York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public Meeting)

Wednesday 30 May 2018

York Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

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

On: Wednesday 30 May 2018

In: The Boardroom, Foundation Trust Headquarters, 2nd Floor Administration Block, York Hospital, Wigginton Road, York, YO31 8HE

TIME	MEETING	LOCATION	ATTENDEES
8.30am – 9am	Corporate Trustee Meeting	Boardroom, Foundation Trust Headquarters	Board of Directors
9am – 10.30am	Board of Directors meeting held in private Part 1.	Boardroom, Foundation Trust Headquarters	Board of Directors
10.45am – 12.30pm	**Board of Directors meeting held in public**	**Boardroom, Foundation Trust Headquarters**	**Board of Directors and members of the public**
12.30pm to 1pm	Lunch		Board of Directors
1pm to 2.40pm	Board of Directors meeting held in private Part 2.	Boardroom, Foundation Trust Headquarters	Board of Directors
3pm - 4pm	Executive Briefing	Boardroom, Foundation Trust Headquarters	Board of Directors

York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public) Agenda

	SUBJECT	LEAD	PAPER	PAGE	TIME
1.	**Apologies for absence and quorum** To receive any apologies for absence	Chair	Verbal	-	10.45 – 10.55
2.	**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chair	A	7	
3.	**Minutes of the meeting held on 28 March 2018** To receive and approve the minutes from the meeting held on 28 March 2018.	Chair	B	13	
4.	**Matters arising from the minutes and any outstanding actions** To discuss any matters or actions arising from the minutes	Chair	Verbal	-	
5.	**Patient Story** To receive the details of a patient letter.	Deputy Chief Executive	Verbal	-	10.55 – 11.05
6.	**Chief Executives Update** To receive an update from the Chief Executive	Deputy Chief Executive	C	25	11.05 – 11.15

	SUBJECT	LEAD	PAPER	PAGE	TIME
7.	**HCV Partnership Update** To receive the latest HCV Partnership Update	Deputy Chief Executive	D	29	11.15 – 11.25
	Our Finance and Performance Ambition: Our sustainable future depends on providing the highest standards of care within our resources				
8.	**Finance and Performance Committee** To receive the minutes of the last meetings (17 April & 22 May 2018) and be advised by the Chair of the Committee of any specific issues to be discussed. Papers for information.	Finance Director & Chief Operating Officer	E	35	11.25 – 11.35
	• Finance Report		E1	49	
	• Efficiency Report		E2	67	
	• Performance Report		E3	73	
	Our Quality and Safety Ambition: Our patients must trust us to deliver safe and effective healthcare				
9.	**Quality and Safety Committee** To receive the minutes of the last meetings (17 April & 22 May 2018) and be advised by the Chair of the Committee of any specific issues to be discussed. Papers for information.	Medical Director & Chief Nurse	F	87	11.35 – 11.45
	• Patient Safety & Quality Report		F1	111	
	• Medical Directors Report		F2	143	
	• Chief Nurse Report		F3	159	

	SUBJECT	LEAD	PAPER	PAGE	TIME
10.	**CNST Maternity Self Certification** To receive and approve the CNST Self Certification for Maternity	Chief Nurse	G	169	11.45 – 11.55
11.	**Complaints Annual Report** To receive the Trust's Complaints Report published under Reg. 18 of the Local Authority and Social Services and NHS Complaints Regulation 2009	Chief Nurse	H	201	11.55 – 12.05
	Our Facilities and Environment Ambitions: We must continually strive to ensure that our environment is fit for our future				
12.	**Environment and Estates Committee** To receive the minutes of the last meeting and be advised by the Chair of the Committee of any specific issues to be discussed. Papers for information	Director of Estates & Facilities	I	211	12.05 – 12.15
	Our People and Capability Ambition: The quality of our services is wholly dependent on our teams of staff				
13.	**Workforce and Organisational Development Committee** To receive the minutes of the last meeting and be advised by the Chair of the Committee of any specific issues to be discussed. Papers for information: • Workforce Metrics	Deputy Director of Workforce	J J1	223 231	12.15 – 12.25

	SUBJECT	LEAD	PAPER	PAGE	TIME
14.	**Any other business** • Reflections on the meeting • BAF Alignment	Chair	Verbal	-	12.25 - 12.30

15. Time and Date of next meeting

The next meeting will be held on Wednesday 25 July 2018 in the Boardroom, Foundation Trust Headquarters, York Hospital.

Items for decision in the private meeting: No items

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

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

Register of directors' interests
May 2018

York Teaching Hospital
NHS Foundation Trust

Additions:

Lynne Mellor—full declaration
Lorraine Boyd—full declaration
Brian Golding—Acting Managing Director of York Teaching Hospital Facilities Management LLP

A

Changes:

Deletions:
Libby Raper—Director—Summerhouse Mews Management Company
Dianne Willcocks—Chairman City of York Fairness & Equalities Board, Member— City of York Without Walls Board and Chair—Advisory Board, Centre for Lifelong Learning University of York

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
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
Mr Michael Sweet (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Professor Dianne Willcocks (Non-Executive Director)	**Member—**Great Exhibition of the North (2018) Board **Director**—Clifton Estates Ltd (linked to JRF)	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 **Member—**Executive Committee YOPA **Patron—**OCAY **Director**— York Media Arts Festival Community Interest Company	**Director—**London Metropolitan University **Board Member**—York Museums Trust **Chair of Steering Group** - York Mediale Festival	Nil

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Michael Keaney (Non-Executive Di-rector)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Jenny McAleese (Non-Executive Di-rector)	**Non-Executive Direc-tor**—York Science Park Limited **Director**—Jenny & Kevin McAleese Limited	**50% shareholder and Director**—Jenny & Kevin McAleese Lim-ited	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Trustee**—Graham Burrough Charitable Trust **Member**—Audit Com-mittee, Joseph Rown-tree Foundation	**Member of Court**—University of York	Nil
Dr Lorraine Boyd (Associate Non-executive Director)	Nil	Equity Partner Millfield Surgery	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	GP Providers Lead for North Locality of Vale of York CCG GP Advisor to CAVA	Nil
Ms Lynne Mellor (Associate Non-executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Position with BT (telecom suppliers)
Mr Patrick Crowley (Chief Executive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mr Andrew Bertram (Executive Director Director of Finance)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member** of the NHS Elect Board as a member representative	Nil
Mr Mike Proctor (Deputy Chief Executive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Spouse a senior member of staff in Community Services	Nil
Beverley Geary (Chief Nurse)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
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
Mr Brian Golding (Director of Estates and Facilities)	**Acting Managing Director**—YTHFM LLP	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
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Board of Directors – 30 May 2018
Public Board Minutes – 28 March 2018

Present: **Non-executive Directors**

Ms S Symington	Chair
Mrs J Adams	Non-executive Director
Mr M Keaney	Non-executive Director
Mrs J McAleese	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
Mrs W Scott	Chief Operating Officer
Mr J Taylor	Medical Director

Corporate Directors

Mr B Golding	Director of Estates & Facilities

In Attendance:

Mrs L Provins	Foundation Trust Secretary

Observers:

Sheila Miller – Public Governor – Ryedale and East Yorkshire
Margaret Jackson – Public Governor – York
Jeanette Anness - Public Governor – Ryedale and East Yorkshire
Michael Reakes – Public Governor – York
Gerry Richardson – Stakeholder Governor – University of York
Peter Blackeby – Board Partner
Emily Paynton – Johnson and Johnson
Jim Harrow – Member of the public
Amrita Sidhu - NHSI

Ms Symington welcomed everyone to the meeting.

18/17 Apologies for absence

Apologies were received from Ms Raper.

18/18 Declarations of interest

Mr Golding stated that he was now Acting Managing Director of the York Teaching Hospital Facilities Management LLP.

No further declarations of interest were raised.

18/19 Minutes of the meeting held on the 31 January 2018

The minutes of the meeting held on the 31 January 2018 were approved as a correct record subject to the following amendments:

18/06 – page 15, 4th paragraph – should read 'Ms Symington thanked'.

18/08 – page 18 – 3rd paragraph – should read 'Ms Symington stated that the responsibility'.

18/09 – page 18 – 4th paragraph, 6th line – trust's should read 'trusts'.

18/10 – page 18 – 5th paragraph – vacate should read 'vacant'.

It was agreed that Peter Blackeby will be referred to as a Board Partner.

18/20 Matters arising from the minutes

Page 19 – Ambulance Handovers – JA stated that ambulance handovers were mentioned including a small audit which had been carried out. WS stated that the audit had shown discrepancies between the Trust's data and YAS's data. Following discussions a new procedure to jointly record handover time had been carried out and a further meeting was planned with YAS. There is also a plan to carry out a further audit.

Action Log – Mrs Provins was asked to factor in parity of staff groups into the Board work programme. Ms Symington stated that Board Committee reporting arrangements had started to be discussed and further discussion would take place as work on the strategic objectives progressed.

No further items were discussed.

18/21 Governance Documents

Mrs Provins stated that the documents had been discussed at Audit Committee apart from the research element which had come to light fairly recently. Mrs Adams noted that page 119 (SFI's 15.4.1) should state that the Fund Manager manages the fund not the Finance Director. Mr Bertram stated that this should read 'the Finance Director manages the contract for the Fund Manager'.

Mr Bertram stated that the Finance Team work closely with Mrs Provins on these documents and that they provide important clarity for individuals and also protect individuals by providing permission to act on behalf of the Trust.

The Board approved the documents subject to the one change above and thanked Mrs Provins and the Finance Team for their work.

18/22 Modern Slavery Act

Mrs Provins gave a brief overview of the paper and asked for approval for it to be signed and placed on the website. The Board discussed how smaller suppliers are handled and Mr Bertram stated that the Trust discharges its responsibility to the best of its ability, however, the chains of suppliers can be very long which can present a challenge.. Mr Crowley likened it to the discussions around charitable investments and that all reasonable steps are taken.

The statement was approved.

18/23 Patient Safety

Ms Symington welcomed Dr Smith to talk to the Board about a letter of complaint he had received. Dr Smith read out the letter which he thought summed up the reality for both EDs during the winter period. The letter covered waiting times in ED, incorrect diagnosis, degrading treatment of the elderly, Ambulance crew waits and lack of facilities.

Dr Smith stated he had brought this letter which he had received following a point of maximum stress in the system because it highlighted that things needed to be done differently in our emergency departments. Mr Crowley stated that it provided context for the meeting and that it was about recognising that there were deficiencies in the system at times, but that it should be recognised that the whole country was under pressure.

Mr Crowley stated that this also tied in with item 2 of his report about the letter from the CQC written to all organisations to reinforce the recognition of the pressures and strains that ED staff have been under. Mr Crowley stated that it was important not only to say the right words, but to follow up with action. Ms Symington stated that this was a clear board level responsibility, but the CQC letter fell short of telling organisations what to do.

Dr Smith stated that Scarborough ED reached saturation level about 3 to 4 years ago with critical challenges including patient flow through the hospital, delayed transfers of care, high reliance on local staff who are towards the end of their careers. He stated that despite being at the end of winter staff were demoralised. He asked if there was a mismatch of resource on the sites and sited radiology as an example.

Mrs Scott stated that Mr Crowley had recently chaired a meeting in Scarborough with the clinical leaders. She noted that there was a really good debate about what was not being done and could be done which it was hoped would drive forward some changes. However, it should be recognised that there were constraints around workforce and space which acerbated the pressures. Mrs Scott noted that other Trusts were also feeling the strain and that the Trust's performance had been 81.8% for February whereas Hull had only achieved 77.7%.

Mrs Adams challenged that there are wide variations in performance and that one week in March the Trust was 75 out of 137 and that York's type 1 performance was better than Scarborough. One week in February the Trust had been the worst in the country which

could not be described as the middle of the pack. She wondered whether it would be a good idea to disaggregate performance information as well as financial information for York and Scarborough. Mrs Scott stated that performance in Scarborough was being masked by better performance in York and that it had been agreed with NHSI to separate the reporting so that a debate could be had about any additional support.

Mrs Adams was also concerned that Ernst & Young had been engaged to work with the York team when clearly the Scarborough site had greater challenges. Mr Crowley stated that Scarborough was working to the acute medical model strategy of which it was a national leader and the challenges there were to do with staffing. He noted that the idea would be to learn lessons from the work at York, but he also highlighted that the strategic work was reinforcing some of the differences between the sites. Mr Crowley stated that Dr Smith's example of radiology reporting was a stark example as the Trust was finding it difficult to recruit radiologists to Scarborough so were in fact buying in services from Australia and also looking to implement a central reporting system.

Dr Smith stated that there was significant effort and discussion about how to make the situation better at Scarborough and it was about how the Trust used different sites to reduce pressure whilst keeping the teams motivated to deliver change which the Board needed to focus on.

Ms Symington thanked Dr Smith for his salutary contribution and asked him to thank his team on behalf of the Board for all their work, while also recognising Dr Smith's significant personal contribution.

18/24 Chief Executive Report

Mr Crowley stated that the CQC Report was now a matter of record and that the trust is working through an action plan: he highlighted that the Trust were not assessed against some of the 2015 'requires improvement' elements so those remained 'requires improvement'. Therefore it was difficult to move on due to the nature of the way the assessments are carried out. However, he stated that the Trust had made a massive improvement in 2015 following the inheritance of the East Coast services and this position had been further consolidated. He noted that York and the Community were rated as 'good' and that Bridlington and Scarborough's results remained 'requires improvement', but continued to improve.

Mr Crowley stated that Trust chains although linked were judged on an individual basis, but because York and Scarborough Trusts had merged in 2012 this resulted in an aggregate score.

Mr Crowley noted that the Government's Mandate to NHS England supported the work being done at the Trust on strategy and provided important context. The emergence of the significant improvements planned for the pay deal if agreed could not fail to help with recruitment and retention. The pay deal, if agreed, should be available in the summer and would be back dated to April. It was also recognised that it would provide a big boost to the Trust's lowest paid staff and Mr Golding confirmed that this would not affect affordability in the new subsidiary company. Mr Bertram stated that 1% of the tariff settlement inflation related to pay and anything about the 1% would have to be provided by supplementary funding from the Government.

Mr Crowley highlighted the significant work which has taken place on paper based referrals and noted that the Trust was wholly compliant and staff should be congratulated for that.

Mr Crowley stated that one of the Trust's key partners, Hull York Medical School, has just been given 90 additional training places. It was also noted that the Trust has appointed 2 HYMS graduates as consultants, which underlined the importance of local self-sustainability.

Mr Crowley provided an update on the STP work and stated that the Trust remains extremely involved both in the clinical and managerial elements. He noted that the STP Executive has been refreshed and that 2 work streams around capital and digital maturity have been introduced. Mr Crowley stated that he will be chairing the capital group and this will be about aligning STP priorities right across the patch. The first meeting discussed the high level submission to apply for capital due this Friday and also the next submission required in June and July.

Mrs Adams asked about the CQC action plan. Mr Crowley stated that there is a meeting with CQC in the next couple of weeks and that the plan will then come to the Board when monitoring by the Board Committees would be discussed. However, he did stress that due to the length of time it took to finalise the report, a number of the actions had already been completed.

Ms Symington asked if more students through the HYMS would require more teaching hours by Trust staff. Mr Proctor stated that the students came with a levy which can be used to support, but does not come with capital and so there may need to be creative use of current space. There will be 10 extra students this year and 65 next year.

18/25 Quality and Safety Committee

Mr Taylor reflected on the patient story and operational pressures and that some patients had to wait even longer than that identified in the letter. He provided some context around winter including the increased amount of flu, the higher acuity of patients and the demographics around the growing elderly population with a greater number of co-morbidities which was not due to peak until 2050. Mr Taylor also highlighted the current financial and recruitment positions, the impact on staff morale, the pressures between acute and elective work and that actually there was an argument that the financial situation worked against organisations. All these factors made it culturally challenging for the Trust to deliver patient care.

Mr Taylor stated that the recruitment problems had been highlighted by the CQC and were most acute at Scarborough and that some of the vacancy rate was mitigated by the use of locums which provided a financial and a quality pressure. He stated that the Trust was running faster each winter to remain in the same position.

Mrs Geary stated that the Executives discuss these issues on a daily basis and that the minutiae is gone into at the Committee. It was noted that concerns had been raised on Monday at an extraordinary meeting and that a gold command meeting had been convened at Scarborough to look at solutions in the moment. It was about trying to deliver

the safest care in the best place the Trust can. Mrs Geary stated that the team did not want elderly patients in the corridors of our ED, but in the absence of beds it was the only alternative. She noted the full capacity protocol which was being used and that the Trust had been ordering hot food into ED to ensure patients were fed. She stressed that this was not where the Trust wanted to be, but it was about supporting patients and caring for them in the best way possible.

Mrs Geary highlighted the commitment of staff and that many had walked into work in the snow or stayed over to ensure they could carry out their shifts. She understood the massive pressures staff were under and was proud of staff and how hard they worked every day.

Mrs Scott stated that these were significant issues which were being taken seriously. She accepted Mrs Adams' challenge on ECS, but stressed that month on month the position was better than last year despite this being the worst winter experienced so far: the Trust had managed to improve performance which was a significant achievement. She noted that page 262 of the pack provided the national performance data and that the Trust were at the higher end despite being at the upper end of admissions. Mrs Scott stated that there had been lack of investment in out of hospital care which was a contributing factor and issues were being discussed and collectively owned with partners.

Mr Crowley highlighted that the friends and family test continues to report a high satisfaction rate and that despite difficulties patients are reporting that they are receiving good care.

Mrs Adams asked about the lack of discharges at the weekend. Mr Crowley stated that the Trust interfaces with a number of services which do not work at weekends and this is also linked to the acuity of patients and the dependency on other services.

Mr Proctor also noted that some clinicians in Scarborough were more conservative around risk than others and this needed some work.

Mr Sweet highlighted that despite the background of difficulties with recruitment and increased acuity of patients, the Trust has not had issues with C Dif, which always used to be on the agenda. Mrs Geary noted that other Trusts are currently crippled with norovirus, but that robust processes have been put in place here.

Mrs Geary stated that significant work has taken place around DoLs and safeguarding following the CQC raising it after their inspection. She provided an example of what the CQC had found which related to an acute stroke patient having 1 to 1 care. The CQC asked the agency nurse looking after the patient whether the patient could go to the coffee shop downstairs and the nurse said no, which they assessed as a deprivation of liberty. The Trust will be responding to the improvement notice. A detailed action plan will go to the Safeguarding Adults Group this week and be taken to the next Committee meeting.

Mrs Geary provided an overview of the early analysis around enhanced supervision and that work had been done with wards 37 and 25 and that there had been a significant improvement using volunteers to provide distraction therapy. This work is showing a trend in reduction of falls and will be shared across the organisation.

Prof. Willcocks was pleased to see financial issues being addressed using safety initiatives, but was concerned that 'distraction therapy' was an undignified term.

Mr Taylor briefed the Board on the work around clinical effectiveness and that action plans would go to the next Committee to provide greater assurance. Mrs McAleese stated that an Annual Report on clinical effectiveness will be taken to the Audit Committee time out in July and the Audit Committee will also be tracking DoLs, duty of candour and consent as part of its objectives for next year. Lines were being drawn between overview of process at Audit Committee and effectiveness of the process would be done at Q & S Committee.

Mrs Adams highlighted that the Committee were awaiting a proposal on isolation facilities and Mr Golding responded that it exists and he will ask the Head of Capital Projects to bring it to the next Quality & Safety Committee meeting.

Mrs Adams was concerned that this was the patient safety section of the Board and that it felt rushed. She stated that there were a number of things that the Committee could not report due to the time constraints such as nurse staffing and the good news around maternity. Ms Symington responded and noted that the way the Committees worked and reported back was being discussed as part of the overarching strategy work.

Mrs McAleese stated that Audit Committee were concerned that there was a red line between quality and finance and that the Trust was close to crossing this line.

Mrs Adams stated that there had been an increase in the number of incidents requiring duty of candour reporting, but that due to increased pressures staff did not have time to contact patients and the position had deteriorated in February.

Mr Taylor advised the Board that Becky Hoskins had been appointed as the Deputy Director of Patient Safety.

18/26 Out of Hospital Care Strategy

Mrs Scott provided an overview of the paper which provided an update on the key work streams and the positive work underway with partners to integrate services including piloting new workforce models and supporting nursing and care homes with in-reach models. She highlighted the work between the acute and community interface, the work with the voluntary sector and the complexities and challenges around working with different organisations with different governance systems and requirements. Mrs Scott stated that a key element of the strategy had been to move services from the acute to the community setting, such as the urology one stop service and the mobile chemotherapy unit. Mrs Scott stated that the strategy will now be refreshed in light of the strategic work being done.

Prof. Willcocks stated that she was impressed with the work being done on partnership building and the increased visibility of the Trust with other agencies. She also noted the work being done to anticipate the challenges around an ageing workforce. Prof. Willcocks asked how hospital volunteers could be used to greater effect as she had noted some excellent practice externally and felt the Trust should be more proactive.

Mrs Adams was pleased to see the discharge to assess concept taking hold and wondered if there was any evidence of a reduction in length of stay. Mrs Scott stated that the Trust was working closely with partners to understand the complexities around discharge and it was becoming clear that one blockage was the availability of care packages and the need for providers to be able to provide the levels of care required as patient acuity was higher. Mrs Scott stated that this was being discussed across the system and was a challenge going forwards.

18/27 Finance and Performance Committee

Mr Keaney stated that the Trust was nearly at the end of the financial year and the vital importance of identifying what needs to change next year in light of the high bed occupancy in the hospitals which had been at 99% at some points and the shortages of staff being experienced. He advised that it was important to identify relevant issues and priorities.

Mrs Scott stated that some of the pressures had been raised early in the meeting, but she stressed that February's ECS performance was at 81.8% which had been better than February last year and an improvement on the previous month. She stated that bed occupancy had been exceptionally high and that Scarborough ED had only been below the recommended national level on one day. The flow on both sites had been affected by bed occupancy levels and there had been 15, 12 hour trolley breaches of which 12 were at Scarborough.

Mrs Scott stated that E & Y had been asked to work with the Trust to ascertain whether the right measures were in place and to also provide shared learning from other trusts. E & Y were undertaking a 6 week diagnostic and working alongside staff providing continuous feedback and engagement. They would also look at rotas against demand. The work would be presented back to the Acute Board in mid-April and would also help to refresh the Return to Operational Standards and reduce the number of initiatives being run by prioritising 3 or 4. She noted that Dr Smith had been involved in feedback sessions to enable him to decide if Scarborough would benefit from the same work.

Mrs Scott stated that the RTT standard had deteriorated by 4% over the winter period to 84.81% and that the significant increase related to patients classed as long waits. The new planning guidance states that there is an expectation the position will not deteriorate in 2018-19 and that patients waiting 52 weeks should be reduced. Mrs Scott stated that critically this means the Trust will need to improve performance over the summer months in order to manage the possible deterioration during the winter period. The Trust is due to discuss its plans with NHSI in the coming weeks.

Mr Bertram provided an overview of the information contained in the finance report and that the current position of £25.9m deficit for February is not expected to move materially during month 12. The forecast outturn is around £20m to £25m deficit which is dependent on technical issues around the financial recovery plan schemes. He stated that February had been the lowest spend month this year and that there had been good control over the run rate. There had been a reduced level of income in February, but this was due to the short number of days in the month and that expenditure tends to remain consistent. The key message is that the Trust is where it expected to be.

Mr Bertram stated that the Trust's control total was a £9m deficit which would not be met so the Trust would lose out on £12m STP funding. Mr Bertram thanked all those, including governors, who had lobbied on the Trust's behalf to gain the winter funding which had now been received. In relation to CIP the Trust had achieved £19.8m in February against a target of £22.8m which was positive.

Mr Bertram stated that the links made in the patient story and quality and safety were powerful and he explained that the savings made on agency spend needed to be looked at in conjunction with the overspend on the pay budget of £8.5m. Mr Bertram stated that the Trust's agency cap was £17.2m, but that the Trust had spent around £18m, but that this was also linked to the overspend on pay. He noted that a number of decisions had been taken and were supported by the Board to increase staffing levels and that the greatest overspend was linked to the increase in staffing in ED. He stressed the overspend was a conscious decision to improve services and patient safety. Mr Bertram stated that he was worried that one of the sources of reduction in agency spend was around the reduction of enhanced supervision. However, Mrs Geary's paper described that this reduction had been improved via different more creative work.

Mr Bertram stated that the first draft of next year's plan had taken place. The Trust's control total was a £7m deficit and the plan showed a £19m deficit with a CIP of £22m. The Trust was working to try to close the gap and having discussions with NHSI. However, he continued to struggle with the concept that the Trust would only get the £17m STP funding if it achieved a £7m deficit which would in turn produce a £10m surplus. However, he stressed that achievement of the STP funding remained the ultimate objective. This was also set against the context of the Trust losing its acquisition funding. Mr Bertram did state that the plan showed the deficit reducing next year which was an improvement.

Mr Bertram provided an explanation of the aligned incentive contract (AIC) and that discussions continue on how to achieve this and whether it is able to close the £12m gap next year. The AIC has the potential to bring in a new transformational way of working, however, he stressed it is one of the building blocks not the total solution.

18/28 Environment and Estates Committee

Mr Sweet stated that the Committee were developing a protocol to make the Committee more efficient and reduce the size of papers.

Mr Golding stated that the BAF had been discussed and would be further reviewed following any revision to the wording.

Mr Golding provided an overview of the sustainability work and that this was now moving to engaging with staff to change habits and behaviours. He noted the work with WRM and that payment was based on successful delivery and that the sustainability week in June would be used to launch the work.

Mr Golding stated that the Trust had started to do a quarterly inspection to supplement the yearly PLACE inspections so that issues could be identified and worked on earlier.

Mr Golding stated that the risk register had been reviewed and that once further work on the fire alarms had been carried out, this risk would be reduced. It had also been decided to split the capital risk into maintenance and estate development in light of the squeeze on capital next year.

18/29 Workforce and Organisational Development Committee

Prof. Willcocks stated that the minutes were draft and still required some work.

Mr Proctor highlighted that the Flu CQUIN had been achieved and he noted that the Trust were only 1.5% behind Hull, but that Hull had spent a huge amount incentivising staff whereas this Trust had not.

Mr Proctor noted the report received by the Committee on the gender pay gap and stated that this was skewed by medical staff, but would shift over time.

Mr Proctor noted that the Committee had discussed the Staff Survey results, but that a further paper was going to the next meeting of the Committee and it would be reported on in more depth following that meeting.

Mr Proctor highlighted the Developing People Strategy which the Committee had been instrumental in developing and was around ensuring that staff want to come and work for the organisation and then wanted to stay. Mr Proctor provided a brief overview of the strategy content.

Mrs Adams applauded the strategy and the fact that culture was right at the top.

Prof. Willcocks stated that this strategy was a 'thoroughbred' and commended Mr Proctor and the support from the Committee. She stated that the gender pay gap work had the potential to create a culture that would identify staff through talent management, but that the work had to be taken seriously.

The Board approved the strategy.

Prof. Willcocks highlighted the delicate balance required between safety and finance and that the reduced spend on agency was linked to the creative work with the Bank. She noted the Internal Audit Report which had provided significant assurance around the Bank and was a model of good practice that should be used in other areas.

18/30 Any other Business

Ms Symington highlighted the paper on the Associate NED Induction Programme and stated that the 2 new Associate NEDs, Lynne Mellor and Lorraine Boyd, would start on the 3 April.

Ms Symington apologised for the missing BAF overview, but noted that the BAF would be reviewed, refreshed and updated to more readily reflect the strategic challenges the Trust was facing once the 5 year strategy was completed and agreed. Mrs McAleese stated that there had been a long conversation around the BAF at the Audit Committee and NHSI had been asked if they could provide any examples of good practice.

Reflections on the meeting – Board members echoed Mrs Adams earlier comments about having adequate time to discuss elements of the agenda and how feedback was given by the Board Committees. Ms Symington stated that she was discussing the Board Committees with Mr Crowley and whether the current format led to a silo-ing of contributions. She highlighted that workforce themes had run through most of the discussions and there was a conversation to be had around how the Trust was best served by its Committees and how they could be developed.

18/31 Date and Time of next meeting

The next public meeting of the Board will be held on Wednesday 30 May 2018 in the Boardroom at York Hospital.

Outstanding actions from previous minutes

Minute No. and month	Action	Responsible Officer	Due date
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	Jan 2018 Feb 2018 May 2018
17/104	Board Committee reporting changes to be reviewed in March.	Ms Symington	Work is ongoing

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Chief Executive's Overview

Recommendation

For information ☒
For discussion ☒
For assurance ☐
For approval ☐
A regulatory requirement ☐

Current approval route of report

This report was drafted for the Board of Directors.

Purpose of report

This report provides an overview from the Chief Executive.

Key points for discussion

There are no specific points to raise.

Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Version number: 1

Author: Mike Proctor, Deputy Chief Executive

Executive sponsor: Patrick Crowley, Chief Executive

Date: May 2018

1. Chief Executive Retirement

As of 1 June I will be taking the role of Chief Executive, following Patrick Crowley's retirement. As has been stated publicly, the organisation owes Patrick a debt of gratitude for his many years of service and for his contribution to the NHS. I want to take the opportunity to acknowledge the help and support that Patrick has given me as his deputy, and I recognise that his will be big shoes to fill. My intention and duty is to provide stability over the coming months and I am grateful for the support of the Board in taking on this role.

2. Scarborough and Ryedale Community Services

This month, the community services contract for Scarborough and Ryedale transferred to the new provider of these services, Humber Teaching NHS Foundation Trust. This includes the provision of inpatient beds at Malton Hospital.

We have also completed our withdrawal of outpatient clinics at Whitby Hospital, with the exception of midwifery, audiology, and some radiology provision. Whitby-based patients who wish to access our services can be seen in Scarborough.

3. Nursing and Midwifery Education

The Chief Nurse and I attended a dinner hosted by the University of York to hear their plans around nursing and midwifery education. Their plans are ambitious and focus on developing the nursing leaders and researchers of the future. Whilst we applaud this, we did express concern that as a provider there remains a pressing need for them to be providing us with sufficient qualified nurses to enable us to continue to keep our services running safely. The Vice Chancellor and other academic colleagues recognise this and responded positively to our suggestions.

4. Physician Associates

We are making really pleasing progress in recruiting Physician Associates to the Trust. This is an entirely new role, and is the only new workforce to be added to the NHS in decades, representing a significant opportunity to be a major contributor to safe services as we move forward.

Directorates are thinking strategically about the way their workforce will develop and how we maintain safe services over the next few years (as opposed to what we need for the next few months), with a view to this new role being able to offset some of the gaps in our medical workforce which are currently largely met through the use of agency or locum staff.

We attended a careers fair at Hull University which was hugely popular, followed by an open day at York Hospital. These two events have led to significant interest in the roles, and we have had over 40 applicants for the 10-14 posts we are hoping to recruit to.

The first graduates will complete their courses in October of this year, and we are aiming to recruit over the summer to enable them to begin as soon as possible after graduation. We are offering two-year rotational posts where the Physician Associates can work across their choice of specialties before they sub-specialise.

I will keep the Board updated as this work develops.

5. NHS 70

This year Bridlington Hospital is celebrating its 30th birthday, and as this coincides with NHS 70, staff at the hospital are having a birthday party to showcase the great work of the hospital, both past and present.

The event is taking place on Saturday 7 July 2018, between 10.00am-2.00pm, visitors will be able to visit the mobile chemotherapy unit, visit the wards, take a unique behind the scenes tour of the hospital, food taste in the canteen and much more.

The event is free and open to everyone, with refreshments and free parking available. Everyone is welcome to attend to support Trust colleagues as they celebrate this very special birthday.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Humber, Coast and Vale Partnership Update Report

Recommendation

For information	☒
For discussion	☒
For assurance	☐
For approval	☐
A regulatory requirement	☐

Current approval route of report

This report has not been to any other committee.

Purpose of report

The purpose of the report is to provide an update to the board on the Humber, Coast and Vale Partnership.

Key points for discussion

There are no particular points to raise in relation to the report.

Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Version number: 1

Author: HCVP

Executive sponsor: Mike Proctor

Date: May 2018

Humber, Coast and Vale Partnership Update Report

May 2018

The following report highlights recent work of the Humber, Coast and Vale Health and Care Partnership across some of our key priority areas. A full list of our priorities and further information about our work can be found on our website: humbercoastandvale.org.uk.

Review Meeting with NHS England and NHS Improvement

On 30th April, senior representatives from the Partnership met with regional directors from NHS England and NHS Improvement to discuss progress of the Partnership to date and identify next steps. The regional directors acknowledged the progress that had been made by the Humber, Coast and Vale Partnership over the last six months and the collaborative work that is now being undertaken at both local and regional level. The meeting also highlighted that, whilst partner organisations have agreed plans and contract values for 2018/19, further work will need to be undertaken in year to reduce the scale of financial pressures in the system. We will continue to work closely with NHSE and NHSI over the coming months to strengthen the Partnership and to develop our collective plans, including our capital investment plan (which needs to be finalised by July) and our overall winter plan.

Local "Place-based" Plans

The six local areas within our Partnership are working together to produce system-wide plans for their local health and care systems for 2018/19 and beyond. Local collaborations are focusing on more closely integrating health and social care commissioning (collaboration between local authorities and CCGs) and provision (collaboration between GPs, community services providers, mental health providers, acute hospitals and social care providers). In addition, local areas plans include a focus on improving the health of local populations by addressing wider determinants of health, promoting prevention initiatives and providing better support for people to manage their own health and health conditions. Following feedback from national regulators, there is further work to be done within each local area to understand the impact of actions set out in local plans in 2018/19. The expectation from national regulators for future NHS planning rounds will be that local areas produce plans on a place-based system-wide basis rather than on an organisational basis. In Humber, Coast and Vale this will support the Partnership to continue working toward our system-wide vision.

Strategic Resourcing Boards

In addition to local place-based programmes, the Partnership continues to focus its work across the wider Humber, Coast and Vale geography on our key strategic resourcing areas:

workforce, capital and estates, finance and digital technology. The Capital and Estates Board is continuing to work through the process of developing a regional estates strategy, which will help us to identify where capital investment is required in order for us to deliver transformation and improvements to local services as described in our local and Partnership-wide plans. The Board is working to the July deadline for completion of this strategy document, and the capital investment plan that will underpin it, as required by the national process. We are working hard as a Partnership to ensure we put forward the best possible plan in order to secure the much-needed capital investment across our local health and care system.

Our Strategic Digital Board, which will be responsible for developing a digital strategy for the health and care system in Humber, Coast and Vale, is recruiting a patient representative to join the Board. The Board is seeking an individual with significant direct experience of local health and care services who is passionate about finding ways to improve services for the future through the use of digital technology. More information about the role is available by contacting the Partnership office.

Clinical Priority Programmes – Cancer Alliance

Across the wider Humber, Coast and Vale geography, our collaborative efforts are also focused upon work in six key clinical priority areas:

- Mental health
- Cancer
- Elective care
- Urgent and emergency care
- Maternity services
- Primary care

One of the Partnership's key priority areas is to help more people to survive cancer and support people in our region to live well with and beyond cancer. A vitally important aspect of this work is to improve the collective performance of provider organisations across our area in providing diagnostic tests and treatment within the national target time (62 days from urgent referral for suspected cancer to first definitive treatment). In order to make faster progress, partners have agreed to develop site-specific groups at each of our hospital sites to look at performance against this key target to ensure that all suspected cases of cancer are seen and, where necessary, treated quickly. Providers will strengthen their input into the Cancer Alliance, specifically with a focus of improving collective performance on the 62-day target. In addition, the Cancer Alliance is undertaking a number of programmes to improve the quality of life of people living with and beyond cancer and to help ensure more cancers are detected early. This includes recruiting volunteer cancer champions ensure that more people who have cancer are diagnosed at an earlier stage by improving awareness and uptake of screening – find out more here.

Partnership Event

The next Partnership Systems Leaders Event will take on 19th June 2018. Following discussions with Chairs and other non-executives, it has been agreed that each of the 28 partner organisations will send up to four leaders to join the event to include a mixture of executive and non-executive leaders. Invitations and instructions on how to register for the event have been sent to each partner organisation's Board Chair/Council Leader and copied to Chief Executives. Partner organisations are reminded to please ensure your organisation has registered its attendees by Friday 25th May. Contact the Partnership office with any queries. It is hoped that this and future events will provide a key opportunity for partners to come together and share what is working well and find solutions where there are challenges to collaborative working.

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Board of Directors – 30 May 2018
Finance & Performance Committee Minutes – 17 April 2018

Attendance: Mike Keaney (Chair), Steve Kitching, Andrew Bertram, Mike Sweet, Lynne Mellor, Lynette Smith, Wendy Scott, Charlotte Craig

Apologies for Absence: Lynda Provins, Graham Lamb, Joanne Best

MK welcomed Lynne Mellor to the group and noted the above apologies.

Minutes of the meeting held on the 20 March 2018

The minutes of the last meeting held on 20 March 2018 were approved subject to the following amendments.

Tender Register - TEND2016-17-03 Cervical Screening services – the contract was initially awarded to Newcastle upon Tyne NHS Foundation Trust, they withdrew and YHFT was awarded the contract. The services were mobilised on 1st April 2017.

As the Scarborough Community Services Contract has been awarded to Humber Foundation Trust, we are working in a transfer of services. The TUPE process is virtually complete. There are some staff whose jobs deliver more acute activity than community and they won't TUPE. This will leave gaps in delivery and we will continue to provide some services on a subcontracted basis. Humber Foundation Trust had assumed they would continue to occupy the OPD area at Malton, we have agreed to lease space for 3/12 months only.

Matters arising from the minutes

There were no matters arising discussed.

Emergency Care Standards (ECS) – LS provided an update on March's performance of 81.2% which is a deterioration from February's position, and below the planned trajectory of 95%. It's been one of our highest months for 12 hour trolley breaches, with forty declared and due to the staffing constraints it has not been possible to open other escalation areas. However, we have an increase in attendances coupled with high bed occupancy (99.7%), leading to a challenging position. We will work with the CCGs through the A&E Delivery Board to understand the increase in attendances, notably at Scarborough Hospital. .

Scarborough Acute Board has developed a rapid improvement action plan as a result of the crisis meeting that was held involving senior clinicians and managers. This meeting was focused on 'what else' can be done to support the Scarborough Hospital site whilst

current pressures continue. It was acknowledged that due to the staffing constraints their ability to flex the way they work is challenging. It was noted that Cardiology has changed their working week to offer support into ED. The workforce gaps in ED are being filled by locums where possible but the situation is still challenging. Polly McMeekin will lead a separate piece of work to develop a work force plan for Scarborough that can be shared at the next Scarborough Board meeting. There was discussion about the work that is taking place to maximise the elective work undertaken at Bridlington Hospital in particular ensuring effective theatre utilization.

At the next Scarborough Board the group will consider all of the actions that have been taken and their impact.

LS and WS circulated the draft Ernst and Young report on York ED: Emergency Performance Improvement April 2018 and this will be shared with the Executive Board on the 18th April. A final report will be available at the May F&P Committee meeting. This work has helped to clarify priorities and has made recommendations e.g. the impact of reducing non-admitted breaches. YFT has agreed to extend the EY contract for a further 4 weeks to keep momentum going and to develop the work programme that will support delivery of the 6 key high impact changes.

Action: Final EY report to the next meeting

YFT remains a national outlier regarding ambulance handover time. An action plan is being developed and work is underway with YAS to ensure handover data is accurately recorded and reported.

Cancer - The 62 day performance standard was not achieved in February. This was expected as a number of long wait patients have been treated in February.

Fast Track performance has improved and continues to meet the national target. There remain some patients who have long waits for skin appointments where patients are waiting for appointments in Scarborough. This is being addressed through the move to the Malton one-stop-shop.

The Trust is aware that some urology patients choose to attend Harrogate, rather than go to Malton for their care following the implementation of the one-stop shop in Malton

The Trust is submitting the next round of bids for Cancer Alliance funding.

RTT - The Referral to Treatment (RTT) position for March is 83.3%. Routine electives were cancelled in the run up to Easter and the following week to support urgent care pressures. This has resulted in a further deterioration of the admitted backlog, rising to 2203 patients waiting over 18 weeks. Long waits continue to be a significant concern for the Trust, with 155 patients waiting over 40 weeks. All directorates have been asked to review patients waiting over 40 weeks on a weekly basis.

The Trust is considering the Winter Plan for next year and how to manage seasonal planning and protecting elective capacity.

Diagnostic - The Trust position for March is 97%. The Trust continues to experience delays in Sleep Studies which has been escalated to CCG Contract Management Board.

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Also in MRI GA cases for children, there is insufficient capacity for the demand. The team is looking into how we create an additional list or consider outsourcing to reduce the delays.

A significant issue with Radiology reporting was identified in March which led to a backlog developing quickly. The department has taken immediate action to outsource urgent cases to reduce the backlog.

Finance - The income and expenditure position for the 2017/18 financial year is a £23.075m deficit. The reported positon excludes income associated with the impact of the ADM historic capital VAT recovery.

The Trust's forecast outturn position was a deficit of £25m and our financial recovery plan has prevented further deficit. Our original pre-sustainability funding control was a deficit of £8.6m so we have fallen short of this position and we are not eligible for any of the £11.8m sustainability funding made available this year.

The total agency spend is reported as £18.0m, this represents a 5% overspend against the Trust's NHSI agency cap of £17.2m however it has been brought down from £21m last year, and we continue to work on this.

Our cash position at the end of the year is good; we have had access to the Distressed Cash Regime. We are having some difficulty paying our suppliers, but this is due to difficulties with our new Oracle ledger system. The situation has improved since its launch in January, and will hopefully resolve in the next 2 months.

Referencing the Patient Safety, Quality, Workforce, Finance, Research and Development and Performance Report April 2018 Mr Bertram made the following points.

Page 74 shows the year end income and expenditure position and A Bertram drew the Committee's attention to the positive impact of a recent revaluation of our assets on our Income and Expenditure position.

Page 75 is the chart usually presented to the Board that tracks our FRP improvement against our trajectories. The Committee discussed the fact that at September the Trust had a deficit of £20m and noted that in the second 6 months of the financial year deterioration has been slowed to only a further £3m deficit.

Page 77 confirms our year-end agency analysis and shows we have overspent by £800k. Mr Bertram reminded the Committee that November and December are artificially low due to accruals in the ledger being removed. The Committee discussed the improving position with agency spend but noted the need for further improvement work in this area.
Mr Bertram drew the Committee's attention to Page 80 which includes the key finance metrics that NHSI use to assess performance. The Committee discussed the information in the charts and noted that every chart has an improving trend.

Efficiency – Mr Kitching reported on the year-end position in relation to CIP delivery. He noted that the target had been exceeded by £0.5m. Mr Sweet challenged the recurrent delivery positon and Mr Kitching confirmed this was disappointing and work was underway with Directorates to improve this position by seeking to convert schemes as part of the

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new year process. Mr Keaney commented that delivery at this level has been impressive noting that this is the eighth year the Trust has delivered a similar efficiency target.

Mr Kitching moved on to talk about the new year CIP target and work underway with the Corporate Efficiency Team to re-energise the programme. Mr Kitching commented specifically on the work underway with regard to Quality Impact Assessments (QIA) where Directorates are currently assessing their CIP schemes. A review by Richard Khafagy is underway and schemes assessed to date have been categorised as low risk. Mr Kitching confirmed that any QIA risk will be escalated.

Mr Kitching confirmed that the target for 2018/19 is 21.7m.

Mr Keaney asked Mr Bertram to confirm the latest position with regard to the Trust's financial plan and control total. Mr Keaney specifically asked about how the pay overspend from 2017/18 had been managed in the plan. Mr Bertram confirmed that the new plan will counteract our pay overspend – the new plan is not based on historic budgets, but on our current run rate spend. Mr Bertram explained that this was not a case of rewarding poor financial governance but instead all pressures had been reviewed and where pressures were accepted as operationally legitimate then the plan had provided for these. Mr Bertram confirmed that there are no material contingencies; in the plan and any decision to invest has to be backed by an income source or compensating expenditure reduction.

Mr Bertram then reminded the Committee of the original NHSI Control Total and confirmed that they had asked us to deliver a £7m deficit and in exchange we would be given £17m sustainability funding resulting in a £10 net surplus. Mr Bertram reminded the Committee that the draft shared with the Board at the March meeting confirmed this could not be delivered, with the best outcome being a £19m deficit. Mr Bertram summarised the recent discussions with NHSI on our draft plan and reported to the Committee that a subsequent and improved offer had been made by NHSI. Under this proposal the Trust was asked to deliver a £14.3 deficit in exchange for £13.3m of sustainability funding, effectively delivering a net £1m deficit.

Mr Keaney confirmed he had been at the meeting with NHSI on the previous Thursday where this had been discussed.

Mr Bertram confirmed that he had written to the Board over the weekend to recommend that the revised control total be accepted. Mr Bertram confirmed all members of the Board had responded with positive conformation of acceptance. The Committee discussed the revised plan, the revised control total, the revised sustainability funding and the feedback from the Board of Directors and confirmed that Me Bertram should write to NHSI, as requested by NHSI, that afternoon to confirm acceptance of the new control total. In providing this approval the Committee noted that Mr Bertram would still be bringing a final version of the plan to the Board's April meeting.

Assurance: the Committee supports this position.

CQUIN Delivery – CQUIN 2017-18 has been completed with the reconciliation meeting on the 30th April. The plans for 2018-19 are not under review. The Health and Wellbeing indicators continue to be a risk. LS reminded the committee that the national planning guidance has removed the 'Supporting proactive and safe discharge' CQUIN and the

money will be redistributed. Two additional CQUIN have been agreed for 2018-19 on, on veterans and child sexual exploitation.

Risk Registers & BAF - This has been reviewed but no change.

Items for Board – Year-end financial outturn, revised annual plan and control total, Ernst & Young work

Any other business

The Committee would like to thank Finance and Operations for their hard work.

Action Log:

Month	Action	Responsible Officer	Due date	Completed
Apr 18	Final EY Report to the next meeting	W Scott	22.05.18	

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Board of Directors – 30 May 2018
Finance & Performance Committee Minutes – 22 May 2018

Attendance: Mike Keaney Chairman, Mike Sweet, Andrew Bertram, Wendy Scott, Steve Kitching, Lynette Smith, Graham Lamb, Andrew Bennett, Joanne Best

Guest: Dr Lorraine Boyd

Apologies for Absence: Lynda Provins

MK Welcomed Dr Lorraine Boyd to the meeting, followed by introductions.

MK addressed the Committing noting that the agenda for today's meeting was exceptionally large and asked if the Committee was expected to review all items on the agenda or if some of the items were for information only.

WS told the Committee that item 6 Final Ernst & Young Report was for information only and that by the next meeting an action plan that addresses the key areas of the report will have been developed. This will be shared with the committee for further oversight and discussion.

WS also noted that item 12 Winter Plan is planned to be on the Board agenda next week and therefore was included on the Committee agenda for assurance only that winter planning for this year is underway. Further plans will be shared with the Committee as plans progress.

It was noted that item 11 Operational Plan was also for reference at this stage. This is a refresh of the 2017-19 plan and has been submitted to NHSI as per the required timeframe.

Minutes of the meeting held on the 17th April 2018

The minutes of the last meeting held on 17th April 2018 were approved subject to the following amendments:-

Page 1, paragraph 3 - {As the Scarborough Community Services contract has been awarded to Humber Trust we are working on a handover. TUPE is virtually complete, there are some staff whose jobs are more acute than community and therefore won't TUPE across. This will leave gaps in Humber's services and we will continue to provide some services. Humber assumed they would inherit the Outpatient area, but this is incorrect. We may have to share for a limited time until they can access other accommodation}.

Replace with
{*As the Scarborough Community Services Contract has been awarded to Humber Foundation Trust, we are working in a transfer of services. The TUPE process is virtually complete. There are some staff whose jobs deliver more acute activity than community and they won't TUPE. This will leave gaps in delivery and we will continue to provide some services on a subcontracted basis. Humber Foundation Trust had assumed they would continue to occupy the OPD area at Malton, we have agreed to lease space for 3/12 months only.}*

Page 3 – paragraph 9 Mr Sweet challenged the '*recurrent'* delivery position

Page 4 – paragraph 7 – The plans for 2018 – 19 are *'not'* under review.

Lynnette '*Lynette'* Smith

Emergency Care Standard Delivery

MS asked whether the payment difficulties had been resolved with the new finance system. AB told the Committee that the new Oracle ledger system is now fully functional but that some difficulties still remain with paying aged invoices from the old system. AB confirmed that the team were working incredibly hard to resolve this issue but that we were probably 5 weeks away from complete resolution.

Emergency Care Standard Delivery

LS stated that the Emergency Care Standard performance for April achieved 85.1% against a planned trajectory of 85% for April this is an improvement on March 2018.

It was noted that the planned performance trajectory should achieve 90% by September 2018, to achieve this there would need to be a 1% improvement each month until September.

April was a challenging month and LS stated that it was a credit to staff that the 85% trajectory was achieved.

LS noted that the number of long wait patients on both sites remained a significant concern and that there were thirteen 12 hour breaches at Scarborough Hospital in April 2018. This was, however, an improvement on March 18 in which there had been 40 breaches. There was a high number of patients waiting over 8 hours at both hospitals, with 19 patients waiting over 20 hours in the emergency department.

Improvement was seen at York Hospital following the Ernst and Young Rapid Improvement week which focused on non-admitted breaches, board rounds in ED and assessment pathways. There was a 5% improvement on performance in the second half of April against the first half. .

LS noted that although bed occupancy had improved at York Hospital the number DToC patients in York Hospital increased significantly in April reporting a 50% increase. A rise was anticipated but not to that level. This was primarily due to availability of nursing home and intermediate care / rehabilitation delays.

WS advised the Committee that City of York Council (CYC) is working with the Trust and supporting the multiagency Complex Discharge working group to address the issues and improve the DToC position.

LS stated that that Scarborough Hospital had remained under significant pressure during April with only 4 days experiencing bed occupancy at midnight below the recommended 92% level. LS noted that Scarborough Hospital had declared OPEL 4 (extreme pressure) on one day.

It was noted that the Trust has also asked Ernst & Young to review and validate the bed modeling approach for the Scarborough site and to identify opportunities to use the space differently to support long bed waits. WS told the committee that E&Y will deliver its report to the Trust this afternoon (22nd May 18).

MK enquired that in view of the shortfall of permanent workforce at Scarborough Hospital had there been any suggestions on how this could be addressed.

WS replied that there had been a workshop with colleagues looking at opportunities; the outcome of this would be included in the diagnostic report from E & Y that is due to be presented at Scarborough next Thursday. (31st May 18)

MK asked if the long waits in ED were a risk.

WS discussed the proposed AMM model stating that elements of the model are implemented, but it is still work in progress. Workforce constraints and estate constraints mean that it can't be implemented as per the proposed vision at the moment although work is progressing to ensure that the model is progressed. It is clear that performance against the ECS standard is not where we want it to be.

LS noted that this year it has taken longer for the Trust to recover after the winter pressure.

MK stated that the long waits in Scarborough ED were causing concern and asked if they were affecting Ambulance handovers. LS told the Committee that Trust has a good working relationship with YAS and is targeting ambulance handovers, noting that there is a YAS clinical supervisor now based on the Scarborough site in ED.

YAS have undertaken a walk-around of the York ED with our operational and business intelligence leads to support their understanding of the data inputting and quality issues. These issues will be incorporated into specific action plans which will target ways to improve ambulance handover times.

MK asked the Committee if the planned 95% performance trajectory for March 2019 was moveable or if it was aligned to the financial plan. LS noted that this was an ambitious position for March and that was the work of the teams to support delivery with AB stating that this would support the Trust receiving the sustainability fund through the year but that the March requirement of 95% was obligatory.

The committee discussed how the sustainability fund is divided into quarters with the largest portion of the fund received in the final quarter.

Cancer

LS – The Trust has continued to show improvement in two week waits and met all of the cancer waiting targets for March (this is reported a month in arrears) achieving 85.9% for 62 day wait from GP referral to 1st treatment.

The Trust achieved the 14 day fast track target at 93.6% which equates to 94 breaches of patients who were seen beyond 14 days, 40% of these patients were on a skin pathway, with 79% of these diagnosed with no cancer.

The NHSI Intensive Support Team has been on the York site throughout April working with the team on a range of actions. One specific area is the management of patients off the suspected cancer waiting list to other monitoring routes when a patient does not have a confirmed cancer. This will reduce patient long wait on the suspected Cancer pathway. This is an administrative process and doesn't affect their clinical pathway and LS assured the committee that patients would continue to be tracked. The proposal is going to the Cancer Board in May.

LS stated that there had been a significant increase in prostate and colorectal two week fast track referrals during March; this has been raised with the CCG's for further consideration. This has impacted on the pressure in Endoscopy.

It was noted that the HCV Cancer Alliance was not eligible for any of the additional funding applied for from the national Cancer Alliance funding referred to in the April 18 minutes.

Planned Care

LS told the committee that the RTT position for April is 83.8% this is above the planned trajectory of 83.3% in March an 88.9% in April 2017, although this is not a true comparison as there was an additional Bank Holiday in April 2018.

Waiting lists continue to be of concern with one declared 52 week breach for April in Head and Neck services. This was due to incorrect recording of the clock as a patient was transferred between specialties. April saw an increase in total waiting lists although for the first time since October 17 the number of open clocks waiting over 18 weeks has reduced from the previous month.

April has seen a significant increase in GP referrals. This will be monitored closely through the multi-agency Planned Care Steering Group.

LS stated that the Trusts DNA rate has reduced to 5.7% compared to 6.8% in April 17, reflecting the impact of text messaging service and directorate work to address DNA rates. This is particularly notable at York Hospital which reduced to 5%.

The Committee was told that the Trust there was a potential of a further 52 week breach in May with three being the limit for the year, this was highlighted as a risk and would be reviewed weekly.

MK suggested that the target of 3 breaches is low and asked what the position of other Trusts was. LS replied that the figure is low as the Trust historically does not have many long waits but that she would enquire the level set in other similar Trusts.

Diagnostics

It was noted that the Trusts' position for April has further deteriorated to 96.1% which is significantly lower than the national average. Contributing factors to this have been sleep studies and MRI GA radiology delays. Approval to change the sleep study equipment has now been given and should be in use in the Trust by 21st May 2018, approval has also been secured to transfer long wait children requiring an MRI under General Anaesthetic to Sheffield Hospital.

Endoscopy capacity is not sufficient to meet the current demands, resulting in delays in the diagnostic tests for both urgent and routine patients. The directorate has developed an options paper for Corporate Directors to consider additional capacity.
MK addressed the Committee stating that potentially this was good news.

Finance

GL stated that month one was a promising start to the year with an income and expenditure position showing a deficit of £2.0m against a planned deficit of £2.5m therefore the Trust could assume month 1 PSF (Provider Sustainability Funding) of £0.6m. GL confirmed that to actually receive this funding the Trust must comply with this control at the end of Q1.

GL noted that the Finance Report in the Board Performance Pack now includes a new additional analysis reviewing run rate income and expenditure categories following the NHSI Investigation Report recommendations. He stated that the monthly average expenditure run rate for the previous 6 months to March 17 was £40.6m and that the run rate for April 2018 is at £40.1m, noting that expenditure is down against average levels.

AB explained to the committee how monitoring the 'run rate' would help to indicate any abnormal activity earlier in the year. These reports and the information contained will be developed through the year.

MK noted that the Agency spend for the year is capped at £14.2m and enquired if this had been set for the Trust by NHSI. GL confirmed this was set by NHSI and was part of the continued national drive to reduce agency expenditure. AB stated that for month 1 the Agency spend cap was £1.2m and the Trust reported an actual spend of £1.0m which was favorable against plan.

It was noted that quality and safely is paramount and that Agency spend would need to be discussed further with the Board and the Q&S Committee.

MK took some assurance from the Committee that staff levels were safe and that where extra staff had been used for safety last year they had be included in this years budgets. AB confirmed the staffing overspend in 2017/18 of £8.5m and confirmed most of this had been incorporated into the run-rate based budgets for 2018/19.

It was noted that the I&E report now separately identifies excluded drugs and devices from the main category of drug expenditure. It has been difficult to assess Month 1 clinical income due to the normal time period for clinical coding and the new-year tariff changes. The position had been largely based on plan levels in constructing the report. GL confirmed that since the closing of the ledger the finance team had been able to make a first cut assessment of income and it showed the actual level as around £0.2m higher than plan. This will be incorporated into the month 2 position in due course.

The CIP total target for 2018/19 is £21.7m, £2.5m delivered in full year terms at month 1, notably £2.2m delivered recurrently, representing 10% of the overall CIP target.

Cash

AB discussed the Trusts cash position and the planned deficit forecast for 2018/19 highlighting the Trusts likely reliance on revenue support in-year. The report presented to the committee indicated which months were most likely for cash difficulties. AB discussed the options for management of the position and confirmed the need for ongoing close management through the year. MS and MK commented on the quality of the paper and the very useful information and overview it provided. The committee resolved to include this report in the full Board paper pack; such was the financial governance importance of this issue.

MK and AB discussed the reconciliation process that will take place throughout the year between the Trust and NHSI's cash management team, confirming that the Trust's likely cash needs had been shared and that discussions and shared monitoring will continue.

The committee received assurance with regard to the cash plan.

Efficiency

SK stated that the Trust CIP delivery for April 2018 is £2.5m which is 11% of the £21.7m annual target for 2018/19. This compares to a delivery position of £0.9m in April 2017. Of the £2.5m delivery £2.2m in year has been delivered recurrently, indicating that recurrent delivery is £1.5m ahead of the position in April 2017.

MK told the committee that this is a promising start to the new financial year and that the developments around the overarching efficiency programme were very positive.

CQUIN

LS told the Committee that the final CQUIN position is as the submitted report. The changes to the 2018-19 guidance were briefed at the last Committee, with the introduction of two additional CQUIN, one relating to the armed forces and one relating to child sexual assault assessment services. LS informed the Committee that conversations with the CCG about year 2 of the CQUIN were progressing, highlighting the recurrent risk in CQUIN 4 – Mental Health. LS reminded the Committee that CQUIN 8a had been stood down and the money re-allocated across the remaining community CQUIN measures.

Final Ernst & Young Report

WS told the committee that E&Y had divided the recommended high impact changes into' three buckets', front door, assessment floor and ambulatory care and SAFER and flow, these will be considered and will align with the existing transformation plan which will be refreshed, stating that there will be one single plan and that the first draft of this plan will be delivered at the June Committee.

Senior Information Risk Owner Report (SIRO)

AB told the committee that this report had been submitted as a review document for the 2017/18 financial year. AB asked the Committee to consider and review it today on behalf of the Board.

AB gave the committee an overview of the report stating that the SIRO report is an annual report that indicates the work undertaken in the Information Governance arena over the past year.

AB expended on the work of the relatively newly formed Information Governance Executive Group (IGEG), providing a strategic focus on Information Governance within the organization. The most recent work programme was largely driven by significant changes to Data Protection laws due to come into effect from May 2018 under GDPR. The IGEG is chaired by the Finance Director (SIRO) and includes the Deputy Director of Healthcare Governance, the Director for Systems and Network Services, the Caldicott Guardian and Chief Clinical Information Officer. The group meets four times a year to discuss strategic and operational issues pertaining to the Information Governance Agenda.
The committee discussed a number of IG issues described in the paper and took assurance from the programme of work described for the IGEG.

MK stated that this was a timely paper as there were concerns with regards to serious data breaches within the NHS.

MS asked if there would be a requirement for extra staff to support this, AB acknowledged that there is at least one vacancy within the team that will be recruited to and that other resources were also being explored.

Revision to CIP Programme Management in response to NHSI Undertakings

SK stated that the recent NHSI investigation report highlighted a need for the Trust to shift its focus towards development of a more transformational efficiency agenda.

SK provided an overview of the paper and its recommendations and drew the committee's attention to page 30 Fig. 1 - proposed structure of the revised programme of work

The aim of this structure is to give transparency to all elements of the programme and to bring all the metrics together in one place. AB described the two arms for delivery including both transactional and transformational programmes. AB confirmed that protected Corporate Directors time would be used to manage delivery and that these discussions would be formally supported and minuted by the Corporate Efficiency Team.

MS and MK questioned AB and SK as to the content of the paper and the revised structure, discussing the transactional versus transformational programme, the inclusion of all components of the programme into a single overarching objective and the developments made to the QIA process. MK asked how reporting would be developed for the committee and SK confirmed work was underway on new dashboards and governance documentation and that this would be brought to the committee in due course.

MS asked for and update to be delivered to the next F & P committee meeting.

The committee were pleased with the developments in line with NHSI's recommendations.

Reference Cost Report

AB explained to the Committee that the purpose of this report was to provide an update on the process used to deliver the 2017/18 reference cost submission and upcoming plans to deliver the 2018/19 NHSI Costing Transformation Programme Patient level Cost submissions He stated that NHSI assign a significant level of scrutiny to this process and have recently appointed E&Y undertake an independent audit.

The Committee discussed the paper and MK and MS questioned AB on its content. Reference to internal audit work in this area was also discussed.

AB confirmed that as well as information and assurance giving the paper requested that the committee, on behalf of the Board and acting as an appropriate Board sub-committee, delegate approval to the Finance Director to sign off the Trust's annual reference cost submission. AB described the assurance processes employed as part of this process and Mk and MS confirmed they were acting on behalf of the Board in their sub-committee role and confirmed delegation to AB for sign off. The committee resolved to report this formal delegation to the Board.

Capital Programme Report

A Bennett told the committee that the funding available to invest in capital projects in 2018/19 has been split into four categories, depreciation-based funding, strategic funding that was granted to the Trust when it acquired the Scarborough Acute NHS Trust, loan funding from the Independent Trust Financing Facility (ITFF) and charitable funding. The total amount of depreciation-based funding was circa £8m but this has been reduced to £5.7m to take account of the requirement to repay the loan funding received from the ITFF.

ABennett stated that at this stage of the financial year the over commitment of £2.1m does not cause any particular concern as schemes included in the plan were likely to slip at some level and for various reasons. Examples of the reasons that project may slip were discussed.

ABennett noted that the Capital Projects Department is actively examining the potential for obtaining finance from outside organisations and assured the committee will be made aware of any developments and recommendations in relation to external capital funding opportunities.

It was noted that there is a risk that projects may not be completed due to the strain on capital finance, but the Committee was assured that projects required for safety reasons would be prioritised. The committee noted particularly the fire alarm projects in this discussion.

