York Teaching Hospital NHS
NHS Foundation Trust

The programme for the next meeting of the Trust's Board of Directors day, which will take place:

on: **Wednesday 24th April 2013**
in: **The Boardroom, York Hospital, Wigginton Road, York, YO31 8HE**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Critical Care Seminar Room	Non-executive Directors
9.15am – 11.50pm	**Board of Directors meeting held in public**	**Boardroom**	**Board of Directors and observers**
12.00pm – 1.15pm	Board of Directors to consider confidential information held in private	Boardroom	Board of Directors
2.00pm – 2.30pm	Organ Donation Committee led by Mike Keaney	Boardroom	Board of Directors and Corporate Directors
2.35pm – 2.55pm	Follow up from Board of the Year led by Sue Holden	Boardroom	Board of Directors and Corporate Directors
3.00pm – 4.00pm	Estates Strategy led by Brian Golding	Boardroom	Board of Directors and Corporate Directors

The core values of the Trust are:

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

These will be reflected during all discussions in the meeting

York Teaching Hospital NHS
NHS Foundation Trust

Restricted – Management in confidence

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

On: **Wednesday 24th April 2013**

At: **9.15am – 11.50pm**

In: **The Boardroom, York Hospital**

A G E N D A					
No	***Item***	***Lead***	***Comment***	***Paper***	***Page***
Part One: General **9.15am - 9.30am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for absence** To receive any apologies for absence: No apologies for absence received.	Chairman			
3.	**Declaration of Interests** To receive any changes to the register of directors' declarations of interest pursuant to section 6 of Standing Orders.	Chairman		A	7
4.	**Minutes of the Board of Directors meeting** To review and approve the minutes of the meeting held on 27th March 2013.	Chairman		B	11
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman		Verbal	
6.	**Patient Experience** To hear a letter of complaint and compliment.	Libby Raper & Mike Sweet		Verbal	

No	Item	Lead	Comment	Paper	Page
Part Two: Quality and Safety 9.30am – 10.30am					
7.	**Quality and Safety Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Chief Nurse Report • Medical Director Report	Chairman of the Committee		C C1 C2	21 27 41
8.	**Quarterly Director of Infection Prevention Control (DIPC) Report** To receive the quarterly DIPC Report for assurance around the governance and performance during the last quarter.	Director of Infection Prevention Control	Jennie Adams	D	59
9.	**Complaint Report** To receive the Trust's annual complaint report as required by regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009.	Chief Nurse	Libby Raper	E	105
10.	**National Inpatient Survey** To receive the executive summary of the National Inpatient Survey for review.	Chief Nurse	Jennie Adams	F	113
Part Three: Finance and Performance 10.30am – 11.10am					
11.	**Finance and Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Trust Efficiency Report • Operational Performance Report	Chairman of the Committee		G G1 G2	129 139 145
12.	**Finance Report** To receive the Finance Report.	Finance Director	Mike Sweet	H	151

No	Item	Lead	Comment	Paper	Page
13.	**Capital Programme** To receive the Capital Programme for 2013/15.	Finance Director	Mike Keaney	I	161
Part Five: HR issues **11.10am – 11.20am**					
14.	**Staff survey 2013** To receive the Annual Staff Survey 2013 for review.	Director of HR	Dianne Willcocks	J	171
Part Six: Governance **11.20am – 11.50am**					
15.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		K	177
16.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		L	181
17.	**Fire Policy** To receive for approval the updated Fire Policy.	Director of Estates and Facilities		M	187
18.	**Sustainable Development** To receive the annual report of sustainable development.	Director of Estates and Facilities	Philip Ashton	N	213
Any Other Business					
19.	**Next meeting of the Board of Directors** The Board of Directors meet in public will be held on 29th May 2013 at 9.15am York Hospital in the Boardroom.				
20.	**Any other business** To consider any other matters of business.				

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

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

Items which will be discussed and considered for approval in private due to their confidential nature are:

- Assurance Framework and Corporate Risk Register
- Business Case
- Monitor Quarter 4 submission

Register of directors' interests
April 2013

York Teaching Hospital NHS
NHS Foundation Trust

Additions: None

Changes: None

Deletions: Mr Crowley is no longer **Trustee (and Hon. Treasurer),** York Peptic Ulcer Research Trust
Dr Turnbull is no longer **Board Member—**York Peptic Ulcer Research Trust

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

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

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultan-cies 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 com-missioning 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
Ms Peta Hayward ***(Executive Director Director of Human Resources)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Ms Elizabeth McManus ***(Executive Director Chief Nurse)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Dr Alastair Turnbull ***(Executive Director Medical Director)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Andrew Bertram ***(Executive Director Director of Finance)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	**Member** of the NHS Elect Board as a member representa-tive
Mr Mike Proctor ***(Executive Director Deputy Chief Executive and COO***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital NHS Foundation Trust, held in the Blue Room, Scarborough Hospital on 27th March 2013.

Present:	Mr A Rose	Chairman of the Trust
	Mrs J Adams	Non-executive Director
	Mr P Ashton	Non-executive Director
	Mr A Bertram	Executive Director of Finance
	Ms P Hayward	Executive Director of Human Resources
	Mr M Keaney	Non-executive Director
	Mr M Proctor	Deputy Chief Executive/Chief Operating Officer
	Ms L Raper	Non-executive Director
	Mr M Sweet	Non-executive Director
	Dr A Turnbull	Executive Medical Director
	Professor D Willcocks	Non-executive Director
Attendance:	Mrs A Pridmore	Foundation Trust Secretary

Mr Rose welcomed to the Board meeting as observers: Mrs Jean Wormwell and Bob Murden - East Yorkshire LINks/PAGER, Mr Steven Hinchliffe - Governor for Whitby, Mr Andrew Butler - Governor for Selby, Mr Terry Atherton - Governor for Bridlington, Mr David Wheeler - Governor for Scarborough, Mrs Sheila Miller and Mrs Jeanette Anness - Governors for Ryedale and East Yorkshire, Mrs Helen Mackman - Lead Governor and Governor for City of York and Mrs Lucy Brown - Head of Communications.

13/030 Apologies for absence

Mr P Crowley, Chief Executive and Ms E McManus, Chief Nurse gave their apologies to the meeting.

13/031 Declarations of Interests

The Board of Directors **noted** the interests declared. The members of the Board of Directors were asked to advise Mrs Pridmore of any further changes.

13/032 Minutes of the part 1 meeting held on 27th February 2013

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

13/033 Matters arising from the minutes

13/033.1 *13/020.1 Community Asset Transfer*

Mr Bertram confirmed that the Trust had received a letter from Monitor confirming that Monitor was satisfied that the Trust had complied with the material transaction requirements of the Compliance Framework. Monitor required no further information or action from the Trust prior to financial and legal closure of the transaction.

The Board **noted** receipt of the letter.

13/034 Patient Experience

A letter of complaint was read by Mr Proctor and a complimentary letter was read by Mr Sweet.

13/035 Quality and Safety Committee

Ms Raper as Chairman of the Committee advised that the notes of the meeting provided to the Board were not the final version. She proposed that a fuller final version would be circulated to the Board members outside the meeting.

Ms Raper observed that both the Chief Nurse and Medical Director reports cross-referenced the key risks in the organisation in their reports. Ms Raper advised that this was a welcome development.

Referring to the Francis Report, Ms Raper assured the Board of Directors that the Committee would be including the Francis Report actions as part of its work programme and ensuring that the Trust's learning would sit alongside the national discussions. Ms Raper outlined four subjects the Committee has been looking at: closed wards, C-Diff, accident investigations and leadership walk rounds. She advised that those items would remain on the Committee's agenda for the foreseeable future.

Chief Nurse Report – Ms Raper advised that the Committee had spent time discussing complaints and the current process. The Board was advised that the whole complaints system would be changing in the near future. Dr Turnbull added that the advocacy of the system will transfer to local authorities. Professor Willcocks added that it is important for the Trust to use the committee structure as part of the system for dealing with complaints. The Patient Experience Steering Group was specifically set up to support the management of complaints and the resulting actions that follow.

Ms Raper added that the other significant areas included in the Chief Nurse Report were the focus on assurance methods, accountability and action/reviewing the use of productive ward methodology.

Dr Turnbull commented for Ms McManus and advised that there continued to be huge operational pressures experienced by the Trust during the month; this had challenged the continued maintenance of the Trust's acceptable standards of quality of care. The Board discussed the challenges and impact on both clinical and nursing staff.

The Board was advised that the Clostridium difficile (C-Diff) performance has exceeded the annual trajectory by one case. Monitor has been advised. The effect is the Trust is in breach of the governance rating and as a result the Trust has a current governance rating of amber – red. Dr Turnbull advised that a meeting of the antimicrobial group to consider how to continue to improve the working practices of antimicrobial prescribing.

Mrs Adams asked for assurance that the Trust is not losing focus on healthcare acquired infections. Dr Turnbull assured her that focus was not being lost but one of the difficulties that the microbiologists are working on is managing cases where patients cannot be treated with certain drugs because they are not effective.

The Board noted the discussion in the Committee on staffing levels and acknowledged that the Workforce Strategy Committee would also be considering that work and it was also picked up as part of the mortality reviews and through the Acute Board.

The Board **thanked** Ms Raper for her report and the assurance given.

The Board **noted** the report from the Healthcare Governance Directorate and understood that the Quality and Safety Committee would review the paper in more detail with the author.

The Board **noted** the Senior Risk Officer Report included in the Healthcare Governance Directorate Report.

Medical Director Report – Ms Raper referred to the reducing mortality programme update included in the Medical Director Report and the progress that had been made. The Board noted the workstreams and the progress made. Ms Raper advised that the Committee discussed the adverse incidents and the degree of harm graphs. It was noted that one was shown as "blank". Dr Turnbull advised the 'blank element' is under review to confirm how it should be coded.

Ms Raper referred to the Patient Related Outcome Measures (PROMs) data. Dr Turnbull advised that currently it covered groin, hip and knee surgery outcomes, which is due to be extended to cover other areas, but as yet no detail has been released about what areas. He added that PROMs is not part of Commissioning for Quality and Innovations (CQUIN). The Board discussed the value of PROMs and recognised the future rationale around it. Professor Willcocks suggested that it might be worth incorporating PROMs within the Family and Friends test. The Board **noted** the community dashboards included in the paper.

The Board **noted** the report and the comments made.

13/036 Finance and Performance Committee

Mr Sweet presented the notes from the Committee. He advised that there remains concern about the movement of patients through the hospital, but the Committee did receive significant assurance about plans to address the issues on a short, medium and long-term basis.

Mr Sweet referred to the Cost Improvement Programme (CIP) achievements. He reported that the Committee had been advised that there was the possibility that there would be a slight over-achievement of the targets. He advised that the Committee had received significant assurance on the progress towards the end of the financial year. The area of concern for the Committee is around the level of non-recurrent savings that exist in the current year and the levels that exist in the plans for next year. The team is working on finding methods of converting non-recurrent to recurrent plans, to reduce the risk to delivery of the target for next year.

Referring to the Finance Report, Mr Sweet advised that the deficit had not increased despite the continued overspend on pay and the continued use of escalation facilities across the Trust. He added that many directorates are now working at full capacity and are not able to take on further additional work. Mr Sweet reminded the Board that it had been advised that an approach had been made to the PCT to discuss the non-elective monies available to the PCT (due to the lower marginal tariff) and the fact that these were intended to support the funding of related improvements. He advised that those discussions were continuing but had not been concluded. These discussions will form part of the year-end discussions and reconciliation.

Mr Sweet advised the Board that the Trust had now received the first £5m strategic capital from the Treasury; the Trust is expecting the balance to be paid later in the new financial year.

Mr Sweet asked Mr Bertram to comment on the changes to the absorption accounting principles. Mr Bertram advised that in preparing the Q1 accounts for Scarborough, the Department of Health had just confirmed a change in approach to the presentation of the acquisition. In effect, the DH was cancelling Scarborough's Public Dividend Capital (PDC) and therefore the write down of Scarborough's £79m fixed assets to a zero year end balance would result in a charge to Scarborough's I&E account of £79m. The write off of the balance sheet deficit reserve position (already reported to the Board) of £10m will result in a net technical deficit for Scarborough Q1 of £69m. Mr Bertram reported last month that this figure was anticipated to be a £10m surplus representing only the deficit balance sheet reserve right off; the change in month being the DH decision to cancel Scarborough's PDC. This presentation was technical only and no cash would pass between any parties. The dividend payments relating to PDC have been made in year for both the single organisations and, latterly, the enlarged organisation as would usually be the case. Mr Bertram confirmed that York's accounts would show the net gain on acquisition of £69m surplus applied to the I&E account and the corresponding fixed assets and balance sheet reserves would be reported on the Trust's balance sheet.

The Board enquired if there would be a similar issue for the transfer of community assets. Mr Bertram confirmed that the same discussions of accounting would take place and would be seen in the 2013/14 accounts.

Mr Bertram commented that in terms of the close of the financial year, he advised that he is expecting to be able to advise the Board that the Trust has a near-balanced position, but he did need to advise the Board that there was a small risk that the Trust would end the year with a small financial deficit, which would be directly attributable to the exceptional pressure and the resulting additional costs around infection control, staffing and non-elective escalation facilities that have been put in place. He added that the Trust continues to be vigilant about reducing costs and expenditure wherever possible.

Mr Sweet advised that the C-Diff performance that has already been discussed was discussed by the Committee. He supported the comments made by Dr Turnbull and noted that the Trust had challenged three of the cases that had been declared. The Committee also reviewed the performance in A&E and noted that it had improved but there was still significant pressure in the system.

Mr Sweet referred to the Yorkshire Ambulance Service (YAS) proposed fines. He advised that the Committee was receiving detailed information about the performance and the SHA had suggested a sensible approach to phasing-in the system. The opportunity for YAS to levy fines will be from quarter 3 onwards. More detail is being sought by Mr Proctor.

Mr Sweet advised that the Committee had not been able to discuss the forthcoming tender summary and would do so at the next meeting.

The Board **thanked** Mr Sweet for his report and the assurance given.

13/037 Financial Plan

Mr Bertram presented the financial plan for 2013/14. He advised that the plan could be described as a challenging and austere plan and did not contain any flexibility for

unplanned investment. The plan for 2013/14 and beyond is not the same as previous financial plans. It is a plan that has been affected significantly by the current economic circumstances surrounding the NHS and the wider economy. The plan deals with known pressures but it has not been possible to create contingency funding for new pressures. In practice this means that there are no reserves set aside for the purpose of funding expenditure only business cases. All business cases will need to identify a source of funds; this can obviously either be new income or can be an identified resource transfer.

The plan is a three-year plan and equates to years 2, 3 and 4 of the Integrated Business Plan (IBP) formulated at the time of the acquisition. Mr Bertram asked the Board to note the summary income and expenditure position statement. Mr Bertram advised that the plan will ensure a Monitor Financial Risk Rating (FRR) of “3,3,4” for the three years (under the current compliance framework method). Using the new Risk Assessment Framework, the FRR will be “4,4,4” for the three years. Mr Bertram advised that acquisition support extended one further year beyond this plan and would cease by March 2017. Mr Bertram described to the Board the target surplus positions for each of the 3 years and stressed the importance of building up these surpluses to ensure that when the acquisition support ceases, the organisation is self-sufficient under its own income arrangements. Mr Bertram stressed the importance of resisting the temptation to spend these surpluses, as this would lead to a completely undeliverable plan for 2017/18.

Mr Bertram advised that the new CIP saving plan is £16.2m (4%) for 2013/14. This could increase to a maximum of £29.2m (7.2%), dependent upon the final non-recurrent carry-over figure from 2012/13. As discussed earlier in the meeting, work continues with the Corporate Efficiency Team to close this gap.

Presently, the Trust has not concluded the contract negotiations with the Clinical Commissioning Groups (CCGs). Meetings are being held with the chief executives to finalise the last few points so it is hoped that the contracts can be concluded in the near future.

The Board noted that one of the issues being discussed was the first-to-follow-up ratio. The expectation is that the Trust will undertake significantly fewer follow-ups and more will be undertaken by the GPs (or not at all). Mr Proctor explained that, if implemented at the CCG’s desired level, it would relate to approximately 90,000 follow-ups per annum not taking place in secondary care. The Trust can potentially manage the drop in activity in follow-ups but the concern is that as GPs believe they are currently working at capacity it is not clear how the additional 90,000 follow-ups will be managed. Until the Trust is confident that patients will not come to the Trust for follow-up, it will be difficult to remove the costs. Dr Turnbull added that he felt it would have a negative effect on patients with long-term conditions. Professor Willcocks asked if it would be possible to use the patient experience and expertise to inform the commissioners on how they would like their care to be managed, while also working with public health, patient groups and the volunteer sector. Together with CCGs, this needs to be studied at a specialty level and perhaps phased in.

Mr Keaney commented on the plan. He felt the main concern was ensuring the balance of patient safety and quality was maintained. He added that the under-funding in North Yorkshire of the whole system does mean that there is still not enough money in the system. It is vital that the Trust achieves the CIP plan so that planned investment is not delayed, reduced or cancelled. Mr Keaney added that he felt there was a risk to income that at this stage is not fully known. In terms of expenditure, the concern is the level of spend on agency staff, which again he felt was a big risk.

Mr Bertram advised that the plan would be submitted to Monitor at the end of May, after the May Board meeting. He confirmed there would be a further update given at the May Board meeting for final approval, along with a reconciliation to the plan reported this month.

The Board confirmed the budgets were approved.

Action: Mr Bertram to provide any appropriate update at the April Board meeting and to provide the formal final plan for approval at the May Board meeting.

The Board enquired if the PCT deficit would be passed over to the CCG. Mr Bertram advised that the deficit for the year is expected to be £12m from an original planned deficit of £19m. It is expected that some will be carried across to the CCGs but there are still conflicting views on the final settlement.

13/038 HR Performance Report

Ms Raper commented that the Human Resources (HR) Performance Report was easy to understand but she would like to see more benchmarking data included, if possible. Ms Hayward advised that it was not possible to include more benchmarking data as it did not exist. The Board discussed the use of benchmarking data and asked Ms Hayward to investigate with the Foundation Trust Network (FTN) what benchmarking is used.

In relation to sickness data, the York site is currently very steady with the level of sickness and the focus has moved to the Scarborough site and community. Currently, there has not been significant progress with the community staff around sickness. The Trust is working with NHS Employers and community staff to try and resolve the issues. Agency spend has increased overall but it varies in terms of speciality. Medical spend is mainly on locums where it has not been possible to recruit consultants. This has been reduced by the introduction of locum co-ordinators. The other reason for the increase in the agency spend relates to the level of activity in the Trust at present. Professor Willcocks added that the Workforce Strategy Committee is looking at the arrangements for the introduction of a nurse bank unitary system.

Ms Raper drew the Board's attention to the fact that no compromise agreements had been put in place during the month. Ms Hayward advised that for April 2013 there would be some compromise agreements as a result of the Trust running the Mutually Agreed Resignation Scheme (MARS) process.

The Board **noted** the report.

13/039 Workforce Strategy Committee

Professor Willcocks as Chairman of the Committee updated the Board on the meetings held in December 2012 and March 2013. She reminded the Board that the role of the Committee was not about assurance but about the strategic establishment of the work force. The Committee has been looking at nurse establishment and is now specifically looking at the safe staffing levels and deployment funding so there is a bottom-up re-budgeting of nursing staff being undertaken. A red, amber, green (RAG) rating system has been introduced and will be reviewed in September 2013 and work is underway looking at the nurse-to-bed ratio as a key basis of alignment. The Committee is also looking at the workforce roles and skills mix and expects to undertake a review in the middle of the year. Professor Willcocks added that in relation to CIP and the Francis Report there is a balance between quality and safety that must be struck.

The Board discussed the process for pre-appointment checks and was assured that the system is being addressed. In terms of disciplinary proceedings, there are a small but significant number related to performance issues.

The Board discussed the recent move by Mid-Yorkshire to attempt to reduce its pay bill. The Board recognised that this effectively lead to a risk of industrial action. Ms Hayward advised that the Trust still follows Agenda for Change and would seek to find methods within that framework to reduce costs. Nationally, changes are being considered and will be discussed with the unions in due course. Professor Willcocks reminded the Board that the Board has made a commitment that it will support the implementation of a "living wage".

Ms Hayward mentioned that the Health and Wellbeing strategy and the Sickness strategy were being brought together under one document.

The Board **noted** the report and **thanked** Professor Willcocks for the assurance given.

13/040 Report of the Chairman

Mr Rose advised that the Governors at the recent Council of Governors meeting had approved the re-appointment of Professor Willcocks for a further three years and had noted the positive annual appraisal that Mr Ashton had received.

Mr Rose asked Professor Willcocks to feed back on the Council of Governors meeting she had chaired. Professor Willcocks gave an overview of the meeting and the feedback she had received from the Governors had been very positive. She advised that the meeting with the Governors had been a very busy meeting where the Governors had approved a number of documents including the changes to the Constitution. The Governors also held a lengthy discussion with the Deputy Chief Executive on the acute care strategy and received assurance of the work being undertaken.

Mr Rose advised the Vale of York CCG (VOY) had asked for a meeting with our Board to be arranged. Mr Rose would advise Board members when the meeting has been arranged.

Mr Rose reminded the Board that from April the Board will be meeting in both public and private session. This would require some revision to the availability and publication of papers.

The Board **noted** the report.

13/041 Report of the Chief Executive

In the absence of the Mr Crowley, Mr Proctor gave a verbal report to the Board. He articulated Mr Crowley's personal concern and his commitment to improve the phlebotomy area in York Hospital. He advised that a business case was being developed to support the change.

Mr Proctor advised that York Hospital has secured reaccreditation of the Joint Advisory Group (JAG) accreditation on GI Endoscopy.

Mr Proctor advised that the Trust has agreed to change the management of the membership database to Membership Engagement Services (a subsidiary of the Electoral Reform Society). The change is currently in progress and the new company will have a live database by 9th April 2013.

The Board will remember that it agreed to the introduction of a new supply chain partner as part of Procure 21+. The Trust has now appointed Kier as the partner.

The Board **noted** the report.

13/042 Report on the Governance Regime from Monitor

Mr Ashton summarised the report and raised a query about the liquidity values included in the document. Mr Bertram explained that the figures were correct. From the overall FT sector performance, Monitor deems 20 days financial cover as satisfactory. This includes the working capital facility, of which the average FT facility represents 22 days. Monitor is stripping-out the working capital facility from the liquidity calculation; this therefore equates to "-2 days". The liquidity calculation is not simply cash but is a complicated formula that looks at assets and liabilities with various adjustments.

The Board **noted** the report.

13/043 Constitution amendments

The Board was advised that the Council of Governors had considered the detail at their meeting and had approved the changes. Professor Willcocks explained that the Governors had considered the changes and also the addition of an action plan to be implemented over the next few months. The Governors had noted that the changes included the removal of the PCT as a member of the Council of Governors at this stage but they had agreed they would like to find other ways of including the CCGs.

The Board **considered** the changes in the Constitution and **approved** the document.

The second document for approval was the proposed significant transaction document. The Board understood that the Governors had agreed in principle the "significant transaction" definition but would like further development of the definition over time. The Board noted that the definition was based on the Monitor Compliance Framework.

The Board **approved** the significant transaction definition.

It was agreed that, in future, Business Cases would include the question: "Does this business case represent a "significant transaction" for governance purposes?".

13/044 Policies for approval

The following documents were submitted to the Board of Directors for approval:

13/044.1 Risk Management Policy

The policy had been considered by the Corporate Risk Management Group and it had been agreed to recommend the document for approval by the Board of Directors.

The Board **considered** and **approved** the policy.

13/044.2 Risk Management Strategy

The strategy was considered by the Corporate Risk Management Group and it had been recommended that the strategy should be presented to the Board of Directors for approval.

The Board **considered** and **approved** the strategy.

13/045 Governance Document for approval

The Audit Committee had considered the revised documents at its last meeting and recommended approval by the Board of Directors:

13/045.1 Standing Orders

The Board noted that the changes had been made to ensure the document was compliant with the Health and Social Care Act 2012. The Board of Directors **approved** the revised document.

13/045.2 Standing Financial Instructions

The Board noted the changes made were minimal to ensure the documents were appropriate. The Board of Directors **approved** the revised document.

13/045.3 Reservation of powers and scheme of delegation

The Board noted the changes that had been made, specifically the increase in authority for the Chief Executive. The Board of Directors **approved** the revised document.

13/046 Any other business

There was no other business.

13/047 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 24 April 2013 in the Boardroom, York Hospital.

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NHS Foundation Trust

Quality & Safety Committee – 20th March 2013, Libby McManus Office

Attendance: Libby Raper
Jennie Adams
Elizabeth Raper
Diane Palmer
Anna Pridmore

Apologies: Alastair Turnbull

	Agenda item	Comments	Assurance	Attention to Board
1.	**Notes from last meeting**	No comment		
2.	**Chief Nurse Report**	**Leadership walk rounds** – Libby Raper (LR) reported on the recent walk round she had undertaken with the Medical Director. She asked if there could be more briefing to staff on the areas of concentration of the walk round. Dianne Palmer (DP) advised that she was in the process of revising the paperwork to provide more suitable and effective information. **C-Diff and MRSA -** The Committee noted the Trust has breached the trajectory for C-Diff. The Trust is appealing 3 cases. If the appeal is successful the Trust will be in a position where it has not breached the trajectory. The performance around MRSA has been excellent during the year. Congratulations to all staff.	Leadership walk rounds are being undertaken and improvements are being made to the process and information published.	

	Agenda item	Comments	Assurance	Attention to Board
2.	**Chief Nurse Report**	**Operational performance** – LR asked Elizabeth McManus (EM) to provide an update on the operational performance of the Trust since the last meeting. EM advised that the Trust continues to be very busy. A GP Assessment Unit has been set up and the Trust has experienced another wave of Norovirus which has affected a number of wards. The GP Assessment Unit has been set up to try and ease the flow of patients in the Emergency Department. The staffing for the Unit was from existing staff, and appropriately qualified nursing staff who work corporately are being assigned back to operational duties to support this. EM explained that the complexity of the patients being seen has increased noticeably. Scarborough has the same issues as York, just not quite as significant. LR asked if a risk had been added to the Corporate Risk Register on the continuing operational challenges that were being faced by the organisation. Elizabeth McManus (EM) advised that it had been agreed that a risk would be added. **Pressure ulcers** – EM described the concerns and gaps in process and assurance that have been identified. She described the work that was currently underway to improve the position. EM talked about the type of patients that were experiencing pressure ulcers and the severity.	The introduction of the GP assessment Units and the response to the increase in demand. Inclusion of the risk on the Corporate Risk Register	EM to update the Board on the work around pressure ulcers

	Agenda item	Comments	Assurance	Attention to Board
2.	**Chief Nurse Report**	She explained that there is a proactive strategy in place. The Committee discussed the communication of the strategy and suggested that it should be wider than just nurses. EM agreed to review communication of the strategy. The Board discussed if there were any equipment issues that should be addressed as part of this review. EM advised that some changes had been made to the Tissue Viability Team to ensure that there is a dedicated member of staff who manages the equipment needs of patients with pressure ulcers. **Safety Thermometer** - The Committee asked how hard it would be for the Trust to achieve 95% usage of the system. EM explained that there are areas where this will be a challenge, but it is achievable, but there does need to be some clarity about the target definition. The Trust has agreed to introduce Advanced Clinical Practitioners; their introduction is a new model of delivering care and provides opportunities to do things differently. The use of the model will be picked up through the Workforce Strategy	The development of the systems and the work being done to improve performance	

	Agenda item	Comments	Assurance	Attention to Board
2.	**Chief Nurse Report**	Committee. The benefit of the model is that it allows the Trust to plan the medical workforce differently and gives some big strategic opportunities and shifts the culture. Staffing – EM advised that she had now completed the changes to her senior team; she believes one of the benefits will be that there is stronger reporting through the Corporate Nursing that was in place historically.		
3.	**Quarterly DIPC report**	The paper was not included in the pack due to the meeting being so early in the month. EM advised that she did not believe there was any specific issue of concern to raise with the Committee. She had not seen the final report, but expected it to demonstrate compliance and provide evidence of good quality clinical care and high standards.	Compliance with systems and delivery of the work programme	EM to present to the Board of Directors.
4.	**Annual compliant report**	This report was not included in the pack due to the meeting being so early in the month. EM explained that the report was a factual report about the numbers of complaints received during the year. This report is a very factual report and does not give any qualitative detail. It is required that the Board receives this report once a year.		Presented separately on the Board agenda.
5.	**National Inpatient survey**	This report was not included in the pack due to the meeting being so early in the month. EM explained that the Board will receive the executive summary	The changes described will provide additional assurance to members of the Board.	Presented separately on the Board agenda

	Agenda item	Comments	Assurance	Attention to Board
6.	**Medical Director Report**	DP described the changes that will be made to the MD report over the next few months. **Mortality** – The Committee discussed the progress being made and the actions being taken and recognised the excellent work that was being carried out. It was also recognised that there was still lots more work to do. DP reported that the Standard Hospital Mortality indicatory (SHMI) would be reported by the Medical Director at the Board. **Safety Briefings-** DP advised that there was now clear evidence that safety briefings were taking place, but not being recorded properly. DP has arranged that the confirmation required in the system has been moved so that it is required earlier. The second element is to discuss the quality of the safety briefings. This is being discussed through the Executive Board. With regard to the Scarborough site, there are a very small number of briefings completed and the system does not at present include Bridlington. When the electronic system is in place in Scarborough there will be a better idea about the completion of briefings.		The Medical Director to report on the SHMI

	Agenda item	Comments	Assurance	Attention to Board
6.	**Medical Director Report**	EM added that the Executive Board are considering a paper that deals with compliance and the removal of deviance to agree how the Trust deals with non-compliance. **Adverse incidents** - The Committee raised their concern in the increase in the number adverse incidents and the backlog has been growing. DP explained that a more streamline system and as a result it has identified a gap in the process. This is being addressed. **PROMs Data** – This involves hips and knees and at this stage the Trust is not an outlier. **CRR** – There has been no significant changes to the identified risks except for the development of the risk discussed earlier.		

C1

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Chief Nurse Report – Quality of Care

Action requested/recommendation

The Executive Board is asked to accept this report as assurance of standards of care for patients and note areas of both risk and significant progress.

Summary

The Chief Nurse report provides assurance against the implementation of the Quality & Safety Strategy and evidence in support of our Quality Account. The report will also reflect the work streams of the Nursing and Midwifery Strategy once approved at Board.

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Elizabeth McManus – Chief Nurse
Author	Beverley Geary – Deputy Chief Nurse
Date of paper	April 2013
Version number	Version 28

Board of Directors – 24 April 2013

Chief Nurses Report – Quality of Care – February 2013 report

1. Key priorities

Our priority as nurses is to ensure safe and highest possible quality of care for all of our patients. We have this year agreed to focus on areas to better support nurses and midwives in an increasingly busy era with patients whose complex care needs require ever increasing amounts of assessment and appropriate care.

The Nursing & Midwifery Strategy will be presented through Executive Board next month and into the Board of Directors for full approval following a wide consultation and involvement exercise which gave helpful feedback.

2. Quality & Safety in care

Pressure Ulcers

As the Board is aware we have recently undertaken detailed work to scrutinise the way in which we prevent and manage pressure ulcers. This included an external review of pressure areas which was undertaken in December, and a look back exercise to identify any issues in reporting and escalation.

Initially, we found conflicting data and inconsistent reporting across the wider organisation and also a number of issues in the way in which we assess and manage pressure areas. Education of non registered staff was variable.

In response to this a committee was set up to manage and deliver the resulting action plan. It was also agreed that due to the conflicting data a 'look back exercise' should be undertaken in order to assure ourselves that we are using best practice in terms of all aspects of care including assessment, treatment and any required reporting and learning.
A retrospective review of data for February and the 1st week in March highlighted variation in practice and reporting. During this period we have reported 5 patients with Category 4 pressure ulcers.
In line with policy these have been declared as SI's and detailed RCA's are currently being undertaken.

In addition to the actions already identified as part of the review, a detailed project plan has been developed with additional actions to address these more recent findings, these include:

- A programme of reduction has been agreed.
- Investment in HCA training. (already planned)
- A full review of the assessment process will be undertaken.
- A Pressure Ulcer Panel (Chaired by myself) will be set up.
- An organisation wide review of the Tissue Viability Service will be undertaken.

Whilst I am disappointed in this I am confident that we can focus on the right things and make adjustments to ensure we have an even stronger resolve to prevent skin damage

where possible.

Matrons will need your support and understanding of this as one of our priorities.

Safety Thermometer
Data is included at appendix 2.
The Safety Thermometer audits have now been conducted for 10 months. The number of patients reviewed has remained consistent throughout the data collection periods providing assurance that all patients required to be surveyed with the Safety Thermometer are being reported.

The data from the previous months surveys will now be used to determine a baseline measure for improvement to qualify for CQUIN payments in the new financial year. The organisations 'Harm Free Care' composite based on the collective data gives a mean value of 87.88%, the national goal is to achieve 95%.
Pressure ulcers remain the most prevalent harm and the reduction of these are a main priority as described above.

NCI's
Data is included at appendix 1.
A detailed examination of the NCI data is being undertaken to look at key themes, data collection and accuracy, and how we measure the quality of care will be undertaken.
I am planning to work with the ward Sisters to establish what data is meaningful to them and also seek to reduce the bureaucracy at ward and department level.
Work around Nutrition and Pressure area care has already begun

Falls
There is a noted increase in number of falls reported within Community Hospitals in the last reporting period. Individual reports on each area are being developed combining data from various sources to further analyse the data and identify areas for improvement. The newly appointed Senior Nurse for Quality and Patient Safety will lead this work.

Key themes this month
The operational difficulties experienced in February have continued throughout March due to the high demand on services. This has continued to place considerable pressure across the organisation and the challenge to nurse staffing levels and quality patient care remains. The use of temporary staffing continues and areas of high risk are reviewed on a shift by shift basis in order to ensure safe nursing levels. Incidents and any themes are being closely monitored.

3. Corporate Risks

Infection Prevention and Control:
The reduction of Healthcare Associated Infection (HCAI) remains a patient safety priority. Performance against the Infection Prevention (IP) Annual Plan 2013/14 reflects the achievement of all key objectives aimed at delivery of an effective service.

There has been no incidence of MRSA bacteraemia (bloodstream infection) on the York site for the year 2013/14 and one case on the Scarborough site against a combined trajectory of 6. Combined incidence for *Clostridium difficile* infection (CDI) was three cases over trajectory 54/51 with the greatest incidence occurring on the York site. A strict CDI reduction

strategy and antimicrobial stewardship framework is in place with performance and compliance monitored by the senior IP team, Clinicians and Pharmacy leads overseen by the Hospital Infection Prevention Group.

4. Key Achievements & Progress

Nursing and Midwifery strategy

A new strategy for Nursing and Midwifery has been developed and sets out the direction for nursing in the organisation the next three years. We await final approval at Board next month.

The overall aim is to refocus nursing and midwifery care across the organisation in line with the recent Chief Nursing Officer vision and widely publicised 6 C's (Compassion, Commitment, Competence, Communication and Courage) aimed at building compassion in caring.

The strategy includes priority areas and key deliverables and focuses upon staff & patient experience, and safety and impact of care. Detailed work plans will be developed by the nursing teams with priorities being set locally.

A communication programme to all nursing staff is planned in the next few months.

Senior Nursing Team

The past year has seen a significant change and developments in the direction of nursing in the organisation, this will continue as part of the strategy as described above.

I have recently undertaken a major restructuring of the senior nursing team. Corporate Nursing has now changed - aligned with changes in Directors portfolios and as previously communicated to you all I have developed a new Chief Nurse Team.

The team will work together with the wider nursing workforce with an aim to focus on patient care, improving experience and will also promote excellence in nursing and leadership.

We will work closely with the Matrons to identify priorities to ensure the delivery of the Nursing and Midwifery strategy.

It's My Ward

One of the strategies adopted to improve leadership at ward level is the It's My Ward (IMW) programme.

To date 6 of the 8 planned cohorts have completed the initial programme and the first skills day from the Chief Nurses' Team has been delivered. The content of the day included professional standards, accountability, regulation and compliance and patient experience and the Ward Sisters role in this. The objective was to reinforce some fundamental principles, give an overview of the wider operational and regulatory requirements and also to promote confidence in the role as ward leader with permission to act.

As part of the programme staff were asked to make suggestions of ways in which we could change practice to improve care. These were captured as 'bright ideas' and we are currently looking into ways in which some of these can be implemented by the ward sisters across the organisation with the support of the Chief Nurse's Team and Matrons. Feedback is planned at future evaluation sessions where best practice will be shared.

The remaining cohorts will complete the programme before the end of the year and further Senior Nursing skills days will be delivered in the coming months. In addition skills days for Effectiveness (including finance & facilities management) and Human Resources &IT are also planned.

Whilst the benefits and results of the programme will be seen over time, all of the evaluations to date have been extremely positive and I am confident that this is the foundation to promoting stronger nursing leadership at ward level across the organisation.

Advanced Clinical Practitioners
In order to improve safety and quality and to test new workforce models we have introduced a new role of Advanced Clinical Practitioner.
These are new roles for trained nurses or AHP's who undertake significant additional training in advanced clinical practice, this includes non medical prescribing, advanced assessment skills, xray interpretation and Advanced Life Support.
A cohort of 7 trainees have been appointed and have begun their 2 year programme, recruitment of qualified practitioners is ongoing.

5. Recommendation

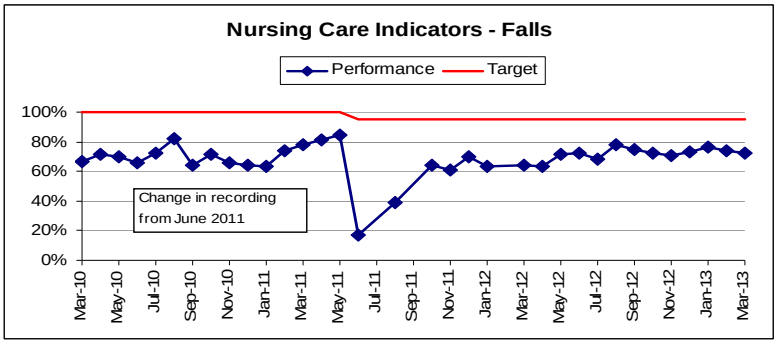
The Executive Board is asked to accept this report as assurance of standards of care for patients and note areas of both risk and significant progress.

Author	**Beverley Geary, Deputy Chief Nurse**
Owner	**Elizabeth McManus, Chief Nurse**
Date	**April 2013**

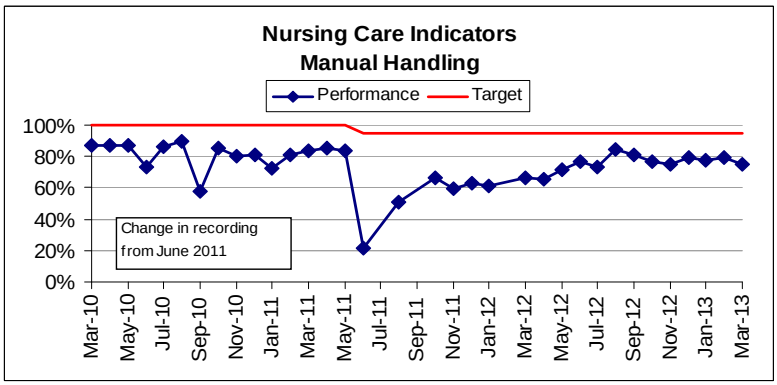
Nursing Care Indicators results for 2013

