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 30 September 2015**

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

PROGRAMME FOR THE DAY

Time	Meeting	Location	Attendees
8.15am – 8.55am	Non-Executive Director Meeting with Chair	Susan Symington's Office	Non-executive Directors
9.00am – 12.45pm	**Board of Directors meeting held in public**	**Boardroom, York Hospital**	**Board of Directors and observers**
1.00pm – 1.30pm	Lunch in the Boardroom		
1.30pm – 2.45pm	Board of Directors meeting held in private	Boardroom, York Hospital	Board of Directors
2.45pm – 3.00pm	Break		
3.00pm – 4.15pm	Remuneration Committee	Boardroom, York Hospital	Non-executive 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 30th September 2015**

At: **9.00am – 12.45pm**

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** • Sue Rushbrook • Jim Taylor	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 19 August 2015** To review and approve the minutes of the meeting held on 19 August 2015.	Chair	B	11
5.		**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chair		
6.	9.10-9.25	**Patient Story**	Chief Nurse	Verbal	

No	Time	Item	Lead	Paper	Page
7.	9.25-9.45	**Chief Executive Report** To receive an update on matters relating to general management in the Trust.	Chief Executive	C	19
Part Two: Quality and Safety					
8.	9.45 - 10.15	**Quality and Safety Performance issues** To be advised by the Chair of the Committee of any specific issues to be discussed. • Patient and Quality Safety Report • Medical Director Report • Chief Nurse Report • Safer Staffing • Infection Prevention and Control Annual Report	Chair of the Committee	D D1 D2 D3 D4 D5	25 35 69 77 87 95
9.	10.15-10.25	**Community Care Update** To receive an update on Community Care from the Community Director.	Community Director	E	119
Part Three: Finance and Performance					
10.	10.25 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	F F1 F2 F3 F4	129 137 147 161 169
Break for refreshments					
Part Four: Communications					
11.	11.10-11.30	**Communication and Engagement Strategy** To receive for approval.	Chief Executive and Head of Communication	G	173

No	Time	Item	Lead	Paper	Page
Part Five: Human Resources (HR) Information					
12.	11.30-12.10	**HR Report – Workforce of the Future** To receive a report and consider and decide on the recommendations included in the report.	Chief Executive	H	195
13.		**Research and Development (R&D) Report** To receive for information a report updating the Board on the R&D Strategy.	No lead (paper for information)	I	205
14.		**Education Report** To receive for information a report updating the Board on the Education Strategy.	No lead (paper for information)	J	209
Part Six: Estates and Facilities					
15.	12.10-12.20	**Food and Drink Strategy** To receive for approval.	Director of Estates and Facilities	K	215
16.	12.20-12.30	**PLACE Results 2015** To receive the results of the Patient Led Assessments of the Care Environment (PLACE).	Chairman of the Committee	L	225
Part Seven: Audit Committee					
17.	12.30-12.35	**Key matters arising from the meeting of the Audit Committee held on 14 September 2015** To receive a summary of the discussions held at the September Audit Committee and note the key issues highlighted.	Chairman of the Audit Committee	Verbal	
18.	12.35-12.45	**Annual Report of the Audit Committee** To receive the report for information.	Chairman of the Audit Committee	M	241

No	Time	Item	Lead	Paper	Page
Any other business					
19.		**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 28th October 2015 in the Lecture Room St Catherine's Hospice Scarborough.			
20.		**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.

Additions: No changes

Changes: Sue Holden on secondment for 12 months has been removed from the declarations

Deletions: No changes

A

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

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

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

B

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Boardroom, The York Hospital on 19 August 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
	Executive Directors	
	Mr P Crowley	Chief Executive
	Mr A Bertram	Director of Finance
	Mrs B Geary	Chief Nurse
	Mr M Proctor	Deputy Chief Executive
	Dr E Smith	Interim Medical Director
	Mr J Taylor	Interim Medical Director
	Mrs J Walters	Chief Operating Officer
	Corporate Directors	
	Mrs S Rushbrook	Director of Systems and Networks
In Attendance:		
	Mrs A Pridmore	Foundation Trust Secretary
	Mrs W Scott	Community Director
Observers:	Mrs M Jackson	Public Governor - York
	Ms L Pratt	Healthwatch - York
	Mrs J Moreton	Public Governor, Ryedale and East Yorkshire
	Mr S Douglass	Badenoch and Clark

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

15/125 Apologies for absence

Apologies were received from Professor D Willcocks, Non-executive Director, Mrs B Geary, Chief Nurse, Mrs S Holden, Director of Workforce and Organisational Development and Mr B Golding, Director of Estates and Facilities

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

15/126 Minutes of the meeting held on the 29 July 2015

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

15/127 Matters arising from the minutes

15/113 Report from the Chief Executive – Turnaround Avoidance Programme – Delivering Success (TAP)

Mr Sweet asked for an update on the TAP and about the feedback Mr Crowley had received from the Directorates in relation to TAP..

Mr Crowley advised he had received feedback from the majority of directorates. A separate individual briefing had been circulated to the consultant body. Open discussion events are being planned and will take place over the next few weeks to help answer any outstanding questions staff may have.

15/128 Report from the Chief Executive

CQC reports – Mr Crowley advised the draft reports had been received and are currently reviewed. A response was due to be submitted by Friday 21st August, but an extension has been granted and the response will be submitted by Friday 28th August. The review addresses any technical or factual inaccuracies that may exist in the draft reports. It was agreed the submission would be shared with Board members.

Mr Crowley advised that the Quality Summit date has still not be confirmed, it is anticipated that the date will be in September. As soon as the date has been confirmed he will update the Board.

Action: Mr Crowley to share the submission responding to the CQC reports with Board members when it was completed.

Mr Crowley will confirm the date for the Quality Summit with CQC as soon as it is available.

Mr Crowley updated the Board on the tripartite meeting that had been held recently. He reminded the Board of the parties involved in the meeting (Monitor, the Trust, NHSE, Local Authorities, CCGs) and that the objectives being sought by the meeting. On this occasion the meeting was chaired by Monitor and all parties were challenged about their support for whole system solutions. This meeting was followed by the planned visit to the Trust by Monitor concluding the Annual Planning process. Mr Crowley summarised the meeting held with Monitor and the Executive Directors and felt Monitor had been positive and supportive and understood the challenges that exist in the system. He added that Monitor seemed to be reassured by the actions being taken by the Trust while expressing concern about the system dynamics.

Mr Keaney accepted actions were in place, but he was keen to see improvements being made.

Mr Crowley reported the Trust had received two letters relating to financial control from Monitor in advance of the visit. One of the letters outlined the actions the Trust should take to make a suggested additional savings of £3.4m. The finance department is currently reviewing the actions, most of which already in place.

At the meeting held between the Executive Directors and Monitor Mr Bertram was keen to encourage Monitor's new Provider Sustainability Director and the new directorate on pricing to make contact with the Trust. Mr Bertram felt some of our experiences with the acquisition and the current financial challenges would be of interest to them.

The Board noted the comments made by Mr Crowley and the information in his report.

15/129 Finance Report

Mrs Raper advised the Quality and Safety Committee had not met as planned, but there were some areas of concern included in the performance information that she would like to explore either within the Board meeting or outside the meeting if that was preferable. It was agreed that on this occasion it would be appropriate to explore the issues outside the meeting.

Mr Bertram advised that the Finance and Performance Committee had met in August to discuss the key issues.

Mr Keaney asked Mr Bertram to comment on the deteriorating financial position and the rise in the use of agency staff.

Mr Bertram advised the Trust had an actual deficit of £4.6m against a planned deficit of £2.1m resulting in an adverse variance from plan of £2.5m. This is despite sustained additional elective care activity and income levels being above plan. Expenditure has increased and significantly contributed to the deteriorating position. The majority of the increased expenditure related to agency costs. In July the Trust spent £1.5m on nursing agency costs. For the whole of the last financial year the Trust spent £3.5m. If the Trust continues at the current rate the bill for the year will be between £12 - £15m which is unaffordable for the Trust.

Mr Bertram advised the he and Mr Crowley had met with the Matrons and a representative of the Chief Nurse's office to discuss the position and the actions to take. It was agreed in the meeting that the established principles of the safer staffing initiative must be applied but that these should be in a safe and proportionate manner and must be mindful of the financial position of the Trust. There was a clear imperative to reduce reliance on agency staff. Key actions were agreed including removing the use of the most expensive agency from a growing number of hospital sites with the ultimate ambition to ban outright. At present this agency is able to supply staff to York, other agencies are not. As an interim control measure the use of this agency must be approved by the Chief Nurses office on a case by case basis.

A briefing noted has been prepared and circulated to Directorate staff that explains the measures that are being put in place for the use of agency staff.

Monitor has asked all Trusts to provide updated forecast information on a monthly basis. Currently the forecast for the end of the year, assuming the Trust achieves the cost improvement programme and assuming the expenditure control actions in place are effective, is an additional deficit of £1.5m. This will result in a year-end deficit position of

circa £3.8m after Monitor's normalising adjustments. Mr Bertram said that he expected this position would not affect the Trust's rating with Monitor and that it would be within Monitor's tolerances. There are currently no cash issues this year

Mrs Adams noted that there had been nothing spent on the internal bank staff in the last month, she asked if staff were not keen to join the bank.

Mr Bertram confirmed the Trust had switched from NHS Professional to a local staffing bank, but there had not been any growth in it and the Trust has used agency staff instead. He confirmed there had been difficulties recruiting staff to the bank, mainly because the agencies are offering staff guaranteed work and higher rates of pay than the bank. This creates a significant dilemma for our Trust and the Board discussed the issue at length.

Mr Crowley explained that the safer staffing initiative has created a change in how ward establishment is viewed. The initiative has created a perception of a minimum level of staffing, which does not take into account the professional view of the senior nursing staff and a view on the balance of risk.

Mr Proctor proposed that the Trust should cease using agency staff. He acknowledged that the position would be difficult for a few short weeks while the culture was changed. The Board noted the proposal and agreed if it was to be accepted it is action that should be taken before winter.

Mr Keaney asked Mr Bertram if an analysis had been completed on the level of agency spend and vacancies. Mr Bertram advised it was a piece of work currently being undertaken by the HR team.

Mr Bertram advised there was a significant increase in the number of one to one patient to nurse requests being made as part of the falls reduction programme. Mr Bertram outlined the measures the Chief Nurse's office had put in place, including the requirement to discuss every morning with the Chief Nurse's Office, any patient that requires one to one nursing that day. The second is the variations in the application of the e-rostering rules and principles which are currently being reviewed and action taken to address any outliers.

Mrs Adams asked for assurance that Patient Safety would not be put at risk from any changes. Mr Bertram advised that Patient Safety would not be compromised. He advised there was a relevant escalation system in place that would be used by the Matrons. There is a review of the acuity of patients to ensure the high acuity areas have appropriate staffing level. Quality may be affected on occasions, but safety will not be. Other areas where assurance can be gained is from the trend of pressure ulcers, falls and infection control.

It was recognised by the Board that the decision on the use of agency was an operational decision, but the Board asked to be kept informed of any decisions that are made.

Mr Crowley agreed he would keep the Board informed.

Action: Mr Crowley to keep the Board informed of any decision about the use of agency staff.

15/130 Performance Report

Mrs Walters updated the Board on the performance metrics. She advised that performance in the Emergency Department had improved, although there was more improvement to be made over the next few months. The National Emergency Care Support Team (ECIST) were currently visiting the Trust and providing valuable support to the Directorate. Their immediate concern was the lack of intermediate support in the Scarborough area. They are meeting with the Scarborough/Ryedale CCG to discuss their concerns.

Mrs Walters reported there had been a 12 hour breach in Scarborough during the month. This related to a mental health patient. The patient had no medical condition; the delay was in the transfer of the patient to a mental health bed. A serious incident has been declared and is being investigated.

Mrs Walters reported that the Trust had achieved six of the seven cancer targets. Breast symptomatic target had not been achieved as a result of patient choice for July. It is anticipated the target will be achieved by the end of Quarter 2.

With regard to 18-weeks RTT the delivery plan has slipped. It is anticipated the target will be achieved in December. The directorates have refreshed their 18-week plans and work is increasing on achieving the plans.

Mrs Walters reported work continues to be undertaken to achieve the target by October in diagnostics.

Mr Keaney added that he has seen tangible improvements when he has undertaken walk rounds and visited ward areas. He was pleased to see the number of cancelled operations had dropped to 6 from the previously level of around 200 a month.

The Board noted the report and comments made by Mr Keaney.

15/131 Community services

Mrs Scott updated the Board on the current tendering of community services by Scarborough/Ryedale CCG. She reminded the Board that the current contract the Trust holds for community services will expire early in 2016. The proposed timeline suggests the award would not be made until October 2016 and the Trust has been asked if it would continue to provide the service until the provider was in place.

Mrs Scott advised she has worked with the Communications Team to develop a brief to share with staff at a meeting on 1 September, explaining the current situation.

The Board discussed who might respond to the tender; Mrs Scott suggested a few organisations would be interested.

15/132 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 30 September 2015, in the Boardroom, York Hospital.

15/133 Any other business

Ms Symington advised the Board that the meeting in September was likely to be extensive and that Directors should arrange their diaries for that day accordingly.

Outstanding actions from previous minutes

Minute number and month	Action	Responsible officer	Due date
15/114 Quality and Safety Committee	Present a progress paper on the Implementation of the Nursing and Midwifery Strategy	Mrs Geary	January 2016
15/115 Quarterly DIPC report	Provide a further update on the infection control governance review at the September Board meeting	Mrs Geary	September 2015
15/116 Patient Experience Strategy	Present the implementation plan for the Patient Experience Strategy	Mrs Geary	October 2015
15/117 Community Care update	Provide further detail on the re-ablement discussions when available. Include the issue around review of re-ablement service with the system leadership discussions.	Mrs Scott Mrs Walters	When available Report to Board when completed
14/174 Procurement update	Develop and bring to the Board a food and drink strategy.	Mr Golding	September
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 19 August 2015

Minute number	Action	Responsible office	Due date
15/128 Report from the Chief Executive	To share the submission responding to the CQC reports with Board members when it was completed. To confirm the date for the Quality Summit with CQC as soon as it is available.	Mr Crowley Mr Crowley	ASAP ASAP
15/129 Finance Report	Keep the Board informed of any decision about the use of agency staff.	Mr Crowley	When available

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 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	September 2015
Version number	Version 1

Board of Directors – 30 September 2015

Chief Executive Report

I am writing this report as I await my flight to Seattle following a fascinating visit to Southcentral Foundation (SCF) based in Anchorage, Alaska. SCF is contributing to the Pioneer programme and has indeed been partnered with Vale of York CCG. There has been much to see, hear and absorb and I have committed to sharing my observations in due course to colleagues and the Council of Governors.

SCF is a primary care organisation serving the Alaskan native population primarily around Anchorage but also provides services to extremely remote communities across the state. The organisation has been recognised for its approach at the highest level within the USA and internationally.

Its philosophy is founded on regarding its patients as "customer owners" and embedding this philosophy, its values and principles in everything it does, everything it provides and how it supports and develops its staff. There is a a very clear set of expectations and behaviours for all staff irrespective of seniority and status and a constant reinforcement of this. My first impression is that there are parallels with my own beliefs and much of what we have developed is consistent with the SCF approach, albeit at a different scale and in a different setting. However, the sense of integrated working, common purpose and collective ownership is profound and hugely impressive. As an organisation they have established a balance between the need for "order" and the freedom to act. For example their use of data and information is a vehicle for liberating creativity and innovation rather than control and restraint – they trust in the belief that not everything can be measured and neither should it be unless it can add value to the delivery of services and outcomes.

Above all I have been overwhelmed by the generosity I have experienced. From top to bottom SCF staff have been generous with their time, their evident commitment and pride in all they do (and willingness to demonstrate this) and significantly their willingness to listen and learn.

I look forward to working with SCF in the future.

CQC reports
As I reported at our last Board meeting, we received our CQC reports in draft in mid-August and were given the opportunity to submit a factually accuracy response. Our response was shared with Board members and has been sent to the CQC for their consideration and we are now awaiting the final reports. I hope to be in a position to share the report conclusions in more detail shortly but in the meantime preparations for the Quality Summit are ongoing. This is currently planned for early October, where we will have the opportunity to further consider the reports, present our response and agree any associated actions plans with our regulators.

Nurse Agency spending rules
Monitor and the Trust Development Authority have released a set of rules for nursing agency spend, with the aim of assisting Trusts in "meeting the complex workforce challenges facing the sector and to help improve patient safety."

The rules stipulate an annual ceiling for total nursing agency spending for each trust and mandatory use of approved frameworks for procuring agency staff. There are also plans to implement price caps later in 2015.

A letter was sent to all Trusts including guidance on applying the rules, and the spending ceiling for each organisation. Whilst this is not currently mandatory for our organisation, we have elected to comply as Monitor will take into account what they perceive to be "inefficient or uneconomic spending practices" when considering regulatory action and we should use this framework as a means of assuring them of our continued vigilance in this area.

At this stage the rules only apply to nursing and midwifery staff, however further guidance on other staff groups is expected to follow.

Freedom to speak up
In July 2015 the Government published a report entitled 'Learning not Blaming' which incorporated the response to the Freedom to Speak Up consultation. The outcome of the consultation resulted in the Government endorsing the principle set out by Robert Francis QC that there should be a 'Freedom to Speak Up Guardian' in every NHS organisation. The Guardian is appointed by the Chief Executive and is required to act as a genuinely independent figure. After discussion with the Chair and the Non-executive Directors I have appointed Philip Ashton to the role, as I see this complementing his Senior Independent Director role.

Nationally, there will also be an independent national officer based in the CQC with responsibility for leading a national renewal and reinvigoration of an open and learning NHS culture.

Emergency care improvement Programme
As part of the national focus on the most challenged health systems we have been identified to take part in an enhanced Emergency care improvement Programme, supported by ECIST (Emergency Care Intensive Support Team), to help improve patient flow and our emergency care pathways.

We already work with ECIST, however this latest development means that we will receive extra support as a result of being part of a challenged system, and will involve all partners in the health and social care system who have an impact on acute care. This is consistent with the current tripartite arrangements and I believe presents an opportunity to further reinforce the importance of whole system integration and collective ownership that we should embrace.

I will share further details about this programme of work as they are finalised.

In the news
Our recruitment position continues to be high on the agenda for our local media, with local BBC radio and the York Press both covering various elements of this. The communications team is working with the nursing team on securing some positive coverage around our newly qualified recruits, who join us later in the year.

There was also significant interest in some of the action we are taking as part of the Turnaround Avoidance Programme, in particular our greater scrutiny of vacancies at band 7 or above. Whilst often framed in a negative way by the media, by having them raise these questions it gives us the opportunity to explain some of the challenges we're facing and some of the context around why we take these actions.

Likewise, the issue of paid breaks for domestics and other staff was a story that ran for several days, generating a number of news articles and drawing comment from regional union leaders. Whilst it would never be appropriate for us to carry out staff consultation via the pages of the local media, it is important for us to respond to these stories and to take the opportunity to present our perspective.

A number of positive pieces of coverage were gained, and I was pleased to attend an event at Selby Hospital to mark 30 years of Selby Friends' support. The Trust also had positive coverage for the work of the Malton Community Response team, and for a number of fundraising activities. Two striking pieces of artwork were also unveiled at both York and Scarborough Hospitals ahead of National Transplant Week, in recognition of organ donors, and this attracted positive media attention.

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

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York Teaching Hospital NHS
NHS Foundation Trust

Quality & Safety Committee – 22 September 2015 Ward 35 Seminar Room, York Hospital

Attendance: Libby Raper, Philip Ashton, Jennie Adams, Ed Smith, Beverley Geary, Liz Jackson, Emma Ferguson

Apologies: Anna Pridmore

	Agenda Item	Comments	Assurance	Attention to Board
1	**Last meeting notes dated 21 July 2015**	The notes from the last meeting were approved as a true and accurate record.		
2	**Matters arising**	All of the matters arising from the last meeting were covered by agenda items. The Committee welcomed Emma Ferguson who is part of the Faculty of Medicine and Health at Leeds University and was observing the meeting. The Committee congratulated BG on the Nursing and Midwifery conference. BG advised the Committee that the verbal feedback received was excellent. LR advised the rest of the Committee that she had been in attendance at the Finance and Performance Committee and the papers commenced with the key risk registers for review. The Committee agreed that it would be helpful for future Quality and Safety Committee papers to contain the Chief Nurse and Medical Director Risk Registers.		

	Agenda Item	Comments	Assurance	Attention to Board
3	**Quality and Safety Performance Report**	The Committee acknowledged all of the sections of the Patient Safety and Quality page in the integrated dashboard and agreed to focus its attention on specific areas. **Infection Prevention** – BG advised the committee that there had been no MRSA or MSSA reported in September to date and drew attention to the detailed DIPC Annual Report. An external review of the infection prevention governance structure had been completed and will be presented at Board with the proposed structure going forward. Priorities have been set and are going to HIPCG for approval. A strategic plan will be put in place to main stream IPC. BG explained that work is underway to review the range of IPC data currently collected. This will inform the work to better ensure that the most appropriate information is collected. PIRs are now taking place in Scarborough as well as York and reports are being shared with Commissioners. The Commissioners have agreed that some are complex cases which are unavoidable and will not result in fines if they take the Trust over trajectory. The Committee queried how and where learning is shared across the organisation. ES explained that this varies across directorates. A formalised governance infrastructure is currently being worked on with a proposal being made in coming weeks.	The Committee were assured by and very supportive of the work being undertaken around IPC.	BG to take to Board.

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee raised concern over the limited resource in the IPC team and BG explained that focus will be given to areas that need improvement as well as the key role that all clinical leadership groups have in this area. Clostridium Difficile – The Committee noted that C-Diff remains a challenge. ES confirmed that anti-biotic prescribing is improving. MSSA – The Committee noted the improvement in MSSA cases in September and asked about the changes that had been made. BG explained that there has been a noticeable improvement in the recording and early removal of cannulas and cannula care, especially since the implantation of the electronic prompt on CPD. ANTT training has taken place and the Specialty line nurse has now been in place for 10 months concentrating on the high risk areas. **Measures of harm** – The Committee focussed on one specific serious incident regarding a delayed diagnosis of a head injury that had been detailed in the Supplementary Medical Directors Report, and queried the lessons learnt from this case. ES explained that NICE guidance regarding head injuries is nationally accepted and should always be adhered to. The pressures faced by Radiology in Scarborough have been discussed at the Radiology PIM and there will be zero tolerance for not following guidelines. ES advised the Committee that Fiona Jamieson is currently working on an amended SI process paper as the existing one can be improved to support the embedding of key learnings.		ES to take to Private Board.

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee commented on the positive presentation at the Nursing Conference around Falls and Pressure UIcers and agreed that focus needs to continue on both of these issues. **Care of the Deteriorating Patient** – The Committee raised concerns over the decreasing number of patients on the Scarborough site not receiving a senior review within 12 hours of admission. ES advised the Committee that a meeting has been held with the Acute Physicians in Scarborough to discuss how this can be moved forward as the current model is not working. ES explained that the ward round takes place on a morning and the acute physicians are available on the ward until 7pm, patients admitted in the evening are therefore not seen within 12 hours. The directorate delivering the service need to look in to the numbers and configuration of the staffing resource and also make use of the numbers available as to the times that patients present. The Committee queried if joint working with York Consultants had been considered. ES explained that the General Medicine directorate had not yet combined across both sites, although some of the General Medicine Consultants have a clear strategy on how to combine their individual specialisms. The Committee discussed the Post take ward round CQUIN and how this relates to this issue. ES explained that this is the checklist that includes all elements of the senior review and should be undertaken within 12 hours of admission. Some Consultants have fed back that they already do		ES to take to Board.

	Agenda Item	Comments	Assurance	Attention to Board
		everything on the checklist but having reviewed SIs it has been noted that if the checklist had been followed accurately the occurrences could have been prevented. **Maternity Dashboard** – The Committee once again were pleased to see the additional Maternity Dashboards. The Committee raised concerns around three areas on the York dashboard. The number of women having a post-partum haemorrhage is increasing every month, one to one care in labour and the availability of a labour ward co-ordinator. BG advised the Committee that a proposition had come to Corporate Directors regarding realigning the existing workforce with many of the more senior midwives now retiring. On-calls in the evening will be looked in to so that more people will be available in the daytime. BG explained that the rising complexity of the women has increased risk.	The Committee took assurance from the clear attention of BG and ES to Maternity.	
4	**Key reports** - Supplementary Medical Director Report - Chief Nurse Report	**Supplementary Medical Directors report** **SHMI** The Committee agreed that SHMI had been discussed in detail at Board and did not need to be revisited. **Anti-microbials and Serious Incidents** were discussed under agenda item 3. **EPMA Project** BG explained that during the Public Health England Meeting, Leeds NHS Foundation Trust advised that they had purchased an EPMA package 3 years ago and were still in the implementation process.		

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee had met with Sue Rushbrook (SR) for additional assurance around this project and the time frames. ES assured the Committee that he was confident that the time frame was correct and that changes would be seen in the new year. The Committee agreed that the roll out would be challenging due to a complete change in culture across the Trust. ES advised the Committee that the Medicines Safety Group has highlighted reoccurring trends, such as the co-prescription of anti-coagulants, which the visual prompts in the electronic system should militate. The Committee raised concerns about the large laptops that would be attached to the medicine trollies, on display at the Open Day, as previous assurance had been given that it would be modern and sleek. ES advised the Committee that SR is currently looking in to alternatives and that should the hardware be changed the software will remain the same. **Chief Nurse Report** **Safer Staffing** The Committee re-visited concerns about the accuracy of vacancy reporting, BG advised that this was explained in the Safer Staffing paper. BG advised the Committee that 74 staff nurses have been successfully recruited and will be starting in the next couple of weeks. There is an advert currently live for European Nurses and Skype interviews are scheduled to take place in October. The aim is to	The Committee were assured by BGs comments that it is a significant priority for the Chief Nurse Team to continually recruit.	

	Agenda Item	Comments	Assurance	Attention to Board
		recruit 60 registered nurses to cover winter recruitment, commencing in cohorts of 20 between November to January. BG explained that there is an increase in attrition with a significant number of people retiring, if the European recruitment is successful then additional nurses may be recruited to mitigate for this. BG advised the committee that more data could be captured by directors around the reason why staff are leaving. BG also explained that nurse revalidation may prompt more experienced nurses to retire. Helen Hey is auditing the budgeted establishments and the skill mix in Elderly Medicine is being looked at. 12 months acuity and dependency data is now available and will be presented at next month's Committee meeting. The Committee discussed the varying acuity of patients in different directorates and how this can change with external factors, such as seasonal variation and agreed that Matrons should be risk assessing and making staffing decisions every day including the approval of the use the agency staff. The Committee went on to discuss the importance of Matron decision making and BG confirmed that the Assistant Directors of Nursing would be closely supporting those matrons that may need training. The Committee agreed that it was unclear in the TAP paper that Directorate managers were able to delegate the budget for agency spend to Matrons.		

	Agenda Item	Comments	Assurance	Attention to Board
		Clinical review, quality impact assessment of CIP The Committee queried the effect that this risk review would have on Helens workload and if she had the appropriate support as there is no medic involved. BG explained that this is currently on hold as Helen has scheduled a meeting with Steve Kitching to ensure there is a robust process in place. **Patient Experience** The Committee queried if there had been any improvement in the staffing of and the visibility of the PALs team. BG explained that the review of the PALs team was still taking place, however there is long term sickness and disciplinary issues with the staff. There is a possibility of recruiting a part time registered nurse to join the team and also reinstating the PALs desk in the main entrance of York Hospital. Patient Experience Strategy – BG advised the Committee that the Patient Experience Group had met last week and an implementation plan has been put in place. BG advised the Committee that the key objectives for Patient Experience are Staffing, the complaints management process and training, which will commence next month.	The Committee were not assured that the governance of the risk review was complete with the absence of a Medic.	To take to Board.

	Agenda Item	Comments	Assurance	Attention to Board
5	**Overview of TAP** - Summary document - Fines avoidance - Workforce - CQUIN	The Committee asked for assurance around the CQUINs. ES explained that the CQUINs are all challenging and some contradict other Trust targets. The Committee raised concern over the statement regarding the current assumption around the achievability of the CQUINs.		
6	**DIPC Annual Report**	As discussed under item 3. The Committee noted the contents of the report, the information in which had been reviewed quarterly. BG also highlighted that the risk register had been included which appropriately records the risks in the area. **Ward accreditation** BG explained that ward accreditation is a spot audit which includes the cleanliness of the environment and adherence to the uniform policy. The first audit will take place on all wards between September and December. The audit will be completed annually in areas of no risk and areas where risk is identified will be re-visited with actions being monitored by the Matron. Productive Ward will be revisited with the principles of lean methodology being utilised with the intention of refreshing and further embedding good practice.		BG to take to Board.

	Agenda Item	Comments	Assurance	Attention to Board
7	**Current Nurse Staffing – Adult inpatient focus**	As discussed under item 4.		
8	**Safer Staffing Report**	As discussed under item 4.		
9	**Any other business**	**Patient Safety Walk Rounds** The Committee noted the varying priorities of all of the Directors and senior staff and agreed that the Patient Safety Walk Rounds should remain quality and safety orientated. They are an important tool to open up discussion with staff and embed lessons learned. The Committee queried the plan for the night time leadership walk rounds which BG assured was being looked in to by DP.		To take to Board
10	**Other** Work Programme	No other business was discussed.		

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

York Teaching Hospital NHS
NHS Foundation Trust

Patient Safety & Quality Report

September 2015

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

Patient Experience

There has been an increase in the number of PALS contacts on the York site to 530, data is not currently available for the Scarborough site.

The number of complaints continues to reduce on the York site but increased to 21 from 20 in Julyat Scarborough.

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

The percentage of inpatients recommending the Trust has continued to exceed the 90% target on all sites, however there was a slight decrease on previous months at Scarborough to 95.74% in July to 95.02% in August.

The response rate for York ED has decreased slightly in August to 9.2% (July - 10%). August also saw an increase in the percentage of patients recommending the department.

The response rate for Scarborough ED remains low and has decreased further in August to 5.75% (July - 6.3%). However the proportion of patients recommending the department has increased to 80.12%.

Measures of Harm

11 Serious Incidents (SIs) were declared in August (4 x York, 2 x Scarborough and 5 x Community). 4 of the SIs were attributed to 'clinical incidents', 2 were attributed to 'slips, trips and falls' and 5 to pressure ulcers.

Infection Prevention

8 cases of Cdiff were identified in August, (York; 3, Scarborough; 4 and 1 Community). The YTD total is now 32 against an annual maximum of 48, therefore above trajectory.

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

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

There were also 6 cases of E-Coli.

Quality and Safety - Miscellaneous

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

Cancelled Operations
The number of operations cancelled within 48 hours of the TCI due to lack of beds rose slightly further in August to 17 from 15 in July. Year to date 237 patients have had their surgery cancelled within 48 hours due to a lack of beds.

Cancelled Clinics/Outpatient Appointments
The number of cancelled clinics with less than 14 days notice decreased compared to July (168) to 150, with a corresponding fall in the number of cancelled appointments (792). This remains a risk for Quarter 2 (maximum 745).

Ward Transfers between 10pm and 6am
The number of inappropriate ward transfers reduced to 82 (37 in York and 45 in Scarborough) from 92 in July and is below the monthly maximum of 100.

Care of the Deteriorating Patient

York achieved 85% of Medicine and Elderly patients receiving a senior review within 12 hours of admission, with Scarborough decreasing to 56%.

76% of Medicine and Elderly patients were seen by a doctor within 4 hours of admission, across both sites.

The Trust has an internal target of 90% of routine observations being undertaken within 1 hour of the prescribed time. It is currently achieving 87.4% overall, with Scarborough showing a continual improvement and achieving 90.8% in August.

Drug Administration

The number of insulin errors at York decreased to 8 in July from 2 in August, and fell from 2 in July to 1 in August on the Scarborough site.

Prescribing errors at York fell from 20 in July to 10 in August, however Scarborough saw a rise from 7 (July) to 10 in August.

Mortality

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

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

The number of deaths in August was in line with previous months. There was a rise in deaths across both York and Scarborough EDs, these were reviewed as part of the Patient Safety meeting and no areas of concern were identified.

CQUINS update

The Quarter 1 2015/16 CQUINS schemes with the exception of Dementia training, Ambulatory Care (York) and Scan Reporting have been signed off as delivered by the CCGs. Additional information has been requested by the CCGs to further evidence delivery of the three outstanding schemes.

Quarter 2 2015/16 CQUINS; all schemes are RAG rated as green with the exception of:

Ambulatory Care (Scarborough)
Dementia Carers
Post Take Ward Round Checklist
Scan Reporting Times

Further actions are in place and ongoing to ensure delivery of these schemes for quarter 2.

Litigation

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

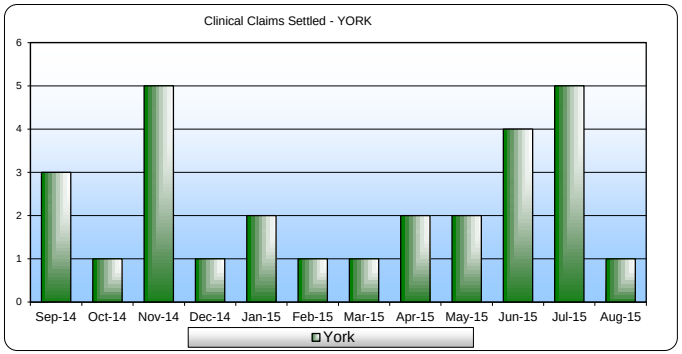
In August, 6 clinical claims were settled; 1 attributed to York & 5 attributed to Scarborough.

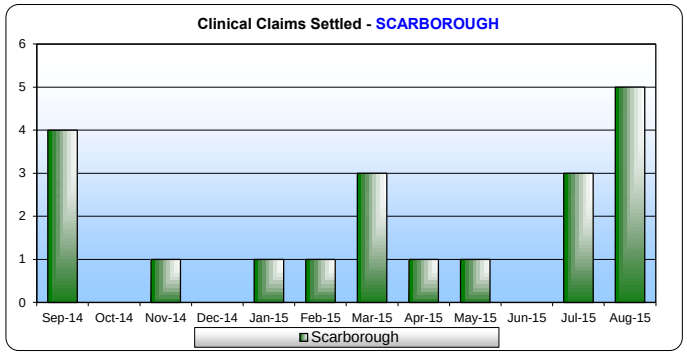
3 clinical negligence claims were received for York site and 1 was received for Scarborough. York had 11 withdrawn/closed claims .

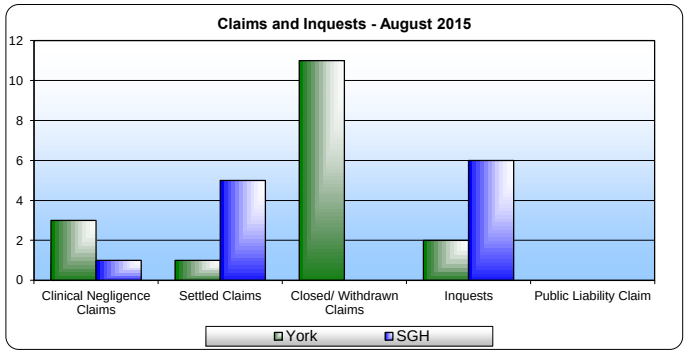
There were 8 Coroner's Inquests heard (2 York & 6 Scarborough).

Litigation

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







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 16 new complaints registered to the York site and 21 to the Scarborough site in August.

PALS contacts
There were 530 PALS enquiries at York Hospital in August, Scarborough figures are not currently available

New Ombudsman Cases
2 attributable to York & 1 attributable to Scarborough during August.

Complaints – Late Responses
4 recorded at York in August, Scarborough unavailable.
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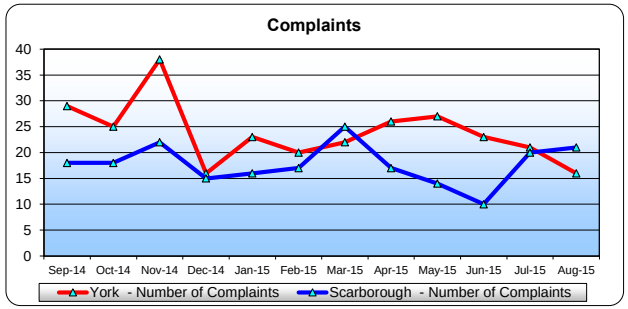
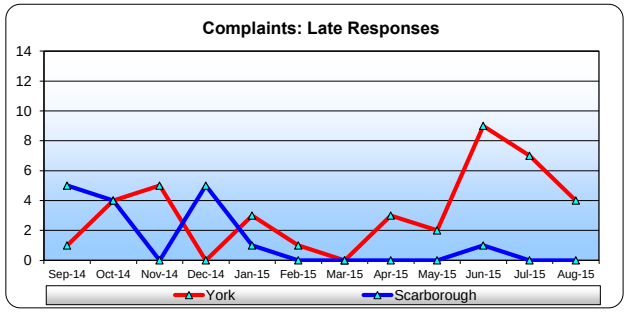
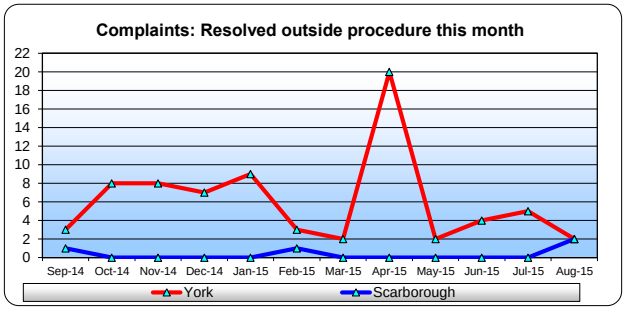
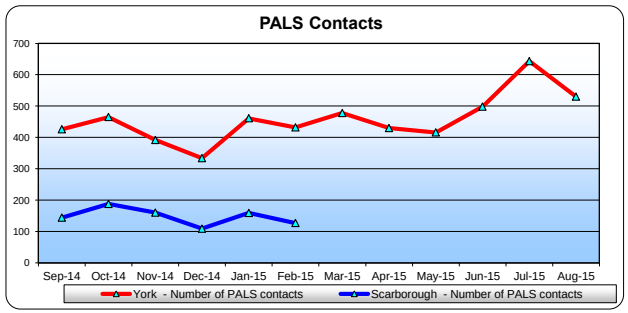
Patient Experience

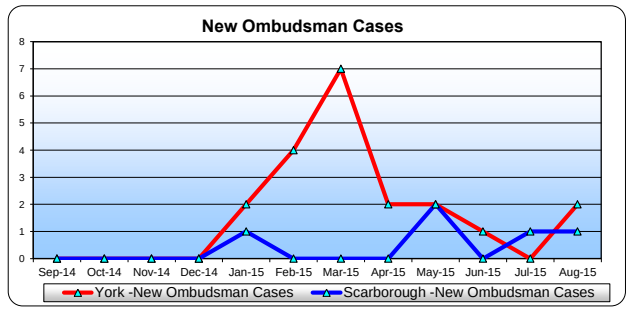
Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Complaints	York	29	25	38	16	23	20	22	26	27	23	21	16
	Scarborough	18	18	22	15	16	17	25	17	14	10	20	21
PALS contacts	York	426	465	392	334	461	432	478	430	416	498	643	530
	Scarborough	144	188	160	109	159	127	0	0	N/A	N/A	N/A	N/A
New Ombudsman Cases	York	0	0	0	0	2	4	7	2	2	1	0	2
	Scarborough	0	0	0	0	1	0	0	0	2	0	1	1
Complaints - Late Responses	York	1	4	5	0	3	1	0	3	2	9	7	4
	Scarborough	5	4	0	5	1	0	0	0	0	1	N/A	N/A
Complaints - Resolved outside procedure this month	York	3	8	8	7	9	3	2	20	2	4	5	2
	Scarborough	1	0	0	0	0	1	0	0	0	0	0	2











Patient Experience

August 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	1	1
Community Services (Y)	1	0	1
Corporate (Y,S)	0	0	0
Elderly Medicine (Y)	0	1	1
Emergency Medicine (Y)	5	4	9
Facilities (Y,S)	0	1	1
General Surgery and Urology (Y), Surgery (S)	1	3	4
Head and Neck and Ophthalmology (Y)	1	0	1
Medicine (General and Acute, Y), Medicine (S)	1	4	5
Obstetrics and Gynaecology (Y)	1	1	2
Operations (Y)	1	0	1
Orthopaedics (Y)	3	2	5
Pharmacy (Y)	0	0	0
Physiotherapy (Y)	1	0	1
Radiology (Y)	1	2	3
Sexual Health (Y)	0	0	0
Specialist Medicine (Y)	0	1	1
Theatres Anaesthetics and CC(Y)	0	1	1
Labatory Medicine	0	0	0
Total	16	21	37

PALS Contact by Subject	York	S'boro	Total
Action Plan	3	n/a	n/a
Aids / appliances / equipment	1	n/a	n/a
Admissions, discharge, transfer arrangements	11	n/a	n/a
Appointments, delay/cancellation (inpatient)	13	n/a	n/a
Appointments, delay/cancellation (outpatient)	39	n/a	n/a
Staff attitude	14	n/a	n/a
Any aspect of clinical care/treatment	64	n/a	n/a
Communication issues	56	n/a	n/a
Compliment / thanks	49	n/a	n/a
Alleged discrimination (eg racial, gender, age)	0	n/a	n/a
Environment / premises / estates	4	n/a	n/a
Foreign language	1	n/a	n/a
Failure to follow agreed procedure (including consent)	0	n/a	n/a
Hotel services (including cleanliness, food)	1	n/a	n/a
Requests for information and advice	233	n/a	n/a
Medication	4	n/a	n/a
Other	3	n/a	n/a
Car parking	3	n/a	n/a
Privacy and dignity	1	n/a	n/a
Property and expenses	17	n/a	n/a
Personal records / Medical records	9	n/a	n/a
Safeguarding issues	2	n/a	n/a
Signer	1	n/a	n/a
Support (eg benefits, social care, vol agencies)	1	n/a	n/a
Patient transport	0	n/a	n/a
Totals:	530	n/a	n/a

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	13	14	27
Appointment delay/cancellation (inpatient)	0	0	0
Appointments delay/cancellation (outpatient)	1	0	1
Attitude of staff	1	2	3
Communication/information to patients (written and oral)	0	2	2
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	0	2	2
Patients' privacy and dignity	0	0	0
Patients' property and expenses	0	1	1
Patients' status, discrimination	0	0	0
Personal records	0	0	0
Policy and commercial decision of Trust	0	0	0
Total	16	21	37

Friends and Family

Indicator		Target	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Inpatients – York	York IP Response Rate	Monitoring Only	31.7%	34.9%	39.4%	35.1%	32.9%	38.4%	45.4%	16.0%	17.4%	18.3%	20.6%	17.4%
Inpatients – Scarborough	Scarborough IP Response Rate		43.1%	39.5%	50.0%	37.9%	41.2%	52.4%	55.8%	16.4%	16.5%	15.3%	21.3%	18.2%
Inpatients - Bridlington	Bridlington IP Response Rate		83.6%	72.3%	77.2%	85.9%	77.0%	90.2%	69.5%	56.0%	47.5%	46.0%	51.6%	69.0%
Inpatients – Combined	**Trust IP Response Rate**		**37.6%**	**38.2%**	**44.1%**	**38.4%**	**37.7%**	**44.7%**	**49.4%**	**18.6%**	**19.2%**	**19.4%**	**22.6%**	**20.3%**
ED – York	York ED Response Rate	Monitoring Only	8.5%	9.6%	15.4%	14.2%	14.8%	14.0%	19.2%	8.3%	8.6%	8.3%	10.0%	9.2%
ED - Scarborough	Scarborough ED Response Rate		31.5%	27.4%	32.7%	19.1%	28.2%	36.8%	29.8%	6.7%	7.3%	6.1%	6.3%	5.8%
ED – Combined	**Trust ED Response Rate**		**16.7%**	**15.9%**	**21.5%**	**16.0%**	**19.3%**	**21.6%**	**22.8%**	**7.8%**	**8.2%**	**7.6%**	**8.8%**	**8.0%**
Maternity – Antenatal		None	37.2%	39.8%	42.8%	32.2%	30.6%	27.6%	36.0%	26.4%	27.5%	31.7%	29.1%	23.7%
Maternity – Labour and Birth			20.4%	17.2%	39.7%	15.8%	19.9%	27.9%	38.5%	31.0%	25.6%	26.7%	28.5%	23.3%
Maternity – Post Natal			29.4%	26.5%	47.1%	19.4%	27.9%	31.9%	32.6%	30.4%	29.0%	29.3%	27.3%	25.5%
Maternity – Community			17.2%	19.5%	18.4%	18.2%	21.3%	14.6%	23.1%	24.3%	18.4%	20.3%	18.7%	19.8%

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

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

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

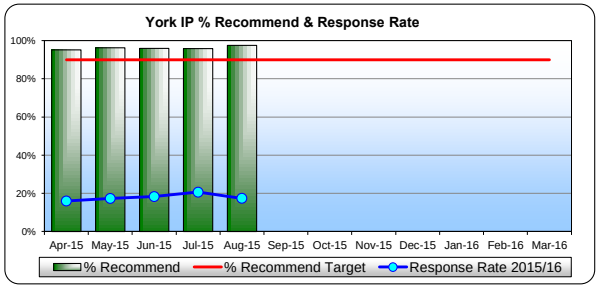
The focus for the Trust is to gain and understand patient feedback and encourage Directorates to use that feedback to drive improvements. Each ward displays a 'Knowing How We're Doing' board which is a giant poster sharing FFT data and comments from that particular ward, along with news and improvements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

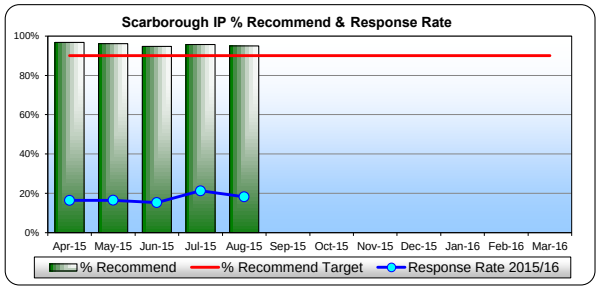
Friends & Family: Inpatients & ED

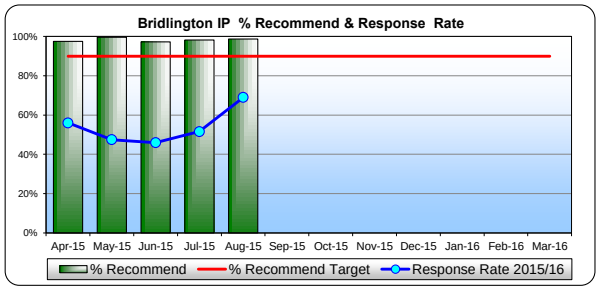
The Friends & Family Test (FFT) has now been rolled out across the Trust, including all Inpatients and Daycases, (previously daycase s and patients <16 were excluded) those attending ED, Community patients and women accessing maternity services being asked the question; "would you recommend this ward/ED/antenatal/labour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

Indicator	Consequence of Breach (Monthly)	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Jun-15	Jul-15	Aug-15
Trust Inpatient Response Rate (including daycases)	None - Monitoring Only	none	39.80%	40.10%	43.90%	19.09%	19.41%	22.63%	20.33%
York Inpatient Response Rate (including daycases)	None - Monitoring Only	none	35.58%	36.39%	39.00%	17.25%	18.31%	20.61%	17.42%
York Inpatient % Recommend	None - Monitoring Only	none					95.95%	95.84%	97.53%
York Inpatient % Not Recommend	None - Monitoring Only	none					1.79%	0.93%	0.75%
Scarborough Inpatient Response Rate (including daycases)	None - Monitoring Only	none	42.52%	42.25%	49.44%	15.98%	15.25%	21.26%	18.16%
Scarborough Inpatient % Recommend	None - Monitoring Only	none					94.78%	95.74%	95.02%
Scarborough Inpatient % Not Recommend	None - Monitoring Only	none					0.26%	1.26%	1.39%
Bridlington Inpatient Response Rate (including daycases)	None - Monitoring Only	none	80.68%	78.19%	78.06%	49.43%	45.97%	51.57%	68.97%
Bridlington Inpatient % Recommend	None - Monitoring Only	none					97.25%	98.21%	98.71%
Bridlington Inpatient % Not Recommend	None - Monitoring Only	none					1.37%	0.36%	0.32%

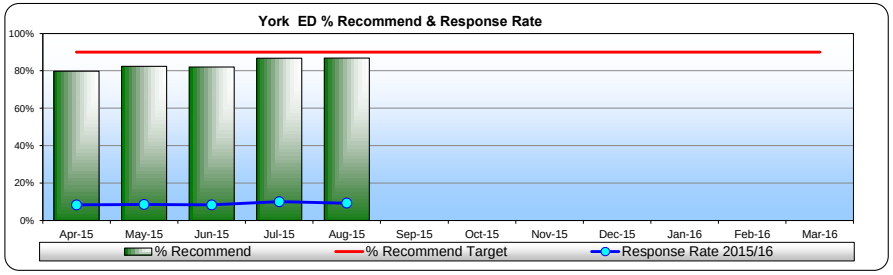
Daycase patients and young people (<16 years) included in FFT April 2015

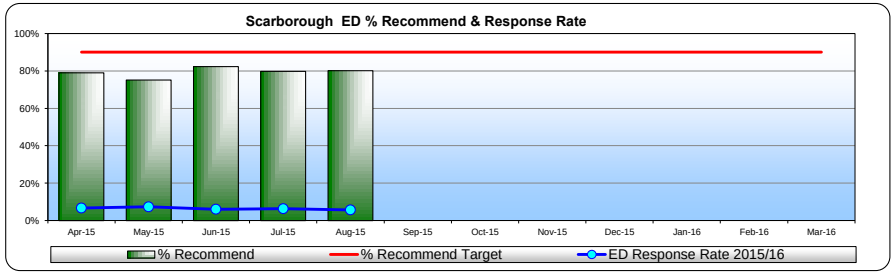






Indicator	Consequence of Breach (Monthly)	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Jun-15	Jul-15	Aug-15
Trust Emergency Department Response Rate	None - Monitoring Only	none	19.90%	17.70%	21.30%	7.84%	7.56%	8.75%	7.97%
York Emergency Department Response Rate	None - Monitoring Only	none	10.85%	13.00%	16.08%	8.38%	8.29%	9.99%	9.22%
York Emergency Department % Recommend	None - Monitoring Only	none					82.06%	86.76%	86.84%
York Emergency Department % Not Recommend	None - Monitoring Only	none					12.92%	8.06%	8.92%
Scarborough Emergency Department Response Rate	None - Monitoring Only	none	34.90%	26.46%	31.44%	6.69%	6.05%	6.32%	5.75%
Scarborough Emergency Department % Recommend	None - Monitoring Only	none					82.31%	79.76%	80.12%
Scarborough Emergency Department 5 Not Recommend	None - Monitoring Only	none					9.52%	13.69%	16.27%





Headline Scores

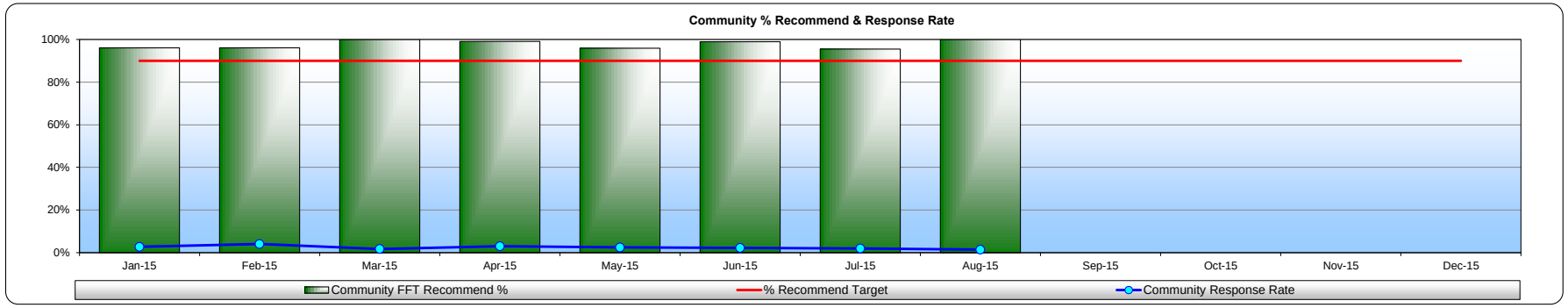
$$\textbf{Recommend (\%)} \quad \frac{\text{Extremely Likely + Likely}}{\text{Extremely Likely + Likely + Neither + Unlikely + Extremely Unlikely + Don't know}} \times 100$$

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

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	Jun-15	Jul-15	Aug-15
Community Response Rate	None - Monitoring Only	none	2.50%				2.20%	1.90%	1.33%
Community FFT % Recommend	None - Monitoring Only	none					99.01%	95.56%	100.00%
Community FFT % Not Recommend	None - Monitoring Only	none					0.00%	2.20%	0.00%

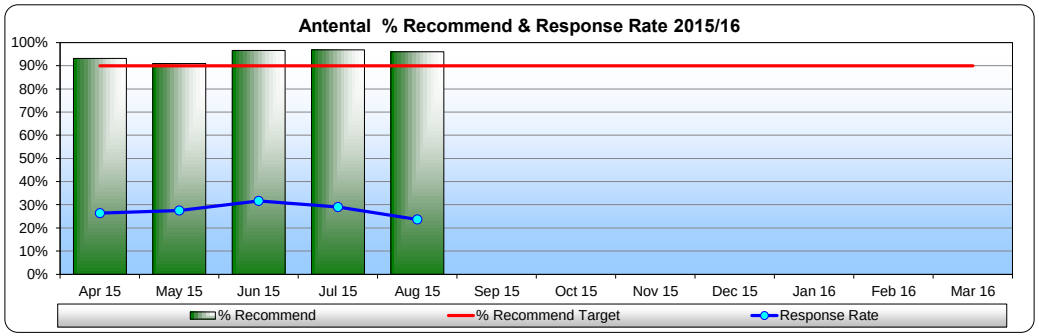


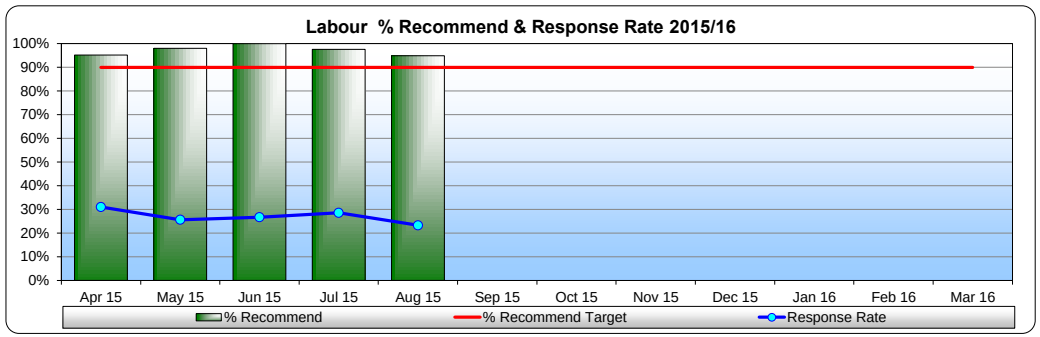
Service/Area	Consequence of Breach (Monthly)	Threshold	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Jun-15	Jul-15	Aug-15
Community Inpatient Services	None - Monitoring only	None	153				55	46	41
Community Nursing Services	None - Monitoring only	None	41				7	3	2
Specialist Services	None - Monitoring only	None	58				22	11	7
Children & Family Services	None - Monitoring only	None	11				2	7	0
Community Healthcare Other	None - Monitoring only	None	54				15	23	11

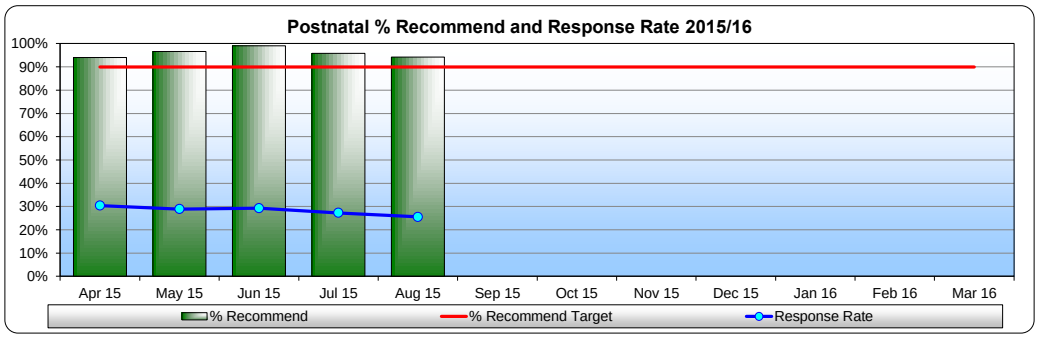
Friends & Family: Maternity

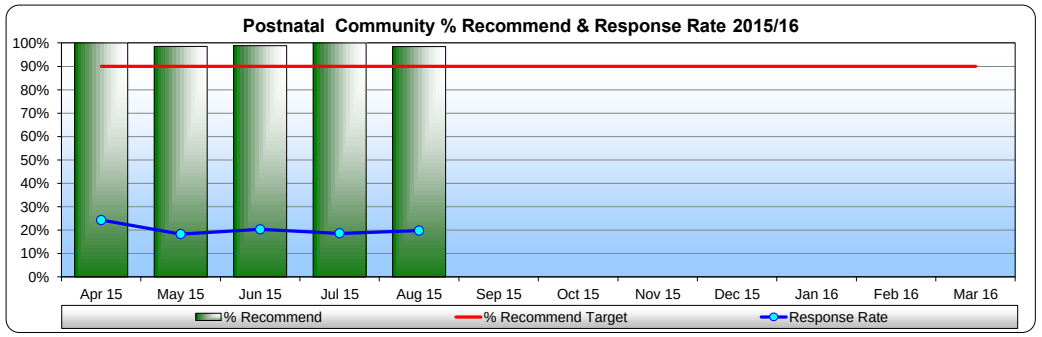
York Teaching Hospital NHS
NHS Foundation Trust

Indicator	Consequence of Breach (Monthly)	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Jun	Jul	Aug
Antenatal Response Rate	None - Monitoring only	none	32.4%	38.3%	31.4%	28.5%	31.65%	29.05%	23.67%
Antental % Recommend	None - Monitoring only	none					96.64%	96.90%	96.08%
Antental % Not Recommend	None - Monitoring only	none					0.00%	0.00%	0.00%
Labour and Birth Response Rate	None - Monitoring only	none	18.60%	23.50%	28.84%	27.78%	26.71%	28.54%	23.28%
Labour and Birth % Recommend	None - Monitoring only	none					100.00%	97.60%	94.90%
Labour and Birth % Not Recommend	None - Monitoring only	none					0.00%	0.80%	1.02%
Postnatal Response Rate	None - Monitoring only	none	24.8%	30.6%	30.9%	29.5%	29.26%	27.30%	25.52%
Postnatal % Recommend	None - Monitoring only	none					99.03%	95.79%	94.19%
Postnatal % Not Recommend	None - Monitoring only	none					0.00%	0.00%	2.33%
Postnatal Community Response Rate	None - Monitoring only	none	20.00%	18.70%	19.87%	21.09%	20.33%	18.65%	19.81%
Postnatal Community % Recommend	None - Monitoring only	none					98.82%	100.00%	98.44%
Postnatal Community % Not Recommend	None - Monitoring only	none					0.00%	0.00%	0.00%









2014/15 Performance

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

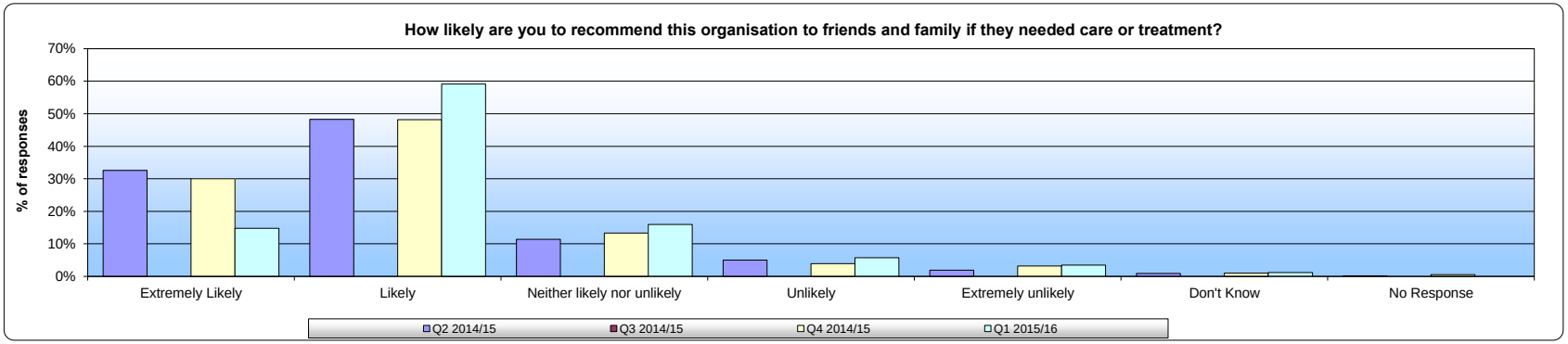
Friends and Family: Staff

York Teaching Hospital NHS
NHS Foundation Trust

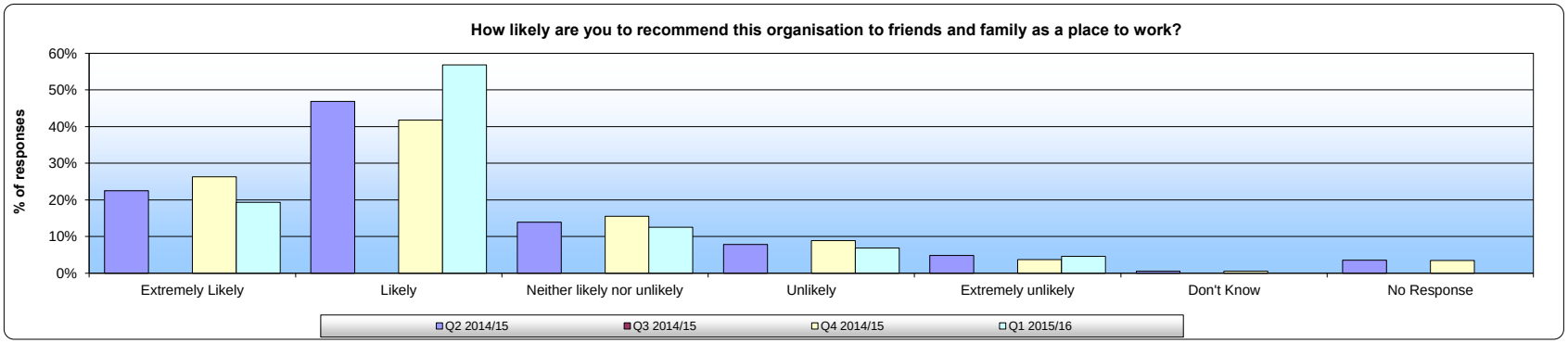
As part of the National Friends and Family CQUIN 2014/15, the Trust was required to submit evidence which demonstrates implementation of staff FFT across all Acute and Community areas.

