York Teaching Hospital NHS
NHS Foundation Trust

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

on: **Wednesday 31 May 2017**

in: **Boardroom, York Hospital, Wigginton Road, YORK, YO31 8HE**

Time	Meeting	Location	Attendees
10.45 – 13.00	**Board of Directors meeting held in public**	**Boardroom, York Teaching Hospital**	**Board of Directors and members of the public**
13.00 – 13.30	Lunch		Board of Directors
13.30 – 15.45	Patient Safety Walkround	Starting from the Boardroom	Board of Directors
16.00 – 17.30	Board of Directors meeting held in private	Boardroom, York Teaching Hospital	Board of Directors

The values of the Trust are:

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

…with patients at the centre of everything we do

These will be reflected during all discussions in the meeting

York Teaching Hospital NHS
NHS Foundation Trust

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

On: **Wednesday 31 May 2017**

At: **10.45 am**

In: **Boardroom, York Hospital**

A G E N D A					
No	***Time***	***Item***	***Lead***	***Paper***	***Page***
General					
1.	10.45 – 10.55	**Welcome from the Chairman** The Chair will welcome observers to the Board meeting.	Chair		
2.		**Apologies for Absence and Quorum** • Beverley Geary	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	07
4.		**Minutes of the Board of Directors meeting held on 29 March 2017** To review and approve the minutes of the meeting held on 29 March 2017.	Chair	B	13
5.		**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chair		
6.	10.55 – 11.05	**Patient Story** To receive the details of a patient letter.	Chief Executive	Verbal	

No	Time	Item	Lead	Paper	Page
Our Quality and Safety Ambition: Out patients must trust us to deliver safe and effective healthcare					
7.	11.05 – 11.25	**Chief Executive Report** To receive an update. To include: • STP Update • Cyber Attack Update	Chief Executive	C	29
8.	11.25 – 11.45	**IT Strategy** To discuss the IT Strategy for the Trust	Chief Executive	D	37
9.	11.45 – 12.00	**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 • Trust Complaints Report published under Reg. 18 if the Local Authority and Social Services and NHS Complaints Regulation 2009	Chair of the Committee	E E1 E2 E3 E4 E5	39 50 84 92 107 115
10.	12.00 – 12.05	**Patient Safety Walkrounds** To receive a paper detailing the new approach to the Board walkrounds.	Chair	F	125
Our People and Capability Ambition: The quality of our services is wholly dependent on our teams of staff					
11.	12.05 - 12.20	**Workforce and Organisational Development Committee Issues** To be advised by the Chair of the Committee of any specific issues to be discussed and receive the minutes from the meeting. • Workforce Metrics and Update Report • Draft minutes of the meeting held on 16th May 2017	Chair of the Committee	 G1 G2	 131 142

No	Time	Item	Lead	Paper	Page
Our Finance and Performance ambitions: Our Sustainable future depends on providing the highest standards of care within our resources					
12.	12.20 – 12.30	**Freedom to Speak Up/Safer Working Guardian Report** To receive a report detailing the work of the Freedom to Speak Up/Safer Working Guardian.	Chief Executive	H	153
13.	12.30 – 12.45	**Finance and Performance issues** To receive the minutes from the meeting and associated key papers: • Finance Report • Efficiency Report • Performance Report	Chair of the Committee	I I1 I2 I3	171 179 196 201
Our Facilities and Environment ambitions: We must continually strive to ensure that our environment is fit for our future					
14.	12.45 – 13.00	**Environment & Estates Committee** To receive the minutes from the meeting.	Chair of the Committee	J	209
Any Other Business					
15.	13.00	**Any Other Business** To consider any other matters of business.			
16.		**Board Assurance Framework Reflection**			
17.		**Reflections on the meeting**			
18.		**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 26 July 2017 in the Boardroom at York Hospital.			

Items for decision in the private meeting:

NHSI Licence Self-Assessment – to approve
Board Committees Terms of Reference – to approve

There are no items for decision to report.

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

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

York Teaching Hospital NHS
NHS Foundation Trust

Additions: Libby Raper—Trustee York Music Hub

Changes: No changes

Deletions: No changes

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

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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)	**Member—**Great Exhibition of the North (2018) Board	Nil	Nil	**Chair—Charitable Trustee** **Act as Trustee** –on behalf of the York Teaching Hospital Charity **Trustee and Vice Chair—**of the Joseph Rowntree Foundation and Joseph Rowntree Housing Trust **Chair—**Advisory Board, Centre for Lifelong Learning University of York **Member—**Executive Committee YOPA **Patron—**OCAY **Chairman** - City of York Fairness and Equalities Board **Member –**Without Walls Board	**Director—**London Metropolitan University **Vice Chairman—**Rose Bruford College of HE	Nil

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

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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
Mr James Taylor (Medical Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mrs Wendy Scott (Director of Out of Hospital Care)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mrs Sue Rushbrook (Director of Systems & Networks)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Brian Golding (Director of Estates and Facilities)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Spouse is Director of Strategy and Planning at HEY NHS FT	Spouse is a Director at HEY NHS FT and Trustee of St Leonards Hospice

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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 at York Hospital on 29 March 2017.

Present: **Non-executive Directors**

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

Executive Directors

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

Corporate Directors

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

In Attendance:

Mrs L Provins	Foundation Trust Secretary
Ms McMeekin	Deputy Director of HR

Observers:

Jeanette Anness - Public Governor – York
Ann Bolland – Public Governor - Selby
Margaret Jackson – Public Governor - York
David Robson – Healthwatch – York
Michael Reakes – Public Governor - York

Ms Symington welcomed Mrs McAleese, Ms McMeekin and the members of the public to the meeting.

17/030 Apologies for absence

No apologies were received.

17/031 Declarations of interest

No further declarations of interest were raised.

17/032 Minutes of the meeting held on the 22 February 2017

The minutes of the meeting held on the 22 February 2017 were approved as a correct record subject to the following amendment:

17/025 – Quality & Safety Issues - ribotying should be spelt ribotyping.

17/033 Matters arising from the minutes

No further matters arising were discussed.

17/034 Patient Story

Mr Crowley stated that at an informal Board meeting held in August last year the Board had received a presentation from Mr Kirkup of the Dementia Alliance. Following the training, Mr Crowley was inspired to spend some time with one of the Assistance Chief Nurse's, Emma George, who is the lead for dementia in the Trust. He stressed that the Trust needs to become an increasingly dementia friendly organisation to enhance patient experience for those patients with dementia and those living close to patients with dementia, as well as our staff.

The dementia appeal had been launched in Scarborough with the aim of raising £200k across the organisation to promote and provide essential equipment to enhance patient experience. One element of the campaign is to launch an appeal to fill film cases with the old pound coins – "round pounds"- which are due to go out of circulation in October 2017. Mr Crowley provided each of the Board members with a film case and challenged them to fill it by the next Board meeting. He noted that the launch had created a huge amount of interest and the goal was to make every ward dementia friendly. The money would be used to buy aids and adaptations especially as the number of patients with dementia was increasing year on year.

Mr Crowley then read out a letter from someone whose mother had dementia: the son wished to share his experience and it was useful to remind the Board of the difficulties patients with dementia faced. The letter described a lack of meaningful engagement with the patient, for whom hospital was a strange and unsettling environment.

Mr Ashton asked whether the aids and adaptations would be able to be used for more than one patient. Mrs Geary stated that some items like twiddle muffs would be single use, but that all the items bought would be passed by the Infection Control Team and would be able to be cleaned.

Ms Symington stated that she was pleased and proud to support this appeal. She proposed that the board support the appeal during 2017-18.

17/035 Chief Executive Report

Mr Crowley stated that further guidance around the 5 Year Forward View is awaited together with guidance around how the governance of STPs will be provided. He noted that one of the weaknesses around STPs was the need to gain consensus due to organisational sovereignty. The position currently has been complicated by the financial environment which continues to deteriorate.

Mr Crowley provided some context on the current environment and stated that activity levels had peaked higher than when the Trust had declared a MAJAX in Scarborough in January 2015. He stated that demands continued to grow and that the 4 hour target had been at its lowest position nationally since being implemented. The Trust was been in the bottom 25th percentile of ED performance in the early part of 2017 (in the context of unprecedented high activity levels.) He said the Trust had significant insight into the acuity of patients during that period: 50% of patients could be classed as very sick at both main hospitals. Therefore, high levels of demand had been compounded with high levels of acuity. He also stressed the fragility of the workforce and recruitment challenges which were only just emerging two years ago.

Mr Crowley stated that it was now about how the organisation worked more effectively to manage the system to ensure recovery. He noted the significant improvements which have been seen in the 4 hour target and confirmed that these improvements are being scrutinised and reviewed. He noted that work was also being done to maintain and develop positive behaviours in a stressed system. Mr Crowley highlighted that North West Academic Health Science Network had spent some time in the Trust at the request of the CCGs and had commented on the whole system dynamics. The early feedback had been that staff were hardworking, committed and caring, but that the system was overloaded. Bed occupancy at midnight was 95%, which meant that it would be more than 100% during the day. The optimum level was 85% and for Scarborough it should be 75% and each percentage above implies potential chaos and inefficiencies. There was also feedback that commissioners and out of hospital care providers needed to relieve that pressure and that currently the system was too hospital centric. The feedback was balanced and it was also noted that there was a lack of ownership of flow in some areas of the Trust. Mr Crowley stated that the Trust needs to respond and an assessment of the position is currently being undertaken.

In relation to this period post the ED crisis, Mr Crowley stated that the organisation needed to provide care, attention and support to staff in an equitable way to ensure

ownership across the organisation. He also noted that a degree of honesty was required and that the organisation can do better and a sense of purpose needs creating across the system together with a reshaping of the recovery plans.

Mrs Adams asked about the operational management redeployment mentioned and Mr Crowley stated that it was about getting the balance of management right across the two main sites as York tends to get more attention due to scale. Mr Crowley stated that it was also about responding to the variation in demand. Mr Crowley highlighted decisions which had been made to create more assessment capacity which most Trusts would have waited until May this year to implement, but Mr Golding's team had managed to get them in place in December and that this work still needs to fully embed. Mrs Adams was pleased to note that the Trust is looking at the variation in demand now and not waiting for next winter.

Mr Crowley stated that the Trust would be 5 years post-merger in July and that a strategy session was being held next week which was looking to plan with ambition for the medium term.

Mr Crowley highlighted the opening of the Energy Centre at Scarborough which had taken place last week and was the final part of work which would save the Trust £1.5m a year and formed another part of the sustainability agenda that the Trust was committed to.

17/036 Workforce & Organisational Development Performance Issues

Ms Symington highlighted the reordered agenda due to the importance of recruitment and the current fragility of the workforce.

Prof. Willcocks stated that the first thing she wished to highlight was the Recruitment Marketplace which had taken place on Saturday that evidenced a whole hospital and community approach and had included the Local Authority and various voluntary organisations.

Prof. Willcocks stated that the new CQUIN in relation to sickness may be challenging. Ms McMeekin stated that there are three questions linked to the national CQUIN which include the annual staff survey, positive actions on health and wellbeing and musculoskeletal injuries and work related stress. Ms McMeekin highlighted that the Trust has a good reputation in relation to staff health and wellbeing and has been an exemplar Trust for over 12 months. However, this will make the achievement of the CQUIN more difficult as the Trust is already starting from a higher position. Prof. Willcocks stated that the Committee routinely discuss the work of the Health and Wellbeing Group and will keep a careful watch on the CQUIN.

Ms McMeekin was also asked to comment on the new rules around use of agency staff. Ms McMeekin stated that new rules had come out from NHSI and HMRC and that this would affect a number of medical and nursing staff. In relation to medical staff it was aimed at reducing the number of self-employed contractors and would affect staff who

have previously set up their own company. Directorates are being provided with support from HR and staff in this position are being contacted to encourage them to become substantive employees. **There is an expectation that medical agency spend has to reduce by 15%.**

In relation to nursing, the Trust will not be able to employ agency staff from the 1 April who are already substantively employed by another Trust. These staff would have to join the Trust's bank. Mrs Geary was concerned about this as it may make some staff leave the NHS. Ms Raper stated that this seemed to be part of a broader public sector approach and was also affecting Local Authorities and she noted that it would be interesting to look at figures in a couple of months' time to see if there was any change.

Prof. Willcocks stated that the City of York were making a bid to become a Human Rights City. A self-declaration is being prepared by the University of York. The Fairness Forum has been involved and was asking the Board to sign up to the declaration. Mr Crowley stated that it would depend on what the Trust were being asked to sign up: for example the Trust supports the Living Wage initiative, but could no longer commit to it as it would compromise the Trust's finances. It was agreed that this would be looked at by the Executive Team.

Mrs Rushbrook stated that the health and wellbeing piece regarding staff lacking access to PCs was only true of certain groups. The Trust now has 6000 PCs across site and further plans to roll out 600 laptops across the community which when benchmarked with other Trusts is a good position.

Mrs Adams highlighted recent medical recruitment which was very positive.

17/038 Staff Survey Report

Ms McMeekin provided an overview of the report into the staff survey highlighting the 48% completion rate, stressing that the survey provides a "snapshot in time". The report covered the positive observations including the favourable comparison in relation to equality and diversity, fewer staff indicating that they felt unwell due to work related stress, fewer staff observing potentially harmful incidents and an increase in the number of appraisals carried out.

Areas for improvement included the six key findings around violence, harassment and bullying, the findings in relation to areas below average regarding staff confidence in reporting errors, an increase in staff feeling pressure to attend work when feeling unwell and the use of patient feedback.

Mr Keaney stated that he thought 16% of staff feeling bullied was high (it was noted that this included assaults by patients on elderly wards with dementia which needed a different response than the traditional zero tolerance to violence and aggression). Mr Crowley agreed that any form of bullying is unacceptable but also advised the board that

bullying can also be perceived, but is not always borne out in fact. He stated that the NHS does have a culture of staff not liking being told what to do. He also noted that a number of sources of information are being triangulated in relation to this issue, including that from the new Freedom to Speak Up Guardian. Mr Crowley also thought that the scale would cast doubt on this figure. Mr Golding stated that the Environment and Estates Committee looked at the data in relation to this and there were 109 reported assaults of which 104 were due to elderly patients with dementia so the numbers being described were not being evidenced through the incident reporting system.

Mr Proctor stated that in relation to staff feeling pressurised to come to work when unwell, this may also be down to personal expectation and that sometimes this was not a bad thing as jobs are important.

Ms Raper stated that the staff survey results in relation to appraisals were different to the metrics. Ms McMeekin thought that it was more likely that the staff survey results were accurate as staff know when they have had an appraisal and she noted that recording of appraisal completion was now being done centrally by the Learning Hub and that this change still needed to embed.

Mrs Adams stated that incident reporting and the value in reporting had still not been cracked and that this had been a discussion in relation to the quality priorities being set. Ms Symington also noted that the issue of incident reporting is regularly discussed at the Corporate Risk Committee.

Mr Crowley stated that the absolute response rate continues to improve and that while the relative rate has fallen behind and he was still of the opinion that some staff are reporting perception and not reality. He also stated that communication underpins much of this and although you can do this from the top, it was about how the Trust breaks some of the communication blocks at the middle and junior management level.

17/038 Modern Slavery and Human Trafficking Act 2015

Mrs Provins stated that under the Modern Slavery and Human Trafficking Act 2015, the Trust is required to make a declaration and the declaration needed to be signed by both the Chief Executive and Chair and placed on the Trust website. A declaration had been made last year and this had not changed significantly, but did include references to both Adult and Child Safeguarding.

The Board approved the declaration.

17/038 Quality and Safety Performance Issues

Mrs Adams stated that the Committee has adopted a more systematic approach to receiving information from sub groups so that this information can come up through the Committee to the Board.

Mrs Geary provided the Board with a brief overview of the Non-invasive ventilation risk which was due to the high turnover of staff. She stated that a training plan for newly qualified staff had been put in place and that the Critical Care Team and HDU were being used to mitigate the risk.

Mrs Adams wanted to highlight changes coming in via the EU about information governance/data protection which would be fairly onerous and would still apply despite BREXIT. Mrs Rushbrook stated that the Trust was aware of these changes and that they would result in changes to data protection and the information governance toolkit. Mr Bertram stated that a small group had been formed to look at this and had met for the first time two weeks ago. The group included himself as Senior Information Risk Officer, Mr Taylor as Caldicott Guardian and Mrs Rushbrook in relation to Systems and Networks. Mr Taylor stated that the fines being talked about were 20m euros or 4% of turnover.

Mrs Geary provided an overview of nurse recruitment including work that had been done on acuity audits. She noted that contributing factors were in relation to the withdrawal of bursaries and changes to pensions. There had been a reported 25% reduction in applications for training positions and Sheffield Hallam were reporting a reduction of 35% to 45%. However, there has been little impact to the Trust this year, as the impact will be more in relation to mental health and learning disability nursing.

Mrs Geary stated that safe staffing was an absolute priority for her team and she also highlighted that the attrition rate for the 60 nurses recruited from Spain was low and the ones that left had stated it was due to homesickness. The team has also put out a generic vacancy on an on-going basis with interviews scheduled every two weeks together with the continued promotion of the option to recommend a friend, a new internal transfer system has been created so that these can be facilitated quickly, hard to recruit areas are continually looked at in relation to how skill mix can be enhanced and preceptorship has been increased to 10 months.

Mrs Geary stated that the workforce transformation team are using the Calderdale Framework and the band 4 Assistant Practitioner programme has taken on the first cohort. She also noted that the Trust is an HEE fast follower site in relation to the band 4 role. She stated that there has been a great deal of discussion about these roles by the nursing unions as they will be able to administer medication so will receive high standards of training. The Trust had had 110 applicants for 20 posts which was really exciting. Mrs Geary highlighted that turnover of nursing staff has reduced in 2016, which should be celebrated.

Mrs Geary stated that all these initiatives will continue this year and that there will also be a new initiative to introduce a 4 month rotation programme for newly qualified staff, which will start nurses in AMU with the intention of increasing their skill and knowledge in relation to the deteriorating patient. The Trust has already booked places at a number of careers fairs and is working with Coventry University to grow the first cohort of registered nurses for Scarborough. In relation to the India nursing exchange programme being arranged by HEE, Mrs Geary stated that this has stalled due to the amount of red tape

involved. Mrs Geary stated that the Trust is still working with HEE and that hopefully this is back on track, but it is unlikely that the 20 nurses will be in place by July.

Mr Proctor stated that he has heard of places contacting staff who have left the Trust for the private sector to ask them to return to the Trust, as staff did not always find the transition easy or satisfactory, this may be an “easy” way to come back into the Trust.

Prof. Willcocks stated that an enormous amount of effort, agility and flexibility is being put into nurse recruitment and she commended Mrs Geary and her team.

Ms Symington stated that she has requested a strategic organisational recruitment strategy come to the Board which will bring all the elements together and will seek to provide a long term, 5-10 year, vision of recruitment needs and plans.

Mrs Adams also wished to congratulate the team around their efforts with ward staffing.

Mrs Adams stated that a paper on 7 day working had come to the Committee and she asked Mr Taylor to provide some more detail. Mr Taylor stated that the audit of 7 day services included time to first consultant review, access to diagnostics, access to interventional services and on-going review for critically ill patients. Mr Taylor noted the previous issues in Scarborough Radiology and the transformational work which had been done in both Scarborough and York. Mr Taylor highlighted that another audit will be carried out in April. He stated that many Trusts are in the same position in relation to 7 day working.

Mrs Adams stated that the Committee continues to look at limited assurance internal audit reports within their remit and the Committee is currently focusing on DNACPR and patient consent. Mr Taylor noted that the Trust largely complies with the spirit of the DNACPR work, but that there is work to be done on the process to ensure evidence is completed. He did also stress that it was difficult to assess and deliver these discussions when you have only just met the patient for the first time and that there was a significant degree of clinical complexity around these decisions. Mr Taylor stated that most of the work suggested has now been delivered. It was agreed that this is an important issue with which the trust must ensure compliance.

Mrs Adams stated that the Committee had seen the first draft of the Quality Report and were in discussion regarding the priorities for the coming year. She stated that she was keen to focus emphasis on continuous improvement, some areas of which, like incident reporting had come up in discussion today. The Committee has also started to review the first question on the BAF and had discussions on scoring mechanisms and how this could be made more scientific. It was decided to retain the green rating for the first item on the BAF, but continue to assess whether strict measures can be used in order to better quantify the rating. Mr Ashton stated that the Committee did wish to remove the wording ‘all day every day’ from this item, which does not really make sense. Ms Symington stated that this was due to the positive use of the wording in the Our Commitment to You document, which described the trusts high-level ambitions, being turned into a negative for use in the BAF which the Board agreed did not really work in this instance.

17/038 Organ Donation Update

Dr Berridge stated that he was the Clinical Lead for Organ Donation in the Trust and was pleased to be able to report the significant progress that had been made to the Board. Previously the Trust had not been referring from its critical care units and now the Trust was nearly at a 100% referral rate. Unfortunately, he noted that referrals from ED were still an issue, but this will be addressed going forward. He stated that the increased referral rate is due to a specialist nurse being involved in the consent process. The Trust's referral rate is 11, which makes it a level 2 organisation as referrals need to be between 6 and 12. If referral rates continue to grow it is likely that the Trust will become a level 1 organisation which is down to the hard work of the team. National targets are currently 19 referrals per 1 million with a target of 26 referrals per 1 million by 2020.

Dr Berridge stated that he wanted to highlight two pieces of work to the Board which he would like to promote going forward. One was regarding work done in Bristol to place patients with brain injuries in ITU instead of leaving them in ED as there had been seen to be a 10% to 15% survival rate when the patients had been cared for on ITU. The other piece of work was around the consent process being provided by someone trained in relation to organ donation. He noted that the training is free. He also wanted to create a clear strict pathway to be followed in ED.

Ms Symington stated that she supported organ donation and was interested to hear the progress and issues raised.

Mrs Geary asked whether the increased use of ITU would out strip capacity, but Dr Berridge stated that there is evidence that this would actually free up beds. Mrs Adams asked about the ethical debate around priorities for ITU beds and Dr Berridge stated that this was on a 'first come, first served' basis along with flexibilities to transfer within a network.

Mr Keaney highlighted that the Trust was a level 3 organisation 18 months ago and that the progress is remarkable and receiving recognition nationally.

Ms Symington thanked Dr Berridge for his very informative presentation.

17/038 Finance and Performance Issues

Mr Keaney stated that the Committee continue to look in depth at the challenges facing the organisation and that despite all the initiatives in place, the position is not where the Trust would want to be. Mr Keaney asked Mr Bertram and Mrs Walters to take the Board through the elements highlighted in the minutes. Mr Keaney highlighted the continued fantastic achievement in relation to CIP, and also that despite operational pressures the Committee continued to receive assurance around patient safety, especially in relation to ambulance handovers. Mrs Walters stated that the Trust has started to see a recovery in the ED position during March, although she stressed that the Trust was still not where it would like to be she felt all the elements which had been put in were starting to come

together. Some changes in attendances have been seen, but nothing significant and the percentages only equate to about 1 patient per day. The ECS at the end of February was 81% and the current un-validated position for March is 89% which provided a level of reassurance to the board. Mrs Walters stated that a phenomenal amount of work has been done, but needs to embed and that bed occupancy remains high on both sites.

Mrs Walters stated that an improvement has been seen at York in relation to ambulance handovers and that there is an action plan in place and the Trust continues to work closely with the Yorkshire Ambulance Trust. She highlighted that Scarborough is an undersized department and the site has been under significant pressure and that further work is being progressed with the out of hospital care team. The overall strategy is about recruiting, to enable greater assessment to take place, and exploring the option of a bed reconfiguration as there are currently about 40 medical outlying patients.

Ms Symington stated that Jim Mackey, the Chief Executive of NHSI, had made it clear that improvement in ED performance was required in areas of poor performance and that the areas the system is most concerned about are those where performance is inconsistent and volatile. Mrs Walters stated that this could be seen at Scarborough and it was about getting to a sustainable position while focusing on patient safety. She noted that patients waiting to be handed over from ambulance staff are not simply left, but are often seen and assessed before handover can take place. Mrs Walters also stated that there are a number of ambulances which should go directly to the urgent care centre and not come through ED. There have been early signs of progress on both sites, although Scarborough had also experienced a recent dip.

Mrs Adams stated that she was pleased to hear of the work around the possibility of using a different metric for Scarborough due to the introduction of the acute medical model. Mrs Walters stated that discussions have been held with the CCGs and Governors about running a different set of metrics in parallel and that a meeting was due to go ahead with the Director of the Emergency Care Support Team do discuss this.

Ms Raper asked about the number of beds at Scarborough and that it was noted that the site was a ward short. Mrs Walters stated that this was all about providing the right care in the right place, which was not always in hospital.

Mr Bertram stated that the Trust has achieved a £1m surplus at the end of February which was disappointing in relation to the planned position, however, on the plus side, the Trust is still reporting a surplus which is better than the national position. In relation to the forecast outturn the Trust is not going to hit the control total at the end of March, but a further improvement in the position is being targeted and the Trust should end the year at between £1m and £3m in surplus, due to the significant discretionary spend controls in place. Mr Bertram stated that the Trust had also been incredibly busy in relation to elective activity. If the Trust achieves the £3m surplus position, this will be £7m short of the £10m control total. Mr Bertram highlighted that the Trust would lose the STP funding for the quarter which amounted to £3.4m.

In relation to the use of resources, the charts on page 166 of the pack show the Trust's position. The rating of 2 is consistent with the single oversight framework scoring, but he stressed the deteriorating position within a number of the areas that made up the rating. He noted that the Board approved plan would be submitted tomorrow and the position continues to be rated 2. He advised the board of the significant risks in relation to the 8th consecutive year of the CIP programme together with the impact of helping the CCGs to achieve their QIPP programmes.

Mr Bertram stated that the Trust is on target to deliver this year's CIP programme of £26.4m and at the end of February had already delivered £24m. Next year's programme requires another £24m and this was discussed at the Committee as it is the 8th consecutive year delivery is required, but the Trust will also have to focus on the CCG QIPP programmes, which will be a significant risk. Mr Bertram stated that the only way to mitigate the risk was to keep the objectives visible and this would be done through the Carter Steering Group to ensure that the Trust was not trying to spread resources too thinly and that monitoring was kept up throughout the year.

Mr Keaney asked about the risk of not hitting the control total this year. Mr Bertram stated that failure to hit the control total would cost the Trust the £3.4m STP funding this year and approximately £1.9m next year due to a CQUIN penalty for also not hitting the control total. Mr Bertram noted that plan for next year reflects that position.

Mrs Adams noted that the TAP programme, CIP and Carter were all now under the same umbrella, but asked about whether the benchmarking of service activity was still on-going. Mr Bertram stated that the Trust had received the full pack of back office corporate services benchmarking data and this will be shared with directorates and a report prepared. Directors will be asked to respond on 'a comply or explain' basis to the Carter Steering Group. Mr Bertram highlighted the Pharmacy transformation work which was being progressed was also part of this work. There was also a big national procurement project in place which would share information on the pricing of products.

17/038 Environment and Estates Performance Issues

Mr Sweet stated that he was encouraged to see that a number of subjects raised by the other Board Committees were also tracked through the Environment and Estates Committee which showed an integrated work programme. He highlighted that the Committee is fairly new, but is now on a formal bimonthly footing and covers the right items including the BAF and risk registers. He was pleased to note the raised awareness around sustainability and that this had been written into Board job descriptions and was part of the business case process. He also noted the opening of the Scarborough Energy Centre which along with the other developments made an annual saving of £1.5m, saved 30% of the fuel bill and stopped the emission of 6000 tons of carbon dioxide.

Mr Sweet stated that the Committee covered non-clinical health and safety and reported to NHS Protect each year. He noted the year on year improvements, but also commented on the patients with severe dementia on ward 37 and whether this was the right place for them. Mrs Geary stated that it was not the right place because of the

absence of dedicated EMI facilities in the community. She stated that this has been raised externally and a group is being formed by the commissioners, of which she will be the nursing lead in order to look at the issues. Mr Taylor stated that it is very much an anomaly to have a chronic mental health facility in an acute Trust.

Mr Golding stated that a review is being performed to see whether staff in high risk areas such as ward 37 would benefit from mandated face to face conflict resolution training instead of the e-learning that is presently available. Mrs Geary stated that the training programme would also look at doing risk assessments for patients with dementia.

Mrs Rushbrook stated that it is also this cohort of patients who have long stays. She stated that length of stay can go up from 30 days to around 100 days and she stressed that this is not the right place for them and does not provide optimal patient experience.

Mrs McAleese stated that she was aware that a group had been looking at the cohorting of patients who fell between nursing homes and hospitals approximately 18 months ago and that TEWV had been open to exploring what could be done. Mr Golding stated that the Trust is currently discussing a model with the City Council, which would use Bootham Park Court. The model is being worked up so that funding can be discussed.

Prof. Willcocks stated that this was a very useful conversation as ward 37 should be a psychiatric assessment ward, not a long stay one. Ms Symington also noted that TEWV are consulting on a new hospital and this requirement needed to be included in their development plans.

Mr Sweet stated that the Fire Policy had been reviewed in detail and approved by the Committee. The Board endorsed the Committee's approval of the Fire Policy.

The Board discussed the fire alarm systems and noted the clutter and obstructions observed during walkrounds on occasions. This had also been raised at the fire training which had been received earlier in the day. Mr Golding informed the Board that the fire alarms were approaching the end of their life span and would involve a massive scheme to provide replacements. The designs have been worked up over the last 18 months, but due to limited capital would not be started until after April and may take a long time to complete due to the complexity of installation. It was highlighted that any obstructions to fire doors or clutter must be challenged on the patient safety walkrounds. Mr Sweet stated that the Scarborough fire alarm will be updated first.

Mr Sweet noted that the Trust Security Policy had been amended, then reviewed and approved by the Committee. Mrs McAleese asked about arrangements for delegated authority and it was noted that this has been put in the Board Committees terms of reference. The Board endorsed the approval of the Security Policy.

Mr Sweet highlighted the significant sustainability agenda in the Trust. Mr Golding stated that most of the big ticket items had been done first and the work now was about engaging staff around smaller initiatives. A tender is currently being analysed which asked firms how they would go about this work. The first phase costs about £10k to

£15k, but the second phase is dependent on savings being made from the first phase, which provides firms with an incentive to make savings.

Mrs Rushbrook stated that the Trust has approximately 6000 PCs and following an audit, it was noted that only approximately 300 were left switched on overnight, which was really good news. Ms Symington stated that there should also be some communication on turning lights off.

Mr Sweet stated that the introduction of the premises assurance model has been a success story. The work was mandated across the NHS and was about standards of safety, quality, efficiency and good governance. He noted that the Trust has made significant improvements in the last 10 months. Mr Golding stated that the charts show a stark difference to how they were at the start of the work and this is mainly due to Mr Biggins and the team. All the work is evidence based and broken down by site. Focus is now on the remaining red areas.

17/038 Archways Reconfiguration Update

Mrs Scott stated that the key element of the Out of Hospital Strategy was to develop a wider range of services. She noted that a significant number of audits had been undertaken in the community units some of it with ECIST support to look at patients who instead of being admitted to a community bed could have been supported at home if services were available. She noted previous reports which have highlighted that patients become deconditioned when they stay too long in hospital so it was key to minimise length of stay. This work had been behind the decision to close Archways on the 19 December 2016, which had been agreed with VoY CCG and other partners.

Information was provided about the range of services implemented together with case studies of patients. She stressed that patients who still require beds are able to access them and that the Community Response Teams are able to admit these patients. Changes have also been made to the RATS Team to enable referrals to home based care.

Mrs Adams asked if this would end up creating its own demand. Mrs Scott stated that work had been done to increase awareness of the alternatives to an inpatient bed and that the Ambulance Service could also directly refer in instead of the traditional ED route. The Community Response Team have the capacity to respond to referrals in a timely way and can provide 2 to 4 hours of home support. Mr Proctor stated that hospital admissions continue to grow and this was about improving efficiency and consuming the natural growth in acute care through the community provision.

Prof. Willcocks stated that this was a positive development and paves the way for the STP discussions on the Accountable Care Organisation and it would be useful to have this evidence for any anticipated change and the effect it might have. Mr Proctor stated that the Overview and Scrutiny Committee would be discussing this in April and that it may also be useful to take this information to the STP Executive.

17/039 Any other Business

Mrs Adams stated that the Organ Donation Update was very useful and it may be an idea to have individual areas like cancer present to the Board.
Ms Symington highlighted the BAF overview on page 26 and that it was useful to check to ensure all the key areas of risk to the trusts strategic plans were covered in the meeting. She noted that all areas had been covered.

Ms Symington reminded everyone that the new Board format will commence in April and there will be a Board to Council of Governors meeting and a short Charitable Trustee meeting.

Ms Symington stated that she and Mr Crowley were committed to the Board leading the way on the dementia charity appeal so the Board may be asked to support some events/initiatives.

No further business was discussed.

17/040 Date and Time of next meeting

The next meeting of the Board will be held on Wednesday 26 April 2017 in the Boardroom at York Hospital.

Outstanding actions from previous minutes

Minute number and month	Action	Responsible office	Due date
17/025	Provision of a paper on isolation facilities	Mr Golding	May 2017
17/027	Recruitment Strategy to be provided to the Board	Mr Crowley	May 2017
17/012	Parity of other staff groups with junior doctors in relation to exception reporting criteria (20 mins) to be added to the work programme.	Mrs Provins	Added to May agenda
16/158	ED and Community Developments	Mrs Walters Mrs Scott	June 2017
16/140	Mr Taylor to provide antibiotic monitoring in his next report	Mr Taylor	April 2017
16/112	The Board to receive the refreshed Equality and Diversity objectives	Mr Golding	Changed - May Public Board

15/087 Diverse Workforce	A proposal around investment in training for specialist and middle grade doctors in the future to be presented to the Board when developed	Mr Taylor	April 2017
16/057 Communications Strategy Update	Present a further update on the Communications Strategy at the November Board meeting	Mrs Brown	April 2017

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Chief Executive's Report

Action requested/recommendation

The Board is asked to note the report.

Summary

This report provides an overview from the Chief Executive.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC outcomes.

Progress of report	Board of Directors
Risk	No risk.

Resource implications	No resource implications.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	May 2017
Version number	Version 1

Board of Directors – 31 May 2017

Chief Executive's Report

1. Chief Executive's Overview

Our Common Purpose

As I have stated many times, I believe that the current environment in which the Trust operates is the most challenging I have experienced.

Each year we are managing with fewer resources in real terms than in the previous year, and in the last few years this has equated to a reduction of around 5% in our spending power year on year. Recruitment in many areas continues to be difficult.

The demand for services continues to rise, due to the growing population and the changing nature of their health and care needs. Demand for services will predictably grow as the numbers requiring support increases but equally, and perhaps more importantly, the nature of the demand placed on us changes as we all live longer, and we are already seeing the effects of this in higher numbers of our patients requiring more complex support and simply being more acutely unwell.

The performance regime is unremitting, regulatory intervention has never been more searching, and central control is reducing our freedoms to act.

Our patients perhaps expect more of us, whilst being understanding of the pressure we face, but our own expectations of ourselves have also never been higher – which is a good thing! It would be so easy to use these challenges, of which there are many, as a crutch to lean on or an excuse not to push for improvement. I am determined this shall not be the case, and to help make sense of our priorities and harness the expertise and commitment of all of our staff to meet this head on, we must continue to focus on doing the right thing for our patients, our community and ourselves.

We will build this around developing our "**Common Purpose**" - a statement of guiding principles that will reinforce as our central purpose and priority the support and care we must provide for the most acutely ill in our community, whatever the setting, and reflect the national priorities that are emerging around financial performance and acute care.

This will complement our values and objectives as set out in "**Our Shared Commitment**" and the behaviours I expect of all of us that are captured in our "**Living the Trust Values**". It is my intention that all staff, whatever their professional background, will be able to identify with this and understand the contribution they make to delivering healthcare, which is why each and every one of us work in the service.

Developing the common purpose is a key part of re-framing the standards we expect from everyone in relation to our values, our behaviours, and our priorities. Our sense of individual and collective responsibility is vital, respecting each other's contributions, valuing teamwork and mutual support and above all else demonstrating the behaviours that we should all expect of each other.

Cyber attack

I want to take the opportunity in this report to reflect on our response to the cyber attack, and to address some of the assumptions and assertions circulating in the national media.

The cyber attack hit the trust on 12 May, and events unfolded rapidly, not only in our own organisation, but across the world. The source of attack and the methods used are of course subject to international enquiries; however for us it presents the opportunity to assess our own vulnerabilities and our future cyber security.

The impact of the virus was the loss of two thousand, of our six thousand, PCs across the Trust. We also took down large parts of the network to help minimise the spread of the virus and to preserve, as far as possible, our clinical systems.

As a result, CPD, our patient database, was not affected; however access to CPD was hindered due to the number of PCs available for staff to use to access it.

Based on the level of uncertainty we were facing, and the sheer size and scale of our organisation, what we were able to achieve in keeping the majority of services running was nothing short of phenomenal, and it is always impressive and humbling to see the manner in which our staff respond when faced with a crisis.

The task of resuming normal service was clearly immense. It was fantastic to see people from all across the organisation volunteering their time to come in and help their colleagues, so that we could do the best we could for our patients in a really difficult and unprecedented situation.

Feedback from patients has been overwhelmingly positive. There was recognition that our staff worked round the clock - and as a result - we avoided a major loss of services over that weekend and into the following week.

There will be lessons to learn from this. We must accept that, given we were impacted, we must by definition have been vulnerable at some level. Inevitably there is much speculation in the media, and mixed messages have been circulating regarding our preparation for, and management of, cyber security.

The Trust takes its responsibility for cyber security extremely seriously. Best practice suggests that the key elements of a cyber-security strategy should include employing a fully supported operating system, up-to-date antivirus software, a comprehensive backup system and process and both an effective contingency and business continuity plan.

We employ in this regard:

- Windows 7, which is fully supported
- An antivirus capability supplied by McAfee
- A comprehensive backup system that meets best practice standards
- A contingency and business continuity plan

Importantly, System and Network Services employ a comprehensive and sophisticated monitoring system that enables a rapid response to any performance issues emerging across the organisation. This allows our technical team to safeguard core systems and processes quickly in a targeted manner.

The Trust routinely tests business continuity plans at both corporate and operational level. The maintenance and rapid recovery of services was dependent on these.

As widely trailed, an upgrade was received in March. The implementation team fully tested its compatibility and operability with CPD, and all other applications, and began a process of phased application.

This is consistent with our normal practice, although the scale of the upgrade further slowed its implementation. The process of testing, piloting and phasing an implementation ensures that our clinical systems and clinical services remain minimally interrupted during an upgrade wherever possible and, importantly, the system we employ is stable.

It is recognised that this process implies a delay in applying an upgrade and following a prior review of our cyber-security, in light of escalating risks, we had already begun seeking advice to further strengthen our processes to conform to best practice, whilst maintaining our clinical services.

It is emphasised that at the time of the attack we were in the process of a phased implementation of the patch or upgrade. We have evidence that PCs were infected in those areas we had already upgraded. The "patch" had been developed in March to address a specific vulnerability in Microsoft and it is important to recognise that this virus was a new variant and in part a new risk.

The broader investigation into this attack will continue for some time to come, but what this highlights more than ever is the increasing prevalence of cyber crime and the risks we face.

Emergency preparedness and business continuity

Linked to the cyber attack, and in direct response to the tragic events in Manchester, all NHS organisations have received a letter from NHS England advising us that the threat level has been raised to critical, and of where we should be seeking assurance around our preparedness for any future attack. This issue may be discussed as part of today's agenda, and Mark Hindmarsh, Head of Operational Strategy, has been working with the teams directly identified in NHS England's letter to ensure we have the necessary plans and resources in place.

Clinical strategy time out

In April we held our clinical strategy time out. This is the second time we have held this event, which marks an important stage in our annual planning cycle.

The aim of the day was to guide all directorates as to the key issues they should be considering as part of their annual planning, to provide time for joint working across directorates to develop organisation wide strategies and plans, and to celebrate some of the excellent achievements made in the organisation since the first time out last Spring.

The event presented an opportunity to hear from Emma Latimer (Chief Officer, Hull CCG and lead for our STP) who explained the latest position, and time was allocated to consider and work through the implications and contribution the Trust and directorates can make to the STP.

Phil Mettam (Chief Officer, Vale of York CCG) and Simon Cox (Chief Officer, Scarborough and Ryedale CCG) also spoke at the event about their commissioning intentions and plans for 2017/18 and beyond.

The next steps will be for directors to focus on reviewing the clinical strategy document based on feedback from the day, with a revised version being circulated in the summer to help inform directorate strategies.

Cystic Fibrosis service

I am delighted to share the news that our collaborative cystic fibrosis service, in partnership with Hull and East Yorkshire Hospitals NHS Trust, has begun.

This arrangement has been initiated to improve outcomes for York and Hull residents in line with the recommendations made by the peer review in 2015.

NHS England has agreed to contract a central CF service with us, and we will contract services for the wider geographical area from Hull.

This is a fantastic endorsement of our the service provided by our CF team, and it is a positive step for our organisation that we have the opportunity to work with partners to deliver services to a larger population than that covered by our Trust.

Communications strategy update

The Trust's three year corporate communications and engagement strategy was approved by the Board in 2015. The specific actions identified in the plan have been addressed, and work is continuing in the key priority areas identified in the strategy including staff engagement, branding and visual identity, and working with partners to agree a system-wide messages and a joint approach to communications and engagement. The strategy is due to be refreshed in 2018, and will be brought to the Board for approval.

BAF at a glance

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

2. Recommendation

The Board is asked to note the report.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley, Chief Executive**
Date	**May 2017**

York Teaching Hospital NHS
NHS Foundation Trust

Board Assurance Framework – At a glance.

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

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

IT Strategy

Action requested/recommendation

The Board is asked to accept and approve the Digital Strategy.

Executive Summary

The Digital Strategy will enable and support the Trust to deliver it's ultimate objective "To be a valued and trusted partner within our care system delivering safe effective care to the population we serve". The Strategy contains the following themes:

- The consolidation and exploitation of existing investment
- Exploiting opportunities and transformation
- Providing enhanced security for systems and 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 regulations

There are no references to CQC regulations.

Progress of report	Board of Directors
Risk	No risk
Resource implications	No resource implications
Owner	Sue Rushbrook, Director of Systems and Network Services
Author	Sue Rushbrook, Director of Systems and Network Services
Date of paper	May 2017
Version number	Version 1

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Meeting Minutes

Action requested/recommendation

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

Executive Summary

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

Review of Chief Nurse and Medical Directors Risk Registers.

Patient Safety items for this month

- Nurse Staffing
- Infection Prevention and Control
- Quarterly Pressure Ulcer Report and Quarterly Falls Reports
- Serious Incidents and Never Events
- Sign up to Safety update

Clinical Effectiveness items for this month

- Medical Revalidation Action Plan
- Antibiotic Prescribing Audit

Patient Experience items for this month

- Complaints Annual Report

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

1. JT to highlight developing issue with junior doctor numbers post August changeover
2. BG's representative to highlight annual complaints report and the work of the Patient Experience team

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

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

Reference to CQC regulations

References to CQC outcomes.

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

Progress of report	These minutes have only been submitted for the Board.
Risk	
Resource implications	Resources implication detailed in the report.
Owner	Jennie Adams, Non-Executive Director
Author	Liz Jackson, Patient Safety Project Support Officer
Date of paper	May 2017
Version number	Version 1

Quality & Safety Committee – 23 May 2017 Boardroom, York Hospital at 1.30pm

Attendance: Jennie Adams, Philip Ashton, Libby Raper, Ed Smith, Diane Palmer, Helen Hey Lynda Provins, Liz Jackson

Apologies: Beverley Geary, James Taylor and Donald Richardson

	Agenda Item	Comments	Assurance	Attention to Board
	Last meeting notes dated 18 April 2017	The minutes from the April meeting were approved as a true and accurate record. HH advised of one amendment to the Ward Accreditation Tool Quarterly Report, the CCG have asked to shadow the Ward Accreditation visits not the CQC.		
	Matters Arising – Action Log CCR Ref: MD2 CRR Ref: MD4	Item 8 – ES confirmed that little progress has been made with the Scarborough Physicians. The managerial changes on the Scarborough site should speed up the agenda; however ES was unaware of official time frames. The plans for the Acute Medical Model on the Scarborough site have been reviewed by Vince Connelly, the Medical Director at NHSI North, who agreed that they are appropriate. The Committee discussed the issues around recruitment of Core Medical Trainees on both sites. ES confirmed that the rotas rely heavily on training grades. The Committee discussed non-training roles and noted the SGH Staff Grade appointments in general medicine and the work being done to convert locums into permanent positions following the IR 35 legislation. ES advised that the junior doctor issue will become more acute post the August changeover and the directorates need to be proactive and creative in recruiting, as gaps in the training grade rotas are flagged by the Deanery at the last minute. There has been some pre-emptive recruitment in anticipation of these gaps appearing. The Committee queried how this affects the escalation of the deteriorating patient, DP confirmed that if a middle grade is not available then the patient should be escalated to the Consultant, patients with a NEWs of 7 are automatically flagged to the Outreach Team on CPD. Work is ongoing to improve this process. The Committee agreed to revisit the medical staffing issue in August when the new intake is finalised and noted that the WOD committee were also following this issue from their HR/OD perspective. This type of triangulation between the committees was felt to be a healthy sign of robust governance.		JT to highlight developing issue of junior doctor numbers post the August changeover.

	Agenda Item	Comments	Assurance	Attention to Board
		Item 35 – DP advised the Committee that it is no longer the governance team that conduct the DNACPR Audit, this is now the responsibility of Kath Sartain through the DNACPR Group, which will report to the Patient Safety Group. The End of Life Care Strategy is currently being redrafted into a final version and the detail should be available for the next meeting. **Action: DP to ask for the DNA CPR Audit results and present them to the committee.** Item 38 – The Committee welcomed Sue Rushbrook, who had been invited to discuss Board Assurance Item 1.6 in more detail. SR confirmed that discussions had taken place with JT and BG regarding fast moving technology and the use of technology within the Trust. Following on from a City of York Council initiative, the availability of WiFi for patients is being looked in to. This is a significant project and discussions are taking place with external IT companies. This service should be available in the coming weeks but it will not enable patients to stream video content onto mobile devices. A text messaging service has been put in place to remind patients of outpatient appointments and this will be rolled out into waiting lists. The ability to email patient letters is also being looked in to; however this is a slow process as mobile numbers and email addresses need to be checked with patients whilst they are in hospital. Discussions are taking place regarding single point of access, with the Trust collaborating to make contact easier for patients. This would require customer relation management, a huge change programme and a significant investment. The Committee queried the data collected from the bedside and if electronic tablets could be used. SR confirmed that tablets have been trialled previously, however, with the increasing amount of data that needs to be recorded, people asked for keyboards which then led to laptops being made available. Tablet battery life was also a concern for SR. The Trust is increasingly looking in to new technology; however, Apple products cannot be used as they are incompatible with the Oracle platform. The EPMA system has been designed so that it can be moved on to a tablet if necessary. Due to the large amount of data recorded voice recognition would be the best option; however, the technology is not yet	The Committee look forward to receiving the new SNS strategy which will provide further assurance around BAF risk 1.6	

	Agenda Item	Comments	Assurance	Attention to Board
		available. HH added that she had previously worked in a Trust where all of the observations and any audits were completed on tablets and docking stations were made available. SR advised that each ward now has a number of laptops available to complete assessments, observations, audits and ward rounds. The Committee showed some concern that escalation of the deteriorating patient is not being recorded on the computer system due to time pressures – giving a distorted picture of the care given in these cases. ES added that consistency cannot be met when there is both a paper and an electronic system in place. SR added that the Trust is open minded to new technology and is exploring a number of new developments. Video conferencing is now available with Full Sutton Prison and further work is being undertaken to allow video consultations with patients but more could be done in the area of telemedicine. Medicine apps. are a growing feature of healthcare but individual use applications needed to be adapted and scrutinised for wider organisational use. The revised Systems and Network Services Strategy will be available in due course. The committee retained some reservations around the “green” rating allocated to this risk in the BAF but were happy to retain it and review again in the light of the upcoming SNS Strategy.		
	Risk Register for the Medical Director and Chief Nurse CRR Ref: CN13 CRR Ref: MD3	CN13 - The Committee discussed the new risk on the Chief Nurse Risk Register. HH advised that the Matron for AMU/B is currently away and another senior nurse is reviewing the rotas and micromanaging the ward on a daily basis. A summer staffing proposal is being developed and recruitment is taking place, but only 3 applicants have been shortlisted. HH added that the popularity of working on an acute medical is going down and recruitment is becoming harder. Three staff from ward 15 have agreed to work on AMU for three months which will relieve some pressure, a clinical educator role is being developed and leadership is being reviewed. MD3 – SR Confirmed that no patient information was accessed from outside the Trust during the cyber-attack, the virus attacked the PCs not the applications.		

	Agenda Item	Comments	Assurance	Attention to Board
	CRR Ref: MD9 CRR Ref: MD1	MD9 – The Business Case for the Medical HOB on the York site has gone back to the directorate for review and further detail to be added. The Committee discussed if IT failure needs to be included on the Medical Directors Risk Register. During the cyber-attack, IT were able to keep radiology and pathology working quickly, HH expressed concern that if prescribing medicines had been electronic there would have been no business continuity, a back-up plan needs to be put in place.		To raise at board as part of the resilience discussion.
	Patient Safety			
	Nurse Staffing CRR Ref: CN2 & CN11 & MD4	HH advised the Committee that there were still high levels of vacancies throughout the Trust with new recruits pending a start date in autumn. Bespoke work is taking place in Scarborough Emergency Department and one or two other wards are also starting to flag (Maple, Chestnut). The Trust is attending the Nursing Times job fair next week and discussions are taking place with Coventry University around running a nursing degree course on the east coast and the curriculum is being reviewed this summer. Interest has been significant with 120 contacts for 15 potential places. HH has reviewed board papers from other Trusts and Care Hours per Patient Day are being reported in the same way. The CN intends to refresh the information on nursing numbers coming to the committee to focus on specific areas of concern rather than high level data.		
	Infection Prevention and Control CCR Ref: CN7 & CN8	The Committee took assurance from the recent infection prevention data following the outbreaks last year. The Committee queried the rise in Catheter Associated Infections that was presented in the Performance Report. The data in the report is from Safety Thermometer that is a point prevalence audit, there has been an increase in SGH and the Community Hospitals. HH added that there has been some inconsistency with the individuals completing the audit and it may be due to variable understanding of the definitions. The Community Hospitals were also showing higher levels of PUs and Insulin		

	Agenda Item	Comments	Assurance	Attention to Board
		errors this month and the committee requested additional assurance from the CN team. **Action: CN team to investigate and report back to the committee**		
	Quarterly Pressure Ulcer Report and Quarterly Falls Report	DP advised the Committee that the overall instances of Pressure Ulcers reported has increased, with the instances resulting in significant harm decreasing. This is expected with the launch of the new policy, reinforced expectations and increased awareness. Focussed work is still required in the community and is being overseen by Ginni Russell. There was a slight increase in the incidence of falls over the winter period, which may be expected due to the pressures within the organisation, however, the overall number of falls continues to decrease along with the number resulting in serious harm. The Committee agreed that although Falls and Pressure Ulcers are no longer part of the organisational priorities, they would like to continue to receive the quarterly reports for assurance. The Committee queried the rise in the number of falls and pressure ulcers reported on AMB. DP explained that these patients may have come in with the pressure ulcers and the data will include instances that are not attributed to the organisation. The increase in falls may be due to the client group for that area.		
	Serious Incidents and Never Events	DP explained to the Committee that there had not been an Executive Board, hence no SIs were included in the Medical Directors Report. The Committee were concerned that reporting of Sis is very “lumpy” due to the reduced frequency of Executive Board meetings. A Never Event has occurred in Bridlington, with a left knee prosthesis being inserted in to a right knee during a knee replacement. The equipment had been checked by three individuals before insertion. The patient has been advised and is considering her options, but has confirmed that she is in no pain or discomfort. The labelling of the item has been checked and was correctly labelled. Nick Carrington, the Clinical Director for Orthopaedics is investigating this incident		

	Agenda Item	Comments	Assurance	Attention to Board
		and reviewing the checking system. This is the third Never Event that has taken place in Bridlington, with the others being due to broken equipment and a wrong site incision. The Committee will be keen to see the conclusions of the investigation as assurance is required that this team is learning from past adverse events.		
	Sign up to Safety Update	The Trust joined the sign up to safety campaign three years ago and the report provided both qualitative and quantitative updates on the five pledges that were made. The pledges mirrored the Patient Safety Strategy at the time and included further initiatives. The future of the national campaign is uncertain and it is hoped that the first draft of the revised Patient Safety Strategy will be available in September to build upon this good work and ensure that momentum is not lost. The Committee queried the remit of the Diabetes Team and DP confirmed that the York based team are available throughout the hospital site to give advice where necessary. The the Scarborough based team are very community focussed. Both the Blood Glucose measurement and Insulin Prescribing local CQUINs have been successful in raising awareness of this common condition. DP advised the Committee that the Foundations in Patient Safety and Quality Programme abstract has been accepted at both the Patient Safety Conference and the National Patient Safety Congress. DP celebrated the growing confidence of the juniors throughout the programme with many of the attendees submitting abstracts for their quality improvement projects to the Patient Safety Conference. Evaluation of the programme is still on-going and will be publicised when complete.	The Committee took assurance form the work undertaken as part of the Sign up to Safety campaign.	
	Clinical Effectiveness			
	Medical Revalidation	The Committee noted the inclusion of the Medical revalidation action plan. LP to confirm if this needs to go to board.		LP to confirm.
	PROMS Data	The Committee agreed that the PROMs data provided was not in context and benchmarking data would be more applicable. DP advised that the data included		

	Agenda Item	Comments	Assurance	Attention to Board
		showed only the participation rates not patient outcome scores. There are four outcome measures for each procedure and DP will provide this data via scatter graphs when available. **Action**: **DP to provide PROMS data with trends and benchmarks when published**		
	Antibiotic Prescription Audit	DP advised the Committee that the Trust remains in reasonable position with the data tying in with the Anti-biotic CQUIN. The percentage of patients prescribed anti-biotics is going down, however, this CQUIN has potential to contradict the Sepsis CQUIN. .		
	Patient Experience			
	Complaints Annual Report	The Committee congratulated the Patient Experience Team on the focused work undertaken around complaints and the complaints procedure. Themes and actions have been identified and HH advised that an audit will be undertaken on the actions and Hester will feedback. Once the new process is embedded the responsibility will go to the directorates. All members of staff need to be aware of the process and learning. Further work needs to be undertaken around a collaborative approach to multi-directorate complaints. The Committee noted the rise in complaints in regard to privacy and dignity and delays in treatment. The Committee noted that one of the identified themes was basic care needs and queried the review of the COMFE tool. HH confirmed that the revised COMFE tool is being presented at Senior Nurses this month and the launch will refresh its use. Communication can be challenging due to the pressure on the wards and the use of agency staff. However, directorate teams should be empowered to give complainants a quick and effective response. The Committee noted that the Ombudsman appears to be upholding a larger amount of complaints and that the number of new clinical negligence claims has increased significantly this month. There have also been some very large settlements in the last two months. **Action: LP to check with the Health Care Governance Team about the**	The Committee took assurance from this focused work.	Deputy for BG to highlight to Board changes in process and improved levels of assurance

	Agenda Item	Comments	Assurance	Attention to Board
		nature of the clinical negligence claims and settlements and report back to the committee. HH reiterated the success of the work that has been undertaken by the Patient Experience Team and the process orientated changes that can be seen throughout the organisation.		
	Additional Items			
	2017/18 CQUINs	The Committee noted the CQUINs allocated to the Chief Nurse and the Medical Director. DP advised that Sepsis remains a significant challenge and is worth a large amount of money. HH explained that many of the Chief Nurse CQUINs require collaboration with primary care and other providers (mental health) and programmes are currently being established.		
	Quality Report	LP advised the Committee that the document is almost finalised, it has been to Health watch, the Governors and the Audit Committee and will be presented at Board.		
	Non-Executive Representation	The Committee queried if a new Non-Executive Director was needed for the Patient Safety Group. DP confirmed that the Group is Chaired by the Medical Director so issues can be highlighted to the Committee through this channel. DP agreed to invite LR and JA to observe the Group. **Action: DP to provide PSG dates for LP and JA** DP highlighted that a Non-Executive is needed for the Mortality Steering Group however may not need to attend every meeting. JA agreed to be the contact.		
	Next meeting of the Quality and Safety Committee: 20 June 2017 Boardroom, York Hospital at 1.30pm.			

Quality & Safety Committee – Action Plan – June 2017

No.	Month	Action	Responsible Officer	Due date	Completed
8	Jun 2016	Outcome of discussions with CD for Medicine and action plan (Re: Scarborough Physicians time out 27.09.16)	Medical Director	Nov 16 Jan 17 Monthly updates	
21	Oct 2016	Night Owl Initiative update following receipt of the National Inpatient Survey.	Deputy Chief Nurse	Following receipt of National Inpatient Survey – June 2017	
35	Mar 2017	DNACPR Audit report – Being undertaken by the End of Life Team, reported through DNACPR Group and Patient Safety Group.	Deputy Director for Patient Safety	April 2017 – Awaiting results – June 17	
36	Mar 2017	Patient Consent Audit report	Director of Healthcare Governance	May 2017 June 2017	
37	Mar 2017	The Committee requested an update on the actions around the Radiology Risk	Medical Director	Sept 2017	
38	Apr 2017	To invite Sue Rushbrook to discuss Board Assurance Item 1.6 in further detail.	Foundation Trust Secretary	May 2017	Completed
39	May 2017	End of Life Care Strategy – final version	Deputy Director of Healthcare Governance	Jun 2017	
40	May 2017	Lack of training middle grades in Acute Medicine	Medical Director	Aug 2017	

Patient Safety and Quality Performance Report

May 2017

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

Patient Safety & Quality Performance Report
Chapter Index

Chapter	Sub-Section
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Quality and Safety Summary: Trust

Patient Experience	Target/ Threshold 2017/18	Monthly Target/ Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Litigation - Clinical Claims Settled	-	-	6	2	5	9	5	1	8	2	2	3	5	1
Complaints	-	-	30	30	30	50	44	36	37	33	43	32	38	34

Care of the Deteriorating Patient	Target/ Threshold 2017/18	Monthly Target/ Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
12 hour Post Take - York	85%	85%	84%	87%	84%	84%	82%	82%	85%	87%	84%	85%	81%	82%
12 hour Post Take - Scarborough	80%	80%	60%	58%	58%	52%	52%	53%	61%	60%	69%	62%	67%	60%
14 hour Post Take - York	82%	Q1 82% Q2 82% Q3 85% Q4 90%	91%	94%	91%	92%	89%	89%	91%	93%	89%	91%	89%	90%
14 hour Post Take - Scarborough	52%	Q1 52% Q2 60% Q3 70% Q4 80%	69%	69%	68%	60%	61%	66%	72%	70%	80%	72%	75%	72%
Acute Admissions seen within 4 hours	80%	80%	83%	81%	87%	80%	74%	77%	81%	88%	87%	92%	87%	85%
NEWS within 1 hour of prescribed time	90%	90%	87.6%	87.1%	87.7%	87.8%	88.1%	87.8%	87.9%	87.1%	86.5%	87.1%	87.9%	89.4%
All Elective patients to have an Expected Discharge Date (EDD) recorded within 24 hours of admission	93%	93%	87%	86%	88%	88%	88%	88%	88%	85%	87%	89%	87%	87%

Measures of Harm	Target/ Threshold 2017/18	Monthly Target/ Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Serious Incidents	-	-	12	31	15	17	12	9	18	14	28	18	10	9
Incidents Reported	-	-	1197	1230	1252	1258	1062	1169	1202	1224	1401	1259	1374	1204
Incidents Awaiting Sign Off	-	-	780	724	686	763	813	752	670	768	963	1059	1129	828
Patient Falls	-	-	235	254	225	218	194	226	212	260	271	216	224	225
Pressure Ulcers - Newly Developed	-	-	73	62	56	65	92	121	125	115	142	113	140	136
Pressure Ulcers - Transferred into our care	-	-	116	123	149	109	63	64	65	70	94	62	87	74
Degree of harm: serious or death	-	-	4	11	8	10	7	8	5	5	10	6	5	7
Degree of harm: medication related	-	-	120	108	144	145	114	139	149	153	163	172	172	145
VTE risk assessments	95%	95%	98.9%	98.7%	98.6%	98.3%	98.5%	98.7%	98.3%	98.3%	98.3%	98.4%	98.6%	98.5%
Never Events	0	0	0	1	1	1	0	0	0	0	0	0	0	0

Drug Administration	Target/ Threshold 2017/18	Monthly Target/ Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Insulin Errors	-	-	9	10	9	10	10	13	9	8	8	4	6	11
Omitted Critical Medicines	-	-	13	12	8	15	17	15	17	18	18	16	13	9
Prescribing Errors	-	-	28	24	37	43	32	30	27	26	51	32	34	24
Preparation and Dispensing Errors	-	-	13	13	11	14	9	22	34	18	12	16	14	21
Administrating and Supply Errors	-	-	58	48	64	57	42	59	47	63	57	87	73	63

Safety Thermometer	Target/ Threshold 2017/18	Monthly Target/ Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
% Harm Free Care - York	-	-	97.5%	95.6%	95.1%	97.1%	96.7%	96.5%	96.8%	96.9%	94.6%	96.3%	97.0%	96.3%
% Harm Free Care - Scarborough	-	-	95.6%	94.5%	94.1%	91.2%	90.9%	93.2%	92.6%	94.2%	94.2%	92.6%	92.7%	91.9%
% Harm Free Care - Community	-	-	90.5%	91.2%	83.6%	93.5%	92.3%	91.0%	88.1%	87.9%	93.1%	91.7%	94.4%	87.5%
% Harm Free Care - District Nurses	-	-	93.8%	96.5%	96.3%	95.4%	95.6%	95.4%	96.1%	95.4%	96.2%	95.1%	95.7%	94.5%

Mortality Information	Target/ Threshold 2017/18	Monthly Target/ Threshold	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16
Summary Hospital Level Mortality Indicator (SHMI)	100	100	97	98	99	102	103	101	101	99	99	99	100	99

Infection Prevention	Target/ Threshold 2017/18	Monthly Target/ Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Clostridium Difficile - meeting the C.Diff objective			1	3	3	2	1	3	2	8	10	5	5	2
CDIFF Cumulative Threshold	48 (year)	48 (year)	5	8	11	14	17	22	27	35	40	45	48	4
Clostridium Difficile -meeting the C.Diff objective - cumulative			4	7	10	12	13	16	18	26	36	41	46	2
MRSA - meeting the MRSA objective	0	0	0	1	0	2	0	2	0	1	0	0	0	0
MSSA	30	2	2	2	2	5	0	8	4	5	5	5	5	3
MSSA - cumulative			11	13	15	20	20	28	32	37	42	47	52	3
ECOLI			5	7	8	14	10	4	5	5	9	8	5	6
ECOLI - cumulative			10	17	25	39	49	53	58	63	72	80	85	6
MRSA Screening - Elective	95%	95%	84.5%	85.8%	89.9%	83.7%	85.0%	89.8%	86.3%	84.7%	87.7%	88.5%	87.9%	90.0%
MRSA Screening - Non Elective	95%	95%	83.6%	86.3%	86.6%	86.7%	86.4%	86.0%	85.9%	84.8%	85.7%	86.4%	86.2%	87.1%

Stroke (one month behind due to coding)	Target/ Threshold 2017/18	Monthly Target/ Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Proportion of patients spending >90% on their time on stroke unit	80%	80%	92.1%	85.2%	82.9%	88.3%	93.6%	90.6%	87.1%	89.5%	90.5%	89.7%	83.7%	1 month behind
Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%	75%	100.0%	68.8%	79.0%	73.7%	73.9%	92.6%	64.7%	90.5%	95.2%	n/a	n/a	1 month behind
Scanned within 1 hour of arrival	50%	50%	76.2%	50.0%	60.0%	54.2%	63.6%	75.0%	68.0%	79.0%	60.0%	55.6%	69.2%	1 month behind
Scanned within 24 hours of hospital arrival	90%	90%	94.1%	93.2%	92.9%	93.5%	92.5%	96.5%	96.3%	93.6%	91.9%	94.0%	89.9%	1 month behind
Proportion of stroke patients with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	n/a	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1 month behind

AMTS	Target/ Threshold 2017/18	Monthly Target/ Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
AMTS Screening	90.0%	90.0%	91.3%	90.4%	92.5%	85.4%	86.5%	91.2%	87.8%	87.8%	90.1%	88.3%	88.9%	86.7%

Patient Experience
(Patient Experience Team)

Friend and Family Test (FFT) Latest Results – March 2017
Our target is to achieve 90% of patients to recommend the Trust. This was achieved for Inpatients (96.4%) and Maternity (97.1%) but not for the Emergency Department (84.2%)

The Patient Experience Team continues to proactively engage with the matrons, sisters and directorate managers in the areas where response rates can be most improved. Themes identified in April include:
Noise and disruption: Chestnut Ward, Ward 22, Ward 16, Coronary Care Unit. All wards are being encouraged to engage with the Night Owl Initiative and to continue to promote it with all ward staff.
Time to answer call bells: Wards 33 and 35. The comfort rounding process is being relaunched and will help ensure that patients have their basic needs met in a timely manner.
Staff being overstretched: Holly Ward. As well as the ward, this feedback was shared with the Human Resources Team to match against staff feedback.

