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 25th June 2014**
in: **The Blue Conference Room, Scarborough Hospital**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Seminar Room Postgraduate Centre Scarborough Hospital	Non-executive Directors
9.15am – 12.10pm	**Board of Directors meeting held in public**	**Blue Conference Room Scarborough Hospital**	**Board of Directors and observers**
12.10pm – 1.15pm	Board of Directors to consider confidential information held in private	Blue Conference Room Scarborough Hospital	Board of Directors
Lunch			
2.00pm – 3.25pm	Risk Management Training	Blue Conference Room Scarborough Hospital	Board of Directors
3.30pm-4.30pm	Remuneration Committee	Blue Conference Room Scarborough Hospital	Non-executive Directors

The values, drivers and motivations of the Trust are:

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

These will be reflected during all discussions in the meeting

Restricted – Management in confidence

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

On: **Wednesday 25th June 2014**

At: **9.15am – 12.10pm**

In: **The Blue Conference Room, Scarborough Hospital**

A G E N D A					
No	**Item**	**Lead**	**Comment**	**Paper**	**Page**
Part One: General **9.15am – 9.45am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for Absence** Ms L Raper Dr A Turnbull Mr M Proctor Mrs S Rushbrook	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 28th May 2014.	Chairman		B	11
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman			
6.	**Patient Experience** Patient Experience from a community perspective.	Director of Nursing		Verbal	

No	Item	Lead	Comment	Paper	Page
Part Two: Quality and Safety 9.45am – 10.30am					
7.	**Quality and Safety Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Patient Safety Dashboard • Medical Director Report • Duty of Candour • Chief Nurse Report • Annual update from pressure ulcer reduction programme • Estates and facilities issues directly related to quality and safety	Chairman of the Committee		C C1 C2 C3 C4 C5 C6	23 31 53 63 69 91 105
8.	**Safer Staffing Project – NHS England Nurse Staffing Return** To approve the return.	Director of Nursing		D	113
9.	**Review of Patient Experience Service** To consider the proposed paper and approve the recommendations.	Director of Nursing	Dianne Willcocks	E	125
Part Three: Finance and Performance 10.30am – 11.00am					
10.	**Finance and Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Operational Performance Report • Finance Report • Trust Efficiency Report	Chairman of the Committee		F F1 F2 F3	153 163 169 181

No	Item	Lead	Comment	Paper	Page
Part Four: Workforce 11.00am – 11.10am					
11.	**Workforce Strategy Committee issues** To be advised by the Chairman of the Committee of any specific issues to be discussed.	Chairman of the Committee		G	191
Part Five: Strategy Work 11.10am – 11.25am					
12.	**5 year Strategic Plan** To approve the 5 year strategic plan prior to submission to Monitor.	Director of Corporate Development	Philip Ashton	H (to follow)	
Part Six: Governance 11.25am – 11.45pm					
13.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		I	203
14.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		J	207
15.	**Corporate Governance Statement** To approve the statement in advance of submission to Monitor.	Foundation Trust Secretary		K	211
Part Seven: Business Cases 11.45am - 11.55am					
16.	**2012-13/75: Interim Cardiology Developments**	Director of Finance	Mike Keaney	L	223
Any other business					
17.	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 30th July 2014 in the Boardroom York Teaching Hospital.				

18.	**<u>Any other business</u>** 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.

York Teaching Hospital NHS
NHS Foundation Trust

Additions: No additions

Changes: No changes

Deletions: No deletions

A

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	Nil
Mr Philip Ashton (Non– Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Member of the Board of Directors—** Diocese of York Education Trust	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 **Chairman and Director -** Leeds College of Music	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 and Joseph Rowntree Housing Trust **Chair—**Advisory Board, Centre for Lifelong Learning University of York **Member—**Executive Committee YOPA **Patron—**OCAY **Chairman** - City of York Fairness and Equalities Board **Member –**Without Walls Board	**Director—**London Metropolitan University **Vice Chairman—**Rose Bruford College of HE	Nil
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
Mrs Sue Holden ***Executive Director of Corporate Develop-ment***		**Director –** SSHCoaching Ltd		**Member -**Conduct and Standards Committee – York University Health Sciences **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	**Member** of the NHS Elect Board as a member representa-tive	Nil
Mr Mike Proctor ***(Executive Director Deputy Chief Executive, COO and Chief Nurse***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Spouse a senior member of staff in Community Services	Nil

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Boardroom, The York Hospital, on 28 May 2014.

Present:

Non-executive Directors

Mr A Rose	Chairman
Mrs J Adams	Non-executive Director
Mr P Ashton	Non-executive Director
Mr M Keaney	Non-executive Director
Ms L Raper	Non-executive Director
Mr M Sweet	Non-executive Director
Professor D Willcocks	Non-executive Director

Executive Directors

Mr P Crowley	Chief Executive
Mr A Bertram	Executive Director of Finance
Mr M Proctor	Deputy Chief Executive/Chief Operating Officer/ Chief Nurse
Mrs S Holden	Executive Director of Corporate Development & Research/Interim Director of HR
Dr A Turnbull	Medical Director

Corporate Directors

Mrs B Geary	Corporate Director of Nursing
Mr B Golding	Corporate Director of Estates and Facilities
Mrs S Rushbrook	Corporate Director of Systems and Networks

Attendance:

Mrs A McGale	Director of Ops (Scarborough), for item 14/080
Mrs A Pridmore	Foundation Trust Secretary
Mrs W Scott	Director of Community Services, for item 14/084

Observers: 3 Governors and a member of the public.

14/077 Apologies for absence

There were no apologies for absence received by the Board.

14/078 Declarations of Interests

The Board of Directors **noted** the current list of interests declared. The Board were reminded that if there were any changes to the interests declared they should advise Mrs Pridmore.

14/079 Minutes of the meeting held on the 30 April 2014

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

14/080 Matters arising from the minutes

14/061 Matters arising - Chief Executive Report – Perfect Week (Scarborough)

Mr Rose invited Mrs McGale to provide a short update to the Board on the 'Perfect Week'. She advised that the week had been very good and had focused on changing culture in terms of attention to detail, using escalation processes and communication.

The Emergency Department had seen its highest attendance for the whole year during the week. The week had focused on discharging patients and increasing the number of discharges during the year. The command structure that had been put in place had been effective and meant that the hospital felt quieter than would have been expected. The pledges identified by the departments were very successful. Mrs McGale added that Mrs Rushbrook's input around Clinical Patient Database (CPD) had been invaluable. Housekeepers were also working differently and again this was very successful and released nursing staff to undertake other roles. The introduction of the Ward Liaison Officers (WLO) was also successful. An additional benefit to those staff who acted as WLO was that most were non-clinical staff and they all saw this as an excellent opportunity to gain more understanding of how a ward works and what nursing staff do. The other significant change was that Local Authority (LA) staff were based in the hospital. Ward staff confirmed that the introduction of the LA staff on site made a big difference to the arrangements for the discharge of patients. The active support of the commissioners, mental health trust, Yorkshire Ambulance Service and other stakeholders and partners was important to the success of the week.

Mrs McGale advised that she and colleagues would be reviewing the outcomes from the 'Perfect Week' and prepare a report for presentation to the Board in July. Lessons learned may well assist the enhancement of flows at the York site too.

Action: Mrs McGale to prepare a report for presentation to the Board in July.

Mr Proctor added that he had noticed a real buzz around the hospital during the week. New relationships had been formed by staff working in different environments and with people they don't normally work with. It was clear that nursing staff saw the benefits of earlier discharges. The next stages that Mrs McGale is now moving into in terms of reviewing the findings will inform what resources need to be put in place.

Professor Willcocks added her thanks and appreciation for the work and leadership shown by Mrs McGale. She added that the multi-disciplinary team work between the Trust, CCG and social services was excellent and showed real professionalism.

Mr Crowley echoed the comments made by Professor Willcocks and added that he was overwhelmed by the planning and leadership. He felt that momentum grew during the week. He added that this is now the second major initiative the Trust has undertaken recently. The first being the transfer of orthopaedics from Scarborough Hospital to Bridlington Hospital, and the second being the 'Perfect Week'.

The Board thanked Mrs McGale for all her work around making the 'Perfect Week' such a success.

Mrs McGale left the meeting.

14/081 Patient Experience – Patient Experience Team

Mrs Geary explained the work that had been undertaken in reviewing the Patient Experience Team. She explained that this had included looking at the Patient and Public Involvement (PPI) and the Patient Experience Team in the wider sense. She advised that the review had been supported by the Corporate Improvement Team and was now complete. The principles maintained throughout the review were around bringing the two teams (York and Scarborough) together and taking areas that demonstrate good practice and facilitating their implementation across the organisation. Mrs Geary gave the example of the Head and Neck Directorate, which is seen as maintaining good practice in terms of patient experience. She added that the intention is to continue with the very senior oversight of complaints and to provide more training about the management of complaints to managers. The final element is to ensure the revised Department provides more support to community services and that they can facilitate more public involvement. These principles have resulted in a review of skills mix and looking at working more closely with some other departments, such as the Risk and Legal Team.

Mrs Geary advised that the report will be presented to the Patient Experience Group in the next couple of weeks and will be presented to Board in June.

Action: Mrs Geary to present the report on the review of Patient Experience Team.

14/082 Quality and Safety Committee

Ms Raper highlighted the key points from the meeting and advised that there were a small number of areas where she would like the leads to provide more detail to the Board.

Safer Staffing – Mrs Geary explained that there have been a number of changes to the timescales and expectations since she reported to Board on the item in April. Mrs Geary explained the changes and advised that the submission of the prescribed data was now the number of nurses against the planned number, day and night, by the hour. This information would be published on the Trust's and NHS Choices website. The information on NHS Choices would be RAG (red, amber, green) rated, although no definition has been provided yet as to what red, amber, green means. The information is required to cover up to 31 May 2014 and has to be uploaded to the centre by 10 June. It will be RAG rated and published on 24 June. During that period the Trust does have an opportunity to adjust the information if it is found to be necessary. Mrs Geary confirmed that she was working with the HR Department and the Information Department to ensure the information is captured.

Professor Willcocks asked if there would be an opportunity to add a narrative to the information. The Board agreed this would be important to ensure the context of the figures was understood by the reader. The Board debated the point and it was agreed that once the narrative had been developed it would be circulated to all Board members for comment.

Action: Mrs Geary to ensure the narrative for the safer staffing information is circulated to all Board members in advance of its publication.

The Board discussed the cost implications of this work and the value it will give the public. The Board noted the view of Chief Nurses around the country was that the system was to complex and it was not clear what it was going to tell people. Mrs Holden added that no national system has been provided to support the system, which means that it is the interpretation of local Trusts that will be published, rather than creating a national picture.

The Board **agreed** that the information should continue to be reviewed by the Quality and Safety Committee, which is always held before the publication date.

Dr Turnbull advised that NICE were about to publish a report on evidenced-based guidelines on staffing levels. Specifically, in June, it would be safer staffing on adult wards and later in the year staffing on maternity wards. He added that the guidelines were not taking the simple model of 1:8, but were looking more holistically at other factors.

Family and Friends data

Ms Raper referred the Board to the Patient Safety and Quality Report and the Friends and Family information included in the report. She thanked Mrs Geary for the additional information.

Draft Quality Report

Ms Raper advised that the Committee had reviewed the draft report and had agreed some changes to the priorities for 2014/15, which had now been included in the document. She explained that the Committee had agreed four basic principles to follow:

- Demonstrate continuous improvement
- Focus the report
- Benchmark wherever possible
- Converge with the Patient Safety Strategy

She added that she was looking for the report to increase the number of patient experience priorities in the future, so that there is a better balance.

Ms Raper advised that the Patient Safety Strategy had been held over from the meeting today as a result of the discussions held at the Quality and Safety Committee. It was expected that the report would be included in the Board papers for June.

Action: Patient Safety Strategy to be included in the Board papers for June.

Dr Turnbull added that the document is in its final form and he was grateful to the Committee for taking ownership of the strategy.

Mr Rose asked if the regulators, our peers and stakeholders would have a view on it. Dr Turnbull explained that he would expect it to be reviewed by CQC as part of a regulator visit. He added that he would hope that the CCG would use it.

Mr Crowley explained that the intention was to launch the strategy at the Annual General Meeting.

Mr Rose asked if the Quality and Safety Committee wanted to raise any issues about any particular metrics to the Board. Ms Raper confirmed the Committee did not want to raise any in particular.

Mrs Adams raised the point that the Committee had reviewed the most up to date National Reporting and Learning System data and it was clear that there was a link to the Duty of Candour. The report showed there had been 500 incidents in the period covered by the report and asked if it would involve the Trust notifying each patient of the incident. Dr Turnbull advised that the "being open" policy was currently being audited and there was work being undertaken to look at how the Trust captures that the patient has been advised. At present the discussion is included in the patient notes, but there needs to be a central system developed. The review is looking specifically about how this can be done electronically.

The Board **noted** the comments from the Quality and Safety Committee and the assurance given by them.

14/083 Finance and Performance Committee

Mr Sweet referred to the notes from the committee meeting and highlighted the progress being made around the acute strategy. He advised that there was excellent progress being made and some projects were coming to fruition. He suggested that the Board might consider having a presentation from Mrs Booth as part of an afternoon session in the near future.

Mr Sweet referred to the comments on the Efficiency Report included in the board pack. He advised that the performance in month 1 was ahead of the same point last year at £1.7m, but £1.8m behind the Monitor plan. Mr Sweet asked Mr Bertram to explain the reasons for that. Mr Bertram explained how the year position was reported and how the in month position impacted on the trust performance.

Mr Sweet commented that the Committee had reported to the Board last month that there was a planning gap of £2.3m in the current year plan. This gap has grown to £6.2m, and the Committee has asked for detailed information around the full 4 year plans.

Mr Sweet also referred the Board to the two additional papers the Committee had received – one on the management of vacancy factors and one on the impact of increased staffing levels. He confirmed that the Committee was assured by the discussion and the information included in the reports.

Mr Sweet also commented that the Committee had noted that there were a small number of directorates with a poor record of achieving cost improvement programmes; he advised that the Committee had asked to see the action plans associated with those directorates at the next meeting.

Mr Sweet referred to the Access Targets. He commented that the Trust had achieved the 18 week target on an aggregate basis, but there had been some specialities that had failed. He added that work continues to bring down the number of patients waiting more than 36 weeks.

Mr Proctor reminded the Board that the Intensive Support Team had not reported to the Trust following their visit, but he was expecting some interesting outcomes from their report and some insight into how the Trust and commissioners could work differently. He did expect it to be available so it could be included in the June Board papers.

Action: Mr Proctor to include the Intensive Support Team report as part of the Board papers for the June meeting.

Mr Sweet referred to the continuing issues around the delivery of the breast symptomatic service at Scarborough. He advised the Committee understood that the recruitment process was underway. Dr Turnbull advised that the market for this type of speciality is very thin at the moment, as a result the Trust has been reviewing how the service is delivery and is in the process of changing the model to ensure the issues are addressed and the two days of service can be provided at Scarborough. The Board asked if patients had been given the opportunity to have the appointment in York, Dr Turnbull confirmed they had, but they had chosen to wait.

Mr Sweet noted that there had been an increase in the number of referrals on the 14 day pathway, but there had not been a corresponding increase in diagnosis. He asked if it could be confirmed if the Trust was speaking to the commissioners about this. Mr Proctor confirmed that it was being discussed with the commissioners. He added that the commissioners had been specifically asked if they were happy with the number of referrals and, if not, if they could undertake some further education with the GPs.

Mr Sweet referred to the Emergency Department results – he noted that the results were good for quarter 4, but unfortunately there had been some stress in the system and the Trust had not achieved April targets. There had also been an increase in the number of occasions penalties had been levied by the Yorkshire Ambulance Service during the month.

Mr Proctor added that the results in May may be worse. He explained that this is in part due to the funding of the winter initiatives including the middle grade doctor and the out of hours service ceasing. Mr Rose asked what the implications would be if the Trust failed ED this quarter. Mr Crowley advised that Monitor would obviously wish to understand the reasons and take the issue in context. He added that he had received advanced notice that Monitor would like to discuss the 18 week performance which was a “planned fail” notwithstanding that they were notified of in advance.

Mr Rose also enquired if Scarborough had achieved the ED target during ‘Perfect Week’. Mr Proctor confirmed that they had not achieved the type 1 part. The Board discussed the reasons for this and noted that it had been a challenge in York over the last month too. Mr Proctor advised that levels of activity are still very high and admission avoidance schemes are up and working.

Dr Turnbull added that there is the added challenge that recruitment to middle grade doctors and consultants to Emergency Medicine is very difficult, as it is not seen as an attractive area of medicine.

The Board was reminded that there was no science behind the target of 95% when it was set. However, breaches represent an opportunity to build relationships with other stakeholders in identifying how all parties can work differently.

Mr Sweet referred to the Commissioning for Quality and Innovation (CQUIN) schemes for 2014/15. He advised that there were fewer schemes this year and although all the schemes had been agreed not all the fine detail had been. The value of the schemes for 2014/15 was £9m. Two of the schemes were related to dementia screening and post-take reviews. It was noted that the Trust had achieved the target in York last year and that a senior clinician out of the current cohort had been appointed to take this forward in Scarborough. Dr Turnbull explained in terms of the post-take reviews the target was set at 12 hours for patients to be reviewed after admission. This was a challenge outside the normal working hours and the College of Physicians had proposed that out of normal working hours this time should be extended to 14 hours, but reduced to 6 hours within working hours. The difficulty the Trust has with the 12 hour target is that patients who have come in overnight and are being reviewed next morning should be seen on a clinical needs basis, rather than because by seeing that patient the Trust does not breach the target.

Professor Willcocks asked for the information around the dementia screening to be included in future Medical Director Report. It was confirmed that it would be.

Action: Dr Turnbull to include dementia screening in his Medical Director report.

Mr Sweet referred to the finance report and explained as this was month 1 of the year there was not a significant amount to report. He highlighted that the income and expenditure account showed a planned £0.3m deficit for the month of April. The actual reported position is that of an income deficit against expenditure of £0.7m, resulting in a negative variance of £0.4m against plan.

Mr Sweet asked Mr Bertram to update the Board on the contract position and confirm the year end position.

Mr Bertram advised that the Audit Committee had met the previous day and considered the final accounts as part of its work around the year end. He explained that the position had changed from that reported to the Board in April. This was following the auditing of the accounts where a change to the reported impairments had been identified. The proposed deficit before impairments and adjustments had been reported to the Board in April as £955k. This has now improved to a £49K surplus. He added that he had assured himself, and the auditors had also assured themselves, which this was not a systemic failure; it was just as a result of an error being made with the one off impairment calculation.

Mr Bertram referred to the contract position and advised that the contract have not been signed with any commissioners with the exception of the Local Authorities where there is a two year contract in place. He added that he expected the main contracts to be signed at the beginning of June. He assured the Board that payment mechanisms were in place, so there was no risk to income from the contracts not being signed. The only contract that is still demonstrating some challenges is the specialist commissioning contract, particularly in East Yorkshire, but nationally this is an issue.

Mr Bertram also updated the Board on the national financial position of Trusts. He advised that at quarter 3 about 1/3 of foundation trusts were in deficit and around 1/2 of non-foundation trust acute trusts. He added that as part of the year end each trust will be asked to sign a going concern statement, he is aware that there will be some trusts that will find it very difficult to sign that statement without some assurance from the DoH that some additional support will be available to them.

The Board noted that the physical environment would be changing in York as the new ambulance handover areas were complete and would be open in the near future. The Board asked if the building work had contributed to the drop in performance. It was confirmed that was not the case.

The Board **noted** the comments from the Finance and Performance Committee and the assurance given by them.

14/084 Community Hubs

Mr Rose welcomed Mrs Scott to the meeting. Mrs Scott outlined the progress that had been made with the development of the community hubs. She advised that there had been particular progress at Malton and Selby. A project manager had been appointed to support the programme of work and a Community Programme Management Board had been established which would meet for the first time in June. She explained that the Community Programme Management Board would look at general community business and the development of the hubs.

Mrs Scott advised that progress had been made at Selby, but it was slower. The project group had been formed, but as yet the Selby GPs were not as engaged as Mrs Scott would like. She advised that planning is underway to hold a stakeholder event in June which will describe where the development has got to and what the next steps are.

Mrs Scott advised that there were some challenges that were currently being overcome, specifically the completion of the agreement to share information. She expected that to be completed and agreed by the next meeting on 16 June. There is also work going on to understand how the North Yorkshire County Council views the development and their involvement in it. She explained that there are still some detailed conversations to be had to resolve any concerns or outstanding issues.

In terms of our trust's relationship to the Priory Med community "hub" (based around frail elderly in nursing homes, initially), four areas of work have been agreed:

- Funding of the a community phlebotomy service
- Review of the case manager
- Support for district nurses to not visit homes where the patient is clearly mobile and could attend a clinic
- The setting up of an IV service

Mr Proctor added that primary care, secondary care and social services working together is new and is not how they have worked in the past. It does rely on everyone trusting each other and the recognition that all three partners own any problems.

Mr Crowley added that this part of the development feeds into the vision of the Trust in terms of building on the 'Perfect Week', the Bridlington project and now the community hub models that are being developed. These projects collectively begin to describe how services will be provided in the Trust.

Mrs Scott advised that in terms of the East side of the patch the Trust was in discussion with the CCG around similar approaches. Mr Proctor added that the Trust does hold the community contract and within it has the authority to experiment with different models and importantly it has been recognised that secondary care is central to ensure the delivery in the future.

Some of the challenges on the East Coast and particularly in Scarborough are that a significant number of the GPs will be retiring in the near future and the CCG is experiencing some difficulties in recruiting new GPs into the area.

Professor Willcocks added that she felt the introduction of the WLO during the 'Perfect Week' had shown how different ways of working could be beneficial and make the service more patient-centric.

Mr Rose thanked Mrs Scott and Mr Proctor for the work being undertaken.

Mr Rose asked about the existing community services and how they were going. Mrs Scott advised that the CCG were focusing on the Better Care Fund rather than strategy and there is a lack of momentum in making decisions about the services.

Mr Rose asked Mrs Geary and Dr Turnbull to comment on their feeling about the community hubs and their engagement with the projects. Mrs Geary commented that she was very comfortable with the development. She felt she had been engaged in the process and felt that it was an opportunity to engage staff in different ways of working in the future.

Dr Turnbull referred to the "Stethoscope" report included as part of the Quality and Safety Report, which shows that there are missed opportunities to treat patients in the community. He added that he thought the distinction between primary and secondary care was now out of date and should be abolished. If the community hubs help to achieve this, then the artificial barrier could be gradually removed.

Mr Ashton asked if the community beds were part of the debate. Mr Proctor confirmed they were.

14/085 Report of the Chairman

The Chairman drew the Board's attention to his report, and specifically the national downward pressure on finance and reflected on the comments made earlier by Mr Bertram.

The Chairman also commented on the work that Sir David Dalton has been asked to undertake around the form of Trusts and corporate governance.

The Chairman referred to expected attendance of Monitor at the Board meeting in October. He advised that a plan is being pulled together.

The Chairman advised that both Mr Ashton and Professor Willcocks had confirmed they would lead for the Board on procurement and end of life care, the purpose being that Non-executive Directors become more aware of the topics.

Finally the Chairman referred to the July board meeting, at which the afternoon session will be devoted to a Board-to-Council meeting with the Governors, mainly to discuss the five year strategy.

The Board **noted** the report from the Chairman.

14/086 Report of the Chief Executive

The Chief Executive drew the Board's attention to some highlight points in his report. He advised that the discussions with Leeds and York Partnership NHS Foundation Trust re their planned withdrawal from Bootham Park Hospital were progressing. Mr Proctor had taken the lead in those discussions and at present the Trust was considering the letter they had recently sent before responding.

Mr Crowley referred to the CQC inspections and advised that he expected the Trust to be included in the inspections sometime over the next 12 months. He advised that work is being undertaken to look at the compliance programme and ensure there is a comprehensive review programme. He confirmed he would keep the Board updated of any developments.

Mr Crowley highlighted that the Trust had won the CHKS top-40 award. The award has been won by the Trust for 11 out of the 12 years it has been running. The Trust won it the first year, but lost it the following year. Even when there is "disarray" in the system, the Trust has managed to produce a balanced budget and demonstrate reasonably consistent performance during the year. We have reduced the SHMI noticeably year-on-year, so the receipt of the award is a reflection of our achievements.

Mr Crowley mentioned that the new Scarborough Staff Shop had been opened on Monday and was very busy; staff were delighted to have the facility.

The Board **noted** the report from the Chief Executive.

14/087 Next meeting of the Board of Directors

The next meeting of the Board of Directors will be held in the Blue Conference Room, Scarborough Hospital, on 25 June 2014.

14/088 Any other business

Mr Rose reminded the Board that the 5 year strategic plan presented to the Board in June; the draft would be going to a subgroup of governors and could be available to the Non-executive Directors if they wished.

The Non-executive Directors confirmed they would like to see the draft in advance of the Board meeting.

Action: Mrs Holden to arrange for the draft strategic plan to be circulated to the Non-executive Directors in advance of the Board meeting.

Outstanding actions from previous minutes

Minute number and month	Action	Responsible office	Due date
13/134 Dementia Strategy	To include an update on the dementia strategy in his board report on a quarterly basis.	Dr Turnbull	February 2014
14/040 Open and Honest programme	Mr Proctor to present the pilot document to the Board for review and a final decision about the Trust's involvement in the programme would be made at that stage.	Mr Proctor	April/May 14
13/119 Scheme of Delegation (September)	To consider increasing the authority of the Capital Programme Committee to be undertake during the next stage review	Mr Bertram/ Mrs Pridmore	June 2014
13/120 Quarterly HR Report (September)	To circulate the annual report from the Workforce Strategy Committee	Ms Hayward	By December 2013
14/055.1 2013 - 14/127: Bridlington Orthopaedic Elective Surgery	Evaluation Report pending the release of further capital	Mr Bertram	November 14
14/041 Patient Experience - Matron refreshment	Update the Board on the progress of the introduction of the new nursing structure	Mr Proctor/ Mrs Geary	December 14
14/063 Quality and Safety	Include in the monthly safer staffing report in the Chief Nurse report	Mrs Geary	June 14
14/063 Quality and Safety Committee	Provide the six monthly acuity audit report.	Mrs Geary	June 14
14/068 Finance and Performance Committee	Present a paper providing further clarity on the duty of candor and current policy on being open	Dr Turnbull and Mrs Geary	June 14
14/072 Chief Executive Report	Strategic Annual Plan to be presented to the Board of Directors	Mr Crowley Mrs Holden	June 14

Action list from the minutes of the 28th May 2014

Minute number	Action	Responsible office	Due date
14/080 Matters arising – Perfect Week	Prepare a report on the Perfect Week for presentation to the Board in July.	Mrs McGale	July 2014
14/081 Patient Experience – Patient Experience Team	present the report on the review of Patient Experience Team	Mrs Geary	June 2014
14/082 Quality and Safety Committee – Safer Staffing	Ensure the narrative for the safer staffing information is circulated to all Board members in advance of its publication	Mrs Geary	June 2014
14/082 Quality and Safety Committee – Patient Safety Strategy	Patient Safety Strategy to be included in the Board papers for June.	Dr Turnbull	June 2014
14/083 Finance and Performance Committee	Include, if available the Intensive Support Team report as part of the Board papers for the June meeting	Mr Proctor	June 2014
14/083 Finance and Performance Committee	Include dementia screening in his Medical Director report.	Dr Turnbull	June 2014

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York Teaching Hospital NHS
NHS Foundation Trust

Quality & Safety Committee – 17 June 2014

Attendance: Libby Raper, Jennie Adams, Philip Ashton, Beverley Geary, Alastair Turnbull, Anna Pridmore, Brian Golding, Diane Palmer

Apologies:

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last meeting notes 20 May 2014**		Accepted as a true record.		
2	**Matters arising**		**Patient Safety Strategy –** AJT tabled the revised strategy and suggested that the paper should be presented to the July Board. The Committee agreed that it would be helpful for members of the Committee to review the revised draft in advance of its discussion at the Board. It was also agreed that in the light of the requirement for wider consultation around the setting of the annual quality priorities this item would be added to the committee's annual plan for discussion in October and finalisation in February. AP highlighted the need to involve a broader group of stakeholders in this process.		AT to bring final version of Patient Safety Strategy to July Board
3	**Integrated Dashboard**	**AFW** MD3,4,5 COO1 CN1,3,4,5 **CRR** 44,20	The Committee reviewed the dashboard and noted the number of serious incidents that had been declared during the month. AJT advised that the number was made up in the main of fractures as a result of patients falling (3) and pressure ulcers (11 grade 3 &4).	The Committee noted the performance and the challenges being experienced. The Committee noted the work being undertaken to address the	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3 cont'd	**Integrated Dashboard**		BG referred to the pressure ulcers and explained that 6 of the incidents occur in the community. Staff can advise patients how to avoid pressure ulcers, but cannot insist that a patient follows that advice. She added that there are also themes emerging around the use of devices and education and training. AJT advised there had been no never events reported during May. He added that there was now a new requirement that the GMC are to be advised of any never events declared by the Trust. The committee expressed some concern about the number of outstanding incidents. AT advised that in the case of SIs the move to a clinician led investigation may be slowing the process down a little. Cancellation of Exec Boards in recent months had also added to this delay in reporting to committee as closed SIs must first be reported to Executive Board. BG referred to the friends and family test and reported that there had been deterioration in the net promoter score in the emergency department at York. She explained that she would be discussing the issue with the Directorate and requesting an action plan from them. AJT commented that the C-Diff performance had improved. There had been 8 cases in the year to date against a trajectory of 15. He added that it had been 65 days since the last case in Scarborough had been reported and 115 days since the last case was reported in the community.	challenges.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3 cont'd	**Integrated Dashboard**		AJT added that there had been a reduction in cases of MSSA following a spike in April. In terms of CRE there is one case where it is suspected the transmission was through the hospital as a result further work is being undertaken around hygiene and hand washing. He added that it is planned to bring the hand washing audit to the next meeting. BG explained that internally there had been a change in the approach to recording hand hygiene audits; this was now undertaken by the Infection Prevention Nurse. DP drew attention to fact that the production of the dashboard would shortly be handed over to Systems & Networks. Some duplication of data could be expected in the handover period.		BG to update the Board on C-Diff.
4	**Patient Safety Group Annual Report**		The Committee received the annual report from the Patient Safety Group and were struck by the breadth of its remit. PA is a member of the Group and advised that he is always amazed by its scope, but he is also struck that attendance is not always good.	The Committee were impressed by the span of information considered at the group, but noted the planned revision to its governance	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
4 cont'd	**Patient Safety Group Annual Report**		The Committee discussed the report and asked AJT to describe its purpose. AJT explained that it receives a number of highlight reports from other groups and provides a forum for clinician consultation, engagement and support across a broad range of Patient safety issues. The Committee noted that the Group had revised its terms of reference recently, but this had not included a review of its governance. The committee felt that there could be scope to tighten the membership and focus of the group and to introduce some added value to next year's annual report by way of a "key issues debated" section. AP added that there were concerns about the number of groups reporting to the Group and how the Group works, it was included in some planned work to review the governance around the Group.		
5	**Supplementary Medical Director report**	**AFW** MD2 **CRR** 4	AJT referred the Committee to the Summary Hospital Level Mortality Indicator (SHMI) showing at 97.1. He advised that he is reviewing the areas where the Trust has more deaths than expected. AJT referred the Committee to the position the Trust is in relation to the rest of Yorkshire. AJT presented the serious incident summary. The Committee discussed one of the summaries and asked for it to be returned to the Directorate for further discussion. It was felt that there were further actions that could be considered. The Committee discussed the antibiotic prescribing audit results. It was noted that there was 80% compliance across the organisation.	The Committee was pleased to see the SHMI and the position against other Trusts in the region. The Committee were assured by the intention to return the report to the Directorate for further consideration.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
5 cont'd	**Supplementary Medical Director report**		AJT's expectation is that this will improve. He added that this is a single snapshot audit and so does not provide an on-going picture. AJT commented on the 12 hour senior review. He explained that he would bring 6 and 12 hour review information to the next meeting.		
6	**14 day breast symptomatic**		AJT provided an overview of the changes to the service. He explained that the challenges were related to the difficulties of appointing a new Sonographer specialist. AJT reminded the Committee of the background to the issue and added that as temporary measure patients are seen by a Consultant Breast Surgeon in Scarborough without the radiology support on the day. This should provide an effective short term solution although not the one stop shop that we aim to achieve. He added that discussions were being held with the Scarborough Whitby and Ryedale CCG about a longer term solution but those discussions had not been completed as yet. The CCG is supportive of the service that has been put in place and clinically it has been confirmed that it is safe. It was noted that the Finance and Performance Committee would be asking the Chief Operating Officer to comment at the Board meeting.	The Committee were concerned about the issues around the service. They were assured by the comments made by AJT about the temporary adjustment to the service that had been put in place.	Mike Proctor to Brief Board
7	**Patient Experience Report**		BG presented the paper which outlined the revised approach to patient experience. The Committee welcomed the report. It was keen to support the move away from a complaints focused team and towards a much broader patient	The Committee noted the report was included for discussion at the Board meeting and were assured by the approach being taken	BG to comment at the Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
7 cont'd	**Patient Experience Report**		experience remit to include F&F, surveys, PALs, incidents and closer liaison with other stakeholders. BG felt that the key to achieving this objective would be the appointment of a new Lead for Patient Experience. An excellent field of candidates for this role was developing and an appointment is imminent. Wide representation on the appointment panel is being sought.		
8	**Supplementary Chief Nurse report**	**AFW** CN1,3,5	BG referred to her report and highlighted the section on open and honest care. She advised that it was becoming apparent that there continues to be a number of data issues amongst organisations at present. Internally a pilot has begun to ensure the right processes are in place to capture accurate data. It is anticipated that a draft will be available to the Board of Directors for approval in July. BG referred the Committee to the Safer Staffing Project; Staff and have worked very hard and have achieved the demanding deadlines for data input to the national database across the whole estate. The RAG rating has been withdrawn until further notice. An exception report of outlying wards will be bought to board this month with explanatory narrative. BG reported some examples of fill rates for Scarborough and York and highlighted the challenges the information is going to give to those interpreting it. BG added that the first 6 month acuity audit had been completed and she was expecting some	The Committee were assured by the comments made by BG.	BG to comment at the Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			actions to come out of the audit.		
9	**Chief Nurse Annual Report – progress against the Pressure Ulcer Reduction Programme (PURP)**		The Committee noted the annual report and agreed that it was disappointing not to see the level of progress they had hoped for. It was keen to support this important work and pleased to hear that progress around training and strengthening the Tissue Viability team had been made. The importance of compliance with comfort rounds was noted and the committee expressed a wish to have more information on this at future meetings.	The Committee was assured by the information in the report, but would have like to have seen more progress	
9	**Estate issues around quality**		B Golding was welcomed to the Committee. He presented his paper which articulated the day to day operational issues estates address as part of their duty to quality. B Golding outlined the three CQC standards that relate to estates and facilities and explained how they are addressed by the team. The discussion focussed particularly on ward configuration compared to latest recommended standards and the shortage of single room accommodation. The potential effect on infection control was highlighted. The committee identified a governance issue around how risks of this type are escalated to the CRR – they did not fall into the Chief Nurse or MD directorates and were not really a Health and Safety matter. The Committee noted the helpful report and agreed that B Golding should provide an update on a quarterly basis.	The Committee were assured by the comments made.	JA to raise governance issue at Board – with view to amending the CRR to include high level Estates risks relating to quality and safety.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
10	**Duty of Candour**		AJT presented a paper at the committee. The paper laid out the key statutory requirement regarding a Duty of Candour by NHS Trusts to inform patients when they have experienced harm (moderate or worse) whilst in the care of the Trust. A contract fine for non-compliance of £10,000 or the cost of care can be levied per incident. The practical implementation of this duty will fall to ward staff. In most cases patients are already informed of such events however this interaction will now have to be formally evidenced. AJT explained the difference between the Duty of Candour and the Being Open and Honest Policy that exists in the Trust. DP explained that there was some work to undertake in terms of the Trust providing a clear definition of moderate harm.	The Committee noted the specific requirements of the Duty of Candour and the difference between it and the Being Open and Honest Policy.	
11	**Any other business**		None		
12	**Date and time of next meeting**		The next meeting will be 22nd July at the Neurosciences Resources Room.		

York Teaching Hospital NHS
NHS Foundation Trust

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Patient Safety and Quality Report

June 2014

Our ultimate objective To be trusted to deliver safe, effective healthcare to our community.

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Executive summary

- 18 Serious Incidents (Sis) were declared in May.

- No Never Events were reported.

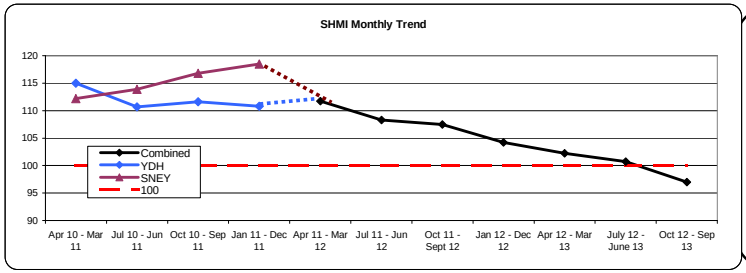
- Patient falls remains the most frequently reported incident category.

- Two cases of toxin positive c. difficile were identified in May.

- Compliance with dementia screening for patients admitted to hospital has improved at Scarborough Hospital but remains below the 90% target.

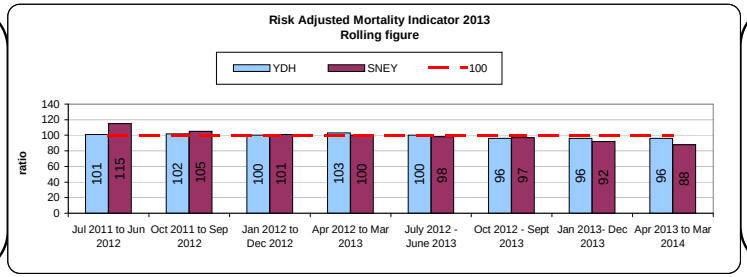
Patient Safety

Mortality



The latest SHMI report for the period October 2012- September 2013 indicates the Trust to be in the 'as expected' range. The SHMI is 97 and represents a significant reduction.

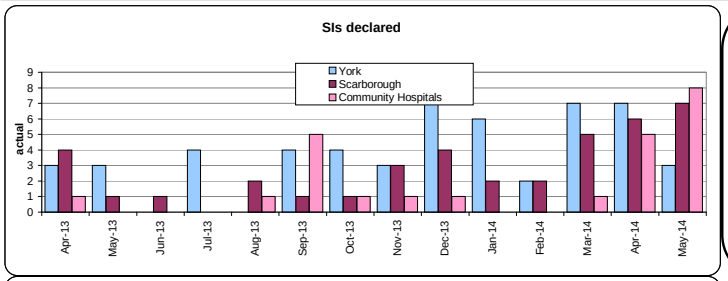
Data source: Information Centre



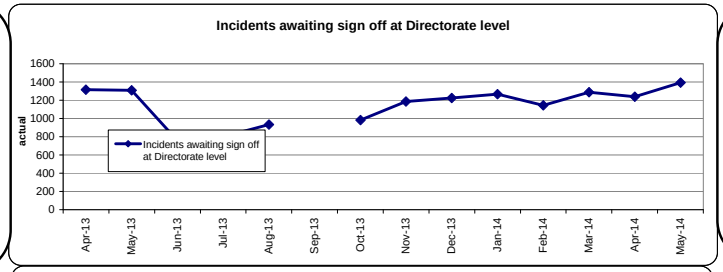
The Risk Adjusted Mortality Indicator (RAMI) for the reporting period April 2013- March 2014 has remained constant for York Hospital compared to the last two reporting periods. At Scarborough Hospital there continues to be a reduction.
Awaiting up to date data from CHKS.

Data source: CHKS - does not include deaths up to 30 days from discharge.

Measures of Harm

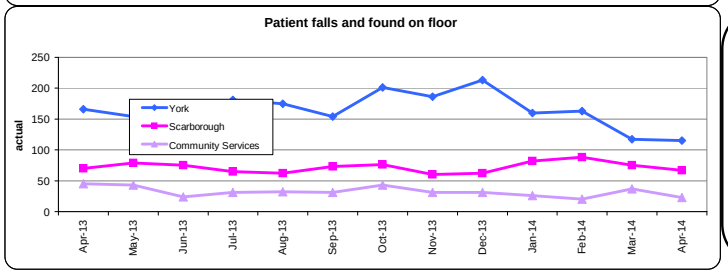


There were 18 serious incidents (SIs) reported in May. Three from York Hospital; one patient fall, one patient abscond, and a maternity services intrapartem death. Seven from Scarborough/Bridlington Hospital; five category 3 pressure ulcers, one maternity services system failure and a one patient histopathology results transposed. There were eight SI's from the Community; six category 3 pressure ulcer and two patient falls.



At the time of reporting there were 1394 incidents awaiting sign-off by the directorate managers.

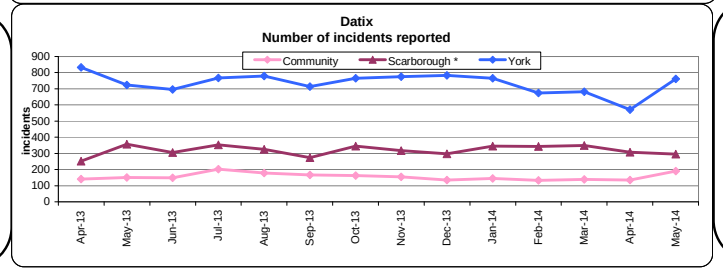
Data Source: Datix



Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. 115 patients fell and were found on the floor at the York site, 67 patients at Scarborough and 23 patients within the Community Hospitals in April.

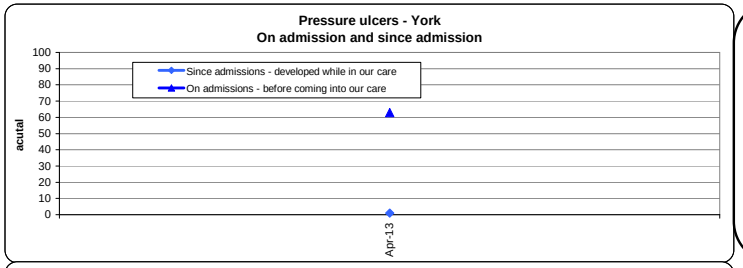
Awaiting May data to be validated.

Data Source: Datix



The total number of incidents reported in the Trust during May was 1247. 762 incidents were reported on the York site, 295 on the Scarborough site and 190 from Community Care/Hospitals.

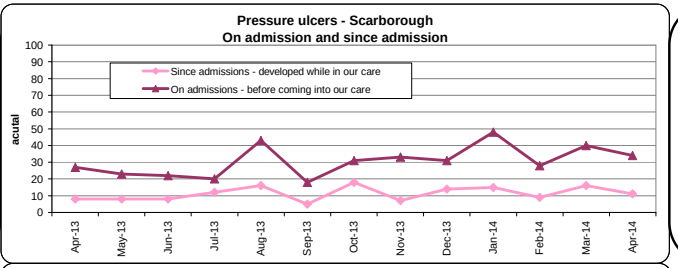
Data Source: Datix



During April a total of 19 pressure ulcers were reported to have developed on patients in York Hospital.

These figures should be considered as approximations as not all investigations have been completed.

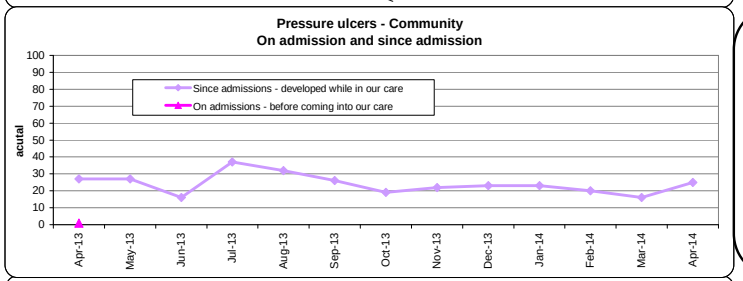
Data Source: Datix



During April a total of 11 pressure ulcers were reported to have developed on patients in Scarborough Hospital.

These figures should be considered as approximations as not all investigations have been completed.

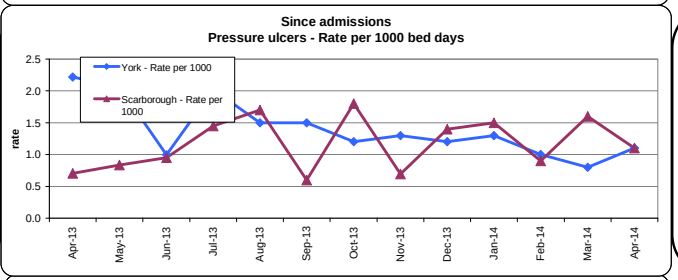
Data Source: Datix



During April a total of 25 pressure ulcers were reported to have developed on patients in our community hospitals or community care.

These figures should be considered as approximations as not all investigations have been completed.

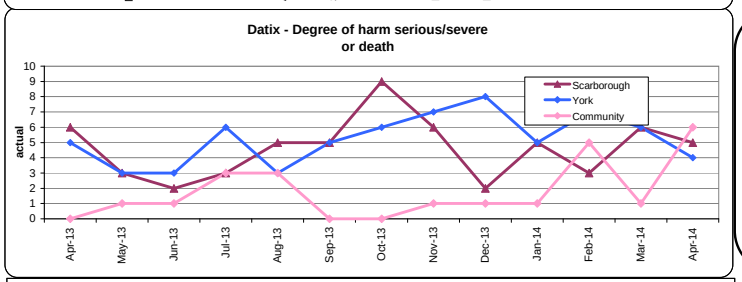
Data Source: Datix



The rate of pressure ulcer development in York Hospital in April was 1.1/1000 bed days.

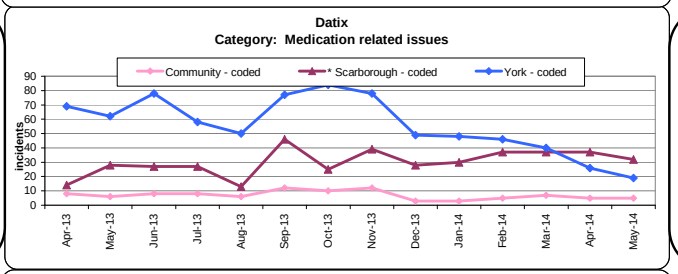
The rate of pressure ulcer development in Scarborough Hospital in April was 1.1/1000 bed days.

The May data is not available at the time of reporting.



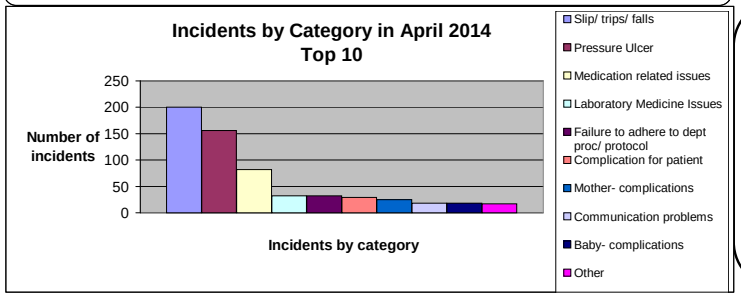
During April a total of 15 patient incidents were reported which resulted in serious or severe harm or death.

Data Source: Datix



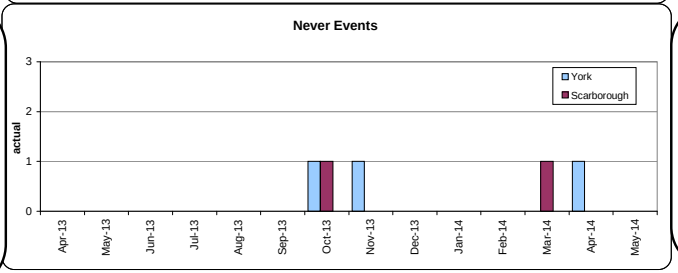
During May there was a total of 56 medication related incidents reported, although this figure may change following validation.

Data Source: Datix



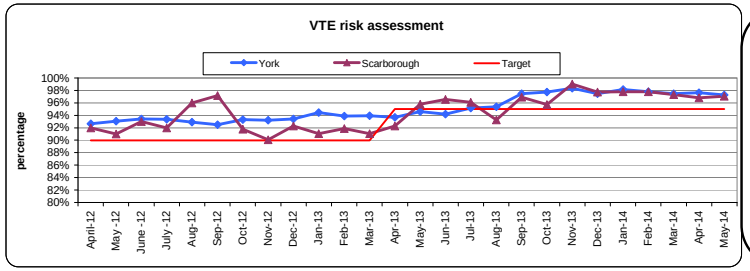
During April, 200 incidents were reported as a slip/ trip/ fall, 156 pressure ulcers and 82 medication related incidents.

Data Source: Datix



There were no Never Events declared in May, due to one being de- logged on the York site relating to a drug error methotrexate. This is now a CI.

Data Source: Datix



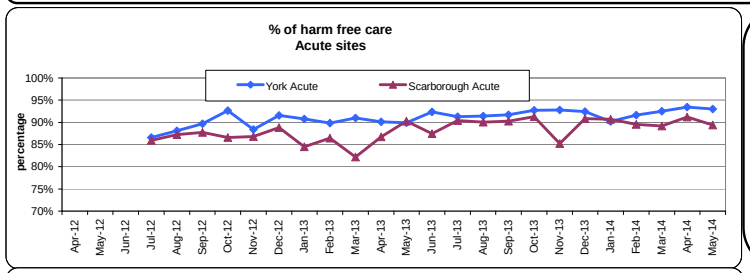
The target of 95% of patients receiving a VTE risk assessment has been maintained on both sites during May.

However we must ensure that this is completed for all patients and in a timely manner.

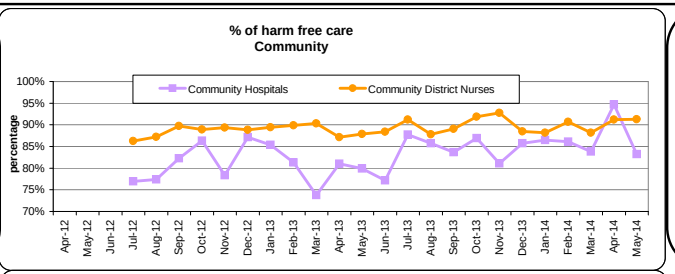
Data Source: Systems & Network Services

Safety Thermometer

Safety Thermometer
The NHS Safety Thermometer provides a 'temperature check' on harm, by measuring the percentage of patients who are harm free from pressure ulcers, catheter associated urinary tract infections, venous thromboembolism and fall whilst in our care. Collection of robust data on harm free care is linked to the national CQUIN scheme. The Trust has agreed an improvement incentive on delivery of harm free care related to pressure ulcers.