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

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



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



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

Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 11 SIs reported in August; York 4, Scarborough 2, Community 5 & Bridlington 0.
Clinical Incidents 4; York 4 & Scarborough 0.
Slips Trips & Falls 2; Both Community.
Pressure Ulcers 5; York 0, Scarborough 2 & Community 3.

Patients Falls and Found on Floor (source: Datix)
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During August there were 145 reports of patients falling at York Hospital, 78 patients at Scarborough and 75 patients within the Community Services. This is a decrease from the number reported in July (266), however figures may increase still as more investigations are completed.

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during August was 1,273; 681 incidents were reported on the York site, 395 on the Scarborough site and 197 from Community Services. This is a 8.06% increase from July.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 1229 (increase from 1178 at the end of July) 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 August 19 pressure ulcers were reported to have developed on patients since admission to York Hospital, 25 pressure ulcers were reported to have developed on patients since admission to Scarborough and 28 pressure ulcers were reported as having developed on patients in our community hospitals or community care.
These figures should be considered as approximations as not all investigations have been completed.

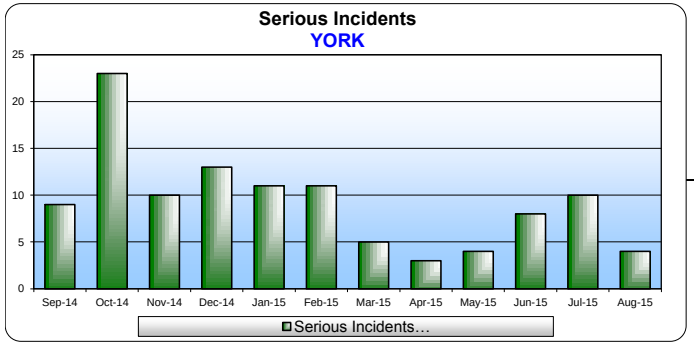
Degree of Harm: Serious/Severe or Death (source: Datix)
During August a total of 3 patient incidents were reported which resulted in serious or severe harm (preliminary data subject to validation).

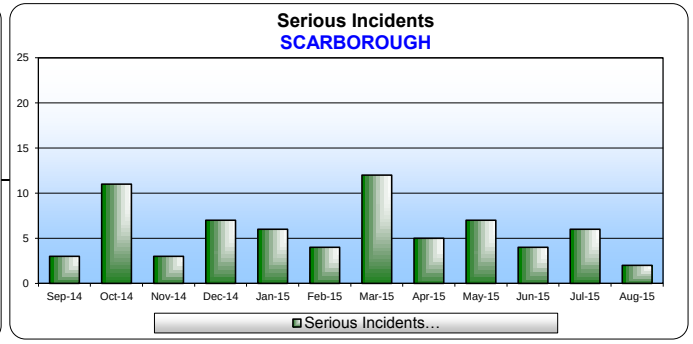
Medication Related Issues (source: Datix)
During August there was a total of 115 medication related incidents reported, although this figure may change following validation.

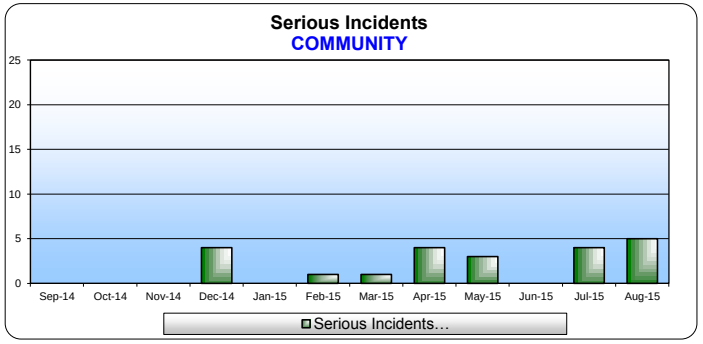
Never Events - There were zero Never Events declared in August.

Measures of Harm

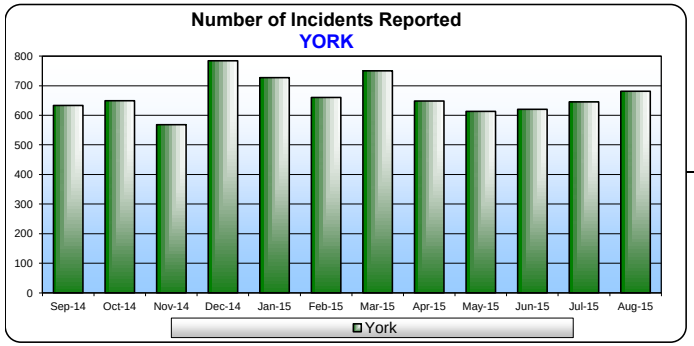
Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Serious Incidents source: Risk and Legal	York	9	23	10	13	11	11	5	3	4	8	10	4
	Scarborough	3	11	3	7	6	4	12	5	7	4	6	2
	Community	0	0	0	4	0	1	1	4	3	0	4	5
Serious Incidents Delogged source: Risk and Legal (Trust)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

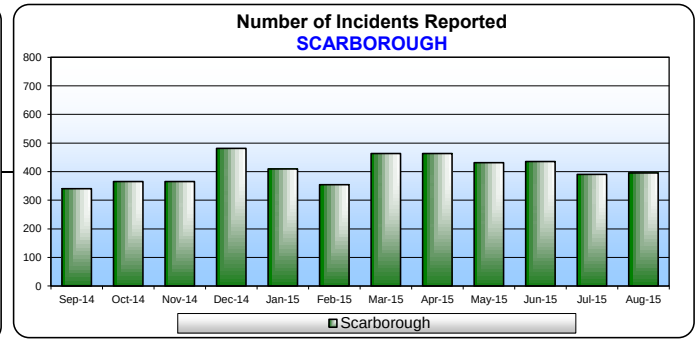


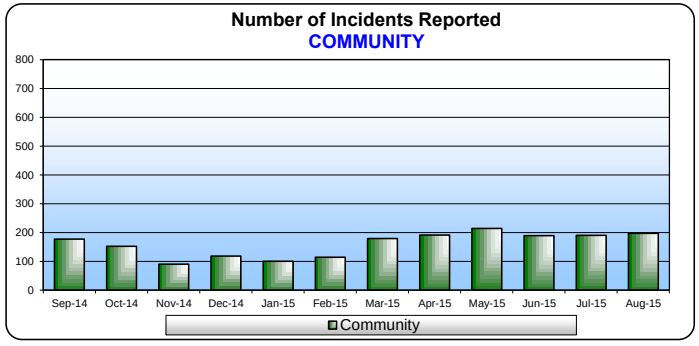




Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Number of Incidents Reported source: Risk and Legal	York	633	649	568	784	727	660	750	648	613	620	645	681
	Scarborough	340	365	365	481	409	354	463	463	431	435	390	395
	Community	177	152	90	118	100	114	179	191	214	189	190	197
Number of Incidents Awaiting sign off at Directorate level		1497	1408	858	272	1444	516	546	1302	863	947	1178	1273

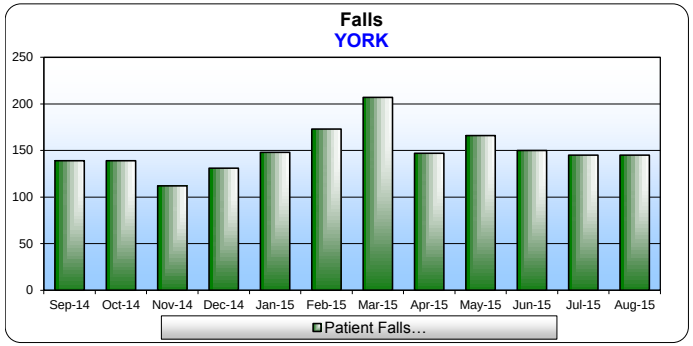


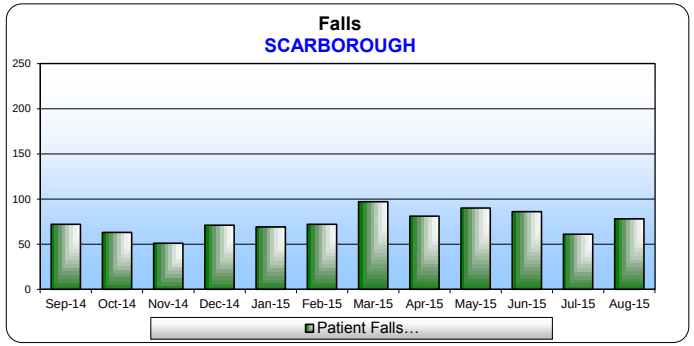


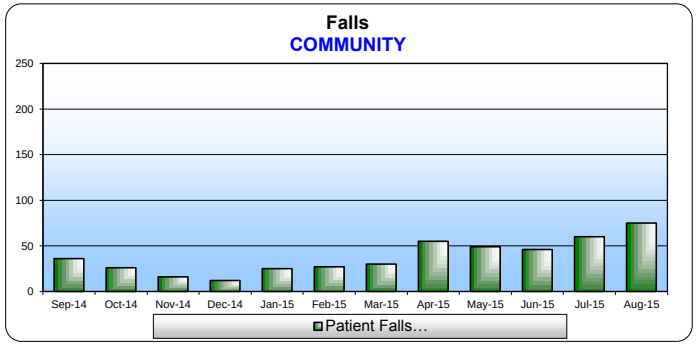


Measures of Harm

Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Patient Falls source: DATIX	York	139	139	112	131	148	173	207	147	166	150	145	145
	Scarborough	72	63	51	71	69	72	97	81	90	86	61	78
	Community	36	26	16	12	25	27	30	55	49	46	60	75

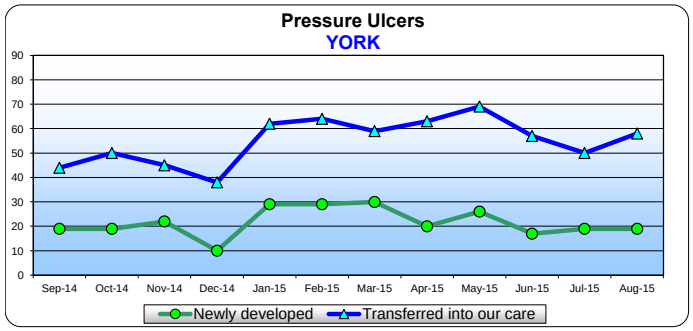


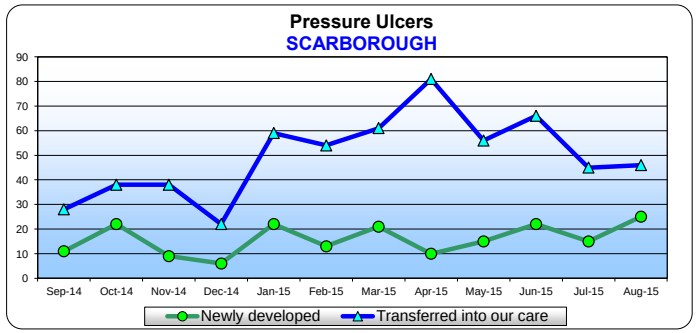


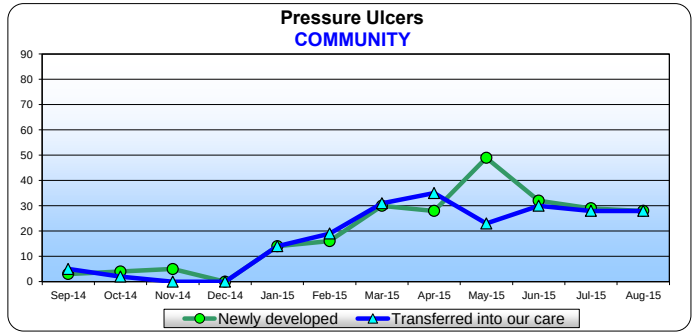


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Indicator			Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Pressure Ulcers source: DATIX	York	Newly developed	19	19	22	10	29	29	30	20	26	17	19	19
		Transferred into our care	44	50	45	38	62	64	59	63	69	57	50	58
	Scarborough	Newly developed	11	22	9	6	22	13	21	10	15	22	15	25
		Transferred into our care	28	38	38	22	59	54	61	81	56	66	45	46
	Community	Newly developed	3	4	5	0	14	16	30	28	49	32	29	28
		Transferred into our care	5	2	0	0	14	19	31	35	23	30	28	28



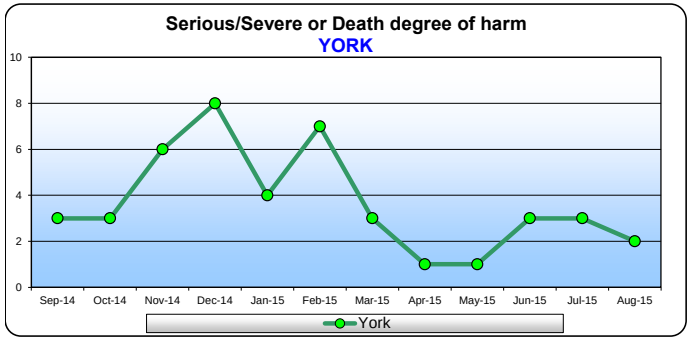


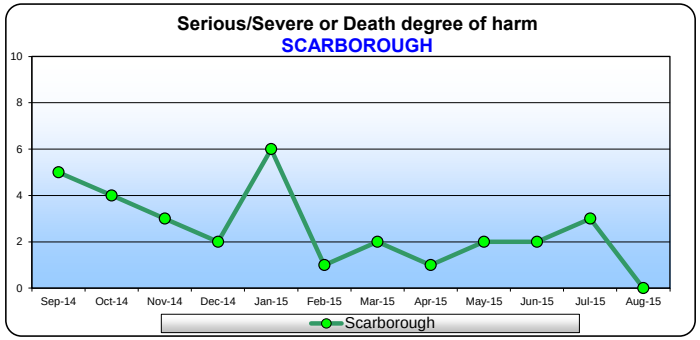


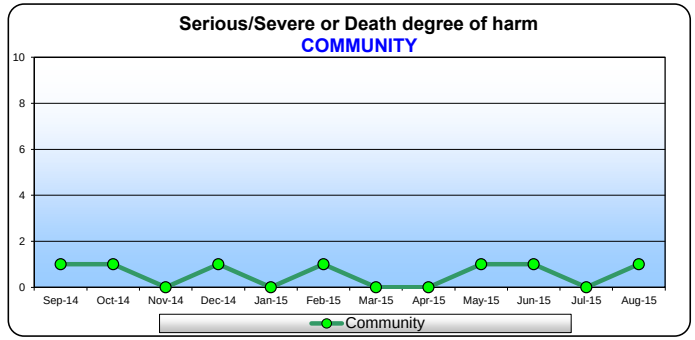
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised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

Measures of Harm

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

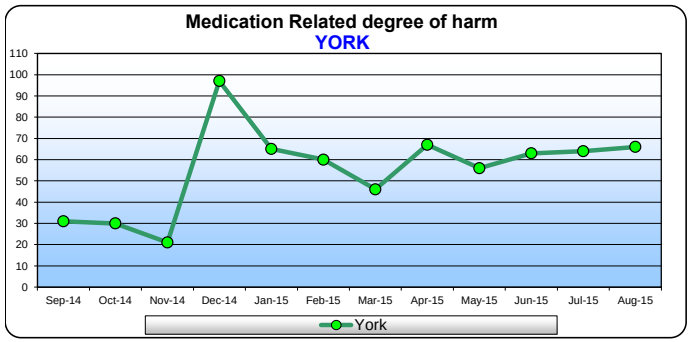


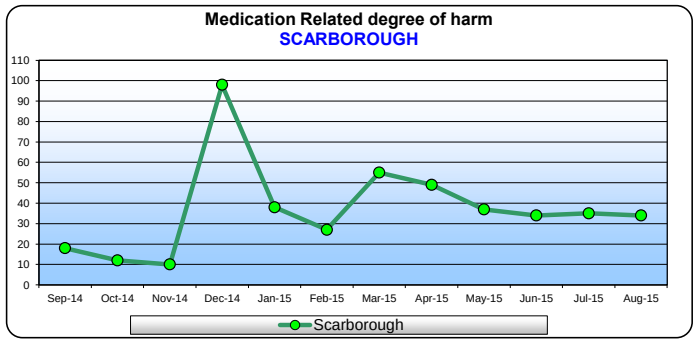


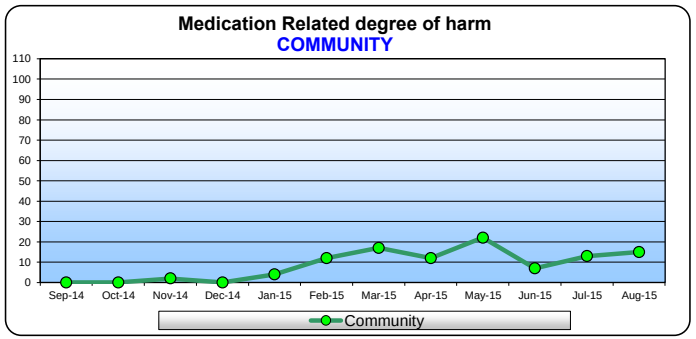


Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Degree of harm: Medication Related Issues source: Datix	York	31	30	21	97	65	60	46	67	56	63	64	66
	Scarborough	18	12	10	98	38	27	55	49	37	34	35	34
	Community	0	0	2	0	4	12	17	12	22	7	13	15

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.

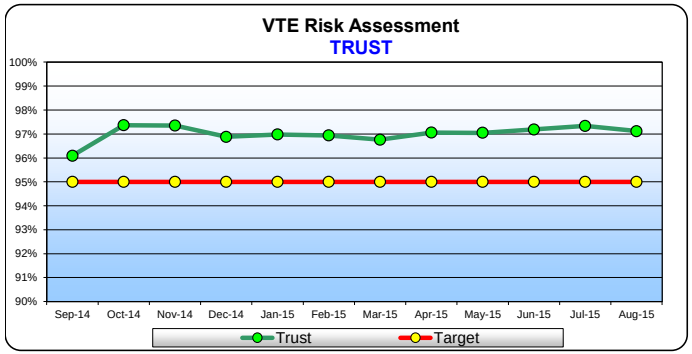


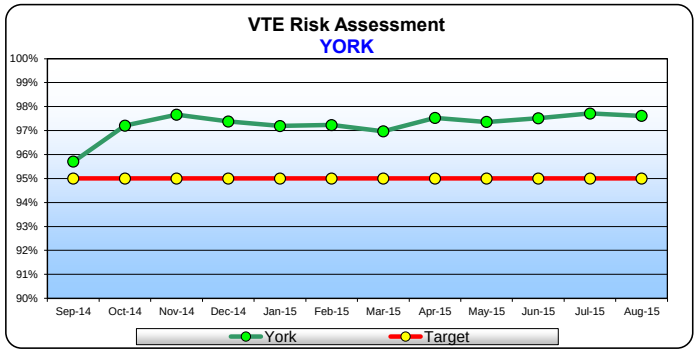


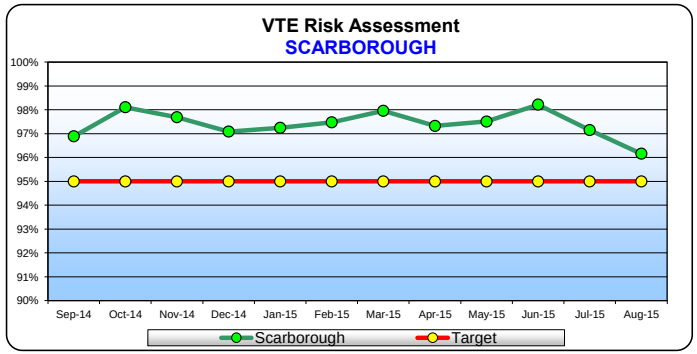


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Jun	Jul	Aug
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%	97.2%	97.3%	97.1%
		York	95%	96.8%	97.4%	97.1%	97.5%	97.5%	97.7%	97.6%
		Scarborough	95%	97.2%	97.6%	97.6%	97.7%	98.2%	97.2%	96.2%







Never Events

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

Drug Administration

Omitted Critical Medicines
The audit of critical medicines missed during August indicated 0.21% for York and 4.98% for Scarborough .

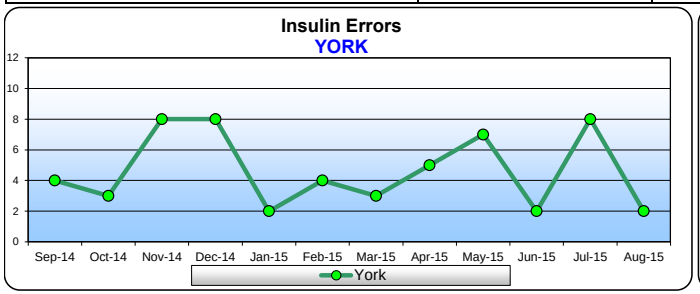
Prescribing Errors
There were 20 prescribing related errors in August; 10 from York, 10 from Scarborough and 0 from Community.

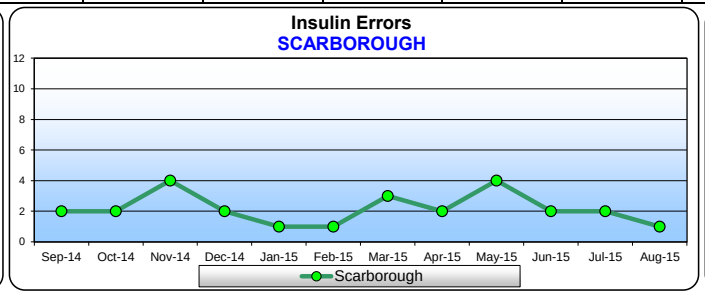
Preparation and Dispensing Errors
There were 18 preparation/dispensing errors in August; 10 from York, 5 from Scarborough and 3 from Community.

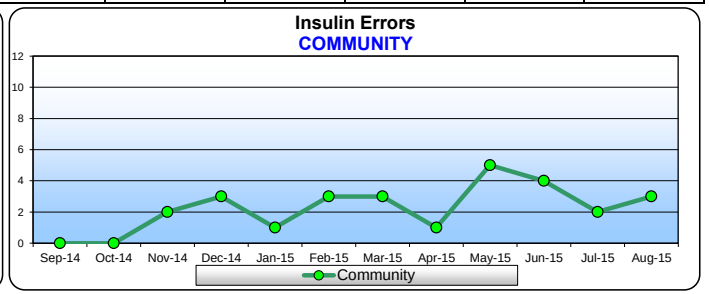
Administrating and Supply Errors
There were 51 administrating/supplying errors in August; 33 from York, 9 from Scarborough and 9 from Community.

Drug Administration

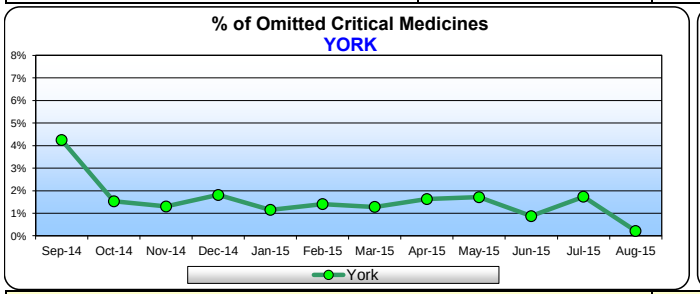
Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Insulin Errors source: Datix	York	4	3	8	8	2	4	3	5	7	2	8	2
	Scarborough	2	2	4	2	1	1	3	2	4	2	2	1
	Community	0	0	2	3	1	3	3	1	5	4	2	3

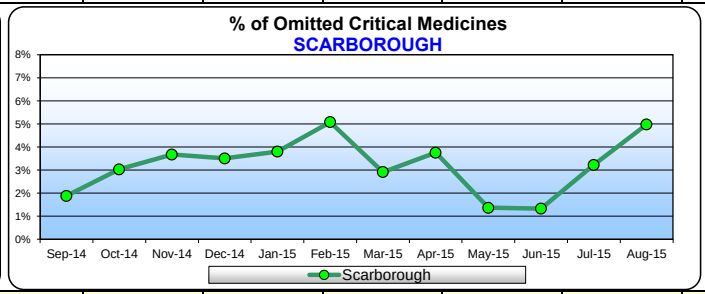


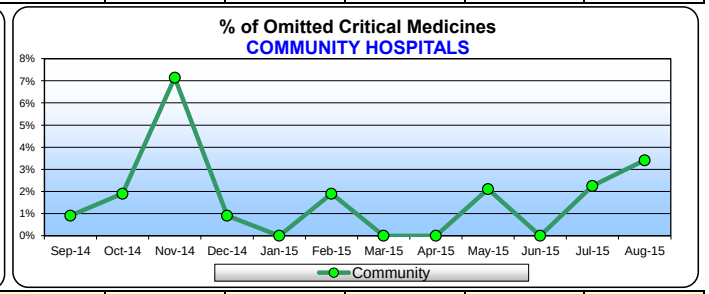




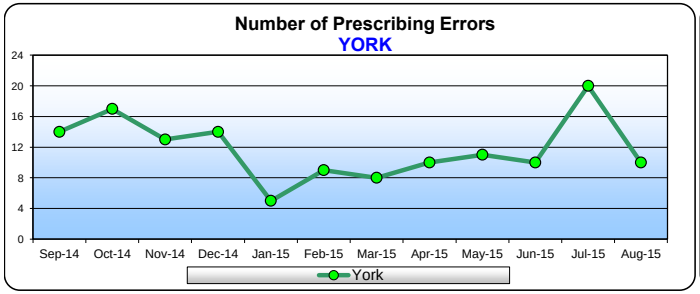
Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Number of Omitted Critical Medicines source: Datix	York	18	7	6	8	6	6	6	7	9	4	8	1
	Scarborough	4	7	9	9	9	12	7	9	3	3	7	10
	Community Hospitals	1	2	7	1	0	2	0	0	2	0	2	3

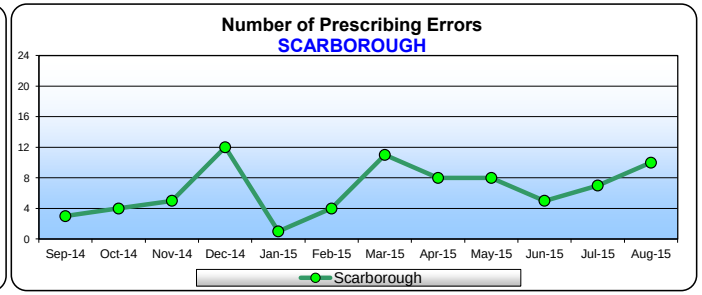


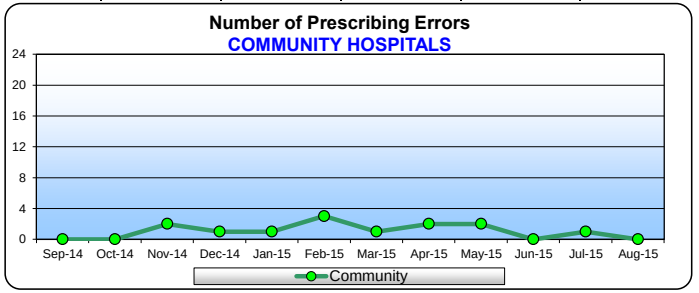




Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Number of Prescribing Errors source: Datix	York	14	17	13	14	5	9	8	10	11	10	20	10
	Scarborough	3	4	5	12	1	4	11	8	8	5	7	10
	Community Hospitals	0	0	2	1	1	3	1	2	2	0	1	0

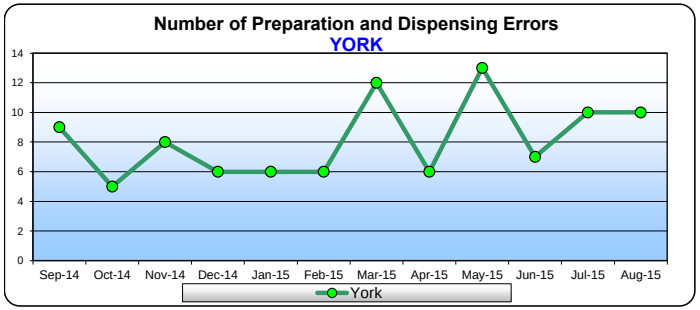


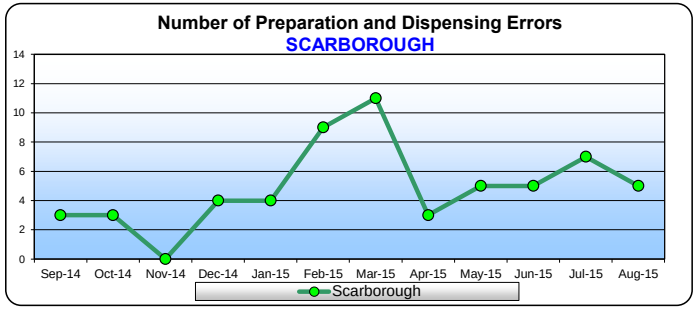


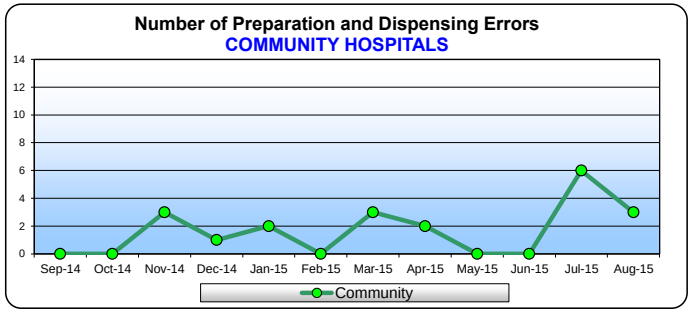


Drug Administration

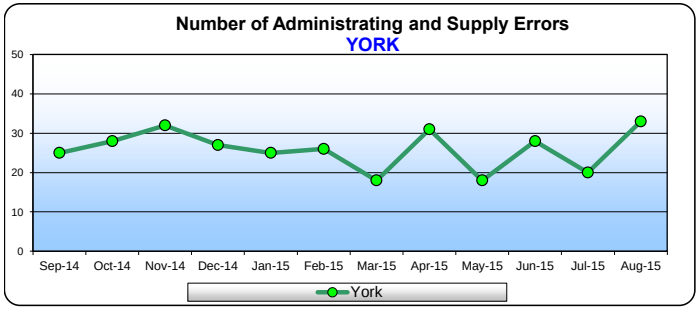
Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Number of Preparation and Dispensing Errors source: Datix	York	9	5	8	6	6	6	12	6	13	7	10	10
	Scarborough	3	3	0	4	4	9	11	3	5	5	7	5
	Community Hospitals	0	0	3	1	2	0	3	2	0	0	6	3

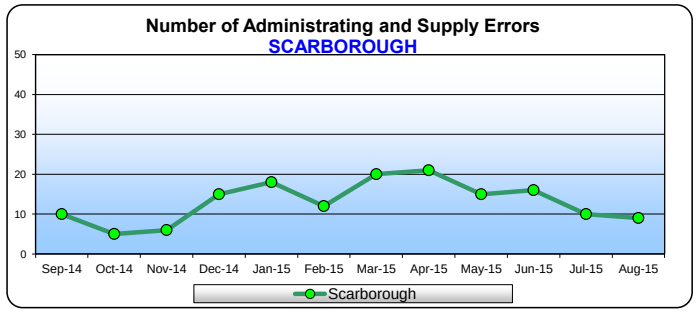


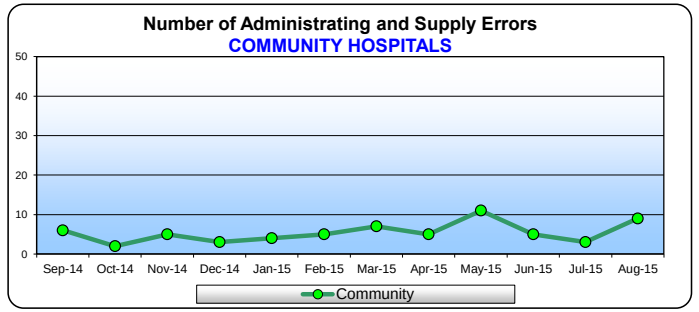




Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
Administrating and Supply Errors source: Datix	York	25	28	32	27	25	26	18	31	18	28	20	33
	Scarborough	10	5	6	15	18	12	20	21	15	16	10	9
	Community Hospitals	6	2	5	3	4	5	7	5	11	5	3	9







Measures of Harm: Safety Thermometer

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

Harm Free Care

The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In August the percentage receiving care “free from harm” following audit is below:

·York: 95.8%
·Scarborough: 90.7%
·Community Hospitals: 92.6%
·Community care: 94.4%

VTE

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

·York: 0.0%
·Scarborough: 0.4%
·Community Hospitals: 0.9%
·Community Care: 0.4%

Harm from Catheter Associated Urinary Track Infection

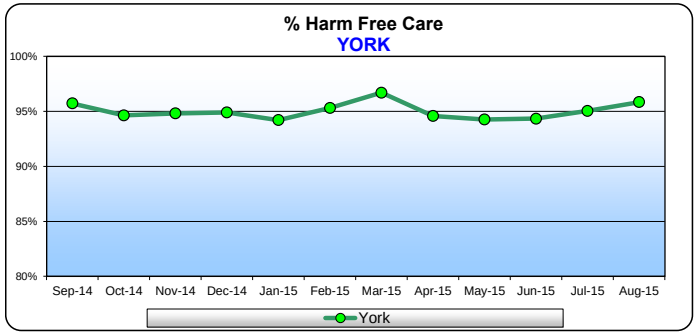
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence:

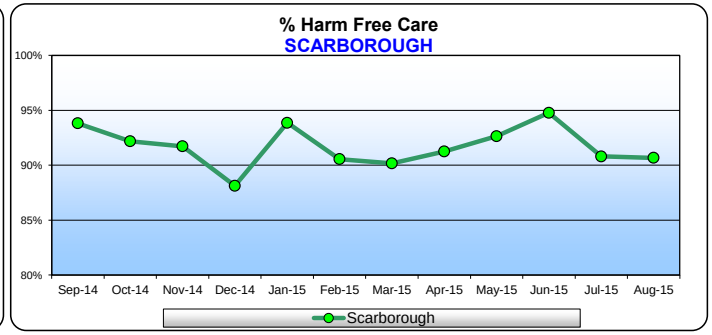
·York: 1.3%
·Scarborough: 3.0%
·Community Hospitals: 0.9%
·Community Care: 0.4%

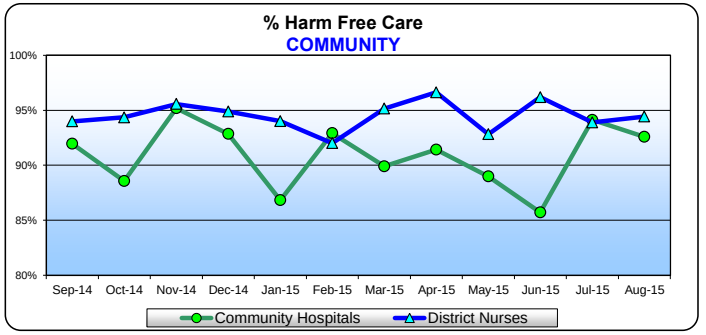
Safety Thermometer

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

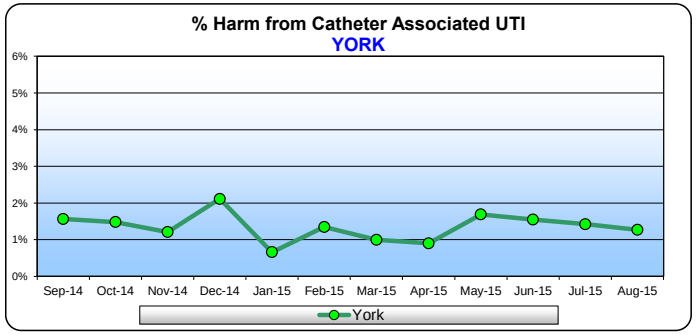
Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
% of Harm Free Care source: Safety Thermometer	York	95.7%	94.6%	94.8%	94.9%	94.2%	95.3%	96.7%	94.6%	94.3%	94.3%	95.0%	95.8%
	Scarborough	93.8%	92.2%	91.7%	88.1%	93.9%	90.6%	90.2%	91.3%	92.6%	94.8%	90.8%	90.7%
	Community Hospitals	92.0%	88.6%	95.2%	92.9%	86.8%	92.9%	89.9%	91.4%	89.0%	85.7%	94.1%	92.6%
	District Nurses	94.0%	94.4%	95.6%	94.9%	94.0%	92.0%	95.2%	96.6%	92.8%	96.2%	93.9%	94.4%

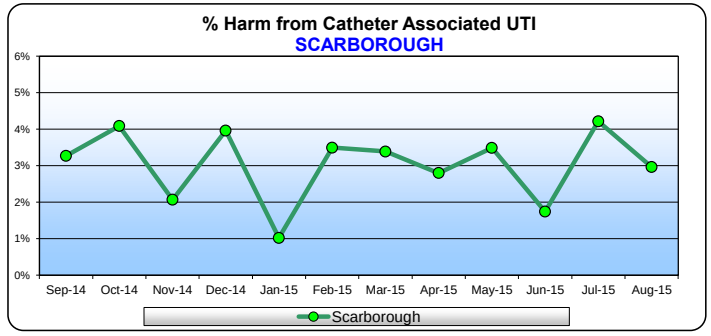


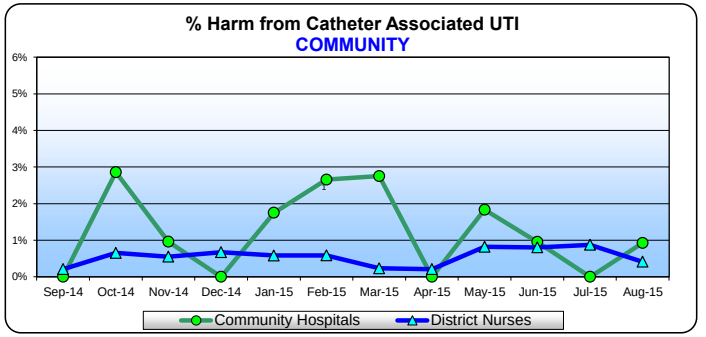




Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	1.6%	1.5%	1.2%	2.1%	0.7%	1.3%	1.0%	0.9%	1.7%	1.5%	1.4%	1.3%
	Scarborough	3.3%	4.1%	2.1%	4.0%	1.0%	3.5%	3.4%	2.8%	3.5%	1.7%	4.2%	3.0%
	Community Hospitals	0.0%	2.9%	1.0%	0.0%	1.8%	2.7%	2.8%	0.0%	1.8%	1.0%	0.0%	0.9%
	District Nurses	0.2%	0.7%	0.6%	0.7%	0.6%	0.6%	0.2%	0.2%	0.8%	0.8%	0.9%	0.4%



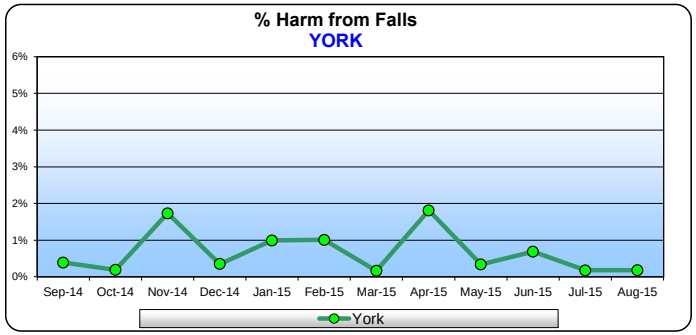


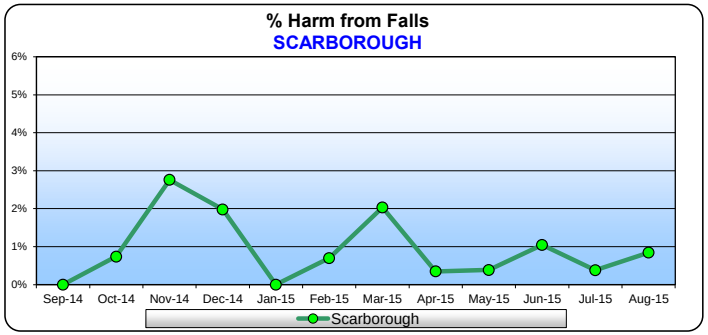


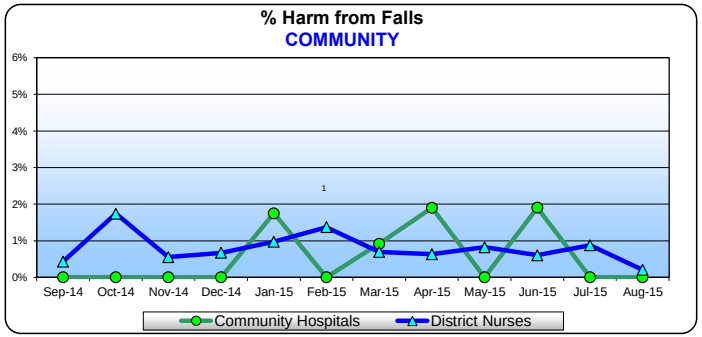
Safety Thermometer

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

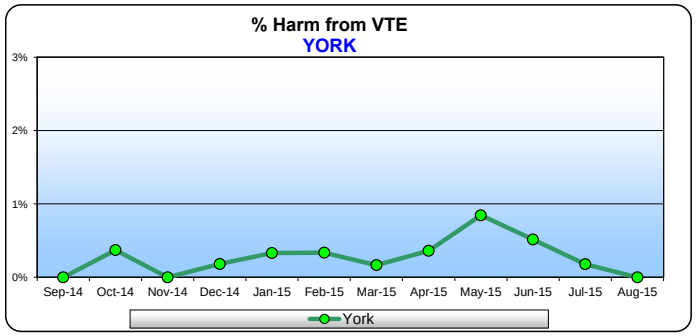
Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
% of Harm from Falls source: Safety Thermometer	York	0.4%	0.2%	1.7%	0.4%	1.0%	1.0%	0.2%	1.8%	0.3%	0.7%	0.2%	0.2%
	Scarborough	0.0%	0.7%	2.8%	2.0%	0.0%	0.7%	2.0%	0.4%	0.4%	1.0%	0.4%	0.8%
	Community Hospitals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

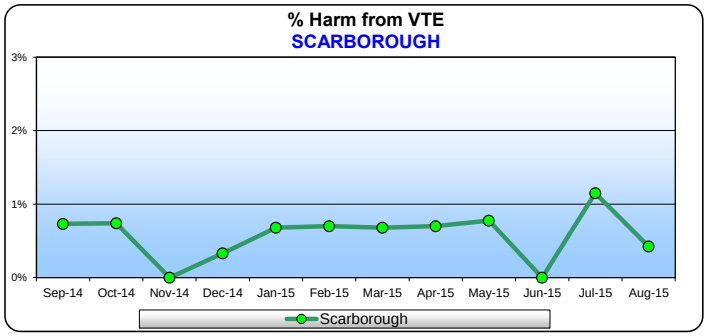


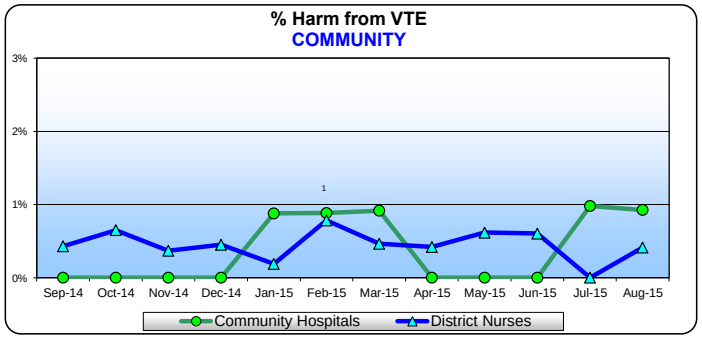




Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
% of VTE source: Safety Thermometer	York	0.0%	0.4%	0.0%	0.2%	0.3%	0.3%	0.2%	0.4%	0.8%	0.5%	0.2%	0.0%
	Scarborough	0.7%	0.7%	0.0%	0.3%	0.7%	0.7%	0.7%	0.7%	0.8%	0.0%	1.1%	0.4%
	Community Hospitals	0.0%	0.0%	0.0%	0.0%	0.9%	0.9%	0.9%	0.0%	0.0%	0.0%	1.0%	0.9%
	District Nurses	0.4%	0.7%	0.4%	0.5%	0.2%	0.8%	0.5%	0.4%	0.6%	0.6%	0.0%	0.4%



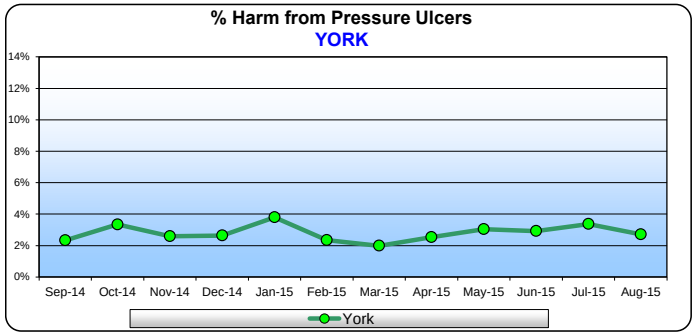


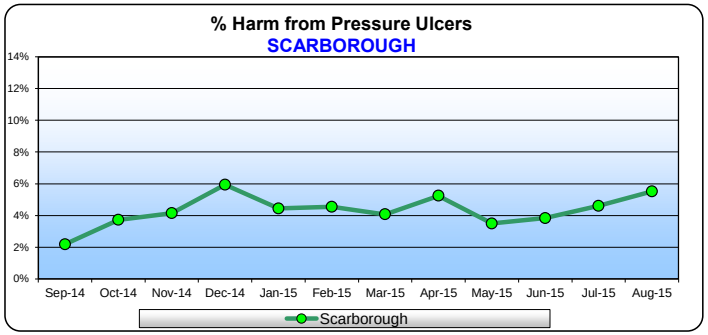


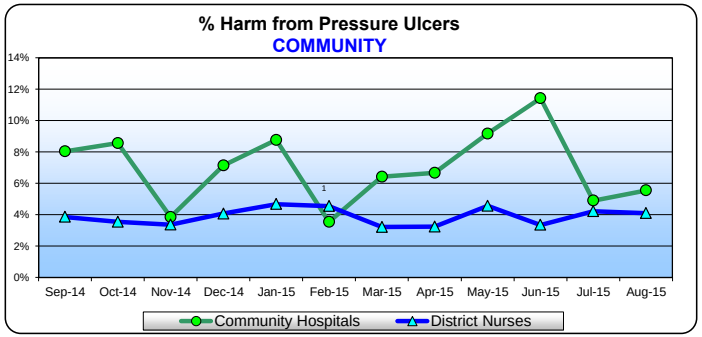
Safety Thermometer

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

Indicator		Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15
% of Pressure Ulcers source: Safety Thermometer	York	2.3%	3.3%	2.6%	2.6%	3.8%	2.3%	2.0%	2.5%	3.0%	2.9%	3.4%	2.7%
	Scarborough	2.2%	3.7%	4.1%	5.9%	4.4%	4.5%	4.1%	5.2%	3.5%	3.8%	4.6%	5.5%
	Community Hospitals	8.0%	8.6%	3.9%	7.1%	8.8%	3.5%	6.4%	6.7%	9.2%	11.4%	4.9%	5.6%
	District Nurses	3.9%	3.6%	3.4%	4.1%	4.7%	4.6%	3.2%	3.2%	4.6%	3.4%	4.2%	4.1%







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

SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Flag Source	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Av. Monthly YtD
Activity	Births	Bookings	1st m/w visit	CPD	≤210	211-259	≥260	prev. stats	162	157	157	168	127					
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	CQUIN	92.0%	91.1%	87.9%	81.0%	92.9%					
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	CQUIN	6.8%	5.7%	8.9%	16.1%	7.1%					
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	CQUIN	27.3%	33.3%	42.9%	22.2%	44.4%					
		Births	No. of babies	CPD	≤170	171-189	≥190	prev. stats	131	117	134	134	139					
		No. of women delivered	No. of mothers	CPD	≤170	171-189	≥190		131	114	133	134	139					
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more		0	0	0	0	0					
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more		0	0	0	0	0					
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more		1	0	0	0	0					
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0					
		SCBU at capacity	No. of times	SCBU	0	1	2 or more		12	4	7	4	6					
		SCBU no of babies affected	No. of babies affected	SCBU	0		1 or more		1	0	0	0	0					
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	35-31	≤31.0	DH	41.2	42.2	36.6	39.1	36.8					
		1 to 1 care in Labour	CPD	CPD	≥100%		<100%		95.4%	88.6%	85.0%	86.6%	83.5%					
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%		<100%		56.0%	81.0%	80.0%	84.7%	75.4%					
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	Safer Childbirth	40	40	40	40	40					
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10		≤9		3	3	3	3	3					
		Supervisor : M/w ratio 1 :	Ratio	Rota - Contact SOM	15	16-18	≥17	SHA	14	14	14	14	14					
Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%		66.4%	69.3%	63.9%	62.7%	72.1%					
	Morbidity	Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17%	≥18%	prev. stats	9.2%	6.1%	6.0%	11.2%	10.1%					
		C/S Births	Em & elect - %	CPD	≤26%	26-28%	>28%	prev. stats	23.7%	22.8%	29.3%	26.1%	18.7%					
		Eclampsia	No. of women	CPD	0		1 or more		0	0	0	0	0					
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	prev. stats	0	1	0	0	0					
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more		3	3	2	3	1					
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	prev. stats	0	1	1	3	1					
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	0	1	0	0	0					
		Neonatal Death	No of babies	Risk team- EBC	0		1 or more		0	2	0	0	0					
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more		0	0	0	0	0					
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more		0	0	0	0	0					
		Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70%	>70%		46.6%	51.8%	50.7%	55.2%	43.9%					
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%		18.3%	21.1%	25.6%	23.9%	21.0%					
	Risk Management	SI's	No. of SI's declared	Risk Team	0		1 or more		0	0	0	0	0					
		CI's	No. of CI's declared	Risk Team	0		1 or more		1	0	1	0	0					
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more		1	1	2	2	0					
		PPH > 1.5L as % of all women	% of births	CPD								2	0					
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	RCOG	0	3	4	2	2					
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.5- 4%	≥4%	RCOG	0.8%	0.9%	1.5%	2.9%	0.7%					
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more		0	0	0	1	1					
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more		1	0	0	0	1					

Mortality

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

Definition

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

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

Analysis of Performance

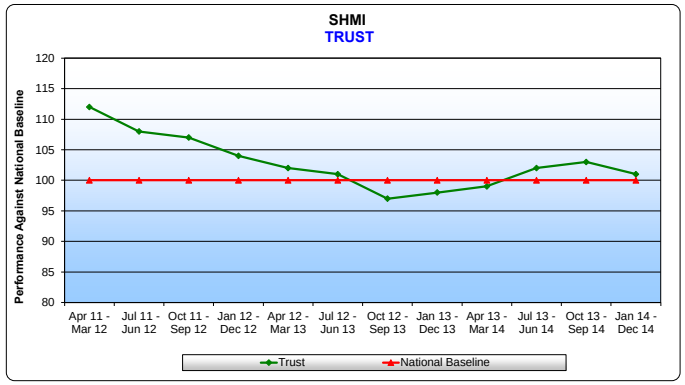
The latest SHMI report for the period January - December 2014 indicates the Trust to be in the 'as expected' range. Both York and Scarborough had a 2 point reduction from the previous release.