Complaints
The new complaints process was introduced on 1 February 2017. Since then there has been a significant downward trend in the number of open complaints (93 at end of April). After an initial spike, the number of open complaints that have not received a response within the 30 working day target is now also coming down (38 at the end of April).

A monthly audit of a sample of closed complaints is now being carried out by the complaints team. This checks for compliance with the Trust's complaints policy and checks for evidence that the stated action plans have been completed.

Measures of Harm

No Never Events were declared in April 2017.

9 Serious Incidents were declared; 3 at York, 2 at Scarborough and 4 in Community.
1 of the SIs was attributed to 'Clinical Incident', 3 were attributed to 'Slips, Trips and Falls', and 5 were attributed to Pressure Ulcers.

Infection Prevention

The Trust reported no cases of MRSA in April. This remains a zero tolerance measure in 2017/18.

In April 2017 the Trust reported 2 cases of CDIFF, both at Scarborough. The yearly threshold for 2017/18 remains at 48, monthly allocation allows for 4 cases.

3 cases of MSSA were reported in April. 2 cases were reported at York and 1 at Scarborough.

6 cases of ECOLI were reported in April. 5 cases were reported at York and 1 Community (St Monica's).

Quality and Safety - Miscellaneous

Stroke (reported 1 month behind due to coding)
In March the Trust achieved target for the proportion of patients spending > 90% of their time on a stroke unit and urgent scans within 1 hour. The Trust failed to achieve target for the proportion of patients scanned within 24 hours. Data currently unavailable for High Risk TIA.

Cancelled Operations
46 operations were cancelled within 48 hours of the TCI date in April. This is a significant decrease compared to the same month in the previous 3 years (April 2016 - 137).

Cancelled Clinics/Outpatient Appointments
151 clinics were cancelled with less than 14 days notice; this is a 20.1% decrease on April 2016. The number of hospital cancelled outpatient appointments for non clinical reasons compares favourably to April 2016; figures show a 9.5% decrease.

Ward Transfers between 10pm and 6am
79 ward transfers between 10pm and 6am were reported in April 2017 (Scarborough - 17, York - 62). This is comparable with April 2016 when the Trust reported 78 transfers.

AMTS
The Trust failed to achieve the 90% target for AMTS screening in April, performance was 86.7%. The Trust has failed to achieve the target in 7 months of the last 12.

Care of the Deteriorating Patient

Targets were achieved across both sites for the proportion of Medicine and Elderly patients receiving a senior review within 14 hours in April. York achieved 90% against the 82% target for Q1 and Scarborough achieved 72% against the 52% target for Q1.

89.4% of patients had their NEWS scores completed within 1 hour in April against the Trust's internal target of 90%. Scarborough continue to consistently achieve target with performance of 92.21% in April, York achieved 87.59%.

87% of Elective patients had their Expected Date of Discharge recorded within 24 hours of admission across the Trust in April. The target of 90% was therefore not achieved.

Drug Administration

11 insulin errors were reported in April, including 7 within Community. This is the highest number reported in Community in the previous 12 months.

24 prescribing errors were reported across the Trust in April, 79.2% were attributed to York.

The number of dispensing errors at York have seen a continued improvement since the spike in October and November 2016, however numbers remain up in comparison to April - September 2016. Scarborough and Community figures are comparable with previous months.

Mortality

The latest SHMI report indicates the Trust to be in the 'as expected' range. The July 2015 - June 2016 SHMI saw a 1 point decrease for the Trust and Scarborough, and a 1 point increase for York. Trust - 99, York 96 and Scarborough 106.

175 inpatient deaths were reported across the Trust in April; 108 were reported at York and 54 were reported at Scarborough.

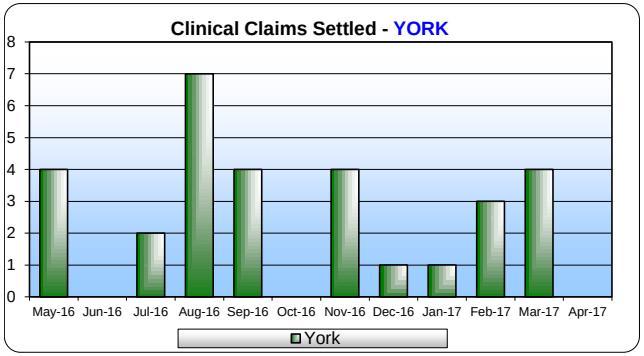
12 deaths in ED were reported in April; 4 at York and 8 at Scarborough.

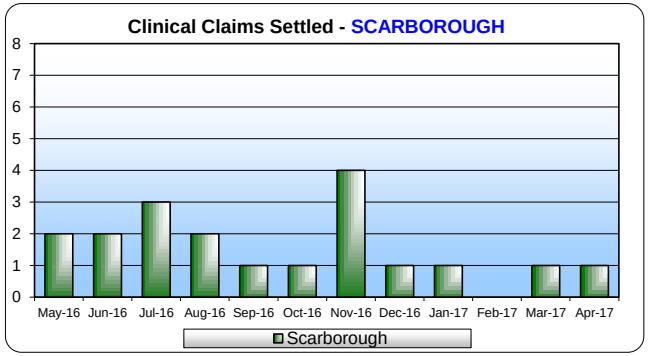
CQUINS update **(Operations Team)**

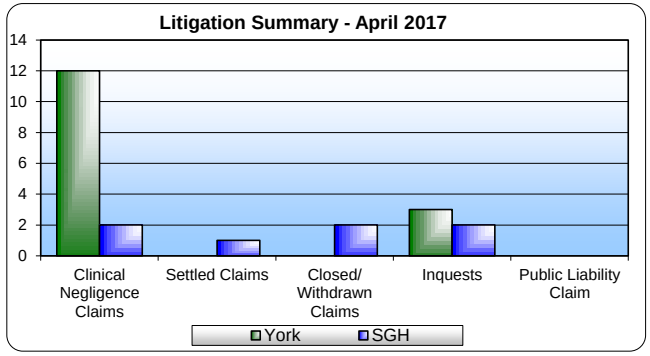
The Trust will receive full payment for CQUINS in Q4 with the exception of Sepsis screening in ED where part payment is currently being negotiated with the CCGs. Partial payment will also be received for Adult Critical Care Timely Discharge and negotiations are on-going with NHSE on the Health Inequalities - Screening for people with learning difficulties or mental health conditions CQUIN.

Litigation

Indicator	Site	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Clinical Negligence Claims Received	York	9	9	4	7	6	7	3	7	7	6	7	12
	Scarborough	7	8	8	3	4	6	11	4	4	2	2	2
Clinical Claims Settled	York	4	0	2	7	4	0	4	1	1	3	4	0
	Scarborough	2	2	3	2	1	1	4	1	1	0	1	1
Closed/ Withdrawn Claims	York	2	5	13	7	6	3	7	6	6	11	7	0
	Scarborough	3	5	4	17	7	7	6	2	2	12	3	2
Coroners Inquests Heard	York	2	2	1	5	5	1	4	0	0	1	3	3
	Scarborough	3	6	3	2	2	2	5	6	6	2	1	2







Patient Experience

PALS Contacts
There were 273 PALS contacts in April.

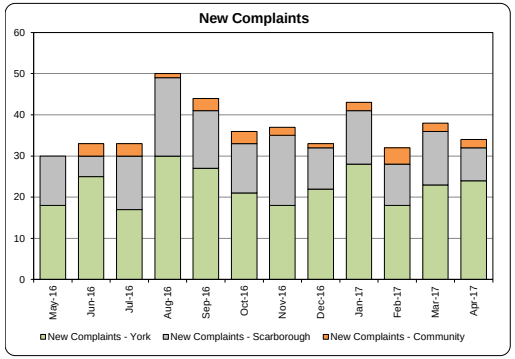
Complaints
There were 34 complaints in April; 24 were attributed to York, 8 to Scarborough and 2 to Community.

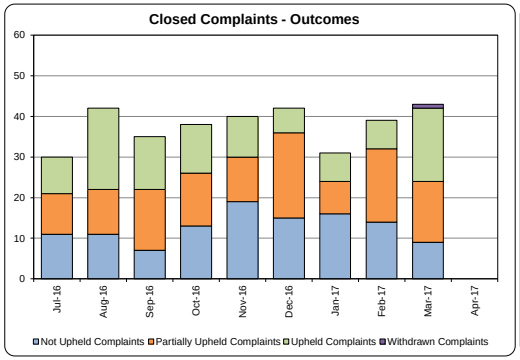
New Ombudsman Cases
There were no New Ombudsman Cases in April .

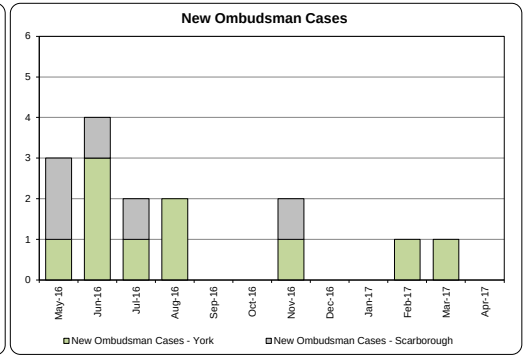
Compliments
118 compliments were received in April 2017. Up until December 2016 compliments reported were only those received directly by the Chief Executive and PALS. From January 2017 numbers from wards and departments are included.

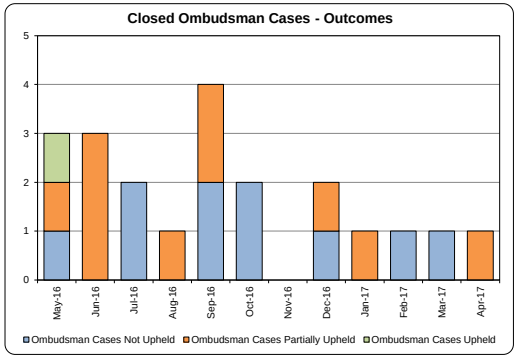
Patient Experience

May-17



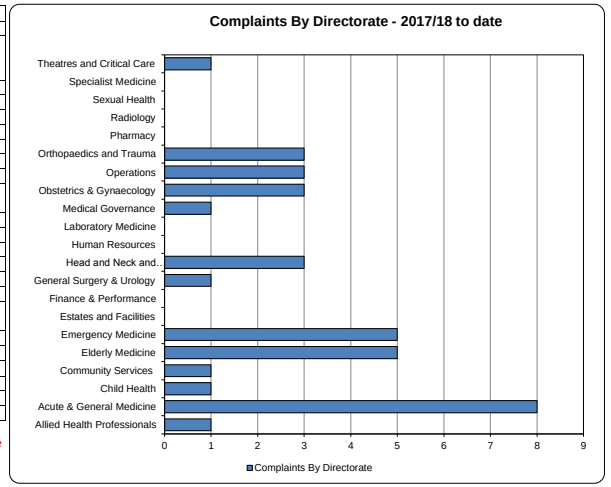






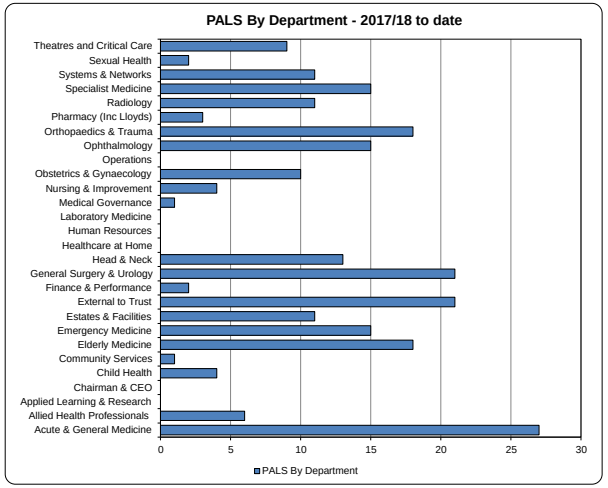
Complaints By Subject	Apr-17	YTD
Access to treatment or drugs	0	0
Admissions, Discharge and Transfer Arrangements	7	7
All aspects of Clinical Treatment	26	26
Appointments, Delay/Cancellation	3	3
Commissioning	0	0
Comms/info to patients (written and oral)	6	6
Complaints Handling	0	0
Consent	0	0
End of Life Care	0	0
Facilities	3	3
Mortuary	0	0
Others	0	0
Patient Care	15	15
Patient Concerns	2	2
Prescribing	2	2
Privacy and Dignity	4	4
Restraint	0	0
Staff Numbers	0	0
Transport	0	0
Trust Admin/Policies/Procedures	1	1
Values and Behaviours (Staff)	10	10
Waiting times	0	0
TOTAL	**79**	**79**

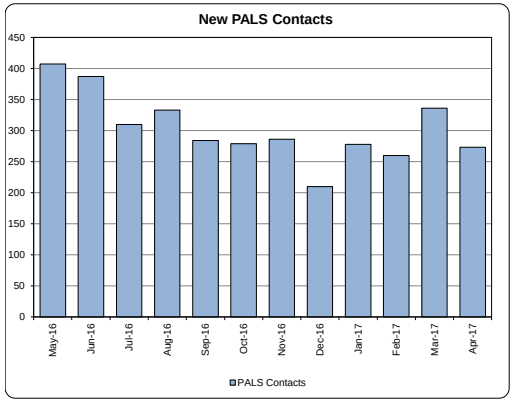
Due to new reporting the number of complaints/PALs contacts by subject is greater than the total number of complaints because each subject within the complaint can be identified as opposed to just the one deemed to be the 'primary'.

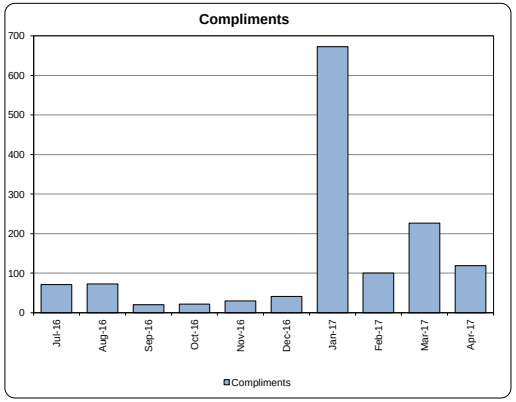


PALS By Subject	Apr-17	YTD
Access to Treatment or Drugs	12	12
Admissions and Discharges (Excluding Delayed Discharge due to absence of care package)	15	15
Appointments	57	57
Clinical Treatment	26	26
Commissioning	1	1
Communication	62	62
Consent	0	0
End of Life Care	1	1
Facilities	9	9
Integrated Care (including Delayed Discharge Due to Absence of a Care Package	0	0
Patient Care	14	14
Patient Concerns	12	12
Prescribing	5	5
Privacy, Dignity & Respect	4	4
Staff Numbers	0	0
Transport	1	1
Trust Admin/Policies/Procedures Inc. pt. record management	10	10
Values and Behaviours (Staff)	31	31
Waiting Times	13	**13**
Total	**273**	**273**

Since July 2016 there was a change in how PALS log cases. Issues such as misplaced calls from switchboard or requests to speak to other departments are no longer logged. The new IT system allows cases to be updated rather than creating new logs.

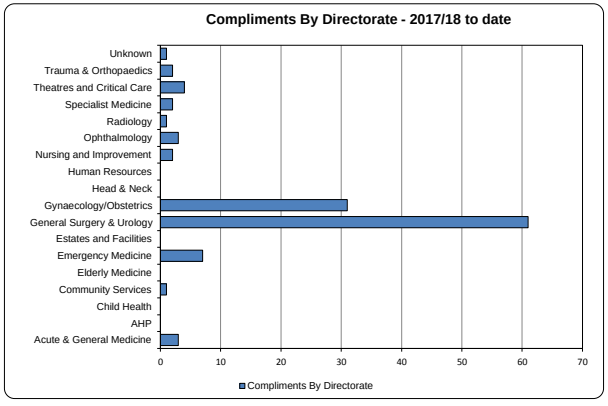






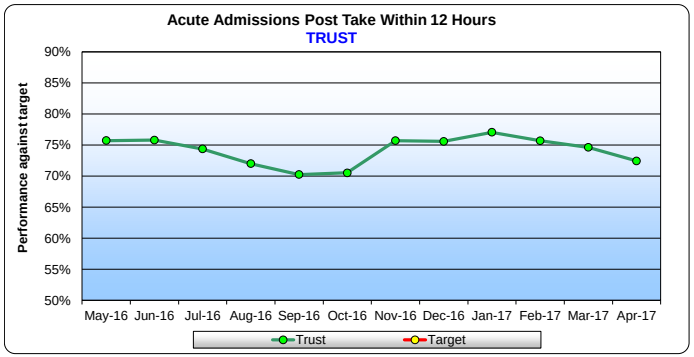
Compliments By Directorate	Apr-17	YTD
Acute & General Medicine	3	3
AHP	0	0
Child Health	0	0
Community Services	1	1
Elderly Medicine	0	0
Emergency Medicine	7	7
Estates and Facilities	0	0
General Surgery & Urology	61	61
Gynaecology/Obstetrics	31	31
Head & Neck	0	0
Human Resources	0	0
Nursing and Improvement	2	2
Ophthalmology	3	3
Radiology	1	1
Specialist Medicine	2	2
Theatres and Critical Care	4	4
Trauma & Orthopaedics	2	2
Unknown	1	1
Total	**118**	**118**

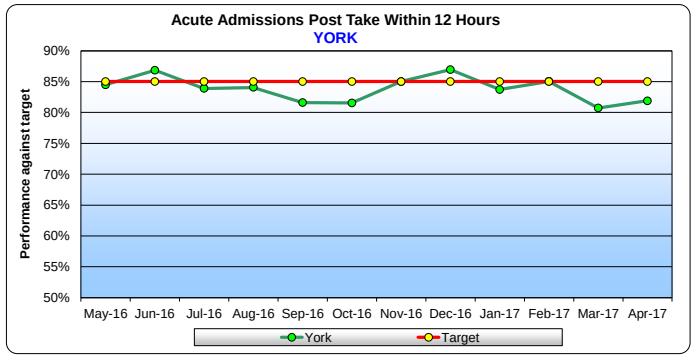
Up until December 2016 compliments reported were only those received directly by the Chief Executive and PALS. From January 2017 numbers from wards and departments are included

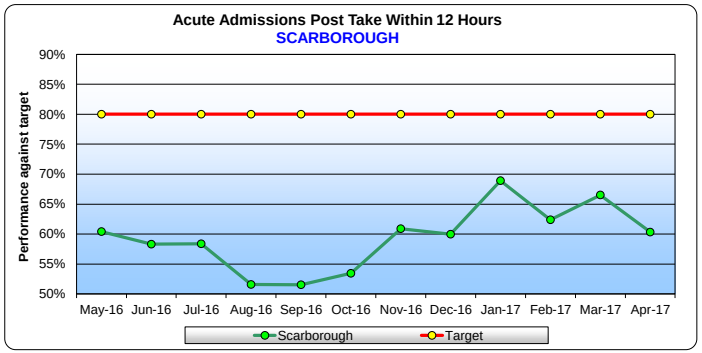


Quality and Safety: Care of the Deteriorating Patient

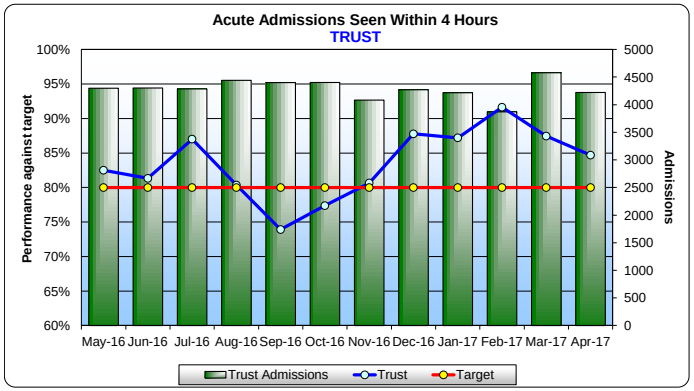
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Feb	Mar	Apr
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (SCARBOROUGH)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	80%	60%	54%	58%	66%	62%	67%	60%
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (YORK)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	85%	87%	83%	84%	83%	85%	81%	82%

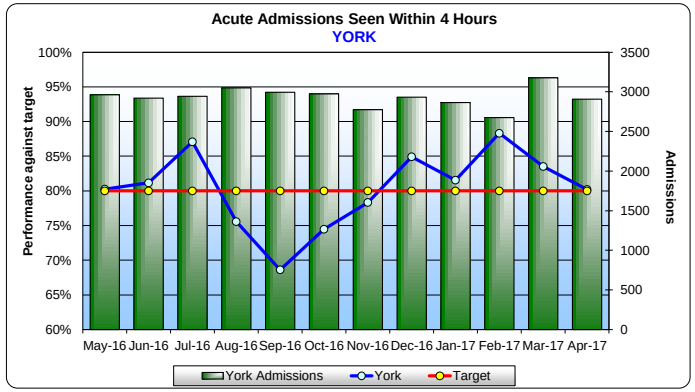


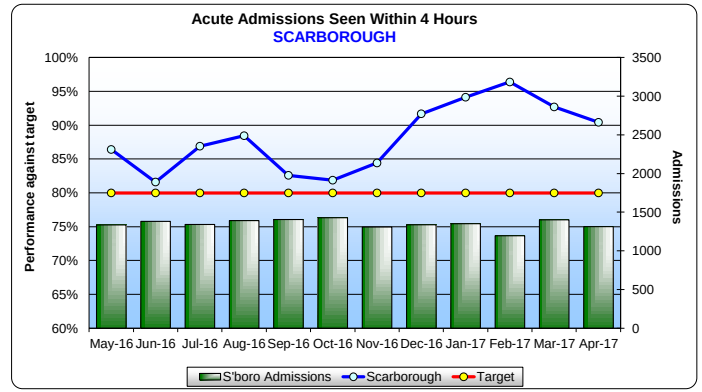




Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	**80% by site**	83.8%	80.4%	81.7%	88.7%	91.6%	87.5%	84.7%

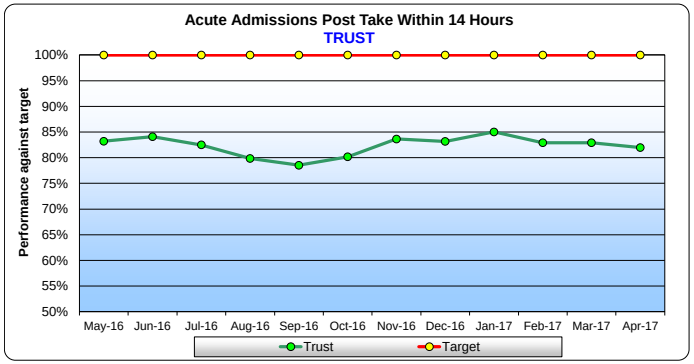


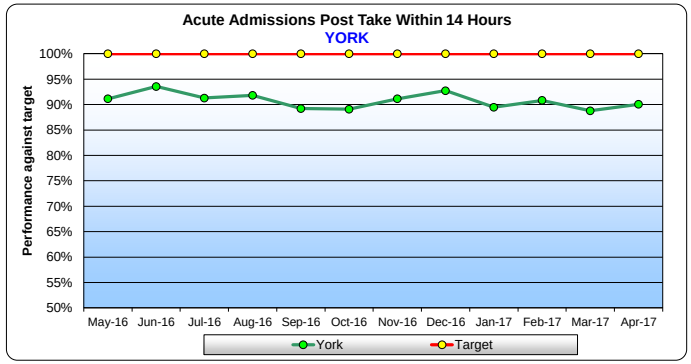


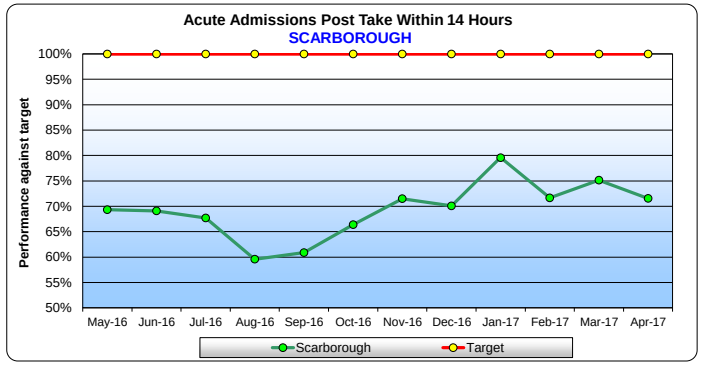


Quality and Safety: Care of the Deteriorating Patient

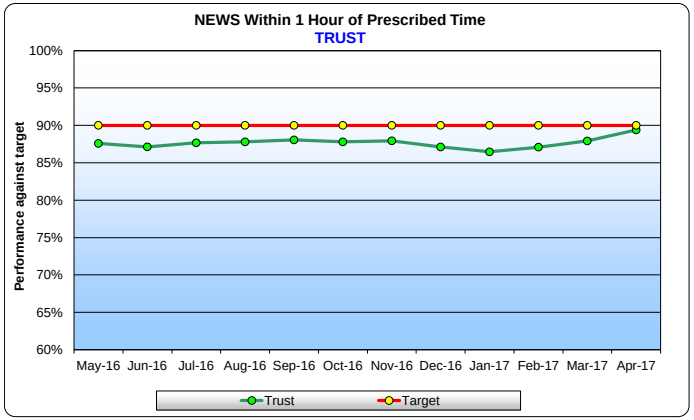
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Feb	Mar	Apr
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI		83.9%	80.3%	82.2%	83.6%	82.9%	82.9%	82.0%

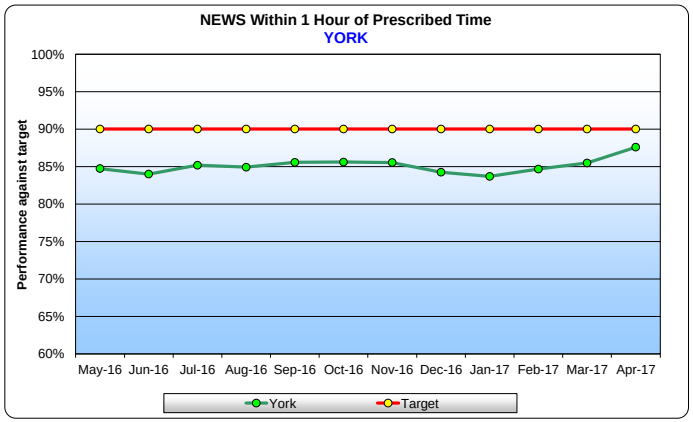


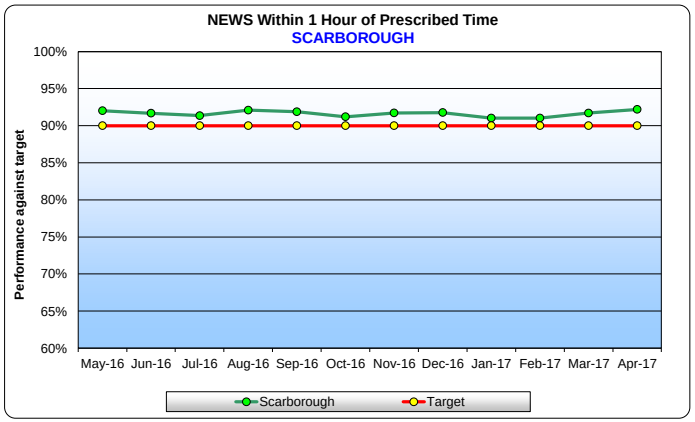




NEWS within 1 hour of prescribed time	None - Monitoring Only		87.3%	87.9%	87.6%	87.2%	87.1%	87.9%	89.4%







Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 9 SIs reported in April; York 3, Scarborough 1, Bridlington 1 & Community 4.
Clinical Incidents: York 1.
Slips Trips & Falls: 3; York 2, Scarborough 1.
Pressure Ulcers: 5; Community 4, Bridlington 1.

Patients Falls and Found on Floor (source: Datix)
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During April there were 118 reports of patients falling at York Hospital, 82 patients at Scarborough and 26 patients within the Community Services (225 in total).

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during April was 1,339; 738 incidents were reported on the York site, 446 on the Scarborough site and 155 from Community Services.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 828 incidents awaiting sign-off by the Directorate Management Teams.

Pressure Ulcers (source: Datix)
During April 72 pressure ulcers were reported to have developed on patients since admission to York Hospital, 33 pressure ulcers were reported to have developed on patients since admission to Scarborough and 31 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.

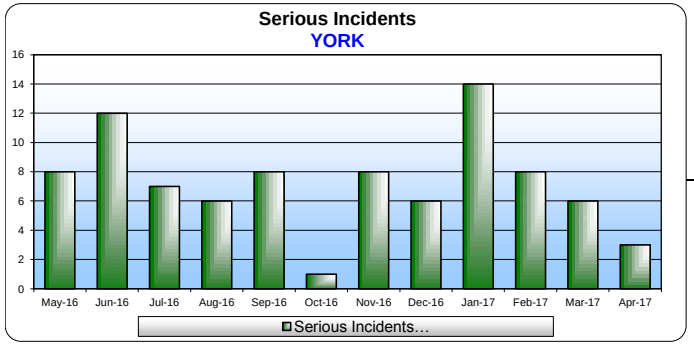
Degree of Harm: Serious/Severe or Death (source: Datix)
During April 7 patient incidents were reported which resulted in serious or severe harm or death. Numbers are subject to change as levels of harm are reviewed and investigations are completed.

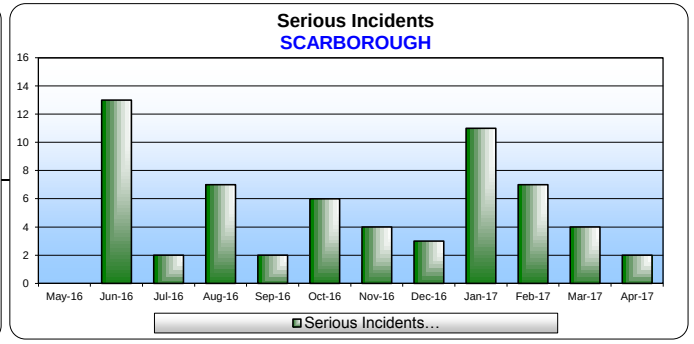
Medication Related Issues (source: Datix)
During April there were a total of 145 medication related incidents reported although this figure may change following validation.

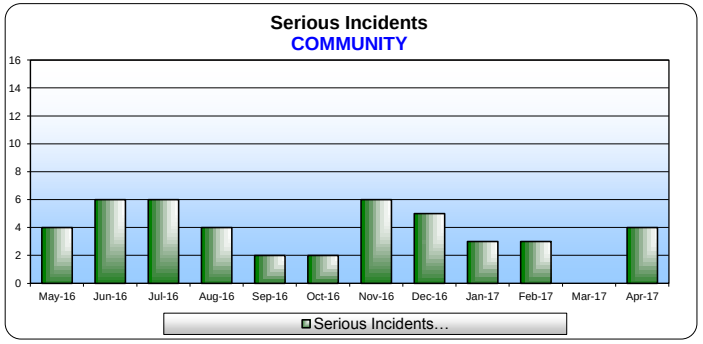
Never Events – No Never Events were declared during April.

Measures of Harm

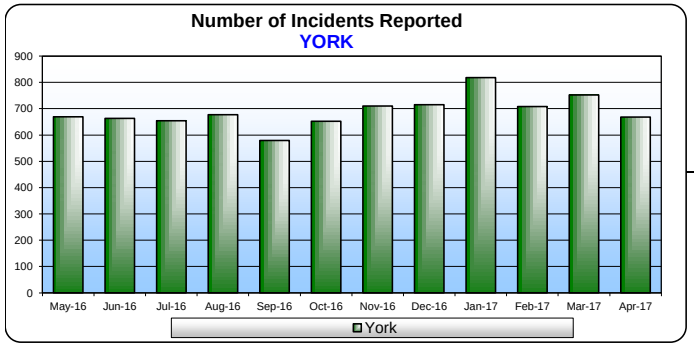
Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Serious Incidents source: Risk and Legal	York	8	12	7	6	8	1	8	6	14	8	6	3
	Scarborough	0	13	2	7	2	6	4	3	11	7	4	2
	Community	4	6	6	4	2	2	6	5	3	3	0	4
Serious Incidents Delogged source: Risk and Legal (Trust)		0	0	0	0	0	0	0	0	0	0	0	0

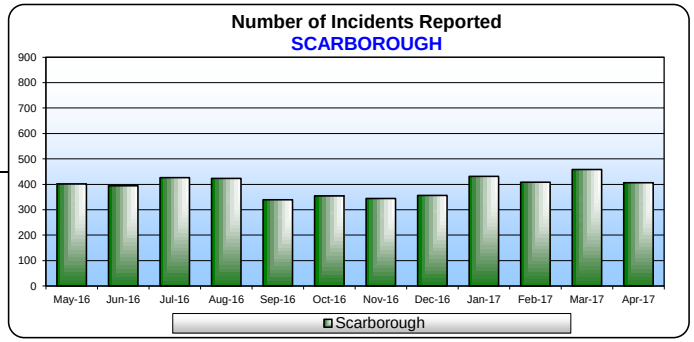


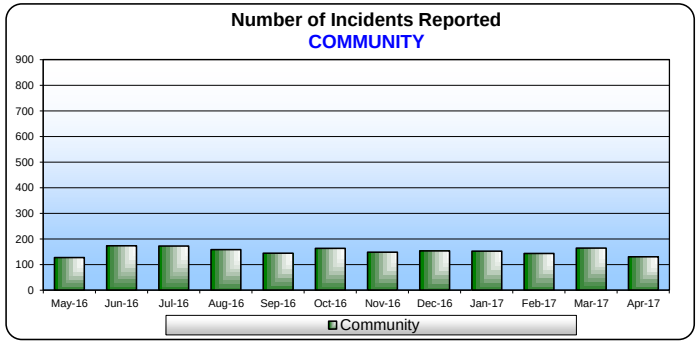




Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Number of Incidents Reported source: Risk and Legal	York	669	663	654	677	579	652	710	715	818	708	752	668
	Scarborough	401	394	426	423	339	354	344	356	431	408	458	406
	Community	127	173	172	158	144	163	148	153	152	143	164	130
Number of Incidents Awaiting sign off at Directorate level		780	724	686	763	813	752	670	768	963	1059	1129	828

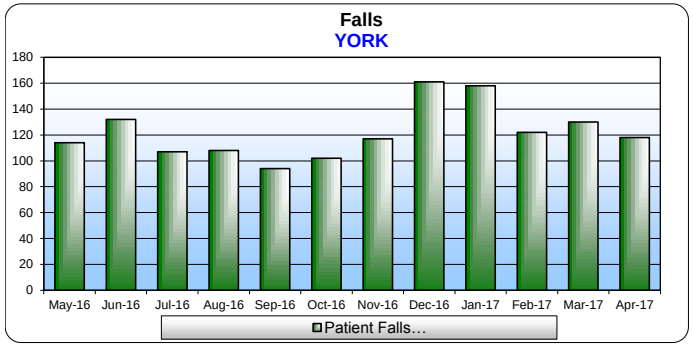


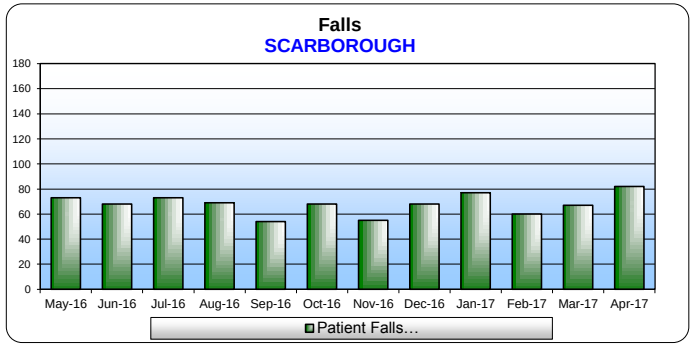


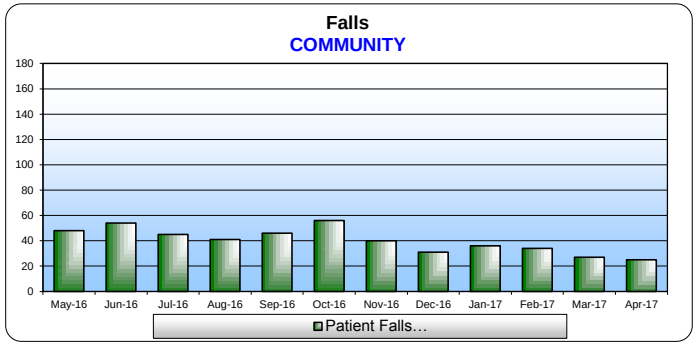


Measures of Harm

Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Patient Falls source: DATIX	York	114	132	107	108	94	102	117	161	158	122	130	118
	Scarborough	73	68	73	69	54	68	55	68	77	60	67	82
	Community	48	54	45	41	46	56	40	31	36	34	27	25

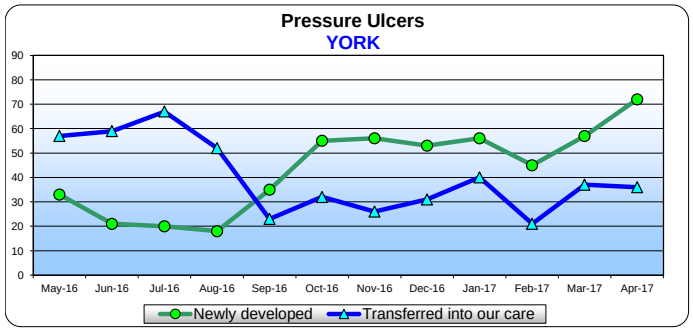


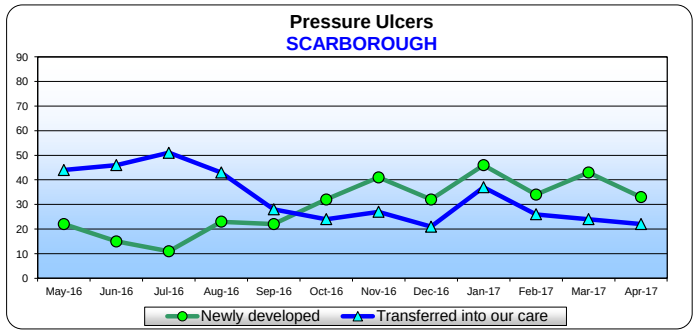


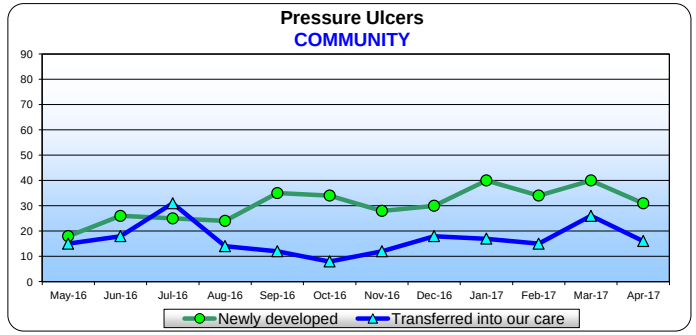


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.
Increases in December and January reflect the increase in the number of frail and elderly patients in hospital.

Indicator			May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Pressure Ulcers source: DATIX	York	Newly developed	33	21	20	18	35	55	56	53	56	45	57	72
		Transferred into our care	57	59	67	52	23	32	26	31	40	21	37	36
	Scarborough	Newly developed	22	15	11	23	22	32	41	32	46	34	43	33
		Transferred into our care	44	46	51	43	28	24	27	21	37	26	24	22
	Community	Newly developed	18	26	25	24	35	34	28	30	40	34	40	31
		Transferred into our care	15	18	31	14	12	8	12	18	17	15	26	16



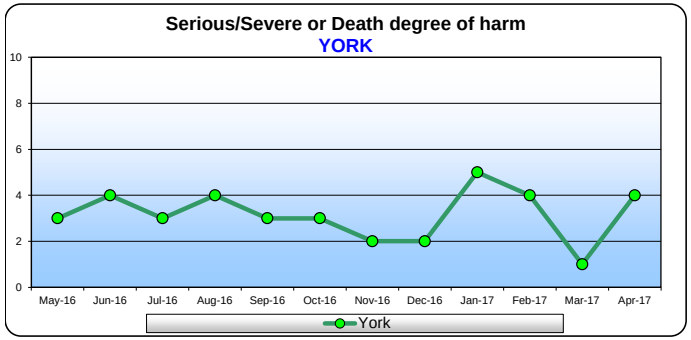


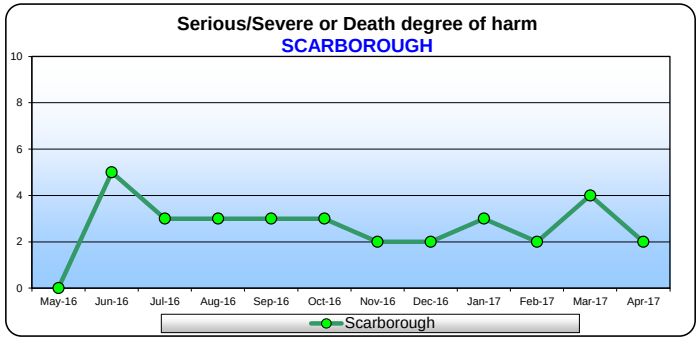


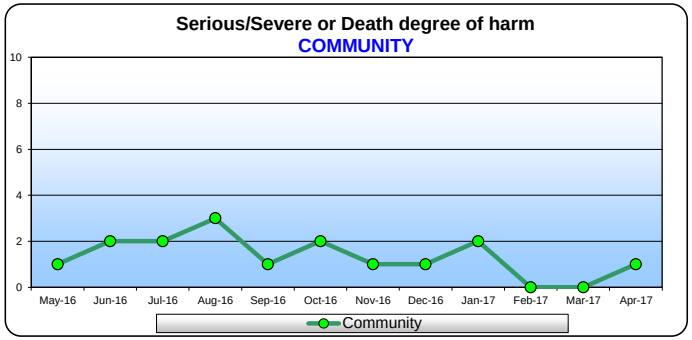
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised as a 'Deterioration of a previously reported ulcer'.
The increase in newly developed or deteriorated under our care is thought to be attributable to a re-classification of the data on the Datix system implemented on 01/09/16, recognising more accurately our responsibility for patients in the community.

Measures of Harm

Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Degree of harm: serious/severe or death source: Datix	York	3	4	3	4	3	3	2	2	5	4	1	4
	Scarborough	0	5	3	3	3	3	2	2	3	2	4	2
	Community	1	2	2	3	1	2	1	1	2	0	0	1

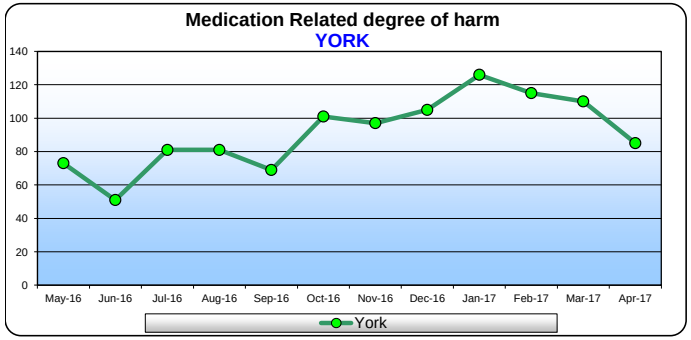


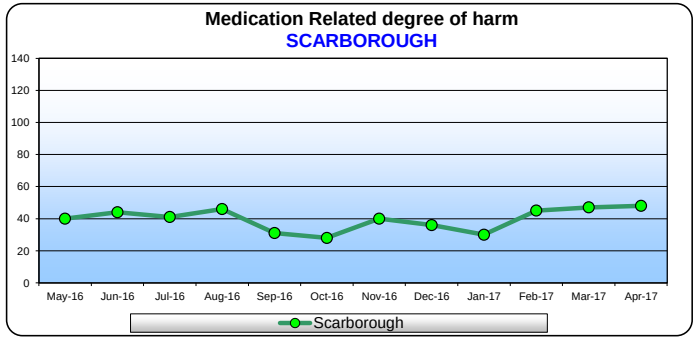


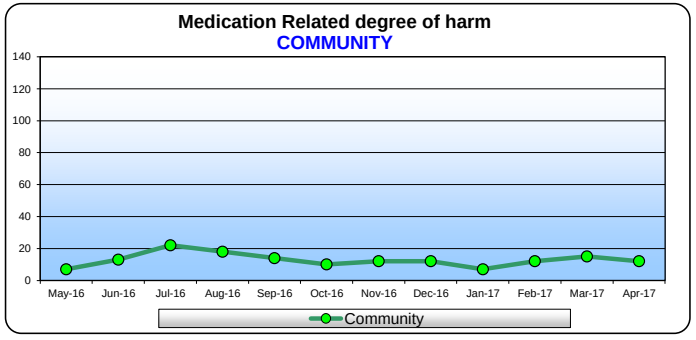


Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Degree of harm: Medication Related Issues source: Datix	York	73	51	81	81	69	101	97	105	126	115	110	85
	Scarborough	40	44	41	46	31	28	40	36	30	45	47	48
	Community	7	13	22	18	14	10	12	12	7	12	15	12

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

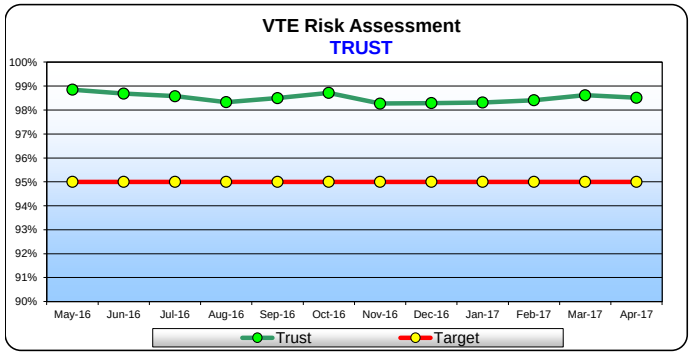


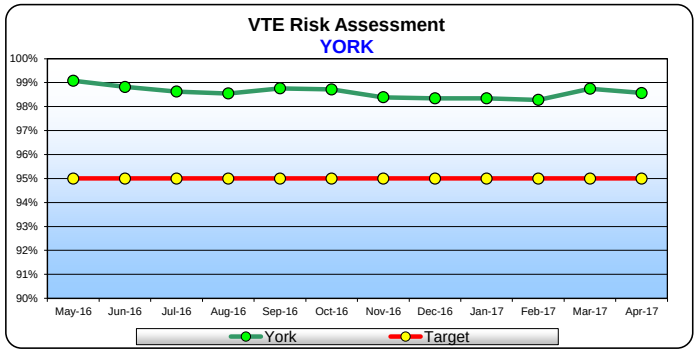


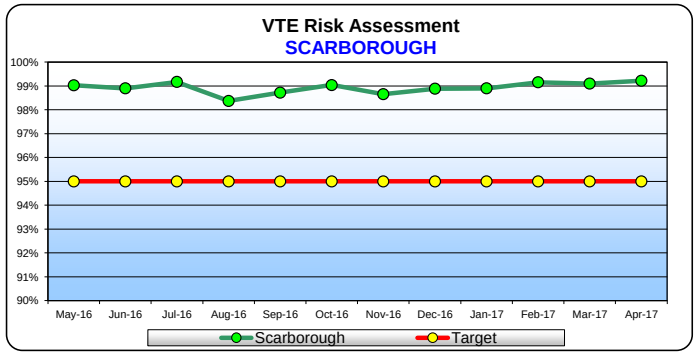


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Feb	Mar	Apr
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance source: CPD	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Trust	95%	98.7%	98.5%	98.4%	98.5%	98.4%	98.6%	98.5%
		York	95%	98.9%	98.7%	98.5%	98.5%	98.3%	98.8%	98.6%
		Scarborough	95%	98.9%	98.8%	98.9%	99.1%	99.2%	99.1%	99.2%







Never Events

Indicator	Consequence of Breach	Threshold	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Feb	Mar	Apr
SURGICAL									
Wrong site surgery	As below	**>0**	**2**	**1**	**0**	**0**	0	0	0
Wrong implant/prosthesis		**>0**	**0**	**0**	**0**	**0**	0	0	0
Retained foreign object post-operation		**>0**	**0**	**0**	**0**	**0**	0	0	0
MEDICATION									
Wrongly prepared high-risk injectable medication	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	**0**	**0**	**0**	**0**	0	0	0
Maladministration of potassium-containing solutions		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong route administration of chemotherapy		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong route administration of oral/enteral treatment		**>0**	**0**	**1**	**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 April indicated 0.46% for York and 2.42% for Scarborough.

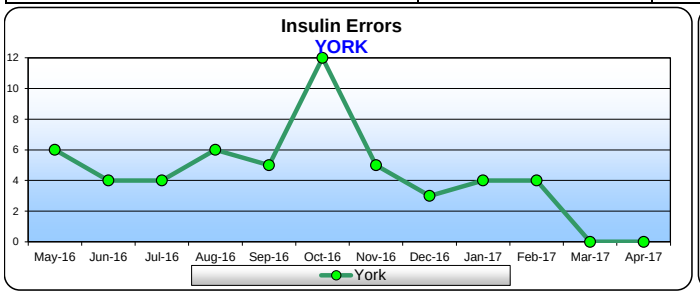
Prescribing Errors
There were 24 prescribing related errors in April; 19 from York and 5 from Scarborough .

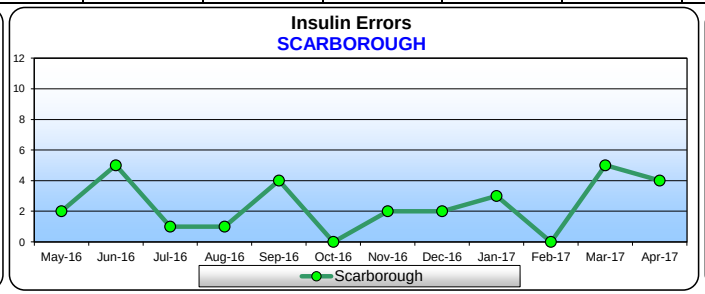
Preparation and Dispensing Errors
There were 21 preparation/dispensing errors in April; 15 from York, 5 from Scarborough and 1 Community.

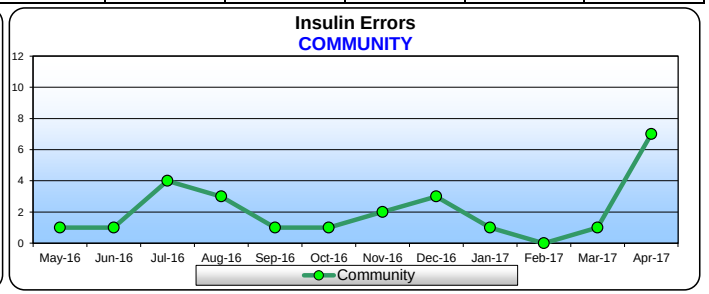
Administrating and Supply Errors
There were 63 administrating/supplying errors in April; 33 were from York, 20 from Scarborough and 10 from Community. Audit work on missed doses has raised the awareness of the importance of reporting medication errors, and this is thought to have contributed to the increase in administration errors from December onwards.

Drug Administration

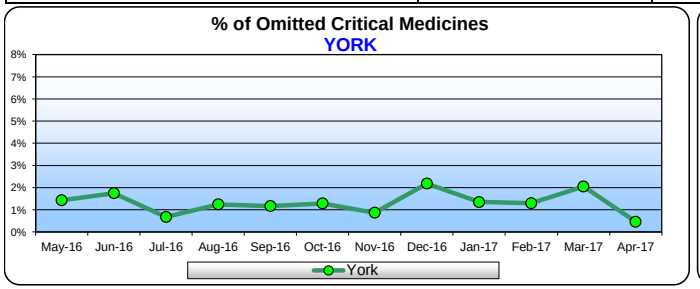
Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Insulin Errors source: Datix	York	6	4	4	6	5	12	5	3	4	4	0	0
	Scarborough	2	5	1	1	4	0	2	2	3	0	5	4
	Community	1	1	4	3	1	1	2	3	1	0	1	7

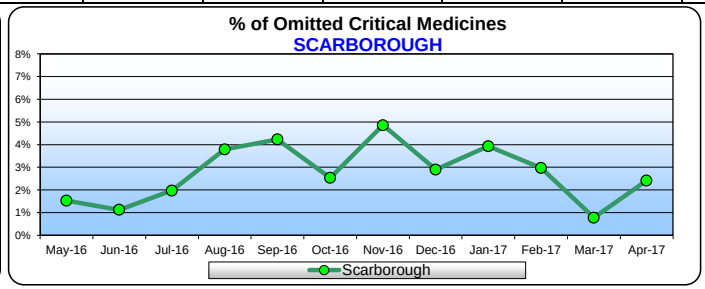


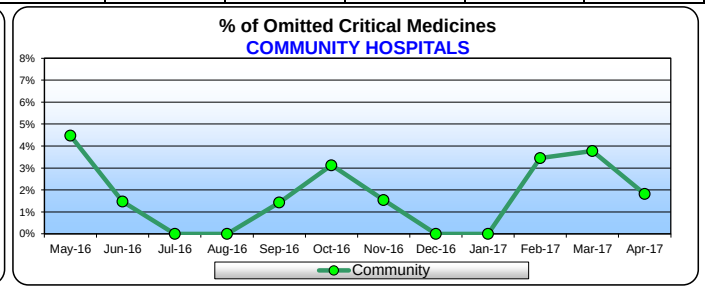




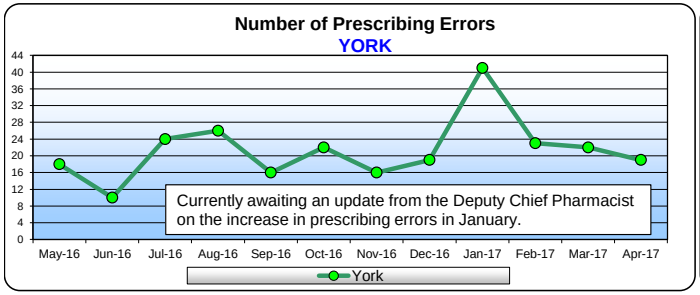
Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Number of Omitted Critical Medicines source: Datix	York	6	8	3	5	5	6	4	10	7	6	9	2
	Scarborough	4	3	5	10	11	7	12	8	11	8	2	6
	Community Hospitals	3	1	0	0	1	2	1	0	0	2	2	1

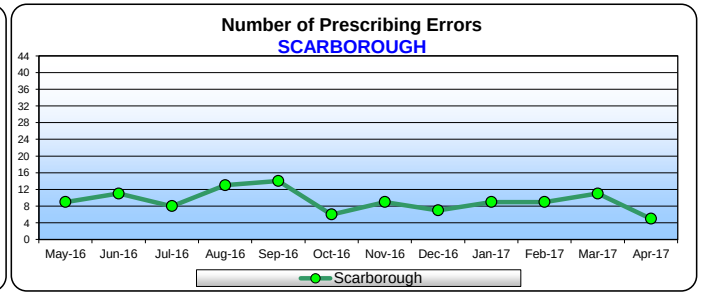


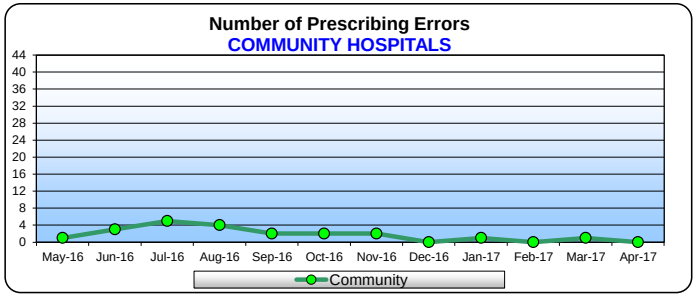




Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Number of Prescribing Errors source: Datix	York	18	10	24	26	16	22	16	19	41	23	22	19
	Scarborough	9	11	8	13	14	6	9	7	9	9	11	5
	Community Hospitals	1	3	5	4	2	2	2	0	1	0	1	0

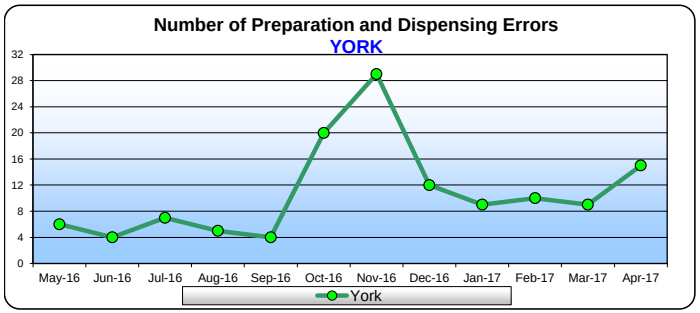


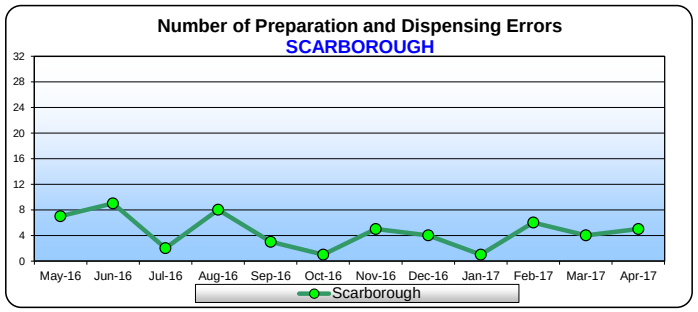


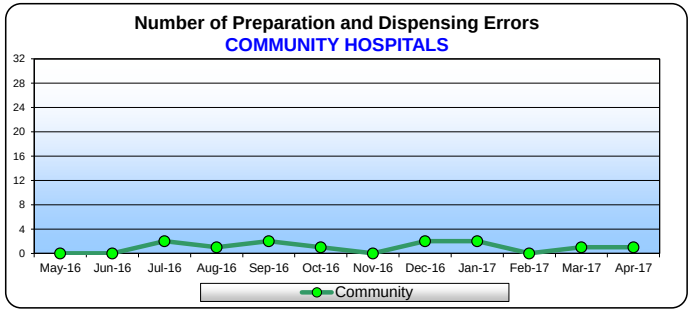


Drug Administration

Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Number of Preparation and Dispensing Errors source: Datix	York	6	4	7	5	4	20	29	12	9	10	9	15
	Scarborough	7	9	2	8	3	1	5	4	1	6	4	5
	Community Hospitals	0	0	2	1	2	1	0	2	2	0	1	1

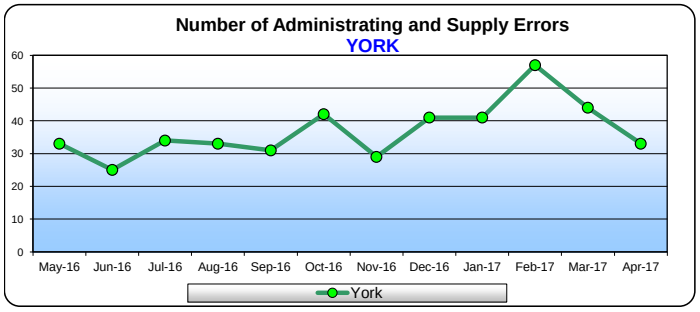


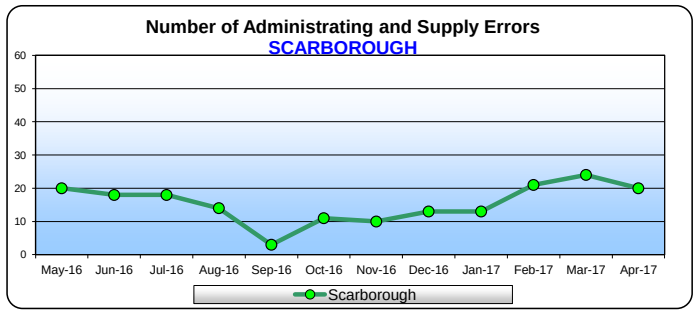


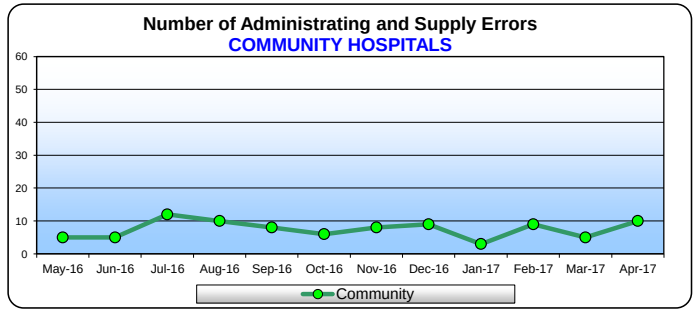


Note re increase in Dispensing Errors - Healthcare at Home have recently experienced a high turnover of staff which has contributed to the increase in errors as the service has mostly been delivered by locums. The vacancies are currently being recruited to and a new manager has been appointed. Trust Senior Pharmacy staff are also meeting with the Chief Pharmacist from Healthcare at Home on a weekly basis and they have provided an action plan that includes the review of all policies and processes. Trust Pharmacy staff are in the process of delivering training to their old and new staff to help to improve the situation.

Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Administrating and Supply Errors source: Datix	York	33	25	34	33	31	42	29	41	41	57	44	33
	Scarborough	20	18	18	14	3	11	10	13	13	21	24	20
	Community Hospitals	5	5	12	10	8	6	8	9	3	9	5	10







Note re increase in medication error reporting - audit work on missed doses has raised the awareness of the importance of reporting medication errors, and this is thought to have contributed to the increase in administration errors from December onwards.

Measures of Harm: Safety Thermometer

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

Harm Free Care

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

·York: 96.3%
·Scarborough: 91.9%
·Community Hospitals: 87.5%
·Community care: 94.5%

Harm from Catheter Associated Urinary Tract Infection

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

·York: 0.7%
·Scarborough: 3.4%
·Community Hospitals: 5.4%
·Community Care: 0.8%

VTE

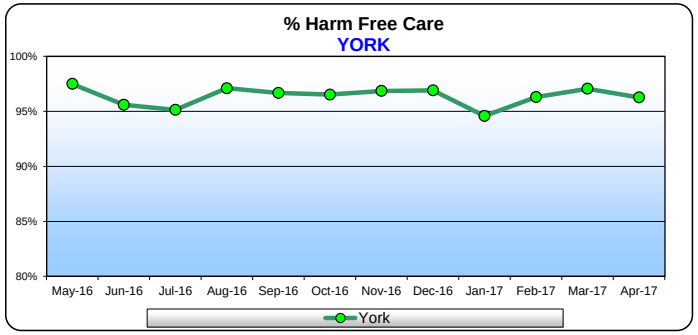
The percentage of patients affected by VTE as measured by the Department of Health definition, monthly measurement of prevalence:

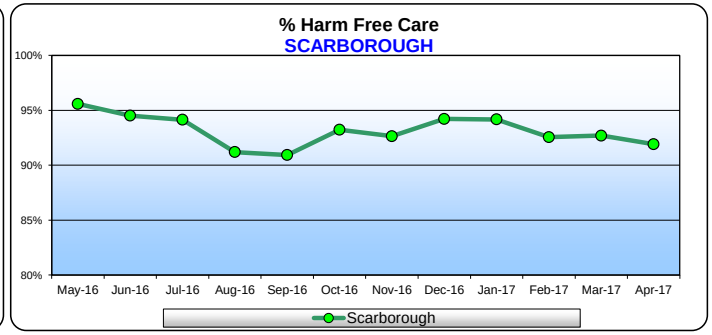
·York: 0.0%
·Scarborough: 0.7%
·Community Hospitals: 0.0%
·Community Care: 0.5%

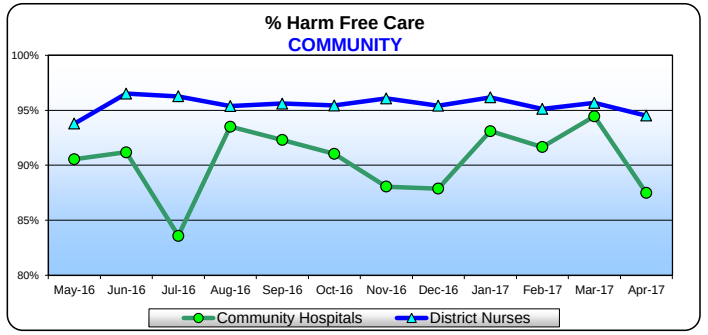
Safety Thermometer

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

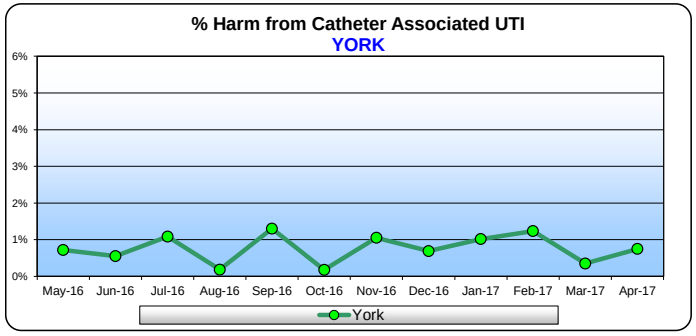
Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
% of Harm Free Care source: Safety Thermometer	York	97.5%	95.6%	95.1%	97.1%	96.7%	96.5%	96.8%	96.9%	94.6%	96.3%	97.0%	96.3%
	Scarborough	95.6%	94.5%	94.1%	91.2%	90.9%	93.2%	92.6%	94.2%	94.2%	92.6%	92.7%	91.9%
	Community Hospitals	90.5%	91.2%	83.6%	93.5%	92.3%	91.0%	88.1%	87.9%	93.1%	91.7%	94.4%	87.5%
	District Nurses	93.8%	96.5%	96.3%	95.4%	95.6%	95.4%	96.1%	95.4%	96.2%	95.1%	95.7%	94.5%

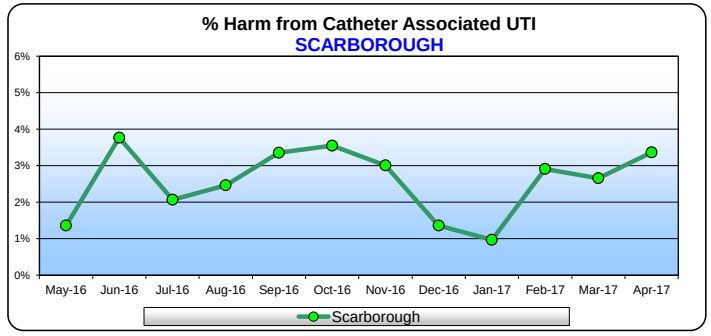


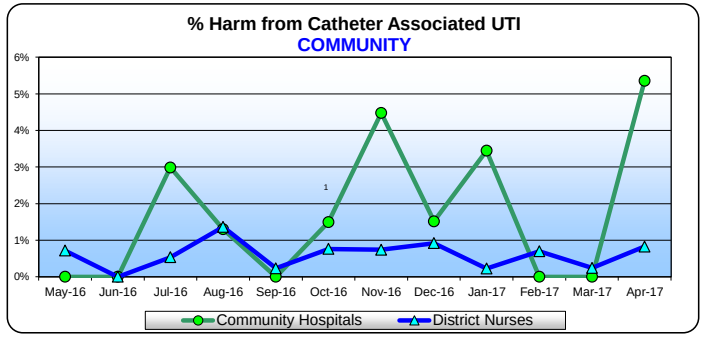




Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	0.7%	0.6%	1.1%	0.2%	1.3%	0.2%	1.1%	0.7%	1.0%	1.2%	0.3%	0.7%
	Scarborough	1.4%	3.8%	2.1%	2.5%	3.4%	3.5%	3.0%	1.4%	1.0%	2.9%	2.7%	3.4%
	Community Hospitals	0.0%	0.0%	3.0%	1.3%	0.0%	1.5%	4.5%	1.5%	3.4%	0.0%	0.0%	5.4%
	District Nurses	0.7%	0.0%	0.5%	1.4%	0.2%	0.8%	0.7%	0.9%	0.2%	0.7%	0.2%	0.8%



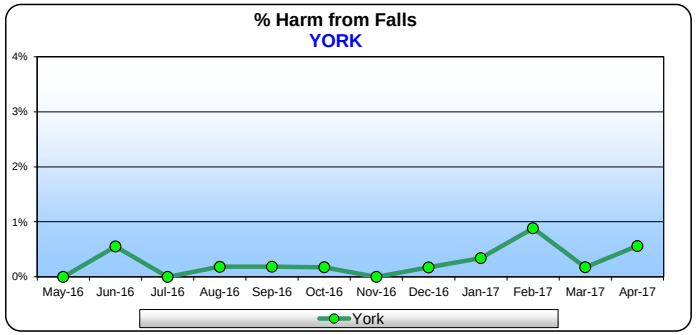


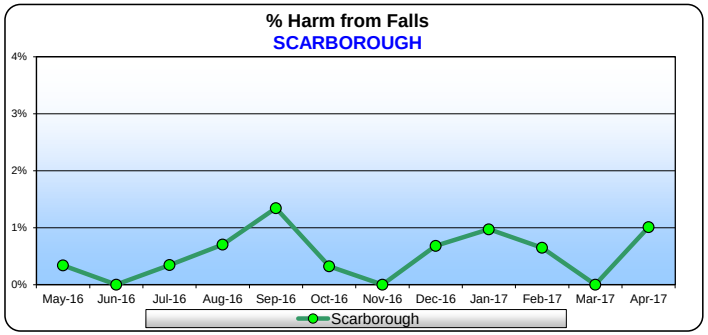


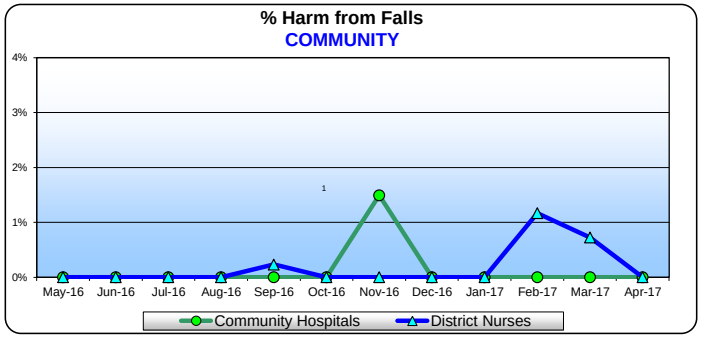
Safety Thermometer

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

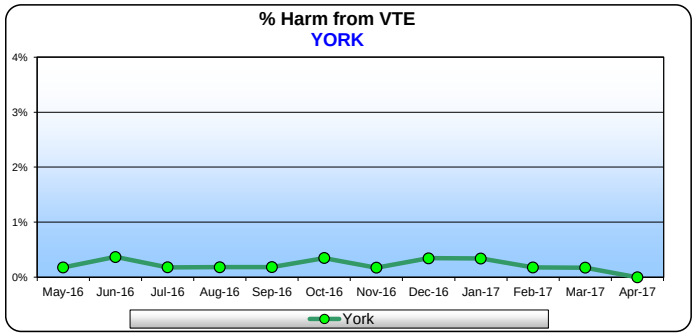
Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
% of Harm from Falls source: Safety Thermometer	York	0.0%	0.6%	0.0%	0.2%	0.2%	0.2%	0.0%	0.2%	0.3%	0.9%	0.2%	0.6%
	Scarborough	0.3%	0.0%	0.3%	0.7%	1.3%	0.3%	0.0%	0.7%	1.0%	0.6%	0.0%	1.0%
	Community Hospitals	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%
	District Nurses	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	1.2%	0.7%	0.0%

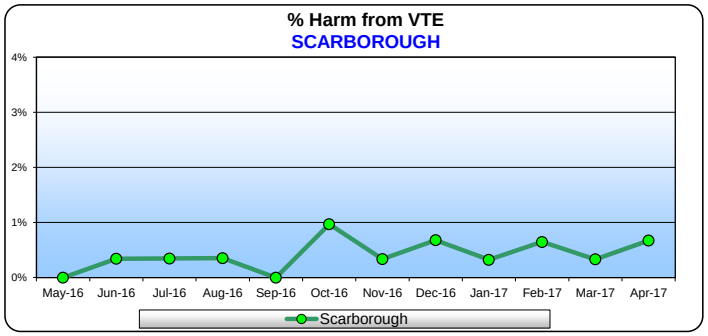


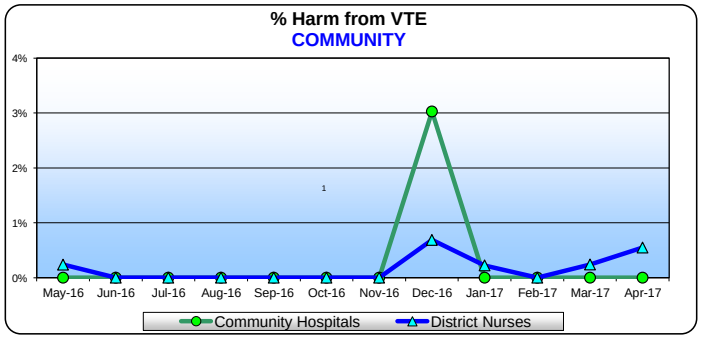




Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
% of VTE source: Safety Thermometer	York	0.2%	0.4%	0.2%	0.2%	0.2%	0.3%	0.2%	0.3%	0.3%	0.2%	0.2%	0.0%
	Scarborough	0.0%	0.3%	0.3%	0.4%	0.0%	1.0%	0.3%	0.7%	0.3%	0.6%	0.3%	0.7%
	Community Hospitals	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	0.0%
	District Nurses	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.2%	0.0%	0.2%	0.5%



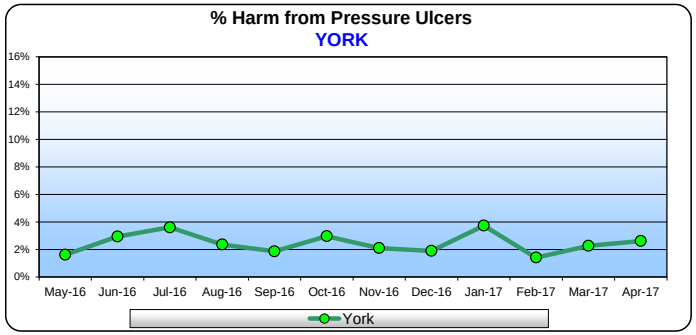


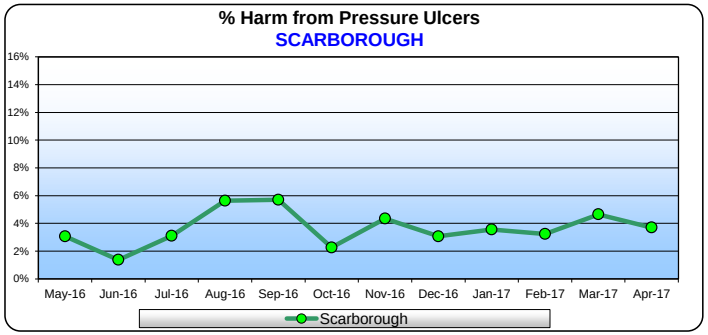


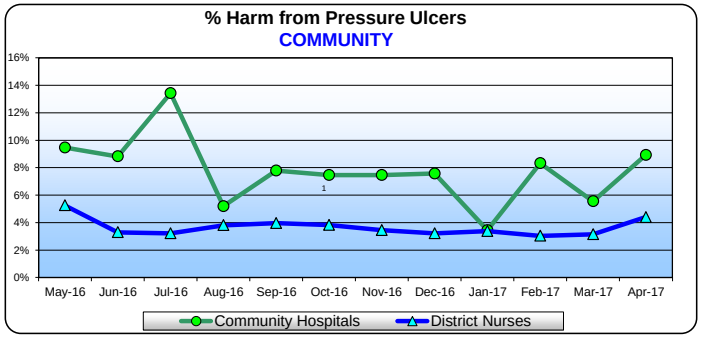
Safety Thermometer

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

Indicator		May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
% of Pressure Ulcers source: Safety Thermometer	York	1.6%	2.9%	3.6%	2.4%	1.9%	3.0%	2.1%	1.9%	3.7%	1.4%	2.3%	2.6%
	Scarborough	3.1%	1.4%	3.1%	5.6%	5.7%	2.3%	4.3%	3.1%	3.6%	3.2%	4.7%	3.7%
	Community Hospitals	9.5%	8.8%	13.4%	5.2%	7.8%	7.5%	7.5%	7.6%	3.4%	8.3%	5.6%	8.9%
	District Nurses	5.3%	3.3%	3.2%	3.8%	4.0%	3.8%	3.4%	3.2%	3.4%	3.0%	3.1%	4.4%







Mortality

Indicator	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16
SHMI – York locality	93	93	95	98	99	97	96	95	93	94	95	96
SHMI – Scarborough locality	104	105	107	108	109	107	108	107	107	108	107	106
SHMI – Trust	**97**	**98**	**99**	**102**	**103**	**101**	**101**	**99**	**99**	**99**	**100**	**99**

Definition

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

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

Analysis of Performance

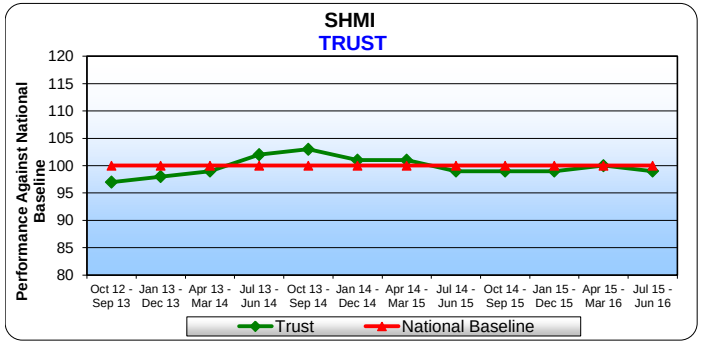
The latest SHMI report indicates the Trust to be in the 'as expected' range. The July 2015 - June 2016 SHMI saw a 1 point decrease for the Trust and Scarborough, and a 1 point increase for York. Trust - 99, York 96 and Scarborough 106.

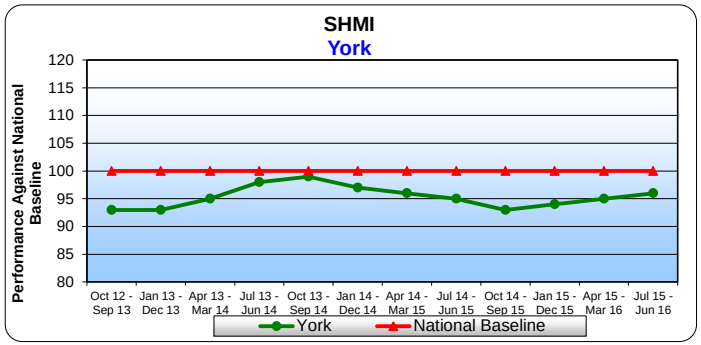
175 inpatient deaths were reported across the Trust in April; this is the highest number reported since April 2016 (189). 108 deaths were reported at York hospital, this compares favourably with April 2016 (2.7% decrease). The % of patients discharged as died vs all patient discharges remains comparable; 1.3% for both periods. 54 deaths were reported at Scarborough, again this compares favourably with April 2016 (16.9% decrease). Scarborough has seen the % of patients discharged as died vs all patient discharges drop from 2.0% in April 2016 to 1.6% in April 2017. The Trust saw a total of 11 deaths across the Community sites in April 2017.

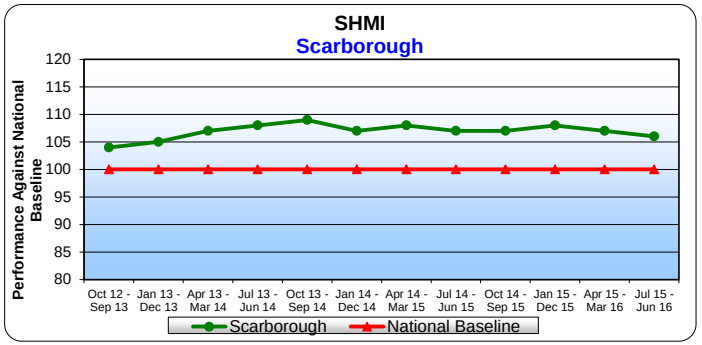
12 deaths in ED were reported in April; 4 at York and 8 at Scarborough. This compares favourably with April 2016 (17 deaths in total; 13 at York and 4 at Scarborough).

Mortality

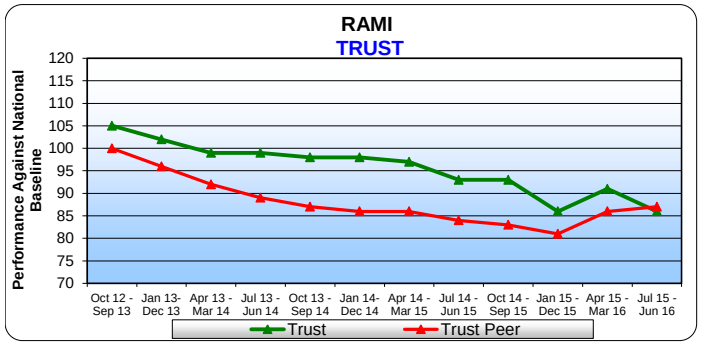
Indicator	Consequence of Breach (Monthly unless specified)	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	101	101	99	99	99	100	99
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	97	96	95	93	94	95	96
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	107	108	107	107	108	107	106

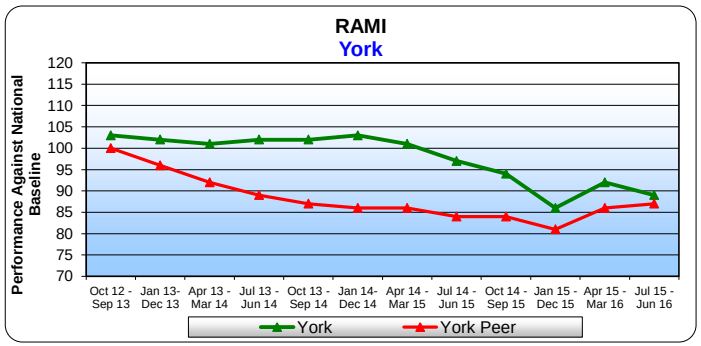


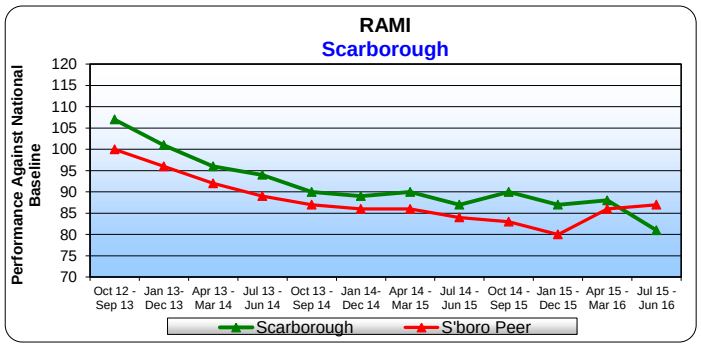




Indicator	Consequence of Breach (Monthly unless specified)	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16
Mortality – RAMI (TRUST)	**none - monitoring only**	98	97	93	93	86	91	86
Mortality – RAMI (YORK)	**none - monitoring only**	103	101	97	94	86	92	89
Mortality – RAMI (SCARBOROUGH)	**none - monitoring only**	89	90	87	90	87	88	81



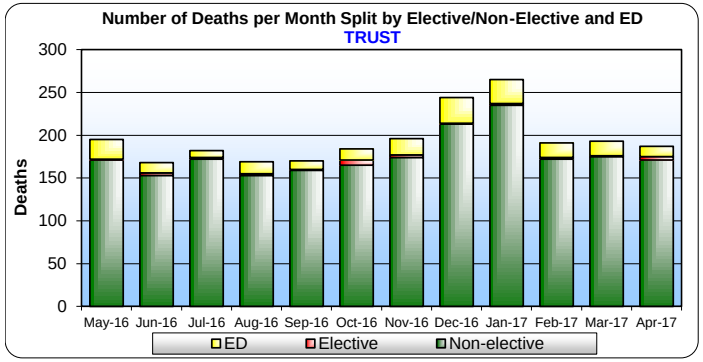


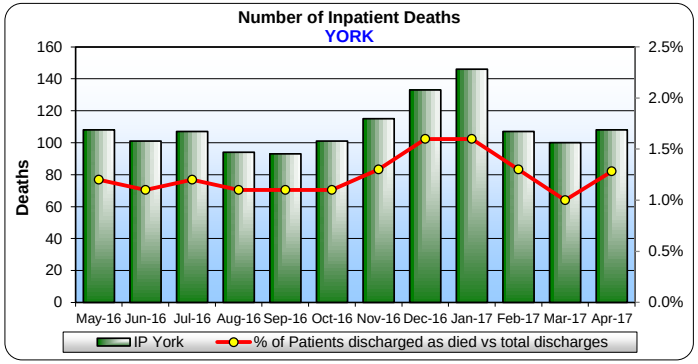


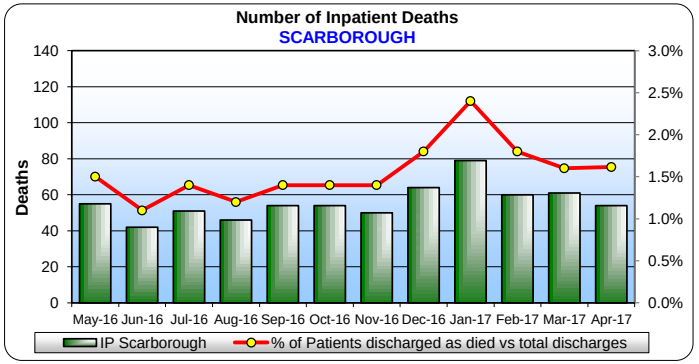
Mortality

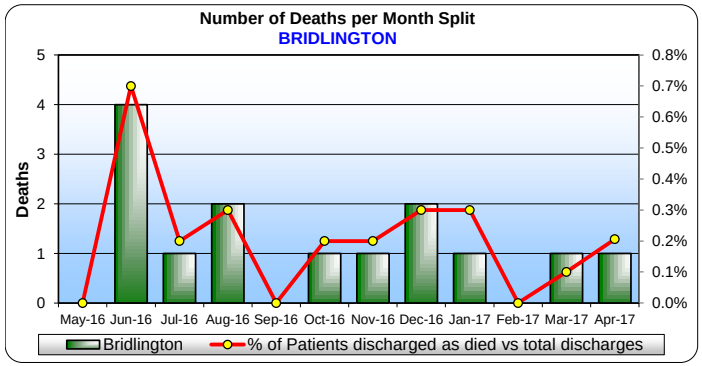
York Teaching Hospital NHS
NHS Foundation Trust

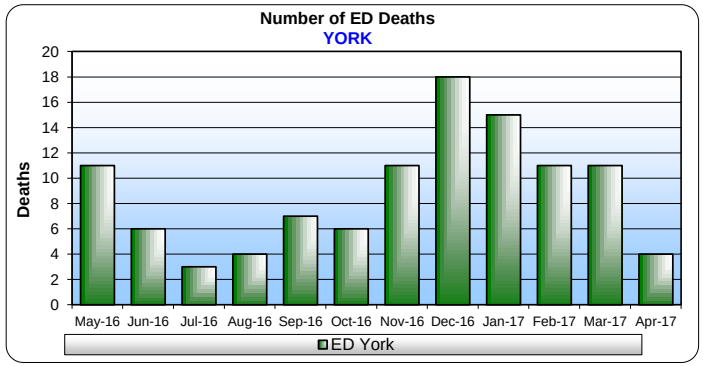
Indicator	Consequence of Breach (Monthly unless specified)	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Feb	Mar	Apr
Number of Inpatient Deaths	None - Monitoring Only	517	489	562	587	174	176	175
Number of ED Deaths	None - Monitoring Only	52	32	62	62	17	17	12

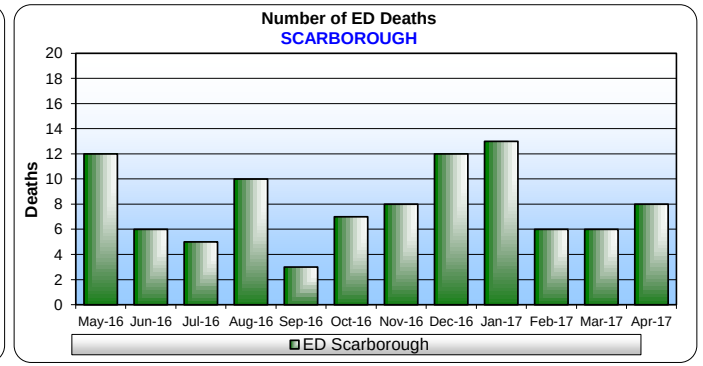


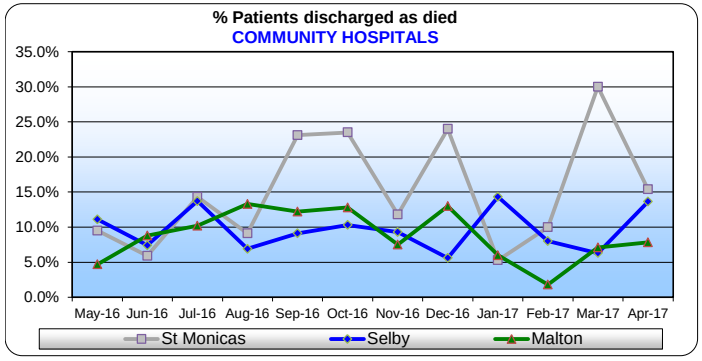


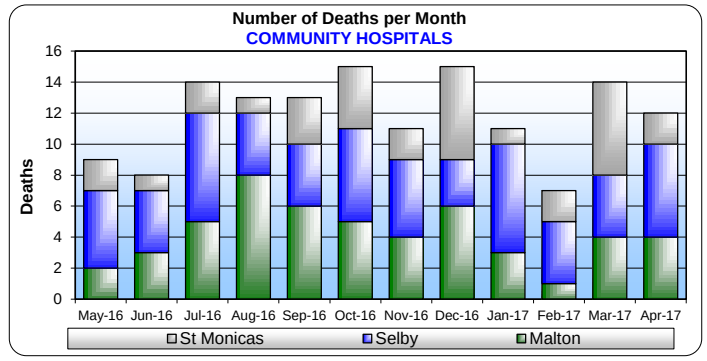












Month	Malton	Selby	St Monicas	Brid
May-16	2	5	2	0
Jun-16	3	4	1	4
Jul-16	5	7	2	1
Aug-16	8	4	1	2
Sep-16	6	4	3	0
Oct-16	5	6	4	1
Nov-16	4	5	2	1
Dec-16	6	3	6	2
Jan-17	3	7	1	1
Feb-17	1	4	2	0
Mar-17	4	4	6	1
Apr-17	4	6	2	1

Patient Safety Walkrounds – April 2017

York Teaching Hospital NHS
NHS Foundation Trust

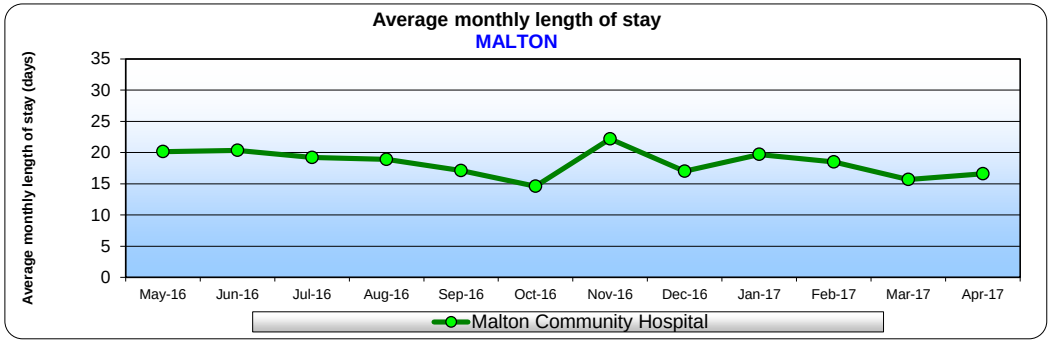
Date	Location	Participants	Actions & Recommendations
15/03/2017	Theatres & PACU	Brian Golding – Director Tariq Hoth – Clinical Director Gemma Ellison – Directorate Manager Pauline Guyan – Matron Sue Symington – Chair Michael Zar – Middle grade doctor (observer)	**Previous actions** Progress had been made with most of the issues that had been identified. Still outstanding, and of significant concern, was the lack of space across the department for storage, although the Vascular Imaging Project has received funding approval for storage facilities. Action – Management Team to liaise with Capital Planning Team to ensure design of vascular imaging project maximises gain for theatres and follow up PIRs submitted to capital planning team. **Near Misses/ Harm events** Of note was an adverse reaction to local anaesthetic. This has been investigated as a SI which has resulted in the appointment of a Local Anaesthetic Lead and the development of trust wide protocols. Of concern were a number of wrong site surgery events, which have been reported as Never Events and fully investigated. We were assured that the clinical governance sessions are used to discuss learning from incidents in a multidisciplinary setting. Four consultants have SPA time allocated to review Datix and share learning. **Environmental issues** There are communication problems between the theatre management team, estates and external design team for the current theatre 10 project. Action - BG to ask Andrew Bennett to review. There have been problems with commercial representatives entering theatres and removing equipment in an unplanned way. Action – Management Team to review processes.
06/04/2017	CCU & Cardio – Respiratory	Juliet Walters – Director David Humphriss – Clinical Director Sharon Lewis – Directorate Manager Carol Halton – Matron Michael Keaney – Non-Executive Director	Report to follow
11/04/2017	Selby War Memorial	Andy Bertram – Director Sharon Hurst – Locality Manager Helen Helps – Ward Manager Mike Sweet – Non-Executive Director Julie Rae – Community Team Leader	Patient Day Room potential for under-use. Action - Visit to Ward 37 for ideas of how to re-design with the help of charitable funds, staff, patient and public involvement and Friends of Selby Hospital.
21/04/2017	Ward 25 & 37	Juliet Walters – Director Karen Goodman – Clinical Director Jamie Todd – Directorate Manager Lee Fry – Matron Mandy Ward - Sister Libby Raper – Non – Executive Director	**Ward 25** All previous actions from the last patient Safety Walk Round have been completed. Increase in HCA staffing to support enhanced supervision and prevent patient falls means that the most likely cover sought will be provided by agency staff and will therefore incur significant premium costs. Action – For Jamie Todd and Lee Fry to explore the potential cost avoidance of uplifting the substantive HCA establishment to support the ward and avoid unnecessary premium spend. It was highlighted that the ward does not have a dedicated beverage service, although this has been successful on Ward 23. Action – Jamie Todd and Lee Fry to consider the best possible use of the volunteer workforce to facilitate this improvement. The signage of the sunroom could be. Action – for Lee Fry/Mandy Ward. The 'Traffic Light' Jug Lid system to improve hydration of patients on the ward was noted and is running successfully. Board Rounds and Safety Huddles and also daily senior review and use of ACPs to support the patient pathway are all working well. **Ward 37** All actions from the last patient Safety Walk Round had been completed. It was previously agreed to support the ward with an interim increase of additional HCA staff for the management of patients at risk of falling and to provide enhanced supervision. There has been a significant reduction in the number of patients falling but the staffing costs cannot be sustained. Action – For Jamie Todd and Lee Fry to explore the potential cost avoidance of uplifting the substantive HCA establishment to support the ward and avoid unnecessary premium spend. The ward does not have substantive dedicated junior doctor provision due to the removal of the psychiatric trainee by TEWV and the deanery. Action – For Jamie Todd and Lee Fry to develop ACP role in this specialty. A significant number of patients remain on the ward awaiting mental health packages of care to support. Action – Jamie Todd to continue to highlight on Sitrep. The work to progress the Dementia Café is fully underway. Future plans include the development of a dedicated delirium and dementia pathways to transfer swiftly from the Emergency Dept to Ward 37.
25/04/2017	St Monica's - Easing	Wendy Scott – Director Rachel Anderson – Locality Manager Ginny Vernon – Ward Manager Philip Ashton – Non-Executive Director	Under occupancy was raised at the last visit in April 2015 however the bed occupancy has since improved. Local GPs are admitting more patients and unit full with 12 patients at the time of this visit. Creation of a storage area from the previous chapel of rest needs to be complete to reduce clutter in the corridor. Action - Rachel Anderson to liaise with the Estates Team. Electronic board are installed but not functioning and staff are unable to access patient historical data. Action - Rachel Anderson to discuss and agree actions with the SNS Team. Infection Control Hand hygiene audit compliance remains good. IPC visited on 24 April and identified two outstanding issues. Action - both issues are currently being addressed by Ginny Vernon. Patients transferred from York Hospital do not always have a discharge notification summary. This means the receiving GP/Unit staff are not aware of current medication and relevant information. Action – Wendy Scott to raise with Sue Rushbrook.

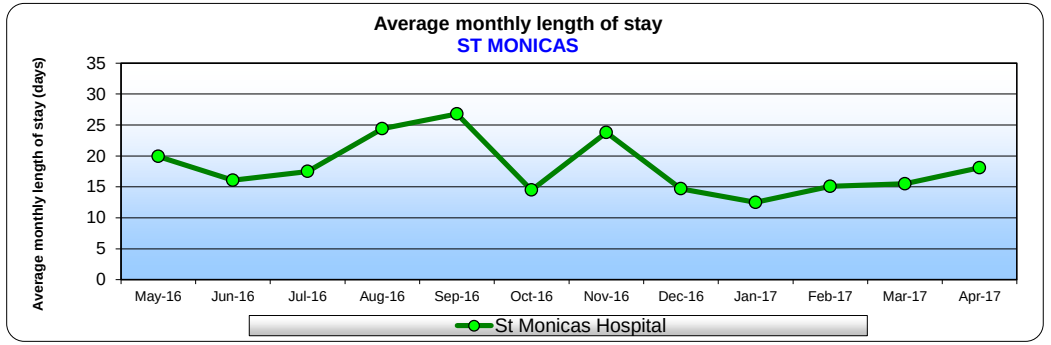
YORK - MATERNITY DASHBOARD			Measure	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Activity	Births	Bookings	1st m/w visit	≤302	303-329	≥330	276	319	294	294	280	297	252	186	323	299	302
		Bookings <13 weeks	No. of mothers	≥90%	76%-89%	≤75%	90.4%	84.6%	80.6%	83.7%	82.9%	83.5%	85.3%	84.9%	83.3%	85.3%	92.4%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	< 10%	10.1%-19.9%	>20%	3.6%	4.7%	4.1%	6.8%	6.8%	4.0%	4.4%	2.2%	5.0%	4.0%	3.6%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	≥90%	76%-89%	≤75%	80.00%	66.70%	50.00%	85.00%	78.90%	83.30%	72.70%	50.00%	93.80%	58.30%	81.50%
		Births	No. of babies	≤295	296-309	≥310	292	282	291	290	298	303	258	282	269	244	264
		No. of women delivered	No. of mothers	≤295	296-310	≥311	291	279	288	284	296	297	248	280	264	240	261
	Closures	Homebirth service suspended	No. of suspensions	0-3	4-6	7 or more	0	0	0	0	0	0	0	0	0	0	0
		Women affected by suspension	No. of women	0	1	2 or more	0	0	0	0	0	0	0	n/a	0	0	0
		Community midwife called in to unit	No. of times	3	4-5	6 or more	2	4	5	5	9	5	4	n/a	5	3	3
		Maternity Unit Closure	No. of closures	0		1 or more	0	0	0	0	0	1	0	0	0	0	0
		SCBU at capacity of intensive cots	No. of times	0	1	2 or more	6	4	5	0	0	0	0	0	9	15	7
		SCBU no of babies affected	No. of babies affected	0		1 or more	0	2	0	0	0	0	0	0	0	0	6
Workforce	Staffing	M/W per 1000 births	Ratio	≥35.0	35-31	≤31.0	28	31	28	28	28	28	28	29	29	29	28
		1 to 1 care in Labour	CPD	≥100%		<100%	74.6%	74.9%	73.6%	72.9%	67.9%	76.8%	75.0%	78.8%	78.8%	82.5%	78.9%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	≥100%		<100%	63.0%	60.0%	61.2%	55.0%	43.0%	56.0%	60.0%	61.0%	61.0%	78.0%	74.0%
		Consultant cover on L/W	av. hours/week	40		≤39	76	76	76	76	76	76	76	76	76	76	76
		Anaesthetic cover on L/W	av.sessions/week	10		≤9	10	10	10	10	10	10	10	10	10	10	10
		Supervisor : M/w ratio 1 :	Ratio	15	16-18	≥19	12	12	12	12	12	12	12	12	12	12	12
Clinical Indicators	Neonatal/Maternal	Normal Births	No. of svd - %	≥60.6%	60.5-55%	<55%	62.8%	65.0%	66.1%	66.0%	63.1%	62.6%	59.2%	66.5%	56.3%	61.8%	63.0%
		Assisted Vaginal Births	No. of instr. Births - %	≤13.2	13.3-17.9%	≥18%	9.6%	12.2%	12.8%	11.3%	12.5%	14.5%	14.9%	11.1%	17.4%	10.0%	11.1%
		C/S Births	Em & elect - %	≤26%	26.1-27.9%	>28%	27.1%	22.6%	21.2%	23.6%	24.7%	23.2%	27.0%	21.8%	26.5%	28.3%	25.3%
		Eclampsia	No. of women	0		1 or more	0	0	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	2 or less	3-4	5 or more	0	0	1	0	0	0	3	0	0	0	1
		HDU on L/W	No. of women	3 or less	4	5 or more	14	7	14	8	29	20	15	17	11	18	4
		BBA	No. of women	2 or less	3-4	5 or more	2	6	3	3	1	2	2	1	1	4	1
		Diagnosis of HIE	No. of babies	0	1	2 or more	0	0	1	0	0	1	0	0	1	0	0
	Morbidity	Neonatal Death	No of babies	0		1 or more	0	0	1	0	0	0	0	0	0	0	0
		Antepartum Stillbirth	No. of babies	0	1	2 or more	1	1	1	0	1	0	0	1	2	0	0
		Intrapartum Stillbirths	No. of babies	0		1 or more	0	0	0	0	0	0	0	0	0	0	0
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	>74.4%	74.3-70.1%	<70%	76.6%	74.2%	76.7%	74.3%	75.7%	78.1%	69.0%	78.2%	74.2%	72.5%	73.6%
		Smoking at time of delivery	% of women smoking at del.	<11%	12-14%	>15%	12.7%	10.4%	8.7%	10.2%	10.5%	8.4%	10.1%	10.0%	11.0%	12.1%	12.3%
		SI's	No. of Si's declared	0		1 or more	1	0	1	0	1	0	1	0	0	0	0
		PPH > 1.5L	No. of women	2 or less	3-4	5 or more	9	4	9	3	9	10	4	6	4	12	2
		PPH > 1.5L as % of all women	% of births				2.9%	1.4%	3.1%	1.1%	3.0%	3.4%	1.6%	2.1%	1.5%	5.0%	0.8%
		Shoulder Dystocia	No. of women	2 or less	3-4	5 or more	2	3	3	1	1	1	1	3	0	0	3
		3rd/4th Degree Tear	% of tears (vaginal births)	≤2.5%	2.6- 3.9%	≥4%	1.5%	1.8%	3.0%	2.2%	1.3%	3.0%	2.6%	3.6%	2.0%	2.8%	5.1%
	New Complaints	Informal	No. of Informal complaints	0	1-4	5 or more	0	1	3	2	0	1	0	0	0	0	1
		Formal	No. of Formal complaints	0	1-4	5 or more	0	2	3	3	1	0	1	0	2	0	0

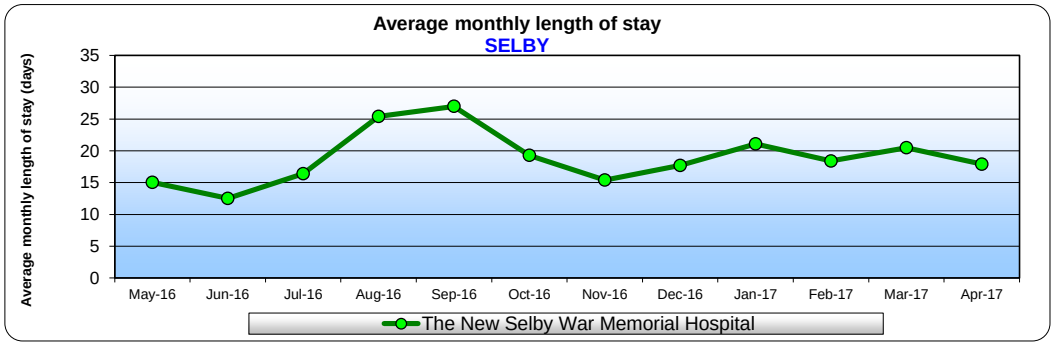
SCARBOROUGH - MATERNITY DASHBOARD			Measure	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Activity	Births	Bookings	1st m/w visit	≤210	211-259	≥260	198	212	193	217	194	160	195	108	216	191	178
		Bookings <13 weeks	No. of mothers	≥90%	76%-89%	≤75%	86.9%	83.5%	88.6%	92.6%	84.0%	88.8%	90.8%	92.6%	93.1%	89.5%	91.0%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	< 10%	10%-20%	>20%	11.1%	10.8%	8.3%	4.6%	11.3%	6.3%	6.7%	7.4%	5.1%	6.3%	4.5%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	≥90%	76%-89%	≤75%	100%	83%	63%	90%	100%	90%	54%	75%	73%	83%	88%
		Births	No. of babies	≤170	171-189	≥190	148	134	135	141	154	135	112	140	124	138	128
		No. of women delivered	No. of mothers	≤170	171-189	≥190	148	134	135	140	152	133	111	139	122	137	127
	Closures	Homebirth service suspended	No. of suspensions	0-3	4-6	7 or more	1	0	0	1	0	0	0	0	0	0	0
		Women affected by suspension	No. of women	0	1	2 or more	0	0	0	0	0	0	0	0	0	0	0
		Community midwife called in to unit	No. of times	3	4-5	6 or more	0	0	0	1	0	0	0	0	0	0	0
		Maternity Unit Closure	No. of closures	0		1 or more	0	0	0	0	0	0	0	0	0	0	0
		SCBU at capacity	No. of times	0	1	2 or more	5	8	3	11	7	8	1	0	0	0	n/a
		SCBU no of babies affected	No. of babies affected	0		1 or more	0	2	1	6		0	2	0	0	0	n/a
Workforce	Staffing	M/W per 1000 births	Ratio	≥35.0	35-31	≤31.0	38.3	38.1	38.0	38.8	38.5	40.2	41.0	41.0	41.0	40.8	40.2
		1 to 1 care in Labour	CPD	≥100%		<100%	84.0%	85.1%	85.9%	87.1%	92.8%	92.5%	84.7%	89.9%	88.5%	89.8%	89.8%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	≥100%		<100%	80.0%	85.0%	80.6%	91.0%	70.0%	89.0%	85.0%	66.0%	80.6%	78.6%	85.5%
		Consultant cover on L/W	av. hours/week	40		≤39	40	40	40	40	40	40	40	40	40	40	40
		Anaesthetic cover on L/W	av.sessions/week	10		≤9	3	3	3	3	3	3	3	3	3	3	3
		Supervisor : M/w ratio 1 :	Ratio	15	16-18	≥19	12	12	12	12	12	12	12	12	12	12	12
Clinical Indicators	Neonatal/Maternal	Normal Births	No. of svd - %	≥60.6%	60.5-55%	<55%	74.3%	63.2%	67.4%	70.9%	72.4%	67.2%	61.9%	66.4%	70.2%	72.5%	69.9%
		Assisted Vaginal Births	No. of instr. Births - %	≤13.2	13.3-17.9%	≥18%	9.5%	7.5%	8.1%	7.1%	5.3%	7.5%	14.4%	10.8%	13.9%	6.6%	5.5%
		C/S Births	Em & elect - %	≤26%	26.1-27.9%	>28%	16.2%	29.9%	24.4%	22.1%	22.4%	25.6%	24.3%	23.0%	16.4%	21.2%	26.8%
		Eclampsia	No. of women	0		1 or more	0	0	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	2 or less	3-4	5 or more	0	0	0	2	1	0	0	0	0	1	1
		HDU on L/W	No. of women	3 or less	4	5 or more	4	2	8	4	5	2	1	1	3	4	4
		BBA	No. of women	2 or less	3-4	5 or more	1	1	3	3	1	2	4	1	2	2	2
		Diagnosis of HIE	No. of babies	0	1	2 or more	0	0	0	0	0	0	0	0	1	0	
	Morbidity	Neonatal Death	No of babies	0		1 or more	0	0	1	0	0	0	1	0	0	0	
		Antepartum Stillbirth	No. of babies	0	1	2 or more	2	0	0	1	0	0	0	1	0	0	0
		Intrapartum Stillbirths	No. of babies	0		1 or more	0	0	0	0	0	0	0	0	0	0	0
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	>74.4%	74.3-70.1%	<70%	60.8%	61.9%	60.7%	57.9%	55.3%	63.2%	64.0%	58.3%	58.2%	58.4%	51.2%
		Smoking at time of delivery	% of women smoking at del.	<11%	12-14%	>15%	20.3%	21.6%	20.0%	17.9%	24.8%	18.2%	23.4%	17.3%	18.9%	18.2%	23.6%
		SI's	No. of Si's declared	0		1 or more	0	0	1	0	0	1	1	0	0	0	0
		PPH > 1.5L	No. of women	2 or less	3-4	5 or more	3	1	6	1	5	2	0	0	3	2	5
		PPH > 1.5L as % of all women	% of births				2	0	4	1	3	2	0	0	3	2	4
		Shoulder Dystocia	No. of women	2 or less	3-4	5 or more	1	0	2	0	0	2	1	2	2	1	2
		3rd/4th Degree Tear	% of tears (vaginal births)	≤2.5%	2.6- 3.9%	≥4%	1.6%	0.0%	2.0%	2.7%	3.3%	1.0%	1.2%	0.0%	2.9%	2.8%	1.1%
	New Complaints	Informal	No. of Informal complaints	0	1-4	5 or more	0	0	0	1	2	1	1	0	3	0	0
		Formal	No. of Formal complaints	0	1-4	5 or more	1	0	2	1	0	0	0	1	1	1	1

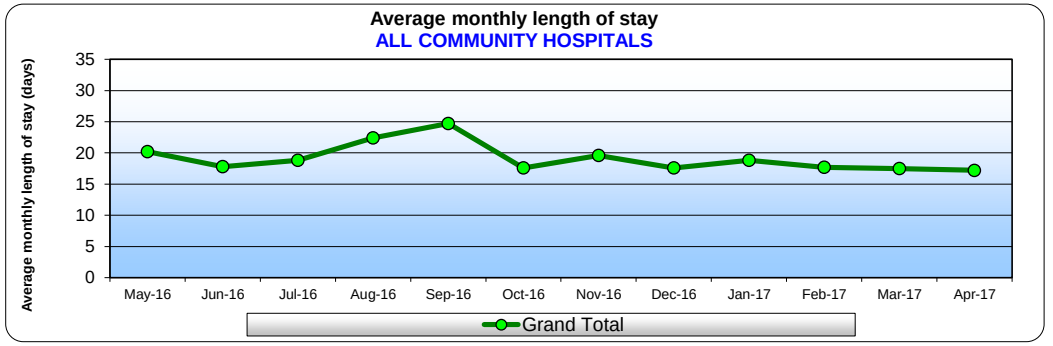
Community Hospitals

Indicator	Hospital	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Feb	Mar	Apr
Community Hospitals average length of stay (days) Excluding Daycases	**Malton Community Hospital**	18.8	18.5	18.6	17.9	18.5	15.7	16.6
	St Monicas Hospital	16.4	22.7	17.2	14.4	15.1	15.5	18.1
	The New Selby War Memorial Hospital	14.1	23.0	17.7	20.2	18.4	20.5	17.9
	Total	17.9	21.9	18.3	18.0	17.7	17.5	17.2



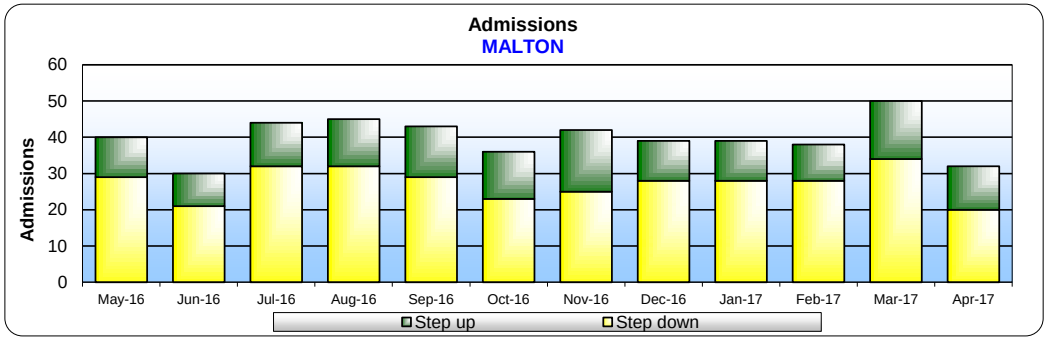


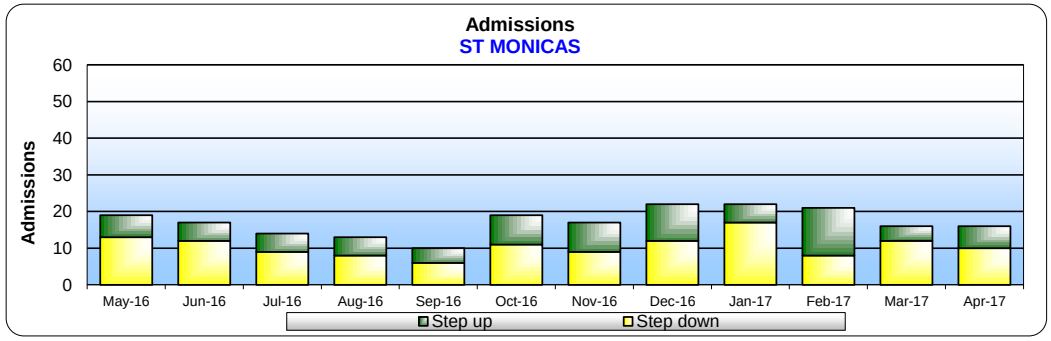


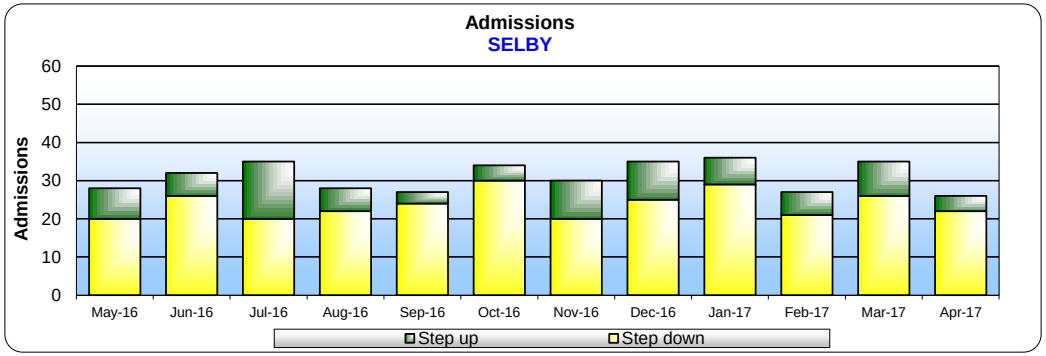


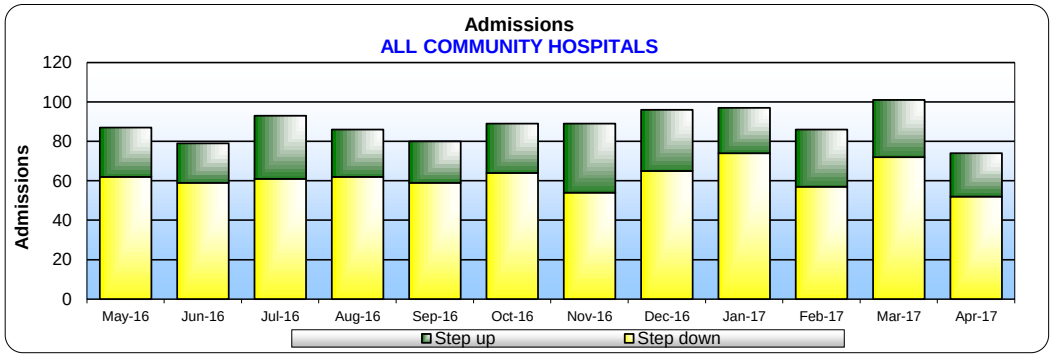
Community Hospitals

Indicator	Hospital		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Feb	Mar	Apr
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.	**Malton Community Hospital**	**Step up**	34	39	41	37	10	16	12
		Step down	84	93	76	90	28	34	20
	St Monicas Hospital	**Step up**	17	14	26	22	13	4	6
		Step down	37	23	32	37	8	12	10
	The New Selby War Memorial	**Step up**	22	24	24	22	6	9	4
		Step down	75	66	75	76	21	26	22
	Total	**Step up**	83	81	100	81	29	29	22
		Step down	267	246	234	203	57	72	52









Quality and Safety: Misc

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Feb	Mar	Apr
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**	13	2	2	18	5	3	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
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	0	5	0	0	0
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	100%	100%	100%	100%	100%	100%	100%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.9%	99.9%	99.6%	To follow	99.8%	To follow	To follow
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	98.8%	98.8%	98.2%	To follow	98.3%	To follow	To follow
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	5.0%	5.8%	3.3%	3.9%	4.9%	4.2%	n/a
Delayed Transfer of Care – All patients medically fit for discharge and issued a 'notification notice' as per joint protocol for the transfer of care	As set out in Service Condition 3 and General Condition 9	**Set baseline in Q1 and agree trajectory**	Monthly Provider Report						
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	100.0%	94.9%	100.0%	100.0%	100.0%	100.0%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	As set out in Service Condition 3 and General Condition 9	**Best Practice Standards**	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced and tabled at sub CMB quarterly.						
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	99.8%	99.8%	99.8%	100.0%	100.0%	100.0%	100.0%
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
All Red Drugs to be prescribed by provider effective from 01/04/15, subject to agreement on list	Recovery of costs for any breach to be agreed via medicines management committee	**0**	CCG to audit for breaches						
All Amber Drugs to be prescribed as per shared care guidelines from 01/04/15	Recovery of costs for any breach to be agreed via medicines management committee	**0**	CCG to audit for breaches						

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Complaints and PALS												
New complaints this month	30	30	30	50	44	36	37	33	43	32	38	34
Top 3 complaint subjects												
All aspects of Clinical Treatment	26	18	17	26	71	40	36	18	32	16	39	26
Communications/information to patients (written and oral)	6	12	10	26	72	19	17	12	16	2	16	6
Patient Care	11	7	14	18	26	13	36	10	35	17	23	15
Top 3 directorates receiving complaints												
Acute & General Medicine	8	5	6	7	6	3	5	4	8	4	7	8
Emergency Medicine	3	3	6	7	6	10	5	7	8	1	6	5
General Surgery & Urology	3	1	5	6	3	3	7	4	6	5	4	1
Number of Ombudsman complaint reviews (new)	3	4	2	2	0	0	2	0	0	1	1	0
Number of Ombudsman complaint reviews upheld	1	0	0	0	0	0	0	0	0	0	0	0
Number of Ombudsman complaint reviews partly upheld	1	3	0	1	2	0	0	1	1	0	0	1
New PALS queries this month	407	387	310	333	284	279	286	210	278	260	336	273
Top 3 PALS subjects												
Communication issues	25	23	60	60	51	51	76	52	50	56	62	62
Any aspect of clinical care/treatment	55	47	24	34	28	23	20	22	24	28	30	26
Appointments	37	50	31	61	60	50	44	43	40	29	46	57
Serious Incidents												
Number of SI's reported	12	31	15	17	12	9	18	14	28	18	10	9
% SI's notified within 2 working days of SI being identified	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
* this is currently under discussion via the 'exceptions log'												
Compliance with Duty of Candour for Serious Incidents*:												
-Verbal Apology Given												
-Written Apology Given *												
-Invitation to be involved in Investigation	1	2	2	3	3	1	8	3	2	1	4	0
-Given Final Report (If Requested)	2	0	3	2	1	2	0	1	2	1	2	0
Pressure Ulcers**												
Number of Category 2	44	32	31	36	62	76	81	74	91	66	93	92
Number of Category 3	6	6	2	3	1	4	5	2	4	5	3	7
Number of Category 4	0	1	1	1	0	1	1	1	0	0	0	2
Total number developed/deteriorated while in our care (care of the organisation) - acute	53	37	28	39	57	85	99	85	101	76	100	104
Total number developed/deteriorated while in our care (care of the organisation) - community	20	25	28	26	35	36	26	30	41	37	40	32
Falls***												
Number of falls with moderate harm	3	3	3	2	2	0	0	2	4	0	3	5
Number of falls with severe harm	4	9	3	8	4	3	2	2	4	3	1	2
Number of falls resulting in death	0	0	0	0	0	1	0	1	0	0	0	0

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Safeguarding												
% of staff compliant with training (children)	86%	85%	86%	86%	86%	86%	86%	87%	87%	85%	85%	85%
% of staff compliant with training (adult)	85%	85%	85%	86%	86%	85%	86%	88%	87%	85%	86%	86%
% of staff working with children who have review CRB checks												
Prevent Strategy												
Attendance at the HealthWRAP training session												
Number of concerns raised via the incident reporting system												
Claims												
Number of Negligence Claims	16	17	12	10	10	13	14	11	10	8	9	14
Number of Claims settled per Month	6	2	5	9	5	1	8	2	7	3	5	1
Amount paid out per month ****	£66,500	£125,000	£342,500	£989,450	£262,750	£35,000	£780,500	£250,000	£128,226	£75,000	£3,338,000	£1,200,000
Reasons for the payment	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability

* The Trust is currently developing its processes for recording Duty of Candour and reporting has been temporarily suspended until this has been implemented.