York & York and Selby Community Hospitals

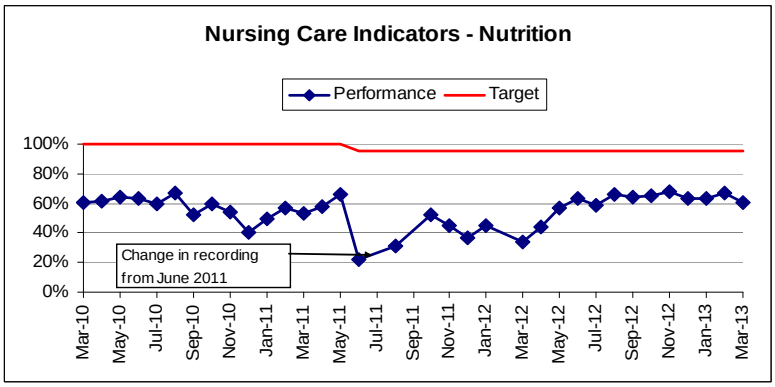
Falls



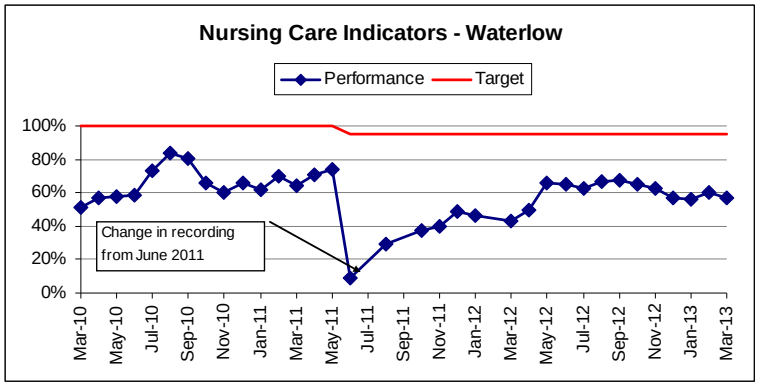
Manual Handling



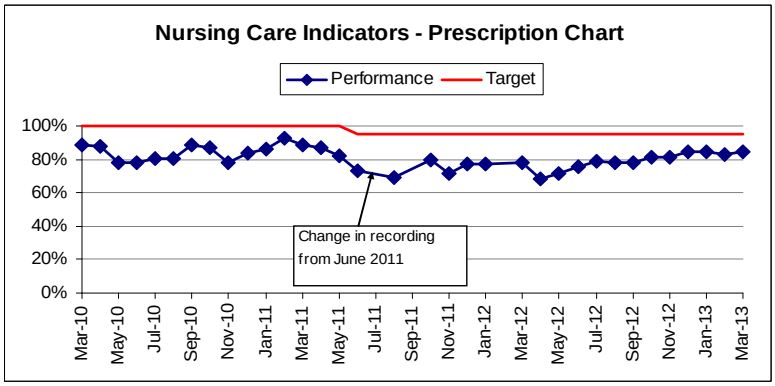
Nutrition



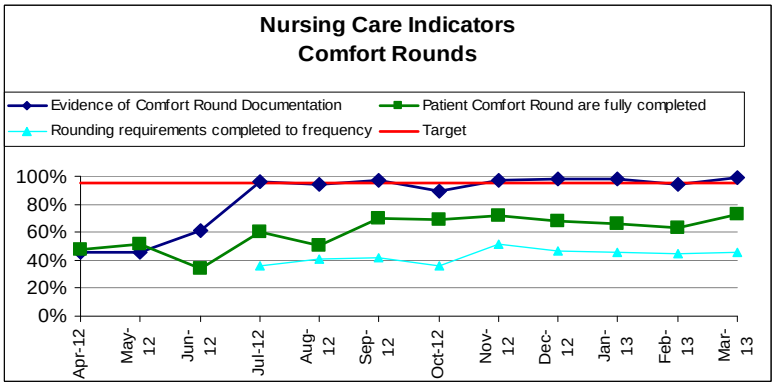
Waterlow



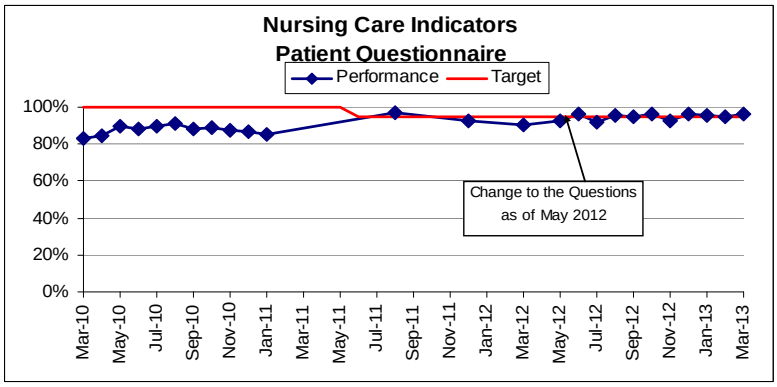
Prescription Chart



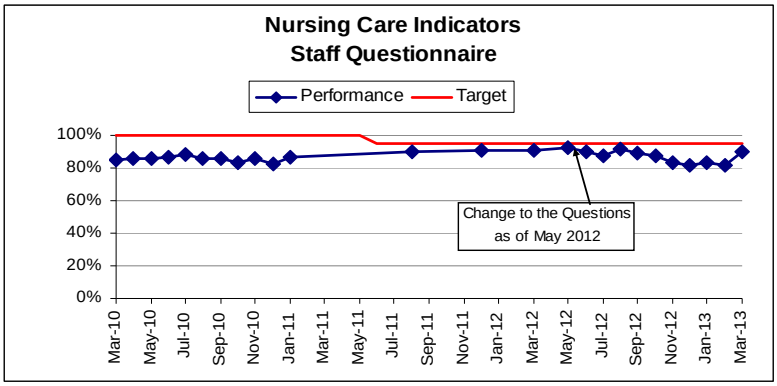
Comfort Rounding



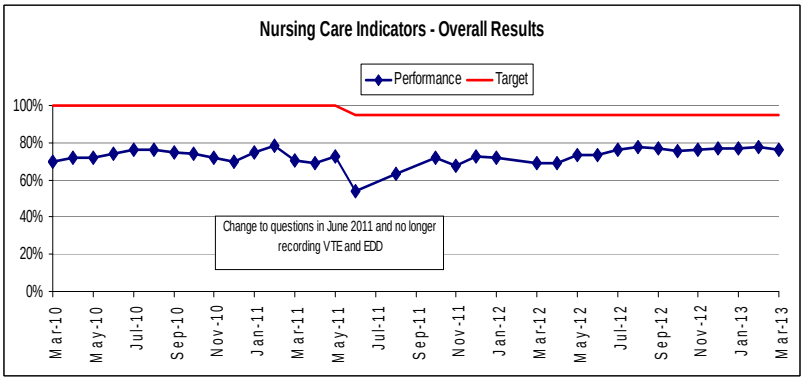
Patient Questions



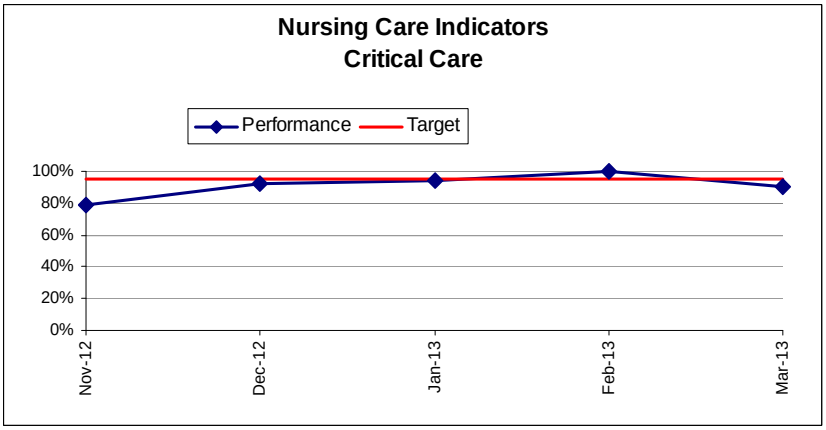
Staff Questions



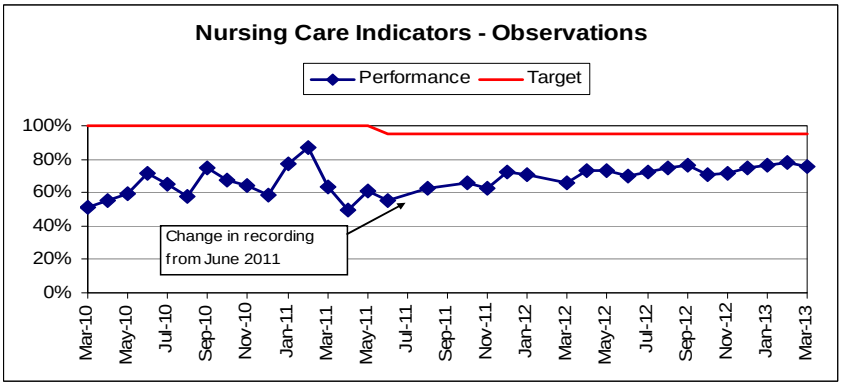
Overall Results



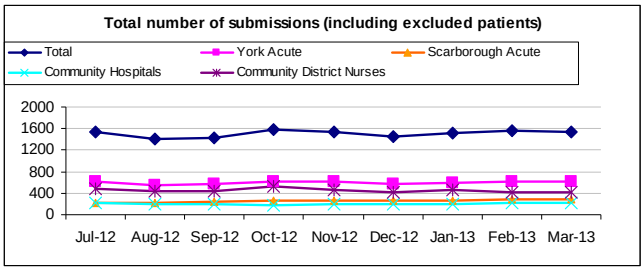
Critical Care NCIs – York only

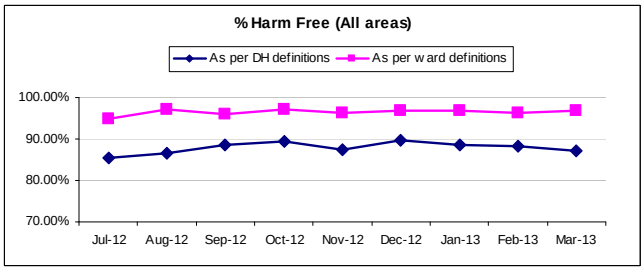


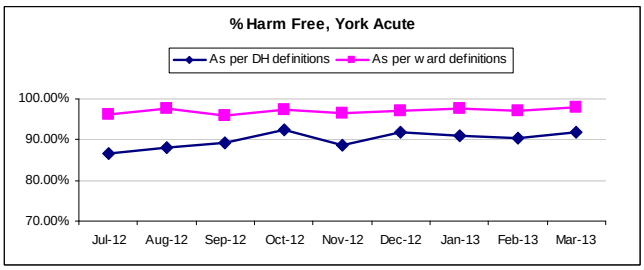
Patient Observations – York only

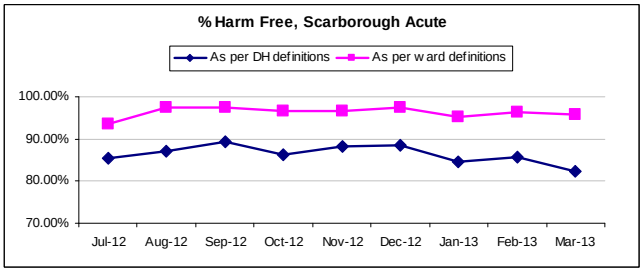


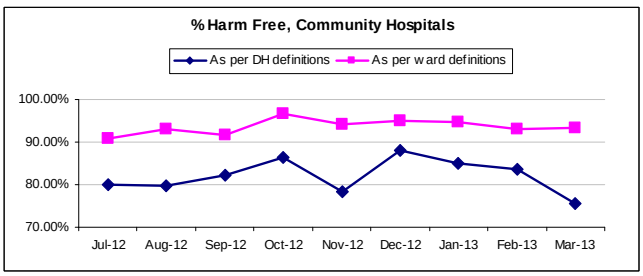
Safety Thermometer Data

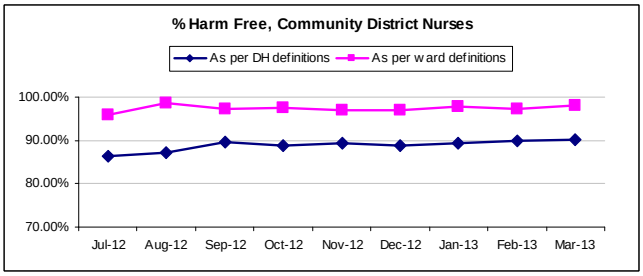


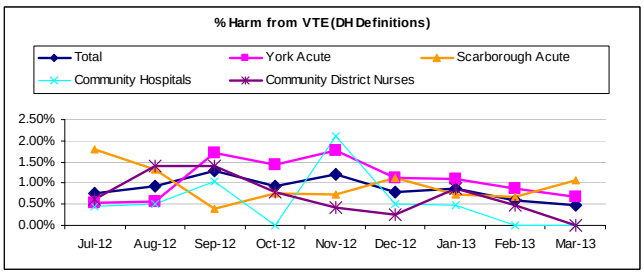


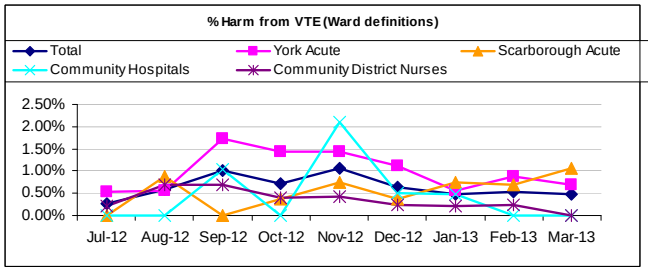


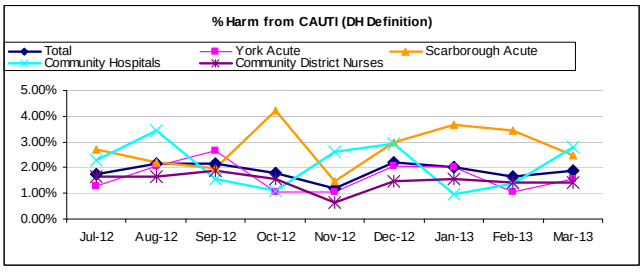


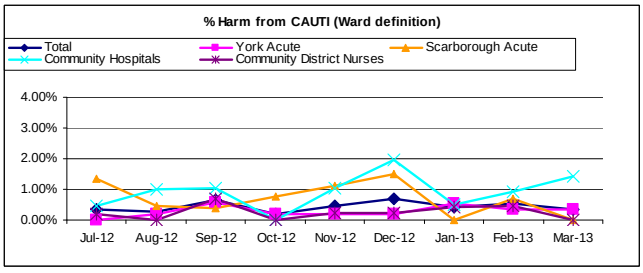


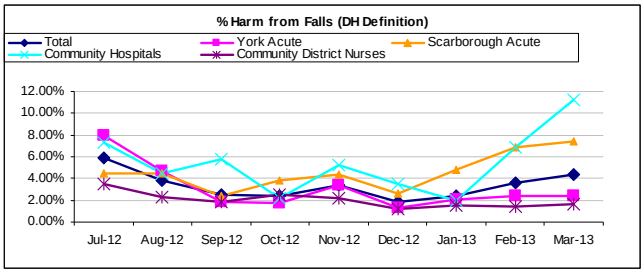


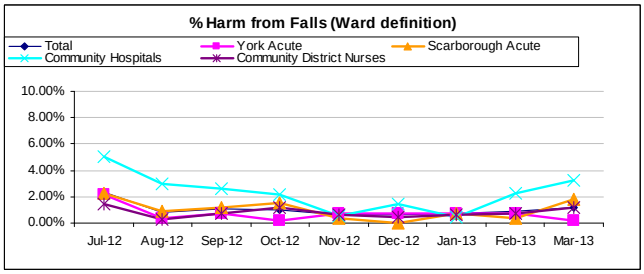


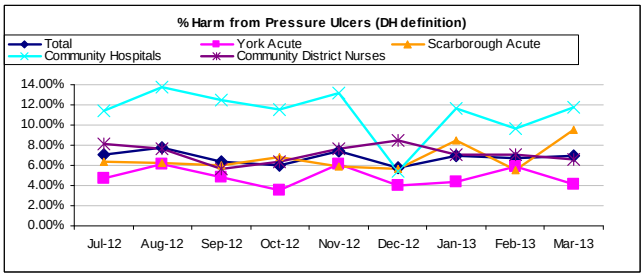


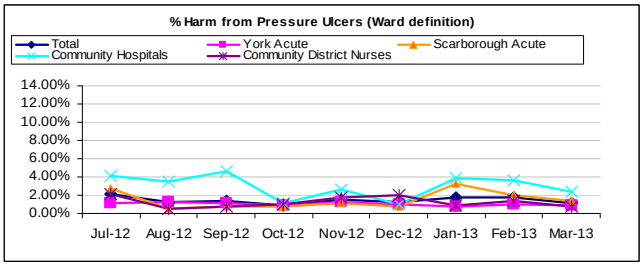





% Harm from Falls (DH Definition)
Total
York Acute
Scarborough Acute
Community Hospitals
Community District Nurses
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13


% Harm from Falls (Ward definition)
Total
York Acute
Scarborough Acute
Community Hospitals
Community District Nurses
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13

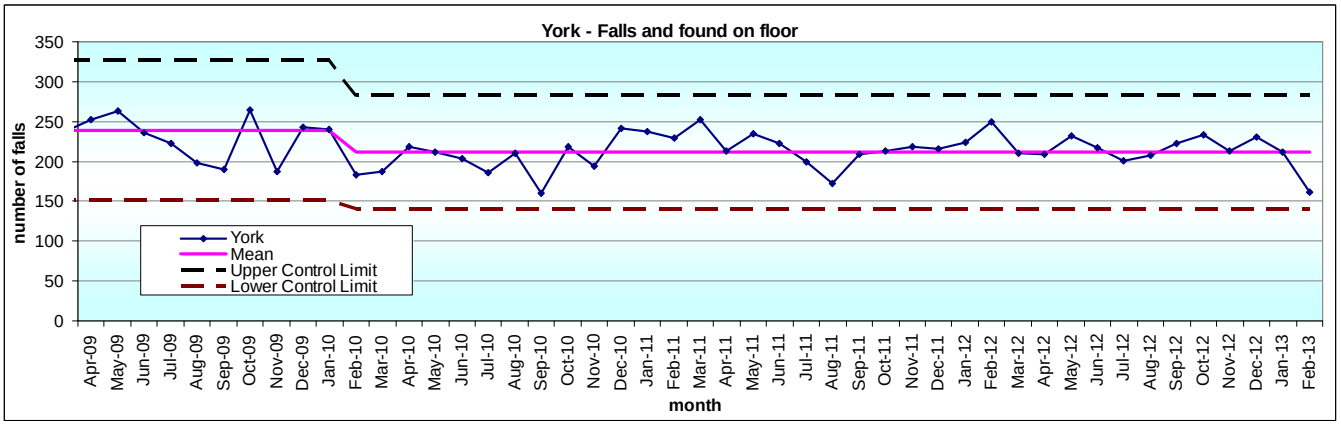

% Harm from Pressure Ulcers (DH definition)
Total
York Acute
Scarborough Acute
Community Hospitals
Community District Nurses
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13


% Harm from Pressure Ulcers (Ward definition)
Total
York Acute
Scarborough Acute
Community Hospitals
Community District Nurses
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13

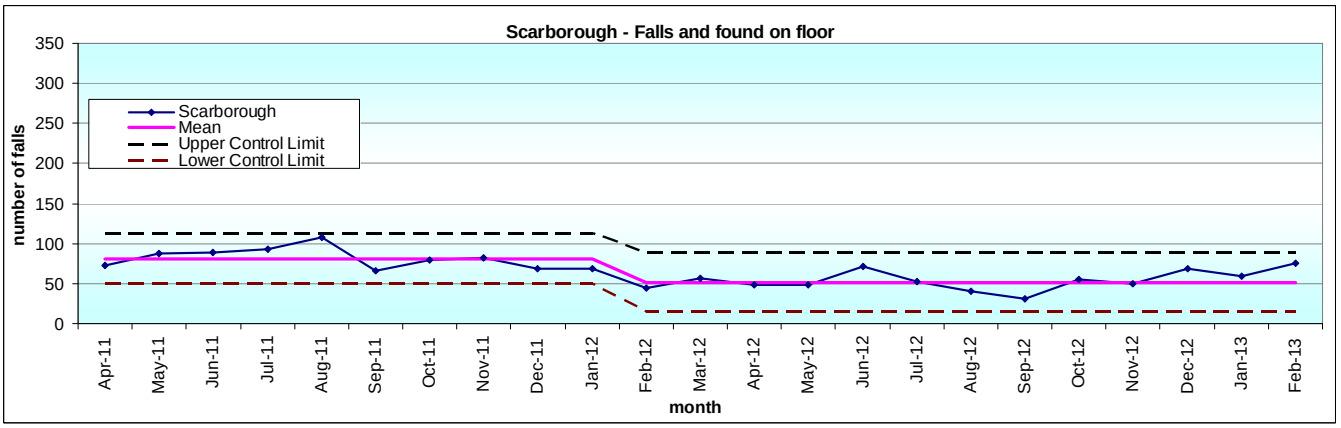
Falls and pressure ulcer adverse incident data

Falls

York Hospital falls data:

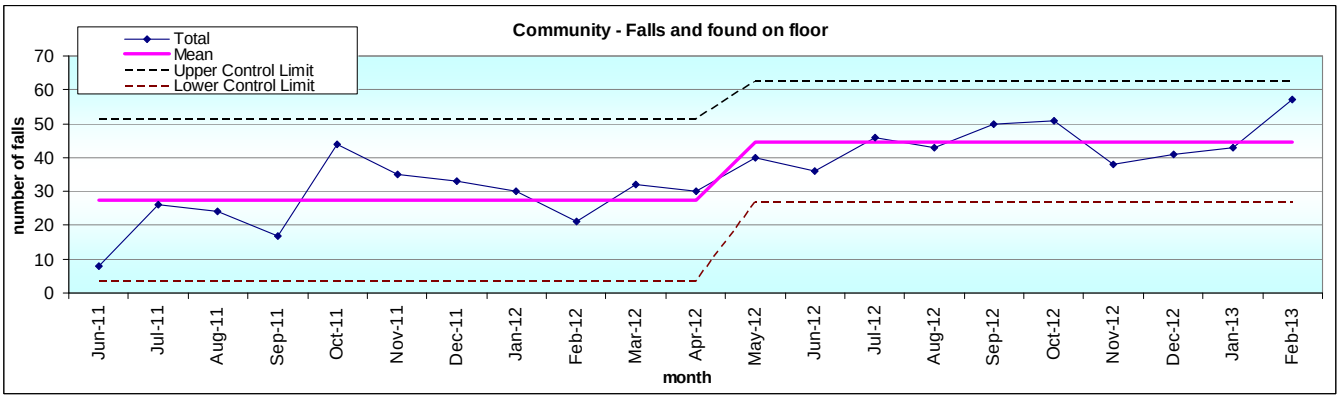


Scarborough Hospital falls data:



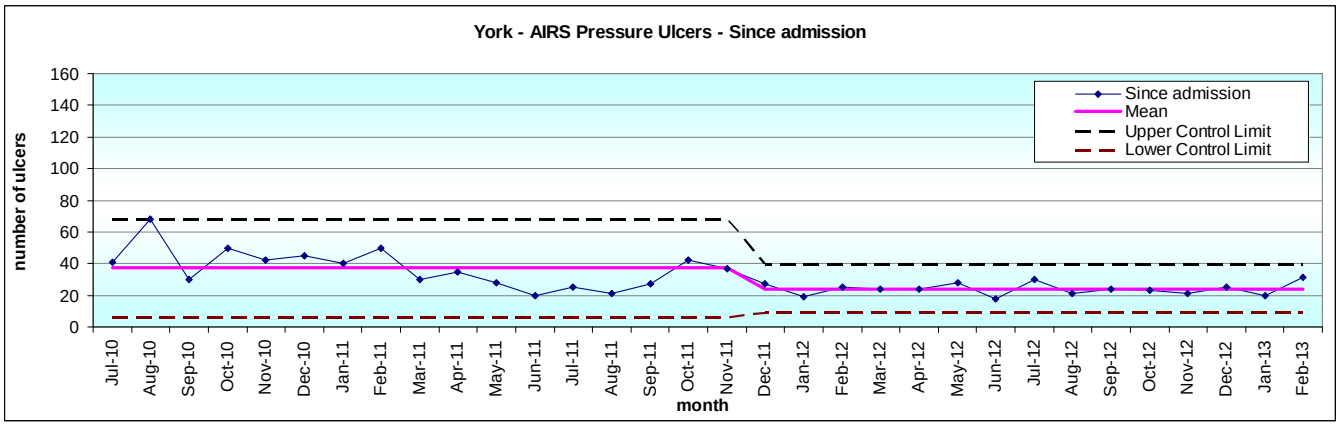
Community falls data:

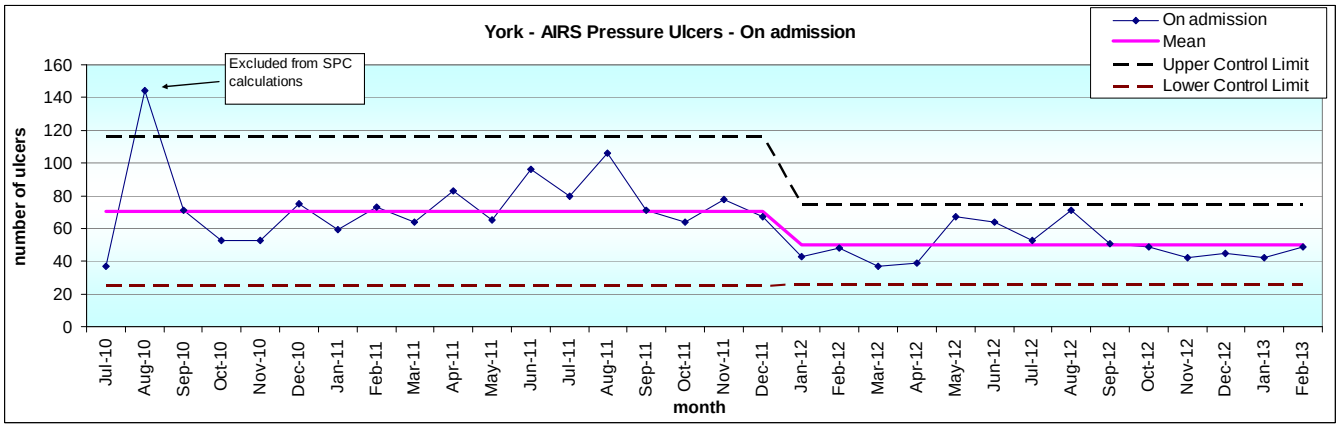
Data includes all community (Archways, Selby, St. Monicas, Whitby and Malton and virtual wards)



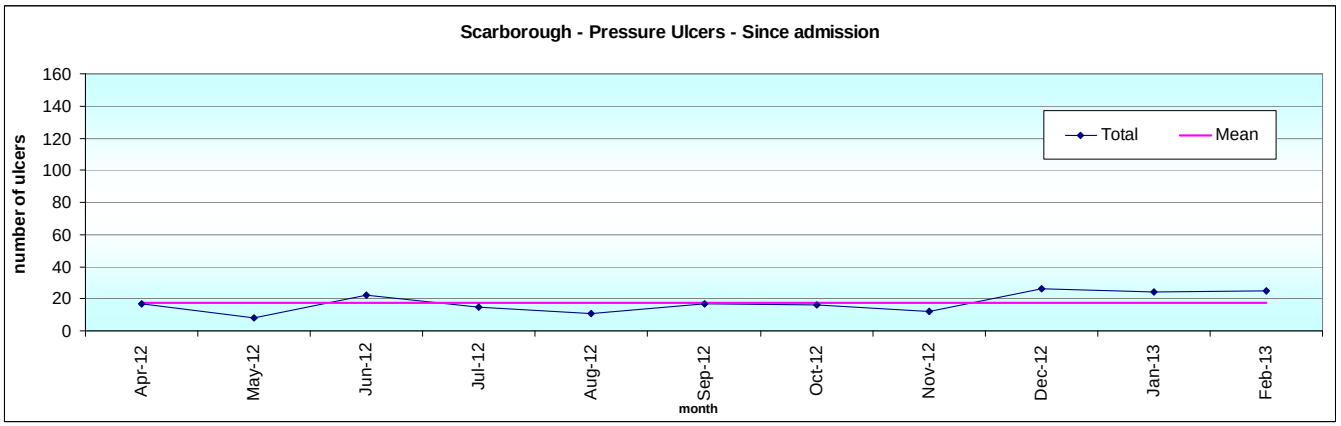
Pressure ulcers:

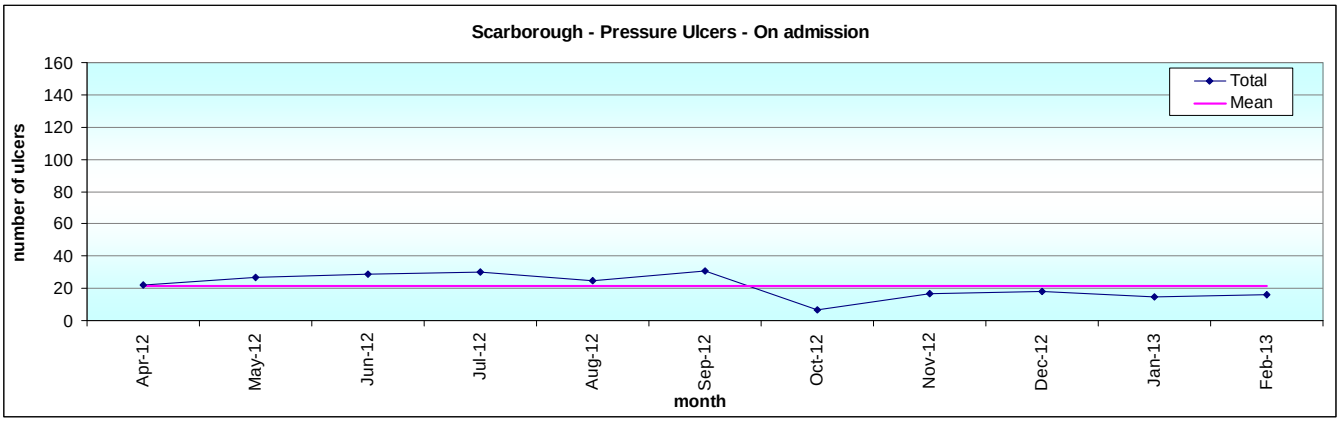
York Hospital pressure ulcers data:





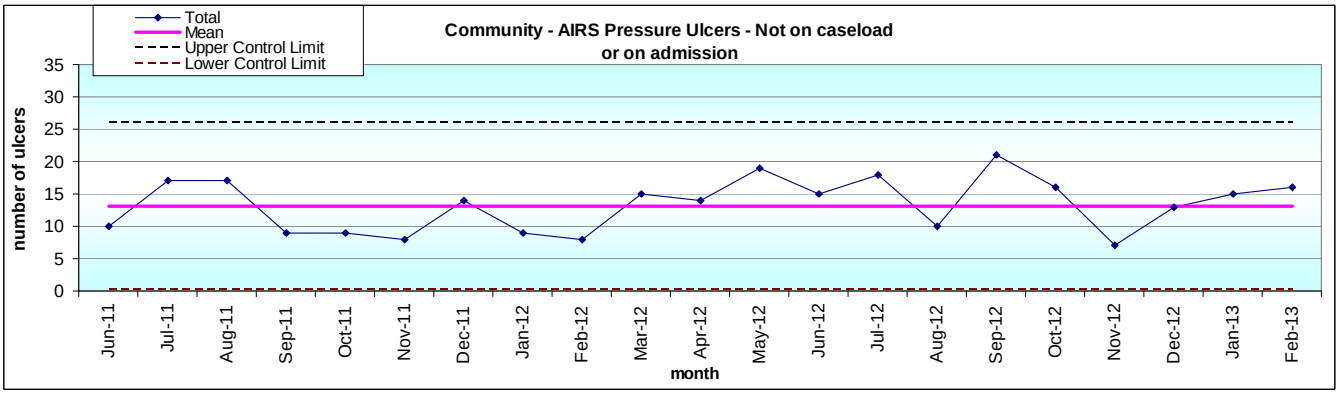
Scarborough Hospital pressure ulcers data:

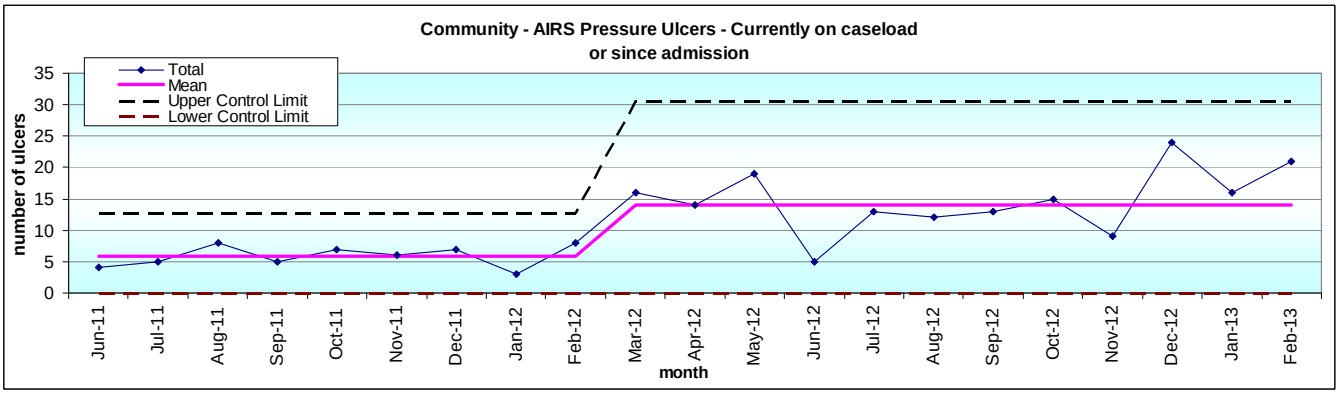




Community pressure ulcers data:

Data includes all community (Archways, Selby, St. Monicas, Whitby and Malton and virtual wards)





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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Medical Directors Patient Safety Report

Action/Recommendation

To accept the report and note the ongoing work with the Reducing Mortality Programme.

Summary

Top three issues this month:

1. Reducing mortality – publication of SHMI
2. PROMs update
3. Review of Influenza campaign.

Strategic Aims	**Please cross as appropriate**
1. Improve Quality	☒
2. Improve our effectiveness, capacity and capability	☒
3. Develop stronger citizenship through our working with partners	☐
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

No implications for equality and diversity.

Reference to CQC outcomes

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

Progress of report	This report is only written for the Executive Board.
Risk	No additional risks indicated other than those reported on the 'Risk Register' item.
Resource implications	None identified
Owner	Dr Alastair Turnbull, Medical Director

Author	Diane Palmer, Deputy Director for Patient Safety
Date of paper	15th April 2013
Version number	1

Board of Directors – 24 April 2013

Medical Directors Report - April 2013

1. Introduction

Top three issues this month:

1. Reducing mortality – publication of SHMI
2. PROMs update
3. Review of Influenza campaign.

2. Patient Safety

2.1 Key patient safety priorities:

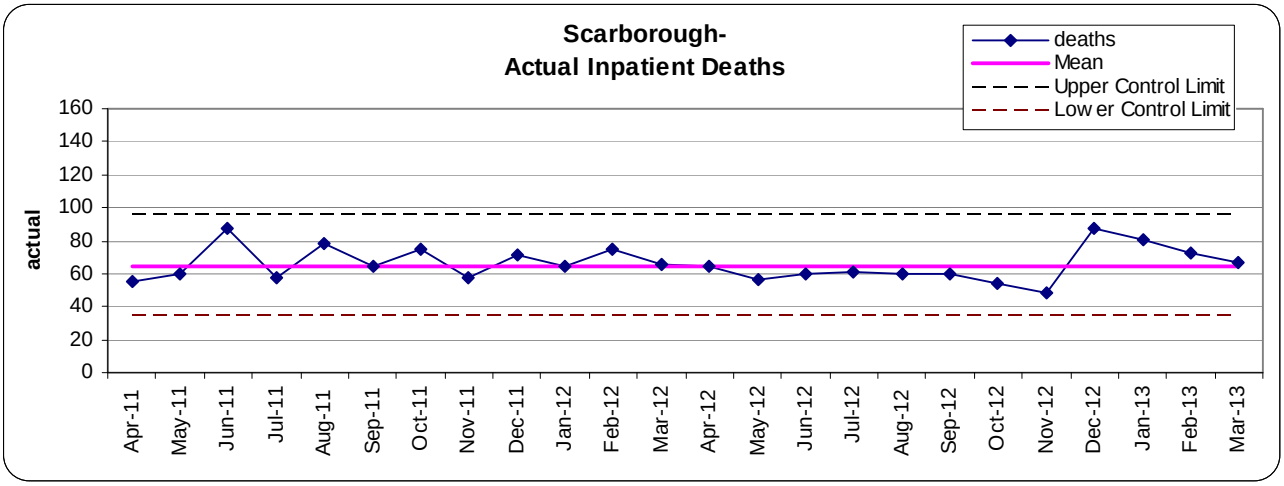
- Reducing mortality by
  - *ensuring a 7 day service*
  - *reviewing systems for measurement*
  - *reducing harm and deterioration*
  - *excellence in end of life care.*

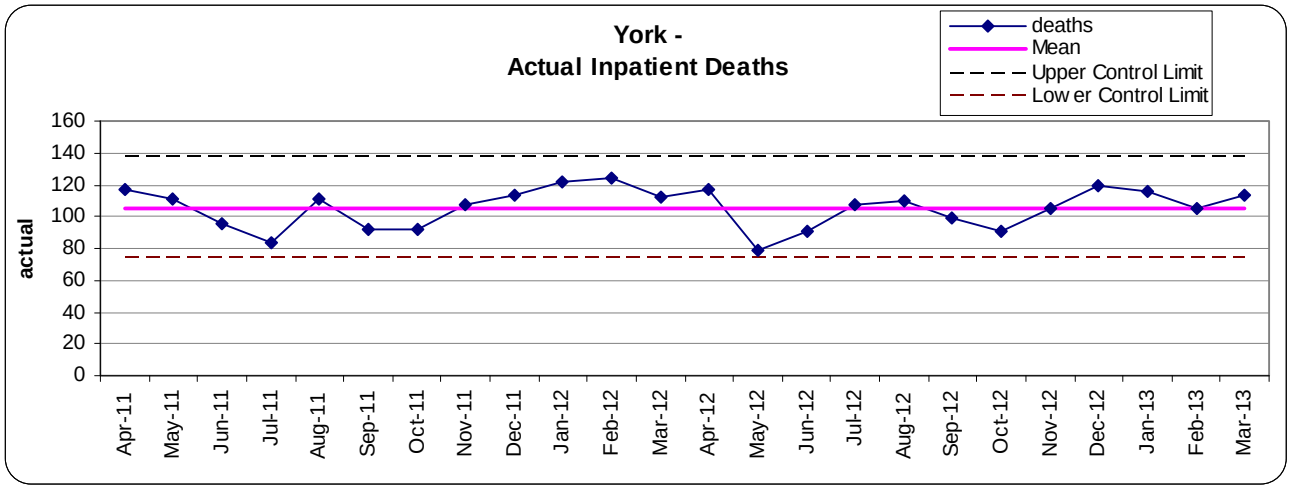
Others - *compliance with WHO surgery checklist*

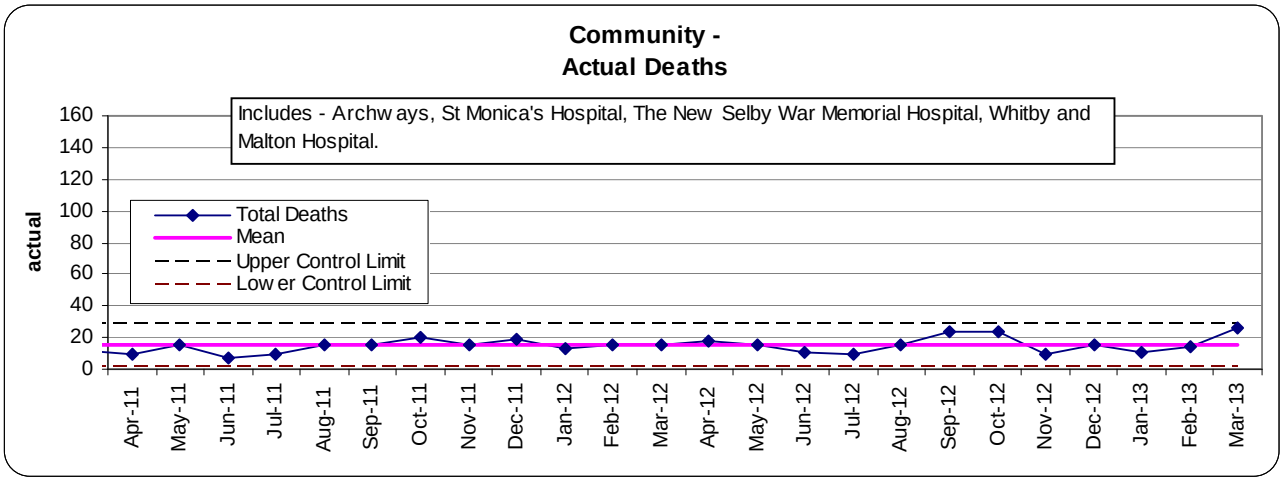
- *compliance with VTE assessment, prophylaxis and treatment regimens*
- *reducing medication related incidents.*

In patient deaths

The number of inpatient deaths are summarised in the graphs below.







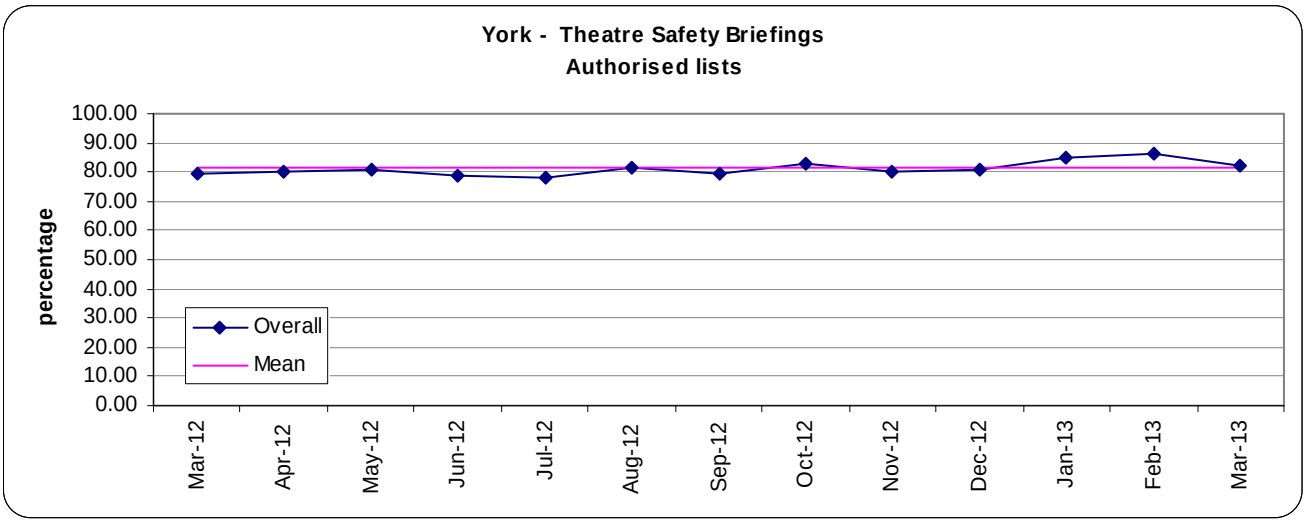
The Summary Hospital-level Mortality Indicator (SHMI) is due to be published on 24th April therefore the Board of Director's will receive a tabled report on the Trust position.

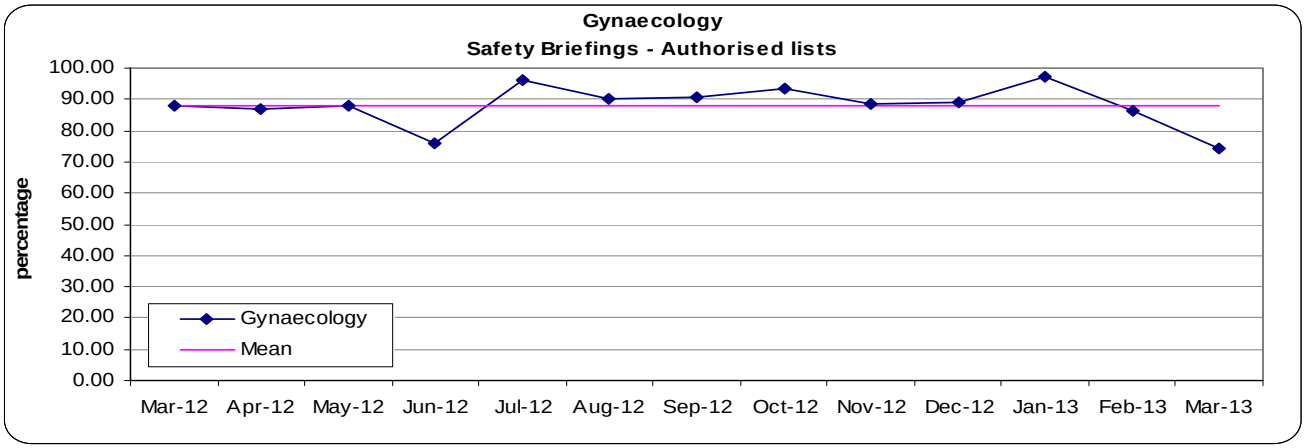
Reducing mortality programme

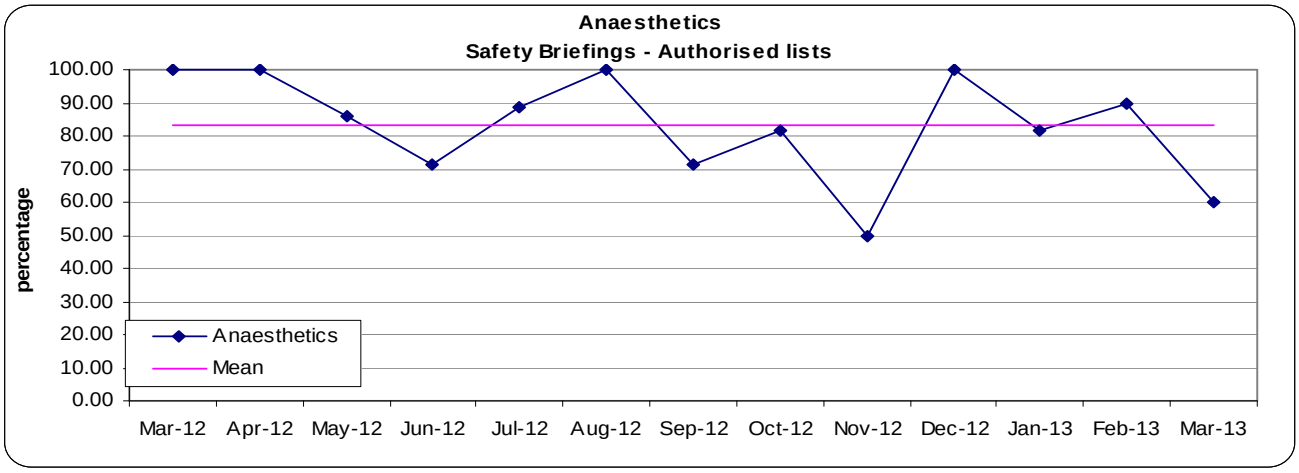
An update on the reducing mortality work-streams is presented as Appendix 1.

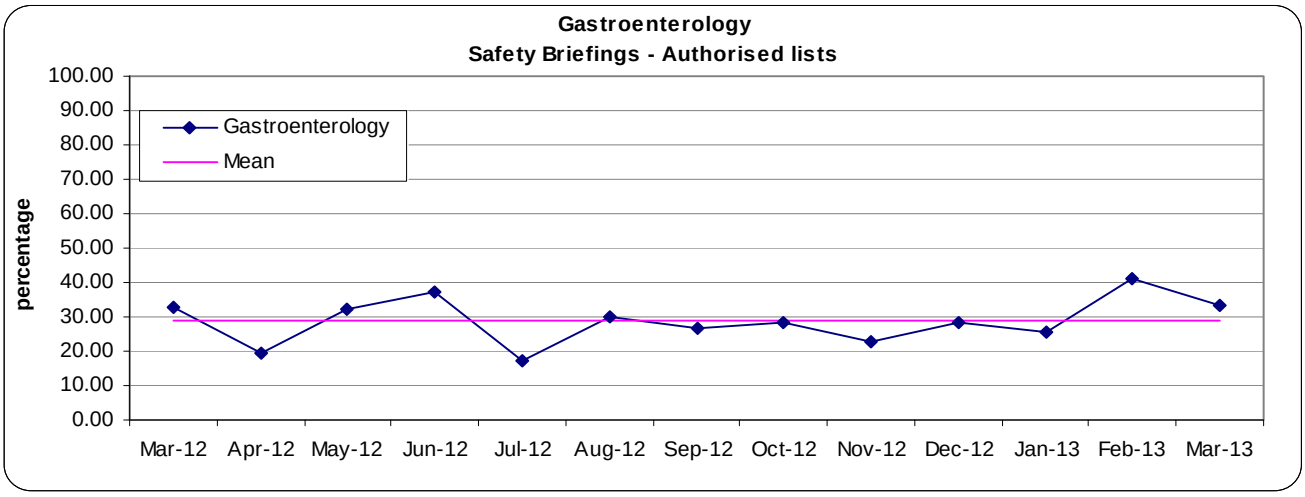
Theatre safety briefings

A summary of compliance with theatre safety briefings for the last 12 months at York Hospital is illustrated below. The overall compliance rate is 81.9% which is a slight reduction from the 86.6% compliance recorded last month. During March, three specialties had compliance of less than 80%; gynaecology (74%), anaesthetics (60%) and gastroenterology - endoscopy (33%), who have met with S and N to agree a plan for better recording.

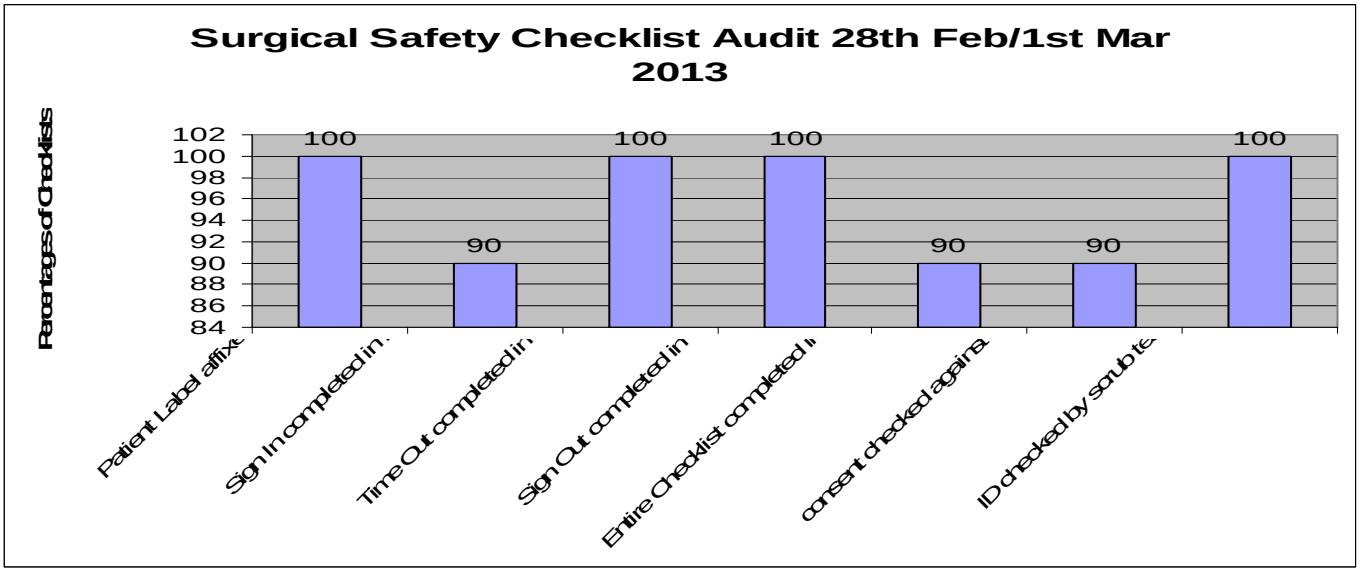






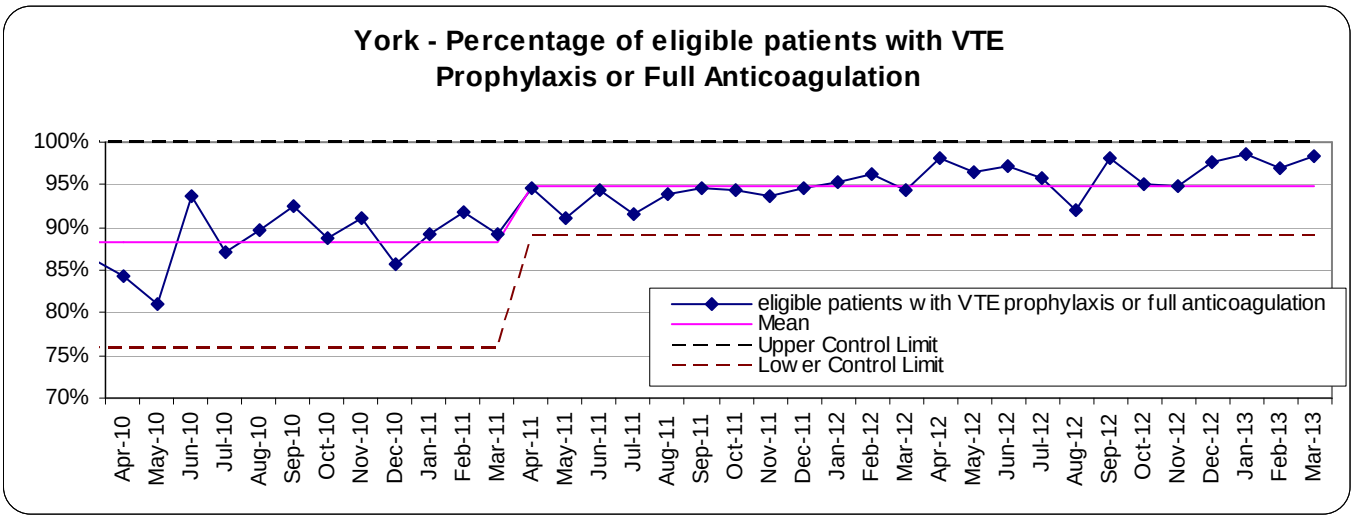


The chart overleaf illustrates results of an audit of 10 theatre cases at Scarborough Hospital: one case of sign out was not completed in ENT, one checklist out of 10 was not completed in full as the sign out had not been completed ,and one case in urology was not checked for consent prior to surgery.