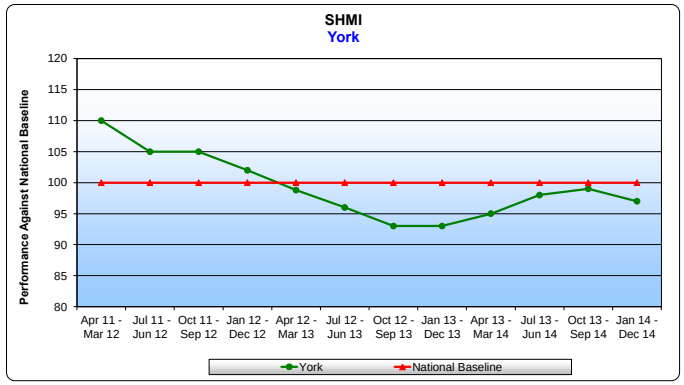
The number of inpatient deaths in August was in line with previous months. The percentage of deaths against all discharges at York has increased from 0.9% in July to 1.1% in August, however this is a decrease on August 2014 (1.2%). Similarly Scarborough also saw an increase from 1.0% in July to 1.4% in August, August 2014 was also 1.4%.

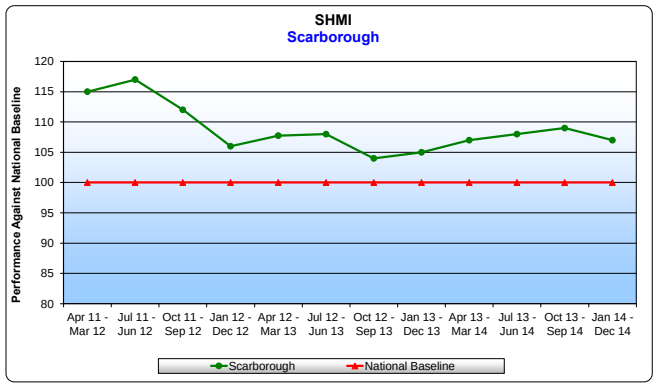
Of note, in August ED has had the highest number of deaths than any other month going back to April 2013 - 15 at York and 11 at Scarborough. These were all reviewed by the Quality and Safety team and no areas of concern were identified.

Mortality

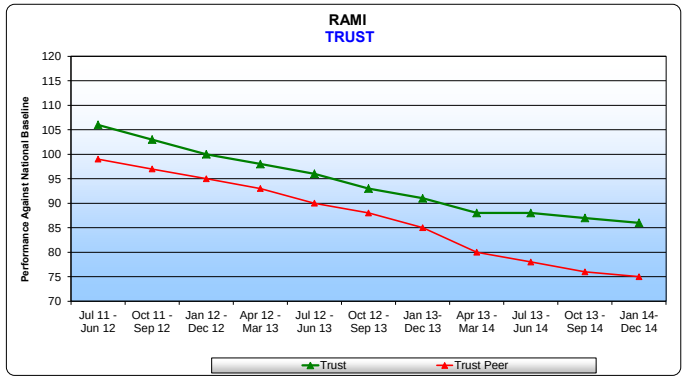
Indicator	Consequence of Breach (Monthly unless specified)	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	101	97	98	99	102	103	101
Mortality – SHMI (YORK)	**Quarterly:** General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

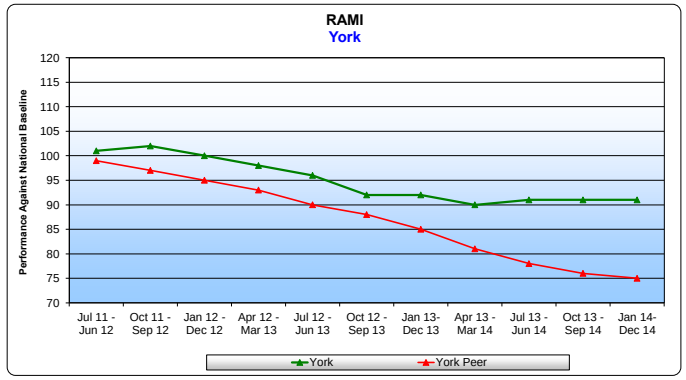


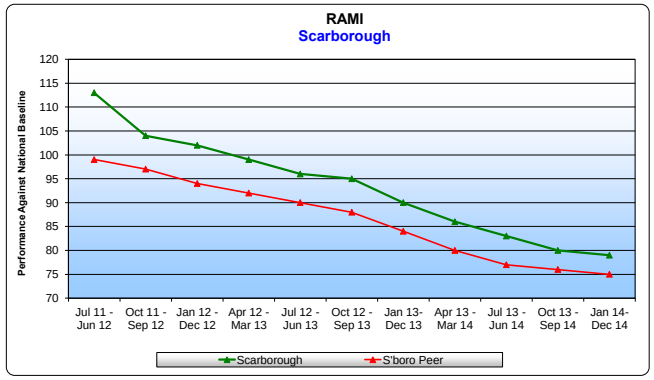




Indicator	Consequence of Breach (Monthly unless specified)	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sept 14	Jan 14 - Dec 14
Mortality – RAMI (TRUST)	**none - monitoring only**	96	93	91	88	88	87	86
Mortality – RAMI (YORK)	**none - monitoring only**	96	92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

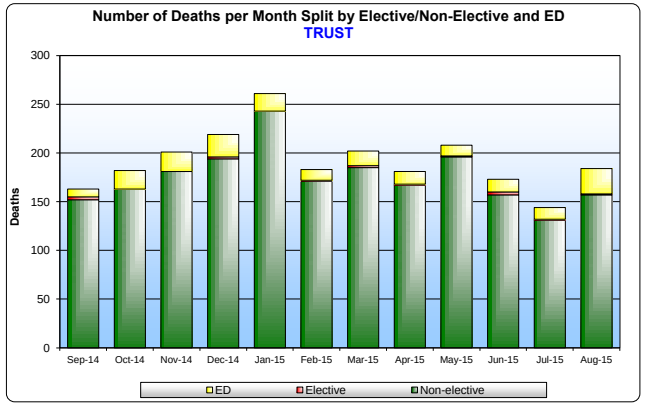


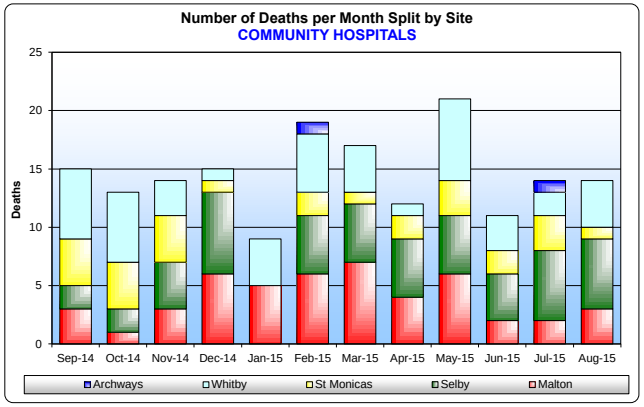




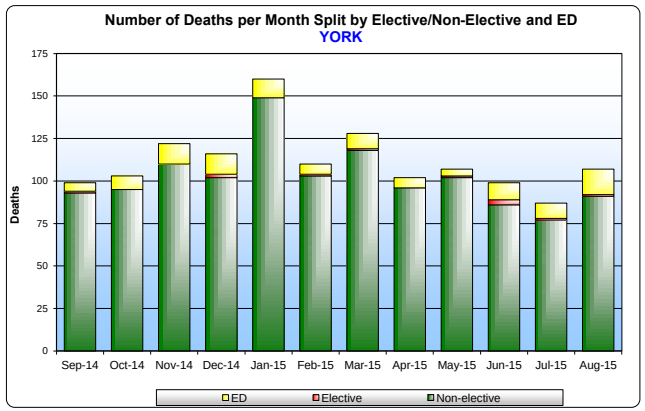
Mortality

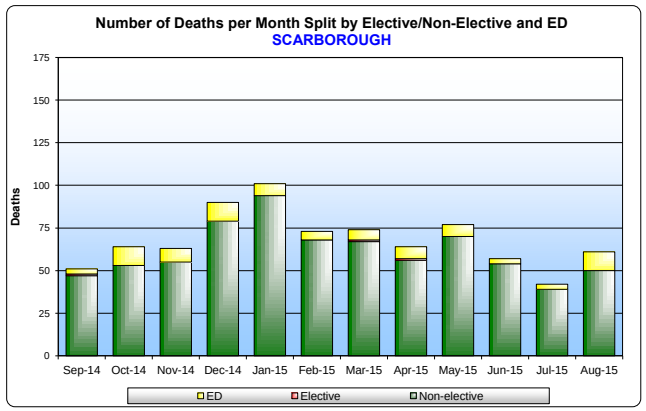
Indicator	Consequence of Breach (Monthly unless specified)	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Jun	Jul	Aug
Number of Inpatient Deaths (excludes deaths in ED)	None - Monitoring Only	471	540	602	525	160	132	158

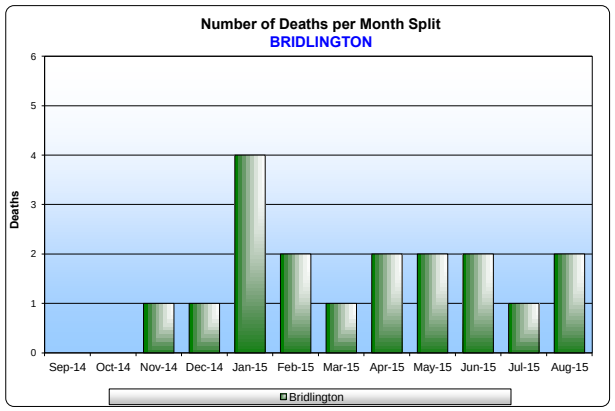




Month	Malton	Selby	St Monicas	Whitby	Archways	Bridlington
Sep-14	3	2	4	6	0	0
Oct-14	1	2	4	6	0	0
Nov-14	3	4	4	3	0	1
Dec-14	6	7	1	1	0	1
Jan-15	5	0	0	4	0	4
Feb-15	6	5	2	5	1	2
Mar-15	7	5	1	4	0	1
Apr-15	4	5	2	1	0	2
May-15	6	5	3	7	0	2
Jun-15	2	4	2	3	0	2
Jul-15	2	6	3	2	1	1
Aug-15	3	6	1	4	0	2





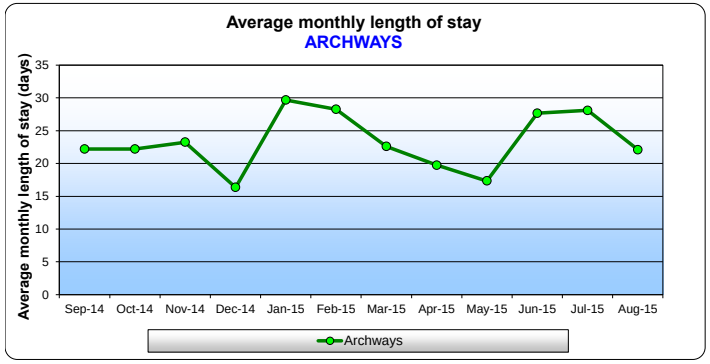


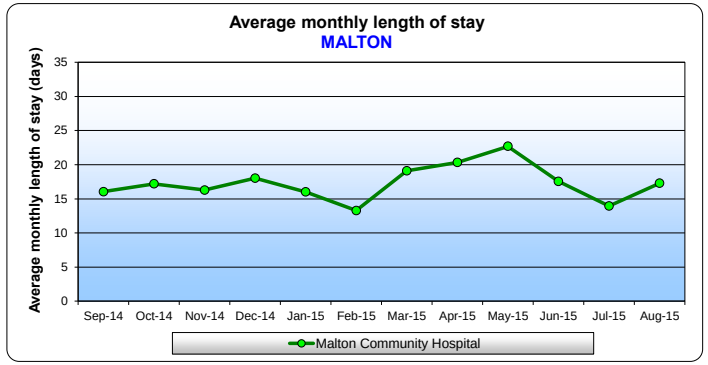
Patient Safety Walkrounds – August 2015

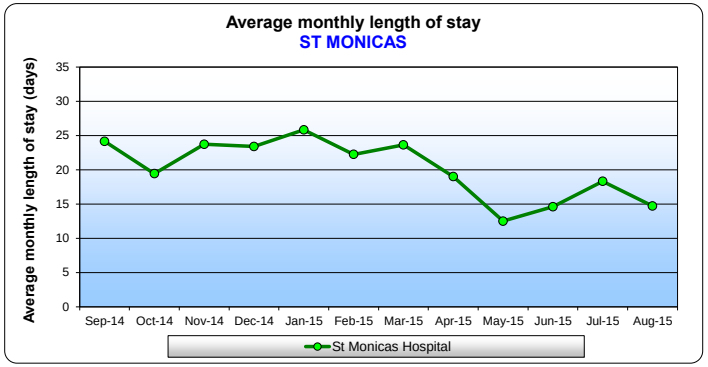
Date	Location	Participants	Actions & Recommendations
22/07/2015	AMU & Short Stay Ward	Patrick Crowley – Chief Executive Nigel Durham – Clinical Director Sharon Lewis – Directorate Manager Tracey Wright – Matron	Walk round postponed – to be rescheduled.
11/08/2015	St Helens	Juliet Walters – Executive Director Rachel Anderson – Locality Manager Janice Sellars – Ward Manager	Walk round postponed – to be rescheduled.
13/08/2015	Lilac and Maple	Diane Palmer – Deputy Director Stevan Stojkovic – Clinical Director Liz Hill – Directorate Manager Beth Horsman – Matron Mike Keaney – Non-executive Director	Lilac Ward The SAU is working well, but delays in obtaining radiology investigations results in delay with treatment decisions. The opening and closing times of the SAU may need to be modified to a later start and finish each day. The emergency call bells in the side rooms are located at one side of the bed which impedes on easy access. Action: Estates to be asked to review. The ward has not got sufficient numbers of a permanent nursing workforce. Action: Additional nurses are being recruited as part of the Trust strategic recruitment plan. Medical patients don't get routinely reviewed on a weekend. Action: to discuss with Medical Directorate CD. Maple Ward Medical patients on the HOB don't get a daily medical review. Action: to discuss with Medical Directorate CD. Escorting patients to York for an ERCP puts an additional strain on the nursing workforce. Action: to monitor. The ward has not got sufficient numbers of a permanent nursing workforce. Action: Additional nurses are being recruited as part of the Trust strategic recruitment plan. As a result of incident investigation a checklist prior to discharge is being introduced. Action: Sister to introduce and monitor effectiveness.
20/08/2015	Cherry Ward and Dales Unit	Mike Proctor – Executive Director David Humphriss – Clinical Director Sharon Lewis – Directorate Manager Tracey Wright – Matron Jennie Adams – Non-executive Director	Actions from previous visit reviewed; still outstanding was the location of the doctor's handover office. Problems relate to confidentiality as patients could overhear conversations. Action: Estates to confirm if alternative accommodation was planned. The ward sister confirmed that 4 RN's per shift instead of 5 was now the norm. Whilst safety was maintained this impacted on patient flow so this is being monitored. The interface between GP admissions and ED admissions was not clear, some GP admissions 'turning up' on the ward when there was no bed for them. Action: to be discussed with Ops Team. Recent experience of staff attending Coroner's Inquests has resulted in improved record keeping.
26/08/2015	Cardio Respiratory Unit	Bev Geary – Executive Director Nigel Durham – Clinical Director Jane Allen – Head of Department Sharon Lewis – Directorate Manager Chris Morris – Matron Mike Sweet – Non-executive Director	Report to follow.

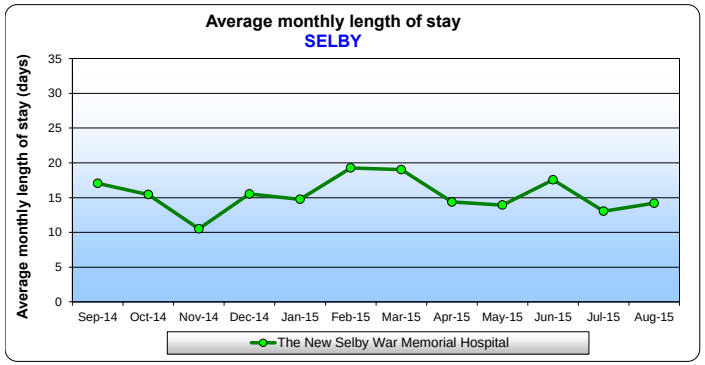
Community Hospitals

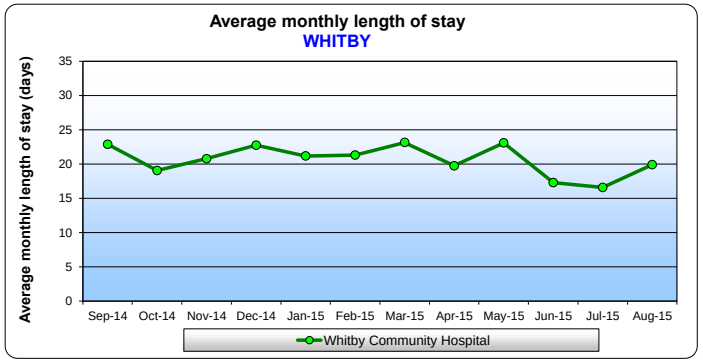
Indicator	Hospital	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Jun	Jul	Aug
Community Hospitals average length of stay (days)	Archways	22.1	20.6	26.8	21.1	27.7	28.1	22.1
	Malton Community Hospital	18.6	17.1	16.0	19.9	17.6	13.9	17.3
	St Monicas Hospital	23.2	22.0	24.0	15.5	14.6	18.3	14.7
	The New Selby War Memorial Hospital	15.6	13.7	17.6	15.3	17.6	13.1	14.2
	Whitby Community Hospital	20.3	20.9	21.9	20.0	17.3	16.6	19.9
	Total	19.4	18.1	20.2	18.5	18.4	16.3	18.0

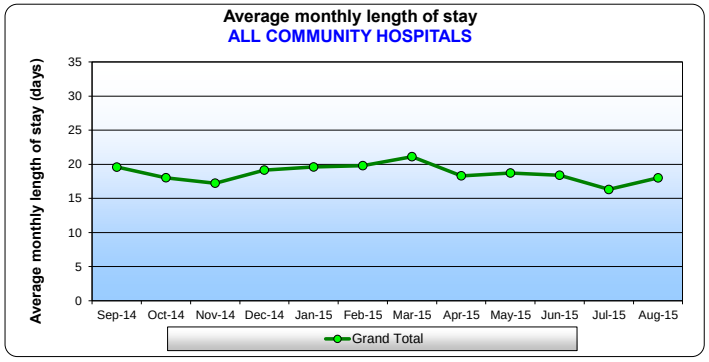






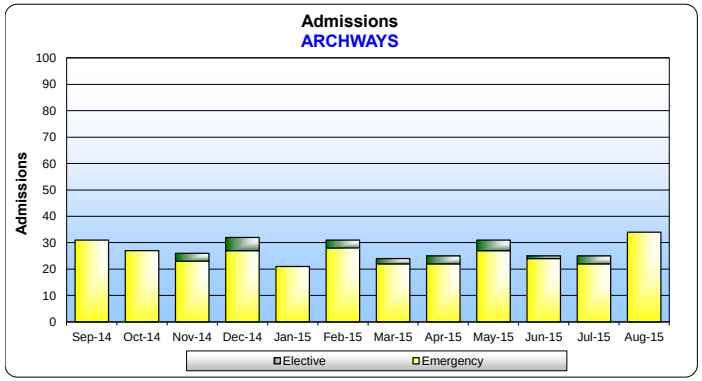


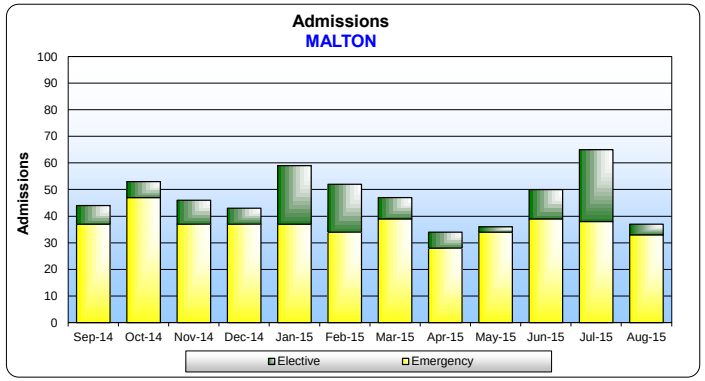


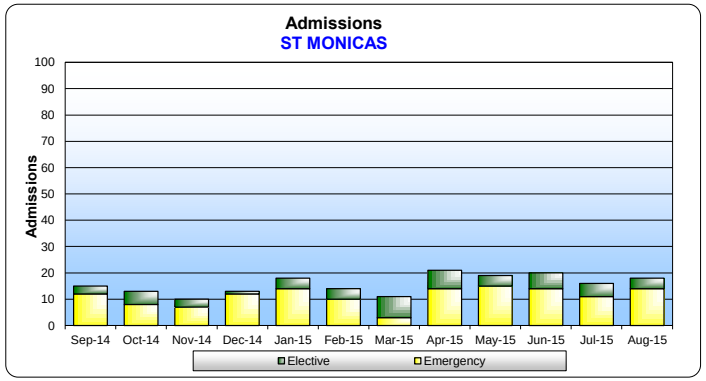


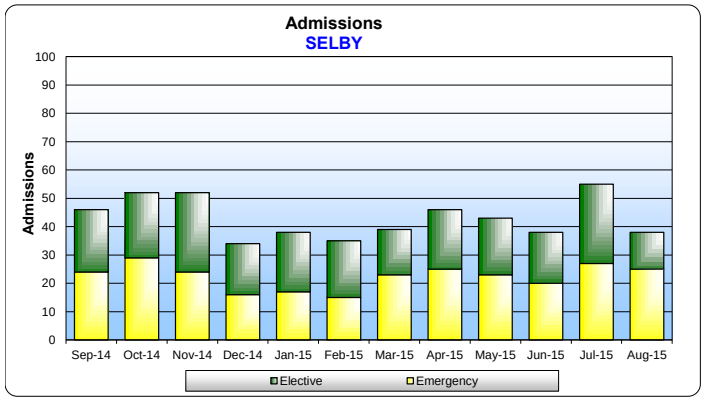
Community Hospitals

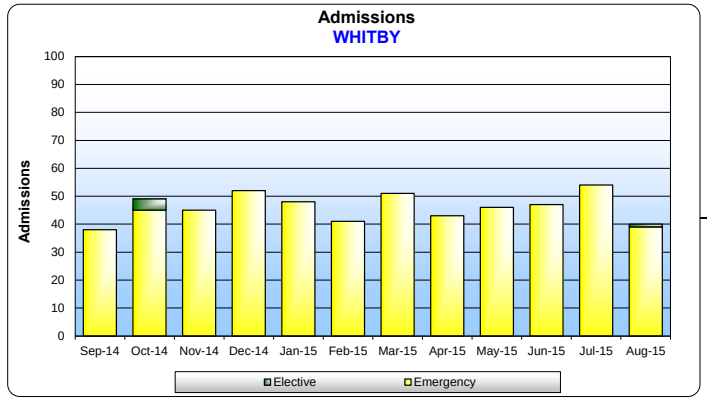
Indicator	Hospital		Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Jun	Jul	Aug
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	4	8	5	8	1	3	0
		Emergency	91	77	71	73	24	22	34
	Malton Community Hospital	Elective	10	21	48	19	11	27	4
		Emergency	114	121	110	101	39	38	33
	St Monicas Hospital	Elective	13	9	16	17	6	5	4
		Emergency	35	27	27	43	14	11	14
	The New Selby War Memorial	Elective	62	69	57	59	18	28	13
		Emergency	66	69	55	68	20	27	25
	Whitby Community Hospital	Elective	1	4	0	0	0	0	1
		Emergency	123	142	140	136	47	54	39
	Total	Elective	90	111	126	121	36	63	22
		Emergency	429	436	403	441	144	152	145

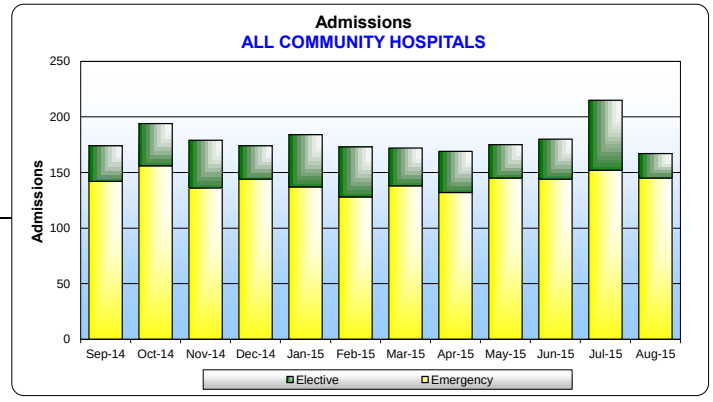












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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Medical Director's Report

Action requested/recommendation

Board of Director's should:

- Consider the Trust latest Summary Hospital level Mortality Indicator (SHMI) and how improvements can be made
- Acknowledge consultants new to the Trust
- Review the Antimicrobial prescribing audit
- Consider the EPMA progress report
- Note that a review of SI processes has commenced.

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	This report 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	September 2015
Version number	1

Board of Directors – 30 September 2015

Medical Director's Report

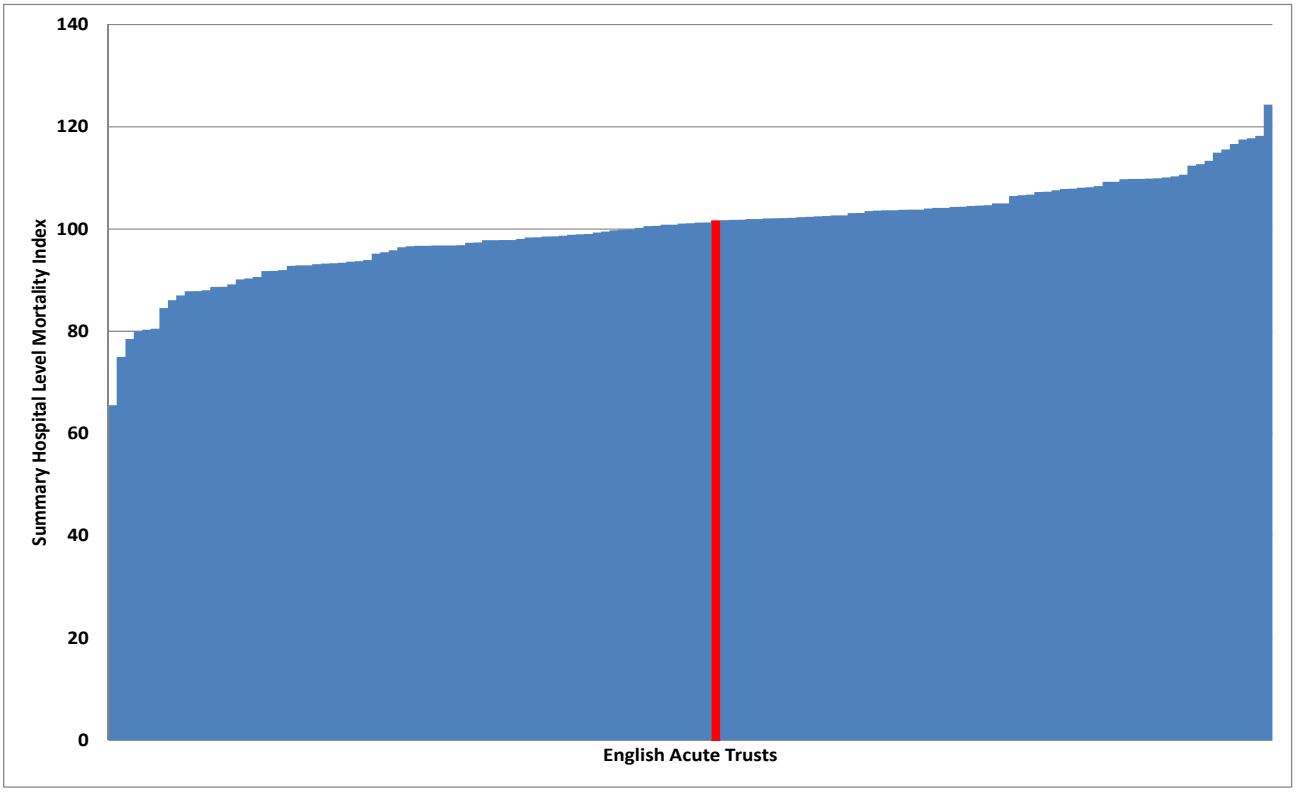
1. Introduction and background

In the report this month:

- Summary of Hospital level Mortality Indicator (SHMI)
- Consultants new to the Trust
- Antimicrobial Prescribing Audit
- Update on EPMA
- Advanced notice of review of serious incident processes.

2. SHMI

The Trust SHMI for the period January to December 2014 was published as 101.2, on 29th July. This represents a slight reduction from 102.9 in the last period. There were 34 excess deaths, 50 less than in the last report. The Trust position in comparison to all English Acute Trusts is illustrated by the bold line on the graph below.



The SHMI categories where the Trust had greater than 10 deaths more than expected are shown in the table below. Cerebrovascular disease excess deaths have reduced by two, other connective tissue disease reduced by four, congestive heart failure increased by three, but there are less cases overall and four less deaths. Septicaemia deaths have reduced by ten, but there are less cases overall. Cystic fibrosis excess deaths have reduced by five and pneumonia has reduced with five fewer deaths than expected.

SHMI Group	Description	Cases	Observed Deaths	Expected Deaths	SHMI	Excess Deaths
66	Acute cerebrovascular disease	1,078	220	191.48	114.89	28.52
113	Other connective tissue disease	1,216	44	24.02	183.16	19.98
65	Congestive heart failure non hypertensive	706	131	111.93	117.04	19.07
101	Urinary tract infections	1,924	128	112.61	113.67	15.39
2	Septicaemia and shock	421	117	103.12	113.46	13.88
81	Cystic fibrosis other lower respiratory disease	249	35	21.42	163.43	13.58

The table below provides a comparison with other Yorkshire Trusts.

Trust	SHMI	Trust	SHMI
Sheffield	91.8	Calderdale & Huddersfield	109.3
Leeds	103.1	Hull & East Yorkshire	107.3
Airedale	93.9	York	101.2
Bradford	96.8	Doncaster & Bassetlaw	112.4
Mid Yorkshire	87.9	Barnsley	102.5
Harrogate	101.3	Rotherham	106.4

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3. Consultants new to the Trust

Deena ElSharief
Consultant in Breast & Oncoplastic Surgery
York Hospital
Started 03/08/2015

David Cash
Consultant in Trauma & Orthopaedic Surgery
Bridlington Hospital
Started 01/08/2015

4. Antimicrobial prescribing audit

SUMMARY OF ANTIBIOTIC PRESCRIPTION AUDIT RESULTS
January – August 2015

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

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

% patients >65 years co-prescribed VSL#3 (NB the audit did not investigate if any of the patients >65 years who were not on VSL#3 met any of the exclusion criteria)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
York Hospital	71%	64%	59%	72%	57%	56%	64%	46%

Scarborough Hospital	79%	67%	59%	85%	68%	76%	69%	74%
Trust average	75%	65%	59%	77%	62%	66%	67%	56%

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Electronic Prescribing and Medicines Administration

Progress with EMPA

Summary of Key Dates:

Requirement documents formally issued to IT	May 2015
Allergies Management roll out	September 2015
Beta Version of EPMA system	October 2015
Hardware / wireless etc. in place	December 2015
System development complete	December 31st 2015
User Acceptance Testing	January 2016
Test Ward	January/February 2016
Pilot	February/March 2016
Rollout Phase 1 (c. 7 months duration)	March/April 2016 onwards

Project Progress to date:

- Clinical Safety Hazard Log drafted, agreeing mitigation measures
- Baseline data collection for benefits realisation work
- New drug trolley agreed & ordered
- Installation of required power points on-going
- Trialling laptop trolleys for Pharmacy team (York & Scarborough)

Development Progress to date:

- 60% of the coding (programming) for EPMA is complete
- HSCIC Common User interface guidance informing development
- Formulary management screens development 100% complete
- Identification of Formulary drugs data in FDB Drug database is 95% complete
- Working with Pharmacy on the following functionality: Order Sets; brand/generic links; time critical drugs; formulation information; suggested/customised doses

Whilst the IT development will be driven by the functional specifications there will be an iterative nature to it depending on feedback received at each of the demonstration stages.

Anticipated progress next quarter:

- Beta version of EPMA system for wide clinical engagement
- Business continuity plan drafted
- Agreement on rollout order / understanding of requirements for training
- Completion of installation of additional power points
- Agreed programme for rollout of drug trolleys / laptops

Key Risks:

The Clinical Safety Hazard log will provide assurance to the Trust of the clinical safety of the product. There is a Project Risk Register in place which is reviewed monthly. The current red risks are detailed below:

- Failure to agree programme in timely manner
- Other system developments take precedence over EPMA
- Inadequate clinician / prescriber 'buy-in'.

6. Review of Serious Incident Policy

A small working group has been established to review our processes associated with serious incident investigation and reporting. A discussion paper will be presented to Executive Board next month.

7. Recommendations

Board of Director's should:

- Consider the Trust latest Summary Hospital level Mortality Indicator (SHMI) and how improvements can be made
- Acknowledge consultants new to the Trust
- Review the Antimicrobial prescribing audit
- Consider the EPMA progress report
- Note that a review of SI processes has commenced.

Author	**Diane Palmer, Deputy Director for Patient Safety**
Owner	**Dr Ed Smith, Interim Medical Director** **Mr Jim Taylor, Interim Medical Director**
Date	**24th September 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Chief Nurse Report – Quality of Care

Action requested/recommendation

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

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	Executive Board Board of Directors
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	September 2015
Version number	Version 1

Board of Directors – 30 September 2015

Chief Nurse Report – Quality of Care

1. Key priorities

Nursing and Midwifery Strategy

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

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

An update with priorities and outstanding actions has previously been received by board and it is anticipated that a final report detailing the achievements of the strategy will be presented to board in the next quarter.

We are now planning a new strategy and to begin this work a consultation exercise will be undertaken at the Nursing and Midwifery conference at the end of September, this will include Nurses and Midwifes from across the organisation (and also student nurses) who can help to shape the priorities for the next 3 years. We hope that by engaging the wider team in the development phase we will ensure local ownership and delivery.

2. Staffing

2.1 Safer Staffing

The safer staffing report for August 2015, is detailed in a separate paper. The Trust continues to see during August a large number of patients who had enhanced supervision needs. This is being audited on a monthly basis to ensure that staff are being deployed effectively to cohort patients were possible. The continuing pressure on registered nurse numbers has also resulted in a variation of skill mix across a number of wards.

2.2 Nurse Recruitment

The Chief Nurse team continues to make active preparations for 65 newly qualified nurses to join the Trust over the next few months. Of these 19 are expected to commence at Scarborough Hospital, 44 at York Hospital and 2 in Community Services. One stop shop events have been held in York and Scarborough for these new nurses to meet their new colleagues, and to undertake all their pre-employment checks.

Plans are progressing for European recruitment for more nurses to commence in mid to late September 2015. The Trust aims to recruit approximately 60 nurses across York and Scarborough hospitals, with the aim for their commencement from December 2015.

Open Days for Healthcare Assistants will be taking place in September in preparation for winter planning requirements.

3. Situational Awareness For Everyone ('SAFE')

The Children's Directorate has recently submitted an application and have been successfully accepted into the second wave of the "SAFE" programme.

SAFE is a two year programme led by the Royal College of Paediatrics and Child Health which, in partnership with initially twelve hospitals, has developed and trialled a suite of quality improvement techniques aimed at reducing preventable deaths and error occurring in the UK's paediatric departments – currently there are an estimated 2,000 preventable deaths each year compared to the best performing countries in Western Europe.

The initial twelve hospitals have trialled models of care including the 'huddle' technique - a ten minute free, frank exchange of information between clinical and non-clinical professionals involved in a patient's care – in a bid to encourage information sharing and to equip professionals with the skills to spot when a child's condition is deteriorating as well as prevent missed diagnosis.

The programme is funded as part of the Health Foundation's Closing the Gap in Patient Safety programme, with additional support from WellChild and UCLPartners, the programme aims to:

- Reduce avoidable error and harm to acutely sick children by 2016
- Improve communication between all healthcare professionals involved in a child's care as well as families to ensure treatment is consistent and of the same high standard regardless of postcode or class
- Close the disparity in health outcomes for children in UK vs other countries as well as between children's care and adult care
- Involve parents, children and young people to be better involved in their children's/own care

The programme will bring together paediatric units from hospitals from across England into a collaborative, with each running a local quality improvement project aimed at improving outcomes for paediatric patients. While there will be a set of central measures collected, each participating unit has the freedom to focus their project on a particular measure they want to improve.

Using a collaborative model allows participating units to share their knowledge and experience with other collaborative partners, demonstrating both their successes and failures. This provides the opportunity for good practice to be spread and adapted within the collaborative, and for this to contribute to the single common aim of the programme, to reduce preventable deaths and error from occurring.

The second wave programme will involve learning sessions and action periods through which to build situation awareness into local quality improvement activities. A webinar series will be available, in addition to site visit support from the project team through the duration of the programme.

4. Early Warning Trigger Tool

The Early Warning Trigger Tool has been refined since the last report to build a validation functionality into the system. This additional functionality has reduced the time it takes for Matrons to validate the ward submissions each month and provides a clear audit trail each month. A full review of the Early Warning Trigger Tool is on-going and will be completed in the New Year.

In addition, a separate Maternity Early Warning Trigger Tool has been developed and will be piloted from 1st October 2015 with a plan to implement in November 2015.

The most recent EWTT submission was made on 2nd September 2015. No ward has been flagged as red rated this month, whilst 10 wards are Amber rated, the highest of which is AMU at York Hospital which has scored 19.

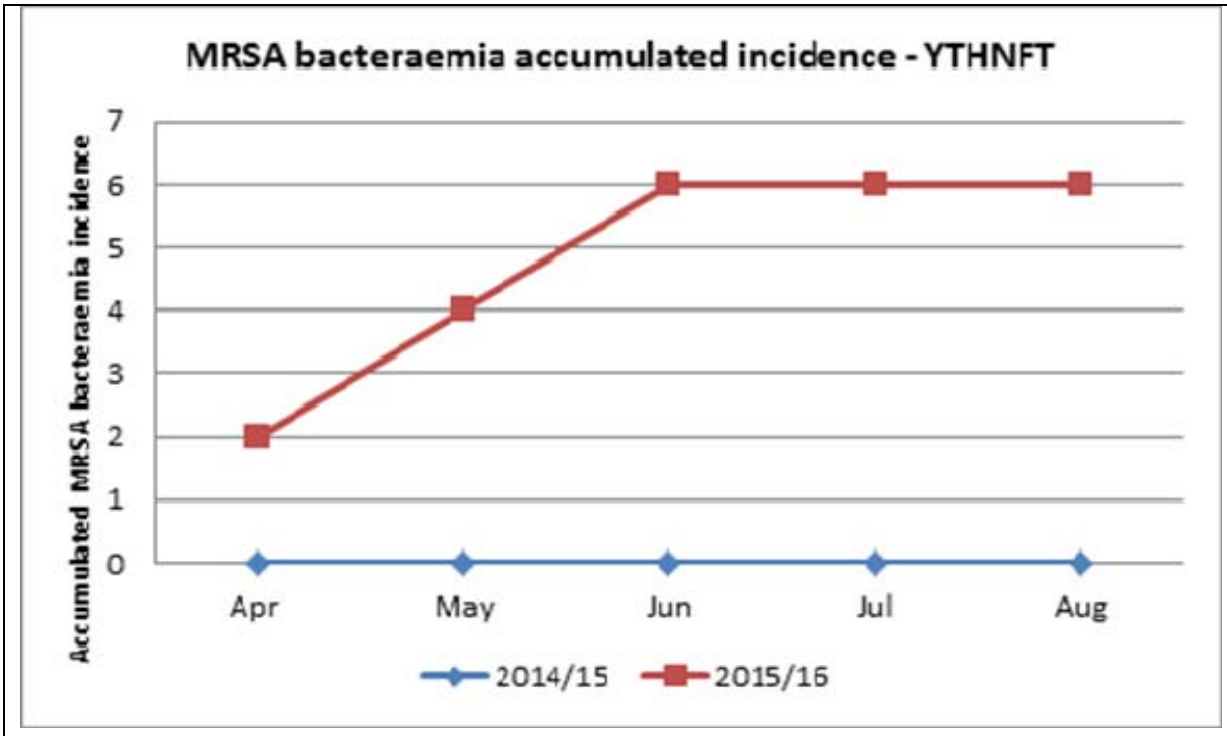
5. Infection Prevention Update

The Board will be aware that following the retirement of the previous Medical Director the DIPC role has been assumed by the Chief Nurse. An external review of Governance arrangements and reporting was commissioned in order that the Board are assured that the structures are robust and fit for purpose. It is anticipated that a draft report with any recommendations will be submitted in the coming weeks.

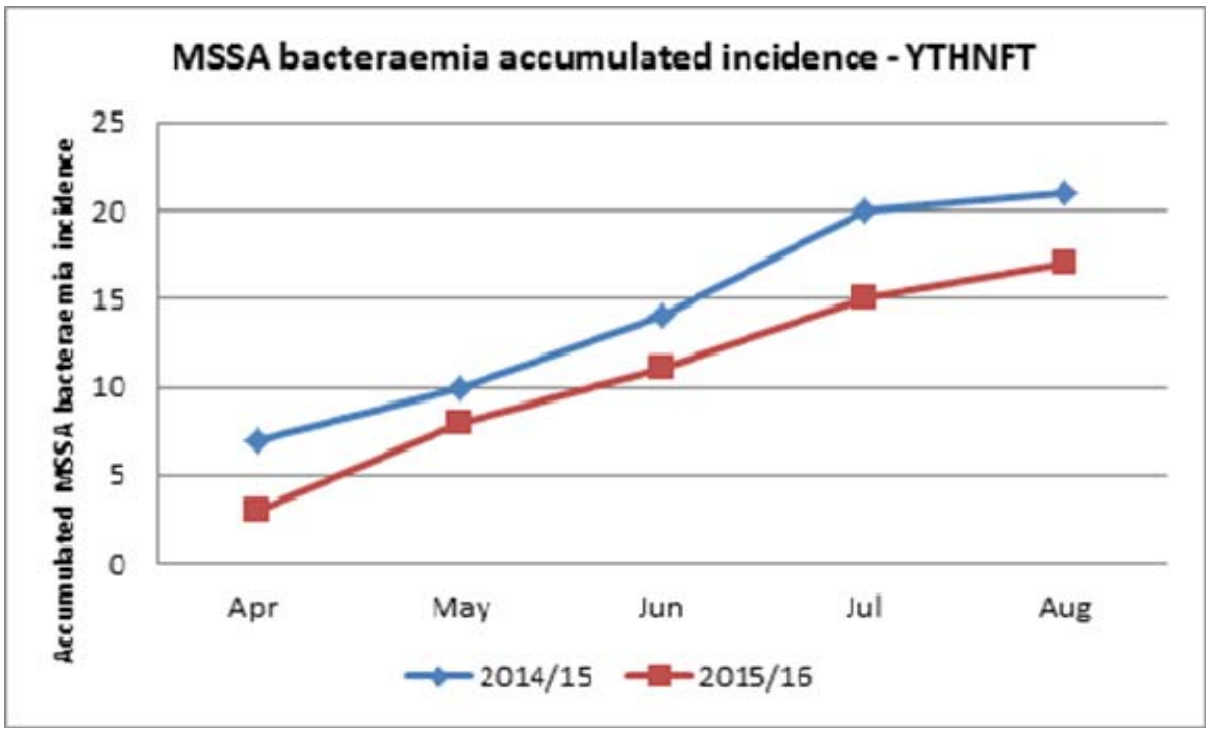
During the first Quarter of 2015/16 the Trust experienced a period of increased incidence of Healthcare Associated Infection compared with the same period last year. However following Post Infection Review (PIR), targeted interventions and control measures that focus on clinical practice and device management. Now, in quarter 2 we are beginning to see a downward trend of MRSA bacteraemia and there have been no cases of MRSA bacteraemia for 79 days. Prior to the recent cluster of MRSA bacteraemia 578 days had elapsed since the last case demonstrating the Trust`s ability to deliver excellent performance.

Electronic capture on CPD of insertion and on-going care of peripheral cannula aims to monitor compliance with policy and best practice standards in relation to this procedure. Early audit data shows work is required to ensure documentation of all insertions to enable monitoring of on-going care and phlebitis scores. This is being developed with IT and Matrons.

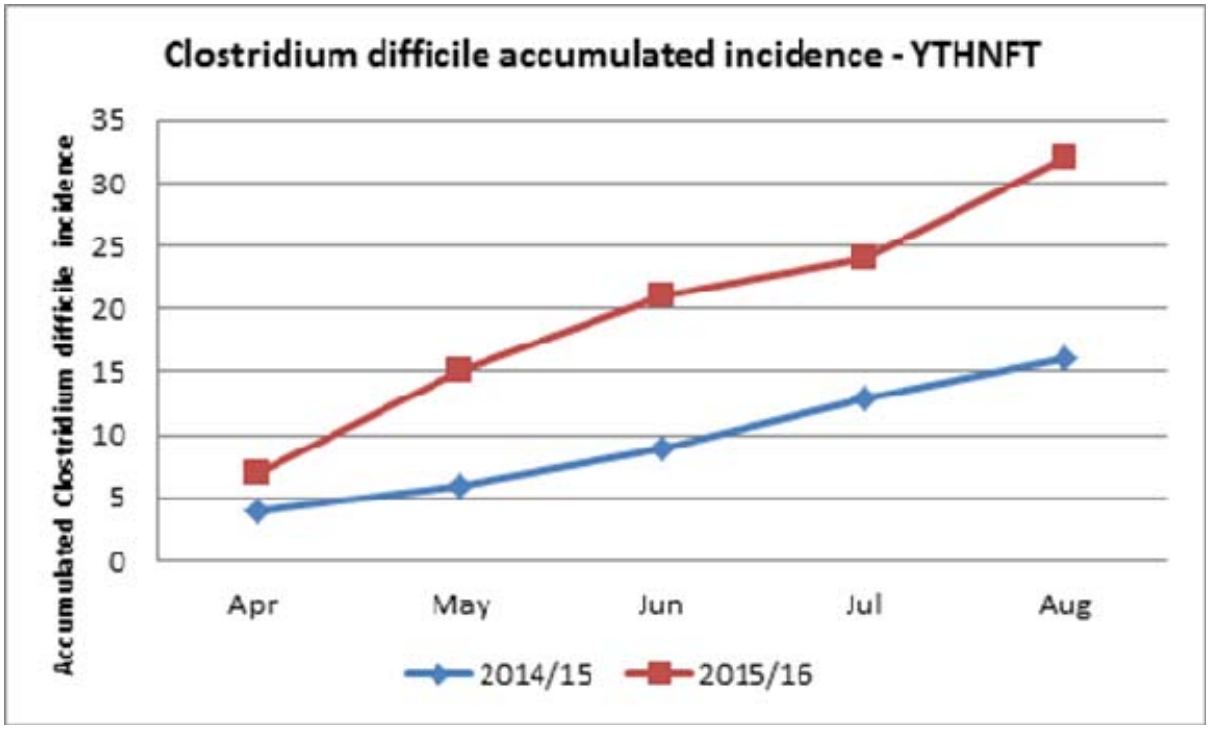
Clostridium difficile incidence is increasing regionally and nationally. Whilst there will always be unavoidable cases, the aim is to continue to reduce cases to the irreducible. On-going audit of antimicrobial prescribing compliance shows significant improvement in terms of indication and duration of use, with only 20% of patients prescribed antimicrobials against a national benchmark of 30%.



MSSA bacteraemia	2014/15	2015/16
Apr	7	3
May	10	8
Jun	14	11
Jul	20	15
Aug	21	17



CDI toxin positive	2014/15	2015/16
Apr	4	7
May	6	15
Jun	9	21
Jul	13	24
Aug	16	32



We continue to support and maintain the delivery of proactive and targeted interventions to maintain the downward trend of bacteraemia and continue to identify initiatives to reduce CDI.

6. Medicines Management

The Board are aware that improved medicines management is a key patient safety priority and one of our main risks. In order to understand some of the ward area issues' and support staff a Nursing and Midwifery Medicines Group has been introduced. We held the first meeting in July and key priorities have been identified. This group will meet monthly with an overall objective to provide a forum for engagement, communication and development of medicines management processes.

After a successful pilot of self- administration of medication (SAM) on Ward 31, wards were asked to 'opt-in' to the SAM initiative. To date 18 wards across the organisation have enrolled. A roll out programme has now been developed and implementation is underway. The objective is to reduce errors and to improve patient experience and patient safety.

7. Patient Experience

The Patient Safety Strategy for 2015-2018 has now been developed and identifies four key objectives:

- Involving
- Listening
- Responding
- Learning

The overall aim of the strategy is to improve patient experience and to nurture a culture of openness, respect and responsibility.

The strategy will be launched this month at the AGM and the Nursing and Midwifery Conference. A detailed implementation plan has been developed and will be presented for approval to the Patient Experience Steering Group at the September meeting.

Quarterly updates on the progress will be reported to Board via Quality and Safety Committee.

8. End of life Care

Seven Day Specialist Palliative Care Service
NICE palliative and supportive care (SPC) guidance (2004), stated that: '*SPC should be staffed to a sufficient level to undertake face to face assessment at home or in hospital during normal hours, 7 days a week'.* This has been further endorsed by National End of Life Care Strategy (2008) and the National Care of the Dying Audit (2014).

The aim and objectives are to:

- improve access to service
- improve quality of care
- help to reduce avoidable hospital admissions
- support rapid discharge from hospital, and
- increase place of death in the usual place of residency.

A pilot of a 7 day SPC service across York and Scarborough acute, and York community will be rolled out and aims to have a Clinical Nurse Specialist available for all three areas from November 2015.

Criteria for referral on a weekend or bank holiday would include:

- Escalating or intractable pain or symptoms which have not been resolved by giving appropriate treatment e.g. intractable vomiting, dyspnoea, acute agitation
- Medication advice for patients already on specialist or unusual drug regimes
- Support for complex social and emotional carer needs that cannot be resolved by telephone contact
- Professionals involved with the patient and family
- For a patient at home, the normal district nursing (DN) number will be used and the DN will triage if SPC is required.

During the pilot period, all data will be captured including 'soft data' which affects the normal Monday to Friday process. This will be collated and shared with the senior nursing team on a monthly basis and will contribute toward a formal evaluation.

There will be a communications release nearer the launch date, to inform the clinicians, nurses and community colleagues of the service change and criteria.

9. Safeguarding Adults

Care Act
The Committee have previously been asked to note the introduction of Section 42 – 46 of The Care Act 2014 and its relevance to Safeguarding Adults within the Trust from April 2015.

The Trust Safeguarding Adults policy has been amended in line with The Care Act but was awaiting formal guidance before finalisation from the Local Authorities. The Lead Nurse for Safeguarding Adults has now been invited by the City of York Council to participate in the development of the Multi-agency policy.

Deprivation of Liberty Safeguards (Cheshire West)
The Board have been advised of the progress of implementation of the above ruling in previous reports.

The implementation plan was presented to the Safeguarding Adults Governance Group on 2nd July 2015 and the team was asked to provide a briefing paper to Trust Board which provided the following information:

a. Evidence to support the proposed "non-negligible" time frame
b. Evidence of research of other Trust Practice
c. Applications statistics

This work is on-going and progress will be delivered at the next Safeguarding Adults Governance Group in October with recommendations to Board the following month.

The Safeguarding Adults Team continues to support staff with this agenda through training, awareness raising, and in staff forums.

Implementation of the ruling has already been highlighted for the Risk Register and further updates and risks will be presented to Board as they become apparent.

11. Recommendation

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

12. References

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

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

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D4

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Safe Nurse and Midwifery Staffing Report

Action requested/recommendation

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

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	September 2015
Version number	Version 1

Board of Directors – 30 September 2015

Safe Nurse and Midwifery Staffing Report

1. Introduction and background

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

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

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

2. High level data by site

	Day		Night	
Site Name	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**
Archways	94.4%	97.4%	112.9%	93.5%
Bridlington & District Hospital	90.2%	85.8%	79.8%	121.5%
Malton Community Hospital	82.6%	105.1%	100.0%	96.8%
Scarborough General Hospital	81.5%	113.2%	90.0%	119.5%
Selby War Memorial Hospital	88.4%	104.5%	100.0%	100.0%
St Helen's	95.2%	104.5%	100.0%	100.0%
St Monica's	91.6%	91.6%	95.1%	100.0%
Whitby Community Hospital	100.9%	99.1%	100.0%	100.0%
White Cross Court	100.8%	94.8%	95.2%	100.0%
York Hospital	87.6%	104.9%	93.7%	109.0%

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**	
Johnson	Ann Wright	Ward 23	Ward 31
	Chestnut	Ward 33	Ward 34
		Ward 37	

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

Provision of Safe Ward Cover

The Matrons are responsible for ensuring staffing levels are as safe as possible throughout the day and night. This means that staffing is assessed throughout the day and for out of hours and weekends and effective and safe plans are implemented. This does result in staff moving from their base wards on occasions.

