7%	112.9%	97.9%	136.1%
YORK HOSPITAL - RCB55	Coronary Care Unit	320 - CARDIOLOGY		1800	1680	330	300	1320	1177	0	0	93.3%	90.9%	89.2%	-
YORK HOSPITAL - RCB55	Extended Stay Area	100 - GENERAL SURGERY	120 - ENT	990	1012.5	495	540	396	429	0	88	102.3%	109.1%	108.3%	-
YORK HOSPITAL - RCB55	G1	502 - GYNAECOLOGY		1440	1332	720	750	660	660	660	616	92.5%	104.2%	100.0%	93.3%
YORK HOSPITAL - RCB55	G2	501 - OBSTETRICS		1080	1008	540	516	660	638	330	616	93.3%	95.6%	96.7%	186.7%
YORK HOSPITAL - RCB55	G3	501 - OBSTETRICS		720	642	360	336	660	649	0	0	89.2%	93.3%	98.3%	-
YORK HOSPITAL - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5400	4717.5	450	502.5	3960	3498	330	308	87.4%	111.7%	88.3%	93.3%
ARCHWAYS INTERMEDIATE CARE UNIT	Archways	925 - COMMUNITY CARE SERVICES		720	720	900	876	330	330	660	660	100.0%	97.3%	100.0%	100.0%
MALTON COMMUNITY HOSPITAL - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		1125	1065	1575	1740	660	638	660	660	94.7%	110.5%	96.7%	100.0%
SELBY AND DISTRICT WAR MEMORIAL HOSPITAL - RCB97	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1125	1027.5	1125	1140	330	330	660	660	91.3%	101.3%	100.0%	100.0%
ST HELENS REHABILITATION HOSPITAL - RCBTV	St Helens	430 - GERIATRIC MEDICINE		900	817.5	1125	1125	330	330	330	330	90.8%	100.0%	100.0%	100.0%
ST MONICAS HOSPITAL - RCB05	St Monicas	925 - COMMUNITY CARE SERVICES		615	577.5	772.5	757.5	330	330	330	330	93.9%	98.1%	100.0%	100.0%
WHITBY COMMUNITY HOSPITAL - RCBG1	Abbey	925 - COMMUNITY CARE SERVICES		675	690	1125	1192.5	330	330	330	330	102.2%	106.0%	100.0%	100.0%
WHITBY COMMUNITY HOSPITAL - RCBG1	War Memorial	925 - COMMUNITY CARE SERVICES		900	892.5	1350	1237.5	330	330	660	649	99.2%	91.7%	100.0%	98.3%
WHITE CROSS REHABILITATION HOSPITAL - RCBP9	Whitecross Court	430 - GERIATRIC MEDICINE		900	787.5	1125	1125	660	583	330	341	87.5%	100.0%	88.3%	103.3%
	Total			77624	69101	50382	56348	43076	40997	27412	32153				

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Infection Prevention and Control Quarterly Update

Action requested/recommendation

The board of Directors are asked to:

- Receive the IPC update report on quarter one performance.
- Acknowledge the immediate actions undertaken to review Governance and reporting.
- Approve a revision of reports to Board to include outbreaks, and actions to mitigate risk.

Summary

Good infection prevention and control (IPC) are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone.

In line with regulatory requirements (CQC outcome 8) patients and the public should be cared for in a clean environment and protected.

The quarterly report summarises Trust compliance and performance against key infection standards and indicators.

The Trust is exceeding trajectory for C.difficile infection and has reached the de-minimus limit of 6 MRSA Bacteraemia. Actions taken and interventions to bring the organisation back on trajectory are described in the 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 outcomes

Outcome 8: Cleanliness and infection control

Progress of report	Quality & Safety Committee (as part of the Chief Nurse Report)
Risk	Risk to patient safety if compliance falls below required standards.
Resource implications	Potential for fines to be incurred as a result of poor performance.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	July 2015
Version number	Version 2

Board of Directors – 29 July 2015

Infection Prevention and Control Quarterly Update

1. Introduction

Good infection prevention and control (IPC) are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone (ref 1).

In line with regulatory requirements (CQC outcome 8) patients and the public should be cared for in a clean environment and protected.

National mandatory reporting process however, for ecoli and MSSA there are no nationally agreed objectives.

However we have a locally agreed number of 30 MSSA.

The Trust current NHSE standard for IPC incidence for the year 2015/16 is:
Clostridium difficile (CDiff) 48
MRSA 0 tolerance (de-minimus 6)
MSSA less than 30 (locally agreed with CCG)

In 2014/15 the agreed tolerance against actual incidence was as follows:
CDiff: 59 actual 59
MSSA:30 actual 55
We had 1 MRSA bacteraemia

Currently we report quarterly to Board on incidence of infection.

2. Update

The Board are aware that following the realignment of some Executive portfolios the Director of Infection Prevention role is now part of the Chief Nurse role.

Currently quarterly reports are presented to Board with an overview of performance and an update of compliance and performance against the key IPC standards (appendix 1.)

Given the current performance (in particular with relation to MRSA Bacteraemia) it is recommended that Board reporting should be reviewed quickly in order that timely information is reported and received for scrutiny; and to update on current and anticipated risks with details of the actions taken.

In addition; and in line with the Trust review a detailed evaluation of the governance of the IPC agenda will be undertaken in in order to ensure robust ward to board assurance and accountability. Given current incidence this has been commissioned by the DIPC, due to capacity issues the review will be undertaken by an external consultant.

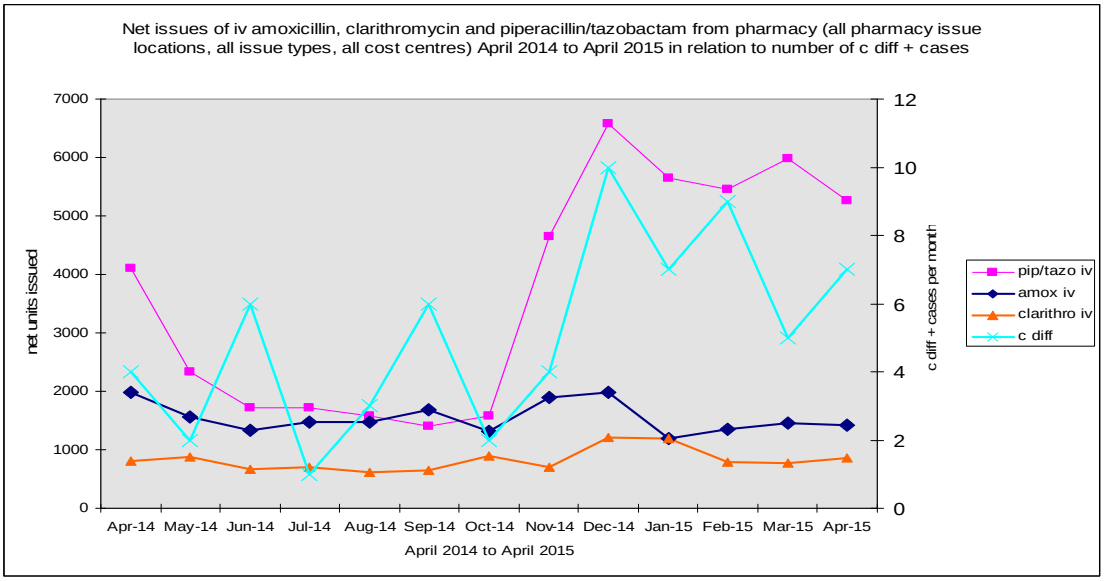
3. Incidence

We have seen an increase in infection prevention incidents across the Trust sites, the details of the end of quarter one performance is detailed below:

C.difficle incidence (CDI) – rose to 21 cases in total, 11 at York and 10 at Scarborough placing the Trust over our monthly trajectory.

Post Infection Reviews (PIR) have been undertaken, themes and learning from these will be identified and reported to Board as soon as the information is available.

There is an indication from the IPC team that there may be a correlation with the use of some antimicrobials' and the incidence of C.diff, further information has been requested.



6 MRSA bacteraemia cases - 5 at Scarborough site and 1 at York. 2 of the cases are likely to be contaminants. Post infection review (PIR) identifies variation in screening and treatment compliance and cannula care. IPT training at ward level for high incidence wards and IP workshops for the Multi -Disciplinary Team have been arranged. The targeted assessment of acute admission areas of high risk patients having had appropriate screening proposed.

MSSA bacteraemia 11 cases in total. 6 at York, 5 at Scarborough

In order to reduce the incidence of bacteraemia the following initiatives have been implemented:

- ANTT e-learning alongside Statutory and Mandatory introduced
- ANTT core clinical skill train the trainer/champion programme to commenced 15th July across both acute sites focussing on cannula insertion/ ongoing care to include Safe blood culture sampling
- Introduction of safer blood sampling equipment to prevent contamination being led by Lab staff
- Non ported cannula to reduce inoculation risk is being market tested pre implementation
- Cannulation packs are being introduced to re-focus practice as an aseptic, invasive device procedure
- An MSSA Task and finish group has been convened to oversee engagement with and

implementation of IP MSSA reduction strategy

- Catheter Associated Urinary Tract Infection (CAUTI) surveillance extended to one Directorate per month at York, 2 wards per month at SGH from 1st April. Early outcomes showing low incidence.
- IP Awareness day took place at York on 30th June but good feedback and will be replicated at SGH 22nd July.

4. Conclusion

In quarter one the Trust 21 C.difficile infections (against and annual trajectory of 43) this take us over our monthly trajectory.

During the same period 6 MRSA and 11 MSSA bacteraemia were reported. Work is being undertaken to understand the causes and identify any themes, and strategies are being employed to bring us back into line and reduce risk to patients.

Following changes in Executive portfolios the Chief Nurse is now Director of Infection Prevention.

In line with the organisational review; a full appraisal of IPC governance and reporting structures is being undertaken. Due to current performance and capacity an external consultant has been appointed by the Chief Nurse to begin this in July. It is anticipated that the final report with any recommendations will be completed by the end of September.

5. Recommendation

The Board of Directors are asked to:

- Receive the IPC update report on quarter one performance.
- Acknowledge the immediate actions undertaken to review Governance and reporting.
- Approve a revision of reports to Board to include outbreaks, and actions to mitigate risk.

6. References and further reading

1 - The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, DOH 2010

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

Appendix 1

Director Infection Prevention and Control QUARTERLY INFECTION PREVENTION REPORT FOR TRUST BOARD. Q1 2015-2016

Parameter		Incidence 2014/15	Apr	May	June	YTD	Notes
MRSA Bacteraemia attributable to Trust	Community	0	0	0	0	0	
	Elderly	0	**1**	**1**	**1**	3	1 case at York. 5 cases at SGH, 2 probable blood culture contaminants. ANTT e-learning in place from May. Facilitated workshops for clinical staff July. IP induction training secured for new Medical staff. Switch to non-ported cannula and cannulation packs. Working with IT to develop learning package to improve documentation of cannula on CPD to improve monitoring and ongoing care. Case studies developed from PIR outcomes focussing on lack of/variation in screening and treatment compliance presented and dsicussed at governance, PNLF, Senior nurse and ward meetings.
	Head + Neck	0	0	0	0	0	
	Medicine	0	**1**	**1**	0	2	
	Obstetrics + Gynaecology	0	0	0	0	0	
	Ophthalmology	0	0	0	0	0	
	Paediatrics	0	0	0	0	0	
	Specialist Medicine	0	0	0	0	0	
	Surgery + Urology	0	0	0	**1**	1	
	Trauma + Orthopaedics	1	0	0	0	0	
	Trust	1	2	2	2	6	
MSSA Bacteraemia attributable to Trust Annual threshold 2015 to 2016 = 30 cases	Community	1	0	0	0	0	
	Elderly	10	**1**	**2**	**1**	4	6 cases on each acute site. Actions to reduce as for MRSA bacteraemia. MSSA reducition strategy devleoped 2014 now being overseen by Task and Finish Group
	Head + Neck	0	0	0	0	0	
	Medicine	27	**2**	**1**	**1**	4	
	Obstetrics + Gynaecology	0	0	0	0	0	
	Ophthalmology	0	0	0	0	0	
	Paediatrics	4	0	0	0	0	
	Specialist Medicine	2	0	0	0	0	
	Surgery + Urology	9	0	0	**1**	1	
	Trauma + Orthopaedics	2	0	**2**	0	2	
	Trust	55	3	5	3	11	
MSSA per 100000 bed days attributable to Trust	York	17.5	11.2	10.7	11.2		
	Scarborough + Bridlington	14.5	9.7	27.7	9.9		
	Community hospitals	2.1	0.0	0.0	0.0		
	Trust	14.3	9.2	14.6	9.2		

Parameter		Incidence 2014/15	Apr	May	June	YTD	Notes
E coli Bacteraemia attributable to Trust No threshold set	Community	8	0	**2**	0	2	
	Elderly	22	**2**	**2**	**3**	7	
	Head + Neck	0	0	0	0	0	
	Medicine	18	**4**	**3**	**2**	9	
	Obstetrics + Gynaecology	2	0	0	0	0	
	Ophthalmology	0	0	0	0	0	
	Paediatrics	0	0	0	0	0	
	Specialist Medicine	14	0	0	0	0	
	Surgery + Urology	41	**2**	**1**	**3**	6	
	Trauma + Orthopaedics	0	0	0	0	0	
	Trust	105	8	8	8	24	
Elective MRSA admission screening (report produced by SNS Team)	York sites		88%	89%	88%		Green = >95%, Amber = 75%-95%, Red = <75%
	Scarborough sites		73%	77%	80%		
	Trust		83%	86%	85%		
Emergency MRSA admission screening (report produced by SNS Team)	York sites		62%	69%	67%		Actions to improve screening compliance as described for Bacteraemia.
	Scarborough sites		63%	73%	66%		
	Trust		62%	70%	66%		
Clostridium difficile Infection (CDI) attributable to Trust Annual threshold 2015 to 2016 = 48 cases	Community	7	0	0	0	0	
	Elderly	30	**5**	**4**	**5**	14	
	Head + Neck	0	0	0	0	0	Use of Tazocin contributory - no alternative currently.
	Medicine	10	**1**	**3**	**1**	5	
	Obstetrics + Gynaecology	0	0	0	0	0	PIR shows lack of consultation with Microbiology in some cases before prescribing broad spectrum antimicrobials. Being addressed vis stewardship group and PIR process.
	Ophthalmology	0	0	0	0	0	
	Paediatrics	0	0	0	0	0	
	Specialist Medicine	5	0	0	0	0	
	Surgery + Urology	6	**1**	**1**	0	2	
	Trauma + Orthopaedics	1	0	0	0	0	
	Trust	59	7	8	6	21	
CDI per 100000 bed days attributable to Trust	York	11.9	39.3	10.7	11.2		
	Scarborough + Bridlington	24.4	0.0	55.5	39.5		
	Community hospitals	8.5	0.0	0.0	0.0		
	Trust	15.3	21.5	23.4	18.5		
CDI Saving Lives care bundle compliance	York		96%	95%	98%		Green = >95%, Amber = 75%-95%, Red = <75%
	Scarborough + Bridlington		91%	88%	95%		
	Trust		94%	92%	96%		
Deaths where Clostridium difficile is reported on certificate Part 2 unless	Community	0	0	0	0	0	
	Elderly	7	0	0	**1**	1	
	Head + Neck	0	0	0	0	0	
	Medicine	1	0	0	0	0	
	Obstetrics + Gynaecology	0	0	0	0	0	
	Ophthalmology	0	0	0	0	0	
	Paediatrics	0	0	0	0	0	

Parameter		Incidence 2014/15	Apr	May	June	YTD	Notes
Part 2 unless specified otherwise	Specialist Medicine	0	0	0	0	0	
	Surgery + Urology	1	0	0	0	0	
	Trauma + Orthopaedics	0	0	0	0	0	
	Trust	9	0	0	1	1	
Readmissions within 30 days where CDI is diagnosed on and thought to be reason for admission - NB: refers to discharging directorate	Community	0	0	0	0	0	
	Elderly	3	0	0	0	0	
	Head + Neck	0	0	0	0	0	
	Medicine	0	0	0	0	0	
	Obstetrics + Gynaecology	0	0	0	0	0	
	Ophthalmology	0	0	0	0	0	
	Paediatrics	0	0	0	0	0	
	Specialist Medicine	0	0	0	0	0	
	Surgery + Urology	3	0	0	0	0	
	Trauma + Orthopaedics	0	0	0	0	0	
	Trust	6	0	0	0	0	
Antimicrobial pathway compliance with indication (information from Antimicrobial Stewardship Team)	Elderly		90%	93%	91%		Green = >95%, Amber = 90%-95%, Red = <90%
	Head + Neck		100%	100%	83%		
	Medicine		91%	85%	90%		
	Obstetrics + Gynaecology		50%	29%	80%		
	Specialist Medicine		80%	50%	100%		Being managed by Antimicrobial Stewardship Team. Sticker to be developd for drug chart to prompt 48 hour review. To be discussed at next Executive Board.
	Surgery + Urology		80%	88%	85%		
	Trauma + Orthopaedics		82%	77%	55%		
	Trust		87%	85%	87%		
Antimicrobial pathway compliance with duration or review date (information from Antimicrobial Stewardship Team)	Elderly		96%	89%	91%		Green = >95%, Amber = 90%-95%, Red = <90%
	Head + Neck		50%	50%	100%		
	Medicine		89%	86%	87%		
	Obstetrics + Gynaecology		100%	100%	40%		
	Specialist Medicine		60%	50%	100%		Sticker to be developed for drug chart to promt 48 hour review.
	Surgery + Urology		87%	81%	88%		
	Trauma + Orthopaedics		82%	86%	55%		
	Trust		89%	85%	86%		
Percentage patients >65 years co-prescribed VSL#3 (information from Antimicrobial Stewardship Team)	Elderly		92%	86%	94%		Green = >95%, Amber = 90%-95%, Red = <90%
	Head + Neck		50%	67%	75%		
	Medicine		72%	60%	71%		CDI lead continues to prompt medical staff to prescribe
	Surgery + Urology		50%	30%	27%		NB: exclusion criteria not checked if patient not on VSL#3
	Trauma + Orthopaedics		75%	56%	43%		
	Trust		77%	62%	66%		
Ventilator acquired pneumonia in ICU (information provided by ICU)	York ICU	1	0	0	0	0	
	Scarborough ICU	0	0	0	Awaiting data	0	
	Trust	0	0	0	0	0	
CVC associated infections in ICU (information provided by ICU)	York ICU	1	0	0	0	0	
	Scarborough ICU	1	0	0	Awaiting data	0	
	Trust	2	0	0	0	0	

Parameter		Incidence 2014/15	Apr	May	June	YTD	Notes
Trust attributed CAUTI Elderly Care Directorate (IPT surveillance)	Elderly		5	2	1	8	
Trust attributed CAUTI (Safety Thermometer data)	York		0	2	3	5	
	Scarborough + Bridlington		3	0	2	5	
	Community hospitals		0	0	0	0	
	Trust		8	2	5	15	
Hand Hygiene compliance	Anaes,Theatre and Crit care		87%	92%	82%		Green = >95%, Amber = 75%-95%, Red = <75%
	Community		94%	100%	95%		
	Elderly		88%	86%	86%		
	Emergency		63%	72%	70%		
	Head + Neck		86%	93%	92%		
	Medicine		92%	91%	96%		
	Obstetrics + Gynaecology		92%	100%	100%		
	Ophthalmology		100%	100%	100%		
	Paediatrics		98%	100%	96%		
	Radiology		94%	100%	94%		
	Sexual Health		100%	96%	100%		
	Specialist Medicine		95%	93%	100%		
	Surgery + Urology		87%	95%	90%		
	Therapies (AHPs)		100%	91%	x		
	Trauma + Orthopaedics		92%	95%	97%		
	Trust total		91%	92%	93%		
Environment audit results	Anaes,Theatre and Crit care		93%	97%	96%		Green = >95%, Amber = 85%-95%, Red = <85%
	Community		99%	98%	98%		
	Elderly		94%	94%	96%		
	Emergency		100%	100%	99%		
	Head + Neck		68%	95%	96%		
	Medicine		97%	92%	94%		
	Obstetrics + Gynaecology		99%	97%	96%		
	Ophthalmology		92%	x	x		
	Paediatrics		99%	100%	99%		
	Radiology		99%	97%	99%		
	Sexual Health		100%	100%	100%		
	Specialist Medicine		100%	x	98%		
	Surgery + Urology		95%	98%	96%		
	Therapies (AHPs)		100%	100%	96%		
	Trauma + Orthopaedics		99%	97%	97%		
	Trust total		97%	96%	97%		
Infection Prevention training completion (data provided by Corporate, Learning and Development Team)	Anaes,Theatre and Crit care	190	20	35	44	99	
	Community	178	27	41	39	107	
	Elderly	117	21	9	9	39	
	Emergency	43	13	10	7	30	
	Head + Neck	45	3	6	13	22	
	Medicine	169	29	17	23	69	
	Obstetrics + Gynaecology	113	5	12	10	27	
	Ophthalmology	41	8	9	7	24	
	Paediatrics	79	14	8	13	35	
	Radiology	102	10	7	14	31	
	Sexual Health	20	1	2	5	8	
	Specialist Medicine	67	13	15	16	44	
	Surgery + Urology	102	11	6	9	26	
	Therapies (AHPs)	173	8	22	21	51	
	Trauma + Orthopaedics	43	4	6	8	18	
	Trust total	1482	187	205	238	630	

F

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Patient Experience Strategy 2015-18

Action requested/recommendation

It is recommended that the Board of Directors consider and approve the Patient Experience Strategy 2015-18.

Summary

The strategy sets out how the Trust will achieve it's vision for patient experience:

A culture where staff, in partnership with patients, work together to support good health, learn from feedback and achieve a positive experience of 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 this strategy is likely to have a positive impact on the requirements of or the protected groups identified by the Equality Act by promoting the importance of personalised care, which reflects patients' individual needs and preferences.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Patient Experience Steering Group and Quality and Safety Committee
Risk	No risk
Resource implications	No changes to existing resources are proposed.
Owner	Beverley Geary, Chief Nurse
Author	Hester Rowell, Lead for Patient Experience
Date of paper	July 2015
Version number	Version 1

Find out more

To ask a question about this strategy, patient experience at York Teaching Hospital NHS Foundation Trust or to find out how you can get involved please contact:

Patient Experience Team
Email: patientexperienceteam@york.nhs.uk
Tel: 01904 725137

To tell us about your experience of care please contact our Patient Advice and Liaison Service:
Email: pals@york.nhs.uk
Tel: 01904 726262

Please telephone or email if you require this information in a different language or format

如果你要求本資訊是以不同的語言或版式提供，請致電或寫電郵

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York Teaching Hospital NHS
NHS Foundation Trust

Your Experiences **Matter**

Our Patient Experience Strategy 2015-2018

Foreword

Working in the NHS means that we often see people at the most vulnerable times in their lives. In these moments, by demonstrating that we care, we are creating an impression that can last a lifetime.

I am immensely proud to be a nurse and to work with fantastic colleagues across the Trust.

As Chief Nurse, I have overall responsibility for patient experience. I am absolutely committed to working with Board colleagues and all staff to deliver this Patient Experience Strategy to achieve the best quality of care for our patients.

As patients' needs become ever more complex, we are continuing to learn how to work differently together as a team – doctors, nurses, administrators, porters along with many others - to deliver the best care possible and to meet their expectations.

It is our obligation and privilege to ensure that patients are cared for as we would want for ourselves and those closest to us.

If I could give one piece of advice to all staff it would be to listen to patients and their relatives, they are the experts and know what they need. By doing everything that we can, however small, to tailor care to individuals' needs, we are demonstrating that their experience matters to us.

Beverley Geary
Chief Nurse

Implementation

To deliver this strategy we will have an implementation plan detailing the actions to be led by the Patient Experience Team over the next three years.

The Board will receive assurance on the delivery of the implementation plan via the Quality and Safety Committee.

References

1. High Quality Care for All, NHS Next Stage Review, June 2008, HM Government
2. What Matters to Patients? Developing the Evidence Base for Measuring and Improving Patient Experience, Kings College London and the Kings Fund, 2010
3. How to Engage Staff in the NHS and Why it Matters, The Point of Care Foundation, January 2014
4. Picker Institute, Patient-Centred Care Improvement Guide, 2008
5. Patients In Control, Why Patients With Long Term Conditions Must Be Empowered, Centre For Policy Research, September 2014
6. NHS Forward View, NHS England, October 2014
7. NHS Foundation Trust Code of Governance, Monitor, July 2014
8. Measuring Patient Experience, Evidence Scan, The Health Foundation, June 2013
9. NHS Constitution, Department of Health, March 2013

Our son is being treated on HDU and everyone - consultants, nurses and cleaners - is absolutely superb..

A culture of learning and responsibilty

It is the commitment, professionalism and dedication of staff working for the benefit of the people the NHS serves which really makes the difference.[9]

In laying the foundations for all other elements of this strategy there is no more important place to start than with our own staff.

Delivering our commitment to nurturing a culture of learning and responsibility we will create an environment where:

- All staff welcome feedback and encourage and support patients to feel confident about talking directly to our ward and service staff as soon as issues arise.

- Staff see feedback positively as an opportunity for reflection and learning.

- Recognise and celebrate staff who have demonstrated excellent care and a passion for serving others.

- People involved feel able to offer a genuine apology where something has gone wrong.

- Staff at all levels take responsibility for the quality of patient experience in their ward, service or directorate, actively seek out feedback and take responsibility for actions.

"The reason for writing this letter is to ensure that other families don't have a similar experience to us."

Introduction

Achieving excellent patient experience means delivering care organised around patients' individual needs and preferences. It is an essential part of providing high quality care, alongside clinical effectiveness and safety[1].

Patients tell us they want to feel informed, supported and listened to so that they can make meaningful decisions about their own care[2]. They want to be treated as individuals and respected for who they are.

The way we involve and value the roles of families, friends and carers play a vital part in patients' experiences. Where we use the term 'patients' throughout this document, we also include the people close to them during their care.

Research has established strong associations between aspects of staff engagement and the quality of care[3]. This strategy aims to inspire, enable and support our staff to achieve a positive patient experience in practice.

"Patient-centred care does not replace excellent medicine – it both complements clinical excellence and contributes to it through effective partnerships and communication." [4]

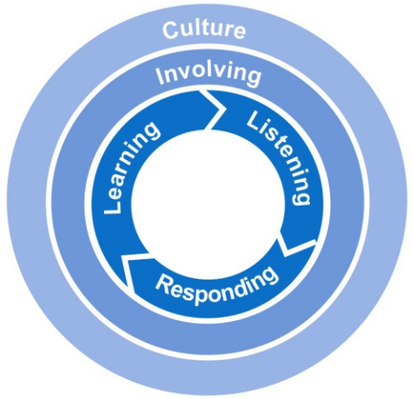
"I was treated as an individual - my concerns were listened to"

Our vision for patient experience

A culture where staff, in partnership with patients, work together to support good health, learn from feedback and achieve a positive experience of care.

This strategy sets out our high level objectives to improve the experience of patients over the next three years. We will achieve this through five overarching commitments:

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



Our strategy is supported by a detailed implementation plan that will be monitored to ensure we deliver on these commitments.

"What matters to me most is that my husband gets the right care and attention to enable him to come home."

Learning and Improving

The importance of feedback is not how much we collect but what we do with it.

Demonstrating that we are learning from individual experiences as close as possible to the point at which the feedback is given allows us to recognise excellence, address concerns and build a platform for longer-term changes which will benefit patients of the future.

Delivering our commitment to learning and improving from feedback we will:

- Work with directorates to develop regular patient experience sessions where feedback themes are reported, learning is identified and actions are agreed and monitored.
- Develop a Trust-wide working group which looks specifically at learning and improving from feedback.
- Work with colleagues to link learning from patient feedback, incidents and staff feedback, and monitor actions for improvement.
- Continue to use patient narratives and stories in key meetings across the Trust and develop this to encourage reflection and promote learning.
- Build a partnership between the Patient Experience Team and learning and development colleagues so that communications skills are core to all staff's training and development, and that training is informed by real experiences and feedback.

"Small changes could make such a difference."

Responding and Reporting

Responding positively to and acting on feedback is crucial to patients feeling that their views matter and to building trust in our care.

Delivering our commitment to reporting and responding to feedback we will:

- Support staff at all levels to respond positively and act on feedback as close as possible to the time it is given.
- Develop our patient experience reports to allow comparison of experience across our services, how it changes over time and to identify emerging issues in a timely manner.
- Ensure that patient experience is a routine quality performance measure.
- Review how we respond to complaints and concerns so that our responses are empathetic, thorough and give people assurance that we have taken their issues seriously.
- Openly share the results of surveys and other patient feedback at Trust, service and ward-level so that patients, public, staff and visitors can see what patients are saying.

I wish I felt I could ask someone to push me up to the ward in my wheelchair to visit my husband.

Our Values

In 2012 the Trust developed a set of Core Values which all members of staff are expected to work to. These are:

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

Good patient experience comes from demonstrating these values in our day-to-day actions and our interactions with patients, fellow staff and colleagues in other organisations.

Local Context

This strategy is aligned with our organisational values and our Nursing and Midwifery Strategy 2013-2016 where Patient Experience is one of the strategy's four key areas.

The Trust's ultimate objective is to be trusted to deliver safe and effective healthcare to the communities we serve.

Whole team are friendly and listen patiently while I babble away with nerves.

Involving

People with long-term conditions use health services more often than other people, and need healthcare support not to cure or fix ailments, but to help them manage their conditions over a lifetime.[5]

We will work towards patient-centred, coordinated care through:

Patients as partners in their own care - there is increasing recognition[6] that good health outcomes result from involving patients (with their families and carers) as equal partners in their own health and care.

Patient and public voice and influence - as a Foundation Trust we are accountable to our local communities and to the patients who use our services[7]. We will provide opportunities for patients and the public to be involved in the planning and delivery and evaluation of our services.

Delivering our commitment to involving patients we will:

- Develop Patient Experience Volunteers who will actively seek views of patients and increase opportunities for face-to-face feedback.
- Encourage patient and public involvement through partnership with Healthwatch, listening weeks, involvement in Trust patient forums and other activities.
- Strengthen our links with community groups and communities of interest, providing greater opportunities for them to make their voices heard and get involved.
- Draw on the skills and experiences of our governors and members.
- Have nominated patient and public involvement leads within each directorate and support and encourage their work.

Listening

Listening to feedback enables our staff to gain real insight into patients' experiences of care. We recognise that we need many types of feedback to build up an accurate picture of patient experience.[8]

Delivering our commitment to listening to patients, their families and carers, we will:

- Provide a range of mechanisms for patients to give their feedback and promote these effectively so as many people as possible tell us what we are doing well and where we need to improve. These will include:
  - national surveys including the inpatient survey and cancer survey
  - trust depth surveys looking at experiences of particular services or patient groups
  - The Friends and Family Test
  - complaints and concerns
  - Patient Advice and Liaison Service (PALS)
  - user and support groups
  - patient narratives and stories
  - Healthwatch
  - social media.
- Review the accessibility of our PALS team and ensure that patients can find PALS when they need their help.

"I know my body and symptoms - believe me!"

"Very thorough, every stage was explained and I felt as if I was being fully listened to"

York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 21 July 2015 – Ward 37 Seminar Room

Attendance: Mike Keaney Chairman, Mike Sweet, Graham Lamb, Steve Kitching, Lucy Turner, Anna Pridmore, Juliet Walters, Sue Rushbrook

Apologies: Andrew Bertram

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1	**Last Meeting Notes Minutes Dated 16 June 2015**	The agenda covered the following AFW and CRR items	The Committee agreed that the reference to a further discussion outside the meeting about the issues in the Emergency Department should have reflected that the Emergency Department would be picked up as part of wider discussion about the Turnaround Avoidance Programme (TAP). The minutes were approved as a true record of the meeting.		
2	**Matters arising**	AFW EF1 DoF1,2, 4,7	There were no matters arising. It was agreed to defer the discussion on the Tender Register to the September meeting.		
3.	**Risks related to the Finance and Performance Committee**	CRR CE1 DoF 1-3	The Committee noted the risk registers included in the paper. It was noted that further work would be completed on the registers before the next meeting of the Committee meeting.	The Committee were assured that the risks included in the registers were being discussed by the meeting.	
4.	**Operation performance**		SR explained the approach to the narrative in the report has been changed. SR outlined the changes and explained the work being undertaken to ensure the TAP project was reported appropriately without	The Committee was assured by the comments made additional work on the internal turnaround	JW to provide an update to the Board regarding

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			duplicating existing reporting. The Committee discussed the challenges to this change in reporting and MK and MS were concerned about ensuring the information provides the level of assurance needed by the NEDs around the fines incurred by the Trust as well as performance. LT presented the performance report. **Cancer –** **14 day fast track and 62 day targets** LT reminded the Committee that the final validated figures for cancer are not available for a further 6 weeks, but on the validation that has been completed in house the Trust is compliant with both targets at quarter 1. She confirmed there was still further work to complete to maintain the position and patients were still being tracked individually. SR added nationally there is heightened monitoring of 62 day targets, specifically around diagnostic testing. **31 day subsequent – surgery and 14 day symptomatic –breast** The Trust has not achieved the target in June for 31 day or 14 day symptomatic breast. An audit is being undertaken against 14 day symptomatic breast patients who chose to wait longer than 14 days through patient choice. The Trust is working with the CCG to support the GPs in	avoidance programme The Committee noted the progress against the cancer targets and the improvements that have been achieved over the last 6 months.	emergency care

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			their discussion with patients about the 14 day pathway. In terms of 31 day subsequent – surgery there were some cancellations which are being reviewed. It was noted that it is anticipated the Trust will achieve 31 day subsequent – surgery target at quarter 1, and the 14 day symptomatic breast target in June. The Committee noted the position and recognised the huge progress that has been made over the last 6 months and the commitment that has been shown by all staff to improve performance. The Committee discussed moving services back to Scarborough and agreed that it would only be when they were sustainable on a long term basis. MK asked if fines were applied to breaches in cancer target, LT confirmed they were. **RTT – 18 weeks** LT reminded the Committee that the admitted and non admitted target had been abolished from 1 April and replaced with the incomplete target. She advised the Trust had achieved the target at aggregate level, although there continues to be specialty level fails predominately in Maxillo Facial, Neurology and Urology. The operations team will continue to support the departments and monitor progress.	The Committee noted the national changes to the 18 week targets.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			LT reported on the third party provider, New Medica, who starts working with the Trust from this weekend. New Medica will provide ophthalmic service in Scarborough. It is anticipated this arrangement will continue until the end of August. Urology is working with the Nuffield to address their backlog. There are no Gynae patients on the Scarborough site who have waited over 18 weeks without a TCI. Trauma and Orthopaedics are working up a model for theatre 'business lists'. MS asked if there would be a shortage of anaesthetists during the summer due to leave. JW explained the way theatres are currently organised. Work is underway to review the planning in theatres so that it fits with the TAP project. The intention is to move to more static sessions. **Diagnostics –** In June the target was failed, but improvements have been made. The highest number of breaches was in Gastroscopy where there has also been an increase in completed diagnostic tests, excluding planned and emergency procedures. Medinet is providing services at the weekend in Scarborough to address the capacity shortfalls. Cystoscopy has seen an increase in the number of breaches. A review of their capacity is being undertaken and the Trust is working with NHS Elect to identify what	The Committee were assured by the work described, but remains concerned about some areas of performance. The Committee were pleased to see the improvements that had been made over the last 6 of months. It was assured by the additional work being undertaken to ensure the modalities return to compliance	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			plans could be put in place to address the issues. LT advised that a further admin issue has been identified around the offering of a second reasonable appointment when the first is declined by a patient. It has been identified that the second appointment is not consistently being offered. Work is underway to address the issue and reassess the diagnostic trajectories and an action plan has been put in place. MS asked for assurance that this error would not have an effect on performance. LT explained that at this stage she could not give him that assurance; it will depend on what is found when the issue is investigated. SR reminded the Committee that when CPD was introduced in Radiology in Scarborough some issues were identified. It has now been uncovered that the Standard Operating Procedure (SOP) used in York may not be as robust as it should be. Some work is now being undertaken to improve the SOP. MK commented that he gets assurance from hearing that glitches in the system are being uncovered and addressed. The Committee agreed with his view and added that it was encouraging to see that staff were happy to raise these issues and not try and solve them on their own. MS asked how long Medinet would be in the Trust. LT explained that initially it had been planned they would be there for 14 weeks, but it is now felt this would not be long enough to address the back log.	The Committee was assured that system issues were being identified and addressed. The Committee was assured by the open and transparent reporting that CPD ensured.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			JW outlined how the backlog occurred and explained that as a result of introducing CPD there has been a more open and transparent reporting approach. The Committee agreed that bringing all stand alone systems into CPD does provide more transparency and openness. MS asked if the issues around ultrasound in Scarborough had now been resolved. LT confirmed they had been. **Emergency Department –** JW gave a detailed presentation on the complexities in the Emergency care pathway. She explained that a paper would be included in the board pack for discussion at the Board at the end of the month. JW outlined the work being undertaken to support the Emergency care pathway, which would have a positive impact on the Emergency Department. This included the frailty unit and the ambulatory care work. MS asked about the in-reach work from specialists that is being piloted at Scarborough. JW explained the work and gave the example of the use of a geriatrician in the department to see older patients. JW reminded the Committee of the significance of the workforce costs being incurred because of shortages resulting in the high usage of locum staff. Discussions have been held with the CCG around the cost of running an emergency department and	The Committee was assured by the presentation given by JW and the work being undertaken. The Committee recognises the hard work and progress that has been made and remains concerned about the sustainability of the service.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			they recognise it is in their interests to have a sustainable emergency department service. SR reminded the Committee of the impact of changing systems and introducing other parties. She reminded the Committee that the number of patients coming through the department is less important than the level of acuity of each patient and non-elective admissions. MK thanked JW for a very positive presentation – he agreed the issues could not be fixed overnight and asked if some further information could be included in the Board paper about what has been achieved. JW agreed she would include some information in the Board report. The Committee was advised that performance had improved from 89% in June to 92% in July. JW added that the ambulatory care approach is effective, but at present it may have to close over the weekend due to a lack of staff to support it. This is being addressed. JW explained she had reviewed the plans with ECIST and when they returned she would request them to concentrate on Scarborough. Other work being undertaken includes bed modelling and the introduction of discharge to assess. MK and MS confirmed they received a level of assurance by the improvements being reported and the description of the work being undertaken.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			However, they would need to understand the work streams involved in the TAP project before they could give full assurance to board colleagues that the systems were in place to deliver the required performance. The Committee recognised the sustainability challenge is still being addressed. SR added that it has now been recognised that the 4-hour target is not just an ED target, it requires all specialties to work together to deliver the target. The Committee thanked all contributors.		
5.	**CQUIN**		The Committee received the report and noted the progress. It was agreed that a further report in August would provide more detail to discuss.		
4.	**Finance Report**		GL presented the finance report. He explained that the income and expenditure position has deteriorated during June and there is an actual deficit of £3.2m against a planned deficit of £2.3m at the end of June. An analysis of the income shows a run rate of around £35m for June in comparison to £33m for both April and May. Expenditure has also increased and for June was nearly £39m compared to £37m in April and May. This change in profile maybe as a result of June being a five week month, or some stocking up on supplies. This can be confirmed in August. Contract penalties continue to be of concern. The Trust has written to the CCG to request some re-	The Committee is concerned about the level of penalties levied in the first quarter of the financial year, but were assured the discussions taking place with the CCG	PC to update the Board

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			imbursement of penalties. Those discussions are progressing and proving to be very positive. The Trust has returned a provisional COSR rating of 3 which is consistent with the plan. GL reminded the Committee of the changes Monitor had introduced to the regulatory framework. Pay expenditure also increased in June, this was influenced by the recent pay awards plus continued and particularly high agency and locum costs. Drug expenditure has increased and currently stands at £1.5m ahead of plan, but this largely relates to high cost out of tariff drugs for which recharges are made to commissioners. The CIP position is adversely impacting on the I&E position by £1.9m. MK asked if there were contingencies to address the current deficit. GL explained the contingency was in part to discuss the challenges with the CCG and encourage the re-investment of penalties. He added the CCG were planning to create a fund that organisations could bid against. Early discussions with the CCG have proven to be positive about the sort of case the Trust would put forward for funding. MS noted the Trust had moved from NHS Professionals to the use of an internal bank, but had not as yet addressed the use of other agencies. It was agreed that Mrs Holden would be asked to provide a recruitment update.		Mrs Holden to comment on recruitment

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
5.	**Efficiency Report**		SK presented the report and highlighted progress against the annual target of £25.8m. He reported the Trust had now identified overall savings of £9.6m which includes £4.8 in June. The Q1 report to Monitor will however show a £1.9m adverse position. SK outlined the in-year planning position and the four year planning position. SK highlighted the progress on the Quality Impact Assessments identifying that 838 assessments have been completed, which leaves only 100 schemes to be assessed. MK asked how the TAP would fit with the efficiency team. SK explained that he believed his work would not change and the reporting of savings would continue to be made in the same way.	The Committee was assured by the progress against plan.	PC to comment
7	**Next meeting**		An extra meeting has been arranged for the Committee to be held on 17 August at 9am and will be held in the Boardroom.		

Providing care together in York, Scarborough, Bridlington, Malton, Whitby, Selby and Easingwold communities.

York Teaching Hospital NHS
NHS Foundation Trust

Monthly Performance Report

July 2015

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

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Apr	May	Jun
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail:** £400 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**90%**	81.6%	82.0%	80.7%	75.6%	74.8%	78.2%	74.2%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail**: £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TCB	**95%**	95.9%	95.5%	95.4%	95.2%	95.2%	95.5%	95.0%
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	**Specialty fail:** £150 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**92%**	93.4%	93.0%	92.5%	92.8%	92.1%	92.1%	92.8%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	0	0	2	3	1	1	1

Access Targets: Cancer

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

Indicator	Consequence of Breach	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Mar	Apr	May
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	86.1%	85.9%	85.4%	89.8%	93.4%	93.8%	93.9%
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	45.6%	78.6%	90.5%	91.0%	89.9%	90.2%	90.1%
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	98.6%	97.9%	98.4%	96.1%	95.7%	97.6%	96.3%
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	96.4%	94.9%	95.3%	95.6%	92.0%	94.7%	91.3%
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	100.0%	99.1%	100.0%	98.5%	97.6%	100.0%	98.2%
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	87.8%	87.6%	85.0%	76.5%	80.5%	88.0%	86.9%
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	96.6%	93.8%	92.5%	92.2%	100.0%	94.1%	100.0%
62 Day Consultant Upgrade	General Condition 9	**85%**	50.0%	-	-	-	-	-	-

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Apr	May	Jun
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£120 fine per patient below performance tolerance (maximum 8% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	92.6%	89.1%	89.1%	88.3%	87.8%	87.7%	89.3%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**> 30min**	489	514	520	539	207	176	156
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**> 60min**	255	371	383	415	164	177	74
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q2 2014/15**	**Q3 2014/15**	**Q4 2014/15**	**Q1 2015/16**	**Apr**	**May**	**Jun**
	NHS VALE OF YORK CCG	30mins - 1hr	70	154	161	163	70	48	45
		1hr 2 hours	19	109	109	114	45	37	32
		2 hours +	13	54	44	26	9	17	0
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	202	176	177	152	55	57	40
		1hr 2 hours	88	77	83	101	35	49	17
		2 hours +	12	25	25	28	16	12	0
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	122	127	134	146	52	47	47
		1hr 2 hours	73	54	70	76	32	33	11
		2 hours +	9	13	17	22	8	12	2
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	34	17	20	27	13	6	8
		1hr 2 hours	12	13	15	14	5	5	4
		2 hours +	2	1	2	3	1	1	1
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	1	2	6	1	0	0	1
		1hr 2 hours	1	1	0	0	0	0	0
		2 hours +	0	0	0	0	0	0	0
	OTHER	30mins - 1hr	60	38	22	50	17	18	15
		1hr 2 hours	25	16	12	27	11	9	7
		2 hours +	1	8	6	4	2	2	0
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**> 12 hrs**	2	2	11	0	0	0	0
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	96.9%	97.0%	97.6%	To follow	97.4%	To follow	To follow

Mortality

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

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Apr	May	Jun
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**53 (TBC)**	10	16	21	21	7	8	6
Number of Clostridium difficile due to "lapse in care"	*TBC*	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**108 (TBC)**	20	28	27	24	8	8	8
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) cases	**Quarterly:** General Condition 9	**29**	9	19	13	11	3	5	3
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	0	1	6	2	2	2
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 14 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
Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95%**	88.7%	88.5%	86.0%	85.1%	83.9%	85.5%	85.7%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95%**	72.7%	70.1%	66.2%	72.2%	72.6%	73.6%	70.3%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Apr	May	Jun
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 fine per patient below performance tolerance	**99%**	98.0%	97.9%	95.9%	95.2%	92.7%	91.6%	95.2%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	2	0	0	0	0
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hosp	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	0	3	15	9	0	5	4
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	75	229	548	205	60	123	22
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	£200 in respect of each excess breach above threshold	**95%**	96.9%	97.1%	96.9%	97.1%	97.1%	97.1%	97.2%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.6%	99.7%	99.9%	To follow	99.9%	To follow	To follow
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	6.5%	5.1%	4.3%	Not available	3.7%	3.0%	Not available
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 87% Q2 - 89% Q3 - 91% Q4 - 93%**	86.4%	86.3%	92.0%	89.1%	91.0%	87.0%	89.4%
Delayed Transfer of Care to be maintained at a minimum level	As set out in General Condition 9 - Trust only to be accountable for Health delays.	**<1%**	1988	1612	1160	1476	385	529	562
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance						
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**200 per month**	518	563	514	452	149	143	160
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**End Q2 745; end Q4 721**	2287	2381	2375	2365	742	758	865
% Compliance with WHO safer surgery checklist	No financial penalty	**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**	367	394	364	1 month coding lag	141	128	1 month coding lag
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	1238	1388	1331	1 month coding lag	457	392	1 month coding lag
Reduction in the number of inappropriate transfers between wards and other settings during night hours (Reduction in avoidable site transfers within the Trust after 10pm)	General Condition 9	**100 per month**	269	353	374	302	93	103	106

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Apr	May	Jun
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)	General Condition 9	**80% by site**	84.0%	83.4%	80.8%	87.5%	83.7%	89.1%	89.9%
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	98.6%	98.3%	99.3%	99.7%	99.1%	100.0%	100.0%
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Proportion of stroke patients who spend >90% of their time on a stroke unit	Non delivery of 90% at Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £5k in line with respective finance baselines (TBC)	**80%**	90.5%	86.2%	80.7%	one month behind	86.7%	78.9%	one month behind
Proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours of seeing a health professional	Non delivery of Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £2k in line with respective finance baselines (TBC)	**75%**	86.0%	82.0%	80.4%	one month behind	75.0%	78.9%	one month behind
Proportion of patients presenting with stroke with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	General Condition 9	**85%**	100.0%	100.0%	96.4%	one month behind	87.5%	0.0%	one month behind
Percentage of stroke patients and carers with joint care plans on discharge from hospital to have a copy of their care plan (except RIP or who refuse health/social care assessment/intervention)	General Condition 9	**70%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Patients who require an urgent scan on hospital arrival, are scanned with in 1 hr of hospital arrival (TBC)	No financial penalty	**Q2 > 60% Q4 > 70%**	71.2%	70.8%	73.2%	one month behind	70.4%	34.0%	one month behind
Proportion of stroke patients scanned within 24 hours of hospital arrival	No financial penalty	**90%**	96.5%	93.2%	91.5%	one month behind	90.9%	90.0%	one month behind
Immediate Discharge letters - 24 hour standard: Overall Trust Position Monthly report and quarterly audit . Action plan to be provided where the target failed in any one month. 25 cases from SR and 25 cases from ERY.	General Condition 9	**>98% for admitted patients discharged and >98% for A&E patients discharged**	Quarterly audit						
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Rydale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology). 25 cases from SR and 25 cases from ERY	General Condition 9	**Q1 - 94% Q2 - 95% Q3 - 96% Q4 - 97%**	Quarterly audit						
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	General Condition 9	**Q1 - 90% Q2 - 92% Q3 - 94% Q4 - 96%**	Quarterly audit						
All Red Drugs to be prescribed by provider effective from 01/04/14	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 01/04/14	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	86.9%	86.3%	85.9%	87.0%	86.8%	87.0%	87.3%

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Apr	May	Jun
Never Events	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	0	0	0	1	0	0	1

District Nursing Activity Summary

Indicator	Source	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Apr	May	Jun
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	n/a	1871	1975	1768	2443	778	638	1027
	Community nurse/service	n/a	1018	767	741	825	257	262	306
	Acute services	n/a	912	845	859	949	263	340	346
	Self / Carer/family	n/a	398	291	364	406	141	103	162
	Other	n/a	253	226	202	283	82	89	112
	Grand Total	n/a	4452	4104	3934	4906	1521	1432	1953
Community Adult Nursing Contacts	First	n/a	2758	2895	2931	3847	1070	1185	1592
	Follow up	n/a	31976	31372	33380	39244	12162	12964	14118
	Total	n/a	34734	34267	36311	43091	13232	14149	15710
	First to Follow Up Ratio	n/a	11.6	10.8	11.4	10.2	11.4	10.9	8.9
Community Hospitals average length of stay (days)	Archways	n/a	22.1	20.6	26.8	21.1	19.7	17.3	27.7
	Malton Community Hospital	n/a	18.6	17.1	16.0	19.9	20.3	22.7	17.6
	St Monicas Hospital	n/a	23.2	22.0	24.0	15.5	19.0	12.5	14.6
	The New Selby War Memorial Hospital	n/a	15.6	13.7	17.6	15.3	14.4	13.9	17.6
	Whitby Community Hospital	n/a	20.3	20.9	21.9	20.0	19.7	23.1	17.3
	Total	n/a	19.4	18.1	20.2	18.5	18.3	18.7	18.4
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	4	8	5	8	3	4	1
		Emergency	91	77	71	73	22	27	24
	Malton Community Hospital	Elective	10	21	48	19	6	2	11
		Emergency	114	121	110	101	28	34	39
	St Monicas Hospital	Elective	13	9	16	17	7	4	6
		Emergency	35	27	27	43	14	15	14
	The New Selby War Memorial	Elective	62	69	57	59	21	20	18
		Emergency	66	69	55	68	25	23	20
	Whitby Community Hospital	Elective	1	4	0	0	0	0	0
		Emergency	123	142	140	136	43	46	47
	Total	Elective	90	111	126	103	37	30	36
		Emergency	429	436	403	421	132	145	144

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Complaints and PALS												
New complaints this month	57	46	47	43	60	31	39	37	47	43	41	33
Complaints at same month last year	59	42	56	52	45	27	52	16	16	50	38	58
Number of complaints upheld (cumulative)*	not known yet	not known yet	not known yet	not known yet	not known yet	not known yet	not known yet	not known yet	not known yet	not known yet	not known yet	not known yet
Number of complaints partly upheld (cumulative)**												
Number of Ombudsman complaint reviews	3	0	0	0	0	0	3	4	7	2	4	1
Number of Ombudsman complaint reviews upheld	0	0	0	0	0	0	0	0	0	0	0	0
Number of Ombudsman complaint reviews partly upheld	2	0	0	0	0	0	1	1	2	0	0	0
Late responses this month (at the time of writing)***	9	4	1	8	5	5	4	1	0	3	2	10
Top 3 complaint issues												
Aspects of clinical treatment	39	37	35	31	44	18	21	20	32	30	27	21
Admission/discharge/transfer arrangements	3	2	0	5	4	0	2	3	2	1	3	1
Appointment delay/cancellation - outpatient	0	1	0	0	0	4	1	2	2	2	2	0
Staff attitude	10	6	5	0	5	5	10	7	5	3	7	3
Communications	3	0	4	0	0	0	2	2	4	4	1	3
Other	0	0	2	0	0	0	1	0	0	1	1	
New PALS queries this month	531	488	570	653	552	443	620	559	478	430	416	498
PALS queries at same time last year	563	498	445	536	419	385	503	470	367	378	369	406
Top 3 PALS issues												
Information & advice	140	158	192	42	150	136	189	173	126	158	155	171
Staff attitude	0	15	0	0	0	17	19	14	12	19	14	23
Aspects of clinical treatment	104	93	86	89	105	66	77	47	84	69	63	72
Appointment delay/cancellation - outpatient	67	56	65	24	63	41	47	28	52	29	35	46

**note: upheld complaints are reported quarterly to allow for investigation timescales*

***note: we do not record partly - if a complaint generates 1 or more actions for improvement then it is reorded as upheld*

****note: if extensions are made in agreement with the complaint, responses are not considered late*

Serious Incidents												
Number of SI's reported	16	16	12	34	13	24	17	16	18	12	14	12
% SI's notified within 2 working days of SI being identified*	100%	100%	92%	100%	92%	96%	100%	100%	100%	100%	100%	100%
% SI's closed on STEIS within 6 months of SI being reported	0%	0%	0%	0%	8%	0%	0%	0%	66%	100%	TBC	TBC
Number of Negligence Claims	15	21	8	16	8	8	12	17	15	15	15	12
Extension requests made at least 4 weeks prior to deadline of report due date, and reason given is acceptable to CCG.										0	2	0
Duty of Candour demonstrated within SI Reports										1	1	1
Percentage of reported SI's, investigated and closed as per agreed timescales										77%	73%	83%
Percentage of reported SI's with extension requested.										0	0.13	0

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

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Pressure Ulcers**												
Number of Category 2	22	29	28	31	32	30	50	35	44	37	50	
Number of Category 3	5	5	8	7	6	3	4	2	5	5	4	
Number of Category 4	0	0	0	1	1	0	1	0	1	0	1	
Total number developed/deteriorated while in our care (care of the organisation) - acute	15	24	28	39	32	42	47	30	41	31	41	
Total number developed/deteriorated while in our care (care of the organisation) - communit	19	18	20	22	37	18	25	25	33	26	49	
Falls***												
Number of falls with moderate harm	3	3	3	6	1	7	3	2	3	2	4	
Number of falls with severe harm	1	2	2	3	2	5	1	5	4	2	7	
Number of falls resulting in death	0	0	0	0	0	0	0	0	0	0	0	
Safeguarding												
% of staff compliant with training (children)	45%	47%	51%	54%	53%	55%	58%	59%	62%	65%	68%	74%
% of staff compliant with training (adult)	40%	43%	40%	42%	43%	45%	56%	59%	62%	64%	69%	74%
% of staff working with children who have review CRB checks												
Prevent Strategy												
Attendance at the HealthWRAP training session	3 in total	3 in total	3 in total	3 in total								
Number of concerns raised via the incident reporting system	nil	nil	nil	nil								

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Finance Report

Action requested/recommendation

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

Summary

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

At the end of June the Trust is reporting an Income and Expenditure (I&E) deficit of £3.2m against a planned deficit of £2.3m for the period. The Income & Expenditure position places the Trust behind its Operational plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Finance & Performance
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	July 2015
Version number	Version 1

Briefing Note for the Board of Directors Meeting 29 July 2015

Subject: June 2015 (Quarter 1) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for Quarter 1

The income and expenditure position has deteriorated during June and now stands at an actual deficit of £3.2m against a planned deficit of £2.3m, showing an adverse variance from plan of £0.9m.

During April the Trust recorded a £0.5m adverse variance from plan (£1.5m deficit vs a planned £1m deficit) and for the period to May this improved slightly down to a £0.4m adverse variance (£2.6m deficit vs £2.2m planned deficit). At the end of the quarter this adverse variance has increased to £0.9m.

Income has been coded and costed for April and May and estimates have been used for the month of June based on prevailing activity levels.

Of note are significantly increased NHS clinical income levels in June, reflecting the absence of bank holidays, the absence of school holidays and much improved elective throughput. An analysis of the run rate shows income at around £35m for the month of June (plus £4.5m non-clinical income and other income) in comparison to around £33m for both April and May. Unfortunately expenditure levels have also been exceptionally high at approaching £39m for June in comparison to a little over £37m in April and May.

It is possible that an analysis of the profile of expenditure will show an untypical expenditure pattern for June reflecting 5-week delivery/payment cycles and some degree of stocking up of supplies. However, this will not be confirmed until we have the August position available.

The position in relation to contract penalties continues to be worrying and disappointing with a significant adverse impact over the first quarter of the financial year. Of note though is some improvement in the month of June. This continues to have a material impact on our reported income and expenditure position. The performance report summarises the full implications of the penalties.

The income position reflects the national withdrawal of the 18-week admitted and non-admitted penalties. The Board should also be aware that the reported income position assumes 50% success with our claim to the CCGs for re-investment of ED 4-hour penalties and ambulance turnaround penalties. Both main CCGs have indicated a willingness to consider our claim for support and formal requests have been made. The Board will be kept informed of progress with this claim.

The position returns a provisional COSRR rating of 3, consistent with months one and two. The Board should be aware of a significant development in this regard. Monitor has changed its regulatory framework and has implemented for quarter one a rule that if either

of the individual components of the COSRR (liquidity or capital service cover) score 1 then this can be considered a trigger for investigation. The Board will see from the COSRR analysis in the performance report that the Trust's Capital Service Cover has scored 1 due to our deficit position.

As part of our submission we will be discussing this position with Monitor. I will keep the Board updated in this regard. At this stage, whilst formal investigation is an option for Monitor, the regulatory framework does not mandate Monitor takes this action.

Expenditure Analysis

Pay expenditure was £26.5m for the month of June (compared to an average of £26.1m for April and May). Key influencing issues include the cost of the recent pay award plus continued, and particularly high, agency and locum costs. We continue to draw heavily on the planned contingencies to cover the premium agency costs.

Drug expenditure is also high in month at £4.3m (compared to an average of £3.9m). It currently stands at £1.5m ahead of plan but this largely relates to high cost out of tariff drug costs for which direct recharges are made to commissioners. This area will be developed in terms of reporting this year as under the revised specialist commissioning arrangements payment of growth will only be made at 70%, potentially leaving the Trust with a new cost pressure.

Clinical supplies and services expenditure is also high at £4.0m for the month in comparison to an average of £3.5m. And similarly other costs are high at £4.1m as opposed to a previous average of £3.6m.