The Committee discussed the planned completion of the new fire alarm system on all sites and the possible next large projects. ABennett gave a brief overview of future schemes that will bring pressure to the available capital finance in 2018/19 and subsequent years. (page 65 appendix 4). MK asked for a view on the level of backlog maintenance the Trust has. ABennett confirmed that a full survey was currently underway and the findings would be reported to the Board in due time.

Operational Plan

Report for information only – reflection following CQC inspection.

Winter Plan

Update for information, submission to Board next week. WS - The winter plan is in line with the previous year, stating that it would be useful to be made aware of any additional winter funding as early as possible.

MK stated that it is reassuring that the Winter Plan has been presented to the Committee at the end of May.

Board Assurance Framework

No further updates.

Any other business

Care Report – WS stated that this was for information only and that if anyone required further information she would be happy to oblige either personally or at the next meeting.

MK – asked if moving forward the Trust would be reviewing using technology especially within the community.

Date and time of the next meeting - 19 June 2018, 9.30-11.30am in the Boardroom, York Hospital

DRAFT

E1

NHS

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Finance Report

Recommendation

For information ☒
For discussion ☒
For assurance ☒
For approval ☐
A regulatory requirement ☐

Current approval route of report

Overview report prepared for the Finance & Performance Committee and Board of Directors meeting.

Purpose of report

To report on the financial position of the Trust.

Key points for discussion

This report details the 2018/19 month 1 financial position for York Teaching Hospital NHS Foundation Trust.

The Trust is reporting an Income and Expenditure deficit of £2.0m against a planned deficit of £2.5. The Trust is currently reporting a £0.5m favourable variance to plan.

Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Version number: Version 1

Author: Andrew Bertram, Finance Director

Executive sponsor: Andrew Bertram, Finance Director

Date: May 2018

Briefing note from Andrew Bertram for the Finance & Performance Committee and Board of Directors Meeting - May 2018

2018/19 Month 1 Summary Financial Position

The month 1 income and expenditure position is a deficit of £2.0m against a planned deficit of £2.5m. The Trust is therefore reporting a £0.5m favourable variable against plan.

Excluding Provider Sustainability Funding (PSF) the month 1 control total was a £3.3m deficit. This position was slightly exceeded and therefore the Trust is eligible for month 1 PSF of £0.6m. This has been reflected in the position. No release of PSF is made for in-quarter performance and the Trust must comply with the control total at the end of Q1 to secure the funding. The Board are reminded that 70% of PSF is secured on delivery of the control total and the balance of 30% is conditional on delivering the ECS improvement trajectory. For Q1 both requirements have been met by the Trust.

The detailed Finance Report in the Board's Performance Pack includes new and additional analysis reviewing run rate income and expenditure categories as per the NHSI Investigation Report recommendations. The monthly average expenditure level for the last 6 months of 2017/18 was £40.6m and for month 1 of 2018/19 this has been reported as £40.1m. Notably pay expenditure was down £0.2m on the average.

Agency expenditure has been reset at a total cap of £14.2m as per NHSI's direction for the Trust. For month 1 this suggests a spend cap of £1.2m. The actual reported agency expenditure was below cap at £1.0m.

The reports now separately identify excluded drugs and devices from the main category of drug expenditure. The report confirms excluded drug and device expenditure at very close to the plan of £3.5m for April and the balance of non-excluded drug expenditure is £0.1m favourable against plan.

There are no indicators that I would wish to draw to the Board's attention at this stage that suggest any material movement away from trends established under the Financial Recovery Plan during 2017/18. Similarly there are no adverse trends evident in relation to expected expenditure trends for 2018/19.

Month 1 income levels are notoriously difficult to assess due to the normal time period for clinical coding and new-year tariff changes that will ultimately impact on the average spell prices used for in-month estimations. At the time of producing the finance report all income lines were simply balanced to plan, with the exception of excluded drugs and devices expenditure where the actual position was known. Since the closing of the ledger and the production of the finance report we have been able to make a first cut indicative assessment of the value of month 1 activity and this suggests overall levels are around £0.2m above plan. The reported income position is, therefore, most likely prudent.

The CIP target for 2018/19 has been profiled this year using intelligence around previous years' delivery trajectories. The total target for 2018/19 is £21.7m with £2.5m delivered in full year terms at month 1; notably £2.2m delivered recurrently, representing 10% of the overall CIP target.

There are no cash issues to report in relation to month 1 but a separate paper mapping out cash issues for the full 2018/19 year has been prepared for separate discussion.

All commissioner contracts have been agreed for 2018/19 and all are currently based on standard or PbR principles. Discussions continue with the Trust's three main CCGs (VoY, S&R and ER) as to the potential movement away from PbR to an Aligned Incentive Contract. This has not yet been agreed and will be subject to a separate briefing as the detail develops. The Trust can use the contract variation process to move away from its existing contracts, by mutual agreement, if and when alternative terms are agreed.

Finance Performance Report

May 2018

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

Finance Report
Chapter Index

Summary Income and Expenditure Position
Month 1 - The Period 1st April 2018 to 30th April 2018

York Teaching Hospital NHS Foundation Trust

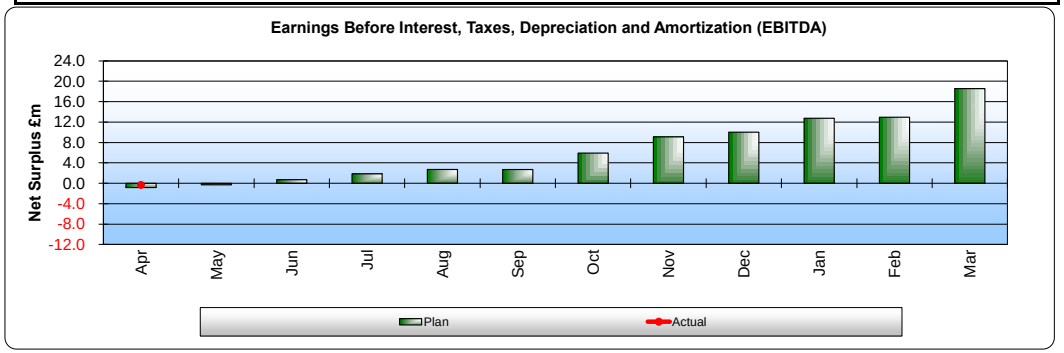
Summary Position:

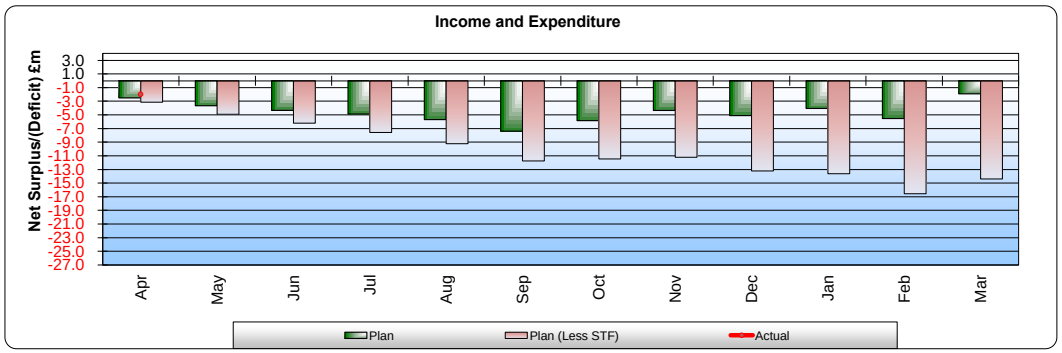
* The Trust is reporting an I&E deficit of £2m, placing it £0.5m ahead of the operational plan.

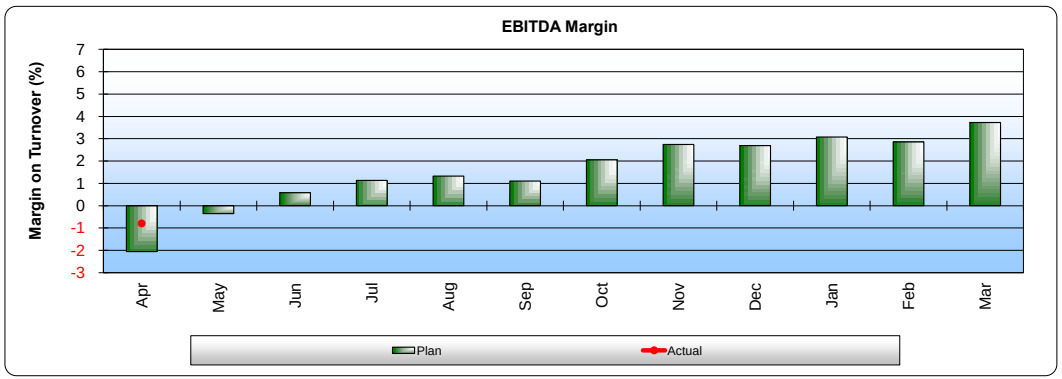
* Income is £0.4m behind plan, with clinical income being on plan and non-clinical income being £0.4m behind plan.

* Operational expenditure is behind plan by £1m, with further explanation given on the 'Expenditure' sheet.

* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is -£0.3m (-0.8%) compared to plan of -£0.8m (-2.09%), 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	24,068	1,922	1,922	0	24,068	0
Planned same day (Day cases)	40,054	3,056	3,056	0	40,054	0
Non-Elective Income	117,823	9,405	9,405	0	117,823	0
Outpatients	60,710	4,802	4,802	0	60,710	0
A&E	16,073	1,313	1,313	0	16,073	0
Community	19,660	2,487	2,487	0	19,660	0
Other	116,884	9,143	9,143	0	116,884	0
Pass-through excluded drugs expenditure	43,853	3,529	3,500	-29	43,853	0
	439,125	**35,657**	**35,628**	**-29**	**439,125**	**0**
Non-NHS Clinical Income						
Private Patient Income	1,042	87	114	27	1,042	0
Other Non-protected Clinical Income	1,560	130	147	17	1,560	0
	2,602	**217**	**261**	**44**	**2,602**	**0**
Other Income						
Education & Training	13,654	1,138	1,111	-27	13,654	0
Research & Development	2,546	212	141	-71	2,546	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	25,326	2,111	1,757	-354	25,326	0
Sparsity Funding	2,600	217	217	0	2,600	0
STF	12,479	624	624	0	12,479	0
	57,228	**4,354**	**3,902**	**-452**	**57,228**	**0**
Total Income	**498,955**	**40,228**	**39,791**	**-437**	**498,955**	**0**
Expenditure						
Pay costs	-342,448	-28,000	-27,550	451	-342,448	0
Pass-through excluded drugs expenditure	-43,853	-3,529	-3,500	29	-43,853	0
PbR Drugs	-12,616	-1,182	-1,049	133	-12,616	0
Clinical Supplies & Services	-48,028	-3,992	-3,871	121	-48,028	0
Other costs (excluding Depreciation)	-52,605	-4,195	-4,140	55	-52,605	0
Restructuring Costs	0	0	0	0	0	0
CIP	19,155	-172	0	172	19,155	0
Total Expenditure	**-480,395**	**-41,070**	**-40,110**	**961**	**-480,395**	**0**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**18,560**	**-842**	**-319**	**524**	**18,560**	**0**
Profit/ Loss on Asset Disposals	0	0	3	3	0	0
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation - purchased/constructed assets	-11,717	-976	-976	0	-11,717	0
Depreciation - donated/granted assets	-395	-33	-33	0	-395	0
Interest Receivable/ Payable	130	11	12	1	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	-967	-63	-64	-1	-967	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	**-1,905**	**-2,504**	**-1,978**	**527**	**-1,905**	**0**

Summary Trust Run Rate Analysis

Month 1 - The Period 1st April 2018 to 30th April 2018

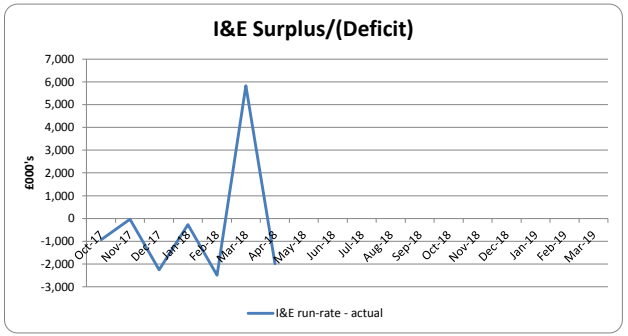
York Teaching Hospital NHS Foundation Trust

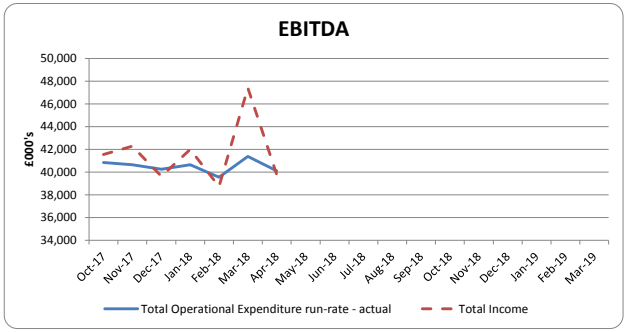
Key Messages:

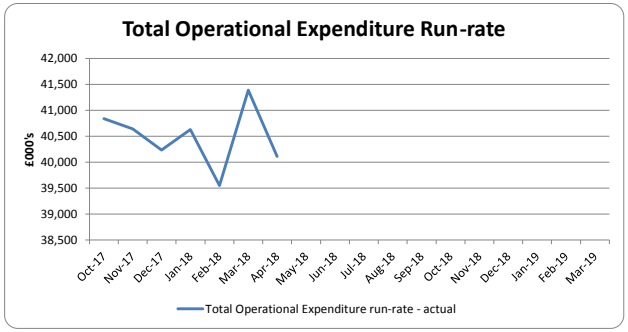
* The total operational expenditure in April was £40.1m. The average total operational expenditure in the previous six months was £40.6m. Resulting in a favourable variance of £0.4m.

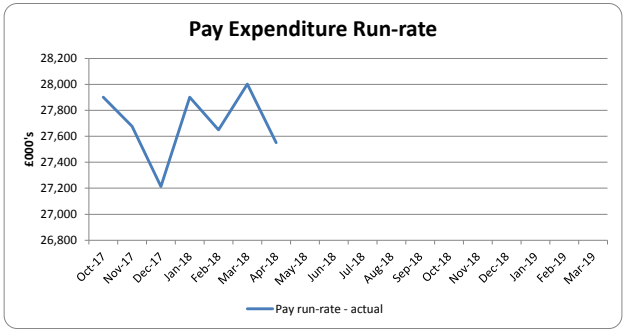
* Pay expenditure was lower than the average for the previous six months by £0.2m.

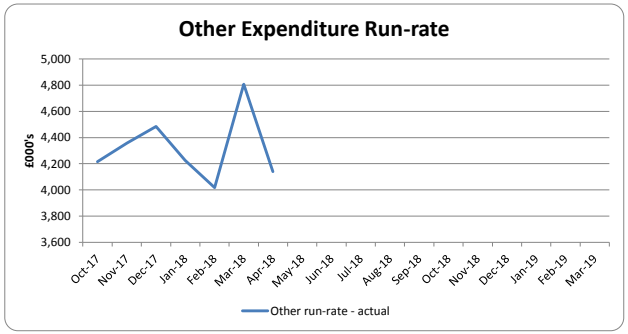
* In month operational expenditure exceeded income by £0.3m, resulting in a negative EBITDA for the month.

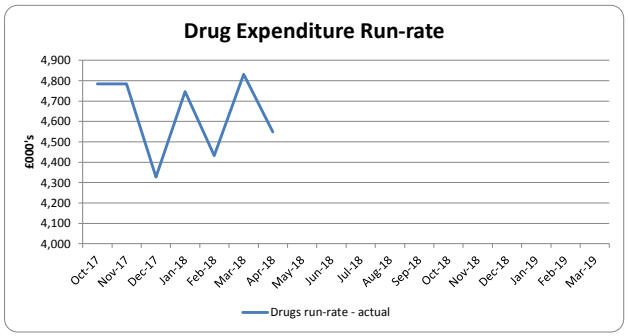


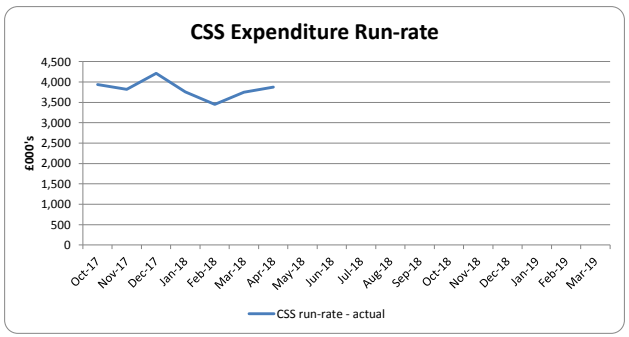












	Monthly Spend																		Monthly Ave	Variance
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19		
Total Income	41,538	42,272	39,613	42,003	38,738	47,400	39,791	-	-	-	-	-	-	-	-	-	-	-	41,927	- 2,136
Pay Expenditure	- 27,901	- 27,678	- 27,214	- 27,902	- 27,651	- 28,002	- 27,550	-	-	-	-	-	-	-	-	-	-	-	- 27,725	175
Drug Expenditure	- 4,785	- 4,785	- 4,327	- 4,747	- 4,433	- 4,832	- 4,549	-	-	-	-	-	-	-	-	-	-	-	- 4,652	103
CSS Expenditure	- 3,938	- 3,822	- 4,208	- 3,754	- 3,452	- 3,745	- 3,871	-	-	-	-	-	-	-	-	-	-	-	- 3,820	- 51
Other Expenditure	- 4,217	- 4,358	- 4,484	- 4,225	- 4,017	- 4,807	- 4,140	-	-	-	-	-	-	-	-	-	-	-	- 4,351	211
EBITDA	697	1,629	- 620	1,375	- 815	6,014	- 319	-	-	-	-	-	-	-	-	-	-	-	1,380	- 1,699

Contract Performance

Month 1 - The Period 1st April 2018 to 30th April 2018

York Teaching Hospital NHS Foundation Trust

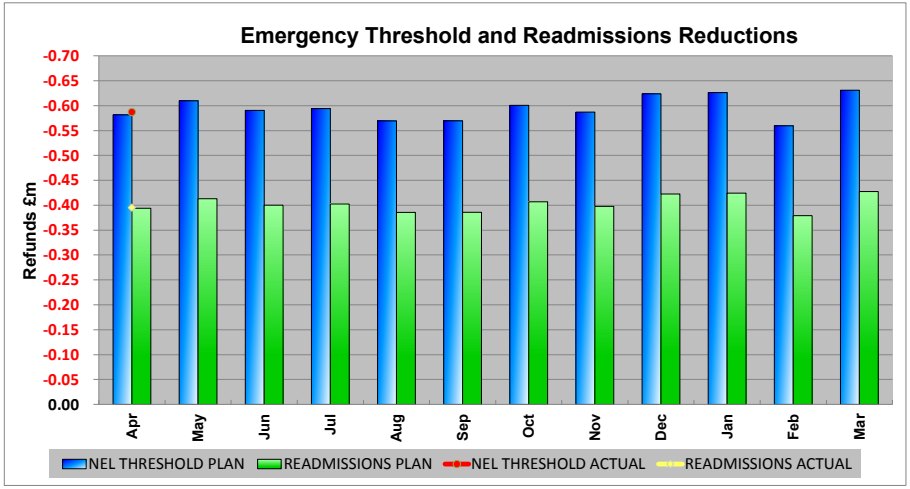
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	215,772	17,346	18,118	772
Scarborough & Ryedale CCG	77,065	6,903	7,042	139
East Riding CCG	41,883	3,286	3,380	94
Other Contracted CCGs	17,372	1,375	1,396	21
NHSE - Specialised Commissioning	42,548	3,428	3,413	-15
NHSE - Direct Commissioning	15,340	1,235	1,128	-107
Local Authorities	4,434	371	374	3
Total NHS Contract Clinical Income	**414,414**	**33,944**	**34,851**	**907**

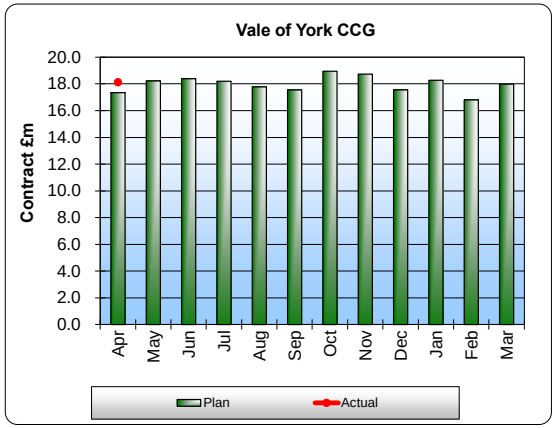
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	12,124	957	994	37
Risk Income	12,587	756	0	-756
Total Other NHS Clinical Income	**24,711**	**1,713**	**994**	**-719**

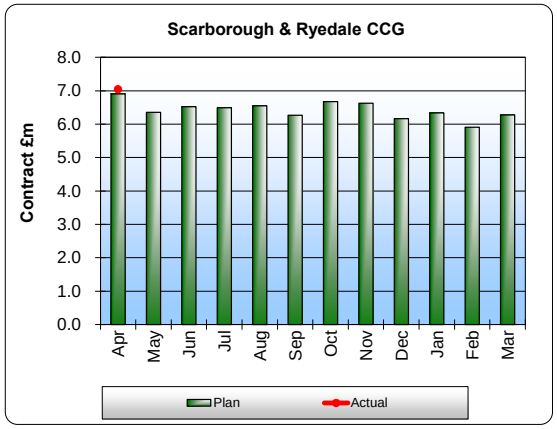
Sparsity funding income moved to other income non clinical	-217
Winter resilience monies in addition to contract	0

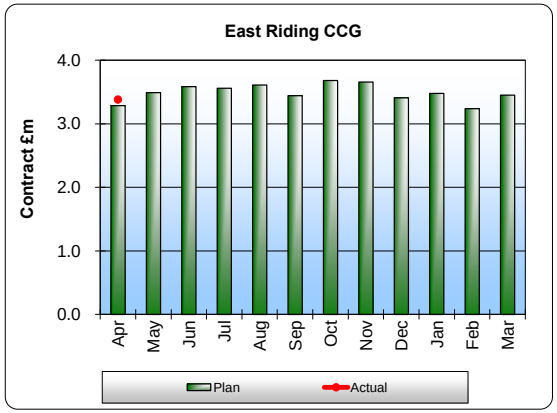
Total NHS Clinical Income	**439,125**	**35,657**	**35,628**	**-29**

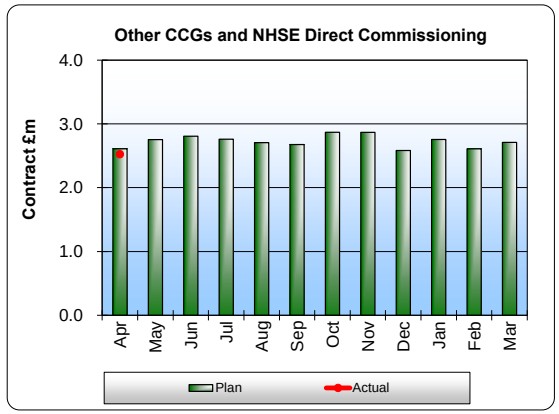
Early indications are that actual clinical income will be close to planned levels so, as April activity data was less than 50% coded, clinical income has been stated at planned levels (with the exception of actual excluded drugs income).

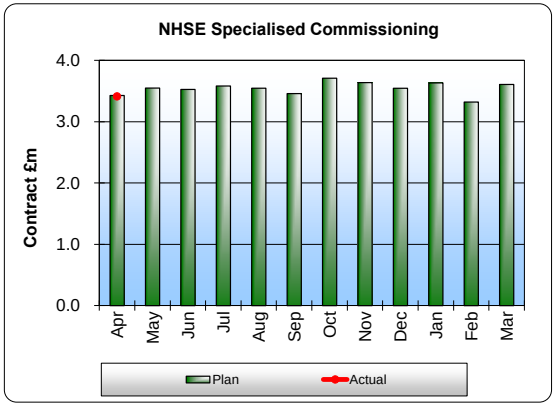


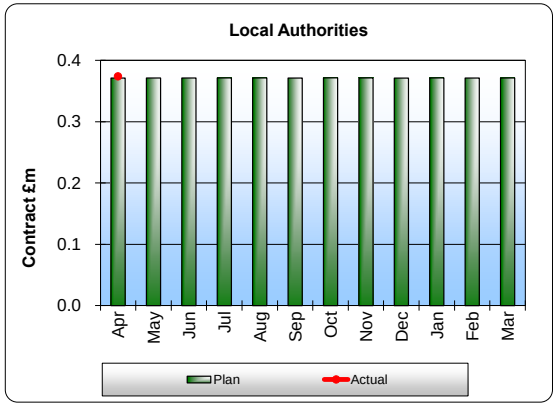












Agency Expenditure Analysis

Month 1 - The Period 1st April 2018 to 30th April 2018

York Teaching Hospital NHS Foundation Trust

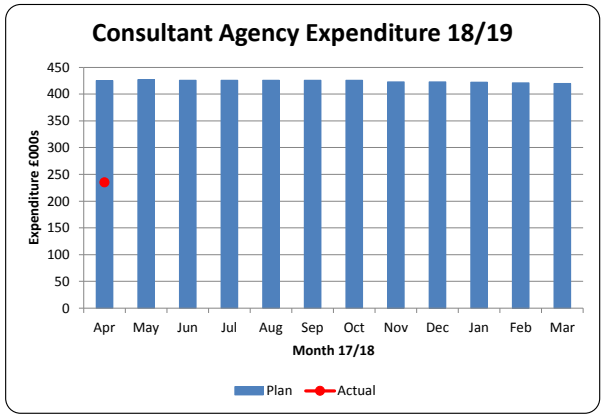
Key Messages:

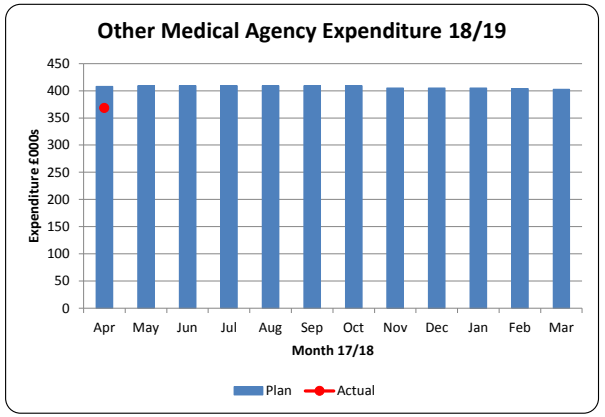
* Total agency spend year to date of £1m, compared to the NHSI agency ceiling of £1.2m.

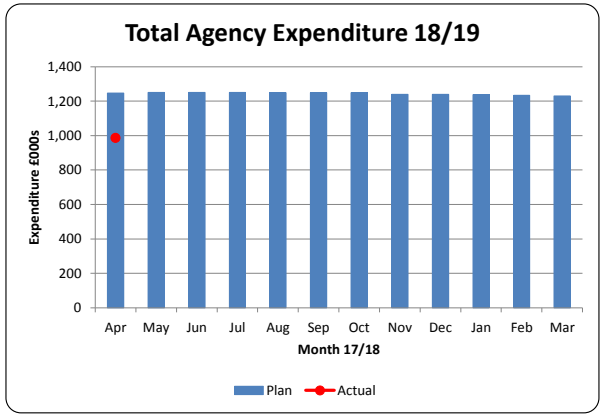
* Consultant Agency spend is behind of plan by £0.2m.

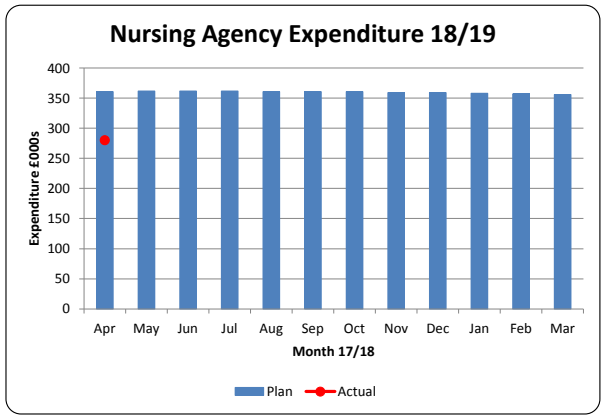
* Nursing Agency is behind plan by £0.1m.

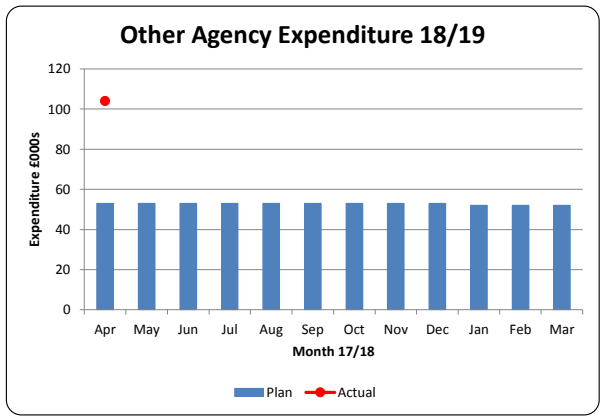
* Other Medical Agency spend is behind plan £40k.











Expenditure Analysis

Month 1 - The Period 1st April 2018 to 30th April 2018

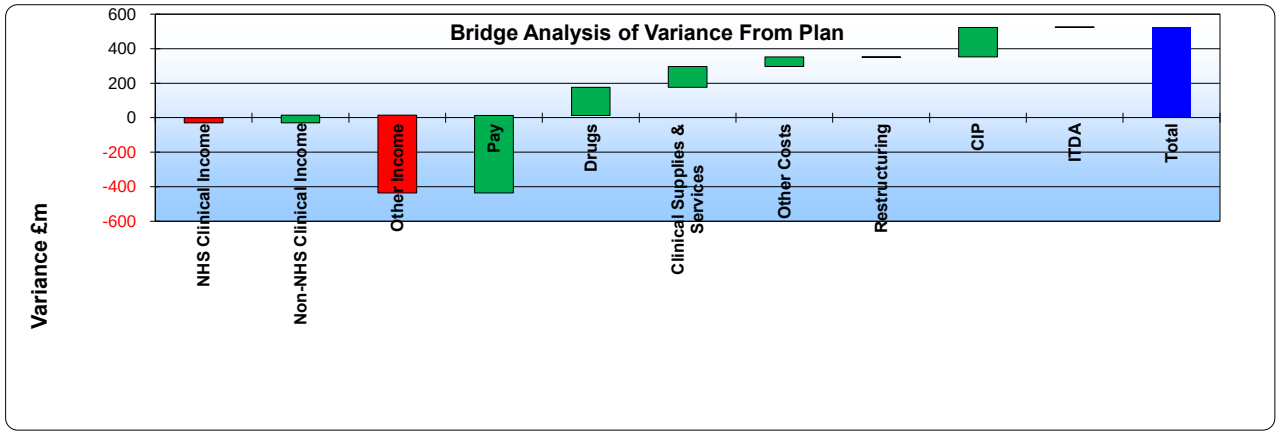
York Teaching Hospital NHS Foundation Trust

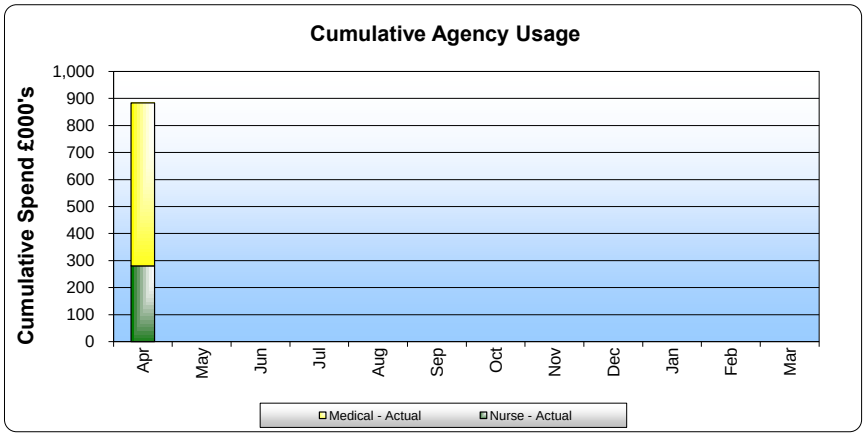
Key Messages:

There is a favourable expenditure variance of £1m at the end of April 2018. This comprises:

* Pay budgets are £0.5m behind plan.
* Drugs budgets are £0.2m behind plan.
* CIP achievement is £0.2m ahead of plan.
* Other budgets are £0.2m behind plan.

Staff Group	Annual Plan	Year to Date Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Previous Variance	Comments
Consultants	58,047	4,591	4,573	-	4	-	235	4,741	-150	0	
Medical and Dental	42,766	3,397	2,516	-	124	-	368	2,968	429	0	
Nursing	96,137	7,929	6,813	49	0	639	280	7,675	254	0	
Healthcare Scientists	13,327	760	849	17	19	1	54	927	-166	0	
Scientific, Therapeutic and technical	16,314	1,307	1,066	12	180	3	13	1,257	49	0	
Allied Health Professionals	22,359	1,877	2,066	9	5	0	22	2,070	-193	0	
HCAs and Support Staff	49,275	4,066	3,550	63	6	4	8	3,576	490	0	
Chairman and Non Executives	186	15	14	-	-	-	-	14	1	0	
Exec Board and Senior managers	12,143	1,030	1,173	-	-	-	-	1,155	-125	0	
Admin & Clerical	35,358	2,830	3,053	17	23	9	8	3,061	-230	0	
Agency Premium Provision	4,364	364	0	0	0	0	0	0	364	0	
Vacancy Factor	-9,021	-266	0	0	0	0	0	0	-266	0	
Apprenticeship Levy	1,192	99	106	0	0	0	0	106	-6	0	
TOTAL	**342,448**	**28,000**	**25,779**	**167**	**360**	**656**	**987**	**27,550**	**450**	**0**	





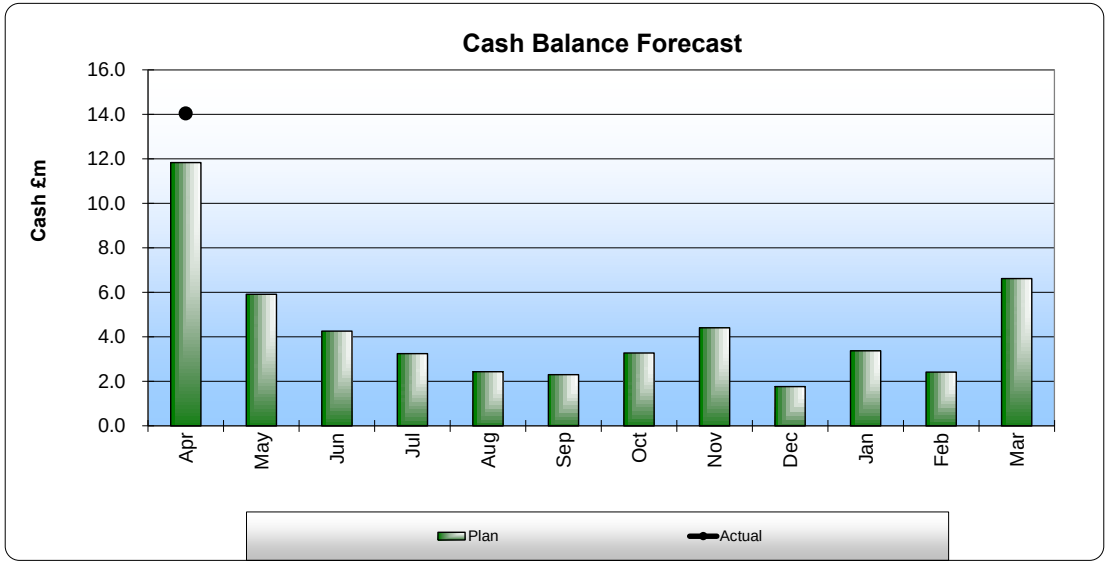
Cash Flow Management

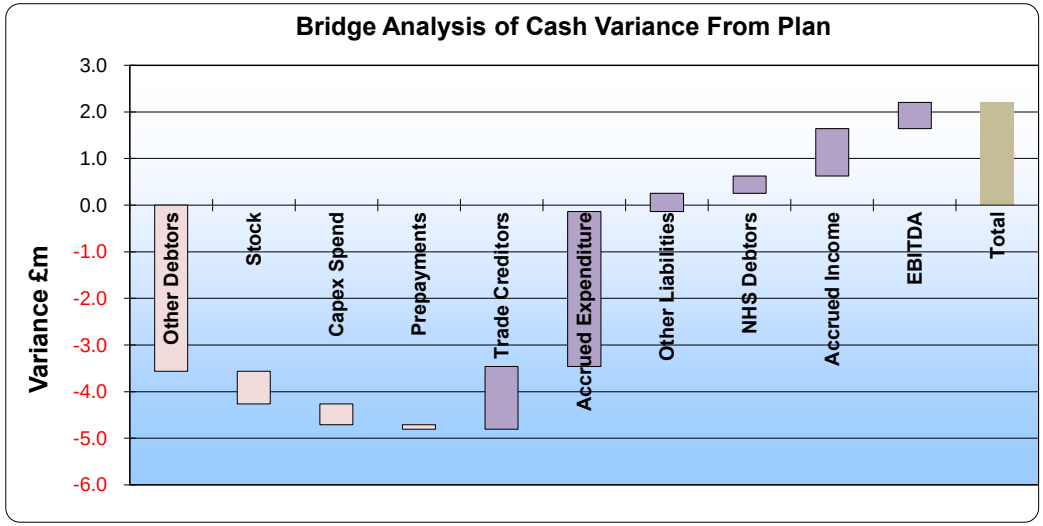
Month 1 - The Period 1st April 2018 to 30th April 2018

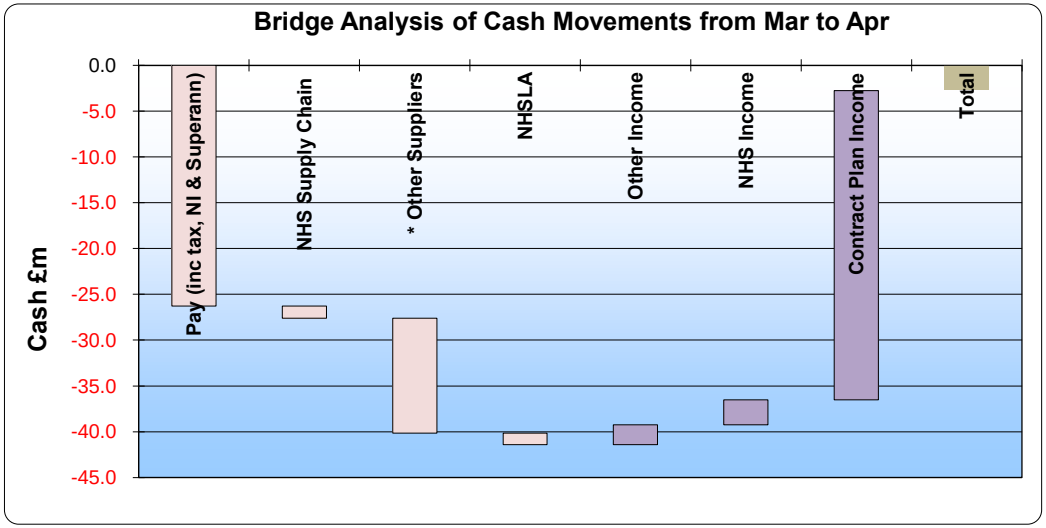
York Teaching Hospital NHS Foundation Trust

Key Messages:

* The cash position at the end of April was £14m, which is £2.2m ahead of plan.
* This is mainly due to management of creditor payments and accruals.
* The Trust positive variance to plan has also marginally contributed to the cash position.







*** Categorisation of expenditure was not available at the time of reporting**

Cash Flow Management
Month 1 - The Period 1st April 2018 to 30th April 2018

York Teaching Hospital NHS Foundation Trust

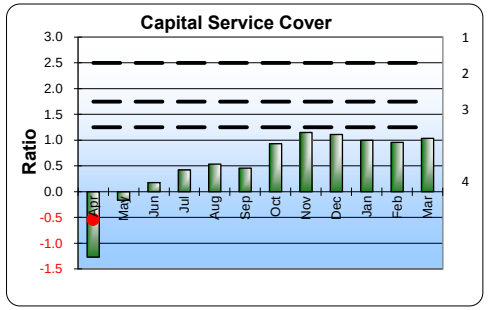
Key Messages:

* The receivables balance at the end of April was £12.5m, which is on plan.
* The payables balance at the end of April was £17.8m, which is above plan. This is due to increased invoice processing in the last 4 weeks.
* The Use of Resources Rating is assessed as a score of 3 in April, and is reflective of the I&E position.

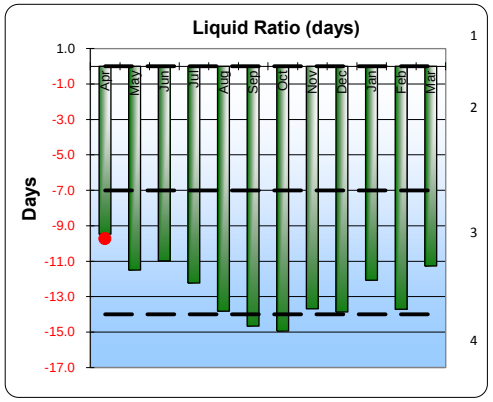
Significant Aged Debtors (+6mths)

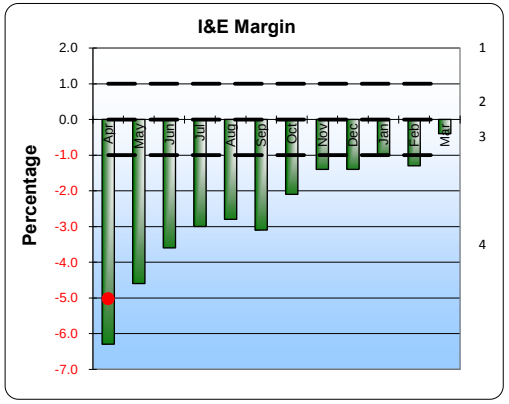
Hull & East Yorkshire NHS Trust	**£275K**
NHS Property Services	**£228K**
Depuy Ireland	**£133K**

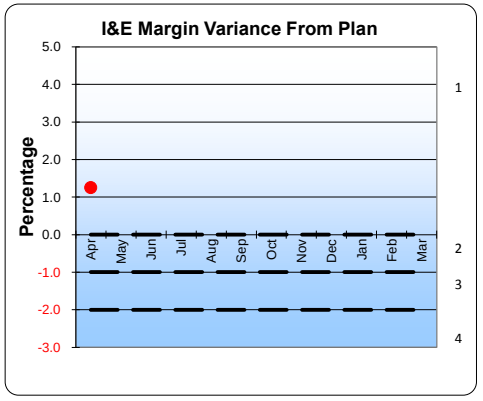
	Current	1-30 days	31-60 days	Over 60 days	Total
	£m	£m	£m	£m	£m
Payables	10.85	2.08	1.28	3.59	17.80
Receivables	2.57	5.87	1.23	2.85	12.52

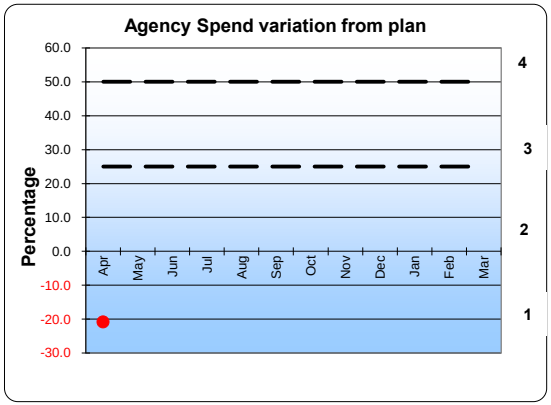


	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (20%)	3	3	3	3
Capital Service Cover (20%)	4	4	4	4
I&E Margin (20%)	3	4	4	3
I&E Margin Variance From Plan (20%)	1	1	1	1
Agency variation from Plan (20%)	1	1	1	1
Overall Use of Resources Rating	**3**	**3**	**3**	**3**









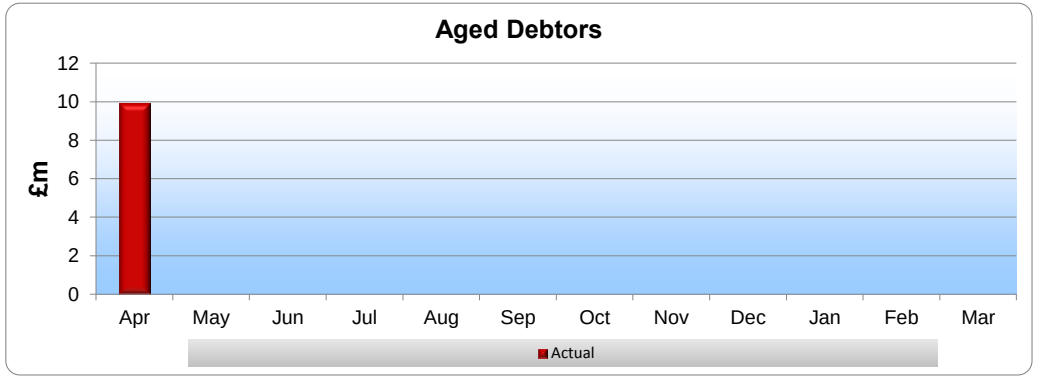
Debtor Analysis

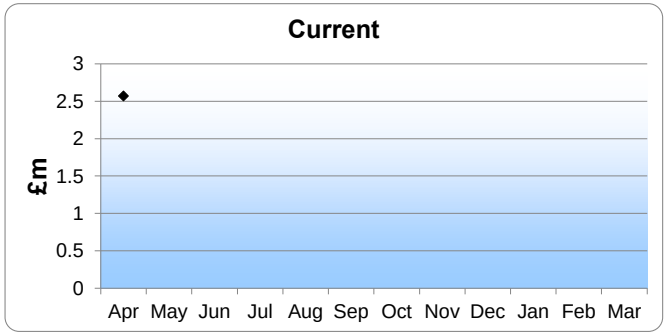
Month 1 - The Period 1st April 2018 to 30th April 2018

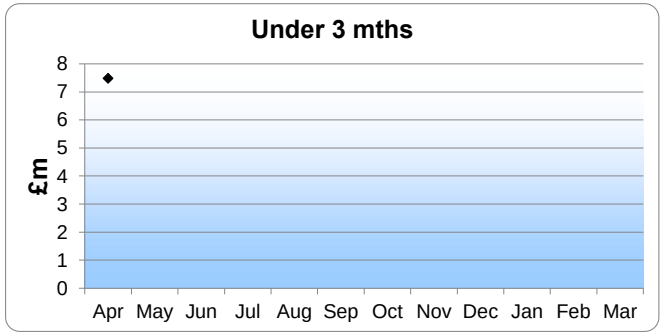
York Teaching Hospital NHS Foundation Trust

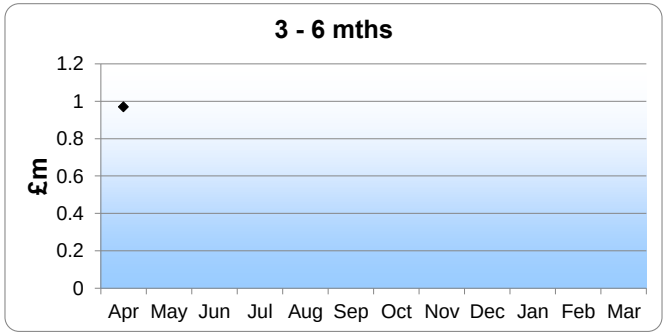
Key Messages:

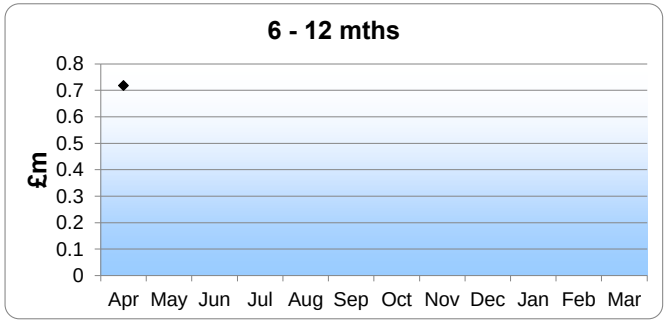
* At the end of April, the total debtor balance was on plan and totalled £12.5m. £2.6m of this relates to 'current' invoices not due.
* Aged debt totalled £10m, this is higher than previous months but is influenced by large commissioner invoices which are expected to be resolved in May.
* Debtors over 6 months old remain at consistently low levels with debt collection a constant focus for the Trust.
* Accrued income is on plan.

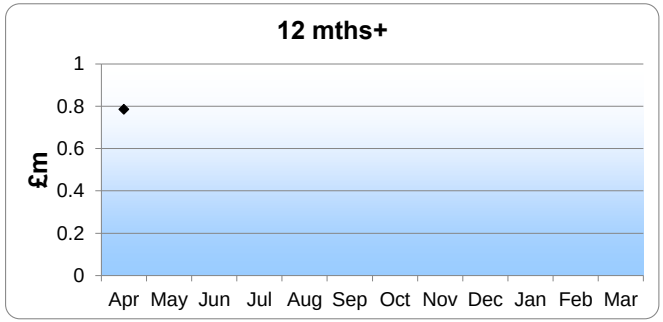


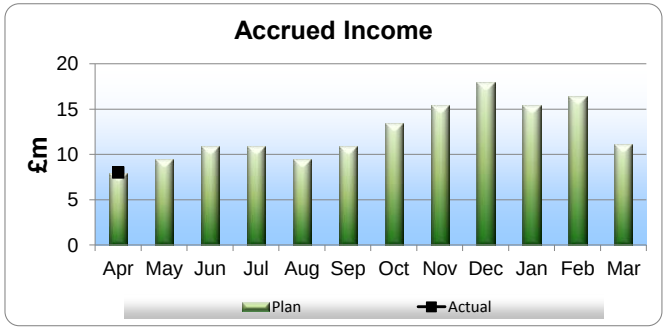












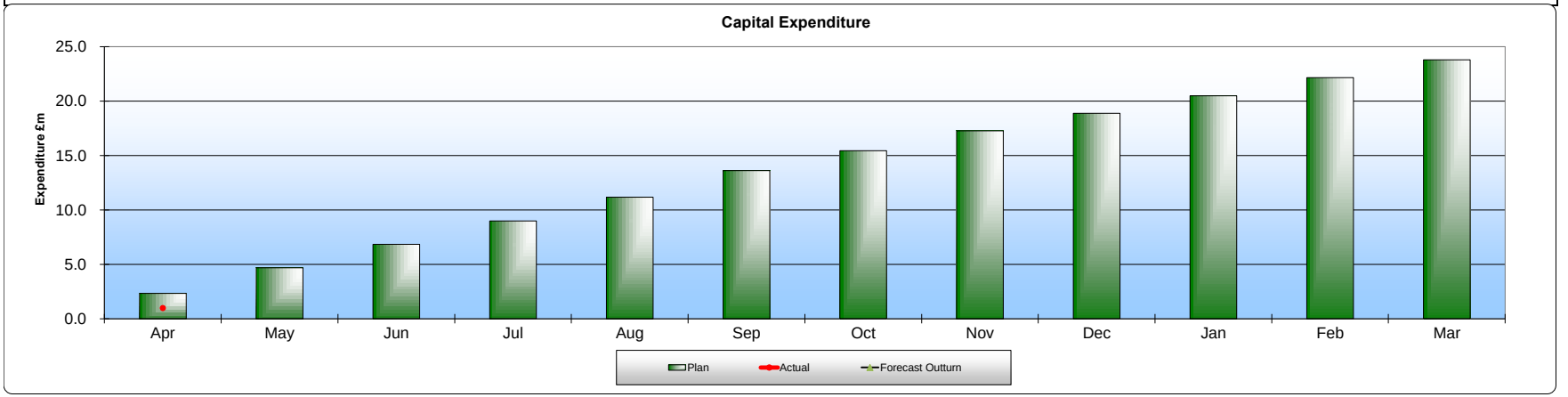
Capital Programme

Month 1 - The Period 1st April 2018 to 30th April 2018

York Teaching Hospital NHS Foundation Trust

Key Messages:

* The Capital plan for 2018-19 is £23.803m
* This is mainly funded by the loan supported schems for both the Endoscopy Extension and the VIU Development at York Hosital with a combined total of £11m
* Main schemes on the Scarborough site include the replacement of the Fire Alarm system, the lifts in Radiology and the MRI and Xray rooms
* The main schemes on the York site are the Fire alarm replacment, the Cardiac/VIU lab replacements and the completion of the MRI replacement.
* This is alongside the Trustwide backlog maintenance plan and the systems and network plan with a combined total of £3.465m



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
SGH /York MRI Replacement	1,999	528	1,999	0	
SGH X ray Rooms	660	0	660	0	
York VIU/Cardiac Equipment	1,379	1	1,379	0	
Radiology Lift Replacement SGH	860	126	860	0	
Fire Alarm System SGH	1,529	0	1,529	0	
Other Capital Schemes	650	98	650	0	
SGH Estates Backlog Maintenance	1,000	7	1,000	0	
York Estates Backlog Maintenance - York	1,265	37	1,265	0	
Cardiac/VIU Extention	3,000	0	3,000	0	
Medical Equipment	450	9	450	0	
IT Capital Programme	1,200	47	1,200	0	
Capital Programme Management	1,455	78	1,455	0	
Endoscopy Development	8,000	0	8,000	0	
Charitable funded schemes	623	0	623	0	
Fire Alarm System York	1,120	0	1,120	0	
Slippage to be managed in year	-1,387	0	-1,387	0	
Estimated In year work in progress	0	0	0	0	
TOTAL CAPITAL PROGRAMME	**23,803**	**931**	**23,803**	**0**	

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£000	£000	£000	£000	
Depreciation	5,538	276	5,538	0	
Loan Funding b/fwd	2,401	529	2,401	0	
Loan Funding	11,000	0	11,000	0	
Charitable Funding	623	0	623	0	
Strategic Capital Funding	4,026	126	4,026	0	
Sale of Assets	215	0	215	0	
TOTAL FUNDING	**23,803**	**931**	**23,803**	**0**	

Efficiency Programme

Month 1 - The Period 1st April 2018 to 30th April 2018

York Teaching Hospital NHS Foundation Trust

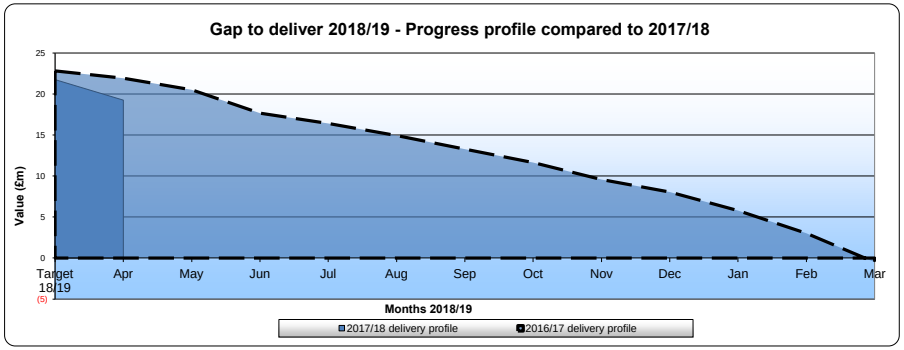
Key Messages:

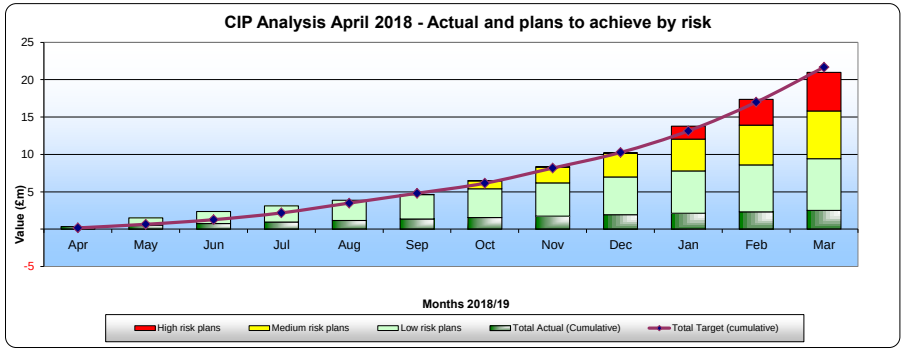
* Delivery - £2.51m has been delivered against the Trust annual target of £21.66m, giving a shortfall of (£19.16m).
* Part year NHSI variance - The part year NHSI variance is £0.17m.
* In year planning - The 2018/19 planning shortfall is currently (£0.69m).
* Four year planning - The four year planning surplus is £0.42m.
* Recurrent delivery - Recurrent delivery is £2.20m in-year, which is 10% of the 2018/19 CIP target.

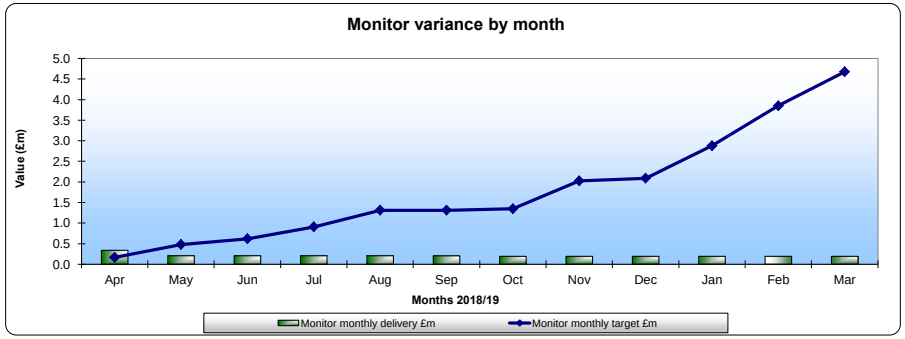
Executive Summary - April 2018	
	Total £m
TARGET	
In year target	21.66
DELIVERY	
In year delivery	2.51
In year delivery (shortfall)/Surplus	-19.16
Part year delivery (shortfall)/surplus - NHSI variance	0.17
PLANNING	
In year planning surplus/(gap)	-0.69
FINANCIAL RISK SCORE	
Overall trust financial risk score	HIGH

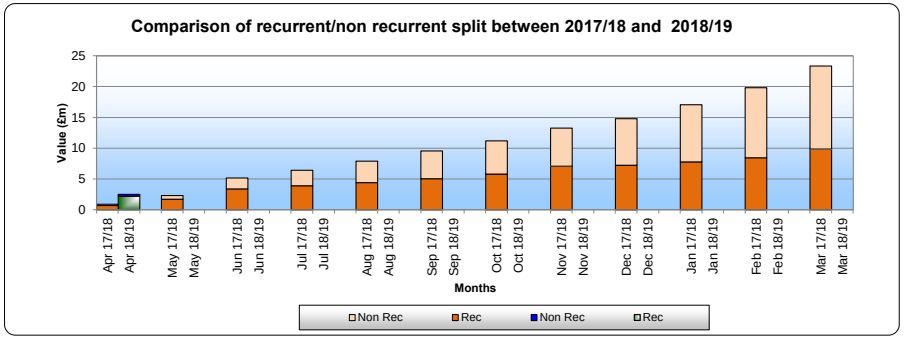
4 Year Efficiency Plan - April 2018					
Year	2018/19	2019/20	2020/21	2021/22	**Total**
	£m	£m	£m	£m	**£m**
Base Target	21.66	9.60	9.60	9.60	**50.45**
Plans	20.97	13.53	8.58	7.79	**50.87**
Variance	-0.69	3.93	-1.01	-1.81	**0.42**
%	**97%**	**141%**	**89%**	**81%**	**101%**

Risk Ratings			
Financial			
Risk	April		Trend
High	17		
Medium	7		
Low	3		
Governance			
Risk	April		Trend
High	1		
Medium	8		
Low	18		









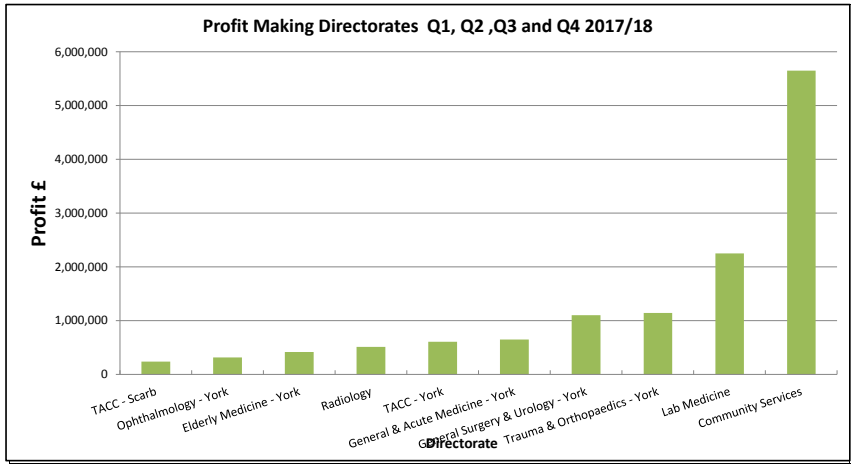
Service Line Reporting

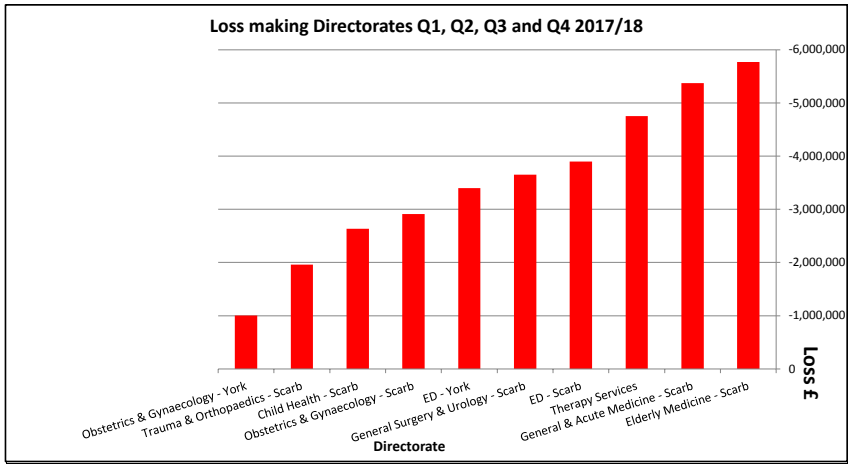
Month 1 - The Period 1st April 2018 to 30th April 2018

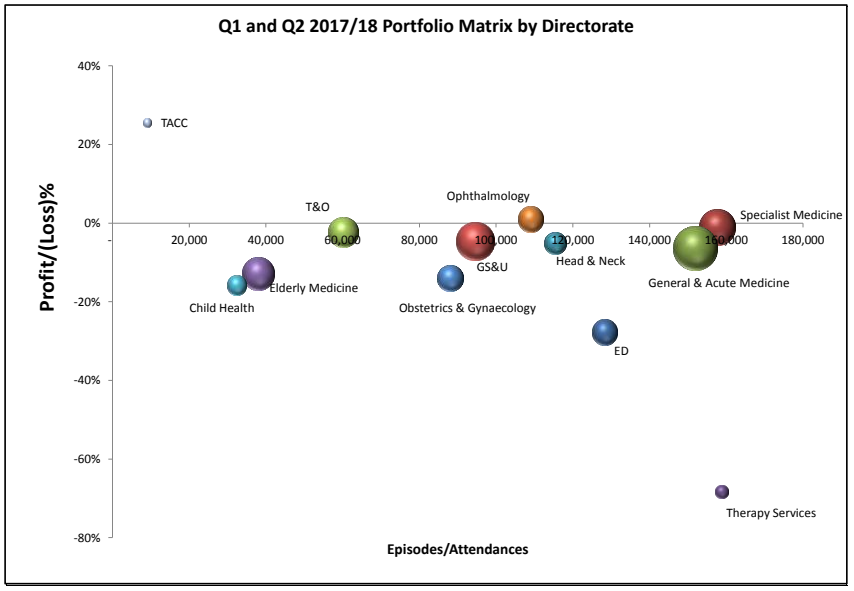
York Teaching Hospital NHS Foundation Trust

Key Messages:

* Current data is based on Q1, Q2, Q3 and Q4 2017/18
* The annual mandatory Reference Cost submission is now the key focus for the team
* The SLR Leadership Programme was launched on 25th September 2017 will continue to run until late May 2018







DATA PERIOD	Q1, Q2 and Q3 2017/18
CURRENT WORK	* Reference Costs are now the key focus for the team * The SLR Leadership Programme was launched on 25th September 2017. The is a programme of work to enable the Finance Managers to become confident users of the SLR system and data, and also to provide a structured process for investigating loss making activity and areas for improvement *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
FUTURE WORK	* The SLR Leadership Programme will continue until the end of May 2018 * Q1 2018/19 SLR reports and the NHSI Costing Transformation Programme requirements will become the focus once Reference Costs has been submitted * 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	**£3.68m**

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Efficiency Programme Update

Recommendation

For information	☒
For discussion	☒
For assurance	☐
For approval	☐
A regulatory requirement	☐

Current approval route of report

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

Purpose of report

The Board is asked to note the April 2018 position.