Bed Occupancy

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

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

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

Vacancies, Sickness and Annual Leave

The Trust's ability to fill shifts due to sickness and vacancies reduce the average percentage staffing levels each month. It is recognised that August is commonly a more challenging time to cover shifts with bank or agency staffing. This is because individuals who choose to undertake bank or agency only contracts often do so to meet their family / care needs during school holidays. The following wards have reported reduced actual staffing for these reasons:

Bridlington	Scarborough	Community	York
LLoyd	Ann Wright		CCU
	Cherry		ESA
	Maple		Ward 26
	Oak		

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

4. Vacancies by Site

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

The vacancy detail for the adult in-patient wards as at the end of August 2015 is presented in a second Board paper.

This revised style of data collection for vacancies has further demonstrated the need to reconcile and align the budgets with the ward establishments and the requirement for detailed narrative to ensure from ward level to trust board there is adequate assurance and the context of changes are understood and explained. It is important to note that the budgetary changes implemented in July and August have added to the registered nurse vacancy level, namely;

- AMU at York – increased registered nurses following business case by 6.63 WTE
- Ash Ward – introduction of ward budget agreed increased registered nurses by 12.25 WTE

In addition, in month changes to the budgets also influenced the level of registered nurse vacancies overall, for example, Sexual Health Services – introduction of budget following successful tender increased registered nurses by 20.0 WTE.

Furthermore, as detailed in the separate report this month there has been a significant increase in attrition. The principle known reason is due to retirement. Therefore, it is clear that as a minimum quarterly the Trust requires a review of registered nurse turnover in order to ensure any projections are as accurate as possible.

There are a number of complexities that will be addressed during September and October through the ward reconciliation meetings. The ambition is for November / December 2015 for the Board report to change to provide both high level trust and site data but also provide detailed ward / unit / department level data that demonstrates level of risk and provides narrative description.

5. Sickness, Bank and Agency Fill Rates

Sickness

The overall absence rate for the Trust for the month of July 2015 was 3.81% By site, sickness within the Nursing and Midwifery workforce across the inpatient areas was, as follows:

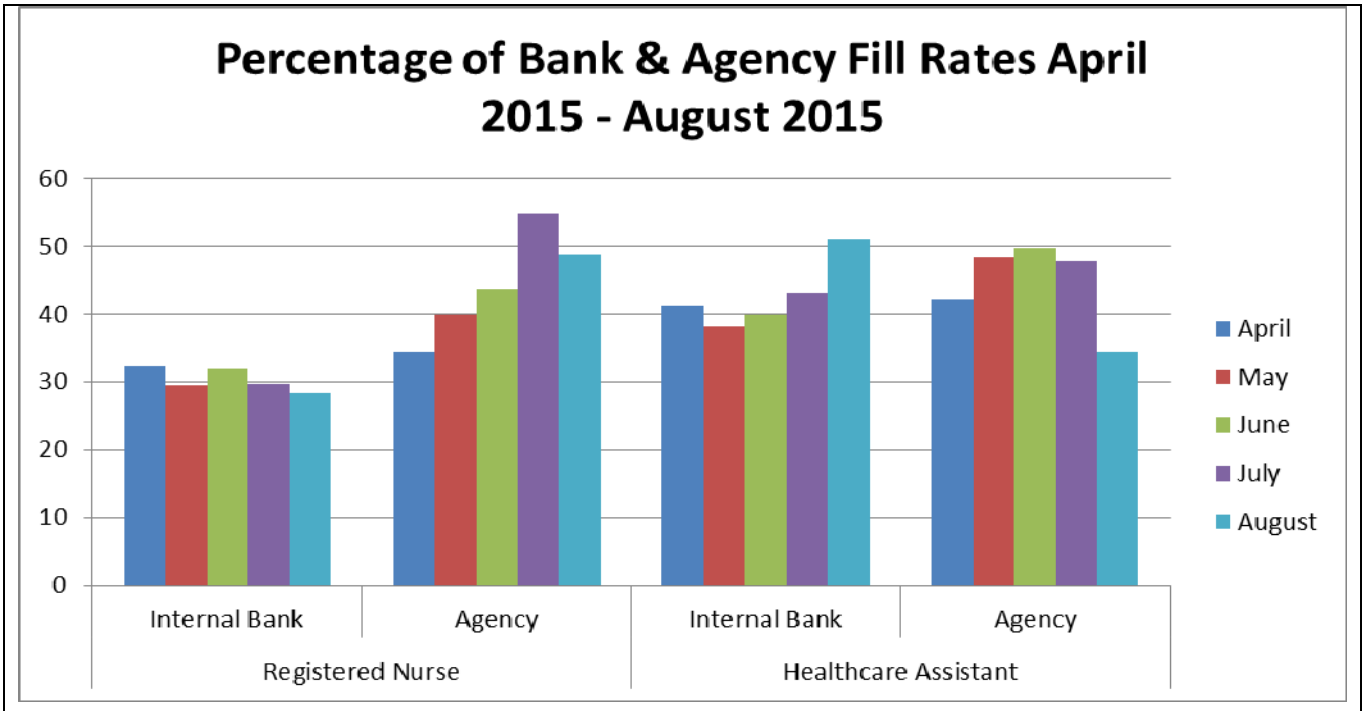
York Acute Hospital – 2.56%
Scarborough Acute Hospital – 5.15%
Community Services – 4.24%

Temporary Staffing

Overall fill rate of bank shifts requested through the internal bank was 37.13%, an improvement of 1.21% from July 2015. The fill rate for qualified shifts was 28.35%, a reduction of 1.31% on July whilst, the fill rate for unqualified shifts was 51.09%, an improvement of 8.02%.

The percentage of shifts filled by agency reduced this month for both RN shifts and unqualified shifts with 43.15% of shifts being filled by external agency compared with 51.46% in July.

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



6. Recommendation

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

7. References and further reading

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

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

RCB **York Teaching Hospital NHS Foundation Trust**
August_2015-16

		Day				Night				Day		Night	
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
Site Code	Site Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
RCBAW	ARCHWAYS INTERMEDIATE CARE UNIT	744	702	930	906	341	385	682	638	94.4%	97.4%	112.9%	93.5%
RCBNH	BRIDLINGTON AND DISTRICT HOSPITAL	3652.5	3294	3942	3382.5	2233	1782	869	1056	90.2%	85.8%	79.8%	121.5%
RCBL8	MALTON COMMUNITY HOSPITAL	1162.5	960	1627.5	1710	682	682	682	660	82.6%	105.1%	100.0%	96.8%
RCBCA	SCARBOROUGH GENERAL HOSPITAL	23110.5	18831	14089.5	15948	13981	12584	7161	8558	81.5%	113.2%	90.0%	119.5%
RCB07	SELBY AND DISTRICT WAR MEMORIAL HOSPITAL	1162.5	1027.5	1162.5	1215	341	341	682	682	88.4%	104.5%	100.0%	100.0%
RCBTV	ST HELENS REHABILITATION HOSPITAL	930	885	1162.5	1215	341	341	341	341	95.2%	104.5%	100.0%	100.0%
RCB05	ST MONICAS HOSPITAL	622.5	570	622.5	570	765	727.5	341	341	91.6%	91.6%	95.1%	100.0%
RCBG1	WHITBY COMMUNITY HOSPITAL	1627.5	1642.5	2557.5	2535	682	682	1023	1023	100.9%	99.1%	100.0%	100.0%
RCBP9	WHITE CROSS REHABILITATION HOSPITAL	930	937.5	1162.5	1102.5	682	649	341	341	100.8%	94.8%	95.2%	100.0%
RCB55	YORK HOSPITAL	45849	40173	25107	26344.5	25157	23584	15807	17226	87.6%	104.9%	93.7%	109.0%

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Director of Infection Prevention and Control (DIPC) Annual Report 2014/15

Action requested/recommendation

The Committee is asked to:

- Receive the Infection Prevention and Control annual report 2014/15
- Approve the report prior to publication on the Trust website as required by the Health and Social Care Act 2008

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

CQC Outcome 8 – Cleanliness and Infection Control (Health and Social Care Act 2008: Code of Practice for the Prevention of Infections and related guidance

Progress of report	Quality and Safety Committee
Risk	Risk to patient safety from Healthcare Associated Infection when compliance with best practice falls below required standards.
Resource implications	Staffing, activity and capacity when clusters, outbreaks and periods of increased incidence of infection occur.
Owner	Beverley Geary, Chief Nurse
Author	Vicki Parkin, Deputy Director of Infection and Prevention Control
Date of paper	September 2015
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Director of Infection Prevention and Control

Annual Report

2014 -15

Author: Vicki Parkin, Deputy Director Infection Prevention and Control
Owner: Beverley Geary, Director of Infection Prevention and Control

Governance: Presented to Board of Directors
Date of Report: Sept 2015

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1. Executive Summary

This report aims to provide assurance that the Trust is compliant with the criteria of the Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance.

2014/15 was a challenging year not least due to national Healthcare Associated Infection (HCAI) reduction targets and extended, unanticipated levels of operational activity leading to pressure on all areas of the Trust.

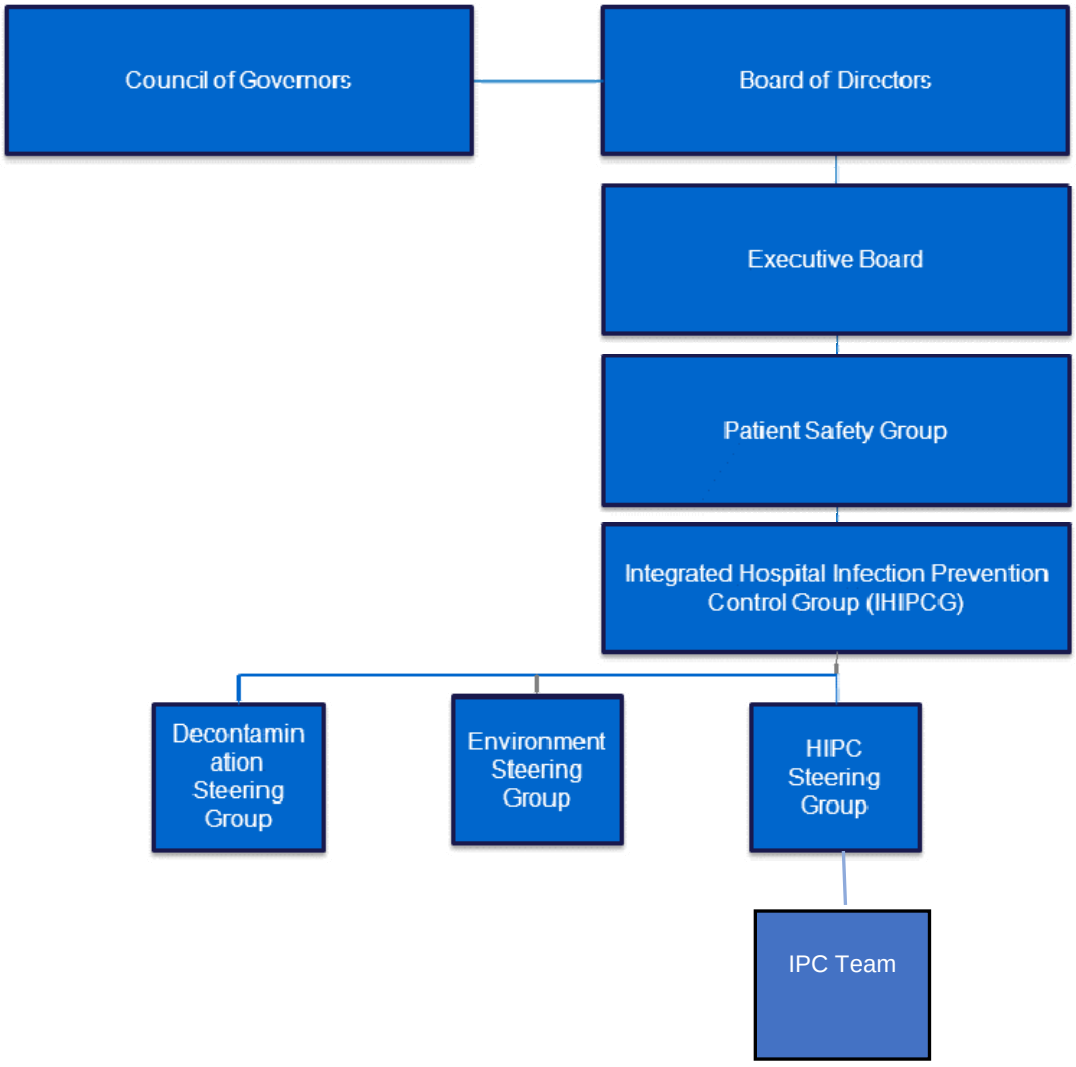
There were 59 cases of *Clostridium difficile* against a trajectory of 59 which was a significant improvement on the previous year. To not exceed this trajectory against operational and staffing pressures reflects the hard work and commitment of Trust staff who strive to deliver the trust values of providing safe care with the best outcome. However the aim in 2015/16 must be to reduce this incidence further.

Unfortunately the same improvements were not seen with MSSA Bacteraemia rates however early indications late in the year following targeted clinical interventions, training and education initiatives begin show a downward trend. There was one case of MRSA bacteraemia at the beginning of 2015 after a period of 527 days.

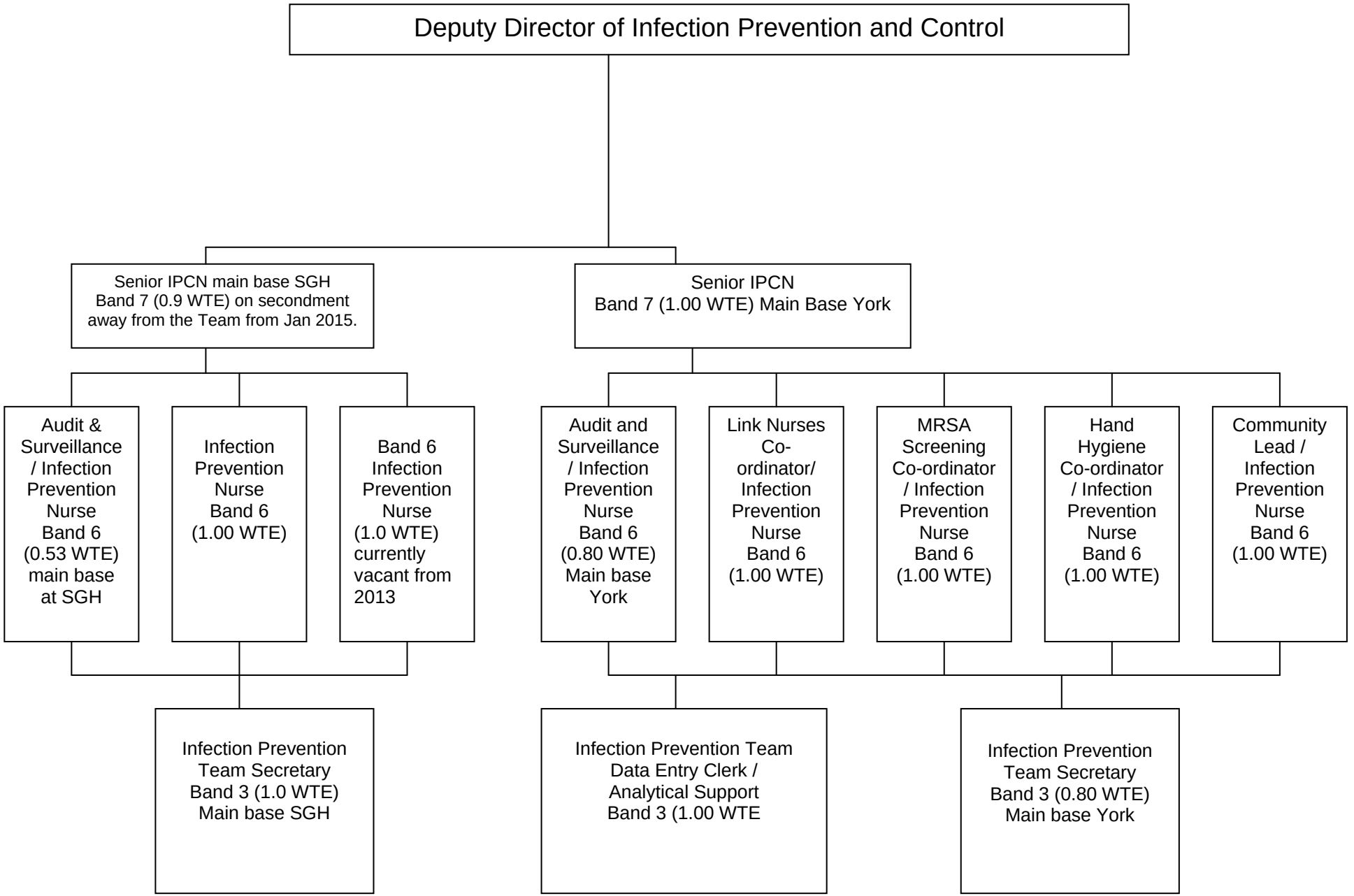
Hand hygiene compliance, following re-education of staff into the application of the WHO 5 moments has begun to establish better understanding and knowledge reflected in audit outcomes with average compliance of 93/95%.

Lack of decant space to enable deep cleaning and high level disinfection in addition to a lack of isolation capacity remain significant risks and gaps in infection in prevention and reduction.

2. Infection Prevention Reporting Structure 2014/15



Nursing Infection Prevention Team Structure 2014/15



Team Structure

The Infection Prevention Team (IPT) provides a service across the ten Trust sites and to our community staff.

It is delivered and supported by:
Director of Infection Prevention and Control (DIPC) and Chief Nurse
Infection Control Doctor/Consultant Microbiologist
Deputy DIPC
1 Band 7 Operational Lead, Second post to be appointed.
6 Band 6 Operational IPN`s
1.4 wte Audit and Surveillance IPN`s
2.8 Admin and Clerical support.

The Team is supported by a Principle Pharmacist/Antimicrobial lead, Consultant Microbiologists and Link Workers across all wards and depts.

IP is represented on various forums across the Trust including Capital Planning, Estates and Facilities, Water Safety Committee, Patient Safety meeting, Performance Improvement meetings, Senior Nurse Meeting and Professional Nurse Leader's forum.

The IP Team work to an Annual Plan that incorporates requirements and recommendations of the Health and Social Care Act 2008;Code of Practice on the prevention and control of infections, NICE and relevant experts bodies.

3. HCAI Performance Summary.

Surveillance of HCAI is carried out to meet Dept of Health mandatory reporting and commissioning requirements of:
Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia – bloodstream infection
Methicillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia
Clostridium difficile infection

MRSA Bacteraemia - In 2014/15 1 case was attributable to the Trust a reduction on the previous year. Tables 1 and 2 shows quarterly and annual incidence since 2012; Figure 1 and table 2 demonstrate comparative regional and national rates per 100.000 bed days.

Table 1: Quarterly MRSA Bacteraemia incidence 2012/15	Apr – Jun 12	Jul – Sep 12	Oct - Dec 12	Jan - Mar 13	Apr – Jun 13	Jul – Sep 13	Oct - Dec 13	Jan - Mar 14	Apr – Jun 14	Jul – Sep 14	Oct - Dec 14	Jan - Mar 15
Attributed to Trust	0	1	0	0	0	2	0	0	0	0	0	1
Trust rate per 100 000 bed days	0.00	1.22	0.00	0.00	0.00	2.21	0.00	0.00	0.00	0.00	0.00	0.99
National rate per 100 000 bed days	1.10	1.13	1.07	1.32	1.12	0.97	1.14	1.01	0.78	0.73	0.86	0.96

Figure 1

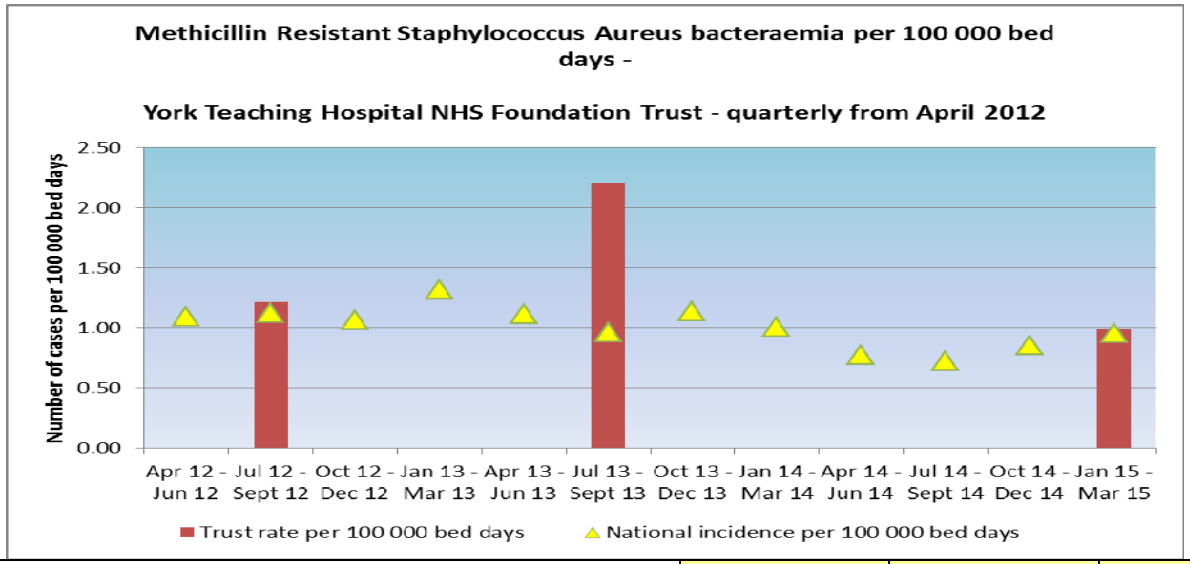


Table 2: Annual MRSA bacteraemia incidence 2012/15	2012-2013	2013-2014	2014-2015

Total number attributed to Trust	1	2	1
Trust rate per 100 000 bed days	0.28	0.6	0.26
Regional rate per 100 000 bed days	1.3	1.13	Unknown
National rate per 100 000 bed days	1.16	1.2	0.8

MSSA Bacteraemia – In 2014/15, 55 cases were attributable to the Trust showing an increase on the previous year. Analysis and investigation showed no link or common source however recurring theme from internal PIR carried out by infection prevention highlighted the presence of invasive devices as probalble contributory factors for which a reduciton strategy has been developed. Objecitves focus largely on improving competence and compliance with Aseptic Non Touch Technique (ANTT) in relation to insertion and ongoing care. ANTT is the internationally accepted practice standard for invasive device management the principles of which translate into safe practice. They ensure a standardized approach that ensures best practice optimizing patient safety.

Early indications are that ANTT e-learning, now integral to Trust Statutory and Mandatory required learning for nursing and medical and a series of competency based workshops for registered staff are having a positive impact in reducing incidence.

Tables 3 and 4 shows quarterly and annual incidence since 2012; Figure 2 and table 4 demonstrate comparative regional and national rates per 100.000 bed days.

Table 3: Quarterly MSSA Bacteraemia incidence 2012/15	Apr–Jun 12	Jul – Sep 12	Oct - Dec 12	Jan - Mar 13	Apr–Jun 13	Jul – Sep 13	Oct - Dec 13	Jan - Mar 14	Apr–Jun 14	Jul – Sep 14	Oct - Dec 14	Jan - Mar 15
Attributed to Trust	10	7	10	6	10	9	5	11	14	9	19	13
Trust rate per 100 000 bed days	12.2	8.53	11.5	6.77	11.1	9.96	5.5	11.3	14.8	9.70	19.3	12.9
National rate per 100 000 bed days	8.29	7.64	7.71	7.73	8.26	8.32	6.95	7.93	7.95	7.9	8.3	8.23

Figure 2

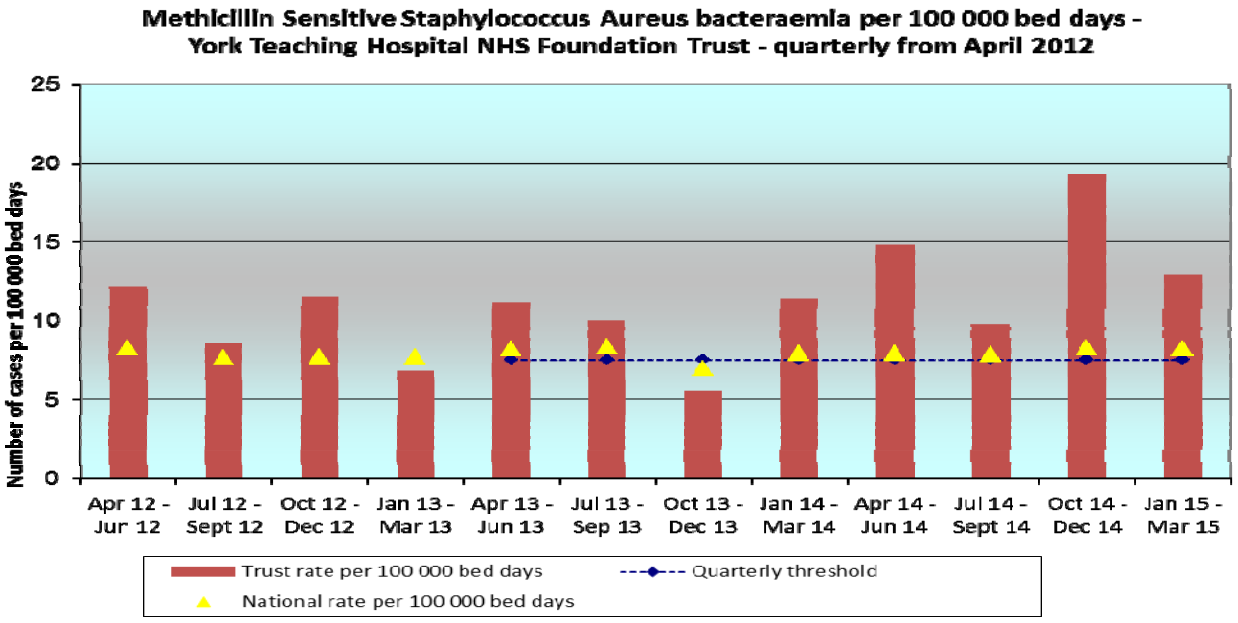


Table 4: Annual MSSA bacteraemia incidence 2012/15	2012-2013	2013-2014	2014-2015
Total number attributed to Trust	33	36	55
Trust rate per 100 000 bed days	90.	10.9	16.6
Regional rate per 100 000 bed days	8.4	9.1	Unknown
National rate per 100 000 bed days	7.8	7.9	8.1

Clostridium difficile infection (CDI) toxin positive – A succesful year in that the Trust achieved its trajectory of 59 cases, a reduction on the previous year. However, the Trust must maintain vigilance and continue to deliver improvements in hand hygiene, sampling, environmental disinfection and antimcrobial prescribing if reduction is to be maintained. Continued monitoring and identification of reductiton initiatives through the CDI Operational Group and reduction strategy that consider all potential Organisational risks are key contributors to sustained reduction that remains a priority for the IP Team.

A probiotic – VSL# was inroduced in August 2014 with the aim of reducing CDI incidence. The impact and benefit will be evaluated as part of Masters Degree by one of our infection prevention nusres and presented to the Antimicrobial Stewardship Team Sept/Oct 2015. The intention to publish this work will be significant contribution to an equivoacal and limited evidence base in relation to the efficacy of probiotic use.

Tables 5 and 6 shows quarterly and annual incidence since 2012; Figure 3 and table 6 demonstrate comparative regional and national rates per 100.000 bed days.

Table 5: Quarterly *C.difficile* incidence 2012/15	Apr – Jun 12	Jul – Sep 12	Oct - Dec 12	Jan - Mar 13	Apr – Jun 13	Jul – Sep 13	Oct - Dec 13	Jan - Mar 14	Apr – Jun 14	Jul – Sep 14	Oct - Dec 14	Jan - Mar 15
Attributed to Trust	13	13	12	16	21	12	21	13	12	10	16	21
Trust rate per 100 000 bed days	15.8	15.8	13.8	18.1	23.4	13.3	23.1	13.4	12.7	10.8	16.3	20.9
National rate per 100 000 bed days	17.7	16.9	17.7	17.1	15.6	15.2	14.6	13.3	14.1	15.9	14.9	15.6

Figure 3

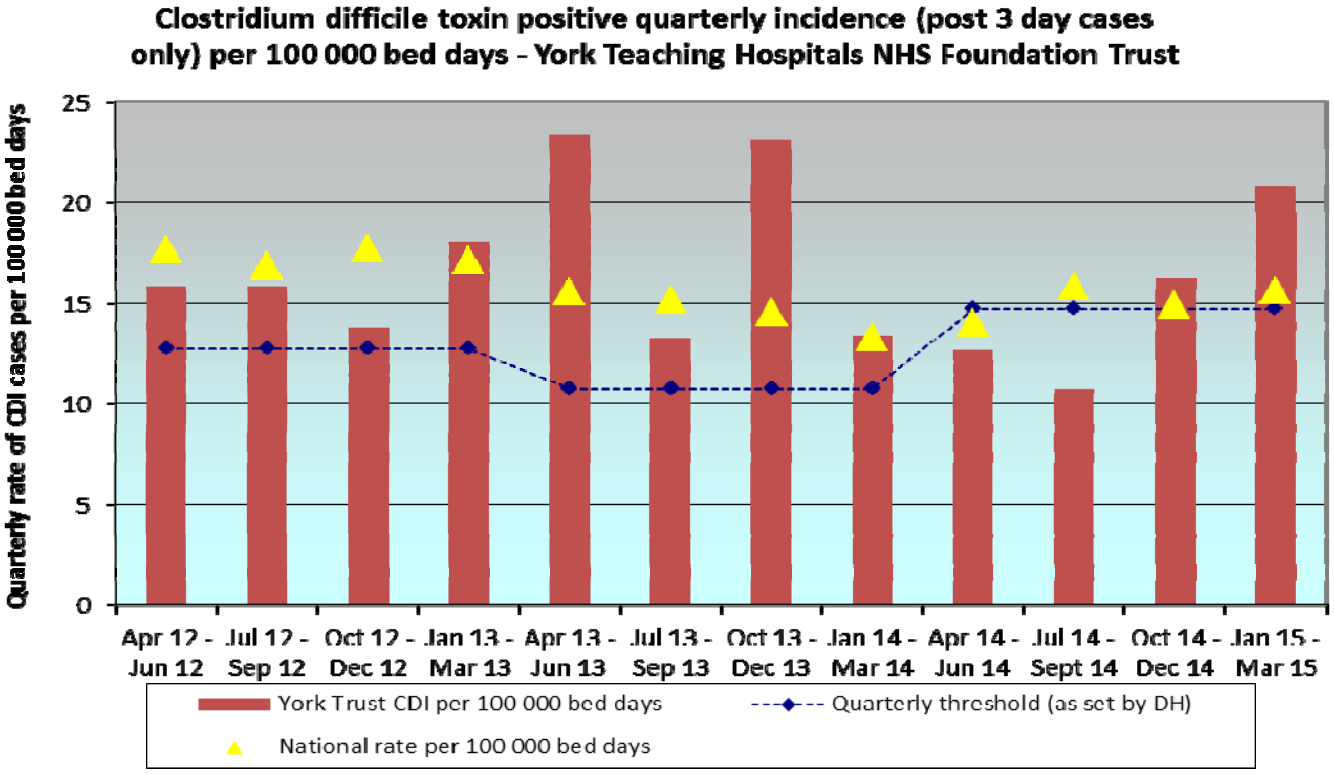
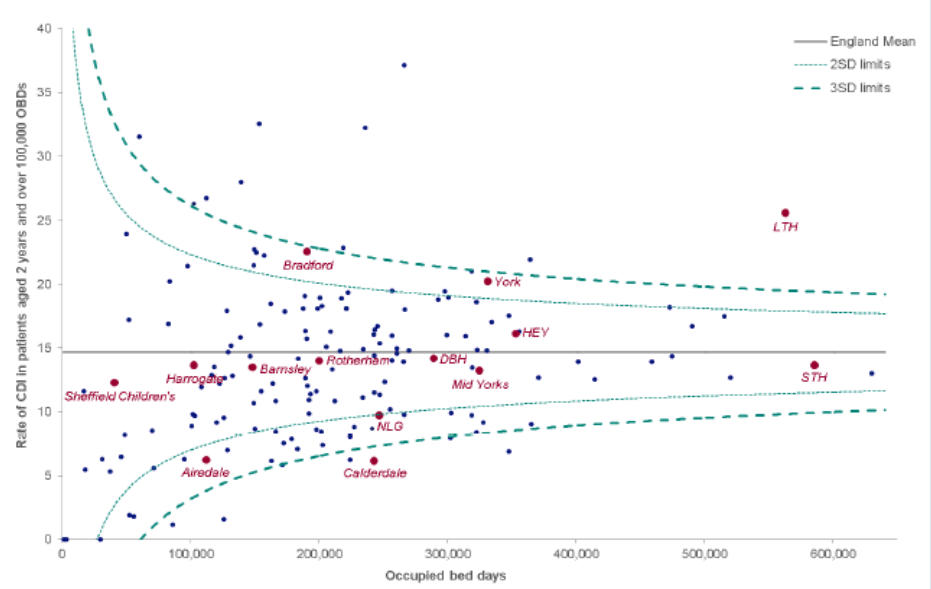


Table 6: Annual *Clostridium difficile* incidence 20102/15	2012-2013	2013-2014	2014-2015
Total number attributed to Trust	54	67	59

Trust rate per 100 000 bed days	15.2	20.2	17.8
Regional rate per 100 000 bed days	18.2	15.8	Unknown
National rate per 100 000 bed days	17.4	14.7	15.1

CDI data below from Yorkshire and Humber HCAI annual reports show the Trust to be 2 standard deviations from the mean in 2014/15 (draft) compared to 3 the previous year demonstrating a downward trend.

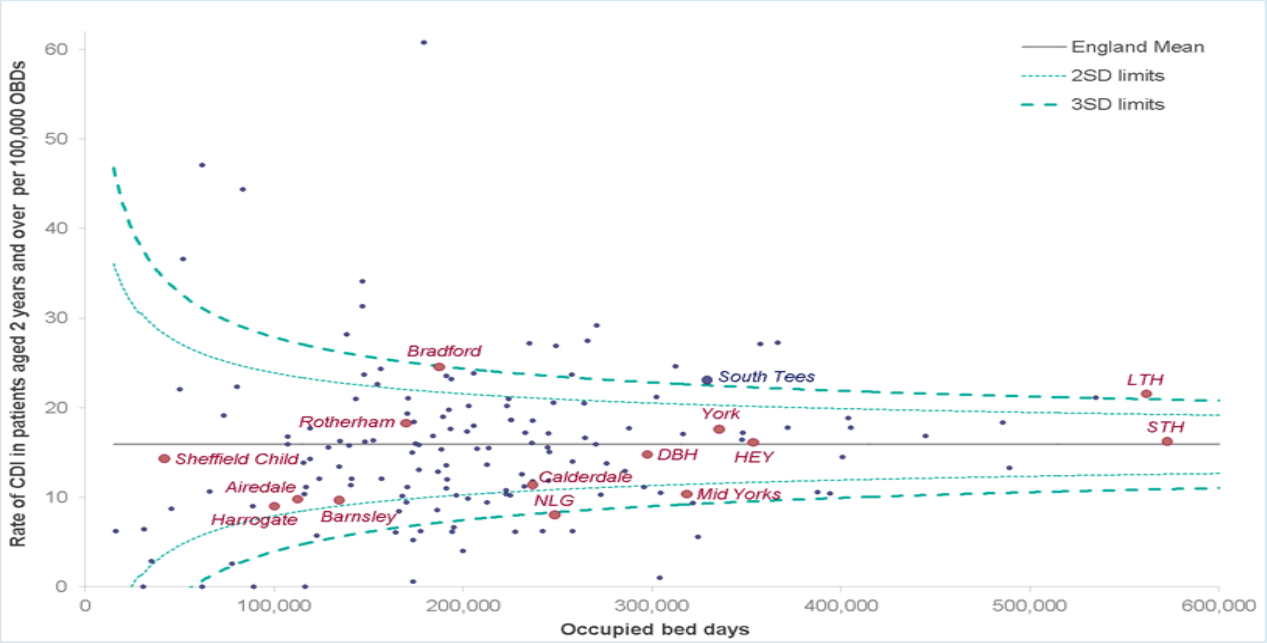
Figure 6: Trust-apportioned *Clostridium difficile* infection (CDI) rates per 100,000 bed days for all England acute NHS trusts in 2013/14
Source: HCAI Data Capture System, May 2014; Points represent all acute NHS trusts in England. Trusts within Yorkshire and the Humber are highlighted; Dashed lines represent control limits at 2 and 3 standard deviations (SDs) around the mean to allow for identification of outlying trusts



NLG = Northern Lincolnshire and Goole; DBH = Doncaster and Bassetlaw Hospitals; Mid Yorks = Mid Yorkshire Hospitals; HEY = Hull and East Yorkshire Hospitals; LTH = Leeds Teaching Hospitals; STH = Sheffield Teaching Hospitals

Figure 8: Trust-apportioned *Clostridium difficile* infection (CDI) rates per 100,000 bed days for all England acute NHS trusts in 2014/15

Source: HCAI Data Capture System, July 2015; Points represent all acute NHS trusts in England. Trusts within Yorkshire and the Humber are highlighted; Dashed lines represent control limits at 2 and 3 standard deviations (SDs) around the mean to allow for identification of outlying trusts



NLG = Northern Lincolnshire and Goole; DBH = Doncaster and Bassetlaw Hospitals; Mid Yorks = Mid Yorkshire Hospitals; HEY = Hull and East Yorkshire Hospitals; LTH = Leeds Teaching Hospitals; STH = Sheffield Teaching Hospitals

Outbreaks and Clusters

Annual seasonal Norovirus (winter vomiting virus) outbreaks occurred late in the year with some, but less impact than in previous years on operational and elective capacity. The locking of connecting ward doors to prevent them being used as thoroughfares and a proactive Hydrogen Peroxide Vapour (HPV) high level disinfection programme developed and delivered using a multidisciplinary approach appear to have had significant impact. The programme enabled ward decoration and refurbishment in some areas, necessary to improve the environment and patient experience.

Figures 4 and 5 show the number of ward closures due to Norovirus for the season 2014/15

Figure 4

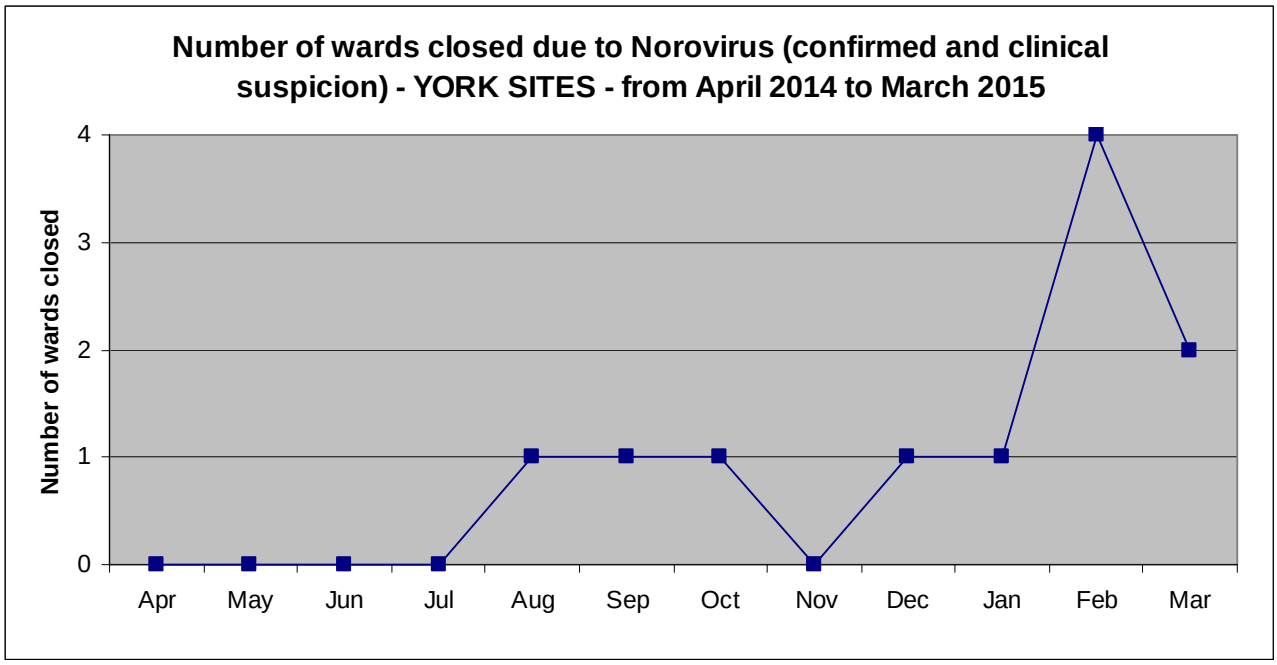
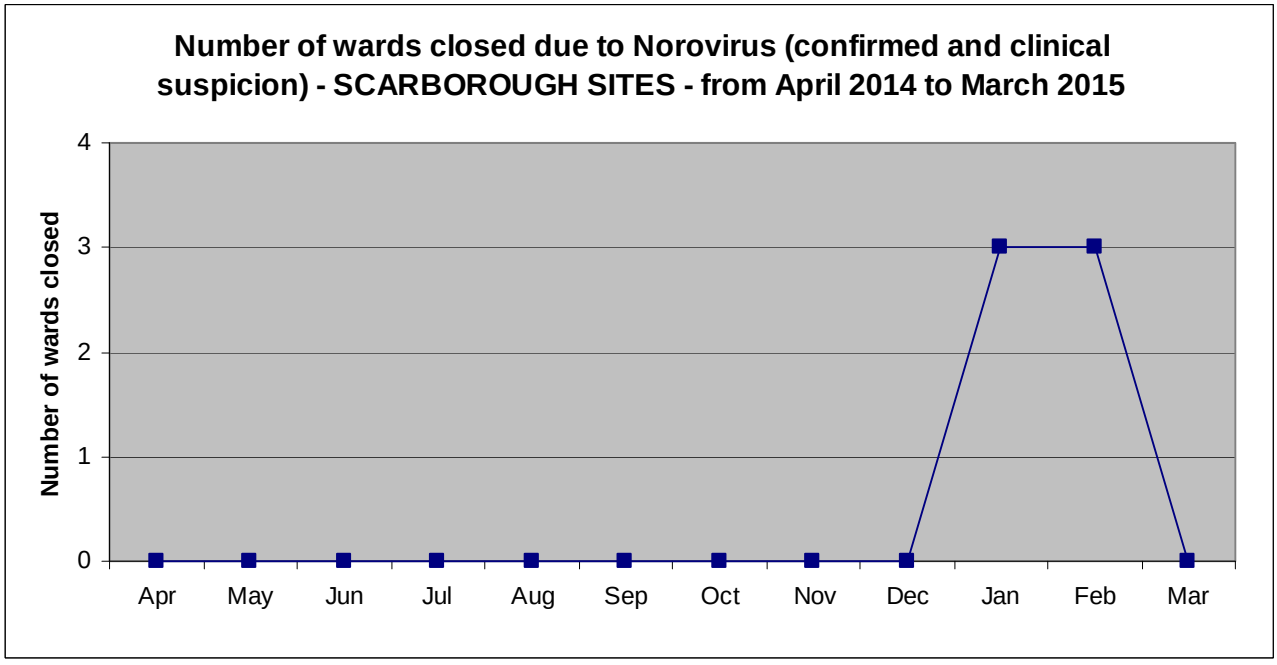


Figure 5



Post infection Review is undertaken for all cases of bacteraemia and CDI. This enables greater scrutiny of cases to identify variation in care and practice. Understanding this generates actions for improvement and quality in patient care/safety.

All patients who develop HCAI are closely monitored and followed up daily by the infection prevention nurses with nursing and when necessary, medical staff.

4. Hand Hygiene

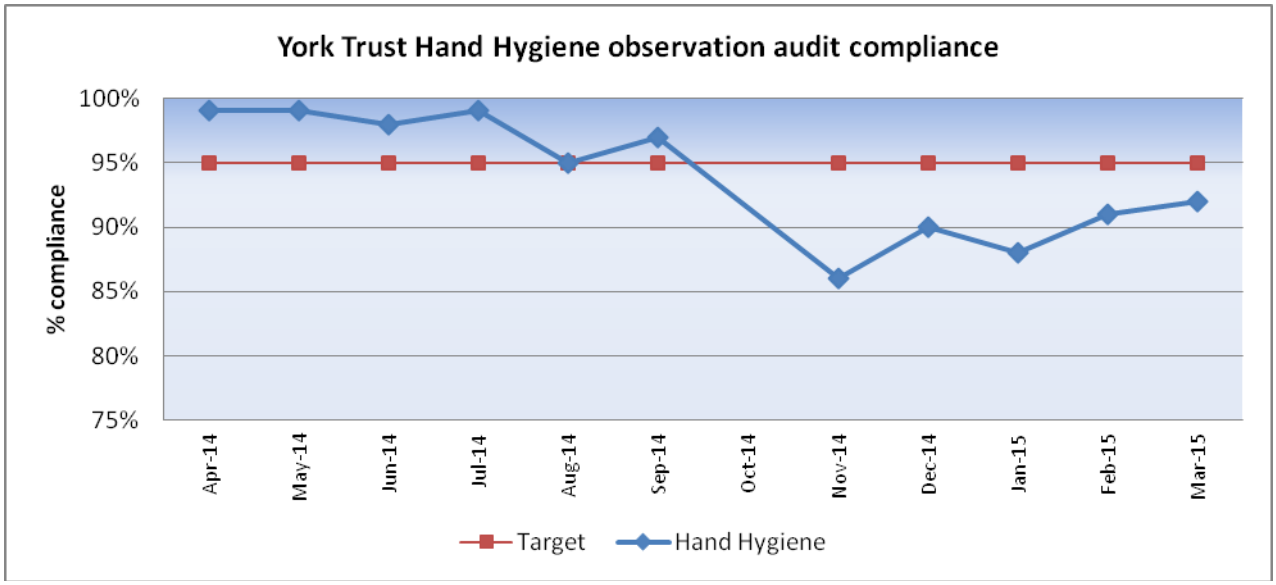
A Trust wide improvement plan implemented during 2014 has led to greater understanding of the World Health Organisation 5 moments for hand hygiene amongst clinical staff. The hand hygiene observation audits have shown consistently improved compliance and less variation in practice across all sites. Actions taken to achieve this include:

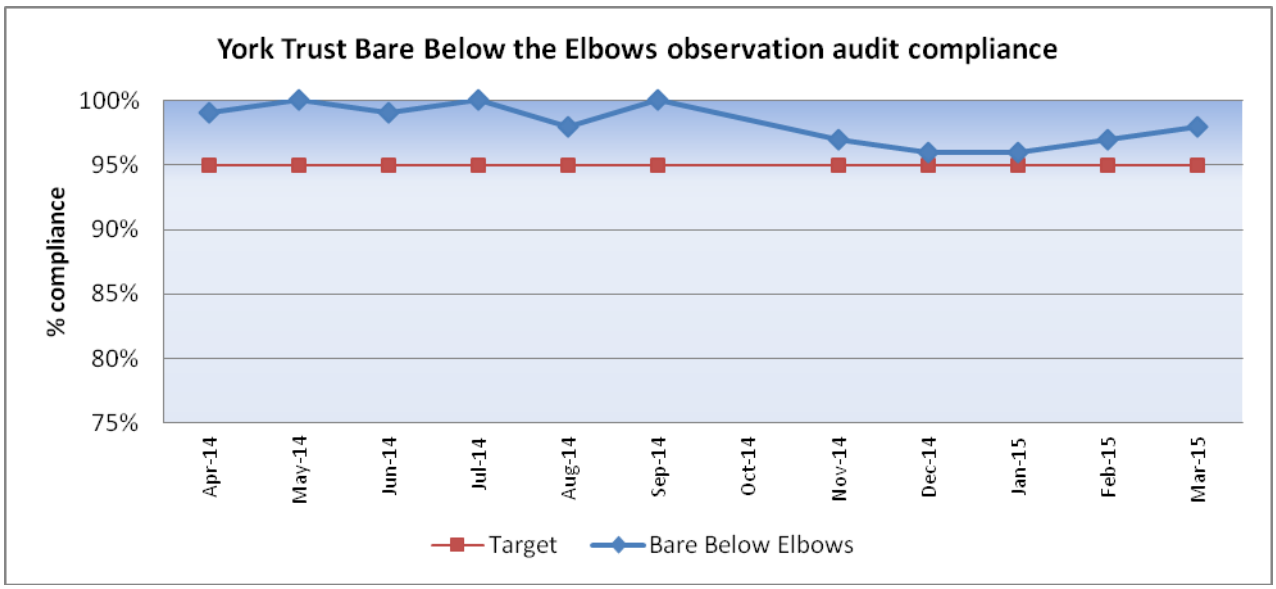
- Revision of the hand hygiene policy/ guidelines
- Revision of the observation audit tool to ensure understanding and consistency.
- Trust wide staff education programme
- Public awareness stands at Trust open days
- Posters to promote easy access to hand wash facilities and inform visitors of the availability and location of hand wash facilities throughout the Trust.

In Nov 2014 the IPT undertook validity testing of the 100% compliance with hand hygiene reporting by conducting an external review that showed actual compliance of 27 – 33%. Our response was to re-evaluate the audit tool and educate staff on how to recognize opportunities for hand hygiene, observe and report accurately.

Subsequent audits demonstrate significant improvement in the quality and accuracy of observation and recording enhancing patient safety and experience.

Data below describes improvements





5. Audit and Surveillance

Audit and surveillance activity continues to monitor and report IP performance internally and HCAI incidence against mandatory requirements of the DH and locally to Commissioners in line with contractual agreements.

IP performance is continually measured against national and local standards/guidance enabling benchmarking, comparison and improvement when required.

Audit and surveillance outcomes are fed back internally to ward/dept leads to support and inform accountability and best practice recommending change/improvement when required.

An Internal Audit Dept report into the management of CDI resulted in significant assurance against 4 key standards and objectives:

- Adequate governance arrangements in place
- Implementation of the Antimicrobial Policy/Formulary
- Implementation of CDI guideline
- Systems in place to ensure compliance is monitored and reported from Ward to Board

6. Policies and Guidelines

All polices and guidelines reflect the requirements of the Health and Social Care Act 2008 (Hygiene Code) and are up to date. Incorporating national/ local evidence, standards and

guidance, implementation is by IP audited to monitor and measure compliance that is reported both to users and the Effectiveness Dept to inform change/improvement where appropriate. These are available to all Trust staff via the IP intranet webpage and to the public via the Trust internet site

7. Antimicrobial Stewardship

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

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

In March 2015 the results for these were 87% and 89% respectively, as compared to 70% and 72% in March 2014. Areas which perform poorly in these audits have had extra input form the antimicrobial pharmacy team to help improve the quality of their prescribing.

Our trial of prescribing of VSL#3 probiotics in conjunction with antibiotics in high risk patient groups is on-going and will be reviewed in Sept 2015

Weekly antimicrobial stewardship ward rounds which include members of the pharmacy antimicrobial team together with microbiology consultants/registrars have proved very successful in reviewing inpatient antibiotic prescriptions.

The Trust participated in the European Antibiotic awareness day in November 2014 with a stand in the main hospital foyer together with promotional materials such as a hospital wide screensaver, quizzes, leaflets and posters. This event was popular with both members of the public and staff and helped to promote our message of safe and effective use of antibiotics.

8. Risk Register

The IP register continues to be subject to quarterly review of risk rating and mitigation through the HIPCG and the Trust Risk Lead.

Risks of 15 and above are discussed with the DIPC via HIPCG and the Trust Risk Lead with consideration as to whether they should considered for escalation to the Corporate Risk Register.

The most significant risks currently focus on the lack of isolation capacity and the inability to deliver an annual deep clean and proactive HPV programme due to lack of permanent decant space. The Infection Prevention and Control Risk Register can be seen in Appendix 1.

9. Clean Safe Environment

Work streams identified through the Strategic Cleaning Review are progressing and the work in relation to staffing levels and hours has progressed. Staffing have been briefed regarding potential changes to working patterns which will Work continues through the Strategic Cleaning Review reports and recommendations to ensure that available Domestic services resources are in the right place at the right time which will ensure that the Trust maintains effective and efficient cleaning arrangements throughout its properties.

An internal audit of cleaning services across the Trust was undertaken during July 2015. The object of the audit was to provide assurance to management, the Board and the Audit Committee that the Trust has effective systems and processes in place to ensure the expected standards of cleaning are met.

The audit established the Trust has effective systems and processes in place to ensure the expected standards are met.
It was acknowledged that cleaning across the Trust is currently undergoing a significant review and recommendations within the audit are being addressed as part of the review. Significant assurance was therefore given.

Facilities continue to work closely with Infection Prevention and Matrons to ensure provision of a clean and safe environment is that of every individual and is embedded as routine best practice.

The Scarborough Environment Steering Group (ESG) continues to meet and is still key to initiating significant environmental improvements to enhancing patient and staff experience.
The York ESG was reconvened prior to the CQC inspection and will continue to meet on a planned basis.

Patient Led Assessments of the Care Environment (PLACE) were undertaken on all in-patient sites between 3rd March and 17th April 2015. The National average for the cleanliness element of the assessment was 97.25%, the Trust average was 99.54%. This was 0.09% lower than 2014 however seven out of our ten sites achieved 100%.

As in 2013, the enhanced cleaning questionnaire for Domestic Assistant's was repeated. This is a set of questions aimed at assessing the knowledge and understanding of the cleaning and disinfection process by Domestic Assistant's when using Chlor clean. This was further supported by refresher training to ensure the competency and consistency of cleaning.

Working with the provider of our disinfectant wipe system IP developed and delivered the `Wipe Out` campaign to nursing and domestic staff. Aimed at improving cleaning/ decontamination

processes in the clinical environment, the programme enhanced awareness of the importance of the contribution of effective cleaning in preventing environmental sources of infection.

Hydrogen Peroxide Vapour (HPV) Disinfection - During the period 01/04/2014 to 31/03/2015 500 HPV deployments were carried out across the Trust of the 500: 285 were reactive (following infection incidents) and the remaining 215 were proactive (planned)

A fully established HPV team was in place by the end of 2014 offering 12 hour cover over 6.5 days per week (Mon - Sat + 1/2 day Sun)

Over that time successful proactive programmes have been carried out at both York and Scarborough with infection control and bed managers playing a major role in making these successful.

Maximum deployment of the service is compromised by lack of permanent decant space on both sites a resource key to maintaining high level disinfection essential to eradication of environmental reservoirs of infection.

10. Patient Information

Patient information in relation to HCAI is available on the Trust internet and intranet sites. Information leaflets regarding specific HCAI are given to patient/relatives on diagnoses fulfilling the requirements of NICE guidance and the Health and Social Care Act 2008; guidance on the prevention and control of infection

11. Education and Training

To increase uptake of training and improve access for all staff groups we have developed a set of e-learning packages. This comprises of a series of scenario based questions and rag rated answers. When a candidate responds, they are taken to a rationale of why their answer is correct (green) mostly correct (amber) or wrong (red) thus even for incorrect responses learning is taking place. We have recently been asked for permission by Corporate Learning and Development to share our particular training resource between other trusts in the region and also a hospital in Lancashire.

Following introduction of e-learning in 2014/15 our compliance has jumped from <50% to being in the green across the board.

Infection Prevention and Control Level 1	5104	4474	88%
Infection Prevention and Control Level 2 (Theory)	4040	3447	85%

PIR outputs:
Invasive device management and variation in compliance with antimicrobial prescribing were a recurring themes identified at Post Infection Review in relation to CDI and bacteraemia incidence. Raising awareness through ward based teaching, PNLF and F2 training days appear to be initiating a downward trend however e-learning and competency based training are being developed for early 2015/16 in relation to ANTT with the aim of expediting further reduction. Feedback of the audit of compliance with antimcrobial prescribing is generating greater awareness and engagement from clinicians in adopting good prescribing and stewarship.

12. Link Worker Network

104 staff are designated IP link workers across the Trust which includes nursing and allied health professionals.

Bi- monthly meetings continue at both York and Scarborough with an average attendance of between 6 and 12 attendees reflecting the constraints of frontline pressures acknowledged across the NHS impacting on the ability of staff to be released from clinical areas to access specialist training and educational opportunities outside of Statutory and Mandatory that support best practice and professional development. The Trust is working hard to address this through staffing and recruitment initiatives.

