York Teaching Hospital NHS
NHS Foundation Trust

The next general meeting of the **Trust's Council of Governors** meeting will take place

on: **Thursday 16 June 2016**

at: **4.00pm – 6.00pm**

at: **White Cross Court Social Club, White Cross Road, York YO31 8JR**

Time	Meeting	Attendees
3.00pm – 3.45pm	Private meeting of the Council of Governors	Governors with Trust Chair
4.00pm – 6.00pm	**Council of Governors meeting**	**Governors, Members and the Public**

The Trust Values are:

- Caring about what we do
- Respecting and valuing each other
- Listening in order to improve
- Always doing what we can do be helpful with patients at the centre of everything we do

We will strive to reflect these during our discussions in the meeting



If you are a Governor, Member of our Trust or member of the public and would like to ask a question, please contact the Foundation Trust Secretary, Anna Pridmore:

Email: Lynda.provins@york.nhs.uk Telephone: 01904 725076

A G E N D A

No	*Time*	*Item*	*Lead*	*Paper*	*Page*
1.	4.00 - 4.20	**Chair's Introduction and welcome** The Chair will introduce the meeting and welcome any Members of the Trust and of the public who are in attendance.	Chair	Verbal	
2.		**Apologies for absence** To receive any apologies for absence: • Steve Hinchliffe • Diane Rose • Andrew Bertram	Chair	Verbal	
3.		**Declaration of Interests** To receive the draft declarations of interests.	Chair	A	05
4.		**Minutes and Action Log from the meeting held in public on 10 March 2016** To approve the minutes of the meeting held on 10 March 2016	Chair	B	09
5.		**Matters arising from the minutes** To consider any other matters arising from the minutes.	Chair	Verbal	
6.		**Update from the Private Meeting held earlier** To receive an update from the Chair on the topics and decisions of the business discussed in the private meeting held prior to the meeting in public.	Chair	Verbal	
7.	4.20 – 4.40	**Governors' Reports** To receive the reports from governors on their activities from: • Lead Governor Report (Margaret Jackson) • Art Strategy Group (Jeanette Anness) • Fairness Forum (Ann Bolland) • Community Services Group meeting (Margaret Jackson)	Governors	C	17

8.	4.40 – 5.05	**Sustainability & Transformation Plan**	Director of Out of Hospital Care	Verbal	
9.	5.05 - 5.30	**Chief Executive's Report** To receive a report from the Chief Executive including	Chief Executive	D	57
10.	5.30 - 5.40	**Update from the Membership Development Group** To receive an update on the work of the membership development group	Governor & Membership Manager	E	63
11.	5.40 - 5.50	**Governor Elections 2016** To receive a paper on the election process	Governor & Membership Manager	F	67
12.	5.50 - 6.00	**Any other business** To consider any other items of business			
13.		**Time and date of next meeting** The next Council of Governors meeting (in public) will be held on 8 September 2016 at St Catherine's Hospice, Scarborough.			

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Register of Governors' interests
June 2016

York Teaching Hospital NHS
NHS Foundation Trust

Deletions:

Paul Baines—end of term of office
Jane Dalton—end of term of office
Liz Jackson—resigned
Steve Lane—deceased
Jenny Moreton—end of term of office
Penelope Worsley—resigned

A

Governor	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
Jeanette Anness *(Public: Ryedale and East Yorkshire)*	Nil	Nil	Nil	Nil	Member**,** Derwent Practice Representative Grp Member**,** NY Health watch Member, SRCCG Patient Representative Grp	Nil
Michael Beckett *(Appointed: North Yorkshire and York Forum)*	North Yorkshire and York Forum	North Yorkshire and York Forum	Nil	Chair—Ryedale and District Mencap Parliamentary Spokesperson Member– North Yorkshire and York Forum	Non-executive Director—North Yorkshire and York Forum Ryedale and District Mencap	South Yorkshire Credit Union Yorkshire Building Society Smile Co-Operative Bank
Andrew Bennett Staff Scarborough and Bridlington	Nil	Nil	Nil	Nil	Nil	Nil
Ann Bolland *(Public: Selby)*	Nil	Nil	Nil	Nil	Nil	Nil
Andrew Butler *(Public: Selby)*	Nil	Nil	Nil	Nil	Nil	Nil
John Cooke *(Public: York)*	Nil	Nil	Nil	Nil	Nil	Nil
Helen Fields (Public York)	Nil	Nil	Nil	Nil	Nil	Nil

Governor	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
Cllr John Galvin (City of York Council)	Nil	Nil	Nil	Nil	**Councillor—**City of York Council	**Councillor—** City of York Council
Stephen Hinchliffe (Public: Whitby)	Nil	Nil	Nil	Nil	Nil	Nil
Sharon Hurst (Staff: Community Staff)	Nil	Nil	Nil	Nil	Nil	NIl
Margaret Jackson (Public: York)	Nil	Nil	Nil	Nil	Nil	Nil
Rowena Jacobs (Partner: University of York)	Nil	Nil	Nil	Nil	Nil	Nil
Mick Lee Staff York	Nil	Nil	Nil	Nil	Nil	Nil
Sheila Miller (Public: Ryedale and East Yorkshire)	Nil	Nil	Nil	**Member**—Derwent and SRCCG Patients Groups **Member**—Health Watch North Yorkshire (non-voting)	Nil	Nil

Governor	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
Clive Neale *(Public: Bridlington)*	Nil	Nil	Nil	Member of Healthwatch East Riding.	Nil	Nil
Helen Noble (Staff: Scarborough)	Nil	Nil	Nil	Nil	Nil	Nil
Cllr Chris Pearson (North Yorkshire County Council)	Nil	Nil	Nil	Nil	**Councillor—**North Yorkshire County Council	**Councillor—**North Yorkshire County Council
Diane Rose (Public: Scarborough)	Nil	Nil	Nil	Nil	Nil	Nil
Patricia Stovell (Public: Bridlington)	Nil	Nil	Nil	Nil	Nil	Nil
David Wheeler (Public: Scarborough)	Nil	Nil	Nil	Nil	Nil	Nil
Robert Wright (Public: City of York)	Nil	Nil	Nil	Volunteer for York Healthwatch	Employee—NHS Leadership Academy	Nil

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the Meeting of the York Teaching Hospital NHS Foundation Trust Council of Governors, in public, held on 10th March 2016, Malton Rugby Club, The Gannock, Malton YO17 7EY.

Present at the meeting

Chairman of the meeting:

Ms Sue Symington, Chair

Public Governors:

Mrs Jeanette Anness, Ryedale & East Yorkshire
Mr Paul Baines, City of York
Mrs Ann Bolland, Selby
Mr Andrew Butler, Selby
Mr John Cooke, City of York
Dr Jane Dalton, Hambleton District
Mrs Helen Fields, City of York
Mr Stephen Hinchliffe, Whitby
Mrs Sheila Miller, Ryedale & East Yorkshire
Dr Jenny Moreton, Ryedale and East Yorkshire
Mr Clive Neale, Bridlington
Mrs Diane Rose, Scarborough
Mrs Pat Stovell, Bridlington
Mr David Wheeler, Scarborough
Mrs Penelope Worsley, City of York
Mr Robert Wright, City of York

Appointed Governors:

Mr Michael Beckett, North Yorkshire & York Forum
Prof Rowena Jacobs, University of York

Staff Governors:

Mrs Sharon Hurst, Community
Mr Mick Lee, York
Mrs Helen Noble, Scarborough/Bridlington

Attendance:

Mrs Jennie Adams, Non-executive Director, York Teaching Hospital
Mr Andrew Bertram, Director of Finance
Mrs Lynda Provins, Governor and Membership Manager
Mr Mike Sweet, Non-executive Director, York Teaching Hospital

Cllr C Runciman & Ms Wallis

16/01 Chairman's Introduction and Welcome

Ms Symington welcomed everyone to the meeting.

16/02 Apologies for absence

Apologies were received from the following governors:

Mr Philip Ashton, Non-executive Director
Dr Andrew Bennett, Staff Governor - Scarborough/Bridlington
Mr Patrick Crowley, Chief Executive
Cllr John Galvin, Stakeholder Governor - City of York Council
Mrs Margaret Jackson, Public Governor - City of York
Miss E Jackson, Staff Governor - York
Ms Libby Raper, Non-executive Director
Prof Dianne Willcocks, Non-executive Director

Cllr Steve Lane, Stakeholder Governor - East Riding of Yorkshire Council and Cllr Chris Pearson, Stakeholder Governor - North Yorkshire County Council did not attend the meeting.

16/03 Declaration of Interests

There were no changes to the declaration of interests noted.

16/04 Minutes of Council of Governors Public Meeting – 9th December 2015

The minutes of the meeting held on the 9th December 2015 were agreed as a correct record subject to the following amendments:

- Prof Diane Rose should read Mrs Diane Rose
- Dr Rowena Jacobs should read Prof Rowena Jacobs
- Stephen Hinchcliffe should read Stephen Hinchliffe

16/05 Matters Arising from the Minutes

Minute No: 15/52 Ms Symington noted that although Patient Safety walk rounds had been discussed at the Board, the subject required further discussion.

Minutes No: 15/45 Mrs Miller noted that the clash of meeting dates was discussed at the recent transport meeting.

16/06 Update from the Private Meeting held earlier

Ms Symington reported that the review of Non-executive directors and the Chair was discussed at the Private meeting together with succession planning. She was also pleased to note that Prof Dianne Willcocks reappointment was approved for a third and final term.

16/07 The role of the Health & Wellbeing Board

Ms Symington welcomed Cllr Runciman & Ms Wallis to the meeting.

Cllr Runciman provided an overview of her background and the role of the City of York Health & Wellbeing Board (H&WB Board). The H&WB Board is a high level strategic group with a mixture of agencies. She noted that in order to provide dedicated time to priorities, meetings are themed. The last meeting, held yesterday was around Mental Health, one of the H&WB Board's priorities. Cllr Runciman also noted the continued engagement with the North Yorkshire and East Riding Health & Wellbeing Boards.

Mr Wright asked about public engagement and Ms Wallis stated that approximately 10 members of the public attended each meeting, but the web cast was usually watched by a further 100. It was noted that engagement with the public very much depended on agenda items.

Cllr Runciman stated that the H&WB Board was a Committee of the Council and performance was measured through key performance indicators. There were also a number of checks and balances in place to evaluate the H&WB Board's effectiveness. An example of pump priming from the Better Care Fund was the additional psychiatric staff placed in the Emergency Department. Cllr Runciman stated that it was about knowing whether the right people were coming in and out of the hospital, however, it was more complicated in relation to Clinical Commissioning Groups and she was not convinced that this area was right. She noted that three GPs sat on the H&WB in East Yorkshire, which provided a good link with the "ground floor", as strategy needed to fit with practice.

Ms Symington stated that the Board to Board in April would look at the Sustainability and Transformation Plan in order to generate more understanding of recent place-based developments in thinking, together with the how the Trust fits in with the bigger picture both locally and regionally. She asked how the H&WB Board would be involved. Cllr Runciman stated that the H&WB Boards for the area would need to come together to look at their own areas, but also the larger footprint.

Mrs Miller asked about super councils and devolution. Cllr Runciman stated that the picture was not clear and this was very much to do with politics. Manchester are obviously trialling this, but it would be a difficult decision to take in such a larger rural area such as this.

Ms Symington thanked Cllr Runciman and Ms Wallis for attending and providing an insight into the work of the H&WB Board.

Cllr Runciman and Ms Wallis left the meeting.

16/08 Governor Reports

Lead Governor's Report – No questions were raised.

Transport Group – Mrs Miller noted that Virgin had stated the intent to run fast trains between Scarborough, York and London.

Fairness Forum – Dr Moreton clarified that the 'ritual washing capital scheme' had been about providing Muslims facilities to wash before going to prayer. Mr Butler asked whether the Council of Governors was happy with the interpretation service and the level of exposure it was getting. Dr Moreton stated that the Forum had recognised the service was inadequate and had resulted in the previous provider being asked to resupply the service. Dr Moreton highlighted the planned staff road show. It was agreed that an update should be provided in the next Forum report.

Action: Mrs Bolland to provide an update on interpretation service in the next Forum Report.

Mrs Bolland highlighted the work on equality and diversity being progressed by the group, which was an issue that related to every aspect of the Trust's work, but was concerned that staff remained unaware of it. Ms Symington asked whether this would be a useful topic for the next meeting and agreed to talk to Mr Golding about it.

Action: Ms Symington to talk to Mr Golding about using Equality and Diversity as an agenda item for the next meeting.

Community Services Group – this was noted as an excellent meeting with a very interesting presentation on community discharge. Mrs Rose endorsed the discharge to assess round table meeting that had taken place, which she felt was a brilliant idea and helped to free up beds.

Mrs Anness wanted to express her thanks to Mrs Pridmore for all the help and support provided to the Council.

Charitable Funds – Mrs Worsley stated the report gave a general overview of the work of the committee. Mr Bertram noted that there were three staff involved in the charitable funds service working flexibly across York and Scarborough.

Dr Dalton and Mr Wright left the meeting.

16/09 Chief Executive's Report

Mr Bertram asked whether the Council had any questions.

Mr Wheeler asked for further information about the opportunity for improving orthopaedics at Bridlington. Mr Bertram gave an overview of the development of the orthopaedic work at Bridlington including the introduction of a second modular flow theatre and the difference this had made to orthopaedics being able to continue to operate electively during the winter months for the last two years. He noted that a further business case is nearing completion, which looks at further developments including more theatres. Mr Bertram stated that this will require robust discussion at the Board due to the current financial constraints and it may be that further improvements to the service are on an incremental basis.

Prof Jacobs asked for information on the financial impact of the Junior Doctors strike. Mr Bertram provided some unvalidated figures around the number of operations and outpatient attendances that had been cancelled. Mrs Noble

stressed that there were also bed pressures at Scarborough, which had required some operations to be cancelled.

Mr Hinchliffe asked when the Urology build would start at Malton. Mr Bertram noted that building had already started and would be completed in the Autumn. Mr Beckett asked whether there had been any additional funding available due to the strike disruption and Mr Bertram confirmed there had been no extra funding.

Mrs Miller asked about agency fees. Mr Bertram stated that the use of agency fees had increased fairly quickly and the Trust did not have the resources to plan for the level of unprecedented spend. He stressed the number of initiatives on-going across the organisation that had stopped the figure being higher than it is. One of these initiatives had been to grow the number of staff on the bank and this had been done by listening to what staff wanted like weekly pay, which has been put in place. Mr Bertram also noted that agencies were now being pushed to be part of a framework to be an approved supplier. Overseas recruitment was also discussed.

Mr Baines asked about the number of mature nurses leaving the Trust and what was being done to reverse this. Mr Bertram noted that the Corporate Nursing Team is looking at ways to encourage nurses to stay by creating new roles. Mrs Hurst noted that nursing had changed considerably over the years and that a tremendous amount of work was now going into looking at new roles at bands 2, 3 and 4. She noted that revalidation had placed a lot of extra work on nurses, but there was support in place to get them through the process.