Note ** and *** - falls and pressure ulcers subject to validation. Falls resulting in deaths are investigated as Serious Incidents and the degree of harm will be confirmed upon completion of investigation.

All falls and pressure ulcer data is refreshed monthly to reflect ongoing monitoring and reporting of falls and pressure ulcers. A change on the way the Trust reports pressure ulcers was implemented on 01/09/16 resulting in a slight increase in the pressure ulcers reported as developing under our care. Category 3 pressure ulcer data excludes Category 3 ulcers which are recorded as having developed within 72 hours of admission to inpatient care.

**** One claim settled in March was settled for a £3,000,000 lump sum plus £59,000 per annum for life. Only the lump sum is reflected in the amount paid out.

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Medical Director's Report

Action requested/recommendation

The Board is asked to:

- Consider the summary reports and learning from a recent serious incident
- Note the PROMs participation rates
- Note the Medical Revalidation Action Plan
- Consider anti-microbial prescribing audit results.

Executive Summary

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

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

Implications for equality and diversity

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

Reference to CQC regulations

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

http://www.cqc.org.uk/content/regulations-service-providers-and-managers)

Progress of report	This report will be discussed at Executive Board.
Risk	No risk
Resource implications	No resources implications are detailed in this report
Owner	Mr James Taylor, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	May 2017
Version number	Version 1

Board of Directors – 31 May 2017

Medical Director's Report

1. Introduction and Background

In the report this month:

Patient Safety-
- summary report and learning from a recent serious incident

Clinical Effectiveness-
- PROMs participation rates
- Medical Revalidation Action Plan

Patient Experience-
- antimicrobial prescribing audit results.

2. Clinical Effectiveness

2.1 Patient Reported Outcome Measures (PROMs)

Participation rates for March 2017 were as follows:

Participation Rate Hernia	Participation Rate Hip	Participation Rate Knee	Participation Rate Vein
52%	74%	83%	32%

Numerator used for this reported period:
Absolute numbers of scanned questionnaires by procedure.

Total Scanned HERNIA	31
Total Scanned HIP	36
Total Scanned KNEE	38
Total Scanned VEIN	15

Denominator used for this reported period
Monthly average of eligible PROMs operations performed by your Trust/Provider (taken from the 12 month period (**April 2015-March 2016, published February 2017)**

HES Hernia	HES Hip	HES Knee	HES Vein
59	48	46	47

2.2 Medical Revalidation Action Plan

The Medical Revalidation Action Plan is attached as Appendix A.

3. Patient Experience

3.1 Antibiotic prescription audit results

SUMMARY OF ANTIBIOTIC PRESCRIPTION AUDIT RESULTS
January – April 2017

indication on antibiotic prescription	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
York Hospital	90%	91%	92%	90%								
Scarborough Hospital	76%	84%	86%	89%								
Trust average	84%	88%	89%	90%								

duration / course length on antibiotic prescription	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
York Hospital	89%	87%	89%	84%								
Scarborough Hospital	85%	86%	90%	85%								
Trust average	87%	86%	90%	84%								

% of in-patients prescribed antibiotics	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
York Hospital	28%	28%	25%	26%								
Scarborough Hospital	36%	33%	31%	29%								

Proportion of iv & oral antibiotics (Trust wide results)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
iv antibiotics	47.7%	49.3%	45.8%	45.8%								
oral antibiotics	52.3%	50.7%	54.2%	54.2%								

Evidence of clinical review within 72 hours of prescribing	Jan; Feb; Mar. target 90%		
CQUIN data determined from a random sample of 50 prescriptions Trust wide. Evidence looked for in medical notes / recorded on antibiotic prescription	88% 44/50	94% 47/50	98% 49/50

ELDERLY MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of antibiotic prescriptions audited	108	84	67	49								
Antibiotic prescriptions with INDICATION	87%	95%	93%	90%								
Antibiotic prescriptions with DURATION / REVIEW	93%	99%	96%	90%								

MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of antibiotic prescriptions audited	120	106	110	110								
Antibiotic prescriptions with INDICATION	83%	86%	89%	89%								
Antibiotic prescriptions with DURATION / REVIEW	87%	82%	93%	80%								

SPECIALIST MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of antibiotic prescriptions audited	10	13	7	10								

Antibiotic prescriptions with INDICATION	90%	100%	100%	90%								
Antibiotic prescriptions with DURATION / REVIEW	90%	92%	100%	90%								

ORTHOPAEDICS & TRAUMA DIRECTORATE	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Number of antibiotic prescriptions audited	12	21	19	16								
Antibiotic prescriptions with INDICATION	83%	67%	79%	100%								
Antibiotic prescriptions with DURATION / REVIEW	75%	71%	74%	88%								

GENERAL SURGERY & UROLOGY	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Number of antibiotic prescriptions audited	64	52	54	68								
Antibiotic prescriptions with INDICATION	86%	92%	89%	90%								
Antibiotic prescriptions with DURATION / REVIEW	88%	87%	89%	88%								

Obs & Gynae DIRECTORATE	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Number of antibiotic prescriptions audited	7	5	1	2								
Antibiotic prescriptions with INDICATION	0%	100%	100%	100%								
Antibiotic prescriptions with DURATION / REVIEW	0%	80%	100%	100%								

HEAD & NECK DIRECTORATE	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Number of antibiotic prescriptions audited	5	9	6	4								
Antibiotic prescriptions with INDICATION	100%	56%	100%	75%								
Antibiotic prescriptions with DURATION / REVIEW	60%	44%	33%	50%								

4. Recommendations

The Board is asked to:

- Consider the summary report and learning from a recent serious incident
- Note the PROMs participation rates
- Note the Medical Revalidation Action Plan
- Consider anti-microbial prescribing audit results.

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Mr James Taylor, Medical Director**
Date	**May 2017**

Medical Revalidation
right for patients, right for doctors

NHS England

Action plan template

Please complete the below action plan and return to:
England.revalidation-north@nhs.net
By: 6th January 2016

Name of designated body	York Teaching Hospital (YTH)	
Name of responsible officer	Dr James Taylor	
Action	**Timescale**	**Update 20/03/2017**
YTH to consider bringing appraisals forward so that no appraisals are planned for March.	April 2017	Appraisals due March 2018 now being brought forward
YTH to tightly manage the undertaking of appraisals; and place some focus on the appraisers to advocate this.	31st March 2017	New processes in place, including formal letters. We are seeing an improvement in engagement using this approach
YTH to consider some form of allocation process going forwards. Two options were explored; • From April 2017 following discussion to move to an allocation system for all, supported by discussions re the rationale in advance • From April 2017 to allocate all doctors who were not a measure 1a for 2015/16 to support their timely and most constructive undertaking of their medical appraisal.	April 2017	In discussion

Medical Revalidation
right for patients, right for doctors

NHS England

YTH to look to QA appraisals on a more regular basis, carry out the level of QA that level they feel is appropriate, recommend 2 per appraiser each year. The 1:1's are then supported by this and the appraisee feedback.		31st March 2017	Alternate Input Forms and corresponding Output Forms being QA'd
YTH to explore protected time for the appraisers to meet together across the 2 sites. Could look to create some senior appraisers as discussions are taking place regarding having a senior doctor in the team. YTH to look to have appraisers for SAS doctors.		April 2017	Annual updates will in future include a peer/calibration opportunity
PW to share guidance on requirements of revalidation with the regional team.		23rd December 2016	Done
YTH to consider including 3 year trend data e.g. appraisal rates, missed appraisals and number of deferments within their board report.		April 2017	To be included in 2017 report
YTH to consider linking in with other organisations about PReP.		April 2017	YTH hosting user forum May 2017
Regional team to share the list of IT platform users (item 3). If PW requires contact details then please contact the regional team.		Complete	
YTH to share the SLA they have in place with the hospices and the Retreat.		Complete	
The regional team to share the good practice characteristics for an external RO described at the focused network for hospices in 2015 and the summary notes from the recent follow up meeting.		Complete	
Regional team to share links to useful documents.		Complete	
Follow up meeting / Telecon			
As responsible officer I confirm that the information above has been discussed and agreed	*Signature & Date* James Taylor 20.3.2017		

with my Board or equivalent		
Date of Board sign-off	26 April 2017	

E3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 31 May 2017

Chief Nurse Report – April 2017

Action requested/recommendation

The Board is asked to note the Chief Nurse Report for May 2017.

Executive Summary

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

The nursing and midwifery strategy has four main focus areas:

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

The new strategy is currently being written following wide consultation with Nurses & Midwives of all grades. The strategy 'Caring with Pride' will be launched at this year's Nursing and Midwifery conference on 3rd October at York Racecourse.

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

The CQC fundamental standards are integral to all aspects of the report.

Risk

Resource implications	No resource implications unless explicitly identified.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	May 2017
Version number	Version 1

Board of Directors - 31 May 2017

Chief Nurse Report – Quality of Care

1. Background

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

The nursing and midwifery strategy has four main focus areas:

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

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2. Patient Safety

2.1 Nursing and Midwifery Staffing

The adult inpatient vacancy position across the Trust at the end of April 2017 is as follows:

	Vacancies		Pending Starters		Unfilled Vacancies	
	RN	**Care Staff**	**RN**	**Care Staff**	**RN**	**Care Staff**
Bridlington	0.6	7.03	2	3	-1.4	4.03
Community	6.42	3.75	1.68	2.2	4.74	-0.99
Scarborough	58.46	7.16	14	12.2	44.46	-5.04
York	86.57	34.05	75.8	37.73	10.77	-3.73
Total	**152.05 fte**	**51.99fte**	**93.48fte**	**55.13fte**	**58.57fte**	**-3.14fte**

Work is in continuing to recruit both experienced and newly qualified nurses into the Trust across all sites. The Chief Nurse Team will be attending Nursing Times Careers Live on 25th May 2017 to continue its nurse recruitment campaign.

Over-recruitment of care staff has taken place in some areas, providing additional support to where the is difficulty recruiting to RN vacancies, as well as appointments being made where staff are currently working their notice periods.

It is anticipated that future reports will present vacancy information by exception, and with RAG ratings attributed to those areas of greatest risk. Risks and mitigations will be reported by exception by the ADN's on a monthly basis in the nursing dashboard.

The Chief Nurse Team continues to work with the Workforce Transformation Team to look at new

models of working and the introduction of new roles.

2.2 Trainee Nursing Associates

In April, the first cohort of 16 Trainee Nursing Associates commenced in post as part of a national pilot. The trainees will spend two years in clinical placements, attending university each week whilst they achieve the clinical and theoretical requirements of the programme. The trainees have been placed in clinical areas throughout the Trust and will rotate through three clinical placements each year, in order to provide them with a breadth of experience across a variety of specialties.

Feedback from the induction programme was very positive from both the trainees and trainees and presenter. The group were delighted to be able to have a live chat with Lisa Bayliss Pratt, Director of Nursing and Deputy Director of Education and Quality at Health Education England to discuss the new role and the opportunities and challenges this presents for the future workforce.

Work is on-going nationally to adapt and develop the programme in this early pilot phase. A work-stream on regulating the role will be hosted by the NMC, representatives from the Chief Nurse team will be involved to influence this important aspect of the work.

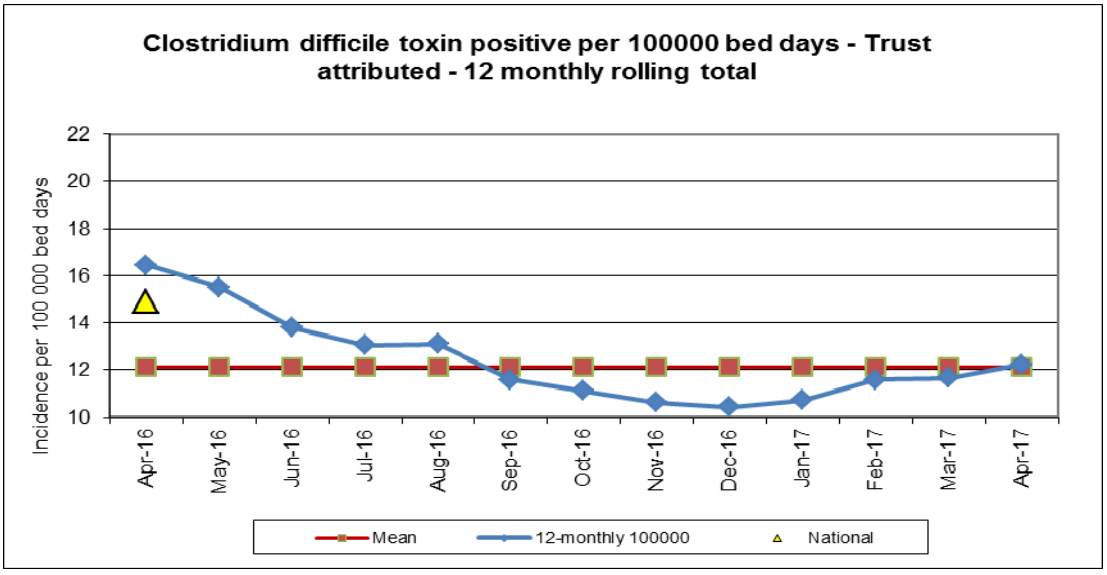
2.3 Infection Prevention and Control Update

Current incidence:

MRSA bacteraemia= 0 (but still pending 1 case – awaiting confirmation of the sample sent to London for further testing)
MSSA bacteraemia = 4 (2 York, 2 Scarborough)
E Coli bacteraemia = 9 (7 York, 1 Scarborough, 1 Community sites)
CDI = 3 (all Scarborough site)

Clostridium difficile

Post Infection Review for the 2 cases of *Clostridium difficile* for Q1 have highlighted prescribing anomalies that have been investigated and escalated.



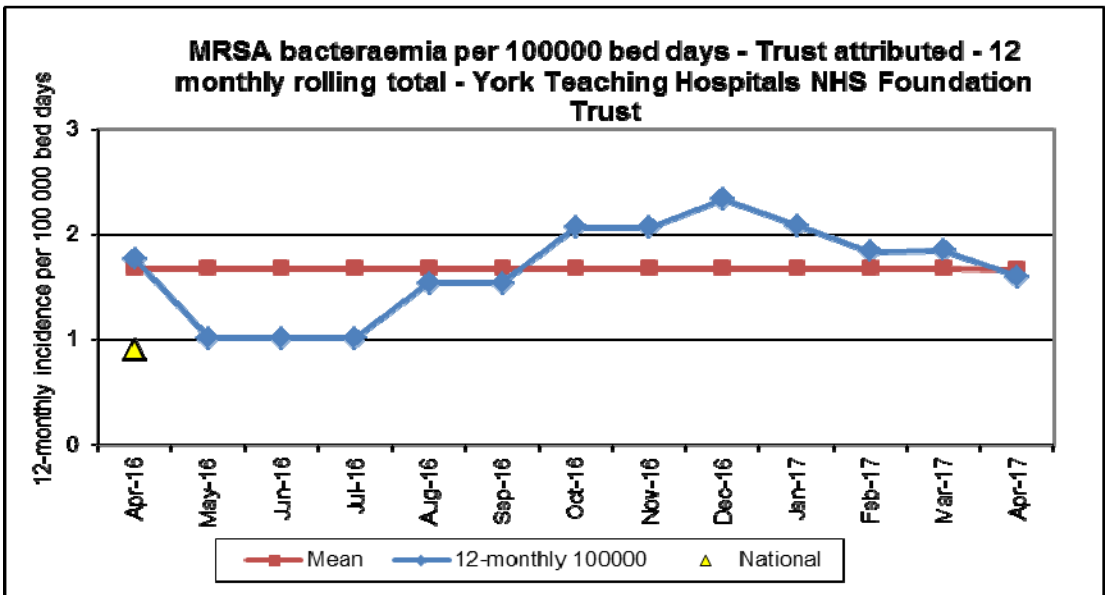
MRSA

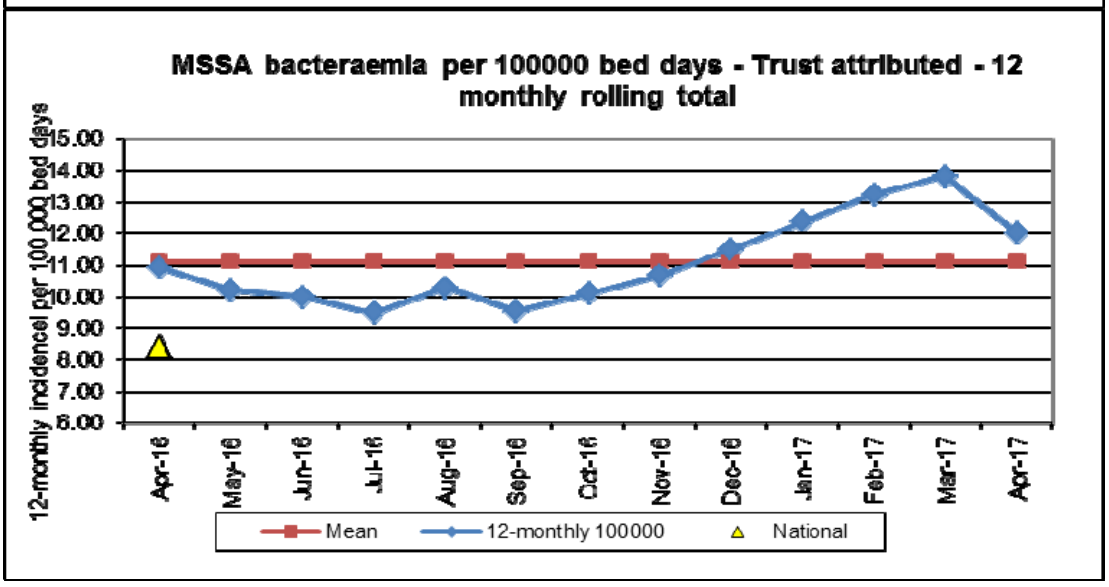
Since the launch of the new MRSA guidance, compliance with prescribed suppression treatment

has improved significantly i.e. prescriptions signed as having been administered pre-launch 46%; post-launch 78% providing assurance of compliance.

MRSA suppression washes

New care plans have been introduced for MRSA suppression washes and have been specifically designed so that carers, next of kin the patients themselves and Health Care Assistants can sign to confirm that the washes have been carried out. It is an acknowledgment that it is not just registered staff that participates in patients' care but where appropriate, carers and patients can too.





The IPC team are currently working on a new structure to ensure equity of cover across the organisation and also to develop new roles to support the clinical areas.

3. Patient Experience

3.1 Friend and Family Test (FFT) Latest Results – March 2017

The Trust's target is to achieve 90% of patients to recommend the Trust.

	% Patients Satisfied March	National Average % (Feb 17)	% Response Rate March	National Average % (Feb 17)
Inpatient	96.4	96	29.2	25.1
Emergency Department	84.2	87	10.7	12.7
Maternity	97.1	94	35.9	23.1

The Patient Experience Team continues to proactively engage with the matrons, sisters and directorate managers in the areas where response rates can be most improved. Themes identified in April include:

- Noise at night: Chestnut Ward, Ward 22, Ward 16, Coronary Care Unit. In order to mitigate this all wards are being encouraged to engage with the Night Owl Initiative and to continue to promote it with all ward staff.

- Time to answer call bells: Wards 33 and 35. The comfort rounding process is being re-launched and will help ensure that patients have their basic needs met in a timely manner.

- Staff being busy: Holly Ward. As well as the ward, this feedback was shared with the Human Resources Team to match against staff feedback.

Overall the feedback is highly positive, complimentary of staff and services and shows high satisfaction in in-patient areas and maternity services.

3.2 Complaints

The new complaints process was introduced in February 2017. Since then there has been a significant downward trend in the number of open complaints (93 at end of April). After an initial spike, the number of open complaints that have not received a response within the 30 working day target is now also coming down (38 at the end of April).

Examples of learning and actions from complaints closed in April 2017 include:

Management of patients with dementia in surgical areas

Training for junior Doctors around diagnosis

Training with Clinical Navigator role in early detection of stroke

- An operational procedure will be produced for staff to be clear when to escalate to the stroke specialist nurse and high acuity stroke unit nurse, and how decisions will be made by these clinicians.

- ED to ensure that patients who have not been seen within an adequate length of time and remain in the waiting room receive regular clinical observations.

- General Surgery
  - Nurses and discharge liaison officers will work with the ward's doctors to try to ensure electronic discharge notifications are completed in a timely manner.

A monthly audit of a sample of closed complaints is now being carried out by the complaints team. This will examine compliance with the Trust's complaints policy and checks for evidence that the stated action plans have been completed with a review of evidence to support.

3.3 Volunteering

All of the first group of volunteers recruited under the cohort system (applications in January 2017) have now completed the process and the majority have been placed. A new process for placing volunteers on the Elderly Medicine wards is being developed, better engaging the ward sisters and providing a better experience for the volunteers. Applications opened again in April 2017 and interviews for the second cohort are underway. A new bespoke training package was delivered in April to the eleven new dementia volunteers who are now in place in York and Bridlington.

3.4 Night Owl Initiative – reducing noise at night

The focus for 2017 is to build and sustain engagement with ward staff and to spread good practice. Early adopters have emerged on Acute Medical Unit York, Cherry Ward and Chestnut Ward. Ward 32 are starting to offer the sleep packs (eye mask and ear plugs) to anyone who feels they would benefit with the evening drinks rounds.

4. Effectiveness

The Ward Accreditation Tool continues to assess the risks on clinical area and support the ward teams to improve both patient safety and environment. In order to support Ward Sisters to work towards gold accreditation, deliver on the actions identified and prepare for the forthcoming CQC inspection a series of development days are planned. These will seek to support the Ward Sisters and Charge Nurses to improve and maintain ward standards and develop leadership capability. The sessions will begin in June.

5. Recommendation

The Committee is asked to note the Chief Nurse Report for May 2017.

Author	**Beverley Geary, Chief Nurse**
Owner	**Beverley Geary, Chief Nurse**
Date	**May 2017**

Nursing Dashboard - York

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Cum.Total	May	June	July	August	September	October	November	December	January	February	March	April
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU				1	3	3	2	4	4	4	3	7	1	3	9
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU				0	1	0	0	0	0	0	0	0	0	0	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU				0	2	2	2	3	3	3	2	4	0	2	6
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU				1	0	0	0	1	1	1	1	3	1	1	3
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	1	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				12	20	10	8	9	6	14	9	13	15	7	16
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				0	1	0	1	0	0	0	1	1	1	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%			97.50%	95.59%	95.14%	97.71%	96.66%	96.52%	96.85%	96.90%	94.58%	96.30%	97.05%	96.27%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS				4	3	6	1	7	1	7	4	6	7	2	4
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				6	8	3	5	5	6	4	10	7	6	9	2
	Drug Errors	Drug Errors (inpatient wards only)		Datix						54	72	62	95	90	106	121	112	106	82
	NEWS	Compliance with NEWs (inpatient wards only)		Signal				79.76%	80.62%	80.33%	80.40%	77.31%	77.88%	77.79%	80.10%	78.78%	84.49%	85.70%	85.54%
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	1	2	0	0	0	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				1	2	1	1	1	2	0	0	2	1	1	0
	VTE Other	VTE Other		Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team				74.63	67.66	71.16	78.07	73.81	51.9	60.92	53.54	68.28	79.96	86	86.58
		Inpatient area vacancies - HCA	Number	CN Team				41.43	37.9	30.11	41.3	47.8	53.07	35.63	42.17	26.86	27.68	13.87	34.05
	Vacancy Rate	Inpatient area -RN	%	CN Team															17.89%
		Inpatient area- HCA	%	CN Team															10.96%
	Sickness	Sickness (In Patient Areas)	%	Workforce Info				3.96%	3.55%	3.74%	3.51%	3.46%	4.32%	4.69%	3.97%	4.24%	4.40%	4.25%	
	Maternity Leave	Trustwide nursing / HCA	%	Workforce Info				3.45%	3.21%	3.09%	3.60%	3.28%	3.18%	3.04%	3.20%	3.46%	3.59%	3.63%	3.62%
	Appraisals	Registered Nurses (Ward Areas)	%	Workforce Info	75%					62.51%	61.67%	67.19%	67%	70.03%	70.53%	69.01%	65.28%	64.15%	61.46%
		Healthcare Assistants (Ward Areas)	%	Workforce Info	75%					71.58%	69.10%	75.29%	74.68%	77.72%	78.54%	74.09%	73.67%	71.96%	70.87%
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%			86.30%	88.00%	87.90%	85.30%	89.80%	91.00%	93.70%	92.40%	93.30%	93.80%	91.20%	91.0%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%			95.90%	102.30%	96%	96.90%	106.10%	98%	98.30%	97.30%	99.50%	96.40%	94.90%	110.8%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%			102.10%	95.60%	105.10%	105%	96.20%	107.30%	110.30%	108.30%	104.80%	106.70%	108.40%	92.6%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%			106.50%	113.30%	113.20%	112.20%	115.80%	114.80%	119.50%	113.70%	118.80%	118.60%	117.10%	119.6%
	Care Hours per patient Day	Registered Nurses		Safer Staffing Return				4.9	4.9	5.1	5	4.1	4	3.7	3.8	3.7	3.8	3.8	3.8
		Healthcare Assistants		Safer Staffing Return				2.6	2.7	3.0	3	3.1	2.9	2.8	2.8	2.6	2.7	2.9	3.0
		Total		Safer Staffing Return				7.5	7.6	8.1	8.0	7.3	6.9	6.5	6.6	6.3	6.5	6.7	6.8
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info				42.80%	38.20%	43.20%	39%	40.30%	39.40%	43.10%	40.80%	42.10%	43.50%	46.80%	46.40%
	Agency Fill Rate	Fill Rate	%	Workforce Info				33.40%	37.80%	36.10%	37.40%	40.60%	43.30%	41.40%	39.60%	37.10%	39.10%	36.80%	33.80%
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0		4	0	1	0	0	0	1	0	1	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%			6.59%	64.80%	61.41%	57.78%	52.17%	53.74%	78.70%	73.48%	66.83%	62.11%	65.97%	61.52%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%			82.29%	80.49%	81.76%	81.20%	79.34%	78.63%	58.65%	59.31%	77.57%	78.44%	78.53%	78%
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	48		4	1	3	3	2	0	2	1	6	5	4	2	0
	MSSA	MSSA Bacteraemia	Cummulative	IC Team			27	1	2	1	4	0	7	0	2	3	3	3	2
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team			47	3	4	4	9	6	1	4	4	4	4	2	5

Risk Management (Trust wide)	**Serious Incidents**	SI's declared	Number	Datix - Healthcare Governance				8	12	4	6	4	1	8	6	14	8	6	3
	Clinical Incidents	CI's reported	Number	Datix - Healthcare Governance				0	0	3	5	4	1	7	5	10	3	3	1
	Never Events	Never Events declared	Number	Datix - Healthcare Governance				0	1	0	0	0	0	0	0	0	0	0	0
		Metric	**Measure**	**Data Source**	**Trajectory**	**RAG**	**Cum.Total**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**
Patient Experience	**Friends and Family**	Inpatient Friends & Family Test	%Recommend	Signal				96.92%	96.06%	96.30%	95.75%	95.88%	95.88%	95.60%	95.62%	95.17%	96.16%	95.70%	
			%Not Recommend	Signal				0.73%	1.45%	0.90%	1.11%	1.26%	1.26%	1.43%	1.34%	1.18%	0.60%	1.25%	
		A&E Friends and Family Test	% Recommend	Signal				80.98%	81.44%	86.48%	88.04%	83.52%	83.52%	84.64%	84.32%	84.90%	81.84%	85.75%	
			% Not Recommend	Signal				11.63%	11.68%	8.16%	7.12%	9.74%	9.74%	10%	10.45%	9.38%	10.34%	7.48%	
		Maternity (Ante Natal)	% Recommend	Signal				95%	97.56%	98.18%	100%	100%	100%	98.70%	96.29%	93%	100%	94.34%	
			% Not Recommend	Signal				0%	0%	0	0%	0%	0%	0%	1.85%	0%	5	3.78%	
		Birth	% Recommend	Signal				99%	99.11%	100.00%	97.27%	100%	100%	96.93%	97.54%	99%	98.80%	94.45%	
			% Not Recommend	Signal				0%	0.88%	0%	0%	0%	0%	0.61%	0%	0%	1.20%	1.12%	
		Maternity (Post Natal)	% Recommend	Signal				98%	100%	99.10%	97.89%	100%	100%	97.67%	100%	95%	94.74%	94.29%	
			% Not Recommend	Signal				0%	0%	0%	1.05%	0%	0%	0%	0%	0%	1.68%	3%	
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team				20	12	17	15	21	19	13	17	26	15	20	11
		Staff Attitude	Number	PE Team				2	1	3	5	1	0	1	4	2	2	3	20
		Patient Care	Number	PE Team				4	2	2	2	0	2	3	1	5	5	3	0
		Privacy & Dignity	Number	PE Team															0
		Communication	Number	PE Team				1	3	2	1	2	4	0	3	2	0	1	0

Assistant Director Narrative - Michael Shanaghey

No exception narrative available.

Nursing Dashboard - Scarborough

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trust Trajectory	Cum Total	May	June	July	August	September	October	November	December	January	February	March	April
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU			4	2	1	1	2	4	4	3	3	0	5	3
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU			1	0	0	0	0	0	0	0	0	0	1	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU			2	0	1	0	0	3	3	2	3	0	0	2
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU			1	2	0	1	0	1	1	1	0	0	4	1
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	0	1	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS			10	4	7	9	15	7	18	15	13	10	3	5
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS			0	0	1	1	2	0	0	1	0	1	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%		95.58%	94.52%	94.31%	95.07%	90.94%	93.23%	92.64%	94.22%	94.17%	92.56%	92.69%	91.92%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS			4	11	17	15	10	11	7	4	10	9	8	10
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS			4	3	5	10	11	7	12	8	11	8	2	6
	Drug Errors	Drug Errors (inpatient wards only)		Datix					23	44	25	27	33	34	26	40	40	41
	NEWS	Compliance with NEWs (inpatient wards only)		Signal			85.70%	85.54%	85.45%	85.21%	85.53%	84.78%	90.80%	90.60%	83.46%	83.47%	84.62%	86.48%
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			0	0	0	0	0	2	1	0	0	1	0	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			0	1	1	1	0	1	0	2	1	1	1	1
	VTE Other	VTE Other	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			0	0	0	0	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team			38.4	40.27	50.71	49.63	43.01	37.86	42.06	40.46	47.84	52.61	57.54	58.46
		Inpatient area vacancies - HCA	Number	CN Team			7.94	10.28	10.14	13.06	17.8	16.7	10.03	6.84	8.98	3.68	0.88	7.16
	Vacancy Rate	Inpatient area -RN																22.19%
		Inpatient area - HCA																4.26%
	Sickness	Sickness (In Patient Areas)	%	Workforce Info			3.47%	3.88%	4.83%	4.75%	4.54%	4.72%	4.57%	4.92%	5.27%	4.42%	4.17%	
	Maternity Leave	Inpatient nursing / HCA	%	Workforce Info			2.71%	2.23%	2.39%	2.21%	1.92%	1.60%	2.10%	2.21%	2.77%	3.16%	3.24%	3.17
	Appraisals	Registered Nurses (Ward Areas)	%	Workforce Info	75%			59.69%	64.12%	63.42%	66.97%	63.91%	68.28%	70.13%	71.10%	72.85%	74.94%	74.79%
		Healthcare Assistants (Ward Areas)	%	Workforce Info	75%			45.52%	56.31%	57.24%	59.88%	69.90%	65.10%	81.73%	64.91%	69.81%	71.96%	75.79%
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%		86.20%	85.00%	82%	82.10%	86%	88.70%	90.40%	89.50%	86%	83.30%	81.40%	82.7%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%		89.70%	96.20%	92.90%	94%	98.20%	95.10%	99.10%	96.30%	93.50%	91.10%	92.40%	106.7%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%		99.90%	91.60%	100.20%	97.00%	93.40%	97.10%	102.40%	100.10%	98%	99.20%	103.50%	88.1%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%		111.70%	108.60%	111%	108.10%	118.60%	110.10%	114.80%	109%	104.30%	102.80%	104.50%	105.5%
	Care Hours per patient Day	Registered Nurses		Safer Staffing Return			5.1	4.6	4.9	5.3	3.9	3.9	4	4.1	3.8	3.7	3.7	3.8
		Healthcare Assistants		Safer Staffing Return			2.6	2.4	2.7	2.7	2.8	2.7	2.8	2.8	2.6	2.7	2.7	2.9
		Total		Safer Staffing Return			7.7	7.0	7.6	8.0	6.6	6.6	6.8	6.9	6.4	6.4	6.4	6.7
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info			74.90%	63.10%	58.80%	55.50%	59.90%	57.30%	59.20%	57%	66%	62.30%	61.30%	58.80%
	Agency Fill Rate	Fill Rate	%	Workforce Info			5.90%	8.30%	14.40%	19.30%	14.80%	18.20%	18.20%	16.40%	13.60%	14.70%	15.30%	17.70%
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0	3	0	0	0	2	0	0	0	0	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%		34.69%	37.17%	36.69%	43.26%	38.51%	42.37%	44.23%	42.98%	42.86%	40.20%	43.09%	30.58%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%		86.51%	75.82%	88.99%	89.34%	88.08%	90.12%	82.52%	78.46%	87.50%	88.95%	90.73%	88.55%
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	48	16	0	0	0	0	0	0	3	2	3	1	2	2
	MSSA	MSSA Bacteraemia	Cummulative	IC Team	<30	14	0	0	1	2	0	1	1	0	1	4	2	1
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team		38	2	3	4	4	2	2	1	1	5	1	3	0
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Governance			0	11	1	3	1	6	4	1	10	7	4	1
	Critical Incidents	CI's reported	Number	Datix - Healthcare Governance			0	0	1	3	0	2	4	3	7	5	3	0
	Never Events	Never Events declared	Number	Datix - Healthcare Governance			0	0	0	0	0	0	0	0	0	0	0	0

		Metric	Measure	Data Source	Trust Trajectory	Cum Total	May	June	July	August	September	October	November	December	January	February	March	April
		Metric	**Measure**	**Data Source**	**Trajectory**	**Mar**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**
Patient Experience	**Friends and Family Test**	Inpatient Friends and Family Test	%Recommend	Signal			96.35%	96.88%	97.56	98.96%	97.94%	97.40%	97.55%	97.51%	98.23%	97.40%	97.75%	
			%Not Recommend	Signal			0.42%	0.66%	0.98%	0.78%	0.74%	0.78%	0.53%	0.52%	0.18%	1.04%	0.75%	
		A&E Friends and Family Test	% Recommend	Signal			81.63%	78.26%	71.43%	75.52%	75.97%	78.20%	66.06%	84.62%	80.82%	79.31%	76.19%	
			% Not Recommend	Signal			8.84%	13.91%	21.14%	19.27%	17.53%	17.29%	17.43%	7.69%	10.96%	15.52%	13.10%	
		Maternity (Ante Natal)	% Recommend	Signal			96%	100%	95.45%	100%	97.44%	98.65%	99.17%	96%	96%	100%	97.00%	
			% Not Recommend	Signal			0%	0%	0%	0%	0%	0.00%	0.00%	0%	0%	0%	2.36%	
		Birth	% Recommend	Signal			99%	100%	96.55%	100%	97.96%	99.09%	98.54%	100%	92%	100%	100%	
			% Not Recommend	Signal			1%	0%	0%	0%	0%	0.00%	0.00%	0%	0%	0%	0%	
		Maternity (Post Natal)	% Recommend	Signal			100%	100%	100%	100%	100%	97.80%	96.95%	100%	98%	100%	100%	
			% Not Recommend	Signal			0%	0%	0%	0%	0%	0.00%	0.00%	0%	1.96%	0%	0%	
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team			2	3	5	12	8	10	14	17	10	9	8	9
		Staff Attitude	Number	PE Team			0	2	1	1	1	1	1	4	1	2	3	3
		Patient Care	Number	PE Team			1	0	2	1	1	1	1	2	3	2	0	0
		Communication	Number	PE Team			1	0	2	0	3	1	1	3	0	0	1	1

Assistant Director Narrative - Emma George

Appraisal rate is just below 75 % at 74.79% , all Band 7 s are monitored through matron one to ones to ensure appraisals are undertaken and have recently had a presentation at PNLF to ensure they know how to electronically submit their completed appraisal

RN vacancy is at 22.19% , this is monitored through the Recruitment / Reporting and Retention meeting which the ADN attends and reports into and an action plan is in place to address the RN vacancy position across the sites.

Nursing Dashboard - Bridlington

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	CummTotal	May	June	July	August	September	October	November	December	January	February	March	April
	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU				2	0	1	0	0	0	0	3	0	1	1	2
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	3	0	0	0	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU				2	0	1	0	0	0	0	0	0	1	1	2
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				0	1	0	0	0	0	0	0	1	0	0	6
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				0	0	0	0	0	0	0	0	0	0	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%			90.00%	90.63%	82.31%	81.82%	91.84%	92.11%	100%	87.50%	90.57%	88.46%	93.10%	78.57%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS				0	0	1	1	1	1	7	4	3	1	0	1
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				3	0	0	3	0	0	1	0	4	0	1	0
	Drug Errors	Drug Errors (inpatient wards only)		Datix						2	0	0	1	2	1	4	4	1	7
	NEWS	Compliance with NEWs (inpatient wards only)		Signal				93.04%	91.50%	92.96%	92.09%	92.88%	91.21%	91.80%	93%	90.77%	82.55%	83.20%	84.51%
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	0	0	0	1	0	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	0	0	0	0	0	0
	VTE Other	VTE Other		Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team				7.4	7.4	5	5	5	7	6.15	7.36	5.33	-0.33	0.44	0.6
		Inpatient area vacancies - HCA	Number	CN Team				3.44	1.5	2.44	0.7	4.84	5.6	4.19	6.5	8.43	7.63	7.83	7.03
	Vacancy Rate	Inpatient area -RN																	1.49%
		Inpatient area - HCA																	18.41%
	Sickness (In Patient Areas)	Sickness	%	Workforce Info				14.40%	16.33%	15.49%	13.40%	15.55%	12.58%	10.15%	8.61%	12.24%	13.02%	8.83%	
	Maternity Leave	inpatient nursing / HCA	%	Workforce Info				0.95%	0.95%	0.72%	0	1.43%	1.56%	2.69%	3.48%	3.46%	3.46%	3.46%	3.47%
	Appraisals	Registered Nurses (Ward Areas)	%	Workforce Info	75%				64.88%	65.37%	66.92%	53.66%	57.16%	67.71%	76.19%	79.76%	77.68%	78.16%	78.16%
		Healthcare Assistants (Ward Areas)	%	Workforce Info	75%				62.36%	60.67%	63.85%	52.78%	70.83%	81.73%	96.15%	95.83%	95.83%	93.75%	87.50%
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%			88.90%	95.10%	85.00%	89%	83.10%	97.90%	80.50%	78.60%	89.20%	85.20%	87.60%	80.1%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%			79.40%	84.20%	87.50%	75.30%	92.10%	74.40%	63.60%	88.10%	76%	79.90%	76.10%	95.5%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%			85.80%	72.70%	72.30%	87.20%	64.50%	84.90%	93.10%	88.10%	93.80%	84.30%	99.90%	74.5%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%			133.90%	143.30%	159.70%	138.70%	191.70%	132.30%	201.70%	204.80%	164.50%	158.90%	140.30%	175.0%
	Care Hours per patient Day	Registered Nurses		Safer Staffing Return				9.1	8.1	7.8	6.7	3.5	3.4	3.4	3.6	3.1	3	3.2	2.9
		Healthcare Assistants		Safer Staffing Return				4.0	3.5	4.1	3.7	3.9	3.7	3.9	4.1	3	2.9	3.2	3.1
		Total		Safer Staffing Return				13.1	11.6	11.9	10.4	7.5	7.1	7.3	7.7	6.2	5.6	6.5	6.1
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info				84.70%	76.30%	78.40%	84.80%	85.50%	82.20%	84.20%	74.90%	74.20%	82.60%	81.50%	75.50%
	Agency Fill Rate	Fill Rate	%	Workforce Info				0.80%	2.90%	1.80%	1.60%	0.60%	0.30%	1.70%	5.80%	9.40%	4.20%	3.30%	10%
Infection Prevention	MRSA	MRSA Bacteraemia	Accumulated number of patients	IC Team	0	Green	3	0	0	0	0	0	0	0	0	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%			95.20%	97.32%	97.10%	100%	97.99%	99.34%	97.56%	97.66%	100.00%	67.89%	99.40%	100%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%			100%	100%	99.28%	--	100%	100%	100%	100%	100%	75%	100%	100%
	C.Difficile	C DIF Toxin Trust Attributed	Accumulated number of patients	IC Team	48	Green	3	0	0	0	0	0	0	1	0	0	0	0	0
	MSSA	MSSA Bacteraemia	Accumulated number of patients	IC Team	<30	Red	0	1	0	0	0	0	0	1	0	0	0	0	0
	E-Coli	E-Coli Bacteraemia	Accumulated number of patients	IC Team			4	0	1	0	0	0	1	0	0	0	0	0	0

		Metric	Measure	Data Source	Trajectory	RAG	CummTotal	May	June	July	August	September	October	November	December	January	February	March	April
Risk Management (Trust wide)	**Serious Incidents**	SI's declared	Number	Datix - healthcare governance				0	3	0	0	1	0	0	0	1	0	0	1
	Critical Incidents	CI's reported	Number	Datix - healthcare governance				0	0	0	1	0	0	0	0	0	0	0	0
	Never Events	Never Events declared	Number	Datix - healthcare governance				0	0	0	0	0	0	0	0	0	0	0	0
		Metric	**Measure**	**Data Source**	**Trajectory**	**RAG**	**Cum.Total**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**
Patient Experience	**Friends and Family**	Inpatient Friends and Family Test	%Recommend	Signal				97.23%	98.31%	96.57%	98.32%	98.74%	98.74%	98.90%	99.73%	100%	98.60%	98.01%	
			%Not Recommend	Signal				0.79%	0%	0%	0%	0.32%	0.32%	0%	0%	0%	0%	0.00%	
		A&E Friends and Family Test	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
		Maternity (Ante Natal)	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
		Birth	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
		Maternity (Post Natal)	% Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--	--	--	--
	Complaints	Complaints Total	Number	PE Team				0	0	0	1	1	0	2	0	2	0	1	0
		Staff Attitude	Number	PE Team				0	0	0	1	0	0	0	0	0	0	0	0
		Patient Care	Number	PE Team				0	0	0	0	0	0	1	0	1	0	0	0
		Communication	Number	PE Team				0	0	0	0	0	0	0	0	0	0	0	0

Assistant Director Narrative - Emma George

The HCA night is at 175% due to the increase in bed base on Waters ward since November 2017 due to winter pressures. The bed base decreased back to 11 in May 2017

Sickness is 8.83% a reduction from 13.02% last month, this is due to long term sickness , all have a plan in place and are discussed with the ADN and Matron

Nursing Dashboard - Trustwide

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Cumm. Total (Financial Year	May	June	July	August	September	October	November	December	January	February	March	April
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - New PU				17	16	13	9	15	17	17	20	18	9	18	21
		Cat 4	No. of Patients (PP)	Safety Thermometer - New PU				1	1	1	0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - New PU				3	4	1	1	2	3	3	2	0	0	2	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - New PU				10	4	6	4	11	7	7	11	10	5	8	13
		Unstageable	No. of Patients (PP)	Safety Thermometer - New PU				3	7	5	4	1	7	7	7	8	4	8	8
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - New PU				0	0	0	0	1	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				31	32	27	20	28	23	40	28	31	36	20	30
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				0	1	1	2	3	0	0	1	1	4	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer -CQUIN HARM FREE %	95%	Red		95.33%	95.33%	94.31%	95.07%	94.71%	95.15%	95.27%	95.33%	94.90%	94.45%	94.89%	93.87%
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - UTI - NEW UTI				19	14	17	17	15	19	34	18	26	17	11	21
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				16	13	8	18	17	15	19	20	23	17	17	9
	Drug Errors			Datix						89	135	101	133	138	152	159	168	163	141
	NEWS			Signal				87.60%	87.40%	87.70%	87.80%	88.10%	87.90%	87.90%	87%	86.30%	86.72%	87.90%	98.40%
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type				1	0	0	0	0	2	2	5	1	2	1	1
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type				1	3	2	2	1	3	0	4	3	2	2	3
	VTE Other	VTE Other	No. of Patients (PP)	Safety Thermometer - VTE Treatment Type				0	0	0	0	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN (month end)	Number	CN Team				133.76	130.35	142.28	149.99	141.91	105.5	117.26	109.42	125.88	138.05	149.79	152.05
		Inpatient area vacancies - HCA (month end)	Number	CN Team				59.11	56.82	47.56	62.63	80.38	75.65	59.37	59.86	47.56	42.78	26.97	51.99
	Vacancy Rate	Inpatient area -RN (month end)	%	CN Team															18.03%
		Inpatient area - HCA (month end)	%	CN Team															--
	Turnover	Registered Nurses	%	Workforce Info				11.32%	11.03%	10.62%	10.63%	10.70%	10.03%	9.77%	9.91%	9.65%	11.07%	9.03%	72.02%
		Healthcare Assistants	%	Workforce Info				9.22%	9.80%	10.36%	8.19%	9.84%	8.22%	8.31%	7.55%	7.40%	7.11%	8.12%	76.03%
	Sickness	Trustwide nursing / HCA sickness	%	Workforce Info				3.89%	3.79%	3.84%	3.73%	5.01%	4.40%	4.15%	4.52%	4.76%	4.43%	4.08%	
	Maternity Leave	Trustwide nursing / HCA	%	Workforce Info				2.84%	2.95%	2.90%	2.78%	2.84%	2.65%	2.75%	2.89%	2.82%	2.79%	2.76%	2.79%
	Appraisals	Registered Nurses	%	Workforce Info		75%			66.10%	68.64%	70.95%	70.99%	71.53%	73.33%	73.88%	71.16%	74.50%	73.22%	72.07%
		Healthcare Assistants	%	Workforce Info		75%			67.79%	69.31%	72.11%	71.63%	71.27%	75.34%	77.45%	77.93%	78.49%	77.52%	76.03%
	Safer Staffing Return	**Qualified** Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%	Green		92.80%	93.70%	90.19%	90.30%	91.32%	94.04%	92.44%	91.67%	92.72%	91.11%	92.50%	92.4%
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%	Red		92.00%	97.80%	89.05%	84.50%	97.01%	94.42%	94.38%	91.91%	93.91%	93.46%	92.80%	92.1%
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%	Green		97.80%	94.10%	99.94%	98.90%	91.19%	99.23%	101.53%	99.77%	98.33%	99.86%	102.50%	100.5%
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%	Red		111.50%	108.20%	118.64%	122.00%	117.34%	108.50%	121.58%	115.22%	114.98%	116.74%	118.60%	115.4%
	Care Hours per patient Day	Registered Nurses		Safer Staffing Return				5.4	5.1	5.1	4.8	3.01	3.12	3	3.2	2.9	2.9	3	3.2
		Healthcare Assistants		Safer Staffing Return				3.0	2.9	3.1	3.1	2.9	3.01	3	3.1	2.7	2.8	3	3.1
		Total		Safer Staffing Return				8.4	8.0	8.2	7.9	5.91	6.14	6	6.3	5.6	5.6	6	6.3
	Bank & Agency	**Overall** Fill Rate	%	Workforce Info				78.55%	75.92%	78.33%	77.41%	79.86%	81.33%	83.19%	78.18%	80.36%	82.02%	82.16%	80.05%
		Bank Fill Rate RN	%	Workforce Info				50.67%	46.18%	46.74%	40.97%	47.60%	46.28%	51.94%	48.66%	50.10%	49.13%	49.63%	48.25%
		Bank Fill Rate HCA	%	Workforce Info				60.76%	53.75%	56.69%	56.79%	51.78%	51.35%	51.77%	49.97%	54.60%	56.25%	60.13%	57.80%
		Bank - RN Hours filled	Number of Hours	Workforce Info				15,569	14,186	15,273	14,845	15,194	15,047	15,949	14,515	17,553	17,082	19,627	16,607
		Bank - HCA Hours filled	Number of Hours	Workforce Info				14,273	14,395	16,829	17,562	16,872	16,282	17,649	16,815	17,437	18,178	20,780	19,675
		Agency Fill Rate RN	%	Workforce Info				22.48%	25.47%	26.47%	29.55%	30.82%	33.90%	31.24%	29.52%	28.31%	30.98%	28.54%	26.31%
		Agency Fill Rate HCA	%	Workforce Info				24.84%	27.07%	27.26%	28.71%	29.49%	31.16%	31.02%	30.13%	27.91%	27.92%	26.60%	27.80%
		Agency - RN Hours filled	Number of Hours	Workforce Info				6,908	7,823	8651	10,706	9,840	11,023	9,594	8,804	9,917	10,772	11,287	9,057
		Agency - HCA Hours filled	Number of Hours	Workforce Info				5,835	7,250	8,078	8,878	9,609	9,882	10,576	10,137	8,914	8,990	9,195	9,463

		Metric	Measure	Data Source	Trajectory	RAG	Cumm. Total (Financial Year	May	June	July	August	September	October	November	December	January	February	March	April
Stat & Mand Training	Statutory & Mandatory Training	Statutory Training		CLAD	75%			85%	85.62%	84.23%	75.54%	69.78%	70.21%	84.35%	69.84%	59.72%	84.73%	89.05%	87.68%
		Mandatory Traiing		CLAD	75%			83.60%	85.18%	84.23%	78.94%	78.61%	79.24%	83.75%	77.79%	73.12%	85.11%	85.55%	89.78%
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0	Red	7.00	0	1	0	2	0	2	0	1	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%	Red		62.96	64.24	62.52	63.89	58.77%	61.75%	82.48%	78.51%	71.77%	67.89%	69.36%	62.56%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%	Red		83.7	78.91	84.19	83.88	82.29%	82.62%	65.89%	64.81%	81.11%	82.01%	82.62%	81.59%
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team		Green	48.00	1	3	3	2	1	3	2	8	10	5	5	2
	MSSA	MSSA Bacteraemia	Cummulative	IC Team		Red	55.00	2	2	2	5	0	8	4	5	5	6	4	3
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team			91.00	5	9	6	14	10	4	5	5	9	8	5	6
	Hand Hygiene	Hand Hygiene Compliance 95%	Compliance %	IC Team	95%	Amber		93%	94%	95%	93%	94%	94%	94%	93%	94%	95%	94%	94%
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Goverance Team				12	31	15	17	12	9	18	14	28	18	10	9
	Critical Incidents	CI's reported	Number	Datix - Healthcare Goverance Team				0	0	6	5	4	3	11	7	17	10	6	1
	Never Events	Never Events declared	Number	Datix - Healthcare Goverance Team				0	1	1	1	0	0	0	0	0	0	0	0
Patient Experience	Friends and Family	Inpatient Friends and Family Test	%Recommend	Signal				96.92%	96.47%	96.52%	96.53%	96.70%	96.70%	96.21%	96.79%	96.51%	96.81%	96.40%	
			%Not Recommend	Signal				0.73%	1.13%	0.89%	0.93%	1.03%	1.03%	1.15%	0.97%	0.79%	0.60%	1.00%	
		A&E Friends and Family Test	% Recommend	Signal				81.09%	80397%	83.84%	85.58%	82.76%	83.52%	81.61%	84.37%	84.25%	81.49%	84.18%	
			% Not Recommend	Signal				11.16%	12.01%	10.44%	9.51%	10.81%	9.74%	11.21%	10.02%	9.63%	11.06%	8.40%	
		Maternity (Ante Natal)	% Recommend	Signal				95.35%	98.37%	97..4%	100%	98.65%	98.65%	99.17%	96.12%	94.45%	100%	95.65%	
			% Not Recommend	Signal				0%	0%	0%	0%	0%	0%	0%	0%	1.82%	0%	2.90%	
		Labour & Birth	% Recommend	Signal				98.99%	99.33%	99.30%	97.89%	99.09%	99.09%	98.54%	98.34%	97.56%	99.19%	98.61%	
			% Not Recommend	Signal				0%	0%	0%	0%	0%	0%	0%	0%	0%	0.81%	0.00%	
		Maternity (Post Natal)	% Recommend	Signal				97.16%	100%	99.26%	98.32%	97.80%	97.80%	96.95%	98.21%	99.11%	99.13%	96.03%	
			% Not Recommend	Signal				0.57%	0%	0%	0.84%	0%	0%	0%	0%	0%	0%	0.79%	
		Community Post Natal	% Recommend	Signal				99.15%	99.12%	98.81%	97.44%	100%	100%	98.18%	100%	97.17%	96.72%	98.15%	
			% Not Recommend	Signal				0%	0%	1.19%	1.71%	0%	0	0%	0%	0%	1.64%	0.93%	
	Complaints	Complaints Total	Number	PE Team				30	33	26	28	33	31	30	26	39	27	30	31
		Staff Attitude	Number	PE Team				2	4	4	1	2	1	2	4	3	5	6	5
		Patient Care	Number	PE Team				5	2	4	7	1	3	5	2	9	8	4	0
		Communication	Number	PE Team				2	3	4	3	5	5	1	4	2	0	2	1

E4

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Safe Nurse and Midwifery Staffing Report

Action requested/recommendation

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

Executive Summary

The Trust continues to submit to NHS Choices, actual against planned staffing data for day and night duty in hours and by ward. A detailed breakdown for April 2017 staffing levels is contained within the main report.

The adult inpatient vacancy position across the Trust at the end of April 2017 is as follows:

	Vacancies		**Pending Starters**		**Unfilled Vacancies**	
	RN	**Care Staff**	**RN**	**Care Staff**	**RN**	**Care Staff**
Bridlington	0.6	7.03	2	3	-1.4	4.03
Community	6.42	3.75	1.68	2.2	4.74	-0.99
Scarborough	58.46	7.16	14	12.2	44.46	-5.04
York	86.57	34.05	75.8	37.73	10.77	-3.73
Total	**152.05 fte**	**51.99fte**	**93.48fte**	**55.13fte**	**58.57fte**	**-3.14fte**

It is anticipated that future reports will present vacancy information by exception, and with RAG ratings attributed to those areas of greatest risk.

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

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the

issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	First presentation
Risk	No risk
Resource implications	Resources implication detailed in the report
Owner	Beverley Geary, Chief Nurse
Author	Nichola Greenwood, Nursing Workforce Projects Manager
Date of paper	May 2017
Version number	Version 1

Quality & Safety Committee – 23 May 2017

Safe Nurse and Midwifery Staffing Report

1. Introduction and background

The Trust continues to submit to NHS Choices, actual against planned staffing data for day and night duty in hours and by ward. A detailed breakdown for April 2017 staffing levels is attached at Appendix 1.

The Trust also continues to report Care Hours per Patient Day (CHPPD) data. This report, at section 3, provides details of the CHPPD based on the actual staffing provided across the inpatient wards during April 2017. CHPPD data has been collected since May 2016 and the Trust is now looking at the eleven months' worth of data collected as part of its continuous review of nurse staffing levels across all wards.

At present, no national benchmark data is available on CHPPD to compare our Trust against other organisations.

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 (%)**
Bridlington and District Hospital	80.1%	95.5%	74.5%	175.0%
Malton Community Hospital	92.7%	101.4%	100.0%	93.3%
Scarborough General Hospital	82.7%	106.7%	88.1%	105.5%
Selby And District War Memorial Hospital	96.7%	103.3%	86.7%	130.0%
St Helens Rehabilitation Hospital	98.3%	94.0%	98.3%	100.0%
St Monicas Hospital	100.0%	102.0%	100.0%	100.0%
White Cross Rehabilitation Hospital	97.5%	90.0%	96.7%	100.0%
York Hospital	91.0%	110.8%	92.6%	119.6%

3. Care Hours per Patient Day

	Care Hours Per Patient Day (CHPPD)			
	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Bridlington and District Hospital	1520	2.9	3.1	6.1
Malton Community Hospital	617	2.8	3.6	6.3
Scarborough General Hospital	8598	3.8	2.9	6.7
Selby and District War Memorial Hospital	558	3.0	2.9	5.8
St Helen's Rehabilitation Hospital	568	2.7	2.4	5.1
St Monica's Hospital	327	2.8	3.4	6.2
White Cross Rehabilitation Hospital	377	4.0	3.6	7.6
York Hospital	15837	3.8	3.0	6.8

4. Exceptions

There were 7 wards where RN staffing during the day fell below 80% in April. These wards were Ann Wright, Chestnut, Holly, ITU, Lilac and Maple in Scarborough due to vacancies and sickness and AMB in York due to vacancies.

There were 5 wards where RN planned staffing levels fell below 80% on night shifts. These wards were ITU in Scarborough and AMU and Frailty Unit in York due to vacancies, Kent and Lloyd in Bridlington all due to low bed occupancy; resulting in staff being redeployed to other wards.

A detailed exception breakdown is detailed below.

Enhanced Supervision

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

Bridlington	Community	Scarborough	York	
Waters	St Monica's	Chestnut	AMU	AMB
		Holly	Ward 11	Ward 17
		Stroke	Ward 23	Ward 25
			Ward 26	Ward 28
			Ward 32	Ward 33
			Ward 35	Ward 36
			Ward 37	Ward 39

Provision of Safe Ward Cover

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

support the shortfall of registered nurses or increased Registered Nurses when the acuity of patients requires additional support. These wards during April were:

Bridlington	Community	Scarborough		York
Johnson	Fitzwilliam	Ann Wright	Beech	AMU
	Selby	CCU	Chestnut	AMB
		Graham	Holly	G1
		ITU	Maple	Ward 23
		Oak	Stroke	Ward 28
				Ward 34

ICU at York has been able to use rostering efficiencies to have care staff working on shift without additional expense to the Trust.

Bed Occupancy

Lloyd and Kent wards at Bridlington changed their ratio of registered and unregistered staff according to bed occupancy, with staff being deployed to other ward areas. On occasions Kent and Lloyd wards were closed when there were no patients requiring overnight stay or no clinical activity being undertaken.

Care staff provision on CCU at York fell below 80% due to support given to other ward areas on occasions.

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

5. Vacancies by Site

The adult inpatient vacancy position across the Trust at the end of March 2017 is as follows:

	Vacancies		Pending Starters		Unfilled Vacancies	
	RN	**Care Staff**	**RN**	**Care Staff**	**RN**	**Care Staff**
Bridlington	0.6	7.03	2	3	-1.4	4.03
Community	6.42	3.75	1.68	2.2	4.74	-0.99
Scarborough	58.46	7.16	14	12.2	44.46	-5.04
York	86.57	34.05	75.8	37.73	10.77	-3.73
Total	**152.05 fte**	**51.99fte**	**93.48fte**	**55.13fte**	**58.57fte**	**-3.14fte**

The overall RN vacancy position for the adult inpatient areas stands at 18.03%, an increase of 0.27% on the position reported to April Board meeting (2.26fte) with new April starters offsetting some leavers during the month. However the number of unfilled RN vacancies has increased by 11.22fte at the end of April, this is due to the development of new posts and increasing capacity – ITU at Scarborough site for example required an additional 5.6 WTE RN's to open the additional bed. Whilst attrition is at the lowest we have seen for some time vacancies increase due to organisational developments.

70.39% of the pending starters are newly qualified nurses commencing with the Trust between August and October 2017. Work is in continuing to recruit both experienced and newly qualified nurses into the Trust across all sites. The Chief Nurse Team will be attending Nursing Times Careers Live on 25th May 2017 to continue its nurse recruitment campaign.

Over-recruitment of care staff has taken place in some areas, providing additional support to

where there is difficulty recruiting to RN vacancies, as well as appointments being made where staff are currently working their notice periods.

It is anticipated that future reports will present vacancy information by exception, and with RAG ratings attributed to those areas of greatest risk.

The Chief Nurse Team continues to work with the Workforce Transformation Team to look at new models of working and the introduction of new roles.

6. Recommendation

The Committee is asked to receive the nurse staffing report for information.

