York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public Meeting)

Wednesday 25 July 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 25 July 2018

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

TIME	MEETING	LOCATION	ATTENDEES
9.00 – 10.15	Board of Directors meeting held in private	Boardroom, Foundation Trust Headquarters	Board of Directors
10.45 – 1.55	**Board of Directors meeting held in public**	**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 • Mike Proctor • Wendy Scott (Melanie Liley attending) • Lucy Brown • Sue Rushbrook • Lynne Mellor	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	9	
3.	**Minutes of the meeting held on 30 May 2018** To receive and approve the minutes from the meeting held on 30 May 2018.	Chair	B	15	
4.	**Matters arising from the minutes and any outstanding actions** To discuss any matters or actions arising from the minutes	Chair	Verbal	-	

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	SUBJECT	LEAD	PAPER	PAGE	TIME
5.	**Patient Story** To receive the details of a patient story.	Dep. Chief Executive/ Matron – General Surgery, Urology & Critical Care	Verbal	-	10.55 – 11.05
6.	**Chief Executives Update** To receive an update from the Chief Executive	Dep. Chief Executive	C	23	11.05 – 11.15
	Partnerships & Alliances				
7.	**HYMS Academic Year** To receive a presentation on HYMS work in the Trust	HYMS Clinical Dean	Presentation	-	11.15 – 11.45
8.	**Student Projects Presentation** To receive a presentation on work with students on understanding life in medicine	Paul Laboi	Presentation	-	11.45 – 12.05
9.	**Out of Hospital Care Report** To receive the Out of Hospital Care Report	Deputy Director Out of Hospital Care	D	29	12.05 – 12.15

	SUBJECT	LEAD	PAPER	PAGE	TIME
Our Finance and Performance Ambition: Our sustainable future depends on providing the highest standards of care within our resources					
10.	**Finance and Performance Committee** To receive the minutes of the last meetings. Papers for information.	Finance Director/ Chief Operating Officer	E	41	12.15 – 12.30
	• Finance Report		E1	55	
	• Efficiency Report		E2	73	
	• Performance Report		E3	85	
11.	Short break				12.30 – 12.40
Our Quality and Safety Ambition: Our patients must trust us to deliver safe and effective healthcare					
12.	**Quality and Safety Committee** To receive the minutes of the last meetings. Papers for information:	Chief Nurse/ Medical Director	F	99	12.40 – 12.55
	• Patient Safety & Quality Report		F1	117	
	• Medical Directors Report		F2	149	
	• Chief Nurse Report		F3	167	
	• Quarterly Patient Experience Report		F4	205	

	SUBJECT	LEAD	PAPER	PAGE	TIME
13.	**Adult In-Patient Survey** To receive the results of the Adult In-Patient Survey	Chief Nurse	G	231	12.55 – 1.05
Our Facilities and Environment Ambitions: We must continually strive to ensure that our environment is fit for our future					
14.	**Environment and Estates Committee** To receive the minutes of the last meeting. Papers for information:	Director of Estates & Facilities	H	247	1.05 – 1.20
	• Memorandum of Understanding		H1	261	
Our People and Capability Ambition: The quality of our services is wholly dependent on our teams of staff					
15.	**Workforce and Organisational Development Committee** To receive the minutes of the last meetings. Papers for information:	Acting Director of Workforce & OD	I	To follow	1.20 – 1.35
	• Workforce Metrics • Workforce Race Equality Standard 2018		I1 I2	265 279	
16.	**Freedom to Speak Up/ Safer Working Guardian Reports** To receive the Freedom to Speak Up/Safer Working Guarding Reports.	Freedom to Speak Up/ Safer Working Guardian	J	303	1.35 – 1.55

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	SUBJECT	LEAD	PAPER	PAGE	TIME
17.	**Any other business** • Reflections on the meeting • BAF Alignment		Verbal	-	1.55
18.	**Time and Date of next meeting** The next meeting will be held on Wednesday 26 September 2018 in the Boardroom, Foundation Trust Headquarters, York Hospital.				

Items for decision in the private meeting:

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

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

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Register of directors' interests
July 2018

York Teaching Hospital
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Additions:

Lucy Brown, Acting Director of Communications - awaiting declaration
Polly McMeekin, Acting Director of Workforce and Organisational Development - awaiting declaration

A

Changes:

Lynne Mellor, Non-Executive Director
Dr Lorraine Boyd, Non-Executive Director
Mike Proctor, Chief Executive
Andrew Bertram, Deputy Chief Executive

Deletions:

Patrick Crowley
Michael Sweet

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

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 Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Jenny McAleese (Non-Executive Director)	**Non-Executive Director**—York Science Park Limited **Director**—Jenny & Kevin McAleese Limited	**50% shareholder and Director**—Jenny & Kevin McAleese Limited	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Trustee**—Graham Burrough Charitable Trust **Member**—Audit Committee, Joseph Rowntree Foundation	**Member of Court**—University of York	Nil
Dr Lorraine Boyd (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 (Non-executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Position with BT (telecom suppliers)

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 Mike Proctor (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
Mr Andrew Bertram (Executive Director Director of Finance/ Deputy Chief Executive)	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
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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NHS
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Board of Directors – 25 July 2018
Public Board Minutes – 30 May 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
Ms L Raper	Non-executive Director
Mr M Sweet	Non-executive Director
Professor D Willcocks	Non-executive Director
Dr L Boyd	Asc. Non-executive Director
Ms L Mellor	Asc. Non-executive Director

Executive Directors

Mr A Bertram	Director of Finance
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
Mrs S Rushbrook	Director of Systems & Networks

In Attendance:

Mrs L Provins	Foundation Trust Secretary
Ms P McMeekin	Deputy Director of Workforce
Mrs H Hey	Deputy Chief Nurse (attending for Mrs Geary)

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
Lesley Pratt – Healthwatch York
Ann Bolland – Public Governor – Selby
Chris Pearson – Stakeholder Governor – NYCC
Daniel Emmott – Member of Estates Staff
Jill Sykes – Staff Governor
Sharon Hurst – Staff Governor

Mick Lee – Staff Governor
Linda Oliver – CQC
Sally Light – Member of the public

Ms Symington welcomed everyone to the meeting.

18/17 Apologies for absence

Apologies were received from Beverley Geary, Chief Nurse.

18/18 Declarations of interest

No further declarations of interest were raised.

18/19 Minutes of the meeting held on the 28 March 2018

The minutes of the meeting held on the 28 March 2018 were approved as a correct record subject to the following amendments:

Page 15 – Minute No. 18/23 should read Patient Story not Patient Safety.

Page 15 – Minute No. 18/23 last paragraph should read that 'One week in February, Scarborough was…'

Page 16 – Minute No. 18/24 penultimate line should read anything above 1%.

18/20 Matters arising from the minutes

Action Log: item 17/012 this needed further discussion.

Action Log: item 17/104 this conversation is in progress.

No further items were discussed.

18/23 Patient Story

Mr Proctor read out a positive letter from a patient's relative regarding observations in ED. Mr Proctor stated that the Board had heard at their meeting in March a very sobering, difficult story about ED and this letter sought to redress the balance.

It was resolved that the Board welcomed the patient story which set the tone of the meeting, reminding the board of its overall purpose

18/24 Chief Executive Report

Chief Executive Retirement - Mr Proctor talked about Mr Crowley's retirement on the 31 May and that he had worked with him since 1993. The Board and those present joined Mr Proctor in wishing Mr Crowley a successful, happy and long retirement.

Scarborough and Ryedale Community Services – Mr Proctor stated that community services had transferred to Humber this month. He thanked all the staff transferring and noted that Humber were inheriting a great group of staff and that the Trust would be sad to see the staff and services go. He also highlighted that the Trust had withdrawn from more Outpatient Services at Whitby.

Nursing and Midwifery Education – Mr Proctor stated that he and Mrs Geary had attended a dinner hosted by the University of York. They had taken the opportunity to network with peers, explaining that the University needed to provide a workforce for the future - not only the leaders - and that this is why the Trust was now working in collaboration with Coventry University. Mrs McAleese stated that this was an important message which she would also share with colleagues at the university. Prof. Willcocks stated that the Trust's partners were also working with the Hull York Medical School to look at leading on nursing apprenticeships.

Physicians Associates – Mr Proctor stated that the Trust had attracted more than 40 applicants for PA roles. Ms McMeekin stated that she was in the process of identifying interview dates and that the Trust was looking to appoint to 10 to 15 positions. Mr Proctor stated that it was about using a different workforce model and that these were not additional posts. Ms. McMeekin also noted that the STP area was aiming to recruit 40 positions in total, some of which would also be used in primary care. The Trust is offering a rotation and continuous learning programme which is why it has attracted a number of candidates. Dr Boyd stated that this was an example of transformational working.

Bridlington Hospital 30th Birthday – it was noted that there is an event in Bridlington on the 7th July to mark this occasion.

It was resolved that the Board noted and accepted the report.

18/24 HCV Partnership Update

Ms Symington stated that this update would now be a standing item on the agenda.

Mr Proctor highlighted that the place based plans are very important and that the STP has 3 strategic groups; capital and estates, workforce and digital, which were in various stages of development. It was noted that Mr Golding sat on the capital and estates group and that Mr Proctor chaired the workforce group. Mr Proctor stated that there was a partnership event being held on the 19 June and places were still available. It was noted that Ms Symington and Mrs Rushbrook will be attending.

It was resolved that the Board noted and accepted the report: Ms Symington and Mrs Rushbrook will provide feedback on the event to colleagues.

18/25 Finance and Performance Committee

Mrs Scott stated that the Trust had negotiated a performance improvement trajectory for ECS and had achieved the 85% required for April. Performance needs to gradually increase to 90% in September and the mandatory 95% in March 2019. The Trust is currently on track for May with 24 hours to go. However, she noted that bed occupancy was still high with York experiencing only 15 days below 92% and Scarborough only 4

days. There had been 13, 12 hour trolley breaches and the number of long waits was of significant concern. Mrs Scott stated that Ernst and Young had completed their work in York and the diagnostic feedback from Scarborough would be received tomorrow.

Mrs Scott stated that YAS had deployed staff to both York and Scarborough EDs and this was helping the Trusts to work jointly and dispel any myths.

All the cancer targets for March including the 62 day had been met which was a significant achievement especially as the HCV cancer alliance is dependent on achieving the 62 day target to get extra funding. The Trust is also continuing to work with the NHSI Intensive Support Team.

Mrs Adams was pleased the Trust overall had met the ECS for April, however, she noted that Scarborough was worse again. Mrs Scott expressed concern about the deterioration in Scarborough and that is why E & Y have been asked to do a diagnostic and also look at bed modelling to see whether the Trust's methodology can be validated. The feedback about E & Y from staff has been extremely positive. One of E & Y's team has previously been an NHSE Medical Director and he has advised the Trust to stop focussing on the AMM model and start trying to change behaviours. Mr Taylor stated that the Trust is also working with the Regional Medical Director for NHSI who is going through the pathway and this may get the Trust some support for the capital development at Scarborough. Mr Taylor and Mrs Scott will be meeting to consolidate all this work.

Mr Bertram gave an overview of the financial position and that the Trust is required to achieve a £14.3m deficit to be eligible for £12.5m in sustainability funding which will be a challenge. He noted that the Trust was currently £500k ahead of plan, but stressed the margins are tight. The report had been discussed in detail at the Finance and Performance Committee including the development of the new run rate reports. He noted that the spend rate for the last 6 months had been £40.6m and in April it was less at £40.1m revealing that expenditure continues to be controlled carefully.

Mr Bertram stated that the Committee had also gone through the detail of the SIRO Report which was heavily focused on getting ready for GDPR and providing assurance.

Mr Bertram also highlighted the Reference Cost Report which had gone to the Committee and showed the Trust's score as 94, with an average of 100 so the Trust was 6% lower than the national average. He noted that the Committee had given him delegated authority to submit the report which was underway.

Ms Raper asked whether there was any chance of clawing back PSF if it was lost. Mr Bertram stated that if the Trust hit the financial target it would get 70% of the PSF and another 30% was dependent on achieving the ECS. The Trust keeps the money if the targets are achieved, but it can also earn back any monies lost.

Mr Keaney stated that the May agenda had been the largest yet by far and the minutes were a good reflection of the conversation. He noted the papers that came including the E & Y Report, the Cash Flow Report, the SIRO Report, the Revised CIP Programme Report, the Reference Cost Report, the Capital Programme Report, the Operational Plan and the Winter Plan.

Mr Keaney stated that the risk in regard of the Capital Plan was the lack of available funds and the key question was about what the Trust was **not going to do** which would be discussed at the next meeting.

The CIP was off to a positive start achieving £2.2m recurrently in April. The 2018-19 target is £22m.

It was resolved that the Board noted and accepted the report.

18/26 Quality and Safety Committee

Mr Taylor wished to highlight 3 things including recruitment issues in Scarborough which would be discussed at a later meeting. He stated that work continued on the Patient Safety Strategy and that he was still talking to colleagues about this. He expressed concern about incidents in theatres, but that these were being dealt with and that many incidents were dealt with in the moment.

Prof. Willcocks stated that the Trust had a wealth of data, but raised that the Mortality Review Group continues to meet, but is not quorate and that SJCRs are not being completed due to competing pressures. She stated that a recent audit had delivered a red-amber finding which she would not expect to see. Prof. Willcocks asked how engagement was going to be encouraged. Mr Taylor stated that the Lead for Mortality had fed back his concerns and there was some concern that this process could be seen as criticism rather than an opportunity to learn. Mr Taylor wondered if it would be a good idea to push ahead with the appointment of a Medical Examiner as Trusts piloting this had said it was a more structured way to deliver.

Mrs Hey provided an update on the visiting times pilot which had taken place. Another audit had been conducted and it was decided through consensus to move the visiting times to 1pm to 8pm, although flexibility on this is at the Ward Manager's discretion.

Mrs Hey stated that the Chief Nurse's Report detailed action being taken in relation to staffing and education. She noted that the Trust has 70 student nurses starting this autumn; however, the recent Recruitment Marketplace was less well attended that previous events potentially reflecting nurses realisation that they can have the pick of the jobs available. Mrs Hey highlighted the work with Coventry University which was going well and now included a non-medical prescribing accredited course.

Mrs Adams stated that the Committee had reviewed both the CNST Self-certification and Annual Complaints Report which were on the agenda. She was pleased to note that the number of wards with a fill rate of less than 80% had come down to under 10 in April.

Prof. Willcocks thanked Mrs Adams for circulating the End of Life Care Report which was really positive and she was confident it was in safe hands.

It was resolved that the Board noted and accepted the report.

18/27 CNST Maternity Self-certification

Mr Proctor provided an overview of the CNST self-certification required including Board approval.

Mrs Adams stated that the Directorate Manager for Women's Health had provided a presentation at the Quality & Safety Committee and that the Committee went through the papers in detail and were assured the position stated was an accurate reflection.

Mr Bertram noted that the position would provide the Trust with a £500k discount on the premium, which would then be £11.5m. He highlighted a conversation at the year-end Audit Committee which was about tackling the root causes and making the Trust as safe as possible.

Mr Proctor noted that the Commissioners also provided their endorsement to the self-certification and he wished to thank the Directorate Manager, Kim Hinton, for all the work done.

It was resolved that the Board approved the CNST self-certification.

18/28 Complaints Annual Report

Mrs Hey stated that the Annual Report was a regulatory requirement and that actions were a part of the 3 year Patient Experience Strategy. She provided an overview of the number of complaints and stated that a new system had been introduced to encourage Directorate ownership of complaints, so decreasing the number of PALS issues being turned into formal complaints. This was about working with Directorates to seek early resolution. One persistent issue is responding to complainants within30 days and this will be a priority for the next year of the Strategy.

Mrs Hey stated that an Internal Audit Report has shown significant progress on learning from complaints. The report had also recommended more mandatory training be provided around investigation so she was working with the Medical Director and Deputy Director of Healthcare Governance as much of the SI training would be the same.

Mr Sweet supported the benefits of using early intervention and Mr Keaney highlighted that the report provided a table on page 206 which detailed the subject themes. He was surprised that the issues the Board talked most about only received a low number of complaints such as staffing and waiting times. Mrs McAleese was surprised about the high number of complaints in relation to values and behaviours.

Mrs Adams asked what had happened to the beverage service and Mr Golding stated that a small number of wards had been identified for the service due to the expense. It was recognised that volunteers could play a role in this and Mrs Hey stated that a new Volunteers Manager starts on the 3 July.

Mrs Hey stated that staff work really hard in ED to ensure people are comfortable and communicated with: we know that appropriate and timely communications mitigate complaints. It was also noted that patients see how hard staff are working in ED.

Prof. Willcocks was pleased about the emphasis on the investigating officer role and wondered whether they needed more status like the Fairness Champions.

Mr Proctor suggested it may be useful to audit those complainants who did not get back in touch as the Trust may learn something. Mrs Hey stated that this was already part of the Patient Experience Strategy.

It was resolved that the Board noted and accepted the report.

18/28 Environment and Estates Committee

Mr Golding provided an update from the Committee and highlighted that the Committee currently only has one NED member and that the meeting covers a huge agenda. Mr Golding stated that the Committee had looked at privacy and dignity in relation to the BAF and noted that a key indicator would be the new PLACE assessments which would take place quarterly.

Mr Golding stated that the Committee had approved the Health and Safety Policy following its review and also been apprised of a change of legislation which meant the CQC now have the regulatory powers that HSE previously held. He also highlighted that the sustainability section of the Annual Report had been commended for data quality for the second year running. The Trust is also partnering with York City Council to promote the use of electric vehicles, which will improve air quality. The Committee also reviewed its limited assurance Internal Audit Reports and looked at the plan for this year.

Mr Sweet added that he wished to raise to the Board the shortage of capital for backlog maintenance due to the need to pay back loans. This meant that only items which needed doing for quality and patient safety reasons would get funding. He also wished to raise the profile of sustainability and asked whether a 6 monthly report could be produced for the Board and Board Committees.

It was resolved that the Board noted and accepted the report. The Board noted the concerns raised by Mr Sweet in relation to limited capital for backlog maintenance.

18/29 Workforce and Organisational Development Committee

Ms McMeekin raised 2 items in relation to medical staffing. She noted that there were currently 115 vacancies in the Trust which was 12.9% of the current staff (6.2% York - 19.3% Scarborough). Recent recruitment has seen 38 offers of employment of which 7 have been accepted and 31 are still being processed. She noted that the Trust Grade position which had been traditionally used to fill gaps has become increasingly competitive and that she is drafting a paper which explores offering other incentives such as research work and professional development. The Trust is also exploring international recruitment and is thinking of partnering with an agency to recruit through the British Association of Physicians of Indian Origin.

Ms McMeekin stated that her team is currently looking at the annual junior doctor rotation which sees over 300 positions change. The current fill rate is 78% for doctors in training, which is a 12% improvement on this time last year. The Trust is also running parallel recruitment with the changeover process to fill gaps.

Ms McMeekin also stated that the Trust is working hard to increase the bank fill rate which is at 97%. The Trust is partnering with Chelsea and Westminster Hospital to run the pilot of an app, and staff in Child Health and ED are being trained to use the app.

Ms Raper stated the Committee continues to focus on staff sickness, welcomed a new report on employee relations and reflected on new information for the BAF action plan.

Mrs Adams asked about the pay increases mentioned on page 241 and Mr Bertram stated that the Trust has already received 1% of the funding, but has been told the rest will also be directly funded. Ms McMeekin stated that the funding will not apply to those staff in the ADM; however, this will be in relation to year 2 and 3 when staff have transferred. Mr Bertram stated that he had heard this was still being debated nationally.

Mr Bertram highlighted page 226 stating that 2 posts had been advertised, but 3 offers had been made. He just wished to note that significant assurance had been received from the Directorate around the posts and that one would not start until 2020, but it was part of succession planning. The Chair had been involved in the interviews and Chair's approval had been taken outside of Board in order to take up the opportunity.

It was resolved that the Board noted and accepted the report.

18/30 Any other Business

Organ Donation – Mr Keaney provided an update on Organ Donation within the Trust. He stated that during the last 12 months, there have been 14 potential donors and of these 11 were confirmed donors facilitating 24 patients with life-saving or life-changing transplants. In the previous year there were 9 donors facilitating 16 transplants. The Trust is now a Level 2 site and was only 1 donor off becoming a Level 1 site. In the Yorkshire and Humber region 318 people benefited from transplants; however 34 patients died waiting for transplants and 483 patients are still on the waiting list.

18/31 Date and Time of next meeting

The next public meeting of the Board will be held on Wednesday 27 June 2018 in Room S33 at Scarborough 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 tbc
17/104	Board Committee reporting changes to be reviewed in March.	Ms Symington	Work is ongoing

NHS
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Board of Directors – 25 July 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, Chief Executive

Executive sponsor: Mike Proctor, Chief Executive

Date: July 2018

1. NHS 70

I want to start this report by reflecting on the fantastic range of celebrations that took place right across the Trust in recognition of the NHS's 70th anniversary.

The Trust's NHS70 activities began at the start of the year with a campaign to collect 70 faces of the NHS and showcase them on social media and on the Trust's website. Thanks to all those who have taken part so far, the campaign has generated strong engagement from staff and public alike.

York Hospital lit up blue for the birthday week and staff celebrated with around 20 tea parties across all parts of the Trust, in support of York Teaching Hospital Charity. The Charity's Sparkling SevenTea party at the Hospitium in York was also a huge success. BBC Look North filmed at St Monica's in Easingwold, the region's smallest hospital, and BBC Radio York broadcast their breakfast show from York Hospital on the day, featuring interviews with staff and patients from York and Scarborough.

On Saturday 7 July Bridlington Hospital celebrated its 30th birthday, as well as NHS70, and Selby Hospital also held an Open Day.

The mobile chemotherapy unit project was a finalist in the NHS 70 Parliamentary awards, which I attended with Professor Steve Leveson, Chair of York Against Cancer who funded the unit. Sadly we did not win but it was a great afternoon and our partnership with York Against Cancer was displayed to the wider NHS. It is something we a rightly proud of. Our Celebration of Achievement event will continue the NHS70 theme and we will be rounding off the year at our annual York Minster NHS Carol Service.

2. LIVEX18

Another important event took place during the week of the NHS's birthday, one that focused on preparing our staff to respond to potential threats that, sadly, have become all too familiar for our modern-day health service.

The Army Medical Services Training Centre (AMSTC), part of the Army's 2nd Medical Brigade, supported the Trust in delivering a live training exercise to test our Major Incident Response Plans.

LIVEX18 was an immersive simulation exercise based in AMSTC's hospital trainer, which is normally used to train the military's medical response to major incident and conflict situations - ranging from the response to the Ebola epidemic to operations in Iraq and Afghanistan. The exercise took place within a full-scale reconstruction of the emergency departments of both acute hospitals and supporting areas.

Live actors, simulation bodies, mannequins and other effects were used to create as realistic an environment as possible, and clinical staff had to 'treat' the casualties as they would in real life.

The size and scale of what was achieved in the planning and delivery of the event was truly impressive, and I know that a number of Board colleagues were able to visit at various points during the week to see LIVEX18 for themselves.

The event received widespread media coverage including taking the lead news story spot on both BBC Look North and ITV Calendar.

Thanks must go to the team who made the event possible after 12 months of planning, and thanks also to the team at AMSTC, with whom our relationship continues to go from strength to strength.

3. Aligned Incentives Contract

As discussed at previous Board meetings, the Trust has now agreed an Aligned Incentives Contract with its three main commissioners, NHS Vale of York CCG, NHS Scarborough and Ryedale CCG, NHS East Riding of Yorkshire CCG.

This new model moves away from payment for activity- clinic appointments, operations and admissions to hospital- and recognises the need for secure funding for our hospitals to support service transformation for health improvement.

In contract terms, this means agreeing funding up front for the Trust to pay for staff, equipment and treatments rather than relying on the current "Payment by results" (PBR) system which relies on counting and coding activity. In this new system, keeping people out of hospital and in their best health is in the interests of all involved.

The contract sets a fixed funding amount for the hospital, rather than an agreement to pay for each item of activity. This allows better forward planning and gives security of income to the trust. As part of the agreement, all partners have agreed a process for what will happen if the activity costs more than the money set aside, and how this will be managed, but the approach assumes that all parties will work throughout the year to reduce the risk of this.

As new challenges arise, the partners will review the contract to make sure it is working for patients and supporting all organisations in their statutory duties. The intention is to maximise the benefit to the whole health economy and the local population.

All of these new ways of working and providing services will be monitored by a System Transformation Board which will be co-chaired by the CCGs and the Trust.

4. Scarborough review

As outlined by Wendy Scott, Chief Operating Officer, at our last Board meeting, we are undertaking an independent review of the configuration of Scarborough acute services.

The review is in partnership with Scarborough and Ryedale CCG and East Riding CCG, working under the auspices of the Humber, Coast and Vale Health and Care Partnership.

The review will look at how we can do things differently to get the best possible hospital services for people in the Scarborough area.

Whilst several services have been made sustainable as a result of the merger between York and Scarborough Trusts, it is fair to say that the provision of some acute services has become increasingly difficult over a number of years due to well documented recruitment pressures facing some specialties as well as some of the geographical and demographic challenges facing Scarborough.

One particular issue that we are currently facing is the provision of acute surgery. In the short term, I am confident that we have a workable plan to continue to deliver acute surgery at Scarborough Hospital. This is a solution that involves surgeons from the York team travelling to Scarborough to support colleagues and ensure there is no detrimental impact for patients.

A partner is being sought, through a tendering process, to carry out the review on our behalf and we anticipate that they will begin their work in mid-late August.

A key feature will be the need for widespread clinical team engagement, and staff input and ownership will be a vital part of the review.

The main purpose of this review is to consider the most appropriate configuration of Scarborough's acute services to ensure that they are adequately supported by other specialties and that they are fit for purpose, sustainable, accessible and deliver the highest possible quality of care.

5. New Secretary of State

Finally, I would like to welcome Matt Hancock as the New Secretary of State for Health and Social Care. Mr Hancock takes up the role following Jeremy Hunt's departure to the Foreign Office after six years in post. As Board colleagues may be aware, in the days prior to Mr Hunt's departure we had begun a conversation with him about potential support for our work to ensure that services in Scarborough can be sustainable, and the potential to for this work to develop as part of a group of unavoidably small hospitals. Mr Hunt had requested that we put a proposal forward, and in light of recent events we intend to attempt to continue this dialogue with the new Secretary of State. Clearly this is important work and a priority for the Trust, which must continue regardless, however having encouragement from those at the highest possible level would bring obvious benefits.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Out of Hospital Care Board Quarterly Strategy Report

Recommendation

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

Current approval route of report

This report is presented for the first time to the Board of Directors.

Purpose of report

The purpose of this quarterly report is to provide the Board of Directors with a strategic update relating to out of hospital services.

Key points for discussion

This report provides the Board of Directors with an overview of the recent 'Home First' engagement exercise. As the over-riding ethos behind the Out of Hospital Care Strategy and a key theme of the Trust five year strategy, it is important to understand what our local communities think about the Home First approach. This report summarises the learning from the first phase of this engagement and recommends a number of next steps.

The report also provides a brief update on the response to the recent CQC Review of Health and Social Care, the refresh of the Out of Hospital Care Strategy and the next steps in delivering the transformation of the community nursing workforce.

The Board of Directors is asked to support the recommended next steps in the Home First engagement 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

There are no references to CQC regulations.

Version number: Version 1

Author: Steve Reed, Joint Head of Strategy, Lucy Brown, Acting Director of Communications

Executive sponsor: Wendy Scott, Chief Operating Officer

Date: June 2018

1. Introduction and Background

The purpose of this quarterly report is to provide the Board of Directors with a strategic update relating to out of hospital services.

This report provides the Board of Directors with an overview of the recent 'Home First' engagement exercise. As the over-riding ethos behind the Out of Hospital Care Strategy and a key theme of the Trust five year strategy, it is important to understand what our local communities think about the Home First approach. This report summarises the learning from the first phase of this engagement and recommends a number of next steps.

The report also provides a brief update on the response to the recent CQC Review of Health and Social Care, the refresh of the Out of Hospital Care Strategy and the next steps in delivering the transformation of the community nursing workforce.

2. A conversation with local people about Home First

In December 2017, the accountable officers for health and social care organisations in North Yorkshire and York commissioned an engagement exercise that would begin a conversation with local people about Home First.

Three objectives were agreed for the exercise:

1. to raise awareness of Home First amongst key stakeholder;
2. to ask for their views on how Home First could work in practice, and;
3. to seek feedback on how best to talk to communicate with patients, relatives and carers about Home First.

Over a six month period, discussions were held with a range of community groups and networks across the patch. In total over 400 people took part in these discussions, 100 completed questionnaires were received, and 172 comments were recorded. Informal briefings were held with the Health and Social Care Oversight and Scrutiny Committee chairs from City of York Council and North Yorkshire County Council.

A summary report (appendix 1) presents the initial findings from this exercise, outlining the engagement work to date and the key themes that emerged during the discussions.

2.1 Headline feedback

Those attending the engagement sessions were asked to rate their knowledge about Home First on a scale of 1 to 10. The average score before the session was 4 and the average score following the session was 7. This achieved the first objective of raising awareness of Home First across a range of stakeholder groups.

Groups were asked to identify the factors that would be critical in delivering a Home First approach. Seven themes emerged from over 100 responses received.

1. *The need to involve carers/families in decision making*

This was thought to be important by members of the groups we spoke to. Giving carers the opportunity to have an input is something that was felt may make the transition to home easier.

2. *Communication - both with patients and carers and between professionals*

Being clear about what is happening next when people leave hospital was felt to be key to allaying concerns and helping people understand what is happening and why. Comments were also made in relation to improving communication between different parts of the system.

3. *The importance of recognising and assessing patients' individual needs and circumstances*

There was a clear desire amongst patients that they want to receive care that is personal to them, and to be treated as an individual. They did not want their preferences to become 'lost' when they go home.

4. *Pre-planning as early as possible for what will happen when someone leaves hospital - particularly if their admission was planned*

Examples were fed back of when people have gone into hospital for a planned procedure and felt that planning for what happens when they go home could have been better.

5. *The need for joined-up working*

There was a clear call for working together, integration, and sharing resources and information. There was also recognition of the important role the third sector plays in this sort of care.

6. *Recognition of the impact on families and carers*

There was discussion of the potential risk of over-reliance on carers and families, but also recognition of the invaluable work they do and how it can often be unacknowledged or unaccounted for. They are a source of knowledge and should be involved in discussions and decisions about care, along with the patient.

7. *The issue of social isolation*

It was clear from the feedback and in talking to the groups we attended that loneliness and social isolation are considered to be significant problems and a real potential barrier to people being comfortable with a Home First approach. However, it was also clear that almost everyone we spoke to agreed with the approach and believed that most people would rather be at home than in hospital.

Groups were also asked to consider how messages about Home First could most effectively be communicated. Five themes emerged from the responses:

1. Be clear about the rationale;
2. Be clear about what Home First is (and isn't);

3. The evidence is an important tool;
4. Changing the culture amongst staff;
5. The sort of materials that could be used.

2.2 Next steps

The recommended next steps following the review are:

1. Present the results to the commissioning health and social care organisations;
2. Present the results to the City of York Overview and Scrutiny Committee and share with the chair of the North Yorkshire committee;
3. Work with partner organisations to develop suggested responses to the themes identified (either ongoing work or new developments);
4. Carry out the second phase of the engagement exercise to present the results and suggested responses back to a range of stakeholder groups, this will include challenging groups as to what they can do to address the issues raised.

3. General Update

The Board of Directors has previously received reports on the findings of the CQC Review of Health and Social Care (in the City of York) and requested an update be provided in July 2018 on progress towards the recommendations. This update will be provided through the quarterly Out of Hospital Care Board sub-committee report in July. A key action within the plan was the establishment of a 'Place Based Improvement Board' for the City of York. This has taken place and the Board is now meeting monthly, with senior leaders from all major organisations represented.

In December 2017 the Board of Directors approved the recommendations of the Community Nursing Workforce Review. Work to implement the recommendations in order to transform the community nursing workforce has commenced with the appointment of a Lead Nurse for Community Services (on a two year fixed-term basis). The Lead Nurse will be responsible for delivering the transformation work which will include the development of mobile working for community teams and the community administration review.

The March 2018 Out of Hospital Care Strategy report set out the intention to carry out a refresh of the strategy. This will be informed by the recent publication by NHS Improvement of their report 'NHS operational productivity: unwarranted variations – Mental health and community health services', the recent Health and Social Care Select Committee report on integrated care and the Kings Fund report 'Reimagining community services'. An initial time out session has been held with the senior operational managers from the Out of Hospital Care Directorate to explore if the three key theme areas remain the most important and to determine the development areas for each of these through the remaining years of the strategy.

4. Recommendation

The Board of Directors is asked to support the recommended next steps in the Home First engagement plan.

Appendix 1 - Home First engagement exercise: Initial feedback report

1. Executive Summary

In December 2017 the accountable officers for health and social care organisations in North Yorkshire and York agreed to undertake an engagement exercise that would begin a conversation with local people about Home First.

Three objectives were agreed for the exercise: to raise awareness of Home First amongst key stakeholders, to ask for their views on how Home First could work in practice, and to seek feedback on how best to talk to communicate with patients, relatives and carers about Home First.

Over a six month period, discussions were held with a range of community groups and networks across the patch. In total over 400 people took part in these discussions, 100 questionnaires were received, and 172 comments were recorded.

This report summarises the initial findings from this exercise, outlining the engagement work to date and the key themes that emerged during the discussions.

2. Background

The accountable officers for the health and social care partner organisations in North Yorkshire and York recognised the need for a system-wide, large-scale engagement exercise to understand the experience of people who have been in hospital and to help patients, relatives and carers to understand the concept of Home First and discuss how this will work in relation to their care.

There are several local and national drivers for this, and we have gained some understanding of the current situation in North Yorkshire and York and this establishes the starting point for this engagement work.

These include:

- National move towards out of hospital care and reduced reliance on inpatient bed capacity;
- Local strategies for out of hospital care;
- Bed audit findings/stranded patient review;
- National initiatives (#Red2Green, #endPJ paralysis, #Last 1,000 days);
- Stakeholder workshops and validation workshops (with partner organisations);
- Focus groups.

In partnership with a number of communication and engagement leads across the local system it was agreed to work with existing groups and networks where there are already established relationships.

A discussion also took place with the Chairs and Scrutiny Officers of both the York Health, Housing and Adult Social Care Policy and Scrutiny Committee and the North Yorkshire Scrutiny of Health Committee at the outset of the engagement work. The purpose of this was to inform them of the approach being taken and to understand their expectations

around reporting and any further involvement. Both OSCs were comfortable with the proposed approach and we have committed to sharing a report of our findings once finalised.

3. Engagement objectives

Three objectives were agreed for the exercise:

Objective 1: Increase awareness of Home First, and the evidence that supports it (deconditioning, the impact of harm caused to patients by extended stays in hospital) amongst key stakeholders, including patients and their families;

Objective 2: Gather feedback from patients and relatives about how a Home First approach could work;

Objective 3: Gain insights from patients, relatives and others as to how and when to communicate Home First during a patient's episode of care.

4. Overview of engagement activities

Since January 2018, we attended a range of meetings of stakeholder groups and networks, speaking to over 400 people about Home First.

These include:

- Healthwatch Assemblies
- Carers' Advisory Group (York)
- York Carers' Centre
- Scarborough Older People's Forum
- Ryedale Older People's Forum
- York Older People's Assembly
- York CVS forums (including Ageing Well, Voluntary Sector, Mental Health, Community Voices)
- GP practice patient participation groups (Haxby Group practices, Scarborough Practices, and Selby)
- Foundation Trust Council of Governors
- Ryedale U3A (University of the Third Age)

Depending on the format of the meetings, a presentation was given or a discussion was facilitated. Those attending were asked for their feedback and this was captured during the session.

A short questionnaire was also given out at each meeting. Around a quarter of those we spoke to (100 people) returned questionnaires, and a large amount of qualitative information was gathered from the sessions, including the questions asked and notes made during the discussions.

The questionnaire was also made available electronically, along with a brief article about Home First that could be shared in newsletters. This was sent to Foundation Trust members as well as contacts in the community who were able to share it via their various

channels. A very small number of these were returned, which suggests that the information is best captured when people were given the chance to give their feedback there and then. The return rate dropped off significantly once people were able to take the form away and return it later.

As well as featuring as a formal agenda item at these meetings, these discussions also triggered a number of conversations through less formalised sessions.

5. Headline feedback

The first objective of this engagement work was to increase awareness of Home First. By going out and talking to the various groups we hoped to raise awareness of the evidence that supports a Home First approach. To assess this, we asked two questions:

Q.1. Before the session today, how much did you know about this subject?
(Choose between 1 and 10, where 1 is 'I knew nothing about the subject' and 10 is 'I knew a lot about the subject').

Q.2. After hearing the session today, how much do you feel you now know about this subject?
(Choose between 1 and 10, where 1 is 'I know nothing about the subject' and 10 is 'I know a lot about the subject').

The average response for question 1 was a score of between 3 and 4 (mean score = 3.68). The average response for question 2 was a score of between 6 and 7 (mean score = 6.52). This indicates that by presenting the information to people, involving them in a discussion and asking them to share their experiences and feedback of using our services, we were able to increase awareness of Home First amongst these key stakeholders.

Objectives 2 and 3 were to gather feedback about how Home First could work, and how and when it could be best communicated. As well as gathering general feedback from the discussions at the sessions, we asked two further questions on the questionnaire:

Q. 3. Now that you have heard about Home First, and given your experience, how could we make Home First work in practice?

Q. 4. How could we explain to people about why Home First is important to people in hospital, their families and their carers?

These were open questions, and 172 comments and suggestions were received in total.

The groups we spoke to were supportive of the principles of Home First.

"Most people would rather live in their own homes as long as possible so wouldn't need much convincing."

"Most would want to go home. I would better as soon as I went through my own front door."

"I think we would all agree that hospital beds should only be occupied by people needing hands on nursing and medical supervision."

Where concerns were voiced, they were not about the approach, but rather about capacity, suitable assessment, availability of funding and staff. People were concerned about fail safes and backstops - what if something goes wrong or there is an emergency?

"However people need to be confident that there will be sufficient support at home, not just 'left'. We often hear about people getting home and not knowing when follow up appointments are, who's coming in, who to contact if it not working."

People also wanted assurance that those receiving home-based care are not disadvantaged by not being in hospital, for example are their nutritional needs being met in the same way?

"Simple things like food and time spent with patients is important."

6. How can we make Home First work?

The responses on how we can make Home First work in practice fell into seven main themes:

6.1. The need to involve carers/families in decision making

This was thought be important by members of the groups we spoke to. Giving carers the opportunity to have an input is something that it was felt may make the transition to home easier.

"Talk to the family/carers in plenty of time - what can/can't they do - what support will they need as well as patient. Work together, for example involve them in meeting planning."

"Families need to be involved in their loved ones care and decision making."

6.2. Communication - both with patients and carers and between professionals

Being clear about what is happening next when people leave hospital was felt to be key to allaying concerns and helping people understand what is happening and why. Comments were also made in relation to improving communication between different parts of the system.

6.3. The importance of recognising and assessing patients' individual needs and circumstances

There was a clear desire amongst patients that they want to receive care that is personal to them, and to be treated as an individual. They did not want their preferences to become 'lost' when they go home.

6.4. Pre-planning as early as possible for what will happen when someone leaves hospital - particularly if their admission was planned

There were some examples that were fed back of when people have gone into hospital for a planned procedure and felt that planning for what happens when they go home could have been better.

6.5. The need for joined-up working

There was a clear call for working together, integration, and sharing resources and information. There was also recognition of the important role the third sector plays in this sort of care.

"Ever closer cooperation between NHS hospital care and local authority care system."

"Closer liaison between hospitals and care providers should ensure care needs after leaving hospital are not overlooked."

"Ensure all agencies work together and do not bounce patients and their carer round the system."

6.6. Recognition of the impact on families and carers

There was discussion of the potential risk of over-reliance on carers and families, but also recognition of the invaluable work they do and how it can often be unacknowledged or unaccounted for. They are a source of knowledge and should be involved in discussions and decisions about care, along with the patient.

6.7. The issue of social isolation

It was clear from the feedback and in talking to the groups we attended that loneliness and social isolation are considered to be significant problems and a real potential barrier to people being comfortable with a Home First approach. However it was also clear that almost exclusively everyone we spoke to agreed with the approach and believed that most people would rather be at home than hospital.

"Not everybody is lucky enough to have relatives or good friends who could respond."

7. How might we communicate?

There were also a number of clear themes in the responses to how best to communicate with patients, families and carers, how best to get the message across, and what that message might be.

7.1. Be clear about the rationale:

On several occasions people said that we need to be clear that this is not about closing beds or hospitals, or indeed saving money or cutting services.

"You'd need to dispel cynicism that this is just about increasing throughput to save money."

7.2. Be clear about what Home First is (and isn't)

A large number of the responses suggest a gap in understanding as to what Home First might be. Comments such as *"not everyone has a family capable of looking after a sick person. I live on my own, my daughter is 200 miles away"* and *"presumably this isn't just for people who live alone - so carers/families need to know about reablement/physio - how to support the person - so they don't just 'do it for them'"* could suggest that people think the intention is to remove or

reduce care someone might have received if they had staying in hospital, or to expect friends or family members to take this on.

This suggests that Home First should be explained in a way that helps people to understand that it is about rehabilitation, recovery, and avoiding harm, rather than long term care or nursing needs. It is not about replacing the care given by professionals with family or volunteers, we are re-providing this in people's homes, using the appropriate staff.

7.3. The evidence is an important tool

People fed back that the evidence and data presented regarding harm caused is compelling and should be used to help explain why people should not remain in hospital longer than necessary.

7.4. Changing the culture amongst staff

Another key theme was around making sure staff understand and support Home First, as they are a key conduit for information and a trusted source. This should not just include hospital staff, but GPs and other health and social care professionals.

"A bit of a culture change across staff within health as a whole, to emphasise the risks inappropriate hospital use can raise."

"[Communicate] through the people that are going to be on the front line."

7.5. What sort of materials could be useful?

People suggested some practical approaches to getting the message across, with many people favouring literature and leaflets, preferably to be given whilst in hospital. Using the media, and potentially 'real life' case studies, was another recurring theme, along with the development of a campaign, with the phrase 'use it or lose it' being mentioned on more than occasion.

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NHS
York Teaching Hospital
NHS Foundation Trust

Finance & Performance Committee – 19 June 2018

Attendance: Mike Keaney (MK)Chairman, Mike Sweet (MS), Andrew Bertram (AB), Wendy Scott (WS), Steve Kitching (SK), Andrew Hurren (AH), Lynda Provins (LP), David Thomas (DT), Sarah Barrow (SB), Joanne Best.

Apologies for Absence: Lynette Smith, Graham Lamb

Minutes of the meeting held on the 22nd May 2018

The minutes of the last meeting held on 22nd May were agreed subject to the following amendments:-

Page 5, paragraph 1 – 'MK addressed the '*Committee'*

Matters arising from the minutes

MS asked the Committee for an update in relation to the new financial system issues. AB stated that all main issues have now been resolved and the position has continued to improve but we have not yet removed all aged creditors from the system. Work to clear the backlog continues.

Page 7, YAS update - MS asked if the DToC patient numbers had improved, and was told that the increase in DToCs is a continuing trend and this is being considered/discussed by the complex discharge group.

DT gave the Committee a brief update on the work with Yorkshire Ambulance Service which is a key element of the emergency care transformation plan and a focus this year for the system 'Action On' work. A joint action plan has been developed and this includes key priority areas such as self-handover, recording of handover times and diversionary pathways. The issues relating to the recording of accurate handover times continues but there is a shared understanding of the work that needs to take place.

Page 8, Prostrate & Colorectal fast track referrals – MS asked the Committee for an update.

WS stated that the spike in referrals, discussed at the last meeting seemed to have settled,
Page 9, Endoscopy – WS stated that a proposal has been developed that seeks to address the capacity issues; this proposal is predicated on outsourcing a level of activity.

Action log - MK asked for an action log to be included at the end of the F & P minutes.

Operational Performance report – WS asked the Committee to note the performance update and that two key issues be discussed.

Firstly, in relation to performance against the ECS, WS stated that long waits in ED during May had reduced on both the York and Scarborough sites, notably York had seen an easing of winter pressures in early April and Scarborough had seen pressure easing some two weeks later than this. Both departments have seen an improvement in ECS performance since then. It was noted that York ED had its busiest month this decade.

Andrew Hurren talked the committee through the diagnostic report and subsequent investigation into the 14x 52 week breaches that have occurred in the Head and Neck Directorate. An action plan has been developed to address the issues and mitigate future risks. An SI has been declared as a full investigation will be undertaken. NHSI have been informed and the diagnostic report, investigation and action plan has been shared and discussed with them.

Emergency Department Update – DT gave an overarching update of the emergency care Transformational Plan which has been developed in response to the diagnostic work completed by Ernst & Young In both York and Scarborough.

Some of the actions relate to:

- To develop the capacity and capability to improve the streaming functions at the front door of ED
- To further develop and build on the ambulatory care/assessment units – increasing the range of ambulatory care pathways
- To ensure 2 hourly board rounds are undertaken in ED
- Review the possibility of NHS 111 directly booking into the UCC

DT gave an overview of the action plan including the fact that ED consultant leads have been nominated to lead on each individual action/project. WS outlined the agreed DM portfolio changes with DT changing his base to Scarborough to manage ED, Acute Medicine, COE and flow and Jamie Todd, doing similar in York.

MK, noting that clinical leads have been nominated for each action/project noted that it is a positive move to involve front line staff in these changes. WS stated that EY had helped with this support and engagement of staff. DT told the Committee that ED Consultants have engaged with these changes and that five ED Consultants have volunteered to support Scarborough ED in the short term. They have offered to undertake shifts in Scarborough ED to support covering the rota

MK expressed that this is a very positive update.

Following the declaration of one 52 week wait breach was in Head and Neck at the end of April which was due to an administrate error, the Corporate Performance team has been working with the directorate throughout May conducting a detailed review of their waiting list. This identified that the reporting error identified in April was not an isolated incident and that a number of patient pathways had had incorrect ‘clock end dates’ recorded.

Performance Improvement / recover plan(s) and reports – AH told the Committee that the requirement to have no increase in the RTT total waiting list compared to March 18 was not achieved at the end of May however this has been adversely affected by the 9% YTD growth seen in GP referrals. Following the declaration of one 52 week wait breach was in Head and Neck at the end of April which was due to an administrate error,

The Corporate Performance team has been working with the directorate throughout May conducting a detailed review of their waiting list. This identified that the reporting error identified in April was not an isolated incident and that a number of patient pathways had had incorrect ‘clock end dates’ recorded.

AH explained the findings of the review to the Committee, giving details of the recording errors and the reason that they had not been picked up by the Trusts validation checks. (Appendix A).

AH stated that the Trust’s information team had reviewed the RTT waiting list and initial findings are that these issues appear to be limited to one department. Investigations are continuing.

It was noted that once these issues were identified immediate remedial actions were put in place, as listed in Appendix A (page 26). These actions include revalidation training for administration staff, E-learning packages for clinicians with guidance notes, weekly meetings between Patient Pathway Co-coordinator and Head and Neck Service Manager and authorisation to appoint four additional Band 3 trackers to support the directorates was approved by Corporate Directors. Discussions are ongoing with the SNS Directorate to review the PAS clinic outcomes module and to make amendments to support the investigation findings.

AH told the Committee that a full review of the Maxillo-Facial RTT waiting list will be completed within the next two weeks.

WS noted that NHSI had responded positively to the fact that the Trust has undertaken an internal audit to ensure that 18 weeks RTT is managed effectively.
The Committee was assured that the Trusts Internal Audit Committee were involved in reviewing sample data from a number of directorates and had provided significant assurance around the validation process.

MK enquired if this should be linked to Data Quality team, it was agreed to add this to the action plan. WS told the Committee that NHSI as part of its feedback on the Operational Plan refresh submission had asked the Trust to consider whether or not it wanted to amend the proposed ECS improvement trajectory to reflect an ambitious but more pragmatic trajectory reflecting the likely impact of winter. A revised ECS trajectory has been agreed and will be resubmitted tomorrow

A discussion continued with regard to the Trusts qualification for PSF. AB stated that an enquiry has been made to NHSI.
MK agreed that the Committee support the revised Emergency Care Standard trajectory.

MK asked if the recent lift of restrictions on Visas will make a difference to staffing levels, AB stated that it is thought this could help but that may take some time to work through the system. HR are exploring the possibility of allocating dedicated time for overseas recruitment and more specifically overseas head hunting. It was noted that NLaG have been successful with recruiting in this manner.

MS discussed with the committee low attendance numbers at a recent Nurse Recruitment fair, noting that moving forward the Trust may have to examine different ways for future recruitment opportunities.

MK requested that the retired Chief Executives name be removed from the CQUIN Status Summary table.

WS update to Board on the 14 x 52 week breaches and ECS performance and actions.

MK noted that on the whole the updates so far felt positive.

Finance – AB stated that the income and expenditure position at the end of month 2 is showing a deficit of £2.2m against a planned deficit of £3.6m, reporting a £1.4m favourable variation against plan. It was noted that the Trust is eligible to receive month 2 PSF of £1.2m although no release of PSF will be made until the end of the first quarter. AB confirmed the Trust must continue to comply with control totals at the end of Q1 to secure the funding.

AB referred to the Trust Run Rate Analysis (page76) explaining to the Committee the data that will be recorded in future and the expected run rate trends, noting that there is no suggestion of any alarming trends at this time. AB commented that the May run rate figure of spend of £40.7m was in line with the previously established trends.

It was noted that agency spend has been reset at a total cap of £14.9m as directed by NHSI, this suggests a spend cap of £2.5m for month 2, the Trust reported an actual agency expenditure for month 2 of £2.5m which is exactly on cap. Month 1 reported under cap but spend in month 2 across all areas has increased.

AB gave an overview of the key changes to the operational plan which had previously been approved by the Board.

AB confirmed that in relation to the development of an AIC the Trust's Executive Team had successfully negotiated and agreed the terms requested by the Board at its May meeting. As such AB confirmed that he along with Mike Proctor and Wendy Scott had briefed the Chair that morning (19 June 2018) and the Chair confirmed on behalf of the Board agreement to the AIC. This would now be communicated to the CCG and wider Trust.

AB reminded the committee of the AIC issues raised by the Board at its May meeting and confirmed the position now agreed with the CCGs:

1. What happens if activity increases?

   AB confirmed that should emergency activity increase above the levels underlying the AIC agreement then costs associated with providing additional capacity would be met. This would not be at PbR rates but would be by negotiation and agreement of open book additional costs.

   AB confirmed the same open book cost principle would also apply to planned activity with the exception that the Trust had no right of unilaterally undertaking additional planned activity. Instead this must only be undertaken by joint system agreement. All parties agreed to jointly involve both regulators should this be necessary in managing the waiting lists and any consequences of providing insufficient capacity.

2. Cash

   The CCGs have agreed to work with the Trust on revising the cash payment profile to minimise any borrowing the Trust may need to undertake. This will be within the NHSE rules around CCG payments to Trusts. AB confirmed this work was bow underway.

3. The final issue the Board requested clarity on was detail of the people resource the CCGs would be placing into the system to deliver the QIPP. AB confirmed that this information has been shared and that Wendy Scott is now working on a time out session to bring together the Trust and CCG teams.

AB noted that CQUIN has been fixed with no financial penalties, but stressed that delivery and performance monitoring must still occur.

AB told the Committee that this is a ONE year agreement but with the expectation that this is the future direction of travel. Noting that to manage the Trust expenditure a watchful eye must be kept on changeable trends which must be managed promptly.

WS noted that the Governance of the monitoring team is still being mapped.

Given this change to our contract AB advised that he felt it appropriate to resubmit a revised financial and operational plan to NHSI that reflected this new agreement. AB confirmed he and WS had been in contact with NHSI in this regard. AB presented the paper to the committee that described the changes to the financial plan. The committee discussed the changes and MK stated that the Finance and Performance committee approved the proposed Operating Plan 2018/19 resubmission to NHSI, adding that this is a very good outcome.

Efficiency Programme – SK stated that the Trusts annual CIP for 2018/19 is £21.7m and that month 2 delivered £4.77m which is 22% of the annual target which is a positive comparison to May 2017 when £2.3m was delivered.

£2.7m of the £4.77m (12%) has been categorised as high risk, noting that at this point the four year plan is looking very positive.

MK noted that this is a very positive report which shows a much improved position on last year. SK agreed with this comment explained to the Committee that the efficiency cycle does not appear to align with financial year.

SK referred to the new reporting graphs explaining how the data recorded would support the recording of CIPs.

MK asked if the ongoing Theatre review had produced any conclusion, WS gave the committee a brief update.

Tender Opportunities – SB told the Committee that at the present time the Trust is not actively involved in any new tenders but gave an update on two future opportunities.

The first is HPV Primary Screening, for which the Trusts current contract has been extended to December 2019. SB noted that NHSE plan to follow a National Procurement Framework although timescales have yet to be determined. Currently there are 53 labs but

the intention is centralise the number of labs reducing this to 13 labs by the end of 2019. SB noted that this could suggest a possible risk to staff and that there has not been any indication from the commissioners to suggest that the Trust current contract will be extended further.

The second tender opportunity is the integrated sexual health services which the Trusts current contract expires at the end of June 2018, but the City of York council has extended this for one year to the end of June 2019. A market place engagement event will take place on 19th July 18 and the Trust has registered interest, there is no expectation of any significant changes. It is anticipated that the tender will be issued shortly after that date.

MK enquired who decides which tenders the Trust engages with.

AB noted that there will be a scheme of delegation update that would describe the contract value level at which the Board should be involved in the final decision making process. The value was still to be agreed by AB confirmed he would be making a recommendation to the June Board meeting.

SB told the Committee that she had recently been approached by a GP group to discuss an 'Improved Access' tender and although the GP group had not taken this further, this was viewed as a positive approach.

Board Assurance Framework (BAF) – There were no revisions to the BAF. LP noted that the strategic risks are being revised and a paper is going to the Board.

Any Other Business – there was no further business to discuss.

MK addressed the Committee stating that MS would be retiring from the Trust at the end of June 2018, he was wholeheartedly thanked for his support to the Trust.

Date and Time of next meeting 17th July 2018 – 9.30 – 11.30 YTHFT Boardroom

Action Log:

Month	Action	Responsible Officer	Due date	Completed
Jun 18	Create an Action Log	Lynda Provins		Completed
Jun 18	To consider adding waiting list data to the Data Quality Group work programme	Andy Bertram	21.08.18	

Finance and Performance Committee – 17 July 2018

Attendance: Mike Keaney (MK) Chairman, Andrew Bertram (AB), Lynette Smith (LS) Graham Lamb (GL), Steve Kitching (SK), Melanie Liley (ML), Lynda Provins (LP), Jonathan Hodgson (JH), Joanne Best.

Apologies for Absence: Wendy Scott

Minutes of the meeting held on the 19 June 2018

The minutes of the last meeting held on 19 June 2018 were agreed subject to the following amendments:-

Page 2, paragraph 1 – change of wording

It was noted that York ED had its busiest month *'this decade'*.

Page 2, paragraph 4 – insert additional bullet

- *review the possibility of NHS 111 directly booking into the UCC*

Page 2, paragraph 5 – merge paragraphs at 'WS Outlined'

DT gave an overview of the action plan including the fact that ED consultant leads have been nominated to lead on each individual action / project. *WS outlined the agreed DM portfolio changes with DT changing his base to Scarborough to manage ED, Acute Medicine, COE and flow and Jamie Todd, doing similar in York*.

Page 2, paragraph 8 – start new paragraph

'*Following the declaration of one 52 week wait breach was in Head and Neck at the end of April which was due to an administrate error, the Corporate Performance team has been working with the directorate throughout May conducting a detailed review of their waiting list. This identified that the reporting error identified in April was not an isolated incident and that a number of patient pathways had had incorrect 'clock end dates' recorded'.*

Page 3, paragraph 2 – insert word

AH stated that the Trusts information *'team'* had reviewed

MK welcomed everyone to the meeting, the Committee then proceeded to have a short discussion with regards to the planned forthcoming changes to Board and Committee meetings.

It was agreed that a short Finance and Performance meeting should be held in August 2018, noting that there will be a planned discussion regarding the role of Committees.

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AB addressed the Committee stating that the Trust will move to two day Board meetings from September 2018 onwards, with an expectation that the Board will cover transitional, transformational and strategic plans.

LP gave a brief overview of the plans so far noted that a draft agenda had been submitted to the Trust Chairwoman Sue Symington and that there may be a requirement for the Board to discuss some reports as well as offering assurance.

MK noted that the Finance and Performance Committee had proved to be extremely successful and suggested that there may still be a need for it to continue on a bimonthly basis.

Matters arising from the minutes - LP noted that there is now an action log attached to the F&P minutes.

Emergency Care Standards - LS stated that the Emergency Care Standard for June achieved 90% against the planned trajectory for June which was 87%. It was noted that this had been achieved although June continued to see raised levels of demand on the service in both York and Scarborough. There was a 3.6% increase of Type 1 attendees across the Trust and a 5.6% increase in Types 1&3 attendees representing a growth of 4.5% above planned for June.

LS stated that the achievement of 90% for June was a credit to the staff concerned as there have been added pressures on nursing staff, this may be due to reduced take of shifts by Bank staff.

LS explained to the Committee that NHSE have published key guidance this month relating to unplanned care and notably the Provider Sustainability Funding (PSF) guidance for Q1 was published at the end of June. This guidance was set out differently to the Trusts expectations as indicated by NHSI. It was noted that despite over-achieving the planned trajectory which had been agreed with NHSI and demonstrating improvement on Q4 2017-18, the Trust has not met the gateway to access the PST (under the latest published guidance). LS stated that this was very disappointing and that the Trust has appealed to NHSI.

MK enquired what the Trust position would be if the appeal was not successful. GL indicated that the letter implied that the 30% element relating to the ECS may not be recoverable, but this was not yet confirmed.

LS referred to the increase in ED Type 1 (major) and type 3 (minor) attendees stating that the data was under review checking if this may relate to primary care issues or possibly due to delays on waiting list.

MK stated that this was a very pragmatic move to support the achievement of targets.

MK asked for further clarity on the additional winter guidance for 'super stranded' patients.

LS - The Trust has been set a target to reduce the number of bed days associated with 'super stranded' patients by 25% by December 2018, noting that this includes both community and acute bed days. This is under discussion with NHSI.

ML explained to the Committee that a patient with an in-stay of more than 7 days is classed as 'stranded' and that 21 days and over is deemed 'super stranded', noting that

50% of the patients have constraints that can be addressed by the Trust and / or partner agencies, noting that the acute and emergency pathways, and complex discharge pathways will support these patients.

ML told the Committee that out of 385 patients who have had a stay of 7 days 129 (34%) are deemed super stranded of which 35 patients are DTOC patients.

AB enquired if there had been any change since the attendance of Ernst & Young (EY).

ML told the Committee that there had been a notable change in the engagement of clinical teams and that many of the EY recommendations have been moved forward.

Cancer - LS – The Trust did not achieve the 62 day to 1st Treatment from GP referral in May, achieving 78.4% against the 85% standard target, noting that June is indicating an improvement at 82%. It was noted that all other targets had been achieved. There is a number of patient breaches across a number of tumour sites with Urology tumours comprising of 43% of these affected by the delays in TRUS biopsies and significant delays in prostatectomy's. There is an issue with delay access to treatment at Hull with a 6-8 week delay to access robotic surgery. These pressures in relation to the Urology and Colorectal pathways have been escalated at the Cancer Alliance Board and to the Commissioners. Treatment and Pathway clinical task and finish groups have been established by the Cancer Alliance Board to address these pathway delays. It was noted that there has also been a significant delay in endoscopies and that the CCG is working with the Trust to pilot a triage referral scheme in Selby for colorectal fast track in August.

It was noted that by not achieving the 62 day target across the STP the Cancer Alliance is anticipating a £2m loss of the Cancer Alliance funding.

MK enquired what this loss actually means to the Trust. LS stated that some of the current schemes may be stood down. A Cancer Alliance Workshop is planned for the 8th August to consider the prioritisation of funding.

Planned Care - LS **–** The RTT position for June is 84.1% which is above the planned trajectory of 83.6%. It was noted that the number of patients on the waiting lists has increased representing a 5% increase against plan for June, with is an increase of 4.2% from March 18. There has been a reduction in GP referrals of 8.2% against June 17, however due to significant increases in April and May 18 Q1 shows an increase of 3.18% overall compared to 2017-18. This has impacted on waiting lists and in outpatients with 1st attendance from GP referral significantly above Trust AIC plan for June.

As reported last month the Trust had declared a number of 52 week breaches which were due to the administrative errors affecting the Head and Neck department. A further 9 breaches have been declared in June.

LS referred the Committee to Appendix A which is and updated report on the 52 week breaches in Head and Neck which includes an action plan which has been shared with the regulators to ensure they are fully sighted on the actions that the Trust is taking. It was noting that no clinical harm has been identified to date.

A full review of all 40 week waits in all Directorates has taken place, no further errors were identified.

Work is progressing on theatre productivity, aligned to the CIP Transformation Plan. SK stated that this is fundamentally part of the efficiency programme with a cost out of £1.8m and income of £3m profit. It was noted operational plans at the Bridlington Hospital have supported a significant improvement on productivity. Jenny Hey undertakes weekly productivity meetings working on sustainability service plans. LS stated she could provide more detail for the August meeting.

Diagnostic- LS – June has not shown any significant change to the Diagnostic position from May, achieving 96.3% with the issues reported last month remaining the same these include capacity issues in sleep studies, endoscopy and MRI. It was noted that all children waiting an MRI under GA have been offered their diagnostic at Sheffield Hospital, 15 have accepted this with the remaining patients not taking this up this offer.

The Trust has engaged with NHS Elect to complete a demand and capacity review in radiology, this will inform the development of detailed service level standards for turnaround and reporting purposes. The first meeting was held on 11th July. A review of the weekly diagnostic meeting has been completed. The Terms of Reference have been reviewed with a new focus to target recovery work.

CQUINS - LS stated that Sepsis and Mental Health issues still remain at risk but that this risk offers no financial penalties at this time. As recorded in previous minutes all other CQUIN are continuing to be monitored showing either an amber or green status. LS noted that front line teams are extremely committed to achieving these CQUINS.

AB noted that CQUIN monitoring supports quality improvement and should definitely continue with a focus on quality improvement.

Finance – GL – Month 3 ends the first quarter and is the first month reporting under the provision of the AIC (Aligned Incentive Contract). The income and expenditure position at the end of month 3 shows a deficit of £4.8m against a planned deficit of £4.3m giving an adverse variance of £0.5m against plan.

It was noted that for Q1 the pre-PSF (Provider Sustainability Funding) control total was a £6.3m deficit and the Trust has improved on this position with a reported £6.2m deficit. The Trust is therefore eligible for Q1 PSF of up to £1.9m. However as 30% of this is conditional on delivering the ECS improvement trajectory, which was not achieved, the Trust has lost £0.6m. AB and LS confirmed this position has been appealed.

The Committee discussed the impact on the financial position in relation to the AIC and was assured by AB that the Trust was on Plan and the most likely settlement under AIC had been fully reflected in the reported position. MK stated that this felt like an improvement on the position this time last year.

GL stated that the monthly average expenditure level for the last 6 month of 2017/18 was £40.6m this has risen over Q1 to a monthly average of £41.0m. GL explained the increase in monthly expenditure noting that this had been driven by one-off payments in the first quarter and the planned inflationary impact of accrued expenditure for the prospective 1% pay award and increased CNST premiums along with growth in excluded drug and clinical supplies expenditure all partially offset by reducing expenditure linked to the Scarborough community service transfer in May. The group noted and discussed the run-rate charts in the finance report and sought assurance from the reported position.

DRAFT

It was noted that there was no notable increase in agency spend with a reported agency spend for month 3 of £3.9m, Consultant and Nursing spend were broadly on plan with Medical and other staff groups slightly ahead of plan. This spend is £0.2m above the Trust's cap but reflects the best position against cap for some considerable time.

GL drew the Committees attention to the last 2 paragraphs on page 41 or the report highlighting the adjustments that have been made in accordance with the AIC requirement.

The CIP target for 2018/19 is £21.7m this has been set using intelligence around previous years delivery trajectories. GL confirmed the current position against target and explained this would be covered in detail by SK shortly.

It was noted that the figures on Page 42 paragraph 1 had been miss typed and would be updated accordingly for the Board papers.

There are no issue to report at the end of month 3 in relation to cash, noting that a detailed cash paper was discussed at the April Board meeting.

AB told the Committee that at this time he does not see any need for a cash loan within the next two months.

Efficiency – SK highlighted that Trust Efficiency programme target for 2018/19 is £21.7m and that as at the end of June 18 delivery is £7.3m which is 34% or the annual target compares to £5.2m in June 2017.

It was highlighted that month 3 had continued to be strong continuing to show improvement in the risk profile of plans. Focus is on high and medium risk plans to convert them to low risk deliverable schemes.

June has seen the commencement of 2 weekly reporting of planning forecast delivery and actual delivery of the efficiency programme to the Trust regulator NHSI. SK noted that this has created an additional workload but acknowledged that this is a good discipline to adopt and should support more robust planning.

MK noted that the charts are very clear and easy to read, SK explained that they are still under development with plans to develop summary charts.

SK referred to P84 or the pack giving the Committee a brief explanation on how to read the heat maps.

SK explained to the group that the current live QIA process has identified a small number of red-amber related schemes. SK confirmed these would be reported to the new Efficiency Delivery Group (membership including Medical Director and Chief Nurse) and these would be formally reviewed in due course. The new QIA process had been implemented and early indications were that the process was working with high risk schemes being appropriately identified for further in depth review.

Internal Audit Strategic Plan – JH delivered a brief overview of the Internal Audit Strategic Plan 2018 – 21 and Operational Plan for 2018-19 referring to the previously submitted paper F. JH discussed Internal Audit's roles and responsibilities as per the Public Sector Internal Audit Standards for the provision of a meaningful Head of Internal

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Audit Opinion to support the Trust's Annual Governance Statement and confirmed compliance.

JH explained to the Committee the risk based process of how audit plans are developed, including key staff, Corporate Directors and senior Trust staff input and the approval process by the Audit Committee. MK enquired about assurance of IT systems to which JH replied that Internal Audit has coverage within the audit plan under the IM&T section and also wider system reviews. JH discussed how an audit would provide assurance on systems and processes and not necessary focus on network resilience, unless it was the specific objective of the audit. There is also opportunity for audits to validate that systems are operating in line with guidance / best practice.

MK referred to the previously recorded data breach and system failure within the Trust noting that the IT system appears to have large periods of down time. JH echoed MK's concern and noted that this is not just an isolated Trust issue, but had also occurred at other organsiations and that in relations to the CPD uptime, the down time periods could be benchmarked against other Audit Yorkshire clients should MK feel that would be of use.

JH explained that the assurances MK appeared to be seeking were wider than just from Internal audit and it would be beneficial for IT performance to be reported and monitored by the Board. A good starting point could be through the Trust's BAF and the assurances provided by internal audit could also be reflected where applicable. JH also offered to further discuss with MK how he thought internal audit could provide further assurances over his concerns.

JH referred the Committee members to appendix B and discussed the wider IM&T areas which had been risk assessed and included as part of developing the three year strategic plan, which is refreshed annually as part of the operational planning round.

AB noted that this was a very useful chart.

BAFF - LP stated that there had been no significant changes to either the Risk Register or the Board Assurance Framework, but stated that a new strategy was agreed in June and that an update will be delivered to the July Board.

Out of Hospital Care Quarterly Board Sub-Committee Report – submitted for information only

AOB

MK enquired if there was any update in relation to using IT in the community, ML explained SystemOne is the IT platform in the community and one concern is the inequitable access to IT support compared to CPD infrastructure within the Trust.

Items to Board:
Provider Service Material take up
Financial Implications – Cancer
Key Performance Issues - 52 Week Breaches
Finance Q1 position – PSF appeal

Date and time of next meeting - 21 August 2018 – Board Room YTHFT

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Action Log:

Month	Action	Responsible Officer	Due date	Completed
Jun 18	To consider adding waiting list data to the Data Quality Group work programme	Andy Bertram	21.08.18	

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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 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 3 financial position for York Teaching Hospital NHS Foundation Trust.

The Trust is reporting an Income and Expenditure deficit of £4.8m against a planned deficit of £4.3. The Trust is currently reporting a £0.5m adverse 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: Graham Lamb, Deputy Finance Director

Executive sponsor: Andrew Bertram, Acting Deputy Chief Executive & Finance Director

Date: July 2018

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

2018/19 Month 3 (Q1) Summary Financial Position

This report for month 3 marks the end of the first quarter, and the first month in reporting under the provisions of the Aligned Incentive Contract (AIC) agreed during June 2018, and effective from April 2018. The month 3 (Q1) income and expenditure position is a deficit of £4.8m against a planned deficit of £4.3m. The Trust is therefore reporting a £0.5m adverse variance against plan.

Excluding Provider Sustainability Funding (PSF) the month 3 control total was a £6.3m deficit. This position has been exceeded (actual £6.2m deficit) and therefore the Trust is eligible for the Q1 PSF of £1.9m. The Board is 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, the Trust has secured delivery of its control total, but has failed to meet its required ECS performance trajectory, resulting is a loss of £0.6m PSF for Q1. Further details regarding the failure to meet the ECS performance trajectory are contained under separate cover in the Performance report to the Board.

The detailed Finance Report in the Board's Performance Pack includes the 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 has risen to £41.0m monthly average over Q1. The increase in average run rate is being driven by one-off payments in the first quarter adding an average £0.1m to the run rate; the planned inflationary impact of accrued expenditure for the prospective 1% pay award, and increased CNST premiums; growth in excluded drug and clinical supplies expenditure, all partially offset by reduced expenditure linked to the Scarborough community service transfer in May.

Agency expenditure has been reset at a total cap of £14.2m as per NHSI's direction for the Trust. For month 3 this suggests a spend cap of £3.7m. The actual reported agency expenditure was above cap at £3.9m. Whereas Consultant and Nursing spend is broadly on plan for the quarter, other Medical and other staff groups are slightly ahead of plan.

The reports now separately identify excluded drugs and devices from the main category of drug expenditure. The report confirms excluded drug and device expenditure ahead of plan by £0.8m. Under the AIC, reimbursement for the CCG component of this additional spend is only at 50%, and an adjustment to the overall reported income level has been made to reflect this arrangement. The share of excluded drug and device expenditure commissioned by NHSE is not subject to any AIC adjustment.

Reported income levels reflect excessive non-elective demand and ED attendances. Again an adjustment has been made to reduce this income level in accordance with the requirements of the AIC. There is much work to do to develop the reporting under AIC arrangements and this will be overseen through the Systems Transformation Board. For now the reported income level reflects the most likely outturn before reconciliation under the AIC arrangement.

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 £7.3m delivered in full year terms in Q1; notably £5.3m delivered recurrently, representing 24% of the overall CIP target.

There are no cash issues to report in relation to month 3 following the detailed cash paper that was discussed at the April Board meeting.

Finance Performance Report

July 2018

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

Finance Report
Chapter Index

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

Summary Income and Expenditure Position
Month 3 - The Period 1st April 2018 to 30th June 2018

York Teaching Hospital
NHS Foundation Trust

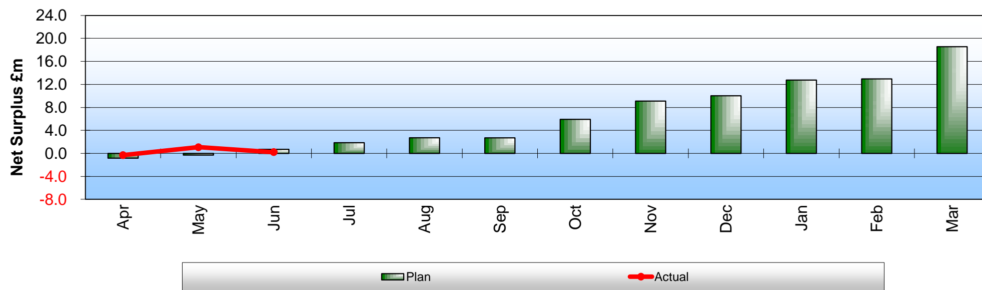
Summary Position:

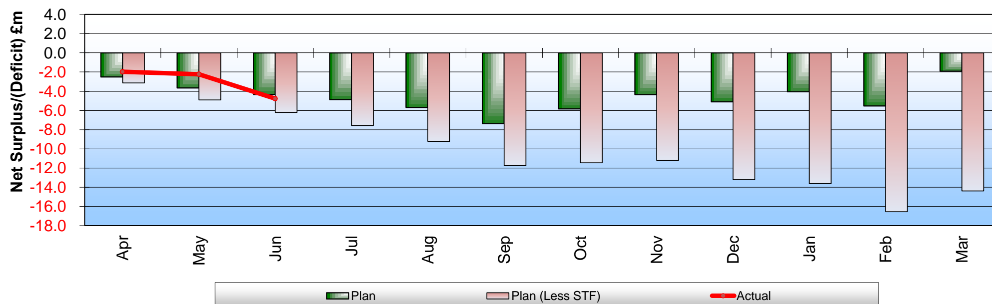
* The Trust is reporting an I&E deficit of £4.8m, placing it £0.5m behind of the operational plan.

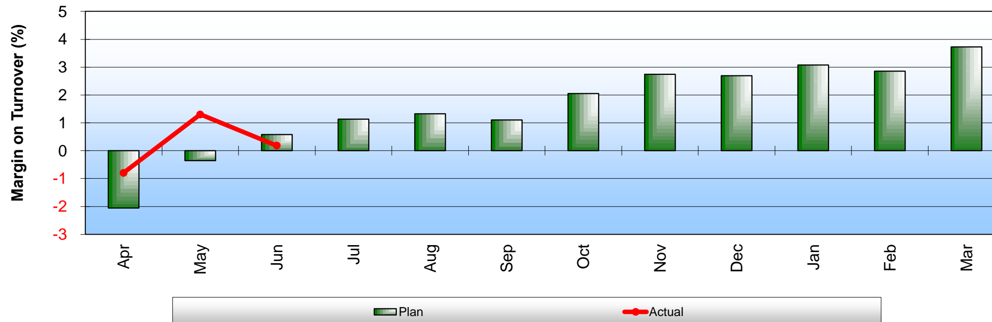
* Income is £0.3m ahead of plan, with clinical income being £0.8m ahead of plan and non-clinical income being £0.5m behind plan.

* Operational expenditure is ahead of plan by £0.3m, with further explanation given on the 'Expenditure' sheet.

* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £0.2m (0.18%) compared to plan of £0.3m (0.25%), 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	22,967	6,394	6,347	-47	22,967	0
Planned same day (Day cases)	35,496	10,192	10,074	-118	35,496	0
Non-Elective Income	115,387	29,229	29,715	486	115,387	0
Outpatients	58,848	15,096	15,158	62	58,848	0
A&E	15,390	4,134	4,167	33	15,390	0
Community	21,044	5,606	5,698	92	21,044	0
Other	113,856	27,889	27,719	-170	113,856	0
Pass-through excluded drugs expenditure	44,215	11,092	11,520	428	44,215	0
	427,203	**109,632**	**110,398**	**766**	**427,203**	**0**
Non-NHS Clinical Income						
Private Patient Income	1,042	260	196	-64	1,042	0
Other Non-protected Clinical Income	1,560	390	448	58	1,560	0
	2,602	**650**	**645**	**-6**	**2,602**	**0**
Other Income						
Education & Training	13,736	3,434	3,293	-141	13,736	0
Research & Development	2,546	637	684	47	2,546	0
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	623	156	156	0	623	0
Other Income	26,423	5,804	5,949	145	26,423	0
Sparsity Funding	2,600	650	650	0	2,600	0
STF	12,479	1,872	1,310	-562	12,479	0
	58,407	**12,552**	**12,041**	**-510**	**58,407**	**0**
Total Income	**488,212**	**122,834**	**123,084**	**250**	**488,212**	**0**
Expenditure						
Pay costs	-332,880	-82,136	-83,283	-1,147	-332,880	0
Pass-through excluded drugs expenditure	-44,215	-11,092	-11,863	-771	-44,215	0
PbR Drugs	-7,089	-1,832	-1,705	126	-7,089	0
Clinical Supplies & Services	-48,618	-12,408	-13,158	-749	-48,618	0
Other costs (excluding Depreciation)	-52,713	-13,551	-12,860	690	-52,713	0
Restructuring Costs	0	0	0	0	0	0
CIP	14,315	-1,511	0	1,511	14,315	0
Total Expenditure	**-471,200**	**-122,529**	**-122,869**	**-340**	**-471,200**	**0**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**17,012**	**305**	**215**	**-90**	**17,012**	**0**
Profit/ Loss on Asset Disposals	0	0	41	41	0	0
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation - purchased/constructed assets	-10,717	-2,679	-2,928	-249	-10,717	0
Depreciation - donated/granted assets	-395	-99	-99	0	-395	0
Interest Receivable/ Payable	130	33	26	-7	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	-211	-219	-8	-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	-6,670	-1,667	-1,804	-137	-6,670	0
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**-1,907**	**-4,318**	**-4,768**	**-450**	**-1,907**	**0**

Summary Trust Run Rate Analysis

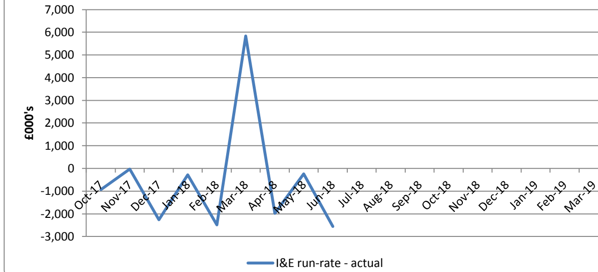
Month 3 - The Period 1st April 2018 to 30th June 2018

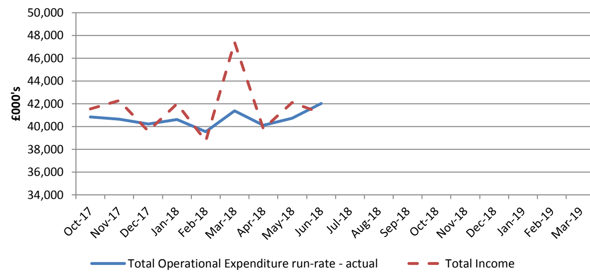
York Teaching Hospital
NHS Foundation Trust

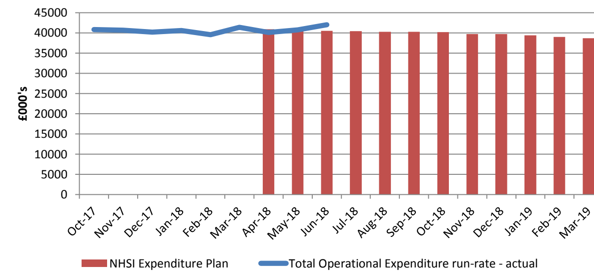
Key Messages:

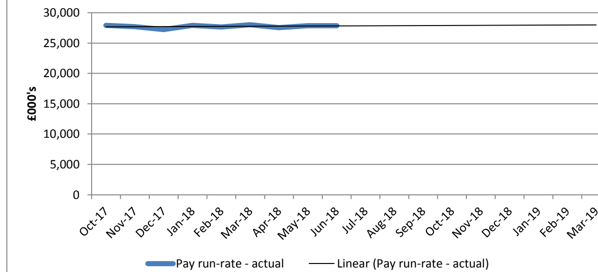
* The total operational expenditure in June was £42m. The average total operational expenditure in the previous eight months was £40.5m. Resulting in an adverse variance of £1.5m.

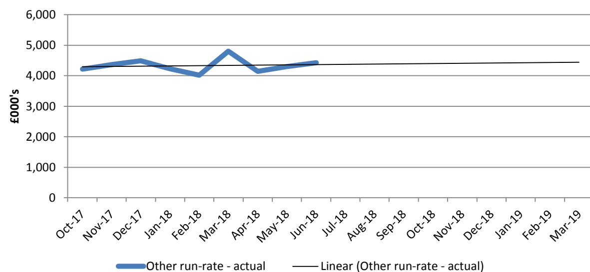
* In month operational expenditure exceeded income by £0.8m, resulting in a negative EBITDA for the month.

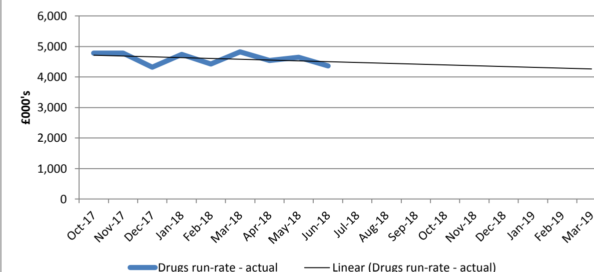


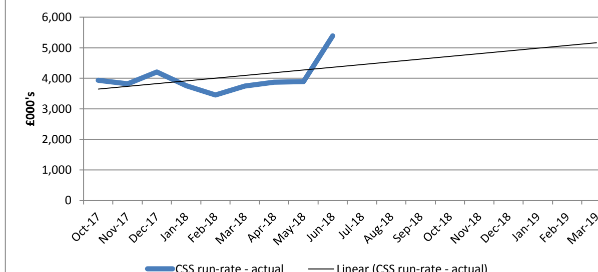












	Monthly Spend																		
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Monthly Ave	Variance
Total Income	41,538	42,272	39,613	42,003	38,738	47,400	39,791	42,110	41,183	0	0	0	0	0	0	0	0	0	41,683	-500
Pay Expenditure	-27,901	-27,678	-27,214	-27,902	-27,651	-28,002	-27,550	-27,881	-27,852	0	0	0	0	0	0	0	0	0	-27,722	-130
Drug Expenditure	-4,785	-4,785	-4,327	-4,747	-4,433	-4,832	-4,549	-4,651	-4,368	0	0	0	0	0	0	0	0	0	-4,639	271
CSS Expenditure	-3,938	-3,822	-4,208	-3,754	-3,452	-3,745	-3,871	-3,895	-5,392	0	0	0	0	0	0	0	0	0	-3,836	-1,556
Other Expenditure	-4,217	-4,358	-4,484	-4,225	-4,017	-4,807	-4,140	-4,296	-4,424	0	0	0	0	0	0	0	0	0	-4,318	-106
EBITDA	697	1,629	-620	1,375	-815	6,014	-319	1,387	-853	0	0	0	0	0	0	0	0	0	1,169	-2,022

Contract Performance

Month 3 - The Period 1st April 2018 to 30th June 2018

York Teaching Hospital
NHS Foundation Trust

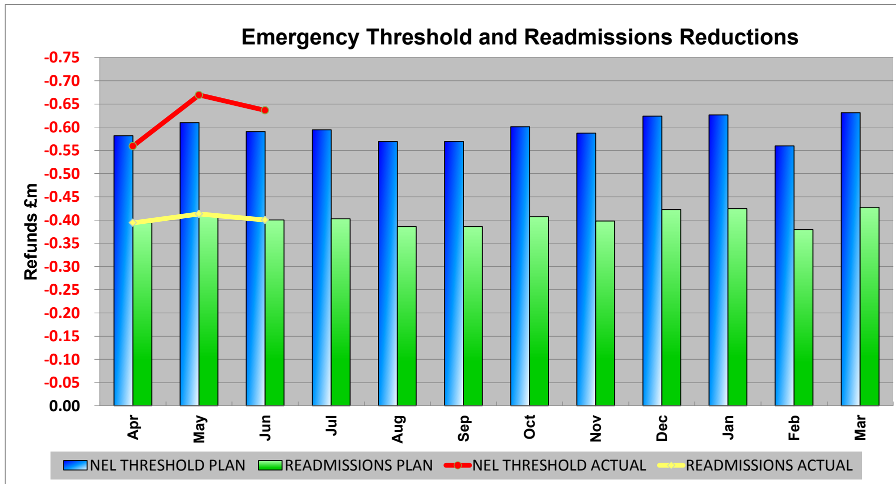
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	219,316	55,528	56,994	1,466
Scarborough & Ryedale CCG	77,783	20,280	20,686	406
East Riding CCG	42,696	10,674	10,760	86
Other Contracted CCGs	17,372	4,330	4,336	6
NHSE - Specialised Commissioning	42,548	10,504	11,012	508
NHSE - Direct Commissioning	15,340	3,841	3,601	-240
Local Authorities	4,456	1,114	1,114	0
Total NHS Contract Clinical Income	**419,511**	**106,271**	**108,503**	**2,232**

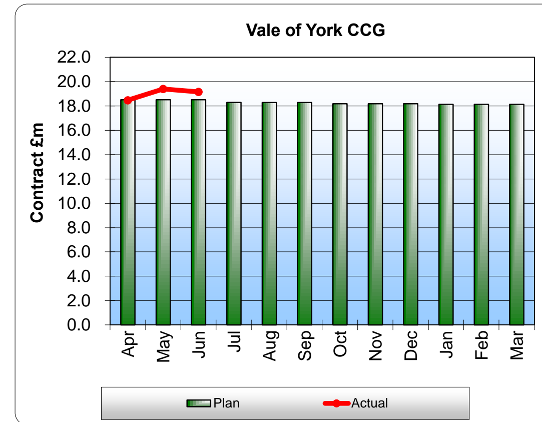
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	12,088	2,994	2,545	-449
Risk Income	-4,396	367	0	-367
Total Other NHS Clinical Income	**7,692**	**3,361**	**2,545**	**-816**

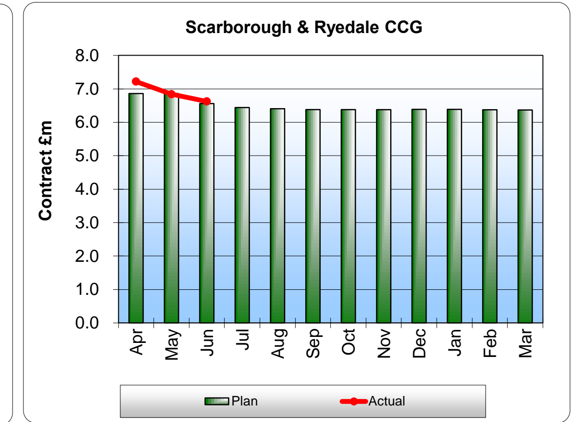
Sparsity funding income moved to other income non clinical	-650
Winter resilience monies in addition to contract	0

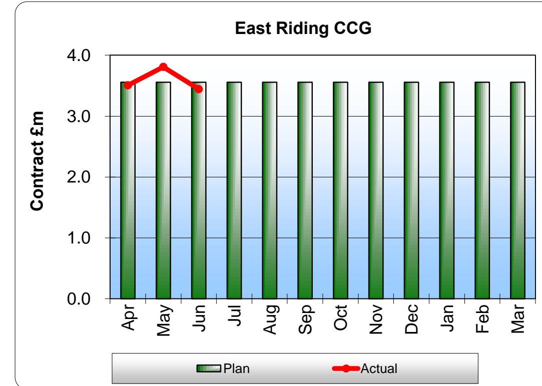
Total NHS Clinical Income	**427,203**	**109,632**	**110,398**	**766**

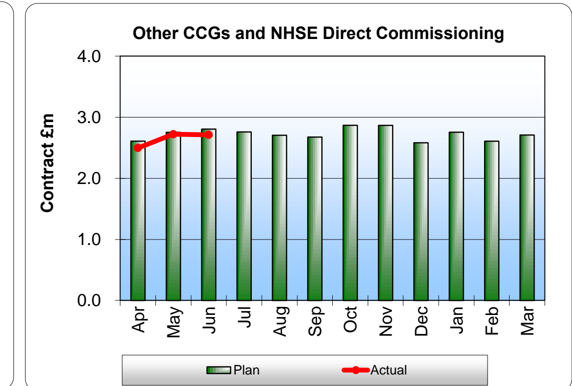
Activity data for June is partially coded (63%) and May data is 91% coded. There is therefore some element of income estimate involved for the uncoded portion of activity.