Purchase order numbers were discussed as some of the Governors were surprised that these had not always been required. Mr Bertram stated that purchase order numbers were not widely used in the NHS, but this was being tightened up within the Trust and from April no purchase will be made without a PO Number.

16/10 Update on Membership

Mrs Provins gave a short brief on the paper, which asked for approval of a number of documents.

Dr Moreton stated that the 'Meet the Governor' sessions had generated a number of reports. The Ryedale report suggested that sessions for the public on providing care at home would be useful. Mrs Provins noted that in the first instance, a number of sessions had been planned for members on CPR by the Communications Team.

Mr Butler asked about the reference to the position of Chair of the Group in the Terms of Reference. Mrs Provins stated that she had been asked to chair the group to endorse that the Trust were taking responsibility for the recruitment of members. Mrs Provins will add this to the Terms of Reference.

Action: Mrs Provins to amend the Terms of Reference

Prof Jacobs asked for the links with the university to be strengthened especially in relation to using the membership for research. Mrs Provins agreed to link with

her to look at this further.

Action: Mrs Provins to link with Prof Jacobs around membership and research.

Mrs Bolland was concerned about any changes to the membership newsletter. Mrs Provins noted that any changes would be part of the Group's discussions.

Mrs Noble left the meeting.

16/11 Operational Plan and Sustainability & Transformation Plan (STP)

Ms Symington stressed the importance of the STP for the Trust at both a local and regional level.

Mrs Provins noted that consultation had started with Governors on the Operational Plan and the final draft was due to go to the Board for approval on the 30th March. She also noted that the Board to Board on the 7th April would be used to discuss various developments, which would be used to demonstrate the Trust's level of ambition and breadth of work across sites.

Action: Mrs Provins agreed to send the headings of the group discussions out in the Friday communication.

A slide pack was circulated and Mr Bertram provided a brief overview of the 2016/17 Draft Financial Plan, which looked at the following:

- NHS Provider Forecast Outturn 2015/16
- Cash Position
- Headline Financial Settlement 2016/17
- Sustainability Funding
- 2016/17

16/12 Any Other Business

Ms Symington thanked everyone for attending the meeting.

No further business was discussed.

16/13 Time and date of the next meeting

The next meeting will be held on 16th June 2016 at White Cross Court Social Club, White Cross Road, York YO31 8JR

Council of Governors Action Log						
Date of Meeting	Private/ Public	Action	Owner	Due Date	Open / Closed	Comment
09.12.15	Public	Raise walkrounds at the next Quality & Safety Committee	Ms Raper	Next Q&S	Closed	BoD 30.03.16 - noted night walk rounds reintroduced
09.12.15	Public	Report back to the Governors regarding the Patient Experience Team and Volunteer numbers in early January.	Ms Symington	11.01.16	Closed	Volunteer paper circulated. Chair's June report met with PALs Team and discussed patient complaints and compliments with the Patient Experience Team Leader.
10.03.16	Public	Mrs Bolland to provide an update on interpretation service in the next Forum Report.	Mrs Bolland	16.06.16	Closed	Contained in Governor Reports paper - Fairness Forum section.
10.03.16	Public	Ms Symington to talk to Mr Golding about using Equality and Diversity as an agenda item for the next meeting.	Ms Symington	31.03.16		Equality & Diversity Strategy going to the BoD at the end of June. CoG Sept.
10.03.16	Public	Mrs Provins to amend the Membership Terms of Reference	Mrs Provins	31.03.16	Closed	
10.03.16	Public	Mrs Provins to link with Prof Jacobs around membership and research.	Mrs Provins	31.03.16	Closed	Meetings in progress - linking with University, Trust's Research Dept, Comms & PPI
10.03.16	Public	Mrs Provins agreed to send the headings of the group discussions out in the Friday communication.	Mrs Provins	11.03.16	Closed	

Council of Governors Action Log						
Date of Meeting	Private/ Public	Action	Owner	Due Date	Open / Closed	Comment
09.12.15	Private	Mrs Provins to be main point of contact	All Governors	Immediate	Closed	
09.12.15	Private	Circulate the Lincolnshire notes & Harrogate Outputs from AMM	Mrs Provins	31.12.15	Closed	Emailed 23.12.15
09.12.15	Private	Check whether DBS checks are required for place assessments	Mrs Pridmore	31.12.15	Closed	
09.12.15	Public	Governors to let Mrs Brown, the Head of Communications have details of the sessions on the 14th January 2016.	All Governors	31.12.15	Closed	
09.12.15	Public	Discuss with Mr Golding the clash between Transport Group and Board to Board meeting dates.	Mrs Provins	31.12.15		Contacted Zara Ridge who is looking at all future dates.
09.12.15	Public	Circulate the lessons learnt information from the Chief Executive's visit to Alaska			Closed	Emailed 23.12.15
09.12.15	Public	Council of Governors to received an update on the visit to China	Mr Crowley	10.03.16	Closed	
09.12.15	Public	Find out when the Clinical Excellence Awards Group will finish their work.	Mrs Pridmore	31.12.15	Closed	
09.12.15	Public	Discuss Annual Report presentation with Mr Bertram (presenter to note Governors views)	Mrs Provins	31.12.15	Closed	
09.12.15	Public	Raise walkrounds at the next Quality & Safety Committee	Ms Raper	Next Q&S		Discussed at BoD on 24.02.16. Further discussion req'd.
09.12.15	Public	Report back to the Governors regarding the Patient Experience Team and Volunteer numbers in early January.	Ms Symington	11.01.16		Volunteer paper circulated.
09.12.15	Public	Check the status of the volunteer interviews	Ms Symington	31.12.15	Closed	Mrs Provins contacted relevant individuals

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York Teaching Hospital NHS
NHS Foundation Trust

Council of Governors – 16 June 2016

Governor Reports

Action requested/recommendation

The Council of Governors is asked to note the report and the authors will respond to any questions or comments, as appropriate.

Summary

This paper provides an overview from Governor activities.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report is only written for the Council of Governors – Public Meeting.

Risk	No risk.
Resource implications	Resources implication detailed in the report.
Owner	Lynda Provins, Governor & Membership Manager
Authors	Margaret Jackson, Lead Governor Jeanette Anness, Public Governor Ryedale & East Yorks Ann Bolland, Public Governor Selby Steve Reed, Head of Strategy for Out of Hospital Services
Date of paper	June 2016
Version number	Version 1

Council of Governors Meeting – 16 June 2016

Governor Reports

1. Lead Governor Report

March 2016 was the last Council of Governors and time this year seems to be passing very quickly. The Trust continues to work hard to meet targets and manage the financial situation. As a Governor, it has been very beneficial to attend the Board meetings to listen to the debates, witness first-hand the challenge to the Directors made by the Non-executive Directors and to hear detailed outlines of the issues currently being debated.

As part of seeing the Non-executive Directors in action some of us have been able to observe them participating in a meeting. Those who attended have found this a very useful process and would like further opportunity to do this on a regular basis. I will have a discussion with Sue Symington to debate the possibilities for this to happen.

Philip Ashton and I met with Sue Symington to review her work to-date and to agree her objectives for the next year. Thank you to those of you who gave feed-back which I was able to share with Sue and Philip. Philip spoke to his NED colleagues and to the Executives and both Philip and I spoke with 2 external colleagues each to get their feed-back on how Sue and the Trust are viewed throughout the region. Following these discussions Philip and I met with Sue to give her feed-back. As part of the discussion we agreed with Sue that she would share an outline of her work programme with colleagues once finalised.

Sheila Miller, Jeanette Anness and I met on your behalf with Anna Pridmore and other colleagues in the Trust to discuss the draft Quality Report 2015/16. Last year's audit carried out on behalf of the Council of Governors was that patients who require it have an appropriate and inclusive DNACPR decision making discussion. The outcome was that the Trust complied with this target. This year's audit was that at least 90% of patients who were 75 years of age or over at the time of admission were assessed with a dementia specific tool. This is an issue that Governors have continued concerns about and want to ensure that the agreed target is met.

I attended the second national conference for Governors put on by NHS Providers. The presentations have been circulated to everyone, but the day showed the depth of the problems the NHS in general faces. It was made clear that it was felt to be a system failure rather than down to local individuals or teams. It was a very good day, but didn't really address the issue of how members were recruited and engaged.

A small number of us had the opportunity to visit "Project Choice" at Scarborough. We were very warmly welcomed and the team and the young people were keen to tell us about their work. If you have an opportunity to go, it is to be recommended.

Can I take the opportunity to thank Penelope Worsley and Liz Jackson for their contribution to the Council of Governors and as they step down as Governors wish them both well for the future. All vacant Governor posts will be included in the election process to take place later this year.

Margaret Jackson - Lead Governor and Public Governor York

2. Arts Strategy Group

A meeting of the Art' Strategy Steering Group was held on 5th May 2016. This was the first meeting since October 2016 due mainly to the resignation of Kat Hethertington, our excellent Arts Officer to pursue a business of her own. The meeting was chaired by Gill Greaves who will also be finishing her work with the Arts Team on the 1st June. The Arts Officer post is under review but in the meantime Jess Sharp [Arts and Design Project Co ordinator] has increased her hours to full time and continues to manage on-going and new projects with great enthusiasm. One recently completed project is the York Hospital `Walks of Art` map which are available on a stand in the main entrance. These maps suggest two routes to see some of the art work taking between 10 and 30 minutes. It also stresses the benefit of walking for health. It is a very well presented leaflet.
Recent exhibitions on the long street in York have included one for Downs Syndrome Awareness Week which was in March. This included paintings by Sue Clayton of young people who have Down's Syndrome and photographs by two photographers one of whom has Down's Syndrome. The Arts team worked with the York Museum Trust to mount a World War One exhibition of loaned prints and it is hoped that this collaboration will continue for future small exhibitions. In March two members of the Trust staff provided photographs for a small exhibition about the Indian festival of Holi. Projects within the hospital sites have included new artworks in the waiting rooms on ward 27 and mosaic pieces in the newly decorated Outpatients Department. Jo Davis Arts Officer for HAFNEY has commissioned an Artist to create work for the Bridlington Canteen and this artist will be working with students from Bridlington School as part of the project. Jo has also organized Reminiscence Workshops with patients on Anne Wright Ward in association with the Pannett gallery in Whitby. Requests from departments for new artwork do exceed the team's ability to provide it.
The main part of the meeting focused on the current situation and a review of the existing document "Operational Framework for the Arts Service 2010 – 2015" and what next? The Group decided that this document should be revised to take in to account changes in the Trust since integration. We discussed the Role of the Arts in supporting and fulfilling the Trust's vision and values, in supporting and promoting the Patient Experience Strategy, the role of Arts in Hospital in trust wide communications and engagement strategy amongst other aspects of Arts in hospital. New Terms of Reference will be prepared and taken to the Board for approval – probably at the June meeting.

Jeanette Anness, Public Governor Ryedale and East Yorkshire

3. Report from Fairness Forum Meeting 5th May 2016

The Patient Story

Laura Branigan attended the meeting. Laura is friend of York Hospital. Laura has mobility problems and uses a mobility scooter to help her get around. Laura usually supports by working on the front desk at York Hospital. Laura has a lot of concerns and she raised a number of them. Her concerns specifically were regarding those with mobility issues and how they can access for example, the hospital rest rooms. Bins in hospital require foot pressure to open them, mirrors in toilets are too high. There are also issues around getting in and out of cars by themselves in the hospital car parks. Laura has been in contact with Paul Bishop (Facilities Management) who was in the process of addressing the concerns brought to his attention.

A paper on 'How can we become more LGBT friendly' was presented. Concerns were raised about members unable to attend the meetings. The Chair asked that, for future reference; if

a member is unable to attend that they appoint a suitable replacement, or provide a written report.

Interpretation and Translation

The Big Word (Language Technology Business) has now replaced Pearl Linguistics in providing the above service for the Trust. Services have improved across the Trust. A need was identified to create a list of users. At the moment there are a number of issues in accessing BSL. Unlimited training with the new package has been offered to staff, The system provides verbal and written interpretations of language used. A comprehensive telephone based translation is available throughout our hospital.

Margaret Milburn presented a paper on Equality Assurance. This was assimilated to a Risk Assessment in that it involves predicting and assessing the implications of a policy on wide ranging, different groups with varying needs. MM also provided an update from the EDS2 assessment event; held in Malton in February.

Work Stream updates were received from:
Capital Planning
Chaplaincy
Elderly Services & Dementia
Human Resources
Visual Impairments
Fairness Champions
LGBT Staff Network

A leaflet 'What do you do if you are not happy with the services that you have received' was discussed and the decision was made to work further on the document.

Fairness Forum Terms of Reference were also reviewed.

Ann Bolland, Public Governor Selby

4. Community Services Group meeting 13 May 2016

Summary of topics discussed

- Terms of reference;
- CCG procurement of community services;
- Out of Hospital Care Strategy;
- New out of hospital care model;
- The new Out of Hospital Care directorate.

There are fewer actions arising from this group than normal as the session was principally given over to discussing the detail of the new out of hospital care strategy.

Actions Agreed

- Circulate Terms of Reference for reference (SR);
- If Strategy is approved at Board of Directors to be shared with Council of Governors in June (SR/MJ);
- Include an update on move to Out of Hospital Care Directorate with meeting summary (below).

In view of the Trust's commitment to delivering the vision of 'Community First' within the strategy document the decision has been taken to bring together the Community Services and Allied Health Professions and Psychological Medicine directorates. The new Out of Hospital Care Directorate will be led by the new Deputy Director of Out of Hospital Care, Melanie Liley. Melanie has been invited to the September meeting as an opportunity to introduce herself to the governors group.

Out of Hospital Care Strategy

Attached to this report is a copy of the Out of Hospital Care Strategy which was approved at the board of directors in June.

Future Meetings

The group will meet on 16 September 2016. The agenda will include:

- Discharge to Assess – including a discussion on the comms with the public and those using services (SR).

Members are asked to let Steve Reed know of any agenda items they would like to discuss in advance of the meeting.

Steve Reed, Chair of the Group

5. Note from the Chair:

We will take additional verbal emphasis from the author, questions and/or comments on any of the above, at the Council of Governors; We will also be happy to receive any additional reports verbally. We will experiment with this approach, designed to ensure there is a good written record of Governor activity, as appropriate, and to help any person who is unable to attend the meeting to learn of these activities through the papers. Please aim to make your reports less than 250 words and send to Anna at any time prior to one week before Council of Governor meetings. Thank you.