Key points for discussion

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2018/19 target is £21.7m and delivery, as at April 2018 is £2.51m.

Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

Reference to CQC Regulations

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

Version number: 1

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

Executive sponsor: Andrew Bertram, Finance Director

Date: May 2018

Briefing note for the Finance & Performance Committee meeting 22 May 2018 and Board of Directors meeting 30 May 2018

1. Summary reported position for April 2018

1.1 Current position – highlights

Delivery - Delivery is £2.5m in April 2018 which is (11%) of the £21.7m annual target. This position compares to a delivery position of £0.9m in April 2017.

Four year planning – The four year planning shows a surplus of £0.69m. The position in April 2017 was a gap of (£16.6m).

Recurrent vs. Non recurrent – Of the £2.5m delivery, £2.20m (88%) in-year has been delivered recurrently. Recurrent delivery is £1.5m ahead of the same position in April 2017.

Quality Impact Assessments (QIA) –

A review of the QIA process is underway to address the recommendations of the NHSI Investigation and review work to ensure that the process continues to be fit for purpose and provides assurance to our Board and regulators. The completion date will be June 2018.

1.2 Overview

Delivery in April exceeds prior year's delivery for the same period. Of the £2.5m delivered, £1.4m relates to the full year effect of schemes carried forward to 18/19; the balance of £1.1m relates to April delivery.

Appendix 2 attached provides a summary of delivery by Directorate.

A review of the Efficiency Programme has been undertaken and the attached paper (Efficiency Programme Review and Update May 2018 V1) summarises these changes. The purpose of the document is to provide a framework for the delivery of the Trust's Efficiency Programme and address the recommendations of the NHSI Investigation and review work to ensure that the programme continues to be fit for purpose and provides assurance to our Board and regulators.

2.0 Risk

Recurrent delivery and planning remain the key risks to the programme.

Risk	Proposed Actions to address Risks
Recurrent Delivery	• Executive Leads to be identified for transformational workstreams. • Incentivise recurrent delivery. • Review of non-activity related underspends over last 3 years to be taken recurrently. • Performance Management of Delivery is picked up through formal performance meetings. • Efficiency Panels continue and are chaired by the Chief Executive and/or Director of Finance.
Planning	• Joint working with the Operational Team and Corporate Improvement Team to identify plans and efficiencies through the various transformational work streams of: Emergency Care, Planned Care, Integrated Care and Other. • NHSI Work Programme – to firm up plans with the potential for new plans to be developed. • Align Efficiency Plans with QIPP – work has started with our two main commissioners to identify shared savings and system improvements. This will avoid duplication of efficiencies and produce robust plans. • Model Hospital – this will help us to identify opportunities and will be used as a signpost to our internal Service Line Reporting (SLR) model. • Resource Management meetings with Directorate teams will continue to evolve and will encompass a multi-disciplinary approach where appropriate.

APPENDIX 1

YTD Directorate CIP Progress - April 2018

DIRECTORATE	Annual Target	YTD Budget	April Achieved	YTD Achieved	YTD Variance	% YTD Target Achieved
	(£000)	(£000)	(£000)	(£000)	(£000)	%
TACC	2,559	20	14	14	-6	70%
GS&U	2,122	16	33	33	17	202%
SPECIALIST MEDICINE	1,995	15	4	4	-12	23%
RADIOLOGY	1,681	13	5	5	-8	40%
GEN MED YORK	1,406	11	8	8	-2	78%
AHP & PSYCHOLOGICAL MEDICINE	1,404	11	4	4	-7	36%
WOMENS HEALTH	1,164	9	5	5	-4	53%
OPHTHALMOLOGY	1,096	8	3	3	-5	39%
EMERGENCY MEDICINE	1,095	8	3	3	-5	41%
CHILD HEALTH	877	7	1	1	-6	17%
MEDICINE FOR THE ELDERLY	869	7	23	23	17	349%
GEN MED SCARBOROUGH	704	5	2	2	-4	30%
HEAD AND NECK	704	5	2	2	-3	45%
ORTHOPAEDICS	704	5	51	51	46	956%
LAB MED	509	4	9	9	5	236%
PHARMACY	407	3	3	3	-0	94%
COMMUNITY	257	2	1	1	-1	41%
SEXUAL HEALTH	198	2	17	17	16	1134%
CORPORATE						
ESTATES AND FACILITIES	2,751	21	15	15	-6	73%
CHIEF NURSE TEAM DIRECTORATE	435	3	4	4	1	134%
SNS	400	3	1	1	-2	29%
HR	268	2	25	25	23	1243%
OPS MANAGEMENT YORK	243	2	4	4	2	205%
FINANCE	207	2	49	49	47	3072%
CHAIRMAN & CHIEF EXECUTIVES OFF	200	2	24	24	22	1551%
LOD&R	79	1	6	6	5	915%
MEDICAL GOVERNANCE	49	0	0	0	-0	49%
TRUST TOTAL	**24,384**	**186**	**317**	**317**	**131**	**170%**

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Public Performance Report

May 2018

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

Performance Report
Chapter Index

Chapter	Sub-Section
Performance	Trust Performance Index
	STF Trajectory
	Performance Benchmarking
	Trust Unplanned Care - Emergency Care Standard
	Trust Unplanned Care - Adult Admissions
	Trust Length of Stay & Delayed Transfers of Care
	Trust Paediatric Admissions
	Trust Planned Care Outpatients
	Trust Planned Care - Elective Activity & Theatre Utilisation
	Diagnostics & 18 Weeks RTT Incomplete
	Cancer

Activity Summary: Trust

Operational Performance: Unplanned Care	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Emergency Care Attendances			16834	16330	17438	17134	15979	16570	15158	16236	14712	13719	15845	16374
Emergency Care Breaches			2018	1328	2268	2033	2697	2222	1263	2766	2728	2499	2983	2439
Emergency Care Standard Performance	95%	95%	88.0%	91.9%	87.0%	88.1%	83.1%	86.6%	91.7%	83.0%	81.5%	81.8%	81.2%	85.1%
ED Conversion Rate: Proportion of ED attendances subsequently admitted			37.0%	36.8%	35.9%	36.5%	37.7%	37.7%	39.0%	40.8%	40.9%	40.0%	39.0%	38.6%
ED Total number of patients waiting over 8 hours in the departments			378	158	323	274	528	371	152	791	833	668	872	607
ED 12 hour trolley waits	0	0	3	0	2	1	1	2	0	5	14	15	40	13
ED: % of attendees assessed within 15 minutes of arrival			72.8%	72.9%	70.7%	68.8%	67.9%	66.7%	69.3%	57.1%	63.1%	61.2%	57.2%	63.9%
ED: % of attendees seen by doctor within 60 minutes of arrival			40.1%	43.3%	36.6%	43.6%	34.7%	35.5%	42.1%	40.5%	44.7%	42.7%	40.2%	41.1%
Ambulance handovers waiting 15-29 minutes	0	0	272	335	360	446	469	745	649	823	702	679	784	671
Ambulance handovers waiting 30-59 minutes	0	0	164	150	215	258	331	368	172	537	424	360	471	313
Ambulance handovers waiting >60 minutes	0	0	92	75	96	106	207	257	55	548	390	367	419	297
Non Elective Admissions (excl Paediatrics & Maternity)			4378	4476	4421	4411	4251	4411	4304	4575	4515	4092	4525	4447
Non Elective Admissions - Paediatrics			664	607	616	495	673	790	800	934	736	654	844	706
Delayed Transfers of Care - Acute Hospitals			908	902	806	1238	965	932	958	865	660	885	1010	1134
Delayed Transfers of Care - Community Hospitals			313	298	352	234	445	312	439	506	483	357	266	464
Patients with LoS >= 7 Midnights (Elective & Non-Elective)			1109	1013	1063	1015	1048	1057	1045	1130	1153	1034	1108	1004
Ward Transfers - Non clinical transfers after 10pm	300 per Qtr	100	90	60	110	70	84	67	57	113	99	106	94	106
Emergency readmissions within 30 days			800	815	772	745	712	738	796	876	768	756	2 months behind	2 months behind

Operational Performance: Planned Care	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Outpatients: All Referral Types			17604	18568	17686	16977	16599	18088	17966	14977	17804	15711	17026	16772
Outpatients: GP Referrals			9208	10097	9386	9134	9044	9751	9758	7794	9672	8637	9452	9191
Outpatients: Consultant to Consultant Referrals			2209	2283	2286	2240	2007	2314	2215	1894	2143	1936	1968	1971
Outpatients: Other Referrals			6187	6188	6014	5603	5548	6023	5993	5289	5989	5138	5606	5610
Outpatients: 1st Attendances			12318	12517	11979	11741	11721	12797	12665	10091	12309	10091	12666	11171
Outpatients: Follow Up Attendances			27794	27820	26708	26558	26826	28311	29312	24019	29717	24019	29845	25553
Outpatients: 1st to FU Ratio			2.26	2.22	2.23	2.26	2.29	2.21	2.31	2.38	2.41	2.38	2.36	2.29
Outpatients: DNA rates			7.1%	7.2%	7.0%	6.7%	6.6%	6.1%	6.1%	6.1%	6.3%	6.2%	6.3%	5.7%
Outpatients: Cancelled Clinics with less than 14 days notice	180	180	163	147	129	121	188	176	167	133	210	213	194	168
Outpatients:Hospital Cancelled Outpatient Appointments for non-clinical reasons			891	942	834	823	817	862	780	702	949	757	844	886
Diagnostics: Patients waiting <6 weeks from referral to test	99%	99%	98.1%	98.8%	98.9%	99.1%	98.9%	98.3%	98.5%	97.5%	98.1%	97.9%	97.0%	96.1%
Elective Admissions			749	758	715	721	683	790	790	597	568	604	531	637
Day Case Admissions			6216	6364	5896	6047	5846	6254	6151	5179	6069	5538	5827	5532
Cancelled Operations within 48 hours - Bed shortages			57	10	23	12	38	27	2	74	118	129	168	62
Cancelled Operations within 48 hours - Non clinical reasons			154	57	64	57	84	91	65	169	191	189	205	115
Theatres: Utilisation of planned sessions			86.9%	89.3%	88.4%	89.6%	89.2%	88.4%	92.5%	86.4%	82.7%	84.8%	84.0%	88.9%
Theatres: number of sessions held			621	633	629	590	619	704	718	542	599	543	520	565
Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)			84	71	72	56	77	57	54	76	74	50	105	76

Activity Summary: Trust

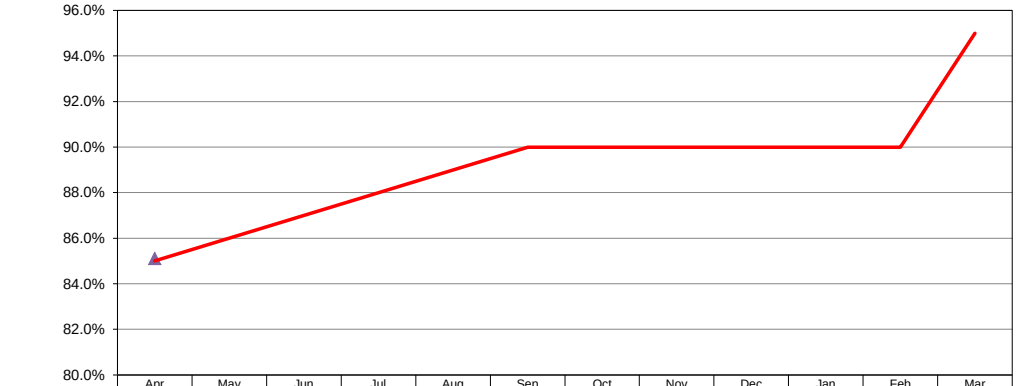
18 Weeks Referral To Treatment	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Incomplete Pathways	92%	92%	89.6%	89.1%	88.2%	87.5%	86.9%	87.4%	87.2%	85.8%	85.3%	84.8%	83.3%	83.8%
Waits over 52 weeks for incomplete pathways	0	0	1	0	1	1	0	1	0	0	0	1	2	1
Waits over 36 weeks for incomplete pathways	0	0	165	156	152	197	197	199	202	238	260	297	356	409
Total Admitted and Non Admitted waiters	< 26303	< 26303	25746	26202	26499	26148	25526	25174	24894	25006	25185	25334	26303	26967
Number of patients on Admitted Backlog (18+ weeks)	-	-	1376	1331	1418	1353	1457	1465	1448	1623	1818	1928	2223	2303
Number of patients on Non Admitted Backlog (18+ weeks)	-	-	1302	1520	1720	1976	1884	1699	1761	1816	1880	1921	2179	2070

Cancer (one month behind due to national reporting timetable)	Target/ Threshold 2018/19	Quarterly target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Cancer 2 week (all cancers)	93%	93%	86.2%	87.0%	80.7%	83.4%	84.8%	86.8%	93.4%	92.5%	94.4%	94.7%	93.6%	1 month behind
Cancer 2 week (breast symptoms)	93%	93%	95.0%	95.1%	97.1%	98.2%	98.6%	97.0%	94.5%	94.0%	94.6%	99.1%	98.9%	1 month behind
Cancer 31 day wait from diagnosis to first treatment	96%	96%	96.6%	98.4%	98.3%	97.7%	97.9%	96.8%	98.7%	99.6%	99.2%	98.6%	98.7%	1 month behind
Cancer 31 day wait for second or subsequent treatment - surgery	94%	94%	94.1%	97.2%	95.2%	97.1%	95.7%	82.5%	97.4%	96.9%	93.9%	100.0%	97.1%	1 month behind
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	98%	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
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	85%	76.8%	80.6%	82.4%	83.2%	76.4%	73.9%	86.3%	87.2%	85.0%	81.0%	85.9%	1 month behind
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	90%	93.5%	96.4%	86.8%	98.5%	93.1%	90.9%	90.6%	89.5%	95.5%	95.1%	93.6%	1 month behind

Sustainability and Transformation Fund Trajectory (STF) and Performance Recovery Trajectories

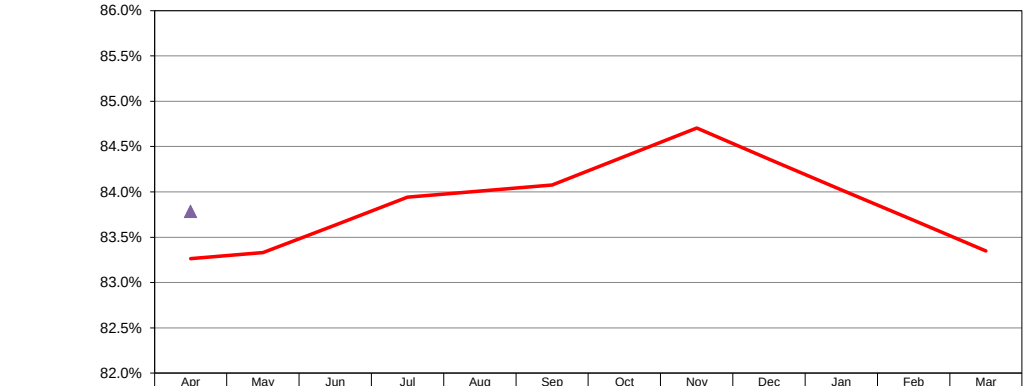
May 2018

Emergency Care Standard Improvement Trajectory



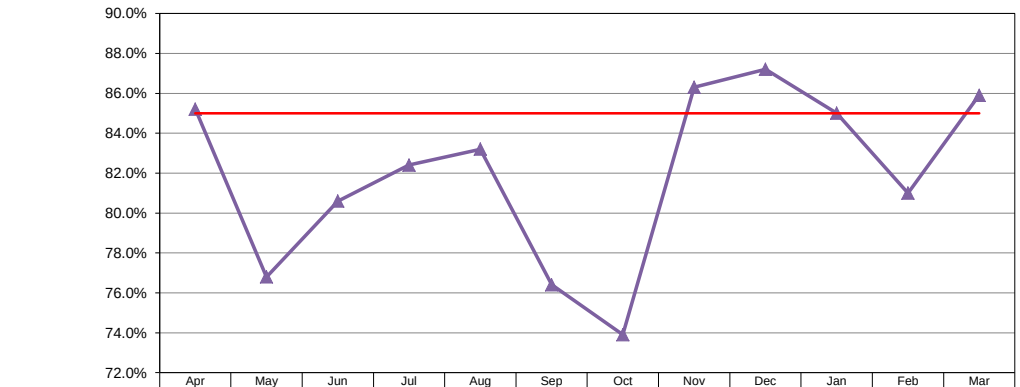
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance	85.1%											
STF Trajectory	85.0%	86.0%	87.0%	88.0%	89.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	95.0%

Referral To Treatment Incomplete Pathways



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Incomplete Pathways	83.8%											
Trajectory	83.3%	83.3%	83.6%	83.9%	84.0%	84.1%	84.4%	84.7%	84.4%	84.0%	83.7%	83.4%

Cancer 62 Day Waits For First Treatment (From Urgent GP Referral)

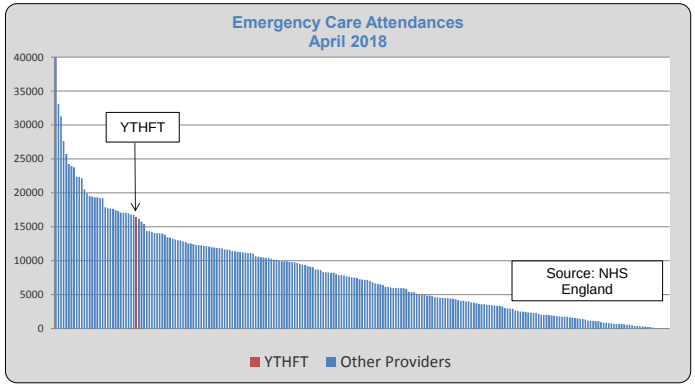


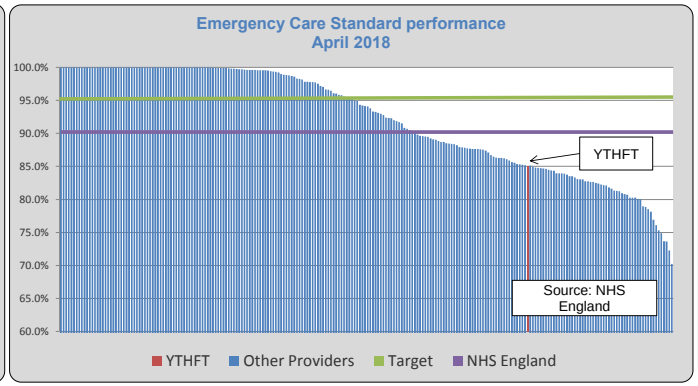
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cancer 62 Day Waits	85.2%	76.8%	80.6%	82.4%	83.2%	76.4%	73.9%	86.3%	87.2%	85.0%	81.0%	85.9%
Trajectory	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

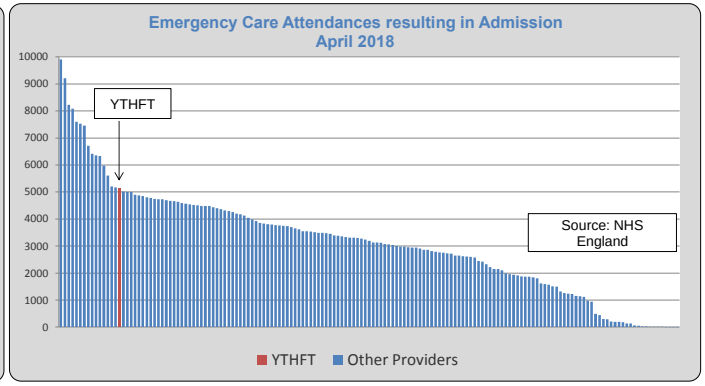
Performance Benchmarking

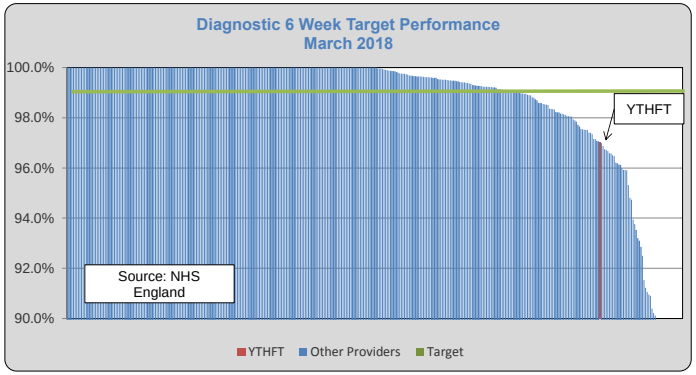
April 2018

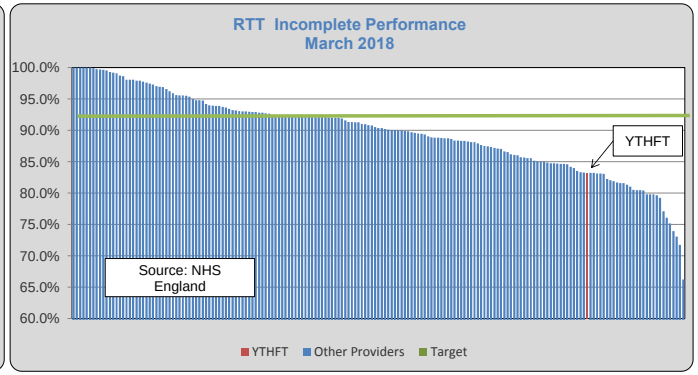
All graphs are benchmarked against latest available national data

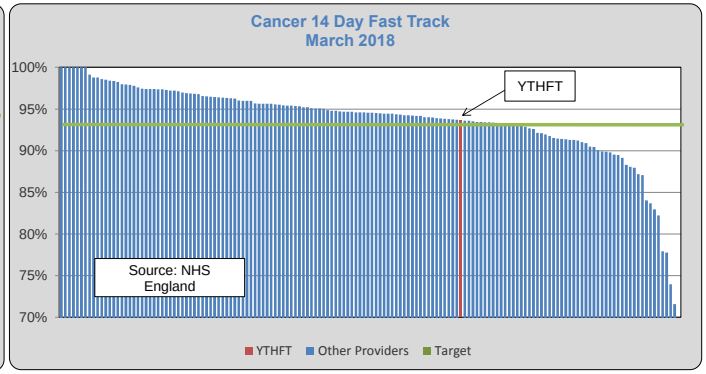


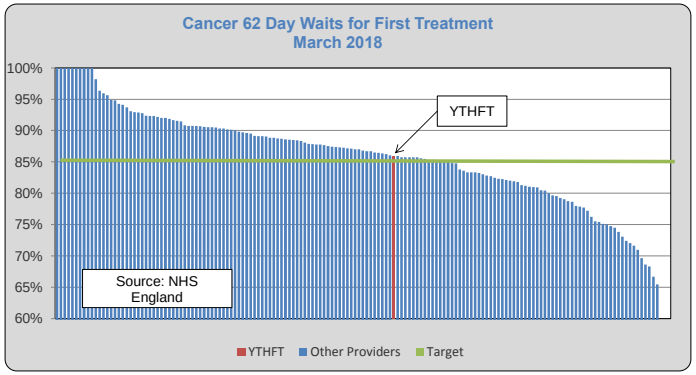








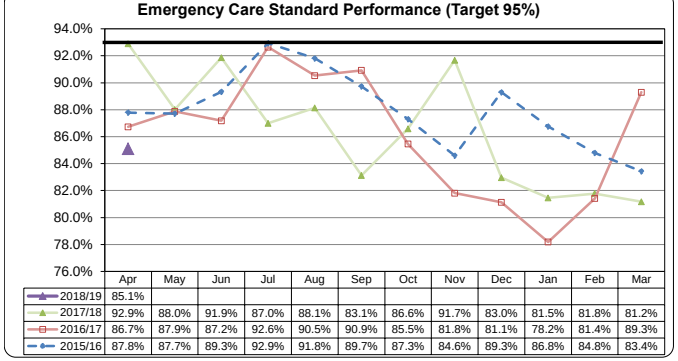




Trust Unplanned Care
Emergency Care Standard

May 2018

Emergency Care Standard Performance (Target 95%)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	85.1%											
2017/18	92.9%	88.0%	91.9%	87.0%	88.1%	83.1%	86.6%	91.7%	83.0%	81.5%	81.8%	81.2%
2016/17	86.7%	87.9%	87.2%	92.6%	90.5%	90.9%	85.5%	81.8%	81.1%	78.2%	81.4%	89.3%
2015/16	87.8%	87.7%	89.3%	92.9%	91.8%	89.7%	87.3%	84.6%	89.3%	86.8%	84.8%	83.4%

Total Emergency Care Attendances (ED, UCC & MIU)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	16374											
2017/18	16099	16834	16330	17438	17134	15979	16570	15158	16236	14712	13719	15845
2016/17	15129	16979	16091	17709	17385	16371	16491	14904	15414	14524	13560	15695
2015/16	16497	16773	16477	17420	17728	16307	16892	15654	15567	15662	15527	16781

Type 1 Emergency Care Attendances

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	9253											
2017/18	8903	9531	9358	9804	9367	9112	9519	9042	9667	8731	8211	9291
2016/17	9101	10133	9700	9561	9180	9121	9370	8771	9147	8546	7930	9036
2015/16	10808	11107	10765	11214	11539	10442	10073	9502	9424	9471	9506	10116

Ambulance Handovers

ED: % of attendees assessed within 15 minutes of arrival

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	63.9%											
2017/18	79.7%	72.8%	72.9%	70.7%	68.8%	67.9%	66.7%	69.3%	57.1%	63.1%	61.2%	57.2%
2016/17	40.1%	40.4%	43.5%	45.3%	66.3%	67.5%	65.7%	62.3%	60.7%	57.8%	61.3%	73.6%
2015/16	59.3%	55.6%	55.6%	58.0%	56.5%	57.0%	51.1%	49.5%	49.4%	42.1%	36.5%	36.4%

ED: % of attendees seen by doctor within 60 minutes of arrival

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	41.1%											
2017/18	51.8%	40.1%	43.3%	36.6%	43.6%	34.7%	35.5%	42.1%	40.5%	44.7%	42.7%	40.2%
2016/17	39.5%	34.5%	36.4%	45.0%	48.1%	41.2%	36.0%	36.7%	36.0%	37.5%	41.9%	48.2%
2015/16	37.1%	38.4%	36.7%	44.8%	42.6%	42.5%	37.5%	33.3%	46.3%	40.5%	34.3%	33.5%

ED Time in Department (Number of Patients)

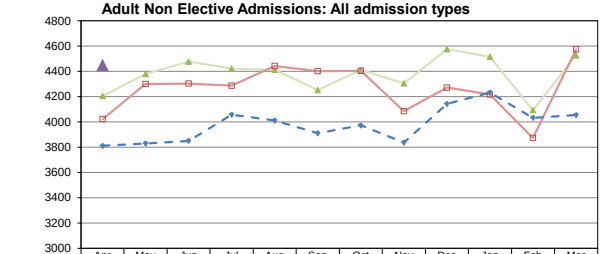
ED Admissions

ED Conversion Rate; Proportion of ED attendances subsequently admitted

Trust Unplanned Care
Adult Admissions

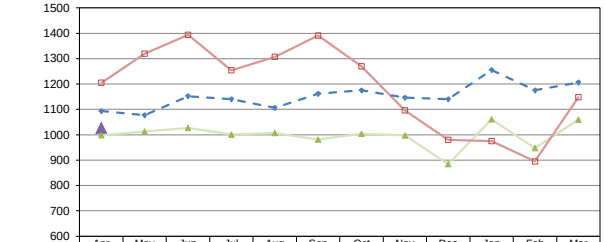
May 2018

Adult Non Elective Admissions: All admission types



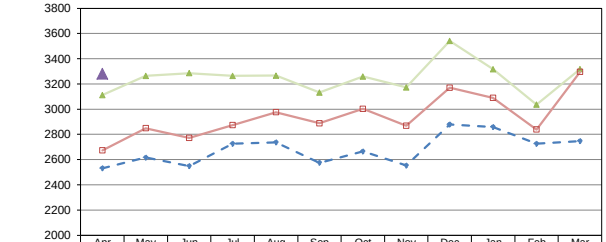
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	4447											
2017/18	4204	4378	4476	4421	4411	4251	4411	4304	4575	4515	4092	4525
2016/17	4022	4299	4303	4286	4442	4401	4403	4084	4271	4216	3872	4574
2015/16	3810	3829	3850	4057	4010	3910	3972	3836	4142	4232	4032	4054

Adult Non Elective Admissions: GP Admissions



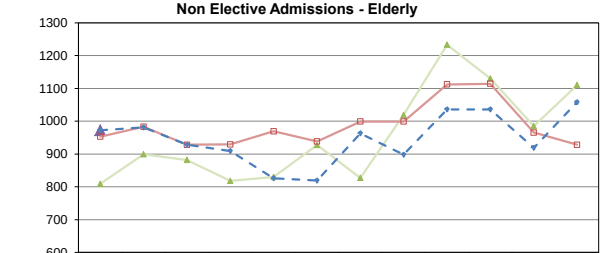
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1027											
2017/18	998	1013	1027	1001	1007	981	1004	997	884	1061	947	1060
2016/17	1205	1320	1394	1254	1307	1391	1270	1096	980	975	895	1148
2015/16	1093	1077	1152	1140	1106	1162	1175	1146	1140	1255	1175	1206

Adult Non Elective Admissions: ED Admissions



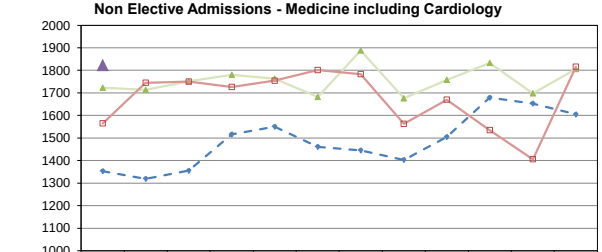
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	3281											
2017/18	3111	3264	3286	3264	3266	3132	3259	3172	3541	3317	3036	3318
2016/17	2674	2849	2772	2874	2976	2888	3003	2869	3170	3090	2839	3296
2015/16	2532	2616	2549	2726	2737	2575	2665	2553	2879	2859	2726	2747

Non Elective Admissions - Elderly



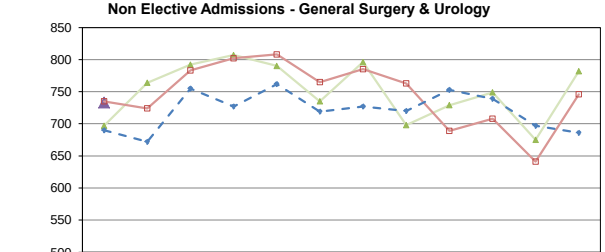
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	972											
2017/18	809	899	882	818	830	927	827	1019	1233	1130	985	1110
2016/17	953	983	928	929	969	938	999	999	1112	1114	965	928
2015/16	972	981	928	909	826	819	963	898	1036	1036	919	1058

Non Elective Admissions - Medicine including Cardiology



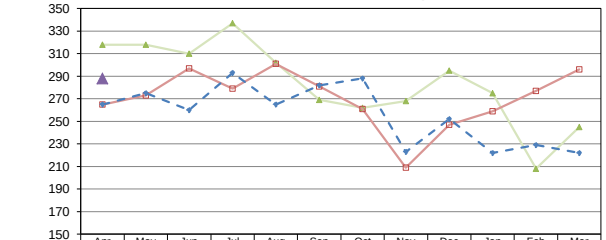
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1822											
2017/18	1723	1714	1751	1780	1763	1682	1888	1676	1758	1833	1698	1806
2016/17	1565	1745	1750	1726	1754	1801	1783	1563	1670	1535	1406	1816
2015/16	1353	1319	1355	1516	1550	1461	1445	1403	1505	1679	1653	1605

Non Elective Admissions - General Surgery & Urology



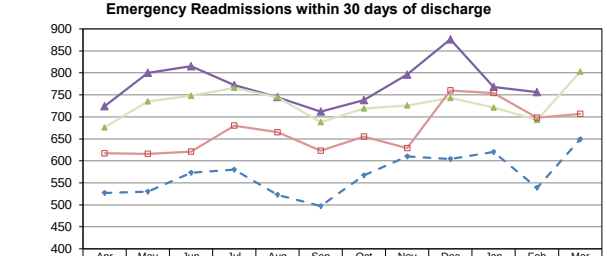
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	733											
2017/18	697	764	792	807	790	735	796	698	729	749	675	782
2016/17	735	724	783	802	808	765	785	763	689	708	641	746
2015/16	690	672	755	727	762	719	727	720	753	739	697	686

Non Elective Admissions - Trauma & Orthopaedics



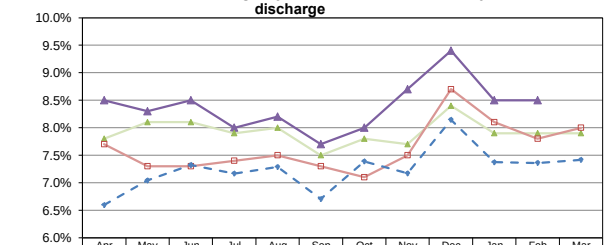
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	288											
2017/18	318	318	310	337	302	269	262	268	295	275	208	245
2016/17	265	273	297	279	301	281	261	209	247	259	277	296
2015/16	265	275	260	293	265	282	288	223	252	222	229	222

Emergency Readmissions within 30 days of discharge



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	724	800	815	772	745	712	738	796	876	768	756	
2016/17	676	735	748	766	745	688	719	726	743	721	693	803
2015/16	617	616	621	680	665	623	655	629	760	754	698	707
2014/15	527	530	573	580	523	497	567	610	604	620	539	649

Readmission Rate: Emergency Readmissions within 30 days of discharge

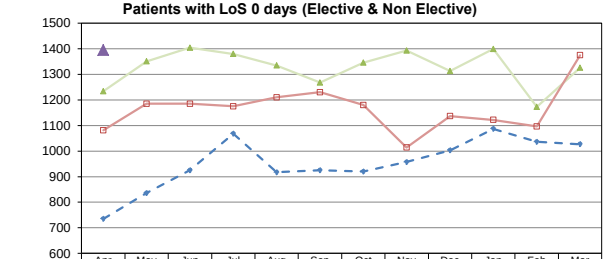


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	8.5%	8.3%	8.5%	8.0%	8.2%	7.7%	8.0%	8.7%	9.4%	8.5%	8.5%	
2016/17	7.8%	8.1%	8.1%	7.9%	8.0%	7.5%	7.8%	7.7%	8.4%	7.9%	7.9%	7.9%
2015/16	7.7%	7.3%	7.3%	7.4%	7.5%	7.3%	7.1%	7.5%	8.7%	8.1%	7.8%	8.0%
2014/15	6.6%	7.0%	7.3%	7.2%	7.3%	6.7%	7.4%	7.2%	8.1%	7.4%	7.4%	7.4%

Trust Length of Stay & Delayed Transfers of Care (DTOC)

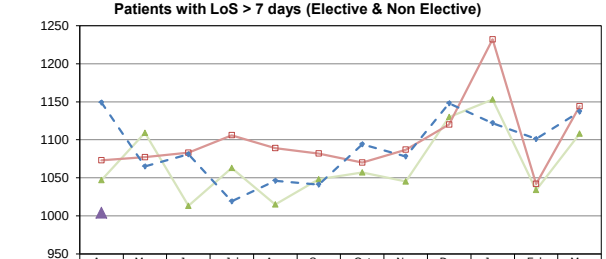
May 2018

Patients with LoS 0 days (Elective & Non Elective)



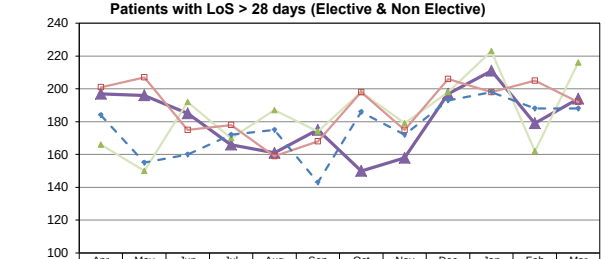
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1395											
2017/18	1234	1351	1404	1380	1335	1268	1346	1393	1313	1399	1173	1326
2016/17	1081	1185	1185	1175	1210	1230	1180	1014	1137	1122	1096	1375
2015/16	735	836	925	1068	917	925	920	957	1003	1087	1036	1027

Patients with LoS > 7 days (Elective & Non Elective)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1004											
2017/18	1047	1109	1013	1063	1015	1048	1057	1045	1130	1153	1034	1108
2016/17	1073	1077	1083	1106	1089	1082	1070	1087	1120	1232	1042	1144
2015/16	1149	1065	1081	1019	1046	1041	1094	1078	1148	1122	1101	1137

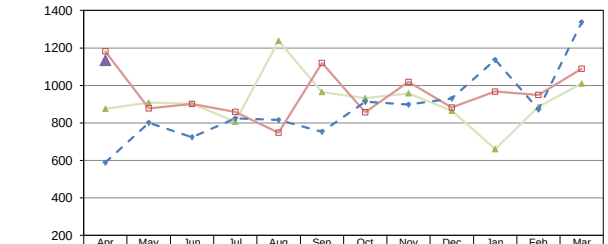
Patients with LoS > 28 days (Elective & Non Elective)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	197	196	185	166	161	175	150	158	197	211	179	194
2016/17	166	150	192	170	187	174	198	179	198	223	162	216
2015/16	201	207	175	178	159	168	198	175	206	198	205	192
2014/15	184	155	160	172	175	143	186	172	193	198	188	188

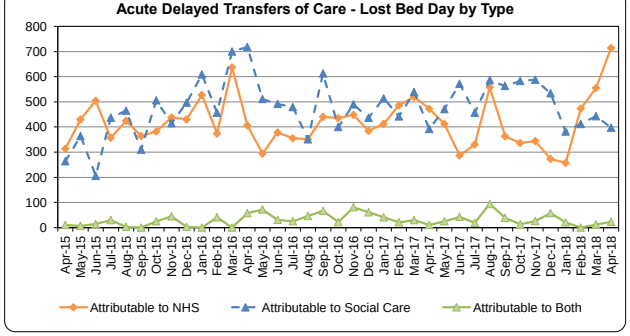
Updated one month in arrears

Acute Delayed Transfers of Care - Lost Bed Days

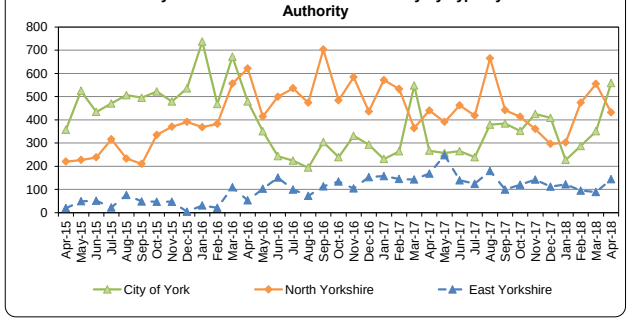


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1134											
2017/18	875	908	902	806	1238	965	932	958	865	660	885	1010
2016/17	1182	877	901	859	748	1120	857	1019	882	967	949	1089
2015/16	588	801	724	824	815	753	913	898	930	1136	872	1337

Acute Delayed Transfers of Care - Lost Bed Day by Type



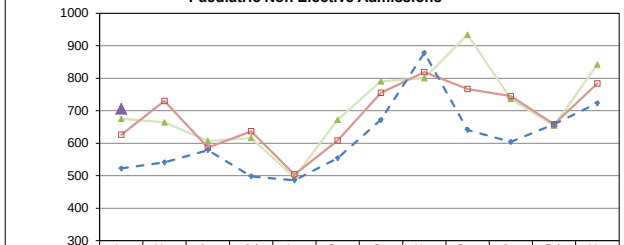
Acute Delayed Transfers of Care - Lost Bed Day by Type by Local Authority



Paediatric Admissions

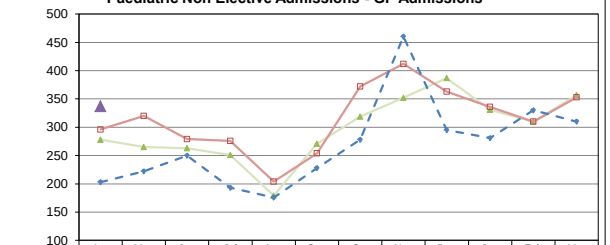
May 2018

Paediatric Non Elective Admissions



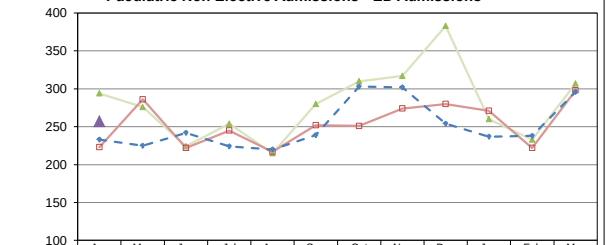
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	706											
2017/18	675	664	607	616	495	672	790	800	934	736	654	842
2016/17	626	730	586	637	504	608	755	819	767	745	658	784
2015/16	522	541	579	498	486	554	672	878	641	604	658	723

Paediatric Non Elective Admissions - GP Admissions



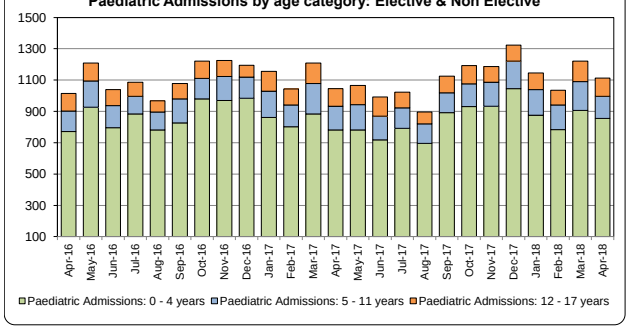
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	337											
2017/18	278	265	263	251	179	271	319	352	387	331	310	357
2016/17	296	320	279	276	204	254	372	412	363	336	310	353
2015/16	203	222	250	193	176	228	278	460	295	281	330	310

Paediatric Non Elective Admissions - ED Admissions

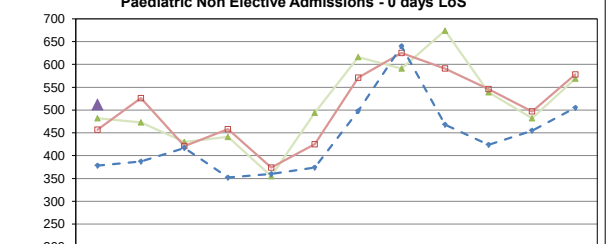


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	257											
2017/18	294	276	224	254	215	280	310	317	383	260	233	307
2016/17	223	286	222	245	217	252	251	274	280	271	222	298
2015/16	233	225	242	224	220	239	303	302	254	237	238	296

Paediatric Admissions by age category: Elective & Non Elective

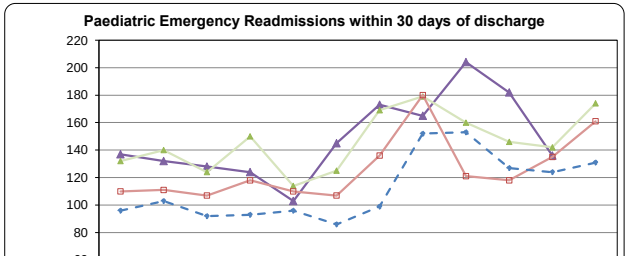


Paediatric Non Elective Admissions - 0 days LoS



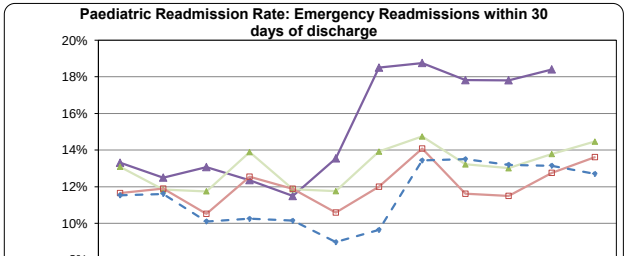
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	512											
2017/18	482	473	430	441	355	494	616	591	674	539	482	569
2016/17	457	526	421	458	374	425	571	625	591	546	497	578
2015/16	378	387	417	352	360	374	498	640	468	424	455	505

Paediatric Emergency Readmissions within 30 days of discharge



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	137	132	128	124	103	145	173	165	204	182	136	
2016/17	132	140	124	150	114	125	169	179	160	146	142	174
2015/16	110	111	107	118	110	107	136	180	121	118	135	161
2014/15	96	103	92	93	96	86	99	152	153	127	124	131

Paediatric Readmission Rate: Emergency Readmissions within 30 days of discharge

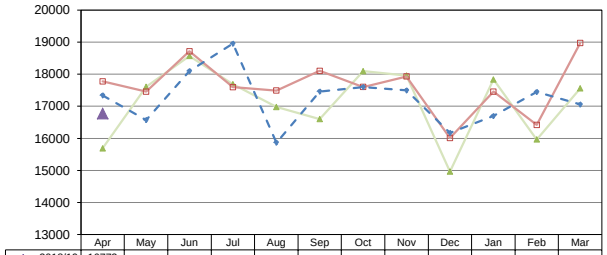


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	13.3%	12.5%	13.1%	12.4%	11.5%	13.6%	18.5%	18.8%	17.8%	17.8%	18.4%	
2016/17	13.1%	11.9%	11.8%	13.9%	11.9%	11.8%	13.9%	14.7%	13.2%	13.0%	13.8%	14.5%
2015/16	11.7%	11.9%	10.5%	12.6%	11.9%	10.6%	12.0%	14.1%	11.6%	11.5%	12.8%	13.6%
2014/15	11.5%	11.6%	10.1%	10.3%	10.1%	9.0%	9.6%	13.4%	13.5%	13.2%	13.1%	12.7%

Trust Planned Care Outpatients

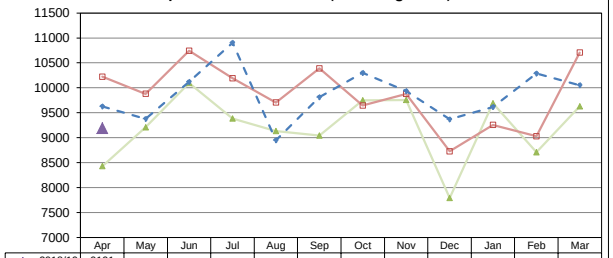
May 2018

Outpatients: All Referral Types (excluding AHPs)



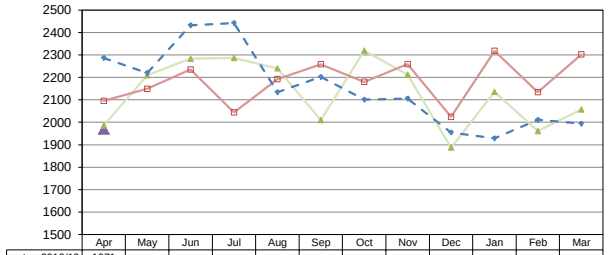
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	16772											
2017/18	15688	17604	18568	17686	16977	16601	18091	17957	14965	17832	15964	17559
2016/17	17774	17455	18711	17594	17489	18102	17600	17930	16011	17455	16415	18972
2015/16	17337	16572	18098	18950	15864	17459	17599	17492	16169	16696	17445	17056

Outpatients: GP Referrals (excluding AHPs)



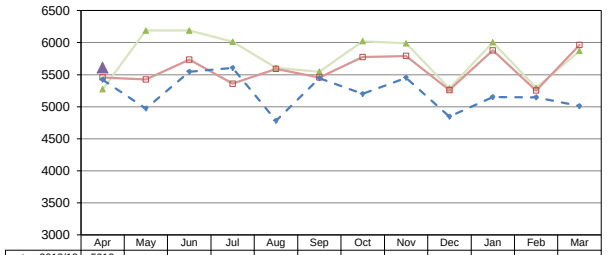
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	9191											
2017/18	8431	9208	10097	9386	9134	9044	9751	9757	7793	9692	8710	9630
2016/17	10223	9881	10742	10192	9706	10388	9645	9879	8728	9259	9029	10707
2015/16	9628	9379	10119	10903	8949	9812	10299	9934	9369	9616	10287	10052

Outpatients: Cons to Cons Referrals (excluding AHPs)



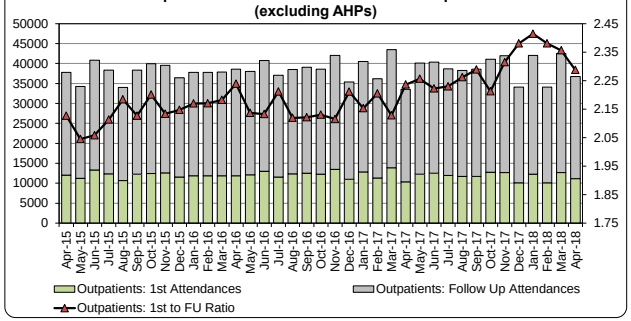
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1971											
2017/18	1985	2209	2283	2286	2240	2010	2319	2212	1888	2135	1961	2057
2016/17	2095	2149	2235	2044	2192	2258	2180	2259	2024	2318	2134	2302
2015/16	2287	2220	2432	2442	2134	2202	2101	2106	1955	1929	2011	1994

Outpatients: Other Referrals (excluding AHPs)

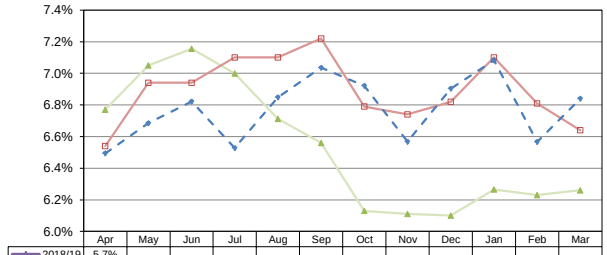


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5610											
2017/18	5272	6187	6188	6014	5603	5547	6021	5988	5284	6005	5293	5872
2016/17	5456	5425	5734	5358	5591	5456	5775	5792	5259	5878	5252	5963
2015/16	5422	4973	5547	5605	4781	5445	5199	5452	4845	5151	5147	5010

Outpatients: Attendances & 1st to Follow Up Ratio (excluding AHPs)

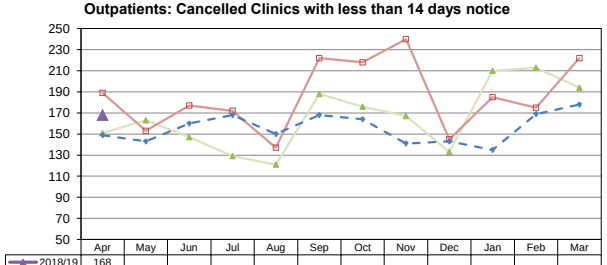


Outpatients: DNA rates



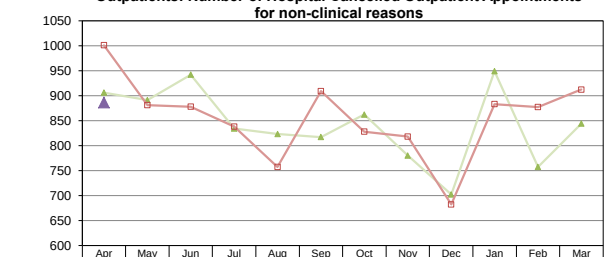
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5.7%											
2017/18	6.8%	7.1%	7.2%	7.0%	6.7%	6.6%	6.1%	6.1%	6.1%	6.3%	6.2%	6.3%
2016/17	6.5%	6.9%	6.9%	7.1%	7.1%	7.2%	6.8%	6.7%	6.8%	7.1%	6.8%	6.6%
2015/16	6.5%	6.7%	6.8%	6.5%	6.8%	7.0%	6.9%	6.6%	6.9%	7.1%	6.6%	6.8%

Outpatients: Cancelled Clinics with less than 14 days notice



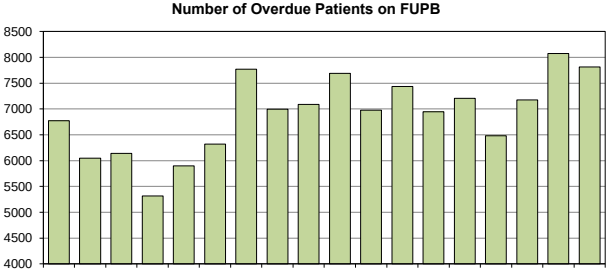
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	168											
2017/18	151	163	147	129	121	188	176	167	133	210	213	194
2016/17	189	153	177	172	137	222	218	240	145	185	175	222
2015/16	149	143	160	168	150	168	164	141	143	135	169	178

Outpatients: Number of Hospital Cancelled Outpatient Appointments for non-clinical reasons



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	886											
2017/18	906	891	942	834	823	817	862	780	702	949	757	844
2016/17	1001	881	878	838	757	909	828	818	682	883	877	912

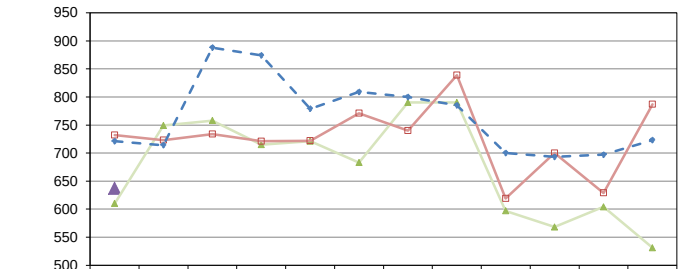
Number of Overdue Patients on FUPB



Trust Planned Care
Elective Activity & Theatre Utilisation

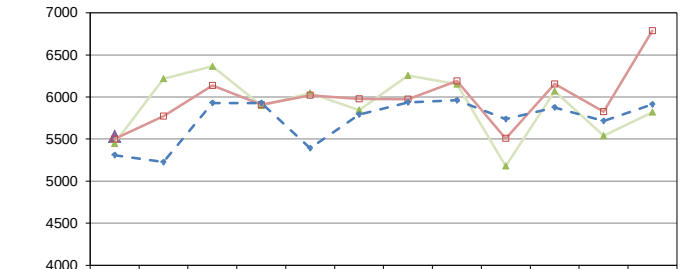
May 2018

Ordinary Elective Admissions



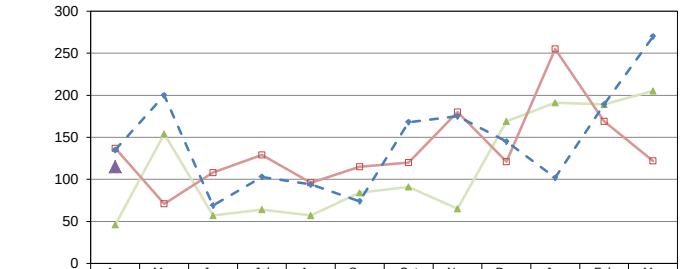
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	637											
2017/18	610	749	758	715	721	683	790	790	597	568	604	531
2016/17	732	723	734	721	722	771	740	839	619	700	629	787
2015/16	721	714	888	874	779	809	800	785	700	693	697	723

Ordinary Day Case Admissions



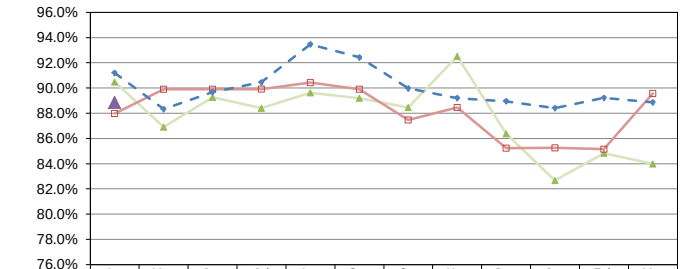
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5532											
2017/18	5447	6216	6364	5896	6047	5845	6254	6151	5179	6069	5538	5819
2016/17	5500	5771	6137	5907	6019	5977	5973	6189	5507	6154	5824	6786
2015/16	5309	5226	5929	5929	5392	5792	5936	5960	5737	5876	5715	5912

Elective operations cancelled within 48 hours - Non clinical reasons



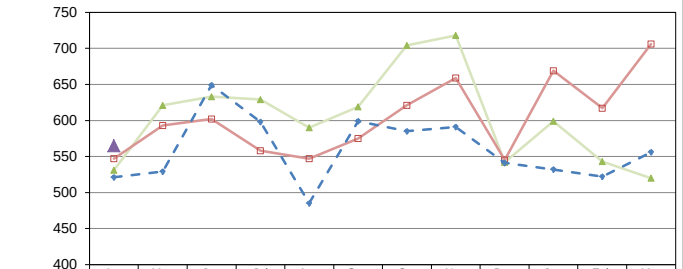
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	115											
2017/18	46	154	57	64	57	84	91	65	169	191	189	205
2016/17	137	71	108	129	96	115	120	180	121	255	169	122
2015/16	135	200	69	103	94	74	168	175	145	102	189	270

Theatres: Utilisation of planned sessions



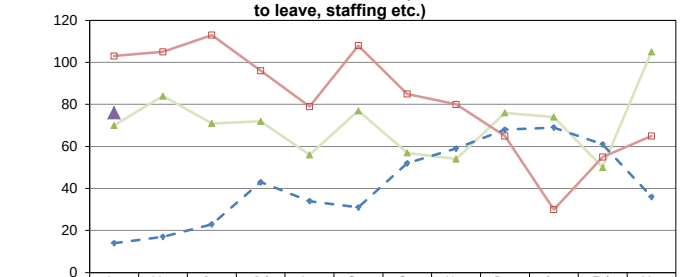
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	88.9%											
2017/18	90.5%	86.9%	89.3%	88.4%	89.6%	89.2%	88.4%	92.5%	86.4%	82.7%	84.8%	84.0%
2016/17	88.0%	89.9%	89.9%	89.9%	90.4%	89.9%	87.5%	88.4%	85.2%	85.3%	85.2%	89.6%
2015/16	91.2%	88.3%	89.7%	90.5%	93.5%	92.4%	90.0%	89.2%	89.0%	88.4%	89.2%	88.9%

Theatres: Number of sessions held



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	565											
2017/18	531	621	633	629	590	619	704	718	542	599	543	520
2016/17	547	593	602	558	547	575	621	659	545	669	617	706
2015/16	521	529	649	598	485	599	585	591	541	532	522	556

Theatres: Lost sessions < 6 weeks notice (list available but lost due to leave, staffing etc.)



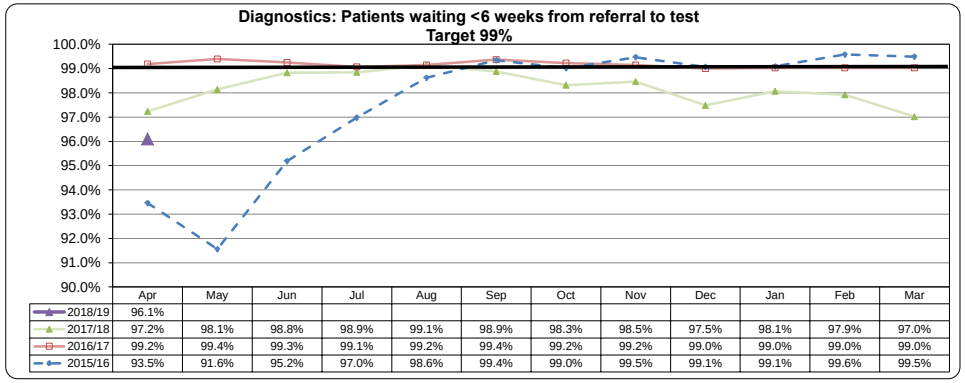
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	76											
2017/18	70	84	71	72	56	77	57	54	76	74	50	105
2016/17	103	105	113	96	79	108	85	80	65	30	55	65
2015/16	14	17	23	43	34	31	52	59	68	69	61	36

All cancellations are within 6 weeks of the planned procedure date. Cancellations exclude lists added in error and those that have been rescheduled.