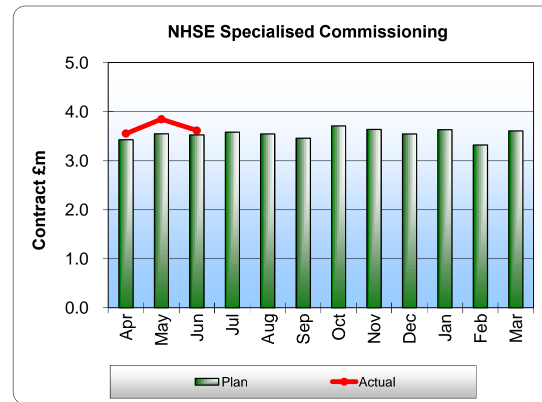


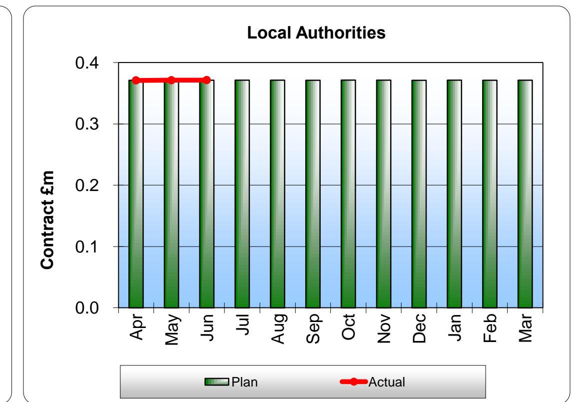












Agency Expenditure Analysis

Month 3 - The Period 1st April 2018 to 30th June 2018

York Teaching Hospital NHS Foundation Trust

Key Messages:

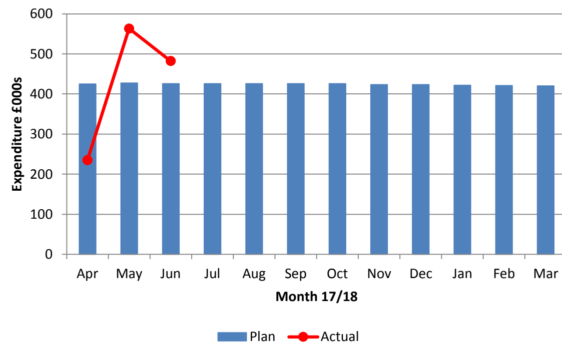
* Total agency spend year to date of £3.9m, compared to the NHSI agency ceiling of £3.7m.

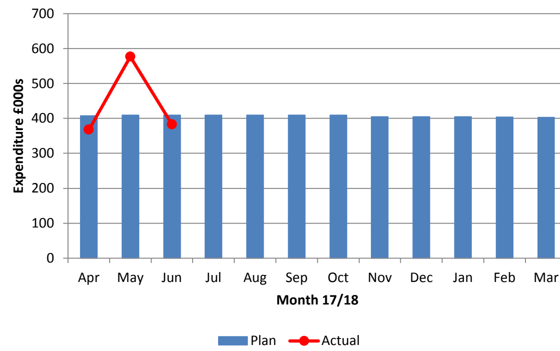
* Consultant Agency spend is on plan.

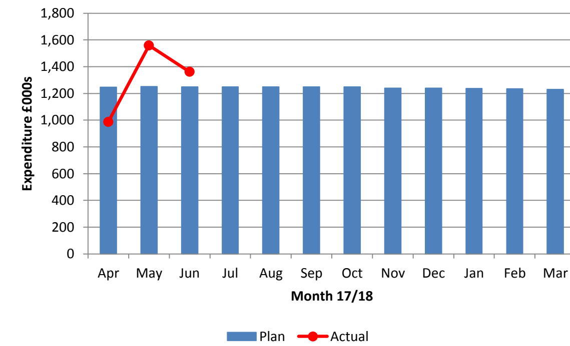
* Nursing Agency is on plan.

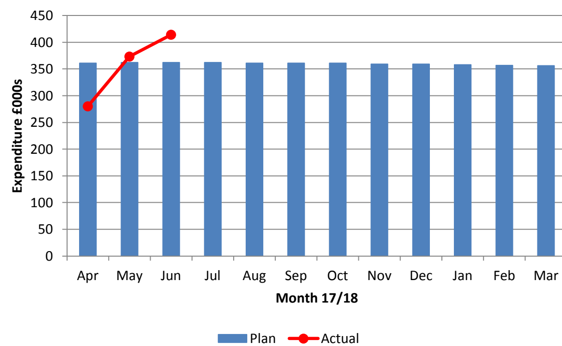
* Other Medical Agency spend is ahead of plan £0.1m.

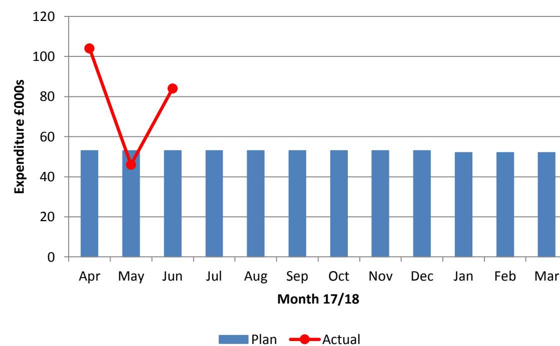
* Other Agency spend is ahead of plan £0.1m.

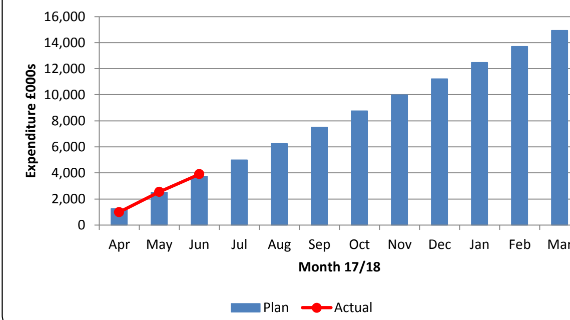












Expenditure Analysis
Month 3 - The Period 1st April 2018 to 30th June 2018

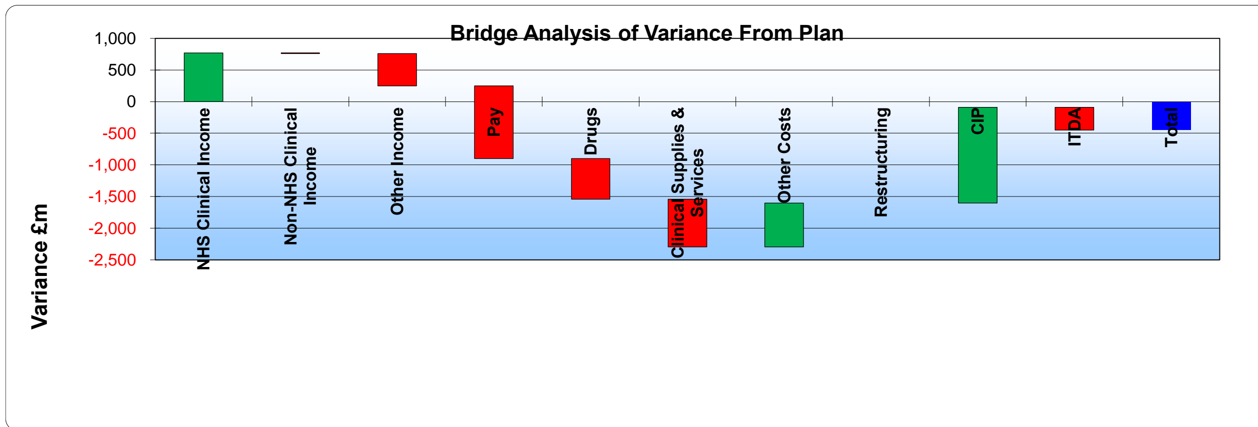
NHS York Teaching Hospital NHS Foundation Trust

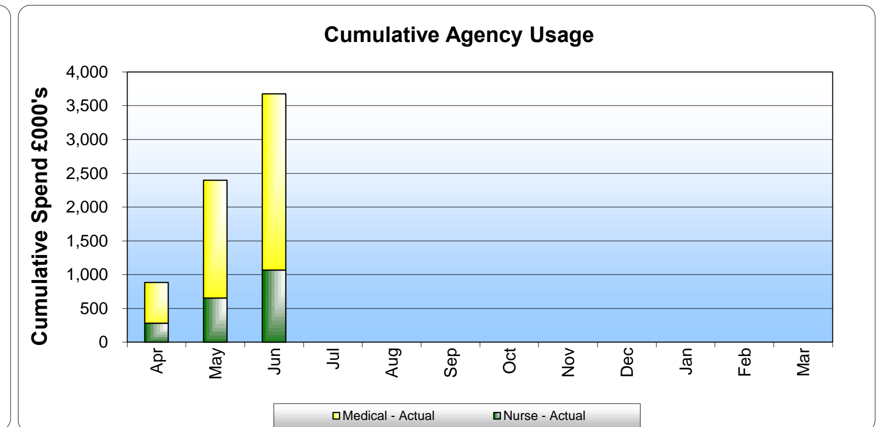
Key Messages:

There is an adverse expenditure variance of £0.3m at the end of June 2018. This comprises:

* Pay expenditure is £1.1m ahead of plan.
* Drugs expenditure is £0.6m ahead of plan.
* CIP achievement is £1.5m ahead of plan.
* Other expenditure is £0.1m ahead of plan.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	60,108	15,042	13,404	-	325	-	1,281	14,869	173	0	
Medical and Dental	30,354	7,408	8,068	-	46	-	1,327	9,353	-1,945	0	
Nursing	94,087	23,793	19,790	114	22	2,414	1,067	23,189	604	0	
Healthcare Scientists	13,442	2,233	2,644	2	3	2	64	2,690	-456	0	
Scientific, Therapeutic and technical	15,887	3,969	3,710	28	0	9	45	3,756	213	0	
Allied Health Professionals	26,228	6,494	5,933	31	48	3	57	6,014	480	0	
HCAs and Support Staff	45,472	11,521	10,463	157	16	13	48	10,596	924	0	
Chairman and Non Executives	186	46	42	-	-	-	-	42	4	0	
Exec Board and Senior managers	15,556	3,812	3,458	2	-	-	-	3,427	385	0	
Admin & Clerical	37,955	9,443	9,021	39	14	23	20	9,031	412	0	
Agency Premium Provision	4,241	1,060	-	-	-	-	-	0	1,060	0	
Vacancy Factor	-11,529	-2,984	0	-	-	-	-	0	-2,984	0	
Apprenticeship Levy	1,192	298	316	0	0	0	0	316	-18	0	
TOTAL	**333,180**	**82,136**	**76,848**	**373**	**474**	**2,462**	**3,909**	**83,283**	**-1,147**	**0**	





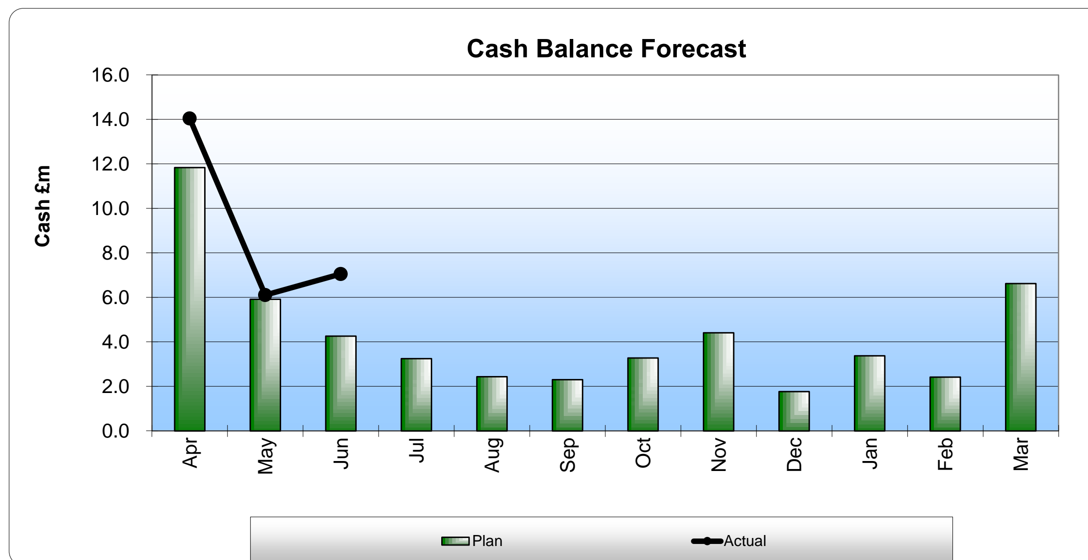
Cash Flow Management

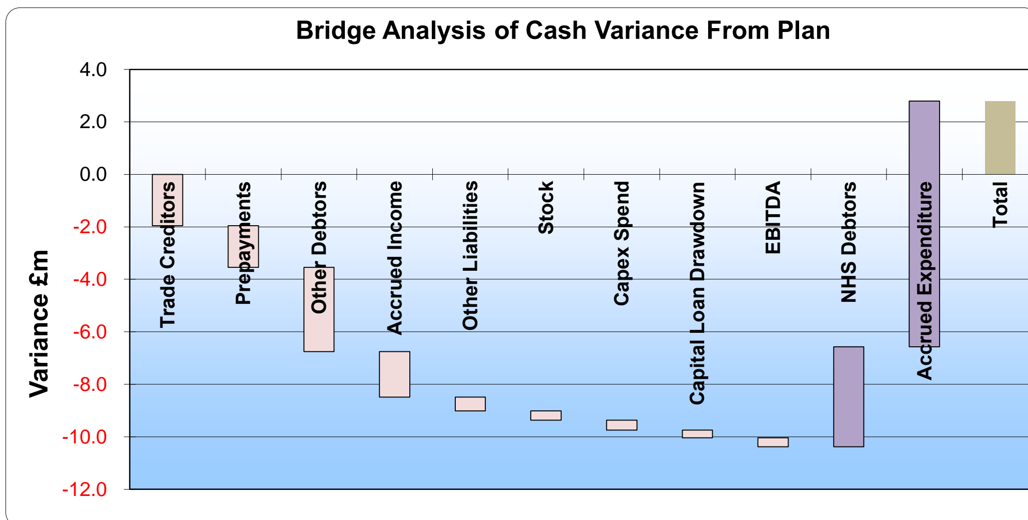
Month 3 - The Period 1st April 2018 to 30th June 2018

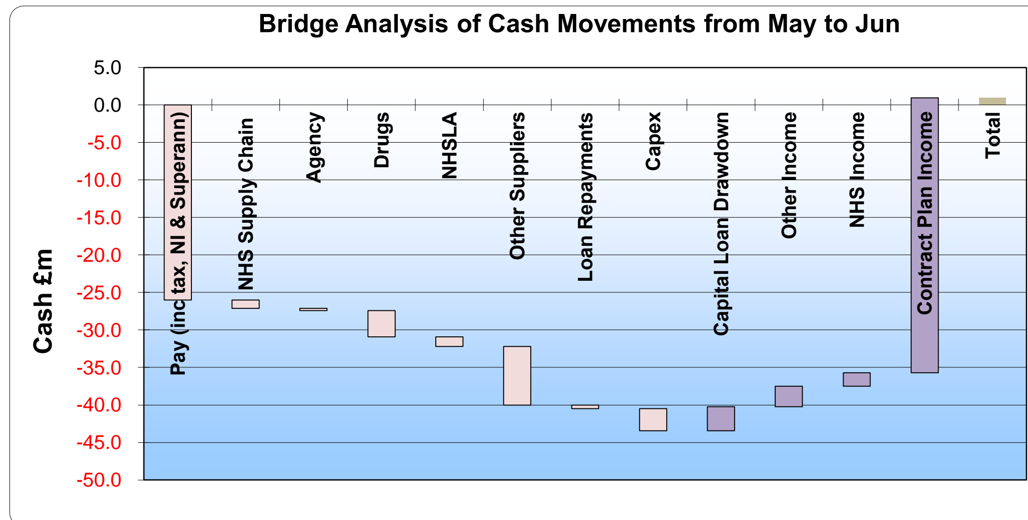
York Teaching Hospital NHS Foundation Trust

Key Messages:

* The cash position at the end of June was £7m, which is above plan.
* This is significantly influenced by creditor balance sheet movements which are favourable to the Trust's cash flow plan submitted to NHSI.
* AP continue to process legacy invoices following the migration to the Oracle Cloud ledger system.







Cash Flow Management

Month 3 - The Period 1st April 2018 to 30th June 2018

York Teaching Hospital
NHS Foundation Trust

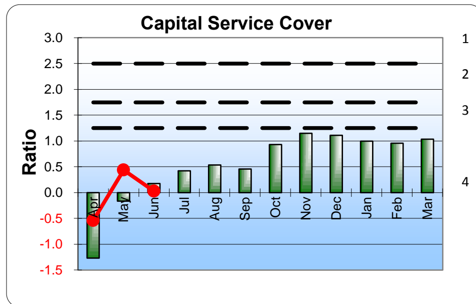
Key Messages:

* The receivables balance at the end of June was £11.7m, which is slightly below plan.
* The payables balance at the end of June was £13.5m which is above plan. This is attributable to new system invoice validation backlogs.
* The Use of Resources Rating is assessed as a score of 3 in June, and is reflective of the I&E position.

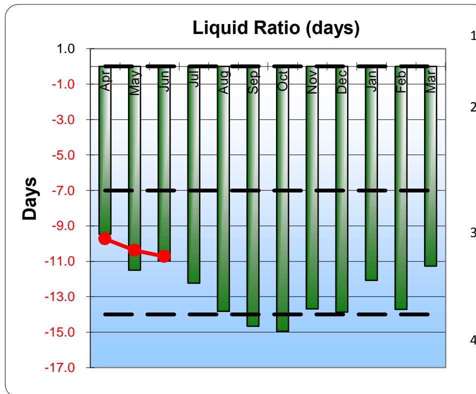
Significant Aged Debtors (Invoices Over 90 Days)

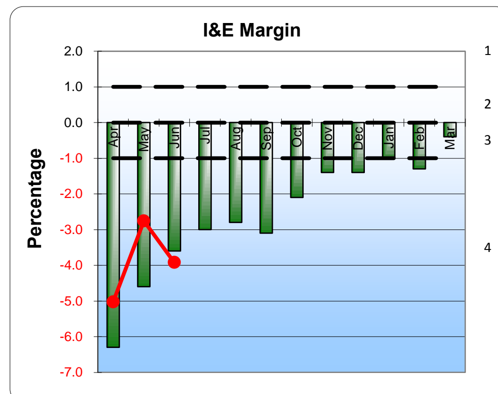
Hull & East Yorkshire NHS Trust	**£357K**
City Healthcare Partnership	**£285K**
Northern Doctors Urgent Care	**£258K**
NHS Property Services	**£233K**
Humber NHS Foundation Trust	**£209K**

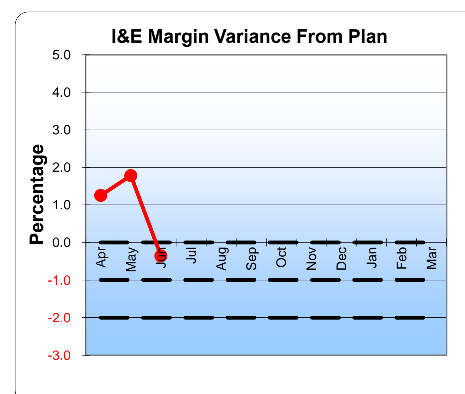
	Current £m	1-30 days £m	31-60 days £m	Over 60 days £m	Total £m
Payables	4.85	2.30	2.22	4.15	13.52
Receivables	4.78	1.58	1.97	3.38	11.71

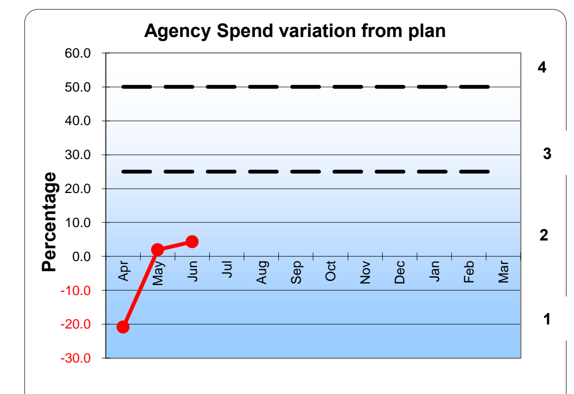


	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (20%)	3	3	3	3
Capital Service Cover (20%)	4	4	4	4
I&E Margin (20%)	3	4	4	3
I&E Margin Variance From Plan (20%)	1	1	2	1
Agency variation from Plan (20%)	1	1	2	1
Overall Use of Resources Rating	**3**	**3**	**3**	**3**









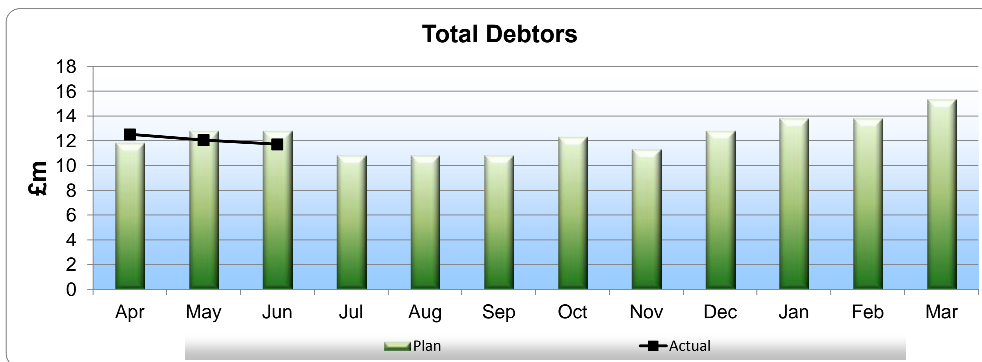
Debtor Analysis

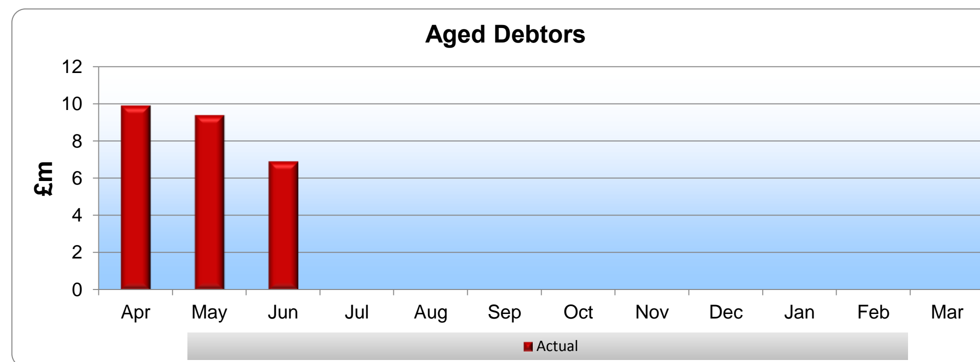
Month 3 - The Period 1st April 2018 to 30th June 2018

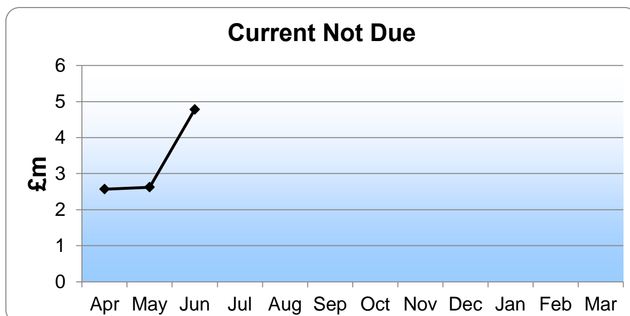
York Teaching Hospital
NHS Foundation Trust

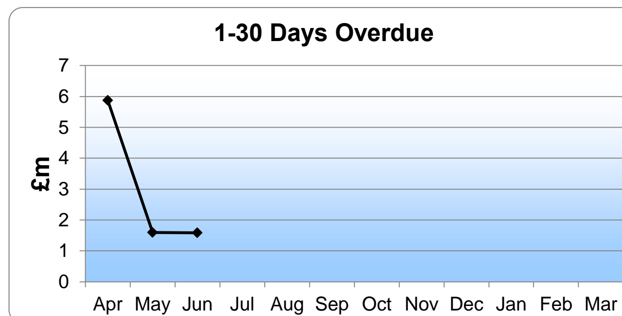
Key Messages:

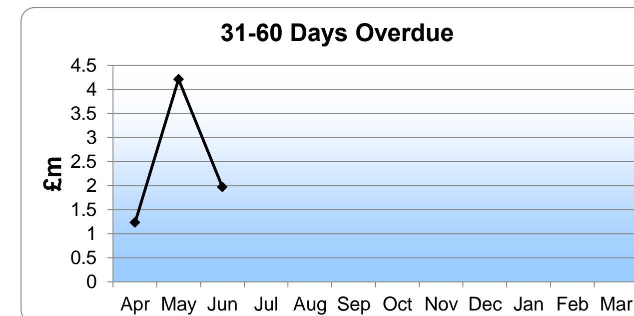
* At the end of June, the total debtor balance was slightly below plan and totalled £11.7m. £4.8m of this relates to 'current' invoices not due.
* Aged debt totalled £6.9m. This has reduced by £2.5m on the previous months position with the resolution of some large commissioner invoices.
* The charts below have been restated to align with the reporting funcitionality of Oracle Cloud and provide more detailed representation of debtor management.
* The focus over the coming months is to reduce long term debtors (Over 90 Days).
* Accrued income is higher than planned levels. Focus is required to turn accruals in to invoices to secure cash payments.

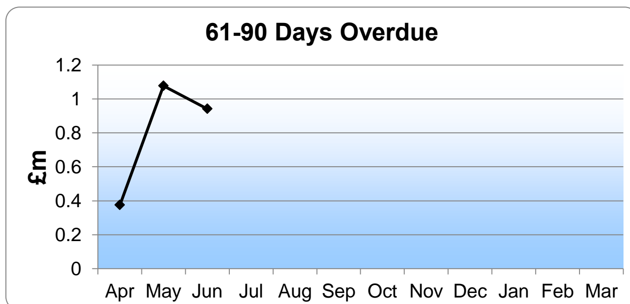


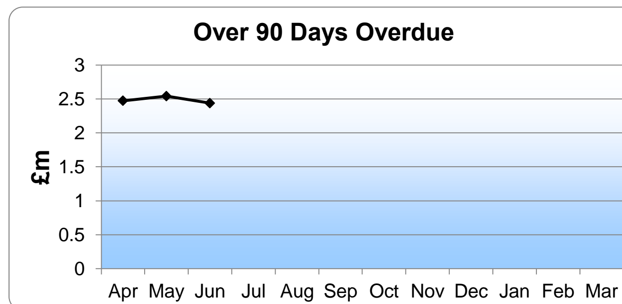


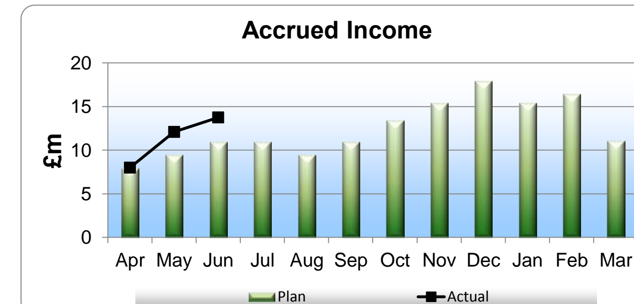












Capital Programme
Month 3 - The Period 1st April 2018 to 30th June 2018

York Teaching Hospital NHS Foundation Trust

Key Messages:

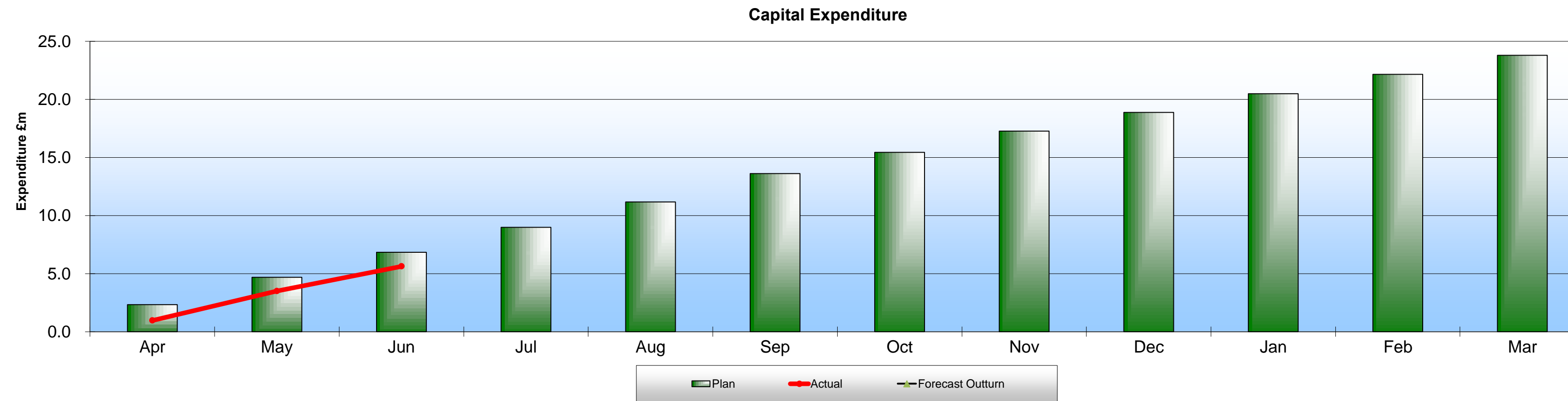
* The Capital plan for 2018-19 is £23.803m

* 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

* The 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	780	1,999	0	
SGH X ray Rooms	660	10	660	0	
York VIU/Cardiac Equipment	1,379	78	1,379	0	
Radiology Lift Replacement SGH	860	527	860	0	
Fire Alarm System SGH	1,529	296	1,529	0	
Other Capital Schemes	650	723	650	0	
SGH Estates Backlog Maintenance	1,000	108	1,000	0	
York Estates Backlog Maintenance - York	1,265	86	1,265	0	
Cardiac/VIU Extention	3,000	216	3,000	0	
Medical Equipment	450	58	450	0	
SNS Capital Programme	1,200	286	1,200	0	
Capital Programme Management	1,455	473	1,455	0	
Endoscopy Development	8,000	1,629	8,000	0	
Charitable funded schemes	623	163	623	0	
Fire Alarm System York	1,120	204	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**	**5,637**	**23,803**	**0**	

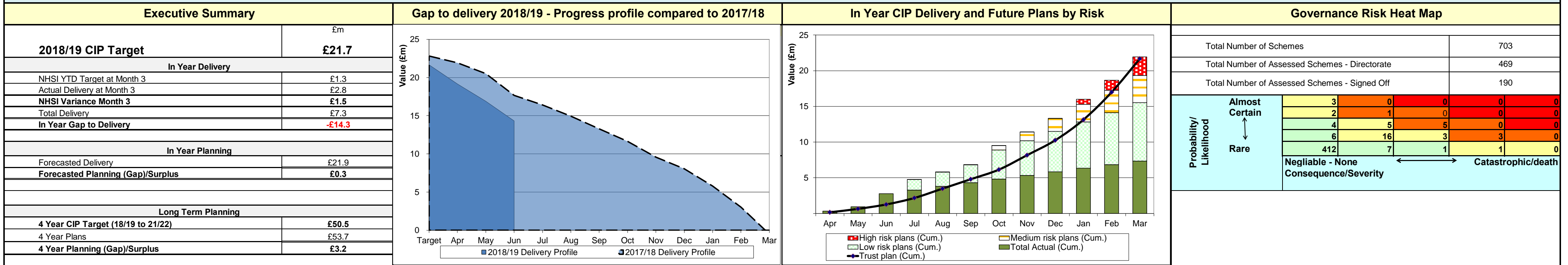
This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£000	£000	£000	£000	
Depreciation	5,538	1,938	5,538	0	
Loan Funding b/fwd	2,401	773	2,401	0	
Loan Funding	11,000	1,930	11,000	0	
Charitable Funding	623	163	623	0	
Strategic Capital Funding	4,026	833	4,026	0	
Sale of Assets	215	0	215	0	
TOTAL FUNDING	**23,803**	**5,637**	**23,803**	**0**	

Efficiency Programme
Month 3 - The Period 1st April 2018 to 30th June 2018

Key Messages:

* Delivery - £7.3m has been delivered against the Trust annual target of £21.66m, giving a shortfall of (£14.3m).
* Part year NHSI variance - The part year NHSI variance is £1.5m.
* In year planning - The 2018/19 planning surplus is currently £0.3m.
* Four year planning - The four year planning surplus is £3.2m.
* Recurrent delivery - Recurrent delivery is £5.3m in-year, which is 24% of the 2018/19 CIP target.

Efficiency - Total CIP



Executive Summary

	£m
2018/19 CIP Target	**£21.7**
In Year Delivery	
NHSI YTD Target at Month 3	£1.3
Actual Delivery at Month 3	£2.8
NHSI Variance Month 3	**£1.5**
Total Delivery	£7.3
In Year Gap to Delivery	**-£14.3**
In Year Planning	
Forecasted Delivery	£21.9
Forecasted Planning (Gap)/Surplus	**£0.3**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£50.5**
4 Year Plans	£53.7
4 Year Planning (Gap)/Surplus	**£3.2**

Gap to delivery 2018/19 - Progress profile compared to 2017/18

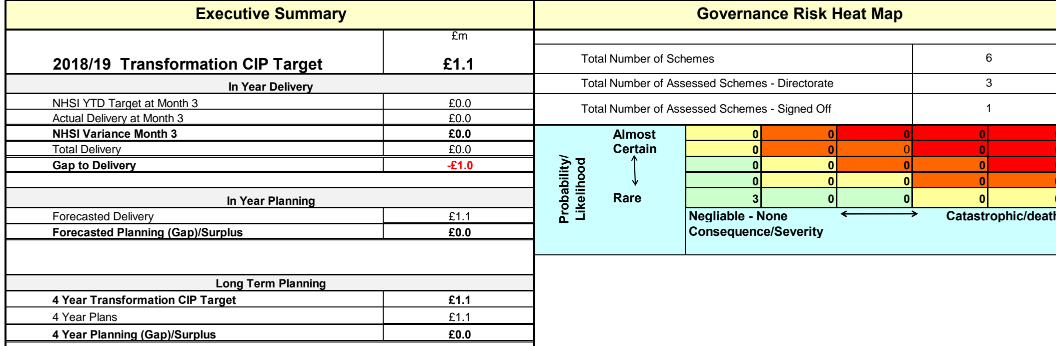
In Year CIP Delivery and Future Plans by Risk

Governance Risk Heat Map

Total Number of Schemes	703
Total Number of Assessed Schemes - Directorate	469
Total Number of Assessed Schemes - Signed Off	190

Probability/ Likelihood					
Almost Certain	3	0	0	0	0
	2	1	0	0	0
↕	4	5	5	0	0
	6	16	3	3	0
Rare	412	7	1	1	0
	Negligable - None Consequence/Severity	⟷			Catastrophic/death

Efficiency - Transformation Programme



Executive Summary

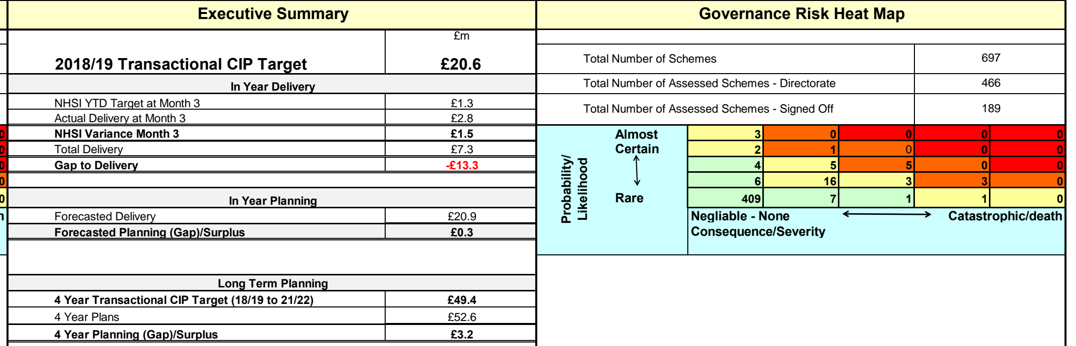
	£m
2018/19 Transformation CIP Target	**£1.1**
In Year Delivery	
NHSI YTD Target at Month 3	£0.0
Actual Delivery at Month 3	£0.0
NHSI Variance Month 3	**£0.0**
Total Delivery	£0.0
Gap to Delivery	**-£1.0**
In Year Planning	
Forecasted Delivery	£1.1
Forecasted Planning (Gap)/Surplus	**£0.0**
Long Term Planning	
4 Year Transformation CIP Target	**£1.1**
4 Year Plans	£1.1
4 Year Planning (Gap)/Surplus	**£0.0**

Governance Risk Heat Map

Total Number of Schemes	6
Total Number of Assessed Schemes - Directorate	3
Total Number of Assessed Schemes - Signed Off	1

Probability/ Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
↕	0	0	0	0	0
	0	0	0	0	0
Rare	3	0	0	0	0
	Negligable - None Consequence/Severity	⟷			Catastrophic/death

Efficiency - Transactional CIP



Executive Summary

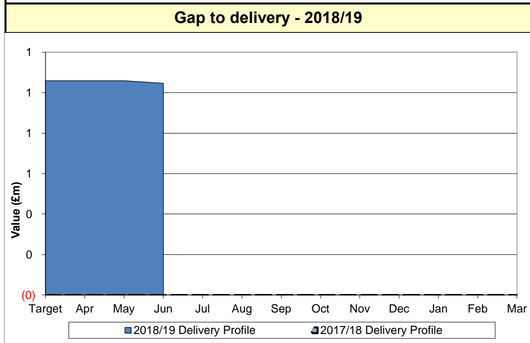
	£m
2018/19 Transactional CIP Target	**£20.6**
In Year Delivery	
NHSI YTD Target at Month 3	£1.3
Actual Delivery at Month 3	£2.8
NHSI Variance Month 3	**£1.5**
Total Delivery	£7.3
Gap to Delivery	**-£13.3**
In Year Planning	
Forecasted Delivery	£20.9
Forecasted Planning (Gap)/Surplus	**£0.3**
Long Term Planning	
4 Year Transactional CIP Target (18/19 to 21/22)	**£49.4**
4 Year Plans	£52.6
4 Year Planning (Gap)/Surplus	**£3.2**

Governance Risk Heat Map

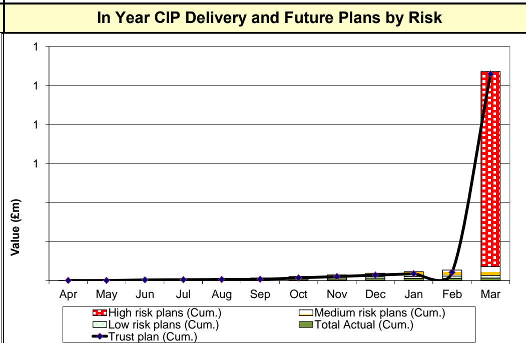
Total Number of Schemes	697
Total Number of Assessed Schemes - Directorate	466
Total Number of Assessed Schemes - Signed Off	189

Probability/ Likelihood					
Almost Certain	3	0	0	0	0
	2	1	0	0	0
↕	4	5	5	0	0
	6	16	3	3	0
Rare	409	7	1	1	0
	Negligable - None Consequence/Severity	⟷			Catastrophic/death

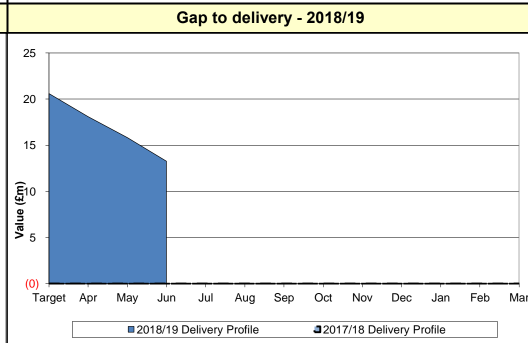
Gap to delivery - 2018/19



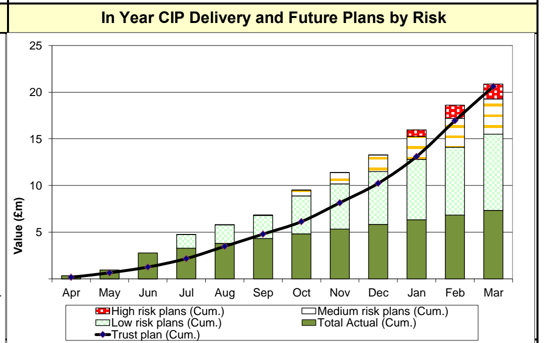
In Year CIP Delivery and Future Plans by Risk



Gap to delivery - 2018/19



In Year CIP Delivery and Future Plans by Risk

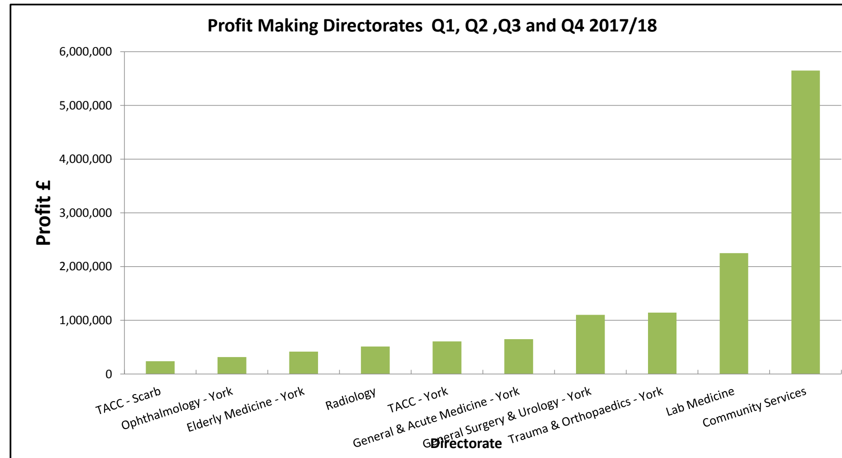


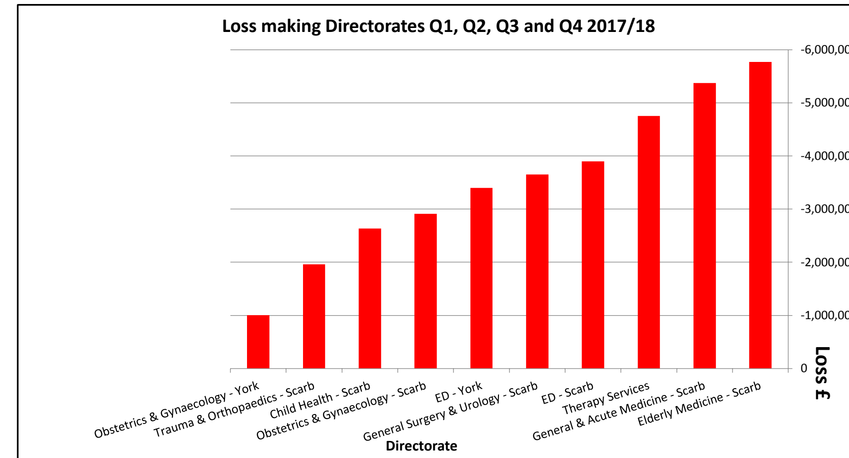
Service Line Reporting

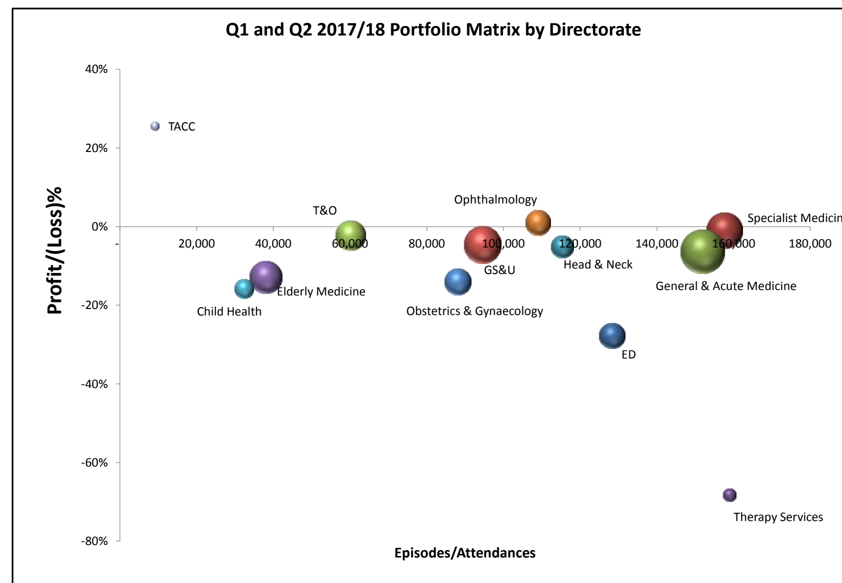
Month 3 - The Period 1st April 2018 to 30th June 2018

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 with phase one ending in May 2018
* Phase two of the SLR Leadership Programme will soon be launched for any Finance Managers who have not yet been through the process







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. This 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. Phase one of the SLR LP completed in May 2018. Phase two will focus on any new Finance Managers who have not yet been through the programme and those that are continuing to build their confidence in the system. *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	* 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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E2

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 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 June 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 June 2018 is £7.3m.

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, Acting Deputy Chief Executive & Finance Director

Date: July 2018

Briefing note for the Finance & Performance Committee meeting 17 July 2018 and Board of Directors meeting 25 July 2018

1. Summary reported position for June 2018

1.1 Current position – highlights

Delivery - Delivery is £7.3m to June 2018 which is (34%) of the £21.7m annual target. This position compares to a delivery position of £5.2m in June 2017.

In year planning - At June 2018 CIP is over-planned by £0.3m in the following risk categories:

Planning Risk	Prior Month £'m	Current Month £'m	Change
Low	12.1	15.6	↑
Medium	6.8	3.8	↓
High	2.7	2.6	↓
TOTAL	**21.6**	**22.0**	↑

Four year planning – The four year planning shows a surplus of £3.2m. The position in June 2017 was a gap of (£14.1m).

Recurrent vs. Non recurrent – Of the £7.3m delivery, £5.3m (73%) in-year has been delivered recurrently. Recurrent delivery is £2.0m ahead of the same position in June 2017.

1.2 Overview

Delivery in month 3 continues to be strong with continued improvement in the risk profile of plans. High Risk plans remain a concern improving marginally in month from £2.7m down to £2.6m. Focus is required on the High and medium risk plans to convert these to low risk deliverable schemes.

In June we commenced reporting on a fortnightly basis to our regulator NHSI in terms of planning, forecast delivery and actual delivery of the Efficiency Programme. While this is an additional workload it is a good discipline to adopt and should make for more robust planning.

The Directorates are continuing with the Quality Impact Assessment (QIA) of schemes; of the 703 schemes 469 have been self-assessed and 190 of these have been signed off by the Clinical Lead for Efficiency. The new QIA process will be implemented this month and a review of schemes will take place in August/September.

Appendix 1 attached provides a summary of the Transactional CIP – Directorate Performance for 2018/19.

2.0 Risk

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

Risk	**Proposed Actions to address Risks**
Recurrent Delivery	• Executive Leads to be identified for transformational workstreams – ongoing. • 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.
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 – Ongoing. • NHSI Work Programme – to firm up plans with the potential for new plans to be developed – Ongoing 2nd wave implementation stage. • 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 - Ongoing, £2m CIP identified at risk with QIPP. • 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.

Transactional CIP - Directorate Performance 2018/19 - June Position

Specialist Medicine

Executive Summary

	£000
2018/19 CIP Target	**£1,995**
In Year Delivery	
NHSI YTD Target at Month 3	£116
Actual Delivery at Month 3	£24
NHSI Variance Month 3	**-£92**
Total Delivery	£149
In Year Gap to Delivery	**-£1,846**
In Year Planning	
Forecasted Delivery	£1,700
Forecasted Planning (Gap)/Surplus	**-£295**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£3,774**
4 Year Plans	£3,400
4 Year Planning (Gap)/Surplus	**-£373**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m); Apr–Mar; High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	33
Total Number of Assessed Schemes - Directorate	25
Total Number of Assessed Schemes - Signed Off	7

Probability/Likelihood (Almost Certain ↕ Rare) vs Consequence/Severity (Negliable - None ↔ Catastrophic/death)

0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
25	0	0	0	0

Radiology

Executive Summary

	£000
2018/19 CIP Target	**£1,681**
In Year Delivery	
NHSI YTD Target at Month 3	£98
Actual Delivery at Month 3	£91
NHSI Variance Month 3	**-£7**
Total Delivery	£184
In Year Gap to Delivery	**-£1,497**
In Year Planning	
Forecasted Delivery	£541
Forecasted Planning (Gap)/Surplus	**-£1,139**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£3,783**
4 Year Plans	£2,429
4 Year Planning (Gap)/Surplus	**-£1,354**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m); Apr–Mar; High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	33
Total Number of Assessed Schemes - Directorate	21
Total Number of Assessed Schemes - Signed Off	0

Probability/Likelihood (Almost Certain ↕ Rare) vs Consequence/Severity (Negliable - None ↔ Catastrophic/death)

0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	1	0	0	0
19	0	1	0	0

Moderate Risk Plans: 1 - relates to reconfiguration of Breast Screening and potential loss localised mobile service

Plans to be reviewed and signed off following new process Aug/Sep 18

Child Health

Executive Summary

	£000
2018/19 CIP Target	**£877**
In Year Delivery	
NHSI YTD Target at Month 3	£51
Actual Delivery at Month 3	£13
NHSI Variance Month 3	**-£38**
Total Delivery	£64
In Year Gap to Delivery	**-£812**
In Year Planning	
Forecasted Delivery	£436
Forecasted Planning (Gap)/Surplus	**-£441**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£2,128**
4 Year Plans	£648
4 Year Planning (Gap)/Surplus	**-£1,479**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m); Apr–Mar; High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	35
Total Number of Assessed Schemes - Directorate	28
Total Number of Assessed Schemes - Signed Off	9

Probability/Likelihood (Almost Certain ↕ Rare) vs Consequence/Severity (Negliable - None ↔ Catastrophic/death)

0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
1	6	0	1	0
19	1	0	0	0

Moderate Risk Plans: 6 - increased activity/capacity issue and service development

High Risk Plans: 1 - relates to Child Protection Team - expert opinion capacity issue

Plans to be reviewed and signed off following new process Aug/Sep 18

Medicine for the Elderly

Executive Summary

	£000
2018/19 CIP Target	**£869**
In Year Delivery	
NHSI YTD Target at Month 3	£51
Actual Delivery at Month 3	£107
NHSI Variance Month 3	**£57**
Total Delivery	£464
In Year Gap to Delivery	**-£405**
In Year Planning	
Forecasted Delivery	£634
Forecasted Planning (Gap)/Surplus	**-£235**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£3,085**
4 Year Plans	£921
4 Year Planning (Gap)/Surplus	**-£2,165**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m); Apr–Mar; High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	17
Total Number of Assessed Schemes - Directorate	10
Total Number of Assessed Schemes - Signed Off	2

Probability/Likelihood (Almost Certain ↕ Rare) vs Consequence/Severity (Negliable - None ↔ Catastrophic/death)

0	0	0	0	0
0	1	0	0	0
0	0	0	0	0
0	0	0	0	0
9	0	0	0	0

High Risk Plans: 1 - relates to high level of nursing vacancies

Plans to be reviewed and signed off following new process Aug/Sep 18

Transactional CIP - Directorate Performance 2018/19 - June Position

Community

Executive Summary

	£000
2018/19 CIP Target	**£257**
In Year Delivery	
NHSI YTD Target at Month 3	£15
Actual Delivery at Month 3	£44
NHSI Variance Month 3	**£29**
Total Delivery	£185
In Year Gap to Delivery	**-£72**
In Year Planning	
Forecasted Delivery	£288
Forecasted Planning (Gap)/Surplus	**£30**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£599**
4 Year Plans	£823
4 Year Planning (Gap)/Surplus	**£224**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m) by month, Target to Mar. Legend: 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) by month, Apr to Mar. Legend: High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	23
Total Number of Assessed Schemes - Directorate	20
Total Number of Assessed Schemes - Signed Off	3

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	1	0	0	0
	0	0	0	0	0
Rare	19	0	0	0	0
Consequence/Severity	Negligible - None		⟷		Catastrophic/death

Moderate Risk Plans: 1 - relates to skill mix of nursing staff

Plans to be reviewed and signed off following new process Aug/Sep 18

General Medicine - Scarborough

Executive Summary

	£000
2018/19 CIP Target	**£704**
In Year Delivery	
NHSI YTD Target at Month 3	£41
Actual Delivery at Month 3	£6
NHSI Variance Month 3	**-£35**
Total Delivery	£25
In Year Gap to Delivery	**-£679**
In Year Planning	
Forecasted Delivery	£1,037
Forecasted Planning (Gap)/Surplus	**£333**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£1,844**
4 Year Plans	£1,792
4 Year Planning (Gap)/Surplus	**-£53**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m) by month, Target to Mar. Legend: 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) by month, Apr to Mar. Legend: High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	26
Total Number of Assessed Schemes - Directorate	18
Total Number of Assessed Schemes - Signed Off	10

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	17	1	0	0	0
Consequence/Severity	Negligible - None		⟷		Catastrophic/death

General Medicine - York

Executive Summary

	£000
2018/19 CIP Target	**£1,406**
In Year Delivery	
NHSI YTD Target at Month 3	£82
Actual Delivery at Month 3	£30
NHSI Variance Month 3	**-£52**
Total Delivery	£122
In Year Gap to Delivery	**-£1,284**
In Year Planning	
Forecasted Delivery	£2,440
Forecasted Planning (Gap)/Surplus	**£1,034**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£4,118**
4 Year Plans	£5,849
4 Year Planning (Gap)/Surplus	**£1,731**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m) by month, Target to Mar. Legend: 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) by month, Apr to Mar. Legend: High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	49
Total Number of Assessed Schemes - Directorate	37
Total Number of Assessed Schemes - Signed Off	22

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	1	0	0
	2	0	0	0	0
Rare	34	0	0	0	0
Consequence/Severity	Negligible - None		⟷		Catastrophic/death

High Risk Plans: 1 - Development of CF Service lack of capacity

Plans to be reviewed and signed off following new process Aug/Sep 18

General Surgery and Urology

Executive Summary

	£000
2018/19 CIP Target	**£2,122**
In Year Delivery	
NHSI YTD Target at Month 3	£124
Actual Delivery at Month 3	£173
NHSI Variance Month 3	**£49**
Total Delivery	£561
In Year Gap to Delivery	**-£1,561**
In Year Planning	
Forecasted Delivery	£1,012
Forecasted Planning (Gap)/Surplus	**-£1,110**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£4,969**
4 Year Plans	£4,221
4 Year Planning (Gap)/Surplus	**-£748**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m) by month, Target to Mar. Legend: 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) by month, Apr to Mar. Legend: High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	37
Total Number of Assessed Schemes - Directorate	33
Total Number of Assessed Schemes - Signed Off	10

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	1	0	1	0	0
Rare	30	0	0	0	0
Consequence/Severity	Negligible - None		⟷		Catastrophic/death

Moderate Risk Plans: 2 - (1) Plastics self payers risk of not booking in chronological order; (2) income related to Plastics Service - no impact on patients - financial risk - rating to be reviewed

Plans to be reviewed and signed off following new process Aug/Sep 18

Transactional CIP - Directorate Performance 2018/19 - June Position

Head and Neck

Executive Summary

	£000
2018/19 CIP Target	**£704**
In Year Delivery	
NHSI YTD Target at Month 3	£41
Actual Delivery at Month 3	£209
NHSI Variance Month 3	**£168**
Total Delivery	£304
In Year Gap to Delivery	**-£400**
In Year Planning	
Forecasted Delivery	£624
Forecasted Planning (Gap)/Surplus	**-£80**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£1,886**
4 Year Plans	£1,086
4 Year Planning (Gap)/Surplus	**-£800**

Gap to delivery 2018/19 - Progress compared to 2017/18

2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	15
Total Number of Assessed Schemes - Directorate	12
Total Number of Assessed Schemes - Signed Off	10

Probability/Likelihood	Negliable - None				Catastrophic/death
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	1	0	0	0
	0	0	0	0	0
Rare	11	0	0	0	0

Consequence/Severity

Moderate Risk Plans: **1 - Paperless clinics - information not being available**

Plans to be reviewed and signed off following new process Aug/Sep 18

Lab Medicine

Executive Summary

	£000
2018/19 CIP Target	**£509**
In Year Delivery	
NHSI YTD Target at Month 3	£30
Actual Delivery at Month 3	£72
NHSI Variance Month 3	**£43**
Total Delivery	£228
In Year Gap to Delivery	**-£281**
In Year Planning	
Forecasted Delivery	£545
Forecasted Planning (Gap)/Surplus	**£36**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£2,812**
4 Year Plans	£2,882
4 Year Planning (Gap)/Surplus	**£70**

Gap to delivery 2018/19 - Progress compared to 2017/18

2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	47
Total Number of Assessed Schemes - Directorate	21
Total Number of Assessed Schemes - Signed Off	8

Probability/Likelihood	Negliable - None				Catastrophic/death
Almost Certain	1	0	0	0	0
	0	0	0	0	0
	1	0	1	0	0
	0	0	0	1	0
Rare	17	0	0	0	0

Consequence/Severity

High Risk Plans: **2 - (1) Skill mix in Microbiology lack of managerial support - reviewed by Directorate downgraded to Moderate**
(2) Specimen Reception staffing impact on turnaround times

Moderate Risk Plan 1 - Microbiology Consolidation of service equipment
Plans to be reviewed and signed off following new process Aug/Sep 18

Ophthalmology

Executive Summary

	£000
2018/19 CIP Target	**£1,096**
In Year Delivery	
NHSI YTD Target at Month 3	£64
Actual Delivery at Month 3	£131
NHSI Variance Month 3	**£68**
Total Delivery	£166
In Year Gap to Delivery	**-£931**
In Year Planning	
Forecasted Delivery	£866
Forecasted Planning (Gap)/Surplus	**-£231**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£3,018**
4 Year Plans	£2,159
4 Year Planning (Gap)/Surplus	**-£859**

Gap to delivery 2018/19 - Progress compared to 2017/18

2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	28
Total Number of Assessed Schemes - Directorate	22
Total Number of Assessed Schemes - Signed Off	15

Probability/Likelihood	Negliable - None				Catastrophic/death
Almost Certain	2	0	0	0	0
	0	0	0	0	0
	0	2	0	0	0
	0	1	1	0	0
Rare	15	0	0	1	0

Consequence/Severity

Moderate Risk Plans: 7 schemes - to be reassessed by Directorate as Financial Risk Plans

Pharmacy

Executive Summary

	£000
2018/19 CIP Target	**£407**
In Year Delivery	
NHSI YTD Target at Month 3	£24
Actual Delivery at Month 3	£51
NHSI Variance Month 3	**£27**
Total Delivery	£142
In Year Gap to Delivery	**-£265**
In Year Planning	
Forecasted Delivery	£375
Forecasted Planning (Gap)/Surplus	**-£32**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£1,153**
4 Year Plans	£792
4 Year Planning (Gap)/Surplus	**-£361**

Gap to delivery 2018/19 - Progress compared to 2017/18

2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	12
Total Number of Assessed Schemes - Directorate	6
Total Number of Assessed Schemes - Signed Off	6

Probability/Likelihood	Negliable - None				Catastrophic/death
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	6	0	0	0	0

Consequence/Severity

Transactional CIP - Directorate Performance 2018/19 - June Position

Sexual Health

Executive Summary

	£000
2018/19 CIP Target	**£198**
In Year Delivery	
NHSI YTD Target at Month 3	£12
Actual Delivery at Month 3	£67
NHSI Variance Month 3	**£55**
Total Delivery	£69
In Year Gap to Delivery	**-£129**
In Year Planning	
Forecasted Delivery	£215
Forecasted Planning (Gap)/Surplus	**£17**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£588**
4 Year Plans	£665
4 Year Planning (Gap)/Surplus	**£76**

Gap to delivery 2018/19 - Progress compared to 2017/18

In Year CIP Delivery and Future Plans by Risk

Governance Risk Heat Map

Total Number of Schemes	10
Total Number of Assessed Schemes - Directorate	8
Total Number of Assessed Schemes - Signed Off	7

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	1	0	0	0	0
	0	0	0	0	0
Rare	7	0	0	0	0
Consequence/Severity	Negligible - None				Catastrophic/death

Womens Health

Executive Summary

	£000
2018/19 CIP Target	**£1,164**
In Year Delivery	
NHSI YTD Target at Month 3	£68
Actual Delivery at Month 3	£78
NHSI Variance Month 3	**£10**
Total Delivery	£194
In Year Gap to Delivery	**-£970**
In Year Planning	
Forecasted Delivery	£460
Forecasted Planning (Gap)/Surplus	**-£704**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£2,825**
4 Year Plans	£887
4 Year Planning (Gap)/Surplus	**-£1,938**

Gap to delivery 2018/19 - Progress compared to 2017/18

In Year CIP Delivery and Future Plans by Risk

Governance Risk Heat Map

Total Number of Schemes	45
Total Number of Assessed Schemes - Directorate	30
Total Number of Assessed Schemes - Signed Off	7

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	2	0	0	0	0
	0	0	0	1	0
Rare	23	4	0	0	0
Consequence/Severity	Negligible - None				Catastrophic/death

High Risk Plans: 1 - Preassessment Clinic - Bridlington activity without infrastructure

ED

Executive Summary

	£000
2018/19 CIP Target	**£1,095**
In Year Delivery	
NHSI YTD Target at Month 3	£64
Actual Delivery at Month 3	£32
NHSI Variance Month 3	**-£31**
Total Delivery	£130
In Year Gap to Delivery	**-£965**
In Year Planning	
Forecasted Delivery	£263
Forecasted Planning (Gap)/Surplus	**-£832**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£3,366**
4 Year Plans	£908
4 Year Planning (Gap)/Surplus	**-£2,458**

Gap to delivery 2018/19 - Progress compared to 2017/18

In Year CIP Delivery and Future Plans by Risk

Governance Risk Heat Map

Total Number of Schemes	23
Total Number of Assessed Schemes - Directorate	15
Total Number of Assessed Schemes - Signed Off	8

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	2	0	0
	0	0	0	0	0
Rare	13	0	0	0	0
Consequence/Severity	Negligible - None				Catastrophic/death

High Risk Plans - 2 schemes relating to staffing skill mix and revised clinical model - lack of resource.

Orthopaedics

Executive Summary

	£000
2018/19 CIP Target	**£704**
In Year Delivery	
NHSI YTD Target at Month 3	£41
Actual Delivery at Month 3	£273
NHSI Variance Month 3	**£232**
Total Delivery	£519
In Year Gap to Delivery	**-£184**
In Year Planning	
Forecasted Delivery	£1,607
Forecasted Planning (Gap)/Surplus	**£903**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£3,001**
4 Year Plans	£4,121
4 Year Planning (Gap)/Surplus	**£1,120**

Gap to delivery 2018/19 - Progress compared to 2017/18

In Year CIP Delivery and Future Plans by Risk

Governance Risk Heat Map

Total Number of Schemes	45
Total Number of Assessed Schemes - Directorate	30
Total Number of Assessed Schemes - Signed Off	22

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	1	0	0	0
Rare	29	0	0	0	0
Consequence/Severity	Negligible - None				Catastrophic/death

Moderate Risk Plans: 1 - Parallel Lists run by Clinical Fellows

Transactional CIP - Directorate Performance 2018/19 - June Position

TACC

Executive Summary

	£000
2018/19 CIP Target	**£2,559**
In Year Delivery	
NHSI YTD Target at Month 3	£149
Actual Delivery at Month 3	£125
NHSI Variance Month 3	**-£24**
Total Delivery	£383
In Year Gap to Delivery	**-£2,176**
In Year Planning	
Forecasted Delivery	£2,371
Forecasted Planning (Gap)/Surplus	**-£188**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£6,740**
4 Year Plans	£3,283
4 Year Planning (Gap)/Surplus	**-£3,458**

Gap to delivery 2018/19 - Progress compared to 2017/18

In Year CIP Delivery and Future Plans by Risk

Governance Risk Heat Map

Total Number of Schemes	47
Total Number of Assessed Schemes - Directorate	27
Total Number of Assessed Schemes - Signed Off	5

Probability/Likelihood	Negliable - None				Catastrophic/death
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	1	0	0
Rare	25	1	0	0	0

Consequence/Severity

Moderate Risk Plans: 1 - Staffing vacancies

AHP and Psychological Medicine

Executive Summary

	£000
2018/19 CIP Target	**£1,404**
In Year Delivery	
NHSI YTD Target at Month 3	£82
Actual Delivery at Month 3	£186
NHSI Variance Month 3	**£104**
Total Delivery	£518
In Year Gap to Delivery	**-£885**
In Year Planning	
Forecasted Delivery	£932
Forecasted Planning (Gap)/Surplus	**-£472**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£3,282**
4 Year Plans	£1,811
4 Year Planning (Gap)/Surplus	**-£1,471**

Gap to delivery 2018/19 - Progress compared to 2017/18

In Year CIP Delivery and Future Plans by Risk

Governance Risk Heat Map

Total Number of Schemes	37
Total Number of Assessed Schemes - Directorate	15
Total Number of Assessed Schemes - Signed Off	12

Probability/Likelihood	Negliable - None				Catastrophic/death
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	15	0	0	0	0

Consequence/Severity

Estates and Facilities

Executive Summary

	£000
2018/19 CIP Target	**£2,751**
In Year Delivery	
NHSI YTD Target at Month 3	£160
Actual Delivery at Month 3	£407
NHSI Variance Month 3	**£247**
Total Delivery	£1,646
In Year Gap to Delivery	**-£1,105**
In Year Planning	
Forecasted Delivery	£3,382
Forecasted Planning (Gap)/Surplus	**£631**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£6,843**
4 Year Plans	£5,590
4 Year Planning (Gap)/Surplus	**-£1,253**

Gap to delivery 2018/19 - Progress compared to 2017/18

In Year CIP Delivery and Future Plans by Risk

Governance Risk Heat Map

Total Number of Schemes	47
Total Number of Assessed Schemes - Directorate	33
Total Number of Assessed Schemes - Signed Off	13

Probability/Likelihood	Negliable - None				Catastrophic/death
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	1	0	0
	1	5	0	0	0
Rare	26	0	0	0	0

Consequence/Severity

High Risk Plans: 1 - Frequency of linen changes - Directorate reassessed score to be re-evaluated.

Moderate Risk Plans: 5 - Soft FM schemes cook/chill, waste, electric points, toilet rolls - financial risk more than quality/safety - to be reassessed by Directorate

SNS

Executive Summary

	£000
2018/19 CIP Target	**£400**
In Year Delivery	
NHSI YTD Target at Month 3	£23
Actual Delivery at Month 3	£65
NHSI Variance Month 3	**£41**
Total Delivery	£48
In Year Gap to Delivery	**-£352**
In Year Planning	
Forecasted Delivery	£523
Forecasted Planning (Gap)/Surplus	**£123**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£1,403**
4 Year Plans	£1,080
4 Year Planning (Gap)/Surplus	**-£323**

Gap to delivery 2018/19 - Progress compared to 2017/18

In Year CIP Delivery and Future Plans by Risk

Governance Risk Heat Map

Total Number of Schemes	15
Total Number of Assessed Schemes - Directorate	14
Total Number of Assessed Schemes - Signed Off	8

Probability/Likelihood	Negliable - None				Catastrophic/death
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	1	0	0	0
Rare	13	0	0	0	0

Consequence/Severity

Moderate Risk Plans - 1 - Paperlite - accessbility of notes

Plans to be reviewed and signed off following new process Aug/Sep 18

APPENDIX 1

Transactional CIP - Directorate Performance 2018/19 - June Position

Finance

Executive Summary

	£000
2018/19 CIP Target	**£186**
In Year Delivery	
NHSI YTD Target at Month 3	£11
Actual Delivery at Month 3	£149
NHSI Variance Month 3	**£138**
Total Delivery	£324
In Year Gap to Delivery	**£137**
In Year Planning	
Forecasted Delivery	£324
Forecasted Planning (Gap)/Surplus	**£137**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£1,077**
4 Year Plans	£324
4 Year Planning (Gap)/Surplus	**-£752**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) Millions; Apr–Mar; High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	17
Total Number of Assessed Schemes - Directorate	11
Total Number of Assessed Schemes - Signed Off	0

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	11	0	0	0	0
Consequence/Severity	Negligible - None				Catastrophic/death

HR

Executive Summary

	£000
2018/19 CIP Target	**£268**
In Year Delivery	
NHSI YTD Target at Month 3	£16
Actual Delivery at Month 3	£63
NHSI Variance Month 3	**£47**
Total Delivery	£65
In Year Gap to Delivery	**-£203**
In Year Planning	
Forecasted Delivery	£326
Forecasted Planning (Gap)/Surplus	**£58**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£918**
4 Year Plans	£1,080
4 Year Planning (Gap)/Surplus	**£162**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) Millions; Apr–Mar; High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	15
Total Number of Assessed Schemes - Directorate	14
Total Number of Assessed Schemes - Signed Off	3

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	2	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	12	0	0	0	0
Consequence/Severity	Negligible - None				Catastrophic/death

Moderate Risk Plans: 2 - relate to financial risk around salary flexibility and medical staff pay progression - to be reassessed by directorate

Plans to be reviewed and signed off following new process Aug/Sep 18

Ops Management

Executive Summary

	£000
2018/19 CIP Target	**£243**
In Year Delivery	
NHSI YTD Target at Month 3	£14
Actual Delivery at Month 3	£19
NHSI Variance Month 3	**£5**
Total Delivery	£103
In Year Gap to Delivery	**-£140**
In Year Planning	
Forecasted Delivery	£112
Forecasted Planning (Gap)/Surplus	**-£132**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£648**
4 Year Plans	£146
4 Year Planning (Gap)/Surplus	**-£502**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) Millions; Apr–Mar; High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	10
Total Number of Assessed Schemes - Directorate	4
Total Number of Assessed Schemes - Signed Off	1

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	4	0	0	0	0
Consequence/Severity	Negligible - None				Catastrophic/death

Chief Nurse Team

Executive Summary

	£000
2018/19 CIP Target	**£435**
In Year Delivery	
NHSI YTD Target at Month 3	£25
Actual Delivery at Month 3	£50
NHSI Variance Month 3	**£25**
Total Delivery	£200
In Year Gap to Delivery	**-£235**
In Year Planning	
Forecasted Delivery	£340
Forecasted Planning (Gap)/Surplus	**-£95**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£760**
4 Year Plans	£372
4 Year Planning (Gap)/Surplus	**-£388**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; 2018/19 Delivery Profile; 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) Millions; Apr–Mar; High risk plans (Cum.); Medium risk plans (Cum.); Low risk plans (Cum.); Total Actual (Cum.); Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	8
Total Number of Assessed Schemes - Directorate	5
Total Number of Assessed Schemes - Signed Off	2

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	1	0	0	0
	1	0	0	0	0
Rare	3	0	0	0	0
Consequence/Severity	Negligible - None				Catastrophic/death

Moerate Risk Plans: 1 - reduction in Agency Nursing spend

Plans to be reviewed and signed off following new process Aug/Sep 18

Transactional CIP - Directorate Performance 2018/19 - June Position

Chief Exec

Executive Summary

2018/19 CIP Target	£000 £200
In Year Delivery	
NHSI YTD Target at Month 3	£12
Actual Delivery at Month 3	£90
NHSI Variance Month 3	**£78**
Total Delivery	£214
In Year Gap to Delivery	**£14**
In Year Planning	
Forecasted Delivery	£214
Forecasted Planning (Gap)/Surplus	**£14**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£512**
4 Year Plans	£214
4 Year Planning (Gap)/Surplus	**-£298**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; ■ 2018/19 Delivery Profile ■ 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) Millions; Apr–Mar; High risk plans (Cum.), Medium risk plans (Cum.), Low risk plans (Cum.), Total Actual (Cum.), Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	4
Total Number of Assessed Schemes - Directorate	2
Total Number of Assessed Schemes - Signed Off	0

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	2	0	0	0	0
Consequence/Severity	Negligable - None				Catastrophic/death

Medical Governance

Executive Summary

2018/19 CIP Target	£000 £49
In Year Delivery	
NHSI YTD Target at Month 3	£3
Actual Delivery at Month 3	£40
NHSI Variance Month 3	**£37**
Total Delivery	£59
In Year Gap to Delivery	**£10**
In Year Planning	
Forecasted Delivery	£59
Forecasted Planning (Gap)/Surplus	**£10**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£172**
4 Year Plans	£59
4 Year Planning (Gap)/Surplus	**-£113**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; ■ 2018/19 Delivery Profile ■ 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) Millions; Apr–Mar; High risk plans (Cum.), Medium risk plans (Cum.), Low risk plans (Cum.), Total Actual (Cum.), Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	3
Total Number of Assessed Schemes - Directorate	1
Total Number of Assessed Schemes - Signed Off	0

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	1	0	0	0	0
Consequence/Severity	Negligable - None				Catastrophic/death

Learning Organisational Development & Research

Executive Summary

2018/19 CIP Target	£000 £79
In Year Delivery	
NHSI YTD Target at Month 3	£5
Actual Delivery at Month 3	£117
NHSI Variance Month 3	**£112**
Total Delivery	£217
In Year Gap to Delivery	**£139**
In Year Planning	
Forecasted Delivery	£244
Forecasted Planning (Gap)/Surplus	**£166**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**£414**
4 Year Plans	£664
4 Year Planning (Gap)/Surplus	**£250**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m); Target, Apr–Mar; ■ 2018/19 Delivery Profile ■ 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) Millions; Apr–Mar; High risk plans (Cum.), Medium risk plans (Cum.), Low risk plans (Cum.), Total Actual (Cum.), Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	14
Total Number of Assessed Schemes - Directorate	6
Total Number of Assessed Schemes - Signed Off	0

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	6	0	0	0	0
Consequence/Severity	Negligable - None				Catastrophic/death

Corporate

Executive Summary

2018/19 CIP Target	£000 -£2,695
In Year Delivery	
NHSI YTD Target at Month 3	-£157
Actual Delivery at Month 3	£60
NHSI Variance Month 3	**£217**
Total Delivery	£60
In Year Gap to Delivery	**£2,755**
In Year Planning	
Forecasted Delivery	£68
Forecasted Planning (Gap)/Surplus	**£2,763**
Long Term Planning	
4 Year CIP Target (18/19 to 21/22)	**-£15,267**
4 Year Plans	£5,486
4 Year Planning (Gap)/Surplus	**£20,752**

Gap to delivery 2018/19 - Progress compared to 2017/18

Value (£m) Millions; Target, Apr–Mar; ■ 2018/19 Delivery Profile ■ 2017/18 Delivery Profile

In Year CIP Delivery and Future Plans by Risk

Value (£m) Millions; Apr–Mar; High risk plans (Cum.), Medium risk plans (Cum.), Low risk plans (Cum.), Total Actual (Cum.), Trust plan (Cum.)