Topics covered

- Water Safety
- Carbapenemase Producing Enterobacteriaceae
- Respiratory virus presentation.
- Practical session on use of PPE
- Training of the GAMA Healthcare 'Wipe Out' Campaign commissioned by the IPT to update clinical and domestic staff on current best practice in relation to the systems and processes required to maintain a safe clean environment
- The Chain of Infection
- HCAI trajectories, performance and responsibilities
- Update on Hand Hygiene and revision of the WHO tool to improve understanding of and compliance with the 5 key moments.
- Update and discussion on Influenza
- Detailed discussion on ANTT practice workbook and e-learning.
- Urinary catheter management delivered by specialist company incorporating ANTT

13. Conclusion

Over the period 2014/15 we have had to adapt ever more to the changing nature of the organisation in terms of client base, activity and capacity. Our bed occupancy continues to increase, as does the number of complex procedures undertaken. Our patients are more vulnerable requiring more medical intervention and antimicrobials. We must therefore, continue to review acutely prevention and control measures and invest more in a proactive approach with regard to Infection Prevention from Board to Ward.

We also continue to reinforce good prescribing practice along with the introduction of probiotics. We continue to improve our investigative and review processes for HCAI to ensure that we can ascertain learning points and form action plans to prevent risk and variation in practice that create the potential for harm from avoidable infection.

HCAI incidence for 2014/15 was - MRSA bacteraemia 1 case against a de-minimus of 6 set by Monitor but national zero tolerance by DH; MSSA bacteraemia 55 cases against a local trajectory of less than 30 cases; *C.difficile* 59 cases against a national trajectory of 59.

Significant challenges remains in relation to isolation capacity and lack of permanent decant space on both acute sites to enable annual deep cleaning and a proactive programme of high level disinfection (HPV) to reduce and eliminate environmental reservoirs of infection. The HPV service is now fully resourced and should be facilitated and supported to deliver what is a key control measure in achieving sustainable reduction in HCAI experienced by more successful Trusts. Reactive deployments with daily review of proactive HPV opportunities by Bed Managers and the HPV team afford some degree of mitigation. Whilst risk assessment on a case by case basis when competition occurs for isolation rooms enables the planning of safe management of HCAI, it also means that patients are moved out of isolation sooner than is best practice.

Infection Prevention Control Risk Register 2014/16

Risk No	Risk Area			Risk Description	Mitigation				Risk Rating	Reduce or Eliminate	CRC VIEW
	What is the area of risk?	Specifics	Current or potentia	Description	Mitigation	Current Status	Responsible Officer	To be completed by	In numbers	R or E	
	What is it overarching area of risk	*What is the specific Sub area*	*Does the risk exist or is it anticipated?*	*Accurately describe the risk*	*Describe the key actions being taken to mitigate the risk*	*What is the current status of the risk*	*Who is leading on the actions*	*When is the completion date*	*What is the current risk rating*	*will the actions reduce or eliminate the risk*	*What is the view of the CRC*
1	Patient Safety	Isolation	Current/Future Risk	There is a signficiant and material risk of outbreaks of infection resulting from insufficient isolation facilities within the trust, caused by growing resistance of organisms to antimicrobials. This is exacerbated by increasing incidences of the Trust being on red alert and having to move patients out of side rooms to balance risk. This may result in severe patient harm/death, regulatory intervention and loss of Monitor license	Action is being taken to mitigate through risk assesment lead by IPC, Bed Managers and Nursing leads aimed at maintaining side rooms for patients with high risk transmissable infections. A programme of deep cleaning each ward and high level HPV disinfection both proactive and reactive. Monitored via HIPCG and The Board	Current Risk with *Clostridium difficile incidence. Proactive HPV programme ceased due to lack of decant space. COO informed June 2015, Op`s Teams to develop prgramme for over summer months.*	DIPC, COO, IPT	Ongoing risk mo	15	R	
2	Patient Safety	Contractual	Current internal Risk	There is a signficiant and material risk of delivering contractual requirements relating to *C.difficile* and Bacteraemia caused by variation incompliance with MRSA screening, hand hygiene, aspetic non touch technique (ANTT), blood culture sampling, antimicrobialstewardship and intravenous line care. This may result in incurring commissioner fines and regulatory intervention	Monitoring of current performance is being undertaken on a weekly basis via Q&S and Corporate Directors and fortnightly through the CDI Operational Group. Post Infection Review (PIR) for cases of *C.diff* and bacteramia are completed. Reporting to the Board is via the DIPC monthly and quarterly via formal DIPC reports. Hand hygiene is audited as is antimicrobial prescribing with feedback being provided to clinical staff . An IV specialist role has been appointed to the Infection Prevention Team and initiatives aimed at enhacning ANTT standards, practice and compliance are being developed. Papers x 2 to EB requesting support for ANTT initiatives submitted March 2005. ANTT e- learing in place via Stat amd Mand training for Nursing and Medical staff from May 2015 - 643 uptake at 20.7.15. ANTT competency workshops delivered to 250 senior nursing staff during July. Cannulation pack, skin prep and electronic documentation being progressed.	Currently over monthly trajectory for *C.diff* MSSA. At de-minimus limit for MRSA.	Infection Preventin Team. DIPC.	31/03/2016	15	R	
3	Patient Safety	Staffing	Current Internal risk	There is a significant and material risk in our ability to proactively develop and deliver the Infection prevention Service across all trust sites. This is caused by long term sickness and subsequent temporary re-deployment of those from Scarborough site creating only a reactive service at Bridlington and local community hospital sites . This may result in an increased incidence of hospital acquired infections and reduction in staff competence with regard to infection prevention	Actions have been taken to deploy IPNs on a rotational basis across the acute sites, and we have transferred our IT Infection Prevention Electronic documentation across both acute sites to enable continuity. Policies have been updated and integrated across sites. This monitored via HIPCG , the HPICG Steering Group and reported to the Board. New staff are now being recruited to the team.	Current risk with reduced staffing numbers on SGH site. However Band 7 commenced July 2015. Band 6 vacancy remains	Deputy DIPC, Chief Nurse	31/05/2015	15	R	
4	Patient Safety	Competence Framework	Current internal Risk	There is a significant and material risk through the lack of a robust competency and training framework for Trust staff who insert and manage invasive devices. This is caused by a lack of measure of operational competence and may result/be contributing to in an increase in MSSA/MRSA bacteraemia and blood culture contamination.	An Intravenous line management nurse has been appointed for 12 hours a week on a 6 month secondment from ICU on the York site. The role will be replicated on the SGH site from March 2015. ANTT initiatives as described will assist with improving knowledge and competency. We are working collaboratively with key front line staff to improve intravenous device practice and management. This is being beng overseen by the HIPCG Steering Group and reported to the Board via the DIPC. There is a need to evaluate with ODIL staff competency frameworks for device management.	Current increase in Bacteraemia and blood culture contamination	Deputy DIPC	31/03/2016	15	R	
5	Patient Safety	Environmental	Current internal Risk	There is a significant and material risk due to the lack of permanent and adequate decant facitlities to enable deep cleaning and high level HPV disinfection on both acute sites. This is caused by a lack of adequate space and operational pressures and may result in patient harm from environmental reservoirs of infection.	There is collaboration with operational leads to factor this into annual resilience planning however this tends to be ad hoc and operational pressures often take priority. This is monitored via HIPCG Steering Group and HIPCG	Risk remains high due to the inability to decant high risk areas in a sustainable way	Deputy DIPC, DIPC, COO	31/03/2015	15	R	

6	Patient Safety	Operational	Current internal Risk	There is a significant and material risk to elective orthopaedic patients on Kent Elective Orthopaedic Ward at Bridlington, this is caused by day case patients (screened and treated) going through the ward. However patients going through a day case unit would not normally be screened and treated. This may result in subjectiing patients to unnecessary screening and treatment. This does not happen in York. Day case patients are subjected to unecessary screening and prophylactic treatment not to protect them but to protect	A meeting to discuss the issues is scheduled to take place and will report the suggested recommendations and policy review to the HIPCG Steering Group	Risk continues to exist as practice remains unchanged pending outcome of plans for Orthopaedic centre to located at BDH.	ICD & Deputy DIPC	Ongoing alongsi	12		
7	Patient Safety	Clinical Standards	Current internal Risk	There is a significant and material risk observed through case follow up of variation in compliance with infection prevention practice at clinical level. This is caused in part by level of knowledge, understanding and implementaion of IP policy and procedures at clinical level for which assurance and accountability requires strengthening. This may result in patient harm caused by a possible increase in infection.	Bespoke training sessions covering key IP practices are being delivered proacitvely at Ward level in addition to when clusters and outbreaks occur . Attendance at Senior Nurse meetigns, PNLF and Governance meetings by IPN`s enables education and learning opportunities. This has been escalated to the Chief Nurse team .	The continued risk is evidenced by HCAI incidence and periods of increased incidence/clusters of infection in specific areas of the Trust	Chief Nurse Team, IPT	31/08/2015			
	Staff and Patient safety	Health and Safety	Current Risk	HSE (OC282/28) state that it is a legal requirement that anyone required to wear a respirator is fit-tested in order to check that an adequate seal can be achieved. Fit testing is model and brand specific and needs to be carried out by a qualified trainer. There are insufficent front line staff fit tested and trained to fit test despite training offered. Low uptake due to lack of avail staff at all levels to attend training provided by Ful lSupport via IP	Escalated to Health and Safety and Occupational Health Leads for advice and collaborative action	Risk remains due to insuficient numbers of fit tested frontline staff.	IPT. OHD and H&S need to respond too		15		

Notes

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Community Services Update

Action requested/recommendation

The Board is asked to note the progress of Community Hubs in Ryedale and Selby and District.

Summary

This paper updates the Board on the progress of Community Hubs in Ryedale and Selby and District.

The Board is asked to note progress to date.

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 Prepared for presentation to the Board of Directors.

Risk	No risk.
Resource implications	Resource implications are detailed in the report.
Owner	Wendy Scott, Director of Community Services
Author	Wendy Scott, Director of Community Services
Date of paper	September 2015
Version number	Version 1

Board of Directors – 30 September 2015

Community Services Update

1. Introduction

In April 2014, York Hospital NHS Foundation Trust (YHFT) was asked by local commissioners to develop a proposal for a 'Care Hub' model in both Selby and District and Ryedale localities. In response to this YHFT developed an initial proposal and this was presented to both Vale of York and Scarborough and Ryedale Clinical Commissioning Groups (CCGs); at this stage the proposal outlined a potential service model along with an estimate of activity and service costs. On this basis permission was granted by the CCGs to progress and a more detailed proposal was developed. This was co-created with local stakeholders including local GPs, voluntary sector organisations and the local authorities. A final, more comprehensive proposal was presented to and signed off by CCGs in September 2014. A service launch date of January 2015 was agreed and funding secured until September 2015. It was acknowledged that ongoing funding would be dependent on the outcome of a jointly agreed evaluation process.

The 'Care Hub' model is an umbrella term used to describe a collection of interrelated and interdependent services that deliver community based care to the population in the Selby and District and Ryedale localities. This model is predicated on the delivery of services by health, social care and voluntary sector professionals working together as an integrated team. These services (where appropriate) can offer a referrer a viable alternative to traditional hospital services. This type of service is often called 'intermediate care'.

As part of the engagement process stakeholders clearly identified that there was an absence of local intermediate care services that could provide an alternative to traditional hospital based services. At this time, in the Selby and District locality 5 of the 7 GP Practices had a hospital admission rate higher than the Vale of York CCG average and they attributed this in part to the lack of alternative provision. Additionally, stakeholders also identified a need to better support residents in care homes, particularly residents in their last year of life. Local GPs were keen to secure protected time, clinical expertise and support from hospital consultants to help them to better manage this cohort of patients.

On this basis the Selby and Ryedale Care Hub models have focused on three key service developments:

1. A Community Response Team - an integrated health and social care 'response and reablement service' that can mobilise quickly (over 7 days) and provide up to 6 weeks reablement/intermediate care. This service has 3 main aims, these are to:

    - Help people avoid going into hospital unnecessarily
    - Help people to be as independent as possible after a stay in hospital

- Prevent people from having to move into residential care after a stay in hospital

2. Care home in-reach – a rolling programme of care home visits, provided jointly by Care of the Elderly Consultants and local GPs.

Weekly multi – disciplinary frailty clinics – Care of the Elderly Consultant led outreach clinics provided at Malton and Selby Community Hospitals and Tadcaster Health Centre.

2. Progress to Date

Selby

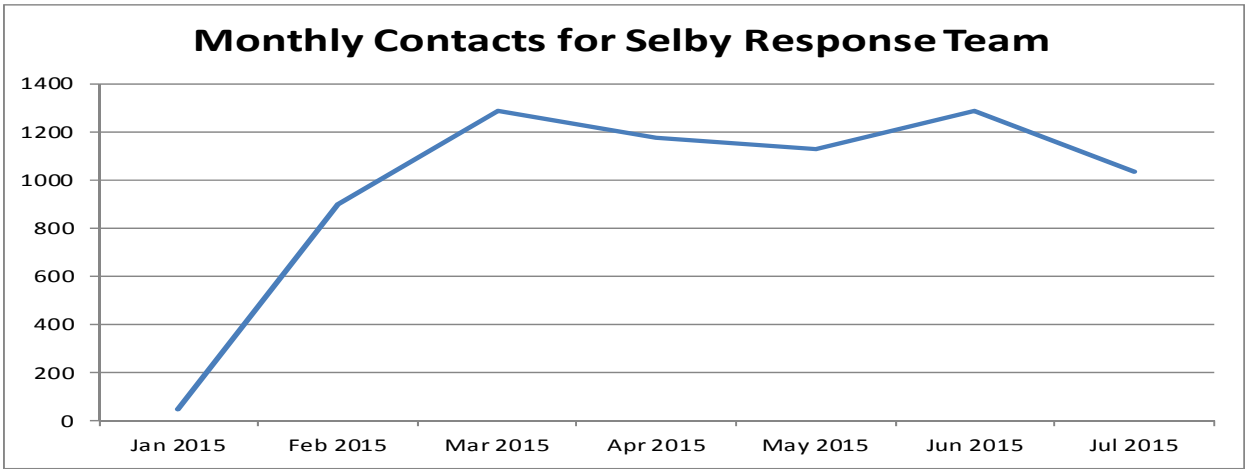
Community Response Team:

Table 1 shows the referrals received by the Selby Community Response Team since the service launched at the end of January 2015. The team is asked to record whether referrals are 'step up' or 'step down'

Table 1

Ref Received Month	Step Up	Step Down	Not Specified	Total by Month
Jan 2015	6	6	9	**21**
Feb 2015	13	21	32	**66**
Mar 2015	32	17	16	**65**
Apr 2015	32	24	10	**66**
May 2015	42	21	3	**66**
Jun 2015	37	27	4	**68**
Jul 2015	47	15	3	**65**
Total to Date	**209**	**131**	**77**	**417**

The graph below illustrates service user contacts generated as a result of these referrals. Over 70% of these contacts are delivered by Generic Support Workers who can deliver nursing, therapy and personal care interventions. At service launch at the end of January 2015, it was recognised that the team was not fully established; the number of contacts has risen quickly as the service has recruited to full establishment; this has been maintained.



It is recognised both locally and nationally that measuring the impact of intermediate care services is challenging. The Kings Fund has developed a body of evidence about this issue. Overall growth in demand for hospital and community services, the multiplicity of local hospital avoidance schemes aimed at tackling this and the time needed to embed intermediate care services such as this present real challenges when trying to demonstrate to commissioners that these services can impact on admission avoidance rates/targets and deliver value for

money.

YHFT has agreed with commissioners a range of key performance indicators and metrics (both quantitative and qualitative). These seek to determine the impact of these new services; they are reported on a monthly basis. Table 2 below sets out data in relation to three key outcome measures, occupied bed days, non-elective hospital admissions and hospital admissions due to falls. For each we have compared the level of activity since the service launched at the end of January 2015 to the equivalent period in 2014. Those GP practices not covered by the Care Hub services are shown as a control group.

Occupied Bed Days

	Selby GPs		Non-Hub GPs	
	Aged 75+	Aged 65+	Aged 75+	Aged 65+
Feb-Jul 14	9041	11713	63154	80373
Feb-Jul 15	8547	11662	67920	87342
% Change	-5%	0%	8%	9%

Non Elective Admissions

	Selby GPs		Non-Hub GPs	
	Aged 75+	Aged 65+	Aged 75+	Aged 65+
Feb-Jul 14	936	1354	5815	8342
Feb-Jul 15	946	1437	6334	9106
% Change	1%	6%	9%	9%

Admissions due to Falls

	Selby GPs		Non-Hub GPs	
	Aged 75+	Aged 65+	Aged 75+	Aged 65+
Feb-Jun 14		136		675
Feb-Jun 15		125		824
% Change		-8%		22%

Table 2 - this table shows that occupied bed days for patients aged over 65 years registered to Selby GPs has remained static whilst the control group increased by 9%. For the over 75 years group patients registered with Selby GPs reduced by 5% whereas the control group increased by 8%. For non-elective admissions patients registered with Selby GPs increased by 6% and 1% respectively in the over 65 years and over 75 years age group compared to a 9% growth in both age groups in the control group. Hospital admissions due to falls in the over 65 years age group saw an 8% reduction in Selby compared to a 22% growth in the control group.

Care Home In-reach:

The care home in-reach service in Selby has to date included 30 joint visits to local care homes. Data analysis relating to 26 of these visits has shown that 213 residents have received a joint review and this in turn has resulted in 259 discontinued medications. Several bespoke training sessions have also been organised for care home staff based on needs identified during the review sessions.

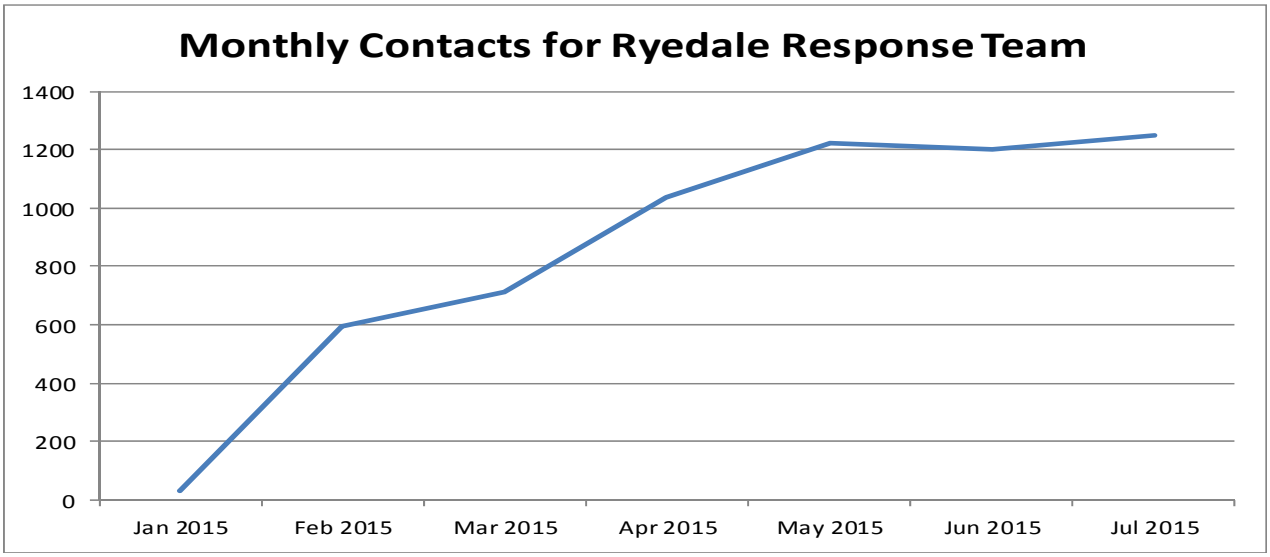
Ryedale

Community Response Team:

The table below shows the monthly referrals received by the Ryedale Community Response Team. The team is asked to record whether referrals are ‘step up’ or ‘step down’.

Ref Received Month	Step Up	Step Down	Not Specified	Total by Month
Jan 2015	3	0	2	**5**
Feb 2015	40	18	1	**59**
Mar 2015	28	18	3	**49**
Apr 2015	23	16	3	**42**
May 2015	35	16	2	**53**
Jun 2015	25	21	3	**49**
Jul 2015	29	18	0	**47**
Total to Date	**183**	**107**	**14**	**304**

The chart below shows the growth in contacts for the Ryedale Community Response Team. Again over 70% of these contacts are delivered by Generic Support Workers. Recruitment into the Ryedale Team has been much more challenging and has taken longer than Selby; this is reflected in a slower growth.



Occupied Bed Days

	Malton GPs		Non-Hub GPs	
	Aged 75+	Aged 65+	Aged 75+	Aged 65+
Feb-Jul 14	6945	9213	63154	80373
Feb-Jul 15	7381	9745	67920	87342
% Change	6%	6%	8%	9%

Non Elective Admissions

	Malton GPs		Non-Hub GPs	
	Aged 75+	Aged 65+	Aged 75+	Aged 65+
Feb-Jul 14	693	1021	5815	8342
Feb-Jul 15	730	1050	6334	9106
% Change	5%	3%	9%	9%

Admissions due to Falls

	Malton GPs		Non-Hub GPs	
	Aged 75+	Aged 65+	Aged 75+	Aged 65+
Feb-Jun 14		75		675
Feb-Jun 15		91		824
% Change		21%		22%

Table 3 -This illustrates the impact of the Ryedale Community Response Team by comparing the Malton GPs with the control group. Ryedale Hub services have been slower to get off the ground as a result of recruitment challenges.

Data suggests that occupied bed days increased by 6% for both 65 years and 75 years age groups compared to 8% and 9% respectively in the control group. Non-elective admissions increased by 3% for those over 65 years and 5% for those over 75 years compared to 9% growth for both age groups in the control. Hospital admissions due to falls were similar at 21% and 22%.

Care Home In- reach:
The care home in reach service in Ryedale has now reviewed all care home residents. This has resulted in 220 medications being stopped, 65 new or updated DNACPR forms being put in place and 151 new or updated care plans being developed. Positive feedback has been received from local GPs, care homes and also North Yorkshire County Council (NYCC) who have reported that this review process has supported their homes in ensuring compliance with Care Quality Commission requirements.

3. Challenges

Recruitment
Both Community Response Teams launched in January 2015. At this time neither team was staffed to full establishment and integration with NYCC social care assessment staff had not yet taken place. Since January significant progress has been made in terms of both recruitment and integration with NYCC teams. Both Selby and Ryedale teams are now nearing full establishment and operating at near optimal capacity. Also NYCC and YHFT staff are now co located at Selby and Malton Hospital and working together to deliver an integrated service.

Uncertainty regarding recurrent funding
Both Care Hub projects are funded via the North Yorkshire Better Care Fund. A review of all Better Care Fund projects is currently being undertaken by both Vale of York CCG and Scarborough and Ryedale CCG in conjunction with NYCC. A decision on future funding arrangements will be made in October 2015.

Challenges in demonstrating the impact of Care Hub services
The challenges associated with evaluating the impact of intermediate care services are well recognised. Often these services take time to develop and embed and bringing health and social care staff together to work in different ways is challenging.

There is a tension in the system; it is generally acknowledged that making judgements about the success or otherwise of major changes should not be made prematurely, indeed lessons from elsewhere show that waiting 2 years before passing judgement is not unreasonable. However, this is contrasted by the sense of urgency created by the pressure in the system to reduce hospital activity and to do it now. There is a danger that CCG's will abandon current schemes to try something else by making judgements too early. There is a need for a collective 'holding of nerve'.

Intermediate care schemes such as those delivered as part of the Care Hub model are in the main aimed at avoiding hospital admissions and facilitating early discharge from hospital. A reduction in hospital admission rates, hospital length of stay and occupied bed days are often used as a proxy measure of success. However, it is also recognised that local health and social care systems will have already implemented a wide range of schemes aimed at supporting admission avoidance and effective discharge from hospital, so these measures are in fact impacted by a much broader range of factors making causality difficult to prove. In addition, rising demand for health and social care services as a result of demographic changes make achieving reductions in activity very challenging and it suggested that managing growth in demand, rather than achieving a significant reduction may be a more realistic ambition.

NYCC, Vale of York and Scarborough and Ryedale CCGs and YHFT recognise that significant progress has been made in establishing Care Hub services and developing integrated multidisciplinary teams. Patient and stakeholder feedback is also extremely positive. Outcome data collected since services launched at the end of January (up to end of July) is relatively inconclusive at this stage, however, there appear to be enough 'green shoots' to support the continuation of these schemes to allow them to continue to mature; more time is needed to embed these services and further work re measuring service impact and patient outcomes is required in order to demonstrate with confidence the effectiveness of the Care Hub services.

The Provider Alliance will take a key role in developing our own hub pilot and those of others (Priory Medical Group and Pocklington) by encouraging the contribution of other providers and by developing a single model for out of hospital care, which brings together the best and most successful elements of each of the sponsored schemes.

4. Partnership Working

Primary Care

Despite initial resistance local GP leads have been enthusiastic champions, leading individual work streams and promoting new services with colleagues. In particular effective relationships have been forged with SHEILD GP Federation in Selby and Derwent Practice in Malton. A local GP from Derwent Practice with an interest in older people's care now jointly delivers a weekly multi-disciplinary clinic at Malton, working alongside a Care of the Elderly Consultant. GPs have reported that the care home in-reach service has given them an opportunity to build relationships with both community and hospital staff.

Local Authority

The Community Response Team service model is jointly delivered by YHFT and NYCC staff working in partnership. Staff have been co-located together and report that this has facilitated a reduction in hand-offs and allowed planning of longer term social care support (including adaptions to housing and access to benefits advice) at the start of an intervention rather than as previously, later in the pathway. Staff are able to exchange knowledge and skills and have a growing appreciation for each other's work. This has facilitated more effective communication and a 'bottom up' approach to identifying new ways of working together.

Community and Voluntary Organisations

In co-producing the Care Hub model, important relationships have been developed with a host of local organisations. In particular, the Ryedale Coast and Vale Community Action (CAVCA) and Selby Association of Voluntary Services. In Ryedale this has resulted in CAVCA

relocating their administrative function to Malton, co-located with the Community Response Team. This has facilitated a partnership approach that has resulted in the trial of an innovative new role, the Community Enabler. The Community Enabler role provides a link between the statutory teams and local community and voluntary organisations. They identify where support could more appropriately be provided by third sector organisations and proactively arrange this. Local GPs are also interested in trialling this approach.

The Provider Alliance now provides the opportunity to develop the relationship between providers on the patch more effectively.

5. Recommendation

The Board is asked to note the progress of Community Hubs in Ryedale and Selby and District.

Author	**Wendy Scott, Director of Community Services**
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Date	**September 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 22 September 2015 – Boardroom, York Hospital

Attendance: Mike Sweet Chairman, Andrew Bertram, Steve Kitching, Lucy Turner, Graham Lamb, Libby Raper, Amanda McGale (item 5 only)

Apologies: Mike Keaney, Anna Pridmore, Juliet Walters, Sue Rushbrook

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes Dated 17 August 2015**	The agenda covered the following AFW and CRR items AFW EF1 DoF1,2, 4,7 CRR CE1 DoF 1-3	The notes of the last meeting have been approved with the following correction: Under section 2 Finance Report the second paragraph should be amended to read "Expenditure remains high. Spend on nurse agency of £1.6m in July and £3.5m in the first four months of the financial year. Last year nurse agency costs were £4m for the full year."		
2.	**Matters arising**		The Committee noted that the SRG (CCG Chaired) has responded to the recent Monitor/TDA Tripartite letter regarding whole system improvement action in relation to 4-hour and ambulance turnaround performance. The Committee expressed its concern that the response was inadequate and did not present an effectively joined up system-wide approach. The Committee welcomed the continued dialogue the Trust Executive team are having with Monitor.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
3.	**Risk Register**		Following a detailed discussion around the risk score for item DoF 5 the register entries were agreed. MS asked AB to justify the score given for this entry. Discussion also considered the risk scores for risks COO2 and COO3. The Committee were ultimately satisfied with the references and scores.	The Committee were assured that the risks included in the registers were being discussed by the meeting.	
4.	**Overview of TAP**		Overview of TAP: The new agenda and format for the meeting that places the focus of the Committee on the Turnaround Avoidance Programme was welcomed, and it was agreed that the manner in which the information in the meeting pack is presented will evolve over the coming months as the amount of duplication is reduced. The Committee also agreed that Gordon Cooney would be invited to join the meeting for the duration of the TAP.	The Committee were assured by the developing reporting around the TAP agenda and agreed access to further assurance at subsequent meetings by inviting the Programme Director to join the F&P Committee.	
5.	**Work Stream 1: Operational Reports**		**ED** – Deterioration of performance in August to 91.81%. OOH performance has been particularly challenging. Attendances have increased but the most significant issue is clinical workforce vacancies and Junior Doctor Handover. AM noted that Scarborough bed occupancy has been consistently under 90% for the last 3 months; this requires a change in the culture of ED at Scarborough, with patients being transferred to wards promptly rather than care being initiated in ED. Plans continue to develop Frailty models and Ambulatory Care Units on both sites. The UCC at Scarborough will open to minor injuries at the end	The Committee was assured by the information given by AM and LT and the continued work being undertaken. The Committee recognises the hard work and progress that has been made and remains concerned about the sustainability of the service. Recent month difficulties have been disappointing.	Deterioration in ED performance – JW

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			of September. Work progressing with CCG on new Front Door model for York site. AM noted that the Trust had received a report & recommendations from ECIST on their recent visit to the Scarborough site and that these are being worked through by the clinically led Acute Task & Finish Group, along with a full programme of work, including a "Listening Exercise" in both ED departments and looking at 'admitting rights' from ED into the hospital. ECIST are due to visit the York site at the end of September. AM noted that there were cultural and leadership challenges in both departments and that these were being addressed as part of the Emergency Care Recovery Plan. She also noted in response to an MS question, that whilst there was enough management resource (e.g. Service Improvement Team) to ensure changes were embedded , day to day clinical leadership still needed to be strengthened. **18wks** – The Trust achieved the incomplete target in August however, did incur some speciality level fines but these were reduced in comparison to July. In terms of the admitted trajectory set out in the Operational Performance Recovery Plan, Max-Fax and ophthalmology remain a concern, other specialities are largely on track to deliver by the December trajectory. Max-Fax continues to undertake additional work at Bridlington and has reduced its backlog by 7.3% in the last 4 weeks. Additional options are being reviewed for additional ophthalmology work, including outsourcing further York work to CESP. In addition to New Medica on	The Committee were assured by the work described, but remain concerned about some areas of performance.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			the Scarborough site. **Cancer** – It is likely that the Trust will not deliver the Fast Track target in Q2. This is largely due to short term consultant sickness in Dermatology over the Summer. It is anticipated that the Trust will achieve the Breast Symptomatic target for Q2 as outlined in the Performance Recovery Plan trajectory. The on-going problem remains 14 day Fast track where the surge in dermatology cases presents a major challenge. **Diagnostics** – Radiology have achieved the 99% standard for August but the Trust narrowly missed delivering the target on aggregate due to capacity issues in Endoscopy and cystoscopy. Additional capacity has been implemented for Endoscopy (Medinet on Scarborough site) and NHS Elect are running a capacity and demand workshop next week regarding cystoscopy. If they could clear the backlog the full target would be achieved.	The Committee noted the progress against the cancer targets and the improvements that have been achieved over the last 6 months. The Committee were pleased to see continuation of the improvements that had been made over the last 6 of months.	Cancer Fast Track - JW
6.	**Work Stream 2: CQUIN Delivery**		LT noted the CCGs had verbally signed off Q1 as achieved. There are 4 CQUINs that are currently RAG rated Red or Amber for Q2. These are: 3.3. Dementia Carers; 4. Ambulatory Care; 6. Scan reporting; 7. Post Take Ward Round Checklist. LT stated that work was continuing to minimise these risks. It should be noted that the since the report was written, risks have been minimised for Post Take Ward Round (PTWR) check list (now rolled out to Surgical Assessment Unit (SAU) and Scan Reporting (scope of CQUIN now agreed with CCGs and trajectories agreed).	The Committee were pleased to see good performance with most CQUINs and were assured by the understanding of risk CQUINs and the actions being taken to secure delivery.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			MS asked that future CQUIN reports were combined into one document for the committee and that only Red and Amber rated schemes brought to the attention of the committee. The Committee noted that the full overview was routinely provided via the full performance booklet. LT agreed to coordinate this with Gordon Cooney.		
7.	**Work Stream 3: Finance Report**		GL presented the finance report. He explained that the net income and expenditure position had further deteriorated during August, and that the Trust was reporting an actual deficit of £6.0m against a planned deficit of £3.5m at the end of August, placing the Trust £2.5m behind plan. GL informed the committee that whereas the overall position had deteriorated by £1.4m during August, this was in line with planned expectations and meant that the Trust had managed to meet its in-month plan. Monitor has now started using the new 'Financial Sustainability Risk Rating' (FSRR), as a replacement for the former 'Continuity of Service Risk Rating', and under the new rating the Trust scored 2 (out of 4). Under Monitor's guidance, a score of 2 could lead to regulatory action by Monitor. An analysis of the income shows a run rate of £38.4m for August in comparison to £40.4m for July. This was expected as historically August has proven to be a relatively low income month due primarily to patient and staff unavailability during the holiday period and the impact of a bank holiday.	The Committee were assured by the in-month progress in terms of holding the financial position (as measured by variance to plan) but remained very concerned about the current year to date financial position. Assurance was taken from the expenditure controls implemented.	AB to update Board

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			Expenditure during August has decreased to £38.3m compared to £40.3m in July. Of particular note was the decrease in pay expenditure from £27.5m in July to £26.7m in August; with a reduction in the level of spend on nurse agency staff compared to previous months being a welcome feature. Contract penalties continue to be of concern, and stand at £1.5m to date after assuming a level of reinvestment by commissioners. The Trust has written to the CCG to request some re-imbursement of penalties, and although discussions continue their response to date has not been overly positive. The CIP position is adversely impacting on the overall I&E position by £3.4m, despite the full year savings identified to date being ahead of the same point in the last financial year. MS asked whether this was more a profiling issue, which should be adjusted. AB gave assurance that this was typical of the profile seen in previous years and was confident it would pull back over the remainder of the year. He further stated that he would prefer to leave the profile as it was and not mask any impact until future months. GL stated that the Trust, along with other Foundation Trusts, was being required to report on a monthly basis to Monitor and included in this report the Trust is to include a forecast outturn position. In the latest report the Trust was forecasting an I&E outturn position of £8.7m deficit placing it £1.3m behind its annual plan. This	The Committee was concerned at the continued level of fines being incurred by the Trust but was very disappointed to hear that the CCGs were continuing to hold the line in terms of no reinvestment of penalties in improvement initiatives. The Committee welcomed Monitor's intervention in this regard.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			forecast would result in a FSRR of 3.		
8.	**Work Stream 3: Efficiency Report**		SK reported on the Efficiency position as at August 2015 (Month 5). Overall delivery of CIP is £11.6m against the annual target of £25.8m; this position is £1m ahead of delivery at the same point last year, which remains encouraging. The part year adverse variance against the Monitor profile is currently £3.4m which is impacting on the overall financial position, it was discussed if a re-profile of the position would provide a more realistic position, however it was agreed that the profile should remain as it is. Action is also underway in month 6 to review the income position to identify any legitimate efficiency benefits. The in-year planning position remains £2.9m behind the target and work is on-going to close this gap. The 4 year planning has improved in month by £2.8m which is encouraging. One directorate remains outstanding in terms of QI assessments, however this is in hand and Helen Hey the Deputy Chief Nurse is providing valuable support in terms of external assurance to efficiency plans in terms of quality and safety. MS requested that the monthly written report include the value of the High & Medium risks.	The Committee was assured by the continued progress against plan.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
9.	**Work Stream 4: Workforce**		It was agreed that the F&P Committee should focus solely on the workforce metrics and where necessary draw matters to the attention of the Board for further discussion. The matter is to be further discussed at the next meeting when a suggested reporting format from MAS will be discussed.		
10.	**Contract and Tender Report Development**		MAS tabled a first draft of a proposal for a "Register of Tenders". Committee members were requested to feedback over the next month and formal discussion was deferred until next month.		
11.	**Any other business**		None discussed.		
12.	**Next Meeting**		The next meeting is arranged for 20th October 2015		

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

York Teaching Hospital NHS
NHS Foundation Trust

Monthly Performance Report

September 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	Jun	Jul	Aug
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%	92.8%	92.3%	93.0%
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	0	0
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	Nil	**Not a 2015/16 target**	81.6%	82.0%	80.7%	75.6%	74.2%	75.7%	78.2%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	Nil	**Not a 2015/16 target**	95.9%	95.5%	95.4%	95.2%	95.0%	95.0%	95.2%

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	May	Jun	Jul
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	85.9%	85.4%	89.8%	93.9%	93.9%	94.0%	93.0%
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	78.6%	90.5%	91.0%	91.4%	90.1%	93.6%	93.3%
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	97.9%	98.4%	96.1%	96.2%	96.3%	94.8%	98.2%
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	94.9%	95.3%	95.6%	94.4%	91.3%	96.4%	97.5%
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	99.1%	100.0%	98.5%	99.6%	98.2%	100.0%	100.0%
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	87.6%	85.0%	76.5%	87.8%	86.9%	88.7%	85.8%
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	93.8%	92.5%	92.2%	98.4%	100.0%	100.0%	86.2%
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	Jun	Jul	Aug
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£120 fine per patient below performance tolerance (maximum 10% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	92.6%	89.1%	89.1%	88.3%	89.3%	92.9%	91.8%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**0 > 30min**	489	514	520	539	156	82	163
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**0 > 60min**	255	371	383	415	74	31	78
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**	**Jun**	**Jul**	**Aug**
	NHS VALE OF YORK CCG	30mins - 1hr	70	154	161	163	45	26	53
		1hr 2 hours	19	109	109	114	32	12	23
		2 hours +	13	54	44	26	0	6	13
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	202	176	177	152	40	25	49
		1hr 2 hours	88	77	83	101	17	9	15
		2 hours +	12	25	25	28	0	0	1
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	122	127	134	146	47	20	36
		1hr 2 hours	73	54	70	76	11	2	11
		2 hours +	9	13	17	22	2	0	1
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	34	17	20	27	8	3	6
		1hr 2 hours	12	13	15	14	4	1	4
		2 hours +	2	1	2	3	1	0	0
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	1	2	6	1	1	0	1
		1hr 2 hours	1	1	0	0	0	0	1
		2 hours +	0	0	0	0	0	0	0
	OTHER	30mins - 1hr	60	38	22	50	15	8	18
		1hr 2 hours	25	16	12	27	7	1	8
		2 hours +	1	8	6	4	0	0	1
Total number of patients waiting over 8hrs in A&E	General Condition 9	Q1 - Establish baseline	438	819	944	734	180	90	140
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**0 > 12 hrs**	2	2	11	0	0	1	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%	97.5%	97.0%	To follow	To follow

Mortality

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

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Jun	Jul	Aug
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**48**	10	16	21	21	6	3	8
Number of Clostridium difficile due to "lapse in care"	Establish baseline and set trajectory	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**108 (TBC)**	20	28	27	24	8	4	6
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases	**Quarterly:** General Condition 9 (identified in 15/16 contract as HPA MESS monthly)	**30**	9	19	13	11	3	4	2
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	0	1	6	2	0	0
Confirmed cases of MRSA Bacteraemia to be notified to commissioner by next working day	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 21 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
All High Risk (non-day case) Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95%**	88.7%	88.5%	86.0%	85.1%	85.7%	86.3%	88.2%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95%**	72.7%	70.1%	66.2%	72.2%	70.3%	74.5%	76.4%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Jun	Jul	Aug
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%	95.2%	97.0%	98.6%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	2	0	0	0	0
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	0	3	15	9	4	0	0
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	75	229	548	205	22	15	17
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%	97.2%	97.3%	97.1%
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%	99.8%	99.8%	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%	n/a	n/a	n/a	n/a
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%	89.4%	90.1%	91.3%
Delayed Transfer of Care to be maintained at a minimum level	As set out in General Condition 9 - Trust only to be accountable for Health delays.	**<1%**	1988	1612	1160	1476	562	435	539
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	160	168	150
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	865	884	792
% Compliance with WHO safer surgery checklist	General Condition 9	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	367	392	386	389	124	147	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	1391	1419	1341	468	430	1 month coding lag
Reduction in avoidable transfers within the Trust after 10pm. Excludes transfers for clinical reasons or for patients transferred to a more appropriate ward	General Condition 9	**100 per month (Baseline 374; Q1;-330; Q2-280;Q3-250;Q4-220)**	269	353	374	302	106	92	82

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Jun	Jul	Aug
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%	100.0%	98.6%	99.5%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	General Condition 9	**Best Practice Standards**	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced quarterly .						
Immediate Discharge letters - 24 hour standard: Overall Trust Position Monthly report and quarterly audit . Action plan to be provided where the target failed in any one month. 25 cases from SR and 25 cases from ERY.	General Condition 9	**>98% for admitted patients discharged and >98% for A&E patients discharged**	Quarterly audit						
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Rydale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology). 25 cases from SR and 25 cases from ERY	General Condition 9	**Q1 - 94% Q2 - 95% Q3 - 96% Q4 - 97%**	Quarterly audit						
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	General Condition 9	**Q1 - 90% Q2 - 92% Q3 - 94% Q4 - 96%**	Quarterly audit						
All Red Drugs to be prescribed by provider effective from 01/04/2015	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
All Amber Drugs to be prescribed by provider effective from 01/04/2015	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	86.9%	86.3%	85.9%	87.0%	87.3%	87.5%	87.4%

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Jun	Jul	Aug
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	1	0	0

District Nursing Activity Summary

Indicator	Source	Threshold	Q2 2014/15	Q3 2014/15	Q4 2014/15	Q1 2015/16	Jun	Jul	Aug
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	-	1871	1975	1768	2443	1042	784	823
	Community nurse/service	-	1018	767	741	825	322	310	229
	Acute services	-	912	845	859	949	351	372	245
	Self / Carer/family	-	398	291	364	406	162	225	193
	Other	-	253	226	202	283	113	114	77
	Grand Total	-	4452	4104	3934	4906	1990	1805	1567
Community Adult Nursing Contacts	First	-	2758	2895	2931	3847	1596	1484	1280
	Follow up	-	31976	31372	33380	39244	14145	14633	14180
	Total	-	34734	34267	36311	43091	15741	16117	15460
	First to Follow Up Ratio	-	11.6	10.8	11.4	10.2	8.9	9.9	11.1
Community Hospitals average length of stay (days)	Archways	-	22.1	20.6	26.8	21.1	27.7	28.1	22.1
	Malton Community Hospital	-	18.6	17.1	16.0	19.9	17.6	13.9	17.3
	St Monicas Hospital	-	23.2	22.0	24.0	15.5	14.6	18.3	14.7
	The New Selby War Memorial Hospital	-	15.6	13.7	17.6	15.3	17.6	13.1	14.2
	Whitby Community Hospital	-	20.3	20.9	21.9	20.0	17.3	16.6	19.9
	Total	-	19.4	18.1	20.2	18.5	18.4	16.3	18.0
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	1	3	0
		Emergency	91	77	71	73	24	22	34
	Malton Community Hospital	Elective	10	21	48	19	11	27	4
		Emergency	114	121	110	101	39	38	33
	St Monicas Hospital	Elective	13	9	16	17	6	5	4
		Emergency	35	27	27	43	14	11	14
	The New Selby War Memorial	Elective	62	69	57	59	18	28	13
		Emergency	66	69	55	68	20	27	25
	Whitby Community Hospital	Elective	1	4	0	0	0	0	1
		Emergency	123	142	140	136	47	54	39
	Total	Elective	90	111	126	121	36	63	22
		Emergency	429	436	403	441	144	152	145

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Complaints and PALS												
New complaints this month	47	43	60	31	39	37	47	43	41	33	41	37
Complaints at same month last year	56	52	45	27	52	16	16	50	38	58	38	0
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	0	0	0	0	3	4	7	2	4	1	1	3
Number of Ombudsman complaint reviews upheld	0	0	0	0	0	0	0	0	0	0	0	0
Number of Ombudsman complaint reviews partly upheld	0	0	0	0	1	1	2	0	0	0	0	0
Late responses this month (at the time of writing)***	1	8	5	5	4	1	0	3	2	10	7	4
Top 3 complaint issues												
Aspects of clinical treatment	35	31	44	18	21	20	32	30	27	21	29	27
Admission/discharge/transfer arrangements	0	5	4	0	2	3	2	1	3	1	1	1
Appointment delay/cancellation - outpatient	0	0	0	4	1	2	2	2	2	0	1	1
Staff attitude	5	0	5	5	10	7	5	3	7	3	3	3
Communications	4	0	0	0	2	2	4	4	1	3	2	2
Other	0	2	0	0	0	1	0	0	1	1	0	2
New PALS queries this month	570	653	552	443	620	559	478	430	416	498	643	530
PALS queries at same time last year	445	536	419	385	503	470	367	378	369	406	442	488
Top 3 PALS issues												
Information & advice	192	42	150	136	189	173	126	158	155	171	237	233
Staff attitude	0	0	0	17	19	14	12	19	14	23	24	14
Aspects of clinical treatment	86	89	105	66	77	47	84	69	63	72	101	64
Appointment delay/cancellation - outpatient	65	24	63	41	47	28	52	29	35	46	59	39

**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	12	34	13	24	17	16	18	12	14	12	20	11
% SI's notified within 48 hours of SI being identified*	92%	100%	92%	96%	100%	100%	100%	100%	100%	100%	95%	100%
% SI's closed on STEIS within 6 months of SI being reported	0%	0%	8%	0%	0%	0%	66%	100%	TBC	TBC	TBC	TBC
Number of Negligence Claims	8	16	8	8	12	17	15	15	15	12	14	8
Extension requests made at least 4 weeks prior to deadline of report due date, and reason given is acceptable to CCG (Threshold - 90% by Q4)								0	2	0	1	0
Duty of Candour demonstrated within SI Reports (Threshold 100%)								100%	100%	100%	100%	100%
Percentage of reported SI's, investigated and closed as per agreed timescales**** (Threshold (90%)								83%	85%	83%	93%	100%
Percentage of reported SI's with extension requested.								0.0%	15.4%	0.0%	6.7%	0.0%

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

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

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

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Finance Report

Action requested/recommendation

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

Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 31 August 2015.

At the end of August the Trust is reporting an Income and Expenditure (I&E) deficit of £6.0m against a planned deficit of £3.5m 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 and 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	September 2015
Version number	Version 1

Briefing Note for the Finance & Performance Committee Meeting 22 September 2015

Subject: August 2015 (Month 5) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for the Period to August 2015

The income and expenditure position has continued to deteriorate during August and now stands at an actual deficit of £6.0m against a planned deficit of £3.5m, showing an adverse variance from plan of £2.5m. The position in July was a deficit of £4.6m, also £2.5m adversely adrift of plan. The in-month deterioration has been £1.4m but of note is that this has been exactly in line with the expected plan. This is not typical of previous months where the actual deterioration has outstripped any expected movement.

During August we have seen expenditure showing signs of coming back under control with lower overall spend levels in comparison to July. Income has been, typically, poor during August with elective activity holiday impact from both surgeon and patient absence. The month was affected by a bank holiday weekend too. A comparison of income reduction between July and August last year reveals the same impact, hence this expectation built into our plan.

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

Whilst the overall expenditure level in August was less than in July (£38.4m as opposed to £40.4m) clinical income was also lower in August (£34.1m as opposed to £36.1m).

Trend analysis from previous years suggests that we can expect income to rise again in September. Last year income was £2m higher in September. Clearly, what is important to our financial performance is that we continue with our expenditure control measures whilst boosting activity and income levels.

The position in relation to contract penalties has worsened this month. Continuation of this work under the TAP programme is a clear priority for the Trust. The accrued position continues to have a material impact on our reported income and expenditure position at £1.5m. 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 a degree of success with our claim to the CCGs for re-investment of ED 4-hour penalties and ambulance turnaround penalties. Disappointingly this is not progressing, although Monitor's intervention in this regard is helpful in seeking to secure appropriate use of these funds.

The detailed finance report includes an assessment of our position in relation to Monitor's new Financial Sustainability Risk Rating (FSRR). Our current position scores 2 (the scale

is 4 strong and 1 poor). A reassessment of our annual plan under the new FSRR shows a target score of 3 for the year end.

As I have briefed before, we are now routinely submitting to Monitor a forecast outturn for the year end. Details are provided of this on the I&E sheet of the finance report. Currently our forecast is for a year end deficit of £8.7m, some £1.3m adrift of plan.

Expenditure Analysis

Pay expenditure has reduced from July (£27.5m down to £26.7m). This is a marked reduction, especially for the month of August with a high prevalence of annual leave. Of note is a significant reduction in agency nurse expenditure during August as expenditure controls are impacting. The use of the Thornbury agency has reduced. Further improvements are expected as the application of these controls continues and as our successful recruitment campaign provides new nurses into the Trust.

Drug expenditure has reduced to more normal levels in month at £3.8m (compared to £4.3m last month). The overspend remains static at £2.2m ahead of plan but this largely relates to high cost out of tariff drug costs for which direct recharges are made to commissioners.

Clinical supplies and services expenditure has dropped back down to £3.6m for the month in comparison to over £4.1m in July. And similarly other costs have dropped to £4.2m compared to £4.4m last month.

CIP delivery continues to be 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 £3.4m.

Contracting Matters

I am pleased to report all contacts have now been signed.

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

September 2015

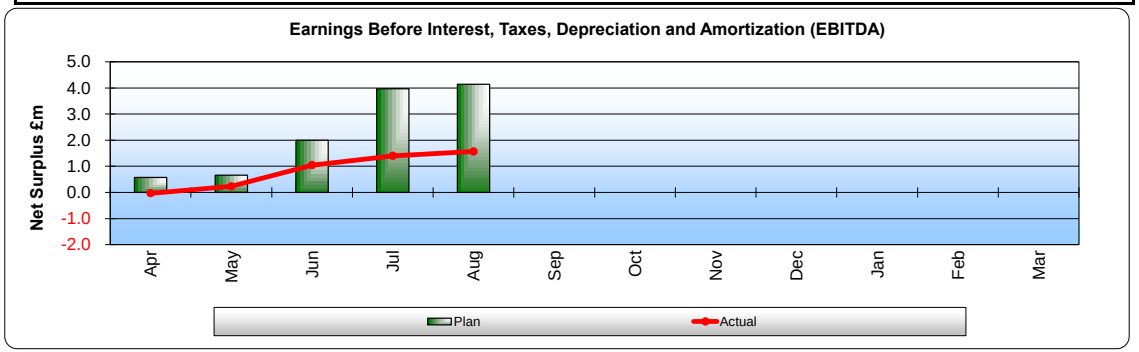
Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

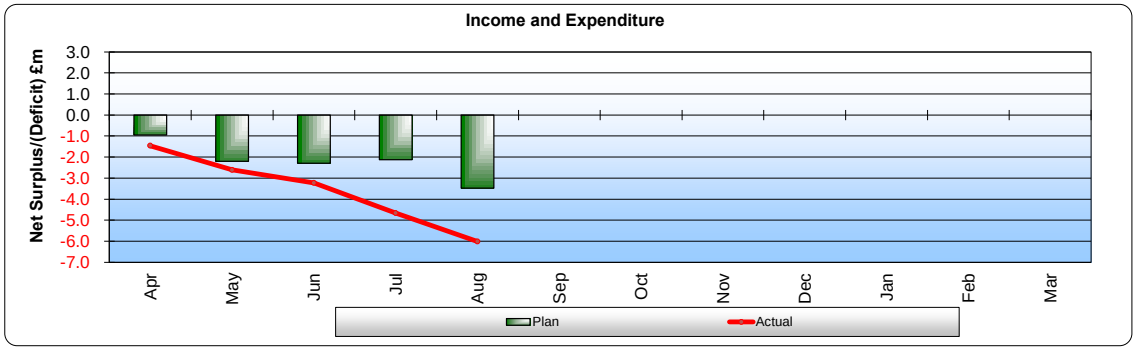
Summary Income and Expenditure Position
Month 5 - The Period 1st April 2015 to 31st August 2015

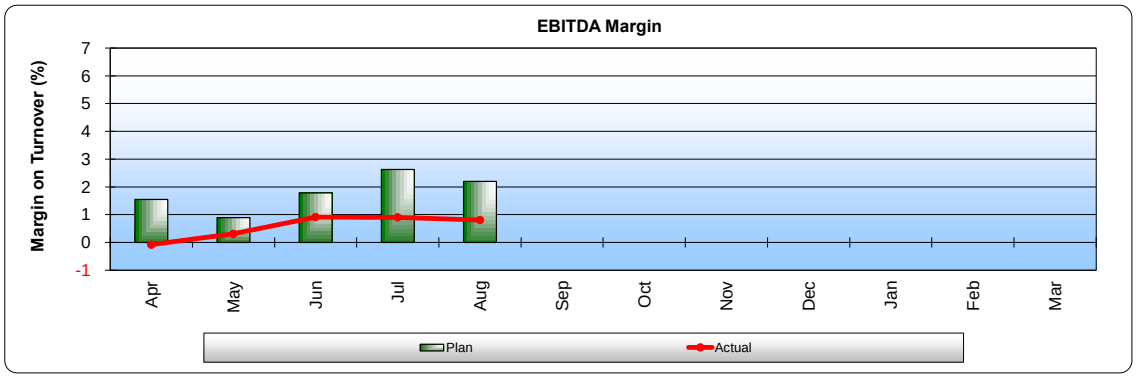
York Teaching Hospital NHS
NHS Foundation Trust

Summary Position:

* The Trust is reporting an I&E deficit of £6.0m, placing it £2.5m behind the operational plan.
* Income is £5.8m ahead of plan, with clinical income being £4.4m ahead of plan and non-clinical income being £1.4m ahead of plan.
* Expenditure is ahead of plan by £8.4m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £1.6m (0.81%) compared to plan of £4.1m (2.20%), and is reflective of the reported net I&E performance.
* Due to the timing of the Board meeting the forecast is the one reported to Monitor the previous month.