Sue Symington, Chair

Authors	Margaret Jackson, Lead Governor Jeanette Anness, Public Governor Ryedale & East Yorks Ann Bolland, Public Governor Selby Steve Reed, Head of Strategy for Out of Hospital Services
Owner	Lynda Provins, Governor & Membership Manager
Date	June 2016

York Teaching Hospital NHS
NHS Foundation Trust

Out of Hospital Care Strategy 2016-2021

Community First



Welcome to York Teaching Hospital NHS Foundation Trust's out of hospital care strategy.

The out of hospital care directorate employs over 1400 staff, which represents nearly 16% of the organisation's total workforce. These staff, from both clinical and non-clinical backgrounds, deliver a wide range of services from many locations across North Yorkshire serving a population of over 450,000 people.

This strategy describes our ambition to work with our local communities, our staff and our partners to transform the way in which we deliver services in the community.

We have listened carefully to what service users, carers and families have told us matters to them. We know that they want accessible, coordinated services so that they only have to tell their story once. They also want their care to be delivered as close to home as possible. They tell us that they want to make decisions with us about their care and they want their families and carers to feel involved and supported.

We know that we cannot deliver our services in isolation; we are committed to working with other partners to improve the care that we provide. Our local population is living longer and many of our service users have complex needs. In order to manage increasing demand and competing priorities we have to seek new ways of providing integrated services that deliver high quality services and value for money.

This strategy sets out our key priorities over the next five years and seeks to describe how we will deliver our services to meet the needs of our local population.



Wendy Scott
Director of Out of Hospital Care

Executive Summary

This document sets out how we will deliver better care for people close to home. It focuses on care provided out of hospital (this includes "traditional" community services and those services that have to date, been provided in a hospital setting but can be transferred to be delivered in community settings). It will highlight the key priorities for the next five years (2016 to 2021) and outline the crucial changes we will make during this time. York Teaching Hospital NHS Foundation Trust is the major provider of healthcare to the residents of York, Scarborough, Selby, Ryedale and Bridlington. This strategy has been developed in response to the rapidly changing health and social care environment in which these services are developed.

Scope

The Out of Hospital Strategy encompasses those services that we provide via the community services contract, those we provide outside of acute hospitals and the work we are undertaking with partner organisations in the local health and social care system. As a signal of our commitment to delivering services out of hospital we recently brought together our Community Services and Allied Health Professional Directorates to form a new Out of Hospital Care Directorate. Outside of the scope of this document is work within the community setting which involves children and young people; the Child Health Directorate are working in partnership with commissioners to develop a local strategy in response to the recently published Facing the Future Together for Child Health 2015 standards.

The Case for Change

Data tells us that, overall, our local communities are less deprived than the national average. However, we do serve a population that are older than the England average, with 20% of people in the Vale of York and 25% of people in Scarborough and Ryedale, over the age of 65 years. It is expected that the number of people over the age of 85 years will grow by 16-18% by 2020. Nationally we know that 15 million people are living with one or more long term conditions and for those aged over 75 years, over 50% will have three or more long term conditions. This growth in population and disease prevalence is creating increased demand for services, with 17,000 additional beds estimated to be required by 2021 if we continue with current models of care. We also know that the relative affluence of our population and overall better than average health outcomes disguises significant health inequalities, with a 12 year gap in life expectancy for men between the most and least deprived areas of Scarborough, and a 7 year gap for women in Selby.

Many individuals require admission to hospital at some point in their lives, usually as a result of an acute illness or injury. However, research suggests that we may do harm to older people if we delay their transfer or discharge home after their acute recovery phase is completed. In addition to the decompensation and loss of confidence that they experience, studies have shown that 10 days of bed rest can cause the equivalent of 10 years muscle ageing in those aged over 80 years. As well as being harmful, hospital care is expensive. Minimising costs where appropriate is essential if the NHS financial challenge set out in the Five Year Forward View, (the NHS requires £22bn of savings to be identified by 2020 for projected funding and spending levels to balance) is to be achieved. Studies have shown that care provided out of hospital can provide a better experience for patients at lower costs, however, shifting resources into community services from other sectors can be challenging.

We also know that in order to deliver services that meet people's expectations we need greater integration which will mean people can '*plan their care with people who work together to understand them and their carer(s), allowing them control, and bringing together*

services to achieve the outcomes important to them'. We have started this process as part of the model of care in Selby and Ryedale (Care Hub developments funded via the Better Care Fund). We also know that we need to move beyond simply integrating care and consider the health of populations i.e. we need to adopt a place-based approach to planning and working with communities to improve health outcomes.

Principles and Vision

We will work within the local system to adopt a 'Community First' culture which focuses on prevention and self-care; delivers care closer to home and allows the system to manage growing demand by increasing efficiency through integration.

We have developed the following principles:

1. Promote independence through prevention and self-care;
2. Person centred, co-produced support involving families and carers;
3. Co-produced new model of care with home as first choice, delivered over seven days;
4. Co-ordinated, integrated and joined up care that people can easily navigate;
5. Timely and rapid response to prevent admission to hospital or a care home;
6. Seamless interface to facilitate safe and timely discharge from hospital;
7. Remove duplication, ensuring cost-effectiveness and value for money.

New Ways of Working

In order to make 'Community First' a reality we will develop a planned programme of work grouped under three key themes:

1. Developing integrated community services to support localities – we will work with other providers and the public to design new integrated care models supporting local populations. We will implement a workforce development programme that supports self-management and peer support.
2. Developing the interface between acute and community services – we will work across the system to implement a 'discharge to assess' approach into an integrated independence service, developing community geriatrician and advanced clinical practitioner roles to work with local GPs. We will grow our capacity within home-based services to ensure more people can be supported at home with a resultant review of the purpose of our community inpatient beds.
3. Moving services from acute to community settings – we will bring together primary and secondary care clinicians to review care pathways to develop community based alternatives and will look to expand the range of planned care services delivered from our community buildings.

Working Together

We recognise that we cannot make this change alone. We have adopted a system leader's role, working with partners in an evolving governance framework. This includes core membership of the local System Leaders Board and active participation in the Ambitions for Health (Scarborough) and Integration and Transformation (York) Boards. We will work with emergent primary care organisations, including the Vale of York Clinical Network, and third sector partners together with local authority colleagues to ensure a sustainable future for North Yorkshire. We aspire to formalise this approach through the development of an accountable care system in York, building on the local progress of our Provider Alliance Board.

Enablers

We will need more than new services and new ways of working in order to be effective and deliver our vision. We will need to ensure that we have a workforce that has the skills to deliver the new care pathways and is supported in making the cultural changes required. We will need information technology that supports seamless and effective communication across services, ensures effective use of new digital technology to support self-care and reduces administrative burdens on staff to free up time to provide care. Our community estate will need to support the new care models with fewer requirements for isolated facilities and a reduction in physical beds, moved towards hub and campus accommodation with partner services. We need to ensure that we can measure the impact of what we do, with timely access to robust outcome data and intelligence from our communities to ensure that the changes we make are improvements.

Next Steps

We have identified a series of developments that we will focus on during 2016-17. These will form the basis of our Out of Hospital Programme and include:

- Adopting a discharge to assess approach and testing the three pathways identified;
- Developing integrated enhanced care teams, wrapped around primary care;
- Developing an 'independence service', integrating intermediate care and reablement, and building home-based capacity including a review of our bed based intermediate care provision;
- Developing a workforce development programme that will embed our focus on prevention, coaching and self-care;
- Work with operational directorates to further develop the out of hospital elements of their directorate strategies, identifying opportunities to move services from acute to community settings;
- Developing a home based ambulatory care service.



Why do we need to change?

Scope and Current Services

> *"NHS community health services are at the forefront of NHS care and support without the high public profile of other NHS services. Never the less they often reach deepest into our lives. They are part of our neighbourhoods; they come into our homes and are with us for the long-term. They partner with colleagues in the NHS, social care, education, charities and local government to personalise care packages which support people to maintain their independence for as long as possible."* Community Health Services: A Way of Life

Community services are both general health and integrated health and care services that take place at home or nearby in local care settings. They include nursing and therapies; multi-disciplinary teams to help people with complex needs remain at home or return home from hospital sooner; and a range of clinical and support services in community hospitals and local care centres.

It is important to note the distinction between services provided under the contract for 'Community Services' awarded to the Trust in 2011 through the 'Transforming Community Services' process and those services provided by the Trust outside of hospital settings. This strategy encompasses both of these.

York Teaching Hospital NHS Foundation Trust (YTH) was awarded the contract to manage community services in 2011 as part of the national Transforming Community Services Programme. These services stretch across the Trust's footprint (with the exception of Pocklington, Bridlington and, from March 2016, Whitby) serving a population of almost half a million across the communities of the City of York, Selby and District, Ryedale and Easingwold and Scarborough. This stretches over a geographical area of 3,400 square miles.

YTH has signalled its commitment to delivering care out of hospital through the creation of an Out of Hospital Care directorate. Initially this directorate will incorporate the previous 'community services' directorate and the directorate of allied health professionals and psychological medicine. This brings together a wide range of services, delivered in a range of settings both in the community and in an acute hospital setting. Our ambition is to grow this directorate, reflecting the increasing drive to provide care and support closer to home.

Community services employ 810 people in adult community services and 570 in our allied health professionals' directorate, with services provided from a range of localities, including community hospitals in Malton, Selby and Easingwold, three inpatient units in York and 7 health centres. The Single Point of Access for Community Services (not including community therapies) handles over 80,000 referrals a year. There are around 2,000 patients on the district nursing caseload and intermediate care teams support around 200 new patients every month. Community therapy teams manage around 9,000 new referrals each year and 1,800 patients were admitted to community inpatient beds in 2015.

A wide range of services are provided as part of this contract including:

- Community nursing;
- Community therapies;
- Intermediate care and rapid response – Community Response Teams;
- Community hospital inpatient care;

- Community Rehabilitation and Intermediate Care Units;
- Single Point of Access to Community Services;
- Specialist nursing services.

As part of the Better Care Fund, a national initiative to pool health and social care funds to invest in new models to deliver integrated care, the Trust has delivered pilot services within Care Hubs serving the populations of Selby and District and Ryedale. Within the Care Hub are:

- Community Response Teams providing intermediate care integrated with social care reablement services;
- Care home inreach schemes involving Consultants, GPs and specialist nurses;
- Older Persons Clinics providing complex care planning from Consultant Geriatricians;
- Social prescribing through a Community Enabler.

The scope of this strategy also reaches beyond the boundaries of services within the community contract. Fundamental to its delivery is the partnership working with a range of local providers and stakeholders. These include (but are not limited to) primary care, social care, voluntary and community organisations, local government, mental health providers and the independent care home sector. Within the Vale of York Clinical Commissioning Group (VoYCCG) area, a Provider Alliance Board has been established, bringing senior leaders from these organisations together to develop and deliver shared work streams.

The strategy also incorporates a range of services delivered by YTH within its main acute contracts, traditionally delivered in acute hospital settings. As more services are identified to be delivered closer to people's own homes this range will grow. The Trust will exploit the opportunities offered as an integrated provider of both acute and community services to challenge the traditional models of care.

Outside the scope of this document, is work within the community setting which involves children and young people. Neonatal, children and young people's community services are delivered by the child health directorate who are currently working with CCG colleagues to develop a child health strategy which includes the recommendations from the Royal College of Paediatric and Child Health (Facing the Future Together for Child Health 2015 standards). These standards apply across the unscheduled care pathway to improve healthcare and outcomes for children, focussing on the acutely mild to moderately unwell child. They aim to ensure there is always high-quality diagnosis and care (safe, effective and caring) early in the pathway, providing care closer to home where appropriate (right care, right time and right place). The standards will ensure specialist child health expertise and support are available directly into general practice services, where the needs of the child and their family are known. The standards will build good connectivity between hospital and community settings; primary and secondary care; and paediatrics and general practice.

There are three overarching principles and 11 standards in total. Standards one to six focus on supporting primary care, to care for the child in the community, preventing unnecessary attendance at an emergency department or unnecessary admission to hospital. It will of course be necessary for some children to be cared for in hospital, and standards five to eight focus on reducing length of stay and enabling children to go home again as safely and as quickly as appropriate (while preventing unnecessary reattendance and readmissions). Standards nine to eleven look more widely at connecting the whole system, streamlining the patient journey and improving the patient experience. Facing the Future Together for Child Health represents a standard of care which children and their parents and carers can expect from the healthcare professionals looking after them.

Local Demographics and Health

Overall, the communities served by YHT are less deprived than the England averages. The 2015 Joint Strategic Needs Assessment (JSNA) updates for the Vale of York and Scarborough and Ryedale CCGs give an insight into local demographics. They show that the population of the Vale of York CCG is 353,000 with 20% of these being over the age of 65 years (compared to 18.1% on average in England) and 3% over the age of 85 (compared to 2.8% on average in England). It is predicted that there will be an increase of 17.7% in the over age 85 years population by 2020. The Scarborough and Ryedale CCG population is shown to be 110,500 with 25% of these being over the age of 65 years and 3% over the age of 85 years. It is predicted that the over age 85 years population will rise by 15.7% by 2020.

The JSNA updates highlight that Vale of York CCG has a higher prevalence of stroke than the England average with a high number of admissions for heart attacks, stroke and kidney diseases for people with diabetes. Coronary heart disease prevalence is also higher than the national average. For Scarborough and Ryedale CCG the report highlights that long term conditions including asthma, cardiovascular disease, Chronic Obstructive Pulmonary Disease (COPD), hypertension and stroke are all significantly higher than national averages, contributing to higher than national average rates of premature death from cardiovascular disease.

The population is a mix of urban centres and rural areas and despite the overall lower deprivation there are areas of specific deprivation with 14 of the 18 most deprived Lower Super Output Areas (LSOA) for North Yorkshire being in Scarborough. The Vale of York has 10 LSOAs which are within the 20% most deprived in England (9 of these are in York, 1 in Selby). The figures also fail to account for rural poverty caused by higher living costs related to heating and travel. The table overleaf shows the 2015 health profiles for the main populations covered by the Trust.