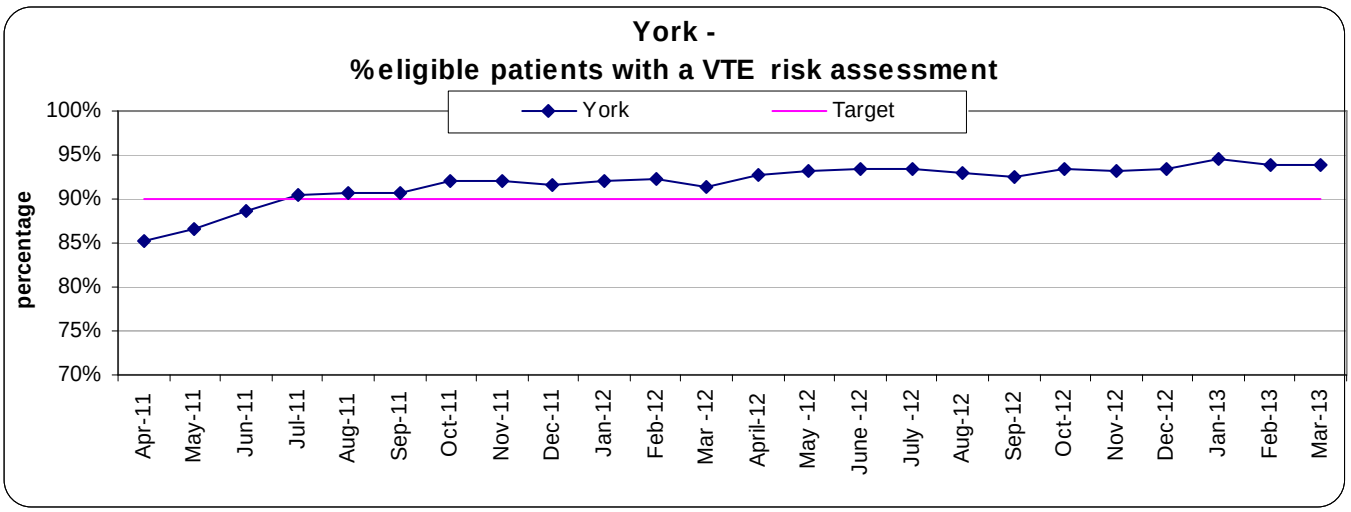


Prevention of VTE

The chart below illustrates good levels of compliance with VTE prophylaxis or anticoagulation for York Hospital. Scarborough Hospital data is awaited at the time of reporting.



Compliance with VTE risk assessment for both Scarborough and York site is illustrated below and overleaf.



Influenza vaccination campaign

A summary of the influenza vaccination campaign 2012/13 and plans for 2013/14 is attached at Appendix 2. The final overall take up rate by staff within the Trust was 47.98%.

3. Adverse incidents

The total numbers of adverse incidents reported during January, February and March are listed below, along with the number of medication related incidents.

Adverse incidents	Community	Scarborough *	York	Total number
March	127	323	857	1307
February	149	348	775	1272
January	135	333	763	1231

*includes Bridlington Hospital

	Number of medication related incidents
March	111
February	95
January	122

On 5th April there were 1317 incidents awaiting managers' action / sign off. Many of these incidents relate to patient falls and pressure ulcers for which there is a standardised report. The Patient Safety Team will review the reporting and investigation process to consider if the investigation process and final signoff can be improved.

Listed below are the top ten incidents reported by category in February and March. The top four categories remain the same as the previous month. There has been a significant increase in the number of reported incidents relating to unavailability of staff.

Top 10 Incidents by Category across the Trust - January 2013

Slip/ trips/ falls	284
Pressure Ulcer	112
Medication related issues	122
Laboratory Medicine Issues	36
Mother - complications	30
Baby - complications	29
Other	29
Violence and aggression	27
Complication for patient	26
Unavailability of staff	25

Top 10 Incidents by Category across the Trust - February 2013

Slip/ trips/ falls	297
Pressure Ulcer	159
Medication related issues	71
Laboratory Medicine Issues	56
Unavailability of staff	43
Mother - complications	34
Communication problems	30
Person injury	27

Equipment/medical device	22	
Complication for patient	21	

4. Community hospitals

The Patient Safety Dashboards from the Community Hospitals Clinical Governance meetings held in March are attached at Appendix 3.

5. Clinical effectiveness

5.1 Patient Reported Outcome Measures (PROMs)

PROMs data up to September 2012 indicated participation rates (all procedures) of 74.4% for the combined Trust (York, Scarborough and Bridlington sites). The reduction in participation rate is due to the failure to recruit patients on the Scarborough and Bridlington sites. All procedure outcomes (preliminary data) are within the expected range for York Teaching Hospital when compared with the national average.

PROMs reports for the full year 2011-12 (not yet finalized) have identified the following trusts within Yorkshire and Humberside to have remained negative outliers on hips and/or knees since 2010/11:
- Barnsley Hospitals NHS FT
- Hull and East Yorkshire NHS Trust
- Bradford Teaching Hospitals NHS FT
- Mid Yorkshire NHS Trust
- Doncaster and Bassetlaw NHS FT
- Sheffield Teaching NHS FT.

5.2 Alerts

The following alert is overdue.
NPSA/2009/PSA004B Safer Spinal (Intrathecal), Epidural And Regional Devices Part B deadline - 2/4/13. This has been added to the Corporate Risk Register as the Trust will not be compliant until the manufacturers have produced a device which has been tested and agreed of a suitable standard. This is a national non compliance issue.

6. Consultant Appointments

No consultants have commenced employment in the Trust during March.

7. Corporate Risk Register

Brief details of the risks identified on the Corporate Risk Register which are being monitored and reviewed by the Medical Director will be available for the Board of Director's Report.

Risk	Key action	Risk rating	Start date
Medication related incidents and errors	Implementation of electronic prescribing and medicines management	20	Oct '03
Lack of patient identification and compliance with NPSA Alert	Identification Policy to be reviewed and revised	16	June '09
Failure to act on abnormal investigation results	Implementation of Notify at Scarborough Hospital	10	Sept '07
Lack of liaison psychiatry	Discussions taking place with local mental health service providers	12	Jan '06
Compliance with Trust Policies and Guidelines	To review arrangements for monitoring compliance with policies and clinical guidelines	12	Mar '12
Lack of Clinical Governance	To review out of hours and escalation	9	Nov '12

	systems in community hospitals	arrangements			
	Failure to comply with NPSA/2009/PSA004B Safer Spinal (Intrathecal), Epidural And Regional Devices Part B	Awaiting availability of new products and testing	12	Apr '13	

8. Recommendations

To accept the report and note the ongoing work from the Reducing Mortality Programme.

Author	**Diane Palmer, Deputy Director for Patient Safety**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**15th April 2013**

Reducing Mortality Programme – update (March 2013)

Ensuring a 7 day service

York Site

- Business case for Clinical Support Worker complete.
- Development plan for critical care outreach team complete.
- Capacity and demand analysis for AMU complete.
- Agreed audit of AMU ward clerk activity.
- Phlebotomy review commenced.
- Cardiac outreach audit commenced.
- ACP recruitment complete.
- Pilot to test if work sharing is possible and beneficial for over-night teams to be presented to surgical board.
- Discussions started with medical consultant teams re change in job plans to give more consultant cover to AMU.

Scarborough Site

The Hospital at Night Programme which commenced in February is going well and progress with the related KPI's will be reported during the 2013/14 period.

Reviewing systems for review and measurement (mortality reviews and coding)

Mortality Review proforma agreed for use in General Medicine, Elderly Medicine and Paediatrics, sent to Systems and Network for CPD development.
Work on developing a proforma and process for ED underway.
Process established at Scarborough Hospital using standardised Mortality Review Proforma:

- Case notes and copies of the Mortality Review proforma sent to all individual consultants to complete reviews
- Target of 3 weeks to have completed forms returned to Patient Safety Team
- Due to high volume in Elderly Medicine, samples of casenotes issued to consultants to undertake reviews. Independant team complete outstanding review and produce summary report.
- Cover sheet to be included detailing coding of deaths, asking consultants to review and agree.

Community Hospitals process and proforma being developed.

Reducing harm and deterioration

- Project plan developed for service redesign of critical care out reach over next 12 months, this will incorporate their training needs and the educational needs of the Trust.
- Three Critical Care consultant appointments to provide outreach support with proposed afternoon ward rounds, starting 4th May.
- Plan to roll out pathway to Medicine and Surgery – York site, by end of April for a further 3 week pilot before printing and supplying to whole hospital.
- Pathway to be piloted on Cherry ward, Scarborough site.
- Liaising with Scarborough ED and other regional ICU's with a view to developing a sepsis bundle for critical care.

- Repeating unscheduled admission to critical care audit.
- Added a question to AIRS forms to help monitoring of incidents across the Trust relating to deteriorating patients.

End of Life Care

- Lead Nurse commenced in Trust.
- External funding agreed for educator post.
- Palliative care rapid discharge pathway being identified.
- End of life care register being developed (with IT).

Appendix 2.

Flu Vaccination Campaign 2012/13

Target Information
2012/13 Actual % uptake **47.98**
2012/13 Actual national % uptake **45.9%**
2012/13 Staff Vaccination Target **70%**

Previous seasons vaccination % uptake
York:
2011/12 **49.2%**
2010/11 **82.8%**
Scarborough:
2011/12 **65.3%**
2010/11 **43.5%**

2012/13 Directorate areas where the uptake of the vaccine = < 45%

Therapies: Dietetics (SWR)	31%,	Psychology	36%
Community (York & Selby)	32%,	Community (SWR)	35%
Opthalmology	38%		
Estates & Facilities: Scarborough	39.5%,	York	42%
Orthopaedics & Trauma	42.5%		
Laboratory Medicine	43%		
Medicine for the Elderly	44%		
SH – HQ (exc. HR)	44%		
SH – Medicine	45%		

Review

- This years' campaign started mid October at Scarborough & at the end of October in York missing the optimum September start, due to worries about vaccine delivery timescales & subsequent possible pre scheduled clinic cancellations.
- Our first season as a 'new' organisation with inherent difficulties of combining 2 separately pre planned campaigns.
- Expectation that OH continues to provide the same level of service despite the staffing demands of the flu programme.
- Change of personnel delivering the vaccine and insufficient vaccinators at periods of high demand.
- Interruptions to sessions due to limited amounts of vaccine stock (maintenance of the cold chain & manual handling factors).
- Loss of lunchtime 'Pat's Place' sessions at Scarborough due to construction works, unable to identify another suitable space to catch 'lunchtime trade'
- General staff attitudes to the vaccine.

York Teaching Hospital NHS
NHS Foundation Trust

Malton Community Hospital
Patient Safety Dashboard – March 2013

	December	January	February
Number of incidents reported	42	18	20**
Number of medication related incidents	0	1	0**
Number of severe incidents – SIs - CIs	0 0	0 0	0 0
Number of settled clinical litigation cases	0	0	0
Number of formal complaints	0	0	0
Admissions	46	45	54
Discharges	45	35	54
% compliance with infection control hand hygiene glove use bare below the elbow	100% 50% 100%	100% 50% 100%	100% 50% 100%
VTE Harm* *(% of patients)*	0 (0%)	1 (3.3%)	0 (0%)
Patient falls* *(% of patients)*	5 (19.2%)	0 (0%)	13 (32.5%)
Slip/ trips/ falls – *Datix: total for month*	19	11	2**
Pressure ulcers* *(% of patients)*	3 (11.5%)	7 (23.3%)	6 (15.0%)
Pressure ulcers – *Datix: total for month* *Since admission* *On admission*	7 1 6	3 2 1	0** 0** 0**
UTI's* *(% of patients)*	1 (3.8%)	0 (0%)	1 (2.5%)
Number of in-hospital deaths	6	3	6
Number of in-hospital deaths without palliative care pathway	4	0	2
Number of urgent transfers to other hospitals	0	0	0
Length of hospital stay – mean *(previous yr)*	15.1 (19)	25.5 (21)	25.4 (20)
Total number of risks on risk register	25	n/a	27

*Patient Safety Thermometer (CQUIN indicator)

York Teaching Hospital NHS
NHS Foundation Trust

St Monica's Community Hospital
Patient Safety Dashboard – March 2013

	December	January	February
Number of incidents reported on	4	7**	2**
Number of medication related incidents	0	0**	0**
Number of severe incidents – SIs - CIs	n/a	n/a	n/a
Number of new and/or settled clinical litigation cases	n/a	n/a	n/a
Number of formal complaints	n/a	n/a	n/a
Admissions	15	17	14
Discharges	15	18	14
% compliance with infection control: hand hygiene glove use bare below the elbow	 95 100 85	 95 100 85	 100 100 88
VTE harm* *(% of patients)*	0(0%)	0(0%)	0(0%)
Patient falls harm* *(% of patients)*	0(0%)	0(0%)	0(0%)
Slip/ trips/ falls – *Datix: total for month*	2	3	1
Pressure ulcers harm* *(% of patients)*	1(8.3%)	0(0%)	1(10%)
Pressure ulcers – *Datix: total for month* Total Since admission On admission	 1 1 0	 2** 1** 1**	 1** 0** 1**
UTI's harm*	0(0%)	0(0%)	0(0%)
Number of in-hospital deaths	2	2	2
Number of in-hospital deaths without palliative care pathway	n/a	n/a	n/a
Number of urgent transfers to other hospitals	n/a	n/a	n/a
Length of hospital stay – mean *(previous yr)*	20.3 (20.3)	33.3 (20.3)	13.1 (11.7)
Total number of risks on risk register	n/a	n/a	n/a

*Patient Safety Thermometer (CQUIN indicator)
** Datix figures may increase as coding for month will not yet be complete

York Teaching Hospital NHS
NHS Foundation Trust

Whitby Community Hospital
Patient Safety Dashboard – March 2013

	December	January	February
Number of incidents reported	17	20**	14**
Number of medication related incidents	2	2**	1**
Number of severe incidents – SIs - CIs	0 0	0 0	0 0
Number of new and/or settled clinical litigation cases	0	0	0
Number of formal complaints	0	0	N/A
Admissions	52	51	37
Discharges	47	49	38
% compliance with infection control: hand hygiene glove use bare below the elbow	 100 100 100	 98 100 93	 100 100 95
VTE harm* *(% of patients)*	1 (3%)	0(0%)	0(0%)
Patient falls harm* *(% of patients)*	0 (0%)	2 (5.9%)	0(0%)
Slip/ trips/ falls – *Datix: total for month*	7	3**	0**
Pressure ulcers harm* *(% of patients)*	2 (6.1%)	1 (2.9%)	3 (8.6%)
Pressure ulcers – *Datix: total for month* Total Since admission On admission	 3 2 1	 2** 0** 2**	 0** 0** 0**
UTI's harm*	0 (0%)	1 (2.9%)	0 (0%)
Number of in-hospital deaths	3	4	6
Number of in-hospital deaths without palliative care pathway	2	1	N/A
Number of urgent transfers to other hospitals	0	0	0
Length of hospital stay – mean *(previous yr)*	18.1 (17)	22.4 (19)	N/A
Total number of risks on risk register	35	34	34

*Patient Safety Thermometer (CQUIN indicator)
** Datix figures may increase as coding for month will not yet be complete

Risks for Whitby -
1. Length of Stay pts stay in hospital not appropriate place once medically discharged
2. Up to date and appropriate training for staff in community setting
3. Reduced occupancy levels - often below 85% (CQUIN target)

York Teaching Hospital NHS
NHS Foundation Trust

Archways Community Hospital
Patient Safety Dashboard – March 2013

	December	January	February
Number of incidents reported	11	11**	12**
Number of medication related incidents	0	0**	0**
Number of severe incidents – SIs - CIs	0 0	0 0	n/a
Number of new and/or settled clinical litigation cases	0	0	n/a
Number of formal complaints	n/a	n/a	n/a
Admissions	29	21	19
Discharges	31	19	20
% compliance with infection control: hand hygiene glove use bare below the elbow	 100 100 100	 100 100 100	 100 100 100
VTE harm* *(% of patients)*	0(0%)	0(0%)	0(0%)
Patient falls harm* *(% of patients)*	0(0%)	0(0%)	1(4.5%)
Slip/ trips/ falls – *Datix: total for month*	9	11**	2**
Pressure ulcers harm* *(% of patients)*	0(0%)	1 (4.5%)	1 (4.5%)
Pressure ulcers – *Datix: total for month* Total Since admission On admission	 0 0 0	 0 0 0	 0 1(grade 3) 0
UTI's harm*	1(5.0%)	0(0%)	0(0%)
Number of in-hospital deaths	0	0	0
Number of in-hospital deaths without palliative care pathway	n/a	n/a	n/a
Number of urgent transfers to other hospitals	n/a	n/a	0
Length of hospital stay – mean *(previous yr)*	15.8 (22.7)	27.6 (24.1)	32.7 (27.2)

*Patient Safety Thermometer (CQUIN indicator)
** Datix figures may increase as coding for month will not yet be complete

Risks for Archways –
GP cover when GP on leave
Night time nursing establishment - heightened risks associated with this
Estate - all patients nursed in single rooms.

Appendix 4.

Information Governance Group

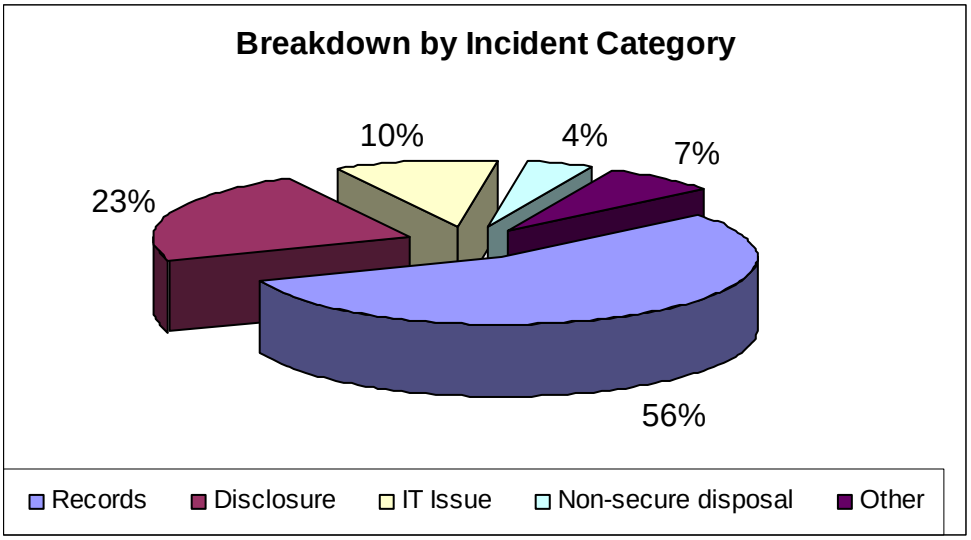
IG Incident Report Jan-Mar 2013

1. Introduction

Work has been ongoing to improve the identification of IG incidents, thought to be under reported, and to develop a better classification scheme. The scheme in this report is derived from those used by the Information Commissioner and DoH. The report covers the period Jan 1st to March 11th 2013.

2. Report

100 incidents were reported on Datix and flagged by the reporter as an IG incident, or categorised as such during review. 2 incidents were found to have been flagged in error, and 3 were reported by Trust staff but originated elsewhere. Of the remaining 95, 74 were reported in York, 21 in Scarborough. The breakdown by category is shown below:



Over half of incidents arose as a result of poor records management, ie problems with tracking/availability of case notes, accuracy/completeness of patient records, insecure storage or disposal. A particular feature was the mixing up of patient records, either through misfiles or errors in patient identification.

Failure to correctly identify patient records contributed to the 23% of incidents classed as wrongful disclosures. Poor targeting of communications was another major cause of breaches of confidentiality. Misdirected faxes and printouts continued to occur despite recent Staff Brief and BIG News items.

Whilst most incidents were detected and contained by Trust staff, 29% of all incidents entered the public domain. It is not possible from incident reports to quantify what has been the impact on patient care of records being missing when required, misfiled or otherwise confused with other patients' records.

3. Action

Individual incident reports are reviewed and followed up as necessary by the Information Governance Manager. Support and advice is given to investigators to ensure causes are identified, lessons learned and perpetrators, where appropriate, called to account.

Patient identification issues will be highlighted in the next Staff Brief and IG newsletter. Learning points will be incorporated into the 2013-14 Statutory and Mandatory Training programme, and flagged with the IT training team and Health Records staff. The Medical Director has written to all medical staff reminding them of their responsibilities in this regard.

4. Further Indicators of Information Risk

a) Complaints – 4 complaints were received during the period that alleged breaches of patient confidentiality.

The Assistant Director of Healthcare Governance now sits on every IG related disciplinary panels to bring consistency of approach in terms of sanctions given.

b) IT Issues

There is some evidence that staff who report IT security issues to Systems and Networks, do not also log them in Datix. This suggests an under-representation in the report of incidents such as sharing logins, system errors/unavailability etc. Sue Rushbrook has called a meeting in the new financial year to address this.

One incident has been reported to and subsequently closed by the Information Commissioner without fine.

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Director of Infection Prevention and Control (DIPC) Report, Quarter 4

Action requested/recommendation

The Board of Directors is asked to note this report and any specific actions for Clinical Directors, Directorate and Clinical Managers. The report summarises IP activity and progress against the 2012/13 strategy and Annual Plan for quarter 4.

Summary

This report together with the Infection Prevention (IP) Performance Dashboard for York and Scarborough sites summarises performance, compliance and outcome against the Health and Social Care Act 2008 - Code of Practice for health and adult social care on the prevention and control of infections and related guidance, DH Dec 2009 (The Hygiene Code), the IP Annual Plan 2012/13 and other key performance indicators.

The Trust continues to support effective infection prevention through critical evaluation of performance and outcome by the IP Steering Group and Hospital Infection Prevention and Control Group (HIPCG) that report to the Patient Safety Group.

IP Integration with Scarborough has made significant progress in Q4 with key IP controls and objectives being implemented:

- Saving Lives
- MRSA Policy
- Environment Steering group
- Link Worker Network
- Cannulation practice audit
- Development of IP action plans in response to compliance visits on the Scarborough site

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

Implications for equality and diversity

No implications for equality and diversity.

Reference to CQC outcomes

Registered providers of health care must ensure that systems are in place to

manage and monitor the prevention and control of infection if they are to comply with the legislation.

Ref: Health and Social Care Act 2008 – Code of Practice for health and adult social care on the prevention and control of infections and related guidance Dec 2009 (The Hygiene Code).

Progress of report	CQC Registration Patient Safety Objectives
Risk	No risk
Resource implications	The cost and operational impact of HCAIs together with improvement and financial penalties that may be incurred from external regulation (CQC, Monitor) and Commissioners.
Owner	Elizabeth Mc Manus, Chief Nurse, Director of Infection Prevention and Control (DIPC)
Author	Vicki Parkin, Deputy DIPC
Date of paper	April 2013
Version number	1

Board of Directors – 24 April 2013

Director of Infection Prevention and Control (DIPC) Report, Quarter 4

1. Executive Summary

Continued engagement and ownership by Directorate and Divisional management teams is demonstrated in data reported on the IP dashboard, App 3

At the end of Q4 the York site exceeded trajectory for Clostridium Difficile Infection (CDI) with an incidence of 39/27. Scarborough incidence at the end of Q4 was 15/24 giving a total combined incidence of 54/51. Monitor observe a trajectory of 51. Progress with the CDI reduction strategy for York site, developed when this challenging target was set is summarised in App 2. It is important to note that compliance with infection prevention practices are critically monitored, reflect best practice and are aimed at keeping patients safe. Root Cause Analysis of all cases continues to identify antimicrobial prescribing as a key concern for which an emergency Stewardship meeting was held at the end of March. Key priorities and actions aimed at developing the drug chart to improve prescribing practice and adherence to formulary were agreed.

There were no cases of MRSA bloodstream infection in Q4 leaving the total at 1 for the year across the Organisation.

Seasonal Norovirus has continued to occur with significant impact on ward closures and elective activity. The IPT work closely with Operational leads to identify ways of maintaining both safe patient placement and flow.

There have been some water safety issues on both sites that have been managed through the site water safety committees. A detailed report will be provided in Q1 when definitive testing results are known following water treatment and filtration interventions. Changes in practice were advised to ensure provision of safe practice and equipment.

This report together with the IP performance dashboard App 3 summarises performance and compliance against the Hygiene Code 2009, key performance indicators and the IP Annual Plan 2012/13. It aims to assure the Board that IP systems and processes aimed at achieving sustainable reductions in the incidence of avoidable Healthcare Associated Infections (HCAIs) are both in place and effective.

2. Discussion

The Annual Plan (App 1) summarises progress with all Trust IP objectives for quarter 4

HCAI Incidence Summary

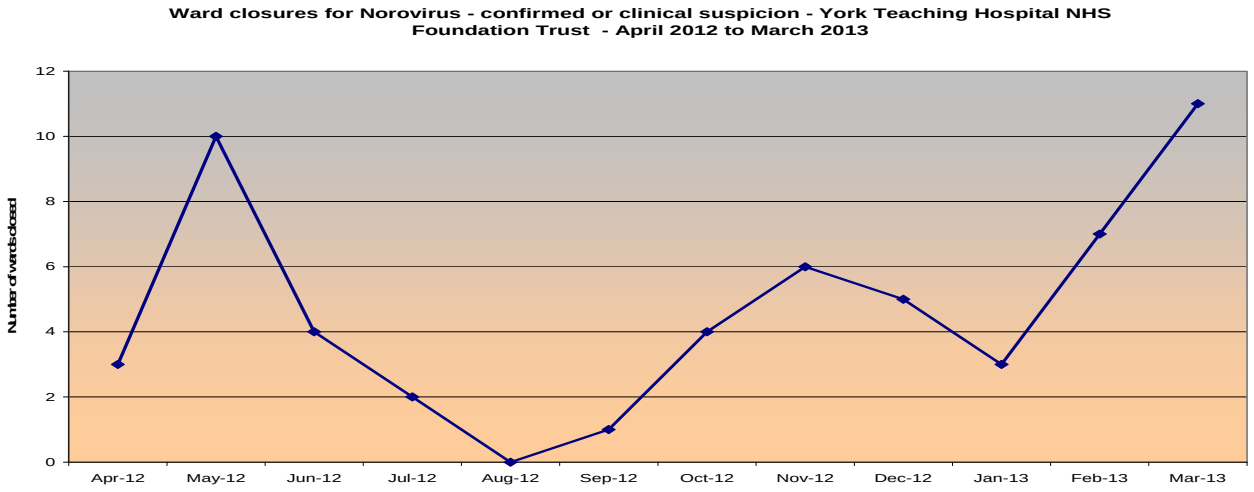
Quarterly report data – Trust attributed cases only

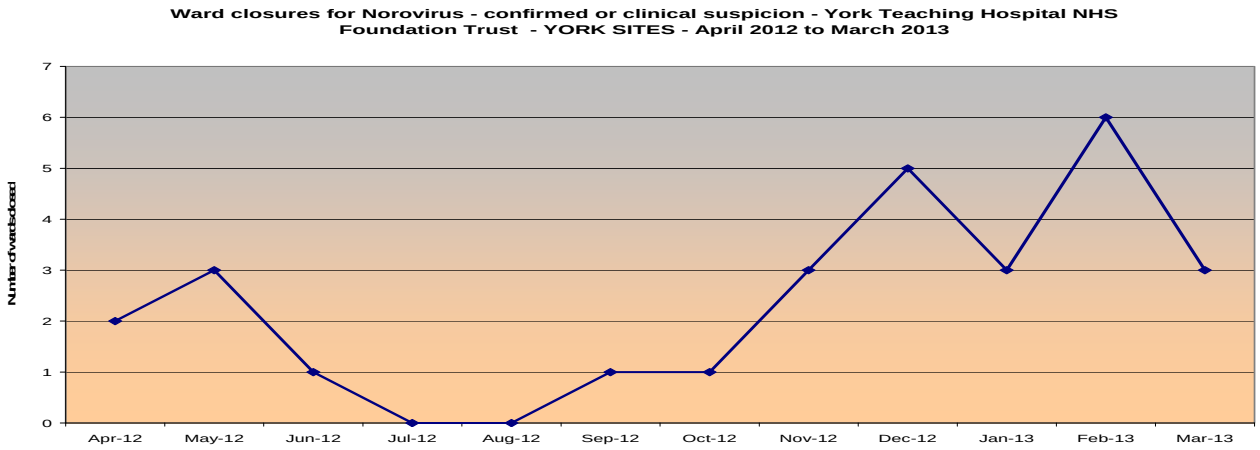
Combined	Q1	Q2	Q3	Q4	Year total
MRSA bacteraemia	0	1	0	0	1
MSSA bacteraemia	10	7	10	6	33
E.coli bacteraemia	24	29	21	34	108
CDI (toxin positive)	12	14	12	16	54

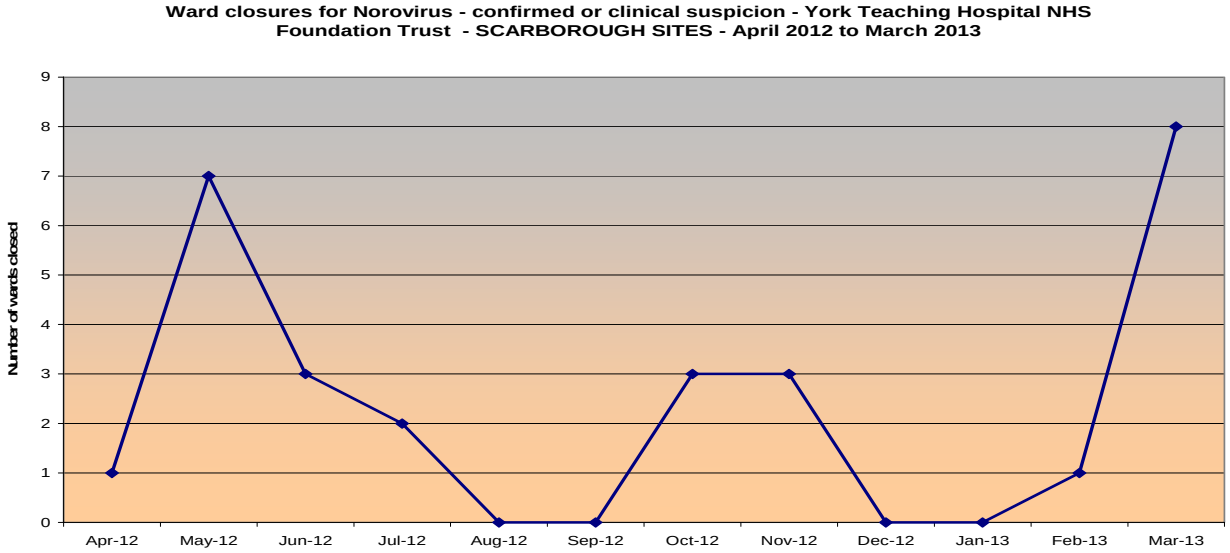
York	Q1	Q2	Q3	Q4	Year total
MRSA bacteraemia	0	0	0	0	3
MSSA bacteraemia	8	5	6	2	21
E.coli bacteraemia	18	18	13	19	68
CDI (toxin positive)	8 (+1 Selby)	10 (+1 Whitby)	9 (+1 Malton)	12 (+1 Malton, +1 Selby)	39

Scarborough	Q1	Q2	Q3	Q4	Year total
MRSA bacteraemia	0	1	0	0	1
MSSA bacteraemia	2	2	4	4	12
E.coli bacteraemia	6	11	8	15	40
CDI (toxin positive)	4	4	3	4	15

Ward closures following Norovirus outbreaks







4. Conclusion

IP performance and compliance with the Hygiene Code 2009 and other indicators continue to Improve. There has been significant progress with implementation key objectives on the Scarborough site

It is important for Directorates and Divisions to own and continually engage with IP priorities if the Trust is to achieve sustainable reduction in HCAI and ensure patient safety

5. Recommendation

The Board of Directors is asked to note this report and any specific actions for Directors and Clinical Leads.

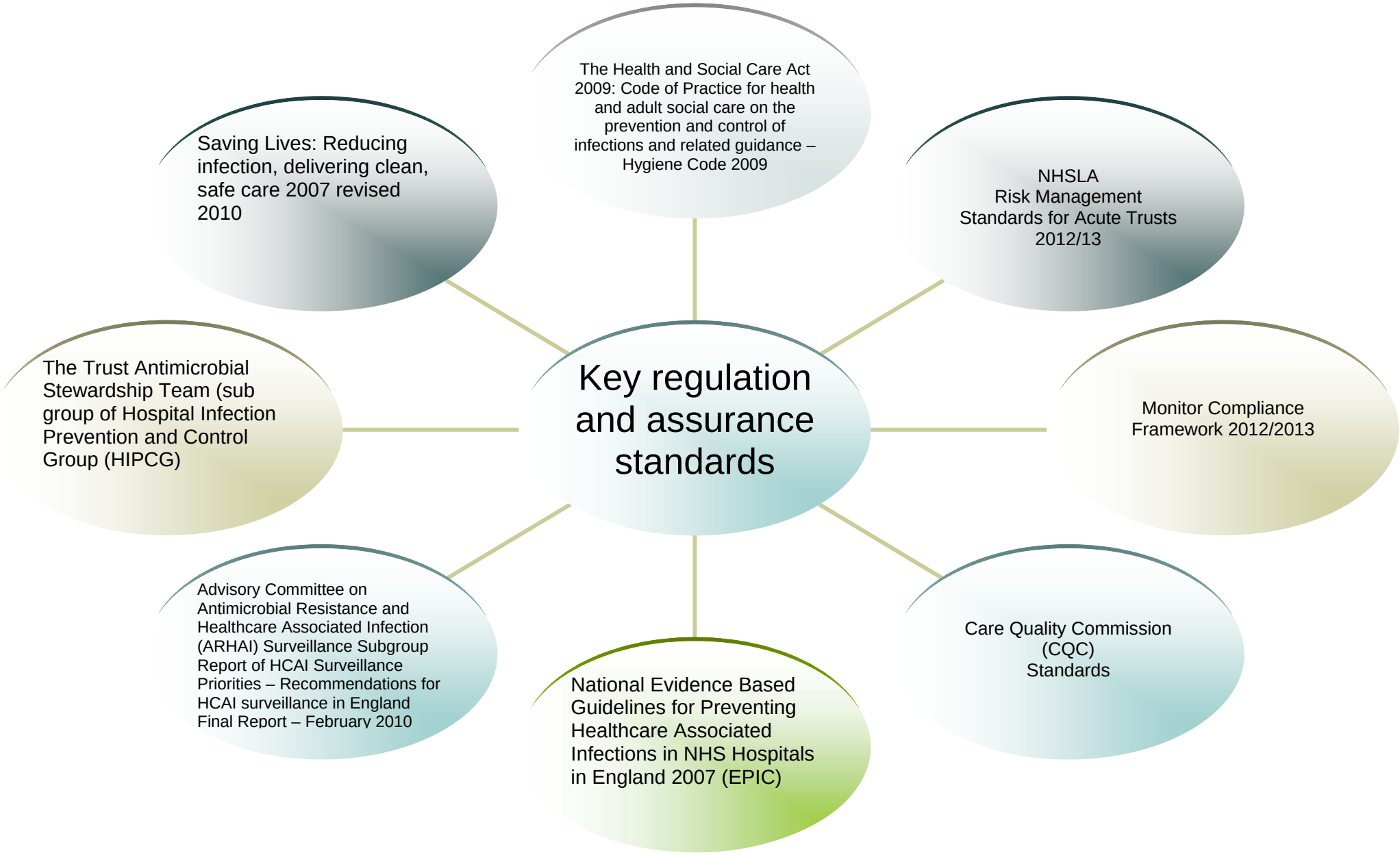
6. References and further reading

Health and Social Care Act 2008 – Code of Practice for health and adult social care on the prevention and control of infections and related guidance, Dec 2009.

Author	**Vicki Parkin, Deputy Director of Infection Prevention and Control (DIPC)**

Owner	**Elizabeth Mc Manus, Chief Nurse, Director of Infection Prevention and Control (DIPC)**
Date	**April 2013**

Infection Prevention Team Integrated Annual Plan 2012/13



All Objectives will apply across the whole Organisation.

1.0 Management

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Q4 Review 2013
1.1 Continue to develop strategies for effective infection prevention (IP) that: • Ensure engagement, ownership and accountability for IP throughout the Organisation • Improve the quality, safety and outcome of patient care through the prevention and sustained reduction of HCAI • Assures patients, Trust Board, commissioners and regulators that IP processes are effectively established and remain a priority for the Trust	• Compliance with the Hygiene Code 2009 • Hospital Infection Control Group (HIPCG) • Environment Steering Committee (ESC) • IP Risk Register • Quarterly DIPC reports to the Board • Monitor Compliance Framework 2012/13 • NHSLA Risk Management Standards for Acute Trusts 2012/13 • NHS Operating Framework 2012/2013 • Root cause analysis (RCA) of HCAIs • Infection Prevention Policies • Saving Lives 2007 • (revised) 2010 • CQUIN Standards	• DIPC Annual and quarterly Trust Board Reports • Hygiene Code Corporate Action Plan (delayed post integration) • Infection Prevention policies • Compliance Audit reports • HIPCG and Board Terms of Reference and minutes • Antimicrobial Stewardship Team (AST) minutes • Job descriptions • SIGNAL Performance metrics/data • ESC minutes and dashboard	• Board of Directors • Corporate Leads identified within the Hygiene Code Corporate Action Plan • Infection Prevention Steering Group • Infection Prevention Team (IPT) • Matrons • Ward and Directorate/Divisional Managers • Community Clinical leads • DIPC • Director/Deputy Director of Estates and Facilities	Permanent Trust objective	Key controls continue to provide assurance on the York site. Implementation of high level controls begun on Scarborough site – MRSA policy, Saving Lives, ESG, cannula audit. Further progress being made with achieving 100 day plan objectives that will now be incorporated into the annual plan for 2013/14. - Integrated Risk register initial work begun in Q2 with Risk & Legal Dept. Progress

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Q4 Review 2013
					required.
1.2 Implement and monitor compliance with the Hygiene Code Corporate Action Plan	Regulatory (CQC, Monitor) and internal compliance standards	Hygiene Code Corporate Action Plan compliance and evidence recording process	As identified with the Corporate Action Plan	Ongoing	Hygiene Code Action Plan is to become Trust assurance framework for IP. To be developed by IP and Governance leads by the end of Q1 2013/14
1.3 With Community and Clinical Commissioning Group (CCG) colleagues develop a whole health economy IP collaboration to reduce the burden of HCAI	• Trust Hygiene Code Corporate Action Plan • District Control of Infection Committee (DCIC) HCAI sub committee • RCA process and outcome reports • CCG Partnership meetings	• DCIC minutes and Terms of Reference • Trust Hygiene Code Corporate Action Plan • RCA Action Plans and reports • CCG reports/IP links/,minutes (to be established and agreed)	• Acute, Primary Care, CCG and Community infection prevention leads • Matrons • Pharmacy and antimicrobial leads • Community Clinical leads (virtual wards) • Antimicrobial Stewardship leads	Ongoing initiative	To remain a medium term development objective within annual plan 2013/14
1.3.1 Develop CCG partnership strategy specific to infection prevention	To be identified and agreed		Deputy DIPC, Strategic Lead	April 2013	To remain a medium term development objective within

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Q4 Review 2013
					annual plan 2013/14
1.4 With the Director of Operations, Director of Infection Prevention and Control (DIPC) and Clinical Leads, critically review the Trust's ability to provide safe and effective isolation.	• Hygiene Code Criterion 7 • Saving Lives (revised) 2010 • AIRS/Datrix reporting • Trust Isolation policy • Management of Outbreak Policy • IP Risk Register • Electronic management of side room allocation via CPD • Trust Resilience Plan 2012//13	• Trust Hygiene Code Corporate Action Plan • IP Outbreak documentation – care plans, door notices, • CPD data • Policy audit reports • Outbreak meeting minutes and action plans • Saving Lives (revised) 2010 • HIPCG, Risk & Assurance Committee meetings, minutes • HCAI incidence data	• Board of Directors • DIPC • IPT • Directorate of Operations leads • Director of Strategy and Planning • Matrons and Ward Managers • Directorate Managers • Director of Estates/Facilities • Capital Planning leads	Long Term objective incorporated into annual Resilience Planning	No progress. Concerns remain re: capacity risks on both York and SGH sites. Operational Leads aware. Feb meeting cancelled due to lack of attendees, rescheduled for April
1.5 Enhance antimicrobial stewardship across all sites	• Antimicrobial Stewardship Team (AST) • Directorate prescribing formularies • Antimicrobial audit process/plan	• Antimicrobial prescribing compliance audit data • AST minutes • HCAI surveillance and incidence data • HIPCG minutes and	• Microbiologists • Consultant Pharmacists • Clinicians • Ward managers • IPN`s	Permanent initiative	Refer to AST meeting minutes.

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Q4 Review 2013
		exception reports			
1.6 Ensure sustainable reduction in HCAI as required by Monitor Compliance Framework (Safety) 2012/13 and the NHS Operating Framework (Domain 5) 2012/13	• IP policies • Statutory and mandatory training provision and associated education initiatives • Resilience plan	• HCAI data and incidence reports • Policy implementation audit reports • Clinical Support Visit (CSV) outcome reports • DIPC Board reports • Isolation AIRS/Datix reports	• Matrons • Ward Managers • IP Team • Clinicians • Trust board • Operational and bed managers	Ongoing	Refer to IP Dashboard Appendix 2
1.7 Develop a process for capturing HCAI data from death certificates	• To be agreed when process established	• To be defined	• Audit and Surveillance IPN`s • Medical Director • Bereavement Leads		Discussion to define and establish a process set up for early Q3. No progress to report
1.8 Develop *C.difficile* Infection (CDI) Reduction Strategy to facilitate achievement of the 2012/13 national target and surveillance of 30 day mortality	• CDI reduction strategy 2012/13 • RCA process and outcomes • Hygiene Code Corporate Action	• Antimicrobial audit and usage data • AST compliance data • CDI reduction strategy	• Clinicians • Ward managers • Matrons • AST/.Pharmacy leads • Microbiologists	April 2013	Refer to CDI Reduction Strategy App 3

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Q4 Review 2013
	Plan	• RCA reports			
1.9 Ensure compliance with all strategic and operational objectives of the IP Integration 100 day plan	• IP integration plan and Team objectives • Annual Plan 2012/13	• IP integration plan progress and achievement reports	• IPT • DIPC • Deputy DIPC`s	April 2013	Progress continues. Outstanding objectives will become integral to annual plan 2013/14
1.10 Identify and prioritise with IT, risks to service development	To be established with IT Leads. Discussions held at IP Steering Group		To be agreed	Q1 2013	Met and agreed with IT Director a plan for improvement
1.11 Evaluate the impact and requirements of NICE guidance CG139 March 2012 .	The Nice Guidance self assessment proforma	The Nice Guidance self assessment proforma	Deputy DIPC Strategic Lead	October 2012	Report submitted to Trust NICE lead October 2012
1.12 Identify IP risks and priorities at the Scarborough site	Risk register	Risk register	• DIPC • Deputy DIPC	October 2012	Risk register obtained from Scarborough. W Discussions held with R&L team re: future strategy

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Q4 Review 2013
					that has yet to be finalised.
1.13 Develop a policy implementation plan and gap analysis for Scarborough site	• Risk register • Integration plan	• Risk register • Integration plan • Policy implementation plan and compliance audits • Gap analysis	• Deputy DIPC`s • Band 7 Lead IPN – operational SGH site	April 2013	Implementation plan and gap analysis developed for MRSA and CDI policies. MRSA policy to be implemented April 2013

2.0 Clinical Standards and Practice

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
2.1 Implement DH Saving Lives: Reducing Infection, delivering clean safe care – revised 2010 at Scarborough and Community sites	• Signal and related performance metrics • NHS Operating Framework 2012/13 • Trust Infection Prevention Policies • IP Policy Audit Strategy • RCA process • Aseptic Non Touch Technique (ANTT) compliance data • Trust Hygiene Code Corporate Action Plan • IP Clinical support visits • EPIC 2007 • IP Audits • IP Risk Register • HIPCG Steering Group	• IP audit reports and action plans • AIRS/Datix reports • Saving Lives compliance data • IP Signal metrics • PMM meeting notes • RCA reports and action plans • Clinical support visits database • IPC database • IP Risk Register • HIPCG and Steering Group minutes • DIPC Board reports	• DIPC • IPT • Matrons • Ward Managers • Community Clinical leads	April 2013	Relevant care bundles implemented **Community Hospitals**: All HII`s relevant to specific areas are in place with escalation processes identified. **Virtual Wards**: Relevant care bundled implemented
2.2 Implement the Aseptic Non Touch Technique (ANTT) Framework at Scarborough and Community sites	• ANTT Standards • IP policies • Saving Lives 2007 framework	• HCAI incidence data • Saving Lives compliance data • Policy compliance	• Band 7 Lead Operational IPNs • Matrons • Ward Managers	April 2013	Yet to be implemented on Scarborough site.