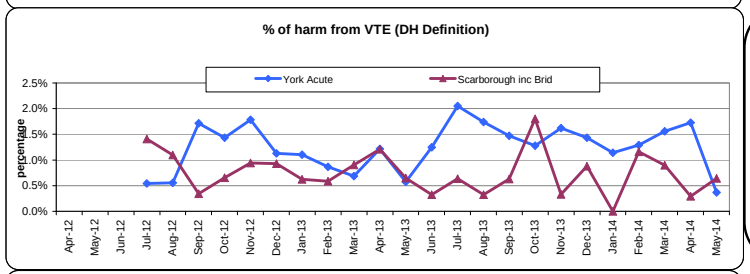


The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In May 93.04% of patients at York and 89.39% at Scarborough were audited as care 'free from harm' on the acute hospital sites. Please note that as of April 2014 White Cross Court and St Helen's Hospital are now apart of Community and not York Acute.
Data source: Safety Thermometer



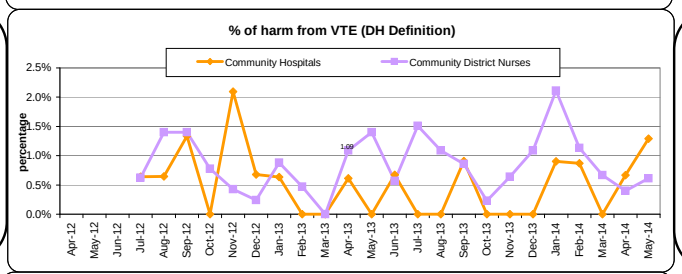
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In May 83.23% of patients in our community hospitals and 91.31% of patients in our care in the community received care 'free from harm'.

Data source: Safety Thermometer



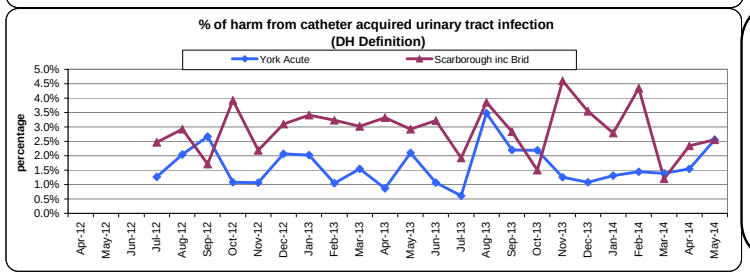
The percentage of patients affected by VTE as measured by the Department of Health (DH) definition, monthly measurement of prevalence, was 0.37% in York and 0.64% in Scarborough acute hospitals in May.

Data source: Safety Thermometer



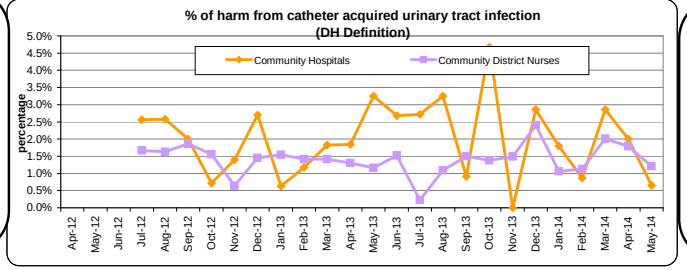
The percentage of patients affected by VTE as measured by the DH definition, monthly measurement of prevalence was 1.29% in community hospitals and 0.61% in community care in May.

Data source: Safety Thermometer



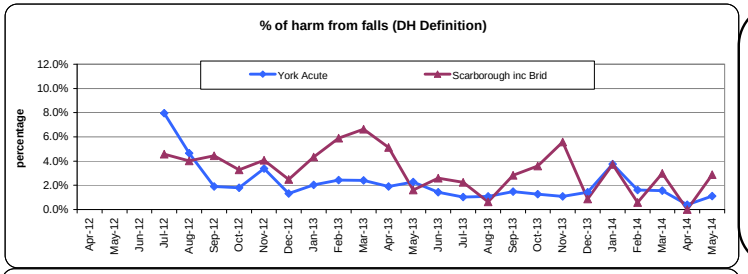
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 2.56% in York and 2.56% in Scarborough acute hospitals in May.

Data source: Safety Thermometer



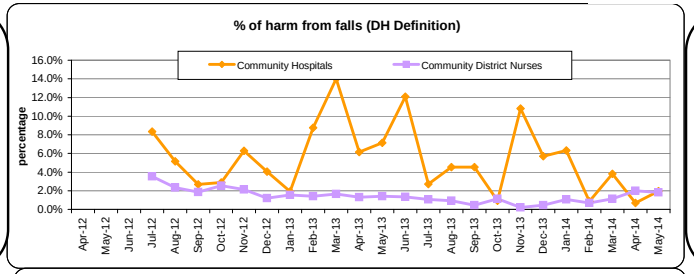
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 0.65% in community hospitals and 1.21% in community care in May.

Data source: Safety Thermometer



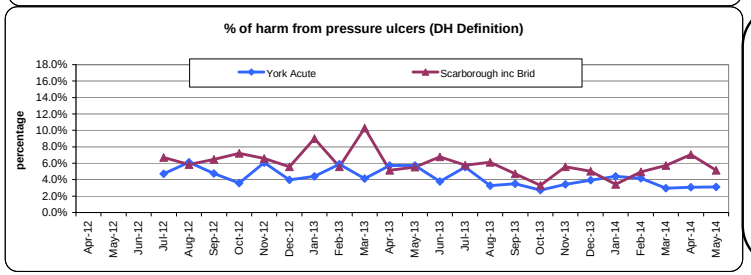
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 1.10% for York and 2.88%for Scarborough acute hospitals in May.

Data source: Safety Thermometer



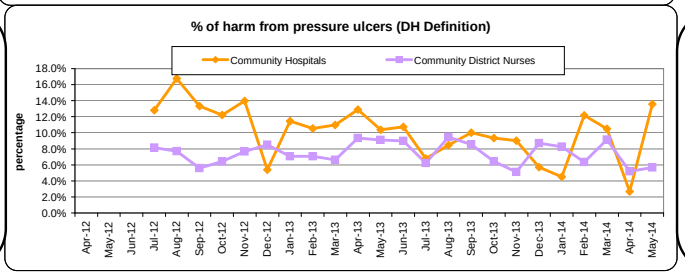
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 1.94% in community hospitals and 1.82% in community care in May.

Data source: Safety Thermometer



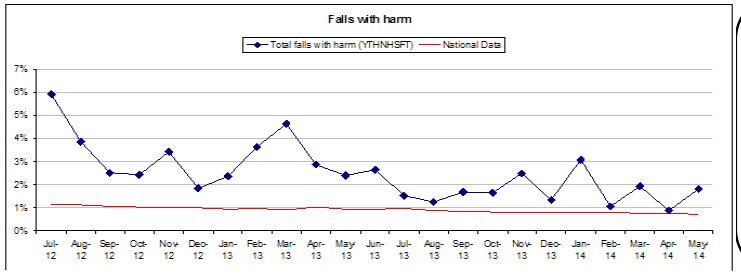
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 3.11% for York and 5.13% for Scarborough acute hospitals in May.

Data source: Safety Thermometer



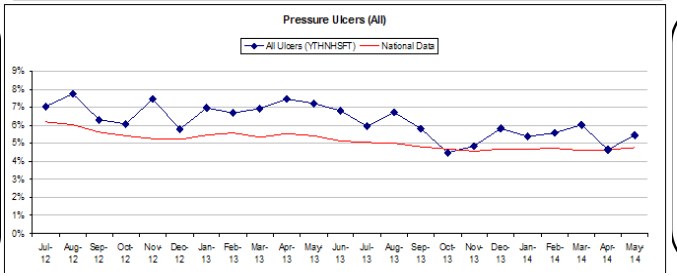
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 13.55% in community hospitals and 5.66% in community care in May.

Data source: Safety Thermometer



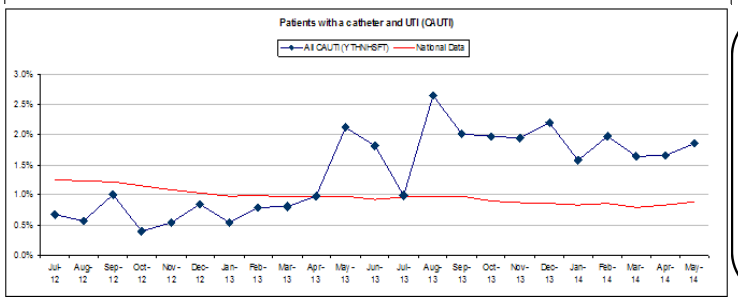
The Trust wide total number of falls with harm as measured for the Safety Thermometer is above the national average.

Data source: Safety Thermometer



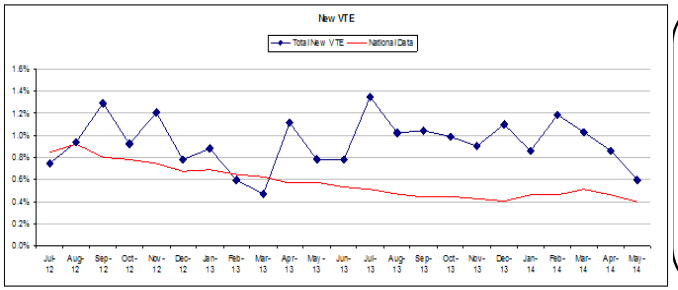
The Trust wide total number of pressure ulcers as measured for the Safety Thermometer is above the national average.

Data source: Safety Thermometer



The Trust wide total number of patients with a catheter and UTI as measured for the Safety Thermometer remains above the national average.

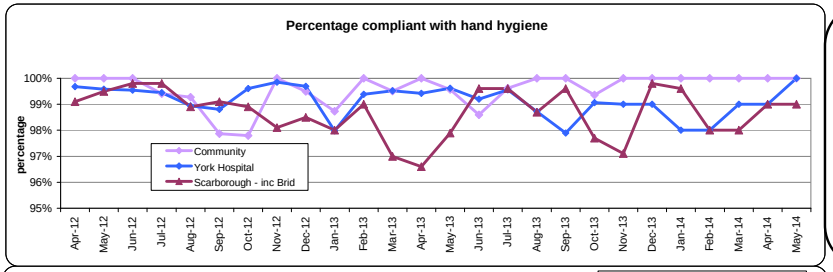
Data source: Safety Thermometer



The Trust wide total number of patients with a new VTE as measured for the Safety Thermometer remains above the national average.

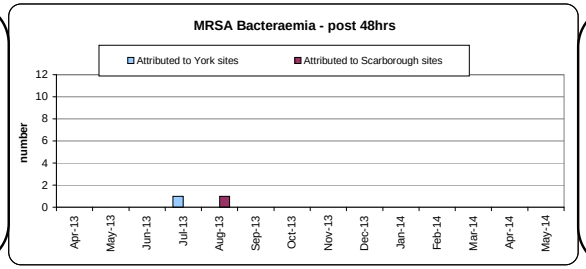
Data source: Safety Thermometer

Infection Control

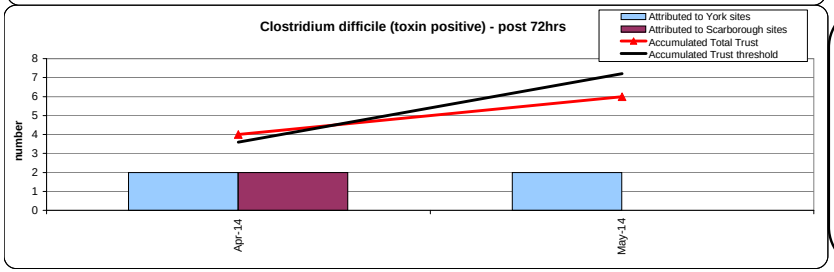


Hand hygiene compliance for York was 100% and Scarborough was 99% in May whilst the Community Hospitals achieved 100%.

Please note, scale starts at 95% to show detail.

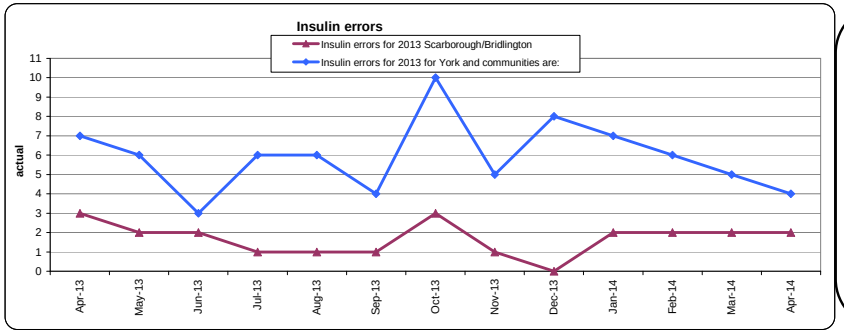


There were no patients in the Trust identifed with healthcare associated MRSA bacteraemia during May.



Two cases of c. diff were identifed in the Trust, both at the York site, during May.

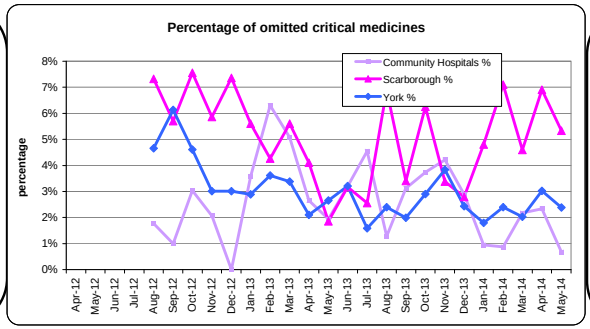
Drug Administration



There were four insulin related errors reported at York and Communities, and two at Scarborough/Bridlington in April.

The data for May is awaiting validation.

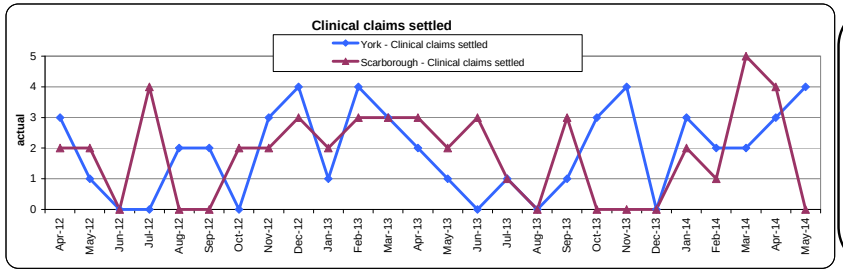
Data Source: Datix



The number of omitted critical medicines has decreased in May across all sites. The percentage of omitted critical medicines for York was 2.4%, Scarborough 5.3% and 0.7% for Community Hospitals in May.

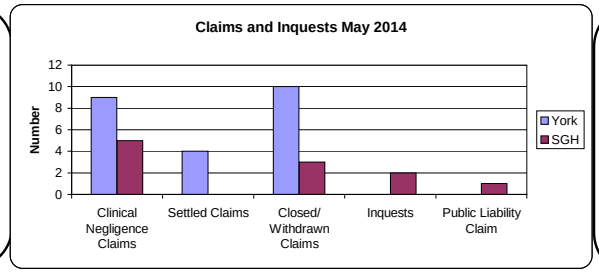
Data source: monthly prevalence

Litigation



In total, four clinical claims were settled in May, which were all attributed to the York site.

Data Source: Risk and Legal Services



In May, nine clinical negligence claims at York were received and five were received at Scarborough. Four claims at York were settled, whereas no claims at Scarborough were settled.

York had ten withdrawn/ closed claims compared to three at Scarborough.

The were two Coroner's Inquests and one Public/ Employment Liability Claim, both attributed to the Scarborough site.

Data Source: Risk and Legal

Patient Safety Walkrounds

Date	Location	Participants	Actions & Recommendations
6th May 2014	**Specialist Medicine** Dermatology OPD MES Haematology/ Oncology OPD Chemo Service Blood taking Ward 31 (York Hospital)	Sue Holden - Director Karen Cowley - DM Mark Quinn - CD Libby Raper - NED	**Dermatology OPD** • The department is too small and does not meet current demand efficiently or effectively. • Need to place more hand gel dispensers in the corridor. • Main OPD service improvement project has greatly improved the efficiency of the clinic room utilisation, however surgical practice and room utilisation could be addressed which could free up more room capacity. This would help to address concerns raised regarding meeting performance targets. • Discussed Scarborough outpatient capacity as the issues there are worse in terms of capacity/ demand. Requires a full service review. • Need to consider smarter strategy to address environmental constraints across the Trust. **MES** • Less cluttered, clean, tidy and inviting. Question raised regarding the name of the area, could change to 'medical day unit' (supported by a feedback form a patient who was leaving, they did not know what the name meant). • Shared space with the pain service has led to constraints with the environment and developing services further to reduce inpatient bed days and enhance patient experience. • One toilet available which is shared by MES and Haematology/ Oncology OPD/ Chemo service – plan is in place to address this. **Haematology / Oncology OPD and Chemotherapy service** • Environment is different from other departments visited; bright, light, well decorated and much more inviting on first impression. • Increasing demand on the services requiring workforce reconfigurations which are ongoing. Space constraints are apparent and work is ongoing to explore satellite areas or mobile units to deliver chemo. • Toilet facilities - an unacceptable situation, a side effect from chemo is diarrhoea and there are times when patients are queuing to use the facilities.
			Blood taking • Much improved service, taken 2 years to turn around with heavy time investment. New outpatient area very busy but much more inviting. • Patient complaints have decreased dramatically even though waiting times can be lengthy still. • It has been agreed to increase staffing levels proportionate to service demand. A post which has just been recruited to should be in post by June 2014. Waiting times should reduce once all staff are in post, this will be audited August / September 2014. • The team are working with some service improvement support to look at the inpatient service. Future plans for enhancing a better patient experience ongoing. **Ward 31** • Very busy but well staffed compared to most wards. • Relatively new ward area is spacious, clean and tidy. • 1 patient complaint in the last 3 years recently. A plan is in place to share the outcome and actions to be put into place. • The service has developed into a very nurse-led area. • Chemotherapy is delivered on the ward and acute onology, telephone triage service out of hours. • Looking into increasing night staff numbers from 2:1 to 3:1 to ensure safety of chemotherapy delivery, patient ongoing care and triage service.
7th May 2014	Ward 17, CAU, SCBU, CDC (York Hospital)	Andy Bertram - Director Liz Vincent - Manager Jo Mannion – Consultant Paediatrics Nicola Lockwood - Matron	**Ward 17** • CCTV (17 and CAU) – Andy Bertram to raise with Security. **Done.** • Parents facilities (Staff room) - Directorate to look at options for improvement, involve James Hayward as appropriate. • Staffing levels -acuity and dependency - Directorate to work with Lucy Connolly and Andy Bertram to raise urgency through corporate directors in preparation for winter particularly. • CDC environment: - PC for OT Office – Andy Bertram to sort. Order raised. - Andy Bertram to raise awareness of CDC general environment through capital programme board. Directorate to work with James Hayward on alternative space usage & design improvements. - CDC Development to be considered as future case for Hospital fundraising committee. • Electronic observations and prescribing – Andy Bertram and Directorate to raise the profile of roll out of both initiatives to Paediatric areas. Noted that Ian Jackson had made contact re Electronic Obs – this to be followed up. Jo Mannion and Ian Jackson met 28.5.14 to discuss.
12th May 2014	Ophthalmic main OPD (Scarborough Hospital)	Mike Keeney – NED Sister S Meek – Sister in charge Gemma Cuss – DM James Hayward – Programme Director Capital and Infrastructure.	• The clinic space is embedded into the main OPD and has limited dedicated clinic space, many rooms are shared, it is small and cramped, space is a real concern and there are too many patients for the space available. This leads to poor quality environment and gives some clinical concerns regarding access and movement around the clinic. • The capacity shortfall is a concern; lack of storage, no complaint (ventilation) treatment rooms for OPD procedures. Only 4 dedicated OPD consulting rooms. Gemma Cuss explained that the Directorate is looking at BDH as an option for clinic expansion. • A long term plan has been formulated to relocate the current ED into a new department. When this happens there will be an opportunity to expand OPD into the old ED space to increase clinic capacity and resolve many concerns. This will be subject to Exec Board and Board of Directors approval. • The Trust is shortly to commence adhearing to A4C national pay rates, this will mean that WLI payments will need to comply with the national framework. A consequence from this is that Saturday mega AMD clinics will cease at the end of May because staff have confirmed they do not wish to accept a lower remuneration than they receive currently. There are concerns that patients might suffer and fail to get timely treatment for AMD conditions without the additional clinics, Gemma Cuss confirmed that she is looking at utilizing a private provider that ahs a facility at the BDH site as a short term measure.
21st May 2014	Ward 32 & CCU (York Hospital)	Brian Golding – Director Jordan McKie – DM Chris Morris – Matron Alan Rose – Chairman /NED Juliet King – Sister – Ward 32 Anne Barfoot – Sister CCU	• Neuro patients on ward 32 often need additional support which is not filled by NHSP which means staff are taken from elsewhere. Action to log unfilled shifts and report to NHSP. • The single biggest cause of delayed discharge is timely completion of EDNs (by juniors). It was agreed to monitor data and share with clinical teams. • There has been a near miss because of a perceived design fault with a bathroom door. The design of the door was correct but this has not been explained to staff. Ward to ensure adequate training post handover for new projects. • Records could be improved if Phillip's monitoring system could interface with CPD. Phillip and SNS working together on this. • Noted the NCI boards are out of dare with many records left as N/A • On both wards there are good friends and family feedback rates.
22nd May 2014	Ward 36 & 39 (York Hospital)	Bev Geary – Director Dr John Coyle – CD Steve Reed – DM Hilary Woodward – Matron Mike Sweet – NED Sandra Hindmarsch- Sister Carol Croser – Stroke Nurse Specialist	• The ward sister's office is a cupboard in a bay and not fit for purpose. A solution was identified on the adjacent ward and the team planned to act on this without delay. • Previous walkrounds highlighted issues with cleaning, these had been addressed. • There are lots of staff offices on the ward from other areas, work is ongoing with the Director of Operations linked with the ongoing reconfiguration work in order to address these. • Discussion held on response times. A recent case of a patient with mental health issues who was fit for discharge but required input from the SW team, this was causing unacceptable delays and posed a risk to the patient whilst they were in an acute setting. Also the availability of acute stroke beds for other patients. • Storage is an issue on both wards and could potentially cause a slip / tripping hazard because there is no space to store equipment, including hoists. • Staff often moved to other areas to support wards with less registered nurses, this could potentially compromise the ability to deliver the acute service. The ward sister is very proactive and completed datix on all of these occasions. The team demonstrate an appreciation of the risk that other areas face and acknowledge this. • Ward 38 posed a risk as the doors were often unlocked and patients could potentially wander into these and be out of site. It was agreed to get the doors locked without delay and to escalate to the Bed Management Team to ensure they were locked at all times when not occupied. • There is an issue with computers and a lack of access to these featured a lot. The team described that they were very slow and crashed all of the time, there were not enough to complete all assessments, review scans updates, records, etc. The team also expressed concern regarding patient and public perception that nurses were always on the computer and very little time with patients. • Ward 39 – lack of storage and some environmental issues that had plans in place to be addressed, these are on hold due to the reconfiguration. This was a concern due to the Star appeal monies had been donated some time ago to improve the environment.
23rd May 2014	G1 & Gynae OPD (York Hospital)	Dr Turnbull – Director Mr Evans – CD Mr Jibodu – CD Chris Foster- Matron	• Impressed with the culture of high quality care, nursing and medical. • Compliance with VTE is relatively high but remains under scrutiny. • High friends and family response rate. • Issue of the closure of the door between G1 and G2, at present this is not bolted but available by swipe. This will not change in the foreseeable future and there are no basic access issues identified by the ward sister / matron. • Discussed the possibility of using the side rooms with en-suite facilities for an isolation facility. From this a number of practical issues were raised in relation to the importance of having an area to maintain the privacy and dignity of patients undergoing difficult procedures. • Concerns relating to the larger number of patients waiting in the corridor for acute assessment and this was very evident on the visit. A business case is pending for support for an additional model of service for acute gynaecology. • Concerns highlighted in relation to a large number of elderly outliers increasing the acuity of the ward, a level of acuity which you felt had not been factored into nursing workforce decisions and the major source of datix incident reports from G1 is in relation to nurse staffing levels. • At the time of the visit one third of the beds were occupied, levels that reflect more than simply 24 hour bed occupancy due to the large numbers of acute outpatient attendees.

Cancelled walkrounds

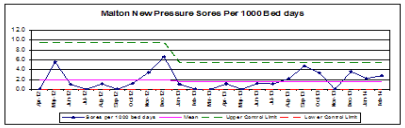
14th May 2014 PACU & Endoscopy, York Hospital – cancelled due to Mike Proctor attending a meeting.

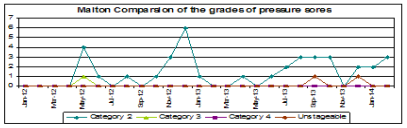
York Teaching Hospital NHS
NHS Foundation Trust

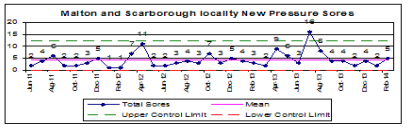
Malton Community Hospital
Patient Safety Dashboard – 15th May 2014

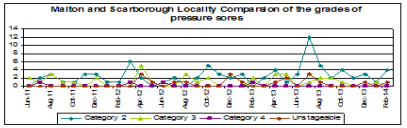
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of incidents reported on - Datix web	17	24	22	25	32	27	20	20	22	21	14	
Number of medication related incidents	1	3	1	1	0	1	1	1	0	0	0	
Number of new clinical litigation cases	0	0	0	0	0	0	1	0	0	0	0	
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	
Number of formal complaints	1	0	0	1	1	1	0	0	0	0	0	
Number of Serious Incidents (SI's)	0	0	0	0	1	0	3	0	1	0	0	
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	

Pressure Ulcers

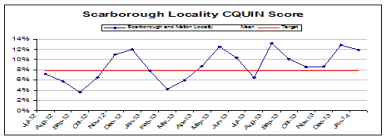


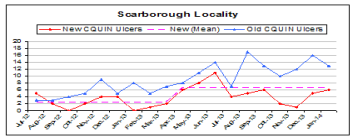




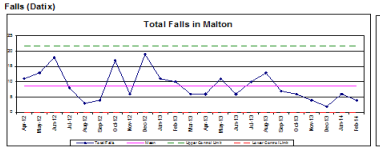


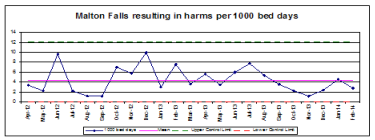
Pressure Ulcer prevalence Malton Community Hospital & South Ryedale & Scarborough Community (CQUIN)





Falls (Datix)

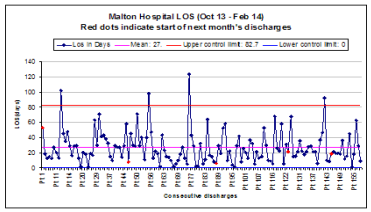




Target of 20 % reduction in falls over 13/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Mean falls with harm per 1000 bed days (Trajectory <3.8 per month)	5.6	3.4	5.9	7.7	3.2	3.5	2.2	1.2	2.4	3.4		

Mean across year so far as of Jan = 3.9

Length of Stay Graph



Deaths & Mortality reviews	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of in-hospital deaths	2 (5.4%)	4 (10.3%)	5 (6.6%)	3 (2.5%)	2 (2%)	5 (5.2)	6 (13.3)	5 (12.5)	5 (13.9)	5 (13.2)	4 (11%)	5 (10.6%)
Number of morality reviews	0	0	3	0	0	0	0	1	1	2	0	5

Activity	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14	
	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye
Admissions	21	34	19	16	32	49	43	76	19	72	19	69	21	13	20	10	11	22	22	13	15	11	14	35
Discharges	23	14	21	19	30	46	40	77	25	75	22	74	26	20	25	15	12	26	24	15	15	21	16	31
length of hosp stay – mean *previous yr	26.5 *27	30.3 *NR	24.0 *20.1	24.8 *NR	17.3 *9.1	22.3 *NR	17.5 *NR	20.0 *NR	24.2 *NR	26.1 *NR	19.9 *NR	42.5 *8.8	31.8 *11.8	33.1 *14.8	24.3 *15.1	36.8 *22.3	23.9 *15.3	29 *15.5	30 *30.5	39 *16.5	31 *24.5	30 *26.8	17.6 *19.9	20.8 *22.5

NR=No Record on 'Signal'

IPC	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14	
Ward	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye
% compliance with hand hygiene	100	100	100	100	75	100	100	100	100	100	100	100	100	100	100	100			100	100			100	100
% compliance with glove use	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100			100	100			100	100
% compliance with bare below the elbow	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100			100	100			100	100
CDIFF >72hrs *(Acc year to date)*	0	0	0	0	0	0	0	0	0	0	1		0	0	0	0	0	0	0	0	0	1		

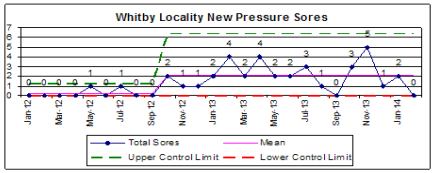
Harm Free Care - Safety Thermometer Prevalence data	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14	
Ward	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye
Overall Ward Harm Free	82%	93%	93%	80%	92%	91%	93%	85%	100 %	83%	79%	83%	93%	100 %	80%	93%	100 %	92%	100 %	100 %	90%	100 %	67%	100 %
VTE *(% of patients with a VTE)*	0%	0%	7% (1 old)	0%	7% (1 old)	0%	7% (1 old)	7% (1 old)	0%	8% (1 old)	0%	0%	0%	0%	0%	0%	20% (3 old)	0%	7%	0%	0%	6%(1 new)	0%	8% (1 old)
Falls *(% of patients who fell)*	17% (3 low harm)	46% (1 low, 3 mod, 3 sev harm)	0%	13% (2 low harm)	23% (3 low harm)	18% (2 mod harm)	14% (1 mod, 1 low harm)	15% (1 no, 1 low harm)	6% (1 low harm)	8% (1 low harm)	42% (1 NH, 3 LH, 2 IMH)	0%	14% (2 no harm)	8% (1 no harm)	33% (4 low harm 1 no harm	0%	40% (4 low harm 2 mod harm	0%	36% (3 Low harm 2 Mod harm	0%	10% (1 low harm)	0%	22% (2 mod harm)	0%
Pressure Ulcers *(% of patients with a new PU-CQUIN)*	5% (1 cat 2)	6% (1 cat 3)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	14% (1 cat 2)	0%	0%	7% (1 cat 2)	0%	7% (1 cat 3)	0%	0%	10% (1 cat 2)	6% (1 cat 2)	0%	0%
Pressure Ulcers *(% of patients with an old PU - CQUIN)*	5% (1 cat 2)	13% (2 cat 2)	0%	20% (1 cat 2, 2 cat 3)	23% (3 cat 2)	27% (2 cat 2, 1 cat 4)	0%	7% (1 cat 4)	6% (1 cat 2)	16% (1 cat2, 1 cat3)	0%	28% (3 cat2, 1 cat4)	14% (1 cat 2, 1 U)	23% (2 cat2, 1 U)	6% (2 cat 2)	7% (1 cat 2)	0%	0%	0%	7% (1 cat 2)	20% (1 cat 2 & 1 cat 3)	17% (3 cat 2)	11% (1 cat 2)%	0%
UTI *(% of patients)*	23% (3 new, 1 old)	20% (3 old)	50% (5 new, 2 old)	6% (1 new)	30% (3 new, 1 old)	0%	14% (2 old)	22% (2 new, 1 old)	22% (2 new, 2 old)	9% (1 new)	21% (3 old)	7% (1 new)	7% (1 new)	15% (2 old)	26% (3 old 1 new)	7% (1 old)	6% (1 new)	7% (1 new)	0%	7% (1 new)	10% (old)	11% (2 new)	33% (3 new)	0%
Empty Admin Boxes	41%	20%	28%	6%	7%	63%	28%	69%	28%	33%	7%	43%	7%	23%	6%	21%	26%	7%	36%	53%	90%	39%	0%	0%
Omission code 4	41%	20%	0%	20%	30%	72%	28%	7%	22%	25%	14%	14%	7%	23%	0%	28%	20%	7%	36%	33%	30%	11%	0%	0%
Omitted Critical Medicines	0%	0%	0%	0%	0%	18%	0%	23%	0%	0%	7%	0%	0%	8%	13%	0%	0%	7%	0%	0%	0%	0%	0%	0%

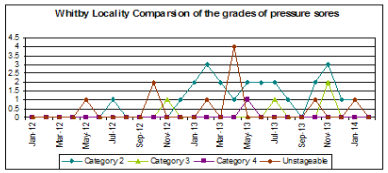
RCA feedback and action planning	RCA for a fractured neck of femur following a fall showed that staff need education around the risk assessment process and associated interventions required on care plan. Lyeanda Berry (Senior nurse Quality & Performance and Darren Fletcher (Patient Safety Manager) have arranged 3 training sessions for staff to cover these points

WHITBY Community Hospital
Patient Safety Dashboard – June 6th 2014

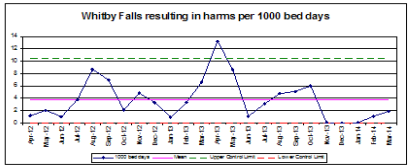
Datix Incident Reporting Whitby Hospital	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan14	Feb 14	Mar 14
Number of incidents reported on Datix web	26	22	19	18	17	14	33	18	11	3	10	5
Number of medication related incidents	0	1	3	0	0	0	2	1	0	0	0	0
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	0
Number of formal complaints	0	0	0	0	0	0		0	0	0	0	0
Number of Serious Incidents (SI's)	0	0	0	0	1	1	0	0	0	0	0	0
Number of Critical Incidents (CI's)	0	0	0	0	1	0	0	0	0	0	0	0

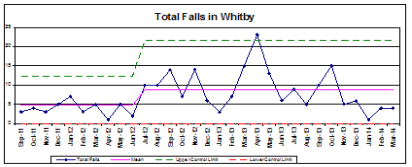
Pressure Ulcers





Falls (Datix)





Target 20% reduction in falls 13/14: Mean number of Falls with harm per 1000 beds days to not exceed 3.6 per month.

Mean falls with harm per 1000 bed days	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
	13	8.6	1	3	4.8	4.5	4.4	4.5	0	0	1.1	1.9

Mean falls with harm per 1000 bed days over 13/14 = 3.5 ****** 20% reduction in falls with harm achieved!!! ******

Activity	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14	
	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM
Admissions	19	18	17	35	11	24	18	27	10	16	7	11	9	14	11	15	9	15	11	17	15	22	18	28
Discharges	21	19	18	30	10	22	17	26	18	29	10	14	15	30	15	17	19	23	9	16	15	18	19	28
Mean Length of stay *previous yr	20.6 *0	20.8 *0	28.9 *0	16.0 *0	17.2 *0	15.7 *0	36.5 *0	21.6 *0	33.3 *14.7	23.3 *0	41.8 *0	23.5 *0	42.1 *0	29.1 *16.3	43.9 *15.0	21.3 *13.0	29.3 *21.0	44.6 *16.1	54.1 *24.6	26.3 *18.9	35 25*1 4.4	24.5 *27.5	50.1 *37.4	42 *15.6

IPC	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14	
	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM
% compliance with hand hygiene	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
% compliance with glove use	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
% compliance with bare below the elbow	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
CDIFF >72hrs (accumulative Whitby year to date)	1		1		1		0		0		0		0		0		0		0		1		0	

Deaths & Mortality reviews	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan14	Feb 14	Mar 14
Number of in-hospital deaths (discharge as died)	6 (12.5%)	2 (3.6%)	3 (7.7%)	9 (16%)	9 (16%)	6 (18%)	4 (6.9%)	5 (11.6%)	1 (1.9%)	0	4 (9%)	5
Number of morality reviews	2	0	0	0	0	1	0	0	1	0	1	1

Harm Free Care - Safety Thermometer Prevalence data	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14	
	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM
Overall Harm Free care %	*No data on Signal for these dates*						*73%*	*94%*	*93%*	*84%*	*92%*	*82%*	*86%*	*75%*	*90%*	*95%*	*92%*	*100 %*	*100 %*		*80%*	*86%*	*84%*	*85%*	*77%*
VTE *(% of patients with a VTE)*	0%	5% (1 new)	0%	11% (2 old)	7% (1 old)	6% (1 old)	0%	0%	7% (1 old)	0%	0%	5% (1 new)	7% (1 old)	5% (1 old)	9% (1 old)	0%	7% (1 old	20% (3 old)	0%	7%	7%	0%	0%	0%
Falls *(% of patients who fell)*	13% (2 no harm)	10% (2 no harm)	14% (2 low harm)	11% (2 low harm)	57% (1 sev, 3 mod, 4 low)*	12% (2 low harm)	6% (1 no harm)	0%	6% (1 no harm)	0%	0%	6% (1 no harm)	7% (1 mod harm)	0%	0%	7% (1 no harm)	0%	0%	0%	0%	0%	0%	21% (3 no harm)	5%
Pressure Ulcers *(% of patients with a new PU- CQUIN)*	7% (1 cat 2)	0%	0%	0%	0%	6% (2 cat 2)	13% (2 cat 2)	0%	0%	10% (2 cat 2)	0%	0%	7% (1 U)	5% (1 cat 2)	9% (1 cat 2)	0%	7% (1 cat 2)	0%	0%	0%	0%	5% (1 cat 2)	7%	0%
Pressure Ulcers *(% of patients with an old PU - CQUIN)*	0%	10% (2 cat 3)	7% (1 cat 2)	16% (1 cat 3, 2 cat 2)	7% (1 cat 2)	6% (1 cat 4)	6% (1 cat 2)	5% (1 cat 2)	0%	5% (1 cat 2)	7% (1 cat2)	12% (2 cat 2)	7% (1 cat2)	10%	0%	5% (1 cat 2)	0%	0%	0%	13% (2 Cat 2)	13% (2 cat 2)	11% (1cat 1 &1 cat 3)	7%	11%
UTI *(ward harms) (% of patients)*	26% (4 old)	10% (1 new, 1 old)	14% (2 new)	27% (5 new)	7% (1 new)	12% (2 old)	13% (1 new, 1 old)	21% (4 old)	13% (1 new, 1 old)	5% (1 new)	21% (2 new 1 old)	6% (1 new)	13% (2 new)	40% (6 new 2 old)	9% (1 old)	10% (1 old 1 new)	7% (1 new)	0%	0%	0%	7% (1 old)	0%	14% (1 old 1 new)	10% (1 old 1 new)

S T– Local measures	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14	
	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM
Empty Admin Boxes (% missed doses)	20%	5%	35%	0%	50%	56%	0%	0%	0%	10%	0%	0%	0%	20%	45%	0%	10%	7%	0%	7%	0%	0%	0%	0%
Omission code 4 (% drug not available)	46%	5%	42%	0%	21%	31%	0%	5%	0%	5%	0%	0%	13%	10%	0%	10%	0%	47%	0%	0%	0%	5%	7%	11%
% Omitted Critical Medicines	0%	0%	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	7%	0%	0%	0%	0%	0%	0%

Risk Register

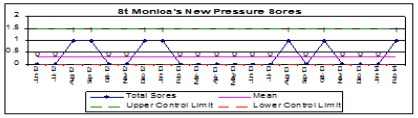
Top 3 Risks on Risk Register	
1.	Failure to meet CQUIN pressure ulcer target
2.	Clinical Governance around MIU.
3.	North York Fire Service work to be carried out following recent review of site.

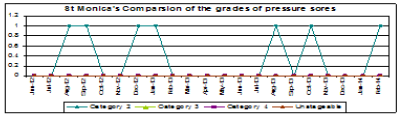
ST MONICA'S Community Hospital
Patient Safety Dashboard – May 08th 2014

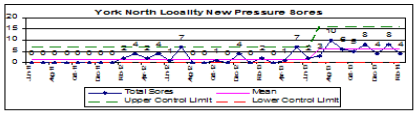
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of incidents reported on - Datix web	2	5	6	4	7	2	3	6	2	4	7	
Number of medication related incidents	0	0	0	3	0	0	0	2	0	1*	0	
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	
Number of formal complaints	0	0	0	0	0	0	0	0	0	0	0	
Number of Serious Incidents (SI's)	0	0	0	0	0	0	0	0	0	0	0	
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	

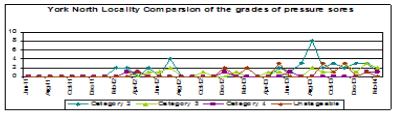
*Pt had two medicine charts in use, marked 1 of 2 and 2 of 2. the pharmacist reviewed his medicine charts and added Warfarin spo' to his second chart (2 of 2). This was already on the first medicine chart (1 of 2) and was being administered from this prescription. The ward staff noticed this and did not administer the warfarin from the second chart. I discontinued this second prescription to avoid any confusion.

Pressure Ulcers

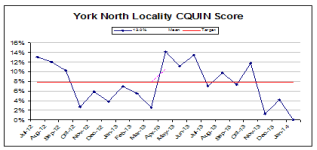


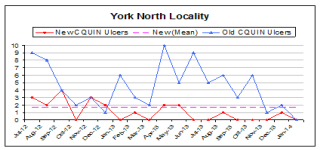




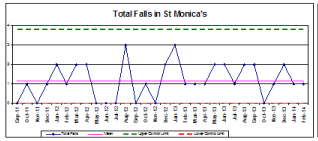


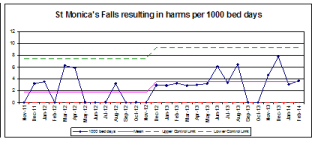
Pressure Ulcer prevalence St Monica's, North Ryedale and North York Community Services (CQUIN)





Falls





Target of 20 % reduction in falls over 13/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Mean falls with harm per 1000 bed days Trajectory 1.7mnth	3.0	3.2	6.1	3.4	3.4	0	0	4.6	7.7	3	3	

Deaths & Mortality reviews	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of in-hospital deaths (%)	4 (19%)	1 (5.6%)	5 (41%)	0	1 (7%)	3 (17%)	2(18%)	2(11%)	2(11%)	4(21%)	4(11%)	2 (33%)
Number of morality reviews	0	0	1	0	0	3	1	1*	1	3	0	0

*as of 23/12/13

Activity	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Admissions	17	14	12	15	14	19	8	14	18	17	16	6
Discharges	18	14	12	15	14	17	11	17	12	19	14	6
Delayed Transfer of Care	No Information available											
Length of hospital stay – mean *(previous yr)*	24 (40)	13.1 (23)	30 (21)	13.9 (50)	24.3	18.7(29)	20.8(16)	19.4(21)	18.2(20)	16(13)	18 (13.1)	22.7 (26.9)

Harm Free Care - Safety Thermometer Prevalence data	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Overall Ward Harm Free	100%	100%	90%	78%	90%	100%	100%	100%	100%	100%	100%	100%
VTE *(% of patients with a VTE)*	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Falls *(% of patients who fell)*	9% (1 no harm)	33% (3 low harm)	10% (1 low harm)	23% (1 no harm, 1 low harm)	0%	0%	0%	0%	16% (1 no harm)	0%	0%	0%
Pressure Ulcers *(% of patients with a new PU)*	0%	0%	0%	0%	10%	0%	0%	11%	0%	0%	0%	0%
Pressure Ulcers *(% of patients with an old PU)*	0%	0%	0%	0%	0	11%	0%	0%	16% (1 cat 3)	10% (1 cat 2)	0%	25% (2 cat 2 + 1 at 4)
UTI *(% of patients)*	19% (1 old, 1 new)	12% (1 old)	20% (1 old, 1 new)	23% (1 old, 1 new)	30% (3 new)	0%	0%	0%	0%	0%	13% (1 old)	0%
Empty Admin Boxes	0	10%	0%	20%	20%	22%	9%	11%	50%	10%	0%	25%
Omission code 4	0%	12%	0%	23%	20%	44%	0%	11%	16%	0%	13%	0%
Omitted Critical Medicines	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	8%

IPC	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
% compliance with hand hygiene	100%	95%	95%	94.3%	100%	100%	100%	100%	100%	100%	100%	100%
% compliance with glove use	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% compliance with bare below the elbow	88%	95%	95%	89%*	100%	100%	100%	100%	100%	100%	100%	100%
CDIFF >72hrs (accumulative Whitby year to date)	0	0	0	0	0	0	0	0	0	0	0	0

*Dr 67%

RCA feedback and action planning	RCA for fractured neck of femur following a fall showed that Comfort rounds need to be more frequent for patients at high risk of falling.

Risk Register

Top 3 Risks on Risk Register	
1.	Lack of storage at St Monica's
2.	Lack of bank staff provision
3.	Staffing establishment

SELBY Community Hospital & Selby Locality
Patient Safety Dashboard – 10th June 2014

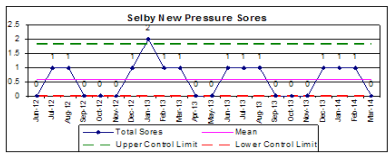
Selby community hospital Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of incidents reported on - Datix web	7											
Number of medication related incidents	0											
Number of settled clinical litigation cases	0											
Number of formal complaints	0											
Number of Serious Incidents (SI's)	1*											
Number of Critical Incidents (CI's)	0											

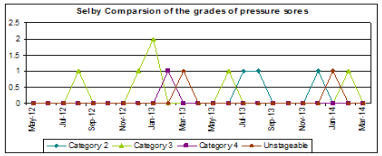
*In-patient fall resulting in a fractured neck of femur

York South DN Teams Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of incidents reported on - Datix web	14											
Number of medication related incidents	1**											
Number of settled clinical litigation cases	0											
Number of formal complaints	0											
Number of Serious Incidents (SI's)	1*											
Number of Critical Incidents (CI's)	0											

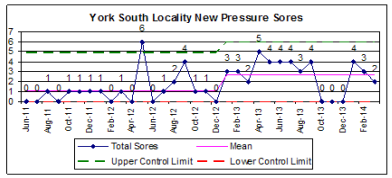
*Community patient with a category 3 pressure ulcer
**patient given duplicate does of insulin

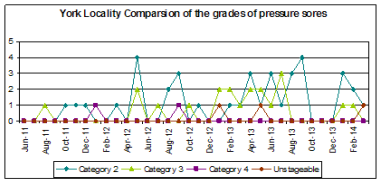
Pressure Ulcer Incidence - Selby community hospital



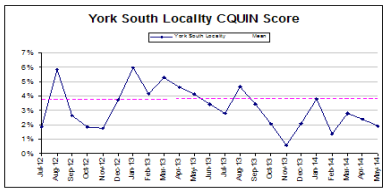


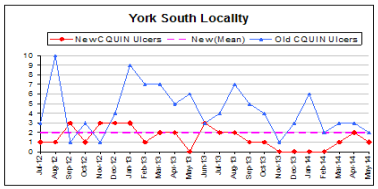
Pressure Ulcer Incidence – York South Locality DN Teams



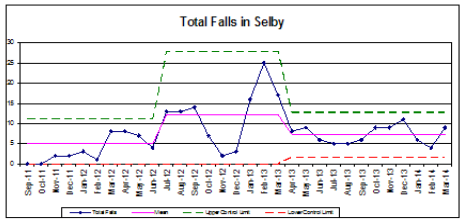


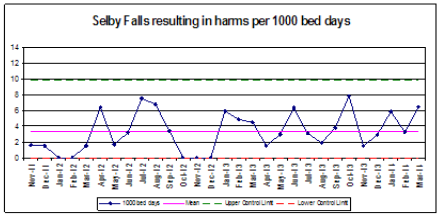
Pressure Ulcer Prevalence Safety Thermometer data - Selby Locality (CQUIN)
Trust target for 14/15 is to achieve 4.39%





Falls Incidence – Selby community hospital





Selby Community hospital Deaths & Mortality reviews	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of in-hospital deaths	4 (7%)											
Number of morality reviews	0											

Selby Community hospital Activity	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Admissions	56											
Discharges	56											
Length of hospital stay – mean *(previous yr)*	19 (32)											

Selby community hospital IPC	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
% compliance with hand hygiene	100											
% compliance with glove use	100											
% compliance with bare below the elbow	100											
CDIFF >72hrs	0											

South York IPC	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
% compliance with hand hygiene	100											
% compliance with glove use	100											
% compliance with bare below the elbow	100											

Selby Safety Thermometer Prevalence data	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Overall Harm free care %	*100%*											
VTE *(% of patients with a VTE)*	0%											
Falls *(% of patients who fell)*	0%											
Pressure Ulcers *(% of pt's with a PU)*	0%											
CAUTI *(% of patients)*	0%											
Local measures												
Empty Admin Boxes	5%											
Omission code 4	0%											
Omitted Critical Medicines	5%											

York South DN Teams Safety Thermometer Prevalence data	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Overall Harm free care %	*91%*											
VTE *(% of patients with a VTE)*	0%											
Falls *(% of patients who fell)*	0%											
Pressure Ulcers *(% of pt's with a PU)*	0%											
CAUTI *(% of patients)*	9%											

Risk Register

Top 3 Risks on Risk Register	
1	Lack of bookable care for fast track packages
2	Community equipment
3	Night staffing at WXC & St Helens hospitals

Dementia

Percentage of Patients Meeting the AMTS Screening Target (Trust)												
Indicator	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Percentage of patients meeting the AMTS target	95.60%	93.90%	92.20%	91.30%	92.00%	92.80%	86.40%	88.60%	89.00%	88.80%	87.40%	90.30%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Patients Meeting the AMTS Screening Target YORK												
Indicator	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Percentage of patients meeting the AMTS target	95.60%	92.80%	90.60%	92.00%	95.70%	92.60%	88.20%	90.70%	94.30%	94.70%	93.30%	92.60%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Patients Meeting the AMTS Screening Target SCARBOROUGH												
Indicator	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Percentage of patients meeting the AMTS target		94.50%	74.40%	90.50%	85.80%	92.40%	83.10%	86.20%	78.10%	81.30%	79.00%	87.10%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

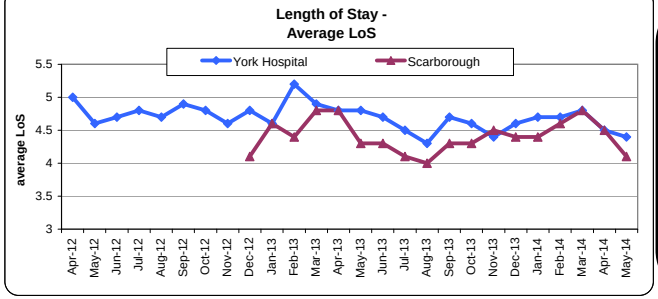
During May over 90% of patients admitted to the Trust were screened for dementia.

Screening at Scarborough Hospital has improved however the 90% target was not achieved.