CIP delivery is strong in full year terms (in comparison to previous year's performance at this stage) but the relentless impact of an even expected profile of delivery throughout the year is adversely impacting the I&E position by £1.9m. This is the most material component pressure on our current deficit position.

Contracting Matters

Discussions continue with all commissioners in relation to 2015/16 contracts. Most outstanding issues have now been resolved and contract documentation is being completed and reviewed. There are no issues I would want to bring to the Board's attention.

Other Issues

Cash levels are satisfactory and capital programme spending is as expected.

There are no other issues I would wish to bring to the Board's attention.

Finance Performance Report

July 2015

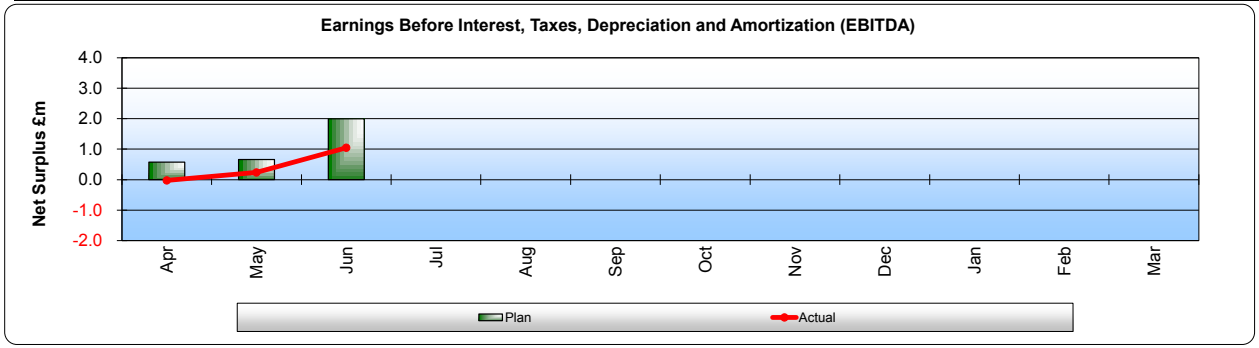
Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

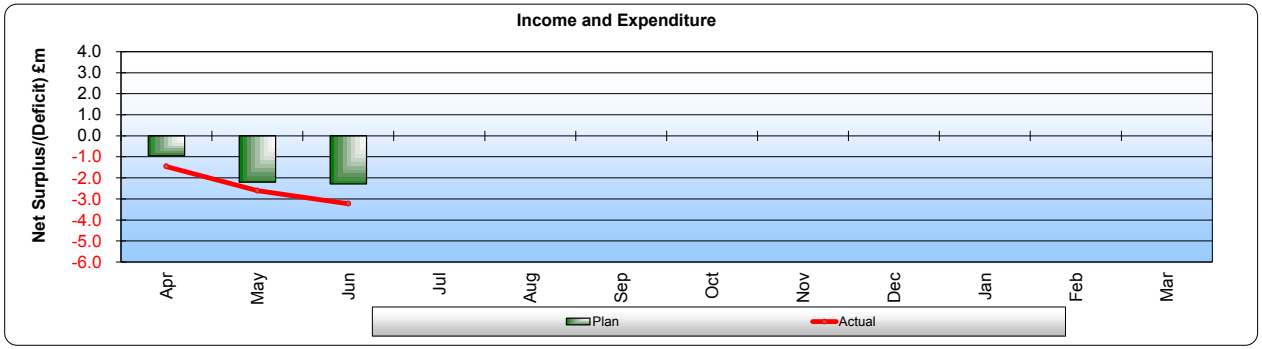
Summary Income and Expenditure Position
Month 3 - The Period 1st April 2015 to 30th June 2015

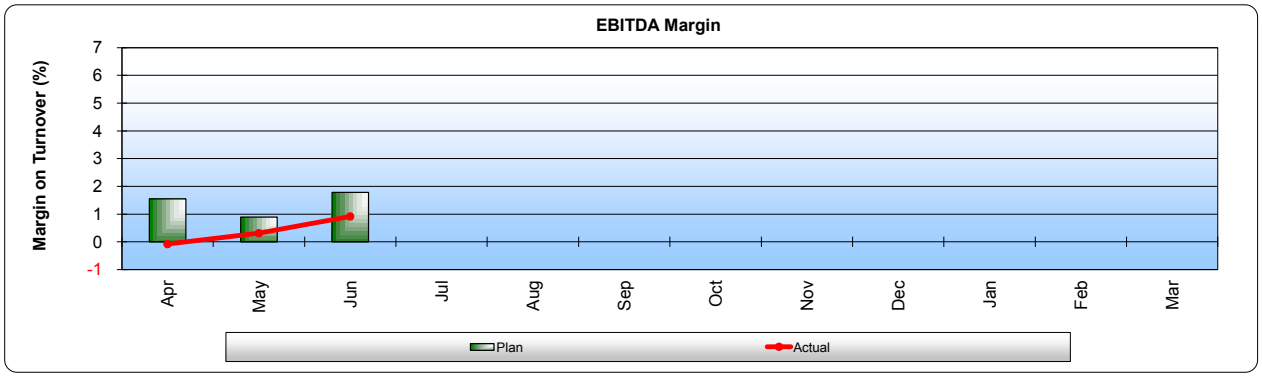
York Teaching Hospital NHS
NHS Foundation Trust

Summary Position:

* The Trust is reporting an I&E deficit of £3.2m, placing it £0.9m behind the operational plan.
* Income is £2.6m ahead of plan, with clinical income being £1.6m ahead of plan and non-clinical income being £1.0m ahead of plan.
* Expenditure is ahead of plan by £3.5m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £1.0m (0.91%) compared to plan of £2.0m (1.78%), 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
	£000	£000	£000	£000
NHS Clinical Income				
Elective Income	24,972	5,949	5,780	-169
Planned same day (Day cases)	33,587	8,001	8,761	760
Non-Elective Income	102,141	24,850	27,372	2,522
Outpatients	67,431	16,053	15,271	-782
A&E	14,775	3,593	3,853	260
Community	34,100	9,623	9,191	-432
Other	127,844	31,570	30,974	-596
	404,850	**99,639**	**101,202**	**1,563**
Non-NHS Clinical Income				
Private Patient Income	1,036	259	245	-14
Other Non-protected Clinical Income	1,790	447	403	-45
	2,826	**707**	**648**	**-59**
Other Income	0	0	0	0
Education & Training	14,333	3,583	3,673	90
Research & Development	3,344	836	1,157	321
Donations & Grants received (Assets)	0	0	0	0
Donations & Grants received (cash to buy Assets)	600	150	185	35
Other Income	16,940	4,235	4,838	603
Transition support	10,907	2,727	2,727	-0
	46,125	**11,531**	**12,580**	**1,049**
Total Income	**453,801**	**111,877**	**114,429**	**2,553**
Expenditure				
Pay costs	-315,489	-77,623	-78,843	-1,220
Drug costs	-43,348	-10,700	-12,235	-1,535
Clinical Supplies & Services	-47,693	-11,621	-11,109	512
Other costs (excluding Depreciation)	-48,336	-11,841	-11,192	649
Restructuring Costs	0	0	-4	-4
CIP	16,169	1,905	0	-1,905
Total Expenditure	**-438,697**	**-109,880**	**-113,383**	**-3,503**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**15,104**	**1,997**	**1,046**	**-950**
Profit/ Loss on Asset Disposals	-4,500	0	0	0
Fixed Asset Impairments	-300	0	0	0
Depreciation	-11,000	-2,750	-2,750	0
Interest Receivable/ Payable	100	25	38	13
Interest Expense on Overdrafts and WCF	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0
Interest Expense on Non-commercial borrowings	0	0	0	0
Interest Expense on Commercial borrowings	-335	-84	-76	8
Interest Expense on Finance leases (non-PFI)	0	0	0	0
Other Finance costs	0	0	-5	-5
PDC Dividend	-6,478	-1,479	-1,479	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**-7,409**	**-2,291**	**-3,226**	**-934**

Contract Performance

Month 3 - The Period 1st April 2015 to 30th June 2015

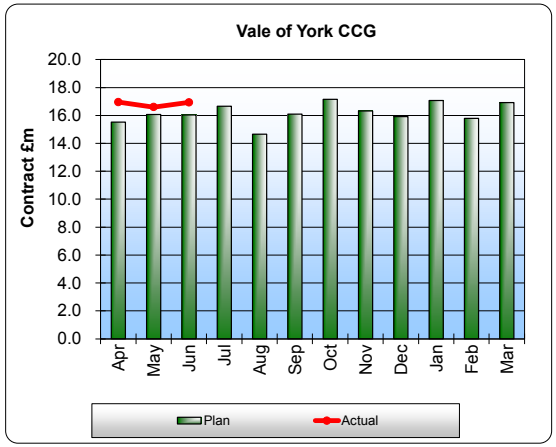
York Teaching Hospital NHS
NHS Foundation Trust

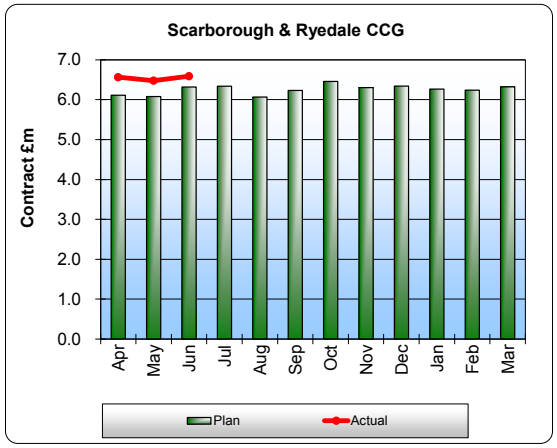
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	194,183	47,926	50,488	2,562
Scarborough & Ryedale CCG	75,075	18,769	19,625	856
East Riding CCG	37,600	9,400	9,629	229
Other Contracted CCGs	19,112	6,008	6,000	-8
NHSE - Specialised Commissioning	35,241	8,810	7,939	-871
NHSE - Public Health	14,104	3,526	3,755	229
Local Authorities	5,319	1,330	1,155	-175
Total NHS Contract Clinical Income	**380,634**	**95,769**	**98,591**	**2,822**

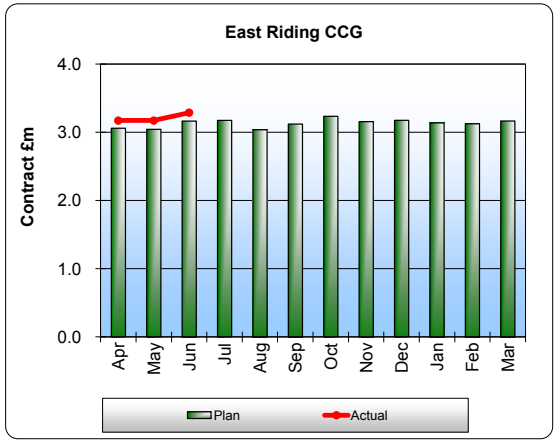
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	9,037	2,259	2,831	572
Risk Income	15,179	1,611	0	-1,611
Total Other NHS Clinical Income	**24,216**	**3,870**	**2,831**	**-1,039**

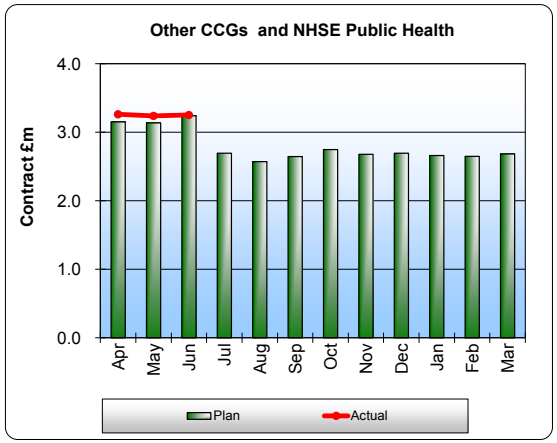
Total NHS Clinical Income	**404,850**	**99,639**	**101,422**	**1,783**

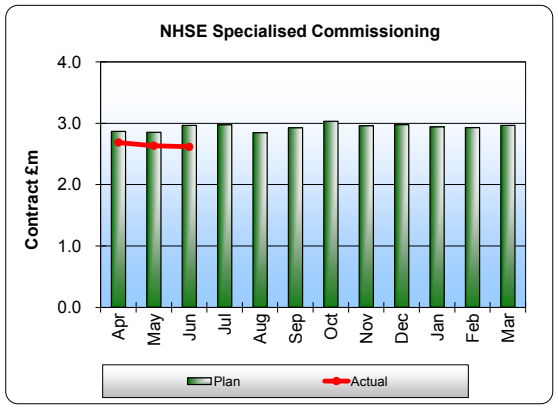
Specialist registrar income moved to other income non clinical	-347
Winter resilience monies in addition to contract	127
Agrees to Clincial Income reported to board	**101,202**

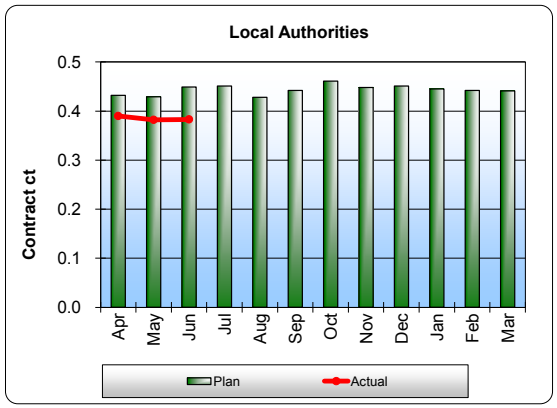












Expenditure Analysis
Month 3 - The Period 1st April 2015 to 30th June 2015

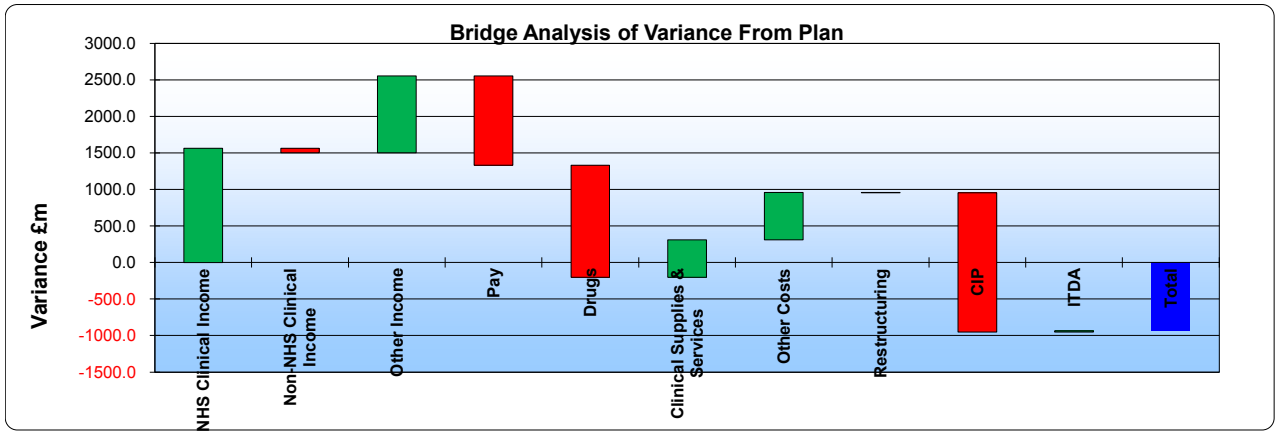
York Teaching Hospital NHS
NHS Foundation Trust

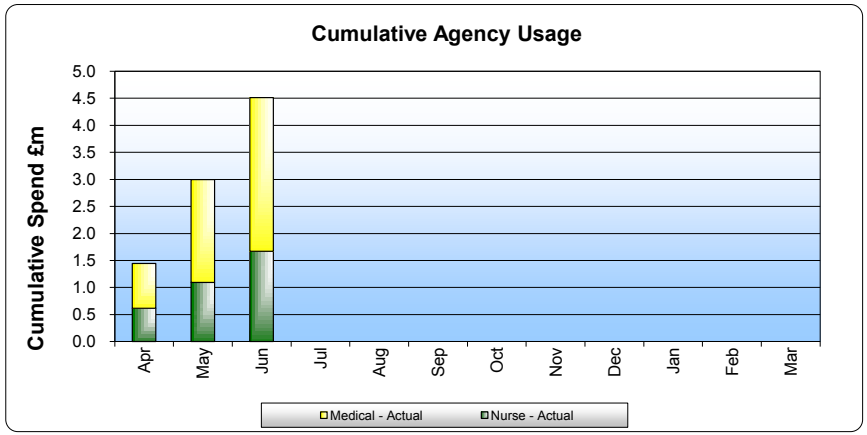
Key Messages:

There is an adverse expenditure variance of £3.5m at the end of June 2015. This comprises:

* Pay budgets are £1.2m adverse, linked to continued high locum and agency costs.
* Drugs budgets are £1.5m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £1.9m behind plan.
* Other budgets are £1.1m favourable.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	54,207	13,537	11,998	0	296	0	1,309	13,603	-66	114	
Medical & Dental	29,865	7,087	6,441	0	31	0	1,534	8,006	-919	-385	
Nursing, Midwifery & Health Visting	93,921	23,667	20,513	132	83	1,017	1,669	23,414	252	614	
Professional & Technical	9,422	2,329	1,943	29	36	0	129	2,138	191	170	
Scientific & Professional	17,372	4,279	3,868	25	11	0	0	3,904	375	265	
P.A.M.s	22,564	5,751	4,901	16	74	0	99	5,090	661	454	
Healthcare Assistants & Other Support Staff	43,392	11,116	10,871	165	34	11	39	11,120	-4	9	
Chairman and Non-Executives	161	40	40	0	0	0	0	40	0	0	
Executive Board and Senior Managers	14,572	3,633	3,351	3	0	0	11	3,366	267	260	
Administrative & Clerical	33,842	8,480	7,992	55	38	0	78	8,163	318	274	
Agency Premium Provision	4,000	1,000	0	0	0	0	0	0	1,000	667	
Vacancy Factor	-7,828	-3,295	0	0	0	0	0	0	-3,295	-1,992	
TOTAL	**315,489**	**77,623**	**71,919**	**426**	**603**	**1,028**	**4,868**	**78,843**	**-1,220**	**450**	





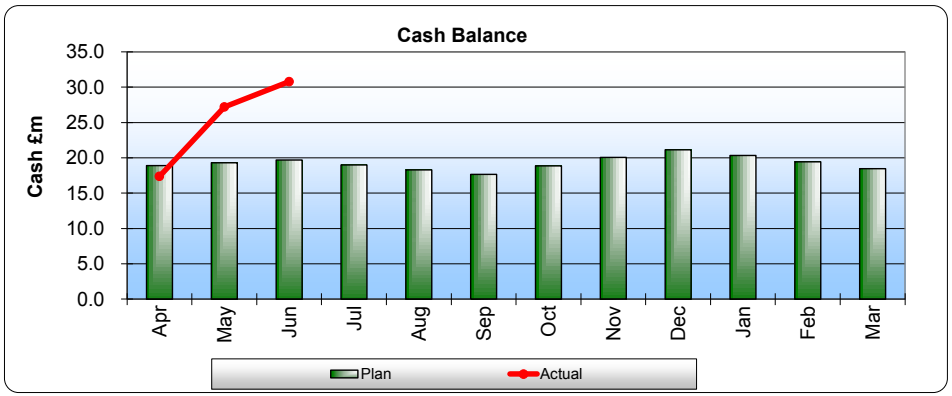
Cash Flow Management

Month 3 - The Period 1st April 2015 to 30th June 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The cash position at the end of June was £30.8m. This is above plan due to the receipt of £10.9m transitional funding from NHS England.
* The receivables balance at the end of June was £8.6m which is below plan due to improved debt collection systems
* The payables balance at the end of June was £6.4m which is slightly above plan.
* The Continuity of Service Risk Rating (CoSSR) is assessed as a score of 3 in May, and is reflective of the I&E position.

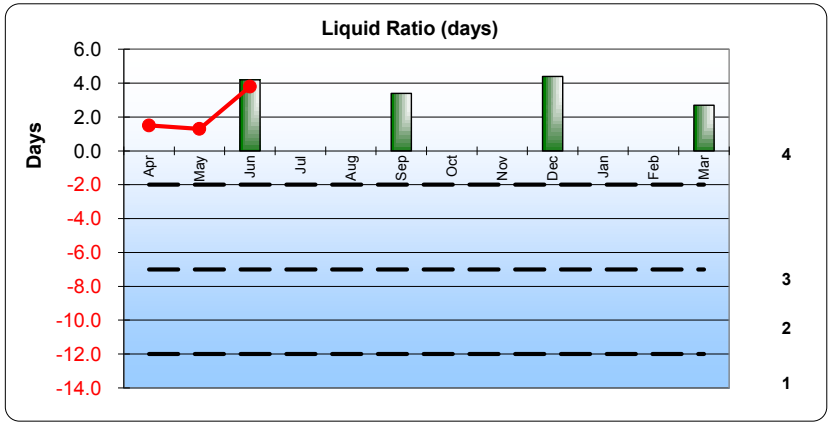


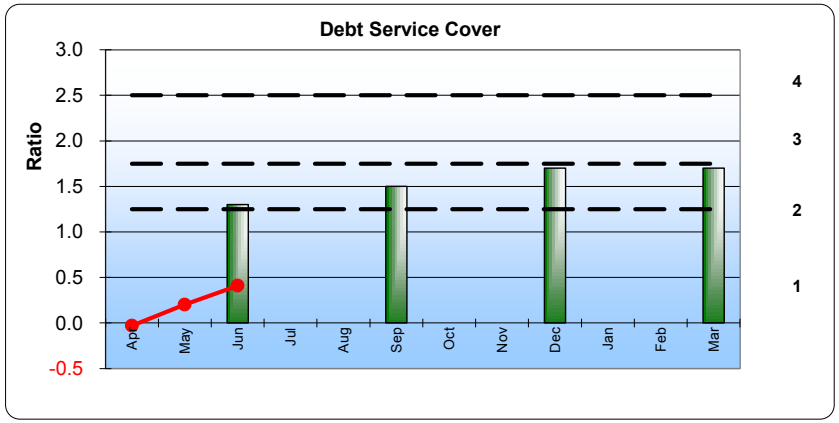
	Under 3 mths £m	3-6 mths £m	6-12 mths £m	12 mths + £m	Total £m
Payables	5.76	0.48	0.15	0.03	6.42
Receivables	6.57	1.14	0.30	0.59	8.60

Significant Aged Debtors (+6mths)

Harrogate and District NHS FT	**£509K**
Leeds and York Partnership NHS FT	**£46K**
Selby District Council	**£45K**

COSRR Area of Review	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquid Ratio (50%)	4	4	4	4
Debt Service Cover (50%)	2	2	1	2
Overall Continuity of Service Risk Rating	3	3	3	3





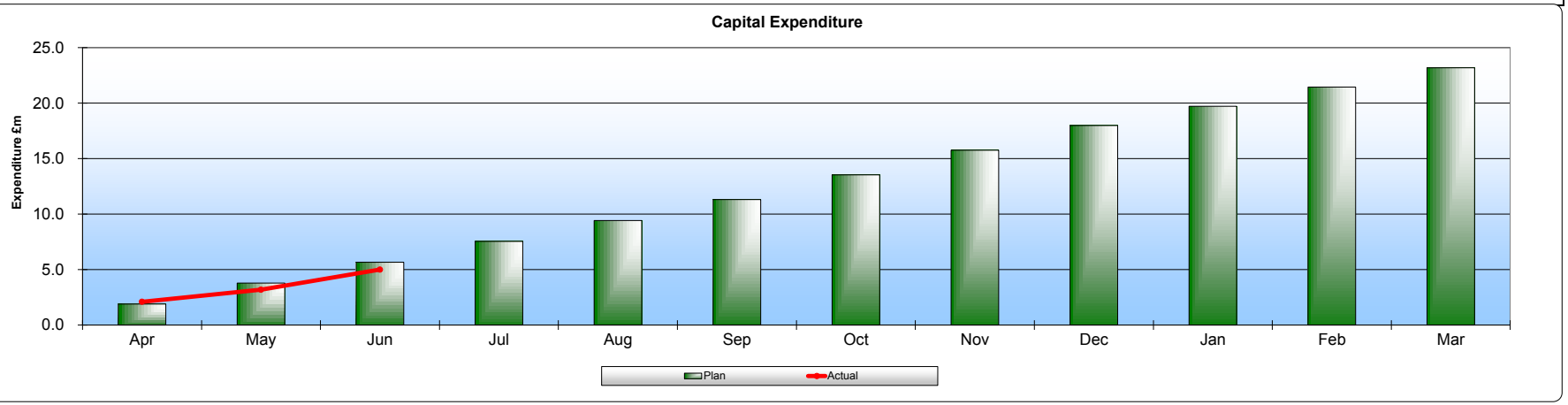
Capital Programme

Month 3 - The Period 1st April 2015 to 30th June 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The Capital Programme for June is running in line with plan.
* Phase 1 of the Scarborough Fire Alarm project has been approved which will include fees to lead the project into Phase 2.
* Other major schemes across both sites include 2 x CT Scanner replacement at £2.015m and other radiology equipment totalling £3.085m
* The Scarborough and Bridlington Carbon Energy Scheme has the largest projected in year spend at £5.087m
* At this point in the year the forecast outturn is as per the plan



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
CT Scanner replacement- York (Owned)	2,015	586	2,015	0	
Strategic Capital Schemes	1,870	308	1,870	0	
SGH Fire Alarm Replacement	1,190	18	1,190	0	
SGH Lifts Radiology	880	-	880	0	
York ED Phase 2	1,264	7	1,264	0	
SGH/ Brid Carbon & Energy Project	5,087	1,552	5,087	0	
Radiology Equipment Upgrade	3,085	-	3,085	0	
IT Wireless Upgrade - Trustwide	1,400	302	1,400	0	
Other Capital Schemes < £500k	595	406	595	0	
SGH Estates Backlog Maintenance	1,000	267	1,000	0	
York Estates Backlog Maintenance - York	1,000	216	1,000	0	
Medical Equipment	650	153	650	0	
IT Capital Programme	1,500	172	1,500	0	
Capital Programme Management	1,150	334	1,150	0	
Capital Creditors	-	671	-	0	
Contingency	500	-	500	0	
TOTAL CAPITAL PROGRAMME	**23,186**	**4,992**	**23,186**	**-**	

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£	£	£	£	
Depreciation	9,614	2,361	9,614	-	
Loan Funding b/fwd	1,386	353	1,386	-	
Loan Funding	9,577	1,785	9,577	-	
Charitable Funding	739	185	739	-	
Strategic Capital Funding	1,870	308	1,870	-	
TOTAL FUNDING	**23,186**	**4,992**	**23,186**	**0**	

Efficiency Programme

Month 3 - The Period 1st April 2015 to 30th June 2015

York Teaching Hospital NHS
NHS Foundation Trust

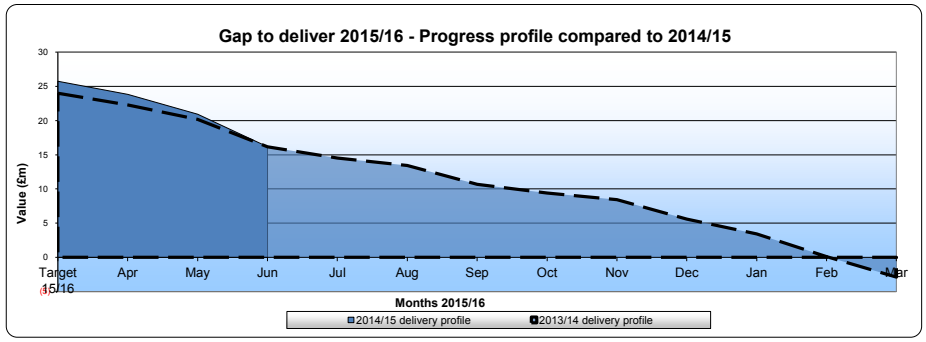
Key Messages:

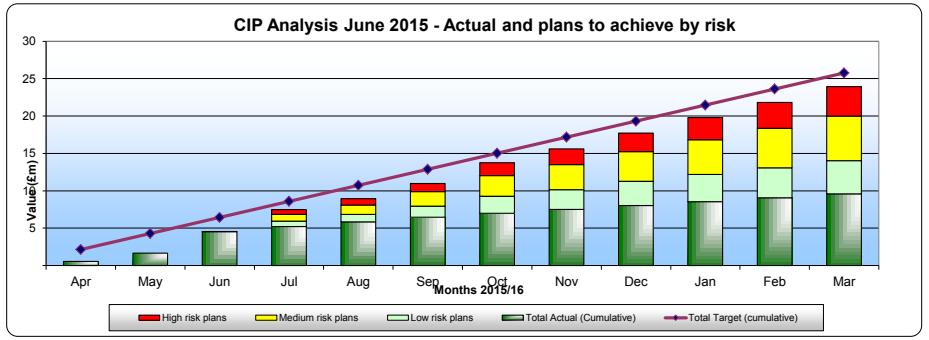
* Delivery - £9.6m has been delivered against the Trust annual target of £25.8m, giving a shortfall of (£16.2m).
* Part year Monitor variance - The part year Monitor variance has a shortfall of (£1.9m).
* In year planning - The in year planning gap is currently (£1.8m), work is continuing to close this gap.
* Four year planning - The four year planning gap is (£24.5m), this is an improvement of £5.4m from the May position.
* Recurrent delivery - Recurrent delivery is £5.9m, which is 23% of the 2015/16 CIP target.

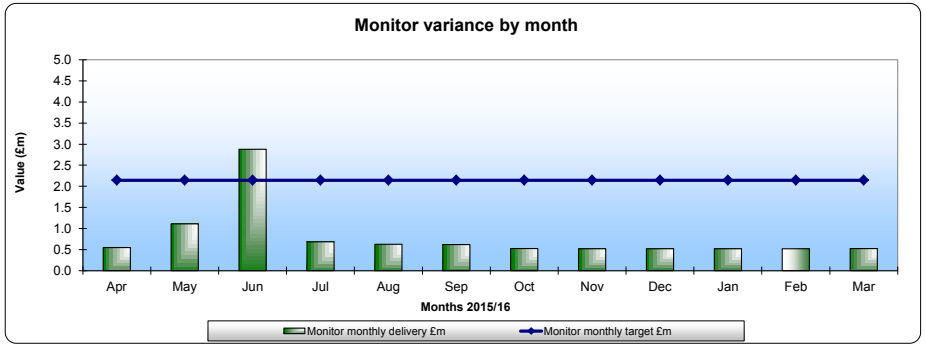
Executive Summary - June 2015	Total £m
TARGET	
In year target	25.8
DELIVERY	
In year delivery	9.6
In year delivery (shortfall)/Surplus	-16.2
Part year delivery (shortfall)/surplus - monitor variance	-1.9
PLANNING	
In year planning surplus/(gap)	-1.8
FINANCIAL RISK SCORE	
Overall trust financial risk score	(2 - RED/AMBER)

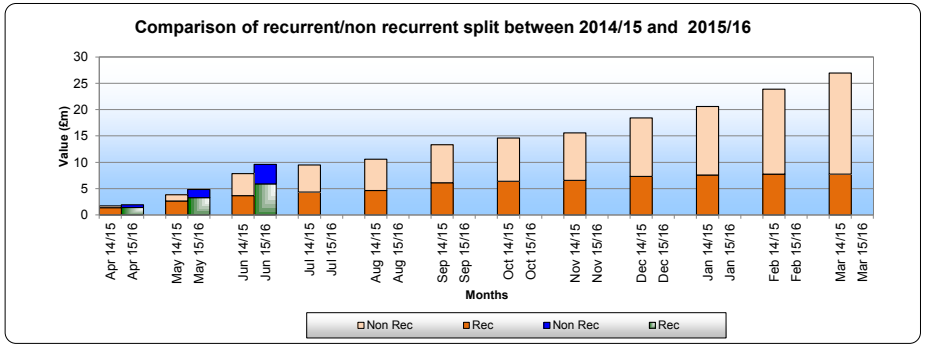
4 Year Efficiency Plan - June 2015					
Year	2015/16	2016/17	2017/18	2018/19	**Total**
	£m	£m	£m	£m	**£m**
Base Target	25.8	15.3	15.2	15.2	**71.4**
Plans	23.9	13.5	6.3	3.2	**47.0**
Variance	-1.8	-1.8	-8.9	-12.0	**-24.5**
%	**93%**	**88%**	**42%**	**21%**	**66%**

Risk Ratings			
Financial			
Score	May	June	Trend
1	17	12	↓
2	5	8	→
3	2	2	↑
4	2	3	↑
5	1	1	→
Governance			
Score	May	June	Trend
Red	20	2	↓
Green	7	24	↑









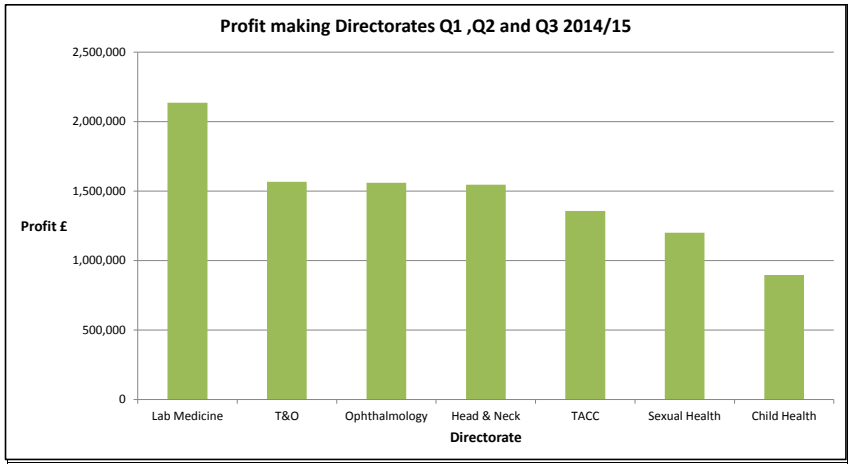
Service Line Reporting

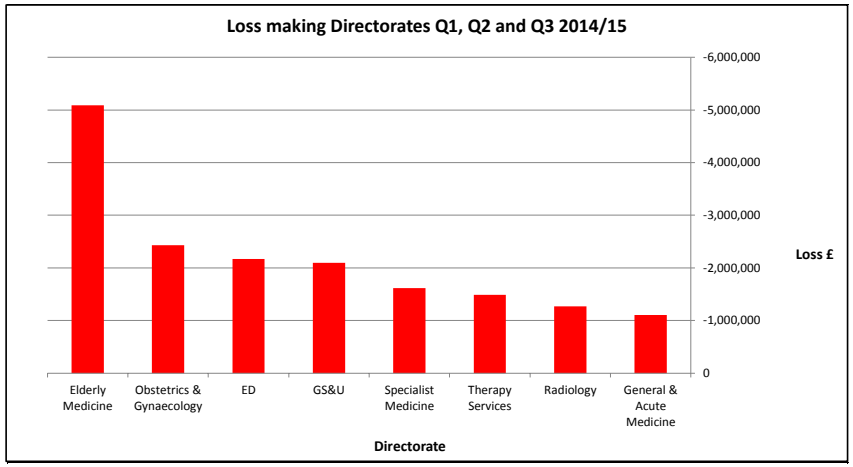
Month 3 - The Period 1st April 2015 to 30th June 2015

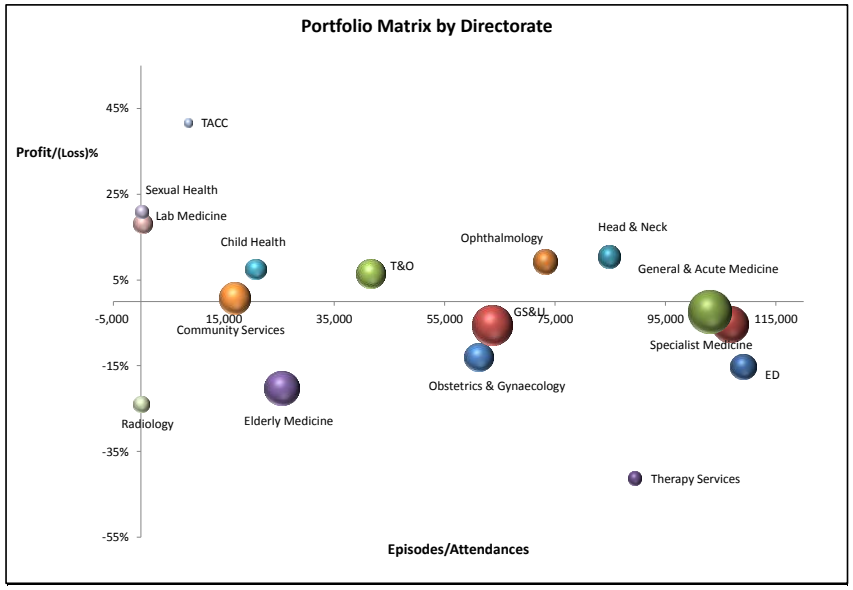
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Current data is based on Q1, Q2 and Q3 of 2014/15
* It is expected Q4 will be completed in October 2015
* The Reference cost submission is currently the key focus of the team with submission on 30 July 2015
* SLR drop in sessions have been arranged for the Directorate and Finance teams, the first two sessions have been held and were well attended
* 2 staff have been appointed to the team - start dates are September 2015 and January 2016







DATA PERIOD	QUARTER 1, 2 and 3 2014/15
CURRENT WORK	* The reference cost submission is the key focus of the SLR & Costing team and will remain so until the final submission on 30th July 2015 * 3 drop in sessions have been arranged for Directorate teams to attend to familiarise themselves with the SLR system, it is intended to continue with these sessions as regular events * Q3 information has been finalised and is reflected in this update * Directorate teams continue to use the system for example Medicine at Scarborough have started to use the SLR system to review their clinics and Specialist Medicine have recently used the SLR system to appropriately code the Lymphodema service, offering a £200k opportunity
FUTURE WORK	* A deep dive for interventional radiology is underway as this service is not profitable * Q4 SLR data is a priority following the reference cost submission, this is expected to be completed in October 2015 * The SLR team are continuing to work with Directorate teams to improve the quality of consultant job plan allocation within the SLR system, a similar piece of work is on going to improve staff allocation to clinics. * A detailed deep dive piece of work will be undertaken with Obs & Gynae between September 2015 and December 2015 with the aim of identifing what the true underlying financial position of the service is.

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

Executive Pack

June 2015

York Teaching Hospital NHS
NHS Foundation Trust

Executive Summary	Inpatient Elective				Inpatient Non-Elective				Inpatient Day Case				Outpatient (1st Att)				Outpatient (Sub Att)				Non Face-To-Face				Outpatient Procedures			
Specialty	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var
Accident And Emergency	0	0	0	0	2910	708	811	103	0	0	2	2	945	225	98	-127	818	195	32	-163	0	0	0	0	0	0	0	0
Acute Medicine	0	0	1	1	219	53	190	137	92	22	61	39	774	184	282	98	1004	239	266	27	94	22	7	-15	0	0	0	0
Anaesthetics	54	13	11	-2	17	4	5	1	1750	417	448	31	1650	393	486	93	2466	587	719	132	0	0	0	0	24	6	18	12
Cardiology	670	160	81	-79	2841	691	502	-189	1098	262	286	24	12125	2888	3573	685	19537	4654	4041	-613	155	37	50	13	5627	1340	1105	-235
Chemical Pathology	0	0	0	0	0	0	0	0	54	13	21	8	14	3	33	30	10	2	56	54	0	0	0	0	0	0	0	0
Clinical Neuro-Physiology	0	0	0	0	0	0	0	0	0	0	0	0	1254	299	307	8	70	17	29	12	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	8	2	0	-2	365	87	20	-67	7292	1737	1343	-394	16299	3883	3777	-106	424	101	6	-95	15441	3678	5466	1788
Ear, Nose And Throat	748	178	185	7	998	243	254	11	952	227	330	103	7810	1861	2055	194	8307	1979	2715	736	12	3	2	-1	8987	2141	1714	-427
Endocrinology	8	2	0	-2	3698	900	696	-204	482	115	156	41	2203	525	567	42	7137	1700	1874	174	506	121	14	-107	0	0	0	0
Gastroenterology	292	70	61	-9	4581	1114	1328	214	9568	2279	2169	-110	4591	1094	1271	177	9353	2228	2258	30	1026	244	246	2	60	14	17	3
General Medicine	5	1	2	1	434	106	171	65	2867	683	750	67	92	22	26	4	133	32	3	-29	18	4	3	-1	79	19	7	-12
General Surgery	2880	686	650	-36	7253	1764	1788	24	10460	2492	2454	-38	15012	3576	3801	225	22695	5406	4926	-480	794	189	239	50	3999	953	844	-109
Genito-Urinary Medicine	0	0	0	0	0	0	0	0	0	0	0	0	25550	3407	3251	-156	11980	1589	1509	-80	0	0	0	0	0	0	0	0
Geriatric Medicine	6	1	2	1	9421	2292	2841	549	172	41	41	0	3844	916	1082	166	3851	917	934	17	941	224	63	-161	46	11	18	7
Gynaecology	822	196	230	34	980	238	297	59	1474	351	419	68	7670	1827	1849	22	5650	1346	1541	195	0	0	0	0	4761	1134	1108	-26
Haematology (Clinical)	42	10	9	-1	156	38	50	12	3672	875	1038	163	1898	452	453	1	12610	3004	3228	224	668	159	170	11	126	30	9	-21
Maxillofacial Surgery	352	84	72	-12	378	92	77	-15	1951	465	521	56	7009	1670	1684	14	8372	1994	1943	-51	0	0	0	0	1846	440	613	173
Medical Oncology	58	14	13	-1	148	36	26	-10	6952	1656	1880	224	4186	997	1052	55	22970	5472	6013	541	25582	6094	4739	-1355	90	21	29	8
Nephrology	72	17	24	7	1606	391	312	-79	784	187	195	8	791	188	186	-2	8311	1980	1951	-29	3714	885	990	105	0	0	0	0
Neurology	14	3	0	-3	132	32	48	16	746	178	217	39	3286	783	775	-8	6115	1457	1383	-74	910	217	212	-5	56	13	0	-13
Obstetrics & Midwifery	24	6	16	10	5338	1298	1912	614	0	0	0	0	46	11	7	-4	1166	278	320	42	0	0	0	0	168	40	22	-18
Ophthalmology	251	60	58	-2	86	21	11	-10	5385	1283	1440	157	16145	3846	3870	24	57783	13765	12000	-1765	0	0	0	0	12929	3080	2678	-402
Orthodontics	0	0	0	0	0	0	0	0	0	0	0	0	1491	355	323	-32	1886	449	487	38	0	0	0	0	9636	2296	2108	-188
Paediatrics	65	16	14	-2	7156	1741	2006	265	214	51	72	21	5198	1238	1302	64	9989	2380	2494	114	424	101	82	-19	670	160	164	4
Palliative Medicine	0	0	0	0	0	0	0	0	0	0	0	0	1048	250	301	51	3938	938	1381	443	418	100	63	-37	0	0	0	0
Plastic Surgery	34	8	12	4	8	2	0	-2	338	81	108	27	407	97	160	63	512	122	149	27	0	0	0	0	29	7	0	-7
Restorative Dentistry	0	0	0	0	0	0	0	0	0	0	0	0	629	150	193	43	441	105	98	-7	0	0	0	0	1619	386	262	-124
Rheumatology	6	1	1	0	14	3	1	-2	2160	515	567	52	2732	651	617	-34	13097	3120	3457	337	1254	299	384	85	0	0	0	0
Thoracic Medicine	86	20	7	-13	3611	878	886	8	498	119	102	-17	3859	919	826	-93	10544	2512	2300	-212	134	32	23	-9	296	71	55	-16
Trauma And Orthopaedic Surgery	1824	435	486	51	3258	793	818	25	2283	544	605	61	18700	4455	4614	159	27248	6491	6964	473	0	0	0	0	1460	348	294	-54
Urology	1566	373	415	42	1598	389	363	-26	5844	1392	2156	764	2662	634	1320	686	4243	1011	2413	1402	14	3	13	10	3788	902	65	-837
Obstetrics & Midwifery Zero Tariff	0	0	0	0	6332	1540	1137	-403	0	0	0	0	8090	1927	2217	290	35308	8411	6776	-1635	0	0	0	0	9460	2254	2247	-7
Gynaecology Zero Tariff	4	1	0	-1	362	88	71	-17	2	0	0	0	4	1	0	-1	42	10	3	-7	0	0	0	0	20	5	7	2
Total	**9883**	**2354**	**2350**	**-4**	**63543**	**15457**	**16601**	**1144**	**60163**	**14332**	**16058**	**1726**	**169007**	**37582**	**39924**	**2342**	**333885**	**78274**	**78040**	**-234**	**37088**	**8835**	**7306**	**-1529**	**81217**	**19348**	**18850**	**-498**

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G3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Efficiency Programme Update – June 2015

Action requested/recommendation

The Board is asked to note the June 2015 position.

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2015/16 target is £25.8m and year to date delivery, as at June 2015, is £9.6m.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report Finance & Performance Committee.

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

Briefing note for the Board of Directors Meeting 29 July 2015

Subject: June 2015 - Efficiency Position
From: Steven Kitching, Head of Resource Management

Summary reported position for June 2015

Current position – highlights

Delivery - Overall delivery is £9.6m in June 2015 which is (37.2%) of the £25.8m annual target; there has been a £4.8m improvement in the month. This position compares to a delivery position of £7.8m (32.5%) in June 2014.

The Q1 report to Monitor will, however, show a (£1.9m) part year adverse variance at the end of Q1, which is a concern, especially given the positive start to the programme overall in 2015/16. This position is marginally worse than the 2014/15 position which was (£1.6m) adverse.

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

In year planning – There is an in year planning gap of (£1.8m) at June 2015, this compares favourably with the June 2014 position, where the gap was (£4.6m). There has been a £3.2m improvement in the planning position in the month, which is pleasing. Work is continuing with Directorate teams to close the remaining in year planning gap.

Four year planning – The four year planning gap is (£24.5m), which is an improvement of £5.4m from the May 2015 position. The comparative position in June 2014 was a gap of (£26.1m). We have a relatively strong planning position for years 1&2 of the plan with £37.4m (91%) worth of plans identified against a target of £41.1m.

Recurrent vs. Non recurrent – Of the £9.6m delivery, £5.9m (61%) has been delivered recurrently, in June 2015. It has been agreed by the Resource Management Executive Group that recurrent delivery, in quarter 1 of 2015/16 only, will be incentivised by 20%, clearly the impact of this has been positive. Recurrent delivery is £2.3m ahead of the same position in June 2014, which is extremely encouraging at this stage. The work continues to identify recurrent schemes.

Quality Impact Assessments (QIA) – All schemes have been sent out to Directorate teams to self assess for their safety impact, only 2 directorates have outstanding self-assessments. There are 938 schemes to be self-assessed of which 838 have been completed; therefore 100 schemes remain outstanding. It should be noted of the 838 schemes self-assessed 8 have been self-assessed as extreme risk and 14 as high risk, these schemes are being prioritised for independent Medical and Nursing assessment.

Overview
We have had an extremely positive start to the programme with Q1 delivery £1.8m ahead of the June 2014 position. Recurrent delivery is also really pleasing with £5.9m delivered in the first three months, this is a £2.6m improvement in the month, and is £2.3m ahead of the position last year.

Risks
Given the positive start in Q1, there remain key risks in the programme.

- There is an overall planning gap of (£1.8m), in year, and a (£24.5m) 4 year planning gap.
- There is a risk that recurrent delivery will fall back following the removal of the 20% incentive.
- There are 12 Directorates who are risk rated 1 at the end of Q1, in terms of planning and delivery.
- There are 22 schemes which have been rated as Extreme or High risk following the self-assessment process and require further investigation by Mr Telfer and Helen Hey.

It is therefore important to continue to support Directorate teams to ensure we continue this positive start and to work collaboratively with the Turnaround Avoidance Programme to ensure all opportunities are exploited.

The current risk positions of the Directorates will inform the programme of work to be challenged and supported through the Efficiency panels starting in September 2015.

RISK SCORES - JUN 2015 - APPENDIX 1

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

RISK SCORES - JUNE 2015 - 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
GEN MED SCARBOROUGH	1,142	2,421	58%	1	4%	1	4%	1	34%	1	4	1
WOMENS HEALTH	2,235	4,019	41%	1	9%	1	2%	1	63%	1	4	1
CHILD HEALTH	1,332	2,849	55%	1	10%	1	6%	1	57%	1	4	1
COMMUNITY	2,437	4,883	44%	1	10%	1	7%	2	84%	1	5	1
SEXUAL HEALTH	470	1,040	37%	1	14%	2	6%	1	54%	1	5	1
SPECIALIST MEDICINE	2,879	6,677	43%	1	14%	2	7%	2	47%	1	6	1
TACC	2,955	7,147	38%	1	14%	2	13%	2	26%	1	6	1
GS&U	2,082	5,239	78%	1	17%	2	12%	2	47%	1	6	1
RADIOLOGY	2,410	4,020	67%	1	19%	2	17%	3	50%	1	7	1
OPHTHALMOLOGY	868	2,428	97%	2	19%	2	14%	3	41%	1	8	2
MEDICINE FOR THE ELDERLY	1,422	3,706	113%	4	11%	2	10%	2	86%	1	9	2
HEAD AND NECK	623	1,821	129%	5	19%	2	6%	1	54%	1	9	2
GEN MED YORK	1,949	5,235	100%	3	23%	3	18%	3	95%	2	11	2
EMERGENCY MEDICINE	1,126	2,463	80%	1	39%	4	38%	5	42%	1	11	2
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1,693	3,780	91%	2	40%	5	23%	4	64%	1	12	3
LAB MED	1,144	3,247	114%	4	65%	5	51%	5	79%	1	15	3
ORTHOPAEDICS	1,350	3,613	129%	5	48%	5	40%	5	91%	2	17	4
PHARMACY	-189	503	140%	5	101%	5	101%	5	204%	5	20	5
CORPORATE												
OPS MANAGEMENT YORK	695	1,090	70%	1	8%	1	0%	1	60%	1	4	1
WORKFORCE AND ORGANISATIONAL DEVELOPMENT	768	1,536	34%	1	13%	2	1%	1	68%	1	5	1
CHIEF NURSE TEAM DIRECTORATE	378	695	15%	1	15%	2	15%	3	8%	1	7	1
SNS	1,156	2,397	75%	1	39%	4	23%	4	41%	1	10	2
MEDICAL GOVERNANCE	103	222	56%	1	56%	5	16%	3	26%	1	10	2
ESTATES AND FACILITIES	3,088	7,650	88%	1	34%	4	31%	5	67%	1	11	2
FINANCE	151	890	159%	5	159%	5	111%	5	44%	1	16	4
CHAIRMAN & CHIEF EXECUTIVES OFFICE	18	407	1194%	5	1194%	5	965%	5	96%	2	17	4
TRUST SCORE	**34,287**	**79,978**	**93%**	**1**	**33%**	**4**	**23%**	**4**	**64%**	**1**	**11**	**2**

G4

York Teaching Hospital NHS

NHS Foundation Trust

Board of Directors – 29 July 2015

Performance Recovery Status Summary: June

Action requested/recommendation

The board are asked to note this report.

Summary

The following Performance Recovery Monthly Status Summary update is split into 4 section. The sections are as follows:-

1. ED 4hr Performance
2. 18 Week Admitted Referral to Treatment Performance
3. Diagnostics Performance
4. Cancer Performance

The report identifies progress against plan and performance delivery risks.

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.

Progress of report Finance & Performance

Risk	Any risk is detailed in the report
Resource implications	Resources implication detailed in the report
Owner	Juliet Walters, Chief Operating Officer
Author	Jenny Hey, Deputy Chief Operating Officer
Date of paper	July 2015
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Operational Performance Recovery Plan

Monthly Status Summary: June 2015

ED

Trajectory: Sept 15

- **Performance**: **Off trajectory**
- **Achievements**: **York**: Discussions ongoing with CCG re community DVT pathway (600 att. per yr). Interim Ambulatory Unit York continues, plans for long term solution in development. Identified lead nurse and Dr for every shift, with hourly Board Rounds. Advert out for 2 FT Locum consultants and middle grades. **Scarboro'**: Commenced 6 wk trial for 24 hr Ambulance HO staffing (1xHCA; 1x nurse) starting 16th July. Dr Ruth Griffin started Elderly in-reach pilot to ED 29th June. Developed comprehensive plan to increase utilisation of Discharge lounge.
- **Risks**: Breach reduction trajectory has not been met for 9 wks in a row.

18 weeks admitted

Trajectory:
Dec 15

- **Performance**: **Ahead of trajectory** (est. 4 Oct).
- **Achievements**: New Medica undertaken first opthal list at Scarborough this weekend with no reported issues. No Gynae patients on Scarbo' site over 18 wks without a TCI. T&O starting to work up model for theatre 'business lists'.
- **Risks**: Shotage of Anaesthetists in next few wks, which will result in planned lists on York site being cancelled. T&O has long waits for main theatre in York (pts with co-morbidities), which is now causing a backlog bottle neck. 1st OPA for opthal plastics on East Coast now Nov; plans being developed to address.

Cancer

Trajectory:
Q1 FT/62 day
Q2 Breast Sy

- **Performance**: **On Trajectory** Q1: FT: 94%; BS 91%; 62: 87%.
- **Achievements**: Delivered 14 day FT & 62 day for Q1 as planned. Planning to re audit 14 day Breast Symptomatic patients who chose to wait longer than 14 days. June BS performance 92.91% (target 93%); significantly higher than April (90.1%) or May (90.2%)
- **Risks**: **BS**: 14 breaches April :10x admin breaches, 10 May breaches (9 pt cxls/choice) 10 breaches in June (8 pt choice).

Diagnostics

Trajectory: Oct 15

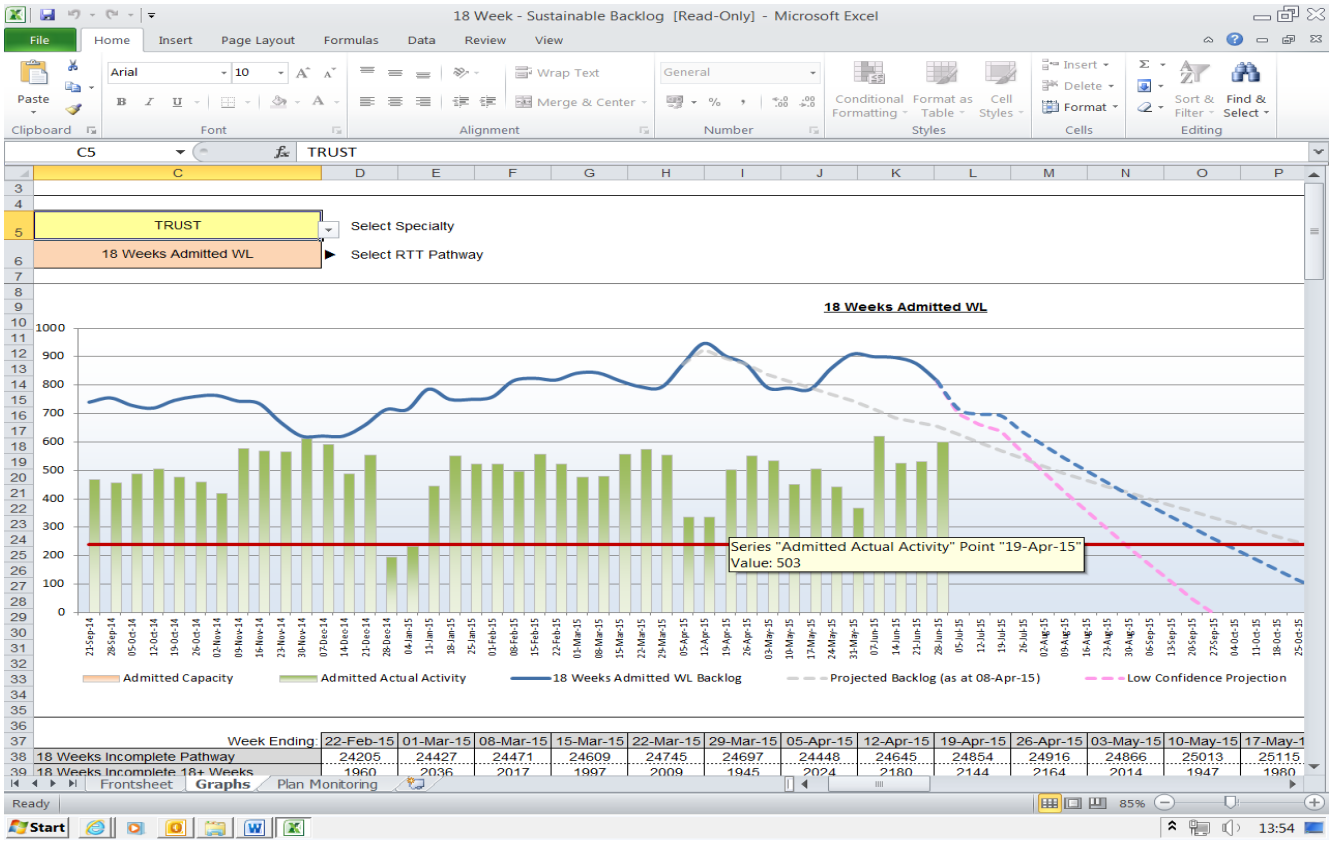
- **Performance**: June Radiology : 95.6% (UNVALIDATED)
- **Achievements**: Reduction in CT FT reporting continues to reduce from 2 wks on York site. High proportion of 275 US breaches from May have now been appointed. Projecting 100 radioloy breaches across all sites/ modalties this month. Yorkshire Health Solutions will commence US scans 2 days a wk [36 scans] from 7th July out of Falsgrave Surgery in Scarbo', under AQP. BC for 3rd CT scanner York approved est. start date Oct.
- **Risks**: Work to prioritise Scarbo' acute CT week is displacing planned work into evening WLI sessions and has also led to an increase in waits for FT CTs on Scarbo' site. Process issues discovered around patient choice and cancellations; trajectory being reassessed in the light of this.