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
		reports • ANTT Competency Register			
2.2.1 Develop ANTT competency register.	• IP policies • Saving Lives framework	ANTT Register	– Band 7 Lead Operational Lead IPN York site		ANTT competency is now part of all competencies for procedures requiring asepsis e.g. cannulation, phlebotomy etc
2.3 Develop an IV access expert steering group	• Hygiene Code 2009 (revised 2010) • EPIC 2007 • Saving Lives framework	• CRBSI and bacteraemia incidence data • IV access steering group minutes • AIRS/SUI reports	• IV access steering group lead by Band 7 Lead Operational IPN`s on York and SGH sites • Matrons • Ward managers • Clinicians	December 2012	IV access policy reformatted as per trust template. Electronic monitoring of insertion of lines and ongoing care is now being developed by Dr Ian Jackson and Kevin Beatson IT Lead as part of the Deteriorating Patient initiative
2.4 Standardise and implement revised peripheral	• Trust policy – care and maintenance of	• Audit reports	• IPT	December 2012	See 2.3

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
cannulation documentation	peripheral cannula • Saving Lives HII2		• Compliance Unit		
2.4.1 Re-develop IP precautions door notices as best practice SOP`s	• IP policies • CSV`s	• Policy implementation audits • CSV reports/data base	• IPN`s • Ward Managers	December 2012	Standards/door noticed in place throughout the Organisation. Compliance monitored via Clinical Support Visits
2.4.2 Evaluate IP documentation on York and Scarborough sites, standardise and implement on both sites. To include electronic documentation	• IP policies • IT support	• CSV reports • IP policy audit reports • RCA reports • AIRS/Datix reports	• Band 7 Lead Operational IPN`s • IT leads	April 2013	Some constraints with IT hinder progress. IT aware
2.5 Develop a policy for Preventing Catheter Associated UTI incidence	• Policy (when completed) • Saving Lives 2010 • Point Prevalence audits • CQUIN Standards	• CAUTI incidence data • Policy compliance audit • Saving Lives data	• IPT • Ward/Department Managers • Matrons • Community Clinical leads	Q3	Policy and consultation almost complete. Implementation and training package in progress. Further MDT scheduled for April
2.6 Implement IP Clinical	• CSV standards and	• Clinical support visits	• Band 7 Lead	Q3	Implementation

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
Support Visits (CSV) and associated documentation across Scarborough and Community sites **2.6.1** Identify strategies for improvement	checklist • Saving Lives framework • IP policies • IPC best practice door notices • IP Audits	database • Policy compliance audits • Saving Lives data	Operational IPN`s • Matrons • Ward Managers • Community Clinical Leads		begun on Scarborough site Jan 2013.
2.7 Improve compliance with MRSA screening of elective and emergency admissions across all sites	• NHS Operating Framework 2012/13 • Trust MRSA Policy • IP policy audit strategy	• Screening compliance data • Signal reporting • PMM notes • HIPCG minutes • Policy audit report	• Matrons • Ward/ Departmental Managers • IPT designated leads Community Clinical leads • IT Leads	Ongoing objective pending outcome of the DH prevalence study 2011	Consistent approach to screening across all sites now reflected in revised MRSA policy. Compliance to be monitored by IPT Potential compliance reporting risks due to different IT systems?
2.8 Develop observational audit and improve hand hygiene initiatives across all sites aimed at sustaining high levels of compliance	• Hand hygiene policy • NHSLA standards • HH Competency Framework • NPSA facilities audit requirements 2008	• Hand hygiene facilities audit report • Hand hygiene compliance data • IP team minutes • Signal data reports	• IPT Hand Hygiene Coordinator • Matrons • Ward Managers • Community Clinical leads	Permanent Objective	Hand Hygiene leads meeting mid Feb to progress the objective. Norovirus outbreaks have

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
	• Clean Hands Saving Lives – DH Gateway refer 10468 • Audit				hindered progress Work required to merge initiatives and competency (OSCE) framework. WHO 5 moments for Hand Hygiene to be re launched at Scarborough
2.9 Develop an IP risk assessment framework	• Hygiene Code Corporate Action Plan 1.2 • Trust IP Policies	• Hygiene Code compliance evidence. • IP and ward documentation	• IPT • Ward Sisters • Matrons • Clinicians	December 2013	Work on a risk assessment tool for *C.difficile* to be implemented via CPD is progressing well. Relevant Clinicians have advised. Tool to be discusses at HIPC Steering Group
2.10 Rationalise skin prep use and recording in theatres	• Saving Lives HII4 • SSI Surveillance • Objectives	• Saving Lives HII4 compliance data • SSI Surveillance	• Surgical Board • Clinicians • Theatre nurse		No progress to report in Q4. Remains under discussion at Surgical Board

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
	• Surgical Board	outcomes	leads		

3.0 Surveillance and Audit

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
3.1 1. Continue targeted surveillance of: 2. Readmissions with surgical site infection (SSI) 4. Catheter associated UTI 5. 30 day mortality associated with *C.difficile*	• Hygiene Code Corporate Action Plan • Saving Lives framework	• Hygiene Code Corporate Action Plan • Saving Lives data • Surveillance data and incidence reports	• IPT • Matrons • Ward Managers • Clinicians	All projects to be established by September 2013	Update in q1 2013/14 and in Annual Report
3.2 Develop a business case for the procurement of IPC Software	• Health and Social Care Act 2008 (Hygiene Code 2009)	• Business Case	• IPT • DIPC • IT leads • Finance • Managers	December 2012	No progress
3.3 Develop an integrated IP audit strategy	• Audit strategy	• Audit data and reports	IPT Compliance Team	Q3	To be defined and agreed post first round of Compliance visits – completed Dec 2012

4.0 Cleanliness and Environment

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
4. 1 Sustain implementation of current and develop new initiatives aimed at improving and maintaining environmental cleaning standards across all sites	• Strategic cleaning policy 2012 • Hygiene Code Criterion 2 • Environment Steering Committee • Decontamination Committee • PEAT/Environment Ownership • Matrons Environment • checklist • Saving Lives H118 • CQC outcome 8	• ESC Minutes and exception reports • ESC Dashboard • Saving Lives HHI 8 data • Decontamination Committee minutes	• ESC • Domestic Service Leads • IPT • Matrons • Ward Managers • Trust Decontamination Lead	Permanent Initiative	Strategic Cleaning Review at consultation phase at end of Q2. Q3 - outcome awaited
4.2 Improve and maintain cleanliness of the near patient environment	• Adenosine Tri-phosphate (ATP) technology	• ATP Monitoring data	• Matrons • Ward Managers • IPT	Ongoing as cases/clusters of infection occur	Monitoring done on a case by case basis. Data base of outcomes being developed. Consultation at MSSE re: procurement of ATP monitoring software April 2013

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
4.3 Evaluate current and new environmental decontamination products – cost, efficiency.	• Decontamination Policy • CIP requirements	• HCAI data/trends • Environmental monitoring data/controls	• Decontamination Lead • IPT	Ongoing	New products being evaluated. Outcome details in Q4

5.0 Education and Learning

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
5.0 Ensure delivery of a programme of education for all staff including community services	• Hygiene Code Criterion 10.1 • Trust Training Needs Analysis (TNA)	• Hygiene Code Corporate Action Plan • Attendance records data via ESR	• CLAD • Dep DIPC-Operational Lead • Matrons • Directorate managers	Ongoing initiative	Interim discussions held with CLAD in Q2 and Q3 re: e learning potential and how statutory/mandatory training could be delivered in the clinical environment.
5.1 Develop the Infection Prevention Link Worker Network at Scarborough site.	• ICLW role description • Hygiene Code 2009	• ICLW meeting minutes	• Deputy DIPC Operational lead with IPNs • Matrons • Ward managers		Initial meeting held March 2013 setting out challenges, expectations and educational plan for the year.

Clostridium Difficile Infection (CDI) Reduction Strategy 2012/13

Objective – To deliver the national C Difficile Infection (CDI) target of 27 cases 2012/13

Action	Timescale	Lead/s	Progress Jan 2013	Comments	Date achieved	Barriers to delivery
1. Measure compliance with Antimicrobial Prescribing Pathway	TBA	RS	Update required from RS. Requested for HIPCG Jan 2013	Business Case in development to enhance pharmacy resource for Antimicrobial stewardship. Significant progress with Antimicrobial Performance looking at 1. Causation of CDI in terms of indication for use of AB`s, appropriateness of choice of agent, and review dates. 2. Antimicrobials Dashboard. 3. Treatment and surgical prophylaxis formulary review. 4. Pilot of an antimicrobial drug chart. Discussed at HIPCG. Paper to go Exec Board March 2013		Pharmacy Resource. BC in development.

Action	Timescale	Lead/s	Progress Jan 2013	Comments	Date achieved	Barriers to delivery
2. Agree and establish action and escalation process through the Operational PMM framework	October 2012	VP, MP, LT	Discussed with Mike Proctor re: enhancing escalation and ownership at Directorate level, PMM framework currently being evaluated. MP will look at placing CDI incidence on Directorate Risk Registers to enable further accountability and action at Executive PMM	Dr Todd advises systematic review of performance via the dashboard and performance process. Need to define and agree through the PMM process what actions individual directorates are accountable for and w ho is responsible for ensuring delivery. Look at allocating upper control limits per Directorate for CDI incidence?	TBA following feedback from Mike Proctor.	
3. Define statutory and mandatory training requirements for nursing and medical staff.	September 2012	RS, LHF, NT, AN	All IP training slides revised.	C.diff disease, clinical care/management, RCA processes and outcomes are included in teaching packages for medical & nursing staff. Case studies developed for Medical staff. Specific session developed for IP Link workers delivered by Consultant Pharmacist. Scenarios developed and integrated into e learning and storyboard for medical staff.	Sept 2012	
3.1 Following discussion with VOYCCG leads, antimicrobial formulary awareness required for Locum staff.	TBA with RS and NT	RS, NT	MDT meeting arranged for 17th Jan 2013 as requested by Dr Todd.	Dr Hamilton to liaise with Rob Swallow re: needs for locum staff.		

Action	Timescale	Lead/s	Progress Jan 2013	Comments	Date achieved	Barriers to delivery
4. Letter to clinicians re target and consequences of breach from Dr Todd and Dr Turnbull	September 2012	AT, NT	AT and NT emailed 4th Dec 2012	E mail reply from Dr Turnbull - This has repeatedly been done before. I am happy to collaborate with NT re another letter but I very much doubt the impact of this. Dr Hamilton advises that this objective requires education and feedback, the optimum time for which is during the AB ward round, at RCA meetings and the CDI ward round which is where the focus will be for the future		
5. Data and evidence package for Clinicians re: incidence data	TBA	NT, RS	Progress update required from RS. Summary requested for Jan 2013 HIPCG. Update presented – see HIPCG minutes.	Content should include using antimicrobials safely. Gentamicin charts already developed. Agreed and MDT meeting Jan 2013 that VP to speak with Dr Turnbull and Dr Hamilton.		
6. Clinical governance half days to have a standing agenda re infection prevention and antimicrobial usage	On agenda for next round of CG days.	DH	Revised agenda presented to Clinical Standards committee in Sept. Now requires approval from Executive Board.	Agenda items - C. Diff Route cause analysis (RCA outcomes). Signal data and formulary compliance data.		
7. Death Certification - capture *C Difficile* diagnoses.	December 2012	JB, AW (AT with SR re: CPD	Further meeting arranged for Dec to discuss progress and	Numbers low – 14 CDI related deaths out of 160 at last review.		

Action	Timescale	Lead/s	Progress Jan 2013	Comments	Date achieved	Barriers to delivery
		requirement)	define a process	HCAI now added to Doctors checklist. Requires more work		
8.Improve sampling: - quality of specimens - time of collection - time to laboratory	Ongoing	IPN's with link workers and ward staff – advice and input from Lab staff.		Practice significantly improved. Not identified now as key issues in RCA. Dr Todd advises more focus on incidence and action in relation to diarrhoea. Staff training will include this.	Improvement from Sept 2012	
9. Redesign RCA documentation – to look at risks and justifications for AB use in clinical decision making	October 2012	AN with NT	LHF currently working with Risk & Legal to incorporate AIR's and RCA process that will address the objective. Progress hindered by competing priorities in R&L	See comments for objective 1. By end of Jan, JB and DH to modify RCA documentation to capture events that lead to AB`s being prescribed, their appropriateness and the potential impact of previous AB therapy. Meeting arranged with IT Director for Feb 2013 to discuss risks to service development from IT constraints.		
10. Publish internally, data re: re-admissions within 30/7 with CDiff	Dec 2012	JB	Data capture enabled from Dec 2012 and fed back in weekly update to Senior Managers and Directors. Reported at HIPC in DIPC quarterly reports and Q&S briefings.		Dec 2012	
11. Establish Antimicrobial ward	October	RS/LHF	Weekly grand round	Advice, outcome and actions	July2012	

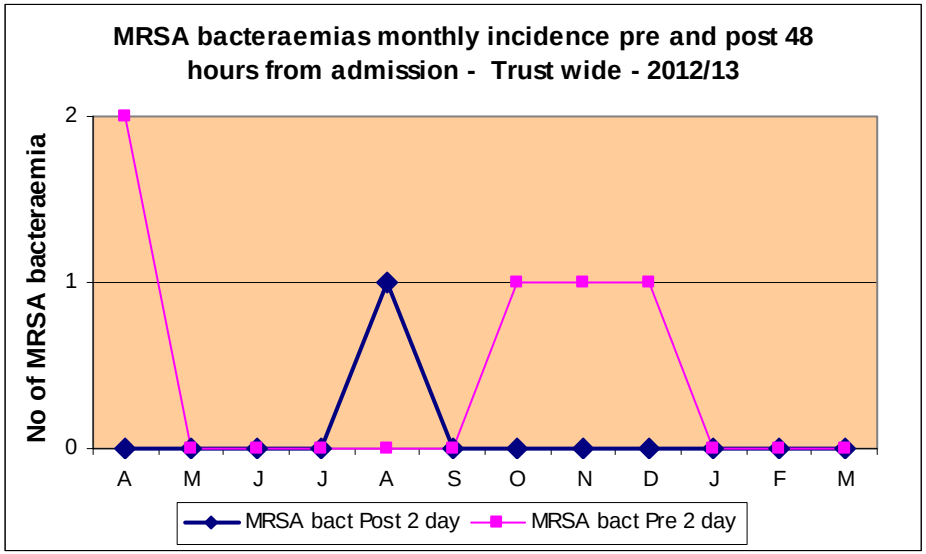
Action	Timescale	Lead/s	Progress Jan 2013	Comments	Date achieved	Barriers to delivery
rounds with microbiologists, an IPN and a pharmacy representative	2012		established.	recorded in medical notes by Microbiologist.		
12. Develop sticker for medical notes re: antibiotic review having taken place – frequency of review to be agreed with RS/Pharmacy.	September 2012	RS to lead with LHF	Due to the format and documentation process of the antimicrobial ward rounds a sticker is no longer required		Sept 2012	
13. Evaluate cleaning and regulatory standards	September 2012	PM CT	Update from Carol Tarren, • Development of a culture where cleanliness and the environment are an individual's responsibility. The Environment Steering Groups will greatly assist with a group having been set up in Scarborough and Bridlington to replicate the successful York Hospital group. • Consistency of cleaning documentation across all sites both	Carol Tarren advises on Hospital Hygiene Committee that will be joint across all sites. Suggests to raise compliance with NHS cleaning specs at this forum, along with the evaluation of alternative cleaning/disinfection products e.g. Tristel		

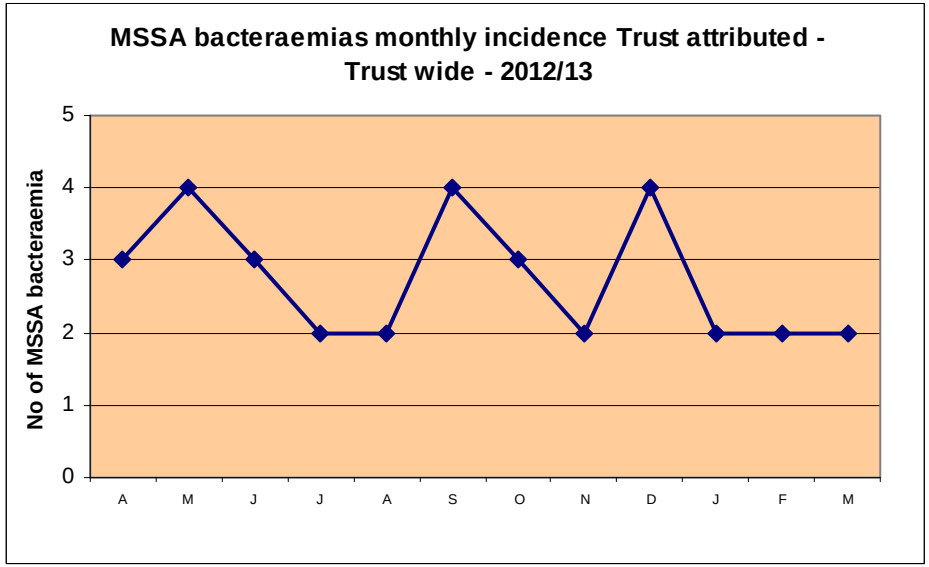
Action	Timescale	Lead/s	Progress Jan 2013	Comments	Date achieved	Barriers to delivery
			in terms of standardisation and compliance when completing. • Review of training for domestic assistants to ensure consistent and high quality training is delivered and personnel are competent to deliver the cleaning services within the Trust. • Review of current monitoring regimes to ensure all sites are consistent in the way monitoring and auditing is undertaken and reported. • Correct and consistent use of cleaning materials and COSHH compliance.			

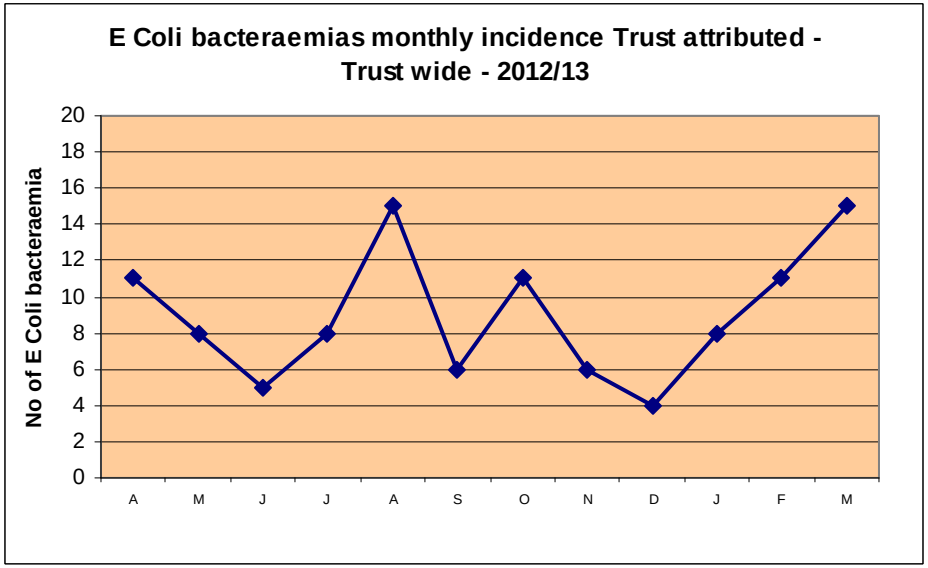
Action	Timescale	Lead/s	Progress Jan 2013	Comments	Date achieved	Barriers to delivery
14. Agree a process of escalation when enhanced cleaning processes are not delivered twice daily. Define/agree how this is implemented with Domestic services managers	September 2012	WD PM CT	Update required from WD and PM. Non received Dec 2012	Suggest - When objective not met escalate to Domestic Supervisor, IPT + AIRS. Number of best practice breaches in relation to cleaning onto? Signal and to Environment Steering Committee (ESC) to discuss impact on subsequent cases. Quality review by IPN`s of all toxin/PCR positive cases via Saving Lives audit tool.	Escalation to Supervisors in place via Chlor Clean check sheet. Reports via Signal and ESC to be developed further. Aug 2012	
15. Carry out ATP monitoring when cases of CDI occur	Immediate	AT VP LHF WD	Monitoring is sporadic due to timing issues post cleaning to gain optimum results	When ATP service provider is agreed, Domestic supervisors will be trained in undertaking ATP monitoring		Awaiting quotes from 2 companies. Email sent 21st Jan 2013
16. Investigate options for a bed / equipment store to allow removal of escalation beds and equipment from wards when cases of C.diff are present .i	September 2012	SP & Estates	PM and WD advise that beds and equipment are moved to enable effective cleaning. M.McGale advises that escalation beds and	Lack of bed/equipment storage means that wards are cluttered and cleaning is compromised. Impact is on risk of environmental contamination and possible environmental		

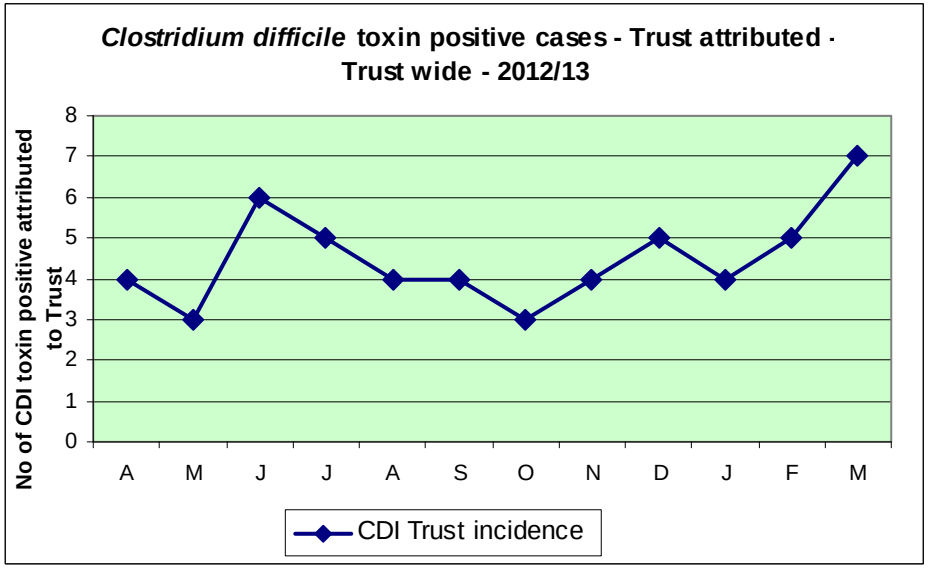
Action	Timescale	Lead/s	Progress Jan 2013	Comments	Date achieved	Barriers to delivery
			equipment cannot be removed from the wards as there is no accessible storage and it is often required urgently.	reservoirs increasing the risk of further cases. Jan 2013, escalation beds still in use and have been on wards where symptomatic patients are located. To be placed on Risk Register		
17. Review Action Plan progress at integrated IP Steering Group	Ongoing	VP/LHF/SP	Standing agenda item on Steering Group			
New objective Jan 2013. 18. Develop a CDI risk assessment tool on CPD for use on admission that identifies patients at risk and enables appropriate management	March 2013	AN, AW. LS, AT	Template developed. To be discussed with Dr Smale			
19. Additional and specific IP Clinical Support Visits to focus on `hot spot` areas	Ongoing as cases occur	IPN`s				

TRUST WIDE INFECTION PREVENTION PERFORMANCE DASHBOARD (All Trust)





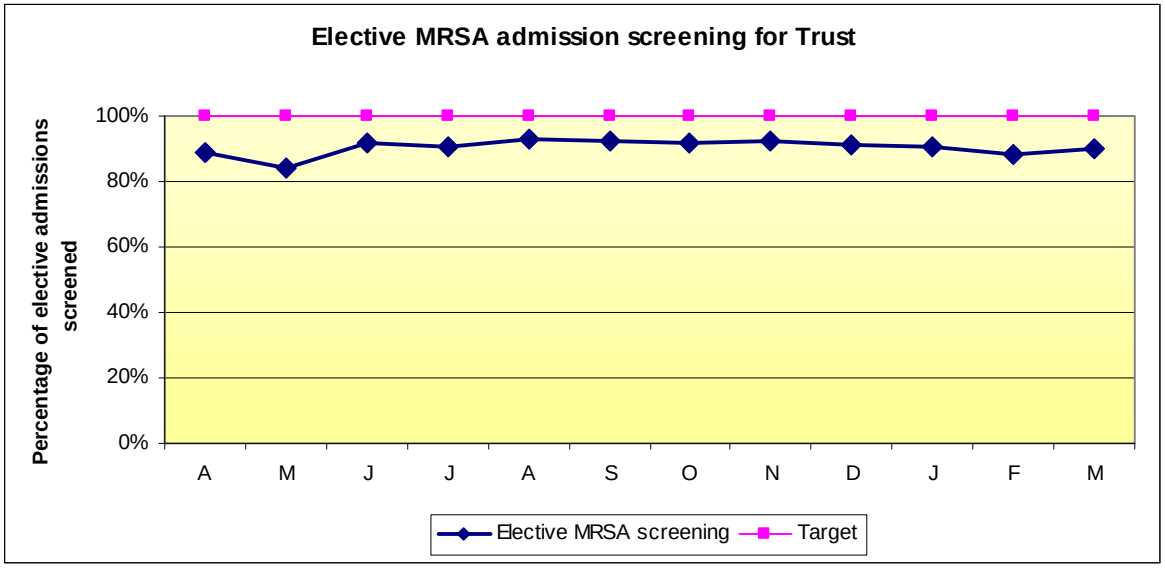




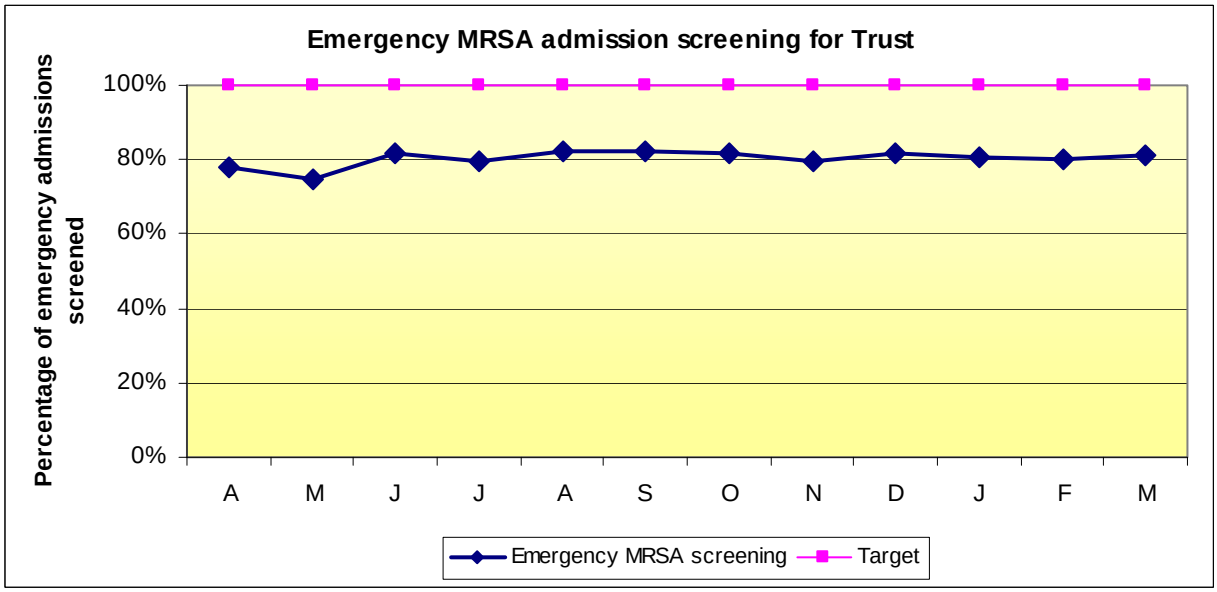
Isolate	2012/13 trajectory	Cases in 2012/13													Cases (to date)	Comments
				A	M	J	J	A	S	O	N	D	J	F	M		
MRSA Bacteraemia cases per year	Six post 48 hour cases - de minimus threshold set by Monitor	All cases		2	0	0	0	1	0	1	1	1	0	0	0	6	Pre + post 48 hour cases
		MRSA bact Post 2 day		0	0	0	0	1	0	0	0	0	0	0	0	1	Monitor de minimus threshold of 6 post 48 hour cases
		MRSA bact Pre 2 day		2	0	0	0	0	0	1	1	1	0	0	0	5	
***Clostridium difficile* Associated Diarrhoea**	51 post 72 hour cases (27 York, 24 Scarborough)	Post 3 day Toxin positiveTrust incidence	CDI Trust incidence	4	3	6	5	4	4	3	4	5	4	5	7	**54**	
MSSA Bacteraemia cases per year		MSSA bact Post 2 day		3	4	3	2	2	4	3	2	4	2	2	2	33	
E Coli Bacteraemia cases per year		E Coli bact Post 2 day		11	8	5	8	15	6	11	6	4	8	11	15	108	

2012/13 trajectory set by DH

Elective MRSA screening	(percentage of elective admissions screened).	A	M	J	J	A	S	O	N	D	J	F	M
		89%	84%	92%	91%	93%	93%	92%	93%	91%	91%	89%	90%
Target		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

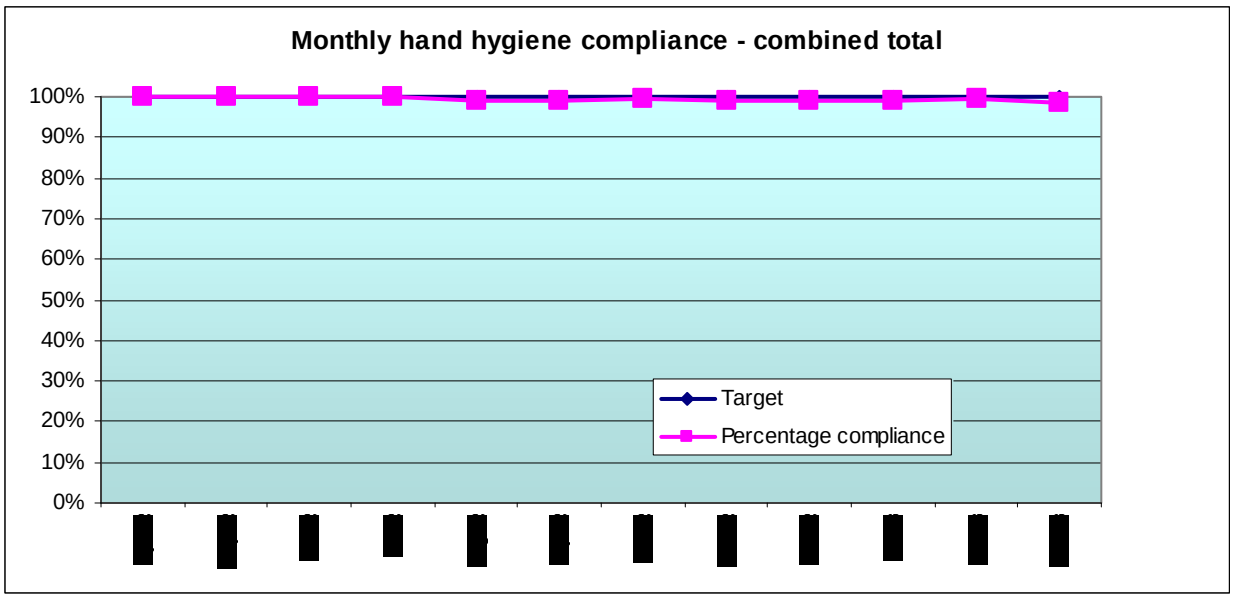


Emergency MRSA screening	(percentage of emergency admissions screened).	A	M	J	J	A	S	O	N	D	J	F	M
		78%	75%	82%	80%	83%	82%	82%	80%	82%	81%	80%	81%
Target		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

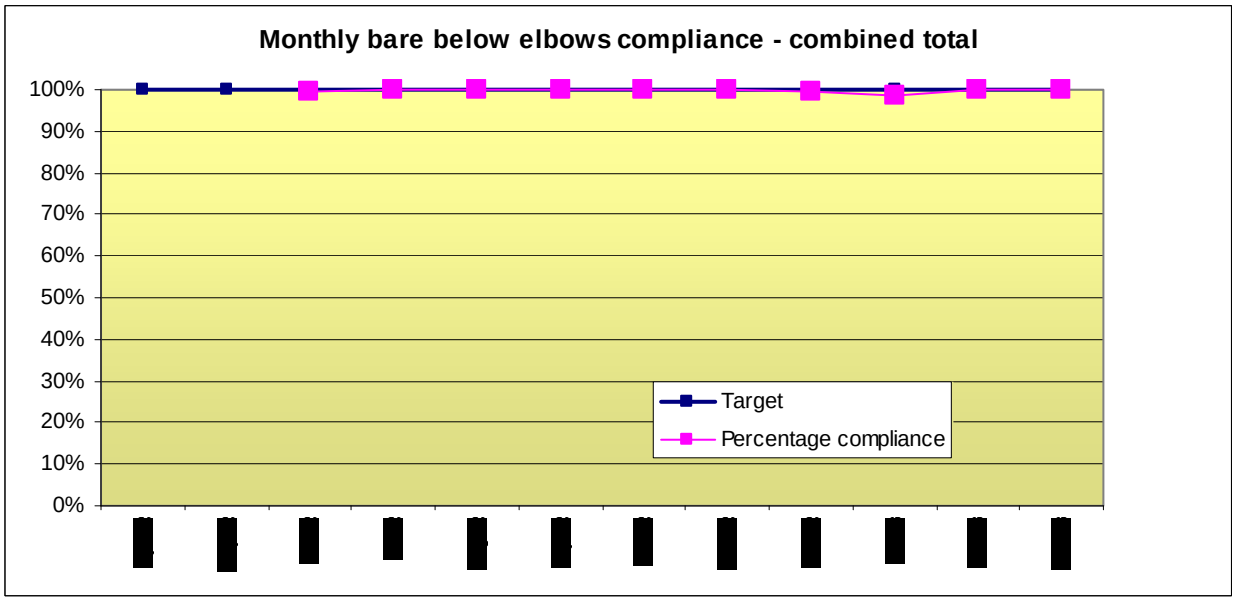


Data provided by Information Department, York and Scarborough

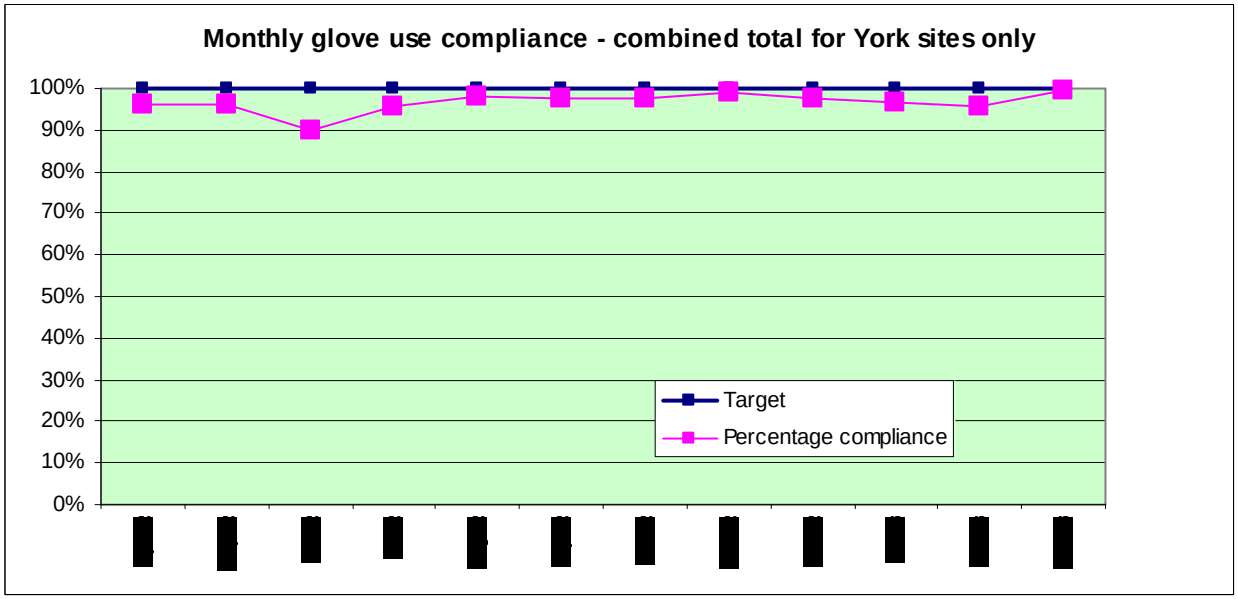
HAND HYGIENE



BARE BELOW THE ELBOWS



GLOVE USE - York sites only



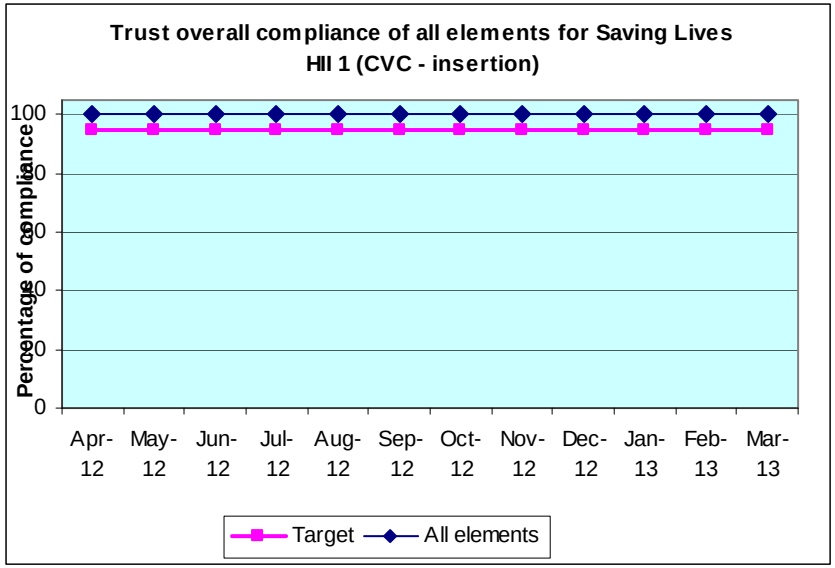
Data from Hand Hygiene files on Q drive (York), supplied by Information Team (Scarborough)

SAVING LIVES

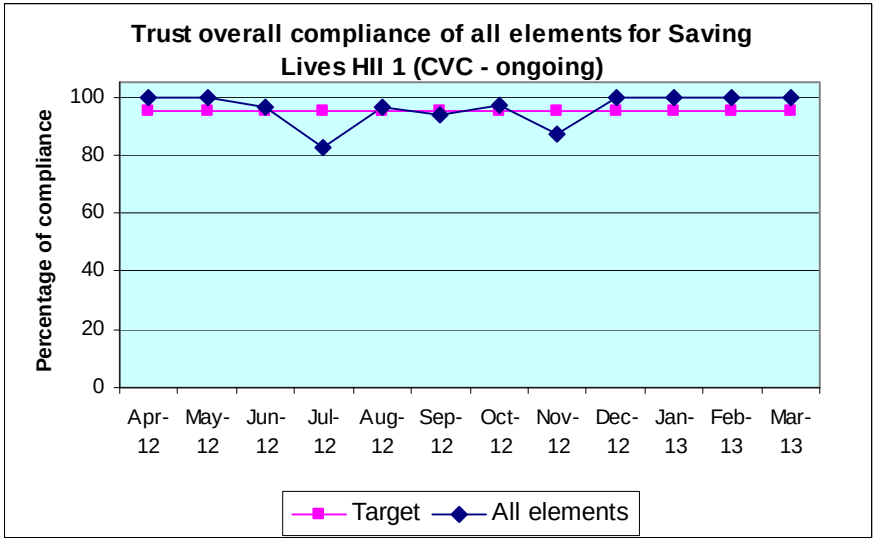
Colour coding: from November 2011	>95%	75%-94%	<75%

Rolling programme of Scarborough inclusion from September 2012

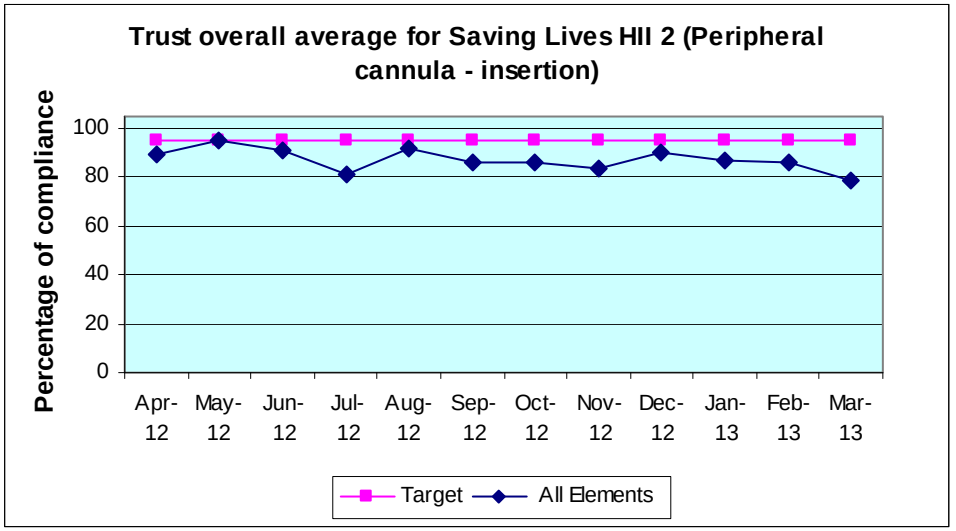
HII 1 (CVC care bundle - insertion_										
	Catheter type	Insertion site	Skin preparation	Personal Protective Equipment	Hand Hygiene	Dressing	Safe disposal of sharps	Documentation	All elements	Target
Apr-12	100	100	100	100	100	100	100	100	100	95
May-12	100	100	100	100	100	100	100	100	100	95
Jun-12	100	100	100	100	100	100	100	100	100	95
Jul-12	100	100	100	100	100	100	100	100	100	95
Aug-12	100	100	100	100	100	100	100	100	100	95
Sep-12	100	100	100	100	100	100	100	100	100	95
Oct-12	100	100	100	100	100	100	100	100	100	95
Nov-12	100	100	100	100	100	100	100	100	100	95
Dec-12	100	100	100	100	100	100	100	100	100	95
Jan-13	100	100	100	100	100	100	100	100	100	95
Feb-13	100	100	100	100	100	100	100	100	100	95
Mar-13	100	100	100	100	100	100	100	100	100	95



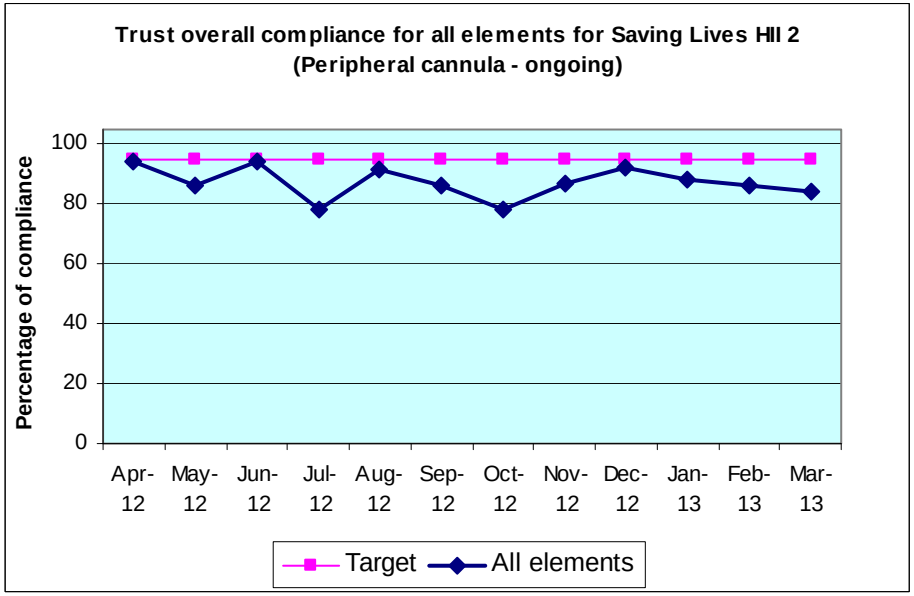
HII 1 (CVC care bundle - ongoing)									
	Hand hygiene	Catheter site inspection	Dressing	Catheter injection ports	Catheter access	Administration set replacement	Catheter removal	All elements	Target
Apr-12	100	100	100	100	100	100	100	100	95
May-12	100	100	100	100	100	100	100	100	95
Jun-12	100	100	100	100	100	100	94	96	95
Jul-12	89	89	89	89	89	80	68	82	95
Aug-12	100	96	96	96	100	100	92	96	95
Sep-12	100	94	100	100	100	100	100	94	95
Oct-12	100	97	100	100	100	100	95	97	95
Nov-12	100	100	88	100	100	100	90	88	95
Dec-12	100	100	100	100	100	100	100	100	95
Jan-13	100	100	100	100	100	100	100	100	95
Feb-13	100	100	100	100	100	100	100	100	95
Mar-13	100	100	100	100	100	100	100	100	95



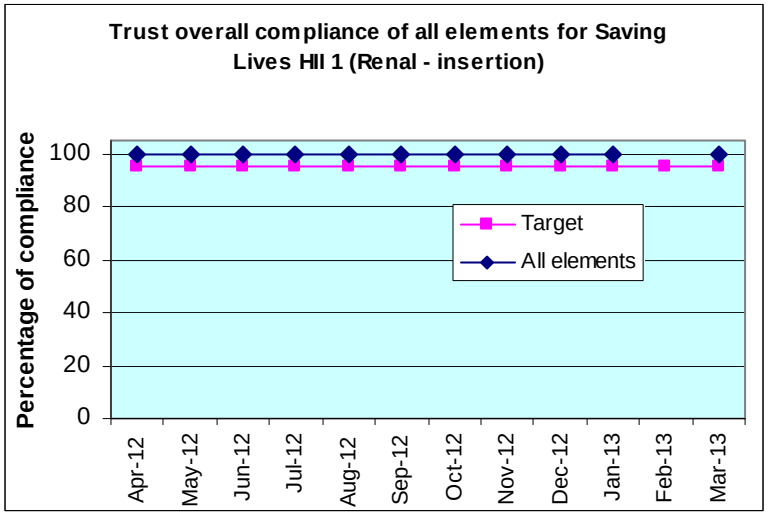
HII 2 (Peripheral cannula care bundle - insertion)								
	Aseptic Non Touch Technique	Hand hygiene	PPE	Skin preparation	Dressing	Documentation	All Elements	Target
Apr-12	97	97	96	97	97	91	89	95
May-12	99	100	100	100	100	96	95	95
Jun-12	97	96	96	97	97	91	91	95
Jul-12	87	86	86	87	87	80	81	95
Aug-12	97	96	97	97	97	94	92	95
Sep-12	97	97	94	96	97	88	86	95
Oct-12	96	95	94	96	97	88	86	95
Nov-12	97	96	92	98	98	90	84	95
Dec-12	98	98	95	97	98	91	90	95
Jan-13	100	99	95	100	100	92	87	95
Feb-13	97	96	93	97	99	88	86	95
Mar-13	93	92	91	93	94	82	79	95



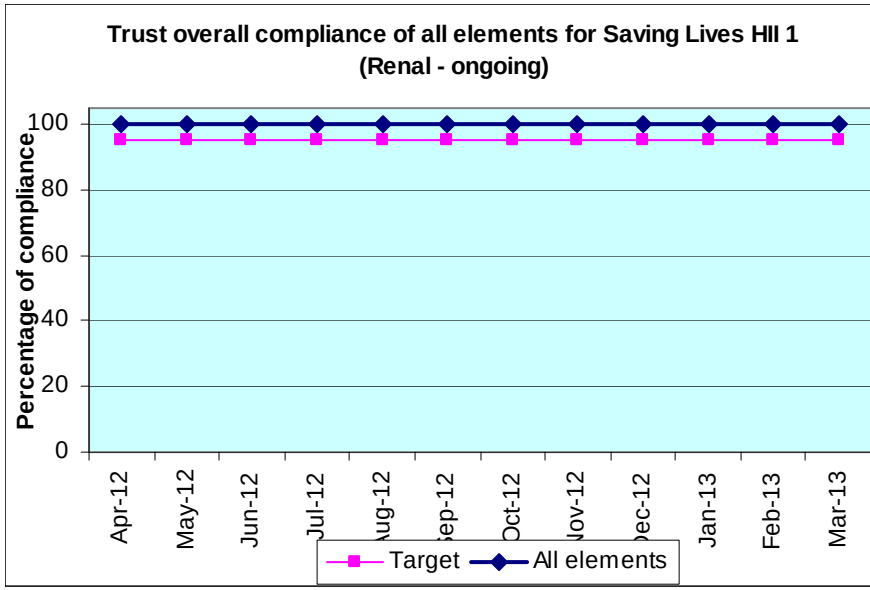
HII 2 (Peripheral cannula care bundle - ongoing)									
	Hand hygiene	Continuing clinical indication	Site inspection	Dressing	Cannula access	Administration set replacement	Routine cannula replacement	All elements	Target
Apr-12	100	96	94	95	99	99	97	94	95
May-12	100	94	96	97	97	98	95	86	95
Jun-12	100	98	99	99	96	100	100	94	95
Jul-12	82	83	82	81	82	79	69	79	95
Aug-12	100	99	100	99	98	96	90	92	95
Sep-12	100	95	98	98	98	93	90	87	95
Oct-12	95	90	88	90	90	92	81	79	95
Nov-12	95	94	95	97	95	96	94	87	95
Dec-12	98	97	97	98	98	93	94	93	95
Jan-13	100	96	98	97	99	95	91	88	95
Feb-13	100	93	99	97	100	98	93	86	95
Mar-13	94	92	92	93	94	86	87	85	95