Data source: Signal

Clinical Effectiveness Dashboard

Clinical Effectiveness



The Length of Stay (LOS) for in-patients (excluding day cases and babies) decresed during May.

The average length of stay for patients at York Hospital for May was 4.4 days and patients at Scarborough was 4.1 days.

Data source: Signal

Corporate Risk Register (Quality and Safety issues)- March 2014

Corporate Risk Register-March 2014		
Risk description	**Risk Rating**	**Start date**
Capacity Issues	20	Feb-13
A risk to patients of harm through Drug Errors both within acute and community services E.g. Never event that occurred at Whitby Hospital	20	Oct-03
Risk of harm to patients due to lack of patient ID and failure to follow policy. (updated November 2010) Variation in compliance with patient ID policy	16	Jun -09
Risk to patient safety from the lack of a commissioned service to specialist advice regarding paediatric mental health as there is no 'out of hours' service provision by the mental health specialist services.	15	Feb-11
Secondary care patients at risk of sub-optimal care due to lack of psychiatry liaison.	15	Jan-06
Exceeding trajectories for C. diff	15	Feb-11
Inability to fulfil the Training requirements of the PREVENT Strategy to the standards as laid out in the Department of Health Document; "Building Partnerships, Staying Safe, the health sector contribution to HM Governments Prevent strategy.	12	Jun-12
Public/Stakeholder/Political reputation/media turbulence as reconfiguring proposals begin to be in the public domain	10	Feb-11
Delay in treatment due to failure to act on abnormal test results	8	Sep-07
Risk to compliance with Children's safeguarding standards due to levels of staff trained at levels 2 and 3	6	Sep-12

Report: Patient Safety > Patient Safety Scorecard
Hierarchy: Trust overview
Site time period: Apr 2013 to Feb 2014 Peer time period: Apr 2013 to Feb 2014

Description	Change	Value Current Period	Value Previous Period	Site Numerator	Site Denominator	Peer 25th Percentile	Peer 75th Percentile	Peer Average	Peer Numerator	Peer Denominator	Rating
Data Quality Index (HRGv4 based)	Current period is 0% worse than previous period.	94.3	94.5	148,299	157,251	95	96.8	95.6	15,670,306	16,392,023	Red
% FCEs with palliative care code	Current period is 2% better than previous period.	0.69%	0.70%	1,054	153,688	0.99%	0.60%	0.77%	124,086	16,184,574	Amber
% Deaths with Palliative care code	Current period is 8% worse than previous period.	15.90%	14.78%	283	1,780	24.34%	14.85%	19.73%	34,169	173,145	Amber
% Sign or symptom as a primary diagnosis	Current period is 7% better than previous period.	10.89%	11.72%	16,729	153,688	11.80%	9.04%	10.10%	1,635,279	16,184,574	Amber
Outpatient DNA Rate	Current period is 14% better than previous period.	5.70%	6.60%	32,233	566,345	9.90%	7.10%	9.00%	2,028,941	22,497,654	Green
Readmissions 7 days	Current period is 5% better than previous period.	2.90%	3.00%	3,681	127,326	3.60%	2.80%	3.10%	439,316	14,037,064	Amber
Readmissions 30 Days	Current period is 6% better than previous period.	6.40%	6.80%	7,910	123,818	7.50%	5.80%	6.50%	891,666	13,738,732	Amber
Mortality	Current period is 8% better than previous period.	1.44%	1.56%	1,778	123,818	1.48%	1.17%	1.24%	171,045	13,738,732	Amber
Infection rate following caesarean section	Current period is 60% better than previous period.	0.19%	0.47%	2	1,056	0.45%	0.08%	0.33%	476	146,516	Amber
Rates of deaths in hospital within 30 days of Non-elective surgery	Current period is 1% better than previous period.	1.70%	1.80%	140	8,049	1.70%	1.10%	1.40%	13,859	978,365	Red
Rates of deaths in hospital within 30 days of Elective surgery	Current period is 14% worse than previous period.	0.02%	0.02%	5	25,332	0.04%	0.02%	0.03%	862	2,792,970	Amber
Discharge to usual place of residence within 28 days of emergency admission from there with a hip fracture	Current period is 9% better than previous period.	56.20%	51.30%	304	541	41.80%	54.70%	48.70%	23,971	49,180	Green

Maternity Dashboard - York and Scarborough

York Teaching Hospital NHS
NHS Foundation Trust

York Maternity Dashboard:

			Measure	Data source	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Flag Source	June	July	August	September	October	November	December	January	February	March	April	May	Av. Monthly YtD
Activity	Births	Bookings	1st m/w visit	CMIS from Jan CPD	≤302	302-329	≥330	prev. stats	298	313	325	278	308	301	305	394	316	291	273	249	304
		Bookings <13 weeks	No. of mothers	CMIS from Jan CPD	≥90%	76%-89%	≤75%	CQUIN	91%	91%	89%	88%	87%	89%	88%	86%			82%	81%	87%
		Bookings ≥13 weeks (exc transfer	No. of mothers		≥90%	76%-89%	≤75%	CQUIN											23.00		
		Bookings ≥ 13wks seen within 2 w	No. of mothers	Mat Rec	≥90%	76%-89%	≤75%	CQUIN													
		Births	No. of babies	CMIS	≤295	296-309	≥310	prev. stats	241	299	282	296	293	279	285	295	234	285	248	287	277
		No. of women delivered	No. of mothers	CMIS					233	294	271	289	283	274	276	288	230	279	242	285	270
	Closures	Homebirth service suspended	No. of closures	Comm. Manager	0-3	4-6	7 or more		2	0	1	1	6	6	4	1	2	4	0		2
		Homebirth service suspended	No. of women	Comm. Manager	0	1	2 or more		0	0	0	0	2	0	0	0	1	0	0		0
		Escalation Policy implemented	No. of times	Comm. Manager	3	4-5	6 or more		0	1	0	5	3	3	2	3	0	2	1		2
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	1	0
		SCBU closed to admissions	In utero transfers	Transfer folder	0	1	2 or more		0	0	2	4	3	0	3	0	0	0	0	5	1
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	30.5	30.5	30.1	29.7	28.4	28.4	29.8	31.0	31.0				29.9
		M/W per births	Ratio	Matron				safer childbirth									24.8				33.0
		HCA's	WTE	Matron				staffing paper	20.62	20.62	19.82	20.02	20.02	20.02	21.01	19.43	19.43				20.11
		1 to 1 care in Labour		Risk Team																75.00	
		L/W Co-ordinator supernumary %		Risk Team					86	65	48	55	48	47	45	51	80	65	71	51	59
		Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	76	76	76	76	76	76	76	76	76	76	76	76	76
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10		10	10	10	10	10	10	10	10	10	10	10	10	10
		Supervisor : M/w ratio 1 :	Ratio	Rota	12	13-15	15	SHA	13	13	15	15	13	13	13	12	13	14	14	14	14
Clinical Indicators	Neonatal/	Sponateous Vaginal Births	No. of svd	CMIS	≥65%	64%	≤63%		56.8	67.2	62.7	63.5	68.3	64.8	62.1	61.7	61.5	59.6	58.0	58.5	62.1
	Maternal	Operative Vaginal Births	No. of instr. births	CMIS	≤15%	16-19%	≥20%	prev. stats	17.8	11.7	12.4	8.4	10.9	10.7	12.9	9.5	15.8	12.6	15.7	14.0	12.7
	Morbidity	C/S Deliveries	Em & elect	CMIS	≤24%	24.1-25.9	≥26%	prev. stats	25.3	21.1	24.8	27.7	20.8	24.0	24.5	28.8	22.6	27.7	25.8	26.0	24.9
		Eclampsia	No. of women	CMIS	0		1 or more		0	0	0	0	0	0	0	1	0	0	0	1	0
		Undiagnosed Breech in Labour	No. of women	CMIS	2 or less	3-4	5 or more	prev. stats	1	1	4	1	3	3	1	1	0	0	0	2	1
		ICU transfers	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	1	2	1	0	1	0	1	2	0	0	0	0	1
		HDU on L/W	No. of days	Handover Sheet					12	21	15	15	25	15	14	18	17	11	10	30	17
		Uterine Rupture from Jan 14	No of women	CPD	0	1	2 or more									0	0	0	0	0	0
		P/N Hysterectomies < 7days p/n	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	0	1	0	0	0	1						
		BBA	No. of women	Risk Team - Datix	1	2-3	4 or more	prev. stats	1	3	7	2	6	4	1	4	2	3	4	5	4
		Meconium Aspirate	No. of babies	SCBU sister	0	1	2 or more	prev. stats	0	0	1	0	0	0	0	0	1	0	0	0	0
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	0	2	1	1	0	0	0	0	0	0	0	0	1
	Risk	SI's	Total	Risk Team	0	1	2 or more		0	1	0	0	0	0	0	0	0	0	0	1	0
	Management	PPH > 2L	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		2	2	5	4	7	7	1	1	2	1	1	5	3
		Shoulder Dystocia - True	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	RCOG	2	3	1	3	6	6	3	0	0	2	1	3	2
		3rd/4th Degree Tear	% of tears (vaginal	CMIS	≤1.5%	1.6-6.1%	≥6.2%	RCOG	6.1	5.9	4.2	3.7	3.4	6.1	2.8	4.7	4.4	6.8	4.4	4.1	4.7
	Training	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		80	90	90	90	90	89	99	94	96	95	96	94	92
	Attendance	YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		69	69	39	48	55	50	69	78	81	81	78	83	67
		Training cancelled	No. of staff affected	Risk Team	0		≥1		8	44	0	7	1	0	1	1	0	0	0	0	0
	New	Informal	Total	Matron	0	1-4	5 or more		2	1	1	0	0	1	0	3	0	1	3	0	#DIV/0!
	Complaints	Formal	Total	Matron	0	1-4	5 or more		1	3	3	1	2	1	2	2	1	0	2	0	#DIV/0!
	New Claims		Total	Directorate Manager	0	1	2 or more		0	1	0	1	0	0	0	2	1	0	1	0	1

Scarborough Maternity Dashboard:

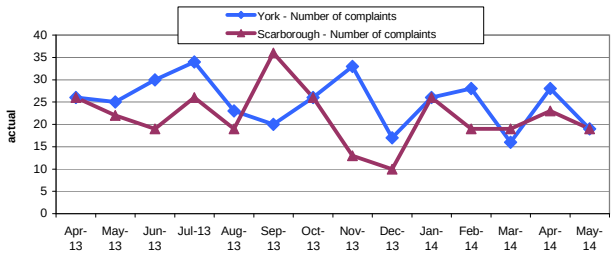
York Teaching Hospital NHS
NHS Foundation Trust

			Measure	Data source	No Concern (green)	Of Concern (Amber)	Concerns (Red)	Flag Source	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Av. Monthly YtD
Activity	Births	Bookings	1st m/w visit	IS - Evolution	≤200	201-249	≥250	prev. stats	159	200	169	185	216	196	165	247	190	156	79	89		187
		Bookings <13 weeks	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	81%	87%	83%	82%	81%	96%	100%	100%	100%	100%	76%	72%		90%
		Bookings <13 weeks (exc transfers etc)	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	97%	88%	99%	86%	TBC	96%	n/a	n/a	n/a	n/a	2%			92%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers		≥90%	76%-89%	≤75%	CQUIN											3.0			
		Births	No. of babies	IS - Evolution	≤170	171-189	≥190	prev. stats	108	140	154	135	145	131	124	145	128	119	75	118		133
		No. of women delivered	No. of mothers	IS - Evolution	≤170	171-189	≥190	prev. stats	107	140	153	133	142	129	122	143	126	118	74	118		132
	Closures	Homebirth service suspended	No. of closures	Comm Team Leader	0-3	4-6	7 or more		0	0	0	0	0	0	0	0	0	0	0	0		0
		Homebirth service suspended	No. of women	Comm Team Leader	0	1	2 or more		0	0	0	0	0	0	0	0	0	0	0	0		0
		Escalation Policy implemented	No. of times	Matron	3	4-5	6 or more		0	0	0	0	0	0	0	0	0	0	0	0		0
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0		0
		MLU Closure	No. of closures	Matron	0	1-2	3 or more		0	0	1	2										0
		MLU Closure	No. of women	Matron	0	1-2	3 or more		0	0	0	1										0
		SCBU closed to admissions	In utero transfers	Risk Team	0	1	2 or more		0	0	0	0	1	1	2	1	0	4	0	0		0
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0			44.0
		HCA's	WTE	Matron				staffing paper	18.55	18.55	18.79	18.79	19.59	19.59	19.59	18.32	18.32	18.32	18.32			17.82
		1:1 care in labour		IS - Evolution					95%	94%	96%	96%	96%	98%	99%	96%	98%	99%				96%
		L/W Co-ordinator Supernumary %		L/W Manager									56%	56%	n/a	41.93%	n/a	n/a	5	4		56%
		Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	40	40	40	40	40	40	40	40	40	40	40	40	40	40
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10	Safer Childbirth	3	3	3	3	3	3	3	3	3	3	3	10	10	3
		Supervisor : M/w ratio 1 :	Ratio	Matron	15	16-19	20	NMC	13	13	15	15	13	13	13	14	14	14	14	14		14
Clinical	Neonatal/Maternal	Sponateous Vaginal Births	No. of svd	IS - Evolution	≥65%	64%	≤63%		76.9%	76.4%	77.9%	70.4%	64.8%	65.6%	67.7%	68.3%	71.9%	72.3%	56.0%	80.0%		71.9%
Indicators	Morbidity	Operative Vaginal Births	No. of instr. births	IS - Evolution	≤15%	16-19%	≥20%	prev. stats	4.6%	5.0%	4.5%	8.1%	8.3%	6.1%	4.0%	3.4%	4.7%	5.9%	4.0%	8.0%		5.3%
		C/S Deliveries	Em & elect	IS - Evolution	≤24%	24.1-25.9	≥26%	prev. stats	17.6%	17.9%	16.2%	20.0%	24.8%	26.0%	26.6%	26.9%	21.9%	21.0%	14.0%	28.0%		21.5%
		Eclampsia	No. of women	IS - Evolution	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0		0
		Undiagnosed Breech in Labour	No. of women	Risk Team	2 or less	3-4	5 or more	prev. stats	1	1	1	0	1	1	0	0	0	0	1	1		1
		ICU transfers	No. of women	IS - Evolution	0	1	2 or more	prev. stats	1	0	0	1	0	0	0	0	0	0	0	0		0
		HDU on L/W	No. of days	Risk Team							0	2	2	5	4	2	3		3	0		2
		P/N Hysterectomies < 7days p/n	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	0		0
		BBA	No. of women	IS - Evolution	1	2-3	4 or more	prev. stats	1	1	4	1	1	0	1	1	1	0	0	0		1
		Meconium Aspirate	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	1	0	1	0	0	1		0
		Diagnosis of HIE	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	1		0
	Risk Management	SI's	Total	Risk Team	0	1	2 or more		0	0	0	0	0	0	0	0	1	0	1	0		0
		PPH > 2L	No. of women	IS - Evolution	1 or less	2-3	3 or more		0	0	0	1	0	1	1	0	1	0	2	0		1
		Shoulder Dystocia - True	No. of women	IS - Evolution	1 or less	2-3	3 or more	RCOG	1	1	1	0	4	0	0	1	1	0	0	1		1
		3rd/4th Degree Tear	% of tears (vaginal	IS - Evolution	≤1.5%	1.6-6.1%	≥6.2%	RCOG	0.9%	1.4%	2.6%	0.8%	1.4%	0.8%	2.5%	4.9%	4.0%	0.0%	1.0%	3.0%		1.9%
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%			67	67	77	85	92	98	91	93					86
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%			57	57	53	79	82	90	37	92					70
		Training cancelled	No. of staff affecte	Risk Team	0		≥1			0	0	0	0	0	1	0	0	0	0	0		0
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		1	1	0	0	1	3	1	1	3	2	0	1		1
		Formal	Total	Matron	0	1-4	5 or more		1	1	1	0	1	1	1	1	1	0	2	0		1
	New Claims		Total	Risk Team	0	1	2 or more		0	1	0	0	0	0	0	0	2	1	0	1		1

Patient Experience Dashboard

Patient Experience

Number of complaints

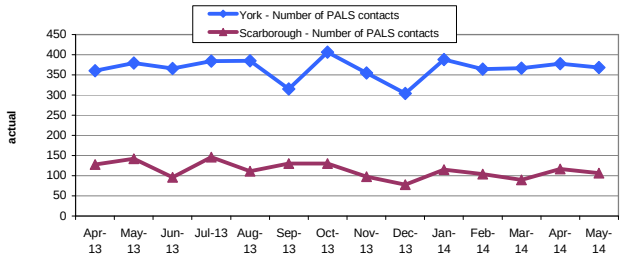


Complaints registered in York relate to York Hospital and Community Services.

Complaints registered in Scarborough relate to Scarborough Hospital and Bridlington Hospital.

There were 19 new complaints registered to the York site and 19 to the Scarborough site in May.

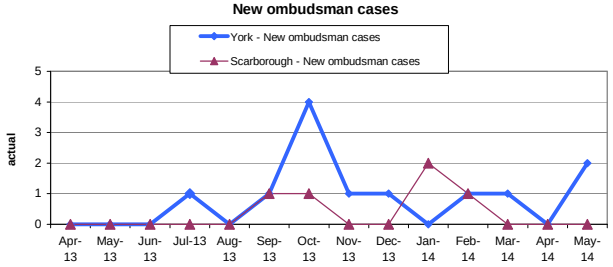
Number of PALS contacts



PALS contacts include face to face contact or contact by telephone or e-mail. Completed comment cards are also included in these figures.

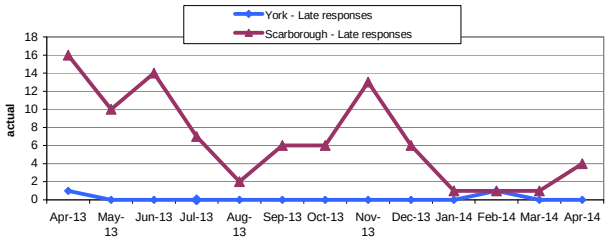
There were 368 PALS enquiries at York Hospital and 106 PALS enquiries at Scarborough in May.

New ombudsman cases



There were two new ombudsman cases reported from the York site, and none at the Scarborough site in May.

Complaints - Late responses



Late responses are defined as those complaints which do not meet the agreed response time. Complaint investigations that have been extended and agreed with the complainant are not included unless the extended deadline is not achieved.

There was four late responses to complainants at the Scarborough site compared to none at the York site in April.

York Complaints by Directorate March 2014	
Medicine (General & Acute)	3
Elderly Medicine	2
Head & Neck	2
Obstetrics and Gynaecology	2
Theatres Anaesthetics and Critical Care	1
Community Services (intermediate care team)	1
Emergency Medicine	1
Specialist Medicine	1
Nursing and Improvement (re SI process)	1
Operations (discharge liaison)	1
General Surgery & Urology	1
Totals:	16

York Complaints by subject March 2014	
All aspects of clinical treatment	11
Appointments, delay/cancellation (out-patient)	2
Communication/information to patients (written and oral)	1
Attitude of staff	1
Admissions, discharge and transfer arrangements	1
Totals:	16

Scarborough's Top three complaint issues from DATIX March 2014	
1. All aspects of clinical treatment	12
2. Attitude of staff	4
3. Admissions, discharge and transfer arrangements	2

Friends & Family Test Results

York Teaching Hospital NHS
NHS Foundation Trust

01 Apr 2014 - 30 Apr 2014 — **Inpatient / A&E**

Your Friends & Family Test Score is....	63	Last month your score was....	60

Highest score
Lowest score
Negative score

Top 3 most improved performing wards/services	6 Month Average	This Month	Improvement	Trend
Ward 37	67	100	33	
Beech	63	92	29	
Haldane	61	78	17	

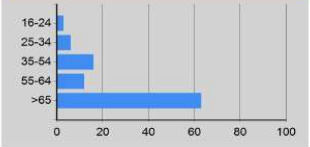
Top 3 consistently high performing wards/services	6 Month Average	This Month	Improvement	Trend
CCU York	97	100	3	
Lloyd	95	94	-1	
ESA	90	100	10	

Top 3 consistently low peforming wards/services	6 Month Average	This Month	Improvement	Trend
A&E York	40	37	-3	
A&E Scarborough	55	63	8	
Haldane	61	78	17	

Please note that only wards with 5 or more responses for the month show in the tables above.

Who responded?

Response Rate	Male or Female	Age Profiles %
Eligible Patients 9455	44%	56%
Patient Responses 2196		
23%		



Patients extremely likely to recommend our Trust said:	Patients unlikely or extremely unlikely to recommend our Trust said:
"Staff brilliant, ward excellent, physio staff excellent."	"Most of the staff are excellent, good medical care."
"Excellent care. Proffesional and kind staff."	"Not enough staff. One toilet for six people is not acceptable. "

Produced by: picker Institute Europe

The Friends and Family score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent

Calculating the Net Promoter Score:

The best possible score the Trust can get is 100, where 100% of respondents are 'extremely likely' to recommend ('promoters'). The worst possible score is -100, where 100% of people are 'not likely' to recommend ('detractors'). Everyone who is 'neither likely nor unlikely', 'unlikely' or 'extremely unlikely' to recommend the ward or department counts as 'not likely'.

'Don't know' responses are disregarded when the FFT score is calculated.

People who are 'likely' to recommend are included in the calculation and are counted as 'neutral' (i.e. they are neither promoters nor detractors).

The FFT score is calculated as:

percentage of people extremely likely to recommend

minus

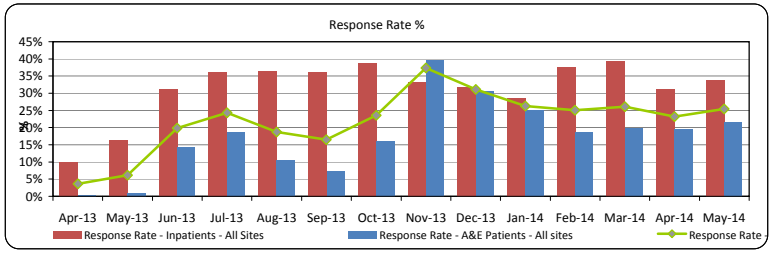
percentage of people not likely to recommend

The Friends and Family Test
Inpatients/Maternity and the Emergency Department

The Friends and Family Test (FFT) has now been rolled out across the Trust, with all adult inpatients, those attending ED and women accessing maternity services being asked the question "would you recommend this ward/ED/antenatal/labour and postnatal service to your family and friends".The Trust achieved the CQUIN requirements for Q4 and now focuses on the 2014/15 requirments on increased response rate in ED and Inpatients; roll out to community hospital inpatients, all outpatients, day cases and community services. The FFT Steering group and project workstreams continue to meet and take forward the implementation and development of FFT across the Trust. The focus for the Trust, in addition to roll-out is to ensure that the qualitative feedback gained through FFT is used to effectively inform patients of what we are doing to improve their experience of our services. Of 855 comments for April, only 8 comments were negative. A FFT Project Manager is currently being recruited to on a fixed one year contract.

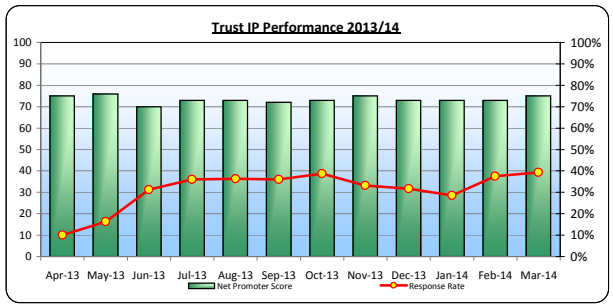
York ED is struggling to achieve the required response rate each month and is being supplemented by the good response rate at Scarborough ED. The Directorate are developing plans for the longer term to increase and maintain the response rate in ED. NHS England is reviewing the use of token systems for the purpose of FFT as some trusts use only the token system to capture quantitative feedback and not qualitative feedback. This Trust provides patients with a comment card to use in conjunction with the token. Qualitative feedback has reduced since the implementation of FFT but this will form part of future plans to improve responses in ED. The Trust awaits guidance from NHS England about the future of token systems.

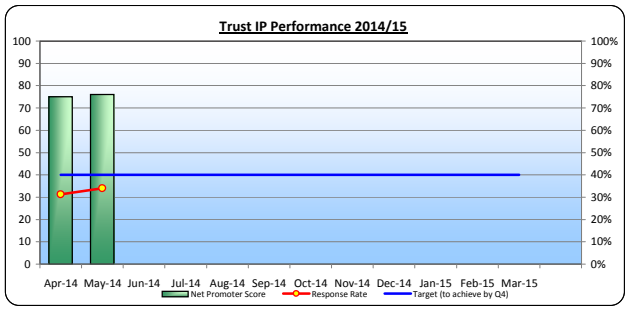
The Friends and Family Test rolled out to Community Hospital Inpatients at the beginning of May, ahead of the national roll-out date of December 2014. Reports will be produced from June 2014.

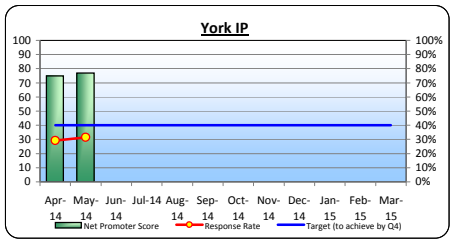


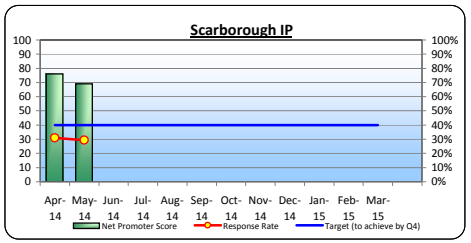
Inpatient Performance		Apr-14	May-14
Trust	Eligible patients	2988	3206
	Responses	936	1088
	Response Rate	**31.33%**	**33.94%**
	Net Promoter Score	75	76
York	Eligible patients	2003	2182
	Responses	584	686
	Response Rate	**29.16%**	**31.44%**
	Net Promoter Score	75	77
Sboro	Eligible patients	872	830
	Responses	269	243
	Response Rate	**30.85%**	**29.28%**
	Net Promoter Score	76	69
Brid	Eligible patients	113	194
	Responses	83	159
	Response Rate	73.45%	81.96%
	Net Promoter Score	72	84

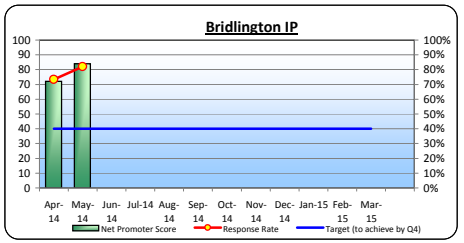
	No. Eligible	Responses	Target	Response Rate
Q1	30,369	2,975	15%	9.80%
Q2	29,611	5,933	20%	20.04%
Q3	28,098	8,550	20%	30.43%
Q4	27,149	7,007	20%	25.81%

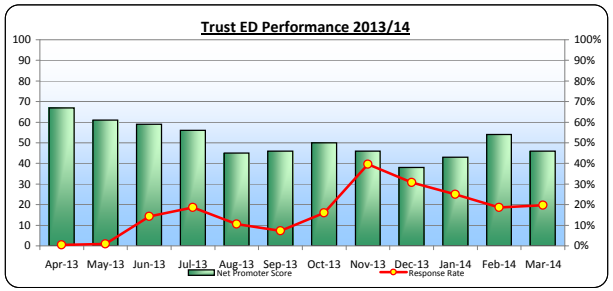




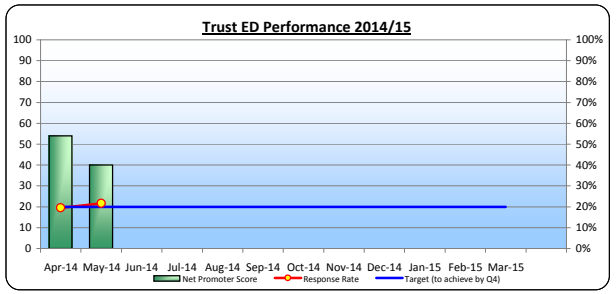


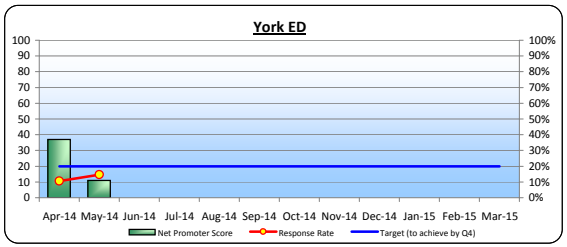


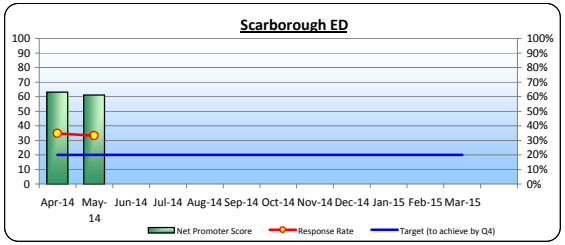




ED Performance		Apr-14	May-14
Trust	Eligible patients	6467	6970
	Responses	1260	1502
	Response Rate	**19.48%**	**21.55%**
	Net Promoter Score	54	40
York	Eligible patients	4079	4356
	Responses	429	636
	Response Rate	**10.52%**	**14.60%**
	Net Promoter Score	37	11
Sboro	Eligible patients	2388	2614
	Responses	831	866
	Response Rate	**34.80%**	**33.13%**
	Net Promoter Score	63	61





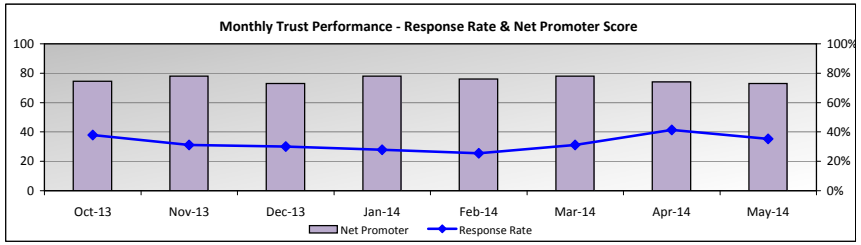


Friends and Family Test - April 2014 data				
Trust Name	**IP Response Rate %**	**IP FFT Score**	**A&E Response Rate**	**A&E FFT Score**
York Teaching Hospital NHS Foundation Trust	31	75	19.5	54
Hull & East Yorkshire Hospitals NHS Trust	39	82	14	63
Harrogate & District NHS Foundation Trust	40	75	21	60
Calderdale and Huddersfield NHS FT	37	75	21.5	49
Leeds Teaching Hospitals NHS Trust	40	74	16	46
Barnsley Hospital NHS Foundation Trust	29	81	15	63
Doncaster & Bassetlaw Hospitals NHS FT	29	74	16.5	54
Northern Lincs & Goole NHS FT	29	71	6	64
Airedale NHS Foundation Trust	44	73	14	58
Bradford Teaching Hospitals NHS FT	33	68	13	49
The Rotherham NHS Foundation Trust	29	76	22	60
Mid Yorkshire Hospital NHS Trust	32	76	24.5	64
Sheffield Teaching Hospitals NHS FT	36	78	23.5	47

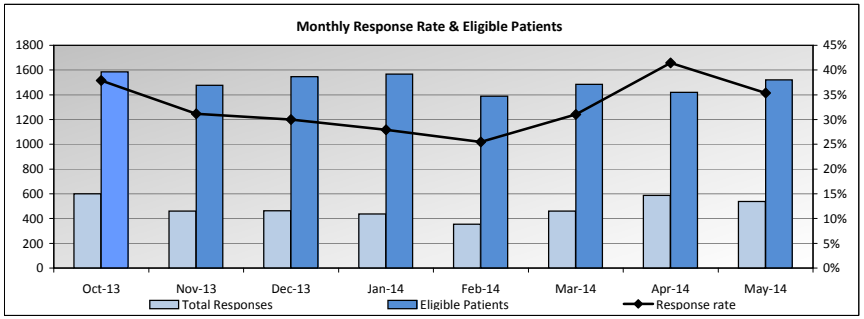
Maternity FFT

The FFT across the maternity pathway continues to achieve a good response rate and net promoter scores. April saw an increase to the 41% response rate, the highest rate since it commenced. The directorate produces quarterly action plans from the qualitative feedback received from patients and actions to address feedback which is considered negative. Staff from across the maternity directorate and the Maternity Services Liaison Committee are involved in agreeing plans and action from the FFT.

Trust Performance:

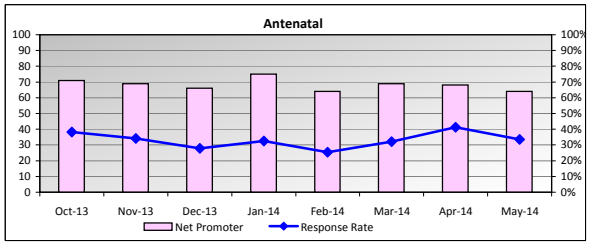


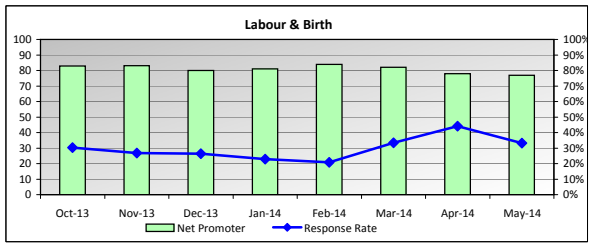
		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Q3	Q4
Total	Response Rate	37.92%	31.14%	30.01%	27.93%	25.47%	31.06%	41.44%	35.39%	33.09%	28.21%
	Net Promoter	74	78	73	78	76	78	74	73		
Antenatal	Response Rate	38.20%	34.06%	27.79%	32.46%	25.33%	32.11%	41.30%	33.60%	33.33%	29.81%
	Net Promoter	71	69	66	75	64	69	68	64		
Labour & Birth	Response Rate	30.35%	26.76%	26.43%	22.90%	20.92%	33.50%	44.13%	33.25%	27.89%	25.86%
	Net Promoter	83	83	80	81	84	82	78	77		
Postnatal	Response Rate	49.21%	34.48%	46.10%	31.27%	32.01%	38.41%	47.02%	39.23%	43.21%	33.91%
	Net Promoter	72	78	70	73	80	79	70	75		
Postnatal Community	Response Rate	36.61%	29.73%	23.20%	25.75%	25.17%	20.45%	34.20%	37.22%	29.88%	23.73%
	Net Promoter	73	85	79	84	83	83	82	79		

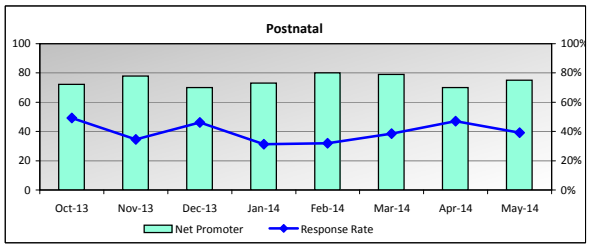


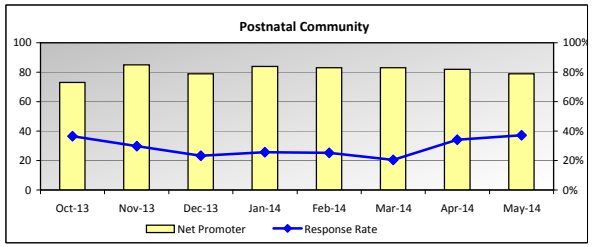
Trust Performance

Report Month	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know	Total Responses	Eligible Patients	Response rate	FFT Score
Oct-13	77.37%	19.13%	2.16%	0.83%	0.17%	0.33%	601	1585	37.92%	74
Nov-13	80.00%	17.39%	1.74%	0.43%	0.22%	0.22%	460	1477	31.14%	78
Dec-13	75.43%	21.98%	1.72%	0.65%	0.22%	0.00%	464	1546	30.01%	73
Jan-14	80.37%	17.12%	2.28%	0.23%	0.00%	0.00%	438	1568	27.93%	78
Feb-14	78.81%	18.64%	1.98%	0.00%	0.56%	0.00%	354	1390	25.47%	76
Mar-14	79.39%	18.22%	1.74%	0.22%	0.00%	0.43%	461	1484	31.06%	78
Apr-14	75.51%	22.62%	1.36%	0.34%	0.00%	0.17%	588	1419	41.44%	74
May-14	76.02%	20.07%	2.97%	0.37%	0.19%	0.37%	538	1520	35.39%	73









The Friends and Family Test – Roll-out to Outpatients, Day Cases and Community Services

A project work-stream has been set up to implement the roll out to Day Cases and Outpatients and a separate work-stream has been set up to implement FFT across Community Services. The latter group has not yet met, but is due to have its first meeting in June.

Comment cards, as used across our inpatient areas, are being used in the roll-out for outpatients. Pilot areas commenced early May in Neurology, Dermatology, Oncology treatment and OPD, Rheumatology, MES, Haematology treatment and OPD and VIU. Services to be roll out during June are Therapies, Renal, Selby War Memorial Hospital OPD, Sexual Health, X-ray/CT/MRI/Ultrasound
Eye day case (Scarborough).

Commissioning for Quality and Innovation (CQUIN) 2014/15

The CQUIN requirements for 2014/2015 are detailed below:

Q1 – Staff Friends and Family Test roll-out
Q1 – Patient Friends and Family Test – improved response rate (Q1 A&E >15%, IP >25%; Q4 A&E >20%, IP >30%)
Q2 – Patient Friends and Family Test roll-out to Day Case, Outpatients and Community Hospitals and Services
Q4 – Patient Friends and Family Test – improved response rate (March 2015 IP > 40%)

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Medical Director's Report

Action/Recommendation

Board of Directors are requested to:

- consider the Trust SHMI position when compared nationally and regionally and the progress achieved to date
- be aware of the results from the monthly antibiotic prescribing audit which relates to the recording of indication and duration of the prescription.

Summary

This report provides an update from the Medical Director on current patient safety issues.

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

Implications for equality and diversity

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 Board of Directors.
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 of Patient Safety
Date of paper	18th June 2014
Version number	1

Board of Directors – 25 June 2014

Medical Directors Report

1. Introduction

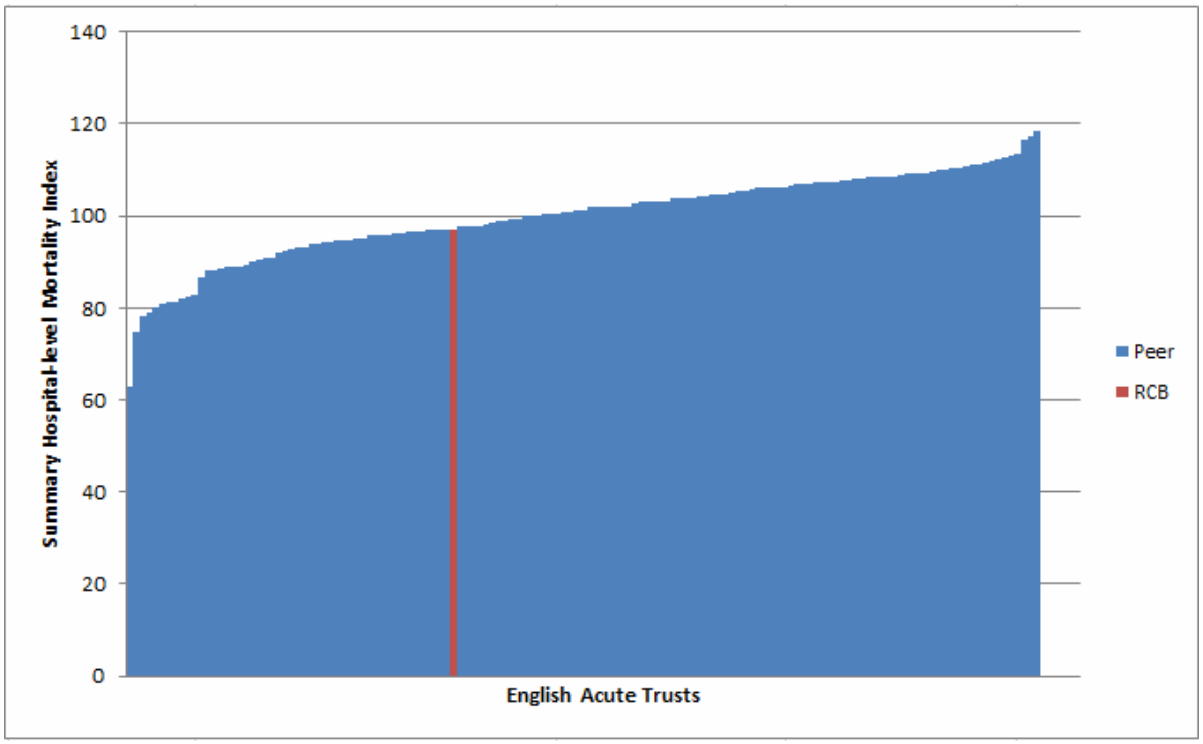
In the report this month:

- SHMI Update October 2012 to September 2013
- Consultant appointments
- Antibiotic Prescribing Audit Results April 2014

2. SHMI Update October 2012 to September 2013

The Trust SHMI:

Cases	Observed Deaths	Expected Deaths	SHMI	Excess Deaths
76100	3030	3119.7	97.1	-89.7



Overall there were still groups where the Trust had more deaths than expected those with ten or more are shown below.

SHMI Category	Condition	Cases	Observed	Expected	SHMI	Excess Deaths
65	Congestive heart failure nonhypertensive	636	139	111.424	124.75	27.576
66	Acute cerebrovascular disease	1023	210	188.791	111.23	21.209
75	Chronic obstructive pulmonary disease and bronchiectasis	1244	108	93.6908	115.27	14.3092
83	Intestinal infection	1312	53	40.8973	129.59	12.1027
10	Cancer of colon	260	47	36.3708	129.23	10.6292

The position for Yorkshire Trusts is reported in the table below.

Trust	SHMI	Trust	SHMI
Sheffield	89.0	Bradford	100.1
Airedale	92.0	Hull & East Yorkshire	102.1
Mid Yorkshire	94.5	Calderdale & Huddersfield	106.1
Harrogate	94.8	Barnsley	107.2
York	97.1	Doncaster & Bassetlaw	108.2
Leeds	97.1	Rotherham	108.6

3. Consultant appointments

Dr Roger Skilton

Locum Consultant in Anaesthetics

Miss Joanna Liput

Consultant in Ophthalmology

Dr Sachin Thakur

Acting Up Consultant in Acute Medicine (until 5/08/14)

Locum Consultant in Acute Medicine (6/08/14 - 5/05/15)

4. Monthly Antibiotic Prescribing Audit May 2014

Please find below the latest antibiotic prescribing audit results for the Trust. The results for May have shown a great improvement from previous months with almost 90% of antibiotic prescriptions having an indication and a duration or a review date.

% Antimicrobial prescriptions with INDICATION					
	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014
York Hospital	58%	72%	70%	71%	94%
Scarborough H	78%	82%	69%	75%	86%
Trust average	68%	76%	70%	73%	87%
% Antimicrobial prescriptions with DURATION or REVIEW DATE					
	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014
York Hospital	58%	75%	72%	80%	96%
Scarborough H	77%	72%	73%	82%	80%
Trust average	68%	74%	72%	80%	87%

Please see below for a more detailed report of each Directorate:

Monthly Antibiotic Prescribing Audit Results for Directorate of Elderly Medicine 2014

- The indication must be documented on all antibiotic prescriptions
- The duration or a review date must be documented on all antibiotic prescriptions

ELDERLY MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	43	45	56	52	50	
Antibiotic prescriptions with INDICATION	77%	84%	88%	85%	92%	
Antibiotic prescriptions with DURATION / REVIEW DATE	77%	91%	88%	90%	96%	

Elderly Medicine : Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded					
	Jan	Feb	Mar	Apr	May	Jun
23	**56%**	**75%**	**88%**	**75%**	**100%**	
24	**80%**	**75%**	**100%**	**0%**	**100%**	
25	**100%**	**100%**	**80%**	**78%**	**n/a**	
26	**80%**	**100%**	**100%**	**80%**	**100%**	
35	**n/a**	**75%**	**100%**	**91%**	**90%**	
37	**100%**	**100%**	**100%**	**n/a**	**100%**	
39	**25%**	**n/a**	**100%**	**100%**	**100%**	
ASU	**100%**	**n/a**	**100%**	**100%**	**100%**	
Ann Wright	**100%**	**100%**	**67%**	**86%**	**100%**	
Oak	**91%**	**100%**	**80%**	**89%**	**75%**	
Stroke	**100%**	**33%**	**n/a**	**0%**	**0%**	
Trust average	68%	76%	70%	73%	87%	

Ward	% antibiotic prescriptions with DURATION / REVIEW DATE recorded					
	Jan	Feb	Mar	Apr	May	Jun
23	**67%**	**75%**	**100%**	**100%**	**100%**	
24	**80%**	**75%**	**100%**	**0%**	**100%**	
25	**0%**	**67%**	**70%**	**78%**	**n/a**	
26	**60%**	**100%**	**100%**	**80%**	**100%**	
35	**n/a**	**100%**	**100%**	**100%**	**100%**	
37	**100%**	**100%**	**100%**	**n/a**	**100%**	
39	**25%**	**n/a**	**100%**	**100%**	**100%**	
ASU	**100%**	**n/a**	**100%**	**100%**	**100%**	
Ann Wright	**100%**	**100%**	**67%**	**86%**	**100%**	
Oak	**100%**	**100%**	**80%**	**100%**	**75%**	
Stroke	**100%**	**100%**	**n/a**	**0%**	**100%**	
Trust average	68%	74%	72%	80%	87%	

Monthly Antibiotic Prescribing Audit Results for Directorates of General Surgery & Urology and Obstetrics & Gynaecology

- The indication must be documented on all antibiotic prescriptions
- The duration or a review date must be documented on all antibiotic prescriptions

GENERAL SURGERY & UROLOGY AND GYNAECOLOGY DIRECTORATES	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	65	74	65	70	66	
Antibiotic prescriptions with INDICATION	58%	61%	60%	80%	85%	
Antibiotic prescriptions with DURATION / REVIEW DATE	63%	72%	69%	77%	92%	

General Surgery & Urology and Obstetrics & Gynaecology : Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded					
	Jan	Feb	Mar	Apr	May	Jun
11	**83%**	**90%**	**100%**	**92%**	**100%**	
14	**0%**	**45%**	**100%**	**81%**	**100%**	
16	**33%**	**75%**	**40%**	**67%**	**82%**	
G1	**0%**	**80%**	**25%**	**100%**	**50%**	
G2	Not audited			**n/a**	**n/a**	
G3	Not audited			**n/a**	**0%**	
Ash	**n/a**	**50%**	**n/a**	**n/a**	**n/a**	
Aspen (HOB)	orthopaedics			**n/a**	**0%**	
Haldane	**75%**	**75%**	**100%**	**72%**	**71%**	
Maple /Graham	**54%**	**47%**	**47%**	**100%**	**100%**	
Trust average	68%	76%	70%	73%	87%	

Ward	% antibiotic prescriptions with DURATION / REVIEW DATE recorded					
	Jan	Feb	Mar	Apr	May	Jun
11	**100%**	**90%**	**100%**	**92%**	**100%**	
14	**67%**	**86%**	**100%**	**81%**	**93%**	
16	**33%**	**75%**	**60%**	**73%**	**100%**	
G1	**67%**	**60%**	**25%**	**100%**	**83%**	
G2	Not audited			**n/a**	**n/a**	
G3	Not audited			**n/a**	**0%**	
Ash	**n/a**	**0%**	**n/a**	**n/a**	**n/a**	
Aspen (HOB)	orthopaedics					
Haldane	**71%**	**88%**	**100%**	**44%**	**100%**	
Maple /Graham	**38%**	**53%**	**67%**	**100%**	**100%**	
Trust average	68%	74%	72%	80%	87%	

Monthly Antibiotic Prescribing Audit Results for Directorate of Head & Neck

- The indication must be documented on all antibiotic prescriptions
- The duration or a review date must be documented on all antibiotic prescriptions

HEAD & NECK DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	16	15	9	12	21	
Antibiotic prescriptions with INDICATION	44%	40%	44%	33%	43%	
Antibiotic prescriptions with DURATION / REVIEW DATE	56%	67%	89%	83%	38%	

Head & Neck : Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded					
	Jan	Feb	Mar	Apr	May	Jun
15	**44%**	**40%**	**44%**	**33%**	**43%**	
Trust average	68%	76%	70%	73%	87%	

Ward	% antibiotic prescriptions with DURATION / REVIEW DATE recorded					
	Jan	Feb	Mar	Apr	May	Jun
15	**56%**	**67%**	**89%**	**83%**	**38%**	
Trust average	68%	74%	72%	80%	87%	

Monthly Antibiotic Prescribing Audit Results for Directorates of Medicine, Acute Medicine and Specialist Medicine

- The indication must be documented on all antibiotic prescriptions
- The duration or a review date must be documented on all antibiotic prescriptions

MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	105	107	110	144	82	
Antibiotic prescriptions with INDICATION	66%	86%	76%	73%	95%	
Antibiotic prescriptions with DURATION / REVIEW DATE	67%	69%	66%	79%	88%	

Medicine : Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded					
	Jan	Feb	Mar	Apr	May	Jun
32	**57%**	**100%**	**100%**	**45%**	**100%**	
33	**17%**	**92%**	**50%**	**78%**	**100%**	
34	**33%**	**50%**	**65%**	**70%**	**100%**	
AMU (YH)	**70%**	**83%**	**83%**	**67%**	**89%**	
CCU (YH)	n/a	n/a	**100%**	**0%**	**n/a**	
SSW (21)	**92%**	**91%**	**100%**	**93%**	**100%**	
31	**29%**	**75%**	**88%**	**67%**	**100%**	
AMU (Cherry)	**87%**	**100%**	**73%**	**91%**	**100%**	
Beech	**71%**	**95%**	**64%**	**90%**	**70%**	
CCU (SH)	**80%**	**100%**	**100%**	**50%**	**100%**	
Chestnut	**79%**	**100%**	**88%**	**42%**	**100%**	
Graham	**100%**	**86%**	**100%**	Surgical	Surgical	

				ward	ward	
Willow	**67%**	**100%**	**n/a**	**75%**	**n/a**	
Trust average	68%	76%	70%	73%	87%	

Ward	% antibiotic prescriptions with DURATION / REVIEW DATE recorded					
	Jan	Feb	Mar	Apr	May	Jun
32	**71%**	**100%**	**100%**	**55%**	**100%**	
33	**50%**	**85%**	**67%**	**78%**	**100%**	
34	**53%**	**50%**	**60%**	**88%**	**100%**	
AMU (YH)	**50%**	**33%**	**44%**	**60%**	**100%**	
CCU (YH)	n/a	n/a	**100%**	**100%**	**n/a**	
SSW (21)	**92%**	**82%**	**100%**	**93%**	**86%**	
31	**43%**	**63%**	**50%**	**56%**	**78%**	
AMU (Cherry)	**80%**	**100%**	**60%**	**91%**	**100%**	
Beech	**71%**	**73%**	**64%**	**90%**	**70%**	
CCU (SH)	**60%**	**33%**	**100%**	**100%**	**67%**	
Chestnut	**57%**	**0%**	**88%**	**83%**	**77%**	
Graham	**100%**	**71%**	**100%**	Surgical ward	Surgical ward	
Willow	**100%**	**25%**	**n/a**	**75%**	**n/a**	
Trust average	68%	74%	72%	80%	87%	

Monthly Antibiotic Prescribing Audit Results for Directorate of Orthopaedics & Trauma

- The indication must be documented on all antibiotic prescriptions
- The duration or a review date must be documented on all antibiotic prescriptions

ORTHOPAEDICS & TRAUMA DIRECTORATE	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Number of antibiotic prescriptions audited	23	21	19	13	19	
Antibiotic prescriptions with INDICATION	43%	86%	37%	46%	89%	
Antibiotic prescriptions with DURATION / REVIEW DATE	39%	90%	68%	69%	89%	

Orthopaedics & Trauma : Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded					
	Jan	Feb	Mar	Apr	May	Jun
28	**38%**	**80%**	**30%**	**33%**	**91%**	
29	**67%**	**100%**	**100%**	**100%**	**67%**	
Aspen	**n/a**	**n/a**	**n/a**	Surgical ward		
Holly	**33%**	**82%**	**29%**	**50%**	**100%**	
Trust average	68%	76%	70%	73%	87%	

Ward	% antibiotic prescriptions with DURATION / REVIEW DATE recorded					
	Jan	Feb	Mar	Apr	May	Jun
28	**31%**	**100%**	**70%**	**33%**	**100%**	
29	**67%**	**100%**	**100%**	**100%**	**100%**	
Aspen	**n/a**	**n/a**	**n/a**	Surgical ward		
Holly	**33%**	**82%**	**57%**	**100%**	**60%**	
Trust average	68%	74%	72%	80%	87%	

5. Recommendations

Board of Directors are requested to:

- consider the Trust SHMI position when compared nationally and regionally and the progress achieved to date
- be aware of the results from the monthly antibiotic prescribing audit which relates to the recording of indication and duration of the prescription.