Weekly Breach Reduction Trajectory – TYPE 1

Week Ending	19-Apr	26-Apr	03-May	10-May	17-May	24-May	31-May	07-Jun	14-Jun	21-Jun	28-Jun	05-Jul	12-Jul
Target	406	406	266	266	266	266	266	203	203	203	203	172	172
Actual	**460**	**271**	**496**	**393**	**560**	**449**	**437**	**356**	**376**	**469**	**419**	**211**	**312**

York Target (61% total)	248	248	162	162	162	162	162	124	124	124	124	105	105
York Actual	**306**	**183**	**342**	**153**	**347**	**227**	**262**	**174**	**234**	**305**	**240**	**150**	**215**
Scarborough Target (39% total)	158	158	104	104	104	104	104	79	79	79	79	67	67
Scarborough Actual	**154**	**88**	**154**	**240**	**213**	**221**	**175**	**182**	**142**	**164**	**179**	**61**	**97**

18 Week Admitted Backlog Trajectory



Grey dotted Line – original trajectory

Blue dotted line – updated trajectory, based on actual activity (high & medium confidence plans)

Pink dotted line – updated trajectory, based on actual activity (high, medium & low confidence plans)

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Emergency Care Recovery Plan

Action requested/recommendation

The Board is asked to note the progress and risks.

Summary

This is the first progress report that aims to provide a status summary update which tracks progress against the Trust Emergency Care Recovery Plans.

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 and Performance
Risk	Note trajectories that are off plan.

Resource implications	None.
Owner	Juliet Walters, Chief Operating Officer
Author	Mandy McGale, Deputy Chief Operating Officer Lucy Turner, Head of Operational Performance
Date of paper	July 2015
Version number	Version 1

Board of Directors – 29 July 2015

Emergency Care Recovery Plan

1. Background and Performance Requirements

Whilst emergency care requires a 'whole system' approach, performance is ultimately measured on a national basis at the 'front door' of the Emergency Department. The Emergency Department has several key performance indicators which we are required to measure and report on. The most prominent of these are:

- Emergency care standard – measure of the number of patients who spend over 4 hours in the Emergency Department, from arrival to admission, transfer or discharge.
- 12 hour target from decision to admit – measure of the number of people who have waited over 12 hours from the time the decision to admit them was made (not from arrival time) or when treatment in A & E is completed (whichever is later to the time when the patient is admitted).
- Ambulance Quality Standard: time to initial assessment – time from arrival to start of full initial assessment, which includes a brief history, pain and early warning scores, for all patients arriving by emergency ambulance.
- Ambulance Handover Times – Patients transported to the Emergency Department by ambulance must be handed over to Emergency Department staff within 15 minutes of arrival. The Trust has contract KPIs that zero patients must waiting longer than 30 minutes or 60 minutes.

The National target for emergency care is that 95% of patients should be admitted, transferred or discharged within this time. This was revised from 98% in June 2010.

Trust performance is calculated from the York and Scarborough Emergency Departments (Type 1 units) and the Minor Injury Units at Bridlington, Malton, Selby and Whitby (Type 3 units). From 1 July 2015, it was anticipated that Whitby would no longer be counted as the Trust's activity, this has now been delayed due to contracting issues. New timescales are, as yet, unclear.

2. Where are we now?

The Trust has not met 95% for the 4 hour emergency care standard for any quarter of 2014/15. The quarterly percentages for the last 3 years' are as follows:

	2014/15	2013/14	2012/13
Quarter 1	93.9%	96.28%	97.06%
Quarter 2	92.6%	94.05%	95.65%
Quarter 3	89.1%	93.35%	93.93%
Quarter 4	89.11%	96.23%	92.55%

Overall, the Trust had 185,268 Emergency Department attendances in 2014/15. Of these,

16,095 patients breached the 4-hour target. To comply with the 4-hour target, a maximum of 6,832 patients could have been seen outside the of the 4-hour target in 2014/15.

In addition, during 2014/15 there have been 15 instances where patients have waited over 12 hours for a bed from the conclusion of treatment in ED. There have been 1,824 ambulance handovers which were beyond the 30 minute target and 941 beyond the 60 minute target (April – February 2015).

3. What are the challenges affecting the Trust's performance?

From the outset, it is important to view performance against the emergency care standard as part of an urgent care system, which is affected by:

- demand from primary care;
- acuity of patients;
- effective ambulatory care and frailty models of care;
- effectiveness of internal ED processes;
- effectiveness of assessment of patients;
- focussing on discharge processes to reduce patients length of stay;
- streamlined discharge pathways into the community;
- reduced delayed discharges; and
- system wide resilience.

Each of these are inter-dependent elements of a patient flow process. There is no one single problem impacting on performance against the emergency care standard; solutions are multi-factorial and need to be aimed at achieving improvements in all parts of the system.

Both hospital sites have experienced significant operational pressures as a result of the above and, in particular:

- workforce shortages;
- changes in the numbers of patients attending and their acuity;
- increased levels of non-elective admissions (+7.4% against plan), especially patients aged 75 years+;
- high levels of bed occupancy >90% and reduced capacity to 'flex';
- recent changes in the assessment process of patients at York site; and
- insufficient support across the health economy to support timely discharge.

<u>York Site</u>

Attendances (York)

The following table shows the total number of attendances by month (including category 2: booked revisits) and the percentage year on year change using 2010-11 as a baseline. The highest number of attendance start times is between 9am and 3pm (39.3%), followed by 37.6% attending between 3pm and 10pm and 23.1% between 10pm and 9am.

Year	York ED	Walk in Centre (off-site)	% Change
2010/11	73606	19388	
2011/12	74412	19588	1.1%
2012/13	88271	926	-5.1%
2013/14	84087		-5.7%
2014/15	84662		0.7%

Whilst attendances are relatively stable over the last two years the acuity of patients has increased, resulting in more time needed to assess and treat (or admit) patients. As with the national picture, ED staffing is significantly pressured with vacancies in consultant, mid-grade and nursing posts resulting in significant delays through the ED department. The situation was further exacerbated in April as a result of the CQC inspection resulting in a change to the assessment process of patients. In effect, this change resulted in additional steps being put into the process, which impacted on nursing staff and is currently covered by Bank and Agency staff when available.

During Q1 2015/16, York attendances have increased by 1.6% [353 patients] in comparison to Q1 2014/15.

Non- Elective Admissions (York)

The table below shows the number of non-elective admissions by month, with the percentage change against the previous year. The overall increase since the 2010-11 baseline is an additional 3686 admissions (11.5%).

Year	Admissions	Change	% Change
2010/11	31986		
2011/12	32860	874	2.7%
2012/13	34122	1262	3.8%
2013/14	34267	145	0.4%
2014/15	35672	1405	4.1%
Overall Change		3686	11.5%

Whilst the number of non-elective admissions has increased significantly, nursing and medical staff shortages has impacted on beds and patient flow as there has been minimal escalation capacity available at peak times. The discharge of patients that are Delayed Transfers of Care has also increased as the 'winter' funding used to spot purchase additional capacity ceased at the end of May. As a result the number of patients whose discharge has been delayed have increased by 46% [385 to 562] when comparing April 2015 to June 2015. The monthly average in Q1 2014/15 was 369.

Scarborough Site

Attendances (Scarborough)

For the period May 2014 to Mar 2015 there was a 5.7% rise in attendances compared to the previous year. Since the start of April 2015 1,547 attendances have been redirected to the Urgent Care Centre operated by Yorkshire Doctors.

The highest number of attendances are between 3pm and 10pm (38.9%) followed by 9am and 3pm (37.4%) and 10pm and 9am (23.7%). Scarborough has seen 13.6% decrease in attendances in Q1 2015/16 in comparison to 2014/15; this is largely as a result of the opening of the Urgent Care Centre, run by Yorkshire Doctors.

Non- Elective Admissions (Scarborough)
The table below shows the number of non-elective admissions by month, with the percentage change against the previous year. The overall increase since the 2013-14 baseline is an additional 808 admissions (4.9%).

	Admissions	Change	% Change
2013/14	16343		
2014/15	17151	808	4.9%

In addition, as with York, the impact of safer staffing levels coupled with staffing shortages has resulted in an unavoidable net reduction within the inpatient bed base. Continued ward closures as a result of Norovirus outbreaks has also significantly reduced inpatient capacity.

4. What are we doing to address the challenges?

Our primary aim is to reduce pressure on our Emergency Departments and improve patient flow across the whole system and to have the flexibility to manage peaks in demand. Although the way this has been approached varies slightly in each locality the focus remains consistent.

The actions we are taking are detailed in the following documents:-

- ED recovery plan, attached as Appendix 1, details the actions that we are taking to improve 5 key areas :

  - Emergency Department Flow
  - Patient flow
  - Pathway re-design inc ambulatory care
  - Workforce
  - Trust-wide systems

  Operation Fresh Start is an 18 month improvement programme included in the ED Recovery Plan. This is a whole system redesign of patient flow designed to achieve a 90% bed occupancy by focusing on discharge processes and a staff behaviour change that embeds a principle of a 'no delay culture' across the whole care system. The interim evaluation report and agreed improvement measures will be completed by end July 2015.

- Acute Task and Finish Group, Terms of Reference attached as Appendix 2 and is Chaired by Nigel Durham and focusses on delivery across the acute pathway and the ED Recovery Plan.

- The System Recovery Plan, attached as Appendix 3, details how the whole system is working together to improve patient flow processes. The Urgent Care Working Group (a subset of System Resilience Group) will monitor this plan. *Operation Fresh Start is also included the System Recovery Plan.*

- Additional support has also be sought from the Trust's Service Improvement Team to review and support internal system changes. In addition, we are also continuing to work with the (national) Emergency Care Intensive Support Team who provide independent expert advice and guidance.

5. What actions have been taken to date?

Detailed below are the actions taken to date to support the recovery of the emergency care standard. Against each action is an indication of the expected impact.

Progress/Action	Impact
Enhanced senior leadership, including new investment into a senior Band 8a presence on both sites.	Emergency Department flow
Reviewed ED processes including analysis of all 4hr breaches (split by admitted & non-admitted), which has formed the basis of an action plan.	Emergency Department flow
Reviewed ED processes to ensure ambulance handover achieved in less than 30-min. This work is ongoing	Emergency Department flow
Implemented predictor tool showing ED performance and Bed Activity which is updated every 15 minutes. This provides the Ops teams and Bed Managers the most current status of the hospitals.	Emergency Department flow & patient flow
Established fully resourced Discharge Lounges on both sites and set ward level targets for morning discharges to the lounge	Patient Flow & reduced bed occupancy
Combined AMU/SSW at York	Patient Flow & reduced length of stay (bed occupancy)
Introduced Surgical Assessment Unit at Scarborough	Pathway re-design, reduced pressure on ED
Introduced “Plan for Every Patient” at Scarborough	Reduced length of stay
Agreed timed pathways with local authorities(NYCC and ERCC) for all patients on a complex care pathway at Scarborough	Patient Flow, reducing delayed discharges & length of stay (bed occupancy)
Increased capacity in radiology for inpatients at Scarborough Hospital	Patient Flow
Established Ambulatory care Units at York & Scarborough with a plan to roll-out all pathways (where clinically feasible). This included software development.	Pathway re-design, admission avoidance, reduced pressure on ED
Piloted Elderly Care in-reach Frailty service at Scarborough (see Appendix 4 for Initial Report and summary below)	Pathway Redesign, admission avoidance, reduced pressure on ED & length of stay (bed occupancy)
Introduced a Nurse/Dr in charge of ED Dept with 1 hr board rounds	Emergency Department Flow, reduced length of time in ED
ED system modification to support patient flow including “Ready for Transfer” to highlight to bed managers that a patient is now ready for transfer.	Patient flow
Piloting an alternative ED model at Scarborough with less dependency on ED Physicians – currently being piloted across specialties.	Emergency Department flow and Workforce, reduced pressure on ED
Introduced Advanced Clinical Practitioner roles at Scarborough to reduce dependency on ED physicians	Emergency Department flow and workforce
Introduced 24/7 Patient Flow team at York (impact to be tested before further roll-out)	Patient flow

Re-designed 3 x daily patient flow meetings (both sites) to improve patient flow, reduce bottlenecks and improve operational grip/over-sight.	Patient flow
Introduced Community Discharge Liaison Team	Patient flow, reduced delayed discharges & length of stay (bed occupancy)
Community Mobile Working - pilots underway - using mobile technology to support community staff to receive and manage referrals on the move, to coordinate and manage workloads more effectively and record patient info and activity 'out in the field'. Aim of the pilots is to demonstrate an increase in patient contact time	Patient flow & workforce
Implemented electronic Board Rounds to support MDT board rounds and patient at glance. Implementation across York Hospital completed; roll out commenced across Community Hospitals.	Patient flow
Implemented Transfer Boards to support safe and transparent patient flow. Implemented in ED; AMU/AMB; Bed Managers and the Discharge Lounge in York Hospital	Patient flow
Implemented Discharge Board to support discharge planning. Implemented in York Hospital and being rolled out into community	Patient flow & delayed discharges
Implemented electronic submission of Section 2s and 5s to the 3 Local Authorities (York & Scarborough). Next stage to roll out to Community Hospitals.	Patient flow & delayed discharges

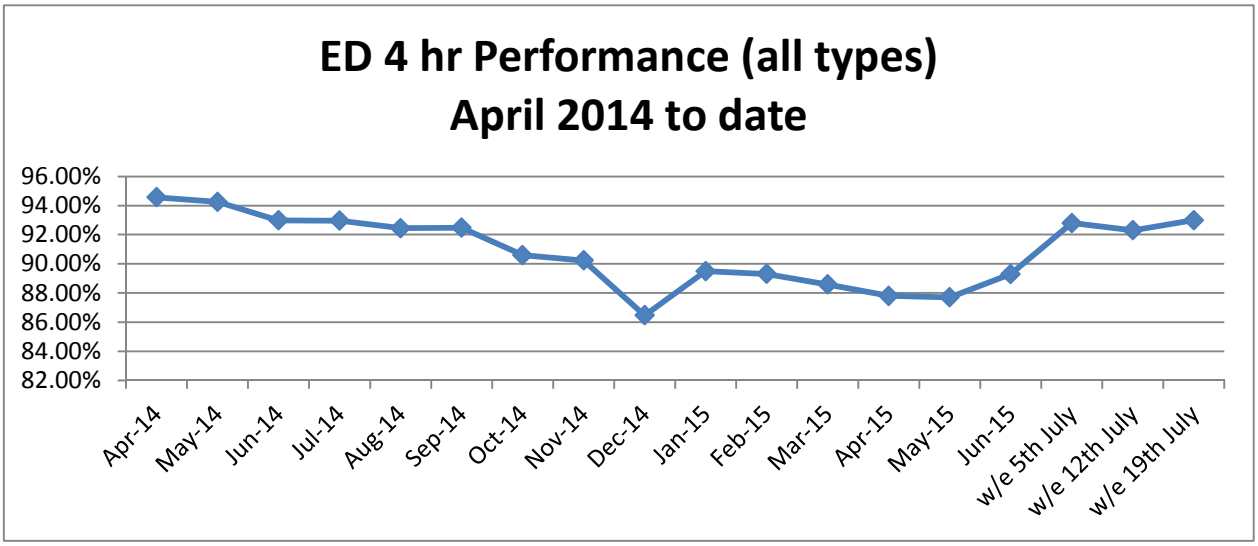
6. What has been the impact of the actions taken?

Whilst a number of the actions highlighted in 5 are continuing to be embedded, we routinely monitor the impact of these in order to evidence their success or otherwise. A suite of key performance indicators are available within the monthly Performance Report, however, ad hoc reports are also generated in order to evidence and monitor impact.

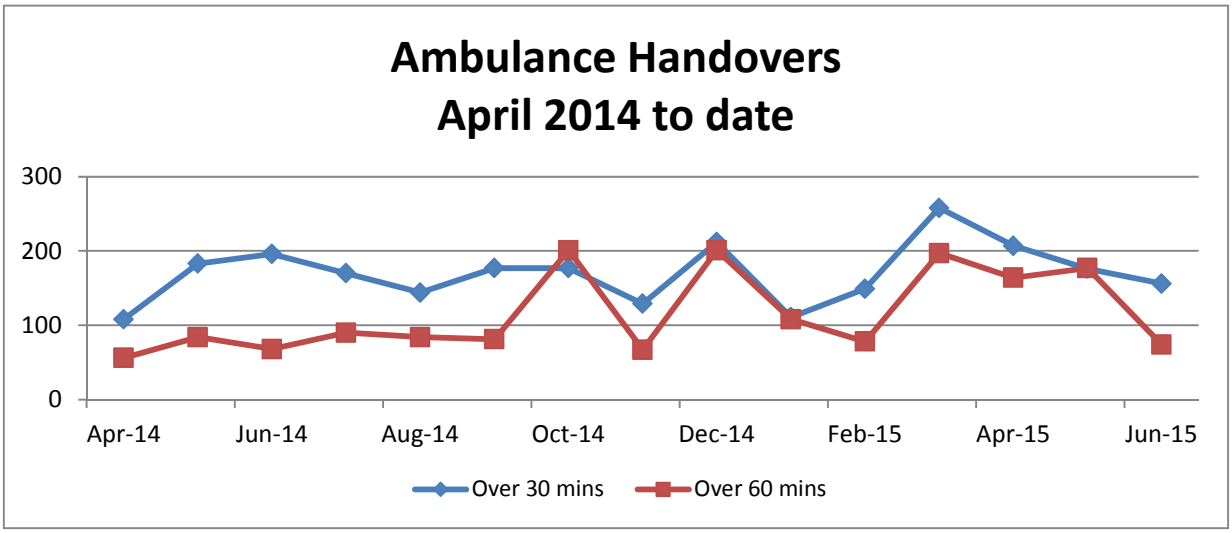
The key performance indicators below have been highlighted to give an indication of where improvements are being made as a result of the actions and service improvements made to-date.

- 4 Hour Emergency Care Standard – All Types
- Ambulance turnaround Times
- Time to Assessment in ED
- Length of stay
- Bed Occupancy
- Cancelled Electives

As can be seen, the indicators and data support the fact that progress is now being made towards recovering operational performance.

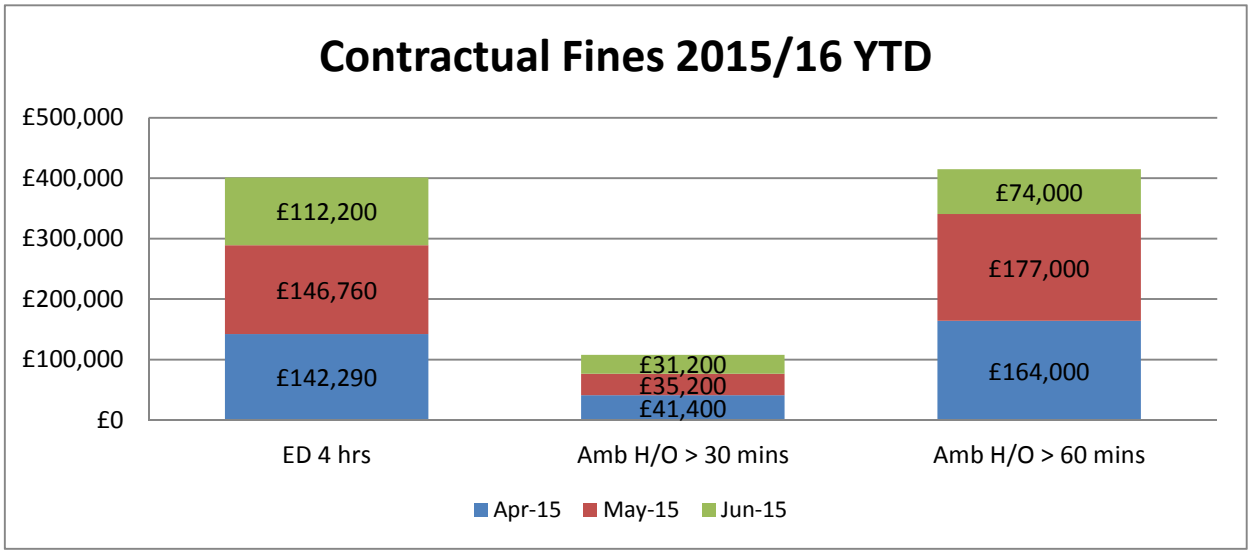


The first 3 weeks in July 15 show a recovery of the Trust's performance against the 4 hr Emergency Standard to levels similar to those seen prior to the Winter period and similar to performance achieved in July 14.

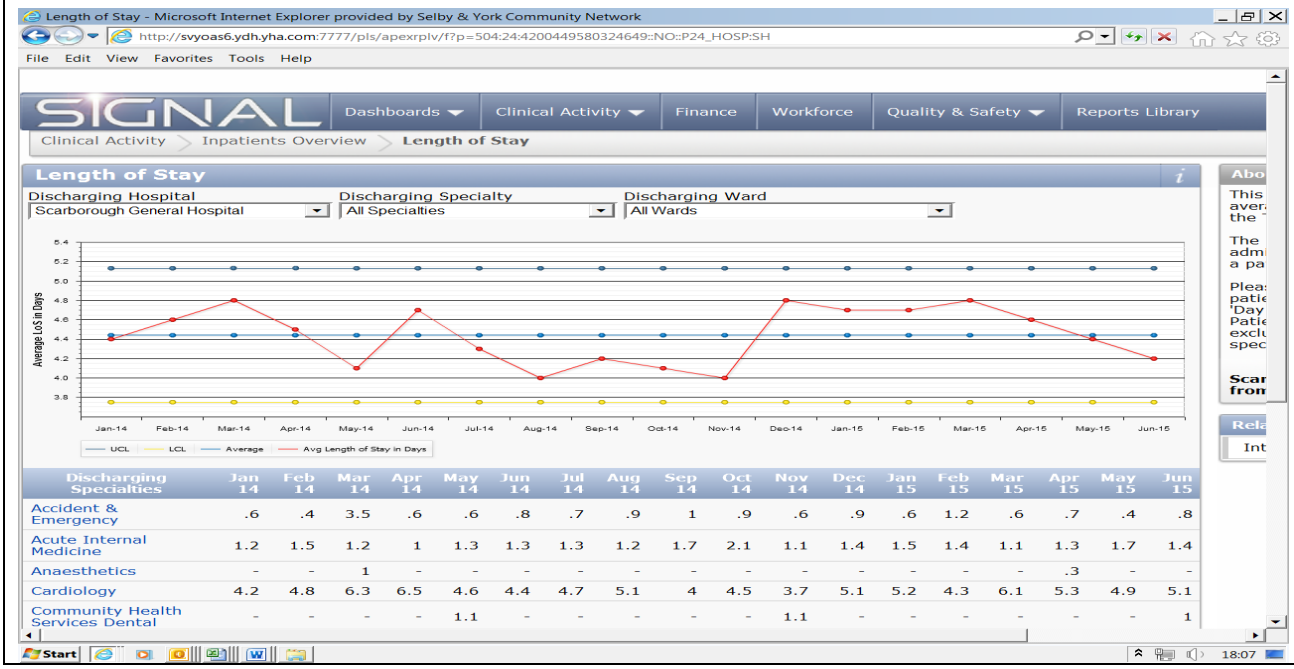


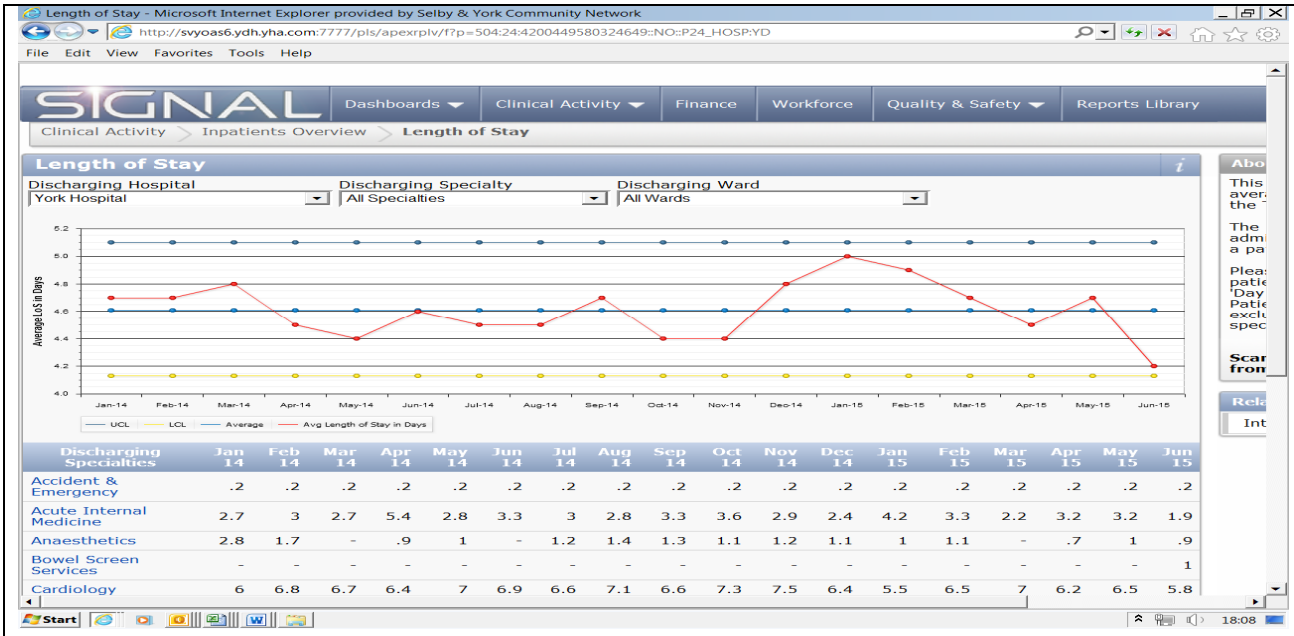
After peaking in March 2015, the number of patients waiting both over 30 and 60 minutes for Ambulance Handovers has reduced to similar levels as summer 2014.

The improvement in operational performance has been matched by a decrease in the value of imposed contractual fines. There has been a decrease of £130,290 in the amount of fines imposed for the three contractual fines associated with the Emergency Flow when comparing April 15 to June 15.

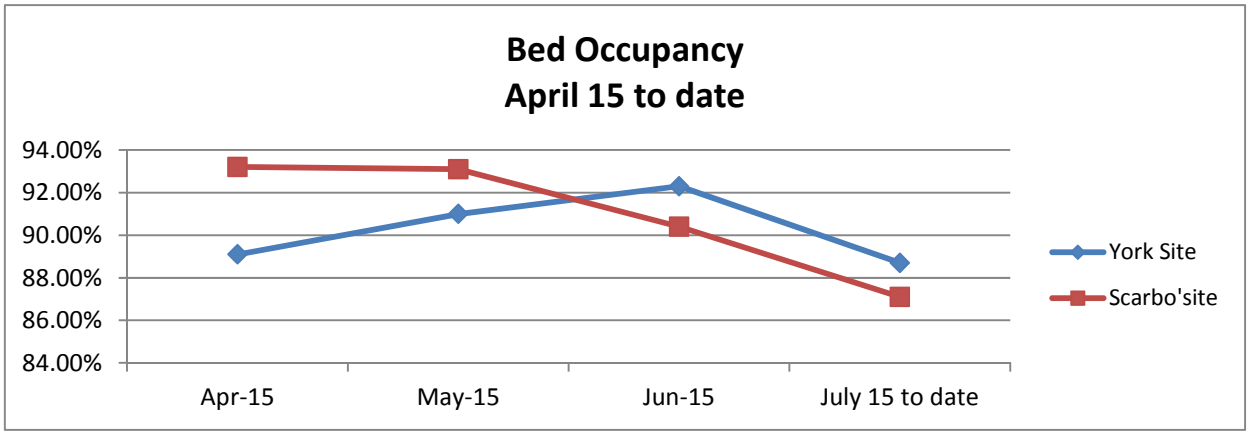


Both Scarborough & York Hospital sites have seen a statistically significant decrease in length of stay in June 2015. The length of stay is based on admission and discharge dates of a patients' spell of care. Please note that this excludes patients that were admitted as a 'Day Case' or 'Baby'.

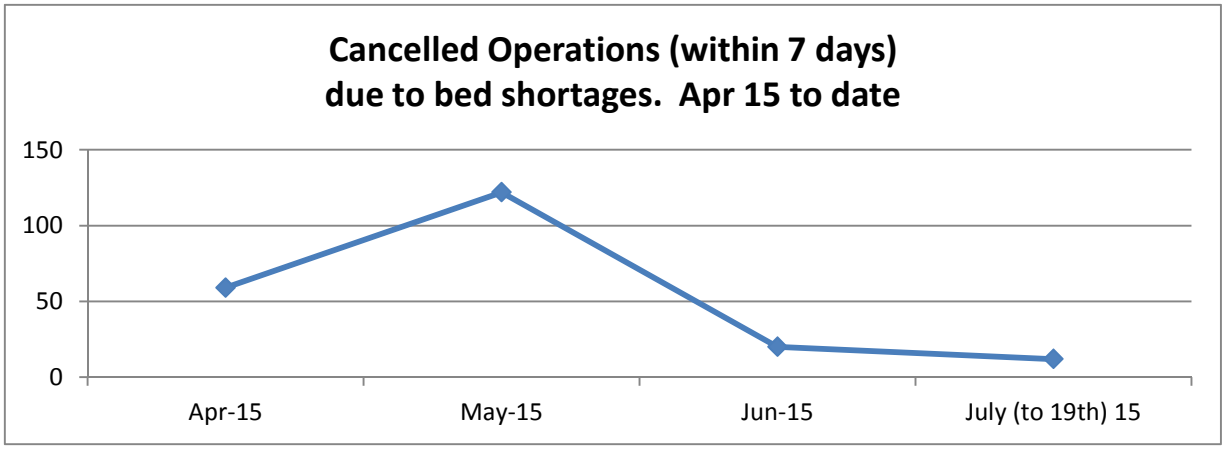




Bed Occupancy on both sites has also reduced since the start of the financial year. This is a key driver to ensure there is flow both from ED, through the hospital and timely discharges.



The Trust has cancelled 84% fewer operations in June 15 when compared to March 15, indicating better flow through the hospital, fewer outliers and better bed availability.



Whilst there is significant progress still to be made in relation to sustainably achieving the 95% emergency care standard, we believe the data demonstrates an improving position.

7. What key actions are we taking over the next six months?

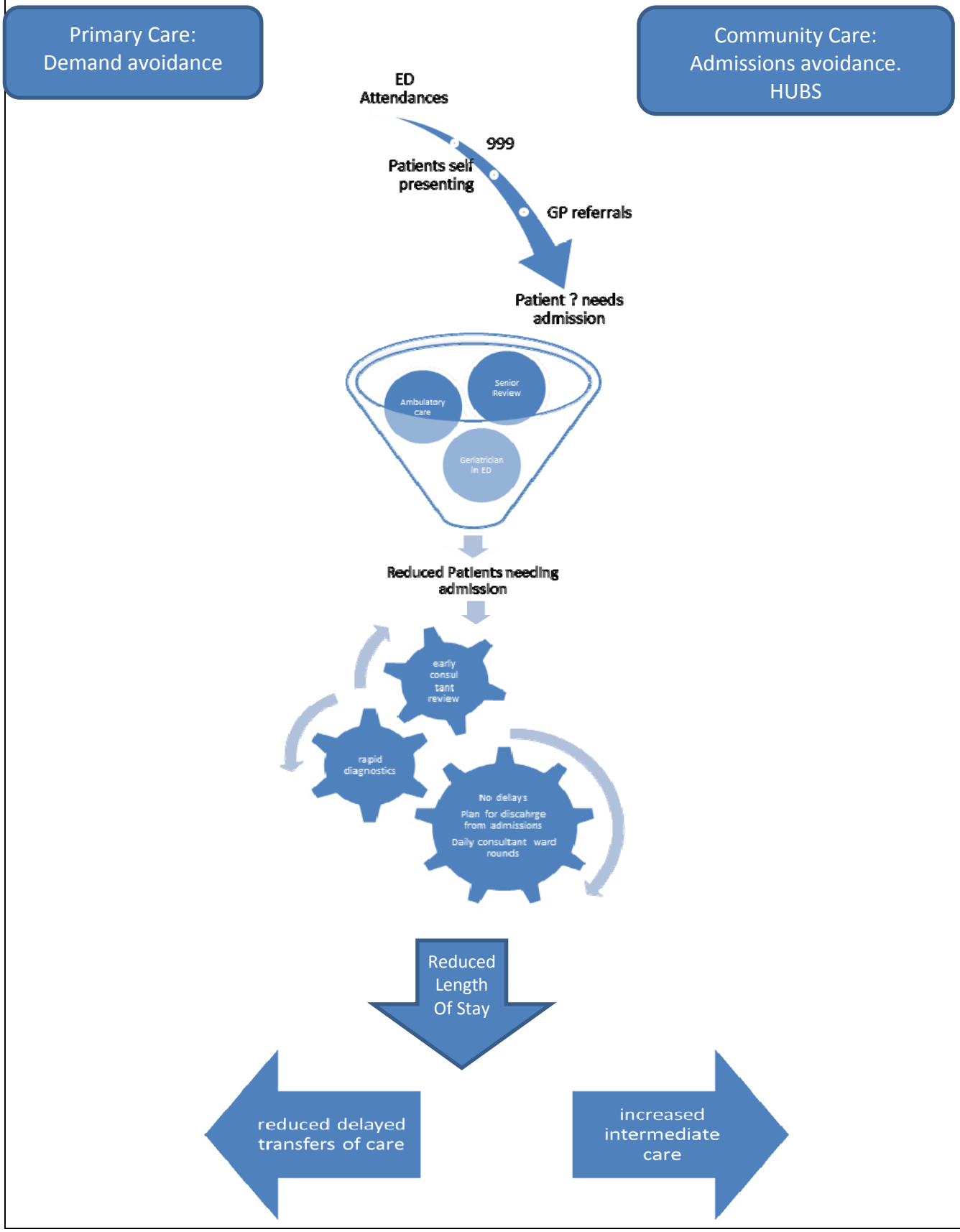
The following actions are considered to be key priorities for the next 6-months to support the recovery of the emergency care standard.

Enablers	Expected Impact
Agree workforce plan for both emergency departments	Workforce
Non - Registered workforce plan - work is underway to enhance the skills and competencies of the community non registered workforce to free up registered nurse capacity	Workforce
Develop a Discharge to Assess model of Care	Patient Flow, reduced delayed discharged & length of stay (bed occupancy)
Finalise new ED model at Scarborough	Workforce & pathway re-design
Agree primary care 'front door' model at York	Workforce, pathway re-design & reduced pressure on ED
Development of ED Board to enable the proactive monitoring and of the pathway through ED; enabling a "patient at a glance", including patients who have been triaged but are in the waiting room; enabling clear task allocation (live end August).	Emergency Department flow & patient flow
Develop single whole system/health economy Escalation Policy	Patient flow & reduced delayed discharges
Review existing models of Early Supported Discharge and expand where appropriate	Reduced length of stay (bed occupancy)
Extend pathways within Ambulatory Care Units on both sites	Pathway re-design, admission avoidance, reduced pressure on ED
Introduce a community DVT pathway on York site (CCG led)	Pathway Re-design & reduced pressure on ED
Implement Older Persons Assessment Lounge and SSW on York site	Pathway Redesign, patient flow & reduced length of stay (bed occupancy)
Complete Bed Modelling on both sites and adjust bed provision	Bed occupancy & patient flow
Develop plans for 7-day working - acute	Patient flow & reduced length of stay (bed occupancy)
Reduce Delayed Discharges and Delayed Transfers of Care	Patient flow & length of stay (bed occupancy)
Reduce delays to transfer to other community units and hospice	Patient flow & length of stay (bed occupancy)
Expedite ED Admission rights policy	Emergency Department Flow
Implement 2nd phase of Yorkshire Doctors Urgent Care model Scarborough.	Reduce pressure on ED & Emergency Department flow
Completed ECIST review of ED processes at Scarborough and community service provision	Emergency Department and patient flow. Support case for additional community support.
Finalise winter resilience plan (end September) including bed escalation capacity	Patient flow, length of stay (bed pressures)
Access to CPD by Social Workers for patients on Section 2s & 5s (currently being piloted on ward 35/CYC, followed by Ann Wright/NYCC).	Patient flow & delayed discharges

8. What are we trying to achieve?

The diagram below details our ultimate ambition for the delivery of emergency care across the health economy:

Whole System approach to delivering Emergency care



Leadership across the health economy from all professional groups is vital to the success of the Emergency Care Recovery Plan. Another key element is to ensure the Trust has sufficient capacity to match emergency care demand and that we also have the flexibility to respond to peaks in demand.

The Trust has invited the Emergency Care Intensive Support Team to work with us again to review the plans related to the Scarborough site to ensure we are focusing on the right things and that our plans are robust and will deliver the outcomes that we are expecting. This review will subsequently be extended to York.

9. Risks to delivery

Given the complexity and interdependencies of emergency care delivery there are a number of significant risks, which can impact on the success or otherwise of our plans. These risks are:

- Workforce shortages
- Increased non-elective admissions & acuity of patients
- Increased attendances
- Norovirus
- Bed pressures and availability of flex capacity
- Reduction in home care packages within local authority services
- Social Services input

10. Conclusions

Performance against the emergency care standard poses a significant challenge both internally and for the whole system. It is imperative the whole health economy works together in order to ensure the effective and timely management of emergency patients. The overall measure of success is the 95% emergency care standard, which the Trust aimed to achieve by the end of September. Whilst progress towards achieving the target has been disappointing and slower than expected the intention is to remain focussed on its achievement this calendar year.

However, our ambitions remain:

- To improve performance month-on-month;
- Achieve the 95% emergency care standard sustainably;
- To have sufficient workforce and capacity to manage increased demands effectively;
- To smooth patient flow;
- To improve staff and patient experience.

11. Recommendation

The Board is asked to note the progress and risks.

12. References and further reading

Appendix 1 ED Recovery Plan: Weekly Progress Update
Appendix 2 Acute Task and Finish Group, Terms of Reference
Appendix 3 System Recovery Plan
Appendix 4 Designated Care of the Elderly Consultant in Emergency Department – Initial Report

Author	**Mandy McGale, Deputy Chief Operating Officer** **Lucy Turner, Head of Operational Performance**
Owner	**Juliet Walters, Chief Operating Officer**
Date	**July 2015**

Appendix 1

	Scheme	Completion Date	Lead	RAG	Progress	Key Risks
ED						
1	Enhance senior leadership, including new investment into a senior Band 8a presence on both sites.	31/08/2015	RM	Green	**07/05**: 2 appts made. Yet to start in post **14/05**: SA to start 20/07; ML to start 01/06. Inductions being booked. **21/05:** as above **29/05**: as above	
2	Develop comprehensive workforce plan across all disciplines	01/06/2015	RM	Amber	**07/05**: Nursing Workforce Review underway, to Inc. HCA Band uplift/transfer/AHO/Resus staff; additional 2 RCN per shift per day per site. RCN BEST Dependency tool underway YK, SC next week. York medical vision agreed (Inc. to 15 cons). MW&RM to work up middle grade model. Workforce Plan ready to share 28/05/15 **05/06:** No further update **14/05:** Staffing as indicated in NICE Guidance completed both sites. PHS reviewed YK data, ED to look at Scarb.. Scarb BEST tool to be undertaken next week. EPMM to be booked w/c 1st June to collate and present all findings. R&R premium agreed so can now go out to advert for cons posts. Joint advert to be agreed by 21/05. **21/05:** To be discussed with Andy/ Pat/ Juliet 9th June for non medical workforce plan as an Emergency PMM. **29/05**: as above **12/06:** RM to meet with Andy Betram later today and with Bev Geary 18/6 June to enlist there help in moving forward. RM to discuss a planned overspend for an agreed period to employ nursing staff staff the AAA. The plan will include making sure that staff do not get integrated into main department. MLocker and SE to look if this staffing is acheivable in house. RM to look at on a short term basis that overtime could be given. Need to gain HR support as not wanting to set a precedent for whole trust. RM to increase banding of Band 2 HCA's at York to Band 3. **19/06:** No further update. **26/06:** 2 long term locum adverts for York out to advert. Payment and model for medical workforce not yet agreed. RM to take unfunded posts to JW/AB for way forward (£1.2m). RM pulling un-taken BC funding into ED's. **10/07:** ED York to employ two long term consultant locums. At this stage 1 has been confirmed with a view to start mid August, disucssions taking place with agencies to source suitable candidates. The substantive advert has not yet gone out due to some queries surrounding the 2 PA's of special interest. SH - 2 Middle Grade vacancies from August/ Spetember. 1 Long term consultant locum already in post. The establishment is nearly full at SH but this does not entirely meet demand. Nursing at Adverts out for band 5+6's both sites. £1.1m unfunded posts accross the directorate.	

Emergency Care Recovery: Process Against Operational Improvement Plan

Scheme		Completion Date	Lead	RAG	Progress	Key Risks
3	Analysis of all 4hr breaches (split by admitted & non-admitted) with investigations and non-admitted without investigations)	30/04/2015	RM	Amber	**07/05**: Trends established from data collection. Weekly Breach analysis to attribute to directorate will commence once 8as are in post. MW to discuss with Ortho re direct admissions. **14/05**: High level daily breach analysis started Scarb site and due to commence in York 18/05. Need to agree professional standards that sit behind breach allocation (ECIST standards). Agreed ED pathway should be complete by 3hrs. **21/05:** York started last week. Results surprising - time to Dr assessment, being reviewed internally in ED. **29/05:** RM to provide list to Mike. Mike to talk to Ed. Orthopaedic email sent by Mike. JW - Expect developing a working model as priority. Summary of breaches at the end of the 1st month to be published **05/06**: Now in place. York showing issue with late ED Dr Review (over 3hrs currently classified ? too long). Need similar reports across both sites. Mike Lee to lead York site work to enable greater analysis. **12/06:** In place. GT to work with Becky Stephenson to ensure Scarborough breaches are correctly captured. Definition sheet for each type of breach label to be created by next week. **19/06:** No further update. **26/06:** Once 4 weeks of data achieved, a monthly analysis will be discussed at this meeting and shared with CCG's. **10/07:** ML/GT to provide a monthly report on breach analysis. The theme certainly appeared to be beds in SH at the beginning and at York it is delay to seeing ED Dr. MMcG - Stated that the breaches at SH tend to occur in the last 3-4 hours of the day and that it should be identified if there is anything that can be done to support the staff in the last few hours of the day. ES - The breaches were a hangover from earlier in the day and the reasons for breaches were often multi factorial. David Humphries is relooking at admission rights for ED. MMcG said taht it was important the the staff realise their admitting rights and what it means to them. DH will be talking at a physicians meeting to both the Elderly and Medical Teams so that a coherant approach is taken. JW - Immediate escalation should be taken if other departments are not complying. SH - PfEP - Foraml Escalation process working well. YH - NIC/DIC escalate to Bed managers hourly.	
4a	YK: Review ED processes to ensure ambulance handover achieved in less than 30-mins	30/04/2015	RM	Amber	**07/05**: Process changes. Awaiting data to see if improvements made with standard. **14/05**: Wait to initial assessment significantly reduced. Not changed ambulance handover times. **21/05:** Starting model for ambulance handover bays critical to marking change. **29/05:** No changes to update. **05/06**: Mike Lee to pick up with Jill Wilford - has action had impact on target times? **12/06:** York in place. **19/06:** No further update. **26/06:** ML reviewing Ambulance crew 'ready to leave' times are consistent with when crew leave. **10/07:** NIC actively managing the handover and log out times. Improvement seen.	

Emergency Care Recovery: Process Against Operational Improvement Plan

	Scheme	Completion Date	Lead	RAG	Progress	Key Risks
4b	SC: Review ED processes to ensure ambulance handover achieved in less than 30-mins	30/04/2015	RM	Red	**07/05**: No change yet made to processes **14/05:** Unable to make YK changes due to clinical model of early Dr triage. Feasibility of changing CPD screen for Scarb. site underway. **21/05:** Process changed Mon/ Tues. It system doesn't support clinical model. Kevin B to develop one element for Scarborough site. **29/05:** No changes to update. **05/06:** Simon Etches to confirm if CPD changes are now in place. **12/06:** The process in YH can not be replicated in SGH as discussed with both Clinical Directors. CPD needs a system change to adapt to the two slight different clinical models. RM discussed with Sue Rushbrook and this change is among many other CPD change requests. It will be allocated in due course but not for some time. This can not move forward without this change. **19/06:** No further update. **26/06:** 6 week trial of ambulance handover at Scarborough. 24hrs using overtime. **10/07:** Pilot for 6 weeks commenced 6th July.	
5	Develop and enhance support and relationship around GP OOH service	30/06/2015	RM	Amber	**07/05:** Improvement on both sites, regular mtgs established. Further work needed to move primary care work out of ED - JW to raise with Monitor/NHS Eng mtg. **14/05**: not raised with Monitor. Internal mtg 20/05 to discuss most useful GP model in ED and resolve governance issues. **21/05:** Internal and CCG group to look at different OOH models for York and contract more skin to Scarborough model. **29/05:** UCC - minor injuries SGH ?40%. Meeting to be set up st GP front end - JW/MW. **05/06**: 2nd phase incorportaing minor injuries about to go live at Scarbo'. Should take volume up to 40%. 2 wks to agree protocols. Mtg arranged with Andrew Phillips to look at model for pts being seen in ED who are more suited to primary care. **12/06:** SGH this is progressing. Minor Injuries from a date in July to be agreed. Clinical conditions that will transfer in draft. Waiting for VOCARE to agree the list. Note, this will turn all Minor Injuries into type 3 patients form type 1 with the potential to make the type 1 achievement reduce on the SGH site. YH a revised model of GP care being discussed by Juliet Walters, Mike Williams and CCG Clinical Lead for Emergency Care. **19/06:** No further update. **26/06:** JW continues to discuss with Andrew Phillips. **10/07**: Meeting re YH on 17/07 to discuss the GP in ED service and to help understand the clinical pathways for these types of patients. Yorkshire Doctors very clear that there is no change to the service that they are providing.	
Patient Flow						

Emergency Care Recovery: Process Against Operational Improvement Plan

Scheme		Completion Date	Lead	RAG	Progress	Key Risks
1a	YH: Promote further use of the Discharge Lounge review staffing model to facilitate prompt transfers	04/05/2015	MMG	Red	07/05: 11% April. Need data by Ward. MMG to bring paper update of ward utilisation held by Lounge next wk. **14/05:** JH brought March and Apr data. Av 21 pts per day discharged to lounge and only 61 pts per month are morning discharges. Action needed to move pm Disch. lounge to am and increase overall numbers. Julie P to come to mtg in 2/52 to present plan to increase utilisation. **21/05:** Nurse to be released when 24 closes, agency nurse shifts filled ad hoc int interim. SOP to be developed by JP. JP linking with Meds. Management to educate discharge lounge. Julie and Rodger to develop single plan and SOP. **29/05:** MMcG - Staff recruited to on both sites and will be in post by end July. **05/06**: JP to provide wards with monthly performance report . Expect throughout to double to 60 pts per day by end July. YH site - are undertaking an audit to ensure CPD includes all their workload. **12/06**: JH had prepared the figures surrounding the DL. MMcG suggested that it was needed to operationally show the DC numbers could be doubled. RF/JP to provide performance report re DL to provide evidence on the impact that this has had. Now being shown on Bed managers wards lists rather than paper based. **19/06:** Plan in place for staff in post - this is to make a clear increase in the numbers going through the DC. Need to ensure that the wards where beds are required ie Medical beds are utilisng this facility fully. 26/06: Qualified Nurse available in DL from 29/06. Lou Parker working with departmnet for detailed improvement plan and increasing utilisation rates. Highest user of lounge is ESA. All wards to be given improvement targets. Discrepancy re FL figures and CPD: currently 10% - 25% of discharges through lounge. **03/07:** Permenant Staff nurse n ow in post. JP to provide acton plan for next meeting (10 July) as Time Out was cancelled for 2nd July. JH stated that the figures were increasing steadily and that York was on tracK to make the 50% increase on figures (March 19). **10/07:** JP/LP have developed detailed plan. DL seeing increase in numbers JP to supply current figures for York. SH - Significant incrase in since April (5% use) to June (31% use).	
1b	SC: Promote further use of the Discharge Lounge review staffing model to facilitate prompt transfers	04/05/2015	MMG	Amber	**07/05**: Increased from 5-30%. Target is 60%. **14/05:** Rodger to bring Scarb plan in 2/52. **21/05:** To discuss in 1 week. **29/05:** McMG - Joint staff time out day planned for end July/early Aug to facilitate staff training and consistency and a work plan to agree a work plan for increasing utilisation. , including meds management training. Joint protocol (SOP) is with Emma Day re SH site. Completion for next week. **05/06**: No further update. **12/06**: The online system that has recenly been implemented at York will be trialled for 4 weeks and then rolled out at Scarborough. **19/06:** Detailed improvement plan with an increase to 75.9%. **26/06:** Roger completing Project plan. Paper to be sent out in advance of meeting on 3rd July. Same model as using for York. Targets TBA. **03/07:** RF provided plan. Please see additional handout. **10/07:** No further update.	

Emergency Care Recovery: Process Against Operational Improvement Plan

Scheme		Completion Date	Lead	RAG	Progress	Key Risks
2	Roll out of real time reporting in ED, inpatient transfer and live bed-state	01/06/2015	MMG	Amber	**07/05**: MMG met with IJ and Dr and plan in development. Training programme needed. Boards live in YK ED, not yet in SC ED **14/05**: Deferred in MMG absence, no update available. **21/05:** Next roll out is ED to pend transfer to ward don't have to input conclusion time. **29/05:** MMcG - Implemented in York on Monday 1 June. Dr Richardson is aiming to facilitate a day in SH on Wednesday 10 June to start staff training and process changes with appropriate staff. Screens ordered, awaiting delivery and fitting. **05/06**: York pts now pended and ED declaring pts fit for transfer on CPD. Dr R writing SOPs. Once trial complete in York , plan to roll out to Scarborough. **12/06**: Complete at York - in AMU and ED. This will help to improve the communications between the two areas even if it does not directly improve transfer times. **19/06:** No further update. **26/06:** Hardware on order for Scarborough site. Developed BM 'Safer' Bundle at Scarborough, will be shared with York. **03/07**: Waiting for equipment. RM to ask SNS for update. **10/07:** Location of boards identified, safer bundle can not operate without the hardware. Noted to be small number of IT glitches - for eg patients stuck in system - SR talking to team to try and resolve any of these glitches.	
3a	YK: Develop Integrated Operations Centre with Standardise layout, use of IT, Visual Hospital and patient flow structure	30/08/2015	JP	Green	**07/05**: IT item agreed, capital scheme approved but dependent on other capital schemes for go live date **14/05**: JH to update on date for completion of scheme 1/52. **21/05:** Trying to reduce scheme time. Start date imminent. Julie to feedback to Gail Tanner on start date. **29/05:** Consistency in use of electronic system. JP to provide update on progress **05/06**: Currently with contractor. Waiting for start and completion dates. Model of working already in place. **12/06:** Progressing well. Contractors started. GT to obtain update from JP. **19/06:** Scheme is underway, Screens are ordered. Time our Monday am - which part of this includes how the ops centre works. There is an ops centre at both sites with a potential growth to a single integrated centre. **26/06:** On plan. **03/07**: On plan. **10/07:** No further update.	
3b	SC: Develop Integrated Operations Centre with Standardise layout, use of IT, Visual Hospital and patient flow structure	30/08/2015	Roger Frampton	Green	**07/05**: Ian Jackson reviewing SC data items w/c 04/05. **14/05**: Air con ordered and screen available. **21/05:** RM to ask Andy Betts for update. **29/05:** Consistency in use of electronic system. RF to provide update on progress **05/06:** Waiitng for trial to run in York. Will implement 6 screens (York 3) **12/06:** Due for completion 30 August. **19/06:** MMcG - this is agreed. **26/06:** On plan. Agreed equipment standards. **03/07:** On plan. **10/07:** No further update.	

	Scheme	Completion Date	Lead	RAG	Progress	Key Risks
4	Develop single Trust wide Patient Flow Escalation Policy	31/05/2015	MMG	Red	**07/05**: Policy will be out for consultation by 21/05. est. end of June for final approval **14/05:** MMG has delegated to SL, RM and JT. Will not be ready for consultation by 21/05. Need to think of whole health economy approach escalation levels also. **21/05:** RM/ SL/JT/JP met 20/05 to review Morcambe Bay policy, will now review South Tees/ Birmingham policies to see if we can use these. A lot more work to do, more realistic to draft a policy for consultation by 22/06. **29/05:** Internal escalation plan to be prepeared by Jamie Todd, Sharon Lewis and Richard Morris with a view of having this read for Urgent Care boards - 6weeks. JW to take to UCWG to request a region wide approach to escalation JW to table as an agenda item. **05/06**: Whole Health Ecocnomy escalation plan is important but Internal Group continues to meet to finalise details. **12/06:** JT, SL, RM to meet to discuss the escalation policy. Need to decide on internal trigger points to put into the policy. JT stated that there is 2 different issues involving this; a regional response and internal understanding of when/ who to escalate. **19/06**: Internal meeting to take place end of week commencing 22 June between RM, SL, JP, RF and Sue Hendry. This is to identify the local trigger points for escalation. MMcG working on the Trust wide escalation policy in terms of external excalation and the points decided form the meeting will feed in to this.	
					26/06: Met with CCG's 22/06 and they will lead as a Task and Finish group. Based on triggers and actions for whole health economy. Internal group working on triggers which will feed into this group. **03/07:** SL/JT/Rm to work up trigger points for escalation. For the whole system looking at an end of September finish. **10/07**: No further update.	
Pathway Redesign						
1	Combine AMU/SSW at York	30/05/2015	SL	Green	**07/05**: Ambulatory care starts 12/05 and Inc. a more merged bed base. Staffing shortages are a limiting factor. Need go live date for full merger. **14/05:** Ambulatory Care pilot delayed. No update on SSW/AMU merger. **21/05:** Issue with staffing levels over night. To start 01/06, unit open 60 beds inc Ambulatory unit. Some shifts will have to be filled by Bank Shifts. Will reduce transfers. **29/05**: To commence Monday 1st June. **05/06**: JW requested SL to provide baseline and progress data on reduced transfers. **26/06: Issues with identifying patients suitable to outlie. Staff are positive re the merger.** **03/07: Since the merger it has been noted that the flow has slightly slowed. However this was not due to the merger - 3 Elderly Consultants down and that there is fragmentation within the Middle Grades between SSW and AMU.**	
2	Include Trauma admissions in SAU at Scarborough	01/08/2015	MMG	Green	**07/05**: Discussions on-going between GS/T&O. Decision expected in 2/52 about suitable pts. Need to develop similar direct admission process on YK site. **21/05:** SAU currently full of medical patients. **29/05:** Agreed when SAU returns. Waiting clinical sign off Paul R actively chasing this. **05/06**: SOP agreed for Trauma Pts. **12/06:** No update. **19/06:** Functioning. Paul R and Liz Hill agreed process.	

Emergency Care Recovery: Process Against Operational Improvement Plan

Scheme		Completion Date	Lead	RAG	Progress	Key Risks
3a	Pilot a Plan for Every Patient at Scarborough	30/05/2015	MMG	Green	**12/06:** Plan was to role out within 18 months which would be a completion date of March 16. **19/06:** On target for March 16 completion date. Compliance audit used. **26/06:** 3 wards to go live in the next three weeks: Oak, Chestnut and Beech. **03/07:** 3 ward are running, 1 of them struggling with compliance. To go live at 4 more wards; Beech, Chesnut, Oak and Lilac. **10/07:** 4 more wards have now gone live. The compliance levels are now improved.	
3b	PfEP Link with electronic Board Round system	30/05/2015	MMG	Green	07/05: Rollout has commenced on key wards. Agreed that symbols will be changed on electronic boards. Training not yet agreed. 14/05: No update available in MMG absence 21/05: SOP in place by 2nd week in June. Timings in SOP being reviewed. 29/05: NB note change in completion date. MMcG - Good progress made. - Board rounds rolling out in York. SOP under development by Donald Richardson. Staff training will follow. SH roll out will then be agreed with Bev Geary and Emma Day. Symbols will be reviewed with Donald and Emma next week. 05/06: Group agreed to revert back to original date in Perf Recovery Plan for target - note that this has slipped. Noted that roll out to ED would require sufficient admin support. **12/06:** MMCG Meeting with Bev Geary and Emma Day to agree role out plan for SGH site on 16/06. **19/06:** Emma Day to provide timeline on this. **26/06:** No update. **03/07:** Waiting for roll out. SOP being developed. At ward level this is being used at safety briefings. **10/07:** The board has been developed with SR, RM to see how it looks.	
3c	PfEP roll out to ED.	20/09/2015	RM	Green	**12/06:** Temporary funding would be allocated for an admin person 12hrs per day. SE to provde a written process of managing pt flow. To be tested in ED and rolled out to AMU if achievable. Implement in July 2015. **19/06**: This is ongoing. The board has been ordered. SOP has been drawn up.MMG has identified a Band 3 administrator to operate as the Discharge Liaison Officer. **26/06:** Temporary DLO in post. Boards to go up next week. Going live in ED with revised patient timeline (110 min timed pathway). To go live 1st July. **03/07:** Started in its entirety on Monday in ED. This shows bands of time for each process for each patient. **10/07:** DLO managing the board. Live on the 6th. Some senior staff finding it difficult (feels like they have lost control) however this is individual staff dependant. Blood results returning can be causing delay. The doctors are engaged in this process.	