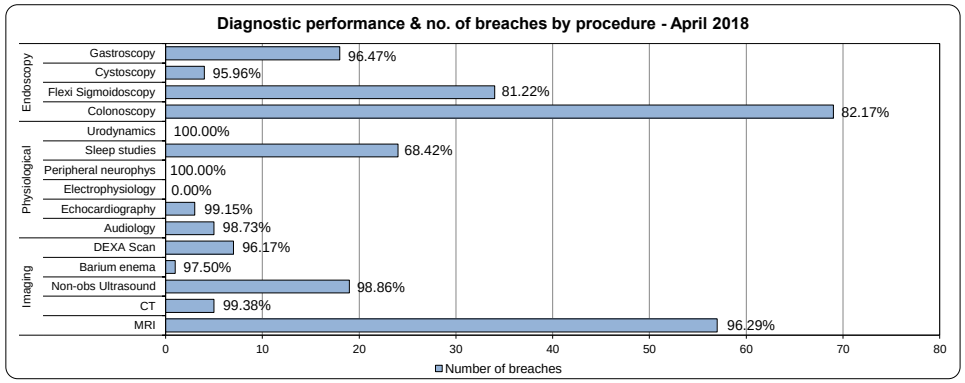
Diagnostics & Referral To Treatment

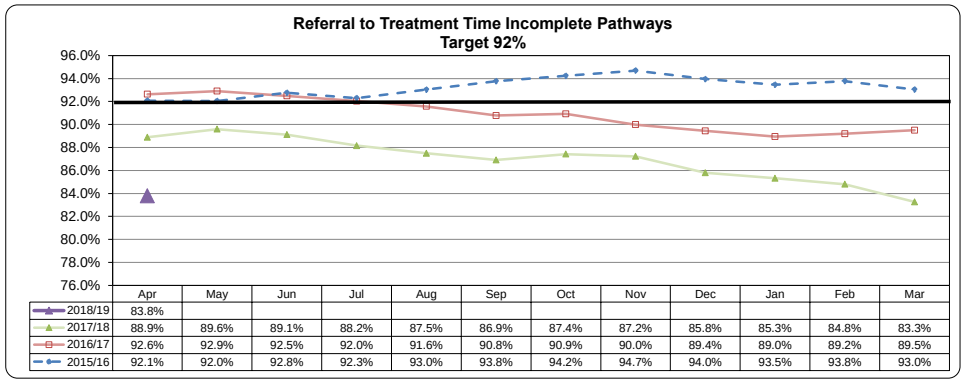
May 2018

The Trust is monitored at aggregate level against the Diagnostic & Referral to Treatment Incomplete Targets.

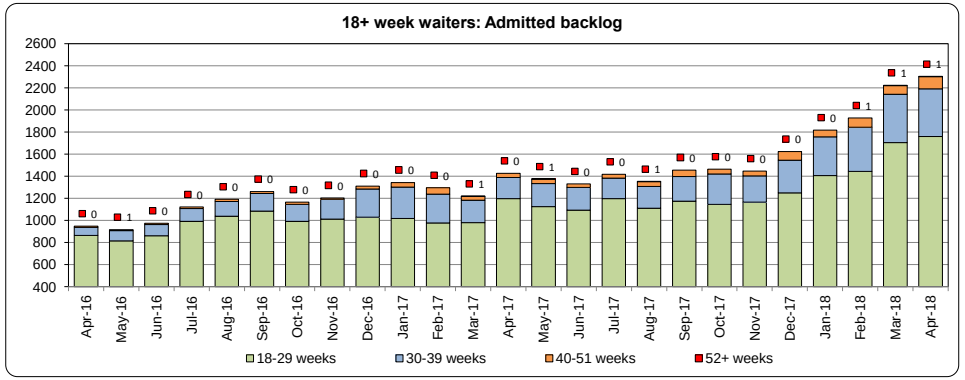


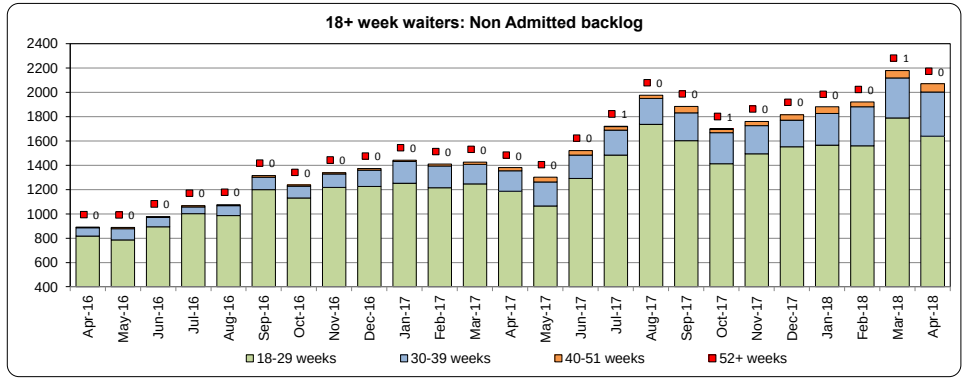
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	96.1%											
2017/18	97.2%	98.1%	98.8%	98.9%	99.1%	98.9%	98.3%	98.5%	97.5%	98.1%	97.9%	97.0%
2016/17	99.2%	99.4%	99.3%	99.1%	99.2%	99.4%	99.2%	99.2%	99.0%	99.0%	99.0%	99.0%
2015/16	93.5%	91.6%	95.2%	97.0%	98.6%	99.4%	99.0%	99.5%	99.1%	99.1%	99.6%	99.5%





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	83.8%											
2017/18	88.9%	89.6%	89.1%	88.2%	87.5%	86.9%	87.4%	87.2%	85.8%	85.3%	84.8%	83.3%
2016/17	92.6%	92.9%	92.5%	92.0%	91.6%	90.8%	90.9%	90.0%	89.4%	89.0%	89.2%	89.5%
2015/16	92.1%	92.0%	92.8%	92.3%	93.0%	93.8%	94.2%	94.7%	94.0%	93.5%	93.8%	93.0%

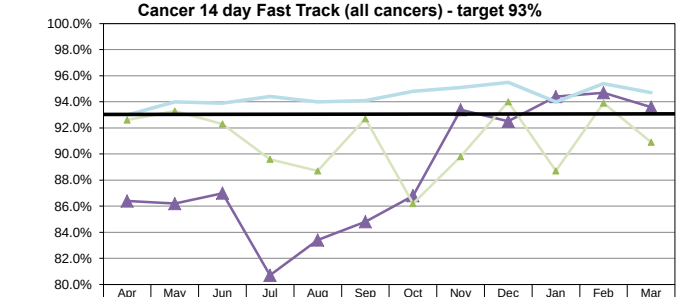




Trust Cancer

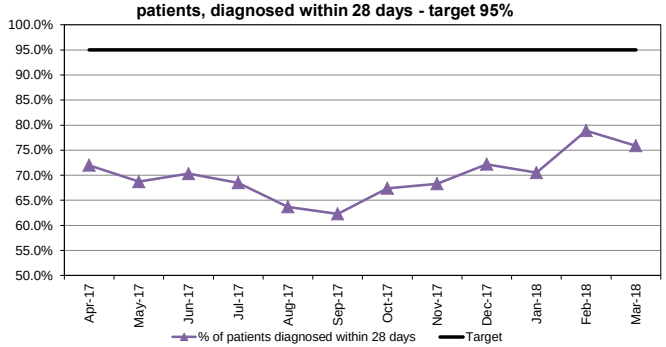
May 2018

Cancer 14 day Fast Track (all cancers) - target 93%

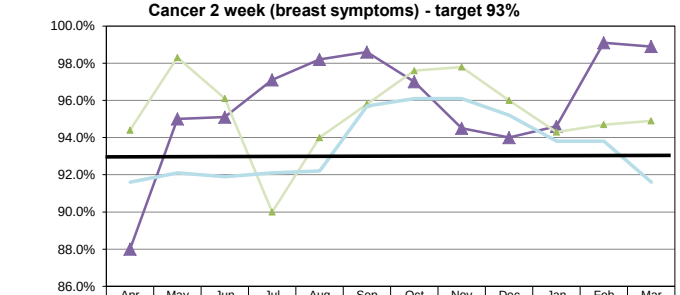


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	86.4%	86.2%	87.0%	80.7%	83.4%	84.8%	86.8%	93.4%	92.5%	94.4%	94.7%	93.6%
2016/17	92.6%	93.3%	92.3%	89.6%	88.7%	92.7%	86.2%	89.8%	94.0%	88.7%	93.9%	90.9%
NHSE 16/17	93.0%	94.0%	93.9%	94.4%	94.0%	94.1%	94.8%	95.1%	95.5%	94.0%	95.4%	94.7%

% of Fast Track & Symptomatic Breast referrals, and screening patients, diagnosed within 28 days - target 95%

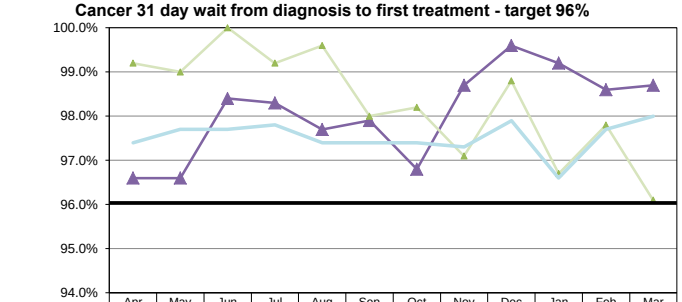


Cancer 2 week (breast symptoms) - target 93%



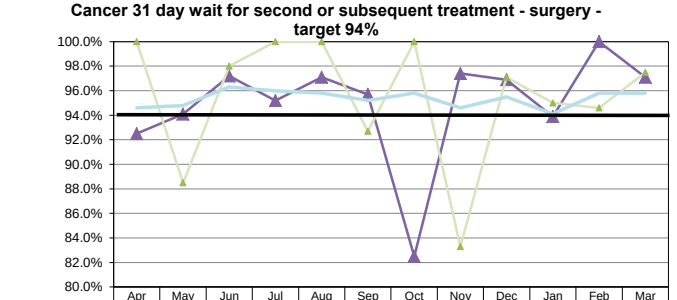
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	88.0%	95.0%	95.1%	97.1%	98.2%	98.6%	97.0%	94.5%	94.0%	94.6%	99.1%	98.9%
2016/17	94.4%	98.3%	96.1%	90.0%	94.0%	95.8%	97.6%	97.8%	96.0%	94.3%	94.7%	94.9%
NHSE 16/17	91.6%	92.1%	91.9%	92.1%	92.2%	95.7%	96.1%	96.1%	95.2%	93.8%	93.8%	91.6%

Cancer 31 day wait from diagnosis to first treatment - target 96%



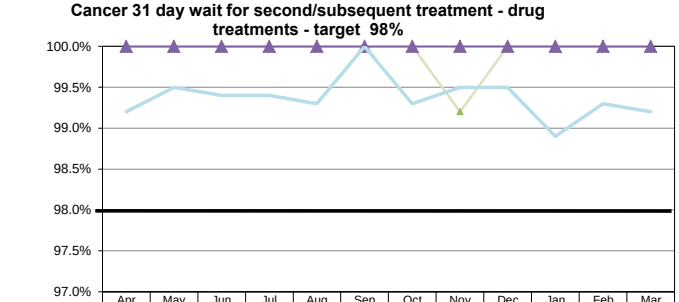
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	96.6%	96.6%	98.4%	98.3%	97.7%	97.9%	96.8%	98.7%	99.6%	99.2%	98.6%	98.7%
2016/17	99.2%	99.0%	100.0%	99.2%	99.6%	98.0%	98.2%	97.1%	98.8%	96.7%	97.8%	96.1%
NHSE 16/17	97.4%	97.7%	97.7%	97.8%	97.4%	97.4%	97.4%	97.3%	97.9%	96.6%	97.7%	98.0%

Cancer 31 day wait for second or subsequent treatment - surgery - target 94%



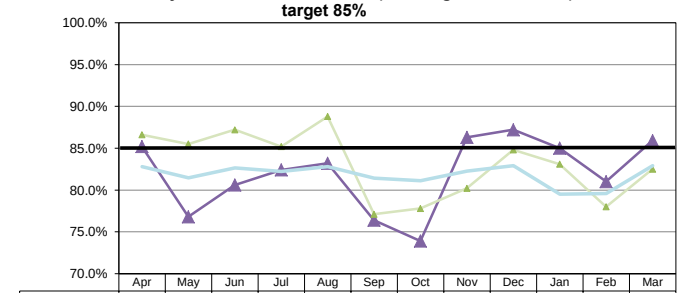
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	92.5%	94.1%	97.2%	95.2%	97.1%	95.7%	82.5%	97.4%	96.9%	93.9%	100.0%	97.1%
2016/17	100.0%	88.5%	98.0%	100.0%	100.0%	92.7%	100.0%	83.3%	97.1%	95.0%	94.6%	97.5%
NHSE 16/17	94.6%	94.8%	96.3%	96.0%	95.8%	95.2%	95.8%	94.6%	95.5%	94.1%	95.8%	95.8%

Cancer 31 day wait for second/subsequent treatment - drug treatments - target 98%



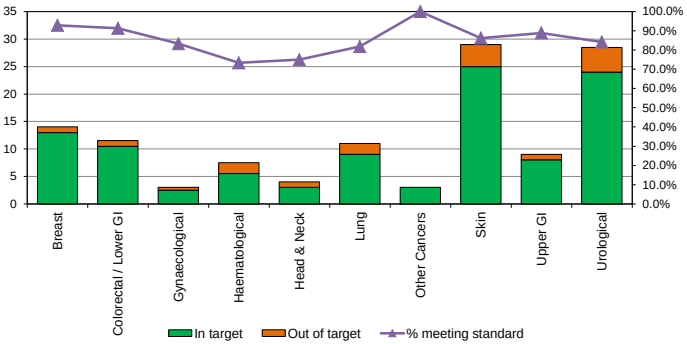
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	100.0%	100.0%	100.0%
2017/18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
NHSE 16/17	99.2%	99.5%	99.4%	99.4%	99.3%	100.0%	99.3%	99.5%	99.5%	98.9%	99.3%	99.2%

Cancer 62 Day Waits for first treatment (from urgent GP referral) - target 85%

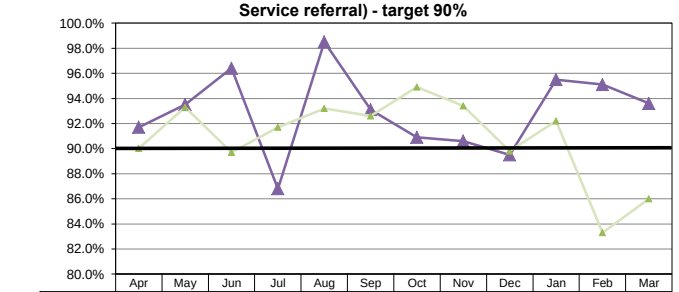


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	85.2%	76.8%	80.6%	82.4%	83.2%	76.4%	73.9%	86.3%	87.2%	85.0%	81.0%	85.9%
2016/17	86.6%	85.5%	87.2%	85.2%	88.8%	77.1%	77.8%	80.2%	84.8%	83.1%	78.0%	82.5%
NHSE 16/17	82.8%	81.4%	82.7%	82.2%	82.8%	81.4%	81.1%	82.3%	82.9%	79.5%	79.6%	82.9%

Cancer 62 day target performance by site -target 85%



Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - target 90%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	91.7%	93.5%	96.4%	86.8%	98.5%	93.1%	90.9%	90.6%	89.5%	95.5%	95.1%	93.6%
2016/17	90.0%	93.3%	89.7%	91.7%	93.2%	92.6%	94.9%	93.4%	89.8%	92.2%	83.3%	86.0%

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Quality and Safety Committee – 17 April 2018

Recommendation

For information	☒
For discussion	☒
For assurance	☒
For approval	☐
A regulatory requirement	☒

Current approval route of report

The minutes are approved by the Quality and Safety Committee.

Purpose of report

The purpose of the Quality and Safety 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.

Chair's Summary

1.Due to unforseen circumstances the Chief Nurse was not represented at the meeting and we therefore focused more of our attention on the Medical Director's items. We were also joined by Andrew Bennet to discuss a long-awaited paper on Trust plans for improved isolation facilities.

2.The committee continued its quest to gain a greater level of assurance around clinical effectiveness of trust services and were very pleased to receive high level action plans resulting from national clinical audits on the treatment of bowel cancer and sepsis. This work will now be a regular feature of the committee agenda – helping to satisfy a gap in the assurance process identified by ourselves and the audit committee.

3.Inevitably there was a great deal of focus upon current risks to quality and safety of care arising from ongoing operational pressures and staffing challenges particularly in ED and acute medicine. The committee requested that more information be provided on "real time" safety concerns via a monthly round up of newly declared incidents. Longer term plans to address medical staffing shortages were discussed along with some improvement work within the existing workforce. The group endorsed the ongoing work around mortality reviews and the emerging themes that have been identified.

4.The committee were pleased to hear that the MD has engaged in productive consultation with the clinical body on the forthcoming Patient Safety Strategy and that the possibility of sharing best practice amongst directorates around service level/site level safety dashboards are emerging.

5.The committee received a significant amount of information on both children's and adult safeguarding – including the Adult Safeguarding Annual Plan. We noted the complexity and volume of the work being undertaken by these teams and some key areas for future focus in the light of both internal audit reports and the CQC feedback. Much of this improvement work centres around additional training and education of staff to improve understanding of processes around the Mental Care Act and Deprivation of Liberty Safeguards. We noted that this issue has been added to the CRR of the Chief Nurse.

6.The committee received a Quarterly Report from the IPC team and noted that challenging thresholds for Healthcare acquired infections have been set for the Trust in for 2018/19. The flu situation is improving and cohorting of patients on the York site proved very effective during the peak periods. A new risk has been added to the CRR of the Chief Nurse to reflect infection risks on one of our remaining Nightingale wards on the Scarborough site. Regarding the Estates plan for improving isolation facilities, the committee were somewhat disappointed by the limited scale of the proposals, the absence of a thorough needs analysis or any costings. There is a requirement for greater stakeholder engagement. The committee felt that this is a very high priority project for the Trust and that they wished to bring this matter to the attention of the Board for a cross executive discussion around next steps.

7.Within the information dashboard the committee noted the declining performance on dementia screening (AMTS). This is an area of concern and has been selected by the Governors as their Quality Priority item for 2018/19.

Key points for discussion
This month the Committee has selected the following for the particular attention of the Board;

1. Isolation Facilities Proposal – JA/BG/JT
2. Patient Safety Strategy progress and exemplar areas - JT
3. Operational Pressures and safety – JT
4. New risks added to Chief Nurse Corporate Risk Register (AWW, DoLs) – BG

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☐ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☐ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☐ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Author: Liz Jackson, Patient Safety Project Support

Executive sponsor: Jennie Adams, Non-Executive Director

Date: 17 April 2018

Quality & Safety Committee Minutes – 17 April 2018

Attendance: Jennie Adams, Libby Raper, James Taylor, Fiona Jamieson, Chris Foster, Lorraine Boyd, Andrew Bennett and Liz Jackson

Apologies: Beverley Geary, Lynda Provins, Liz Ross

Minutes of the meeting held on the 20 March 2018

The notes from the meeting held on the 20 March were approved as a true and accurate record.

Action Log Items

Item 73 – The Committee revisited the data quality issue around nursing appraisals and in the absence of a representative from the Chief Nurse Team asked that this be deferred to the May meeting.

Item 74 - CRR REF: CN8 – Andrew Bennett, Head of Capital Projects, had been invited to the Committee to discuss the isolation facilities proposal. The paper was dated November 2017 and AB advised that this has been discussed at the Capital Programme Executive Group. Ward 22 on the York site has been the focus of the feasibility study and has been used as an exemplar ward. AB led the Committee through the three options for the ward, which have been shared with nursing, operations, infection prevention and microbiology. The proposal includes full isolation facilities and pricing options are being looked in to, including charitable funding. Individuals will regroup to discuss the proposal in more detail.

The Committee raised concern that the options put forward were on a smaller scale than expected and the Trust appear to be a long way from achieving change. JT questioned whether there had been a detailed assessment of the scale of the Trust's need for isolation facilities and the agreed shortfall, what impact the possible options would have on staffing and if costings for and against the changes had been considered. He underlined that the costs of inadequate isolation facilities could be very high indeed for patients – up to and including death in some instances. The Committee agreed that earlier stakeholder consultation was required on such projects and that further discussion with stakeholders was going to be necessary. York has a generic estate and isolation is difficult which causes great frustration; however, the loss of bed capacity may also prove difficult. The Committee agreed that the need for isolation facilities was a key priority as it is a risk for both staff and patients and queried if there were other solutions or other available spaces - such as those that have not been opened this winter or non-clinical areas. The Committee agreed that this requires discussion at Board level to engage the senior team in a joined up approach.

Board – JA to raise at Board

AB advised that there is a current capital project to explore the possibility of an intermediate care in a facility outside of the hospital, which is linked to the stranded patient work stream.

The Committee also queried the actions following the CQC inspection the Children's facilities in the Emergency Department. A bid for funds has been made to improve the Emergency Department reception areas and treatment rooms, which would result in the children's area being relocated for a period of time. External funding has been approved and the fundraising team will be approached for the children's area. The feasibility of relocating Orthopaedic Outpatients from the ED Department is under discussion. This will be discussed further at the Capital Planning Exec Group; however work will commence by summer. FJ added that the Children's Assessment Unit will be open for longer hours from May to ensure that children are in a more appropriate environment. The Committee queried if the Arts Team had been involved and AB confirmed that Capital Planning meet with them quarterly regarding any projects.
Assurance: The Committee was pleased to see that the Trust is developing a scheme that will help to address the CQC comments.

An options appraisal is being undertaken in the plan to move the Bronte Unit and Chemotherapy Unit to the same area on the Scarborough site. This work is included in the Capital Investment Schedule and an amalgamation of funding routes is being looked in to.
Action: JA and LP to liaise with Dianne Willcocks regarding charitable funding.

Item 75 – FJ confirmed that the Information Governance SIRO report will be submitted to Board in May and this could also come to the May Committee meeting.
Action: FJ to provide SIRO report to the May Committee.

Item 76 – The Chief Operating Officer Risk Register was not included in the papers for information. The Committee requested that this come to the May meeting.

Item 77 – As there was no representative from the Chief Nurse Team the Committee requested that feedback regarding the proposed visiting times comes to the May meeting with JA requesting an update in the interim.
Action: JA to request update from BG.

Item 79 – FJ reviewed the inconsistent Duty of Candour figures included in the March performance report which have now been corrected. The Committee noted that this month's figures show an improvement with 47% compliance. JT advised that clinicians are very good at being open and apologising and they have a professional duty to do so. It is the written apology on behalf of the Trust that is reducing compliance. FJ advised that establishing a central team has been discussed; however, it was felt that this would make written responses less personal. Many of these cases are SIs and follow the official process, gaps have been identified, for example letters being sent at the end of the

process rather than earlier. JT confirmed that compliance with Duty of Candour is a national issue.

Item 80 – The Committee had discussed the Bowel Cancer and Sepsis audits at the March meeting and FJ provided the action plans for review. The Committee noted the good progress in each of the action plans and out of interest and for assurance in the process requested sight of the full Briefcase for each audit.
Action: FJ to provide Briefcase and final reports for each audit.

Matters Arising

Patient Safety Team

JT advised that Becky Hoskins has been appointed to the role of Deputy Director for Patient Safety and will be invited to attend Committee meetings once in post. The team acts as a support function throughout the organisation and will begin to work more closely with nursing and operations. The Head of Patient Safety in York is leaving the Trust this week and recruitment to this post has been delayed while BH reviews the team. BG has plans to redevelop the senior nursing team and Infection Prevention have also reorganized and are working closely at ward level. The Committee noted these positive changes.

Clinical Director Appointments

JT confirmed that three Clinical Directors have now been appointed; Mike Harkness for Elderly Medicine, Jon Poels for Radiology and Richard Gale for Ophthalmology. Interviews for the Medicine Clinical Director are taking place this week. Appointment of these individuals has aligned with the directorate structure which is still under discussion. The Committee agreed that any reorganization requires fairness, equality and transparency and should strengthen governance and improve joined up thinking.

Patient Safety Strategy

JT advised that positive feedback has been received from the clinicians on the draft of the Patient Safety Strategy. Service dashboards are being explored to improve assurance and there is a wish to ensure that data is used in a meaningful way, with consideration as to whether to report by locality or by specialty. Some areas, such as renal, use national data to inform practice and but this has never been reported to Board. The Committee agreed that areas of best practice should be highlighted to Board to encourage other areas to adopt such an approach. JT will bring the final strategy to the May meeting dependent on the strategic work.
Board: JT to discuss exemplar areas at Board.

Operational Pressures

CRR Ref: MD2a, MD2b, MD4, MD6a, MD6b and MD10

The Committee were concerned that the Trust performance figures for March were challenging. The figures for Scarborough Emergency Department were poor, with a significant number of 12 hour trolley waits and the Committee requested assurance on how this was being reviewed. JT confirmed that ~~crisis~~ meetings are taking place regarding the deteriorating position in Scarborough. Ernst and Young consultancy company are feeding back their diagnostic report from York Emergency Department and will continue to support the department on a monthly contractual basis. Better York site performance would offset some of the SGH performance in terms of Trustwide metrics but would not deal with patient safety concerns on the East Coast. The Committee raised concern around clinical and operational leadership and management of the Scarborough site.

JT explained that the numbers of consultants have remained static; however the need has increased. There is no sense of availability of doctors to recruit and other recruitment options are being explored. The British Association of Physicians of Indian Origin (BAPIO) has undertaken recruitment work in India, which has been successful in Wales. Other areas are now joining this programme. Over production of doctors has taken place in Greece; and this may be another potential source of recruitment - however they receive different training. The recruitment team is also reviewing their internal cultures and processes.

Hull and York Medical School have received their full allocation of 75 new places. Their strategy is to recruit local candidates where possible as others are not always retained in York following completion of the course; this concern is parallel to the retention of nurses attending York University.

The Committee queried the immediate safety on the Scarborough site with the concerns around capacity and workforce. JT explained that there are improvements that can still be achieved within the current medical workforce. Job plans, ward rounds and board rounds are being looked at ensure that current resources are being used effectively.
Board – JT to raise at Board

Risk Register for the Medical Director and Chief Nurse

The Committee were pleased to note the additions to the Chief Nurse Risk Register.

CRR Ref: CN16 – The Deprivation of Liberty and Mental Capacity Act Risk has been added.

CRR Ref: CN17 – FJ advised the Committee that a new risk has been added to the Chief Nurse Risk Register around the isolation issues on the nightingale wards in Scarborough. This issue is also included on the Infection Prevention and Control Risk Register.

CRR Ref – MD6a and MD6b – The Committee queried if the additional risks around 12 hour waits in the Emergency Departments were going to be included on the Medical Directors Risk Register. FJ confirmed that this can be amalgamated in to the existing MD Emergency Department risks.

CRR Ref: MD9 and CN12 – The Committee noted the inclusion of an SI, in relation to an NIV patient with Learning Difficulties, in the Medical Directors Report. JT and FJ advised that this incident has been discussed in detail at the Monday Quality and Safety Group and BG has proposed an ambitious plan to deliver nurse led NIV on Ward 34 by August.

Patient Safety

Nurse Staffing
CRR Ref: CN2, CN11 and CN13

As there was no representation from the Chief Nurse Team, the Committee had a short discussion around nurse staffing, highlighting concern around the staffing numbers on the key acute wards. JT advised that historic staffing numbers are in place out of hours although the acuity of patients has increased. The Committee noted that the unfilled shift rate has improved with some recovery of agency usage and discussed the mix between ward and specialist nurses, which are easier to recruit to. The Committee agreed to review this through the Workforce and Organisational Development Committee.
Action: JA to liaise with BG and LR to invite BG to the WOD.

Infection Prevention and Control Quarterly Report
CRR REF: CN7 and CN8

The Committee noted the new thresholds included in the Infection Prevention and Control Quarterly report. There remains a zero tolerance to MRSA, the CDIFF trajectory has reduced by one to 47 and the Trust are expected to demonstrate a significant reduction in the number of E-Coli cases, which may be challenging. JT advised that there will be some system changes in relation to CDIFF, reporting must take place within 48hours instead of 72 hours and cases where patients are diagnosed within a month of discharge will now be attributed to the Trust rather than Primary Care. Discussions around this new reporting system and its effect on the number of cases are taking place.

The Committee noted the success around the cohorting of flu patients.

Safeguarding Children
CRR Ref: CN9

The Committee noted the progress that has been made with the action plan following the CQC visit and highlighted actions still to be addressed; which included, the recruitment of a perinatal mental health midwife and the children's area in Emergency Medicine. The CQC raised concern around the use of adult nurses with additional training to manage children in the Emergency Department. FJ advised that following discussion around the shortage of Paediatric Nurses, the CQC are now accepting of the plan.

FJ advised that a high level CQC action plan has been developed and the Committee queried how this will be reviewed. The CQC are yet to approve the plan and actions relating to quality and safety will come to the Committee on a quarterly basis together with a progress report.

Safeguarding Adults
CRR Ref: CN16

The Committee agreed that an executive summary of the key messages in the Adult Safeguarding annual report would have been helpful and noted the complexity of the legal framework involved. The Committee noted the areas reporting safeguarding issues and agreed that an education plan was necessary and underway. Further education is also required around the Mental Capacity Act.

Clinical Effectiveness

Serious Incidents and Never Events
CRR Ref: MD8

The Committee queried the SI report for SI2017/26743 and whether the correct lessons had been learned from this incident given the further information provided by the coroners report. JT advised that confusion had arisen because the coroner's report was not available until after the SI was competed. The hemorrhage following the operative procedure was not a routine complication of the procedure and was hard to spot and the patient had an underlying heart condition which meant the blood loss had a catastrophic effect.

The Committee noted that the SI reports included in the Medical Directors report were relatively historic and queried how the committee could obtain a feel for the 'real time' safety environment. JT advised that all deaths and SIs are reviewed on weekly basis, in depth investigations and mortality reviews can be expedited at this time. FJ explained that several of the 31 clinical SIs declared in the last three months were 12 hour trolley waits and agreed to include a thematic table in the monthly Medical Directors report.
Action: FJ to include SI thematic table in the Medical Directors Report.

The Committee queried if there were any significant changes in reporting. FJ advised that there has been an increase in reporting from clinicians and also highlighted that the contents of datix reports don't always reflect reality.

Summary Hospital-level Mortality Indicator (SHMI)

The Committee highlighted the gap between the SHMI score for the York and Scarborough sites. JT explained that both sites are within the expected range and the difference between them is not statistically significant. Discussions are taking place around the possibility of replacing SHMI with crude mortality data.

Quarterly Mortality Report

19 structured judgement case note reviews (SJCRs) were completed in the last quarter and the Committee were assured by the good progress in the process. JT advised that there is still some focused work to do around the learning process and gaining acceptance of conclusions by clinicians who may feel some implied criticism. Themes are being identified including failure to escalate the deteriorating patient and winter pressures. Actions can be focused around these themes. The Medical Examiner roles will be in post by 2019.

Clinical Effectiveness Group and Patient Safety Group Minutes

The Committee noted the inclusion of the minutes from both Groups and highlighted that no items had been escalated to the Committee. FJ advised that the Clinical Effectiveness Group had now widened it membership and Clinical Governance Leads will be invited to present. As the Group reestablish it can select items for escalation. The Committee queried how the LocSSIPs work, discussed at Patient Safety Group, links with the WHO Surgical Safety checklist. JT confirmed that LocSSIPs are being put in place for all procedures that take place outside of theatres. JT is confident that a process has been largely agreed and should be adopted promptly.

Patient Experience

National Maternity Survey 2017

The Maternity papers had been resubmitted to the Committee as Liz Ross was going to be in attendance to discuss them in detail. The Committee highlighted that the maternity users were pleased with the service they receive. FJ advised that from April all qualifying Maternity incidents will go through the Healthcare Safety Investigation Branch (HSIB) which will be a parallel system to the SI process. The Committee were keen to know how the outcomes of these investigations will be reported through to committee.
Action: JA to ask BG to confirm new process

Additional Items

Dementia Screening

The Committee noted that compliance with dementia screening was beginning to drop. JT agreed to liaise with Helen Noble from the Patient Safety Team.
Action: JT to liaise with Helen Noble.

Draft Quality Report

The draft Quality Report was included in the papers for information. JA asked that Committee members send any comments to LP by 20 April 2018.

Board Assurance Framework

Amendments from the Strategic Time Out are yet to be made to the Board Assurance Framework.

Post Meeting Note:
Following the meeting, and given the absence of a senior nurse at the meeting, JA clarified the following issues with the Chief Nurse:

Visiting Hours: A poll of patients and staff is being undertaken which will inform a decision on any changes.

Safeguarding Staffing resource: The Trust are well resourced compared to many other Trusts with a WTE for both adult and Children's safeguarding.

Next meeting of the Quality and Safety Committee: 22 May 2018, Neurosciences Resource Room, York Hospital

Quality & Safety Committee – Action Plan – May 2018

No.	Month	Action	Responsible Officer	Due date	Completed
36	Mar 17	Foundation Trust Secretary to liaise with Medical Director for the Patient Consent Audit report	Helen Noble	May 17, Jun 17, Jul 17, Aug 17, Sept 17, Jan 18, Feb 18, July 18	
68	Dec 17	JT to bring amended Patient Safety Strategy	Medical Director	Feb 18 March 2018 May 18	
73	Feb 18	Nursing appraisal data	BG	Mar 18, April 18, May 18	
74	Feb 18	Review isolation facility proposals from Estates Director	BG	Mar 18, April 18	Completed
75	Mar 18	SIRO report to be added to the Q&S work plan	LP	April 18, May 18	
76	Mar 18	COO Risk Register to come to Committee for information	LP	April 18, May 18	
77	Mar 18	Proposed visiting times to be discussed at Senior Nurse Meeting	BG	April 18, May 18	
78	Mar 18	To include Childrens Safeguarding update in the April Chief Nurse Report	BG	April 18	Completed
79	Mar 18	To review accuracy of the DoC data in the Board pack	FJ	April 18	Completed
80	Mar 18	Bowel Cancer and Sepsis Action Plans to be reviewed by the Committee	FJ	April 18	Completed
81	Apr	To liaise with Dianne Willcocks regarding charitable funding for capital projects.	JA & LP	May 18	
82	Apr 18	Bowel Cancer and Sepsis Briefcases and final reports to be reviewed by the Committee	FJ	May 18	
83	Apr 18	SI thematic table to be included in the Medical Directors Report	FJ	May 18	
84	Apr 18	To liaise with Helen Noble regarding Dementia screening compliance	JT	May 18	

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Quality and Safety Committee Minutes – 22 May 2018

Recommendation

For information	☒
For discussion	☒
For assurance	☒
For approval	☐
A regulatory requirement	☒

Current approval route of report

The minutes are approved by the Quality and Safety Committee.

Purpose of report

The purpose of the Quality and Safety 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.

Chairs report

1. The committee were pleased to note ongoing work with clinical directorates to develop individual safety strategies and dashboards to underpin the overarching refresh of the Patient Safety Strategy and the plans to share exemplary work within the Trust in areas such as Renal Medicine, Elderly Medicine and Maternity

2. The Committee's work to improve levels of assurance around clinical effectiveness continues to gain momentum with the review of a sample set of key national clinical audits and action plans now established and embedded in the annual work plan.

3. The committee expressed continued concern around an identified theme within Sis and Never Events of failures of Theatre Checklist procedures. They requested an update to Board from the Medical Director on mitigating actions taken to date and planned for the future.

4. Within the Chief Nurse report the committee gained assurance from the introduction of the Safecare nursing workforce management tool on the York site and it's imminent introduction to SGH. This will enable identification and mitigation of nurse staffing issues in real time – and more accurate data for assurance purposes. There was also positive news around senior nursing presence on both acute sites during evenings and weekends and a reduced number of wards with a sub 80% RN day fill rate on both acute sites. Further information was requested around the recent limited assurance audit into e-rostering.

5. A slight adjustment to ward visiting times is to be introduced following a listening exercise from 11am-8pm to 1pm-8pm.

6. A discussion of the Corporate Risk Registers revealed some innovative work on the Respiratory Ward in York to better deliver nurse led Non-Invasive Ventilation.

7. The committee reviewed the Patient Experience Quarterly Report and noted that the Annual Complaints Report would need to be presented to the Board. Numbers of complaints are falling as more are being dealt with via local resolution.

8. The Committee received the Annual End of Life Care Report and noted the improvements made since the national audit of 2015 – of particular note is the availability of 7 day bereavement services and better compliance with DNACPR procedures. Areas of challenge remain around training resources but innovative ward based approaches are being developed.

9. The Committee reviewed the CNST self-assessment toolkit for Maternity Services and were assured that it was a fair reflection of the Trusts position and that we therefore qualify for the 10% maternity insurance premium reduction of approx. £0.5m this year.

Key points for discussion

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

1. Maternity CNST – BG
2. Complaints Annual Report – BG
3. Theatre Safety – JT
4. Patient Safety work with Directorates - JT

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☐ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☐ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☐ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Author: Liz Jackson, Patient Safety Project Support
Sponsor: Jennie Adams, Non-Executive Director

Date: 22 May 2018

Quality & Safety Committee Minutes – 22 May 2018

Attendance: Jennie Adams, Libby Raper, James Taylor, Beverley Geary, Fiona Jamieson, Kim Hinton, Liz Jackson

Observing: Linda Oliver, Care Quality Commission

Apologies: Lynda Provins

Minutes of the meeting held on the 17 April 2018

The notes from the meeting held on the 17 April were approved as a true and accurate record. JA highlighted one change to be made prior to Board.

The Committee discussed the new Executive Summary and agreed that its inclusion would be very helpful when discussing the papers at Board.

Action Log Items

Item 36 – JA highlighted that the Audit Committee had discussed the limited assurance of the Quarter 2 Patient Consent re-audit. The audit team had expressed some frustration around the lateness of the action and Donald Richardson had commented that there was some focused work taking place.
Action: JT to liaise with Helen Noble from Patient Safety

Item 68 – JT advised that the Patient Safety Strategy is waiting on the whole Trust strategy piece. The Patient Safety team is currently missing two senior posts, one has been appointed to and the other has been put on hold until the former is in post. Work streams are currently in place; Safety Performance Assurance Meetings are taking place with directorates developing their own local patient safety strategies and dashboards; One to one discussions are taking place with clinical leads and a formal presentation will take place at exec board in summer. Patient Safety work is being discovered in directorates which should be shared across the trust to set a standard; for example, the renal dialysis work and the dashboards in Maternity and Elderly Medicine. The Committee found it encouraging that there were so many strong models throughout the Trust and queried how these could be promoted more. JT advised that engagement was key for directorates to own patient safety at their local level and also agreed that the vast amount of data within the organisation could be used more wisely.

Item 73 – BG advised that Helen Hey is leading on a piece of work to produce accurate figures for nursing appraisal compliance. 25% of the nursing workforce are on long term sick or maternity leave and these will be removed from the data before it is recalculated and reported. There has been a lot of focus on the safeguarding children's statutory and mandatory training and new ways of disseminating this training. A further update will come to the Committee in July.
Action: BG to update the Committee in July.

Item 74 – CRR Ref: CN8 & CN17 - The isolation facility proposals were discussed at April's private board. The Committee questioned if the Estates team would be attending the Infection Prevention meetings going forward. BG confirmed that Estates and Infection Prevention will attend the same meeting that will report in to the Committee and the topic remains a standing item on the Hospital Infection Prevention and Control Agenda.

Item 81 – JA has contacted Dianne Willcocks regarding charitable funding for capital projects. Lucy Clegg, the Trusts corporate fundraiser has suggested the focused fundraising events could take place. Lucy will liaise directly with Andrew Bennett.

Item 82 – The Audit Committee had asked the Committee to monitor a sample of clinical audits and the Committee requested to see the full briefcase and action plan report for the Bowel Cancer and Sepsis audits. FJ agreed to provide the Sepsis information in June and the Bowel Cancer reports in July. JT advised that the Trusts Clinical Bowel Cancer Lead has been appointed as the Lead for the Cancer Alliance to work on an urgent action plan. This will require one or two Pas a weeks.
Action: FJ to provide the Sepsis Briefcase/ Action plans in June and the Bowel Cancer ones in July

Item 83 – The Committee explained that they can feel detached from real time safety issues. FJ advised that current SI themes are provided to Patient Safety Group. The Committee requested that this is included in the Medical Directors Report going forward. FJ advised that the themes over the winter period included; 12 hour trolley waits, failure to escalate the deteriorating patient, system failures and falls, with some falls with harm being escalated to clinical investigations. Similar patterns can be seen in the annual SI analysis which will come to the Committee in June.
Action: FJ to include current SI themes in Medical Directors report

Item 84 – The Committee had raised concern around the drop in compliance with dementia screening. JT advised that Helen Noble, Patient Safety, has been asked to look in to this.

All other Action Log items were included on the meeting agenda.

Matters Arising

Emergency Department pressures
CRR Ref: MD4, MD6a, MD6b and MD10

The Committee requested feedback around the focused work in the Emergency Departments on both sites. JT explained that the agreed target for Q1 month one was met and that the Trust is on track for the month two target. Ernst and Young, including Prof. Hugo Massey-Taylor, are now working on the Scarborough site and the Medical Director from NHSI is liaising with Ed Smith. Validation has been requested on the Acute Medical model and advice and feedback is awaited on ED and the Acute and Urgent Care Pathway.

Action: JT to update committee upon receipt of reports

Care Quality Commission Recommendations

The Chief Nurse and the Medical Director have 5 key actions on their high level action plan and FJ advised that the underpinning action plan is currently being worked on and will come to the June Committee meeting for review. BG advised of the NHS Improvement initiative 'Going for Good' which will commence within the Trust soon. NHSI will provide diagnostics and focused help and support aiming for the Trust to receive a rating of good from the CQC.

Risk Register for the Medical Director and Chief Nurse

The Committee noted that neither the Chief Nurse Risk Register nor the Medical Directors Risk Register had changed since the April meeting.

CRR Ref: CN12, MD7 & MD9 – The Committee asked for an update regarding the provision of NIV on the York Hospital site. BG advised that an action plan is in place. Associate Practitioners were included in the Ward's establishment before Christmas and a new Ward Sister and additional Band 6's have been recruited. The Clinical Nurse Specialists have been active on the ward to initiate NIV and work is being undertaken with the Work Based Learning Team to upskill the band 4 staff. This risk will be reviewed again when all of the staff have received training and NIV is being delivered on a regular basis. JT added that due to the low number of high dependency beds on ICU/HDU, this ward work should relieve some of the pressure in that area.

CRR Ref: CN16 – The majority of the action plan around Deprivation of Liberty knowledge has now been completed. The safeguarding team will conduct an audit and once this work is fully embedded the risk will be reviewed with the view to deescalate.

CRR Ref: MD2a &MD2b – The Committee queried the out of hours medical provision on the Bridlington site. JT advised that new Resident Medical Officers (RMOs) have been recruited and the current system will be replaced from this month. There have been some concerns raised around quality and an action plan has been put in place; including a robust induction for all individuals and an audit process for any patient transfers.

BG advised that the risk around influenza has now been removed from the Chief Nurse Risk Register.

Action: FJ agreed to provide A3 copies of each risk register to each Committee meeting going forward – for those members without 20:20 vision.

Patient Safety

Nurse Staffing
CRR Ref: CN2, CN11 and CN13

BG advised that the recent recruitment fair held on the York site was quieter than usual, which may be due to the event being held twice a year rather than once. 73 new registrants have applied to begin in September in York and an additional 30 BSC student places have been agreed to start on the Scarborough Coventry campus. The Trust will attend the Nursing Times careers event in June. 80 individuals have been placed in HCA posts and it is hoped to progress some HCAs into Associate Practitioner roles; however, the limiting factor is the need for mentors for these individuals.

Nursing application numbers are falling, with York University reducing their numbers of pre-reg students to focus on postgraduate students. A number of other Universities have been approached including Coventry and York St John, and this national programme has proved challenging. York College are running a Nurse Associate programme in association with York University.

Overseas recruitment is being revisited; however, will look beyond Europe. This is a medium term solution as there is a 44 week lead time when recruiting overseas, a business case will be pulled together for approval. Hull have had some success, however some individuals have failed their OSCEs once they have got to the UK, a regional piece of work is taking place to review the test centres. Visa availability has been an issue with medical recruitment outside of the EU.

The Committee were pleased to see that SafeCare is now in place across York and the implementation has commenced in Scarborough. The Committee queried the limited assurance audit around E-Rostering, BG agreed to look in to this and advised that the two systems do link to each other. SafeCare is completed on a tablet and shows in the moment staffing, staff can be reallocated and sickness can be added. Reallocations and staff sickness had to be added to e-roster at the end of the month, which didn't work well. Care hours per patient day has not given an accurate reflection of staffing, as the census is undertaken at midnight and there have been empty beds and staff reallocation in Bridlington. SafeCare will give an accurate reflection of staffing and the nursing dashboard and the staffing paper will change significantly to reflect this better quality data.

The Committee noted the improved fill rates across the organisation, BG explained that there has been a high use of agency and bank nurses and nurses have been reallocated to fill shifts in an effort to ensure safe levels of staffing. The Associate Practitioner role has had a positive impact so far and this will be formally evaluated soon. BG will look in to the data accuracy for St Monicas.

Action: BG to review limited assurance E-Rostering audit
Action: BG to look in to the data accuracy for St Monicas

Nursing Strategy Update

The Committee took the document as read and were pleased to see the ward accreditation tool and the out of hours and weekend work evolving. BG advised that the

Chief Nurse team were supported to over recruit for York Matrons and are now advertising for the Scarborough site. Matrons will be available 7 days a week and the budget has come from the gaps in the deputy directorate manager posts. The Committee were assured to hear that there would be more Matron visibility and agreed that this was needed on the East Coast. The Committee queried the items in the work plan that contained 'no evidence' in the May update, BG advised that these had not been completed as yet due to pressures within the Chief Nurse Team.

Dementia Strategy

The Dementia Strategy is a huge piece of work across the organisation which has grown year on year and will continue. There is a significant amount of work taking place, including charitable funding and staff training. The Dementia volunteers are having a huge impact and the Trust will seek to increase the numbers of these individuals. Work will also take place with lasts year's nursing conference key note speaker, Tommy Whitelaw. Through the use of charitable funds, the Trust are looking to appoint a Dementia Specialist nurse who will work across all areas. This would be a fixed term task and finish role. The Committee queried if the Dementia Lead, Emma George, would like to attend the Committee to highlight this work directly to Board and agreed to flag the Dementia Group as an opportunity to the new Non-Executive Directors.
Action: BG to invite Emma George to attend some Committee meetings
Action: Committee members to flag the opportunity to attend the Dementia Group to the new Non-Executives

Clinical Effectiveness

Serious Incidents and Never Events
CRR Ref: MD8

The Committee noted the inclusion of 5 completed SI reports in the Medical Directors Report and highlighted their frustration that some of these were related to further Theatre checklist failures. JT explained that one of these SIs was due to lack of consent at the time of procedure however the procedure did not commence and the other was a wrong site procedure that again was rectified. This wrong site procedure was not classified as a never event at the time but this type of error has now been added to the list for 2018/19. The last Theatre Clinical Governance session included training from Amanda Vipond and the Clinical Theatre Team on completion of the Theatre checklist. JT advised that there is currently a focus on auditing compliance of the WHO checklist and a comparison between elective and emergency theatres will take place. The Committee understood the significant management challenge and highlighted the need for continuous pressure on staff to get this right. JT advised that there has been significant progress on site marking and the focus should now be on improved compliance and patient engagement. Ward management is managed by directorate, which links with the new patient safety strategy and further conversations will take place with Amanda Vipond. Support from the CCG has been requested as it is difficult to monitor internally.
Board: JT to raise at Board

Clinical Effectiveness Group and Patient Safety Group Minutes

The Committee noted the inclusion of the minutes from both Groups and highlighted that the Clinical Effectiveness minutes had been reviewed before. JT will highlight items from these Groups through the Medical Directors Report going forward.

CNST Maternity Self-Certification

Kim Hinton, Directorate Manager for Maternity was invited to attend the Committee to discuss the CNST Self-Certification. KH explained that there are 10 standards that organisations have to self-certify against and the document contains all supporting evidence. NHS Resolution have agreed that the Trust is compliant against all 10 standards.

The Committee has previously discussed many areas of good practice and highlighted the directorates struggle to reduce the number of women smoking during pregnancy, especially on the East Coast. KH advised that to be compliant with the standards the Trust must show that there is a plan in place, and the implementation of these various interventions had led to a reduction in number of women smoking during pregnancy in the last quarter. The Committee noted the discrepancy between the number of brain injuries reported within the Trust and those reported to NHS Resolution Early Notification scheme (Item 10). KP explained that the self-certification has strict criteria, for example those reported within the first seven days of life, and would expect this to be picked up by MBRRACE. The Committee queried if this would affect the Trust rates, it is hoped there would be a change as the new process is used going forward. There was a question around Trust compliance with transitional care (Item 3), however compliance has now been confirmed as the Trust do not look after babies with feeding tubes etc. This is something that will be looked in to in the future. The Committee also noted that the Duty of Candour requirements were all fulfilled. KP added that this CNST discount is worth around £0.5 million to the organization this year and may not continue in this format.
Assurance: The Committee was assured by the good practice demonstrated in Maternity especially around governance and risk management
Board: BG to highlight at Board

National Paediatric Diabetes Audit

The Committee had reviewed the content of the Paediatric Diabetes Audit and had struggled to match the narrative to the data. FJ advised that the narrative is produced externally; however the figures do speak for themselves. The Committee queried if an action plan was available and FJ explained that ~~as~~ the data was from some time ago and things will have moved on. The Committee requested the next stage of the audit for review.
Action: FJ to provide the next stages of the National Paediatric Diabetes Audit after the bowel Cancer and Sepsis plans are presented (August)

The Committee requested sight of the Sentinel Stroke Audit and the National Cardiac Arrest Audit and asked FJ to also provide a local audit for review. The Committee also requested that the NCEPOD report currently being prepared be included in the Medical Directors report.
Action: FJ to schedule audits for review

Action: FJ and JT to include NCEPOD in Medical Directors Report
Action: JA to liaise with FJ and LP to finalise the Clinical Effectiveness work programme of the Committee.

SIRO report
CRR Ref: MD3
FJ introduced the SIRO report explaining that there are 44 standards to which the Trust self-assesses and must achieve a minimum of level 2, which is a satisfactory, green rag rating. This is 88% achieved this far. There is now a new version of the toolkit with 10 standards, which is a piece of work for the Information Governance Group and a gap analysis will be undertaken to inform a work plan. Expectations will be higher; however there is no longer a focus on clinical coding and less focus on patient records management. A review of the standards will be undertaken by FJ, Sue Rushbrook and Human Resources. The Committee noted the report for information.

Patient Experience

Patient visiting times

Following consultation, visiting times have been trialed at 11am – 8pm although some concerns were raised. Further engagement has taken place and due to the effect that these times are having on early morning ward rounds, lunch time medication rounds and patient washing, it has been agreed to change the visiting times to 1pm – 8pm. Open visiting will continue for patients with dementia at the discretion of the ward sister. The Committee requested that the Governors be briefed on this change. BG will liaise with LP.
Action: BG to liaise with LP regarding briefing the Governors on the new visiting times.

Patient Experience Quarterly Report

BG highlighted that the Trust are below the national average for complaints which may be due to the focused work promoting local resolution. Training has taken place with the Patient Advise and Liaison Service, Ward Sisters and Matrons which has had an impact on the resolution of issues.

The Committee were pleased to see that the identified theme of Paediatric facilities in the Emergency Department is already receiving focus.

BG advised that the Dementia carers survey has highlighted that further work is required around the ‘about me’ document and family and carers having more opportunities to talk to staff. This work will be led by the safeguarding team. The Committee was encouraged by the open visiting for dementia patients.

The Committee noted the inclusion of the complaints data and BG advised that a separate complaints report will be submitted to Board.
Board: BG to discuss the complaints annual report at Board.

End of Life Care Annual Report

The Committee noted the inclusion of the End of Life Care Annual report, which contained the ambitions from the 2015 report with an update around concerns and progress, and highlighting that there were some stubborn items. The Committee showed their frustration around the delivery of the end of life staff training and Scarborough mortuary facilities. BG advised that Helen Hey and Kath Sartain are exploring alternative delivery methods. The Committee discussed the much improved seven day availability of the team. The Committee reviewed the current position in relation to the National Care of the Dying Audit self-assessment which is much improved. BG advised that this is an area where there will always be additional work to do.

The Committee queried the Trust compliance position with DNACPR. JT advised that this is referred to as ceiling of care, significant improvements have been seen in Elderly Medicine and the rest of the directorates need to follow this exemplar leadership. Scarborough CCG is initiating meetings to standardise procedures and processes across the system from DNACPR to RESPECT.

Additional Items

14 hour review

The Committee noted that the Scarborough Hospital threshold for the 14hour senior review was at 52%, on page 9 of the performance report. JT agreed to look in to this as it may just be a mistake.The NHS England 7 day standard target is 100%.
Action: JT to look in to Scarborough 14 hour review threshold.

Patient Safety Agenda

BG advised that JT and herself are aligning the Patient Safety agenda and pulling the resources together. The role of Deputy Director for Patient Safety will become Deputy Chief Nurse for Patient Safety and report to the Chief Nurse. The Committee queried whether there would be adequate resource available to the MD to produce his report to the Committee under the new arrangement.

Board Assurance Framework

The Board Assurance Framework was not discussed.

Next meeting of the Quality and Safety Committee: 19 June 2018, Room TBC

Quality & Safety Committee – Action Plan – May 2018

No.	Month	Action	Responsible Officer	Due date	Completed
36	Mar 17	Foundation Trust Secretary to liaise with Medical Director for the Patient Consent Audit report	Helen Noble	May 17, Jun 17, Jul 17, Aug 17, Sept 17, Jan 18, Feb 18, July 18	
68	Dec 17	JT to bring amended Patient Safety Strategy	Medical Director	Feb 18 March 2018 May 18 Summer	
73	Feb 18	Nursing appraisal data	BG	Mar 18, April 18, May 18, July 18	
75	Mar 18	SIRO report to be added to the Q&S work plan	LP	April 18, May 18	Completed
76	Mar 18	COO Risk Register to come to Committee for information	LP	April 18, May 18	Completed
77	Mar 18	Proposed visiting times to be discussed at Senior Nurse Meeting	BG	April 18, May 18	Completed
81	Apr	To liaise with Dianne Willcocks regarding charitable funding for capital projects.	JA & LP	May 18	Completed
82	Apr 18	Bowel Cancer and Sepsis Briefcases and final reports to be reviewed by the Committee	FJ	May 18 Sepsis Jun 18 Bowel Cancer Jul 18	
83	Apr 18	SI thematic table to be included in the Medical Directors Report	FJ	May 18 June 18	
84	Apr 18	To liaise with Helen Noble regarding Dementia screening compliance	JT	May 18	Completed
85	May 18	Review limited assurance E-Rostering audit	BG	June 18	
86	May 18	To review the data accuracy for St Monicas staffing	BG	June 18	
87	May 18	National Paediatric Diabetes Audit next stages and action plan	FJ	June 18	
88	May 18	Audits for review; Sentinel Stroke Audit National Cardiac Arrest Audit A local audit	FJ	Aug 18 Sept 18 Oct 18	

89	May 18	NCEPOD Report to be included in the Medical Directors Report	JT & FJ	June 18	
91	May 18	Brief the Governors on the new visiting times	BG	June 18	
91	May 18	To review the Scarborough 14 hour review threshold in the data pack	JT	June 18	

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

York Teaching Hospital NHS
NHS Foundation Trust

Patient Safety and Quality Performance Report

May 2018

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

Patient Safety & Quality Performance Report

Chapter Index

Quality and Safety Summary: Trust

Patient Experience	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Litigation - Clinical Claims Settled	-	-	10	7	6	2	5	2	5	2	2	3	4	7
Complaints	-	-	46	36	51	43	50	38	37	27	28	31	35	30

Duty of Candour	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Incident Graded Moderate or Above	-	-	8	15	13	12	16	8	19	23	21	15	18	14
Verbal Apology Given	-	-	6	14	12	7	11	8	14	12	9	6	13	8
Written Apology Required	-	-	8	13	11	11	14	7	14	15	8	12	11	7
Written Apology Given	-	-	6	11	7	8	9	7	4	3	4	3	4	2

Care of the Deteriorating Patient	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
14 hour Post Take - York	82%	Q1 82% Q2 82% Q3 85% Q4 90%	91%	91%	91%	89%	91%	92%	89%	92%	94%	90%	90%	90%
14 hour Post Take - Scarborough	52%	Q1 52% Q2 60% Q3 70% Q4 80%	63%	79%	80%	74%	74%	73%	73%	72%	77%	75%	83%	74%
Acute Admissions seen within 4 hours	80%	80%	83%	86%	93%	86%	92%	86%	90%	87%	89%	87%	89%	88%
NEWS within 1 hour of prescribed time	90%	90%	87.2%	89.2%	89.0%	88.8%	88.2%	90.2%	90.3%	89.0%	88.3%	89.1%	88.6%	85.1%
All Elective patients to have an Expected Discharge Date (EDD) recorded within 24 hours of admission	93%	93%	86%	86%	84%	88%	84%	87%	84%	84%	90%	88%	91%	86%

Measures of Harm	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Serious Incidents	-	-	20	19	14	12	8	16	10	12	22	22	26	19
Incidents Reported	-	-	1196	1245	1323	1212	1268	1257	1247	1326	1436	1238	1353	1251
Incidents Awaiting Sign Off	-	-	698	746	868	832	766	733	684	892	900	883	837	656
Patient Falls	-	-	228	231	218	216	268	223	258	292	302	266	237	239
Pressure Ulcers - Newly Developed	-	-	134	109	113	97	107	101	104	132	157	131	152	123
Pressure Ulcers - Transferred into our care	-	-	67	77	82	60	77	68	51	71	71	71	82	77
Degree of harm: serious or death	-	-	1	9	2	1	7	2	7	11	9	5	6	4
Degree of harm: medication related	-	-	128	159	160	128	128	161	171	191	165	128	129	107
VTE risk assessments	95%	95%	97.9%	98.3%	97.6%	97.9%	97.7%	98.3%	98.7%	98.0%	98.2%	97.7%	98.0%	97.4%
Never Events	0	0	1	0	1	1	0	1	0	0	0	0	0	0

Drug Administration	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Insulin Errors	-	-	11	10	12	9	11	11	9	15	9	11	13	8
Prescribing Errors	-	-	33	34	40	24	32	45	65	95	66	31	47	23
Preparation and Dispensing Errors	-	-	14	27	24	7	13	16	18	5	11	8	15	13
Administrating and Supply Errors	-	-	50	58	58	62	54	70	54	62	49	64	45	44

Mortality Information	Target/ Threshold 2018/19	Monthly Target/ Threshold	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	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar -17	Jul 16 - Jun 17	Oct 16 - Sep 17
Summary Hospital Level Mortality Indicator (SHMI)	100	100	101	101	99	99	99	100	99	98	97	97	98	100

DoLS	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Standard Authorisation Status Unknown: Local Authority not informed the Trust of outcome	-	-	25	29	16	20	7	4	5	6	11	5	3	1
Standard Authorisation Not Required: Patient no longer in Trust's care and within 7 day self-authorisation	-	-	12	5	7	11	9	11	8	11	13	9	14	15
Under Enquiry: Safeguarding Adults team reviewing progress of application with Local Authority or progress with ward	-	-	0	0	0	0	0	0	0	0	3	7	6	6
Standard Authorisation Granted: Local Authority granted application	-	-	0	0	0	0	2	0	0	0	1	0	0	1
Application Not Granted: Local Authority not granted application	-	-	0	1	0	0	0	1	0	0	1	0	0	0
Application Unallocated as Given Local Authority Prioritisation: Local Authority confirmed receipt but not yet actioned application	-	-	0	0	0	0	0	2	4	1	0	0	1	0
Safeguarding Adults concerns reported to the Local Authority against the Trust	-	-	1	3	4	4	5	1	1	3	6	2	3	3

Infection Prevention	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Clostridium Difficile - meeting the C.Diff objective			2	5	2	3	5	7	4	3	5	4	3	4
CDIFF Cumulative Threshold	48 (year)	48 (year)	8	12	16	20	24	28	32	36	40	44	48	4
Clostridium Difficile - meeting the C.Diff objective - cumulative			4	9	11	14	19	26	30	33	38	42	45	4
MRSA - meeting the MRSA objective	0	0	1	0	0	3	1	0	0	0	0	0	0	1
MSSA	30	2	3	7	5	6	3	3	3	4	2	0	0	2
MSSA - cumulative			6	13	18	24	27	30	33	37	39	39	39	2
ECOLI			8	9	4	7	3	8	8	13	12	2	7	4
ECOLI - cumulative			14	23	27	34	37	45	53	66	78	80	87	4
MRSA Screening - Elective	95%	95%	84.7%	88.3%	85.2%	87.9%	81.7%	88.1%	89.6%	85.4%	87.7%	84.6%	86.4%	85.4%
MRSA Screening - Non Elective	95%	95%	84.3%	85.9%	88.2%	89.5%	88.3%	89.6%	90.3%	87.5%	85.9%	86.7%	86.4%	87.7%

Stroke (one month behind due to coding)	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%	75%	83.3%	100.0%	62.5%	62.5%	73.7%	94.7%	54.5%	85.7%	93.8%	93.3%	93.1%	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%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	1 month behind
	SSNAP Scores		May 17 - Aug 17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18			
Proportion of patients spending >90% on their time on stroke unit	85%	85%	90.5% (B)	90.1% (A)	88.9% (B)	96.4% (A)	89.1% (B)	86.2% (B)	91.7 %(A)	90.7% (A)	77.8% (D)			
Scanned within 1 hour of arrival	43%	43%	51.8% (A)	55.4%(A)	60.0% (A)	46.0% (B)	56.3% (A)	42.4% (C)	50.7% (A)	44.2% (B)	46.6% (B)			
Scanned within 12 hours of hospital arrival	90%	90%	92.6% (B)	89.1% (C)	94.3% (B)	95.2% (A)	95.8% (A)	89.4% (C)	92.8% (B)	88.3% (C)	93.9% (B)			

AMTS	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
AMTS Screening	90.0%	90.0%	79.3%	85.1%	81.7%	80.5%	82.0%	82.8%	83.4%	80.3%	78.4%	81.7%	75.8%	77.2%

Patient Experience
(Patient Experience Team)

Friend and Family Test (FFT) Latest Results – March 2018

The inpatient satisfaction rate for January was 97.6%, (the highest for 12 months), in February it was 97% and 96.2% in March 2018. This is slightly above the national average for March of 96%.
The ED satisfaction rate was 87.3% in January, 86.5% in February and 84.5% in March 2018.
The narratives from FFT for Scarborough ED, show the biggest theme is waiting times, and for York ED, the main theme is also about waiting times and being kept informed about waiting.