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**18th June 2014**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 25 June 2014

Duty of Candour

Action requested/recommendation

The Board of Directors is asked to note the organisations responsibility for exercising the Duty of Candour.

Summary

It is a requirement under the NHS Standard Contract, issued by the NHS Commissioning Board , to ensure that patients and their families are told openly about patient safety incidents that affect them. The Trust must ensure that patients and their families :

- Receive appropriate apologies
- Are kept informed of investigations
- Are supported to deal with the consequences

This paper will define those incidents that Duty of Candour applies to, and the organisations approach to fulfilling this important obligation, a duty entirely aligned with the core values of the Trust.

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

Implications for equality and diversity

The Duty of Candour is inclusive to all patients

Reference to CQC outcomes

Reference to all CQC Outcomes

Progress of report First Presentation

Risk No risk (replace this text if necessary).

Resource implications	Potential Resource Implications
Owner	Dr Alastair Turnbull, Medical Director Beverley Geary, Director of Nursing
Author	Fiona Jamieson, Deputy Director of Healthcare Governance
Date of paper	June 2014
Version number	2

Board of Directors - 25 June 2014

Duty of Candour

1. Introduction and background

It is a requirement under the NHS Standard Contract, issued by the NHS Commissioning Board, to ensure that patients and their families are told openly about patient safety incidents that affect them. The Trust must ensure that patients and their families :

- Receive appropriate apologies
- Are kept informed of investigations
- Are supported to deal with the consequences

This paper will define those incidents that Duty of Candour applies to, and the organisations approach to fulfilling this important obligation, a duty entirely aligned with the core values of the Trust.

2. Which Incidents does Duty of Candour apply to?

The duty applies to patient safety incidents that occur during care provided under the NHS Standard Contract and that result in :

- Moderate harm
- Severe harm
- Death

The definitions of levels of harm are as follows :

No Harm
Impact prevented – any patient safety incident that had the potential to cause harm but was prevented. (A “Near miss”)

Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS care.

Low Harm
Any patient safety incident that required extra observation or minor treatment and that caused minimal harm.

Whilst there is no statutory obligation to report No / Low harm incidents under Duty of Candour, the Being Open policy is clear that these will be discussed by the ward staff with the patient and their family and that this discussion is documented.

Moderate Harm
Any patient safety incident that resulted in a moderate increase in treatment (eg, increase in length of hospital stay by 4-15 days) and which caused significant but not permanent harm, to one or more persons receiving NHS funded care

Severe Harm
Any patient safety incident that appears to have resulted in permanent harm to one or more persons.

Death
Any patient safety incident that directly resulted in the death of one or more persons under our care.

2.1 Is this Different from 'Being Open' ?

The Duty of Candour must be read and implemented in conjunction with the Being Open Policy, revised June 2014.

It is the contractual element to ensure that the Being Open Policy is followed when a patient safety incident occurs resulting in moderate/severe harm or death. The Commissioners require evidence of our compliance with this as part of contract monitoring,

The requirements of Duty of Candour are determined by our commissioners whose expectation is :

- We advise patients and their families of any safety incident rated at moderate and above.
- That where an investigation takes place they patient and their families are advised
- That we provide quarterly monitoring of the above to the CSU.

2.2 How will we recognise such incidents?

The DATIX proforma used to report an adverse incident has been amended to include a box that indicates that the family/relative have been informed. The proforma also requires an initial severity assessment to be completed. This will be validated by the officer signing off the incident report and further validated by the Risk Management Team. Particular focus needs to be placed on those incidents falling into the Moderate category as a proportion are actually 'no or low' harm, with a small number being 'severe'

Currently evidence indicates that whilst relatives are being informed of an incident, they are not being adequately informed that an investigation is taking place and what it's outcomes are. To help bridge this gap, the Risk Team are following up any incident at moderate and above with a call to the ward sister to ensure the patient/family are aware of the investigation. Across the Trust, and at all levels, there is a need to foster and improve further the culture of swift reporting of harm incidents.

2.3 Contractual penalties for failure to meet the Duty of Candour

The requirements for Duty of Candour are contained within the NHS Standard Contract 2014/15 - Schedule 4 - National Quality Requirements

For 2014/15 each failure to notify the relevant person of a suspected or actual Reportable Patient Safety Incident (as per guidance) can result in

- Recovery of the cost of the episode of care, or £10,000, if the cost of the episode of care is unknown or indeterminate.

This will be monitored Quarterly and reported at Board,

3. Conclusion

This paper has outlined the obligation that the Trust has in complying with Duty of Candour and the steps being taken to ensure that this is fulfilled.

The organisation will continue to monitor compliance with its obligation to meet the requirements to deliver the Duty of Candour.

4. Recommendation

The Board of Directors is asked to note the organisations obligations for delivering the Duty of Candour and to support the principles of Being Open.

5. References and further reading

NHS Standard Commissioning Contract
The Francis Report February 2013

Author	**Fiona Jamieson, Deputy Director of Healthcare Governance**
Owner	**Dr Alastair Turnbull, Medical Director** **Beverley Geary, Director of Nursing**
Date	**June 2014**

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C4

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Chief Nurse Report – Quality of Care

Action/recommendation

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

Summary

The Chief Nurse report provides assurance against the implementation of the Nursing & Midwifery Strategy and evidence in support of our Quality Account. It outlines key priorities and progress.

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

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	Executive Board.
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Michael Proctor, Chief Nurse
Author	Beverley Geary, Director of Nursing
Date of paper	June 2014
Version number	Version 1

Board of Directors – 25 June 2014

Chief Nurse Report – Quality of Care

1. Key priorities

Nursing and Midwifery Strategy
The Nursing and Midwifery identifies priorities' for the years 2013-2016 and is aligned to national recommendations and the Chief Nursing Officers strategy for nursing (the '6C's') and has four focus areas:

- Patient Experience
- Delivering High Quality Safe Patient Care
- Measuring the impact of care delivery
- Staff Experience

A number of key priorities and work-streams have been identified and progress is being made toward these. Updates are included within this report and a detailed update on the year two work-plan is attached at appendix 1.

Open and Honest Care
The Board is committed to publishing patient safety and experience data in public and in order to afford transparency plans to sign up to the Open and Honest initiative. As reported previously a Task and Finish group was set up with a view to delivery of this programme.

A representative from the Chief Nurse Team attended an event facilitated by NHS England where a number of data issues were highlighted amongst the organisations present. There continues to be disparity in the requirements of the project in terms of data submissions and as yet, these remain unresolved.

An internal pilot has begun in areas on both acute sites. The pilot aims to ensure the Trust has processes in place to capture accurate information, to test the processes, understand how the information can be validated, and to ensure we can meet the timescales set by NHS England. It is anticipated that an example of the final publication will be presented to the Board of Directors during the pilot in order that board approval can be gained for external publication.

Safer Staffing Project
Significant progress has been made against the actions within both 'Hard Truths' (HT) and the National Quality Board (NQB) 10 key recommendations for ensuring safe staffing.
Progress is matched against each of the domains below:

HT (b) & NQB 8
From 2 June, all inpatient areas are publishing daily staffing levels at local level for public viewing.

HT (a) & NQB 1, 3, 7
From 2 June, all inpatient areas have commenced a 2 week daily acuity and dependency audit, with acute and high activity areas completing this twice daily.

HT (c) & NQB 1, 7
Following the mandate form the Secretary of State, all inpatient areas are currently entering

planned versus actual staffing levels on a shift by shift basis, with planned submission via UNIFY by 10 June deadline. Wards will continue to capture this information until further notice. Wards with staffing shortages will be reported to Board by exception at the June Board.

Daily staffing meetings continue to take place on both main sites, where staffing issues are escalated and recorded. An audit of compliance with this is currently underway and will be included in the Chief Nurse report in July.

In a letter from NHS England received on 6th June Trusts were informed that the RAG rating for the report of staffing levels actual versus planned will be postponed until further notice.

Early Warning Trigger Tool

The Board are aware that in order to examine the quality of care at ward level and predict any potential contributory factors to poor care an Early Warning Trigger tool will be introduced to replace Nursing Care Indicators. Some delays have been experienced during the testing phase but the tool is currently being piloted in areas on both acute sites including maternity and also in Bridlington and Malton hospitals.

The results of the pilot will be fed back through assurance meetings and evaluated with a summary report presented to the Board of Directors in August ahead of full implementation.

Nursing Documentation

The work to align nursing documentation across the organisation is on-going and a significant amount of documents continue to be sent to the group for ratification. This illustrates that the governance of version control and development of new documentation is working well.

The nursing core care plan is in draft and near completion, and is currently out to consultation with ward sisters. The comfee tool (the record of comfort rounding) has been revised and has received very positive feedback from nursing staff in ward areas.

The electronic discharge note has been revised and will be approved in June and then piloted across all sites.

All newly approved documents are being uploaded on Q pulse so that review dates can be monitored.

In addition to the revision of nursing documentation and reduction in beurocracy, the Chief Nurse team is leading a piece of work to understand the type and number of audits that are currently regularly undertaken at ward level; this is to understand value, identify any overlap and to determine any gaps in assurance. An initial meeting was held in June with key stakeholders to begin to collate all of the audits and to examine how we can streamline and improve the data collection to ensure it is meaningful and provides assurance of the quality of care provided.

In addition, the action plans that are developed as a result of the audits and compliance visits were examined.

The compliance team are involved in the protect and the group is currently working to identify priorities for audit and compliance visits that will address any areas of development or improvement, it is anticipated that the new approach and any resulting action plans will act as evidence for forthcoming CQC inspections.

The next stage is to widen membership of the group and to carry out a process mapping exercise to determine what audits are undertaken and by whom.

When all of this information is gathered recommendations will be agreed as to what audits should

be undertaken and their frequency, ensuring these are streamlined and multi-professional and that they will provide all of the information required

Medicines Management
Medicines compliance visits continue to be undertaken in outpatient areas with action plans being developed where remedial action is required.

The lead nurse for medicines management is leading an insulin safety group as a sub group of Think Glucose. This group is reviewing and standardising all insulin prescription documentation in order to provide consistency across the Trust. As part of the CQUIN framework, discussions are underway to determine how this could support the work to reduce missed doses of critical medicines; including Insulin.

Furthermore, a group continues to develop the role of the Health Care Assistant in the administration of Insulin within the community setting. Progress with this work is governed by both the Advancing Clinical Practice Group and Medicines Management Group.

In preparation for electronic prescribing and medicines administration (EPMA), the trials of medicine trolleys for EPMA have concluded. The most popular trolley will need some adjustments to be made, for which discussions with the company have proved positive.

The self administration of medication policy is currently under review. There will be some minor changes required to reflect the needs of our community units. An implementation plan will support the policy.

In order to facilitate timely administration of medicines and avoid unnecessary admissions to acute to hospital, the first meeting of the task and finish group to support Health Care Assistants to administer medications to patients in their own homes has taken place: six work streams have been identified.

2. Patient Experience

The Friends and Family Test
The Friends and Family Test (FFT) has now been rolled out across the Trust, with all adult inpatients, those attending the Emergency Department (ED) and women accessing maternity services being asked the question “would you recommend this ward/ED/antenatal/labour and postnatal service to your family and friends”.

The Trust achieved the CQUIN requirements for Q4 and now focuses on the 2014/15 requirements on increased response rate in ED and Inpatients; roll out to community hospital inpatients, all outpatients, day cases and community services. The FFT Steering group and project work-streams continue to meet and take forward the implementation and development of FFT across the Trust. The focus for the Trust, in addition to roll-out is to ensure that the qualitative feedback gained through FFT is used to effectively inform patients of what we are doing to improve their experience of our services. Of 855 comments for April, only 8 comments were negative**.** A FFT Project Manager is currently being recruited to on a fixed one year contract.

York ED is struggling to achieve the required response rate each month and is being supplemented by the good response rate at Scarborough ED. The Directorate are currently developing plans for the longer term to increase and maintain their response rate.

NHS England is reviewing the use of token systems for the purpose of FFT as some trusts use only the token system to capture quantitative feedback and not qualitative feedback. Locally we provide patients with a comment card to use in conjunction with the token. Qualitative feedback has reduced since the implementation of FFT but this will form part of future plans to improve responses in ED.

We await further guidance from NHS England about the future of token systems.

The Friends and Family Test rolled out to Community Hospital Inpatients at the beginning of May, ahead of the national roll-out date of December 2014. Reports will be produced from June 2014.

Staff Friends and Family Test

The Staff Friends and Family Test (SFFT) was launched on 1st May 2014 ahead of the national required date of implementation by 31st July 2014. This allowed the Trust two months to pilot the Test. The SFFT like, the patient FFT, a card and on-line survey which asks the questions:

'*How likely are you to recommend York Teaching Hospital NHS FT to friends and family if they needed care or treatment?' and*

How likely are you to recommend York Teaching Hospital NHS FT to friends and family as a place to work?'

The response options range from *Extremely Likely* to *Extremely Unlikely* with a *Don't Know* option.

The CQUIN attached to the SFFT that states**: "**30% of the funding for FFT for full implementation of the staff FFT across all acute areas and in Community by 31st July 2014'.

The first six weeks of the pilot have provided the Trust with a 6% response rate (approx 500+ cards completed). The CQUIN for 2014/2015 does not stipulate a required response rate as required with the patient FFT.

Early feedback from staff about the SFFT process have been around the anonymity of the survey as staff are required to state their 8 digit employee number. Whilst staff need to enter their employee number to access the survey online, it is anonymous to the Trust. An external organisation, Capita Surveys & research is running the survey on behalf of the Trust and only Capita staff will see the questionnaires. Using employee numbers ensures there are no duplicate entries and enables the Trust to receive analysis on the responses received by Trust and Directorate level only. This helps us make improvements in working conditions and practices locally. When Capita process the data they will ensure that individual responses are not identifiable by anonymising the results.

The Trust is currently working with Capita to use the national learning from Q1 to consider ways in which we can overcome the concerns around anonymity. However, given the low response rate and the concerns from staff about anonymity Capita will remove the employee number from Q2 surveys and will move to allocating responses to Directorates by asking staff to write their directorate on.

One of the recommendations that the SFTT work-stream is considering is that whilst all staff are given the opportunity to answer the questions on a quarterly basis, a directorate/directorates is/are chosen to focus on in a certain period over the year. This should increase the number of responses in chosen directorates and reduce any lethargy to being asked the question frequently. Those directorates may be selected based on low patient FFT feedback or low Staff FFT responses in these areas. This is to be considered further and discussed at the FFT Steering group in June.

HR lead for SFFT, Zinnia Ritz reports into the Trust FFT Steering Group where progress on implementation across the Trust is reported.

The SFFT is being led by HR and the patient FFT is being led by Corporate Nursing (through the Patient Experience Team), with all strands of FFT reporting into the overall Steering Group.

In the initial phases of the SFFT the results will be reported in the Quality & Safety booklet as part of the FFT results. As phase of FFT evolves consideration will be given to its reporting and management.

3. End of Life Care

Currently a significant amount of work is being undertaken to improve standards of End Of Life Care (EOLC) nationally across organisations.

A National Care of the Dying Audit has recently been reported upon and a summary report was received last month. This detailed that we are performing at a similar level to other trusts nationally. However, the results illustrate that the work that needs to be undertaken in relation to this area of care. Further details of local findings will be submitted in a report to the Patient Experience Committee in order that evidence can be triangulated and action plans developed where appropriate.

Key priorities are being delivered in line with the work streams highlighted by the EOLC board. This includes the co-ordination of services ensuring that we are working more collaboratively across sites and settings.

Education remains a key priority in improving the standards of care and plans to recruit a part time educator to work 30 hours per week is underway. The post funded by Multi-Professional Education and Training monies from Health Education England for a 12 month period. The introduction of this post will mean that the trust has 1 FT post and 1 PT post to focus upon EOL Education.

Engaging with external agencies (mainly with York Carers Forum) has helped to demonstrate the public that measures are being taken within the locality to continually improve EOLC. This relationship has meant that our awareness of service user experience has increased and we have tried to use this information in a meaningful way within the locality. In order to identify barriers to the care delivered and to celebrate good practice a local bereavement survey has been developed and will commence roll out next month, we also plan to participate in the National Bereavement Audit in August 2014.

In an attempt to improve care for relatives following bereavement a listening service is being proposed for relatives that have lost a loved one who has died in the acute trust. This will be run by volunteers and supported by a Cognitive Behavioral Therapist.

Following the withdrawal of the Liverpool Care Pathway in 2013, the EOLC team have been working on a local document to help to ensure that appropriate care is delivered at the end of life and to support staff in clinical decision making. A patient / relative diary will also feature in the care for some patients as part of a trial (if consent is obtained). The implementation of this document is scheduled for 1st September 2014.

The End of Life Lead Nurse is leaving her post on the 11th June 2014. The recruitment process to reappoint has commenced and interviews are scheduled for 12th June 2014.

4. Midwifery

Open and honest care: Maternity safety thermometer
Work continues in piloting the national maternity safety thermometer.
Scarborough were involved in the early stage of the pilot work with York commencing collecting data this month.

The Maternity safety thermometer collects clinical data;

- Maternal infection
- Perineal trauma

- Major haemorrhage
- Babies born in poor condition at birth (includes stillbirths in this section)

And psychological information on the following:
- Women feeling they were left alone in labour at a time that worried them
- Term babies separated from their mother

Concerns raised during labour and birth not taken seriously

Following the pilot a full report will be presented to the Board with recommendations for next steps.

Maternity theatre upgrade project Scarborough site
This project has been delayed for over 2 months due to unexpected electrical issues and ventilation problems.
There is no date as yet for handover as awaiting ventilation and microbiological testing.

Midwifery Led Unit (MLU) Scarborough site
The MLU closed on October 1st 2013 to facilitate staff required for the theatre upgrade project. Plans are to re open the MLU one week after the handover of the theatre (to allow for cleaning as it has been used to store theatre equipment)

Smoking at Time of Delivery - East Coast Project
Smoking in pregnancy is known to have a significant impact on the developing baby and is associated with increased risks of stillbirth.

The aim of the East Coast 'Smoking at Time of Delivery' project was to reduce the percentage of women smoking at the time of birth. Scarborough and Bridlington sites have achieved a 3% decrease during 2013/14 with a significant increase in referrals to the stop smoking service.

2013/14 data: York : 8.7% Scarborough : 21%

Carbon monoxide monitoring in pregnancy commenced last year on Scarborough site and earlier this year on York site along with education for midwives from the stop smoking service.

Insight work into the 'barriers and facilitators to stopping smoking' has been difficult to recruit to with poor response/engagement from women and family members.

This year long project has now ended, however Midwives continue to work to sustain the reduction and further reduce the number of pregnant women who smoke.

Maternity Tour de France plan
Plans are in place to achieve safe staffing levels with cover if required at short notice with extra on call staff (who live within walking distance of the Hospital).

The homebirth service will be suspended for a period of 24 hours for safety reasons at York as there will be a high risk of delay in midwives attending due to access problems and a risk of delay if an emergency ambulance if required during labour and birth (a third of women are transferred in by ambulance during labour and birth).

Women booked for homebirth over the weekend will be offered the MLU facility at Scarborough and also offered to visit the labour ward at York in advance to see the low risk labour rooms and birthing pools available for their use.

All women will be advised to attend Hospital when in labour earlier rather than later. Provision for partners to stay with them will be made and an information sheet developed to be handed to

women and also put on the Hospital website.

Maternity triage staff will be increased to deal with calls and attendances.

Neighbouring maternity services have been made aware of the potential impact of women accessing a Maternity service outside of York if they encounter access difficulties in York. We are also in communication with Harrogate Maternity services who have developed similar plans.

In order to detail the work ongoing in all aspects of Midwifery an annual report will be written and submitted to the Trust Board will be submitted in July 2014

5. Recommendation

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

Author	**Beverley Geary, Director of Nursing**
Owner	**Michael Proctor, Chief Nurse**
Date	**June 2014**

Nursing and Midwifery Strategy Implementation Plan: Year 2 ,2014

The Nursing and Midwifery strategy sets out priorities to achieve high quality nursing care over the next 3 years and was approved at Board in May 2013.The implementation plan outlines current work streams and priorities and demonstrates progress to date.
The strategy has been aligned to the Chief Nursing Officers 6 C's in order to ensure compassion in care and to embed these values and behaviours in all Nursing and Midwifery practice.
C1 -Care
C2 -Compassion
C3 -Competence
C4 -Communication
C5 -Courage
C6 -Commitment

Priority 1	**Improve Patient Experience**

Number	**6C's**	**Action**	**Target Date**	**Update / Evidence**	**Lead**
1 a)	C1 C4	Develop PPI strategy.	Revised May 2014	Work plan agreed in Patient Experience Committee. Delay in the development of a strategy due to the in-depth review of PPI activity in order to inform the new strategy. Service users being involved in development of maternity bereavement service Scarborough site. MSLC chair being involved in FFT action plan written by Head of Midwifery	Lead Nurse Patient Experience/ Director of Nursing

1b)	C2 C4	Undertake a review of the Patient Experience service, function and capacity and make recommendations to the Nursing Board.	June 2014 Completed	Questionnaires re: training circulated, results to be presented at the next Patient Experience Committee. Review of processes commenced. Review of the PET team completed and awaiting approval at patient steering group. To Board of Directors June 2014.Job description written, pending AFC matching for the Lead for PET Maternity FFT feedback involved in service action planning	Chief Nurse Team
1c)	C4 C5	Strengthen the role of ward sister in the management of and learning from complaints in their areas	.	Afternoon of discussion and presentations planned on Patient experience and complaints management for PNLF. NHS Elect training commenced. Midwifery Ward sisters involved in the management of complaints with support from the Matron Complaints and patient experience included in Maternity mandatory training for all staff	Matrons, PPI team
1d)	C1 C4	Continue to develop the patient experience steering group to include further work around PPI. Undertake a benchmarking exercise as to what groups are the Trust involved in and what are we doing in house, (ie older peoples forum on York site)	December 2014	Integral to PPI strategy The dementia delivery group is reviewing what PPI activity is undertaken across sites and is developing a plan to further build on the work todate. Healthwatch presented at the Patient Experience PNLF, which was well attended by ward sisters and clinical nurse specialists. The ward sisters	Chief Nurse Team / PPI team

				worked in groups, reviewing complaints and best practice. Pledges were made to improve the patient experience and will be reviewed in 6 months. MSLC group. Communication sub group attended by Maternity Matron looking at FFT processes and staff experience. Home birth support group has been set up to involve users also	
1e)	C5 C6	Explore and agree the priorities of the new Matron group in the delivery of the PPI agenda	September 2014	Development programme planned for April 2014, started working with ODIL team re: ongoing programme	Matrons/ Chief Nurse Team
1f)	C2 C4	Review of trust visiting policy in order to meet the needs of patients and relatives.	September 2014 Revised	New Matron group to review and revise policy in conjunction with the protected meal time policy and present recommendations to Matrons meeting / Nursing Board	Matrons
1g)	C6	Introduce Friends and Family Test for OPD, Community services and community inpatient areas.	October 2014 Completed	F&F commenced in community hospitals ahead of roll out, data report will be produced June 2014	Patient Experience Team
1h)	C1 C2 C4	Improve Patient involvement in the Safeguarding Adults Process	Sept 2014	1) Generic patient information Leaflet development – awaiting approval and publication 2) Family/patient specifically involved in Safeguarding Adults Process leaflet – awaiting approval and publication PPI to be included in membership of Safeguarding Adults Governance Group	Lead Nurse for Safeguarding Adults

		Early identification (at start of hospital journey) of vulnerable adults and embed prevention of and protection from abuse in care planning		1) Vulnerable adult recognition on ED admission proforma (Scarborough Acute)	
1i)	C1 C2 C3	Develop guidance for Mental Health Support in acute setting to support patients who have/develop Mental ill-health in acute settings Phase 1 1) Task and Finish Group 2) Policy Development 3) Staff Training (MH First Aid) 4) Service Level agreement with MH Provider Phase 2 1) Business case for MH support Team 2) Recruitment	April 2015		Lead Nurse for Safeguarding Adults
1j)		Maternity Friends and Family Feedback		Quarterly action plans developed in Maternity from qualitative F&F feedback with user representatives input	Head of Midwifery

Priority 2	Delivering High Quality Safe Patient Care

Number	6C's	Action	Target Date	Update / Evidence	Lead
2a)	C5 C6	Strengthen nursing leadership by empowering ward sisters and charge nurses to ensure all care is of a high standard and meets values of the organisation	Ongoing	Reviewed the It's My Ward Programme with skills days on-going. Ward Sisters meeting commenced, Director of Nursing Q&A session at each. Increased attendance and input at PNLF Consultation with Ward Sister planned re: reporting structures. Plan to work with ODIL to review and evaluate the IMW programme.	ODIL Chief Nurse Team
2b)	C1 C6	Ensure the right staff are in the right place at the right time.	Ongoing (planned April & October)	Safer Staffing Project commenced Meeting with Keith Hurst took place in April 2014, Matrons trained in the awareness of the AUKUH tool, presentation to Ward Sisters during May 2014. Acuity Audit commenced for 2 weeks in June. Staffing SOP reviewed and daily staffing meetings in place.	Chief Nurse Team

				Publishing of daily staffing at ward level commenced Submission of staffing data via UNIFY commencing June 2014	
2c)	C1 C2 C6	Work with patient safety and compliance teams to ensure delivery of patient safety strategy. Evidence	April 2014 and ongoing	Pressure Ulcer Reduction Plan updated and action plan for 2014/15 developed – update to Board June 2014. Work to reduce missed medications continues. Business case being developed to identify nursing resource required to support Electronic Prescribing Supervisors of midwives will be undertaking work around medication errors and missed meds	Patient Safety Team Chief Nurse Team
2d)	C5 C6	Continue to review nursing documentation in order to reduce paperwork and to have consistent records across the organisation	ongoing	3 work streams full established that focus upon: 1:pathways This work is significant as there are over 26 pathways. The first plan is to look at the generic aspect of all pathways and then wok with IT to determine how this moves from paper to electronic. 2:single record of care The draft is complete and is out with ward sisters for consultation. The Comfee tool has been changed within this and has been well received. The final draft will be complete within the	Chief Nurse Team

				next month. 3:Discharge Electronic discharge nursing document has been written in draft and is planned for approval in June. This will then require a pilot and implementation plan. A significant amount of paperwork has been reduced with assessments electronic	
2e)	C1 C3	Lead the work on falls reduction across the organisation, review the documentation and assessment process in order to streamline and ensure a consistent approach across the organisation	September 2014	Falls Steering Group set up, membership agreed. Terms of reference approved. Delivery groups at both main sites and community. Strategy to be developed. Revised risk assessment and implementation plan in draft. To be shared with ward sisters via the documentation steering group in June 2014.	Chief Nurse Team
2f)	C1 C2	Introduce Advanced Clinical Practitioner's to facilitate early decision making and timely access to treatment.	Completed May 2014	Second cohort of trainees recruited to development of the ACP role continues in collaboration with clinical and educational teams	CLAD, Chief Nurse Team
2g)	C1	Make a significant contribution to the CDI reduction strategy Infection Prevention (IP): Improve and sustain competency in clinical practice and invasive device	Ongoing	Walkrounds commenced in January 2014 capturing patients visiting times and speaking with staff about their experience and concerns. Use of data to change and improve practice to reduce HCAI incidence	IP&C, Chief Nurse Team Matrons

		management that ensures the prevention of avoidable harm from Healthcare Associated Infection (HCAI) through: Implementation and audit of IP policies and guidelines that reflect the requirements of the legislative Hygiene Code. Effective use of IP performance data and the Trust performance framework to ensure accountability and responsibility for the prevention and control of HCAI and patient safety from Ward to Board.		varied and not consistently integral to Directorate performance meetings. To develop and agree with Chief Nurse Team a process for improved use and action in response to IP outcome data. April 2014 New Matron team to devise an approach to prioritise this agenda and raise awareness in their clinical areas Use of Directorate risk registers to record and escalate IP and associated patient safety risks. Maternity - Re launching with staff the 5 moments of Hand Hygiene and the importance on infection prevention following talk by DIPC. Directorate risk register reviewed at risk meetings both site and updated as needed	
2h)	C3 C4 C6	Formalise Trust wide approach to shared learning from Safeguarding Adults Investigations where actions are identified.	Sept 2014	Full Matron/ward sister involvement in Safeguarding Adults Investigation	Matrons/Lead Nurse for Safeguarding Adults
2i)		Third and forth degree tear rate	Dec 14	multidisciplinary working group to audit, review practise and recommend actions to reduce rates	Head of Midwifery

Priority 3	Measuring the impact of care

Number	6C's	Action	Target Date	Update / Evidence	Lead
3a)	C5 C6	Introduce Early Warning Trigger Tool to highlight potential problem areas and to ensure nurses and midwives have meaningful data to influence the delivery of care.	September 2014	Testing phase ongoing, pilot commenced Early warning trigger tool being trialled on Hawthorn ward	Chief Nurse Team
3b)	C3 C5	Introduce Nursing Dashboard to give an overview of key quality indicators for all areas	Completed May 2014	Draft Dashboard developed, project team identified to work in conjunction with the EWTT This has been developed as a stand alone dashboard and is complete other than the background ward specific information. This will be presented at the June PNLF and Matrons meeting. More work re: data collection needed Maternity dashboard established and reviewed at Directorate Clinical Governance meetings	Chief Nurse Team
3c)	C1 C3	Explore feasibility of IT solutions to documentation	Ongoing	Assessment documents now electronic Further work is being undertaken to move more nursing documentation using the IT system. A business case has been written to support a band 7 project role for a senior nurse to support the development, training and education at ward level and to provide the clinical expertise.	Chief Nurse Team /IT

3d)	C1 C6	Develop a Nursing Policy and procedures' Group in order to ensure all polices are up to date and reflect current best practice	Completed June 2014	Initial meeting to plan TOR, wider meeting to involve all key stake holders planned for April 2014 Maternity guidelines groups established cross site	Chief Nurse Team
3e)	C3 C6	Evaluate the Productive Ward programme and agree next steps	April 2014	Evaluation of impact of targeted work at Scarborough site very positive for most areas. Meeting planned to consider future approach – evaluation undertaken – project suspended due to project support needed for safer staffing initiative.	Chief Nurse Team
3f)	C2 C3 C4	Work with the compliance unit to review delivery of actions from visits to clinical areas in order to provide assurance to the Nursing Board re: quality of care	December 2014	A review of all audits undertaken at ward and department level will start in June. This will link to the CQC 5 questions. The plan is to streamline and reduce repetition and develop achievable actions plans. The group will process map in June and develop recommendations and subsequent implementation plan. Patient safety walk arounds planned, undertaken on G1	Chief Nurse Team / Compliance Unit
3g)	Ci C2 C4 C6	Open and Honest	Sept 2014	Introduce this initiative to publish patient safety and experience data. Task and finish group set up. Pilot begun on both acute sites	
3h)	C3 C4 C6	Safeguarding Adults Team to report quarterly Safeguarding Adults Activity to Matrons and ward Sisters at relevant meetings.	Sept 2014	Quarterly reporting of activity to Safeguarding Adults Governance Group Board reporting	Lead Nurse for Safeguarding Adults

Priority 4	Staff experience

Number	6C's	Action	Target Date	Update / Evidence	Lead
4a)	C2 C4	Utilise staff survey feedback to understand key themes and identify priorities.	April 2014 and ongoing	Family and Friends staff questionnaire was undertaken in June. The results will be shared with matrons. Staff 'listening exercises' considered in Maternity following staff survey results. Multidisciplinary group arranged to develop action plan. Maternity newsletter developed for staff to help improve communication	Chief Nurse Team with HR Workforce team
4b)	C4 C6	Ensure all Nurses and Midwives receive a valid appraisal which includes an agreed development plan	Ongoing	Ongoing work in all Directorates' to achieve annual appraisal. Chief Nurse Team meeting with external partners to explore electronic solutions to include revalidation – meeting taken place. Attendance at NMC Re-validation event June 2014 HR are working on an IT solution for appraisal and are currently in the early stages, with a steering group set up. The IT company is showcasing the example in June.	Matrons, Ward Sisters

				ongoing monitoring of appraisal rates by matrons	
4c)	C3	Explore and consider the training requirements of nurses and midwives and identify alternative methods of delivery.	Ongoing April 2015	Review of Statutory & Mandatory training requirements for Nursing & Midwifery staff commenced, task and finish group set up to conduct this work and report to nursing Board Mandatory maternity specific training reviewed annually in line with current guidance	Chief Nurse Team/ ODIL
4d)	C4 C6	Develop the knowing how we are doing boards to reflect what patients and relatives and staff want to see and include positive patient feedback and also work that we have done to reflect patient feedback and measure the effectiveness of this change	September 2014	Sisters and Matrons discussion and suggestions have begun, recommendations due back May 2014 The ward sisters have met with one ADN and their opinions have been acknowledged. It has been agreed that the laminate will be removed form the boards, which will leave them blank. The boards will then be converted in July to include daily safer staffing and patient experiences, using family and friends and patient feedback. “Use said, we did” Positive patient feedback given on monthly mandatory maternity training, at staff meetings with Matron and sent out to staff via e-mail. Changes made to knowing how we are doing boards to fit client group	Chief Nurse Team with HR Workforce team
4e)	C5 C6	Consider centrally supported recruitment process to reduce duplication, ensure recruitment in a timely fashion.	April 2014 and ongoing	Work continues with an aim to reduce vacancies One stop shop recruitment is working	Chief Nurse Team with HR Workforce team

				well, as did the city tour to Glasgow with a number of registered nurses recruited. The recruitment process is working well, with changes to the VC process and DBS. Cross site recruitment for midwives at Band 5 commenced in Maternity	
4f)	C4 C6	Continue to work with HR to utilise e-rostering to make the most efficient use of resources. Introduce e-rostering at Scarborough site	September 2014	principles of e-roster commenced on paper roster at Scarborough site Maternity in preparation for e-roster implementation	Chief Nurse Team with HR Workforce team
4g)	C4 C6	Conduct an evaluation of the local induction arrangements for Nurses and Midwives	December 2014	New Matrons group to work with Ward Sisters to introduce a robust system across the organisation that represents local priorities. Induction packages reviewed and in place for band 5&6 midwives. Band 7 development package commenced.	Matrons
4h)	C1 C4 C6	Development of Supervision model and implementation	Jan 2014		Lead Nurse for Safeguarding Adults/Director of Nursing

<u>Assurance Processes</u>

- Nursing Board for approval, monitoring, identifying risks and progress
- Exceptions discussed at Matrons 1:1's and NMT
- Quarterly update to Board of Directors via Chief Nurse report

Beverley Geary
Director of Nursing
June 2014

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Chief Nurse Report – Annual Report – Progress against the Pressure Ulcer Reduction Plan (PURP)

Action/recommendation

The Board is asked to accept this report as assurance of overall quality standards of care for patients and note areas of both risk and significant progress. The Board is asked to discuss the report and the recommendations to reduce pressure ulcers.

Summary

This report gives an overview of progress to date on the PURP since it began and makes recommendations for further improvement.

Strategic Aims	**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

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	Quality and Safety Committee
Risk	Associated risks have been assessed
Resource implications	Associated equipment
Owner	Beverley Geary, Director of Nursing
Author	Michelle Carrington, Head of Patient Safety
Date of paper	May 2014
Version number	Version 1

Board of Directors – 25 June 2014

Chief Nurse Report – Annual Report – Progress against the Pressure Ulcer Reduction Plan (PURP)

1. Background and context

Nationally and locally there has been an increased focus to further reduce the incidence of pressure ulcers. The Chief Nurse commissioned an independent peer review of clinical actions being taken in our Trust in December 2012. This was conducted by Professor Janice Stevens. The purpose of this review was to:

- Determine if the overall actions the trust was currently taking were sufficiently robust to achieve agreed standards.
- Know if there were additional actions needed to be taken to increase confidence that the current position could be quickly improved upon, sharing examples of known good practice and details of any organisations that could help.
- Ensure governance and assurance processes underpinning this work were operating in an effective and efficient manner.

The Review recommendations were presented to Board of Directors and formed the basis of the Trust's Pressure Ulcer Reduction Plan (PURP).

2. Aim of this report

This report provides an overview of findings and details progress to date with further suggested recommendations and priorities.

It was identified at the time that a programme of work this size and complexity that it will take 18 months to 2 years before we are likely to see sustained improvements. It is also worth noting that a rise in reporting of incidents was anticipated given the renewed focus.

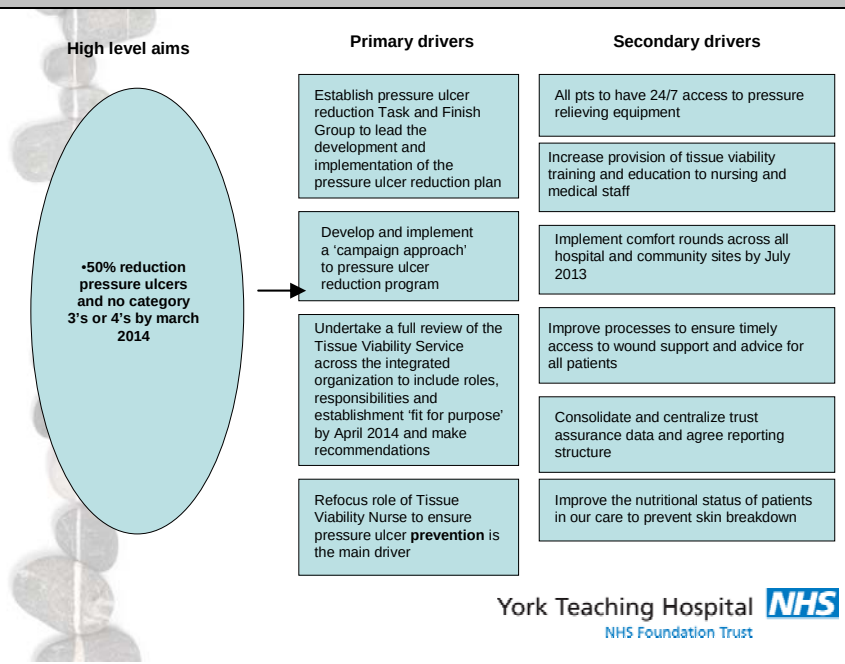
3. Governance arrangements

The Executive Sponsor for the PURP is the Chief Nurse.

The PURP was overseen strategically by the PURP Project Board. This has now been replaced with a new Pressure Ulcer Steering Group.

Progress against the PURP is updated in the Chief Nurse report to Executive and Board of Directors on a regular basis. The PURP also features at the quarterly Patient Safety Group.

4. High level aims of the PURP



A year on, it is recognised that the high level aim was unrealistic but provided a basis for further motivation for improvement.

5. Progress in more detail

Aim 1 - All patients to have 24/7 access to pressure relieving equipment:

Progress to date:

An audit of equipment provision and processes for use was undertaken and recommendations made.

Discussions regarding the contractual arrangements for equipment in community services has commenced at Contract Management Board.

Process to hire pressure relieving equipment in urgent and appropriate situations agreed for community services.

Appointed a Tissue Viability Nurse Assistant for Equipment (TVNa) in York Hospital who had dramatically increased provision of mattresses in particular and reduced calls to Medical Engineering Department.

A similar appointment has just been made in community services and a focussed piece of work begun on community processes and contractual arrangements for the provision of equipment.

Please note: The cost of privately hiring equipment for community nursing patients is not covered within the community contract. This has caused a cost pressure in the Trust since 2011. For the 13/14 financial year funding of £130k to cover this cost pressure was allocated through the annual plan. Therefore although there is no identified cost pressure against the Trusts current financial plan, this remains an issue as it creates a shortfall on the community contract. Private hire requests are increasing month on month as the joint equipment stores

are unable to respond in a timely way to equipment requests. It's likely therefore that 14/15 will result in an additional cost pressure.

Recommendation:

- Agree timeline for the establishment of a central equipment library for York, which would include pressure relieving equipment.

Aim 2 - Increase provision of tissue viability training and education to nursing, AHP, midwifery and medical staff:

Progress to date:

Standardised training for all clinical staff is now being delivered.

Undertook 4 'rapid spread' events ('Every Contact Counts') with representation from all clinical areas.

Competency assessment tool developed for registered nurses with agreement to be part of yearly appraisal from July 2014.

Guidance for patients who choose not to comply with pressure reduction strategies developed and approved.

Policy and guidance with supporting resources standardised.

Recommendation:

- Roll out competency tool in order to identify knowledge / theory gap and address.
- Launch all revised supporting documentation (i.e. policies, guidance, decision making tools, care plans, referral criteria etc) by July 2014.
- Address knowledge provision in undergraduate nurse training.
- With commissioners and social care agree strategy for addressing knowledge gap in nursing homes and with carers.
- Harness the ability and enthusiasm of the unregistered workforce to raise standards and provide training as part of the Tissue Viability Nurse (TVN) review.

Aim 3 - Implement comfort rounds across all sites by July 2013:

Progress to date:

Network of 'skin champions' developed for peer support and to share good practice linked to national tissue viability champion network.

Increase in the use of comfort rounding as measured by Nursing Care Indicators (up to December 2013).

Comfort rounding adapted and now taking place in paediatrics, maternity, PACU, theatres and ED.

Developed specific actions required of Matrons in order to ensure focus on *prevention* within their clinical teams and improved assurance back to the Chief Nurse Team.

Rounding in development for outpatient areas where the risk of skin damage can be high for some patients.

Started development work with Yorkshire Ambulance Service to ensure adequate pressure relieving interventions continue when patients are transferred between care settings.

Recommendation:

- Develop the process for auditing pressure ulcer processes and documentation now Nursing Care Indicators no longer in use.
- Strengthen further the assurance feedback to the Chief Nurse Team by Matrons in line with the reorganisation.

Aim 4 - Improve processes to ensure timely access to wound support and advice for all patients:

Progress date:

Review of TVN service (and the interface with other skin services) underway.

New RCA process and tool agreed and training provided to Matrons.

Aide memoir checklist developed and implemented to prevent deterioration of pressure ulcers.

Agreed referral criteria for TV service incorporating signposting to safeguarding and other services.

Electronic pressure ulcer risk assessment across acute sites allowing TVN team to proactively screen high risk patients.

Recommendation:

- Formalise service level agreements with mental health, GPs and Practice Nurses for tissue viability provision.
- Focussed work on improving communication between care settings when transferring and discharging patients with pressure ulcers.
- Implement a training programme for RCA of serious incidents for ward sisters and district nurses.

Aim 5 - Consolidate and centralise trust assurance data & agree reporting structure:

Progress to date:

A monthly 'Pressure Ulcer Panel' chaired by Chief Nurse Team was established in June 2013 to gain assurance, extract and share learning and apply the definition of 'avoidable / unavoidable' consistently.

Learning from panels widely disseminated and discussed monthly with Matrons.
Established weekly reporting by Matrons of all ulcers which developed in 'our care'.
Validation of all pressure ulcer incidence data.

Agreed improved definitions for use in datix of those ulcers which developed in 'our care' and resources to support staff in the reporting process.

Commenced work on review of plaster cast products, application and monitoring of patients as investigations show a trend for pressure ulcer development in these patients.

Agreement reached for standard and tool to be used for skin assessments in community services.

Recent development of a pressure ulcer 'dashboard' to provide further assurance and data.

Recommendation:

- Establish a timeline to report compliance with electronic nursing assessments in acute hospitals to provide improved assurance and drive up standards.

Aim 6 - Improve the nutritional status of patients in our care to prevent skin breakdown:

Progress to date:

Agreement from the Trust Nutritional Operation Group to take on the work plan which includes raising the standard of nutritional assessment and improving compliance with protected mealtimes.

Electronic nutritional risk assessment across acute sites allowing dieticians to proactively screen for 'at risk' patients.

6. Progress with our strategic aim to reduce pressure ulcers by 50% and no category 3 and 4 ulcers by March 2013

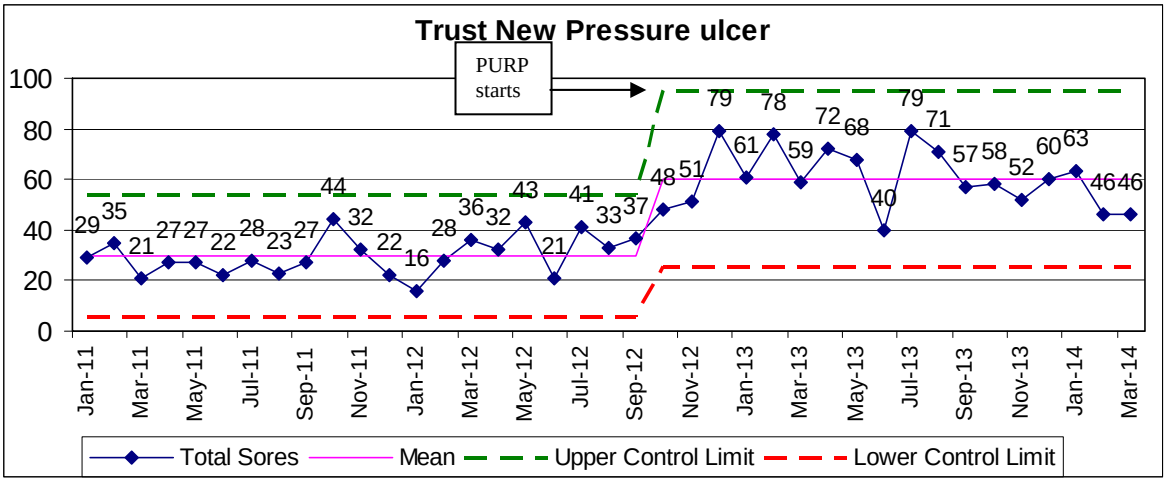
Data used for comparison is April 2012-March 2013 compared to April 2013 – March 2014

Current position all incidents – datix reports:
There has been an increase of 45% in reported pressure ulcers indicating that we have not achieved our high level aim. However, as previously stated it will take 18 months to 2 years before we are likely to see sustained improvements. A rise in reporting of incidents was anticipated given the renewed focus and evidence of previous under-reporting in some areas.

Category 4 ulcers: there were 6 category 4 ulcers this year compared to 12 in the previous year, a 50% reduction.

Category 3 ulcers: there were 88 category 3 ulcers this year compared to 71 the previous year, a 24% increase. In addition to the increase in reporting, the rise is also thought to be due to better awareness of the difference between a category 2 and 3 ulcer now a programme of education has been established.

It is also worth noting that in community services *all* patients are now screened for skin damage which has increased the number of incidents.



Current position prevalence – data is collected using the National Safety Thermometer on one day each month, in real time. This data details an improvement in the number of ulcers over time.

Acute services showed a 36% reduction using safety thermometer, partly achieving the CQUIN target (which was 50%).

Community showed a 19.5% reduction using safety thermometer, achieving the CQUIN target (which was 15%).

Learning from Panel over the year:
The main learning from Panel is that there are 3 main issues:

- Care of patients with devices particularly plaster casts and oxygen tubing
- Care of patients with anti-embolic stockings and
- Patients who choose not to take the advice of nursing staff in pressure ulcer prevention strategies, particularly in community services.

Category 3 ulcers, from April 2014, are also declared serious incidents allowing further learning to be extracted through root cause analysis.

Recommendation:

- Further define the term avoidable / unavoidable.
- Amend the high level aim to 'no *avoidable* category 3&4 pressure ulcers'.
- Undertake a review of plastering services to ensure service provision and standards of care are appropriate.

7. Conclusion

This report details that significant progress has been made against the PURP. It demonstrates that staff awareness and engagement has increased. Pressure ulcers have become and remain a high priority and assurance has improved. Gaps in process and knowledge have been exposed and plans to address this put in place. Staff report that they feel more confident to make changes and as a result improve care.

The TVNs report increased referrals and delivery of education and feel that a programme of work of this size has been difficult alongside integration and they welcome a review of their service.

Recommendations have been made throughout this report and additional suggestions would be:

- Strengthen the role of the Matron in driving up standards of care in order to prevent and reduce deterioration of pressure ulcers and have tighter performance management of the issue.
- Expedite an early review of the TVN service
- For community services to focus on the key aspects of the plan which can make the most difference and as such develop a community PURP with an identified clinical lead, actions and timescales - equipment remains a priority.

8. Recommendations

The Board is asked to accept this report as assurance of overall quality standards of care for patients and note areas of both risk and significant progress. The Board is asked to discuss the report and the recommendations to reduce pressure ulcers.

Author	**Michelle Carrington, Head of Patient Safety**
Owner	**Beverley Geary, Director of Nursing**
Date	**May 2014**

Update from Pressure Ulcer Panel – April 2014 Panel	

In total RCAs were undertaken on 7 patients who developed pressure ulcers or whose ulcers deteriorated while in our care.

One pressure ulcer was deemed to be a trauma wound and 6 were pressure ulcers.