7. References and further reading

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

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

Author	**Nichola Greenwood, Nursing Workforce Projects Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**May 2017**

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Please provide the URL to the page on your trust website where your staffing information is available
(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

Comments

Only complete sites your organisation is accountable for				Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
Hospital Site Details		Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1080	858	720	1020	660	660	660	638	79.4%	141.7%	100.0%	96.7%	530	2.9	3.1	6.0
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ash	100 - GENERAL SURGERY		900	892.5	900	877.5	660	649	330	330	99.2%	97.5%	98.3%	100.0%	452	3.4	2.7	6.1
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Beech	300 - GENERAL MEDICINE		1440	1182	1260	1308	990	924	660	693	82.1%	103.8%	93.3%	105.0%	884	2.4	2.3	4.6
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Cherry	326 - ACUTE INTERNAL MEDICINE	300 - GENERAL MEDICINE	1800	1494	1440	1368	1650	1320	1320	1276	83.0%	95.0%	80.0%	96.7%	694	4.1	3.8	7.9
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1440	1104	1080	1284	660	660	660	726	76.7%	118.9%	100.0%	110.0%	817	2.2	2.5	4.6
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2250	1927.5	900	802.5	1320	1122	330	363	85.7%	89.2%	85.0%	110.0%	575	5.3	2.0	7.3
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Duke of Kent	420 - PAEDIATRICS		1627.5	1417.5	465	435	682	660	341	319	87.1%	93.5%	96.8%	93.5%	301	6.9	2.5	9.4
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Graham	430 - GERIATRIC MEDICINE		900	780	720	942	660	660	660	660	86.7%	130.8%	100.0%	100.0%	563	2.6	2.8	5.4
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Hawthorn	501 - OBSTETRICS		720	720	360	360	660	660	0	0	100.0%	100.0%	100.0%	-	358	3.9	1.0	4.9
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1080	756	900	1080	660	660	660	704	70.0%	120.0%	100.0%	106.7%	555	2.6	3.2	5.8
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE	100 - GENERAL SURGERY	3150	2257.5	450	487.5	2310	1573	0	0	71.7%	108.3%	68.1%	-	117	32.7	4.2	36.9
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Lilac	101 - UROLOGY		1800	1477.5	1800	1777.5	990	935	990	968	82.1%	98.8%	94.4%	97.8%	735	3.3	3.7	7.0
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Maple	100 - GENERAL SURGERY		2250	1942.5	1125	1282.5	1320	1221	660	737	86.3%	114.0%	92.5%	111.7%	592	5.3	3.4	8.8
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Oak	430 - GERIATRIC MEDICINE		1440	1170	1980	1944	990	880	990	1034	81.3%	98.2%	88.9%	104.4%	966	2.1	3.1	5.2
SCARBOROUGH GENERAL HOSPITAL - RCBCA	Stroke	328-STROKE MEDICINE		1080	1014	720	846	990	814	330	616	93.9%	117.5%	82.2%	186.7%	459	4.0	3.2	7.2
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Johnson	430 - GERIATRIC MEDICINE		900	822	1260	1206	660	638	330	341	91.3%	95.7%	96.7%	103.3%	784	1.9	2.0	3.8
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		1125	720	900	795	660	242	0	242	64.0%	88.3%	36.7%	-	101	9.5	10.3	19.8
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Lloyd	100 - GENERAL SURGERY		600	382.5	740	262.5	176	66	0	22	63.8%	35.5%	37.5%	-	17	26.4	16.7	43.1
BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Waters	430 - GERIATRIC MEDICINE	101 - UROLOGY	900	900	900	1365	660	660	330	550	100.0%	151.7%	100.0%	166.7%	618	2.5	3.1	5.6
YORK HOSPITAL - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1464	1302	864	924	660	660	660	748	88.9%	106.9%	100.0%	113.3%	840	2.3	2.0	4.3
YORK HOSPITAL - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1665	1416	1080	1032	1080	979	660	561	85.0%	95.6%	90.6%	85.0%	704	3.4	2.3	5.7
YORK HOSPITAL - RCB55	16	100 - GENERAL SURGERY		2475	2422.5	1125	1072.5	1320	1243	660	627	97.9%	95.3%	94.2%	95.0%	827	4.4	2.1	6.5
YORK HOSPITAL - RCB55	17	420 - PAEDIATRICS		1488	1332	372	378	1023	902	341	330	89.5%	101.6%	88.2%	96.8%	450	5.0	1.6	6.5
YORK HOSPITAL - RCB55	23	430 - GERIATRIC MEDICINE		1575	1680	1350	1432.5	660	660	990	1078	106.7%	106.1%	100.0%	108.9%	884	2.6	2.8	5.5

Only complete sites your organisation is accountable for				Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
Hospital Site Details	Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
YORK HOSPITAL - RCB55	25	430 - GERIATRIC MEDICINE		1260	1224	1080	1320	660	660	990	1210	97.1%	122.2%	100.0%	122.2%	694	2.7	3.6	6.4
YORK HOSPITAL - RCB55	26	110 - TRAUMA & ORTHOPAEDICS		1575	1560	1350	1912.5	660	660	990	1364	99.0%	141.7%	100.0%	137.8%	875	2.5	3.7	6.3
YORK HOSPITAL - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1440	1404	1080	1026	660	836	660	825	97.5%	95.0%	126.7%	125.0%	824	2.7	2.2	5.0
YORK HOSPITAL - RCB55	29	430 - GERIATRIC MEDICINE	103-BREAST SURGERY	1440	1260	720	684	660	638	660	638	87.5%	95.0%	96.7%	96.7%	479	4.0	2.8	6.7
YORK HOSPITAL - RCB55	31	370 - MEDICAL ONCOLOGY		2025	1755	900	825	660	660	330	330	86.7%	91.7%	100.0%	100.0%	512	4.7	2.3	7.0
YORK HOSPITAL - RCB55	32	320 - CARDIOLOGY	361 - NEPHROLOGY	1452	1296	1080	1644	660	638	990	1551	89.3%	152.2%	96.7%	156.7%	813	2.4	3.9	6.3
YORK HOSPITAL - RCB55	33	301 - GASTROENTEROLOGY	301 - GASTROENTEROLOGY	1440	1344	1080	1056	660	660	990	1045	93.3%	97.8%	100.0%	105.6%	864	2.3	2.4	4.8
YORK HOSPITAL - RCB55	34	340 - RESPIRATORY MEDICINE		1440	1260	1080	1014	660	671	990	946	87.5%	93.9%	101.7%	95.6%	858	2.3	2.3	4.5
YORK HOSPITAL - RCB55	35	430 - GERIATRIC MEDICINE		1260	1086	1080	1356	660	660	990	1034	86.2%	125.6%	100.0%	104.4%	878	2.0	2.7	4.7
YORK HOSPITAL - RCB55	37	430 - GERIATRIC MEDICINE		1050	967.5	1875	2970	660	660	660	1628	92.1%	158.4%	100.0%	246.7%	584	2.8	7.9	10.7
YORK HOSPITAL - RCB55	39	430 - GERIATRIC MEDICINE	430 - GERIATRIC MEDICINE	1260	1116	1080	1488	660	627	660	979	88.6%	137.8%	95.0%	148.3%	714	2.4	3.5	5.9
YORK HOSPITAL - RCB55	36 - Acute Stroke Unit	328-STROKE MEDICINE	430 - GERIATRIC MEDICINE	1440	1434	1260	1524	990	968	990	1276	99.6%	121.0%	97.8%	128.9%	635	3.8	4.4	8.2
YORK HOSPITAL - RCB55	Acute Medical Unit	326 - ACUTE INTERNAL MEDICINE		2250	1822.5	1800	1770	1650	1177	990	1078	81.0%	98.3%	71.3%	108.9%	744	4.0	3.8	7.9
YORK HOSPITAL - RCB55	Frailty Unit	326 - ACUTE INTERNAL MEDICINE	430 - GERIATRIC MEDICINE	2250	1717.5	1800	1702.5	1650	1232	990	1056	76.3%	94.6%	74.7%	106.7%	789	3.7	3.5	7.2
YORK HOSPITAL - RCB55	Coronary Care Unit	320 - CARDIOLOGY		1800	1582.5	300	187.5	1320	1122	0	0	87.9%	62.5%	85.0%	-	179	15.1	1.0	16.2
YORK HOSPITAL - RCB55	Extended Stay Area	100 - GENERAL SURGERY		870	832.5	412.5	390	308	275	0	11	95.7%	94.5%	89.3%	-	148	7.5	2.7	10.2
YORK HOSPITAL - RCB55	G1	120 - ENT	502 - GYNAECOLOGY	1800	1740	900	802.5	990	957	330	374	96.7%	89.2%	96.7%	113.3%	562	4.8	2.1	6.9
YORK HOSPITAL - RCB55	G2	501 - OBSTETRICS		1080	948	720	576	660	594	330	330	87.8%	80.0%	90.0%	100.0%	492	3.1	1.8	5.0
YORK HOSPITAL - RCB55	G3	501 - OBSTETRICS		720	696	360	318	660	660	0	0	96.7%	88.3%	100.0%	-	197	6.9	1.6	8.5
YORK HOSPITAL - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5400	4927.5	450	517.5	3960	3597	330	330	91.3%	115.0%	90.8%	100.0%	291	29.3	2.9	32.2
MALTON COMMUNITY HOSPITAL - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		1125	1042.5	1575	1597.5	660	660	660	616	92.7%	101.4%	100.0%	93.3%	617	2.8	3.6	6.3
SELBY AND DISTRICT WAR MEMORIAL HOSPITAL - RCB07	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1125	1087.5	1125	1162.5	660	572	330	429	96.7%	103.3%	86.7%	130.0%	558	3.0	2.9	5.8
ST HELENS REHABILITATION HOSPITAL - RCBTV	St Helens	430 - GERIATRIC MEDICINE		900	885	1125	1057.5	660	649	330	330	98.3%	94.0%	98.3%	100.0%	568	2.7	2.4	5.1
ST MONICAS HOSPITAL - RCB05	St Monicas	925 - COMMUNITY CARE SERVICES		600	600	765	780	330	330	330	330	100.0%	102.0%	100.0%	100.0%	327	2.8	3.4	6.2
WHITE CROSS REHABILITATION HOSPITAL - RCB09	Whitecross Court	430 - GERIATRIC MEDICINE		900	877.5	1125	1012.5	660	638	330	330	97.5%	90.0%	96.7%	100.0%	377	4.0	3.6	7.6
	Total			73051.5	64435.5	49533.5	52975.5	44519	40249	27412	31603					28402			

E5

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 31 May 2017

Complaints Annual Report

Action requested/recommendation

The Board of Directors are asked to accept this report as:

- Meeting the requirements of the NHS Complaints Regulations for an annual complaints report
- Assurance that a process is in place within the Trust to receive, respond to and learn from complaints.

Executive Summary

The Trust received 471 formal complaints in 2016-17. 18 new cases were investigated by the Parliamentary and Health Service Ombudsman, with an uphold rate of 42%. The most frequent subjects of complaint is clinical care, patient care and communication. The Trust's Policy on Complaints and Concerns was fully revised and reissued in 2016-17. Operational reports on complaints handling performance and themes/trends are issued each month and assurance reports provided to Patient Experience Steering Group and Quality & Safety Committee. A complaints audit process was introduced in Q4 2016-17 to check for completion of action plans.

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

Implications for equality and diversity

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

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

identified by the Equality Act.

Reference to CQC regulations

This report particularly relates to Outcome 1 (respecting and involving people who use services) and Outcome 17 (complaints).

Progress of report	This report has not been received by any previous committees.
Risk	No new risks are identified in the report.
Resource implications	There are no resource implications detailed in the report.
Owner	Beverley Geary, Chief Nurse
Author	Hester Rowell, Lead for Patient Experience
Date of paper	May 2017
Version number	Version 1

Complaints Annual Report: 2016-17

1. Introduction

The NHS Complaint Regulations require every NHS organisation to produce a complaints annual report.

Effective complaints management is a key part of the Trust's Patient Experience Strategy 2015-2018 which has five overarching commitments:

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

The information set out below meets each requirement as set out in the NHS Complaint Regulations.

18.—(1) Each responsible body must prepare an annual report for each year which must—
(a) specify the number of complaints which the responsible body received;

(b) specify the number of complaints which the responsible body decided were well-founded;

(c) specify the number of complaints which the responsible body has been informed have been referred to—
(i) the Health Service Commissioner to consider under the 1993 Act; or
(ii) the Local Commissioner to consider under the Local Government Act 1974; and

(d) summarise—
(i) the subject matter of complaints that the responsible body received;
(ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;
(iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.

2. The number of complaints which the responsible body received and the number of complaints which the responsible body decided were well-founded

Quarter	Site Name	Total New	Total Resolved	Number Upheld	Number Partially Upheld	Number Not Upheld
Q1	York Teaching Hospitals NHS FT	118	77	3	54	20
Q2	York Teaching Hospitals NHS FT	136	93	6	71	16
Q3	York Hospital	59	50	21	12	17
	Scarborough Hospital	40	51	15	18	18
	Bridlington Hospital	4	3	1	1	1
	Community Services	4	5	0	1	4
Q4	York Hospital	70	56	11	21	24
	Scarborough Hospital	35	31	10	8	13
	Bridlington Hospital	3	3	0	1	2
	Community Services	2	0	0	0	0
Total		**471**	**369**	**67**	**187**	**115**

These are the number of complaints reported via the statutory KO41 return to the Health and Social Care Information Centre.

The decision as to whether the complaint is well founded is made by the investigating officer based on the outcome of the investigation. This is then reviewed for a sample of cases as part of the complaints audit process.

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

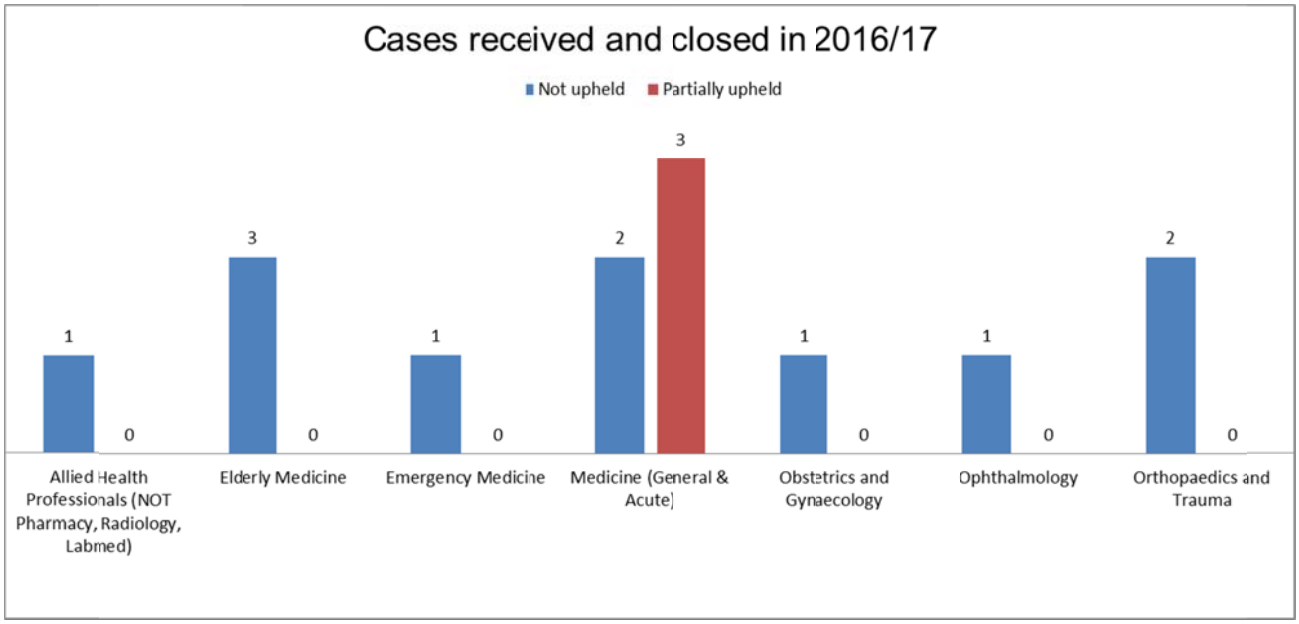
The PHSO investigated a total of 18 cases in 2016/17 compared with 24 in 2015/16.

The table below shows the outcomes of all Parliamentary and Health Service Ombudsman cases closed in 2016-17. The ten closed cases reported in the first quarter were received in 2015-16 and concluded by the PHSO in 2016-17. Four cases received in 2017-18 remain open.

Outcome	Q1	Q2	Q3	Q4	Total
Not upheld	3	2	7	2	14
Partially upheld	6	0	2	1	9
Upheld	1	0	0	0	1
Total	**10**	**2**	**9**	**3**	**24**

Our uphold rate is 42%. The latest data from the Ombudsman (Q2 2016-17) shows that the national uphold rate is also 42%.

The table below shows the outcomes for the 2016-17 cases closed to date by directorate.



4. The subject matter of complaints that the responsible body received

The data below shows the complaints received by directorate.

Directorate	Q1	Q2	Q3	Q4
Allied Health Professionals	5	2	2	3
Acute & General Medicine	21	19	12	19
Child Health	6	5	1	3
Community Services	1	5	4	4
Elderly Medicine	15	12	13	13
Emergency Medicine	11	19	22	15
Estates and Facilities	0	0	1	2
Finance & Performance	0	0	0	2
General Surgery & Urology	8	14	14	15
Head and Neck and Ophthalmology	4	7	5	4
Human Resources	0	0	1	0
Laboratory Medicine	1	0	0	0
Obstetrics & Gynaecology	7	17	8	12
Operations	0	2	1	1
Orthopaedics and Trauma	6	13	9	6
Pharmacy	0	0	1	0
Radiology	4	5	2	4
Sexual Health	0	0	1	0
Specialist Medicine	4	6	5	5
TACC	6	1	4	5
TOTAL	**99**	**127**	**106**	**113**

The table below shows the number of complaints received by subject.

One complaint may have a number of different subjects associated with it. This recognises that complaints are rarely about a single issue and ensures that the Trust's data reflects what patients and relatives are concerned about.

The key themes from this data (which are described in more detail, along with examples of actions and learning in section 6) are:

- Clinical care
    - delay/failure of treatment or procedure
    - missed/incorrect diagnosis
- Patient care: issues about meeting patients' basic care needs
- Communication: giving explanations in a way people can understand and listening to what patient and/or carers are wanting to say.

Subject	Q1	Q2	Q3	Q4
Access to treatment or drugs	3	17	0	1
Admissions, Discharge and Transfer Arrangements	21	42	24	25
All aspects of Clinical Treatment	65	114	94	87
Appointments, Delay/Cancellation	10	67	17	9
Commissioning	0	1	1	0
Comms/info to patients (written and oral)	32	108	48	34
Complaints Handling	0	0	0	0
Consent	0	3	4	3
End of Life Care	3	4	3	5
Facilities	1	13	5	3
Mortuary	0	0	0	0
Others	0	0	0	0
Patient Care	28	58	59	75
Patient Concerns	0	12	3	3
Prescribing	5	11	16	4
Privacy and Dignity	4	9	18	22
Restraint	0	0	0	0
Staff Numbers	0	3	3	2
Transport	2	5	0	0
Trust Admin/Policies/Procedures	3	55	14	9
Values and Behaviours (Staff)	20	76	50	48
Waiting times	0	14	7	9
TOTAL	**197**	**611**	**366**	**339**

5. Any matters of general importance arising out of those complaints, or the way in which the complaints were handled

5.1 Policy on Concerns and Complaints

The Policy and Procedure for Complaints and Concerns was fully revised this year, following significant engagement with internal and external stakeholders.

The new procedure makes directorate managers responsible for the quality and timeliness of responses and for ensuring the person making the complaint is kept informed throughout the process. They are supported by the Assistant Directors of Nursing, Matrons and their deputy directorate managers. The aim of this approach from a patient's perspective is to ensure they receive timely contact (ideally by telephone or face to face) from the person investigating and a timely final response. From an internal perspective the aim is to increase the efficiency of the system (removing repeated re-writes) and increase directorate ownership of issues raised and learning points.

The policy was approved at the January 2016 Patient Experience Steering Group and communicated to stakeholders via the Staff Room intranet policy library, the weekly staff bulletin and direct email to investigating officers. Complaints officers continue to offer support and guidance on the new policy at directorate complaint meetings and on a one to one basis.

5.2 Reporting and data

A monthly Complaints, Compliments and PALS report is sent to Matrons, directorate managers and deputy directorate managers. This includes social media responses from NHS Choices and Patient Opinion. The report was developed throughout the year to include data on compliance with the 30 day target for complaints responses and uphold rates by directorate.

This detailed report is the basis from which higher-level reports for Patient Experience Steering Group and the Board of Directors are created. In November 2016 a new Patient Experience Section for the Board of Directors' Patient Safety and Quality Performance Report was created to give greater assurance about complaints and PALS handling and support the identification of themes and trends.

The increased ownership of quality and timeliness by directorates is being supported by the Patient Experience Team through new Datix dashboards. The Patient Experience team has developed dashboards for each directorate showing live data on current open complaints/concerns and themes and trends by subject and month. Directorates are able to use this information to support their governance processes, including risk identification and agreement/monitoring of action plans.

The Patient Experience team has created new reports to assist Assistant Directors of Nursing with monitoring timelines of Matron-led responses and escalation reports are routinely prepared for the directorate performance assurance meetings. Particular emphasis is being placed on the time to response and whether the investigating officer has kept in touch with the person complaining.

5.3 Training and development

In October 2016 30 investigating officers attended complaint letter writing training, delivered by a specialist external provider. This follows the success of the October 2015 cohort, and again, the feedback was excellent. Individual and team training sessions were delivered by the Patient Experience Team to groups who requested additional support with investigating complaints, giving or requesting statements or using the Datix information management system.

Members of the Patient Experience Team attended the investigating officer training for serious incidents to share the learning and ensure consistency between Trust investigations. The Patient Experience Team also received an investigation skills training session, which was delivered by the Head of Investigations and Learning from another NHS Trust.

5.4 Monitoring Learning and Improvement

An internal audit of the Trust's complaints handling was carried out and reported in Q4.

The following key aspects of the Trust policy were tested within the audit:

- Defined roles and responsibilities for handling complaints and concerns within the Trust and across organisational boundaries.
- Promoting early resolution and a person-centred approach, which focuses on the outcome sought by the person making contact.
- Reducing the risk of repeated failures by ensuring that necessary improvements are appropriately identified and acted upon as a result of feedback.

The outcome was that there was **significant assurance** on compliance with the Local Authority Social Services and National Health Service Complaints Regulations 2009. This covers the Trust's legal responsibilities for handling complaints.

There was **limited assurance** that actions and learning arising from upheld complaints were implemented in practice. This was based on the lack of a systematic process for checking whether actions had been completed and a clear route for providing assurance on learning and improvement.

An action plan has been agreed including:

- Introducing a monthly audit of complaint cases, including following up any agreed actions and the evidence of completion.
- Reviewing the Terms of Reference of the Patient Experience Steering Group to include receiving assurance on learning from complaints.
- Ensuring investigating officers receive adequate training on complaints handling.

6. Any matters where action has been or is to be taken to improve services as a consequence of those complaints.

Clinical care remains the top subject for complaints. Within this, delay/failure of treatment and procedure and missed/incorrect diagnosis are the most frequent sub-subjects. Learning this year has included improving the support provided to ED by the stroke specialist nurse, and teaching for junior doctors about unusual presentations.

Patient Care is the next most frequent subject of complaint. This includes issues around patients' basic care needs: food, hydration, continence, infection prevention, comfort and falls avoidance. Throughout the year matrons have used the learning from complaints to support reflection and improvements in their teams. Particular areas of learning include supporting dementia patients who are not on care of the elderly wards and improving the comfort rounding documentation.

The importance of good **communication** with patients and families continues to be demonstrated clearly through learning from investigations. The new, extended, visiting times of 11am – 8pm and the introduction of John's Campaign aims to support better communication and engagement with families and carers. Work to raise patient awareness that feedback is welcome and give confidence to ask questions includes: new posters on every ward, new Your Experiences Matter leaflet and website content and the relaunch of the Patient Advice and Liaison Service. Communications skills have formed part of the new nurse preceptorship programme and the Patient Experience Team has supported matrons and other service managers with team development sessions throughout the year. Communications skills training is offered through the Advanced Communications for Clinicians workshop and the Sage and Thyme workshop.

Learning regarding **patient access** to services informed work to introduce an online system for contacting the Patient Access Contact Centre to make or amend an appointment. Learning was also used to support the design and introduced of new functionality in the Trust's patient record system (CPD) so that information about patient's communication needs (eg a requirement for an interpreter or translator) are captured.

7. **Looking Ahead to 2017-18**

There are two key areas for development for 2017-18. These are:

7.1 Further developing and embedding the complaints audit process, particularly focussing on checking for evidence that agreed action plans are being completed, and reporting the outcomes to the appropriate operational/assurance groups.

7.2 Working in partnership with directorates, to become more systematic in identifying themes and issues from complaints and triangulating this information with learning from other patient experience sources; then using this learning to inform actions and monitor improvement.

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

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Patient Safety Walkrounds

Action requested/recommendation

Board of Directors are requested to:

- Consider this paper and take note of the instructions provided
- Note that while Patient Safety Walkabouts are very well embedded in the culture of our trust, integrating board walk rounds into the board day is 'experimental' and directors are asked to be willing to contribute to discussion about how this activity to could developed and improved on future occasions.
- Consider how this practical activity can impact on the strategic concerns of the board.

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 other than those specifically referenced in the paper.
Resource implications	None identified.
Owner	Diane Palmer, Deputy Director of Patient Safety
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	May 2017
Version number	1

Board of Directors – 31 May 2017

Patient Safety Walkrounds

1. Introduction

Patient Safety Walkrounds provide an informal opportunity for Executive and Non-Executive Directors to talk with front line staff and patients about safety issues in the Trust. Focusing solely on patient safety during these rounds is a successful strategy for promoting a culture of safety.

As part of the trusts new approach to board working, twice a year, the board will undertake a Patient Safety Walkround on the day of the board. In May this will take place in York and in November this will take place in Scarborough.

Incorporating 2 board walkrounds each year into the board calendar, seeks to ensure that patient safety and listening to staff remain paramount objectives of the board of directors of our trust, as well as developing the visibility of the board on board days. Board walkrounds are at this stage 'experimental' by nature and the board will be asked to provide feedback on how well the process worked and provide any feedback to ensure that the board are continually improving their engagement with the wider trust.

The board walkabouts will share the same goals as all other walkrounds.

Key goals:

- **to help staff become more confident and willing to engage with the safety agenda**
- **to make senior managers and directors more aware of patient and staff safety issues**
- **to follow up on safety issues quickly and effectively**
- **to make staff more aware of safety issues**
- **to improve relationships between the leadership teams and frontline staff.**

Generally the time and place of Patient Safety Walkrounds is announced in advance and should be at a time which allows the Clinical Director, Directorate Manger and Matron to participate. In the case of board day walkabouts, specific directorate management teams will not be expected to participate although their attendance will be most welcome.

We aim to schedule at least four Patient Safety Walkrounds each month in order that all clinical areas and associated departments on all sites of the Trust will have a Patient Safety Walkround annually. Additionally, more recently we have scheduled four out of hours Walkrounds annually.

Staff should be reassured that the purpose is not to inspect or interrogate them but to allow them to raise patient safety concerns and to discuss with the leaders of the Trust how patient safety can be improved.

2. Points to highlight:

- as a Trust we promote a culture of learning from incidents, complaints and near misses
- we know that our staff can provide some of the best solutions to reduce risk and harm to our patients
- we want to develop a culture where we learn from our mistakes and change systems to prevent repeated errors.

3. Suggested questions:

- Can you think of any events in the past day or few days that have resulted in prolonged hospitalization for a patient?
- Have there been any near misses that almost caused patient harm but didn't?
- Have there been any incidents lately that you can think of where a patient was harmed?
- What aspects of the environment are likely to lead to the next patient harm?
- Is there anything we could do to prevent the next adverse event?
- Can you think of a way in which systems or your environment fails you on a consistent basis?
- What more should we do to actively promote a fair and just culture?

4. Organisation

Timings	**Activities**
1-1.50pm	Lunch
1.50-2.00	Introduction to Mike Chitty (NHS Leadership Academy)
2.00-3.15pm	Walkabout
3.15-3.30	Complete actions/notes template
3.30-4.30	Facilitated feedback with Mike Chitty

At the end of the department / ward visit the Patient Safety Walkround lead should agree with all participants, any actions or recommendations identified during the Walkround and document them on the template provided.

The leader should make a brief note of the visit and actions and send these using the template, to Diane Palmer, Deputy Director of Patient Safety and send a copy to all participants of the Walkround.

A monthly summary report of all Patient Safety Walkrounds will be reported by the Medical Director to the Trust Executive Board and Board of Directors.

Who? Note: Executives Board Members will act as the lead for the walkround.	**Where?**
Sue S and Jim T	Elderly Care: Ward 39
Philip A and Brian G	General Surgery: Ward 11 and 14
Dianne W and Andy B	ED and Urgent Care
Libby and Juliet and Wendy	Trauma and Orthopaedics: Wards 28 and 29
Mike S and Mike P	Critical Care and Theatres
Mike K and Sue R	Acute Medical : Wards 33 and 34
Jenny M and Bev G	Paediatrics and SCBU
Jennie A and Patrick	AMU AMB AMC

Board members are asked to return promptly to the board room at 3.30pm in readiness for a facilitated discussion about the findings/outcomes of the walkabouts. This discussion will be facilitated by Mike Chitty from the NHS Leadership Academy who will draw together the common findings from the walkabouts. The board will be challenged to consider how this practical activity can impact on the strategic concerns of the board.

5. Recommendations

Board of Directors are requested to:

- Consider this paper and take note of the instructions provided
- Note that while Patient Safety Walkabouts are very well embedded in the culture of our trust, integrating board walk rounds into the board day is 'experimental' and directors are asked to be willing to contribute to discussion about how this activity to could developed and improved on future occasions.
- Consider how this practical activity can impact on the strategic concerns of the board.

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Diane Palmer, Deputy Director of Patient Safety**
Date	**May 2017**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Workforce Report – May 2017

Action requested/recommendation

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

Summary

The attached document provides information up to April 2017, relating to key Human Resources indicators including; sickness and appraisals.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Outcomes 12, 13 & 14

Progress of report	Board of Directors
Risk	No risk
Resource implications	There are Human Resources implications identified throughout this report.

Owner	Patrick Crowley, Chief Executive
Author	Polly McMeekin, Deputy Director of Workforce
Date of paper	May 2017
Version number	Version 1

Board of Directors – 31 May 2017

Workforce Report – May 2017

1. Introduction and background

This paper provides coverage of work being undertaken to address workforce challenges, as well as key workforce metrics up to April 2017. Of particular note:

- An update on plans to reduce medical locum costs through electronic rostering, job planning reviews and the development of the medical locum bank;
- A high level overview of the Trust's 2016 Staff Survey results, and plans to focus an action plan on weaker results related to violence, harassment and bullying;
- The Trust has received a record 469 applications connected with its Buying and Selling of Annual Leave Scheme;
- The monthly sickness absence rate in March was 4.08%, decreasing from 4.43% in February;
- Demand for temporary nurse staffing in March reached 420.13 FTE.

2.1 Medical Rota Management

Following the approval of a business case to invest in the Medical Rota Management service at the Trust a number of initiatives have commenced:

- Roll out of an electronic rostering system (DRS Realtime) to ensure that all Junior Doctors rota patterns continue to comply with the many complex requirements of the new Junior Doctors contract. This roll out will commence in June 2017 with a pilot of the software, with the full system roll out being completed over 24 months. It is anticipated that an electronic system will free up further resource within the Team to allow for more proactive rota planning and ensure cover is optimised across medical rotas.

- Further development and increase of the Trust's Locum Bank to enable the Trust to cover vacant shifts with the most cost effective resource. The Team have planned an initial campaign to test the market. When the team have evaluated the success of the campaign, this will then be adapted and repeated to ensure that the Bank has the optimum number of locums. To date, 10 junior doctors have moved on to the Bank from agencies including 4 STR Lower and 6 STR Higher grade doctors. Apart from 2 of the STR Higher grades, all of these were previously above the capped rates and incurred a breach each time they worked.

- In conjunction with the Corporate Efficiency team we are adapting a new software system (Giltbyte) that allows for Bank Locum timesheets to be completed electronically from start to finish. The Corporate Efficiency Team is constructing a Business Case to ensure that this system can be implemented. As Giltbyte has the functionality to store all information in an end to end package this will potentially save significant resource as locum claim forms will no longer need to be printed, scanned and tracked.

Other developments include the utilisation of smart phones to improve the efficiency of communication between locums and the Rota Management Team.

2.2 Job Planning

For all 2017-18 Consultant and SAS grade Job Plans, the Trust has established a new approval process. Job Planning Executive Panels for each Directorate have been running since 3 February 2017 reviewing all Job Plans for the forthcoming financial year. At 30 April, 13 Directorate panels had been completed, with 201 Job Plans received to date. A small number of panels are rescheduled in early May, and a number of additional sessions, primarily to focus on the SAS grade Job Plans, are being arranged for May/June.

In addition, a Business Case is currently in production to propose the introduction of an electronic job planning tool at the Trust. This will make the process of job planning simpler and more transparent for clinicians and directorates. If the proposal is accepted it is anticipated that a procurement exercise would be undertaken in the summer, followed by the selection of a preferred supplier and implementation during the autumn.

Full details on 2017-18 completion rates and further analysis will be available at the end June.

2.3 Changes to temporary staffing regulations

NHS Improvement had advised that from 1st April 2017, the Trust could no longer engage staff via agency who were employed substantively in the NHS. The Trust had readied itself to comply with this rule from the point of its introduction; however, following extensive feedback to NHS Improvement about the impact of the rule on temporary workforce supply, NHS Improvement has paused this regulation for an indefinite period of time. As such, the Trust is continuing to engage agency workers irrespective of where they hold substantive employment pending further instruction from NHS Improvement.

Another change affecting agency workers from 6th April 2017 concerns the application of IR35 rules in the public sector. The regulations set out that anyone who provides their services as a limited company (Personal Service Companies / PSCs) must have Paye as You Earn tax and NI deducted from their pay at source. The Trust's position is that all roles undertaken by agency workers who operate as PSCs fall inside of IR35.

NHS Improvement had asked the Trust to submit its plans to comply with the regulations and a further direction that the Trust's expenditure on temporary staffing should not increase as a consequence of IR35. Having reviewed the plans, they have confirmed that they are satisfied with the systems that are in place for the employment of workers via PSCs. They have therefore granted approval for the Trust to continue to employ workers via PSCs during the new financial year should the Trust deem this appropriate.

For its part, the Trust intends to reduce usage of these arrangements where possible, as they contribute to the number of shifts which are being reported weekly to NHS Improvement as breaches of its price cap rules. The new regulations provide an opportunity to review our medical locum bank package and work is currently being undertaken to improve the attractiveness of this option. In the meantime, the IR35 rules have already enabled the Trust to negotiate with two of its most expensive Locum Consultants who were providing their services via PSCs. They have swapped this arrangement for the security of either a bank or substantive contract with the Trust which will be remunerated at a reduced hourly rate.

2.4 Recruitment

<u>York NHS & Adult Social Care Recruitment & Careers Event</u>

The York NHS & Adult Social Care Recruitment and Careers Event was held on 25 March 2017. This involved the Trust working collaboratively with City of York Council and Skills for Care as a means of

enabling the NHS to support adult social care providers in recruiting to fill vacancies.

Approximately 350 people attended the event. There were 29 stands in total at the event from a wide range of areas and specialties. Two of the areas represented; Nursing (including Nurse Preceptorship, Elderly, Critical Care, Renal, General Medicine, Older Peoples Services and Bank Nursing) and Domestic Services, held interviews on the day and were successful in interviewing and offering places to 13 Domestic staff and 13 Nursing Staff. The nursing staff successful in being offered a place included a mixture of qualified nurses, newly qualified nurses who will start in September and staff wishing to join the Nurse Bank only.

Domestic Services Recruitment Event

A Domestic Services Recruitment Event, aimed at recruiting staff for York Hospital was held at Job Centre Plus in Monkgate on 25 April. The Event incorporated an information session in the morning followed by support with application forms and pre-booked interviews in the afternoon. On the day offers were made to and accepted by 11 people, resulting in a total of 274 vacant hours being filled.

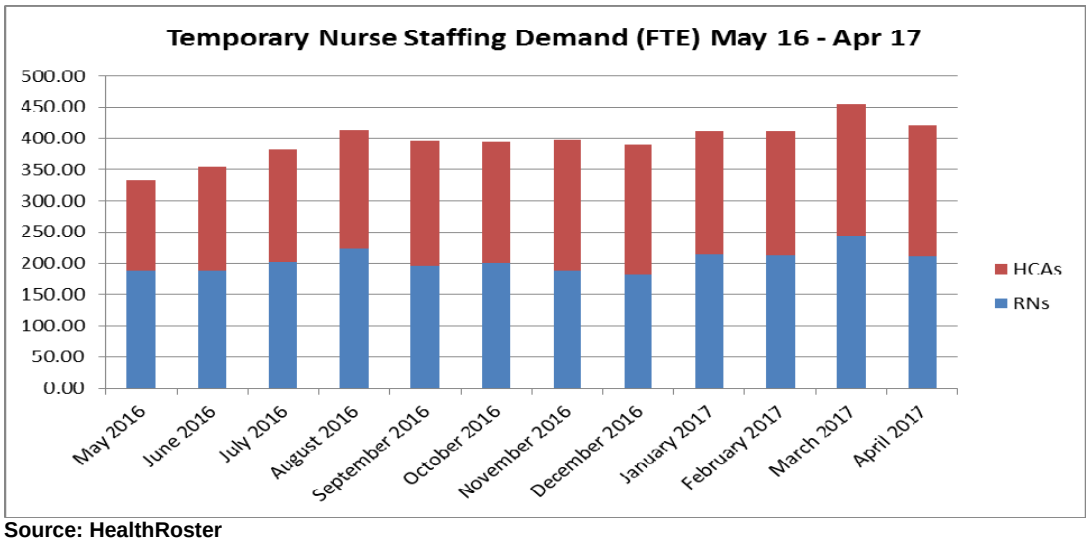
Following this success, another event has been arranged for 8 June to recruit more Domestic Assistants for York Hospital. This will take place at the same venue and will follow the same format.

2.5 Temporary Nurse staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has equated to around 396 Full Time Equivalent (FTE) staff on average per month. However, after having reached its highest ever level in March 2017 since the Nurse Bank was brought in house (454.81 FTE), demand in April 2017 did reduce but was still high at 420.13 FTE. Demand overall in April 2017 was 23% higher than demand in the same month of the previous year (demand in April 2016 was 340.80 FTE).

Demand for both RNs and HCAs exceeded 200 FTE (RN demand was 211.23 FTE and HCA demand was 208.89 FTE).

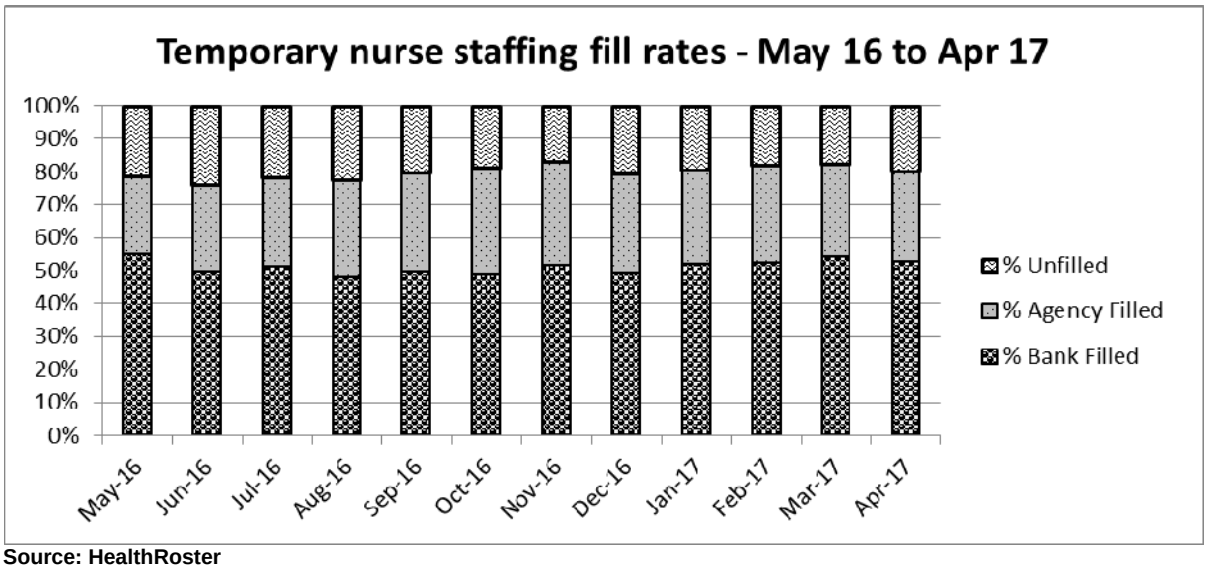
Graph 1 – Temporary Nurse Staffing Demand



Source: HealthRoster

Graph 2 below shows the proportion of all shifts requested that were either filled by bank, agency or were unfilled. Overall, bank fill rates made up 53.0% of all requests in April (reducing slightly from 54.5% in March). Agency fill rates decreased marginally from 27.6% in March to 27.1% in April. The benefits introduced in December 2016 running until 31 May 2017 to incentivise work on the Nurse Bank continue to have a positive impact on bank fill rates particularly given the increasing levels of demand over this period.

Graph 2 –Temporary Nurse Staffing Fill Rates



Source: HealthRoster

Nurse Rostering Project impact on temporary workforce spend

As part of the Nurse Rostering Project, Deep Dive processes are currently underway examining the rostering practises within 28 wards / areas across the organisation. As a means of quantifying the impact of the deep dive work, analysis has been undertaken using agency expenditure as a measure. Although it difficult to gauge, as the reason for temporary workforce expenditure is multi-factoral (vacancies, sickness, enhanced supervision, seasonal demand, etc.,) the analysis does show that those areas who have entered the deep dive process have collectively achieved a net reduction in their agency expenditure of £56,600 over a three-month period to the end of February 2017. Although there is still significant room for improvement in rostering practice among these areas, the findings are an indication that progress is being made.

2.6 Staff Survey

In March, the Trust received the detail its 2016 Staff Survey results. This reported 32 key findings themed around nine areas. The key findings were presented as scores which were benchmarked against those obtained by other combined acute and community NHS trusts, and the Trust's scores from the 2015 Survey. The Trust's results compared favourably to other organisations in areas including equality and diversity, health and wellbeing, appraisals and for the low numbers of staff who witnessed potentially harmful errors, near misses and incidents. There were also a number of findings which ranked below average, which are the focus of an action plan that aims to improve staff experience at the Trust.

The primary focus of this plan is to address some of the Trust's weaker findings related to violence, harassment and bullying. The Trust recorded a 3% increase in the number of its staff experiencing physical violence from patients, relatives or the pubic over last 12 months. The results also highlighted that a high proportion of respondents who experienced violence (38%) hadn't reported their most recent experience. Experiences of harassment, bullying or abuse were also under-reported, with 58% of respondents who experienced abuse not reporting their last experience.

The Trust has a Personal Responsibility Framework but it is recognised that this Framework is not well recognised across the Trust. Work will commence immediately to revise this framework and re-launch it. The work of the Trust's Freedom to Speak Up Guardian is also pivotal. The Guardian has plans in place to mobilise a team of like-minded staff who will act as ambassadors for staff by demonstrating and role modelling appropriate behaviours, challenging inappropriate behaviours and providing support for those who experience any form of bullying or abuse. The plan is to champion the group's work via corporate communication channels. This will then be complimented with the

refresh and re-launch of the Challenging Bullying and Harassment policy, which will build on information received via the staff survey and staff side colleagues.

Updates on these developments, together with other corporate and local initiatives linked to findings from the Staff Survey will be provided later in the year.

2.7 Buying and Selling of Annual Leave Scheme

The Trust's Buying and Selling of Annual Leave Scheme gives employees the flexibility to alter their contractual annual leave entitlement, by either buying some additional leave or selling some of their current entitlement.

Extra holiday may appeal for all sorts of reasons – the chance to spend more time with family, special holidays or time to complete a special project. Alternatively, if employees wish to use less than their full leave entitlement, the scheme gives them the opportunity to exchange some of it for extra salary. This supports the Trust's health and wellbeing agenda in promoting employee engagement, empowerment and ultimately motivation, and creating a positive cultural difference in the Trust.

The 2017-18 scheme was launched in January and has received a significant response. Taking the number of applications received this year together with the data from previous year's schemes, the following has been established:

- The number of applications received has increased each year since the launch of the scheme. In 2011, 150 applications were received. The Trust has received 469 applications in response to the 2017-18 scheme;
- The past two years has seen the greatest increase in applications;
- Approval rates from managers connected to requests to buy or sell leave have increased by an average of 8% over the 6 years the scheme has been running;
- The number of applications over the last 6 years to buy leave has increased from 141 to 445 this year (an increase of 215%);
- The number of applications to sell has increased from 9 to 24 over 6 years (166%);
- The 2016/17 saving for directorates from the scheme was £240,000 and the savings for the Trust from tax and NI was £30,000.

Applications Received

	2011-12	2012-13	2013-14	2015-16	2016-17	2017-18
Total Applications	150	195	250	318	397	469
Applications to Buy	141	184	233	296	373	445
Applications to Sell	9	11	17	22	24	24

Approval Rates

	2011-12	2012-13	2013-14	2015-16	2016-17	2017-18
Total Approved	126	152	208	265	374	426
Percentage Approved	84%	78%	83%	83%	94%	91%
Approved Buying	117	142	191	244	350	406
Approved Selling	9	10	17	21	24	20
Declined Buying	24	42	42	49	20	39
Declined Selling	0	1	0	4	3	4

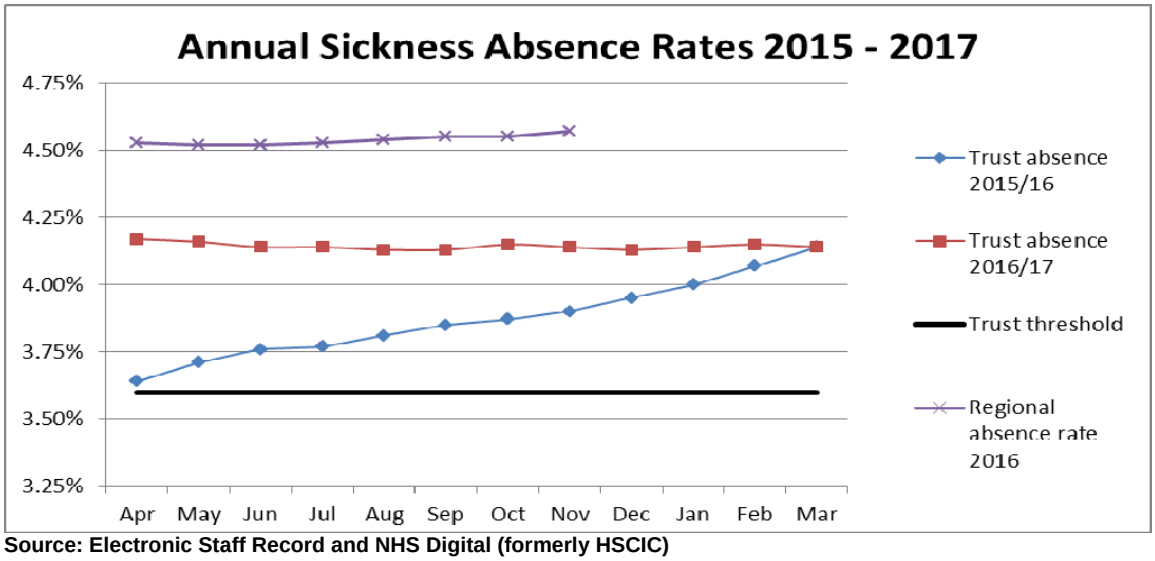
2.8 Sickness Absence

Sickness absence rates

The graph below compares the rolling 12 month absence rates to the Trust's locally agreed threshold and to the regional (Yorkshire and Humber) sickness absence rates. In the last 10 months the Trust's cumulative annual absence rate has remained between 4.13% and 4.15%.

The Trust absence rate continues to compare favourably with sickness absence across the region. There is a delay in the publication of the regional data and currently only data up to November 2016 is available. In the year to November 2016, the regional annual absence rate was 4.57% compared to a Trust rate of 4.15%.

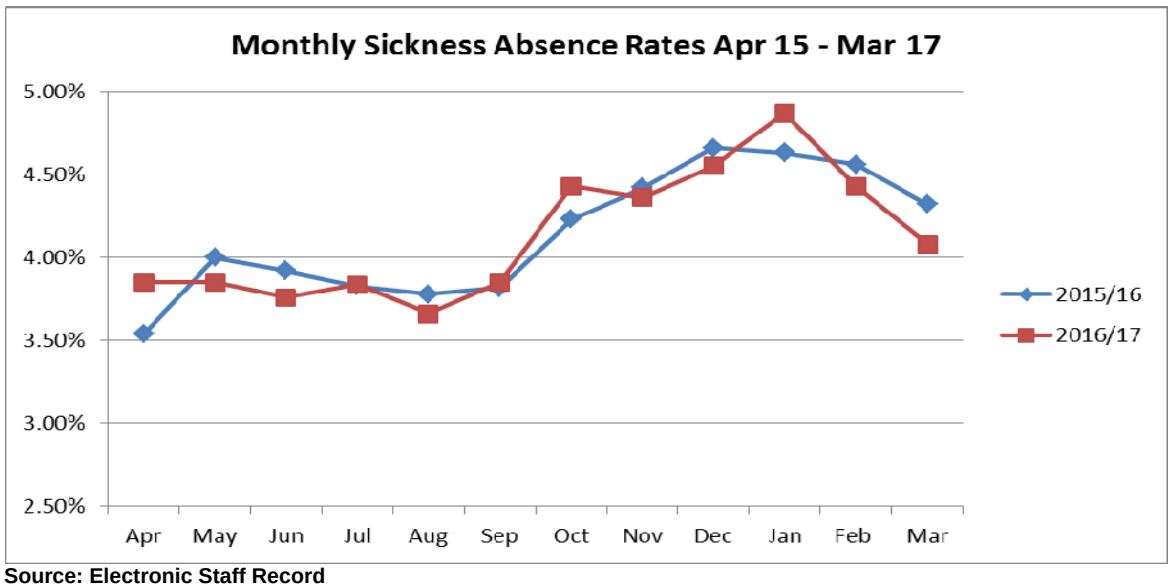
Graph 3 – Annual sickness absence rates



Source: Electronic Staff Record and NHS Digital (formerly HSCIC)

The graph below shows the monthly absence rates from April 2015 to March 2017. The monthly absence rate of 4.08% in March 2017 was a reduction from the previous month's absence rate of 4.43%. It was also lower than the absence rate in the same month the previous year (the absence rate in March 2016 was 4.32%).

Graph 4 – Monthly sickness absence rates



Source: Electronic Staff Record

Sickness absence reasons

The top three reasons for sickness absence in the year ending March 2017, based on both days lost (as FTE) and number of episodes are shown in the table below:

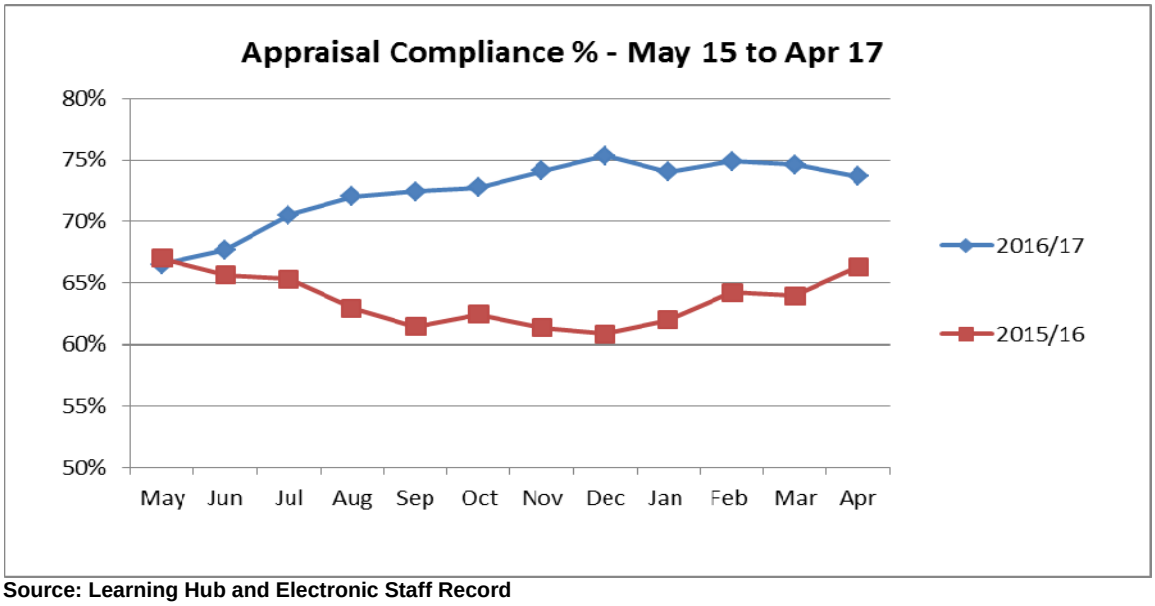
Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
MSK problems, inc. back problems – 20.10% of all absence days lost	Gastrointestinal – 20.73% of all absence episodes
Anxiety/stress/depression – 19.27% of all absence days lost	Cold, cough, flu – 18.67% of all absence episodes
Gastrointestinal – 10.34% of all absence days lost	MSK problems, inc. back problems – 11.22% of all absence episodes

Although sickness absence due to both 'Gastrointestinal' and 'Cold, Cough, Flu – Influenza' accounted overall for just under 40% of all sickness absence episodes in March; there was a reduction in the actual number of sickness episodes due to these reasons with both being at their lowest in the last six months. This, together with the decrease in the monthly sickness absence rate in March, indicates a deceleration in the seasonal sickness absence variation.

2.9 Appraisals

The graph below shows appraisal completion compliance from May 2015 to April 2017.

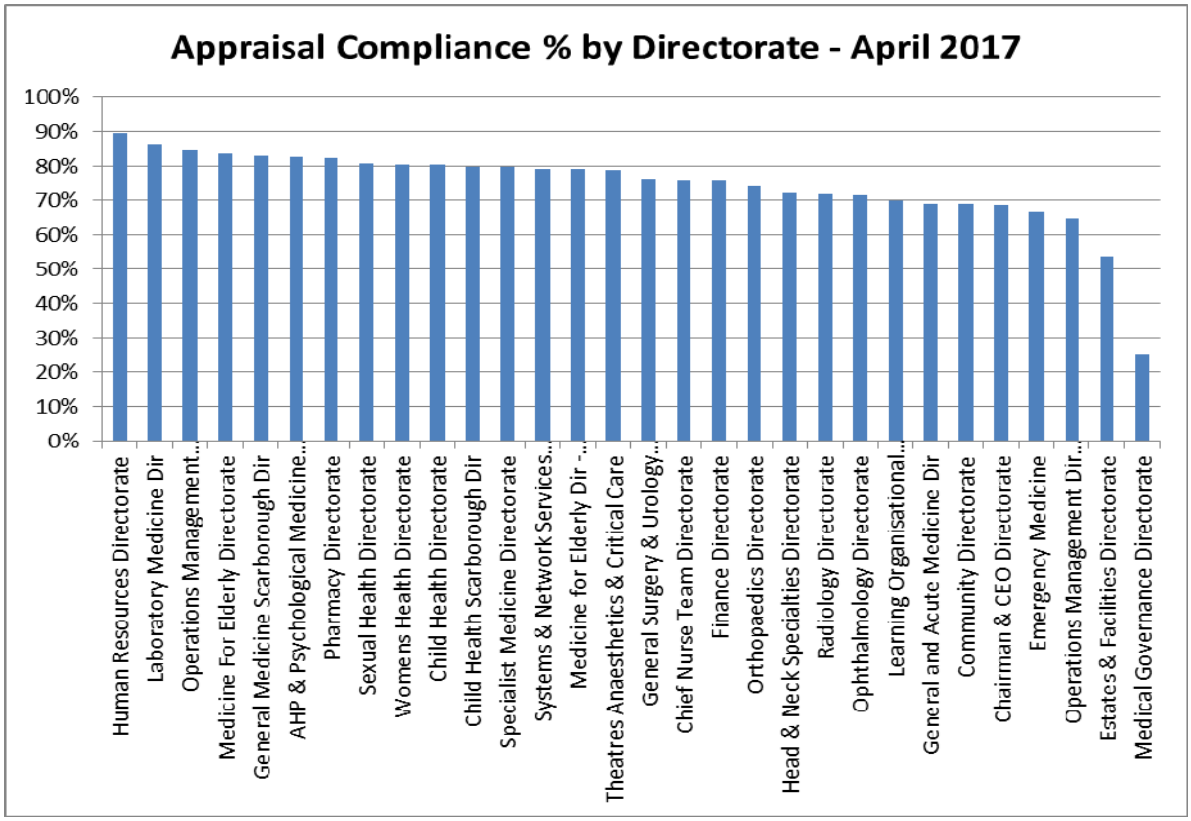
Graph 5 – Appraisal Compliance %



Source: Learning Hub and Electronic Staff Record

The overall Trust appraisal activity in April 2017 stood at 73.7%, a small reduction from the previous month's rate of 74.6%.

Graph 6 – Appraisal Compliance % by Directorate – April 2017



Source: Learning Hub and Electronic Staff Record

Graph 6 shows the appraisal compliance for each directorate in April 2017. Our Staff Survey results indicate that significantly more appraisals – 88% are taking place than are being reported. Directorate management teams continue to be supported to continue to deliver appraisals in line with national and Trust expectations.

2.11 Immigration Skills Charge

From 6 April 2017, the Trust will be required to pay an Immigration Skills Charge when recruiting skilled workers from outside of the European Economic Area (EEA). The charge is a flat rate of £1,000 per person per year of employment, payable upfront at the point at which the Trust finalises an offer of employment to the applicant, and non-refundable in the event that the employment ends prematurely. The Government intends to utilise the funds raised from these charges to address the skills gap in the UK workforce. The charges will not apply to migrant workers who move employers, provided they were already working in the UK prior to 6 April 2017.

Based on analysis of recruitment activity at the Trust during the last two-years, it is expected that the charges will cost the Trust in the region of £48,000 per year. This is based on an average of sixteen medical staff from outside of the EEA being appointed every year. The typical length of a doctor's employment visa has been three-years.

3. Conclusion

This report has detailed key workforce metrics highlighting any issues or trends. In those areas where there are issues, actions which have already been identified have been detailed. The impact of actions will become apparent in subsequent reports.

4. Recommendation	
The Board of Directors is asked to read the report and discuss.	
Author	**Polly McMeekin, Deputy Director of Workforce**
Owner	**Patrick Crowley, Chief Executive**
Date	**May 2017**

Workforce & Organisational Development Committee (WFODC) – 16th May 2017 – YH HQ Boardroom

Attendance: Libby Raper (LR) (Chair) Dianne Willcocks (DW) Polly McMeekin (PM) Brian Golding (BG) Jenny McAlees (JM)
Tracy Astley (mins) (TA)

Apologies: Mike Proctor (MP) Lynda Provins (LP)

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
	The Chair welcomed Jenny McAlees to the committee and noted that she was joining at a time of transition for its work. The Chair thanked Dianne Willcocks for her work in establishing the Committee, and in shepherding it through its development to date.				
1.	**Last Meeting Notes 22nd March 2017**		The minutes were approved as a true record of the meeting and ratified.		
2.	**Matters arising and Action Log**		Action log ratified. <u>Helpforce</u> **Action**: The committee has agreed for Helen Hey to provide a report for the July meeting and invite Kay Gamble to present it. <u>Apprenticeship Strategy</u> **Action**: BG will present paper at the June meeting. <u>York Human Rights City Network</u> The committee was informed that the Trust has signed up to this and DW attended the launch.		
3	**Workforce Board Report**	CRR HR1/2/4 BAF 3.1 – 3.6	PM gave an overview of the Workforce Board Report and outlined some salient points. <u>Medical Rota Management</u>	The Committee were assured by the information received.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			• DRS Realtime will commence roll out in June 2017. DW asked if it will help with some of the issues raised with the Trust's Safer Working Guardian. PM advised that it will help with examining exception reporting and calculate whether this is valid. • 10 locum doctors have moved onto the Trust's Bank from agencies. In hard to fill vacancies the bank rates have had to be flexed in order to entice them with the hope that they will join the Trust in a substantive post in the future. LR enquired how the Trust fairs alongside other trusts. PM advised that some trusts are standing firm with their bank rates. DW advised that over the last year the committee has picked up a lot of intervention from PM with regard to flexibility in working times, in rates, with job plans and requested a paper be presented on flexibility to the committee. PM advised that this will be included in the Retention & Recruitment Strategy that she is to present in September. <u>Job Planning</u> • Job Planning began in February with 13 directorates having meetings to date. This is to continue in May and June to include Specialty and Associate Specialist doctors grades. 201 job plans have been received so far. There is a business case being put forward on the 8th June for an electronic job planning system which should really help the directorates incorporate what has been learnt this time round. **Action:** Invite Glenn Miller to the October meeting to discuss job planning. The committee enquired about Jim Taylor's role as mediator. PM advised that to date there have only been a very small number. JT meets with the directorate concerned and any appeal is managed by HR to a panel which includes an external doctor for an independent view.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			The committee asked if the peer presence at the job planning meetings still exists. PM advised that there are a few who attend who are also LNC reps. <u>Recruitment</u> From the Domestic Services Recruitment Event held on 25th April, 11 staff were recruited to domestic services. BG and PM have joined with UNITE to discuss the retention issue on the York site and they are also getting staff to feedback. Gail Dunning in ODIL is also involved with improving their working environment. <u>Immigration Skills Charge</u> From 6th April 2017 the Trust will be required to pay an Immigration Skills Charge when recruiting skilled workers from outside of the EEA. The charge is a flat rate of £1000 per person per year of employment, payable up front. Based on analysis of recruitment activity it is expected that the charges will cost the Trust in the region of £48k per year. <u>Appraisals</u> The committee noted the spread of performance across Directorates. It asked about that of the Chairman & CEO directorate and wondered what might be done to assist it in being a leader by example. The committee enquired how the Trust monitors appraisal rates. PM advised that they are discussed in the Performance Assurance Meetings, and each directorate gets a breakdown each month. <u>Sickness</u> The committee asked for assurance that everything possible is being done. PM advised that:- • The sickness policy is being reviewed to put support in place at stage 1 of the sickness process rather than at stage 3 as it is at present.		The Chair will note this at Trust Board. The Chair will note this at Trust Board.