Emergency Care Recovery: Process Against Operational Improvement Plan

Scheme		Completion Date	Lead	RAG	Progress	Key Risks
4	Review existing models of Early Supported Discharge and expand where appropriate	01/09/2015	ML	Green	07/05: SC ESD live by end of July. MH to update for next time. 14/05: No update provided 21/05: Gail Tanner to ask MH for update. 29/05: No update provided 05/06: Need to update lead for this to Mel Liley or MMcG - MMcG to advise at next mtg 12/06: Mel Liley to update. **19/06:** Mel Liley to update. **26/06:** Mel Liley to update. **03/07:** ML provided the following update - Stroke ESD service fully operational for City of York and Scarborough Ryedale; Vale of York CCG have not commissioned the service of the NYCC geography of their population at this time, but we continue to try to influence the expansion of the York service; ER CCG have not commissioned a stroke ESD service for the ERCC geography at this time, but we continue to try to influence this plan. ESD principles are now expected to be part of the review of existing therapy led pathways and for the development of all new pathways, strengthening the links between inpatient therapy teams and community therapy rehab teams. **10/07**: No further update.	
5a	YK: Develop Ambulatory Care	not in plan	SL	Amber	**07/05**: Start date on AMU 12/05. Can't mirror pilot as lack of space on AMU [DVT to remain in ED]. Interim solution. MH working up LT options appraisal paper. **14/05:** Pilot could not start as took 10 beds out of system. Mtg to discuss options for ward 24 this week. **21/05:** If can empty 24a, interim ambulatory care to be established on June 1st. Options under consideration for location of unit long term. **29/05:** Monday 1st June ward 24 opens as temporary Amb Care. 2 weeks time for business case costs from capital team Andrew Bennet providign this. Full BC in 4 weeks written by MH **05/06**: Interim solution opened 01/06. Numbers pts dropped as wk progressed (16-6). JW requested weekly figures of pts going thro' unit. SL to provide. Noted DVT pts remain in ED so figures will not be as high as previous pilot. **12/06**: MH and RM meeting Capital Planning 15/06 to understand all the costed options to be able to present in the business case. **19/06:** W24 for the forseeable would remain AMC. This is a capital planning building scheme with costs expected to be £800 - £850k. the earliest it could possibly be delivered is late November/ December. There has been a number of options been considered including the physio gymn on W24 and the Orthopaedic admin suite with Ortho OPD. Vikki Parkin to give her thoughts by next week.	

Scheme		Completion Date	Lead	RAG	Progress	Key Risks
					26/06: Very low numbers on a weekend. **03/07:** There has started to be an increase in the number going through the AMC. The majority of disposals are discharges. Meeting to be held this pm re AMC. This again will try and decide the best possibility for the permenant position of the facility. RM stated that there needs to be a contingency for winter as any facility would not be ready until at least December Business case going in on 6th. **10/07:** Ward 24 working ok. Not having a great impact on ED, more impacting the Medical Team. GT to provide figures re DVT breaches in ED. Longer term location needs to be decided upon. Meeting took place where the majority decided that the 2nd floor near medics would be best.	
5b	SC: Develop Ambulatory Care	not in plan	RM	Amber	**07/05**: Opt Hal moved out of Dales, capital completed by 30/06 then will be opened as Ambulatory Area. Currently sees 5-6 pts. per day, need analysis of predicted numbers post June. **14/05:** If move goes ahead requires £100k capacity to enable which will also cause time delays. **21/05**: Meeting held 20/05 to discuss Dales as a unit environment. No longer considered such a big capital scheme. Need to look at seperate cold and hot ambulatory care pathways. **29/05:** Inital plans drawn up and work commencing on dales unit led by Andy Betts team not capital team. Agreed to progess by Brian Golding. **05/06**: Confirmed air handling not req'd. 4 wks work needed. Est. in unit by end of July. **12/06:** Work started 10/6 have been assured will take 4 weeks. MH preparing Buisness Case. **19/06:** This is to be ready from 20th July from a building perspective. This is happening on the Dales unit. SL stated that there was still discussions re hot and cold but is possible that Bridlington could take the cold. **26/06:** Karen Cowley working up options for cold med elective work (deadline still 20th July). **03/07:** Building due to be ready on 20th July. The hot and cold work can not be split. **10/07:** SH running to schedule. Hot and cold can not be split due to casemix. MH/RM/SL to meet to decide which "cold" could go to Bridlington. Prject plan to be in place by 17th.	
	YK: Develop Acute Frailty Model	01/09/2015	JT	Green	**07/05**: Geriatrician to work in ED 1300-1700 M-F with RATs to help with admission avoidance **14/05:** Continuing to test change, collaborative model being questioned by CD **21/05:** Remove geriatrician interface with ED, working up frailty unit instead. Referral criteria for unit under way. JT to see if can do inreach model in short term whilst frailty model worked up. **29/05:** Not discussed **05/06:** Moved from in-reach model to a frailty unit model. Older People Assessment Lounge - proposal = hybrid of ambulatory and assessment 11am-8pm 5 days per week. Linked to SSW for older people. **12/06:** SOP needed from JP re the practicalities about referring up. A July implemetation date is in place. Meeting with Gen Med, ED and Elderly on 15/06 to agree impleention time frame. **19/06:** Meeting held last week. Questions have arised following that meeting. SOP to be agreed for finer details. **26/06:** No Update. **03/07:** RM again stated tht MH had the that the finer details were yet to be defined.	

Scheme		Completion Date	Lead	RAG	Progress	Key Risks
6a					**10/07**: JT Issues around identifying most suitable location. THE SOP has been work up and the pathway defined. There was meeting on 9th July to get the clinical view on the best location. Progress being made in upgrading the Business Case for this project. LT - Streaming of this is difficult. 600 bed days reduced by seeing the geriatrician earlier. JT stated that all tools are there - just needs a Corporate Steer to get the plan moving and to implement.	
6b	SC: Develop Acute Frailty Model	01/09/2015	JT	Amber	**07/05**: Tested for 8 days, results variable. Workforce availability key limiting factor. To re-test based on ED in reach vision. **14/05:** Pilot of in reach clinical cover continues on Scarborough site. **21/05:** Plans and SOP to be agreed for inreach model to ED. Costs are worked up. Sign off costs for costs of model waiting for JW to approve. **29/05:** Not discussed **05/06:** Seeking funding from corporate directors on 08/06 for 4wk in-reach pilot utilising Ruth Griffin. **12/06:** Ruth Griffin in place. Deciding how to make best use if this placement whether to base Ruth solely in ED or jointly between Graham (10 bed) ward and ED. **19/06:** MMcG stated that this was starting in Scarborough 29th June. **26/06:** Ruth griffin starts 29/06 for 1 month. Locum to backfill Ruth in York. **03/07:** RG is in post and is solely being kept in ED as to give a true picture of the volume of frail patients that she is seeing, assessing and discharging from ED. **10/07:** Very positive feedback re Ruth Griffin in Scarborough. After pilot would have to decide on what the plan will be.	
Trust-Wide System						
1	Model bed requirements across Trust (current and future state)	31/05/2015	MH	Red	**07/05**: Awaiting data from Sue R. JW to update next wk. **14/05:** No further update **21/05:** Model under development with **SNS.** **29/05:** Not discussed **05/06**: Model developed, in testing phase. No completion date as yet. **12/06:** Not discussed **19/06:** MH to Update. **26/06**: MH and SNS to meet with Directors to go through model and assumptions. **03/07:** MH to provide update. The following update has been supplied - There have been a series of meetings with each specialty area individually, which begin a couple of weeks ago. The remaining specialties will be meeting over the next two weeks. Each specialty area will have a meeting with the bed modelling team, before agreeing with SNS the methodology that will be undertaken to conclude what changes may be needed to specialty bed bases. Following the conclusion of these meetings timeframes will be set to produce the final bed number models. **10/07:** SNS to meet with LT. Need to decide what will be done from the data collected and the methodology behind it.	

Emergency Care Recovery: Process Against Operational Improvement Plan

	Scheme	Completion Date	Lead	RAG	Progress	Key Risks
2	Develop plans for 7-day working - acute	31/05/2015	MH	Amber	**07/05**: Baseline WR position est. & GAP analysis to Corp Dir. next wk. 42 sessions short. Small working group to be est. to look at Keogh Standards **14/05:** Top organisational priority and plans under development by directorates, Significant gaps. **21/05:** Directorate asked to complete NHS England template by 25/05. **29/05:** Not discussed **05/06**: York on line assessment 70% complete. Scarbo' to be done by 18th June. **12/06**: Not discussed **19/06:** MH writing plan for this. **26/06:** 2nd phase and data re-released on both sites as same data items incomplete. **03/07:** Open now for 'refresh' on website.The high level report needs more indepth specialty information adding to it. **10/07:** To invite MH to attend meetings on ad hoc basis to give updates.	
3	Ensure sufficient community bed capacity & services to support discharges	31/05/2015	WS	Red	**07/05**:no update available **14/05:** Reconfiguration of WXC/ SH no start date as yet. Community Discharge Liaison to start Aug. **21/05:** Locality managers part of DL team time out 20/05. **29/05:** Not discussed **05/06:** Unclear what this indicator is now - need to quantify - ?? who is responsible for this? **12/06:** Not discussed **19/06:** RM to provide update. **26/06:** Need update from Wendy Soctt re community discharge liaison - RM to chase. **03/07:** GT to request update from WS. WS has provided the following:We are seeking to ensure that we optimise capacity across community services, including Community Hospital IP beds. We have appointed to a Band 7 Community Discharge Liaison Post to manage complex community hospital discharges and will appoint to the supporting team (a Band 5 and a Band 3) over the next few months. Target LOS reductions have been identified as part of the project work that supports these appointments. This in turn will support increased throughput and utilisation of the community hospital IP beds. In addition the Community Response Teams in York, Selby and Ryedale are screening community hospital waiting lists to ensure that patients who can be manage and supported at home are diverted into appropraite community teams, rather then placed into a community hospital bed. **10/07:** No further update	

Emergency Care Recovery: Process Against Operational Improvement Plan

Scheme		Completion Date	Lead	RAG	Progress	Key Risks
4a	Reduce Delayed Discharges and Delayed Transfers of Care.	30/06/2015	MMG	Amber	**07/05**: Team time out day planned to change pathways and ways of working, Inc. LA, community and SIT. Need to agree as a Trust % of delays we think are reasonable. MMG to email JW with delays other than 2s/5s **14/05**: CCG using Winter Resilience plans to spot purchase beds in May so reduces winter funds available. RM to find out date of time out. **29/05**: MMcG - Good progress made. Multidisciplinary 1st time out day happened as planned on the SH site 17 may to review SH way of working. The York time out day will be in July. The final stakeholder day to agree to a common working practice across H&SC will be facilitated in Sept **12/06:** Not discussed **19/06:** Trust "Time Out" in July and the last "Time Out" day planned for September. MMcG to find out exact date and then update mtg. **26/06:** Reciprocal visit to take place next week. Aim to agree cross-site common model. Lou Parker developing draft project plan. **03/07:** GT to request update from Lou Parker. **10/07:** Await update from Lou Parker.	
4b	Reducing delays to transfer to other community units and hospices.	24/07/2015	JH	Amber	**21/05:** DL team time out to look at visual hosp and how council worked. Follow up meeting to discuss next steps. York re-est. weekly escalation SITREP meetings to discuss increasing patients medically fit for discharge waiting for packages of care at home. Looking at alternatives and escalating. **05/06:** Action notes needed from time-out. JH picking up DD Escalation latter for pts discharged to care and own home. York council have ongoing recruitment difficulties - JH to pick up with Wendy Scott re different recruitment models. **19/06:** Currently there is a small element of staff in certain areas which need to get on board with the fact that it is not ok for a patient to turn down community bed if one available in order to stay an inpatient of the hospital. JH advised the group that the prinicple of the letters were agreed, although the letters still needed a little work on them to be at the correct comprehension level for patients. RF/JH to co-ordinate. The information leaflets would need to be signed off by Pamela Hayward-Sampson to ensure that there is no "Jargon" contained. Ultimately the Ward Sister, DM's and Consultants and CD's will have to sign these. **26/06:** Commissioners and LA involved in updating patients letter. Home of choice and step down facilities are now included in the letter. Will have to go through legal process. Letters will be undersigned by clinical colleagues (Sister/CD/Med. Director/ Direc. of Nursing). Letters will be presented to Hospital Boards prior to final sign off. **03/07:** PHS has has passed by BG, the expectations of JW re escalation. The discharge policy has been updated which is welcomed but it needs to include the correct letters. MMG suggested that there could be training needs for staff to meet with families. RF agreed and said that there was need to gain consistency and clarity of expectations. **10/07:** JH to update.	

Terms of Reference

Acute Care Task & Finish Group

Purpose
The purpose of the Task and Finish Group is to provide senior clinical and operational leadership to a range of priority initiatives in order to support the roll-out of the Trust's clinical strategy and address its operational and financial recovery.

The Task & Finish Group will be a small action focussed group comprising key individuals that collectively will be empowered and have delegated authority from the Trust Executive Board to set priorities, agree performance outputs, drive forward those priorities and set the pace of change. Key to the role of the Group is to ensure a high level of clinical input and engagement.

Membership of the Group will flex according to the priority initiatives agreed. It is intended that only a small number of priorities will be focussed on at any one time in order to ensure focus and delivery. Whilst small in number, these priorities will have a significant impact on the Trust's overall recovery.

The immediate priorities the Task and Finish Group will be responsible for delivering are:

- Emergency Department - oversee the delivery of new models of working with primary care, within the EDs at both sites, and in terms of development of new pathways, e.g. DVT
- Ambulatory Care - oversee the implementation and expansion of ambulatory care services at both acute sites across the Trust.
- Scarborough Recovery Plan and new model of working in ED and AMU – oversee the short-term operational recovery of the site and agree the acute medical model.
- 7 Acute Services (as set out in the NHS England national clinical standards) - this will include the following tasks to be completed (not exhaustive list):
    - Approve the baseline assessment of 7 day services across the Trust
    - Use the baseline assessment to complete a coherent plan to deliver 7 day services
    - Agree new models of working and working arrangements for all relevant staff groups and professions to support 7 day services
    - Hold directorates to account for delivering changes to their current working practices, as decided upon by this group, including review of job plans
- Acute Frailty – oversee the development and roll-out of acute frailty and elderly assessment models
- Trust Winter Resilience Plan for 2015/16 – formulate the plan to ensure resilience is optimised.

Timeframes
These will need to be agreed on an item by item basis by the group once it has convened.

Membership
1. Nigel Durham – Clinical Director for Acute & General Medicine in York (chair)
2. Hasan Al-Shakerchi – Clinical Lead for Acute Medicine
3. Nick Carrington – Clinical Director, Trauma & Orthopaedics
4. Karen Goodman – Clinical Director for Elderly Medicine
5. James Haselden – Clinical Director for Radiology
6. Ed Jones – Clinical Lead for Elderly Medicine, Scarborough
7. Helen Hey – Deputy Chief Nurse
8. Mark Hindmarsh – Head of Operational Strategy
9. David Humphriss – Clinical Director for Acute & General Medicine in Scarborough
10. Sharon Lewis – Directorate Manager, Acute and General Medicine
11. Melanie Liley – Head of AHP Services & Psychological Medicine Directorate
12. Mandy McGale – Deputy Chief Operating Officer

13. Mike Williams – Clinical Director for Emergency Medicine
14. Juliet Walters – Chief Operating Officer
15. Sue Rushbrook – Director of Systems & Networks
16. Ed Smith – Emergency Medical Consultant and Interim Medical Director
17. Neil Todd – Clinical Director for Pathology

To be invited as per specific items on the agenda:

- David Alexander – Clinical Lead for Cancer Services
- David Pitkin – Directorate Manager for Pharmacy
- Graham Lamb – Deputy Finance Director
- Directorate Managers
- James Hayward – Head of Capital Estates Projects

Accountability
The group is directly accountable to the Trust Executive Board. An update from this Group will be a standing item on the Executive Board Agenda, and the appointed Chair will provide an update monthly.

Key links to other groups
Representatives from the Group will also provide, where appropriate, updates to the other following Trust forums:

- Planned Care Task & Finish Group
- Operations Steering Group
- York and Scarborough Hospital Boards
- Executive Board

Frequency and scheduling
The meeting should be monthly in the first instance and should last no longer than two hours. This should be reviewed after three months to check appropriateness.

The meeting should be scheduled to take place a week before the Trust Executive Board meeting.

Administration
Papers should be circulated two days before. Any proposed agenda items should be approved by the Chair prior to the agenda being circulated.

Review
These terms of reference should be reviewed after three months to ensure they accurately reflect the function of the group.

Vale of York, Scarborough and Bridlington System Recovery Plan 2015-16

Aim: Ensure safe, sustainable health care services delivering NHS Constitution Standards

	Prevention and Informed Patient	Reducing avoidable admissions	Effective assessment and streaming	Unblock flow constraints	Improve transfer of care	Regional Review
	Public Health & Primary Care			Secondary Care		Tertiary Care
Unplanned Care	Alcohol and Substance Misuse Pharmacy/ Minor Ailments Arclight homelessness support worker Choose Well Campaign Flu Vaccinations Effective self-management of long term conditions	Community Hubs York Community Integration model Scarborough and East Riding Community Services Revised Specifications Intermediate Care Frailty Pathway IAPT Social Care 7 day working Street Triage Block purchase step down residential nursing home beds	Out of Hours VoY GP Practice at the front door Ambulatory Care Emergency Care Practitioners Liaison Psychiatry SRCCG Integrated OOH/Urgent Care Service SRCCG Operation Fresh-Start	Trust recovery plan - analysis of 4 hr breach - ED workforce plan - Patient flow escalation - Real time data - Integrated Operations Centre - Review of ED processes Hospital OOH support worker (Age UK) Review of Critical Care 7 day working	Plan for every patient Early supported discharge Intensive Reablement Support Beds & block purchase step down residential nursing home beds Use of Discharge lounge	Urgent Care Network Y&H review of stroke pathways Review of cardiac pathways

Key Performance Measure: 4 hour ED Target

Programme Board: Collaborative Improvement Board
Programme Office: Joint Programme Team – primary care/ CCG/ Trust/ NHSE
Delivery Groups: Urgent Care and Planned Care Working Groups, Primary Care Strategy Group
Cross Cutting Work-streams: Workforce, IT

Vale of York, Scarborough and Bridlington System Recovery Plan 2015-16 - Delivery Plan (Final draft)

Aim: Ensure safe, sustainable health care services delivering NHS Constitution Standards

UNPLANNED CARE

Workstream	Associated Actions	Locality	Timescale	Lead Organisation	Timescale for ongoing impact*
Prevention and Patient Choice	Choose Well Campaign	All		Public Health/ CCG	Medium term
	Survey of A&E attendees	Vale of York	Initial survey completed. Additional surveys planned during Q2	Healthwatch	Short term
	Minor Ailments Scheme	Vale of York	Q3	CCG	Short – medium term
	Arclight homeless support worker	City of York	In place	CCG	Immediate
	Alcohol Strategy	All	Q3	Public Health	Medium – long term
	Flu jabs	All	Q3-4	Public Health/ NHS employers	Short term
	Effective self-management of long term conditions	All	Diabetes pathway in place Review of Stoma Care in-year	CCG	Medium to long term
Primary Care Access	Demand and Capacity modelling	Vale of York	Q2	CCG/ Primary Care	Short- medium term
	Incentivise primary care extended access	All	Q4	CCG	Short – medium term
	Foundation Trust Access Study to determine capacity requirements	SRCCG	Q2	CCG	Medium to long term

Workstream	Associated Actions	Locality	Timescale	Lead Organisation	Timescale for ongoing impact*
	Primary Care led assessment in A&E	York site	Q4	CCG	Short- medium term
	Community Hospital Screening	Selby & Malton	Q3	Trust	Short-Medium term
Reducing Avoidable Admission	Review of all SRG schemes	All	Q2 to demonstrate impact	CCG	Short term
	Implementation of high impact interventions	All	Q2- Q4	CCG	Short – medium term
	Intermediate care frailty pathway	All	Q3	CCG	Medium term
	Primary care frailty model	SRCCG	Q3	CCG	Medium to long term
	Street Triage	York SRCCG	In place In place	CCG	Immediate
	RATS extension	All	In place	CCG	Immediate
	Community Integration model/ Community hubs	Vale of York SRCCG	Pilot hubs in place Provider model development ongoing	CCG	Medium-long term. Some in-year impact through Care Hub pilots
	Urgent Care Practitioners	All	Q2	YAS	Short term
	Hospice at home	Vale of York SRCCG	In place	CCG	Immediate
	Step up Beds	Scarborough and Ryedale CCG	tbc	CCG	
	Effective out of hours service	All	In place Enhanced service specification for Vale of York	Out of hours Providers	Short- medium term

Workstream	Associated Actions	Locality	Timescale	Lead Organisation	Timescale for ongoing impact*
	Review and benchmark intermediate care services across the patch	All	Q3	CYC/ Trust/ CCG	Long term
	Social Care 7 day working	All	To be scoped	Local authority	Long term
Effective Assessment and Streaming	Ambulatory Care -extend to all pathways	All	Ongoing - York 6 pathways established remaining require business case and capital investment - Scarborough 3 pathways established roll out of remaining pathways	Trust	Immediate
	Integrated OOH/urgent care service	Scarborough and Ryedale	1st phase minor ailments in place 2nd phase 0 minor ailments to be rolled out	CCG	Immediate
	Liaison Psychiatry	York Site	In place	Mental Health provider	Immediate
	Operation Fresh Start	Scarborough and Ryedale	In place	CCG/ Trust	Immediate/ short term
	Primary care assessment model at ED 'front door'	York	Q2 (quarterly review)	CCG/Trust	To be determined
	Comprehensive workforce plan for A&E	All	Q3	Trust	Short – medium term
	Acute Frailty Model	All	Q3	Trust	Short – medium term

Workstream	Associated Actions	Locality	Timescale	Lead Organisation	Timescale for ongoing impact*
Unblock patient flow	Implement internal trust recovery plan structure	All	Ongoing	Trust	Short – medium term
	Implement discharge to assess model	All	Q1	Trust/ CCG/ LA	Tbc
	Develop single trust wide patient flow escalation policy (all)	All	Q1	Trust	Short term/ Medium Term
	Intensive reablement support beds and step down residential nursing home beds	All	In place York Tbc	CCG	Immediate
	Ensure sufficient community bed capacity and services to support discharges	All (no community beds Scarborough and Ryedale)	Q1 Baseline	Trust	Short term
	Review existing models of Early Supported Discharge and expand as appropriate	All	Q2 baseline	Trust	Short-medium term
	Model bed requirements across the Trust (Bed optimisation)	All	Q2 Baseline	Trust	Short – medium term
	Reduce delayed discharges and Delayed Transfers of Care	All	Ongoing	Trust/ CCG/ LA	Short term
	Implement treat and triage model for stroke care	Scarborough (impact York)	Q4	Trust	Impact to be determined
	Community Discharge Liaison	All	In place	Trust	Immediate/ short

Workstream	Associated Actions	Locality	Timescale	Lead Organisation	Timescale for ongoing impact*
	Service				term
	'Status Boards' (pro-active 'pulling' of patients)	Malton, Selby & York	Q3	Trust	Short- medium term
	Reconfiguration of the York Community Hospitals Units	York	Q3	Trust	Medium term
	Implement 'Home of Choice' policy	All	Q2	Trust	Short term
	Implement treat and triage model for stroke care	Scarborough (impact York)	Q4	Trust	Impact to be determined
	Development of an urgent care network	All	Q3	CCG	Short – medium term
	Implement plan for every patient	Scarborough	Roll out Q1 (18 month plan)	Trust	Long term
Improve transfer of care	Review of Cardiac pathways	All	to be confirmed		
	Development of an urgent care network	All	Tbc	CCG	

Designated Care of the Elderly Consultant in Emergency Department – Initial Report

1. Introduction & Scope

The Emergency Department (ED) at Scarborough Hospital has approximately 53,000 attendances per annum (an average of 145 per day), of these attendances a high proportion are older people – defined for this pilot as individuals aged 78 years or older.

Within the current model of assessment and care provided in ED many of these patients are admitted and have a significant impact on the use of the hospital bed base.

In May 2014 Scarborough Hospital undertook a 'Perfect Week' initiative. During 5 days of this 8 day period Elderly Care Consultants worked from 09.00 – 17.00 based in ED to assess and plan care for all patients of 78 years and above. This was assessed as being a successful element of the Perfect week, with on one day 50% of this cohort of patients being assessed and discharged safely back into the community.

The drivers for this are seen as:

1.1 Pressure of the ED target and achieving consistent 4 hour emergency waiting times.
1.2 Reduction in admission of older people who could be better cared for in their home or other community environment.
1.3 Reduction in hospital bed occupancy and outliers.
1.4 Reduction of risk of hospital acquired infections in older people who often when admitted have a significant length of stay.
1.5 Impacts on diagnostics as older people often when admitted undergo many diagnostic tests.
1.6 Overall impact on patient experience as generally people find it preferable to be cared for near to their home.

2. Objectives

- Reduce time spent in ED for patients aged 78 and above.
- To reduce the number of unplanned admissions to a hospital bed for patients aged 78 and above.
- Ensure all patients of 78 and above have a comprehensive plan of care including a planned date of discharge.
- To increase the number of direct admissions from ED to the CoOP specialty wards.

3. Date of Pilot and Hours of Operation

3.1 This pilot will commence on 29th June 2015 and will run for three months finishing on 25th September 2015 (the pilot consultant has study leave 20th – 24th July).
3.2 The ED attendance profile of patients 78 years and older shows that attendances occur in the main between 09.00 – 17.00, so the pilot will start with these as core hours, but this will be reviewed.
3.3 Due to the fact that there is only one individual funded to act in the role as Care of the Older Person Consultant ED the pilot will run Monday to Friday.

4. Staffing

4.1 The staffing model for the three month pilot is as follows:-

Staffing
1 Consultant – PAs – 10 **Working clinically Mon, Tues, Thur, Fri** **Admin – Wed**

5. Pilot Performance

For the purposes of this analysis the data to be assessed will be as follows:

- Monday 15th June 2015 – Sunday 28th June 2015 (This is the two weeks prior to the pilot commencing)
- Monday 29th June 2015 – Sunday 12th July 2015 (This is the first two weeks of the pilot being in operation)

It is acknowledged that the above time period for collection of data and contrasting period data may not yet provide a robust basis to make final assessments or success of the pilot however it is agreed that this early analysis will give an overall feel for potential benefits realisation and provide an insight into the performance of the pilot.

5.1 Analysis

As detailed earlier in this report, the pathway operates between the hours of 9am and 5pm Monday to Friday and therefore it is data between these time and date periods which will be presented and reflected in any conclusions that are drawn from this initial analysis.

The following criteria were utilised to filter the data:

- Site (Scarborough)
- Time period (i.e. date range)
- Sub location (ED Majors)
- Age (>78)
- Disposal type (i.e. either Admit to Trust or Discharged)

Table 1

Patients >78 attending ED Majors	**2 Weeks Prior to Pilot** 15/06/15 - 28/06/15	**First 2 weeks of Pilot** - 29/06/15 - 12/07/15	**Difference**	**% Improvement / Difference**
Total Attendances 9am-5pm	122	97	25	20.49%
Total Admissions to Trust 9am-5pm	86	53	33	38.37%
Total Direct Discharges from ED 9am-5pm	23	39	-16	-69.57%

5.2 Commentary

As detailed above, within the control period prior to the pilot there were 20.49% higher attendances of patients >78 into ED majors. However it is clear that contrasting the two periods that proportionately there was a significant improvement in numbers within the cohort admitted into the organisation from ED and a comparative improvement in numbers of patients being discharged from ED.

Additionally, early review of data suggests that further improvement against metrics such as time to see Dr in ED and length of time in department have also improved, as well as performance against 4 hour standard. This however is anecdotal at this stage and review and verification of these indicators will be required.

The information below gives a breakdown of patients seen by the Consultant deployed within the pilot, in addition to their destination following assessment:

Table 2

CoOP Activity for Pilot period (From 29/06 – To 15/07)					
Day	**Seen**	**Admitted**	**Home**	**Other Facility**	**Total Discharged**
Week 1					
Mon 29/06	6	2	4	0	4
Tues 30/06	8	1	6	1	7
Thurs 02/07	5	1	3	1	4
Fri 03/07	7	2	5	0	5
					Total = 20
Week 2					
Mon 06/07	7	5	2	0	2
Tues 07/07	6	0	6	0	6
Thurs 09/07	6	1	4	1	5
Fri 10/07	11	5	6	0	6
					Total = 19

Based on the above an initial financial efficiency could be calculated as follows:

- Additional discharges in pilot compared to control period (As per Table 1) = **16** (69%)
- Current Directorate average length of stay = **12.9 days**

16 (Avoided admissions) x 12.9 (Av. Length of stay) = **206.4 bed days**
206.4 (Bed days) x £250 (Approx cost of bed day) = **£51,600**

Potential Efficiency to date = £51,600

6. Next Steps

The pilot is scheduled to end on Friday 2nd October however at present the consultant leading the pilot in ED (Dr Ruth Griffin) has only agreed to undertake this role until the end of July 2015 due to annual leave commitments in August 2015. Therefore in the short term it is agreed that the pilot will cease across this period to give further depth to the analysis (Control period) as it is accepted that the success to date is heavily reliant upon the individual consultant and their approach to the patient cohort. It has however been agreed with Dr Griffin that the pilot will re-commence following her annual leave and she will continue to run this until the end date of 2nd October 2015.

In the longer term discussions have begun within the directorate to assess development of the pathway, early discussions for development includes:

- Identification of space, potentially co-located with ED, to develop stand-alone Older People's Assessment Lounge (OPAL). This would improve environment for this patient cohort, release capacity in ED and in turn support improved flow.
- Develop pathway to allow designated Older Patients the ability to 'by pass' Cherry ward / AMU if admission is required – It is widely acknowledged that following early assessment by geriatrician in ED / OPAL streaming patients into AMU will add no value into patient pathway and increases length of stay.
- Reconfigure current ward set up to create designated Older Peoples Short Stay ward – This would allow consistency with patient pathway and maximise, where possible, the management and throughput of Older Patients within the directorate and bed base

To begin to work towards the above the following actions will be undertaken:

- Further analysis of pilot over a longer period
- Bring together a task and finish group to oversee pathway development and implementation
- Discussions with Estates and Facilities regarding potential locations for OPAL
- Development of relevant business case to support pathway transformation and benefits realisation

7. Summary

It is recognised that the above gives a very rough and high level analysis and potential benefit of the pilot to date however the data does demonstrate a significant difference and improvement to the control period. Overall it can be concluded that the pilot to date shows:

- Reduction of 38.37% in admissions of patients >78 between the hours of 9am and 5pm
- An increase of 69.57% in discharges of patients >78 from ED majors between the hours of 9am and 5pm
- Anecdotally at this stage, qualitative feedback suggests further improvements to metrics such as time to see Dr in ED and length of time spent in the department however this is to be verified and quantified.
- Performance against ED 4 hour standard has improved compared to control period prior to the pilot beginning, although this could also coincide with other on-going transformation and recovery programmes.
- In the short term agreement has been reached with Dr Griffin for the continuation of her role within the pilot following a period of annual leave in August 2015.
- Task and finish group to be put in place to develop plan and deliver changes to pathway in the medium / longer term

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Information to meet publishing requirements:

- **The Equality Act 2010**
- **NHS England Workforce Race Equality Standard (WRES)**
- **NHS England Equality Delivery System 2 (EDS2)**

Action requested/recommendation

To note the benchmarking details contained within and identification of further work required.

To approve the publication of the documents on the Trust website in accordance with the public sector quality duty to publish information and equality objectives plus NHS England WRES and EDS2 reports which are now part of the NHS standard contract.

The Board remain mindful of the importance of effective data collection and analysis to enable production of current and meaningful reports that are reflective of our community, services and workforce.

Executive Summary

The attached Annual Report provides a detailed summary of the work undertaken during the year by the Trust to comply with the Equality Act.

During the year the Trust has continued to comply with the general equality duty. The evidence associated with the compliance is detailed in the report. The report includes rich detail on the demographics of the community serviced by the Trust along with detail about the membership of the Trust.

The equality analysis information outlines the toolkit developed by the Trust to standardise the approach across the organisation. In relation to procurement, the Trust has carried out a baseline assessment of the main suppliers to determine their small and medium enterprise (SME) status. The report outlines the extensive list of languages the Trust is able to support through the various translation and interpreting services accessed by the Trust.

Significant work has been undertaken during the year around safeguarding adults and learning disability liaison including reviewing the processes in line with the Care Act 2014.

The report provides detail about the breakdown of patient by gender, age and ethnicity. The information demonstrates that there is a reasonably equal split between the treatment of male and female patients for both elective care and day-case patients, but the Trust sees noticeably more women than men for non-elective admissions.

The age breakdown confirmed that over 75% of our patients are aged 50 and over with only 2.73% of patients being 18 or under.

The staffing section of the report provides detail on the current profile of staff, those joining the organisation and those leaving and the temporary workforce. The information shows there has been an increase in the number of female staff being appointed during 2014/15 when compared to the previous year. There has been an increase in the level of recording of ethnicity and disabilities and sexual orientation amongst new starters.

The report also details the breakdown of staff involved in employment tribunals and grievances.

Presented with the annual report are two further reports, the EDS2 summary report. This report shows the Trust's level of compliance against the Equality Delivery System.

The final report outlines the equality objectives to ensure compliance with the Equality Act 2010 over the next two years.

The reports highlight that the Trust still have much room for improvement in understanding how staff and patients experience our services and, more importantly, how we use the information we have regarding protected characteristics to inform how we plan and deliver these services. This agenda is central to our values in demonstrating how we respect difference and increasingly ensure that we reflect our community and provide fair and equal opportunities for patients and staff.

The Board is asked to note that the Public Sector Duty to report this data is an annual requirement.

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	☐

<u>Implications for equality and diversity</u>

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 these papers, 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) and on how well protected characteristics fare compared with people overall. This report specifically identifies areas for improvement with regard to care of patients and staff who have a registered protected characteristic.

Reference to CQC outcomes

From April 2016 progress will be considered as part of the well led domain during CQC inspections.

Progress of report	Board of Directors
Risk	Not applicable
Resource implications	Not applicable
Owner	Sue Holden, Director Workforce and Corporate Development. Lead Director for Equality and Diversity
Author	Margaret Milburn, Trust Equality and Diversity Facilitator
Date of paper	July 2015
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Annual Equality, Diversity and Human Rights Report

2014-2015

Date: July 2015

Contents

Foreword

This last year we have seen an increasing recognition across the Trust regarding our duty to ensure we treat all staff, patients and carers in a way which reflects our Trust values. We have started to look at how we visibly raise the opportunities for staff to be involved including the introduction of fairness champions.

We have successfully launched our own staff LGBT network and embrace the opportunities this gives to understanding better how and what we need to change to benefit from the contribution these staff can bring to making our hospital more reflective of our community.

We are particularly pleased to have worked closely with Leeds & York Partnership Foundation Trust and Vale of York Clinical Commissioning Group (CCG) in developing greater awareness of how we can work together and address some of the challenges posed by the Equality Delivery System EDS2 and create a shared consciousness in addressing issues of education and access. The contribution made by our community partners in the third sector was salutary and humbling and gave us real insight into the impact of not addressing equality as a core part of our care.

The environment of providing healthcare does not get easier; however keeping ourselves connected to what can make a difference to users of services who have in the past experienced discrimination will keep the momentum and commitment to continuous improvement.

Sue Holden
Trust Lead – Equality and Diversity
Director of Workforce and Organisational Development

Professor Dianne Willcocks CBE DL
Equality and Diversity Champion
Non-Executive Director

Summary

The ultimate objective of York Teaching Hospital NHS Foundation Trust is to be trusted to provide safe, effective, sustainable healthcare within our communities. Integrating equality, diversity and human rights into our day to day practice will enable the delivery of services and employment of a workforce that is inclusive of the communities we serve.

The following table provides a summary of the evidence about how we meet our general equality duty including the section of the report where this is covered should further detail be required. This report and our equality objectives are published on the Trust website.

General Duty	Evidence	Section
Eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act 2012	• Governance structure for equality and diversity	i
	• Directors / managers informed and involved to assure E&D and human resource practices	2.6 and 2.7
	• Staff undertake training at a level to support them carrying out their role effectively	2.6
	• Policies in place and reviewed in accordance with Trust policy guidance and amended as new legislation and guidance requires	1.1
	• Recruitment policies are fair and transparent	2.7
	• Incidents are reported	1.7 and 2.8
	• Patient Experience monitor comments, compliments and other concerns	1.9 and 1.12
	• Access audits to ensure services are accessible	1.6

General Duty	Evidence	Section
Advance equality of opportunity between persons who share a protected a relevant characteristic and persons who do not share it • Remove or minimise disadvantages connected with a relevant protected characteristic • Take steps to meet the different needs of persons who share a protected characteristic • Encourage persons who share a relevant protected characteristic to participate in public life or any other activity in which they are under-represented	• Equality analysis to identify potential risks to the outcomes of patients as part of the decision making process • Human resource practices to promote equality of opportunity for all staff at all levels • Commitment to promoting staff side activities • Work with partner agencies from public and voluntary sector • Two tick employer • Engagement with local communities • Interpreting Services in place • Work of Fairness Forum • Learning and development of staff	1.1 2 2 2.6 2 1.13 1.4 i 2.6

Foster good relations between persons who share a protected characteristic and persons who do not share it
 	
• Tackle prejudice
• Promote understanding
	• Trust membership
	
	• Engagement with:
	  • Service users and carers
	  • Members and governors
	  • Staff and volunteers
	  • Partners
	  • Statutory partners
	
	• Awareness events
		d
		
		1.13
		
		1.13 and 2.6

Introduction

In line with good practice taken from “Publishing equality information: Commitment, engagement and transparency – Assessment of public authorities’ implementation of the specific duty to publish equality information” (Equality and Human Rights Commission 2012) this report is designed to demonstrate our compliance with the equality duty to publish information.

The report is aimed to be reader friendly with a clear structure and information to establish the current situation including progress, achievements since last years report and where further work is required.

a) Overview of York Teaching Hospital NHS Foundation Trust

York Teaching Hospital NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare services for approximately 530,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale – an area covering 3,400 square miles.

Our annual turnover is over £400 million; we manage ten hospital sites, 1,127 beds (including day case beds) and have a workforce of over 8,000 staff working across our hospitals and in the community.

Our hospitals:

- The York Hospital
- Scarborough General Hospital
- Bridlington District Hospital
- Whitby Community Hospital
- Malton Community Hospital
- The New Selby War Memorial Hospital
- St Monica's Hospital, Easingwold
- Archways Intermediate Care Unit, York
- White Cross Rehabilitation Hospital, York
- St Helens Rehabilitation Hospital, York

b) Trust Mission, Values, Drivers and Motivators

The NHS Constitution establishes the principles and values of the NHS in England setting out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

York Teaching Hospital NHS Foundation Trust is committed to the principles outlined in the constitution, which is reflected in 'our commitment to you'. This document takes on board the views of our staff and governors, and outlines our values and priorities providing a basis for setting out what you can expect from us and what we expect from both our staff and patients.

Our Shared Commitment: Caring with Pride

Our ultimate objective is to be trusted to provide safe, effective, sustainable healthcare within our communities.

Our values, drivers and motivators:

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

How we promote safe and effective healthcare for all who need it and work to provide it is outlined in “our shared commitment” and “How we live our values” which are published on our website.

c) Local Demographics

As mentioned in part a the Trust covers a large geographic area, the following information has been taken from the Office of National Statistics website https://www.nomisweb.co.uk/ 2011 Census data based on the seven constituencies and specific constituency wards as per the Trust constitution Annex 1. Data for disability, gender reassignment, pregnancy and maternity and sexual orientation is not available from this source.

Summary of the following tables:

Age: York has an increased percentage of 18+ to 24 years which can be correlated to higher education establishments in the city

Gender: Higher numbers of females in all areas which links to longer life expectancy

Ethnic Group: York is our most diverse area with 94.3% being white residents Hambleton is the least diverse with 99.2% White residents

Religion: Christianity is the dominant religion, no religion and religion not stated the next highest categories.

Marital Status: this is the first Census to include registered same sex civil partnerships with the Civil Partnerships Act coming into effect December 2005.

It is noted that whilst percentages for some categories may appear to be low and as a consequence they may not be viewed by some as statistically significant, it is nonetheless vital that we engage and consult with our communities and workforce for qualitative data about experience to inform our views, decision making and enable inclusivity.

Age

Age	Bridlington		Hambleton		Ryedale and East Yorkshire		Scarborough		Selby		Whitby		York		Total	
	number	%	number	%	Number	%	number	%	number	%	number	%	number	%	number	%
Age 0 to 4	3,185	4.7	867	5.0	7,393	4.8	4,274	5.1	4,875	5.8	1,043	4.2	10,960	5.4	32,597	5.1
Age 5 to 7	1,917	2.8	562	3.3	4,557	2.9	2,405	2.9	2,741	3.3	687	2.7	5,971	2.9	18,840	3.0
Age 8 to 9	1,228	1.8	398	2.3	2,873	1.8	1,553	1.9	1,818	2.2	426	1.7	3,770	1.8	12,066	1.9
Age 10 to 14	3,588	5.3	1,081	6.3	8,647	5.6	4,429	5.3	4,852	5.8	1,289	5.1	10,261	5.0	34,147	5.4
Age 15	825	1.2	224	1.3	1,954	1.3	981	1.2	1,028	1.2	304	1.2	2,202	1.1	7,518	1.2
Age 16 to 17	1,571	2.3	442	2.6	3,904	2.5	1,971	2.4	2,167	2.6	568	2.3	4,528	2.2	15,151	2.4
Age 18 to 19	1,465	2.1	366	2.1	3,241	2.1	2,211	2.6	1,812	2.2	505	2.0	8,095	4.0	17,695	2.8
Age 20 to 24	3,040	4.4	708	4.1	6,690	4.3	5,098	6.1	4,453	5.3	1,170	4.7	19,992	9.8	41,151	6.5
Age 25 to 29	2,973	4.4	651	3.8	6,597	4.2	4,262	5.1	4,346	5.2	1,105	4.4	14,355	7.0	34,289	5.4
Age 30 to 44	11,098	16.2	2,936	17.0	26,366	17.0	13,594	16.2	16,589	19.9	3,697	14.7	39,866	19.5	114,146	17.9
Age 45 to 59	14,158	20.7	4,092	23.7	33,591	21.6	17,242	20.6	18,761	22.5	5,939	23.7	37,948	18.5	131,731	20.7
Age 60 to 64	5,962	8.7	1,300	7.5	13,281	8.6	6,378	7.6	6,001	7.2	2,342	9.3	12,209	6.0	47,473	7.4
Age 65 to 74	9,567	14.0	2,003	11.6	19,818	12.8	10,111	12.1	7,702	9.2	3,200	12.8	17,572	8.6	69,973	11.0
Age 75 to 84	5,506	8.1	1,170	6.8	11,761	7.6	6,509	7.8	4,554	5.5	2,025	8.1	11,909	5.8	43,434	6.8
Age 85 to 89	1,491	2.2	300	1.7	3,066	2.0	1,741	2.1	1,147	1.4	518	2.1	3,282	1.6	11,545	1.8
Age 90 and over	758	1.1	148	0.9	1,561	1.0	940	1.1	603	0.7	276	1.1	1,694	0.8	5,980	0.9

Gender

	Bridlington		Hambleton		Ryedale and East Yorkshire		Scarborough		Selby		Whitby		York		Total	
Gender	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
All persons	68,332	100.0	17,248	100.0	86,968	100.0	83,699	100.0	83,449	100.0	25,094	100.0	204,614	100.0	569,404	100.0
Males	33,051	48.4	8,403	48.7	42,880	49.3	40,343	48.2	40,947	49.1	12,227	48.7	99,555	48.7	277,406	48.7
Females	35,281	51.6	8,845	51.3	44,088	50.7	43,356	51.8	42,502	50.9	12,867	51.3	105,059	51.3	291,998	51.3

Ethnic Group

Ethnic Group	Bridlington		Hambleton		Ryedale and East Yorkshire		Scarborough		Selby		Whitby		York		Total	
	number	%	number	%	number	%	number	%	number	%	number	%	number	%	number	%
All usual residents	68,332	100.0	17,248	100.0	86,968	100.0	83,699	100.0	83,449	100	25,094	100.0	204,614	100.0	569,404	100.0
White: English/Welsh/Scottish/Northern Irish/British	66,513	97.3	16,741	97.1	83,682	96.2	79,232	94.7	79,686	95.5	24,393	97.2	184,635	90.2	534,882	93.9
White: Irish	194	0.3	60	0.3	382	0.4	232	0.3	326	0.4	69	0.3	1,131	0.6	2,394	0.4
White: Gypsy or Irish Traveller	49	0.1	11	0.1	95	0.1	30	0.0	158	0.2	7	0.0	300	0.1	650	0.1
White: Other White	736	1.1	234	1.4	1,468	1.7	1,851	2.2	1,907	2.3	290	1.2	6,922	3.4	13,408	2.4
Mixed/multiple ethnic groups: White and Black Caribbean	152	0.2	16	0.1	149	0.2	198	0.2	190	0.2	30	0.1	544	0.3	1,279	0.2
Mixed/multiple ethnic groups: White and Black African	44	0.1	22	0.1	83	0.1	95	0.1	50	0.1	14	0.1	312	0.2	620	0.1
Mixed/multiple ethnic groups: White and Asian	119	0.2	29	0.2	189	0.2	260	0.3	271	0.3	64	0.3	889	0.4	1,821	0.3
Mixed/multiple ethnic groups: Other Mixed	81	0.1	24	0.1	128	0.1	171	0.2	115	0.1	37	0.1	719	0.4	1,275	0.2
Asian/Asian British: Indian	96	0.1	21	0.1	94	0.1	370	0.4	175	0.2	13	0.1	1,540	0.8	2,309	0.4
Asian/Asian British: Pakistani	9	0.0	5	0.0	42	0.0	114	0.1	17	0	55	0.2	419	0.2	661	0.1
Asian/Asian British: Bangladeshi	4	0.0	2	0.0	29	0.0	96	0.1	2	0	13	0.1	370	0.2	516	0.1
Asian/Asian British: Chinese	97	0.1	18	0.1	158	0.2	247	0.3	170	0.2	40	0.2	2,623	1.3	3,353	0.6
Asian/Asian British: Other Asian	117	0.2	30	0.2	198	0.2	386	0.5	129	0.2	30	0.1	2,001	1.0	2,891	0.5
Black/African/Caribbean/Black British: African	42	0.1	19	0.1	112	0.1	165	0.2	170	0.2	11	0.0	912	0.4	1,431	0.3
Black/African/Caribbean/Black British: Caribbean	25	0.0	3	0.0	59	0.1	47	0.1	33	0	4	0.0	209	0.1	380	0.1
Black/African/Caribbean/Black British: Other Black	7	0.0	0	0.0	22	0.0	11	0.0	9	0	2	0.0	92	0.0	143	0.0
Other ethnic group: Arab	27	0.0	8	0.0	30	0.0	109	0.1	9	0	14	0.1	500	0.2	697	0.1
Other ethnic group: Any other ethnic group	20	0.0	5	0.0	48	0.1	85	0.1	32	0	8	0.0	496	0.2	694	0.1

Marital Status

Marital Status	Bridlington		Hambleton		Ryedale and East Yorkshire		Scarborough		Selby		Whitby		York		Total	
	number	%	number	%	number	%	number	%	number	%	number	%	number	%	number	%
All usual residents aged 16+	57,589	100.0	14,116	100.0	72,287	100.0	70,057	100.0	68,135	100	21,345	100	171,450	100.0	474,979	100.0
Single (never married or never registered a same-sex civil partnership)	14,766	25.6	3,269	23.2	18,082	25.0	20,558	29.3	18,088	26.5	5,569	26.1	65,584	38.3	145,916	30.7
Married	29,952	52.0	8,239	58.4	40,306	55.8	33,417	47.7	37,705	55.3	11,075	51.9	76,206	44.4	236,900	49.9
In a registered same-sex civil partnership	125	0.2	26	0.2	126	0.2	161	0.2	125	0.2	56	0.3	446	0.3	1,065	0.2
Separated (but still legally married or still legally in a same-sex civil partnership)	1,334	2.3	301	2.1	1,549	2.1	1,846	2.6	1,618	2.4	478	2.2	3,359	2.0	10,485	2.2
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	5,883	10.2	1,216	8.6	6,406	8.9	7,696	11.0	6,059	8.9	2,142	10	14,487	8.4	43,889	9.2
Widowed or surviving partner from a same-sex civil partnership	5,529	9.6	1,065	7.5	5,818	8.0	6,379	9.1	4,540	6.7	2,025	9.5	11,368	6.6	36,724	7.7

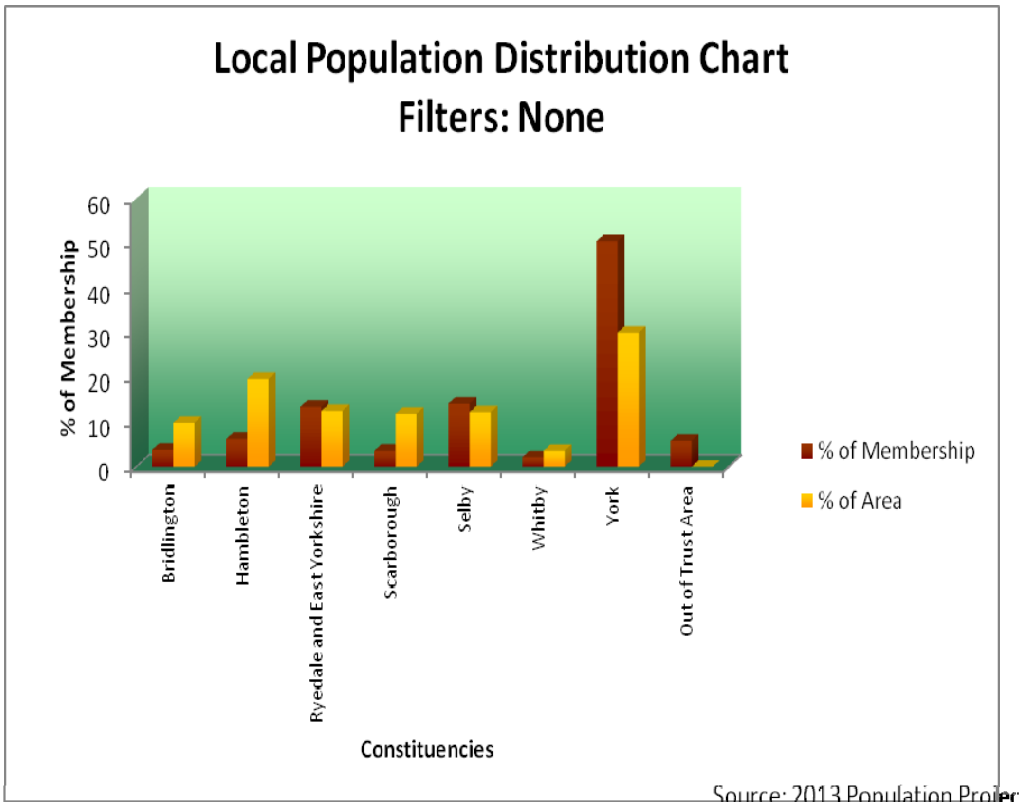
Religion

	Bridlington		Hambleton		Ryedale and East Yorkshire		Scarborough		Selby		Whitby		York		Total	
	number	%	number	%	number	%	number	%	number	%	number	%	number	%	number	%
All categories: Religion	68,332	100.0	17,248	100.0	86,968	100.0	83,699	100.0	83,449	100.0	25,094	100.0	204,614	100.0	569,404	100.0
Christian	46,646	68.3	12,527	72.6	61,679	70.9	54,731	65.4	59,182	70.9	17,813	71.0	122,461	59.8	375,039	65.9
Buddhist	129	0.2	27	0.2	241	0.3	243	0.3	133	0.2	52	0.2	1,057	0.5	1,882	0.3
Hindu	37	0.1	10	0.1	58	0.1	156	0.2	87	0.1	11	0.0	988	0.5	1,347	0.2
Jewish	30	0.0	10	0.1	38	0.0	54	0.1	60	0.1	13	0.1	213	0.1	418	0.1
Muslim	94	0.1	23	0.1	216	0.2	476	0.6	95	0.1	75	0.3	2,100	1.0	3,079	0.5
Sikh	22	0.0	0	0.0	12	0.0	7	0.0	51	0.1	1	0.0	134	0.1	227	0.0
Other religion	219	0.3	50	0.3	294	0.3	292	0.3	206	0.2	110	0.4	755	0.4	1,926	0.3
No religion	16,047	23.5	3,360	19.5	18,098	20.8	21,519	25.7	18,070	21.7	5,146	20.5	61,070	29.8	143,310	25.2
Religion not stated	5,108	7.5	1,241	7.2	6,332	7.3	6,221	7.4	5,565	6.7	1,873	7.5	15,836	7.7	42,176	7.4

d) Trust Membership

One of the benefits of being a Foundation Trust is that the structure allows us to work more closely with local people and service users to help us better respond to the needs of our communities. People can become involved in helping the Trust develop the right services in a number of ways, but one of the best ways is to become a member of the Trust. The Council of Governors is made up of individuals who have been elected by the public membership – public governors, individuals who have been appointed by key stakeholders - appointed governors and staff who have been elected by their colleagues to represent them on the Council of Governors – staff governors. The Governors have two main duties – to hold the Non-executive Directors to account and to ensure governors represent the interests of the members of the Trust as a whole and the interests of the public. We apologise for the size of text in the charts of this section but we are unable to change due to the computer package used.

The Trust seeks to recruit membership that reflects the demographics of the local area, at present the Trust has 11,855 public members across its 7 constituencies. The attached chart shows the current membership against the local population. This shows that the Trust is well represented in York and Selby, Hambleton and Ryedale and East Yorkshire, but underrepresented in Scarborough, Whitby and Bridlington.

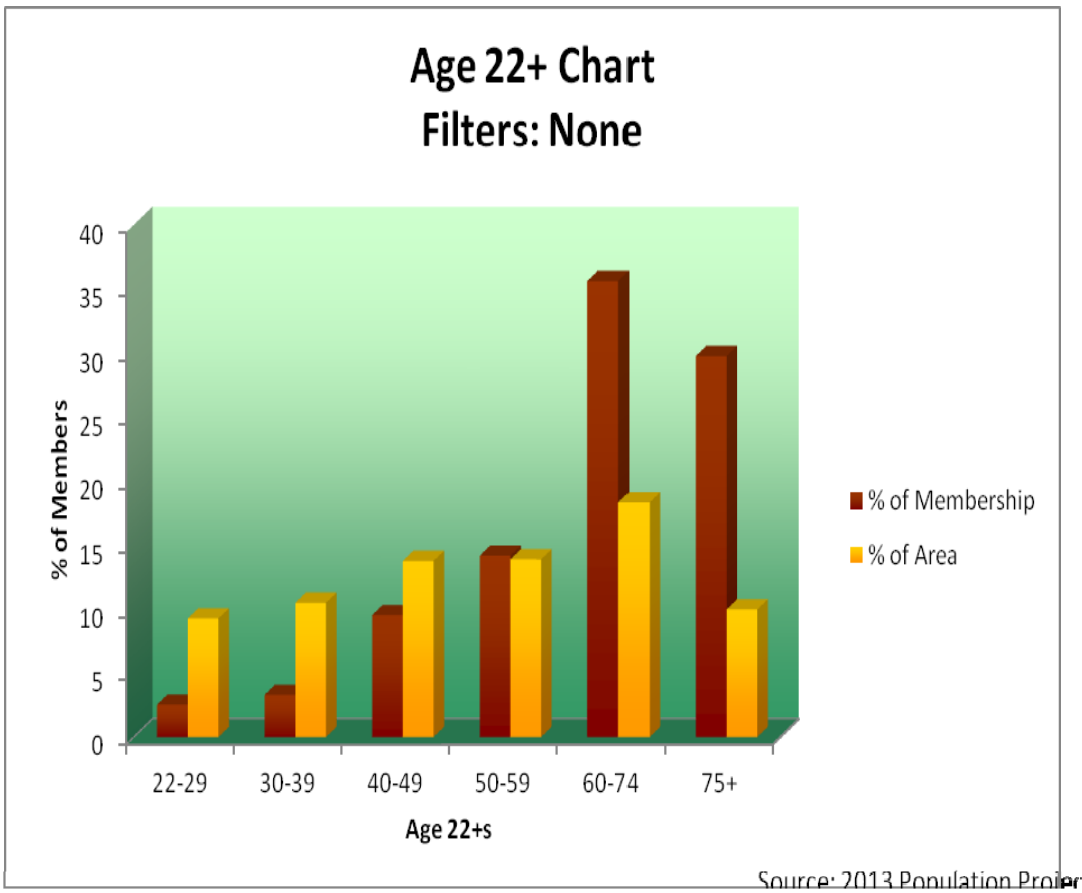


Source: 2013 Population Projections CACI Ltd

Age profile

The Trust is over represented by members in the 60 and above age bracket and under represented in the younger age groups from 22 to 50. This is consistent with other Foundation Trusts. Over 50% of our current membership is in the 50 to 75+ age brackets. The Trust is keen to increase the membership of the younger age groups and is looking at ways this can be achieved.