Of the 6 ulcers – 5 were category 4 and 1 was category 3.

2 of the category 4 ulcers had been to a previous panel when they were category 3 and the wounds had deteriorated further.

2 of the ulcers were on the sacrum, 1 on the heel, 2 on the ischial tuberosity (same patient) and 1 on the shoulder blade.

4 ulcers were deemed unavoidable and 2 avoidable. Details of the avoidable ulcers are below:

Avoidable ulcers:		
Clinical area:	**Details:**	**Main learning:**
Community services	44 year old male patient, paraplegic under the care of district nurses for 10 years. Patient was given a 'trial' wheelchair cushion by the wheelchair centre which was unsuitable for his needs. The direct pressure of this cushion and the patient wishing to sit out for longer periods caused the ulcer.	
Orthopaedic ward	86 year old patient was being discharged from hospital. Patient needs were communicated to the ambulance crew but do not appear to have been followed. Patient fell while in the ambulance and then taken directly to her care home. Care home brought the patient back where she was diagnosed with bilateral fractures of legs. Plaster cast put on and patient developed a heel ulcer under the cast. The investigation described some issues with communication / documentation between plaster room and the ward.	Governance arrangements in the wheelchair centre need to be addressed particularly for trial items of equipment. Cushion sent to MHRA.
Rationale for unavoidable decision applied		Review of plastering services as described in the PURP action plan.

to 4 ulcers		For the ambulance service to address the action regarding the care of the patient while in their care.
• That a pressure ulcer developed even though the clinical team could demonstrate that the patient's clinical condition and pressure ulcer risk factors had been assessed, care was planned and implemented, monitored and evaluated or • The patient chose not to adhere to prevention strategies in spite of education of the consequences of non-adherence.		

York Teaching Hospital NHS Foundation Trust

Pressure Ulcer Reduction Plan (PURP) – Acute Services 2014-2015

Overall aim – 50% reduction in pressure ulcers and no avoidable category 3 or 4 by April 2015			
Objective	**Action**	**Lead**	**Update May 2014**
All pts to have 24/7 access to pressure relieving equipment	1. Appoint on a substantive basis 'TVNA-E' (York site) to maximize the use and efficiencies of pressure relieving mattresses and cushions by April 2014. Expand the role to manage TNP and other Tissue Viability related equipment by June 2014 2. Review and update processes to reflect change in equipment provision service with appointment of TVNA-E post by July 2014 3. Review provision of pressure relieving equipment in theatres and out patient areas by July 2014 and make recommendations to Chief Nurse 4. Review provision of bariatric pressure relieving equipment in hospital sites by July 2014 and make recommendations to Chief Nurse 5. Standardise procurement of pressure relieving equipment i.e. chairs, cushions, mattresses across acute sites by August 2014	Senior Nurse Patient Safety	1. TVN(a) appointment made
Maintain provision of tissue viability training and education to nursing, midwifery, medical and AHP staff	1. Review and standardise statutory mandatory training in pressure ulcer prevention across hospital sites by June 2014 2. Standardise HCA and RN induction education by June 2014. 3. Ensure all reference material and supportive documentation is standardised and cascaded to all clinical areas by May 2014 4. Sustain visible presence of TVN's in order to provide ad-hoc and flexible training 5. Commence assessment of competence of all RN's by Ward Sister or delegated other (in patient assessment of risk, care planning, equipment choices and documentation) by July 2014 6. Ward Sisters to complete competency assessment of all current RNs by October 2014 and new staff within 3 months of commencement 7. Link competency to appraisal system by July 2014 8. Develop SLA with Leeds and York Partnership NHS Foundation Trust to provide Tissue Viability Service for Mental Health Service in York by July 2014 9. Explore potential for collaboration between Tissue Viability Service and local Health and Social Care community by September 2014	1-4. Tissue Viability Specialist Nurses 5-6. Ward Sisters 7-9. Patient Safety Team	1. Stat and mand training provision agreed 2. HCA and RN induction now agreed with establishment of community induction by July 2014 3. Policy to be approved by Nursing Board June 2014
Embed and sustain comfort rounds across all hospital sites	1. Review of comfort round document by documentation steering group and recommendations by July 2014 2. Ensure compliance with rounding is performance managed by matrons, included in walkrounds and 1:1 time with Ward Sisters 3. Develop measurement of compliance of comfort rounding by July 2014 4. Undertake audit of compliance commencing October 2014	Chief Nurse Team	1. New documentation in draft and being tested

Objective	Action	Lead	Update May 2014
Improve processes to ensure timely access to wound support and advice for all patients	1. Re-launch 'wound prevention and management policy' by July 2014 2. Publicize and implement referral criteria to acute services staff by July 2014 3. Standardise TVN service provision across acute sites i.e. standardise patient assessment process, service provision and recording of activity by August 2014 4. Explore potential for collaboration between Tissue Viability Service and associated professionals i.e. dermatology, vascular and podiatry	1-2. Patient Safety Team 3. Chief Nurse 4. Patient Safety Team	1. Policy and associated standards to go to Nursing Board for approval at next meeting 3. TVN review started
Consolidate and centralize trust assurance data and agree reporting structure	1. Pressure Ulcer Panel' to be held monthly with agreed terms of reference by April 2014. 2. Quarterly report to Board and subgroups reflecting incidents, ST, learning and progress against action plan from April 2014 3. All category 3 and 4 pressure ulcers developed or deteriorated in our care to be declared SI's with full RCA from April 2014 4. Education programme for staff completing RCA to be agreed from June 2014 and delivered to timescales 5. Resources to support staff with reporting and investigating process to be disseminated across acute sites by March 2014 6. Full implementation of safety cross in acute hospitals by June 2014 and managed by Matrons. 7. Undertake safety thermometer (ST) for acute sites every month 8. Develop audit programme for measuring compliance with pressure ulcer standards, process and outcomes by July 2014 9. Undertake audit by September 2014 and develop action plan	1. Chief Nurse 2. Patient Safety Team 3. Matrons 4. Tissue Viability Specialist Nurses 5. Patient Safety Team 6. Matrons 7. Ward Sisters and District Nurses 8. Chief Nurse 9. Chief Nurse	1. Panel established 2. Format of quarterly report to Board agreed starting May 2014 3. All cat 3 and 4 declared as Si 4. RCA training provided to Matrons, additional training for ward sisters and district nurses to be developed 5. New RCA tool and process agreed and in use
Improve the nutritional status of patients in our care to prevent skin breakdown	1. Full implementation and sustainability of protected mealtimes by July 2014 managed by Matrons 2. Ensure protected mealtimes are embedded and compliance monitored by the Ward Sister 3. 80% compliance with nutritional assessments by March 2014 and 90% by December 2014 4. Develop fluid management policy with associated documentation by August 2014 5. Develop and implement new food charts by August 2014 6. Develop mechanism for auditing compliance with food and fluid charts by September 2014 and commence audit December 2014	Nutrition Operational Group	1. Policy in development, full implementation not yet achieved 3. Assessment electronic since Dec 2013, compliance data not yet available from SNS 4. Fluid management policy in development 5. Draft food and fluid charts being tested

Pressure Ulcer Reduction Plan (PURP) – Community 2014-2015

CIT 26 : Pressure Ulcer Reduction

Project Description:

Executive Sponsor:	**Mike Proctor**
Operational Project Lead:	**Wendy Scott / Jenny Carter/ Annette Wilkes**
Project Manager:	**Ali Horton**
Service Improvement Lead:	**Ali Horton**
Contracting Meeting:	

Detailed Plan

v1 11 Apr 14 (AJB) **DRAFT**

			Responsible/ Actioned By	CI Team Support	RAG (type 'Green', 'Amber' or 'Red')	Start Date	Completion Date
		GOVERNANCE & REPORTING					
		Authority, Approach, Roles & Controls					
		Outline Business Case					
		Establish Project Board membership & meeting schedule					
		Business Case					
		Project Initiation Documentation					
		Establish reporting route & accountability					
		Measures, data collection, analysis & reporting					
		Agree measures (including balancing measures)					
		Establish data collection mechanisms & reporting schedule					
1		**Risk Screening Tool Ali Horton, Lyeanda Berry**					
	1.1	risk screening tool rolled out	LB			04.03.2014	04.06.2014
	1.2	risk screening tool education inc AHP's	LB/TVN'S			27.03.2014	01/07/2014
	1.3	risk screening tool pilot audit	AH			01.05.2014	01/06/2014
	1.4	risk screening tool final audit 3 months	AH			02.06.2014	31/07/2014
	1.5	risk screening tool final audit 6 months	AH			02/09/2014	31/10/2014
	1.6	Develop patient information leaflet and disseminate	LB/AH		**Green**	01/11/2014	01/02/2014
	1.7	Audit use of patient information	AH			01/05/2014	01/06/2014
2		**Hand-Over Practice Alison Gibson, Clare Pethulis**					
	2.1	Scope current handover practice	AG/CP			01/05/2014	**To add**
	2.2	Develop template for best practice based on SBAR	AG/CP			14/05/2014	**To add**
	2.3	Pilot template and amend	AG/CP			31/06/2014	**To add**
	2.4	Develop roll-out plan	AG/CP			01/07/2014	**To add**
	2.5	Roll out documentation	AG/CP			31/08/2014	**To add**
3		**Equipment Bev Proctor, Rebecca Grant, Kath Ward**					
	3.1	Review and improve the provision of equipment for pressure ulcer care				**To add**	**To add**
	3.2	Provide education and training re equipment				**To add**	**To add**
4		**Education and Training Gemma Hancock**					
	4.1	Competency tool to be developed	GH		**Green**	31/04/2014	01/05/2014
	4.2	Pilot of competency tool	GH			01/05/2014	30/06/2014
	4.3	Training to be provided on the tool	TVN's			01/07/2014	31/08/2014
	4.4	Team leaders to assess their staff using the competency tool	Team L's/LM's			01/09/2014	01/01/2015
	4.5	Ensure a process for central training record	AH/BC			01/05/2014	01/06/2014
	4.6	Standardisation of Statutory and Mandatory training PUP	TVN/AH			01/04/2014	14/05/2014
	4.7	Develop induction programme with Cathy Skillbeck	CS/AH			01/06/2014	31/07/2014
5		**Improved Datix Reporting Linda Mcdonaugh, Lyeanda Berry**					
	5.1	Agree standard for Datix reporting	LM/LB		**Green**		31/04/14
	5.2	Audit of Datix to determine complaince	LM/LB			01/05/2014	31/06/14
	5.3	Ensure all DN Team Leaders can amend datix reports	LM/LB			01/05/2014	31/06/14
	5.4	Deliver datix training to DN Teams	LM/LB			01/06/2014	31/12/2014
	5.5						
6		**Root Cause Analysis Linda Mcdonaugh, Lyeanda Berry**					
	6.1	Develop and agree RCA tool	LM/LB		**Green**	01/02/2014	01/04/2014
	6.2	Roll out RCA tool	LM/LB			31/02/2014	31/05/2014
	6.3	Agree training programme for RCA	LM/LB			01/05/2014	31/07/2014
	6.4	Roll out education programme	LM/LB			01/08/2014	31/08/2014
	6.5	Audit of RCA completion	LM/LB			01/08/2014	31/08/2014
7		**Documentation Ali Horton, TVN's, DN's**					
	7.1	Develop wound care plan	AH,TVN's,DN's			01/03/2014	31/05/2014
	7.2	Roll out wound care plan	AH,TVN's,DN's			01/06/2014	01/08/2014
	7.6	Pilot wound care plan	AH,TVN's			01/08/2014	01/10/2014
	7.3	Agree PURAT	AH,TVN's,DN's			01/05/2014	31/05/2014
	7.4	Roll out PURAT documentation	AH,TVN's,DN's			01/06/2014	31/07/2014
	7.5	Launch PU Wound Policy	BG/MC				31/06/2014
	7.7	Audit compliance with above documentation	AH /DN's			01/08/2014	31/11/2014
8		**Interface with Carers/Care Agencies Joyce Sims/Ann Potter**					
	8.1	Identify key individuals and agree work plan	JS/AP				31/09/2014
	8.2	Identify strategy for improved documention and support	JS/AP				01/04/2015
9		**Non-concordance/Refusal of Care or Advice - Gemma Hancock**					
	9.1	Non compliance documentation to be developed	GH			01/04/2014	31/06/2014

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Estates and facilities Issues directly related to quality and safety

Action requested/recommendation

Non-estates professionals carrying out leadership walkrounds might consider using the Day to Day operational issues section as a checklist when engaging with local staff.

The committee should apprise themselves of the constraints inherent in the existing building stock, and identify further specific risk areas for prioritisation as they come across them.

Summary

This paper aims to serve as an introduction to areas where patient safety and quality are directly influenced by estates related issues for non-estates professionals.

Three of the CQC outcomes, **Outcome 8: Cleanliness and infection control, Outcome 10: Safety and suitability of premises** and **Outcome 11: Safety, availability and suitability of equipment** are strongly dependant on estates and facilities, whilst there are elements of many of the others that are related at least in part.

The built environment plays a significant part in our compliance, and given the age and condition of much of the estate presents some challenges.

The paper is split into two sections, the first dealing with the management of day to day issues, and provides leaders who do not have an estates background with some key principles to bear in mind when conducting patient safety walkrounds. The second section considers problems inherent in the design of the existing estate, and links them to the emerging site masterplans.

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

4. Improve our facilities and protect the environment ☒

Implications for equality and diversity

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

The Equality act and building control regulations concerning disabled access are some of the design guidance referred to in the paper.

Reference to CQC outcomes

This paper directly references outcome 8, 10 and 11.

Progress of report

Risk	Paper identifies risks in the management and construction of the built environment
Resource implications	
Owner	Brian Golding, Director of Estates and Facilities
Author	Brian Golding, Director of Estates and Facilities
Date of paper	June, 2014
Version number	1.1

Board of Directors – 25 June 2014

Estates and facilities Issues directly related to quality and safety

1. Introduction and background

This paper aims to serve as an introduction to areas where patient safety and quality are directly influenced by estates related issues for non estates professionals.

Three of the CQC outcomes, **Outcome 8: Cleanliness and infection control, Outcome 10: Safety and suitability of premises** and **Outcome 11: Safety, availability and suitability of equipment** are strongly dependant on estates and facilities, whilst there are elements of many of the others that are related at least in part.

The built environment plays a significant part in our compliance, and given the age and condition of much of the estate presents some challenges.

The paper is split into two sections, the first dealing with the management of day to day issues, and provides leaders who do not have an estates background with some key principles to bear in mind when conducting patient safety walkrounds. The second section considers problems inherent in the design of the existing estate, and links them to the emerging site masterplans.

2.1 Day to Day operational issues

Never Events
Two of the NHS Never Events are directly estates related: falls from windows and scalding.

Windows
A patient falling from an unrestricted window is a never event. For this reason all windows in patient accessible areas, (and these might be off the ward), must be fitted with devices that prevent them opening more than 100mm. The restrictors must need a tool to be overridden. This often leads to conflict between staff wanting greater ventilation in the summer – but the patient safety issue is paramount.

Water safety
There are 2 significant risks associated with water systems: - Legionnaires disease and scalding.

Legionnaires disease is caused by bacteria that is present in water supplies, and multiplies significantly at temperatures below 60C. Elderly and immunosupressed patients are at greatest risk. To prevent a build up of the bacteria, all water outlets should be regularly flushed, and records kept.

To guard against Legionella the domestic hot water is stored above 60C centigrade. However the water cannot be delivered at this temperature, as it presents the scalding risk that is the never event. To reduce the outlet temperature the hot water is blended through a thermostatic mixing valve, (which is likely to be below the basin or bath), so that it is always below 44C. All patient accessible outlets should be fitted with mixing valves. The only exception is where high temperatures are required for a particular function, (eg in kitchens),

and these outlets should be labelled with cautionary notices).

Other Day to Day issues
The most common risks are in the following areas:

Basic electrical safety
There should be no exposed wiring, or broken faceplates. Portable appliances should be routinely inspected annually, (we have just moved to Bi-Annual inspection based on a risk assessment), and all appliances should have a green sticker identifying the date of the next test. Leads and plugs should be examined for damage before equipment is plugged in.

Nurse call
A nurse call facility should be available for every patient. The call system should have a handset that can be used both in bed and when sitting in a chair adjacent to the bed.

Hot surfaces
There should be no surface that presents a risk of burning from prolonged contact. Heating systems that operate at high temperatures should be fitted with guards.

Beds
Beds should be in good working order with functional side rails and the ability to adjust the height, either for carrying out procedures or to reduce the impact of falls.

Anti ligature curtain rails
In areas identified as high risk in respect of potential suicide, wards should be fitted with anti ligature, (collapsible) curtain rails. In high risk areas bathrooms should have been risk assessed and ligature points removed. In particular there should be no cistern chains or hooks.

Medical Equipment
All medical equipment is subject to periodic inspection and recalibration. Devices should be clearly labelled with the date for their next service.
There should be no visible signs of damage to equipment, cables and pipes.
Sufficient equipment, including pressure relieving mattresses, should be available when needed.

Patient hoists
All fixed and mobile lifting equipment is subject to periodic inspection and testing. Equipment should be clearly labelled with the date of the next inspection.

Floors
Floors should generally be in good condition and free from trip hazards. There should be local equipment available to highlight spillages, and procedures to ensure they are cleaned up promptly.

Estates and facilities operate helpdesks for the reporting and progressing of faults and problems. At Scarborough/ Bridlington it is ext 2020, and at York/Selby ext 5566. Local staff should be encouraged to report problems via their helpdesk, and seek progress reports as necessary.

2.2 Design Considerations

Design standards
The built environment is governed and influenced by a plethora of design guidance and

standards.

Some are legislative, others are best practice.

Over and above the national and European standards, healthcare is covered by a series of NHS standards and guidance set out in Health Building Notes, (HBNs) and Health Technical Memoranda, (HTMs).

Over the years the standards set in the HBNs and HTMs have been amended to reflect technological and clinical changes. Space standards in particular have increased dramatically.

Whilst the space standards are not usually retrospective, some of the technical standards are. An example of this would be theatres, where most of our operating theatres, having been built over 30 years ago, would be much smaller than equivalent new theatres, but we would still expect the ventilation systems to achieve the current pressure and cleanliness standards. Where we don't meet latest standards, we would carry out a risk assessment in conjunction with Infection Control and the Clinical Teams to understand and document the risks associated with any non conformance.

In all new projects the design team's starting point is the relevant HBN. If space or budget constraints prevent full compliance, the design team will seek Trust approval for variations to the standard. These are known as 'derogations', and protect the design consultants from claims against their professional indemnity insurance. It is not unusual to have a significant number of derogations in refurbishment projects, where space constraints dictate the achievable design solution. There is likely to be a move away from centrally produced HBNs in the future, leaving Trusts to agree their own space standards based on their own particular circumstances and experience.

Consultation
All designs are subject to approval of specialists such as Infection Control, Health and Safety, Fire Safety, Medical Engineering etc. Depending on the clinical services involved there may well be a number of external authorities that need to approve the design. For example Endoscopy suites need to secure approval from the Royal College's Joint Accreditation Group, (JAG).

Wherever possible designers seek to consult with staff and service users, either through formal groups where these exist or with local service users. This ensures that we consider the impact of the design on the quality of the experience from a patient's perspective.

Common Areas where we fall short of current standards

Bed Head Services
Not all of our wards have enough sockets at the bedhead, nor do they have their own piped medical gas supplies, sometimes sharing services, or having to rely on bottled supplies. This leads to an increased use of extension leads and supplementary equipment, and adds to general clutter in the clinical areas.

Bed centres
Current HBN standards set 3,6m as the distance between adjacent bed centres. Many of our wards are built to 2.4m, and occasionally we worsen this position by adding escalation beds.

Overall ward area
Our existing wards fall well short of the current space standards. For example at York

Hospital a typical 30 bedded ward has a gross internal area of 650 square metres. To the latest standards a 24 bedded ward would occupy 1,000 square metres. This leads to clutter around the beds and in corridors, and to a sense of overcrowding.

Availability of single ensuite facilities
The latest standards suggest that at least 50% of beds should be in single ensuite rooms. This responds to a growing expectation amongst the population, and allows better infection control management and enhanced privacy and dignity. Currently no more than 15% of our beds are in single rooms, and the majority of these are not ensuite. An audit of the current bedstock is underway.

Isolation Rooms
Some infections require specialist isolation rooms, where the ventilation can be controlled to limit the risk of cross infection. The Trust has very few isolation rooms, (typically they can be found on ICU and neutropenic areas, such as ward 31 at York). The ward block review at York is looking to identify an area to create additional rooms, and a similar exercise will be carried out at Scarborough.

Ward ventilation
The conflict between ventilation and window safety, (as described in section 2.1 above), leads to overheating in some areas.

Patient handling equipment
There is a general lack of built in patient hoists. This creates the need for mobile equipment, which is generally large, and further exacerbates the storage and congestion problems.

Local control of heating and lighting
Very few, if any areas, have individual bedside controls. This leads to patients feeling uncomfortable and frustrated at their lack of ability to influence their environment. This is compounded by the requirement to limit window openings.

Observation
The layout of many of the wards, with central nurse stations, limits the ability of nursing staff to observe patients. This could increase the risk of falls in vulnerable patients.

Security
Wards generally do not have a lock down facility, which means that patients from other wards, or visitors to the hospital, can gain access to vulnerable patients. Installation of access control will be commenced this year, allowing wards to manage their access arrangements. This system will also prove useful when wards need to be controlled due to infection outbreaks.

Shortcomings specific to particular locations
The following are specific localised problems in the patient environment:

York Vascular Imaging Unit
Elimination of mixed sex accommodation is difficult - this together with the overall capacity of the department is a key investment priority in the York masterplanning.

Privacy and dignity in York Endoscopy unit – as above.

Condition of main theatres and PACU at York – as above.

Scarborough ICU lacks appropriate ventilation. This will be addressed within the

Scarborough masterplanning.

Scarborough Chemo therapy suite, despite recent improvements this department lacks appropriate ventilation.

This list is likely to grow as further problems are identified, and design standards continue to develop. Leaders carrying out walkrounds should feel free to report specific concerns to the Director of Estates and Facilities.

Site masterplanning
The site masterplans for York and Scarborough are seeking to support the emerging clinical strategy whilst accommodating and eliminating the shortfalls described above.

At York there is an interim proposal to reconfigure the wards, to segregate into separate blocks the surgical and medical specialties. This will eliminate the need for staff and patients to use adjacent wards as corridors, and so reduce the potential to spread airborne infections.

2. Conclusion

All staff should be aware of the risks associated with the estate, and know how to report problems.

The majority of the Trust's estate is not built to current design standards, and makes provision of clinical services more challenging.

3. Recommendation

Non-estates professionals carrying out leadership walkrounds might consider using the Day to Day operational issues section as a checklist when engaging with local staff.

The committee should apprise themselves of the constraints inherent in the existing building stock, and identify further specific risk areas for prioritisation as they come across them.

4. References and further reading

CQC Outcomes.
York and Scarborough masterplans.

Author	**Brian Golding, Director of Estates and Facilities**
Owner	**Brian Golding, Director of Estates and Facilities**
Date	**June 2014**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Safer Staffing Project – NHS England Nurse Staffing Return

Action requested/recommendation

The Board of Directors are asked to accept the report for information and to agree the recommendations as detailed in section 4 of the main report.

Summary

Following recommendations' from *Hard Truths* and subsequent work undertaken by NHS England; all Trusts must meet the expectation from the National Quality Board (NQB) of reporting in public planned versus actual staff.

In late May a directive was issued by from NHS England that the staffing return should be undertaken retrospectively and the data must be submitted in early June for publication on NHS Choices website on 24th June. In addition, as the Board are aware; the expectation is that any outlying areas regarding staffing levels are reported to Trust Board and detail the following information:

- Site
- details of issues and any mitigations
- details of actions taken to reduce risk highlighted.

The Board will want to seek assurance that there are processes in place to highlight risks to patient care caused by deficient staffing and that there are escalation policies and contingency plans in place for those times where staffing capacity and capability falls short of that required to provide a high quality service to patients.

Currently the senior nurse team review actual against planned staffing on a daily basis. There is a recognised procedure for escalating concerns and taking immediate actions in relation to any short falls in nurse staffing. (appendix 1 & 2)

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Outcome 13.

Progress of report

Risk	Potential risk to organisational reputation due to non compliance with recommendations from Hard Truths.
Resource implications	Possible additional resources needs, to be determined.
Owner	Michael Proctor, Chief Nurse
Author	Beverley Geary, Director of Nursing
Date of paper	June 2014
Version number	Version 1

Board of Directors – 25 June 2014

Safer Staffing Project – NHS England Nurse Staffing Return

1. Introduction and background

Following recommendations' from *Hard Truths* and subsequent work undertaken by NHS England; all Trusts must meet the expectation from the National Quality Board (NQB) of reporting in public planned versus actual staff.

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The Board will want to seek assurance that there are processes in place to highlight risks to patient care caused by deficient staffing and that there are escalation policies and contingency plans in place for those times where staffing capacity and capability falls short of that required to provide a high quality service to patients.

Currently the senior nurse team review actual against planned staffing on a daily basis. There is a recognised procedure for escalating concerns and taking immediate actions in relation to any short falls in nurse staffing. (appendix 1 & 2)

2. Context

The Trust has 2 acute sites and 7 community sites with a total of 1113 in-patient beds and 78 potential escalation beds. The table below details the number of beds by site and the number of potential escalation beds.

	Beds	Comments	Potential Escalation Beds
York	596	This doesn't include G2 G3 24a and SCBU Ward 24 is also an escalation area which is 20 beds plus we have 24a which is our frailty unit of 10 beds	20-30 (ward 24) 16
Scarborough	297		32 (Graham and winter escalation)
St Helens	20		
White Cross Court	23		
Whitby	35		

Selby	23		
St Monicas	12		
Bridlington	77		
Malton	30	Moved from 2x15 bedded ward to one 28 bedded ward in mid-May	

The return highlighted a fill rate of between 44% to 122% (appendix 3) the exceptions are listed below.

3. Exceptions

York site
During May Ward 24 at York site has been open due to demand for increased capacity, the beds ranged between 8 and 30 and staffing was flexed accordingly (note: we are currently not required to declare staffing fill rates for escalation areas).
In order to staff this area temporary workforce were employed and staff were moved from established areas to maintain safety. These wards were then backfilled with staff working additional hours, bank staff (NHSP,) or agency.

Ward 17 - Paediatrics'. The area is a significant outlier in terms of their untrained ('care staff') fill rate. The establishment in summer is 3+2 and 4 + 1 in winter.
During May there was sickness of a HCA, they are also carrying a vacancy, there was also some movement of staff from nights to days to address staff shortages and acuity of patients

ITU & CCU
These are level 2 and level 3 units and therefore have a much higher trained to untrained staffing ratio, sickness and vacancies in these areas have reflected the 'care staff fill rate negatively. Due to the role the impact of the quality of patient care would be insignificant

Over 100% fill rate & 1:1 observations (specialling)
A number of areas show an over 100% fill rate – usually in care staff. This is due to the 'specialling' of patients who require a higher level of observations such as those who wander, are very high risk of fall or have mental health issues.
These areas include:
Ward 39- Elderly medicine
Ward 21 – SSU
Ward 23 – elderly medicine
Ward 25 elderly medicine
Ward 26 Elderly Medicine
Ward 32 – Cardiology
Ward 37 – Complex elderly (Dementia)
Ward 39

Scarborough Site:
Ann Wright – Complex Elderly (Dementia)
Oak – Elderly Medicine

Bridlington Site:
Kent – Trauma and Orthopaedics'

Malton Site:
Fitzwilliam – Community Care

Mid month Malton moved from 2x15 bedded ward to one 28 bedded wards; this would account for the over 100% fill rate. The patients are level 3 and 4 dependency and are admitted for slow stream rehabilitation.

Scarborough Site
Overall the site had an 80% fill rate.

White Cross Court
This area was over established (night shifts) due to a programme of acceleration improvement work which commenced in May. The area is a step down only slow stream rehab ward.

4. Communication and External Reporting.

All organisations are required to publish the data on their local website, following consultation with the Communication Team Manger an area of the Trust's website has been identified where an explanatory narrative will be published alongside a link to the data on NHS Choices. Media queries will be dealt with through the Trust's press office, unless they relate to the Safer Staffing Programme as a whole (for example the methodology, comparisons with other Trusts, rationale etc) in which case they will be referred to NHS England who have stated that they will manage media queries. Staff will be informed through the Trust's internal communications channels that the data is now available and will be published on a monthly basis.

5. Conclusion

This report details the first monthly staffing return of data of actual against planned staffing for day and night duty in hours by ward.

The report gives high level exceptions and details action taken to address short falls and mitigate risk on a daily basis.

Recognition should be given to the Ward Sisters who were required to input a significant amount of data in a short time frame and also to the team from Systems and Network who supported the initiative.

Feedback received around 'lessons learned' Lessons learned are that the weekly returns should not be submitted until they are validated and 'signed off'.

The board is asked to receive the paper for information and to acknowledge the significant amount of resource that may be required to deliver this requirement on an ongoing basis.

6. Recommendation

The Board of Directors are asked to accept the report for information and to agree the recommendations as detailed in section 4 of the main report.

7. References and further reading

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

Hard Truths*: The Journey to Putting Patients First* , Department Of Health, January 2014

Author	**Beverley Geary, Director of Nursing**
Owner	**Michael Proctor, Chief Nurse**
Date	**June 2014**

Appendix 1

DAILY STAFFING BRIEF - SCARBOROUGH	York Teaching Hospital NHS NHS Foundation Trust

Date(s):	Present:

Matron's actions before 4pm

Directorates must identify staffing shortfalls and a list of any uncovered shifts together with their staffing contingency plans.

STAFFING – PLEASE WILL ALL MATRONS INFORM THE WARDS THAT THE BED MANAGERS WILL ONLY BE ABLE TO DEAL WITH NEW SICKNESS CALLS OUT OF HOURS.

Directorate Staffing shortfalls and contingency plans

Please detail staffing shortfalls and what the plans are for cover, or whether the ward will tolerate the shortfall.
Matrons must also ensure that the ward team are aware of their plan by using the agreed ward communication tool.

Where staff are moved between ward areas please record names

Ward	Early Planned	Late Planned	Night Planned		RN / HCA shortfalls	Shift	Contingency plans and actions (include names of staff who are moved).	
A Wright	3+3	3+2	2+1		HCA	E	Member of staff on carers leave	
ESA	3+2	2+2	2+0					
Beech	4+4	4+3	3+2					
CCU	6+1	5+1	4+1					
AMU	5+4	5+4	5+4					
Chestnut	4+3	4+3	2+2					
Graham	3+2	2+2	2+1					
Haldane	3+3	3+2	2+1					
Holly	3+3	3+2	2+2					
ICU	6+1	6+1	5+0					
Johnson	3+4	2+3	2+1					
Kent	3+2	2+2	2+0					
Maple	6+3	5+2	4+2					
Oak	5+5	5+4	3+3					
Stroke	4+2	4+2	3+1					
Waters	3+3	2+2	2+1					
Willow	1+1	1+1	1+1					

Other relevant comments:

Out of Hours Bed Manager update

Please detail all out of hour shortfalls or changes to staffing and the action taken.

Ward	Shortfall / Change	Action taken

Name of bed manager:

In and out of hours - If a decision is made to re-allocate a staff nurse from Stroke Unit or Outreach nurse, please provide rationale for decision

Date	Time	Rationale

This briefing must be saved using the floppy disk icon on the toolbar and filed on the Q drive.

Appendix 2

DAILY STAFFING BRIEF - YORK	York Teaching Hospital NHS NHS Foundation Trust

Date(s):	Present:

Matron's actions before 4pm

Directorates must identify staffing shortfalls and a list of any uncovered shifts together with their staffing contingency plans.

STAFFING – PLEASE WILL ALL MATRONS INFORM THE WARDS THAT THE BED MANAGERS WILL ONLY BE ABLE TO DEAL WITH NEW SICKNESS CALLS OUT OF HOURS.

Directorate Staffing shortfalls and contingency plans

Please detail staffing shortfalls and what the plans are for cover, or whether the ward will tolerate the shortfall.
Matrons must also ensure that the ward team are aware of their plan by using the agreed ward communication tool.

Where staff are moved between ward areas please record names

Ward	Early Planned	Late Planned	Night Planned		RN / HCA shortfalls	Shift	Contingency plans and actions (include names of staff who are moved).	
G1	4+2	4+2	2+1					
G2	3+2	3+1	2+1					
G3	2+1	2+1	2+1					
ESA								
Wd 11	4+3	4+2	2+2					
Wd 14	4+3	5+3	3+2					
Wd 15	4+4	4+2	3+1					
Wd 16	5+2	5+2	4+2					
Wd 17	3+2	3+2	3					
Wd 18	1+1	1+1	Closed					
AMU	6+5	6+5	5+4					
SSW	4+3	4+3	2+2					
Wd 23	4+3	4+2	2+2					
Wd 24	3+2	2+2	2+1					
Wd 25	4+3	4+2	2+2					
Wd 26	4+3	4+2	2+2					
Wd 27								
Wd 28	5+3	4+2	2+2					
Wd 29	4+2	4+2	2+1					
CCU	4+1	4+0	4+0					
Wd 31	5+2	4+2	2+1					
Wd 32	5+3	4+3	2+2					
Wd 33	4+3	4+3	2+2					
Wd 34	4+3	4+3	2+2					
Wd 35	4+3	4+2	2+2					

Wd 36	4+3	4+2	3+2					
Wd 37	3+4	3+3	2+2					
Wd 39	3+3	3+2	2+1					
ICU	11+1	11+1	11+1					
ED	8+2	8+2	7+1					
WXC	2+3	2+2	1+1					
St Helen's	2+3	2+2	1+1					

Other relevant comments:

Out of Hours Bed Manager update

Please detail all out of hour shortfalls or changes to staffing and the action taken.

Ward	Shortfall / Change	Action taken

Name of bed manager:

In and out of hours - If a decision is made to re-allocate a staff nurse from Stroke Unit or Outreach nurse, please provide rationale for decision

Date	Time	Rationale

This briefing must be saved using the floppy disk icon on the toolbar and filed on the Q drive.

Appendix 3

	Day				Night							
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Day		Night	
Site Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
St Monicas Hospital	630	531.25	795	654.25	372	372	372	372	84.3%	82.3%	100.0%	100.0%
Selby and District War Memorial Hospital	1162.5	962.83	1162.5	1102.5	341	352.75	682	651.5	82.8%	94.8%	103.4%	95.5%
York Hospital	50422.5	42305.89	30907.5	27748.14	25529.65	23433.64	15087.95	16596.24	83.9%	89.8%	91.8%	110.0%
Scarborough General Hospital	24727.5	19283	14527.5	12859.44	13756.75	12397.24	6850.6	6564.34	78.0%	88.5%	90.1%	95.8%
Whitby Community Hospital	1627.5	1473.17	2557.5	2286.92	744	682	1116	999	90.5%	89.4%	91.7%	89.5%
Malton Community Hospital	930	943.91	1627.5	1231.16	682	521	682	677	101.5%	75.6%	76.4%	99.3%
Bridlington and District Hospital	3487.5	2863.76	3720	3402.43	2139	1766.49	712	963.34	82.1%	91.5%	82.6%	135.3%
White Cross Rehabilitation Hospital	930	891	1162.5	994.5	356.3	503.5	356.3	347.5	95.8%	85.5%	141.3%	97.5%
St Helens Rehabilitation Hospital	930	778	1162.5	1067.25	348.45	356.5	348.45	356.25	83.7%	91.8%	102.3%	102.2%

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Review of Patient Experience service – Update on the review

Action/recommendation

The board is asked to approve the following recommendations:

- The development of a Patient Experience Strategy with an education plan to support the primary focus of patient experience, early resolution and complaints handling, with the emphasis on the lessons learnt and organisation wide learning.
- Standardise pay bands for PALS team to band 4 for all post holders (there is a cost of approx £800 per annum to uplift the band 3 at Scarborough)
- Establish PALS cover at Scarborough within the current PALS team establishment
- Advertise the vacant 8A as Lead for Patient Experience with overall responsibility for the team.
- Review all job descriptions and person specifications once the 8a Lead post is appointed and review the current structure as part of the next stage of work.
- Band 5 Complaints and PALS Manager(Scarborough) post to revert to band 5 Patient Experience Officer, with post band 5 posts having a change in title
- Both sites to have access to the same IT function, allowing staff to access the same information
- Develop the role of complaints officer to include family liaison officer, supporting the SI investigator and acting as single point of contact for the family
- Foster cross site working within the team, this may require co-location to a central area to ensure full integration is maintained and all staff work in the same way for 1 year.
- Continue weekly Chief Executive Officer, Director of Nursing, Chief Nurse review meetings
- Continue complex complaints review meetings
- Introduce clinical supervision/support for staff involved in complex complaints
- Continue to promote and strengthen the role of the Director in the management of highly complex cases
- Where all internal processes have failed to resolve the concerns external review should be sought
- Implement quarterly team meetings
- Implement a process whereby complainant's views are sought once the complaint has been resolved to ensure the complainants views are sought and acted upon.
- Further develop the input from the patient and public involvement,

ensuring good practice is shared organisation wide.
- Revise the use of the Knowing How We are Doing boards to focus on patient experience and include "*You said, We Did*"
- Continue and further develop the patient experience stories at all levels
- Develop patient experience dashboard for board information

Summary

The purpose of this paper is to review the Patient Experience Team function and roles, with the aim to further integrate the team, focusing on patient experience, with standardisation of roles and pay bands, along with supporting the development of a patient experience strategy and education programme.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Outcomes 1, 4, 9 & 16

Progress of report	Corporate Directors
Risk	
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Beverley Geary, Director of Nursing

Author	Pamela Hayward-Sampson, Assistant Director of Nursing
Date of paper	June 2014
Version number	Version 1

Board of Directors – 25 June 2014

Review of Patient Experience service – Update on the review

1. Introduction

In January 2014 terms of reference (appendix 1) were approved to support a review of the Patient Experience Team role and function. As part of our internal review processes gaps were identified within the Trust in relation to timescales for investigating complaints, early resolution and sharing the lessons learnt from complaints at both Directorate level and Trust wide. Actions plans were completed but in some cases, those identified as leads to complete the action were not aware of the plan or recommendations. Potential gaps and overlap sometimes resulting in duplication of effort was identified when a Serious Incident investigation was also being investigated through the complaints process.

The administration of complaints is managed by the Patient Experience Team (PET), who work closely with complaints investigators to support the complainant and the investigator to ensure that complaints are responded to in a timely and appropriate manner. This team collate the information, liaise with the DM and assist with administration. The PET also helps with meeting complainants and the investigator when required. (The process is detailed in Appendix 2.)

The complaints investigators are generally Directorate Managers (DM's) or their deputies (DDM's) and Matrons.

The DM receives the initial formal complaint and this is then allocated to the most appropriate staff member to investigate. The review did highlight that at times this allocation is not always delegated to the most appropriate member of staff. For example, Matrons are sometimes asked to investigate complaints regarding Consultants or waiting list problems rather than focusing on nursing issues; with DDM's investigating issues regarding quality of care.

It is acknowledged that the complaints process itself is supported by statutory regulations and cannot be changed. However, it is important to recognise that the focus on the patients experience is essential to ensuring that lessons are learnt, additionally staff must be equipped with the right skills to support early resolution at ward and department level.

The review considered the training needs for staff identified as complaints investigators.
A listening exercise was undertaken by the Corporate Improvement Team, supporting the review, to understand the views of the team and it function. This included the patient experience team establishment and how best the team could operate within the resources available.

Limited assurance was provided prior to the review that the directorates owned and implemented the actions and recommendations following a complaint.

2. Review

The basis of this review was to understand the current complaints process and how this links to patient experience, rather than providing a complaints management function. The review considered the team's current establishment and how they could function more effectively across sites, recognising that demand and capacity was inequitable post integration across the

sites, with the Scarborough site historically receiving more complaints with fewer resources compared to the demand. The two teams are still working in isolation, this could be due to the separate locations but it appears little team development has been undertaken post integration.

2.1 Training Needs Analysis

A training needs analysis was undertaken to identify any gaps in knowledge and training for staff that investigate and handle complaints. Those targeted were complaints investigators; these were department managers, DM's, DDM's, Ward Sisters and Matrons. A total of 86 members of staff responded to the questionnaire.

The key themes from the training needs analysis were:

- 66% of respondents had not received formal training in handling complaints. Those that had commented stated it was "process focused" rather than focusing on the patients experience. Some of the training took place a number of years ago.
- 28% felt the training was insufficient although 54% felt it was sufficient to some extent. (Table 1)
- 32% had received external training in complaints handling, mostly through external leadership training.

Responders felt supported by the patient experience team but found dealing with complaints stressful reporting that they did not always feel that they had received the most appropriate training to manage more complex issues.
Detailed information and the results of the analysis is attached at appendix 3.
It is important to note that a training programme led by NHS elect is currently ongoing with all Matrons undertaking the 'train the trainer' programme.

2.2 Patient Experience Team roles, function and resources:

The review considered the current patient experience team establishment, along with roles and functions. This included what happens currently and how the complaints process works. This included feedback from Health watch, York, who provided the patient and relatives view of the complaints process. They received feedback from some patients stating that they felt that once they raised a complaint or concern "they became part of a process", when sometimes they just wanted to talk about the issues they had raised. The review also looked at patient feedback directly into the organisation, acknowledging that whilst some complainants are dissatisfied with responses, we have had a number of letters thanking the team and individuals for their complaint response and expressing confidence in the process and outcome.

A number of issues were identified, such as inequity on the Scarborough site compared to the York site, inequity of banding on all sites and vacant posts. The team does carry some vacancies and recommendations have been made to as to the most resourceful use of these posts. Cover for PALS at Scarborough is not currently provided and this was highlighted in the review as a risk. The PALS team could be utilised differently to provide cover either remotely or on site within the existing resources.

The team is motivated and is willing to work more closely with directorates to support the lessons learnt from complaints, identifying key themes Trust wide and acting as the conduit for sharing these, therefore preventing duplication of effort within the directorates. The team displayed professional behaviour throughout the review and were open and honest in their feedback.

2.3. Outcome of the listening exercise:

The corporate improvement team led the listening exercise, which included all members of the patient experience team.

The key themes were:

- A motivated and willing team, eager to make a difference and explore new ways of working, including working as one team.
- There needs to be full integration across the sites, with the possibility of co-locating onto one site.
- A review of the roles and job descriptions is required, standardising banding across the sites
- An update IT systems as current system (Datix) does not operate at the Scarborough site, this limits communication function, as this is the primary interface for documenting formal/informal contacts within the Trust.
- PALS do not feel part of the team and the focus is on the complaints process rather than the patient experience and shared learning.
- The Head and Neck directorate were identified as an area of good practice and a benchmark for the Trust, taking ownership and set realistic action plans which are delivered.
- Training should be improved for clinical staff, ensuring that the responsibility for the complaint sits with the directorate.
- Consideration should be given as to how the patient experience team supports Community Services, to ensure consistency in the handling of complaints.
- Senior support possibly director level, for complex complaints and use external support when needed to provide independent advice.
- There is a need for team meetings to take place, minimum of quarterly, which includes information on the previous quarter relating to the service and action plans
- Review and address the skill mix inequity for some roles.

2.4. Complex complaints

A number of complaints are very complex and reflect a complete pathway, patient journey or include a number of health care organisations. These are often difficult to manage which causes delays in response and difficulty in implementing actions and sharing learning. In recent cases non clinical Director leads have been appointed by the Chief Executive to oversee the investigation process, meet with families and share learning across the organisation. This practice has proven successful and it is recommended that this should continue with the CEO allocating the review.

In addition, it has been acknowledged that the complaints process can have a significant impact upon the patient experience team and/or the investigators, a system for review, support and where appropriate; clinical supervision should be put in place.

Where complainants remain unhappy with the response, and after internal review, external review should be sought by an agreed acute trust. Reciprocal arrangements with a number of acute trusts have previously been used for this purpose, in the spirit of collaboration it is recommended that this practice should continue.

A recent review of Serious Incidents has identified that in some cases a disconnect between the SI process and complaints process is evident, this has left relatives liaising between legal services and the Patient Experience Team. There is a need for a family liaison role within the PET who will work with the SI investigator to ensure the family have a single point of contact to agree time scales etc are adhered to. This will strengthen links with the Risk and Legal department and prevent any patient/relative from falling between gaps and being unsupported or given incorrect information.

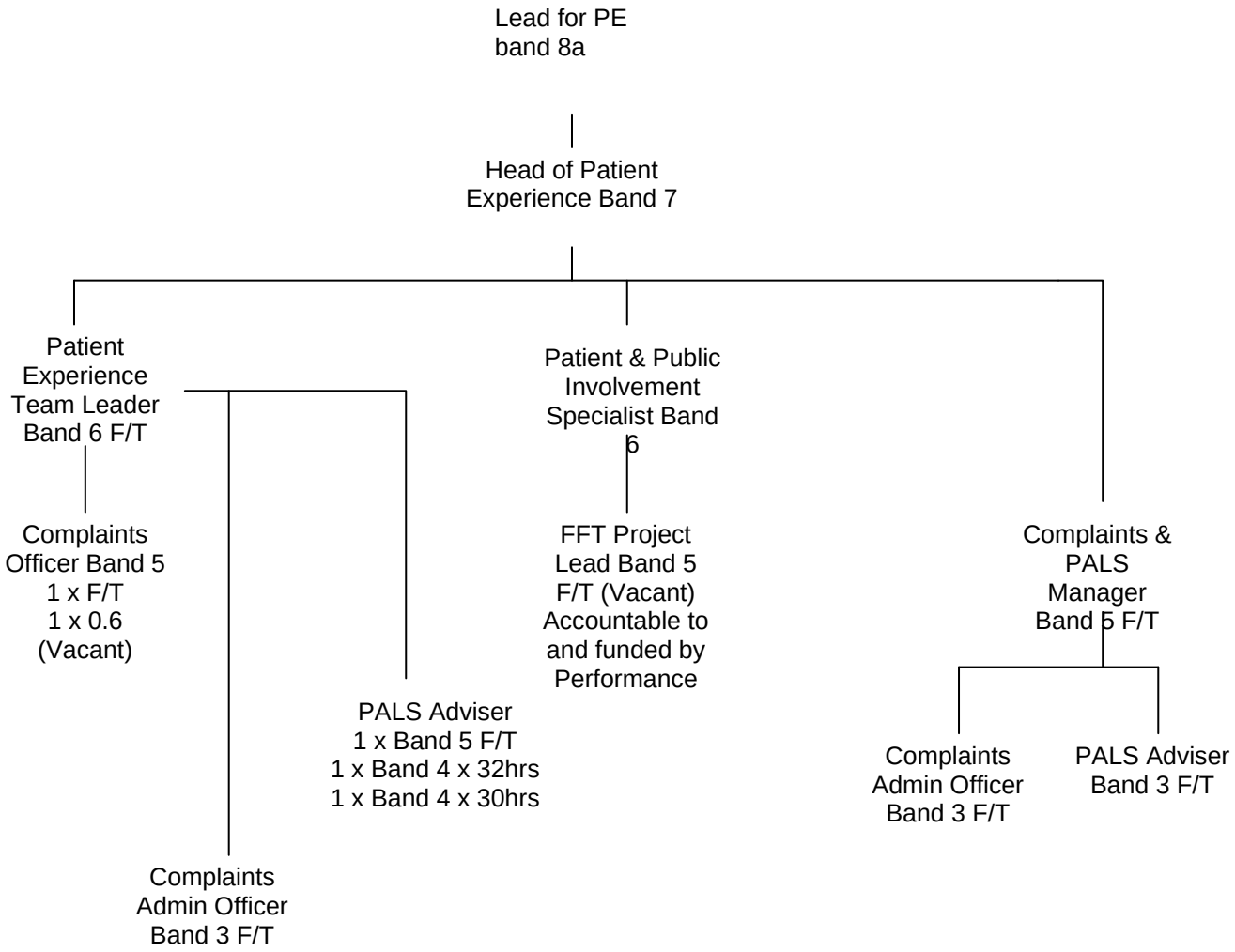
2.5. PET Establishment

The team's current establishment is shown in table 1. In total the team has 12.60wte (including PALS) of which there are 2.6 wte vacant posts, one post is the Lead Nurse post who is the team manger, the second is a project lead for Family and Friends and the third is 0.6 wte complaints officer. The Family and Friends post is not within the existing budget and creates a cost pressure of £18,000, which will be considered when the 8a lead post is appointed to and a restructure considered after their appointment. It is recommended that the 8a reviews all job descriptions and outlines a proposed structure, which will support the family and friends post within the existing budget. However, work to look at the Job Description of the more senior roles should begin without delay in order to introduce a more formal family liaison role.

The PALS team has 3.42 wte on the York site and 1wte on the Scarborough site. The PALS advisors are a mix of bands, ranging from band 5 to band 3. Scarborough has 1 complaints manager and 1 administrator. The job descriptions differ on both sites. This cost of aligning all the PALS posts to a band 4 will be approximately £800 per annum.

Current establishment

Table 1.



The current establishment is inequitable with a variation in job titles and banding, and there is a limited number of staff on the Scarborough site where demand in relation to complaint management is greater (table 2)

Table 2

Complaints	York	Scarborough
Number received	71	64
Resolved outside procedure	32	-
Total	103	64

3. External Benchmarking and good practice

Examples of good practice from other organisations were sought and this included Northumbria Acute Hospitals, Sheffield Hospitals and Cambridge University Hospitals. Reassurance was gained from this benchmarking exercise that the complaints processes are similar to York. However reporting to Trust board differed in the other organisations with some excellent examples provided of patient experience dashboards and board papers.

Additional to this was the information provided at ward level, using the family and friends qualitative data displayed at ward level and real time feedback to the actions that had been taken at locally to address any concerns.

Through the Elderly Care Forum views were previously sought on the ward 'Knowing How We are Doing Boards'. However, feedback from patients and their relatives illustrated that they did not understand the information and wanted more detail on patient experience.

The Trust receives a significant amount of patient feedback, with national and local questionnaires, including Family and Friends, which provides the organisation with qualitative and quantitative data. This is not currently shared with patients at ward level.

Many organisations have a stand alone Patient Experience Strategy, the development of this locally has been highlighted as an objective in our current Nursing and Midwifery strategy and the Patient Experience Steering Group advocate this development.

Health-watch have provided feedback to us from patients and their relatives, this highlighted that once an issue was raised they felt that they had become part of a process, however, most said that they had originally just wanted to talk through their concerns with a member of staff.

A number of site visits and meetings are planned to learn from organisations' with a reputation for good practice.

4. Conclusion

A significant amount of work has started in relation to the moving the focus of the patient experience team from that of complaints management to one of improving the patient experience.

Changes already made include weekly complaints review meetings with the Chief Executive and the Chief Nurse, a re-launch of the Patient Experience Steering Group, chaired by the Director of Nursing, and non-clinical Director reviews of complex complaints.