Governance Risk Heat Map

Total Number of Schemes	8
Total Number of Assessed Schemes - Directorate	1
Total Number of Assessed Schemes - Signed Off	0

Probability/Likelihood					
Almost Certain	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Rare	1	0	0	0	0
Consequence/Severity	Negligable - None				Catastrophic/death

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

York Teaching Hospital NHS
NHS Foundation Trust

Public Performance Report

July 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

York Teaching Hospital NHS
NHS Foundation Trust

Activity Summary: Trust

Operational Performance: Unplanned Care	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Emergency Care Attendances			17438	17134	15979	16570	15158	16236	14712	13719	15845	16374	17985	17242
Emergency Care Breaches			2268	2033	2697	2222	1263	2766	2728	2499	2983	2439	1786	1722
Emergency Care Standard Performance	95%	95%	87.0%	88.1%	83.1%	86.6%	91.7%	83.0%	81.5%	81.8%	81.2%	85.1%	90.1%	90.0%
ED Conversion Rate: Proportion of ED attendances subsequently admitted			35.9%	36.5%	37.7%	37.7%	39.0%	40.8%	40.9%	40.0%	39.0%	38.6%	37.9%	37.6%
ED Total number of patients waiting over 8 hours in the departments			323	274	528	371	152	791	833	668	872	607	195	159
ED 12 hour trolley waits	0	0	2	1	1	2	0	5	14	15	40	13	0	0
ED: % of attendees assessed within 15 minutes of arrival			70.7%	68.8%	67.9%	66.7%	69.3%	57.1%	63.1%	61.2%	57.2%	63.9%	67.0%	62.7%
ED: % of attendees seen by doctor within 60 minutes of arrival			36.6%	43.6%	34.7%	35.5%	42.1%	40.5%	44.7%	42.7%	40.2%	41.1%	42.4%	40.1%
Ambulance handovers waiting 15-29 minutes	0	0	360	446	469	745	649	823	702	679	784	702	762	765
Ambulance handovers waiting 30-59 minutes	0	0	215	258	331	368	172	537	424	360	471	325	317	260
Ambulance handovers waiting >60 minutes	0	0	96	106	207	257	55	548	390	367	419	302	152	110
Non Elective Admissions (excl Paediatrics & Maternity)			4421	4411	4251	4411	4304	4575	4515	4092	4525	4442	4791	4607
Non Elective Admissions - Paediatrics			616	495	673	790	800	934	736	654	844	703	734	641
Delayed Transfers of Care - Acute Hospitals			806	1238	965	932	958	865	660	885	1010	1134	1092	1020
Delayed Transfers of Care - Community Hospitals			352	234	445	312	439	506	483	357	266	464	358	240
Patients with LoS >= 7 Midnights (Elective & Non-Elective)			1063	1015	1048	1057	1045	1130	1153	1034	1108	1002	1069	982
Ward Transfers - Non clinical transfers after 10pm	300 per Qtr	100	110	70	84	67	57	113	99	106	94	106	58	71
Emergency readmissions within 30 days			772	745	712	738	796	876	771	763	798	774	2 months behind	2 months behind

Operational Performance: Planned Care	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Outpatients: All Referral Types			17686	16977	16599	18088	17966	14977	17804	15711	17026	17475	18349	17330
Outpatients: GP Referrals			9386	9134	9044	9751	9758	7794	9672	8637	9452	9435	9853	9198
Outpatients: Consultant to Consultant Referrals			2286	2240	2007	2314	2215	1894	2143	1936	1968	2076	2201	2090
Outpatients: Other Referrals			6014	5603	5548	6023	5993	5289	5989	5138	5606	5964	6295	6042
Outpatients: 1st Attendances			11979	11741	11721	12797	12665	10091	12309	11116	11657	11223	12578	12300
Outpatients: Follow Up Attendances			26708	26558	26826	28311	29312	24019	29717	25312	26855	26899	28903	27837
Outpatients: 1st to FU Ratio			2.23	2.26	2.29	2.21	2.31	2.38	2.41	2.28	2.30	2.40	2.30	2.26
Outpatients: DNA rates			7.0%	6.7%	6.6%	6.1%	6.1%	6.1%	6.3%	6.2%	6.3%	5.7%	5.8%	5.9%
Outpatients: Cancelled Clinics with less than 14 days notice	180	180	129	121	188	176	167	133	210	213	194	168	149	145
Outpatients:Hospital Cancelled Outpatient Appointments for non-clinical reasons			834	823	817	862	780	702	949	757	844	849	728	885
Diagnostics: Patients waiting <6 weeks from referral to test	99%	99%	98.9%	99.1%	98.9%	98.3%	98.5%	97.5%	98.1%	97.9%	97.0%	96.1%	96.1%	96.3%
Elective Admissions			715	721	683	790	790	597	568	604	531	636	781	754
Day Case Admissions			5896	6047	5846	6254	6151	5179	6069	5538	5827	5549	6185	6146
Cancelled Operations within 48 hours - Bed shortages			23	12	38	27	2	74	118	129	168	59	18	7
Cancelled Operations within 48 hours - Non clinical reasons			64	57	84	91	65	169	191	189	205	117	103	89
Theatres: Utilisation of planned sessions			88.4%	89.6%	89.2%	88.4%	92.5%	86.4%	82.7%	84.8%	84.0%	87.6%	92.4%	92.1%
Theatres: number of sessions held			629	590	619	704	718	542	599	543	520	565	628	636
Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)			72	56	77	57	54	76	74	50	105	76	60	61

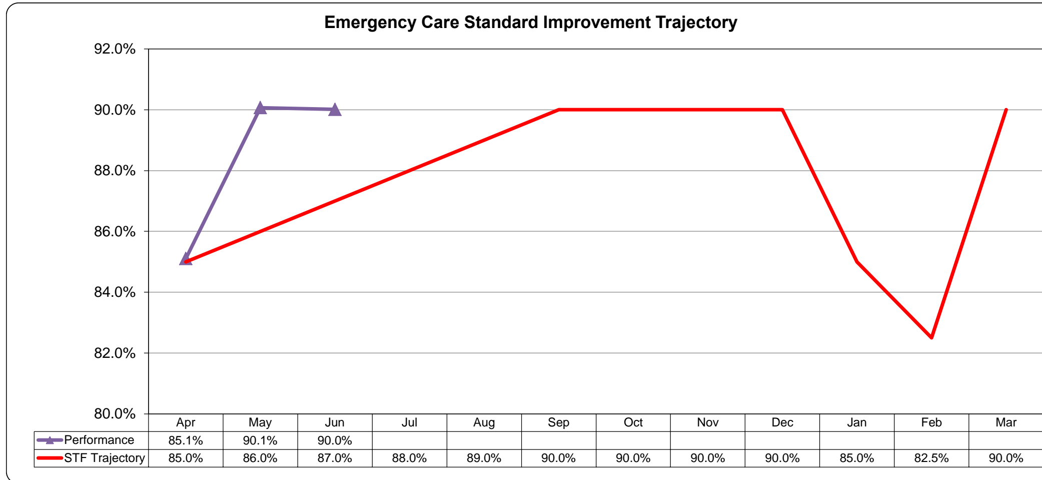
Activity Summary: Trust

18 Weeks Referral To Treatment	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Incomplete Pathways	92%	92%	88.2%	87.5%	86.9%	87.4%	87.2%	85.8%	85.3%	84.8%	83.3%	83.8%	84.2%	84.1%
Waits over 52 weeks for incomplete pathways	0	0	1	1	0	1	0	0	0	1	2	1	14	9
Waits over 36 weeks for incomplete pathways	0	0	152	197	197	199	202	238	260	297	356	409	450	438
Total Admitted and Non Admitted waiters	< 26303	< 26303	26499	26148	25526	25174	24894	25006	25185	25334	26303	26967	27480	27425
Number of patients on Admitted Backlog (18+ weeks)	-	-	1418	1353	1457	1465	1448	1623	1818	1928	2223	2303	2334	2330
Number of patients on Non Admitted Backlog (18+ weeks)	-	-	1720	1976	1884	1699	1761	1816	1880	1921	2179	2070	2002	2041

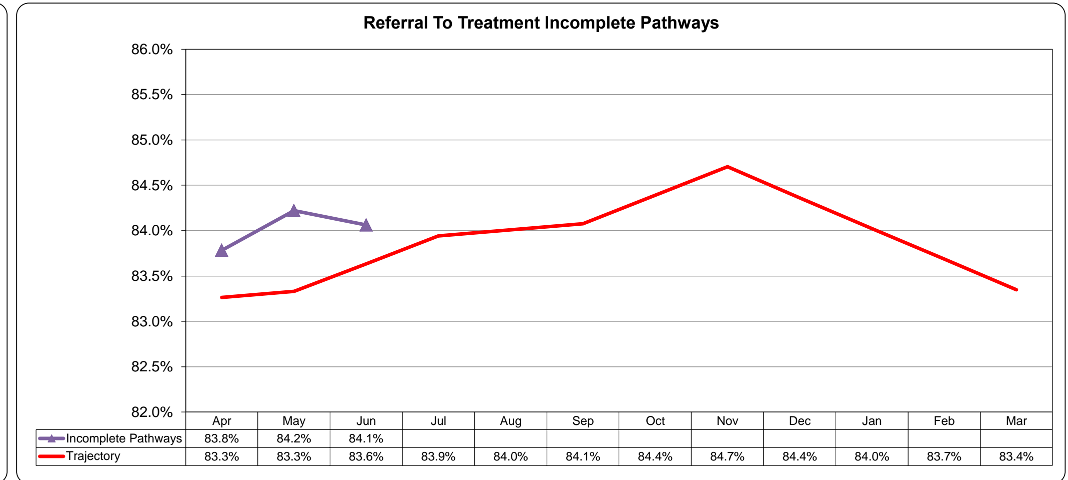
Cancer (one month behind due to national reporting timetable)	Target/ Threshold 2018/19	Quarterly target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Cancer 2 week (all cancers)	93%	93%	80.7%	83.4%	84.8%	86.8%	93.4%	92.5%	94.4%	94.7%	93.6%	93.9%	93.7%	1 month behind
Cancer 2 week (breast symptoms)	93%	93%	97.1%	98.2%	98.6%	97.0%	94.5%	94.0%	94.6%	99.1%	98.9%	96.2%	96.1%	1 month behind
Cancer 31 day wait from diagnosis to first treatment	96%	96%	98.3%	97.7%	97.9%	96.8%	98.7%	99.6%	99.2%	98.6%	98.7%	98.2%	99.2%	1 month behind
Cancer 31 day wait for second or subsequent treatment - surgery	94%	94%	95.2%	97.1%	95.7%	82.5%	97.4%	96.9%	93.9%	100.0%	97.1%	96.6%	97.4%	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%	82.4%	83.2%	76.4%	73.9%	86.3%	87.2%	85.0%	81.0%	85.9%	78.0%	78.4%	1 month behind
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	90%	86.8%	98.5%	93.1%	90.9%	90.6%	89.5%	95.5%	95.1%	93.6%	90.9%	84.3%	1 month behind

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

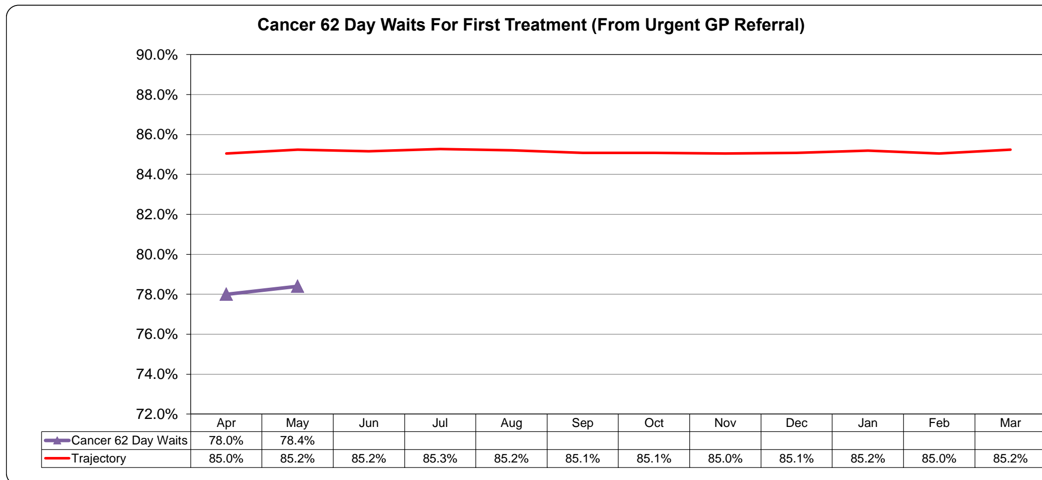
July 2018



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance	85.1%	90.1%	90.0%									
STF Trajectory	85.0%	86.0%	87.0%	88.0%	89.0%	90.0%	90.0%	90.0%	90.0%	85.0%	82.5%	90.0%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Incomplete Pathways	83.8%	84.2%	84.1%									
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%

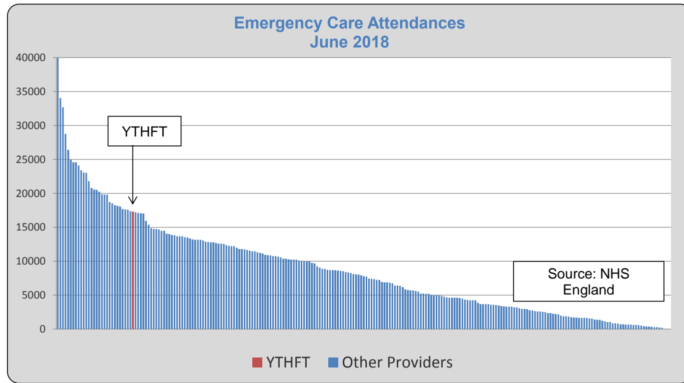


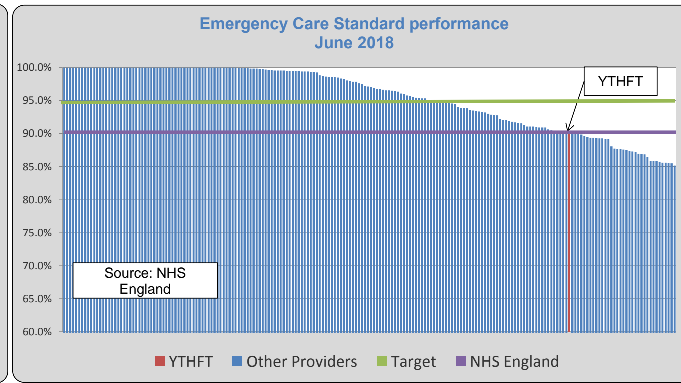
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cancer 62 Day Waits	78.0%	78.4%										
Trajectory	85.0%	85.2%	85.2%	85.3%	85.2%	85.1%	85.1%	85.0%	85.1%	85.2%	85.0%	85.2%

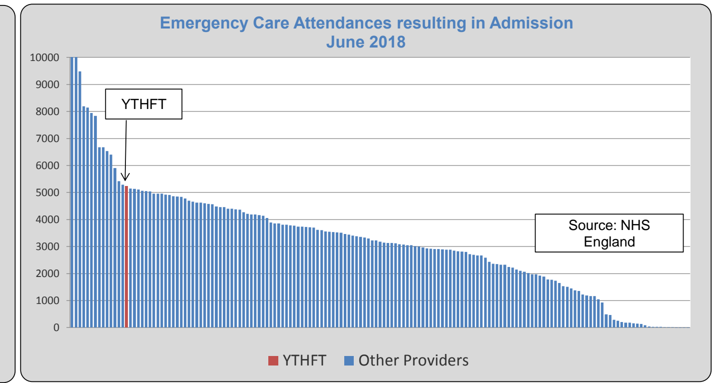
Performance Benchmarking

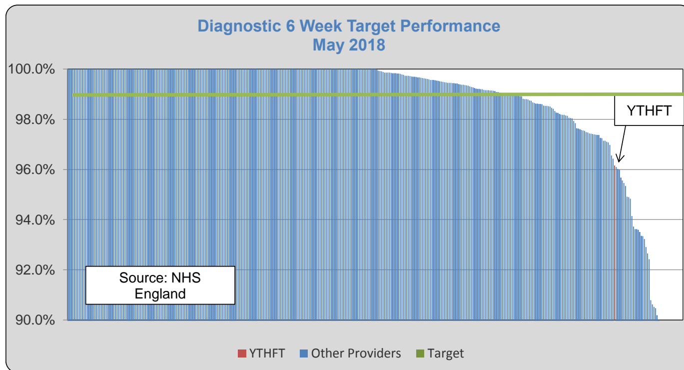
June 2018

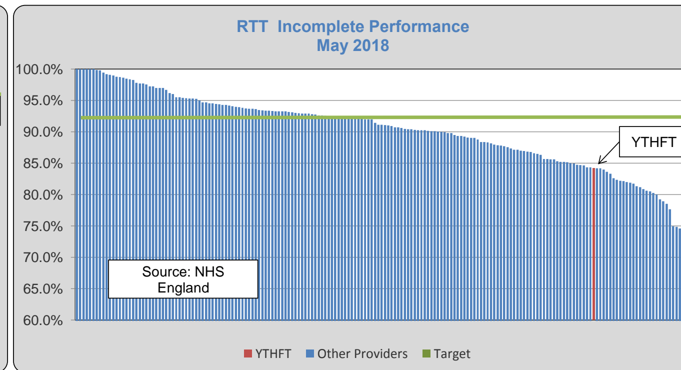
All graphs are benchmarked against latest available national data

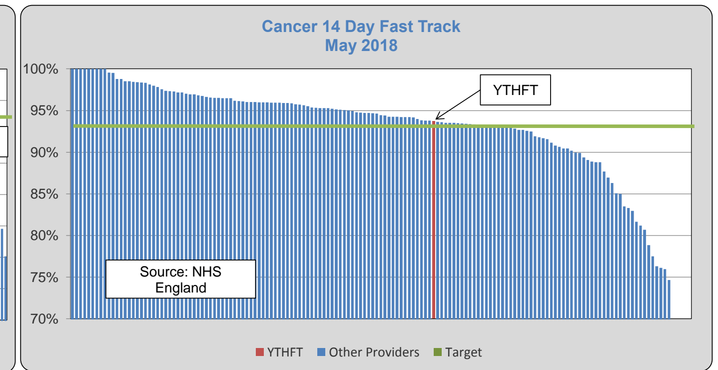


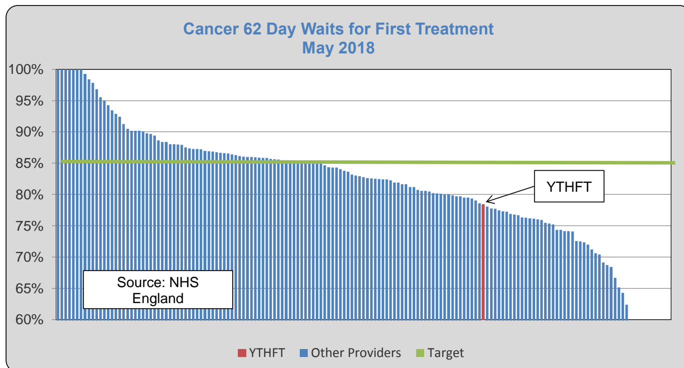








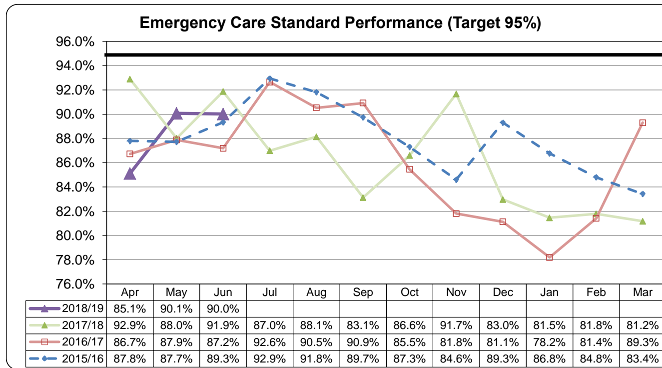




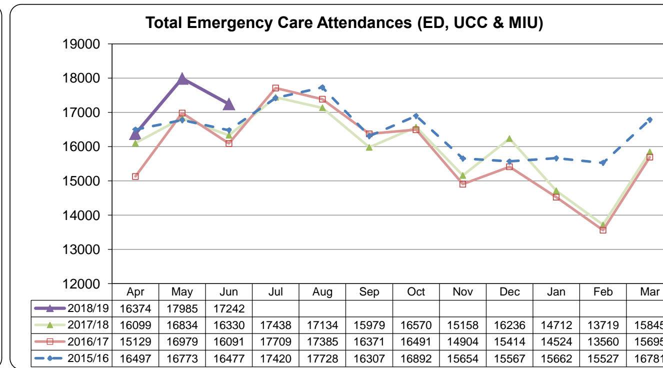
York Teaching Hospital NHS Foundation Trust

Trust Unplanned Care
Emergency Care Standard

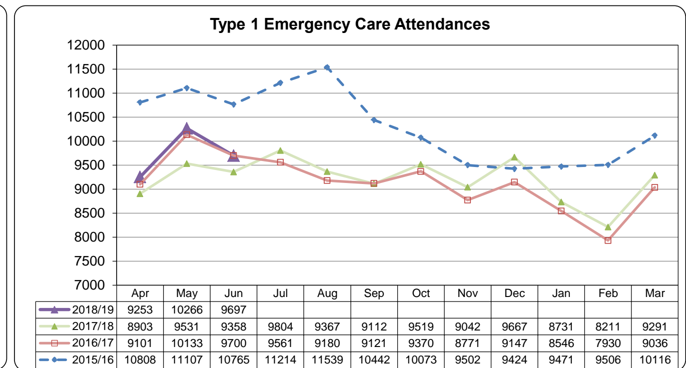
July 2018



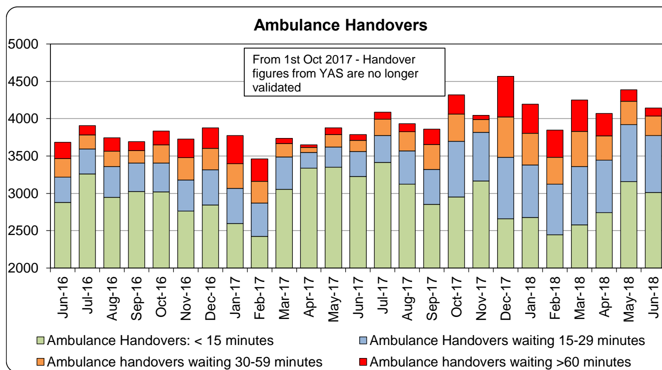
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	85.1%	90.1%	90.0%									
2017/18	92.9%	88.0%	91.9%	87.0%	88.1%	83.1%	86.6%	91.7%	83.0%	81.5%	81.8%	81.2%
2016/17	86.7%	87.9%	87.2%	92.6%	90.5%	90.9%	85.5%	81.8%	81.1%	78.2%	81.4%	89.3%
2015/16	87.8%	87.7%	89.3%	92.9%	91.8%	89.7%	87.3%	84.6%	89.3%	86.8%	84.8%	83.4%

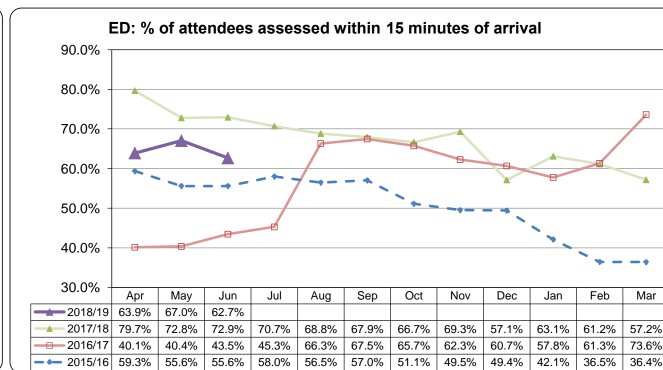


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	16374	17985	17242									
2017/18	16099	16834	16330	17438	17134	15979	16570	15158	16236	14712	13719	15845
2016/17	15129	16979	16091	17709	17385	16371	16491	14904	15414	14524	13560	15695
2015/16	16497	16773	16477	17420	17728	16307	16892	15654	15567	15662	15527	16781

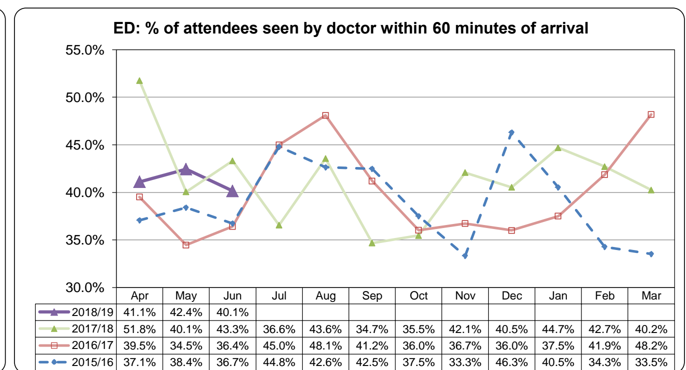


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	9253	10266	9697									
2017/18	8903	9531	9358	9804	9367	9112	9519	9042	9667	8731	8211	9291
2016/17	9101	10133	9700	9561	9180	9121	9370	8771	9147	8546	7930	9036
2015/16	10808	11107	10765	11214	11539	10442	10073	9502	9424	9471	9506	10116

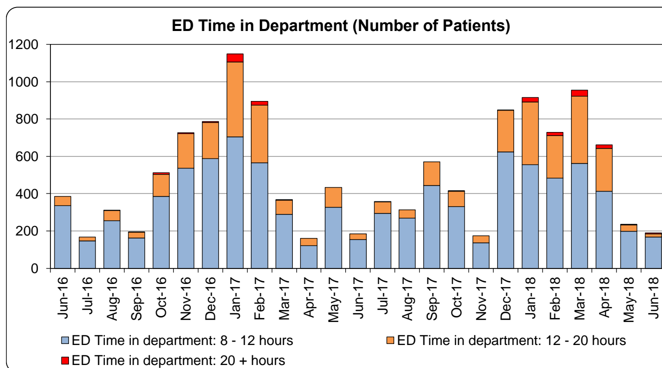


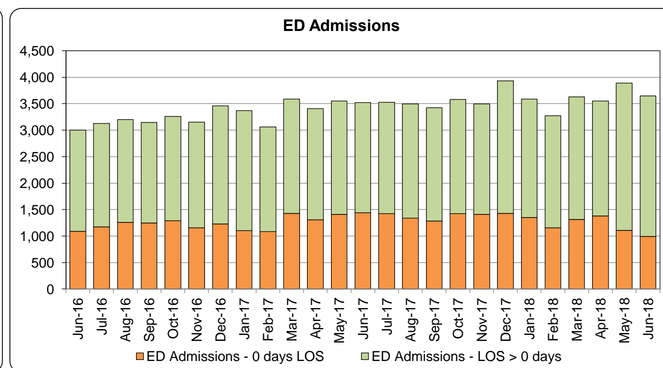


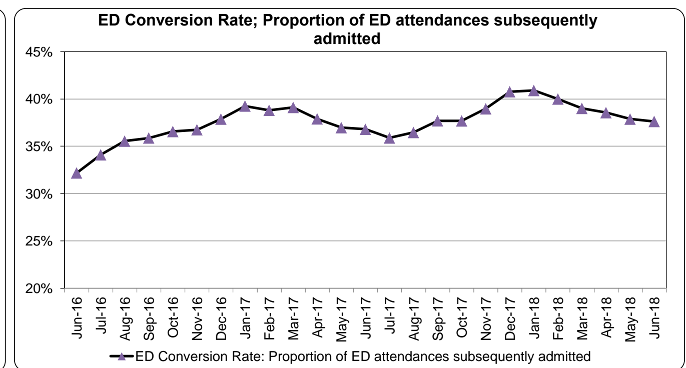
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	63.9%	67.0%	62.7%									
2017/18	79.7%	72.8%	72.9%	70.7%	68.8%	67.9%	66.7%	69.3%	57.1%	63.1%	61.2%	57.2%
2016/17	40.1%	40.4%	43.5%	45.3%	66.3%	67.5%	65.7%	62.3%	60.7%	57.8%	61.3%	73.6%
2015/16	59.3%	55.6%	55.6%	58.0%	56.5%	57.0%	51.1%	49.5%	49.4%	42.1%	36.5%	36.4%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	41.1%	42.4%	40.1%									
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%







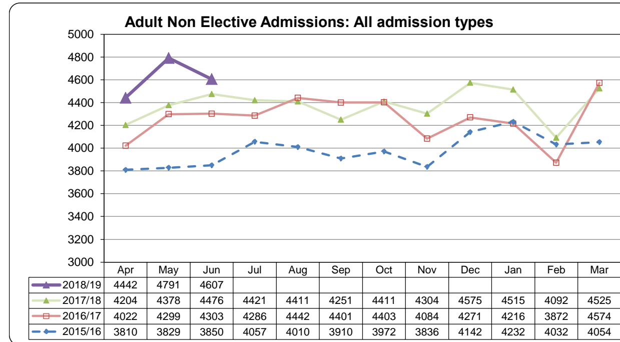
Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

Please note: scales on graphs may be different.

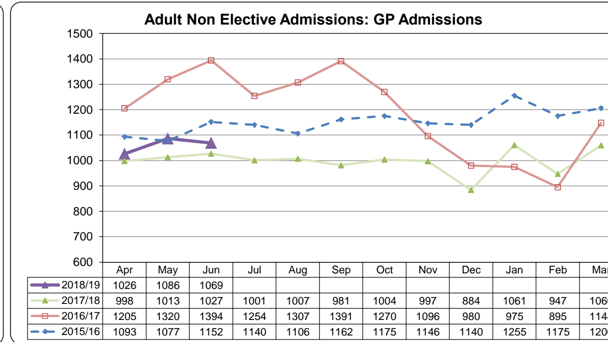
Unplanned Care
Information Team
System and Network Services

Trust Unplanned Care
Adult Admissions

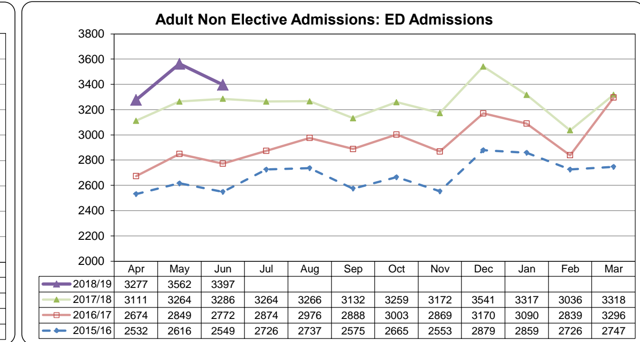
July 2018



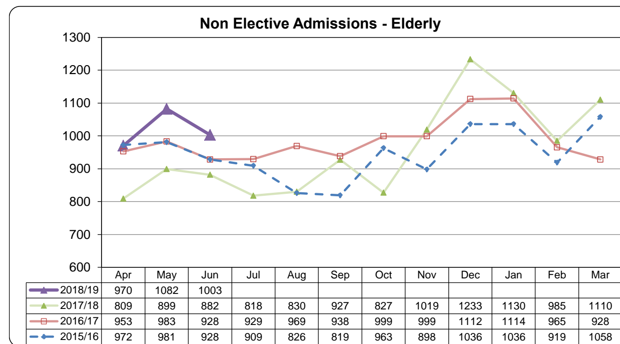
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	4442	4791	4607									
2017/18	4204	4378	4476	4421	4411	4251	4411	4304	4575	4515	4092	4525
2016/17	4022	4299	4303	4286	4442	4401	4403	4084	4271	4216	3872	4574
2015/16	3810	3829	3850	4057	4010	3910	3972	3836	4142	4232	4032	4054



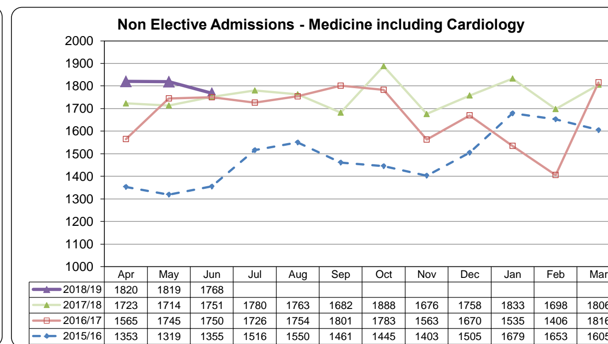
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1026	1086	1069									
2017/18	998	1013	1027	1001	1007	981	1004	997	884	1061	947	1060
2016/17	1205	1320	1394	1254	1307	1391	1270	1096	980	975	895	1148
2015/16	1093	1077	1152	1140	1106	1162	1175	1146	1140	1255	1175	1206



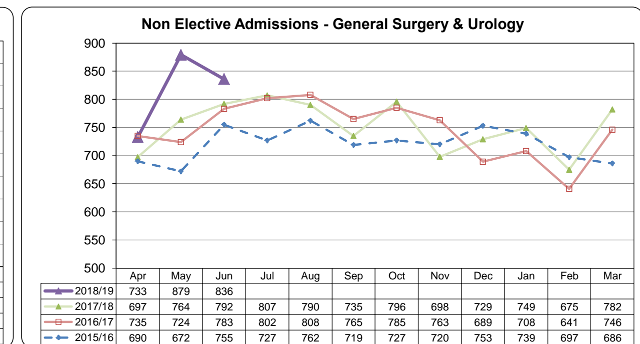
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	3277	3562	3397									
2017/18	3111	3264	3286	3264	3266	3132	3259	3172	3541	3317	3036	3318
2016/17	2674	2849	2772	2874	2976	2888	3003	2869	3170	3090	2839	3296
2015/16	2532	2616	2549	2726	2737	2575	2665	2553	2879	2859	2726	2747



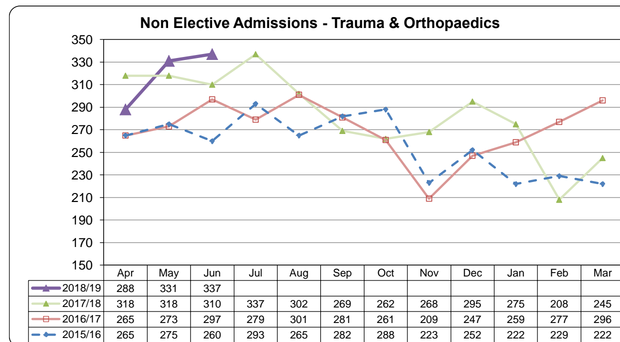
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	970	1082	1003									
2017/18	809	899	882	818	830	927	827	1019	1233	1130	985	1110
2016/17	953	983	928	929	969	938	999	999	1112	1114	965	928
2015/16	972	981	928	909	826	819	963	898	1036	1036	919	1058



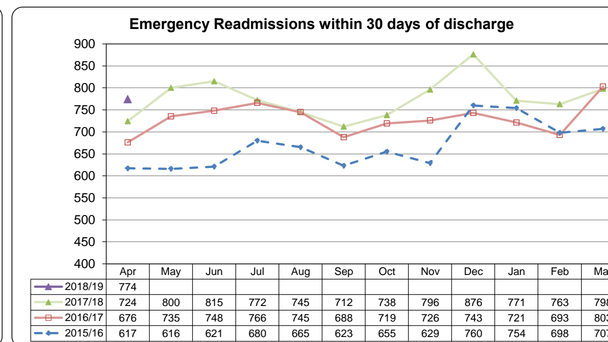
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1820	1819	1768									
2017/18	1723	1714	1751	1780	1763	1682	1888	1676	1758	1833	1698	1806
2016/17	1565	1745	1750	1726	1754	1801	1783	1563	1670	1535	1406	1816
2015/16	1353	1319	1355	1516	1550	1461	1445	1403	1505	1679	1653	1605



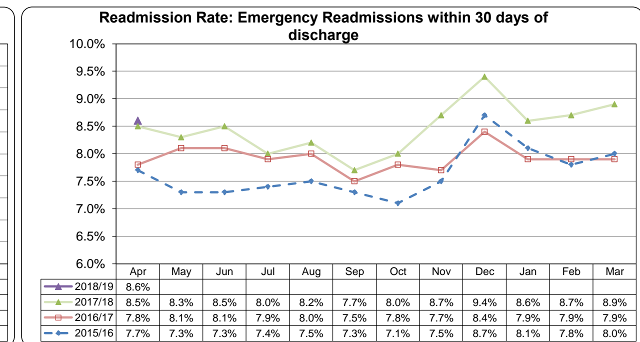
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	733	879	836									
2017/18	697	764	792	807	790	735	796	698	729	749	675	782
2016/17	735	724	783	802	808	765	785	763	689	708	641	746
2015/16	690	672	755	727	762	719	727	720	753	739	697	686



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	288	331	337									
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



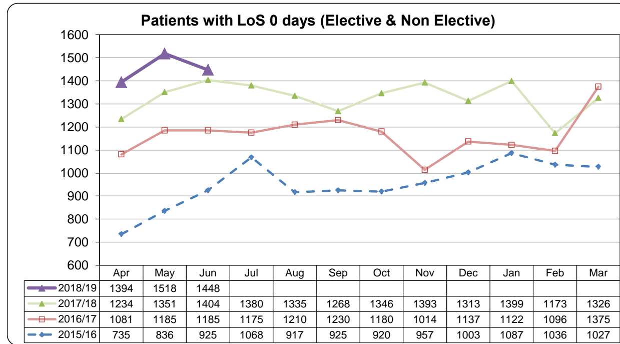
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	774											
2017/18	724	800	815	772	745	712	738	796	876	771	763	798
2016/17	676	735	748	766	745	688	719	726	743	721	693	803
2015/16	617	616	621	680	665	623	655	629	760	754	698	707



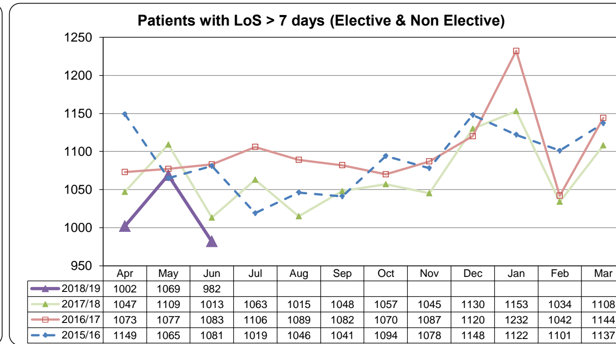
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	8.6%											
2017/18	8.5%	8.3%	8.5%	8.0%	8.2%	7.7%	8.0%	8.7%	9.4%	8.6%	8.7%	8.9%
2016/17	7.8%	8.1%	8.1%	7.9%	8.0%	7.5%	7.8%	7.7%	8.4%	7.9%	7.9%	7.9%
2015/16	7.7%	7.3%	7.3%	7.4%	7.5%	7.3%	7.1%	7.5%	8.7%	8.1%	7.8%	8.0%

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

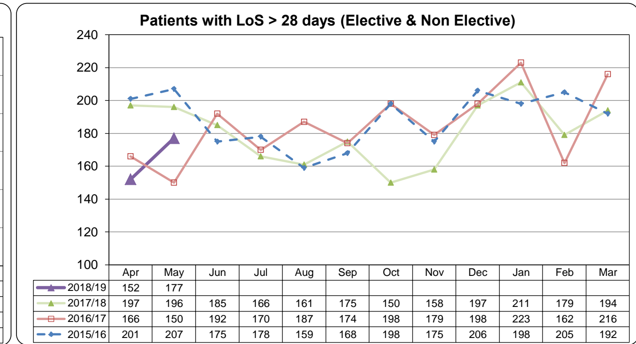
July 2018



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1394	1518	1448									
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

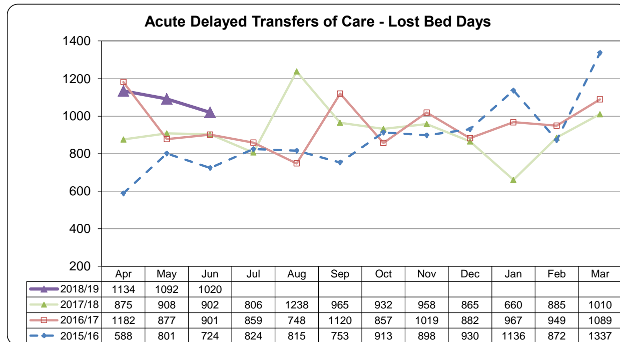


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1002	1069	982									
2017/18	1047	1109	1013	1063	1015	1048	1057	1045	1130	1153	1034	1108
2016/17	1073	1077	1083	1106	1089	1082	1070	1087	1120	1232	1042	1144
2015/16	1149	1065	1081	1019	1046	1041	1094	1078	1148	1122	1101	1137

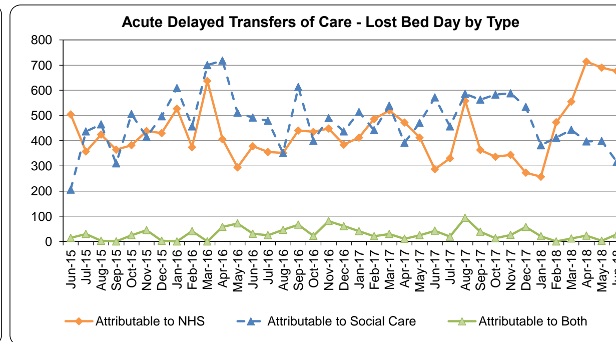


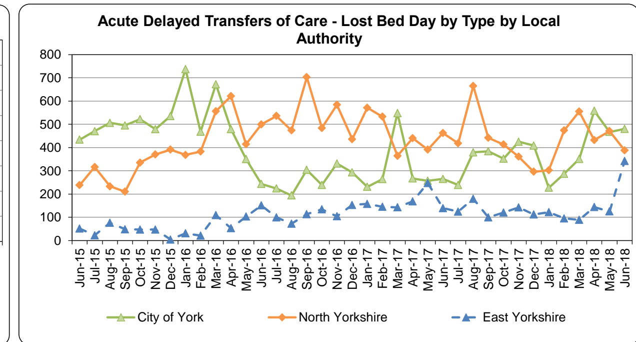
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	152	177										
2017/18	197	196	185	166	161	175	150	158	197	211	179	194
2016/17	166	150	192	170	187	174	198	179	198	223	162	216
2015/16	201	207	175	178	159	168	198	175	206	198	205	192

Updated one month in arrears



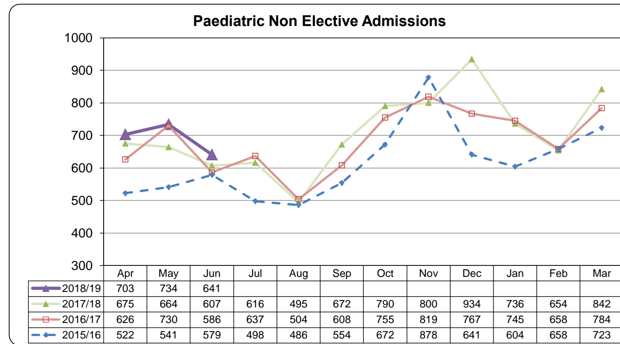
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1134	1092	1020									
2017/18	875	908	902	806	1238	965	932	958	865	660	885	1010
2016/17	1182	877	901	859	748	1120	857	1019	882	967	949	1089
2015/16	588	801	724	824	815	753	913	898	930	1136	872	1337



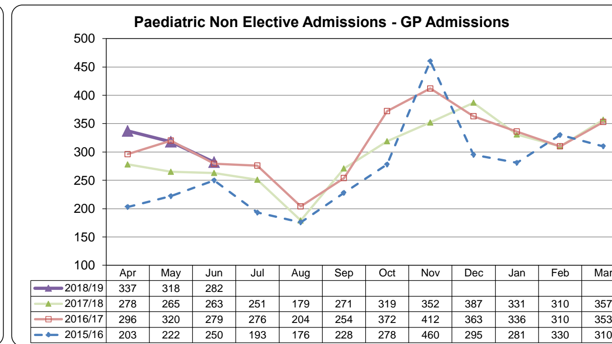


Paediatric Admissions

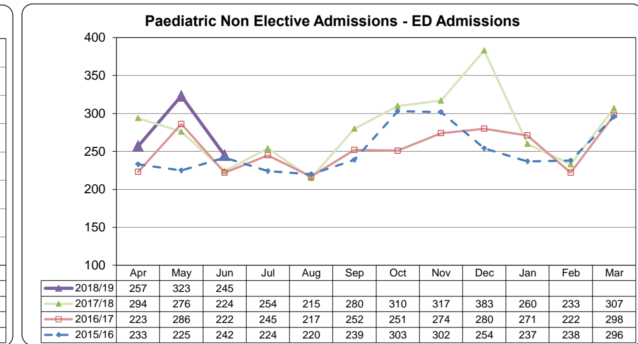
July 2018



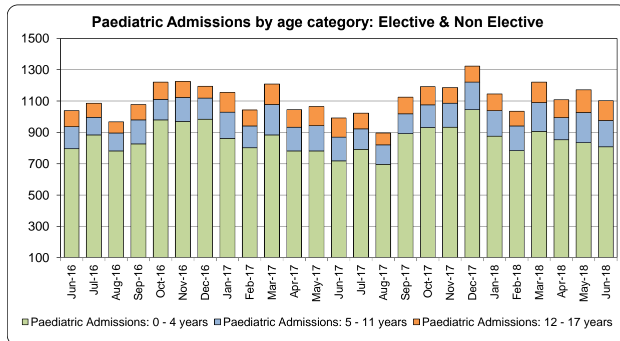
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	703	734	641									
2017/18	675	664	607	616	495	672	790	800	934	736	654	842
2016/17	626	730	586	637	504	608	755	819	767	745	658	784
2015/16	522	541	579	498	486	554	672	878	641	604	658	723

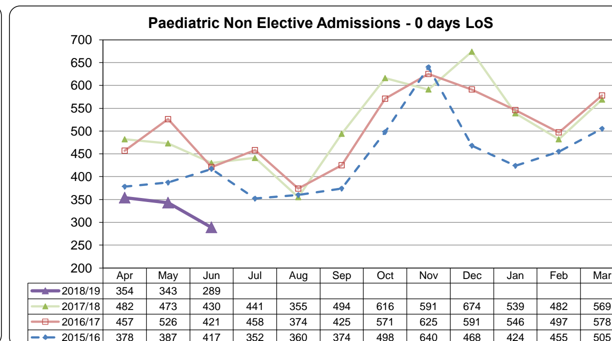


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	337	318	282									
2017/18	278	265	263	251	179	271	319	352	387	331	310	357
2016/17	296	320	279	276	204	254	372	412	363	336	310	353
2015/16	203	222	250	193	176	228	278	460	295	281	330	310

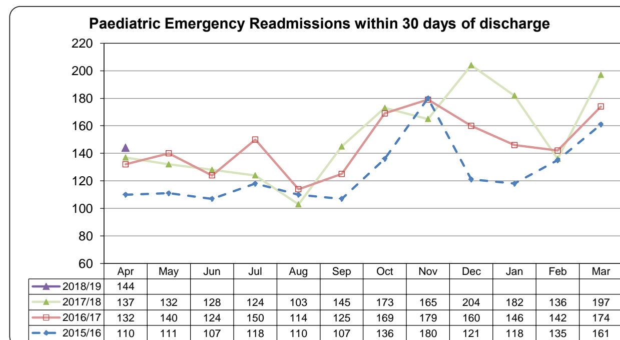


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	257	323	245									
2017/18	294	276	224	254	215	280	310	317	383	260	233	307
2016/17	223	286	222	245	217	252	251	274	280	271	222	298
2015/16	233	225	242	224	220	239	303	302	254	237	238	296

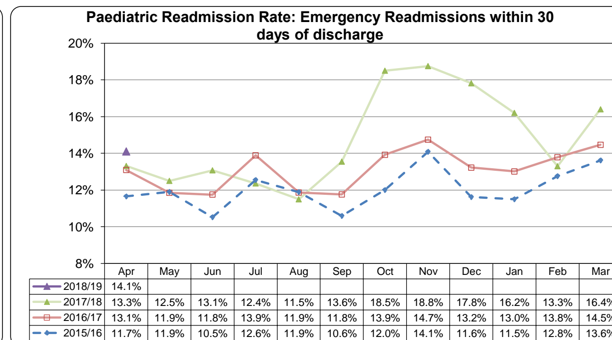




	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	354	343	289									
2017/18	482	473	430	441	355	494	616	591	674	539	482	569
2016/17	457	526	421	458	374	425	571	625	591	546	497	578
2015/16	378	387	417	352	360	374	498	640	468	424	455	505



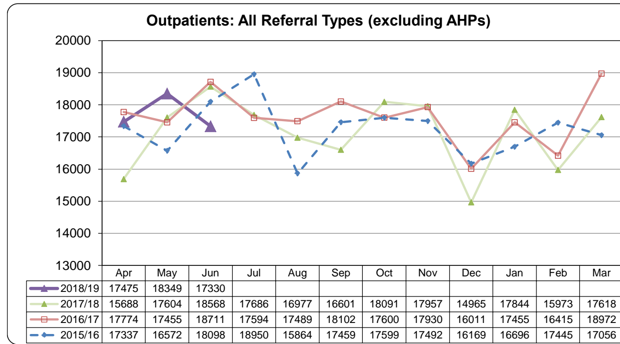
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	144											
2017/18	137	132	128	124	103	145	173	165	204	182	136	197
2016/17	132	140	124	150	114	125	169	179	160	146	142	174
2015/16	110	111	107	118	110	107	136	180	121	118	135	161



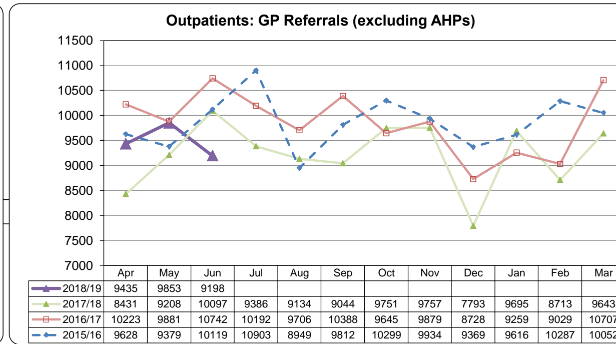
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	14.1%											
2017/18	13.3%	12.5%	13.1%	12.4%	11.5%	13.6%	18.5%	18.8%	17.8%	16.2%	13.3%	16.4%
2016/17	13.1%	11.9%	11.8%	13.9%	11.9%	11.8%	13.9%	14.7%	13.2%	13.0%	13.8%	14.5%
2015/16	11.7%	11.9%	10.5%	12.6%	11.9%	10.6%	12.0%	14.1%	11.6%	11.5%	12.8%	13.6%

Trust Planned Care
Outpatients

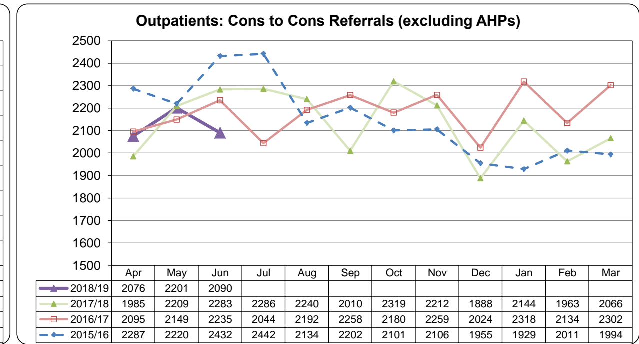
July 2018



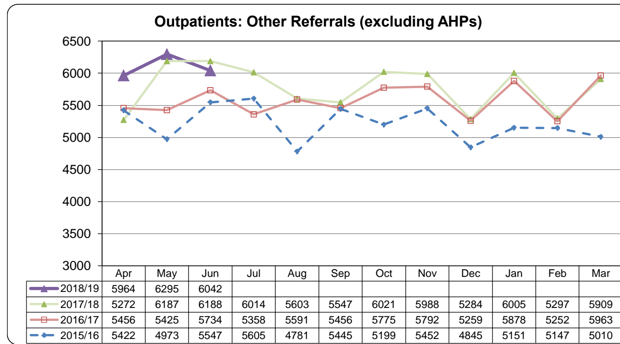
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	17475	18349	17330									
2017/18	15688	17604	18568	17686	16977	16601	18091	17957	14965	17844	15973	17618
2016/17	17774	17455	18711	17594	17489	18102	17600	17930	16011	17455	16415	18972
2015/16	17337	16572	18098	18950	15864	17459	17599	17492	16169	16696	17445	17056



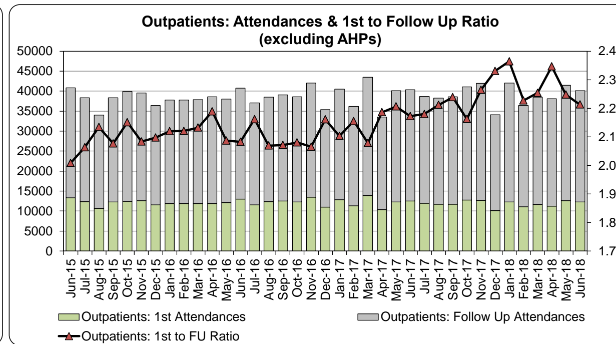
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	9435	9853	9198									
2017/18	8431	9208	10097	9386	9134	9044	9751	9757	7793	9695	8713	9643
2016/17	10223	9881	10742	10192	9706	10388	9645	9879	8728	9259	9029	10707
2015/16	9628	9379	10119	10903	8949	9812	10299	9934	9369	9616	10287	10052

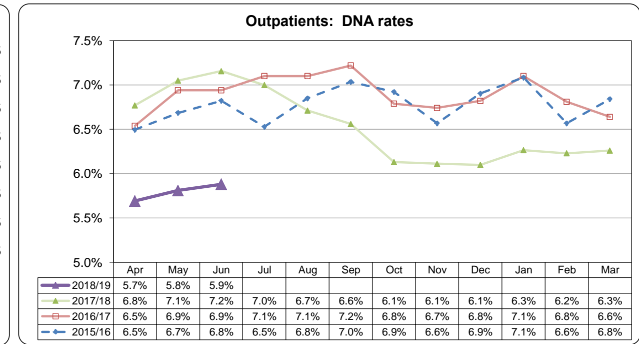


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	2076	2201	2090									
2017/18	1985	2209	2283	2286	2240	2010	2319	2212	1888	2144	1963	2066
2016/17	2095	2149	2235	2044	2192	2258	2180	2259	2024	2318	2134	2302
2015/16	2287	2220	2432	2442	2134	2202	2101	2106	1955	1929	2011	1994

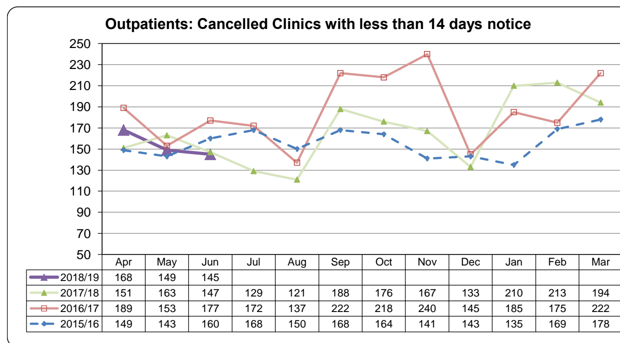


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5964	6295	6042									
2017/18	5272	6187	6188	6014	5603	5547	6021	5988	5284	6005	5297	5909
2016/17	5456	5425	5734	5358	5591	5456	5775	5792	5259	5878	5252	5963
2015/16	5422	4973	5547	5605	4781	5445	5199	5452	4845	5151	5147	5010

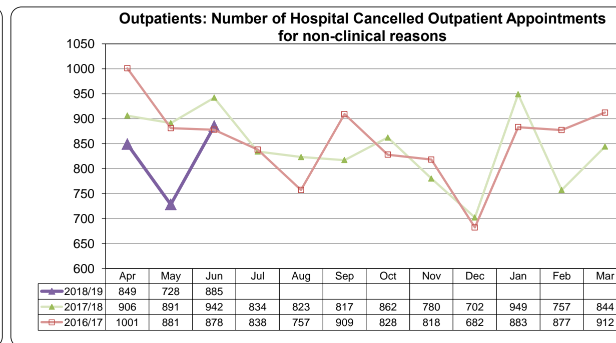




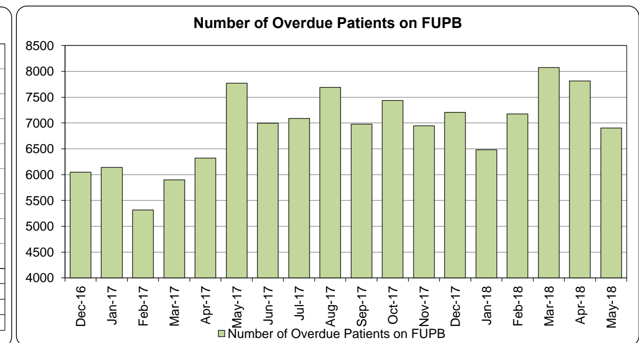
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5.7%	5.8%	5.9%									
2017/18	6.8%	7.1%	7.2%	7.0%	6.7%	6.6%	6.1%	6.1%	6.1%	6.3%	6.2%	6.3%
2016/17	6.5%	6.9%	6.9%	7.1%	7.1%	7.2%	6.8%	6.7%	6.8%	7.1%	6.8%	6.6%
2015/16	6.5%	6.7%	6.8%	6.5%	6.8%	7.0%	6.9%	6.6%	6.9%	7.1%	6.6%	6.8%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	168	149	145									
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

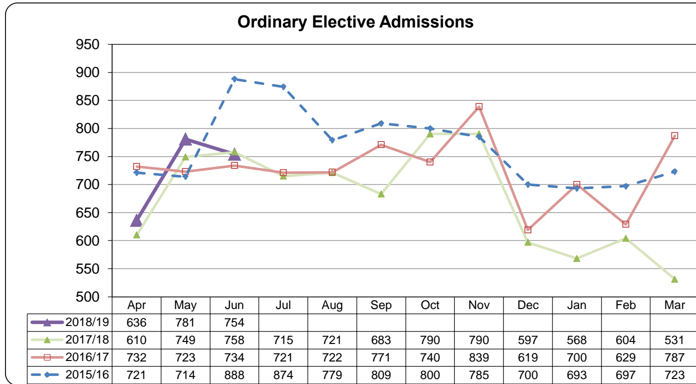


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	849	728	885									
2017/18	906	891	942	834	823	817	862	780	702	949	757	844
2016/17	1001	881	878	838	757	909	828	818	682	883	877	912

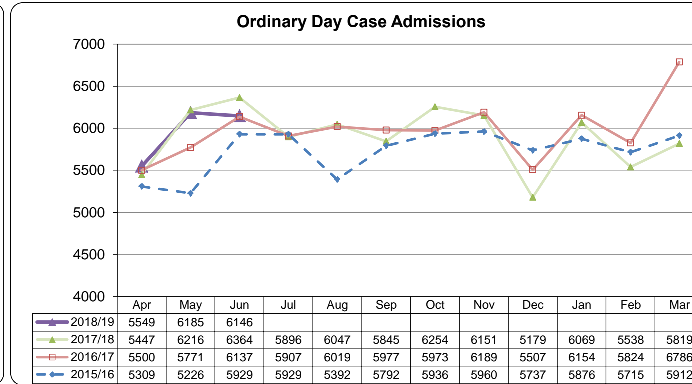


Trust Planned Care
Elective Activity & Theatre Utilisation

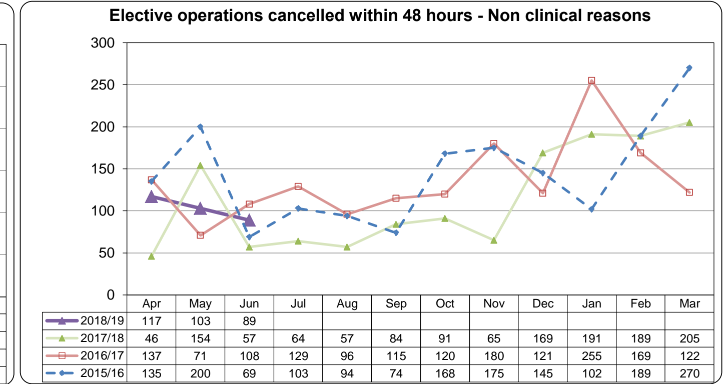
July 2018



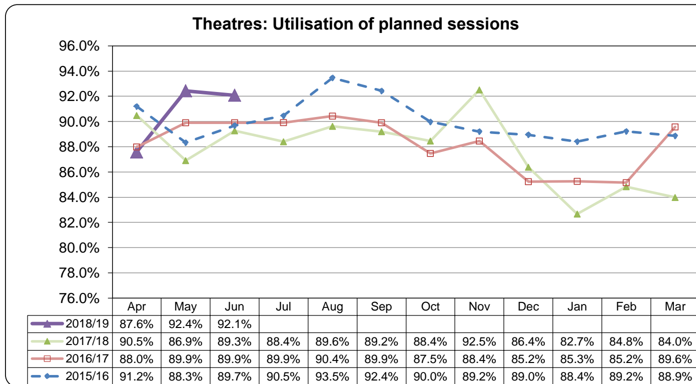
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	636	781	754									
2017/18	610	749	758	715	721	683	790	790	597	568	604	531
2016/17	732	723	734	721	722	771	740	839	619	700	629	787
2015/16	721	714	888	874	779	809	800	785	700	693	697	723



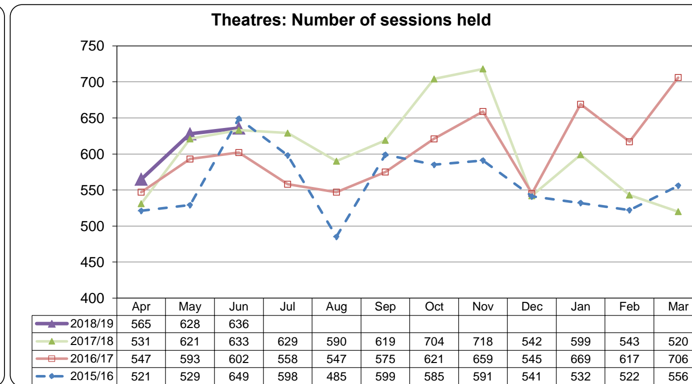
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5549	6185	6146									
2017/18	5447	6216	6364	5896	6047	5845	6254	6151	5179	6069	5538	5819
2016/17	5500	5771	6137	5907	6019	5977	5973	6189	5507	6154	5824	6786
2015/16	5309	5226	5929	5929	5392	5792	5936	5960	5737	5876	5715	5912



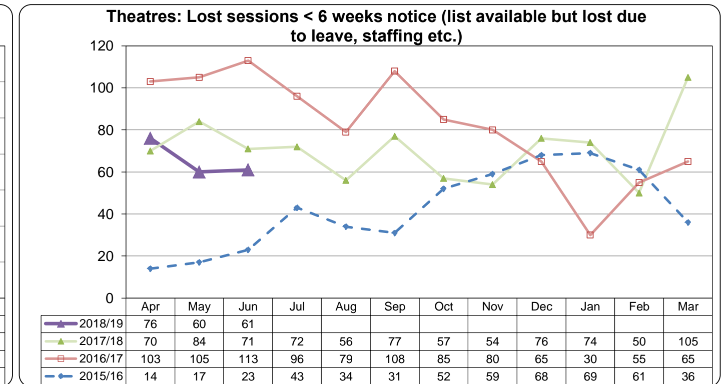
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	117	103	89									
2017/18	46	154	57	64	57	84	91	65	169	191	189	205
2016/17	137	71	108	129	96	115	120	180	121	255	169	122
2015/16	135	200	69	103	94	74	168	175	145	102	189	270



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	87.6%	92.4%	92.1%									
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%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	565	628	636									
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



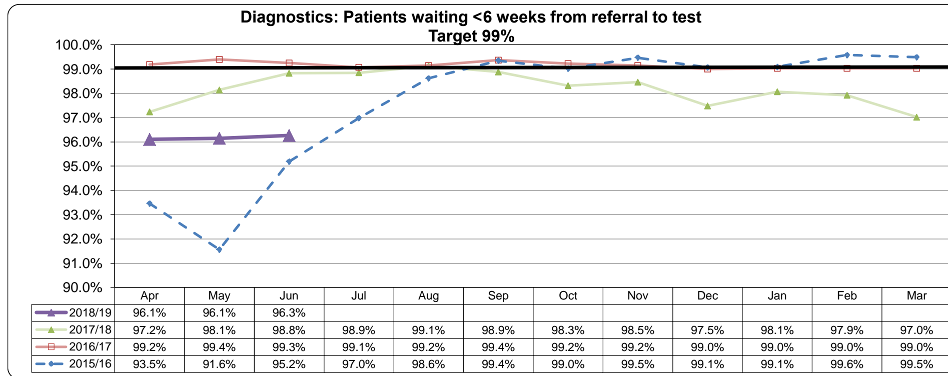
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	76	60	61									
2017/18	70	84	71	72	56	77	57	54	76	74	50	105
2016/17	103	105	113	96	79	108	85	80	65	30	55	65
2015/16	14	17	23	43	34	31	52	59	68	69	61	36

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

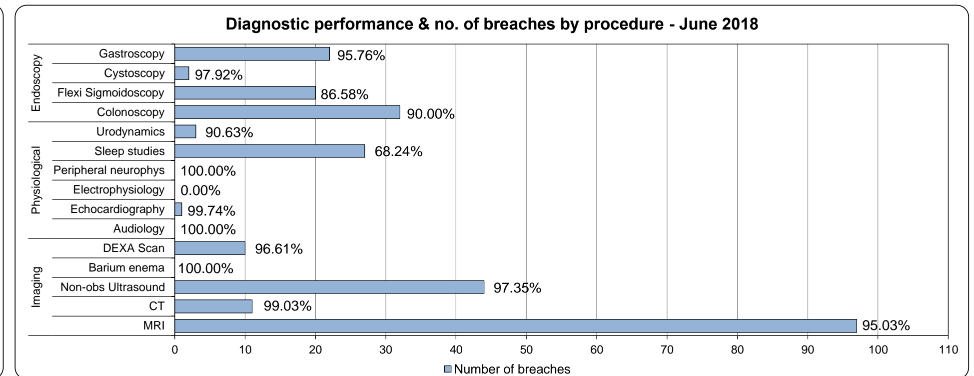
Diagnostics & Referral To Treatment

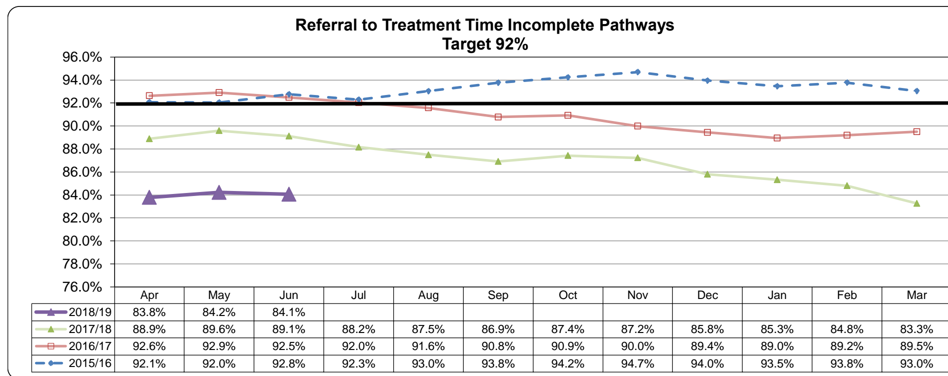
July 2018

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

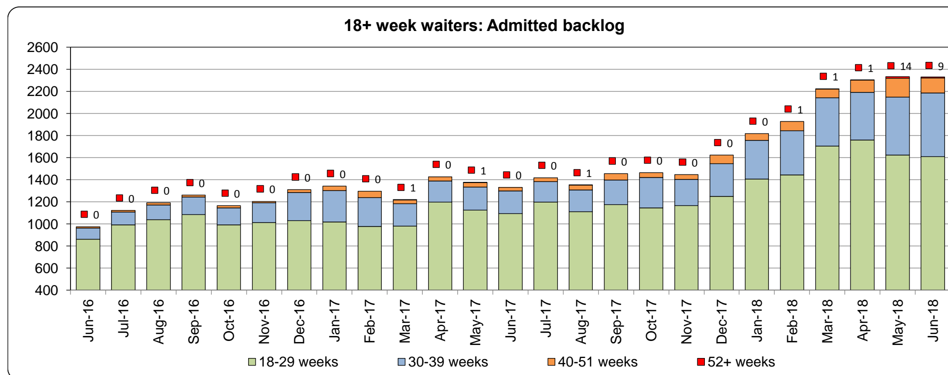


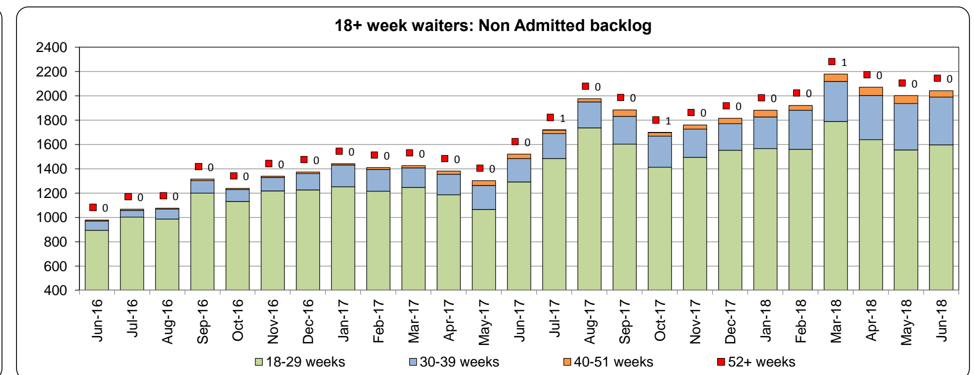
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	96.1%	96.1%	96.3%									
2017/18	97.2%	98.1%	98.8%	98.9%	99.1%	98.9%	98.3%	98.5%	97.5%	98.1%	97.9%	97.0%
2016/17	99.2%	99.4%	99.3%	99.1%	99.2%	99.4%	99.2%	99.2%	99.0%	99.0%	99.0%	99.0%
2015/16	93.5%	91.6%	95.2%	97.0%	98.6%	99.4%	99.0%	99.5%	99.1%	99.1%	99.6%	99.5%





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	83.8%	84.2%	84.1%									
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%



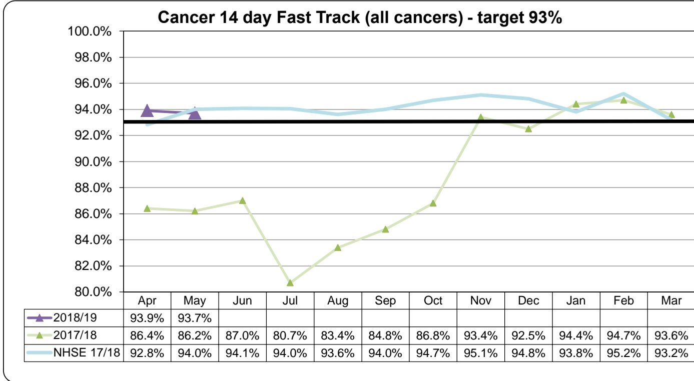


Please note: scales on graphs may be different.

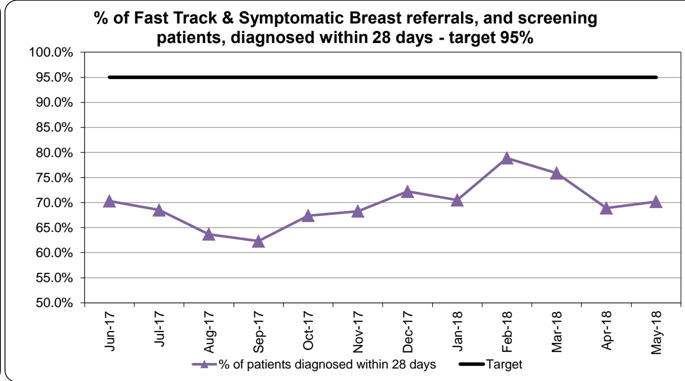
Trust Cancer

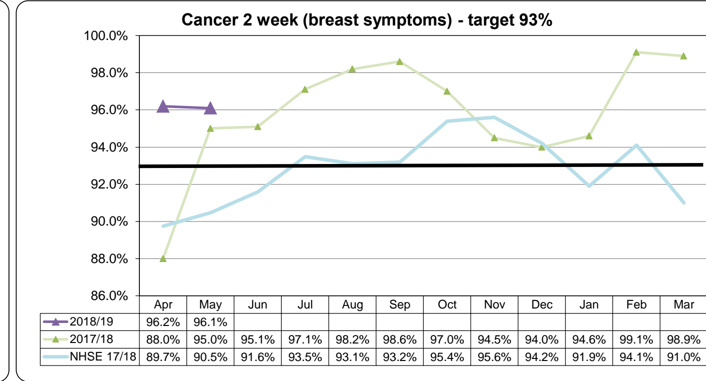
July 2018

Note: The system for submitting and reporting national Cancer Waiting Times performance has undergone major changes this month. Data for April represent what is showing nationally, but IT systems remain 'in development'

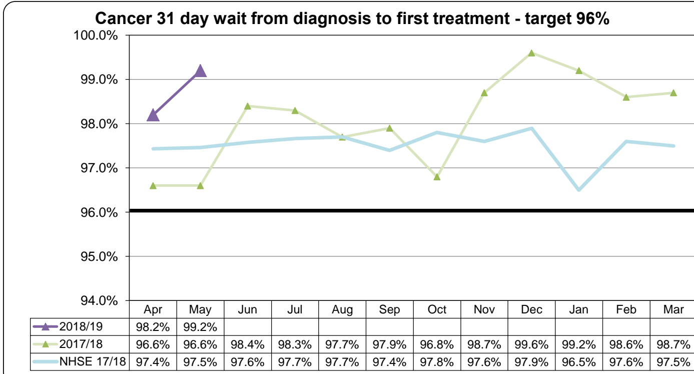


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	93.9%	93.7%										
2017/18	86.4%	86.2%	87.0%	80.7%	83.4%	84.8%	86.8%	93.4%	92.5%	94.4%	94.7%	93.6%
NHSE 17/18	92.8%	94.0%	94.1%	94.0%	93.6%	94.0%	94.7%	95.1%	94.8%	93.8%	95.2%	93.2%

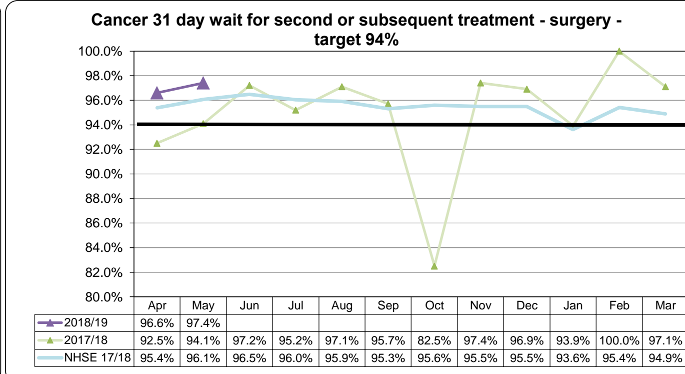




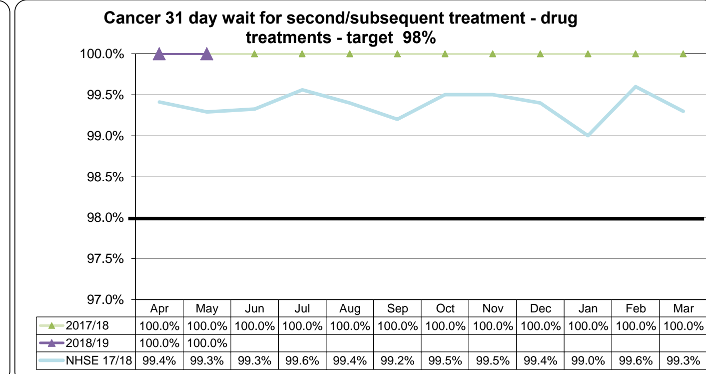
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	96.2%	96.1%										
2017/18	88.0%	95.0%	95.1%	97.1%	98.2%	98.6%	97.0%	94.5%	94.0%	94.6%	99.1%	98.9%
NHSE 17/18	89.7%	90.5%	91.6%	93.5%	93.1%	93.2%	95.4%	95.6%	94.2%	91.9%	94.1%	91.0%



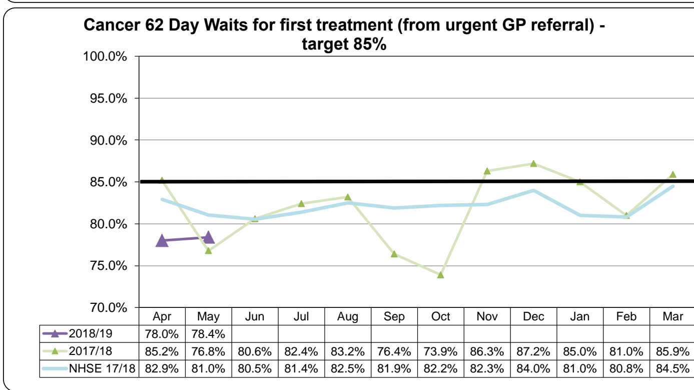
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	98.2%	99.2%										
2017/18	96.6%	96.6%	98.4%	98.3%	97.7%	97.9%	96.8%	98.7%	99.6%	99.2%	98.6%	98.7%
NHSE 17/18	97.4%	97.5%	97.6%	97.7%	97.7%	97.4%	97.8%	97.6%	97.9%	96.5%	97.6%	97.5%



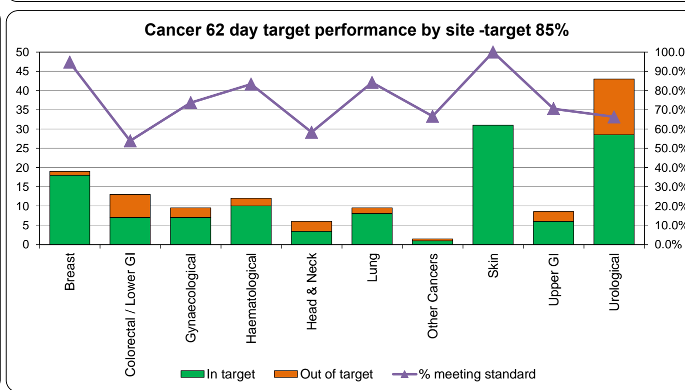
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	96.6%	97.4%										
2017/18	92.5%	94.1%	97.2%	95.2%	97.1%	95.7%	82.5%	97.4%	96.9%	93.9%	100.0%	97.1%
NHSE 17/18	95.4%	96.1%	96.5%	96.0%	95.9%	95.3%	95.6%	95.5%	95.5%	93.6%	95.4%	94.9%

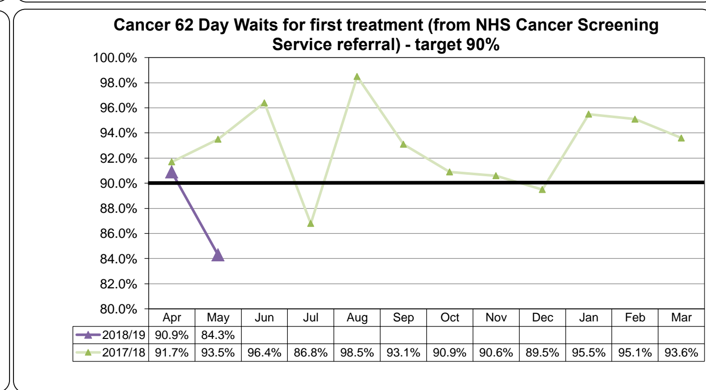


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2018/19	100.0%	100.0%										
NHSE 17/18	99.4%	99.3%	99.3%	99.6%	99.4%	99.2%	99.5%	99.5%	99.4%	99.0%	99.6%	99.3%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	78.0%	78.4%										
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%
NHSE 17/18	82.9%	81.0%	80.5%	81.4%	82.5%	81.9%	82.2%	82.3%	84.0%	81.0%	80.8%	84.5%





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	90.9%	84.3%										
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%

NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Quality and Safety Committee – 19 June 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.

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

1. Lack of availability of decant facilities CRR Ref: CN20 – BG
2. Medical Staffing highlights – JT
3. Mental Health Report - 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

Sponsor: Libby Raper, Non-Executive Director

Date: 19 June 2018

Quality & Safety Committee Minutes – 19 June 2018

Attendance: Libby Raper, Lorraine Boyd, Beverley Geary, Ed Smith, Fiona Jamieson, Liz Jackson

Apologies: James Taylor, Jennie Adams, Lynda Provins

Minutes of the meeting held on the 22 May 2018

The notes from the meeting held on the 22 May were approved as a true and accurate record. There were no matters arising that weren't included as agenda items.

Action Log Items

Item 83 – The SI thematic table has been included in the Medical Directors report.

Item 85 – BG explained that there is a paper going to Workforce and Organisational Development Committee regarding the limited assurance audit of e-rostering, this will go to board for information. BG highlighted that the system lock down is not successfully implemented, a dashboard is being developed which will be monitored at the monthly PMMs. The auto-roster function does not correctly allocate shift times and if anyone has more than 7.5 hours' time-owing, this should be fed through the bank. Work will be undertaken in conjunction with the audit team to find solutions to these issues. The deep dives have been completed and work is ongoing, this will be led by Polly McMeekin with support from nursing.

Item 86 – The Committee had queried the data accuracy for St Monicas in the Safer Staffing report. BG explained the details of the staffing model and advised that 100% staffing both day and night was correct. BG highlighted that the staffing figures for Bridlington are also correct. The vacancy figures at Bridlington are at 1% for registered nurses and 0.51% for care staff, which is based on a workforce of 6.6 wte. There is no registered nurse sickness or maternity leave and sickness and maternity leave for care staff is low (20.38% and 14.53%). All temporary staffing requests have been filled by the nurse bank. The Committee were encouraged that data anomalies can be highlighted and a further understanding can be gained.

Item 87 – The FJ explained that the Paediatric Diabetes Audit had not been included on the audit review programme requested by the Committee and agreed to provide this in November. This action will now be included in action 88.

Item 91 – BG advised that the Governors have been briefed on the revised visiting times.

Item 92 – Although there has been some improvement, Scarborough remain behind York with compliance with the 14 hour review standard, with York at 88% and Scarborough at

76%. Changes have been made to the way that the Physicians in Scarborough work and there are still a number of changes to take place. The Committee queried why the threshold in the data pack was 82% for York and 52% for Scarborough. ES suggested that these may be historical figures. FJ agreed to look in to this.
Action: FJ to look in to 14 hour review thresholds

Risk Register for the Medical Director and Chief Nurse

CRR Ref: CN20 – BG advised that a new risk has been added to the Chief Nurse Risk Register around the lack of decant facilities, which impacts on deep cleaning the ward areas. As all sites are full to capacity deep cleans have been reactive; with a CPE outbreak in York last year and a winter clean of Anne Wright Ward, which was challenging. Financial constraints have previously been an issue, however the lack of decant facilities now poses both patient safety and operational risks. BG also highlighted the age of the Scarborough Hospital site.
Board: BG to highlight at Board.

CRR Ref: CN16 - The Audit Committee have advised that the MCA/DoLs risk can now be removed from the Chief Nurse risk register. The decision has been made for this to remain until the work has embedded and practice changed at a ward level. A clinical audit will be undertaken by the Safeguarding Team and Matrons in the autumn, as the previous audit provided limited assurance. The Committee noted that numbers included in the performance report are starting to shift but there is no pattern as yet. There remains a backlog of DoLs applications with York City Council, there is around an 8 week turnaround time, which has been flagged to the CQC and the Trust is mindful that we are not the only organisation sending applications to the York City Council. A complaint was received around a patient held on DoLs for 5 weeks and following investigation good practice was illustrated in this case. This has been flagged to the CQC which may cause reputational damage.

CRR Ref: MD2a, MD2b, MD4, MD6b & MD10 - ES explained that there have been some positive steps with the Physicians on the east coast, with some appointments being made. The senior workforce plan will be dependent on the long term strategy for Scarborough and will be specific to the requirements of the service. Junior doctor recruitment remains difficult, the August changeover is approaching and there are no Emergency Medicine GP trainees in post. Following discussion with the Clinical Senate Lead this is the picture throughout England. A medical staffing plan needs to be put in place and discussions are taking place regarding reviewing this as a composite whole rather than by directorate, which then provokes contractual debate. There is a hope to implement the medical model by February, which includes both front and back of house staff. Separating ward and acute covers in a sustainable way provides continuity front of house. Any gaps in rotas will be identified and the non-medical workforce can be used appropriately.

All workforce opportunities are being explored as creatively as possible. A huge number of Physicians Associates have been recruited to nationally; five have been through the training scheme, one of which has applied to work at York. It is hoped that others will apply if exciting and interesting rotational roles are offered. This may mean that they won't contribute to service delivery for a while but should be an investment worth making. BG highlighted that many of the Physicians Associates are nurses by background, who then

go through a two year training programme. A current GP will be commencing as a Leadership Fellow in August and the idea is for her to focus on the cross over between primary and secondary care. There are also individuals on the Certificate of Eligibility for Specialist Registration (CESR) programme to explore.

Ernst and Young have provided a draft report on their findings, none of which come as a surprise but do offer a degree of external validation of the internal findings. The company arrived when some of the operational pressures were relieving; however, they did find some delays in the initial assessments and focussed work is taking place in this area. ES explained that the acute medical unit in Scarborough is usually full until 21:00 and many patients are placed there unnecessarily to avoid a 12 hour breach. Their review of the Emergency Care Standard found that the average time was seven hours in York and ten hours nine minutes in Scarborough. 47% of admitted patients breached the four hour target and an action plan is in place to look at a solution.

ES explained that there are 150 A&E attendances and 47 admissions per day, which is high and many factors impact on this. An external partner is being considered to join a strategy meeting which will aid in the organisational structure work and strengthening the senior team. BG added that seven day working for Matrons will be put in place on both acute sites.

Assurance: The Committee were assured by the creative approaches to medical recruitment.

Patient Safety

Nurse Staffing

CRR Ref: CN2, CN11 and CN13

100 nurses are due to commence with the Trust in September and October. The Trust attended the Nursing Times recruitment event this week and we are awaiting feedback. International recruitment continues to be explored; however, there is a 44 week lead time. BG is scheduled to meet with Coventry University in July to explore the feasibility of them becoming educational partners for a second cohort of TNA's. At a recent meeting the University of York shared plans to potentially reduce their numbers of pre-reg students to focus on post-graduate nursing; however, there is scope for negotiation.

Individuals recruited as Associate Practitioners have been working as HCAs but have now progressed into their band four roles. The Chief Nurse Team in collaboration with Corporate Learning and Development are supporting HCAs in obtaining their functional skills qualification in Maths to enable them to progress in to Trainee Nurse Associate roles. BG explained that many HCAs are progressing in to these roles but Maths and English are the stumbling blocks. The Committee were impressed by the current 50% success rate for this new initiative.

BG detailed the 200% fill rate at Bridlington. Kent and Lloyd wards have a low bed occupancy, which can be reduced on a night and at weekends, this attributes to a decreased need for staff. The increased staff in the day time is due to patients at risk of falls and the need for 1:1 care.

SafeCare remains in the roll out phase. This is an 'in the moment' acuity and dependency tool. Wards and Matrons have IPads to monitor this and get the best out of the workforce

by redeploying staff. E-rostering was unreliable. The system aggregates numbers per site highlighting red areas and any red flags determined by NICE, the detail is necessary to understand these red areas. Work is being undertaken with ward areas around this new tool and Hull, who have had SafeCare for 18 months, are highlighting similar issues to York.

Assurance: The Committee took assurance from this great step forward with the use of technology.

Action: BG to share with board in August under patient experience.

Falls and Pressure Ulcers Quarterly Reports

Pressure ulcers have slightly increased in quarter 4 compared to last year, with an increase in unstageables. Further analysis of unstageables is being undertaken and many have occurred on heels, which will be removed from the data. Numbers may change further as category 3 and 4 ulcers are de-logged following panel discussions. There have been no category 4 pressure ulcers reported in quarter 4 and only a small number of category 3s, there has been an expected increase in category 2s. The Tissue Viability Team restructure is now complete and safeguarding around pressure ulcers will be fed in to the work stream going forward.

There has been an increase in falls in quarter 4 compared with the last few years. There has been a large increase on ward 28 and Aspen ward, this may be due to ward 28 being an elderly ward, rather than orthopaedics, over the winter period. There has been a significant decrease in the number of falls on ward 23 with focussed work being undertaken on intentional rounding and a decrease on ward 16 which has been reconfigured. Workshops have been developed and held across the organisation. There was an increase in the number of falls sensors available across the organisation; however, they are not compatible with the new mattresses. It is thought they may lead to a false sense of security and their use is currently being reviewed. The bed risk assessment has been updated and a new distance vision check, designed by the Royal College of Physicians has been implemented. The policy is also being reviewed.

There has been a significant reduction in falls and pressure ulcers over time and Becky Hoskins will undertake a review of the falls and pressure ulcer work streams, refreshing the panels and the steering groups, there is currently no completion date for this. FJ added that compliance with the Duty of Candour is increasing and progress is being made.

Assurance: The Committee took assurance that staff throughout the organisation are engaged with the falls and pressure ulcer agendas.

Mental Health Annual Report

CRR REF: CN9

BG advised the Committee that the Mental Health Annual Report was included for information and the Trust is obliged to report to board. The paper has been written by the providers, Tees, Esk and Wear Valley. The Committee highlighted that there were two cases of patients being transferred without documentation and were pleased that these had been recognised and learning fed back in to the system. BG advised that the biggest concern around mental health is children as this is a very challenging group.

Infection Prevention and Control
CRR REF: CN7 and CN8

The Trust is one CDIFF case above trajectory for June. Three non-lapses in care have been identified and post infection reviews are taking place. BG highlighted that many of the cases are the same patient who has been discharged and readmitted and ES added that it is difficult to account for these statistical anomalies when the numbers are so low.

Clinical Effectiveness

Maternity Dashboard
The Committee highlighted that there was a high number of 3rd and 4th degree tears included on the Maternity dashboard. BG agreed to obtain further information from the team.
Action: BG to look in to the number of 3rd and 4th degree tears.

Serious Incidents and Never Events
CRR Ref: MD8

ES led the Committee through the spectrum of SI's included in the Medical Directors Report.

SI2018/700 - This SI highlighted that NEWs doesn't pick up patients that flag in a different way. Investigations need to be undertaken in a timely manner to ensure patients don't come to harm.

SI2018/3239 and SI 2018/5119 - These are administrative errors that highlight the complexity and confusion around the system.

SI2018/1913 – This delayed diagnosis was due to human error.

SI2018/3879 – Medical air is only utilised in certain areas, for example for NIV patients. Options regarding storage and availability of this are being reviewed and it may be decided that these canisters are removed from other areas.

SI2018/3899 – The LocSSIPs work should eliminate any risk of wrong patient identification. This incident was a human factors error.

SI2018/4950 – The Committee raised concern around the workload on the day of this SI, with no junior doctor available. ES explained that having a junior with you as consultant can work both ways. The Committee queried if there is a tool to assess the skill set and competence of the clinical team, ES advised that there wasn't currently anything available and explained that workers should be supported and challenge where appropriate and also understand the team dynamics and the risks.

CRR REF: CN17 SI2018/1907 – This SI highlights the challenge around the winter flu epidemic; there were large numbers of patients, a new flu test and some patient to patient transmission. This also links with the work around decant facilities, refurbishments and

estates. These are challenges for infection prevention and the risks need to be reduced going forward. BG explained that IPC have conducted a look back exercise and the focus is on the success of the flu ward in York, the provision of care, ward structure, reconfiguration and refurb and deep clean. Mobile wards are being considered; however, these may be cost prohibitive.

ES advised that the Trust are working within a safer system, staff are now reporting as many clinical SI as falls and pressure ulcers, highlighting that reporting culture is changing.

FJ has included in the SI report in the papers, this report goes to the SI Group every two weeks for review and includes a breakdown of all SIs reported over the previous 12 month period. A list of outstanding recommendations is also provided to the SI Group to ensure that these are escalated and deescalated as appropriate. The report gives a flavor of the themes and trends, the last 12 months of which have been dominated by 12 hour trolley waits and falls and pressure ulcers. FJ has attended the Acute and General Medicine Clinical Governance day and they advised that they only datix serious incidents as those that are less serious are dealt with in the moment. The directorate has been asked to report all incidents for one week so that themes can be identified. This may be repeated on a six monthly basis. The SIs reviewed by the Group do not often have a serious level of harm, the challenge is the differing views on lapses in care and it can also be difficult to view SIs from a patient perspective. There is a definite improvement in the reporting culture.
Action: SI report to be reviewed by the Committee on a six monthly basis.

Assurance: The Committee appreciated and took assurance from the informed and detailed discussion of all of the SIs.

Antibiotic prescription audit

The Trust has reduced the usage of piperacillin/tazobactam but have not achieved the necessary reduction and overall anti-biotic usage has not reduced, meaning that the CQUIN target has not been achieved. The Committee highlighted that the documented review date has dropped for York following the implementation of EPMA. ES advised that the clinicians had asked for this not to be included. The audit data between directorates is variable and requires focused work. BG advised that the EPMA board is scheduled to take place and JT can feedback to the Committee in July.
Action: JT to feedback from the EPMA board to the Committee in July.

Clinical Effectiveness Group Minutes

The Committee found it continually encouraging that the Clinical Effectiveness Group minutes were being received and queried item 10, to be escalated to the Committee. FJ advised that there has been a recent conversation regarding registering smaller local pieces of research which would have a resource implication for the Health Care Governance Team. The Committee advised that the review and implications of the team would require an executive decision.

Bowel Cancer Briefcase
Action log: Item 82

The Bowel Cancer Briefcase is the first briefcase to the come to the Committee for review. FJ explained that a briefcase contains an overview of the study, the methodology, the findings and the outcomes. National audits will also contain benchmarking data with the networks. The audit showed that there was good contact with the clinical nurse specialists. The directorate felt that the data supplied didn't reflect their caseload and will look to strengthen their data collection and keep local ownership. One of the actions from the audit is to appoint a data handler for colorectal to deal with data quality and collection.

Additional Items

Board Assurance Framework

The Board Assurance Framework will be refreshed following the implementation of the revised strategy. The Committee agreed that the current BAF broadly reflects the Committees position.

Any other business

NCEPOD

No NCE Pod data was included in the papers; FJ queried which data the Committee would like to see. LP will look in to and liaise with FJ.
Action: LP to advise FJ of the NCEPOD data required by the Committee (action 89)

Mortality Report

The Mortality Report was not included in the papers, the Committee asked to review this in July.

Next meeting of the Quality and Safety Committee: 17 July 2018, Neurosciences Resource Room=, York Hospital

Quality & Safety Committee – Action Plan – June 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	
82	Apr 18	Bowel Cancer and Sepsis Briefcases and final reports to be reviewed by the Committee	FJ	May 18 Bowel Cancer Jun 18	

				Sepsis Jul 18	
83	Apr 18	SI thematic table to be included in the Medical Directors Report	FJ	May 18 June 18	Completed
85	May 18	Review limited assurance E-Rostering audit	BG	June 18	Completed
86	May 18	To review the data accuracy for St Monicas staffing	BG	June 18	Completed
87	May 18	National Paediatric Diabetes Audit next stages and action plan	FJ	June 18	Combined with Action 88
88	May 18	Audits for review; Sentinel Stroke Audit National Cardiac Arrest Audit A local audit Paediatric Diabetes Audit	FJ	 Aug 18 Sept 18 Oct 18 Nov 18	
89	May 18	NCEPOD Report to be included in the Medical Directors Report	JT & FJ	June 18 July 18	
91	May 18	Brief the Governors on the new visiting times	BG	June 18	Completed
92	May 18	To review the Scarborough 14 hour review threshold in the data pack	JT FJ	June 18 July 18	
93	Jun 18	To share SafeCare with board under patient experience	BG	August 18	
94	Jun 18	Update the Committee on the number of 3rd and 4th degree tears in Maternity	BG	July 18	
95	Jun 18	Feedback from the EPMA Board	JT	Jul 18	
96	Jun 18	Mortality Report to come to the Committee for review	JT	Jul 18	
97	Jun 18	SI to come to the Committee for review on a six monthly basis – to add to work plan	LP	Jul 18	

NHS

York Teaching Hospital

NHS Foundation Trust

Board of Directors – 25 July 2018
Quality and Safety Committee minutes – 17 July 2018

Recommendation

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

Current approval route of report

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Purpose of report

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Chair's Summary

1. The Committee were joined by Helen Hey and Liz Ross (Head of Midwifery) in place of the Chief Nurse. We also welcomed Becky Hoskins to her first meeting as Deputy Director of Patient Safety and said goodbye and thank you to Libby Raper on her final Committee meeting before retiring from the Trust at the end of the month.
2. This month the committee reviewed the Annual Complaints Report, the Quarterly IPC Report, the Quarterly Patient Experience Report, the National In-Patient Survey and the bi-annual Maternity Services report.
3. The Committee noted the ongoing work of the Medical Director and clinical directorates to finalise both the high level and more detailed aspects of the refreshed Patient Safety Strategy – a key element of the Trust's new strategy.
4. Recent increases in the number of cases of c-diff within the Trust were noted along with several related additions to the Chief Nurse Risk register along the theme of Infection Prevention and Control. Many of these risks contain an element of infrastructure planning around ability to deep clean, need for ward refurbishment and lack of isolation facilities. We felt that this should be highlighted and discussed at Board given the broad implications for ops, estates and finance.

5. The bi-annual Maternity Services Report provided the Committee with significant assurance around the quality and safety of this service and the excellence of governance arrangement operating in the department and across the wider region. Of particular note are the improvements in stillbirth and neonatal death rates and progress with smoking cessation and breast-feeding rates on the East Coast.
6. The Committee took assurance from the presentation of actions following the national clinical audit of Sepsis Treatment and recent data showing improvements in compliance with national standards,
7. The Committee discussed a number of issues where there were queries around data quality and reporting. Most notably within Datix reporting and on nursing fill rate calculations. These will be investigated further as it is important that information providing Board assurance is accurate.
8. The Committee were pleased to note the revival of the Patient Safety Walk Round programme and were delighted to learn that Wi-Fi access for patients was imminent.

Key points for discussion

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

1. BG to provide highlights form bi-annual Maternity Services Report
2. BG to raise Infection Prevention and Control concerns/risks
3. JT to highlight possible changes to PMM process following recent experience
4. JT to discuss EPMA developments

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.

Author: Charlotte Craig, Administration Assistant

Sponsor: Jennie Adams, Non-Executive Director

Date: 18 July 2018

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Quality & Safety Committee Minutes – 17 July 2018

Attendance: Jennie Adams, Libby Raper, Lorraine Boyd, Rebecca Hoskins, Fiona Jamieson, James Taylor, Helen Hey, Liz Ross, Charlotte Craig, Lynda Provins

Apologies: Beverley Geary, Liz Jackson

Minutes of the meeting held on the 19 June 2018

The notes from the meeting held on the 19 June were approved as a true and accurate record. There were no matters arising that weren't included as agenda items.

Action Log Items

Item 36 – Patient Consent Audit - RH stated this is scheduled for August. The outcome of the audit should be available for October.

Item 68 – JT is to produce a paper outlining the refreshed Patient Safety Strategy. JT highlighted that Maternity and Elderly Medicine have produced effective local strategies, and Renal services also follow national guidance – these examples of best practice will be used to encourage other directorates to develop their own safety programmes. This more collective approach is an example of the wider cultural change that the Trust wishes to foster amongst its staff.
Directorates haven't all been well prepared for Quality & Safety PMM meetings and there may be a case for adding Q&S back into the normal PMM meeting. JT feels we need to reframe the PMM focusing on an exception based process.
The new strategy will be one of the pillars of the refreshed Trust strategy.
Board: JT to share new Patient Safety Strategy with Committee and Board when finalised.

Item 73 – Nursing Appraisal Rates: HH informed the Committee that the Trust is not achieving the original target of 95% for appraisals. It has been proposed that a more realistic target of 85% be adopted. This provides a stretch target for current compliance of 80%, and reflects the % unavailability calculated to cover carers leave, maternity leave etc. Polly McMeekin is currently working on tailoring the appraisal process to be individualised.
Action: LR to share with Workforce meeting.