Complaints - April 2018

30 new complaints were received and 8 cases were reopened for further investigation.
24% of complaint cases closed in April met the Trust's 30 day response target. This is below the 2017-18 annual average of 27%
Three cases were addressed using the next working day process, resulting in a quick resolution for the complainant.
The patient experience team continue to provide the Chief Nurse and Deputy Chief Nurse with directorate-level performance reports on complaints management.

PALS Management - April 2018

The PALS actively dealt with 173 enquiries, comments and concerns. The team also had 164 queries that were not formally logged.
72% of PALS cases were closed within the target timescale of 10 working days (down 5% from March 2018).

Measures of Harm

No Never Events were declared in April 2018.

19 Serious Incidents were declared; 4 at York, 10 at Scarborough and 5 in Community. 9 of the SIs were attributed to Clinical Incidents, 6 were attributed to Slips, Trips and Falls and 4 were attributed to Pressure Ulcers.

Infection Prevention

The Trust reported 1 case of MRSA in April at York. This remains a zero tolerance measure in 2018/19.

In April 2018 the Trust reported 4 cases of CDIFF, 3 at York and 1 in Scarborough. The yearly threshold for 2018/19 remains at 48, monthly allocation allows for 4 cases.

2 cases of MSSA were reported in April, both at York.

4 cases of ECOLI were reported in April, 3 at York and 1 at Scarborough.

Quality and Safety - Miscellaneous

Stroke (reported 1 month behind due to coding)
The Trust achieved a 'D' rating for the proportion of patients spending > 90% of their time on a stroke unit, however this only represents a small number of patients (14 out of 18). A 'B' rating was achieved for patients scanned within 1 hour and 12 hours of arrival. The 75% target was met for TIA patients assessed within 24 hours (93.1%).

Cancelled Operations
62 operations were cancelled within 48 hours of the TCI date due to lack of beds in April. This is a significant increase on April 2017 when 4 operations were cancelled.

Cancelled Clinics/Outpatient Appointments
168 clinics were cancelled with less than 14 days notice; this figure is a 6% increase on April 2017 and is below the monthly threshold of 180. 886 outpatient hospital appointments were cancelled for non clinical reasons which is a 2.2% decrease on April 2017 (906).

Ward Transfers between 10pm and 6am
106 ward transfers between 10pm and 6am were reported in April, the threshold is 100 threshold per month. This is an increase on April 2017 when 79 transfers occurred.

AMTS
The Trust failed to achieve the 90% target for AMTS screening in April, performance was 77.2%. The Trust has failed to achieve target since January 2017.

Care of the Deteriorating Patient

The target was achieved for York for the proportion of Medicine and Elderly patients receiving a senior review within 14 hours in April. York achieved 82% against the 90% target for Q1. Scarborough achieved 74% and therefore passed the 52% target for Q1.

85.1% of patients had their NEWS scores completed within 1 hour in April against the Trust's internal target of 90%, failing its target for the fifth consecutive month. Scarborough continue to consistently achieve target with performance of 91.3% in April, York achieved 81.4%.

85.8% of Elective patients had their Expected Date of Discharge recorded within 24 hours of admission across the Trust in April. The target of 93% has not been achieved, and this remains consistent with previous months. The last time this target was achieved was March 2016.

Drug Administration

8 insulin errors were reported in April, including 4 for York and 4 for Community.

23 prescribing errors were reported across the Trust in April, with 13 for York, 8 for Scarborough and 2 for Community.

13 dispensing errors were reported across the Trust in April. The number of dispensing errors was 8 at York, 3 at Scarborough and 2 in Community. Numbers remain higher than the reduction seen in December 2017 when a total of 5 errors were made.

Mortality

The latest SHMI report indicates the Trust to be in the 'as expected' range. The October 2016 - September 2017 SHMI saw a 2 point increase for York, a 2 point increase for Scarborough and a 2 point increase for the Trust. Trust - 100, York 95 and Scarborough 108.

178 inpatient deaths were reported across the Trust in April; 95 were reported at York and 68 were reported at Scarborough.

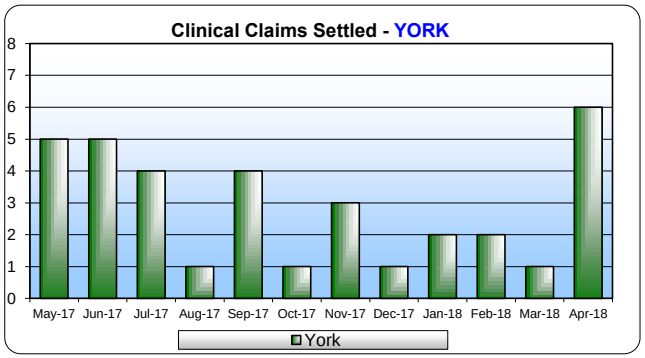
18 deaths in ED were reported in April; 10 at York and 8 at Scarborough.

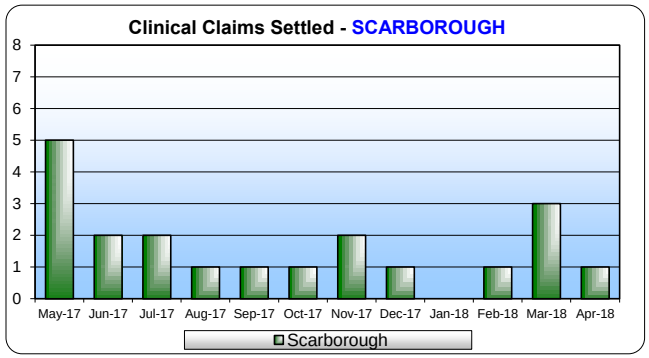
CQUINS update (Operations Team)

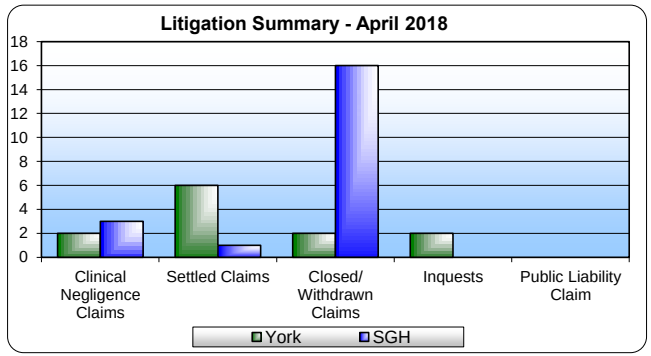
The Trust is currently collating evidence reports to show compliance against 2017/18 Q4 CQUINs, please refer to CQUINS page 4 for details.

Litigation

Indicator	Site	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Clinical Negligence Claims Received	York	7	10	8	10	7	6	7	6	10	12	5	2
	Scarborough	8	7	5	6	3	6	5	4	4	4	8	3
Clinical Claims Settled	York	5	5	4	1	4	1	3	1	2	2	1	6
	Scarborough	5	2	2	1	1	1	2	1	0	1	3	1
Closed/ Withdrawn Claims	York	1	5	4	5	4	3	6	6	5	9	6	2
	Scarborough	1	4	7	1	3	7	6	4	0	14	6	16
Coroners Inquests Heard	York	2	3	6	3	4	1	3	9	3	2	7	2
	Scarborough	1	4	1	1	1	1	3	1	1	2	2	0



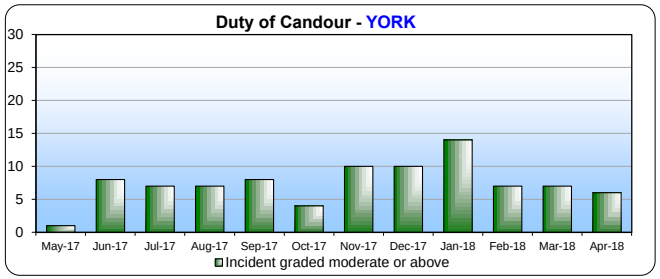


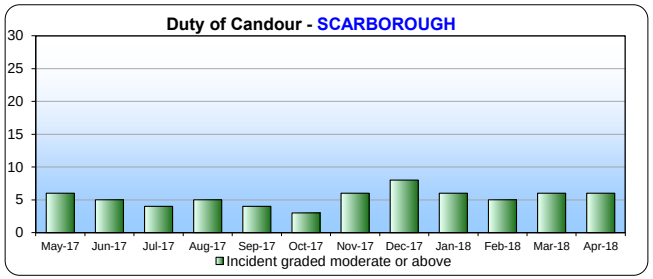


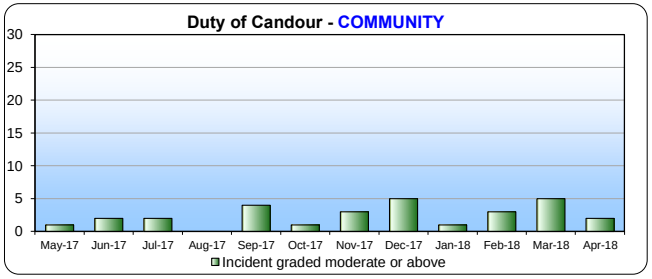
Duty of Candour

Indicator	Site	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Incident graded moderate or above	York	1	8	7	7	8	4	10	10	14	7	7	6
Verbal apology given		1	7	7	3	6	4	8	4	6	1	5	2
Written apology required		1	8	6	6	7	4	8	6	6	6	3	3
Written apology given		1	6	3	4	5	4	2	1	3	2	1	0
Incident graded moderate or above	Scarborough	6	5	4	5	4	3	6	8	6	5	6	6
Verbal apology given		4	5	3	4	1	3	5	5	3	4	6	4
Written apology required		6	4	3	5	4	3	4	7	2	3	4	3
Written apology given		4	3	3	4	1	3	1	1	1	0	2	1
Incident graded moderate or above	Community	1	2	2	0	4	1	3	5	1	3	5	2
Verbal apology given		1	2	2	0	4	1	1	3	0	1	2	2
Written apology required		1	1	2	0	3	0	2	2	0	3	4	1
Written apology given		1	2	1	0	3	0	1	1	0	1	1	1

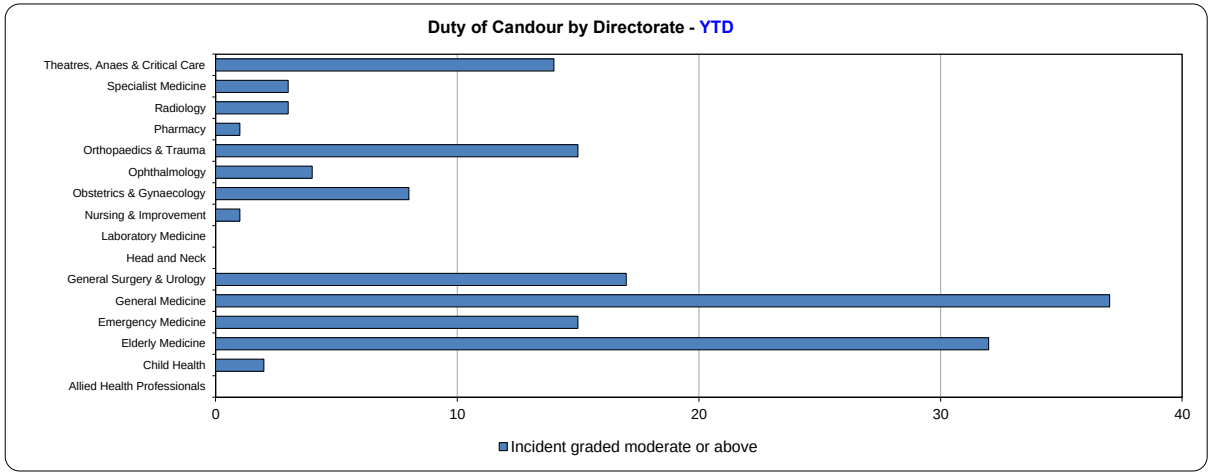
Note: data from April 2017 onwards all subject to ongoing validation.







Specialty	Indicator - YTD: Verbal apology given	Written apology required	Written apology given
Allied Health Professionals	0	2	0
Child Health	0	2	1
Elderly Medicine	21	23	12
Emergency Medicine	11	12	6
General Medicine	20	23	7
General Surgery & Urology	13	14	4
Head and Neck	0	0	0
Laboratory Medicine	0	0	0
Nursing & Improvement	1	0	0
Obstetrics & Gynaecology	8	8	8
Ophthalmology	3	4	4
Orthopaedics & Trauma	7	12	5
Pharmacy	1	1	1
Radiology	2	2	2
Specialist Medicine	3	2	1
Theatres, Anaesthetics & Critical Care	8	8	4



Patient Experience

PALS Contacts
There were 221 PALS contacts in April

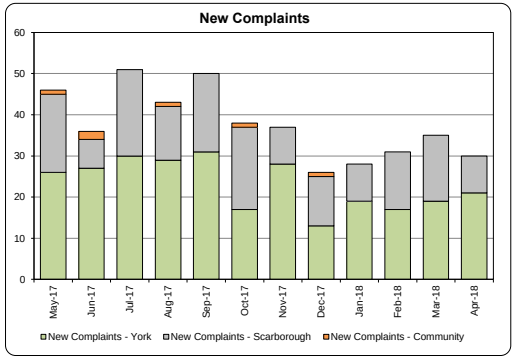
Complaints
There were 30 complaints in April

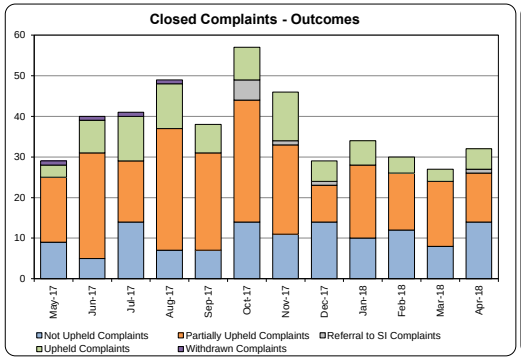
New Ombudsman Cases
There were 0 new Ombudsman Cases in April

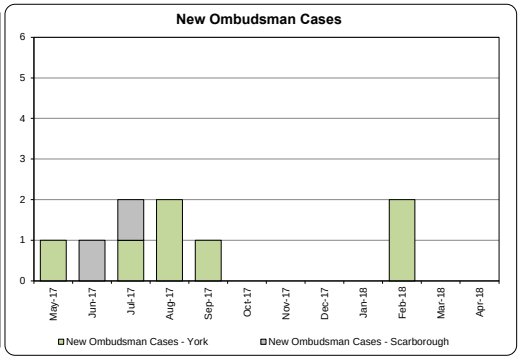
Compliments
630 compliments were received in April 2018. The number of compliments per month peaked in September 2017 with 1,519 being received. During Quarter 4 17/18 the number of compliments received was 1,854, compared to 2,092 for Quarter 3 17/18.

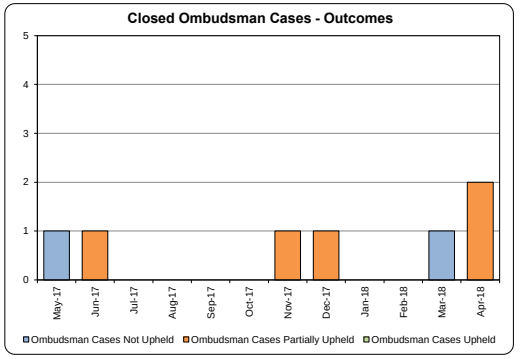
Patient Experience

May-18



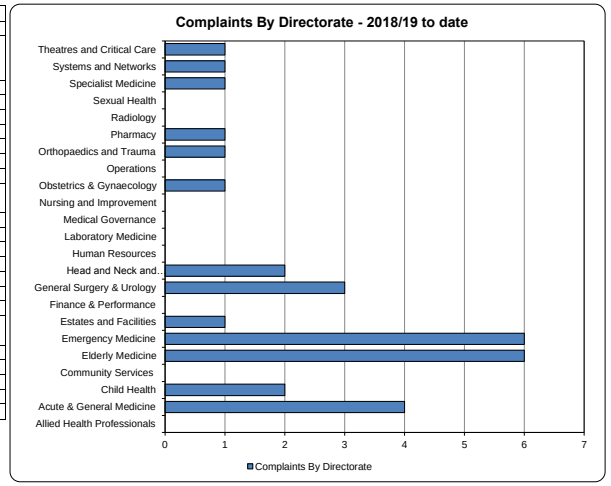






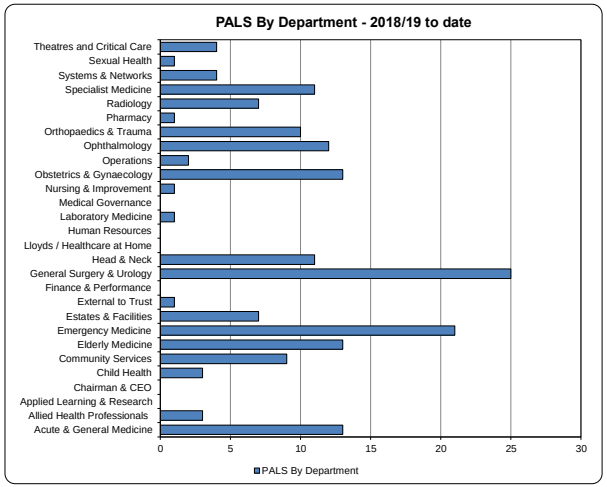
Complaints By Subject	Apr-18	YTD
Access to treatment or drugs	0	0
Admissions, Discharge and Transfer Arrangements	10	10
All aspects of Clinical Treatment	21	21
Appointments, Delay/Cancellation	2	2
Commissioning	0	0
Comms/info to patients (written and oral)	12	12
Complaints Handling	0	0
Consent	0	0
End of Life Care	0	0
Facilities	2	2
Mortuary	0	0
Others	0	0
Patient Care	17	17
Patient Concerns	1	1
Prescribing	0	0
Privacy and Dignity	7	7
Restraint	0	0
Staff Numbers	0	0
Transport	0	0
Trust Admin/Policies/Procedures	1	1
Values and Behaviours (Staff)	7	7
Waiting times	1	1
TOTAL	**81**	**81**

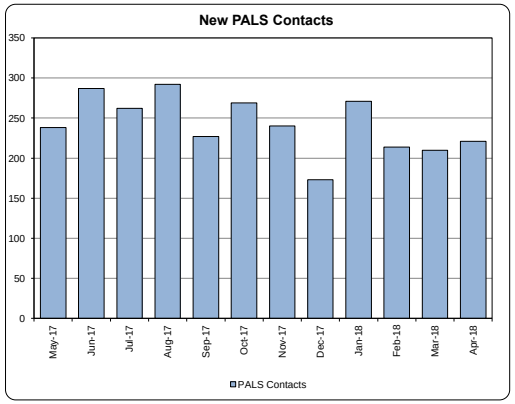
The number of complaints/PALs contacts by subject is greater than the total number of complaints because each subject within the complaint can be identified as opposed to just the one deemed to be the 'primary'.

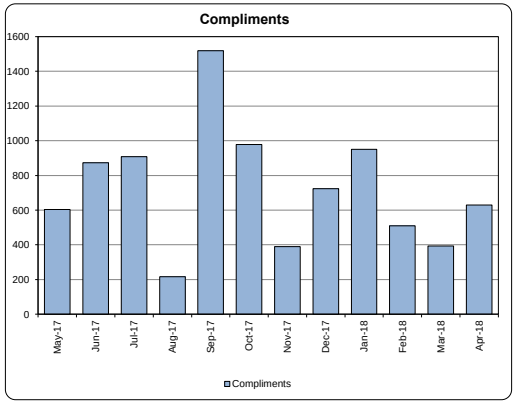


PALS By Subject	Apr-18	YTD
Access to Treatment or Drugs	18	18
Admissions and Discharges (Excluding Delayed Discharge due to absence of care package)	13	13
Appointments	35	35
Clinical Treatment	32	32
Commissioning	2	2
Communication	31	31
Consent	0	0
End of Life Care	1	1
Facilities	8	8
Integrated Care (including Delayed Discharge Due to Absence of a Care Package	0	0
Mortuary	0	0
Patient Care	15	15
Patient Concerns	11	11
Prescribing	3	3
Privacy, Dignity & Respect	3	3
Staff Numbers	2	2
Transport	0	0
Trust Admin/Policies/Procedures Inc. pt. record management	11	11
Values and Behaviours (Staff)	29	29
Waiting Times	7	7
Total	**221**	**221**

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.

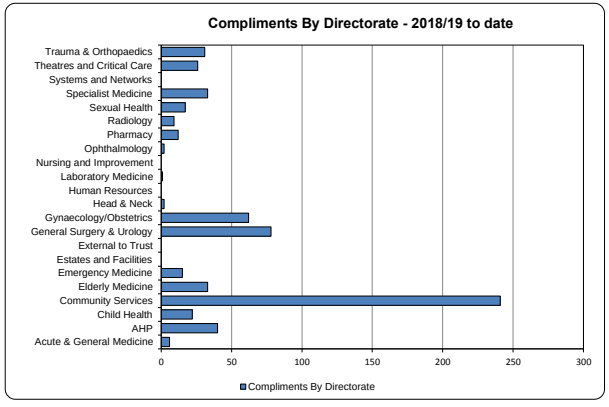






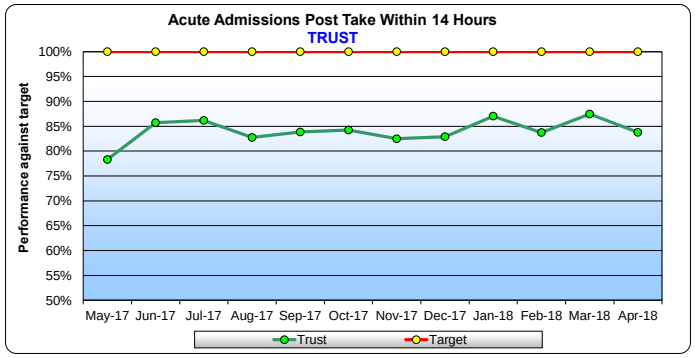
Compliments By Directorate	Apr-18	YTD
Acute & General Medicine	6	6
AHP	40	40
Child Health	22	22
Community Services	241	241
Elderly Medicine	33	33
Emergency Medicine	15	15
Estates and Facilities	0	0
External to Trust	0	0
General Surgery & Urology	78	78
Gynaecology/Obstetrics	62	62
Head & Neck	2	2
Human Resources	0	0
Laboratory Medicine	1	1
Nursing and Improvement	0	0
Ophthalmology	2	2
Pharmacy	12	12
Radiology	9	9
Specialist Medicine	33	33
Systems and Networks	0	0
Theatres and Critical Care	26	26
Trauma & Orthopaedics	31	31
Total	**630**	**630**

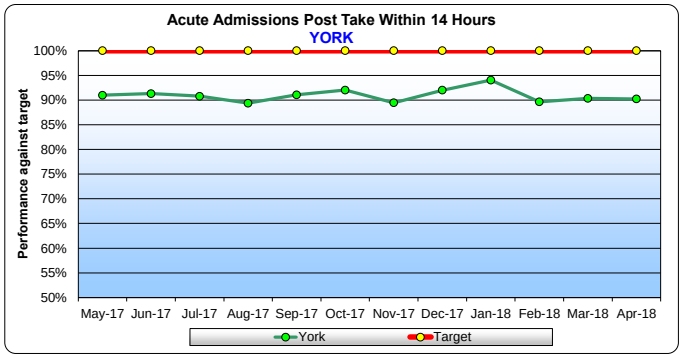
Up until December 2016 compliments reported were only those received directly by the Chief Executive and PALS. From January 2017 numbers from wards and departments are included

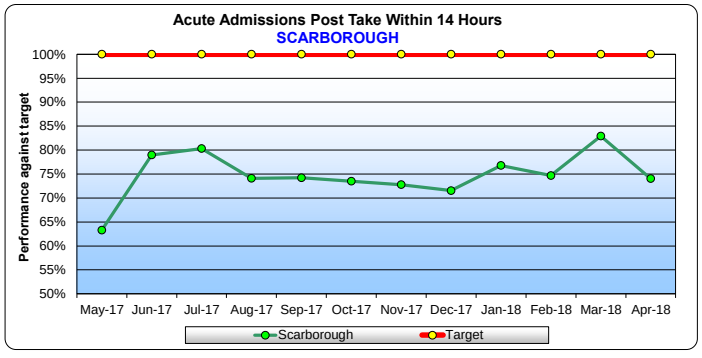


Quality and Safety: Care of the Deteriorating Patient

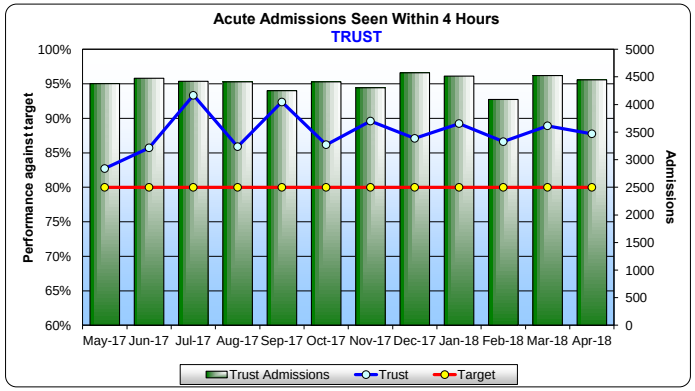
Indicator	Consequence of Breach (Monthly unless specified)	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Feb	Mar	Apr
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival (YORK) - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	91%	90%	91%	91%	90%	90%	90%
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival (SCARBOROUGH) - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	71%	76%	73%	78%	75%	83%	74%

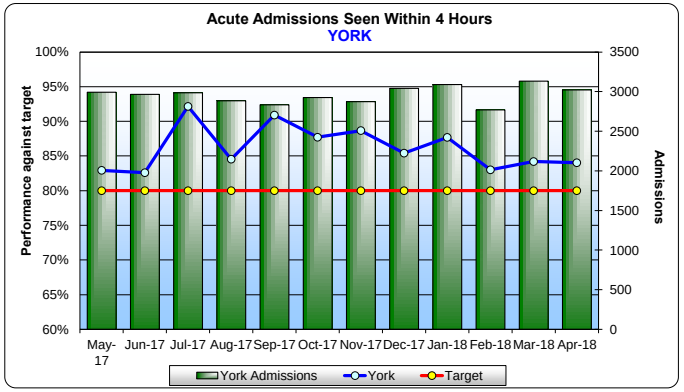


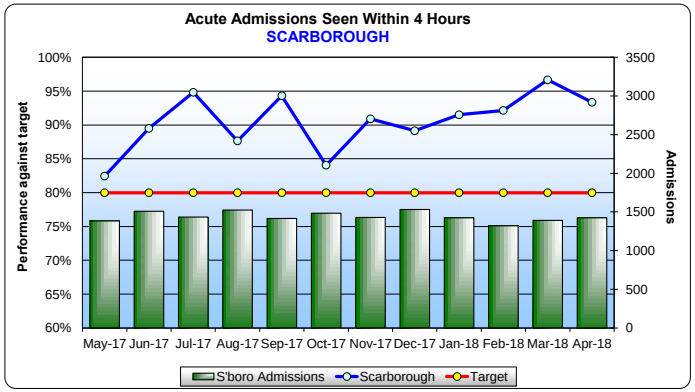




Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	**80% by site**	84.4%	90.5%	87.6%	88.3%	86.6%	88.9%	87.8%

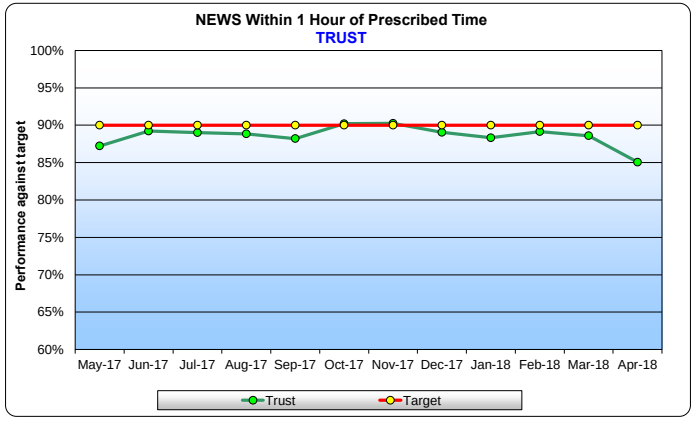


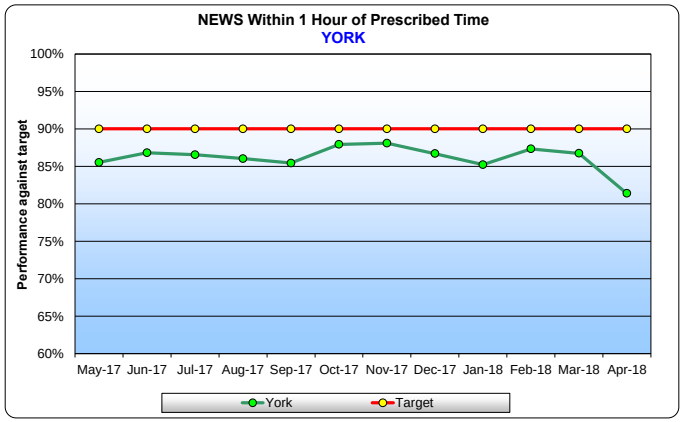


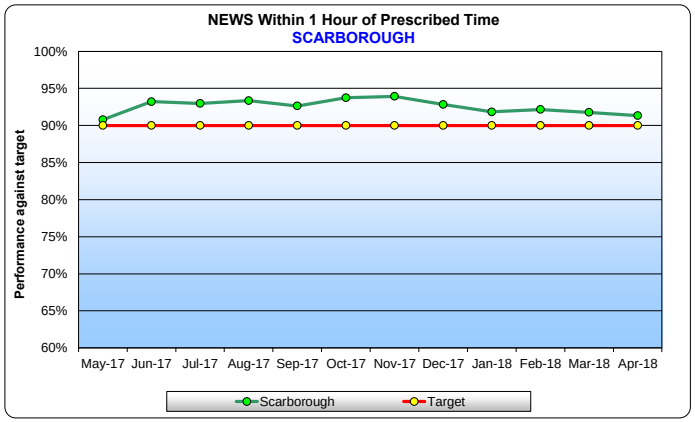


Quality and Safety: Care of the Deteriorating Patient

Indicator	Consequence of Breach (Monthly unless specified)	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Feb	Mar	Apr
NEWS within 1 hour of prescribed time	None - Monitoring Only	88.7%	88.7%	89.8%	88.7%	89.1%	88.6%	85.1%







Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 19 SIs reported in April; York 4, Scarborough 10, Community 5.

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 132 reports of patients falling at York Hospital, 74 patients at Scarborough and 33 patients within the Community Services (239 in total).

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during April was 1,251; 677 incidents were reported on the York site, 401 on the Scarborough site and 173 from Community Services.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 656 incidents awaiting sign-off by the Directorate Management Teams.

Pressure Ulcers (source: Datix)
During April 62 pressure ulcers were reported to have developed on patients since admission to York Hospital, 35 pressure ulcers were reported to have developed on patients since admission to Scarborough and 26 pressure ulcers were reported as having developed on patients in our community hospitals or community care. These figures should be considered as approximations as not all investigations have been completed.

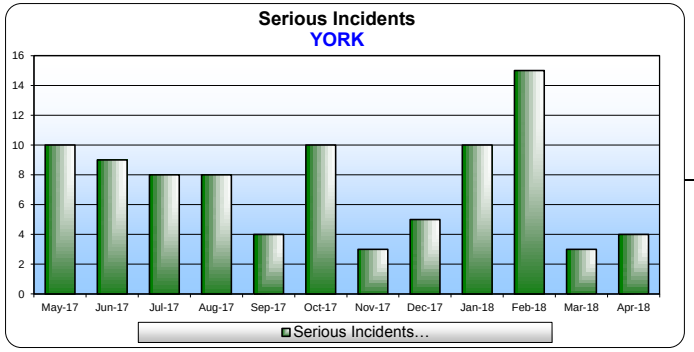
Degree of Harm: Serious/Severe or Death (source: Datix)
During April 4 patient incidents were reported which resulted in serious or severe harm or death. Numbers are subject to change as levels of harm are reviewed and investigations are completed.

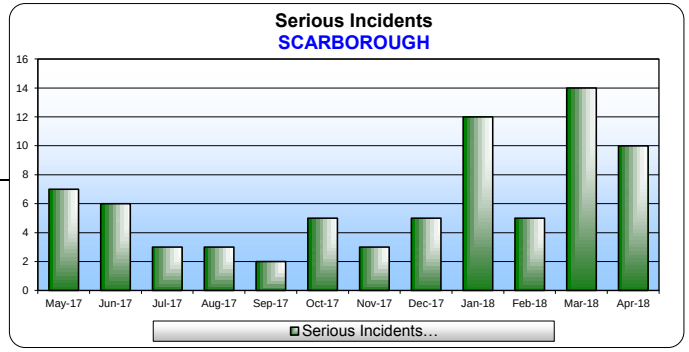
Medication Related Issues (source: Datix)
During April there were a total of 107 medication related incidents reported although this figure may change following validation.

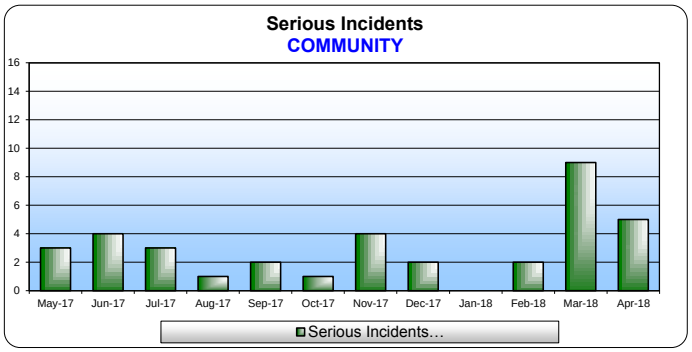
Never Events – No Never Events were declared during April.

Measures of Harm

Indicator		May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
Serious Incidents source: Risk and Legal	York	10	9	8	8	4	10	3	5	10	15	3	4
	Scarborough	7	6	3	3	2	5	3	5	12	5	14	10
	Community	3	4	3	1	2	1	4	2	0	2	9	5
Serious Incidents Delogged source: Risk and Legal (Trust)		0	0	2	1	0	2	0	0	0	3	6	7

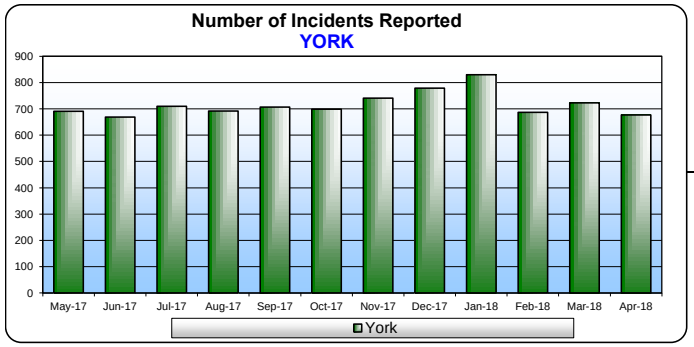


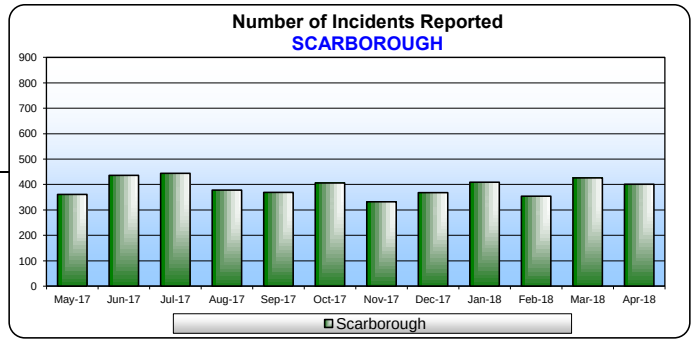


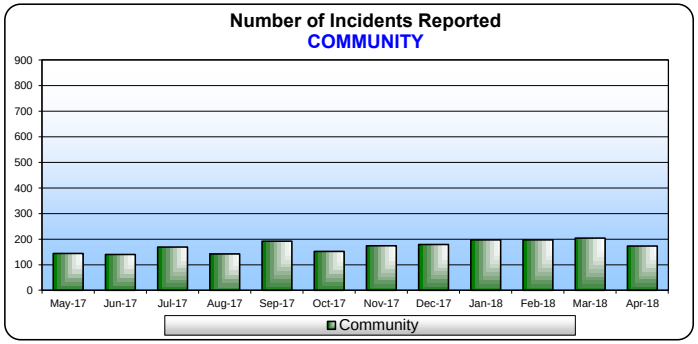


Note - 12 Hour breaches are listed as Operations for the Directorate Investigating (although the location is ED).

Indicator		May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
Number of Incidents Reported source: Risk and Legal	York	691	669	710	692	707	699	741	779	830	687	723	677
	Scarborough	361	436	444	378	369	406	332	368	409	354	426	401
	Community	144	140	169	142	192	152	174	179	197	197	204	173
Number of Incidents Awaiting sign off at Directorate level		698	746	868	832	766	733	684	892	900	883	837	656

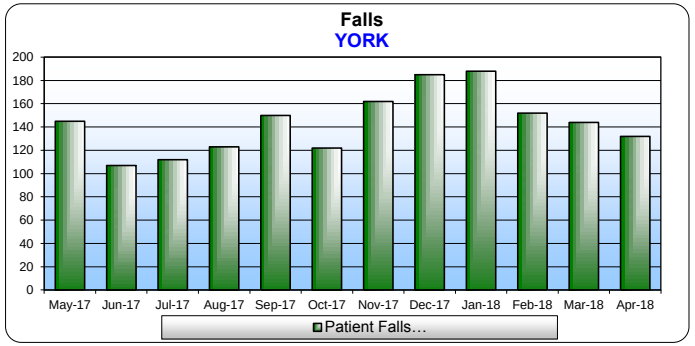


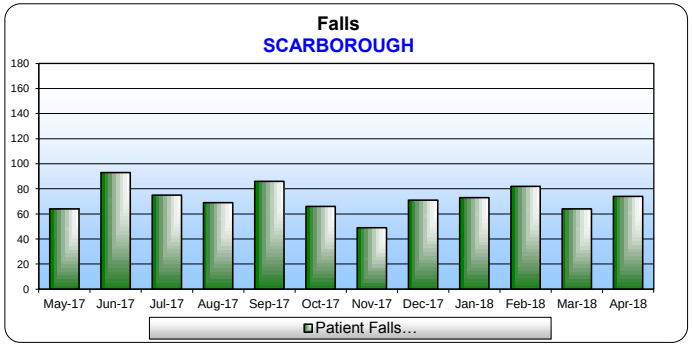


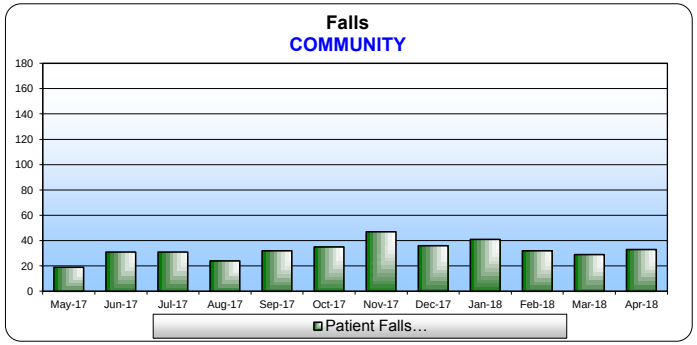


Measures of Harm

Indicator		May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
Patient Falls source: DATIX	York	145	107	112	123	150	122	162	185	188	152	144	132
	Scarborough	64	93	75	69	86	66	49	71	73	82	64	74
	Community	19	31	31	24	32	35	47	36	41	32	29	33

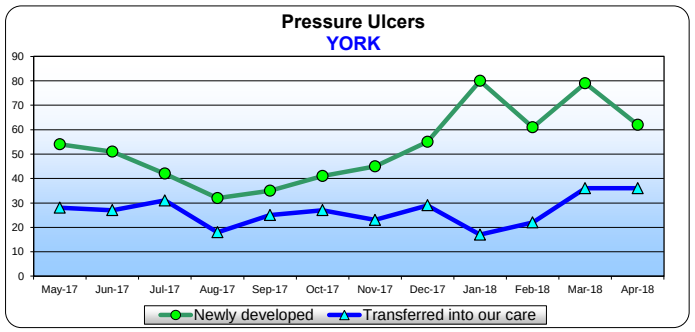


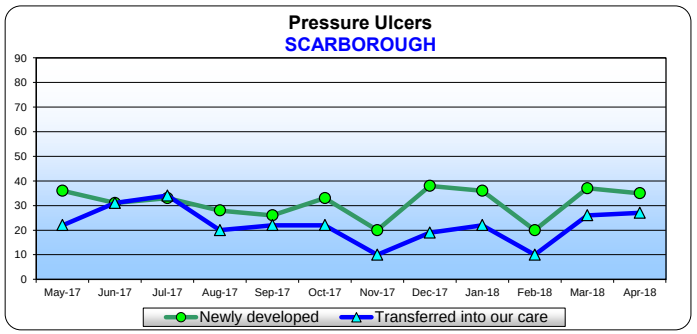


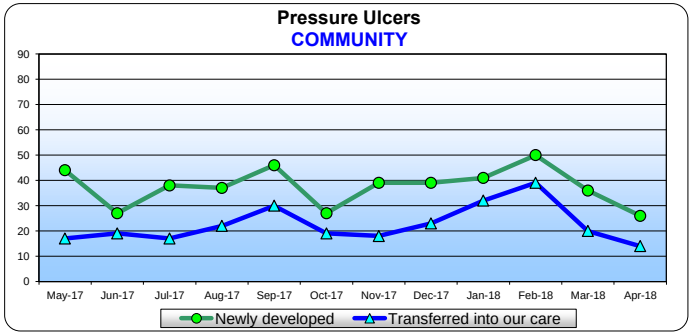


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.
Increases in the number of falls in January 17 and December 18 reflect the increase in the number of frail and elderly patients in hospital.

Indicator			May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
Pressure Ulcers source: DATIX	York	Newly developed	54	51	42	32	35	41	45	55	80	61	79	62
		Transferred into our care	28	27	31	18	25	27	23	29	17	22	36	36
	Scarborough	Newly developed	36	31	33	28	26	33	20	38	36	20	37	35
		Transferred into our care	22	31	34	20	22	22	10	19	22	10	26	27
	Community	Newly developed	44	27	38	37	46	27	39	39	41	50	36	26
		Transferred into our care	17	19	17	22	30	19	18	23	32	39	20	14



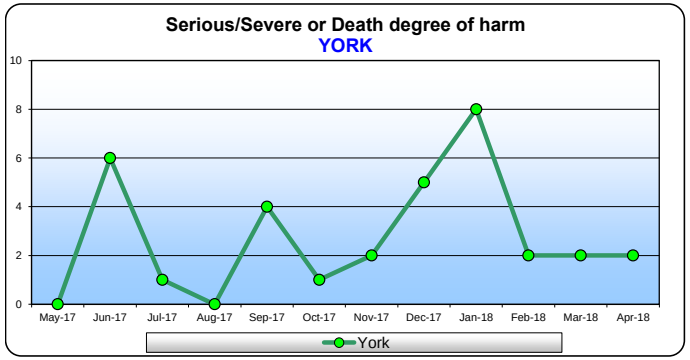


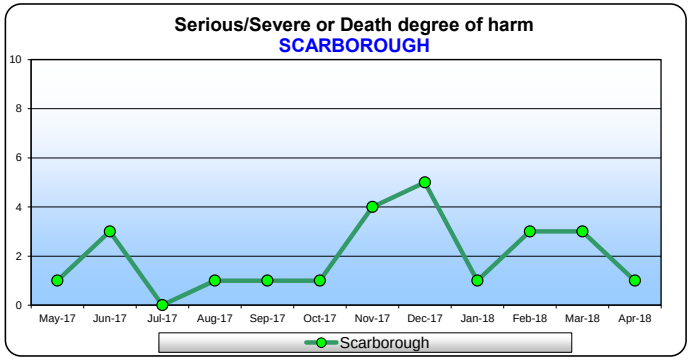


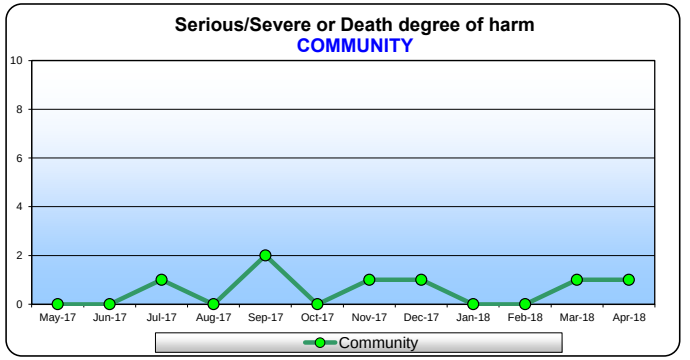
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised 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.
Increases in December 17 and January 18 reflect the increase in the number of frail and elderly patients in acute hospitals.

Measures of Harm

Indicator		May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
Degree of harm: serious/severe or death source: Datix	York	0	6	1	0	4	1	2	5	8	2	2	2
	Scarborough	1	3	0	1	1	1	4	5	1	3	3	1
	Community	0	0	1	0	2	0	1	1	0	0	1	1



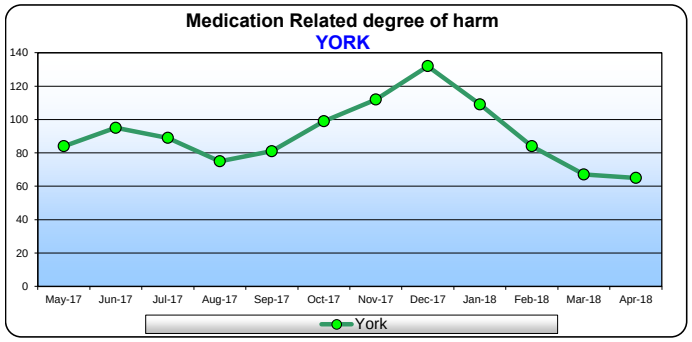


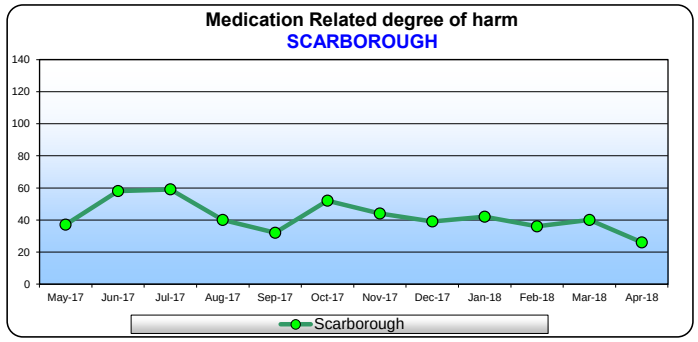


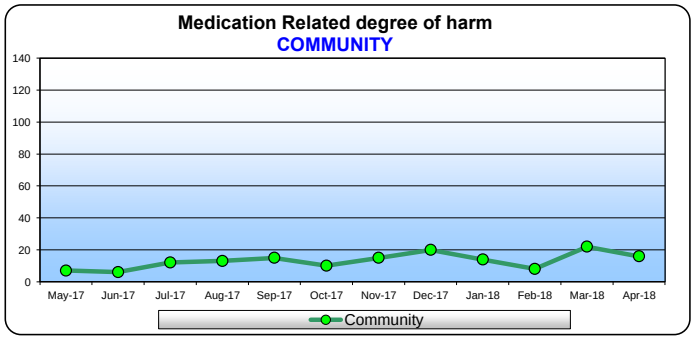
Note: data from October 2016 onwards all subject to ongoing validation

Indicator		May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
Degree of harm: Medication Related Issues source: Datix	York	84	95	89	75	81	99	112	132	109	84	67	65
	Scarborough	37	58	59	40	32	52	44	39	42	36	40	26
	Community	7	6	12	13	15	10	15	20	14	8	22	16

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.

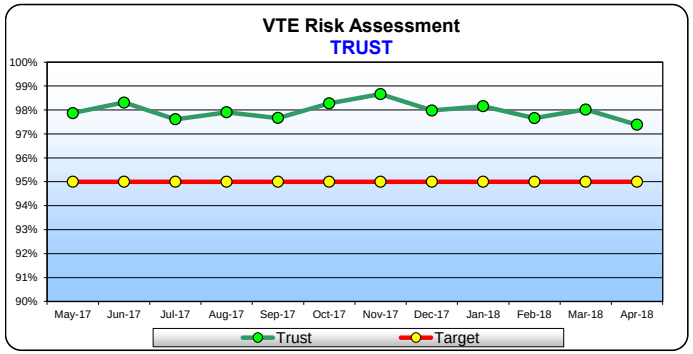


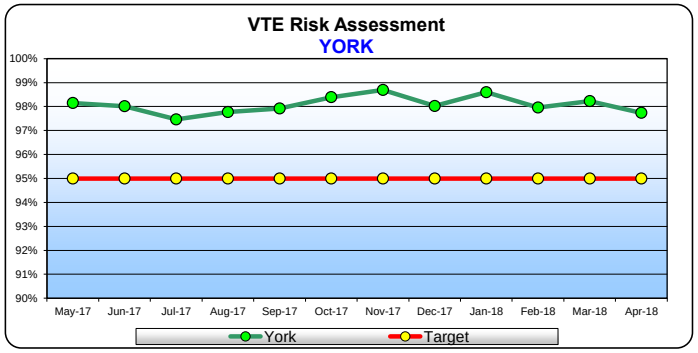


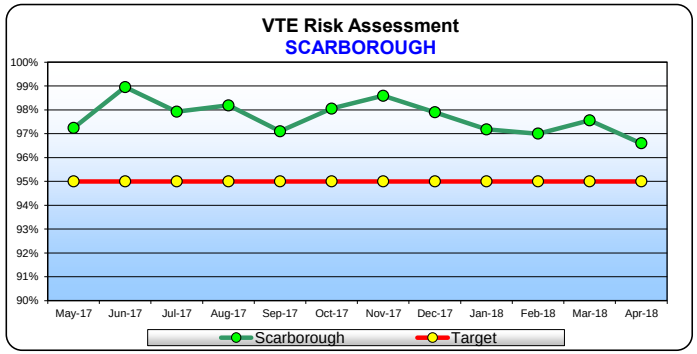


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	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%	98.2%	97.7%	98.4%	98.0%	97.7%	98.0%	97.4%
		York	95%	98.2%	97.7%	98.4%	98.3%	98.0%	98.2%	97.7%
		Scarborough	95%	98.1%	97.7%	98.3%	97.2%	97.0%	97.6%	96.6%







Never Events

Indicator	Consequence of Breach	Threshold	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Feb	Mar	Apr
SURGICAL									
Wrong site surgery	As below	>0	0	2	0	0	0	0	0
Wrong implant/prosthesis		>0	1	0	0	0	0	0	0
Retained foreign object post-operation		>0	0	0	0	0	0	0	0
MEDICATION									
Wrongly prepared high-risk injectable medication	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	>0	0	0	0	0	0	0	0
Maladministration of potassium-containing solutions		>0	0	0	0	0	0	0	0
Wrong route administration of chemotherapy		>0	0	0	0	0	0	0	0
Wrong route administration of oral/enteral treatment		>0	0	0	0	0	0	0	0
Intravenous administration of epidural medication		>0	0	0	0	0	0	0	0
Maladministration of insulin		>0	0	0	0	0	0	0	0
Overdose of midazolam during conscious sedation		>0	0	0	0	0	0	0	0
Opioid overdose of an opioid-naïve Service User		>0	0	0	0	0	0	0	0
Inappropriate administration of daily oral methotrexate		>0	0	0	0	0	0	0	0
GENERAL HEALTHCARE									
Falls from unrestricted windows	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	>0	0	0	0	0	0	0	0
Entrapment in bedrails		>0	0	0	0	0	0	0	0
Transfusion of ABO incompatible blood components		>0	0	0	0	0	0	0	0
Transplantation of ABO incompatible organs as a result of error		>0	0	0	0	0	0	0	0
Misplaced naso- or oro-gastric tubes		>0	0	0	0	0	0	0	0
Wrong gas administered		>0	0	0	0	0	0	0	0
Failure to monitor and respond to oxygen saturation		>0	0	0	0	0	0	0	0
Air embolism		>0	0	0	0	0	0	0	0
Misidentification of Service Users		>0	0	0	1	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

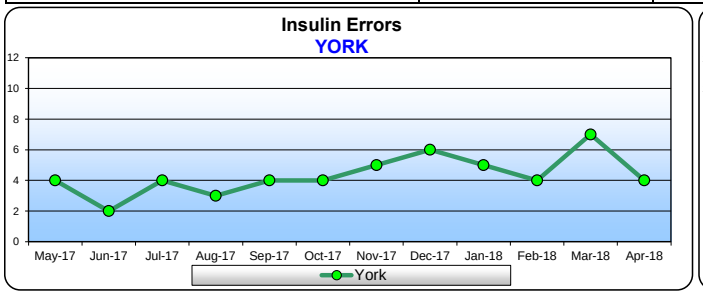
Prescribing Errors
There were 23 prescribing related errors in April; 13 from York, 8 from Scarborough and 2 from Community.

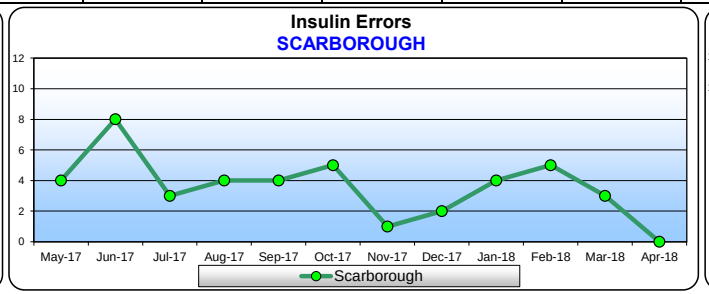
Preparation and Dispensing Errors
There were 13 preparation/dispensing errors in April; 8 from York, 3 from Scarborough and 2 from Community.

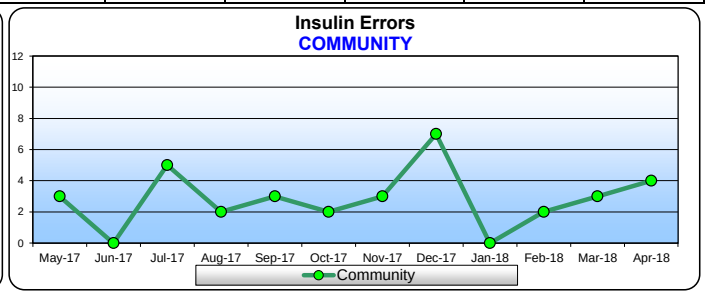
Administrating and Supply Errors
There were 44 administrating/supplying errors in April; 27 were from York, 8 from Scarborough and 9 from Community.

Drug Administration

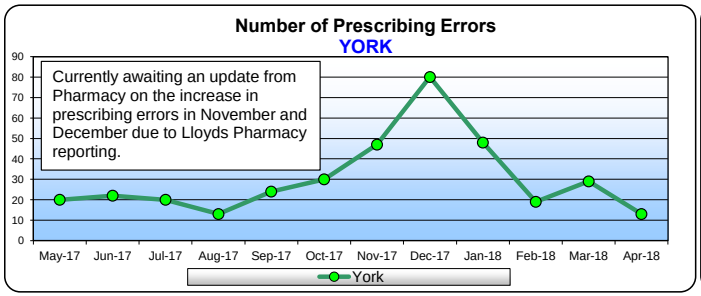
Indicator		May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
Insulin Errors source: Datix	York	4	2	4	3	4	4	5	6	5	4	7	4
	Scarborough	4	8	3	4	4	5	1	2	4	5	3	0
	Community	3	0	5	2	3	2	3	7	0	2	3	4

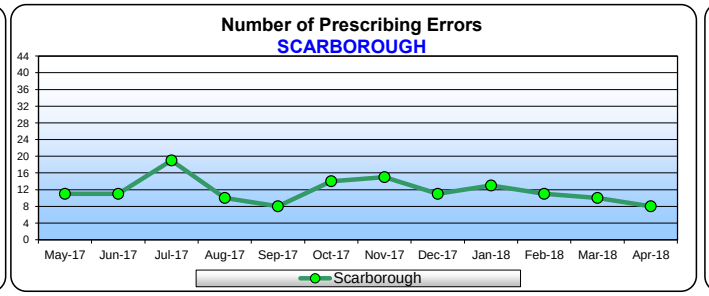


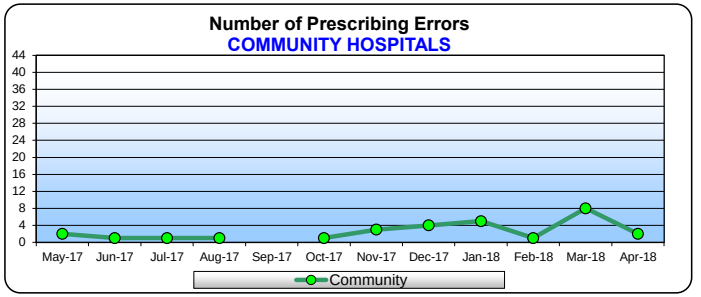




Indicator		May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
Number of Prescribing Errors source: Datix	York	20	22	20	13	24	30	47	80	48	19	29	13
	Scarborough	11	11	19	10	8	14	15	11	13	11	10	8
	Community Hospitals	2	1	1	1	0	1	3	4	5	1	8	2

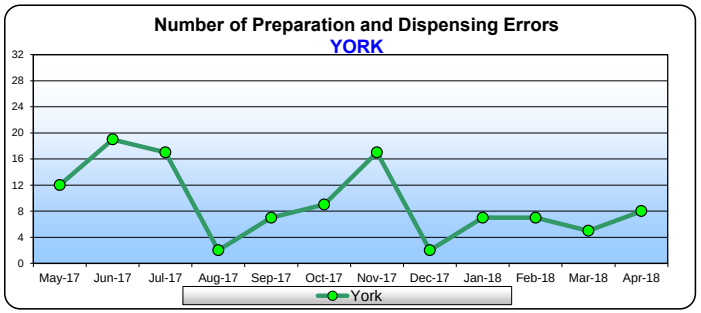


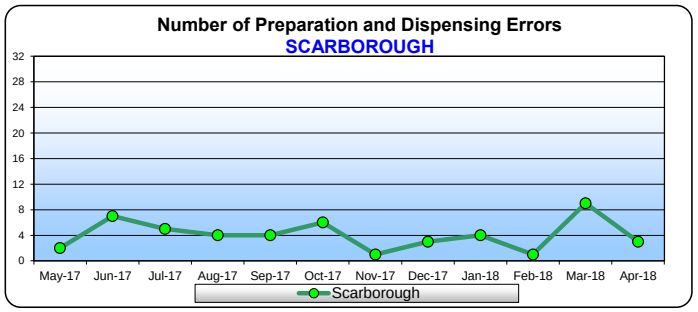


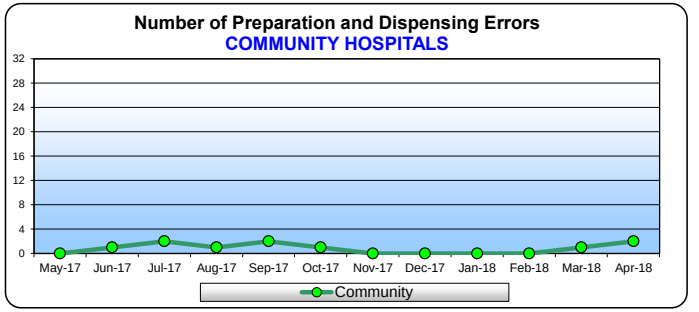


Drug Administration

Indicator		May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
Number of Preparation and Dispensing Errors source: Datix	York	12	19	17	2	7	9	17	2	7	7	5	8
	Scarborough	2	7	5	4	4	6	1	3	4	1	9	3
	Community Hospitals	0	1	2	1	2	1	0	0	0	0	1	2

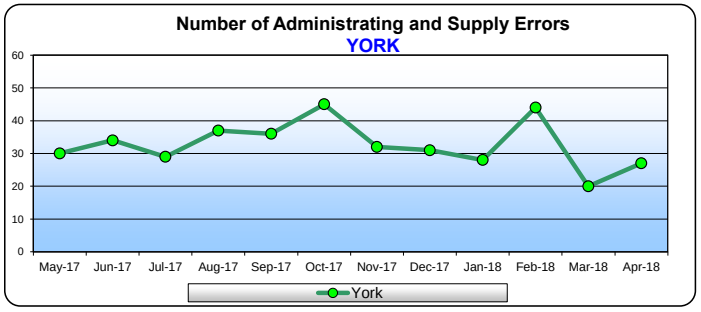


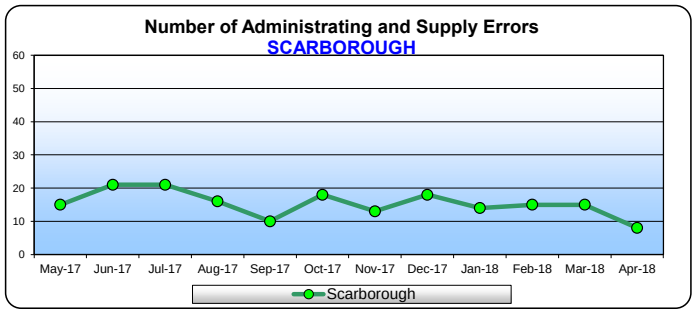


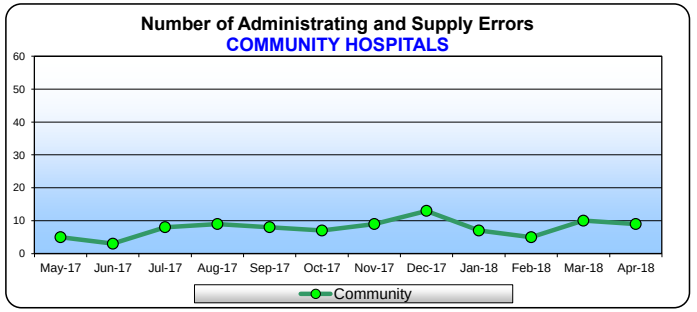


Note re increase in Dispensing Errors - Healthcare at Home have recently experienced a high turnover of staff which has contributed to the increase in errors as the service has mostly been delivered by locums. The vacancies are currently being recruited to and a new manager has been appointed. Trust 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 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
Administrating and Supply Errors source: Datix	York	30	34	29	37	36	45	32	31	28	44	20	27
	Scarborough	15	21	21	16	10	18	13	18	14	15	15	8
	Community Hospitals	5	3	8	9	8	7	9	13	7	5	10	9







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.