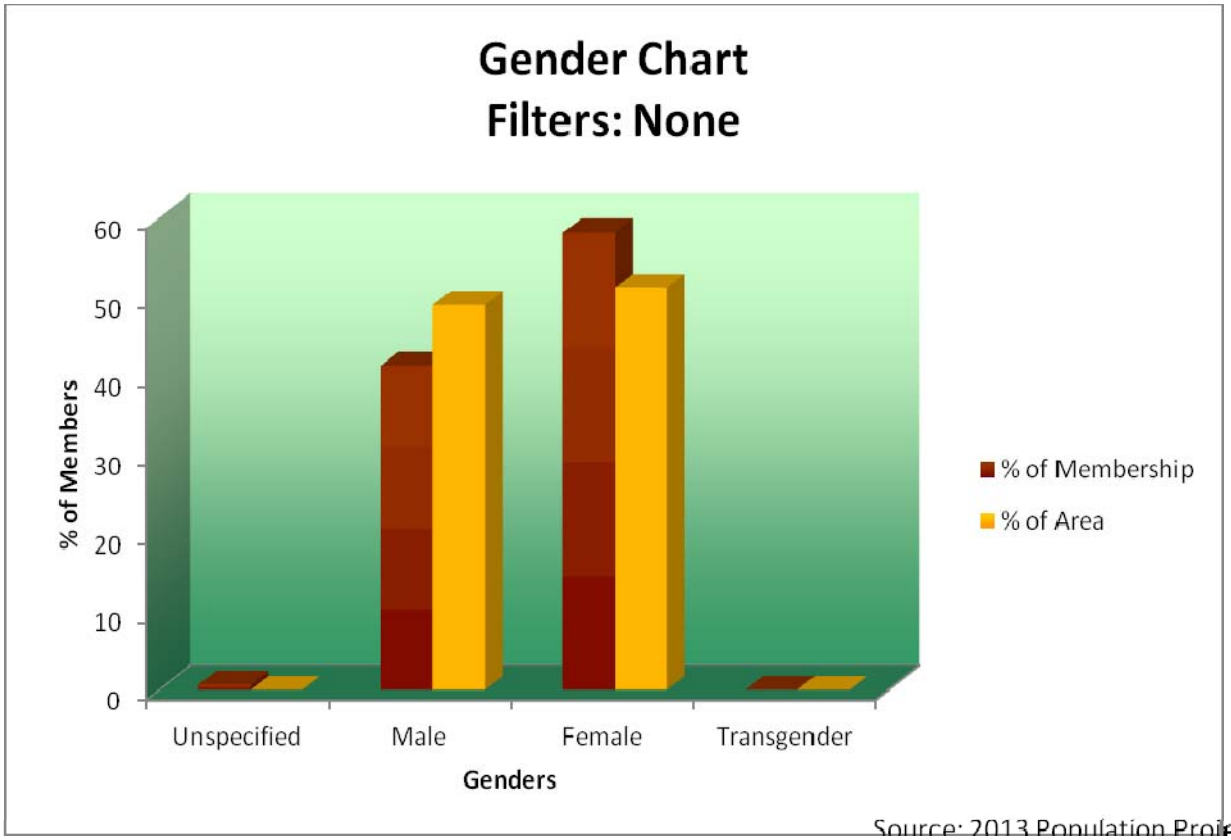
The Trust will be revising the membership strategy to ensure representation across the membership is reflective of our age demographics.



Source: 2013 Population Projections CACI Ltd

Gender profile

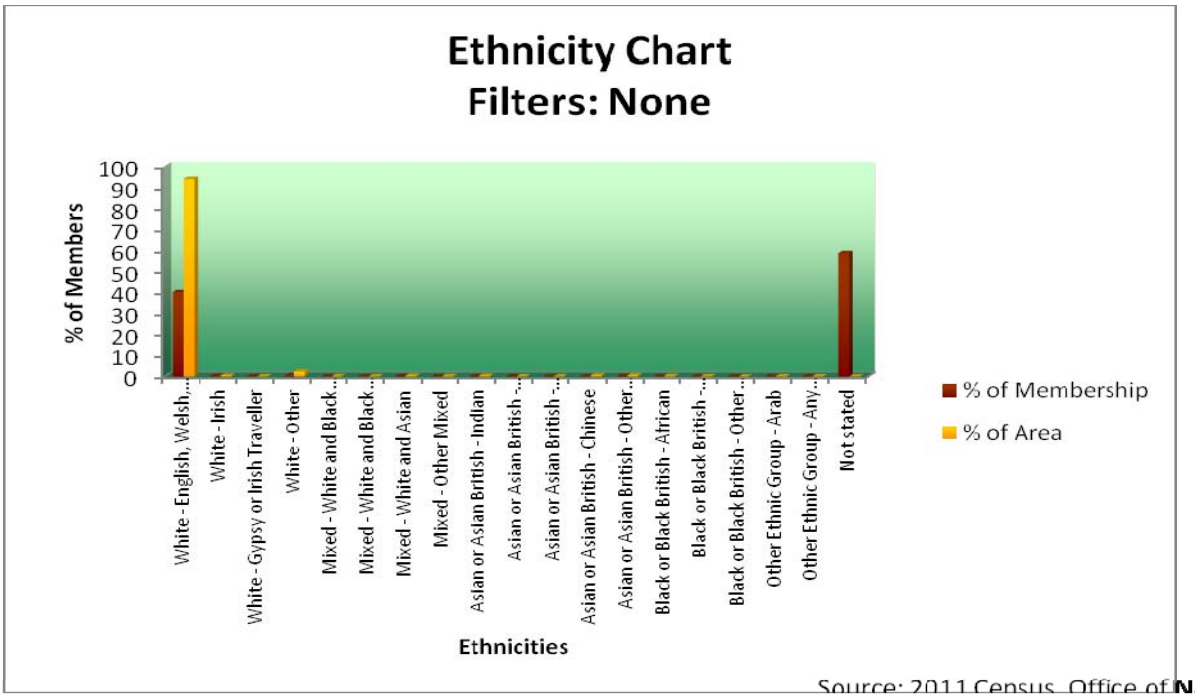
The current membership is relatively reflective of the gender profile that exists in the community. The Trust has more members not wishing to declare their gender than the percentage for the area and is slightly over represented by women and under represented by men.



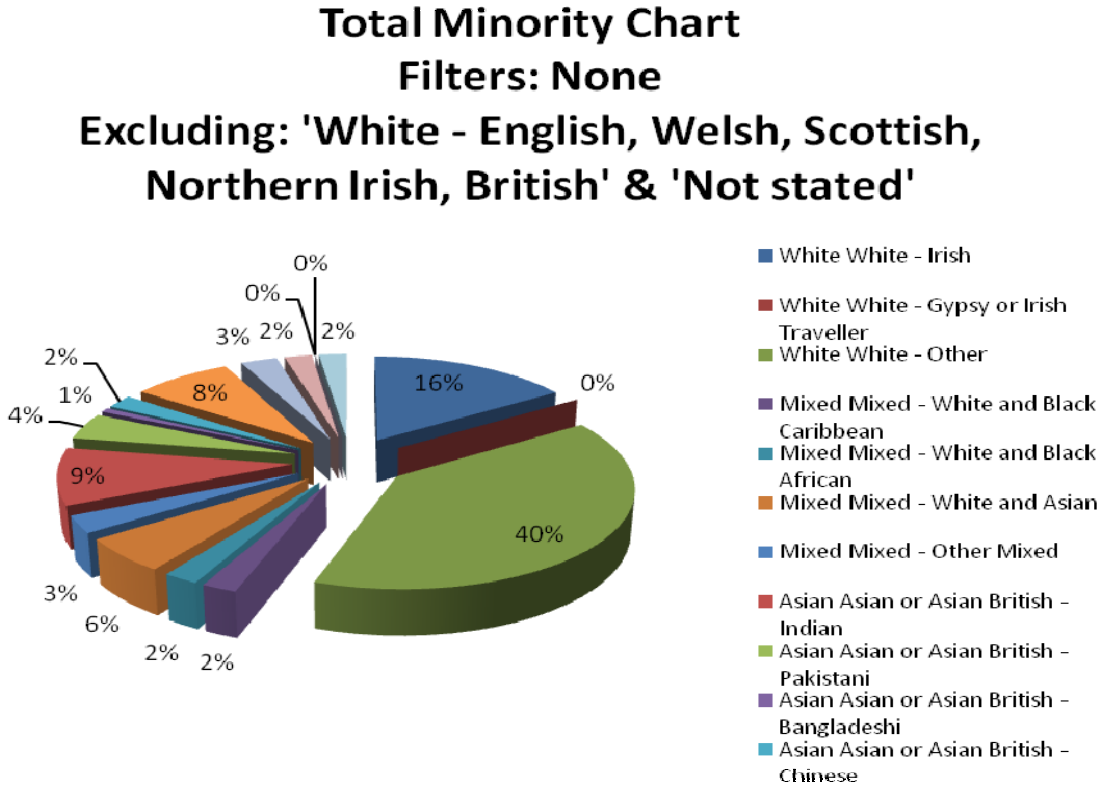
Source: 2013 Population Projections, CACI Ltd

Ethnicity profile

A significant proportion of the Trust's membership has chosen not to disclose their ethnicity as can be seen from the chart. The Trust does collect this information but members choose not to provide it.



Source: 2011 Census, Office of National Statistics



Other characteristics

The Trust does not collect data on the following characteristics for the membership database: disability, religious beliefs, sexual orientation, gender reassignment, marriage and civil partnerships and pregnancy and maternity. Consideration will be given to how this data could be collected.

Governors

A Council of Governors elected from the public membership, staff and representatives from the Trusts key stakeholder in health and social care provide support and advice to the Trust to:

- Ensure that the Trust delivers services that best meet the needs of patients and the communities we serve
- Ensure that the Trust provides high quality, effective and patient-focused services
- Promote effective dialogue between the Trust and the local communities we serve.

Currently there is no data of the demographic profile of governors

The Trust is be mindful of the need for continuous improvement in data collection.

e) Equality Act 2010

In April 2011, a new public sector equality duty was introduced by the Equality Act 2010. The duty covers age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation - these are known as the protected characteristics.

The duty has two parts; the general duty and specific duties.

The **General Equality Duty** means the Trust must have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act 2012
- Advance equality of opportunity between persons who share a protected a relevant characteristic and persons who do not share it
  - Remove or minimise disadvantages connected with a relevant protected characteristic
  - Take steps to meet the different needs of persons who share a protected characteristic
  - Encourage persons who share a relevant protected characteristic to participate in public life or any other activity in which they are under-represented
- Foster good relations between persons who share a protected characteristic and persons who do not share it
  - Tackle prejudice
  - Promote understanding

The duty to have due regard to the need to eliminate discrimination also applies to marriage and civil partnership.

The **Specific Equality Duty** requires the Trust to publish:

- Information to demonstrate our compliance with the Equality Duty by 31st January 2012 and then at least annually
- Equality objectives by 6th April 2012 and then at least every 4 years

f) Care Quality Commission

The Care Quality Commission (CQC) is the current health and social care regulator for England; it ensures that essential standards of quality and safety are being met where care is provided. To get to the heart of patients' experiences of care, the CQC asks the following five questions of every service and provider:

- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive to people's needs?
- Are services well-led?

During their inspections, the CQC seek assurance that all patients and service users receive individualised care, treatment and support as the Trust actively promotes equality, diversity and human rights across all its services and functions. This requires the Trust to embed effective equality and diversity management into core business activity to achieve compliance.

g) Equality Delivery System (EDS)

The Equality Delivery System (EDS) was originally a product of the Department of Health Equality and Diversity Council (EDC) designed to help NHS organisations, in discussion with local partners to review and improve performance and help to meet their statutory and regulatory obligations for equality, diversity and human rights.

York Teaching Hospital NHS Foundation Trust held our first grading day in March 2012 which included the development of our equality objectives. Nationally in 2012 the implementation of the EDS was independently evaluated and subsequent consultation with NHS organisations developed a refreshed EDS called EDS2 that was launched in November 2013 allowing more flexibility for local implementation.

EDS2 has 4 goals and 18 outcomes, with enough in common between the original and EDS2 for meaningful comparisons to be made over time.

1. Better health outcomes for all
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

During 2014 those with responsibility for equality and diversity at York Teaching Hospital Foundation Trust, Leeds York Partnership Foundation Trust and Vale of York Clinical commissioning Group (CCG) agreed to work together with community representatives to make best use of time and resources.

Stakeholders were invited to a planning meeting to discuss a preferred approach to EDS2, how they wanted to be involved and how the assessment and grading would be carried out with representation from each of the protected characteristics. The stakeholders approved this new way of working and agreed there should be a focus on one goal (Improved patient access and experience) to enable time for meaningful discussion and assessment.

Each organisation compiled evidence which was distributed prior to an assessment and grading event 24th March 2015. The summary report for each organisation is published on respective websites as required by NHS England. The most valuable output from this been the identification of joint objectives for the three organisations and the commitment to work collaboratively to promote equality and diversity with the support of community representatives.

h) Equality Objectives

Our objectives were first developed by the Equality Delivery System (EDS) grading panel March 2012. In March 2015 at the EDS2 assessment and grading event York Teaching Hospital Foundation Trust, Leeds and York Partnership Foundation Trust, Vale of York Clinical commissioning Group (CCG) and community representatives agreed joint equality priorities. These priorities have been added to our equality objective action plan; the overall objectives remain with actions amended. Completed actions have been removed and new priorities added.

Our four objectives are to:

1. Improve data collection, analysis and monitoring for protected characteristics
2. Further develop engagement and involvement of patients, carers, governors and staff to reflect local demographics
3. Develop strong partnerships with social care and GP's to ensure patient pathways are free from barriers between providers for everyone
4. Continue with staff development programme ensuring equality and diversity is embedded into all decision making processes

Our equality objectives and action plan is published in more detail separately on our website. The Trust Fairness Forum monitors the action plan with a progress report presented to the Board on an annual basis.

Future Work Required:

- Continue to monitor progress against the equality objective action plan
- Utilise EDS2 assessment and grading events to identify new and review existing equality objectives.

i) Trust Structure for Equality and Diversity

The Director of Workforce and Organisational Development leads Equality and Diversity in the Trust and is supported by the Equality and Diversity Facilitator. A Non-Executive Director also champions Equality and Diversity at Board level.

The Trust Fairness Forum (formerly the Equality and Diversity Group) continues to meet on a quarterly basis and the membership comprises:

- Trust Equality and Diversity Lead (Chair)
- Equality and Diversity Facilitator
- Foundation Trust Secretary
- Non-Executive Director
- Directorate Manager
- Governors (a minimum of 2)
- Head of Patient Access
- Senior Human Resources Manager
- Faith representative
- Head of Capital Planning
- Head of Risk & Legal Services
- Nursing representative
- Elderly Services Representative
- Safeguarding adults and Learning Disabilities Representative
- Estates & Facilities Representative
- Procurement Representative
- Patient Experience Team Representative
- Health watch Representative
- Visually Impaired Representative
- Staff side Representative

The Forum reports to the Workforce Strategy Committee which is chaired by a Non Executive Director and is sub group of the Board of Directors.

j) Progress and Achievements

Our progress and achievements are threaded through this document; we would like to note some highlights of 2014/2015:

- Following the 2014 LGBT History month staff survey to determine the level of interest and demand for developing a staff LGBT network, the Trust Equality and Diversity Facilitator has empowered a group of staff to form a network that meets on a regular basis and developed the 2015 awareness event that formed part of York LGBT History month.

- Introduction of Fairness Champions, a group of staff who volunteered to undertake training and form a network promoting fairness and respect for everyone across the organisation.

  Both staff involvement groups meet on a regular basis and report issues and progress to the Fairness Forum, their time and support of equality and diversity issues is appreciated.

- Adopting the Living Wage forms part of our aim to be an employer of choice in all the communities that we provide services for, and despite the significant additional cost, overall it was felt strongly to be the right thing to do.

- Training and awareness events including corporate induction, NHS Employers Equality and Diversity Week in May, National Eye Health Week with York Blind and Partially Sighted Society in September, Inter-faith week in November and LGBT History month in February.

- Continued membership of Innov8 a regional NHS scheme to reframe diversity leadership

- An Access to Services Group have developed an action plan in response to Healthwatch Reports received by the Trust (Access to Health and Social Care for Deaf People December 2013 and Discrimination Against Disabled People June 2014) The plan was discussed and amendments agreed at an open meeting with Healthwatch, members of the Deaf community, Vale of York Clinical Commissioning Group and North Yorkshire County Council. The Access to Services Group has passed the plan to the Fairness Forum for monitoring.

- Collaborative work with Leeds York Partnership Foundation Trust, Vale of York Clinical Commissioning Group and local stakeholders to progress the Equality Delivery System enabling the identification of joint priorities which we have incorporated into our Equality Objective action plan.

- An alignment of interpretation and translation services across all our sites enabling consistency centralised records and improved monitoring. Further developments are planned when a new contract is introduced in June 2015

Section 1: Our Services and Policies

1.1 Equality Analysis

The Trust is responsible for making a wide range of decisions from policy, budget setting, service redesign, improvements and day to day decisions that affect individuals. Equality Analysis (Formerly equality impact assessment) is the method used to help us consider the effect of these decisions on the community we serve and especially members of our community with protected characteristics.
By carrying out timely and effective equality analysis the Trust can ensure it obtains the business benefits of Diversity which include:

- Improved patient experience;
- Improved service delivery for all users or potential users, including patients, carers, staff and members of the public;
- Identifying what is working well, as well as what needs improving;
- Focusing on positive outcomes and solutions;
- Minimising the risk of legal action;
- Offering choice and more informed decision making;
- Focusing resources on key equality areas;
- Encouraging greater openness by meaningful engagement and public involvement in change and policy making; and
- Assisting with the formulation of equality objectives.

Our equality and diversity report published January 2013 identified equality analysis was completed for policies and procedures and is picked up via our compliance team however service redesign and improvement projects were not monitored. During 2013 a new toolkit was developed for equality analysis to standardise the approach across the organisation, this has not been well received and further work is required to strengthen due regard and enhance transparency.

Further Work Required:

- Consultation and development of a new approach to equality analysis
- Centralise monitoring of equality analysis

1.2 Equality in Procurement

We recognise that, as a major procurer of goods and services and as an anchor institution, we have a general responsibility to the local area and to the local communities we serve.

Good business involves inclusion of as wide a range (of suppliers) as possible to provide all the needs the customer requires. 'Good' procurement is about ensuring these requirements are sourced with the optimum quality, at the lowest acquisition costs, with the least detriment to the environment and ensuring all suppliers are treated equitably and without discrimination. Larger multi-national companies often have teams of staff to deal with the complicated legislative regimes in place which can often mean smaller, more local, suppliers get squeezed out.

The (new) procurement regulations, The Public Contracts Regulations 2015, came into force in February and they place a number of mandated requirements when carrying out procurements. The main aim of the Regulations is to ensure that there is transparency and probity in the awarding of contracts. The Regulations go further by allowing contracts to be reserved for social or sheltered workshops (Regulation 20).

To build upon the work referenced in last year's report (Supporting SME's - Small and Medium Enterprises[1]) we have carried out a baseline assessment of our main suppliers (the top 80% by spend) to determine their SME status. The data analysed was from 2013/14 as this was the last full year at the time the analysis was completed.

In all 3,300 suppliers were used in the year 2013/14. 162 suppliers account for 80% of everything the Trust spends on goods and services across all categories / divisions / directorates and sites. The analysis shows that 10% is being spent with SME suppliers equalling £12M p.a (see Figure 1 on following page)

[1] http://ec.europa.eu/enterprise/policies/sme/facts-figures-analysis/sme-definition/index_en.htm

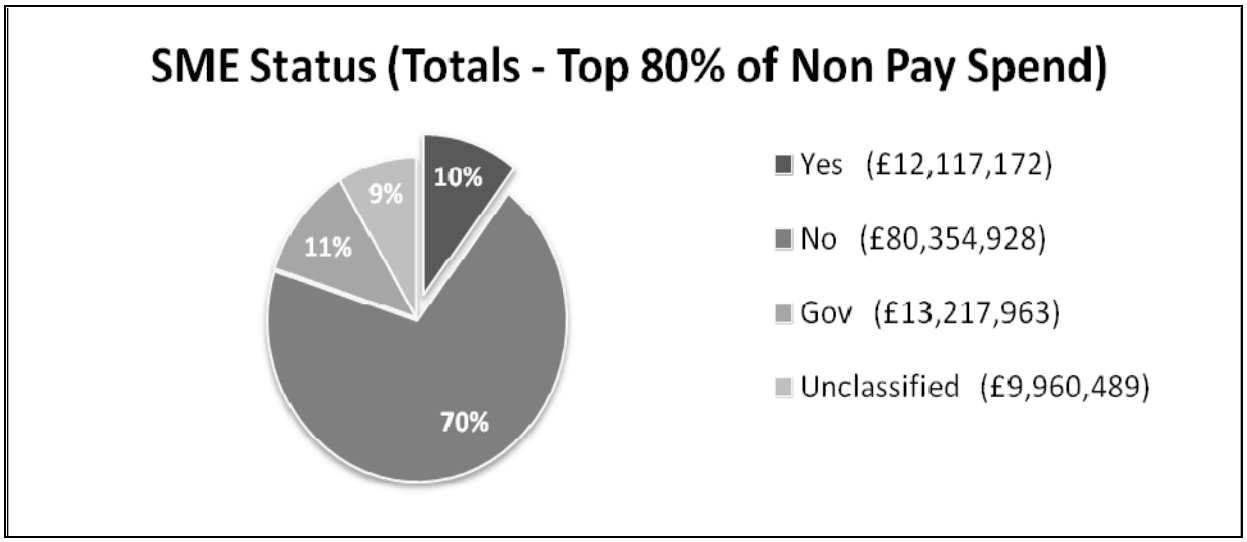


Figure 1 - 2013/14 Small and Medium EnterpriseStatus

We have also redrafted the tender report for to record the social, economic and environmental aspects of any procurement. These tender reports are sent to the Finance Director and Chief Executive.

We have introduced a set of standard tender questions. These ask; the country or countries of origin for the manufacture of the supplies; if the suppliers use the Ethical Trading Initiative's base code as a source of guidance for Ethical Trading; i.e. minimum standards to address pay and conditions, right to safe and decent working conditions, to be paid at least the legal minimum wage, and to join and form unions so they can bargain collectively for their rights. It also includes working with suppliers to eliminate child labour; what percentage of (UK) staff receives the Living Wage; how many apprentices do you have currently; and do they have a Sustainability Policy?

Further Work Required:

In line with our Procurement Strategy aims, and as a way to further mainstream equality considerations in procurement, we have plans in the coming year to:

- Analyse our smaller suppliers (those accounting for the smallest 20% of spend) regarding their SME's status. Our plan to get as far into the 3000+ suppliers we use so that we have a baseline figure for SME suppliers that we can grow our spend with smaller suppliers where the law allows.
- Add a formal Equality and Diversity section into the standard questions and, where weaknesses exist, provide support to suppliers to improve.

1.3 Accessible Patient Information

The Trust's patient information policy is included in the Trust policy: consent to examination or treatment policy, as an appendix. The policy sets out how information must comply with a range of standards that applies to all patient information leaflets provided by the Trust in support of its treatments and procedures.

We provide guidance to staff via the Patient Information Leaflet Team through written and verbal guidance. Our written guidance includes our POPPiY Guide (Practicalities of Producing Patient Information in York Teaching Hospital NHS Foundation Trust) a set of standards and guidelines for staff when producing written communications with patients. The guide specifies the essential content in patient leaflets relating to providing alternative formats such as Braille, large print or audio, and includes readability standards with templates for patient leaflets available to staff. All our written guidance is available to staff via the Trust Intranet.

Our patient information leaflets will carry a standard accessibility statement on the back cover or as close to the cover as possible (for sponsored leaflets). The statement includes one point of contact (telephone and email) for patients and relatives to request information in a different language or format. This is being introduced as leaflets are reprinted or reviewed.

We are making our patient leaflets available for patients, relatives and carers to view online on our website. Currently these are uploaded as PDF files but we are looking at further development of patient leaflets on the Trust website to utilise the built in translation and audio functions.

We are also mindful of the new Accessible Information standard ISB 1605 which is currently in draft form and proposes that organisations will have a year to implement the standard. This will require us to identify patients/service users who have a need for accessible information and provide this in a format and ways that the person requires/chooses. There are four areas that will need to be met:

- Need for communication support
- Need for specific contact method
- Need for specific Information Format
- Requires communication professional

Further Work Required:

- Continue to introduce the amended different format template from POPPiY as leaflets are reprinted if possible or if not on review, which is usually every two years
- Look at ways in which patient information leaflets can be presented electronically via the Trust Website.
- Review our current patient and service user administration and record systems, processes and documentation; if necessary update, change or replace to conform with the ISB 1605 standard by 31st March 2016

1.4 Access to Interpreting and Translation

The following interpreting services are available for patients attending services provided by the Trust:

Telephone Interpreting	Face-to-Face Interpreting
Sign Language Interpreting	Typetalk & Hearing Loops
Document Translation	Braille/Audio/CD

These services are provided in conjunction with:

- The Big Word
- National Registers of Communication Professionals (NRCP)
- Yorkshire British Sign Language (BSL) Interpreters
- York Blind and Partially Sighted Society (YBPSS)

The number of contacts by language is consistent with last year, with Polish and British Sign Language (BSL) having the highest use.

During 2014/2015 the Interpreting service has undergone a review which will also see Pearl Linguistics appointed as the Trusts preferred supplier for Interpreting Services from 1st June 2015. This will enhance the service for both patients and staff accessing these services provided by our Trust.

Further Work Required:

- Develop/enhance the single process for interpretation and translation across all Trust sites to promote consistency and monitoring including a central record of document translations
- Follow up the recommendations identified in the Access to Services Action Plan which is based on the York Healthwatch reports (see 1.13)
- Work with Trust staff to promote the interpreting services available and how to utilise these services to the benefit of the patient.
- Engage with local communities to gain feedback on these services provided and where we can improve
- Ongoing review of current providers to ensure contingency provision is in place for a sustainable service.
- Review and update documentation to ensure clear guidance and support.

Summary of interpreting face to face contacts:

Language	Contacts		Total Contacts
	York	Scarborough	
Arabic	2		2
Bengali	7	14	21
Bulgarian	8	4	12
British Sign Language	138	64	202
Cantonese	16	3	19
Czech	3	1	4
French	1		1
Gujarati	1		1
Hindi	3		3
Hungarian	1		1
Italian	6		6
Lithuanian	3		3
Mandarin	14	4	18
Nepalese	2		2
Nepali	7		7
Polish	93	84	177
Portuguese	14		14
Romanian	4	1	5
Russian	1		1
Slovak	1	6	7
Spanish	2		2
Swahili	1		1
Tamil		1	1
Thai		1	1
Turkish	15	4	19
Urdu	1		1
Vietnamese	2		2
Total	346	187	533

Summary of interpreting telephone contacts:

Language	Contacts		Total Contacts
	York	Scarborough	
Arabic	10	1	11
Bengali	9		
Bulgarian	7	9	16
Cantonese	18		
Czech	34		
Farsi (Persian)	3		
French	6		
German	1		
Gujarati	3		
Hindi	3		
Hungarian	4	3	7
Italian	19	2	21
Korean	1		
Kurdish (Bahdini)	1		
Kurdish (Sorani)	5		
Latvian	2		
Lithuanian	5		
Mandarin	27		
Nepali	9		
Pashto	1		
Polish	169	14	183
Portuguese	27		
Punjabi	5		
Romanian	9		
Russian	9		
Slovak	9	4	13
Spanish	6		
Swahili	1		
Tigrinya	3		
Turkish	26		
Urdu	5		
Total	437	35	472

1.5 Access to the Trust Website

The Trust's website covers information about all of the Trust's sites and services. The site, which can be viewed at www.york.nhs.uk , complies with WCAG/WAI web standards and guidelines, as required by the NHS and all other UK public sector organisations. The site also includes "BrowseAloud" (a free screen reader service for people with visual impairments, learning disabilities, etc) text resizing and access keys. There is a translation tool for languages other than English.

During 2014 a mobile-compatible version of the website was launched to make the site more accessible for people using mobile phones, tablets, and other devices to browse the internet.

1.6 Access to Buildings

The Trust monitors access to our properties and services through a number of ways predominantly through feedback from individuals and the user support groups. Accessibility issues are always considered in new and improvement schemes.

This year it was suggested that in our busy working lives it would be useful to develop a quick reference set of principles to ensure change is inclusive and we enable an accessible environment and services. A task and finish group from the Fairness Forum developed “Welcoming Changes to the Environment” which is a one page chart including contacts which prompts us to consider:

Way finding
Equipment
Lighting
Colour
Organisation
Meals
Interest
Nature
Guidance

Further Work Required:

- Publish and promote the one page Welcoming guide on the intra net
- Develop an audit access tool and programme

1.7 Safeguarding Adults and Learning Disability Liaison

The Trust is committed to safeguarding adults and works in partnership with a range of other agencies to ensure appropriate actions are taken locally to protect adults at risk of abuse. The Trust follows a multi-agency procedure for responding to suspected abuse of vulnerable adults.

This has now been reviewed in line with the Care Act, introduced from 1st April and mirrors the guidance offered in the Local Authorities Multi-Agency Procedures for Safeguarding Adults.

The Care Act Safeguarding Adults process places more focus on any enquiries being person centred and establishing the wishes of the alleged victim or family/advocate dependent on capacity. The responsibility of establishing the outcome will be that of the Trust Safeguarding Adults Team. There will be a requirement for a member of the team to discuss what the person wants from the safeguarding adults' process. The resultant enquiry will work towards these outcomes. .

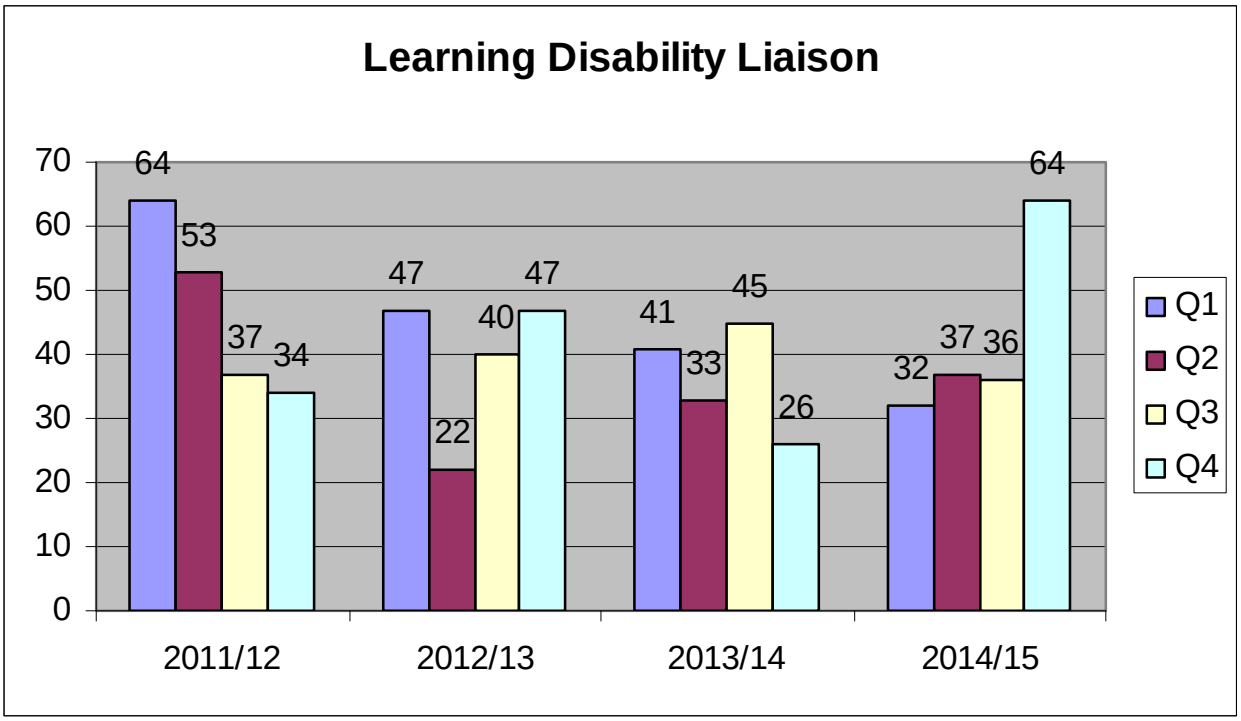
In addition the Trust has the following policies and guidance to support staff to care for an adult at risk:

- Mental Capacity Act Guidance
- Deprivation of Liberty Safeguards Guidance
- Therapeutic Restrictions Guidance
- Learning Disability Services specification

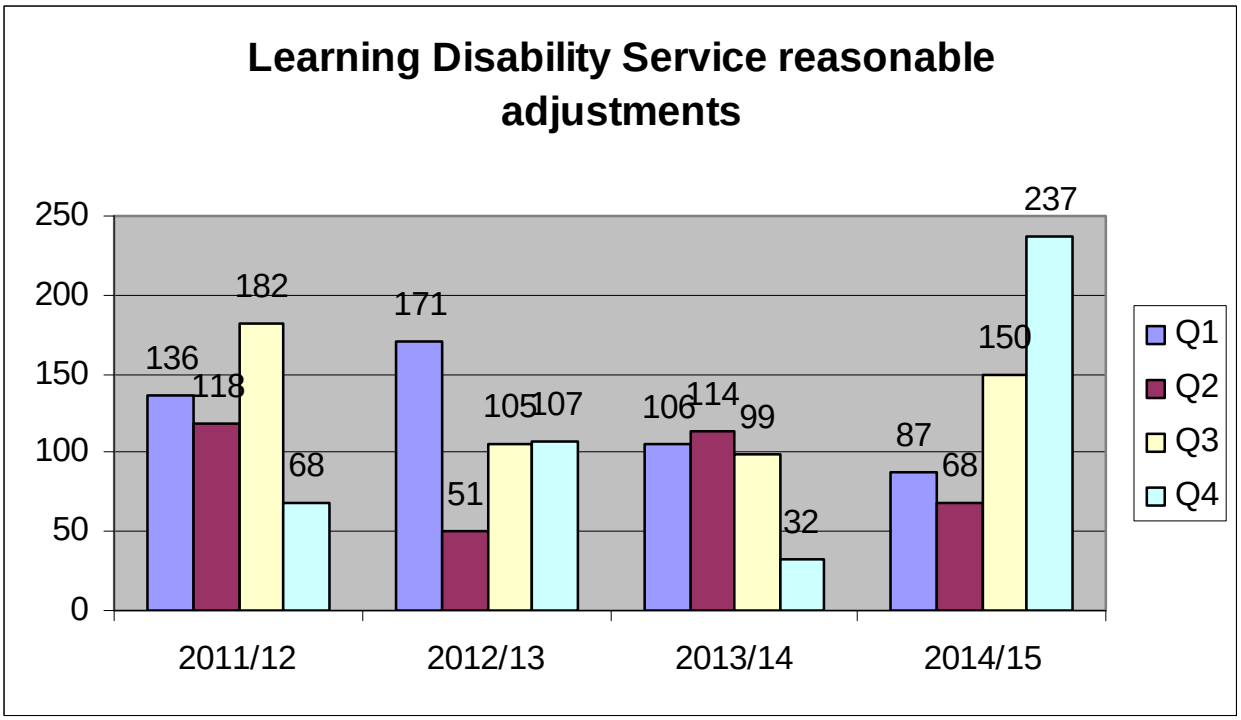
A learning disability nurse is available to support patients with learning disabilities in acute settings along with their family/carers facilitating reasonable adjustments to ensure equality in healthcare. Whether the hospital care required is an appointment or an overnight stay they gather information and plan for the hospital staff to ensure appropriate care for each individual.

There were 150 Safeguarding Adults alerts received in 2014/15. This figure relates to all alerts referred through the Safeguarding Adults Team raised either against or by the Trust.

During 2014/2015 support was given to 169 patients with learning disabilities.



Reasonable adjustments were made in 2014/2015 as follows:



Reasonable adjustments include:

Carer Support

Needs summary

Ward visit

Home Visit

Familiarisation programmes

Accessible information

Parking/transport support

A reduction in referrals was apparent initially in 2014. This is because of the increased demand from the safeguarding adults agenda. This meant that only priority cases have been supported where previously the Learning Disability Liaison Service offered support to patients who may not have an imminent appointment. However following a change in structure Learning Disability Liaison now to has the resources to offer broader pre-emptive support and as a result referrals and support has noted a significant and continuing rise

Further Work Required:

- Discussion with other agencies to ensure collection of data across protected characteristics

Patient Activity 1.8

This section of the report relates to patient activity, which has been extracted from our Core Patient Database (CPD).

There are many national and local access and performance targets that the Trust is measured against. We have chosen to look at:

- Inpatient Admissions (Day Case, Elective, Non Elective)
- Outpatient Attendance / DNAs (Did Not Attend)
- Emergency Department 4 hour wait to treatment/admission/transfer (Breach/ Non breach)

We have assessed these key national indicators against the following protected characteristics:

- Gender
- Age
- Ethnicity

Data is presented in three sets; Trust as a whole, York locality, Scarborough locality and the. A summary of the data can be seen after the tables.

Inpatient Admissions: April 2014 - March 2015

Trust (both York and Scarborough Areas)

Admissions Split by Gender

Gender	Day Case - Elective		Ordinary - Electives		Ordinary - Non Electives		Total Admissions
	Spells	% of Daycases	Spells	% of Electives	Spells	% of Non Electives	
Female	33360	51.89%	5065	51.75%	39363	61.24%	77788
Male	30930	48.11%	4722	48.25%	24914	38.76%	60566
Grand Total	**64290**	**100.00%**	**9787**	**100.00%**	**64277**	**100.00%**	**138354**

Admissions Split by Age group

Age Group	Day Case - Elective		Ordinary - Electives		Ordinary - Non Electives		Total Admissions
	Spells	% of Daycases	Spells	% of Electives	Spells	% of Non Electives	
0 - < 18	1758	2.73%	326	3.33%	7831	12.18%	9915
18 - < 50	13663	21.25%	2063	21.08%	22109	34.40%	37835
50 - < 65	16206	25.21%	2301	23.51%	7358	11.45%	25865
65 - < 75	16799	26.13%	2432	24.85%	7933	12.34%	27164
75+	15864	24.68%	2665	27.23%	19046	29.63%	37575
Grand Total	**64290**	**100.00%**	**9787**	**100.00%**	**64277**	**100.00%**	**138354**

Admissions split by Ethnicity

Ethnicity	Day Case - Elective		Ordinary - Electives		Ordinary - Non Electives		Total Admissions
	Spells	% of Daycases	Spells	% of Electives	Spells	% of Non Electives	
African	43	0.07%	4	0.04%	83	0.13%	130
Any other asian background	85	0.13%	7	0.07%	135	0.21%	227
Any other black background	4	0.01%	4	0.04%	20	0.03%	28
Any other ethnic group	105	0.16%	23	0.24%	162	0.25%	290
Any other mixed background	34	0.05%	2	0.02%	120	0.19%	156
Any other White Background	2136	3.32%	384	3.92%	6350	9.88%	8870
Bangladeshi	52	0.08%	1	0.01%	48	0.07%	101
British	56986	88.64%	8318	84.99%	49937	77.69%	115241
Caribbean	18	0.03%	4	0.04%	17	0.03%	39
Chinese	80	0.12%	10	0.10%	81	0.13%	171
Indian	114	0.18%	14	0.14%	143	0.22%	271
Irish	183	0.28%	28	0.29%	156	0.24%	367
Not Stated	4326	6.73%	960	9.81%	6775	10.54%	12061
Pakistani	35	0.05%	8	0.08%	63	0.10%	106
White and Asian	57	0.09%	7	0.07%	104	0.16%	168
White and Black African	14	0.02%	4	0.04%	44	0.07%	62
White and Black Caribbean	18	0.03%	9	0.09%	39	0.06%	66
Grand Total	**64290**	**100.00%**	**9787**	**100.00%**	**64277**	**100.00%**	**138354**

York Area

Admissions Split by Gender

Gender	Day Case - Elective		Ordinary - Electives		Ordinary - Non Electives		Total Admissions
	Spells	% of Daycases	Spells	% of Electives	Spells	% of Non Electives	
Female	23219	52.49%	3455	51.77%	26517	61.61%	53191
Male	21014	47.51%	3219	48.23%	16522	38.39%	40755
Grand Total	**44233**	**100.00%**	**6674**	**100.00%**	**43039**	**100.00%**	**93946**

Admissions Split by Age group

Age Group	Day Case - Elective		Ordinary - Electives		Ordinary - Non Electives		Total Admissions
	Spells	% of Daycases	Spells	% of Electives	Spells	% of Non Electives	
0 - < 18	1655	3.74%	296	4.44%	5075	11.79%	7026
18 - < 50	9876	22.33%	1510	22.63%	15785	36.68%	27171
50 - < 65	11200	25.32%	1568	23.49%	4988	11.59%	17756
65 - < 75	11229	25.39%	1501	22.49%	5239	12.17%	17969
75+	10273	23.22%	1799	26.96%	11952	27.77%	24024
Grand Total	**44233**	**100.00%**	**6674**	**100.00%**	**43039**	**100.00%**	**93946**

Admissions split by Ethnicity

Ethnicity	Day Case - Elective		Ordinary - Electives		Ordinary - Non Electives		Total Admissions
	Spells	% of Daycases	Spells	% of Electives	Spells	% of Non Electives	
African	38	0.09%	4	0.06%	68	0.16%	110
Any other asian background	51	0.12%	5	0.07%	118	0.27%	174
Any other black background	2	0.00%	1	0.01%	15	0.03%	18
Any other ethnic group	73	0.17%	19	0.28%	117	0.27%	209
Any other mixed background	28	0.06%	2	0.03%	86	0.20%	116
Any other White Background	1879	4.25%	330	4.94%	3524	8.19%	5733
Bangladeshi	48	0.11%	1	0.01%	32	0.07%	81
British	38489	87.01%	5432	81.39%	32463	75.43%	76384
Caribbean	16	0.04%	4	0.06%	10	0.02%	30
Chinese	58	0.13%	8	0.12%	66	0.15%	132
Indian	102	0.23%	10	0.15%	117	0.27%	229
Irish	155	0.35%	22	0.33%	123	0.29%	300
Not Stated	3184	7.20%	815	12.21%	6120	14.22%	10119
Pakistani	31	0.07%	6	0.09%	52	0.12%	89
White and Asian	49	0.11%	7	0.10%	77	0.18%	133
White and Black African	14	0.03%	2	0.03%	21	0.05%	37
White and Black Caribbean	16	0.04%	6	0.09%	30	0.07%	52
Grand Total	**44233**	**100.00%**	**6674**	**100.00%**	**43039**	**100.00%**	**93946**

Scarborough Area

Admissions Split by Gender

Gender	Day Case - Elective		Ordinary - Electives		Ordinary - Non Electives		Total Admissions
	Spells	% of Daycases	Spells	% of Electives	Spells	% of Non Electives	
Female	10141	50.56%	1610	51.72%	12846	60.49%	24597
Male	9916	49.44%	1503	48.28%	8392	39.51%	19811
Grand Total	**20057**	**100.00%**	**3113**	**100.00%**	**21238**	**100.00%**	**44408**

Admissions Split by Age group

Age Group	Day Case - Elective		Ordinary - Electives		Ordinary - Non Electives		Total Admissions
	Spells	% of Daycases	Spells	% of Electives	Spells	% of Non Electives	
0 - < 18	103	0.51%	30	0.96%	2756	12.98%	2889
18 - < 50	3787	18.88%	553	17.76%	6324	29.78%	10664
50 - < 65	5006	24.96%	733	23.55%	2370	11.16%	8109
65 - < 75	5570	27.77%	931	29.91%	2694	12.68%	9195
75+	5591	27.88%	866	27.82%	7094	33.40%	13551
Grand Total	**20057**	**100.00%**	**3113**	**100.00%**	**21238**	**100.00%**	**44408**

Admissions split by Ethnicity

Ethnicity	Day Case - Elective		Ordinary - Electives		Ordinary - Non Electives		Total Admissions
	Spells	% of Daycases	Spells	% of Electives	Spells	% of Non Electives	
African	5	0.02%		0.00%	15	0.07%	20
Any other asian background	34	0.17%	2	0.06%	17	0.08%	53
Any other black background	2	0.01%	3	0.10%	5	0.02%	10
Any other ethnic group	32	0.16%	4	0.13%	45	0.21%	81
Any other mixed background	6	0.03%		0.00%	34	0.16%	40
Any other White Background	257	1.28%	54	1.73%	2826	13.31%	3137
Bangladeshi	4	0.02%		0.00%	16	0.08%	20
British	18497	92.22%	2886	92.71%	17474	82.28%	38857
Caribbean	2	0.01%		0.00%	7	0.03%	9
Chinese	22	0.11%	2	0.06%	15	0.07%	39
Indian	12	0.06%	4	0.13%	26	0.12%	42
Irish	28	0.14%	6	0.19%	33	0.16%	67
Not Stated	1142	5.69%	145	4.66%	655	3.08%	1942
Pakistani	4	0.02%	2	0.06%	11	0.05%	17
White and Asian	8	0.04%		0.00%	27	0.13%	35
White and Black African		0.00%	2	0.06%	23	0.11%	25
White and Black Caribbean	2	0.01%	3	0.10%	9	0.04%	14
Grand Total	**20057**	**100.00%**	**3113**	**100.00%**	**21238**	**100.00%**	**44408**

Outpatient Attendances: April 2014 - March 2015

Trust (both York and Scarborough Areas)

Attendances Split by Gender

Gender	Attendances				DNAs				Total Attendances
	1st Attendances		Followups		1st Attendances		Followups		
Female	117317	57.9%	278425	59.2%	6852	52.7%	14091	51.1%	416685
Male	85296	42.1%	191891	40.8%	6158	47.3%	13466	48.9%	296811
Unknown	1	0.0%	0	0.0%	0	0.0%	0	0.0%	1
Grand Total	**202614**	**100.0%**	**470316**	**100.0%**	**13010**	**100.0%**	**27557**	**100.0%**	**713497**

Attendances Split by Age group

Age group	Attendances				DNAs				Total Attendances
	1st Attendances		Followups		1st Attendances		Followups		
0 - < 18	26550	11.6%	57021	11.9%	2812	18.6%	6310	22.4%	92693
18 - < 50	66292	28.9%	121869	25.4%	6818	45.1%	10434	37.1%	205413
50 - < 65	44187	19.2%	89939	18.7%	2318	15.3%	4815	17.1%	141259
65 - < 75	40639	17.7%	92379	19.2%	1211	8.0%	2780	9.9%	137009
75+	51883	22.6%	118855	24.8%	1956	12.9%	3792	13.5%	176486
Grand Total	**229551**	**100.0%**	**480063**	**100.0%**	**15115**	**100.0%**	**28131**	**100.0%**	**752860**

Attendances split by Ethnicity

Ethnicity	Attendances				DNAs				Total Attendances
	1st Attendances		Followups		1st Attendances		Followups		
African	169	0.1%	356	0.1%	18	0.1%	38	0.1%	581
Any other Asian background	335	0.2%	933	0.2%	20	0.2%	58	0.2%	1346
Any other black background	46	0.0%	89	0.0%	6	0.0%	4	0.0%	145
Any other ethnic group	539	0.3%	1364	0.3%	41	0.3%	82	0.3%	2026
Any other mixed background	225	0.1%	597	0.1%	22	0.2%	52	0.2%	896
Any other White Background	10075	5.0%	26440	5.6%	609	4.7%	1116	4.0%	38240
Bangladeshi	121	0.1%	370	0.1%	18	0.1%	45	0.2%	554
British	147586	72.8%	361448	76.9%	9233	71.0%	20541	74.5%	538808
Caribbean	66	0.0%	198	0.0%	4	0.0%	18	0.1%	286
Chinese	279	0.1%	794	0.2%	25	0.2%	29	0.1%	1127
Indian	378	0.2%	1068	0.2%	26	0.2%	95	0.3%	1567
Irish	476	0.2%	1271	0.3%	22	0.2%	61	0.2%	1830
Not stated	41731	20.6%	73774	15.7%	2907	22.3%	5278	19.2%	123690
Pakistani	140	0.1%	517	0.1%	13	0.1%	46	0.2%	716
White and Asian	227	0.1%	598	0.1%	23	0.2%	33	0.1%	881
White and Black African	102	0.1%	261	0.1%	13	0.1%	25	0.1%	401
White and Black Caribbean	119	0.1%	238	0.1%	10	0.1%	36	0.1%	403
Grand Total	**202614**	**100.0 %**	**470316**	**100.0%**	**13010**	**100.0%**	**27557**	**100.0 %**	**713497**

York Area

Attendances Split by Gender

Gender	Attendances				DNAs				Total Attendances
	1st Attendances		Followups		1st Attendances		Followups		
Female	83960	57.9%	216748	59.6%	4379	52.4%	9730	50.7%	314817
Male	60930	42.1%	146746	40.4%	3973	47.6%	9462	49.3%	221111
Unknown	0	0%	0	0%	0	0%	0	0%	0
Grand Total	**144890**	**100%**	**363494**	**100%**	**8352**	**100%**	**19192**	**100%**	**535928**

Attendances Split by Age

Age group	Attendances				DNAs				Total Attendances
	1st Attendances		Followups		1st Attendances		Followups		
0 - < 18	18306	11.6%	43367	12.2%	1599	17.7%	4222	22.3%	67494
18 - < 50	47526	30.0%	92408	25.9%	4228	46.9%	7157	37.7%	151319
50 - < 65	30651	19.4%	67283	18.9%	1423	15.8%	3283	17.3%	102640
65 - < 75	26991	17.1%	66138	18.6%	717	7.9%	1835	9.7%	95681
75+	34727	22.0%	87026	24.4%	1057	11.7%	2476	13.1%	125286
Grand Total	**158201**	**100.0%**	**356222**	**100.0%**	**9024**	**100.0%**	**18973**	**100.0%**	**542420**

Attendances split by Ethnicity

Ethnicity	Attendances				DNAs				Total Attendances
	1st Attendances		Followups		1st Attendances		Followups		
African	150	0.1%	329	0.1%	18	0.2%	35	0.2%	532
Any other asian background	276	0.2%	810	0.2%	14	0.2%	43	0.2%	1143
Any other black background	36	0.0%	74	0.0%	5	0.1%	2	0.0%	117
Any other ethnic group	377	0.3%	1016	0.3%	21	0.3%	39	0.2%	1453
Any other mixed background	188	0.1%	541	0.1%	13	0.2%	45	0.2%	787
Any other White Background	7972	5.5%	23958	6.6%	448	5.4%	888	4.6%	33266
Bangladeshi	89	0.1%	340	0.1%	10	0.1%	41	0.2%	480
British	104323	72.0%	275959	75.9%	5728	68.6%	14014	73.0%	400024
Caribbean	60	0.0%	181	0.0%	3	0.0%	14	0.1%	258
Chinese	212	0.1%	654	0.2%	17	0.2%	20	0.1%	903
Indian	298	0.2%	932	0.3%	19	0.2%	83	0.4%	1332
Irish	408	0.3%	1095	0.3%	12	0.1%	42	0.2%	1557
Not stated	30030	20.7%	56157	15.4%	2011	24.1%	3819	19.9%	92017
Pakistani	116	0.1%	489	0.1%	8	0.1%	42	0.2%	655
White and Asian	182	0.1%	511	0.1%	11	0.1%	23	0.1%	727
White and Black African	75	0.1%	237	0.1%	8	0.1%	15	0.1%	335
White and Black Caribbean	98	0.1%	211	0.1%	6	0.1%	27	0.1%	342
Grand Total	**144890**	**100.0%**	**363494**	**100.0%**	**8352**	**100.0%**	**19192**	**100.0%**	**535928**

Scarborough Area

Attendances Split by Gender

Gender	Attendances				DNAs				Total Attendances
	1st Attendances		Followups		1st Attendances		Followups		
Female	33357	57.8%	61677	57.7%	2473	53.1%	4361	52.1%	101868
Male	24366	42.2%	45145	42.3%	2185	46.9%	4004	47.9%	75700
Unknown	1	0.0%	0	0.0%	0	0.0%	0	0.0%	1
Grand Total	**57724**	**100.0%**	**106822**	**100.0%**	**4658**	**100.0%**	**8365**	**100.0%**	**177569**

Attendances Split by Age group

Age group	Attendances				DNAs				Total Attendances
	1st Attendances		Followups		1st Attendances		Followups		
0 - < 18	8244	11.6%	13654	11.0%	1213	19.9%	2088	22.8%	25199
18 - < 50	18766	26.3%	29461	23.8%	2590	42.5%	3277	35.8%	54094
50 - < 65	13536	19.0%	22656	18.3%	895	14.7%	1532	16.7%	38619
65 - < 75	13648	19.1%	26241	21.2%	494	8.1%	945	10.3%	41328
75+	17156	24.0%	31829	25.7%	899	14.8%	1316	14.4%	51200
Grand Total	**71350**	**100.0%**	**123841**	**100.0%**	**6091**	**100.0%**	**9158**	**100.0%**	**210440**

Attendances split by Ethnicity

Ethnicity	Attendances				DNAs				Total Attendances
	1st Attendances		Followups		1st Attendances		Followups		
African	19	0.0%	27	0.0%		0.0%	3	0.0%	49
Any other asian background	59	0.1%	123	0.1%	6	0.1%	15	0.2%	203
Any other black background	10	0.0%	15	0.0%	1	0.0%	2	0.0%	28
Any other ethnic group	162	0.3%	348	0.3%	20	0.4%	43	0.5%	573
Any other mixed background	37	0.1%	56	0.1%	9	0.2%	7	0.1%	109
Any other White Background	2103	3.6%	2482	2.3%	161	3.5%	228	2.7%	4974
Bangladeshi	32	0.1%	30	0.0%	8	0.2%	4	0.0%	74
British	43263	74.9%	85489	80.0%	3505	75.2%	6527	78.0%	138784
Caribbean	6	0.0%	17	0.0%	1	0.0%	4	0.0%	28
Chinese	67	0.1%	140	0.1%	8	0.2%	9	0.1%	224
Indian	80	0.1%	136	0.1%	7	0.2%	12	0.1%	235
Irish	68	0.1%	176	0.2%	10	0.2%	19	0.2%	273
Not stated	11701	20.3%	17617	16.5%	896	19.2%	1459	17.4%	31673
Pakistani	24	0.0%	28	0.0%	5	0.1%	4	0.0%	61
White and Asian	45	0.1%	87	0.1%	12	0.3%	10	0.1%	154
White and Black African	27	0.0%	24	0.0%	5	0.1%	10	0.1%	66
White and Black Caribbean	21	0.0%	27	0.0%	4	0.1%	9	0.1%	61
Grand Total	**57724**	**100.0%**	**106822**	**100.0%**	**4658**	**100.0%**	**8365**	**100.0%**	**177569**

ED/MIU Attendances: April 2014 - March 2015

Trust (ED and MIU Units)

Attendances Split by Gender

Gender	Breach		Non Breach		Total Attendances
	Attendances	%	Attendances	%	
Male	7557	47.16%	68080	49.57%	75637
Female	8468	52.84%	69241	50.42%	77709
Unknown		0.00%	8	0.01%	8
Grand Total	**16025**	**100.00%**	**137329**	**100.00%**	**153354**

Attendances Split by Age group

Age Group	Breach		Non Breach		Total Attendances
	Attendances	%	Attendances	%	
0 - < 18	694	4.33%	28328	20.63%	29022
18 - < 50	4898	30.56%	56719	41.30%	61617
50 - < 65	2589	16.16%	19951	14.53%	22540
65 - < 75	2366	14.76%	12441	9.06%	14807
75+	5478	34.18%	19854	14.46%	25332
Unknown		0.00%	36	0.03%	36
Grand Total	**16025**	**100.00%**	**137329**	**100.00%**	**153354**

Attendances split by Ethnicity

Ethnicity	Breach		Non Breach		Total Attendances
	Attendances	%	Attendances	%	
African	9	0.06%	87	0.06%	96
Any other asian background	15	0.09%	120	0.09%	135
Any other black background	5	0.03%	38	0.03%	43
Any other ethnic group	32	0.20%	319	0.23%	351
Any other mixed background	9	0.06%	176	0.13%	185
Any other White Background	475	2.96%	5226	3.81%	5701
Bangladeshi	6	0.04%	86	0.06%	92
British	12756	79.60%	86635	63.09%	99391
Caribbean	1	0.01%	24	0.02%	25
Chinese	12	0.07%	112	0.08%	124
Indian	19	0.12%	184	0.13%	203
Irish	39	0.24%	228	0.17%	267
Not Known	2619	16.34%	43649	31.78%	46268
Not Stated	3	0.02%	39	0.03%	42
Pakistani	2	0.01%	71	0.05%	73
White and Asian	9	0.06%	141	0.10%	150
White and Black African	6	0.04%	83	0.06%	89
White and Black Caribbean	8	0.05%	111	0.08%	119
Grand Total	**16025**	**100.00%**	**137329**	**100.00%**	**153354**

ED Units (York and Scarborough)

Attendances Split by Gender

Gender	Breach		Non Breach		Total Attendances
	Attendances	%	Attendances	%	
Male	7556	47.17%	58908	49.33%	66464
Female	8462	52.83%	60508	50.67%	68970
Unknown		0.00%	8	0.01%	8
Grand Total	**16018**	**100.00%**	**119424**	**100.00%**	**135442**

Attendances Split by Age group

Age Group	Breach		Non Breach		Total Attendances
	Attendances	%	Attendances	%	
0 - < 18	694	4.33%	23893	20.01%	24587
18 - < 50	4897	30.57%	49655	41.58%	54552
50 - < 65	2588	16.16%	16795	14.06%	19383
65 - < 75	2363	14.75%	10683	8.95%	13046
75+	5476	34.19%	18369	15.38%	23845
Unknown		0.00%	29	0.02%	29
Grand Total	**16018**	**100.00%**	**119424**	**100.00%**	**135442**

Attendances split by Ethnicity

Ethnicity	Breach		Non Breach		Total Attendances
	Attendances	%	Attendances	%	
African	86	0.07%	9	0.06%	95
Any other asian background	116	0.10%	15	0.09%	131
Any other black background	37	0.03%	5	0.03%	42
Any other ethnic group	303	0.25%	32	0.20%	335
Any other mixed background	166	0.14%	9	0.06%	175
Any other White Background	4783	4.01%	475	2.97%	5258
Bangladeshi	86	0.07%	6	0.04%	92
British	78016	65.33%	12753	79.62%	90769
Caribbean	23	0.02%	1	0.01%	24
Chinese	106	0.09%	12	0.07%	118
Indian	184	0.15%	19	0.12%	203
Irish	209	0.18%	39	0.24%	248
Not Known	34880	29.21%	2615	16.33%	37495
Not Stated	38	0.03%	3	0.02%	41
Pakistani	68	0.06%	2	0.01%	70
White and Asian	135	0.11%	9	0.06%	144
White and Black African	80	0.07%	6	0.04%	86
White and Black Caribbean	108	0.09%	8	0.05%	116
Grand Total	**119424**	**100.00%**	**16018**	**100.00%**	**135442**

MIU Units (Malton and Whitby)

Attendances Split by Gender

Gender	Breach		Non Breach		Total Attendances
	Attendances	%	Attendances	%	
Male	1	14.29%	9172	51.23%	9173
Female	6	85.71%	8733	48.77%	8739
Unknown	0	0.00%	0	0.00%	0
Grand Total	**7**	**100.00%**	**17905**	**100.00%**	**17912**

Attendances Split by Age group

Age Group	Breach		Non Breach		Total Attendances
	Attendances	%	Attendances	%	
0 - < 18		0.00%	4435	24.77%	4435
18 - < 50	1	14.29%	7064	39.45%	7065
50 - < 65	1	14.29%	3156	17.63%	3157
65 - < 75	3	42.86%	1758	9.82%	1761
75+	2	28.57%	1485	8.29%	1487
Unknown		0.00%	7	0.04%	7
Grand Total	**7**	**100.00%**	**17905**	**100.00%**	**17912**

Attendances split by Ethnicity

Ethnicity	Breach		Non Breach		Total Attendances
	Attendances	%	Attendances	%	
African	0	0.00%	1	0.01%	1
Any other asian background	0	0.00%	4	0.02%	4
Any other black background	0	0.00%	1	0.01%	1
Any other ethnic group	0	0.00%	16	0.09%	16
Any other mixed background	0	0.00%	10	0.06%	10
Any other White Background	0	0.00%	443	2.47%	443
Bangladeshi	0	0.00%	0	0.00%	0
British	3	42.86%	8619	48.14%	8622
Caribbean	0	0.00%	1	0.01%	1
Chinese	0	0.00%	6	0.03%	6
Indian	0	0.00%	0	0.00%	0
Irish	0	0.00%	19	0.11%	19
Not Known	4	57.14%	8769	48.98%	8773
Not Stated	0	0.00%	1	0.01%	1
Pakistani	0	0.00%	3	0.02%	3
White and Asian	0	0.00%	6	0.03%	6
White and Black African	0	0.00%	3	0.02%	3
White and Black Caribbean	0	0.00%	3	0.02%	3
Grand Total	**7**	**100.00%**	**17905**	**100.00%**	**17912**

If we compare York locality's 2014 -2015 findings with those from 2013/14 report the following can be observed:

In Patient Admissions

- There has been no material change in the Admissions gender split
- 1.91% rise in day case admissions of patients aged 75+ and nearly 2% rise in the same age category for ordinary non elective admissions.
- There has been a rise in the number of admissions with ethnicity 'not stated' for Day case and ordinary elective admissions but a reduction from 12.55% to 10.54% for non elective admissions. It is believed this is due to focussed work by a senior AMU ward clerk on the York site.