	Annual Plan	Plan for Year to Date	Actual for Year to Date	Variance for Year to Date	Forecast Outturn	Annual Plan Variance
	£000	£000	£000	£000	£000	£000
NHS Clinical Income						
Elective Income	24,972	10,125	10,606	481	25,346	374
Planned same day (Day cases)	33,358	13,525	14,750	1,225	34,533	1,175
Non-Elective Income	101,911	41,671	45,150	3,479	110,461	8,550
Outpatients	66,338	26,386	25,215	-1,171	65,928	-410
A&E	14,891	6,087	6,537	450	15,341	450
Community	33,047	14,947	15,565	618	34,392	1,345
Other	131,718	54,323	53,647	-676	126,188	-5,530
	406,235	**167,064**	**171,470**	**4,406**	**412,189**	**5,954**
Non-NHS Clinical Income						
Private Patient Income	1,036	432	388	-44	986	-50
Other Non-protected Clinical Income	1,890	787	755	-32	1,656	-234
	2,926	**1,219**	**1,143**	**-76**	**2,642**	**-284**
Other Income	0	0	0	0	0	0
Education & Training	14,333	5,972	6,386	414	14,912	579
Research & Development	4,156	1,732	2,120	388	4,486	330
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	600	250	308	58	739	139
Other Income	17,086	7,134	7,784	650	19,453	2,367
Transition support	10,907	4,545	4,544	-0	10,906	-1
	47,082	**19,633**	**21,142**	**1,509**	**50,496**	**3,414**
Total Income	**456,243**	**187,916**	**193,755**	**5,839**	**465,327**	**9,084**
Expenditure						
Pay costs	-315,701	-129,350	-133,109	-3,759	-310,013	5,688
Drug costs	-43,917	-18,111	-20,372	-2,261	-48,705	-4,788
Clinical Supplies & Services	-46,933	-19,417	-18,825	592	-46,086	847
Other costs (excluding Depreciation)	-48,159	-20,330	-19,851	479	-46,173	1,986
Restructuring Costs	0	0	-32	-32	-100	-100
CIP	14,132	3,433	0	-3,433	0	-14,132
Total Expenditure	**-440,578**	**-183,775**	**-192,189**	**-8,414**	**-451,077**	**-10,499**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**15,665**	**4,141**	**1,566**	**-2,575**	**14,250**	**-1,415**
Profit/ Loss on Asset Disposals	-4,500	0	3	3	-4,497	3
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation	-11,000	-4,583	-4,583	0	-11,000	0
Interest Receivable/ Payable	100	42	67	25	156	56
Interest Expense on Overdrafts and WCF	0	0	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0	0	0
Interest Expense on Non-commercial borrowings	0	0	0	0	0	0
Interest Expense on Commercial borrowings	-335	-140	-125	15	-303	32
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	-7	-7	-6	-6
PDC Dividend	-7,040	-2,933	-2,933	0	-7,040	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**-7,410**	**-3,474**	**-6,012**	**-2,539**	**-8,740**	**-1,330**

Contract Performance

Month 5 - The Period 1st April 2015 to 31st August 2015

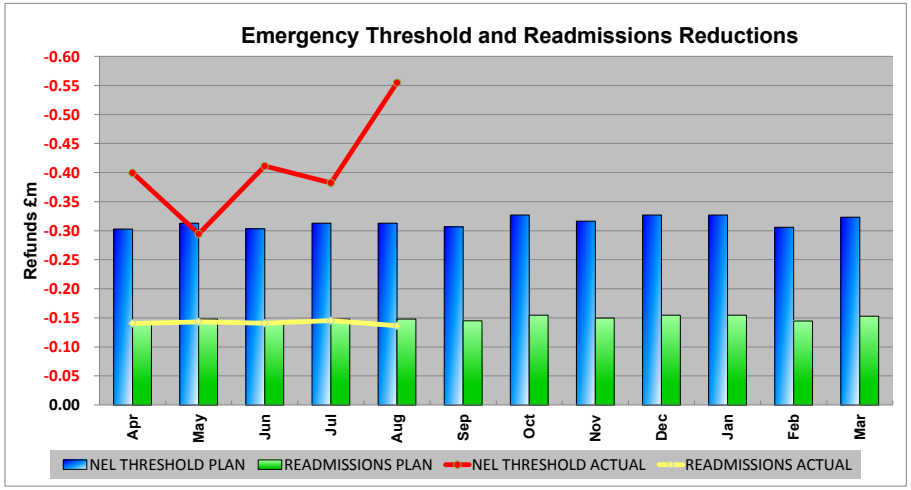
York Teaching Hospital NHS
NHS Foundation Trust

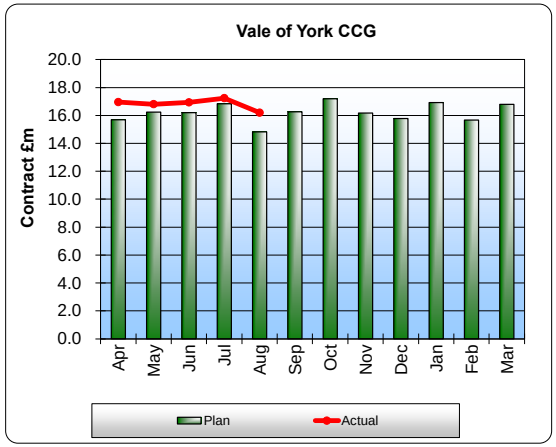
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	194,548	79,773	84,129	4,356
Scarborough & Ryedale CCG	75,075	30,496	32,965	2,469
East Riding CCG	37,600	15,157	16,809	1,652
Other Contracted CCGs	20,593	9,754	10,167	413
NHSE - Specialised Commissioning	35,241	14,681	13,979	-702
NHSE - Public Health	14,465	6,384	6,205	-179
Local Authorities	7,706	2,900	2,178	-722
Total NHS Contract Clinical Income	**385,228**	**159,145**	**166,432**	**7,287**

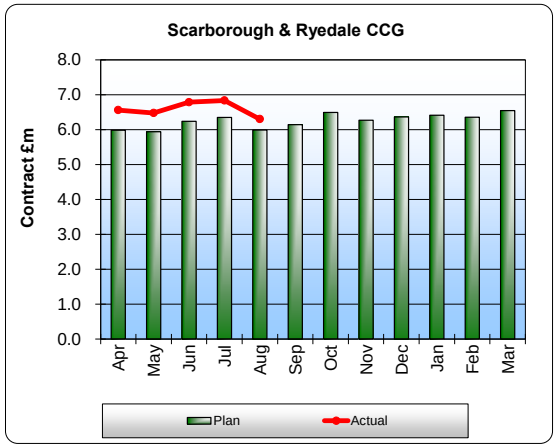
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	9,898	4,131	5,446	1,315
Risk Income	11,109	3,788	-386	-4,174
Total Other NHS Clinical Income	**21,007**	**7,919**	**5,060**	**-2,859**

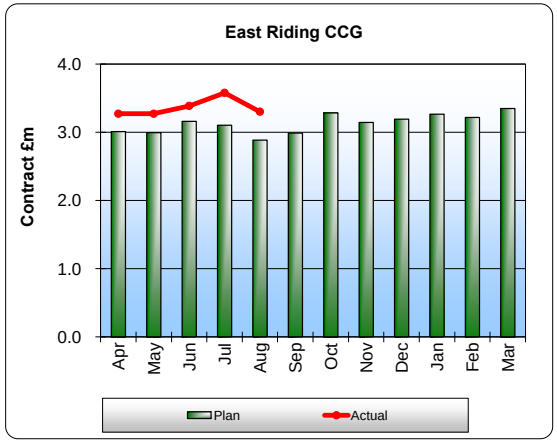
Total NHS Clinical Income	**406,235**	**167,064**	**171,492**	**4,428**

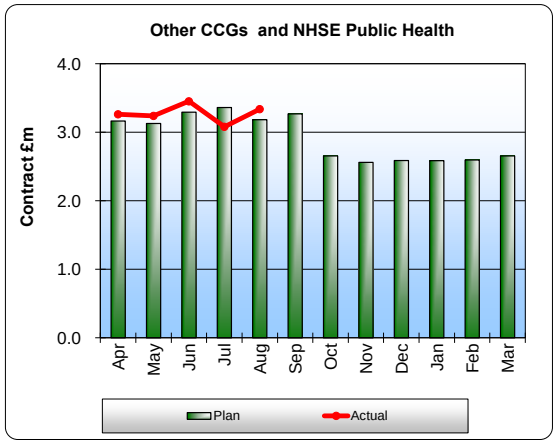
Specialist registrar income moved to other income non clinical	-578
Winter resilience monies in addition to contract	556
Agrees to Clincial Income reported to board	**171,470**

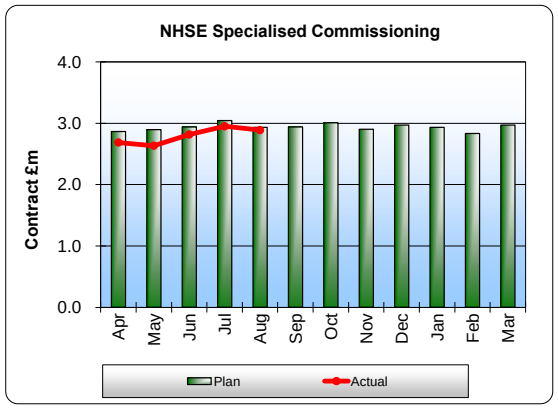


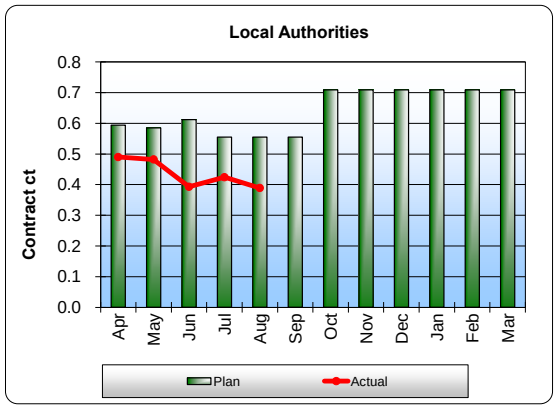












Expenditure Analysis
Month 5 - The Period 1st April 2015 to 31st August 2015

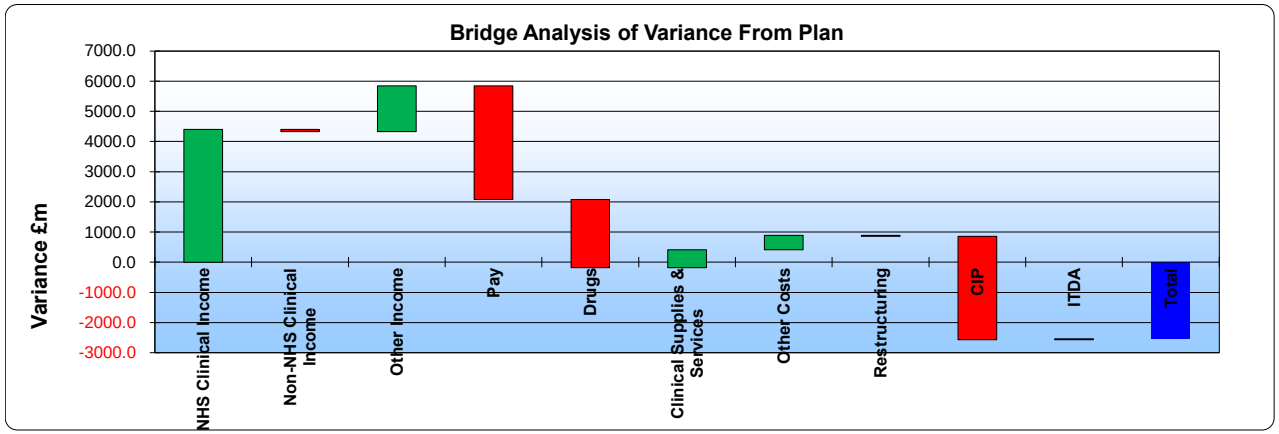
York Teaching Hospital NHS
NHS Foundation Trust

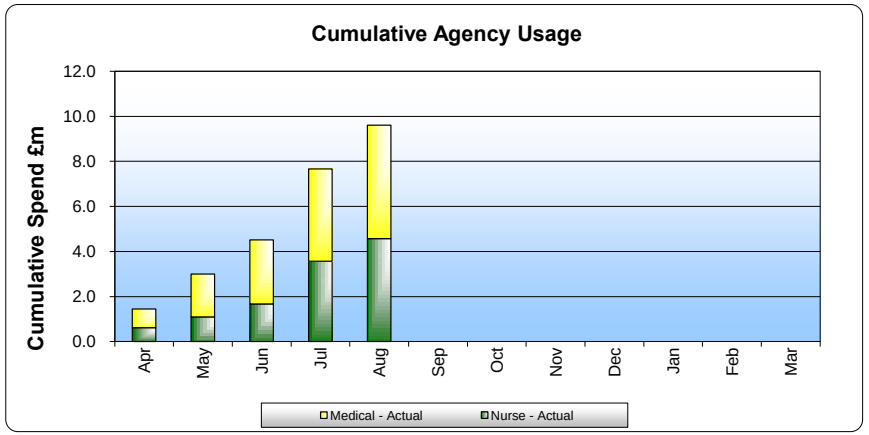
Key Messages:

There is an adverse expenditure variance of £8.4m at the end of August 2015. This comprises:

* Pay budgets are £3.8m adverse, linked to continued high locum and agency costs.
* Drugs budgets are £2.3m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £3.4m behind plan.
* Other budgets are £1.0m favourable.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	54,386	22,491	19,893	0	763	0	2,369	23,024	-533	-522	
Medical & Dental	29,646	12,065	10,812	0	85	0	2,667	13,563	-1,498	-1,196	
Nursing, Midwifery & Health Visting	94,314	39,185	33,868	217	137	1,322	4,569	40,113	-928	-768	
Professional & Technical	9,580	3,923	3,263	52	65	0	339	3,719	204	127	
Scientific & Professional	17,260	7,124	6,472	40	17	0	47	6,576	548	511	
P.A.M.s	22,443	9,438	8,176	25	124	0	187	8,513	925	838	
Healthcare Assistants & Other Support Staff	43,881	18,400	17,899	269	54	17	65	18,304	95	96	
Chairman and Non-Executives	161	67	67	0	0	0	0	67	0	0	
Executive Board and Senior Managers	14,637	6,087	5,557	4	0	0	17	5,578	510	419	
Administrative & Clerical	34,108	14,117	13,356	89	63	0	144	13,652	465	353	
Agency Premium Provision	4,000	1,667	0	0	0	0	0	0	1,667	1,333	
Vacancy Factor	-8,715	-5,214	0	0	0	0	0	0	-5,214	-4,342	
TOTAL	**315,701**	**129,350**	**119,363**	**697**	**1,308**	**1,339**	**10,403**	**133,109**	**-3,760**	**-3,150**	





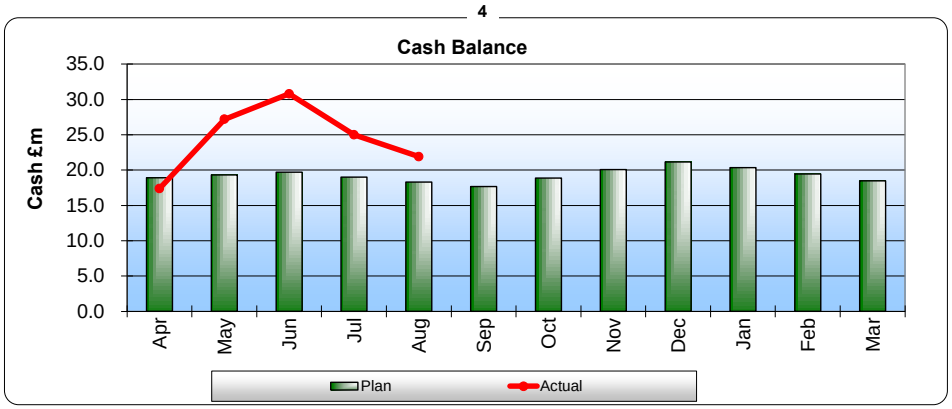
Cash Flow Management

Month 5 - The Period 1st April 2015 to 31st August 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The cash position at the end of August was £21.9m. This is slightly above plan.
* The receivables balance at the end of August was £8.39m which is below plan due to improved debt collection systems.
* The payables balance at the end of August was £8.7m which is slightly above plan.
* The Continuity of Service Risk Rating (CoSSR) has now been replaced by the Financial Sustainability Risk Rating (FSRR), which is assessed as a score of 2 in August, and is reflective of the I&E position.

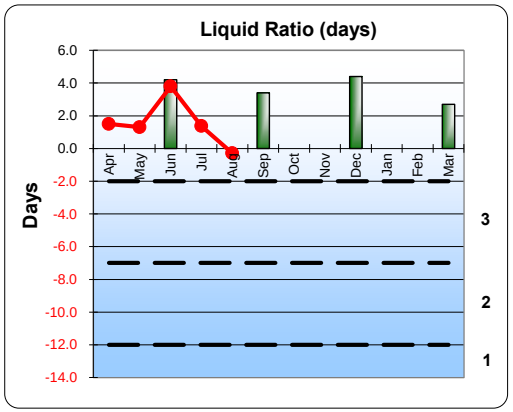


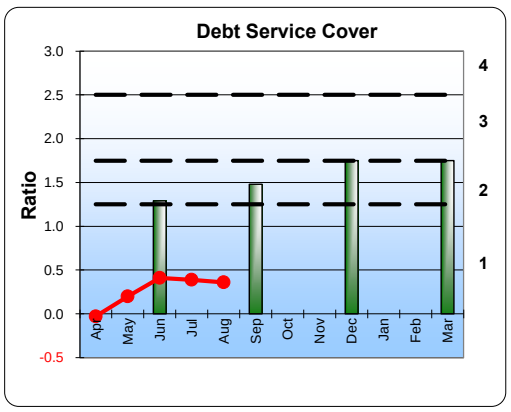
	Under 3 mths £m	3-6 mths £m	6-12 mths £m	12 mths + £m	Total £m
Payables	7.40	0.60	0.50	0.20	8.70
Receivables	5.25	1.95	0.57	0.62	8.39

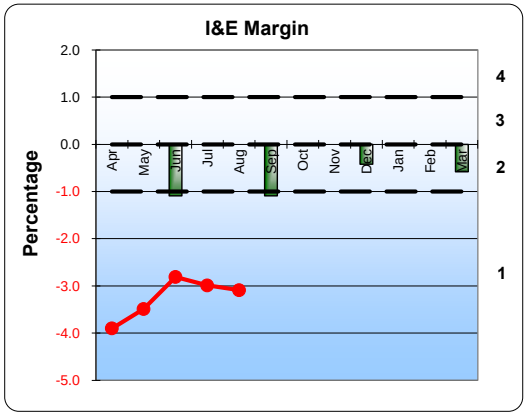
Significant Aged Debtors (+6mths)

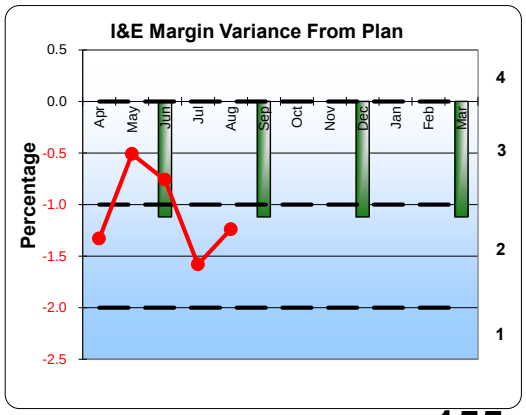
Harrogate and District NHS FT	**£609K**
Leeds Teaching NHS Trust	**£62K**
NHS Property Services	**£58K**

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









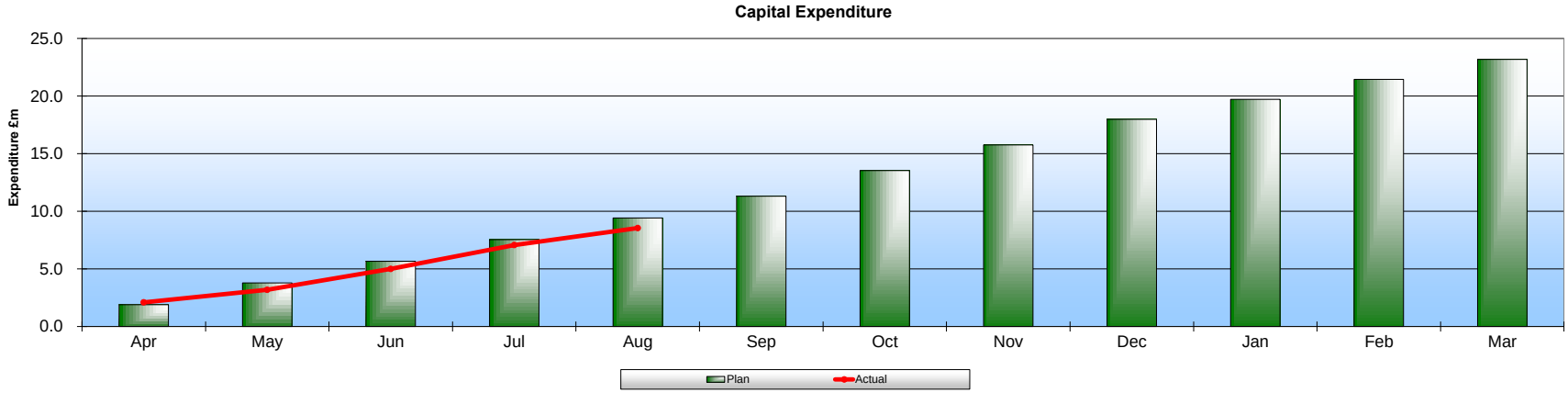
Capital Programme

Month 5 - The Period 1st April 2015 to 31st August 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The Capital Programme for August is running in line with plan.
* Strategic funding has been allocated to existing projects including the Scarbrough Fire Alarm and Lift replacement schemes.
* The Scarborough and Bridlington Carbon Energy Scheme has the largest projected in year spend at £5.087m
* 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	865	2,015	0	
Strategic Capital Schemes	1,870	460	1,870	0	
York ED Phase 2	1,264	157	1,114	150	
SGH/ Brid Carbon & Energy Project	5,087	2,502	5,087	0	
Radiology Equipment Upgrade	3,085	-	3,085	0	
IT Wireless Upgrade - Trustwide	1,400	302	1,400	0	
Other Capital Schemes	2,665	1,780	2,815	-150	
SGH Estates Backlog Maintenance	1,000	389	1,000	0	
York Estates Backlog Maintenance - York	1,000	645	1,000	0	
Medical Equipment	650	269	650	0	
IT Capital Programme	1,500	475	1,500	0	
Capital Programme Management	1,150	694	1,150	0	
0	-	-	-	0	
Contingency	500	-	500	0	
0	-	-	-	0	
0	-	-	-	0	
TOTAL CAPITAL PROGRAMME	**23,186**	**8,538**	**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	3,499	9,614	-	
Loan Funding b/fwd	1,386	353	1,386	-	
Loan Funding	9,577	2,635	9,577	-	
Charitable Funding	739	185	739	-	
Strategic Capital Funding	1,870	393	1,870	-	
TOTAL FUNDING	**23,186**	**7,065**	**23,186**	**0**	

Efficiency Programme

Month 5 - The Period 1st April 2015 to 31st August 2015

York Teaching Hospital NHS
NHS Foundation Trust

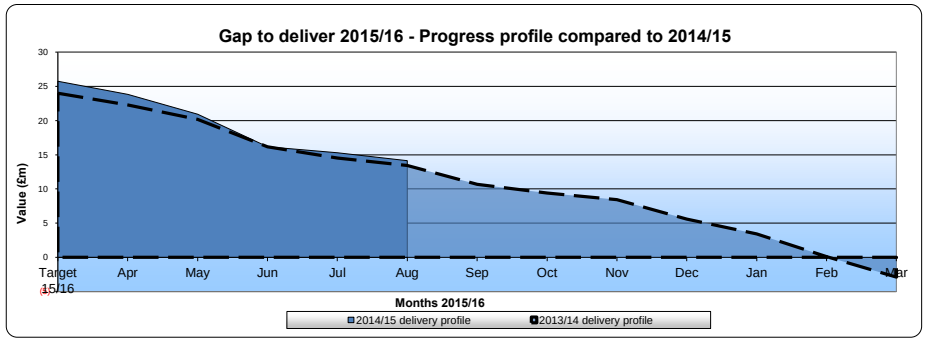
Key Messages:

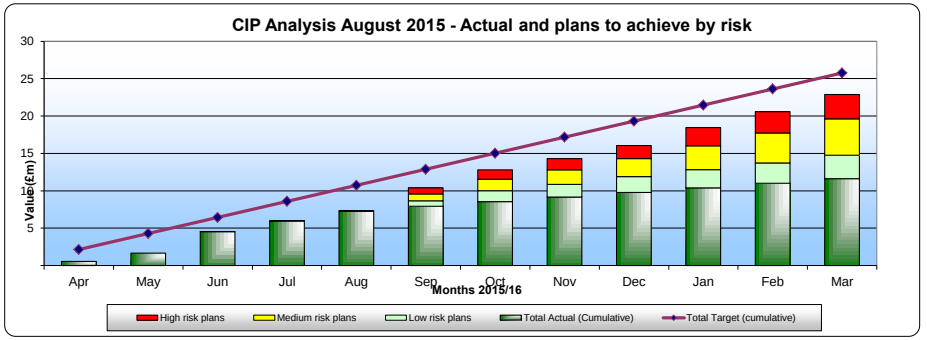
* Delivery - £11.6m has been delivered against the Trust annual target of £25.8m, giving a shortfall of (£14.1m).
* Part year Monitor variance - The part year Monitor variance has a shortfall of (£3.4m).
* In year planning - The in year planning gap is currently (£2.9m), work is continuing to close this gap.
* Four year planning - The four year planning gap is (£21.4m).
* Recurrent delivery - Recurrent delivery is £6.8m, which is 26% of the 2015/16 CIP target.

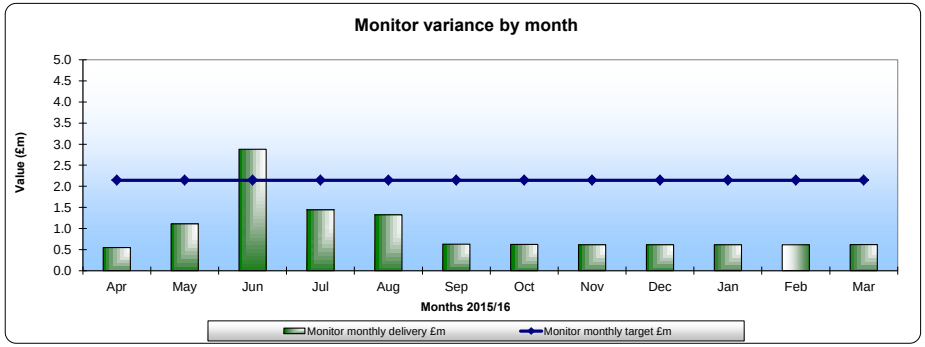
Executive Summary - August 2015	Total £m
TARGET	
In year target	25.8
DELIVERY	
In year delivery	11.6
In year delivery (shortfall)/Surplus	-14.1
Part year delivery (shortfall)/surplus - monitor variance	-3.4
PLANNING	
In year planning surplus/(gap)	-2.9
FINANCIAL RISK SCORE	
Overall trust financial risk score	(1 - RED)

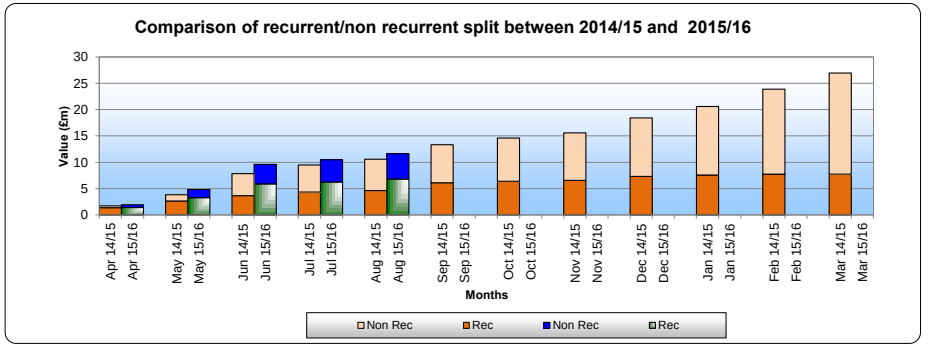
4 Year Efficiency Plan - August 2015					
Year	2015/16	2016/17	2017/18	2018/19	**Total**
	£m	£m	£m	£m	**£m**
Base Target	25.8	15.3	15.2	15.2	**71.4**
Plans	22.9	15.4	7.1	4.6	**50.0**
Variance	-2.9	0.1	-8.1	-10.6	**-21.4**
%	**89%**	**101%**	**47%**	**31%**	**70%**

Risk Ratings			
Financial			
Score	July	August	Trend
1	16	15	↓
2	5	5	→
3	1	1	→
4	3	4	↑
5	1	1	→
Governance			
Score	July	August	Trend
Red	1	1	→
Green	25	25	→









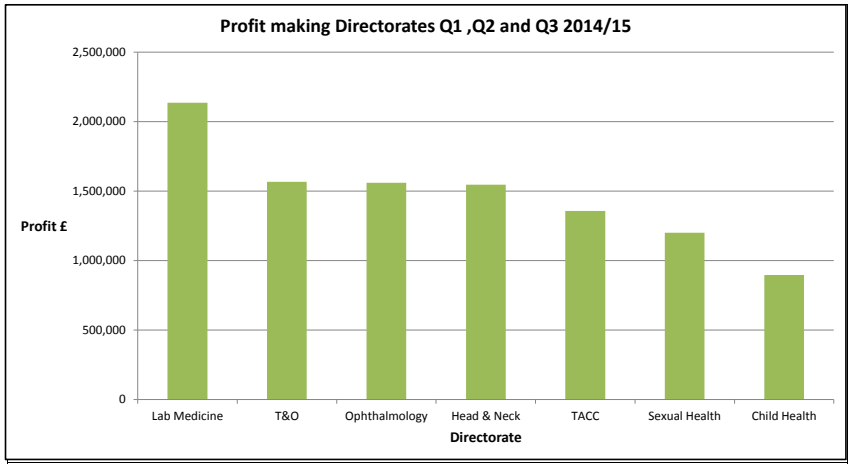
Service Line Reporting

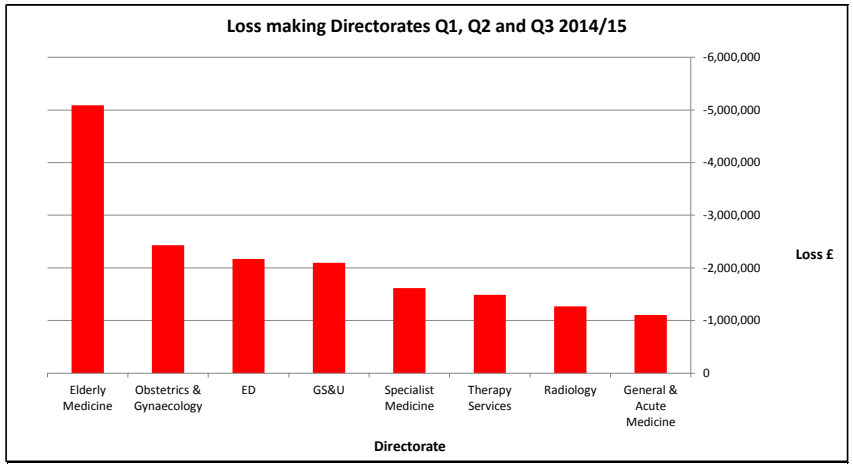
Month 5 - The Period 1st April 2015 to 31st August 2015

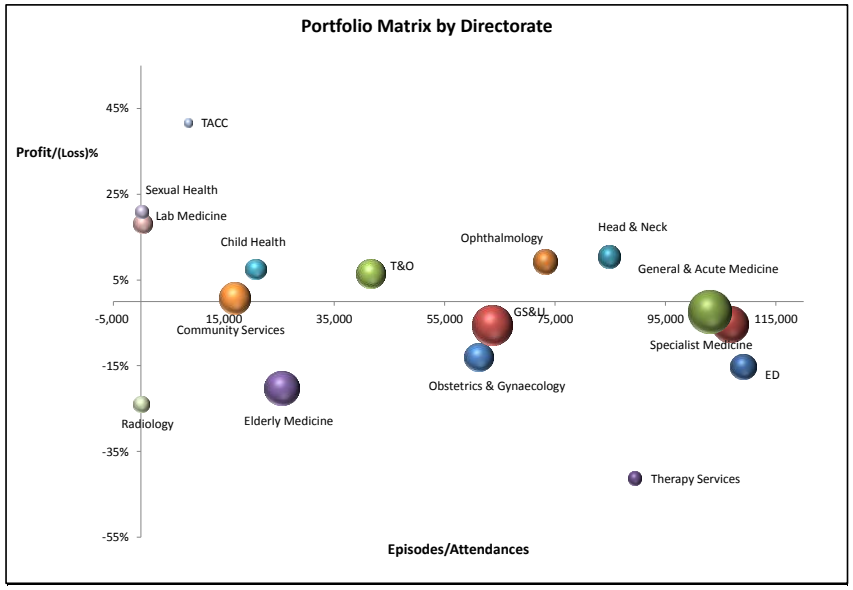
York Teaching Hospital NHS
NHS Foundation Trust

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 calculation was successfully submitted on 30 July 2015
* SLR drop in sessions have been arranged for the Directorate and Finance teams, the first three 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 calculation was successfully submitted to the Department of Health on 30th July 2015 * Q4 SLR data is now the key focus following the reference cost submission, this is expected to be completed in October 2015 * 3 drop in sessions have taken place for Directorate teams to attend to familiarise themselves with the SLR system, it is intended to continue with these sessions as regular events * Directorate teams continue to use the system for example Medicine at Scarborough have started to use the SLR system to review their Ambulatory Care activity and Specialist Medicine have recently used the SLR system to appropriately code the Lymphodema service, offering a £200k opportunity
FUTURE WORK	* Q1 2015/16 SLR data will be the priority following the completion of Q4 * A deep dive for Interventional Radiology is underway as this service is not profitable * 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 is currently in progress for Womens Health with the aim of identifying what the true underlying financial position of the service is and to improve the quality of the data presentation in Qlikview

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

Executive Pack

August 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	1190	1398	208	0	0	4	4	945	383	141	-242	818	332	58	-274	0	0	0	0	0	0	0	0
Acute Medicine	0	0	2	2	219	90	367	277	92	37	82	45	774	314	478	164	1004	407	424	17	94	38	12	-26	0	0	0	0
Anaesthetics	54	22	16	-6	17	7	11	4	1750	710	762	52	1650	669	782	113	2466	1000	1200	200	0	0	0	0	24	10	45	35
Cardiology	670	272	127	-145	2841	1162	957	-205	1098	445	522	77	12125	4916	5787	871	19537	7921	6542	-1379	155	63	130	67	5627	2281	2127	-154
Chemical Pathology	0	0	0	0	0	0	0	0	54	22	29	7	50	21	55	34	82	34	103	69	0	0	0	0	0	0	0	0
Clinical Neuro-Physiology	0	0	0	0	0	0	0	0	0	0	0	0	1254	508	523	15	70	28	38	10	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	8	3	2	-1	365	148	38	-110	7292	2957	2182	-775	16299	6608	6114	-494	424	172	12	-160	15441	6260	8746	2486
Ear, Nose And Throat	748	303	302	-1	998	408	425	17	952	386	519	133	7810	3167	3205	38	8307	3368	3929	561	12	5	6	1	8987	3644	3625	-19
Endocrinology	8	3	2	-1	3698	1512	1167	-345	482	195	241	46	2203	893	899	6	7137	2894	3127	233	506	205	17	-188	0	0	0	0
Gastroenterology	292	118	100	-18	4581	1873	2265	392	9568	3879	3705	-174	4591	1861	1963	102	9353	3792	3551	-241	1026	416	449	33	60	24	28	4
General Medicine	5	2	4	2	434	177	254	77	2867	1162	1085	-77	92	37	33	-4	133	54	10	-44	18	7	4	-3	79	32	15	-17
General Surgery	2880	1168	1139	-29	7253	2966	2940	-26	10460	4241	4245	4	15012	6087	6309	222	22695	9202	8334	-868	794	322	343	21	3999	1621	1445	-176
Genito-Urinary Medicine	0	0	0	0	0	0	0	0	0	0	0	0	25550	8392	6462	-1930	11980	3928	3192	-736	0	0	0	0	0	0	0	0
Geriatric Medicine	6	2	7	5	9421	3852	4466	614	172	70	81	11	3844	1559	1709	150	3851	1561	1522	-39	941	382	105	-277	46	19	28	9
Gynaecology	822	333	383	50	980	401	504	103	1474	598	640	42	7670	3110	3053	-57	5650	2291	2502	211	0	0	1	1	4761	1930	1869	-61
Haematology (Clinical)	42	17	16	-1	156	64	90	26	3672	1489	1705	216	1898	770	758	-12	12610	5113	5356	243	668	271	251	-20	126	51	16	-35
Maxillofacial Surgery	352	143	127	-16	378	155	167	12	1951	791	928	137	7009	2842	2821	-21	8372	3394	3388	-6	0	0	0	0	1846	748	1041	293
Medical Oncology	58	24	18	-6	148	61	47	-14	6952	2819	3234	415	4186	1697	1764	67	22970	9313	10168	855	25582	10372	8106	-2266	90	36	46	10
Nephrology	72	29	43	14	1606	657	444	-213	784	318	352	34	791	321	292	-29	8311	3370	3000	-370	3714	1506	1635	129	0	0	0	0
Neurology	14	6	2	-4	132	54	72	18	746	302	369	67	3286	1332	1279	-53	6115	2479	2240	-239	910	369	347	-22	56	23	0	-23
Obstetrics & Midwifery	24	10	24	14	5338	2183	2613	430	0	0	0	0	46	19	14	-5	1166	473	529	56	0	0	0	0	168	68	44	-24
Ophthalmology	251	102	109	7	86	35	25	-10	5385	2183	2446	263	16145	6546	6242	-304	57783	23428	20601	-2827	0	0	0	0	12929	5242	4443	-799
Orthodontics	0	0	0	0	0	0	0	0	0	0	0	0	1491	605	527	-78	1886	765	715	-50	0	0	0	0	9636	3907	3562	-345
Paediatrics	65	26	23	-3	7156	2926	3007	81	214	87	120	33	5217	2114	2055	-59	10180	4119	4056	-63	424	172	145	-27	670	272	256	-16
Palliative Medicine	0	0	0	0	0	0	0	0	0	0	0	0	1048	425	419	-6	3938	1597	1876	279	418	169	116	-53	0	0	0	0
Plastic Surgery	34	14	15	1	8	3	2	-1	338	137	196	59	407	165	250	85	512	208	244	36	0	0	0	0	29	12	2	-10
Restorative Dentistry	0	0	0	0	0	0	0	0	0	0	0	0	629	255	319	64	441	179	157	-22	0	0	0	0	1619	656	507	-149
Rheumatology	6	2	1	-1	14	6	3	-3	2160	876	977	101	2732	1108	1058	-50	13097	5310	5779	469	1254	508	646	138	0	0	0	0
Thoracic Medicine	86	35	20	-15	3611	1477	1531	54	498	202	197	-5	3859	1565	1317	-248	10544	4275	3884	-391	134	54	37	-17	296	120	95	-25
Trauma And Orthopaedic Surgery	1824	740	847	107	3258	1332	1386	54	2283	926	995	69	18700	7582	7842	260	27248	11048	11755	707	0	0	0	0	1460	592	492	-100
Urology	1566	635	696	61	1598	653	678	25	5844	2369	3881	1512	2662	1079	2105	1026	4243	1720	3832	2112	14	6	23	17	3788	1536	112	-1424
Obstetrics & Midwifery Zero Tariff	0	0	0	0	6332	2589	2613	24	0	0	0	0	8090	3280	3655	375	35308	14315	11066	-3249	0	0	0	0	9460	3836	4037	201
Gynaecology Zero Tariff	4	2	0	-2	362	148	135	-13	2	1	1	0	4	2	1	-1	42	17	15	-2	0	0	0	0	20	8	9	1
Total	**9883**	**4007**	**4023**	**16**	**63543**	**25983**	**27569**	**1586**	**60163**	**24393**	**27354**	**2961**	**169062**	**66578**	**66299**	**-279**	**334148**	**134542**	**129307**	**-5235**	**37088**	**15037**	**12385**	**-2652**	**81217**	**32929**	**32590**	**-339**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Efficiency Programme Update – August 2015

Action requested/recommendation

The Committee is asked to note the August 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 August 2015, is £11.6m.

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	This report is presented to the Board of Directors and Finance & Performance Committee.

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

Briefing note for the Finance & Performance Committee Meeting 22nd September 2015
Briefing note for the Board of Directors Meeting 30th September 2015

Subject: August 2015 - Efficiency Position
From: Steven Kitching, Head of Resource Management

Summary reported position for August 2015

Current position – highlights

Delivery - Overall delivery is £11.6m in August 2015 which is (45%) of the £25.8m annual target; there has been a £1.2m improvement in the position in month. This position compares to a delivery position of £10.6m (44%) in August 2014.

The month 5 part year adverse variance is (£3.4m) which has declined by (£0.8m) in the month. This position is behind the 2014/15 position which was (£2.9m) adverse.

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

In year planning – There is an in-year planning gap of (£2.9m) at August 2015, this has remained steady in the month but is marginally behind the 2014/15 position by (£0.3m). Work is continuing with Directorate teams to close the remaining in year planning gap.

Four year planning – The four year planning gap is (£21.4m), this position has improved in the month by £2.8m. The comparative position in August 2014 was a gap of (£22.2m). We have a relatively strong planning position for years 1&2 of the plan with £38.3m (93%) worth of plans identified against a target of £41.1m.

Recurrent vs. Non recurrent – Of the £11.6m delivery, £6.8m (59%) has been delivered recurrently, in August 2015. Recurrent delivery is £2.2m ahead of the same position in August 2014, which remains encouraging at this stage. The work continues to identify recurrent schemes.

Quality Impact Assessments (QIA) – All schemes have been sent out to Directorate teams to self assess for their safety impact, only 1 directorate has outstanding self-assessments. There are 909 schemes to be self-assessed of which 862 have been completed; therefore 47 schemes remain outstanding. It should be noted of the 862 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. Helen Hey, the Deputy Chief Nurse, has now started to review schemes.

Overview

The delivery position remains relatively positive with delivery remaining ahead of last year by £1.0m. The in-year planning gap is steady in the month at (£2.9m); however we have seen an improvement in the 4 year planning position. We currently have plans for 93% of the combined year 1&2 target.

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

Recurrent delivery remains relatively strong, with the percentage recurrent delivery remaining at 59% of overall delivery which is positive.

One directorate remains outstanding in terms of the QIA self-assessment process.

Efficiency panels meetings are now in the diary and due to commence at the end of September 2015.

Risks

Given the positive start in the first 5 months, there remain key risks in the programme.

- There is an overall planning gap of (£2.9m), in year, and a (£21.4m) 4 year planning gap.
- There is a risk that recurrent delivery will fall back following the removal of the 20% incentive, and this will continue to be monitored.
- There are 22 schemes which have been rated as extreme or high risk following the self-assessment process; however a senior nursing review has started.
- There are 15 Directorates who are risk rated 1 at the end of period 5, in terms of planning and delivery; 14 of these are behind where we need to be in terms of delivery and are shown in table 1 below.

Table 1- Directorate	Overall rating	Delivery % at Q4
WOMENS HEALTH	1	12%
TACC	1	17%
COMMUNITY	1	19%
GS&U	1	25%
SPECIALIST MEDICINE	1	27%
SEXUAL HEALTH	1	29%
RADIOLOGY	1	29%
HEAD AND NECK	1	24%
GEN MED SCARB.	1	32%
OPHTHALMOLOGY	1	33%
ELDERLY MEDICINE	1	16%
OPS MANAGEMENT	1	13%
CHIEF NURSE TEAM	1	20%
WORKFORCE AND ORG DEV.	1	38%

It is therefore important to continue to support Directorate teams to ensure we continue this positive start and to work collaboratively as part of 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 at the end of September 2015.

SLR

Appendix 3 has been included following a request from the Finance & Performance Committee at the August 2015 meeting.

The appendix summarises the current work on going with Directorate teams.

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

RISK SCORES - AUGUST 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
WOMENS HEALTH	2,235	4,019	42%	1	12%	1	4%	1	65%	1	4	1
TACC	2,955	7,147	41%	1	17%	1	16%	1	27%	1	4	1
COMMUNITY	2,437	4,883	48%	1	19%	1	13%	1	86%	1	4	1
GS&U	2,082	5,239	86%	1	25%	1	16%	1	51%	1	4	1
SPECIALIST MEDICINE	2,879	6,677	47%	1	27%	1	19%	1	50%	1	4	1
SEXUAL HEALTH	470	1,040	67%	1	29%	1	8%	1	67%	1	4	1
RADIOLOGY	2,410	4,020	42%	1	29%	1	23%	1	50%	1	4	1
HEAD AND NECK	623	1,821	90%	2	24%	1	10%	1	41%	1	5	1
GEN MED SCARBOROUGH	1,142	2,421	52%	1	32%	1	28%	2	38%	1	5	1
OPHTHALMOLOGY	868	2,428	86%	1	33%	1	28%	2	37%	1	5	1
MEDICINE FOR THE ELDERLY	1,422	3,706	101%	3	16%	1	12%	1	81%	1	6	1
EMERGENCY MEDICINE	1,126	2,463	96%	2	41%	2	40%	4	63%	1	9	2
CHILD HEALTH	1,332	2,849	71%	1	51%	3	39%	4	64%	1	9	2
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1,693	3,780	100%	3	58%	4	28%	2	71%	1	10	2
LAB MED	1,144	3,247	106%	3	88%	5	67%	5	82%	1	14	3
GEN MED YORK	1,949	5,235	103%	3	67%	5	46%	5	108%	3	16	4
ORTHOPAEDICS	1,350	3,613	129%	5	81%	5	53%	5	101%	3	18	4
PHARMACY	-189	503	140%	5	101%	5	101%	5	224%	5	20	5
CORPORATE												
OPS MANAGEMENT YORK	695	1,090	73%	1	13%	1	0%	1	62%	1	4	1
CHIEF NURSE TEAM DIRECTORATE	378	695	20%	1	20%	1	15%	1	11%	1	4	1
SNS	1,156	2,397	80%	1	44%	2	28%	2	43%	1	6	1
WORKFORCE AND ORGANISATIONAL DEVELOPMENT	768	1,536	67%	1	38%	2	34%	3	89%	1	7	1
ESTATES AND FACILITIES	3,088	7,650	87%	1	46%	3	40%	4	90%	2	10	2
MEDICAL GOVERNANCE	103	222	101%	3	101%	5	16%	1	47%	1	10	2
FINANCE	151	890	199%	5	199%	5	116%	5	34%	1	16	4
CHAIRMAN & CHIEF EXECUTIVES OFFICE	18	407	1371%	5	1371%	5	965%	5	62%	1	16	4
TRUST SCORE	**34,287**	**79,978**	**89%**	**1**	**45%**	**3**	**26%**	**2**	**70%**	**1**	**7**	**1**

Current SLR Workstreams - September 2015

APPENDIX 3

Directorate	Workstream	Description
Womens Health	Deep Dive	A detailed Deep Dive process has started in order to agree the income and expenditure allocations within SLR and to improve the data presentation for Maternity services
Womens Health	Outpatient Staffing	Continuing work to improve and validate the staffing group costs allocated to each clinic within the Directorate to understand the true cost of clinics
Specialist Medicine	Outpatient Staffing	Continuing work to improve and validate the staffing group costs allocated to each clinic within the Directorate to understand the true cost of clinics
General Medicine Scarborough	30th September Letter to CCG's	Support and data provided to the Directorate to inform Coding and Counting changes resulting in the opportunity for additional income generation
Specialist Medicine	30th September Letter to CCG's	Support and data provided to the Directorate to inform Coding and Counting changes resulting in the opportunity for additional income generation
Elderly Medicine	30th September Letter to CCG's	Support and data provided to the Directorate to inform Coding and Counting changes resulting in the opportunity for additional income generation
All Directorates	Consultant Jobs Plans	Continuing work to improve and validate the Consultant job plan allocations for each quartely SLR model
Workforce and Organisational Development	Education and Training Return	New data collection processes are being developed with the Directorate to support the annual Education and Training cost collection exercise

York Teaching Hospital NHS
NHS Foundation Trust

Operational Performance Recovery Plan

Monthly Status Summary

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

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

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

Produced by: Senior Operations Team

Operational Performance Recovery Plan

Monthly Status Summary: August 2015

ED

Trajectory: Sept 15

- **Performance**: **Off trajectory:** 4hr Perf (all types): 91.82%.
- **Achievements**: Plan to move Minor Injuries to UCC in SGH on 28th September.
- **Risks**: Medical and nursing workforce vacancies, Junior Doctor changeover and variable locum cover have all impacted on departmental efficiency and wait to see a Dr. There was a total of 1,452 breaches across the Trust (increase of 220 vs July). Of the 1451 Type 1 breaches 57.3% were subsequently admitted and 42.7% discharged.

18 weeks admitted

Trajectory:

Dec 15

- **Performance**: **Off trajectory.**
- **Achievements**:It is currently projected that the following specialties will achieve in line with trajectory; General Surgery - Nov 2015; Gynaecology - Dec 2015; Urology - Nov 2015; T&O - already achieved. Trust backlog reduced by 10% in last 12 wks.
- **Risks**: Changes in Opthal plans have a significant impact on overall trust delivery; directorate now projected to achieve sustainable delivery in April 16. Further work with the model is being undertaken to understand why the impact of the slight operational changes have had such a large impact. Max Fax continues to have a plan which does not deliver sustainability, although their backlog has decreased by 7.3% in last 4 wks. Currently exploring further avenues of additional capacity for MF. 17 patients on the 18wk pathway were cancelled this month due to lack of beds.

Cancer

Trajectory:

Q1 FT/62 day

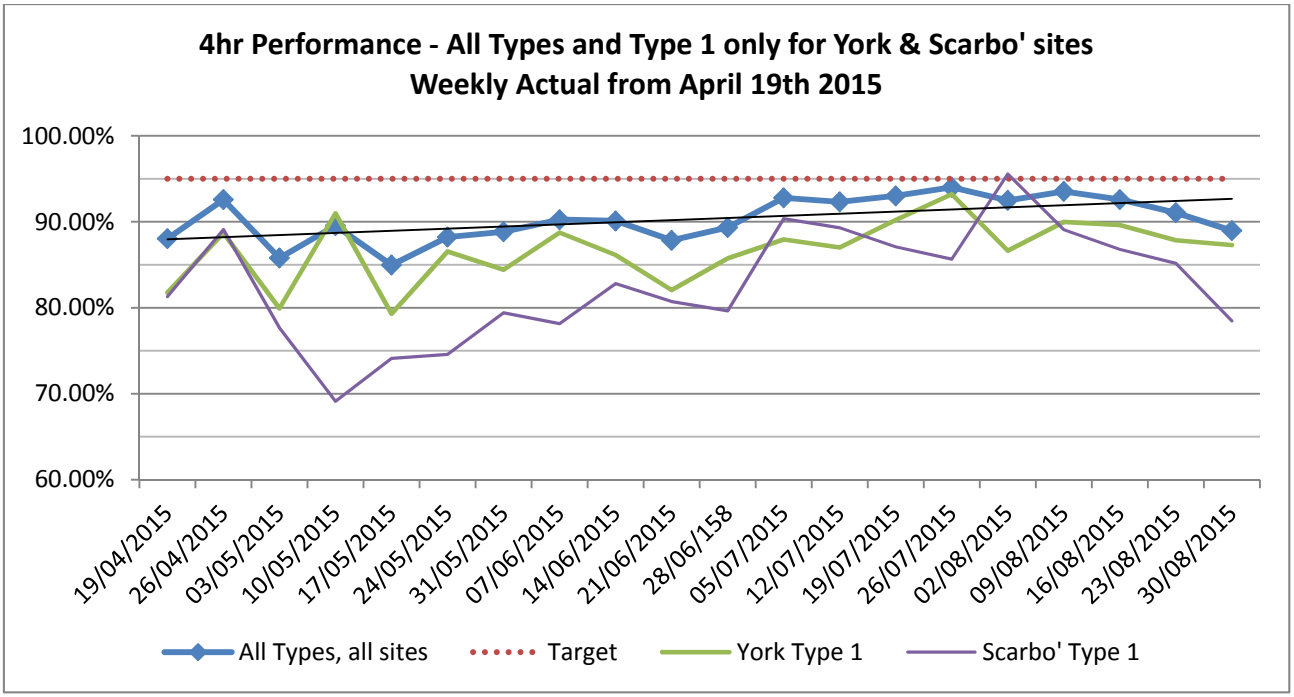
Q2 Breast Sy

- **Performance**: **Off trajectory (FT)** Q2: FT: 92.24%; BS **93.97**%; 62: **85.74%**.
- **Achievements**: Achieved BS target QTD. Holding one CT slot per day on York site to minimise delays in lung pathway is working well.
- **Risks**: Dermatology has experienced capacity shortfalls due to staff sickness, which has impacting on delivery of the TWW target; some referrals have been diverted to Head and Neck. A new locum has now started in post which will minimise breaches in September.

Diagnostics

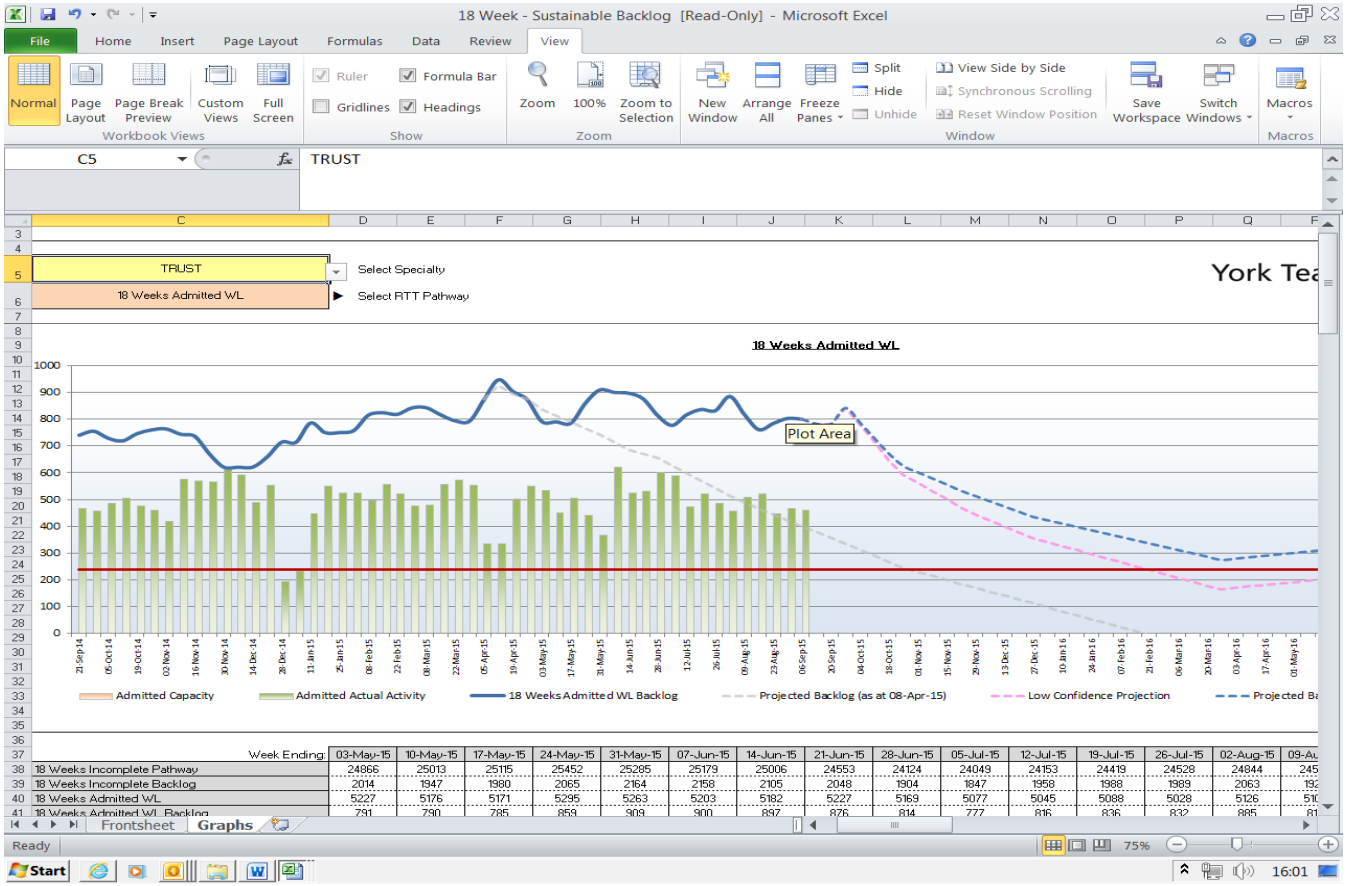
Trajectory: Oct 15

- **Performance**: **On Trajectory**: Radiology achieved 99% target Aug 15.
- **Achievements**: 19 patients away from achieving the diagnostic target on aggregate in August. Reduced endoscopy and cystoscopy breaches due to additional capacity.
- **Risks**: High risk of Echo breaches of the Scarborough site in October due to staffing difficulties. Several staffing options are currently being explored.



18 Week Admitted Backlog Trajectory

NB. Model being reworked again in light of operational changes to opthal additional activity delivery



York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Corporate Communications and Engagement Strategy

Action requested/recommendation

Board of Directors are requested to approve the strategy and associated action plan.

Summary

Since the last communications strategy was approved in 2010 the needs of the Trust have changed significantly, both in scope and complexity.

There is a continual need to ensure all communication activity conducted by the Trust is of the highest possible standards and is in tune with the Trust's core values and strategic objectives.