At the time of integration of Scarborough and York Hospitals an integration meeting took place with the respective Patient Experience Teams. This resulted in a number of recommendations and actions. However, the actions were not followed through at the time and this has led to frustration within the team. This review has identified that further work is required to fully integrate the teams and this should be actioned as priority and is essential to the delivery of the Patient Experience agenda.

The listening exercise illustrated that team is highly motivated and willing to work closely with the Directorates and to support them with the delivery of actions following the lessons learnt from complaints. Given the themes are often similar throughout the organisation this would significantly reduce time and effort and ensure a cohesive approach to improving the patient experience within the Trust.

Significant work has been undertaken in relation to Patient and Public involvement but it appears that historically this has not been viewed as an integral part of the patient experience team; the listening exercise demonstrated that it is viewed as separate by some team members.

Work that has been undertaken tends to focus on directorate initiatives supported by the PPI Lead and this information is not always shared organisationally. The Trust has rich data from complaints, Family and Friends and national surveys and this information should be shared more widely within the organisation, including lessons learnt. This would provide greater assurance at board level and greatly improve the patients' experience.

5. Recommendations

The board is asked to approve the following recommendations:

- The development of a Patient Experience Strategy with an education plan to support the primary focus of patient experience, early resolution and complaints handling, with the emphasis on the lessons learnt and organisation wide learning.
- Standardise pay bands for PALS team to band 4 for all post holders (there is a cost of approx £800 per annum to uplift the band 3 at Scarborough)
- Establish PALS cover at Scarborough within the current PALS team establishment
- Advertise the vacant 8A as Lead for Patient Experience with overall responsibility for the team.
- Review all job descriptions and person specifications once the 8a Lead post is appointed and review the current structure as part of the next stage of work.
- Band 5 Complaints and PALS Manager(Scarborough) post to revert to band 5 Patient Experience Officer, with post band 5 posts having a change in title
- Both sites to have access to the same IT function, allowing staff to access the same information
- Develop the role of complaints officer to include family liaison officer, supporting the SI investigator and acting as single point of contact for the family
- Foster cross site working within the team, this may require co-location to a central area to ensure full integration is maintained and all staff work in the same way for 1 year.
- Continue weekly Chief Executive Officer, Director of Nursing, Chief Nurse review meetings
- Continue complex complaints review meetings
- Introduce clinical supervision/support for staff involved in complex complaints
- Continue to promote and strengthen the role of the Director in the management of highly complex cases
- Where all internal processes have failed to resolve the concerns external review should be sought
- Implement quarterly team meetings
- Implement a process whereby complainant's views are sought once the complaint has been resolved to ensure the complainants views are sought and acted upon.
- Further develop the input from the patient and public involvement, ensuring good practice is shared organisation wide.
- Revise the use of the Knowing How We are Doing boards to focus on patient experience

and include "*You said, We Did*" • Continue and further develop the patient experience stories at all levels • Develop patient experience dashboard for board information	
Author	**Pamela Hayward-Sampson, Assistant Director of Nursing**
Owner	**Beverley Geary, Director of Nursing**
Date	**June 2014**

Appendix 1

Terms of Reference Patient Experience Team review

Following the recent publication of the Clwyd report, the parliamentary and health service ombudsman report and the Francis report a number of recommendations have been made nationally regarding complaints management and the role of a patient experience team in early intervention and resolution. The Trust has identified some gaps within the existing complaints process and how this links with patient experience and assurances in relation to action plans and recommendations. It has been agreed to undertake a review of the existing process and function.

Purpose

To undertake a review of the process and function of the patient experience team. This will include the complaints process and the sharing of lessons learnt alongside the function of patient and public involvement across all sites.

Membership

The review process will be led by:

Pamela Hayward-Sampson, Assistant Director of Nursing

Supported by:
Dianne Willcocks, Non Executive Director
Gemma Cuss, Directorate Manager
Gordon Cooney
Lucy Brown

Timescales for the review

The review will be completed by the end of March 2014 with relevant recommendations and actions plans

The review will consider the following:

- Understand the current complaints policy and how this links to patient experience rather than a complaints process.
- Determine trends, responses, actions and outcomes. This will include compliance with timescales as per policy, extensions, outstanding actions and recommendations and review outcomes.
- Map the process from ward/dept level to completion.
- Identify areas of good practice and opportunities for shared learning.
- Identify gaps in the complaints process and patient experience.
- Review capacity and demand and consider where the service best fits.
- Review the organisational structure of the service.
- Understand the existing training and education provision and who accesses this and undertake training needs analysis.
- Review the use of Datix web IT systems to support the complaints process or recommend an alternative approach.

- Review serious complaints process and actions, including those complaints that result in Ombudsmen involvement.
- Review the involvement of the patient and public across the sites.
- Review role of PALS and their function across all sites.
- Determine how complaints data, including trends, is shared Trust wide and publicly in a meaningful and transparent way. (Cultural barometer, “you said, we did”, improved patient involvement, friends and family).
- Consider how the Trust provides an independent investigation where serious incidents/complaints occur and develop guidance as to appropriate escalation and referral for external review.
- Review how national and local data from patient surveys, friends and family is shared publicly and Trust wide.
- Review the role of the ward sister in relation to early resolution and prevention of complaints.

Reporting to:

The lead will be responsible for formulating recommendations and actions to address changes following the review.

Accountability and Governance

The lead will report recommendations and actions to the Patient Experience Steering Group, with timescales and delegation of accountability for delivery.

References
clywd
A review of the NHS Hospitals complaints system, putting patients back in the picture, Ann Clwyd 2013

NHS Governance of Complaints Handling Parliamentary and Health Service Ombudsmen June 2013

The NHS hospital complaints system, a case for urgent treatment? Parliamentary and Health Service Ombudsmen April 2013

Designing good together, transforming hospital complaints handling. Parliamentary and Health Service Ombudsmen August 2013

Author: **Pamela Hayward-Sampson, Assistant Director of Nursing**

Appendix 2

York Teaching Hospital NHS
NHS Foundation Trust

Meeting the requirements of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Process for PET (Updated April 2014)

All complaints to be assessed by a Complaints Officer (PETL or HoPE in COs absence) before being registered by the Complaints Administrator (and acknowledged within 3 days of receipt)

COMPLAINTS OFFICER ASSESSMENT - Name: Date complaint received in PET	
All contacts should be considered by COs as to whether they could be resolved outside procedure, that is, resolved quickly and to the contact's satisfaction. For Example: Does it feel excessive/unreasonable to make the contact wait 30 days for an answer?	
1. Consider if the complaint could be a Serious Incident (SI) in which case take advice from Gail Addinall, SI Investigator & Elaine Miller, Head of Risk & Legal before proceeding. 2. Check if any SI's are declared YES / NO	
3. Is the complaint within the 12 month time period? YES / NO If unsure, defer to Marilyn Thirlway.	
4. Risk assessment category	Probability: Severity: Colour:
5. Check Datix Claims Module to see whether there is a claim running. 6. Check Datix Complaints Module to see whether the complainant has complained before and if so, are the issues the same/similar.	YES / NO If Yes contact Sarah Fletcher, Legal Services, to agree whether it will be handled as a claim or a complaint YES / NO If yes refer to CO/PETL
7. Does the letter need forwarding to SF, Legal Services (i.e. possible claim, or inquest if patient dies in hospital)	YES / NO Justification –
8. a) End of Life issues? (EOL) b) Safeguarding/Vulnerable Adults alert? (SGA) c) Child Protection alert? (CP) d) Professional conduct? (PC) e) Medicines Management? (MM)	YES / NO send to DM for Spec Med YES / NO send to Nicola Cowley YES / NO send to Liz Vincent YES / NO send to Dr Turnbull for awareness (medical staff) or Pamela Hayward-Sampson (nursing staff), any other staff groups. If Midwifery Conduct send to Liz Ross. YES/NO - send to Jennie Booth **If yes administrator to enter abbreviations in Datix description (EOL/SGA/CP/PC/MM)**

9. Does the complainant mention CQC, Monitor or media attention? If so include Bev Geary & Lucy Brown when emailing the docs out.	YES / NO
10. Timescale for response	10 30 50 days
11. Identify Investigating Officer & Directorate (Lead IO where applicable) ***n.b. Community Services – state locality (see Office Manual Contacts for further info)***	**Name:** **Directorate:** **Speciality:**
12. Do other directorates, MP, agencies or organisations (advocacy) need to be involved/copied in?	
Datix Service Area:	Datix Subject:
Summary of complaint to be entered on Datix description **(including all wards/areas)**	
Is letter of consent required?	Yes/No
Patients Case Note number: Patients Age: DOB: **Date(s) of admission**: **Date(s) of discharge**: -	
Complainant is:	**Re:** **Deceased:** **DOD:** **Relationship:** (to complainant)

Done	**Task**	
	Allocate complaint reference number from Complaint Register: (Add deceased after name, if applicable) • **WRITE FULL NAME IN CAPITALS** • **Record risk assessment on front of file**	**Y14/15 -**
	Check DATIX for PALS contacts • Print any off for pink file. • File behind original complaint, in pink complaint file. • Check pending file **Please put these in a plastic wallet, marked "contact prior to complaint"**	
	Register complaint on DATIX system using information above **(enter the patient's age on the complainant screen)**	
	Add the complaint reference number to the complaint letter, scan and make 2 copies (1 for the Green file and 1 for Complaint file). Save scanned copy in electronic file – save as 'original complaint'.	
	Timescale for response –see point 7. **Note: day one is the day that the complaint was received.** **Response due to PET 1 week before the target date.**	Due to PET: Due to comp:
	Write the acknowledgement letter **(and consent form if applicable)** using information in points 7, 8 and 9. Print 2 copies (1 for file / 1 for post). Print/write complainant's address on envelope provided in pink file. **Check below for additional info to include in the letter**	
	Additional Information For Administrator	
	Enter details on the complaint summary sheet – Print and file in section 2 of the pink file.	

	Enter complaint details on status sheet.
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Email the following to the investigating officer, the Directorate secretary & others identified by CO above. Remember to check whether complaint should be sent to additional people i.e. Risk & Legal, Safeguarding, etc: • scanned letter (highlighted & numbered) • complaint acknowledgement letter • complaint resolution plan • complaint report • covering letter • complaint action plan • statement guide & template • statement request involved & statement request not involved • save sent 'declaration' email to electronic folder
Your name:	**Date:**
	Take the pink file to the investigating officer. Hand it to a responsible person. ***n.b. Community Services – retain pink file in this office.***
	Monitor progress via the complaint status sheet.
	Quality assure the report and covering letter. Ask Sarah Fletcher, Legal Services to review if applicable. Pass to lead nurse for approval.
	Obtain Chief Executive's signature and post response to the complainant and other agencies involved. (Ensure the complainant receives the original NOT the copy)
☐ ☐ ☐ ☐ ☐ ☐	Close the complaint on PET systems: • Complaint register • Status sheet • DATIX • Summary sheet in pink file • Copy letter and report to Investigating Officer (+ PALS/PCT/Other Agency if applicable) • Enter staff involved on spreadsheet
	Monitor the complaint action plan. • If action plan not received, email IO and request it. • Write on whiteboard and follow up every two weeks • When received, print and add to pink file/ add to Datix/save electronically • Wipe off whiteboard • When evidence of actions is received (following the monthly review by directorates) add this to Datix and print off the Datix report to save in the action plan section of the pink file • Designated complaints manager (MT) to sign off completed complain action plan
	Meet the requirements for complaint monitoring and reporting.
Your name:	**Date:**

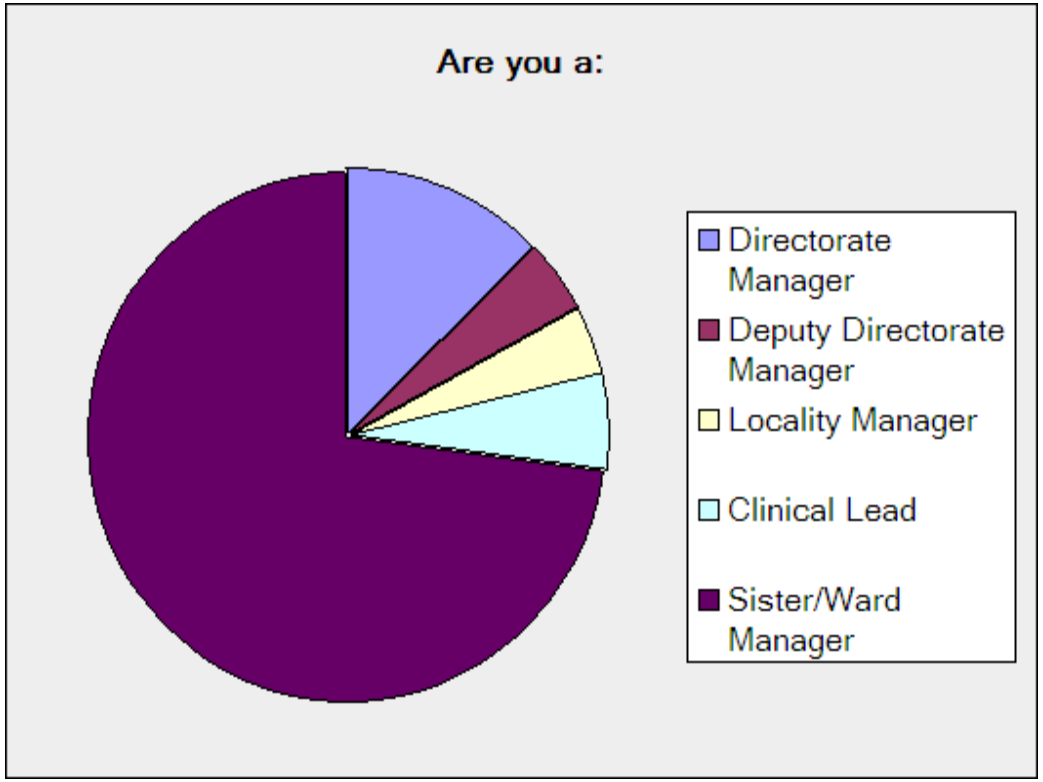
Appendix 3

COMPLAINTS MANAGEMENT

Are you a:

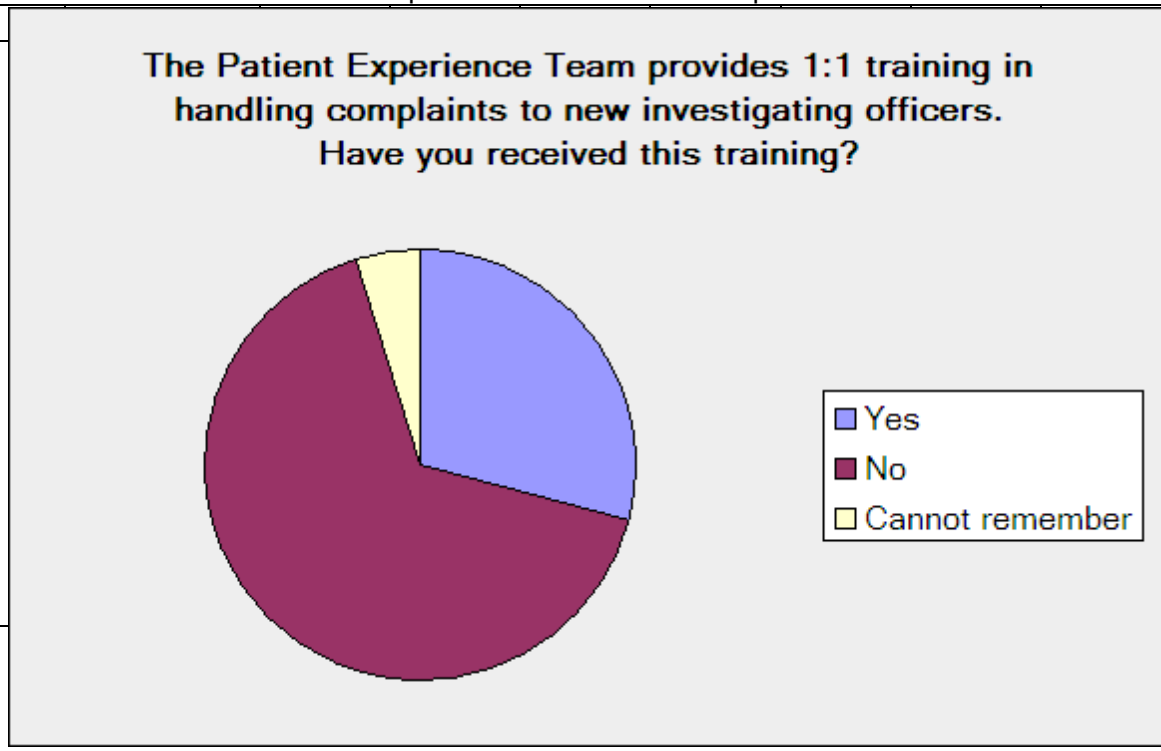
Answer Options	Response Percent	Response Count
Directorate Manager	12.9%	9
Deputy Directorate Manager	4.3%	3
Locality Manager	4.3%	3
Clinical Lead	5.7%	4
Sister/Ward Manager	72.9%	51
Other (please specify)		18
answered question		70
skipped question		16

Matron			10
Other (please specify)	**Categories**		
Deputy Directorate Manager and Matron			
Matron			
matron			
Deputy Sister			
matron			
Consultant and Deputy Medical Director			
School health nurse band 6			
School Health Team manager			
Matron/Team Manager			
Matron			
Matron			
Matron			
Advanced Nurse Practitioner			
deputy sister			
Matron			
Bed/Duty Manager.			



The Patient Experience Team provides 1:1 training in handling complaints to new investigating officers. Have you received this training?		
Answer Options	**Response Percent**	**Response Count**
Yes	29.1%	25
No	66.3%	57
Cannot remember	4.7%	4
Comments:		13
answered question		86
skipped question		0

Comments:	Categories
I met with a member of PET when I was appointed, but not receive any formal training, I was made aware of the complaints process.	
i don't think i have, but have had a 1:1 meeting with the team.	
I met with the Team when I started my secondment and they talked through the process - was that the training?	
I am also a risk reviewer I think it is ten years since I did a course for managing complaints	
I did 6 month secondment to the Complaints team a few years ago and found it to be an invaluable experience. Learnt a lot and helped me to communicate more effectively.	
I had 1:1 training when I commenced in a seconded Matron role	
Had training before they started providing this training.	
A long time ago and at my own request	
Is this the same training as handling investigations?	
long time ago	
Some time ago	
only minimal however	
When i started the job	



What did this training involve?	
Answer Options	**Response Count**
	28
answered question	**28**
skipped question	**58**
Response Text	
1:1 training when first appointed as Matron Also had training many years ago too	
Discussion of policy and process Review of case complaints	
Discussion and support from patient experience team, review of drafts and feedback for improvements.	
1;1	
1:1 session going through complaint response writing/wording	
When i first joined trust as a management trainee-I spent time with the team understanding their processes-the best way to resolve complaints etc and then took on a number of complaints reviewing my responses with the team-learning from each one. Now as DM I ahve regular contact with the team and we review and learn and in fact have a formal quarterly review with my team.	
Examples of response letters to complainants. Templates with terminology and standard clauses often used.	
Penny Harrison	
I sat down with WB and JA and looked at a couple of complaints Talked through time lines, action plan and completing the complaint resolution plan General discussion around PALS issues Training covered meeting with complainants	
As above	
It was tailored to the individual and I was told that they thought I wrote good responses, provided evidence of the investigation findings and said they did not feel I needed further training at this time. I was asked what I thought would make it easier and what they could help with which for me was training with staff on the wards who are asked to provide statements.	
Route cause analysis and how to manage the complaint	
n/a	
n/a	
I sat down with Penny Harrison and went through expectations etc, timings, submission format. I thought it was an informal catch up not formal training though.	
Meeting with PET staff for approx one hour. Discussed strategies for managing complaints	
Going through the forms, terminology and process	
A 2 day course 'dealing with Complaints' not sure of the correct title	
Discussion about roles and responsibilities. Training was a very long time ago - don't recall it including timeframes, gathering statements and / or governance around the checking of responses.	
Support through first complaint with complaints officer	
spending the day with the complaints team, going through the process	
going through an optimum complaints response and its structure	

The only training I have received is dealing with and handling investigations into incident (CI & SI)	
Policy and procedure. It was group training I think but can't remember.	
Background into the legislation that underpins the process. The Trust process and documents used, timescales, support available etc.	
informal discussion, went through process, question and answer session	
Someone sat in same room while i did the response to a complaint, so they were able to help where needed, although did not go through the process	
Just a review of the complaints process and timescales required.	

Comments:	Categories
Have not had the training	
Responding to a complainant requires a number of skills. Learnt a lot through the experience. The team are supportive and guide where required.	
N/A	
There are many aspects to complaints handling that were not discussed which would have been useful	
I have dealt with complaints for some time and have picked most of it up as I have gone along.	
Such a long time ago	
not applicable as training was over 15 years ago	
not had any training	
n/a	
n/a	
n/a	
An update would be useful e.g patients accessing their case files & the legislation relating to this.	
A refresher would be very useful	
However much training you receive the reality of handling a complaint is very different. You learn on the job so to speak.	

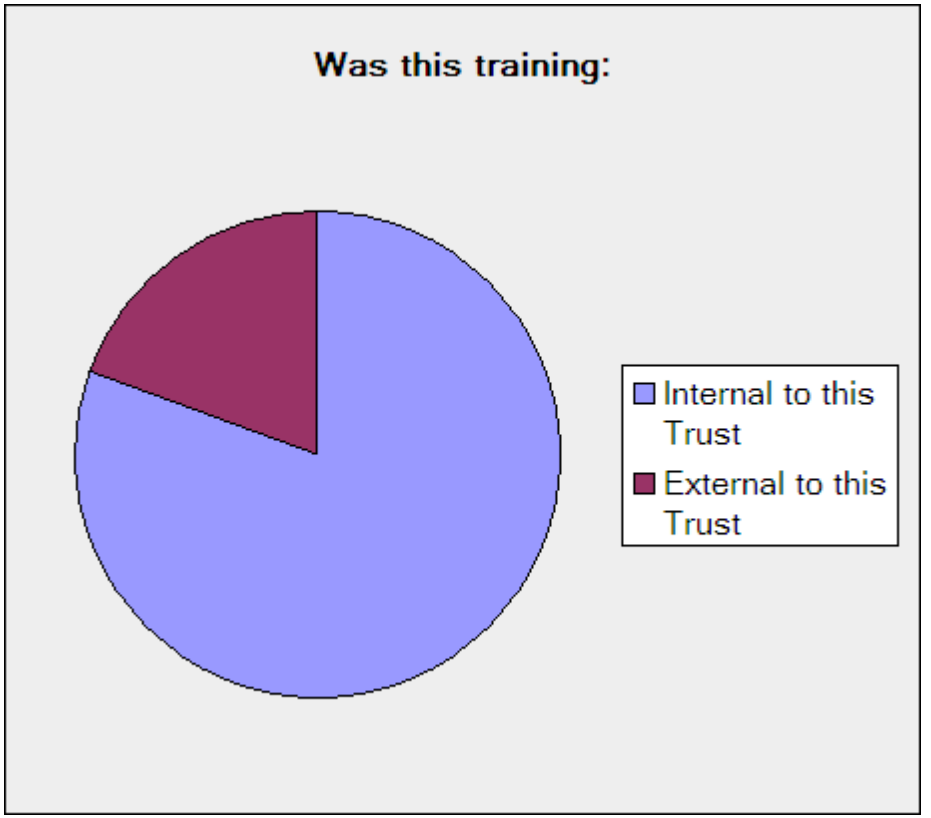
Have you received any other training in complaints handling?		
Answer Options	**Response Percent**	**Response Count**
Yes	32.1%	27
No	67.9%	57
If YES, please describe the training		22
answered question		84
skipped question		2

If YES, please describe the training
Group meeting to review previous complaints.
Many years ago from Penny Goff. It was investigator training. It was very good. I can still remember her point that you will spend 80% or more of your time investigating 20% of the complaint. You might never get the answer you are looking for. It's still true today.
met with PALS patient experience session
Full day provided by external trainers
training in how to use the complaints folder only
Ward Sister Master class Complaints & lessons learnt
Group training session
It was a Trust facilitated session by risk and legal
Mainly documentation etc. Cannot remember who did it
No formal training but very good advice and guidance from my DM
I attended a session some time ago but it was more about the process than about how to investigate and respond to complaints
I have met with the team on a regular basis and discussed how the response could be improved. Although this is not formal, I have made changes to my replies as a direct result
In previous organisation SYPCT and NYYPCT
support from matron
At a previous Trust - their policy and process to follow
I think I have had some training in the past on a management course

Some time ago but not in any great detail								
One day training in 2004 at Scarborough hospital. This was more about fact finding, and documentation								
Its my ward								
During various management/leadership courses.								
Previous experience (pre NHS) was dealing with customer correspondence								
Out of YH in another organisation in prior post.								

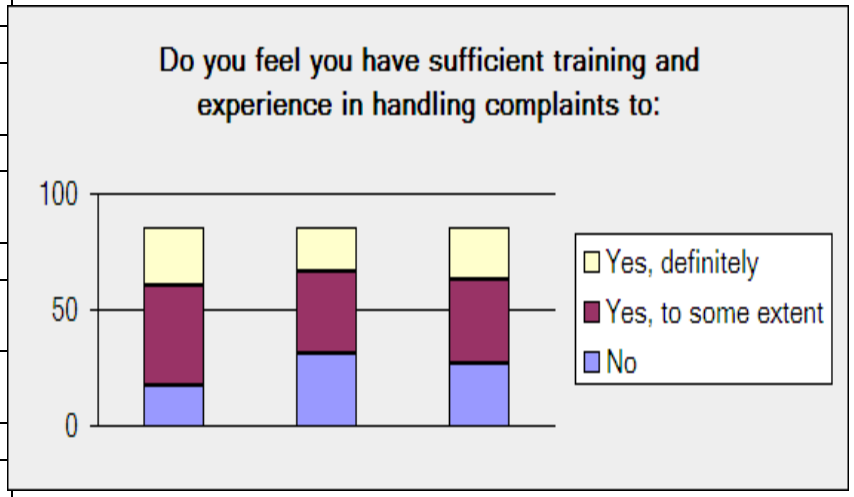
Was this training:			
Answer Options		**Response Percent**	**Response Count**
Internal to this Trust		80.6%	25
External to this Trust		19.4%	6
Please provide further details			13
		answered question	31
		skipped question	55

Please provide further details	**Categories**	
Previous job in another trust		
Support and guidance from Matron.		
nhs institute		
Provided for this Trust by external providers		
Provided by the Complaints Manager at that time.		
Over 15 yrs ago		
N/a		
Management course.		
N/a		
Institute Of heath Service Management Managing health services (Open University.)		
Previous line manager		
N/A		
N/A		



Do you feel you have sufficient training and experience in handling complaints to:				
Answer Options	**Yes, definitely**	**Yes, to some extent**	**No**	**Response Count**
investigate complaints	25	43	17	85
write a complaint response	19	35	31	85
meet with a complainant/relatives	22	36	27	85
Comment:				20
answered question				**85**
skipped question				**1**

Comment:
I would need help and training with the written report and on how to meet with complainant
Where the complaint is very complex I would still seek support from my professional lead.
Most of my experience has been learned on the job. 'Trial by fire' would probably best describe how i have learned to manage and improve my complaint responses.
I do not think I have had any training in the last element.
i have dealt with complaints that come through the pals desk and discussed with patients and relatives their concerns. I have never written a complaint response
would welcome more training
I would need to know the up to date format for a complaint response and to hold a formal meeting with relatives the appropriate/relevant senior member of staff.
Have collected statements from staff & given written responses to Directorate Manager & been involved in clarifying their written investigations
I have dealt with complaints via phone and email
You can always improve. I have never really been trained in these aspects and have just picked it up as I have gone along. However I do feel relatively confident in handling the above and if I am unsure I will always ask for advice and help from the Patient Experience Team.
building experience and confidence all the time
I do not have staff and work autonomously, however there have been occasions where patients have made a complaint about a clinic and I respond as the directorate risk reviewer, usually the line manager or Matron will deal with the complaint.
In the course of my role I already do this, without the benefit of recent formal training
Although on the job experience, any training would be valuable.
to make a formal report I have not taken part in.



i can't recall any formal training. I apply skills acquired through experience and other training particularly in relation to managing difficult situations and conflict resolution,					
response relates to "experience"					
An update, & feedback is always useful.					
I feel that this is an area in which I am always learning but we are well supported by PET.					
A lot of learning from experience, and sometimes by getting it wrong					

COMPLAINTS MANAGEMENT

If you have any comments that you would like to share with us about handling complaints, please use the space below to tell us:

Answer Options	Response Count
	29
answered question	29
skipped question	57

Response Text	Categories	
I did gain some experience through courses such as Clinical Leadership and Health and Safety in the past which helps but would certainly gain from help with written responses.		
I think the complaints dept could populate the resolution plan. They used to. It was helpful and they withdrew the service due to staffing issues. Once the team was up to full compliment, the service was not restarted. I know there are pros and cons for but it is helpful and saves some time.		
i would definitely appreciate a more formal approach to this training, certainly in regard to the written responses we are asked to provide.		
This is always very difficult on busy wards, the existing system where Matrons lead and the ward sisters address specific issues I feel works well and affords a comprehensive investigation		
Although I now feel confident to investigate/ respond to complaints as well as meet with families. I feel I have learnt this through experience and asking for feedback when I have completed complaint reports. Some more formal training when I came in to post, or even prior to this when I was a ward Sister would have been very beneficial.		
Handling complaints is very challenging because of the amount of time it takes and sometimes in order to meet deadlines it means coming in at the weekend or evening in order to write the reports. This is because of conflicting demands on time and in order to write a good report you need to have uninterrupted time to complete.		
Sometimes find the Datix incidents quite time consuming to answer and also complaints take up a lot of time.		
Some up to date training would be good. A refresher and letting us know the most up to date formats etc.		
Deadlines are often tight and I personally feel that often extensions are unnecessary as these result due to differences in grammar from the investigators initial response to that reviewed by the complaints team resulting in amendments. I appreciate the help and advice of the complaints team but often feel that the amendments made are just more of a personal preference. Experience teaches me to try to complete quicker than ever to allow for this now so as to still achieve the target deadline.		
Would appreciate & will ask for some formal training.		
I have handled quite a few complaints by telephone but have had no training to do this. Any training would be appreciated.		
I would find training in this area beneficial		

When you first start to handle complaints I think it you should be provided with structured training before you start. I also think it would be beneficial if an experienced complaints handler was allocated to you to provide training and advice as you go along. Constructive feedback would also be useful.		
I feel it is important for nursing staff at all levels to be able to deal with a complaint and at least to know of whom to turn to.		
only peripherally involved with complaints although have suggested for a long time that we need to connect complaints outcomes to trust development work and in particular workforce induction and development		
Experience has helped develop personal skills in the handling of complaints, and I have always had the support of my Matron, plus the Complaints and PALS Department.		
Matron within our directorate handles formal complaint letters and meets with family. I feel trained to take part in the investigation, but not to take the investigation further.		
I feel i would benefit from training in complaints handling		
In my role I deal with complaints from the public on a day to day basis. I additionally have recently been requested to write a report releasing to a complaint that I affected a member of staff that I manage. I do find these events extremely stressful and feel that I would benefit from training and on going support.		
I think there should be much more onus on meeting with complainants and offering verbal assurance etc		
This has never been offered to me despite me raising it as a learning need at IPR		
As a ward sister the issue is the time to dedicate to interviewing and then writing a good response, When I did a matron job I could allocate time for complaint response. If ward sisters get a written complaint to manage they should also be taken out of the numbers and given the appropriate time.		
There is a place for training of junior staff to enable them to defuse/deal with a situation as it arises, rather than giving the "how to complain" leaflet		
Participated in the delivery of training with previous ' Patient Experience Manager.'		
Complex complaints that cross multiple directorates should be co-ordinated centrally		
would like an update or to have a 1:1 tri annually		
We often forget face to face contact with those who complain, I think we should consider how we can resolve complaints quicker through a face to face approach.		
The consistency across the Trust on complaints handling needs to be addressed. I am certain from conversations I have had that individuals handle complaints in different ways.		
bespoke training would be really useful, covering the whole process including time lines, and investigation requirements		

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York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 17th June 2014, Boardroom, YH

Attendance: Mike Sweet, Chairman
Mike Keaney
Debbie Hollings-Tennant
Lucy Turner
Andrew Bertram
Graham Lamb
Liz Booth
Anna Pridmore
Lisa Gray

Apologies: There were no apologies

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last Meeting Notes Minutes Dated 20th May 2014**		MS raised a correction to the minute related to the Short Term Acute Strategy, frailty model in that the model was needs based care and not needs driven care as stated. Other than this correction the notes were approved as a true record of the meeting.		
2	**Matters arising**		**Possible cap on first to follow up ratio** – AB advised that the financial and activity schedules have now been agreed with all commissioners. Final agreements are to be made between NHS England and commissioners around specialist commissioning. Vale of York CCG have asked that there is not a deterioration of the first to follow up ratio, In principle this has been accepted but with the additional agreement that there will be areas of exception to take into account.	The Committee noted the comments and the assurance given by AB around the principle being employed	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			14 Fast track concerns related to cancer services – LT advised that the increase in fast track referrals is beginning to cause some capacity issues in several specialities. A paper prepared for the commissioning board to consider was well received and additional information has been requested by Scarborough Whitby and Ryedale CCG. **Emergency Department funding from CCG** – LB advised that the funding that had been in place as part of the additional monies allocated towards the end of 2013 was removed at the end of March. Requests have been made to the CCG to reinstate the funding, but to date this has not been successful. Further discussions are being held through the Urgent Care Board. **Ambulance hand over bays** – LB advised that these would be open on 19th June. A formal opening of the bays has been arranged for 23rd June.		
3	**Short Term Acute Strategy**		**Bed Reconfiguration** – LB advised that the consultation had been closed; the responses received have been very positive and supportive. LB outlined the plan and advised that a final proposal was being drafted for consideration in the near future. **Rapid improvement event** – LB advised that this was taking place towards the end of the month and would include introducing new ways of working.		
4	**Efficiency Report**	CRR 39	The 2014/15 target is £24m. Full year delivery in May 2014 is £3.8m leaving a gap to be delivered of £20.2m. This is ahead of the delivery at May 2013. However the current Monitor variance (£2.7m) is behind plan putting pressure on the Trust's financial position.	Although the efficiency target is behind plan the Committee was assured by the knowledge that the performance is in line with	AB to provide further detail to the Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			The May 2014 delivery includes £2.6m (68%) of recurrent and £1.2m (32%) non-recurrent schemes. This compares favourably with last year where there was 51% recurrent and 49% non-recurrent schemes. The committee expressed concern at the in-year planning gap (£6.4m).DHT reminded them that a gap at this stage in the year is normal and the Review Panels that are planned for the next months will focus on closing any gaps. DHT explained that the Directorates are required to develop plans covering four years. As with the 14/15 gap the Committee were concerned that the 4 year plan contained a shortfall of £30.8m and that a major effort involving corporate-wide schemes would be required to close it. The Committee was assured that this gap will be addressed as part of the on-going planning work, although it is recognised that this is a significant shortfall and presents a major risk to delivery of the four year plan. DHT explained that further governance score reviews and quality assessments were being undertaken and as many new schemes had been identified at this stage the majority of the directorates are showing red for governance. These would reduce as the assessments are completed.	previous years.	
	Efficiency Report – Opportunity Paper		This paper has been produced in response to a request from the Committee for information on the Trust's approach to making the big savings that will be required over the coming years. DHT presented the paper and explained the Trust operates a 6 year planning programme for efficiencies. She added that a significant number of schemes have been identified for the period. This longer term approach enables the Trust to undertake transformational planning.	The Committee were assured by the level of planning in the organisation and recognised that many other organisations do not generally plan further than the current year. The Committee recognised the work involved and were assured by the level of detail already in place.	AB to comment further

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			DHT explained that most of the planning gap identified in the 6 year plans relates to years 4-6 and work is continuing with Directorates to improve the position. The Committee recognised the delivery of future efficiencies will increasingly depend on corporate wide initiatives. Reviewing the paper DHT outlined the efficiency planning themes and opportunities. She highlighted that Service Line Reporting was now fully embedded with the Efficiency Team and working well. SLR is considered by the Committee to be a key tool in improving efficiency and reducing costs. The other schemes identified included the theatre efficiencies, the use of benchmarking, the management of acute services and clinical integration. The Committee discussed the progress of clinical integration and noted that it is on-going. It was agreed that a further report would be requested for presentation at Board in the near future. The Committee noted the paper and agreed to keep the work plan under review.		
4	**Efficiency Report – response to Monitor's review of the Corporate Efficiency Programme**		DHT had prepared a report that summarised the Trust's response to the letter received from Monitor following their review of the Corporate Efficiency Programme. She highlighted that Monitor confirmed the Trust has a good solid programme in place. She explained that the Trust had built the programme using the guidance released by Monitor. DHT went through the recommendations and explained the actions that would be taken against each one. The Committee discussed the use of project methodology as proposed in one of the recommendations. The Committee noted the comments from AB that historically	The Committee noted the comments and were assured by the response and the recommendations proposed.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			that had not been the approach taken with Directorates. the Trust's approach had been much more of a collaborative and supportive nature. AB added that for some of the more corporate wide efficiency schemes being identified for the future it would be useful to introduce more of a project based approach. The intention would be to develop a mixed approach. The Committee noted the comments and asked if the team is sufficiently resourced to deal with the demands presented by the recommendations and the current planning gaps.. AB confirmed that there may be a need to strengthen the project team in time. It was agreed that progress would be reviewed at the October meeting.		
5	**Operational Report**	**AFW** DoF7 COO3 **CRR** 36	**Access Targets –** **52 weeks –** LT advised that 3 patients had waited over 52 weeks for treatment in May. This followed the patients initially being transferred to the private sector. Unfortunately the patients had not been treated and were transferred back to the NHS. LT advised that she is in discussion with the private provider and has suggested that they adopt the access policy held by the Trust. **18 weeks -** LT reported that all three 18 week targets have been achieved on aggregate as a Trust, although there are still some challenges to resolve at specialty level. LT also reported that there had been an increase in the number of patients waiting over 36 weeks between April and May and that more work was required to reduce the numbers. LT reported that there are two new reporting requirements that have been introduced – the first is to submit a 2014/15 18 week capacity and activity assessment to NHS England.	The Committee was disappointed to see the performance, but recognised the work being undertaken to address the issues and identify the reasons for the challenges.	Given that a number of access targets are raising concerns, in addition to those highlighted below MP is asked to provide a general overview on the future achievement of access targets and the risks presented.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			The second submission is a weekly patient tracker list which is a national requirement. **Cancer –** **14 day breast symptomatic –** LT confirmed that there continue to be significant challenges in achieving the target specifically related to capacity and radiology cover at Scarborough. She advised that it is not anticipated that the target will be achieved for Q1 and may also be failed in Q2. The Committee were advised of the alternative temporary solutions that had been put in place. She added that this centralisation of the service in York will ease the issues, but not solve them. The Committee understood there would be a discussion with Monitor over the challenges the Trust is experiencing around recruiting the specialist sonographer required to provide the gold standard service. LT confirmed that the Trust was working closely with the CCG. **Emergency Department –** LB advised that the Trust failed to deliver the 95% target in May, adding that achieving the target for Q1 would be very challenging. LB advised that the issues causing the deterioration in performance were related to the level of bed occupancy. The Trust has been on Amber or Red Alert for most of the month, there have been a number of bed closures, attendances in the Emergency Department have also increased from the levels in the winter months and there have also been limited discharges. In terms of ambulance handover, LB advised that disappointingly there had been deterioration in the achievement of the target in May. She added that on May Day there were 317 patients arriving by ambulance arrivals. LB advised that the level of fines for May was disappointing and the Committee considered that if these were not brought under control the impact on the Trust's finances would be a serious. The opening of the additional bays	Again the Committee was disappointed to see the performance for May, but recognised the work being undertaken to resolve the performance and the opening of the ambulance handover bays.	MP to brief the Board further MP to update the Board further

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			should reduce some of the delays in handover. LB advised added that a recovery plan is in place, but the removal of the winter monies which paid for overnight staff has compounded the problems. LB advised that a further paper has been prepared for presentation to the Urgent Care Board which requests support to enable the Trust to deliver the level of care expected. LB added that the Trust does have a GP who is interested in working with the Trust to support the GP access on site. **Commissioning for Quality and Innovation (CQUIN) –** The Committee noted the report and the work being undertaken to finalise the plans. It is to be noted that in the main it is the absence of finalised / agreed plans against the targets that has resulted in some schemes being rated "amber". **Infection control and Quality and Safety –** **6 week referral to diagnostic tests –** LB advised that the Trust had failed the target in May due to the high number of radiology breaches at Bridlington and Scarborough. The CCG have suggested that the Trust should use any qualified provider to satisfy the need. But the challenge is there is a national shortage of sonographers and no one suitable in the locality. **C-Diff –** It was noted that there was a reduced number of cases that had been reported this quarter compared to last year and last quarter. The other targets were discussed and it was noted that there was further work to be completed to understand fully what was causing the reduced performance.	The Committee was pleased to see the improved performance and the assurance that gave	MP to provide a further update to the Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
6	**Finance Report**	**AFW** DoF2/ 3/5/7 **CRR** 35, 40, 41	GL reported that at the end of May 2014 there was a reported deficit of £2.5m, £1.7m behind the deficit position expected at this stage in the year. This returns a provisional continuity of services rating of 3 against a planned position of 4. Income has been relatively flat compared to the significant over-trading position of 2013 and broadly matches plan. But expenditure pressures from agency medical and nursing staff ,the higher than anticipated contract penalties and the CIP shortfall (2.7) have all contributed to the deteriorating position.. The Committee was assured that all overspends are being investigated, available reserves are being reviewed and action plans to control costs are being considered. The Committee discussed the issues that were facing the Trust and agreed that there was beginning to be evidence that the challenge in ensuring that the Trust maintains quality and provides the level of access that patients expect is becoming more demanding.	The Committee noted the challenges and the specific issues being addressed.	AB to provide an overview of the current financial position and the financial challenges facing the Trust
7	**Any Other Business**		MS advised the Committee that this would be DHT's last meeting as she moves into a new role in the Trust. He thanked her for her excellent work and the contribution that she had made to the Committee since its inception and wished her well. MS also advised that he would be stepping down as Chairman of the Committee following the September meeting and Mike Keaney would take over the Chair. MS advised he would remain part of the Committee in the short term, but there were likely to be other changes in membership between the F&P and the Q&S Committees.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Two additions were made to the work Plan. October 2014: Review of progress on the Monitor letter recommendations November 2014: Review of poorly performing directorates within the CIP.		

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York Teaching Hospital NHS
NHS Foundation Trust

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Monthly Performance Report

May 2014

Information Team
Systems and Network Services

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Apr	May	Jun	Q1 Actual
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail:** £400 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**90%**	91.1%	91.3%		
Non Admitted Pathway: Percentage of non-admitted patients starting treatmen within a maximum of 18 weeks from Referral	**Specialty fail**: £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TCB	**95%**	96.6%	97.2%		
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	**Specialty fail:** £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**92%**	94.3%	93.6%		
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	0	3		
Zero tolerance RTT waits over 36 weeks	None - monitoring only	**0**	43	53		

Access Targets: Cancer

NB: Cancer Figures Run One Month Behind Due to National Reporting Timescales

Indicator	Consequence of Breach	Threshold	Apr	May	Jun	Q1 Actual
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	87.3%	not available yet		
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	48.3%	not available yet		
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	99.5%	not available yet		
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	96.9%	not available yet		
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	100.0%	not available yet		
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	92.9%	not available yet		
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	91.4%	not available yet		
62 Day Consultant Upgrade	General Condition 9	**85%**	none	not available yet		

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Apr	May	Jun	Q1 Actual
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£200 fine per patient below performance tolerance (maximum 8% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	94.6%	94.3%		
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**> 30min**	112	205		
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**> 60min**	61	89		
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**> 12 hrs**	0	0		
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	91.2%	96.5%		

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Apr	May	Jun	Q1 Actual
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**TBC**				93
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	**TBC**				104

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Apr	May	Jun	Q1 Actual
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**59**	4	2		
Number of Clostridium difficile due to"lapse in care"	*TBC*	**TBC**	TBC	TBC		
Number of E-Coli cases	**Quarterly:** General Condition 9	**108**	12	10		
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) cases	**Quarterly:** General Condition 9	**35**	7	3		
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	0		
Notification of MRSA Bacteraemia to be notified to commissioner within 2 working days	General Condition 9	**100%**	n/a	n/a		
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 14 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a		
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a		
Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	79.6%	82.5%		
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	68.2%	74.2%		

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Apr	May	Jun	Q1 Actual
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 fine per patient below performance tolerance	**99%**	97.9%	96.7%		
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0		
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hosp	Non-payment of costs associated with cancellation and non- payment o reimbursement (as applicable) of re-scheduled episode of care	**0**	0	0		
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0		
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	8	35		
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	£200 in respect of each excess breach above threshold	**95%**	97.1%	97.1%		
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	98.8%	99.6%		
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	7.5%	5.4%		
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 89% Q2 - 90% Q3 - 92% Q4 - 95%**	82.0%	84.9%		
Delayed Transfer of Care to be maintained at a minimum level	TBC	**TBC**	400	555		
Trust waiting time for Rapid Access Chest Pain Clinic	None	**99%**	100.0%	100.0%		
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance			
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**200 per month**	110	101		
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**Baseline 784; end Q2 745; end Q4 722**	733	743		
% of ED Admissions With a NEWS Score		**TBC**	78.1%	79.7%		
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	100.0%	100.0%		
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	2 month coding lag	2 month coding lag		
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	2 month coding lag	2 month coding lag		
Reduction in the number of inappropriate transfers between wards and other settings during night hours (Reduction in avoidable site transfers within the Trust after 10pm)	General Condition 9	**Q2 onwards 80 p.m. (TBC)**	87	91		

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Apr	May	Jun	Q1 Actual
Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	General Condition 9	**80% by site**	91.9%	84.9%		
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	91.6%	90.6%		
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%		
Proportion of stroke patients who spend >90% of their time on a stroke unit	Non delivery of 90% at Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £5k in line with respective finance baselines (TBC)	**80%**	78.2%	one month behind		
Proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours of seeing a health professional	Non delivery of Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £2k in line with respective finance baselines (TBC)	**70% (TBC)**	84.6%	one month behind		
Proportion of patients presenting with stroke with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	General Condition 9	**65%**	90.0%	one month behind		
Percentage of stroke patients and carers with joint care plans on discharge from hospital to have a copy of their care plan (except RIP or who refuse health/social care assessment/intervention)	General Condition 9	**70%**	n/a	one month behind		
Patients who require an urgent scan on hospital arrival, are scanned with in 1 hr of hospital arrival (TBC)	No financial penalty	**50%**	81.8%	one month behind		
Proportion of stroke patients scanned within 24 hours of hospital arrival	No financial penalty	**90% (TBC)**	90.1%	one month behind		
Transmission of IDLs to GPs within 24 hours of discharge (Q1-Q3 elective and non-elective activity IP only excluding DC, Maternity and by end Q4 to include surgical DC activity too) - Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology.	Failure to deliver the quarterly target will result in the application of a £4k penalty per quarter Maximum sanction of £16K per annum based upon respective commissioners financial baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	73.7%	75.0%		
Immediate Discharge Letters (IDLs) handed to patients on Discharge	General Condition 9	**98%**	Annual letter of assurance to be provided to CMB			
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver quarterly trajectories at Trust aggregate level for each quarter will result in the application of a £10K sanction relating to each underperforming quarter. Maximum sanction of £40k per fiscal year. The penalty will be applied by the commissioners in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	Quarterly audit			
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver the quarterly target will result in the application of a £6k penalty per quarter. Maximum sanction of £24k in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 94%**	Quarterly audit			
All Red Drugs to be prescribed by provider effective from 01/04/14	£50 penalty for any request to primary care for prescription of Red Drugs (TBC)	**100% list to be agreed**	CCG to audit for breaches			
All Amber Drugs to be prescribed by provider effective from 01/04/14	No financial penalty	**100% list to be agreed**	CCG to audit for breaches			
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	87.2%	86.8%		

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Finance Report

Action requested/recommendation

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

Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 31 May 2014.

At the end of May the Trust is reporting an Income and Expenditure (I&E) deficit of £2.5m against a planned deficit for the period of £0.8m. The Income & Expenditure position places the Trust behind its Operational plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	June 2014
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Briefing Note for the Finance & Performance Committee Meeting 17 June 2014
Briefing Note for the Board of Directors Meeting 25 June 2014

Subject: May 2014 Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for May 2014

Month two reports reveal a disappointing and concerning position for the Trust's income and expenditure position. At the end of May the position is that of a deficit of £2.5m, this is some £1.7m behind the deficit position expected at this stage in the year.

This position returns a provisional COSR rating of 3, which is out of line with our planned position of 4.

In month the position has deteriorated by £1.8m. In summary income has been relatively flat and broadly matches plan, expenditure pressures from agency medical and nursing staff have been incurred and anticipated contract penalties have worsened.

CIP performance is £2.7m (year-to-date) behind the required savings level. This is in line with the position reported this time last year, although last year our reserve position and the level of activity provided above plan compensated for the CIP shortfall and we were able to report a broadly balanced income and expenditure position. Our estimated trading position this month does not provide cover. The Finance Team is currently undertaking a full review of all reserves provided to assess the level of compensation that can legitimately be provided as we approach the reporting cycle for quarter one.

Income Analysis

The April estimate reported last month has been validated through coding and costing and has not materially changed. The reported position this month includes this validated April data plus estimated May data (still to be fully coded and costed). This is common in terms of an approach as the need to clinically code data after the month end, review the data and then submit to the national SUS system for pricing reconciliation all drive a national reconciliation timetable.

We have significantly increased our likely contract penalties; £136k last month but now estimated at £457k (these are provisional and are not agreed). The most notable of the penalties is the ambulance turnaround time breach; early indications of which suggest this is £213k for the first two months of the year. However, given the withdrawal of CCG winter-funded schemes at the end of March there is a debate underway as to the application of this penalty and, if this is applied, the use of the resource to support the prevention of further turnaround delays. The Board are aware the Trust's capital scheme to create an extended ambulance hand over area on the York ED site is close to completion. This coupled with additional staffing is expected to improve the position considerably.

Expenditure Analysis

Pay budgets and provisions are £0.4m over spent for May. This is being investigated with Directorate management teams. Operational budgets are under spending but locum and agency medical staff and nursing staff expenditure is running at an unaffordable premium level. Pressure areas include: medical agency staff in Scarborough for Elderly, Acute Medicine and Ophthalmology and medical staff agency spend at York in ED. There is also considerable nursing agency expenditure in General Medicine, specifically AMU/SSW and Ward 33. As in previous years, work is being undertaken to assess the extent of reserve application necessary to support agreed pressures and cost controls are being discussed with Directorates.