Out Patient Attendance / Did Not Attend (DNA's)

- OP attendances have reduced by 8346 overall.
- Increase from 20.5% to 22.6% of patients over 75 yrs of age attending a first OP appointment and a reduction of DNAs in this category from 10% to 9.7%.

Emergency Department (ED)

4 Hour Wait to treatment / admission / transfer

- Attendances at ED and MIUs have increased by 3764 but patients who breach the 4 hour standard have increased by 7041 patients.
- Females who breach the standard have increased from 49.61% to 52.84%.
- There has been an increase of 303 attendances in the 75yrs + age range. Breaches in this age range have increased from 30.15% to 34.18%.

- In the two EDs, an attendance by patients aged over 75years has increased by 11% but the number of breaches in this age category has increased by 102%. This is reflective of the increasing complex needs of these patients and strategies to address these needs currently from part of the Trust's Operational Performance Recovery Plan.

The Trust remains mindful of the impact of other local issues on activity figures such as the tourist industry especially during the summer months and the impact of York Races which attracts people from a very wide catchment area.
During the year there has been continued focussed effort on engaging staff in the importance of recording ethnicity as a protected characteristic and we achieved our local improvement target for recording ethnicity, when patients are admitted to hospital.

Further Work Required

- Scope the feasibility of recording more protected characteristics onto our Core Patient Database (CPD).
- Ensure data capture is aligned to other data sets to allow comparisons
- Consider looking at Cancer targets and any potential protected characteristics that may prevent timely access.
- Continue progress in increasing the capture rate of protected characteristics on CPD by means of staff awareness.
- Continue work to ensure the Hospitals are able to adequately meet the needs of older persons attending as Emergencies.

1.9 Patient* Experience

*We use the term ‘patient’ to represent patients, their carers, their families and any other people involved in their care.

The Trust Patient Experience Team sits within the Chief Nurse team with a focus on making sure that patients’ experiences can be heard and to encourage feedback on their experience of our Trust through:

- Patient and Public Involvement (PPI)
- Patient Advice and Liaison Service (PALS) and
- concerns and complaints

York Teaching Hospital NHS Foundation Trust is committed to improving the experiences of patients accessing our services. We want everyone who accesses our services to have a high quality, positive experience. Listening to, involving and responding to patients allows us to focus on providing services which are responsive to their needs.

Patient Experience is a key element of quality alongside clinical excellence and safe care. It is integral to our Trust values, which centre on the core value “patients at the centre of everything we do”. By continually listening to our patients and placing them at the heart of our services, we can continue to make improvements and successfully deliver high quality health services.

The Trust’s Patient Experience Strategy – “Your Experiences Matter” – will be launched in September 2015. This document outlines the importance of patient experience and of collecting feedback. This follows the launch of a new leaflet with the same name, published in February 2015. This leaflet provides information about how all patients can share feedback with the Trust.

1.10 National Surveys

Each year the Trust takes part in a national programme of patient surveys led by the CQC. The responses to these, alongside the other work the Patient Experience Team does, contribute to our understanding of patients' experiences within the Trust.

The annual National Inpatient Survey selects patients who have had an inpatient stay within a certain month of the year to take part in the survey. The questions within the survey cover:

- The patient's pathway from when admitted to hospital;
- The treatment and care they receive whilst in hospital;
- The quality of our communication with patients and
- The information we provide through to the point at which they are discharged from hospital.

In 2014/15 the Trust also took part in the:

- National Paediatric Survey
- National Cancer Survey

Some results from the National Cancer Survey:
89% were always treated with respect and dignity
90% were given easy to understand written information about their test
88% got understandable answers to important questions
97% knew who to contact if worried post discharge

All national surveys invite respondents to complete E&D monitoring information and most patients complete this; responses from the most recent National Inpatient Survey:

- 98% (n=353) are English/Welsh/Scottish/ Northern Irish/British. 0.6% (n=2) Irish, 0.8% (n=3) 'Any other White background', 0.3% (n=1) for each of 'White and Black Caribbean' and 'Pakistani'.
- 47% male, 53% female
- 14% have no religion, 82% are Christian
- 92% are heterosexual

Results from all national surveys are available in the news and publications section of our website.

The Friends and Family Test (FFT)

The FFT is a national survey which asks inpatients, outpatients, emergency department attendants and maternity service users “how likely are you to recommend our ward/service to friends and family if they needed similar care or treatment?” with answers ranging from extremely likely to extremely unlikely. We ask a follow-up question to find out why answers were given or how we could change things for the better. Findings from FFT are used across the Trust to help improve areas where patients report issues.

The Trust asks the question through various means, a card with the option for patients to scan a code and complete on-line, in our Emergency Departments a text message system where patients receive a text following their attendance at the Emergency Department and can reply via their phone to the questions.

In March 2015 the font size on the cards was increased and additional equality and diversity monitoring questions were asked. While previously cards asked questions only about age and gender, we now ask about disability and ethnicity. More work is to being planned in line with recommendations from EDS2 to align the protected characteristic category options.

Over the last 12 months approximately 55,000 responses were received from the FFT cards. 40% were completed by men, 60% by women. Nearly 5000 have been completed by women accessing maternity services. Over half of the cards are completed by patients over the age of 65. As of 1 April 2015 the Trust will ask children the same question, therefore gaining gain more views from children and young people who access our services.

Analysis from the FFT cards with the new E&D monitoring information shows that approximately 20% of respondents consider themselves to have a disability. 98% identified themselves as white. These are early findings but as additional services move to the new card, the Trust will be able to analyse the results from a greater number of responses and ensure all patients are given the opportunity to provide feedback, regardless of protected characteristics.

Translations into a large selection of languages have been completed by NHS England to support the promotion of the NHS Friends and Family Test and these are detailed and available online.

1.11 Local Service Led Surveys

Across the Trust we use a range of different ways to capture patient feedback, for example:

- Paper and online surveys
- Volunteers speaking directly to patients
- Electronic tablets and text messages
- Patient Narratives
- Focus groups and listening exercises

Our Directorates actively encourage feedback from patients and staff, and all undertake surveys each year to fully understand how patients experience their services. For example the Renal Services Team ran a patient satisfaction survey which showed that transport was an issue for patients, and that there was a perception of low staffing levels. The Patient Experience Team worked with senior nursing staff within the renal team to create a poster which fed the results back to patients, along with plans for how they will try and overcome these concerns.

Directorates use information from patient experience feedback to make improvements to services. It is important that patients appreciate how they can influence services and what we do with the information they provide, what the improvements (or reasons why we can't make improvements) have been. To enable this we have introduced "Knowing How We're Doing" posters. These are large posters displayed on every ward around the Trust which were rolled out during 2014/2015 displaying recent Friends and Family Test data and comments from patients (specific to the ward or area). Like the poster for the Renal service mentioned above, these inform patients and visitors about recent improvements. On each poster there is information about how to provide feedback, raise a concern and contact PALS. Also included is an important message to re-iterate to patients that raising a concern will not compromise their care and treatment in any way but serves to make improvements.

1.12 Concerns, Complaints and PALS

The Patient Advice and Liaison Service (PALS) provides help, advice and support to patients. The team listens to suggestions or queries and tries to help settle any concerns quickly. A patient can make a complaint or raise a concern in a number of ways:

- In person
- Over the phone
- By email
- By letter
- Completion of a Friends and Family Test card
- Via our website or NHS Choices
- Using social media

A monitoring form to capture protected characteristics for all formal complaints is issued when the acknowledgment letter is sent out. Numbers vary from month to month, but over the course of a year we expect fewer than 20% of complainants to return the monitoring form.

Examples of meeting individual needs during complaint handling:
• Providing letters in larger fonts
• Meeting with a complainant to share outcomes of an investigation verbally for a patient with mild learning disability
• Liaising with the Learning Disability Nurse to alter written information into a format and language which meet recipients' requirements
• Translating leaflets, letters etc into other languages
• Arranging meetings in venues suitable for complainants with mobility issues.

Equality monitoring information for a PALS contact is recorded only when it is raised as part of the issue. In the last year we recorded six contacts as being concerns about 'discrimination'. Two were regarding access to facilities (wheelchair cannot easily go over pebbles to garden area; immobile patients cannot reach TV lounge and do not have access to TV near bed). One concern was regarding a lack of understanding of homosexuality, another about attitude towards use of contraception by a Muslim. Two callers were worried about being victimised or treated differently at future appointments because they had previously complained. All concerns are passed on to the appropriate areas and action was taken where possible.

Further work required:
Review the accessibility of PALS

1.13 Involvement and Engagement

The Trust actively seeks patient and public feedback through user reference and support groups across the Trust including:

- Maternity Services Liaison group
- Eye Clinic Partnership group
- York District Cancer Partnership group
- Older People's Liaison group
- Stroke Patient and Carer group
- York Limbless Support group

Healthwatch
Healthwatch England is the independent consumer champion for health and social care in England and ensures that the voices of those who use services reach the ears of decision makers. Local Healthwatch provides a way to influence local health and social care services. Healthwatch helps the local community to get the best out of local health and social care services.

All Healthwatch organisations serving the Trust are represented on a number of Trust groups including the Fairness Forum and the Patient Experience Steering Group.

In 2014 the Trust worked with Healthwatch on reports received from Healthwatch York (Access to Health and Social Care for Deaf People December 2013 and Discrimination Against Disabled People June 2014) An Access to Services Group have developed an action plan in response to Healthwatch. The plan was discussed and amendments agreed at an open meeting with Healthwatch, members of the Deaf community, Vale of York Clinical Commissioning Group and North Yorkshire County Council. The Access to Services Group has passed the plan to the Fairness Forum for monitoring.

Further Work Required:
Respond to Access to Services action plan
Respond to actions identified via EDS2

Section 2: Our Workforce

Our policy and practices are reviewed and implemented in conjunction with our staff side organisations and professional bodies.

The Trust is working towards EDS2 goals and with reference to our workforce is committed to progressing Goal 3 – A representative and supported workforce.

The NHS has also published a Workforce Race Equality Standard (WRES) and the Trust's first submission of information required to monitor progress under the standard will take place in summer 2015. The information submitted will reflect staff responses to the Annual Staff survey as well as data collected from recruitment, disciplinary and training records. The standard seeks to tackle a particular aspect of equality – the less favourable treatment of the Black Minority Ethnic (BME) workforce. It is the case that most if not all of our further work will progress both the WRES and EDS2 and both support our public sector equality duty requirements.

During 2014 and 2015 the trust has had a number of initiatives to enhance the data held on its' workforce, particularly in relation to disability; religion; ethnicity and sexual orientation. In this year's report the primarily focus in the analysis is on permanent and fixed term employees (i.e. excluding those on bank contracts[2]).

To follow good practice in data protection and ensure personal privacy, we have combined some categories so that there are at least 10 people in each category. This helps to protect the anonymity of staff. Below is an overview of the trust's workforce, followed by a profile of those joining and leaving the organisation and findings within pay bands.

[2] For the first year there is however a small section which summarises the key findings for our temporary workforce

2.1 Staff Profile

The staff profile here is based on a snapshot of all members of staff working for the York Teaching Hospital as at 31 March 2015. We also show data from 31 March 2014 to compare how the profile has changed.

The overall number of Trust staff increased from 8,573 on 31 March 2014 to 8,739 on 31 March 2015.

Gender

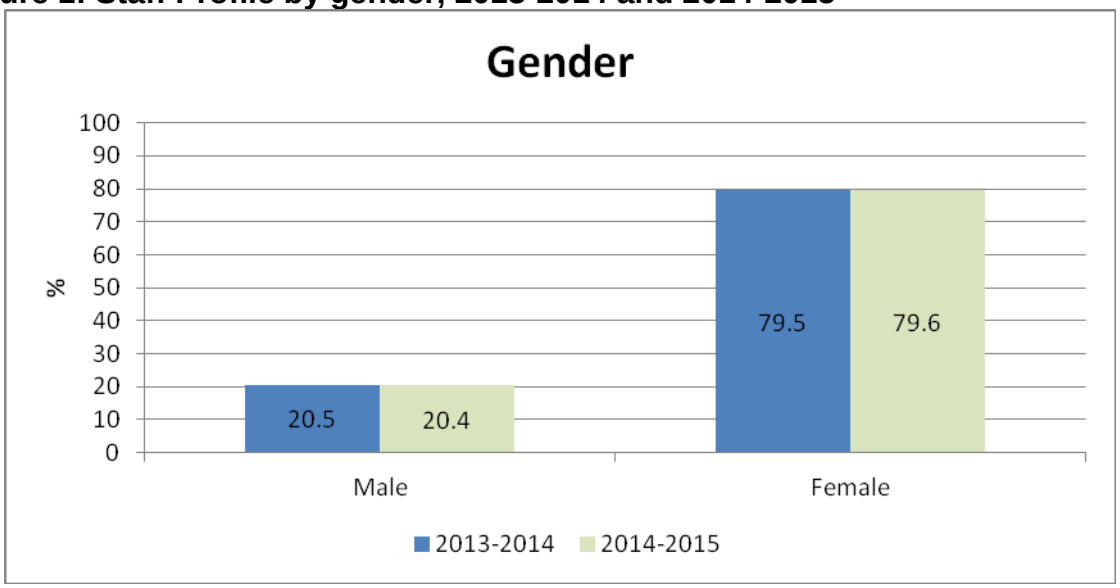
Women make up 79.6% of the Trusts workforce (effectively the same as last year's figure of 79.5%). The largest percentage of staff is seen for those in Nursing and Midwifery roles (93.7% of this group are women, reflecting this being a sector which traditionally employs more women than men).

Table 1: York Teaching Hospitals Foundation Trust staff profile by gender, 2013-2014 and 2014-2015

Gender	*Number of staff March 2015*	*% total staff March 2015*	*Number of staff part time 2015**	*Number of staff full time 2015**	*Number of staff March 2014*	*% total staff March 2014*	*Number of staff part time 2014*	*Number of staff full time 2014*	*Change in staff % from 2014*
Female	6,959	79.6	3,711	3,247	6,813	79.5	3,673	3,140	0.1
Male	1,780	20.4	333	1,447	1,760	20.5	344	1,416	-0.1
Total	8,739		4,044		8,573		4,017	4,556	

* Note – at the end of March 2015 one person's part time / full time status was shown as undefined. This applies to all tables with part time / full time status analysis

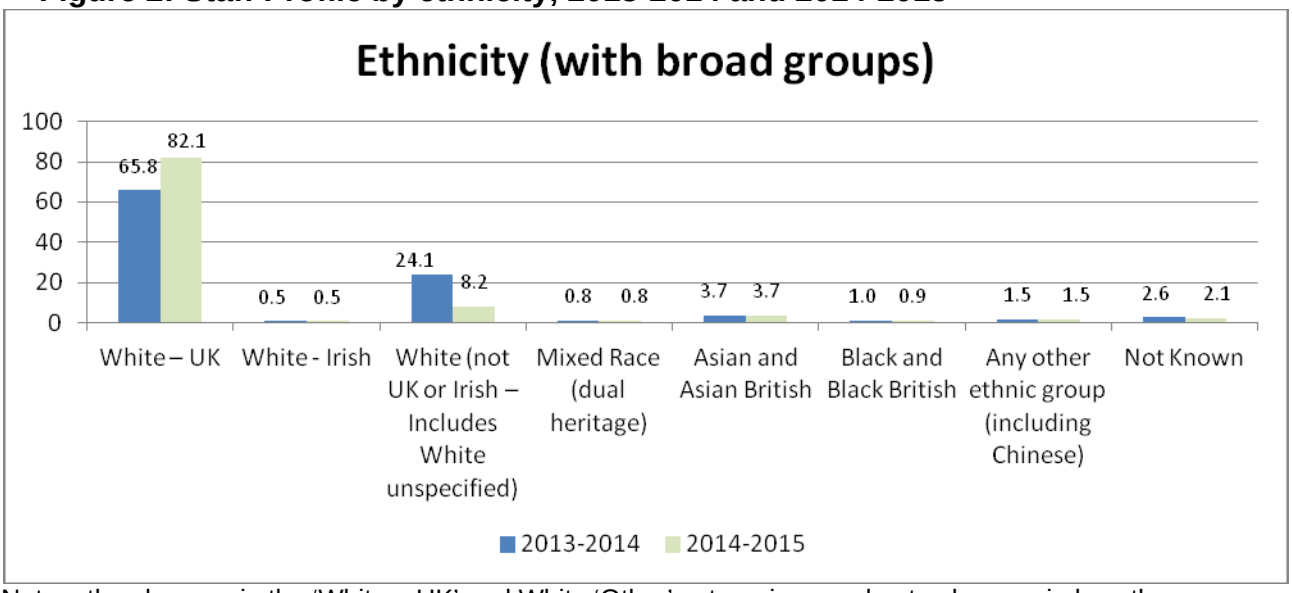
Figure 1: Staff Profile by gender, 2013-2014 and 2014-2015



Ethnicity

The percentage of our staff who identify their ethnicity as being White (90.9%) is broadly the same as last year (90.4%). The overall percentage of BME staff is 7.0%.

Figure 2: Staff Profile by ethnicity, 2013-2014 and 2014-2015



Note – the changes in the 'White – UK' and White 'Other' categories are due to changes in how these are measured between years

In terms of more detailed categories the largest category is White UK (82.1%), followed by White – Other (8.2%). The largest BME group was Asian and Asian British, accounting for 3.7% of all staff. There are few changes since last year - the picture being broadly very similar to as it is now.

Table 2: York Teaching Hospitals Foundation Trust staff profile by ethnicity, 2013-2014 and 2014-2015

Ethnicity	Number of staff March 2015	% total staff March 2015	Number of staff part time 2015	Number of staff full time 2015	Number of staff March 2014	% of staff March 2014	Number of staff part time 2014	Number of staff full time 2014	Change in staff % from 2014
White – UK	7,178	82.1	3,728	3,449	5,644	65.8	2,696	2,948	16.3
White - Irish	45	0.5	27	18	41	0.5	19	22	0.0
White – other	717	8.2	344	373	2,062	24.1	1,051	1,011	-15.9
White total	7,940	90.9	4,099	3,840	7,747	90.4	3,766	3,981	0.5
Mixed Race (dual heritage) total	68	0.8	46	22	70	0.8	25	45	0.0
Asian and Asian British total	327	3.7	285	42	315	3.7	55	260	0.0
Black and Black British total	83	0.9	64	19	84	1.0	15	69	-0.1
Any other ethnic group (inc.Chinese)	135	1.5	113	22	132	1.5	27	105	0.0
BME total	613	7.0	508	105	642	7.5	141	501	-0.5
Not Known	186	2.1	87	99	225	2.6	129	96	-0.5
Total	8,739		4,694	4,044	8,573		4,017	4,556	

Sexual Orientation

The percentage of staff where we do not know / the person does not want to disclose their sexual orientation continues to decline (from 68.5% in 2014 to 61.7%). Although this is still a high figure two years ago this was as high as 74.7% of all staff.

57 of our staff are lesbian, gay or bisexual (0.7% of all staff, up from 0.5% last year). The percentage of heterosexual staff has increased from 31.1% to 37.7%, most likely due to enhancements to the information held by the trust.

Figure 3: Staff Profile by Sexual Orientation, 2013-2014 and 2014-2015

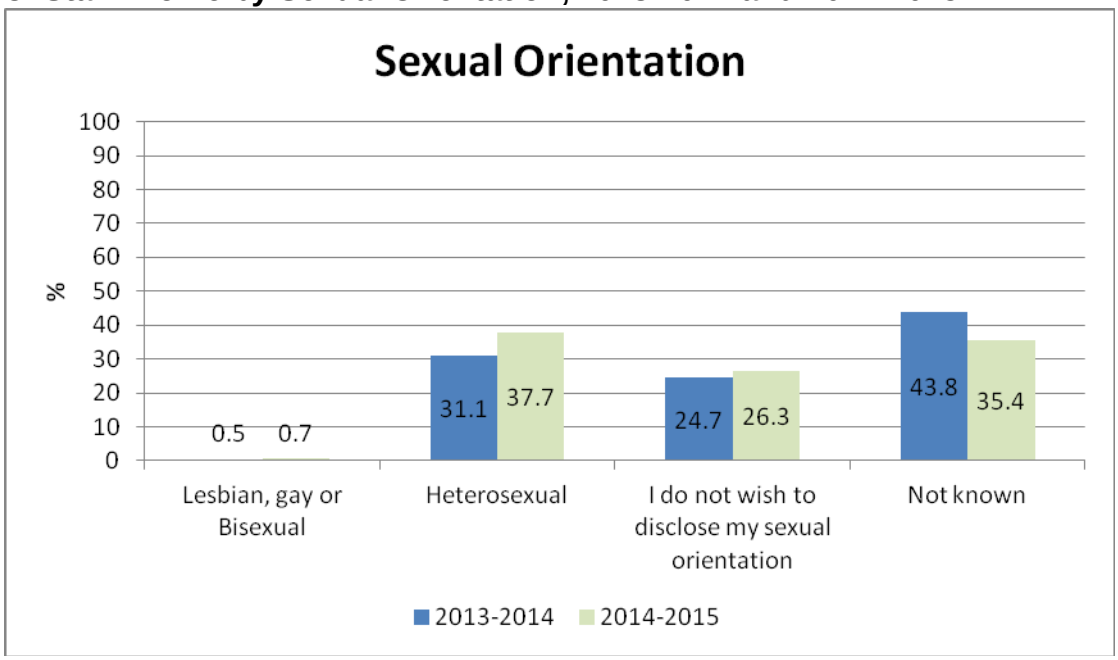


Table 3: York Teaching Hospitals Foundation Trust staff profile by sexual orientation, 2013-2014 and 2014-2015

Sexual Orientation	Number of staff March 2015	% total staff March 2015	Number of staff part time 2015	Number of staff full time 2015	Number of staff March 2014	% of staff March 2014	Number of staff part time 2014	Number of staff full time March 2014	Change in staff % 2014
Lesbian, gay or Bisexual	57	0.7	To protect anonymity of staff the part / full time analysis cannot be shown here		39	0.5	<10	<10	0.2
Heterosexual	3,293	37.7			2,660	31.1	1,073	1,587	6.6
I do not wish to disclose my sexual orientation	2,294	26.3			2,116	24.7	1,172	944	1.6
Not known	3,095	35.4			3,758	43.8	1,767	1,991	-8.4
Total	8,739				8,573		4,012	4,522	

Religion and Belief

The percentage where we do not know the staff's religion and beliefs continues to improve and we can see reduced numbers reported in this category (albeit still accounting for 35.4% of all staff). A quarter of our staff (24.8%) do not wish to disclose their religion / beliefs.

Christians make up 28.6% of the staff, up from 25.0% the previous year.

Figure 4: Staff Profile by Religion and Belief, 2013-2014 and 2014-2015

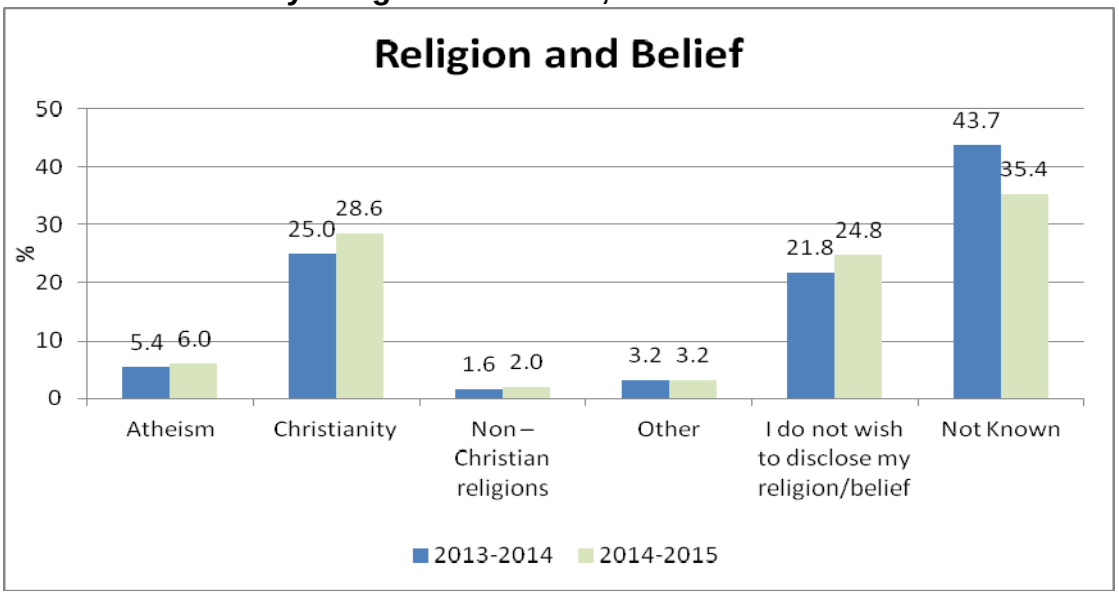


Table 4: York Teaching Hospitals Foundation Trust staff profile by Religion and Belief, 2013-2014 and 2014-2015

Religion and Belief	Number of staff March 2015	% total staff March 2015	Number of staff part time 2015	Number of staff full time 2015	Number of staff March 2014	% total staff March 2014	Number of staff part time 2014	Number of staff full time March 2014	Change in staff % 2014
Atheism	521	6.0	156	365	461	5.4	130	331	0.6
Christianity	2,498	28.6	1,135	1,362	2,135	25.0	938	1,197	3.6
Non – Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	175	2.0	21	154	138	1.6	31	107	0.4
Other	284	3.2	105	179	227	3.2	80	147	0.0
I do not wish to disclose my religion/belief	2,167	24.8	1,166	1,001	1,869	21.8	1,078	791	3.0
Not Known	3,094	35.4	1,461	1,633	3,743	43.7	1,760	1,983	-8.3
Total	8,739		4,044	4,694	8,573		4,017	4,556	

Age

The age profile is similar to last year. The most notable changes were however in the percentage of staff who are under 25 years old – this increasing from 8.1% in 2014 to 8.5%, whilst those in the 41-45 age group fell from 13.2% to 12.7%.

Figure 5: Staff Profile by Age, 2013-2014 and 2014-2015

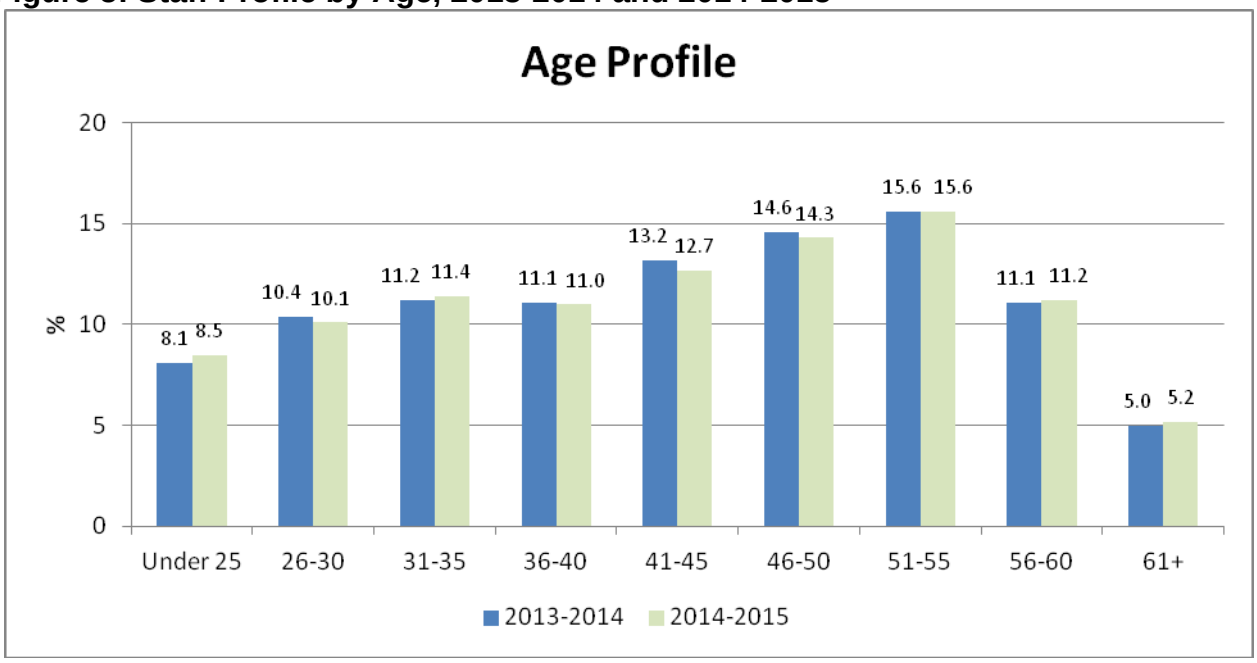


Table 5: York Teaching Hospitals Foundation Trust staff profile by age, 2013-2014 and 2014-2015

Age	Number of staff March 2015	% total staff March 2015	Number of staff part time 2015	Number of staff full time 2015	Number of staff March 2014	% total March 2014	Number of staff part time 2014	Number of staff full time 2014	Change in staff % from March 2014
Under 25	740	8.5	575	268	690	8.1	175	515	-0.4
26-30	881	10.1	613	450	888	10.4	282	606	0.3
31-35	996	11.4	546	472	959	11.2	442	517	-0.2
36-40	958	11.0	486	537	948	11.1	463	485	0.1
41-45	1,114	12.7	577	590	1,128	13.2	564	564	0.5
46-50	1,252	14.3	661	678	1,247	14.6	572	675	0.3
51-55	1,361	15.6	683	563	1,337	15.6	678	659	0
56-60	983	11.2	420	321	948	11.1	542	406	-0.1
61+	454	5.2	133	4,044	428	5.0	299	129	-0.2
Total	8,739		4,694		8,573		4,017	4,556	

Disability

The trend has continued with regard to increases in the number of staff who indicated that they have a disability (up from 90 in 2014 to 103 in 2015). This

increase appears to have been primarily driven by the those joining the Trust, rather than a significant increase in existing staff who have acquired an impairment and have had their information updated in the ESR system.

Based on data held in ESR the Trust still appears to have a low percentage (1.2%) of staff identifying themselves as disabled. It may be the case that some staff may be reluctant to declare that they are disabled for a number of reasons. This low percentage is not reflected in the annual staff survey (2014) where 16% of staff identified themselves as having a long-standing illness, health problem or disability. This figure (16%) is also higher than the 13% of public sector workers that are disabled and the number of disabled employees in the UK's workforce (10.5%).

The percentage of staff whose disability status is 'not known' has also fallen from 68.3% to 54.4%, reflecting the trust's efforts to improve the quality of such information.

Figure 6: Staff Profile - Disability, 2013-2014 and 2014-2015

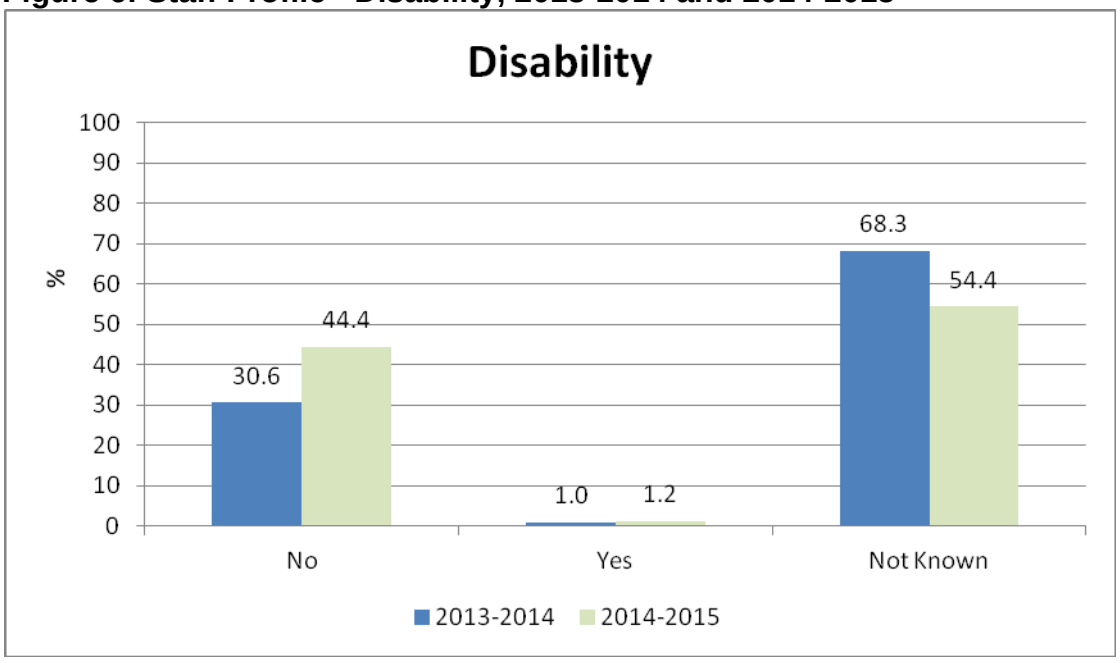


Table 6: York Teaching Hospitals Foundation Trust staff profile - disability status, 2013-2014 and 2014-2015

Disabled Person	Number of staff March 2015	% of staff March 2015	Number of staff part time 2015	Number of staff full time 2015	Number of Staff March 2014	% of staff March 2014	Number of staff part time 2014	Number of staff full time 2014	Change in staff %from 2014
No	3,881	44.4	1,698	2,182	2,624	30.6	1,274	1,350	13.8
Yes	103	1.2	44	59	90	1.0	34	56	0.2
Not Known	4,755	54.4	2,302	2,453	5,859	68.3	2,709	3,150	-13.9
Total	8,739		4,044	4,694	8,573		4,017	4,556	

Within Appendix 1 are a number of charts which highlight the findings within staff groups, e.g. the age profile of our Nursing and Midwifery Workforce.

Further Work Required:

- The capture of protected characteristics information at all points of the employment cycle continues to be a key priority. This includes information in relation to recruitment, learning and development, appraisal, disciplinary and grievance processes, and leavers. The emphasis is on accuracy and encouraging staff to record protected characteristic information which is reflected in a continued reduction in the proportion of 'do not knows'. A data cleansing exercise has been undertaken in the past year which has significantly improved some of the diversity information that we hold for our staff, although some gaps do remain. Work has also been undertaken to ensure that Trust forms (starters, personal change forms etc) capture all of the required information
- We need to continue to raise staff awareness and confidence in the use of such data in order to identify inequalities between different staff groups, monitor incidents of discrimination, facilitate change and proactively tackle identified issues. In the future staff will also be able to review and update their personal information via ESR Self Service.

2.2 Staff Joining the Trust

This data is based on 1,096 new members of staff who joined the Trust between 1 April 2014 and 31 March 2015. The figures for 2014 -2015 do not include Junior Doctors as including this group would adversely reflect on the data and on the findings and conclusions which are then drawn. This is likely to account for the variances from the previous year.

Gender

Males made up 20.9% of new starters – this in line with the 20.4% of all staff employed in the trust who are male. It is however the case that the percentage of all starters who were male has fallen from 28.4% in 2013-2014.

Figure 7: Staff joining the Trust by Gender, 2013-2014 and 2014-2015

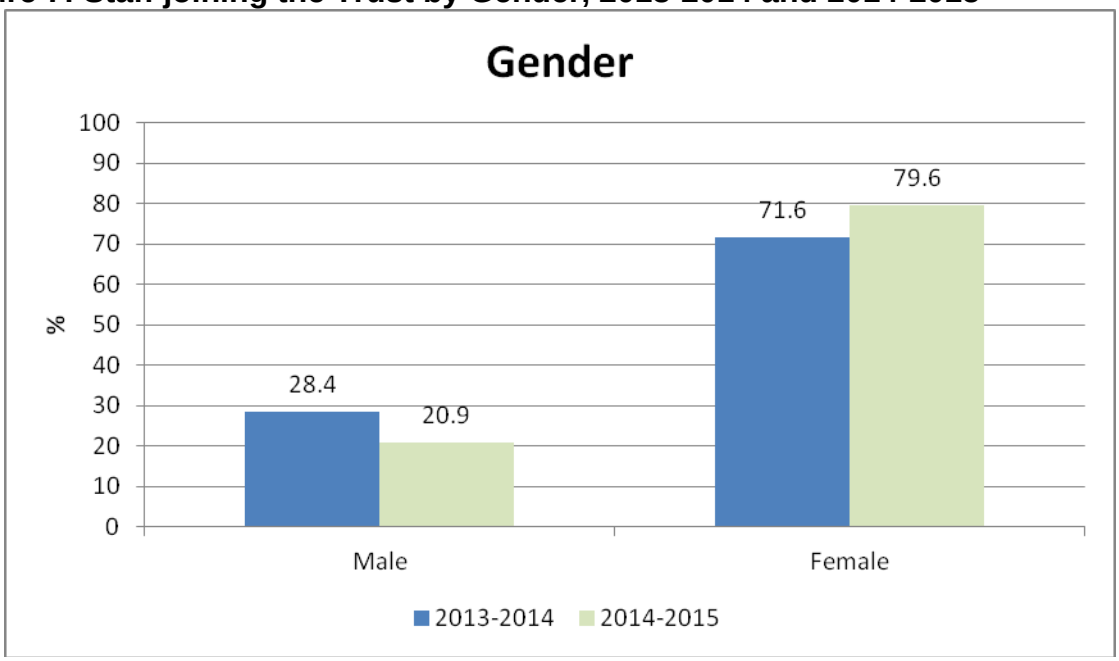


Table 7 - Staff joining York Teaching Hospitals Foundation Trust from 1 April 2014 to 31 March 2015 by gender

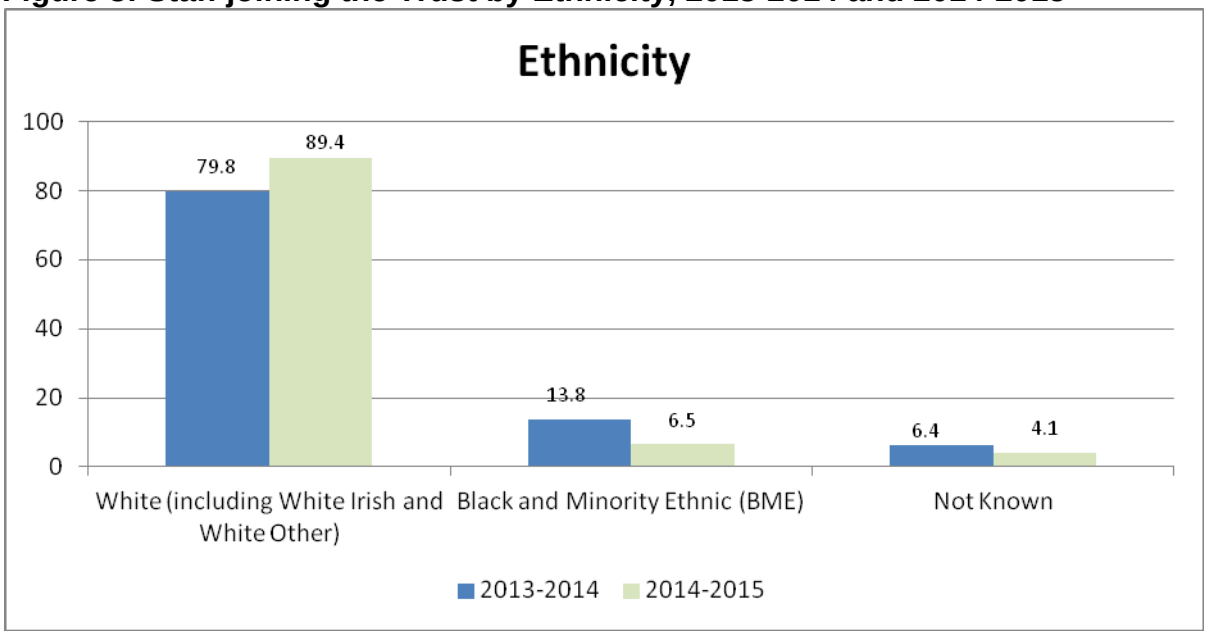
	Total new staff during the year	% of new staff during the year	% total staff at 31 March 2015	% new staff previous year
Gender				
Female	867	79.1	79.6	71.6
Male	229	20.9	20.4	28.4
Total	1,096			

Note – all data here excludes Rotational Doctors

Ethnicity

The percentage of new staff whose ethnicity was unknown fell to 4.1% (down from 6.4% in the previous year). This is also notably better than the levels of 'unknowns' seen for both disability and sexual orientation. The percentage of new starters who said they were from BME groups was 6.5% (compared to 7.0% of all staff).

Figure 8: Staff joining the Trust by Ethnicity, 2013-2014 and 2014-2015



Note – the methodology was revised in 2014-2015 aligning to WRES guidance. This means the figures aren't directly comparable between the two years, so it therefore difficult to make meaningful comparisons, particularly in relation to the percentage of starters from BME groups falling from 13.8% to 6.5% . This is now a good basis for future analysis.

Table 8 - Staff joining the Trust from 1 April 2014 to 31 March 2015 by ethnicity

	Total new staff during the year	% of new staff during the year	% total staff at 31 March 2015	% new staff previous year
Ethnicity				
White (including White Irish and White other)	980	89.4	90.9	79.8
Black and minority ethnic people (Black, Asian, Mixed race and any other group)	71	6.5	7.0	13.8
Not Known	45	4.1	2.1	6.4

Disability

Of the 1,096 new starters 20 people identified themselves as a disabled person. This equates to 1.8% of all starters, which is higher than the 1.2% of all trust staff. The number of 'not known' has fallen to 3.0% of people joining the trust compared to 63.8% in 2013 – 2014.

Figure 9: Staff joining the Trust - Disability, 2013-2014 and 2014-2015

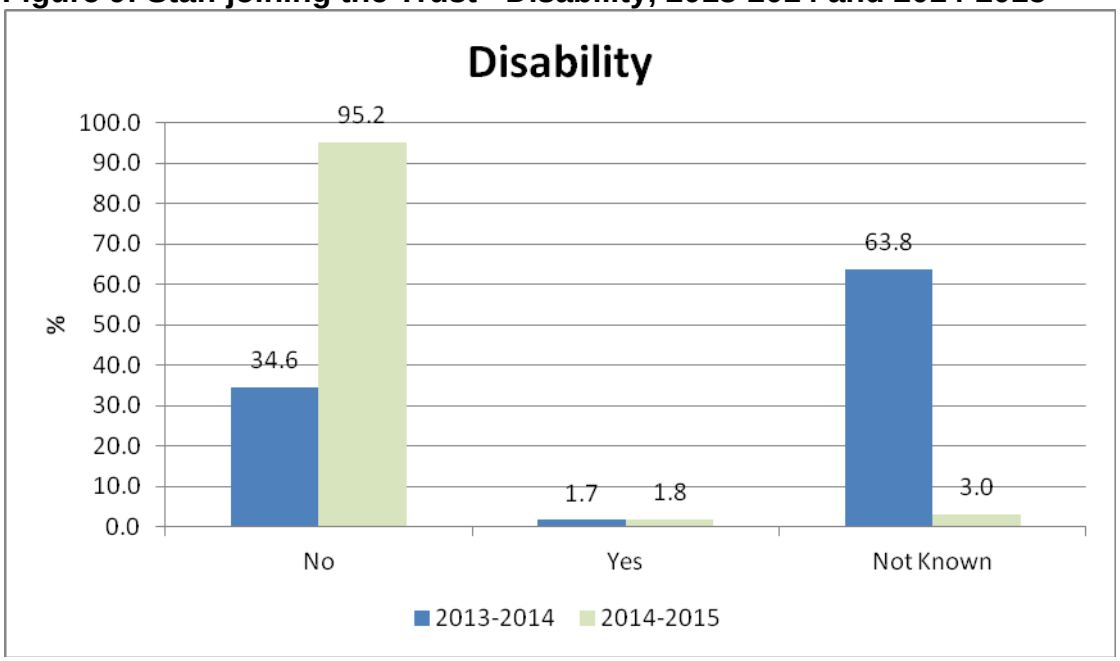


Table 9 - Staff joining the Trust from 1 April 2014 to 31 March 2015 - disability status

	Total new staff during the year	% of new staff during the year	% total staff at 31 March 2015	% new staff previous year
Total	1,096			
Disabled Person				
No	1,043	95.2	44.4	34.6
Yes	20	1.8	1.2	1.7
Not known	33	3.0	54.4	63.8
Total	1,096			

Sexual Orientation

16 (or 1.5% of all starters) identified themselves as lesbian, gay or bisexual (more than double than the figure seen for lesbian, gay and bisexual people in the overall trust's workforce 0.7%). This percentage is also higher than seen last year (0.8% of all starters).

Figure 10: Staff joining the Trust by Sexual Orientation, 2013-2014 and 2014-2015

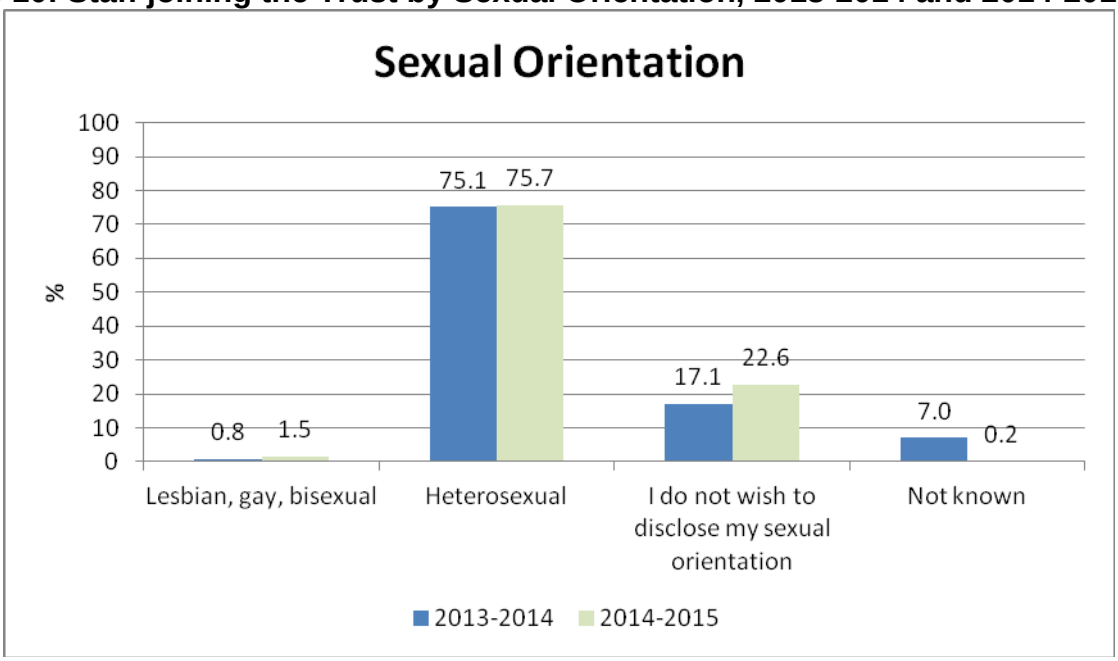


Table 10 - Staff joining the Trust from 1 April 2014 to 31 March 2015 by Sexual Orientation

	Total new staff during the year	% of new staff during the year	% total staff at 31 March 2015	% new staff previous year
Sexual orientation				
Lesbian, gay, bisexual	16	1.5	0.7	0.8
Heterosexual	830	75.7	37.7	75.1
I do not wish to disclose my sexual orientation	248	22.6	26.3	17.1
Not known	2	0.2	35.4	7.0
Total	1,096			

Religion and Belief

Of the new staff joining 49.4% stated they were Christian. Initially it appears that this is notably higher than the equivalent percentage of Christians in the trust's overall workforce (28.6%). However if the 'unknowns' are excluded (which account for a high proportion of the trust's overall workforce), 44.3% were Christians[3].

The percentage of new starters who practice other religions also saw a higher percentage than the equivalent percentage in the trust's overall workplace.

[3] More specifically this involves excluding the 3,094 staff where their religion and beliefs are unknown (as shown in Table 4) and then re-calculating the percentage who were Christians

Figure 11: Staff joining the Trust by Religion and Belief, 2013-2014 and 2014-2015

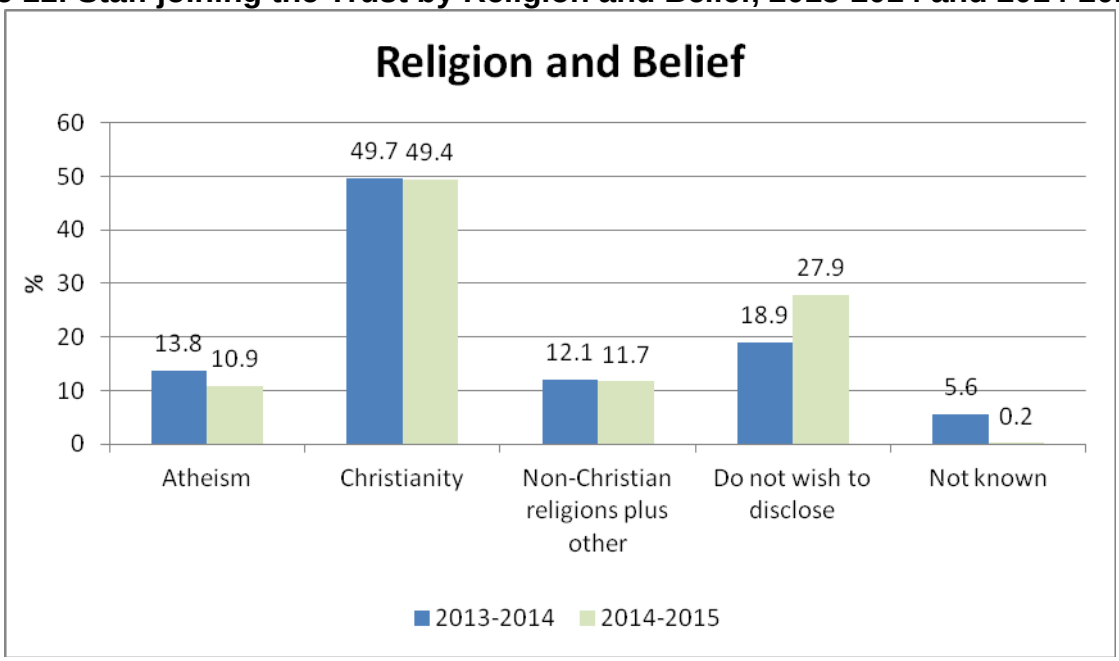


Table 11 - Staff joining the Trust from 1 April 2014 to 31 March 2015 by Religion and Belief

	Total new staff during the year	% new staff during the year	% total staff at 31 March 2015	% new staff in previous year
Religion and belief				
Atheism	119	10.9	6.0	13.8
Christianity	541	49.4	28.6	49.7
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism) plus other	128	11.7	5.2	12.1
Do not wish to disclose	306	27.9	24.8	18.9
Not known	2	0.2	35.4	5.6
Total	1,096			

Age

Similar to last year new starters tend to be younger than that is seen for the trust's overall workforce. Individuals aged 25 and under made up 29.0% of all starters but only 8.5% of all staff.

Figure 12: Staff joining the Trust by Age, 2013-2014 and 2014-2015

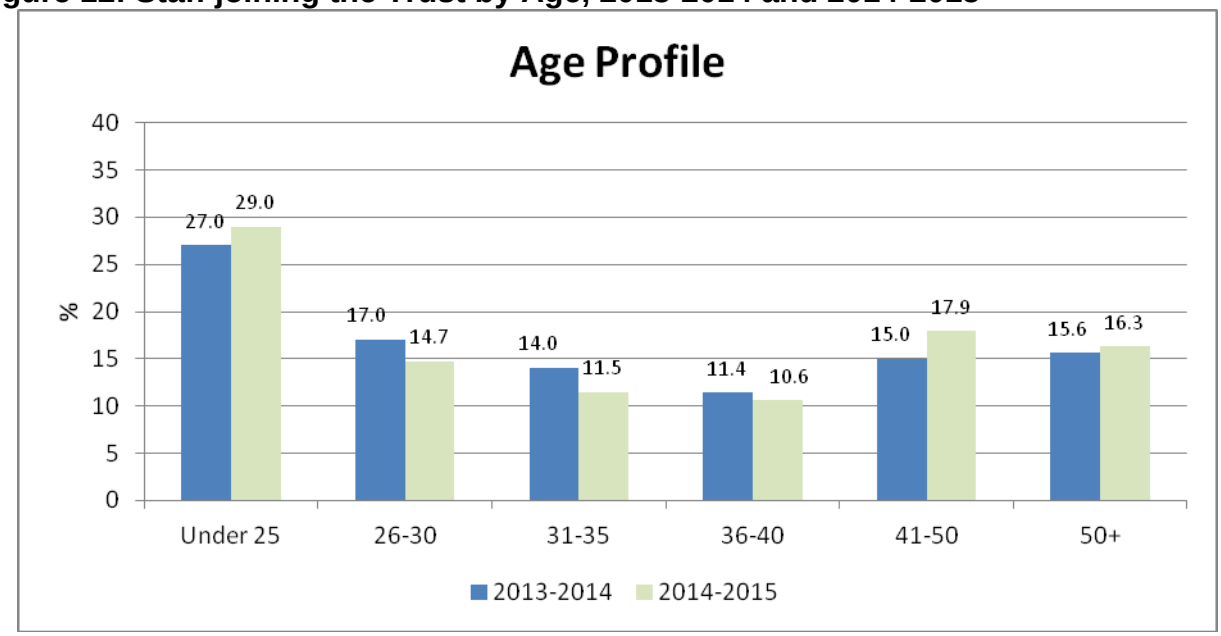


Table 12 - Staff joining the Trust from 1 April 2014 to 31 March 2015 by age

	Total new staff during the year	% new staff during the year	% total staff at 31 March 2015	% new staff in previous year
Under 25	318	29.0	8.5	27.0
26-30	161	14.7	10.1	17.0
31-35	126	11.5	11.4	14.0
36-40	116	10.6	11.0	11.4
41-50	196	17.9	27.0	15.0
50+	179	16.3	32.0	15.6
Total	1,096			

2.3 Staff Leaving the Trust

This data is based on 924 staff who left the Trust between 1st April 2014 and 31 March 2015 – this figure is similar to the previous years when there were 931 leavers. The figures shown do not include Junior Doctors as including this group can adversely impact on the findings and the conclusions which were drawn.

Gender

Men now account for 19.8% of leavers, down from 23.6% last year. In contrast 80.2% of all leavers are women, up from 76.4%.

Figure 13: Staff Leaving the Trust by Gender, 2013-2014 and 2014-2015

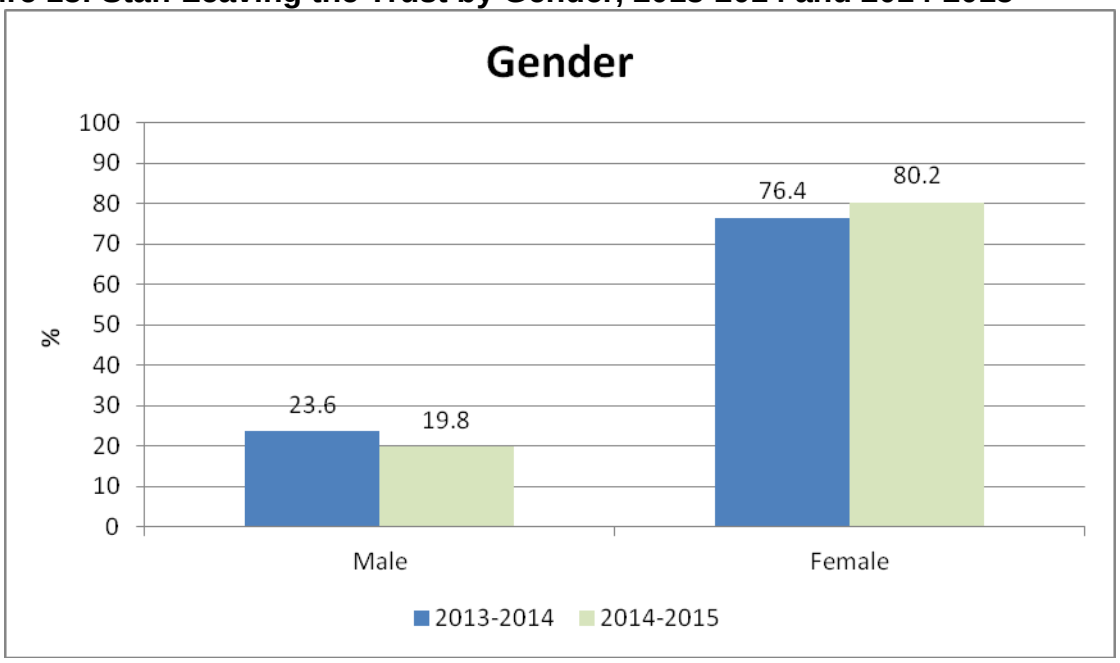


Table 13 - Staff leaving York Teaching Hospitals Foundation Trust 1 April 2014 to 31 March 2015 by gender

Publishable data – no category <10	Total number of staff leaving Trust	% staff leaving	% total staff	% staff leaving in previous year
Gender				
Female	741	80.2	79.6	76.4
Male	183	19.8	20.4	23.6
Total	924			

Ethnicity

The percentage of staff leaving the Trust from a BME group fell from 8.6% last year to 6.5%. This is also slightly lower than the overall Trust percentage that BME staff account for (7.0%).