	Population	Life expectancy	Health needs	Local priorities
Ryedale	52,000 Deprivation lower than England average but 10% children live in poverty	1 year better than national average for men National average for women Gap between most and least deprived areas is 4.4 years for men and 5 years for women	Worse than England average for: • Excess weight • Excess winter deaths • Killed or injured on roads	Reducing inequalities in cardiovascular disease Reducing prevalence of obesity Reducing harm caused by alcohol
Scarborough	108,000 Deprivation lower than England but 19% children live in poverty. Long term unemployment is significant worse than the England average	1 year worse than national average for both men and women Gap between most and least deprived areas is 12.5 years for men and 5.6 years for women	Worse than England average for: • Excess weight • Prevalence of opiate use • Smoking related deaths • Deaths from cardiovascular disease • Killed or injured on roads	Reducing inequalities in cardiovascular disease Reducing prevalence of obesity Reducing harm caused by alcohol
Selby	85,000 Deprivation lower than England but 12% children live in poverty.	At national average for men and women Gap between most and least deprived areas is 4.7 years for men and 6.9 years for women	Worse than England average for: • Excess weight • Excess winter deaths • Deaths from cancer • Killed or injured on roads	Reducing smoking prevalence Reducing prevalence of obesity Reducing harm caused by alcohol
York	202,000 Deprivation lower than England but 12% children live in poverty	At national average for men and women Gap between most and least deprived areas is 7.4 years for men and 5.8 years for women	Not significantly worse than England average for any indicator	Giving every child a good start in life Alcohol Mental health

National Context

People today are living longer, healthier lives than ever before. Once fatal diseases can be cured or managed, this adds years or even decades to a person's life. This is an extraordinary achievement and testament to the many who have dedicated their lives to improving people's health and wellbeing. But progress brings challenges, people may be living for longer but they are often living with several complex conditions. In 2014, over 15 million people in England lived with one or more long term conditions. At age 35 years, only 10% of the population will suffer from two or more chronic conditions, by age 60 this rises to 50% and for those aged over 85 years it is 80%. For those aged over 75 years, 50% of people will have 3 or more chronic conditions, 10% will have 5 or more.

As a result of this, demand for acute hospital care is increasing in England. Demographic change alone is estimated to lead to 1.7% annual growth in demand for acute hospital services and this is expected to be compounded by changes in disease prevalence. The Nuffield Trust estimates that without changes in the way in which care is provided, 17,000 new hospital beds will be needed in England by 2021-22.

Research has highlighted the harm done to patients by de-conditioning associated with hospital stays. For older people, within 24 hours of admission muscle power reduces by 2-5% and circulating volume (blood) by up to 5%. Within 7 days, circulating volume can reduce by up to 20%, oxygen uptake reduces by 8-15%, muscle strength reduces between 5-10%, functional reserve (lung) capacity by 15-30% and skin integrity reduces. 10 days in a hospital bed leads to the equivalent of 10 years ageing in the muscles of people aged over 80. Not only is hospital based care unaffordable, it harms the people it exists to help.

The NHS Five Year Forward View, published in 2014 and developed by all the major national health bodies, set out a clear direction of travel for the NHS through to 2020. It showed that the projected gap between spending and funding would be £30 billion by 2020 if action is not taken to change how care is delivered. Although the 2015 Comprehensive Spending Review confirmed the government's election promise to fund the £8 billion requested from central government to meet the gap, this leaves £22 billion of efficiency savings for the NHS to deliver.

The guidance argues for a more engaged relationship with patients and carers, setting up partnerships with local communities, the need for local flexibility in breaking down barriers in how care is provided and the need for care to be provided more locally. There is a strong focus on the importance of prevention and empowering people with long term conditions in managing their own health. It also proposes new care models, which were to be tested through local 'vanguard' sites. As well as urgent and emergency care networks and smaller viable hospitals these models included:

- Multi-specialty community providers (MCPs) – primary care led models where groups of practices work together to deliver services to a local population, including many that would traditionally be provided in an acute hospital setting;
- Primary and Acute Care Systems (PACS) – vertically integrating primary care with acute providers providing care to defined populations.

'Delivering the Forward View: NHS planning guidance 2016/17-2020/21' provided detailed advice for the NHS on implementing the Five Year Forward View. It highlights the move towards place based planning for populations rather than organisation based planning. It specifies that local leaders need to come together as a team to produce a Sustainability and Transformation Plan (STP), developing a shared vision with local communities and planning

a programme of activities to deliver this. Our local Sustainability and Transformation Plan will set out how collectively we will:

1. Close the health and wellbeing gap through a 'radical' upgrade in prevention, patient activation, choice and control and community engagement;
2. Close the care and quality gap through new care model development, improving against clinical priorities and rolling out digital healthcare;
3. Close the finance and efficiency gap through achieving financial balance across the local health system and improving the efficiency of NHS services.

The King's Fund has produced a range of documents supporting organisations to identify the key priorities and outcomes required to meet the challenges associated with caring for an ageing population. 'Making our Health and Care systems fit for an ageing population' outlined 10 key components of care that should be in place:

1	Healthy, active ageing and supporting independence
2	Living well with simple or stable long-term conditions
3	Living well with complex co-morbidities, dementia and frailty
4	Rapid support close to home in times of crisis
5	Good acute hospital care when needed
6	Good discharge planning
7	Good rehabilitation and reablement after acute illness or injury
8	High quality nursing and residential care for those who need it
9	Choice, control and support towards the end of life
10	Integration to provide person-centred co-ordinated care

In 2013, the King's Fund, in recognition of the focus on the necessary structural changes in the 2008 Transforming Community Services programme, produced 'Community Services: How they can transform care' which identified the following main steps:

- Reduce complexity of services;
- Wrap services around primary care;
- Build multi-disciplinary teams for people with complex needs;
- Support these teams with specialist medical input and redesigned approaches to consultant services – particularly for older people and those with chronic conditions;
- Create services that offer an alternative to hospital stay;
- Build an infrastructure to support the model based on these components including much better ways to measure and pay for services;
- Develop the capability to harness the power of the wider community.

The report goes on to say that this approach requires locality based teams that are grouped around primary care and natural geographies and with a multi-disciplinary team, offering 24/7 services as standard and complemented by highly flexible and responsive community and social services. It advises that the new service needs to be capable of very rapid response and to work with hospitals to speed up discharge.

In 2013, the National Collaboration for Integrated Care and Support (bringing together the main national bodies for health and social care along with the National Voices coalition of health and social care charities) published 'Integrated Care and Support: Our Shared Commitment'. This formed a call to action for health and social care organisations to make integrated care and support happen. The document provided a definition of integrated care,

developed through engagement with people who use services, and stated, "*I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me*". As with the Five Year Forward View, the document emphasised the importance of local systems coming together with their communities to be innovative in delivering this. The shared vision for the collaborative was for integrated care and support to become the norm over the following five years (to 2018).

The National Voices paper 'Integrated care: what do patients, services users and carers want?' emphasises that whilst patients and users of services identify integration as a key priority, this is an expectation that professionals work together 'as a team around the patient' rather than an interest in organisational integration. The paper also emphasises that services working in a planned and co-ordinated way was a means to delivering the things that people told them matter to them – continuity of care; smooth transitions; fast access; effective treatment; respect for their preferences; support for self-care and the involvement of family and carers. **It is important to remember that integration is a means to these ends rather than an end in itself.**

In 2015-16, the national Better Care Fund initiative mandated local areas to pool part of health and social budgets (equating to £3.8 billion nationally) to improve outcomes for the public, provide better value for money and ensure services are more sustainable. The pooled budget was shared between the NHS and local authorities to fund services that would deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. The performance element of the fund focussed on the avoidance of hospital admission. The guidance for 2016-17 suggests that this focus will be widened to include delays in transfers of care, a recognition of the importance in integrated services working to support a rapid transition to people's usual place of residence following an acute hospital admission.

The 2015 'Population health systems: Going beyond integrated care' from the King's Fund challenges those involved in implementing the changes laid out above to 'join up the dots' with public health and extend this to consider the broader health of local populations. It recognises that health is affected by a wide range of determinants and therefore improving population health is not just the responsibility of health and social care services but requires co-ordinated efforts across population health systems. They identify a small number of examples from other countries where this has been successfully employed. The move to considering population health fits closely with concepts of 'place based' care where services are built around localities and their communities.

In 2015, Think Local, Act Personal convened a summit of national leaders who described their shared commitment towards engaging and empowering communities to achieve sustainable health and well-being. This commitment is to create the conditions for strong and inclusive communities:

- create communities and places that enable people to live healthier lives, nurture strong connections between people and empower the most marginalised to have a voice in local decision making;
- design local services that enable aspiration and contribution, strengthening community connections rather than replacing them;

- remove the barriers and create the right conditions for community-centred approaches to flourish;
- encourage commissioners and communities to develop shared plans.

In addition to the guidance supporting a move to new models of integrated care (as opposed to 'health' and 'social' care) is research supporting moves to transfer care out of hospital settings. In 2011, the Health Foundation produced 'Getting out of hospital?' which reviewed the available evidence comparing the effectiveness of hospital based care with community equivalents. It concluded that, whilst the evidence on cost suggesting that savings could be made was not yet sufficient to be certain that this would always be the case, the findings on patient satisfaction were less equivocal. Patients expressed greater satisfaction with treatment at home regimes compared with hospital inpatient care. The findings also showed that health outcomes in most studies were broadly similar for community based services and inpatient care.

These findings were replicated in the 2015 Monitor report 'Moving healthcare closer to home' which noted that schemes are likely to have clinical outcomes that are equal to hospital care and sometimes better. Their financial analysis showed that, when implemented well, schemes could deliver care at a lower cost than comparable care in an acute setting in the longer run. However, they also noted that even where schemes offer lower cost per patient interventions it is difficult for local systems to realise the savings. This is due to the need to close inpatient capacity to make savings and the confidence in commissioners and providers that community schemes can absorb existing activity and predicted demand rises before doing this. The report also notes that it can take up to three years to see the impact of schemes. It concludes that well designed schemes can bring patient benefits and may be able to deliver care at lower cost over time. It advises that such schemes should be developed, such as providing more proactive care to prevent people from entering crisis to address the immediate challenges facing acute hospitals.

Strengths, Weaknesses, Opportunities and Threats Analysis

We have conducted an analysis of the strengths, weaknesses, opportunities and threats presented for us as a provider of community services.

Strengths	Weaknesses
Integrated provider of acute and community services Community services rated 'Good' by CQC Track record of implementing change in community Relationship with local authorities and GP federations – including through the Provider Alliance Board	Historic under investment in community services, Workforce recruitment challenges particularly in Scarborough and Ryedale, Geographical spread of services impact on economies of scale, Under-developed market for long term care
Opportunities	**Threats**
System is signed up to delivering new models of out of hospital care Relatively high number of community beds offers opportunity to review community bed base resources differently to support home based models of care	The health and social care system is financially challenged, YFT projected deficit in 15/16 Procurement of community services could distract from transformation efforts

Factors Driving Change

In summary, the following factors are driving this strategy:

- The harm done to people by the de-conditioning impact of bed based care;
- Meeting the predicted rise in demand from our ageing population;
- National policy directive to move to new models of care in order to meet the £22 billion efficiency challenge to 2020;
- The need to deliver the seamless, co-ordinated care people who use our services deserve;
- To implement the best practice identified nationally, and internationally, in delivering place-based, population health;
- To close the gap in health inequalities across our communities.

What will our priorities be?

> *"The nature of the 'patient' or 'service user' in a community context is very different from other parts of the NHS. Other parts of the NHS clearly deal with patients who recognise themselves to be patients, seeking specific care and treatment for specific needs, in institutions designed for that purpose. Community services support people in their homes and neighbourhoods when providing care. They have the privilege of access to the homes of the people they support and are guests there. They support people with information, motivation and advice about health and lifestyle, especially in the context of health visiting and school nursing. The label* patient *is neither useful nor meaningful for many of these important services."* Community Health Services: A Way of Life

National Priorities

The national guidance and best practice documents summarised to date present a clear direction of travel for out of hospital services. Services will need to:

- Focus on prevention and supporting individuals to self-care;
- Be joined up, with traditional health, social and voluntary sector organisations integrating around the needs of individuals;
- Be able to respond rapidly to support people in, or before, a crisis;
- Have a seamless interface with hospital based services to ensure patients can return home as soon as possible;
- Redesign the roles of specialists to ensure these can support new models of care;
- Work with local communities and stakeholders in designing new models of care that are delivered in the community rather than hospital;
- Be delivered consistently over seven days.

The key outcomes that services must deliver can be found in the national outcomes frameworks for the NHS, Adult Social Care, Public Health and the Better Care Fund. In delivering this strategy, it will be important to consider how developments contribute to these outcomes. The high level outcomes are displayed in the table below. Both the Vale of York CCG and Scarborough and Ryedale CCG have confirmed their intention to move towards outcome based contracts for community services. Whilst these outcomes are still to be finalised, it is anticipated that these will draw from the national frameworks.

NHS Outcomes Framework	Adult Social Care Outcomes Framework
1. Preventing people from dying prematurely 2. Enhancing quality of life for people with long-term conditions 3. Helping people to recover from episodes of ill-health or following injury 4. Ensuring that people have a positive experience of care 5. Treating and caring for people in a safe environment and protecting them from avoidable harm	1. Enhancing quality of life for people with care and support needs 2. Delaying and reducing the need for care and support 3. Ensuring that people have a positive experience of care and support 4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm
Public Health Outcomes	**Better Care Fund Outcomes**
1. Improving the wider determinants of health 2. Health protection 3. Health improvement 4. Healthcare, public health and preventing premature mortality	1. Reducing the number of emergency admissions 2. Reducing delayed transfers of care 3. Improving the effectiveness of reablement 4. Reducing admissions to residential and nursing care 5. Improving patient and service user experience 6. Reducing falls (local measure)

Trust Strategic Vision

York Teaching Hospital NHS Foundation Trust has the ultimate objective **to be trusted to deliver safe, effective and sustainable healthcare within our communities**. Through our values of **caring** about what we do; **respecting** and valuing each other; **listening** in order to improve and always doing what we can to be **helpful**, the Trust seeks to:

- Improve quality and safety;
- Develop and enable strong partnerships;
- Create a culture of continuous improvement;
- Improve our facilities and protect the environment.