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			The support should be agreed at return to work interviews. • She advised that the principles have been agreed with staff side and now it is a matter of adding in the details. • She also advised that HR are expected to be more challenging as many managers do not want to have those difficult conversations due to retention issues. The committee queried why there was a steady increase from April last year until now which has leveled out. PM replied that it appears reflective of the pressure the Trust is under. Shifts are currently extremely busy and can feel hectic, and staff may take this into consideration when deciding whether they are fit to attend work.		
4	**Medical Staffing Update**	CRR 1/4/8/9 BAF 3.1-3.6	PM gave an overview of the Medical Staffing Report. The key point was that in order to entice more staff to the Trust the BMJ adverts are being rebranded and a video is being made to showcase the unique selling points of working at Scarborough. **Action**: PM to send to the committee the BMJ adverts.		
5	**Review of Workforce & OD Strategy - Learning**	BAF 5/6	Members of the committee commented that it does not really address the issue of being a learning environment which the Trust aspires to be. Key issues need to be added that would indicate what the strategic aim is. BG added that the apprenticeship program needs to be incorporated into it. JM highlighted the numeracy issue which occurred when recruiting to the new trainee nursing associates program and asked if the Trust could not link with the local college who would offer numeracy and literacy skills in order to maximize all staffs' potential. DW recognised that the paper at present concentrates very much on formal learning with measureable skills and outcomes. She advised that learning takes place in all sorts of ways and would like Gail Dunning to continue working on this and come and talk to the committee about it.	The committee was assured on receipt of the WFOD Strategy, but felt that the learning element could be better expressed.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			Action: Invite Gail Dunning to the next meeting in June.		
6	**Apprenticeship Update and Monitoring Report**		BG gave overview of the Apprenticeship Reforms – Project Managers' update. He advised that Kathy Skilbeck is leading on the clinical side and Julie Colquhoun is leading on the non-clinical side. The Skills Funding Agency has allocated the Trust an accounts Manager called Mike Long. BG advised that the contents of the report will be submitted to the Trust Executive Board for information only. The committee was advised that, within the organisation, this will sit with Anne Devaney and Gail Dunning. The committee then moved on to the Apprenticeship Progress Monitoring Report. BG anticipated that the non-clinical posts will be going live in June/July this year with a significant number starting August/September to coincide with college start dates. The committee asked for a committed acknowledgement at this stage that there are firm plans in place. BG advised that his team would need to manually track progress and determine how to measure success. BG added that there is currently no mechanism for medical training grades to be involved in the apprenticeship levy programme, and felt that this might present an opportunity for the future. The committee agreed that BG would update them on a quarterly basis and include statistics of any outliers where the Trust is failing to get movement.	The Committee was assured by the receipt of the quarterly report.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
7	**Staff Survey Action Plan 2017**		PM gave overview of the Staff Survey Action Plan 2017. Key points were:- • Personal Responsibility Framework (PRF). She advised that this document needed rebranding and re-launching. • FSU Guardian is expanding on the Fairness Champions who will model appropriate behaviours throughout the Trust. • The Bullying & Harassment Policy will be reviewed and will take into account inappropriate behaviours from patients, particularly the elderly with dementia. • Fiona Jamieson is leading on revamping the Datix reporting system and will be producing a report for the Executive Board in the Summer. At present staff feel they are not being made aware of outcomes and therefore feel reluctant to report anything. The committed noted CQC interest in Datix. LR felt this needed to be brought to the Board's attention. • Presenteeism. The sickness policy is being revamped. PM advised that the paper will be presented to the Corporate Directors next Monday (22/05).		Chair wanted to bring this to the Board's attention.
8	**Education Review Group TOR**		In the absence of Mike Proctor it was agreed by the committee to defer this paper and re-submit in June.		
9	**Arts Steering Group TOR**		The committee agreed that the Arts Steering Group should report into the WFOD Committee annually.		
10	**ERG Minutes**		To the committee for information only.		
11	**Fairness Forum Minutes**		The committee expressed an interest in being kept up to date with the Fairness Forum.		

	Agenda item	AFW/ CRR	Comments	Assurance	Attention to Board
12	**Risk Register and BAF action plans**		Risk Register HR12 PM informed that she had added a risk regarding the medical workforce and the risk to service delivery caused by low fill rates from HEE for Core Medical Trainees at SGH. The committee enquired how PM is managing that between herself and the medical director's team. PM advised that she is having conversations about trainee fellowship roles, and looking at other trainee type roles, Advanced Clinical Practitioners (ACPs), etc. The committee asked if the development of the new roles is a way forward. PM replied that it is only round 1 and she expects the position to improve but is dependent on the areas as there is still a cultural huddle of doctors who do not want the creation of new roles. PM informed the committee that she is leading on work for ACP need across the STP for the next 5 years. She is working towards training up 15 ACPs per year to plug the gaps. Other ideas include embracing the medical training initiatives. HR9 PM gave an overview of the current lack of electronic rostering solution for medical staff, as stipulated within the new junior doctor contract. She advised that links are being made with provider of an electronic rostering solution and a business case is being developed for procurement. HR10 Lack of professional accountability for all bank only workers. The committee requested PM to alter HR10 to take into account the Trust's support.		New risk HR12

	Agenda Item	AFW/CRR	Comments	Assurance	Attention to Board
13	**AOB**		BG brought to the Committee's attention the issue on pay banding of Band 1 Domestic Assistants. Historically they started on the minimum scale and progressed for 2 years. Over time this became eroded with the introduction of the National living wage and A4C. An options paper will be shared with staff side and will be presented to the corporate directors on Monday (22/05). It will also be tabled at JNCC next week (25/05). The committee enquired how the Trust is helping its European staff to feel more secure. DW advised of support offered at York St Johns. PM confirmed measures in progress across the Trust.		
14	**Items for Board**		• <u>New Risk Register No: HR12</u> Risk to service delivery caused by low fill rates from HEE. Although the position may improve in rounds 2 and 3 it is unlikely that all places will be filled. • <u>Immigration Skills Charge</u> Based on analysis of recruitment activity it is expected that the charges will cost the Trust in the region of £48k per year. • <u>Datix Reporting System</u> Highlight to the Board that this was in the CQC report and anticipate this will be revisited upon their return. • <u>Appraisal rate in Chairman & CEO directorate</u> This directorate needed to lead by example. • <u>Staff Survey</u> The committee wanted to reiterate the need for embedded learning into any actions from the results of the staff survey.		
15	**Next Meeting**		The next meeting is arranged for 20th June 2017, 16:00 – 17:30, YH HQ Board Room.		

Action Points: Workforce & Organisational Development

Committee Date of Meeting – 16th May 2017

Month	Action	Responsible Officer	Due date	Completed
January	Produce a Mental Health workstream update to the committee in six months' time.	Elaine Middleton	June meeting	Elaine Middleton to attend.
March	Produce a Recruitment & Retention Strategy for SAS grades updated to the committee in six months' time.	PM	September meeting	
May	Present Apprenticeship strategy paper at next meeting.	BG	June meeting	On agenda.
May	Ask Helen Hey to provide a report on Helpforce for July meeting and invite Kay Gamble to present it.	PM	July meeting	Helen Hey informed. Invitation sent to Kay Gamble.
May	Invite Glenn Miller to the October meeting to discuss job planning.	PM	October meeting	Invitation sent.
May	Send to the WFODC the BMJ adverts.	PM	Immediately	Adverts sent 16/05/17

May	Give apprenticeship update on a quarterly basis including statistics.	BG	September meeting	
May	Review of Research Strategy deferred until June meeting. Invite Lydia Harris.	MP	June meeting	Lydia Harris to attend.

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Freedom to Speak Up Report

Action requested/recommendation

The Board read and note the report.

Summary

This is the second report of the Freedom to Speak Up Guardian (FTSUG) which summarises the number and nature of concerns being raised to the FTSUG, the development of the role over the last six months and the impact it has had within the organisation.

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

No reference to CQC outcomes.

Progress of report	Report on Freedom to Speak Up
Risk	No Risk

Resource implications	Implications for the FTSU Guardian.
Owner:	Patrick Crowley, Chief Executive
Author:	Lisa Smith, Freedom to Speak Up Guardian
Date of paper	May 2017
Version number	V1

Board of Directors – 31 May 2017

Freedom to Speak Up Report

1. National Guardian Office (NGO) update

The trust hosted a visit by the NGO in February. Feedback was very positive and following on from this we have been identified to lead nationally on some areas of good practice, including the joined up work between the FTSUG and the Organisational Development and Improvement Learning (ODIL) team around leadership programmes. The trust also hosted the second Regional meeting, chaired by our Freedom to Speak Up Guardian (FTSUG).

The first annual national conference was held in March which was attended by the trust FTSUG, which included presentations on the handling of concerns and the management of whistleblowing, given by the Civil Aviation Authority and Aviva Insurance Group, as well as a very personal and moving experience presented by a consultant anaesthetist who was himself a 'whistle-blower'.

From 12 June 2017 the NGO will officially commence its case review process to look into cases referred to it where it appears that there is evidence that an NHS trust has not appropriately responded to a concern raised by its staff. Referrals will be accepted from current individual members of NHS staff, FTSUG or regulators (plus staff whose employment ended up to two years ago).The process will run for a twelve-month trial period, after which it will be reviewed and any necessary changes and improvements made. This will include considering all feedback received from those parties involved in a case review. The principal purposes of a case review are to look into how a speaking up case was handled and to make recommendations where this did not meet with good practice. Standards of good practice against which a review will assess the handling of concerns and involvement of other agencies is set out in the Francis Freedom To Speak Up report. A central focus will be learning, not blaming. Case review recommendations can include asking a Trust to take action to remedy problems identified with speaking up culture, policies or procedures. They will work collaboratively with the Care Quality Commission (CQC) and NHS Improvement to ensure that where a case review identifies the need for improvement to support speaking up the necessary steps to achieve this will be taken. As part of their new inspection process CQC inspectors will assess the processes trusts have in place to support Freedom To Speak Up Guardians, as well as speaking up policies, procedures and culture.

The trust FTSU Guardian contributed to the development of the case review process through a stakeholder meeting and has provided advice to the NGO on criteria for the CQC inspection regarding speaking up.

2. Freedom to Speak Up

Promoting the FTSUG role

Further to the initial launch of the role in the autumn, work has continued to raise the profile, visibility and accessibility of the FTSUG in the Trust. In April the FTSUG joined the Chief Executive on his regular Staff Brief video in response to the staff survey results. From May the FTSUG will be attending each corporate induction or using the above video clip to ensure all new starters are aware

of the role.

Work is currently underway jointly with the communications team and the ODIL team to integrate the Health Education 'raising and handling concerns' training video with local messages and upload these onto the Learning Hub as well as introducing them as part of the local induction programme. 'Drop-in' sessions at Malton, Selby and Bridlington were advertised throughout March, but not one staff member attended.

The FTSU Guardian will be part of the exhibitions at the forthcoming Patient Safety Conference at York Racecourse.

Training and development

Throughout March and April the FTSUG gave training presentations to a regional Audit Committee, Nursing Associates and Health and Social Care students, both internal and external with very positive feedback.

The FTSU Guardian is working with the ODIL team to develop some bespoke training on raising and handling concerns as part of all the leadership programmes.

In July, the FTSUG and Chief Nurse have been invited to give a joint presentation at the national Deputy Chief Nurse Congress on how to support creating an environment for nurses to speak out, and deliver a case study to demonstrate what's working, and what the results are so far.

Trust culture / staff survey results

Being free to speak up requires a significant culture change in the NHS, the FTSU Guardian role cannot achieve this single-handedly in the organisation, culture change comes from leadership at all levels in the organisation and living the Trust values makes a huge contribution to this culture. Ensuring staff are aware of how to raise and handle concerns is everybody's responsibility.

The 2016 staff survey indicated a deterioration in:

- The percentage of staff who feel confident and secure in reporting unsafe clinical practice
- The percentage of staff experiencing physical violence from staff in the last 12 months
- The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
- The percentage of staff experiencing discrimination at work in the last 12 months.

There is an action plan being drafted to address these issues, but clearly there is a role for the FTSUG in improving the staff experience. There still appears to be a reluctance for staff to use the trust's Datix/Airs reporting system due to a number of factors; 'clunkiness' of the system, lack of feedback, fear of reprisal and apathy that it will bring about improvement or change.

There are a number of projects the FTSUG is involved in, including:

Fairness Champions

The culture of an organisation has a huge impact on its ability to improve quality and safety. This project aims to support a campaign which focuses on the Trust values by promoting an open and

transparent culture where staff feel safe and free to raise concerns in the interests of patient and staff safety through the recruitment and development of the Fairness Champion role. Fairness Champions can play a key part in tackling the issues highlighted in the staff survey. By improving the experiences of staff we improve the experience of the patients under our care. In order to do this effectively and to reach all parts of an organisation that is geographically diverse it is important to develop a network of Champions who will promote the Freedom to Speak Up agenda.

The ambition is to recruit a much wider, diverse range of staff from all grades/departments who colleagues can relate to across all sites and the recruitment campaign is being launched in the summer.

Swartz Rounds

Schwartz Rounds (SR) provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care. The underlying premise for Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work.

The trust will go live with Swartz Rounds in the Autumn, and the FTSUG will play a key role on the Steering Group by providing 'soft intelligence' to the group on areas where a SR may be beneficial and by linking parts of the organisation together to help raise the profile of 'speaking up' and has already discussed with the possibility with emergency department as being the pilot for a SR.

Internal audit

Audit fieldwork is still on-going and feedback to date has indicated that the trust is compliant with the 'Freedom to Speak Up' principles. We anticipate the report will be issued in the next few weeks.

Raising concerns / whistle-blowing policy

NHS England has set minimum standards for whistle-blowing / raising concerns and the expectation of the National Guardian is that these are incorporated into trusts own local policies. As a result, the trust policy has been amended and updated to reflect these standards and is now available on Staff Room.

3. Concerns raised

Since the launch of the role at the end of September 2016 to the end of April 2017 the total number of individual 'speak up' contacts has been 67. The current number of 'open' cases is 12. Trust site breakdown is as follows:

- 41 York
- 20 Scarborough

- 5 Bridlington
- 1 Community.

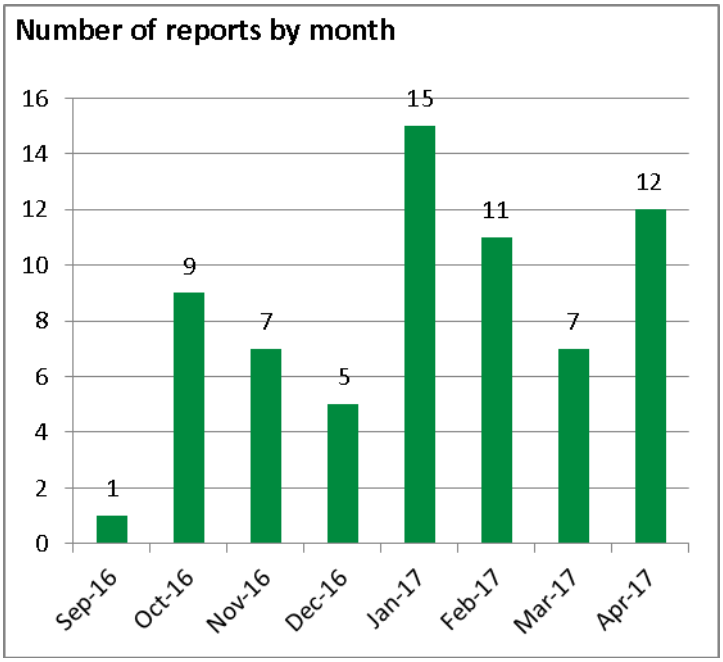
None of the individuals who have contacted the FTSU Guardian have done so anonymously – this is encouraging as it helps establish trust in the independence and confidentiality of the role, as well as providing the FTSU Guardian an opportunity to feedback to individuals and ensure no detriment is suffered as a result of raising a concern.

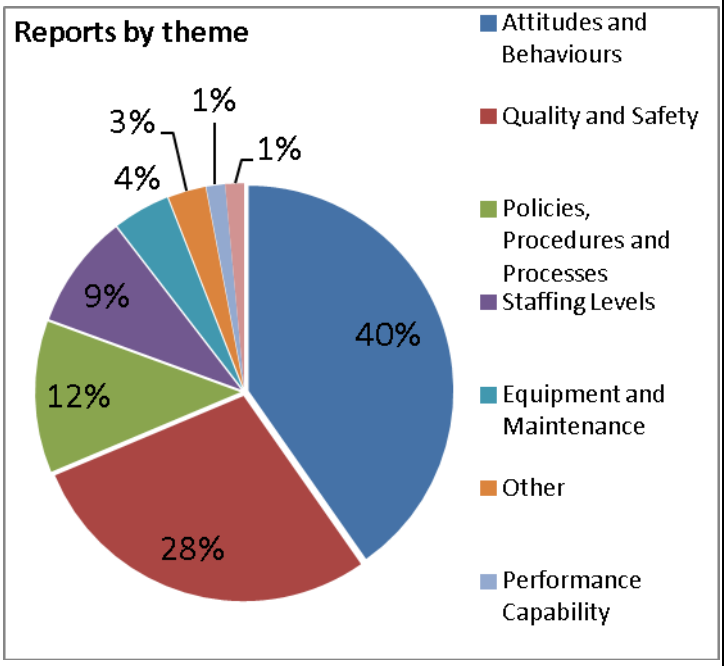
Intelligence gleaned from the regional network suggests this number remains somewhat higher than that experienced by FTSU Guardians nationally, early indications of average number of speak up contacts per month is between 3-5 depending on the size of the trust – compared to 9.5 per month for this trust.

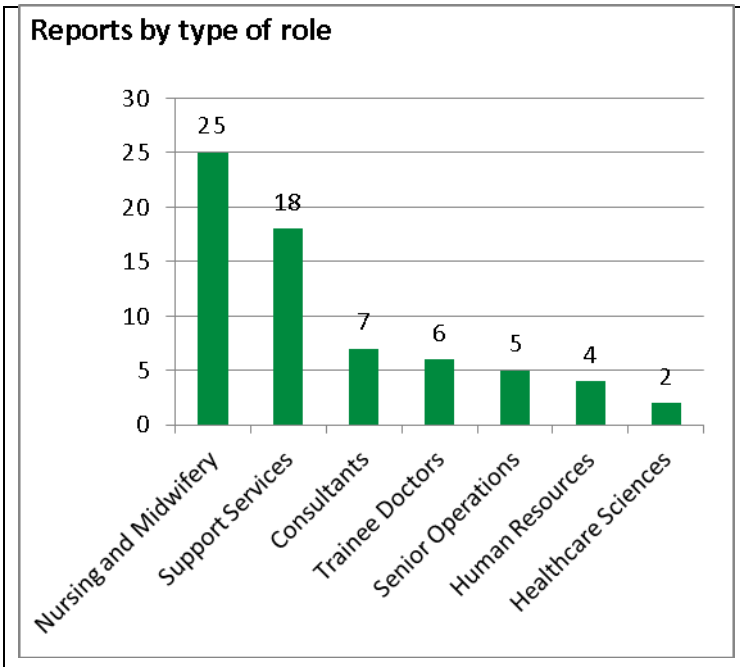
The charts below detail numbers of concerns received for each month, the job roles of the individuals contacting the FTSU and the main themes. The wide range of individuals who are raising concerns indicates that the role has reached all parts of the organisation. However, there is a challenge around the community services, where there has only been one contact made with the FTSU Guardian in seven months.

Many trusts nationally are struggling to engage junior doctors in the freedom to speak up agenda. It is therefore encouraging to note that a number of junior doctors have felt safe to raise concerns and this may be attributed to the fact that the trust has appointed one individual to the role of FTSU and Guardian of Safe Working, they account for 10% of all contacts which is proportionally high given they only make up 5% of the overall workforce.

There have been no immediate patient safety concerns raised.







Following the closure of a concern, where appropriate, individuals are sent an anonymous survey to complete. The results to date are shared below.

- *How did you find out about the Freedom to Speak Up Guardian role?*
  - 30% 'Staff intranet' / 60% 'Staff newsletters' 10% 'Other'

- *How did you find the response from the Guardian?*
  - 100% said 'very helpful'

- *Did you feel your concerns were taken seriously?*
  - 100% said 'Yes'

- *Did you receive regular feedback from the Guardian?*
  - 100% said 'Yes'

- *Has your concern been addressed?*
  - 70% said 'Yes' / 30% said 'in part'

- *Did you feel you were treated confidentially?*
  - 100% said 'Yes'

- *Have you suffered any detriment as a result of raising your concern?*
  - 90% No 10% Yes

- *Based on your experience of raising a concern, would you do it again?*
  - 100% said 'Yes'

Some examples of individual feedback

"I understand that there have been some improvements, but we will continue to monitor the situation and take further action if required. Many thanks for your time- just talking things through with you

gave me the courage to deal with this."

"Thanks so much for listening. Everyone was keen to know how we had got on and is relieved to know that you took our concerns seriously. It is a relief just to have sat down and acknowledged that we have a problem. Your help is very much appreciated."

"Someone who not only gave us their word but delivered too. Thank you very much indeed for speaking up on behalf of our team. It sounds promising and has given us hope that improvement is on the way. I will certainly keep you informed of the progress of the ward. We are all very grateful to you."

"I feel reassured that I have voiced my concerns; and thank you for the email below."

"I think it is being tackled sensitively as a meeting had happened but it sounds like it was diplomatic etc. so fingers crossed but all the necessaries have or are =starting to be addressed/highlighted – thank you for helping."

"Thank you for your email and for meeting with me. I really do appreciate your advice and support it's great to see that other issues are being addressed as well in addition to the concerns I have expressed about staffing. So thanks for all your efforts!"

"Yes I am aware of some of the actions already being taken by the senior nurses and manager and I was at the meeting It's very encouraging to see these responses from them and it's great to see that other issues are being addressed as well in addition to the concerns I have expressed about staffing. So thanks for all your efforts!"

"I was advised to get in touch with you, I'm so glad I did, your help and support was a breath of fresh air you made sure everything was done fairly, you gave me the courage to carry on, your hard work is invaluable, once again thank you so very much for all your support."

Learning not blaming

The FTSU Guardian is able to provide is a unique perspective from the employee confiding candidly about how Human Resources (HR) deal with staff and support managers, and how their practises impact on them.
The FTSU Guardian currently attends the HR senior team meeting to share intelligence, but from this month it has been agreed that there will be a monthly anonymous case review to share learning and implement required changes to improve staff experiences where this impacts on HR policies, procedures and processes.

Currently the HR team is reviewing the grievance and disciplinary procedures to reflect a more personal approach that helps manage expectations. Information from concerns raised has helped HR with the view that the Personal Responsibility Framework needs to be re-designed and re-launched.

The FTSU Guardian also attends the senior ODIL team meetings to share intelligence around current OD projects and where there may be some challenges that are best addressed through an organisation learning approach (as opposed to HR procedures) and this approach is currently being delivered in one department in response to a number of individual concerns raised to the FTSU Guardian.

Challenges

Challenges remain around ensuring staff feel safe to speak up and that by speaking up it will make a difference.

The FTSUG handles complex cases, ensuring policies work in parallel to tackle the issues being raised is part of the learning and sharing relevant intelligence and, where appropriate to identify patterns of behaviour/wider underlying issues (e.g. bullying, victimisation) to identify appropriate people or functions to support employees.

Ensuring FTSUG resilience and capability, training and development needs are key to the success of the role and the positive impact it can have on an organisation.

4. Conclusion

Whistleblowing is an essential component of good corporate governance which needs to be embraced at the top of the organisation. An effective Board will ensure that the right culture is in place, paying particular heed to employee confidence in raising concerns and to monitoring the ways in which they are dealt with – avoiding any repercussion or detriment is essential.

The expectation is that implementation of all the above actions and projects will help improve the experience of all of our staff and the results will be seen in next year's staff survey.

5. Recommendations

The Board read and note the report.

Author	**Lisa Smith. Freedom to Speak Up Guardian**
Owner	**Patrick Crowley. Chief Executive.**
Date	**15/05/17**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Guardian of Safe Working Report (May 2017)

Action requested/recommendation

The Board are asked to

1. read and note this report.
2. encourage clinical directors, directorate managers and educational and clinical supervisors to be aware of their responsibilities within the new contract and continue to support junior doctors to work safely.

Summary

This paper sets outs the background and context around the introduction of the Guardian of Safer Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust.

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

No reference to CQC outcomes.

Progress of report	Initial Report
Risk	Lack of engagement from affected staff. System failure.
Resource implications	Implications for clinical time from supervisors. Significant new administration functions requiring additional resource. Payment and TOIL to junior doctors for working over work schedule
Owner	Patrick Crowley, Chief Executive
Author	Lisa Smith, Guardian of Safe Working
Date of paper	May 2017
Version number	Version 1

Board of Directors – 31 May 2017

Guardian of Safe Working Report (May 2017)

1. Introduction

This paper sets out to execute the responsibilities of the Guardian of Safe Working (GSW) by giving assurance to the board that doctors are working safe hours. The report includes aggregated data on exception reporting, broken down by categories such as speciality, directorate and grade and where appropriate, and will give details of any fines levied against departments for breach of terms and conditions relating to safety.

It aims to:

- Identify to the board any areas where there are current difficulties maintaining safe working hours, including rota gaps / staff vacancies and locum usage
- Outline to the board any plans already in place to address these
- Highlight to the board any areas of good practice and/or persistent concern which may require a wider, system solution.

2. Update from the Guardian of Safe Working

The second national conference for GSW was held in March in London. The trust GSW was one of four guardians nationally to be asked to run the workshop sessions in the afternoon. This helped to raise the profile of the trust in the way it has implemented the role and the links being made to the overall culture of raising concerns.

For the first time nationally, links were made between the GSW and the Freedom to Speak Up Guardian (FTSUG) and there was recognition from the Care Quality Commission (CQC) that learning was to be had from the implementation of the FTSUG role in trusts. CQC will be inspecting the GSW role as part of the well-led domain.

However according to a recent survey by Royal College of Physicians, only one in five doctors know who the FTSUG is in their trust and, of those who do, fewer than one-third believe that the guardians have helped to improve the culture of transparency and raising concerns in their organisation. Those surveyed were also asked, more broadly, whether doctors in their organisation feel confident in raising concerns and issues. The results indicated that doctors are almost split down the middle on this – with fewer than half agreeing that this was the case, and a similar number stating that they did not feel doctors in their organisation were confident to speak up.

While it is likely that the many FTSUG are still bedding down into their organisations, it is concerning that the majority of doctors don't know who their guardian is, and that, of those who do, the vast majority feel that they have made no improvement to the culture of transparency and raising concerns. It has never been more important that doctors, and all staff working within the NHS, are confident in raising concerns over patient safety.

Therefore, it is encouraging to note that a number of junior doctors have felt safe to raise concerns with this trust's Freedom to Speak Up Guardian (junior doctors account for 11% of all staff raising concerns) and this may be attributed to the fact that the trust has appointed one individual to the role of FTSU and GSW whereas many trusts nationally are struggling to engage junior doctors in the Freedom to Speak Up agenda.

In addition, this is one of the only organisations to have also appointed a non-medic to the role of Guardian, which may be contributing to the confidence the juniors have in the independence of the role.

The GSW will be part of the exhibitions at the forthcoming patient safety conference to promote the role and the impact on patient safety and will be joined by the Vice Chair of the Juniors Doctors Forum.

The GSW attended the anaesthetic clinical governance meeting in May to give a presentation on the new contract and exception reporting which was well received by the department.

Junior Doctors Forum

The DME and the Guardian have established the Junior Doctor Forum; there is one forum across both hospital sites. After a slow start, engagement from junior doctors has become more encouraging, there are now 14 junior doctor's members, although regular attendance has been patchy. In an attempt to improve attendance the Medical Director has agreed to give all junior doctors protected time to attend meetings. All members receive a certificate of achievement at the end of their academic year to put into their portfolios.

A junior doctor was appointed as the Vice-Chair in March which has been a significant benefit to engagement and transparency and discussions are on-going around the constitution and voting rights of members, particularly regarding the issue of disbursements of fines.

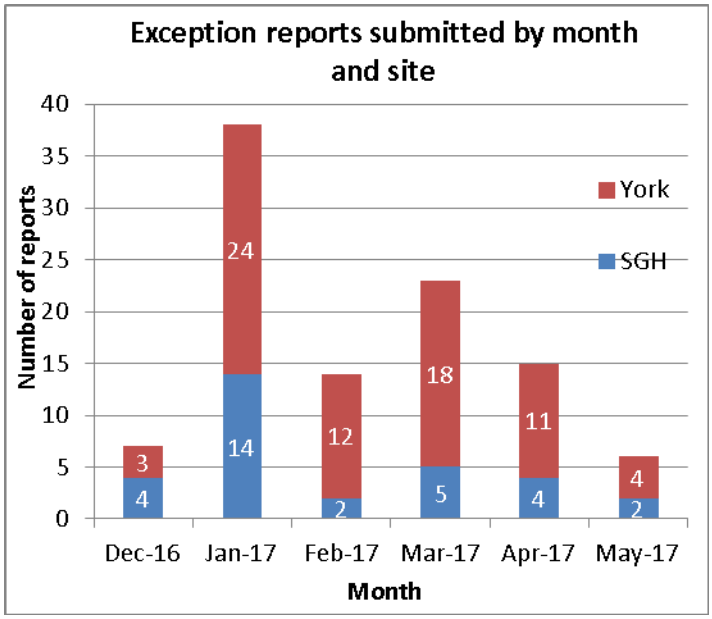
The forum is currently drafting a newsletter to disseminate some of the messages around the new contract and to promote the work of the forum.

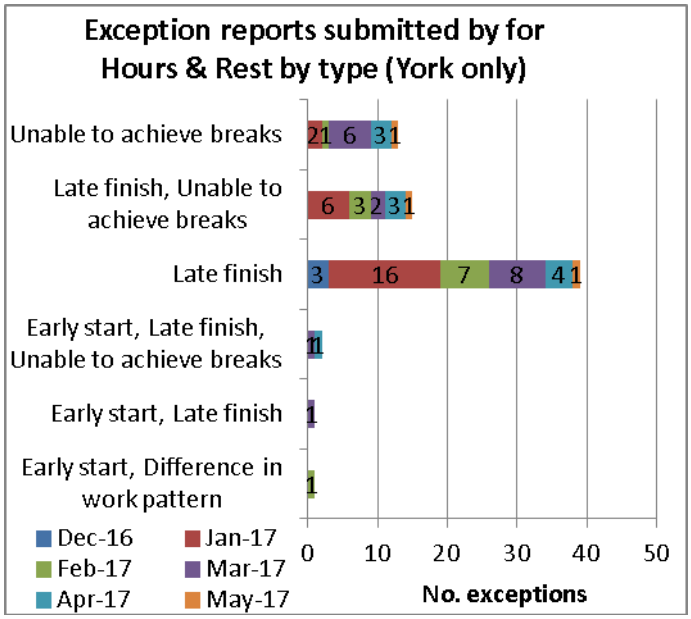
Exception reports and fines

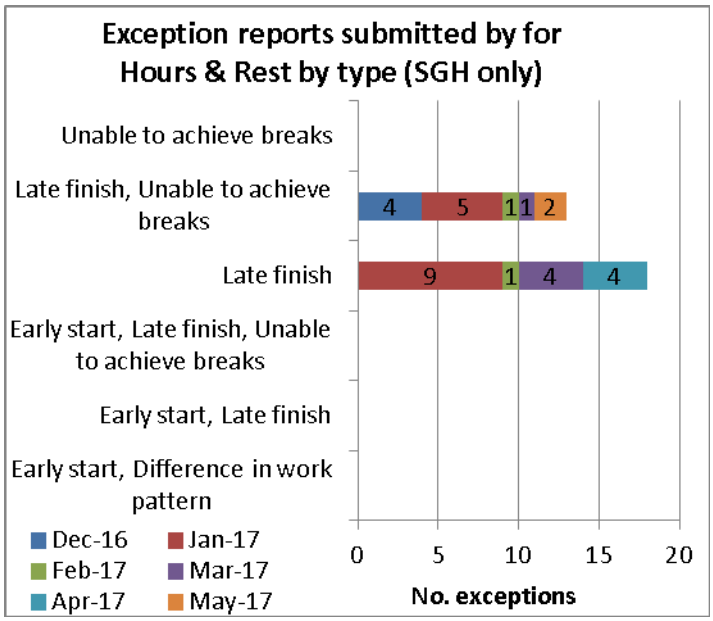
- To date there have been no guardian fines levied against the Trust. This is due to a number of reasons; the pro-active monitoring system that the administrator has introduced to ensure efficient and effective response to exception reports, the escalation of appropriate exception reports to the GSW to allow supportive intervention to prevent breaches and the work in departments by clinicians and managers to keep our junior doctors, and ultimately our patients safe.
- All are concerning hours and rest – no submissions to date for education and training
- The 103 reports came from 18 doctors, 7 in December and 38 in January, 14 February, 23 in March, 15 in April and 6 in May
- 40 have resulted in payment to the trainee for additional hours worked (total of 44.75 hours claimed with a value of £567.98)
- 38 have resulted in TOIL being approved (total of 45.5 hours claimed)
- 14 had no impact on TOIL or additional hours – mainly monitoring for missed breaks
- 11 open cases

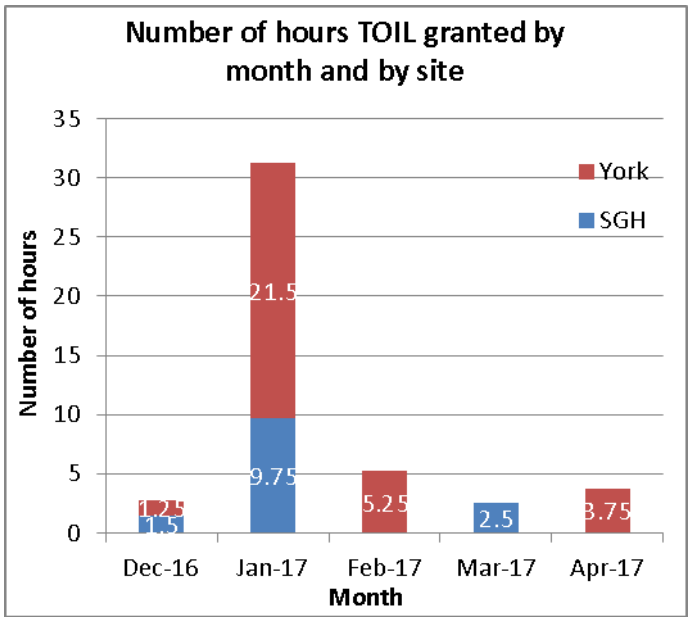
- 78% closed within 14 days.

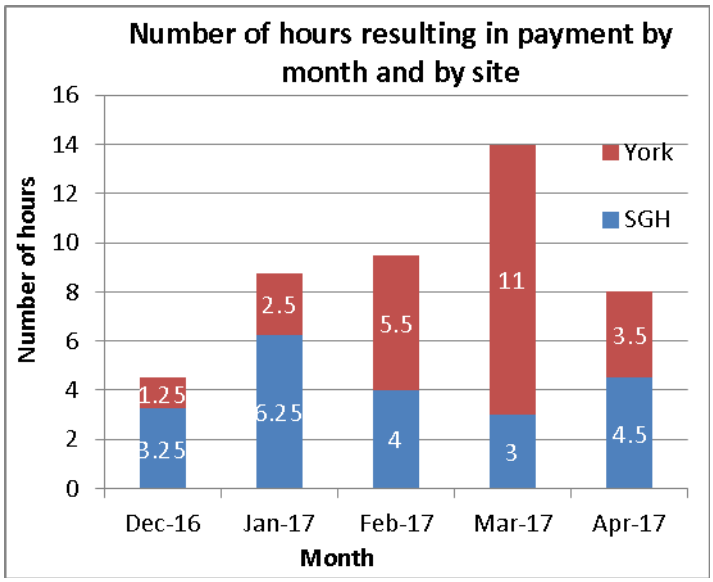
Below are the charts using aggregated data from exception reporting

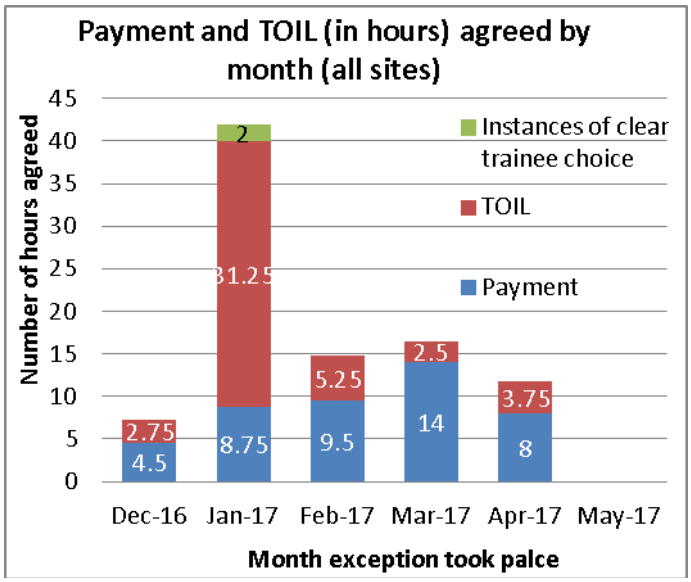


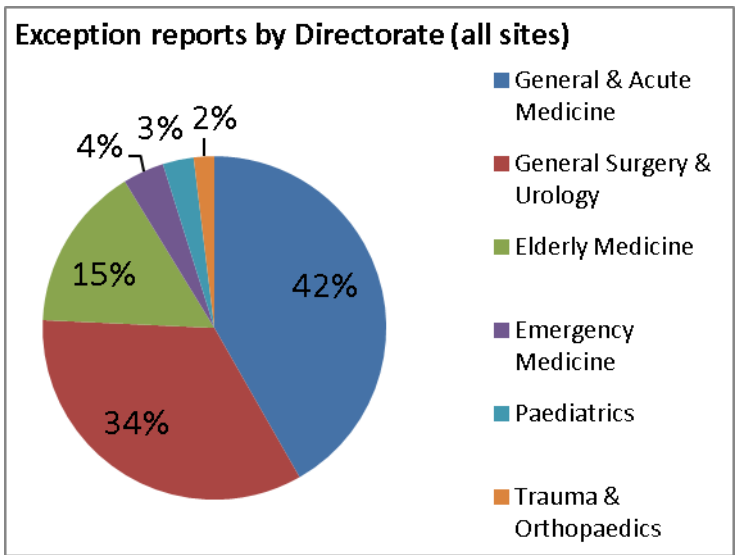












Positive outcomes from exception reporting: areas where there have been difficulties maintaining safe working hours, plans in place to address them and sharing good practice

Chestnut Ward Case Study

Following concerns raised by junior doctors on this particular ward and as a result of exception reporting, the GSW was able to identify a pattern of issues and concerns on the above ward and a number of actions were taken with the management team and juniors at Scarborough to address these. Following initial meetings one of the FY1 trainees who was on the ward last year (prior to the introduction of the new contract) found it hard to raise concerns about the working conditions he and his colleagues were experiencing which were impacting on patient safety, asked for a meeting to explore some of the issues.

The meeting was led by GSW and the deputy medical director and was attended by the directorate manager, clinical director, rota team and six junior doctors. The meeting was intended to be an open, informal discussion during which those in attendance felt comfortable exploring the issues

being considered without attributing blame or judgement. It was a supportive and open forum where the juniors felt safe to discuss the concerns they had and we all had an opportunity to offer solutions, including the current trainees helping to put together an induction pack for future trainees.

The concerns on Chestnut will continue to be monitored and support offered to all the staff.

Rota changes

Following a number of exception reports where a theme was emerging around night shift handover making it difficult to finish within the safe time limits, a very positive meeting took place with the emergency department (ED) and a change was made to the rota pattern. In addition to this, ED has produced a departmental agreement with all trainees which outlines the support for their placement which we will be sharing as good practice across the trust.

Supervisor role

There have been a number of reports completed by supervisors that have been examples of good practice, where the supervisor has made recommendations for the GSW to take forward to departments. Below is an example of one such report:

"I have discussed with the trainee and addressed how we can improve on common themes listed below and made suggestions on how we could have done better. What we cannot improve are both departmental and organisational problems. Hopefully the educational supervisor can discuss with CD the importance of patient safety and the juniors training so that she is supported in her role."

Peer survey

Due to the fact that we have only received exception reports from 18 (16%) of doctors on the new terms and conditions, there is potential for under reporting. The forum has designed a 'peer' survey for all junior doctors working in the trust to try and understand what issues or problems juniors may be facing in relation to exception reporting – the results will give a very candid insight into some of the issues and perceptions and results will be shared with the board in the summer.

The BMA recognises much of the above work as good practice and has credited the Trust with this when sharing outside the organisation.

Challenges

Culture and Engagement

Concerns by junior doctors have been expressed in relation to pressure by clinical or education supervisors not to submit reports and by some of the reprisals they have encountered when they have reported and this only serves to promote a 'blame culture' and discourage junior doctors from reporting.

Engagement remains a challenge in terms of junior doctors themselves, educational and clinical supervisors and wider management teams in respect of their responsibilities around exception reporting. Some of this is being addressed through attending each junior doctor induction, training events for consultants such as clinical governance meetings, grand round, etc, and meetings with

management teams.

The Director of Medical Education and Medical Director are supporting a proposal for the trust to make the HEE training on exception reporting for educational supervisors mandatory.

A clinical director has expressed an interest in becoming an' exception reporting 'champion' to work alongside the GSW and the DME and GSW are meeting this month to discuss this potential.

Software system

The DRS4 system for logging exception reports has a number of issues and not, in its own right, sufficient to handle all of the reporting requirements of the Guardian of Safe Working. A local Excel-based system is being run in parallel which allows for robust mining of data and for corrections to be made where submissions have been recorded inaccurately or incorrectly by trainees and supervisors within DRS4. This has created a significant amount of additional administration but contributes to the efficient management of exception reporting.

Rota gaps for Doctors currently on new contract

Currently we have 113 junior doctors within the Trust that have transferred onto the contract. By the end of 2017 all 325 junior doctors will be on the new contract.

A rota gap is a post in a rota pattern that is vacant and not filled with a doctor (training or non-training) and therefore a department is essentially one person (or potentially more) down in numbers. This doesn't mean that the burden falls to the other doctors, (if this was the case then a rota change would be applied) as either a full time locum or where deemed manageable the out-of-hours element of the rota would cover the rota.

Current information on rota gaps is limited as most of the positions are those that we are awaiting confirmation from the Deanery regarding the new rotations in August. Following confirmation, we may need to fill these vacancies with Trust grades or they may be training posts that remain vacant.

Scarborough vacancies

- Psychiatry - F1 x rotation; the psychiatry element of this post does not need to be covered as it is not a York Trust post.
- Child Health - 4 s ST gaps; we currently have parallel recruitment in place and advertising out to backfill with Trust grades the posts in child health. In the interim we have three of the four posts that have been covered with full time agency locums and the other post has been filled with bank staff.
- General Surgery and Urology - 1 x ST; this post has only been vacant since March 2017 and the on-calls for this time only are being covered by an agency locum.

York

- General Surgery and Urology - Core Surgical Trainee x 1; this is currently being covered by bank staff where applicable and when not available this will be covered by agency locums.
- Trauma and Orthopaedics - CT x 1; this post has recently been filled with a Trust grade post and prior to this it had been filled with full time bank staff.

- Child Health - ST x 2; at present these posts have not been filled and currently the rota team fill the on-calls on an ad-hoc basis with a combination of agency and bank staff.
- The Anaesthetic rotation remains unfilled as the F1and is deemed super nummerary.

The link between the above rota gaps and exception reporting can be drawn from General Surgery and Urology, which has the second highest rate of exception reporting (34% across both sites).

3. Conclusion

Exception reporting has been active for six months now. We have made some initial progress and had some good outcomes. We have also encountered some problems. Some early outcomes associated with these reports include; identifying some individuals who need to be better supported and others which have resulted in quite practical solutions such as additional IT, access to phlebotomy on wards and changes to rota patterns. However, there remains a view that junior doctors are reluctant to report excess hours for fear of damaging their relationship with their training supervisor – even possibly affecting their jobs in the future, hence the culture of no blame being of utmost importance.

4. Recommendation

The Board are asked to

1. read and note this report.
2. The Board are asked to encourage clinical directors, directorate managers and educational and clinical supervisors to be aware of their responsibilities within the new contract and continue to support junior doctors to work safely.

Author	**Lisa Smith, Guardian of Safe Working**
Owner	**Patrick Crowley, Chief Executive**
Date	**May 2017**

York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 23rd May 2017 – Boardroom, York Hospital

Attendance: Mike Keaney (Chairman), Mike Sweet, Steven Kitching, Lynda Provins, Lynette Smith, Andy Bertram, Gordon Cooney, Joanne Best

Apologies: Graham Lamb, Juliet Walters, Sue Rushbrook

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes 18 April 2017**	The agenda covered the following AFW and CRR items AFW DoF COO CRR DoF 1-4, 8 & 9 COO 2, 3 & 6	The minutes of the meeting held on 18 April 2017 were agreed subject to the following amendments: Page 8 – MS asked about the Malton centre having an impact on diagnostics due to reporting methods. This was in respect of flexible and rigid cystoscopies, which were now being done as part of an OPD appointment - add in – and therefore lowers the numerator.		
2.	**Matters arising**		MK asked whether the ECS trajectory would be cumulative. AB stated that the ECS trajectory is cumulative but there is a complication with the Trust having an improvement trajectory as opposed to a fixed target. This potentially will allow for some degree of interpretation to the Trust's performance. AB also confirmed that the STP funding split would be 70% finance and 30% ECS based on the latest unconfirmed intelligence. LS highlighted the ECS stating that it looked more positive for April and there had been a 10% performance improvement since February. This has been supported by improving streaming at front of house, focus on non-admitted breaches and flow. There has been an increase of non-elective	The Committee were assured by the performance report and noted the work being done to address recovery.	JW to update the Board on the current position.

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			admissions on both sites. LS stated that there still increased acuity and stated that we need to ensure that all assessment and admission pathways are right with on-going review at both sites. LS stated that there has been a significant reduction in Ambulance handover times, but she noted that due to the cyber issues there may be an increase in the next month's figures. LS stated that the acute medical model (AMM) continues on the Scarborough site and that they are now focusing on being able to sustain this improvement against AMM metrics. MS asked if the Trust had received the report from North West Academic Health Science Network. AB stated that the report had only just been received and was being reviewed. MK shared concerns about the bed occupancy remaining high and asked if this was the norm and whether the Trust had the capacity for this level of demand. LS agreed that bed occupancy is high and that patient delays are been looked at through the discharge work stream. The intention is to review patients daily, ensure patients are in the right place with a view to discharging if appropriate. LS stated that a multi-agency work stream is established to work across between agencies to support complex discharge cases. LS stated that one area under review for flow the early evening period slot due to a combination of GP admissions, handover processes and assessment unit closure times. The Trust is engaged in working with the CCGs on transport. System issues are discussed at the A&E Delivery Board.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			LS stated that there have been long waits in ED none of these were 12 hour trolley breaches in April 136 Patients waited over 8 hours. She stated that although there have been improvements; the numbers are still too high. This is being addressed through the flow and discharge work. Cancer – LS stated that the Trust achieved 4 out of the 7 cancer targets. Screening remained challenging with regards to the 62 day to first treatment. There were 27 breaches for the 62 days from GP referral to 1st treatment 10 of which were due to capacity issues. LS noted that this included some complex cases requiring more than one speciality to be involved. The 14 day fast track is remains challenging primarily due to the dermatology capacity against demand. AB shared with the group a suggestion that had been made by Glenn Miller. He has suggested that perhaps the plastics team could help with the fast track screening. This possibility was discussed and how this could work. This is currently being considered by the Ops team. LS told the group that all GP surgeries in Scarborough now have access to dermatoscopes which should improve referrals. The GP's have all received training in the use of the dermatoscopes and the expectation is that the system will move to only accept referrals accompanied by photographs in due course. LS highlighted that the Trust is completing a self-assessment against 10 high Impact Actions to support 62 days performance The Trust is currently working through their submission. LS noted that the Trust continued to experience some delays with Tertiary centres waiting times and this has been escalated.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			LS stated that RTT performance had reduced in April and is below the planned recovery trajectory. The Directorates are looking at maximising their capacity through Outpatients and Theatres, in addition to current outsourcing and extra clinics and lists working with the Corporate Improvement Team. MS enquired about the 52 week breaches and LS responded that the Trust review long wait patients every week and it remains a concern. The specialities experiencing the majority of long waits were discussed and some were due to complex requirements. MK enquired if we were on plan to return to trajectory by October. LS stated that there were a number of factors involved including out sourcing and she would be reviewing the situation again at the end of May. AB provided an update on capped expenditure process. LS stated that the Trust is working hard to recover the position to deliver the planned trajectory in October. Diagnostics – LS stated that the Trust had has the first fail for 18 months. This was primarily due to the DEXA scanner equipment issues Scarborough, with a result of 50 breaches in April. The scanner was also taken out of action by the cyber attack. The team are working hard to mitigate the impact but continues to be a risk for May MRI – had 10 breaches in April. Finance – AB reported that April has been a good opening to the new financial year. There had been no material down turn in income and in relation to cash the CCG's were paying the		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			contract in tenths. The Trust is reporting a £2.7m deficit against a planned deficit of £4.4m. AB stated that the agency spend is broadly in line with expectations and actions continue to reduce the spend further. MS enquired if electronic prescribing has been rolled out throughout the Trust. AB assured him that it is being piloted in specific areas with roll out across the rest of the Trust due to start July 2017. SK stated that the total savings requirement for 2017/18 is £22.8m. Current delivery is at £0.9m of which £0.7m is recurrent. This position is £100k behind list years opening position but SK was not unduly concerned. SK stated that in year planning was at £15.4m which had moved back by £5m and left an in year gap of £7.4m. Work is starting with directorates to look at the planning gap as this remains a risk. Work is starting with directorates to look at the planning gap as this remains a risk. MS asked if any incentive is being provided for recurrent delivery. SK responded that a 20% incentive is being offered in quarter one. SK stated that he is expecting a very tough year especially in light of the need to deliver both QIPP and CIP's. However he also stressed the need to focus on the CIP's. GC provided an overview of the work of the Corporate	The Committee were assured by the positive April position.	AB to update the Board on the April position and CEP.

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			Improvement Team and highlighted that works is divided into three levels. GC stated he would focus on the delivery of the level 1 schemes and highlighted that the teams efforts were focused on the following :- 44% on acute pathways 30% - planned care work including Theatres and Critical Care and 23% on core process such as finance and procurement. GC provided an update on the frailty work at Scarborough, Theatres and the visit to Sheffield. He noted that Theatre utilisation is in top quartile at York but needs further work especially on improving the number of day cases. GC provided an update on the work of the Business case panel, which was proving very successful. Theatre utilisation was discussed and GC stated that there were a number of measures that could be used to determine efficiency levels. The committee discussed how staff are deployed when lists are cancelled.	The Committee were assured by the work of the Corporate Improvement Team.	
3	**TAP – Key Priorities: Emergency Care Standard Delivery**		CQUIN 1a – LS highlighted that this was amber as the Trust had performed well in the Staff Survey, meaning further improvement was more challenging, and the CCG had agreed partial payments in response. Flu vaccination – green, it is too early to predict how this CQUIN will perform but in light of last year's performance it is hoped that this will be achieved.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
	Finance Control Total Delivery		Sepsis – LS stated this is amber but remains challenging. Mental health – Green for Quarter 1 - LS stated that the Trust need to agree a list but the remaining element of this work will be down to TEWV. LS stated that an agreement over payment will be confirmed following identification of the cohort in Q1. Proactive discharge – LS noted that April LoS for patients over 65 with a LoS over 2 days has been significantly higher in April. If this continues the risk rating may increase. . Mk enquired about the total value and AB responded that this was about £10m.		
5.	**Reference Costs Process Education and Training Update Report**		AB asked if there were any comments with regards to paper H & I. The papers requested that the committee give approval for AB to take responsibility for the 2016 / 17 reference cost return and the 2016 / 17 education and training return. AB was asked if there were separate costs for York and Scarborough sites, he replied that the information was not broken down in this way but could be if requested. The committee had a discussion about how overheads are allocated and AB stated that it is prescribed and the Trust complies with the NHS National Cost Manual. The committee approved AB taking responsibility for both returns.		AB to update the Board on the delegated responsibility for reference costs and education and training.
8.	**Risk Registers & BAF**		LS confirmed that diagnostics was added to the Risk register last month but did not appear on this version. She stated that updates had been made in in respect of ED long waits and bed	The Committee were assured that risks were being amended	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			occupancy. . The committee agreed that the business continuity score should be reviewed in light of the cyber-attack. AB stated that he had significantly reviewed his risks in light of the CEP. MS stated that he was happy that in general the risks had been discussed throughout the meeting.	as appropriate.	
9.	**Any other business**		No other business was discussed.		
10.	**Next Meeting**		The next meeting is arranged for the 20 June 2017 in the Boardroom, York Hospital		

Finance & Performance Committee – Action Log – May 2017

No.	Month	Action	Responsible Officer	Due date	Completed

No current actions.

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Finance Report

Action requested/recommendation

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

Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 30 April 2017.

At the end of April the Trust is reporting an Income and Expenditure (I&E) deficit of £2.7m against a planned deficit of £4.4m for the period. The Income & Expenditure position places the Trust ahead of its Operational plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	May 2017
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Briefing Note for the Finance & Performance Committee Meeting 31 May 2017
Briefing Note for the Board of Directors Meeting 23 May 2017

Subject: April 2017 (Month 1) Financial Position

From: Andrew Bertram, Finance Director

Summary Financial Plan and Sustainability Funding

The Board will recall that we have committed to delivering a £3m control total surplus for the financial year 2017/18. Essentially the Trust is running with a £9m deficit but has the possibility of earning Sustainability Funding, totalling £12m, resulting in the planned £3m surplus.

Of note in 2017/18 is that the Sustainability Funding is not paid in equal quarters. The table below summarises the payment profile. This profile is replicated in our income and expenditure plan profile and contributes to the surplus/(deficit) income and expenditure profile reported in the main finance report.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	**Total**
Sustainability Funding	£1.775m	£2.366m	£3.550m	£4.141m	**£11.832m**
	15%	20%	30%	35%	**100%**

Summary Reported Position for April 2017

The Trust has opened the new financial year with an encouraging start. The headline income and expenditure plan profile was for a deficit of £4.4m but this position has been improved on with a deficit of £2.7m. At month 1 the Trust is £1.7m ahead of plan.

The Trust's income position is an estimate. This is based largely on planned activity adjusted for more detailed valuations of outpatients and ED attendances and adjusted for high-level trend indications for elective activity, non-elective activity and excluded from tariff drugs and devices.

Expenditure is fully accurate and has been compiled using all normal expenditure feeder systems.

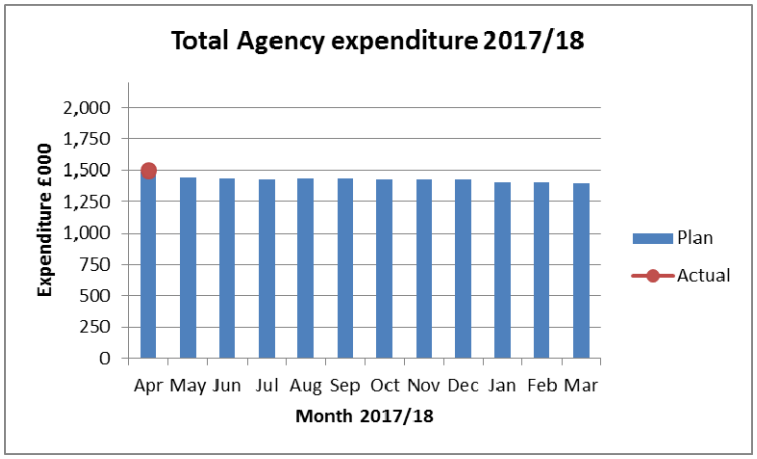
Operational expenditure in April was £39.9m and is broadly comparable to the 2016/17 monthly average of £39.5. Overall expenditure is reported as £0.14m under plan.

The month 1 CIP position shows £0.9m removed from budget in full year terms against the £22.8m target. There is a material gap of £7.4m against the planning requirement and this will need to be carefully monitored as we progress through the financial year.

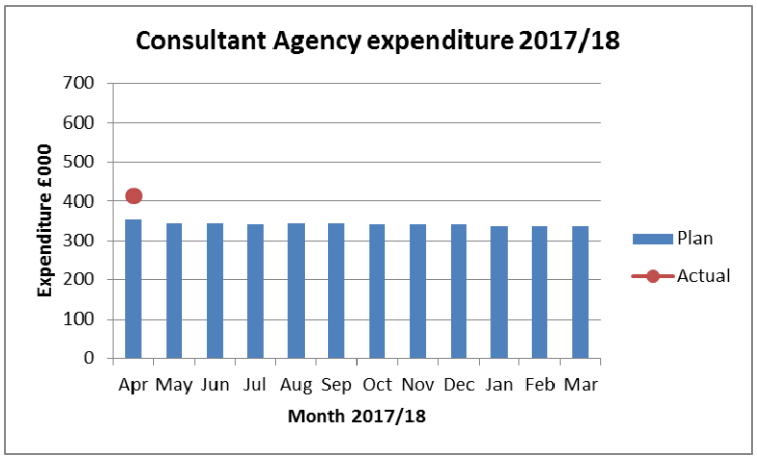
Enhanced Agency Expenditure Analysis

As discussed previously at the Board we have developed our agency staff cost reporting to ensure full visibility against the Trust's overall improvement trajectory. The Board are aware that NHSI has set the Trust an upper capped limit and that this remains at £17.2m for 2017/18.

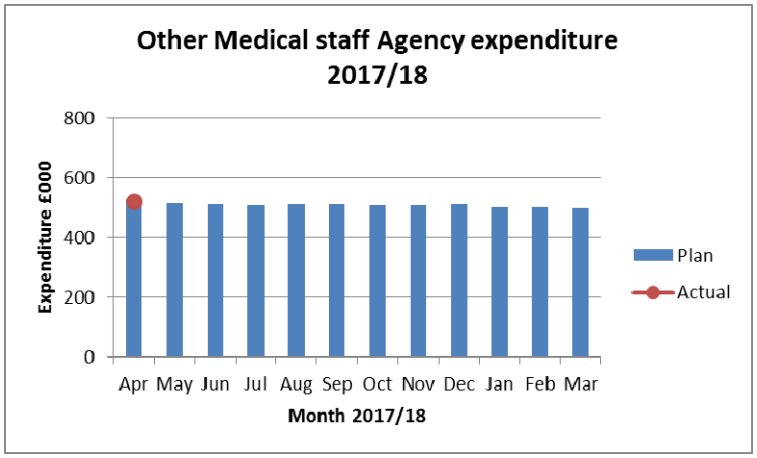
We have developed a suite of charts that set indicative targets for agency expenditure in the categories of Consultant, Other Medical, Nursing and Other Staff. The sum of each of these targets reconciles back to our capped plan of £17.2m.



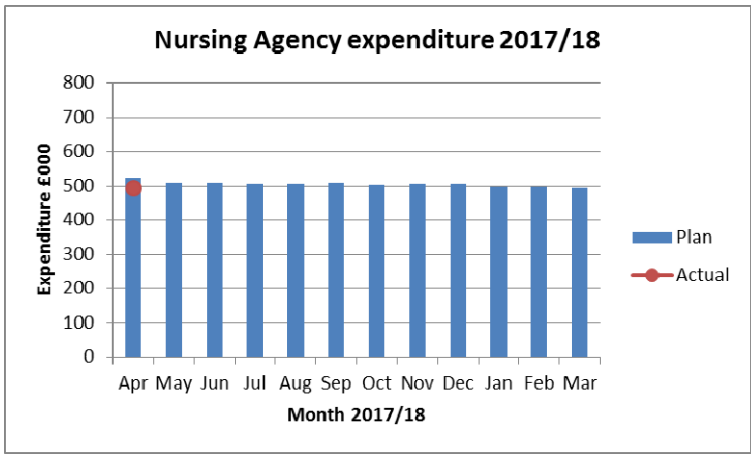
This first chart shows the monthly overall agency target; set at approximately £1.4m per month and totalling £17.2m. Spend in April overall is in line with our overarching capped rate. This is encouraging given the spike evident in the last two months of the old financial year.



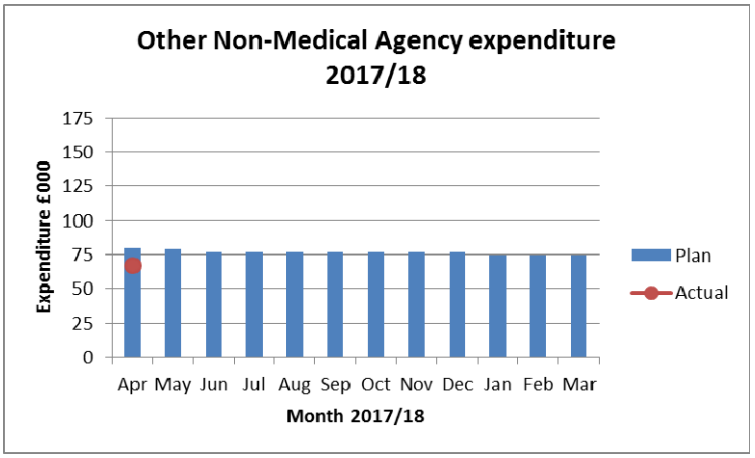
Consultant medical staff agency expenditure has been a significant pressure area and the indication for April is that we have still exceeded our planned and capped value. This is an area where considerable work is underway to reduce costs.