This renewed strategy provides a framework for communications and engagement activity for the next three years.

Actions are highlighted throughout the strategy and are detailed in an action plan at the end of the document.

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).

Whilst 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, it is fundamental that when designing communications systems and processes the requirements of the protected groups are taken into consideration.

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	Board of Directors
Risk	No risk
Resource implications	No resource implications are detailed in the report.
Owner	Lucy Brown, Head of Communications
Author	Lucy Brown, Head of Communications
Date of paper	September, 2015
Version number	1

York Teaching Hospital NHS
NHS Foundation Trust

Corporate communications and engagement strategy

Draft for approval: September 2015
2015-2018

1. Background:

The Trust's first communications and engagement strategy was approved by the Board of Directors in October 2010. This was superseded by the integration communications strategy (approved in 2011) which outlined both how the integration would be communicated internally and externally, and how the communications function would be integrated to serve the new organisation.

Since the last communications strategy was approved the needs of the Trust have changed significantly, both in scope and complexity. The organisation is going through significant change, which brings with it an increase in the number of media organisations, patient groups and other stakeholders, making coordination essential. We have multiple lines of engagement, with links being made at various levels. We also cover a vastly increased geographical area with distinct localities, each with different communications needs. We are increasingly seeing the impact of a competitive market, and the complexity of the environment we work in means a clear identity and message is increasingly important.

We have always been a high performing organisation, however this context is making it harder for us to effectively 'tell the story'.

There is a continual need to ensure all communication activity conducted by the Trust is of the highest possible standards and is in tune with the Trust's core values and strategic objectives. We are now at a point where a renewed strategy is needed, to provide a framework for communications and engagement activity for the coming years.

An effective communications function should protect and enhance the reputation of the organisation through several strands, including proactive media management, internal communications, patient and public involvement and stakeholder engagement, clear crisis management plans and consistent corporate identity and branding.

These must be delivered in partnership with the operational teams.

Actions are highlighted throughout the strategy and detailed in an action plan (Appendix A).

A short report will be prepared for the Board of Directors every six months, outlining progress against the action plan and other significant developments.

This strategy should complement and work alongside the following Trust documents:

- Membership development strategy
- Patient experience strategy
- Fundraising strategy
- Staff engagement strategy
- Annual plan

2. High level priorities:
The communications department will support the organisation in delivering its objectives by focussing on the following priorities:

Championing our brand:
Supporting the organisation in its 'one trust' philosophy by reinforcing the brand consistently across the Trust and by maintaining and enhancing the Trust's reputation

Supporting an engaged and informed workforce:
Working with staff to move from being passive receivers of information to active participants/contributors to the organisation

Becoming a trusted voice in the community:
Through strong partnership working and stakeholder engagement, working with patients and public, members and governors, and being a trusted voice in the media

The delivery of these will be underpinned by:

Getting the basics right:
Ensuring that the systems we have in place are high quality, fit for purpose and responsive to the needs of staff and stakeholders

Building a business-like approach:
Adopting an agency-style approach to communications projects, with individuals supporting projects based on their skills and expertise. Ensuring we have the suitable skills to operate in the new environment, for example, marketing, contributing to tenders, running public consultation and engagement exercises. Getting this right would open up the potential for income generation.

3. Internal communications:
Effective internal communications channels are essential for the successful operation of any organisation, and this has been a key priority for the Trust, both before and after the merger.

The results of the 2013 Listening Exercise and the most recent staff survey both indicate that this is something staff value highly, and that there are improvements we can make in this area.

We have had a real focus on this, and based on suggestions from staff and the need to adapt how we communicate to better reflect the new make-up of the organisation, our revised approach to internal communications was relaunched in September 2014. The purpose of this was to make clear for staff all the ways in which they can access information about the Trust, to increase senior leadership visibility and to be more overt in our communications efforts.

We introduced several new tactics as part of this approach, including chief executive drop-in surgeries at all sites, filmed staff briefings, and a weekly staff bulletin email.

We hope to see a gradual improvement in staff survey scores as a result of these changes, however it is important to recognise that whatever systems are put in place, it is not a substitute for good management and leadership, and this is only one element of the whole picture around staff engagement. We will therefore continue to work closely with the HR team to contribute to this agenda.

We will evaluate our internal communications channels to determine their effectiveness and how responsive they are to the needs of our staff.

A key risk for internal communications is fragmentation of channels. A balance must be struck between directorates and departments taking responsibility for communication and the development of too many channels, for example newsletters.

This would be improved through the further development of the Trust's intranet site, so we will need to ensure the necessary improvements are made to Staffroom before we can make significant progress in this area (see section 9).

Further focus will be given to improving communication with hard to reach staff, for example shift workers, those who are not desk-based, junior doctors and those not based at the main sites (for example, community-based staff).

The communications team is now responsible for delivery of the awards programme for the Trust. Several changes have been made to the monthly star award process with a view to raising awareness of the scheme more widely and increasing participation.

'Our Staff Matter', the document outlining our internal communications channels for staff, is at Appendix B.

We will:

- Evaluate our internal communications channels using feedback from staff and use the findings to make adjustments and improvements to the approach
- Continue to work closely with the HR team around staff engagement.
- Carry out a review of newsletters within the organisation and make recommendations as to how best to manage the flow of such information.
- Review the monthly star award to ensure it meets its new objectives following changes to the process
- Learn from other sites who are regarded as exemplars in staff engagement and communication

4. Media relations

The Trust has a stable and well-functioning press office, with good relationships with local journalists.

This is a busy and largely unpredictable element of the work of the communications team, with the team responding to in excess of 40 media queries a month on average.

Traditional media (local print media and radio) remain highly influential locally, and whilst there has been some increase in new media contact we have not yet seen a shift away from traditional media in the same way as some other sectors.

Due to our participation in a number of news and current affairs programmes we continue to be in demand as the voice on local health issues and are regularly approached to take part in TV series and news features.

We keep under review the best way to manage the press office, and there was some useful learning from the recent major incident in Scarborough and the Tour de Yorkshire that will be fed in to the revised emergency planning documents.

This is a pivotal area in terms of the work of the communications team and should be kept under review to ensure that all members of the team maintain their skills.

Recent changes at Board level and in other senior posts have meant a number of key spokespeople have left the organisation. Media training will be provided for those senior managers who would be expected to act as spokespeople through the course of their role. The communications team will continue to provide support to other staff who may be asked to interact with the media.

The media handling and external communications guidelines were revised and approved by the Executive Board in November 2014. These include

guidelines for staff regarding media handling, and an outline of the on-call process for media. These are available on the intranet for all staff.

We will:

- Identify key members of the senior team who require media training to ensure a broad range of credible and accountable spokespeople are trained across the Trust

- Continue to work with the wider health and social care sector to ensure consistent messages are released regarding future changes in local services.

- Revise media handling elements of major incident plans, including local press office processes.

- Review media handling and external communications guidelines, in line with Trust policy.

5. Stakeholder engagement:

The Trust has a number of established activities and channels for communicating with stakeholders, however as the NHS continues to change new areas are becoming more significant and of a higher priority, and we need to ensure we have the appropriate skills, expertise and processes to deal with this effectively. We need to ensure that the right links are being made at the right time with the right people.

Identifying our stakeholders and prioritising them will enable us to develop a planned approach to building and strengthening our relationships with them, and also a clearer way of communicating with them. It will also help us to decide where to focus our efforts, as this should be planned and purposeful, rather than ad hoc and reactive.

A list of stakeholders for the organisation is at appendix C.

We will:

- Map our stakeholders and review our methods of engagement to identify gaps
- Participate in regional networks and maintain good working relationships with other communications teams in partner organisations.

6. Branding and visual identity:

In an increasingly competitive marketplace, a strong consistent brand is essential. Having a single, clear identity is important for many areas of the Trust's business, from recruitment to tendering for contracts.

There is a lack of buy-in in some areas of the organisation to the Trust's visual identity and corporate branding. Scarce graphic design resource, easy availability of desktop design packages and a lack of a clear process for the production corporate materials mean that there is variable compliance and it is all to easy for people to go their own way. Discussions take place frequently with staff wishing to develop their own branding for a service or initiative, diverting the communications team from other priorities.

A review of the organisation's graphic design and print resource will be carried out to assess the current situation and make recommendations for a more coordinated approach that is easier for staff to understand and offers a more effective service to the organisation.

We will:

- Strengthen the Trust's visual identity guidelines and relaunch them, alongside template for people to use for basic communications materials
- Impose a moratorium on the use of branding that does not conform with the Trust's corporate identity, and support these teams in a move towards using the Trust's branding.
- Carry out a review of graphic design requirements and associated resource and spend across the organisation, resulting in recommendations for meeting the organisation's needs in this area

7. Social media:

The communications team has operated official social media accounts for the Trust since 2010, however we have taken a planned and more focussed approach over the last year, enabling this to become a stronger element of the range of methods we use for communication and engagement.

Although primarily launched with the public in mind, we have found that increasing numbers of staff are engaging with the organisation through our social media channels.

This has led to us using social media as a major vehicle in some of our recent campaigns, for example, 'Hello my name is', 'You said, we did' and 'Our staff: living the values'. It is also a popular way of sharing some of the reward and recognition stories, for example monthly star award winners.

As with any communications channel it is important that people consider carefully why it is needed and how it will be managed. There is a risk of contributing to the noise and lack of clarity of message and duplicating other content, and people become overwhelmed and switch off.

For this reason we continue to monitor the accounts linked to the Trust, and to advise and support staff wishing to use social media. We have produced guidelines for staff and a checklist for them to complete if they wish to set up a social media account associated with the Trust.

We will:

- Work with the patient experience team to further develop and strengthen how we use social media to support patient and public involvement and to gather feedback.
- Continue to build a network of followers to our social media sites

- Continue to support staff within the trust who wish to use social media in a work capacity.

- Ensure we maintain our current levels of responsiveness on social media.

- Further strengthen our staff engagement approach by using social media for staff engagement (for example, twitter forums, live twitter chats, video content via YouTube). This will increase leadership visibility and offer more opportunities for people to keep themselves informed.

8. Membership and governors:

The Trust's approach to membership is being refreshed following a lack of proactive work in this area since the acquisition. A strategy will need to be produced for developing the membership, and we will work with the Foundation Trust Secretary on identifying gaps. There is also a great deal of enthusiasm from governors to move this forward.

Due to conflicting priorities we have not carried out any proactive recruitment campaigns since the acquisition, however we have continued to communicate With the membership via quarterly newsletters.

Recent changes in the team (described in section 10) mean that there is now some resource to enable a greater focus on membership, and plans are being developed. Governors are also involved in this work, and a task and finish group has been established consisting primarily of governors. Improving our offer for existing members should also help with recruitment as we will be able to articulate for the first time the tangible benefits of membership.

We will work to build stronger links across teams for example, membership, fundraising and volunteering. These are all areas where people have expressed an interest or support for the organisation at some level, and we should ensure that we are making explicit links, for example promoting fundraising events to our members, and asking our volunteers to sign up as members, or promoting volunteering opportunities to our membership.

We will also work with the patient experience team to identify how we may further involve the membership in gathering feedback on our services. This links to our values, and putting the patient at the centre of everything we do.

Whilst some recruitment activity is necessary to maintain membership numbers, we have a large membership and our priority remains to focus on engagement rather than recruitment, rather than utilising existing networks and groups. The recruitment activity that does take place should focus on under-represented demographic and geographic areas, and we will deliver targeted recruitment campaigns to do this.

We will:

- Work with the governors and support them to engage with the membership in their constituencies
- Work with the staff governors to raise their profile within the organisation
- Develop an annual programme of events for members
- Implement one or two campaigns a year to recruit new members in under-represented demographic and geographic areas
- Work with the patient experience team to develop ways of involving the membership in patient and public involvement
- Make greater links between membership, volunteering and fundraising, for example, shared mailings, presence at events etc

9. Intranet and website:

The Trust's new website was launched in 2012 and is primarily managed through the communications team. Website continues to develop. Careful consideration is given to the development of separate service sites, and these are only supported where there is a clearly identified business need or if it is a specific requirement of our commissioners (e.g. sexual health).

Staffroom, the Trust's intranet site, was launched at the point of acquisition to service the whole of the newly-formed organisation. The aspiration is for the intranet to be the 'go to' first port of call for all news and updates about the organisation. We still have some way to go before this is achieved, and the development of the site has been slow for various reasons, however staff are now being trained to update their own areas, and the weekly staff bulletin all-user email links people back to the site, which should encourage staff to become more familiar with the site, and increase traffic to it.

We will:

- Evaluate staff room in its current form and make changes to the structure accordingly

- Establish a working group to finalise the move of any remaining content from the old intranet sites to staffroom, to enable the old sites to be switched off permanently.

- Continue to drive staff to the intranet and work with the system provider to put in place measurement and evaluation for this method of communication.

- Review website content and put in place a work programme to plug any gaps

- Evaluate the website and make any necessary changes based on the feedback

10. Resources:
We provide a comprehensive internal and external communications service to the Trust, including media relations and PR, stakeholder engagement and internal communications. The specialist staff within the team deliver this work through a range of channels including websites and the intranet, newsletters and corporate publications, social media and events.

It was recognised that there was need for greater coordination of the Trust's outward-facing functions, and our internal and external communications and engagement activities. The decision was made in 2014 to bring a number of teams into the Chair and Chief Executive's Office under a single senior manager who would have oversight of each of these functions. The three teams are communications, fundraising, and events.

It is important for these teams to retain their individual specialist skills and functions, however by working more closely together we can maximise the resources we have and offer an increased level of support both within the team and to the wider organisation. For example the events team can provide event management support for any team within the Trust wishing to host an event, and are now also providing support to the fundraising team, alongside the communications team, who are providing an increased level of PR support to fundraising.

The success of the charity goes hand-in-hand with people's good will towards their hospital, which in turn is dependent on its reputation and a patient's individual experience, so being able to offer increased communications and PR support is invaluable, and frees up time for the fundraising team to focus their efforts elsewhere.

Work is underway to ensure that from the start the team share the same aims and values, and that constructive relationships are formed within the team, with everyone's role being valued. Time is being invested in the development of the team, and any skills gaps are being identified. Our aspiration is to operate as an in-house agency, where any part of the organisation can commission work and members of the team will be allocated to projects on the basis of the skills needed.

We expect to see benefits as a result of these changes, for example in reward and recognition, membership, and support to the fundraising team.

We will:

- Introduce commissioning forms for communications projects (e.g. documents, events, films, websites)
- Focus on the development needs of the team and how any skills gaps can be met

APPENDICES:
A: action plan
B: Our Staff Matter: internal communications
C: Stakeholder list

CORPORATE COMMUNICATIONS AND ENGAGEMENT STRATEGY
V1 DRAFT FOR APPROVAL
SEPTEMBER 2015

	ACTION	DETAILS	COMPLETION DATE
1	Evaluate our internal communications channels using feedback from staff and use the findings to make adjustments and improvements to the approach	Questionnaire for staff	November 2015
2	Continue to work closely with the HR team around staff engagement.	Review CQC feedback and next staff survey results (due March 2016) to develop plans. Link closely with development of staff engagement strategy.	June 2016
3	Carry out a review of newsletters within the organisation and make recommendations as to how best to manage the flow of such information.		August 2016.
4	Review the monthly star award to ensure it meets its new objectives following changes to the process	Review meetings are planned for October.	October 2015
5	Learn from other sites who are regarded as exemplars in staff engagement and communication	Arrange a visit to Leeds Trust to look at their staff engagement arrangements. Continue to link with	Dates TBC

		national NHS communications good practice networks.	
6	Identify key members of the senior team who require media training to ensure a broad range of credible and accountable spokespeople are trained across the Trust	Key spokespeople already identified. Quotes are being sourced from training companies.	February 2016
7	Continue to work with the wider health and social care sector to ensure consistent messages are released regarding future changes in local services	Groups are being established for this purpose, for example the Ambition for Health communications group	Ongoing
8	Revise media handling elements of major incident plans, including local press office processes		June 2015
9	Review media handling and external communications guidelines in line with trust policy two years after publication		November 2017
10	Map our stakeholders and review our methods of engagement to identify gaps		March 2016
11	Participate in regional networks and maintain good working relationships with other communications teams in partner organisations.	A number of communications networks have already been established	Ongoing
12	Strengthen the Trust's visual identity guidelines and relaunch them, alongside the templates for staff to use for basic communications materials		March 2016
13	Impose a moratorium on the use of branding that does not conform with the Trust's corporate identity, and support these teams in a move towards using the Trust's branding	No new approvals for logos/branding granted with immediate effect.	All teams compliant by September 2016

		Existing owners of logos contacted with new guidance, and a changeover planned on a case by case basis.	
14	Carry out a review of graphic design requirements and associated resource and spend across the organisation, resulting in recommendations for meeting the organisation's needs in this area	A paper outlining the options will be offered to corporate directors for consideration and decision re next steps	December 2015
15	Work with the patient experience team to further develop and strengthen how we use social media to support patient and public involvement and to gather feedback	Agree a process for responding to social media contacts, and for increasing its proactive use	December 2015
16	Continue to build a network of followers to our social media sites	Increase the number of followers to each site by 50% in 12 months	September 2016
17	Continue to support staff within the Trust who wish to use social media in a work capacity	Contact owners of dormant accounts on a quarterly basis	Ongoing (quarterly)
18	Ensure we maintain our current levels of responsiveness on social media.		Ongoing (monthly monitoring)
19	Further strengthen our staff engagement approach by using social media for staff engagement (for example, twitter forums, live twitter chats, video content via YouTube). This will increase leadership visibility and offer more opportunities for people to keep themselves informed.	Link with the staff engagement strategy development and respond to feedback from staff on internal communications channels	March 2016

20	Work with the governors and support them to engage with the membership in their constituencies	Plans are being developed through a task and finish group	December 2015
21	Work with the staff governors to raise their profile within the organisation	Meet with the staff governors to agree methods and a timeline	December 2015
22	Develop an annual programme of events for members		December 2015
23	Implement one or two campaigns a year to recruit new members in under-represented demographic and geographic areas	Begin first campaign in Jan 2016 (likely to focus on maternity), followed by a campaign with schools and colleges	Begin in January 2016
24	Work with the patient experience team to develop ways of involving the membership in patient and public involvement		December 2015
25	Make greater links between membership, volunteering and fundraising, for example, shared mailings, presence at events etc	Review databases. Map opportunities for reaching shared audiences.	September 2016

26	Evaluate staff room in its current form and make changes to the structure accordingly	Survey for staff. Re-run focus groups.	March 2016
27	Establish a working group to finalise the move of any remaining content from the old intranet sites to staffroom, to enable the old sites to be switched off permanently.	Working with IT and the intranet provider to move this forward	March 2016
28	Continue to drive staff to the intranet and work with the system provider to put in place measurement and evaluation for this method of communication	Meet with the intranet provider to understand monitoring and evaluation capabilities of the system.	June 2016
29	Review website content and put in place a work programme to plug any gaps	Meet with areas with the most gaps and support them in producing content	April 2016
30	Evaluate the website and make any necessary changes based on their feedback	Survey embedded on the website and emailed to Foundation Trust members.	June 2016
31	Introduce commissioning forms for communications projects (e.g. documents, events, films, websites)	Forms to be developed for completion by staff who want to commission a communications project to ensure objectives, timescales, budget etc are agreed from the outset. This will be introduced as part of a service improvement project.	September 2016

32	Focus on the development needs of the team and how gaps can be met	Time out day held in April 2015. Skills audit completed. Training needs to be identified and monitored through appraisal process.	October 2015

STAFF

Staying in
Touch
Always
Features
First

Contact

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Ext 772 5233

York Teaching Hospital NHS Foundation Trust

@YorkteachingNHS

York Teaching Hospital NHS
NHS Foundation Trust

Our Staff Matter

How we communicate with you




Staff Room	The intranet – the Trust's internal website. View the news feed, announcements and alerts for timely messages. The first port of call to find information about what is going on at the Trust. Staff Room will automatically appear when you are logged onto a Trust computer and open up an internet page.
Staff Brief	Chief Executive Patrick Crowley's face-to-face brief with managers which takes place every six weeks. Key messages are cascaded through the organisation.
Staff Broadcast & Blog	Staff Broadcast brings you Patrick's key messages from Staff Brief in an accessible video format which you can view via Staff Room. Have your say via the accompanying blog, feedback comments to your manager or email staffbriefsuggestions@york.nhs.uk
Staff Matters	Our monthly 12-page Staff magazine, available electronically on Staff Room. Printed copies are also distributed throughout the Trust. Send in your suggestions, inclusions and photographs to staffmattersmagazine@york.nhs.uk

Staff Social	You are encouraged to follow us on Twitter, Facebook and You Tube to keep up to date via your smartphone with our latest news and press coverage. If you have something that you would like to be 'tweeted' from the Trust's social media accounts let us know!
Staff Bulletin	An electronic staff bulletin which is distributed to all staff via email every week.
Staff Screens	Screensavers display timely messages, news and events on computers throughout the Trust. Visit Staff Room for guidance on how to create an effective screensaver.
Staff Surgeries	Informal drop in clinics with the Chief Executive and members of the Executive Team where you can ask questions or feedback on issues from your ward or department. For dates of upcoming surgeries see Staff Room.
Staff Recognition and Events	Recognising and rewarding staff through the monthly Star Award, annual Celebration of Achievement, long service and retirement events.
Staff Benefits & Wellbeing	Offering a range of staff benefits and wellbeing schemes via our website www.york.nhs.uk/staff

Appendix C
Stakeholder list

- Patients (current and future)
- Public
- Volunteers (our own plus hospital Friends groups, voluntary sector etc)
- GPs and practice managers
- Current and future staff
- Carers
- Neighbouring NHS Trusts (including Hull and East Yorkshire Hospitals NHS Trust, Harrogate and District NHS Foundation Trust, Yorkshire Ambulance Service, Tees, Esk and Wear Valleys NHS Foundation Trust)
- Non-NHS providers in the locality
- NHS England
- Commissioners (NHS Vale of York CCG, NHS Scarborough and Ryedale CCG, NHS East Riding CCG, Hambleton, Richmondshire and Whitby CCG)
- Commissioning Support Unit
- Voluntary organisations
- Community Groups
- Local Authority including Social Services, Education and Public Health (North Yorkshire, East Riding and City of York)
- Local MPs (Kevin Hollinrake, Greg Knight, Robert Goodwill, Julian Sturdy, Rachel Maskell, Nigel Adams)
- Media (key players: York Press, Yorkshire Post, Scarborough News, Whitby Gazette, Bridlington Free Press, Hull daily Mail, Malton Gazette and Herald, Selby Times, Selby Post, BBC Look North, ITV Calendar, BBC Radio York, BBC Radio Humberside, Yorkshire Coast Radio, Minster FM, HSJ and other trade publications)
- Trade union representatives
- Governors
- HYMS
- Universities
- Local schools and colleges
- Contactors and suppliers
- Professional bodies
- Royal Colleges, deaneries
- Overview and Scrutiny Committees (City of York, North Yorkshire, East Riding)
- CQC
- Monitor
- FTN/NHS Confederation
- Foundation Trust members (current and future)
- Healthwatch groups (North Yorkshire, York and East Riding)
- Patient support and advocacy groups (PAGER, Bridlington Health Forum, Whitby Action Group, York Older People's Assembly, Blind and Partially Sighted Society)

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Workforce of the Future

Action requested/recommendation

The Board of Directors is asked to read the report and discuss.

Summary

This paper describes the work undertaken since integration to change the shape of the workforce in response to internal and external influences. The paper also describes further work which will take place to deliver a sustainable, effectively managed workforce in the future.

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

This paper presents some details in relation to the demographic profile of the workforce and actions that are being or may need to be taken in response to this. The content of the paper should be viewed in light of potential discrimination considerations linked to the suggested actions.

Reference to CQC outcomes

Outcome 13 – Staffing

Progress of report	Workforce Strategy Committee – 13th October 2015
Risk	Risks identified within the report relate to issues of workforce supply and demand
Resource implications	There are human resource implications identified throughout this report
Owner	Patrick Crowley, Chief Executive

Author	Polly McMeekin, Deputy Director of Workforce
Date of paper	September 2015
Version number	Version 1

Board of Directors – 30 September 2015

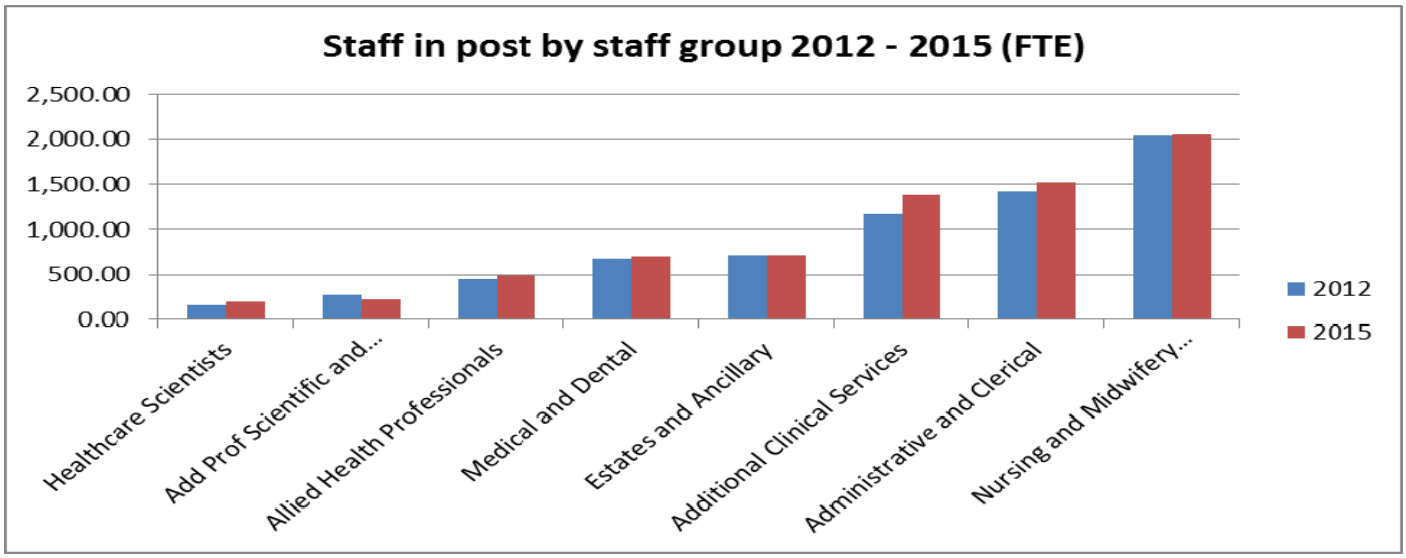
Workforce of the Future

1. Introduction and background

The aim of this paper is to describe how the shape of the organisation's workforce has changed since integration with Scarborough in 2012 and the reasons for those changes. The paper will also describe future known risks and challenges and the work which will be undertaken to mitigate those risks and to ensure that we have a workforce in the future which is sustainable and effectively managed.

2. Workforce profile

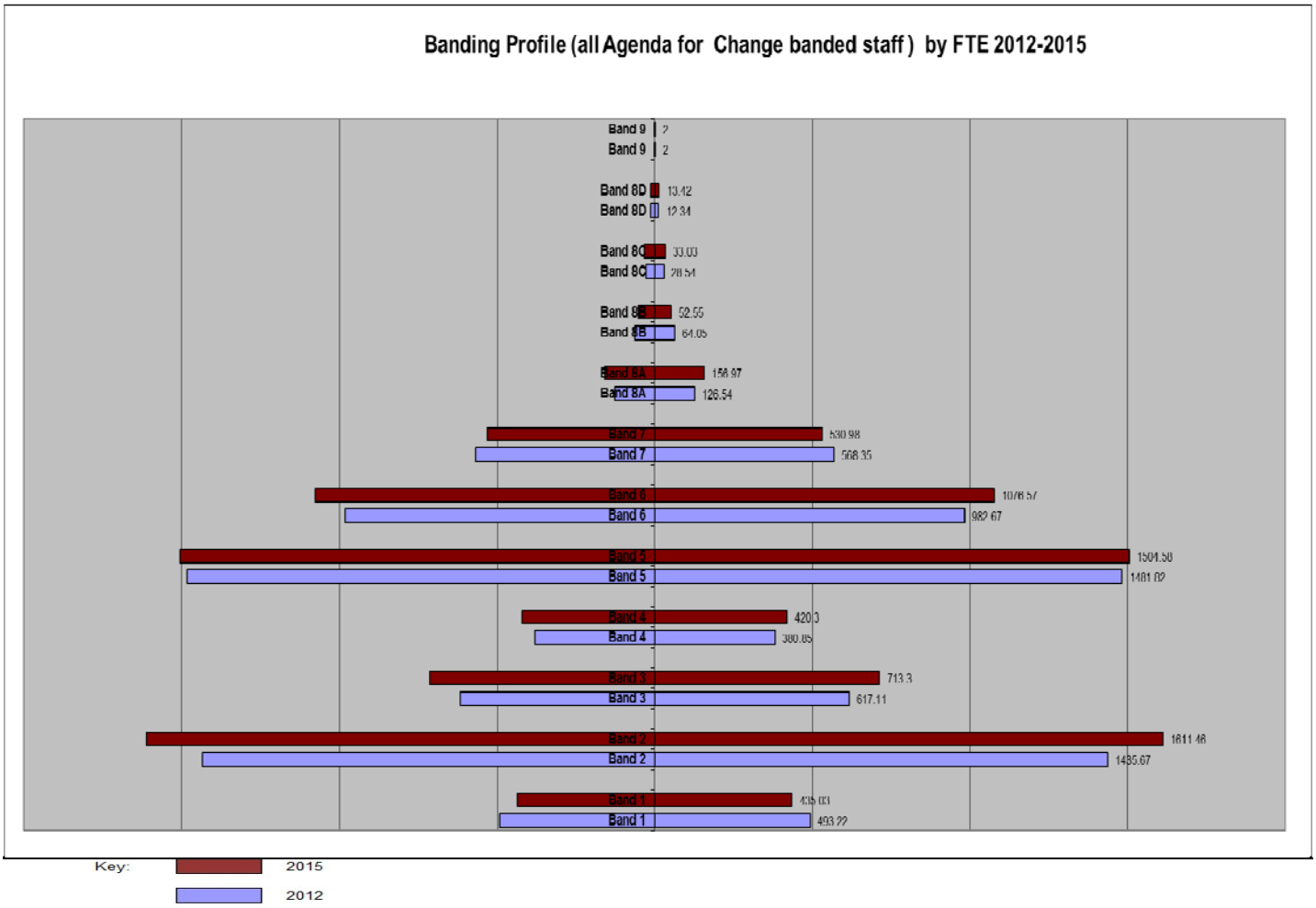
The graph below details the change to the number of staff employed substantively broken down by staff group from July 2012 to July 2015. Additional to the figures shown in the graph below, there are currently in excess of 2,000 active bank assignments of which more than 900 are registered nurses and midwives, almost 800 are additional clinical services (this group includes HCAs) and in excess of 100 doctors.



It is worth noting that updated national occupation coding has affected both the Professional, Scientific and Technical group and the Healthcare Scientists group. Forty-two individuals previously coded as Professional, Scientific & Technical are now coded as Healthcare Scientists.

3. Shape of the workforce

The following 'Christmas Tree' diagram illustrates the shape of the workforce on Agenda for Change (AfC) terms and conditions of employment from July 2012 against July 2015.



The largest proportional increases of staff in post by Agenda for Change band are those in bands 2, 3, 4, 8A and 8C.

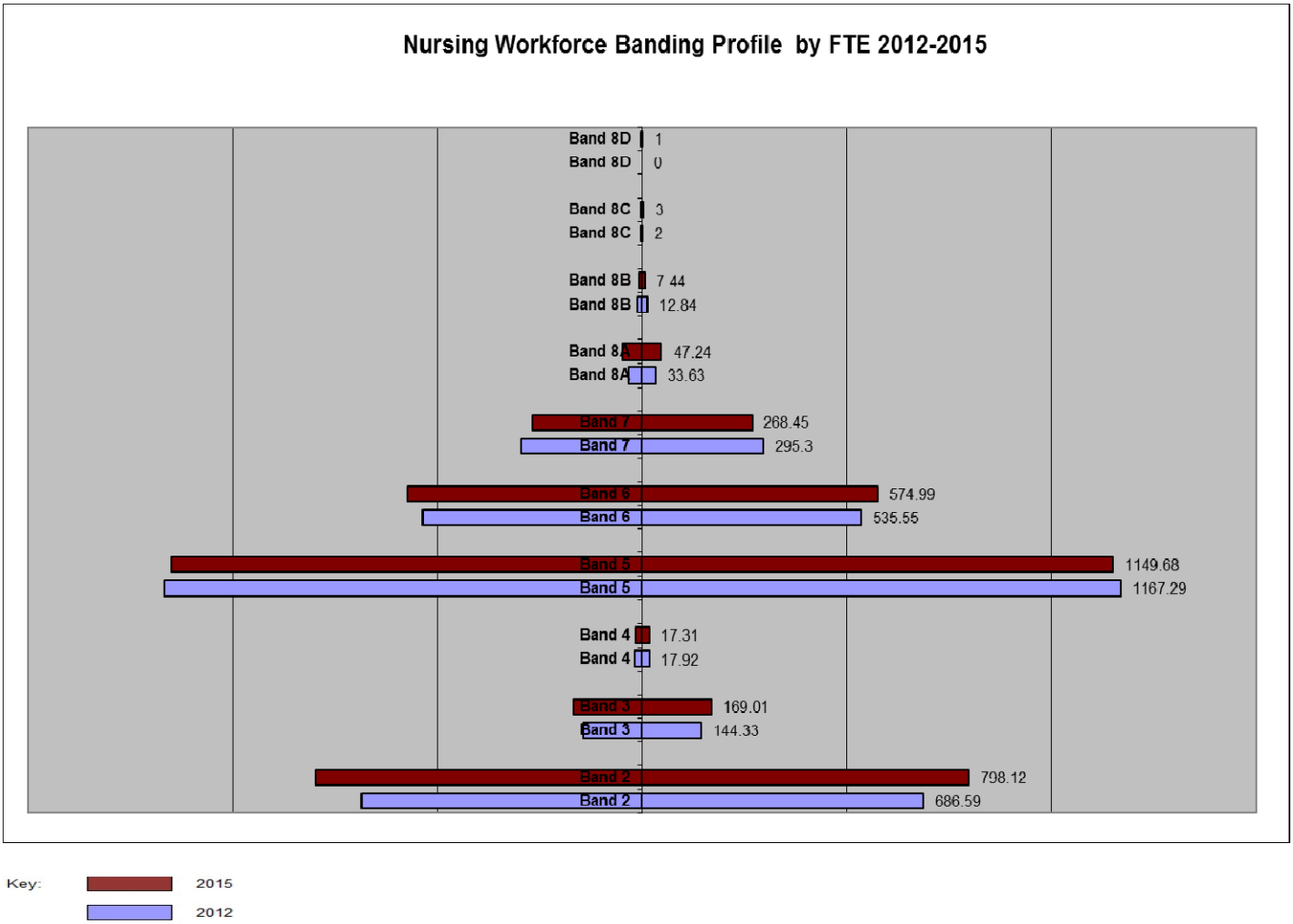
Prior to integration; work was undertaken to identify positions at the two separate Trusts with the same job titles but different pay bandings. Almost 30 positions were identified covering a significant number of staff. The Human Resources Directorate has consulted with appropriate professional leads to resolve any inequities. The outcomes account for changes in the diagram above.

Other work which has been undertaken over the past three years has been the development of new roles to address workforce challenges specifically in relation to the registered nursing and medical workforce.

Staff on Agenda for Change band 1 whose point on the pay scale would result in an hourly rate below the current living wage as determined by the Living Wage Foundation (£7.85 per hour) receive a pay uplift to bring them in line with the Living Wage. This decision was taken by the Trust in 2014.

Nursing

The diagram below shows how the shape of the nursing workforce (registered and unregistered) has changed since 2012.



The difficulties in recruiting to nurse vacancies has been well documented and has been reported to the Board of Directors previously. This is also acknowledged as being a significant challenge at a national level. Band 5 nursing comprise the majority (approximately 38%) of the nursing workforce. Whilst it was the Trust's initial plan, post publication of the Francis report and associated recommendations, to significantly increase registered nursing numbers this has proved to be difficult due to issues of supply and demand from other healthcare providers in a similar position to our Trust.

As the diagram above details; since integration the Full Time Equivalent (FTE) of band 5 nurses has reduced. However, following a successful recruitment campaign approximately 90 FTE registered nurses have accepted offers of employment with the trust with the intention of commencing employment before the end of 2015. More than half of these job offers are made to newly qualified nurses. In addition we plan to recruit up to 60 FTE registered nurses through a European Union recruitment campaign.

The overall turnover rate for the Trust since integration has increased by less than 1%; although the turnover rate for registered nursing staff has increased by more than 2% to an annual rate of turnover of more than 11.5%. The concerns linked to ability to recruit to vacancies and increased turnover are further exacerbated by the planned implementation of nurse revalidation in 2016 and the expectation that a proportion of our nurses may choose not to revalidate. Approximately a third of all our registered nurses are over the age of 51.

In response to these future challenges the Trust is increasing the number of nursing support roles (Healthcare Assistants - HCAs), including the development of a band 3 Senior Healthcare Assistant role. Although this is a relatively new development, the initial impact can already been seen in the diagram above.

This is positive for the organisation in terms of achieving sustainability for the future but also for staff in those roles who can now easily identify a path for career progression in nursing.

Our future plans now also include the development of band 4 (unregistered) nursing roles. This may offer opportunities to those looking to progress further through the band 2 and 3 HCA/nursing support route. However we also plan to offer this as an opportunity for those staff who may choose not to revalidate but who are not yet ready to retire. Those band 4 roles would be offered to be paid at the top of the band and may prove an attractive alternative to supporting retention of our experienced nurses.

The Trust's Workforce Plan which is submitted annually to Health Education Yorkshire and Humber indicated a 1% increase in registered nursing staffing in each of the next five years. This equates to an increase of approximately 150 FTE staff over that time. We showed this as a steady increase over the 5 year period and therefore with the level of recruitment successfully undertaken and with future planned recruitment of a further 60 FTE the Trust will be well ahead of the plan by the start of the next financial year.

Our planned increase in demand for nursing support roles at bands 2 to 4 has also been reflected in the workforce planning returns. The Trust submitted a 1% increase each year which over the five year period would be approximately 80 FTE staff. There has already been an increase of approximately 25 FTE at band 3.

What can also be seen from the diagram above is an increase in band 8A roles in nursing. Part of this is due to a realignment of banding for the Matron role across sites. In addition we have also introduced the role of the Advanced Clinical Practitioner (ACP). The initial aim of the development of this role was as part of the response to challenges in the medical workforce and long term vacancies at some grades, in some specialties. We now employ eight qualified ACPs and are supporting another ten through the training programme. Again, this is positive in terms of responding to a challenge to create a sustainable future but also offers progression opportunities for nurses and staff from other professional groups who might have a preference to remain in a clinical role.

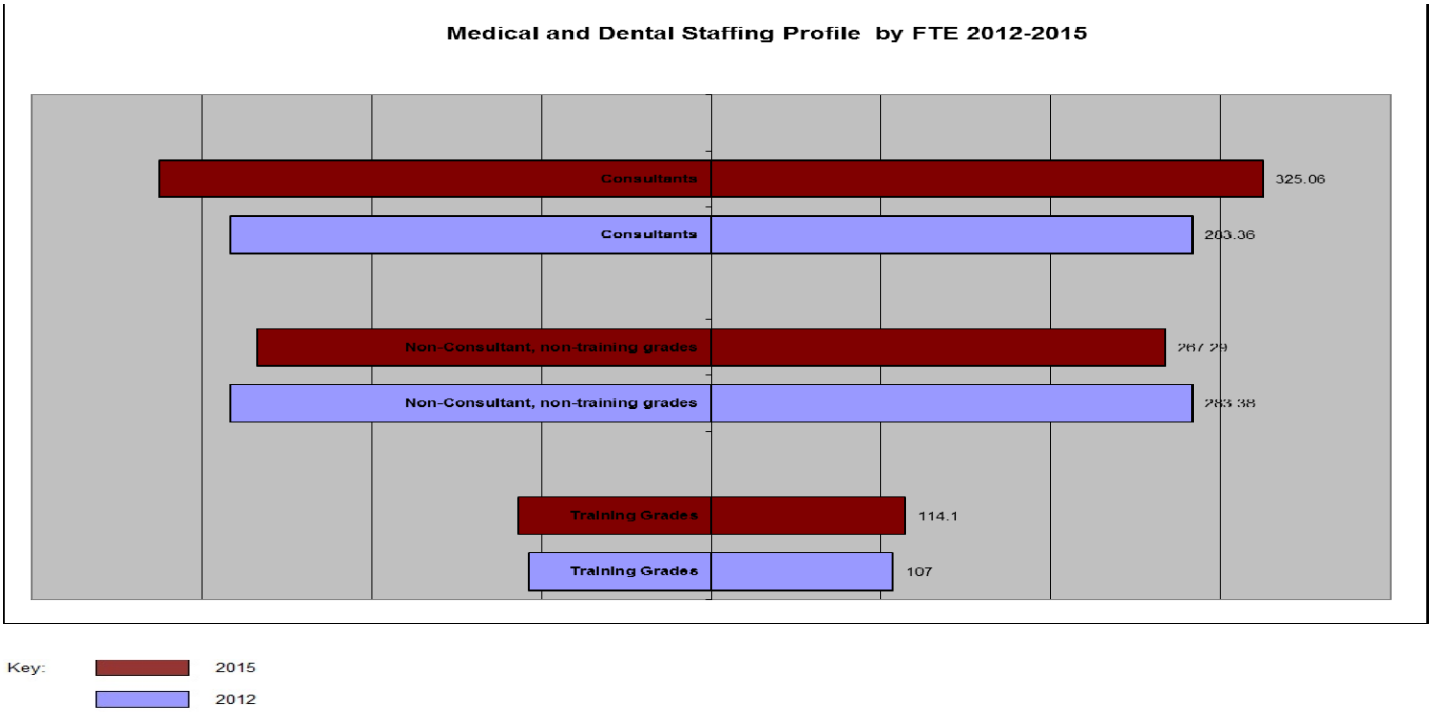
<u>Administrative and Clerical</u>

Since acquisition considerable work has been undertaken to ensure occupational codes are aligned across sites. For example porters and domestic staff could either go in the category of "Admin/Estates" or they could go in the category of "HCA and Other Support Staff. There is little national guidance on this. As a result of the recoding there is a shift in numbers across staff groups and therefore presenting a 'Christmas Tree' comparison is not truly representative.

It is important to note that reviews have been undertaken to ensure that administration work is being undertaken at an appropriate level and within appropriate roles and in particular to ensure that admin work is not inappropriately being undertaken within clinical roles.

Medical and Dental

Finally, the diagram below shows how the shape of the medical workforce has changed since July 2012.



Overall the medical workforce has increased with, most notably, the biggest increase being Consultant numbers which has seen an increase of just fewer than 15% in the 3 year period. This increase is not necessarily due to an overall increase in establishment but rather having successfully recruited into vacancies. There remain specialties that are extremely difficult to recruit to due to insufficient numbers being trained nationally and these have been partly addressed by the development of Advanced Clinical Practitioners roles.

Agency Spend

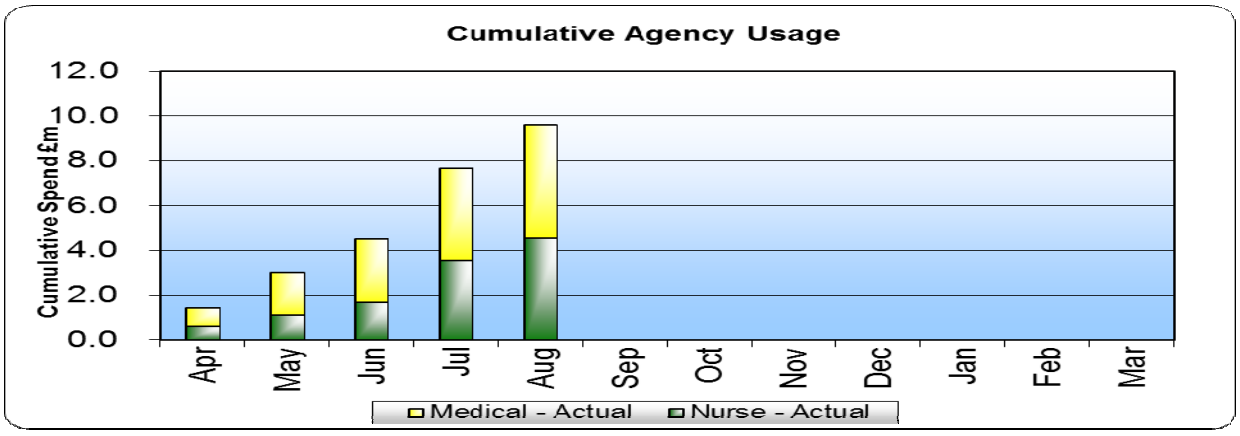
The graph below details the levels of agency spend across medical and nursing staff groups. It details a month on month increase in both areas between April to August 2015.

Whilst the Trust is not in a unique position with this level of agency spend a considerable amount of work is being undertaken to arrest the spend in this area. Centralised eRostering is being implemented across the Scarborough site to ensure we have consistent and effective rosters. Ward Managers and Matrons are being supported in the management of their rosters on the York site by the Nurse Deployment Team.

Proposals to incentivise joining the Nurse Bank have been shared with our Trade Union colleagues with the intention of obtaining ratification on 1st October 2015. These proposals would be subject to immediate implementation to ensure the Trust has adequate staffing arrangements in place for Winter.

In addition, all gaps of longer than 12-weeks will be routinely advertised with a view to secure substantive arrangements. This should reduce such reliance on agency usage. However, when agency is required to fill short term gaps or when alternatives fail; the Trust will utilise a 'framework'

agency for which it has a Master Vendor contract.



4. Future developments

Workforce requirements for the future are subject to constant review and discussion. Some of the issues described above highlight how even when plans have been made for expected future requirements, external influences lead us to have to reconsider these plans.

Current plans for the future include further redesign of the nursing workforce with increases in Agenda for Change band 2 to 4 roles. We anticipate a number of registered nurses will choose not to revalidate and as such we are developing a band 4 un-registered position to support the nursing workforce of the future. This job description has been agreed and is to be piloted in the Emergency Department and Endoscopy. Staff have already been recruited from within Endoscopy to undertake Foundation Degrees and develop them into the band 4 roles – the academic course will take two years to complete. Two have already commenced.

It is also key to ensure the most effective utilisation of our substantive and temporary workforce. 1,600 nursing staff across 63 units/wards are now rostered electronically. Whilst areas at the York and Community sites use a devolved model for rostering, i.e. the rosters are created by the ward sisters; a centralised model is being implemented across the units at Scarborough with rosters created by the Nurse Deployment Team. The implementation of central rostering is an opportunity to challenge practices and to improve understanding of the barriers to effective rostering. The Nurse Deployment Team will continue to work with the Senior Nursing Team to ensure the creation and deployment of cost effective, safe rosters.

The Workforce Information Team are undertaking a data cleansing exercise relating to job role information for all staff groups to ensure that it is easily understood internally but also aligned to nationally agreed data reporting conventions. This is a significant piece of work but ultimately will allow us to improve reporting on the changing shape of the workforce at a granular level.

There are many other projects and plans underway to ensure that we have a workforce in the future that can deliver appropriate and safe care for our patients. Many of these have previously been highlighted to the Board of Directors including working with schools, apprenticeships and development of service contracts.

5. Conclusion

This report has described how the shape of the workforce has changed since integration and the

reasons for this. Workforce planning is a continual 'live' exercise and we will continue to strive to work with stakeholders across and outside of the organisation to ensure our plans are fit for purpose in the long term.
6. Recommendation
The Board is asked to read the report and discuss.

Author	**Polly McMeekin, Deputy Director of Workforce**
Owner	**Patrick Crowley, Chief Executive**
Date	**September 2015**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Research and Development Update

Action requested/recommendation

The Board is asked to note the update on the Research and Development activities related to the R&D Strategy - September 2015.

Summary

The current Research and Development strategy is for 2014-2016. This summary highlights the objectives that are either complete at the time of writing or are actively being addressed.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report This is a periodical update

Risk	No risk.
Resource implications	Resources implication detailed in the report
Owner	Holden, Sue/Proctor, Michael
Author	Foster, Damon
Date of paper	September 2015
Version number	Version 1

Board of Directors – 30 September 2015

Research and Development Update

1. Introduction and background

The current Research and Development strategy is for 2014-2016. This summary highlights the objectives that are either complete at the time of writing or are actively being addressed.

2. Summary

1. **Strengthen the research culture within the Trust**
   Since the start of the strategy the R&D Unit has increased the number of email/newsletter articles that are accessed by staff. The notice board in the Learning and Research Centre displays research publications.

2. **Actively support and encourage Trust staff to pursue high quality research**
   The Trust's Research Advisors continue to work with our experienced investigators to develop investigator led studies.

3. **Secure funding from a national research funding programme for Trust generated research project(s)**
   The Trust has secured a number of awards to fund research – mostly from industry partners. We are currently looking to procure an web-based grant finding software package (http://www.idoxgrantfinder.co.uk/) on a three year deal.

4. **Expand the work of the York Clinical Research Facility (YCRF)**
   A joint workshop is planned for late October/early November which will see investigators from the Trust meet with investigators from the University of York. One of the focuses of this workshop is to explore collaborative research – in particular translational research that can be hosted by the YCRF.

5. **Increase the income we generate through research activity**
   As part of the TAP we are looking to reconfigure the Trust's income distribution model and reinvest a larger share of the income back into research delivery staff, who in turn will focus on delivering more commercially sponsored (income generating) research.

6. **Deliver robust and flexible financial management of our research income**
   Again as part of the TAP we intend to centralise all research income before the end of the current financial year.

7. **Streamline research management and governance services across the integrated organisation and our Clinical Alliance partners**
   The recently mandated Health Research Authority (HRA) are currently redefining what is meant by research management and governance and the Trust is actively involved in developments and in regular contact with our regional HRA change lead.

8. **Create opportunities for patients and their families to be informed about, and involved in, Trust research and our research processes**
   The Trust's website has a section about R&D. We have increased the number of posters around the Trust, in particular the Stroke Unit. Information about research is now included in leaflets that are sent out to patients. The Trust and the University are currently working together to set up a PPI group to work with researchers.

9. **Continue to work with the National Institute for Health Research (NIHR) and the Yorkshire and Humber LCRN to provide professional support for research**
   The Trust's research staff are centrally managed and work cross theme where appropriate. Training for these staff is coordinated through the R&D Unit.

10. Build and strengthen our research relationships with local universities, local NHS organisations and regional centres of national networks such as the AHSN and CLARHC

The Head of R&D holds regular meetings with key individuals at the University of York with a workshop due in October/November (see point 4). The York Tissue Bank is housed at the University of York and supported by the Trust.

The R&D Unit is actively seeking membership for the Trust of our local CLARHC.

3. Conclusion

Further clarification of any of the points listed above can be sought from the author.

4. Recommendation

The Board is asked to note the update on the Research and Development Strategy - September 2015.

Author	**Damon Foster, Head of Research and Development**
Owner	**Michael Proctor, Deputy Chief Executive**
Date	**September 2015**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Education Report

Action requested/recommendation

The Board of Directors is asked to note the report.

Summary

There has been continued growth month on month in all mandatory training subjects. No subjects fall below 50% compliance, with the majority of subjects now over the target of 75% compliance. There are currently no red indicators. It is predicted that all subjects will fall into the compliant category by December 2015, with the exception of the following subjects;

- DNACPR (currently 59% compliance)
- Nutrition (currently 59% compliance)

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This update has was only written for the Board of Directors.
Risk	No risk.
Resource implications	No resource implications.
Owner	Michael Proctor, Deputy Chief Executive
Author	Anne Devaney, Deputy Director of Applied Learning & Research
Date of paper	September 2015
Version number	Version 1

Board of Directors – 30 September 2015

Education Report

1. Statutory Mandatory training

The compliance percentages include all training that had been achieved for all staff groups prior to the implementation of Learning Hub. This was taken from ESR and other learning platforms.

There has been continued growth month on month in all mandatory training subjects. No subjects fall below 50% compliance, with the majority of subjects now over the target of 75% compliance. There are currently no red indicators. It is predicted that all subjects will fall into the compliant category by December 2015, with the exception of the following subjects;

DNACPR (currently 59% compliance) – Current low compliance for DNACPR is due to the subject only having been part of the mandatory programme for 5 months. Over 430 staff have completed this eLearning package since its launch and compliance continues to grow each month. It is estimated that compliance will reach 75% by March 2016, based on current monthly completions.

Nutrition (currently 59% compliance) – Whilst month on month compliance uplift continues, nutrition remains at a significantly lower compliance than all other subjects. This is due to the delivery of the training currently being face to face (similar to BLS), however an eLearning package is currently in development. It is estimated that this will be completed and 'live' by January 2016. From this point we would expect a significant increase in completions and lift in compliance.

The delay in the development of the nutrition e-learning package highlights an issue that has arisen with LH generally. Because of its success and flexibility there are increasing requests for new e learning packages to be developed. Also links made through the Hub to departmental information e.g. local induction handbooks can be tracked to see who has accessed it e.g. trainees. This has led to a backlog of learning waiting to be developed.

During the implementation phase the Postgrad AV technician was asked to suspend his 'day' job, (which does not include e learning development), over a 12 month period to support the launch which resulted in a backlog of his own work. That is now being addressed and consequently the development of new e learning has slowed significantly. Organisational changes to Internet Explorer versions have also created additional work on existing packages. At this point only learning that is related to CQUINS and corporate risk is being considered and this will remain the case, because of the skill set needed, until additional support can be agreed.

2. ACPs

The second cohort of ACPs (11) are now in their final placements, with one academic year yet to complete. All have passed the non- medical prescribing module which presented significant challenge on top of their clinical and academic responsibilities. They will begin an in house clinic al skills training programme at the end of September with OSCEs in May 2016. A third cohort is being considered and discussions are underway with several DMs as

to how these individuals will be supported and financed during training and following qualification.
3. Recommendation
The Board of Directors is asked to note the report.

Author	**Anne Devaney, Deputy Director of Applied Learning & Research**
Owner	**Michael Proctor, Deputy Chief Executive**
Date	**September 2015**

Stat Mand Compliance Report - 2nd September 2015

Certification	Number of staff who require this training	Number of staff currently compliant	Compliance percentage	Compliance percentage last month	Status (month on month)
Basic Life Support	5788	4774	82%	83%	↓
Blood Safety	4496	3700	82%	82%	=
Care of the Patient with Diabetes	2223	1650	74%	74%	=
Conflict Resolution	9182	6593	72%	70%	↑
Dementia Awareness	5196	4238	82%	80%	↑
Dementia- Higher Level	441	292	66%	55%	↑
DNACPR	732	431	59%	56%	↑
End of Life Care	3405	2229	65%	64%	↑
Fire Safety Awareness (High Risk)	3257	2474	76%	74%	↑
Fire Safety Awareness (Low Risk)	5931	5006	84%	84%	=
Food Hygiene Awareness	3940	3302	84%	83%	↑
Health & Safety inc. Risk Management	9182	8074	88%	87%	↑
Infection Prevention and Control Level 1	5126	4580	89%	89%	=
Infection Prevention and Control Level 2 (Theory)	4060	3603	89%	87%	↑
Information Governance	9189	7791	85%	83%	↑
Learning Disabilities Awareness	5705	4095	72%	72%	=
Manual Handling Theory (Module A)	9182	7792	85%	84%	↑
Medical Devices Awareness (Non-Medical Staff)	4810	4041	84%	78%	↑
Medical Devices Awareness (Medical Staff)	864	629	73%	70%	↑
Medicines Management	2580	2169	84%	84%	=
Non-Medical Consent	677	597	88%	86%	↑
Nutrition	3075	1821	59%	58%	↑
Pressure Ulcer Prevention	4209	3213	76%	76%	=
Patient Safety (formerly Quality & Safety)	4823	3463	72%	70%	↑
Safeguarding Adults Awareness	3430	3125	91%	91%	=
Safeguarding Adults Level 1	2545	1928	76%	72%	↑
Safeguarding Adults Level 2	3200	2314	72%	70%	↑
Safeguarding Children Level 1	3262	2902	89%	89%	=
Safeguarding Children Level 2	5107	3842	75%	72%	↑
Safeguarding Children Level 3	813	602	74%	74%	=
Total:	**126430**	**101270**	**81%**	**79%**	↑

≥ 75%

≥ 50% and ≤ 75%

< 50%

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

Food and Drink Strategy

Action requested/recommendation

The Board is asked to adopt the Food and Drink Strategy.