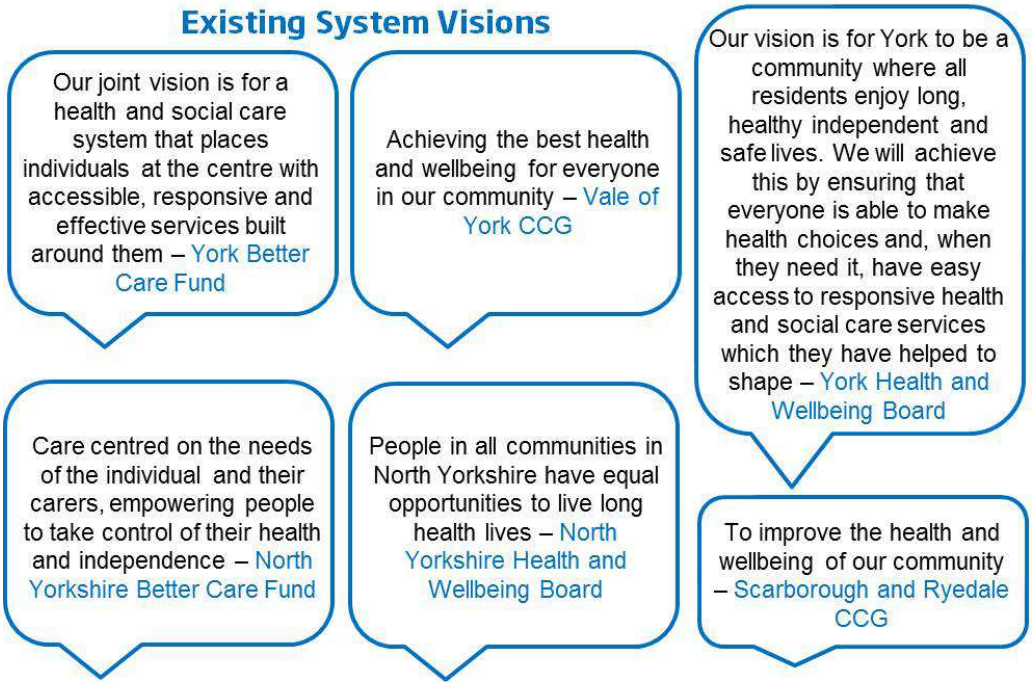
The Trust's key strategic themes are to:

- Be a valued and trusted partner within the local care system(s);
- Save and improve lives through reliable and safe care;
- Recognise our role and potential in promoting health and wellbeing;
- Drive service efficiency to deliver planned financial performance;
- Develop out of hospital care and lead the integration of services throughout the whole system in each of our localities;
- Be the community and secondary care provider of choice for the population we serve;
- Seek and cultivate alliances with other secondary care organisations which benefit our populations;
- Maintain and grow our Provider services in the interests of developing integration;
- Work with partners to reconfigure services across our localities - specifically:
    - Separate elective and emergency care delivery;

  - Maintain the viability of Scarborough hospital as a provider of acute, consultant led obstetrics and paediatric care;
- Develop and reform emergency care with less emphasis on admission and greater focus on rapid diagnostics, assessment and ambulatory care;
- Increase our market share for elective services;
- Develop and grow our specialist services;
- Recruit and retain the necessary workforce and ensure we offer opportunities for each member of staff to maximise their potential;
- Become a high quality, high volume deliverer of research.

Local System Strategic Vision

In developing a vision for out of hospital services it is important to consider the visions and priorities of the wider system. Some of these are displayed in the diagram below.



A whole system event was held in the Vale of York in June 2015, involving commissioners and providers from a range of services. The event discussed the feedback collated by the CCG from engagement activities with local people who told them:

"I only want to tell my story once"
"I want good information to help me plan my care"
"I want to feel safe and trust my provider"
"I want fast access to care and support"
"I want my care to be coordinated through a key link person"

It concluded that the collective vision for integrated care was "*We will support and enable the population of the Vale of York to improve their health and wellbeing by organising our services around the needs of the person, their family and the community to provide integrated care and support.*"

Developing an Accountable Care System in York

Currently, the health and care community in York is facing unprecedented financial and service delivery pressure. This is due to some of the factors listed previously but also that:

- Our current care pathways are particularly unfit for older people and the current way care is funded and structured does not support clinical teams in radically redesigning care for this key group;
- The health and care system will overspend by more than £50M in 2015/16. This includes both a significant overspend on the CCG funding allocation and also importantly, and for the first time, an overspend on provider budgets in both York Hospital NHS Foundation Trust and City of York Council adult social care. There is absolute understanding across all partners that an overspend of this level is unacceptable and unsustainable and requires radical solutions that both reduce overhead costs and support the delivery of integrated and more efficient care pathways. The emerging consensus is that doing more of the same is not a viable option and that planning and delivery at scale through the merging and sharing of both clinical and non-clinical resources is required;
- The system is also failing to meet its urgent care targets in-year with recognition across all organisations that this is a result of system-wide issues, particularly in relation to the care of frail older people. There is a shared desire to improve urgent care, again through radical pathway redesign and the delivery of new care models that span primary, community acute and social care;
- Related to the point above, care pathways for too many patients are currently highly fragmented and disjointed, with too many 'hand-offs' and an inappropriate 'default' to hospital care for many people who would be better treated in their own homes or in community facilities by primary, community and social care teams;
- It is recognised that the local system is paternalistic and risk averse in its approach to supporting health and social care need, in turn this has driven a culture of dependency and an over reliance on statutory service provision. There is little emphasis on early intervention and access to alternative provision and support that in turn empowers individuals to manage their own condition;
- There is limited opportunity or incentive to focus on city-wide 'wellness' or prevention of ill health. The current funding and regulatory systems do not allow individual organisations to prioritise work in this area, which will be required to improve population health for future generations and reduce the financial burden of ill health in York in future years;
- Local GP Practices are experiencing overwhelming demand for primary care services. Primary care development and reform are an essential component of system transformation, ensuring this is effectively supported and resourced is essential.

In particular the current system:

- Doesn't support strong system leadership;
- Has high transaction costs coupled to short-term contracts which are a disincentive to health and social care providers to come together to deliver better quality healthcare within the limited resources available;
- Doesn't support integrated IT systems and telehealth which have been shown to support improved care for this group in other systems in the UK and internationally.

There is a history of partnership working across York as an integrated care pioneer and there is an aspiration across acute, primary and social care and between commissioners and providers to develop new models of care that will improve clinical quality and patient experience and, over time, will offer benefits to population health.

In relation to the provider landscape, York Hospital NHS Foundation Trust is the local acute and community provider and already delivers a diverse range of integrated services from both acute and community sites across York, Selby, Scarborough, Ryedale and Bridlington. We are committed to working in partnership with other organisations and agencies to ensure the delivery of high quality, integrated care.

The Vale of York GPs have recently outlined their intention to integrate primary and community care services, delivering integrated provision to support a defined geographical area. There are now emerging plans for GP practices to 'cluster' or create 'hubs' to ensure that local, accessible enhanced primary care is provided taking a place-based approach. The two groups need to be supported to work together (and with colleagues from City of York Council) to design new care pathways that are both more cost effective and improve experience and outcomes (as they reduce duplication and enable more people to be cared for outside of hospital).

It is recognised by the organisations within the York health and care system that current organisational and financial structures do not support this integrated working and that internationally other systems have addressed similar issues successfully by creating Accountable Care Systems (ACS) or Accountable Care Organisations (ACO). There is therefore a desire to explore further the option of developing a model that delivers accountable care in York that creates a single health system or organisation for the whole population incorporating both health and care services and with a single budget covering provision and commissioning.

In achieving accountable care in York it is recognised that this must address the documented issues which are flagged in the Vale of York CCG turnaround plan. This would include improving individual and population health, promoting primary and preventative care and lessening the need for expensive services. Over time, the aim would be for the population to experience improved health outcomes and lower costs, thereby reducing reliance on intensive care intervention.

Commissioning Intentions

The Vale of York system-wide integration event in June 2015 identified a series of high level actions for moving towards the new system vision. These included:

- Create new team identities based on a defined locality with a sense of community;
- Create seamless multi-professional and multi-disciplinary teams across all partner organisations with a skill set to meet local needs;
- Work to improve professional roles through bringing specialist skills into locality teams;
- Empower teams to take decisions that put the person and their needs and choices first; identifying "what matters to you" not "what is the matter with you";
- Work to organise and co-ordinate services with people rather than refer people to services;
- Work constructively as a flexible system that is informed by feedback, learning from mistakes, errors and successes;
- Ensure that all services have the ability to respond to patient need rapidly when needed, supporting the delivery of high quality, effective care;
- Implement a new informatics system that draws information from across agencies through an interoperable platform;
- Join up commissioning budgets and approaches to support integration and to share risk and reward;

- Rebalance investment towards prevention and early intervention to optimise health and well-being and support independence;
- Seek out examples of duplication as a system and actively remove and disinvest in these services.

In its case for procuring community services, Scarborough and Ryedale CCG set out the changes they expected to see in moving towards their vision. These included:

- Providing easy access to high quality, responsive primary care – GPs and primary care teams will be at the centre of co-ordinating out of hospital care;
- A greater emphasis on keeping people healthy, preventing ill-health and reducing health inequalities – all healthcare professionals will have a role to play;
- Clearly understood planned care pathways to ensure care is delivered outside of the hospital setting;
- Providing services that are available and accessible in the community to meet the needs of the population;
- Providing rapid response to urgent needs to prevent the need to access hospital services;
- Health and social care providers working together with the patient at the centre to proactively manage long-term conditions, frail elderly and end of life care outside of hospital;
- Patients having a named co-ordinator and GPs and patient teams having rapid access to specialist skills closer to home;
- Early supported discharge into proactive organised community care so that patients spend an appropriate time in hospital if required.

Organisations have come together in the Scarborough and Ryedale area to form the Ambitions for Health programme. This will tackle a range of issues facing the local health and social care system, including a dedicated out of hospital workstream.

Our Vision for Out of Hospital Care

Based on the national drivers and local system perspectives we have developed a vision for out of hospital care. This is:

Community First.

We will work within the local system to adopt a 'Community First' culture which focuses on prevention and self care; delivers care closer to home and allows the system to manage growing demand by increasing efficiency through integration.

We will deliver this vision by adopting the principles shown in the diagram below. This also shows how the principles relate to the national planning guidance. The following section explains each of the principles in more detail.

Principles for Out of Hospital Services



1. Promote independence through prevention and self care.

We recognise that we need to move from being a paternalistic service provider which does things to and for people, creating a culture of dependence, to supporting and empowering people to take responsibility for their own care needs. We will draw on the existing strengths of staff in community services to develop a coaching culture across our workforce, building the expertise and confidence to manage their long term conditions (as they do already for the 99% of time when professionals are not present).

We will work with the public health unit, local authority and voluntary sector colleagues on initiatives to support the prevention of ill-health, including the wider factors that impact on an individual's health and well-being. This could include the redefining of specialist input to target those at risk of ill-health rather than, as now, those with the most acute needs. We will exploit the potential of personal health budgets to allow people to take control of decisions regarding their care and support.

2. Person-centred, co-produced support involving families and carers

We need to move from asking "what is the matter with people" to basing our interventions on "what matters to them". We need to focus on helping people to achieve the things that are important to them and this will require involving people in developing care plans and listening to what they tell us.

We need to recognise the role of families and carers and the wealth of knowledge they possess. By fully including them as part of the care team we can harness this and ensure that their views are heard and acted upon. We also need to recognise the importance of carers in preventing people from accessing higher levels of care and support and ensure that their needs are considered when assessments take place.

3. Co-produced new models of care (services) with home as first choice, delivered over seven days

Working on the principle that those who are affected by a service are best placed to help design it we must ensure a broad range of stakeholders can come together to design the new models of care that will transform our system. Whilst recognising the importance of standardisation in delivering our efficiency requirements we need to free local innovation to design the models that best meet the needs of local communities.

As part of our culture of 'Community First' we need to ensure all services are designed to be delivered in, or as near to, a person's own home or place of residence as possible. We need to challenge ourselves as to why a particular service cannot be delivered at home, rather than making the case for moving services out of acute settings. To deliver this will require us to spend less money on 'beds' and spend more on home based support services.

Recognising that people's care needs do not correspond to office hours we need to ensure that services are available at the times they are needed, across seven days of the week.

4. Co-ordinated, integrated and joined-up care that people can easily navigate

We know that often the frustrations reported by users of our services arise from trying to navigate the 'system' with confusion over the different people involved in their care. As part of delivering more person-centred care we need to ensure that the staff supporting an individual work together, regardless of their employing organisation. We need to model this in how organisations work together in the system and listen to what staff working on the front-line tell us are the barriers to doing this.

As we develop new models of care we need to reduce, not increase, complexity in the system, making it easier for professionals and those who use services to access the right support, first time. Linked to the need to avoid duplication we need to ensure that people only have to tell their story once and not be subjected to repeated assessments. We will ensure that integration is a means to delivering the best care, rather than an end in itself.

5. Timely and rapid response to prevent admission to hospital or a care home

We recognise that if community based services are to offer a credible alternative to hospital admission they must be able to respond quickly to identified needs. Whether addressing a crisis or providing support to prevent a crisis occurring, services need to provide an urgent response to prevent further deterioration, giving confidence to individuals, their families and carers and, not least, to referrers.

In order to achieve this we must plan for sufficient capacity in services, where teams are constantly working at 100% of capacity there is no flexibility to respond urgently as required. We need to understand the demand and activity associated with key services in order to do this, including where this cuts across a number of services providing similar functions.

6. Seamless interface to facilitate safe and timely discharge from hospital

We know that prolonged hospitalisation harms the people we aim to care for and therefore we need to ensure that we provide robust intermediate care services that allow people to return to their home as soon as it is safe to do so. As an integrated provider we need to simplify the process to move from acute to community settings and create a culture where patients are 'pulled' from hospital back into the community at the earliest opportunity.

We need to understand the needs of patients coming home from hospital to make sure community services are designed to meet these, building the confidence of hospital teams to allow patients' care to continue in their own homes. We also need to ensure that we reduce the de-conditioning impact of hospitalisation by promoting independence wherever possible for inpatients. This will facilitate their transition home and also minimise the support required for individuals upon returning home.

7. Remove duplication, ensuring cost-effectiveness and value for money

We must ensure that every pound spent is used to its greatest possible effect. This means we must be relentless in our efforts to remove waste, particularly duplication, from our services. This could be ensuring assessments that have already taken place are not repeated; for instance through 'trusting' assessments that have already been completed, or simplifying referral processes so the right person attends first time.

We need to benchmark with peers and adopt best practice; to do this we have to ensure that our information is robust and consistently collected.

What will we do differently?

> *"The NHS needs to be free to both develop its new models of community-based, person-centred care and deliver its traditional services at the same time. Transition is not instant; it takes time, commitment, experimentation, imagination, investment and conviction."* Community Health Services: A Way of Life

If our vision is to become a reality, we will need to transform how we work. This will not happen overnight but we need to ensure that all efforts and action are moving us toward this. As a system, we need to commit to making this happen; ensuring resources are dedicated to the change we want to see. We will need to prioritise the developments that can make the greatest impact or those that enable wider change to be delivered. The actions we will need include:

- Deliver care closer to home, where it makes sense to do so; delivering care at home must be the default position;
- Be based on clinical evidence and best practice;
- Aim to deliver fewer hand offs, repeated assessments and delays;
- Support people/families to keep well and stay healthy;
- Detect problems early and prevent deterioration (early diagnosis, assessment and care planning) – most studies suggest that 20-30% of admissions in people over 75 years old can be avoided if appropriate alternative services are available, most notably intermediate care services;
- Keep people out of hospital and long term care where appropriate to do so – increasing bed numbers in response to increasing demands may in fact increase length of stay with no actual benefit on patient throughput;
- Facilitate timely and supported discharge;
- Deliver services in a joined up way with partners/other stakeholders;
- Empower patients to be independent, instead of promoting dependency – to do this, we have to listen to what is important to the person, traditional assessments have a tendency to focus on what is important to us.