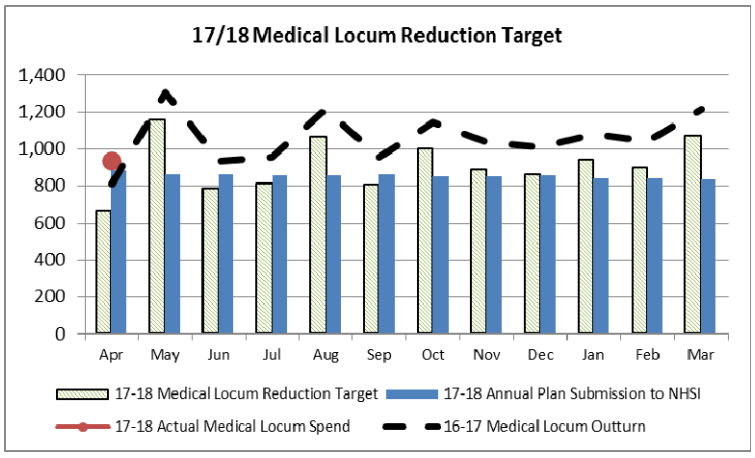
Given the previous year's pressure in this area it is encouraging to see for April that spend is in line with plan and capped rates.



Nursing staff agency expenditure spiked at the end of the old financial year and it is encouraging to see this return to planned and capped levels for the month of April.



This chart shows non-medical and non-nursing agency staff expenditure. In relative terms this is low level agency usage and there are no issues I would wish to bring to the Board's attention.



This chart illustrates an important development in the new financial year. On top of our £17.2m NHSI capped spend we have also been targeted with a 15% reduction on last year's medical agency spend. This chart shows that whilst we are within the medical indicative share of the £17.2m spend we are not meeting the 15% reduction in April.

Old year Contract Settlements

At the time of writing this report there are no updates to provide on the trading position with the old year contracts for those commissioners where it was not possible to agree an early outturn position. Discussions continue as the coding information continues to follow the national reconciliation timetable.

Finance Performance Report

May 2017

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

Finance Report
Chapter Index

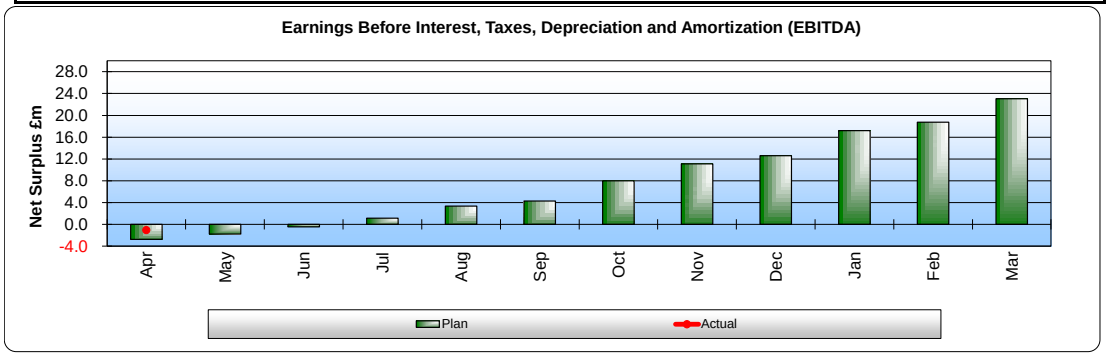
Chapter	Sub-Section
Finance	Finance Chapter Index
	Summary Income and Expenditure Position
	Contract Performance
	Expenditure Analysis
	Cash Flow Management
	Debtor Analysis
	Capital Programme
	Efficiency Programme
	Carter

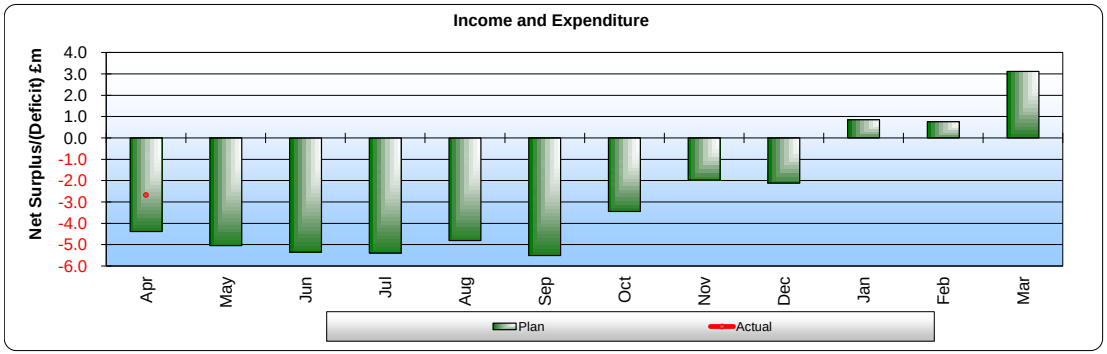
Summary Income and Expenditure Position
Month 1 - The Period 1st April 2017 to 30th April 2017

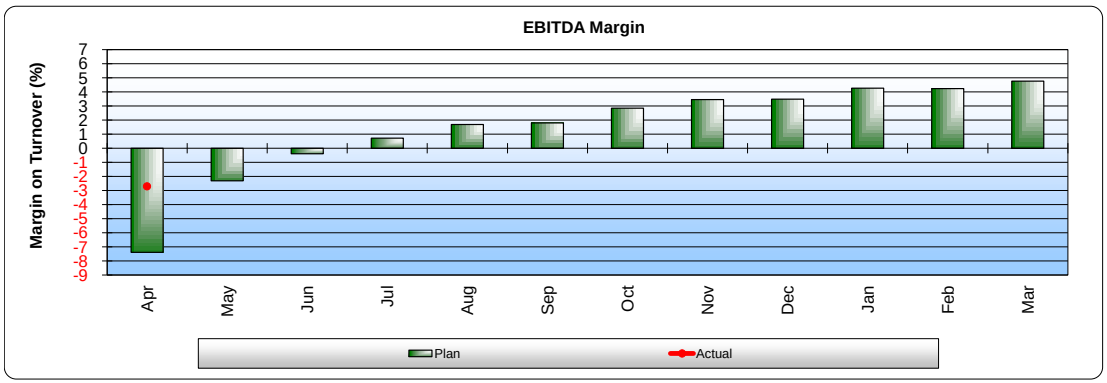
York Teaching Hospital NHS Foundation Trust

Summary Position:

* The Trust is reporting an I&E deficit of £2.7m, placing it £1.7m ahead of the operational plan.
* Income is £1.6m ahead of plan, with clinical income being £1.4m ahead of plan and non-clinical income being £0.2m ahead of plan.
* Operational expenditure is ahead of plan by £0.1m, with further explanation given on the 'Expenditure' sheet.
* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is -£1.1m (-2.71%) compared to plan of -£2.8m (-7.39%), and is reflective of the reported net I&E performance.







	Annual Plan	Plan for Year to Date	Actual for Year to Date	Variance for Year to Date	Forecast Outturn	Annual Plan Variance
	£000	£000	£000	£000	£000	£000
NHS Clinical Income						
Elective Income	24,319	1,737	1,969	232	24,319	0
Planned same day (Day cases)	35,006	2,490	2,843	353	35,006	0
Non-Elective Income	103,578	8,388	9,310	922	103,578	0
Outpatients	57,871	4,116	4,340	224	57,871	0
A&E	15,122	1,225	1,225	0	15,122	0
Community	30,036	2,503	2,553	50	30,036	0
Other	162,217	12,623	12,218	-405	162,217	-0
	428,149	**33,082**	**34,458**	**1,376**	**428,149**	**-0**
Non-NHS Clinical Income						
Private Patient Income	956	80	51	-29	956	0
Other Non-protected Clinical Income	1,510	126	159	33	1,510	0
	2,466	**205**	**210**	**4**	**2,466**	**0**
Other Income						
Education & Training	12,946	1,079	1,094	15	12,946	0
Research & Development	3,356	280	272	-8	3,356	0
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	623	52	52	0	623	0
Other Income	21,392	1,783	1,960	177	21,392	0
Sparsity Funding	2,600	217	217	0	2,600	0
STF	11,832	592	592	0	11,832	0
	52,750	**4,001**	**4,186**	**185**	**52,750**	**0**
Total Income	**483,365**	**37,289**	**38,854**	**1,565**	**483,365**	**-0**
Expenditure						
Pay costs	-330,254	-27,328	-27,296	32	-330,254	0
Drug costs	-52,206	-4,386	-4,604	-219	-52,206	0
Clinical Supplies & Services	-48,739	-3,990	-3,674	316	-48,739	0
Other costs (excluding Depreciation)	-51,060	-4,627	-4,332	296	-51,060	0
Restructuring Costs	0	0	0	0	0	0
CIP	21,930	284	0	-284	21,930	0
Total Expenditure	**-460,330**	**-40,047**	**-39,906**	**141**	**-460,330**	**0**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**23,035**	**-2,758**	**-1,052**	**1,706**	**23,035**	**-0**
Profit/ Loss on Asset Disposals	0	0	0	0	0	0
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation - purchased/constructed assets	-11,658	-972	-972	0	-11,658	0
Depreciation - donated/granted assets	-342	-29	-29	0	-342	0
Interest Receivable/ Payable	130	11	10	-0	130	0
Interest Expense on Overdrafts and WCF	0	0	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0	0	0
Interest Expense on Non-commercial borrowings	0	0	0	0	0	0
Interest Expense on Commercial borrowings	-528	-41	-34	7	-528	0
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	0	0	0	0
PDC Dividend	-7,216	-601	-601	0	-7,216	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**3,121**	**-4,390**	**-2,677**	**1,713**	**3,121**	**-0**

Contract Performance

Month 1 - The Period 1st April 2017 to 30th April 2017

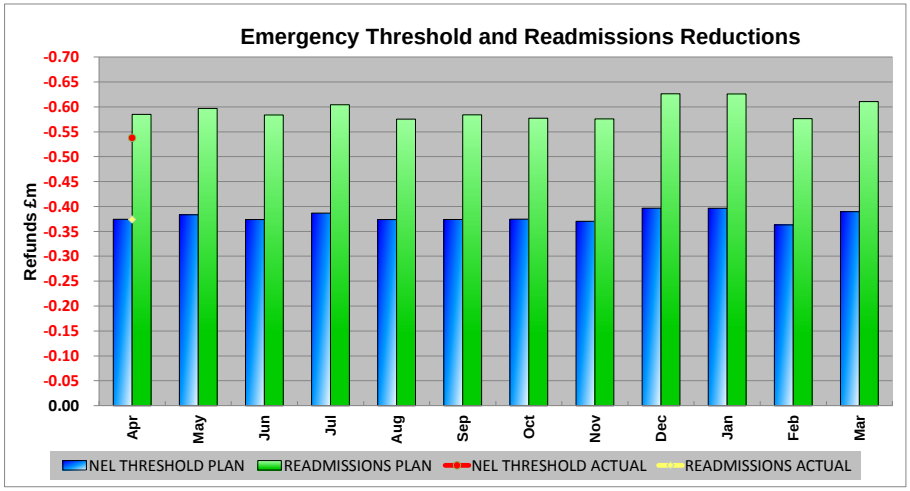
York Teaching Hospital NHS
NHS Foundation Trust

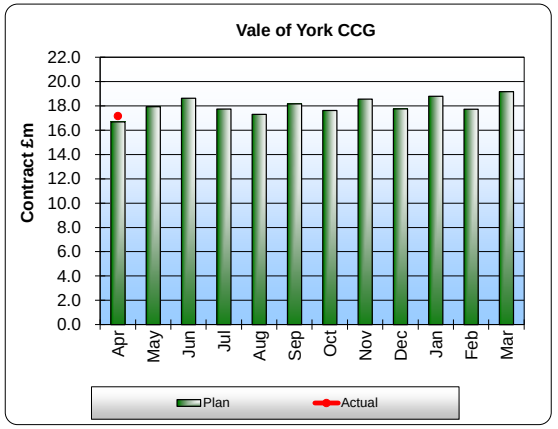
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	217,424	16,678	17,154	476
Scarborough & Ryedale CCG	79,346	6,154	6,595	441
East Riding CCG	41,883	3,233	3,415	182
Other Contracted CCGs	16,823	1,292	1,334	42
NHSE - Specialised Commissioning	40,804	3,223	3,395	172
NHSE - Public Health	15,289	1,162	1,155	-7
Local Authorities	4,582	381	381	0
Total NHS Contract Clinical Income	**416,151**	**32,123**	**33,429**	**1,306**

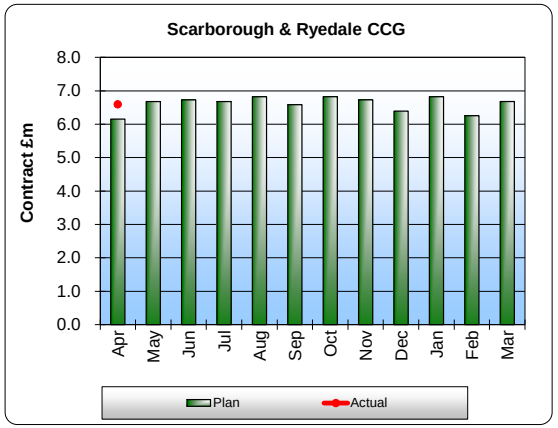
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	12,300	984	1,029	45
Risk Income	-302	-25	0	25
Total Other NHS Clinical Income	**11,998**	**959**	**1,029**	**70**

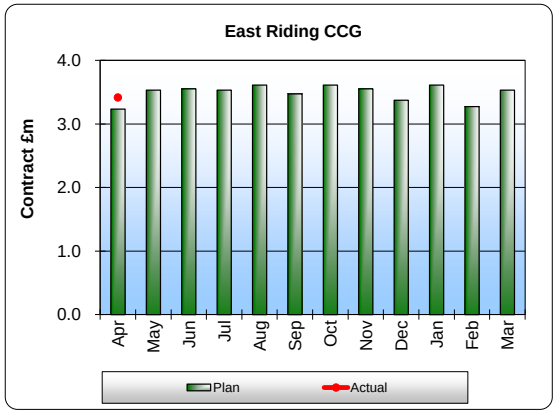
Specialist registrar income moved to other income non clinical	0
Winter resilience monies in addition to contract	0

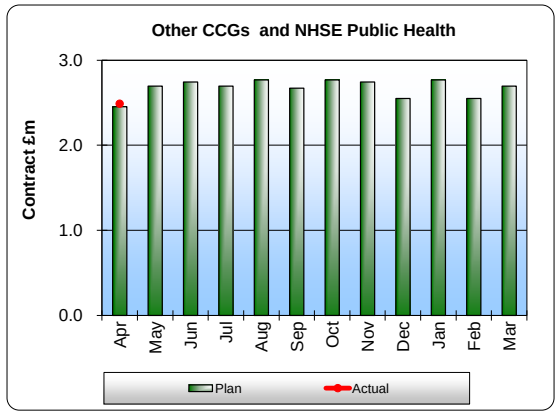
Total NHS Clinical Income	**428,149**	**33,082**	**34,458**	**1,376**

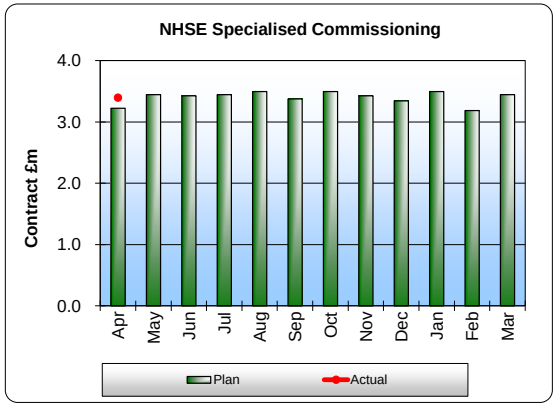


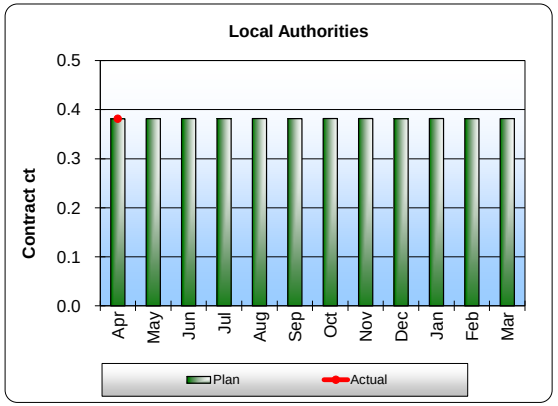












Expenditure Analysis

Month 1 - The Period 1st April 2017 to 30th April 2017

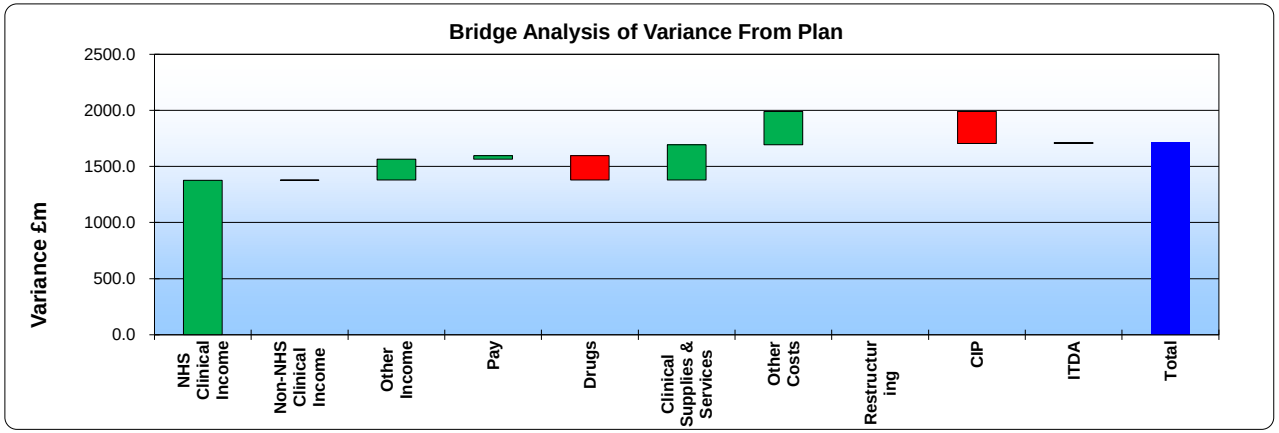
York Teaching Hospital NHS
NHS Foundation Trust

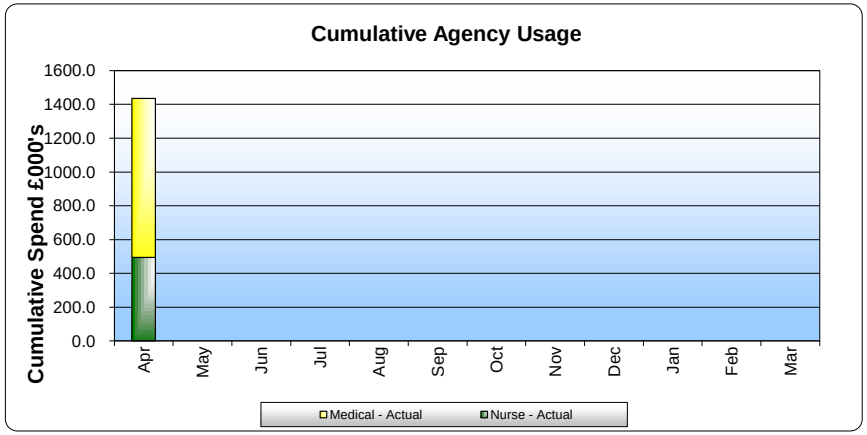
Key Messages:

There is a favourable expenditure variance of £0.1m at the end of April 2017. This comprises:

* Pay budgets have £0.0m variance.
* Drugs budgets are £0.2m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £0.3m behind plan.
* Other budgets are £0.6m favourable.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	60,289	4,979	4,239	0	104	0	414	4,757	222	0	
Medical and Dental	29,427	2,480	2,260	0	25	0	527	2,813	-333	0	
Nursing	96,446	8,102	6,610	49	41	866	494	8,061	42	0	
Healthcare Scientists	11,799	1,009	793	25	14	0	19	853	157	0	
Scientific, Therapeutic and technical	15,793	1,320	1,206	8	0	5	17	1,237	83	0	
Allied Health Professionals	24,912	2,068	1,917	5	21	5	3	1,950	118	0	
HCAs and Support Staff	44,333	3,706	3,306	67	12	6	3	3,395	311	0	
Chairman and Non Executives	161	13	15	0	0	0	0	15	-2	0	
Exec Board and Senior managers	13,666	1,186	1,165	1	0	0	0	1,165	21	0	
Admin & Clerical	37,747	3,136	2,881	21	9	12	18	2,939	196	0	
Agency Premium Provision	5,164	430	0	0	0	0	0	0	430	0	
Vacancy Factor	-10,676	-1,202	7	0	0	0	0	7	-1,209	0	
Apprenticeship Levy	1,192	99	104	0	0	0	0	104	-5	0	
TOTAL	**330,254**	**27,328**	**24,503**	**175**	**226**	**895**	**1,496**	**27,296**	**32**	**0**	





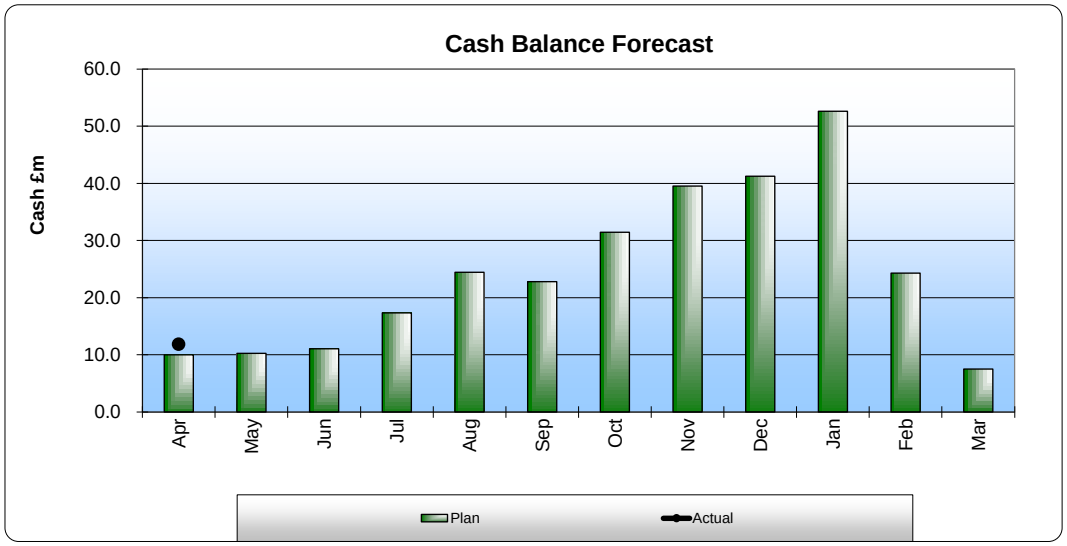
Cash Flow Management

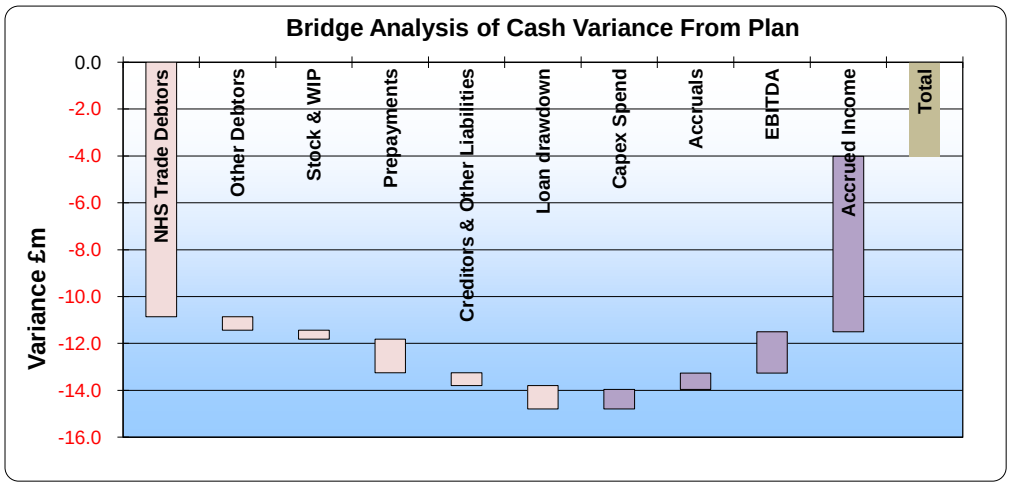
Month 1 - The Period 1st April 2017 to 30th April 2017

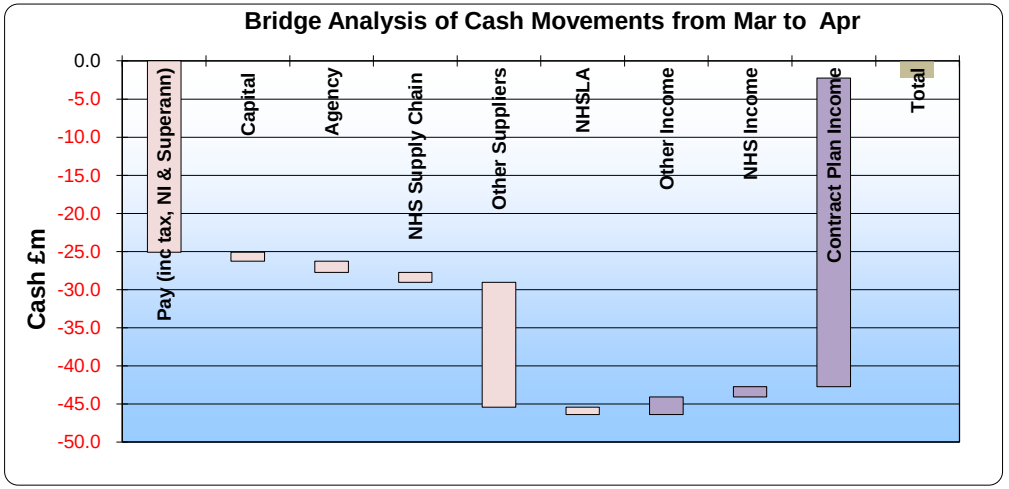
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The cash position at the end of April was £11.8m, which is ahead of plan.
* The key factors influencing cash are:
- Positive impact with activities undertaken to raise more invoices which has resulted in a favourable planned variance for accrued income levels.
- Negative impact due to NHS debtors;
- This is due to not receiving payment of commisioner year end accrual invoices (£4m) and timing delays with the payment of the April LDA invoice (£1m).







Cash Flow Management
Month 1 - The Period 1st April 2017 to 30th April 2017

York Teaching Hospital NHS
NHS Foundation Trust

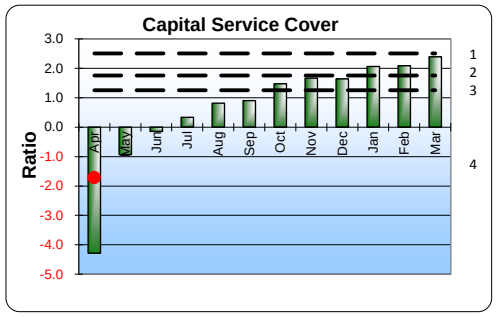
Key Messages:

* The receivables balance at the end of April was £14m, which is slightly above plan.
* The payables balance at the end of April was £9.7m, which is below plan.
* The Use of Resources Rating is assessed as a score of 3 in April, and is reflective of the I&E position.

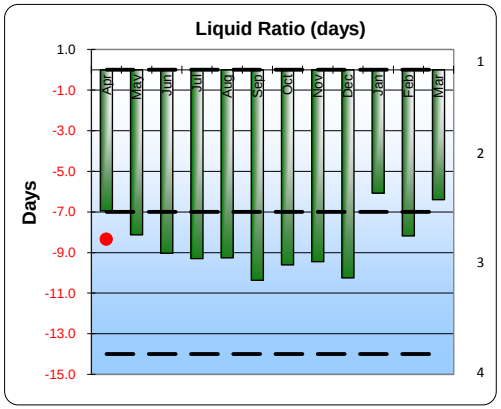
Significant Aged Debtors (+6mths)

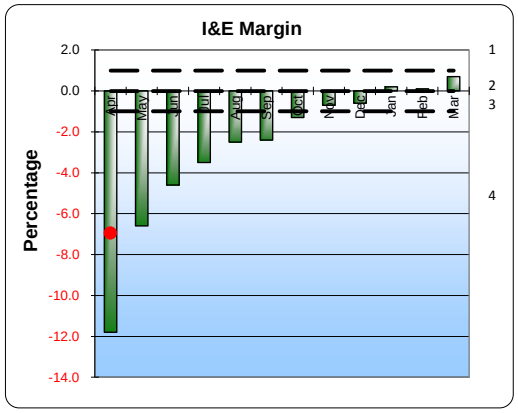
NHS Property Services	**£290K**
Hull & East Yorkshire FT	**£184K**
Depuy	**£144K**

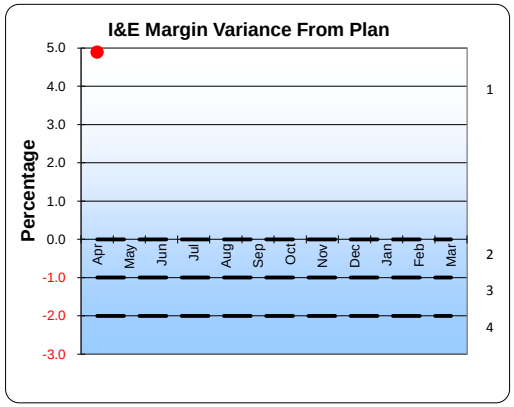
	Under 3 mths	3-6 mths	6-12 mths	12 mths +	Total
	£m	£m	£m	£m	£m
Payables	7.57	0.86	0.66	0.58	9.67
Receivables	12.19	0.63	0.42	0.87	14.11

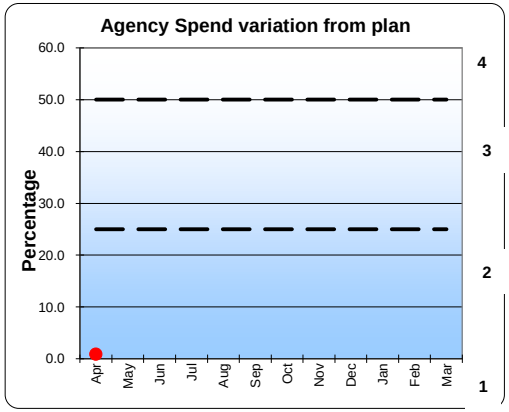


	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (20%)	2	2	3	2
Capital Service Cover (20%)	2	4	4	2
I&E Margin (20%)	2	4	4	2
I&E Margin Variance From Plan (20%)	1	1	1	1
Agency variation from Plan (20%)	1	1	2	1
Overall Use of Resources Rating	**2**	**3**	**3**	**2**









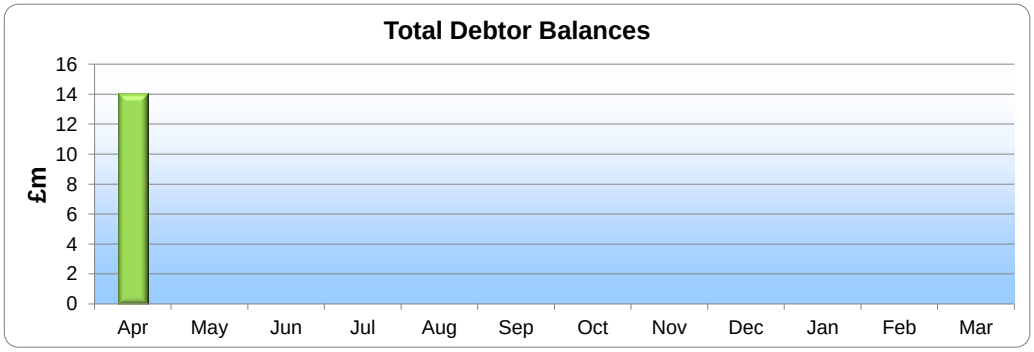
Debtor Analysis

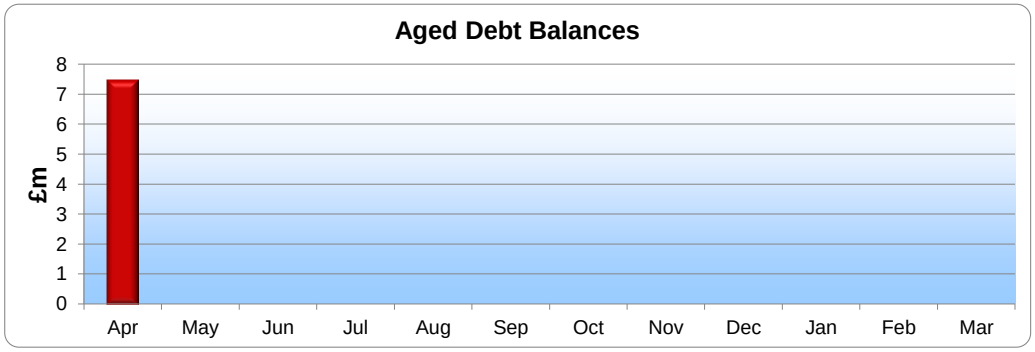
Month 1 - The Period 1st April 2017 to 30th April 2017

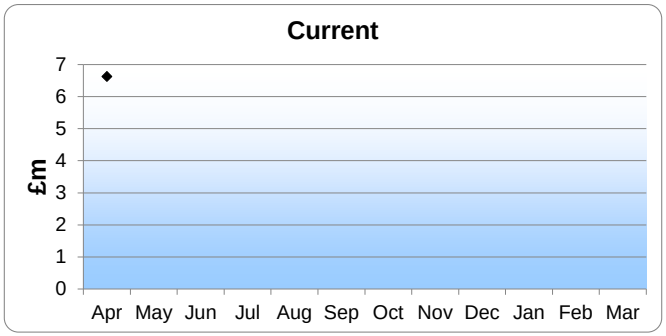
York Teaching Hospital NHS
NHS Foundation Trust

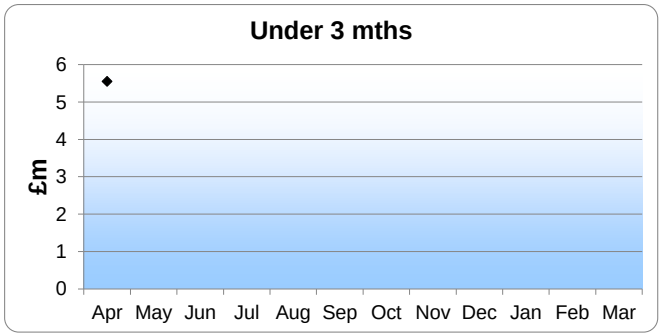
Key Messages:

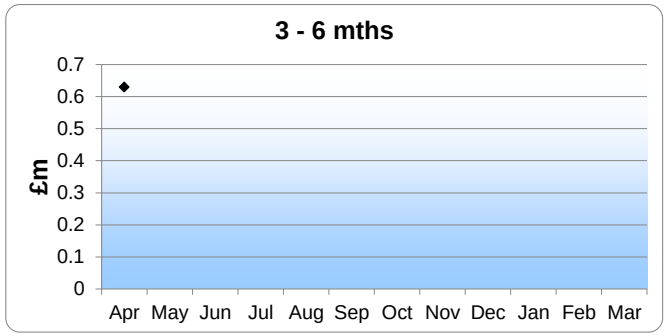
* At the end of April, the total debtor balance was £14m, with £6.6m relating to 'current' invoices not due.
* £4.5m of the 'current' balance relates to overtrade/year end agreements with Vale of York CCG, Scarborough & Ryedale CCG, Wakefield CCG & NHS England.
* Aged debt totalled £7.5m and is influenced by a number of commissioner invoices.

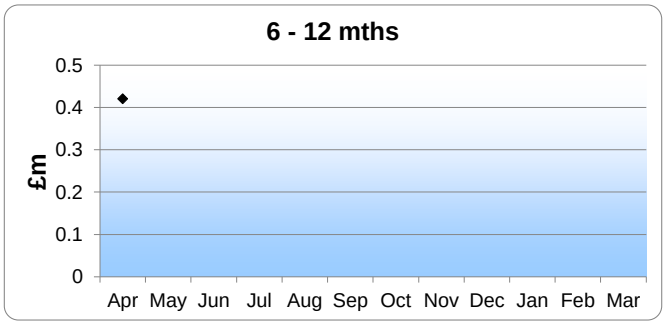


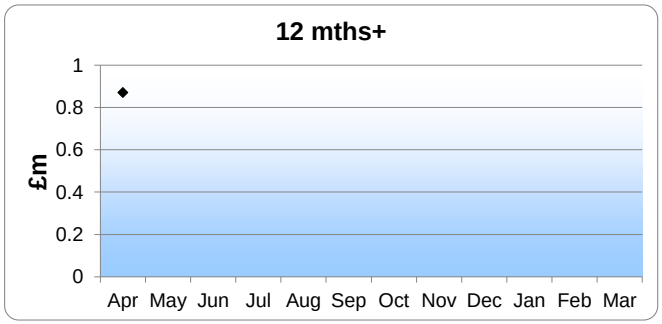










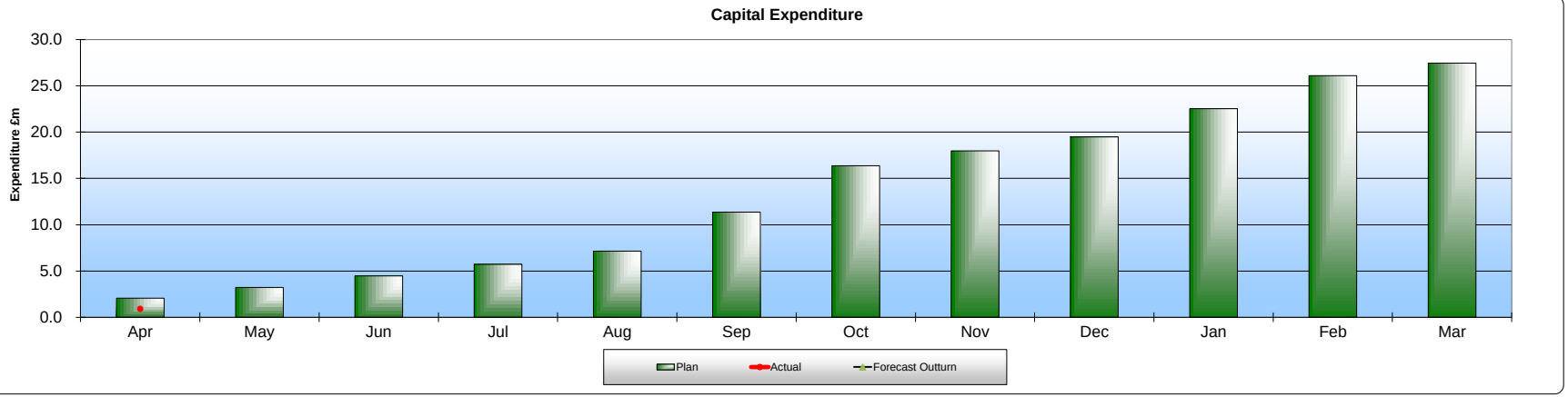


Capital Programme
Month 1 - The Period 1st April 2017 to 30th April 2017

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

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



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
York Micro/ Histology integration	2,411	-	2,411	0	0
SGH Pathology /Blood Sciences	1,251	-	1,251	0	
Theatre 10 to cardiac/vascular	1,265	-	1,265	0	
Radiology Replacement	5,526	1	5,526	0	0
Radiology Lift Replacement SGH	799	1	799	0	0
Fire Alarm System SGH	940	-	940	0	0
Other Capital Schemes	985	122	985	0	0
SGH Estates Backlog Maintenance	1,300	19	1,300	0	0
York Estates Backlog Maintenance - York	1,200	83	1,200	0	
Cardiac/VIU Extention	1,000	-	1,000	0	
Medical Equipment	500	39	500	0	
IT Capital Programme	1,500	96	1,500	0	
Capital Programme Management	1,450	75	1,450	0	
SGH replacement of estates portakabins	1,339	-	1,339	0	
Endoscopy Development	5,500	-	5,500	0	
Contingency	500	-	500	0	0
Estimated In year work in progress	-	469	-	0	
TOTAL CAPITAL PROGRAMME	**27,466**	**905**	**27,466**	**-**	

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£	£	£	£	
Depreciation	10,554	772	10,554	-	
Loan Funding b/fwd	4,450	11	4,450	-	
Loan Funding	6,500	-	6,500	-	
Charitable Funding	623	-	623	-	
Strategic Capital Funding	5,339	122	5,339	-	
TOTAL FUNDING	**27,466**	**905**	**27,466**	**0**	

Efficiency Programme

Month 1 - The Period 1st April 2017 to 30th April 2017

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Delivery - £0.9m has been delivered against the Trust annual target of £22.8m, giving a shortfall of (£21.9m).
* Part year NHSI variance - The part year NHSI variance is (£0.3m).
* In year planning - The 2017/18 planning gap is currently (£7.4m).
* Four year planning - The four year planning gap is (£16.6m).
* Recurrent delivery - Recurrent delivery is £0.7m in-year, which is 3% of the 2017/18 CIP target.

Executive Summary - April 2017

	Total £m
TARGET	
In year target	22.8
DELIVERY	
In year delivery	0.9
In year delivery (shortfall)/Surplus	-21.9
Part year delivery (shortfall)/surplus - NHSI variance	-0.3
PLANNING	
In year planning surplus/(gap)	-7.4
FINANCIAL RISK SCORE	
Overall trust financial risk score	(1 - RED)

4 Year Efficiency Plan - April 2017

Year	2017/18	2018/19	2019/20	2020/21	**Total**
	£m	£m	£m	£m	**£m**
Base Target	22.8	12.7	12.7	12.7	**61.0**
Plans	15.4	13.6	8.3	7.1	**44.4**
Variance	-7.4	0.8	-4.4	-5.6	**-16.6**
%	**67%**	**107%**	**66%**	**56%**	**73%**

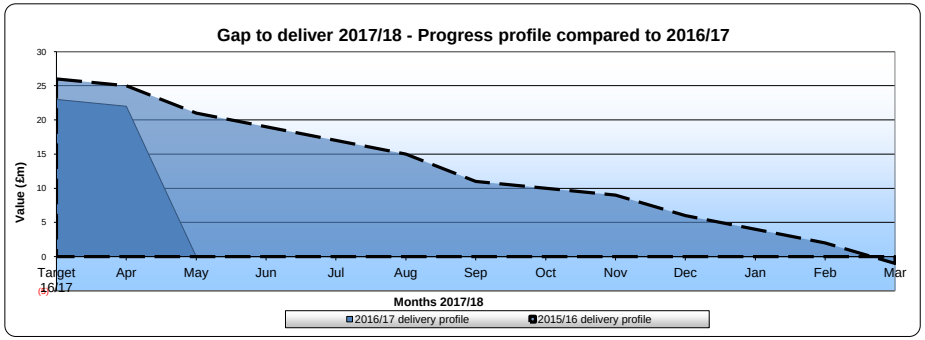
Risk Ratings

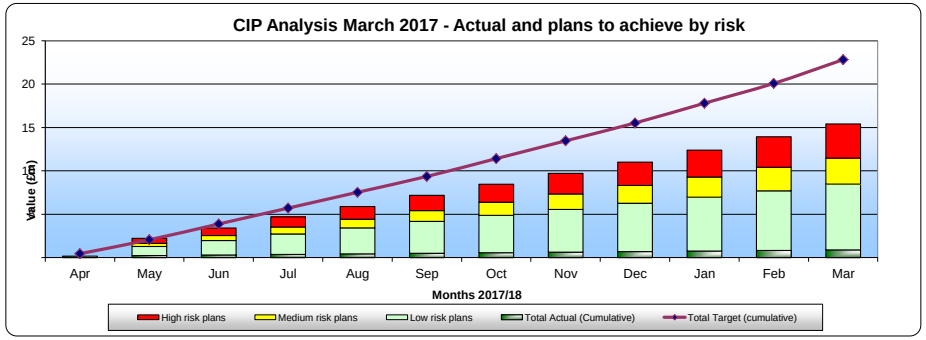
Financial

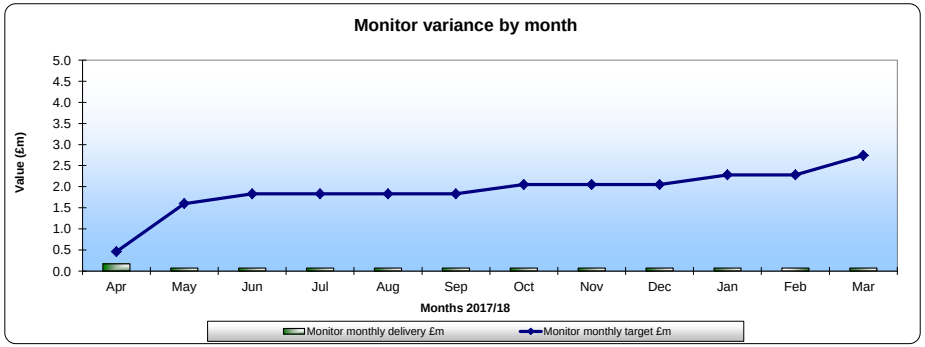
Risk	April	0	Trend
High	24		
Medium	2		
Low	1		

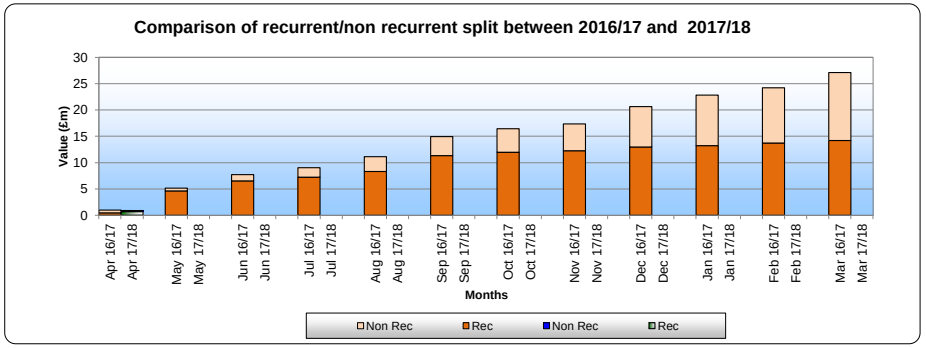
Governance

Risk	April	0	Trend
High	27		
Low	0		









Carter
Month 1 - The Period 1st April 2017 to 30th April 2017

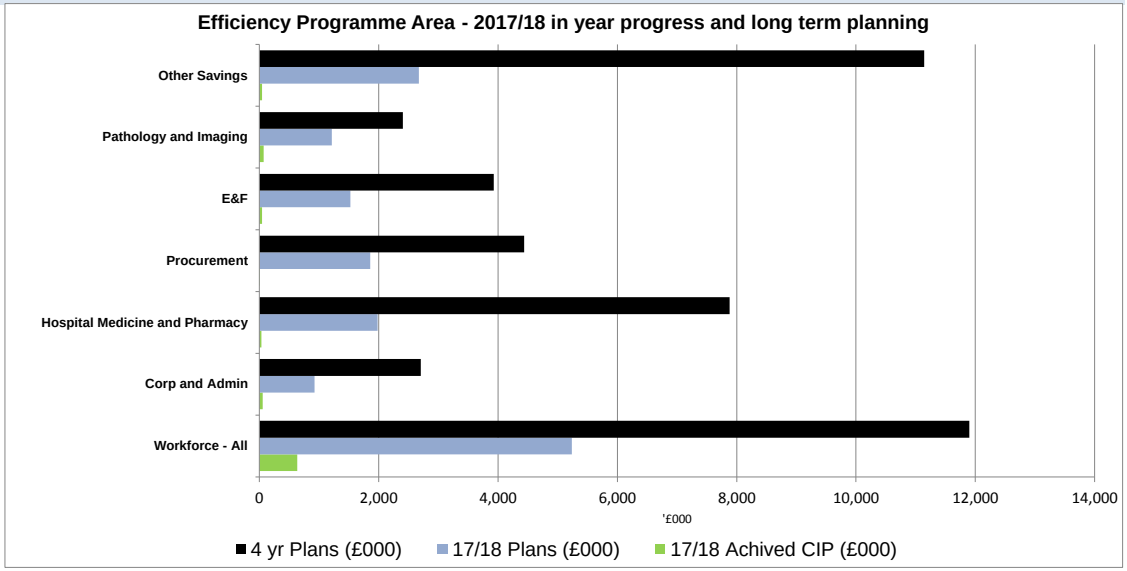
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

The Carter Leads for each workstream provide an update on progress against the Carter Agenda to the Carter Steering Group.
The Model Hospital Benchmarking Tool has been updated with 2015/16 Reference Cost Data - this is being rolled out to Diretorates to identify areas of opportunity.

EFFICIENCY PROGRAM - CARTER WORKSTREAM PERFORMANCE APRIL 2017

Efficiency Programme Area	4 yr Plans (£000)	17/18 Plans (£000)	17/18 Achived CIP (£000)
Workforce - All	11,900	5,237	634
Corp and Admin	2,706	926	57
Hospital Medicine and Pharmacy	7,880	1,984	34
Procurement	4,441	1,860	6
E&F	3,931	1,523	45
Pathology and Imaging	2,406	1,214	75
Other Savings	11,144	2,671	45
TOTAL	44,408	15,415	895



WORKFORCE	HOSPITAL PHARMACY AND MEDICINE
1. Draft Internal Dashboard set up and is being reviewed by the Workforce Lead. 2. Back office Costs Data Collection has been validated and final submission sent on 6 January 2017. The Model Hospital will be updated by NHSI to reflect this submission. Work ongoing to identify opportunities. 3. Review ongoing with Nurse E-Rostering System being led by Senior Nursing Team, E-Roster Team, HR and the Efficiency Team.	1. Draft Internal Dashboard set up and is being reviewed by the Pharmacy Lead. 2. NHSI updated Model Hospital Portal with National Pharmacy Dashboard August 16. 3. Electronic Prescribing rolled out to Trust.
PROCUREMENT	**ESTATES AND FACILITIES**
1. Procurement Steering Group set up and monthly meetings are being held to drive the programme forward. 2. Workshop held with Procurement and a follow-up held in September with schemes being identified and updated on a monthly basis. 3. Procurement Purchasing Price Index (PPIB) Benchmarking Tool being piloted in Max Fax with a view to roll out Trustwide (comparison of pricing)	1. Work progressing on Internal Dashboard. 2. National Dashboard now live on Model Hospital and being reviewed.
CORPORATE AND ADMIN	**PATHOLOGY AND IMAGING**
1. Corporate and Admin review outcome received; leads in areas to comply or explain variation and plans to be developed where appropriate.	1. Pathology data collection submitted and loaded on to Model Hospital. Directorate assessing and identifying areas of opportunity. The overall position is positive when compared to peers.

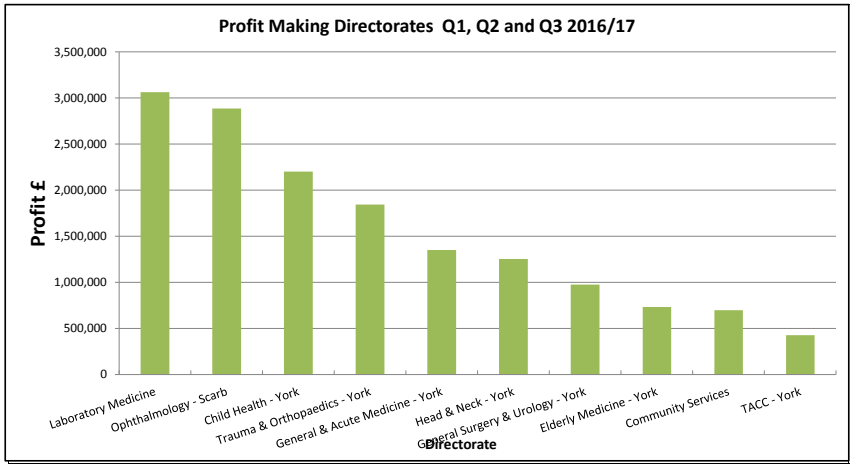
Service Line Reporting

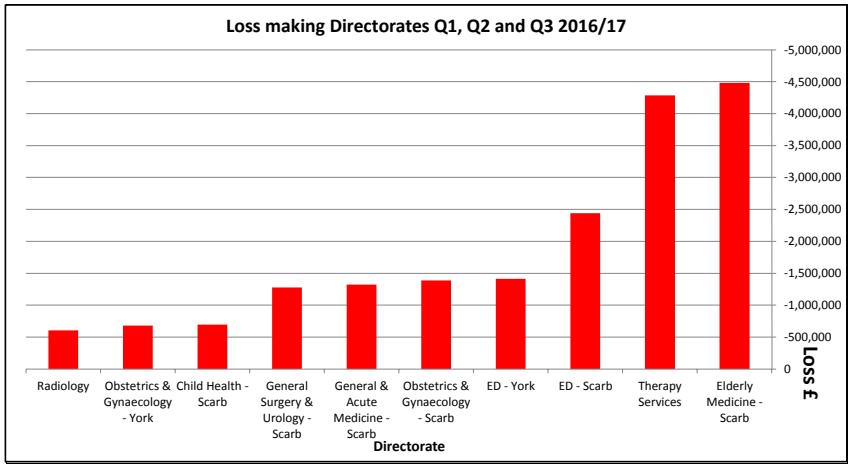
Month 1 - The Period 1st April 2017 to 30th April 2017

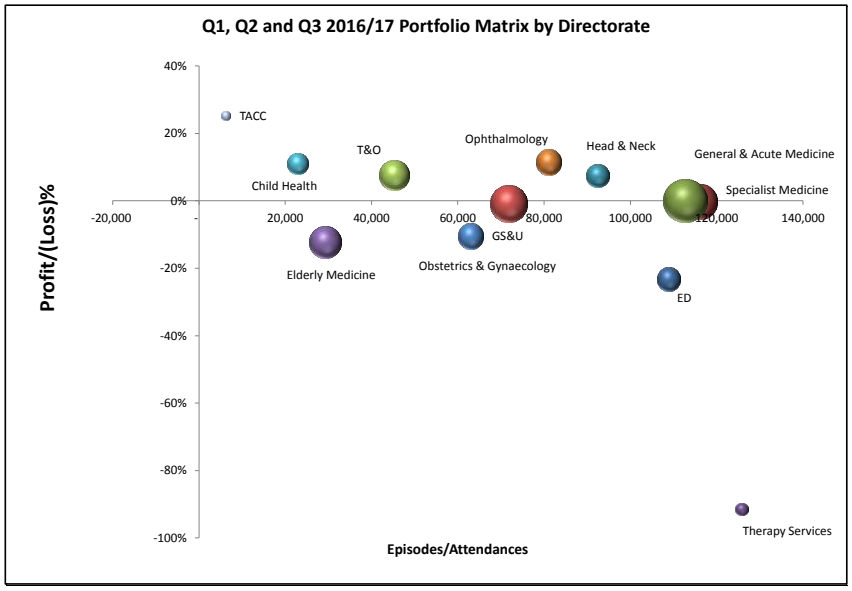
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Current data is based on Q1, Q2 and Q3 2016/17
* It is expected that Q4 2016/17 will be completed towards the middle of June 2017
* Qlikview user guides are continued to be developed to help users log in and navigate round the system







DATA PERIOD	Q1, Q2 and Q3 2016/17
CURRENT WORK	* Q4 2016/17 SLR PLICS reports and Reference Costs are now the key focus for the team *Qlikview user guides have been published to help users log in and navigate round the system. More user guides covering different areas of Qlikview will be released over the coming months * Work with Directorate teams is currently on-going to improve the quality of consultant PA allocations used within the SLR PLICS system for each quarterly reporting period * The SLR team are continuing to work with Directorate teams to improve the quality of outpatient staffing group costs within SLR PLICS
FUTURE WORK	* Work on the Q1 2017/18 SLR PLICS data will commence once the Reference Cost return has been submitted * Future work around junior doctor PA allocations will improve the quality of the SLR data and also inform the annual mandatory Education & Training cost collection exercise * Planning for the NHSI Costing Transformation Programme will soon begin to ensure that we are prepared for future mandatory reporting requirements

FINANCIAL BENEFITS TAKEN SINCE SYSTEM INTRODUCTION	**£2.78m**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Efficiency Programme Update – April 2017

Action requested/recommendation

The Board is asked to note the April 2017 position.

Executive Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2017/18 target is £22.8m and delivery, as at April 2017 is £0.9m.

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

Implications for equality and diversity

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

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

Reference to CQC regulations

There are no references to CQC regulations

Progress of report	Finance & Performance Committee
Risk	The Efficiency Programme presents a significant

	financial risk to the organisation.
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Andrew Bertram, Finance Director
Author	Steve Kitching, Head of Corporate Finance & Resource Management
Date of paper	May 2017
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Briefing note for the Finance & Performance Committee Meeting 23 May 2017 and Board of Directors Meeting 31 May 2017 –

Subject: April 2017 - Efficiency and Carter update

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

Summary reported position for April 2017

Current position – highlights

Delivery - Delivery is £0.9m in April 2017 which is (4%) of the £22.8m annual target. This position compares to a delivery position of £1m in April 2016.

Part year delivery is £0.3m behind the profiled plan submitted to NHSI.

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

In year planning – At April 2017 CIP planning is £15.4m (68%) with a gap of £7.4m, the comparative position in April 2016 was a gap of £8.5m.

Four year planning – The four year planning gap is (£16.6m). The position in April 2016 was a gap of (£33.2m).

Recurrent vs. Non recurrent – Of the £0.9m delivery, £0.7m (78%) in-year has been delivered recurrently. Recurrent delivery is £0.2m ahead of the same position in April 2016.

Quality Impact Assessments (QIA) –

Of the 575 schemes that have been assessed 3 have been categorised as Extreme Risk and 4 as High Risk.

The 3 Extreme Risk are capacity related and 3 of the 4 High Risk schemes are to be re-assessed by the Directorate concerned. These schemes are to be reviewed at the Carter Steering Group in June 2017.

Overview

The April 2017 position reflects a slow start to the year but is consistent with prior years. To encourage delivery an incentive of 20% will apply to all recurrent CIP's delivered in the first quarter of 2017/18.

The Resource Management Team's focus will be on supporting Directorates to develop firm plans to close the £7.4m in year planning gap with a number of Workshops organised for Directorates. A further roll-out of Workshops will continue throughout the year.

Carter

The Procurement Purchasing Price Index Benchmarking tool (PPIB) is being piloted in Max Fax and will be rolled out to the wider Trust to take advantage of the opportunities presented. PPIB high level figures suggest an opportunity of circa £2m for York and this continues to be validated.

The Corporate and Admin review has been re-issued and Leads in these areas are being asked to comply or explain where there are variances and develop plans where appropriate.

Work is continuing with the Nurse E-rostering system; due to the nature of the complexity of this scheme it is anticipated that efficiencies should materialise in 2017/18.

Risk

The key risks in the programme:

- The in-year planning gap of £7.4m
- The 4 year planning gap of (£16.6m).
- Reducing the carry forward balance of non-recurrent delivery by 2019.
- QIPP schemes.

DIRECTORATE	Yr1 Target	4Yr Target	Yr 1 Plan v Target		Yr 1 Delivery v Target		Y1 Recurrent Delivery v target		4 Yr Plan v Target			Overall Risk	Governance Risk
	(£000)	(£000)	%	Risk	%	Risk	%	Risk	%	Risk	Total Score		
EMERGENCY MEDICINE	865	2,555	41%	High	0%	High	0%	High	0%	High	12	High	High
TACC	2,662	6,751	89%	High	0%	High	0%	High	48%	High	12	High	High
SPECIALIST MEDICINE	2,818	6,975	47%	High	1%	High	1%	High	29%	High	12	High	High
GEN MED YORK	1,801	5,662	75%	High	1%	High	1%	High	89%	High	12	High	High
HEAD AND NECK	717	1,838	79%	High	0%	High	0%	High	91%	High	12	High	High
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1,257	3,439	44%	High	1%	High	1%	High	38%	High	12	High	High
RADIOLOGY	1,863	3,417	30%	High	2%	High	2%	High	19%	High	12	High	High
CHILD HEALTH	849	2,099	110%	Low	0%	High	0%	High	68%	High	10	High	High
GS&U	1,952	4,939	40%	High	3%	High	2%	High	73%	High	12	High	High
WOMENS HEALTH	1,654	3,364	44%	High	3%	High	3%	High	44%	High	12	High	High
PHARMACY	431	1,027	65%	High	4%	High	4%	High	90%	High	12	High	High
OPHTHALMOLOGY	826	2,758	109%	Medium	0%	High	0%	High	96%	High	11	High	High
LAB MED	551	2,522	107%	Medium	7%	High	7%	High	67%	High	11	High	High
MEDICINE FOR THE ELDERLY	1,225	3,424	118%	Low	11%	High	3%	High	56%	High	10	High	High
GEN MED SCARBOROUGH	696	1,839	122%	Low	4%	High	4%	High	87%	High	10	High	High
COMMUNITY	438	780	169%	Low	0%	High	0%	High	149%	Low	8	Medium	High
SEXUAL HEALTH	540	1,021	103%	Medium	20%	Medium	20%	Low	100%	High	8	Medium	High
ORTHOPAEDICS	682	3,026	141%	Low	37%	Low	37%	Low	111%	Low	4	Low	High
CORPORATE													
MEDICAL GOVERNANCE	253	459	0%	High	0%	High	0%	High	0%	High	12	High	High
CHIEF NURSE TEAM DIRECTORATE	351	673	34%	High	0%	High	0%	High	18%	High	12	High	High
FINANCE	465	1,300	0%	High	0%	High	0%	High	0%	High	12	High	High
OPS MANAGEMENT YORK	171	595	36%	High	0%	High	0%	High	18%	High	12	High	High
CHAIRMAN & CHIEF EXECUTIVES OFFICE	74	255	0%	High	0%	High	0%	High	0%	High	12	High	High
SNS	433	1,408	91%	High	0%	High	0%	High	86%	High	12	High	High
HR	256	848	62%	High	7%	High	0%	High	75%	High	12	High	High
ESTATES AND FACILITIES	2,101	6,114	72%	High	2%	High	0%	High	64%	High	12	High	High
LEARNING ORGANISATIONAL DEVELOPMENT & RESEARCH	169	527	76%	High	15%	Medium	0%	High	92%	High	11	High	High
TRUST SCORE	**26,100**	**69,614**	**37%**	**High**	**4%**	**High**	**3%**	**High**	**73%**	**High**	**12**	**High**	**High**

I3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Operational Performance Headlines

Action requested/recommendation

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

Executive Summary

The Trust performance recovery plan 'Return to Operational Standards' (RTOS) sets out the actions to support performance against the Emergency Care Standard, Referral to Treatment times, Cancer waiting times and sets out the revised trajectories for performance recovery.