Mortality

Indicator	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	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar -17	Jul 16 - Jun 17	Oct 16 - Sep 17
SHMI – York locality	97	96	95	93	94	95	96	94	94	93	93	95
SHMI – Scarborough locality	107	108	107	107	108	107	106	106	104	105	106	108
SHMI – Trust	**101**	**101**	**99**	**99**	**99**	**100**	**99**	**98**	**97**	**97**	**98**	**100**

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 October 2016 - September 2017 SHMI saw a 2 point increase for York, a 2 point increase for Scarborough and a 2 point increase for the Trust. Trust - 100, York 95 and Scarborough 108.

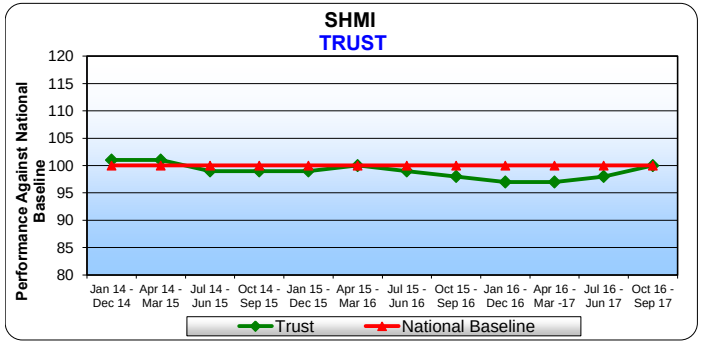
178 inpatient deaths were reported across the Trust in April. 95 deaths were reported at York Hospital, this compares favourably with April 2017 (12% decrease). 68 deaths were reported at Scarborough, a 25.9% increase on April 2017. The Trust saw a total of 15 deaths across the Community sites in April 2018, an increase on the 11 recorded in April 2017.

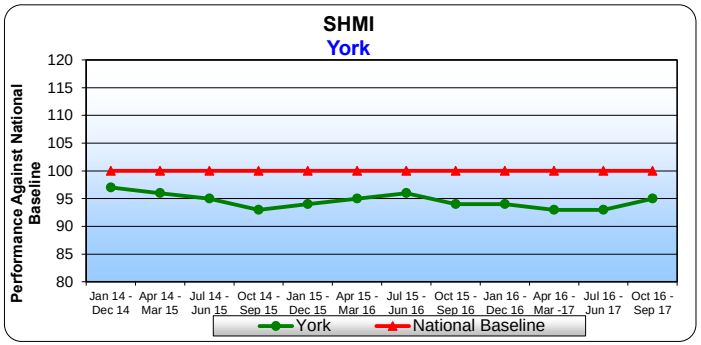
18 deaths in ED were reported in April; 10 at York and 8 at Scarborough. This is an increase on April 2017 (12 deaths in total; 4 at York and 8 at Scarborough).

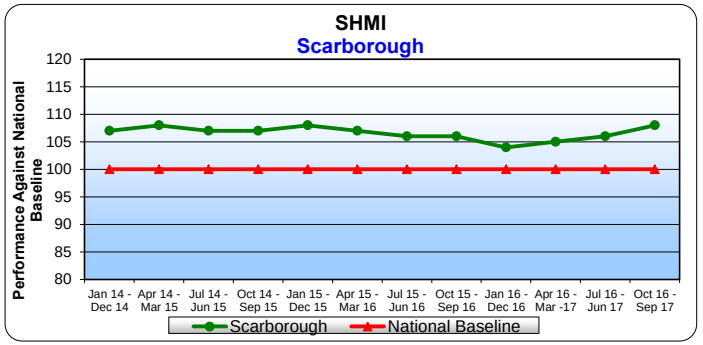
Mortality

York Teaching Hospital NHS
NHS Foundation Trust

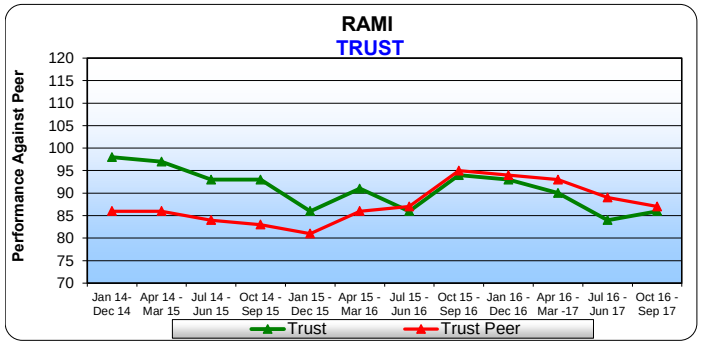
Indicator	Consequence of Breach (Monthly unless specified)	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar -17	Jul 16 - Jun 17	Oct 16 - Sep 17
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	100	99	98	97	97	98	100
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	95	96	94	94	93	93	95
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	107	106	106	104	105	106	108

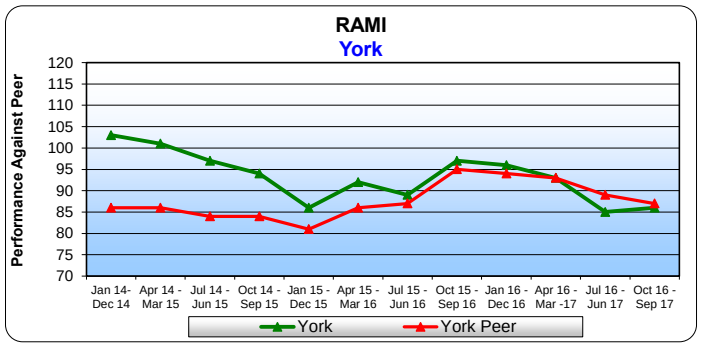


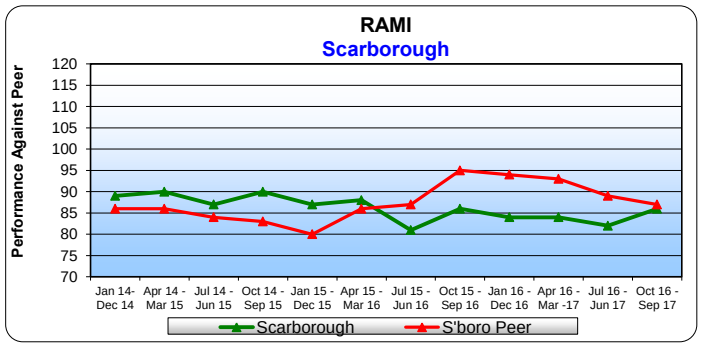




Indicator	Consequence of Breach (Monthly unless specified)	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar -17	Jul 16 - Jun 17	Oct 16 - Sep 17
Mortality – RAMI (TRUST)	**none - monitoring only**	91	86	94	93	90	84	86
Mortality – RAMI (YORK)	**none - monitoring only**	92	89	97	96	93	85	86
Mortality – RAMI (SCARBOROUGH)	**none - monitoring only**	88	81	86	84	84	82	86



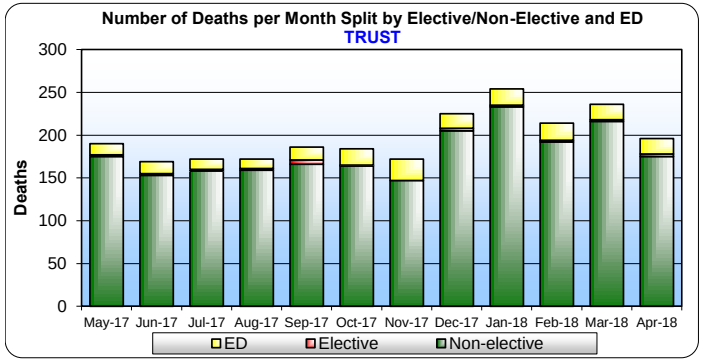


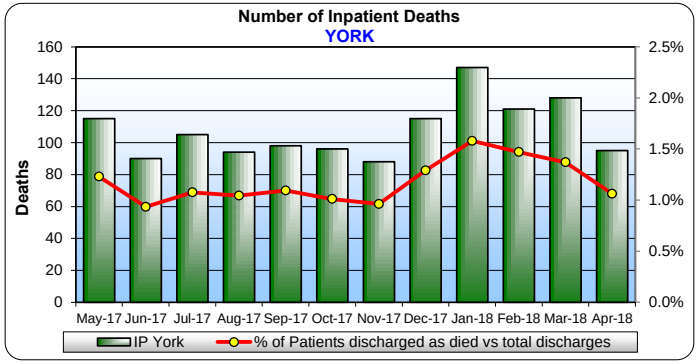


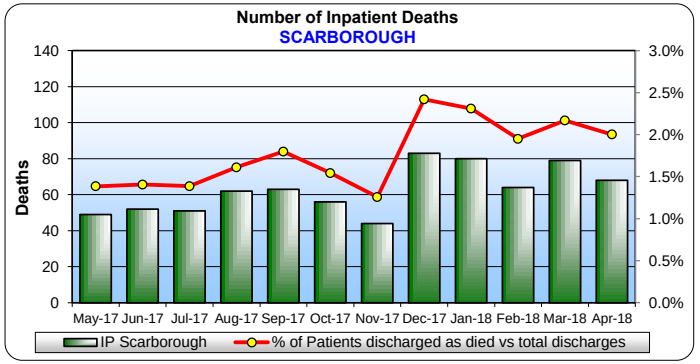
Mortality

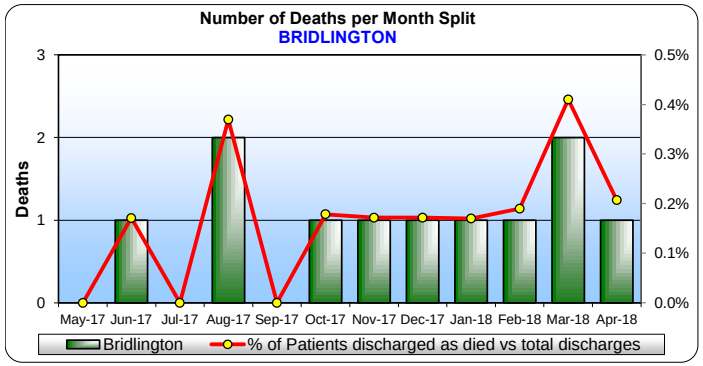
York Teaching Hospital NHS
NHS Foundation Trust

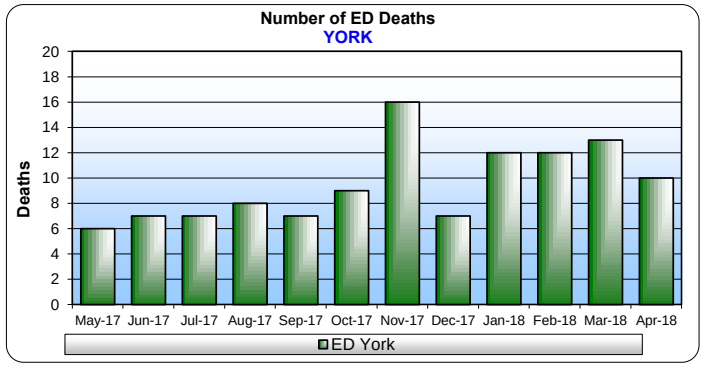
Indicator	Consequence of Breach (Monthly unless specified)	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Feb	Mar	Apr
Number of Inpatient Deaths	None - Monitoring Only	507	492	520	647	194	218	178
Number of ED Deaths	None - Monitoring Only	39	38	61	57	20	18	18

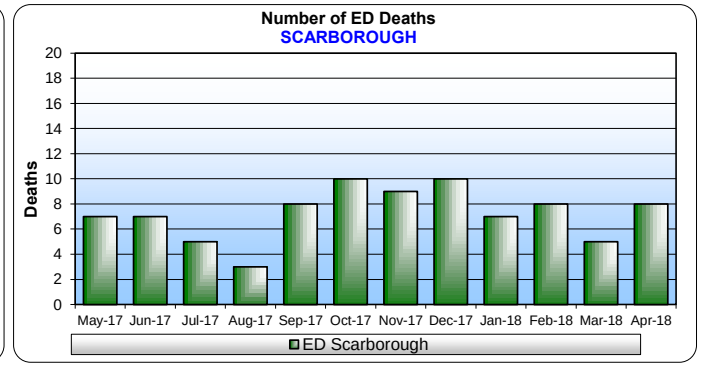


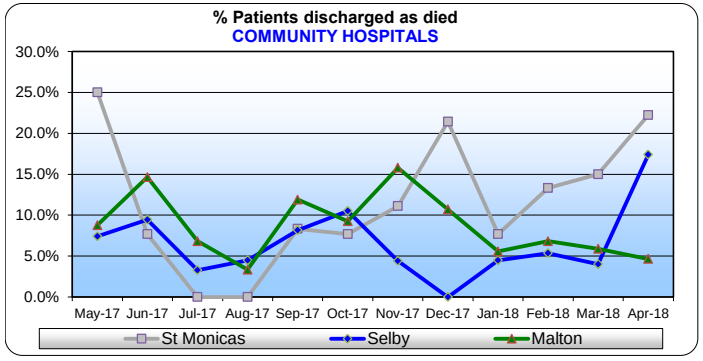


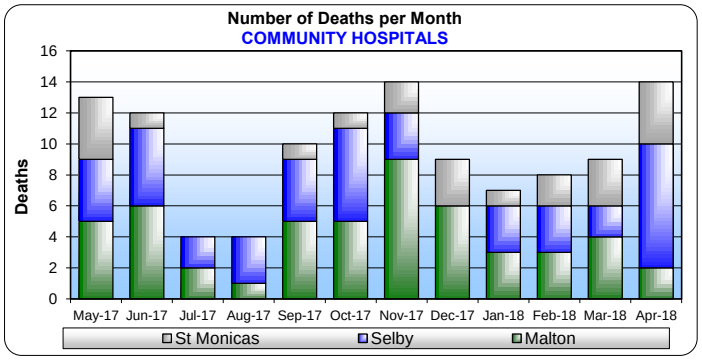












Month	Malton	Selby	St Monicas	Brid
May-17	5	4	4	0
Jun-17	6	5	1	1
Jul-17	2	2	0	0
Aug-17	1	3	0	2
Sep-17	5	4	1	0
Oct-17	5	6	1	1
Nov-17	9	3	2	1
Dec-17	6	0	3	1
Jan-18	3	3	1	1
Feb-18	3	3	2	1
Mar-18	4	2	3	2
Apr-18	2	8	4	1

Patient Safety Walkrounds – April 2018

Date	Location	Participants	Actions & Recommendations
04/04/2018	St Helens Community Hospital	Andrew Bertram – Director of Finance Sharon Hurst- Operational Manager, Selby and South York Donna Gibson – Deputy Sister Debra Naylor – Allied Health Professionals Team Leader	Amber result for Ward Accreditation undertaken in August 2017. **Action** – Ward is ready for re-audit. Adjustable height chairs required. **Action** – Debra Naylor to order via Andrew Bertram through hospital charitable funds. Electric recliner chair requested. **Action** – Debra Naylor to order via Andrew Bertram through hospital charitable funds. Inpatient hoists are different to the hoists that are available in the patients' homes. **Action** – Consider purchasing or hiring similar equipment to practice with whilst the patient undergoes their programme of rehabilitation at St Helens. New mattresses required. Not included in the acute trust roll out. **Action** – Andrew Bertram to speak to Sam Haigh tissue viability nurse re St Helens to be included and given a date for roll out. Minor works required to move Controlled Drug Cupboard. **Action** – Donna Gibson to submit request. Stores are ordered by nursing staff. Risk of over ordering. **Action** – Ian Willis's team to support new ordering system and craven shelving in clinical room. Minor works required to clinical room to accommodate craven shelving. **Action** – Submit request. Large lounge converted to store room. **Action** – Multi-disciplinary team to decide how best to re-define the large room – Donna Gibson and Debra Naylor to lead. Patient shower to be refurbished. **Action** – Sharon Hurst to submit "wet room" style plans. (Waiting for Damian Moon to respond with specification.) Time between breakfast and lunch is too short to facilitate rehabilitation for majority of patients as most like to rest after lunch. **Action** – Sharon Hurst to request lunch at 1pm to extend the morning to increase rehabilitation time for patients. Most rehabilitation occurs in the morning but this coincides with consultant MDT/Ward rounds. **Action** – Sharon Hurst to request to move the ward round/MDT to the afternoon. To discuss with elderly medicine DM as moving the time will impact on consultant job plans. Occupational therapy kitchen is no longer used to assess patients' ability to prepare a hot drink or food. **Action** – Reconsider the functionality of the space – Debra Naylor to lead. To consider having an activity co-ordinator to enhance the patient experience. **Action** – Sharon Hurst to contact volunteers at YH to ascertain the possibilities of having a volunteer to assist with activities/hobbies as directed by the occupational therapist.
19/04/2018	Macmillan Unit Dermatology OPD, Scarborough	Mike Proctor – Executive Director Karen Cowley – Directorate Manager Carol Halton – Matron Mike Keaney –Non – Executive Director	**Dermatology OPD** Space and staff capacity to meet the demand on the service. Staff aware of directorate plans. **Action** – Continue to work with team to improve environment. **Chemotherapy Unit** Space within unit. **Action** – No staff gaps, unit vastly improved in airiness, décor and feel, not cramped since mobile unit commenced. **Bronte Unit** Space to meet the demand on the service. Staff aware of directorate plans. **Action** – Continue to develop area using charitable funds.

YORK - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Activity	Births	Bookings	1st m/w visit	CPD	≤302	303-329	≥330	288	301	287	294	295	301	294	186	315	284	311	248
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	88.9%	88.0%	87.5%	87.1%	85.1%	91.4%	92.2%	82.3%	91.1%	94.0%	89.7%	87.5%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10.1%-19.9%	>20%	5.9%	7.3%	5.9%	4.8%	7.1%	5.3%	4.4%	5.9%	7.3%	4.2%	7.1%	5.2%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	64.70%	81.80%	70.60%	71.40%	81.00%	68.80%	76.90%	54.50%	87.00%	83.30%	68.20%	69.20%
		Births	No. of babies	CPD	≤295	296-309	≥310	267	259	273	269	302	272	264	253	250	243	256	257
		No. of women delivered	No. of mothers	CPD	≤295	296-310	≥311	263	253	269	262	297	269	261	250	248	241	251	254
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	0	0	0	1	0	0	0	0	0	0	1	0
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	0	1	0	0	0	0	0	0	1	0
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	0	3	2	1	4	0	0	0	0	0	0	2
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	1	0	0	0	0	0	0	0	0
		SCBU at capacity (since May 2017)	No of times	SCBU				0	0	0	2	0	0	0	0	0	0	0	0
		SCBU at capacity of intensive cots	No. of times	SCBU				2	0	1	3	0	2	1	0	0	0	0	0
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more	0	0	0	0	0	0	1	0	0	0	0	0
Workforce	Staffing	MW to birth ratio	Ratio	Matron	≤29.5	29.6 - 30.9	>31	35	34	34	30	30	32	34	31	30	31	30	32
		1 to 1 care in Labour	CPD	CPD	100%	80% - 99.9%	≤79.9%	76.0%	77.5%	72.5%	73.7%	68.0%	72.1%	73.1%	86.4%	80.2%	82.6%	78.5%	82.3%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	100%	80% - 99.9%	≤79.9%	69.0%	65.0%	62.0%	51.0%	50.0%	62.0%	68.0%	84.0%	89.0%	60.7%	77.0%	71.6%
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	76	76	76									
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10	4-9	≤3	10	10	10	10	10	10	10	10	10	10	10	10
Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%	61.9%	58.9%	63.2%	59.6%	62.9%	49.1%	61.4%	59.2%	58.9%	57.7%	57.6%	51.5%
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	9.9%	14.6%	11.2%	10.7%	10.1%	15.2%	14.6%	15.2%	11.7%	14.1%	13.5%	15.4%
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	28.1%	26.1%	25.3%	29.8%	27.6%	35.3%	23.8%	24.4%	29.0%	27.8%	29.5%	32.7%
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	1	1	1	1	2	1	1	1	2	1	1	1
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	11	23	12	14	23	18	9	11	11	17	13	7
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	1	5	4	3	4	1	3	6	2	2	4	2
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	2	0	0	0	2	1	0	0	1	0	1	0
		NHS Resolution cases	No of cases		0	1	2 or more	2	0	0	0	2	0	0	0	0	0	1	0
	Morbidity	Neonatal Death	No of babies	Risk team- EBC	0		1 or more	1	0	0	0	0	0	0	0	0	0	1	0
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	1	0	3	1	0	2	0	1	0	1	1	0
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	1	0	0	0	0	0	0	0	0	0	0	0
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70.1%	<70%	77.6%	75.5%	73.6%	77.1%	75.8%	77.7%	80.8%	76.4%	73.0%	77.6%	78.1%	80.7%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	9.1%	6.7%	12.6%	11.5%	9.8%	7.1%	6.5%	8.8%	11.3%	12.4%	12.0%	6.3%
		SI's	No. of Si's declared	Risk Team	0		1 or more	4	1	0	1	0	1	0	0	0	0	0	0
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	4	8	9	9	9	9	7	5	10	9	8	5
		PPH > 1.5L as % of all women	% of births	CPD				1.5%	3.6%	3.3%	3.4%	3.0%	3.3%	2.7%	2.0%	4.0%	3.7%	3.2%	1.9%
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	2	2	3	6	1	1	3	4	1	1	2	1
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	1.6%	4.2%	2.9%	2.6%	2.7%	1.1%	2.5%	5.7%	2.2%	1.7%	2.2%	2.9%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	3	2	0	3	0	2	0	1	1	1	1	1
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	2	2	2	1	2	0	0	2	0	1	1	0

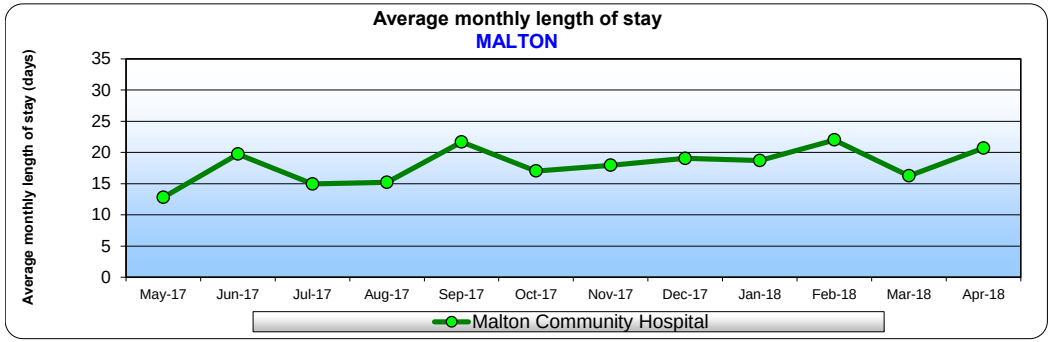
Maternity Dashboard metrics were reviewed on 01.08.2017

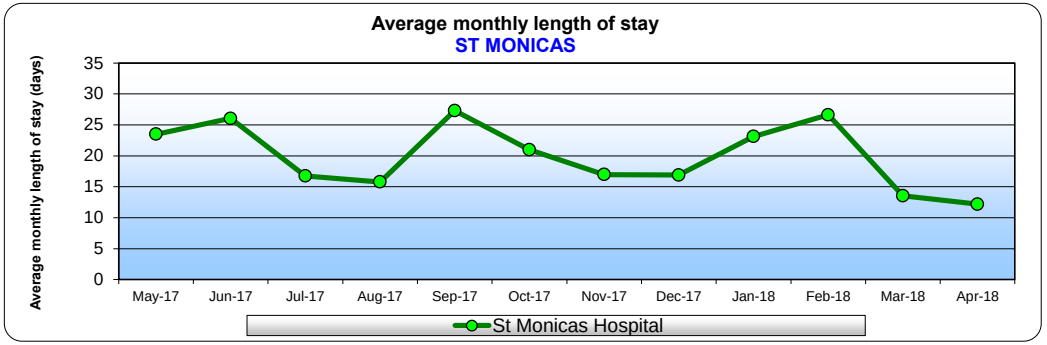
SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Activity	Births	Bookings	1st m/w visit	CPD	≤210	211-259	≥260	206	171	177	188	185	163	196	135	199	142	207	147
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	90.8%	89.5%	91.5%	90.4%	90.3%	88.3%	87.8%	88.9%	91.5%	93.0%	88.4%	89.1%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	8.3%	9.9%	6.8%	6.4%	8.1%	9.8%	9.7%	5.2%	5.5%	5.6%	8.7%	6.8%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	82%	82%	75%	92%	100%	94%	89%	86%	91%	100%	83%	90%
		Births	No. of babies	CPD	≤170	171-189	≥190	121	108	127	118	145	117	114	125	127	120	119	113
		No. of women delivered	No. of mothers	CPD	≤170	171-189	≥190	120	108	127	116	145	115	110	124	126	118	118	113
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	0	0	0	0	0	0	0	0	2	0	0	0
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	0	0	0	0	0	0	0	0	0	0
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	0	0	0	0	0	0	0	0	1	1	0	1
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		SCBU at capacity (since May 2017)	No of times	SCBU					1	0	0	0	2	6	2	5	2	11	0
		SCBU at capacity of intensive care cots	No. of times	SCBU				4	1	5	2	0	0	2	1	2	3	1	0
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more	0	0	0	1	0	2	3	3	0	0	7	0
Workforce	Staffing	M/W to birth ratio	Ratio	Matron	≤29.5	29.6-30.9	>31	24	24	24	24	26	25	25	26	25	25	25	24
		1 to 1 care in Labour	CPD	CPD	≥100%	80% - 99.9%	≤79.9%	80.8%	88.8%	82.7%	90.5%	91.0%	87.0%	88.2%	87.9%	86.5%	81.4%	80.5%	86.7%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%	80% - 99.9%	≤79.9%	88.3%	80.0%	75.8%	80.6%	55.0%	82.0%	73.3%	68.0%	87.0%	71.0%	69.0%	70.0%
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	40	40	40									
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	≥10	4-9	≤3	3	3	5	5	5	5	5	5	5	5	5	5
Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	CPD	≥60.6%	60.5-55%	<55%	66.9%	63.6%	63.6%	68.9%	68.5%	77.1%	63.2%	72.8%	78.0%	70.8%	58.0%	69.0%
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	5.8%	12.0%	7.1%	7.8%	8.3%	6.1%	10.9%	8.1%	4.0%	7.6%	13.6%	8.0%
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	27.5%	23.1%	27.6%	21.6%	22.8%	15.7%	27.3%	19.4%	18.3%	21.2%	28.0%	23.0%
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	0	0	1	0	3	1	0	0	0	1	0	1
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	2	4	5	1	3	1	2	4	0	3	5	3
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	5	3	2	1	2	2	0	4	4	0	0	2
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	0	0	1	0	1	0	0	1	0	0	0	0
		NHS Resolution cases	No of cases		0	1	2 or more	0	1	0	0	0	0	0	1	0	0	0	0
	Morbidity	Neonatal Death	No of babies	Risk team- EBC	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	1	0	1	0	0	0	1	1	0	0	0	0
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
	Risk Management	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	>74.4%	74.3-70.1%	<70%	54.2%	59.3%	57.5%	63.8%	55.2%	59.1%	59.1%	58.1%	65.9%	55.1%	61.0%	64.6%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	18%	19%	17%	25%	16%	22%	25%	18%	18%	22%	14%	14%
		SI's	No. of Si's declared	Risk Team	0		1 or more	0	1	0	0	0	0	0	0	0	0	0	0
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	2	3	4	0	2	0	2	4	0	2	4	4
		PPH > 1.5L as % of all women	% of births	CPD				1.7	2.8	3.0	0.0	1.4	0.0	2	3.2	0	2	4	4
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	0	2	1	1	0	1	2	1	0	1	2	0
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	0.0%	1.2%	0.0%	1.1%	3.6%	2.0%	1.2%	2.0%	1.0%	1.1%	1.2%	2.3%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	0	0	0	0	0	1	0	0	0	0	1	0
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	0	0	0	1	1	0	2	1	1	0	0	0

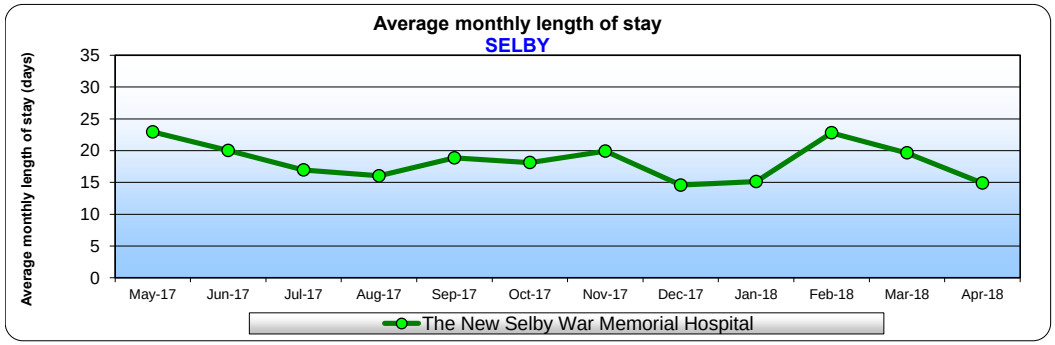
Maternity Dashboard metrics were reviewed on 01.08.2017

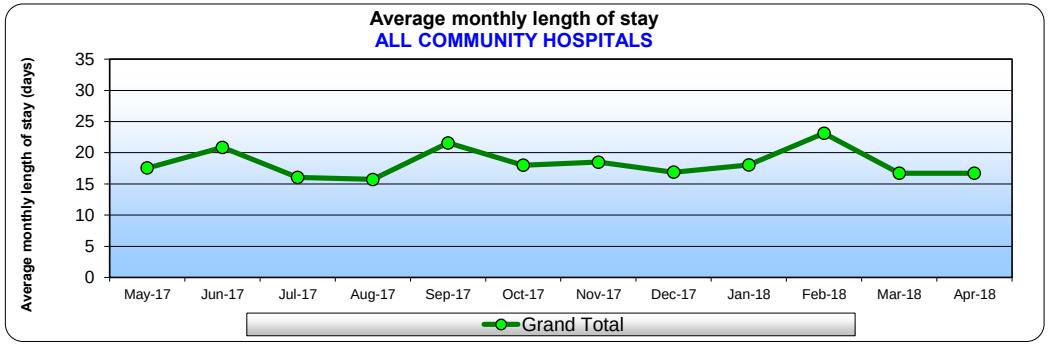
Community Hospitals

Indicator	Hospital	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Feb	Mar	Apr
Community Hospitals average length of stay (days) Excluding Daycases	**Malton Community Hospital**	17.9	16.0	17.4	17.9	22.0	16.3	20.7
	St Monicas Hospital	14.4	22.6	19.6	18.1	26.6	13.6	12.2
	The New Selby War Memorial Hospital	20.2	20.4	17.2	17.6	22.8	19.7	14.9
	Total	18.5	17.6	17.8	19.2	23.1	16.7	16.7



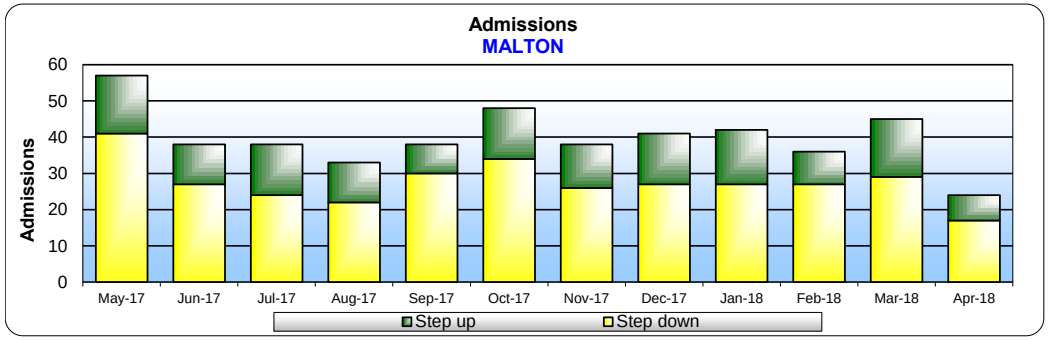


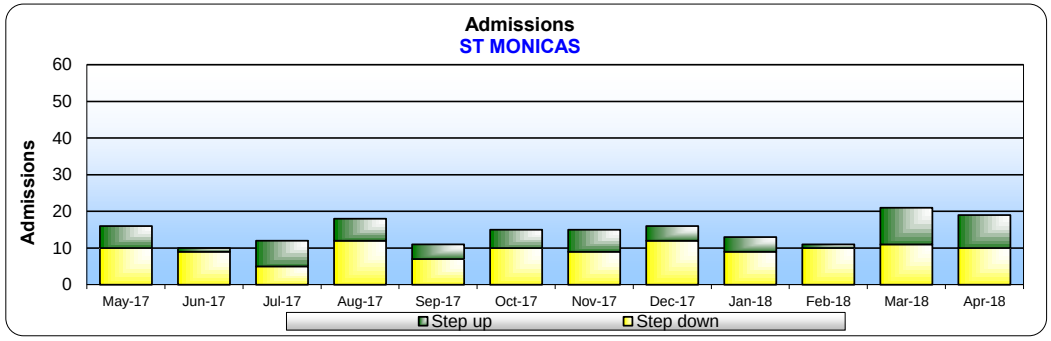


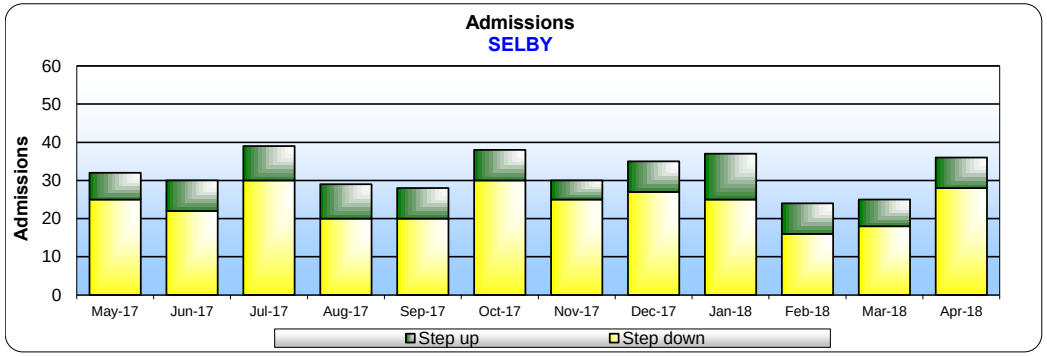


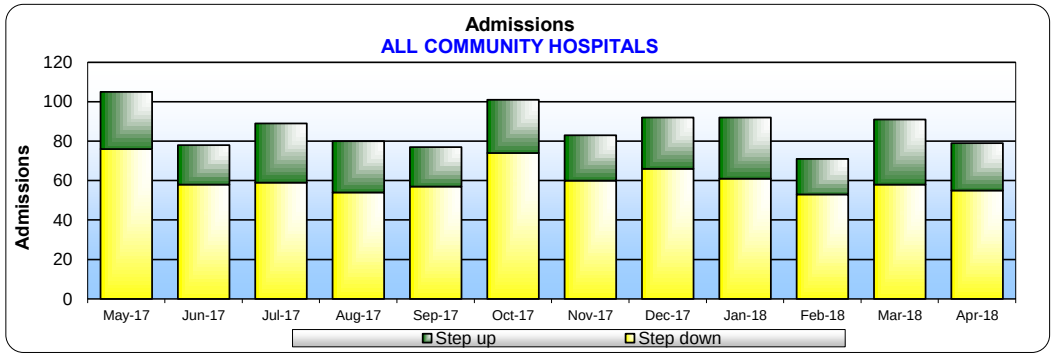
Community Hospitals

Indicator	Hospital		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	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**	39	33	40	40	9	16	7
		Step down	88	76	87	83	27	29	17
	St Monicas Hospital	**Step up**	13	17	15	15	1	10	9
		Step down	29	24	31	30	10	11	10
	The New Selby War Memorial	**Step up**	19	26	21	27	8	7	8
		Step down	69	70	82	59	16	18	28
	Total	**Step up**	71	76	76	82	18	33	24
		Step down	186	170	200	172	53	58	55









Quality and Safety: Misc

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	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**	3	2	1	21	10	7	7
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	20	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%**	99.7%	99.6%	99.8%	99.8%	99.8%	99.8%	To follow
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	97.9%	97.2%	98.0%	98.5%	98.5%	98.7%	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%**	7.1%	6.9%	5.6%	4.5%	4.4%	6.4%	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%**	99.0%	71.7%	95.0%	95.0%	100.0%	89.8%	26.5%
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%**	90.5%	88.7%	91.5%	91.3%	93.7%	89.2%	88.1%
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-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Complaints and PALS												
New complaints this month	46	36	51	43	50	38	37	27	28	31	35	30
Top 3 complaint subjects												
All aspects of Clinical Treatment	36	22	37	26	29	21	26	18	15	23	27	21
Communications/information to patients (written and oral)	10	18	15	17	6	11	11	6	11	8	17	12
Patient Care	11	19	20	17	18	5	8	9	19	5	18	17
Top 3 directorates receiving complaints												
Acute & General Medicine	7	3	4	11	8	2	3	2	3	3	7	4
Emergency Medicine	4	5	5	5	4	5	4	4	3	4	2	6
General Surgery & Urology	7	3	7	1	6	8	11	2	2	4	7	3
Number of Ombudsman complaint reviews (new)	1	1	2	2	1	0	0	0	0	2	0	0
Number of Ombudsman complaint reviews upheld	0	0	0	0	0	0	0	0	0	0	0	0
Number of Ombudsman complaint reviews partly upheld	0	1	0	0	0	0	1	1	0	0	0	2
New PALS queries this month	238	287	262	292	227	269	240	173	271	214	210	221
Top 3 PALS subjects												
Communication issues	56	90	91	60	54	54	53	43	46	32	37	31
Any aspect of clinical care/treatment	17	18	16	19	18	25	29	24	21	24	19	32
Appointments	53	55	42	48	30	51	43	24	47	22	25	35
Serious Incidents												
Number of SI's reported	20	19	14	12	8	17	10	12	22	22	26	19
% SI's notified within 2 working days of SI being identified	100%	100%	100%	100%	100%	94%	100%	100%	100%	95%	100%	100%
* this is currently under discussion via the 'exceptions log'												
Compliance with Duty of Candour for Serious Incidents*:												
-Verbal Apology Given	9	8	8	6	4	7	5	5	6	3	9	7
-Written Apology Given *	8	7	6	2	4	6	0	2	1	2	2	3
-Invitation to be involved in Investigation	7	8	5	5	2	5	3	2	1	1	1	0
-Given Final Report (If Requested)	2	3	0	5	5	2	5	1	4	3	2	2
Pressure Ulcers**												
Number of Category 2	79	69	68	60	55	74	71	80	99	79	84	65
Number of Category 3	7	3	5	1	4	3	5	9	4	5	5	2
Number of Category 4	2	2	1	2	1	0	2	3	0	0	1	2
Total number developed/deteriorated while in our care (care of the organisation) - acute	89	82	79	58	68	75	65	93	116	84	117	100
Total number developed/deteriorated while in our care (care of the organisation) - community	45	27	34	39	39	26	39	39	41	47	35	23
Falls***												
Number of falls with moderate harm	2	3	1	1	4	1	3	6	5	3	1	1
Number of falls with severe harm	1	1	2	0	4	0	2	5	8	3	4	4
Number of falls resulting in death	0	0	0	0	0	0	0	0	0	0	0	0

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Safeguarding												
% of staff compliant with training (children)	85%	84%	84%	83%	83%	83%	83%	84%	84%	83%	83%	83%
% of staff compliant with training (adult)	86%	86%	86%	85%	85%	85%	85%	85%	85%	84%	84%	84%
% of staff working with children who have review DBS checks												

Prevent Strategy												
Attendance at the HealthWRAP training session												
Number of concerns raised via the incident reporting system												

Claims												
Number of Negligence Claims	15	17	13	16	10	12	12	10	14	16	13	5
Number of Claims settled per Month	10	9	6	2	5	2	5	2	2	3	4	7
Amount paid out per month ****	£674,869	£6,382,000	£83,500	£105,000	£1,808,000	£90,000	£243,733	£1,900	£281,500	£29,000	£365,979	£446,017
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 has been developing its processes for recording Duty of Candour and reporting since 1 April 2017.

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 & 4 pressure ulcer data excludes Category 3 ulcers which are recorded as having developed within 72 hours of admission to inpatient care. The increase in pressure ulcers in January 18 reflects the number of frail and elderly patients in the acute Trust.

**** one claim in April was settled for a lump sum payment of £450,000 (included in the data) with yearly payments of £145,000 to fund care needs, with the Claimant's life expectancy being between 3 and 5 years. The ongoing care costs are excluded from the above data as they cannot be quantified at present. Amount paid shows the damages. 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. A claim was settled in June for £6m lump sum with annual payments for life which all totals approximately £14,999,999. Only the lump sum is reflected in the amount paid as the the remainder of the payment is approximate. A claim was settled in September for a £1.5m lump sum with a £50,000 periodical payment per annum. Only the lump sum is reflected in the amount paid.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Medical Director's Report

Recommendation

For information ☒
For discussion ☒
For assurance ☒
For approval ☐
A regulatory requirement ☐

Current approval route of report

This report is only written for the Board of Director's.

Purpose of report

This report provides an update from the Medical Director.

Key points for discussion

- Consultants new to the Trust
- Clinical effectiveness minutes
- Paediatric diabetes audit
- Antibiotic prescribing audit

Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Version number: 1

Author: Mr Glenn Miller, Deputy Medical Director

Executive sponsor: Mr James Taylor, Medical Director

Date: May 2018

1. Introduction and Background

In the report this month:

Clinical Effectiveness-

- consultants new to the Trust
- clinical effectiveness minutes
- paediatric diabetes audit

Patient Experience-

- antibiotic prescribing audit results

2. Clinical Effectiveness

2.1 Consultants new to the Trust

The following consultants joined the Trust in April:

James Rowe
Locum Consultant Emergency Medicine
York

Maciej Morawski
Locum Consultant Anaesthetics
Scarborough

2.2 Clinical Effectiveness minutes.

Please see Appendix A.

2.3 National Paediatric Diabetes Audit

Care Processes and Outcomes 2015/16

The NPDA is part of the Quality Account and National Clinical Audit and Patient Outcomes Programme (NCAPOP) and investigates acute emergency hospital admissions where the primary diagnosis is related to diabetes in children and young people cared for in Paediatric Diabetes Units (PDUs) in England and Wales.

The 2015/2016 Annual Report was published in 2017 and is the 3rd report from this National Audit.

The primary aim of the NPDA is to examine the quality of care in children and young people with diabetes and their outcomes against NICE CG15: Type 1 Diabetes: Diagnosis and Management of Type 1 Diabetes in Children, Young People and Adults recommendations.

	York		Scarborough		National
	2014/15	2015/16	2014/15	2015/16	2015/16
HbA1c recorded (all ages)	99.3%	100%	100%	98.60%	99.30%
% <58mmol/mol	19.4%	21.4%	42.80%	48.20%	47.50%
% >80mmol/mol	22.1%	18.2%	18.80%	14.50%	17.90%
Blood Pressure	99%	100%	100%	95.60%	90.80%
Body Mass Index	88%	100%	100%	97.20%	97.90%
Albuminuria	46.7%	30%	51.20%	44.40%	66%
Eye Screening	82.2%	66.7%	97.70%	62.20%	66.20%
Foot Examination	41.3%	0%	44.20%	17.80%	65.80%
Thyroid Disease	0%	0%	79.50%	65%	77.70%
Coeliac Disease on Gluten Free Diet	38.5%	0%	64.40%	72.70%	62.30%
Received Structured Education	12%	12%	95%	95.70%	71%
No psychology referral required	0%	0%	N/A	0%	59.70%
Referred and seen by psychology services	23.8%	0%	63%	98%	30%

In York measures of care outcomes have improved with better results for the key target of HbA1c levels.

Recording of care processes (Blood pressure, BMI, albuminuria, eye screening, and thyroid function) has improved although there still needs to be further improvement in the completion and recording of foot checks, albuminuria and thyroid function at annual reviews to achieve national standard.

The completion and documentation of foot examinations for patients with Type 1 Diabetes has significantly fallen in York from **41.3%** in 2014/15 to **0%** in 2015/16.

There is also a need identified to improve how well recording is completed for structured education.

In Scarborough the percentage of patients seen with a Hba1c <58mmol/mol remains comparable to national level, whilst the percentage with a Hba1c >80mmol/mol has reduced and is now below the national level.

Like in York the completion and documentation of foot examinations for patients with Type 1 Diabetes has also significantly fallen in Scarborough from **44.2%** in 2014/15 to **17.8%** in 2015/16.

There was a reduction in the percentage of patients recorded as having thyroid disease screening, albuminuria screening and eye screening, indicating that action needs to be taken to ensure all patients achieve all of the 7 key care processes at the Scarborough site.

Positively the number of children and young people referred to and seen by psychology service has improved and compares well to national figures and this demonstrates the benefit of having a named clinical psychologist as part of the MDT who attends clinics.

This is the 3rd report from this National Audit and the comparison against the current report findings and the data reported between 2014/15 evidences that year on year both Scarborough and York Hospitals are making steady improvements against the audit criteria. However the areas where there has been a decline in performance against the National Standards need to be addressed.

Nationally the results show that the national improvements in diabetes control and completion of health checks has not been accompanied by reductions in the number of diabetes related admissions to hospital. Furthermore, the National report does not demonstrate any improvement in the rate of ketoacidosis in those with newly diagnosed Type 1 diabetes across three consecutive years.

3. Patient Experience

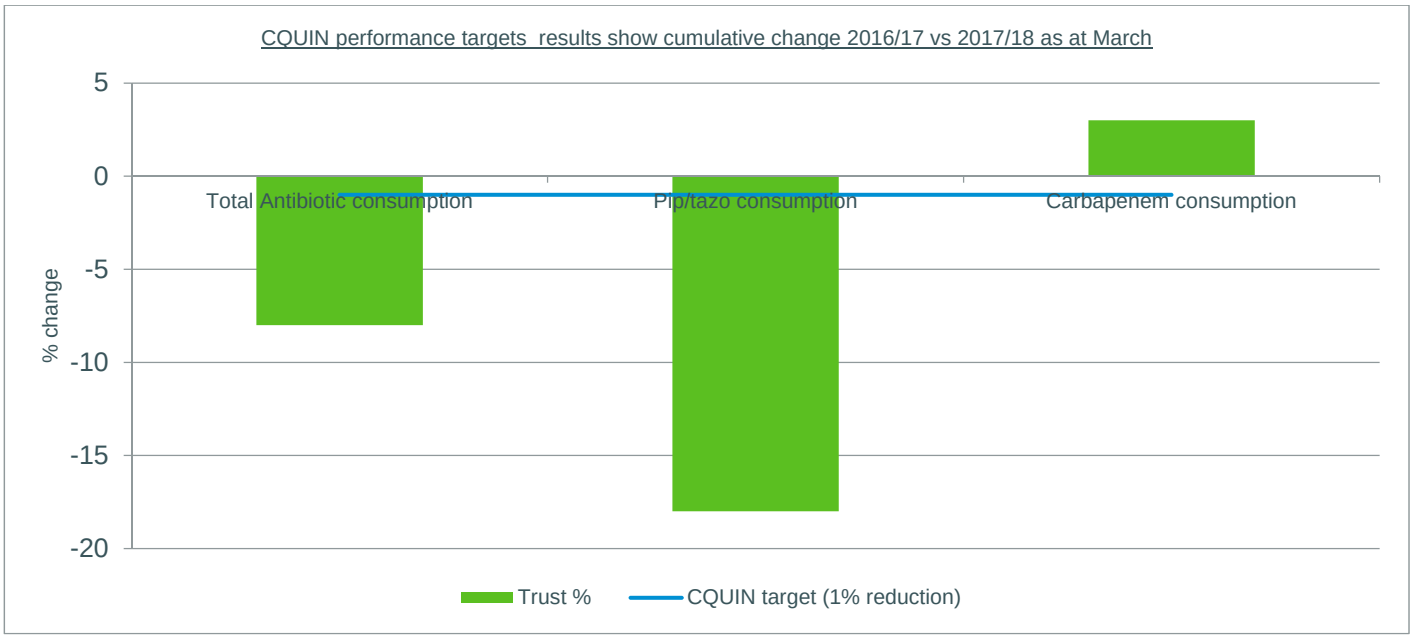
3.1 Antibiotic prescription audit results

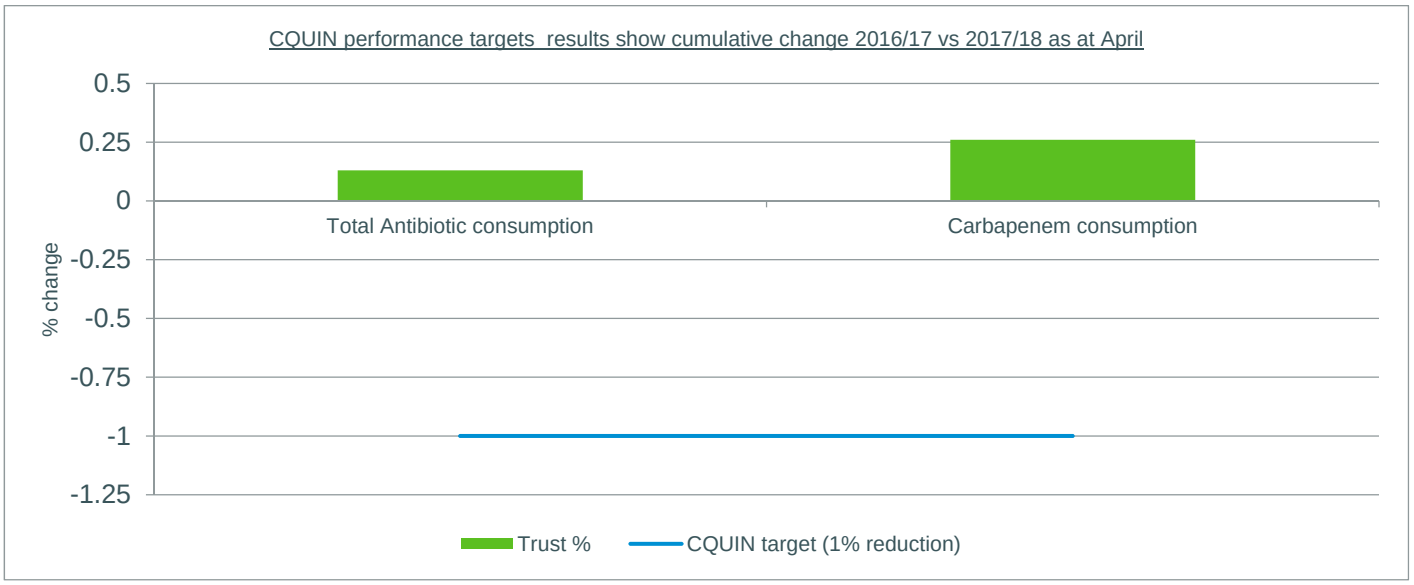
The summary of the antibiotic prescriptions from the April prescription audit are presented below.

Antibiotic Usage Summary Report April 2018 to March 2019

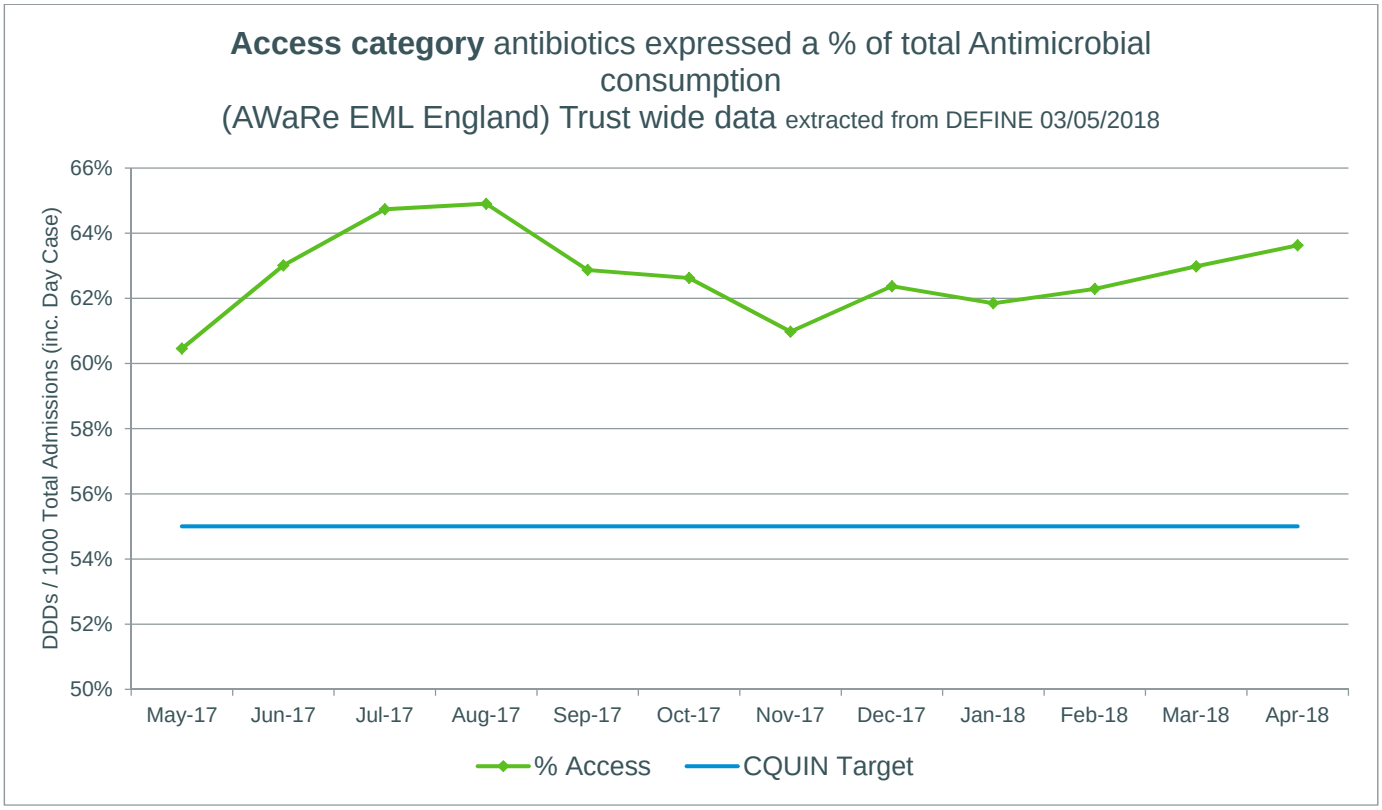
Consumption data % change of cumulative totals 2016/17 vs 2017/18 as at April 2018

CQUIN Targets - Trust wide





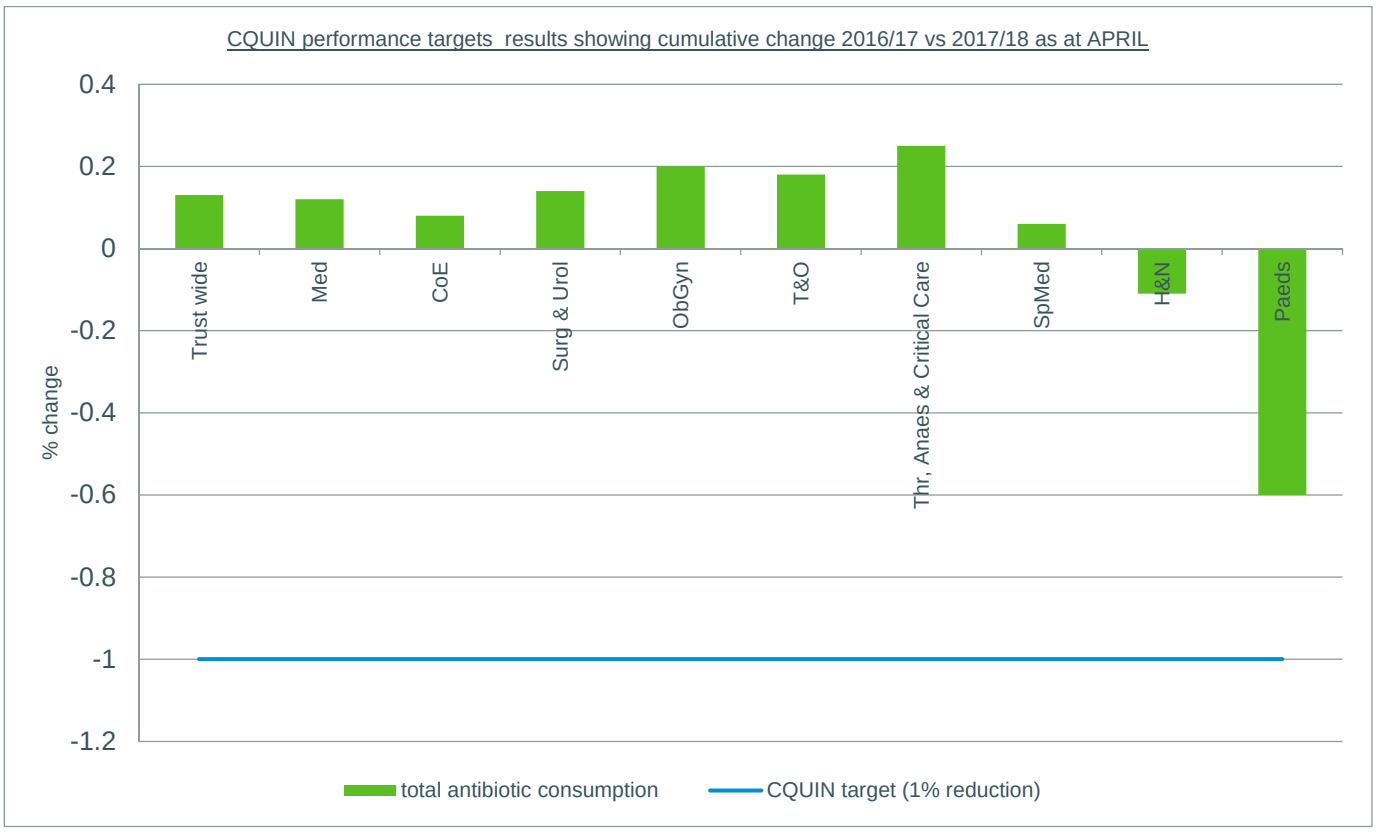
Comments: The Trust pharmacy antimicrobial team continues to work closely with Clinicians and "Team Micro" to actively promote the review of all patients prescribed antibiotics to cut any unnecessary doses where ever possible. Although piperacillin/tazobactam (pip/tazo) no longer carries a CQUIN carrot / stick we continue to monitor prescribing of it and all other broad spectrum antibiotics because of the threat posed by antibiotic resistance.



Comments: AWaRe EML England classifies antibiotics into 3 different categories, Access Watch and Reserve. The Access list covers the majority of the antibiotics that feature on the Trust formulary and therefore those that are most frequently prescribed. The CQUIN target is trying to encourage the balance of antibiotics used by an organisation to be in

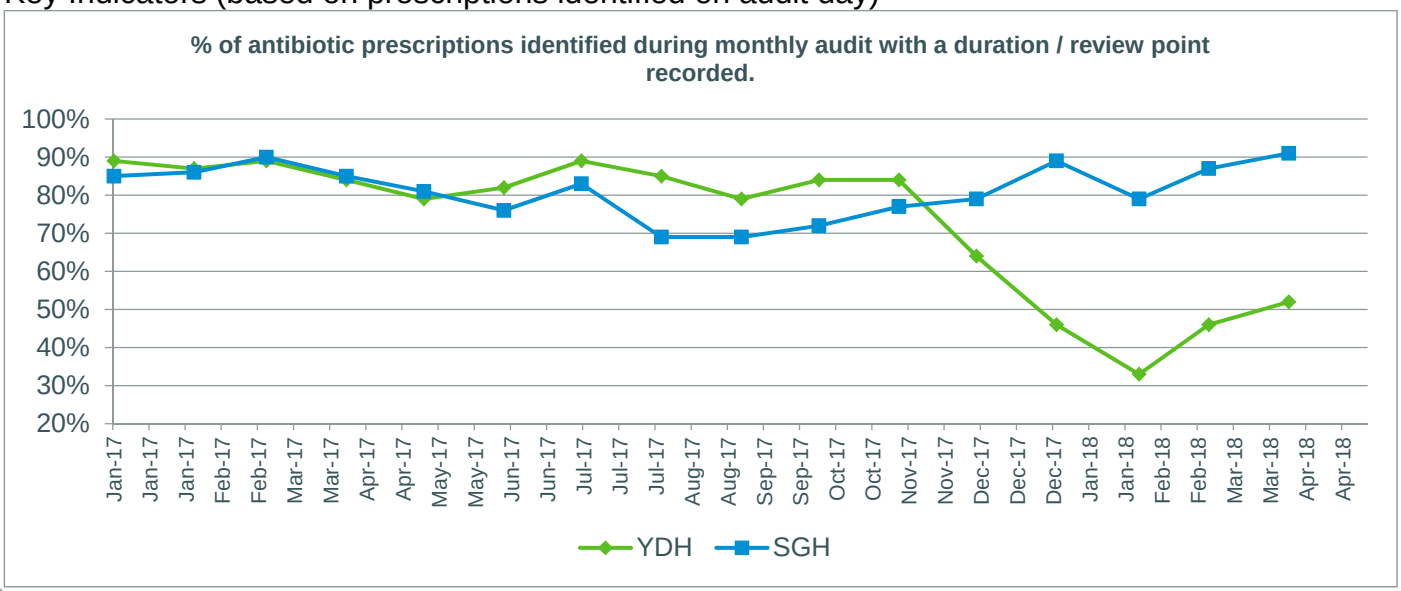
favour of the Access list and encourage a decreased use of Watch and Reserve antibiotics (these are antibiotics this organisation have described as restricted or to be prescribed only on the advice of "Team Micro").