Pay expenditure overall is £0.5m higher in May than in April. £0.2m of this relates to the planned pay awards coming through but there is also growth in agency/locum expenditure of £0.2m. A variety of lower level spend issues make up the balance.

There are no material pressures to report in terms of other operational budgets. There is a positive reserve balance reported through other expenditure that results in a £1m favourable position within this category.

The report shows that the CIP programme is impacting adversely on the position by £2.7m. This is the most material adverse impacting issue and is dealt with in the CIP report. This is consistent with the opening position in previous years.

2013/14 Contract Reconciliation

There are no issues to report to the Board in relation to developments with the final year end reconciliation process. The Board are aware that contract settlements for 2013/14 have not been agreed with HaRD CCG and HRW CCG. These disputes are not material at £0.4m in total and have been appropriately represented in our accounts. The usual national reconciliation process is now underway.

Contracting Matters

I am pleased to be able to report to the Board that contract details have now been agreed with all CCGs. This includes the finance and activity schedules for Vale of York which have proved difficult to bring to a conclusion due to affordability pressures. Contracts have not been signed yet as there still remains a residual issue between NHSE (Specialised Commissioning) and our commissioning CCGs. This is an allocation issue and whilst we have been involved in the supply and analysis of data the matter is between NHSE and CCGs. Until this matter is resolved contracts are unlikely to be signed.

Agreeing finance and activity schedules is an important step and monthly invoicing will now move to mirror these agreements. Even though formal contracts are not yet in place, payments are being made on account to the Trust and cash flow is not being compromised. I expect the NHSE/CCG issue to be resolved in the next few weeks.

Other Issues

At this stage in the financial year there are no other issues I would wish to bring to the attention of the Board. Cash levels are satisfactory and capital programme spending is as expected.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31 May 2014

High Level Overview

* A net I&E deficit for the period of £2.5m means the Trust is £1.7m behind plan.

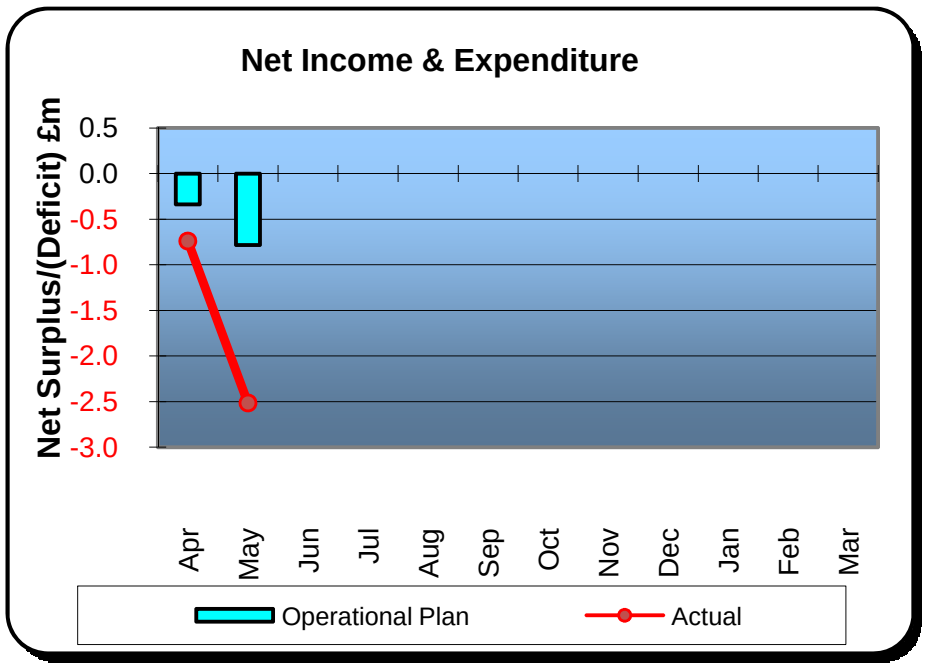
* CIPs achieved at the end of May total £3.8m. The CIP position is running £2.7m behind plan.

* Contracts are currently unsigned, however estimated overall actual activity value is forecast to be £0.4m behind overall contract total.

* Cash balance is £31.9m, and is £3.9m ahead of plan.

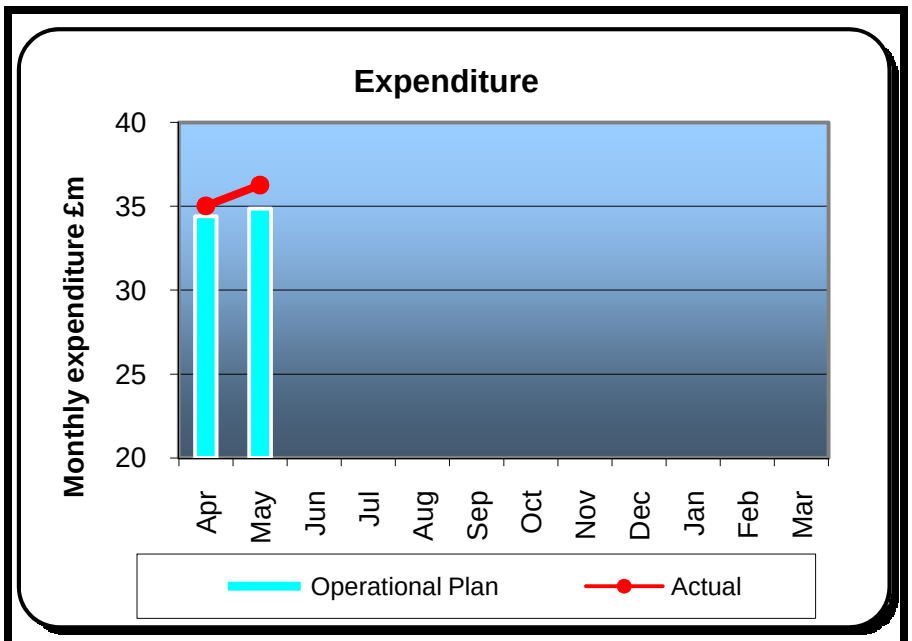
* Capital spend totalled £2.4m, and is £0.8m behind the plan.

* The Continuity of Service Risk Rating is 3.



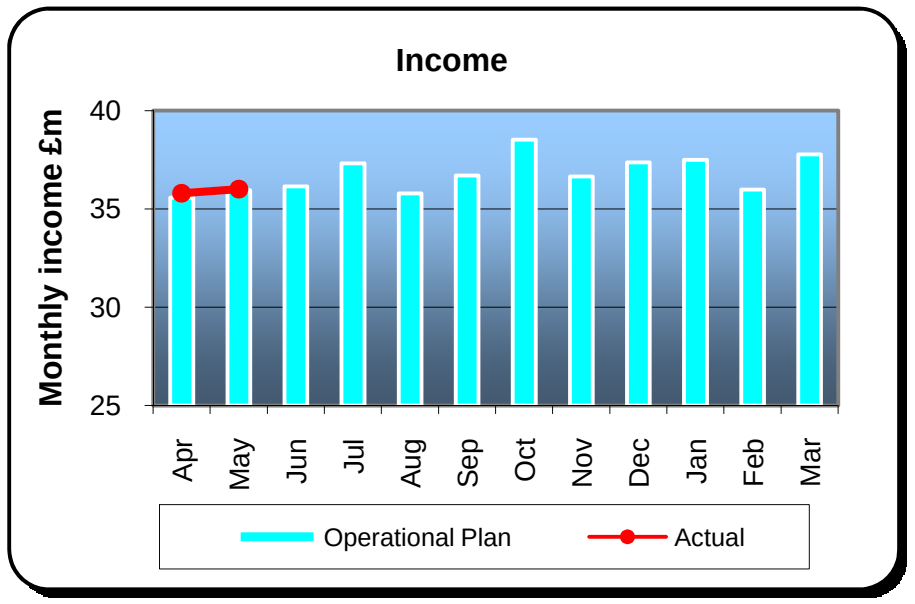
Key Period Operational Variances			
	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. VET)	61.1	61.6	0.5
Clin.Inc.(VET))	2.4	1.7	-0.7
Other Income	8.0	8.5	0.5
Pay	-48.7	-49.1	-0.4
Drugs	-6.9	-6.9	-0.0
Consumables	-7.9	-7.6	0.2
Other Expenditure	-8.8	-10.6	-1.8
	-0.8	**-2.5**	**-1.7**

(VET = Vitreous Eye Treatments)



At the end of May there is an adverse variance against operational expenditure budgets of £2.0m. This comprises:-

- Operational pay being £0.4m overspent.
- Drugs is broadly in balance
- Clinical supplies £0.2m underspent.
- Other costs are £1m underspent, primarily due slippage on planned investments
- Restructuring costs are £0.1m overspent
- CIPs are £2.7m behind plan

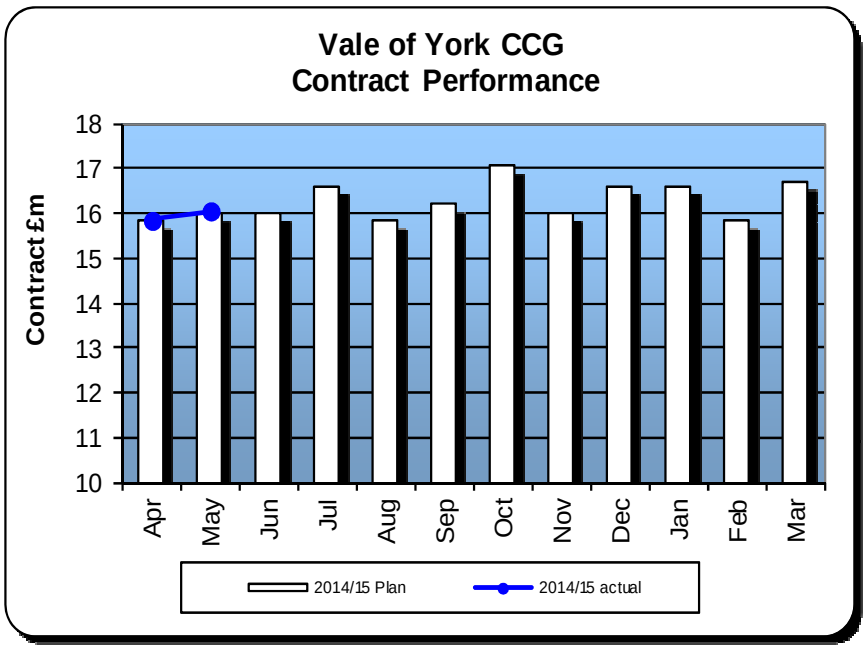


At the end of May income is marginally ahead of plan by £0.3m. This comprises:

- Elective and day case income are behind plan by £0.2m.
- Non elective income is £0.7m ahead of plan
- Out patient income is behind plan by £0.5m

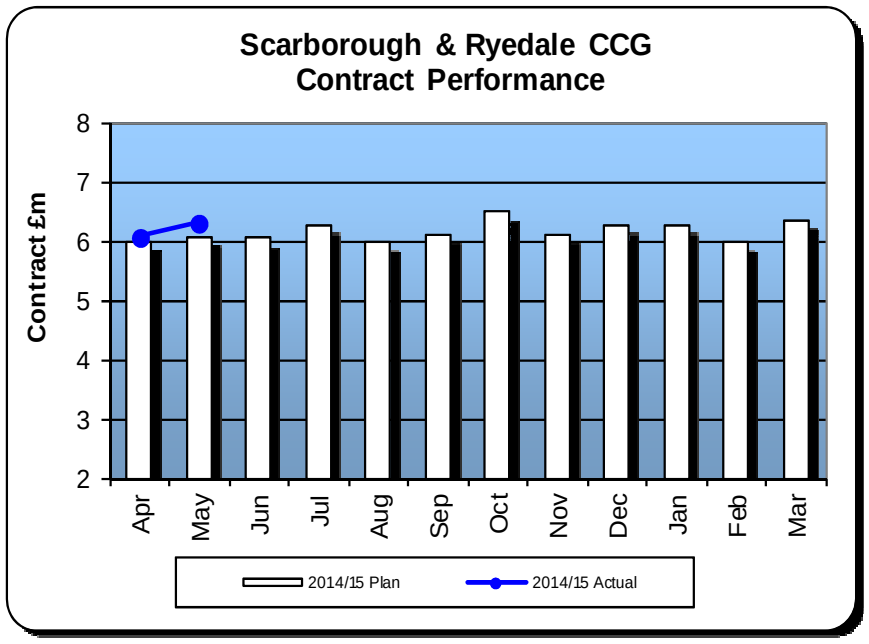
- Other clinical income is ahead of plan by £0.3m.
- Other income is £0.5m ahead of plan
- Potential contract penalties and fines are estimated at £0.5m.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31 May 2014



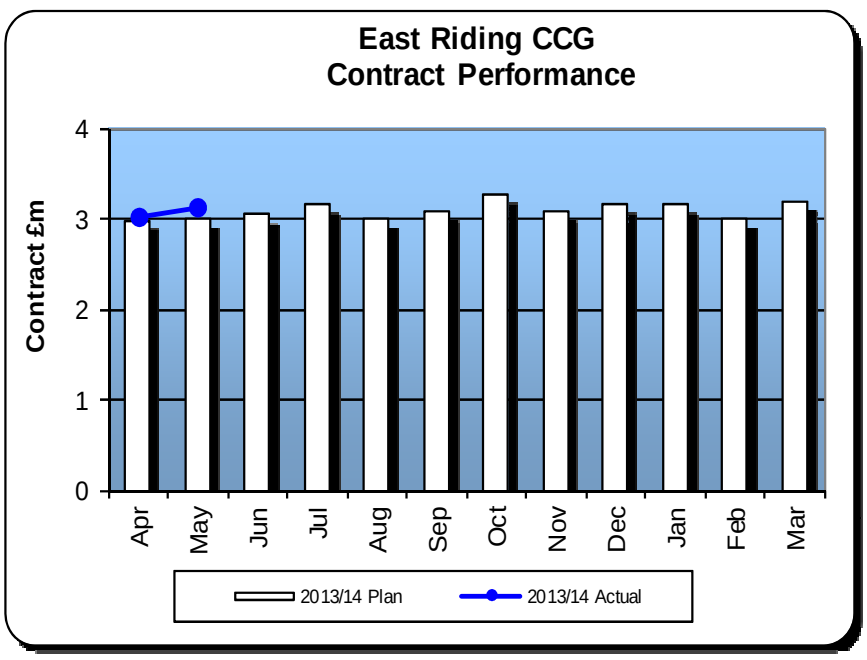
The contract value is estimated to be £195.4m.

The contract is not signed yet, however the estimated actual value to date is forecast to be marginally ahead of contract by £0.1m. This position includes estimates for May.



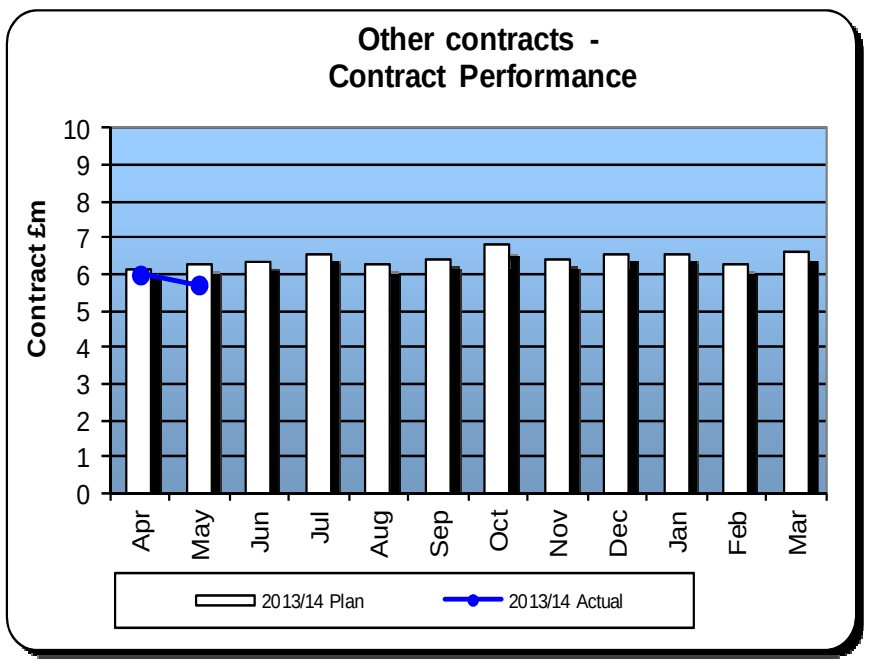
The contract value is estimated to be £73.7m.

The contract is not signed yet, however the estimated actual value to date is forecast to be marginally ahead of contract by £0.3m. This position includes estimates for May.



The contract value is estimated to be £37.2m.

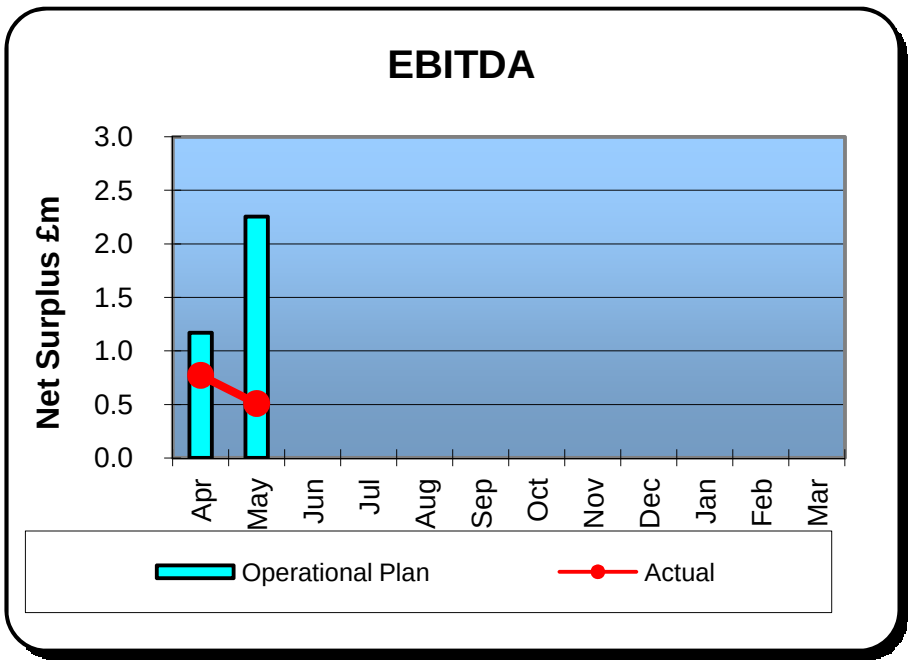
The contract is not signed yet, however the estimated actual value to date is forecast to be marginally ahead of contract by £0.1m. This position includes estimates for May.

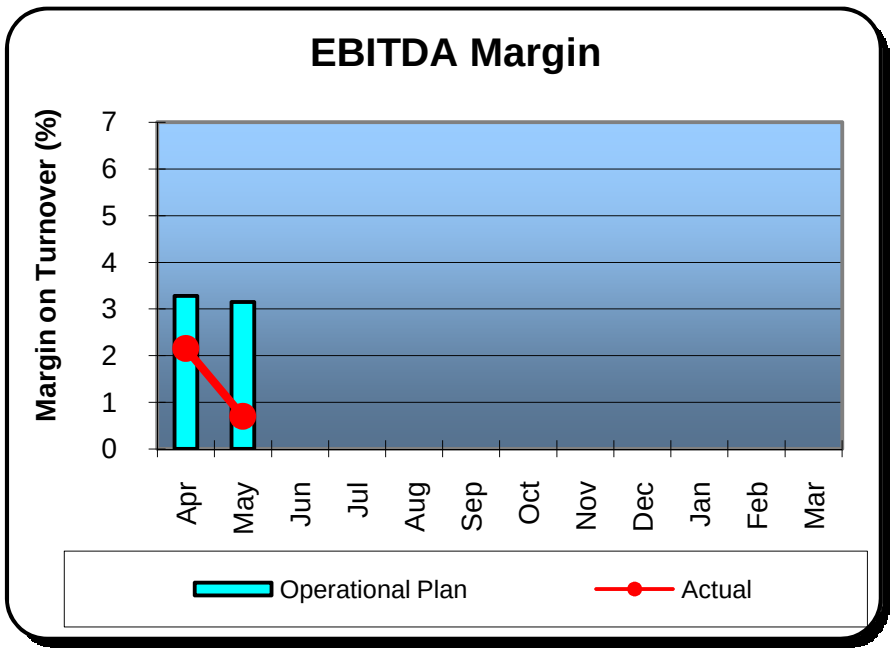


The contract value is estimated to be £77.2m.

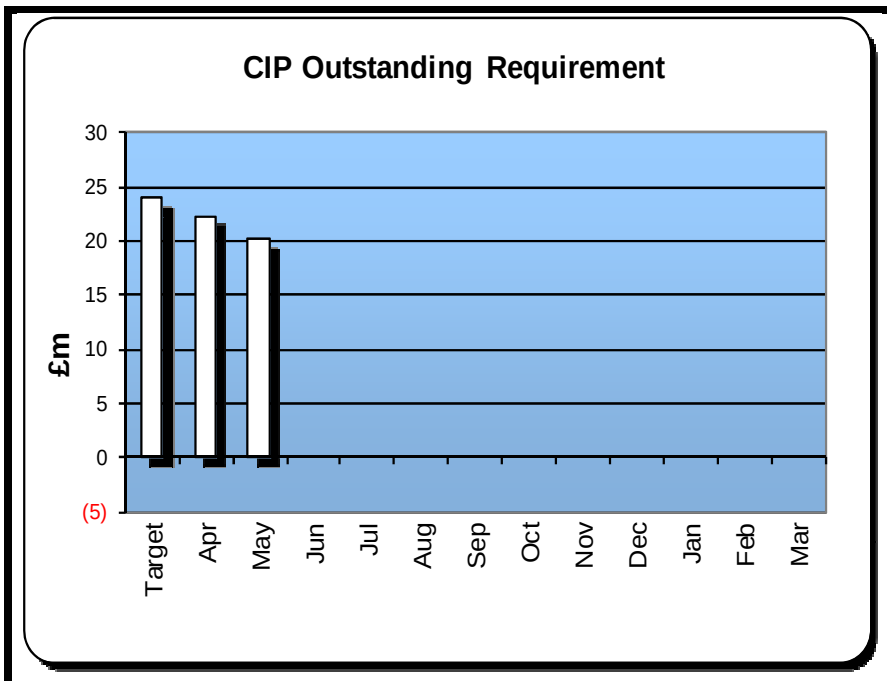
These include the smaller CCG, NHS England (both public health services and prescribed specialist services), and Local Authority contracts. Overall, the actual position is estimated to be behind contract by £0.9m. The contracts are not yet signed, and the actual value is estimated at this stage. A high volume of uncoded data may affect the allocation of income against individual contracts, and particularly the undertrade on the Prescribed specialist services of -£0.8m.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31 May 2014

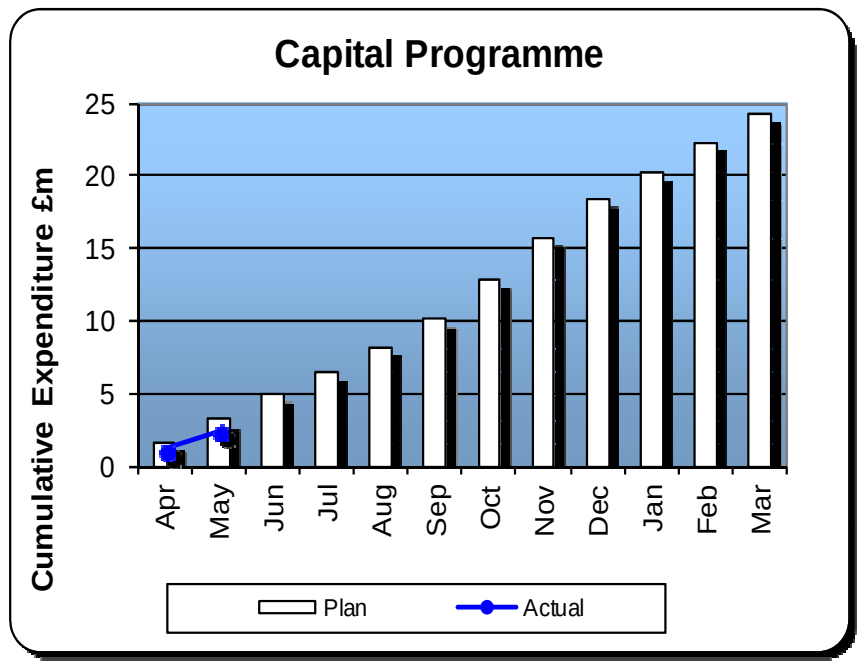




Actual EBITDA at the end of May is £0.5m (0.7%), compared to operational plan of £2.3m (3.15%), and is reflective of the overall I&E performance.



The full year efficiency requirement is £24.0m. At the end of May £3.8m has been cleared.



Capital expenditure to the end of May totalled £2.4m and is £0.8m behind plan.

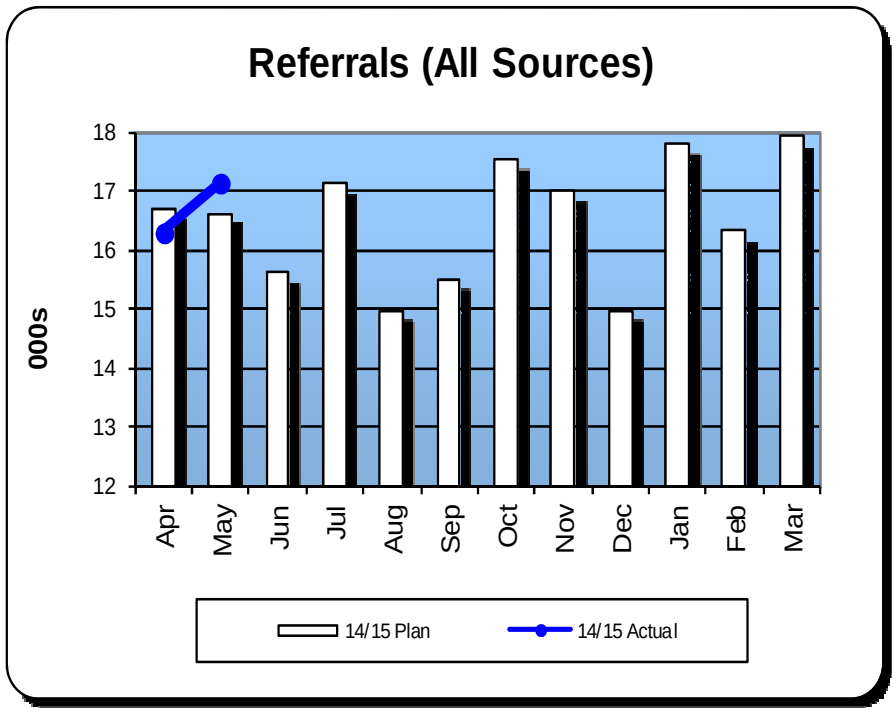
Capital schemes with significant in year spend to date include the on going upgrade of the Mallard restarurant and kitchens, Endoscopy decontamination expansion and the carbon & energy scheme. In Scarborough the nearly completed new carpark and the maternity theatres upgrade .

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31 May 2014

Continuity of Service Risk Rating (CoSSR):

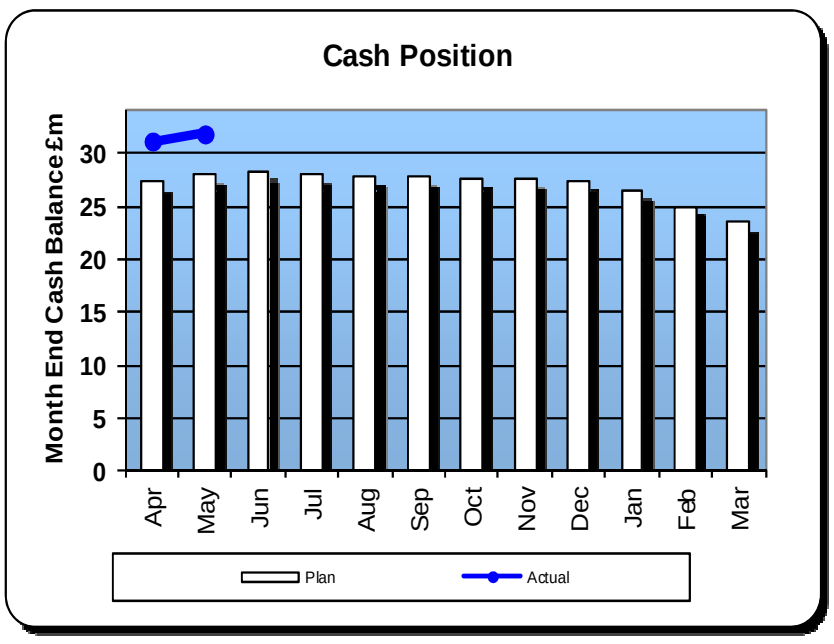
Debt Service Cover rating	1
Liquidity rating	4
Overall CoSSR	**3**

The debt cover rating is reflective of the reported I&E position.



Annual plan 198,057 referrals (based on full year equivalent of 2013/14 outturn)

Variance at end of May: +134 referrals (+0.4%)
GP referrals +282 (+1.5%)
Cons to Cons referrals -792 (-15%)
Other referrals +644 (+7%)



The cash balances at the end of May totalled £31.9m, and is £3.9m ahead of plan due to prompt payment of year end NHS debtors and capital spend slippage.

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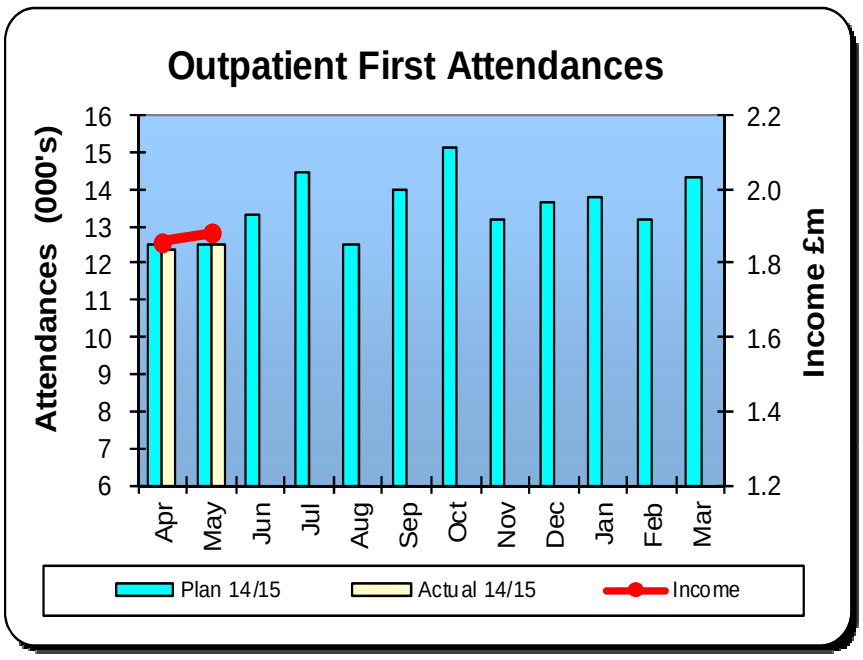
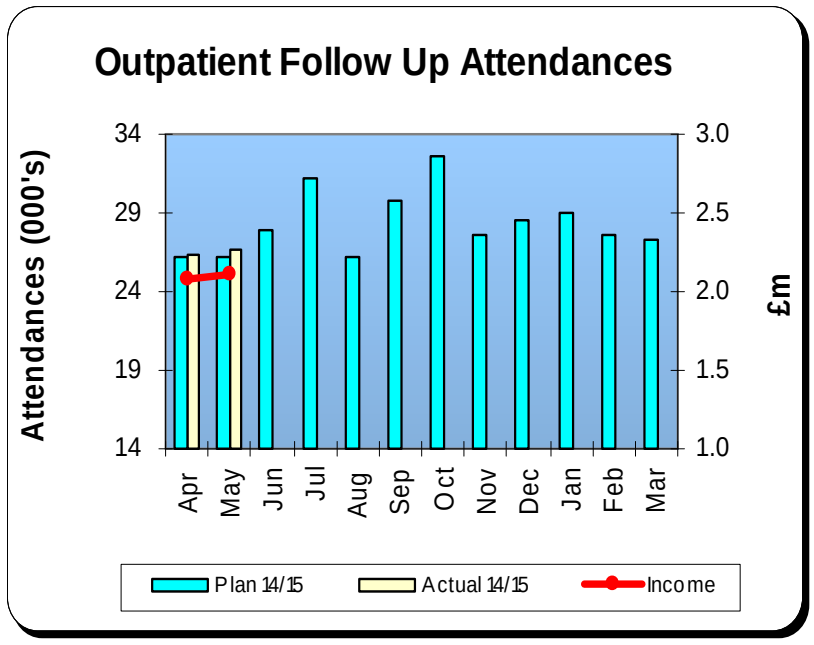
Financial Report for the Period 1 April 2014 to 31 May 2014



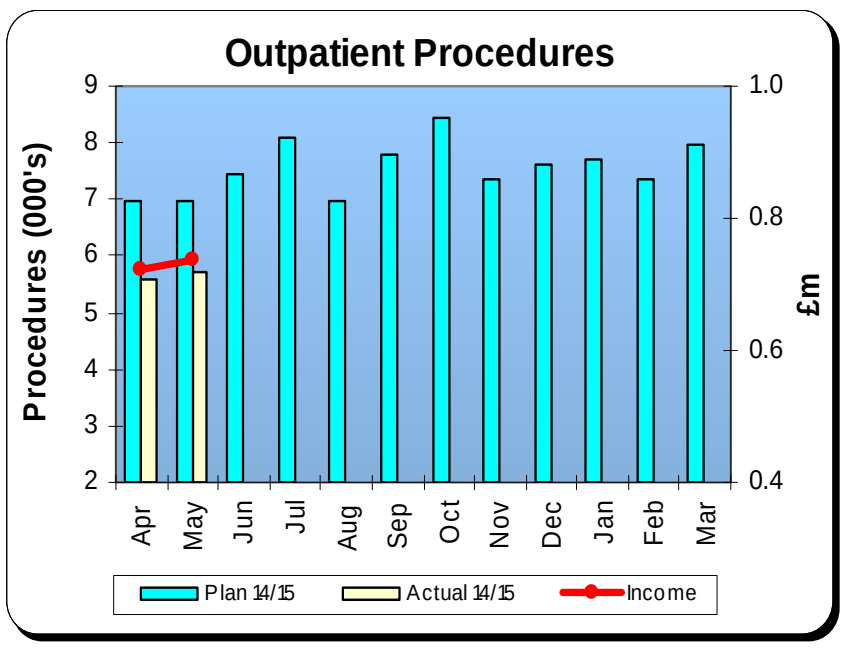
Annual Plan (Attendances) 162,401
Variance at end of May: -290 attendances (-1.1%).

Main variances: Opthalmology +384 (+16%), ENT +37 (+3%), Gastroenterology -207 (-26%), Cardiology -249 (-12%)



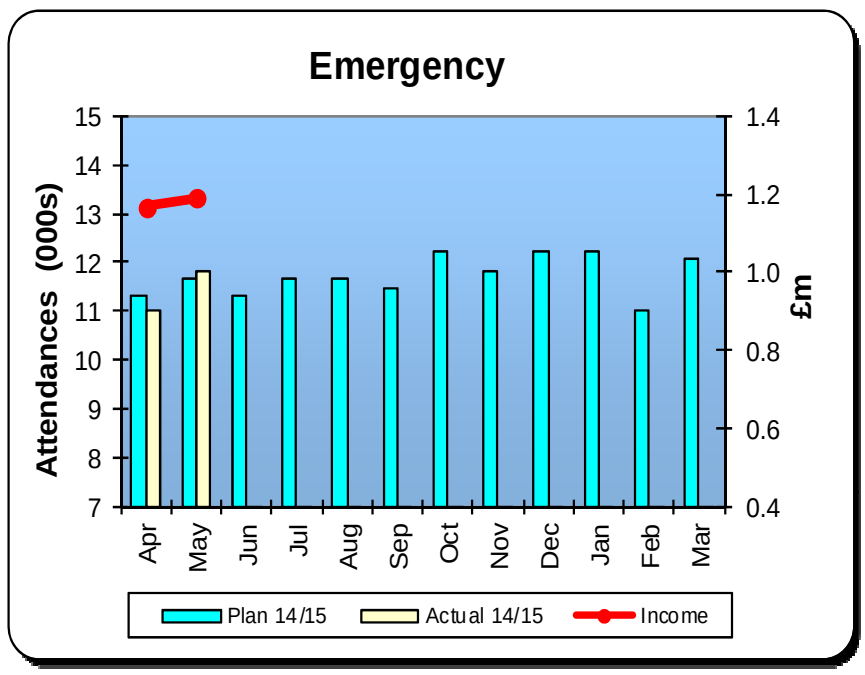
Annual Plan (Attendances) 340,039
Variance at end of May: +346 attendances (+1%).

Main variances: General Surgery +295 (+9%), Urology +135 (+9%), Opthalmology +234 (+3%), Anaesthetics -104 (-19%), and Medical Oncology -64 (-2%)



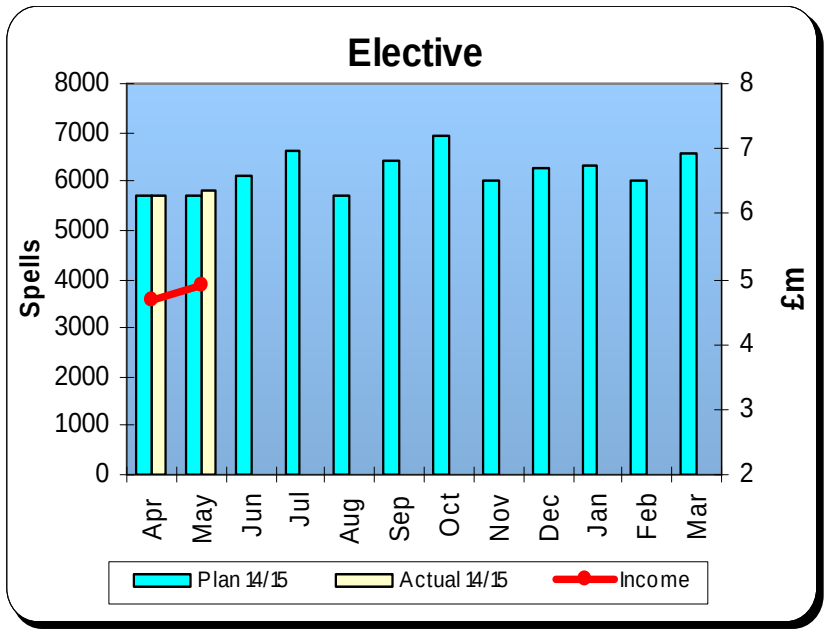
Annual Plan (Procedures) 90,710
Variance at end of May: -2,723 procedures (-19%).

Main variances: ENT -168 (-11%), Orthodontics +43 (+3%), Trauma and Orthopaedics -423 (-76%), Cardiology -94 (-12%), and Gynaecology -49 (-8%).



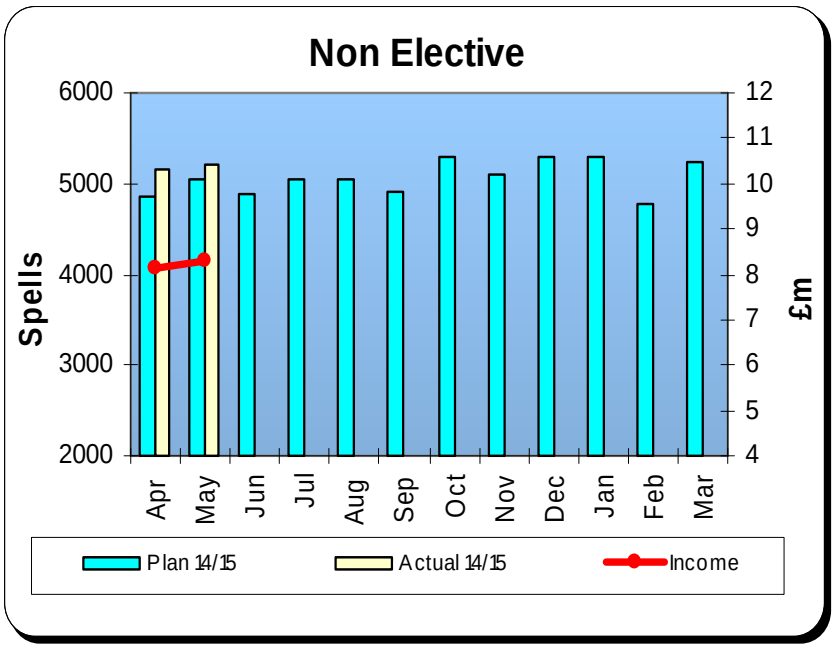
Annual Plan (Attendances) 140,831
Variance at end of May: -187 attendances (-8.1%).

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 31 May 2014



Annual Plan (Spells) 74,445
Variance at end of May: -49 spells (-0.4%): inpatient +128; daycase -177

Main variances: General surgery +34 (+2%), Gastroenterology +113 (+6%),Urology -105 (-6%), and Haematology -114 (-16%).



Annual Plan (Spells) 60,765
Variance at end of May: +457 spells (+5%).

Main variances: ENT +42 (+29%) Gastroenterology +155 (+25%). Cardiology -37 (-9%), Thoracic Medicine -38 (-6%), and Trauma & Orthopaedics -15 (-3%).

Contract Penalties

Penalties	YTD Actual	Penalty £000	Comments
52 week breaches	3	30	£5k penalty per breach per month. 12 GenSur (York); 3 GenSur (Scar); 2 Ophthal (Scar); 2 Gynae (York). 1 Urology (York), 1 Urology (Scar).
18 week breaches:			Figures are estimates and awaiting confirmation.
- Admitted (90% target, weighting 37.5%)	n/a	16	GenSur £3k; T&O £11k; ENT £2k.
- Non-admitted (95% target, weighting 12.5%)	n/a	7	Cardiology £0.8k; resp. medicine £1.6k; Rheumatology £3k.
- Incomplete pathways (92% target, w'ting 50%)	n/a	19	T&O £8k' Gastro £ 5k; ENT £1k.
Cancer waits		72	Cancer 2 week waits/ Breast symptom two week waits.
NHS Numbers		5	£10 fine per case with no NHS number
A&E 4 hr performance	n/a	38	Faliure to admit, transfer or discharge patients within 4 hours of arrival. Target 95%. Fine is £200 per breach.
Ambulance handover		213	Ambulance handover exceding 30 (£200 each) and 60 minutes (£1,000 each).
Diagnostics		58	6 weeks target 99%. relates to tests including radiology, NPU, cardiology tests and endoscopies.
		458	

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
SUMMARY INCOME & EXPENDITURE POSITION
FOR THE PERIOD 1st APRIL 2014 to 31st May 2014

	ANNUAL PLAN	PLAN FOR PERIOD	ACTUAL FOR PERIOD	PERIOD VARIANCE
	£000	£000	£000	£000
INCOME				
NHS Clinical Income				
Elective Income				
Tariff income	27,474	4,231	3,928	-303
Non-tariff income	169	26	12	-14
Planned same day (Day cases)				
Tariff income	35,029	5,394	5,538	144
Non-tariff income	651	100	89	-11
Non-Elective Income				
Tariff income	94,313	15,416	16,202	786
Non-tariff income	1,840	301	265	-36
Outpatients				
Tariff income	58,754	9,048	8,687	-361
Non-tariff income	4,688	722	596	-126
A&E				
Tariff income	14,059	2,298	2,296	-2
Non-tariff income	490	80	63	-17
Community				
Tariff income	1,112	182	195	13
Non-tariff income	34,034	5,697	5,622	-75
Other				
Tariff income				
Non-tariff income	121,633	20,028	20,278	250
Potential Fines and Contract Penalties			-457	-457
				0
	394,246	**63,523**	**63,314**	**-209**
				0
	394,246	**63,523**	**63,314**	**-209**
Non-NHS Clinical Income				
Private Patient Income	976	163	167	4
Other Non-protected Clinical Income	1,722	287	282	-5
	2,698	**450**	**449**	**-0**
Other Income				
Education & Training	14,026	2,338	2,365	28
Research & Development	2,005	334	595	261
Donations & Grants received of PPE & Intangible Assets	0	0	0	0
Donations & Grants received of cash to buy PPE & Intangible Assets	600	100	100	0
Other Income	16,489	2,751	2,949	198
Transition support	12,218	2,036	2,036	0
	45,338	**7,559**	**8,045**	**486**
Total Income	**442,282**	**71,532**	**71,809**	**277**
EXPENDITURE				
Pay costs	-301,296	-48,715	-49,130	-415
Drug costs	-41,916	-6,918	-6,946	-28
Clinical Supplies & Services	-45,592	-7,853	-7,606	247
Other costs (excluding Depreciation)	-51,999	-8,494	-7,525	969
Restructuring Costs	0	0	-95	-95
CIP	20,178	2,703	0	-2,703
Total Expenditure	**-420,625**	**-69,277**	**-71,302**	**-2,025**
EBITDA (see note)	**21,657**	**2,255**	**507**	**-1,748**
Profit/ Loss on Asset Disposals	0	0	0	0
Fixed Asset Impairments	-300	0	0	0
Depreciation	-10,854	-1,809	-1,809	0
Interest Receivable/ Payable	100	17	28	11
Interest Expense on Overdrafts and Working Capital Facilities	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0
Interest Expense on Non-commercial borrowings	-270	-45	-39	6
Interest Expense on Commercial borrowings	0	0	0	0
Interest Expense on Finance leases (non-PFI)	0	0	0	0
Other Finance costs	0	0	0	0
PDC Dividend	-7,204	-1,201	-1,201	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**3,129**	**-784**	**-2,514**	**-1,731**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Efficiency Programme Update – May 2014

Action requested/recommendation

The Committee is asked to note the May 2014 position with its future potential risks to delivery. Significant and sustained action is required to close these gaps.

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2014/15 target is £24m and full year delivery in May 14 is £3.8m, leaving a gap to be delivered of (£20.2m). There is a significant planning gap of (£6.4m) following a review of all in year plans.

The Monitor variance is (£2.7m) behind plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report is presented to the Board of Directors, Finance & Performance Committee and Efficiency Group.
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	June 2014
Version number	Version 1

Board of Directors – 25 June 2014

Efficiency Programme Update – May 2014

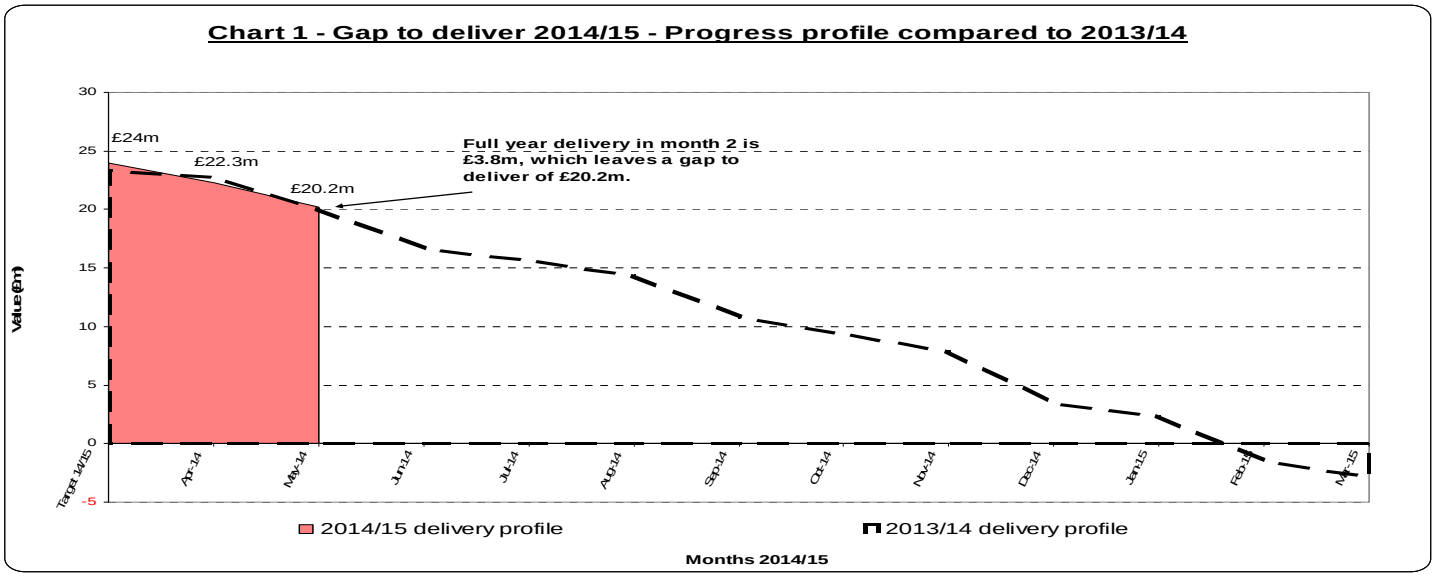
1. Executive Summary

This report provides a detailed overview of the Trust's Efficiency Programme.

See table 1 and chart 1 below.

Table 1 – Executive Summary – May 2014	Total
	£'m
TARGET	
In year target	**24.0**
DELIVERY	
In year delivery	**3.8**
In year delivery shortfall	**(20.2)**
Part year delivery shortfall - Monitor variance	**(2.7)**
PLANNING	
In year planning surplus/(gap)	**(6.4)**
FINANCIAL RISK SCORE	
Overall Trust financial risk score	**(2 Red/Amber)**

Position – current year vs. 2013/14



Governance	Risk to delivery
Current month Of the 32 Directorates and Corporate HQ functions 3 remain as green. Work is about to start on reviewing new schemes.	**Current month** The current planning gap is (£6.4m), which is a concern. Full year delivery in May 2014 is £3.8m which has improved by £2.1m from April 2014, which is positive. The Monitor variance is (£2.7m) adverse.
Last Month Of the 32 Directorates and Corporate HQ functions 5	**Last month** The April 2014 planning gap was (£6.2m). Full year

remain as green.	delivery in April 2014 was £1.7m which compares favourably with April 2013 and the Monitor variance was (£1.8m) adverse.

2. Introduction and background

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme for May 2014. This includes;

3.1 Progress against the Monitor Plan
3.2 Analysis of full year delivery
3.3 Further plans and in year risk
3.4 Four year planning.
3.5 Financial risk rating
3.6 Governance risk assessment.

Directorate level detail is provided in the attached appendices 1&2.

2.1 Trust plan to Monitor

The combined position is (£2.7m) behind the Trust plan to Monitor as at May 2014; see Tables 2 & 3 and chart 2 below.