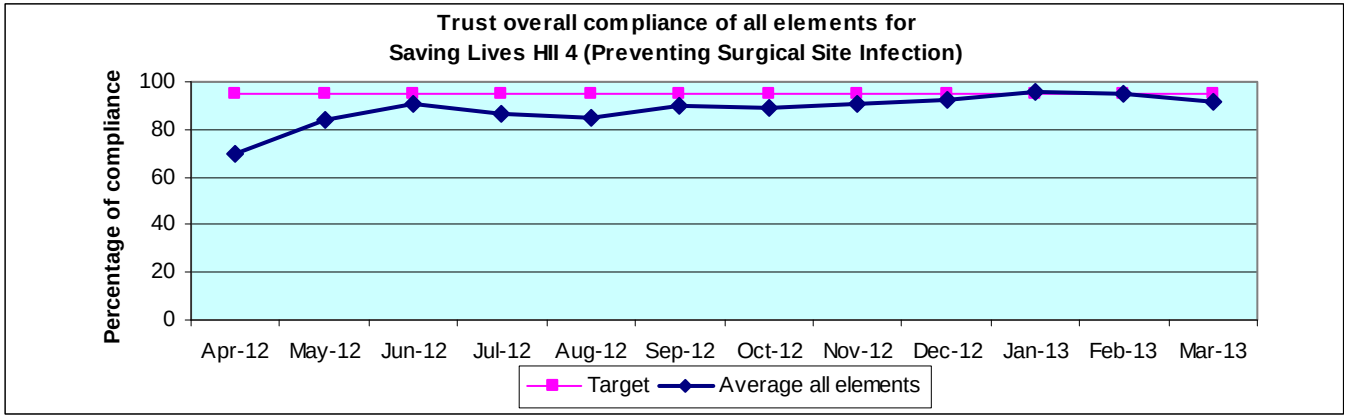
HII 3 (Renal lines care bundle - insertion)											
	Dialysis Catheter type	Insertion site	Skin preparation	Personal Protective Equipment	Hand Hygiene	Aseptic Technique	Dressing	Safe disposal of sharps	Documentation	All elements	Target
Apr-12	100	100	100	100	100	100	100	100	100	100	95
May-12	100	100	100	100	100	100	100	100	100	100	95
Jun-12	100	100	100	100	100	100	100	100	100	100	95
Jul-12	100	100	100	100	100	100	100	100	100	100	95
Aug-12	100	100	100	100	100	100	100	100	100	100	95
Sep-12	100	100	100	100	100	100	100	100	100	100	95
Oct-12	100	100	100	100	100	100	100	100	100	100	95
Nov-12	100	100	100	100	100	100	100	100	100	100	95
Dec-12	100	100	100	100	100	100	100	100	100	100	95
Jan-13	100	100	100	100	100	100	100	100	100	100	95
Feb-13	No events to report										95
Mar-13	100	100	100	100	100	100	100	100	100	100	95



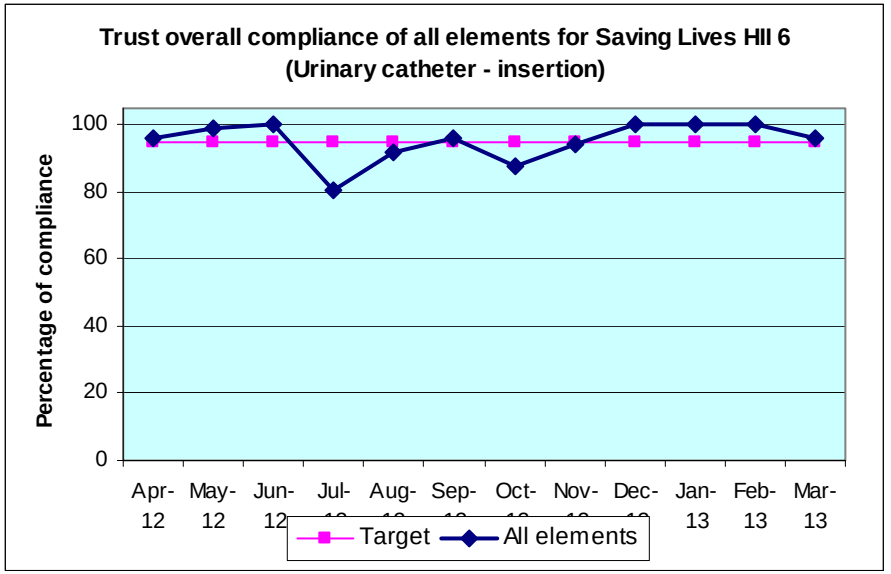
HII 3 (Renal lines care bundle - ongoing)									
	Personal Protective Equipment	Hand hygiene	Insertion Site inspection	Dressing	Catheter replacement	Catheter access	Antimicrobial lock	All elements	Target
Apr-12	100	100	100	100	100	100	100	100	95
May-12	100	100	100	100	100	100	100	100	95
Jun-12	100	100	100	100	100	100	100	100	95
Jul-12	100	100	100	100	100	100	100	100	95
Aug-12	100	100	100	100	100	100	100	100	95
Sep-12	100	100	100	100	100	100	100	100	95
Oct-12	100	100	100	100	100	100	100	100	95
Nov-12	100	100	100	100	100	100	100	100	95
Dec-12	100	100	100	100	100	100	100	100	95
Jan-13	100	100	100	100	100	100	100	100	95
Feb-13	100	100	100	100	100	100	100	100	95
Mar-13	100	100	100	100	100	100	100	100	95



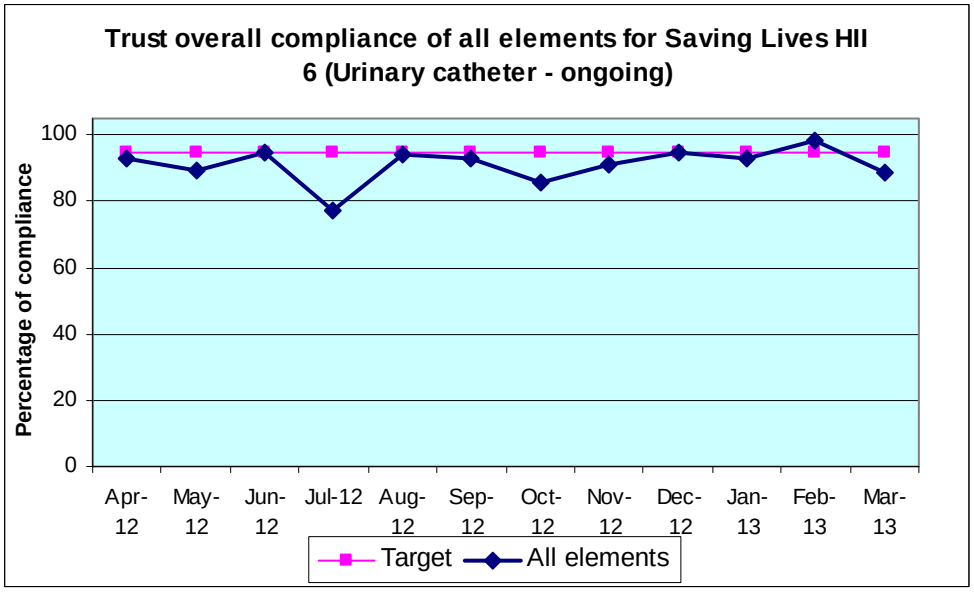
HII 4 (Preventing surgical site infections)																
Theatres	MRSA screening	MRSA decolonisation	Pre-operative showering	Hair removal	Prophylactic antimicrobial	Skin preparation	Normo-thermia	Incise drapes	Supplemented oxygen	Theatre Dressing	Glucose control	Surgical Dressing	ANTT	Hand Hygiene	Average all elements	Target
	Pre-operative phase				Intra-operative phase						Post-operative phase					
Apr-12	89	80		60	39						84				70	95
May-12	94	100		100	38						89				84	95
Jun-12	92	100	100	71	41	100	100	75	100	100	91	100	100	100	91	95
Jul-12	91	100	Data not collected		37	100	100	88	100	100	84	80	80	80	87	95
Aug-12	90	75	100	100	36	83	83	71	83	83	88	100	100	100	85	95
Sep-12	91	100	86	100	33	92	100	96	100	100	90	90	90	90	90	95
Oct-12	91	100	86	58	39	96	95	88	100	100	96	100	100	100	89	95
Nov-12	91	92	88	88	42	92	100	94	100	100	83	100	100	100	91	95
Dec-12	89	100	95	95	45	90	100	90	100	100	95	100	100	100	93	95
Jan-13	89	100	100	77	86	98	100	96	100	100	92	100	100	100	96	95
Feb-13	85	100	99	100	88	94	86	93	94	96	93	100	100	100	95	95
Mar-13	90	100	80	69	89	98	99	94	100	100	91	93	92	93	92	95



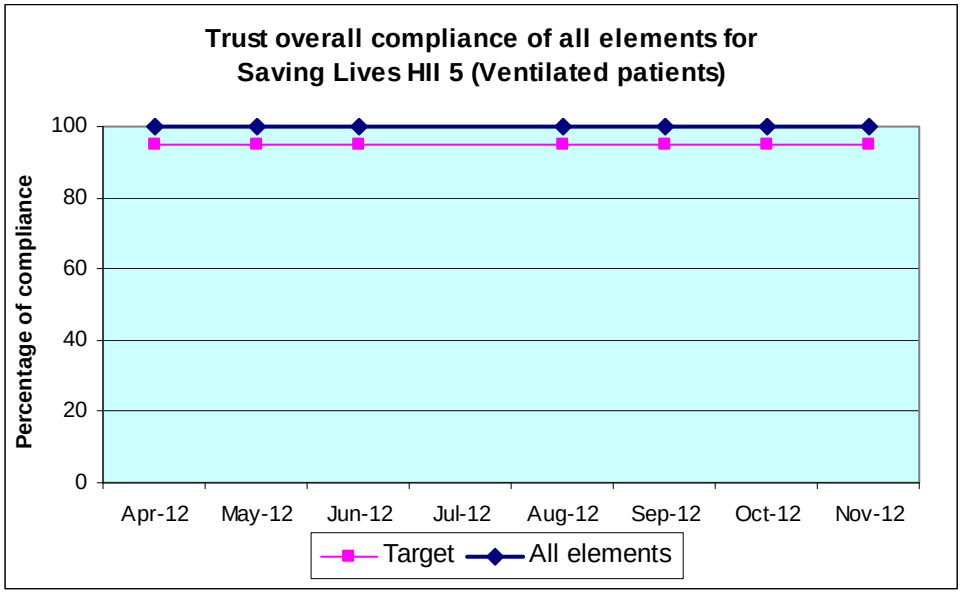
HII 6 (Urinary catheter care bundle - insertion)									
	Is the catheter needed?	Cleaning the urethral meatus	Sterile closed drainage system	Hand hygiene	Aseptic technique	PPE	Docu	All elements	Target
Apr-12	96	96	96	96	96	96	96	96	95
May-12	99	100	100	100	100	100	99	99	95
Jun-12	100	100	100	100	100	100	100	100	95
Jul-12	81	81	80	81	81	81	81	81	95
Aug-12	92	92	92	92	92	92	92	92	95
Sep-12	96	96	96	96	96	96	96	96	95
Oct-12	89	89	89	89	89	89	88	88	95
Nov-12	96	94	96	96	96	96	96	94	95
Dec-12	100	100	100	100	100	100	100	100	95
Jan-13	100	100	100	100	100	100	100	100	95
Feb-13	100	100	100	100	100	100	100	100	95
Mar-13	100	100	100	100	100	100	96	96	95



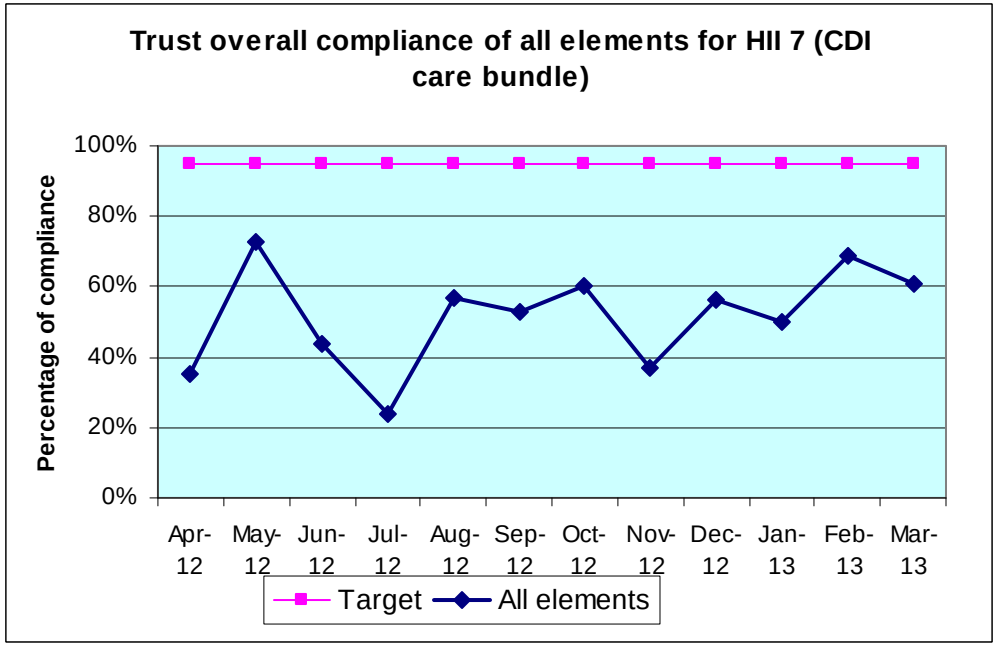
HII 6 (Urinary catheter care bundle - ongoing)								
	Hand hygiene	Catheter hygiene	Sampling	Drainage bag position	Catheter manipulation	Assessment of need	All elements	Target
Apr-12	100	99	100	100	100	94	93	95
May-12	95	93	93	95	94	91	89	95
Jun-12	100	100	100	99	100	96	95	95
Jul-12	80	80	69	81	76	77	77	95
Aug-12	100	100	100	100	100	99	94	95
Sep-12	95	95	92	94	94	94	93	95
Oct-12	89	91	85	90	88	89	86	95
Nov-12	95	94	87	93	94	94	91	95
Dec-12	100	100	97	100	95	99	95	95
Jan-13	100	98	96	100	95	94	93	95
Feb-13	100	99	100	100	100	99	98	95
Mar-13	97	97	91	95	95	96	89	95



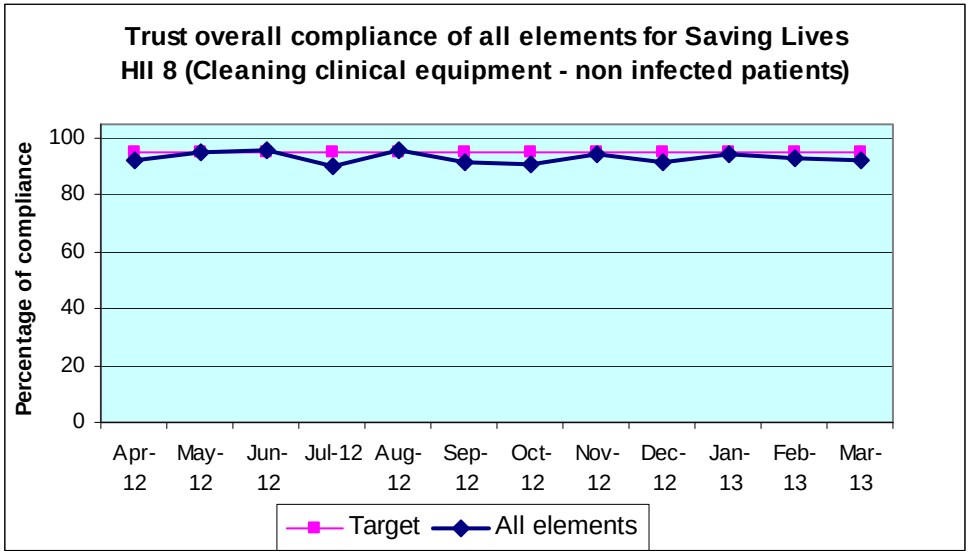
HII 5 (Ventilated patient care bundle)								
	Oral hygiene	Suglottic aspiration	Tracheal tube cuff pressure	Elevation of head of bed	Sedation level assessment	Stress ulcer prophylaxis	All elements	Target
	SCBU and ICU		ICU only				SCBU + ICU	
Apr-12	100	100	100	100	100	100	100	95
May-12	100		100	100	100	100	100	95
Jun-12	100	100	100	100	100	100	100	95
Aug-12	100	100	100	100	100	100	100	95
Sep-12	100	100	100	100	100	100	100	95
Oct-12	100	100	100	100	100	100	100	95
Nov-12	100	100	100	100	100	100	100	95
Dec-12	100	100	100	75	100	100	75	95
Jan-13	100	100	100	100	100	100	100	95
Feb-13	100	75	100	100	100	88	83	95
Mar-13	100	88	100	100	100	100	92	95



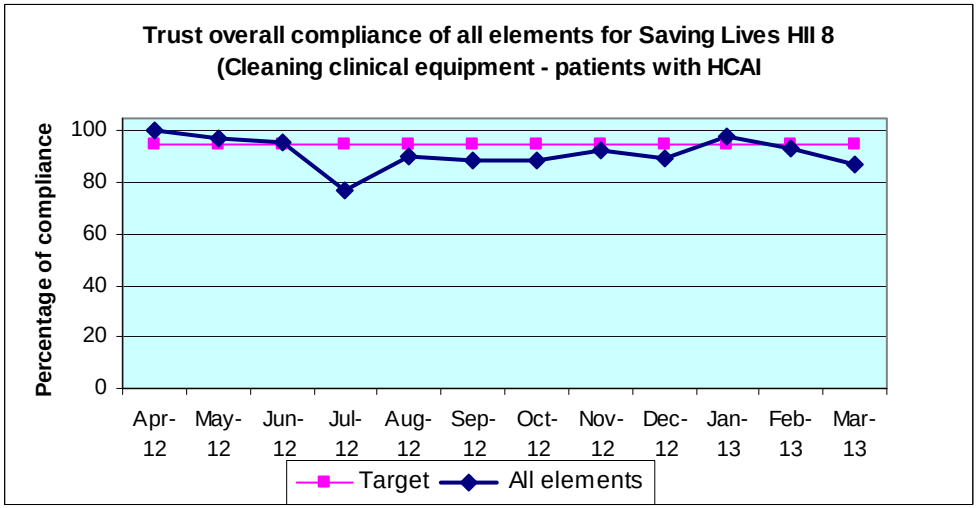
HII 7 (Clostridium Difficile Infection Care bundle)								
	Stool chart completed	Prudent antibiotic prescribing	Correct hand hygiene	Environmental decontamination	Personal protective equipment	Isolation/ cohort nursing	All elements	Target
Apr-12	x	66%	75%	60%	100%	93%	35%	95%
May-12	93%	90%	100%	79%	100%	100%	73%	95%
Jun-12	78%	54%	83%	62%	100%	100%	44%	95%
Jul-12	83%	85%	100%	29%	100%	98%	24%	95%
Aug-12	93%	86%	100%	67%	100%	96%	57%	95%
Sep-12	100%	97%	100%	70%	100%	83%	53%	95%
Oct-12	88%	100%	100%	65%	100%	100%	60%	95%
Nov-12	83%	80%	100%	47%	100%	73%	37%	95%
Dec-12	93%	94%	100%	76%	100%	75%	56%	95%
Jan-13	93%	94%	100%	63%	100%	95%	50%	95%
Feb-13	98%	91%	100%	70%	100%	96%	69%	95%
Mar-13	90%	100%	93%	73%	100%	91%	61%	95%



HII 8 (Cleaning clinical equipment care bundle - non-infected)								
	Location of cleaning activity	Correct hand hygiene	PPE	Cleaning	Storage	Documentation	All elements	Target
Apr-12	95	95	94	95	94	95	92	95
May-12	100	100	99	100	98	97	95	95
Jun-12	98	99	98	97	98	96	96	95
Jul-12	93	93	92	92	91	92	90	95
Aug-12	97	97	97	96	97	96	96	95
Sep-12	94	94	94	94	94	93	92	95
Oct-12	93	93	91	92	92	91	91	95
Nov-12	98	99	99	97	99	96	94	95
Dec-12	96	96	96	95	95	94	92	95
Jan-13	98	98	98	97	97	95	94	95
Feb-13	97	98	96	96	97	95	93	95
Mar-13	97	98	98	96	95	96	93	95



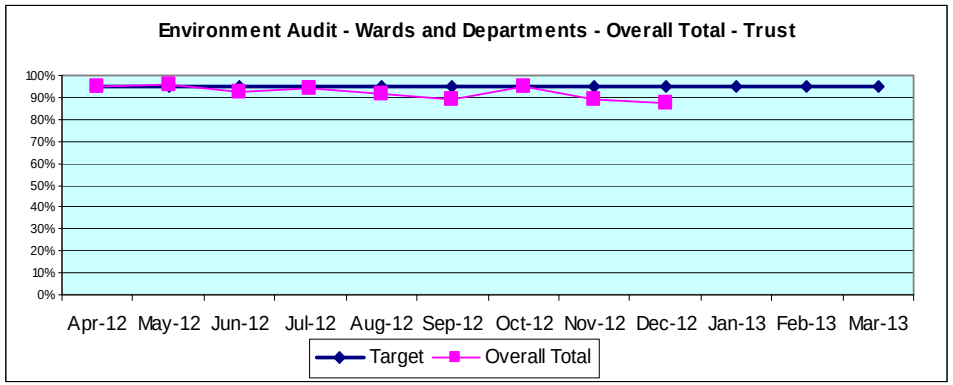
HII 8 (Cleaning clinical equipment care bundle - patients with HCAI)								
	Location of cleaning activity	Correct hand hygiene	PPE	Cleaning	Storage	Documentation	All elements	Target
Apr-12	100	100	100	100	100	100	100	95
May-12	99	100	99	100	100	99	97	95
Jun-12	97	97	97	95	97	97	95	95
Jul-12	78	78	78	78	78	77	77	95
Aug-12	90	92	92	92	92	92	90	95
Sep-12	91	93	91	90	93	93	89	95
Oct-12	89	90	89	90	90	89	89	95
Nov-12	96	97	97	95	98	96	92	95
Dec-12	95	95	94	95	93	94	90	95
Jan-13	99	100	100	99	99	99	98	95
Feb-13	95	95	95	95	95	95	94	95
Mar-13	92	93	93	93	89	92	87	95

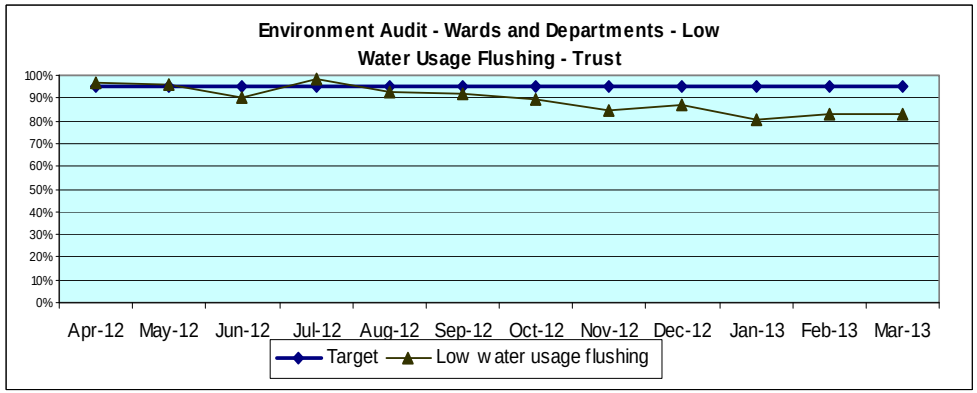


ENVIRONMENT AUDITS

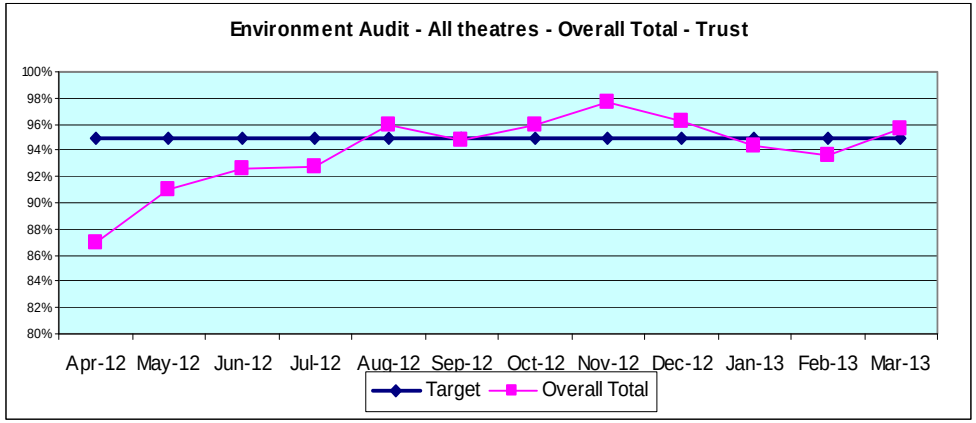
Scarborough included from January 2013

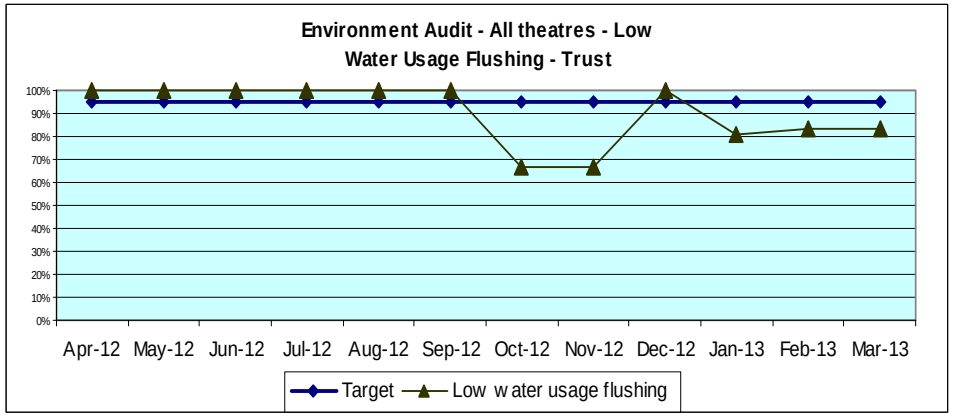
Trust Ward and Departments												
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Ward/ Department Area	94%	94%	95%	96%	96%	92%	96%	93%	89%	93%	88%	88%
Patients' Toilets and Bathrooms	96%	97%	92%	97%	97%	94%	96%	94%	91%	98%	91%	88%
Linen	95%	97%	96%	97%	98%	95%	96%	93%	91%	97%	90%	87%
Storage Room	91%	90%	92%	93%	94%	91%	92%	88%	85%	97%	91%	89%
Treatment Room	93%	94%	93%	94%	96%	90%	90%	88%	84%	92%	84%	84%
Clinical Room	96%	95%	95%	93%	95%	94%	92%	88%	86%	93%	88%	87%
Sluice	94%	95%	94%	95%	96%	94%	96%	90%	89%	96%	87%	86%
Overall Total	94%	94%	94%	95%	96%	93%	94%	92%	89%	95%	89%	88%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Low water usage flushing	97%	96%	90%	98%	93%	92%	90%	85%	87%	81%	83%	83%
Standard Operating Procedures				73%	80%	81%	58%	65%	71%	86%	78%	79%





Trust theatres												
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
General all areas	82%	86%	87%	88%	92%	95%	94%	95%	91%	91%	90%	93%
Scrub areas	100%	96%	100%	100%	100%	87%	98%	100%	100%	100%	98%	100%
Anaesthetic room	80%	89%	91%	90%	95%	97%	93%	93%	94%	93%	94%	95%
Prep room	75%	84%	84%	84%	95%	90%	94%	90%	95%	95%	91%	96%
Operating theatre	83%	87%	95%	91%	94%	96%	94%	95%	96%	92%	96%	95%
Sluice	65%	90%	87%	87%	94%	92%	96%	94%	94%	92%	87%	94%
Storage	71%	67%	75%	92%	87%	94%	83%	83%	100%	89%	90%	94%
Linen	100%	100%	98%	96%	100%	100%	100%	100%	100%	95%	96%	97%
Waste	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	97%
Overall Total	87%	91%	93%	93%	96%	95%	96%	98%	96%	94%	94%	96%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Low water usage flushing	100%	100%	100%	100%	100%	100%	67%	67%	100%	81%	83%	83%
Standard Operating Procedures				100%	89%	89%	67%	67%	100%	86%	78%	79%





DOMESTIC MONITORING

Data provided by domestic services

DOMESTIC MONITORING % Score.

Very High Risk (VHR): Directorate Priority 93% and under. Urgent Action Required 94-97%. Compliant 98% and above.
High Risk (HR): Directorate Priority 84% and under. Urgent Action Required 85-94%. Compliant 95% and above.
Significant Risk (SR): Directorate Priority 79% and under. Urgent Action Required 80-84%. Compliant 85% and above.

Data provided by domestic services

	A	M	J	J	A	S	O	N	D	J	F	M
Very High Risk areas	98%	98%	95%	97%	97%	97%	97%	98%	98%	96%	96%	97%
High Risk areas	94%	93%	94%	91%	93%	93%	93%	93%	95%	94%	95%	94%
Significant Risk areas	96%	96%	94%	91%	97%	90%	94%	94%	91%	90%	95%	93%
Low risk areas										93%	93%	91%
Trust overall	96%	96%	94%	95%	96%	96%	96%	96%	94%	94%	95%	92%

PEAT REPORTING % Score. YORK ONLY

Very High Risk (VHR): Directorate Priority 93% and under. Urgent Action Required 94-97%. Compliant 98% and above.
High Risk (HR): Directorate Priority 84% and under. Urgent Action Required 85-94%. Compliant 95% and above.
Significant Risk (SR): Directorate Priority 79% and under. Urgent Action Required 80-84%. Compliant 85% and above.

YORK ONLY

	A	M	J	J	A	S	O	N	D	J	F	M
Very High Risk areas	97%	97%	97%	96%	94%	None audited	96%	96%	96%	93%	97%	97%
High Risk areas	90%	94%	95%	92%	92%	93%	92%	94%	95%	93%	91%	91%
Significant Risk areas	92%	97%	93%	91%	None audited	90%	86%	93%	94%	93%	88%	88%
Trust overall	93%	96%	94%	92%	92%	92%	93%	94%	95%	93%	92%	92%

INFECTION PREVENTION MANDATORY TRAINING BY STAFF GROUP

	April to December
Allied Health Professionals	123
Registered staff - Nurses	639
Unregistered staff - HCAs	367
Medical staff	147

Data provided by Corporate Learning and Development Team
Figures refer to the number of staff who attended training

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Annual Complaints Report

Action requested/recommendation

The Board is asked to note the regulatory declaration of complaints activity.

Summary

Complaints provide us with a valuable insight into the experience of patients at the Trust and enable us to make improvements to our services. They also enable us to feedback to staff when they are providing an excellent service. Patients, their families and carers are encouraged to share any concerns or suggestions they have with us so that their comments and suggestions can be investigated and responded to, and so that we can learn lessons from their experiences.

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

No implications for equality and diversity.

Reference to CQC outcomes

The content of the report covers a raft of CQC outcomes. Of particular importance is Outcome 4, Quality of Care. Implicitly all 16 quality and safety outcomes are in some way implied within the report.

Progress of report	This report is only presented to the Board of Directors.
Risk	No risk.
Resource implications	No resource implications.

Owner	Elizabeth McManus, Chief Nurse
Author	Wendy Brown, Lead Nurse Patient Experience
Date of paper	April 2013
Version number	Version 1

Local Authority and National Health Service Complaints (England) Regulations 2009 Annual Complaint Report

1 April 2012 to 31 March 2013
York Teaching Hospital NHS Foundation Trust

The annual reports for complaints received on the York and Scarborough sites are presented separately. Future reports will be presented for the whole Trust.

The Trust's practice in relation to the handling of Complaints was audited in November 2012. The objective of this audit was to provide assurance that the Trust has systems in place to consider and resolve complaints fairly and efficiently and for key lessons to be learned by the organisation.

Overall an opinion of **HIGH** Assurance was given on the systems and processes in place to manage complaints across the enlarged organisation based on the objectives tested as part of this audit.

'This audit has found the Trust has robust systems in place to consider and resolve complaints fairly and efficiently. Our testing has shown that the Trust strives to be open, accountable and fair in its response to concerns and complaints raised about the services provided. Lessons learnt as a result of actions arising out of complaints are documented in the annual report.

Complaints provide us with a valuable insight into the experience of patients at the Trust and enable us to make improvements to our services. They also enable us to feedback to staff when they are providing an excellent service. Patients, their families and carers are encouraged to share any concerns or suggestions they have with us so that their comments and suggestions can be investigated and responded to, and so that we can learn lessons from their experiences.

'...instead of seeing complaints as a burden, or a distraction, or something to be dealt with outside the mainstream of service provision, we must see complaints as integral to the improvement of we provide. Think about it – learning from our mistakes, listening to complaints, comparing what we do, evaluating our performance and constantly seeking to improve our quality –these are the features of the best-performing organisations in every sector – and they are there in the best-performing NHS organisations already.'
Andrew Lansley MP, former Secretary of State for Health

The Trust has an established Concerns and Complaints Policy and Procedure. Complaints can be made in person, by letter, email or telephone. All complainants receive an acknowledgement letter detailing who will investigate the complaint, their contact details and when to expect a response. The acknowledgement letter advises that independent advocacy services are available to provide assistance. If other kinds of support are required, the Complaints Officers liaise with appropriate specialists, for example, Acute Liaison Lead Nurse, Specialist Nurse for patients with Learning Disabilities. The Trust can arrange a local resolution meeting with the appropriate staff

if the complainant finds this helpful, as we usually find that they are beneficial to everyone.

Our Complaint correspondence also includes details of how to contact the Care Quality Commission, the independent regulator of all health and social care services in England

Guidance and individual training is provided by the Patient Experience Team for all staff who undertake complaint investigations. The team also deliver more general patient experience training as part of the Trust induction for new Staff Nurses and Health care Assistants and Junior Doctors.

Bespoke training has been delivered for individual wards in response to complaints received.

A session is delivered on the It's My Ward programme which incorporates building complaint and compliment feedback into every day practice.

Local Authority and National Health Service Complaints (England) Regulations 2009 Annual Complaint Report

1 April 2012 to 31 March 2013

York Teaching Hospital NHS Foundation Trust

Complaints received at York Hospital

Number of complaints received	Number of complaints which you have decided were well founded i.e. upheld	Number of complaints which were referred to the Parliamentary and Health Service Ombudsman
328	47 cases are still current. Of the closed complaints, 189 generated actions for improvement	6

1.Subject Matter of Complaints	Subject Matter	No of Complaints Received
	Aspects of clinical treatment	194
	Attitude of staff	43
	Admission/discharge/transfer	22
	Appointments delay/cancel-outpatient	20
	Communication & information	24
	Privacy & dignity	5
	Failure to follow procedure	1
	Appointments delay/cancel-inpatient	3
	Personal records	5
	Aids/appliances/equipment/premises	1
	Consent to treatment	2
	Policy & commercial decisions	8
2. Any matters of general importance arising out of those complaints, or the way in which they were handled	Under the 2009 complaints regulations 58 complaints were resolved outside the procedure, which gives a total of 386 complaints. Of the 6 complaints investigated by the Health Service Ombudsman, (17 the previous year), 1 was referred back for further local resolution and subsequently closed. 1 was withdrawn to pursue a legal claim. 2 were not upheld and 2 are awaiting a decision on whether the HSO wants to investigate further. Lead Nurse for Patient Experience emailed Investigating Officers highlighting concerns in the number of complaints being extended, returned to PET late, the quality of some reports not meeting standards and the importance of ensuring new Investigating Officers receive training from PET.	
3. Any matters where	Examples of action plans:	

action has been taken to improve services as a consequence of those complaints	Patient experienced delays in ED waiting for doctor and cubicle and then for an inpatient bed. Various actions are being co-ordinated through the Acute Board to improve patient flow. 4 complaints related to the lack of Specialist SALT (Speech & Language Therapy) provision for hearing impaired children in the community (since the retirement of the previous post holder) – vacant post is now being advertised. Parents experienced problems regarding the completion of forms for consent to a post mortem for their baby. A number of actions have been implemented including consent taker training for obstetrics & gynaecology staff and how/who to contact during weekends and bank holidays.
4. Any trends that have been identified	Trends identified from the annual complaint figures continue to be:- 1) all aspects of clinical treatment 2) attitude of staff 3) admission, discharge and transfer 4) communication and information

Complaints received at Scarborough Hospital

Number of complaints received	Number of complaints which you have decided were well founded i.e. upheld	Number of complaints which were referred to the Parliamentary and Health Service Ombudsman
294	In future the number of complaints received on the Scarborough site generating action plans will be reported	9

Please summarise:

1.Subject Matter of Complaints	Subject Matter	No of Complaints Received
	Aspects of clinical treatment	198
	Attitude of staff	33
	Admission/discharge/transfer	8
	Appointments delay/cancel - outpatient	11
	Communication & information	14
	Privacy & dignity	15
	Patient's property and expenses	2
	Appointments delay/cancel - inpatient	4
	Personal records	1
	Aids/appliances/equipment/premises	1
	Policy & commercial decisions	0
	Mortuary and PM arrangements	1
	Hotel Services (including food)	1
	Other	5
2. Any matters of general importance arising out of those complaints, or the way in which they were handled	3 October 2011 saw the introduction of the new complaints procedure, based on York's model. Complaints investigations have improved, however, there are still some concerns over late complaint responses and ensuring the directorates are aware it is their responsibility to inform complainants if they are unable to meet deadline dates and keep the complaints team informed of any extensions.	
3. Any matters where action has been taken to improve services as a consequence of those complaints	Examples of action plans: In light of concerns raised by cardiology patients, a new system has now been put in place by the cardiology team which ensures all referrals to other Trust's are followed up in a timely fashion so referrals are sent, received and actioned promptly. Gold Standard guidance for the discharge of surgical patients has	

	been produced. The lead nurse in paediatrics has undertaken a review of sedation practices on Duke of Kent Ward with follow up clinical audit being undertaken. This involves reviewing how staff explain and gain appropriate consent for holding children for procedures and the use of appropriate distraction therapy practices to ensure that best practice is evidenced and assured in the future. Update received in December 2012 - half day training session held on 10/10/12 for stroke unit staff on the assessment and management of continence in stroke. Training arranged by Lesley Beadle and presented by the Nurse Continence advisor. Staff from Stroke and rehab unit attended and evidence of attendance supplied and filed in pink folder.
4. Any trends that have been identified	Dashboard reports are submitted to the Head Of Patient Experience every month, which highlight issues of concern. To analyse this year's figures, it is encouraging to note that the number of complaints received in relation to communication has decreased from last year's figures. However, in general the number of formal complaints received at Scarborough Hospital has increased by 13% based on last year's figures, Trends identified from the annual complaint figures continue to be:- 5) all aspects of clinical treatment 6) attitude of staff 7) privacy and dignity.

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

National Inpatient Survey 2012

Action requested/recommendation

The Board is asked to consider and discuss the report and how the Trust can improve. The findings from the survey were released by the CQC on 16th April and are now available publicly.

Summary

The Executive Summary is attached for high level information. Plan to present more detailed analysis and plan for improvement at next Trust Board.

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

Implications for equality and diversity

No implications for equality and diversity.

Reference to CQC outcomes

1,4,9,16

Progress of report	Board of Directors – April 2013 Presentation to Scarborough Directorates – 11 April 2013 Presentation to York Directorates – 16 April 2013 Council of Governors – date tba
Risk	Potential Trust Reputation
Resource implications	No resource implications identified
Owner	Elizabeth McManus, Chief Nurse
Author	Kay Gamble, Patient and Public Involvement Specialist

Date of paper	17th April 2013
Version number	Version 1

Board of Directors - 24 April 2013

Inpatient Survey 2012

1. Introduction and background

This report summarises the key findings of the Inpatient Survey 2012, carried out by the Picker Institute, on behalf of York Teaching Hospital NHS Foundation Trust. The Picker Institute was commissioned by 72 UK trusts to undertake the Inpatient Survey 2012 which asks the views of adult inpatients having at least one overnight stay in hospital during August 2012. The survey covers the issues that patients consider important in their care and offers an insight into their experience.

This is the first patient survey which provides us with a combined analysis for both York Hospital and Scarborough Hospital sites. The number of patients taking part in the survey is larger than previous years. This is due to the sample being doubled to 1700 to reflect the new organisation. This will be reviewed prior to the 2013 survey.

The response rate was 56% compared with an average response rate of 48%.

2. Findings
(see attached Executive Summary Report)

Key Positive Findings:

80% always had confidence and trust in their doctors
95% reported that the hospital room/wards were very or fairly clean
88% said they always had enough privacy when being examined or treated
91% reported that the toilets were very or fairly clean

Key Negative Findings:

The Hospital and Ward:
42% of patients reported that they were bothered by noise at night from other patients
34% of patients reported that not all staff introduced themselves
27% of patients reported that they definitely got enough information about ward routines, such as timetable and rules

Doctors:
49% of patients reported that they did not always get opportunity to talk to a doctor
52% of patients felt that there was not enough opportunity for family to talk to doctor
30% of patients said that they did not always get clear answers to questions

Nurses:
41% of patients reported that they did not always get opportunity to talk to a nurse

Summary:

- Admission process for planned admissions particularly good. Patients do not wait too long and nor is the date changed.
- The ward is a good place to be. Food, personal belongings, cleanliness, mixed sex all good. Food particularly good at Scarborough.
- Since the merger, Scarborough has shown improvement. York has shown improvement on information and communication.
- Patients unlikely to be asked about the quality of their care across both sites.
- Noise at night an issue across the Trust.
- The two hospital sites compare differently in relation to some questions about Doctors and Nurses which may not immediately highlight these as areas for us to focus on in Scarborough
- Involvement is an issue at Scarborough Hospital

3. Conclusion

The In-Patient Survey 2012 has provided the Trust with a baseline going forward. It highlights areas where the Trust is performing well and also highlighted the areas in which the Trust needs to improve in and prioritise action planning.

We are one of the worst performing Trust nationally on asking patients to give their views on the quality of their care. With the implementation of the Friends and Family Test from this month, the Trust must build on this and ensure that we address this as a key priority.

* Whilst there are no resource implications identified in this report, we must highlight that the Friends and Family Test which came into effect from 1st April 2013 does have CQUIN payments attached in relation to response rate. The Trust, as previously stated, performs poorly in gaining the views of our patients (as reported in the Inpatient Survey 2012). We must ensure that not only do we increase our performance in this area to move the Trust to a higher position nationally, but we must also improve in this area to secure the CQUIN payment in 2013.

4. Recommendation

It is recommended that the In-Patient Survey results and priorities for service improvement be shared across the organisation. By utilising other surveys, PALS and Complaints information, patients and staff should be involved in developing an action plan, and any resulting quality improvement activities. The Picker Institute delivered two presentations to directorates in Scarborough and York for Directorates to fully consider the findings and consider their speciality findings. Corporate Directors are also being presented with the findings from the In-Patient survey in the near future.

The Council of Governors should receive the survey findings at a future meeting.

The Patient Experience Team, working with key staff from Directorates to facilitate the action planning process on behalf of the Trust. It is further recommended that a Directorate Manager and a member from the Patient Experience Team present the action plan to a Board of Directors meeting in the future.

5. References and further reading

The full report and individual hospital site reports can be accessed through the Patient Experience Team, as can speciality and patient comments.

Author	**Kay Gamble, PPI Specialist**
Owner	**Elizabeth McManus, Chief Nurse**
Date	**April 2013**

picker Institute Europe

Making patients' views count

NHS

Inpatient Survey 2012

YORK HOSPITALS NHS FOUNDATION TRUST

FEBRUARY 2013

Executive Summary

Trust ID: RCB UKINP2012/14

How are your results reported?

The Picker Institute presents your survey results in the form of **problem scores.** The problem score shows the percentage of patients for each question who, by their response, have indicated that this particular aspect of their care could have been improved.

The questionnaire includes **86** questions which have been analysed in this way. A detailed explanation of how problem scores are calculated is provided in the Introduction to the full report, but the following should be kept in mind when looking at your results:

- **Lower problem scores are better**
- Problem scores highlight issues that need **further investigation**
- Problem scores are a **simple summary** measure used for comparison and for helping to focus on areas for quality improvement
- Problem scores are an **interpretation of the results** by the Picker Institute – the Care Quality Commission will not see the problem scores

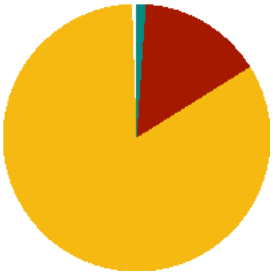
Introduction

This document summarises the findings from the Inpatient Survey 2012, carried out by Picker Institute Europe, on behalf of York Hospitals NHS Foundation Trust. The Care Quality Commission report is due for publication in May 2012.

The Picker Institute was commissioned by 69 trusts to undertake the Inpatient Survey 2012. A total of 1686 patients from your Trust were sent a questionnaire. 1514 patients were eligible for the survey, of which 851 returned a completed questionnaire, giving a response rate of 56%. The average response rate for the 69 'Picker' trusts was 48%.

Your results at a glance

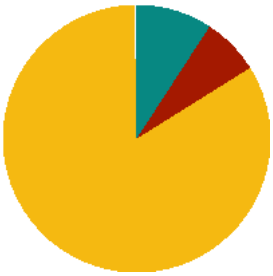
Have we improved since the 2011 survey?



A total of 73 questions were used in both the 2011 and 2012 surveys.
Compared to the 2011 survey, your Trust is:

- Significantly BETTER on 1 question
- Significantly WORSE on 11 questions
- The scores show no significant difference on 61 questions

How do we compare to other trusts?



The survey showed that your Trust is:

- Significantly BETTER than average on 8 questions
- Significantly WORSE than average on 6 questions
- The scores were average on 72 questions

Understanding your results

Survey results highlight areas that need improvement to provide a better service for patients. When deciding upon the improvements you would like to make there are a number of ways of looking at the results to decide which issues to focus on first.

Compare results over time - have you improved since the 2011 survey?

The Inpatient survey is currently repeated on an annual basis. Looking at trends over time helps to focus attention on improvements and on those areas where performance might be slipping.

Comparisons to the data from 2004 to present are available in Section 5 of the full report.

The Trust has improved significantly on the following questions:

Lower scores are better

	2011	2012
Hospital: food was fair or poor	43 %	34 %

The Trust has worsened significantly on the following questions:

Lower scores are better

	2011	2012
A&E Department: not given enough privacy when being examined or treated	16 %	23 %
A&E Department: waited 4 hours or more for admission to bed on a ward	14 %	26 %
Planned admission: admission date changed by hospital	8 %	15 %
Admission: process not at all or fairly organised	27 %	36 %
Hospital: hand-wash gels not available or empty	2 %	5 %
Doctors: did not always have confidence and trust	14 %	19 %
Doctors: talked in front of patients as if they were not there	20 %	26 %
Doctors: some/none knew enough about condition/treatment	7 %	12 %
Care: could not always find staff member to discuss concerns with	54 %	62 %
Surgery: anaesthetist / other member of staff did not fully explain how would put to sleep or control pain	12 %	19 %
Overall: not asked to give views on quality of care	79 %	84 %

Compare results with others

Picker Institute Europe ran Inpatient surveys for 69 trusts nationwide in 2012. Your results are shown alongside the others to help you make comparisons against the average for all trusts where the Picker Institute implemented the survey. They will help you to focus on areas where your performance is poor compared to others and where there is plenty of scope for improvement, as well as highlighting your successes.