Making the vision a reality - Developing Care Hubs in 2015/16

In 2015 York Teaching Hospital FT worked with partners (including North Yorkshire County Council, local GPs, voluntary service organisations and our commissioners) to test new ways of working in Selby and Ryedale. Our 'care hubs' provide enhanced support to people to allow them to remain in their own homes during a health crisis or to return home sooner following a stay in hospital. Health and social care staff work together providing short term support when people need it most. Between February and November 2016, over 1,150 people had received support from the teams – with around 2,500 contacts every month.

Our teams were established with a learning culture, meaning they are always seeking ways to improve and develop their service. With this in mind both teams held large events in September and October 2016 where they invited people with an interest in the service to come and tell them what was going well, and what they could do better. This included a range of people who had used the service who were able to share their moving experiences of the difference it had made to their lives, and to those who provided care and support to them.

Within our 'care hub' developments we have also looked to provide support to people who live in care homes. A consultant who specialises in the care of older people carried out reviews in partnership with GPs, specialist nurses and care home managers. These looked at the medicines people were taking, stopping those that offered little benefit, and the care plans that were in place. They discussed with individuals and their families what their preferences were and jointly agreed the best treatment options. Over 500 care home residents have now been reviewed and plans are in place for this to continue in 2016. In Ryedale, these reviews resulted in over 200 medicines being stopped and over 150 new care plans being put in place.

Within our Ryedale service we were also excited to trial a new partnership with the voluntary sector. Coast and Vale Community Action (CAVCA) support community and voluntary organisations across Scarborough and Ryedale and have re-located to base themselves in the hub. We worked together to develop a new 'Community Enabler' role, employed by CAVCA, who can provide signposting and guidance to those using our services to find community support to maintain their independence. This could include local activity clubs, help with managing correspondence or dementia services.

What is next for 2016-2017?

The developing care hubs were designed with commissioners to understand how we could deliver services in the community that would be fit for the future and fit with our vision for 'community first'. We know that we cannot do this alone. The King's Fund recently published 'Place Based Systems of Care' which outlined the changes the NHS organisations needs to make to work differently with partners in our communities. The report drew attention to the development in York of a 'Provider Alliance Board' where those who provide health and care services (including voluntary organisations) come together to agree on new ways of working.

The Provider Alliance Board is developing a blue print for a new model of care in the community. Working in defined geographical areas we want to bring together those working in the community into integrated teams, working in partnership with local GP surgeries. This will help us to deliver what people have told us matters to them – only needing to tell their story once, better co-ordination between the different individuals who provide support and helping them to achieve the goals that are important to them.

New Pathways of Care - 2016-2021

In order to deliver the seven priorities that we have identified and to make 'Community First' a reality, we will incorporate the local commissioning intentions and learning from our Care Hub pilots into a planned programme of works. We have organised these into three key themes which are as follows:

1. Developing integrated community services to support localities;
2. Developing the interface between acute and community services;
3. Moving services from acute to community settings.

In the following section we will show what we will do differently under each of the themes and describe the associated outcomes.

1. Developing integrated community services to support localities

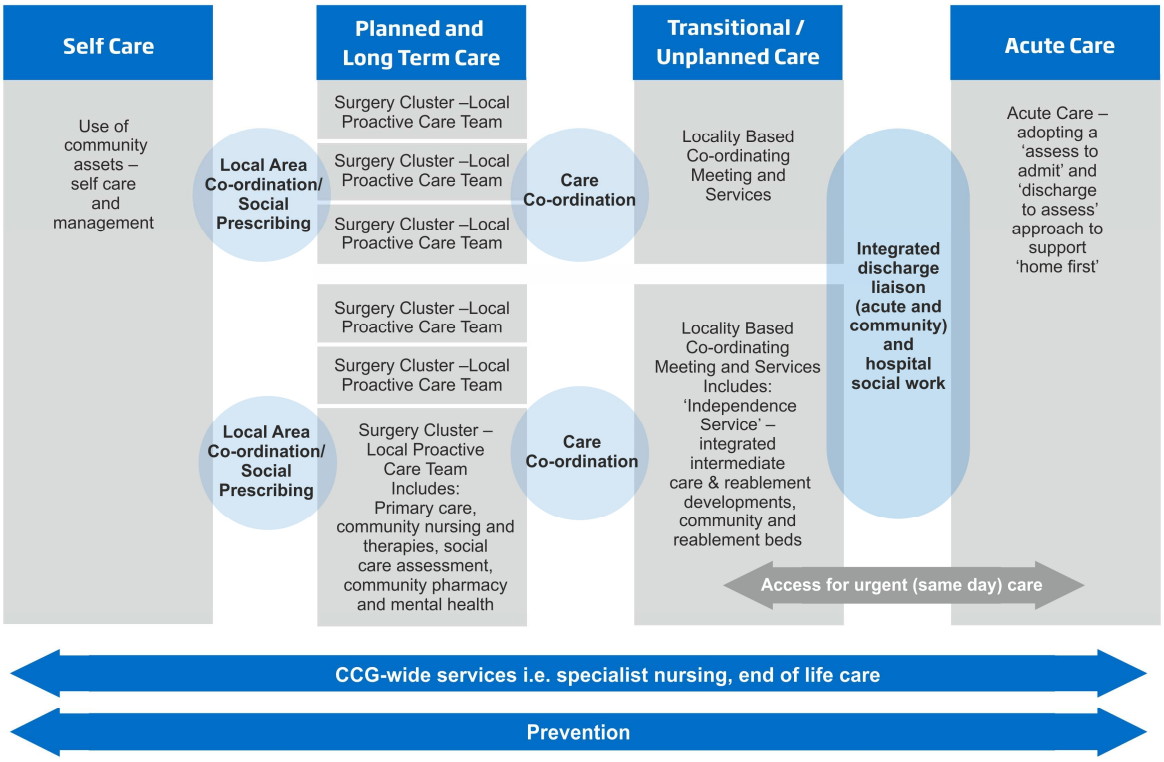
Current pattern of care

The people who work in and use our services tell us that the quality of care received from individual teams is good, with staff going above and beyond to support people on their caseloads. We know that this breaks down where individuals need support from multiple teams. This can be co-ordinated, but requires significant effort from individuals and professionals to navigate. Roles and functions of teams in the community can vary from place to place, as do levels of commissioned capacity. Years of focus on individual organisational performance has created artificial barriers which are a frustration to frontline staff.

We also know that there is a complexity resulting from the range of different services and teams, operated by different providers. These often perform similar functions and many have criteria or referral processes that can be confusing to those trying to access services. A focus on delivering care and measuring process steps has made it harder for staff to consider the whole person and undertake prevention activities.

What will we do differently?

Providers (across all health and social care settings and the third sector) and commissioners have come together to design **new integrated care models** to support our localities. The section 'How we will work together' gives more details on the changes to localities and partnerships that will underpin this transformation. The new care models reflect the need for local innovation but provide a template for design that incorporates the key features expected. The diagram overleaf shows an overview of the model.



At the Transitional / Unplanned Care level we would expect the functions of rapid response and facilitated and supported discharge to be delivered. At the Planned and Long Term Care level we would see maximising independence, complex care management and planned ongoing care be delivered. **Care co-ordinators** working across GP surgeries would provide a navigation function for both individuals and professionals.

We will also implement a workforce development programme for **developing self-management and peer support** ensuring that this runs through all of our services. We will continue to work with partners to develop our models of **support to care homes** ensuring that residents can access high quality preventative support and also a timely response to deteriorations in health.

2. Developing the interface between acute and community services

Current pattern of care

We know that the current provision of intermediate care services (those that can provide short term support to allow someone to remain at home or return home sooner) is inconsistent across the communities we serve. We also have different models of care in place in different areas. For referrers, particularly our acute hospitals who care for patients from across a range of localities, this can be confusing and makes referrals into services less likely to happen. Insufficient capacity in some areas can mean people are not able to receive the support in a timely enough manner to prevent admission or can need additional days in hospital until capacity becomes available.

Whilst our Care Hub pilots in Ryedale and Selby bring intermediate care and reablement closer together, there is much more that we can do across all of our localities to join up the

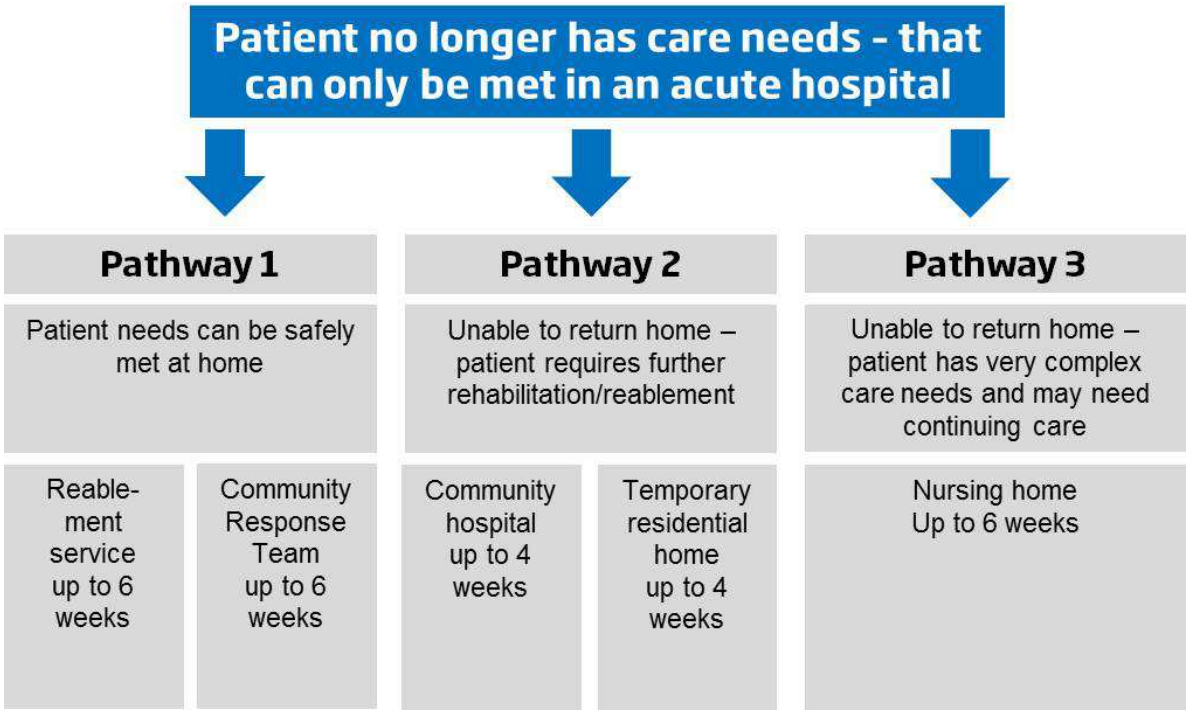
support that teams can offer. For referrers the distinction between the services is often unclear, with referrals being sent to the team perceived to respond in the timeliest manner.

Audits of our community inpatient facilities have shown that a significant proportion of people could be cared for at home, if services were available. We recognise that our community hospitals in particular are highly valued in their local areas. We know that criteria for the community inpatient beds is ill-defined and there is a perception that these beds exist to support the acute hospital sites.

With the exception of our community inpatient beds and the recent Care Hub pilot developments we have little medical input to community services. The medical models for our community inpatient beds are varied with a mixture of GP and consultant delivered services and variation in the level of input (that has been historically commissioned). We also know that our acute hospitals operate an 'assess to discharge' model where patients remain in hospital beds to undergo assessments for their long term care needs.

What will we do differently?

We will work with system partners to develop a **'discharge to assess' model** where patients only stay in an acute setting until they are medically optimised. After this time, the majority would move home with support from **integrated intermediate care and reablement** with any assessments required taking place at home. This will improve the quality of the assessments undertaken, reducing the current duplication of assessments taking place in both hospital and home settings. For those who cannot safely return home, we will develop alternative pathways to promote independence and allow required assessments to take place in a more appropriate environment. The following model illustrates the proposed approach.



In order to deliver this model we will need to ensure a consistent offer across all our localities from an **integrated intermediate care and reablement service**. This will facilitate timely discharge from hospital settings as well as providing a rapid response to prevent people from needing admission in the first place. We will develop **community consultant**

geriatrician and **advanced clinical practitioner roles** and also work with local GPs to ensure that services are able to manage the medical needs of those being supported.
We will develop more generic roles with less specialism working across health and social care in both acute and community settings, for example **integrated discharge liaison teams**. They will help individuals and professions to navigate the system and provide case management for individuals to ensure they receive the support they need, without delay.

We will also **review our provision of community inpatient beds** (including the number of virtual beds that can provide wrap around services in a person's own home); reducing our number of physical beds through the development of home-based alternatives. We will ensure that the function of our community inpatient beds is explicit, developing models of sub-acute care (including ambulatory care); specialist rehabilitation and end of life care.

3. Moving services from acute to community settings

Current patterns of care

We know that currently the majority of activity carried out by the Trust takes place on our acute hospital sites. The split in primary and secondary care has meant that 'specialist' services have traditionally been carried out by hospital provider trusts, concentrating services within their estate. Initiatives over previous years to move care 'out of hospital' have focussed on the transfer of services to community based providers, including primary care. This created the potential for the fragmentation of specialist services, and threats to the viability of acute specialist services.

A number of specialties have started to move services traditionally delivered in acute settings into community locations. Musculoskeletal services, neurology, dermatology and diabetes are all pursuing new models of care delivery.

What will we do differently?

We will continue to bring together primary and secondary care clinicians to **review care pathways to identify opportunities to develop community based alternatives**. We will need **contracting and payment mechanisms to be modernised** to reflect the new care models and the role of the specialist will need to be redefined.

We will review the care delivered to our inpatients, such as **intravenous therapy** where patients can spend weeks in hospital in order to receive daily infusions of medication, and look to develop home or community based alternatives. Wherever possible, we will develop self-care alternatives ensuring that we continue to promote independence, especially in those managing chronic conditions.

We will also look to **expand the range of planned care services** (whether delivered as outpatient or day case interventions) that are delivered in our community buildings. This will ensure that people have access to the widest range of services possible close to their home and also ensure that we make the most cost-effective use of our estate possible.

The strategy can be summarised on the following 'plan on a page'.

York Teaching Hospital NHS
NHS Foundation Trust

Out of Hospital Care Strategy - Community First

We will work within the local system to adopt a 'Community First' culture which focuses on prevention and self care; delivers care closer to home and allows the system to manage growing demand by increasing efficiency through integration.

DRIVERS:

- Harm caused by bed based de-conditioning;
- Predicted rise in demand from an ageing population;
- Need for new models of care to meet £22bn efficiency challenge;
- Need to deliver seamless, co-ordinated care;
- Implement best practice in delivering place-based population health;
- Close the gap in health inequalities across our communities.