Figure 14: Staff Leaving the Trust by Ethnicity, 2013-2014 and 2014-2015

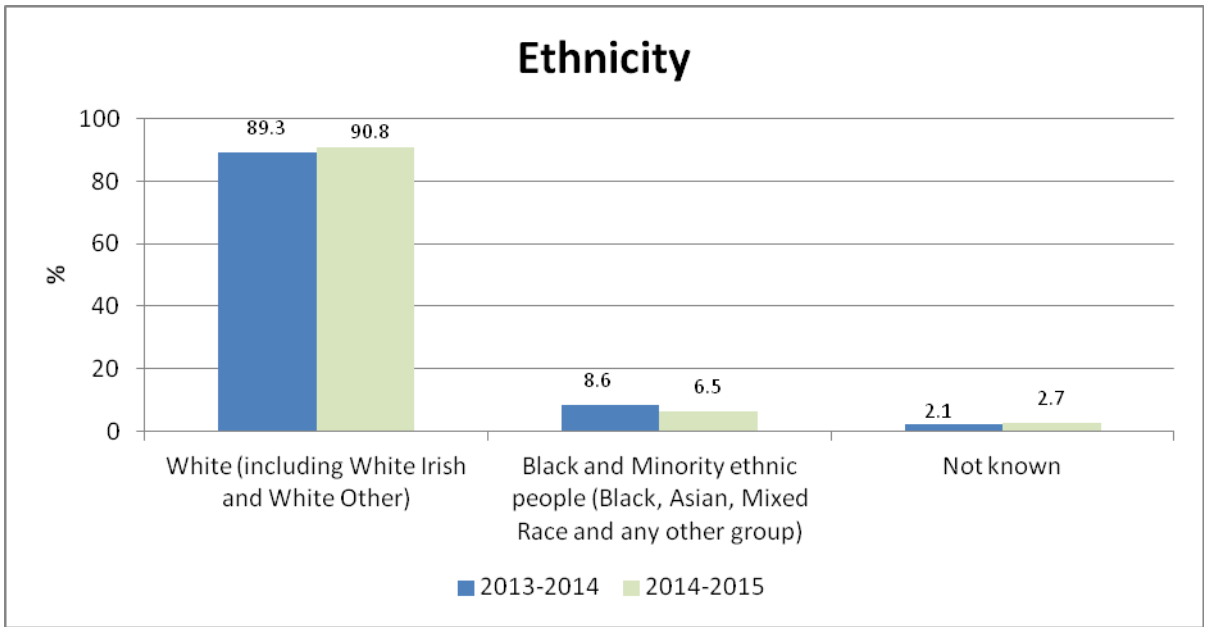


Table 14 - Staff leaving the Trust 1 April 2014 to 31 March 2015 by ethnicity

Publishable data – no category <10	Total number of staff leaving Trust	% staff leaving	% total staff	% staff leaving in previous year
Ethnicity				
White	839	90.8	90.9	89.3
Black and Minority ethnic people (Black, Asian, Mixed Race and any other group)	60	6.5	7.0	8.6
Not known	25	2.7	2.1	2.1
Total	924			

Disability

1.6% of those leaving the Trust were disabled people – this compares to 1.2% of Trust's overall workforce. For both leavers and the overall workforce, around half of all such staff were however recorded as 'Not known' and this may be skewing the results.

Figure 15: Staff Leaving the Trust - Disability, 2013-2014 and 2014-2015

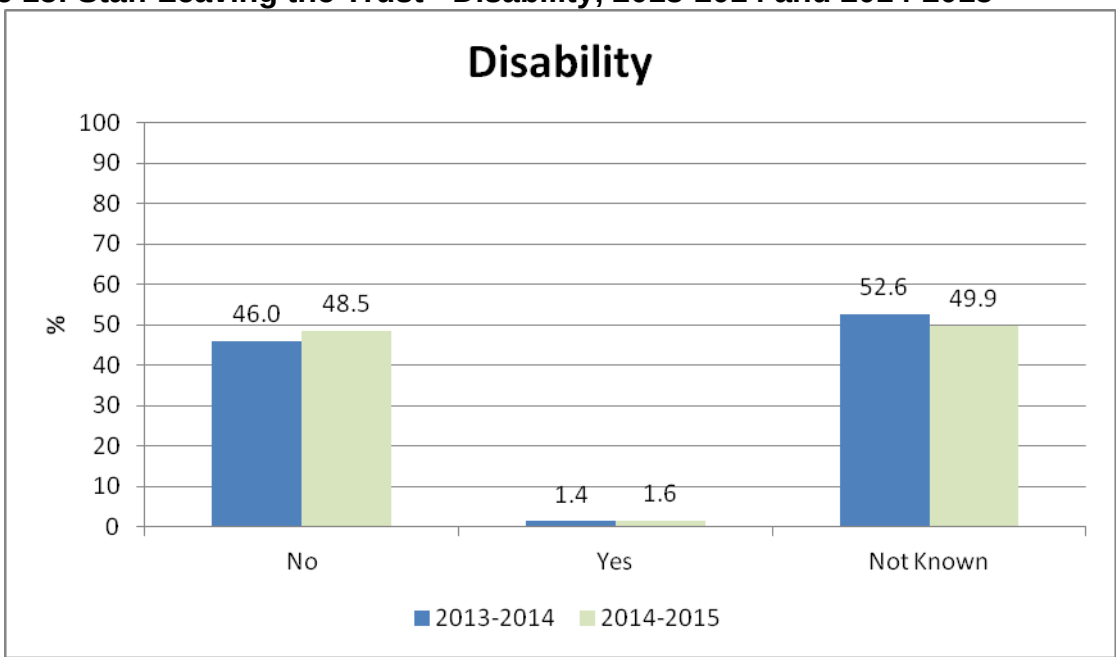


Table 15 - Staff leaving York Teaching Hospitals Foundation Trust 1 April 2014 to 31 March 2015

Publishable data – no category <10	Total number of staff leaving Trust	% staff leaving	% total staff	% staff leaving in previous year
Disabled person				
No	448	48.5	44.4	46.0
Yes	15	1.6	1.2	1.4
Not Known	461	49.9	54.4	52.6
Total	924			

Sexual Orientation

Due to following good practice in data protection and to ensure personal privacy we are unable to make any meaningful conclusions here. Some data has however been included below.

Table 16 - Staff leaving the Trust 1 April 2014 to 31 March 2015 by Sexual Orientation

Publishable data – no category <10	Total number of staff leaving Trust	% staff leaving	% total staff	% staff leaving in previous year
Sexual Orientation				
Lesbian, Gay, Bisexual, Heterosexual	392	42.5	38.4	-
I do not wish to disclose my sexual orientation	235	25.4	26.3	-
Not Known	297	32.1	35.4	-
Total	924			

Note - due to confidentiality issues we are unable to report findings for Lesbian, Gay, Bisexual staff as a specific group

Religion and Belief

29.2% of staff who left the Trust were from Christian religions / beliefs – in comparison they account for 28.6% of the overall workforce.

Figure 16: Staff Leaving the Trust by Religion and Belief, 2013-2014 and 2014-2015

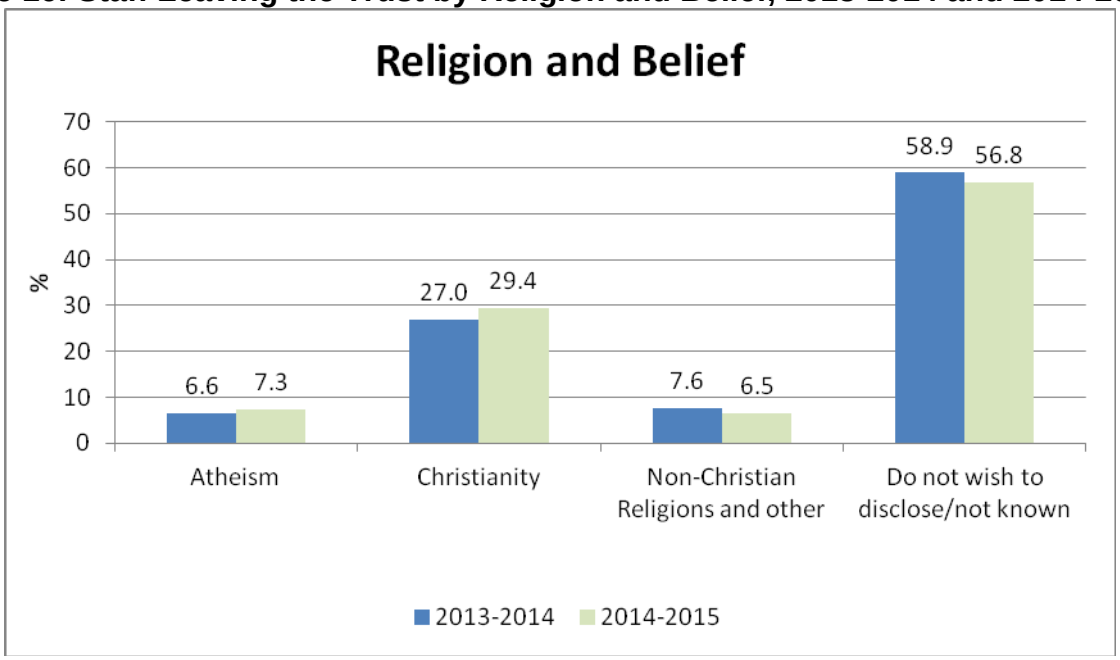


Table 17 - Staff leaving the Trust 1 April 2014 to 31 March 2015 by Religion and Belief

	Total new staff during the year	% new staff during the year	% total staff at 31 March 2015	% new staff in previous year
Religion and belief				
Atheism	119	10.9	6.0	13.8
Christianity	541	49.4	28.6	49.7
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism) plus other	128	11.7	5.2	12.1
Do not wish to disclose	306	27.9	24.8	18.9
Not known	2	0.2	35.4	5.6
Total	1,096			

Age

The 'leavers rates' are unsurprisingly high for both the age groups under 30 and 61+. This is likely to be due to younger people generally moving around more to find a job that suits them, with older staff it is primarily due to retirement.

Staff aged over 50 made up 32.0% of the Trust's overall workforce but 40.7% of leavers (which is similar to last year with 31.7% and 39.9% respectively).

18.6% of staff were under 30, yet this age group makes up 26.6% of staff leaving the Trust.

Figure 17: Staff Leaving the Trust by Age, 2013-2014 and 2014-2015

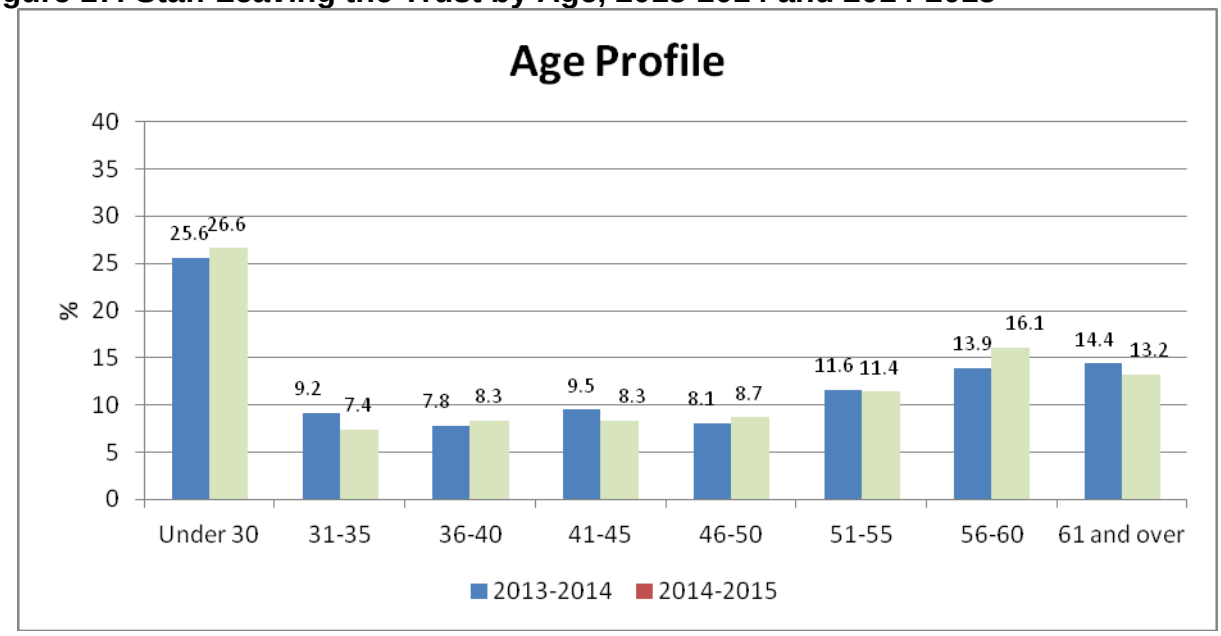


Table 18 - Staff leaving the Trust 1 April 2014 to 31 March 2015 by age

Publishable data – no category <10	Total number of staff leaving Trust	% staff leaving	% total staff	% staff leaving in Previous year
Age				
Under 30	246	26.6	18.6	25.6
31-35	68	7.4	11.4	9.2
36-40	77	8.3	11.0	7.8
41-45	77	8.3	12.7	9.5
46-50	80	8.7	14.3	8.1
51-55	105	11.4	15.6	11.6
56-60	149	16.1	11.2	13.9
61 and over	122	13.2	5.2	14.4
Total	924			

Further Work Required:

The Trust's Leavers Procedure was updated and rolled out in October 2014. An updated Leavers questionnaire has been prepared and will be rolled out during 2015. The key priority is to ensure that leavers information is captured to enable areas of concern to be addressed. This in turn can support improved retention.

2.4 Staff profile by pay grade

Below is a brief summary of the key findings. This analysis includes Junior Doctors.

Within this work we have had to combine many of the categories together to protect the anonymity of individuals.

The highest numbers of staff are in pay bands 2 and 5. This is because band 2 includes most of the administrators and healthcare assistants whilst band 5 is the entry grade for all nursing staff which is the largest staff group in the Trust.

Pay grade by gender

The analysis for this work is not an equal pay audit; it is not looking at equal pay for equal work but at distribution of staff across pay bands by gender.

The overall number of female staff is higher in each pay band apart from Medical and Dental grades where there were more men (277 to 472) - this group also account for 26.5% of all male staff. In contrast 4.0% of female staff were from Medical and Dental grades.

In volume terms a higher number of women are in grades 8a+ than men (203 female staff compared to 79 male staff). This banding includes a variety of different roles including senior nursing roles (matrons) which tends to attract a higher number of women. It is however the case that in percentage terms men are more likely to be band 8a+ roles (i.e. accounting 4.4% of the male workforce) than women (representing 2.9% of the female workforce).

Table 19: Pay grade by gender, 2015

	Description of band	Pay Range	Female	% Female staff in this pay band	Male	% male staff in this pay band	Total	% total staff in this pay band
Band 1	Cooks, Domestics Assistants	£15,100 - £15,363	542	7.8%	180	10.1%	722	8.26%
Band 2	Administrators, Healthcare Assistants	£15,100 - £17,800	1,617	23.2%	345	19.4%	1,962	22.45%
Band 3	Senior Admin posts, Community Healthcare Assistants	£16,633 - £19,461	717	10.3%	130	7.3%	847	9.69%
Band 4	Officers,	£19,027 -	376	5.4%	92	5.2%	468	5.36%

	Craftsperson, Medical Secretary	£22,236						
Band 5	Nurses, Advisors Physiotherapists,	£21,692 - £28,180	1,587	22.8%	195	11.0%	1,782	20.39%
Band 6	Managers, Sisters, Senior Roles	£26,041 - £34,876	1,120	16.1%	158	8.9%	1,278	14.62%
Band 7	Senior managers, Area Leads	£31,072 - £40,964	499	7.2%	111	6.2%	610	6.98%
Band 8a, b, c, d and 9	Directorate Managers, Area Leads	£39,632 - £98,453	203	2.9%	79	4.4%	282	3.23%
Medical and Dental	Consultants, Specialty Doctors, Clinical Assistants		277	4.0%	472	26.5%	749	8.57%
Personal Pay scale*	Apprentices, Non Exec Directors		21	0.3%	18	1.0%	39	0.45%
Total Staff			6,959	100.0%	1,780	100.0%	8,739	100.00%

* In all such analysis this group includes a small number of staff who are usually in other staff groups, e.g. Medical and Dental staff; Estates and Ancillary staff; Theatre Practitioners; Student Health Visitors, etc.

Pay grade by ethnicity

The highest percentage of BME staff is seen for Medical and Dental pay scales (37.0%), equating to 227 people. Compared to this, only 6.3% of all White staff are in Medical and Dental payscales, albeit these totalling 507 people.

Table 20: Pay band by ethnicity, 2015

Pay band	White staff	% White staff	BME staff (White Irish, mixed race, Asian and Black/Black British/Chinese	% BME staff	Ethnicity not known	% ethnicity not known	Total staff	% total staff in this pay band
Band 1	690	8.7	21	3.4	11	5.9	722	8.3
Band 2	1,841	23.2	74	12.1	47	25.3	1,962	22.5
Band 3	806	10.2	15	2.4	26	14.0	847	9.7
Band 4	454	5.7	<10	*	<10	*	468	5.4
Band 5	1,540	19.4	209	34.1	33	17.7	1,782	20.4
Band 6	1,207	15.2	43	7.0	28	15.1	1,278	14.6
Band 7	584	7.4	13	2.1	13	7.0	610	7.0
Band 8a, b, c, d and 9	279	3.5	<10	*	<10	*	282	3.2
Medical and Dental	503	6.3	227	37.0	19	10.2	749	8.6
Personal Pay scale	36	0.5	<10	*	<10	*	39	0.4
Total Staff	7,940		613		186		8,739	

Note - * signifies percentages cannot be shown due to confidentiality issues

It is not possible to provide monitoring data specifically about the Board of Directors (included within the Personal Pay Grade group) due to the small numbers and the risk of this becoming personally identifiable. However, the data shows that the make-up of the Board of Directors is not representative of the overall staff workforce profile in respect of gender and ethnicity.

Pay grade by disability

Due to confidentiality issues we are unable to make any meaningful conclusions here. A key factor here is the very small numbers of staff in many paybands and we still don't have an accurate figure of how many disabled staff we employ.

Table 21: Pay band by disability

Disabled	Number of staff below band 6	% staff below band 6	Number of staff band 6 and above, personal pay scale and Medical & Dental	% of staff band 6 and above	Total	Total %
Non - Disabled Staff	2,693	46.6	1,188	40.2	3,881	44.4
Disabled staff	83	1.4	20	0.7	103	1.2
Not known	3,005	52.0	1,750	59.2	4,755	54.4
Total staff	5,781		2,958		8,739	

Note – due to confidentiality issues it is only possible to report data based on very broad paybands

Pay grade by sexual orientation

Partly due to confidentiality issues we are unable to make any meaningful conclusions here. Lesbian, gay or bisexual staff data account for a small proportion of staff, we note the impact of around two thirds of staff sexual orientation isn't known, or that staff prefer not to disclose.

Table 22: Pay band by sexual orientation, 2015

Disabled	Number of staff below band 6	% staff below band 6	Number of staff band 6 and above, personal pay scale and Medical & Dental	% of staff band 6 and above	Total	Total %
Lesbian, Gay or Bisexual	40	0.7	17	0.6	57	0.7
Heterosexual	2,308	39.9	985	33.3	3,293	3737
Not known/do not wish to disclose	3,433	59.4	1,956	66.1	5,389	61.7
Total staff	5,781		2,958		8,739	

Note – due to confidentiality issues it is only possible to report data based on very broad paybands

Pay grade by religion and belief

To protect the anonymity of individual staff, the data included in the appendices has been grouped into broad pay band categories.

A high proportion of staff from Non-Christian religions is seen in Medical and Dental roles (accounting for 16.4% – in contrast they account for 2.0% of the overall workforce).

Table 23: Pay band by religion and belief, 2015

Religion	Number of staff below band 6	% staff below band 6	Number of staff band 6 and above and personal pay scale	% of staff band 6 and above and personal pay scale	Number of staff in Medical & Dental Grade	% of Staff in Medical & Dental grade
Atheism	352	6.1	105	2.4	64	8.5
Christianity	1,786	30.9	545	12.5	167	22.3
Buddhism, Hinduism, Islam, Judaism, Sikhism	39	0.7	13	0.3	123	16.4
Other	200	3.5	65	1.5	19	2.5
Not known	1,923	33.3	945	21.6	226	30.2
I do not wish to disclose my religion/belief	1,481	25.6	523	12.0	150	20.0

Pay grade by age

Younger workers tend to be concentrated in the lower pay bands. This includes 43.9% of those aged under 25 being in the lowest two pay bands of staff (albeit this being similar to last year – 47.0%). Whilst a further 29.3% of those under 25 were in band 5 roles, less than 5% were band 6 or higher.

Table 24: Pay band by age

	Under 25 Years	% staff under 25 years	26 – 50 years	% staff 26-50 years	Over 50 years	% over 50 years	Total staff	% total staff in this pay band
Personal Salary	11	1.5	11	0.2	17	0.6	39	0.4
Medical and Dental	68	9.2	503	9.7	178	6.4	749	8.6
Band 1	72	9.7	380	7.3	270	9.6	722	8.3
Band 2	253	34.2	1,029	19.8	680	24.3	1,962	22.5
Band 3	57	7.7	494	9.5	296	10.6	847	9.7
Band 4	31	4.2	244	4.7	193	6.9	468	5.4
Band 5	217	29.3	1,119	21.5	446	15.9	1,782	20.4
Band 6	31	4.2	884	17.0	366	13.1	1,278	14.6
Band 7			355	6.8	253	9.0	610	7.0
Band 8a+			182	3.5	99	3.5	282	3.2
Total	740		5,201		2,798		8,739	

Note - due to confidentiality only totals for band 6 and above and under 25 years can be shown

Further Work Required:

A scoping exercise to explore how an Equal Pay audit could be carried out within the Trust was undertaken in early 2015 and a number of practical recommendations were included. An action plan will be developed to ensure the Trust meets legal obligations and can utilise the information gathered in the audit.

2.5 Our Temporary Workforce Staff

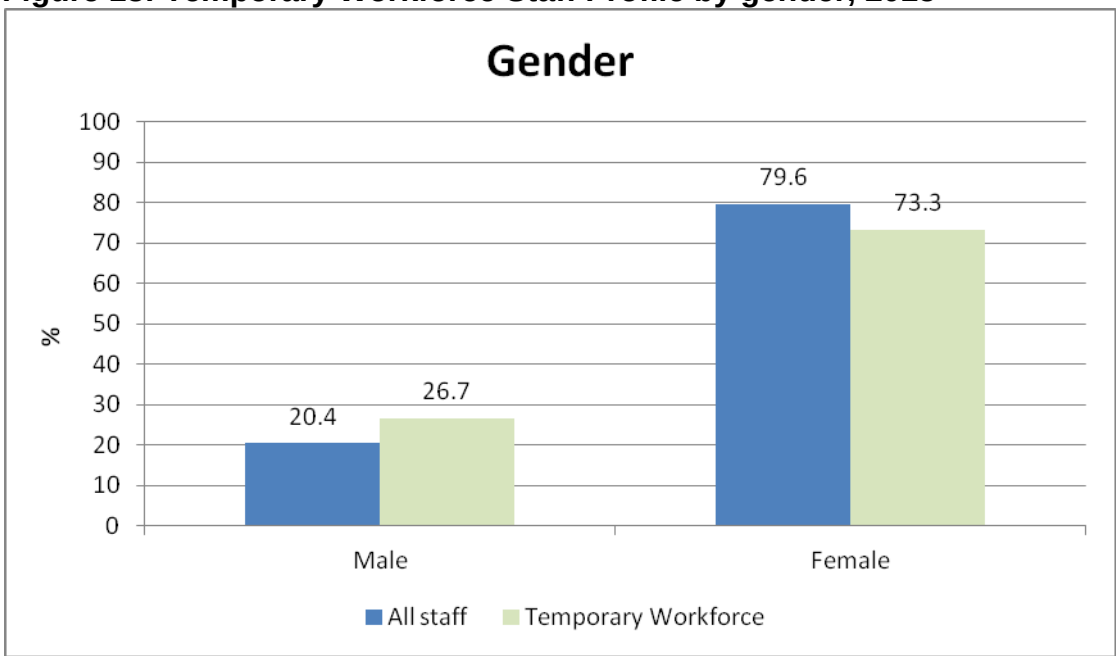
This is the first year where there is a specific focus on temporary workforce staff - these include Locum doctors, but also those in a number of bank roles, e.g. Nurses; Midwives; Healthcare Assistants and those in working in areas such as Radiology and Physiotherapy.

As of March 2015 there was a total of 495 temporary staff on which the analysis is based. This figure will increase significantly from April 2015 due to the Trust expanding its' 'internal nurse bank', reflecting the important role played by our temporary workforce, hence why the information is included here.

Due to confidentiality issues it is only possible to report any meaningful information on gender; age and religion and beliefs, with this data also being compared to the overall workforce for the trust. The key findings include that our temporary staff were:

- More likely to be male than the overall workforce (26.7% compared to 20.4%)
- See a higher percentage (compared to the trust's overall workforce) who were 25 years old or younger. They are also less likely be aged between 51 and 60, but more likely to be aged 61 or older
- More likely to be from Non-Christian religions and beliefs (5.9% compared to 2.0% of all staff).

Figure 18: Temporary Workforce Staff Profile by gender, 2015



Note – all the analysis is solely based on those where their 'main role in the organisation was recorded as bank or locum.

Figure 19: Temporary Workforce Staff Profile by age, 2015

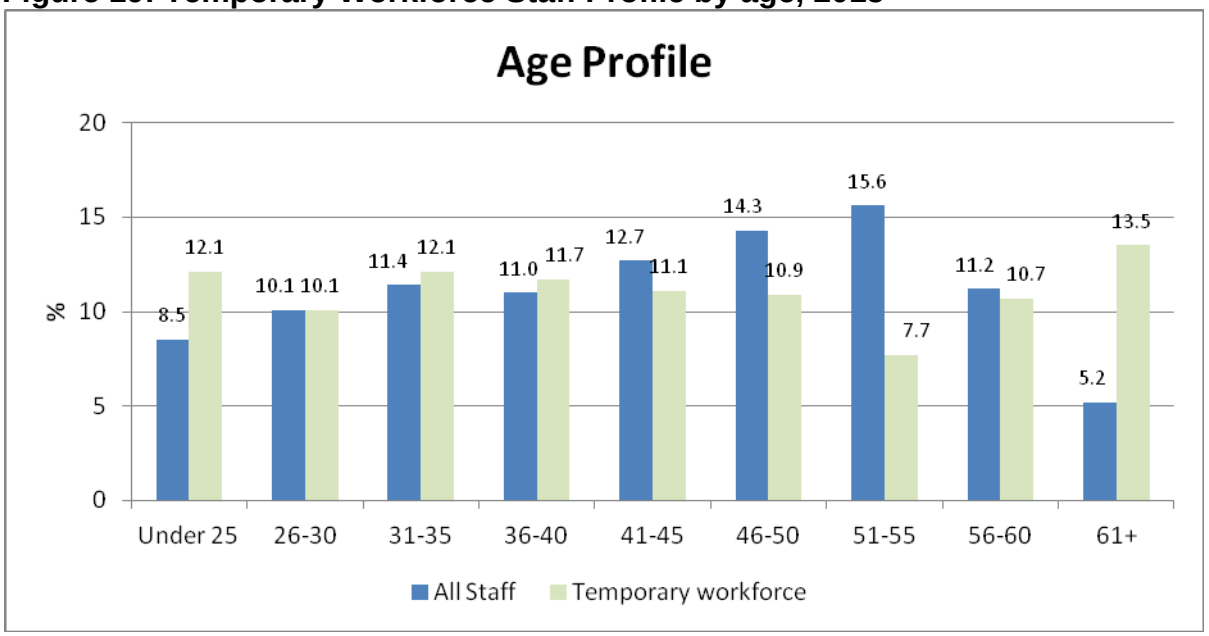
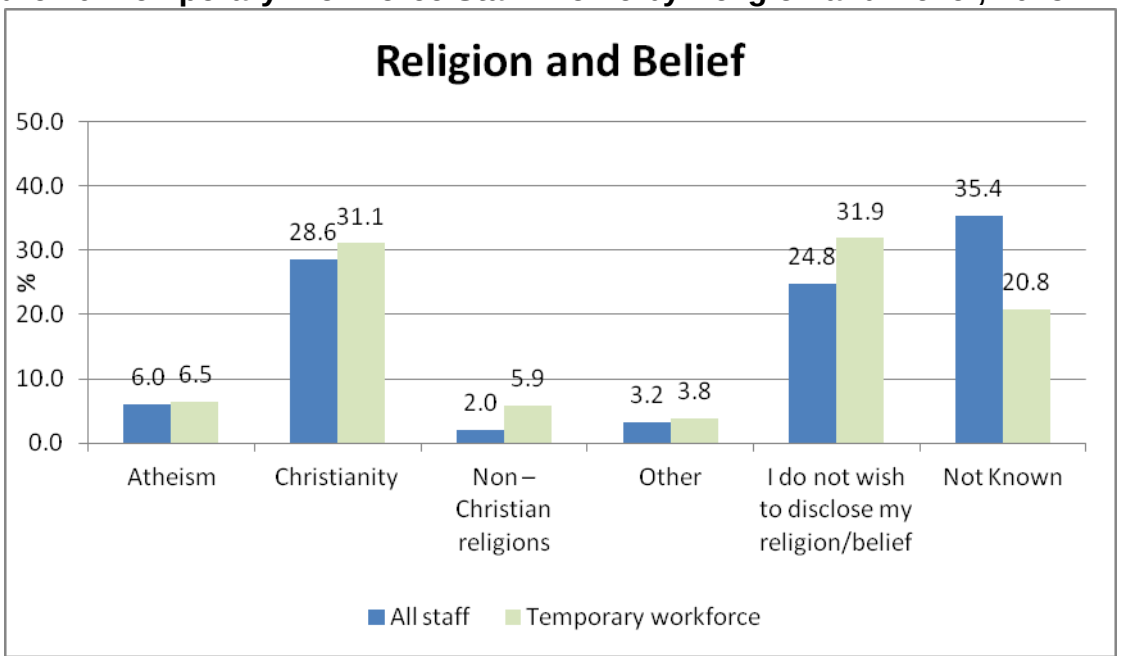


Figure 20: Temporary Workforce Staff Profile by Religion and Belief, 2015



Note – this data is influenced by the fact the levels of staff not wishing to disclose this and also 'Unknowns' are better for temporary workforce staff

2.6 Staff Learning and Development

Staff Appraisal

The Trust's appraisal process has been developed over the last 12 months to support a shift to a values based approach as well as the development of a formal talent development framework. To support this approach a number of new tools have been developed which will start to support open and honest conversations about capability (performance against objectives) and attitude (behaviours compared to the Trust values) becoming the norm.

The revised process embeds the competencies from the Agenda for Change Knowledge & Skills Framework (KSF), the Trust Values, and the Personal Responsibility Framework. These competencies can be used to assess skills, attitudes, behaviours and performance and assist with discussing examples and giving feedback.

An e-learning tool will be launched in 2015/2016, which managers and staff can access to find out more about the new process and understand the importance of appraisals generally.

Organisational Development and Improvement Learning (ODIL)

The ODIL team exists to support the organisation to achieve it's objectives by supporting staff to work in the most effective way they can, through opportunities for applied learning and development.

Access to relevant ODIL support is offered and advertised to individuals, teams and whole departments across all staff groups. This support may include leadership development at a number of levels, team development, coaching, mentoring or mediation, in addition to taught tools and techniques such as improvement methodology.

Input around values, and emotional and social intelligence and valuing difference feature in many interventions, with the aim of supporting people to increase self-awareness and management, and maximise working relationships.

Partnership work with local organisations including the Army Training Centre at Strensall, the Joseph Rowntree Foundation Trust and City of

York Council offers a diverse perspective in relation to the organisations ODIL portfolio.

The table below indicates attendance at ODIL courses and programmes through 2014-15 by area.

Table 25: Attendance at ODIL courses and programmes: 2014-15 by age

Financial Year 2014-15		
Age Range	Attendees in range	Percentage
20-29	92	6.45%
30-39	382	26.79%
40-49	538	37.73%
50-59	350	24.54%
60-65	27	1.89%
Not recorded	37	2.59%
Total	1426	100.00%

Table 26: Attendance at ODIL courses and programmes: 2014-15 by gender

Gender of Delegates Attending ODIL Courses and Programmes		
Financial Year 2014-15		
Gender	Total	Percentage
Female	1154	80.93%
Male	235	16.48%
Not recorded	37	2.59%
Grand Total	1426	100.00%

Table 27: Attendance at ODIL courses and programmes: 2014-15 by ethnicity

Ethnicity of Delegates Attending ODIL Courses and Programmes		
Financial Year 2014-15		
Ethnicity	Total	Percentage
A White - British	1017	71.32%
B White - Irish	4	0.28%
C White - Any other White background	13	0.91%
C3 White Unspecified	110	7.71%
CA White English	126	8.84%
CB White Scottish	3	0.21%
CY White Other European	9	0.63%
D Mixed - White & Black Caribbean	8	0.56%
GF Mixed - Other/Unspecified	7	0.49%
H Asian or Asian British - Indian	32	2.24%
J Asian or Asian British - Pakistani	9	0.63%
M Black or Black British - Caribbean	4	0.28%
N Black or Black British - African	13	0.91%
SC Filipino	17	1.19%
Z Not Stated	17	1.19%
Not recorded	37	2.59%
Grand Total	1426	100.00%

Table 28: Attendance at ODIL courses and programmes: 2014-15 by religion

Religion of Delegates Attending ODIL Courses and Programmes *Financial Year 2014-15* Religion	Total	Percentage
Atheism	107	7.50%
Buddhism	2	0.14%
Christianity	421	29.52%
Hinduism	18	1.26%
I do not wish to disclose my religion/belief	316	22.16%
Other	28	1.96%
Undefined	497	34.85%
Not recorded	37	2.59%
Grand Total	1426	100.00%

Table 29: Attendance at ODIL courses and programmes: 2014-15 by disability

Able Bodied/Disabled Delegates Attending ODIL Courses and Programmes *Financial Year 2014-15* Disability	Total	Percentage
No	530	37.17%
Not Declared	72	5.05%
Undefined	772	54.14%
Yes	15	1.05%
Not recorded	37	2.59%
Grand Total	1426	100.00%

Table 30: Attendance at ODIL courses and programmes: 2014-15 by sexual orientation

Sexuality of Delegates Attending ODIL Courses and Programmes *Financial Year 2014-15* Sexual Orientation	Total	Percentage
Gay	20	1.40%
Heterosexual	491	34.43%
I do not wish to disclose my sexual orientation	381	26.72%
Undefined	497	34.85%
Not recorded	37	2.59%
Grand Total	1426	100.00%

The Learning Hub

The Learning Hub continues to be used as the organisations online learning platform. It is now routinely used by learners across the trust to self-enrol onto classroom learning and/or undertake learning online.

Throughout system roll out opportunities have been taken to ensure that inclusive best practice has been embedded into system and content design used e.g. tonal contrast, font sizes and language. These principles have also been applied to support processes and documentation.

The Learning Hub is the central database for all corporate learning records/online learning provision and the catalogue of learning available via the system is increasing. This is complimented by a wide range of classroom delivery giving learner's choice of learning provision. There is also a manual process in place for staff with 'access', or, 'use of computer' issues, this removes the need for learners to request learning via the Learning Hub. Additional support is available when required.

Learner evaluation has been an ongoing process since Learning Hub implementation. This method of evaluation will continue to be closely monitored to eliminate any other barriers that have not been anticipated. A recent internal audit exercise gave the Learning Hub and its associated processes an overall rating of 'Significant Assurance'.

The Learning Hub is populated with data from sources that include the Electronic Staff Record which will ensure that the new system will allow the continued reporting/breakdown of learning data into six of the protected characteristics. It is anticipated that future upgrades will enable more sophisticated reporting.

The following tables show learning undertaken at the various different sites within the Trust. The phrase 'Learning Interventions' is used to describe the baseline data used.

Ethnicity

Table 31 below shows the number of staff accessing learning provision has increased in all groups, with the overall total increasing by over fourteen thousand Learners compared to the same time last year. The biggest increase by percentage in a known ethnic group that attend a session was Mixed Race (dual heritage) which increased by 72.5% compared to the previous year. The number of Asian and Asian British learner access increased by 50.9% compared to the previous year.

Table 31: Staff Learning and Development by ethnicity

Ethnicity	Learner 'access' April 2014 - March 2015	Learner 'access' April 2013 - March 2014	% change year on year
White – UK	55,715 (81%)	38,224 (70%)	45.8
White – Irish	461 (0.7%)	328 (0.6%)	40.5
White (e.g. not UK, White unspecified)	4394 (6.4%)	10,409 (19%)	-57.8
White total	60570 (88%)	48,961 (89%)	23.7
Mixed Race (dual heritage) total	764 (0.1%)	443 (0.8%)	72.5
Asian and Asian British total	3304 (4.8%)	2,190 (0.4%)	50.9
Black and Black British total	713 (0.1%)	628 (0.1%)	13.5
Any other ethnic group (including Chinese)	1212 (1.8%)	859 (1.6%)	41.1
BME total (mixed race, Asian and Asian British)	6454 (9.4%)	4,448 (8.2%)	45.1
Black and Black British, Chinese and Irish people)			
Not known	1908 (2.8%)	1,348 (2.5%)	41.5
Total Learning Interventions	68,471	54,429	

Gender

As expected, the percentage of female staff (81%) greatly outweighs the percentage of male staff (19%). However there has been a 4% shift in comparison to last years' data, reflecting the increase in retention of male staff within the organisation.

Table 32: Staff Learning and Development by gender

Gender	Learner 'access' April 2014 - March 2015	Learner 'access' April 2013 - March 2014	% change year on year
Female	55,779 (81%)	46,319 (85%)	20.4
Male	12,692 (19%)	8,110 (15%)	56.5
Total	68,471	54,429	

Disability

The number of disabled learners accessing learning provision accounts for 1.2% of the total learners which is expected due to the low number of 'declared' disabled staff within the Trust. However, the largest category is 'No' which accounts for 59% of all learners. The last twelve months has seen a significant drop the 'Not known/Not Declared' category, this is now 39.8% compared with 63.4% the previous year. This could be attributed to improved methods of capturing and updating workforce information/data cleanse.

Table 33: Staff Learning and Development by disability

Disability	Learner 'access' April 2014 - March 2015	Learner 'access' April 2013 - March 2014	% change year on year
No	40,287 (59%)	19,134 (35%)	110.6
Yes	907 (1.2%)	790 (1.6%)	14.8
Not known/not declared	27,277 (39.8%)	34,505 (63.4%)	-20.9
Total Learning Interventions	68,471	54,429	

Age

Learners ‘under 25’ are the largest staff group by age accessing learning provision. This may be indicative of the significant amount of recruitment that has taken place during the last 12 months, as the trust reshapes due to workforce retirement and job role reconfiguration.

Table 34: Staff Learning and Development by age

Age	Learner 'access' April 2014 - March 2015	Learner 'access' April 2013 - March 2014	% change year on year
Under 25	10,496 (16%)	6,093 (11%)	72.3
26 - 30	9,194 (13%)	5,543 (10%)	65.9
31 - 35	8,080 (12%)	6,297 (12%)	28.3
36 - 40	7,456 (11%)	6,268 (12%)	19.0
41 - 45	8,396 (12%)	7,216 (13%)	16.4
46 - 50	8,700 (13%)	7,840 (14%)	11.0
51 - 55	8,207 (12%)	8,340 (16%)	-1.6
56 - 60	5,678 (8%)	5,053 (9%)	12.4
61+	2,264 (3%)	1,779 (3%)	27.3
Total Learning Interventions	68,471	54,429	

Religion

This is a new area of reporting and therefore it is not possible to compare with previous years. The number of ‘Christian’ learners is 33.1%. With ‘I do not wish to specify’ (26%) and ‘not known’ (24.4%) respectively. This may be due to an unwillingness to declare this type of information. The figures demonstrate the diversity of the workforce compared with the local population, with a high ‘do not wish to specify’ percentage compared with the census.

Table 35: Staff Learning and Development by religion

Religion	Learner 'access' April 2014 - March 2015	% of total delegates sessions
Atheism	5,512	8.0
Buddhism	278	0.4
Christianity	22,643	33.1
Hinduism	728	1.1
Islam	1,030	1.5
Jainism	26	0.03
Judaism	60	0.07
Sikhism	118	0.2
Other	3,062	4.5
Not known	16,729	24.4
I do not wish to specify	18,285	26.7
Total Learning Interventions	68,471	

Sexual Orientation

A new area of reporting. A similar pattern appears to that seen for Religion. The number of 'heterosexual' learners is 48.7%, 'not known' (26%) and 'I do not wish to specify' (24.4%).

Table 36: Staff Learning and Development by sexual orientation

Sexual Orientation	Learner 'access' April 2014 - March 2015	% of total delegates sessions
Bisexual	190	0.3
Gay	296	0.4
Lesbian	161	0.2
Heterosexual	33,291	48.7
Not known	17,803	26.0
I do not wish to specify	16,730	24.4
Total Learning Interventions	68,471	

Payscale

A new area of reporting. The number of Band 5 learners is 24.4%, closely followed by Band 2 at 23.4%. This is probably indicative of learning patterns operating within the trust, with significant attention being paid to those in these bands either because it's a starter role in the organisation or the learner is moving into senior management role, requiring a breadth of knowledge and skill. This reduces significantly from Bands 7 to 9 as learning required will be more specialist/role specific.

Table 37: Staff Learning and Development by payscale

Payscale	Learner 'access' April 2014 - March 2015	% of total delegates sessions
Band 1	3,601	5.3
Band 2	15,988	23.4
Band 3	6,140	9.0
Band 4	1,920	2.8
Band 5	16,681	24.4
Band 6	10,010	14.6
Band 7	4,329	6.3
Band 8	902	1.3
Band 9	224	0.3
Personal Salary	8,676	12.6
Total Learning Interventions	68,471	

Support Staff Learning Team

A newly formed team, whose role is to concentrate on the learning and development needs of trust staff currently working in Band 1-4 roles. This includes within its remit corporate provision of Numeracy, Literacy, ESOL, and Basic Computer Skills. This includes on request access to special learner support.

2.7 Equality in Recruitment

This is the second year that we have reported equality levels in our recruitment. We use the NHS jobs website for all our recruitment exercises which enables us to monitor equality aspects of applicants for all job roles. The tables on the following pages show data on Applicants and short listed candidates for the 1st April 2014 – 31st March 2015 broken down by protected characteristics using data taken from the NHS Jobs website

Applicants are generally required to apply for jobs at the Trust through the NHS Jobs website. Applicants can, however, request a hard copy application form to complete.

Values Based Recruitment

The Trust continues to promote a values-based approach to the recruitment of staff. Central to Values Based Recruitment (VBR) is the belief that experience and qualifications can be provided to candidates, however values are core to an individual and are not something that can be taught.

In essence VBR encompasses the assessment of candidates' motivation, attitude and behaviour on the basis that if you achieve the right fit between your organisation's values and those of your workforce, you will optimise your organisation's performance. Research has shown that VBR also increases workforce diversity as it takes a much broader view, not only of applicants but of the attributes which make someone suitable to undertake a particular role.

The Trust's Recruitment Training promotes a values based approach. Evaluation of our recruitment and selection training has been positive - every respondent who has attended the training has stated that they have come away with a clear understanding what VBR is about. Building on this, we have a plan later in the year to offer 2 short recruitment modules:

1. Individuals who have undertaken the Trust recruitment and selection training but who would like to develop their understanding of VBR; and
2. A separate module for managers involved in observing assessment centre exercises to buttress the values based approach. As part of this exercise, we will be looking to increase the diversity of our observer pool.

Careers Events
During the last 12-months, the Trust has attended/hosted careers events involving local schools in our communities on average every 5-weeks. Events have been aimed at students between the ages of 14-19 with a focus on engaging them in relation to career opportunities within the NHS.

Summer contracts
During 2014/2015 work was undertaken for the Trust to be able offer paid work experience opportunities to students from our local communities; this will commence over the summer of 2015. Students will undertake a variety of roles in both clinical and non-clinical settings to build on the Trust's work to promote itself locally as an employer of choice, with a view to increasing the number of young people in our workforce.

Apprentices
During the last 2 years, 29 people from the local community have enrolled on a range of apprenticeships across the organisation. The retention rate for apprentices at the Trust has consistently hovered between the 80-90% mark, and these posts continue to offer a pathway into the organisation for people with little or no prior work experience.

Project Choice
Project Choice enables a work-based learning experience to young people with learning difficulties with the aim of providing them with pathways into employment. This year, with the support of a regional co-ordinator employed by Tees, Esk and Wear Valleys NHS Foundation Trust our Trust has delivered a number of work placements in support roles at Scarborough Hospital. We hope to be able to attract more applications from a group which has, traditionally, been marginalised in the labour market.

Volunteers
Volunteers provide support across the Trust do so in their own time and actively assist in support for patients and their relatives and carers. They are not paid employees, but provide an essential contribution which complements the work of staff and helps to enhance the overall patient experience.

During the year to 31st March 2015 there were nearly 100 'active' volunteers at Scarborough hospital and in the Community, with more than 150 volunteers at York Hospital. This gives a total in excess of 250 volunteers across all sites and last year's target of increasing volunteer

numbers by 50% was therefore met. We are always looking to recruit and develop further the volunteer roles and identify the importance of this role within the Trust.

Trust volunteers are currently split into four main roles:

1. **The Volunteer Visitor** – this role provides company for those patients who have no visitors.
2. **The Clinic/Department Liaison** - this role provides information to patients when they arrive in a department or clinic. They provide information when clinics are running late and reassurance to patients as they wait to be seen.
3. **Chaplaincy Volunteers** - recruited by the Trust Chaplain these volunteers provide spiritual support to our patients.
4. **Dining Companions** - this role required specific training and provides patients with some help at meal times.

There are also a small number of specialist volunteer roles such as the Bereavement Suite Volunteer, who provide specific support to patients and their families in niche areas.

R**ecruitment by Gender**

Males made up 31.0% of the total applicants – in contrast they account for 24.6% of those that were shortlisted. Females make up 68.6% of the total applicants, with 75.0% of those that were shortlisted.

Table 38: Recruitment by gender, 2014-2015

Category	Applied April 2014 to March 2015	Shortlisted April 2014 to March 2015	% applications shortlisted	% applications	% shortlistings
Male	6,916	1,923	27.8%	31.0%	24.6%
Female	15,310	5,863	38.3%	68.6%	75.0%
Undisclosed	83	31	37.3%	0.4%	0.4%
Total	22,309	7,817	35.0%	100.0%	100.0%

Recruitment by Disability

We can see from table 39 that 35.4% of disabled applicants are shortlisted which is effectively the same figure as for non-disabled applicants (35.0%). This shows that whilst disabled people are at least as successful at getting shortlisted. It should also be noted that there is a high percentage of applicants where their disability Status is 'undisclosed' (39.8%) which may be impacting on these findings.

The Trust is a two tick employer. This means that we guarantee to interview all disabled applicants who meet the minimum criteria. Where

we use the desirable criteria to shortlist applicants, this might explain why disabled people do not appear to have disadvantage at the short listing stage.

Table 39: Recruitment by disability, 2014-2015

Category	Applied April 2014 to March 2015	Shortlisted April 2014 to March 2015	% applications shortlisted	% applications	% shortlistings
Yes	1,482	525	35.4%	6.6%	6.7%
No	20,563	7,187	35.0%	92.2%	91.9%
Undisclosed	264	105	39.8%	1.2%	1.3%
Total	22,309	7,817	35.0%	100.0%	100.0%

Recruitment by Ethnicity

The following table shows that the number of applicants who are White were the most successful group in getting shortlisted from their job applications when compared to all the other ethnic groups. This will be taken forward as part of the WRES – to investigate reasons for why BME staff are less likely to be shortlisted.

Table 40: Recruitment by ethnicity, 2014-2015

Category	Applied April 2014 to March 2015	Shortlisted April 2014 to March 2015	% applications shortlisted	% applications	% shortlistings
White - British	15,797	6,142	38.9%	70.8%	78.6%
White - Irish	135	66	48.9%	0.6%	0.8%
White - Any other white background	1,657	413	24.9%	7.4%	5.3%
Asian or Asian British - Indian	1,046	289	27.6%	4.7%	3.7%
Asian or Asian British - Pakistani	850	161	18.9%	3.8%	2.1%
Asian or Asian British - Bangladeshi	104	21	20.2%	0.5%	0.3%
Asian or Asian British - Any other Asian background	495	125	25.3%	2.2%	1.6%
Mixed - White & Black Caribbean	29	13	44.8%	0.1%	0.2%
Mixed - White & Black African	88	20	22.7%	0.4%	0.3%
Mixed - White & Asian	69	19	27.5%	0.3%	0.2%
Mixed - any other mixed background	85	29	34.1%	0.4%	0.4%
Black or Black British - Caribbean	76	23	30.3%	0.3%	0.3%
Black or Black British - African	898	207	23.1%	4.0%	2.6%
Black or Black British - Any other black background	64	23	35.9%	0.3%	0.3%
Other Ethnic Group - Chinese	77	24	31.2%	0.3%	0.3%
Other Ethnic Group - Any other ethnic group	395	104	26.3%	1.8%	1.3%
Undisclosed	444	138	31.1%	2.0%	1.8%
Total	22,309	7,817	35.0%	100.0%	100.0%

Recruitment by Age

The following table shows that success in being shortlisted at the Trust increases with age. This reflects that with age people gain both experience and new skills required for jobs.

Table 41: Recruitment by age, 2014-2015

Category	Applied April 2014 to March 2015	Shortlisted April 2014 to March 2015	% applications shortlisted	% applications	% shortlistings
Under 18	55	16	29.1%	0.2%	0.2%
18 to 19	360	103	28.6%	1.6%	1.3%
20 to 24	4,246	1,340	31.6%	19.0%	17.1%
25 to 29	4,520	1,348	29.8%	20.3%	17.2%
30 to 34	3,135	1,061	33.8%	14.1%	13.6%
35 to 39	2,436	923	37.9%	10.9%	11.8%
40 to 44	2,099	850	40.5%	9.4%	10.9%
45 to 49	2,156	874	40.5%	9.7%	11.2%
50 to 54	1,614	710	44.0%	7.2%	9.1%
55 to 59	1,232	430	34.9%	5.5%	5.5%
60 to 64	384	143	37.2%	1.7%	1.8%
65 and above	39	11	28.2%	0.1%	<0.1%
Undisclosed	33	8	24.2%	0.1%	0.1%
Total	22,309	7,817	35.0%	100.0%	100.0%

Recruitment by religion and belief

The most successful group of applicants at the short listing stage were Christians (with 38.2% of applications being shortlisted compared to 35.0% of all applicants) and Atheists (36.3%).

Table 42: Recruitment by religious belief, 2014-2015

Category	Applied April 2014 to March 2015	Shortlisted April 2014 to March 2015	% applications shortlisted	% applications	% shortlistings
Atheism	3,385	1,229	36.3%	15.2%	15.7%
Buddhism	273	82	30.0%	1.2%	1.0%
Christianity	11,450	4,377	38.2%	51.3%	56.0%
Hinduism	546	142	26.0%	2.4%	1.8%
Islam	1,755	338	19.3%	7.9%	4.3%
Sikhism	51	10	19.6%	0.2%	0.1%
Other (including Jainism and Judaism)	2,129	701	32.93%	9.54%	8.97%
Undisclosed	2,720	938	34.5%	12.2%	12.0%
Total	22,309	7,817	35.0%	100.0%	100.0%

Recruitment by Sexual Orientation

The following table shows that lesbian candidates are more successful at being shortlisted. Those stating they were Heterosexual do however account for 92.1% of all those being shortlisted.

Table 43: Recruitment by sexual orientation, 2014-2015

	Applied April 2014 to March 2015	Shortlisted April 2014 to March 2015	% applications shortlisted	% applications	% shortlistings
Lesbian	97	41	42.3%	0.4%	0.5%
Gay	174	58	33.3%	0.8%	0.7%
Bisexual	267	75	28.1%	1.2%	1.0%
Heterosexual	20,215	7,197	35.6%	90.6%	92.1%
Undisclosed	1,556	446	28.7%	7.0%	5.7%
Total	22,309	7,817	35.0%	100.0%	100.0%

The annual staff survey asks staff whether they believe that the Trust provides equal opportunities for career progression or promotion. Whilst overall 92% of staff support this statement the figure falls to 80% for BME staff.

Further development required:

The reporting of recruitment information has been limited by the need to use two data sets i.e. NHS Jobs and ESR. This means that new starter information is provided through ESR and recruitment information up to and including shortlisting through NHS Jobs. Further work should therefore be undertaken to explore the most effective means of uploading successful applicant data to NHS Jobs in order to ensure that full and consistent reporting of the entire recruitment process can take place from one data set.

2.8 Grievance, disciplinary and Bullying and Harassment issues

Bullying & Harassment

The percentage of staff in our 2014 Staff Survey who said they had experienced harassment, bullying or abuse from patients, relatives or the public within the past 12 months has increased by 1% to 27% compared to our 2013 figures.

In addition, the number of staff who had experienced harassment, bullying or abuse from staff in the past 12 months had also increased, to 23% compared to 22% in 2013.

With reference to specific protected characteristics, of staff who declare themselves disabled in the staff survey 37% said they had experienced bullying, harassment or abuse from patients/service users or their relatives or from a manager/team leader or other colleague in the last 12 months and 16% reported experiences of physical abuse from patients/service users or their relatives.

Again in the 2014 staff survey men who responded appeared to have overall, slightly more positive experiences at work than women. This included better scores for men on all of the Key Findings relating to violence and harassment, with men reporting fewer experiences of physical violence, harassment, bullying or abuse from patients/service users or their relatives and managers/team leaders or other colleagues.

The number of bullying and harassment complaints reported during 1 April 2014 – 31 March 2015 was 10; this does not correlate to the number of staff who reported that they experienced bullying and harassment within the Staff Survey.

The Trust is committed to a zero tolerance approach to bullying and harassment. Therefore, during 2014/ 2015 we have undertaken a number of actions to raise awareness of Harassment & Bullying issues to improve their resolution. These include;

- Updating the Harassment and Bullying (H&B) Policy to simplify the process and ensure issues are dealt with at an early stage. This includes promotion of the Trust's mediation service

- Reviewing the training provided to managers on how to deal with cases of H&B;

We will continue to measure staff experience of harassment and bullying by asking staff a number of questions in our 2015 annual Staff Survey.

To follow good practice in data protection and ensure personal privacy and to help protect the anonymity of staff, we are unable to report on all characteristics due to the small number of disciplinary, grievance and bullying and harassment cases recorded.

Employment Tribunals

This year 1 Employment Tribunal (ETs) claim was received.

Employment Tribunal and MHPS (medical and dental staff) cases are recorded on ESR. This allows further detailed analysis of employee relations data to be undertaken.

Grievances

From the figures shown in table 44 as per last year, the majority of cases were raised by White - British staff, the main reason behind this is most likely due to White British staff accounting for the largest percentage of staff within the Trust.

Table 44: number of grievances by ethnic origin, 2013-2014 and 2014-2015

	Number of Grievances year ending 31 March 2015	Number of Grievances year ending 31 March 2014
White – UK	14	11
White - Irish	<10	0
White (not UK or Irish – Includes White unspecified)	<10	0
Mixed Race (dual heritage) total	0	0
Asian and Asian British total	0	<10
Black and Black British total	0	0
Any other ethnic group (including Chinese)	0	0
Not Known	0	0
Total	*	-

Note - * signifies that this figure cannot be shown due to confidentiality issues

Investigations and Disciplinary Action

The following tables show the number of disciplinary investigations, formal sanctions, and suspensions within the Trust by protected characteristic.

The number of disciplinary investigations which resulted in formal sanctions is 74% of cases.

The majority of cases (more than 90%) involved staff within the groups of White UK, White Irish and White other groups.

Of all investigations undertaken 34% of employees were suspended.

Further work required:

Specific training is being developed for Investigating Officers, which will help further develop manager's skills in undertaking investigations to ensure that these are done fairly and equitably.