Your results were significantly better than the 'Picker average' for the following questions:

Lower scores are better +

	Trust	Average
Planned admission: should have been admitted sooner	16 %	21 %
Hospital: shared sleeping area with opposite sex	6 %	8 %
Hospital: patients in more than one ward, sharing sleeping area with opposite sex	3 %	5 %
Hospital: toilets not very or not at all clean	4 %	6 %
Hospital: nowhere to keep personal belongings safely	44 %	61 %
Hospital: food was fair or poor	34 %	42 %
Hospital: not always healthy food on hospital menu	28 %	32 %
Hospital: not offered a choice of food	17 %	21 %

Your results were significantly worse than the 'Picker average' for the following questions:

Lower scores are better −

	Trust	Average
Hospital: bothered by noise at night from other patients	42 %	39 %
Hospital: Not all staff introduced themselves	34 %	30 %
Nurses: did not always get the opportunity to talk to when needed	41 %	37 %
Surgery: anaesthetist / other member of staff did not fully explain how would put to sleep or control pain	19 %	14 %
Discharge: did not receive copies of letters sent between hospital doctors and GP	43 %	34 %
Overall: not asked to give views on quality of care	84 %	76 %

Areas where patients report most problems

Questions where more than 50% of respondents reported room for improvement are listed below.
Focusing on these areas could potentially improve the patient experience for a large proportion of your patients.

N.B. Questions where less than 50 patients answered the question have been highlighted with [-]

✚ scores significantly better than average	**Trust**	The problem score for your Trust
▬ scores significantly worse than average	**Average**	Average score for all Picker trusts

Lower scores are better

	Trust	Average	
Discharge: delayed by 1 hour or more	86 %	85 %	
Overall: not asked to give views on quality of care	84 %	76 %	▬
Discharge: not told how long delay in discharge would be	70 %	67 %	
Hospital: didn't get enough information about ward routines	65 %	65 %	
Planned admission: not offered a choice of hospitals	64 %	62 %	
Care: could not always find staff member to discuss concerns with	62 %	60 %	
Overall: Did not receive any information explaining how to complain	62 %	61 %	
Planned admission: not given choice of admission date	61 %	65 %	
Discharge: not fully told side-effects of medications	58 %	59 %	
Discharge: not fully told of danger signals to look for	54 %	55 %	
Care: not enough opportunity for family to talk to doctor	52 %	52 %	

National CQUIN indicators - Commissioning for Quality and Innovation

The Commissioning for Quality and Innovation (CQUIN) payment framework links a proportion of providers' income to the achievement of local quality improvement goals. A single, composite measure "Improving responsiveness to personal needs of patients" for each organisation has been defined for inclusion as a CQUIN indicator. This composite measure is made up of the following five survey questions, the results of which are summarised here:

Improving responsiveness to personal needs of patients (CQUIN)

Lower scores are better

	2011	2012	Average
Care: wanted to be more involved in decisions	40 %	45 %	44 %
Care: could not always find staff member to discuss concerns with	54 %	62 %	60 %
Care: not always enough privacy when discussing condition or treatment	27 %	29 %	26 %
Discharge: not fully told side-effects of medications	56 %	58 %	59 %
Discharge: not told who to contact if worried	17 %	19 %	20 %

In most cases, CQUIN payments will be made on the basis of 'final standardised data' for the five CQUIN questions and the composite indicator (the data will be standardised by age, gender and admission method, and the data will be identical to that published in April/May by CQC). The 'problem scores' shown here have not been standardised in this way, but since trust demographic profiles don't tend to change extensively within a year, they should still give you an indication of your trust's performance. For further information, or for assistance in using the 'Patient Experience benchmarking tool' to calculate your composite indicator, please contact Lucas Daly (full contact details are listed on the back page of this report).

Correlations with overall satisfaction

As part of Picker Institute Europe's *Discussion paper: the core domains of patient experience*, a basic correlation analysis was undertaken to ascertain which individual questions correlated most strongly with the 'overall satisfaction' question (*Overall, how would you rate the care you received?*). The results for the twelve questions which correlated most strongly with 'overall satisfaction' are summarised below.

These results suggest that how nurses and doctors interact with patients was a key determinant of overall satisfaction with care; and in particular, how coordinated their efforts were and whether they treated patients with dignity and respect.

For further information, or to order a copy of the discussion paper, please contact Lucas Daly (full contact details are listed on the back page of this report).

Top twelve correlations with overall satisfaction

Lower scores are better

	2011	2012	Average
Overall: not treated with respect or dignity	17 %	21 %	20 %
Care: wanted to be more involved in decisions	40 %	45 %	44 %
Doctors: did not always have confidence and trust	14 %	19 %	19 %
Care: could not always find staff member to discuss concerns with	54 %	62 %	60 %
Doctors: did not always get clear answers to questions	27 %	30 %	30 %
Care: staff contradict each other	34 %	31 %	31 %
Care: not enough opportunity for family to talk to doctor	57 %	52 %	52 %
Nurses: did not always get clear answers to questions	30 %	30 %	30 %
Care: not enough (or too much) information given on condition or treatment	18 %	18 %	20 %
Nurses: did not always have confidence and trust	23 %	22 %	24 %
Care: staff did not do everything to help control pain	27 %	31 %	29 %

Next Steps

Communicating results and priorities for service improvement, across the organisation and in your local area, is key to ensuring that changes are implemented successfully. Patients and staff should be involved in developing an action plan and any resulting quality improvement activities.

Once priorities have been identified:

- Look at **internal benchmarks** (sites / specialties) – compare results within the trust to help identify problem areas and examples of best practice from within the trust
- **Additional analysis** available from the Picker Institute (including demographic / regional breakdowns), to aid in targeting improvements in the areas where they are needed most
- Look at **patient comments** for details and suggestions – available on-line (https://www.picker-results.org)
- Tie in with **other surveys** / PALS / complaints
- **On-site presentation** of your results, or **action planning meeting** chaired by an experienced Picker project manager (included in your survey package)
- Develop an **action plan**
- Raise awareness about the patient surveys – **publish** results and action plans

We provide a range of tools to help you make best use of your patient survey results, including a database of good practice examples, educational guides and a range of factsheets. The Quality Improvement team can be commissioned to run workshops or deliver presentations and practical sessions that are tailored specifically to your Trust's needs. Our exciting new programme - *Moving Beyond Measurement* - offers dedicated and practical support in turning your patient and staff experience surveys into real and sustainable improvements in service quality.

Further details of how to use your survey results, and links to these Quality Improvement tools are outlined in Section 1 of the full survey report (How to use this report).

If you need further assistance with understanding your results, or on any other aspect of the Inpatient Survey please contact **Lucas Daly, Tim Markham** or another member of the Survey Team at Picker Institute Europe (Tel: 01865 208100), who will be happy to help you.

Full contact details are listed overleaf.

Contacting Picker Institute Europe

For more information about your survey report please contact Lucas Daly, Tim Markham, or another member of the Picker Institute Survey Team.

Picker Institute Survey Team:

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Grace Baker
Josianne Breeden
Stephen Bough
Sarah-Ann Burger
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Andrew Cameron
Lucas Daly
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Finance and Performance Committee –16th April, Park House meeting room

York Teaching Hospital NHS Foundation Trust

Attendance: Mike Sweet Chairman
Philip Ashton
Mike Keaney
Andy Bertram
Debbie Hollings-Tenant
Graham Lamb
Anna Pridmore
Mandy McGale
Sarah Lovell

Apologies: Lucy Turner

	Agenda item	AFW	Comments	Assurance	Attention to Board
1.	**Last meeting notes Dated 19th March 2013**		Accepted. The chair proposed, and it was agreed, that whenever possible future meetings be scheduled for 2 hours to ensure that the committee covered its (increasing) workload.		
2.	**Acute Strategy plan**		Sarah Lovell (SL) presented a document that translated the Acute Strategy into a set of delivery driver diagrams (attached). She explained how they had been built-up and how it would allow for the strategy to be delivered. The Committee was keen to understand what the timing and costs would be. Sarah explained that until the individual delivery groups have met and agreed their individual objectives it was difficult to be clear about the timescales but these would be provided to the committee at the earliest opportunity. She added that from a cost perspective it was expected that the cost would be neutral to the organisation. Sarah described the current use of acute physicians and the changes to the system of assessment	The development of the strategy into a delivery plan under the leadership of Mike Proctor and SL.	

	Agenda item	AFW	Comments	Assurance	Attention to Board
2.	**Acute Strategy Plan**		that are proposed. The Committee questioned the exclusions to the strategy especially mental health. Sarah advised that some elements of mental health such as psychiatric liaison would be included. It was agreed that SL would attend the meeting every other month and would provide a short update report on a monthly basis. SL would also provide a copy of the action plan at the June meeting.		
3.	**Efficiency Report -**conversion of non-recurrent to recurrent savings	2.8	Debbie Hollings-Tenant (DHT) updated the Committee on the year end position. She was able to advise that the Trust had over achieved on both sites. The over achievement was £1.9m (8%). For the next financial year there is a base target of £16m with a carried forward non-recurrent amount of £13m resulting in an initial £29m target. DHT explained that the team is looking at how some of the non-recurrent savings can be converted to recurrent so reducing the £29m target. She advised the Committee that it is expected that approximately £3m can be converted – more details next month. It was also recognised that the pressure for year on year savings could place the quality of care provided at risk. Currently there are firm plans for about £19m of recurrent savings which leaves a maximum gap	Over achievement of the efficiency target for the year. Plans developed for new approaches to achieving savings	Congratulations to the team and the Directorates for the delivery of the efficiency programme.

	Agenda item	AFW	Comments	Assurance	Attention to Board
3.	**Efficiency Report**		of £10m. DHT advised that the team are working with NHSElect to find methods of improving the delivery of efficiencies, for example anaesthetics, where they have worked hard to produce the savings so far, but there are still opportunities to look at the interface between anaesthetics and the rest of the hospital. The Scarborough site is in the process of appointing a clinician to work on the CIP in a similar manner to Ian Jackson at York. DHT felt that these efficiencies could raise a further £2.5m. This would mean a target for 2013/14 of £24m, which is the same as last year's target.		
4.	**Finance Report** - Service line reporting - Finance Report		Andy Bertram (AB) advised that due to the timing of this Finance and Performance Committee he did not have the final position for the year end. AB tabled a draft income and expenditure account and advised that the final version will be available for the Board meeting. AB took the committee through the draft position and explained the areas where final work was still underway as part of the year-end close down procedures. AB advised that, at this stage, he was expecting the Trust to report (under Monitor's regime) a small surplus position that would result in an FRR of 3. AB talked through committee through the various technical elements to the Trust's income and expenditure accounts relating to the acquisition of Scarborough.		AB to present the full Finance Report at the Board meeting, including reconciliation between the reported income and expenditure reported position and Monitor's underlying performance assessment.

	Agenda item	AFW	Comments	Assurance	Attention to Board
5.	**CQUIN**		The Committee received a year end report, but did not hold any discussion on it. Most of the 2012/13 targets have been met in full and progress is being made on the 2013/14 schemes.		
6.	**Operational Report** - Performance Report	3.1 3.9	Mandy McGale (MM) presented the performance report. She advised that the 18 week data was not available for the report as it was still being validated.		
6.	**Operational Report**		The 95% under 4 hours target for the Emergency Department (ED), The ambulance turn round target and the time spent in the Emergency Department are all interdependent. She explained that the Trust had not achieved the 4 hour target for Q3 or Q4 and is experiencing challenges in achieving the Q1 target. She added that moving patients through the system is challenging and that this is causing blockages / delays in ED. As a response a new system is being tested as part of a recovery plan. An assessment unit for direct GP admissions has been created close to Acute Medical Unit (AMU) to ease pressure on the AMU beds. This system has only been in operation for a couple of days, but initial indications are that it is achieving its objective. The new Directorate Manager in ED is also devoting considerable time to addressing the issues within that department which include	Introduction and implementation of the recovery plan and the link between the recovery plan and the acute strategy.	

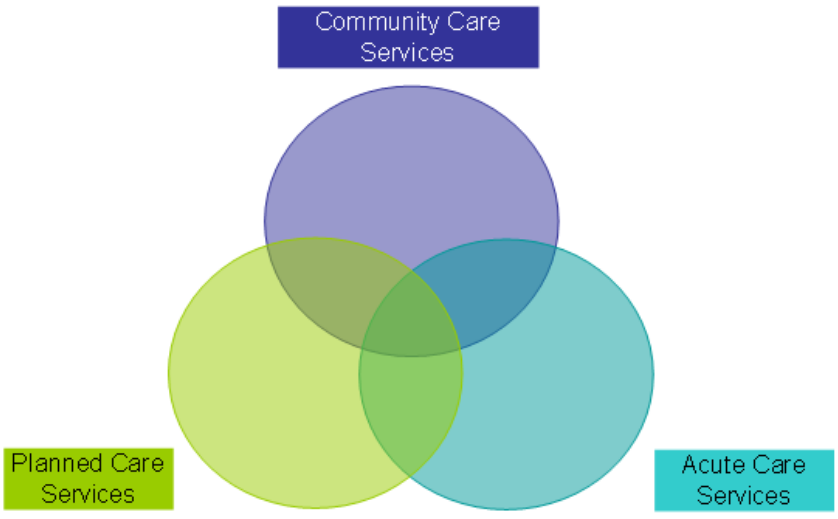
	Agenda item	AFW	Comments	Assurance	Attention to Board
6.	**Operational Report**		Improving the job satisfaction of staff and the systems and methods that will enable that to happen. MM advised that a review of the new monitoring system introduced by the ambulance service has also been undertaken. Some significant amendments to the 'clocking system' have been made. Rather than have ambulance staff responsible for all the keying of activity from now on the ambulance crew will register their arrival, YFT staff (not Yorkshire Ambulance Service staff) will key-in when hand over has been completed and finally the ambulance crew will key in when they have finished preparing the ambulance for return to the road.. This will allow 15 minutes for a patient to be handed over to the Trust and for the Trust to record the patient has been handed over. MM reminded the Committee that it is being suggested that from Q3 Trusts will be measured against the 25 minute target and if it is found that it is not being achieved Yorkshire Ambulance Service (YAS) will be entitled to levy a fine to the Trust. Early indications from the data held by Lucy Turner are that the number of long delays has significantly reduced. With regard to C-Diff the Trust is currently 3 cases over it's trajectory. The committee were reminded of the extremely tight improvement trajectory given the Trust's past and continued	The review of the system will ensure it is clear which party is not using the time properly and so clear adjustments can be made to the system if needed.	

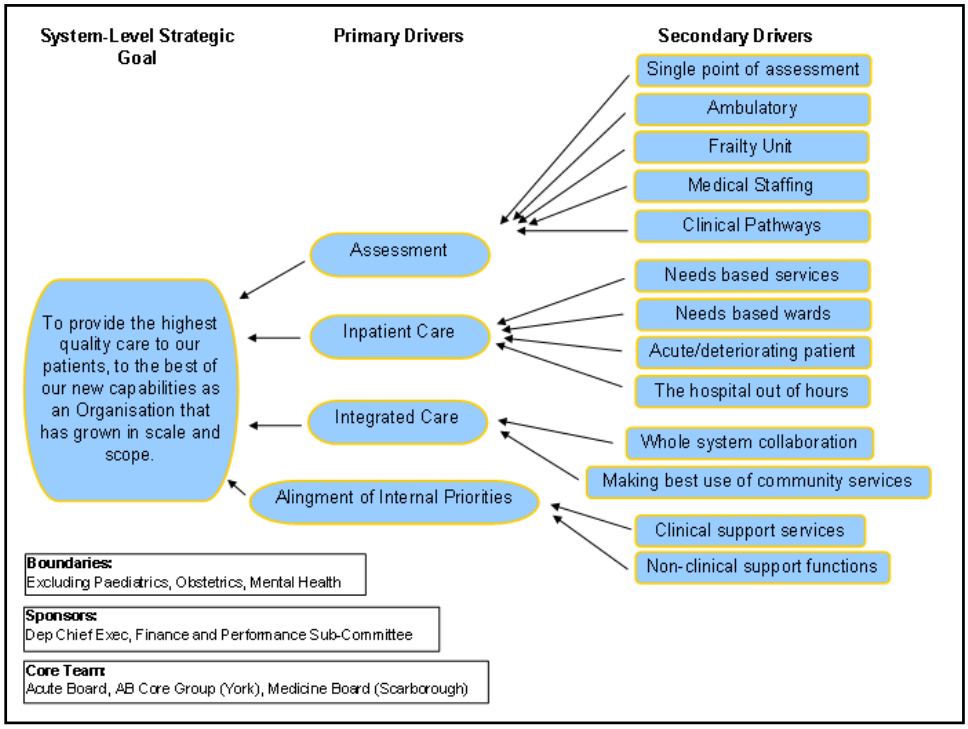
	Agenda item	AFW	Comments	Assurance	Attention to Board
6	**Operational Report**		good performance in this area. The committee were advised that an appeal against 3 of the cases was currently underway. Monitor has been advised of the position as has the Trust's commissioners.		
7.	**Other** - Tender Outlook - Service Line Reporting		Due to the pressure of time it was agreed that this would be discussed at the next meeting Deferred. To be the first item on the agenda at the May meeting.		

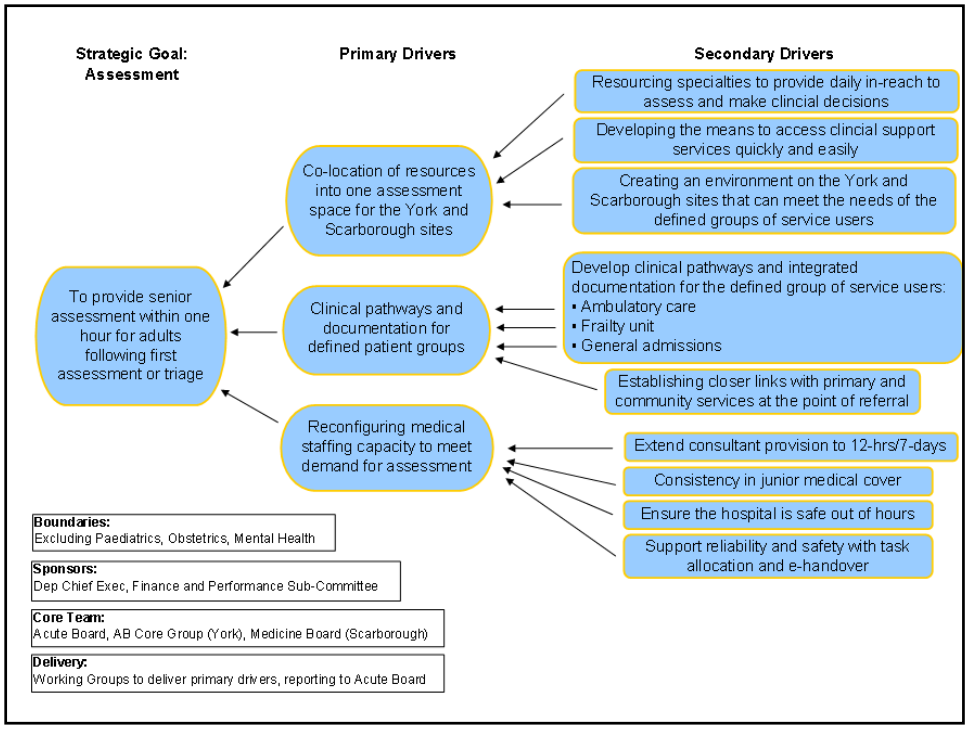
Acute Service Strategy

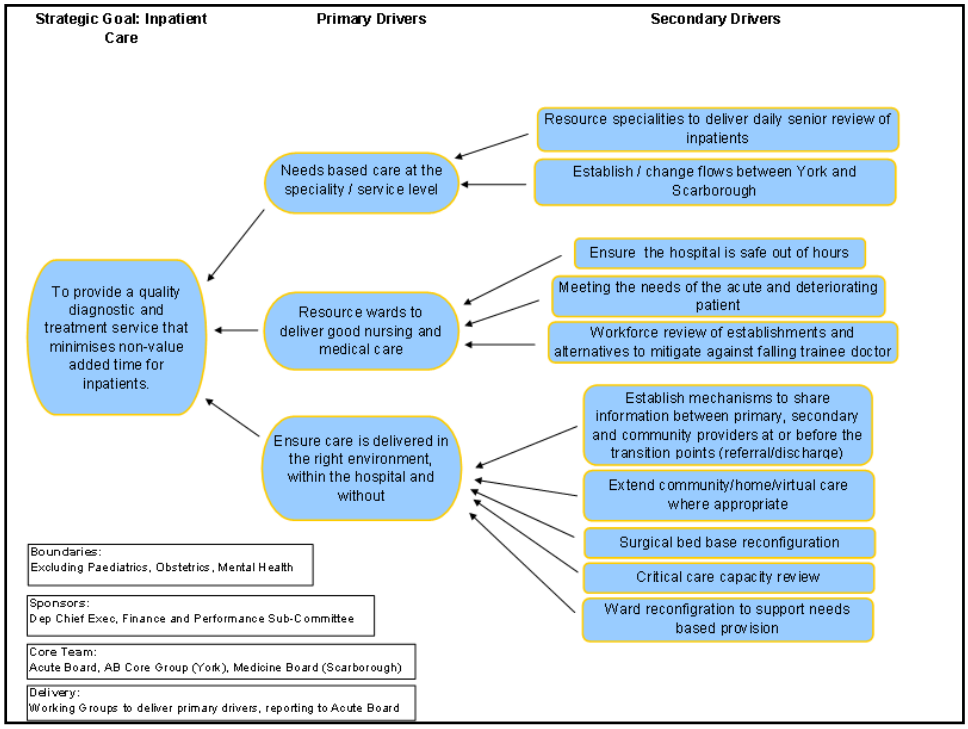
Programme of Work:
Objectives, Measures, Delivery

The Bigger Picture




System-Level Strategic Goal
Primary Drivers
Secondary Drivers
To provide the highest quality care to our patients, to the best of our new capabilities as an Organisation that has grown in scale and scope.
Assessment
Inpatient Care
Integrated Care
Alingment of Internal Priorities
Single point of assessment
Ambulatory
Frailty Unit
Medical Staffing
Clinical Pathways
Needs based services
Needs based wards
Acute/deteriorating patient
The hospital out of hours
Whole system collaboration
Making best use of community services
Clinical support services
Non-clinical support functions
Boundaries:
Excluding Paediatrics, Obstetrics, Mental Health
Sponsors:
Dep Chief Exec, Finance and Performance Sub-Committee
Core Team:
Acute Board, AB Core Group (York), Medicine Board (Scarborough)


Strategic Goal: Assessment
Primary Drivers
Secondary Drivers
To provide senior assessment within one hour for adults following first assessment or triage
Co-location of resources into one assessment space for the York and Scarborough sites
Clinical pathways and documentation for defined patient groups
Reconfiguring medical staffing capacity to meet demand for assessment
Resourcing specialties to provide daily in-reach to assess and make clincial decisions
Developing the means to access clincial support services quickly and easily
Creating an environment on the York and Scarborough sites that can meet the needs of the defined groups of service users
Develop clinical pathways and integrated documentation for the defined group of service users:
• Ambulatory care
• Frailty unit
• General admissions
Establishing closer links with primary and community services at the point of referral
Extend consultant provision to 12-hrs/7-days
Consistency in junior medical cover
Ensure the hospital is safe out of hours
Support reliability and safety with task allocation and e-handover
Boundaries:
Excluding Paediatrics, Obstetrics, Mental Health
Sponsors:
Dep Chief Exec, Finance and Performance Sub-Committee
Core Team:
Acute Board, AB Core Group (York), Medicine Board (Scarborough)
Delivery:
Working Groups to deliver primary drivers, reporting to Acute Board



Next Steps

- Acute Board April 2013
  - Presentation of ‘the how’
  - Discussion about ‘the who’
- April-May 2013
  - Establish Working Group leads
  - Establish membership
  - Ratify objectives, measures and plans
- June 2013
  - Working Groups meet
  - First report to the June Acute Board

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Efficiency Programme Update – Combined report

Action requested/recommendation

To note the contents of the report.

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☐
2. Create a culture of continuous improvement	☒
3. Develop stronger citizenship through our working with partners	☐
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

No implications for equality and diversity.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report	Board of Directors
Risk	The Efficiency Programme presents a significant financial risk to the organisation.
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Andrew Bertram, Director of Finance
Author	Steve Kitching, Deputy Head of Corporate Efficiency
Date of paper	April 2013
Version number	Version V.1

Board of Directors – 24 April 2013

Efficiency Position Update at March 2013 – Combined report

1. Executive Summary

The Joint full year plan to Monitor is £23,638k.

In period 12 we have achieved £25,609k in full year terms, which is an improvement from the February 2013 position of **£3,038k**.

This is an over achievement of our Efficiency target by **£1,971k**.

Table 1 below provides a high level summary of the position.

Table 1 – Executive summary – March 2013

	York Site	Scarborough Site	**Total**
	£'000	**£'000**	**£'000**
In year target			
In year target	16,911	6,727	**23,638**
In year delivery			
Delivery - recurrent	8,536	1,828	**10,364**
Delivery – non-recurrent	9,991	5,255	**15,246**
Total delivery	**18,526**	**7,083**	**25,609**
Delivery (gap)/ Over achievement	**1,615**	**356**	**1,971**
In year planning			
Further in year plans	-	-	**-**
In year planning (gap)/surplus	**-**	**-**	**-**
Part year Monitor position	-	-	**-**
3 Year planning (2013/14 – 2015/16) – no site split from 2013/14			
3 year target (Base Target only)	-	-	**49,140**
3 year plans total (Recurrent plans only)	-	-	**40,907**
3 year planning (gap)/surplus	**-**	**-**	**(8,233)**
Initial non recurrent rollover	-	-	(12,974)
Initial 3 year planning gap	-	-	**(21,207)**

* Please note the Scarborough site position includes Q1.

Q1 target is £1m; Q1 delivery is £0.3m; Q1 variance is (£0.7m).

2. Introduction and background

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme.

3. Efficiency position report

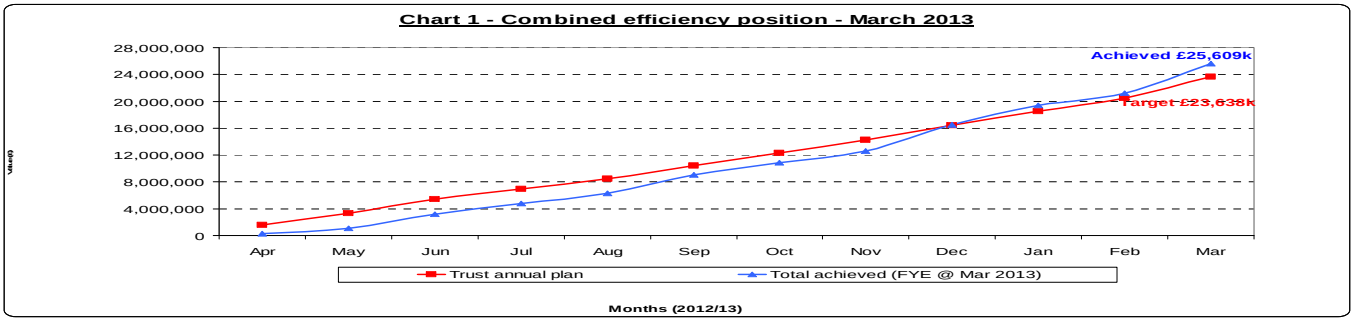
This report covers the period of 12 months to March 2013.

3.1 Trust plan to Monitor

The final position is **£1,971k** ahead of the trust plan to Monitor as at March 2013; see Table 2 and Chart 1 below.

Table 2 – Monitor position - March 2013

	YTD February 2013	March 2013	**Total YTD**
	£,000	**£,000**	**£,000**
Trust plan	20,497	3,142	**23,638**
Achieved	21,571	4,038	**25,609**
Variance	**1,074**	**896**	**1,971**



3.2 Full year position summary

As at March 2013, £25,609k has been achieved in full year terms against the plan of £23,638k (see Table 3 below). This is made up of £10,363k of recurrent and £15,246k non-recurrent schemes. The recurrent element includes £2,253k of income in plan. Non recurrent delivery offers a significant risk to the Trust.

Table 3 – Full Year - Summary – March 2013

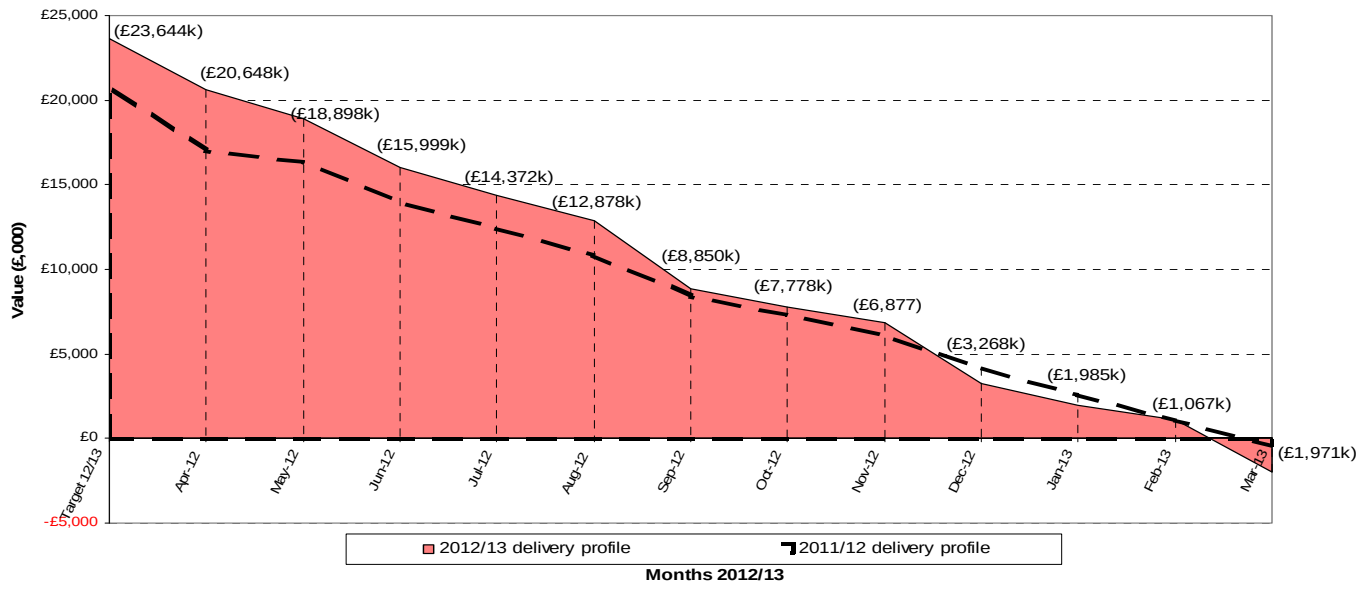
	February 2013	**March 2013**	**Change**
	£,000	**£,000**	**£,000**
Expenditure plan – 12/13	21,385	21,385	0
Income plan – 12/13	2,253	2,253	0
Target – 2012/13	**23,638**	**23,638**	**0**
Achieved - recurrently	7,962	8,110	148
Achieved - non-recurrently	12,356	15,246	2,890
Achieved expenditure	**20,318**	**23,356**	**3,038**
Achieved –Income in plan	2,253	2,253	0
Total achieved	**22,571**	**25,609**	**3,038**
Gap to achieve	**(1,067)**	**1,971**	**3,038**
Further plans	**-**	**-**	**-**

(Gap)/Surplus in plans	-	-	-

3.3 Delivery profile and further plans

The full year position is an over delivery of **£1,971k**. Savings achieved by month are shown in Chart 3 below. The broken line shows delivery in 2011/12 which has been added for information.

Chart 2 - Joint Monthly CIP Progress Chart 2012/2013 - Progress profile compared to 2011/12



3.4 Three year plans

Directorates are required to develop three year plans and Table 4 below summarises this position. There is currently a shortfall of (£8,233k) over 3 years on the base target; if the initial assessed non recurrent carry forward of (£12,974k) is added the gap increases to (£21,207k).

Significant work is on going to reduce the impact of the non recurrent carry forward and schemes continue to be developed and assessed. It should be noted the plans have moved on a year and new non recurrent schemes are not included in plans. The shortfall in plans offers a high risk to delivery.

Table 4 - 3 Year efficiency plan summary – March 2013

Year	**2013/14**	**2014/15**	**2015/16**	**Total**
	£'000	**£'000**	**£'000**	**£'000**
Base target	16,231	16,565	16,344	**49,140**
Plans	19,035	14,518	7,354	**40,907**
Variance	**2,804**	**(2,047)**	**(8,990)**	**(8,233)**
Initial roll over of non-recurrent	(12,974)	-	-	(12,974)
Revised Variance	**(10,170)**	**(2,047)**	**(8,990)**	**(21,207)**

3.5 Risk position

Red rated directorates have decreased from 8 in March 2012 to 7 in March 2013 at the York site. The Scarborough site currently has 13 red rated Directorates in March 2013. Comparative

information from March 2012 is not available due to the previous divisional structure.

It should be noted 3 year planning has now moved on a year as described above, and risks will be re-assessed when the position has become firm.

4. Conclusion

Over delivery of the Efficiency Target by £1,971k is a significant achievement with £25,609k of full year schemes being delivered against the Trust plan of £23,638k; this compares with a combined over delivery of £411k in March 2012.

Non recurrent delivery is a significant risk to the Trust with the current base roll over figure of £12,974k added to our new base target of £16,231k giving a potential target of £29,205k. Work is progressing to mitigate this risk as far as possible.

The 3 year planning position has now moved on a year and highlights a shortfall in base plans of (£8,233k), if the current non recurrent rollover is added this increases significantly to a shortfall of (£21,207k) which is high risk.

5. Recommendation

The Board is asked to note the March 2013 position with its significant future potential risks to delivery. Significant and sustained action is required to close these gaps.

Author	**Steve Kitching, Deputy Head of Corporate Efficiency**
Owner	**Andrew Bertram, Director of Finance**
Date	**April 2013**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 24 April 2013

Corporate Dashboard

Action requested/recommendation

The Board is asked to note the report.

Summary

NB – 18 week data are still being validated and a verbal update will be given to the Board. The Corporate dashboards on Signal will be updated when the data is submitted to the DH.

In terms of performance, the following targets were not achieved by the Trust:-

First to follow up ratios – target 2.1: Combined Trust position is 2.12. York performance is 2.13, Scarborough is 2.09.

ED 4 hr target 95%: The combined position was 92.66%. York performance was 93.24%, Scarborough performance was 91.65%.

Total time spent in the A&E Department 95th Percentile (Type 1) – target 4.00hrs: The combined position was 5:35. York achieved 5:09, Scarborough achieved 6.61.

Time to Initial Assessment 95th Percentile - Type 1 (Ambulance Arrivals Only) – target 15mins: Combined position was 23mins. York performance was 39 mins and Scarborough's was 5 mins.

CDiff – yearly target 51: Combined site position 54. York site 39 against an annual objective of 27. Scarborough site 15 against an annual objective of 24.

Elective Operations Cancelled on the day for non clinical reasons not readmitted within 28 days – target 0: York had 2 patients who failed this standard 1in T&O and 1 GY.

In addition, the following targets were not achieved at hospital site level:-

Ambulance Turnaround in 25 mins – target 60%: York achieved 51.21% (up from 39.63% in Feb), Scarborough achieved 51.71%.

Strategic Aims	**Please cross as appropriate**
1. Improve Quality	☒
2. Improve our effectiveness, capacity and capability	☒
3. Develop stronger citizenship through our working with partners	☐
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

No implications for equality and diversity.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report	This report is only produced for the Executive Board and Board of Directors.
Risk	No risk.
Resource implications	No resource implications.
Owner	Mike Proctor, Deputy Chief Executive
Author	Lucy Turner, Deputy Director of Performance
Date of paper	11 April 2013
Version number	Version 1

Targets - YTHFT

18 Weeks (Acute and Community) and Access Targets

Metric	Target	Status	Sparkline	Feb-13	Mar-13
18 Week Admitted (M S C)	90%	Green		91.88%	
18 Week Non-Admitted (M S C)	95%	Green		96.08%	
18 Week Total Backlog (M S C)	92%	Green		92.64%	
18 Week Audiology (S C)	95%	Green		99.88%	99.65%
Diagnostics - 6 Week Wait (S C)	99%	Green		99.78%	99.38%
Outpatient Clinics - First to Follow Up Ratio (YTD) (C)	2.1	Red		2.14	2.13

Cancer

Metric	Target	Status	Sparkline	Feb-13	Mar-13
14 Day Fast Track (M S C)	93%	Green		93.88%	
14 Day Breast Symptomatic (M S C)	93%	Green		98.25%	
31 Day 1st Treatment - Cancer (M S C)	96%	Green		98.45%	
31 Day Subsequent Treatment - Anti Cancer Drug (M S C)	98%	Green		100%	
31 Day Subsequent Treatment - Surgery (M S C)	94%	Green		96.77%	
Percentage of 62 Day Cancer transfers made before day 38	85%	Red		37.5%	

Emergency Department (Type 1 and Type 3)

Metric	Target	Status	Sparkline	Feb-13	Mar-13
ED 4 Hour Target - All Types (M)	95%	Red		90.76%	93.24%
Unplanned re-attendance rate within 7 days - Type 1 (S C)	5%	Green		2.42%	2.41%
Total time spent in the A and E department 95th Percentile - All Patients - Type 1 (S C)	4:00	Red		5:56	5:09
Left without being seen rate - Type 1 (S C)	5%	Green		4.67%	4.18%
Time to Initial Assessment 95th Percentile - Type 1 (Ambulance Arrivals Only) (S C)	0:15	Red		0:26	0:39
Arrival to treatment - Median below 60 mins - Type 1 (S C)	1:00	Green		0:59	0:53
Ambulances turned round within 25 mins - Type 1 (C)	60%	Red		39.63%	51.21%

Infection Prevention and Control

Metric	Target	Status	Sparkline	Feb-13	Mar-13
MRSA Bacteraemia >48hrs (YTD) (S C)	2	Green		0	0
CDIFF >72hrs (YTD) (M S C)	27	Red		35	39
CDIFF >72hrs Monthly	2.25	Red		3	4
MSSA >48hrs (YTD) (C)				21	21
E-Coli >48hrs (YTD) (C)				62	68

Inpatient

Metric	Target	Status	Sparkline	Feb-13	Mar-13
Elective Operations Cancelled On The Day For Non-Clinical Reasons (C)	25	Green		44	17
Elective Operations Cancelled On The Day For Non-Clinical Reasons Not Readmitted within 28 days (C)	0	Red		1	2
Breaches of Mixed Sex Accommodation (S C)	0	Green		0	0

Care Quality Indicators (CQUINS)

Metric	Target	Status	Sparkline	Feb-13	Mar-13
Acute - VTE Risk Assessment (M S C)	90%	Green		93.86%	93.91%
Improve collection of data using Safety Thermometer - York Hospital	100%	Green		100%	100%
Improve collection of data using Safety Thermometer - Community Hospitals	100%	Green		100%	100%
Improve collection of data using Safety Thermometer - Community	100%	Green		100%	100%
Dementia case finding question asked	90%	Green		91.9%	93.26%
Dementia inpatients with completed diagnostic assessment	90%	Green		100%	100%
Dementia inpatients who have had a diagnostic assessment referred for further diagnostic advice or follow up	90%	Green		100%	100%
Acute Admissions seen by decision making clinician within 4 hours of admission - Acute Medical Unit (AMU)	60%	Green		75.25%	79.98%
Reduction in Average Length of Stay in York Hospital Elderly Bed Base (Days)	20.44	Green		23.03	18.87
Improved utilisation of the Elderly Bed Base in Community Hospitals	85%	Green		94.23%	93.04%

Targets - SNEY

18 Weeks (Acute and Community) and Access Targets

Metric	Target	Status	Sparkline	Feb-13	Mar-13
18 Week Admitted (M S C)	90%	Red		87.07%	
18 Week Non-Admitted (M S C)	95%	Red		93.83%	
18 Week Total Backlog (M S C)	92%	Red		90.9%	
Diagnostics - 6 Week Wait (S C)	99%	Green		99.97%	99.97%
Outpatient Clinics - First to Follow Up Ratio (YTD) (C)	2.1	Green		2.1	2.09

Cancer

Metric	Target	Status	Sparkline	Feb-13	Mar-13
14 Day Fast Track (M S C)	93%	Green		96.98%	
14 Day Breast Symptomatic (M S C)	93%	Green		96.3%	
31 Day 1st Treatment - Cancer (M S C)	96%	Green		100%	
31 Day Subsequent Treatment - Anti Cancer Drug (M S C)	98%	Green		100%	
31 Day Subsequent Treatment - Surgery (M S C)	94%	Green		100%	

Emergency Department (Type 1 and Type 3)

Metric	Target	Status	Sparkline	Feb-13	Mar-13
ED 4 Hour Target - All Types (M)	95%	Red		92.18%	91.65%
Unplanned re-attendance rate within 7 days - Type 1 (S C)	5%	Green		1.88%	2.34%
Total time spent in the A and E department 95th Percentile - All Patients - Type 1 (S C)	4:00	Red		6:07	6:16
Left without being seen rate - Type 1 (S C)	5%	Green		1.6%	1.54%
Time to Initial Assessment 95th Percentile - Type 1 (Ambulance Arrivals Only) (S C)	0:15	Green		0:05	0:05
Arrival to treatment - Median below 60 mins - Type 1 (S C)	1:00	Green		0:19	0:23
Ambulances turned round within 25 mins - Type 1 (C)	60%	Red		53.42%	51.71%

Infection Prevention and Control

Metric	Target	Status	Sparkline	Feb-13	Mar-13
MRSA Bacteraemia >48hrs (YTD) (S C)	1	Green		1	1
CDIFF >72hrs (YTD) (M S C)	24	Green		13	15
CDIFF >72hrs Monthly	2	Green		2	2
MSSA >48hrs (YTD) (C)				10	12
E-Coli >48hrs (YTD) (C)				31	40

Inpatient

Metric	Target	Status	Sparkline	Feb-13	Mar-13
Elective Operations Cancelled On The Day For Non-Clinical Reasons (C)	25	Green		9	24
Elective Operations Cancelled On The Day For Non-Clinical Reasons Not Readmitted within 28 days (C)	0	Green		1	0
Breaches of Mixed Sex Accommodation (S C)	0	Green		0	0

Care Quality Indicators (CQUINS)

Metric	Target	Status	Sparkline	Feb-13	Mar-13
Acute - VTE Risk Assessment (M S C)	90%	Green		91.88%	91.05%
Improve collection of data using Safety Thermometer - Scarborough Hospital				100%	100%
Dementia case finding question asked				94%	91%
Dementia inpatients with completed diagnostic assessment				100%	97%
Dementia inpatients who have had a diagnostic assessment referred for further diagnostic advice or follow up					
Acute Admissions seen by decision making clinician within 4 hours of admission	60%	Green			
Reduction in Average Length of Stay in Scarborough Hospital Elderly Bed Base (Days)				18.1	
End of Life Care - Death in place of Choice - East Riding of York PCT					
End of Life Care - Death in place of Choice - North Yorkshire & York PCT					

SIGNAL | Dashboards | Clinical Activity | Finance | Workforce | Quality & Safety | Private Reports

YTHFT & SNEY Dashboard | York Hospitals Dashboard | Scarborough Hospital Dashboard | Community Dashboard

Targets - YTHFT & SNEY

18 Weeks (Acute and Community) and Access Targets

Metric	Target	Status	Sparkline	Feb-13	Mar-13
18 Week Admitted (M S C)	90%	Green		90.38%	
18 Week Non-Admitted (M S C)	95%	Green		95.12%	
18 Week Total Backlog (M S C)	92%	Green		92.02%	
18 Week Audiology (S C)	95%	Green		99.88%	99.65%
Diagnostics - 6 Week Wait (S C)	99%	Green		99.86%	99.64%
Outpatient Clinics - First to Follow Up Ratio (YTD) (C)	2.1	Red		2.13	2.12

Cancer

Metric	Target	Status	Sparkline	Feb-13	Mar-13
14 Day Fast Track (M S C)	93%	Green		94.63%	
14 Day Breast Symptomatic (M S C)	93%	Green		97.62%	
31 Day 1st Treatment - Cancer (M S C)	96%	Green		98.84%	
31 Day Subsequent Treatment - Anti Cancer Drug (M S C)	98%	Green		100%	
31 Day Subsequent Treatment - Surgery (M S C)	94%	Green		97.22%	
62 Day Cancer (M S C)	85%	Green		88.37%	
62 Day Cancer - Screening (M S C)	90%	Green		100%	

Emergency Department (Type 1 and Type 3)

Metric	Target	Status	Sparkline	Feb-13	Mar-13
ED 4 Hour Target - All Types (M)	95%	Red		91.27%	92.66%
Unplanned re-attendance rate within 7 days - Type 1 (S C)	5%	Green		2.24%	2.37%
Total time spent in the A and E department 95th Percentile - All Patients - Type 1 (S C)	4:00	Red		5:59	5:35
Left without being seen rate - Type 1 (S C)	5%	Green		3.65%	3.24%
Time to Initial Assessment 95th Percentile - Type 1 (Ambulance Arrivals Only) (S C)	0:15	Red		0:21	0:23
Arrival to treatment - Median below 60 mins - Type 1 (S C)	1:00	Green		0:45	0:43

Infection Prevention and Control

Metric	Target	Status	Sparkline	Feb-13	Mar-13
MRSA Bacteraemia >48hrs (YTD) (S C)	3	Green		1	1
CDIFF >72hrs (YTD) (M S C)	51	Red		48	54
MSSA >48hrs (YTD) (C)				31	33
E-Coli >48hrs (YTD) (C)				93	108

Inpatient

Metric	Target	Status	Sparkline	Feb-13	Mar-13
Elective Operations Cancelled On The Day For Non-Clinical Reasons (C)	50	Green		53	41
Elective Operations Cancelled On The Day For Non-Clinical Reasons Not Readmitted within 28 days (C)	0	Red		2	2
Breaches of Mixed Sex Accommodation (S C)	0	Green		0	0

Care Quality Indicators (CQUINS)

Metric	Target	Status	Sparkline	Feb-13	Mar-13
Acute - VTE Risk Assessment (M S C)	90%	Green		93.19%	93%

SIGNAL | Dashboards | Clinical Activity | Finance | Workforce | Quality & Safety | Private Repor

YTHFT & SNEY Dashboard | York Hospitals Dashboard | Scarborough Hospital Dashboard | Community Dashboard

Targets - Community

Community Infection Control

Metric	Target	Status	Sparkline	Feb-13	Mar-13
MRSA Bacteraemia >48hrs (YTD) (S C)				0	0
MSSA >48hrs (YTD) (C)				0	0
CDIFF >72hrs (YTD) (M S C)				3	4
E-Coli >48hrs (YTD) (C)				0	0

Community Inpatient

Metric	Target	Status	Sparkline	Feb-13	Mar-13
Admissions - Ordinary				190	209
Admissions - Day				592	516
Average Length of Stay (Days) - Archways				32.7	19.9
Average Length of Stay (Days) - Bridlington				18.8	15.4
Average Length of Stay (Days) - Malton				25.4	20.9
Average Length of Stay (Days) - St Monicas				13.1	27
Average Length of Stay (Days) - Selby War Memorial Hospital				21.2	21.8
Average Length of Stay (Days) - Whitby				21.7	25.6

Community Outpatient

Metric	Target	Status	Sparkline	Feb-13	Mar-13
Outpatient Attendances - First				2517	2521
Outpatient Attendances - Subsequent				4876	4910
Outpatient Attendances - Total				7393	7431
Outpatient DNA Rate				6.8%	7.8%

Community Referrals

Metric	Target	Status	Sparkline	Feb-13	Mar-13
GP Referral				319	285
Self Referral				53	38
Social Services				9	16
York Hospital / Scarborough Acute Services				108	110
Community Hospital				17	11
Other				167	189
Rejected				0	0

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Finance Report

Action requested/recommendation

To note the contents of this report.

Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the year ended 31st March 2013.