The performance position remains challenging in the first month of 2017-18. The ECS standard has exceeded the planned trajectory and seen further improvements in Ambulance Handover and long waits in ED, however the position remains fragile and increasing pressures were experienced towards the end of April. The RTT and diagnostic position have seen a decline in performance in April. Actions plans are in place through the Task and Finish Groups to maximise capacity, with the Outpatients Programme in scoping. The diagnostic performance was affected by equipment issues, and the recovery actions will be targeted to mitigate future risks. Cancer performance improved for 62 day first treatment from screening and GP referrals, however both remain under the national target. 14 days Fast Track performance dropped below the national standard and remedial action to support skin pathways is ongoing.

Strategic Aims

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

Implications for equality and diversity

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

belief, gender and sexual orientation).
It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC regulations

There are no references to CQC regulations

Progress of report	First presentation
Risk	Risk to patient access standards Risk to Sustainability and Transformation Funding.
Resource implications	The performance element of the Sustainability and Transformation Funding is dependent on meeting planned trajectories for ECS, Cancer, 18 weeks and diagnostics and to improve Ambulance Handover times compared to the previous year.
Owner	Juliet Walters, Chief Operating Officer
Author	Lynette Smith, Head of Operational Performance
Date of paper	May 2017
Version number	Version 1

Board of Directors – 31 May 2017

Operational Performance Headlines

1. Introduction and Background

The Trust performance recovery plan 'Return to Operational Standards' (RTOS) sets out the actions to support performance against the Emergency Care Standard, Referral to Treatment times, Cancer waiting times and sets out the revised trajectories for performance recovery. It brings together the work of the internal Acute and Planned Task and Finish Groups, system work on transformation of planned care and outpatients, Cancer Alliance priorities and internal productivity across service areas. This report sets out the progress of the recovery plan and associated underpinning work.

Performance against key metrics continued to be challenging in April, there were improvements in the Emergency Care Standard, but a reduction in performance for diagnostics and RTT. This paper provides a summary of the key performance indicators and operational response.

2. Performance Headlines: Unplanned Care (pg. 46-49)

April saw continued improvement in the Emergency Care Standard (ECS), with Trust performance at 92.9%, above the planned STF trajectory of 90%. This remains below the national standard of 95%. This built on March 17 performance and represents a 10% improvement from February 17. The Trust made significant improvements in March and performance on ECS was more comparable with the national picture (*Trust 89.3%, England, 90%)* than previous months.

There was a 6.4% (+970) increase in the number of overall attendances in April 17 compared to April 16 and 2.4% (+390) increase from March 17. However, Type 1 attendances reduced by 2.15% (-198) compared to April 16 and 1.6% (-145) from March 17, reflecting the impact of clinical navigation and streaming work. Non elective admissions increased 4.9% from April 16 (+200); this incorporates a significant increase in the number of admissions from ED (increase 16.9% from April 16, +453). The annual increase is prevalent on both sites and factors include new assessment pathways at the York site, streaming at ED directing those with lower acuity to urgent care centre services. The conversion rate remains high from ED attendances to admissions and this is a focus of work through the streaming work and Acute Medical Model at Scarborough.

There was a reduction in GP non-elective admissions in April (998, compared to 1,148 in March 17, and 17% reduction from April 16), however the Easter bank holiday practice closures may have affected this. The RTOS streaming element also focussed on the implementation of the 4 hour protocol at both sites in April, with a zero tolerance approach to non-admitted breaches. The impact has been seen in March and April, with a month on month reduction of non-admitted breaches, down from 891 in February to 302 in April. This is supported through daily monitoring of delays to the internal protocol and communication to teams and ward areas on progress.

Ambulance handovers saw further significant improvement in April – 88% reduction in

ambulances waiting over an hour, and 62% reduction of ambulances waiting between 15-59 mins from February 2017. The new arrangements for recording handover times have been fully implemented, which has supported improved reporting times, average handover time improved from the first week of April to the last (15.22mins to 14.20 mins at Scarborough; 12.59mins to 12.10mins York). Work continues on the Ambulance Concordat to further improve as delays are continuing with 35 handovers recorded at over 1 hour in April 17.

Scarborough Hospital has continued to implement the Acute Medical Model supported by a revised performance framework with metrics across 6 key areas; initial clinical assessment, clinical decision making, avoiding crowding, unplanned re-attendance, staff motivation and patient experience. Improvements have been seen in March on screening with 15mins of arrival in department (50% - *35.1% Feb 17*), Time from arrival in department to a clinical decision being made within 2 hrs as to onward care needs (69.4% - *46.2% Feb 17*) and unplanned return to department within 48 or 72 hours (48hr - 0.2%; 72Hr - 0.2%; *48hr - 0.5% 72Hr - 0.5% Feb 17*). Baselines have been taken for the remaining measures.

The RTOS 'flow' element continues to be implemented to support the timely transfer of patients and reduce delays. Through April the assessment units at the York site have been enhanced and embedded, with 6 weekly clinical review exercises established and supported by daily usage data to review demand. The focus on speciality review and timely transfer from ED has helped reduce the number of long waits in ED by 57% (-183) compared to March. There were no 12 hour trolley waits in ED in April. Nevertheless long waits in ED continue to a significant concern to the Trust, with 136 patients waiting over 8 hours in ED in April. The comprehensive review of patient flow from ED, through assessment and to downstream wards was completed in April, with recommendations due in mid-May. This includes forecasting methodology, escalation of pressures and logistical support to prevent patients delaying.

Bed occupancy was high but slightly improved at the York site, with two days below 85% and variance between 81.24% at midnight to a high of 95.3%. Scarborough Hospital bed occupancy remained challenging ranged from 82.55% to 99.61%, with the last week of the month experiencing 5 out of 7 days over 99%. There were 875 bed days lost due to delayed patients in April, an improvement on 1089 in March 17. In addition there were 210 patients with long lengths of stay (over 28 days) in March 17.

Executive oversight of discharge has been a key focus in April to address long length of stay and reducing patient delays with the development of the emerging 'Common Purpose' incorporating the continued roll-out of SAFER across wards in York and Scarborough site. Use of discharge lounge and proportion of discharges in the morning are key priority areas. The Trust is engaging with the CCGs on revised specifications for patient transport to increase flexibility and the Complex Discharge workstream has commenced to address stranded patients.

The pressure in the system increased over the Easter Holiday, with ECS performance reducing on both sites in the last week of April following the Easter weekend. Whilst overall attendances have remained generally within control limits, performance has been impacted on days where surges of attendance have been sustained for two or more hours over the control total, resulting in increased the number of non-admitted breaches. Additional risk in the system includes GP admissions creating surge points in late afternoon/ early evening and increased dependency on bank staffing for acute wards. The focus through May is on-going improvements against the internal standards against the four hour protocol, including flex of clinical navigation in times of surge on both sites. Review of escalation processes out of hours and implementation of flow review recommendations and embedding of AMM standards at the SGH site.

3. Performance Headlines: Cancer (pg 53)

The Trust met 4 out of the 7 targets for March 2017, with performance under expected levels for:

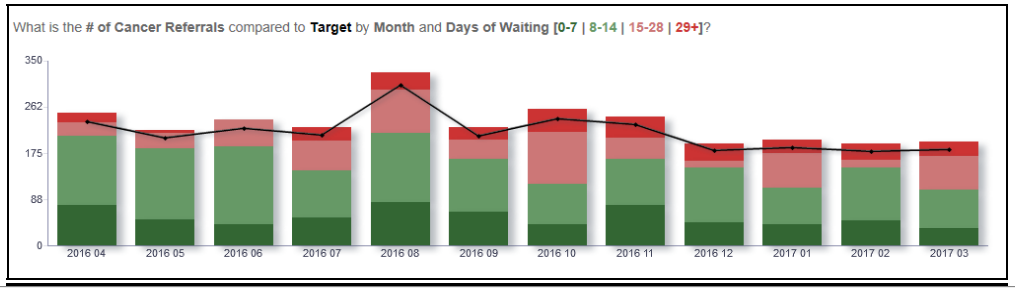
- 14 day Fast Track (90.9% - 124 breaches, of which 76% were diagnosed with no cancer)
    - 62 days 1st Treatment from GP referral (82.5% - 27 breaches, or which 10 were due to capacity issues)
    - 62 days 1st Treatment from screening (86% - 2.5 breaches)

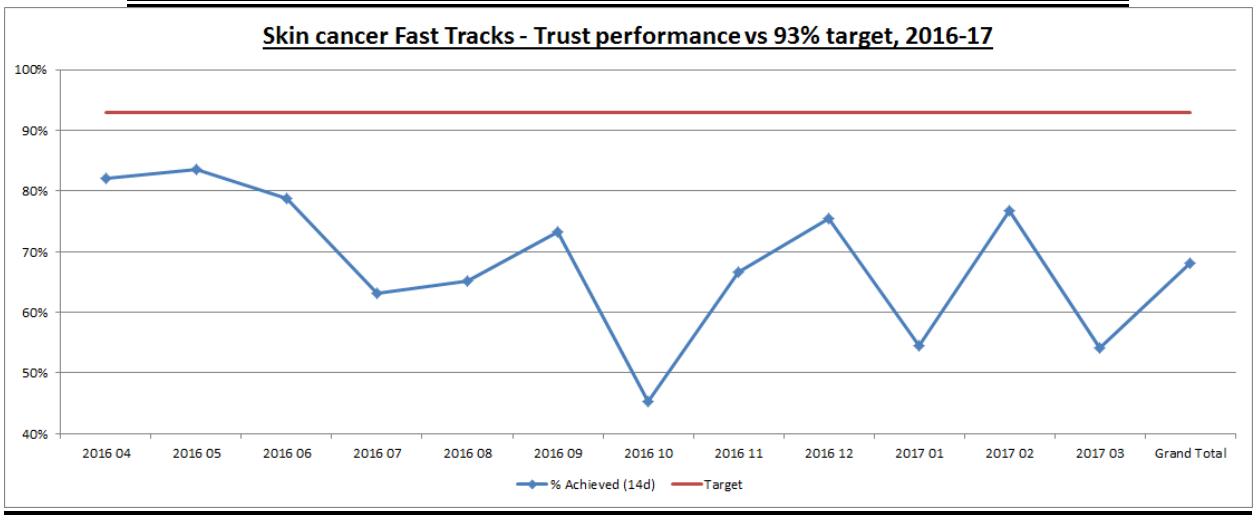
The STF Target for Q4 has not been met for 62 days 1st Treatment. This is a key focus for the recovery work. Nationally the Cancer waiting times were met for March, with the exception of 62 day 1st treatment from GP (83%), and two week breast symptomatic (91.6%). Performance for 62 days from GP referral and screening were both improved on February 17.

A review of cancer governance and performance reporting is underway. This includes refreshing roles and responsibilities and alignment between the Cancer Operational and Strategic Boards, internal weekly performance meetings and the Cancer Alliance developments across the Sustainability and Transformation Plan footprint. There has been an impact of bank holiday and annual leave reducing the number of available clinics in April.

As previously reported, Skin referrals comprise the majority of 14 day fast track breaches (89 of 124 in March 17), with capacity issues at the East Coast. The majority of these were diagnosed as no cancer and work continues with the CCGs to embed the new referral processes and use of Dermatoscopes to improve referral rates. A revised operating model is in development to address the on-going capacity issues, with a business case by the end May. This remains a significant concern for the Trust.

<u>Skin cancer Fast Tracks - Whole Trust - April 2016 to March 2017</u>





There has been an increase in colorectal referrals, which has affected capacity for Fast

Track in April. The trust is working with the CCG to understand the increases through the clinical lead for Cancer.

The Trust is prioritising pathways with underperformance on the 62 day pathway through the Cancer Operational Board and Cancer Alliance. Areas of focus where targets have not been met include Lung, Upper GI and Haematology pathways; these are often more complex pathways 50% of the patients' breaches in March were due to clinical complexity. Mapping the internal pathway from entry point in referral to MDT is focussed on moving towards the 28 day to diagnosis national standard for 2020. There have been significant diagnostic capacity issues in tertiary centres which have been escalated to the Cancer Alliance. Issues have been escalated directly to tertiary centres for elective cardiology CT scanning and robotic surgery.

Cancer sites achieving the target for March are Breast, Gynaecology and Skin.

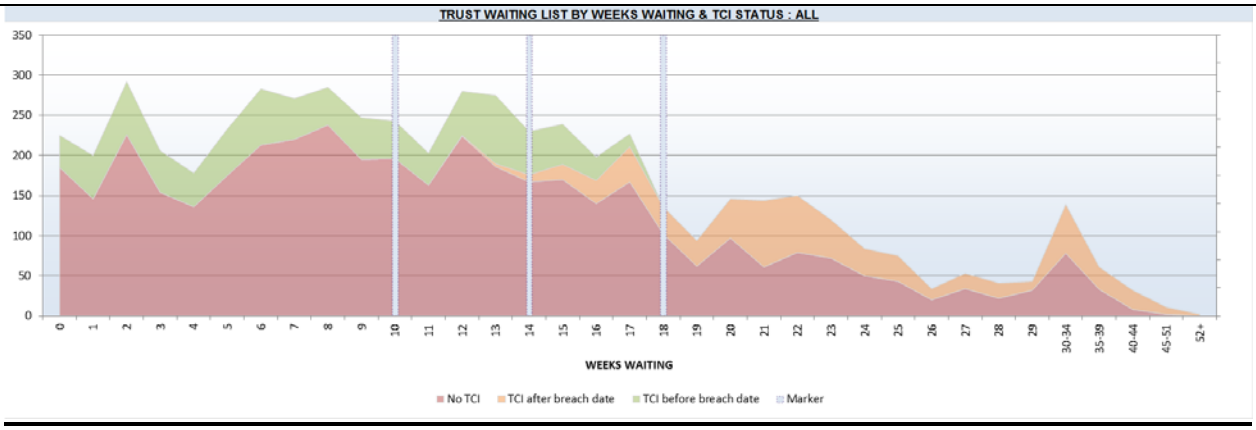
4. Performance Headlines: Planned Care (Pgs 50-51)

Performance has reduced in April to 88.89%, compared to 89.4% in March. This is below the planned trajectory of 89.9% for April. Much of the impact relates to the Easter break and annual leave, with reduced clinic and theatre lists as a result. The admitted backlog for April is 1,426, which is 17% rise from the position at the end of March (1,220) this is linked to the Easter break and the additional RTT Monies provided by NHSE ceasing at the end of March. The non-admitted pathway continues to be a priority focus, with the non-admitted backlog position reducing by 3.3% at the end of April compared to March (1,380 from 1,427). This is being addressed with targeted support for validation and the Outpatients Programme.

Specialities causing concern on the incomplete position include Maxfax, Respiratory, Urology and General Surgery. As previously reported there is specific recovery plan for Maxfax, which was reviewed in April. Additional support for outsourcing is in place through to July. A specific recovery plan is in development for Urology. Urology has been affected by reduced capacity through a consultant vacancy. The new patient pathways are in place at Malton and this will be a core element for long term sustainability. General Surgery has been affected by the bed pressures through February and March. The admitted position remains challenging for General Surgery with a high proportion of the long wait patients. Further work on maximising list utilisation is ongoing.

The Trust RTT position remains below the national average for March, but was more comparable than previous months (Trust: 89.4%, England 90%).

Long waits continue to be a significant risk across a range of specialities. At the time of writing the report 74 patients waiting over 40 weeks. This is a significant increase from 42 at the end of March 17. The highest volumes over 40 weeks are in MaxFax (29%), General Surgery (21%) and Urology (19%). Patients are review weekly through the PTL and prioritised through theatre planning. There were no 52 week breaches in April.



The Trust is working with the CCGs on a range of demand management and service re-design programmes, including e-referrals and advice and guidance processes and community pathways through the planned care programme (QIPP). There has been a reduction in outpatient referrals in April, across GP referrals, consultant to consultant referrals and other referrals. GP outpatient referrals were significantly reduced from March 17 (23.5% reduction, -2,512), and from March 2016, the last comparable Easter period (18.9% reduction, -1,857). This will continue to be closely monitored through the planned care meetings.

Waiting list initiatives and outsourcing continue on challenged specialities. The theatre utilisation programme continues with successful recruitment in theatres with 0.4 Scrub and 3.98 ODP remaining vacancies. The Easter break has affected theatre utilisation with 529 of the 552 requested lists delivered to week commencing 1st May, this is addressed through the planned care task and finish group. There were significantly less cancelled operations within 48 hrs in April 17 from March 17, and in comparison to April 16 (reduction of 66.4% - 91 for the Trust and notably at 71.43%, -50 reduction from April 16 at Scarborough Hospital). This has helped to maintain the admitted backlog position.

The Outpatient Utilisation programme is being scoped to commence in Q1. This will incorporate broader demand, including the challenges in Follow-Up partial booking (FUPB) appointments and patient cancellations or 'Did Not Attend (DNA) rates. There has been a rise in the number of overdue FUPB appointments in April, with a significant increase on the Scarborough site. Capacity and appointment processes are under review by all directorates.

DNA rates increased slightly in April to 6.8%. Text alerting has been implemented across all specialities, with approximately 500 sent per day.

Recruitment to the tracker vacancy has been successful and validation support targeted at Gastroenterology. Service manager meetings are in place to support pathway management.

5. Performance Headlines: Diagnostics (Pg 52)

The Trust has not met the diagnostic target for the first time since August 15 achieving 97.25% against a target of 99%. The primary cause of the position was the breakdown of the DEXA scanner at Scarborough Hospital at the end of April for a few days, which contributed to the 50 breaches for DEXA in April. Patients were rebooked over the bank holiday weekend and in early May.

MRI marginally missed the target (98.82%) with 10 breaches. Areas with significant pressures in April include sleep studies, cystoscopy and DEXA (as reported above). The

diagnostic recovery plan will be developed through May, building upon the Radiology priorities and Urology recovery plan to return to national standards. Key areas of focus include finalising capacity utilisation and demand mapping in Radiology and capacity for rigid cystoscopy. The Sleep Service has engaged the service improvement team and a new Consultant is now in place to implement revised protocols. Initial discussions with the CCG have commenced to review referrals and support demand management for sleep.

The Trust performed better than the national position in March (Trust 99%, England 98.9%).

6. Conclusion

The performance position remains challenging in the first month of 2017-18. The ECS standard has exceeded the planned trajectory and seen further improvements in Ambulance Handover and long waits in ED, however the position remains fragile and increasing pressures were experienced towards the end of April. The RTT and diagnostic position have seen a decline in performance in April. Actions plans are in place through the Task and Finish Groups to maximise capacity, with the Outpatients Programme in scoping. The diagnostic performance was affected by equipment issues, and the recovery actions will be targeted to mitigate future risks. Cancer performance improved for 62 day first treatment from screening and GP referrals, however both remain under the national target. 14 days Fast Track performance dropped below the national standard and remedial action to support skin pathways is ongoing.

7. Recommendation

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

Author	**Lynette Smith, Head of Operational Performance**
Owner	**Juliet Walters, Chief Operating Officer**
Date	**April 2017 (Reporting March 2017)**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 31 May 2017

Environment & Estates Committee

Action requested/recommendation

The Board of Directors is asked to receive the minutes of the Environment & Estates Committee meeting held on 11th April 2017 noting the assurance taken from these discussions and the key items that have been highlighted for the attention of the Board including the Health & Safety Strategy document at enc. 1.

Summary

The purpose of the Committee is to receive assurance and to provide challenge and scrutiny around environment and estates matters within the Director of Estates & Facilities areas of responsibility.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

CQC outcome regulation 15: premises and equipment.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	None
Resource implications	None
Owner	Michael Sweet, Chair – Environment & Estates Committee
Author	Brian Golding, Director of Estates & Facilities
Date of paper	May 2017
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Environment & Estates Committee Meeting – 11.4.17

Committee: Mike Sweet (MS) (Chair), Jennie Adams (JA)

Attendees: Brian Golding (BG), David Biggins (DB), Colin Weatherill (CW), Jacqueline Carter (JC), Andrew Bennett (AB)

	Agenda item	AFW /CRR	Paper	Comments	Assurance	Attention to Board
1.	**Welcome / Introductions**			MS welcomed Andrew Bennett, Head of Capital Projects, to the meeting as a full member of the Committee.		
2.	**Apologies for absence.**			Apologies for absence were received from Lynda Provins, Trust Secretary and Jane Money, Head of Sustainable Development.		
3.	**Minutes of last meeting.**			The minutes of the last meeting held on 7th February 2017 were agreed as a correct record.		
	Matters Arising			**Other departmental Risk Registers** - a question had been raised at a previous meeting as to whether there would be any benefit for CW to interrogate other departmental RRs for any h&s risks that hadn't been captured elsewhere; CW felt currently there is no appetite in the Trust to follow this up however, he said the IA team is undertaking a RR review this year and he has also provided further information on this subject within his H&S Strategy document. **Charitable Rate Exemption** - it was noted that GVA our ratings advisers have written to AB setting out the current position regarding the Trust's involvement in legal action to gain the mandatory rate relief and any risks associated with taking part. He confirmed he will review the advice received and assess		

	Action Log			whether it is in our interests to proceed. **Action: AB.** **Business Cases** - Sustainable development inclusion - JM has agreed with the BC team that a short section on SD will be included essentially asking authors what considerations have been given and to contact JM. This was noted. MS commented that he had suggested to JM about having some form of checklist to assist authors when completing the sustainability section of a BC. **DRR EF01 - Estates capital availability** - a 6 facet survey was still to be undertaken between now and September. BG reminded the Committee this condition survey would drive the backlog maintenance programme for York and Scarborough. **H&S training** - the BC for a new training position was still being developed (awaiting financial pro forma) - CW anticipated that it will have been considered by the next EEC meeting. **Action: CW.** **Non clinical claims schedule** - a question had been raised at the last meeting as to whether the full non-clinical claims schedule should be seen by this Committee - it was felt it was not required at this time and that the EEC would continue with the information it already received contained within CW's quarterly report. **Security Policy** - CW and MS to discuss further the role of a nominated NED as required by the policy. **Action: MS/CW.** **Legislation** - Following CW's presentation to the BoD in March they had requested further information be available in paper form by way of a summary sheet detailing the presentation material along with the published Institute of Directors H&S pamphlet. **Action: CW.** 5. Smoking on site - BG confirmed Polly McMeekin is writing a paper for CDs and JNCC setting out the Trust's position. He has		

				contributed to this from a security point of view and there is some debate still to be had around how we capture the patient journey in that. Once complete the paper can be included in the EEC pack of papers. **Action: BG.**		
4.	**Terms of Reference and Work Programme.**			The EEC received their revised ToR for consideration. It was noted that LP had recently revised a number of Board sub-committee ToR to ensure a consistent approach in the layout and wording. It was noted the standing agenda had now been removed from the ToR and the EEC were content to work with the alternative enclosed work programme instead. Subject to some minor amendments that will be advised to the Trust Secretary the EEC noted the suggested modifications and approved the ToR.		
5.	**Board Assurance Framework**			Deferred to next meeting.		
6.	**Directorate Risk Register**			The EEC reviewed the red and amber risks highlighted on the RR; EF01 - EF11. Items to note: EF01 - Estates capital - BG reported that a Treasury loan had been secured to fund 2 major projects at York but admitted there were still significant projects under consideration at BDH and SGH with no funding identified to support them at present. EF02 - Estates; replacement of fire alarm system - BG was pleased to confirm that the BoD approved programme includes the fire alarm replacement at both York and SGH. EF06 - Estates; chiller failure in ICU - item closed (chiller replaced).		

				EF08 - Estates; Malton fire dampers inspection - CW reported that he will review the scoring of this item. AB confirmed that he was currently scoping a project at the Malton site which can include this. **Action: AB.** EF09 - Estates SGH; inadequate ventilation ICU - to be addressed. BG said an ICU strategy was required for SGH which would be addressed within the Estates Strategy refresh. It was noted a Ventilation Steering Group had been formed as part of our own governance structure and recently had its first meeting. At this point JA asked about the lack of isolation facilities in the hospital which is linked to infection prevention. Infection control items were mainly picked up through the Chief Nurse RR and not necessarily through this route however, AB said he was aware of this and had met with Microbiology and Infection Prevention teams as single rooms will feature heavily in the new Estate Strategy programme of work and so it is about being mindful as to what that would do to capacity on the site and how we can broker compromise with the Operational teams. This was noted. EF10 - Estates York; air handling unit - this is linked to the backlog maintenance programme. Again, where appropriate these maintenance items will be incorporated into planned projects by Capital Planning. **Action: AB.** EF11 - Estates York; inadequate power supply in critical areas. It was noted that Paul Johnson, Estates Maintenance Manager, was undertaking a review of Uninterruptable Power Supply (UPS) systems in each Theatre area to determine those that require immediate attention. Again, an Electrical Safety Group is well established as part of our own governance structure although it was noted some of their governance documentation still required to be updated as part of their remit.		

				CW would update the RR accordingly. **Action: CW.**		
7.	**E&F Policy & Procedure programme.**			The EEC received the updated directorate policy & procedure schedule which forms part of its governance portfolio. As requested a date column had been added to the schedule. DB confirmed he was in the process of setting up various committees and steering groups that are responsible for writing those procedures; a number of these have yet to be developed and the PAM work helps identify these gaps. MS/JA asked if the "latest position" column can be fully completed. This was noted. **Action: DB.**		
8.	**Internal Audit Reports** • **Y1749 residential accommodation follow up**			**Y1741 - residential accommodation follow up** - the follow up internal audit report was received by the EEC. The aim of the report was to gain assurance that the original recommendations made have been implemented. The report has received limited assurance. Section 6 of the report detailed the schedule of findings and recommendations. BG reported that a number of the recommendations had been completed and he had since received assurance that a further 3 were complete. BG reminded the EEC that primarily this related to short term leases for residential accommodation. James Hayward has provided an overview of the current position for the EEC and an explanation of future plans. BG explained that in York we are moving towards using the private sector to provide accommodation. Currently we hold city residences at YSJ for on call medical staff but this is coming to an end; we are working with the University of York to look at their capacity for medical students as well as proposing to use the Archways building which we have agreed with CYC to convert into residential accommodation which will deliver us a CIP. In SGH we have engaged GVA to undertake an assessment of		

	• **Schedule of 2017/18 audit work**			the residential accommodation provision there. A report had been brought to CPEG which recommended that we move all accommodation for on call medical staff to social housing which allows for the estate to be refurbished and improves our Carter footprint. A BC supporting this work will be considered by the BoD in due course. This was noted. MS thanked BG for this update. The EEC noted the recommendations in the report. It was agreed to assess the position in October. **Action: BG** The EEC received the internal audit schedule for 2017/18 which set out the areas to be audited this year. P.12 of the report identified the majority of the areas to be worked on for Estates and Facilities. A question was raised as to whether this work should link to PAM as that covers all the audit areas identified for this year and would aid in highlighting any weak spots. This was noted. P.4 of the document set out how the proposed planned areas have been identified using a number of keys including relevance to Corporate risk register. IA will review integrated risk management arrangements to ensure they are properly established and embedded in the organisation. This was noted. JA was particularly interested in the outcome of the Capital project appraisal set out on p.11 of the document and the prioritisation process. This was noted.		
9.	**Property and Capital**			**Capital Procurement overview** The EEC received an overview report on the Capital Programme and Capital Plan for 2017/18. The paper had been seen by the F&P Committee and BoD. The EEC reviewed the summary of approved projects;		

				Section A1 of the document showed the depreciation funded schemes. Section A2 of the document identified approved strategic capital funding. JA asked what was considered to be depreciation and what were we using the £12m depreciation for. AB said it is a source of capital funding in our terms and we try to strike a balance between the routine backlog maintenance programme and projects that are recommended in order to, deliver a range of service improvements. He also reminded the Committee that projects can deliver an element of backlog maintenance in themselves. AB clarified that routine maintenance is revenue funded, but that once an item exceeds £5k it is capitalised. Up to that point it is considered to be in the revenue budget programme for Estates. BG advised that the total Estates budget for repairs and planning general maintenance was £3m for York and £2m for SGH. He assured the EEC that whilst the outstanding backlog maintenance was large there are quite significant backlog maintenance costs absorbed within other schemes for example, the Radiology lift replacement scheme for SGH where the capital expenditure on the lifts removed the need for an element of backlog maintenanc**e**. MS asked whether this detail was recorded in Business Cases. AB confirmed this should be recorded in the BC. JA said she felt assured on the process and was pleased to see service improvement. JA asked whether there was any scope to reduce professional fees and/or present them in a different way. AB confirmed we do charge those fees to a scheme as soon as a project becomes a BC in order for any fees to be charged to the relevant project as capital. He acknowledged it was an outlay against the	The EEC was assured that although there are existing high backlog maintenance costs there are plans to	

				Capital Programme and there may be some fees that Finance are able to write off. BG assured the EEC it was important to continue to undertake initial design work to establish whether a project is feasible in order to modernise and keep developing the Trust. The design team used is already on an approved procurement framework. **Update on Carter metrics related to space planning** The EEC received a document providing an update on property asset management. A question was raised about the proposed move of Orthopaedic clinical services from Clifton Chapel to the new community stadium as set out on p. 92 of the document. BG confirmed the BC is approved for the relocation of some CLAD services and a further BC will be developed for the Orthopaedic services once firm costs are available from the Council's tender for the stadium. In the meantime the Trust has negotiated a new lease at the Chapel at a reduced rate. **Estates Strategy** The EEC received a copy of the Estates Strategy which showed site development plans over the next 10 years for the Trust sites which links to the work discussed above. The contents were noted. MS thanked AB for this update.	bring about a reduction.	
10.	**Health, Safety & Security**			**H&S/NCRG minutes – 10.2.17** The H&S/NCRG minutes of 10th February were received for comment and noting. The following item was raised: **Medical Gas person training package** - CW confirmed that		

				agreement has been reached on a way forward which has resulted in the learning being offered as part of the Trust's initial S&M requirements. After training a member of staff using gases will be personally responsible for determining how often they need to receive further training in line with any HTM best practice guidance. **Quarterly report** The EEC received the latest quarterly report covering the year to date for comment and noting: The following item was highlighted: Section 1.1 Overview - Trust Monitoring systems - the chart showed a 30% increase in non-clinical risk reports for the year to date. The report was noted. CW was asked to check the spread sheet formulae as they appeared to be incorrect. **H&S Strategy** The EEC received the Health & Safety Strategy for the Trust. The document aims to support strategic and operational management and commits the Trust to continually improve the health and safety of staff and patients by achieving compliance with the h&s policy and assisting in the delivery of an efficient approach to health & safety management. CW explained he wanted to demonstrate the Trust's longer term aims and key to that was delivering appropriate assurance, therefore, he has developed a number of KPIs as set out in the document. It was his intention to work with KN in populating those targets which would supersede the current H&S/NCRG Action Plan. As part of the assurance process JA was keen to see a reduction in RIDDORS year on year and welcomed that target. However, if the Datix reporting system is working effectively it		

				would be expected that there would be an increase in the number of incidents being reported, thereby, ensuring greater scope for action from learning. She said historically we are a low reporting organisation however, she was pleased that the number of serious incidents had dropped. CW agreed to consider how best this can be achieved year on year. It was noted that PAM is an organisation process indicator that could be used for this purpose. **Action: CW.** In relation to the KPIs within the Action Plan MS questioned how measurable they would be in real terms as he felt they were more of an indicator of progress that would provide assurance to the EEC and asked for the heading to be changed from "KPI" to "Indicator" to reflect this. This was agreed. **Action: CW.** It was agreed to approve in principle the draft document subject to the changes above. The document would be forwarded to BoD. **Action: CW/BG.** **Local Heat wave plan** The EEC received the updated Heat wave plan for 2017 for approval. CW has reviewed the plan against the national heat wave guidance to form a local procedure. The document has been forwarded to the Emergency Planning Group as part of business continuity plans. The health watch alert on p.19 of the document identifies the four levels of alert. CW explained that the Trust is planning to meet the requirements of Level 1 (A heat wave and summer preparedness programme 1 June – 15 September) as its base case and would respond appropriately if a higher level of alert were to be initiated by the Met Office. The question was raised as to whether this element of the plan could be presented earlier within the document. This was noted. **Acton: CW.**		BoD to note the H&S Strategy. Enc 1. BoD to note that the EEC has approved the 2017 Heat wave Plan.

				JM welcomed the document; and was keen to see it being used in a practical way. The EEC approved the plan. The document would be placed on Staff Room. **Action: CW.** **Update on NHS protect** Not discussed. **Legislation** See item 3. No new update. **H&S policy** The EEC received the revised H&S Policy for approval. CW has worked on the revision of the policy in line with its review date and in doing so has created a compact document which includes an easy access guidance sheet thereby being reader friendly. Section 4.12 of the document outlines the role of the EEC. This was noted. Section 6 of the document outlines the consultation process - CW assured the EEC that all stakeholders had been contacted. Section 7 of the document outlines the review and revision arrangements. An amendment to the numbering within the text in section 7 is required. This was noted. The EEC approved the policy subject to changes discussed. MS agreed to sign the document on behalf of the BoD. The document would be placed on Staff Room and brought to the attention of relevant staff for dissemination. **Action: CW.**	The EEC was assured that	BoD to note that EEC has approved the H&S Policy.

				Presentation – Incident (Datix) Reporting Prior to the start of the meeting CW presented to the EEC an overview of the online incident Datix reporting system which is accessed through Staff Room. He demonstrated how staff can report any type of incident on the online portal and the individual stages it takes the reporter through in order to achieve a satisfactory investigation and outcome to the incident and at the same time provide the necessary assurance when closing off items.	the Datix system for reporting adverse incidents is effective in respect of non-clinical incidents.	
11.	**Premises Assurance Model (PAM)**			**PAM Annual Report** The EEC received the annual compliance report for PAM for the year to date which would be submitted to the DoH and to NHSi as part of ERIC return information. Appendix 1 of the document shows the Trust's annual position against the model domains since April '16. The EEC were asked to consider the action plan contained in Appendix 2 which showed any gaps in compliance and costs associated with improvement against the PAM model. DB was pleased to report a growth in the level of compliance compared to last year's position. A question was raised as to whether there was anything in the documentation to highlight specifically to the EEC; DB explained the most significant risks are those identified with a compliance red rating within Appendix 2 which are deemed inadequate. He assured the EEC these are being addressed. He confirmed another priority for the year was to improve the patient experience domain scorings. Thereafter, other areas to address were around having the correct policies and procedures in place, ensuring risk assessments are reviewed and costed action plans are available. Unfunded action plans are identified and added to the RR. This was noted.	The EEC was content that the Annual Report shows year on year progress and can be submitted to the Centre.	Bod to be advised that the report had been approved for submission to NHSI.

				MS thanked DB for the update and he and JA offered their congratulations on the significant improvements that had been achieved over the last 12 months. Subject to a minor amendment in section 1 the EEC approved the report and noted the recommendations. **PAG minutes - 29.4.17** The minutes of the first Premises Assurance Group meeting held on 29th April were received for comment and noting. It was noted membership of the Group will be reduced in order to make the meeting more effective. With regard to the ToR for this Group these will be presented for approval to the next EEC meeting. **Action: DB.** **The minutes were noted.**		
12.	**Carter Report – E&F efficiencies** • **Quarterly report**			The EEC received the latest quarterly report showing the Trust's position against the Carter recommendations. The revised dashboard published by NHSi was shown at Appendix 2 of the report. Since the last meeting E&F have worked closely with Corporate Efficiency Team (CET) to further develop specific cost saving work streams and help further align the York Carter dashboard to the E&F CIP Programme. An E&F management pro forma has also been introduced which sets out 6 key templates to be completed on a month by month basis. For the June EEC meeting DB will present the completed April and May templates. **Action: DB.** Regarding the development of CIPs we have existing plans from last year and a number of CIP plans in place for this year. We are monitoring them through the treatment plans with support		

				from CET. As part of the STP work we are working with local health partners to identify joint cost efficiencies and are engaging in peer review on PAM with NLAG and Hull. In relation to space utilisation, the Trust is currently reporting 43% non-clinical floor space against the Carter recommendation of 35%. Tony Burns, Space Manager, is continuing to complete space site audits and will be in a position to update the accuracy of this information. BG said this was in line with other Trusts and assured the EEC a number of schemes are in place to help reduce this including property disposal, a reduction in leases and refurbishment of non-clinical areas. A question was raised as to whether there was anything else to highlight to the EEC; DB said he was looking at opportunities at BDH, in relation to the CIP schemes in place he was forecasting a reduction in laundry and cleaning costs per sq. mtr - a revised cleaning policy is due to be presented for approval at the next EEC. This was noted. The EEC approved and noted the recommendations in the report.		
13.	**Sustainable Development** • **SDMP – update** • **Minutes of last meeting, 15/2** • **NHS Sustainability Day, 23.3.17**			**SDMP Action Plan** The EEC received the latest update of the SDMP Action Plan and noted those recommendations contained within the report including progress on the action plans. BG thanked MS and JA for their contribution in the tender process for engaging external support to expand the engagement work to integrate sustainability through the organisation and as a result the Trust awarded the contract. This was noted.		BoD to be advised of the outcome.

				SDG minutes 15.2.17 The SDG minutes of 15th February were received for comment and noting. No items were highlighted to the EEC. JA asked about the Trust's overall transport strategy and the message the Trust was promoting in the organisation. BG explained the Trust had a contract with Enterprise offering a hire/pool car option for staff travel. They are currently looking to develop this further to see whether they can offer us a car share platform. A question was raised about whether it was feasible to stop some staff from having to travel. BG confirmed that before you book a hire car on Staff Room they take you through a number of steps for you to consider before you book a car. This was noted. **NHS Sustainability Day - 23.3.17** The NHS Sustainability Day had taken place on 23rd March 2017 with a number of events happening around the Trust to raise awareness. This was noted.		
14.	**Any Other business.**			None.		
15.	**Date of next meeting**			Wednesday 7th June 2017 at York Hospital. Site visit @ 10am. Meeting to close at 1pm.		

Environment & Estates Committee – April 2017

Work Programme

	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec

	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Governance												
E&E Committee meetings		7th Feb		11th Apr		7th June		16th Aug		4th Oct		6th Dec
E&E Comm Mins	BoD	EEC	BoD	EEC	BoD	EEC	BoD	EEC	BoD	EEC	BoD	EEC
EEC ToR				EEC								
EEC Annual Report						EEC	BoD					
Policy & Procedure schedule		EEC		EEC		EEC		EEC		EEC		EEC
Directorate RR				EEC		EEC		EEC		EEC		EEC
E&F Structure chart												
Internal Audit Reports		EEC		EEC		EEC		EEC		EEC		EEC
Health, Safety and Security												
H,S&NCRG mtngs		10th Feb @ 1.30pm. BR.YH			24th May @ 11am. BR.YH			23rd Aug @ 11am. BR.YH			22nd Nov @ 11am. BR.YH	

Environment & Estates Committee – April 2017

Work Programme

	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
H&S Annual Report (including Annual Fire Statement and Fire AR) + includes RIDDOR y/e						EEC	BoD					
Any new Legislation, CQC, HSE information		EEC		EEC		EEC		EEC		EEC		EEC
H&S quarterly report		EEC		EEC		EEC		EEC		EEC		EEC
H&S/NCRG ToR								EEC '17				
H&S/NCRG mins		EEC		EEC		EEC		EEC		EEC		EEC
H&S/NCRG Annual Report												
Final Report for Self Assessment Audits												
H&S Strategy				EEC								
(revamped) Fire Safety Policy		EEC										EEC
Health & Safety Policy				EEC								

Environment & Estates Committee – April 2017

Work Programme

	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Security Policy		EEC										
Datix Staff issues – summary report – presentation to **Apr mtng**				EEC								
Declaration to NHS Protect for RPA		EEC										
Briefing on changes to NHS Protect				EEC								
Sustainable Development												
SDG mtngs		15th Feb			11th May			10th Aug				
SDMP		EEC		EEC		EEC		EEC		EEC		EEC
NHS Sustainability Day, 23rd March		EEC		EEC								
SDG mins		EEC		EEC		EEC				EEC		EEC
SDG ToR						EEC '17						
SDG Annual Report												

Environment & Estates Committee – April 2017

Work Programme

	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Premises Assurance Model (PAM)												
Premises Assurance Group (PAG) mtngs	20th Jan				3rd May		14th July				17th Nov	
PAG mins				EEC		EEC		EEC				EEC
PAM quarterly reports		EEC				EEC		EEC		EEC		EEC
PAM AR				EEC								
PLACE												
PLACE results								?EEC	EEC BoD			
PLACE feedback										?EEC		EEC
Cleaning Policy						EEC						
Carter efficiency report												
		EEC		EEC		EEC		EEC		EEC		EEC
Capital Planning												
Capital Programme - overview				EEC								
Estates Strategy -				EEC								

Environment & Estates Committee – April 2017

Work Programme

	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
review												
Update on Carter metrics related to space planning				**EEC**								
Other												
Property & Space Management Report/Presentation update - **April**				EEC								

March '17

York Teaching Hospital NHS
NHS Foundation Trust

Health and Safety Strategy 2017 – 2022

March 2017

Author:	Colin Weatherill, Head of Safety and Security
Owner:	Brian Golding, Director of Estates and Facilities
Publisher:	Estates & Facilities Directorate
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Approved by:	EEC & Board of Directors
Date approved:	TBC
Review date:	March 2022
Target audience:	Trust Wide
Relevant Regulations and Standards	Health and safety legislation UK security management legislation Health and Social Care regulated activities legislation.

Executive Summary

This strategy sets out the overarching strategic approach to ensure a robust system is in place for the management of Health and Safety for York Teaching Hospital NHS Foundation Trust for 2017 – 2022.

Our shared commitments

Our Quality and Safety Ambitions
Our patients must trust us to deliver safe and effective healthcare.

Our Finance and Performance Ambitions
Our sustainable future depends on providing the highest standards of care within our resources.

Our People and Capability Ambitions
The quality of our services is wholly dependent on our teams of staff.

Our Facilities and Environment Ambitions
We must continually strive to ensure that our environment is fit for our future.

Our ultimate objective

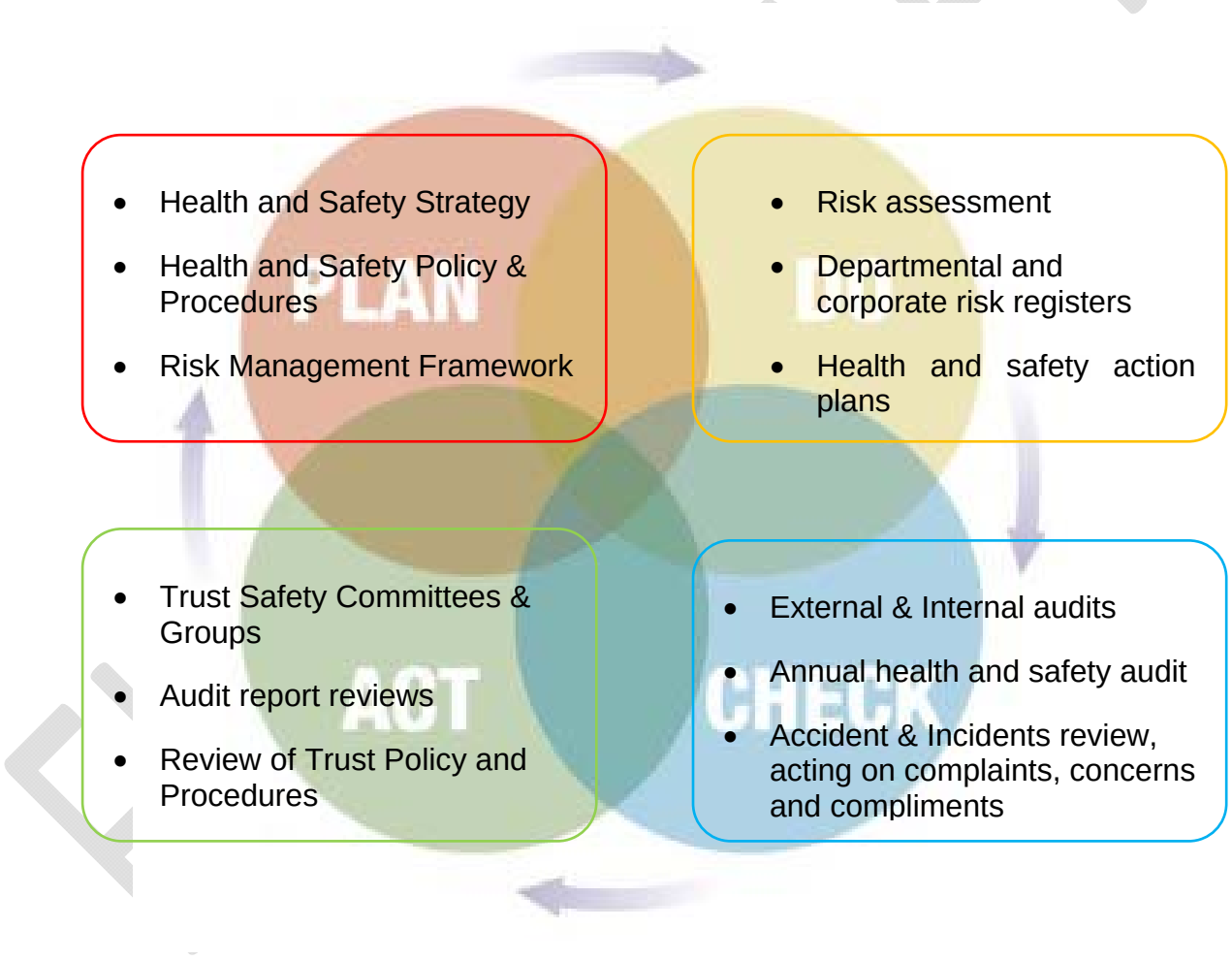
To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.

Our values

Introduction

This Health and Safety strategy has been developed to underpin the Trust's commitments, objectives and values as set out in the Trust's Corporate Strategy. The Health and Safety Strategy aims to support strategic and operational management in the Trust looking to go beyond traditional health and safety role of preventing harm. The strategy commits the Trust to continually improve the health and safety of staff and patients, by achieving compliance with health and safety policy and assisting in the delivery of an efficient, proactive and pragmatic approach to health and safety management; providing for a robust health and safety culture in the Trust, protecting all stakeholders with a safe service and environment.

This strategy describes the overarching approach to health and safety and what we intend to do to achieve this:



Ensuring all aspects of health and safety are fully integrated into the management of risk to enable the Trust to apply principals of sensible and sound risk management.

Background

The Trust's values have been developed to ensure the Trust is seen as a valued and trusted partner within our care system delivering safe effective care to the population we serve. Our values are:

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

All these values are more effectively realised in an environment that is healthy and safe, where positive culture is encouraged and legislative compliance is achieved through full stakeholder engagement.

The Trust aims to have in place a comprehensive and robust safety management system to underpin all work activities and corporate and strategic planning; by ensuring a pragmatic approach to health and safety which is commensurate to the level of risk.

As with all aspects of Trust business the health and safety management does not operate in isolation and is affected by many varying factors key being economic, environmental and political. This strategy reflects the move towards deregulation, economic constraints, ever increasing pressure on NHS and the Trust from patient numbers, expectations of service users and society's reduced tolerance of failure and claims culture.

Achieving an effective health and safety management system to underpin a safer working environment in this climate is as ever challenging and requires a system to be responsive, proactive, and comprehensive whilst remaining pragmatic in management of risk.

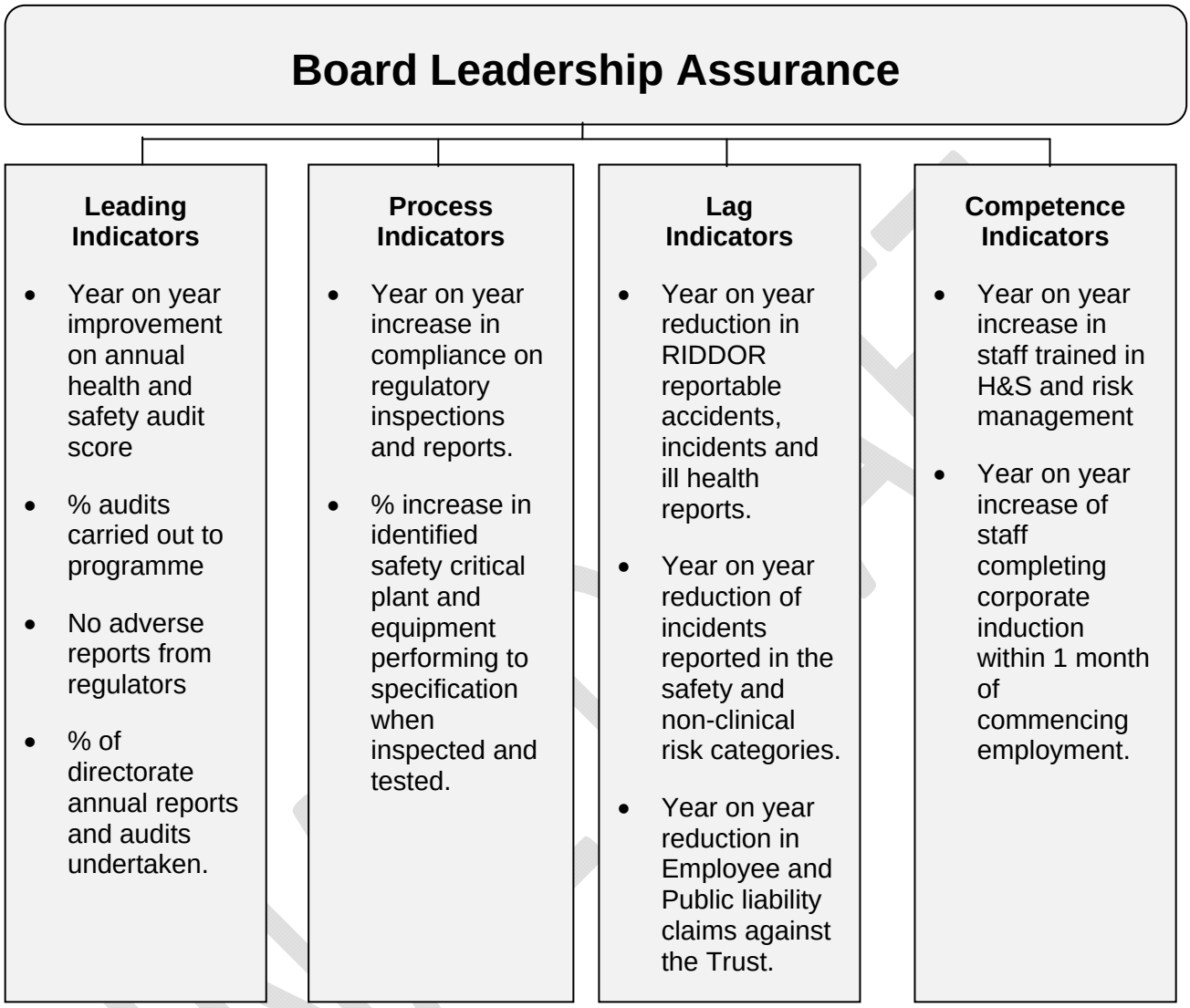
The Trust will ensure it complies with all health and safety legislative requirements, associated guidance and best practice as practicable. The Trust will as required work with key NHS regulatory bodies Health and Safety Executive, Fire Authorities, Environment Agency, Local Authorities and Care Quality Commission etc. to improve safety and environmental standards and wellbeing across the organisation.

Key Themes and Key Performance Indicators

The key challenge for this strategy is to build upon progress already made in the Trust from previous safety policies, strategies and frameworks, in further embedding health and safety into a large, complex and ever changing multisite organisation with complex risk activities. Adopting and adapting themes from current national HSE, CQC, NHS strategies will enable the Trust to better align the management of health and safety by encompassing this wider context. This will help in achieving adherence with safety management systems and behavioural safety in the Trust, ensuring safety and

management of risk becomes an integral part of management and not seen as a separate additional aspect.

Assurance Process



Strategic Health and Safety Themes

Trust identified themes:

A. Leadership and Management

B. Collaborative Working

C. Competence

D. Management of Risk

E. Health and Wellbeing

A. Leadership and Management

Successful health and safety management starts at and is led from the top of the organisation. Visible and active commitment from the Trust Board, Chief Executive, Directors and Managers to health and safety clearly demonstrates a responsibility in management of risk which will in turn be seen by all staff. Proactive management and ownership of health and safety is a clear indicator of a positive safety culture.

Promoting safety – Key Performance Indicators

P1) Establishment of an effective communication system and clear management structure;

P2) Demonstrable evidence that H&S management is integrated into business decisions;

P3) Ensure health and safety performance is reviewed on a regular basis;

P4) Provision of adequate resource to allow for effective implementation of health and safety management system;

P5) Ensure all staff receive appropriate health and safety training.

B. Collaborative Working

Successful health and safety management relies not just on a well led organisation but a collective responsibility in which all staff must play a part. This collective approach must be embedded through the demonstration of management standards.

Collaborative Working – Key Performance Indicators

W1) Consultation with key stakeholders to encourage collaborative working across the Trust;

W2) Ensure all key stakeholders are involved and consulted on health and safety policy, procedures and guidance developed within the Trust;

W3) Ensure appropriate communication channels are in place for the dissemination of health and safety information.

C. Competence

To ensure effective health and safety management varying levels of competence is required for every member of staff to be able to recognise significant hazards and foreseeable risks and have the ability to take measures to control them. The Trust underpins this with health and safety procedures and standards to be followed across the varying aspects of the Trusts business.

Competence – Key Performance Indicators

C1) Ensure health and safety related policies and procedures are reviewed by the relevant competent staff, in date and reflect best practice;

C2) Ensure health and safety policies, procedure and guidance are available to relevant staff groups and others and are understood;

C3) Staff are able to and aware of and how to access competent advice;

C4) Use of appropriate risk assessment and risk management techniques across directorates;

C5) Ensuring effective and comprehensive training programmes are in place and available for staff as commensurate.

D. Management of Risk

The effective management of risk is fundamental in ensuring legal compliance and the safety of staff, patients and others affected by the Trust undertakings.

Risk Management - Key Performance Indicators

R1) Proactive identification of significant hazards across the Trust;

R2) An effective risk management framework is in place and followed to ensure risk is managed and continual improvement is achieved;

R3) Ensure health and safety is an integral part of the planning and review process across the Trust;

R4) Review of identified risks is routinely undertaken and reported on to ensure the Trust is aware of such risks and demonstrate effective risk management.

E. Health and Wellbeing

A healthy and positive workforce significantly contributes to the success of the Trust; ensuring staff are cared for can reduce absenteeism, improve fitness thus resulting in an engaged positive workforce leading to increased productivity

Health and Wellbeing - Key Performance Indicators

H1) Promote and encourage participation in and support occupational health and wellbeing initiatives;

H2) Provide staff support and advice on smoking cessation and healthy lifestyle options.

Health and Safety Making it Happen

Ultimate responsibility for safety of staff, patients and those who visit the Trust rests with the Board of Directors in support of the Chief Executive Officer of the Trust. The operational management of health and safety is delegated through the Trust management structures to Directorate Managers, Departmental Managers, Supervisors and Line Managers.

The Health Safety and Security Department has a key role to play in the development of policy / procedures and monitoring to provide assurance of implementation of safety strategy, policy and procedures. The Trust takes a pragmatic approach to ensure effective implementation of day to day safety management of safety across the Trust, by delegating this responsibility to operational management and line manager.

The Health Safety and Security Department will support operational management by working in partnership on implementation of safety policy, procedures and standards thus empowering managers to actively manage health and safety in their sphere of responsibility.

The Health Safety and Security department will work closely with directorate management, union colleagues and other key stakeholders to promote effective and pragmatic implementation of health and safety promoting a culture of openness, ownership and continuous improvement in Health and Safety.

Action Plan Supporting Health and Safety Strategy 2017 - 2022

Leadership and Management – Promoting Safety				
Objective	**KPI**	**When is this achieved**	**Responsible**	**Date Achieved**
P1) Establishment of an effective communication system and clear management structure.	A committee structure is in place with H&S related decisions communicated to and via sub committees, groups and staff. Structure of management responsibility is set out in health and safety policy.	Committees and groups have terms of reference to define the relevant committee structure. All committees and groups record meetings and report items of significance to through their parent / subcommittee or group[1]. Health and safety policy details levels of responsibilities for management of safety and risk.		
P2) Demonstrable evidence that H&S management is integrated into business decisions.	Health safety and risk management is included at all key stages of business plan development.	The Trust business planning pro-forma includes a safety and risk management section. (R3)		

[1] As defined in the Trust Estates and Facilities Governance Structure

P3) Ensure health and safety performance is reviewed on a regular basis.	Monthly health safety and risk inspections are developed and embedded into operational management structure.	When results of inspections and audits relating to health safety and risk are discussed at directorate and departmental meetings.		
P4) Provision of adequate resource to allow for effective implementation of health and safety management system.	There is a structure in place which can effectively implement health, safety and risk management across the Trust.	Health, safety and risk management are embedded into operational directorates.		
P5) Ensure all staff receive appropriate health and safety training.	Staffs that are directly involved in health, safety and risk management are trained and competent to undertake their roles.	Staff are identified in each directorate to lead on health, safety and risk and a schedule is developed to train staff in this		
Collaborative Working				
Objective	**KPI**	**When is this achieved**	**Responsible**	**Date Achieved**
W1) Consultation with key stakeholders to encourage collaborative working across the Trust.	An effective health, safety and risk committee structure is in place accounting for all key stakeholders.	Committees and groups include relevant staff to be consulted.		
W2) Ensure all key stakeholders are involved and consulted on health and safety policy, procedures and guidance developed in the Trust.				
W3) Ensure appropriate communication channels are in				

place for the dissemination of health and safety information.				
Competence				
Objective	**KPI**	**When is this achieved**	**Responsible**	**Date Achieved**
C1) Ensure health and safety related policies and procedures are reviewed by the relevant competent staff, in date and reflect best practice.	Process is in place to ensure the relevant persons are consulted on as part of policy and procedural review.	Trust policy includes minimum consultation requirements and review periods.		
C2) Ensure health and safety policies, procedure and guidance are available to relevant staff groups and others and are understood;	Copies of policy and procedures are held on a central accessible system and / or as applicable available at local level.	Key polices are available on the Trust intranet. Procedures are held locally.		
C3) Staff are able to and aware of and how to access competent advice;	Key health safety and risk management staff are listed on the Trust intranet.	List of names, roles in the Trust and contact information held on a health, safety and risk management page.		
C4) Use of appropriate risk assessment and risk management techniques across directorates;	Key health, safety and risk management staff are trained in risk assessment, risk management, accident investigation and root cause analysis.	Key health, safety and risk management staff have received prescribed training.		
C5) Ensuring effective and comprehensive training programmes are in place and available for staff as commensurate.				

Management of Risk				
Objective	**KPI**	**When is this achieved**	**Responsible**	**Date Achieved**
R1) Proactive identification of significant hazards across the Trust.	System is developed to ensure hazard identification through proactive risk assessment.	Risk assessments are available in directorates and routinely reviewed.		
R2) An effective risk management framework is in place and followed to ensure risk is managed and continual improvement is achieved.	Risk management policy is in place and managed through risk registers. Risk registers are reviewed and actions taken to address and manage significant risk.	Risk management framework for the Trust is in place and risk registers reviewed as specified.		
R3) Ensure health and safety is an integral part of the planning and review process across the Trust;	Risk assessment and risk management is included as part of the business planning process.	The Trust business planning pro-forma includes a safety and risk management section. (P2)		
R4) Review of identified risks is routinely undertaken and reported on to ensure the Trust is aware of such risks and demonstrate effective risk management.	System is in place to monitor risk assessments undertaken and these are reported on via the risk registers.	Risk registers are reviewed at directorate level at specified timescales.		
Health and Wellbeing				
Objective	**KPI**	**When is this achieved**	**Responsible**	**Date Achieved**
H1) Promote and encourage participation in and support occupational health and wellbeing	Staffs are aware of and provided with information and support to take part in occupational health	OH initiatives are communicated to all staff via		

initiatives;	and wellbeing indicatives.	the intranet.		
H2) Provide staff support and advice on smoking cessation and healthy lifestyle options.	The Trust scopes and develops an occupational health led smoking cessation policy. Provision of guidance to staff to support making healthy life choices.	Specific guidance is available with options for relevant support signposted.		