Item 89 – The Committee queried what was to be included. FJ agreed to bring information on NICE to the August meeting. JT has agreed with JA and Chair of Audit Committee to share with Board significant findings from National Audits or interesting NCEPODs.

Item 92 – 14 hour review: The Committee queried why this target was lower in Scarborough. This was a data error and should read at 90%. This will be rectified in future reports

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Item 94 – This is covered in the Maternity report.

Item 95 – EPMA will be rolled out in Scarborough in October. Work continues to address emergent IT issues. And resolve pharmacist and operating theatre issues. Currently there is no facility to record administration under a Patient Group Directive, or to proactively enter an end date for a course of antibiotics. These issues will be adjusted and Scarborough will benefit from York's learning curve.

Item 96 – The Mortality report will come to the Committee for review in August.

Item 97 – The SI themes will be provided every 6 months for review instead of every meeting.

Risk Register for the Medical Director, Chief Nurse and Chief Operating Officer

CRR Ref: CN20 – HH advised that there is now a pressing need to undertake ward refurbishment and Hydrogen Peroxide vapour (HPV) cleaning. HH gave a summary of the budget considerations for this. The Trust currently has no decant facility on both acute sites which is required to facilitate effective deep cleaning.
Board: BG to highlight at Board.

CRR Ref: CN21 – Recruitment remains a challenge. HH will be investigating why people accept jobs, then decline. Ward 25 workforce issues have temporarily been resolved for the summer by seconding an Orthopaedic nurse for 3 months, and the Trust are looking into creative ways of recruiting to unpopular areas.

CRR Ref: MD8 – There is a radiology risk as the Scarborough MRI is poor quality and won't now be updated until November. The new cross-site on call rota will soon be agreed upon following retirement of one of the three SH radiologist.

The COO risk register was not circulated in the pack prior to the meeting, but was circulated at the meeting for information.

Patient Experience

HH informed the Committee the change in visiting times to 1-8pm has been introduced and as yet had not attracted any adverse feedback.

The Committee reviewed the Annual Complaints Report and Quarterly Patient Experience Report for Q1.

There has been a slight improvement in timeliness of response to complaints, and the Patient Experience team are now fully staffed.
Currently there is no admin support for Volunteers in Scarborough, but some hours will be allocated to address this issue. In York we have a volunteer admin which works well and we would like to try this in Scarborough.

The Safeguarding team have offered education and advice which is starting to have an impact on compliance with statutory requirements. Once this has embedded this will need to be audited again. In the meantime this will remain on the CN CRR.

HH noted some anomalies in the Trustwide Nursing Dashboard that she will investigate; the turnover for HCAs suddenly dropping to 1%; and the appraisal rate. This may be a data issue.
The Committee queried a very low RN fill rate on Cherry Ward and HH notified the Committee of a worrying issue that has just come to light; in that the budget ledger alignment to nursing establishments has not been kept up to date leading to a data quality issue.
Action: HH to investigate.

The Committee also noted that the community hospital vacancy rate for untrained staff has had a surge.
Action: HH to investigate for next meeting.

Quarterly Patient Experience report

The Committee asked if the Annual Complaints Report need to go to Board.
Action: HH to investigate.

Clinical Effectiveness

The Committee reviewed the 6 monthly Maternity Services report. LRoss reported lots of good practice: our stillbirth rate is lower than average and we can now use the excellent regional dashboard to see which Trusts are doing well in the regional dashboard and ask them for advice.
We have made progress with smoking cessation and breastfeeding rates in Scarborough. We are about to start a SKIP-IT programme where pregnant women receive text messages on how smoking effects their foetus. Significant differences still exist between York and Scarborough localities due to socio-economic factors.
We have made a successful bid for perinatal mental health support in York; Tees, Esk & Wear Valley Trust will provide the service. More women are requesting a birth debrief with an impact on the Trusts ability to provide this.
There will be expanding roles for midwives to support junior doctors.
Caesarian section rates are high and rising, reflective of high acuity in York.
There were a high number of 3rd and 4th degree tears and research has shown that episcissors reduce perineal trauma but our experience to date is not reflective of this. There will be an audit for impact. We can also request a recharge after using the episcissors so many times.
Action: HH to take highlights of Maternity Report to Board.
Assurance: The Committee appreciated and took assurance from the good report on data trends of adverse events.

Adult Inpatient survey

The survey has shown an improvement in noise at night, but a poor score on the discharge process. We need to look for themes to identify priorities. HR have been invited

to the Nursing and Midwifery Team meeting to discuss next steps and develop an action plan once a full evaluation has been undertaken.

Serious Incidents and Never Events
CRR Ref: MD8

JT led the Committee through the SI's included in the Medical Directors Report.

SI 2018/6350 - This SI highlighted the use of falls sensors, although JT explained that there were other factors involved in this case The Trust are currently auditing their usefulness and assurance of effectiveness. Issues of compatibility of falls sensors with new mattresses remain.

SI 2018/4600 – An incorrect dose of medication led to an Addisonian crisis.

Assurance: The Committee welcomed the additional of Duty of Candour information at the top of each SI. Variations in compliance with DoC across directorates were noted with Maternity being an exemplar area.

Antibiotic prescription audit

The audit showed marginal changes in performance, JT explained that the Trust started from a relatively good position making further improvements more challenging. EPMA is revealing risks we weren't aware of before in this area. We are working through the issues as we understand them, and making adjustments to the system. Specifically EPMA will need to evolve a way to enable duration of antibiotics to be flagged to enable prompt cessation.

Clinical Effectiveness Group Minutes

FJ reported that going forward this meeting will be split into two parts to improve clinical engagement: Trustwide business; and presenting own programmes/ sharing learning. The sharps audit showed that we are underreporting needle stick injuries via Datix; Occupational Health have had a reminder to report all incidents. Staff are asked to report but do not do so in many cases.
General and Acute Medicine are not currently reporting all incidents; only those resulting in serious harm. For lower grade incidents they respond in the moment, but do not report. FJ has negotiated with the Directorate to commit to report every incident for 1 week, and to scope the scale of underreporting. This will be adopted in other Directorates. The Committee expressed concern that the number of Datix reports has fallen in the last year – and that this is contrary to other Trusts and our objective of increased reporting. A refocus on this may be required. There is still a view in some areas that lack of feedback deters reporting.

RCEM Severe Sepsis & Septic Shock in Adults National Audit Quality Account 2016/17 Briefcase
This paper was presented to continue the Committee's increased scrutiny of the clinical audit process.

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The audit is based upon 2016 data and highlighted that additional work was required to achieve national standards, although improvements on the York site were evident compared to the previous year. The actions resulting from the Audit have been largely completed, and it is anticipated that further improvement will be seen in the 2017 data and going forward. The RCEM audit isn't completely aligned with CQUIN sepsis targets but the quarterly CQUIN data is more up to date and shows good progress. RH shared data from Quarter 4:
Screening 91%
Time to treatment 45%, and we are working with ED to improve this.
Assurance: The Committee took assurance from the Briefcase analysis and the action plan and subsequent improvements as strong evidence of a robust process for clinical audit.

Any other business

August Meeting

JT gave approval for Pete Wanklyn to attend re: mortality. There will be a shorter agenda next month

Mortality Report

The Mortality Report was not included in the papers, the Committee asked to review this in August.

Patient Safety Walkrounds

The Committee were pleased to see that the programme of walkrounds had resumed after the winter suspension. This month's reports have identified a lack of Wi-Fi for patients, FJ assured the Committee this would be rectified imminently following some delays due to GDPR issues. The Committee were very pleased that this longstanding patient experience issue is now resolved.

NHSI

HH noted NHSI have produced new guidance which will change the way pressure ulcers are to be reported; this may result in an increase in reportable SIs.

Drug administration

There has been a spike in insulin errors in York.
Action: RH to investigate

NED

This will be LR's last meeting and the Committee thanked her for her hard work and support both as previous Chair and long serving member.

Next meeting of the Quality and Safety Committee: 21 August 2018, Ophthalmology Room, York Hospital

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Quality & Safety Committee – Action Plan – July 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, Oct 18, 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	
82	Apr 18	Bowel Cancer and Sepsis Briefcases and final reports to be reviewed by the Committee	FJ	May 18 Bowel Cancer Jun 18 Sepsis Jul 18	
88	May 18	Audits for review; Sentinel Stroke Audit National Cardiac Arrest Audit A local audit Paediatric Diabetes Audit	FJ	 Aug 18 Sept 18 Oct 18 Nov 18	
89	May 18	NCEPOD Report to be included in the Medical Directors Report	JT & FJ	June 18 July 18	
92	May 18	To review the Scarborough 14 hour review threshold in the data pack	JT FJ	June 18 July 18	
93	Jun 18	To share SafeCare with board under patient experience	BG	August 18	
94	Jun 18	Update the Committee on the number of 3rd and 4th degree tears in Maternity	BG	July 18	
95	Jun 18	Feedback from the EPMA Board	JT	Jul 18	
96	Jun 18	Mortality Report to come to the Committee for review	JT	Aug 18	
97	Jun 18	SI to come to the Committee for review on a six monthly basis – to add to work plan	LP	Jul 18	

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York Teaching Hospital NHS
NHS Foundation Trust

Patient Safety and Quality Performance Report

July 2018

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

Patient Safety & Quality Performance Report
Chapter Index

Chapter	Sub-Section
Quality & Safety	Quality & Safety Chapter Index
	Quality & Safety Index
	Quality & Safety Summary
	Litigation
	Duty of Candour
	Patient Experience
	Care of the Deteriorating Patient
	Measures of Harm
	Never Events
	Drug Administration
	Mortality
	Patient Safety Walkrounds
	Maternity Dashboards
	Community Hospitals Summary
	Quality and Safety Miscellaneous
	Quantitative Information Report

Quality and Safety Summary: Trust

Patient Experience	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Litigation - Clinical Claims Settled	-	-	6	2	5	2	5	2	2	3	4	7	8	4
Complaints	-	-	51	43	50	38	37	27	28	31	35	30	43	26

Duty of Candour	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Incident Graded Moderate or Above	-	-	13	12	16	8	19	23	21	15	18	14	16	7
Verbal Apology Given	-	-	12	7	11	8	14	12	9	6	13	7	7	3
Written Apology Required	-	-	11	11	14	7	14	15	8	12	11	9	12	7
Written Apology Given	-	-	7	8	9	7	4	3	4	3	4	2	2	1

Care of the Deteriorating Patient	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
14 hour Post Take - York	82%	Q1 82% Q2 82% Q3 85% Q4 90%	91%	89%	91%	92%	89%	92%	94%	90%	90%	90%	88%	91%
14 hour Post Take - Scarborough	52%	Q1 52% Q2 60% Q3 70% Q4 80%	80%	74%	74%	73%	73%	72%	77%	75%	83%	74%	76%	77%
Acute Admissions seen within 4 hours	80%	80%	93%	86%	92%	86%	90%	87%	89%	87%	89%	88%	86%	88%
NEWS within 1 hour of prescribed time	90%	90%	89.0%	88.8%	88.2%	90.2%	90.3%	89.0%	88.3%	89.1%	88.6%	85.1%	90.5%	90.5%
All Elective patients to have an Expected Discharge Date (EDD) recorded within 24 hours of admission	93%	93%	84%	88%	84%	87%	84%	84%	90%	88%	91%	86%	86%	86%

Measures of Harm	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Serious Incidents	-	-	14	12	8	16	10	12	22	22	26	19	9	11
Incidents Reported	-	-	1323	1213	1269	1257	1248	1327	1430	1222	1359	1272	1273	1190
Incidents Awaiting Sign Off	-	-	868	832	766	733	684	892	900	883	837	656	553	666
Patient Falls	-	-	218	216	268	223	258	292	302	264	236	240	234	260
Pressure Ulcers - Newly Developed	-	-	113	97	107	101	104	132	149	122	152	110	107	136
Pressure Ulcers - Transferred into our care	-	-	82	60	77	68	51	71	71	62	80	87	90	88
Degree of harm: serious or death	-	-	2	1	7	2	7	8	13	6	7	10	5	1
Degree of harm: medication related	-	-	160	128	128	161	171	191	166	130	130	111	136	122
VTE risk assessments	95%	95%	97.6%	97.9%	97.7%	98.3%	98.7%	98.0%	98.2%	97.7%	98.0%	97.4%	98.2%	98.0%
Never Events	0	0	1	1	0	1	0	0	0	0	0	0	0	0

Drug Administration	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Insulin Errors	-	-	12	9	11	11	9	15	9	11	13	8	12	14
Prescribing Errors	-	-	40	24	32	45	65	95	67	31	46	27	35	34
Preparation and Dispensing Errors	-	-	24	7	13	16	18	5	11	8	15	12	12	15
Administrating and Supply Errors	-	-	58	62	54	70	54	62	49	65	47	41	60	42

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	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard Authorisation Status Unknown: Local Authority not informed the Trust of outcome	-	-	16	20	7	4	5	6	11	5	3	1	0	42
Standard Authorisation Not Required: Patient no longer in Trust's care and within 7 day self-authorisation	-	-	7	11	9	11	8	11	13	9	14	13	25	10
Under Enquiry: Safeguarding Adults team reviewing progress of application with Local Authority or progress with ward	-	-	0	0	0	0	0	0	3	7	6	1	17	32
Standard Authorisation Granted: Local Authority granted application	-	-	0	0	2	0	0	0	1	0	0	3	1	0
Application Not Granted: Local Authority not granted application	-	-	0	0	0	1	0	0	1	0	0	0	0	0
Application Unallocated as Given Local Authority Prioritisation: Local Authority confirmed receipt but not yet actioned application	-	-	0	0	0	2	4	1	0	0	1	0	0	0
Safeguarding Adults concerns reported to the Local Authority against the Trust	-	-	4	4	5	1	1	3	6	2	3	3	4	5
Application Withdrawn: Patient no longer in Trust's care within the Local Authority 8 week period for assessment	-	-	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	10	7	0

Infection Prevention	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Clostridium Difficile - meeting the C.Diff objective			2	3	5	7	4	3	5	4	3	4	7	6
CDIFF Cumulative Threshold	48 (year)	48 (year)	16	20	24	28	32	36	40	44	48	4	10	17
Clostridium Difficile - meeting the C.Diff objective - cumulative			11	14	19	26	30	33	38	42	45	4	11	17
MRSA - meeting the MRSA objective	0	0	0	3	1	0	0	0	0	0	0	1	0	1
MSSA	30	2	5	6	3	3	3	4	2	0	0	2	0	2
MSSA - cumulative			18	24	27	30	33	37	39	39	39	2	2	4
ECOLI			4	7	3	8	8	13	12	2	7	4	2	4
ECOLI - cumulative			27	34	37	45	53	66	78	80	87	4	6	10
MRSA Screening - Elective	95%	95%	85.2%	87.9%	81.7%	88.1%	89.6%	85.4%	87.7%	84.6%	86.4%	86.4%	90.2%	88.2%
MRSA Screening - Non Elective	95%	95%	88.2%	89.5%	88.3%	89.6%	90.3%	87.5%	85.9%	86.7%	86.4%	88.2%	90.4%	90.5%

Stroke (one month behind due to coding)	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%	75%	62.5%	62.5%	73.7%	94.7%	54.5%	85.7%	93.8%	93.3%	93.1%	90.9%	75.0%	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%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1 month behind

	SSNAP Scores		Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17- Mar 18	Apr-18	May-18	Jun-18
Proportion of patients spending >90% on their time on stroke unit	85%	85%	83.4% (C)	90.5% (A)	90.6% (A)	92.5% (A)	91.8% (A)	95.7% (A)
Scanned within 1 hour of arrival	43%	43%	44.2% (B)	51.8% (A)	48.6% (A)	50.9% (A)	65.9% (A)	58.4% (A)
Scanned within 12 hours of hospital arrival	90%	90%	92.1% (B)	92.6% (B)	92.2% (B)	94.7% (B)	96.6% (A)	98.7% (A)

AMTS	Target/ Threshold 2018/19	Monthly Target/ Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
AMTS Screening	90.0%	90.0%	81.7%	80.5%	82.0%	82.8%	83.4%	80.3%	78.4%	81.7%	75.8%	77.2%	78.8%	81.9%

Patient Experience
(Patient Experience Team)

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

The inpatient satisfaction rate in May 2018 remains stable at 96.7%, slightly higher than the national average for April at 96%. The ED satisfaction rate was 87%, which was at its highest in November 2017 at 90.8%. Scarborough ED satisfaction has increased by 5% from March 2018 to 83% in May whilst York ED has sustained the 85% from March. The ED national average was 87% in April. The narratives for both York and Scarborough ED's show the biggest theme continues to be waiting times. Also for York, themes included lack of communication about waiting times and prioritising children.

The inpatient response rate in May 2018 was 28.6%, the highest since October 2017, and higher than the national average of 24.9%.
The ED response rate was 10.8%, nearly 2% lower than the previous month and the national average of 12.9%.

Complaints and PALS Management - June 2018

26 new complaints were received and 9 cases were reopened for further investigation. 32% of complaint cases closed in May met the Trust's 30 day response target. This is above the 2017-18 annual average of 27%. Nine cases were addressed using the next working day process, resulting in a quick resolution for the complainant.
Patient Experience provides the Chief Nurse, Deputy Chief Nurse and Directorate Managers with directorate-level performance reports.

The PALS actively dealt with 164 enquiries, comments and concerns. The team also had 145 queries that were not formally logged.
74% of PALS cases were closed within the target timescale of 10 working

Measures of Harm

No Never Events were declared in June 2018.

11 Serious Incidents were declared; 8 at York, 1 at Scarborough and 2 in Community. 4 of the SIs were attributed to Clinical Incidents, 4 were attributed to Slips, Trips and Falls and 3 were attributed to Pressure Ulcers.

Infection Prevention

In June the Trust reported one case of MRSA at York. This remains a zero tolerance measure in 2018/19.

In June 2018 the Trust reported 6 cases of CDIFF; all at York. The yearly threshold for 2018/19 remains at 48, monthly allocation allows for 4 cases.

2 cases of MSSA were reported in June at Scarborough.

4 cases of ECOLI were reported in June, all at York.

Quality and Safety - Miscellaneous

Stroke (TIA target reported 1 month behind due to coding)
In June the Trust achieved an 'A' rating for the proportion of patients spending > 90% of their time on a stroke unit, patients scanned within 1 hour and patients scanned within 12 hours of arrival. In May the 75% target was met for TIA patients assessed within 24 hours (75%).

Cancelled Operations
89 operations were cancelled within 48 hours of the TCI date in June. This is a 56% increase on June 2017 when 57 operations were cancelled.

Cancelled Clinics/Outpatient Appointments
145 clinics were cancelled with less than 14 days notice; this figure is comparable to June 2017 (147) and is below the monthly threshold of 180. 885 outpatient hospital appointments were cancelled for non clinical reasons which is a 6% decrease on June 2017 (942).

Ward Transfers between 10pm and 6am
71 ward transfers between 10pm and 6am were reported in June, the threshold is 100 threshold per month. This is an 18% increase on June 2017 when 60 transfers occurred.

AMTS
The Trust failed to achieve the 90% target for AMTS screening in June, performance was 81.89%. The Trust has failed to achieve target since January 2017.

Care of the Deteriorating Patient

The target was achieved for the proportion of Medicine and Elderly patients receiving a senior review within 14 hours in June. York achieved 91.06% against the 82% target for Q1. Scarborough achieved 76.55% against the 52% target for Q1.

90.5% of patients had their NEWS scores completed within 1 hour in June against the Trust's internal target of 90%, passing its target for the second consecutive time in the last six months. Scarborough achieved a performance of 93.1%, York achieved 88.8%.

85.9% of Elective patients had their Expected Date of Discharge recorded within 24 hours of admission across the Trust in June. 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

14 insulin errors were reported in June, including 9 for York, 3 for Scarborough and 2 for Community.

34 prescribing errors were reported across the Trust in June, with 23 for York, 9 for Scarborough and 2 for Community.

15 dispensing errors were reported across the Trust in June. The number of dispensing errors was 9 at York, 5 at Scarborough and 1 in Community. In York numbers remain higher than the reduction seen in December 2017 when a total of 5 errors were made. In Scarborough an increase in errors was seen in March 2018, when a total of 9 errors were made, but numbers have now reduced.

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.

161 inpatient deaths were reported across the Trust in June; 108 were reported at York and 48 were reported at Scarborough.

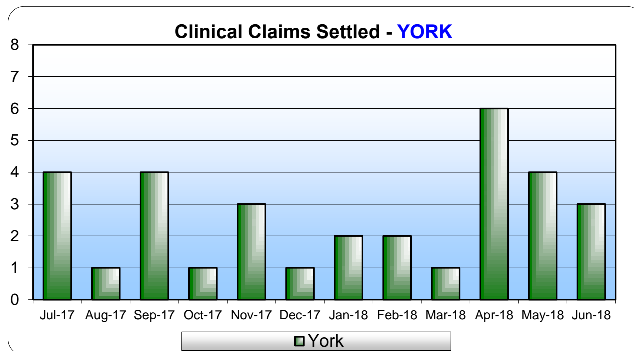
9 deaths in ED were reported in June; 7 at York and 2 at Scarborough.

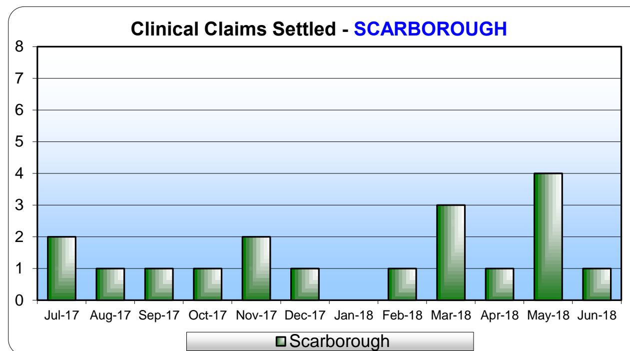
CQUINS update (Operations Team)

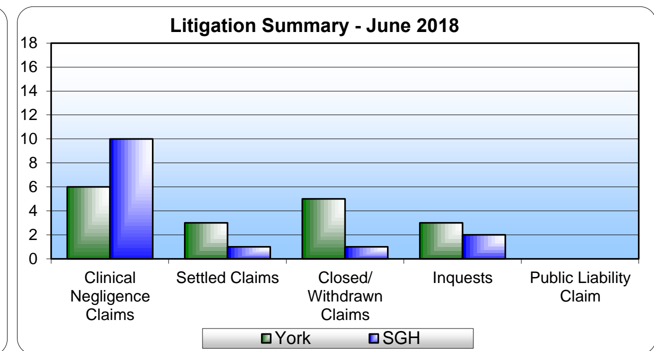
The Trust is currently collating evidence reports to show compliance against 2018/19 Q1 CQUINs, please refer to CQUINS page 4 for details.

Litigation

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



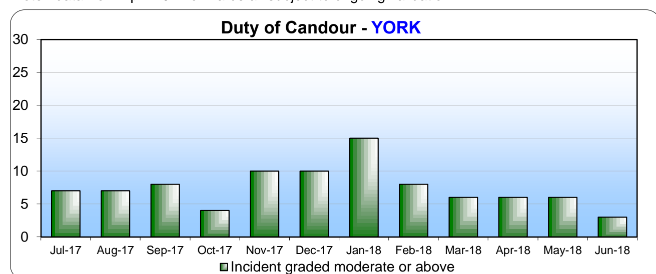


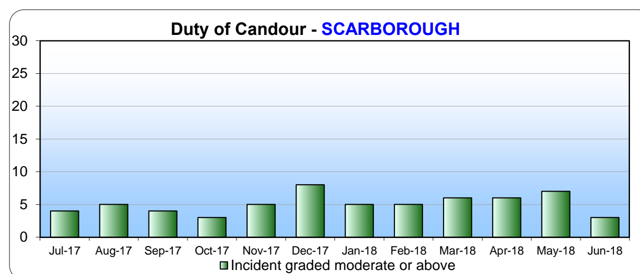


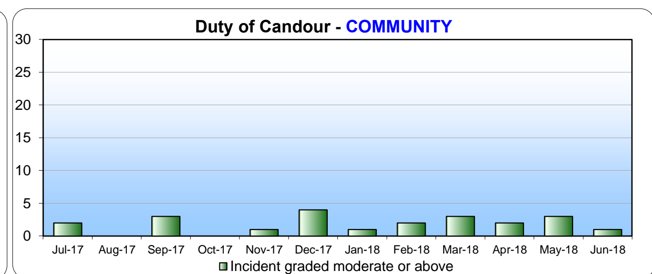
Duty of Candour

Indicator	Site	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Incident graded moderate or above	York	7	7	8	4	10	10	15	8	6	6	6	3
Verbal apology given		7	3	6	4	8	5	7	3	4	1	2	1
Written apology required		5	6	7	4	8	6	10	8	5	5	5	3
Written apology given		3	4	5	4	3	1	5	2	3	0	1	1
Incident graded moderate or above	Scarborough	4	5	4	3	5	8	5	5	6	6	7	3
Verbal apology given		3	4	1	3	4	5	3	4	5	4	5	1
Written apology required		3	5	4	3	4	7	3	4	5	3	5	3
Written apology given		3	4	1	3	1	1	1	0	2	1	1	0
Incident graded moderate or above	Community	2	0	3	0	1	4	1	2	3	2	3	1
Verbal apology given		2	0	3	0	1	1	0	1	1	2	0	1
Written apology required		2	0	3	0	1	3	1	2	2	1	2	1
Written apology given		1	0	3	0	1	0	0	1	1	1	0	0

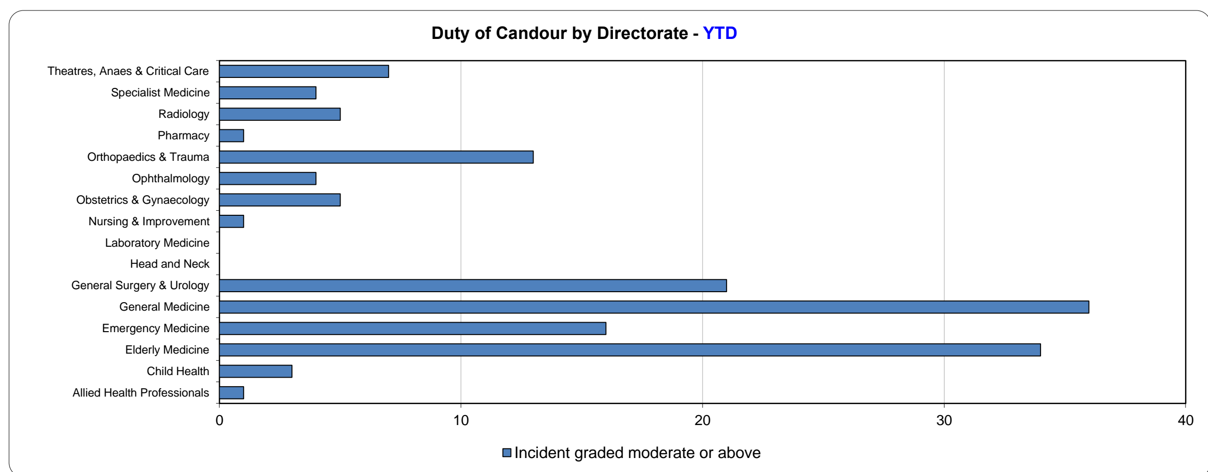
Note: data from April 2017 onwards all subject to ongoing validation.







Specialty	Indicator - YTD		
	Verbal apology given	Written apology required	Written apology given
Allied Health Professionals	1	0	0
Child Health	2	3	2
Elderly Medicine	19	26	12
Emergency Medicine	10	13	6
General Medicine	18	29	5
General Surgery & Urology	16	18	6
Head and Neck	0	0	0
Laboratory Medicine	0	0	0
Nursing & Improvement	1	0	0
Obstetrics & Gynaecology	5	5	5
Ophthalmology	3	4	4
Orthopaedics & Trauma	6	10	2
Pharmacy	1	1	1
Radiology	3	3	2
Specialist Medicine	3	4	1
Theatres, Anaesthetics & Critical Care	5	4	3



Patient Experience

PALS Contacts
There were 231 PALS contacts in June

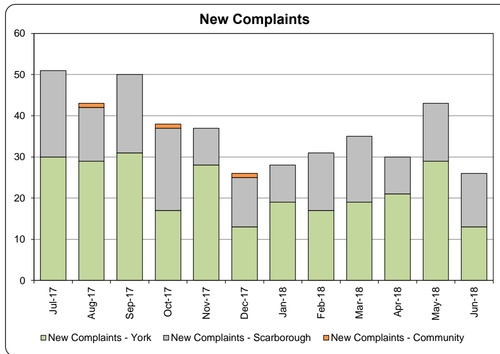
Complaints
There were 26 complaints in June

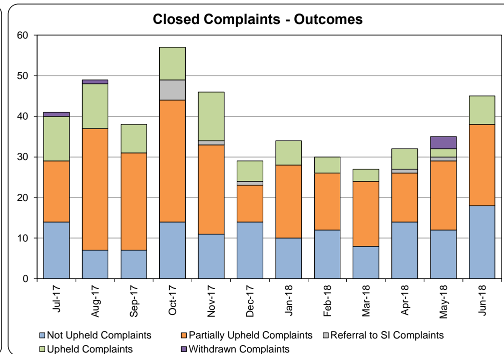
New Ombudsman Cases
There were no new Ombudsman Cases in June

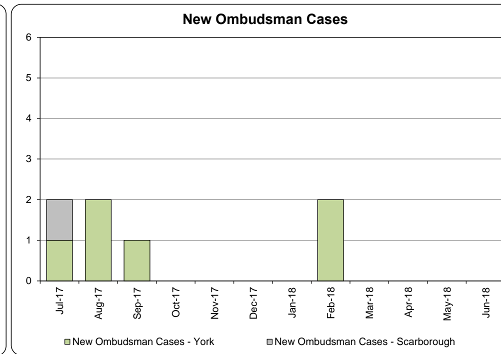
Compliments
509 compliments were received in June 2018. The number of compliments per month peaked in September 2017 with 1,519 being received. During Quarter 4 17/18 the number of compliments received was 1,854, compared to 2,092 for Quarter 3 17/18.

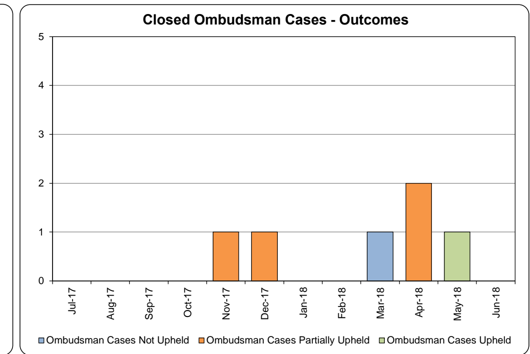
Patient Experience

Jul-18



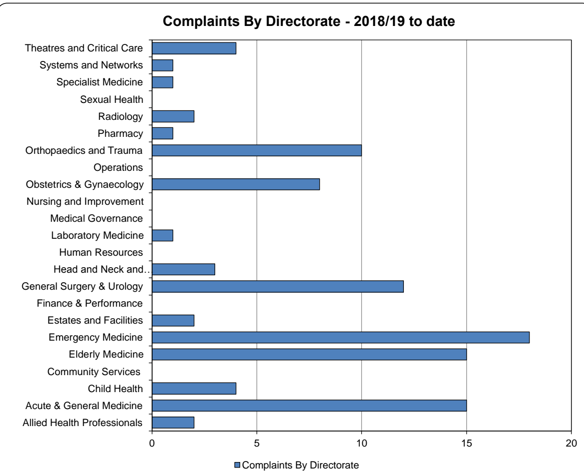






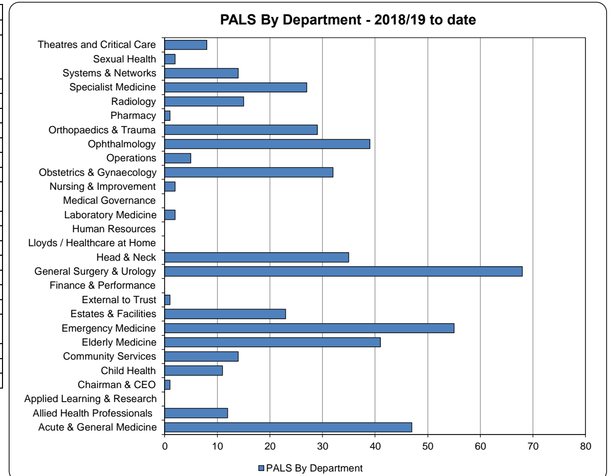
Complaints By Subject	Jun-18	YTD
Access to treatment or drugs	0	3
Admissions, Discharge and Transfer Arrangements	8	24
All aspects of Clinical Treatment	26	79
Appointments, Delay/Cancellation	0	6
Commissioning	0	0
Comms/info to patients (written and oral)	14	39
Complaints Handling	0	0
Consent	1	2
End of Life Care	0	2
Facilities	2	7
Mortuary	0	0
Others	0	0
Patient Care	16	54
Patient Concerns	0	3
Prescribing	3	7
Privacy and Dignity	7	22
Restraint	0	0
Staff Numbers	0	0
Transport	0	0
Trust Admin/Policies/Procedures	4	10
Values and Behaviours (Staff)	12	32
Waiting times	2	8
TOTAL	**95**	**298**

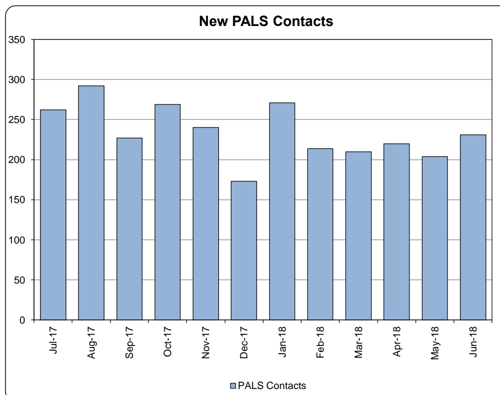
The number of complaints/PALs contacts by subject is greater than the total number of complaints because each subject within the complaint can be identified as opposed to just the one deemed to be the 'primary'.

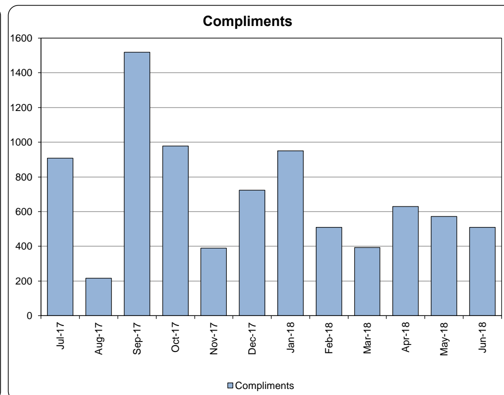


PALS By Subject	Jun-18	YTD
Access to Treatment or Drugs	14	47
Admissions and Discharges (Excluding Delayed Discharge due to absence of care package)	10	34
Appointments	30	86
Clinical Treatment	31	89
Commissioning	0	2
Communication	47	109
Consent	0	2
End of Life Care	4	6
Facilities	7	23
Integrated Care (including Delayed Discharge Due to Absence of a Care Package	0	1
Mortuary	0	0
Patient Care	9	48
Patient Concerns	2	16
Prescribing	1	11
Privacy, Dignity & Respect	3	9
Staff Numbers	28	31
Transport	0	0
Trust Admin/Policies/Procedures Inc. pt. record management	11	35
Values and Behaviours (Staff)	28	88
Waiting Times	6	18
Total	**231**	**655**

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.

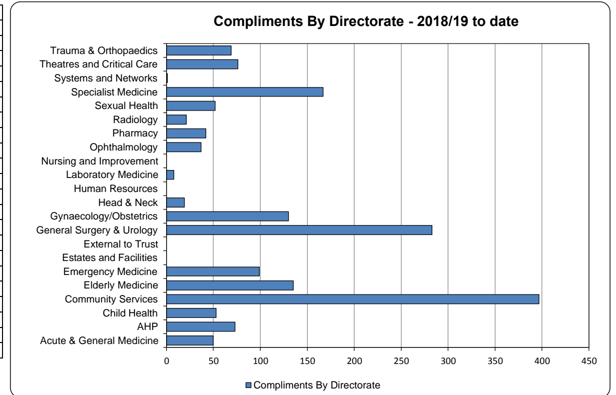






Compliments By Directorate	Jun-18	YTD
Acute & General Medicine	26	50
AHP	13	73
Child Health	10	53
Community Services	96	397
Elderly Medicine	56	135
Emergency Medicine	35	99
Estates and Facilities	0	0
External to Trust	0	0
General Surgery & Urology	123	283
Gynaecology/Obstetrics	42	130
Head & Neck	5	19
Human Resources	0	0
Laboratory Medicine	6	8
Nursing and Improvement	0	0
Ophthalmology	35	37
Pharmacy	13	42
Radiology	2	21
Specialist Medicine	29	167
Systems and Networks	0	1
Theatres and Critical Care	5	76
Trauma & Orthopaedics	5	69
Total	**509**	**1712**

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



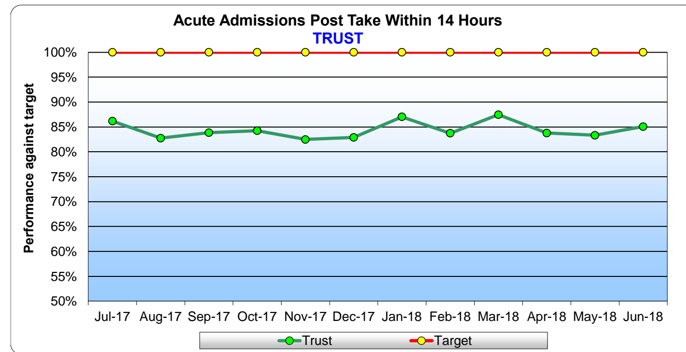
Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

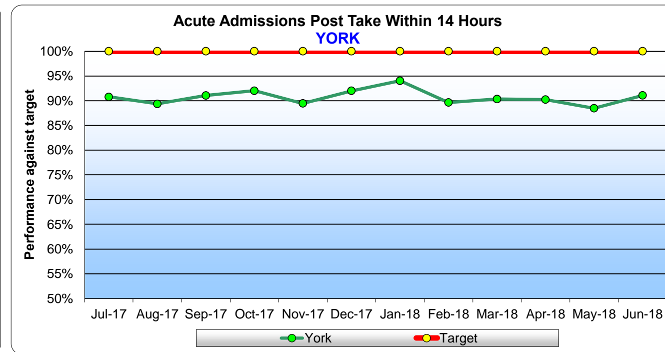
Please note: scales on graphs may be different.

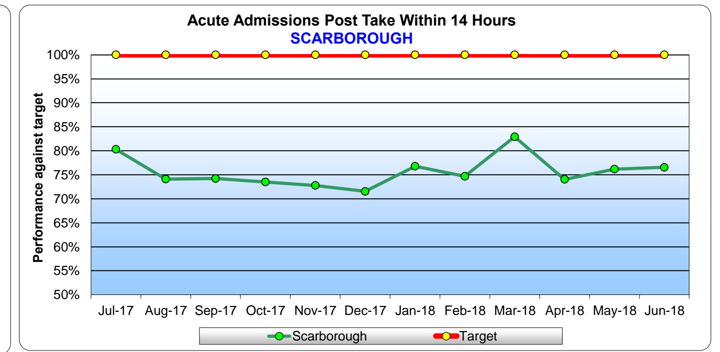
York Teaching Hospital NHS Foundation Trust

Quality and Safety: Care of the Deteriorating Patient

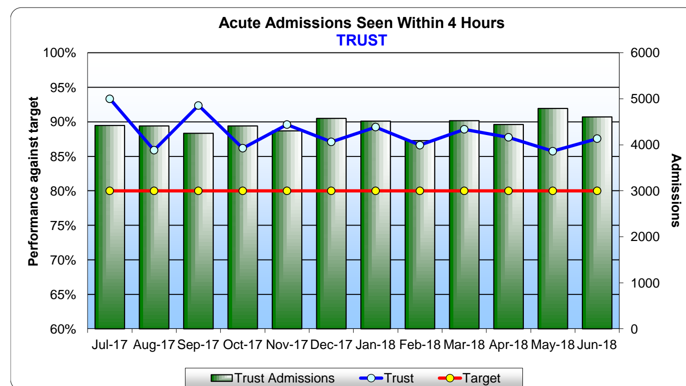
Indicator	Consequence of Breach (Monthly unless specified)	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr	May	Jun
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival (YORK) - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	91%	90%	91%	91%	90%	88%	91%
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%	74%	76%	77%

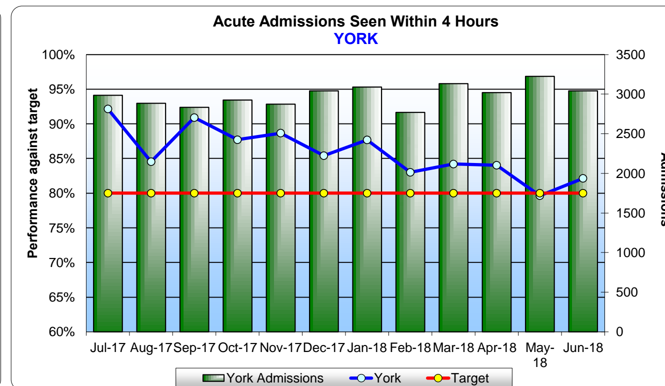


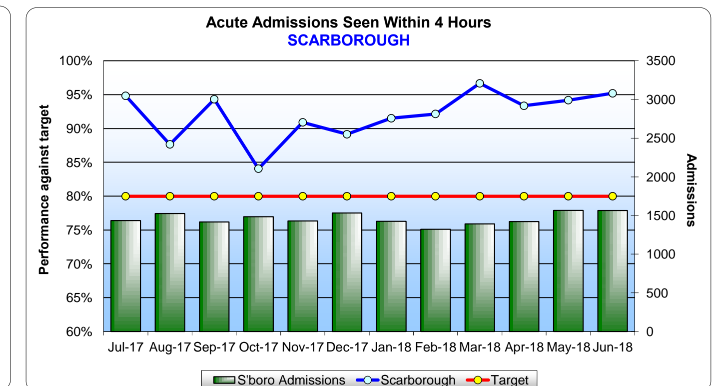




Indicator	Consequence of Breach	Target	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr	May	Jun
Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI	**80% by site**	84.4%	90.5%	87.6%	88.3%	87.8%	85.7%	87.6%



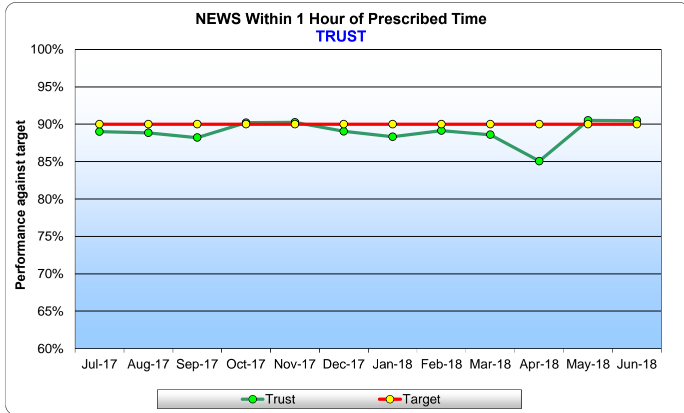


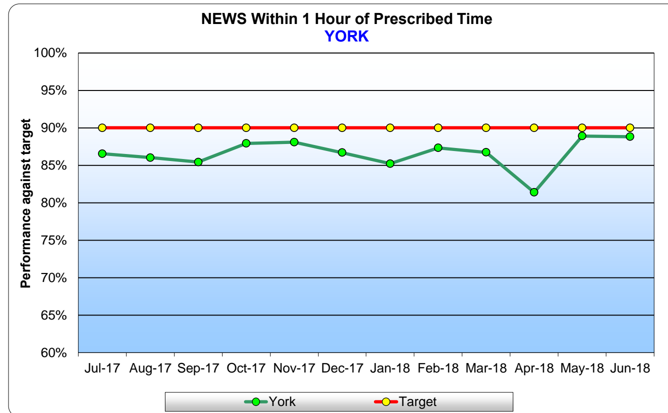


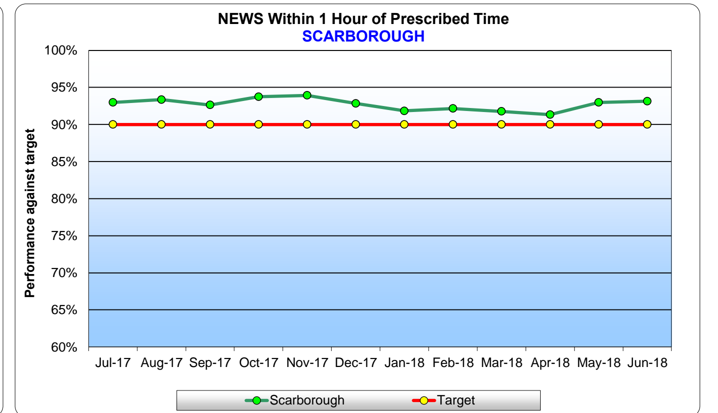
York Teaching Hospital NHS
NHS Foundation Trust

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	Apr	May	Jun
NEWS within 1 hour of prescribed time	None - Monitoring Only	88.7%	88.7%	89.8%	88.7%	85.1%	90.5%	90.5%







Quality and Safety
Information Team
Systems and Network Services

Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 11 SIs reported in June; York 8, Scarborough 1, Community 2.

Patients Falls and Found on Floor (source: Datix)
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During June there were 170 reports of patients falling at York Hospital, 70 patients at Scarborough and 20 patients within the Community Services (260 in total).

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during June was 1,190; 718 incidents were reported on the York site, 319 on the Scarborough site and 153 from Community Services.

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 666 incidents awaiting sign-off by the Directorate Management Teams.

Pressure Ulcers (source: Datix)
During June 60 pressure ulcers were reported to have developed on patients since admission to York Hospital, 31 pressure ulcers were reported to have developed on patients since admission to Scarborough and 45 pressure ulcers were reported as having developed on patients in our community hospitals or community care. These figures should be considered as approximations as not all investigations have been completed.

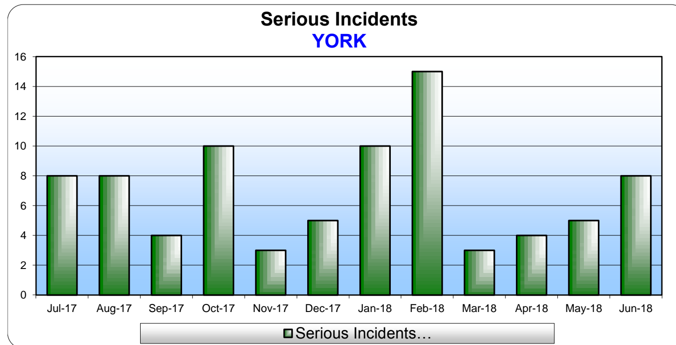
Degree of Harm: Serious/Severe or Death (source: Datix)
During June 1 patient incident was reported which resulted in serious or severe harm or death. Numbers are subject to change as levels of harm are reviewed and investigations are completed.

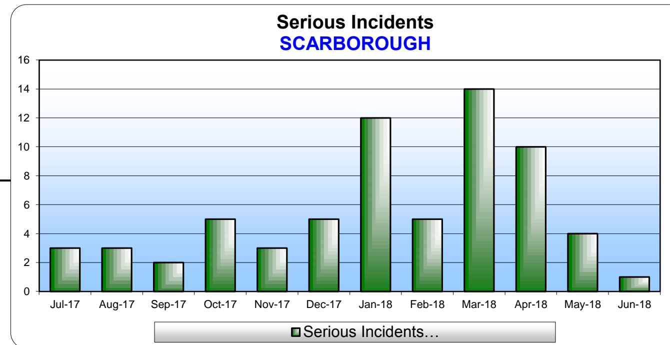
Medication Related Issues (source: Datix)
During June there were a total of 122 medication related incidents reported although this figure may change following validation.

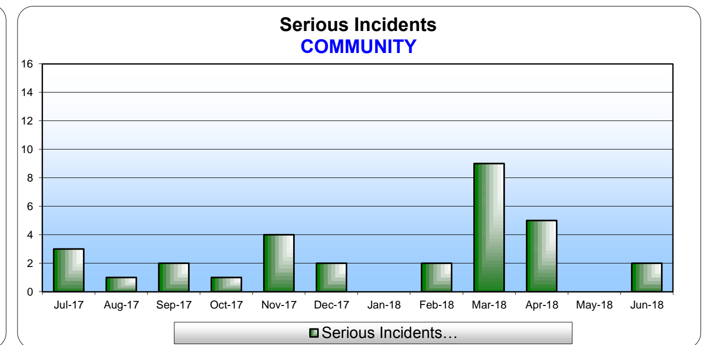
Never Events – No Never Events were declared during June.

Measures of Harm

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

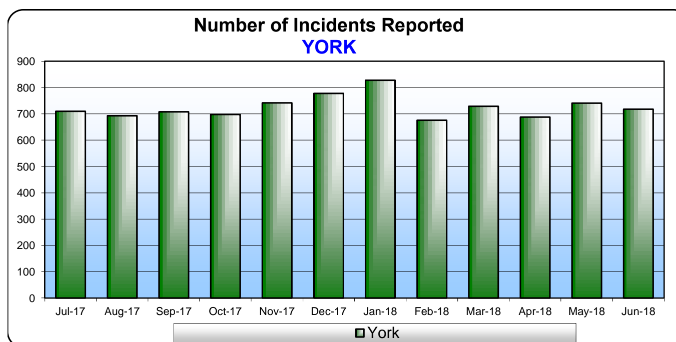


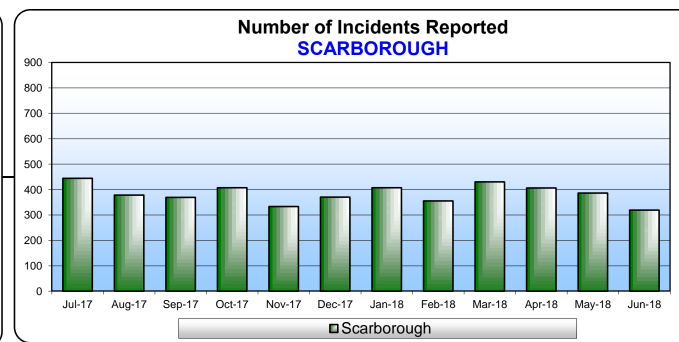


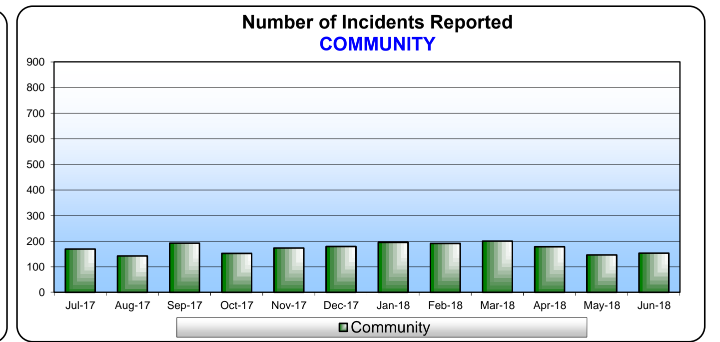


Note - 12 Hour breaches are listed as Operations for the Directorate Investigating (although the location is ED).

Indicator		Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Number of Incidents Reported source: Risk and Legal	York	710	693	708	698	742	778	828	676	729	688	741	718
	Scarborough	444	378	369	407	333	370	407	355	430	406	386	319
	Community	169	142	192	152	173	179	195	191	200	178	146	153
Number of Incidents Awaiting sign off at Directorate level		868	832	766	733	684	892	900	883	837	656	553	666

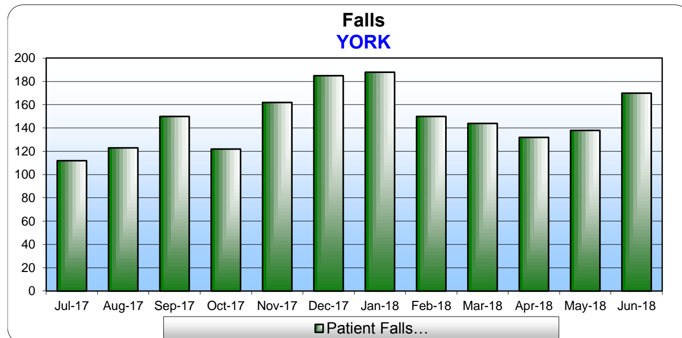


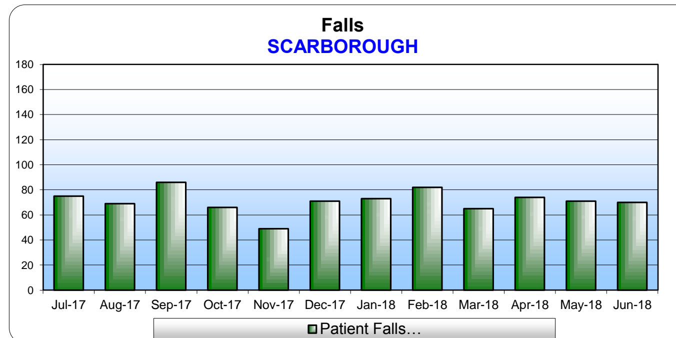


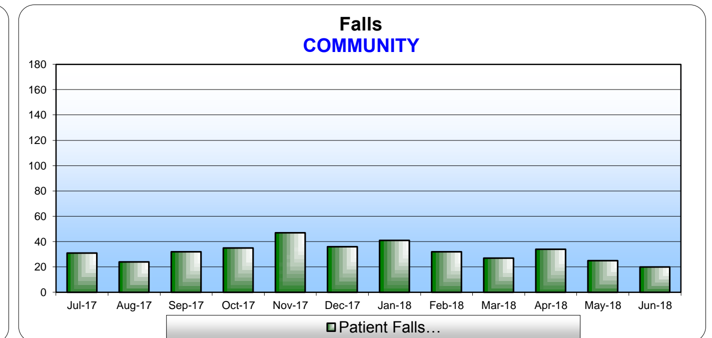


Measures of Harm

Indicator		Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Patient Falls source: DATIX	York	112	123	150	122	162	185	188	150	144	132	138	170
	Scarborough	75	69	86	66	49	71	73	82	65	74	71	70
	Community	31	24	32	35	47	36	41	32	27	34	25	20

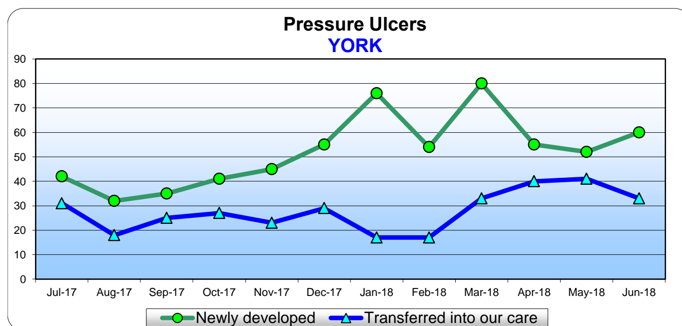


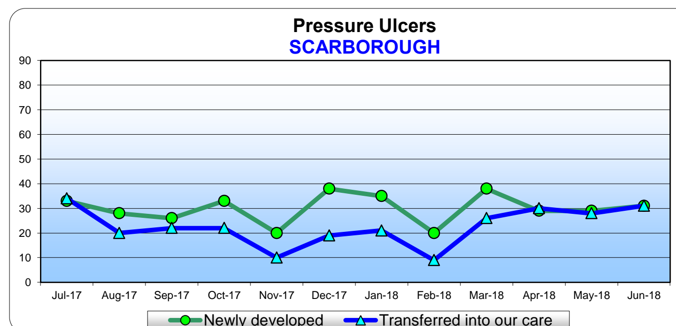


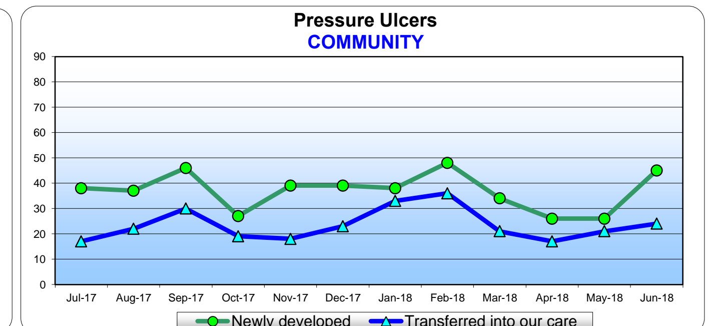


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.
Increases in the number of falls in January 17 and December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

Indicator			Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Pressure Ulcers source: DATIX	York	Newly developed	42	32	35	41	45	55	76	54	80	55	52	60
		Transferred into our care	31	18	25	27	23	29	17	17	33	40	41	33
	Scarborough	Newly developed	33	28	26	33	20	38	35	20	38	29	29	31
		Transferred into our care	34	20	22	22	10	19	21	9	26	30	28	31
	Community	Newly developed	38	37	46	27	39	39	38	48	34	26	26	45
		Transferred into our care	17	22	30	19	18	23	33	36	21	17	21	24



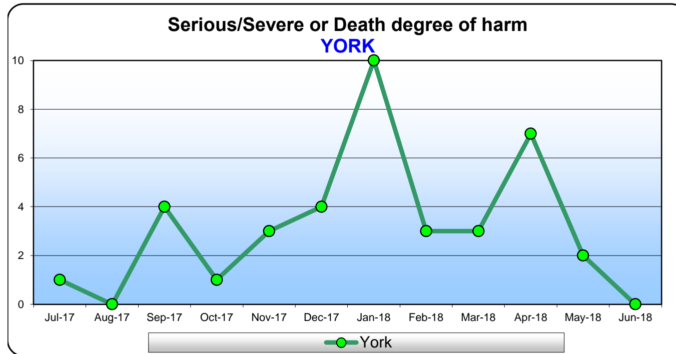


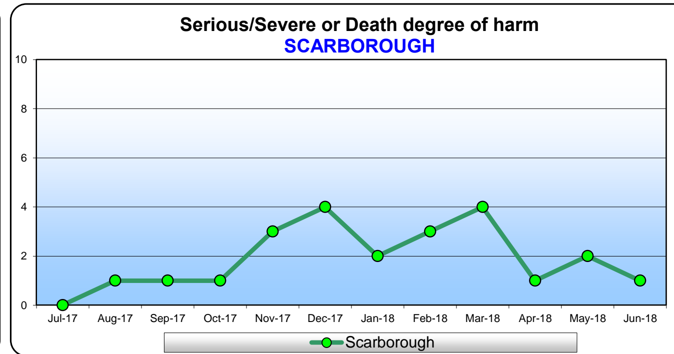


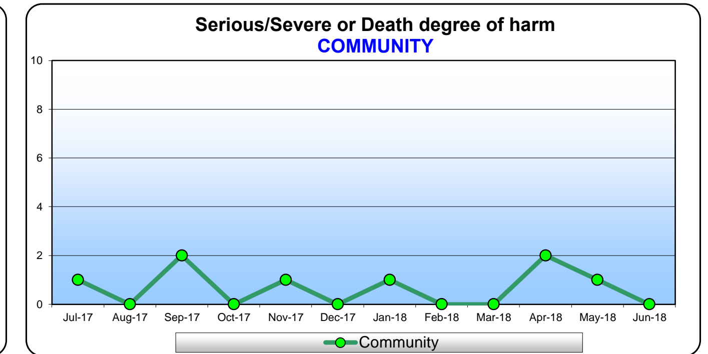
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised 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		Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Degree of harm: serious/severe or death source: Datix	York	1	0	4	1	3	4	10	3	3	7	2	0
	Scarborough	0	1	1	1	3	4	2	3	4	1	2	1
	Community	1	0	2	0	1	0	1	0	0	2	1	0



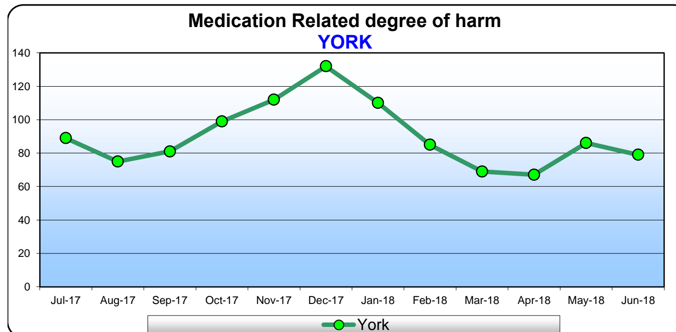


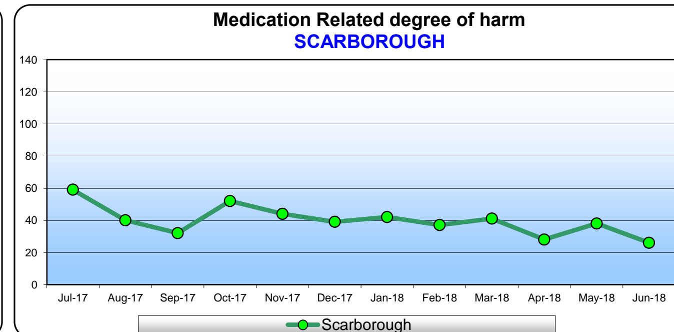


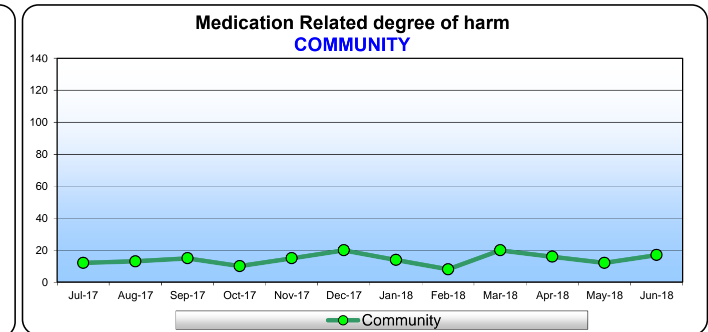
Note: data from October 2016 onwards all subject to ongoing validation

Indicator		Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Degree of harm: Medication Related Issues source: Datix	York	89	75	81	99	112	132	110	85	69	67	86	79
	Scarborough	59	40	32	52	44	39	42	37	41	28	38	26
	Community	12	13	15	10	15	20	14	8	20	16	12	17

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.



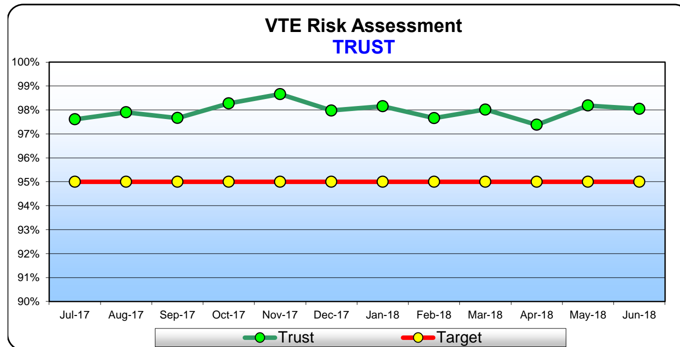


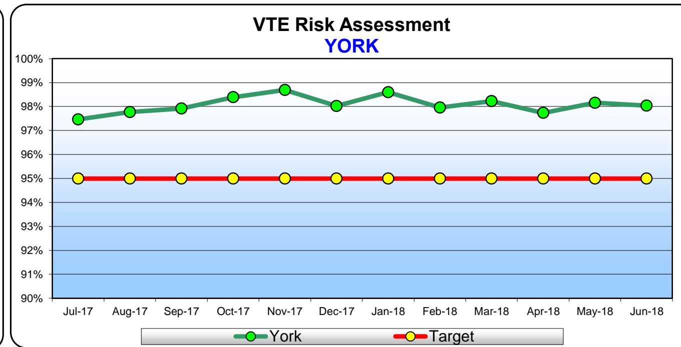


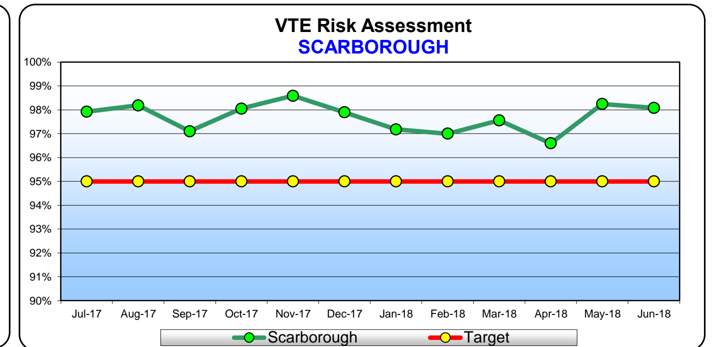
York Teaching Hospital NHS
NHS Foundation Trust

Measures of Harm

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







Never Events

Indicator	Consequence of Breach	Threshold	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr	May	Jun
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

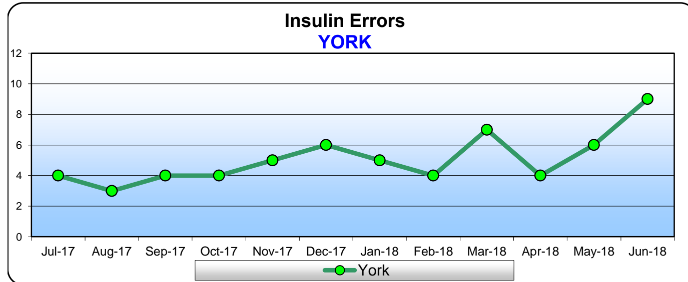
Prescribing Errors
There were 34 prescribing related errors in June; 23 from York and 9 from Scarborough and 2 from Community.

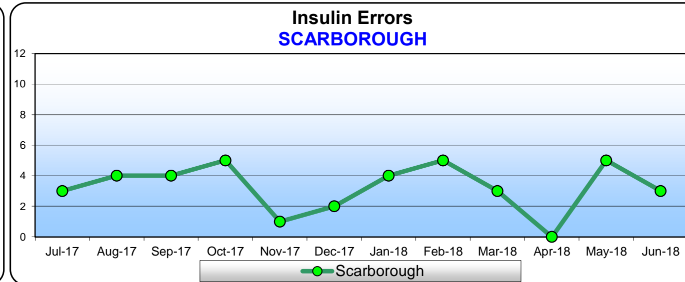
Preparation and Dispensing Errors
There were 15 preparation/dispensing errors in June; 9 from York, 5 from Scarborough and 1 from Community.

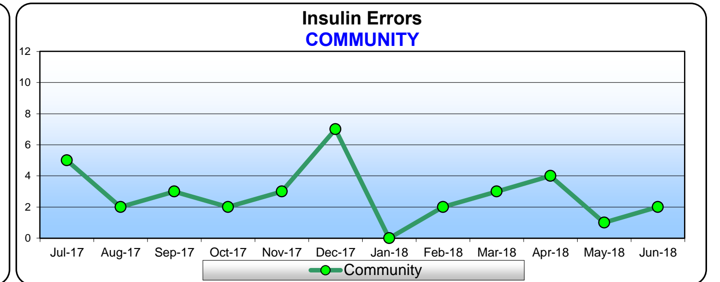
Administrating and Supply Errors
There were 42 administrating/supplying errors in June; 27 were from York, 8 from Scarborough and 7 from Community.

Drug Administration

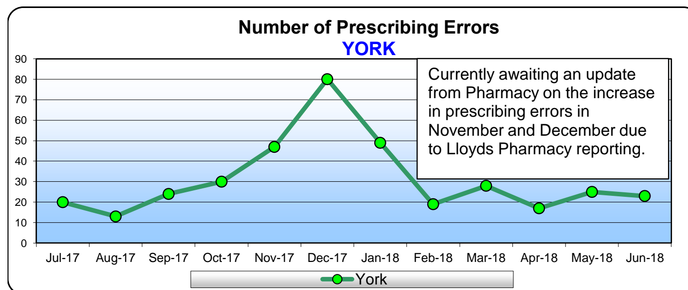
Indicator		Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Insulin Errors source: Datix	York	4	3	4	4	5	6	5	4	7	4	6	9
	Scarborough	3	4	4	5	1	2	4	5	3	0	5	3
	Community	5	2	3	2	3	7	0	2	3	4	1	2

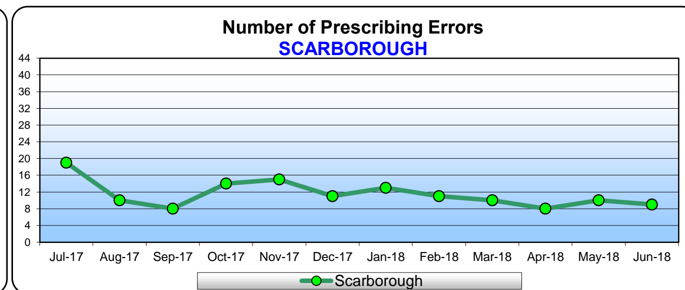


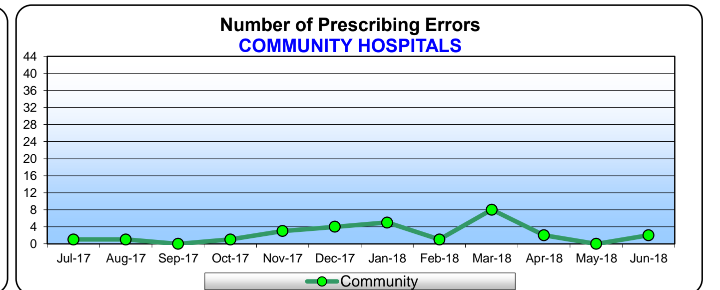




Indicator		Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Number of Prescribing Errors source: Datix	York	20	13	24	30	47	80	49	19	28	17	25	23
	Scarborough	19	10	8	14	15	11	13	11	10	8	10	9
	Community Hospitals	1	1	0	1	3	4	5	1	8	2	0	2

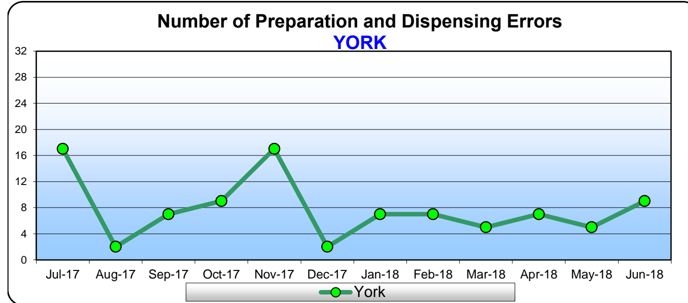


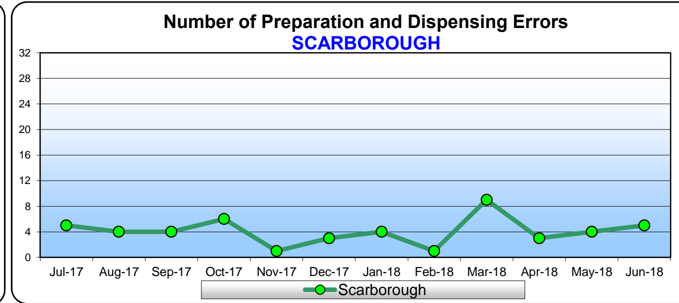


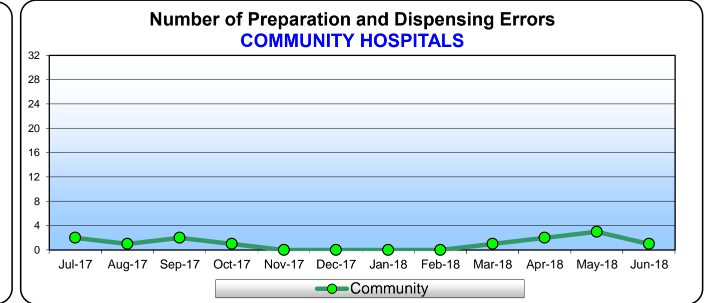


Drug Administration

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

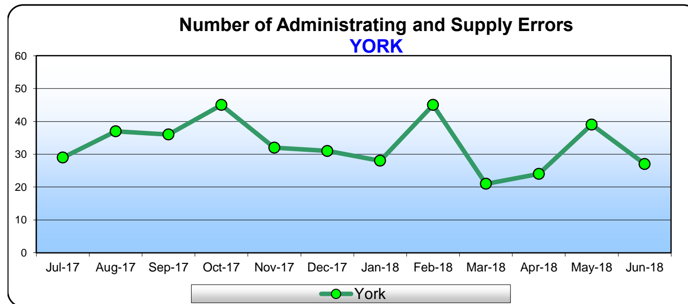


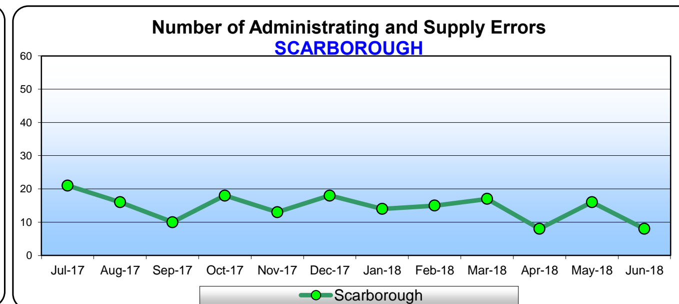


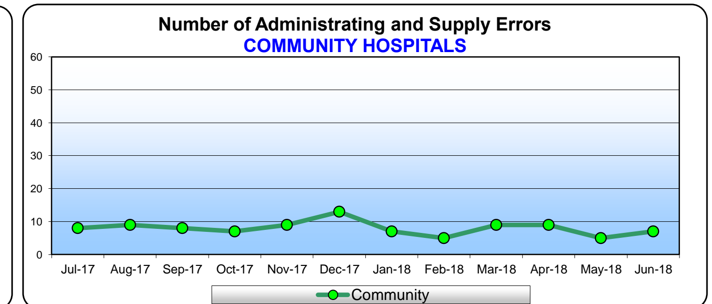


Note re increase in Dispensing Errors - Healthcare at Home have recently experienced a high turnover of staff which has contributed to the increase in errors as the service has mostly been delivered by locums. The vacancies are currently being recruited to and a new manager has been appointed. Trust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

Indicator		Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Administrating and Supply Errors source: Datix	York	29	37	36	45	32	31	28	45	21	24	39	27
	Scarborough	21	16	10	18	13	18	14	15	17	8	16	8
	Community Hospitals	8	9	8	7	9	13	7	5	9	9	5	7







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.

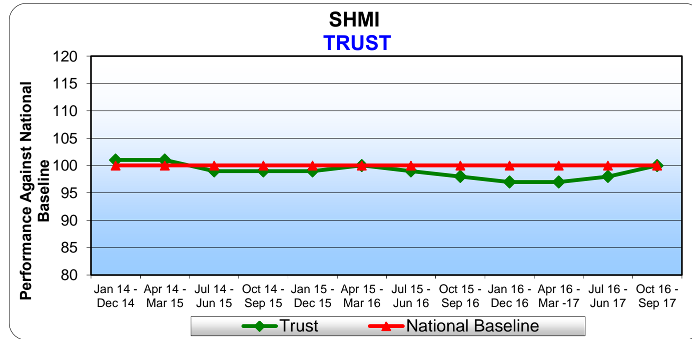
Analysis of Performance
The latest SHMI report indicates the Trust to be in the 'as expected' range. The October 2016 - September 2017 SHMI saw a 2 point increase for York, a 2 point increase for Scarborough and a 2 point increase for the Trust. Trust - 100, York 95 and Scarborough 108.

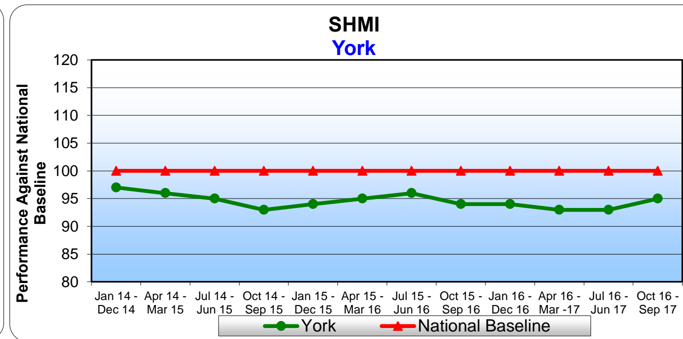
161 inpatient deaths were reported across the Trust in June. 108 deaths were reported at York Hospital, this number is higher than June 2017 (20% increase). 48 deaths were reported at Scarborough, a 7.7% decrease on June 2017. The Trust saw a total of 5 deaths across the Community sites in June 2018, a decrease on the 13 recorded in June 2017.

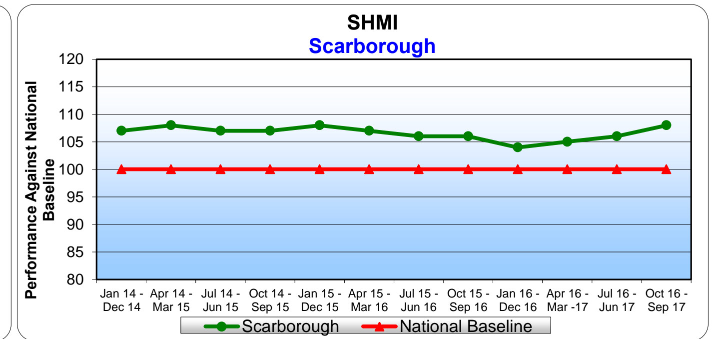
9 deaths in ED were reported in June; 7 at York and 2 at Scarborough. This compares favourably with June 2017 (14 deaths in total; 7 at York and 7 at Scarborough).

Mortality

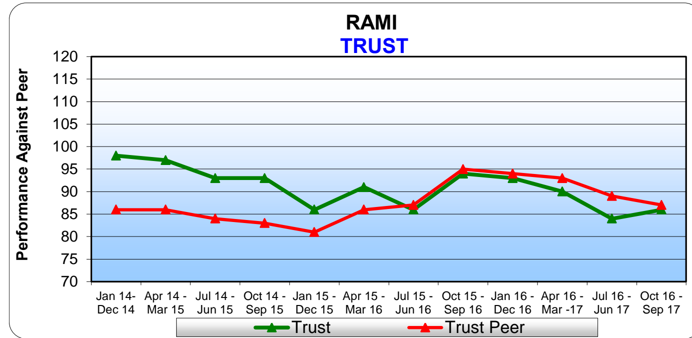
Indicator	Consequence of Breach (Monthly unless specified)	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar -17	Jul 16 - Jun 17	Oct 16 - Sep 17
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	100	99	98	97	97	98	100
Mortality – SHMI (YORK)	**Quarterly:** General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

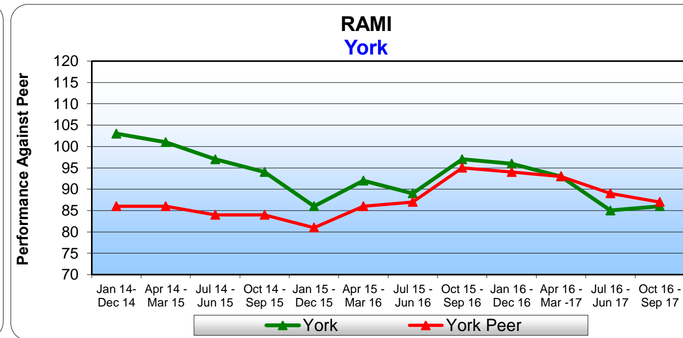


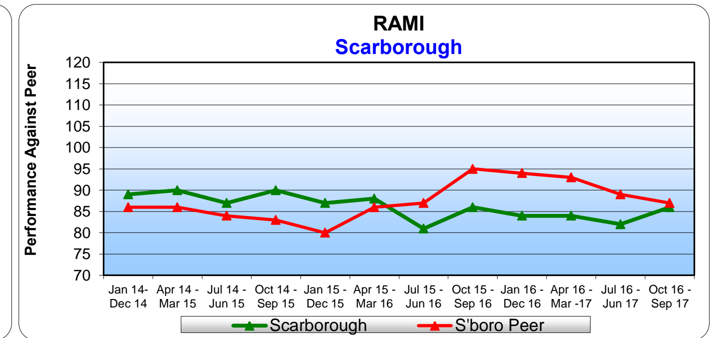




Indicator	Consequence of Breach (Monthly unless specified)	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar -17	Jul 16 - Jun 17	Oct 16 - Sep 17
Mortality – RAMI (TRUST)	**none - monitoring only**	91	86	94	93	90	84	86
Mortality – RAMI (YORK)	**none - monitoring only**	92	89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

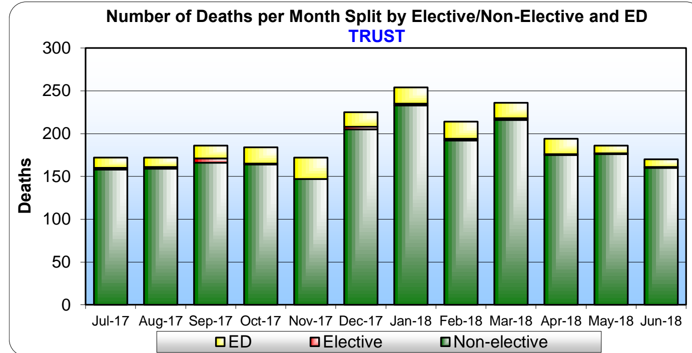


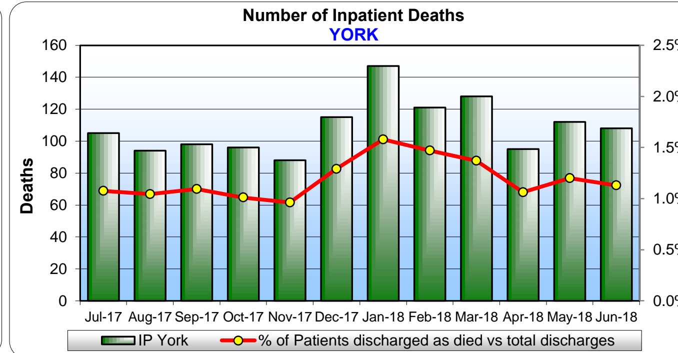


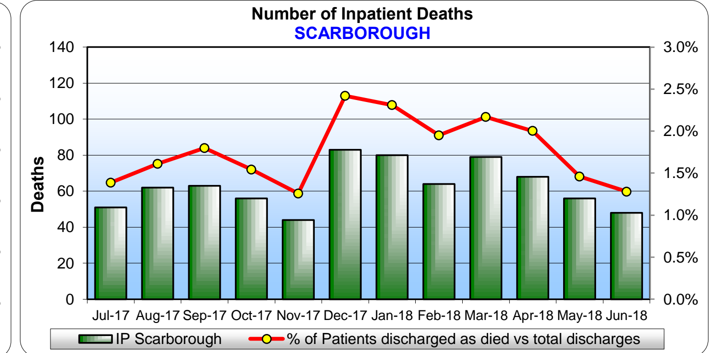


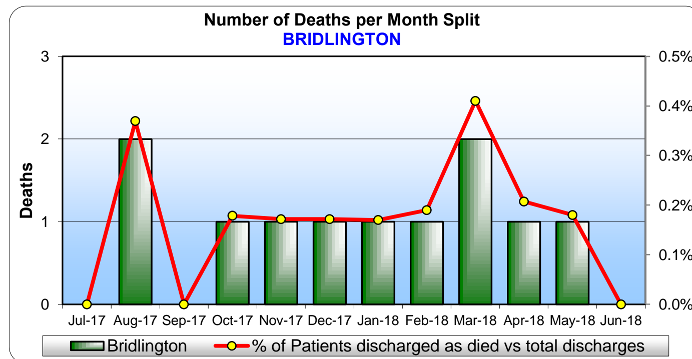
Mortality

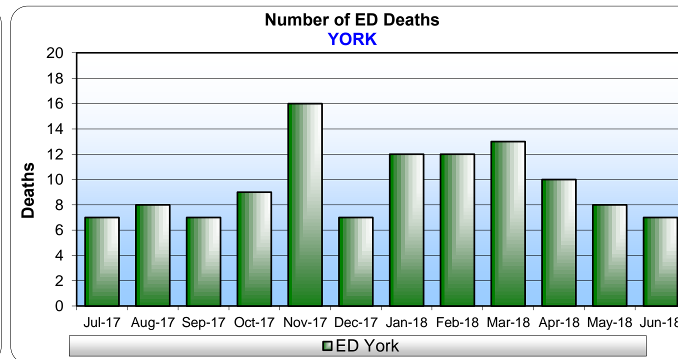
Indicator	Consequence of Breach (Monthly unless specified)	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr	May	Jun
Number of Inpatient Deaths	None - Monitoring Only	507	492	520	647	176	177	161
Number of ED Deaths	None - Monitoring Only	39	38	61	57	18	9	9

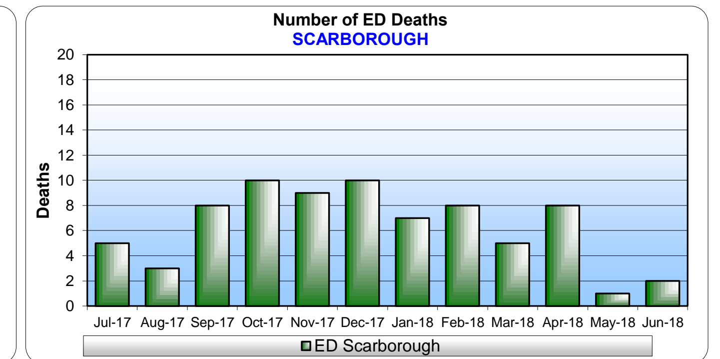


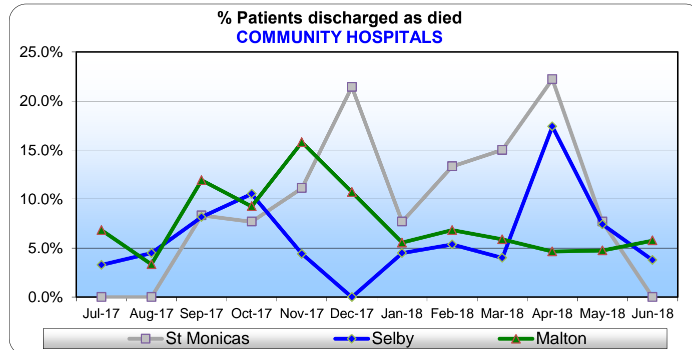


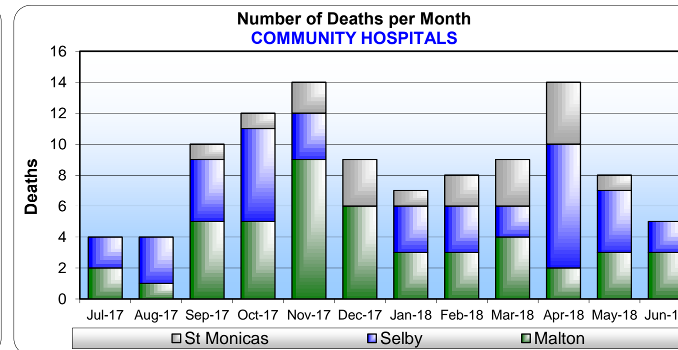












Month	Malton	Selby	St Monicas	Brid
Jul-17	2	2	0	0
Aug-17	1	3	0	2
Sep-17	5	4	1	0
Oct-17	5	6	1	1
Nov-17	9	3	2	1
Dec-17	6	0	3	1
Jan-18	3	3	1	1
Feb-18	3	3	2	1
Mar-18	4	2	3	2
Apr-18	2	8	4	1
May-18	3	4	1	1
Jun-18	3	2	0	0

Patient Safety Walkrounds – June 2018

York Teaching Hospital NHS Foundation Trust

Date	Location	Participants	Actions & Recommendations
06/06/2018	Wards 17, 18 SCBU & Child Development Centre, York	Wendy Scott – Director Jo Mannion – Clinical Director Liz Vincent – Directorate Manager Nicola Lockwood – Matron Dianne Willcocks – Non – Executive Director	No access for children and young people to Wi-Fi on ward 17/18. The wards are frequently requested for access to Wi-Fi, although this has been purchased by the trust, this has not been implemented on Wards 17/18. **Action** – Directorate to ensure installation ASAP. Ensure Children and Young people have access to appropriate on going education, play, and age appropriate activities. **Action** – Undertake and audit to ensure children and young people have access to appropriate on- going education. Play team to provide an annual report, to include activities, service development and service improvements. Progress on the development of the "Cube" (area for 8-11 year old's) to continue. Statutory and Mandatory training of Doctors – poor compliance. **Action** –Continue to try to reach agreement for Junior Doctors (rotational posts) to have evidence of completed statutory and mandatory training which can be agreed across the region for evidence when rotating to different Trusts. Increased level of risky behaviours with Children and Young People. **Action** – Multi-agency review of recent incidents and lessons learned. Review of trust policies and procedure in light of recent events through safeguarding Children's Board. Develop a Risk assessment for children who are admitted to an adult ward for treatment. SCBU. **Action** – Lack of modern compliant facilities. Case for capital investment has been made to CPEG.
15/06/2018	Ophthalmology Outpatients, Eye Ward, Day Unit & Theatre, York	Andrew Bertram – Director Richard Gale – Clinical Director Paul Rafferty – Directorate Manager Pauline Guyan - Matron	Flooring presents a trip hazard in area A Outpatients. **Action** – Encourage repair work to be undertaken out of hours. Congestion in Outpatients limits access to emergency exits and toilets. **Action** – Support development of business case for movement of part of the service to Stadium. Slit lamps are not designed for wheel chairs. **Action** – Assess if existing equipment can be adapted. Look at purchasing new equipment if current equipment cannot be adapted. Unable to provide cover at all times to answer the telephone and therefore calls are not answered immediately. **Action** – Roaming phone to be purchased. Chairs to be replaced in the day unit. **Action** – Access charitable funds for their replacement.
18/06/2018	Wards 23, 26 and 35, York	Brian Golding – Director Michael Harkness – Clinical Director Jamie Todd – Directorate Manager Katie Holgate – Matron Lorraine Boyd – Associate Non – Executive Director Mike Sweet - Non – Executive Director	As a group we reviewed the recommendations from last years' walk rounds and had a general discussion about safety within the directorate before visiting the wards. Our overall impression was the leadership team within Elderly Medicine put patient safety at the top of their agenda and drive best practice through all they do. Staffing – whilst staffing levels continue to be problematic across the Trust it was pleasing to see Assistant Practitioners reaching the point in their training and development where they could be signed off and allowed to practice in their own right. The beverage service that had been piloted on ward 23, and had proved so popular and successful that the directorate had funded it's on going costs. There would be clear benefits both for patient wellbeing and release of staff time if this service could be added to the other 2 wards. The directorate should work up a plan with the catering team and take through their PMM – looking for re-investment of some of the significant savings they have achieved through reducing length of stay. The most common patient safety events related to falls, and whilst falls with significant harm have shown a downward trend over the last few years, there had been a recent cluster of events. The directorate were able to demonstrate a clear focus on this issue. In particular there is a mismatch between the falls sensors and the new mattresses, however it was recognised that falls sensors in themselves are not significant in reducing falls. On all wards we heard that patients are reviewed for falls risk, and where appropriate cohorted into bays adjacent to the nurse station. On all 3 wards the environment was in poor condition, all with the original 40 year old nurse station and very poor ceilings and floor coverings. Ward 26 is in a particularly poor state, and is planned to be the next ward refurbished at York. On ward 23 a 'Palliative Care' room has been created by converting a bathroom. This provides private space for end of life patients and their carers to be together at this distressing time. We discussed the benefits of such spaces, and the importance of keeping these rooms out of the ward's bed base, so that they are available when needed. **Recommendations/ actions:** **Ward 23**, Georgina MacDermid, Deputy Sister Physical Environment. **Action** – Continue to lobby for ward to be included in next round of ward refurbishments. **Ward 26**, Caroline Walker – Deputy Sister Physical Environment **Action** – Continue to lobby for ward to be included in next round of ward refurbishments. Create a Palliative Care room by displacing the memory room to rooms currently used as consultant offices. **Action** – Work with other directorate managers and the estates team to explore the possibility of relocating the consultants off the ward. Seek to introduce beverage service as per ward 23. **Action** – In collaboration with the catering team prepare a proposal to route through PMM seeking approval to fund this service both to benefit patients and to release nursing time. **Ward 35**, Juliette Robinson, Sister Seek to introduce beverage service as per ward 23. **Action** – In collaboration with the catering team prepare a proposal to route through PMM seeking approval to fund this service both to benefit patients and to release nursing time. Create a Palliative Care room by displacing the consultant offices. **Action** – Work with other directorate managers and the estates team to explore the possibility of relocating the consultants off the ward. Physical Environment. **Action** – Continue to lobby for ward to be included in next round of ward refurbishments.