At the financial year end there is an Income and Expenditure surplus of £70.3m against a planned surplus for the period of £1.3m. This position includes a technical exceptional underspend of £68.9m arising from the transfer of assets from Scarborough under absorbtion accounting; £5m strategic capital received as revenue; impairments of £3.5m, and other net technical adjustments which Monitor discount in their assessment of the Trust's underlying performance (£0.3m). The underlying operating I&E position after discounting these issues is a surplus of £0.2m. The Trust has an actual cash balance of £12.8m. The underlying Income and Expenditure position places the Trust behind it's Operational plan.

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

Implications for equality and diversity

None directly identified.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	There are financial risk implications identified in the report.

Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	April 2013
Version number	Version 1

Briefing Note for the Board of Directors Meeting 24 April 2013

Subject: 2012/13 Outturn Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for the Year 2012/13

The finance report presented with the Board of Director's papers confirms a surplus income and expenditure position of £70.3m. This comprises a number of unusual and exceptional issues, largely associated with the acquisition of Scarborough Trust. Most of these issues are technical accountancy presentational issues and are not backed by any cash transaction.

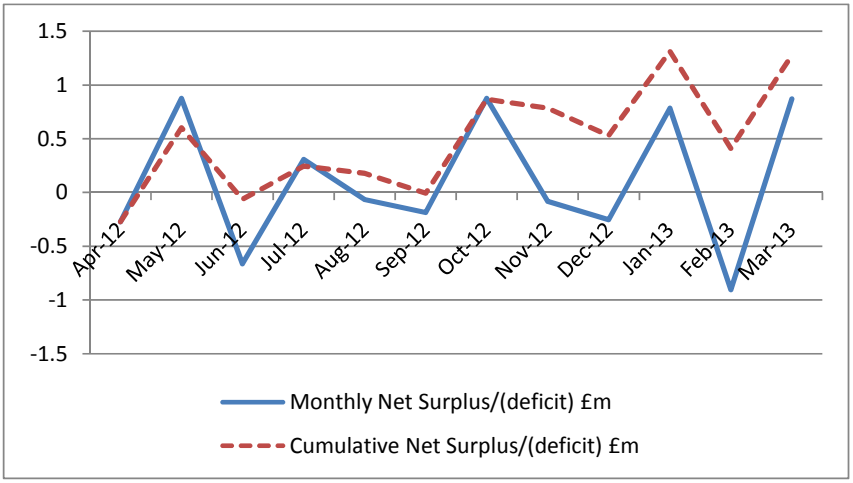
Important for the Board is the underlying performance assessment, stripping out these exceptional items. This position is also used by Monitor for their assessment of the Trust and for their Financial Risk Rating (FRR) calculation. This underlying performance position is assessed as a £0.2m surplus of income over expenditure. This is expected to return an FRR of 3 for the year. Essentially, the Trust has balanced its operational income and expenditure for the year 2012/13.

The table below provides an audit trail between the reported accounts position and Monitor's FRR assessment.

Reported Income and Expenditure Account Position	£70.3m	
Gain on absorption of Scarborough	(£68.9m)	This represents the net gain from the transferred Scarborough assets. Under absorption accounting principles this will be included in our reported I&E position but excluded by Monitor in their FRR assessment.
Receipt of revenue funding for £5m strategic capital investment	(£5.0m)	Originally anticipated as PDC but paid as revenue. Under accounting rules this will be included in our I&E position (recognised as income) but excluded by Monitor in their FRR assessment.
District Valuer Revaluation of Assets	£3.5m	Relates to downward land values and impairment losses on Scarborough escalation ward, York MRI and other capital schemes. Excluded by Monitor in their FRR assessment.
Donated Asset Income	(£0.5m)	Income from the charity to purchase capital assets. Excluded by Monitor in their FRR assessment.
MARS and Redundancy Payments	£0.8m	Restructuring costs excluded by Monitor in their FRR assessment.
Surplus assessment for purpose of FRR calculation	£0.2m	

Expected Movement in Month

Last month the Board was provided with the following chart to explain the expected income and expenditure movements in month. This chart is replicated this month for information about the expected improvement in March.



From the reported position in February of a £1.9m deficit (excluding all technical adjustments) the chart shows that a £1m improvement was expected in March. This improvement did materialise.

Income Analysis

The acute contract position with NYY PCT is estimated to finish the year with £10.2m of additional activity provided to contract. In addition the community contracts have exceeded plans by £0.3m and the MSK contract has fallen short of plan by £0.7m. The total trading position with NYY PCT is therefore £9.8m of additional activity provided. This is as anticipated and as forecasted throughout the year in discussions with the PCT. This position will be reflected in our accounts. This is causing a financial problem for the PCT and they have produced a series of contract challenges and are assuming a lower estimate for March activity than the Trust's early figures suggest took place. The difference amounts to £3m. We have responded with detailed explanations to all contract queries and have received no further challenge at this stage.

The East Riding PCT acute contract position for York has been agreed, finalised, and is reflected in the reported position. The Scarborough position with East Riding has not been finalised and will be subject to the usual reconciliation process. There are no significant risks with the likely contract outturn in this regard.

Reconciliation to the Corporate Risk Register

The current corporate risk register details financial risks associated with management of expenditure budgets, receipt of commissioner income and delivery of the Trust's efficiency programme. In terms of 2012/13 risks relating to the management of expenditure and delivery of the savings requirement have been effectively managed. The Board should be aware that the full and final reconciliation of commissioner income still needs to take place, as per the national reconciliation timetable. Risks remain in relation to this process and the Board will be kept informed of progress.

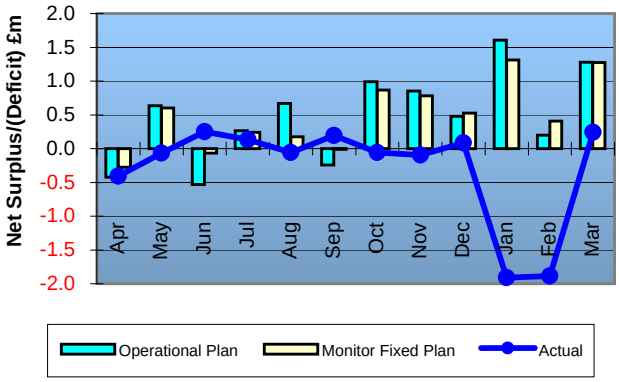
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2012 to 31 March 2013

High Level Overview

* An I&E surplus for the period of £70.3m is reported, which includes exceptional technical adjustments (see note below). The underlying net position is a surplus of £0.2m placing the Trust behind plan by £1m.

* CIPs achieved at the end of March total £25.3m. The CIP outturn position is £2.7m ahead of plan.
* Income for NYY and other PCTs is estimated to be ahead of plan.
* Cash balance is £12.8m, and is lower than plan due to receiving only a quarter of the planned capital funding for Scarborough.
* Capital spend totalled £12m. This is less than plan due to the delayed receipt of capital.
* The provisional Monitor Financial Risk Rating is 3, which is on plan.
* Transitional support is contributing a net £2.0m to the underlying reported I&E position.
* The technical adjustments to I&E are: the transfer of assets from Scarborough under absorption accounting (£68.9m), capital income received as revenue (£5m), fixed asset impairments (£3.5m), restructuring costs (£0.8m) and donated assets (£0.5m).

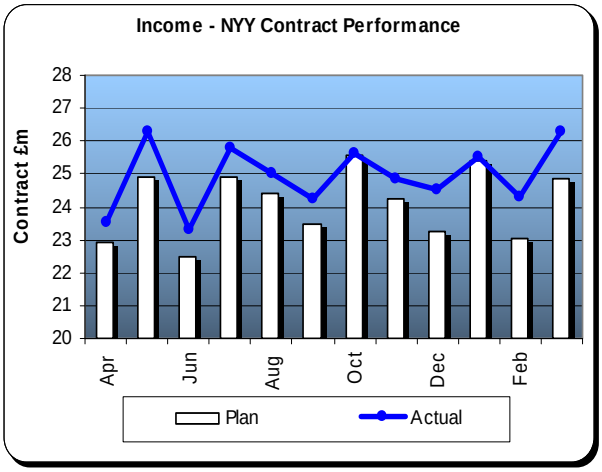
Net Income & Expenditure



Excluding the exceptional technical adjustments.

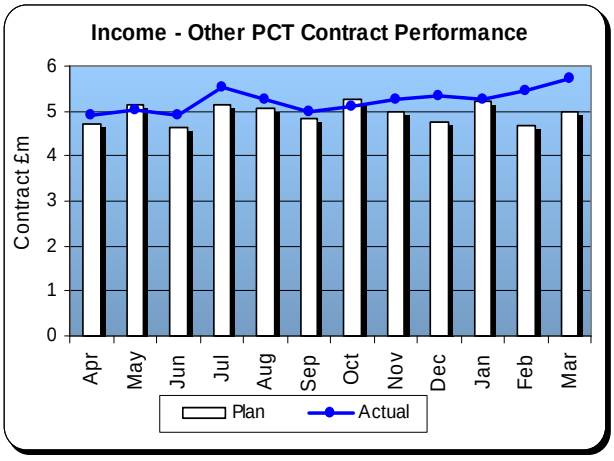
Key Period Operational Variances			
	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. Lucentis)	333.9	335.8	1.9
Clin.Inc.(Lucentis)	9.9	7.4	-2.5
Other Income	53.1	55.7	2.6
Pay	-257.7	-262.5	-4.7
Drugs	-33.1	-33.6	-0.5
Consumables	-36.3	-37.3	-1.0
Other Expenditure	-68.2	-65.4	2.8
	1.6	**0.2**	**-1.3**

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2012 to 31 March 2013



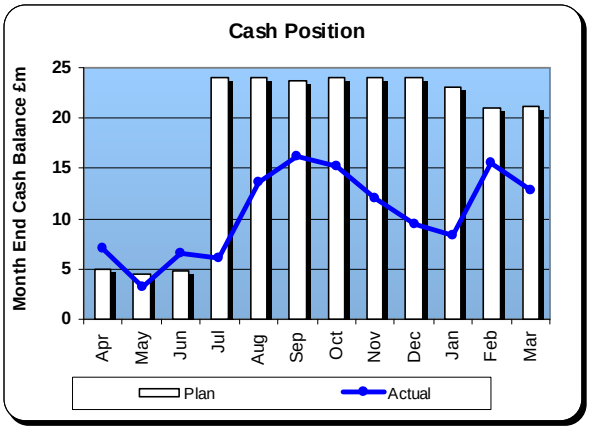
Annual contract value is £289.9m (York £221.7m, Scarborough £68.2m).

Income is estimated to be ahead of the contract plan by £9.8m for the year to date, of which York £7.1m and Scarborough £2.7m. The Scarborough income position prior to aquisition was £0.7m ahead of the contract plan.



Annual contract value is £59.4m (York £29.2m, Scarborough £30.2m).

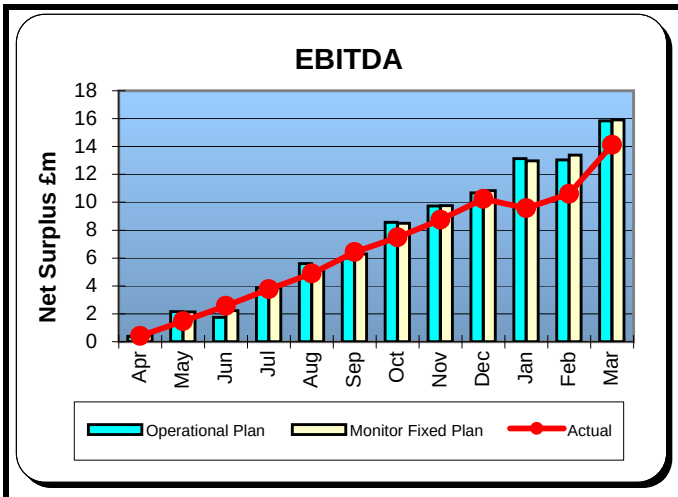
The contract is ahead of plan.

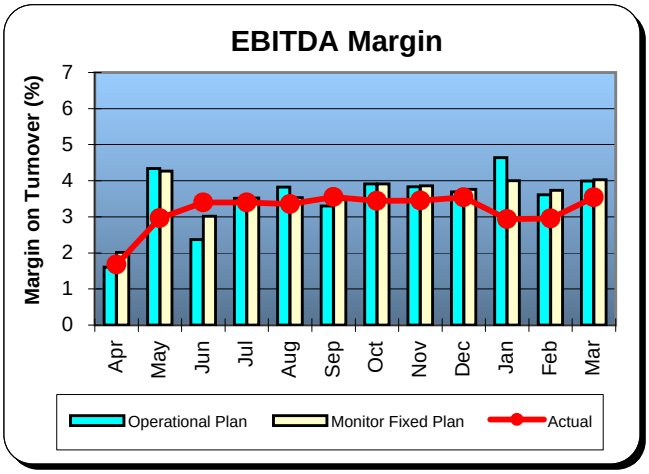


Cash balances at the end of March totalled £12.8m. This is lower than plan, mainly due to the delayed receipt of the balance of £15m capital funding for Scarborough.

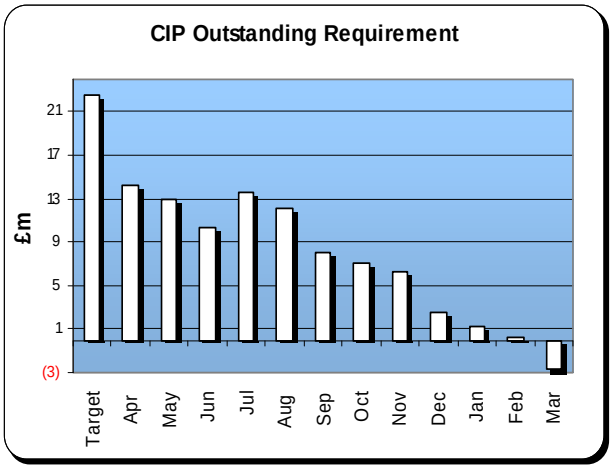
Monitor Liquidity Ratio					
Risk Rating	5	4	3	2	1
Days Cover	60	25	15	10	<10
Trust Actual Days		30			

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2012 to 31 March 2013



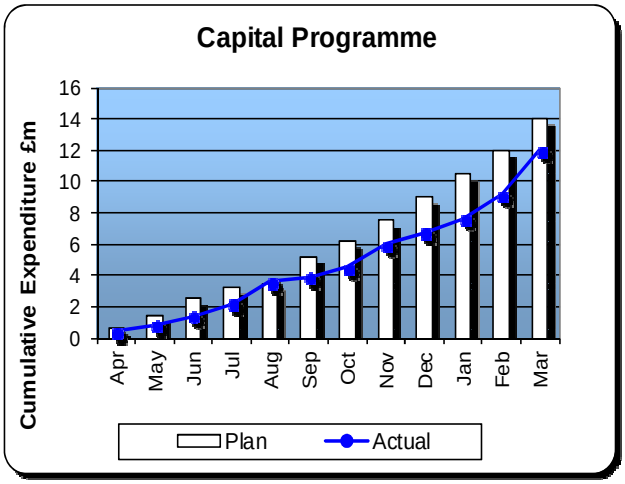


Actual EBITDA at the end of March is £14.1m (3.54%), compared to operational plan of £15.8m (3.99%), and is reflective of the overall I&E performance.



The full year efficiency requirement is £22.6m (York £16.9m, Scarborough £5.7m). At the end of March £25.3m has been cleared; this is £2.7m ahead of plan.

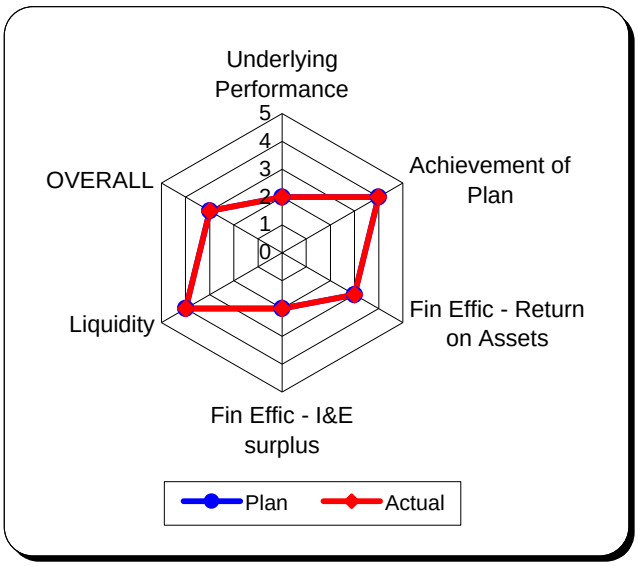
The outstanding target to be achieved in July increased over June due to the Scarborough share of the CIP now being part of the Trust's overall plan.



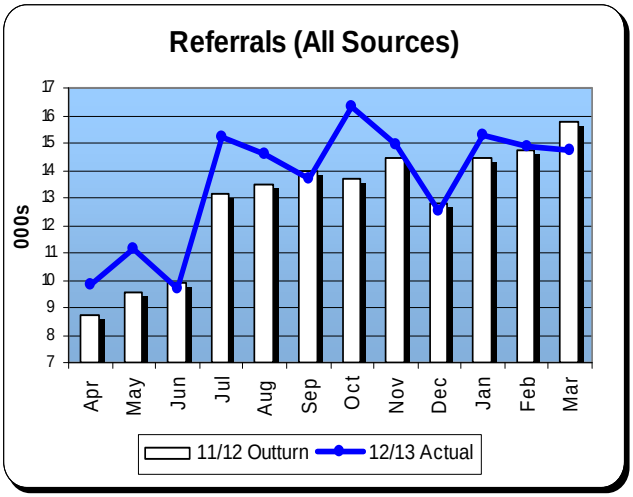
Capital expenditure at the end of March totalled £12m, and was £2m less than plan due to the delayed receipt of capital funding for the Scarborough site.

Schemes with significant in year spend include: the new MRI scanner,the demolition of Bootham Park Court, the upgrade of ward kitchens at York, and the replacement CT scanner at Scarborough. The escalation ward at Scarborough is complete and in use, and planning for Maple 2 commenced.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2012 to 31 March 2013

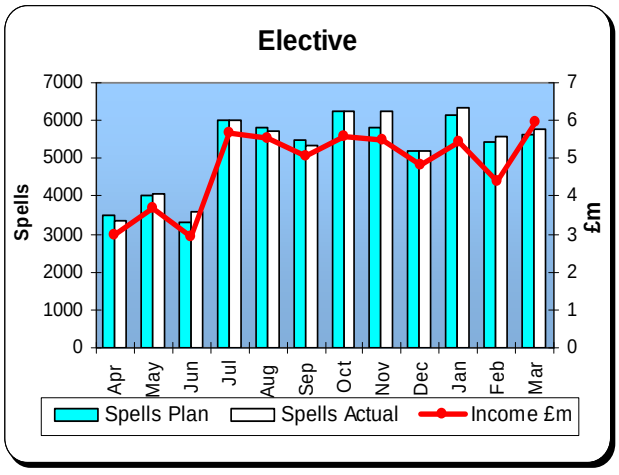


The Trust's provisional overall FRR for the year end is 3, which is in line wih the plan submitted to Monitor.



Annual plan 154,644 referrals (based on 2011/12 outturn)

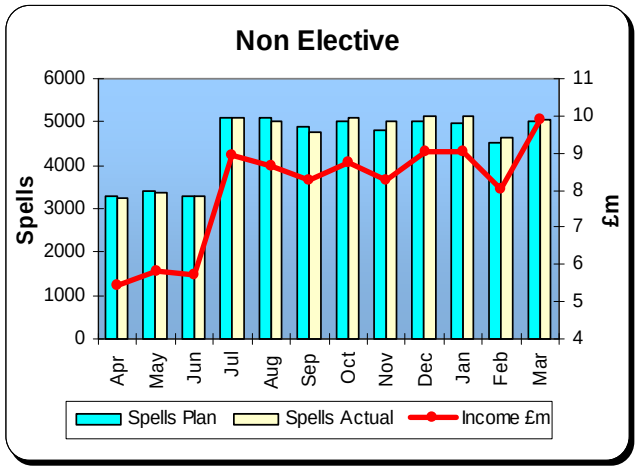
Variance at end of March: +8,196 referrals (+5%)
GP referrals +2,084 (+2%)
Cons to Cons referrals +1,470 (+7%)
Other referrals +4,642 (+11%)



Annual Plan (Spells) 62,647
Variance at end of March: +890 spells (+1.4%): inpatient -1,131; daycase +2021. York +829 (+1.8%); Scarborough +61 (+0.4%).

York variances: Ophthalmology (+26%), Rheumatology (+7%), Anaesthetics (+46%) ahead of plan. General Surgery (-4%), Gynaecology (-13%), Paediatrics (-64%), Medicine for the Elderly (-37%) behind plan.

Scarborough variances: Urology (+12%), Haematology (+13%), Neurology (+11%) General Surgery (+25%),ahead of plan. Ophthalmology (-14%) behind plan.

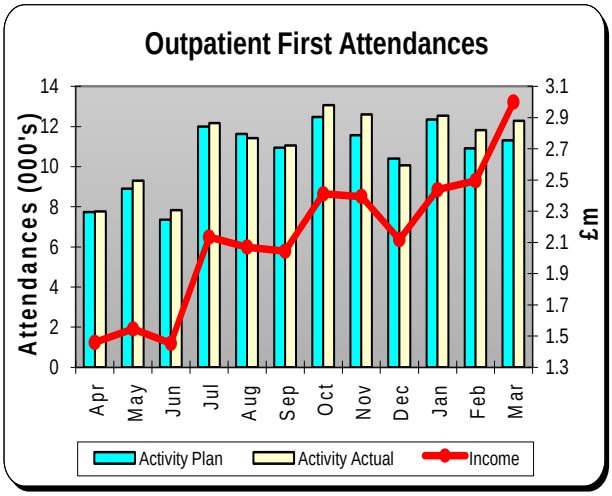


Annual Plan (Spells) 54,399
Variance at end of March: +508 spells (0.9%). York +346 (0.9%); Scarborough +162 (1.2%)

York variances: General Medicine (-14%), Trauma and Orthopaedics (-10%), Medicine for the Elderly (-1%), Ophthalmology (-63%) behind plan. ED (+44%), General Surgery (+6%), Paediatrics (+31%) ahead of plan.

Scarborough variances: General Medicine (+22%), T&O (+2%), Geriatric Medicine (+1%) ahead of plan. General Surgery (-20%), Gynaecology (-21%) behind plan.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2012 to 31 March 2013

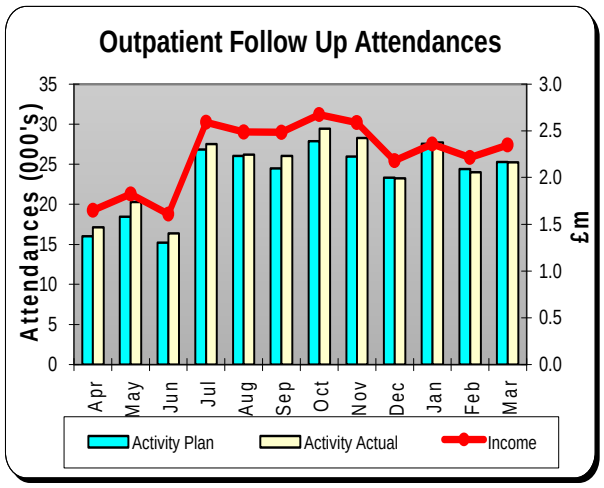


Annual Plan (Attendances) 127,520

Variance at end of March: +4,363 attendances (+3.4%). York -555 (-0.5%); Scarborough +4,918 (+18.0%).

York variances: Anaesthetics (+29%), General Medicine (+3%), T&O (+42%), Obstetrics (+5%) ahead of plan. Dermatology (-39%), Gynaecology (-18%), ENT (-17%) , behind plan.

Scarborough variances: Elderly Medicine (+15%), General Medicine (+21%), General Surgery (+43%), Gynaecology (+83%), ENT (+35%) ahead of plan.

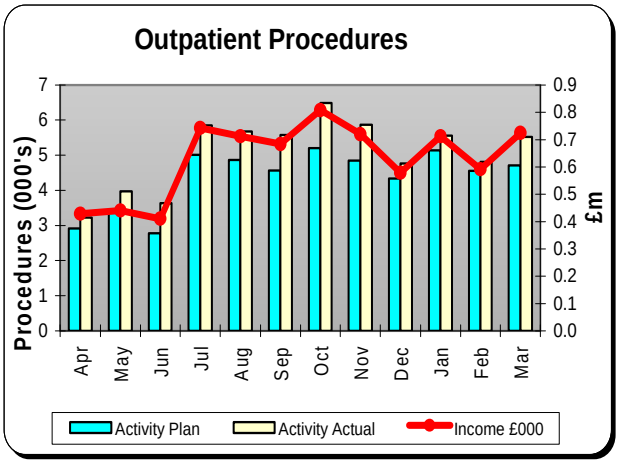


Annual Plan (Attendances) 281,451

Variance at end of March: +9,992 attendances (+3.6%). York +7,123 (+3.4%), Scarborough +2,869 (+4.0%).

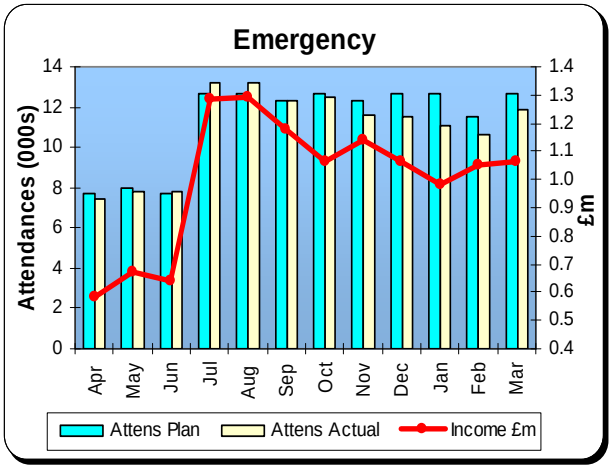
York variances: General Medicine (+4%), Paediatrics (+15%), T&O (+10%), ahead of plan. Dermatology (-26%), Gynaecology (-13%), Oncology (-15%), behind plan.

Scarborough variances: T&O (+6%), Obstetrics (+7%), Rheumatology (+23%) ahead of plan. Dermatology (-15%) , Ophthalmology (-0.8%) behind plan.



Annual Plan (Attendances) 52,282

Variance at end March: +8,653 procedures (+16.6%). York +8,586 (+22.5%); Scarborough +67 (+0.5%)



Annual Plan (Attendances) 135,577

Variance at end March: -4,506 (-3.3%). York -4,831 attendances (-5.1%); Scarborough +325 (+0.8%)

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Outline Capital Programme 2013/14 - Development of a 5 Year rolling plan

Action requested/recommendation

The BOD is asked to :-

- To discuss and approve the summary 2013 / 14 capital programme. (Section 2)
- To note the progress with the development of a 5 year rolling capital investment plan

Summary

This paper sets out the outline proposals for the allocation of capital in 2013/14 and sets a context for the development of a 5 year rolling capital plan.

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

Implications for equality and diversity

Some of the Environmental Improvement projects will address accessibility issues.

Reference to CQC outcomes

Outcome 10, safe and secure environment

Progress of report	Capital Programme Board
Risk	Corporate risk register is considered in the prioritisaion process for capital bids.

Resource implications	Resources implication detailed in the report
Owner	Brian Golding, Director of Estates and Facilities
Author	James Hayward, Programme Director, Estate Development.
Date of paper	April, 2013
Version number	1.1

Board of Directors – 24 April 2013

Capital Programme 2013/14 - Development of a 5 Year rolling plan

1. Introduction and background

This paper sets out the outline proposals for the allocation of capital in 2013/14 and sets a context for the development of a 5 year rolling capital plan.

The working assumptions for the availability of capital excluding strategic funding for 2013 / 14 is £11M :-

Generic locality assumptions;

Trust wide - £10.0M
Community Estate - £ 1.0M (Assuming vesting occurs in April 2013)

The Trust expects additional funding of £20M strategic capital investment for Scarborough. The first tranche of funds circa £5.0M is expected imminently, the timing and receipt profile of the balance has still to be agreed. The planning for delivery of the next phase of schemes is well advanced. To advance the catering strategy the Trust has secured a low interest loan; the major component of this £3.7M scheme will be delivered during 2013/14. This funding is in addition to that set out above. The Trust has also secured Funding from the DoH under the Improving Birthing Environments initiative; the scheme is being tendered and will be executed soonest to meet the spirit of the conditions set out by the DoH.

In addition the Trust has submitted a bid for the national special capital funding for Dementia (£25M nationwide) a substantial bid to upgrade ward 37 has been made and if successful will be executed in year.

The Trust has completed a 6 facet survey at the York site as well as the community estate expected to be vested. In addition development of a coherent estate master plan for the York site is well advanced.

Trust Capital Summary 2013/14		
Category	£M	Comments
Trust Wide	10.0	Depreciation
Community	1.0	Depreciation
Strategic capital	5.0	Tranche 1 of 3
Catering Loan	3.7	
DoH Special Funding	TBC	Maternity / Dementia / Energy / Other
Total	19.7	Assumptions as at Feb 2013

The assumption for depreciation over the next 5 years remains at some £11.0M p.a. for planning purposes, charitable funding is excluded from the paper; however reference is made in section 2.

2. Trust programme 2013 / 14

A key Trust focus remains on reducing the backlog maintenance by replacing essential parts of the estate infrastructure such as the lifts (SGH), electrical distribution panels, medical gas system improvements. A refreshed 6 facet survey for the York site has been completed; this

is aligned with the format used at the Scarborough and community localities. Being risk based it is possible to focus investment recommendations based on solid and credible evidence enabling decisions to be made Trust wide when considering priorities.

High Level Capital Allocation 2013/14
(Excludes Strategic/Loans/Special allocations/Charitable funds)

Capital Categories	2013 / 14 Indicative Allocation £M		
	Trust wide (excl community)	Community*	Sub Total
Carry Forward commitment	1.7	0	1.7
Backlog Maintenance	2.0	0.5	2.5
IT	2.0	0.1	2.1
Med Equipment	0.5	0.1	0.6
Developments	1.8	0.2	2.0
Patient Environment	0.5	0.1	0.6
Contingency	0.7		0.7
Capital Staff costs	0.8		0.8
Total			11.0

* Identified separately as the allocation is contingent on vesting from 1.4.13

2013/14 will see the completion of the long awaited Pharmacy dispensing robot which then creates space for the Endoscopy decontamination suite. In addition the year will see progress with the Mallard restaurant and main kitchen refurbishment.

There are several major schemes under consideration or in development to meet service needs, the Trust will be unable to afford all schemes in year and as such prioritisation will be undertaken to ensure optimal investment decisions' are taken consistent with meeting the organisations strategic objectives. In summary the schemes under consideration include;

York Locality

- An extension to the Vascular Imaging unit
- Main theatre expansion and refurbishment
- Endoscopy expansion (Formation of endoscopy decontamination suite)
- Creation of an acute assessment area / acute medical unit
- 2nd CT Scanner / environmental adaptation
- Changing Places Improvements
- Maternity (Improving Birthing Environments funding)
- Renal services
- Mortuary Improvements
- Laboratory Medicine expansion
- Ward 38/39 realignment
- Ward 37 refurbishment (Dementia funding bid submitted to DoH)
- Community Stadium

Scarborough / Bridlington Locality

- 3rd Endoscopy room conversion
- Prospective formation of a T&O Theatre in Bridlington
- New Car park (Strategic Capital)
- Maple 2 Ward (Strategic Capital)
- Paediatric Unit / OPD / Equipment store (Strategic Capital)
- EAU
- Relocation of CCU / Physio
- Formation of maternity bereavement suite
- Maternity Theatre refurbishment
- Mortuary Improvements

Community Locality

- Formation of a Urology Day case / OPD unit at Malton

Feasibility work is being undertaken to enable high level budget costs to be identified and it is acknowledged that this will place further pressures on the management of the capital resource over the next few years. All schemes will be subject to Business case approval within delegated limits and the CPB will ensure that the programme is not overcommitted on a year by year basis.

In 2013/14 there will be significant challenges in managing the Trust programme against the available funding and prioritisation to ensure the Trust objectives are delivered will be a key factor. Schemes will be programmed for implementation over more than one financial year as a means of managing the funding pressures, accordingly a five year rolling plan is proposed and details are set out in section 3.0 below. As referenced above, the in-house Catering strategy will be delivered through the use of an external low interest rate loan. Slippage on schemes will be managed to ensure we deliver on our financial obligations and plans as reported to Monitor.

Charitable Funds

The capital team will also be delivering a number of schemes funded through charitable sources, this has not been referenced or included above, current schemes under consideration include;

- Star Appeal (Stroke) – York
- Renal Self Care – York
- Maternity Bereavement scheme (Part funding) – Scarborough (subject to approval)

3. 5 Year Rolling Plan

Given the scale of current approvals and prospective bids for capital set against resource limits for 2013/14, it is clear the Trust will need to develop a 5 year rolling capital programme. Accordingly it is right to set the demands against the prospective funding over the next few

years to aid the Trust in establishing an outline baseline plan consistent with financial resource. The plan may change over time but based on current credible information and priorities, it will help inform the best current investment decisions. Priorities will be determined by the corporate directors and executive board in order to meet the Trust strategic objectives.

Prospective 5 year Capital – Source of Funds

Capital Categories	Indicative Source £M*						Comments
	13/14	14/15	15/16	16/17	17/18	Total	
Depreciation	11.0	11.0	11.0	11.0	11.0	55.0	
Strategic Capital	5.0	10.0	5.0			20.0	
Loan	3.7					3.7	Catering upgrade
Total	19.7	21.0	16.0	11.0	11.0	78.7	

* Excludes assumptions in respect of charitable funding and special capital from external sources

Prospective 5 Year Capital – Application of Funds

Capital Categories	Indicative Application £M*						Comments
	13/14	14/15	15/16	16/17	17/18	Total	
Carry Forward	1.7					1.7	Assumes no c/fwd post 13/14
Backlog Maintenance	2.5	2.5	2.5	2.5	2.5	12.5	Risk based on recent 6 facet survey
Medical Equipment	0.6	0.5	0.5	0.5	0.5	2.6	Major items may be leased
Developments	2.0	4.3	5.0	5.3	5.3	21.9	
Patient environment	0.6	0.5	0.5	0.5	0.5	2.6	
IT	2.1	1.5	1.0	1.0	1.0	6.6	
Loan	3.7					3.7	Catering upgrade **
Capital Staff	0.8	1.0	0.8	0.7	0.7	4.0	
Contingency	0.7	0.7	0.7	0.5	0.5	3.1	
Strategic Capital	5.0	10.0	5.0			20.0	£1.0m spent in 12/13 on Graham ward
Total	19.7	21.0	16.0	11.0	11.0	78.7	

- * Excludes assumptions in respect of charitable funding and special capital from external sources
- ** **The Trust may consider borrowing a further sum to fund a more rapid development and execution of its Masterplan**

Prospective 5 Year Capital Plan Headlines 2013/14 – 17/18

The following summary describes in more detail the proposals for capital investment by category over the next 5 years and sets out the summary basis for investment decisions;

Backlog Maintenance

The Trust has a recently completed a 6 facet survey for its entire estate portfolio; this indicates that there is a significant backlog maintenance problem which will to be addressed over the next 5 years. The risk based survey was executed the following NHS / DOH Estates approved methodology. The backlog capital programme for each year will be formulated by the estates operational and capital teams aimed at reducing risk to the organisation.

Medical Equipment

The Trust is refining its medical equipment register; this includes minor and major medical

equipment replacement. The Trust has in the past tended to lease large items of medical equipment or on occasion take out a low interest loan. The prospective plan for the next 5 years suggests that this mode of procurement will continue, however it is prudent to make allowance for more minor equipment purchases based on risk, the investment profile shown above indicates some £2.5M investment over the period, excluding loans or leased equipment. The Medical Equipment Replacement Group will oversee the investment priorities to ensure risk is minimised and service continuity maintained.

Developments

Given the scale and pace of integration, linked to the service efficiency requirements and prospective service and quality changes this category faces the most difficult challenge with limited resources. The capital team have assembled a schedule of current investments requirements and have used best endeavours to spread the proposals over the 5 year period. Not all schemes have been fully worked up, but significant work continues to develop a number of proposals, the indicative plan is as follows;

Capital Development Proposals		
Year	Description	Comments
2013/14	• Phlebotomy Adaptations (Y) • Acute Assessment Unit (Y) • Endoscopy Decontamination (Y) • 2nd CT Scanner (Y) • Office accommodation (Y) • Vascular Imaging (Y) • 3rd Endoscopy room (S) • Changing Places (Y) • Maty Theatre (S) • Malton Urology Centre (M) • Dementia Ward upgrade (S + Y)* • Renal Self Care (Harrogate) • Radiology PACS • Maternity Birthing Improvements (Y) • Bereavement Suite (S) (Charitable appeal)	Some schemes will need to roll over two financial years. Business cases not received for every scheme, the Maty Theatre scheme may be considered backlog Maintenance. * Bid submitted to DOH for specialist funding if successful will ease pressure on available capital
2014/15	• Mortuary refurbishment adaptation (Y + S) • Renal re provision Easingwold • Laboratory Medicine Integration (Y + S) • OPD improvements (Y) • T&O ambulatory care centre (B) • Renal Services (Phase 1) (Y) • Phase 1a Strategic development (Y) • MRI replacement • CHP project * • CCU (S) relocation to Haldane ?	* Proposed bid to CEF of £3.5M which may require a loan, feasibility to be worked up and business case to be developed during 13/14
2015/16	• South entrance refurbishment (Y) • Renal Self Care (Phase 2) (Y) • Ward Refurbishment (Y + S) • Phase 1b Strategic development (Y)	

	• Pharmacy Robot + Dispensary (S)	
2016/17	• Relocation of Physio (S) • Form an EAU (S) • Ophthalmology Centre relocation (B) • Dermatology adaptations (Y) • Whitby Strategic changes (W) • Phase 2a Strategic Development (Y)	
2017/18	• Phase 2b Strategic Development (Y) • Phase 3 Strategic Development (Y)	Await master plan completion for detail and programme.
Key: Y = York; S = Scarborough; M = Malton; B = Bridlington ; W = Whitby		

The corporate directors and executive board will endorse priorities and the order of works once agreed in principle, linked to the Trust strategic frames and business planning priorities.

Patient Environment

A sum of capital will be earmarked year on year for allocation to improve the patient environment; the process will be driven through the matrons and by using feedback from patient's / complaints. The indicative sum for this element is some £2.6M in the period. It is recommended that the Trust Environment Steering Group is delegated responsibility for determining investment priorities.

IT

The Director of Systems and Network Services has developed an IT investment plan for the next 5 years which will focus on renewal of old and outdated technology and provision of new systems to support the business operations and resilience of the Trust systems. The indicative allocation in the period is some £6.6M.

Capital Staffing / Contingency

An allocation has been identified to fund the cost of planning / project managing and delivering the capital programme through in house and external means. In addition an annual allocation is proposed to act as a contingency sum to deal with unforeseen and adverse issues that may crop up in year which may require capital investment to resolve.

Scarborough strategic development capital

The Trust expects additional funding of £20M strategic capital investment for Scarborough. The first tranche of funds circa £5.0M is expected imminently, the timing and receipt profile of the balance has still to be agreed however in the table above an assumption has been made about the income profile.

The planning for delivery of the next phase of schemes is well advanced; more detail is provided in section 4 below.

Strategic Integration Group / Executive Board

The Capital Programme Board have received this paper, it is the intention that the Trust SIG and Executive Board receive this paper to provide assurance that the principle Trust capital developments are being addressed over the next 5 years as the plan develops. The SIG will be invited to comment in the medium term planning proposals and priorities, the Executive Board will be invited to approve the annual investment plan within BOD authorised financial resources.

4. Estate Master Planning (York and Scarborough Localities)

York Hospital

Work is progressing apace to develop a coherent, logical and phased master plan for the York site. There may be a need to execute some short term capital investment to enable clinical service continuity and such decisions' will be taken with due regard to the emerging master plan themes. Strong clinical engagement will continue to be taken, the BOD will be provided with an update on progress early in the new financial year.

Scarborough Hospital

The Scarborough site has a well developed and accepted master plan, the investment profile for the current year will focus subject to receipt of the promised strategic capital on progressing 4 key schemes in 2013/14;

- Car Park Extension – 262 extension to enable development of the Paediatric/OPD Unit
- Maple 2 Ward – Build on top of Maple Ward to form a new surgical 28 bed ward
- Development of the business case to OBC for the proposed Paediatric Unit/OPD and Medical Equipment store.
- Early planning around the form and function of the proposed EAU up to OBC.

The first phase of the plan to deliver an escalation / decant ward was completed in Dec 2012, this will provide in due course the capacity required to enable Maple 1 to close temporarily whilst construction of Maple 2 is in progress.

The estimated programme cost is £20M. The Department of Health are providing this funding in the form of additional Public Dividend Capital, the Trust expects receipt of the first tranche soon, and continued progress is contingent on the arrival of the remainder. The spend profile of the respective schemes will be tailored to match the flow of strategic capital received from the DoH.

5. Community Properties

The Trust had vested to it on 1 April 2013, a number of Community hospitals and other properties, bringing with them new capital funding and capital spending needs. These developments will be incorporated into the Trust's plans later in the year, once the transfer of property ownership is agreed. The Trust has completed as part of its due diligence arrangements a full risk based 6 facet surveys on these properties to assist in making the appropriate recommendations for investment. Malton Hospital will vest on to the Trust

around the end of October 2013 as agreed with the SHA / TEWV NHS FT and the PCT.

6. Progress reports to the Board of Directors

It is proposed that progress reports are submitted via CPB to the Board of Directors on a quarterly basis from April onwards. A new style composite report format ihas been developed and approved by the CPB. The report provides colour coded reference by scheme on time / cost / quality indicators this report is the basis upon which the CPB monitor the programme on a monthly basis.

7. Procure 21+

The BOD received an update from the CEO at the March meeting in respect of progress with the process to secure a Principal Supply Chain Partner (PSCP). The appointment has now been made, work will now accelerate on key strategic projects at the Scarborough site, the BOD will be required to approve relevant buisness cases in due course.

8. Recommendation

The BOD is asked to :-

- To discuss and approve the summary 2013 / 14 capital programme. (Section 2)

- To note the progress with the development of a 5 year rolling capital investment plan.

Author	**James D Hayward RD, Programme Director - Capital**
Owner	**Brian Golding, Director of Estates and Facilities**
Date	**March 2013**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Results of the 2012 NHS Staff Survey

Action requested/recommendation

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

Summary

The attached document highlights the main findings from the 2012 NHS Staff Survey.

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

There are no implications for equality and diversity.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report is only written for the Board of Directors
Risk	No risk
Resource implications	None
Owner	Peta Hayward, Director of Human Resources
Author	Siân Longhorne, Workforce Information Manager
Date of paper	April 2013
Version number	Version 1

Board of Directors – 24 April 2013

Results of the 2012 Staff Survey

1. Introduction and background

All NHS organisations are required to participate in an annual staff opinion survey which covers themes such as staff satisfaction, equality & diversity and infection control & hygiene.

The following summarises the key findings from the 2012 staff survey. 2012 was the first year in which we undertook the survey as an integrated organisation. The report we have received makes references to scores from the 2011 survey and this relates only to the survey which included York & Community staff.

For information, scores from the 2011 reports for York & Community and Scarborough have been included below for all of the key findings that are mentioned.

This paper is intended to provide headlines only. Further, more detailed analysis will be undertaken to understand particular issues across different sites, staff groups and specialties.

Due to changes made to improve and shorten the survey between 2011 and 2012, some of the key findings aren't directly comparable with their equivalents in previous years.

2. Results of the 2012 Staff Survey

Response rate

The Trust achieved a response rate in the survey of 51%. This is above the average of 50% for acute trusts but lower than the response rate of 60% achieved in 2011. The highest response rate achieved by an acute trust in the 2012 survey was 71%.

Overall staff engagement

The overall staff engagement score is based on responses to a number of survey questions. The Trust's score in 2012 was 3.71 which was not changed from last year and was average for acute trusts.

28 key findings

Of the 28 key findings presented in the 2012 staff survey results;

- 14 scores were better than the average for acute trusts
- 7 scores were average compared to other acute trusts
- 7 scores were worse than the average for acute trusts

Of the key findings for which there was a direct comparator from the 2011 survey (York including Community scores);

- The scores for 2 key findings showed statistically significant improvements,
- The scores for 3 key findings showed statistically significant deteriorations,
- For 16 scores there was no statistically significant change.

Top and bottom ranked scores

For each of the 28 key findings, scores for every acute trust in England were placed in order from 1 (top/best ranked score) to 142 (bottom/worst ranked score). The top five key findings, i.e. those ranked closest to 1, and the bottom five key findings, i.e. those ranked closest to 142 are shown here.

Top five ranking scores

Note – for most key findings a higher score is better. Where this is not the case, this has been indicated.

- Key finding (KF) 14 – Percentage of staff reporting errors, near misses or incidents witnessed in the last month;
    - Trust score 2012 – 94%
    - National 2012 average for acute trusts – 90%
    - Trust score 2011 (York including Community) – 98%
    - Trust score 2011 (Scarborough) – 96%

- KF11 – Percentage of staff suffering work related stress in last 12 months (lower score better);
    - Trust score – 31%
    - National 2012 average for acute trusts – 37%
    - Trust score 2011 (York including Community) – 21%
    - Trust score 2011 (Scarborough) – 27%

Although amongst the best ranked scores, this key finding is also included under the section where staff experience has deteriorated since the 2011 survey (see below).

- KF25 – Staff motivation at work;
    - Trust score - 3.93
    - National 2012 average for acute trusts – 3.84
    - Trust score 2011 (York including Community) – 3.84
    - Trust score 2011 (Scarborough) – 3.88

- KF18 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (lower score better);
    - Trust score – 26%
    - National 2012 average for acute trusts – 30%

- KF19 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (lower score better);
    - Trust score – 21%
    - National 2012 average for acute trusts – 24%

There are no comparable scores for KF18 and KF19 from the 2011 survey.

Bottom five ranking scores

- KF7 – Percentage of staff appraised in the last 12 months;
    - Trust score – 76%

    - National 2012 average for acute trusts – 84%
    - Trust score 2011 (York including Community) – 71%
    - Trust score 2011 (Scarborough) – 70%

- KF26 – Percentage of staff having equality & diversity training in last 12 months;
    - Trust score – 43%
    - National 2012 average for acute trusts – 55%
    - Trust score 2011 (York including Community) – 47%
    - Trust score 2011 (Scarborough) – 49%

- KF8 – Percentage of staff having well structured appraisals in last 12 months;
    - Trust score – 31%
    - National 2012 average for acute trusts – 36%
    - Trust score 2011 (York including Community) – 32%
    - Trust score 2011 (Scarborough) – 29%

- KF6 – Percentage of staff receiving job relevant training, learning or development in last 12 months;
    - Trust score – 78%
    - National 2012 average for acute trusts – 81%
    -

There is no comparable score for KF6 from the 2011 survey.

- KF1 – Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver;
    - Trust score – 74%
    - National 2012 average for acute trusts – 78%
    - Trust score 2011 (York including Community) – 74%
    - Trust score 2011 (Scarborough) – 72%

Largest changes since the 2011 survey

Where staff experience has improved

- KF22 – Percentage of staff able to contribute towards improvements at work;
    - Trust score 2012 – 67%
    - Trust score 2011 (York including Community) – 57%
    - Trust score 2011 (Scarborough) – 57%

- KF23 – Staff job satisfaction;
    - Trust score 2012 – 3.62
    - Trust score 2011 (York including Community) – 3.51
    - Trust score 2011 (Scarborough) – 3.42

Where staff experience has deteriorated

- KF11 – Percentage of staff suffering work related stress in last 12 months (lower score better);
    - Trust score 2012 – 31%
    - Trust score 2011 (York including Community) – 21%
    - Trust score 2011 (Scarborough) – 27%

- KF20 – Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell (lower score better);

- Trust score 2012 – 27%
- Trust score 2011 (York including Community) – 21%
- Trust score 2011 (Scarborough) – 26%

Although the scores for KF11 and KF20 have deteriorated, both are better than the average for acute trusts and KF11 is included as one of the top ranked scores.