Summary

In late 2014 the Department of Health published the Hospital Food Standards Panel's "Report on Standards for Food and Drink in NHS Hospitals'.

In response all NHS Trusts are obliged to publish in 2015 a 'Food and Drink Strategy' which sets out their approach to:

- Patient nutrition and hydration
- Healthier eating for patients and staff
- Sustainable procurement

Attached is the final draft of YTHFT's strategy, following development and consultation with catering, dieticians and nursing staff, patients and governors.

The strategy adopts all of the national standards, and aims to provide consistent, nutritious, healthy and appealing food to all of our sites.

In-House production is at the heart of the strategy and it is proposed that the recent investment in the central production unit at York will be maximised, with all hot meals being prepared centrally to ensure consistency and value.

Under the strategy the Trust will adopt the 'Government Buying Standards for Food (published by the Department for Food and Rural Affairs 2014)', which will ensure high standards in relation to environmental standards, sustainable seasonal sourcing, animal welfare and ethical trading.

It is proposed that the Board sample the patient menu at least annually.

Action plans arising from the strategy will be developed by the catering department, and progress shared with the Trust's Nutrition operation Group which reports to the Nutritional Steering Group and onwards to the Quality and Safety Committee.

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).

The strategy makes provision for individual's needs and allows for special dietary requirements arising from health, cultural or religious considerations.

Reference to CQC outcomes

Regulation 14: Meeting nutritional and hydration needs.

Progress of report	Dieticians, Nursing, patients and Governors
Risk	No risk
Resource implications	Resources implication detailed in the report
Owner	Brian Golding, Director of Estates and Facilities
Author	Peter Mills, Head of Catering
Date of paper	September 2015
Version number	1.1

York Teaching Hospital NHS Foundation Trust

Food and Drink Strategy

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Foreword

This Food & Drink Strategy seeks to outline our ambitions over the coming years to provide safe, nutritious and high quality food and drink to our patients, staff and visitors.

We recognise that access to food and drink are the two fundamental needs to sustain life and as a healthcare provider we must ensure that we support these basic needs consistently for all our service users and staff. It is further accepted that the provision of nutritious food and easily accessible drinks not only sustains life but also contributes to the recovery process for our patients. Access to food and drink in relaxing surroundings is also important when considering the health and wellbeing of our staff.

In late 2014 the Department of Health published "The Hospital Food Standards Panel's Report on Standards for Food and Drink in NHS Hospitals" (Department of Health August 2014). The aim of the report is to improve food and drink across the NHS so that everyone who eats and drinks in hospitals has a healthier meal experience.

The report identified a number of standards to be implemented in hospitals and our strategy will capture these as we have interpreted them locally.

Our strategy focuses on three key areas:

1. Patient Nutrition and Hydration
2. Healthier eating across hospitals for our patients and staff.
3. Sustainable procurement of food and catering services.

Introduction

Our strategy will capture how York Teaching Hospital NHS Foundation Trust (the Trust) will address nutritional care for patients, deliver healthier food for the whole hospital community and embed sustainability into its service. It will also pay close attention to the end-quality of food and drink served, so that everyone receives a meal they enjoy.

Our strategy has been developed through consultation with all stakeholders including patients and governors. Its delivery will result in measurable improvements in the way in which food and drink is provided within the Trust delivering excellent practice, product and service delivery.

This strategy will be underpinned by a number of significant work plans, some of which are already in place, which seek to deliver the standards recommended in the Hospital Food Standards Panel's Report.

We also have a wider social responsibility. As a major purchaser and provider of food and catering services, we have the opportunity to put sustainability at the heart of our work. This includes reducing waste, embedding high standards of food production and reducing our carbon footprint.

Patient Nutrition and Hydration

It is well known that our diet significantly affects our health and wellbeing. This is true for both over-nutrition (which can lead to obesity) and under nutrition.

Our aim is to provide a high quality, nutritious and balanced diet for all our patients, based on individual need.

We know that malnutrition and dehydration are a significant risk to older people and cause harm. Malnutrition and dehydration are associated with increased mortality rates and hospital admissions together with the development of comorbidities such as impaired cognitive function and falls. Evidence also shows that poor control of diabetes and hypothermia can also arise.

Malnourished patients in hospital stay longer and are more likely to develop complications or infections. In addition to nutrition, adequate hydration is essential to help prevent and treat pressure ulcers, urinary tract infections and acute kidney injury.

The aim of our strategy is to:
Provide the very best nutritional care, delivered with clinical expertise, compassion and humanity to help people recover from episodes of illness. The aim is to assess patients' individual needs, meet these needs, regularly evaluate plans of care and create an environment where the best possible practice can take place.

We will do this as follows:

- Create the right overall environment for good nutrition and hydration;
- Deliver the right nutritional content within our hospital menu; and
- Ensure that patients individual needs for nutrition and hydration are properly identified and met.

The Trust seeks to embrace all the recommendations made by expert national bodies by meeting the 10 Key Characteristics of Good Nutritional Care (Nutritional Alliance). These are:

1. Everyone using healthcare and care services is screened to identify those who are malnourished or at risk of becoming malnourished.
2. Everyone using care services has a personal care support plan and where possible has had a personal input, to identify their nutritional care and fluid needs and how they are met.
3. The care provider must include specific guidance on food and beverage services and nutritional care in its service delivery and accountability arrangements.
4. People using care services are involved in the planning and monitoring arrangements for food service and beverage/drinks provision.
5. An environment conducive to people enjoying their meals and being able to safely consume their food and drinks is maintained (NB this can be known as 'Protected Mealtimes')
6. All staff/volunteers have the appropriate skills and competencies needed to ensure that the nutritional and fluid needs of people using care services are met. All staff/volunteers receive regular training on nutritional care and management.
7. Facilities and services are designed to be flexible and centred on the needs of the people using them.
8. The care providing organisation has a policy for food service and nutritional care, which is centred on the needs of the people using the service. Performance in delivering that care effectively is managed in-line with local governance and regulatory frameworks.
9. Food service and nutritional care is delivered safely.
10. Everyone working in the organisation values the contribution of people using the service and all others in the successful delivery of nutritional care.

- We will meet the standards for nutritional content of our hospital menus in line with the requirements of the Nutrition and Hydration Digest (The British Dietetic Association)
- We will screen all our patients for malnutrition and ensure their individual needs are met.
- We will provide an environment conducive to people enjoying their meals
- Patients will be supported at mealtimes, ensuring that the meal service is prioritised at ward level in line with the Trust's supported meal time policy.
- Where patients have additional nutritional requirements a plan of individualised care will be in place.
- The Trust will have an overarching nutritional policy which will include all aspects of good nutritional care from basic nutrition to artificial nutrition.
- We will ensure that all staff/volunteers are trained to ensure that the nutritional and fluid needs of people using our services are met.

Healthier Eating Across Our Hospital for Our Patients and Staff

The Trust considers the provision of good quality food and drink to patients, staff and service users to be a priority. We are proud to hold 5* Food Hygiene ratings across the main hospital sites where food is produced verifying that safe and hygienic practices are maintained and the staff involved in the process are well trained and valued.

The in-house catering teams work closely with stakeholders and dietitians to ensure that high standards are achieved and best practice implemented consistently.

Patient Catering Services

We will ensure that our patients receive meals to meet their own individual dietary requirements including therapeutic, cultural and religious needs.

Our menus will be designed and recipes developed in collaboration with Trust dietitians to ensure that the correct nutritional values are achieved for all dishes. All recipes will be tested regularly by taste panels, to include patients and stakeholders to ensure that quality and taste remains consistent. The Board of Directors will test the quality of patient meals no less than once per year.

Our menus and recipes will be reviewed by the Catering team and Dietitians quarterly to ensure that quality remains consistent, seasonal products are included and that competitive prices are paid for the food sustainably procured.

All hot meals will be produced centrally on the York Hospital site using the cook-chill production process. This standardises our offer across all in-patient sites, delivering consistency in quality of food whilst maximising return on investment. The cook-chill process allows fresh food products to be cooked according to standard recipes and blast chilled to prolong the life of the meal. This is achieved with no detriment to nutritional value or quality of the food. The centralised food production process is underpinned by a robust Food Safety system complying with current Food Safety legislation.

Where reasonably practicable the food and drink service at ward level will be conducted by appropriately trained food service personnel who will support the ward team. The responsibility for ensuring that patients receive the correct level of nutrition and hydration remains the responsibility of the clinical team, not the caterer; however, the Trust takes pride in the fact that both clinical and catering teams work collaboratively to ensure our patients receive meals they will enjoy.

Retail Catering Services

Our retail catering services will adopt the Government Buying Standards for Food within all in house provided staff and visitor restaurants together with Healthier and More Sustainable Catering – Nutrition Principles (Public Health England).

Adopting these guidelines will ensure that healthier eating is encouraged whilst still providing customer choice. To ensure the effective implementation of healthier eating principles our customers will be provided with sufficient information about the food and drink they consume to allow informed choices to be made.

Our in-house retail catering brand, known as “Ellerby’s” will be rolled out across all retail catering outlets. The brand will be recognised for promoting healthier eating for all staff and customers.

Our services will be delivered to meet the requirements of local customers without financial subsidy from the Trust.

Our retail catering services will provide evidence in support of Public Health England, Responsibility deal – pledge H4 Healthier Staff Restaurants

A collaborative working group *PHRD Working Group*, including catering managers, dietitians and other stakeholders is in place to implement these objectives.

Staff shops operated by Staff Benefits will be expected to comply with the healthier eating principles described.

All retail and catering contractors on Trust sites will be invited to comply with these objectives.

Sustainable Procurement

Government Buying Standards for Food (Department of Environment, Food and Rural Affairs 2014) will be adopted to underpin the procurement of food and catering services as required.

In striving to achieve these standards we will ensure we consider the following aspects of sustainable procurement:

1. Sourcing food produced to higher environmental standards, fish from sustainable sources, seasonal fresh food, animal welfare and ethical trading considerations.
2. Foods procured and served to higher nutritional standards including reducing salt, saturated fat and sugar.
3. If applicable in the future procure catering operations to higher sustainability standards, including equipment, waste and energy management. The Trust can already evidence that these issues were considered as part of the York Hospital Catering redevelopment project.

To ensure that the required standards are met all catering agreements and contracts will be implemented with the full support of the Trust Procurement Team.

Contracts for services will be procured through existing national and local framework agreements using local suppliers where reasonably practicable. All contracts will be tendered according to Trust Procurement Guidelines.

Monitoring and Review of the Food and Drink Strategy

Patient Services

The Trust will monitor nutritional practice across all services. This will include monitoring of nutritional assessments and compliance against the Nutrition and Hydration Policy.

The Trust's *Nutritional Steering Group* will meet monthly and report to the *Quality and Safety Group*. The steering group will provide a quarterly report to the *Quality and Safety Group.*

York and Scarborough Hospitals operate a *Nutritional Operational Group* which meet monthly and will provide a quarterly report to the *Nutritional Steering Group*.

Patient feedback will be sought through friends and family feedback, Picker Annual Patient survey and local annual nutrition audits.

Patient feedback will also be sought through regular surveys and comment cards available as part of the meal ordering system.

We will continue to monitor the required standards via annual Patient led Assessments of the Care Environment (PLACE).

Retail Services

We will monitor the required standards through the *Health and Wellbeing Network Group* and the *Health and Wellbeing Steering Group* which in turn reports to the *Work Force Strategy Committee* and onwards to the *Board of Directors*

Quarterly Staff surveys

Instant comment cards available in all restaurants.

Sustainable Procurement

A report will be provided annually by the Head of Procurement to the Trust's Sustainable Development Group.

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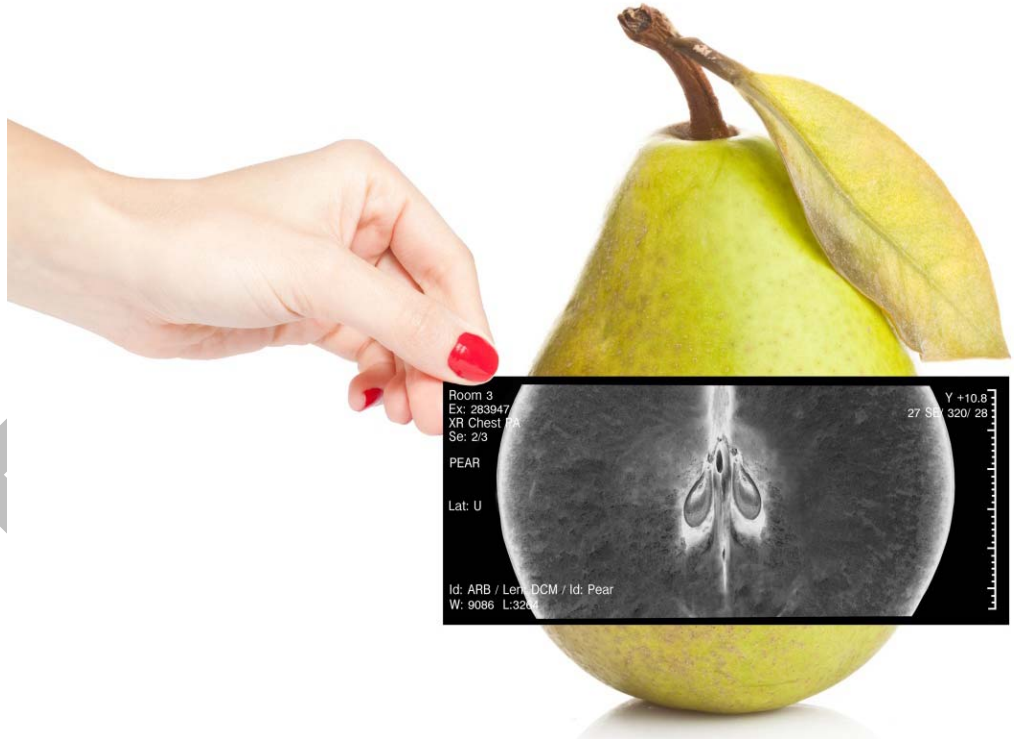
Room 3
Ex: 283947
XR Chest PA
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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 September 2015

PLACE Results 2015

Action requested/recommendation

The Environment & Estates Committee discussed the attached report and requested that it be seen by the Board in advance of the minutes of the committee as the results have already been published.

Summary

This paper sets out the process and the results of the Patient Led Assessments of the Care Environment (PLACE) which took place between 3rd March and 17th April this year in all 10 of our properties with inpatient facilities. All the assessments were self assessments with external validators being used and a result is provided against 5 areas: Cleanliness; Food & Hydration; Privacy, Dignity & Wellbeing; Condition, Appearance & Maintenance and Dementia. Section 8 of the attached report details the scores for each property against the national averages.

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 for 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 5 – Nutrional Needs

Outcome 8 – Cleanliness
Outcome 10 – Safety and Suitability of environmnet

Progress of report	Environment and estates Committee 23 September 2015
Risk	There may be external interest in local and national scores.
Resource implications	None
Owner	Brian Golding, Director of Estates and Facilities
Author	Carol Birch, Head of Facilities – Satellite Properties
Date of paper	September 2015
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Directorate of Estates and Facilities

PLACE Results 2015

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1 Context

The PLACE results were published on 11th August 2015.

2 Process

The Patient Led Assessments of the Care Environment (PLACE) took place between 3rd March and 17th April 2015 on all of the Trust in-patient sites.

All of the assessments were self-assessments with an external validator being used for six sites – Selby, White Cross Court, Whitby, Malton, Archways and Bridlington. The external validators used were Ross Mitchell and Stuart Kelly both from Harrogate District Foundation Trust.

Wendy Dale – York Domestic Manager was able to reciprocate and attended the assessments at Harrogate Trust.

Members of Trust Board of Governors were eligible to act as `patient assessors` within their Trust since their primary role is to represent the interests of patients/public.

In-house training was delivered by Carol Birch prior to the assessments to ensure the assessment process was understood by the patient assessors and Trust staff involved in the assessment process.

3 Assessment Process

PLACE teams consisted of the mandatory 50% patient assessors and leads from Facilities, Matrons and the Infection, Prevention and Control team.

The minimum 25 per cent of wards, departments and non-ward areas with varying age and condition was met which allowed the PLACE teams to make informed judgements about the areas visited.

4 Results

At the end of the process, each hospital/ unit which has undertaken an assessment is provided with a result against each of the five areas of the assessment namely Cleanliness; Food and Hydration; Privacy Dignity and Wellbeing, Condition Appearance and Maintenance and Dementia.

This result is calculated by reference to the score (points) achieved expressed as a percentage of the maximum score (points) which could have been achieved had every aspect of the assessment they undertook achieved the maximum score.

With the exception of the assessment of food, the maximum score for any question is 2.

The food assessment is split into two components – an Organisational component which addresses the catering services provided by the organisation, and an assessment of ward based practice and the quality (taste, texture and temperature) of the food provided. The questions in the Organisational section are scored according to a weighting algorithm which reflects the relative importance of each question. To allow for the fact that different hospital types answer a slightly different number of questions there are three weighting algorithms. All questions in the Ward-based component have a maximum score of 2 with the exception of Food Taste which from 2015 uses the weighted methodology.

Participating organisations and others who may use these data will be able to benchmark their performance or the performance of particular types of organisations.

For the purposes of comparison, a national average of scores from all participating hospitals/ units has been calculated. This average is weighted to take account of the fact that hospitals vary in size and that in larger hospitals not all areas are assessed. The weighting factor used in this calculation is bed numbers. Bed numbers are used since they are common to all organisations, whereas some premises in which assessments are undertaken do not have wards e.g. certain mental health/learning disabilities units and Treatment Centres.

The calculation used to produce the National Average is:

$$\frac{\textit{The sum of [Each site's score (points) multiplied by the number of beds in that site]}}{\textit{The total number of beds in all assessed sites}}$$

In 2015 the scoring methodology to food, taste and temperature was changed. In the case of taste, scoring changed from a three-point scale to a two point-scale. The precise impact of these changes on the National Average for the Food and Hydration score is not known. The changes are not judged to be of sufficient impact to make comparison of the 2015 results with 2014 inappropriate therefore scores for the ward based food assessments are considered to be comparable with 2014.

5 National Results

The number of assessments undertaken was 1,333 compared to 1,356 in 2014.

This table details the national highest, lowest scores and national average across the five domains.

DOMAINS	HIGHEST SCORE	LOWEST SCORE	NATIONAL AVERAGE SCORE
Cleanliness	100%	57.8%	97.60%
Condition, Appearance and Maintenance	100%	56.1%	90.1%
Privacy, Dignity and Wellbeing	100%	44.2%	86.0%
Food and Hydration	100%	60.2%	88.5%
Dementia	100%	40.26%	74.51%

6 Regional Comparisons

The table below details the comparisons across the five domains for the Commissioning Regions.

Region	Cleanliness	Condition, Appearance & Maintenance	Privacy, Dignity & Wellbeing	Food & Hydration	Dementia
North of England Commissioning Region	98.2%	91.2%	87.8%	89.7%	73.5%
South of England Commissioning Region	97.4%	89.9%	85.4%	88.8%	75.3%
Midlands and East of England Commissioning Region	97.1%	89.4%	85.7%	86.9%	74.3%
London Commissioning Region	97.2%	89.1%	83.7%	87.2%	74.2%
Multiple	97.8%	92%	86.9%	93.3%	81.7%

7 York Teaching Hospital NHS Foundation Trust Results

The table below details the final results (%) for York Trust organisation scores against the national averages.

	Cleanliness	Condition, Appearance & Maintenance	Privacy, Dignity & Wellbeing	Food & Hydration	Dementia
National Average Score (%)	97.4%	90.1%	86.0%	88.5%	74.5%
York Trust (%)	**99.45%↑**	**92.39%↑**	**82.43%↓**	**84.54%↓**	**61.89% ↓**

Cleanliness

In 2014 the score for cleanliness at St Monica's was low. This has now improved and all 10 sites are scoring above the national average.

Condition, Maintenance & Appearance

Both Bridlington and Scarborough are showing a marked increase in Condition, Appearance and Maintenance. There is a decrease at some sites which is a result of handrails and seating types being introduced into the scoring. Overall we are above the national average score which is pleasing given the age and variety of our estate.

Food & Hydration

Food and hydration scores are below the national average at York and Bridlington Hospitals. At the time of the inspection the new service had not yet gone live and we expect to see significant improvements in this area next year.

It should be noted that the Community sites scored higher which is due mainly to the patient meal experience and the way meals are served to our patients which predominantly in our community sites is in dining rooms as oppose to the patient's bedside therefore enhancing the meal experience.

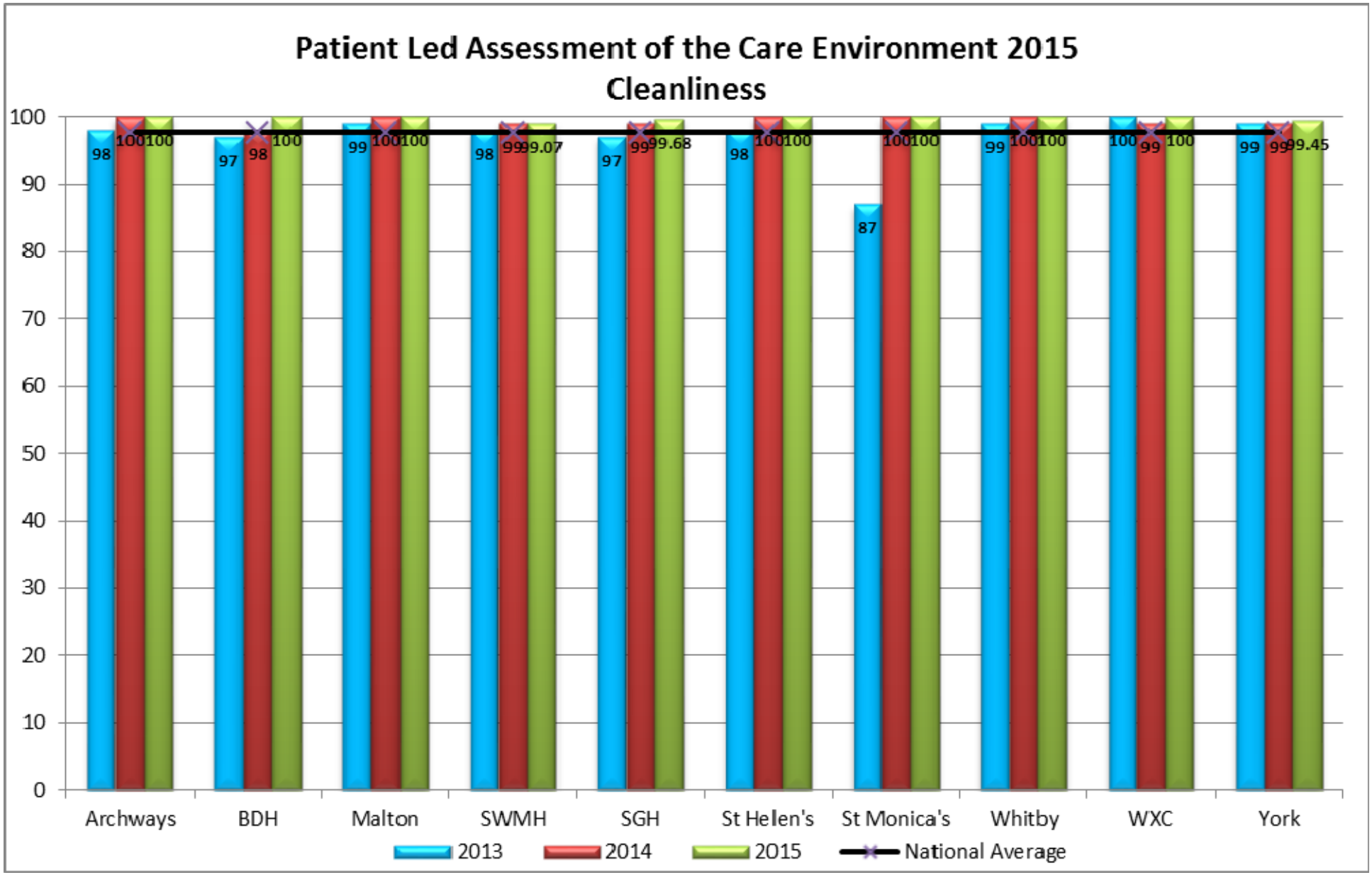
Privacy, Dignity & Wellbeing

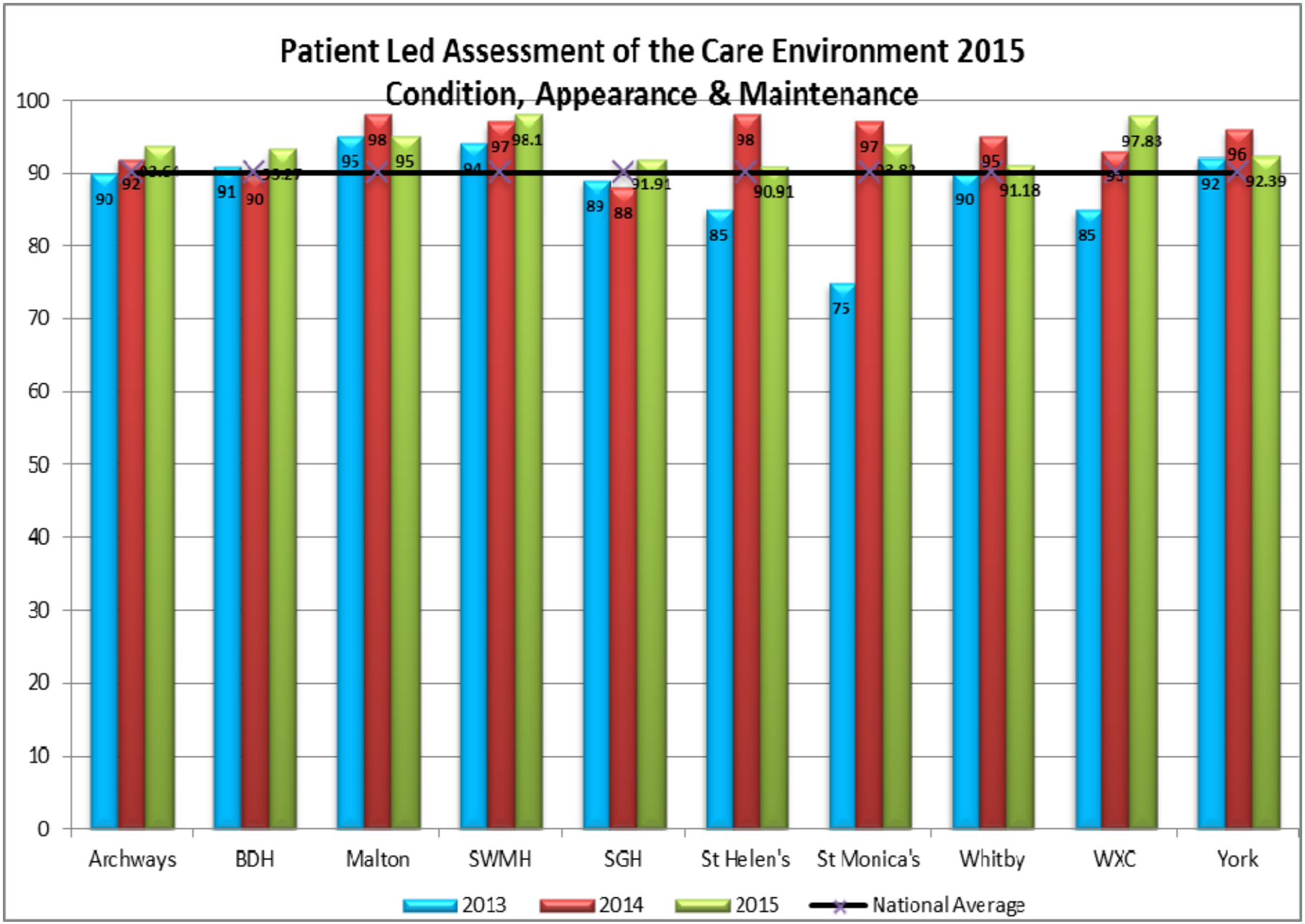
Privacy, dignity and wellbeing scores are down nationally. Locally we are making improvements as and when opportunities arise. Scores in this domain are highly influenced by the form of the built environment.

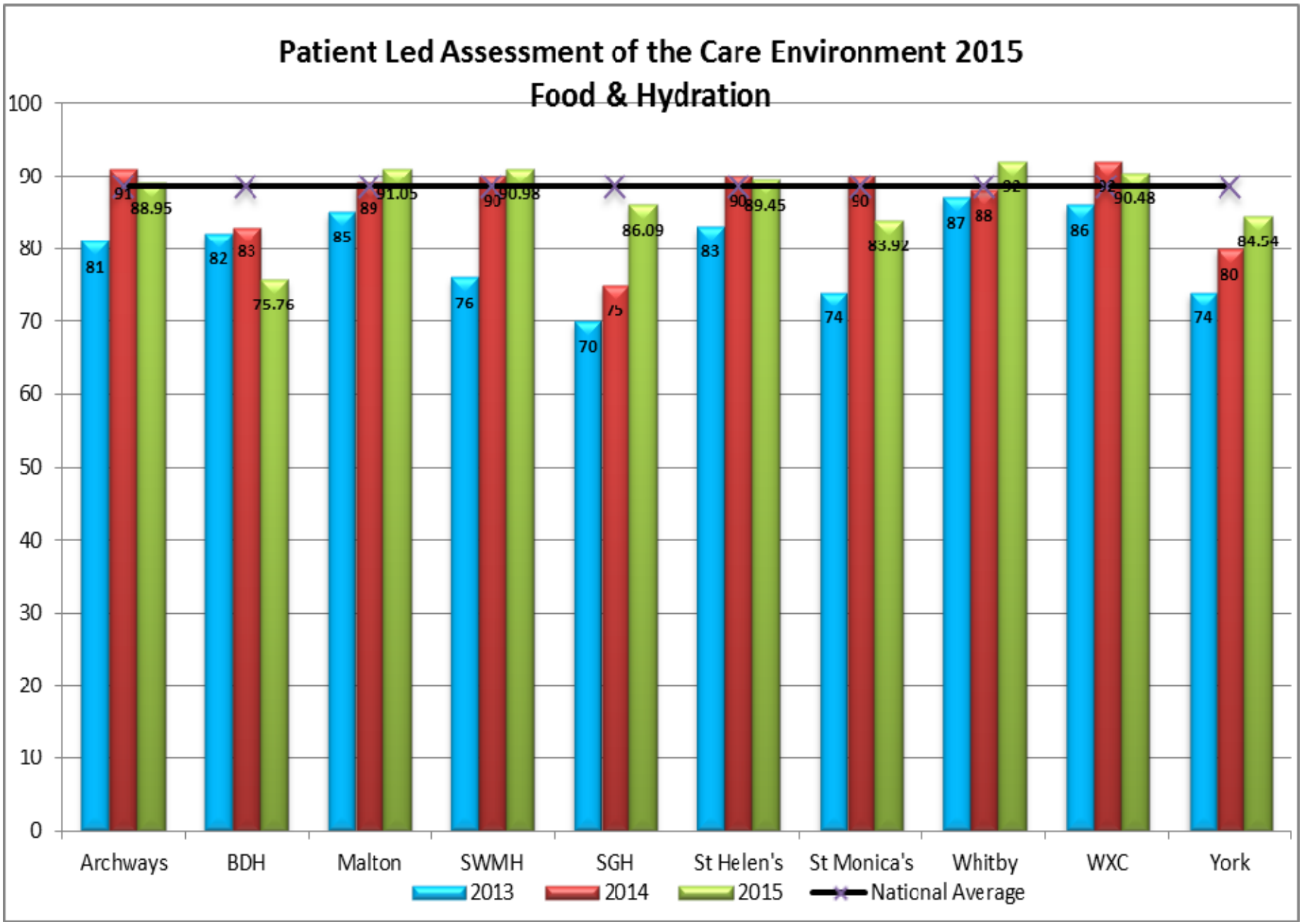
Dementia

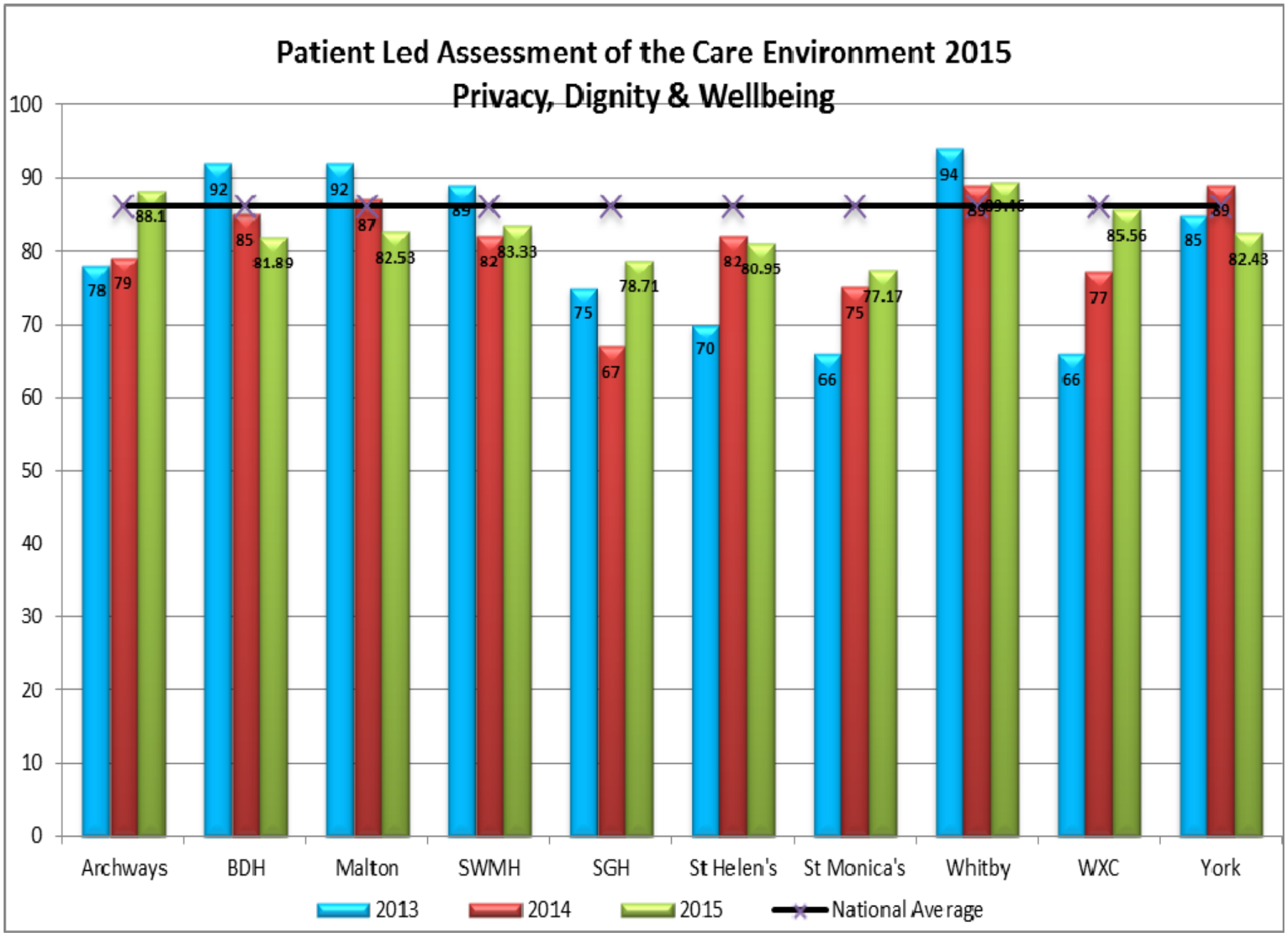
Dementia has been scored for the first time this year. The national average is relatively low although we score below this. Briefings for capital developments will include dementia awareness and it is anticipated that this score will increase gradually over the coming years.

8 Individual Site Results shown as bar charts




Patient Led Assessment of the Care Environment 2015
Condition, Appearance & Maintenance
100
90
80
70
60
50
40
30
20
10
0
Archways
BDH
Malton
SWMH
SGH
St Helen's
St Monica's
Whitby
WXC
York
90
92
91
90
95
98
95
97
98.1
89
88
91.91
85
98
90.91
75
97
90
95
91.18
85
93
97.83
92
96
92.39
2013
2014
2015
National Average


Patient Led Assessment of the Care Environment 2015
Food & Hydration
100
90
80
70
60
50
40
30
20
10
0
81
91
88.95
82
83
75.76
85
89
91.05
76
90
90.98
70
75
86.09
83
90
89.45
74
90
83.92
87
88
92
86
92
90.48
74
80
84.54
Archways
BDH
Malton
SWMH
SGH
St Helen's
St Monica's
Whitby
WXC
York
2013
2014
2015
Naticnal Average


Patient Led Assessment of the Care Environment 2015
Privacy, Dignity & Wellbeing
100
90
80
70
60
50
40
30
20
10
0
78
79
88.1
92
85
81.89
92
87
82.53
89
82
83.33
75
67
78.71
70
82
80.95
66
75
77.17
94
89
66
77
85.56
85
89
82.43
Archways
BDH
Malton
SWMH
SGH
St Helen's
St Monica's
Whitby
WXC
York
2013
2014
2015
National Average

9 Food Domain

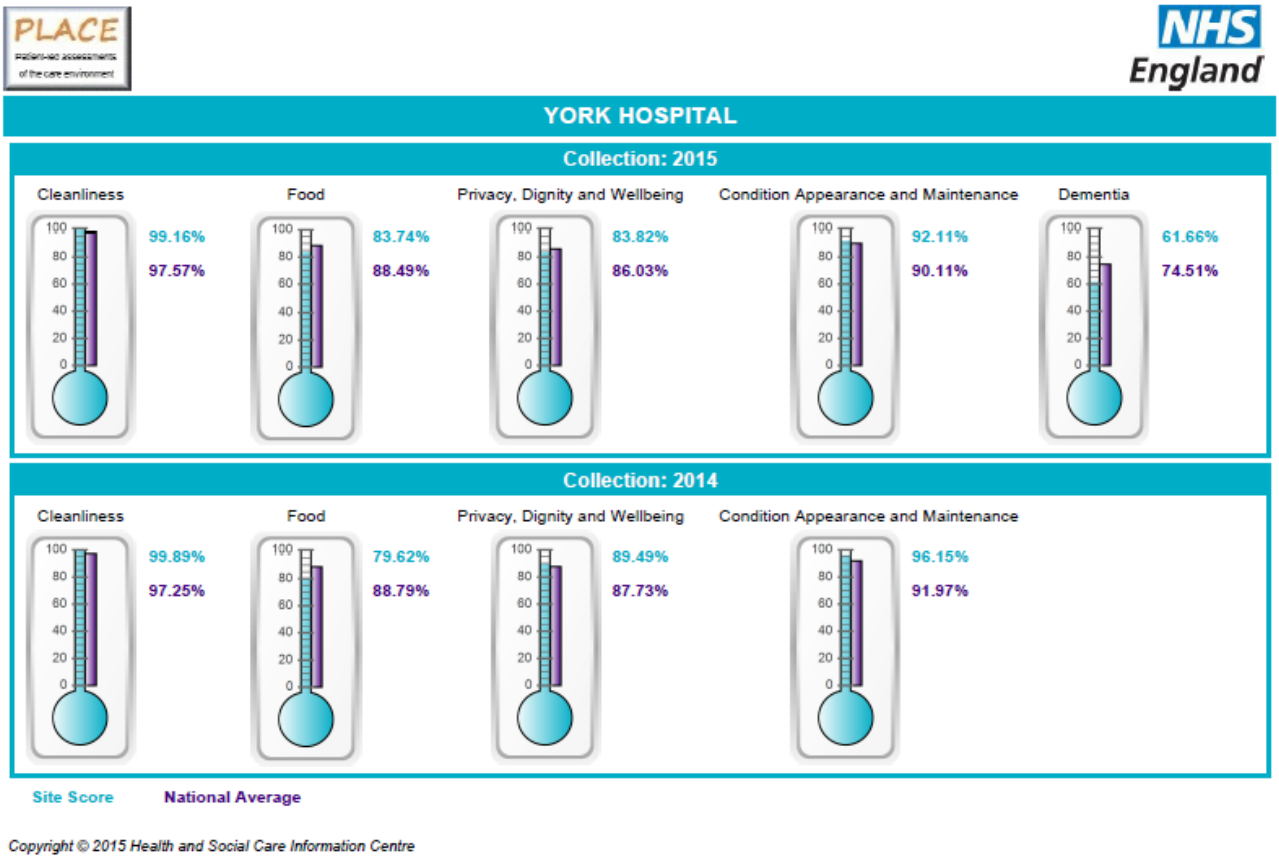
The food scores are reported as an overall Trust % and are then further broken down by site as detailed in the table below.

	Food Overall %	Ward Food %	Organisational Food %
York	83.74%	84.32%	79.56%
Scarborough	86.09%	88.73%	72.45%
Bridlington	75.76%	76.16%	74.85%
Selby	90.98%	97.30%	83.17%
Malton	91.05%	96.68%	83.97%
Whitby	92.00%	97.50%	84.60%
St Monica's	83.92%	94.39%	72.39%
Archways	88.95%	95.81%	79.94%
White Cross Court	90.48%	97.17%	82.60%
St Helens	89.45%	94.20%	83.58%

10 Public Access to results

The public are able to view York Teaching Hospital Trust's 2015 PLACE results through Health and Social Care Information Centre's (hscic) website in the Thermometer style graphs as detailed below.

However for ease of comparison within this report, bar charts and tables have been used to report the scores.



11 Action Plans

A total of 58 action plans were completed which were circulated to the individual wards and departments within 10 days of the assessments taking place. These will be tracked on a monthly basis by Facilities until all actions are closed out.

12 Feedback for Patient Assessors and Governors

The patient assessors and governors are to be invited to attend feedback sessions during October 2015 which will be facilitated by Carol Birch. This will allow the 2015 assessment process, scores and action plans to be discussed and identify how any improvements can be made for the annual 2016 assessments and to review progress of the action plans.

The future numbers of Patient Assessors and Governors will need to be maintained and reviewed. The Head of Facilities – Satellite Properties and the Trust Public and Patient Involvement Specialist will continue to work together to ensure adequate numbers are available for the 2016 assessment period and that adequate training is delivered.

Carol Birch will receive minutes from the Trust Patient Experience Group and will attend the meeting when appropriate to give any feedback relating to the PLACE process.

The Head of Facilities – Satellite Properties will continue to work closely with local Trusts to agree reciprocal arrangements for Peer Review/External Validation.

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York Teaching Hospital NHS Foundation Trust

Board of Directors – 30 September 2015

Annual Report of the Audit Committee

Action requested/recommendation

The Board of Directors is asked to receive the report for information.

Summary

This paper provides the Board of Directors with the Audit Committee's Annual report.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Audit Committee Board of Directors – for information
Risk	No risk.

Resource implications	No resource implications.
Owner	Philip Ashton, Chairman of the Audit Committee
Author	Philip Ashton, Chairman of the Audit Committee
Date of paper	September 2015
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Annual Report of the Audit Committee covering the period from 1 April 2014 to 31 March 2015

September 2015

Introduction

In accordance with best practice and the NHS Audit Committee Handbook, this report has been prepared to provide the Council of Governors and the Board of Directors with a summary of the work of the Audit Committee during the period April 2014–March 2015, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

This has been another challenging year for the Trust as it consolidates the integration work and responds to the national pressures on finance and performance. The Trust has continued to seek benefits from the successful integration of the services across the Trust. Work has continued to develop the risk and assurance systems. The Board of Directors has commissioned a piece of work to review the governance arrangements in the Trust. This work has sought to improve the flow of communication and reduce any occasions were duplication of effort can be identified. The Audit Committee has continued to monitor the impact of the integration on key systems through the Internal Audit programme and has continued to support the development of the risk and assurance systems and influenced the progress of the governance review.

Overview of the year 2014/15

Four Non-executive Directors make up the membership of the Audit Committee as follows:

- Mr Philip Ashton (PA) Chairman
- Mr Michael Sweet (MS)
- Mr Michael Keaney (MK)
- Ms Libby Raper (LR)

Table 1: Audit Committee Attendance

	Meeting Dates					
	19/5/14	**27/5/14**	**28/7/14**	**15/9/14**	**1/12/14**	**26/3/15**
PA	✓	✓	✓	✓	✓	✓
MS	✓	✓	✓	✓	✓	✓
MK	✓	✓	✓	✓	✓	✓
LR	✓	✓	✓	✓	✓	✓

The Audit Committee met on six occasions during 2014/15 and all meetings were quorate. Members of the Committee also attended relevant Audit Committee training events during the course of the year.

The Committee is supported at all of its meetings by:

- Director of Finance

- Head of Corporate Finance
- Foundation Trust Secretary
- External Audit (Partner and Senior Manager)
- Internal Audit (Head of Internal Audit and Internal Audit Manager)

During the year the Internal Audit Manager, Ms I Hall, left the North Yorkshire NHS Audit Services (NYAS) to take up a role with the Care Quality Commission. NYAS appointed a new Internal Audit Manager, Mr J Hodgson, who joined the Audit Committee in March 2015.

Other representatives (e.g. Local Counter Fraud Specialist) attended the Audit Committee at least twice a year.

The Committee received secretarial and administrative support from the Foundation Trust Secretary. There was a documented timetable which scheduled the key tasks to be undertaken by the Committee over the year. This is reviewed on an annual basis. Detailed minutes were taken of all Audit Committee meetings and were reported to the Board of Directors.

Separately, private sessions were held with Internal Audit and External Audit prior to the year end meeting. Internal Audit and External Audit are encouraged to discuss any concerns they may have with the Audit Committee on an adhoc basis.

Duties of the Committee

Following a review of the Audit Committee's Terms of Reference in September 2014, the key duties of the Audit Committee can be summarised as follows:

Governance, Risk Management & Internal Control
• Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives, primarily through the assurances provided by internal and external audit and other assurance functions.
Financial Management & Reporting
• Review the Foundation Trust's Financial Statements and Annual Report, including the Annual Governance Statement, before submission to the Board of Directors. • Ensure that systems for financial reporting are subject to review to ensure completeness and accuracy of information and compliance with relevant legislation and requirements. • Review the Trust's Treasury Management Policy, Standing Financial Instructions and systems in place to ensure robust financial management.
Internal Audit & Counter-Fraud Service
• Ensure an effective internal audit and counter-fraud service that meets

mandatory standards and provides appropriate, independent assurance to management and the Audit Committee. • Review the conclusion and key findings and recommendations from all Internal Audit reports and review of regular reports from the Local Counter Fraud Specialist. • Monitor the implementation of Internal Audit and Counter Fraud recommendations.
External Audit
• Ensure an effective external audit service. • Review the work and findings of external audit and monitor the implementation of any action plans arising.
Clinical Audit
• Review the audit programme • Understand and review the systems and processes used to undertake clinical audits
Other Assurance Functions
• Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. • Review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. Specifically, the Corporate Risk Management Group and the Patient Safety Group.

Work of the Committee/Group

The Committee currently organises its work under five headings *Work Groups*, *Internal Audit, External Audit*, *Governance Issues, Clinical Audit* and *Finance Issues*.

Work Groups - The Audit Committee has a work group reporting directly to it formed in 2010. This group reviews the data quality in the organisation.

The Data Quality Group received presentations from the relevant Trust expert(s) on key systems used to manage the four data streams. These included; financial systems (ledger, asset register, payroll, salary sacrifice), the Trust's Patient Administration System (CPD), the Electronic Staff Record (ESR), the Service Line Reporting System and systems to manage risk incidents within Risk and Legal Services.

The purpose of the presentations was to enhance an understanding of the systems, provide an overview of their operation and to allow the Data Quality Group to question aspects of data quality. The presentations were designed to provide assurance to the Data Quality Group and onwards to the Audit Committee.

The work group has been developing an assurance mapping exercise. This exercise is designed to provide assurance about the accuracy of the information.

Updates were provided verbally at a number of Audit Committee meetings.

In July 2014 the Audit Committee held a time out session where it considered some of the approaches taken to identifying risks in the organisation. As a result of the discussion the Audit Committee introduced a feedback system from other Board Committees - Quality and Safety, Finance and Performance, and Workforce Strategy. The members or chairs of those Committees (who are also members of the Audit Committee) report to the Audit Committee on any key risk areas that have been identified by the Committees. The Audit Committee considers the risk and the appropriateness of requesting Internal Audit to undertake a review or audit of the area.

Internal Audit - Internal Audit and Counter Fraud Services are provided by NYAS. The Chair of the Audit Committee and the Director of Finance sit on the Alliance Board which oversees NYAS at a strategic level. The Board met on four occasions during 2014/15.

An Internal Audit Charter formally defines the purpose, authority and responsibility of internal audit activity. This was originally approved in 2010 with a revised document reviewed and approved by the Alliance Board in July 2012.

The Audit Committee gave formal approval of the 2014/15 Internal Audit Operational Plan in March 2014.

The conclusions (including the assurance level and the corporate importance and corporate risk ratings) as well as all findings and recommendations of finalised Internal Audit reports are shared with the Audit Committee. The Committee can, and does, challenge Internal Audit on assurances provided, and requests additional information, clarification or follow-up work if considered necessary. All Internal Audit reports are discussed individually with the Audit Committee.

During the year Internal Audit were asked to undertake a number of additional audits and reviews following concerns raised by senior management. As a result an increase in the number of 'limited assurance' opinions was seen. The Audit Committee reviewed the reports and was assured by the increasing number that related to functional or operational responsibility for control compliance, rather than control design.

There were four reports presented to the Audit Committee during the year with low assurance, these were examples where senior management had raised concerns and requested Internal Audit to undertake an audit.

A system whereby all internal audit recommendations are followed-up on a quarterly basis is in place. Progress towards the implementation of agreed recommendations is reported (including full details of all outstanding recommendations) to the Director Team and the Audit Committee on a quarterly basis. The Chief Executive continues to review progress towards implementing recommendations made in limited assurance reports.

The Counter Fraud Plan was reviewed and approved by the Audit Committee and the Local Counter-Fraud Specialist (LCFS) presented bi-annual reports detailing progress towards achievement of the plan, as well as summaries of investigations undertaken. The Audit Committee also received the Counter Fraud Annual Report and a copy of the self- assessment action plan.

The Audit Committee commissioned Internal Audit to undertake a piece of work about the possibility for conflicts of interest in the Trust. The work outlined the occasions where a conflict could occur and made recommendations on how those conflicts could be minimised.

External Audit - External Audit services were provided by Grant Thornton for 2014/15. During the 2014/15 financial year, the Audit Committee reviewed External Audit's Interim Report, Annual Governance Report and Management Letter in relation to the 2014/15 financial statements for York Teaching Hospital NHS Foundation Trust.

External Audit regularly updates the Committee on progress against their agreed plan, on any issues arising from their work and on any issues or publications of general interest to Audit Committee members.

The current term of office for Grant Thornton came to an end on 31 July 2015.

During November and December 2014 a small group of governors on behalf of the Council of Governors and working with the Audit Committee undertook a tender process for the appointment of an external audit service.

The process was extensive. It invited service providers to submit a document outlining the service they offer.

A meeting was arranged for management to meet with the eligible firms. The group of governors and members of the Audit Committee were provided with scores from the submitted documents and the outcome of the meeting with management.

The providers were invited to attend a session with the appointment panel (the appointment panel included the small group of governors, the Chairman of the Audit Committee, the Director of Finance and the Deputy Chief Executive. The Foundation Trust Secretary, Head of Internal Audit and Head of Corporate Finance were present to provide advice). Following the session with all candidates the panel formulated a recommendation which was considered and approved by the Council of Governors at the December 2014 meeting. The appointed firm was Grant Thornton LLP. They will hold the contract for three years at which point there will be an option to extend the appointment for a further two years.

On appointment, Grant Thornton confirmed to the Trust that the audit team working with the Trust would be changed to comply with good governance arrangements. The new manager for the audit will be Mr Gareth Kelly; the partner will currently remain as Mr Graham Nunns. An additional senior member of the team, Mr Mark Fletcher will provide additional strategy and governance advice to the Trust.

The Audit Committee reviewed and approved the External Audit Plan in relation to the 2014/15 financial statements and the related audit fee in March 2014.

Governance issues - During 2014/15 the Audit Committee reviewed and, where appropriate, approved the following documents prior to submission to the Board of Directors:

- Assurance Framework and Corporate Risk Register in July, September, December 2014 and March 2015;
- Standing Orders, Standing Financial Instructions and Scheme of Delegation in September 2014;
- A review of compliance with the Code of Governance in May 2015;
- Additionally the Staff Registers of Interests and Gifts and Hospitality for the year ended 31 March were reported to the Audit Committee in May 2015;
- The Annual Governance Statement and the Head of Internal Audit Opinion were scrutinised by the Audit Committee prior to submission to the Board. The Committee also reviewed the Corporate Governance Statement prepared for publication in June 2014;
- Additional certificates required by Monitor.

In relation to the governance of the Audit Committee itself, the Committee undertook the following tasks during 2014/15:

- Review and approval of Audit Committee Terms of Reference and work programme at the time out meeting held in September 2015.
- Ongoing review and revision of the Audit Committee's timetable.
- The Audit Committee supported the work of the revision of the Corporate Risk Register and Assurance Framework.
- The Audit Committee supported the Governance Review being undertaken in the Trust and provided input to the development of the review.

Clinical Audit – During 2014/15 the Audit Committee received information on the national clinical audit programme and discussed the impact on the Trust. The Audit Committee sought further information relating to the local audit programmes and the directorate programmes. The Audit Committee received examples of local audits and a copy of a directorate clinical audit programme. The Audit Committee has continued to seek assurance about the clinical audit work in the Trust to understand the systems employed to ensure recommendations are implemented and re audited.

Financial issues - The Committee oversee and monitor the production of the Trust's financial statements. During the 2014/15 financial year, this included:

- Draft Accounts and Annual Report for the period 1 April 2014 to 30 March 2015
- Review of the risks identified in external and internal audit reports.
- Issues regarding end of year accounts;
- A Committee meeting on 26th May 2015 to approve the final accounts, Annual Governance and Annual Report for 2014/15 (including the Quality Account) prior to submission to the Board of Directors and Monitor.
- Confirmation of year-end Commissioner Trading Agreement 2013/14

In May 2015, the Audit Committee also reviewed and approved:

- Single Tender Actions
- the Losses & Special Payments register.

Other Assurance - The Audit Committee has received verbal updates on the activities of the Patient Safety Group. The Committee has had focussed discussion on the role and nature of clinical assurance and sought evidence of how that is derived from current governance systems.

The Internal Audit programme continues to incorporate clinically focussed system reviews and during 2014/15 included topics such as Mortality Review, Controlled Drugs Management and Do Not Resuscitate Order Management.

Meetings for the coming year

The Audit Committee is keen to build on the communication links it has built with other Board Committees and will seek opportunities to link with other Audit Committees outside the Trust and outside the NHS. It will seek ways in which it can influence and improve the links with stakeholders and understand their assurance processes.

The Committee will continue to seek assurance around the development, introduction and maintenance of systems and processes.

Conclusion

At a time of unprecedented pressures on all sectors of the health economy, the role of the Audit Committee is of ever greater importance in ensuring that control processes and procedures continue to function effectively along with the drive for cost reductions.

The Committee is also conscious of the need to ensure that the Trust obtains value for money from the audit services it commissions – from internal and external audit providers.

All members of the Committee are pleased to note the support for audit work from corporate and clinical directors. The ‘tone from the top’ is very positive which is important.

As we look ahead the Audit Committee can already see a number of governance issues that will require the Committee’s attention in light of the pressures on the system overall.

Philip Ashton Chairman of the Audit Committee
August 2015