Patient Safety Walkrounds – June 2018

Date	Location	Participants	Actions & Recommendations
26/06/2018	Critical Care Unit (ITU/HDU) & Ward 27	Sue Rushbrook – Director Tracey Richardson – Directorate Manager Dr Louise Jolliffe Jenni Lee – Matron Gill East - Matron Lorraine Boyd – Associate Non – Executive Director	Paper based notes. **Action** – Business Case for electronic clinical information system with Andy Bertram for decision. Patients requiring long term ventilation go to third party providers and don't always get best care. **Action** – Considering case for provision of a long term ventilation unit and discuss at PMM. Proposal taken to PAM – now part of Critical Care SWAT. Entrance Doors to the Unit. **Action** – Very slow to open and break often - On-going with estates and facilities department. Also not always a ward clerk on for patients relatives to be let in to the unit, DM to explore options. Implementation of News 2 impact on Critical Care outreach due to increase in News score of 5 and above. **Action** – Dr Jonathan Redman and Cat Balcombe (outreach lead) involved with the planning of News 2. Patient Flow out of ICU into main bed base. **Action** – NIV patients – ward 34 plan to implement 1 patient going on the ward – ICU involved in planning this. Long term Tracheostomy patients sometimes difficult to place on wards due to staffing levels. Lack of level 1 beds in the Trust – business cases developed for Vasc NEU and Medical Hob, awaiting further developments. DM, lead ICU and patient flow manager have monthly monitoring meetings, EH collecting data to identify hot spots. TV at bedside. **Action** – Some bedsides do not have TV, SR suggested flagging with Adrian Shakeshaft the possibility of streaming TV when bandwidth extends. TR to flag to AS. Scarborough ICU sustainability. **Action** – Vacancy levels high for Medical and nursing staff and been unsuccessful at recruiting over the past 2 years. Over recruited nurses at York to help sustain Scarborough ICU, especially during next winter. Part of the Critical Care Delivery Group, strategy for critical care to be developed within this group.

YORK - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Activity	Births	Bookings	1st m/w visit	CPD	≤302	303-329	≥330	287	294	295	301	294	186	315	284	311	278	268	262
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	87.5%	87.1%	85.1%	91.4%	92.2%	82.3%	91.1%	94.0%	89.7%	92.4%	84.7%	87.8%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10.1%-19.9%	>20%	5.9%	4.8%	7.1%	5.3%	4.4%	5.9%	7.3%	4.2%	7.1%	4.3%	8.6%	7.3%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	70.60%	71.40%	81.00%	68.80%	76.90%	54.50%	87.00%	83.30%	68.20%	66.70%	78.30%	63.20%
		Births	No. of babies	CPD	≤295	296-309	≥310	273	269	302	272	264	253	250	243	256	257	279	262
		No. of women delivered	No. of mothers	CPD	≤295	296-310	≥311	269	262	297	269	261	250	248	241	251	254	274	258
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	0	1	0	0	0	0	0	0	1	0	0	0
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	1	0	0	0	0	0	0	1	0	0	0
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	2	1	4	0	0	0	0	0	0	2	0	0
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	1	0	0	0	0	0	0	0	0	0	0
		SCBU at capacity (since May 2017)	No of times	SCBU				0	2	0	0	0	0	0	0	0	0	0	4
		SCBU at capacity of intensive cots	No. of times	SCBU				1	3	0	2	1	0	0	0	0	0	0	4
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more	0	0	0	0	1	0	0	0	0	0	0	2
Workforce	Staffing	MW to birth ratio	Ratio	Matron	≤29.5	29.6 - 30.9	>31	34	30	30	32	34	31	30	31	30	32	31	31
		1 to 1 care in Labour	CPD	CPD	100%	80% - 99.9%	≤79.9%	72.5%	73.7%	68.0%	72.1%	73.1%	86.4%	80.2%	82.6%	78.5%	82.3%	78.1%	80.6%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	100%	80% - 99.9%	≤79.9%	62.0%	51.0%	50.0%	62.0%	68.0%	84.0%	89.0%	60.7%	77.0%	71.6%	74.1%	78.0%
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	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%	63.2%	59.6%	62.9%	49.1%	61.4%	59.2%	58.9%	57.7%	57.6%	51.5%	55.9%	57.3%
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	11.2%	10.7%	10.1%	15.2%	14.6%	15.2%	11.7%	14.1%	13.5%	15.7%	16.1%	15.9%
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	25.3%	29.8%	27.6%	35.3%	23.8%	24.4%	29.0%	27.8%	29.5%	32.5%	28.5%	26.4%
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	0	0	0	0	0	0	0	1	0
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	1	1	2	1	1	1	2	1	1	1	1	0
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	12	14	23	18	9	11	11	17	13	7	9	7
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	4	3	4	1	3	6	2	2	4	2	4	1
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	0	0	2	1	0	0	1	0	1	0	0	0
		NHS Resolution cases	No of cases		0	1	2 or more	0	0	2	0	0	0	0	0	1	0	0	0
	Morbidity	Neonatal Death	No of babies	Risk team- EBC	0		1 or more	0	0	0	0	0	0	0	0	1	0	0	1
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	3	1	0	2	0	1	0	1	1	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%	73.6%	77.1%	75.8%	77.7%	80.8%	76.4%	73.0%	77.6%	78.1%	81.1%	72.6%	73.6%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	12.6%	11.5%	9.8%	7.1%	6.5%	8.8%	11.3%	12.4%	12.0%	6.3%	14.2%	9.7%
		SI's	No. of Si's declared	Risk Team	0		1 or more	0	1	0	1	0	0	0	0	0	0	0	0
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	9	9	9	9	7	5	10	9	8	5	5	4
		PPH > 1.5L as % of all women	% of births	CPD				3.3%	3.4%	3.0%	3.3%	2.7%	2.0%	4.0%	3.7%	3.2%	2.0%	1.8%	1.6%
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	3	6	1	1	3	4	1	1	2	1	6	4
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	2.9%	2.6%	2.7%	1.1%	2.5%	5.7%	2.2%	1.7%	2.2%	2.9%	5.0%	1.5%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	0	3	0	2	0	1	1	1	1	1	1	0
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	2	1	2	0	0	2	0	1	1	0	1	1

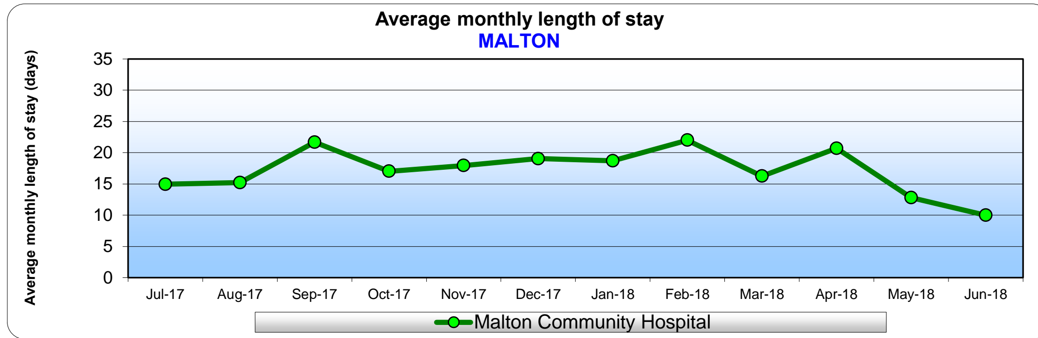
Maternity Dashboard metrics were reviewed on 01.08.2017

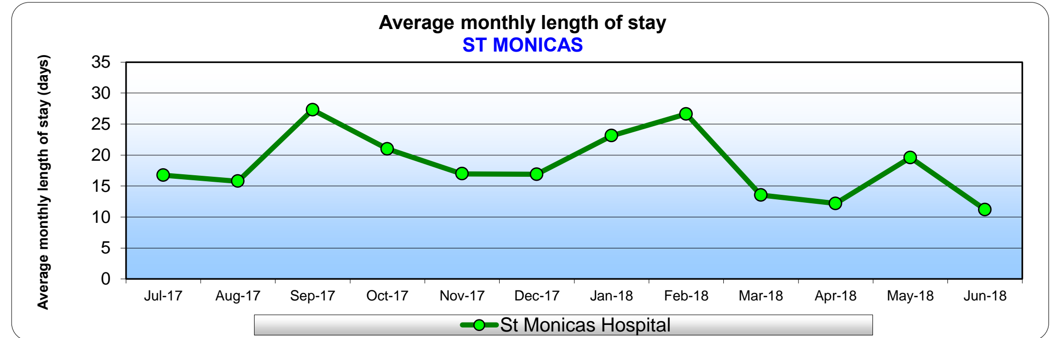
SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Activity	Births	Bookings	1st m/w visit	CPD	≤210	211-259	≥260	177	188	185	163	196	135	199	142	207	158	173	162
		Bookings <13 weeks	No. of mothers	CPD	≥90%	76%-89%	≤75%	91.5%	90.4%	90.3%	88.3%	87.8%	88.9%	91.5%	93.0%	88.4%	90.5%	90.8%	86.4%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10%-20%	>20%	6.8%	6.4%	8.1%	9.8%	9.7%	5.2%	5.5%	5.6%	8.7%	7.0%	8.1%	9.3%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	CPD	≥90%	76%-89%	≤75%	75%	92%	100%	94%	89%	86%	91%	100%	83%	91%	86%	93%
		Births	No. of babies	CPD	≤170	171-189	≥190	127	118	145	117	114	125	127	120	119	114	115	103
		No. of women delivered	No. of mothers	CPD	≤170	171-189	≥190	127	116	145	115	110	124	126	118	118	114	109	103
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3	4-6	7 or more	0	0	0	0	0	0	2	0	0	0	0	0
		Women affected by suspension	No. of women	Comm. Manager	0	1	2 or more	0	0	0	0	0	0	0	0	0	0	0	0
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more	0	0	0	0	0	0	1	1	0	1	0	0
		Maternity Unit Closure	No. of closures	Matron	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		SCBU at capacity (since May 2017)	No of times	SCBU				0	0	0	2	6	2	5	2	11	0	3	4
		SCBU at capacity of intensive care cots	No. of times	SCBU				5	2	0	0	2	1	2	3	1	0	3	0
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more	0	1	0	2	3	3	0	0	7	0	0	0
Workforce	Staffing	M/W to birth ratio	Ratio	Matron	≤29.5	29.6-30.9	>31	24	24	26	25	25	26	25	25	25	24	25	24
		1 to 1 care in Labour	CPD	CPD	≥100%	80% - 99.9%	≤79.9%	82.7%	90.5%	91.0%	87.0%	88.2%	87.9%	86.5%	81.4%	80.5%	86.0%	85.3%	91.3%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	≥100%	80% - 99.9%	≤79.9%	75.8%	80.6%	55.0%	82.0%	73.3%	68.0%	87.0%	71.0%	69.0%	70.0%	80.6%	85.0%
		Consultant cover on L/W	av. hours/week	DM / CD	40		≤39	40											
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	≥10	4-9	≤3	5	5	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%	63.6%	68.9%	68.5%	77.1%	63.2%	72.8%	78.0%	70.8%	58.0%	69.3%	67.8%	70.5%
		Assisted Vaginal Births	No. of instr. Births - %	CPD	≤13.2	13.3-17.9%	≥18%	7.1%	7.8%	8.3%	6.1%	10.9%	8.1%	4.0%	7.6%	13.6%	7.9%	6.4%	3.9%
		C/S Births	Em & elect - %	CPD	≤26%	26.1-27.9%	>28%	27.6%	21.6%	22.8%	15.7%	27.3%	19.4%	18.3%	21.2%	28.0%	22.8%	27.5%	24.3%
		Eclampsia	No. of women	CPD	0		1 or more	0	0	0	0	0	0	0	0	0	0	1	0
		Undiagnosed Breech in Labour	No. of women	CPD	2 or less	3-4	5 or more	1	0	3	1	0	0	0	1	0	1	0	0
		HDU on L/W	No. of women	LW Activity Sheet	3 or less	4	5 or more	5	1	3	1	2	4	0	3	5	3	3	1
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	2	1	2	2	0	4	4	0	0	2	0	0
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	1	0	1	0	0	1	0	0	0	0	0	0
		NHS Resolution cases	No of cases		0	1	2 or more	0	0	0	0	0	1	0	0	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	0	0	1	1	0	0	0	0	1	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%	57.5%	63.8%	55.2%	59.1%	59.1%	58.1%	65.9%	55.1%	61.0%	64.0%	65.1%	60.2%
		Smoking at time of delivery	% of women smoking at del.	CPD	<11%	12-14%	>15%	17%	25%	16%	22%	25%	18%	18%	22%	14%	14%	17%	25%
		SI's	No. of Si's declared	Risk Team	0		1 or more	0	0	0	0	0	0	0	0	0	0	0	0
		PPH > 1.5L	No. of women	CPD	2 or less	3-4	5 or more	4	0	2	0	2	4	0	2	4	3	2	1
		PPH > 1.5L as % of all women	% of births	CPD				3.0	0.0	1.4	0.0	2	3.2	0	2	3	3	2	1
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more	1	1	0	1	2	1	0	1	2	0	2	4
		3rd/4th Degree Tear	% of tears (vaginal births)	CPD	≤2.5%	2.6- 3.9%	≥4%	0.0%	1.1%	3.6%	2.0%	1.2%	2.0%	1.0%	1.1%	1.2%	2.3%	4.9%	0.0%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more	0	0	0	1	0	0	0	0	1	0	0	0
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more	0	1	1	0	2	1	1	0	0	0	0	0

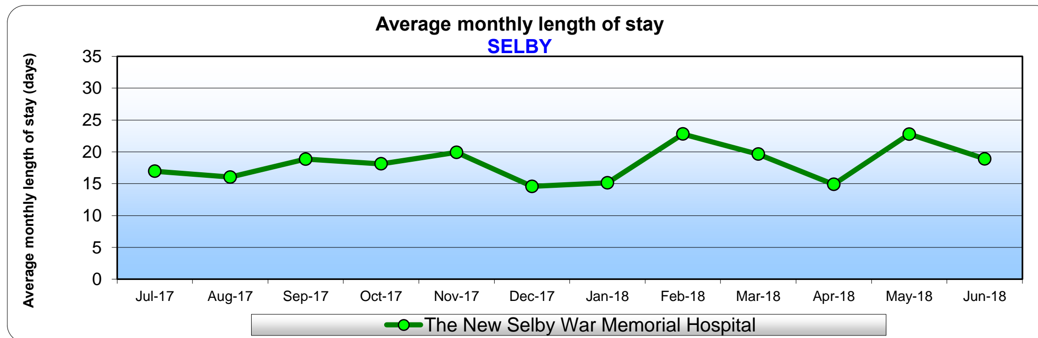
Maternity Dashboard metrics were reviewed on 01.08.2017

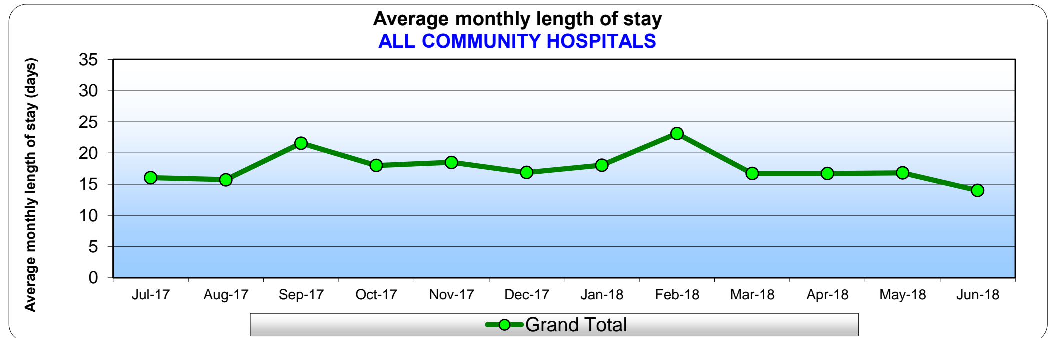
Community Hospitals

Indicator	Hospital	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr	May	Jun
Community Hospitals average length of stay (days) Excluding Daycases	**Malton Community Hospital**	17.9	16.0	17.4	17.9	20.7	12.8	10.0
	St Monicas Hospital	14.4	22.6	19.6	18.1	12.2	19.6	11.2
	The New Selby War Memorial Hospital	20.2	20.4	17.2	17.6	14.9	22.8	18.9
	Total	18.5	17.6	17.8	19.2	16.7	16.8	14.0









York Teaching Hospital NHS
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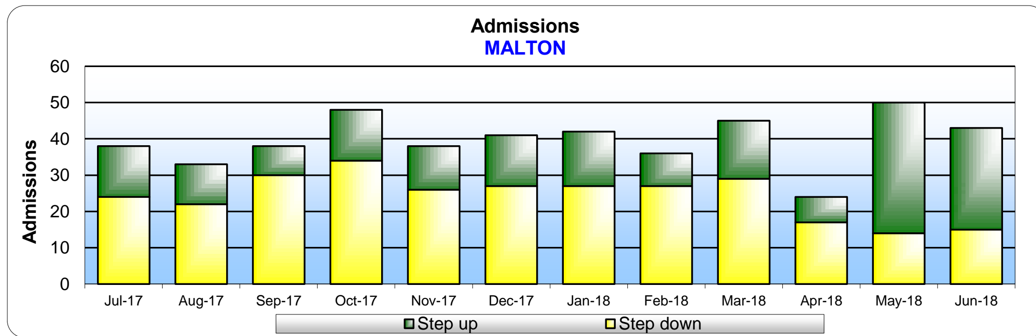
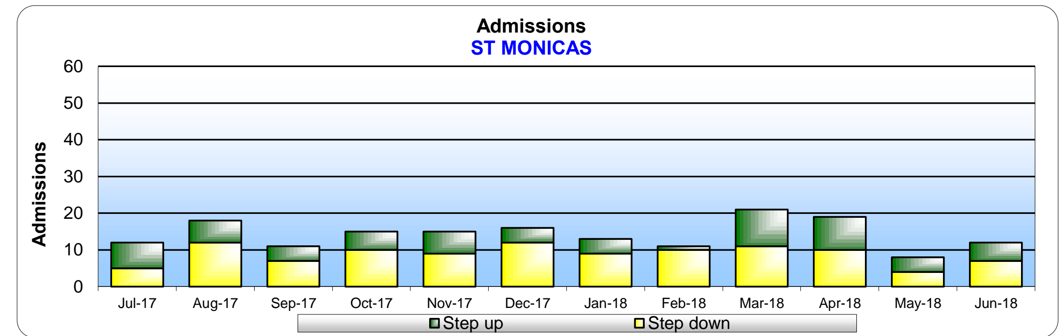
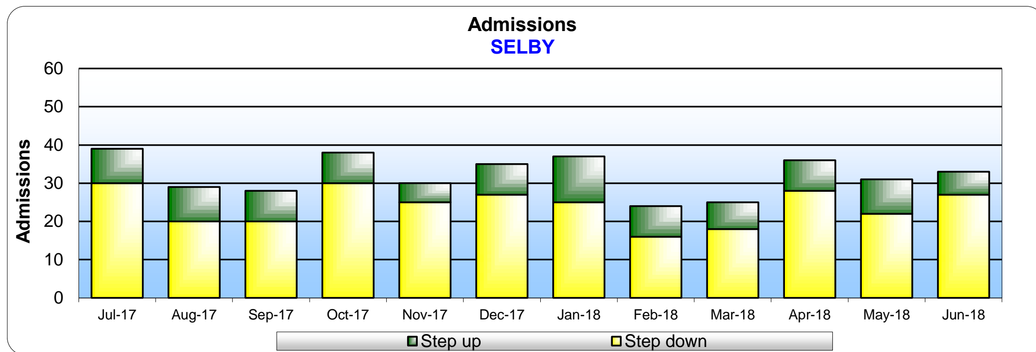
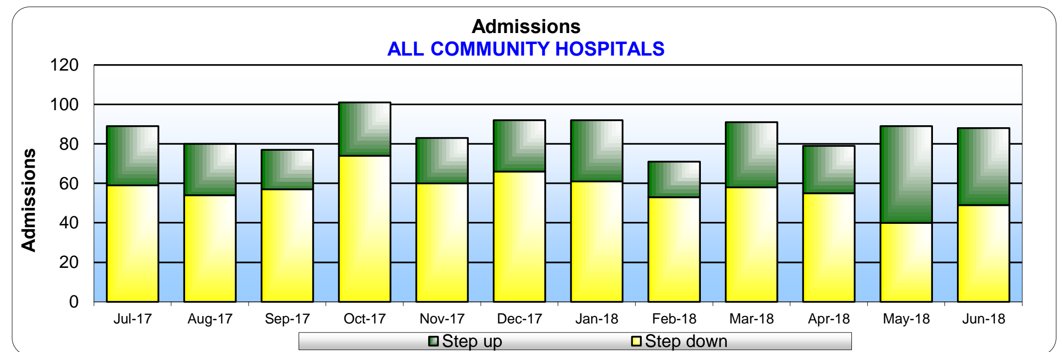
Community Hospitals

Indicator	Hospital		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr	May	Jun
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	**Malton Community Hospital**	**Step up**	39	33	40	40	7	36	28
		Step down	88	76	87	83	17	14	15
	St Monicas Hospital	**Step up**	13	17	15	15	9	4	5
		Step down	29	24	31	30	10	4	7
	The New Selby War Memorial	**Step up**	19	26	21	27	8	9	6
		Step down	69	70	82	59	28	22	27
	Total	**Step up**	71	76	76	82	24	49	39
		Step down	186	170	200	172	55	40	49









York Teaching Hospital NHS
NHS Foundation Trust

Quality and Safety: Misc

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr	May	Jun
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	7	12	4
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
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%	To follow	To follow
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	97.9%	97.2%	98.0%	98.5%	98.7%	98.4%	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%	5.9%	4.9%	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%	26.5%	61.0%	39.5%
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%	91.7%	87.1%	87.3%
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 Foundation Trust

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Complaints and PALS												
New complaints this month	51	43	50	38	37	27	28	31	35	30	43	26
Top 3 complaint subjects												
All aspects of Clinical Treatment	37	26	29	21	26	18	15	23	27	22	31	26
Communications/information to patients (written and oral)	15	17	6	11	11	6	11	8	17	12	13	14
Patient Care	20	17	18	5	8	9	19	5	18	18	20	16
Top 3 directorates receiving complaints												
Acute & General Medicine	4	11	8	2	3	2	3	3	7	4	7	4
Emergency Medicine	5	5	4	5	4	4	3	4	2	6	8	4
General Surgery & Urology	7	1	6	8	11	2	2	4	7	3	6	3
Number of Ombudsman complaint reviews (new)	2	2	1	0	0	0	0	2	0	0	0	0
Number of Ombudsman complaint reviews upheld	0	0	0	0	0	0	0	0	0	0	1	0
Number of Ombudsman complaint reviews partly upheld	0	0	0	0	1	1	0	0	0	2	0	0
New PALS queries this month	262	292	227	269	240	173	271	214	210	220	204	231
Top 3 PALS subjects												
Communication issues	91	60	54	54	53	43	46	32	37	31	31	47
Any aspect of clinical care/treatment	16	19	18	25	29	24	21	24	19	33	25	31
Appointments	42	48	30	51	43	24	47	22	25	34	22	30
Serious Incidents												
Number of SI's reported	14	12	8	17	10	12	22	22	26	19	9	11
% SI's notified within 2 working days of SI being identified	100%	100%	100%	94%	100%	100%	100%	95%	100%	100%	100%	100%
* this is currently under discussion via the 'exceptions log'												
Compliance with Duty of Candour for Serious Incidents*:												
-Verbal Apology Given	8	6	4	7	3	4	6	4	10	8	3	3
-Written Apology Given *	6	3	4	6	2	1	1	6	2	3	2	2
-Invitation to be involved in Investigation	5	5	2	5	3	2	1	3	1	1	2	0
-Given Final Report (If Requested)	0	5	5	2	5	1	4	3	2	2	1	1
Pressure Ulcers**												
Number of Category 2	68	60	55	74	71	80	96	75	87	57	64	66
Number of Category 3	5	1	4	3	5	9	3	5	4	3	2	5
Number of Category 4	1	2	1	0	2	3	1	0	1	2	2	0
Total number developed/deteriorated while in our care (care of the organisation) - acute	79	58	68	75	65	93	111	76	119	85	82	91
Total number developed/deteriorated while in our care (care of the organisation) - community	34	39	39	26	39	39	38	46	33	25	25	45
Falls***												
Number of falls with moderate harm	1	1	4	1	1	6	4	2	1	2	2	3
Number of falls with severe harm	2	0	4	0	3	5	8	3	5	3	4	1
Number of falls resulting in death	0	0	0	0	0	0	1	1	0	0	0	0

Quantative Information
Information Team
Systems and Network Services

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Safeguarding												
% of staff compliant with training (children)	84%	83%	83%	83%	83%	84%	84%	83%	83%	83%	83%	82%
% of staff compliant with training (adult)	86%	85%	85%	85%	85%	85%	85%	84%	84%	83%	83%	82%
% of staff working with children who have review DBS checks												

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Prevent Strategy												
Attendance at the HealthWRAP training session												
Number of concerns raised via the incident reporting system												

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Claims												
Number of Negligence Claims	13	16	10	12	12	10	14	16	13	5	14	16
Number of Claims settled per Month	6	2	5	2	5	2	2	3	4	7	8	4
Amount paid out per month ****	£83,500	£105,000	£1,808,000	£90,000	£243,733	£1,900	£281,500	£29,000	£365,979	£446,017	£42,355	£113,500
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 recent months 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.

NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 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 solely for the Board of Directors.

Purpose of report

This report provides an update from the Medical Director on salient issues related to patient safety, clinical effectiveness and patient experience.

Key points for discussion

- NCEPOD update
- 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 James Taylor, Medical Director

Executive sponsor: Mr James Taylor, Medical Director

Date: July 2018

1. Introduction and Background

In the report this month:

Clinical Effectiveness

- NCEPOD update

Patient Experience

- Antibiotic prescribing audit

2. Clinical Effectiveness

2.1 Consultants new to the Trust

There were no Consultants new to the Trust in June.

2.2 Clinical Effectiveness Group

An update on current NCEPOD studies was discussed at the meeting held in June 2018.

Long Term Ventilation - The initial study specification was presented. Patient selection for the study may be problematic due to the scope of the study. NCEPOD has asked the Trust to identify clinical leads at each hospital site. Dr John White has expressed interest in leading on this from the York Hospital site.

Acute Bowel Obstruction - The Trust lead has confirmed the York & Scarborough Hospitals are eligible for inclusion in this study. All other sites within the Trust will not be included.

Pulmonary Embolism - The Trust has completed the required data collection and now awaits clinician questionnaires for selected cases.

The full minutes from the meeting are available at appendix A.

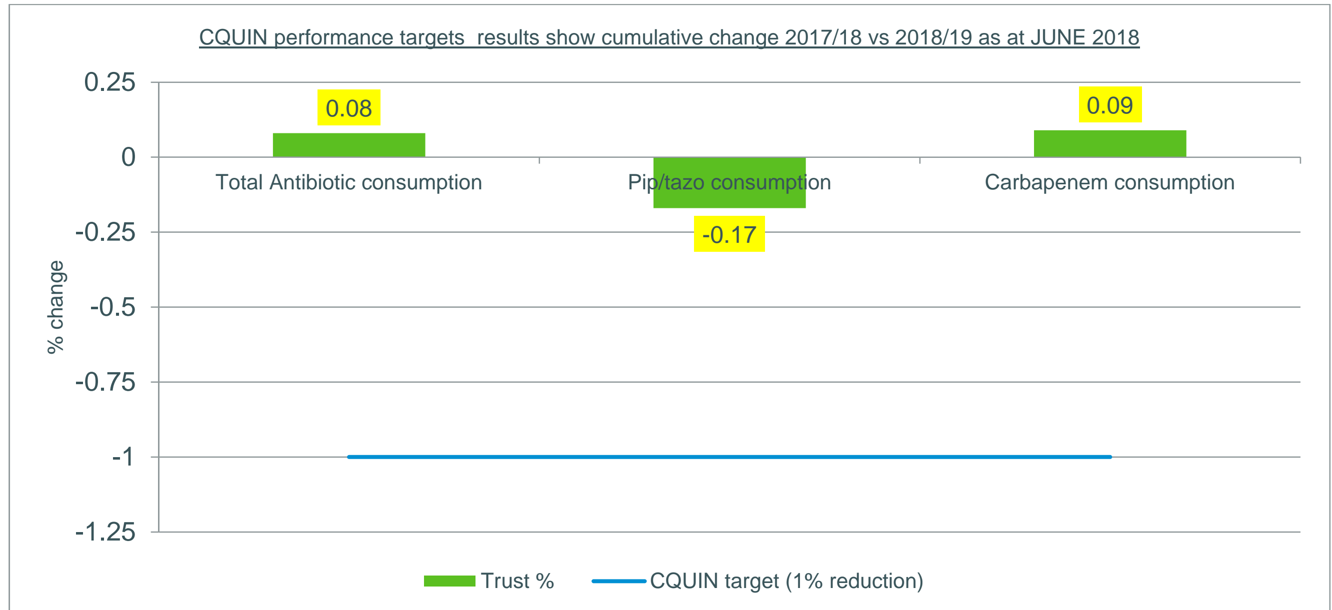
3. Patient Experience

3.1 Antibiotic prescription audit results

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

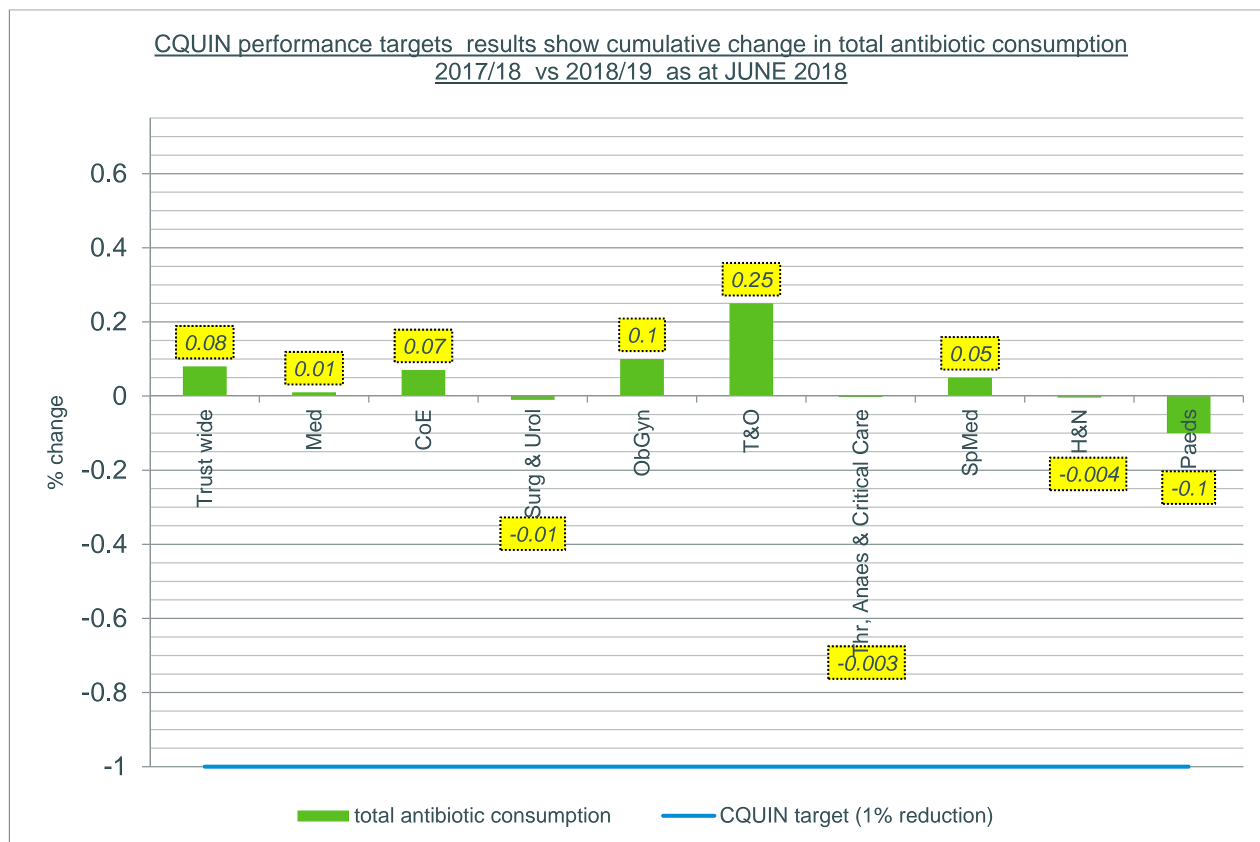
Consumption data % change of cumulative totals 2017/18 vs 2018/19 as at June 2018.

CQUIN Targets – Trust wide

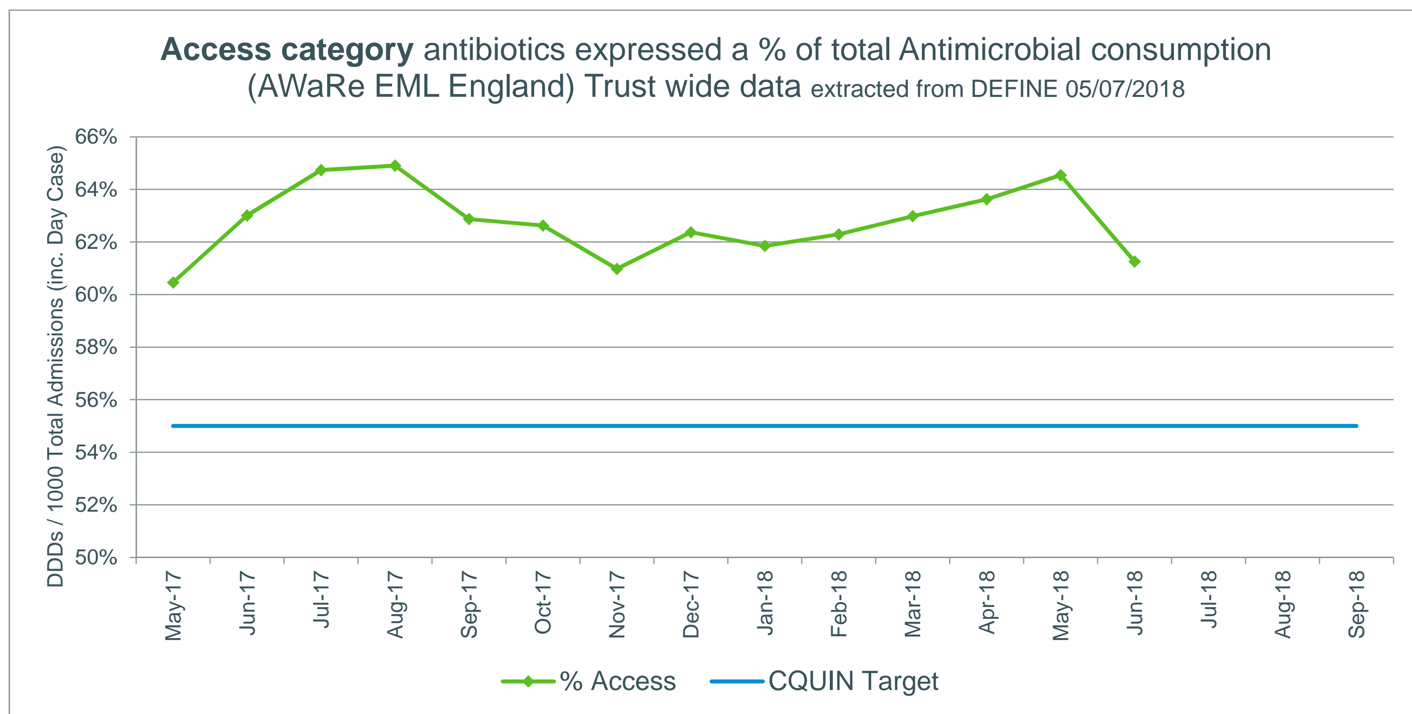


Although pip/tazo (Piperacillin / Tazobactam, a broad spectrum IV antibiotic) consumption is no longer covered by a CQUIN we are pleased to note a decrease in usage this month. This is a positive sign that communication between Prescribers, "Team Micro" and Pharmacy continues. Although there is again a small increase in total antibiotic consumption and an increase in consumption of the Carbapenem class of antibiotics, this continues to be the ongoing balancing act between treating those patients with clinical evidence of an infection and stopping antibiotics promptly when any infection is treated.

CQUIN Targets – By Directorate



The Trust Pharmacy Antimicrobial Team continues to work closely with Clinicians and "Team Micro" on the York and Scarborough sites to actively promote the review of all antibiotic prescriptions. The increase in antibiotic consumption varies between Directorates; this may in part reflect the increase in prescribing of combinations of narrower spectrum antibiotics to target infections, rather than using a single broad spectrum ("Domestos®" type) agent. While this approach may potentially increase the total volume of antibiotics consumed, the more focused approach to targeting infections, combined with actively reviewing patients, promotes an approach more mindful of the problem of antibiotic resistance.



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 aims to encourage the balance of antibiotics used by an organisation to be in favour of the Access list and encourage a decrease in the use of Watch and Reserve antibiotics; these are antibiotics the Trust has described as restricted or to be prescribed only on the advice of "Team Micro".

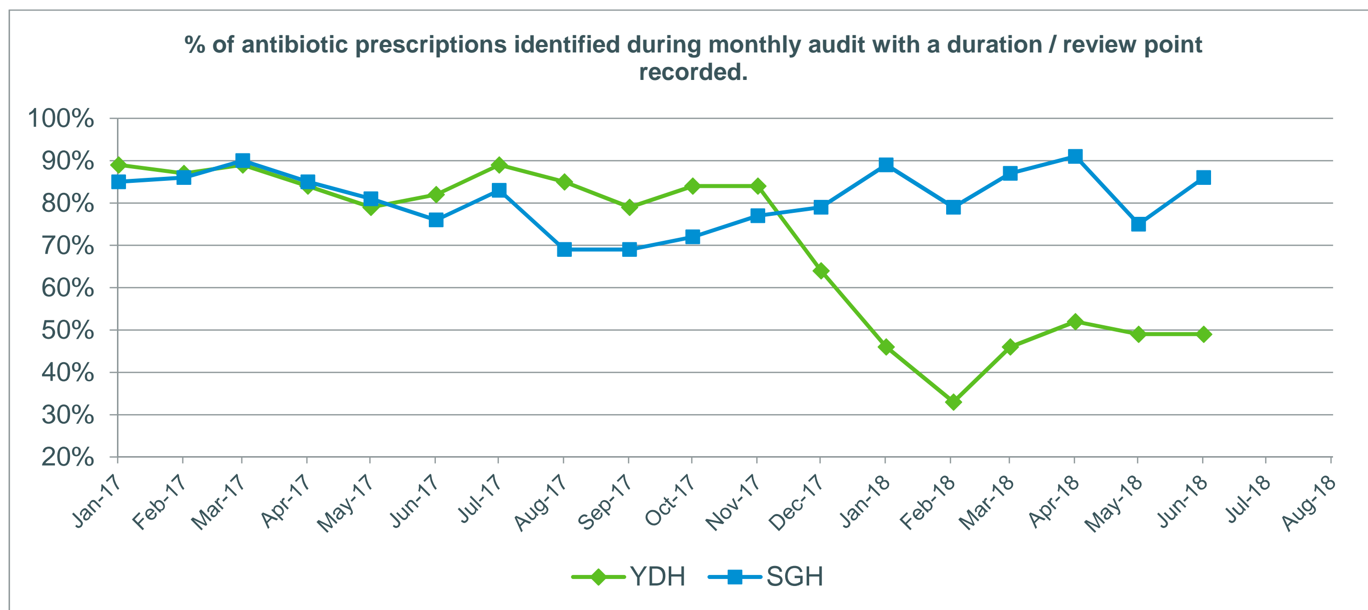
The constant challenge to ensure a balance; ensuring availability of antibiotic doses to prevent missed or delayed doses for our critically unwell patients and actively promoting the review process, to help our improving patients avoid unnecessary doses of antibiotics. This requires collaboration between Clinicians, "Team Micro" and Pharmacy colleagues to get the optimum antibiotic treatment for each patient.

The Pharmacy antimicrobial team continues to carry out a monthly point prevalence audit of antibiotic prescribing across the Trust. Key indicators for antimicrobial prescribing continue to be recorded. These indicators are:

1) The percentage of patients who are prescribed antibiotics to determine whether the Trust continues to be in line with the national / regional average of 30% of the inpatient population prescribed antibiotics on any given day.

2) Indication recorded; with the introduction of ePMA at YDH compliance is consistently now at 100%. SGH continues to perform in a consistent manner.

3) Duration recorded; there is still work to be done to improve compliance with the desired standard of 95% compliance. The monthly audit is useful for benchmarking. The graph below identifies a reduction in compliance in relation to recording duration / course length / review point for antibiotic prescriptions since the introduction of ePMA.



The recording of both an indication and a duration (or review point) on every antibiotic prescription is important patient safety metric. All colleagues involved in the patient care process need to be able to clearly identify which antibiotics are prescribed, why, and that there is clear evidence that the antibiotics are being reviewed frequently. If there is no clinical evidence of an infection or as soon as any infection is effectively treated, antibiotics should be stopped. It is anticipated that ePMA will offer an improved opportunity to identify antibiotic prescriptions and this should facilitate prompts for prescriptions being reviewed by Nursing and Pharmacy colleagues.

Key Indicator results for June 2018 (results based on Consultant Directorate as identified on audit day)

Indicator %	Trust	Med	CoE	Surg & Urol	ObGyn	T&O	SpMed	H&N
pt Rx Abx	32%	39%	22%	35%	0%	34%	65%	37%
% iv Rx	47%	39%	42%	56%	86%	58%	44%	80%
Indication recorded **YDH**	100%	100%	98%	100%	100%	100%	100%	100%
indication recorded **SGH**	87%	85%	95%	75%	100%	100%	NA	NA
duration recorded **YDH**	39%	41%	38%	35%	20%	53%	50%	0%
duration recorded **SGH**	87%	90%	95%	50%	100%	100%	NA	NA

4. Recommendations

The Board of Directors are asked to note the Medical Directors Report for July 2018.

Appendix A

NHS
York Teaching Hospital
NHS Foundation Trust

Clinical Effectiveness Group Meeting Minutes

Neurosciences Resource Room YH & Orchard Room SGH,
Tuesday 12th June 2018, 15:00

Attendance: Fiona Jamieson (FJ), Lorraine Clennett (LC), Jane Crewe (JC), Lyeanda Berry (LB), Christine Foster (CF), Simon Hearn (SH), Colin Jones (CJ), Nick Brown (NB), Alastair Mace (AM), Hock Goh (HG), Javid Ali (JA), Ed Smith (ES)

Apologies: Glenn Miller, Claire Scotter, Ruwani Rupesinghe, Angela Darby, Sue Urwin

Minutes of meeting held on 29th May 2018

The minutes from the meeting held on the 29th May were reviewed and agreed by the Group.

Action log

The action log was not reviewed as the previous meeting was only 2 weeks before; it was felt that there had not been sufficient time for actions to have been considered.

NICE Drug Report

JC presented the TA drug report, there were no changes to report since the previous meeting.

The Drug & Therapeutics (D&T) meeting had had insufficient time to review the outstanding TAs, therefore these will be reviewed virtually by the D&T group.

It was proposed that future TAs will be discussed by the Chemotherapy development group and any issues will be escalated to D&T and in turn to the Clinical Effectiveness Group via the NICE Drug Report.

This was accepted by the Group.

NICE Report

SH reported that there were 3 responses to queries raised at the Group previously:

PH26 Smoking: stopping in pregnancy and childbirth
The Group accepted the reassurance from the clinical lead that 'accredited training' specified by NICE is excessive and not required as the CO monitors used by midwives are simple to use and self-explanatory.

PH27 Weight Management before, during and after pregnancy
The Group accepted the leads reassurance that the pilot study would include all women with a BMI>30 and therefore there was no risk of missing patients with a BMI greater than 30 but less than 35. (BMI>35 is the indicator for glucose tolerance testing).

QS162 Cerebral palsy in children and young people
The Group were apprised of an updated timescale of 1 year (August 2019) for completion of the required actions. The Group however requested further clarification of what would be achievable within that timescale.
Action: SH to request further details & feedback to Group

Partial without action plan

There were **4** NICE Baseline presented to the Group which had been assessed as being partially compliant without action plans:

PH55 Oral Health: local authorities and partners
Recommendation 10: *Promote Oral Health in the workplace*
Agreed, no further action required.

QS19 Meningitis (bacterial) and meningococcal septicaemia in children and young people
Recommendation 13: *Audiological assessment before discharge* – partial no action required.
Agreed, no further action required.

Recommendation 14: *Follow up appointment with a consultant paediatrician within 6 weeks of discharge* – partial, no action plan required.
The Group required further details on the length of delay for follow up. If significant, an action plan would be required in order to address this.

Action: SH to request further update from the Clinical Lead and feedback to Group once this has been received.

QS166 Trauma
Recommendation 2: *People who have had urgent 3D imaging for major trauma have a provisional written radiology report within 60 minutes of the scan* – Partial, no action required.

The Group reviewed the TARN data. CJ expressed the concern the numbers reported by TARN were averages and therefore demonstrate that the Trust is not meeting the target of 60 minutes for the provisional written report.

ES confirmed that TARN data is reported regularly and reviewed by the Trauma group.

Action: SH to update status to 'Not Compliant', to suggest lead to consider adding this to the directorate Risk Register.

QS167 Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups
Recommendation 4: *People from black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme are given a choice of times and settings for the sessions and are followed up in they do not attend* – partial, no action required.

The Group accepted that the Trust does not provide cardiac rehabilitation programmes, but does support patients from ethnic minority groups and encourages these to attend, therefore the Group felt that the Trust is Compliant with this recommendation.

Action: SH to update Trust compliance to Compliant.

Partial Compliance with Action Plan

There was **1** NICE Baseline Assessment presented to the Group for review of the action plan:

QS19 Meningitis (bacterial) and meningococcal septicaemia in children and young people
Recommendation 4: *Children and young people with suspected bacterial meningitis or meningococcal septicaemia receive intravenous or intraosseous antibiotics within an hour of arrival at hospital* – Partial with actions

SH advised the group that the associated clinical audit (C3018-1) was included for review within the Audit section of the meeting. The actions to address this recommendation were included within the proposed re-audit.

Approved, subject to proposed re-audit being added onto BriefCASE for C3018-1

Directorates' Update on NICE/Audit

Out of Hospital Care

LB gave an update on behalf of the Out of Hospital Care Directorate. The directorate has forwarded their contribution to the Trust baseline assessment for NG94 "*Emergency and acute medical care in over 16s: service delivery and organisation*".

SH queried if there was any update on NG74 "*Intermediate care including reablement*". LB was not aware of this guidance, but suggested that the lead for AHP, Anne Hallam, might be more appropriate.

Action: SH to request update from Anne Hallam

LB gave an update on the following clinical audits:

Audit of nutritional screening pilot in community district nurse teams. CG32.
Nutritional Screening Pilot has been completed, LB will chase up the lead for results.

Clinical Record Keeping – LB will write the report.

Audit of leg ulcer assessment in district nursing teams - LB will write the report.

Action: LB to provide reports for these audits.

B5029-1 Falls prevention and monitoring - LB advised that Becky Hardy, ops manager for community hospitals, has taken over as lead for this re-audit.

Action: CET to update responsible audit lead and request progress update.

Head & Neck

The Governance leads for Head & Neck Directorate were present to give updates on their specialities.

GH (Orthodontics) and AM (ENT) confirmed that they had no specific issues as far as they were aware.

NB (Maxillofacial) confirmed that he was working on the outstanding NICE baseline assessment for NG36 *"Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over".* NB acknowledged that this was overdue for completion, and asked for a deadline. SH confirmed that this would need to be completed and returned to the Clinical Effectiveness Team by 2nd July for inclusion at the next CEG meeting.

Action: NB to complete baseline assessment for NG36

NCEPOD Report

SH updated the Group on current NCEPOD studies:

Long Term Ventilation

The initial study specification was presented to the Group. Patient selection for the study can be problematic due to the scope of the study. NCEPOD has asked for the Trust to provide details of willing clinical leads at each hospital site. Dr John White has expressed interest in leading on this from the York Hospital site.

SH sought permission from the Group to promote this study through StaffRoom, or a meeting to gather interested parties together.

Action: SH/FJ to discuss options how to promote study further

Acute Bowel Obstruction

The Trust lead has confirmed the York & Scarborough Hospitals are eligible for inclusion in this study. All other sites within the Trust will not be included.

Pulmonary Embolism

The Trust has completed the required data collection spreadsheet, and we are now awaiting clinician questionnaires for selected cases.

GDPR Notice

NCEPOD informed the Trust's Ambassador (GM) & Local Reporter (SH) that they will no longer hold the names and contact details of clinicians without their consent. This information will remain held locally and clinician questionnaires will be sent to the local reporter for distribution to the relevant clinicians.

SH confirmed that this would have no significant impact on the way clinician questionnaires are currently distributed within our Trust.

Topic suggestions for 2018

SH advised the Group that NCEPOD has sent out a general invitation for topic suggestions for future studies, and encouraged those present to submit topics if they would appreciate the opportunity. Further information is available via the NCEPOD website and this is also available through StaffRoom.

Clinical Audit Report

FJ presented the Clinical Audit Report.

BriefCASEs for Discussion

There were **8** BriefCASEs for review by the Group, **4** of which were Audits against NICE guidance and **1** was against National Audits Standards

2778-3 Daniels Sharps Audit

This is an annual audit undertaken by Daniels Healthcare in collaboration with the Infection Prevention Team. The Daniels Healthcare auditor inspects all sharps facilities within the Trust.

FJ expressed a concern that there was a significant difference in number of incidents regarding sharps which were indicated in the report compared with the number of sharps incidents actually reported within the Trust.

Action: CET to ask DATIX team to compare indicated number of incidents with those reported.

NB queried what ‘unlabelled’ sharps bins meant in the context of this audit. CF clarified that this referred to the number of sharps containers which did not have the attached label completed with the location, time and date, of where the bins had been filled.

C3109-1 Capnography in PACU

Capnography should be used in 100% of patients in the Post Anaesthetic Care Unit (PACU) who have either a supraglottic airway devices (SAD) or endotracheal tubes (ETT) in situ.

The use of Capnography in PACU at Scarborough was audited in 2017 and the result was that capnography use was evident in **63%** of cases. This 2018 re-audit found Capnography use in **56%** of cases.

This re-audit therefore demonstrated the need for continuing education regarding the importance of capnography to reduce the risk of harm to patients.

Approved

Audit Reviewing Patients Achieving the 4 Hour Target in A&E in Oral & Maxillofacial Surgery Specialty

The aim of this audit was to assess the effectiveness of the Oral & Maxillofacial Surgery (OMFS) team at achieving the 4-hour waiting time target in ED and analyse where the problems occur where it is not being met.

The audit identified that there was little that could be done to achieve the 4-hour waiting time for patients referred to OMFS close to, or after, the 4 hour waiting time in ED. However in some cases patients were recorded as breaching 4 hours due to the way OMFS procedures were recorded. The audit proposes to more accurately record OMFS procedures and timings.

Approved

C3248 Factors which influence hospital use in the last year of life

The audit was undertaken by the palliative care lead and aimed to identify factors influencing hospital use in the last years of life. The audit found that key areas of effective end of life care are patient identification, assessment and care planning.

The lead suggested that there is scope to improve the identification of patients in the last year of life and suggested the Supportive & Palliative Care Indicators Tool (SPICT™) would assist with this.

Approved

C3018-1 Re-Audit for: IV antibiotic use in suspected meningitis or meningococcal disease in children

The aim of this re-audit was to evaluate the time between suspecting meningitis or meningococcal disease in children and giving the first dose of IV

antibiotics. This re-audit found that some areas had improved, however further promotion on the protocol for children under 3 months of age.

SH confirmed this was the audit associated with the NICE guidance and QS19 Meningitis. FJ requested therefore that the BriefCASE action plan be updated to include the re-audit, as indicated on the NICE baseline action plan.

Action: CET to inform lead to add re-audit onto action plan

No further BriefCASEs were presented as a discussion of the nature purpose of the CEG meeting took place; resulting in the proposal from FJ that the format of the Group would be changed to a two part meeting. The first part of the meeting would be corporate agenda and for the second part of the meeting governance leads would be invited to present and share learning.

Action: FJ/CF/SH to review format of meeting

Radiology – Modified Axial Projections

LC requested clarification from the Group if the change to practice proposed within Radiology would need to be approved by this Group through the New Procedures process. Essentially, this involves a trail obtaining a different view of the shoulder following trauma.

The Group were able to ascertain:

- There was no resulting increase in cost to the Trust
- There was no resulting increase in radiation exposure
- There was no business case required

The Group concluded therefore that this change to practice did not require approval through the New Procedures process. The advice was for this to be coordinated locally within Radiology.

Escalation to Quality and Safety Committee

The Clinical Effectiveness Annual Report will be escalated to Q&S, and will be uploaded to StaffRoom once approved.

Actions: FJ to take CET Annual Report to Q&S; CET to upload to StaffRoom once agreed.

Any Other Business

FJ welcomed feedback received about the current format of the meeting, comments were considered and as a result the format and content of the meeting will be revised.

Next Meeting *Tuesday 10th July 2018, 16:00*
Neurosciences Resource Room YH, & Orchard Room SGH

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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Chief Nurse Report

Recommendation

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

Current approval route of report

Quality & Safety Committee – 17 July 2018
Executive Board – 18 July 2018
Board of Directors – 25 July 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 to note

- The vacancy position at the end of May 2018
- Staffing Levels during June 2018
- The current position of C-difficile infection cases

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: Beverley Geary, Chief Nurse

Executive sponsor: Beverley Geary, Chief Nurse

Date: July 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.

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

The PALS team actively dealt with 164 enquiries, comments and concerns. The team also had 145 queries that were not formally logged. 74% of PALS cases were closed within the target timescale of 10 working days (up 2% from May 2018).

2.1.1 Complaints and PALS Management

26 new complaints were received and 9 cases were reopened for further investigation. 32% of complaint cases closed in May met the Trust's 30 day response target. This is above the 2017-18 annual average of 27%. Nine cases were addressed using the next working day process, resulting in a quick resolution for the complainant.

There were no new PHSO cases. However, the Trust worked with the PHSO to resolve 2 cases without the need for formal investigations.

504 compliments were received.

2.1.2 Friends and Family Test

The inpatient satisfaction rate in May 2018 remains stable at 96.7%, slightly higher than the national average for April at 96%.

The ED satisfaction rate was 87%, which was at its highest in November 2017 at 90.8%. Scarborough ED satisfaction has increased by 5% from March 2018 to 83% in May whilst York ED has sustained the 85% from March.

The inpatient response rate in May 2018 was 28.6%, the highest since October 2017, and higher than the national average of 24.9%.

The ED response rate was 10.8%, nearly 2% lower than the previous month and the national average of 12.9%.

Satisfaction Scores	% Patients Satisfied Mar 18	Patients Satisfied April 18	% Patients Satisfied May 18	National Average % (April) 18
Inpatient	96.2	96.5	96.7	96
Emergency Department	84.5	85.2	84.5	87
Maternity	97.2	98	97	97

2.2 Workforce

2.2.1 Nursing Dashboards

The revised format nursing dashboards at Trust and Site level for the period ending 31 May 2018 are attached at Appendix 1. A community level dashboard is also now attached.

2.2.2 Nursing & Midwifery Staffing Levels

The report on the nursing and midwifery staffing levels for June 2018 is attached as a separate paper.

2.2.3 Vacancy Position

The adult inpatient vacancy position for adult in patient units at the end of May 2018 is detailed below:

Site	Vacancies		Pending Starters		Pending Leavers/ Transfers		Unfilled Vacancies	
	Trained	Un trained	Trained	Un trained	Trained	Un trained	Trained	Un trained
Bridlington	8.45	3.45	6.8	5.4	11.24	10.63	3.25	-1.35
Community	7.41	6.65	1.6	5.8	0.48	0	6.29	0.85
Scarborough	66.15	23.83	27	26.03	9.4	7.37	48.55	5.17
York	97.19	29.97	46.13	52.6	19.98	6	71.04	-16.63
Total	**179.2**	**63.9**	**81.83**	**89.83**	**41.1**	**24**	**138.47**	**-1.93**

The Trust continues to actively engage in recruitment events targeted at existing and newly qualified nurses, as well as locally managed recruitment to reduce Registered Nurse vacancies.

2.3 Safe, Quality Care

2.3.1 Infection Prevention Update

The current rate of Trust attributed infection is detailed below.

Organism	Trust Threshold	Trust attributed
Methicillin Resistant Staphylococcus Aureus **(MRSA)**	0	**2**
Methicillin Sensitive Staphylococcus Aureus **(MSSA)**	30	**4**
Clostridium Difficile **(C-diff)**	47	**18**
Escherichia Coli **(E-coli)**	68	**10**

C-difficile infection
We now have reached **18** cases of Trust-associated CDI (figure accurate on 06/07/18). The annual threshold for this organism is **47.**

On a flat line trajectory, we would not expect to have more than **12** cases by this point in the year. However, the trajectory is not a flat line and would expect to see fewer cases in the summer months than the winter.

This time last year we had **9** cases.

The table below illustrates HAI rates by organism and Directorate.

	Annual Trust threshold	Threshold to end of July	Total Trust attributed to date	July incidence	Days from last case		Community	Critical Care	Elderly Medicine	Medicine	Specialist medicine	Surgery & Urology	Trauma & Orthopaedics
MRSA bacteraemia	Zero tolerance		2	0	16	Incidence to date				2			
						Incidence per 10000 bed days	0.00	0.00	0.00	0.92	0.00	0.00	0.00
						Days since lastcase	637		280	16	801	627	
MSSA bacteraemia	30	10	4	0	18	Incidence to date		1	1	2			
						Incidence per 10000 bed days	0.00	6.89	0.33	0.92	0.00	0.00	0.00
						Days since lastcase	324	30	75	18	300	230	340
Ecoli bacteraemia	68	22	10	0	20	Incidence to date	2		3	1	2	2	
						Incidence per 10000 bed days	2.95	0.00	0.98	0.46	7.57	1.77	0.00
						Days since lastcase	43	428	17	86	20	26	210
Clostridium difficile toxin	47	16	18	1	5	Incidence to date	2	1	6	3	3	2	1
						Incidence per 10000 bed days	2.95	6.89	1.97	1.38	11.36	1.77	1.54
						Days since lastcase	30	32	7	8	10	3	23

As outlined above the majority of the CDI cases have been at the York site. Cases have occurred across a number of wards and directorates. They have not been related and there have been no outbreaks or periods of increased incidence. This

suggests that the causes and contributing factors are hospital-wide, not confined to specific patient groups or clinical areas.

The IPC team's initial assessment of the situation has identified a number of issues including:

- Delays in sampling
- Non-availability of anti-sporicidal wipes
- Damaged stock of commodes (cannot be effectively decontaminated)
- Issues with environments
- Inability proactively HPV
- Antibiotic usage

A paper will be presented to Trust Infection prevention Committee with a plan to address these and other issues.

The committee are aware of the risk in relation to lack of decant facilities; a group has been set up to look at solutions and the feasibility of some deep clean programs ahead of winter. The Director of Estates and Facilities is exploring availability of ward to 15 enable decant at the York site. An options appraisal is being worked up to tackle the same issue at SGH.

Learning taken from a review of last winter and the management of Respiratory Viruses and flu; explorations for the provision of a Seasonal Influenza ward at Scarborough is now underway.
Work to address the Infection Prevention and Control issues that are presented by both Ann Wright and Graham Wards at Scarborough Hospital continues. An options appraisal for solutions is under way and will be completed by mid-July.

The first of the Fit Testing 'train-the-trainer' took place in in late June. This was hugely successful with attendance rates of over 95%. This training is now being recorded online by CLAD so that we will now be able to easily identify trained individuals.

2.3.2 Reducing smoking in pregnancy to improve outcomes including reducing stillbirth and neonatal death.

Maternity continue to train midwives to deliver brief intervention advice to women about the dangers of smoking in pregnancy and also to monitor women's Carbon Monoxide levels in pregnancy and refer to smoking cessation services. Rates of smoking at the time of birth have fallen in Scarborough over the past 2 years.

Maternity are planning to be involved in an open a study called SKIP-IT across Scarborough & York.

SKIP-IT is a randomised, interventional study that aims to help women to stop smoking in pregnancy by sending text messages with embedded behaviour change techniques (BCT).
Participants will receive texts at various times in the day and at varying levels per week, to mimic 'real life' messaging.

This is a pilot study planned to run short term with the potential to be involved in a larger trial in the future.

This is in addition to smoking cessation information, intervention, referral for support and carbon monoxide screening for pregnant women already in place in maternity services.

The Committee receive regular updates regarding the maternity services including risks and mitigations; incidents and developments a detailed paper is attached at appendix 2.

2.3.3 Safeguarding Adults Update

There have been a number of submissions to external Safeguarding Adult Board Quality and Performance sub groups in this quarter to summarise Achievements and Areas for developments:

They are summarised as follows:

	Key Achievements	**Areas for development**
Awareness and Empowerment	Major Trust Wide Drive in raising Safeguarding Awareness to Staff in the Trust BITESIZE ROLLING PROGRAMME Trust Leaflets give guidance to patients involved in the safeguarding adults process.	Audit programme to commence to monitored continued awareness raising and target areas Identify ways of enhancing Making Safeguarding Personal beyond the in-patient concern.
Prevention	Community Teams are supported to support patients who decline treatment and potentially pose a risk to themselves in doing so. PREVENT Training Needs Analysis reviewed to include WRAP training to be delivered to key areas.	Continue to develop the VARM process (Vulnerable Adult Risk Management) process within Community Teams Development of signposting system where safeguarding not desired or appropriate
Protection and Proportionality	Trust Safeguarding Adults processes are in line with Local Authority Guidelines and Thresholds.	Development of combined consistent Threshold Tool for decision making. Identify ways of enhancing Making Safeguarding Personal beyond the in-patient concern.
	Ongoing commitment to Safeguarding Adults Board sub groups	More involvement at Strategic level with NYCC

	Commitment and representation at Local Authority Lessons Learned Processes Identified gaps have accompanying regularly monitored action plans Strategic links with Quality Safety Committee Commitment to LeDer programme Continued assurance to Clinical Commissioning Groups via self-declaration tools.	

The local commissioning groups are now responsible for coordinating LeDeR reviews for patients who have died and have a learning disability. They have convened monthly panel meetings to review the cases submitted and monitor actions from completed reviews. These will be fed into to the Trust Mortality review Groups.

On 21/06/2018 NHS Improvement published the Learning Disability Improvement Standards for NHS Trusts. The standards; the first of their kind aimed solely at NHS Trusts, are intended to help the NHS measure the quality of service we provide to people with learning disabilities, autism or both.

There are four standards each aimed at improving the care people receive; these include:

- Respecting and Protecting Rights,
- Inclusion and Engagement,
- Workforce and,
- A specialist Learning Disability Services Standard.

As a result, LD Liaison Service are populating an action plan based on the standards to identify evidence of good practice together with areas for development.

We continue to work in partnership with all agencies as per the Multi-agency safeguarding adults policy and procedures. Safeguarding Adults Multi-agency policy and procedures have now been amended. Review of the Trust Safeguarding Policy is underway to mirror the amendments.

3. Recommendation

The Committee is asked to note the Chief Nurse Report for July 2018.

APPENDIX 1

York Teaching Hospital
NHS Foundation Trust

Trust and Site Level Nursing Dashboards

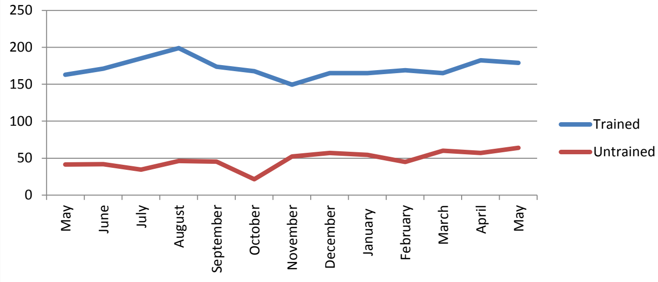
June 2017 - May 2018

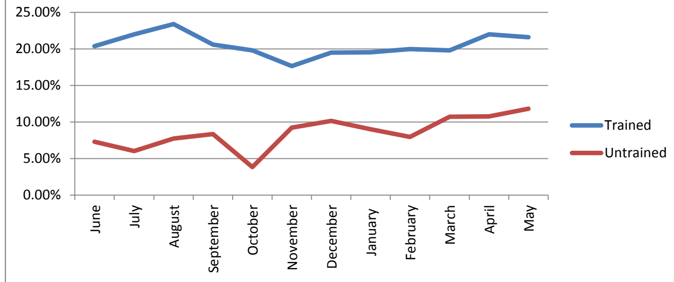
Owner: Beverley Geary, Chief Nurse
Author: Nichola Greenwood, Nursing Workforce Projects Manager

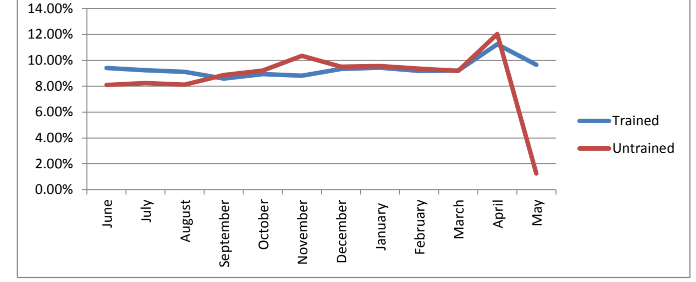
Trustwide Nursing Dashboard

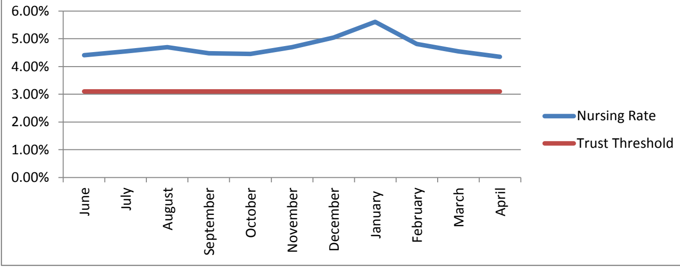
York Teaching Hospital NHS Foundation Trust

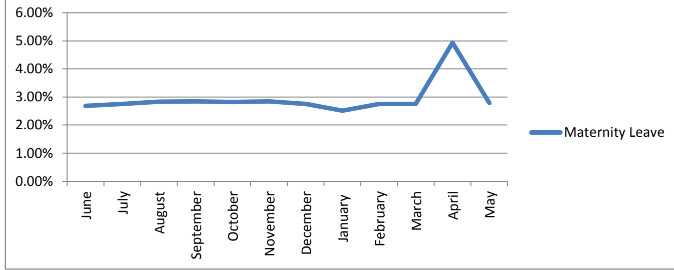
Workforce Metrics

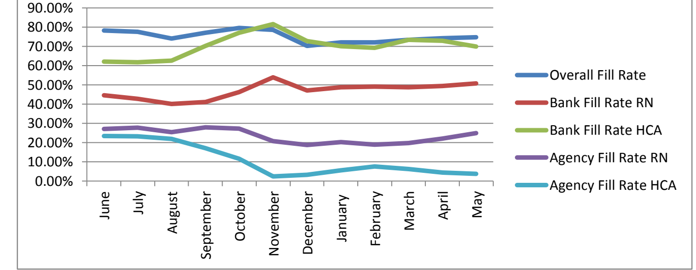


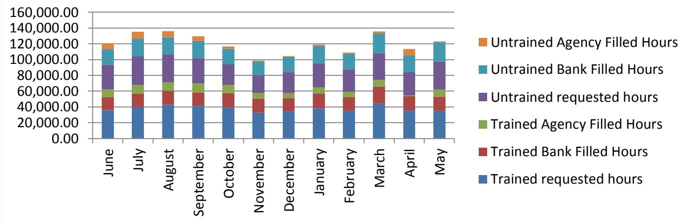


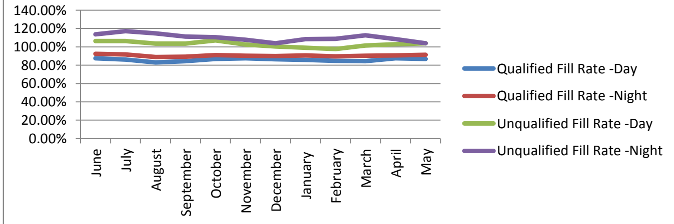


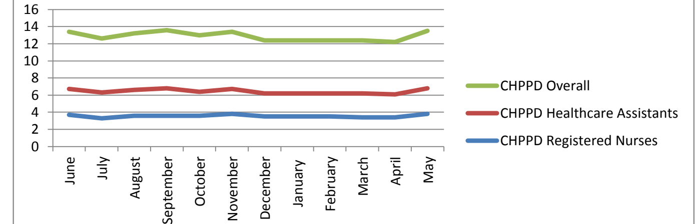






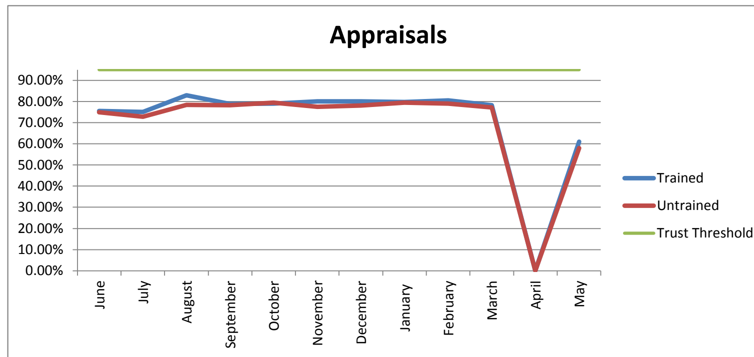


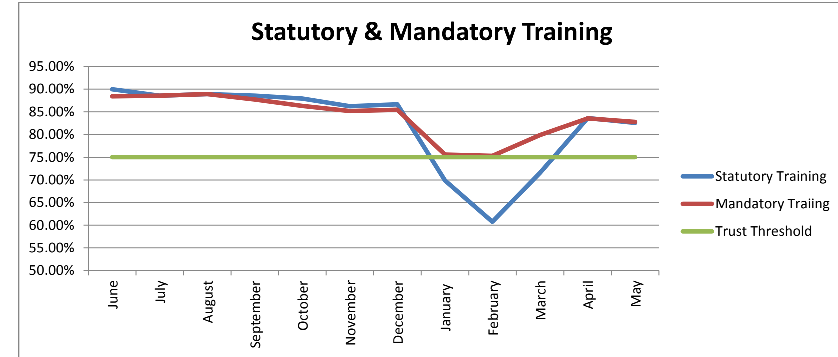




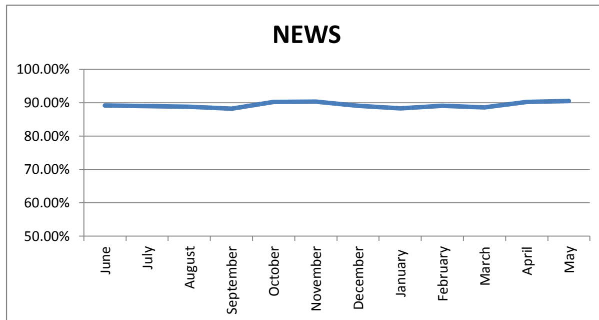
Staff Experience

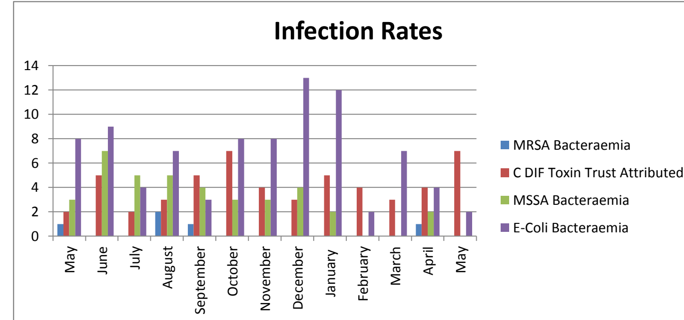
Appraisal rates for April 2018 are not available due to the transfer of reporting to the learning hub

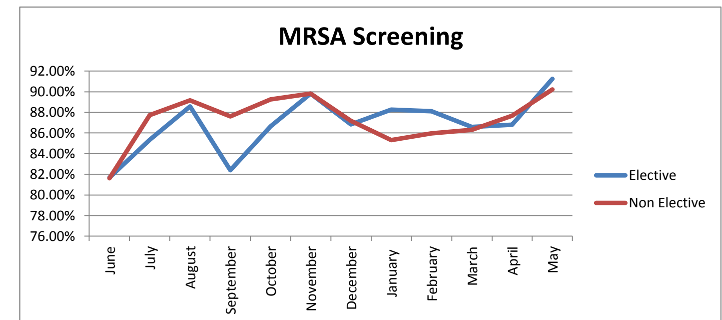


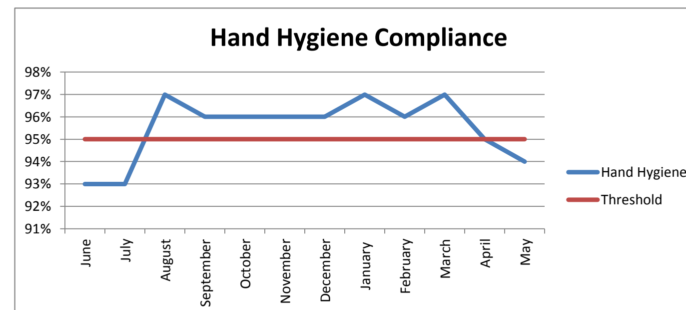


Performance Metrics

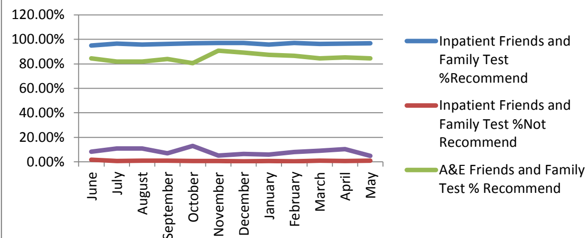


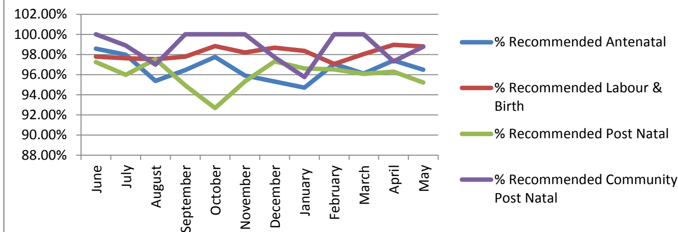


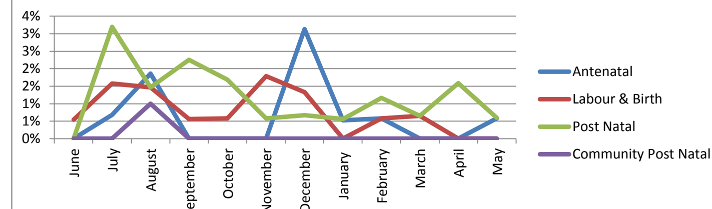


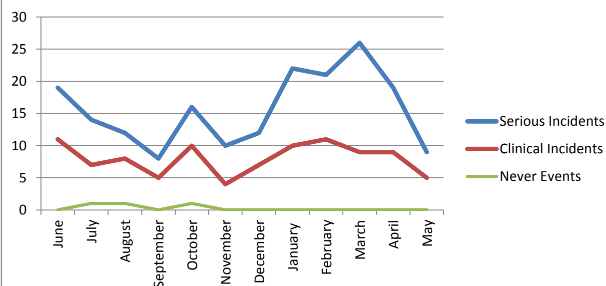


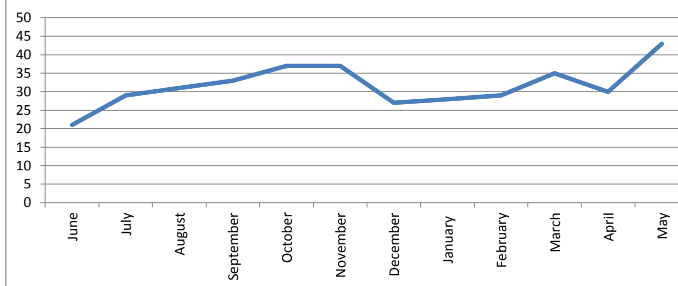
Patient Experience

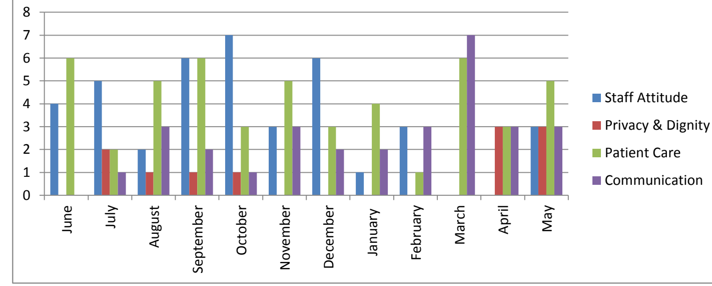








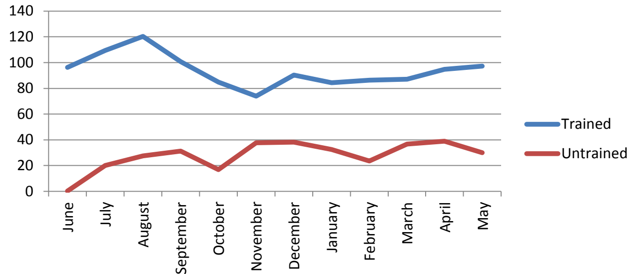


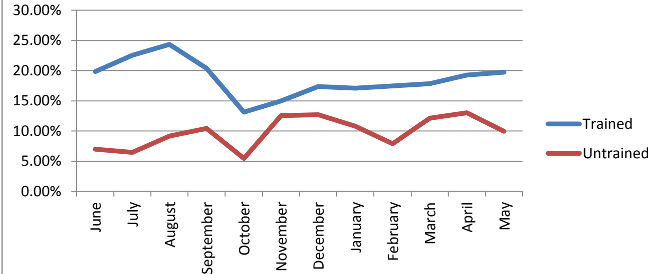


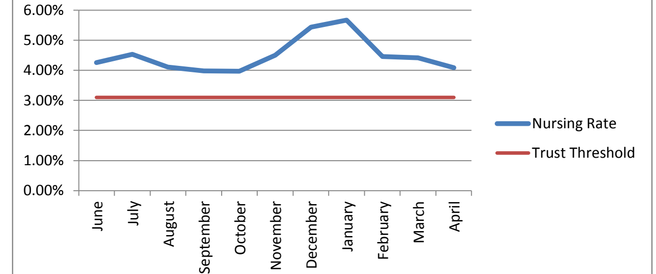
York Hospital Nursing Dashboard

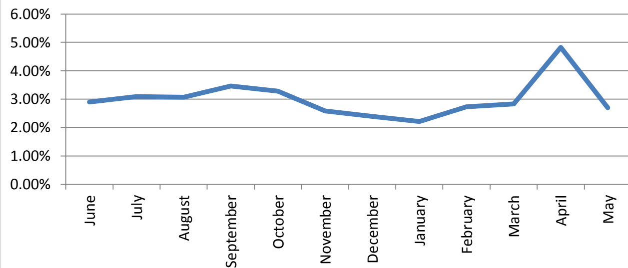
York Teaching Hospital NHS Foundation Trust

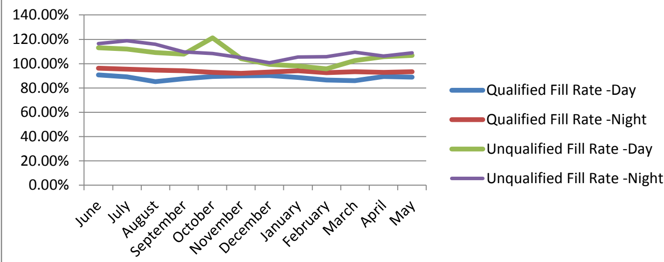
Workforce Metrics

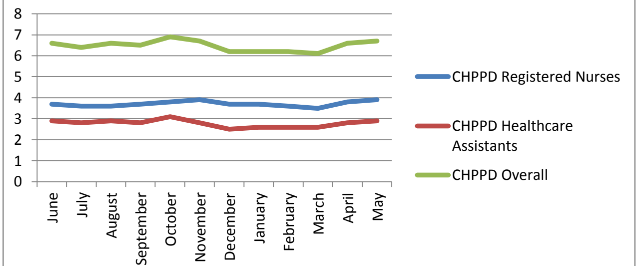


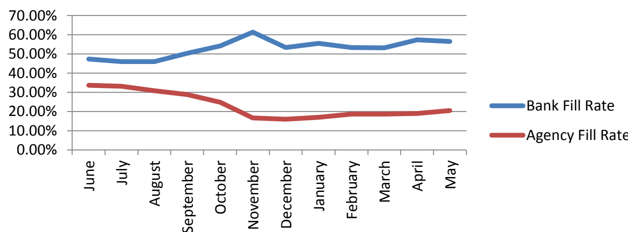


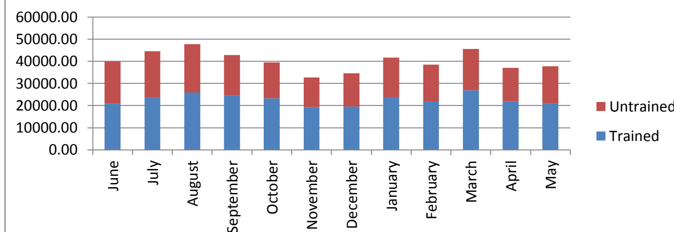


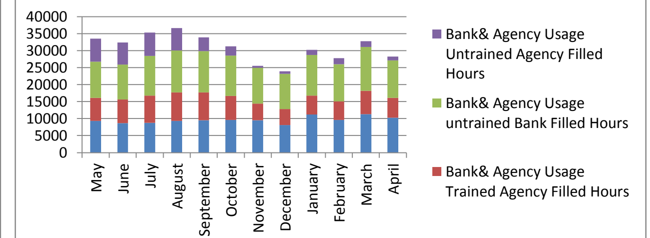












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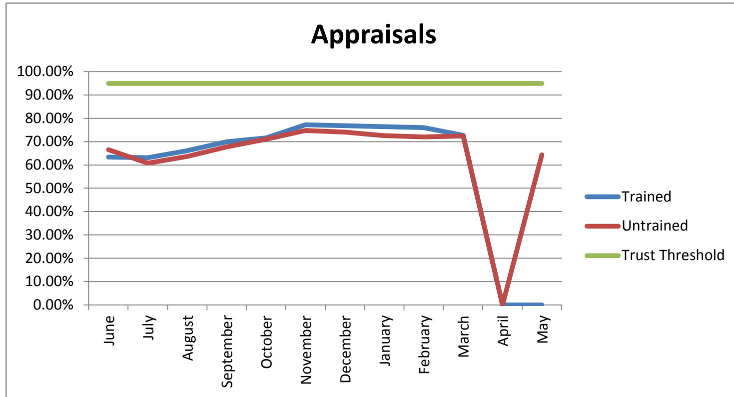
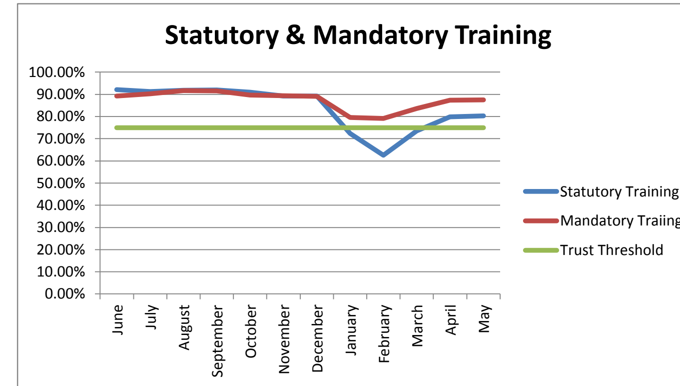
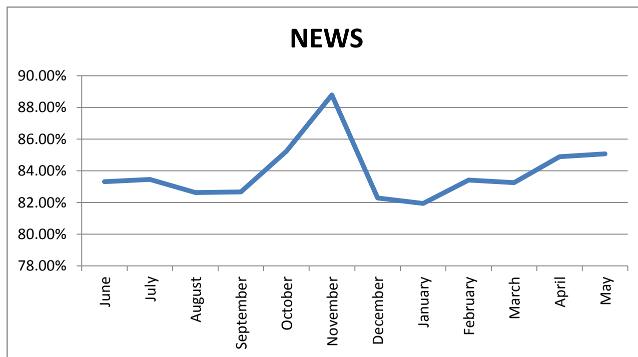
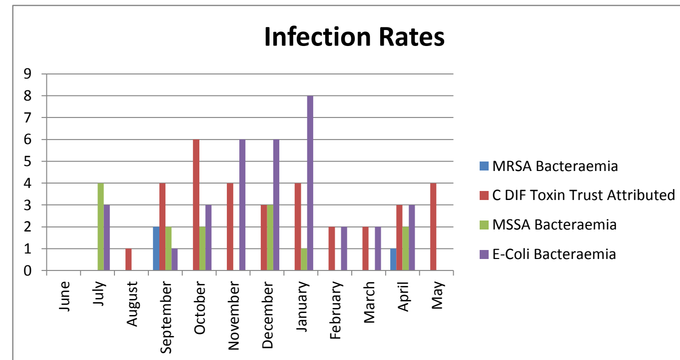
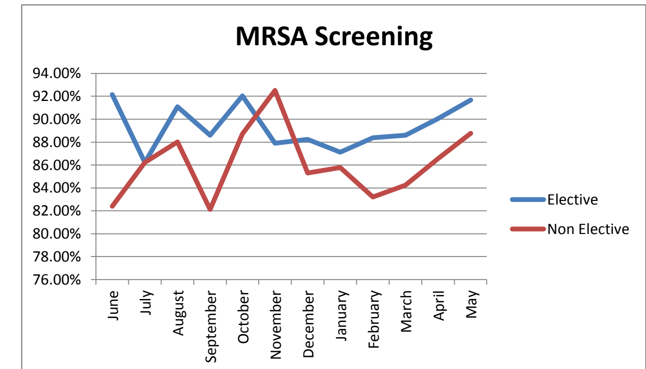