Table 45: Disciplinary investigations, sanctions and suspensions by Ethnicity, 2013-2014 and 2014-2015

Ethnicity	Disciplinary Investigations 2015	Formal Sanctions 2015	Suspensions 2015	Disciplinary Investigations 2014	Formal Sanctions 2014	Suspensions 2014
White – UK	90	63	23	56	43	20
White – Irish	0	0	*	<10	<10	<10
White (not UK or Irish – Includes White unspecified)	<10	<10	*	<10	<10	<10
White total	*	*	23	68	52	20
Mixed Race (dual heritage) total	<10	<10	*	<10	<10	<10
Asian and Asian British total	<10	<10	*	<10	<10	<10
Black and Black British total	<10	0	*	<10	<10	<10
Any other ethnic group (including Chinese)	<10	<10	*	<10	<10	<10
BME total (e.g. mixed race, Asian and Asian British, Black and Black British, Chinese)	*	*	*	<10	<10	<10
Not Known	0	0	0	<10	<10	<10
Total	103	77	35	78	60	27

Note - * signifies figures cannot be shown due to confidentiality issues

Table 46: Disciplinary investigations, sanctions and suspensions by Gender, 2014-2015

Gender	Disciplinary Investigations 2015	Formal Sanctions 2015	Suspensions 2015
Female	69	55	23
Male	34	22	12
Total	103	77	35

Table 47: Disciplinary investigations, sanctions and suspensions – Disability, 2014-2015

Disabled	Disciplinary Investigations 2015	Formal Sanctions 2015	Suspensions 2015
Yes	0	0	0
No	39	31	10
Not Declared	64	46	25
Undefined			
Total	103	77	35

Table 48: Disciplinary investigations, sanctions and suspensions by Sexual Orientation, 2014-2015

Sexual Orientation	Disciplinary Investigations 2015	Formal Sanctions 2015	Suspensions 2015
Heterosexual	32	27	<10
I do not wish to disclose my sexual orientation	24	19	<10
Undefined	47	31	22
Total	103	77	35

Table 49: Disciplinary investigations, sanctions and suspensions by Religion / Belief, 2014-2015

Religion and Belief	Disciplinary Investigations 2015	Formal Sanctions 2015	Suspensions 2015
Atheism	<10	<10	0
Christianity	23	18	<10
I do not wish to disclose my religion/belief	22	19	<10
Undefined	46	31	21
Other	<10	<10	0
Total	103	77	35

For some of the data, the outcomes were not recorded and therefore data cannot be included

Appendix 1

Figure 21: Staff Profile by staff group and gender, 2015

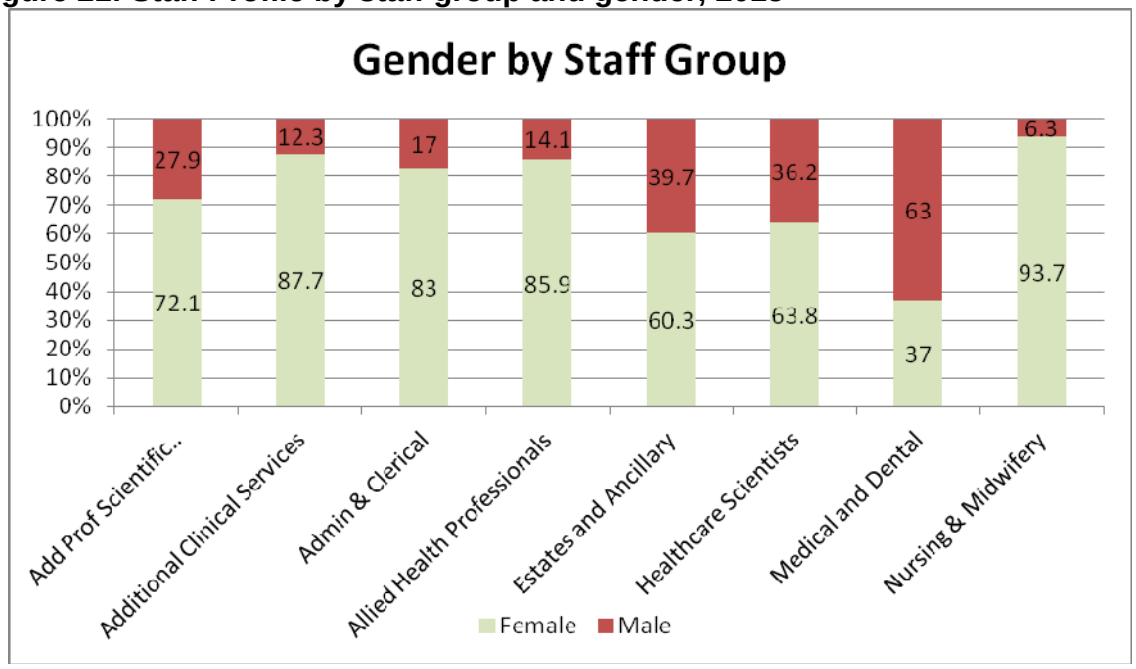


Figure 22: Staff Profile by staff group and age, 2015

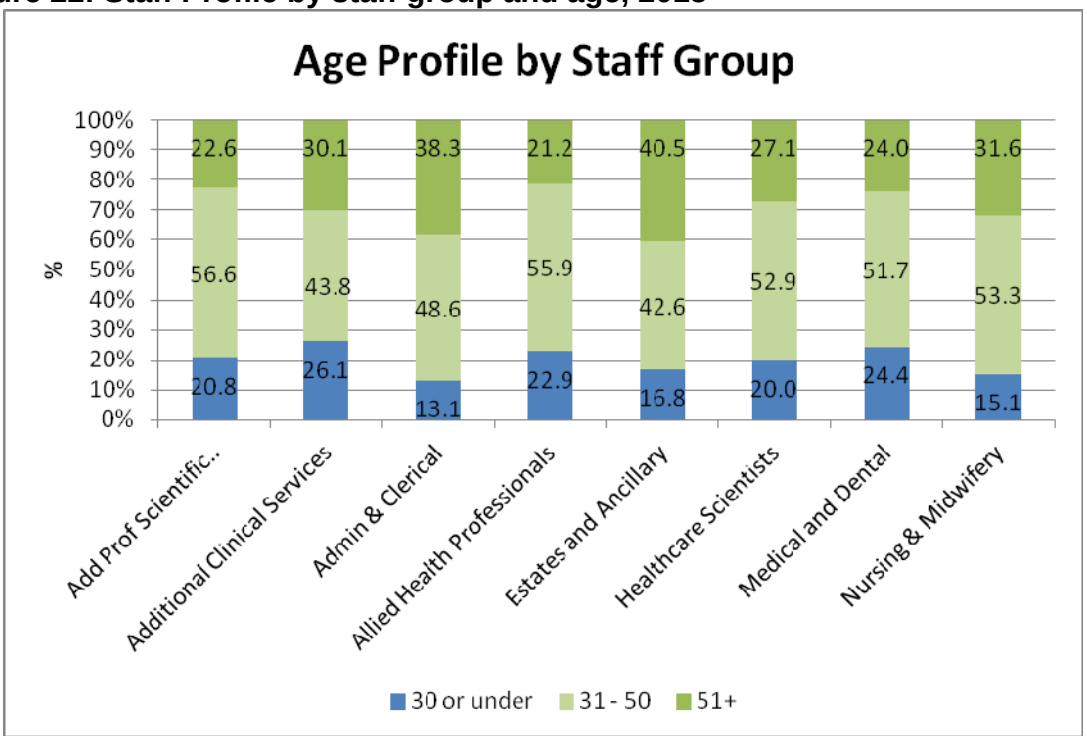
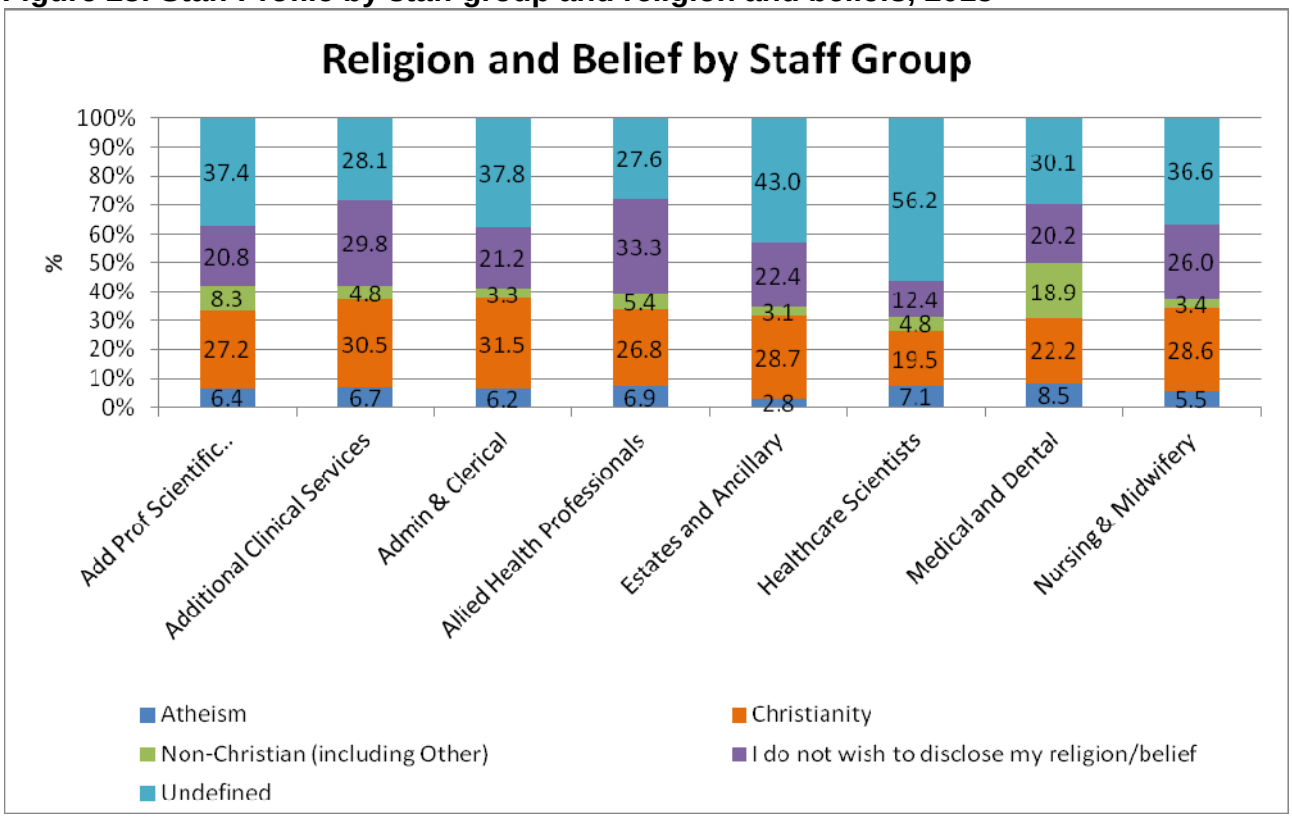


Figure 23: Staff Profile by staff group and religion and beliefs, 2015



Due to confidentiality issues within staff groups we are unable to report on either disability or sexual orientation.

Section 3: Summary of further work required

Our equality objectives are included in the introduction of this report at point h

Section	Actions	Link to Equality Objective
H	Continue to monitor progress against the equality objective action plan Utilise EDS2 assessment and grading events to identify new and review existing equality objectives.	1,2,3 & 4 1,3 & 4
1.1	Consultation and development of a new approach to equality analysis Centralise monitoring of equality analysis	4.4 4.4
1.2	Analyse our smaller suppliers (those accounting for the smallest 20% of spend) regarding their SME's status. Our plan to get as far into the 3000+ suppliers we use so that we have a baseline figure for SME suppliers that we can grow our spend with smaller suppliers where the law allows. Add a formal Equality and Diversity section into the standard questions and, where weaknesses exist, provide support to suppliers to improve.	- -
1.3	Continue to introduce the amended different format template from POPPiY as leaflets are reprinted if possible or if not on review, which is usually every two years Look at ways in which patient information leaflets can be presented electronically via the Trust Website.	- -

Section	Actions	Link to Equality Objective
1.3	Review current patient and service user administration and record systems, processes and documentation; if necessary update, change or replace to conform with the ISB 1605 standard by 31st March 2016	**3.2**
1.4	Develop/enhance the single process for interpretation and translation across all Trust sites to promote consistency and monitoring including a central record of document translations Follow up the recommendations identified in the Access to Services Action Plan which is based on the York Healthwatch reports (see 1.13) Work with Trust staff to promote the interpreting services available and how to utilise these services to the benefit of the patient. Engage with local communities to gain feedback on these services provided and where we can improve Ongoing review of current providers to ensure contingency provision is in place for a sustainable service. Review and update documentation to ensure clear guidance and support	- - - - - -
1.6	Publish and promote the one page Welcoming guide on the intra net Develop an audit access tool and programme	- 3.4.2
1.7	Discussion with other agencies to ensure collection of data across protected characteristics	3.2 & 3.3

Section	Actions	Link to Equality Objective
1.8	Scope the feasibility of recording more protected characteristics onto our Core Patient Database (CPD). Ensure data capture is aligned to other data sets to allow comparisons Consider looking at Cancer targets and any potential protected characteristics that may prevent timely access. Continue progress in increasing the capture rate of protected characteristics on CPD by means of staff awareness. Continue work to ensure the Hospitals are able to adequately meet the needs of older persons attending as Emergencies.	1.5 1.1 1.4 1.3, 1.10 & 4.7 -
1.12	Review the accessibility of PALS	1.10
1.13	Respond to Access to Services action plan Respond to actions identified via EDS2	1, 2, 3 & 4 1,3 & 4
2.1	Continue to capture protected characteristic information at all points of the employment cycle with emphasis on accuracy. Encourage staff to record protected characteristic information by raising staff awareness and confidence in the use of such data. Enable staff to review and update their personal information via ESR Self Service.	-
2.3	Roll out leavers' questionnaire to ensure that leave information is captured to enable areas of concern be identified which in turn can support improved retention.	-

Section	Actions	Link to Equality Objective
2.4	Develop an action plan based on the equal pay audit scoping exercise of 2015	-
2.7	Explore the most effective means of uploading successful applicant data to NHS Jobs to ensure that full and consistent reporting of the entire recruitment process can take place from one data set.	-
2.8	Develop and implement Investigating Officers training, to develop manager's skills to ensure they are conducted fairly and equitably.	-

How are we doing?

We are accountable to our staff, service users and members of the public.

Should you have any feedback or concerns about equality of access to services or in the workplace, please contact:

Margaret Milburn - Equality and Diversity Facilitator
Telephone: 01904 726633
Email: margaret.milburn@york.nhs.uk

Equality Delivery System for the NHS
EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

York Teaching Hospital NHS Foundation Trust

Organisation's Board lead for EDS2:

Sue Holden - Director Workforce and Organisational Development

Organisation's EDS2 lead (name/email):

Margaret Milburn - Trust Equality and Diversity Facilitator

Level of stakeholder involvement in EDS2 grading and subsequent actions:

The Trust undertook to work in partnership with our local CCG's and Leeds and York partnership trust to develop a shared understanding of how the organizations were viewed by stakeholders around this key agenda. The voluntary agencies representing various groups of individuals with protected characteristics were invited to a planning meeting to agree the process and share ideas. A grading session was independently facilitated where our stakeholders discussed a specific goal and graded the organizations against that based upon the evidence presented. This in depth review of goal 2 of the standards allowed for significant discussion and debate. The remaining three standards have been self assessed and agreed through the fairness forum. The partner organizations agreed to work corroboratively to improve the shared approach to the standards identified with a

Organisation's Equality Objectives (including duration period):

1. Improve data collection, analysis and monitoring of protected characteristics.
2. Further develop engagement of patients, carers and staff to reflect local demographics.
3. Develop strong partnerships with social care and GP's to ensure patient pathways are free from barriers between providers for everyone.
4. To continue with Board of Directors and senior leaders development program ensuring equality and diversity considerations are embedded into all decision making processes.

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

The approach undertaken is evidenced good practice in taking a shared approach across three organizations and enables shared understanding of each one's specific contribution to improving how we embed E & D considerations across all elements of practice.

Relevant to Goal 2:
Service user data collection analysis.
Interpreting and translation provision is accessible to all sites.
Partnership working and representation of Healthwatch on the fairness forum.
Healthwatch provide focused feedback on elements of protected characteristics

Publication Gateway Reference Number: 03247

Date of EDS2 grading March 2015 **Date of next EDS2 grading** March 2016

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Pregnancy and maternity; Disability; Race; Gender reassignment; Religion or belief; ✓ Sex; Marriage and civil partnership; Sexual orientation Evidence drawn upon for rating: Specific services are developed related to age and pregnancy e.g. Maternity Services Liaison Committee, the Malton and Selby Hub model of elderly provision. We consistently Document age and gender for all admissions and utilise this data to inform procurement.	✓
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Pregnancy and maternity; ✓ Disability; Race; Gender reassignment; Religion or belief; ✓ Sex; Marriage and civil partnership; Sexual orientation Evidence drawn upon for rating: The assessment process routinely captures information related to the highlighted protected characteristics, including dementia assessment for all admissions.	✓
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Pregnancy and maternity; ✓ Disability; Race; Gender reassignment; Religion or belief; ✓ Sex; Marriage and civil partnership; Sexual orientation Evidence drawn upon for rating: All users of services transiting to another provider have a clear discharge summary and have a written care plan if ongoing service needs are identified.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Quality and safety processes are well managed, there has been significant investment in the adult and child safeguarding team and extensive training for all front of house staff in relation to Deprivation of Liberty Standards. The Board of Directors have undergone training on DoLS.	✓
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** The current sharing of vaccination data is promoted via the Occupational Health Team. Good practice is shared across the patch and shared training interventions have been developed. Any tests which identify a user of acute services requires screening or vaccination would be individually discussed and offered by the attending physician.	✓
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** There was consistent belief that all three organisations were actively promoting different elements of access, however through discussion and debate with stakeholders there was agreement that due to the lack of consistent data to support this we could not assess this standard as achieving. Please also see the good practice identified on the preceding page.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: See 2.1	✓
	2.3	**People report positive experiences of the NHS** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: See 2.1	✓
	2.4	**People's complaints about services are handled respectfully and efficiently** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: See 2.1	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** The utilisation of values based recruitment for all grades of staff ensures that those with protected characteristics have equal access to opportunities.	✓
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** The use of A4C as the framework for pay progression ensures equal and fair review of work. The trust has also for the second year agreed to pay the living wage rather than the minimum wage.	✓
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** The Trust has invested in an on-line learning hub which has improved access for all staff. All programs of education are evaluated and changes to content affected based upon feedback.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☐ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Policies are in place to clearly advise on how issues should be managed, the Whistleblowing Policy was developed in collaboration with Staff Side to ensure it fully reflected the views of staff. We have implemented an anonymous phone line for staff who feel they wish to raise concerns.	✓
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** The Trust has a well developed set of options which are communicated on Staff Room and via manager's briefing. , managers undertake training to ensure they are familiar with all options and the Trust actively promotes finding work life solutions with staff utilising Occupational Health expertise.	✓
	3.6	**Staff report positive experiences of their membership of the workforce** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** The staff survey highlighted that whilst staff engagement scales had fallen slightly those staff from an ethnic background reported a more positive experience of working at the Trust than those from a white ethnic background.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: The Board of Directors support the Equality and Diversity agenda with a named non-executive director and lead director who also chairs the Fairness Forum and the local authority Equalities Board. The Board approve the program of events to celebrate diversity across the Trust.	✓
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Equality considerations are assessed against each paper which the Board reviews, however, there is a need to ensure greater consultation on these issues with users of service and we are working with other partners to look a developing greater engagement. Our governors have a key role in raising issues which they believe are not reflective of an inclusive approach.	✓
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation Evidence drawn upon for rating: The Trust invests in training and development for all managers to understand the considerations they need to make to ensure fair an equal access of staff. The implementation of HR business partnering will ensure that local issues are managed in a consistent and fair manner and reported to the Board.	✓

Addendum to the EDS2 Summary Report dated 27 May 15:

Level of stakeholder involvement in EDS2 grading and subsequent actions:

The Trust undertook to work in partnership with our local CCG's and Leeds and York partnership trust to develop a shared understanding of how the organizations were viewed by stakeholders around this key agenda. The voluntary agencies representing various groups of individuals with protected characteristics were invited to a planning meeting to agree the process and share ideas. A grading session was independently facilitated where our stakeholders discussed a specific goal and graded the organizations against that based upon the evidence presented. This in depth review of goal 2 of the standards allowed for significant discussion and debate. The remaining three standards have been self assessed and agreed through the fairness forum. The partner organizations agreed to work corroboratively to improve the shared approach to the standards identified with a view to affect system wide change. Each organization also undertook to develop separate objectives relevant to their areas of greatest need for development.

The outcome of the organization assessment will be reported at Board level and shared with the local Health and Well Being Boards.

Organisation's Equality Objectives (including duration period):

1. Improve data collection, analysis and monitoring of protected characteristics.
2. Further develop engagement of patients, carers and staff to reflect local demographics.
3. Develop strong partnerships with social care and GP's to ensure patient pathways are free from barriers between providers for everyone.
4. To continue with Board of Directors and senior leaders development program ensuring equality and diversity considerations are embedded into all decision making processes.

The objectives are reviewed at least annually by the fairness forum and run from 2012 - 2016

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

The approach undertaken is evidenced good practice in taking a shared approach across three organizations and enables shared understanding of each one's specific contribution to improving how we embed E & D considerations across all elements of practice.

Relevant to Goal 2:

Service user data collection analysis.

Interpreting and translation provision is accessible to all sites.

Partnership working and representation of Healthwatch on the fairness forum. Healthwatch provide focused feedback on elements of protected characteristics and how we are doing i.e. Discrimination against disabled people in York, Access to health and social for deaf people - these reports are then used to inform action plans on how we can improve.

The Trust has an elderly liaison services group which specifically inform the elderly Directorate on issues which affect elderly users of service.

The Dementia strategy enables targeted consideration of how we improve the access for users with Dementia including dementia friendly wards.

The Trust has committed to provide a ritual washing facility to be completed in the next 6 months.

Accessible information in alternative formats.

The Trust has a process to review all documentation to ensure it complies with the local PoPPiY standards.

The Trust has decided not to use 'easyread' with users of services rather it has implemented a process where individuals are assessed one on one to determine their information needs.

The Trust procured as part of it's standard a taxi firm who could facilitate booking via text and all of the drivers have undertaken dementia friendly training.

To assist users in the local community being able to access the correct service the Trust has developed in collaboration with the CCG a single point of access for advice thereby reducing the number of hand 'offs' and potential errors in users not being directed to the right services.

The Chief executive now provides his briefing by video to improve access.

A core values of the Trust are:
Caring about what we do
Always doing what we can to be helpful
Respecting each other
Listening in order to Improve

These values are part of the appraisal discussion where staff are asked to provide evidence of how they have enacted these behaviours towards colleagues and users of service.

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Workforce Race Equality Standard 2015 – York Teaching Hospital NHS Foundation Trust

This report is a word version of the Workforce Race Equality Standard Template Report we are required to submit to NHS England.

1 Background Narrative

a. Any issues of completeness

The Trust continues to increase awareness of the importance of accurate recording and reporting of protected characteristics

b. Any matters relating to the reliability of comparisons with previous years

The 2013-2014 Trust Equality and Diversity report used BME definitions not consistent with WRES guidance. The definitions of ethnicity provided in the WRES guidance have been adopted for purposes of reporting and were used in the equality and diversity report 2014-2015.

Rotational doctors were included in some figures produced in 2013-2014. This is noted where relevant.

2 Total Numbers of Staff:

a. ***Employed within the organisation at the date of the report:***

Headcount 8,739. The figure is reporting staff that are on fixed term temporary and permanent contracts only

b. Proportion of BME staff employed within the organisation at the date of the report:

7% of staff employed are from the categories for BME

3 Self reporting

a. The proportion of staff who have self reported their ethnicity

100% of those who have reported have self-reported.

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

The Trust continues to increase awareness of the importance of accurate recording and reporting of protected characteristics.

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

The Trust will implement in full by 31 March 2016 a self service product which will allow staff to update their ethnicity on ESR.

4 Workforce data

a. *What period does the organisation's workforce data refer to?*

The data is as at 31 March 2015

5 Workforce Race Equality Indicators

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or Corporate Equality Objectives
For each of these four workforce indicators, the standard compares the metrics for white and BME staff				
1 Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce	0.8% compared to 7% overall	0.3% compared to 7.5% overall	The increase may be due in part to the new WRES guidance document. We should be able to demonstrate improvement in the figures next year	Action plan to be established via Trust Fairness Forum
2 Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.	The relative likelihood of White staff being appointed from short listing compared to BME staff is 2.21 times greater	The relative likelihood of White staff being appointed from short listing compared to BME staff is 1.27 times greater	Different methodology used in the reporting this year 2014/15 (rotational Doctors were excluded)	Continue values based recruitment Plan to introduce centralised recruitment which would allow for improved monitoring and audit Systematic and visible monitoring

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or Corporate Equality Objectives
3 Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year.	The relative likelihood of BME staff entering the formal disciplinary process compared to White staff is 1.65 times greater.	-		Audit in the form of case reviews to include consideration of ethnicity. Checks are already made by the Employee Relations team in determining whether a case should proceed through the disciplinary process.
4 Relative likelihood of BME staff accessing non-mandatory training and Continuing Professional Development (CPD) as compared to White staff	-	-	Data as collected does not currently breakdown to CPD	New learning hub (Trust online learning management system) will enable refinement of data (directorate and occupation) to be developed in the year ahead. Monitoring appraisal process

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or Corporate Equality Objectives
For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff.				
5 KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White 26% BME 24%	White 27% BME 28%	Staff survey was sent to 50% of staff randomly selected and returned by 47% of the sample.	Look to improve return rate within the Trust. Consider more detailed analysis of results (directorate + occupation) Fairness Champions appointed to improve awareness + support
6 KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 23% BME 22%	White 21% BME 30%	As indicator 5	As indicator 5
7 KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion	White 93% BME 80%	White 91% BME 80%	As indicator 5	A new talent management system is in development
8 Q23. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 6% BME 20%	White 5% BME 22%	As indicator 5	Specific directorates alerted to areas of concern. Scoping exercise re BME staff network

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or Corporate Equality Objectives
Does the Board meet the requirement on Board membership in 9?				
Boards are expected to be broadly representative of the population they serve	No BME representation		The population served is 96.8% white based on 2011 ONS census data	Board conscious of data when considering new members. Increase awareness of role models

6. Are there any other factors or data which should be taken into consideration in assessing progress? Please bear in mind any such information, action taken and planned may be subject to scrutiny by the Co-ordinating Commissioner or by regulators when inspecting against the "well led domain."

In addition to the WRES we publish an annual E & D report which includes detailed analysis of workforce information. The Trust has a Fairness Forum which meets every quarter and monitors progress of E & D work. The forum has Board level representation.

7. If the organisation has a more detailed Plan agreed by its Board for addressing these and related issues you are asked to attach it or provide a link to it. Such a plan would normally elaborate on the steps summarised in section 5 above setting out the next steps with milestones for expected progress against the metrics. It may also identify the links with other work streams agreed at Board level such as EDS2.

It may be useful to read this report in conjunction with the Equality & Diversity Report 2014/15

Equality Objectives 2012 – 2016

In compliance with the Equality Act 2010

Updated July 2015

Content

Page

Introduction

York Teaching Hospital NHS Foundation Trust is committed to promoting equality, diversity and human rights in its day to day treatment of all patients, visitors and staff regardless of age, disability, race, ethnic origin, gender, gender identity, marital status, religion or belief or sexual orientation.

Our mission is:

“To be trusted to deliver safe, effective and sustainable healthcare within our communities”

Our values, drivers and motivators to achieve this are:

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

How we promote safe and effective healthcare for all who need it and work to provide it is outlined in “our shared commitment” which is published on our website.

This document explains the need for the Trust to set equality objectives, how we develop these and our progress to date.

The Equality Delivery System (EDS)

The Equality Delivery System (EDS) was originally a product of the Department of Health Equality and Diversity Council (EDC) designed to help NHS organisations, in discussion with local partners to review and improve performance and help to meet their statutory and regulatory obligations for equality, diversity and human rights.

York Teaching Hospital NHS Foundation Trust held our first grading day in March 2012 which included the development of our equality objectives. Nationally in 2012 the implementation of the EDS was independently evaluated and subsequent consultation with NHS organisations developed a refreshed EDS called EDS2 that was launched in November 2013 allowing more flexibility for local implementation.

EDS2 has 4 goals and 18 outcomes, with enough in common between the original and EDS2 for meaningful comparisons to be made over time.

1. Better health outcomes for all
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is graded and action determined.

Adoption of the EDS

In November 2011 to drive up equality performance and embed it into mainstream / core business York Teaching Hospital NHS Foundation Trust adopted the EDS.

It also helps us to meet:

- the requirements of the public sector Equality Duty
- equality aspects of the NHS Constitution
- equality aspects of the NHS Outcomes Framework
- equality aspects of CQC's Essential Standards

In March 2012 we held a grading day which included development of our equality objectives.

During 2014 those with responsibility for equality and diversity at York Teaching Hospital Foundation Trust, Leeds York Partnership Foundation Trust and Vale of York Clinical commissioning Group (CCG) agreed to work together with community representatives to make best use of time and resources and carry out EDS2 collaboratively and begin working towards joint objectives.

Stakeholders were invited to a planning meeting to discuss a preferred approach to EDS2, how they wanted to be involved and how the assessment and grading would be carried out with representation from each of the protected characteristics. The stakeholders approved this new way of working and agreed there should be a focus on just one goal (Improved patient access and experience) to enable time for meaningful discussion and assessment.

Each organisation compiled evidence which was distributed prior to an assessment and grading event 24th March 2015. The summary report for each organisation is published on respective websites as required by NHS England.

Developing Our Objectives

Our objectives were first developed by the EDS grading panel March 2012. In March 2015 at the assessment and grading event mentioned above joint equality priorities were agreed and these have been added to our equality objective action plan. The overall objectives remain the same with actions amended; removing those completing and adding the new priorities.

We have four objectives:

1. Improve data collection, analysis and monitoring for protected characteristics
2. Further develop engagement and involvement of patients, carers, governors and staff to reflect local demographics
3. Develop strong partnerships with social care and GP's to ensure patient pathways are free from barriers between providers for everyone
4. Continue with staff development programme ensuring equality and diversity is embedded into all decision making processes

Objective Action Plan

An action plan for each equality objective following the SMART principle forms the remainder of this document, progress to date is noted. Asterisk * denotes 2015 EDS2 action

Monitoring

Our objectives are monitored by the Trust Fairness Forum (formerly known as the Equality and Diversity Committee) with a progress report presented to the Board on an annual basis.

Objective 1
Improve data collection, analysis and monitoring for protected characteristics
This links to EDS goals 1, 2, 3 and 4

Action		Responsible Director	Target Date	Measures	Progress
1.1	Ensure data from surveys and feedback is capable of analysis by protected characteristic	S Rushbrook S Holden	31/12/15	Explore current exceptions on data sets + action plan Increased completion and return rates of monitoring information	Gaps identified Discussions ongoing with Systems and Network Services(SNS) to ensure capture of protected characteristics
1.2	Review approaches to data collection and Datix system for PET and PALS to ensure ability to disaggregate comments / complaints to protected characteristics	B Geary PET Lead	31/12/15	Improve response rate for complaint monitoring form. Production of evidence based trends/themes	New monitoring form implemented though return rates are low – review including how to raise awareness underway
1.3	Raise awareness to the importance of recording protected characteristics where appropriate: Patients Staff	B Geary S Holden	On going	Decreases in number of prefer not to say responses.	Included in corporate induction, awareness events throughout the year
1.4	Disaggregate performance indicators by protected characteristic and analyse outcomes of different PC's to set objectives	J Walters L Turner	31.12.15	18 week admitted breaches, DNA's, ED and cancer breaches,	Please see 1.1 and 1.4
1.5	Review options for monitoring of patients using CPD including capturing patient protected characteristics and specific requirements	S Rushbrook A Lee	31/12/15	All protected characteristics captured and compliance with Information standard ISB 1605	Please see 1.1
* 1.6	Investigate establishment of a central information hub including monitoring and review process	S Holden M Milburn	31/09/15	Feedback from policy writers and individuals who complete equality analysis Picture bank of inclusive images	Work in progress - to be developed

Action		Responsible Director	Target Date	Measures	Progress
1.7	Work force data - Monitor job applicant conversion rates	S Holden S Longhorne	31/12/15	Analysis of job application conversion rates to be included in annual Equality in Our Workforce Report	Conversion rates included in 2013-2014 Equality, diversity and human rights report
1.8	Workforce data - Monitor development programme applications and progression for Band 4&5	S Holden S Wild	31/04/15 On going	Personal training data capture on Learning Hub Quarterly report to Education Review Board Link to HR data re recruitment/ progression of staff to higher roles	Learning hub now live – data will be available for 2014/2015
* 1.9	Improve collection and analysis of patient/service user data with focus on sexual orientation and age	S Rushbrook S Holden A Lee M Milburn	31/03/16	Improve response rate Decreases in number of prefer not to say responses.	Links to 1.1 -1.6 inclusive
* 1.10	Review current processes to raise concerns, make a complaint or to access PALS support including use of technology to enable greater access	B Geary New PET lead	31/03/16	Revised Patient experience Strategy to be produced following re-structure	Patient experience lead appointed July 2015

Objective 2

Further develop engagement and involvement of patients, carers, governors and staff to reflect local demographics
This links to EDS2 goals 1, 2, 3 and 4

Action		Responsible Director	Target Date	Measures	Progress
2.1	Complete a mapping exercise to identify gaps and develop a plan to ensure we include people with protected characteristics (PC's) reflecting local demographics with focus on specific groups e.g LGBT(Lesbian, Gay, Bi-sexual and Transgender) and gypsies and travellers	S Holden M Milburn	30/09/15	Define demographics of Trust area List of current Trust connections Action plan to address areas where PC's are not engaged/involved/ do not reflect local demographics	Links to 1.6
2.2	Ensure corporate communications and engagement strategy supports Equality and Diversity objectives	P Crowley L Brown	30/06/15	Report on performance to the Board of Directors at agreed intervals	Discussions re Communications strategy in progress
2.3	Capture qualitative data and develop case studies to share experiences and enable learning	B Geary New PET lead	On going	Defined capture process Bank of case studies available for staff	Patient stories captured on naturally occurring basis

Objective 3
Develop strong partnerships with social care and GP's to ensure patient pathways are free from barriers between providers for everyone
This links to EDS2 goal 1and 2

Action		Responsible Director	Target Date	Measures	Progress
3.1	Continue EDS2 grading collaboratively with other health care providers	S Holden M Milburn	31/03/15	Representative Grading Panel + inclusive of the area the Trust covers	Goal 2 assessed March 2015 Other goals to follow
3.2	Review capture of protected characteristics at point of patient entry	S Holden S Rushbrook A Lee		Electronic capture Compliance with Information standard ISB 1605	Develop plan with systems and network to ensure protected characteristics are included as mandatory fields on CPD
3.3	Review availability of this capture across pathways	S Rushbrook A Lee			Links to 1.1 and 1.5
3.4	Improve access to services:				
* 3.4.1	Review outpatient appointment system / choose and book. To include first point of contact processes and consideration of options to increase choice for service users	S Rushbrook A Lee	31/03/2016	Service review identifies areas for improvement and new processes designed to capture data at source	
3.4.2	Develop access audit tool	B Golding	31/12/15		In progress to link with Access to Services Group
* 3.5	Review first point of contact processes and to develop and promote alternative contact processes where appropriate e.g text message	S Rushbrook A Lee	31/03/15	Increased options Improved access to our services	Paper to Directors July 2015 for debate and discussion.

Objective 4
Continue with staff development programme ensuring equality and diversity is embedded into all decision making processes
This links to EDS2 goal 4

Action		Responsible Director	Target Date	Measures	Progress
4.1	Review how data feeds into the Trust Business Cycle	Corporate Directors G.Lamb	ongoing	Evidence within the business plan that decisions are made regarding services which reference protected characteristics	
4.2	Produce evidence of debate related to inclusivity at Board of Directors	P Crowley A Pridmore	¼ly and on going	Corporate risk register and assurance framework presented to the Board Completion of paper front pages Standard Operating Procedure for Corporate Governance Review minutes	
4.3	Review advertising practice for development programmes and monitor applicant conversion and progression for band 4&5	S Holden W Thornton	31/04/15 on going	Review training opportunities at band 5.	Learning hub now live – data will be available for 2014/2015 need to link to HR/ESR change forms
4.4	Review equality analysis process and documentation	S Holden M Milburn L Larcum	31/12/15	New style equality analysis introduced by relevance and then rolling programme Centralise monitoring	In progress
4.5	Develop a champion role	S Holden M Milburn	On going	Contacts monitored Champions spread	Complete First group trained and introduced September 2014

* 4.6	Develop and implement a joint approach to equality and diversity training	S Holden M Milburn	31/03/16	Uptake monitored via Learning Hub	
Action		**Responsible Director**	**Target Date**	**Measures**	**Progress**
* 4.7	Develop training so that staff feel comfortable to ask questions related to protected characteristics	S Holden M Milburn	31/03/16	Uptake monitored via Learning Hub Improved level of recording protected characteristics	Potential link to 4.6

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Staff Survey Update

Action requested/recommendation

Information is provided to Board of Directors about the action plan arising from the staff survey outcomes. Progress against the actions will be provided periodically. Board are asked to support the action plan detailed.

Summary

The policies have been reviewed in accordance with the review schedule.

Strategic Aims	**Please cross as appropriate**
1. Improve Quality	☒
2. Improve our effectiveness, capacity and capability	☒
3. Develop stronger citizenship through our working with partners	☐
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

There are no implications for equality and diversity. Equality Analysis documents completed.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Corporate Directors
Risk	No risk
Resource implications	Not applicable
Owner	Sue Holden, Director of Workforce & Organisational Development
Author	Lydia Larcum, Senior HR Lead
Date of paper	July 2015
Version number	Version 1

Board of Directors Meeting – 29 July 2015

Staff Survey Update

1. Staff Survey Findings

The 2014 staff survey findings have recently been shared with the board. This paper will recommend actions that the organisation should take as a result of these findings. The overall indicator for staff engagement is below average. Of the three key findings that make up this indicator there has been no change in two since the 2013 survey, however there has been a slight increase in the third (those who would recommend the Trust as a place to work or receive treatment). Therefore the focus of this paper will predominantly focus on how staff engagement can be improved using the feedback received as part of the survey.

In previous years each directorate has been expected to use their own results to develop local action plans to address the issues raised. The below paper recommends, rather than each area developing their own local action plan, the organisation as a whole focus on three overarching issues over the next six months before the next survey opens.

These areas which should form the organisational action plan are:

1. Staff and Patient suggestions should be used to inform decisions.
2. Improved communication between staff and senior managers. Specifically feedback must be provided about how staff and patient suggestions have been used.
3. Incident reporting procedures should be (and should be seen to be) fair and effective.

By concentrating on these issues a greater focus can be given to them. It allows for a more consistent message to be shared with the organisation and greater impact created. This will allow for more visible action to be undertaken, ensuring staff feel that their feedback has been taken on board and subsequent actions taken.

2. Update

1. Staff and Patient suggestions to be used to inform decision making.

The survey found that only 24% of those surveyed responded positively when asked if senior managers acted on staff feedback. This was the organisations worst score overall. In addition only 26% responded positively when asked if senior managers try to involve staff in important decisions. This was the organisations second worst scoring question. Similarly to this only 45% felt that feedback from patients/ service users is used to make informed decisions in their directorate or department. When benchmarked against other Trusts this was our worst performing question.

Actions:

- Measures must be taken to capture staff feedback both corporately and locally, formally and informally.
- Reassurance that feedback is genuinely wanted, rather than feeling that this is simply a ‘tick box’ exercise, needs to be provided.
- The staff suggestion scheme should be re-launched with corporate directors backing

that all ‘quick wins’ should be expedited.
- Patient stories should be utilised as part of explanations about why corporate decisions have been made.
- Patient complaints and feedback should be used openly and shared as part of team brief and other corporate communications.
- Patients should be utilised more in corporate decision making and their contributions should be visible to staff.
- The role of staff and patient governors should be highlighted as one way suggestions sought and used.

2. Improved communication between staff and senior managers. Specifically that feedback must be provided about how staff and patient suggestions have been used.

The survey found that only 26% reported good communication between senior management and staff. Only 48% felt that senior management were committed to patient care (one of our bottom 5 scores when benchmarked against other Trusts) and only 39% felt that they were informed about errors, near misses and incidents that happen in the organisation. Tellingly only 41% felt that they were satisfied with the extent to which the Trust values their work.

The survey found that only 36% responded positively when asked if they were given feedback about changes made in response to reported errors, near missed and accidents.

Actions:
- Senior managers should be visible and take the opportunity to talk to staff informally on a regular basis.
- All managers, no matter their seniority, should be encouraged to ask staff for feedback regularly (as part of catch ups, appraisals and team meetings) and then share how these ideas have been used.
- All staff and patient suggestions must be responded to. If suggestions are not achievable honest explanations should be given for this.
- ‘You said we did’ areas/ white boards should be available in every department for local management teams to respond to suggestions made and encourage contributions from teams.
- ‘You said we did’ stories should be shared with the Trust (via corporate communication, but also informally wherever opportunities arise).
- Those ideas that are achievable via the Staff Suggestion Scheme must be progressed quickly and as priorities – bureaucracy should not get in the way.

3. Incident reporting procedures should be (and should be seen to be) fair and effective.

On a scale of 0-5 the Trust scored 3.45 for fair and effective incident reporting procedures. This score was in the lowest 20% of Acute Trust scores and was no change since the 2013 survey. 65% of staff agreed that they would feel secure raising concerns about unsafe clinical practice. This is below the average for acute Trusts and 15% below the best scoring acute score.

Actions:
- Incident reporting procedures should be re-promoted to all staff.
- Reassurance should be provided as to how these are fair and transparent.
- Feedback as to what has occurred when an incident has been reported should be shared in an appropriate manner.

Other Activities

The HR Team will undertake further work on the Trusts appraisal system. Whilst this is not one of the corporate themes above, there has been a reduction in the number of staff reporting that they had an appraisal in the last 12 months and also an issue highlighted about the perceived quality of appraisals.

A revised appraisal process has been developed which will be introduced in May 2015. The introduction of a self-assessment tool and focus on behaviours linked to the Trust values ensure the discussion will be of high quality and meaningful to the appraisee. Reduced paperwork allows the manager to have a more thoughtful discussion, focusing on the individual. This approach also allows for ongoing discussions throughout the year, meaning the appraisal discussion should not be an isolated and formal event.

Local Actions

As part of the HR restructure the HR Managers roles have been re-designed to allow them to provide a more partnered, supportive approach to their directorates. The HR Managers will, in their new capacity as directorate business partners, work with each directorate to translate these corporate objectives into local outcomes. Departments who are performing well in the above areas will be used as case studies for those areas that need to undertake additional work.

The above overarching themes need not only local/directorate responses, but also the corporate actions described above. These corporate actions are needed to ensure there is a highly visible response to the survey. This response must be one that staff can link back to the feedback that they have provided as part of the survey. The survey itself has shown that staff feel that their suggestions, feedback and ideas are not listened to – the corporate response to the survey needs to counter this.

A fuller action plan will be developed with partners from across the Trust to ensure the above objectives are achieved. Corporate Directors are asked to commit to prioritising the above, committed to take action and support in moving this agenda forward within the next six months, before the next staff survey.

3. Recommendations

Information is provided to Board of Directors about the action plan arising from the staff survey outcomes. Progress against the actions will be provided periodically. Board are asked to support the action plan detailed.

Author	**Lydia Larcum, Senior HR Lead (Staff Engagement)**
Owner	**Sue Holden, Director of Workforce & OD**
Date	**July 2015**

York Teaching Hospital NHS
NHS Foundation Trust

Workforce Strategy Committee Meeting
20th July 2015

Attendance:

Dianne Willcocks, Non Executive Director (Chair)
Libby Raper, Non Executive Director (Vice Chair)
Sue Holden, Director – Workforce and Organisational Development
Dawn Preece, Deputy Head of HR
Sian Longhorne, Senior HR Lead, Workforce Utilisation
Gail Dunning, Head of Corporate Development
Anne Devaney, Head of Corporate Learning
Michelle Wayt, Deputy Head of HR

Apologies:
Melanie Liley, Head of AHP Services and Psychological Medicine
Jonathan Thow, Deputy Medical Director (Education)
Beverley Geary, Chief Nurse

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1.0	**Last Meeting Notes Minutes Dated** **Matters arising from June minutes**		It was noted that there were references in the minutes to papers/updates which were requested for the meeting in September which should be for the next meeting in October. **Approved** **Agenda item 2 – Draft WSC Terms of Reference** DW requested that the ToR were recirculated with	SL to re-circulate ToR.	

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			the corrections requested at the previous meeting and including the items from the Corporate Risk Register with workforce implications. **Statutory and Mandatory training** AD updated that the current overall compliance rate is 76%. SH described the process that has been agreed with staff side colleagues for dealing with non-compliance as follows; • Non-compliant staff to be issued with letter and given two weeks' notice to ensure compliance with requirements • If do not meet requirements or offer reasonable mitigation will be issued with a 6 month written warning and their pay progression will be halted This agreed process demonstrates a move in the organisational approach to this issue. AD reported that the ability to access learning hub outside of the organisation was proving a blocker to achieving compliance. DW requested that AD seek information from neighbouring organisations about how many offer access to e-learning from home.	Paper to be presented at October meeting identifying the number of staff who have received a warning and overall compliance rate.	

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2.0	**Workforce Risks Matrix**		The Workforce Risks Matrix was originally presented at the WSC meeting in June. An updated version incorporating comments from that meeting and from Workforce & OD Senior Team meetings was presented at this meeting. (The WSC will also receive those elements of the Corporate Risk Register relating to workforce.) It was acknowledged that the matrix was a helpful document in terms of getting the balance right of where to focus resources and for example, helping to identify where actions might be 'nice to have' but not high impact in terms of addressing risk and therefore might not be a priority at this time. It was suggested that the matrix should also reflect national contract changes and discussions happening at a national level, e.g. de-contracting MHPS.	Workforce Risks Matrix to be provided as an appendix to minutes for the Board meeting	
3.0	**Discussions with Coventry University**		SH provided a verbal update on discussions had with Coventry University regarding the campus being set up in Scarborough and what courses will be offered. Courses will be modular, six weeks blocks, delivered on either mornings or afternoons which will allow learners to work and study. SH has proposed the development of an East Coast Education group involving a number of partners. It was agreed that this is an exciting opportunity for the Trust to recruit, train and appoint locally in the		

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			Scarborough area and could mitigate some of our current workforce challenges.		
			Employer of Choice		
4.1	**Volunteers**		**Paper 3** MW presented a paper and briefed that the Volunteer Strategy will transfer from HR to the Chief Nurse Team (CNT) at the end of July 2015. MW will work with the CNT to develop a business case to detail the resource required to drive this service forward. DW said that she would like to see a big change in our approach to the use of volunteers as a key feature of the workforce. It was also noted that volunteers and how this group are utilised should feature in discussions about the turnaround programme. SH to discuss this with Gordon Cooney.		Board to be aware that the service is currently under resourced to deliver a long term strategy and a business case will be developed
4.2	**Workforce Race Equality Standard (WRES) and equality Delivery System for the NHS (EDS2)**		**Paper 4** MW presented the WRES which has also been presented at a number of other forums recently. The document is to be presented at Board in July for sign off. The following points were made/noted; • MW to speak to Margaret Milburn regarding the fact that there is no BME representative on the local Fairness Forum. • DW stated that she would expect, given the diversity of the workforce and communities	Margaret Milburn undertaking work already to build links with partners including the council. There is also a need to consider how to make better links through our own staff	

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			we serve, that the Executive Board would have BME representation. • SH acknowledged that we don't meet some basic requirements regarding capture and recording of diversity data. • There is a need to respond to the challenge of demonstrating a desire, as an organisation to become more diverse and to take action to achieve this. This should involve the responsibility for achieving this being an explicit objective for all directors.	from BME backgrounds. SH to circulate the WRES comparator data from other local organisations.	
			Workforce Utilisation		
5.1	**Update on quarterly HR 'Deep Dive' Board report**		SL provided a brief verbal update that the next quarterly HR report which would be presented at Board in September would be titled, 'Workforce of the Future'. The paper is intended to address some of the questions raised at previous meetings regarding the shift in the workforce profile since integration. The paper will also describe the organisation's long term strategy in terms of workforce, e.g. plans for future skill mix. The paper will seek to gain agreement that ESR, the integrated HR and payroll system will be the master data source for workforce related information, rather than the finance general ledger.		
5.2	**Agency Expenditure Update**		**Paper 5** SL presented a paper which highlighted continued high levels of agency expenditure, particularly for nurses and medics. The paper also identified		

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			challenges in reducing use of agency staffing. The following points were made/noted; • Agency usage and spend continues to increase, despite numerous steps to better control this by the workforce utilisation team • The Trust is exceeding its budget for temporary staffing • To effect a real change in patterns of temporary workforce usage requires a shift in perception across the organisation, including better utilisation of the substantive workforce through effective (e)Rostering, holding managers to account for use and spend in their areas, moving away from silo working. The committee were supportive of developing a framework through which all areas would be held to account for how they utilised substantive and temporary workforce. DW suggested working more closely with specific groups who could drive change, e.g. Matrons. It was proposed that Temporary Staffing is a standing agenda item for the WSC.	The agenda item should focus on a different aspect of temporary staffing at each meeting, e.g. eRostering. This should also include 'good news stories' or experiences in areas of best practice.	Board to be made aware of the barriers faced to what needs to be achieved to reduce agency use.
6.0	**Any Other Business**		**Centralised Recruitment** SH referred to a paper which was originally developed and presented to Corporate Directors in August 2014 to move to a central recruitment model. This was agreed in principle but there was a need to determine the resource required to deliver this. The resource requirements have now been determined and MW has developed a further paper		

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			to be presented at Corporate Directors on 27th July. This paper seeks agreement to reinvest almost £100k of savings made by HR in legal costs into implementing a centralised recruitment model. The costings within the model demonstrate financial and time savings to be made and highlights how the risks associated with the current devolved model (timeliness of issues contracts, compliance with mandatory pre-employment checks) will be reduced. It was noted that the initial set up costs to deliver this model would be more than the ongoing costs and that some of the required resource would be recruited on a fixed term basis. **Cover arrangements/Workforce and OD priorities** SH briefed that a Senior Team time out on 21st July would identify priorities for the next 12 months. SH also updated on agreements made so far with regards to cover arrangements for the duration of her secondment. AD, GD, Polly McMeekin (Deputy Director or Workforce commencing 1st September) and Damon Foster (Head of R&D) would be responsible for operational day to day service delivery. Patrick Crowley and Mike Proctor would take the executive lead. SH said that she would continue to lead some projects, though these are still to be fully agreed .		Board to be aware that initial set of costs of a central recruitment model anticipated to be less than ongoing costs

	Agenda Item	AFW	Comments	Assurance	Attention to Board
	Next meeting dates		**13th October 2015, 10.00 – 12.00** Classroom 4, Post Grad Medical Education Centre, 5th Floor, York Hospital **8th December, 2015, 10.00 – 12.00** Classroom 4, Post grad Medical Education Centre, 5th Floor **26th January 2016, 13.00 – 15.00** Classroom 4, Post Grad Medical Education Centre, 5th Floor, York Hospital		

WORKFORCE RISKS

Current

Internal	• Apathy/Demoralised staff • Shifting Accountability • Internal Bank - extending opportunity • Retention – HWB/Comms agenda • Training and Resilience interventions • Exploiting appropriately volunteering • 'Mindfulness' employer status • Agency Workforce - flexible opportunities • Centralised Recruitment • Job Planning Monitoring • Staffing pressures – cross directorates variances in resourcing and patient mix • Final CQC report • Loss of OH Business	• Continued recruitment issues • Overseas recruitment • Market pressures around Bank/Agency cost • Tendering • TUPE • Announcements re: VSM pay, redundancy cap and retire & return • Pay Cap – motivation • Partnership Working – specifically with council and local partners
	• Service reconfiguration • Trading Arm developments • Clear talent management strategy • Transparency of opportunity • Working more closely with 3rd sector • 7 day working for all staff groups • Workforce remodelling • Career mapping current staff	• Adherence to national reward framework • Recruitment gaps • Skills shortages • Changes to roles/Health/Social Care • Revalidation requirements • Cost pressures/workforce flexibility • Career advice • De-contract MHPS • National contract changes

Future

External

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 July 2015

Monitor quarter 1 submission

Action requested/recommendation

The Board is asked to consider the information and approve the submission to Monitor at the end of the month.

Summary

The Trust is required to submit the quarter 1 return at the end of the month.

The position being submitted is as follows:

Continuity of Services rating (CoSR) 3. The finance report discussed later in the meeting will confirm the CoSR position.

It should be noted that Monitor has changed the regulatory framework. This change has been implemented from quarter 1. The new rule is that if either of the individual components of the COSR (liquidity or capital service cover) scores 1 then this can be considered a trigger for investigation. At present the Trust's Capital Service Cover has scored 1 due to our deficit position.

Governance – there are a number of targets that have not been achieved this quarter including:

A&E 4 hour target
18 weeks admitted target
Cancer 2 week breast symptomatic
C-Diff target

Attached are copies of the submission documents.

Personnel changes
The submission will identify Dr Turnbull's retirement during the quarter and report on the two interim Medical Directors currently in post.

The Trust continues to comply with the standard licence conditions as required by the Risk Assessment Framework and Monitor Provider Licence.

The Chair and I will review the final supporting letter on behalf of the Board and confirm the letter prior to the submission being made to Monitor.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒

3. Develop and enable strong partnerships ☐

4. Improve our facilities and protect the environment ☒

Implications for equality and diversity

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

Reference to CQC outcomes

This paper supports the overall principles of the CQC outcomes.

Progress of report	Board of Directors
Risk	The risks are associated to the financial position and performance
Resource implications	None identified.
Owner	Patrick Crowley, Chief Executive
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	July 2015
Version number	Version 1

Continuity of Service Risk Ratings (indicators for 2015/16) for York Teaching Hospital NHS Foundation Trust

					Audited For PrevYE ending 31-Mar-15	Plan For Quarter ending 30-Jun-15	Actual For Quarter ending 30-Jun-15	Plan For YTD ending 30-Jun-15	Actual For YTD ending 30-Jun-15
Capital Service Cover									
Adjustments									
Material One-Off Income Adjustment (Revenue Available for Capital Service)		£m	(+/-ve)	i				-	-
Material One-Off Income Adjustment (to Capital Service)		£m	(+/-ve)	i				-	-
Capital service									
PDC dividend expense	*from SoCI*	£m			(6.238)	(1.760)	(1.479)	(1.760)	(1.479)
Interest Expense on Overdrafts and Working Capital Facilities	*from SoCI*	£m			-	-	-	-	-
Interest Expense on Bridging loans	*from SoCI*	£m			-	-	-	-	-
Interest Expense on Non-commercial borrowings	*from SoCI*	£m			-	-	-	-	-
Interest Expense on Commercial borrowings	*from SoCI*	£m			(0.354)	(0.081)	(0.081)	(0.081)	(0.081)
Interest Expense on Finance leases (non-PFI)	*from SoCI*	£m			-	-	-	-	-
Interest Expense on PFI leases & liabilities	*from SoCI*	£m			-	-	-	-	-
Other Finance Costs	*from SoCI*	£m			(0.023)	-	-	-	-
Non-Operating PFI costs (e.g. contingent rent)	*from SoCI*	£m			-	-	-	-	-
Public Dividend Capital repaid	*from SoCF*	£m			-	-	-	-	-
Repayment of bridging loans	*from SoCF*	£m			-	-	-	-	-
Repayment of non-commercial loans	*from SoCF*	£m			(1.082)	(0.624)	(0.623)	(0.624)	(0.623)
Repayment of commercial loans	*from SoCF*	£m			(0.043)	-	-	-	-
Capital element of finance lease rental payments - On-balance sheet PFI	*from SoCF*	£m			-	-	-	-	-
Capital element of finance lease rental payments - other	*from SoCF*	£m			(0.107)	(0.026)	-	(0.026)	-
Capital Service, total		£m			**(7.847)**	**(2.491)**	**(2.183)**	**(2.491)**	**(2.183)**
Revenue Available for Capital Service		£m			15.302	3.222	0.904	3.222	0.904
Capital Service Cover metric		0.0x			2.0	1.3	0.4	1.3	0.4
Capital Service Cover rating		Score			3	2	1	2	1
		Check		i	OK	OK	OK	OK	OK
Liquidity									
Adjustments									
Material One-Off Adjustment (Working capital balance (for use in CoS rating calculation))		£m	(+/-ve)	i				-	-
Material One-Off Adjustment (to Opex within EBITDA)		£m	(+/-ve)	i				-	-
Working capital balance (for use in CoS rating calculation)	*from SoFP*	£m			5.743	5.054	4.583	5.054	4.583
Operating Expenses within EBITDA, Total	*from SoCI*	£m			(436.573)	(108.622)	(113.379)	(108.622)	(113.379)
Liquidity metric		Days			4.7	4.2	3.6	4.2	3.6
Liquidity rating		Score			4	4	4	4	4
Continuity of Services Risk Rating (CoSRR)									
2* Override	*Drop Down*	Text						-	-
1 Rating Trigger		Text		i	No Trigger	No Trigger	Trigger	No Trigger	Trigger
Continuity of Service Risk Rating		Score			4	3	3	3	3

Quarter 1 Performance report for submission to Monitor

Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	N/A	75.6%	Not met
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	N/A	95.2%	Achieved
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	92.8%	Achieved
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	1.0	88.3%	Not met
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	87.6%	Achieved
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	97.5%	Achieved
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	94.7%	Achieved
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	99.6%	Achieved
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	96.8%	Achieved
Cancer 2 week (all cancers)	93%	1.0	93.9%	Achieved
Cancer 2 week (breast symptoms)	93%	1.0	91.4%	Not met
C.Diff due to lapses in care (YTD)	14.75	1.0	21	Not met
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0	N/A	Achieved
Community care - referral to treatment information completeness	50%	1.0	100.0%	Achieved
Community care - referral information completeness	50%	1.0	69.6%	Achieved
Community care - activity information completeness	50%	1.0	95.5%	Achieved
Risk of, or actual, failure to deliver Commissioner Reque	N/A			No
Date of last CQC inspection	N/A			31/03/2015

CQC compliance action outstanding (as at time of submission)	N/A	Report by Exception		No
CQC enforcement action within last 12 months (as at time of submission)	N/A			No
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A			No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A			No
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A			No
Overall rating from CQC inspection (as at time of submission)	N/A			N/A
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A			No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A			No
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A			No