- KF12 – Percentage of staff saying hand washing materials are always available;
  - Trust score 2012 – 54%
  - Trust score 2011 (York including Community) – 62%
  - Trust score 2011 (Scarborough) – 70%

Staff recommendation of the Trust as a place to work or receive treatment

Following the publication of the Francis report it is likely that over the coming months there will be a particular focus on Key Finding 24 – 'Staff recommendation of the Trust as a place to work or receive treatment' and Trust scores against this particular indicator.

The Trust score for this Key Finding in 2012 was 3.59 which was average for acute trusts. The score for York including Community in 2011 was 3.64 and the difference between the scores in the two years is not classed as statistically significant. The score for Scarborough in 2011 for this key finding was 3.31.

When looking at the more detailed analysis for this particular finding, scores do vary significantly between groups. The score for this finding was lower than the trust score amongst adult/general nurses (all sites), 3.32; staff working in Anaesthetics & Theatres (all sites), 3.27; and staff based at Bridlington hospital, 3.33.

3. Conclusion

Overall the results of the survey were positive with 75% of the Trust's score being average or better then average in comparison to other similar organisations.

The focus in the coming months will be on identifying actions for those findings where the Trust's score was ranked lower in comparison to other acute trusts.

Further work will also be undertaken with directorates and staff groups, with support from HR, to develop action plans which will address issues specific to each area or group.

4. Recommendation

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

5. References and further reading

2012 National NHS Staff Survey – Results from York Teaching Hospital NHS Foundation Trust.

Author	**Siân Longhorne, Workforce Information Manager**
Owner	**Peta Hayward, Director of Human Resources**
Date	**April 2013**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Chairman's Report

Action requested/recommendation

The Board of Directors is asked to note the report.

Summary

This paper provides an overview from the Chairman.

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

Any strategy development the Board may undertake considers the implications of equality and development.

Reference to CQC outcomes

There is no reference to CQC outcomes.

Progress of report	This paper is only written for the Board of Directors.
Risk	There are no risks.
Resource implications	There are no resource implications.
Owner	Alan Rose, Chairman
Author	Alan Rose, Chairman
Date of paper	April 2013
Version number	Version 1

Board of Directors – 24 April 2013

Chairman's Report

1. Strategy and Context

Another year is gone – one of the most significant in terms of change for this organisation. In the face of such severe austerity in terms of funding, and the upheaval of the organisation and the broader service, it is impressive that the Trust has delivered a strong performance against virtually all of our plans. The small number of breaches and disappointments are being addressed actively and tenaciously. Our Annual Report and Annual General Meeting will be the place to give this overview and reflection, but we should recognise now the extent of the effort made by all staff to achieve what has been delivered.

My sense is that the gears are now changing as we progress our commitment to "keep on the front foot" as an organisation; for example:

- increasing focus on our core clinical areas, such as the acute pathways
- analysing how to best utilise our portfolio of physical facilities and configurations of services
- accelerating the redesign and support for Community Services
- refreshing our approach to the continued financial squeeze
- building a proactive and open relationship with new commissioners
- re-examining positively our relationships with neighbouring Trusts
- exploring ways to work more with our mental health and public health colleagues

These are just some of the ways in which the Trust has to move on this year; these and other initiatives will help us survive as a sustainable entity and an attractive pace to work – as well, of course, as ensuring we achieve our mission to deliver safe, effective and sustainable healthcare within our communities.

Every Trust around us is absorbed by its own pattern of huge pressures, scrutiny and strategic challenge – we can lead the way by continued strong leadership, development of our staff and the ways we grow ideas and implement them.

Good luck to us all for a successful 2013/14!

2. Governance, Governors and Community

This is our first meeting in public as a Board, excepting our Annual General Meetings, since March 2007, at which point we became a Foundation Trust. The Health and Social Care Act 2012 mandates that this occurs. The meeting is not to answer directly to our public, but to allow anyone to observe the assurance and decision-making process that culminates at Board meetings. Clearly significant assurance and decision-making takes place through the myriad of other processes and interactions that take place all over the Trust every day. However, the Board is where responsibility must formally and ultimately rest for the Trust's work and we are accountable to "the public" (as well as more narrowly to other specific stakeholders) for what we achieve or fail to achieve. Our papers are now in the public domain, as are our minutes. Any member of the public can approach us at any time to question or challenge our work; this can be handled directly or via our quarterly Council of Governors meetings in public – at which

questions can be tabled in advance by anyone. Issues that are commercially sensitive, or confidential regarding specific individuals at the Trust, will continue to be taken in private session.

We have recently completed a number of Governor elections and I am pleased to welcome Helen Fields (Public, City of York), John Roberts (Staff, York) and the re-election of an experienced Governor, Jenny Moreton. Paul Baines and Helen Mackman were re-elected for a third term. Helen will continue as our Lead Governor for one more year. We bid farewell and thank you to Martin Skelton, Alison McDonald, Nevil Parkinson, Brian Thompson and Jim Porteous, each of whom has contributed as a Governor for many years. Thank you also to Philip Hewitson, lay member of the Scarborough & Ryedale CCG, who has acted as an interim Governor for the PCT until the change in our constitution at 1/4/13. Farewell this month also to Penny Goff, who has worked at York for 38 years, and in recent time has been our Membership Development Manager. As part of the acquisition of Scarborough and North-East Yorkshire NHS Healthcare Trust, she led the achievement of the important requirement to recruit a significant body of public Members to ensure that we could run elections for a new set of Governors to represent the communities of Whitby, Scarborough, Bridlington and Ryedale.

Our Governors have been active in recent weeks in considering the ways they wish to bring ”patient-focused” feedback to the Trust, and how they wish to be active in their local constituencies.

The Local Authority-based Health & Wellbeing Boards are now up and running. Patrick will bring us regular feedback from our involvement in these Boards – directly, in the case of City of York, and indirectly, in the case of North Yorkshire County Council and the East Riding of Yorkshire Council.

We are in the final stages of testing the new Trust-wide website – designed to present an improved and clearer face to our communities; we should all sample this to be comfortable about its content and treat it as a continually improving and relevant “live” channel of communication to our patients, public, Members and other stakeholders.

3. Recommendation

The Board of Directors is asked to note the report.

Author	**Alan Rose, Chairman**
Owner	**Alan Rose, Chairman**
Date	**April 2013**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Chief Executive Report

Action requested/recommendation

The Board is asked to note the report.

Summary

This report is designed to provide a summary of the operational issues the Chief Executive would like to draw to the attention of the Board of Directors.

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

Implications for equality and diversity

None directly identified at this stage.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors meeting.
Risk	There are no specific risks for escalation.
Resource implications	There are no resource implications.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	April 2013
Version number	Version 1

Board of Directors – 24 April 2013

Chief Executive Report

1. Improve Quality and Safety

1a. Activity in the Trust

The whole system has remained busy throughout the month with significant bed capacity issues having an impact on the performance of both our major hospitals, both in terms of our performance against targets as well as the quality of service we have been able to provide overall.

This was particularly acute in York Hospital and resulted in the hospital being on Amber alert for all of March as a result of high non elective demand and a loss of inpatient capacity as a result of a significant outbreak of Diarrhea & Vomiting (D&V).

Looking ahead:

- Directorates are continuing to work on contingency plans for managing the May Bank Holidays.
- A winter de-briefing session has been arranged in May for directorates to reflect on the winter months, review the contingences within the resilience plan, measure effectiveness and identify any learning points so that this can inform the update of the Resilience Plan moving forward.

The Deputy Chief Executive will be pleased to provide a fuller briefing at the Board.

1b. Joint Advisory Group (JAG) accreditation

I am delighted to be able to advise the Board that the Trust has at Scarborough Hospital secured JAG accreditation on GI Endoscopy. I would like to congratulate all those involved in the accreditation and thank them for their hard work.

1c. Blood taking (York Hospital)

I am very conscious that this area of the hospital has required development for some time and that it is a major concern to those who use and delivery the service. It is also a personal priority for me to ensure that the area is improved. To that end I have received an update on the plans that are being put in place.

Currently drawings have been prepared to create a new enlarged area for the service and a business case is being prepared to support that vision. In terms of more immediate activity, work is underway to improve the flow in the outpatient area from the various departments that use the service. The team have worked to overcome some immediate challenges around staff sickness and a number of vacant positions have been advertised to increase the team. To improve patient experience the team have been working at improving some of the processes. I will continue to take a particular interest in these developments and I expect to be able to report to the Board on those improvements in the near future.

2. Create a culture of continuous improvement

2a. Secondment of staff

As part of strengthening the relationships we have with Hull NHS Trust, it has been agreed that Neil Wilson Assistant Director of Strategy will work on a part time secondment for 6 months with Hull as their Acting Director of Strategy. Neil's will focus his contribution on the development of joint service plans on behalf of the Alliance Board and act as mentor for the developing team in Hull as the Trust picks its way through a difficult time managerially and the challenges of its Foundation Trust application.

2b. Contributing to the NHS System

I am delighted to advise the Board that Martin Telfer has been invited to be one of the two surgeons on the National Collaborating Centre for Cancer's Guideline Development Group for Malignant Melanoma at the request of NICE. I am equally pleased that Brian Golding, our Director of Estates and Facilities, has been asked by DH to join the team reviewing the national programme to deliver the 111 service.

3b. Clinical Director Appointment

I am pleased to announce the appointment of Peter Campbell as Clinical Director for Trauma & Orthopaedics in York and Nick Carrington as his deputy. Both appointments have been welcomed universally and I genuinely believe we now have a basis for a consistent leadership of this directorate for the foreseeable future.

3. Develop and enable strong partnerships

3a. Strategic Alliances

By the time we meet as a Board the Chair and myself will have led a small team of Executives and Non Executives at a workshop with colleagues from Hull and NLAG to further explore the potential for growing a strategic alliance between our organisations. We will of course be pleased to provide a briefing as appropriate at Board.

I will also be pleased to feedback the outcome Clinical Leadership Time Out help in York on the 17th April that was wholly focussed on further developing the short and medium term strategy for Foundation Trust overall. I was joined at the workshop by the Executive Board, Clinical Strategic Leads and a small number of invited senior managers.

I attended the City of York Council Health and Wellbeing Board last Wednesday that was meeting for the first time. The key item was the formal approval of the Health and Wellbeing Strategy that we have contributed to and will incorporate, as appropriate, in our annual and strategic plans. The Board received two presentations of interest to us. The first outlined the work led to date by NYCC on the option for integrated commissioning in North Yorkshire and the second, which I found stunningly good, on tackling health inequality. I am happy to brief you more fully at the Board if you wish.

4. Financial Summary

I thought it worthwhile incorporating in this briefing, in summary, the message we are currently playing out into the organisation regarding our financial plan and the need for ever great discipline in managing our resources as we progress through the year. The Finance Director and I will be pleased to explore this further if you wish at Board.

1. The financial plan for 2013/14 is an austere plan, affected very much by the current economic backdrop. The plan acknowledges that we are in the fourth year of the sustained annual 4% tariff reduction. It is a different plan to previous plans as it deals with known pressures only; we have not been able to create a contingency to deal with new initiatives we might wish to take forward in year. As such all business cases will need to identify a source of funds; this can obviously either be new income or can be an identified resource transfer.

2. The efficiency requirement amounts to a new £16m savings target this year. However, the raw figures for the delivery of the 2012/13 savings requirement show that £13m was delivered non-recurrently across the organisation. This rolls forward to 2013/14 and directly increases the new year target to £29m. This total represents over 7% of operational budgets. The Corporate Efficiency Team continues to work with Directorates to reduce this carry over by converting non-recurrent savings to recurrent. This is extremely important work and every attempt will be made to convert savings to recurrent budget reductions. Monitor, our financial regulator, points to the fact that evidence suggests that a savings target of over 7% is undeliverable and the organisation will most likely fail. We must reduce this £29m target by converting non-recurrent savings to recurrent.

3. In relation to expenditure control, whilst we are able to relax somewhat the recent exceptional controls put in place concerning purchasing cards and discretionary expenditure it is important that strong corporate and clinical directorate controls remain in force. All expenditure should be reviewed and should be confirmed as necessary and proportionate before authorisation. All expenditure should be checked to ensure adequate budget is in place to cover costs. No budget holder has authorisation to overspend, whatever the case of need. Any budget pressure should be formally supported through PMM discussions. Additional information has been provided to budget managers on standards of business conduct and financial discipline.

It has been confirmed to the organisation that the plan does not contain contingency for failure to deliver the CIP target or for failure to manage against budget. Any Directorate breaching these requirements will potentially destabilise the whole organisation.

By the time we meet I hope to have signed up to the underlying principles of our contract with the Vale of York and Scarborough CCGs and will be pleased to brief you more fully. I believe there is growing respect and atmosphere of mutual support developing between the organisations that is largely down to the inclusive approach the Trust team has taken in all engagement with CCG officers together with an equal measure of persistence, resolve and discipline in negotiations that are so vital to our short term viability and I would wish to thank the whole team for the hard work and endeavour.

5. A Strategy?

I thought you might like this…….

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley, Chief Executive**
Date	**April 2013**

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York Teaching Hospital NHS Foundation Trust

Board of Directors - 24 April 2013

Fire Safety Management Policy

Action requested/recommendation

To endorse the revised policy.

Summary

York Teaching Hospital NHS Foundation Trust will ensure so far as is reasonably practicable, that the risk from fire will be managed in compliance with the Regulatory Reform (Fire Safety) Order 2005, FIRECODE and other appropriate legislative requirements and guidelines. The Chairman, Chief Executive and Board of Directors are fully committed to providing a safe environment for patients, service users, employees and visitors. This is achieved through a framework of policies and procedures ensuring that all Trust premises meet the statutory and mandatory fire safety standards. This policy forms part of the Trust's overall risk management strategy.

The Trust's Fire Policy has been updated in line with its review date and now reflects the needs of the enlarged organisation.

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

Implications for equality and diversity

None identified. The policy is inclusive.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Presented to H&S/NCRG March 2013
Risk	Medium / High if not approved.
Resource implications	No resource implications.

Owner	Brian Golding, Director of Estates & Facilities
Author	Mick Lee and Kevin Hudson, Fire Safety Advisers
Date of paper	April 2013
Version number	Version 1.4 of the Policy.

Board of Directors – 24 April 2013

Health & Safety Policy

1. Introduction and background

York Teaching Hospital NHS Foundation Trust will ensure so far as is reasonably practicable, that the risk from fire will be managed in compliance with the Regulatory Reform (Fire Safety) Order 2005, FIRECODE and other appropriate legislative requirements and guidelines. The Chairman, Chief Executive and Board of Directors are fully committed to providing a safe environment for patients, service users, employees and visitors. This is achieved through a framework of policies and procedures ensuring that all Trust premises meet the statutory and mandatory fire safety standards. This policy forms part of the Trust's overall risk management strategy.

The Trust's Fire Policy has been updated in line with its review date and now reflects the needs of the enlarged organisation.

2. Key Changes to Policy

Addition to 4.3 Non Executive responsibilities for fire management, and amendment to 10.1 Compliance – Fire Safety Advisor to produce annual report.

3. Recommendation

The Executive Board is asked to endorse the Policy prior to final approval by BoD.

Author	**Mick Lee / Kevin Hudson, Fire Safety Advisers**
Owner	**Brian Golding, Director of Estates & Facilities**
Date	**March 2013**

York Teaching Hospital NHS
NHS Foundation Trust

FIRE SAFETY MANAGEMENT POLICY

Author(s):	Mick Lee & Kevin Hudson Fire Advisors YHFT
Owner:	Patrick Crowley Chief Executive
Publisher:	Brian Golding Director Estates and Facilities
Date of first issue:	October 2012
Version:	1.4
Date of version issue:	February 2013
Approved by:	Corporate Directors
Date approved:	
Review date:	February 2015
Target audience:	All Trust Employees
Relevant Legislation & Standards:	The Regulatory Reform (Fire Safety) Order 2005 NHS Fire code HTM 05 (01-03)

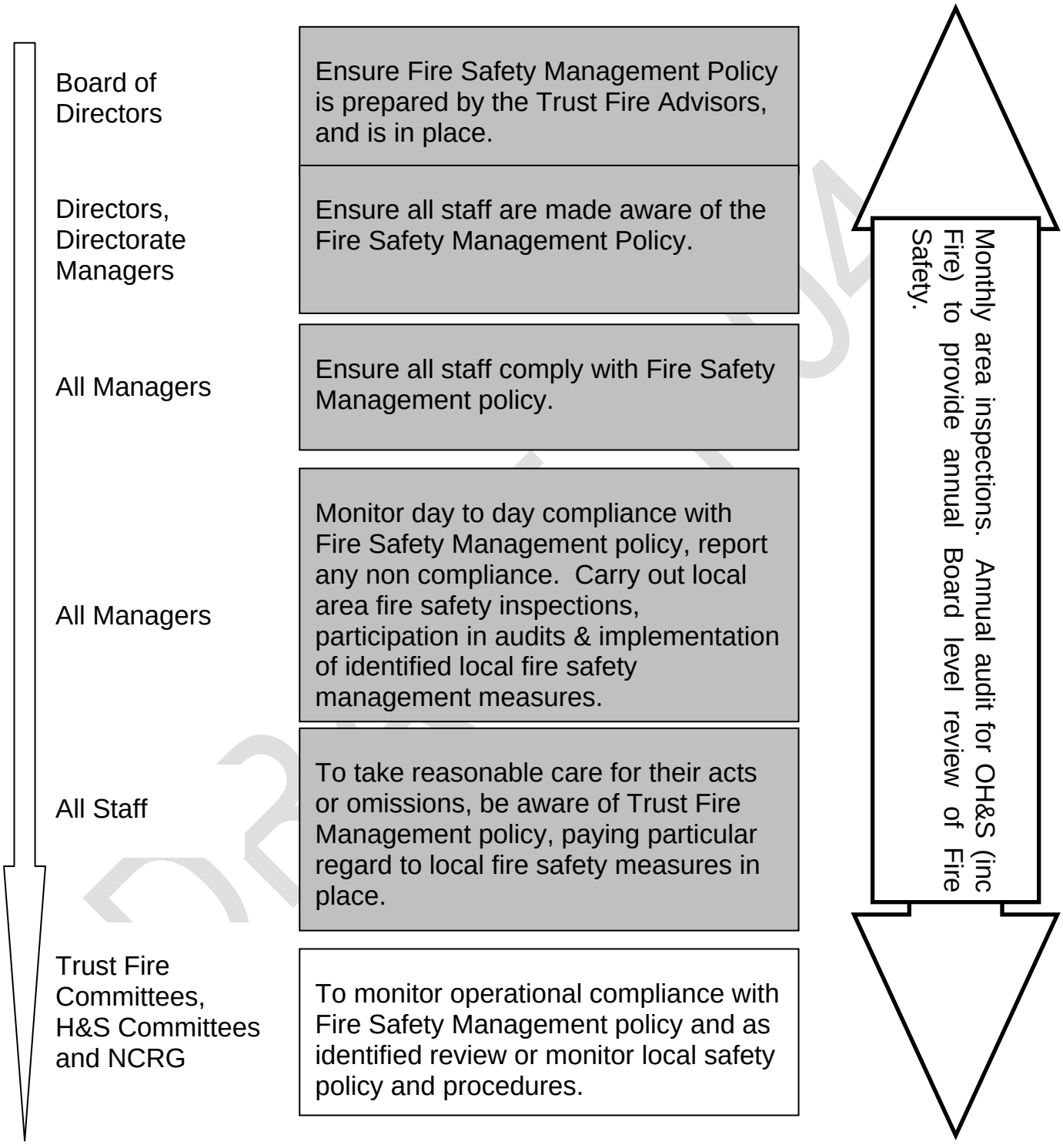
Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
1.0	October 12	M Lee & K Hudson	1st Draft Fire Advisors	Consultation of New Policy for enlarged organisation
1.1	November 2012	M Lee & K Hudson	2nd Draft Fire Advisors & Managers	Consultation and amend arrangements and content
1.2	December 2012	M Lee & K Hudson	3rd Draft Fire Advisors & Managers	Consultation and final amend to arrangements and format
1.3	February 2013	M Lee & K Hudson	Agreed Final Draft Fire Advisors & Managers	Addition to 4.3 Non Executive responsibilities for fire management. Amend final draft into trust format for group / committee promulgation and approval
1.4	February 2013	M Lee	Final Draft	Minor amends to numbering and 10.1 FSC – Fire Advisor produces annual report.

Contents

Process flowchart



1.0 Policy Statement & Commitment Fire Safety

The York Teaching Hospital NHS Foundation Trust (Trust) will ensure so far as is reasonably practicable, that the risk from fire will be managed in compliance with the Regulatory Reform (Fire Safety) Order 2005, FIRECODE and other appropriate legislative requirements and guidelines.

The management of any identified fire risks will be undertaken in such a way as to prevent injury or ill-health to Trust employees, patients, visitors, contractors or others who may be affected by its activities.

The Chairman, Chief Executive and Board of Directors are fully committed to providing a safe environment for patients, service users, employees and visitors. This is achieved through a framework of policies and procedures ensuring that all Trust premises meet the statutory and mandatory fire safety standards.

The Trust recognises that their employees are paramount to the effective management of fire safety and will therefore ensure that they are given the appropriate information, instruction, training and supervision to enable them to undertake their roles & responsibilities. It is also recognised that employees and contractors have a responsibility to ensure the safety of themselves and others who may be affected by their acts or omissions.

The Trust will ensure that all of its employees and contractors are made aware of this requirement; in particular to comply with all current fire safety legislation and procedures.

When commissioning or leasing new buildings, the Trust will ensure that they comply fully with current fire safety legislation.

The Trust has in place, systems which ensure that any policy is regularly reviewed; in this case a biennial review as a minimum or when required to do so by any change in legislation, or if there should there be any other reason to do so.

The safety of all personnel and the minimising of identified risks remains paramount in the Trust risk management of fire safety strategy, the Trust will ensure that adequate resources are made available to enable its effective implementation.

This policy forms part of the Trust's overall risk management strategy.

2.0 Introduction & Scope

The Regulatory Reform (Fire Safety) Order 2005 – (RRO) sets out in detail the roles and responsibilities for those charged with fire safety management in any organisation. The order is enforced by the local fire authority and failure to comply with any aspect of the order can result in significant fines, enforcement action or even custodial sentences.

This policy outlines the framework of measures in place to ensure effective fire safety management; including roles, responsibilities and arrangements. The policy is applicable to all York Teaching Hospital NHS Foundation Trust properties and includes all other premises leased or occupied by the Trust and its employees.

The purpose of this policy is to ensure there are effective systems for the management of fire safety in place across all York Teaching Hospital NHS Foundation Trust premises. The policy applies to all persons connected to or employed by the trust, including; agency staff, patients, contractors, regular visitor's, voluntary workers and any other relevant persons using trust premises to operate a business.

3.0 Equality Impact Assessment

The Trust' statement on Equality is available in the Policy for Development and Management of Policies at Section 3.3.4.

A copy of the Equality Impact Assessment for this policy is at Appendix A

4.0 Accountability & Responsibilities

4.1 Chief Executive

The Chief Executive is required to clearly define fire safety policies for all premises under their control. They are responsible for ensuring compliance with all current fire safety legislation and have ensured appropriate policies and procedures are in place, to maintain and improve fire precautions throughout all Trust properties. They shall ensure that any policies are reviewed in the light of any changes in working practice and or statutory legislation or for any identified significant risks that have not been addressed and ensure that adequate resources be made available to implement the policy and carry out any remedial action or amendments to this policy.

4.2 Directors of the Board

The Trust Board, as a collective, share the ultimate responsibility/accountability for the general activities of the Trust and should act as a role model for best practice. They should ensure that they have appropriate assurances that all current fire safety legislation is being met and complied with.

4.3 Non Executive Directors

It is the role of Non Executive Directors to promote and champion fire safety at board level; by supporting the Board in fire safety management required across the Trust and, where appropriate challenge the Board on matters of fire safety.

4.4 Board level Director (Responsible for Fire)

The Director for Estates and Facilities has been identified as the individual with a responsibility for championing Fire Safety issues at a board level. They are responsible for ensuring provision is made for the day to day management of fire safety throughout the Trust by the appointment of fire safety managers and advisors across the Trust. They will ensure that the appropriate policies, procedures and audit protocols are in place and reviewed.

In addition, 'so far as is reasonably practicable' should ensure the highest fire safety standards are maintained. Offering support to the designated fire safety teams across the Trust, enabling effective fire safety management.

Presenting an annual fire safety report to the Board and ensuring, where applicable annual certificates of compliance are completed and signed off.

4.5 Fire Safety Manager

The Fire Safety Manager is to be an individual of sufficient seniority within the Trust who will, as a member of the designated fire safety team(s) be responsible to the Director for fire safety. Whilst this role may not be the individual's primary task within the Trust they are to be responsible for the managing and co-ordination of activities in regards to Trust fire safety.

The fire safety manager should have a nominated deputy to assume the duties, during any short period of absence; this will normally be a member of the fire safety team (as appropriate). They are to ensure that an appropriate system for carrying out Trust wide fire risk assessments and for the auditing of their effectiveness is in place.

4.6 Fire Safety Advisor

Providing expert advice on the interpretation of fire safety legislation and guidance to the Trust, including technical support in the interpretation of statutory and mandatory fire safety requirements by:

- Developing and advising on Trust fire safety policy & strategy;
- Ensuring that suitable and sufficient fire risk assessments are carried out and in place for all Trust premises and in addition to carry out any associated reviews where applicable;
- Assist in the development of and, as required, the delivery of a suitable and sufficient training programme;
- Liaising with local authority fire and rescue enforcement personnel regarding fire safety issues within the Trust;
- Liaison with, and advice to directorate and senior management personnel in relation to relevant fire safety issues;
- Act as the nominated deputy to the fire safety manager;
- Develop a suitable & sufficient Trust wide action plan which will prioritise any required actions in respect of improving the overall standard/compliance of fire safety related issues;
- To ensure accurate records of all fire safety related issues are maintained by the Trust.
- Carry out where appropriate any investigation into the cause of fire within the Trust, and to report findings and recommendations to the relevant authorities;
- Produce an annual report on behalf of the Director for fire safety, for submission to the Board, which details the current levels of compliance/non compliance in respect of fire safety issues throughout the Trust;
- Ensure that the annual certificate of compliance is completed and a return submitted by the designated due date;
- To keep up to date their knowledge and skills in regards to fire safety management.

4.7 Directorate Managers (DM)

Directorate managers and senior nursing staff are to ensure that the policy and any associated procedures are implemented and adhered to in their areas of responsibility. In addition they are to:

- Ensure that every member of staff in their directorate attends statutory fire training; DM should act as a role model for best practice in this regard;
- Confirm that fire risk assessments are in place, and that they are reviewed and in date;
- Ensure that any actions, precautions or evacuation procedures placed upon their departments as a result of a fire risk assessment, are addressed and measures for controlling the risk from fire maintained;
- Ensure that their areas of responsibility have a suitable and effective evacuation plan in place and that staff are fully aware of their actions and responsibilities in relation to them;
- Ensure that regular inspections are carried out on any identified or recommended control measures in order to monitor their effectiveness.

4.8 Departmental Managers

Are to monitor and maintain an acceptable level of fire safety based on a risk assessed approach, departmental managers will be responsible for:

- Monitoring the fire safety provisions provided in their areas and for reporting any faults or defects;
- Where it is deemed appropriate have nominated individual(s) who can fulfil the role of fire warden as advised by the Trust(s) Fire Safety management teams;
- Ensure that fire safety standards or provisions within their areas of responsibility are never compromised;
- Ensure that they and their staff are adequately trained in fire safety procedures and are familiar with the contents of this policy.

4.9 Fire Wardens

Fire wardens are to monitor their areas of responsibility and report any problems such as wedged open fire doors, missing extinguishers, or any other fire related maintenance/defects etc.

Upon hearing a continuous alarm tone undertake, if safe to do so, a sweep of their area(s) encouraging personnel to move to a place of safety or to a designated assembly point outside the building.

4.10 Employee Responsibilities

All employees share a collective responsibility and “Duty of care” not just for themselves but for others with respect to fire safety and therefore must take care in respect of their acts and omissions.

All employees are required to participate as requested in the fire risk assessment process and are to comply with the arrangements made to control risks from any identified fire hazards. In addition they are to:

- Attend any mandated statutory fire safety training;
- Be familiar with the relevant contents of this policy and the day to day observation of general fire safety precautions;
- Ensure their actions do not compromise any fire safety provisions provided in their place of work;
- Promote and be pro-active in the implementation of good fire safety practices;
- Be aware of their individual roles and responsibilities in an emergency situation and to follow any instructions given to them by their Line Manager, Fire Warden or any other person in authority;
- Report any deficiencies in fire safety provisions or bad practice to their line manager or directly to the trust's fire safety advisor where appropriate;
- Maintain good housekeeping standards in relation to the accumulation of rubbish particularly in and around designated escape/evacuation routes and exits.

4.11 Hospital Support Team

At each site/location within the trust a team of staff will be identified to support the nominated responsible person for fire on that site. Upon any fire alarm activation they will assist in supporting and liaison with the fire services providing site specific information and advice.

The team are under the direct control of the nominated person for fire prior to arrival of the fire service at which point the fire service will take the lead.

The support team may consist of one or more of the following personnel:
Site Co-ordinator / Bed Managers
Fire Safety Manager or Advisor
Specialist Managers
Porters
Estates or contracted engineers
Security personnel
Local Managers
Nominated staff
Fire Wardens

The team will liaise with the responsible person at the incident and offer assistance if evacuation is required and specialist advice when requested.

4.12 Estates / Capital Projects

Estates management (including capital projects) will where appropriate, consult the Trust Fire Safety Advisor and or Manager on matters concerning the design of any new building, the redevelopment or the redesign of any building or area in relation to passive and active fire safety, this may include installed fire alarm systems, automatic fire detection, fire-fighting equipment and emergency lighting. This consultation should remain extant for all new and existing buildings in order to ensure compliance with relevant legislation.

4.13 Fire Safety Committee

The Fire Safety Committee(s) shall be responsible for the review of all trust wide & regional fire safety related issues. The committee(s) will meet at quarterly intervals

as a minimum throughout the year. Standard agenda items for discussion will include:

Fire Incidents
Unwanted Fire Signals
Enforcement Action (Where applicable)
Staff Training
AIR's relating to fire

The FSC will provide terms of reference for its members, minutes and where appropriate Exception Reports which are to be taken forward to the appropriate H&S committee(s).

Reports and minutes of these meetings are to be maintained as evidence that the trust is managing fire safety in line with the trust policy and fully reflects the requirements of the Regulatory Reform (Fire Safety) Order, FIRECODE and other associated guidance.

4.14 Trade Union & Employee Representatives

On occasion make representation to the employer on behalf of members or staff groups in relation to any health, safety or welfare issues and as deemed appropriate represent members in consultation with any enforcing authority such as Local Fire & Rescue Services.

5.0 Fire Safety Policy Arrangements

5.1 Trust Wide Fire Safety

The Trust recognises that the activities undertaken by its employees are varied and are undertaken throughout many premises and locations across the organisation. As far as is reasonably practicable, systems and procedures for fire safety should afford the highest standards of safety to people, Trust property and assets.

The task of preventing fire and for ensuring that no one is put at risk is the collective responsibility of everyone. The trust recognises that it has a statutory duty in regard to fire safety throughout the organisation and to best meet this responsibility, it has ensured that a series of supporting organisational and departmental specific procedures have been developed and put into place.

5.2 Fire Safety Arrangements

This policy is supported by local procedural fire safety documentation, as appropriate elements which may be included in these arrangements may be as indicated in the table below. Whilst it will be necessary for all staff members to be aware of key elements within this section namely actions in the event of fire, means of escape etc, those personnel allocated specific roles and responsibilities within the Trust will need a greater knowledge of specific arrangements such as conducting the risk assessments, reviews & training etc.

Action in the event of fire	Fire safety & electrical equipment
Catering fire safety management	Fire safety furnishings & fabrics
Contingency planning	Fire safety inspections reviews & audits

Emergency lighting	Fire service liaison
Evacuation exercises	Emergency planning
Fixed fire-fighting equipment	Flammable liquids transportation, storage & use
Management of contractors	Fire alarms & detection
Means of escape	Fire investigation & reporting
PEEPs	Fire plans
Extinguishers	Fire risk assessments
Security against arson	Training

5.3 Premises with more than one employer

Where the Trust has shared occupancy of a premise with another employer, each employer is to be made responsible for managing fire safety within their own designated areas. There must be a formal arrangement put in place to share information about any identified risks or emergency procedures. Each employer must cooperate fully with the other to ensure fire safety within the premises is not compromised.

6.0 Consultation, Assurance and Approval Process

This policy is prepared in consultation with the Fire Safety Advisors, Fire Safety Managers and Director responsible for fire safety. The policy will be placed before the relevant committee for consultation, comment and endorsement. This policy will be reviewed and endorsed by the Trust Health and Safety Committees and the Health & Safety Non Clinical Risk Group (HSNCRG) prior to Trust Board presentation and approval.

The Fire Safety Advisors will consult with the Local Authority Fire Brigade (LAFB) and inform them of the new policy and it's procedures before it is fully implemented across the Trust

6.1 Assurance

Following consultation with stakeholders and relevant consultative committees, this policy has been reviewed and published by the Trust Compliance Unit.

6.2 Approval Process

Following completion of the consultation process, this policy, and any subsequent policy revisions will require the approval fire safety advisors / managers and nominated Director to ensure this policy is submitted to the appropriate committee for approval.

7.0 Review and Revision Arrangements

The date of review is given on the front coversheet. This policy will be reviewed biannually or earlier should there be a legislative or any other reason to do so; once reviewed the HSNCRG & as appropriate Trust Board will consult and ratify this policy.

The review of this policy will be in conjunction with those named in section 5 above. The Compliance Unit will notify the author of the policy of the need for its review six months before the date of expiry. On reviewing this policy, all stakeholders identified in section 5 will be consulted.

Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the appropriate committee as determined by the Policy for Development and Management of Policies.

8.0 Dissemination and Implementation

8.1 Dissemination

Once approved, this policy will be brought to the attention of relevant staff as per the **Policy for Development and Management of Policies**, section 8 and Appendix C - Plan for Dissemination .

Additionally, the policy and procedure will also be directly emailed to all Directors, Directorate Managers, Clinical Directors, Senior Managers and Matrons for them to be advised of and to act accordingly. Staff will be made aware of the new version through Team Brief and the "Risky Business" Newsletter. It will be included in the Health and Safety/Risk Management mandatory training sessions. The Policy should be discussed with all staff at the local induction.

This policy can be made available in alternative formats, such as Braille or large font, on request to the author of the policy.

8.2 Implementation of Policies

This policy will be implemented throughout the Trust by the Directors, Directorate Managers and Department Managers.

This policy is available on the Trust's Intranet site and the contents are covered in Mandatory Training.

9.0 Document Control and Archiving

The register and archiving arrangements for policies will be managed by the Compliance Unit. To retrieve a former version of this policy the Compliance Unit should be contacted.

10.0 Monitoring Compliance and Effectiveness

This policy will be monitored for compliance with the minimum requirements outlined below.

The monitoring of this policy is achieved through the findings obtained through the implementation of the Annual Health and Safety Audit (fire safety), inspections and supported by the individual monitoring processes of those relevant polices referred to in this document.

These findings and those of the audit process will be presented in an Annual report to the Trust Health, Safety and non-Clinical Risk Group and summarised to the Trust Board.

10.1 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and to ensure that the minimum requirements are met, the policy will be monitored as follows:

Evidence	Monitoring /Who by	Frequency
Annual Fire Risk Assessments and treatment plans	Divisional managers/Heads of Department	Annually as per Risk Management Policy & Procedure
Incidents DATIX AIRS (Fire incidents) Relevant Committees / Groups documentation eg Fire Committee	Divisional managers/Heads of Department, Fire Advisor & Fire Manager Fire Safety Advisor to produce the annual report, to be received by the Fire Committees, Trust NCRG & Trust Board	Ongoing Annually
Area Inspections OH&S Audit (Fire Safety)	Divisional Managers/Heads of Department Fire Managers / Fire Advisors	Monthly (as defined) Annually
Fire Safety Training reports provided by CLaD	CLaD/Divisional Managers/Heads of Department & Fire Advisors	Annually
Reports from regulatory bodies such as fire inspections and findings	Fire Safety Committees & Non Clinical Risk Group	As undertaken

11.0 Standards & Fire Safety Performance Indicators

These have been developed by the Trust Fire Safety Advisors and will be approved by the Fire safety Committee(s) and Health, Safety and non-Clinical

Risk Group. They will include assessments, inspections, Audits and statistical information.

The key aims are to reduce Fire risks so far as is reasonably practicable and to provide a safe working environment for staff, patients, visitors and others by achieve a positive Fire Safety culture through communication with all stakeholders on fire Safety issues.

To achieve excellence in the Management of Fire Safety through compliance with statutory duties and continuous improvement.

12.0 Training

See section 11 of the **Policy for Development and Management of Policies** for details of the statutory and mandatory training arrangements.

All Trust employees will be informed of the trust fire safety arrangements as part of defined Trust induction and ongoing trust safety training programmes.

13.0 Trust Associated Documents

YHFT (CORP.@@@@) Health and Safety Policy
YHFT (CORP.RL10) Policy for the Development and Management of Policies
YHFT (CORP.RL1) Adverse Incident Reporting System, (AIRS) Policy and Procedure
YHFT (CORP.Rl5) Risk Management Policy & Procedure
YHFT (CORP.RL11) SUI Policy

Other Fire Safety related Trust policies - stored on QPulse and available via Staffroom.

14.0 External References

Regulatory Reform (Fire Safety) Order 2005;
Health & Safety at Work Ect Act 1974;
Management of Health & Safety at Work Regulations 1999;
Human Rights Act 1998
Fire code (2006);
Health & Social Care Act 2008 (Regulated Activities) Regulations 2009;
The Disability Discrimination Act (2005);
The Building Regulations 1991;
HM Government Fire Safety Risk Assessment Guidance: Healthcare Premises (Green Guide);
HM Government Fire Safety Risk Assessment Guidance: Means of Escape for Disabled People (2007);
British Standards Institute. (2001). British Standard 8300:2001, Design of buildings and their approaches to meet the needs of disabled people – Code of Practice. London: BSI.

15.0 Appendices

Appendix A **Equality Impact Assessment**

Appendix B **Checklist for Review and Approval**

Appendix C **Dissemination Plan**

Appendix A: Equality Impact Assessment Tool

To be completed when submitted to the appropriate committee for consideration and approval.

Name of Policy:	Fire Safety Management Policy

1.	**What are the intended outcomes of this work?** The policy sets out the process for the Trust for effective Fire Safety management across all sites.	
2	**Who will be affected?** All staff, visitors, patients and public etc.	
3	**What evidence have you considered?** Legislative compliance, NHSLA requirements, CQC Essential Standards of Quality and Safety and advice from the Inclusivity Lead.	
a	**Disability -** The policy is inclusive	
b	**Sex -** The policy is inclusive	
c	**Race** - The policy is inclusive	
d	**Age** .- The policy is inclusive	
e	**Gender Reassignment** - The policy is inclusive	
f	**Sexual Orientation -** The policy is inclusive	
g	**Religion or Belief** - The policy is inclusive	
h	**Pregnancy and Maternity -** The policy is inclusive	
i	**Carers** - The policy is inclusive	

j	**Other Identified Groups** -The policy is inclusive	
4.	**Engagement and Involvement** The policy is inclusive	
a.	Was this work subject to consultation?	See below
b.	How have you engaged stakeholders in constructing the policy	See below
c.	If so, how have you engaged stakeholders in constructing the policy	See below
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs Engagement and involvement of the development of the policy has included relevant staff at all sites within the Trust, relevant Executive Directors and the Trust's Inclusivity Lead.	
5.	**Consultation Outcome** The policy conforms to the requirements of the Policy for the Development and Management of Policies, relevant legislation and the requirements of the relevant CQC Outcomes and NHSLA RMSAT. *Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups*	
a	Eliminate discrimination, harassment and victimisation	The policy is inclusive
b	Advance Equality of Opportunity	The policy is inclusive
c	Promote Good Relations Between Groups	The policy is inclusive
d	What is the overall impact?	The policy is inclusive
	Name of the Person who carried out this assessment: Mick Lee / Kevin Hudson	
	Date Assessment Completed February 2013	
	Name of responsible Director Brian Golding	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Committee, together with any suggestions as to the action required to avoid/reduce this impact.

Appendix B Checklist for the Review and Approval

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1	**Development and Management of Policies**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or procedures?	Yes	
2	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Has an operational, manpower and financial resource assessment been undertaken?	Yes	
4	**Content**		
	Is the document linked to a strategy?	Yes	
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Are local/organisational supporting documents referenced?	Yes	
5a	**Quality Assurance**		
	Has the standard the policy been written to address the issues identified?	Yes	
	Has QA been completed and approved?	Yes	
6	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have the staff side committee (or equivalent) approved the document?	Yes	
7	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable?	Yes	
11	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name	Brian Golding	Date	February 2013
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Chief Executive	Date	
Signature			

Appendix C Plan for dissemination of policy

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	**Fire Safety Management Policy**
Date finalised:	**February 2013**
Previous document in use?	**Yes**
Dissemination lead	**Mick Lee & Kevin Hudson**
Which Strategy does it relate to?	**Risk Management**
If yes, in what format and where?	**Electronic and Paper via Intranet**
Proposed action to retrieve out of date copies of the document:	**Compliance Unit will hold archive**

Dissemination Grid

To be disseminated to:	**1) All Staff**	**2) Risky Business**
Method of dissemination	**Posted on Staffroom**	**Article**
who will do it?	**Compliance Unit**	**Mick Lee**
and when?	**After ratification**	**After ratification**
Format (i.e. paper or electronic)	**Electronic**	**Electronic**

Dissemination Record

Date put on register / library	
Review date	**February 2015**
Disseminated to	**All staff**
Format (i.e. paper or electronic)	**Electronic**
Date Disseminated	
No. of Copies Sent	
Contact Details / Comments	**Policy will also be shared with all staff as per section 8.1 by Mick Lee & Kevin Hudson**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 24 April 2013

Sustainable Development Annual Report

Action requested/recommendation

The Board is asked to:

- support the formation of a Trustwide Sustainable Development Group
- start to challenge business cases to ensure that sustainability has been considered.

Summary

The report updates the Board on achievements at York and Scarborough relating to sustainable development over the last 12 months. Post acquisition it proposes the establishment of a Trustwide Sustainable Development Group, with membership drawn from across the organisation, and considers some key objectives for that 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 report does not contain any implications for equality and diversity.

Reference to CQC outcomes

There is a passing reference to Outcome 10 – safety and suitability of premises.

Progress of report	Board of Directors April 2013
Risk	The proposed Trustwide Sustainable Development Group will identify and manage risks associated with the sustainability agenda.
Resource implications	Detailed within the report – no new resources required.

Owner	Brian Golding, Director of Estates and Facilities
Author	Brian Golding, Director of Estates and Facilities
Date of paper	April, 2013
Version number	1.1

Board of Directors – 24 April 2013

Sustainable Development Annual Report

1. Introduction and background

Sustainable development remains one of the highest priorities and biggest challenges facing the NHS.

During the last 12-18 months, significant management resource has been consumed ensuring a smooth acquisition of the Scarborough and Community estate. The sustainable development group has not met formally during that time, although a number of initiatives have been progressed.

This report sets out the key achievements during the last 12 months, proposes the establishment of a new Trustwide Sustainable Development Group and outlines the key objectives of that group.

2. Achievements during the last 12 months

York

1. Reduction in the Sulphur content of our fuel oils to comply with EU regulation.

2. Reduction in our volume of waste produced. A new contract has been awarded for the disposal of clinical waste.

3. Significant improvements have been made in relation to Carbon Reduction Projects , some examples are listed below :

    - Reduced transformer voltages
    - Ongoing lamp replacement programme
    - Building Management System and controls replacement programme
    - Ongoing replacement of more efficient steam traps
    - Re-commissioned Air Handling Unit heating battery flow rates
    - Effective energy procurement strategy delivered.
    - Supplier Automatic Meter Reading, (AMR) to be provided for all properties by March 2013.
    - Utility cost/usage management software development strategy to be completed by March 2013, including paperless billing and enhanced reporting
    - Lift replacement programme with higher efficiency equipment.

Scarborough

1. Carbon reduction projects included:
    - Low energy lighting project installed in North wing
    - DTI Knowledge Transfer Partnership with the Institute of Energy and Sustainable Development completed Jan 13
    - New Photo-Voltaic power scheme planned for the South wing at SGH (to be delivered in 2013/14)
    - Introduced the Short Term Operating Reserve, (STOR) scheme in conjunction with

the local electricity network
- Planning completed for a new heat plate exchanger at SGH to improve hot water system efficiency
- Refreshed the locality Green Transport Plan
- Wind turbine / RHI study completed at BDH

Trustwide

1. A new section has been included in all business cases requiring authors to consider the sustainable development consequences of their proposals. Although not yet well understood, this will gain importance in future proposals.
2. Utilities management has been centralised at York.

3. Establishment of a Trustwide Sustainable Development Group.

Following acquisition, it is now appropriate to establish a new Trustwide group that will lead this agenda.

Proposed Membership

The following membership is proposed:

- Director of Estates and Facilities, Chair
- Head of Estates and Facilities
- Lead for Transport
- Lead for Waste Management
- Programme Director, Estate Development
- Head of Procurement
- Directorate Management representative
- Nursing representative
- Senior Finance Manager
- Foundation Trust Governors
- Local authority sustainable development leads

2013/14 objectives

The first meeting of the group will be held in June 2013. The key objectives will include:

- Establish Group's Terms of Reference and membership.
- Monitior the award of a 15 year Carbon Energy Fund contract to reduce carbon emissions form energy usage.
- Canvas each directorate for sustainability champions and formulate specific subgroups to tackle key issues, run campaigns and raise local awareness.
- Establish, and maintain a Sustainable Development Management Plan.
- Coordinate the adoption of the NHS Carbon Reduction Strategy (2009) for England.
- Adopt the Good Corporate Citizenship Assessment Model on behalf of the Trust, and carry out regular reviews of performance.
- Monitor production of a Trustwide Green Travel plan.
- Review feasibility study into railway halt at York Hospital.
- Ensure capital schemes give consideration to ensure design for reduced operating cost is firmly embedded in the capital project process.

4. Conclusion

Successfully embracing and implementing Sustainable Development will deliver the triple wins of:

- Reducing our environmental impact.
- Reducing our operating costs.
- Protecting our reputation.

Sustainable Development is a challenging Trust wide concept and over the last twelve months our challenge has been extended by the take over of the adjacent Scarborough Trust and Community services.

Commitment at the top of our organisation remains essential in order to deliver our stated Sustainable Development obligations and opportunities.

Our Trust must extend and promote a steadfast determination to deliver the Sustainable Development agenda. This is our 2013/14 challenge.

5. Recommendation

The Board is asked to:

- support the formation of a Trustwide Sustainable Development Group
- start to challenge business cases to ensure that sustainability has been considered.

6. References and further reading

NHS Sustainable Development Unit, www.sdu.nhs.uk sets out the NHS strategy for sustainable development.

Author	**Brian Golding, Director of Estates and Facilities**
Owner	**Brian Golding, Director of Estates and Facilities**
Date	**April 2013**