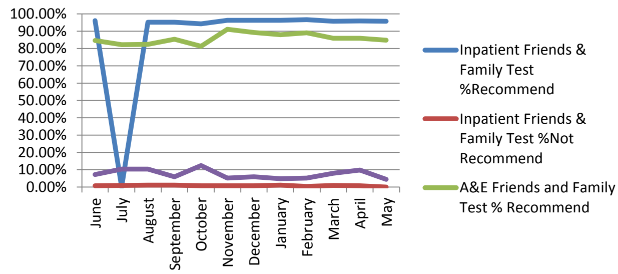
Performance Metrics

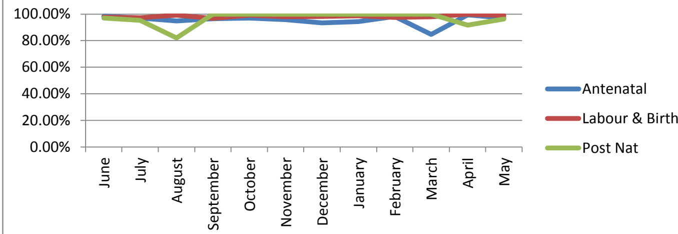


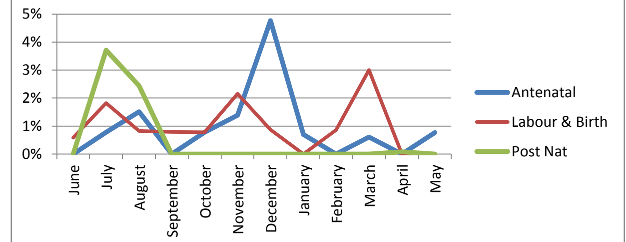


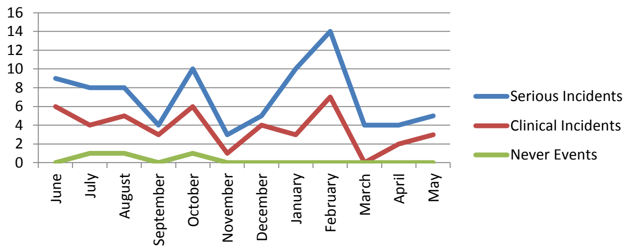


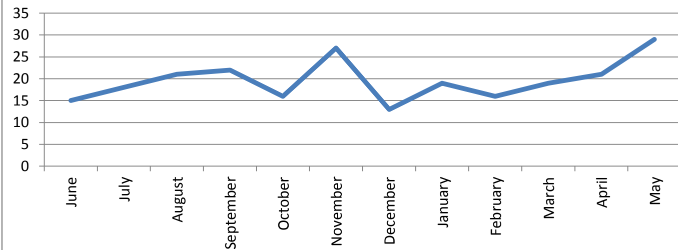
Patient Experience

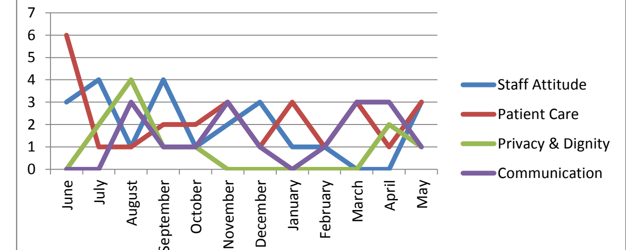








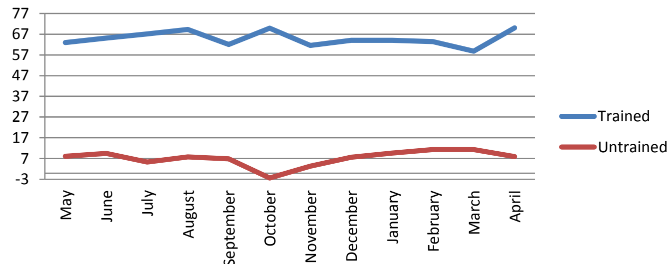


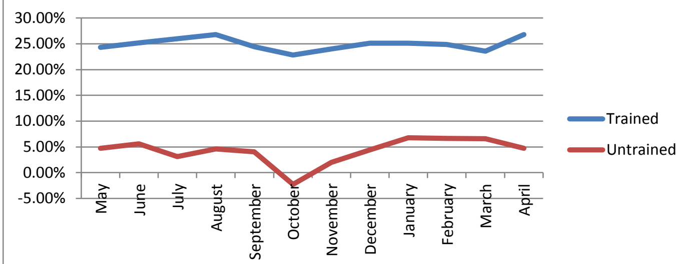


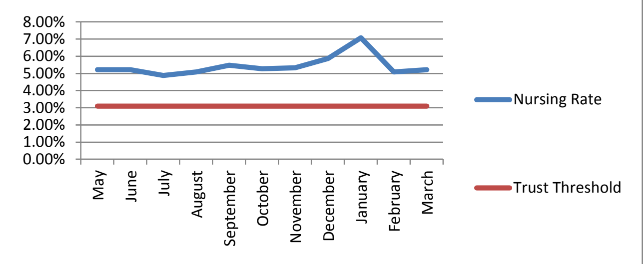
Scarborough Hospital Nursing Dashboard

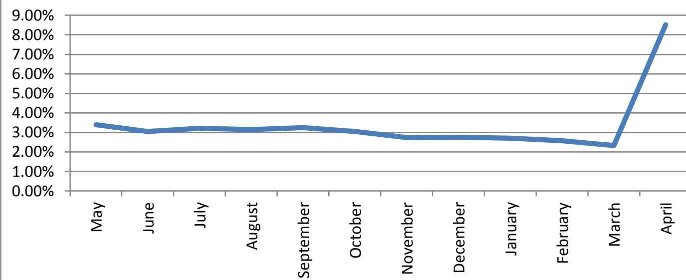
NHS York Teaching Hospital NHS Foundation Trust

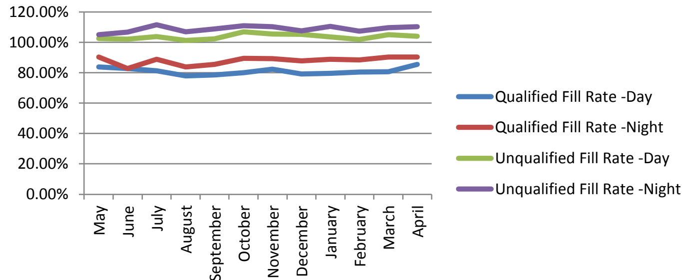
Workforce Metrics

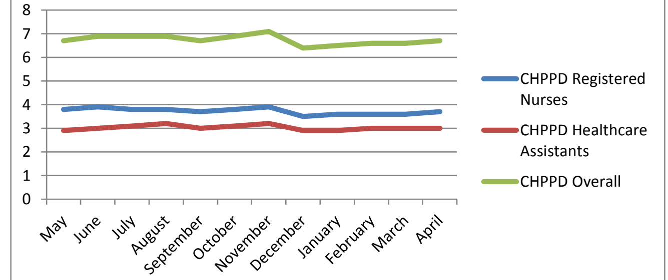


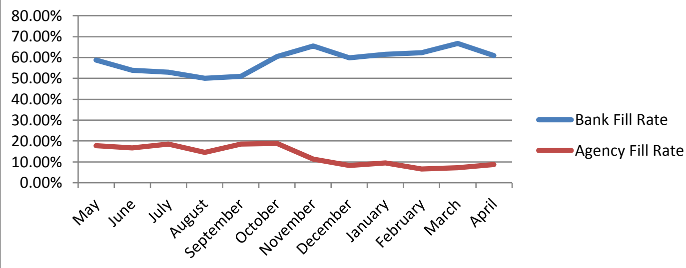


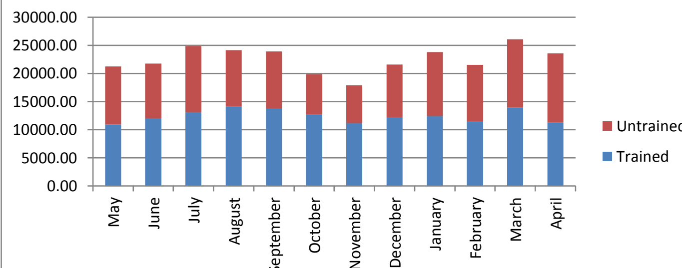


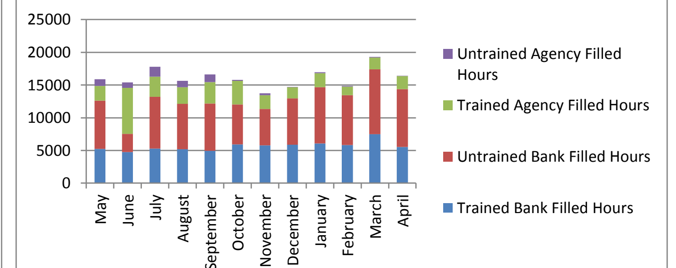












Staff Experience

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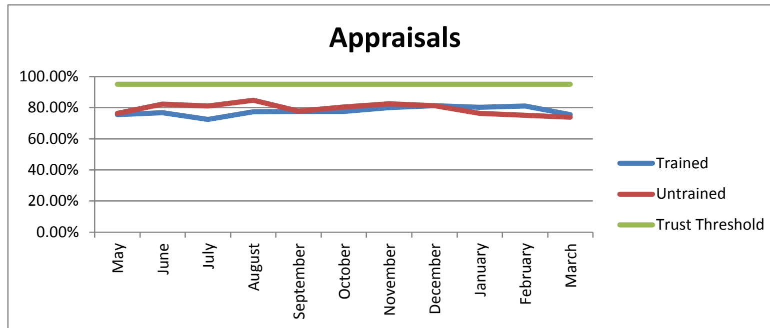

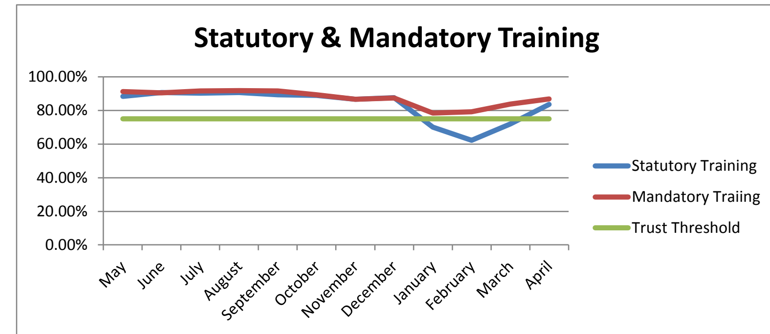

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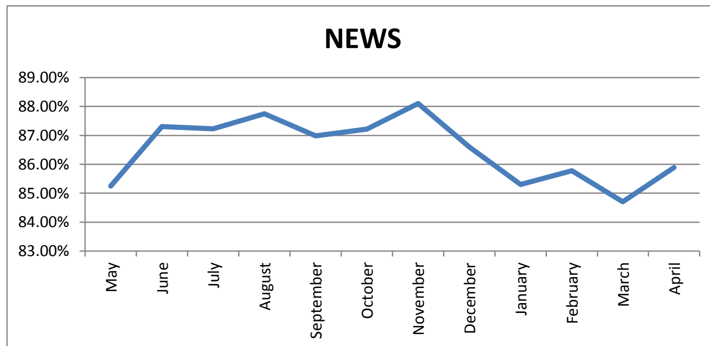
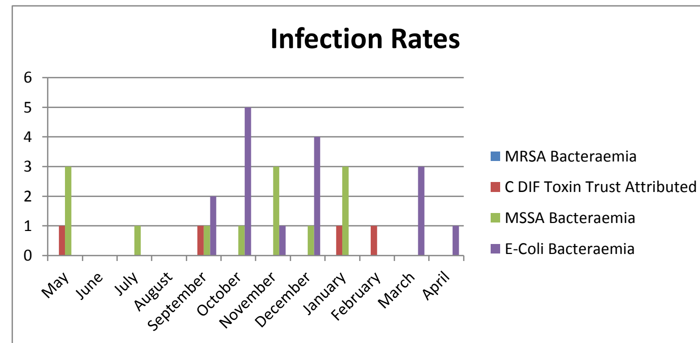
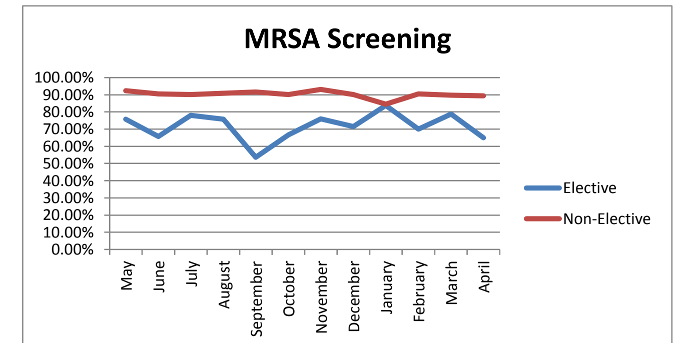
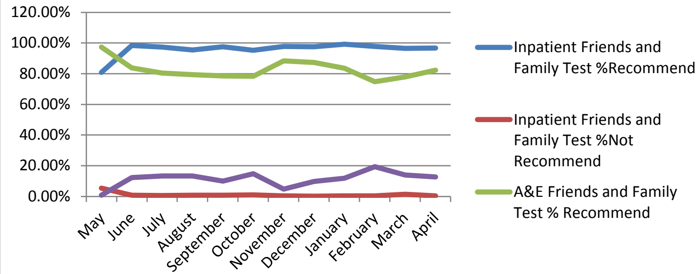
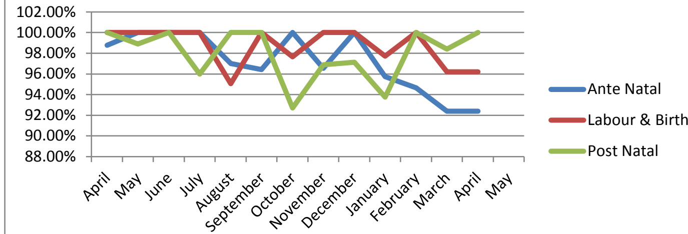


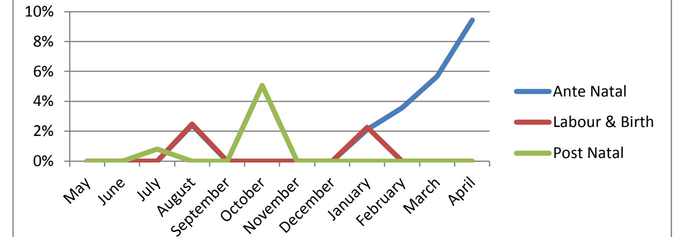


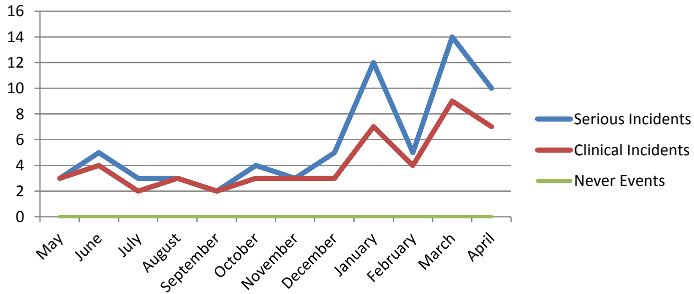


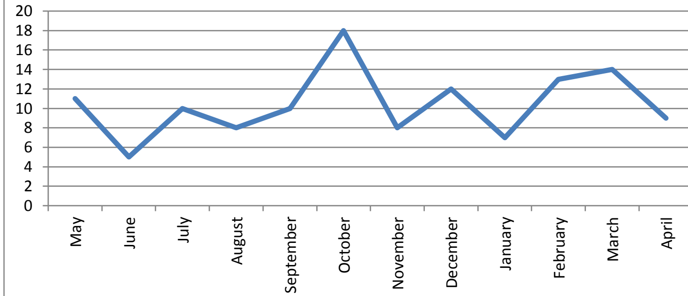
Patient Experience

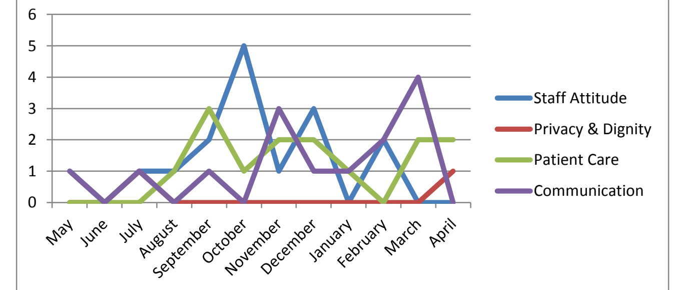








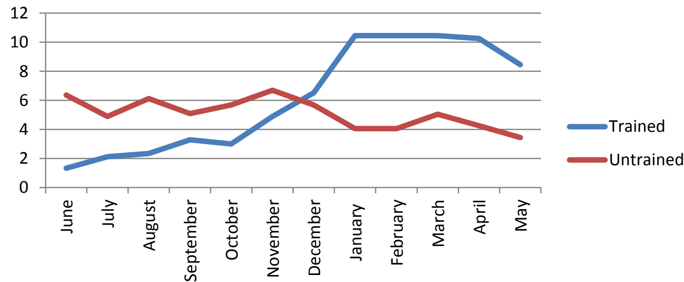


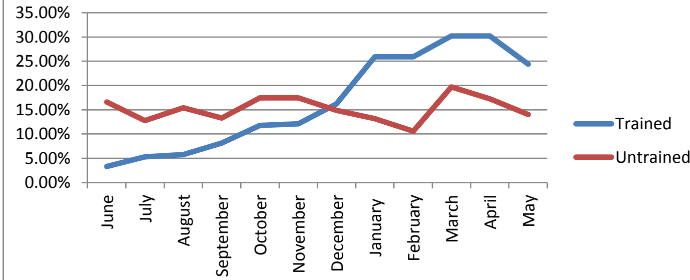


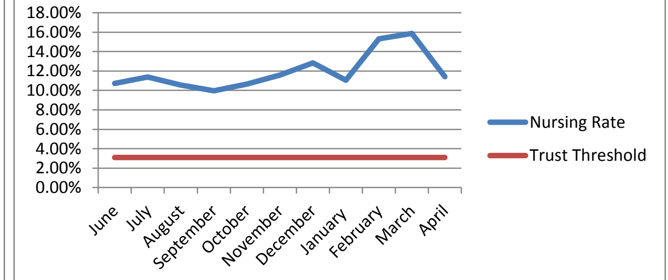
Bridlington Hospital Nursing Dashboard

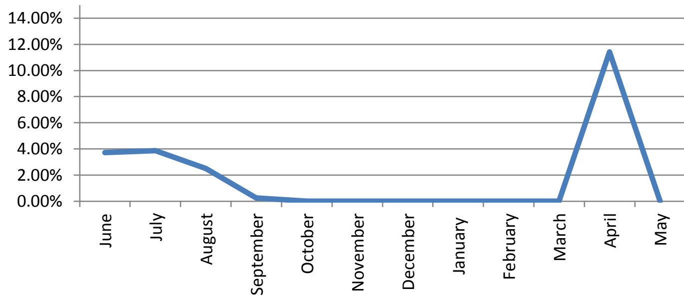
York Teaching Hospital NHS Foundation Trust

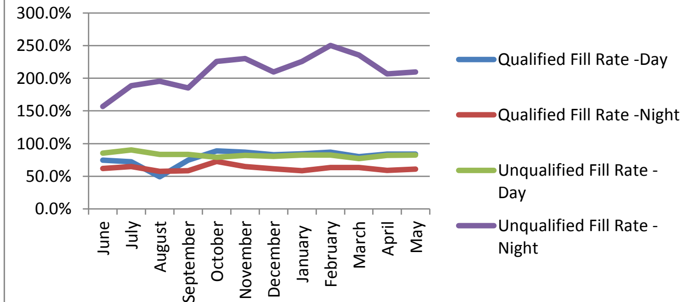
Workforce Metrics

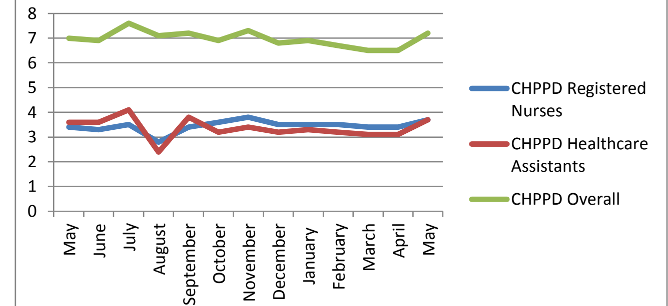


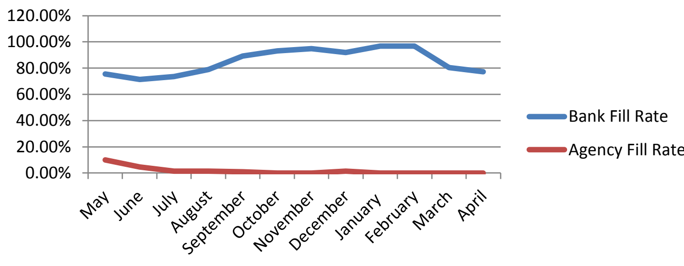


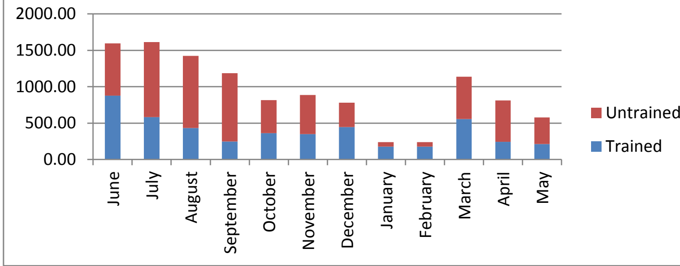


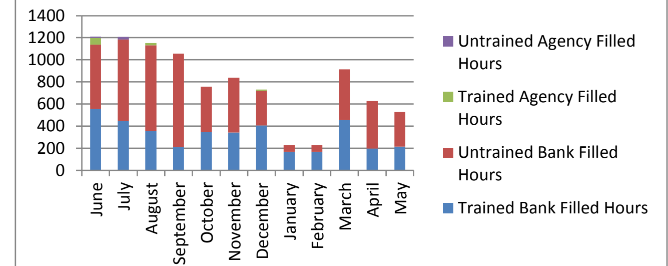












Staff Experience

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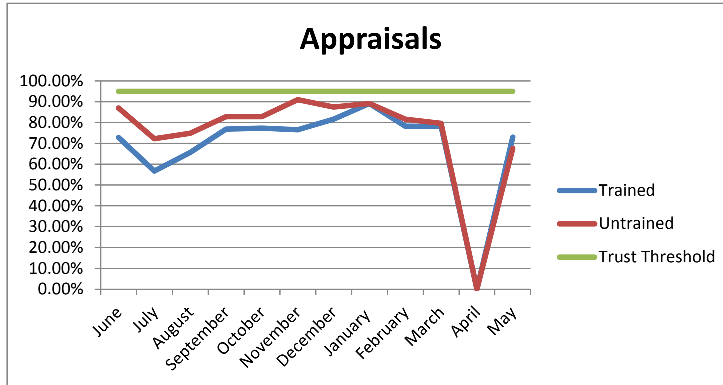
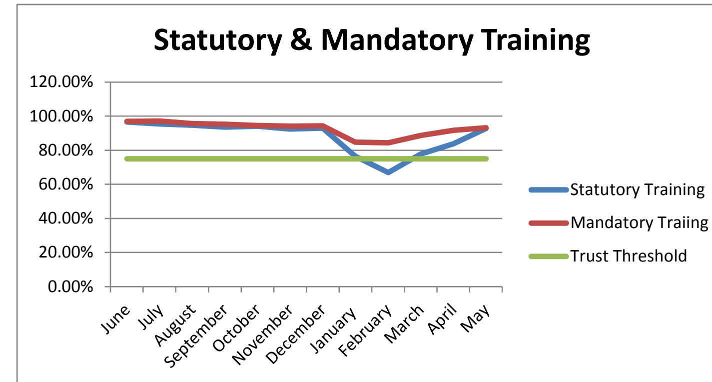
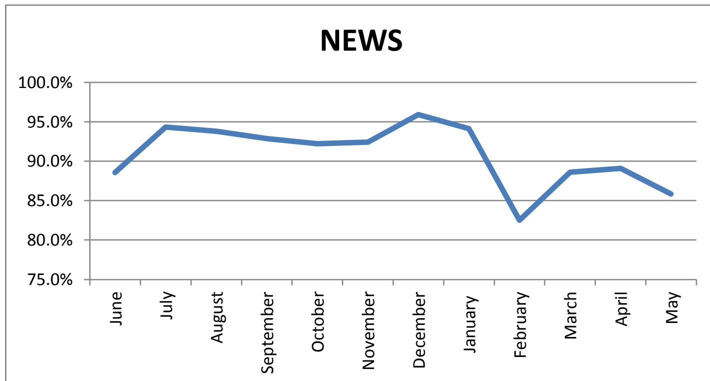
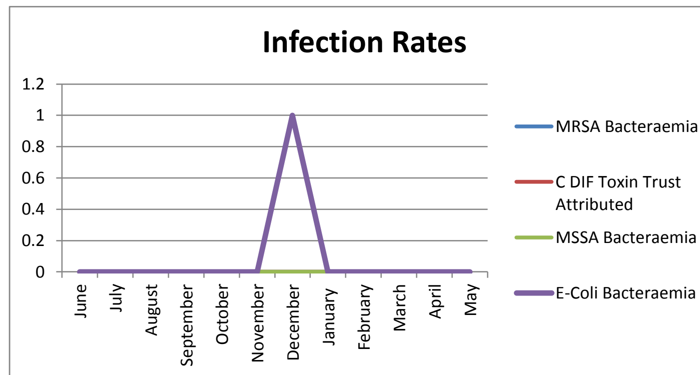
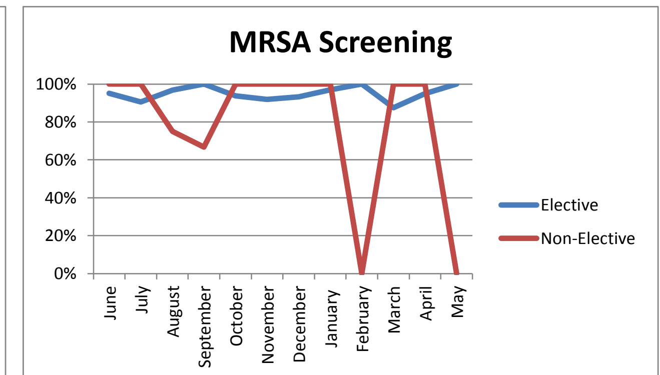




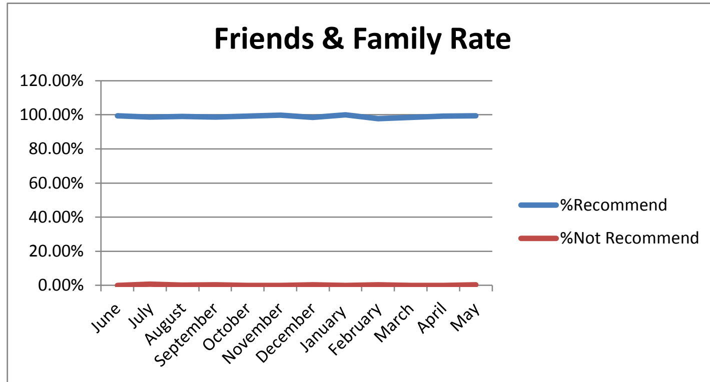
Performance Metrics

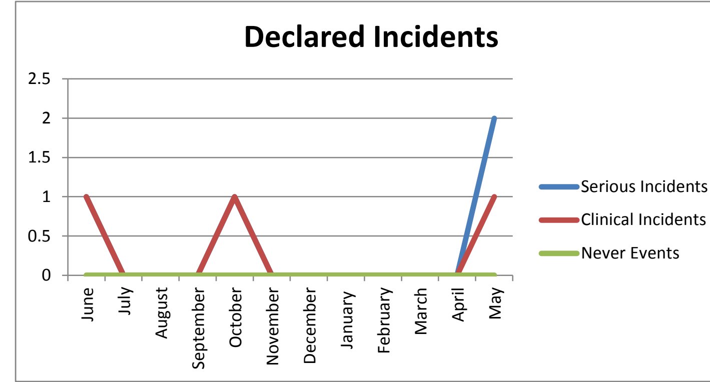


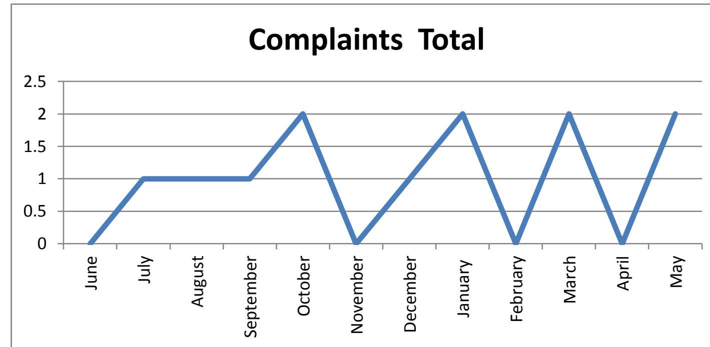


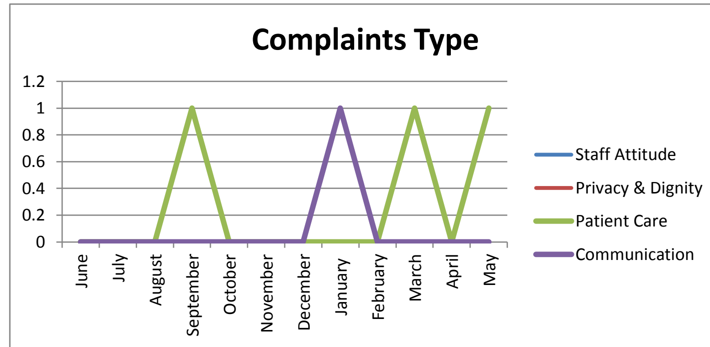


Patient Experience





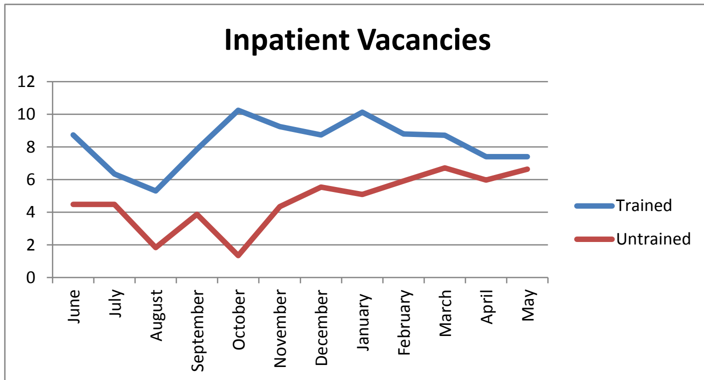


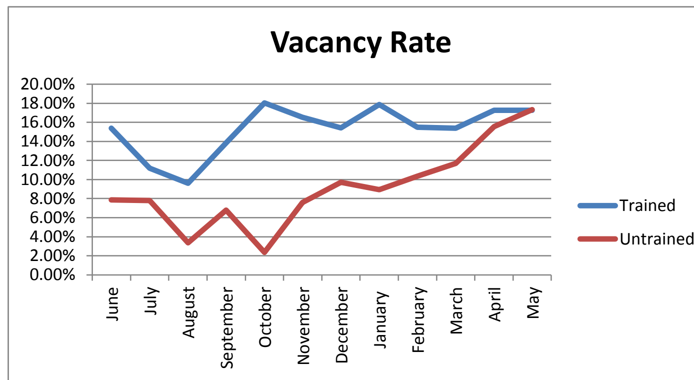


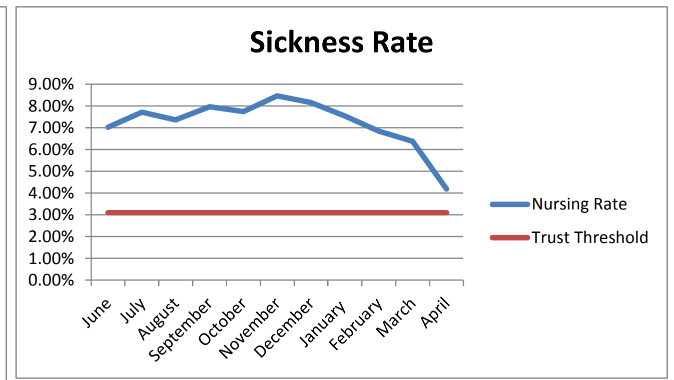
Community Inpatient Unit & Community Nursing Dashboard

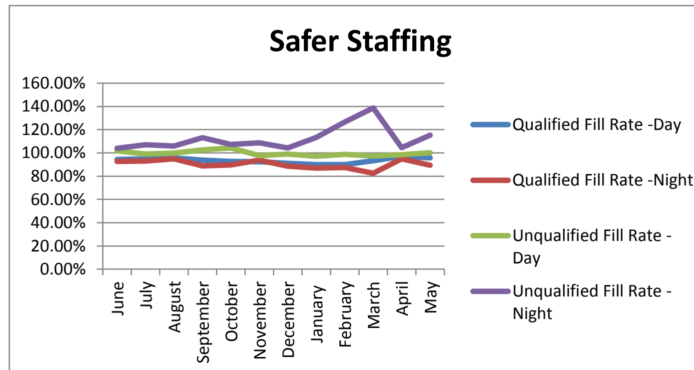
York Teaching Hospital NHS Foundation Trust

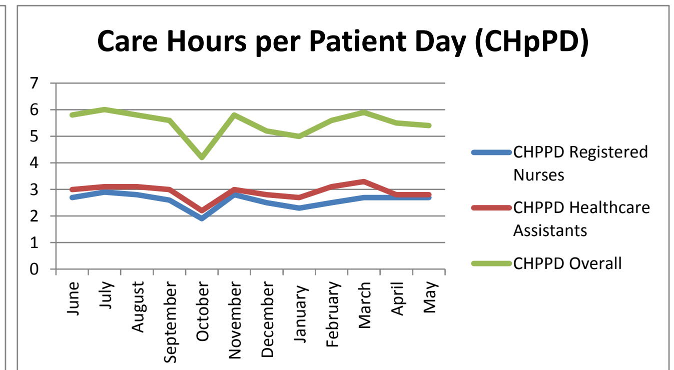
Workforce Metrics

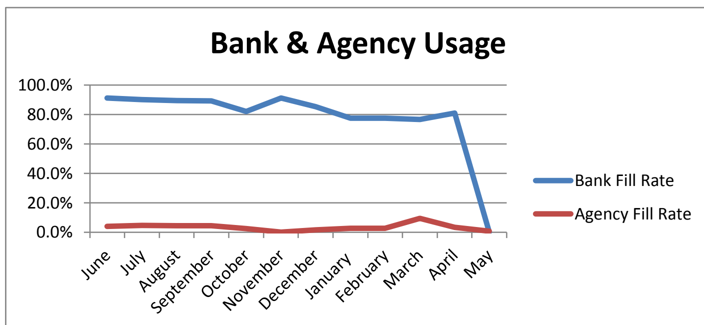


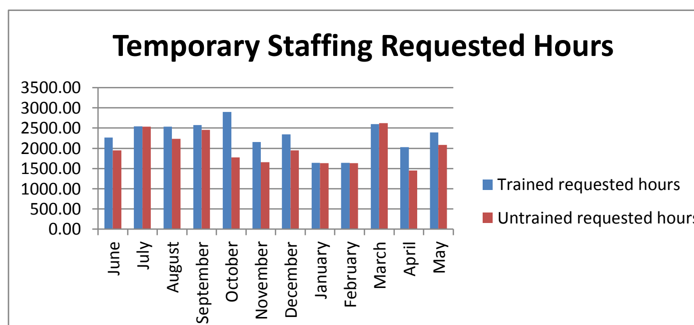


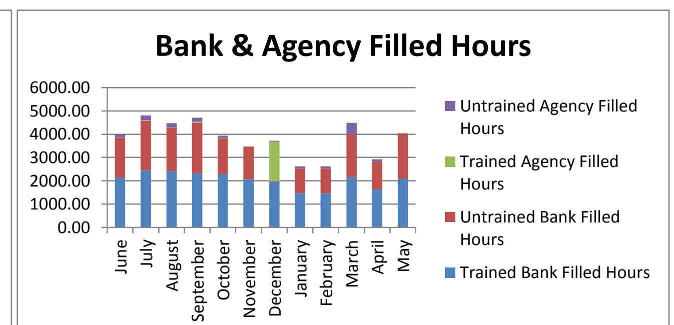












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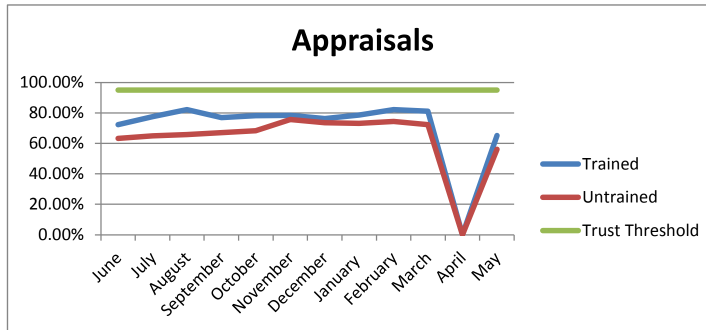

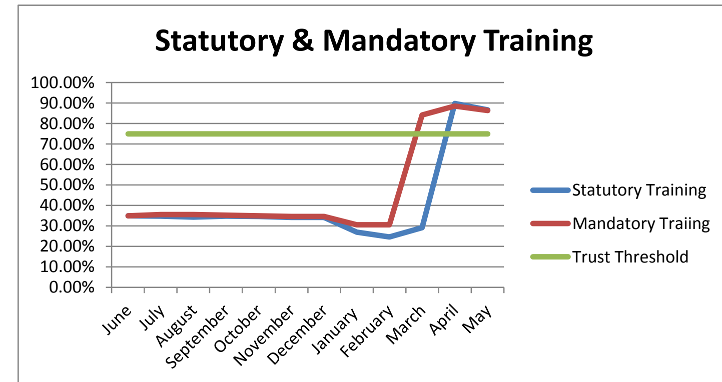

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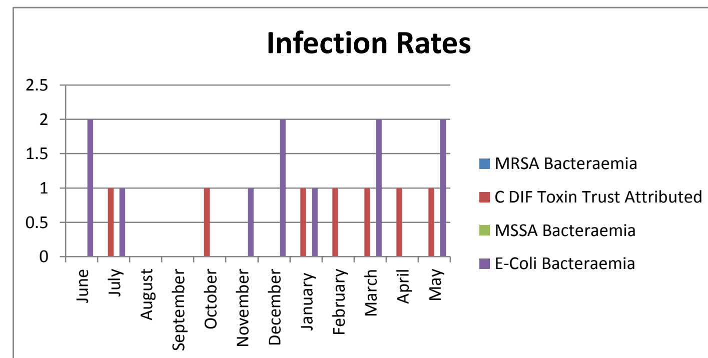

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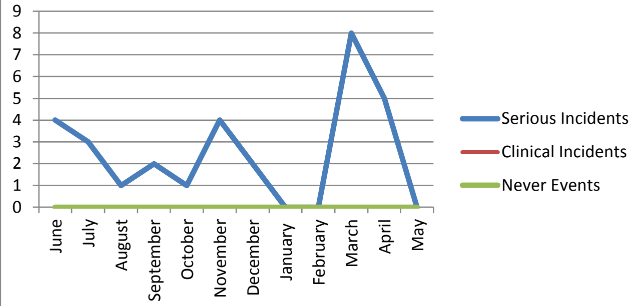
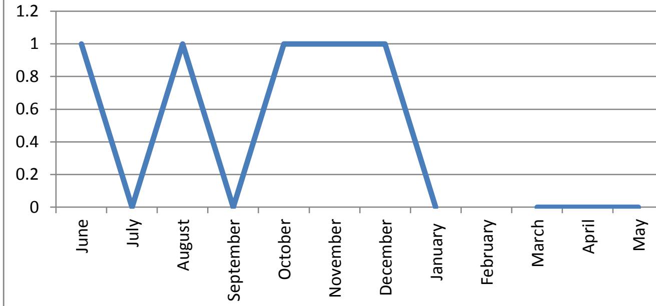
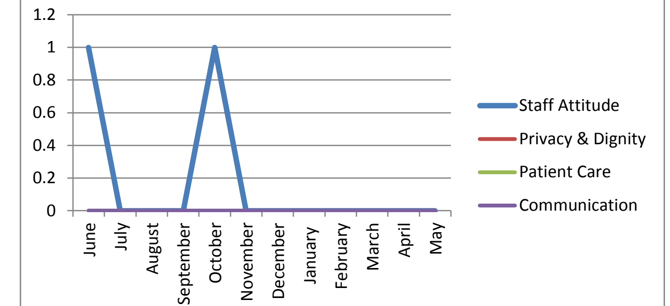






1. Introduction and Background

Maternity transformation is progressing following the publication of the national maternity review 'Better Births' 2016. The national maternity transformation board are driving forward implementation of the recommendations from Better Births through Local Maternity Systems (LMS) with the aim to achieve the Secretary of State for Health ambition in the new maternity strategy to make the NHS the safest place in the world to give birth.

York maternity services are part of national, regional and local work to achieve this ambition working closely with Humber, Coast and Vale Local Maternity System and Yorkshire and Humber Clinical Network. In April 2019 York are scheduled to commence wave 3 of the national maternity and neonatal health safety collaborative quality improvement plan. Maternity Safety Champions meet regularly with the Chief nurse, board level Safety champion to discuss the maternity safety plan.

Increasing service user involvement remains a priority with the newly formed Maternity Voices Partnership (MVP) in the LMS. York and Scarborough MVP (previous Maternity Services Liaison Committee) will feed into the LMS overarching MVP group.
Changes in response to user feedback include reintroducing face to face parent education classes, updating on line parent education and improving staffing levels on the postnatal ward. Results from the national patient experience survey 2017 was very positive with improvement seen from the 2015 survey.

The Maternity service has undertaken 2761 bookings in 6 months and 2245 births across community and two main hospital sites in York and Scarborough. A continued decrease is seen from the same period last year which appears to be a regional and national picture.

Midwife to birth ratios have improved due to the decrease in births with York site now meeting national recommended levels. Whilst the ratio of midwives to births has improved York site are continuing to experience increased acuity of women requiring a higher level of care. Implementation of an on call midwife for Labour Ward and elective caesarean section pathway have improved safety and staffing at York site.

Development of Professional Midwifery Advocates (PMA) following the end of the Supervisors of Midwives role is now in place providing clinical supervision to midwives.

Management of risk in maternity services remains high on the agenda with increasing requirements for case review and investigation following implementation of national reporting systems including RCOG Each Baby Counts, NHS Resolution, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), Child Death Overview Panels (CDOP), neonatal ODN and a new National Perinatal Mortality Review tool launched in February 2018. There are plans nationally to standardise investigation of cases through the Healthcare Safety Investigation Branch (HSIB) later this year.

York stillbirths rates remain below regional average with work continuing to reduce further. Strategies are in place to reduce Post-Partum Haemorrhage (PPH), third and fourth degree tears and smoking in pregnancy. The caesarean section rate is rising at York site; Labour Ward leads are focusing on initiatives to reduce the rate.

Progress has been made in reducing smoking in pregnancy and increasing breast feeding rates at Scarborough site.

Service development for 2018 includes;

- Transitional care for babies with a plan to develop this further and increase the criteria for this model of care.
- ATAIN project (Avoiding Term Admissions into Neonatal units) focusses on use of antenatal steroids and magnesium sulphate, keeping babies temperature at an optimum level with an MDT case review of all term admissions to SCBU.
- PReCePT (Preventing Cerebral palsy in pre term)a national programme aimed at increasing the numbers of eligible women offered magnesium sulphate to prevent cerebral palsy in preterm infants (NICE recommendation). Maternity are linking with Yorkshire and the Humber Academic Health Science Network to roll out this Quality Improvement programme from September 2018.
- Flu vaccine offer in maternity, work undertaken with NHSE immunization and screening team to increase the uptake of the flu vaccine in pregnant women by offering the vaccine in Antenatal clinics and on antenatal wards. This has been successful and a plan is now in place to include whooping cough vaccine.
- Continuity of Carer (antenatal, intrapartum and postpartum) for 20% of women by March 2019 across the LMS.

Partnership working continues with primary care, social care, LMS, neonatal ODN and mental health services. Following a successful bid with Tees, Esk and Wear Valley (TEWV) maternity are involved in the development of a perinatal mental health service in York. Unfortunately the successful bid did not include funding for a perinatal mental health midwife. This specialist role is identified to support development of perinatal mental health care in maternity, training and support for staff. There is a continued rise in women requesting debrief following birth where a specialist role would be of value.

The recruitment of a Quality and Safety Matron role in Maternity and Gynaecology will provide the support needed to meet the quality improvement and safety agenda.

2. Detail of Report and Assurance

Detail of activity, workforce, achievements and challenges including plans to meet national, regional and local priorities, develop the service and reduce and mitigate risk is as follows;

2.1 Maternity workforce strategy

The Obstetrics and Gynaecology Directorate submitted a strategic 5 year workforce plan in February 2017. The Midwifery workforce has been reviewed against the nationally recognised maternity workforce tool Birthrate plus in a table top exercise in April 2017 (reported to Trust Board in July 2017),recently reviewed and updated in June 2018.
The workforce plan was reviewed in March 2018 and a workplan for 2018/19 was agreed at the Executive Performance Assurance Meeting.

Midwifery staff ratios are currently 1 midwife per 27 births which is below the national recommendations of 1 midwife per 29.5 births for hospital and midwifery led units. York site are just below national recommendations whilst Scarborough site are above recommendations due to the minimum level of staff required to provide a safe service.

Trust midwife ratio per births	York site	Scarborough site
1 midwife : 27 births	1: 30	1: 23

Whilst the continued reduction in births has improved the overall midwife to birth ratio the increase in high acuity of women requiring a higher level of care continues in 2018 (this is also seen regionally and nationally)

Aspirational midwifery roles considered with a view to develop are:

- Consultant midwife (recommended Safer childbirth 2007)
- Perinatal mental health midwife (NICE recommendation)
- Public health midwife and substance misuse midwife (NICE)
- Multiple birth midwife (TAMBA and NICE recommendation) to be part of an MDT

Achievements;

- 1st assistant for maternity theatres business case approved and new rota of junior tier doctors to cover 24/7 commenced May 2018

Plans:

- Increase bereavement midwife hours
- Consider a perinatal mental health specialist midwife role
- Increase continuity of carer for women who have a multiple pregnancy (work towards offering 20% of women continuity of carer by March 2019)
- Increase Maternity Support Workers roles in Community to support midwife role, promote healthy lifestyles and provide care to women and babies.

Medical staff are managed by a Clinical Director, covering both sites with a deputy clinical director on each hospital site.

Integration of senior medical staff continues by sessions being undertaken by some consultants on the opposite site.
Both sites have resident consultants to cover 2-3 night shifts during the working week with more senior decision making out of hours and less reliance on middle grade doctors. Recently there has been the successful appointment of 2 substantive consultants (York site), both of which are fulltime replacement posts from retired consultants. One consultant is due to start later this year and the second next year following maternity leave. The consultant resident rota will change on the commencement of these posts to a total of four resident consultants covering 3 nights.

There has been an the increase in the number of less than fulltime trainees, having an impact on rotas (both 1st tier and of more concern the 2nd tier/middle grade rota) and an overall reduction in experienced middle grade doctors placing more onerous work load on other senior members of staff. Nationally, there are now fewer registrars which is recognised as causing challenges both nationally and regionally. Of particular concern for this region is the lack of junior (1st tier ST1) trainees, as there are no trainees of this level within the region. This has an impact on the 1st tier rotas for both sites.

Covering each site with full junior (1st tier) and middle grade (2nd tier) rota is challenging and will continue to be so over the coming year.

Risks and plans to mitigate risks

- Decrease in experienced middle grade.

Consultant midwives have been identified in the Maternity workforce strategy (recommendations from Safer Childbirth report) to provide advanced skills

- Fewer fulltime and competent middle grade doctors leaving gaps in rota.

Medical staff agency is used frequently to fill the gaps; this is at a high cost to the Directorate. The beginning of 2017 saw the appointment of a fulltime senior trust grade doctor on the York site to reduce the need for medical agency doctors. A business case for the appointment of a second fulltime senior trust grade doctor has been approved and is currently being recruited to. This post will be a cross site post, however, likely to be based at Scarborough currently. This post will reduce the need for locum cover.

2.2 Risk Management

Maternity services declared compliance with all 10 CNST maternity standards, signed off by the Trust Board and submitted in June 2018.

2.2.1 Maternity Dashboard

The Yorkshire and Humber regional maternity dashboard has developed further to enable comparisons with other Trusts and LMS's.

A national maternity dashboard is in development (recommendation from the National Maternity review 'Better Births' 2016) however not yet published.

Q3 2017/18 dashboard has been recently published. To note;

- Stillbirth rate below the regional average (on York and Scarborough sites)
- Smoking cessation rate is lower as a Trust (smoking in pregnancy is higher at Scarborough site, although a reduction is now seen)
- Breast feeding initiation rates are good as a Trust (although lower at Scarborough)
- PPH rate and 3rd and 4th degree tear rates are lower than the regional average.
- Caesarean section rate is higher than the regional average and the normal birth rate lower as a Trust (York site have a higher caesarean section rate and lower normal birth rate)

The purchase of 'episcissors-60' endorsed by NICE and RCOG green top guidelines were purchased in February 2017 following a private donation of money. Research has shown a 20 to 50% reduction in obstetric anal sphincter injuries (3rd and 4th degree tears) from the use of these scissors. Evaluation of the use of this equipment is planned in 2018.

Maternity dashboards are discussed at the Labour Ward Forums.

Plan:

- York site Labour Ward Leads have formed a working group to look at initiatives to reduce the caesarean section rate with a view to decrease the rate.

- Evaluate the use and outcomes of Episcissors-60

2.2.2 Incidents

Total number of Datix Jan to June is 652.

NICE red flags reported include delay in suturing and delayed induction of labour. Each case is reviewed at the weekly risk meeting to identify any themes and learning. Periods of high activity and acuity is identified as having an impact on delays in treatment.

Themes from Datix:

- Documentation; blood loss (volume and source of PPH), blood transfusion new documentation, shoulder dystocia initial diagnosis
- Unanticipated admissions to SCBU (term babies) ATAIN work has commenced to reduce separation of mothers and babies.
- Medication errors – Including overdose, omissions and prescription errors. A third of drug errors involved fragmin/clexane. All cases followed up with individuals.
- Misfiling of patient information in hospital and handheld records. Emails have been sent to staff regarding use of unique identifier and caution when filing either paper copies or electronicic.
- Avoidable repeat new born blood samples. Including insufficient samples and incorrect/missing details on request form. All are followed up by the screening team and further training put in place.

No Serious Incidents reported during this 6 month period.

Two Serious Incident cases from 2017 are due to be presented at the regional clinical network safety learning group to share learning across Yorkshire and the Humber in July 2018. Another SI was presented at this forum in January 2018.

Recommendations from previous SIs are followed up by the maternity risk team and trust compliance manager.

There has been one NHS resolution early notification case (also an RCOG Each Baby Counts case) in this 6 month period. Case review is planned.

2.2.3 Neonatal deaths

There have been two Neonatal Deaths Jan to June 2018, both deaths were expected.

All early neonatal deaths (death within 7 days of birth) are reported to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), reported and discussed at the York and North Yorkshire Child Death overview panel and presented and discussed at the monthly multidisciplinary perinatal mortality meeting held in Maternity services.

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK) **annual report June 2018; Perinatal Mortality Surveillance report.** This covers perinatal deaths from January to December 2016.

This national report provides summary rates of fetal loss, stillbirth and neonatal death. MBRRACE-UK have provided Trust specific data with comparisons to similar Trusts.

Overall this is a positive report for York Trust, showing a continued year on year reduction in the rates of both stillbirth and neonatal death.

Perinatal Mortality rates for York Trust in 2016 are as follows;

Type	Per 1000 births (stabilised and adjusted)	Range	Comparison to the average for similar Trusts
Stillbirth (14)	3.69	(3.07 to 4.39)	Up to 10% lower
Neonatal (5)	1.20	(0.80 to 1.91)	Up to 10% Lower
Extended perinatal (19) both together	4,89	(4.29 to 6.09)	Up to 10% Lower

The report compares the Trust case mix to the national picture by maternal age, socio economic deprivation, ethnicity and gestational age.

Main recommendations of the report;

- Utilize the new national review tool (PMRT) to analyze cases and identify learning
- Ensure timely reporting of cases by 30 days to MBRRACE-UK
- Continue to work on public health initiatives such as smoking and obesity reduction
- Ensure provision of unbiased counselling for post-mortem for parents
- Ensure placental histology is undertaken for all stillbirths

The Trust is fully compliant with the stillbirth reduction care bundles, the PMRT tool has been implemented with all cases from Q4 17/18 reviewed.

2.2.4 Stillbirth

In November 2017 the Secretary of State for Health announced a new maternity strategy to half rates of stillbirth by 2025. The government plans to offer independent investigations and coroner involvement in review of cases and the Healthcare Safety Investigation Branch (HSIB) will aim to standardise investigations of cases so that the NHS learns as quickly as possible from what went wrong and shares the learning to prevent future tragedies. The HSIB are starting to recruit in order to commence this work later in 2018. All stillbirths are currently reported to MBRRACE-UK and reviewed locally using the recently published national review tool (National Perinatal Mortality Review Tool; NPMT)

Serious incident investigations are triggered for all stillbirths where the baby was alive at the onset of labour or if concern is found regarding care provided (in line with regional practice) York Trust have seen a reduction of stillbirth rates since 2014/15;

Stillbirth number/rates	York	Scarborough	Trust
2014/15	14 4.1:1000	8 4.9:1000	22 4.4:1000 births
2015	7 2.0:1000	4 2.5:1000	11 2.2:1000 births
2016	9 2.6:1000	4 2.5:1000	13 2.6:1000 births
2017	11 3.45:1000	4 2.7:1000	15 3.2:1000 births
2018 (6 months)	**2**	**1**	**3 (1.3:1000 births)**
Y&H Regional average			3.8:1000 births (Q3 2017/18)

All four elements of the Saving Babies Lives (SBL) care bundles, recognised as evidence-based and best practice have been implemented to aim to reduce the stillbirth rate further;

1. Reducing smoking in pregnancy (CO monitoring, advice and referral to stop smoking services, implementation of Baby Clear at Scarborough)

2. Risk assessment and surveillance for fetal growth restriction (customised growth charts in place)

3. Raising awareness of reduced fetal movement (patient information, guidance and advice, raising awareness messages)

4. Effective fetal monitoring during labour (mandatory training and development)

York NICE compliant documentation guide for assessment of CTG includes 'fresh eyes' approach to CTG interpretation.

Plan;

- The paediatric team must be informed of pertinent risk factors for a compromised baby in a timely and consistent manner.
- Human factors training, awareness, improved communication and oversight of activity

Human factors training for key staff has been completed following the successful bid for maternity safety funding in 2017, this training is included in the maternity obstetric emergency training PROMPT 2018.

All maternity staff have achieved 90% compliance with CTG and emergency training.

Smoking in pregnancy; There continues to be increased focus on reducing rates of women who smoke at time of delivery (SATOD).
There is a difference between the two main sites;

- Scarborough (including Bridlington) 19.9% (year on year reduction from 22.7% in 2014)
- York 10.3% (reduction from 10.8% in 2104)

There has been significant reduction in the SATOD rates at Scarborough site (excluding the Bridlington) with Scarborough and Rydale CCG reporting a reduction from 21.2% in 2014/15 to 17% in 2017/18. This is thought to be related to the combined work undertaken to address the high rates with a particular focus in the last 6 months on ensuring all women receive CO monitoring at booking and 36 weeks.

Joint working with Scarborough and Rydale CCG continues with additional funding of £75000 obtained from central government. This has been used to fund bespoke training for every community Midwife, new CO monitors, consumables, stickers with hard hitting messages about the risk of mortality to infants (applied to notes of all smokers) and teaching aids. A deep dive review of services was also commissioned, with recommendations for stop smoking services and acute services.

2.2.5 Clinical claims

5 claims have been received in 2018;

- 2 alleged failings in care leading to brain injury (twins)
- 1 alleged clinical negligence leading to a stillbirth
- 1 alleged pressure ulcers whilst in hospital having her baby
- 1 alleged failing to identify feeding issues which resulted in hypoglycaemia and brain damage.

Two of these claims are related to care given in 1993.

A full review of all received and settled claims is planned to take place in the clinical governance meeting.

2.2.6 Risk register

The O&G Risk register is reviewed monthly at the Directorate meeting. Maternity specific risks include;

- Provision of one to one care in labour at York site
- Compliance with NICE multiple birth guidance (having an MDT to oversee women with multiple birth)
- Compliance with NICE complex social factors (having MDT working)
- Potential risk to staff exposed to nitrous oxide on labour ward at Scarborough as a recent report indicated higher than recommended levels
- Lone working for community midwives, exposure of staff to harm
- There is a risk to delivering safe patient care due to disengagement in the established governance processes at Scarborough as the Labour Ward forum has not been quorate since Jan 2018 (due to be held cross site July 2018)

Plans;

- Improvement of 1:1 care in labour continues as midwife to birth ratios improve
- Pilot multidisciplinary team care and continuity of carer for women with multiple births in 2018
- Review the directorate governance arrangements in structure and relaunch in July
- Further testing of nitrous oxide on delivery wards to be undertaken

2.3 Patient Experience and User involvement

Maternity Voices Partnership (previously Maternity Services Liaison Committee)

Recommendations from Better births requires Maternity service providers and commissioners to work in co-production with women who use services to develop the service to meet their needs. This is to be achieved through establishing Maternity Voices partnership groups.

Humber, Coast and Vale LMS have developed a Maternity Voices Partnership (MVP) overarching group with funding received to support this.
Maternity and Vale of York CCG attended a York Mumbler event to engage with local women, this was very successful. Plans to hold engagement events in Bridlington, Scarborough and Malton have been made by the Matron with a view to develop an MVP to represent the three locations and make it accessible for women.

The Vale of York MVP is maintained and chaired by the CCG, working in partnership with local maternity providers. This group meets regularly with the aim to increase user involvement in developing services, receive feedback and develop actions from feedback.

Plan: to increase service user involvement in service development and implementing the plans of the LMS to achieve recommendations in Better Births.

2.3.1 Complaints

Maternity services closed 8 formal complaints and currently has 2 open complaints Of the 8 formal complaints closed 1 was fully upheld with 5 partially upheld and 2 not upheld.

Early resolution of informal complaints is in place and carried out by all senior staff in maternity. This often involves a meeting and debrief of the birth experience.

Themes are; attitude of staff, communication and lack of understanding of clinical care provided during birth experience or following a poor outcome for baby.

Actions taken following complaints;

- raising awareness of complaints and themes in monthly maternity mandatory training and through the maternity newsletter.
- individual staff feedback and development.
- increase in perinatal mental health knowledge by multidisciplinary training provided to over 60 staff using national maternity safety training funding. Commencement of monthly perinatal mental health training on maternity mandatory training.
- Improving cross boundary working between midwifery teams

Whilst all complainants are offered a face to face meeting there is a continued rise in women requiring a full debrief of their previous birth experience. This is carried out by Consultants, Community Midwives and Senior midwives.

Plan: to provide a 'birth reflections' clinic supported by a senior midwife or perinatal mental health specialist midwife.

2.4 Service improvement

2.4.1 Perinatal Mental Health (PNMH)

Suicide remains a leading cause of maternal death in pregnancy and up to 12 months following birth (Confidential Enquiry into Maternal Death 2016)
Maternity services received £12,000 in 2017 to deliver and support PNMH training.

Progress made;

- PNMH Guidance has been written in line with NICE standards and supporting the principles of Better Births.
- PNMH pathway updated to reflect care for women with significant mental ill health.
- Collaborative working with TEWV in the NHSE successful bid for funding with ongoing involvement in setting up a local PNMH service.
- Involvement in the LMS work steam to develop PNMH and regional clinical network PNMH subgroup.
- Improved Access to Psychological Therapies (IAPT) clinic held at Scarborough site

Future plans;

- Development of PNMH specialist midwife role
- Birth debrief clinic for women

2.4.2 National maternal and neonatal health safety collaborative

This is a 3 year programme run by NHS Improvement for continuous improvement of safety and safety learning in maternity services as part of the maternity transformation programme (promoting good practice and safer care)

York will be participating in wave 3 of this improvement work to commence in April 2019.

Safety culture surveys will be undertaken at the beginning of the improvement wave across maternity and neonatal services.

Communities in practice (improvement forums) are being developed to support the 44 LMS's.

The Maternity safety Champions are Beverley Geary, Chief Nurse (Board level maternity champion), Nicola Dean Clinical Director, Consultant Obstetrician and Gynaecologist, Liz Ross, Head of Midwifery and Freya Oliver, Matron. The maternity safety champions meet bi monthly to update on progress and escalate safety issues.

Plan: To include paediatrics and service user representatives in the programme and form teams to carry out the improvement work.

2.4.3 Avoiding Term Neonatal Admissions into Neonatal Units (ATAIN)

NHS Improvement published a resource pack in February 2017 to support maternity and neonatal services to improve their service and reduce separation of mothers and babies. Progress made;

- Transitional care introduced on 30 May 2017 with support from SCBU to keep mothers and babies together on postnatal wards. This follows a model of step-down care and is provided either on the postnatal ward or within the parent facility on SCBU.
- Management of hypoglycaemia was reviewed and in line with national guidance.
- Focus on increased use of drugs to improve outcomes; regionally York are reported to have a good use of antenatal steroids (to reduce respiratory problems) and magnesium sulphate (for neuro protection).

Cases for shared learning are discussed at the perinatal mortality and morbidity meetings and York attend a regional joint neonatal operational delivery network (ODN) and Obstetric Clinical forum (newly formed in 2017)

Plan:

- To continue to work with pediatricians, SCBU and the neonatal ODN in Avoiding Term Neonatal Admissions into Neonatal Units (ATAIN)
- Develop transitional care further with SCBU
- Implement PReCePT (Preventing Cerebral Palsy in Preterm) a national programme aimed at increasing the numbers of eligible women offered magnesium sulphate to prevent cerebral palsy in preterm infants (NICE

recommendation). Maternity are linking with Yorkshire and the Humber Academic Health Science Network to roll out this Quality Improvement programme from September 2018.

2.4.4 National Bereavement Care Pathway (NBCP) 2017

The National Bereavement Care Pathway aims to improve the bereavement care parents receive after pregnancy or baby loss, to overcome inequalities and increase quality in the provision and experience of bereavement care.

It helps professionals to support families in their bereavement. The pathway covers five bereavement experiences: miscarriage, termination of pregnancy for fetal anomaly, stillbirth, neonatal death and sudden unexpected death in infancy (SUDI).

The project is backed by the government and received initial funding from the Department of Health.

York maternity became one of 11 pilot sites to introduce the pathways in October 2017 and have carried out a survey, launched the pathway, carried out training and recruited 'bereavement champions'. Feedback from bereaved parents about their experience is now being requested in an online survey, 4 weeks following their bereavement.

The pathway will have a high profile national launch in early 2019

2.4.5 Getting It Right the First Time (GIRTFT)

We engaged with the GIRTFT team and held a cross site meeting . A summary of the discussions along with an action plan was developed following this.

Areas identified to develop are:

1. Review the emergency caesarean section pathway. Develop a pro forma to review the timeline and decision making.

2. Consider hot debrief and discharging mother with a letter to inform her and advise for future delivery.

Both of these areas have leads assigned and are in progress.

2.5 Professional Midwifery Advocates (PMA)

Following the removal of the role of the Supervision of Midwives from statute on 30 March 2017 a new role has been developed; Professional Midwifery Advocate (PMA)

The new A-EQUIP (Advocating for Education and Quality Improvement) model of supervision was published by NHS England with training commenced in October 2017.

Three midwives have undertaken this training with a further 3 midwives currently undertaking training.

The aim of the role is to make quality improvements and to maintain quality and safety via

restorative clinical supervision which supports midwives in reflective practice, education and development.

2.6 Maternity Transformation

Humber, Coast and Vale Local Maternity System (LMS) have developed plans to;

- Ensure the implementation of Better Births by 2021
- Support the Secretary of State's ambition to reduce the rate of stillbirths, neonatal and maternal deaths and brain injuries by 50% by 2025

Funding of £300k is expected for the LMS to support implementation of the LMS plan through 5 workstreams;

- Multi professional working and governance
- Promoting Safer Care
- Choice and personalisation. Continuity of carer
- Maternity Voices Partnership (MVP)
- Perinatal Mental Health

The trust has member representatives on all of the work streams along with the Clinical Director (Miss Dean) and Head of Midwifery (Liz Ross) both sitting on the executive board of the LMS.

The LMS will produce a Local Maternity offer with and for service users to be aware of the choice available across Humber, Coast and Vale.

A Humber, Coast and Vale promotional film has been made to raise awareness and the profile of the LMS, due to be launched on 19 July 2018.

NHS planning guidance includes a trajectory to offer 20% of women across the LMS Continuity of Carer in antenatal, intrapartum and postnatal periods by March 2019.

A project is underway to develop a continuity of carer model for multiple births with consideration being given to extending this to diabetic women, elective LSCS and women requesting homebirth to aim to achieve 20%. It will be a challenge to meet the 20% trajectory across the LMS as not all maternity services are currently developing a continuity of carer model at this time. Senior Midwives across the LMS met with the national maternity team for support in implementation of this.

An audit of continuity of care in the antenatal and postnatal period is being undertaken to as a benchmark.

2.8.2 UNICEF Baby Friendly Initiative (BFI)

Maternity services were re-accredited full Baby Friendly status by the UNICEF Designation Committee in May 2017.

Re assessment is planned in 2019 to include neonatal services on both sites with a longer term plan to achieve a gold sustainability award in 2020.

An updated hypoglycaemia guideline was launched in June 2018 with one to one staff training taking place following the 2 Serious Incidents in 2017.

Breastfeeding initiation rates have increased on both sites (York by 1% and Scarborough by 4%)

Plans to;

- Increase use of specialist appointments for advice and support
- Increase number of paediatric staff trained in breastfeeding management to support women whose babies are readmitted to paediatric services.
- Build on the foundation of knowledge the maternity staff have to support all women and their babies to promote close and loving relationships thus promoting optimal brain development.

Volunteer breastfeeding peer supporters continue supporting women in our community and at Scarborough hospital site.

2.7 Research Studies

Maternity services continue to support a number of research projects;

VESPA: An audit looking at variations in the organisation of early pregnancy assessment units and their effects on clinical, service and patient-centred outcomes. The staff on Ward G1 have helped complete the study. 152 women put forward with 105 consented to take part in the extra voluntary questionnaires for the patient experience outcomes.

PRIDE: The study continued from last November looking at predisposing factors for gestational diabetes. They are also hoping to follow up looking at genetic surrounding gestational diabetes as well. It was a great success with 152 women recruited into the study.

GOT IT: A double blind randomised trial looking at GTN spray for treatment of retained placenta. The study has finished with a total of 20 participants (well over our target of 13).

PITCHES: is a double blind randomised controlled trial looking at treatment of cholestasis with ursodeoxycholic acid. Antenatal clinic have been very supportive. We currently have 9 women recruited to date (with a target of 10 to make by August).

C Stich: a randomised trial comparing different suture types for cervical cerclage. The study is going to continue in 2018

SPIRE reduction of stillbirth care bundles. This study is being led by University of Manchester looking at the effectiveness of the care bundle interventions by reviewing outcomes over the last five years and surveying both staff and service users. Scarborough site are involved in this study.

RESPITE Trial results confirmed that remifentanil reduced the rate of epidurals compared to pethidine and was much preferred by women, providing more effective pain relief. It did confirm the need for one to one care in labour for those women having remifentanil.

Maternity services are continuing to support a wide range of research projects in relation to Maternity services and neonates

Plans;

- Submitted expression of interest for a study comparing carboprost with oxytocin for first line treatment of PPH with the support of labour ward leads
- Continue to support research in maternity

3. Next Steps

Work continues to progress, develop and improve maternity services in line with national regional and local plans, making maternity care safer by;

- Continued work to reduce stillbirths
- Implementing the LMS action plan to achieve recommendations in 'Better Births' and improve outcomes.
- Offering 20% of women continuity of carer by March 2019
- Involving women in the development of the service
- Reducing caesarean section, third and fourth degree tears and postpartum haemorrhage rates
- Developing and extending skills of midwives and maternity support workers
- Supporting research studies for future development and progress
- Reducing term admissions to SCBU and improve neonatal outcomes

Whilst we celebrate achievements it is recognised there are challenges. We strive to continually improve, meet regional and national priorities, respond to feedback and improve experiences of women and their families to deliver a high quality, safe and effective services across all sites of York Teaching Hospital NHS Foundation Trust.

4. Detailed Recommendation

The report aims to provide information to the Quality and safety Committee of activity, achievements and challenges faced by maternity services in the 6 month period January to June 2018 with future plans outlined to improve and provide a safe quality service meeting local, regional and national priorities.

NHS

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Q1 Patient Experience Report

Recommendation

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

Current approval route of report

The report will be presented to the Patient Experience Steering Group, Quality & Safety Committee & Board of Directors in July 2018.

Purpose of report

The Trust's Patient Experience Strategy was launched in September 2015 and runs until September 2018. The strategy focuses on the five core principles of: listening; involving; reporting and responding; acting; and a culture of respect and responsibility.

A detailed implementation plan supports the strategy. This report gives an update on the Q1 Patient Experience activity and identifies priorities for the coming months.

Key points for discussion

The Board of Directors is requested to accept this report as assurance on the delivery of the Trust Patient Experience Strategy.

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 and the report relates 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

Authors: Justine Harle, Lead for Complaints & PALS and Catherine Rhodes, Lead for Patient Surveys & Volunteering

Executive sponsor: Beverley Geary, Chief Nurse

Date: July 2018

1. Introduction and Background

The Trust's Patient Experience Strategy was launched in September 2015. The strategy focuses on the five core principles of: listening; involving; reporting and responding; acting; and a culture of respect and responsibility. Patient and service user experience is critical to both patients and their families and goes beyond the health outcomes of care.

A detailed implementation plan supports the strategy and this report provides a summary of the progress against the implementation plan.

At York Teaching Hospital NHS Foundation Trust we want to improve patients' experience of healthcare. As part of that commitment, quarterly reports collating various sources of patient feedback are produced by the Patient Experience Team.

2. Listening

Patient experience information supports the Trust in making decisions about health services. We listen to local people's experience of services to help decide priorities for the future, and to help plan services that enable people to stay in control of their own health and wellbeing.

Ward Visiting Times
Last year the Trust undertook a listening exercise with patients, visitors and staff to understand how responsive visiting times were, and as a result the Trust moved to a more open style of visiting between 11:00 and 20:00. At the same time, the Trust promised to review the new visiting times after a year to ascertain how well they working.

The review was completed earlier this year and it was clear that there is a great deal of support for having the more open style of visiting; however a number of genuine concerns were raised and in response the Trust has decided to retain open visiting but move the start time to 13:00.

The minor adjustment will ensure that staff have a little more time and space to complete the morning activities, including personal care; ward rounds; environmental cleaning and medical ward rounds. It also ensures some space for lunchtime medication and lunches to be eaten while the wards are quieter.

This change does not detract from the Trust's commitment to support patients and relatives with visiting at all times by negotiation with the nurse in charge, who has full jurisdiction to support visiting outside of standard visiting times.

Health Coaching Skills
ODIL and the Out of Hospital Service is currently developing health coaching skills for staff to have conversations with patients that recognise the expertise and knowledge patients bring to a conversation about their life, and to empower them in managing their health. This initiative supports a wider cultural shift across the whole of health and social care nationally and moves the conversation away from 'what's the matter' to 'what matters to you'.
This is the first phase of health coaching skills training in the organisation and the aim is to train 250-300 staff in Out of Hospital Services.
We know from the experiences of colleagues in other areas of the country that the introduction of a different approach in conversations that encourages empowerment of

patients in their own care can initially result in an increase in the level of patient complaints in that area. The Patient Experience team is supporting ODIL in this work and monitoring out of hospital complaints and concerns. Any cases that relate to the new way of working will be flagged to the implementation team.

Complaints
The Trust received 99 new complaints in Q1 compared to 91 in Q4 and a peak of 144 in Q2 2017-18. Fifteen cases were managed via the de-escalation process without the need for a formal investigation. In addition, there were 28 dissatisfied cases this quarter.

Complaints April – June 0218				
Directorate	Apr 18	May 18	Jun 18	**Total**
Allied Health Professionals	0	1	1	**2**
Child Health	3	0	1	**4**
Elderly Medicine	6	5	4	**15**
Emergency Medicine	6	8	4	**18**
Estates & Facilities	1	1	0	**2**
General Surgery & Urology	3	6	3	**12**
Head & Neck	1	1	0	**2**
Laboratory Medicine	0	1	0	**1**
General Medicine	4	7	4	**15**
Obstetrics & Gynaecology	0	6	2	**8**
Ophthalmology	1	0	0	**1**
Orthopaedics & Trauma	1	6	3	**10**
Pharmacy	1	0	0	**1**
Radiology	0	0	2	**2**
Specialist Medicine	1	0	0	**1**
Systems & Networks	1	0	0	**1**
TAAC	1	1	2	**4**
Total	**30**	**43**	**26**	**99**

For the same time period 113 cases were closed. Of these, two were closed because they were escalated to an SI.

One case had an initial risk code of extreme and was upheld. Twenty-four had an initial risk code of high of which two were upheld, eleven partially upheld and eleven were not upheld. 53 cases had an initial risk code of medium. Of these six were upheld, 24partially upheld and 23 were not upheld. Of the 33 classed as low risk; 7 were upheld, 15 partially upheld and 11 were not upheld.

NHS Digital has published the national complaint dataset for Q4 2017-18. This quarterly collection is a count of written complaints made by (or on behalf of) patients. There were 30,099 new HCHS written complaints in the fourth quarter of 2017-18.

Over the period 26,483 complaints were resolved, of these 8,909 (33.6 per cent) were upheld, 8,127 (30.7 per cent) were partially upheld and 9,447 (35.7 per cent) were not upheld.
For the same period, the Trust upheld 13.5% cases whilst 46% were partially upheld and 40.5% were not upheld.

Data is collected via the KO41 and are for complaints about NHS Hospital and Community Health Services (HCHS) in England, providing benchmark information for complaint numbers per 1000 staff.

For NHS acute trusts in Q4 2017-18:

Organisation(s)	Number of complaints received per 1000 staff
All NHS acute trusts	28.3
York Teaching Hospitals	12.5

The range of scores for acute trusts is 2.7 to 89.1 with a median of 25.5.

The NHS Complaints Regulations require each NHS organization to produce a complaints annual report. This is attached for information at appendix 1.

Patient Advice and Liaison Service
The PALS dealt with 484 cases in Q1. This figure does not include the cases where simple advice was given or callers were signposted to other services and organisations for support.

The top four issues were communication (110), staff values and behaviours (88), clinical treatment (88) and appointments (86).

On average, 73% of cases were resolved by directorates within the ten working day target (down 6% from Q4 2017-18).

Responses within target timescale	April 18	May 18	June 18
Number of cases closed	178	149	160
Number of cases closed within 10 working days	128	107	119
%	**72%**	**72%**	**74%**

In preparation for the NHS70 celebrations, a PALS Adviser was interviewed by BBC Radio York to highlight her role. The staff interviews, which were arranged by the communications team were played throughout the birthday celebrations.

Administration of National Surveys
National surveys give a high level picture of care in our Trust and allow us to track patient satisfaction over the years. They also provide an opportunity to benchmark with other NHS organisations.

We are currently working on three national surveys: Maternity, Adult inpatient and Emergency Department. Timetables are shown below:

Area	Sampling month	Fieldwork	CQC reporting
Maternity 2018	Feb 2018	Apr 18 – Aug 18	January 2019
Adult inpatient 2018	July 2018	Aug 18 – Jan 19	Late spring 2019
Emergency Department 2018	October 2018	Oct 18 – Mar 19	TBC

More information about the surveys is included below:

Survey	Status
Maternity 2018	**Eligibility:** All women (aged 16+) who gave birth in February 2018. **Stage:** The survey must be publicised in line with ethics requirements. Posters are displayed in maternity units and information leaflets are available for 16-18 year olds.
Inpatient 2018	**Eligibility:** All adult inpatients (aged 16+) discharged from hospital in July 2018. **Stage:** Sampling to begin in August. York Teaching Hospital is one of 10 trusts taking part in a pilot to try to increase response rates through an online survey and SMS reminders.
ED 2018	**Eligibility**: All adults (16+) who attended either a Type 1 (A&E) or a Type 3 (Urgent Care Centre) in October 2018. **Stage**: Sampling to begin in November. Dissent posters to be presented to the trusts before sampling period begins.

Friends and Family Test (FFT) Response Rates
The FFT question asks if people would recommend the services they have used and offers responses from extremely likely to extremely unlikely. FFT feedback is collected continuously and reported quickly, making it possible to track almost real-time satisfaction over time. The latest FFT report is at appendix 2.

The inpatient response rate in May 2018 was 28.6%, the highest since October 2017, and higher than the national average of 24.9%. The ED response rate was 10.8%, nearly 2% lower than the previous month and the national average of 12.9%

Patient Experience of the Scarborough Emergency Department
Additional patient experience information is captured for assessing Scarborough ED performance, through the FFT data collection process. The latest results are:

Did you understand the decisions and/or recommendations made by staff?			
Row Labels	**March**	**April**	**May**
Yes, definitely	63%	71%	85%
Yes, to some extent	27%	21%	6%
No	10%	8%	9%
Did you understand what would happen next in your care or treatment?			
Row Labels	**March**	**April**	**May**
Yes, definitely	62%	68%	60%
Yes, to some extent	22%	17%	29%
No	17%	16%	12%

3. Reporting, Responding and Acting

Patient Experience Reporting to Directorates
This quarter the patient experience team has developed new reports that enable Directorates to manage the cases they are contributing to as well as leading on.

In addition, data produced by the patient experience team has been incorporated in to a new dashboard for the Children and Young People's Board which shows claims, incidents and complaints for children and young adults.

Responding to Complaints
Our single most important purpose is to look after patients with compassionate care. That means delivering the best possible patient experience to every single patient, every single time. As part of this we must listen, take seriously and respond promptly, responsibly and openly to any complaint we receive. Poor complaints handling is unacceptable.

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.

Concerns about performance continue; as only 29% of complaints were closed within the 30 day timescale in Q1. Engagement from Directorates is variable and is escalated when appropriate in order to resolve the issues.

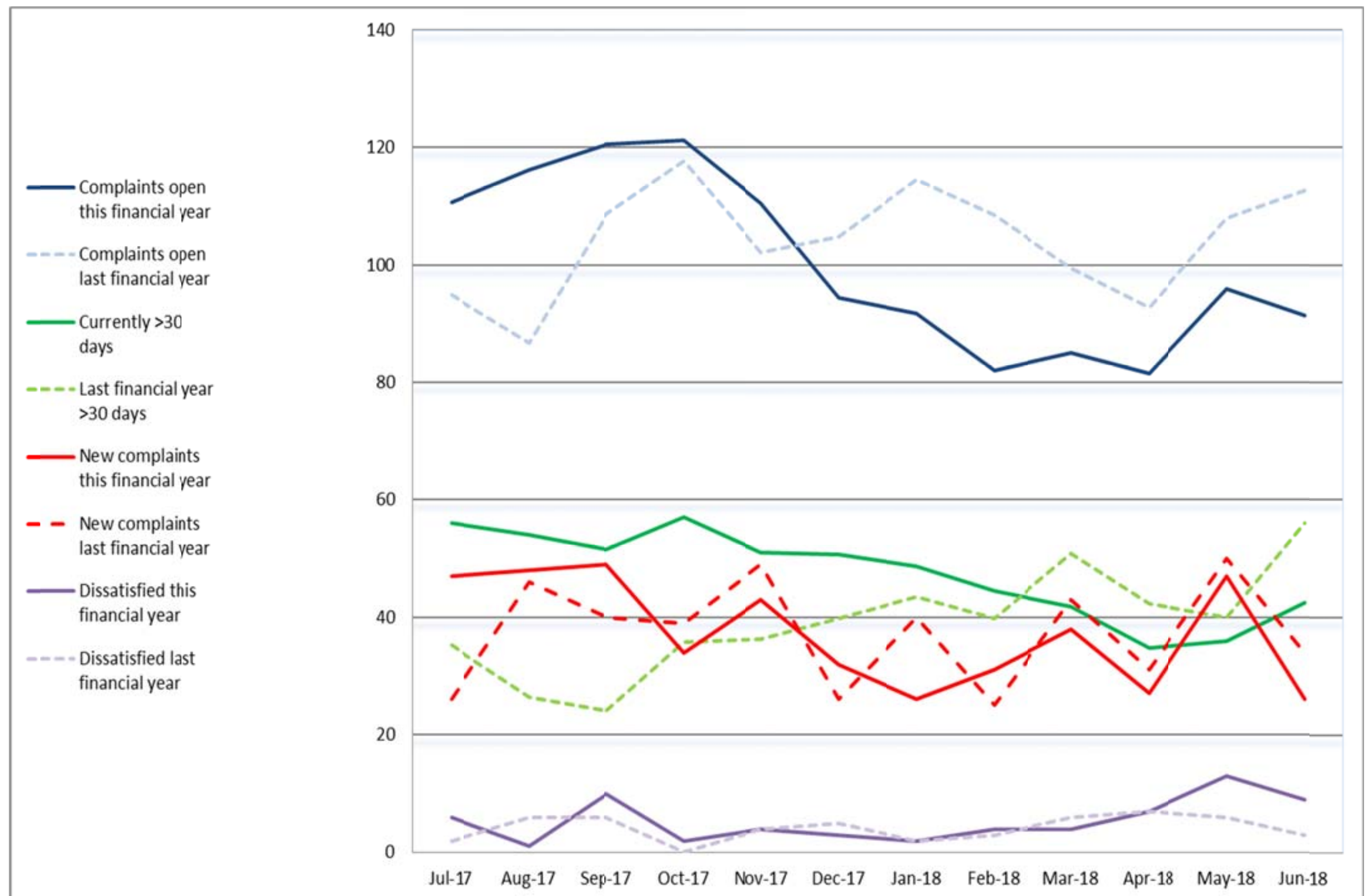
Responses within target timescale	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18
Number of cases closed	33	60	39	59	51	32	35	37	34	37	32	50
Number of cases closed within 30 working days	6	16	13	18	13	8	8	10	8	9	10	16
%	**18%**	**27%**	**33%**	**30%**	**25%**	**25%**	**23%**	**27%**	**24%**	**24%**	**31%**	**32%**

As at 21 June 2018 there were 48% of open complaints over the 30 day target.

Weekly Complaint Numbers	Currently Open	Currently >30 working days	Closed	New	New dissatisfied	Rejected
29/03/2018	85	38	13	9	0	0
05/04/2018	80	41	13	5	3	0
12/04/2018	83	34	8	10	1	0
19/04/2018	83	32	8	7	1	0
26/04/2018	80	32	10	5	2	0
03/05/2018	87	36	5	9	3	0
10/05/2018	91	35	8	11	1	0
17/05/2018	93	30	15	12	5	0
24/05/2018	103	38	5	11	4	0
31/05/2018	104	42	3	4	0	0

07/06/2018	96	37	18	8	2	0
14/06/2018	94	41	16	11	3	0
21/06/18	90	42	8	4	0	0

Complaints Handling Performance



native drinking vessels whilst in bed and will be referred to the occupational therapist if adaptive cutlery is required. At a daily board round it was agreed that doctors will assess patients at the point of admission/transfer for pain relief and prescribe accordingly. The medical directorate holds a junior doctor induction day and this will include a talk from the bereavement officer on the impact of staff behaviour on grieving relatives.

Results of Quarter One Complaints Audit

A retrospective audit of 16 cases closed in quarter one was undertaken to check compliance against the Trust complaints policy and best practice for case handling. 119 cases were closed in quarter one and the sample represents 14% of these cases. The Datix files relating to these complaints were reviewed against the audit checklist enabling actions taken at the various stages of the complaint process to be checked.

The complaints team continues to perform the necessary stages of the complaint process correctly. Investigating officers contacted complainants within the target timeframe to discuss their complaint and agree the terms of reference of the investigation in 50% cases (↑38% last quarter).