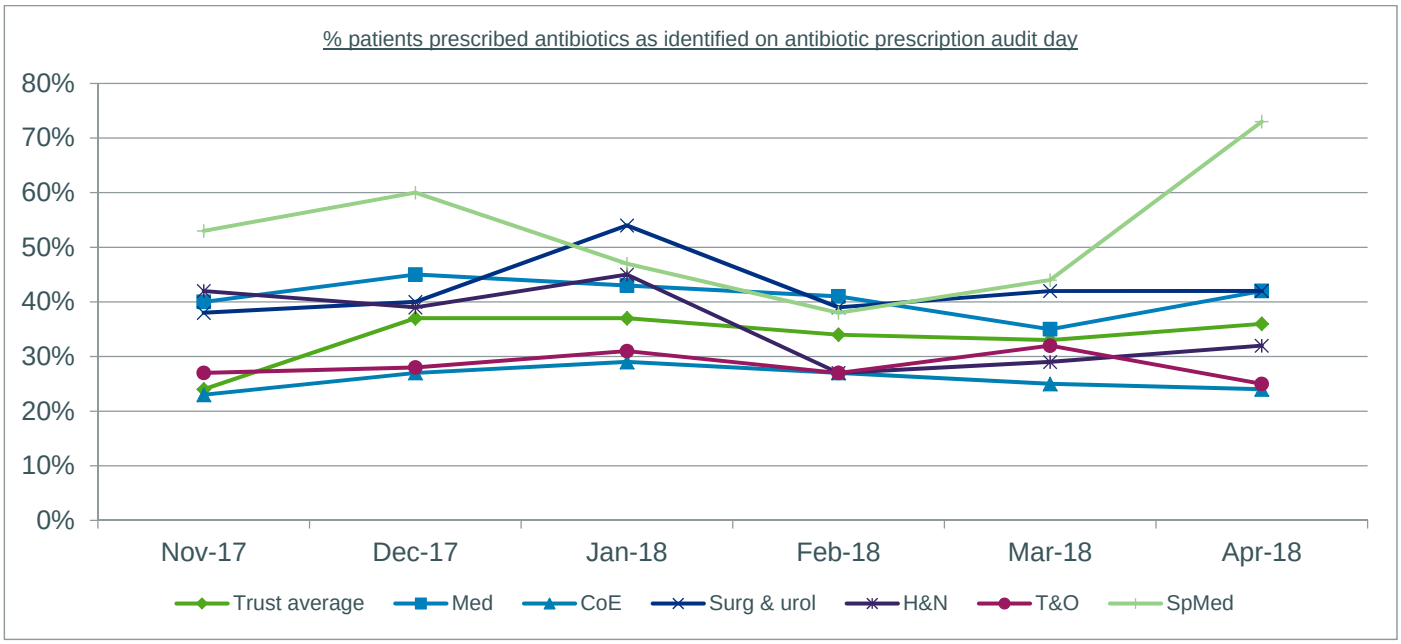
CQUIN Targets - By Directorate



Comments: Holding the concern of antibiotic resistance in everyone's focus and actively promoting the carrying out and recording of a thorough and meaningful review of antibiotic prescriptions will have the bonus effect of reducing antibiotic consumption.

Key Indicators (based on prescriptions identified on audit day)





Key Indicator results for April 2018

Indicator %	Trust	Med	CoE	Surg & Urol	ObGyn	T&O	Thr,Anaes & Critical Care	SpMed	H&N	Paeds
pt Rx Abx	36%	42%	24%	42%	15%	25%	n/a	73%	32%	n/a
% iv Rx	51%	43%	29%	75%	0%	77%	n/a	50%	100%	n/a
Indication recorded **YDH**	99%	100%	100%	100%	50%	100%	n/a	100%	88%	n/a
indication recorded **SGH**	85%	80%	87%	93%	n/a	100%	n/a	n/a	n/a	n/a
duration recorded **YDH**	52%	54%	68%	30%	100%	47%	n/a	57%	63%	n/a
duration recorded **SGH**	91%	91%	96%	86%	n/a	100%	n/a	n/a	n/a	n/a

4. Recommendations

The Board is asked to review and approve the content of the report.

Enclosure A

York Teaching Hospital NHS
NHS Foundation Trust

Clinical Effectiveness Group Meeting Minutes

Meeting Room 1 Park House, 19th January 2018, 14:00 – 16:00

	Agenda Item	Discussion and Actions
	Attendance / Apologies	**Present:** Glenn Miller (GM), Fiona Jamieson (FJ), Claire Scotter (CS), Amanda Vipond (AV), Lucy Glanfield (LG), Kirsti Miller (KM), Ben Blake-James (BBJ), Simon Hearn (SH). **Apologies:** Jane Crewe, Adnan Faraj, Jay Kindelan, Laura Wakely, Ed Smith, Richard Parker, Helen Hey.
1	**Minutes of Previous**	Minutes of the previous meeting (held 27th November 2017) were reviewed by the group.
	Matters arising	**Action Log** The action log was introduced and reviewed. The action log will provide feedback on the actions completed following each meeting and also provide a mechanism to monitor outstanding, incomplete actions at each meeting. **Clinical Audit C3124** Action is allocated to Helen Hey to discuss catheter documentation with Emma George which was only used on specific wards, but felt this should be appropriately measured across the whole Trust. **Action: JS to contact HH for progress update/outcome of the query.** **Outstanding Actions (NICE/Clinical Audit)** GM reiterated discussions from the previous meeting regarding outstanding audit (and NICE) actions. Outstanding actions should be reviewed; any that are out of date or no longer required should be removed from the list. FJ confirmed that this is in line with suggestions from internal audit and feedback from the CQC. CS confirmed that for Clinical Audit outstanding actions this is being actioned as part of the Directorate Annual Audit Programme meetings **Action: SH to coordinate review of outstanding NICE Actions with CDs/DMs/Governance leads** **Clinical Records Audits** The progress of casenote audits in the Trust was discussed. All Directorates have been advised of the need to complete a casenote audit on an annual basis. CS confirmed that at the end of Quarter 3, only 2 or 3 Directorates were still to register their audits and that each of these Directorates had been contacted regarding the need for registration of their Clinical Records Audit.

	Agenda Item	Discussion and Actions
3	NICE	**FJ/CS presented the NICE Report – January 2018** **<u>NICE Guidance for Escalation</u>** **CG174 & QS66 "Intravenous fluid therapy in adults in hospital"** The Trust's baseline assessments for both clinical guidance (CG174) and quality standard (QS66) on IV Fluid management remain incomplete; the current baseline assessment received by the Clinical Effectiveness Team is for York Hospital only despite requests made of the Lead to complete a Trust-wide assessment, therefore the group were asked if they could identify an appropriate lead to undertake the baseline assessment for Scarborough hospital site. GM suggested that an appropriate lead for Scarborough might be one of the Anaesthetists, and AV agreed to discuss this with one of the Scarborough based anaesthetists who thought may be interested in undertaking this. **Action: AV to discuss with Scarborough Anaesthetists to establish a Lead for IV Fluid baseline assessment at Scarborough site.** **NG70 Air pollution: outdoor air quality and health** The Trust's baseline has been partially completed by the Travel & Planning Co-ordinator (Dan Braidley), it was unclear who the overall lead for this guidance should be. FJ suggested that this should be Jane Money. **Action: SH to forward baseline to Jane Money for review & completion.** The group were asked the group to note the appendices to the NICE report. SH asked the group to note that Appendix 3,'Baselines Completed' that those assessed as being 'compliant' or 'not applicable', were listed for information whereas those assessed as 'partially compliant' are those included in the Escalation Report for discussion. There were no partially compliant baselines available for inclusion on this occasion. CS confirmed that none of the expected January 2018 guidance had been published so far this month
4	NCEPOD	**SH presented the NCEPOD Report – January 2018** SH asked the group to note the progress update on current studies provided by NCEPOD. **<u>Acute Heart Failure</u>** NCEPOD have confirmed the data collection for this study is now closed. Whilst the Trust participated in the data

	Agenda Item	Discussion and Actions
		collection and organisational questionnaires, the clinician questionnaire completion rate was poor. This low return rate will be reported by NCEPOD as part of NHS Trusts' Quality Accounts. **<u>Peri-operative diabetes study</u>** In December Trusts' were sent an 'Organisational supplementary' data spreadsheet, and hospital site questionnaires to be completed for each hospital site within the Trust. The anaesthetic leads from York & Scarborough are contributing to the questionnaire and are close to completing these. The data spreadsheet is currently with IT Helpdesk for completion, potentially submission to NCEPOD will be delayed due to the way admissions are coded within the Trust. **<u>Leads for forthcoming studies</u>** The group were asked to suggest clinical leads for the forthcoming studies to assist with promoting and encouraging participation within specialities. GM suggested as follows: • *Pulmonary Embolism* –Acute physician to lead Dr Nigel Durham • *Bowel Obstruction* – Surgical physician to lead Mr Dib Bandyopadhyay • *Long term ventilation* – Relates to paediatric ICU therefore possibly not relevant, but Jo Mannion to be made aware of this study. **Action: SH to make contact with leads & forward study details as they become available from NCEPOD.** **<u>Self-assessment & Action Plans</u>** GM requested an annual review of all action plans from the Trust's self-assessments against published NCEPOD studies. **Action: SH to undertake review of all NCEPOD action plans.**
5	**Clinical Audit**	**CS/FJ presented the Clinical Audit Report – January 2018** **<u>BriefCASEs for Discussion</u>** **2488-1 RCEM Severe Sepsis & Septic Shock in Adults National Audit Quality Account 2016/17** The data suggest that the timeliness of this treatment is improving. There is a Trust Sepsis Lead and we are using a Sepsis protocol; we do educate our staff and there was an Antibiotic stewardship in past years. The RCEM audit has 3 fundamental standards (IV fluids within 4 hours, antibiotics within 4 hours, and a complete set of observations recorded on arrival), and we are achieving two (2) of these in York but not in Scarborough and only 30% patients had

	Agenda Item	Discussion and Actions
		a full set of observations done on arrival within the Trust. FJ informed that the Chief Executive has received a letter from the Department of Health congratulating the Trust for being a top performer on improvement for sepsis. GM asked if this RCEM audit was repeated year on year. LG clarified that this is not an annual audit, however topics for RCEM audits are on a rolling basis, so this will likely be re-audited at some point in the future. **Approved** **2784-1 Re-audit of Ophthalmology emergency admissions** Audit identifies a 100% completion rate on VTE assessment and warfarin and insulin charts, with 82% of patients having a general drug chart completed and 94.1% seen by consultant within 24 hours. 43% of patients requiring dementia screening assessment who did not have this completed, compared to 50% in 2014 and 71% of patients did not have documentation on past medical history, which is an improvement on 25% in 2014. The group noted improvement in most areas; however the recording of past medical history (PMH) was felt to require further improvement. Action plan agreed to have appropriate actions to address recording of past medical history. **Approved**. **A7217 Biological Treatment of Patients with AS and nrAS** This audit identified that the majority of contacts are clinical in nature and therefore appropriate and that contacts are dealt with in a timely manner as required. The introduction of the Clinical Co-ordinator post in 2016 has made a significant impact on the workload of the Registered Nurses with the co-ordinator now triaging all calls and passing only clinical calls to the nurses. FJ suggested that the re-audit of March 2018 might be too soon to measure any improvement from using the tariff generated to add extra capacity. **Action: Approved subject to the CET raising re-audit date with project leads as part of annual audit plan meeting.** **C3068 Fluid Resuscitation of Paediatric Patients Presenting with Diabetic Ketoacidosis** The guidelines appear to be effective in supporting clinical care. Education of staff by the diabetes team appears to be effective. There is good joint-working between paediatric staff and the paediatric diabetes team. The new national guideline with additional local management prompts appears to be working well for the patient group. The group noted the introduction of the new pathway and agreed the action plan to re-audit this in December 2018. **Approved.**

	Agenda Item	Discussion and Actions
		C3144 Chest Trauma Audit – Review of Assessment Pathway Patients admitted to the ED at YDH are not assessed as per the ATLS protocol for chest injuries and upon admission are admitted to the orthopaedic ward. Audit leads therefore propose that all patients with blunt chest injuries have a trauma assessment, including the adequate imaging as per the NICE trauma pathway and if possible to be admitted to HDU under the care of the general surgeons. GM confirmed that the management of Chest Trauma is an area of contention within the Trust, and Mr Stevan Stojkovic is currently in discussion with the Orthopaedic leads around this topic. GM noted that this project did not specify if the audited cases were isolated chest trauma or poly trauma. This audit should therefore be re-audited to include whether cases were isolated chest trauma or poly trauma. **Action: To be re-audit in 2019 and re-audit to include whether injuries were isolated chest trauma or poly trauma** **Approved subject to actions being completed** **D9121 Postmenopausal Bleeding (PMB) Policy** This audit established that the introduction of the new recommendation '*referral for women with PMB under 55 years with risk factors only'* would be safe in our patient population. The group queried if the referral criteria were the same at York & Scarborough. **Action: To establish whether referral criteria are the same at York & Scarborough and check if re-audit has been undertaken** **Approved subject to actions being completed**. **C3140 Consent process and patient recall** Audit finds show that Orthopaedics are good at completing the initial section of consent form but need to improve ensuring that alternatives have been discussed and documented as well as documenting whether or not a copy of the consent is offered to the patient. FJ noted that the patient safety team are currently auditing patient consent. **Action: BriefCASE to be reviewed at a later date by the group along with the results of the patient safety team's audit.** **<u>Outstanding CEG Recommendation for Escalation</u>**

	Agenda Item	Discussion and Actions
		C3096 Time to theatre for surgical paediatrics patients This project was requested by Governance Lead to be discontinued as it was proving to be too difficult to complete. The discussion concluded that without knowing which area of surgery, it was difficult for the group to agree the cancellation of this project. Therefore GM requested further details. **Action: JS to send project registration to GM for review.**
6	**NICE Policy**	**CS Presented the updated NICE Policy** <u>Compliance Status</u> As per the report from Internal Audit, and discussion with GM, the Trust's compliance statuses have been simplified. The policy has been updated to reflect this. <u>Executive lead for NICE</u> Following recommendation from Internal Audit, the Trust's executive lead for NICE has been clarified as the Medical Director, Mr James Taylor. <u>Chair of the Clinical Effectiveness Group</u> CS sought clarification on the Chair of the group; GM & FJ agreed that this will be FJ. **Policy Approved** **Action: CS to update CEG TOR.**
7	**Registration**	CS requested clarification over the governance process for the registration of student dissertations undertaken within the Trust. GM felt that all students undertaking dissertations within the Trust should have a supervisor at the university and supervisor within the Trust, and that it would therefore not be unreasonable for the CET to register dissertation projects on condition that the project lead has obtained ethical approval. **Action: CS to develop a process for registering dissertation projects.**
8	**NICE Drug TA**	Apologies were received from Jane Crewe. No nominated deputy in attendance either at this meeting. Noted that this is 3rd meeting without Pharmacy representation. FJ requested David Pitkin be informed of non-attendance. GM requested that the future Drug TA reports are exception reports only; as the majority of the report is already

	Agenda Item	Discussion and Actions
		discussed at Drugs & Therapies group, so the current report is duplicating information unnecessarily. **Action: CS to contact David Pitkin.**
	AOB	<u>NMPA Audit 2015/16</u> CS presented an update on the National Maternity and Perinatal Audit (NMPA) Whilst the Trust didn't participate in this audit GM stated that the results from this audit should be of interest, and can be used as a standard to audit against. **Action: CET to circulate report once published.** <u>CG Meeting dates 2018/19</u> GM and FJ agreed that 2018/19 meetings will remain monthly, but reduced to 1 hour per meeting, and where possible these should be scheduled for 3pm on a Monday. **Action: CS to arrange dates for 2018/19**
	Date & Time of Next Meeting	Monday 26th February 2018 14:00-16:00 Park House, Meeting Room 1

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NHS

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Chief Nurse Report – May 2018

Recommendation

For information	☒
For discussion	☒
For assurance	☒
For approval	☐
A regulatory requirement	☐

Current approval route of report

Executive Board – 16th May 2018
Quality & Safety Committee – 22nd May 2018
Board of Directors –30th May 2018

Purpose of report

The Chief Nurse report provides assurance on progress towards the delivery of our quality priorities, and highlights any risks to delivery of the Nursing & Midwifery and Patient Experience Strategies. The four themes are:

- Experience and Communication
- Workforce
- Safe, quality care
- Partnerships and efficiency

The themes triangulate with the Patient Experience and Patient Safety strategies in order that priorities are aligned to ensure delivery of the key objectives.

Key points for discussion

No specific points for discussion.

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

No direct reference to CQC regulations.

Version number: 1

Author: Beverley Geary, Chief Nurse

Executive sponsor: Beverley Geary, Chief Nurse

Date: May 2018

1. Introduction and Background

The Chief Nurse report provides assurance on progress towards the delivery of our quality priorities, and highlights any risks to delivery of the Nursing & Midwifery and Patient Experience Strategies. The four themes are:

- Experience and Communication
- Workforce
- Safe, quality care
- Partnerships and efficiency

The themes triangulate with the Patient Experience and Patient Safety strategies in order to ensure delivery of the key objectives.

A full update on the delivery of the Nursing and Midwifery strategy is detailed in another paper

2. Progress on key strategic themes

In line with the Nursing and Midwifery strategy, this report is aligned to the four key themes

2.1 Experience and Communications

2.1.1 Complaints and PALS Management

30 new complaints were received and 8 cases were reopened for further investigation.

24% of complaint cases closed in April met the Trust's 30 day response target. This is below the 2017-18 annual average of 27%.

Three cases were addressed using the next working day process, resulting in a quick resolution for the complainant and 72% of PALS cases were closed within the target timescale of 10 working days.

There were no new PHSO cases but the PHSO concluded two investigations and partly upheld both.

2.1.2 Friends and Family Test

The inpatient satisfaction rate for January was 97.6%, (the highest for 12 months), in February it was 97% and 96.2% in March 2008. This is slightly above the national average for March of 96%.

The ED satisfaction rate was 87.3% in January, 86.5% in February and 84.5% in March 2018.
The narratives from FFT for Scarborough Emergency Department (ED), show the biggest theme is waiting times, and for York ED, the main theme is also about waiting times and being kept informed about waiting.

Satisfaction Scores	% Patients Satisfied Jan 18	% Patients Satisfied Feb 18	% Patients Satisfied Mar 18	National Average % (Feb) 18
Inpatient	**97.6**	**97**	**96.2**	**96**
ED	**87.3**	**86.5**	**84.5**	**85**

The Quarterly Patient Experience report is detailed in another paper.

2.1.3 Visiting Times

In 2017, following consultation, the Trust opted to trial a more open visiting culture. Feedback from patients and visitors had indicated having split times, just after lunch and in the evening made visiting their relatives and friends difficult. Therefore, a trial of standard visiting 11am to 8 pm was established.

At the time some concerns were raised by some service users and staff and it was agreed that the revised visiting times would be reviewed in 2018.

Following an extensive consultation by the Patient Experience Team; involving patients, visitors and all staff groups (Allied Health Professionals; Domestics; Nursing and Medical). The results were presented to the Patient Experience Steering Group where a decision was made to undertake a final piece of work with Ward Senior Sisters and Charge Nurses to ensure their views were taken into consideration.

Whilst the results presented a mixed picture there is compelling narrative from all stakeholders to slightly alter the visiting times.

Patients and relatives really appreciate the standardisation of visiting times that are not split. Nurses really welcome the support visitors provide during the day and at mealtimes. Medical staff had found speaking with families easier and Allied Health Professionals have found it easier to involve relatives in therapy sessions where appropriate.

Conversely, there are multiple reports of staff being unable to support all patients adequately with their hygiene needs prior to 11 am. Medical staff have reported finding maintaining confidentiality during ward round activity more problematic. Domestic staff require more time to complete their morning schedules before visitors arrive and Allied Health Professionals report patients refusing their therapy because they have a visitor. The most significant safety concern raised relates to having visitors on wards during the lunchtimes drug round, as consistently nurses reported that they were subject to many interruptions at this time.

Following this feedback and careful consideration; it is proposed that the start of standard visiting times move to 1 pm. The visiting times will therefore be 1 pm to 8 pm. These will be the general times for standard visiting.

The Senior Nursing Team will work with ward areas and our Comms team to ensure this change is effectively communicated, internally and externally, whilst reinforcing the principles of John's Campaign.

The proposed change will be effective from 1 July 2018.

2.2 Workforce

2.2.1 Nursing Dashboards

Following a review, the nursing dashboards, will be presented in a new format from June 2018. In order to manage the transition of information, no dashboard is included with this report.

2.2.2 Nursing & Midwifery Staffing

A further cohort of Associate Practitioners commenced in post on 23rd April 2018, increasing this group of staff to 52.6fte. Further recruitment is anticipated later in the year.

We are also delighted to report that the 15 Trainee Nursing Associates have now commenced the second year of their programme with a view of completion of their qualification in March 2019. The Trust will be working with the Trainee Nursing Associates to secure their employment within the Trust once qualified.

Recruitment to nursing positions is continuing across the Trust. 70fte student nurses who will be qualifying in September 2018 have already been offered positions.

A nursing market place was held on the York site on 21st April 2018; on the day 15 nurses were interviewed for positions along with 2 ODPs. A further 80 individuals attended the Healthcare Assistant Open Day and around 20 people attended the information sessions for Associate Practitioners and Trainee Nursing Associates. Footfall on the day did not match our previous experience despite the significant publicity surrounding the event; this could be attributed to the warm weather experienced that weekend.

The Chief Nurse Team will also be present at Nursing Times Careers Live on Saturday 16th June 2018, with the intention of interviewing nurses at the event and promote the Trust as a place to work.

The spring cohort of 24 newly qualified nurses across Scarborough and York sites including community have commenced their preceptorship programme. This is the first time spring starters have had their own programme.

Consideration is being given to overseas recruitment. An outline plan will be considered at Corporate Directors in the coming weeks.

2.2.3 SafeCare

All York inpatient units are now operationally live on Safecare. Senior Nurses are now using the software to support staffing decisions and movement of staff. Implementation is due to move to Scarborough at the end of May, with the final phase in community hospitals the following month for completion at the end of June.

2.2.4 Acuity & Dependency Audit

The acuity and dependency audit on the Scarborough and Bridlington sites was undertaken in March 2018 using the existing data collection tool. The data is currently

being analysed by colleagues in SNS. It is anticipated that the report will be provided in June 2018.

In respect of the York site, the implementation of SafeCare has delayed the audit taking place. Work is currently underway to ensure that the three data capture periods are robustly embedded across the wards to enable audit data to be extracted. Early indications suggest that where data entry has been omitted, this has an impact on the acuity and dependency reporting.

Work is being undertaken to ensure that the acuity and dependency and safer staffing data which can be accessed from SafeCare are robust. Whilst this work progresses, the existing mechanisms for reporting the nursing and midwifery staffing levels will continue.

2.3 Safe, Quality Care

2.3.1 Professional Midwifery Advocate

Midwifery launched the Professional Midwifery Advocate (PMA) role at York and Scarborough Hospital on Friday 4th May to coincide with International Day of the Midwife.

The PMA role is in place following the disestablishment of Midwifery Supervision in March 2017.

The PMA is a new model of midwifery supervision for England called A-EQUIP (Advocating & Educating for Quality Improvement) which focusses on restorative clinical practice, quality improvement and education and development.

It offers midwives protected time and a safe space in order to reflect on their experiences and practice, through open discussion and feedback. It has been shown through pilot schemes that restorative supervision sessions can help midwives to feel supported, reducing stress and increasing resilience.
This in turn will impact positively upon the care they give to women and their families and empower midwives to commit to a culture of learning from events, and to contribute to change and development of our excellent service.

The Trust currently has three PMAs with two more in training.

2.3.2 Non-Medical Prescribing

The Non-medical prescribers have all submitted their annual declaration of competence to prescribe and all have been approved.

Links have been forged with Coventry University, Scarborough campus, and the NMC have approved the Coventry NMP course to be delivered commencing in October 2018 on the Scarborough campus. This gives access to more places for all Trust staff and less travel to East coast colleagues.

2.3.3 Safeguarding Children Update

Safeguarding Children training compliance continues to be a challenge for the organisation. In order to address this we are meeting with our Child Health and Paediatric colleagues aiming to solve the reported non- compliance of our medical colleagues. The temporary nature of Junior Doctor placements means we have no means to capture previous learning and we cannot and should not meet 3 years of compliance in 6 months.

The Team has developed a whole day training for level 3 new starters to the trust. The training package is currently out for consultation with our multi agency partners. Our colleagues from Children Social Care in York have also volunteered to assist deliver the training giving practitioners a richer experience. The package will also see the introduction of a competency based work book with the aim of assuring the trust re quality of safeguarding reports that are sent externally. Further, we are also exploring a means of evaluating the level of retained knowledge after 3 months

The team have developed Safeguarding Safety Plans. These were initially designed to provide succinct information for unborn children; that was readily accessible when pregnant women attended at hospital. Recently, and increasingly, we are having frequent attendances of a small cohort of young, vulnerable teenagers. The Safeguarding Safety Plans are being used to highlight to practitioner's individual management plans for these children.

Working with our matron and child health colleagues, the team will establish processes which identify where children are being cared for in adult settings and to ensure appropriate risk assessments are in place.

Thanks to our colleagues in ED, a one year secondment has commenced for a Safeguarding Liaison Nurse in York ED. Performance indicators have been developed to address issues raised by both CQC and latterly our internal audit. The secondment to the Named Nurse role in York has been extended by until November 2018.

2.3.4 Infection Prevention Update

Infection Prevention Surveillance 2018/19:

Organism	Trust Threshold	Trust attributed
Methicillin Resistant Staphylococcus Aureus **(MRSA)**	0	**1**
Methicillin Sensitive Staphylococcus Aureus **(MSSA)**	30	**2**
Clostridium Difficile **(C-diff)**	47	**7**
Escherichia Coli **(E-coli)**	68	**5**

Infection Prevention & Control Team – Care Group Affiliation.

In last month's report, it was reported that Care Group working (Directorate working) would be implemented by the end of May 18. It has now been decided, in consultation with the Director of Infection Prevention & Control (DIPC), that this will be suspended to allow the consultation for organisational Care Group restructure to complete.

Job descriptions for 2 Band 4 Associate Practitioners (AP) have now been developed and have been submitted to Human Resources for ratification. These posts will be advertised as soon as this has been completed. Once these posts have been filled, the restructure of the IPC Team will be complete.

2.3.5 Safeguarding Adults Update

An internal audit of Deprivation of Liberty (DoLS) cases has been concluded and the recommendations and assurance level is being discussed.

There were 7 recommendations made and 6 have now been completed. The remaining recommendation is due for completed by the End of the year as it involves Trust wide bite size training programme. Progress of this action is reported to the safeguarding Adults Strategic Governance Group and monitored by the operational group.

The main gap recognised was the failure to inform CQC of the outcomes of DoLS applications. This was largely due to Local Authority backlog and beyond our control. On further discussion with the local authority advice is as follows:

Local Authority	Advice
City of York Council	DoLS applications submitted to CYC are assessed for priority status. DoLS applications are unlikely to be assessed for 8 weeks by which time a patient may no longer be in out care. If a patient is no longer in our care within that period CYC withdraw the DoLS application. We will therefore list the outcome as DoLS withdrawn. For patients in our care longer than 8 weeks typically CYC inform the applicant of the DoLS outcome. CYC have confirmed that they will now routinely also inform the safeguarding adults team.
North Yorkshire County Council	Best Interest assessors decision has to be agreed by a senior NYCC manager – at which the final decision is made. At that point, the person who made the form 1 application is emailed, to be informed of the assessment outcome. This should be sufficient to inform CQC, and of course, the documentation follows.

The bitesize programme, developed to target bespoke training for departments is underway providing training to approx. 8 departments per month.

Ward Based Support	Face to face bite size training/refresher Template Pack

	Ward Wanders
Ward Managers	PNLF DoLS Link Leads
Matrons/ADN	Senior Nurse Meeting Quarterly reporting

Administration is up-to-date and a robust monitoring process is in place.

The CQC Inspection found gaps in Mental Capacity Act **(**MCA) awareness Trustwide. Actions to address this are included in the Trust CQC Action plan and progress is submitted quarterly. In line with a clearer picture of DoLS applications the safeguarding adults team has completed a baseline awareness Mental capacity Act compliance Audit. This focused on 3 expected high application areas and review:

- Compliance of capacity assessments
- Patient involvement in decision making
- Use of Best Interest process

This baseline will be reviewed again following completion of the bitesize programme.

The Trust continues to work in partnership with multi-agencies as per the Multi-agency safeguarding adults policy and procedures.

The Safeguarding Adults Multi-agency policy and procedures have now been amended. Review of the Trust Safeguarding Policy is underway to mirror the amendments.

2.4 Partnerships & Efficiency

As the Committee are aware there is collaboration with Coventry University to deliver a BSC programme starting in September on Scarborough. In addition we have begun to explore other programmes including Nursing Associate and apprenticeships. A meeting is planned in early June to determine the feasibility and numbers with final approval and planning to begin following the planned strategy meeting in July. Updates will be shared at future meetings.

3. Recommendation

The Board is asked to note the Chief Nurse Report for May 2018.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
CNST Self Certification

Recommendation

For information ☐
For discussion ☐
For assurance ☒
For approval ☒
A regulatory requirement ☐

Current approval route of report

Report discussed at Qualify and Safety Committee – 22 May 2018

Purpose of report

In order to be eligible for a share of the CNST incentive fund the Trust is required to self-certify compliance against 10 actions and demonstrate required progress against all actions with evidence. Completed reports need to be signed off by the Board following consideration of the evidence provided and discussed with the commissioner. The report will then be submitted to NHS resolution (with supporting documentation) and will be reviewed by the national maternity safety champions and the steering group. This must be submitted by 29 June 2018.

Key points for discussion

To consider attached evidence for self-certification of compliance against all 10 actions.

Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Version number: Version 1

Author: Elizabeth Ross, Head of Midwifery

Executive sponsor: Beverley Geary, Chief Nurse

Date: May 2018

1. Introduction and Background

Clinical Negligence Scheme for Trusts (CNST) 2018/19 maternity incentive scheme will support the delivery of the Department of Health and Social Care's maternity safety strategy and has been developed in collaboration with national partners and with the assistance of the National Maternity Safety Champions.

The maternity element of trust CNST contributions for 2018/19 has been increased by 10% to create a maternity incentive fund. Maternity services that can demonstrate progress against 10 actions will be eligible for a share of that incentive fund. In some circumstances this means that the Trust could be returned both the incentive scheme component of its contribution and a share of the balance of any undistributed funds.

To support trusts that are not performing as well, maternity services that do not demonstrate adequate progress may be allocated a smaller sum from the incentive fund to support them to implement the required actions.

The Maternity incentive scheme requires trusts to self-certify (with Board sign-off) their progress against the 10 actions and discuss this with their commissioners before submitting this report and evidence to NHS Resolution by Friday 29 June 2018.

NHS Resolution aims to confirm and pay the value of any incentive payments by the end of August 2018 by way of a one-off credit note (meaning that direct debit payments set up on the basis of your original contribution level will not need to be subsequently adjusted).

NHS Resolution are trialing this approach for 2018/19.

2. Detail of Report and Assurance

Appendix 11 is the NHS Resolution Maternity CNST Self Certification Template that has been completed with supporting evidence that is required to be signed off by the Trust Board and Commissioners. There are 10 standards that the Trust is required to comply with to be eligible for the credit note. The standards are:

1. Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?
4. Can you demonstrate an effective system of medical workforce planning?
5. Can you demonstrate an effective system of midwifery workforce planning?
6. Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?

7. Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?

Vale of York CCG has provided written sign off (appendix 12) on behalf of Vale of York CCG, Scarborough & Ryedale CCG and East Riding CCG.

The report and evidence has been considered at the Quality and Safety Committee on the 22 May 2018 and they are assured we comply with all 10 standards as evidenced.

3. Next Steps

To include update MDS evidence. This is to be provided from NHS digital in the first week of June
To submit signed off report to NHS resolution

4. Detailed Recommendation

Consider evidence and sign off NHS Resolutions CNST self-certification report (appendix 11).

5. Appendix List

Appendix 1 – Standard 1 Evidence
Appendix 2 – Standard 2 Evidence
Appendix 3 – Standard 3 Evidence
Appendix 4 – Standard 4 Evidence
Appendix 5 – Standard 5 Evidence
Appendix 6 – Standard 6 Evidence
Appendix 7 – Standard 7 Evidence
Appendix 8 – Standard 8 Evidence
Appendix 9 – Standard 9 Evidence
Appendix 10 – Standard 10 Evidence
Appendix 11 – NHS Resolution CNST Self Certification Report
Appendix 12 – Letter of sign off from commissioners

Appendix 1 – National Perinatal Mortality Review Tool

Safety action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	The NPMRT was published in February 2018. There have been 3 cases to review from January 2018 to April 2018. All 3 cases have been completed using the NPMRT and submitted on line to MBRRACE. *NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.*	**Yes on York and Scarborough sites**

Appendix 10 – Reporting of Incidents under NHS Resolution's Early Notification Scheme

Safety action	Evidence of Trust's progress	Action met? (Y/N)
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	*Reporting of all qualifying incidents that occurred in the 2017/18 financial year to NHS Resolution under the Early Notification Schemes reporting criteria.* *Trusts should be evidencing the position as at end of March 2018. Self-certification report to Board using template report with Commissioner sign-off.* *NHS Resolution will also use data from the National Neonatal Research Database to verify the Trust's progress against this action.* **Evidence** All qualifying incidents have been reported for 2017/18 Summary of Qualifying Incidents  NHS Resolutions for CNST Evidence April F	**Yes for York and Scarborough sites**

Board report on York Teaching Hospitals NHS Foundation Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 30 May 2018

SECTION A: Evidence of Trust's progress against 10 safety actions:

Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard.

Evidence should be provided to Trust Boards only. Do not send the evidential appendices through to NHS Resolution as it will not be considered

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* *NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.* **Appendix 1**	**Yes on Scarborough and York sites**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* *NHS Resolution will also use data from NHS Digital to verify the Trust's*	**Yes Submitted as a Trust**

standard?	*progress against this action.* **Appendix 2**	
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* *NHS Resolution will cross-check trusts' self-reporting with Neonatal Operational Delivery Networks to verify the Trust's progress against this action.* **Appendix 3**	**Yes on York and Scarborough sites**
4). Can you demonstrate an effective system of medical workforce planning?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document. This should include reference to the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool template* **Appendix 4**	**Yes on York and Scarborough sites**
5). Can you demonstrate an effective system of midwifery workforce planning?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance slides.* **Appendix 5**	**Yes on York and Scarborough sites**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* *NHS Resolution will cross-check trusts' self-reporting with NHS England.*	**Yes on York and Scarborough sites**

	Appendix 6	
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Appendix 7**	**Yes on York and Scarborough sites**
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document. This should include completion of a local training record form.* **Appendix 8**	**Yes on York and Scarborough sites and for all relevant staff groups**
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Appendix 9**	**Yes as a Trust**
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* *NHS Resolution will also use data from the National Neonatal Research*	**Yes on York and Scarborough sites**

Notification scheme?	*Database to verify the Trust's progress against this action.* **Appendix 10**	

SECTION B: Further action required:

If the Trust is unable to demonstrate the required progress against any of the 10 maternity safety actions, please complete an action plan template for each safety action, setting out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering the plan. A completed action plan is required even where Trusts have already completed this section. However, if this section hasn't been completed, the action plan template alone will be sufficient.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund.

Not applicable

SECTION C: Sign-off

……..

For and on behalf of the Board of [INSERT TRUST NAME] confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: ……..

Date: ……..

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

……..

SECTION D: Appendices

Please list and attach copies of all relevant evidential appendices:

****Please note the evidence should be provided to Trust Board only. Please do NOT send the evidential appendices through to NHS Resolution as it will not be considered****

Appendix 1 – Standard 1 Evidence
Appendix 2 – Standard 2 Evidence
Appendix 3 – Standard 3 Evidence
Appendix 4 – Standard 4 Evidence
Appendix 5 – Standard 5 Evidence
Appendix 6 – Standard 6 Evidence
Appendix 7 – Standard 7 Evidence
Appendix 8 – Standard 8 Evidence
Appendix 9 – Standard 9 Evidence

Vale of York
Clinical Commissioning Group

West Offices
Station Rise
York
Y01 6GA
Tel: 01904 555870
RNID typetalk: prefix-18001

Email: valeofyork.contactus@nhs.net
Website: www.valeofyorkccg.nhs.uk

17th May 2018

To whom it may concern,

I am writing on behalf of the Vale of York Clinical Commissioning group and associate commissioners, including Scarborough and Ryedale CCG and East Riding of Yorkshire CCG to acknowledge that we have seen and reviewed the evidence submitted by the maternity services in York Teaching Hospital Foundation Trust as part of their submission.

We have seen and read the Board report and the evidence submitted for standard 10.

Due to the pre-existing scheduled dates of meetings these papers were not able to be presented at our Quality and Performance sub contract Board as they had not yet been received by your internal Board but I can confirm that this will be added to the minutes and an update will be provided at the next meeting.

Yours sincerely,

With kind regards

Deborah Winder

Head of Quality Assurance and Maternity

Vale of York CCG

Appendix 2 – Maternity Services Data Set

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	*Demonstrate progress on at least 8 out of 10 criteria* *NHS Resolution will also use data from NHS Digital to verify the Trust's progress against this action.* Data is being submitted quarterly with 9 out of 10 compliance met in 2017/18 and 18/19 to date. NHS digital have confirmed that they will only provide October to February compliance (attached) as they do not have sufficient time to validate March data prior to the CNST submission deadline.  Copy of CNST Criteria -February 20	**Yes**

Appendix 3 – Transitional Care

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	*Provision of a service delivery model where care, additional to normal infant care, is provided in a postnatal clinical setting or in a bespoke transitional care unit with the mother as primary care giver, supported by appropriately trained healthcare professionals.* *Trusts should assess their transitional care provision as at end of April 2018.* *NHS Resolution will cross-check trusts' self-reporting with Neonatal Operational Delivery Networks to verify the Trust's progress against this action.* **Evidence** Transitional care was commenced as a pilot at York site May 2017 and Scarborough site September 2017. York Teaching Hospitals NHS Foundation Trust are working towards Avoiding Term Admissions In the Neonatal unit (ATAIN) by developing transitional care further following the pilots. In York and Scarborough we have adopted a philosophy of transitional care to keep mothers and babies together where possible. Currently, this is being undertaken for infants meeting a range of criteria.	**Yes on both York and Scarborough sites**

Appendix 3 – Transitional Care

	All transitional care data is captured on Badgernet.  TCU PILOT REPORT 2.docx  TRANSITIONAL CARE SCBU SH 2018	

Appendix 4 – Medical Workforce Planning

Safety action	Evidence of Trust's progress	Action met? (Y/N)
4). Can you demonstrate an effective system of medical workforce planning?	*No more than 20% of middle grade sessions on labour ward filled by consultants acting down from other sessions.* *Trusts to self assess against any consecutive 4 week period in March or April using the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool.* **Evidence** The workforce tools evidence that no more than 20% of middle grade sessions on labour ward filled by consultants acting down from other sessions on both the York Hospital and Scarborough Hospital sites. The workforce tools covered the period of 5 March 2018 to the 1 April 2018 **Completed RCOG Workforce Tool - York**  cnst-workforce-data-collection-tool-reporti **Completed RCOG Workforce Tool – Scarborough**	**Yes**

Appendix 4 – Medical Workforce Planning

	 cnst-workforce-data-collection-tool-reporti **Confirmation email from RCOG of receipt of completed tools**  RE CNST workforce data collection tool re	

Appendix 5 – Effective System of Midwifery Workforce Planning

Safety action	Evidence of Trust's progress	Action met? (Y/N)
5). Can you demonstrate an effective system of midwifery workforce planning?	*Evidence of systematic, evidence based process to calculate midwifery staffing establishments* *Trust Policy demonstrating that, as standard, midwifery labour ward shifts are rostered in a way that allows the labour ward coordinator to have sumpernumerary status* *Good practice includes neonatal workforce in workforce plans* **Evidence** Birthrate plus table top exercise has been completed for York and Scarborough sites in 2017 (based on 2016 maternity birth data and staffing establishment) and 2018 (based on 2017 maternity birth data and staffing establishment) Midwifery staffing is part of the Head of Midwifery report to Board (submitted July 2017 and January 2018) Workforce strategy includes midwifery and support staff. It also includes neonatal workforce information. Birthrate Plus acuity tool is also in place on York and Scarborough Labour Wards.	**Yes at York and Scarborough sites**

Appendix 5 – Effective System of Midwifery Workforce Planning

	Birthrate Plus Table Top  Copy of Birth Rate + Reviews Tool.xlsx **Head of Midwifery Reports to Board**  Cover paper for QS committee July 2017.  July 17 six month update of annual rep  Maternity annual report 2017 .Jan 18.(**Labour ward Staffing**  labour-ward-staffing -v2.pdf **Directorate Workforce Strategy 2018-19**  Obstetrics and Gynaecology Strategi	

Appendix 6 – Saving Babies' Lives Care Bundle

Safety action	Evidence of Trust's progress	Action met? (Y/N)
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	*Ability to demonstrate Board level consideration of the SBL care bundle in a way that supports the delivery of safer maternity services.* *Board minutes demonstrating that each element of the SBL has been implemented or that an alternative intervention put in place to deliver against elements.* *NHS Resolution will cross-check trusts' self-reporting with NHS England.* **Evidence** All 4 elements of the Saving babies Lives care bundles have been implemented; 1. Reducing smoking in pregnancy 2. Risk assessment and surveillance for fetal growth restriction 3. Raising awareness of reduced fetal movement 4. Effective fetal monitoring during labour Information submitted in March to the Maternity Clinical Network NHS England for survey 9 evidences self-reporting of implementation of all elements. Survey 9 (below) received from clinical network on 17 May 2018#	**Yes at York and Scarborough sites**

Appendix 6 – Saving Babies' Lives Care Bundle

Stillbirth Reduction Care Bundle Elements	Survey 5	Survey 6	Survey 7	Survey 8	Survey 9
Carbon monoxide (CO) testing of all pregnant women at booking appointment?	partially	partially	yes	yes	yes
Referrals (as appropriate) to a stop smoking service/specialist, based on an opt out system?	yes	yes	yes	yes	yes
Customised antenatal growth charts for all pregnant women by clinicians who have gained competence in their use?	yes	Yes	yes	yes	yes
Use of a growth chart to aid decision making on classification of risk of fetal growth restriction (FGR)?	yes	yes	yes	yes	yes
Screening and monitoring all pregnancies based on the assessment of risk for FGR?	yes	partially	yes	yes	yes
Performing ongoing audits and reporting of Small for Gestational Age (SGA) rates and antenatal detection rates?	yes	No	yes	yes	yes
Ongoing case-note audits of selected cases SGA not detected antenatally, to identify barriers?	yes	No	yes	yes	yes
Provide mothers with information and an advice leaflet on reduced fetal movement (RFM)?	yes	partially	yes	yes	yes

Appendix 6 – Saving Babies' Lives Care Bundle

	Giving pregnant mothers this information by 24 weeks of pregnancy at the latest and is RFM discussed at every subsequent contact?	yes	yes	yes	yes	yes	
	Discussing RFM with pregnant mothers at every subsequent contact	yes	yes	yes	yes	yes	
	Use of a checklist to manage the care of pregnant woman who report reduced fetal movement?	yes	partially	yes	yes	yes	
	All staff who care for women in labour undertake an annual training and competency assessment on cardiotocograph (CTG) interpretation/ intermittent auscultation?	yes	partially	yes	yes	yes	
	Fresh eyes/buddy system to review cardiotocograph (CTG) interpretation/ intermittent auscultation?	yes	No	yes	yes	yes	
	Buddy system include a protocol for escalation if concerns are raised?	yes	Yes	yes	yes	yes	
	Head of Midwifery Annual Report						

Appendix 6 – Saving Babies' Lives Care Bundle

	Maternity annual report 2017 .Jan 18.(**Board of Directors Public Board Meeting Minutes (23 January 2018, pg 93)** 31.01.18 BoDPub p 93.pdf	

Appendix 7 – Patient Feedback

Safety action	Evidence of Trust's progress	Action met? (Y/N)
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	**Evidence** Maternity Services Liaison Committee at York site; feedback is provided by representatives from user groups and other feedback from surveys is reviewed with actions developed. Perinatal mental health survey undertaken by VoY CCG and York maternity Maternity Friends and Family Test York and Scarborough sites. Quarterly reports shared at MSLC with actions from feedback summarised in the report. National maternity survey 2017 York and Scarborough sites. Action plan developed from this survey shared with Trust board and discussed at MSLC. Feedback from complaints with actions documented on DATIX and shared with staff at mandatory training, e-mail and risk newsletter.	**Yes at York and Scarborough sites**
MSLC minutes and Terms of reference	 Minutes MSLC 7 09 2017 (2)-draft.doc  MSLC Mins Dec 2017.doc  MSLC June 2017.docx  MSLC Mins Sept 2017.doc  Minutes-march 2018v2.docx	

Appendix 7 – Patient Feedback

	VoY CCG MSLC TOR Dec 2016 final.docx	
FFT Quarterly reports	York Trust Maternity Friends Family Q4 Re; York Trust Maternity Friends Family Q1 Re; York Trust Maternity Friends Family Q2 Re; York Trust Maternity Friends Family Q3 Re	
National maternity survey with action plan	Report on National Maternity Survey Res; Action Plan 2018 v 2.docx; Poster maternity survey results.pdf	
Risk newsletter (evidence feedback from complaints)	Newsletter MayJuneJuly 2017.pp; Newsletter NovDecJan 2018.ppt	
Staff training includes responses from complaints	professional standards.ppt	

Appendix 8 - Training

Safety action	Evidence of Trust's progress	Action met? (Y/N)
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	*Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands on workshops.* *Maternity staff attendees should include:* • *Obstetricians (consultants, staff grades and trainees)* • *Obstetrics anaesthetic staff (consultants and relevant trainees)* • *Midwives (including midwifery managers, matrons, community midwives and bank midwives)* • *Maternity theatres and critical care staff* • *Health Care Assistants* *Trusts should be evidencing position as at end April 2018* *Completion of the CNST local training records form following each training day including details of programme as well as entering attendees on their local training database to demonstrate percentage attendance for each staff group.* **Evidence** **Course Programmes**  SGH PROMPT Course Programme 2018.doc  York PROMPT Course Programme 2018.doc	**Yes**

Appendix 8 - Training

Example of CNST local training record from a training day with attendance list


Apr 2018 - FM - York Maternity-Safety-CNS


Dec 2017 - PROMPT-York Maternity-Safety


Dec 2017 Attendance lists.pdf

Compliance – Fetal Monitoring

York Hospital Site

	CTG elearning	Fetal Monitoring/Peer Review
	% trained	% trained
Obstetricians	100%	95%
Midwives	99%	98%

Scarborough Hospital Site

	CTG elearning	Fetal Monitoring/Peer Review
	% trained	% trained
Obstetricians	93%	100%
Midwives	100%	97%

Appendix 8 - Training

Compliance – Obstetrics Emergency Training

York Hospital Site

	% trained
Obstetricians	100%
Midwives	98%
HCA's	96%
ODP's	92%
Anaesthetists	94%

Scarborough Hospital Site

	% trained
Obstetricians	93%
Midwives	96%
HCA's	98%
ODP's	95%
Anaesthetists	93%

Appendix 9 – Trust Safety Champions

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	*Demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bi-monthly with board level champions to escalate locally identified issues.* **<u>Evidence</u>** The Maternity Safety Champions midwives and obstetrician meet bi monthly with the Chief nurse who is Board level maternity safety champion. Meetings are planned for the year 2018 Maternity Safety plan is discussed at this meeting with safety concerns raised for escalation as appropriate to the board.	**Yes as a Trust**
Agenda and minutes of meetings	 February 2018 Agenda Maternity Sa  Feb 18 Action Notes Maternity safety cha  April 2018 Agenda Maternity Safety Cha  April 18 Action Notes Maternity safety cha	

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Complaints Annual Report

Recommendation

For information	☐
For discussion	☐
For assurance	☒
For approval	☐
A regulatory requirement	☒

Current approval route of report

This report has not been received by any previous committees.

Purpose of report

- Published under Regulation 18 of the Local Authority & Social Services & NHS Complaints Regulation 2009
- Assurance that a process is in place within the Trust to receive, respond to and learn from complaints.

Key points for discussion

The Trust received 452 formal complaints in 2017-18.

10 new cases were investigated by the Parliamentary and Health Service Ombudsman. Of the six cases that were concluded this year, 33.3% were not upheld and 66.7% were partially upheld.

The most frequent subjects of complaint are clinical treatment, patient care, communication and staff behaviours.

Operational reports on complaint 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 is undertaken on a quarterly basis to check for compliance with the Trust complaints policy, including the completion of action plans.

Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☐ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

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

Version number: 1

Authors: Helen Hey, Deputy Chief Nurse & Justine Harle, Lead for Complaints & PALS

Executive sponsor: Beverley Geary, Chief Nurse

Date: April 2018

Complaints Annual Report: 2017-18

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

New complaints	Q1	Q2	Q3	Q4	Total
York	77	90	56	52	**275**
Scarborough	33	50	38	35	**156**
Bridlington	1	3	4	4	**12**
Community Services	5	1	3	0	**9**
Total	**116**	**144**	**101**	**91**	**452**

452 complaints were reported via the statutory KO41 return to the Health and Social Care Information Centre.

In addition, fifty eight cases were reopened at the request of the complainant and a further investigation conducted.

Dissatisfied	Q1	Q2	Q3	Q4	Total
York	12	11	7	7	**37**
Scarborough	3	8	3	3	**17**
Bridlington	0	0	0	2	**2**
Community Services	2	0	0	0	**2**
Total	**17**	**19**	**10**	**12**	**58**

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

The table below shows the outcomes of cases closed in 2017-18

Outcome	Q1	Q2	Q3	Q4	Total
Not upheld	31	29	38	38	**136**
Partially Upheld	52	69	60	49	**230**
Upheld	24	28	25	14	**91**
Referral to SI	0	0	7	0	**7**
Withdrawn	2	2	0	0	**4**
Total	**109**	**128**	**130**	**101**	**468**

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

The PHSO investigated a total of 10 cases in 2017/18, compared to 18 in 2016/17 and 24 in 2015/16.

The table below shows the outcomes of all Parliamentary and Health Service Ombudsman cases closed in 2017-18. Of the six cases closed, four were received in 2016-17 and two in 2017-18. Six cases received in 2017-18 remain open (the remaining two were closed in 2018-19).

Outcome	Q1	Q2	Q3	Q4	Total
Not upheld	1	0	0	1	2
Partially upheld	2	0	2	0	4
Upheld	0	0	0	0	0
Total	**3**	**0**	**2**	**1**	**6**

The table below shows the outcomes for cases closed in 2017-18 by directorate

Directorate	Outcome
Elderly Medicine	Partly upheld
Emergency Department	Not upheld
Trauma & Orthopaedic	Partly upheld
Child Health	Partly upheld
A&G Medicine Cardiology	Partly upheld
GS&U	Not upheld

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	Total
Allied Health Professionals	4	3	5	2	**14**
Child Health	2	4	2	2	**10**
Community Services	3	1	1	0	**5**
Elderly Medicine	11	17	9	11	**48**
Emergency Medicine	13	13	12	10	**48**
Estates and Facilities	2	4	0	1	**7**
Finance & Performance	0	1	0	0	**1**
General Medicine	18	23	7	12	**60**
General Surgery & Urology	11	14	21	13	**59**
Head and Neck	3	3	6	5	**17**
Human Resources	0	0	0	1	**1**
Laboratory Medicine	0	1	0	2	**3**
Medical Governance	1	0	0	0	**1**
Nursing & Improvement	1	2	1	1	**5**
Obstetrics & Gynaecology	11	12	12	7	**42**
Operations	3	1	0	3	**7**
Ophthalmology	3	9	1	2	**15**
Orthopaedics and Trauma	17	13	9	13	**52**
Pharmacy	0	0	0	0	**0**
Radiology	4	6	8	1	**19**
Sexual Health	0	1	2	0	**3**
Specialist Medicine	5	10	1	5	**21**
Systems & Networks	0	3	1	0	**4**
Theatres Anaesthetics & Critical Care	4	3	3	0	**10**
Total	**116**	**144**	**101**	**91**	**452**

Acute medicine complaints are included in the figures for General Medicine up until October 2018. Thereafter, they are included in the figures for Elderly Medicine or Emergency Medicine.

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

Subject	Q1	Q2	Q3	Q4	Total
Access to Treatment or Drugs	1	4	2	4	**11**
Admissions, Transfers and Discharges	20	22	11	21	**74**
Appointments	18	15	19	9	**61**
Clinical Treatment	85	95	66	69	**315**
Communication	34	40	28	41	**143**
Consent	2	1	1	0	**4**
End of Life Care	0	2	0	4	**6**
Facilities	9	3	2	1	**15**
Patient Care	45	56	26	44	**171**
Patient Concerns	2	0	0	1	**3**
Prescribing	10	10	6	4	**30**
Privacy, Dignity and Respect	7	16	6	3	**32**
Restraint	1	0	0	0	**1**
Staff Numbers	1	1	1	2	**5**
Trust Admin/Policies/Procedures	8	13	8	7	**36**
Values and Behaviours (Staff)	32	43	32	17	**124**
Waiting Times	1	5	4	7	**17**
Total	**276**	**326**	**212**	**234**	**1048**

One complaint may have several subjects associated with it and this reflects the complexity of many complaints.

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

- Clinical treatment
- Patient care
- Communication with patient and relatives/carers

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

5.1 Making the Complaints System More Responsive

Since the new Policy and Procedure on Concerns and Complaints was implemented on 1 February 2017, directorates have been given increased responsibility for the quality and timeliness of responses and for keeping complainants informed throughout the process.

Some directorates do this effectively and others struggle to prioritise the complaints process against other workload. The length of time that investigations take to complete remains a concern, not least because of the added distress this can cause to complainants and the risk of undermining public confidence in our organisation.

Feedback from the York and North Yorkshire advocacy services was received earlier in the year indicating that a number of their clients have expressed concerns about delays in receiving updates from the investigating officer and the final response and with promised actions being completed within the agreed time period. Each case

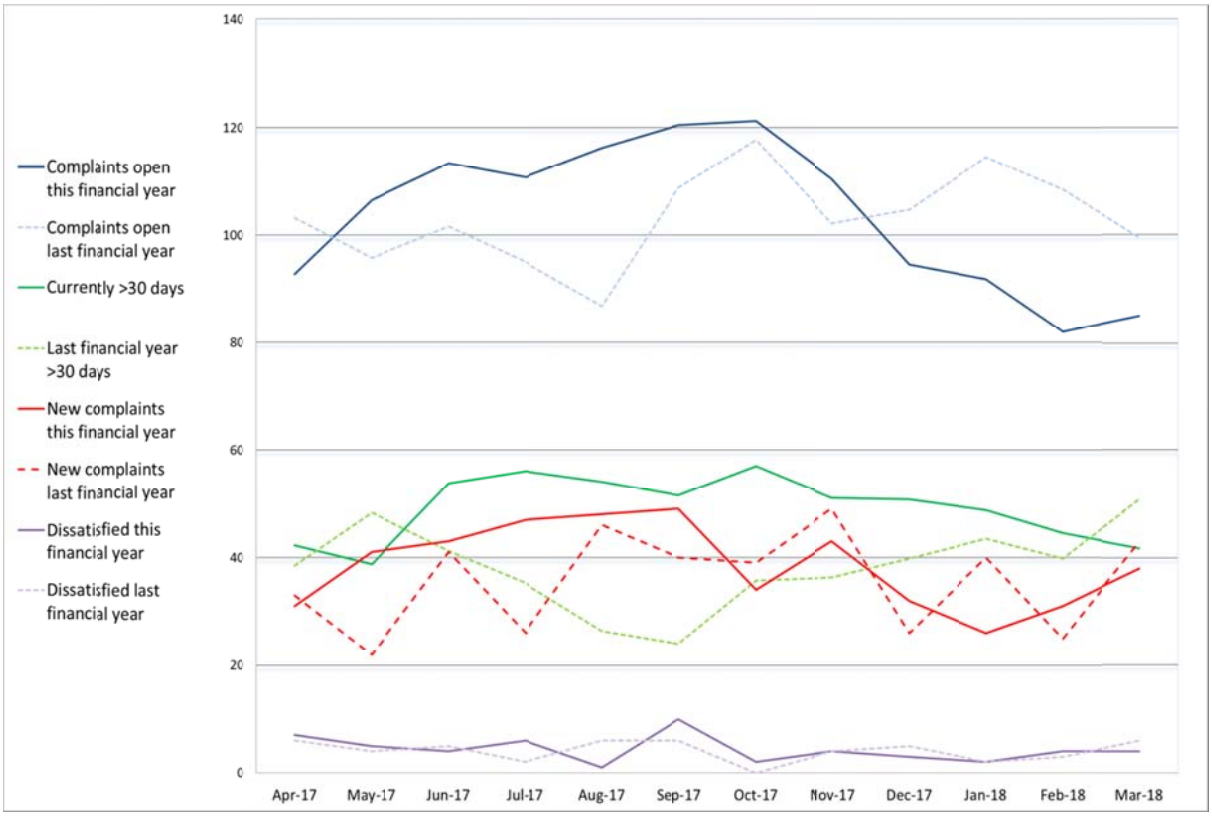
was reviewed to identify the directorates involved and the causes of the delays and open cases were escalated for action.

Responses within target timescale	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Number of cases closed	30	30	45	33	60	39	59	51	32	35	37	34
Number of cases closed within 30 working days	12	8	9	6	16	13	18	13	8	8	10	8
%	**40%**	**27%**	**20%**	**18%**	**27%**	**33%**	**30%**	**25%**	**25%**	**23%**	**27%**	**24%**

The number of complaints over thirty days rose considerably in the first half of the financial year but has been steadily decreasing since October 2017. This coincides with the introduction of performance reports to support each directorate's performance assurance meeting. The quality and safety performance assurance meetings are used to identify issues that are preventing the timely conclusion of complaint investigations and performance against the regulations is monitored at these meetings. Whilst some directorates comply fully within required timeframes others still do not.

However, increasing the speed of investigations should not come at the cost of compromising their quality, and it is accepted that delivering significant improvements may take some time.

Complaints Management Performance



Feedback in 2017 from matrons and directorate managers was that some complaints were being logged formally when, in fact, the best outcome would have been achieved through a timely meeting or conversation rather than a thirty day investigation and written response.

From November 2017, working within the existing Trust Policy on Complaints and Concerns and the NHS Complaint Regulations directorates have until the end of the next working day to contact potential complainants, before logging the complaint. This approach is taken for contacts to the complaints team made verbally and written contacts (email or letter) where the issues raised may be simply resolved or the answers to the questions are already known. There are three possible outcomes following directorate contact: deescalate (agree with the complainant that the issues will be handled as a concern); resolve (case closed) or continue with formal complaints process.

The table below shows the next working day cases closed this financial year.

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	**Total**
Concern	9	7	7	4	5	**32**

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 includes data on compliance with the thirty day target for complaints responses and uphold rates by directorate.

In addition, higher-level reports are produced for the Patient Experience Steering Group and the Board of Directors.

The complaints officers continue to provide support and hold regular meetings with the directorates that receive the highest number of complaints. A key agenda item is reviewing the progress of each open case, offering support where necessary and, if required, prompt the investigating officer to keep the complainant informed about progress. Concerns about specific cases are escalated to the chief nursing team and the deputy chief operating officers.

Each directorate has a Datix dashboard, which shows the real-time caseload and themes/trends over the current and past financial year. There are thematic dashboards for end-of-life/palliative care, dementia and equality/diversity. This allows the professional leads for these services to access learning from any relevant complaints, concerns and compliments.

5.3. Monitoring Learning and Improvement

The Patient Experience Team provides directorates with the data which helps them keep track of their own cases. This should support them to:

- Deliver timely responses
- Identify themes and trends
- Record actions and learning to inform improvement through directorate governance systems

Each directorate has a Datix dashboard which shows:

- Open complaints and PALS cases
- Numbers of cases received by month, ward/service and theme

Dashboards also show numbers, themes and trends for

- End of life care

- Dementia care
- Professional standards

A retrospective audit of cases is undertaken every quarter to check compliance against the Trust complaints policy and best practice for case handling. The Datix files relating to these complaints are reviewed against an audit checklist enabling actions taken at the various stages of the complaint process to be checked. The results are reported to the Patient Experience Steering Group.

There was strong evidence that an apology was given where appropriate and the investigating officers achieved a high score for addressing the issues raised in the complaint and explaining specialist terminology.

Key areas for improvement:

- Response rates
- Investigating officer to maintain contact with the complainant during the investigation

Following the internal audit last year, there is a greater focus on whether action plans have been completed. In order to drive improvements, the Patient Experience Team recommends that directorates prepare action plans, within a specified time frame, to address the failings they identify as part of their investigation. The purpose of these plans is to help prevent failings happening again.

Investigating officers are contacted and asked to confirm that their outstanding actions had been completed and to describe their evidence. Strengthening the process for following up actions is a continuing priority.

The Patient Experience Team, under the guidance of the Steering Group, will continue to support directorates to capture learning and actions from complaints and provide assurance that actions have been completed.

The complaints team has revised the guide for investigating officers and has included a checklist to support investigating officers in completing all the required fields, specifically those that impact on the KO41 returns. This information is also required by the PHSO for independent investigations.

Internal Audit of Complaint Management

In Q4 the internal audit team conducted an audit of complaints management: The objective of the audit was to gain assurance that the recommendations made in Y1764: Follow Up - Management of Complaints, Concerns and Patient Feedback audit report have been fully implemented. The review established that significant progress has been made to implement the recommendations made in the previous audit report of 2017.

It was recommended that training should be mandatory for all new investigating officers, prior to undertaking a complaint investigation. Currently the complaints team provides an induction on complaints management for new starters and provides support to investigating officers as requested. In addition, training on how to conduct investigations has been provided by the SI team.