DEVELOPMENTS:

Developing integrated community services for localities	• New integrated care models • Programme of self-management and peer support • Care co-ordinators • Supporting care homes
Developing the interface between acute and community services	• Discharge to Assess / Early Supported Discharge • Integrated intermediate care and reablement services • Community Geriatrician / Advanced Clinical Practitioner roles • Integrated discharge liaison services • Optimise use of community beds
Moving services from acute to community settings	• Review care pathways to identify community based alternatives • Musculoskeletal services • Ambulatory care pathways • A wider range of planned care services in community settings

PRIORITIES:

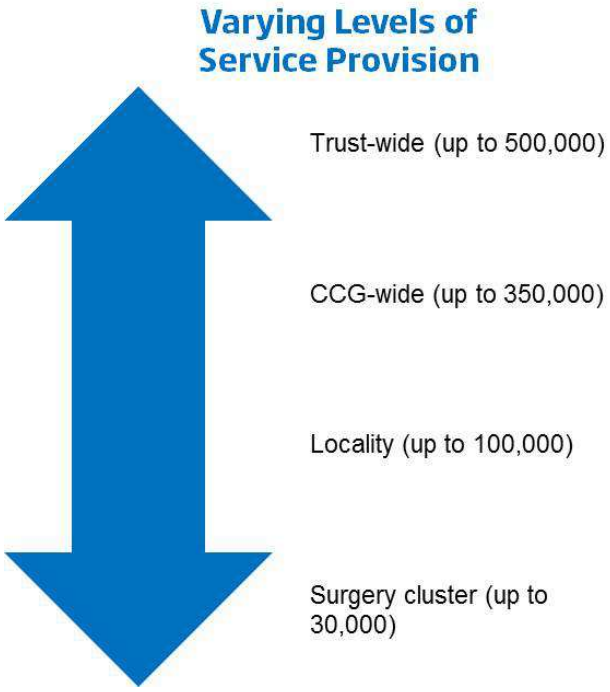
- Promote independence through prevention and self care
- Person-centred, co-produced support involving families and carers
- Co-produced new models of care (services) with home as first choice (delivered over seven days)
- Co-ordinated, integrated and joined up care that people can easily navigate
- Timely and rapid response to prevent admission to hospital or a care home
- A seamless interface to facilitate safe and timely discharge from hospital
- Remove duplication, ensuring cost-effectiveness and value for money

ENABLERS: Workforce; Information Technology; Estates; Knowing how we are doing

Caring about what we do | Respecting and valuing each other | Listening in order to improve | Always doing what we can to help

How will we work together to deliver these changes?

In developing these care models we recognise that there will be a need to work at different levels in order to ensure that services are responsive to local need, can achieve efficiencies and economies of scale and are resilient. As we move to a more 'place-based' approach we will need to ensure that our services share boundaries with partners and come together around natural geographies. The model below illustrates the different levels that services will need to work at.



For each service we will need to determine the most appropriate level of operation. We have worked through the Provider Alliance Board and other forums to define the boundaries of surgery clusters and localities. We will then work through Public Health teams to identify the needs of the populations within these new localities, ensuring that as services are redesigned this is targeted towards the needs identified.

We are clear that this strategy cannot be delivered in isolation. Although there are clearly elements within the Trust's control to deliver, many parts require the wider system to come together to make this happen. We have already seen leads within local systems coming together in a variety of settings in order to do this. Our local Sustainability and Transformation Plan will see partners signing up to a collective vision and blueprint for the future by June 2016. We will ensure that the right governance structures are in place to facilitate this and will continue to work with commissioners to ensure that contracting and payment frameworks support, rather than hinder our collective efforts.

The emerging governance structures locally include the development of a System Leaders Board where leaders of local organisations come together to share collective responsibility for decisions that impact across organisations. Underneath this the York Integration and Transformation Board and Scarborough Ambitions for Health Board oversee transformation programmes for their respective areas. Commissioners are coming together to develop a joint strategic commissioning approach and providers are working together in York through the Provider Alliance Board. GPs within the Vale of York have formed a single entity, the Vale of York Clinical Network, to strengthen the collective role of primary care. We have

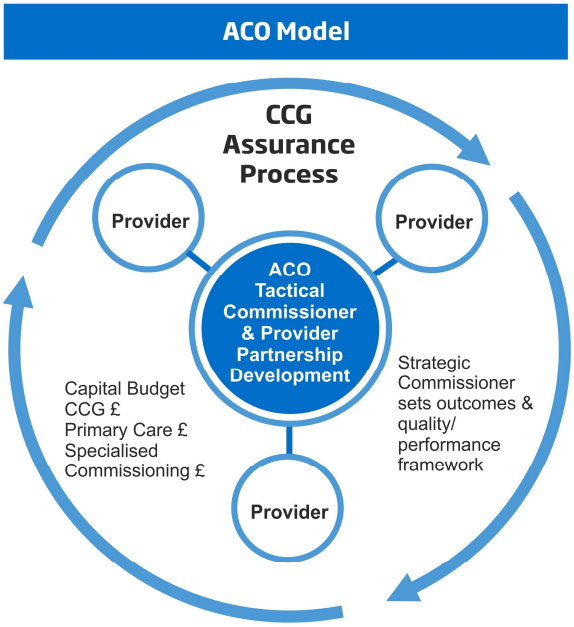
committed through our third sector umbrella bodies and local HealthWatch to adopt a co-production approach to service redesign.

A potential roadmap for the delivery of an Accountable Care approach in York has been developed for consideration, with support from Capsticks Solicitors.

The key principles to guide the development and assessment of the option of creating an Accountable Care System or Organisation (ACS/ACO) model for York are likely to include:

- Key partner / stakeholder endorsement - this is vital both to the success of the approach and to minimise the very real risk of legal challenge;
- The CCG will commission for health outcomes through a capitated funding contract with the ACS/ACO;
- Form should follow function, but the ACS/ACO should comprise all main service providers (including primary care), on a "all in" principle, committed to working in partnership to agreed values in some form of "alliance" or joint venture approach;
- The parties may not favour any prime contractor model of commissioning which houses all the activity and control within one Trust/Organisation but could use that model to test-bed the benefits and disadvantages of a preferred ACS/ACO approach. It is likely for capacity and risk avoidance reasons that this will be York Hospital NHS Foundation Trust;
- The CCG could significantly reduce its overhead costs by devolving transaction responsibilities to the ACS/ACO and potentially through co-commissioning with the City of York Council, NHS England, or potentially another CCG;
- As already described, the ACS/ACO approach is new to the UK, has had mixed success internationally (including, for example, early cost containment followed by overheat) and is untested for challenge by other bodies as anticompetitive. It is imperative therefore that risk is fully assessed and mitigated and that early intervention measures are agreed as part of any sign off process.

The diagram below highlights the key components of the proposed York ACO model



What enablers will be required to support the changes?

We will need more than new services and new ways of working in order to be effective and deliver our vision. We will need to ensure that we have a workforce that has the skills to deliver the new care pathways and is supported in making the cultural changes required. We will need information technology that supports seamless and effective communication across services, ensures effective use of new digital technology to support self-care and reduces administrative burdens on staff to free up time to care. Our estate will need to support the new care models with fewer requirements for isolated facilities and a reduction in physical beds, moved towards hub and campus accommodation with partner services. We need to ensure that we can measure the impact of what we do, with timely access to robust outcome data and intelligence from our communities to ensure that the changes we make are improvements.

Workforce

We will invest in our workforce to ensure that they have the skills required to deliver the new care models. This will include a focus on health promotion, coaching in self-care and intra-disciplinary working (where staff are able to undertake some elements of each others roles to reduce duplication). We need to ensure that career frameworks are in place to attract new staff and that development opportunities exist so that we retain our current workforce. We will need to design new roles, taking into account the new care pathways and likely availability of key professional groups.

We will develop a programme of organisational development support to ensure that the cultural changes required in implementing 'Community First' can be embedded across all of our services.

Information Technology

We will work with system partners to ensure that a shared, inter-operable care record exists; allowing services working together to deliver care and support for individuals to communicate effectively. This will support efforts to reduce duplication as assessments can be shared easily across organisations and people do not need to repeat their story multiple times. We need to ensure that our workforce has mobile access to these records, allowing records to be updated in real time and a move from duplicate electronic and paper records to a true digital record.

We need to embrace technological developments that support self-care, enabling people to take control of their own conditions. Where appropriate, we need to make greater use of telecare and telemedicine. In our community hospitals, we need to ensure that we make full use of the electronic patient record and supporting functions.

Estates

Our new care models will be less dependant on physical infrastructure than we are now. If we truly adopt a home first approach, we will deliver less care in our current buildings. We therefore need an estates strategy that supports a move to more campus style accommodation with partner organisations. This will facilitate co-location of staff and services. With our focus on 'place-based' care these will ideally be located in the communities we serve.

Knowing how we are doing

In this strategy we have been explicit about the need to redesign services to deliver better outcomes for people. In order to know if we have succeeded in this, we will need robust measurement systems and real time data that can tell us if the changes we have made are making a difference. We will use this intelligence to refine our approach, ensuring that we do more of what works and less that doesn't improve outcomes for people.

In order to do this, we will need a mixture of quantitative data and qualitative feedback from those who use our services (and their carers and families). We also need to ensure that those who work in the system can act as our eyes and ears, with meaningful opportunity to influence the changes we need to make and to feedback on their impact.

Next Steps

We have identified a series of developments that we will focus on during 2016-17. These will form the basis of our Out of Hospital Programme and include:

- Adopting a discharge to assess approach and testing the three pathways identified;
- Developing integrated enhanced care teams, wrapped around primary care;
- Developing an 'independence service', integrating intermediate care and reablement and building home-based capacity including a review of our bed based intermediate care provision;
- Developing a workforce development programme that will embed our focus on prevention, coaching and self care;
- Work with operational directorates to develop the out of hospital elements of their directorate strategies, identifying opportunities to move services from acute to community settings;
- Developing a home based ambulatory care service.



References

The following sources were used in the production of this strategy.

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'Moving healthcare closer to home' Monitor, 2015
'Risks of Unnecessary Waiting' Presentation by Dr Ian Sturgess, Associate Medical Director, Monitor [taken from Emergency Care Improvement Programme website 8/1/15 www.ecip.nhs.uk/tools-and-resources/event-resources]
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'Summary of our Five Year Strategic Plan 2015-2020' University Hospitals of Morecambe Bay NHS Foundation Trust, 2015
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'North Yorkshire Joint Strategic Needs Assessment: Annual Update 2015 – Scarborough Ryedale CCG Summary' North Yorkshire County Council, 2015
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'NHS Outcomes Framework 2015 to 2016' Department of Health, 2015
'Our Shared Commitment' York Teaching Hospital NHS FT, 2014
'Vision and Principles for Integration' Output from Vale of York system-wide event 23 June 2015
'An Accountable Care Approach in the Vale of York – Discussion Paper' System Leaders Board paper, March 2016

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York Teaching Hospital NHS
NHS Foundation Trust

Council of Governors – 16 June 2016

Chief Executive's Report

Action requested/recommendation

The Council of Governors are asked to note the report.

Summary

The report aims to provide information on the following subjects:

- System-wide strategic planning
- Performance
- Staff engagement
- Health campaigns

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This paper is solely written for the Council of Governors
Risk	No risk.
Resource implications	No resource implications
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	June 2016
Version number	Version 1

Council of Governors – 16 June 2016

Chief Executive's Report

1. System-wide strategic planning

I was recently invited to join a team of senior leaders to brief Jim Mackey, Chief Executive of NHS Improvement, and Simon Stevens, Chief executive of NHS England, to brief them on the Sustainability and Transformation Plan (STP) for our area. We were invited as one of four highest risk STPs, largely due to the geography of the patch. Overall they were impressed by the clarity of purpose that pre-existed and was now developing further. The Board will be briefed more fully on this later in the board meeting.
On 20 April senior leaders from across the organisation attended a clinical strategy planning day that provided delegates with a broader overview of the current environment in which the Trust is operating and time to discuss the implications of this and the plans for their directorate and clinical services.

The event was also an opportunity to test some of the assumptions we have made in our recent refresh of the Trust-wide vision and mission statement, and our overall Trust-wide strategic objectives, and to enable directorates to work together in their directorate teams to align their own services with this. Key to this was a focus on the core services we provide to our local populations and identifying how they might best be improved in addition to identifying any potential areas for growth in clinical services.

This annual event is key to our planning cycle and importantly provides a major opportunity to engage with our clinical leaders and most senior managers and most recently resulted in the development of our Turnaround Avoidance Programme. Importantly this year we have set out an intention to manage the annual planning cycle in a more systematic manner than we have in the past as a direct response to the Well-led Review, facilitating the development of both Trust-wide and directorate plans and firmly embedding a disciplined and systematic annual process of strategic planning.

I was impressed at the level of engagement and scale of ambition demonstrated by senior clinicians, nurse leaders and other senior managers in developing clinical strategies for our services and directorates, and the purposeful nature of the discussions was encouraging. The teams also responded positively to the need to continue to evolve as an organisation and importantly place an appropriate and significant emphasis on partnership working and stakeholder engagement.

There was a clear recognition that we cannot stand still, and that whilst we may not have the flexibility and freedom we once enjoyed, we will continue to plan with ambition and position our services to the benefit of the community as well as ensure we are placed to make the most of opportunities to grow and respond to changing demands as they emerge.

Planning of this nature requires discipline, and we will consolidate and iterate over time, however it was a good opportunity for people to test their plans and align them with the overall direction of the organisation.

2. Performance

We have entered a new year on 1 April in terms of finance and performance reporting. The table below outlines the Trust's high level performance data for last year (April 2015 to March 2016).

Indicator	Target	Q1	Q2	Q3	Q4
A&E Clinical Quality - Total Time in A&E under 4 hours	95.0%	88.3%	91.5%	87.1%	85.0%
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92.0%	92.8%	93.8%	94.0%	93.0%
Cancer 2 week (all cancers)	93.0%	93.9%	91.9%	95.2%	93.5%
Cancer 2 week (breast symptoms)	93.0%	91.4%	94.0%	94.8%	95.1%
Cancer 31 day wait from diagnosis to first treatment	96.0%	96.2%	99.3%	99.5%	98.6%
Cancer 31 day wait for second or subsequent treatment - surgery	94.0%	94.4%	97.3%	95.5%	96.2%
Cancer 31 day wait for second or subsequent treatment - drug treatments	98.0%	99.6%	100.0%	100.0%	99.2%
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85.0%	87.8%	85.1%	84.5%	85.8%
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90.0%	98.4%	92.0%	97.0%	90.4%

I am delighted to report that we have restored our performance against our cancer targets. Governors will be aware that we had some difficulties in meeting all of our cancer targets, due to growth in demand and a difficult economic environment. Nonetheless, at the end of the year, we have achieved all of our cancer targets for 2015/16.
One area where we continue to see pressure is in our emergency departments, and the achievement of the four-hour emergency access target.