Complaints were extended in 63% of cases and in the sample audited 0% of the complainants were informed about the progress of their investigation when the initial timescale was exceeded (↓ from 10% in quarter 4).

The average response time for the complaints in the sample was 51 days against a Trust target of 30 working days and the response times ranged from 5 days to 129 days.

Internal Audit: Date Quality of Performance Indicators Y1874
In Q1 the internal audit team conducted an audit of the data quality of performance indicators. The objective of this audit was to gain assurance that the data reported within the Patient Safety, Quality, Workforce, Finance and Performance Board report is accurate, valid, reliable, timely, relevant and complete.

The review confirmed that the Trust has appropriate arrangements in place for the management of the data quality of the Patient Safety, Quality, Workforce, Finance and Performance Board Report.

Audit results found that the Complaints data reported in the Board Report matched the data in the Datix system and that appropriate processes are in place to validate the data submitted and the process was given **SIGNIFICANT ASSURANCE**

Parliamentary and Health Service Ombudsman (PHSO)

If a complainant is unhappy with the response received from the Trust, they have the right to contact the PHSO to request an investigation. No new cases were received in Q1. However, the Trust worked with the PHSO to resolve three cases without the need for formal investigations. This included providing an updated action plan, apology for the poor handling of the complaint by the directorate and additional information.

Satisfaction Scores, Themes and Trends from Friends and Family Feedback

	% Satisfied Mar 18	% Satisfied April 18	% Satisfied May 18	National Average April 18
Inpatient	96	97	97	96
ED	85	85	85	87
Maternity	97	98	97	97

The inpatient satisfaction rate in May 2018 remains stable at 97%, in line with the national average. The ED satisfaction rate was 87%, which was at its highest in November 2017 at 91%. Scarborough ED satisfaction has increased from 78% (March 2018) to 83% (May 2018) whilst York ED has sustained 85% since March.

The narratives for both York and Scarborough EDs show the biggest theme continues to be waiting times. In York there were also themes of lack of communication about waiting times and not always prioritising children.

The top themes from ED responses have been linked with the learning from the national ED survey and the national children and young people’s survey to create an action plan. The work to redesign the ED entrance is an important part of improving patients’ experience of

assessment and waiting, in particular giving people greater privacy during assessment and ensuring people have up to date information about waiting times. The Directorate is looking at ways to improve the area based upon the feedback.

The Child Health wards in York currently have low response rates. The sister is working to increase staff engagement, however when cards are handed out it appears that parents are choosing not to complete them. We are about to start a re-procurement exercise for the external FFT contractor. Our specification will include the need for new options for children and teenagers to provide their own feedback. We will also ask for ideas that encourage more parents to respond. The feedback we do have is that the ward is noisy at night, so the Children's Voice FFT action plan includes introducing Night Owl. There are also multiple pieces of feedback about uncomfortable chairs in the waiting room / play area and we are working with the ward to encourage use of their charitable fund to replace the chairs. It is vital that we show we act on the feedback we receive; otherwise there is limited incentive to give or seek feedback.

Night Owl Initiative – Reducing Noise at Night

The Night Owl Initiative continues to be championed by matrons with their wards, with the most engaged wards having members of staff who take a lead for their ward. The Patient Experience Team continues to ensure that stocks of sleep packs (eye masks and ear plugs) are available.

We were recently contacted by another Trust to ask if they could "pinch with pride" as a member of their team had seen the Night Owl initiative and thought it would be well appreciated by patients there. We were of course happy to share the details.

4. Involving

Dementia Carers' Survey

A structured process, timescale and checklist for managing the survey has been put in place. 30 surveys were completed between March 2018 and June 2018. The results are summarised below.

		York	Scarborough
Were you given the About Me document?	**Yes (%)**	10	20
Were you told about support that was available to you and how you could access that support?	**Yes (%)**	25	60
Did you feel that you had opportunities to talk to staff if you wanted to?	**Yes (%)**	60	100
If you wanted to, were you able to stay with the person you were caring for throughout their time in hospital?	**Yes (%)**	100	100
Did you feel there were any restrictions on visiting hours?	**No (%)**	100	90

Examples of comments were:

"Everything was perfect, best Hospital around".

"Dad was often talked over and relative felt that the staff didn't take their time when asking questions".

"I cannot fault the care my wife received at the hospital."

The full results are presented to the Dementia Delivery Group to inform their work in implementing the Trust Dementia Strategy and the Dementia Steering Group are examining the questionnaires' and actions required to improve experience

5. Volunteering

Volunteer Recruitment
Volunteer recruitment continues to be carried out in three cohorts over the calendar year, and applications are currently (July 2018) open for York and Selby. Due to difficulties with recruitment at Scarborough, there has been no administrator to carry out this work for Scarborough, Bridlington and Malton. The new Lead for Surveys and Volunteering joined the Trust on 2 July 2018 and work is underway to review the team requirements.

Current volunteer numbers

	York	Scarborough	Bridlington	Malton	Total
No. of Volunteers	225	78	15	5	300

Cohort 4 recruitment

Volunteer Applications	Applications Successful	Applications Withdrew	Applications Declined
37	31	6	0

The use of TRAC for the recruitment and processing of volunteering applications continues to ensure that applications to York and Selby are processed in a timely manner. There are, however, delays and backlogs in the processing of applications to Scarborough due to the staffing issue. Holding emails are now being sent to those applicants who have had no communication in recent months.

Role and Ward/Department Update

Ward 31
We recently arranged for nine volunteers to join Ward 31 as dedicated Level 1 dining companions. We have had early positive feedback from staff on the ward and will continue to follow the progress of these volunteers. We plan to create a case study based on this piece of work and will present it back to the Patient Experience Steering Group when completed.

Training and Induction
All new volunteers have statutory and mandatory training when they join the Trust. This is delivered through volunteers attending the corporate induction day in York or a volunteer induction in Scarborough, or by accessing the Learning Hub on-line courses. Volunteers also have a local induction in the ward or department they are joining which is given by their volunteer supervisor.

We have been linking with the Statutory and Mandatory Training Team and Corporate Development Team and are continuing to develop a specific training area for volunteers through Learning Hub.

To complement statutory and mandatory training, a Volunteer Corporate Induction Handbook has been developed. The handbook is based on the information received by new staff joining the Trust but adapted to reflect the volunteering role. We have received positive feedback about the Handbook and will continue to monitor it and adapt when necessary.

Celebrating our Volunteers' Contribution
In June 2018 we celebrated National Volunteers Week. A communications board was set up in the main entrance in York Hospital which received positive attention from staff and the public alike. We used the hashtag #ivolunteer to capture testimonials from volunteers which were then shared widely on social media.

HelpForce
The Trust is part of the HelpForce Learning Network – a community of practice to share stories, evidence, innovation and best practice around volunteer services. A network meeting is taking place w/c 9 July which will be attended by the new Lead and our lead governor for volunteering. We continue to build our relationship with HelpForce as we can see huge potential benefits of working with them and the network.

6. Detailed Recommendation

The Board of Directors is asked to accept this report as assurance on the delivery of the Trust's Patient Experience Strategy.

APPENDIX 1

NHS
York Teaching Hospital
NHS Foundation Trust

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).

APPENDIX 1

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**

APPENDIX 1
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

APPENDIX 1

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.

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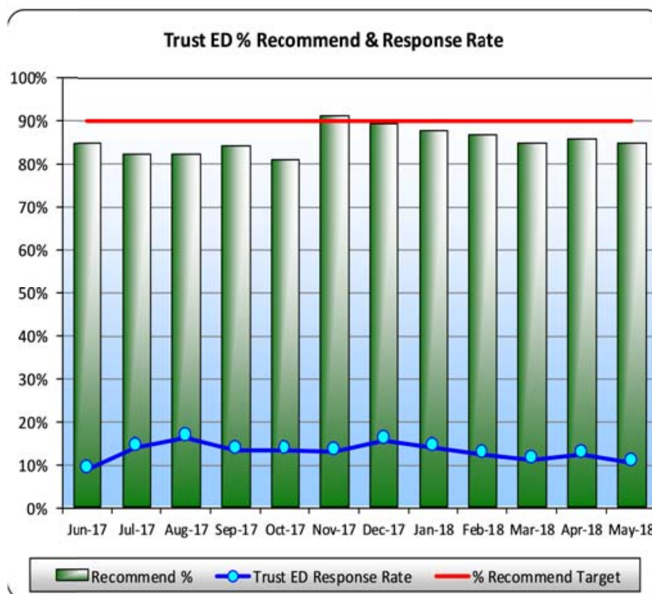
Owner	**Beverley Geary, Chief Nurse**
Date	**May 2018**

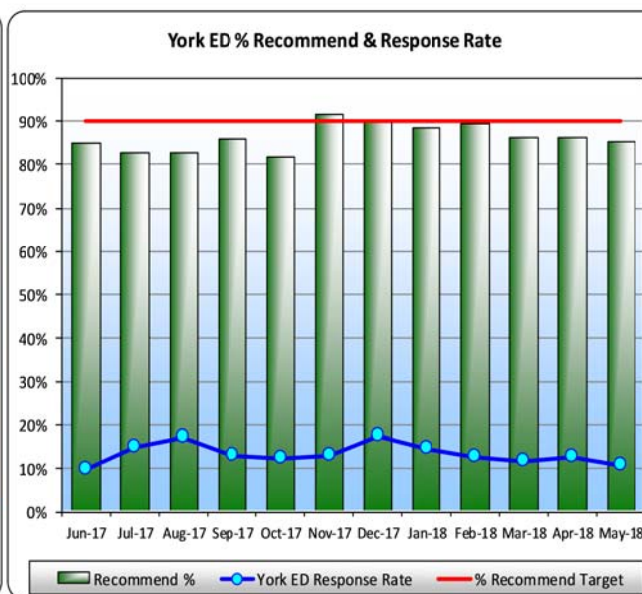
Appendix 2

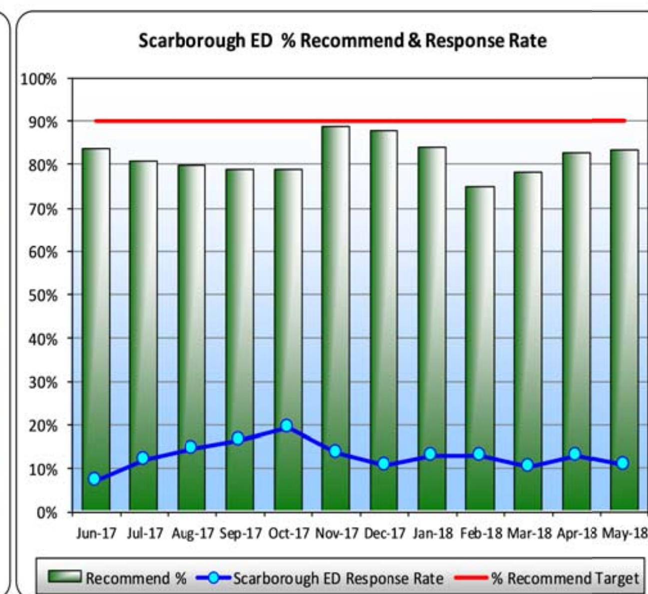
Friends & Family: ED

York Teaching Hospital NHS
NHS Foundation Trust

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
York ED Response Rate	9.66%	14.90%	17.25%	13.05%	12.32%	13.06%	17.30%	14.53%	12.58%	11.55%	12.61%	10.87%
Recommend %	84.71%	82.39%	82.44%	85.46%	81.45%	91.26%	89.35%	88.09%	89.11%	85.93%	85.93%	84.84%
Not Recommend %	7.28%	10.41%	10.38%	5.98%	12.43%	5.28%	5.97%	4.87%	5.33%	8.10%	9.89%	4.53%
Scarborough ED Response Rate	7.17%	11.85%	14.44%	16.57%	19.51%	13.58%	10.64%	13.00%	13.04%	10.45%	13.09%	10.67%
Recommend %	83.51%	80.35%	79.47%	78.52%	78.41%	88.46%	87.38%	83.64%	74.76%	78.00%	82.35%	83.04%
Not Recommend %	12.37%	13.29%	13.25%	10.07%	14.77%	4.81%	9.71%	11.82%	19.42%	14.00%	12.61%	7.14%
Trust ED Response Rate	9.06%	14.14%	16.64%	13.71%	13.58%	13.14%	16.02%	14.25%	12.67%	11.34%	12.70%	10.84%
Recommend %	84.48%	81.96%	81.89%	83.87%	80.69%	90.81%	89.10%	87.35%	86.44%	84.53%	85.27%	84.52%
Not Recommend %	8.25%	11.02%	10.92%	6.91%	13.02%	5.21%	6.44%	6.02%	7.96%	9.14%	10.39%	5.00%







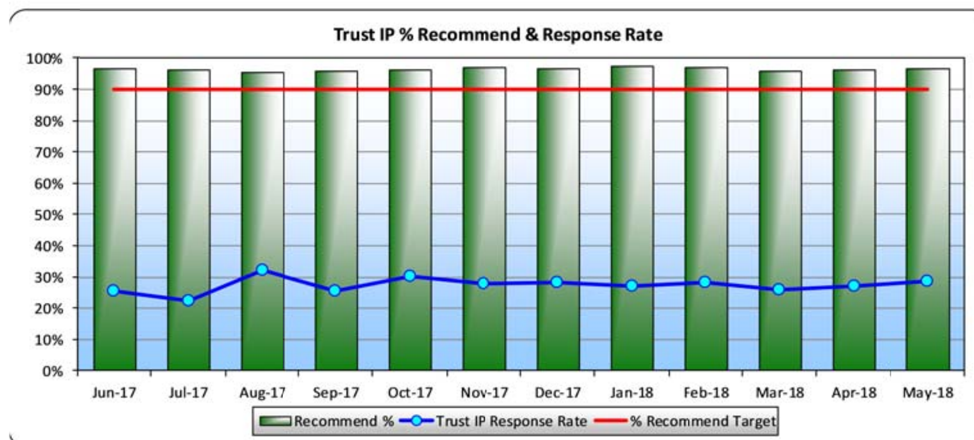
Appendix 2

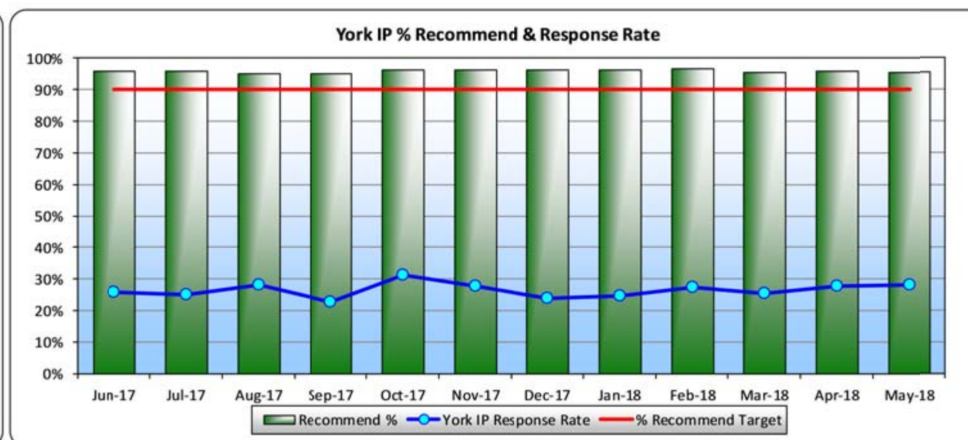
York Teaching Hospital NHS
NHS Foundation Trust

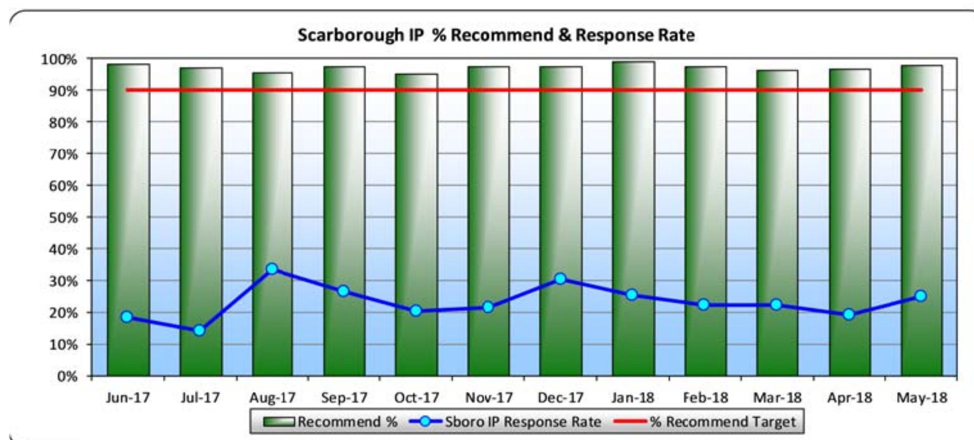
Friends & Family: Inpatients

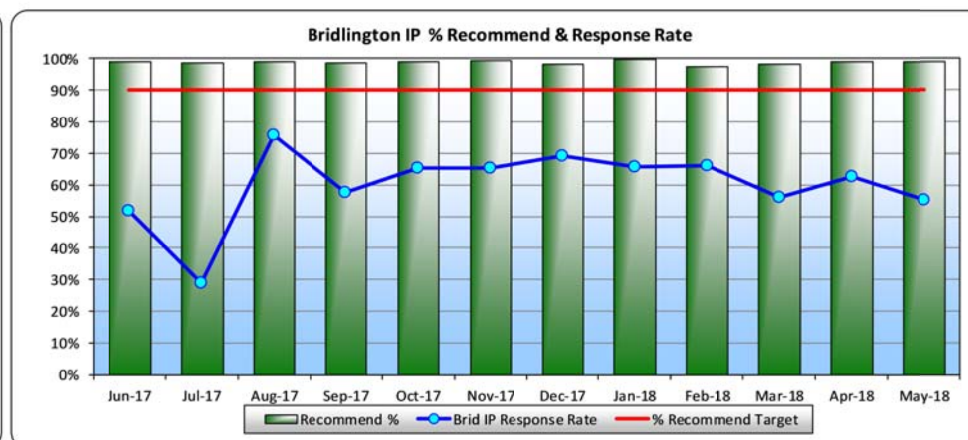
Includes daycase patients and patients <16 as at 10th June 2018

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
York IP Response Rate	25.97%	25.13%	28.15%	22.86%	31.19%	27.79%	23.94%	24.59%	27.42%	25.51%	27.74%	28.17%
Recommend %	96.27%	96.26%	95.24%	95.23%	96.40%	96.39%	96.41%	96.33%	96.79%	95.74%	95.98%	95.76%
Not Recommend %	0.79%	0.98%	1.23%	1.13%	0.67%	0.82%	0.78%	1.22%	0.48%	1.05%	0.91%	1.34%
Scarborough IP Response Rate	18.47%	14.15%	33.53%	26.73%	20.29%	21.62%	30.52%	25.37%	22.31%	22.34%	19.37%	25.03%
Recommend %	98.32%	97.44%	95.56%	97.59%	95.32%	97.74%	97.62%	99.24%	97.68%	96.57%	96.70%	97.92%
Not Recommend %	0.19%	0.51%	0.85%	0.85%	1.08%	0.45%	0.12%	0.30%	0.33%	1.40%	0.37%	0.73%
Brid IP Response Rate	51.70%	28.84%	75.59%	57.50%	65.28%	65.19%	69.17%	65.66%	66.23%	55.97%	62.58%	55.10%
Recommend %	99.34%	98.72%	99.04%	98.64%	99.17%	99.74%	98.53%	100.00%	97.72%	98.53%	99.34%	99.35%
Not Recommend %	0.00%	0.64%	0.24%	0.34%	0.00%	0.00%	0.29%	0.00%	0.28%	0.00%	0.00%	0.32%
Trust IP Response Rate	25.36%	22.59%	32.15%	25.63%	30.13%	28.07%	28.13%	27.27%	28.15%	26.07%	27.03%	28.62%
Recommend %	97.01%	96.63%	95.81%	96.26%	96.53%	97.12%	97.05%	97.58%	97.12%	96.23%	96.52%	96.70%
Not Recommend %	1.78%	0.88%	1.00%	0.96%	0.67%	0.64%	0.52%	0.82%	0.42%	1.03%	0.69%	1.08%





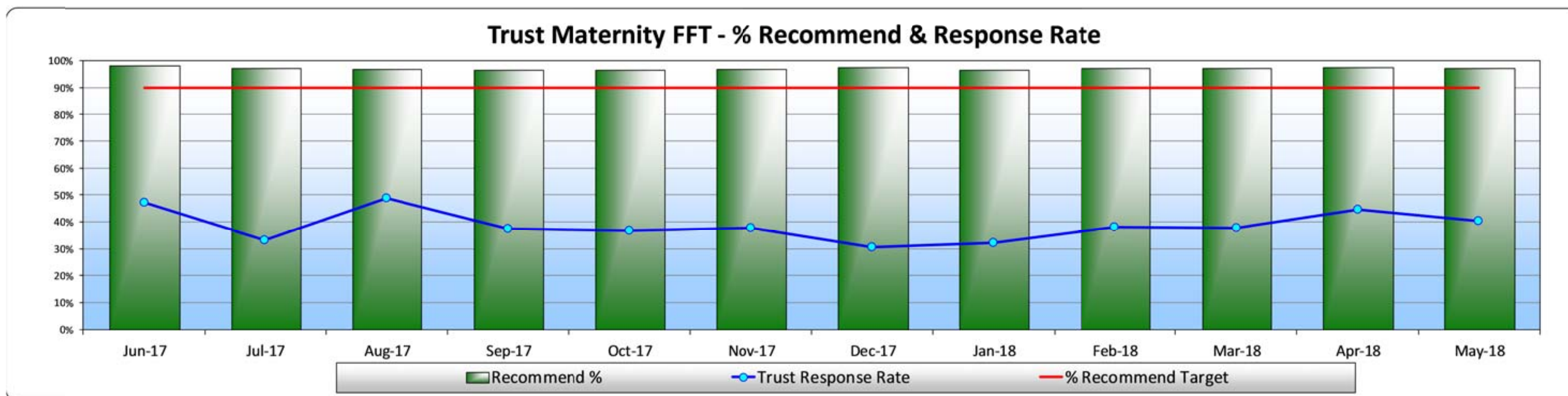




Appendix 2

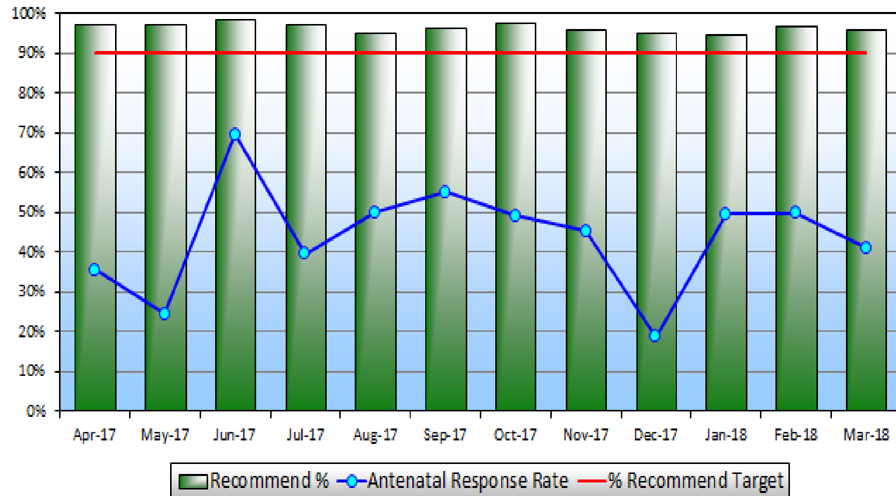
Friends & Family: Maternity May 2018

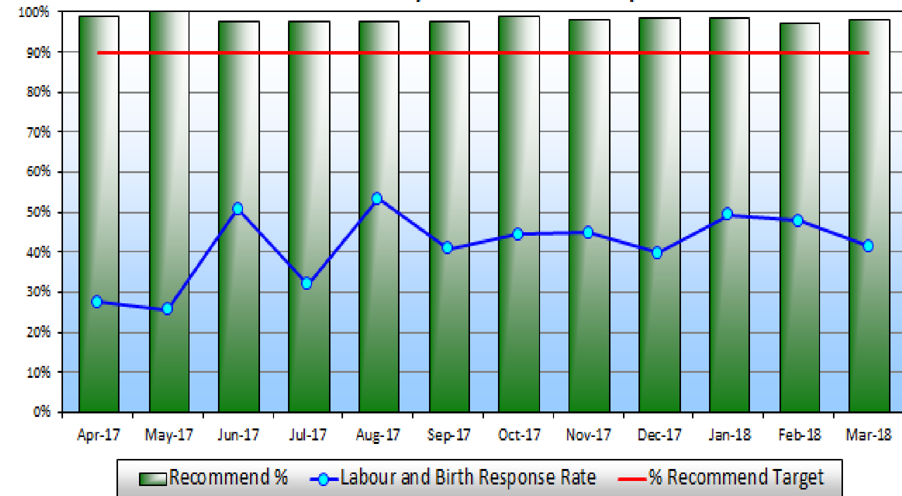
York Teaching Hospital NHS
NHS Foundation Trust

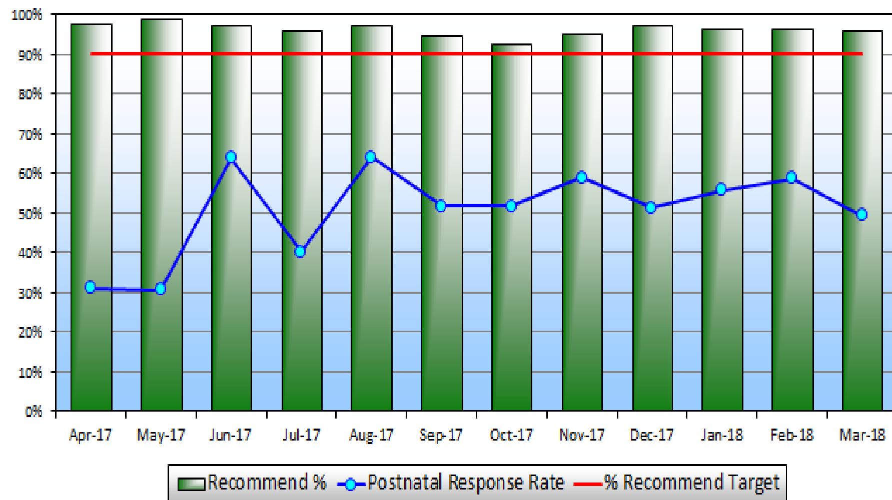


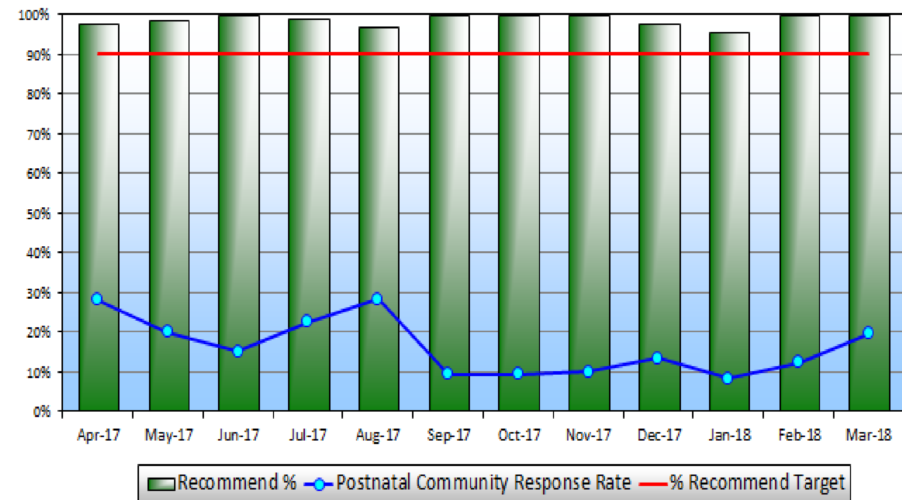
Measure (Trust level)	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Antenatal	69.63%	39.62%	50.00%	55.18%	49.17%	45.38%	18.71%	49.61%	49.85%	41.07%	51.87%	46.85%
Recommend %	98.68%	97.28%	95.37%	96.45%	97.75%	95.93%	95.31%	94.71%	97.08%	96.10%	97.42%	96.49%
Not Recommend %	0.00%	0.68%	1.39%	0.00%	0.00%	0.00%	3.13%	0.53%	0.58%	0.00%	0.00%	0.58%
Labour and Birth	50.83%	32.07%	53.26%	40.82%	44.53%	44.80%	39.79%	49.33%	47.77%	41.51%	52.03%	43.81%
Recommend %	97.83%	97.64%	97.55%	97.78%	98.83%	98.21%	98.67%	98.37%	97.08%	98.05%	98.96%	98.82%
Not Recommend %	0.54%	0.79%	2.45%	0.56%	0.58%	1.79%	1.33%	0.00%	0.58%	0.65%	0.00%	0.00%
Postnatal	63.99%	40.19%	64.15%	51.74%	51.74%	59.04%	51.37%	55.80%	58.70%	49.51%	56.76%	53.16%
Recommend %	97.27%	96.00%	97.55%	94.94%	92.70%	95.38%	97.33%	96.63%	96.51%	96.08%	96.30%	95.24%
Not Recommend %	0.00%	0.80%	1.47%	2.25%	1.69%	0.58%	0.67%	0.56%	1.16%	0.65%	1.59%	0.60%
Postnatal Community	15.24%	22.55%	28.33%	9.53%	9.43%	10.14%	13.46%	8.30%	12.43%	19.71%	19.53%	20.72%
Recommend %	100.00%	98.91%	97.00%	100.00%	100.00%	100.00%	97.73%	95.77%	100.00%	100.00%	97.33%	98.77%
Not Recommend %	0.00%	0.00%	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Trust Response Rate	**47.20%**	**33.04%**	**48.72%**	**37.54%**	**36.87%**	**37.80%**	**30.49%**	**32.26%**	**38.03%**	**37.85%**	**44.52%**	**40.41%**
Recommend %	98.18%	97.35%	96.82%	96.66%	96.67%	96.76%	97.55%	96.46%	97.24%	97.16%	97.54%	97.12%
Not Recommend %	0.15%	0.61%	1.66%	0.84%	0.70%	0.72%	1.23%	0.32%	0.69%	0.38%	0.46%	0.34%

Appendix 2









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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Results of National Inpatient Survey 2017

Recommendation

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

Current approval route of report

The results will be presented to Quality & Safety Committee.

Purpose of report

To inform Patient Experience Steering Group of the results of the National Inpatient Survey 2017.

To provide assurance that the results are being used to celebrate success and support ongoing learning and improvement.

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: Hester Rowell, Lead for Patient Experience

Executive sponsor: Beverley Geary, Chief Nurse

Date: February 2018

1. Introduction and Background

The Care Quality Commission requires all NHS organisations providing inpatient services to participate in this annual national survey.

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

The 2017 survey sample was taken from adult patients who were discharged from inpatient care in July 2017. Patients excluded from the sample were: day cases, deceased patients and maternity patients. Patients who met the criteria received a paper survey form along with a covering letter and a freepost return envelope. Information was provided about how to access the survey in other languages or formats.

The survey was carried out on the Trust's behalf by an external contractor, Patient Perspective.

2. Survey Results

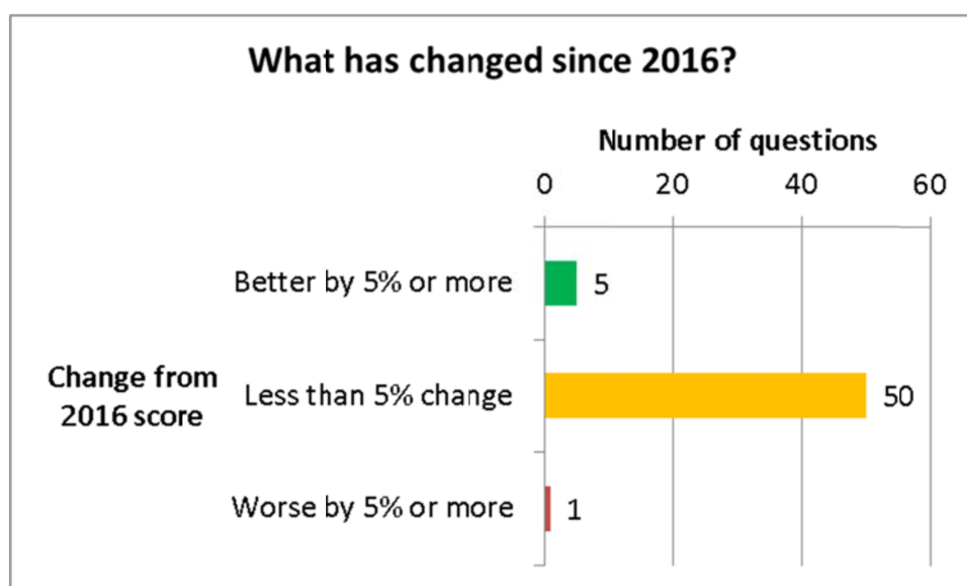
2.1 Sample size and response rate

The number of survey responses was 591from a sample size if 1187. This is a 49.8% response rate (compared to a 53% in 2016). Nationally there has been a trend of reducing response rates. In 2017 our Trust agreed to support a pilot where text message reminders were sent to those with registered mobile numbers and reminder letters were sent earlier.

2.2 Quantitative Results

- **What has changed since 2016?**

The average Trust score for all questions for 2017 was **76%**. This compares to **75%** in 2016.



Questions where we have significantly improved since 2016
Were you ever bothered by noise at night from hospital staff?

Do you feel you got enough emotional support from hospital staff during your stay?

Were you given clear written or printed information about your medicines?

Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?

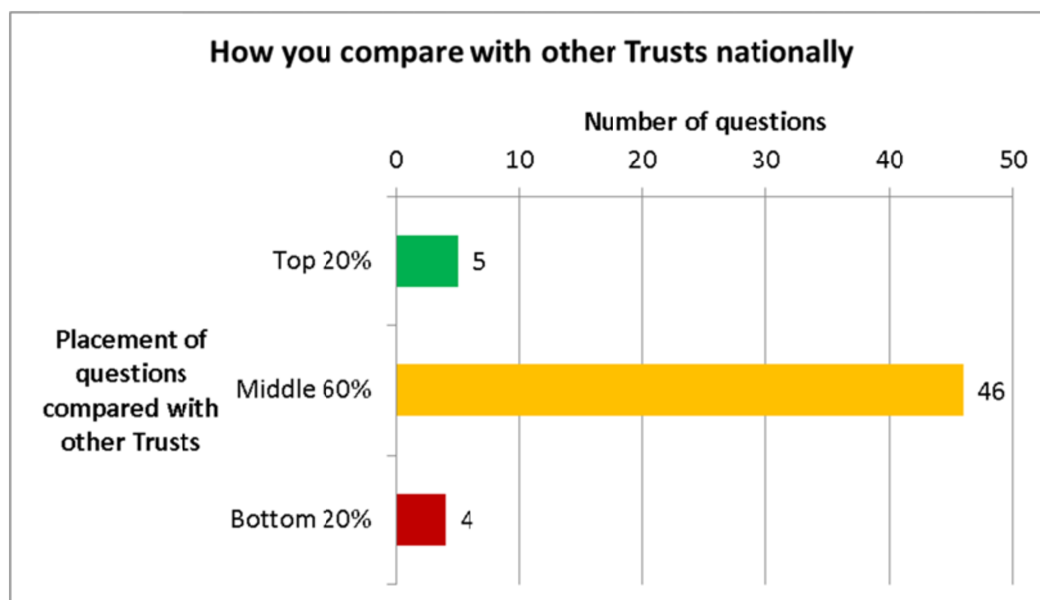
During your hospital stay, were you ever asked to give your views on the quality of your care?

Questions where we have got significantly worse since 2016
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

- **How we compare with other Trusts**

The full benchmark results will not be released by the CQC until mid-2018. As an initial indicator Patient Perspective provides us with a comparison of our 2017 results with the 2016 national averages. As, across all Trusts, there is little change year-on-year this is a reasonable indicator.

The comparisons provided by Patient Perspective indicate whether we are in the top 20% or bottom 20% of Trusts for each question. These bands are wider than the benchmarks released by the CQC, but are helpful in identifying our areas for improvement or good practice.



Questions where we score in the top 20%

Was your admission date changed by the hospital?

Did you get enough help from staff to eat your meals?

Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?

Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?

Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Questions where we score in the bottom 20%

Were you ever bothered by noise at night from other patients?

In your opinion, were there enough nurses on duty to care for you in hospital?

Did you know which nurse was in charge of looking after you?

Were you given enough privacy when discussing your condition or treatment?

- **How our sites compare with each other**

	York	Scarborough	Bridlington
Number of questions scoring significantly better than Trust average	0	0	32
Number of questions scoring significantly worse than Trust average	0	12	0
Number of questions where there are insufficient site responses to be significant	0	0	21

Questions where Scarborough scored significantly worse than the Trust average

From the time you arrived at the hospital, did you feel that you had to wait a long time to get a bed on the ward?

When you had important questions to ask a doctor, did you get answers you could understand?

How much information about your condition or treatment was given to you?

On the day you left hospital, was your discharge delayed for any reason?

When you left hospital, did you know what would happen next with your care?

Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

Did a member of staff tell you about medication side effects to watch for when you went home?

Were you given clear written or printed information about your medicines?

Did a member of staff tell you about any danger signals you should watch for after you went home?

Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?

2.3 Qualitative Results

720 written comments were given to the three questions:

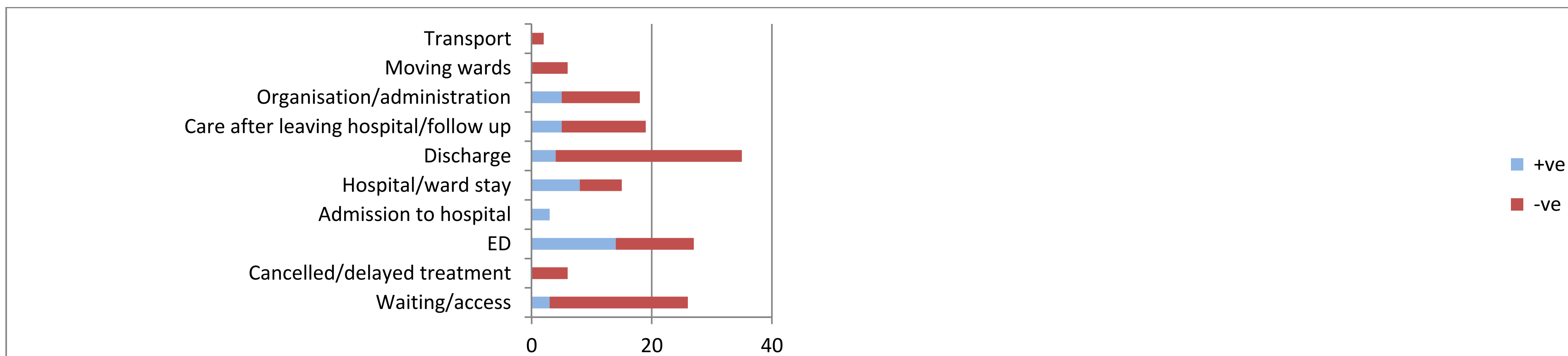
- Was there anything particularly good about your hospital care
- Was there anything that could be improved?
- Any other comments

Every element of every comment was coded for its subject and whether it was positive or negative. This clearly shows the themes of:

- **Positive:** Patients appreciate the care they receive, and offer their thanks to the staff members involved.
- **For improvement:** Experience of discharge; communication by staff; quality of/access to food and drink. Patients have particularly commented that they perceive there are insufficient staff, or they think there should be more staff on the wards.

- **Themes from Narrative Comments**

Pathway of Care



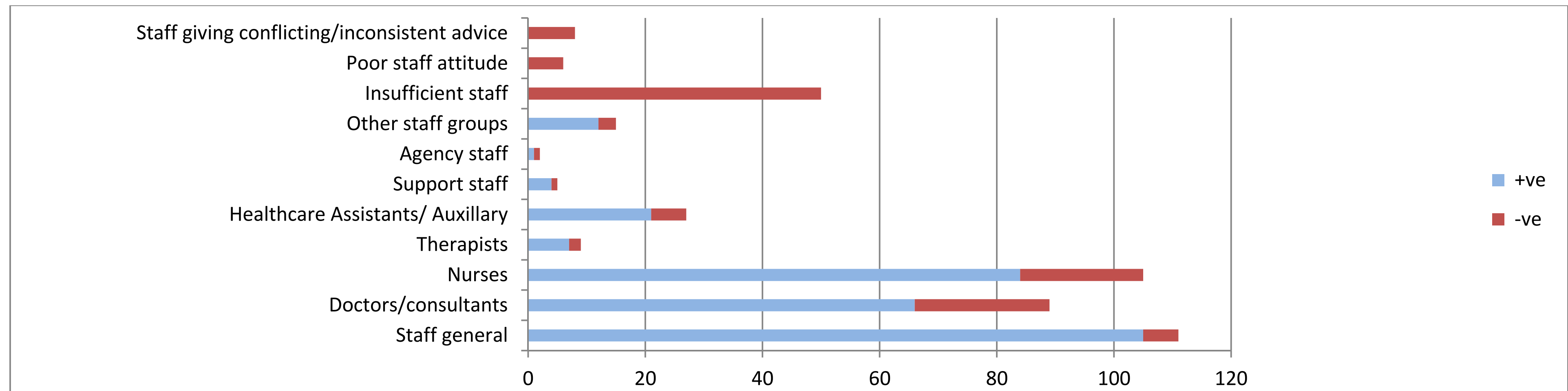
Care and Treatment

Care and treatment (general)
Record keeping
Involvement of family/carers
Medication
Privicy, dignity & respect
Pain management
Able to get hold of staff when needed/resonsiveness
Communication between different staff members
Communication/information giving by staff
Staff took patient's needs/concerns seriously
Staff took into account patient's medical history
Patient's involvement in decisions re care/treatment
Continuity of care
Operations, investigations/procedures
Personal care
Clinical outcome

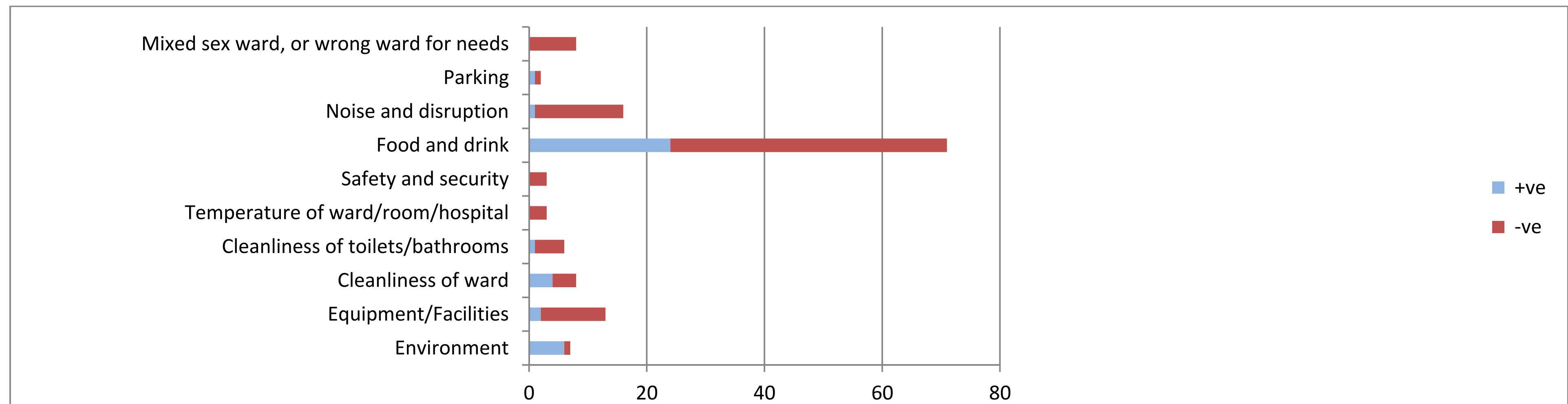
0 20 40 60 80 100 120 140

+ve
-ve

Staff



Hospital Environment



- **Examples from Narrative Comments**

I was worried about being an inpatient in Scarborough but now I would have it as a hospital of preference because of the superb nursing care from staff nurses, HCAs. We are very lucky.

There was not enough nurses. They have far too much work but I found them all very pleasant.

Although I'm 82, I'm not a geriatric. I was in a geriatric ward for 6 days because the cardiac ward was full with more urgent patients. The staff had their problems to cope with but they did their very best to get me transferred to the cardiac ward. I cannot praise the staff enough.

I feel I should've been listened to before my discharge as I didn't feel ready to go home as I was going to be on my own. For a number of hours I was still in pain and discomfort. I felt my discharge was rushed. I was wheeled to the discharge lounge. Someone packed my belongings while I was getting dressed, I felt permission should of been asked.

During my surgery, the consultant/registrar/anaesthetist, nursing staff for the (theatre), were excellent, caring, confidence given, most of all, treated with such respect by professional bodies involved. I give high praise to their professionalism and care before and during.

All the staff I met during my hospital stay were caring and considerate. I was kept well-informed throughout, from my urgent, unexpected admission, to the diagnosis of the problem and subsequent treatment. I had plenty of opportunities to discuss any concerns.

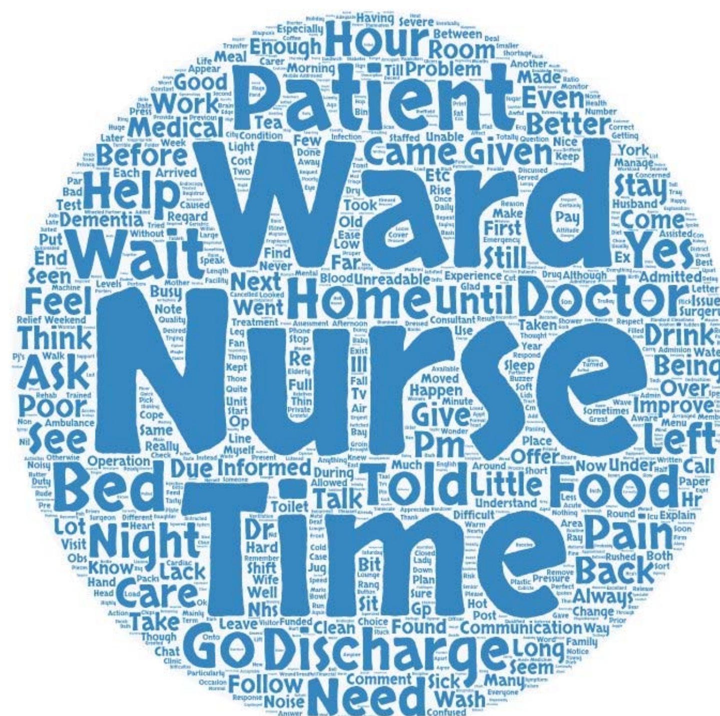
Communication between staff and patients. Staff usually too busy to talk or forget to come back later when not so busy.

- ## Word Clouds

Word clouds are a way of identifying themes in written feedback in a visual way.

Was there anything particularly good about your hospital care?

Was there anything that could be improved?



3. Next Steps: Learning and Improvement

The 2016 action plan is included at appendix 2 showing whether each action has been completed.

The next step for the 2017 survey is to share the results internally and engage clinical leaders in agreeing the priorities for action.

Appendix 1: Mean Rating Scores

Survey	National Inpatient Survey
Organisation:	York Teaching Hospital NHS Foundation Trust
Response Dates:	01 July 2017

Number	Display Text	n	MRS
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	707	81%
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	715	88%
Q6	How do you feel about the length of time you were on the waiting list before your admission to hospital?	445	86%
Q7	Was your admission date changed by the hospital?	443	94%
Q8	In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	473	90%
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	1,158	72%
Q11	While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?	1,176	94%
Q13	Did the hospital staff explain the reasons for being moved in a way you could understand?	365	66%
Q14	Were you ever bothered by noise at night from other patients?	1,158	57%
Q15	Were you ever bothered by noise at night from hospital staff?	1,162	78%
Q16	In your opinion, how clean was the hospital room or ward that you were in?	1,174	88%
Q17	Did you get enough help from staff to wash or keep yourself clean?	1,164	79%
Q18	If you brought your own medication with you to hospital, were you able to take it when you needed to?	1,138	71%
Q19	How would you rate the hospital food?	1,162	61%
Q20	Were you offered a choice of food?	1,138	85%
Q21	Did you get enough help from staff to eat your meals?	1,144	80%
Q22	During your time in hospital, did you get enough to drink?	1,160	94%
Q23	When you had important questions to ask a doctor, did you get answers that you could understand?	1,166	83%
Q24	Did you have confidence and trust in the doctors treating you?	1,164	90%
Q25	Did doctors talk in front of you as if you weren’t there?	1,166	88%
Q26	When you had important questions to ask a nurse, did you get answers that you could understand?	1,168	85%
Q27	Did you have confidence and trust in the nurses treating you?	1,170	89%
Q28	Did nurses talk in front of you as if you weren’t there?	1,168	91%
Q29	In your opinion, were there enough nurses on duty to care for you in hospital?	1,168	70%
Q30	Did you know which nurse was in charge of looking after you?	1,164	57%
Q31	Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?	1,140	87%
Q32	In your opinion, did the members of staff caring for you work well together?	1,170	87%
Q33	Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	1,166	82%
Q34	Were you involved as much as you wanted to be in decisions about your care and treatment?	1,168	74%
Q35	Did you have confidence in the decisions made about your condition or treatment?	1,170	85%
Q36	How much information about your condition or treatment was given to you?	1,174	82%
Q37	Did you find someone on the hospital staff to talk to about your worries and fears?	1,166	57%
Q38	Do you feel you got enough emotional support from hospital staff during your stay?	1,160	73%
Q39	Were you given enough privacy when discussing your condition or treatment?	1,168	83%
Q40	Were you given enough privacy when being examined or treated?	1,172	94%

Q42	Do you think the hospital staff did everything they could to help control your pain?	796	85%
Q43	If you needed attention, were you able to get a member of staff to help you within a reasonable time?	1,164	76%
Q45	Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	701	91%
Q46	Beforehand, were you told how you could expect to feel after you had the operation or procedure?	696	71%
Q47	After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	691	81%
Q48	Did you feel you were involved in decisions about your discharge from hospital?	1,152	69%
Q49	Were you given enough notice about when you were going to be discharged?	1,162	70%
Q50	On the day you left hospital, was your discharge delayed for any reason?	1,150	63%
Q52	How long was the delay?	458	-
Q54	After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	1,095	67%
Q55	When you left hospital, did you know what would happen next with your care?	1,156	69%
Q56	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	1,148	66%
Q57	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	1,152	84%
Q58	Did a member of staff tell you about medication side effects to watch for when you went home?	1,011	46%
Q59	Were you told how to take your medication in a way you could understand?	1,000	85%
Q60	Were you given clear written or printed information about your medicines?	994	81%
Q61	Did a member of staff tell you about any danger signals you should watch for after you went home?	1,148	51%
Q62	Did hospital staff take your family or home situation into account when planning your discharge?	1,152	75%
Q63	Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	1,142	65%
Q64	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	1,154	84%
Q65	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?	1,152	82%
Q66	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	1,150	82%
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	1,160	90%
Q68	Overall, how good was your experience (0=very poor, 10= very good)?	1,148	83%
Q69	During your hospital stay, were you ever asked to give your views on the quality of our care?	1,162	20%
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	1,146	25%
Q71	Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?	1,164	94%

APPENDIX 2: Action Plan – Inpatient Survey 2016

Area for Improvement	Work Underway	Action	Update 2018	Status
Providing emotional support to patients	The chaplaincy are working to increase their visibility in the Trust and staff awareness about what they can offer.	To work with clinical staff on a focused piece of patient engagement work about what emotional support means to people and who needs to be involved to help the Trust improved.	Not completed due to nursing capacity and prioritisation	NOT COMPLETED
		To start from September 2017. Chief Nurse Team to coordinate.		
Communication with patients and families	Scarborough matrons and sisters have started to develop nursing team charters with their wards, capturing how staff will live the Trust values in their day to day work.	To roll the ward charters out to more wards across the Trust. AHPs and medical leads to be engaged in development work.	Developed via Professional Nurse Leaders Forum.	COMPLETED
	Communication is a key session within the nurse preceptorship programme. Effective conversations training is offered by ODIL and a bite-size learning Patient Experience session is being piloted and developed.		Nurse preceptorship sessions delivered for 2017 in partnership with ODIL. Bite-size learning was trialled. With ward staffing pressures it has not been a priority for teams to take this further The learning from the trial emphasises the importance of any patient experience training being created and delivered in partnership with a senior member of the ward team.	COMPLETED
Provision of information about medicines		The learning is being presented to the Medicines Management Group for consideration and to decide appropriate action.		COMPLETED
		Deputy Chief Nurse to present to the group.		

Noise at night	The Night Owl project was launched in September 2015 and continues to be promoted throughout the Trust.		Night Owl Project has been promoted throughout 2017. Funding for sleep packs secured from Charity. Research project with the University of York taking place in 2018.	**COMPLETED**
Privacy (particularly during assessment)		To work with matrons and other colleagues, particularly focusing on short stay wards at York in the first instance, to understand the key issues for patients and how the Trust can improve. To start from September 2017. Lead to be nominated.	Not completed due to nursing capacity and prioritisation	**NOT COMPLETED**
Letting patients know how to give feedback on quality of care and how to complain or give compliments.	New patient and visitor information boards have been produced for every ward and will be going up from June 2017.		Patient and visitor information boards in place.	**COMPLETED**
	The Your Experiences Matter leaflet about how to give feedback has been reviewed and revised and the new version is available throughout our hospitals and on the Trust website.		Availability of Your Experiences Matter leaflets around our hospitals are checked monthly by the people completing FFT collections. An easy read version has also been made available.	**COMPLETED**
	More Patient Experience volunteers are being placed on wards - under the guidance of the ward sister they are listening to patient feedback and sharing the key themes with the ward team.		The Patient Experience Volunteer role was trialled and a review held with the volunteers and sister involved. It is felt that the most benefit for patients and ward staff comes from volunteer visitors, activity volunteers and dining companions, so these roles have been prioritised.	**COMPLETED**

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Environment & Estates Committee Minutes – 06 June 2018

Recommendation

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

Current approval route of report

Board of Directors – 25 July 2018.

Purpose of report

The Board of Directors (BoD) is asked to receive the minutes of the Environment & Estates Committee meeting held on 06 June 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:

Risk Register
In line with its agreed workplan the committee reviewed the Estates and Facilities risk register. It was agreed that as the Trust moves towards the creation of an LLP to deliver Estates and Facilities services, the register should be split to identify those risks that will lie with the LLP separately from those that will remain with the Trust.

Sustainable development
The committee were pleased to review the Sustainable Development Design Guide for new projects which has been produced by the capital development team and will form part of the design brief for all new projects.

Health and Safety
The committee received a briefing paper, a copy of which is included here, explaining changes in responsibilities between CQC and HSE.

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: July 2018

Minutes - Environment & Estates Committee meeting – 6th June 2018 – Bridlington Hospital

Attendance: Michael Sweet (MS) (Chair), Brian Golding (BG), Andrew Bennett (AB), David Biggins (DB), Jane Money (JM), Colin Weatherill (CW), Jacqueline Carter (JC) (Minutes)

In attendance: Pat Stovell (Governor), Clive Neale (Governor), Paul Bishop, Camille Bainbridge

1. Apologies for absence

Apologies for absence were received from Lynda Provins.

2. Minutes of last meeting

The minutes of the last meeting held on 11th April 2018 were agreed as a correct record.

Governance

3. Matters Arising and Action Log:

No. 8 – IA reports – BoD to be advised of backlog maintenance programme selected for audit in Q2.

The Action Log was reviewed by the Committee and will be updated in line with the meeting discussion.

4. Directorate Risk Register

The Directorate Risk Register was reviewed by the Committee in line with its work programme.

The Register is split into 2 areas: corporate risks and directorate risks.

Corporate risks EF01 and EF49 had been separated out to aid transparency following discussion at the previous meeting. EF01 describes the key actions being taken and EF49 relates to the estate condition survey work required against the Trust's financial position. CW had subsequently notified the Corporate Risk Committee of this change but has not received any feedback as yet. This was noted.

Corporate risk EF02 had been progressed, identified risks had been mitigated and the team were well on with the installation programme for the fire alarm replacement systems. BG suggested the Committee consider whether this risk be downgraded and removed from the CRR. Although the scheme is unfinished the main panel had been replaced, therefore, it was felt no longer to be a corporate risk however, it was agreed to contact Paul Johnson in estates for a view on the current level of risk in the system and to report back at the next meeting. **Action: BG.**

Directorate risk EF04 Premises Assurance Model and gaps in assurance. BG asked that those specific gaps and lack of evidence are now identified on the Register. This was agreed. **Action: DB**

Directorate risk EF36 had not been progressed. A structural survey had been originally carried out on the walkway but some further information was required around the defects identified that needed addressing over the medium term. Another condition survey had been carried out and AB thought the outcome of this would support the original position or if something had changed it would provide the update required. BG felt this required urgent attention as he needed to know whether it was safe to use. **Action: CW to contact A.Betts.**

Directorate risk EF47 related to the closure of ward doors. A standard was required to be written that could be rolled out across the Trust. BG asked for this to be progressed and an update provided. **Action: CW.**

Any other comments will be picked up as part of updating the RR in line with the meeting discussion. It was noted that a lot of the risks were maintenance related and BG felt this was an indicator of a potentially larger problem if the lack of capital investment for maintenance is not addressed.

For attention of BoD at private Board meeting.

As E&F moves into the new LLP the risk register will require updating and published to identify the split between LLP risk and Trust risk and BG asked that a mechanism is put in place to capture this. **Action: CW / P.Bishop.**
For attention of BoD – to be re-presented in new format in order to agree what remains with the Trust and what moves with the LLP.

5. Internal Audit Reports

The following Internal Audit reports were received by the Committee:

- **Waste Management**
- **Doctors accommodation**

Both received a significant assurance rating.

6. Board Assurance Framework (BAF)

The Committee received the BAF for review and comment in line with governance arrangements.

It was noted the BAF was being revised in June and any revisions will be taken to the BoD meeting on 27th June. The EEC were asked whether there are any further amendments.

The BAF is structured around 4 key ambitions and in relation to the Environment & Estates ambition, whilst the rating for no. 4 "we fail to develop our facilities and premises to improve our services and patient care" was scored as green, BG felt this should be raised as it related to backlog maintenance issues and asked that within the Assurance column this be broadened out to include NHS PAM and Condition Survey to reinforce on which we are placing reliance which could alter the rating. CW asked whether an action can be

added to the process to create a better link to the Risk Register work as there was uncertainty around when a high risk issue is identified and when it is added to the CRR and how that is highlighted up through the governance structure.

7. Operations

Matters Arising and Action Log

None

FM Compliance Monthly Report

DB presented to the Committee the latest combined compliance report showing the Trust's position against the audit and surveillance activities in line with the premises assurance process for the period ending May '18. It was noted that going forward this would be presented as a monthly report not quarterly.

Key items for the Committee to note were the summary performance dashboard and the KPIs linked to the TAPE assessment and cleanliness in the high risk areas. The paper also highlighted the overdue maintenance for medical equipment at both York and Scarborough hospital sites.

DB confirmed to the Committee that other departments in the Trust have been involved in the setting of the **KPIs** mainly the Infection Prevention Team. In relation to the Policy & Procedure information on the **performance dashboard** compliance for the York site is 62%. The position has slowed down and he was working with colleagues to ensure the appropriate procedures are written and approved in line with governance arrangements. MS asked if there were any gaps that required to be raised. DB confirmed that ventilation processes was a good example to highlight as a gap as there is no up to date procedure underpinning the work however, it was noted that the area in question is being developed.

DB highlighted to the Committee the results of the decontamination audits that were supported by the **TAPE** process of which the EEC were interested in its value to the monitoring programmes already in place. The results for the last 2 quarters were shown in the document which has set a benchmark of 81%. Compliance against the medical equipment surveys is currently being met at Malton and Selby sites. Other sites are not achieving the KPI although it should be noted that the majority of the defects found during surveillance were associated with equipment that is in use or in storage in wards and clinical departments being overdue service or maintenance. This TAPE process has been well received by the Infection Prevention team insofar as they are reducing their audit activity in favour of this new process and more importantly it provides a visible presence of those key staff on the wards and departments who have the opportunity to speak directly with Domestics, Matrons etc.

The Medical Equipment surveillance latest scores were shown at p.7 of the document. Each site is visited at random to sample medical equipment and check their condition, which then provides a snapshot at each particular site. All equipment not compliant was due to their overdue service. BG asked for a view as to why this is the case. DB thought it was mainly linked to device migration and, therefore, not being located in the correct area. He was considering implementing a process/system which might help greatly with this. This was noted.

The accessibility and condition and appearance of our Estate were the defect categories most prevalent when undertaking TAPE assessments in quarter 1. In relation to Bridlington Hospital 20% of the tape assessment failed and the management team have an action plan to address this. 7% of the non-conformances were identified as cleanliness and the environment which is a relatively small number. BG asked that when it comes to site comparison can DB consider how this is articulated as the information shown puts Selby in worse light than it actually is. This was noted.

In relation to the current **NHS PAM Model** position by site which was included in the monthly pack, again, DB will use this tool to drill down to the detail to understand which parts of the domains Managers are not meeting. He was still trying to eradicate the red ratings but because it is a monthly position it did require constant monitoring to ensure compliance did not dip.

It was noted the **PLACE** results which had been submitted to the Centre were shown at p.7 of the report. It was noted that final results will be received around October. Another round of TAPE audits will take place between now and then which will provide trend data.

P. 8 of the document showed the **Facilities Management KPI dashboard** which DB confirmed the management team do find useful. 14 KPIs are agreed and set around a range of areas including PAM, PLACE and the TAPE process. The RAG ratings on the dashboard identifies current compliance and if he was receiving consistently poor data he would raise this at the FM Operational Site Group meetings. On reviewing the data BG had concerns around the York site cleanliness scores as it appeared fairly low. DB acknowledged this but because the information is produced on a monthly basis if there were consistently low scores these would be identified and escalated accordingly for him to review where improvements can be made. This was noted. MS was assured that this acted as an alert tool to those operational managers responsible for the cleanliness, safety and maintenance. PB asked where a downward trend was showing how easy was it for the EEC to scrutinise that information. DB assured the Committee that monthly reports are produced for the Committee and operationally concerns will be raised at the site meetings each month. If a downward trend continued then that would be escalated accordingly.

On p. 47 of the document Endoscopy information appeared to be skewed particularly in SGH and BDH. DB assured the Committee that there are planned actions in place to address this. He was looking to install a Tracking and Traceability system. Regarding their washer disinfectors these are at the end of their life and, therefore, they were dealing with a number of failures of the machines. Whilst it is not critical from a patient safety point of view it is disruptive to clinical activity. This was noted. The RAG rating will always appear red for BDH because they have a single washer and no contingency plans in place, therefore, if we looked to centralise this function that risk would disappear. This was noted. AB confirmed work was underway to address the replacement or ensure there is an annual provision for breakdowns.

The Committee noted that areas were on the whole generally getting better but exceptions appeared to be in the safety domain which was felt to be linked to maintenance apart from Bridlington, therefore, regular scrutiny was required. Subject to a minor amendment on page 4 and making the information clearer, MS welcomed the report. It was felt the report needed to be more accessible to the operational teams perhaps not just in Estates and Facilities departments. The audience for the report has changed and other staff have expressed an interest and it is important they receive a copy. This was noted.

Sustainability

8. Matters Arising and Action Log

Disposal of offensive waste (no. 57 Action Log)
Report back to Committee in 3 months.

SDMP update
To highlight to the Committee that the SDMP update is deferred until the August meeting due to updating of the SD assessment tool which is now completed but there is a need to draw out those key actions.

9. SDG – minutes of last meeting held on 18th April 2018

The EEC received the latest SDG minutes for noting and comment. Items highlighted to the Committee are as follows:

- Waste management /recycling promotion/objectives. 5 objectives to be brought to EEC already in public domain such as reducing plastic waste.
- SDMP action plan priorities for this year.
- Review ToR and Membership.
- The deadline for updates on the national submission to the NHS SU had passed. BG requested that work stream leads update their current level of compliance urgently. The assessment has now been submitted.
- SD engagement project – we are awaiting approval of the BC for phase 2 work – a report will be taken to CDs next week for approval in order to progress this.
- SD design guide. The VIU project will be the first scheme where this guide will be used.

Clive Neale, Governor left the meeting at this point.

10. Sustainability update

JM provided a report to the Committee updating them on the SD and engagement agenda. The main body of the report covered the following areas:

- To advise on the negotiations and monitoring arrangements work relating to phase 2 of the WRM consultants work on SD engagement and carbon reduction.
- To update on sustainability business assurance framework monitoring information including the SDAT.
- To provide an update on the work of the SDG following the April meeting of the EEC.

An SDG sub group has been formed to develop a top 5 list of actions to raise the profile of food sustainability following media coverage about the removal of non-recyclable plastics. A report will be taken to CDs for approval to progress this.

As this point MS asked about the District heating scheme that the CoYC was leading on. JM was not sure whether the Council were going to progress this anymore however, there was mention of using Bootham Park Hospital. Bootham Hospital was originally connected to the CHP as a steam supply but that was disconnected when the hospital closed. BG said the whole site will need an environmental strategy and the SD design guide would

come into use. JM said it has to be a socially driven project and the last meeting that BG and JM attended with the Council the discussion was closed. The opportunity is there but we as a stakeholder are only interested if the work involved was relatively small and the Trust wasn't the driver of the scheme.

The SDAT work has highlighted some areas where the Trust has work still to complete around areas of green space being integrated into any site developments. Green space and biodiversity is a new module and although some elements were included within the buildings module of the GCC it was less focused on having specific plans in place for provision and use of green space within the Trust estates and having a biodiversity action plan. BG said Selby is a good example for that.

MS asked for an update on the adaptation module. JM confirmed this is the work that Andrew Hurren was leading on across the Trust and is part of the emergency planning/business continuity work. He has advised that 380 action cards for business continuity have been written and tested during the last financial year which focused on general things that come up on the national risk register and does include adverse weather. So, in terms of business continuity it is broken down in to loss of staff, IT, power.

In relation to BAF the work of the Sustainable Development Group provides assurance relating to the risk “we fail to positively manage our impact on the wider environment”. The SDG have completed their assessments using the new SDAT. This tool replaces the GCC and it is expected that scoring with the new tool will decrease the scores nationally largely because the statements for benchmarking have been updated. The Trust’s last GCC score was 44%. JM was pleased to report the new score reached was 49%. The Trust recognises that engagement and behaviour change is a key part of improving its performance both against the SDAT benchmarking tool and in fulfilling its obligations under the Climate Change Act by achieving further carbon reductions. It was also felt there had been little corporate engagement regarding the sustainability agenda against the Trust’s Strategic aims. This could be addressed when the sustainability team are better resourced and supported through the sustainability engagement work with WRM.

MS noted the carbon/green house gases module had scored quite low compared to the other sections. JM confirmed this was because every section now has a carbon equivalent in it and if you do not have measures for quantifying carbon then they cannot be scored, such as areas around procurement and some capital projects and models of care.

MS also noted the statement regarding little corporate engagement and asked what can be done generally to raise its profile. JM was confident this would get addressed and if she received approval for the 2nd phase of the project work with WRM on the sustainability engagement agenda then she would have more resources to see this through which could include a regular quarterly report to BoD once these additional resources are in place. MS asked for the Committee’s view on this. Following discussion MS thought sustainability information could be dropped into his operational performance monthly report that he receives. BG agreed to consider this.

JM highlighted to the Committee the NHS Sustainability week 25th – 29th June and the National Clean Air Day 21st June 2018. MS asked whether the nearby coach car park in Clarence Street could be asked to contribute by switching off their engines. This was noted.

Capital and Property

11. Matters Arising and Action Log

Matters Arising and Action Log

None

12. SMG – minutes of last meeting dated 16th January 2018

The EEC received the latest SMG minutes for noting and comment. The purpose of the Committee receiving these is to provide information and assurance on the functioning of the SMG and the matters that it routinely considers and deals with.

Items highlighted to the Committee are as follows:

AB was working closely with Tony Burns to consider whether there was scope for additional resource to support him in managing the Trust's leases and licences work both as a Landlord and as a tenant to optimise the income the Trust receives from its tenants and/or to realise further any revenue savings.

AB was pleased to report that the space auditing work had been completed for space utilisation purposes. In terms of space requests these were divided into major, large, medium external and PIP. AB was looking to put together a more defined and robust formal process in place around the governance arrangements associated with these requests. This will include feeding into the BC Panel of which AB was a member and challenging the authors of BCs about whether additional space is required or whether their BC allows for space to be handed back to the Trust.

With regards to the current unmet space needs and opportunities, the first floor of the administration block, YH, highlights an unusually large space becoming available once the endoscopy work commences. A process will need to be developed for deciding who utilises the space to ensure the Trust has not overlooked potential needs.

MS thanked AB for this information and asked whether he felt he needed clinical representation on the SMG. AB felt at this stage there is a lot of business and process discussed and the amount of times we would appeal to an expert is unresolved at the moment. This was noted. BG confirmed the Operational aspect is represented through Mark Hindmarsh.

13. Sustainable Design Guide for future capital/estates projects

The Committee received a copy of the Sustainable Design Guide that is going to be used as a set of criteria for future capital and estates projects. AB explained that work has been going on for a while and this final document is about ensuring that sustainability is embedded into everyday work in his team and all the projects they deliver to ensure that the output from projects delivers carbon emissions reductions and savings.

AB spoke about the guidance and reference parts and the toolkit information in the guide and said towards the end of the guide is the part that will be most used by project managers which is where the various elements of procedure are contained. He explained the key approach to reducing carbon emissions from the Trust's property assets is to be "mean, lean, green and clean". Mean is to take every reasonable opportunity to improve

building fabric performance, ie to maximise use of natural light. Lean is ensuring that the bms systems for use in the Trust's buildings use energy as efficiently as possible and green and clean involve consideration of renewable technologies and clean energy technologies. The Guidance section sets out a summary table which sets out options available to the capital projects team and what applies to different projects. It is a fundamental shift as to what has happened in the past. The back of the document shows how we are measuring and recognising methodology not just that we measure our projects but that the projects achieve the certain standards outlined in the guidance.

MS was delighted to receive this and thought it was an ambitious document. BG said it will become part of the brief for project managers. It was noted an Executive Summary page was required to complete the document prior to publication. The Committee were pleased to see the Trust now has a published sustainable design guide document which aims to transform the sustainability approach we take on new build and refurbishment projects.

For highlighting to the BoD.

Health, Safety & Security

14. Matters Arising and Action Log

HSE Sharps Surveillance Visit – 3/10/17 (no. 51 Action Log) – the sub group were still meeting and completing a number of actions. CW has met with the Medical Director and agreed a process for preventing unsafe sharps being procured and a procedure will be written in line with this commitment.

Memorandum of Understanding

Following discussion at the last meeting CW presented a memorandum of understanding to the Committee which required to be progressed to the Board of Directors.

In December 17 the CQC and HSE agreed a memorandum of understanding as a means of ensuring there is an effective, coordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public. The MOU outlines considerations for general enforcement in the sector, noting Regulation 15 (premises and equipment) and outlines the responsibilities of the CQC and HSE when dealing with health and safety incidents, inspections and investigations in the health and adult social care sectors and the principles that will be applied where specific exceptions to these general arrangements may be justified.

The MOU states the CQC will now become the lead regulator, inspector and investigating body for health and safety for registered providers with the HSE involvement in a limited number of circumstances.

Following discussion MS suggested setting out on paper the responsibilities of the Trust and the LLP post October.

For attention of BoD. Paper to be included.

15. H&S/NCRG – minutes of last meeting dated 13th April 2018

The EEC received the latest H&S/NCRG minutes for noting and comment. Items highlighted to the Committee are as follows:

- The H&S self-assessment audit report will be included for discussion at the next EEC meeting.
- The Committee agreed to the development of a policy concerning mobility scooters brought on to site.
- It is noted that the "never events" schedule has been revised and includes confusion between medical air and oxygen. The Group will highlight the Medical Gas Committee's recommendation that there is annual refresher training provided to those that need it.
- Heatwave Policy approved.

MS asked for further information regarding the issuing of a Fire safety notice following an alarm activation at YH. CW explained a member of staff had reported to the Fire Brigade that an escape route was blocked. The Fire team undertook an inspection and on completion it was found that this was not the case and the area in question was clear. This was noted.

16. Fire Safety update

CW reported to the Committee that a report had been produced following the Grenfell inquiry which will impact on the Capital Planning team around building control issues and building regulations and the standards that are to be applied. This was noted.

17. Health, Safety & Security Quarterly Report

The Committee received the latest quarterly report for the period ending March '18.

The purpose of the report is to review reported incidents and trending information with regard to health, safety and non-clinical risk.

Section 1.4 of the document gave a summary of non-clinical accidents and incidents. It was noted that the figures reported for slips, trips and falls are still high. CW explained the figure included staff, patients and visitor incidents and a lot of the incidents were patient related due to their clinical condition and immobility.

Following discussion the Committee noted the contents of the report. BG agreed to discuss further with CW about how best to present the information contained within the report to bring it into line with the performance information packs that are received by the BoD.

Finance and Efficiency

18. Matters Arising and Action Log

None.

19. Performance & Efficiency Report against Carter Recommendations

DB presented the latest report to the Committee which set out the Trust's position against the Carter recommendations and the NHS Model Hospital performance dashboard. The following items were highlighted:

- The Directorate is performing well in the cost efficiency elements of the NHS Model Hospital metrics however, there are some opportunities for improvement in efficiencies associated with waste streams, water and sewage costs.
- The Trust currently generates around 1400 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 Lord Carter report recommendations in terms of space utilisation but has a range of measures in place to achieve the requirements by the required 2020 deadline. Information relating to Trust gross internal floor area calculated by the Trust's building services manager is currently being validated as part of the current condition surveys being undertaken across Trust sites.

In terms of efficiency the Trust is achieving efficiency benchmarks against 14 of the 18 estates metrics within the NHS model hospital. The Trust is not meeting metrics associated with water, sewage and waste disposal costs as shown on the FM benchmarking data at Appendix 1 but is doing well and is in the lower quartile for hard and soft FM costs. In relation to the data on the outlying areas, DB has met with Hugh Stelmach to review the waste management information; it was noted the information was based on last year's ERIC return so required updating. DB reminded the group the portal is accessible if anyone wished to review the information in more detail such as for maintenance and food costs

Space utilisation schemes underway at the moment include the Bridlington optimisation work where there is space that is being under utilised and the organisation is trying to rationalise this. As a result of city healthcare partnership moving into a unit at Bridlington hospital the Trust had an opportunity to close the Thornton and Buckrose wards. These are empty but this will identify and achieve savings on areas such as energy efficiency and cleaning. A project group is set up for this site.

Following discussion the Committee noted the contents and recommendations in the report.

Out of Hospital Care

20. Matters Arising and Action Log

None.

21. Quarterly Report

The Committee received the latest report from the Out of Hospital Care Directorate.

The purpose of the paper is to provide the Board sub committees with an overview of activities within the Out of Hospital Care Directorate.

There were no matters arising and nothing for this Committee to note against the latest report.

YTH FM LLP

22. LLP update

Paul Bishop presented an update report to the Committee on the latest position of the formation of an LLP to deliver Estates & Facilities services to the Trust. Previous reporting had been directly through to BoD.

The purpose of the report is to provide assurance to the EEC and give an update on the go live date for the LLP.

The key points were noted in the paper including:

The LLP is currently on track to achieve its commencement date of 1st October 2018.
The new organisation has been incorporated at Companies House and is called York Teaching Hospital Facilities Management LLP.
Unions are involved in the TUPE process.

A number of internal work streams to support the transition are now running including:

Corporate Governance
Human Resources
Finance
Corporate efficiency
Communications
S&NS
Procurement

The main focus of work has been the management of the TUPE process by the HR department to prepare for the transfer of all staff on their existing terms & conditions. Consultation letters have been sent out to all individuals affected. Staff engagement has continued since January '18.

In terms of procurement work it is intended to mirror existing Trust contracts and SLAs as part of the transfer process.

With regard to Finance - awaiting registration with HMRC.

An organisation chart was deemed useful to identify different activities and where they lay both corporate and LLP.

MS thanked PB for this update and felt assured the process was working well.

Any Other Business

23. Sickness Absence Rates

The Committee received a paper on the Directorate sickness absence rates.

The purpose of the report is to highlight the current sickness and absence rate against the Trust target.

Although there are seasonal variations in the figures the general trend had been downwards. An action plan to address this has been developed.

One of the key risks that has been identified is the low ratio of supervisors to operational staff which needs to be tackled if we are to make progress.

24. Time and Date of Next Meeting

Wednesday 15th August 2018 @ 1pm. York Hospital.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Memorandum of Understanding – Care Quality Commission, Health & Safety Executive & Local Government Association

Recommendation

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

Current approval route of report

This report follows a verbal report at the Environment & Estates Committee meeting on 11th April 2018. This report will then be circulated to the Board of Directors for their information.

Purpose of report

This paper is for information.

Key points for discussion / Decisions required

The Committee members are asked to note the information in this 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

Regulation 12(1) Safe Care and Treatment

Version number: Version 1

Author: Colin Weatherill, Head of Safety & Security

Executive sponsor: Brian Golding, Director of Estates & Facilities (non-clinical risk)

Date: May 2018

1. Introduction and Background

In December 2017, the Care Quality Commission (CQC), Health & Safety Executive (HSE) with the support of the Local Government Association (LGA) agreed a memorandum of understanding (MOU). This report summarises the key information for Committee members.

2. Detail of Report and Assurance

The MOU applies to health and adult social care in England with the purpose to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public.

It outlines the responsibilities of CQC, HSE and local authorities (LAs) in England when dealing with health and safety incidents in the health and adult social care sectors, and the principles that will be applied where specific exceptions to these general arrangements may be justified. The MoU applies to all activities and describes the principles for effective liaison and for sharing information and effective co-operation to enable and assist each other to carry out their responsibilities, functions, and effective working arrangements.

Other organisations are also defined in the MOU such as the police, Crown Prosecution Service (CPS) and Safeguarding Adults Boards. The CQC, HSE and LAs will notify relevant bodies of incidents and agree the coordination of activity or work with them as appropriate to protect patients, service users, workers and the public from risk of harm.

The MOU outlines the responsibilities of the CQC and HSE in dealing with health and safety incidents, inspections and investigations in health or adult social care service providers with the CQC taking lead for CQC registered providers and the HSE leading for health and adult social care service not registered with the CQC.

The MOU then outlines considerations for general enforcement in the sector, noting Regulation 15 (premises and equipment) and going on to state;

12 'Regulation 12 (1) of the Regulated Activities Regulations which relates to the need to provide safe care and treatment includes a duty to ensure that the premises used by the service provider are safe to use for their intended purpose'.

*13. Although specific health and safety at work (HSW) legislation may exist, such as Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), **it should generally be the case that CQC can adequately enforce using their legislation, without needing recourse to specific legislation.** In a limited number of cases CQC may exhaust its enforcement powers and may look to HSE/LA for support.*

The emphasis in the MOU on this indicates the CQC will now become the lead regulator, inspector and investigating body for health and safety for registered providers[1] with the HSE involvement in a limited number of circumstances.

---

[1] *Register under Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*

Another point for noting is that the MOU then goes onto state the HSE will be the lead regulator for incidents:

'*involving an activity that is not a regulated activity and is not being managed/supervised by a registered provider (e.g. patient/service user injured while being escorted in a taxi because wheelchair not properly secured, travel in a taxi is not a regulated activity and taxi company not a registered provider, therefore CQC has no vires)'*

When taken in conjunction with the fact the HSE is the leading regulator for health and adult social care services not registered with the CQC, this would mean any organisation which supplies a services to the Trust would fall outside of the CQC regulations and general health and safety legislation would apply; however if the service provider committed an offence then the Trust as a registered provider could be liable for action under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2.1 Implications for Equality and Diversity

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

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

3. Next Steps

This paper is to be circulated to the Board of Directors for their information.

4. Detailed Recommendation

The Committee members are asked to note the information in this report and refer any questions to the author.

NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Workforce Report – July 2018

Recommendation

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

Current approval route of report

No approval route prior to Board of Directors; 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 June 2018).

Key points for discussion

- The monthly sickness absence rate in May was 3.95%, decreasing from 4.38% from the previous month and lower than the monthly absence rate in the same month of the previous year.
- Staff turnover has shown a small increase in June To 10.71%
- Demand for temporary nurse staffing in June equated to 443.80 FTE whilst demand for temporary medical staffing equated to 97.77 FTE.
- The Trust's Statutory/Mandatory Core Training compliance rate for June was 85%, whilst the Essential Training compliance rate was 86%. The Corporate Induction compliance rate was 93%.
- The government has announced a relaxation of Tier 2 visa rules which will see all medical and nursing posts exempt from the Tier 2 visa cap.

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.

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

Version number: 1

Author: Polly McMeekin, Acting Director of Workforce and Organisational Development

Executive sponsor: Polly McMeekin, Acting Director of Workforce and Organisational Development

Date: July 2018

1. Introduction and Background

July'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 includes information on the Trust's statutory & mandatory compliance rates and provides an update on the new initiative for the recruitment of medical staff on the East Coast. The report also provides a summary of the recent government announcement on the relaxation of Tier 2 visa rules.

2. Detail of Report and Assurance

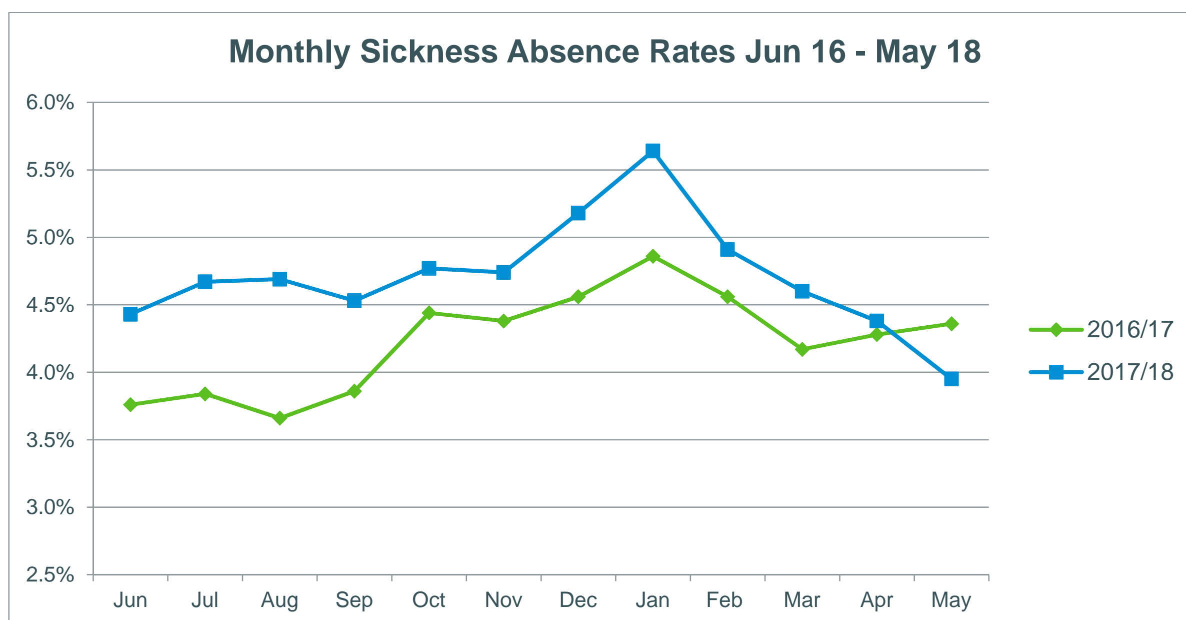
The work referred to in the report forms part of regular discussions around workforce, including at Staff Side and Workforce and Organisational Development Committees. It is informed by a number of key performance indicators which underpin directorate-level workforce plans, and link to the Trust's overall Workforce Strategy.

2.1 Sickness Absence

Graph 1 shows the monthly absence rates for the period from June 2016 to May 2018. The monthly absence rate in May 2018 was 3.95% decreasing from the previous month's sickness absence rate of 4.38% and this is the first time since March 2017 that the monthly sickness absence rate is lower than the sickness absence rate in the same month of the previous year (the absence rate in May 2017 was 4.36%). Additionally the monthly sickness absence rate has dropped below 4% for the first time since September 2016.

This is consequently reflected in a reduction in the cumulative annual sickness absence rate over the same period where the annual sickness rate decreased from 4.74% in April to 4.71% in May.

Graph 1 – Monthly Sickness Absence Rates



Source: Electronic Staff Record

Sickness Absence Reasons

The top three reasons for sickness absence in the year ending May 2018 based on both days lost (as FTE) and numbers of episodes are shown in table 1 below:

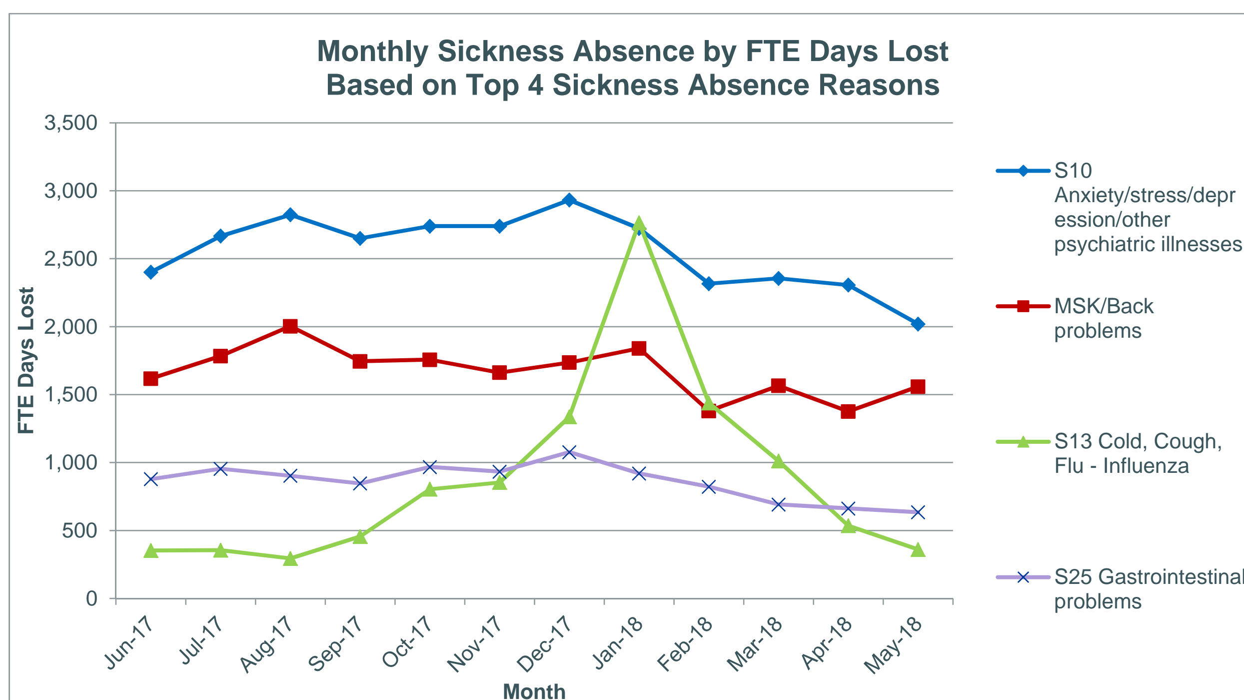
Table 1 – Sickness Absence Reasons - Year to May 2018

Top three reasons (days/FTE lost)	Top three reasons (episodes of absence)
Anxiety/stress/depression – 24.20% of all absence days lost	Cold, cough, flu – 18.22% of all absence episodes
MSK problems, inc. Back problems – 15.80% of all absence days lost	Gastrointestinal – 17.88% of all absence episodes
Cold, cough, flu – 8.33% of all absence days lost	Anxiety/stress/depression – 10.85% of all absence episodes

The sickness reason of Anxiety / Stress / Depression remains the most prevalent sickness reason for the year to May based on FTE days lost followed by MSK problems. Sickness due to Colds, Coughs and Influenza is now the third highest sickness reason based on FTE days lost. This could be attributed to the increase in cases (and over a longer period compared with previous years) at the beginning of the year. Sickness absence due to Cold, Coughs and Influenza also accounted for the highest number of episodes of absence.