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

Clinical Treatment remains the top subject for complaints. Within this, delay/failure of treatment or procedure, missed/incorrect diagnosis and delay/failure to undertake a scan/x-ray are the most frequent sub-subjects. Learning this year has included ward staff being reminded via handover and safety huddles of the importance of timely assessment of pain and action on requests for pain relief. The anticoagulation policy for high risk patients undergoing joint replacement has been updated and this has been communicated via clinical governance meetings.

Patient Care is the next most frequent subject raised in complaints. 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 – changes to supervision of high risk patients, promotion of local resolution, and revision of comfort rounds.

Communication with patients and families is the third most common issue raised. This includes breakdown in communication, between staff, inadequate information provided and conflicting advice given. This has been evident in cases relating to discharge arrangements. The Trust has introduced a project called 'SAFER'. Part of the project focus is on discharges and medications, both at ward level and in the discharge lounge. The aim is to improve the patient experience by ensuring doctors and nurses place as much emphasis and time on safely managing discharges as early in the patient's hospital stay as possible. This process is currently being rolled out on wards.

7. Looking Ahead to 2018-19

There are two key areas for development for 2018-19. These are:

7.1 Getting an effective escalation route when individual complaints are overdue or a directorate is regularly failing to achieve timescales is an essential part of improving the system. Alignment of the Assistant Directors of Nursing to directorates is a step towards this, as they will be responsible for engaging with matrons and directorate management to improve performance. Establishing the Patient Experience Operational Group to oversee the day-to-day performance of the complaints process is an important next step.

7.2 Following conclusion of the operational review, and when the revised directorate structure has been agreed, training needs analysis will be undertaken to identify training requirements for those undertaking complaints investigations. The process of performance assurance meetings will also be reviewed at this time.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Environment & Estates Committee Minutes - 11 April 2018

Recommendation

For information ☐
For discussion ☒
For assurance ☒
For approval ☐
A regulatory requirement ☐

Current approval route of report

Board of Directors - 30 May 2018.

Purpose of report

The Board of Directors (BoD) is asked to receive the minutes of the Environment & Estates Committee meeting held on 11 April 2018 noting the assurance taken from these discussions and the key items discussed.

Key points for discussion / Decisions required

The Committee agreed to highlight the following to the Board:

Board Assurance Framework – the committee reviewed and updated the section of the BAF 'we fail to respect the privacy and dignity of all of our patients', and agreed to monitor this through the recently introduced quarterly assessment process.

H&S Policy – the committee approved the annual review of this policy.

Changes in Legislation – the CQC now have the inspection and regulatory powers of HSE in respect of all matters on healthcare premises.

Sustainability – having reviewed the Sustainable Development Action Plan in detail the committee were pleased to note that the Trust's annual reporting of progress had been recognised nationally for the second year running as best practice.

The Trust is working towards policies that will improve air quality, which is recognised nationally as a health risk.

Internal Audit Reports – the committee discussed the internal audit programme planned for this year as it relates to the estate and noted that it included a review of fire safety.

Trust Ambitions and Board Assurance Framework
(https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☒ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☒ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Regulation 15: Premises and Equipment

Version number: 1

Author: Brian Golding, Director of Estates & Facilities

Executive sponsor: Michael Sweet, Non-Executive Director / Chair - EEC

Date: May 2018.

Minutes - Environment & Estates Committee meeting – 11th April 2018 - Scarborough Hospital

Attendance: Michael Sweet (MS) (Chair), Brian Golding (BG), Andrew Bennett (AB), David Biggins (DB), Jane Money (JM), Colin Weatherill (CW), Lynda Provins (LP), Jacqueline Carter (JC) (Minutes)

In attendance: Richard Thompson (Governor), Jeanette Anness (Governor).

1. Apologies for absence

None.

It was noted that the committee is currently one NED short.

2. Minutes of last meeting held on 7th February 2018

The minutes of the last meeting held on 6th December 2017 were agreed as a correct record subject to a spelling correction on page 5. The EEC also noted a data correction under the claims reporting (which now reads 6 instead of 0) for quarter 3 in the health & safety report on p115 of the meeting pack.

Governance

3. EEC Protocol

Following discussion at the last meeting the Committee received a revised version of the EEC meeting protocol which had been updated to enhance the Meetings and Minutes sections of the document. DB asked whether the Operations section of the agenda could now be included as part of the Governance section. This was agreed. Following discussion the Committee approved the Protocol subject to the above change. A final copy will be circulated to the EEC members. **Action: JC.**

4. Matters Arising and Action Log:

The Action Log was reviewed by the Committee and will be updated in line with the meeting discussion to include the following corporate governance update:

No. 54 - Internal Audit Reports - LP confirmed that all Limited Assurance reports are seen and discussed with the Chief Executive and/or Director of Finance.

5. Policy & Procedure Schedule

The EEC received the P&P schedule for review. DB advised the Committee that going forward this schedule would be incorporated into the EEC Compliance quarterly report rather than being presented as a separate item. This was noted. JM asked whether item 20 Transport Plan document could be renamed as Travel & Transport. This was agreed.

Following discussion the Committee noted the contents of the document subject to the changes identified above. **Action: DB.**

6. Directorate Risk Register

The EEC received the Directorate Risk Register and reviewed the red and amber risks on the schedule.

In line with discussion at the last meeting EF01 had now been separated out into 2 risks (EF01 and EF49). However, on reflection it was felt EF49 required its scoring to be reviewed again as it was deemed too low. **Action: CW.** It was asked that the "responsible group" for risks EF01 and EF49 to include CPEG. **Action: AB.**

The Committee asked for the "last review dates" column to be updated as it did not reflect the latest discussions that had taken place. **Action: CW.**

The Chair asked for a note to be sent out from BG to Chairs of those reporting groups to remind them that Risk Registers should be discussed routinely at their meetings and reported back accordingly. **Action: BG.**

Following discussion the Committee noted the contents of the document subject to the changes identified above. **Action: CW.**

8. Internal Audit Reports

The Committee received the IA programme of work for 2018/19. The areas selected for audit under the remit of Director of Estates & Facilities were identified.

Areas selected for audit in Q1 are:

- **PAM**
- **Fire Safety**
- **Selection and Management of Contracts**
- **Waste Management**

The EEC will note and/or receive all reports in due course and in line with the Audit work programme.

Other sections of the IA discussed:

Backlog maintenance - area selected for audit in Q2.

For attention of the BoD.

9. Work Programme

The Group received the latest EEC Work Programme. The document will be updated in line with meeting discussion. **Action: JC.**

10. Board Assurance Framework (BAF)

Following discussion at the last meeting the Committee received the BAF schedule specifically to discuss further the rating for section 4.2: “we fail to respect the privacy and dignity of all of our patients”.

The CQC Inspection Report had now been received and provided a number of positive comments on privacy and dignity. However, a comment was raised relating to Ward 16 and the use of mixed sex bays. The CQC had also noted that PLACE scores for privacy and dignity had deteriorated.

LP said that although overall our PLACE percentage scores are quite high it is important to monitor this element. DB felt that the monitoring approach taken in the Trust is correct and asked that the TAPE process be included in the "Assurance" column alongside PLACE as it does include specific information on privacy & dignity and well-being. This was agreed. **Action: LP.**

Following discussion the Committee were satisfied that the rating score remained green subject to internal monitoring. **Action: LP/DB.**

Other sections of BAF discussed:

Section 4.1: “we fail to work as part of our overall community to provide the very best health outcomes in the most appropriate setting”. BG asked that this section be updated to include STP under "Controls/Response" column. A patch wide group is now established and this should be evidenced under the Controls/Response column and removed from the "Gaps in control/assurance column". **Action: LP.**

Section 4.3: “we fail to positively manage our impact on the wider environment and keep our own environment clean and tidy”. JM asked that this section be updated to include compliance with NICE under the "Assurance" column. **Action: LP.**

Following discussion the Committee was assured with the contents of the document subject to the changes identified above. **Action: LP.**

For attention to the BoD.

Sustainability

11. Matters Arising and Action Log

Disposal of Offensive Waste (no. 57 Action Log)
Action c/fwd from last meeting. CW to contact Hugh Stelmach regarding better separation of waste streams and whether offensive waste could be used as a refuse derived fuel to produce heat. **Action: CW.**

Definition of sustainability and level of priority in the Trust
Topic not discussed at BoD Time Out Strategy Day. BoD SDMP and Mission Statement to be refreshed. **Action: BG**

12. NHS Sustainability Week 2018

The NHS Sustainability Awareness Week is planned for 25th - 29th June 2018. Exhibition space will be booked at York and Scarborough hospitals. It was not anticipated to use this week as promotion of the WRM work.

13. Sustainability update

The EEC received an update report on sustainable development and the engagement agenda.

The purpose of the report was to:

- **Advise on the outcome of phase 1 of the WRM consultant engagement work and carbon reduction**

Phase 1 is now complete except for negotiations on possible payment deductions for failure to achieve phase 2 and JM is in negotiation on those actual KPIs. WRM have identified for phase 2, 9 project intervention areas as set out on p.6 of the report and the projected cost savings of £94k which has to be realised in the first year. Phase 1 identified little capacity within the Sustainability department. The cost benefit analysis work includes the recruitment of 3 new staff roles to allow the success of the project. This was noted.

A Business Case is being developed for Phase 2. It was also agreed that JM would provide MS with an off-line briefing on the WRM work.

The EEC were assured of progress made and supported the progression to a FBC for phase 2. **Action: BG/JM.**

- **update the Committee on sustainability business assurance framework monitoring information including the section in the Trust's Annual Report**

JM was pleased to report that the Trust was recognised as having "excellent" sustainability reporting in 2016/17 for NHS England and Public Health England for the second year in succession and it was noted this year the Trust has achieved the third highest score in the country. The Chair congratulated JM and would discuss this further with her. **Action: JM/MS.**

- **update the Committee on the SD action plan priority work**

Carbon and energy fund projects have been on-going in increasing recycling, improving waste separation and reducing the amount of waste going to landfill.

The Trust's domestic black bag waste is now being sent to the new Waste Recovery Plant at Allerton Park which will allow for an increase in the percentage of waste recovered. These changes to the processing of waste will serve to further reduce the Trust's carbon footprint.

P.24 of the document showed the tonnage information for Q3 however, JM tabled an updated graph to show the actual breakdown of waste disposal by category and these latest figures show a continuation of an improving trend that will lead to a reduction in carbon emissions.

The Trust has approved the roll out of waste paper consoles across the Bridlington site. In the addition the Trust is exploring whether the feasibility of recycling single use metal items from the Trust's head and neck department with HES our clinical waste contractor.

Hugh Stelmach, Waste Manager, has been reviewing the waste management plan and has started developing actions that would allow new targets to be set which could be presented to a future meeting.

- **advise on the current compliance level with NICE document NG70**

JM highlighted to the Committee the Trust's current partial compliance on NICE Guidance (NG70) which covers road traffic related air pollution and the impact on air quality and health. This links to the SD Engagement work and sustainable travel and will be part of the Travel & Transport Plan which when complete will include electric vehicles. The onsite car parking policy will also be reviewed.

MS suggested promotion through GPs and into the wider community.

MS thanked JM for this update. The Committee were assured of the progress made and noted the recommendations as set out in the Report.

For attention to the BoD.

Capital and Property

14. Matters Arising and Action Log

Space Management minutes - previously concerns had been raised around the potential use of vacated space for non-clinical activity in Scarborough. AB assured the Committee this was not the case. However, he said if that were to happen it would be necessary to take into account to what extent the vacated space would be suitable for use as clinical space and, therefore, only at that point would he consider looking at his non-clinical space requests.

Condition survey - this survey has now been commissioned and should report in time for this year's ERIC data submission.

Health, Safety & Security

15. Matters Arising and Action Log

HSE Sharps Surveillance Visit - 3/10/17 - the sub group had met and was continuing to meet to work through the recommendations following the HSE visit. A number of actions require to be completed by end June '18. This was noted. **Action: CW.**

H&S Strategy / Datix reporting - (no. 33 Action Log) - CW reminded the Committee that the Strategy was a 5 year document and he was still considering how best he can present the information collated from Datix. At the moment the system is very simple in terms of how we evaluate incidents and it is about how to get best use out of the portal and how other data is collected to support this information for reporting at corporate level. This was noted.

16. Fire Safety update

At the last meeting CW provided a verbal briefing to the Committee on the current position regarding building regulations following Grenfell. He confirmed that national discussions are still on-going and there was no further update at this stage.

17. Any new legislation, CQC, HSE information

On 1st April 2018 a new Memorandum of Understanding came into force (February 2018). The Memorandum addresses the regulatory responsibility for health & safety under the CQC fundamental standards. This means that the CQC is now the prime regulator in regards to health & safety issues in the Trust. CW agreed to prepare a briefing paper for the BoD. **Action: CW.**

For attention to the BoD.

18. Bi-monthly Report - Health, Safety & Security

The Committee received the latest report covering the period ending Q3.

The purpose of the report was to review reported incidents and trending information with regard to health, safety and non-clinical risk:

1.1 Overview - Trust Monitoring Systems

Q3 - 6 claims (table to be amended – item 2 above).
Q3 - 0 SIs

MS asked that the graphs which showed trending information by category in Appendix 1 (Section 1.4.1), be reformatted as discussed. **Action: CW.**

Year End Summary RIDDOR Report 17/18

CW tabled the Year end summary RIDDOR report for 2017/18. This information will be included in the Trust's H&S Annual Report later in the year.

The number of RIDDOR reportable incidents for 17/18 had dropped significantly compared to the same period last year. This was mainly due to the change relating to the 7 day reporting category. LP asked how this compared in the region. CW confirmed numbers for these of types of reports and incidents are similar across the region. MS asked about the RIDDOR categories. CW confirmed that RIDDOR had defined categories for example, if a staff member was injured and the injury did not result in a specific category (ie. a fracture) then it is more than likely that it would fall into the more than 7 day category in any event.

The Committee supported the information as set out in the documentation.

19. Health & Safety Policy

The Health & Safety Policy was received by the Committee for review and approval in line with its review date.

Previous requested amendments had been taken into account in the document:

P.146 stated the key changes to the document.
P.13, section 5 of the document had been enhanced.

A number of other procedures are linked to this document and a question was raised as to whether this overarching Policy could be hyperlinked to those for ease of reference. This was noted.

The EEC approved the Policy. **Action: CW.**

For attention to the BoD.

Finance and Efficiency

20. Matters Arising and Action Log

Financial Recovery Plan - DB clarified for the Committee that this item refers to the routine Carter work stream meetings that had already been arranged and included DB's briefing of the Chief Executive. DB assured the Committee that no additional meetings with the Chief Executive are required. This was noted.

21. Performance & Efficiency Report against Carter Recommendations

The EEC received the latest report which set out the Trust's position against the Carter recommendations and NHS Model Hospital performance dashboard. The following points were highlighted:

The Directorate is performing well as far as metrics are concerned in the cost efficiency elements of the NHS Model Hospital metrics however, there are some opportunities for improvement in efficiencies associated with waste streams and water and sewage costs.

The Trust currently generates around 1,400 tonnes of landfill, recyclable and incineration waste per annum and reducing costs in this area would assist the Directorate with its CIP programme.

The Trust is not yet fully meeting the requirements of the Carter Report recommendations in terms of space utilization but has a range of measures in place to achieve the requirements. We are performing well against non-clinical requirements but not doing well against under utilised space which is mainly due to Bridlington hospital. One of the core work streams which is part of the FRP is estates optimisation.

DB will include some Model Hospital data in the next performance report. **Action: DB.**

MS thanked DB for this update. The Committee were assured of the progress made and noted the content and recommendations of the report.

22. Financial Recovery Plan

No update. This standing item to be removed from future agendas.

Operations

23. Matters Arising and Action Log

None.

24. Premises Assurance Group – minutes of meeting held on 19.2.18

The EEC received the latest PAG minutes for noting and comment. Items highlighted to the Committee are as follows:

- **Gaps in compliance with the premises assurance model which require to be addressed.**
- **Directorate Risk Register to be discussed routinely at those reporting group meetings.**

At the last meeting it was noted that a decision had been taken to remove water fountains in the Trust as part of microbial control measures. DB explained that a programme is in place to identify and remove fountains whilst at the same time ensuring that there is appropriate drinking water available. BG confirmed that within a hospital setting there are different risk groups. The Water Safety Group will be asked to keep the EEC informed of progress. **Action: BG.**

25. PAM Annual Report

The EEC received the Annual Report which set out the Trust compliance position against the NHS PAM for 2017/18.

The report highlighted the following points:

The Trust's compliance position against the model is reduced. It was noted though that "inadequate" ratings had reduced considerably.

Significant backlog maintenance is required across sites including increased scrutiny on accessibility and the condition and appearance of the Estate and the environment.

Document management and control required improvement.

Business continuity planning and asset management arrangements required further development.

P.204 showed the Directorate's Action Plans in place for progressing during 18/19.

MS thanked DB for this update. The Committee approved the document and supported the on-going work.

26. FM Compliance Quarterly Report

The Committee received the first combined compliance report which set out the Trust's position again the audit and surveillance activities carried out in accordance with the premises assurance procedure.

The new document included information on the TAPE process and the policy and procedure schedule which were previously separated out.

A number of KPIs have been produced which were set out on page 2 of the report which includes an assessment mechanism for cleanliness based on the CQC findings. Page 4 set out the position against the programme dashboard for each quarter and on page 9, DB referred to the information on medical equipment surveillance visits for each quarter.

The Committee approved the report and agreed to receive this format at future meetings.

Out of Hospital Care

27. Matters Arising and Action Log

None.

28. Quarterly Report

The EEC received the latest Out of Hospital Care Quarterly Report for noting and comment. The report is prepared for all Board Sub Committees and provides an overview of activities. This report focused on the published CQC report of the health and social care interface in York, the recommendations arising from the review and the system response to these. The Committee noted the report and agreed that no further explanation from Steve Reed was needed on this occasion.

29. Any Other Business

Directorate sickness absence rates - deferred to next meeting. **Action: BG.**

30. Time and Date of Next Meeting

Wednesday 7th June 2018. Bridlington Hospital.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 30 May 2018
Workforce & Organisational Development Committee – 22 May 2018

Attendance: Libby Raper, Non -Executive Director (Chair) (LR)
Brian Golding, Director of Estates & Facilities (BG)
Jenny McAleese, Non-Executive Director (JM)
Polly McMeekin, Deputy Director of Workforce (PM)
Mike Proctor, Chief Executive (MP)
Sallie Whitson, PA to Medical Director (Minutes)

Apologies for Absence: Melanie Liley, Deputy Chief Operating Officer (ML)
Lynda Provins, Foundation Trust Secretary (LP)
Dianne Willcocks, Non-Executive Director (DW)

In Attendance: Lorraine Boyd, Associate Non-Executive Director (LB)
Lynne Mellor, Associate Non-Executive Director (LM)

Minutes of the meeting held on the 20th March 2018

The minutes of the last meeting held on 20th March 2018 were accepted as a true record and ratified.

LR asked the committee if there was any other business that needed to be discussed that was not on the agenda. PM said that she would pick up any issues from the recent Internal Audit Report on E-Rostering under Item 9 the Nurse Rostering project Update.

JM asked if there was any news on the Operational Review. MP said that the time was not right for an operational restructure at the moment and that it would be sensible to put the matter on hold until the new Chief Executive was in post

Action Log

Risk Register

PM confirmed that additional items had been added and that LH would be invited to the June Meeting.

Discrepancies in appraisal rates on Learning Hub

PM confirmed that the recording and reporting of appraisals information would now come direct from the Learning Hub and not ESR to ensure no discrepancy. There had been issues regarding the internal movement of staff and it was now agreed that staff moving roles would have a probationary period appraisal within 4 months of starting their new role.

Appointment Panels for Medical Workforce

PM briefed that it was recognised that the consultant appointment process needed to be reviewed and condensed. One of the aims is to hold the assessment centre on the morning of the interview and also to review the assessment centres.

Regarding the size of the current panels both MP and JM felt that the more people on the panel the less of a test the interview is and JM felt that you are less able to probe the candidate. MP said that he was in awe of the caliber of the recent you people that have been through panels that he has been part of recently.

MP said that there would be discussion at the next BOD on 30 May regarding Scarborough recruitment and the sustainability of Scarborough services.

LR welcomed the idea of trying to streamline the appointment panels.

Risk Registers

HR Risk Register

PM briefed that there are four ongoing issues on the register relating to vacancy factor, impact of contract and sickness absence. The new Consultant Contract is still being negotiated nationally and unlikely to be completed until April 2019.

Monthly Information Pack

JM confirmed that there had been a good strong start to the year regarding research.

PM briefed that turnover has increased marginally and sickness absence continues.

Workforce Metrics Report

Sickness Absence

PM briefed that the sickness absence rate fell in March from 4.90% to 4.55% although this was still significantly higher than in the same month of the previous year with seasonal trends having an impact on this rate with the “cough/cold/flu” reason being 35% higher than the year before.

Following an audit last November into the systems and processes used to manage sickness absence of doctors in training a recommendation was made to benchmark the sickness absence rates for this group of staff against 34 other Acute Teaching Hospital Trusts. Our sickness absence was 1.5% against a benchmark ranging from 0.5% - 2.0%. PM said that this was reassuring and she was confident that the data is being captured correctly although she is not confident about managing it.

The top reason for sickness absence based on both days lost and number of episodes is “Anxiety/stress/depression” with a figure of 24.22%. PM tabled some figures produced by NHS Digital which showed that the general trend was increasing – the latest figures

related to 1 November 2016 – 31 March 2017. PM confirmed that she would ask for more up to date information when available.

JM said that although our sickness absence rate was okay compared to other organisations she felt it seemed high and wondered whether anything else could be done to raise general awareness of the cost to the organisation of sickness absence.

PM said that the Trust struggles with the willingness of GPs to sign patients off for long periods of time, sometimes it was not that the patient was actually unwell but that there were issues at work. LB said that this was always a difficult situation because as a GP you could only go on the information the individual brings to you at the time. There are a number of difficulties regarding the sharing of information with GPs/Occupational Health Departments which is riddled with bureaucracy.

MP asked how the Trust could look at presentism as a badge of honor and although difficult to balance the trust needed to take a sympathetic view to sickness.

PM briefed that the National Terms and conditions due to come in later in the year would reduce unsocial hours payments when off sick – this was with the aim of reducing sickness absence.

LR asked if the Operational Management Team in Scarborough which had a sickness absence rate of 10.66% was being proactively managed. PM assured the Board that the HR Manager was dealing with the issue but that the team was very small and had long-term sickness absence.

Locum TAP Software

PM briefed that the Trust will be piloting a new software app called TAP developed by a Junior Doctor with previous experience in IT coding. The pilot will initially run for 6 months in the Emergency Department at Scarborough Hospital and the Child Health Department in York hopefully increasing numbers on the medical bank and consequently reducing the requirement for costly agency locums.

Recruitment

PM briefed on the nursing recruitment marketplace event that took place on 21 April. Over 80 people attended, 17 people were interviewed on the day with 11 being given offers. Recruitment will keep an eye on open days as there is a feeling that they are starting to have had their day.

The Trust recently attended the Lord Lieutenants Awards Ceremony for Reservists and now have a foothold to speak to the Sea Cadets at Scarborough, 4 Battalion York and RAF Leeming, Northallerton, Leeds and Wakefield regarding opportunities that may be open to them regarding employment.

A Physicians Associate careers fair has recently been held at the University of Hull with 41 applications being received by the Trust. A bespoke open day was then held on 4 May. 90% of those who have applied qualify in October and the final 10% next year. The Trust is looking to appoint 10/15 people. The Trust hope to offer the opportunity to rotate and have exposure to other departments which other Trusts do not currently do.

LR said that these were three good examples of recruitment to be welcomed.

Buying & Selling of Annual Leave

PM briefed that 544 applications had been received this year of which 90% have been approved mainly for the buying of Annual Leave. This scheme had always been a good recruitment tool but with the proposed A4C changes this is to become a national scheme. PM said that this had always proved very popular and was well managed by Staff Benefits. JM asked that the scheme be kept an eye on as although a useful tool it could work against the Trust.

PM confirmed that the carry-over of annual leave is now only allowed in exceptional circumstances

Clinical Excellence Awards

PM briefed that NHS Employers and the BMA have agreed an amendment to the Local Clinical Excellence Awards Scheme. The Trust must run annual awards rounds and New CEA's will run for 3 years and will be non-pensionable and non-consolidated. The new agreement also sets a positive context for further negotiations around the new consultant contract which will be resumed in due course.

JM said she felt that this was a step in the right direction.

PM said that more females should be encouraged to apply for the award.

LR confirmed the need for a Non-Executive Director volunteer to sit on the next CEA panel – it was noted that this was time consuming.

NHS Pay Increases

PM briefed that a deal is likely to be formally agreed later in the year with sign-off by the unions in July and backdated to 1 April. It is likely that there will no longer be automatic and annual increments.

Medical Workforce Report

PM confirmed that in March the Trust had 111 medical vacancies compared with 115 in May. Since the last report the organisation has welcomed 7 new consultants and 2 Trust Grade Doctors. 38 offers of employment have been made to medical staff with 7 offers accepted and 31 waiting to hear. These are currently being chased up.

Of particular note were the successful consultant campaigns in both Obstetrics & Gynaecology where 2 high caliber appointments were made and Colorectal and Vascular Surgery where although only 2 posts advertised 3 candidates were appointed due to their high quality.

PM reported on the review of Trust Grade roles that following more than 30 survey responses and a number of conversations with doctors that a revamped Trust Grade role offering the opportunity for research, training, teaching, improvement projects or professional development (e.g. Masters program) alongside their clinical service would be attractive and currently not offered by any other Trust. Although this would come at an added cost to the Trust it was felt that the Trust Grade role should be remodeled in order to promote long-term retention and a Business Case would be prepared – this is a work in progress.
PM briefed that as part of medical workforce planning the Trust has been exploring different options to source doctors from overseas for 'hard to fill posts". Provisional discussions regarding two options have been undertaken – the first BAPIO (the British Association of Physicians of Indian Origin) in partnership with Health Education England and the second a more traditional recruitment campaign partnering with an agency. LR asked how much the agency would cost and PM confirmed that the fee is usually 10/15% of the upper salary in the first year plus associated costs. PM confirmed that both options would require significant investment from the Trust but have potential to address some shortages in the medical workforce

PM confirmed that the Trust is currently working towards the Junior Doctor Changeover on 1 August. The Trust currently employs 307 junior doctors. It has further been agreed with Health Education England that York will act as host employer for 100 GP trainees this coming year. Under the terms of the agreement the Trust will manage employment checks, payroll services etc and this will attract a payment to the Trust of approximately £400 per trainee.

PM briefed that she has been working with Glenn Miller, Deputy Medical Director to deliver on job planning. Work is progressing considerably better than last year with 95 job plans already signed off. There are only 2 further Executive Panels to be arranged for Radiology and General Surgery & Urology and once these have been completed the job plans of every senior doctor in the Trust will have been discussed.

PM also confirmed that plans to procure an electronic job planning system to streamline the job planning process are continuing to progress and two suppliers have been invited to make a presentation to the Executive Board in June.

Apprenticeship Update

BG briefed on the National Apprenticeship reform that came into effect on 6 April 2017 which required the Trust to pay approximately £1.3 million as a levy each year and ensure that at any one time the Trust has 200 apprentices. Communication in the organisation is being ramped up and there have been articles in Staff Matters for the last three months regarding availability of apprenticeships. BG confirmed that he is concerned over the slow take-up in nursing workforce and there are plans to write to all Directorate Managers to explain their share of the 200.

BG said that he is in the process of designing a chart to show visually the number of apprentices the Trust has at any one time and how much the Trust are spending. JM asked BG how confident he was with the figures. He said that he wasn't sure at the moment but as soon as the data is available in chart form it will be shared regularly with the Committee.

A Project Manager for Apprenticeship reform has been appointed. It is a 3 day per week role, based in the Clinical Work Based Learning Team.

LR raised an issue regarding nursing apprenticeship needs and BG said that although he would like to bring this in-house there is no capacity at the moment to do this – healthcare posts are done but not registration posts.

BG also confirmed that there are plans to develop a training programme in conjunction with Selby College that will ensure all staff are able to move from a Band 1 to a Band 2 although if the new pay award if implemented will in effect take out Band 1.
LM asked if there is a clear pathway that apprentices can see. BG confirmed that in Estates and Facilities there is a clear career path from entry level to Managing Director level.

Nurse Rostering Project Update

PM briefed that the project is bringing about efficiencies. There were 19 actions at the start of the project, 16 of which have been completed. 38 rosters have entered the deep dive process of which 21 have been completed and the rest are work in progress.

Standardisation of shift patterns went out for consultation, there were a number of concerns and suggestions made by staff and this will be discussed at a further JNCC meeting.

There is a focus on finalising duties and reducing unused hours, these are monitored via the ward dashboards which are sent out monthly to the Matron and Ward Manager and there has now also been agreement to send the dashboards to the Operational PAMs following the Deep Dive Review.

PM briefed on the Internal Audit Report for E-Rostering. One of the recommendations was in relation to the European Working Time Directive being added to the Trust's staff bank policies and procedures. PM confirmed that work is currently underway around this

Employee Relations Update

PM briefed that Medical and Dental staff as a group made up 9% of the workforce leaving AfC with 91%. PM also confirmed that as this was the first time the paper had been presented to the WODC it did not include sickness cases to ensure that there was no double counting with the MHPS Team. LR welcomed the data and said that it was helpful to understand what is going on with the workforce and take assurance. MP and JM confirmed that there was nothing standing out in the report although BG stated is was very useful to see the figures and of particular note were the high numbers related to the lowest banded staff.

Organisational Transformation Initiatives

Due to time constraints LR agreed to skip over this agenda item.

BAF Action Plan

PM confirmed that this had now been updated following the last WODC Meeting. Of particular note was to recognise Lisa Smith's role as Freedom to Speak Up/Safe Working Guardian.

PM also briefed that further work would be undertaken to analyse the value of Assessment Centres.

Any Other Business

There were no items raised.

Attention to the Board

- Locum TAP Software
- Medical Workforce Report

It was agreed by members of the committee that due to the size of the Board Agenda for May only a brief summary of the Medical Workforce Report relating specifically to vacancy numbers would be shared.

Time and date of next meeting

The next meeting will be held on 19th June 2018, 16.00 – 17.30 p.m. in the Boardroom, York Hospital.

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NHS

York Teaching Hospital

NHS Foundation Trust

Board of Directors – 30 May 2018
Workforce Report – May 2018

Recommendation

For information	☒
For discussion	☒
For assurance	☐
For approval	☐
A regulatory requirement	☐

Current approval route of report

No approval route prior to Board; the report is shared with the Workforce and Organisational Development Committee for information.

Purpose of report

This report provides an overview of work being undertaken to address workforce challenges, and key workforce metrics (data up to April 2018).

Key points for discussion

- The monthly sickness absence rate in March was 4.55%, decreasing from 4.90% from the previous month but still significantly higher than in the same month of the previous year. Seasonal sickness absence is continuing to have an impact on this rate.
- Staff turnover has shown a small increase in April. 7.14% of the overall 10.57% turnover was due to voluntary resignations.
- The number of applications to buy and/or sell annual leave has increased to 544 for the 2018/19 leave year rising from the 150 applications made when the scheme was originally launched in 2011/12.
- A deal looks to be formally agreed by union leaders offering NHS staff on Agenda for Change contracts a pay increase of at least 6.5% over three years.
- Demand for temporary nurse staffing in April equated to 399.01 FTE whilst demand for temporary medical staffing equated to 100.49 FTE.

Trust Ambitions and Board Assurance Framework (https://www.yorkhospitals.nhs.uk/about_us/our_values/)

The Board Assurance Framework is structured around the four ambitions of the Trust. How does the report relate to the following ambitions:

☐ **Quality and safety** - Our patients must trust us to deliver safe and effective healthcare.
☒ **Finance and performance** - Our sustainable future depends on providing the highest standards of care within our resources.
☒ **People and Capability** - The quality of our services is wholly dependent on our teams of staff.
☐ **Facilities and environment** - We must continually strive to ensure that our environment is fit for our future.

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

Version number: 1

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1. Introduction and Background

May's Workforce Report details a number of key workforce metrics, with commentary around: the Trust's current sickness absence levels, the Trust's latest turnover figures and the current levels of temporary medical and nurse staffing utilisation within the Trust. The report provides an update on a number of recruitment campaigns including the recent nursing recruitment marketplace and the Physician Associate Careers Fair and provides an overview of the NHS Pay Increase deal as well as the changes to the Clinical Excellence Awards.

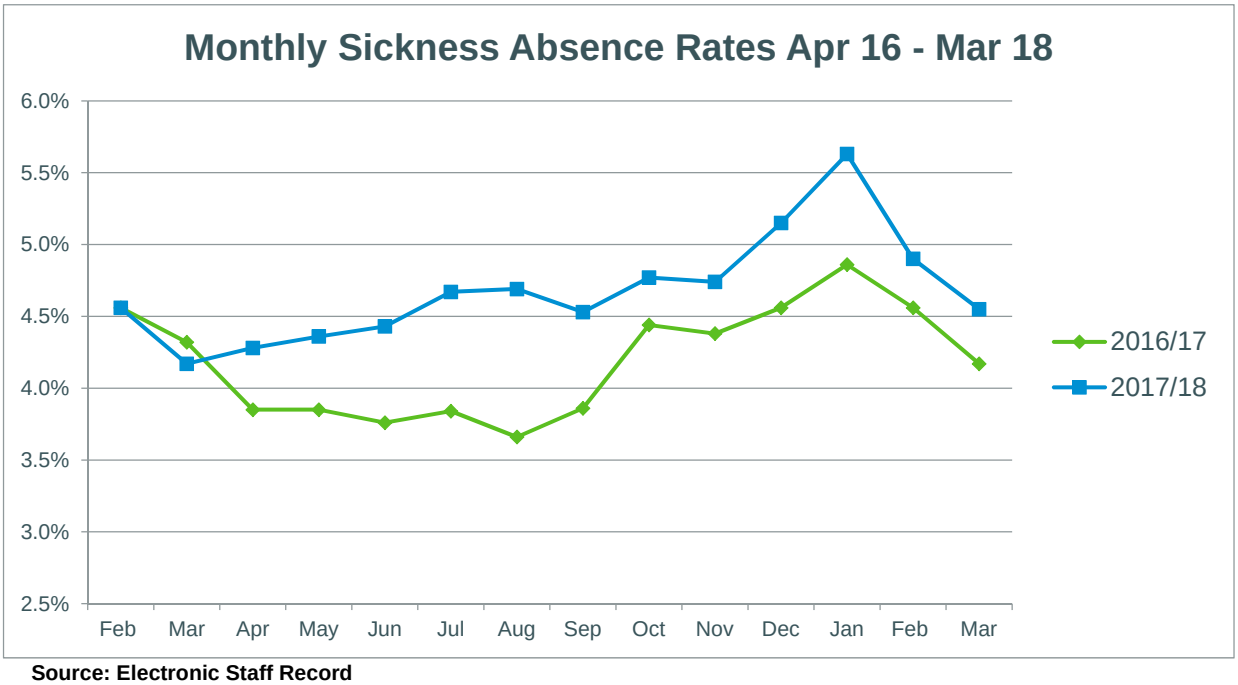
2. Detail of Report and Assurance

The work referred to in the report forms part of regular discussions around workforce, including at Staff Side and Workforce and Organisational Development Committees. It is informed by a number of key performance indicators which underpin directorate-level workforce plans, and link to the Trust's overall Workforce Strategy.

2.1 Sickness Absence

Graph 1 shows the monthly absence rates for the period from April 2016 to March 2018. The monthly absence rate of 4.55% in March 2018 was a decrease from the previous month's sickness absence rate of 4.90% but still considerably higher than the sickness absence rate in the same month of the previous year (the absence rate in March 2017 was 4.17%). Sickness absence since April 2017 has continued to be significantly higher than in the corresponding months of the previous year and is consequently reflected in the continued increase in the cumulative annual sickness absence rate over the same period.

Graph 1 – Monthly Sickness Absence Rates



Source: Electronic Staff Record

Sickness Absence Reasons

The top three reasons for sickness absence in the year ending March 2018 based on both days lost (as FTE) and numbers of episodes are shown in table 1 below:

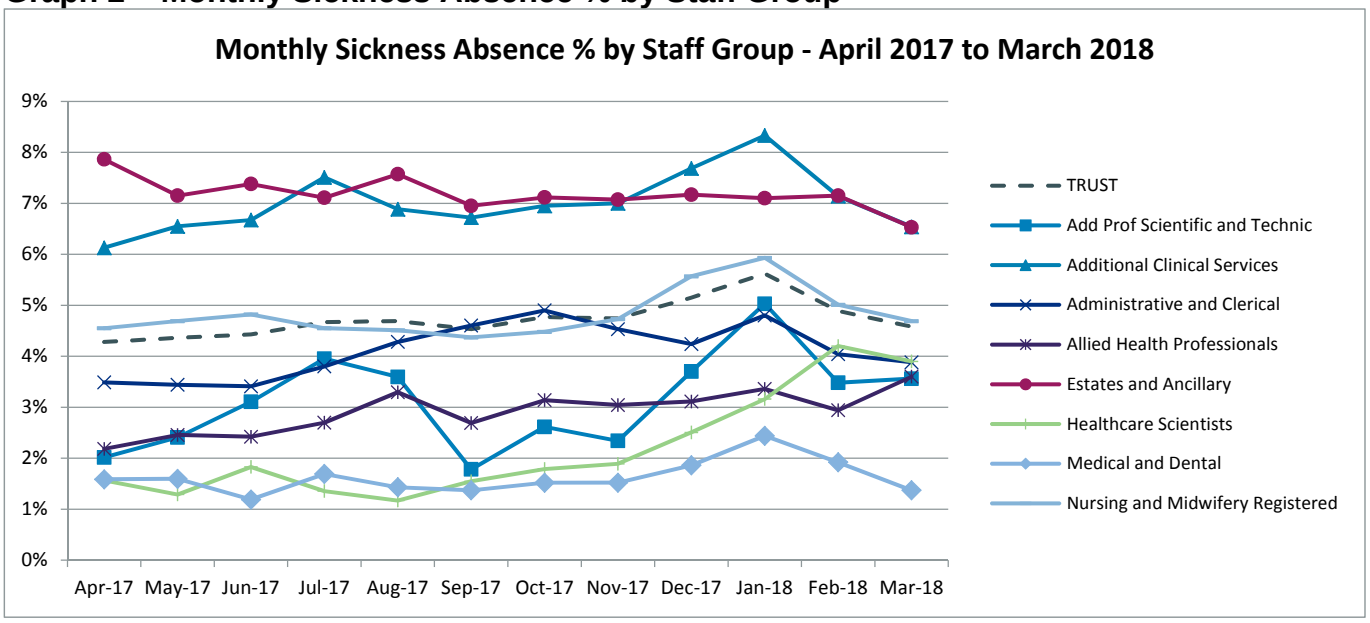
Table 1 – Sickness Absence Reasons for March 2018

Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
Anxiety/stress/depression – 24.22% of all absence days lost	Cold, cough, flu – 18.39% of all absence episodes
MSK problems, inc. Back problems – 16.26% of all absence days lost	Gastrointestinal – 17.97% of all absence episodes
Gastrointestinal – 8.43% of all absence days lost	MSK problems, inc. back problems – 10.85% of all absence episodes

Whilst the sickness reason of Anxiety / Stress / Depression remains the top sickness reason based on FTE days lost followed by MSK problems, seasonal sickness reasons predominated in the number of episodes of sickness absence in March, perhaps partially attributable to the inclement weather that was experienced in that month. In particular sickness absence due to Cold, Coughs and Influenza was the predominant sickness reason based on the number of episodes in March, with almost 35% more episodes than the number of sickness episodes due to same reason in the same month of the previous year.

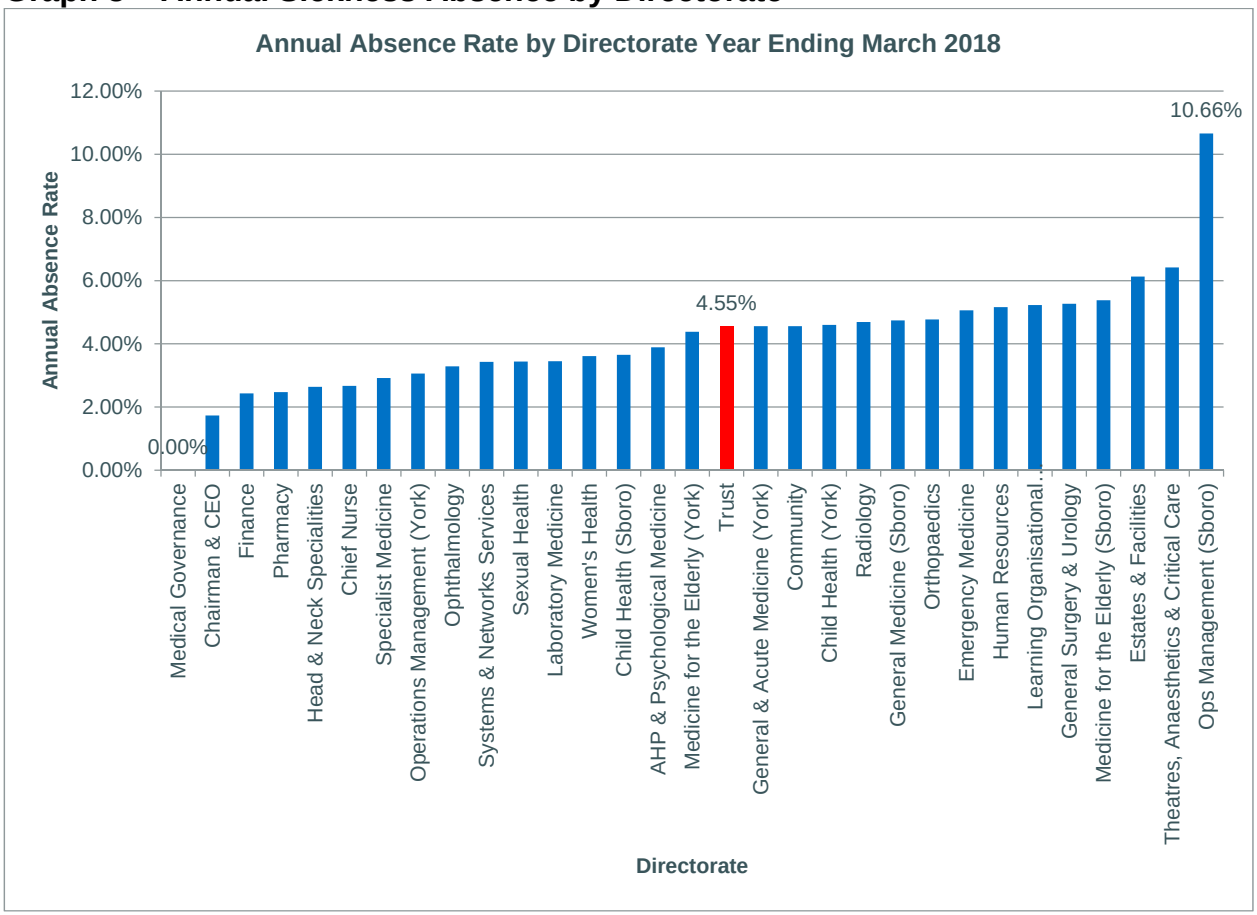
By directorate, Operations Management (Scarborough) has the highest annual sickness absence rate in the year to March 2018 (Graph 3). Proportionately this is one of the smallest directorates within the organisation (with a headcount of 33 staff as at March 2018). By staff group, Additional Clinical Services and Estates and Ancillary, continue to have the highest sickness absence rates (as per Graph 2).

Graph 2 – Monthly Sickness Absence % by Staff Group



Source: Electronic Staff Record

Graph 3 – Annual Sickness Absence by Directorate



Source: Electronic Staff Record

Sickness Absence – Doctors in Training

Following an audit last November into the systems and processes used to manage sickness absence of doctors in training; a recommendation was made to benchmark the sickness absence rates for this group of staff against the other 34 Acute Teaching Hospitals. From February 2017 until January 2018 the sickness absence was 1.5% against a benchmark range from 0.5% to 2.2%.

2.2 Temporary Staffing

Temporary Medical Staffing

In April, 100.49 Full Time Equivalent (FTE) medical locums were requested at the Trust across both York and Scarborough Hospital. In total, 97% of the shifts were filled (97.75 FTE). 42% (46.25 FTE) were filled via Bank whilst 55% were filled via Agency (51.49 FTE). The increase in temporary medical staffing demand in April (compared with a demand of 91.87 FTE the previous month) is partially due to continued requirements for extended winter pressure cover as well as a change in the process for the recording of demand (at the point when a shift is requested) thus allowing for more timely and accurate reporting.

Vacancies have recently been filled for an agency gastro consultant in York and, in Scarborough, an agency respiratory consultant, surgical registrar and CTs in Medicine and

Emergency medicine. This has consequently been a big contributory factor in the increase in agency usage in April.

Locum TAP Software

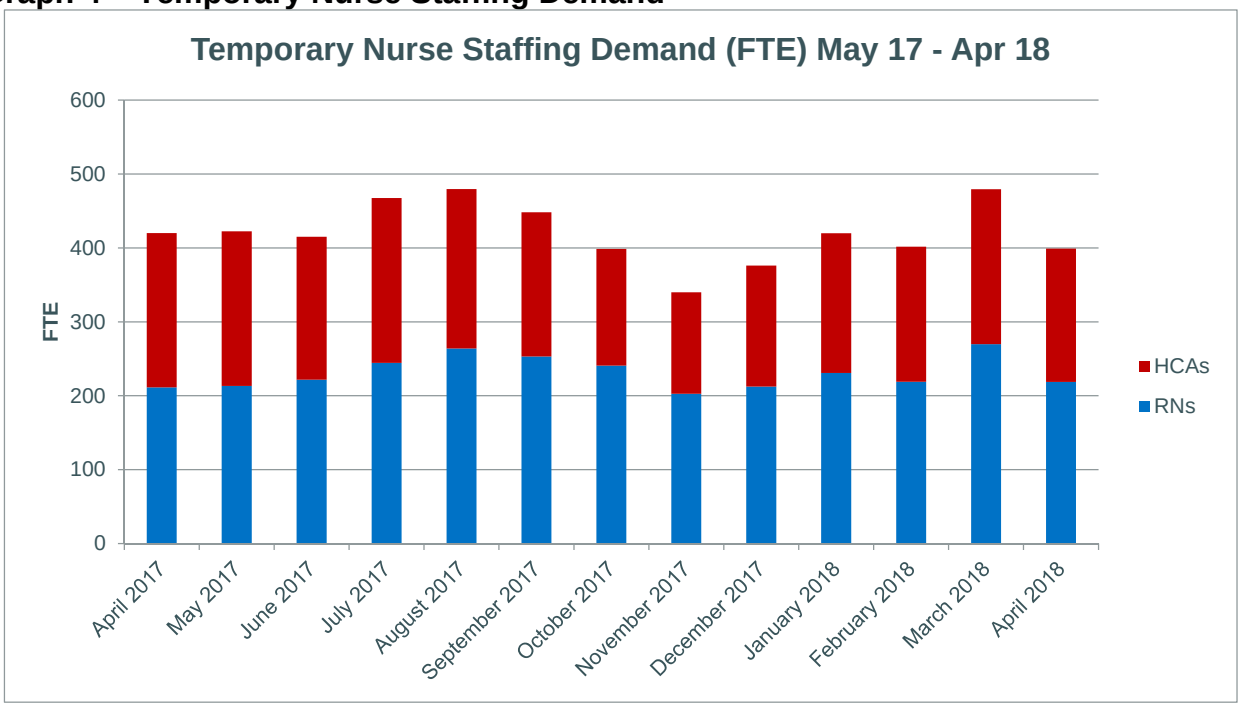
The Trust will be piloting 'TAP' - new bank management software originally launched at Chelsea and Westminster Hospital NHS Foundation Trust and developed by a doctor with previous experience in IT coding. The software is also partially owned by the NHS.

The pilot will run initially for 6 months in Emergency Department at Scarborough and Child Health in York with a view that it will increase numbers on the medical bank and consequently result in cost savings through the reduction in the requirement for more costly agency locum usage. Following a review of the pilot, a decision will be made to roll out the software across the rest of the organisation and a business case will be developed accordingly following lessons learnt from the pilot.

Temporary Nurse Staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has equated to an average of 421 FTE staff per month. Demand in April 2018 equated to 399.01 FTE which was lower than demand in the same month of the previous year (demand in April 2017 was 420.13 FTE).

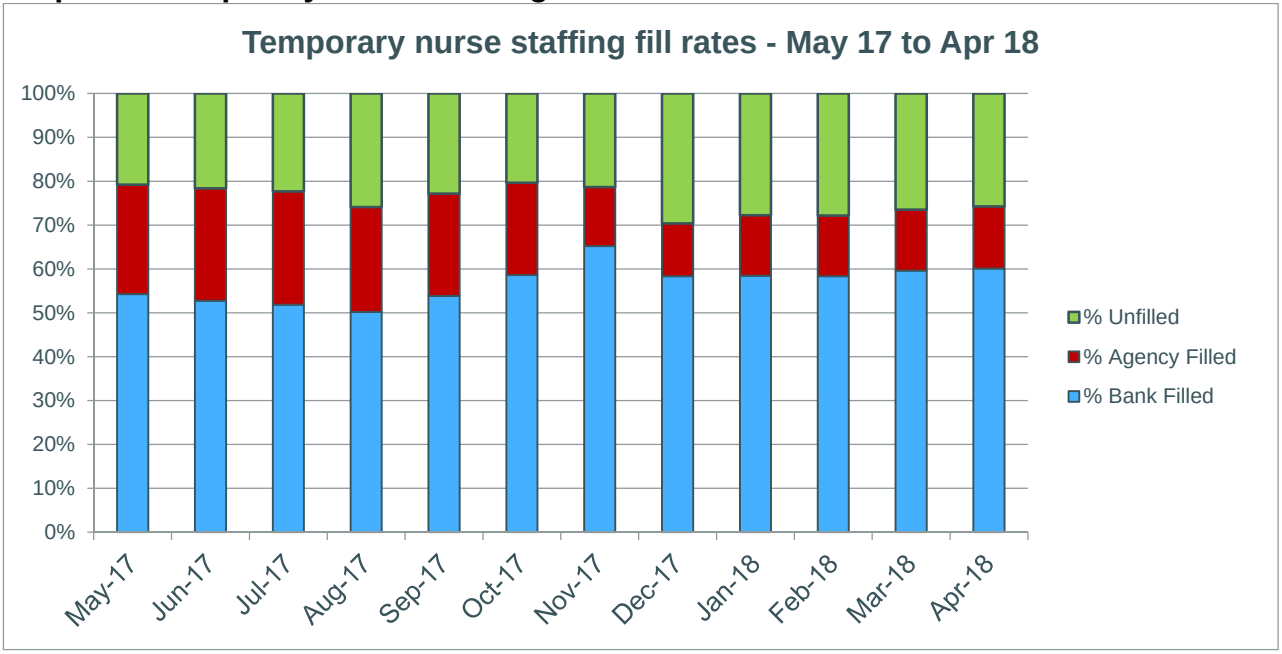
Graph 4 – Temporary Nurse Staffing Demand



Source: BankStaff

Graph 5 shows the proportion of all shifts requested that were either filled by Bank, Agency or were unfilled. Overall, Bank fill-rates made up 60.12% of all requests in April 2018 whilst the Agency fill-rate was 14.14%.

Graph 5 – Temporary Nurse Staffing Fill Rates



Source: BankStaff

2.3 Recruitment

Nursing Recruitment Marketplace

A recruitment marketplace event was held in York on 21 April. This included a number of information sessions around specific roles, and also gave people the opportunity to find out more about the nursing vacancies the Trust is looking to fill.

Over 80 people attended Healthcare Assistant Information sessions and around 20 people attended sessions on Associate Practitioner/Nursing Associates as well as a number of enquiries about applying for nursing positions. 17 people were interviewed for nursing jobs on the day and candidates wishing to progress in the process will have until 6 May to consequently submit an application.

We are continuing to explore all options for how we can engage with student nurses as well as recruit experienced nurses in the Trust.

Engaging with the Military to enhance Recruitment and Retention

The Trust recently attended the Lord Lieutenants Awards Ceremony for Reservists who have gone above and beyond the expectations of their roles. This provided a foothold to discuss further interventions for improving recruitment and retention of reservists in the Trust in the future. To that end we have been invited to speak to the Sea Cadets at Scarborough about careers at the Trust. We have also made contact with 4 Battalion Yorks and have been invited to speak and give a presentation about the Trust and the opportunities which may be open to them.

As with the Regular army, the Cadets and Reservist are trained to lead by example; encourage thinking; apply reward and self-discipline as well as demanding high

performance from themselves as well as their colleagues around them. They encourage confidence within small and large teams and recognise individual strengths and weakness.

Our longer term intentions include giving presentations to RAF Leeming, North Allerton, The Queens Own Yeomanry, Fulford York, Linton-On-Ouse York, Carlton Barracks, Leeds and Reservist Wakefield and beyond. We are also exploring further targeted recruitment to reach wider military personnel.

HEE Y&H 3rd Physician Associate Careers Fair

A Physician Associate Career Fair was held at the University of Hull on 13 April. The Trust was one of approximately 20 NHS organisations exhibiting at the event to around 90 trainee PAs.

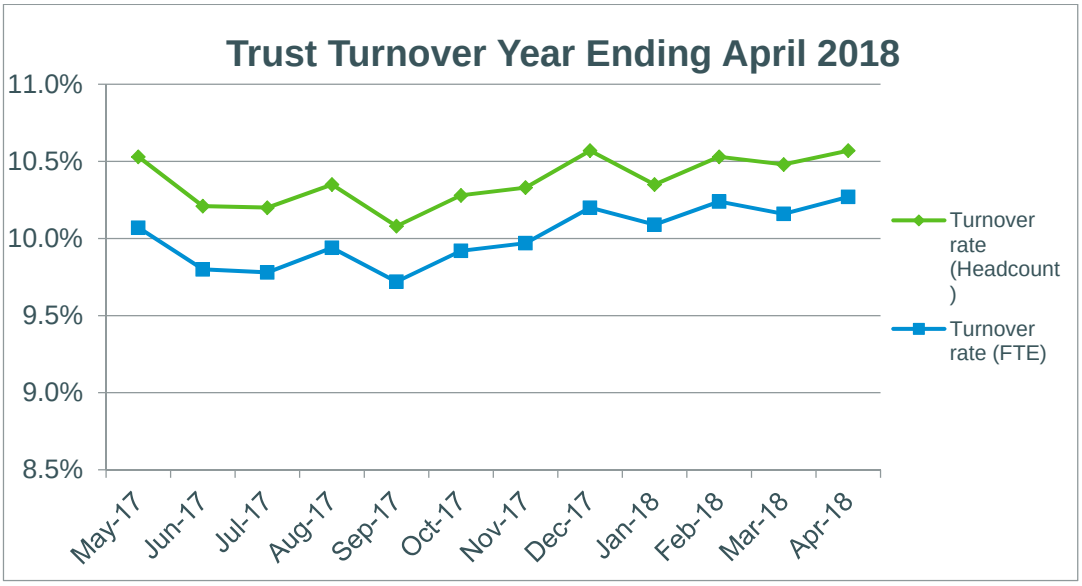
This was an opportunity for organisations to meet the trainee PAs and network with other NHS organisations who are looking to recruit PAs in both primary and secondary care.

Following the PA Careers Fair the Trust received 41 applications and hosted an open day for those interested in learning more about the Trust on Friday 4th May. The open day was well attended and we look to appoint between 10 and 15 into the Trust for when they qualify later this year.

2.4 Staff Turnover

Turnover in the year to the end of April 2018 was 10.57% based on headcount. Turnover calculated based on full time equivalent leavers for the same period was 10.27%. This was an increase from the turnover rate in the year to the end of March 2018 (which was 10.48% based on headcount and 10.16% based on FTE). The turnover rate in the year to the end of April 2018 represented 848 leavers from the organisation.

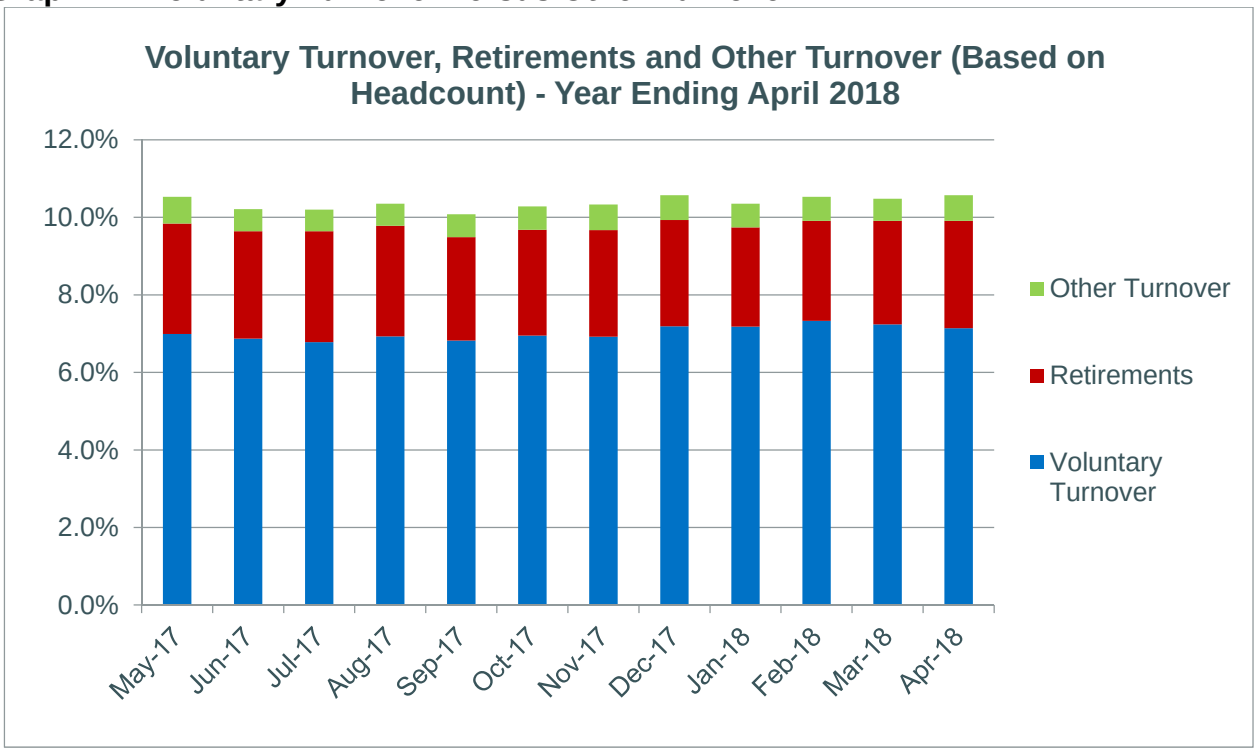
Graph 6 – Overall Turnover Rates



Source: Electronic Staff Record

Graph 7 below shows a breakdown of the Trust's turnover rate based on the proportion of voluntary leavers (such as voluntary resignations due to promotion, relocation, work/ life balance etc.) compared with the proportion of turnover due to retirements and the proportion based on other leaving reasons (such as dismissals etc.). In April 2018 the Trust's turnover rate was 7.14% based on all voluntary resignations (and based on headcount).

Graph 7 – Voluntary Turnover versus Other Turnover



Source: Electronic Staff Record

The turnover rates shown in the graph exclude all staff on fixed term contracts, including all junior doctors on rotational contracts. This is a common convention used across the NHS for calculating turnover. The figures also exclude staff subject to TUPE.

2.5 Buying and Selling Annual Leave Scheme

- The number of applications received has increased each year since the launch of the scheme in 2011 from 150 to 544.
- The approval rates have remained relatively static for the last 2 years at around 90%.

Applications Received

	2011/2012	2012/2013	2013/2014	2015/2016	2016/2017	2017/2018	2018/2019
Total Applications	150	195	250	318	397	469	544
Applications to Buy	141	184	233	296	373	445	520
Applications to Sell	9	11	17	22	24	24	24

Approval Rates

	2011/2012	2012/2013	2013/2014	2015/2016	2016/2017	2017/2018	2018/2019
Total Approved	126	152	208	265	374	426	491
Percentage Approved	84%	78%	83%	83%	95%	91%	90%
Approved Buying	117	142	191	244	350	406	471
Approved Selling	9	10	17	21	24	20	24
Declined Buying	24	42	42	27	23	39	43
Declined Selling	0	1	0	0	0	4	0

2.6 Clinical Excellence Awards

NHS Employers and the British Medical Association (BMA) have agreed an amendment to the Local Clinical Excellence Awards (LCEAs) Scheme.

The changes, which are endorsed by the Department of Health and Social Care and are applicable to consultants directly employed on the Terms and Conditions – Consultants (England) 2003, state that:

- Trusts must run annual awards rounds;
- The investment ratio of new awards will be 0.3 per eligible consultant;
- Awards rounds must be conducted in line with current agreed policies, subject to any changes reached in agreement with your LNC;
- Existing LCEA (those granted before April 2018) will be retained and will remain pensionable and consolidated;
- New CEA (those granted after April 2018) will be non-pensionable and non-consolidated.

NHS Employers and the BMA believe that this agreement provides stability and clarity for consultants and employers on the availability of awards for quality and excellence, acknowledging personal contributions. It also sets a positive context for further negotiations around a new consultant contract, which will be resumed in due course.

2.7 NHS Pay Increases

A deal is likely to be formally agreed by union leaders offering NHS staff on Agenda for Change contracts a pay increase of at least 6.5% over three years. Union members will now be asked to vote on the deal, and rises will be backdated to April 2018 if they agree by the summer.

The deal is tiered with the lowest-paid in each band receiving the biggest rise. In addition:-

- half will get a 6.5% pay rise over three years;
- the other half will receive rises of between 9% and 29% because they are not at the top of their pay bands;

- the lowest full-time salary - paid to those in roles including; cleaners, porters and catering staff - will rise by 15% to more than £18,000;
- these groups will get an immediate £2,000 rise this year;
- a nurse with one year's experience would see their basic pay rise by 21% over three years, giving them a salary of up to £27,400;
- the deal includes a commitment on both sides to reduce the high rate of sickness absence in the NHS.

2.8 Next Steps

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.

2.9 Recommendation

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