The pressure facing hospitals across the country have been well documented, and there are several factors that affected our performance during the time period referenced in this report. A combination of growing numbers in attendance rates, delayed discharges and wards closed due to norovirus resulted in significant pressure on beds. This means that, as with many other hospitals, we have been unable to consistently achieve the expected performance levels.

Achieving the four-hour performance target is not solely the responsibility of the emergency department, and we are working with primary care, social care and our commissioners to reduce delays across all parts of the system.

For example, in York, we are working with primary care to introduce a new way of assessing patients who attend A&E to ensure they are seen by the most appropriate clinician. We have also introduced discharge liaison officers onto the wards to help reduce delays in patients being discharged, which will help to make sure that beds are available for those who need them. This role has already successfully been introduced at Scarborough Hospital.

In Scarborough, we have been accepted onto the Acute Medical Model Support Programme, led by NHS England.

We are one of twelve active participants in the programme which will offer us support at a national level and will enable us, working from an evidence base, to challenge different ways

of working in acute care.

The programme is primarily about the sustainability of smaller, rural hospitals, and will be focussing on Scarborough, however we have asked that York be involved in a later phase of the work. This work gives a national platform to the acute element of Ambition for Health, and will help support the work that is ongoing with our commissioners and other partners.

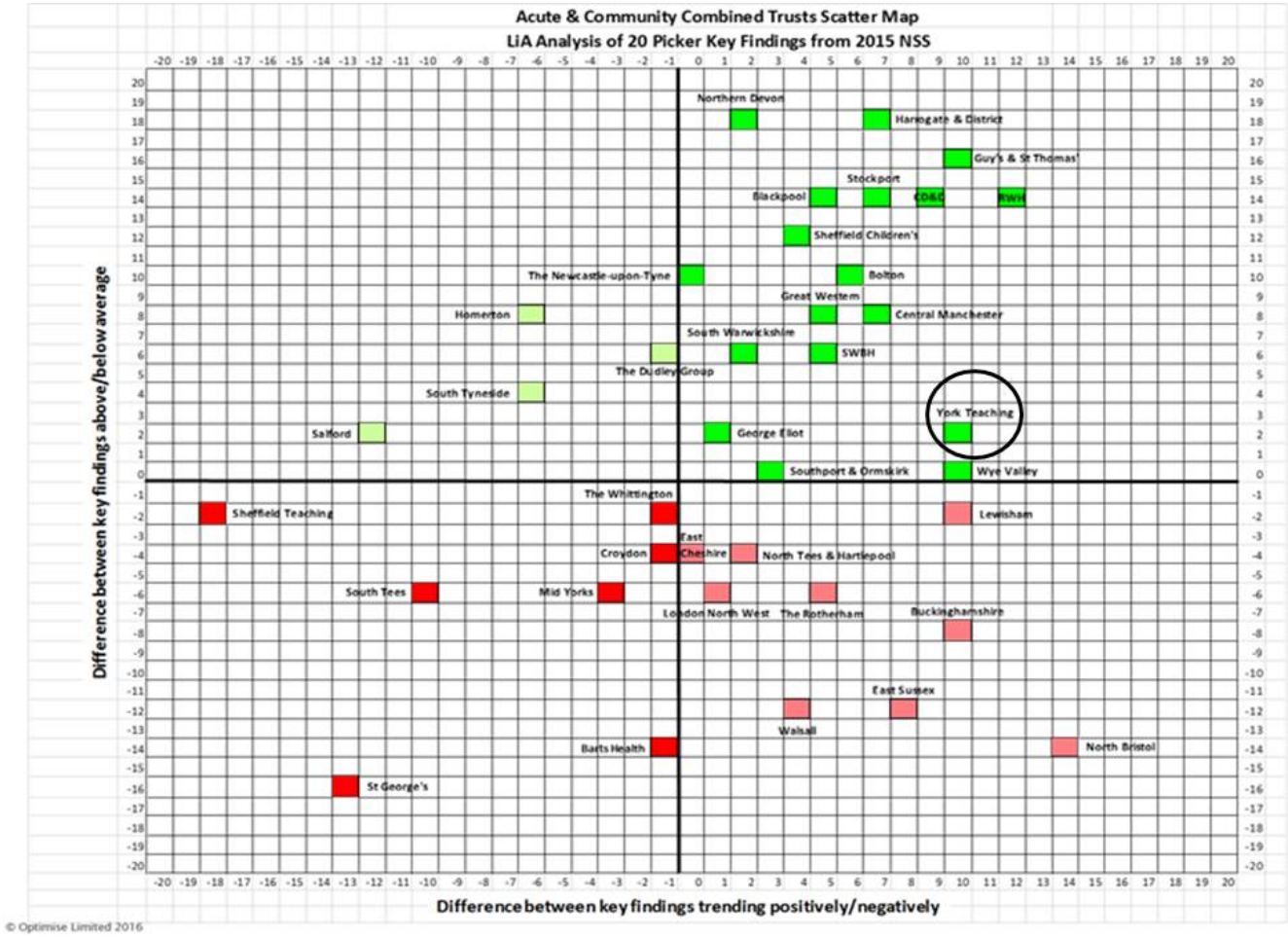
3. Staff engagement

The results of the 2015 NHS Staff Survey were received in March, and almost 4,000 staff gave feedback.

There were a number of overarching themes, many of which perhaps unsurprisingly centre on issues of communication. For example, we are looking at how we can help staff to better understand the important messages around our financial situation and what it means in practice, and likewise staffing and recruitment.

There also continues to be a theme of staff reporting that communication between them and their manager could be improved. We are already looking at this issue, and how we can improve the briefing process. We are also considering how we can support managers in briefing these messages to their teams, and reinforcing the important responsibilities of our managers to share information with staff.

What may also be of interest to Governors is the graph below. This 'scattermap' takes results for 20 key findings from the staff survey for NHS Acute and Community Combined Trusts who have used Picker for their staff survey, and uses them to offer an insight into how staff rate their Trust's 'leadership and the culture'.



Trusts positioned above the horizontal 'x axis', have staff responses that are on or above average for your peer group. Below the horizontal means staff responses put the Trust below the average.

If you are positioned to the right of the vertical 'y axis', it indicates a positive response trend from staff within the Trust relative to their responses in 2014. To the left of the vertical axis means a declining trend from 2014 with staff feeling less positive overall than they did before.

The best-performing Trusts based on how staff feel in 2015 are in the top-right quadrant , with above average performance and trending positively. As you can see, we appear in the top right hand quadrant.

Although this does not tell the whole story and we can clearly improve, it is positive given where we are post-merger and the operational difficulties we have been facing for some time, and does somewhat counter the 'received wisdom' we often hear quoted in relation to staff morale.

4. Health campaigns

Finally, I would like to draw governors' attention to two important areas where we have been focussing on raising awareness among staff and the public; end of life care and dementia.

Dying Matters Week, which took place in May, saw our staff starting 'The Big Conversation' aimed at raising awareness about the importance of talking more openly about dying, death and bereavement.

Getting people to talk about the subject of death and dying can be difficult, but this campaign encouraged people to be prepared and think about their dying wishes.

The end of life care team were raising awareness amongst staff and asking them to share their 'bucket list' ideas.

With an ageing population and people living for longer with life limiting illnesses, discussing dying is increasingly important and we want people to see that help and support is available.

Dementia Awareness Week also took place in May. During the week the Trust made a pledge to adopt John's Campaign, an initiative which recognises the important role that carers play and their right to stay and support people with dementia.

As a Trust we are committed to providing patient-centred care in partnership with carers. We recognise the important role that they play in providing continuity of support during a patient's journey and have pledged to introduce John's Campaign this year to assist patients with dementia, for example we will be revisiting our visitor's guidance in order to promote and encourage more flexible visiting.

5. Recommendation

The Council of Governors is asked to note the report.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley, Chief Executive**
Date	**June 2016**

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York Teaching Hospital NHS
NHS Foundation Trust

Council of Governors – 16 June 2016

Membership Development Group Report

Action requested/recommendation

The Council of Governors is asked to note the report from the Membership Development Group.

Summary

This paper provides an overview of the work of the Membership Development Group.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report is only written for the Council of Governors – Public Meeting.

Risk	No risk.
Resource implications	Resources implication detailed in the report.
Owner	Lynda Provins, Governor & Membership Manager
Author	Lynda Provins, Governor & Membership Manager
Date of paper	June 2016
Version number	Version 1

Council of Governors Meeting – 16 June 2016

Membership Development Group Report

1. Introduction and background

The Membership Development Group review, monitor and support the development of plans for membership recruitment, engagement and involvement on behalf of the Council of Governors.

2. Progress since February

The group wish to bring the following items to the Council of Governors attention:

Recruitment Market Place – The Trust held a recruitment marketplace in York on Saturday 23rd April which was really well attended. A membership stand was in place and a number of new members were signed up and leaflets were handed advertising the CPR events.

CPR Events – The Communications Team have planned a number of CPR seminars at the Trust (4 in York, 3 in Scarborough). The first 2 events were held in May with good attendance and positive feedback. Bookings have been received predominantly from York and Ryedale, but the table below illustrates that members are accessing the events from across constituencies.

York	Scarborough	Bridlington	Ryedale	Selby	Whitby	Hambleton	Staff
29	5	5	14	3	1	5	9

Events – Plans are being formulated to hold further events in the Autumn and to try to tie these in with national health awareness weeks. It has also been suggested that plans for new developments and subsequent openings should be linked to an invitation for members to attend.

Recruitment Campaign – Initial planning has started for a recruitment campaign which will be targeted at pregnant women. The offer of sessions linked to baby (0 – 2yrs) first aid/CPR is being explored.

Membership Matters – a decision has been taken to stop sending out Membership Matters by post. This has been a difficult decision, but is due to the limited budget for communication and the need to prioritise spending. A post card has been designed to send to members encouraging them to provide an email address where ever possible. A number of Trusts are already going down this route. An electronic communication is being designed and this will also link in with a greater use of the Trust's website.

3. Membership Figures

Below are summary tables providing analysis of our public membership from 31 March 2015, 24 November 2015 and with figures updated on 20 May 2016:

Constituency	Total number of Members at 31 March 2015	Total number of Members at 24 November 2015	Total number of Members as 20 May 2016
City of York	6,093	5,845	5784
Hambleton	733	732	719
Selby	1,727	1,663	1643
Scarborough	434	427	430
Bridlington	467	447	446
Whitby	258	255	249
Ryedale and East Yorkshire	1,656	1,572	1551
Out of Area	718	690	677
Total	12,126	11636	11499

It can be seen from the table above that the Scarborough, Bridlington and Whitby areas are the three areas where the percentage of membership is noticeably lower than in other areas.

4. Recommendation

The Council of Governors are asked to note the report.

Author	Lynda Provins, Governor & Membership Manager
Owner	Lynda Provins, Governor & Membership Manager
Date	June 2016

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York Teaching Hospital NHS
NHS Foundation Trust

Council of Governors – 16 June 2016

Election Process for Governors

Action requested/recommendation

Governors are asked to note the content of the report and confirm they will support the election process.

Summary

There are currently a number of vacancies within the governing body due to governors coming to the end of their term of office in March 2016 and resignations. The report shows the outline timetable for the elections. The proposed timetable will ensure the results are known by Thursday 29th September 2016.

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

Implications for equality and diversity

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

The Trust employs an independent organisation to run the election and to act as the returning officer. The elections are open to all members of the public that live within the catchment area of the constituency they are standing for and that are over the age of 16 (this is defined in legislation).

Reference to CQC outcomes

There is no reference to CQC outcomes.

Progress of report	Prepared for the Council of Governors
Risk	No risk.
Resource implications	This is an information report and does not identify any resource implications
Owner	Lynda Provins, Governor & Membership Manager
Author	Lynda Provins, Governor & Membership Manager
Date of paper	June 2016
Version number	Version 1

Council of Governors – 16 June 2016

Election Process for Governors

1. Background

The last election for the Council of Governors was completed in September 2015. Those elected for a 3 year term were;

York 2 seats – Penelope Worsley re-elected and John Cooke appointed
Selby 1 seat - Ann Bolland re-elected
Ryedale 1 seat - Jeanette Anness re-elected
Whitby 1 seat - Steve Hinchliffe re-elected
Stakeholder 4 seats - Rowena Jacobs and Michael Beckett re-elected – John Galvin, Steve Lane and Chris Pearson appointed
Scarborough 1 seat - Diane Rose appointed
Bridlington 1seat - Pat Stovell appointed
Staff constituency 1 seat - Sharon Hurst (Community)

As in past years the Trust has used the Electoral Reform Society (ERS) as the administrator and returning officer for the elections.

2. Elections being held

This year the following constituencies have seats available for election:

Hambleton 1 seat
Selby 1seat
Ryedale and East Yorkshire 1seat
York 2 seats
Bridlington 1 seat
York Staff 1 seat

Successful candidates will be appointed to the role of Governor for three years before they are required to stand for election again.

In previous years, the Trust has held “drop in” sessions for individuals considering standing for election. Unfortunately, these sessions have not been well attended. Therefore, this year information for individuals considering standing for election will be placed on the website. Individuals will be asked to contact the Governor & Membership Manager and meetings will be arranged on a one to one basis. Governors from the constituency of the individual considering standing will also be invited to attend.

3. Timetable	
The timetable for the election is as follows:	
Election stage	**Date**
Trust to send nomination material and data to ERS	Thursday, 30 June 2016
Notice of Election / nomination open	Thursday, 14 July 2016
Nominations deadline	Thursday, 11 August 2016
Summary of valid nominated candidates published	Friday, 12 August 2016
Electoral data to be provided by Trust	Friday, 19 August 2016
Notice of Poll published	Friday 2 September 2016
Voting packs despatched	Monday 5 September 2016
Close of election	Wednesday 28 September 2016
Declaration of results	**Thursday 29 September 2016**

At the beginning of the process, the Trust is required to send nominations material and data to ERS; the Trust will supply ERS with a letter written by the Chairman, and a summary document outlining the role of a Governor. The data will be provided by Membership Engagement Services (MES) the organisation who manages the public database.

Once the letter has been published and sent to all public members, any individual who is interested in standing to be a Governor will be required to contact ERS to receive a nomination form. The nomination form requires candidates to provide a candidate statement of not more than 250 words and a photo.

After the deadline for nominations has passed, validation work is undertaken on the nominations and the notice of poll is published on the Trust website.

Voting packs are despatched by ERS to all members and the closing date for votes is 28 September 2016.

The results of the election will be available from 29 September and will be published on the website as soon as possible.

Unsuccessful candidates will receive a letter from the Trust thanking them for their interest and encouraging them to stand again. A copy of the election result will be included with the letter.

Successful candidates will be contacted to advise of their success and provide them with any additional detail they may need at that time.

4. Recommendation	
Governors are asked to note the content of the report and confirm they will support the election process.	
Owner	**Lynda Provins, Governor & Membership Manager**
Author	**Lynda Provins, Governor & Membership Manager**
Date	**June 2016**