Graph 2 below shows the number of FTE days lost to the top sickness reasons by month over the last year:

Graph 2 – Monthly Sickness Absence by Reason by FTE Days Lost

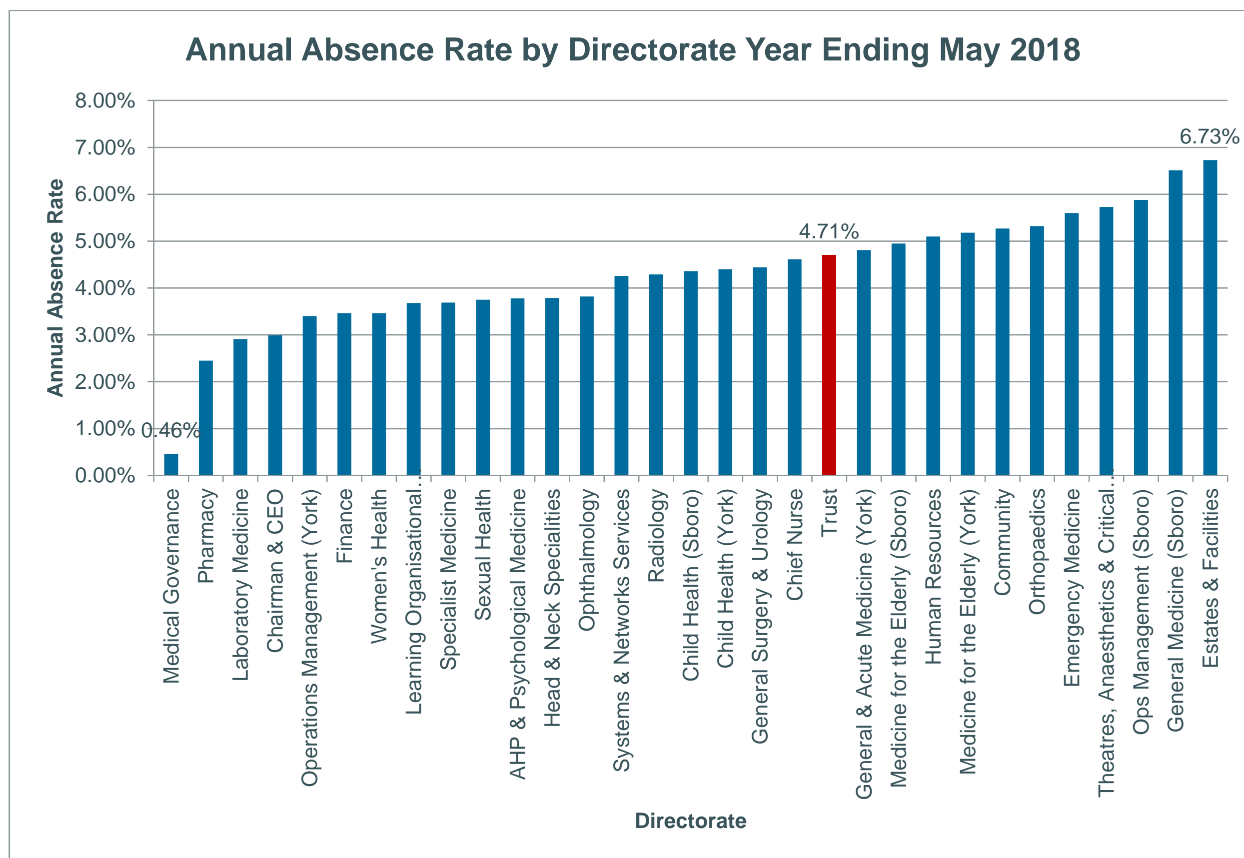


Source: Electronic Staff Record

By staff group, Additional Clinical Services and Estates and Ancillary, continue to have the highest sickness absence rates.

By directorate, Estates and Facilities have the highest annual sickness absence rate in the year to May 2018 (Graph 3). However, their monthly sickness rates has reduced month on month over the last 6 months to 5.26% in May - the lowest monthly rate for this directorate since April 2015.

Graph 3 – Annual Sickness Absence by Directorate



Source: Electronic Staff Record

In Quarter 1 of 2018/19, a number of actions were introduced which are now positively impacting on the Trust's sickness absence rates:-

- A revised training programme for the new sickness policy has been rolled out across all sites since April. Six half day sickness training sessions have taken place during Quarter 1, with 90 managers trained during this time. Sessions have taken place at York, Scarborough and Bridlington sites. Further sessions are scheduled throughout the year. In addition HR is working within service areas to deliver shorter, bespoke, masterclasses and 'bite-size' training to managers in targeted areas.
- HR has established Attendance Challenge Meetings in the Directorates with highest absence rates. These meetings provide a joined-up approach with HR, Occupational Health, Directorate management and senior nursing managers in attendance. Local hotspot absence areas and causations are identified, along with emerging themes, specific challenges and a Directorate action log agreed. In June

2018, meetings took place with Emergency Department, Theatres, General Surgery and General Medicine. Further challenge meetings are scheduled for July and follow up meetings are being scheduled in 2-3 months' time. This will ensure actions are completed and that momentum is sustained as we approach the winter months.

- A Trust wide sickness management action plan for 2018/19 has been developed and is reviewed and updated at the monthly sickness management meeting (HR and Occupational Health)
- To address the mental health absence rates which rose significantly during 2017/18, a number of Health and Wellbeing initiatives including training on mental health for managers, video toolkits on conducting Individual Stress Risk Assessments and Schwartz Rounds have been rolled out during Q1 2018/19.
- The Trust's Employee Assistance Programme provider is Health Assured. In the 5 months from December 2017 (start of contract) to May 2018, there has been a steady increase in the number of employee contacts made. Between December and May, over 300 telephone contacts were made, 94% of these in relation to counselling and mental health. There has also been over 2000 online hits. There has been 120 face to face counselling sessions during this period, again a number which has increased month on month. The top counselling call categories were anxiety (21%); depression (14%); bereavement (9%); work-related stress (8%) and partner (8%). In terms of workplace outcomes, the data shows over 32% of those employees who were out of work at the start of counselling therapy are back in work by the end of it.

2.2 Temporary Staffing

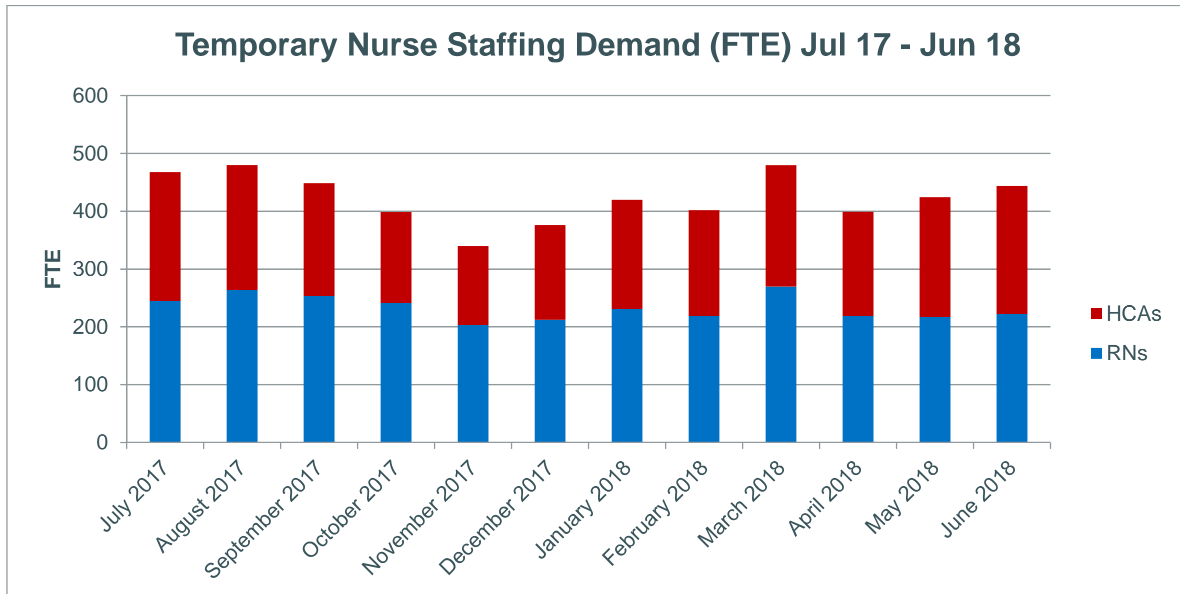
Temporary Medical Staffing

In June, 97.77 Full Time Equivalent (FTE) medical locums were requested at the Trust across both York and Scarborough Hospital. In total, 97.31% of the shifts were filled (94.82 FTE). 32% (38.47 FTE) were filled via Bank whilst 65% were filled via Agency (56.35 FTE).

Temporary Nurse Staffing

Demand for temporary nurse staffing (RNs and HCAs) in the last year has equated to an average of 423 FTE staff per month. Demand in June 2018 equated to 443.80 FTE which was 7% higher than demand in the same month of the previous year (demand in June 2017 was 415.02 FTE). This increase has been seen predominantly in the number of HCA requests made (the equivalent of 221.65 FTE HCA requests were made in June 2018 compared with 193.25 FTE in June 2017) and HCA shift requests made in particular due to the reason of sickness also increased in June (with 37 more shift requests made due to this reason than the previous month). The additional clinical services staff group has had the highest level of monthly sickness absence within the organisation over the last two months.

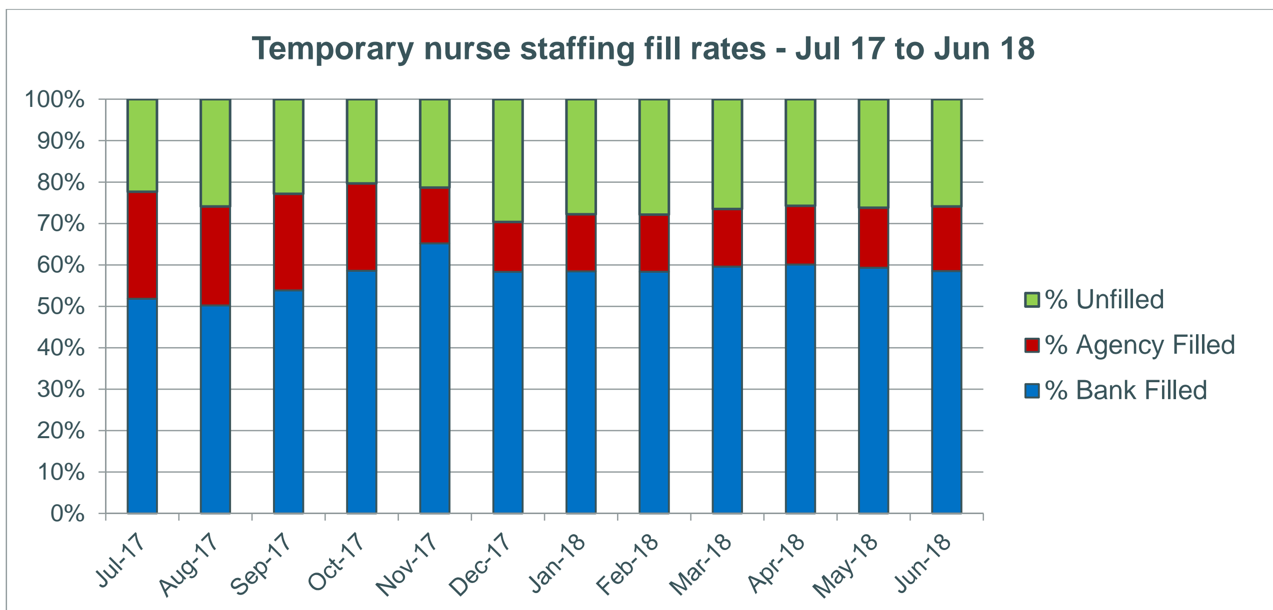
Graph 4 – Temporary Nurse Staffing Demand



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 58.54% of all requests in June 2018 whilst the Agency fill-rate was 15.58%. There has been a gradual increase in the agency fill rate since December and the overall agency fill rates in June was almost 53% greater than in December (the equivalent of 45.29 FTE were filled by agency in December 2017 compared with 69.14 FTE in June 2018). Some of this increase in agency usage can be partially attributable to some continued block bookings of agency staff as well as the knock on effects from an extended winter period. On average, three-quarters of all filled agency requests over the last six months have been due to the reason of both vacancies and sickness.

Graph 5 – Temporary Nurse Staffing Fill Rates



Source: BankStaff

NHS Improvement wrote to Trusts at the end of May 2018 detailing some additional required actions with the aim to further reduce expenditure on temporary staffing. These actions are:

- Chief Executive sign off any shifts (bank and agency) where the cost is £100 per hour or over. It has previously been the case that shifts at or above £120 per hour required Chief Executive sign off and this has achieved a reduction in shifts being worked at this rate.
- Executive Director sign off for shifts that are under £100 per hour but 50% or more above the relevant price cap.

Trusts are required to formally report the above to NHS Improvement via the weekly return from 1st July 2018. This is in addition to the reporting requirements that have been in place since 2015, i.e. to report all agency usage with a breakdown of any off framework agency usage and all agency shifts which are above the relevant price caps. We have updated our internal approvals and reporting processes accordingly and it has been agreed through Joint Local Negotiating Committee to reduce the highest rate paid on the internal medical bank (for Consultant bank work during out of hours) from £100.

Since the start of this calendar year, we have reported to NHS Improvement, on average 454 shifts per week of which, on average 319 are not compliant with the price caps broken down as follows; 183 medical and dental shifts; 128 nursing and midwifery shifts; 8 non-nursing, non-medical staff groups. There has been no off framework agency to report to NHS Improvement at all this year.

2.3 Recruitment

Medical Recruitment on the East Coast

The medical vacancy position on the East Coast has deteriorated over the last six-years. In April 2012, the vacancy position stood at 13%. In May 2018, the Trust recorded a 21% vacancy position.

The supply of doctors globally is running shorter than ever. The UK is seeing significant decreases in people applying to medical schools, foundation programs and specialty training and this fall in throughput is affecting some specialties more acutely than others (e.g. in Paediatrics, last year the Royal College reported that 25 per cent of senior trainee posts were vacant).

Consequently trusts across the UK are consistently reporting shortages of doctors. Rural locations in particular are reporting greater shortages than urban areas and have to work harder to attract candidates to their vacancies.

As employer-led recruitment will not succeed in improving the vacancy position on the East Coast the Trust is proposing a fresh approach to actively target potential candidates through different networks, generating leads, building relationships and converting passive interest into accepted offers of employment.

It is therefore proposed that the Trust maximises its efforts to attract doctors to work at Scarborough Hospital by adopting some of these techniques. Actions include:

- working with agencies to generate new leads;
- reviewing locum doctors already in our employment;
- utilising the services of Jupiter to undertake targeted social media campaigns;
- developing a focused campaign to create and fill Associate Specialist roles;
- seeking employee referrals;
- creating clinical attachment pathways (doctors who wish to gain UK experience spend a period of 4 months on placement, in preparation for employment. This would be supported by a mentoring scheme).

This function will be undertaken by the Medical Workforce Manager who has a strong knowledge of the candidate market, the local community and Scarborough Hospital. Their current role will consequently be back filled with a Medical Staffing Manager for the period of the project to cover other key duties such as the implementation of Schedule 15, completion of the 2018-19 Job Planning Cycle, implementation of Electronic Job Planning, completion of Local Clinical Excellence awards and oversight for GP Lead Employer arrangement.

This has been initially proposed over a 6 month trial period so that the Trust can be satisfied that the approach will achieve results.

2.4 Junior Doctor Change Over

Change over occurs on Wednesday 1st August 2018. The table below details the trainee fill rate provided by Health Education England (HEE) together with the outcome to date of parallel recruitment into Trust Grade positions.

Filled by HEE	Filled by Trust Grades	Total Filled	Total Vacancy
York Hospital			
87.7%	6.9%	94.6%	5.4%
Scarborough Hospital			
69.9%	12.5%	82.4%	17.6%

2.5 Recruitment of Physician Associates

The Trust recently advertised for Physician Associates which is a new role to the NHS. 41 applications were received and 21 were shortlisted. The interviews were held on Friday 6th July with 14 offers made. 13 are to commence positions later this year with the 14th to commence in 2019 post qualification. The positions are predominantly based in medicine in York with a handful selecting Scarborough. They will commence on a two year rotation preceptorship.

2.6 Relaxation of Tier 2 Visa Rules

The government has announced a relaxation of Tier 2 visa rules.

The proposal, which takes effect from 6 July 2018, will see all applications for medical and

nursing posts exempt from the Tier 2 visa cap. This will mean there is no cap on the number of doctors and nurses that can be recruited and also means that there will be significant extra capacity in the system to enable employers to get certificates for a wide range of other roles which have been refused in recent months.

However, this is not a retrospective change and therefore employers will need to apply or re-apply for restricted certificates from July. The deadline for the July panel is 5 July.

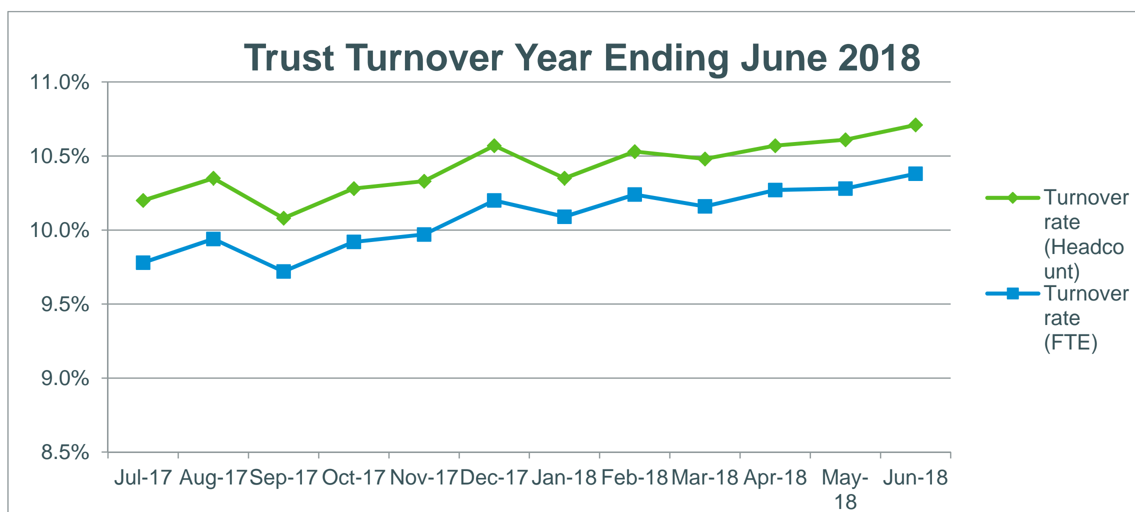
The applications will still be subject to the resident labour market test and all other rules and evidence requirements of Tier 2.

This is an interim measure, and is likely to be in place until Spring 2019.

2.7 Staff Turnover

Turnover in the year to the end of June 2018 was 10.71% based on headcount. Turnover calculated based on full time equivalent leavers for the same period was 10.38%. This was a small increase from the turnover rate in the year to the end of May 2018 (which was 10.61% based on headcount and 10.28% based on FTE). The turnover rate in the year to the end of June 2018 represented 862 leavers from the organisation.

Graph 6 – Overall Turnover Rates

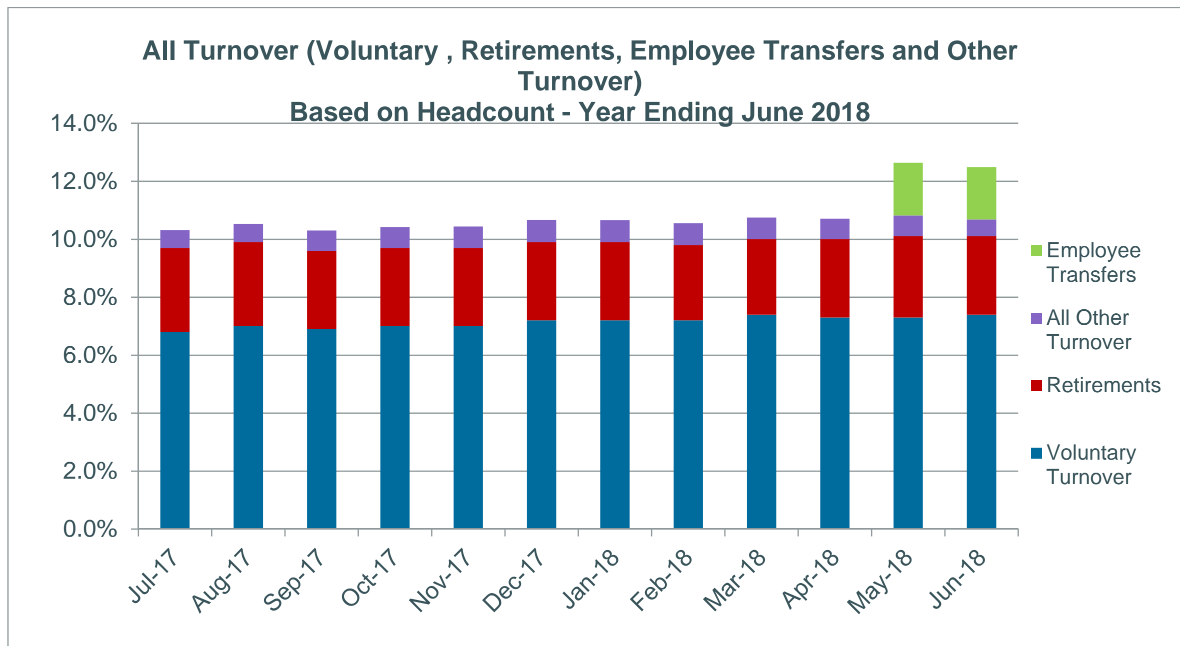


Source: Electronic Staff Record

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 of graph 6 also exclude staff subject to TUPE, a common convention used more locally within the organisation. On 1 May 2018, 196 therapy staff within the AHP and Community directorates transferred over to Humber NHS Foundation Trust via TUPE. Graph 7 below therefore shows the actual impact of these employee transfers to Humber on the Trust's turnover rate with a breakdown of the Trust's overall turnover rate based on voluntary leavers (i.e. voluntary resignations due to promotion, relocation, work/ life balance etc.), retirements, employee transfers and other leaving reasons (such as dismissals etc.).

Graph 7 – Voluntary Turnover versus Other Turnover



Source: Electronic Staff Record

In June 2018, the Trust's overall turnover rate including all TUPE employee transfers was 12.5% (based on headcount). Voluntary turnover accounted for 7.4% of this whilst employee transfers accounted for 1.8%.

2.8 Staff Benefits Fair

The 2018 Staff Benefits Fair was held on 20 June in York and attracted over 700 staff members. This year's event was held on the open area opposite Park House. The weather on the day was unpredictable ranging from high winds, rain to blazing sunshine which resulted in fewer staff attending than in previous years.

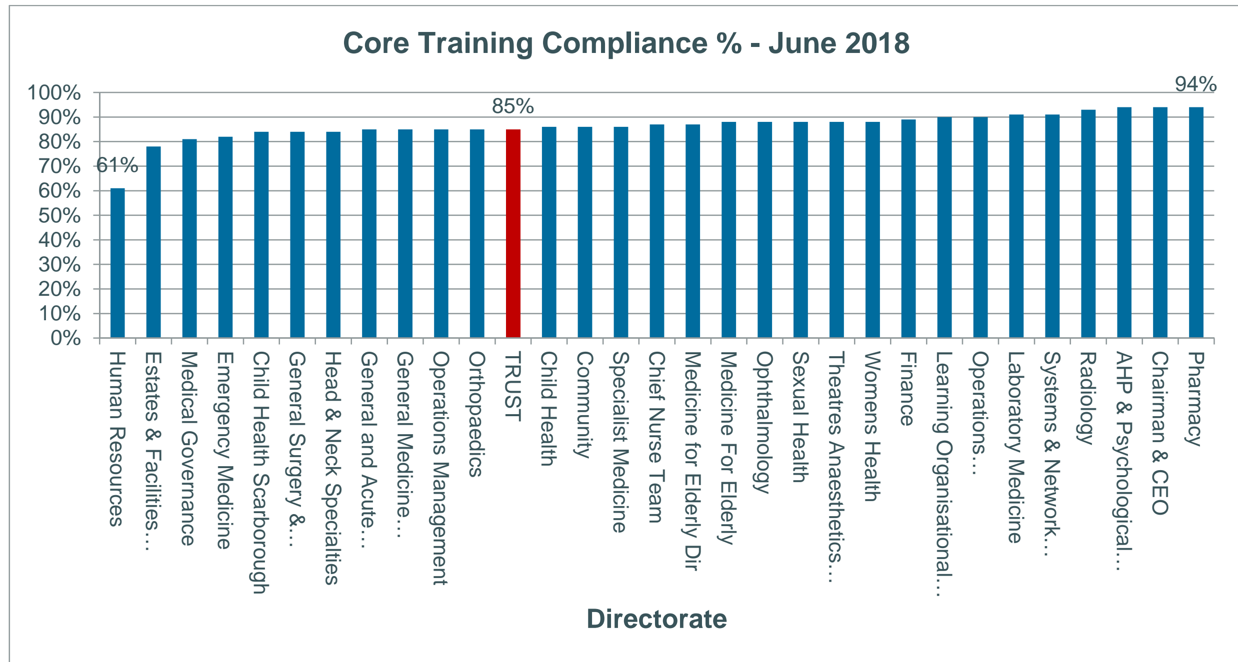
There were 46 stalls overall for staff to visit ranging from solicitors, unions and internal departments such as the York Hospital Charity to hotels, restaurants and attractions including the York Dungeons and Scarborough Sea Life Centre. All the stall holders work with Staff Benefits throughout the year to provide staff with the best benefits package possible.

2.9 Corporate Learning Update

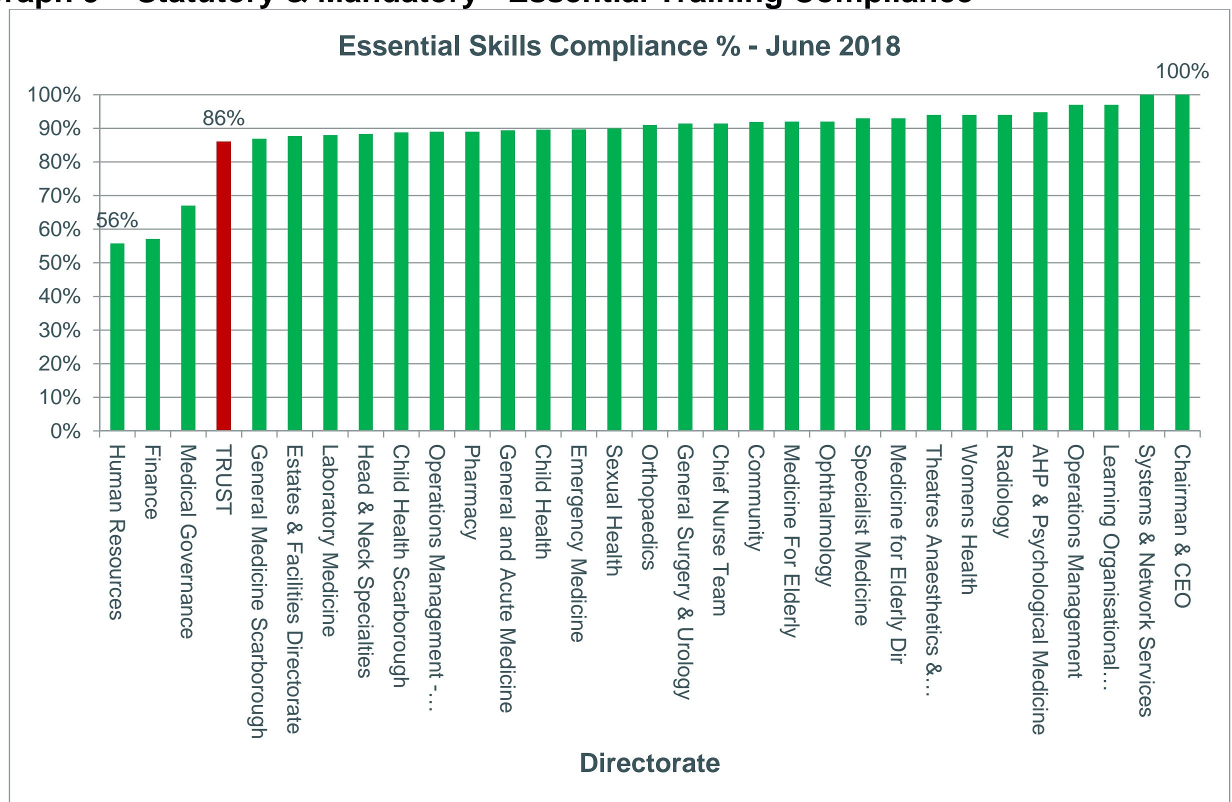
The Trust's statutory and mandatory training compliance rates for June is detailed in the tables below. Statutory and Mandatory training comprises two elements; 'Core' training which all staff are required to complete at some level and 'Essential' training which is job specific.
Trust-wide compliance of Core training stood at 85% in June 2018 whilst the compliance rate for Essential training was 86%.

The Human Resources directorate comprises all staff holding bank contracts (56%). Without the inclusion of bank contracts the compliance for this directorate is 87%.

Graph 8 – Statutory & Mandatory - Core Training Compliance



Graph 9 – Statutory & Mandatory - Essential Training Compliance



Source: Learning Hub

The overall Corporate Induction compliance rate for the Trust in June 2018 was 92.8%. 25 new starters across 9 directorates have not attended Corporate Induction during their first 6 weeks of employment.

2.10 Armed Forces Covenant CQUIN

The Trust's Armed Forces CQUIN focusses on embedding the Armed Forces Covenant and utilising local Armed Forces resources and support services to enable improved health outcomes for Serving Personnel, veterans and their families. Achieving this encapsulates raising staff awareness and training on The Armed Forces Covenant which needs to be sustainably embedded across the organisation.

Part of this work is to embed the training from NHS Education England within the Trust's training offer. The training in total is 2.5 hours long but has been broken down into bite sized eLearning modules in acknowledgement of the busy schedules of staff and to also ensure that it is achievable for staff to complete within a 12 month period. The eLearning modules have now been uploaded and are available on Learning Hub and they include:-

- Caring for Veterans and their Families
- Mental Health Problems in Veterans
- Veterans with Severe or Long-Term Injuries
- The Armed Forces Covenant and the Needs of Service Families

2.11 NHS Terms and Conditions of Service 2018

The NHS Staff Council has now formally ratified the 2018 pay deal and changes to the NHS Terms and Conditions of Service handbook. This is a three year pay deal which will run until 2020/21. The salary changes are effective from 1st April 2018, they will be paid to staff in July salaries and back pay, to reflect the period April 2018 – June 2018, will be paid in August salaries.

The agreed changes mean starting salaries have been increased for all bands, there will be fewer pay points within each band and the top of the pay bands will be increased by 6.5% over the three years (apart from band 8d and 9 which will be capped at the increase of 8c). The minimum rate of pay will be £17,460, which is ahead of the Living Wage Foundation Living Wage rate. There is a requirement for Trusts to implement a pay progression policy for individuals to pass through band spine points however an effective policy and procedure is already in place within York Trust.

Band 1 will be closed to new starters from 1st December 2018 and the Trust will need to agree a process with staff side for upskilling band 1 roles to band 2, for those employees who want to move away from band 1, during the 3 year pay deal.

Further changes to the Terms and Conditions include an adjustment to the unsociable hours percentage rates for Bands 1 -3 and unsocial hours payments will no longer be paid during sickness absence to existing staff with a salary over £18,160 or anyone commencing employment after 1st July 2018.

The NHS Staff Council has also committed to further work being done around:

- apprenticeship pay
- the pay progression system

- enhanced shared parental leave, child bereavement leave and a national framework for buying and selling annual leave
- improving health and wellbeing to improve levels of attendance in the NHS
- exploration of a collective framework for bank and agency working

2.12 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.

2.13 Recommendation

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

NHS

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Workforce Race Equality Standard 2018

Recommendation

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

Current approval route of report

Submission to Workforce and OD Committee
Sign off by Chief Executive

Purpose of report

For submission to the Workforce and OD committee and the Board to discussion prior to submitting the Workforce Race Equality Standard (WRES) Template Report for 2018 to NHS England and sign off by the Chief Executive for the supporting report and WRES Action Plan.

Key points for discussion

- The WRES data is to be submitted to Strategic Data Collection Service (SDCS) by Friday 10 August 2018 there is a requirement for checking data is correct, double checked and signed off by the relevant responsible director or officer within the Trust prior to submission.
- Discussion and agreement of the details of the WRES Action Plan 2018 which set out the next steps and milestones for expected progress against the WRES indicators

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

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☒ **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: Katie Gaeta, HR Business Partner

Executive sponsor: Polly McMeekin, Acting Director of Workforce and Organisational Development

Date: July 2018

1. Introduction and Background

The Trust is required to complete the Workforce Race Equality Standard (WRES) each year and submit the data to NHS England by 10 August 2018. The data and action plan must be published on the Trust website by 28 September 2018.

The NHS Equality and Diversity Council pledged its commitment to tackle race inequality within the NHS in April 2015. The outcome of this pledge was that two measures were implemented to improve equality across the NHS; these being the WRES and Equality Delivery System (EDS2).

The WRES requires us to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation. This sits alongside the EDS2 which is also mandatory and is aimed at helping to improve the services we provide to local communities and better working environments.

The WRES and EDS2 have been included in the NHS standard contract since April 2015 and the Care Quality Commission also uses the WRES as part of their inspection programme to help assess whether organisations are 'well-led'.

2. Detail of Report and Assurance

Following approval, the WRES data and supporting Action Plan 2018 will be added to the August 2018 Fairness Forum agenda for continued discussion.

EDS2 is a self-governing audit which involves a rolling program of engagement events with stakeholders where we are assessed against a mandatory framework. As a Trust we work collaboratively on EDS2 with our local CCG partners. EDS2 will be submitted to the Workforce and OD Committee with the full Equality and Diversity Annual Report.

2.1 Equality and Diversity Annual Report

The full Equality and Diversity Annual Report will be provided to the next Workforce and OD Committee. Whilst it utilises some of the same data sets it is a more broad spectrum report that covers both patient and workforce data across the 9 protected characteristics.

3. Next Steps

- Submission of the WRES data and Action Plan to the Workforce and OD Committee.
- Submission to Board of Directors to be signed off on 25 July 2018.
- Data to be uploaded to the Strategic Data Collection Service (SDCS) by Friday 10 August 2018.
- WRES data and Action Plan to be published on the Trust website by Friday 28 September 2018.

Workforce Race Equality Standard 2018 – York Teaching Hospital NHS Foundation Trust

This report is a word version of the Workforce Race Equality Standard Template Report we are required to submit to NHS England.

1 Background Narrative:

a. Any issues of completeness of data

The Trust continues to increase awareness of the importance of accurate recording and reporting of protected characteristics. In March 2016 employee self-service for ESR was launched which enables employees to review and update their personal data. It is hoped this will result in fewer 'not known' entries for protected characteristics.

b. Any matters relating to the reliability of comparisons with previous years

The sample for the 2017 staff survey was slightly larger than the sample for the 2016 staff survey.

The Trust conducted a full census approach of the Trust's entire eligible workforce (i.e. 8,476 staff) in 2017 inviting all staff to participate in the survey via a paper questionnaire. In total 4,111 staff responded which represented an overall response rate of 48.50%. This was above the average for combined acute and community trusts and also slightly higher than the response rate of 47.54% in the 2016 survey.

The Trust also adopted a paper questionnaire approach to the survey in 2016, inviting all eligible staff (8,214 staff) to participate in the survey. In total 3,905 staff responded which represented an overall response rate of 47.54%.

2 Total Numbers of Staff:

a. ***Employed within this organisation at the date of the report:***

The headcount as at 31st March 2018 was 8,737. The figure is reporting staff that are on fixed term and permanent contracts only.

b. Proportion of BME staff employed within this organisation at the date of the report:

BME staff represent 7.2% of the workforce.

3 Self reporting:

a. The proportion of staff who have self reported their ethnicity

100% of those who have reported have self-reported.

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

The ESR Employee Self-service functionality enables staff to review and update their personal details electronically and there has been further promotion across the organisation of this functionality to encourage staff to log-on and review their protected characteristics data.

Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

As B above.

4 Workforce data:

a. ***What period does the organisation's workforce data refer to?***

The data is as at 31 March 2018

5. Workforce Race Equality Indicators:

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or Corporate Equality Objectives
For each of these four workforce indicators, compare the data for white and BME staff:				
1. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: Non-Clinical staff Clinical staff – of which - Non-Medical Staff - Medical and Dental Staff	See Table A	See Table B	The total overall workforce includes all staff on permanent and fixed term contracts only (thereby excluding bank and locum staff) and includes primary assignments only. Of the total overall workforce figure, of 8787 used for the purpose of this, 297 (3.4%) of the records had an undefined / ‘not known’ ethnicity status.	The Trust holds a number of recruitment events: We attend York Job’s fair annually which is run by CYC. We are building relationships with local schools across York and North Yorkshire through careers events. We held interviews in conjunction with local job centres to encourage individuals in to employment with the Trust We attended a careers event at a local female open prison to provide information and support on applying for roles in the Trust. We have been utilising technology

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or Corporate Equality Objectives
				and alternative resources to enable interviews to be undertaken across the communities of York and North Yorkshire, but also for both national and international candidates We maintain links with York University to support recruitment of our nursing workforce. Link EDS2 Goal 3.1
2. Relative likelihood of staff being appointed from shortlisting across all posts.	The relative likelihood of white staff being appointed from shortlisting compared to BME staff is	The relative likelihood of white staff being appointed from shortlisting compared to BME staff is	During the reporting period we have used TRAC to interrogate the data compared to previous years where data was taken from NHS jobs.	The TRAC system for candidates has now been fully implemented and provides us with accessible Equality and Diversity data reporting which enables us to undertake a greater level of monitoring and analysis of the data, which may inform future

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or Corporate Equality Objectives
	3.95 greater	1.43 greater		events and policy decisions. Link EDS2 Goal 3.1
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	BME staff are 0.59 times less likely than white staff to enter the formal disciplinary process.	BME staff are 0.98 times less likely than white staff to enter the formal disciplinary process.	As proportionately the number of BME staff entering the formal disciplinary process (a rolling average of 2.5) and within the organisation (637 staff are of BME origin) are very small, an increase or decrease of just one person can seemingly have a big swing impact on the relative likelihood.	The Trust is undertaking a full review of the discipline policy, procedure and supporting documentation. Training for managers, investigating officers and HR staff will be form a significant part of the roll out of the policy.
4. Relative likelihood of staff accessing non-mandatory training and CPD	The relative likelihood of white staff accessing non mandatory training and CPD compared to BME is the	The relative likelihood of white staff accessing non mandatory training and CPD compared to BME is 1.98	The Trust continues to capture learning via one central point called Learning Hub.	Based on feedback from learners and the organisation, we have continued to enable Learning Hub remote access for staff through the internet. The Trust has implemented a new process via learning hub for

	same	times greater		recording appraisals. To complete an appraisal, the manager must review completion of statutory and mandatory training Link EDS2 Goal 3.3

5 KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White 26% BME 26%	White 25% BME 29%	The Trust conducted a full census of all eligible staff within the organisation for both the 2016 and 2016 staff surveys. The response rate for the 2017 staff survey was 48.5% which was a small increase from the previous year's staff survey response rate of 47.5%.	The Trust has a corporate action plan which links directly to the results of the staff survey. Following the appointment of the Freedom to Speak Up / Safer working Guardian in August 2016 the trust has developed a rolling program of recruiting new fairness champions under the guidance and support of the freedom to speak up/safer working guardian. The Trust is currently negotiating a new Challenging Bullying and Harassment Policy with our Staff Side Representatives. The Trust has appointed a Challenging Bullying and Harassment Champion to work alongside the Fairness Champions and the Freedom to Speak Up / Safer working Guardian. A training course for managers is currently being written with the aim of supporting line managers to

				develop insight and understanding of their own behaviour and how it may differ from that of others and how to effectively manage staff who are different to themselves. The Trust continues to monitor staff experiences and compare to other combined Community & Acute Trust outcomes. Link EDS2 Goal 3.4 and 4.3
6 KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 24% BME 28%	White 23% BME 30%	As per indicator 5	As per indicator 5
7 KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	White 91% BME 79%	White 90% BME 86%	As per indicator 5	We have undertaken a full review and update of the recruitment and selection policy. We have revised our internal expressions of interest process, bringing this within the scope of the recruitment team to ensure transparency and consistency

				across the Trust.
8 Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 6% BME 18%	White 6% BME 14%	As per indicator 5	As per indicator 5
Board Representation Indicator ***For this indicator, compare the difference for White and BME staff***				
Percentage difference between the organisation's Board membership and its overall workforce disaggregated: - By voting membership of the Board - By executive membership of the Board	No BME representation	No BME representation	The Population served is 96.8% white based on 2011 ONS census data.	The Trust undertook an inclusive Non-Executive Director recruitment program and had undertaken a reflective process to understand if there is any learning.

6. Are there any other factors or data which should be taken into consideration in assessing progress?

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a plan would normally elaborate on the actions summarised in section 5 setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

WRES Indicator	Outcomes from previous Actions	Action to be taken going forward	Timeframe for completion
1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members and senior medical staff) compared with the percentage of staff in the overall workforce.	The Trust has published the updated recruitment and selection policy The recruitment and selection training has also been updated	Continue to raise awareness across the community via regular and varied recruitment events. Continue to roll out delivery of updated recruitment and selection training Review and consider expanding the use of technology to enable ease and accessibility of interviews, locally, nationally and internationally.	On-going
2. Relative likelihood of staff being appointed from shortlisting across all posts	The TRAC system has provided some valuable equality data which has enabled us to fully assess where we are as an organisation.	Review a full year of data from TRAC Undertake international recruitment program. Recruit from local communities to ensure that our pool of candidates is representative.	September 2018 On-going
3. Relative likelihood of staff entering the	Review of discipline policy and supporting	Undertake a rolling program of training across the organisation which supports the	On-going

formal disciplinary process	documentation	policy revisions. Continue to embed the HR Business partner role within each directorate to develop greater insight into E&D issues, providing appropriate advice and guidance is given to support Directorate Managers	
4. Relative likelihood of staff accessing non-mandatory training and CPD	Review of appraisal policy and supporting documentation and consultation and development of a separate development / talent management policy are underway working in consultation with staff side.	Remind managers through HR Business partners of the importance of CPD for their staff. Appraisal policy review Talent Management policy development	On-going
5. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Development of a corporate action plan; development of a new people management training package for line managers. Development of fairness champion role to support the	Build on success of Fairness Champion recruitment and continue to recruit and develop the role. Continue to use the Challenging Bullying and Harassment Champion and the Freedom to Speak Up Guardian to review and promote the strategic position of the Trust on this agenda.	On-going Quarterly and Annually as results are published

	freedom to speak up guardian.	Review the corporate action plan against the next staff survey and staff friends and family results. Develop an online portal for staff discussion and ideas. The Trust is reviewing the Bullying and Harassment policy. Implement the training course for managers with the aim of supporting line managers to develop insight and understanding of their own behaviour and how it may differ from that of others and how to effectively manage staff who are different to themselves.	
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	As 5 above	As 5 above	As 5 above
7. Percentage believing that the Trust provides equal opportunities for career progression or	We have previously reported about introducing a development policy to	The appraisal policy is currently being reviewed and a separate development / talent management policy is being developed. Discussions and consultations	On-going

promotion	incorporate the appraisal policy. The decision was made to keep a separate appraisal policy with a continued focus on a values based approach to managing and developing our staff. Recruitment and selection processes have been reviewed and updated to ensure consistence and fairness across the organisation.	have and will continue to take place with our staff side representatives on any proposed changes. Recruitment and selection - As per 1 above.	
8. Personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	Please note- no actions were set in previous reporting years. The Trust has re-launched personal responsibility	As detailed in 5 above.	

	framework		
9. Board Representation		The Trust are currently undertaking a recruitment process for a new CEO we have engaged an executive recruitment company to undertake the recruitment and will be involving a cross section of staff in the selection process	September 2018

Table A: WRES Staff Breakdown by Grade

		Clinical Staff (%)	Non Clinical Staff (%)	Overall (%)			Clinical Staff (%)	Non Clinical Staff (%)	Overall (%)
BME	Band 1	0.0%	3.3%	3.3%	White	Band 1	0.8%	93.6%	94.4%
	Band 2	3.6%	0.6%	4.2%		Band 2	64.8%	27.0%	91.8%
	Band 3	0.7%	0.7%	1.4%		Band 3	51.1%	44.6%	95.8%
	Band 4	3.8%	1.4%	5.2%		Band 4	23.9%	68.6%	92.4%
	Band 5	11.0%	0.5%	11.5%		Band 5	75.6%	8.8%	84.4%
	Band 6	3.5%	0.5%	4.0%		Band 6	84.2%	9.2%	93.4%
	Band 7	1.9%	1.3%	3.1%		Band 7	75.6%	18.6%	94.2%
	Band 8	1.7%	0.3%	2.0%		Band 8	60.1%	36.8%	97.0%
	Band 9	0.0%	0.0%	0.0%		Band 9	0.0%	100.0%	100.0%
	VSM	0.0%	0.0%	0.0%		VSM	14.3%	85.7%	100.0%
	Senior Medical Manager	0.0%	0.0%	0.0%		Senior Medical Manager	100.0%	0.0%	100.0%
	Apprentice	0.0%	0.0%	0.0%		Apprentice	40.0%	60.0%	100.0%
	M&D Consultants	21.2%	0.0%	21.2%		M&D Consultants	74.9%	0.0%	74.9%
	M&D Non-consultant career grade	28.1%	0.0%	28.1%		M&D Non-consultant career grade	67.7%	0.0%	67.7%
	M&D Trainee Grades	37.9%	0.0%	37.9%		M&D Trainee Grades	53.6%	0.0%	53.6%
	BME as % of total workforce	**6.4%**	**0.8%**	**7.2%**		**White as % of total workforce**	**61.6%**	**27.8%**	**89.4%**

Table B: WRES Staff Breakdown by Grade

		Clinical Staff (%)	Non Clinical Staff (%)	Overall (%)			Clinical Staff (%)	Non Clinical Staff (%)	Overall (%)
BME	Band 1	0.0%	3.0%	3.0%	White	Band 1	1.5%	92.8%	94.2%
	Band 2	3.5%	0.5%	4.0%		Band 2	5.6%	34.6%	92.1%
	Band 3	0.9%	1.3%	2.2%		Band 3	48.1%	47.2%	95.4%
	Band 4	0.9%	1.3%	2.3%		Band 4	19.1%	76.2%	95.3%
	Band 5	10.9%	0.4%	11.3%		Band 5	76.6%	8.6%	85.2%
	Band 6	3.1%	0.2%	3.3%		Band 6	85.8%	8.1%	94.0%
	Band 7	1.8%	0.7%	2.5%		Band 7	76.0%	19.1%	95.0%
	Band 8	1.7%	0.3%	2.0%		Band 8	61.2%	35.7%	96.9%
	Band 9	0.0%	0.0%	0.0%		Band 9	0.0%	100.0%	100.0%
	VSM	0.0%	0.0%	0.0%		VSM	11.1%	88.9%	100.0%
	Senior Medical Manager	0.0%	0.0%	0.0%		Senior Medical Manager	100.0%	0.0%	100.0%
	Apprentice	0.0%	0.0%	0.0%		Apprentice	0.0%	100.0%	100.0%
	BME as % of total workforce	**6.3%**	**0.8%**	**7.1%**		**White as % of total workforce**	**60.2%**	**29.6%**	**89.8%**

NHS England

Workforce Race Equality Standards annual collection

as at March-2017

For any techincal queries or additional clarification relating to the collection please contact:

For any queries or additional clarification relating to submissions please contact: data.collections@nhs.net

Workforce Race Equality Standards

Validations
Please correct all issues listed within the table below. If the issues are not corrected then the pro forma will fail the validation stage in SDCS.

Trust - Frontsheet
Please complete all yellow answer cells on the 'Data for submission' tab. The 'Validation and Data Checks' tab can be used to identify which cells still need to be answered.

SubmissionTemplate
Workforce Race Equality Standards 2017/18 template

Key
Answer Required
Auto Populated
N/A

	INDICATOR	DATA ITEM		MEASURE	31st MARCH 2017 WHITE Prepopulated figures	WHITE Verified figures	BME Prepopulated figures	BME Verified figures	ETHNICITY UNKNOWN/NULL Prepopulated figures	ETHNICITY UNKNOWN/NULL Verified figures	31st MARCH 2018 WHITE Prepopulated figures	WHITE Verified figures	BME Prepopulated figures	BME Verified figures	ETHNICITY UNKNOWN/NULL Prepopulated figures	ETHNICITY UNKNOWN/NULL Verified figures	Notes
1	**Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**		**1a) Non Clinical workforce**														
		1	Under Band 1	Headcount	9	9	0	0	0	0	3	3	0	0	0	0	
		2	Band 1	Headcount	564	564	18	18	14	14	590	599	19	21	13	14	
		3	Band 2	Headcount	652	652	10	10	24	24	435	506	10	11	19	22	
		4	Band 3	Headcount	439	439	12	12	7	7	429	433	7	7	8	8	
		5	Band 4	Headcount	406	406	8	8	8	8	397	399	6	8	7	7	
		6	Band 5	Headcount	147	147	7	7	2	2	141	143	7	8	2	2	
		7	Band 6	Headcount	108	108	4	4	2	2	118	126	7	7	2	2	
		8	Band 7	Headcount	116	116	7	7	2	2	115	118	7	8	4	4	
		9	Band 8A	Headcount	42	42	1	1	1	1	48	49	1	1	0	0	
		10	Band 8B	Headcount	42	30	0	0	0	0	25	25	0	0	0	0	
		11	Band 8C	Headcount	22	22	0	0	0	0	26	27	0	0	0	0	
		12	Band 8D	Headcount	9	9	0	0	0	0	8	8	0	0	0	0	
		13	Band 9	Headcount	2	2	0	0	0	0	2	2	0	0	0	0	
		14	VSM	Headcount	8	8	0	0	0	0	1	6	0	0	0	0	
			1b) Clinical workforce of which Non Medical														
		15	Under Band 1	Headcount	0	0	0	0	0	0	2	2	0	0	0	0	
		16	Band 1	Headcount	9	9	0	0	3	3	14	5	2	0	2	1	
		17	Band 2	Headcount	1086	1086	66	66	49	49	1,287	1215	68	67	56	53	
		18	Band 3	Headcount	446	446	8	8	16	16	496	496	7	7	19	19	
		19	Band 4	Headcount	102	102	5	5	5	5	141	139	22	22	7	7	
		20	Band 5	Headcount	1285	1285	183	183	57	57	1,233	1233	181	180	64	64	
		21	Band 6	Headcount	1121	1121	41	41	34	34	1,157	1152	48	48	33	33	
		22	Band 7	Headcount	458	458	11	11	13	13	483	480	12	12	13	13	
		23	Band 8A	Headcount	127	127	5	5	3	3	129	129	5	5	2	2	
		24	Band 8B	Headcount	29	29	0	0	0	0	30	29	0	0	1	1	
		25	Band 8C	Headcount	14	14	0	0	0	0	15	15	0	0	0	0	
		26	Band 8D	Headcount	5	5	0	0	0	0	5	5	0	0	0	0	
		27	Band 9	Headcount	0	0	0	0	0	0	0	0	0	0	0	0	
		28	VSM	Headcount	1	1	0	0	0	0	2	1	0	0	0	0	
			Of which Medical & Dental														
		29	Consultants	Headcount	267	267	84	84	6	6	290	272	93	77	18	14	
		30	*of which Senior medical manager*	Headcount		1		0		0		1		0		0	
		31	Non-consultant career grade	Headcount	67	67	28	28	6	1	73	65	40	27	7	4	
		32	Trainee grades	Headcount	175	175	115	115	0	22	33	171	28	121	5	27	
		33	Other	Headcount	1	1	0	0	22	1	111	0	64	0	15	0	
2	**Relative likelihood of staff being appointed from shortlisting across all posts**	34	Number of shortlisted applicants	Headcount								295		249		13	
		35	Number appointed from shortlisting	Headcount								178		38		21	
		36	Relative likelihood of shortlisting/appointed	Auto calculated		0.0972789116		0.0682027650				0.6033898305		0.1526104418		1.6153846154	
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated		1.43						3.95					
3	**Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation** **Note: This indicator will be based on data from a two year rolling average of the current year and the previous year**	38	Number of staff in workforce	Auto calculated							7839	7853	634	637	297	297	
		39	Number of staff entering the formal disciplinary process	Headcount								62.5		3		1.5	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated		0.0066477346		0.0065252855				0.0079587419		0.0047095761		0.0050505051	
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated				0.98						0.59			
4	**Relative likelihood of staff accessing non-mandatory training and CPD**	42	Number of staff in workforce (White)	Auto calculated								7853		637		297	
		43	Number of staff accessing non-mandatory training and CPD (White):	Headcount								3168		272		138	
		44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated		0.3778236737		0.1908646003				0.4034127085		0.4270015699		0.4646464646	
		45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated		1.98						0.94					
5	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**	46	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage	24.94%		29.24%				25.86%		26.34%				
6	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**	47	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage	23.24%		29.82%				24.21%		27.54%				
7	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**	48	% staff believing that trust provides equal opportunities for career progression or promotion	Percentage	90.09%		85.71%				90.50%		79.26%				
8	**Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**	49	% staff personally experienced discrimination at work from Manager/team leader or other colleague	Percentage	5.96%		14.12%				6.24%		17.91%				
9	**Percentage difference between the organisations' Board voting membership and its overall workforce** **Note: Only voting members of the Board should be included when considering this indicator**	50	Total Board members	Headcount		16		0		0		15		0		0	
		51	*of which: Voting Board members*	Headcount		14		0		0				0		0	
		52	*: Non Voting Board members*	Auto calculated		2		0		0		15		0		0	
		53	Total Board members	Auto calculated		16		0		0		15		0		0	
		54	*of which: Exec Board members*	Headcount		6		0		0				0		0	
		55	*: Non Executive Board members*	Auto calculated		10		0		0		15		0		0	
		56	Number of staff in overall workforce	Auto calculated		7747		613		270		7853		637		297	
		57	Total Board members - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		58	Voting Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%							
		59	Non Voting Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		60	Executive Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%							
		61	Non Executive Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		62	Overall workforce - % by Ethnicity	Auto calculated	0.00%	89.8%	0.00%	7.1%	0.00%	3.1%	0.00%	89.4%		7.2%		3.4%	
		63	Difference (Total Board -Overall workforce)	Auto calculated		10.2%		-7.1%		-3.1%		10.6%		-7.2%		-3.4%	

SubmissionTemplate
Workforce Race Equality Standards 2017/18 template

	INDICATOR	DATA ITEM		MEASURE	31st MARCH 2017						31st MARCH 2018						Notes
					WHITE		BME		ETHNICITY UNKNOWN/NULL		WHITE		BME		ETHNICITY UNKNOWN/NULL		
			1a) Non Clinical workforce		Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures		Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	1	Under Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		2	Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		3	Band 2	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		4	Band 3	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		5	Band 4	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		6	Band 5	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		7	Band 6	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		8	Band 7	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		9	Band 8A	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		10	Band 8B	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		11	Band 8C	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		12	Band 8D	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		13	Band 9	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		14	VSM	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
			1b) Clinical workforce of which Non Medical														
		15	Under Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		16	Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		17	Band 2	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		18	Band 3	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		19	Band 4	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		20	Band 5	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		21	Band 6	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		22	Band 7	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		23	Band 8A	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		24	Band 8B	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		25	Band 8C	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		26	Band 8D	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		27	Band 9	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		28	VSM	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
			Of which Medical & Dental														
		29	Consultants	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		30	*of which Senior medical manager*	Headcount		OK		OK		OK		OK		OK		OK	
		31	Non-consultant career grade	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		32	Trainee grades	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		33	Other	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
2	Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants	Headcount				OK		OK		Good		Good		OK	
		35	Number appointed from shortlisting	Headcount				OK		OK		Good		Good		OK	
		36	Relative likelihood of shortlisting/appointed	Auto calculated													
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated													
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	38	Number of staff in workforce	Auto calculated													
		39	Number of staff entering the formal disciplinary process	Headcount								Good		Good		Good	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated													
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated													
4	Relative likelihood of staff accessing non-mandatory training and CPD	42	Number of staff in workforce (White)	Auto calculated													
		43	Number of staff accessing non-mandatory training and CPD (White):	Headcount								Good		Good		Good	
		44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated													
		45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated													
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	46	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage													
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	47	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage													
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	48	% staff believing that trust provides equal opportunities for career progression or promotion	Percentage													
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	49	% staff personally experienced discrimination at work from Manager/team leader or other colleague	Percentage													
9	Percentage difference between the organisations' Board voting membership and its overall workforce Note: Only voting members of the Board should be included when considering this indicator	50	Total Board members	Headcount		Good		Good		Good		Good		Good		Good	
		51	*of which: Voting Board members*	Headcount		Good		Good		Good		No Data		Good		Good	
		52	*: Non Voting Board members*	Auto calculated													
		53	Total Board members	Auto calculated													
		54	*of which: Exec Board members*	Headcount		Good		Good		Good		No Data		Good		Good	
		55	*: Non Executive Board members*	Auto calculated													
		56	Number of staff in overall workforce	Auto calculated													
		57	Total Board members - % by Ethnicity	Auto calculated													
		58	Voting Board Member - % by Ethnicity	Auto calculated													
		59	Non Voting Board Member - % by Ethnicity	Auto calculated													
		60	Executive Board Member - % by Ethnicity	Auto calculated													
		61	Non Executive Board Member - % by Ethnicity	Auto calculated													
		62	Overall workforce - % by Ethnicity	Auto calculated													
		63	Difference (Total Board -Overall workforce)	Auto calculated													

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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Freedom to Speak Up

Recommendation

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

Current approval route of report

This report has been written for the Board of Directors.

Purpose of report

This is the six-monthly report of the Freedom to Speak up Guardian (FTSUG) which provides a summary to the Board on the number and nature of concerns being raised to the FTSUG and updates from the National Guardian Office.

Key points for discussion

To discuss the key themes, learning and outcomes.

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)

Freedom to Speak Up forms part of the CQC well-led domain.

Version number: 1

Author: Lisa Smith, Freedom to Speak Up Guardian

Executive sponsor: Mike Proctor, Chief Executive

Date: July 2018

1. Introduction

As you will have seen in the news over the last couple of weeks, the terrible story of what happened at Gosport War Memorial Hospital has been unfolding with the publication of the report into the circumstances surrounding a large number of deaths. Part of that story involves nurses and others speaking up and not being listened to. Something like Gosport does raise the profile of speaking up and therefore it is important to acknowledge that sometimes tragedies like this can be the catalysts that help people focus on the need for something as important as Freedom to Speak Up. This is the first report of 2018 and captures the speaking up data from January to June.

2. National update

2.1 Guidance for Boards

In May, NHS Improvement and the National Guardian's Office (NGO) issued 'Guidance for Boards on Freedom to Speak Up in NHS trusts and foundations trust' which was accompanied by a self-review tool. The guide sets out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement. The self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a Trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

The Workforce and OD committee considered the detail of this guidance at their July meeting. The NGO expects Guardians to fully engage with this guidance and support their boards as appropriate, and for board members to involve their guardians in their considerations and action planning.

2.2 Case reviews

The NGO has now completed three case reviews, Southport and Ormskirk NHS Trust, Northern Lincolnshire and Goole NHS Trust both in September and the most recent one in June at Derbyshire Community NHS Foundation Trust. The reports and recommendations have been shared with board members and will be considered as part of the above action planning.

2.3 Pan Sector Network

The Trusts FTSU Guardian is only one of three nationally to be an invited member of the Pan Sector network which is an opportunity to draw together cross-sector good practice in speaking up by collaborative working. There are members from across the finance, aviation authority and education sectors plus the Army, the BBC, and wider health organisations.

2.4 National data

The NGO requires each FTSU Guardian to submit quarterly data which is then published. This is the picture to date combining the Q1, Q2, Q3 and Q4 figures:

- 6,768 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions
- 2,163 of these cases included an element of patient safety / quality of care
- 3,069 included elements of bullying and harassment
- 356 related to incidents where the person speaking up may have suffered some form of detriment
- 1,259 anonymous cases were received.

The most recent data published by the NGO confirms that York remains in the top 3 of highest number of speak up contacts per quarter for the whole of England.

Trust outliers compared to some national data:

	Quarterly cases	Anonymous cases	Bullying / Behaviours	Patient Safety / Quality	Doctors Speaking Up
National data	10 - average	18%	45%	39%	7%
Trust data	52 - actual	0	59%	18%	13%

3. Supporting Staff to Speak Up – Achievements in last 6 months

- Speaking up culture vision as part of the Developing People Strategy
- Mangers handbook, containing tips and tools for ‘concerns and how to handle them’ now published and issues to directorates
- Regular awareness session on the nurse preceptorship development days
- Supporting T&O directorate to build a ‘speaking up’ culture
- 2nd victim support – establishing a support network and de-brief training for staff experiencing traumatic events
- Supported ‘listening to improve’ events in three departments

3.1 Fairness Champions

We now have a total of 34 Fairness Champions who have completed their induction. We have also now delivered three, half-day training/development sessions for all the Champions.

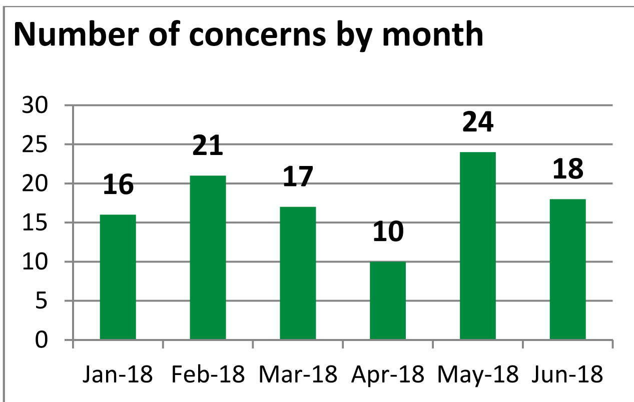
There have been 36 Fairness Champion cases recorded since the first cohort of new champions went live on 19 September, 4 of which remain open. The average amount of time spent on each contact is approximately 1 hour:

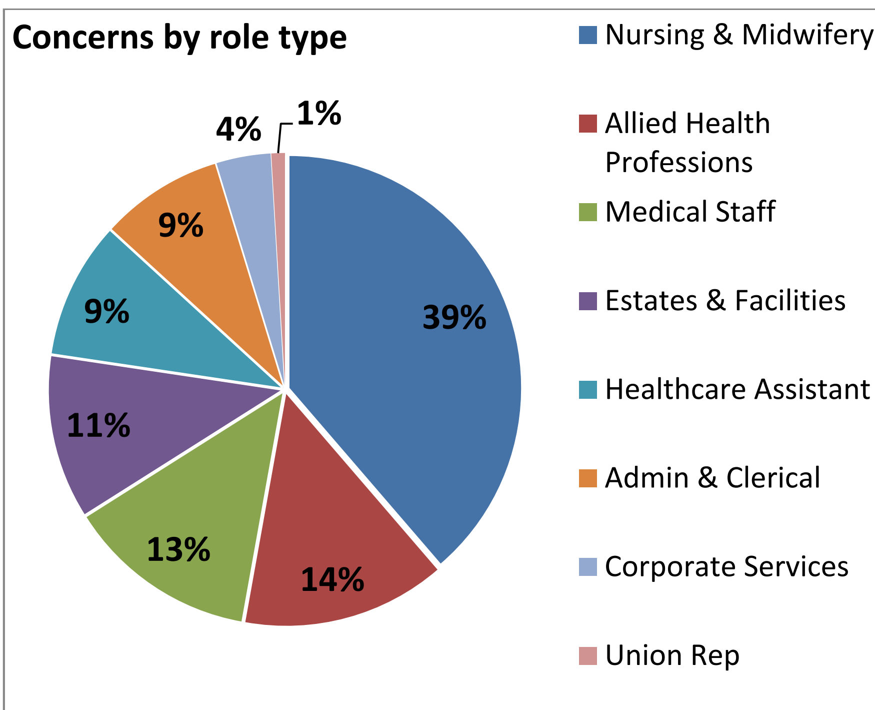
- The most prevalent issue dealt with by Champions is bullying and harassment / low morale/ communication issues, two most recent were issues relating to workplace stress
- Eight have been referred to the Freedom to Speak Up Guardian
- Four have involved support at a formal meeting.

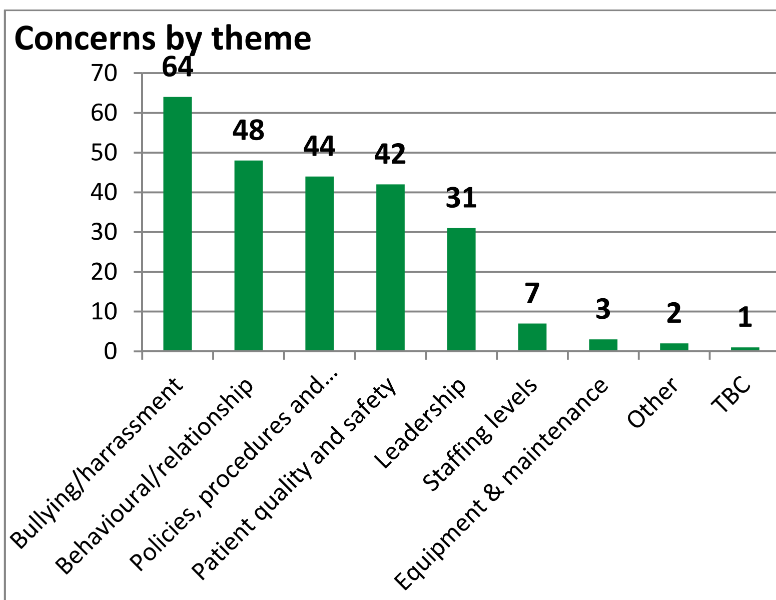
The FTSU Guardian and Champions have had a presence at each of the three Staff Benefits summer fairs. We are actively recruiting more Champions and have interviews scheduled for late summer with an induction day planned for autumn for the new recruits.

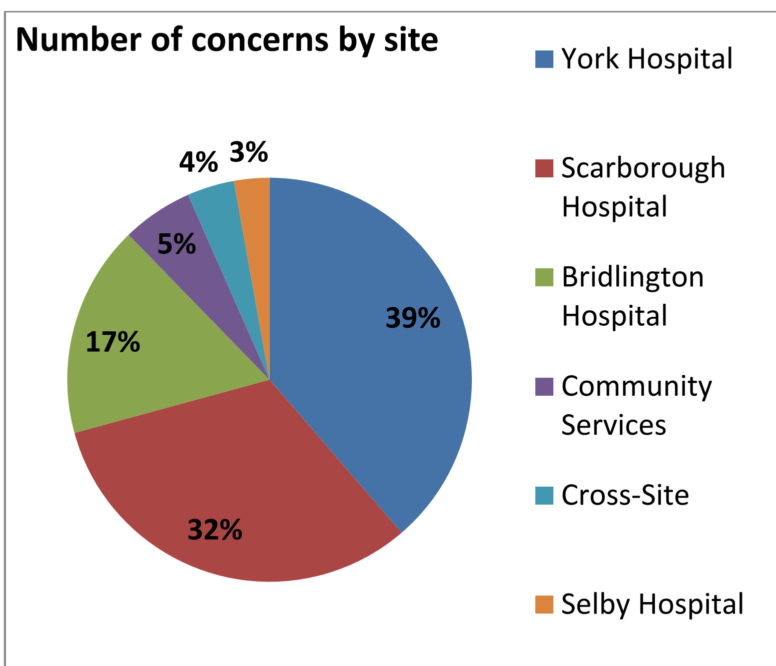
3.2 Concerns raised January 2018 – June 2018

During the past six months the number of individual 'speak ups' contacting the FTSU guardian has increased from an average of 12 per month to 18 per month. 62% cases are closed and 38% remain open.









3.3 Addressing the concerns

Concerns raised over behaviours account for 59% overall when combining bullying and harassment, relationship and leadership concerns. The Trust wants to support staff that speak up and develop an open and transparent culture. It is vitally important that staff feel empowered to do this through their own line management structure and only use the FTSUG to escalate unaddressed concerns. In order to empower staff and support managers a number of projects are underway in the Trust which include:

- A re-write of many HR policies that reflect a more ‘restorative practice’ approach and give managers more flexibility and staff more opportunities to resolve issues informally

- Alongside the policies a steering group including HR, ODIL, staff side, senior managers and the FTSUG have been developing a new ‘management standards training’ which describes expected behaviours based on our Trust values and personal responsibility framework

- The launch of the Schwartz rounds over the summer which supports the health and well being of staff through sharing and reflection.

3.4 Survey results following closure of a concern

Although there are a significant number of responses that indicate that the concern has only been addressed ‘in part’ this is mostly the result of staff having unrealistic expectations of the outcome of raising a concern, particularly when it relates to behaviours. The ‘in part’ reflects that the Trust has listened and taken action but perhaps not to the complete satisfaction of the individual raising the concern.

Based on your experience of raising a concern, would you do it again? 79% 13% 8%
Did you feel you were treated confidentially? 90% 4% 6%
Has your concern been addressed? 48% 50% 2%
Did you receive regular feedback from the Guardian? 88% 13%
Did you feel your concerns were taken seriously? 98% 2%
Yes In part/not sure No

How did you find the response from the Guardian? 85% 13% 2%
0% 20% 40% 60% 80% 100%
Very helpful Reasonably helpful Not very helpful

Do you feel you have suffered unfair treatment since speaking up? 23% 77%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Yes In part/not sure No

Examples staff gave of unfair treatment:

- Just stressful having the courage to 'speak up'
- Ignored by the subject of the complaint etc
- Management not speaking to me being difficult.

Whilst without doubt speaking up can be difficult, the role of the FTSUG is to ensure that individuals are not subject to unfair treatment or detriment as a result of speaking up such as disadvantaged shift patterns, overlooked for promotion, undermining etc.

3.5 Informal Feedback

Below are some examples of emails received by the FTSUG

- Just a short note to express my thanks, I was at my lowest point feeling very isolated, suffering from panic attacks and anxiety, I was advised to get in touch with you, I'm so glad I did, your help and support was a breath of fresh air you made sure everything was done fairly, you gave me the courage to carry on, your hard work is invaluable, once again thank you so very much for all your support.

- Hi I know it has been some time since we spoke – just to let you know that – initially after speaking to you I was full of dread etc. – but since then there has been a number of on going developments that have been positive, and taken on positively by the team – certain issues have also been addressed for the benefit of all and a massive improvement on the governance side of things. Also I feel the confidentiality has being handled very well/ or people have been professional.

- You are a very positive addition to the Trust and well regarded by many

- Thank you so much for listening to me today and for all your help – I don't know how I would have managed through this process without you

- It is reassuring to know that our concerns have been conveyed to xxxx. I'm sure we can learn from the experience and grow from it and we can all help just by providing feedback. Many thanks for your listening ear – just being able to speak to someone in your neutral position was helpful.

- I just feel like I've done the wrong thing by speaking up, but you really don't know how much it means to me to have someone who listened to the real me, you have inspired me.

- That sounds great, thanks for updating me. Yesterday felt really positive and I'm keen to get things moving once we are in a position to. As someone new to the Trust it was really affirming to have my concerns listened to and to be supported to improve things.

3.6 Challenges

- No office for FTSU Guardian to meet staff anywhere confidential
- The importance of responding to issues as soon as possible after they are raised –

this gives confidence to workers that they are being listened to and taken seriously – giving and receiving timely feedback is crucial and usually appreciated by all involved, often investigations into concerns taking too long when a formal process is required but this has challenges for individuals capacity.

4. Conclusion

There has been a rise in the number of individuals contacting the FTSUG to raise concerns and the main concerns continue to relate to behaviours. There are a number of projects being undertaken in the Trust to address these concerns which are described in para 3.3 above.

5. Recommendations

The Board of Directors is asked to:

Consider their approach to completing the self-review tool and developing an improvement action plan that will help us to evidence the commitment to embedding speaking up and help oversight bodies to evaluate how healthy our Trust's speaking up culture is.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 July 2018
Guardian of Safe Working Q1 Report: April - June 2018

Recommendation

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

Current approval route of report

This report has been written for the Board of Directors.

Purpose of report

The Guardian of Safe Working (GoSW) was introduced into the Trust in 2016 as part of the 2016 Terms and Conditions for Junior Doctors and aims to provide the Trust with assurance over the safe working of junior doctors and alert the Board to any areas of concern and is required to report to the Board on a quarterly basis.

Key points for discussion

The impact of exception reporting.
The challenge regarding rota gaps and recruitment.

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)

There are no direct references to CQC outcomes.

Version number: 1

Author: Lisa Smith, Guardian of Safe Working

Executive sponsor: Mike Proctor, Chief Executive

Date: July 2018

1. Introduction

This is the Q1 2018 report to the Board from the Guardian of Safe Working (GoSW) required by the 2016 terms and conditions for doctors and dentists in training.

The Quarterly report is for April - June and details progress with the Junior Doctor Forum (JDF) and the Exception Reporting system, examining issues arising from the process and possible solutions.

2. Junior Doctors' Forum

The JDF has continued to develop and attract new members. Good progress is also being made on many of the 'eight high-impact actions' project plan. The GoSW has been asked to attend the autumn Health Education England School of Medicine development day to present the project.

We are also submitting an abstract and poster display at the 'Leaders in Healthcare 2018 Conference' run by the British Medical Journal and Faculty of Medical Leadership and Management in November.

During the month of July there is a live survey issued to all junior doctors in the Trust to gain feedback on the GoSW role. This year it also includes questions to establish a baseline for their experience of working in the Trust to enable us to measure progress against the project plan.

To better encourage those juniors starting this summer to attend the JDF, we have agreed to hold a 'welcome meeting' in August.

2.1 A 'look back' from the Vice-Chair

Having been the only junior doctor attending the JDF in August last year, to now having a regular attendance of between 5-7 junior doctors feels like a significant achievement. Junior doctors are notoriously hard to engage with and we are keen to ensure that the Forum is a focus for improvement and not just about the new contract and this is being led via the project action plan to deliver eight high-impact changes to improve the working environment for junior doctors. We are currently working on a number of projects which have seen some early successes, including:

- Promoting rest breaks and safe travel home, developing new guidance and securing protected sleep facilities for junior doctors on both sites
- Rotas that improve work-life balance where juniors have raised issues
- Wellbeing, support and mentoring (in particular support for coping with night shifts) and junior doctor involved in the Schwartz rounds

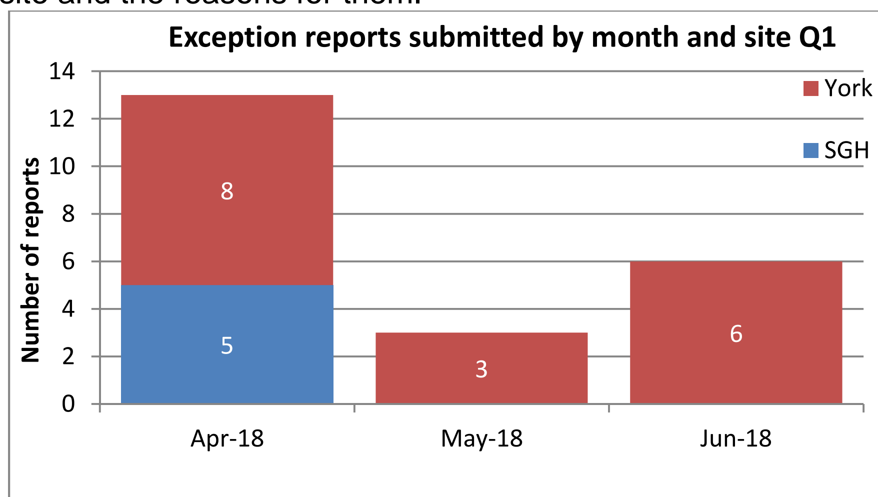
- Improving local inductions to help the junior doctor feel welcomed and a valued team member
- Better engagement with senior management through JDF attendance.

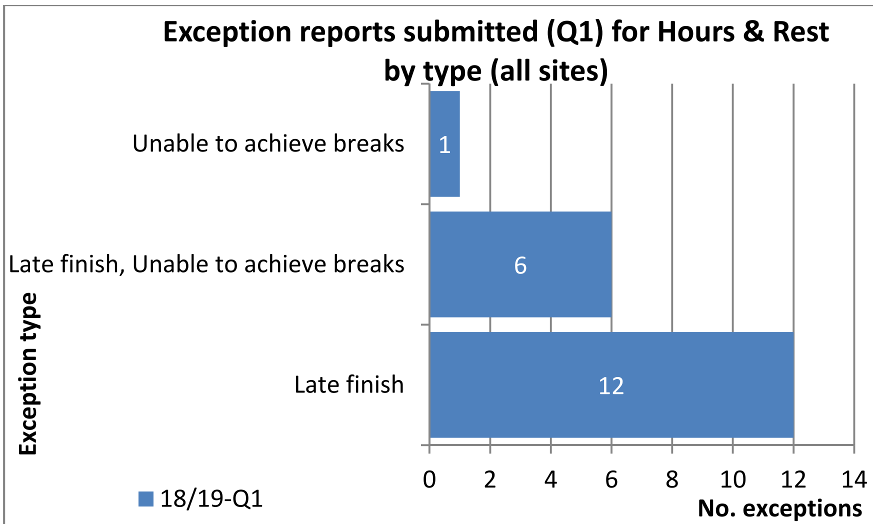
For the year ahead we have projects being developed around paired learning and celebration awards for junior doctors in line with other teaching hospitals.

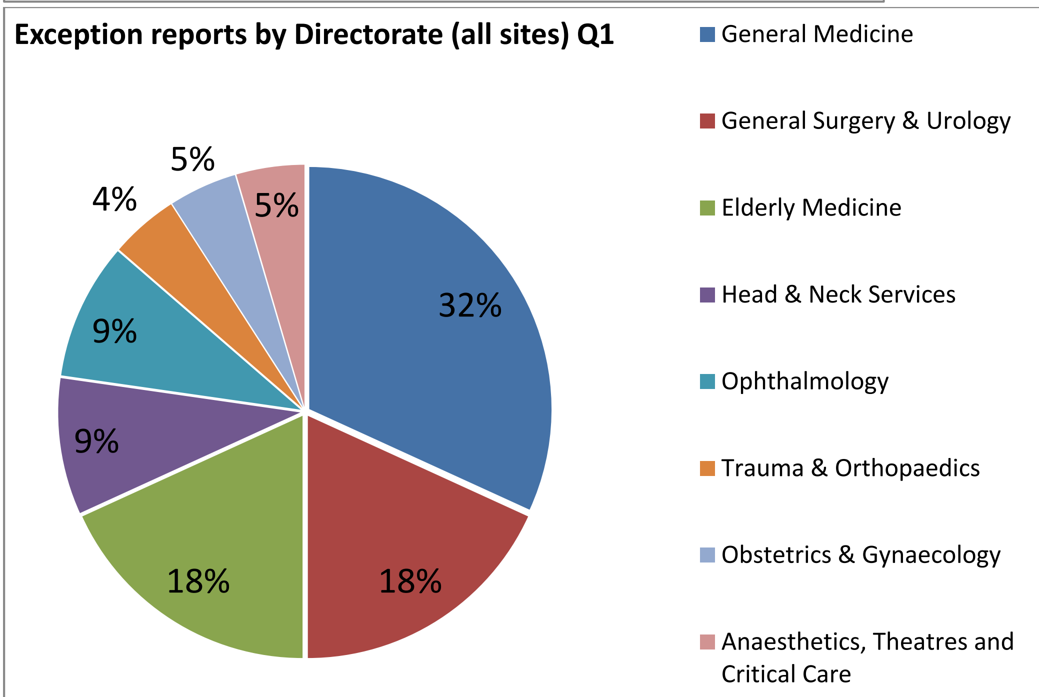
3. Exception reporting and Guardian fines

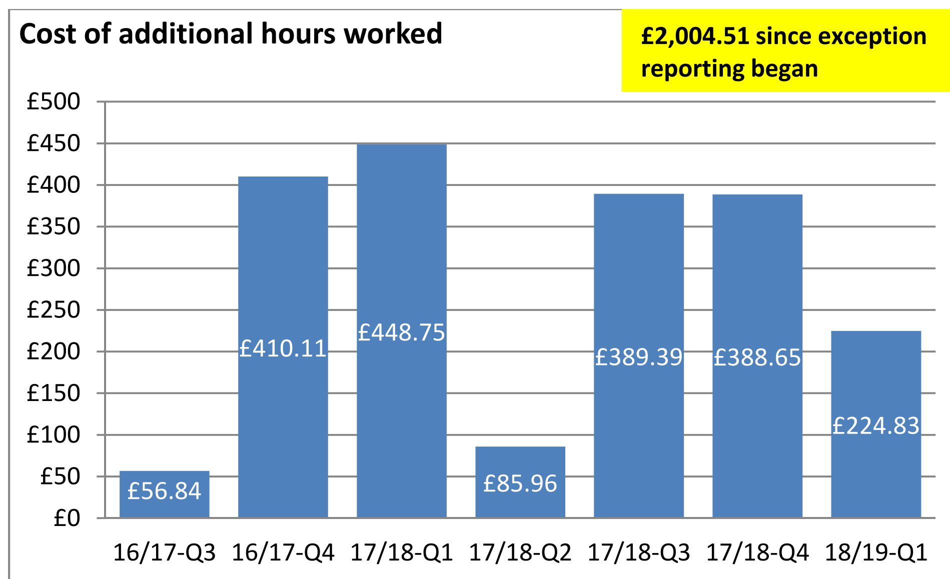
- The 22 reports came from 15 doctors. Two further reports (so making the actual total 24 were rejected as they were submitted more than 14 days after the variation took place
- There have been no Guardian fines levied for Q1
- 66.67 were closed within timescales and 33.33% were not
- 36% were closed by the clinical supervisor, 50% by the educational supervisor and the remaining 14% by either the GoSW or the Director of Medical Education
- 11 have resulted in payment to the Trainee for additional hours worked (total of 15.5 hours claimed with a value of £224.84)
- 6 have resulted in TOIL being approved (total of 12.5 hours claimed)
- 5 had no impact on TOIL or additional hours (mainly monitoring for missed breaks)
- 20 were for Hours & Rest and 1 was for education

The following charts detail the number of exception reports received from each site and the reasons for them.




Exception reports submitted (Q1) for Hours & Rest by type (all sites)
Unable to achieve breaks
1
Late finish, Unable to achieve breaks
6
Late finish
12
Exception type
0
2
4
6
8
10
12
14
No. exceptions
18/19-Q1


Exception reports by Directorate (all sites) Q1
32%
18%
18%
9%
9%
4%
5%
5%
General Medicine
General Surgery & Urology
Elderly Medicine
Head & Neck Services
Ophthalmology
Trauma & Orthopaedics
Obstetrics & Gynaecology
Anaesthetics, Theatres and Critical Care



4. Positive outcomes

As a direct result of exception reports two significant pieces of work are being undertaken in the coming months.

On the York site the majority of exception reports come from surgery and many relate to cultural 'behaviours' from senior doctors. The Clinical Director for surgery and the GoSW are looking at some joint working with the ODIL team to address historical cultural issues by running some facilitated workshops for all doctors and directorate staff.

On the Scarborough site, the majority of exception reports come from medicine and many relate to the rota which is designed around the current acute medical model. Over the next few months the Deputy Medical Director is working with the directorate and the rota team to design a new approach to medical cover for the acute and elderly directorates to help support junior and senior doctors and improve patient safety.

4.1 Challenges

Below are extracts from two exception reports received this quarter. It demonstrates the type of information the GoSW has available about junior doctors experience, not just data about extra hours worked.

- General Surgery York:
  'Alone on vascular with heavy workload. Lots of jobs raised to me by nursing team late in the day. Tried to handover to F1 at 18:00, unable. Also very stressed and overwhelmed. Phoned registrar at 18:20, already left the hospital. Tried again to handover to F1 at 19:00, unable. F1 was assisting in

theatre. Handed over lots of jobs to SHO at 19:45. Worked flat out all day stopped for 15 mins to eat.'

- General Medicine SGH:

'1 junior doctor throughout whole last week. Unable to achieve breaks most of the days of the week. Friday still on ward round until 1830. Difficult to get hold of senior colleagues when needed and hence issue not resolved.'

Junior doctors need to feel that they are being listened to when raising issues such as these in exception reports and that appropriate actions are being taken and being feedback.

5. Summary of rota gaps for doctors currently on 2016 (new) terms and conditions

There continues to be a significant number of vacancies in training posts, however the Medical Staffing Team have supported a number of recruitment campaigns, both internal and external, and therefore some of these posts have now been filled with Trust Grade Doctors. There remain on-going recruitment campaigns that have not yet concluded which might help to ease the situation further.

The training post vacancy position currently stands at 5.4% for York and 17.6% for Scarborough. As of end June 2018, the overall vacancy rate, across all grades and specialties is currently 12.5% which is made up of 20.8% at Scarborough and 9.0% at York.

The Medical Workforce Manager has just commenced on a six-month project to try and support recruitment to post on the East Coast site, as they are struggling with the number of posts that remain vacant and this is having a direct impact on their ability to sustain critical services

Medical Staffing and Rota Co-ordination continue to face issues with the flow of information from the Deanery. We have experienced trainees informing us they have been approved for Less Than Full Time status, when we have not received this information, and receiving information very last minute about trainees who we weren't expecting to commence at the Trust, who we are then expected to accommodate, when arrangements have already been put in place to cover the gap.

Long term sickness continues to have an impact on cover and rota gaps, however changes made to the AMU rota in York should help to reduce this. They have reverted back to rota patterns where on call duties are worked across the whole rota pattern, rather than in a block.

For rota gaps all Directorates all manage their vacancies differently:

- In areas where numerous vacant posts could potentially affect the compliance and cover, these posts are covered with full time locums, or alternatively if numbers were sufficient we would seek to re-write the rota pattern to help manage the gaps (providing the appropriate notice)
- In other areas or in some patterns it is possible to seek locum cover for just the out of hour's element of the rota pattern
- We would also seek to make changes to patterns where juniors have raised concerns via exception reports or the JDF.

6. Conclusion

The number of exception reports has dropped-off this quarter and this is a pattern we saw last year – an assumption may be made it is as juniors approach the end of their year rotation and are focussed on submitting their Annual Review of Competence Progression portfolios to their supervisors, and this is replicated in other teaching Trusts regionally. Exception reporting must be seen throughout the Trust as a positive thing which keeps staff and patients safe by highlighting problems that the Trust can then address. Trainees must not be fearful of submitting them.

A number of the '8 high-impact changes' projects have brought about positive change and this project will continue.

7. Recommendation

The Board of Directors are asked to:

- Encourage and support juniors to raise safety concerns and to make use of the exception reporting system so appropriate action can be taken to ensure safe working and address any worrying trends
- Support a number of actions highlighted in the 8 high-impact changes project (being led via the JDF) to improve the working lives and experiences of junior doctors working in the organisation
- Thank the JDF members for their continued commitment and in particular the Vice-Chair for his commitment to the Forum over the past 12 months.