Table 2	April 2014	May 2014	Total YTD
	£m	£m	£m
Trust plan	2.0	2.0	**4.0**
Achieved	0.2	1.1	**1.3**
Variance	**(1.8)**	**(0.9)**	**(2.7)**

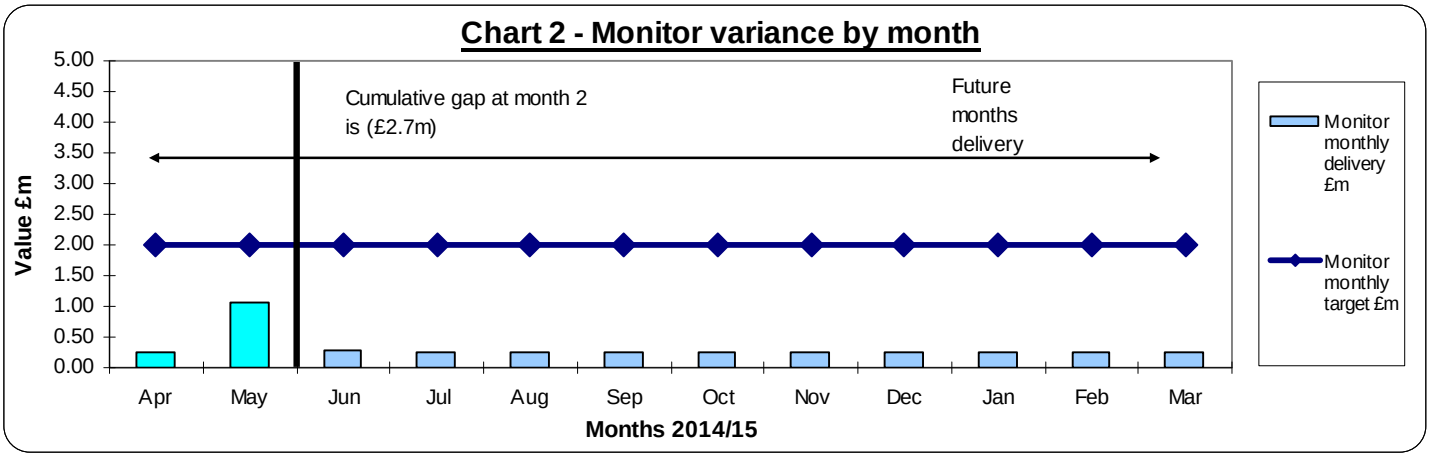


Table 3 – Monitor variance by month and cumulative variance

Months	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 14/15
Monthly delivery £m	0.25	**1.05**	0.29	0.26	0.26	0.26	0.25	0.25	0.25	0.24	0.24	0.24	**3.82**
Monthly target £m	2.00	**2.00**	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	**24.0**
Variance £m	-1.8	**-0.9**	-1.7	-1.7	-1.7	-1.7	-1.8	-1.8	-1.8	-1.8	-1.8	-1.8	-20.1
Cumulative variance	-1.8	**-2.7**	-4.4	-6.2	-7.9	-9.6	-11.4	-13.2	-14.9	-16.7	-18.4	-20.1	

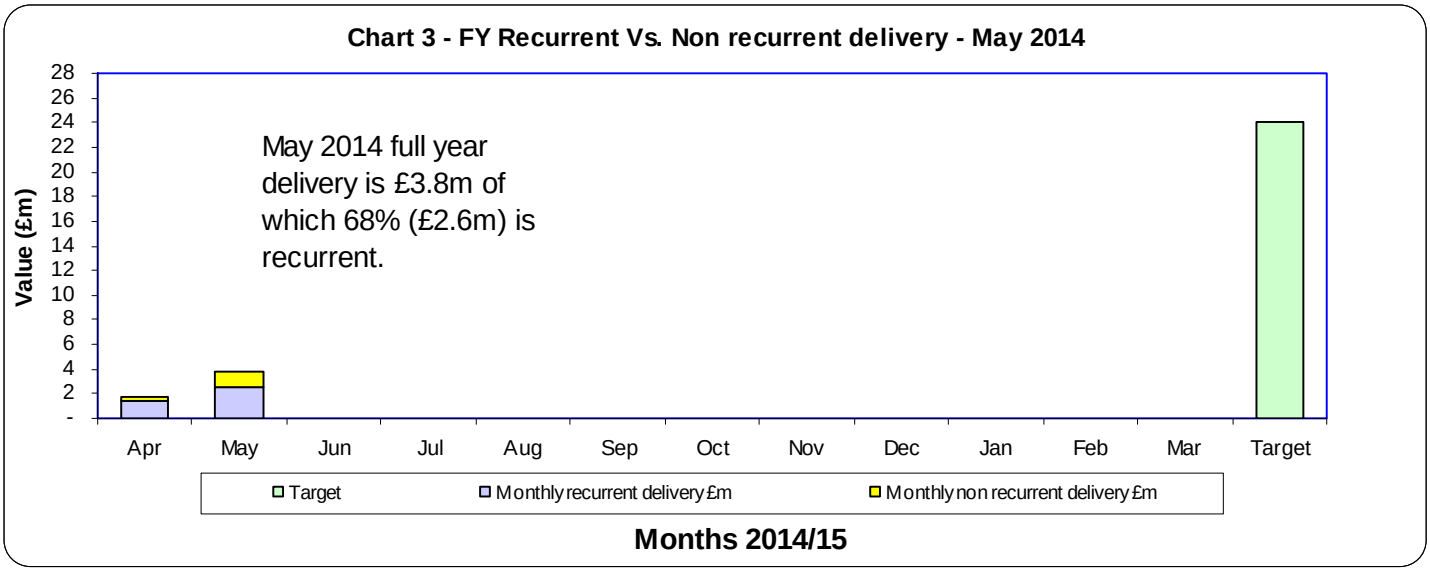
2.2 Full year position summary

As at May 2014, **£3.8m** has been achieved in full year terms against the plan of £24.0m (see Table 4

below).

Table 4	April 2014	May 2014	Change
	£m	£m	£m
Expenditure plan – 14/15	24.0	24.0	0
Target – 2014/15	**24.0**	**24.0**	**0**
Achieved - recurrently	1.4	2.6	1.2
Achieved - non-recurrently	0.3	1.2	0.9
Total achieved	**1.7**	**3.8**	**2.1**
Shortfall	22.3	20.2	**(2.1)**
Further plans	16.0	13.8	(2.2)
(Gap)/Surplus in plans	**(6.2)**	**(6.4)**	**(0.1)**

The May 2014 position is made up of £2.6m (68%) of recurrent and £1.2m (32%) non-recurrent schemes. This compares with £1.7m (51%) recurrent and £1.6m (49%) non-recurrent at May 2013 - see chart 3 below.



2.3 Further planning and assessed risk to delivery

Further plans have been formulated amounting to £13.8m, which gives a shortfall in the planning position of (£6.4m). Plans are summarised in Table 5 below.

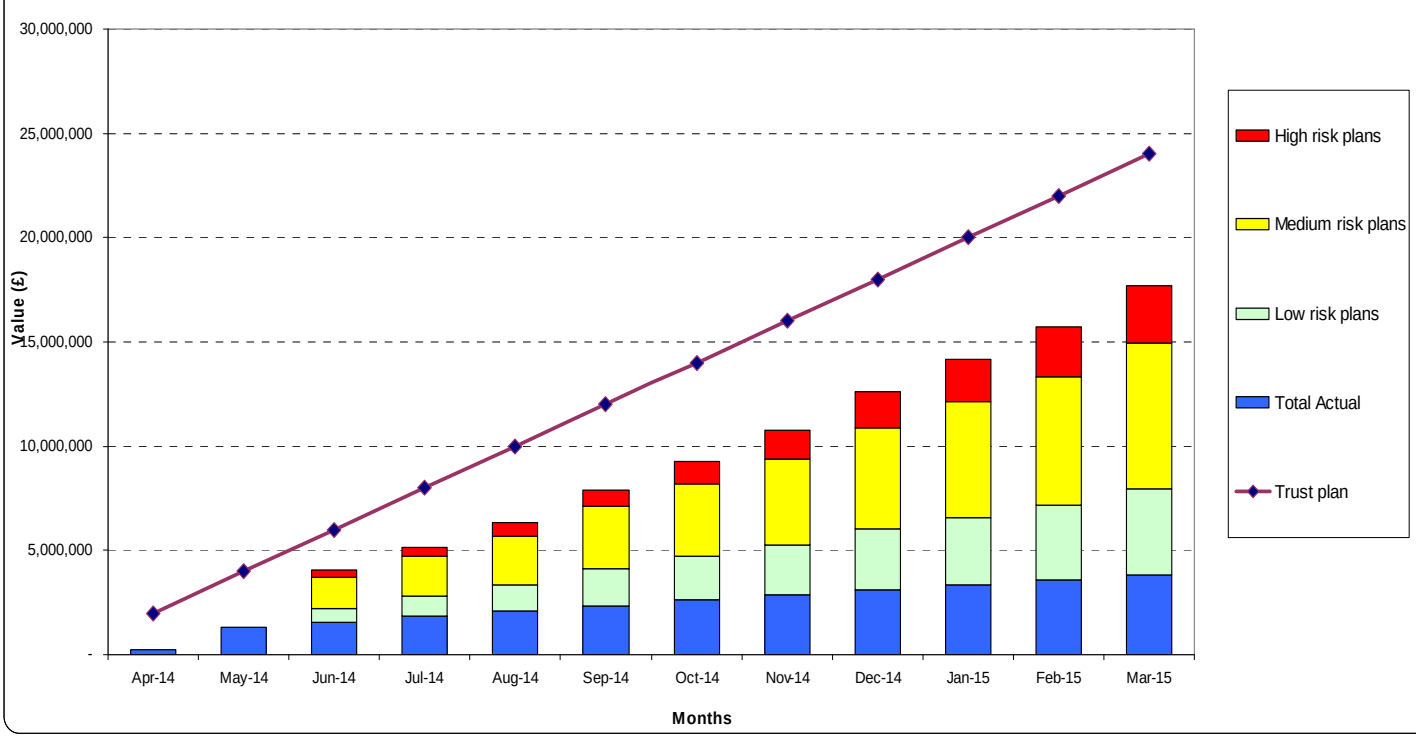
Table 5 – Further plans 2014/15

Risk	Gap Full Year	Plans - Recurrent	Plans - Non Recurrent	**Plans Total**	Gap in plans
	£m	**£m**	**£m**	**£m**	**£m**
Low		2.6	1.4	**4.0**	
Medium		6.3	0.7	**7.0**	
High		2.7	0	**2.7**	
Total	**20.2**	**11.6**	**2.2**	**13.8**	**(6.4)**

Directorate plans are each assigned a risk rating.

The overall May 2014 position is summarised in Chart 4 below. The bottom section has been used to represent savings achieved; with low, medium and high risk plans shown ascending, as detailed on the legend.

Chart 4 - May 2014 - Actual delivery and further plans to achieve by risk



Significant work is continually carried out to re-assess, remove or re-profile plans to ensure an up to date position. There is an in year planning gap of **(£6.4m)** which is high risk. Work is ongoing to improve this position.

2.4 Four year planning

Directorates are required to develop four year plans and Table 6 below summarises this position. There is currently a shortfall of (£30.8m) over 4 years on the base target.

Work is on going to improve the planning position however; the shortfall in plans offers a very high risk to delivery.

Table 6 - 4 Year efficiency plan summary – May 2014

Year	2014/15	2015/16	2016/17	2017/18	Total
	£m	£m	£m	£m	£m
Base target	24.0	16.8	16.8	16.8	**74.4**
Plans	17.6	11.9	9.8	4.3	**43.6**
Variance	**(6.4)**	**(4.9)**	**(7.0)**	**(12.5)**	**(30.8)**

2.5 Finance risk rating

In year delivery is ahead of the same point last year with £3.8m (16%) delivered in May 2014 against £3.3m (14%) in May 2013.

The Directorate risk scoring schedule is attached as Appendix 1 and 2. It should be noted Directorates scoring a 1 or 2 on finance are considered high risk; directorates scoring a 4 or 5 are low risk.

The overall trust risk rating is 2 which is a red/amber risk.

2.6 Governance risk rating

As the new schedules have been built a significant number of new schemes have been added, these will now need assessing for safety. The impact on the governance schedule are that a number of Directorates have dropped from their original green rating, it is not felt this change offers any further safety risk but is a consequence of new schemes at the beginning of the financial year.

It is expected all new schemes will have been assessed by the end of August 2014.

3. Conclusion

In May 2014 £3.8m worth of full year schemes has been delivered against the Trust plan of £24.0m, leaving a delivery gap of (£20.2m); this compares with £3.3m delivery in May 2013. The part year Monitor profile is (£2.7m) behind plan in month 2. The high level of recurrent delivery in the first 2 months, £2.6m (68%) is very positive.

We currently have a planning gap in year of (£6.4m), which is high risk.

The 4 year planning position highlights a shortfall in base plans of (£30.8m), which also offer a significant risk to delivery. Work is ongoing to improve the overall planning position.

It should be noted that a number of Directorates have dropped from their green governance rating; the reason for this is that as the new schedules are developed a significant number of new schemes are added and are awaiting assessment for safety. It is not felt this change offers any further safety risk.

4. Recommendation

The Committee is asked to note the May 2014 position with its 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	**June 2014**

RISK SCORES - MAY 2014 - APPENDIX 1

DIRECTORATE	FINANCE					GOVERNANCE			
	R	RA	A	AG	G	R	RA	AG	G
TACC YORK	1	2	3	4	5				
SPECIALIST MEDICINE	1	2	3	4	5				
T&O YORK	1	2	3	4	5				
RADIOLOGY	1	2	3	4	5				
GEN MED SCARBOROUGH	1	2	3	4	5				
HEAD AND NECK	1	2	3	4	5				
GS&U	1	2	3	4	5				
WOMENS HEALTH	1	2	3	4	5				
OPHTHALMOLOGY	1	2	3	4	5				
TACC SCARBOROUGH	1	2	3	4	5				
CHILD HEALTH	1	2	3	4	5				
T&O SCARBOROUGH	1	2	3	4	5				
LAB MED	1	2	3	4	5				
GEN MED YORK	1	2	3	4	5				
MEDICINE FOR THE ELDERLY	1	2	3	4	5				
ED YORK	1	2	3	4	5				
SEXUAL HEALTH	1	2	3	4	5				
ED SCARBOROUGH	1	2	3	4	5				
MEDICINE FOR THE ELDERLY SCARBOROUGH	1	2	3	4	5				
THERAPIES	1	2	3	4	5				
COMMUNITY	1	2	3	4	5				
PHARMACY	1	2	3	4	5				
CORPORATE									
MEDICAL GOVERNANCE	1	2	3	4	5				
OPS MANAGEMENT SCARBOROUGH	1	2	3	4	5				
HR	1	2	3	4	5				
SNS	1	2	3	4	5				
AL&R	1	2	3	4	5				
ESTATES AND FACILITIES	1	2	3	4	5				
OPS MANAGEMENT YORK	1	2	3	4	5				
FINANCE	1	2	3	4	5				
CORPORATE NURSING	1	2	3	4	5				
CHIEF EXEC	1	2	3	4	5				
TRUST SCORE	1	2	3	4	5				

RISK SCORES - MAY 2014 - APPENDIX 2

DIRECTORATE	Yr1 Target (£000)	4Yr Target (£000)	Yr 1 Plan v Target %	Yr 1 Plan v Target Score	Yr 1 Delivery v Target %	Yr 1 Delivery v Target Score	Y1 Recurrent Delivery v target %	Y1 Recurrent Delivery v target Score	4 Yr Plan v Target %	4 Yr Plan v Target Score	Risk Score Total Score	Risk Score Monitor Rating
TACC YORK	2,421	5,768	37%	1	3%	1	1%	1	18%	1	4	1
SPECIALIST MEDICINE	1,850	5,345	33%	1	5%	1	5%	1	22%	1	4	1
T&O YORK	789	2,331	23%	1	5%	1	4%	1	31%	2	5	1
RADIOLOGY	1,901	3,800	37%	1	7%	1	1%	1	41%	2	5	1
GEN MED SCARBOROUGH	982	2,511	51%	2	1%	1	0%	1	46%	2	6	1
HEAD AND NECK	480	1,863	56%	2	2%	1	0%	1	37%	2	6	1
GS&U	1,708	4,756	67%	2	11%	1	8%	1	47%	2	6	1
WOMENS HEALTH	2,342	4,464	43%	1	17%	1	14%	1	56%	3	6	1
OPHTHALMOLOGY	875	2,667	76%	3	26%	1	26%	2	30%	2	8	2
TACC SCARBOROUGH	879	2,473	64%	2	31%	2	24%	2	38%	2	8	2
CHILD HEALTH	1,247	2,999	66%	2	5%	1	0%	1	73%	5	9	2
T&O SCARBOROUGH	324	1,298	116%	5	29%	1	4%	1	35%	2	9	2
LAB MED	1,672	4,022	62%	2	32%	2	24%	2	57%	3	9	2
GEN MED YORK	1,672	5,114	79%	3	2%	1	2%	1	80%	5	10	2
MEDICINE FOR THE ELDERLY	174	1,717	77%	3	2%	1	1%	1	103%	5	10	2
ED YORK	501	1,426	125%	5	16%	1	5%	1	52%	3	10	2
SEXUAL HEALTH	491	1,129	56%	2	44%	2	32%	2	67%	4	10	2
ED SCARBOROUGH	404	1,329	111%	5	0%	1	0%	1	106%	5	12	3
MEDICINE FOR THE ELDERLY SCARBOROUGH	817	1,698	103%	5	1%	1	0%	1	90%	5	12	3
THERAPIES	1,367	3,772	102%	5	13%	1	4%	1	71%	5	12	3
COMMUNITY	1,648	4,390	94%	4	35%	2	33%	2	104%	5	13	3
PHARMACY	-188	611	101%	5	101%	5	101%	5	160%	5	20	5
CORPORATE												
MEDICAL GOVERNANCE	70	158	24%	1	5%	1	0%	1	11%	1	4	1
OPS MANAGEMENT SCARBOROUGH	329	638	50%	1	0%	1	0%	1	39%	2	5	1
HR	453	1,190	27%	1	0%	1	0%	1	42%	2	5	1
SNS	1,137	2,557	67%	2	6%	1	0%	1	45%	2	6	1
AL&R	185	420	46%	1	34%	2	0%	1	44%	2	6	1
ESTATES AND FACILITIES	2,878	7,804	61%	2	11%	1	9%	1	69%	4	8	2
OPS MANAGEMENT YORK	239	419	80%	3	0%	1	0%	1	81%	5	10	2
FINANCE	251	1,116	83%	3	0%	1	0%	1	78%	5	10	2
CORPORATE NURSING	334	496	159%	5	9%	1	9%	1	107%	5	12	3
CHIEF EXEC	75	448	152%	5	136%	5	136%	5	25%	1	16	4
TRUST SCORE	**30,308**	**80,731**	**73%**	**4**	**16%**	**1**	**11%**	**1**	**59%**	**3**	**9**	**2**

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Present:

Professor Dianne Willcocks, Non Executive Director (Chair)
Sue Holden, Director of Corporate Development
Natalie McMillan, Assistant Director Resourcing
Libby Raper, Non Executive Director
Beverley Geary, Director of Nursing
Melanie Liley, Head of AHP Services and Psychology
Dr J Thow, Clinical Strategy Lead
Rachel Kristiansen, Human Resources Advisor (for minutes)

Apologies:
Patrick Crowley, Chief Executive

The minutes of the meeting have been drafted to reflect how the items were listed on the agenda however the meeting did not follow that order.

	Agenda Item	Comments	Assurances	Attention to the Board
1	Apologies for Absence	These were received from Patrick Crowley, Chief Executive		
2	Minutes of the meeting held on 10th March 2014	Agreed as accurate summary <u>Star Award Nomination for Matron in AMU</u> Confirmed that a nomination had been put forward by Mrs McMillan. <u>Nursing Establishment Review/ Update and Review of other staffing models</u> Ms Geary would give an update on nursing establishment as part of her verbal update on Advanced Clinical Practitioners (ACPs) under point 12. <u>Managing Talent</u> Mrs Holden confirmed that her draft paper on Managing Talent would be picked up under point 13. <u>Consideration of further agenda items</u> To be picked up under Matters Arising.		

		HR Directors Overview As Ms Hayward had now left the organisation Mrs Holden confirmed that she was now also acting as interim Director of HR as part of her existing remit as Director of Corporate Development. Mrs Holden confirmed that she would be providing the overview today and her thoughts on how this may change at future committee meetings. Elderly and Anaesthetics An update on Elderly and Anaesthetics would be provided to the committee as part of point 9 Workforce Planning and the Future. Director of Learning and Research Overview Mrs Holden confirmed that she had not received any further comments passed back to her regarding integrated provision of training for all staff groups. This would be picked up as part of point 4. Draft Volunteer Strategy The updated volunteer paper was an agenda item to be picked up at point 10. Mrs McMillan would be presenting this paper. Living Wage It was confirmed an update would be provided at point 15.		
2	Matters arising from the last minutes	• Consideration of further agenda items It was agreed that Mrs Holden and Professor Willcocks would update and agree future agenda items and timescales for the committee to consider at the next meeting. **Action: Mrs Holden and Professor Willcocks.** • Workforce update on Elderly and Anaesthetics An update on Elderly and Anaesthetics would be provided to the committee as part of point 9 Workforce Planning and the Future.		

		• Integrated Provision of training comments Mrs Holden confirmed following the discussion at the previous committee she wanted to signal a shift in using data to inform planning of workforce. Mrs Holden set out that she was now looking with her team at the Education Strategy and Implementation Plan for the Trust, the use of non registered staff and their skill development, multi professional training and the break down of traditional thinking in terms of funding. Mrs Holden outlined that with the interim arrangements in place regarding her remit it gave her an ideal opportunity to take this work forward. Professor Willcocks outlined that it would be up to the committee oversee this work and ensure that all this work continues to be taken forward. • Workforce Monitoring Mechanisms update Mrs Holden outlined that she felt that there was need to review the HR Quarterly Report from a nursing perspective. This would make it more meaningful and add value to its understanding. Following Lucy Connelly's departure on full time secondment to Chelsea and Westminster Hospital it had been agreed with Mrs Geary and the Senior HR team that workforce monitoring needed to be integrated into the Chief Nurse role and the chief nurse team. This would also fit with what was being driven nationally in terms of safe staffing levels. It was confirmed that the Chief Nurse role would have this aspect incorporated into the Job description. Mrs Holden confirmed that the Quarterly HR Performance Report was a work in progress and it was confirmed that some elements of the report would remain, others would drop off and it would evolve to fit with what was required in terms of continued assurance and our governance framework. Mrs Geary confirmed that the Chief Nurse post would be out to advert by 1st July 2014.		
4/5/6	HR Directors Overview / Learning and Research Overview/	Mrs Holden outlined that she would cover items 4, 5 and 6 together as what she had to say also linked into point 6 of the agenda - Interim Arrangements for discussion.		

	Interim Arrangements for discussion	Mrs Holden outlined as her role now included HR she felt there was a possibility that this meeting could become too focussed on her remit. Mrs Holden confirmed due to the size of her remit she was working very closely with her Senior HR and Corporate Team. This included Mrs Natalie McMillan, Ms Dawn Preece, Mrs Michelle Wayt, Ms Anne Devaney and Mrs Gail Dunning and as such was having to delegate responsibility to them as she had to be realistic about what she was able to do. Mrs Holden outlined bearing this in mind she asked if the committee could consider expanding its remit to include them as they were closer and nearer to the work involved. It was agreed that this would be considered further as part of point 7 of the agenda - Terms of Reference of the Workforce Strategy Committee Learning Hub - Mrs Holden stated that she was pleased to inform the committee that the Trust was now able to bench mark data for training for the first time. This had been a major job for the Corporate team integrating three separate training systems into the Learning Hub. Over 8,000 learning accounts had been set up with personal profiles and details of statutory and mandatory training undertaken. Although the information was not up to date it set a new baseline for the Trust from which improvements could be targeted, and for the first time ever a report could be run which covered all staff. Over the next few months learning accounts would be released to staff and they would be able to review and update their information at a central point. Therefore the information would become meaningful. Mrs Holden outlined that she had put this on the risk register as a corporate risk as the information held at present was not accurate however, she was confident that month on month it would become more accurate as records were amended and populated. Mrs Holden outlined that the system would enable reports to be run and much more detailed information to be provided at a corporate, directorate and individual level. Mrs Holden confirmed that she would be able to demonstrate the system in more detail to the next committee. **Action: Mrs Holden to organise a demonstration of the system at the next committee.**		

		Social Club, Scarborough - Mrs Holden stated that the Social Club at Scarborough ceased to exist from 31st March and the club assets were donated to Staff Benefits for the purpose of improving the health, wellbeing and welfare of staff. The assets include on-site gym, squash court, beach huts and social club facilities. It was planned in partnership with Occupational Health to take forward a business case to utilise the Social Club building to make it a Wellbeing Centre for staff. This will include the relocation of Occupational Health to the Social Club premises. An estimate has now been received to take this work forward and unfortunately this had come in above budget and therefore the scope needed to be rethought. Staff Friends and Family Test - Mrs Holden outlined that the Staff Friends & Family Test was launched in May and the first quarter closes on 30th June. Key learning would be undertaken at each quarter and where appropriate adjustments would be made for the following quarters. Mrs Holden confirmed that this feedback would be communicated to the team for consideration and follow up. **Action: Mrs Holden to discuss with her senior team** Temporary Workforce - Mrs McMillan outlined that the annual NHS Professionals review had demonstrated that whilst demand had continued to increase within the Trust there had been a reduction in spend. This had been as a direct result of the Corporate Nursing and the HR team working more collaboratively together to improve efficiencies and better manage teams. Mrs Holden invited questions or comments about the papers 3a, b and c. Professor Willcocks stated that she was pleased to hear about the pilot of Health & Lifestyle Kiosks within the Trust. No further comments or questions were raised.		
7	Terms of Reference for the Workforce Strategy Committee	A discussion took place regarding the Terms of Reference of the Committee. Mrs Holden expressed that she would like to see the membership extended to enable her senior team to attend, exchange issues and contribute as they now had delegated responsibility for		

		various areas of work. The committee then discussed the membership of the group and agreed it would be useful to have additional members however the balance of committee members needed to be fair so that it was not unbalanced by the number of HR/ Corporate attendees. It was agreed that Professor Willcocks would look into whether it was appropriate for a lay member to be invited onto the group. It was agreed that Mrs Holden would update the Terms of Reference and produce a statement of intent which would be circulated to the committee for comment prior to the next meeting. **Action: Mrs Holden to update the Terms of Reference of the Committee and produce a statement of intent to be circulated to the committee for comment.** **Action: Professor Willcocks to feedback whether a lay member could be invited onto the group and identify a potential nominee.**		
8	Changing Report format for HR reports	Mrs Holden outlined that would like to see more information provided in the reports to make them more meaningful and to generate more informed discussion. She confirmed that she would provide 'mock up' draft HR reports for discussion at the next committee. **Action: Mrs Holden to provide a mock up of the new HR reports for the next committee.** Mrs Holden confirmed that the Board information would remain the same up to September 2014 however, the quarterly HR Performance report would be different.		
9	Workforce Planning and the future	Mrs McMillan outlined that as previously alluded there was a need to move towards prospective reporting so that it would 'hook' in directorates more and provide more detailed information that would help workforce modelling and the development of changing roles. Mrs McMillan outlined the Consultant Age profile report had been drafted by Miss Longhorne as an example of what would be provided within the Trust to better inform decision making. Mrs McMillan stated that in the In the last 5 years (from April 2009 to April 2014) Consultants numbers across the whole organisation had		

		increased by more than a third from 237 to 325. These numbers will increase further still as medical staffing were currently managing recruitment for posts totalling 18 FTE across all sites and specialties. A paper was presented on the workforce data modelling for Theatres and Elderly Medicine. Mrs McMillan outlined that the information could be used to deliver the service in a different way. This could be through development of non training grades and making this a more attractive role by reviewing their terms and conditions, job title and how to attract and retain them in the organisation. Dr Thow confirmed that he felt that non training grade were an under utilised resource within the Trust. These roles were was not embraced within the Trust and offered huge potential for change. The committee agreed this as an important area for future development of the status and contribution of this group of clinicians. Mrs McMillan outlined that there was also a need to review the use of Speciality doctors in Anaesthetics as they were an untapped resource. Also the new roles of ACPs continued to challenge the design of roles and how work could be delivered within the Trust. Having details about age profiles is a good way to start those conversations. Professor Willcocks outlined it was quite timely that this example paper had been produced and offered an opportunity for conversations to take place to put in a place a strategy to explore the options available, timescales to do this and other issues that would need to be considered. Mrs Holden confirmed that meetings were being put in place to take this forward with Directorate Managers, Directors, Medical Directors, OD and HR. Mrs Holden outlined that this was opportunity to use the information that could be provided in a very different way to develop a very different workforce in the next 3 - 5 years. It was confirmed that Mrs Holden would provide a progress report to the next committee.		

		Action: Mrs Holden to provide a progress report to the next committee.		
10	Updated Volunteer paper	Mrs McMillan checked the committee had received a copy of the updated paper and invited questions on it. It was confirmed that paper had gone to board about three years ago and this paper was the review document that was the next stage of the strategy. Mrs McMillan outlined that the programme would start from April 2014. Mrs Geary confirmed that this was a positive step forward for the Trust especially in terms of the dining companions and volunteer visitors which make a huge difference to patients. Mrs Holden reaffirmed this and outlined that this would help support staff to do other things. It was suggested that other funding sources could be investigated to look at perhaps introducing an elder volunteer and whether age concern may have some funding that could be accessed. Mrs McMillan highlighted that the volunteer service was made up 2 part-time band 2 staff members who covered both sites. It was not a big team to manage the volunteer service and therefore its activities had to be balanced with the resources it had. **Action: Professor Willcocks to contact Communications about circulating Staff Matters to all volunteer organisations for information and promotion of Trust activities.**		
11	Update on Advanced Clinical Practitioner's (ACP's)	Mrs Geary confirmed there was currently a cohort of 6 ACP's in their second year and 12 new ACPs were due to start in the organisation on Monday 9 June. Mrs Geary stated that the infrastructure had not been in place to support the first cohort of 6 and people had had to provide this in addition to their normal day job, which had been based on goodwill. It was to be discussed at the next steering group what infrastructure was required and support need to do this.		

		Mrs Geary confirmed there had been some difficulties with the first cohort in relation to staff struggling to be more autonomous and problem solve themselves as they were not used to this. Therefore, they required more support than had been initially thought would be necessary. However, over time the ACP's confidence had grown and now they were working more autonomously and less support was needed. Mrs Geary outlined that she was interested to see if this was the same for the second cohort of staff. It was confirmed that Mrs Geary would provide a further update on the new cohort at the next committee. **Action Mrs Geary to provide an update on the ACPs to the next committee.**		
12	Safe Staffing Levels	Mrs Geary outlined that a Safe Staffing paper had been published in December. In April – Hard Truths was published. This set out a requirement about expectations in terms of actual and planned staff. Mrs Geary stated that this has been discussed at Board in detail and was to be factored in the bi-annual acuity audit. Mrs Geary stated that on 18 May 2014 the Chief Nurse, NHS England published what was required in terms of the May data report in June. The report was not prescriptive in terms of the collection of actual data and gave very tight timescales in which this information had to be uploaded. The electronic system to upload the information into was only available from last Wednesday and is being populated with actual planned figures. The timescales given were to upload the information by 10 June 2014 and publish by 24 June 2014. Mrs Geary outlined that the criteria that this data would be measured against in terms of rag rating red, amber and green was not stated. Mrs Geary outlined the outcomes/ report would be discussed at Board, the Quality and Safety committee and this committee in due course.		
13.	Performance Management/ Development	It was agreed that further discussion was required between Ms Holden and Professor Willcocks regarding this item and the matter would be taken forward as a future agenda item. **Action: Ms Holden and Professor Willcocks to discuss and matter to be included as a future agenda item.**		

14.	HR Quarterly Performance Report	The committee agreed there was nothing further to add following earlier discussions.		
15.	Living Wage	Ms Raper confirmed that the Board of Directors have agreed to implement the Living Wage for the financial year 2014/15. This agreement would be reviewed on a yearly basis. It was outlined that the Living Wage was an hourly rate of pay set independently and calculated according to the basic cost of living in the UK. The current Living Wage, announced in November 2013 was £7.65 an hour. The Living Wage was currently higher than the national minimum wage and employers can chose to pay the rate voluntarily. As a result of this affected staff (those in Pay bands 1 and 2) would be paid a non-contractual pay supplement to 'top up' their basic hourly rate so that it matched the £7.65 per hour that was recommend under the Living Wage initiative.		
16.	New Placement Support Model	Mrs Holden confirmed that the Practice Learning Facilitators Practice Learning Facilitators (PLFs) are hosted by provider organisations, but funded by HEYH, and are experts in learning in practice; responsible for the development and maintenance of quality assured placements and acting as a link between higher education institutions (HEIs) and placement providers. There are currently 43 PLFs working across Yorkshire and the Humber in seven teams that reflect geographical areas, and 25 organisations provide hosting arrangements. In light of the introduction of national tariff for non-medical placements and the changing system demands around quality, it was felt timely to review the current model and the role of the PLFs, with a view to implementing a new system from April 2015. Mrs Holden confirmed at which time more than likely we would become the employer and they would sit alongside the Practice Placement facilitators in the organisation.		
17.	Yorkshire and Humber Local Education and Training – Finance Report including Initial LDA Contract Values Report	It was discussed that this information had been provided for information discussed as part of point 2 - Integrated Provision of training comments.		

18.	Any Other Business	Nothing was raised under any other business.		
19.	Date of next meeting	Thursday 18th September 2014 – 1-3pm Board Room, York Hospital **Action: All to note**		

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Chairman's Items

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

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

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

Reference to CQC outcomes

There is no reference to CQC outcomes.

Progress of report	This paper is only written for the Board of Directors
Risk	No risks
Resource implications	No resource implications

Owner	Alan Rose, Chairman
Author	Alan Rose, Chairman
Date of paper	June 2014
Version number	Version 1

Board of Directors – 25 June 2014

Chairman's Items

1. Strategy and Context

My thoughts this week are dominated by the somewhat dispiriting and tough outlook promulgated at the Foundation Trust Network meeting this month: downward pressure on budgets for about ten years ahead, as the austerity required to bring the national deficit down continues for the life of the next parliament; then we have at least five years continuing to pay massive interest on the huge debt that will continue to accumulate until then -- and in parallel start actually paying the debt burden itself down! All this makes our NHS budget almost inevitably smaller from '15/'16 – whether red or blue flags fly over Downing Street.

At least Simon Stevens, the new Head of NHS England, is sounding flexible and less centralist than the previous regime. The combination of his approach (to be outlined in the Autumn in a five year outlook), the Dalton Review into how to lower barriers to more flexible corporate and collaborative forms and potentially a slightly more flexible Competition and Markets Authority may leave open some options for survival. The mood is for less "top-down diktat" and offers the hope for a degree of local/regional leadership and initiative – something we can offer in North Yorkshire and surrounding areas. Variation of approach may be more accepted.

Mr Stevens struck an interesting note on his opening day when re concluded his first public speech with: "At all times our guiding principle will be: walk in the shoes of the people we serve. Think like a patient, act like a tax payer". This sums-up our permanent balancing act quite neatly, but gives it an action orientation rather than just being a concept of dilemma.

A key challenge is where the capital for system transformation will come from – when most parts of the system are barely balancing the books, let alone creating surpluses to facilitate investment. The feeling is that innovative solutions to this conundrum will need to emerge. Our own Trust's capital planning faces the same dilemma – but we should at least have plans almost "shovel ready", and our discussions later in the year should help us prioritise these.

2. Governance & Governors

I am delighted to report that the Council of Governors (11th June 2014) ratified the recommendation of their Nominations/Remuneration Committee and have reappointed three of our Non-Executive Director team each for a period of three years from 1st September 2014: Philip Ashton, Jennie Adams and Michael Keaney. I am delighted that this will give a large degree of stability to this part of the Board team for a period ahead that is filled with uncertainty and challenge. Congratulations to Philip, Jennie and Michael. In a related move, we are asking Michael Keaney to take over as Chair of the Finance & Performance Committee in the Autumn. Thank you to Michael Sweet for the excellent job you have done in chairing this committee from its formation some two years ago to its current working state as one of our key Board Committees. Michael Sweet will remain as a member of the Committee, providing valuable continuity.

We have committed to report the annual Director remuneration reviews in our public papers. In May, the Remuneration Committee of the Board decided to award a 1% non-pensionable increase to each of the Corporate Directors, effective from 1st April 2014. In addition our

Director of Corporate Development has taken on the additional role of Interim Human Resources Director, following the departure of Peta Hayward and her pay has been raised to the level of the outgoing Human Resources Director on a temporary basis. The Council of Governors has decided to award the Non-executive Directors a 1% increase (with effect from 1st April 2014). Any questions should be directed to me.

Following a very clear and upbeat presentation by Michael Proctor this month, the Governors are excited about the prospect of the two initial community "hubs" to be hosted by the Trust at Malton and Selby. They are very supportive and this will give additional opportunities for them to see visible caring of our patients in settings outside the main acute sites and more cross-system interaction with partners in the local health economies.

The Governor elections (for nine of our twenty six places on the Council of Governors) will take place in calendar Quarter Three this year. We will make additional efforts this round to fill the five Staff Governor roles.

3. Recommendation

The Board of Directors is asked to note the report.

Author	**Alan Rose, Chairman**
Owner	**Alan Rose, Chairman**
Date	**June 2014**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Chief Executive Report

Action requested/recommendation

The Board is asked to note the content of 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

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

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

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	Report developed for the Board of Directors
Risk	No specific risks have been identified in this document.

Resource implications	The paper does not identify resources implication
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	June 2014
Version number	Version 1

Board of Directors – 25 June 2014

Chief Executive Report

I have included at the end of this report the feedback we have received from Monitor following their review of our Operational Plan and Q4 performance. Understandably they are concerned about performance in the acute sector overall and it is equally understandable that they remain concerned at the fragility of some aspects of our performance as the health and social care system, particularly with regards to finance, becomes ever tighter. When we meet I will be in a position to brief the Board of the outcome of the next stage of this review following a planned conference with Monitors review team. However, it is important to recognise that this teleconference will be set in the context of both our main hospitals being under considerable and sustained strain with the York site experiencing in early June the highest level of attendances to ED since mid-2012 and as previously reported the Scarborough ED peaking at its highest level for some years during the Perfect Week. A snapshot of acute demand is perfectly illustrated by the fact that current demand (in the early part of June) is some 15% higher than for the same period last year in York and 7% higher than the first two weeks in May. This is replicated in Scarborough albeit at a lower level of growth.

It is evident that the Clinical Commissioning Group (CCG) investment, fuelled by national funding, had a major beneficial effect on demand in the last quarter of last year and the effect of its withdrawal is on the face of it profound. It is unclear whether the current demand is real growth in the system or deferred from Q4 but either way it is further evidence that real and sustained change is required overall to help manage the pressures we are facing.

The recent "Perfect Week" exercise in Scarborough and the Rapid Improvement Event concluded only last week in York Hospital on the elderly wards has illustrated perfectly for me the power of truly integrated working and we need to ensure that sense of collaboration, risk sharing and common goals is shared at the most senior level in order to provide the environment in which others can flourish. I know that for all organisations, including our own, it is too easy to hide behind our own priorities but I equally know that if we can't provide better and more comprehensive services in the community, collectively, then hospital services will continue to be squeezed at an unaffordable and increasingly unsafe level. I believe the community hubs planned in Selby and Malton, if successful, offer some hope that we can do this but it will require a huge amount of commitment from all parties to change the culture and climate our staff work in and to that end I have invited CCG Chief officers and local authority CEOs to meet with myself and members of our senior team to explore how we really can do this, rather than assume it will happen.

On our part I am also clear that we must re-focus some of our approach and effort to ensure that we provide the environment in which our staff can feel supported in what is an extremely challenging environment. I hosted an Executive Board Time Out earlier this week at which we explored some aspects of these issues with a particular view on avoiding the repolarisation of cultures that as I have previously set out is a tangible risk to all merger and acquisition activity in both the public and private sector. I remain concerned about the stress many of our senior and managerial staff are feeling and I am committed to improving our capacity and capability at every opportunity. As you know I have also been reviewing the construct of our corporate team as a first step to refreshing our approach and will be meeting Non-executive Directors to consider this further, and my recommendations for change, at the

Remuneration Committee following the Board Meeting.

Strategic Partnerships

You will recall that I briefed the Board at its last meeting on the changing landscape around us and in particular the importance of continuing to build on the strategic partnerships we have importantly with Hull and Harrogate, both of which are in the process of a change in senior leadership. I am clear that sound and collaborative relationships with both Hull and Harrogate are invaluable to us and have briefed our senior clinicians to that effect. We will continue to support clinician to clinician collaboration where this can add value to services across the community of North Yorkshire and Humberside and I look forward to working closely with the newly appointed CEOs in each organisation once they are in place.

External Appointments

It always gives me pleasure to update the Board on the external appointments that members of the Trust are asked to fulfil as part of their role. This month I am delighted to be able to report that Dr Alastair Turnbull has been asked to become part of Monitor's Acute Advisory Group at the invitation of Professor Hugo Mascie-Taylor, its Chair. I am sure Alastair will have a major impact on this group and look forward to hearing his reports on its activities.

Monitor's review of the Operational Plan and Quarter 4 submission

Monitor has written to the Trust to confirm that they have completed their high level review of the two year operational plan. This review has also included review of the Q4 submission. The purpose of the high level review is to determine if a change in regulatory approach is required. Based on this work the current Q4 2013/14 and forecast 2014/15 ratings are

	Q4 2013/14	Q1 2014/15	Q2 2014/15	Q3 2013/14	Q4 2013/14
Continuity of Services	4	4	4	4	4
Governance Risk Rating			Under Review		

The Trust breached four performance targets below, that has triggered consideration for further regulatory action. As such, the Trust's governance risk rating at Q4 2013/14 has been reflected as 'Under Review'.

- Its annual C-difficile objective, reporting 67 cases during 2013/14, compared to its annual objective of 43;
- The referral to treatment (RTT) target for admitted patients for the first quarter in 2013/14;
- The Cancer two week symptomatic breast target; and
- The Cancer 62 Day Wait for first treatment.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley Chief Executive**
Date	**June 2014**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Corporate Governance Statement and other returns to Monitor

Action requested/recommendation

The Board is asked to consider and approve the attached statements prior to their submission to Monitor.

Summary

As the Board is aware following the introduction of the Health and Social Care Act 2012, Monitor changed their regulatory arrangements. Monitor moved away from Terms of Authorisation and released a provider licence; Monitor also introduced the Risk Assessment Framework which replaced the Compliance Framework.

Part of the additional regulatory arrangements is that Trusts are required to provide a number of additional statements during the year. Last month the Board was asked to approve a statement related to systems of compliance with license conditions and the availability of resources.

This month the Board is asked to consider and approve

- Corporate Governance Statement – confirming compliance with condition FT (4) of the provider licence
- Certification of AHSCs and governance – as required by Appendix E of the Risk Assessment Framework
- Training of governors' statement – as required by s.151 (5) of the 2012 Act.

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

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and

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

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

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	The information included in the report has been consulted on prior to the Board meeting
Risk	No risk
Resource implications	There are no resource implications
Owner	Alan Rose, Chairman
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	June 2014
Version number	Version 1

Board of Directors – 25 June 2014

Corporate Governance Statement and other Certificates to be submitted to Monitor

1. Introduction and background

As the Board is aware following the introduction of the Health and Social Care Act 2012, Monitor changed their regulatory arrangements. Monitor moved away from Terms of Authorisation and released a licence; Monitor also introduced the Risk Assessment Framework which replaced the Compliance Framework.

Part of the additional regulatory arrangements is that Trusts are required to provide a number of additional statements during the year. Last month the Board was asked to approve a statement related to systems of compliance with license conditions and the availability of resources.

This month the Board is asked to consider and approve

- Corporate Governance Statement – confirming compliance with condition FT 4 of the provider licence
- Certification of AHSCs and governance – as required by Appendix E of the Risk Assessment Framework
- Training of governors' statement – as required by s.151 (5) of the 2012 Act.

2. Corporate Governance Statement

Monitor has provided a framework for this statement based condition FT4 of the provider licence. This framework includes a number of key statements which the Trust is required to respond to.

The Board of Directors is required to approve the statement before it is submitted to Monitor at the end of the Month.

1 The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Response

The Board has reviewed the Code of Governance published by Monitor in 2014 and confirms compliance with all requirements, except for the requirement for all Non-executive Directors to be independent. The spouse of one of the Trust's Non-executive Directors was employed in a strategic role (a Clinical Director) during the year, (this arrangement was changed in March 2014). The Chairman is also in his final year of office having served 8 years as a Non-executive Director and Chairman.

The Board continues to keep the Corporate Governance arrangements under review as part of its approach to good governance. During the year internal audit identified some areas of development for the risk management processes employed in the Trust. The Risk

Management Department have secured the support of an external advisor who will provide some additional training and support to the planned improvements that are being put in place to ensure the organisation has fully integrated risk management arrangements in place during 2014/15. This work is being overseen by the Corporate Risk Committee.

The Board of Directors has confirmed that it complies with the elements of Monitor's Quality Governance Framework. Assurance and compliance are monitored via the Quality and Safety Committee, a subcommittee of the Board of Directors and the Board will review a revised action plan to ensure the Trust continues to comply with the framework.

An Annual Plan is produced each year which underpins the strategic plan that covers 5 years. The Board has reviewed both the Annual Plan and the Strategic Plan. The development of these Plans has involved consultation with the Governors and the key stakeholders of the Trust.

The Board has in place a number of Board Committees that support the Board in the discharge of its duties. These are Quality and Safety, Finance and Performance, Corporate Risk, Audit, Workforce Strategy and Remuneration.

The Board reviews performance monthly through the Performance Report, Patient Quality and Safety Report, Chief Nurse Report and Medical Director Report, Finance Director Report and Chief Executive Report. In preparation for the monthly Board meeting, the Quality and Safety Committee and Finance and Performance Committee meet and discuss the performance in detail. The results of these meetings are included in the Board meeting and so provide current assurance. Quarterly, the Board reviews the draft statements submission to Monitor and confirms that the information included is consistent with the information received by the Board during the quarter.

The Patient Safety and Quality Report provide detailed information about patient safety issues such as mortality, harm events, infection control issues, drugs administration and patient safety walk rounds. It provides information on clinical effectiveness and patient experience. The Medical Director Report supports this information and provides more detail around key topics such as SHMI, PROMS and the Patient Safety Strategy.

The Trust produces an annual quality report. It identifies the priorities for patient safety, clinical effectiveness and patient experience for the coming year. These are aligned to the CQUIN targets and the Patient Safety Strategy.

All members of the Board of Directors have received an appraisal in the last 12 months; the executive directors are appraised by the Chief Executive, and the Chief Executive is appraised by Chairman. The non-executive directors are appraised annually by the Governors, through the leadership of the Chairman. The Chairman is also appraised annually; this appraisal is jointly-led by the Senior Independent Director and the Lead Governor

The Board has developed and articulated a clear vision for the organisation which is supported by the strategies that have been formulated by the Trust.

The Trust has in place a fully developed clinical audit programme which is led by the Medical Director. The programme includes national audits and confidential enquires, along with local clinical audits designed to improve the quality of healthcare provided.

The Trust implements a programme of patient safety walk rounds that involve all Board members. The output from these walk rounds is reviewed and actioned by the executive

directors and reviewed by the Quality and Safety Committee and reported monthly to the Board.

The Trust has in place a Nursing & Midwifery Strategy and a new Patient Safety Strategy. These strategies underpin the approach the Trust adopts to quality and safety.

The Board receives a quarterly update from the Director of Infection Prevention and Control on the performance of infection control and the actions being undertaken to improve performance. This quarterly report is underpinned by the monthly update the Board receives as part of the monthly performance reporting presented by the Medical Director.

The Board agenda is designed so the Board considers patient safety and quality issues first and all other items are related back to patient safety and quality.

2 **The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time**

Response

The Board has put in place a system where all guidance on good corporate governance is reviewed and any areas of non-compliance are reported to the board on a 'comply or explain' basis.

3 **The Board is satisfied that the Trust implements:**

(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation.

Response

The Board has recently reviewed the committee arrangements and has created a new Board Committee to address the management of key risks and the assurances identified by the executive directors as part of the assurance framework. The Board keeps the governance structure under review during the year to ensure it remains fit for purpose.

The accountability arrangements in place at Board and Committee level are clearly understood and acted upon. The Chairs of the Committees report regularly to the Board of Directors on the progress of the work in the Committee. The key committees associated to performance in the Trust (Quality and Safety and Finance and Performance) report monthly to the Board and provide assurance around the previous month's reports.

As part of a governance review the Trust has reviewed the accountability arrangements across the organisation and is undertaking a further piece of work to strengthen the understanding that staff have around their reporting lines and accountability arrangements across the Trust.

4 **The Board is satisfied that the Trust effectively implements systems and/or processes:**

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's

operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

Response

The Board is satisfied that the Trust has effectively implemented systems and processes that ensure compliance with the Licensee's duty to operate efficiently, economically and effectively. As part of the year-end process, the Trust undergoes an independent audit which includes a review of the use of resources. The external auditors gave an unqualified opinion of the use of resources in the Trust. The Trust's Audit Committee reviews the systems and processes (including clinical audit) that are in place, which includes those parts of the Licensee duty and reports regularly to the Board of Directors on the findings and assurances the committee has received. The Trust has in place a robust internal audit service provided by an independent organisation and an agreed work programme of audits that are undertaken during the year. These audits are reported directly to the Audit Committee.

The Board has received information on the requirements of the licence and during the year has reviewed the quarterly compliance of the Trust with the expected targets and trajectories.

The Board maintains awareness of the regulatory, legal and standard requirements that are placed on Trusts and raises them at the Board as they become known and as they come into effect. The most recent example of this is the recent requirement around staffing establishment in ward areas.

The Board has received assurance from the External Auditors on the effectiveness of the systems and processes in place around effective financial decision making, management and control. This has formed part of the year end assurances received by the Board. This is also underpinned by the Internal Audit programme of audits undertaken during the year. Reports are submitted for review to the Audit Committee. The Audit Committee raises any concerns with the Board of Directors. The Trust also underwent a review by Monitor on the Cost Improvement Programme. That report was positive in most regards about the systems and processes in place in the organisation around the management of cost improvements and provided recommendations, which have been accepted, to further strengthen the programme.

The Board has a robust work programme which ensures that information required at the Board is received in a timely manner. The Committees supporting the Board meet on a regular basis and have a detailed forward work programme which is fed from the Board and other more operational groups and which feeds information forward to the Board. Between

meetings there is ongoing debate between the Chairman, Chief Executive, other Directors, Non-executive Directors and Foundation Trust Secretary to ensure any adjustments to programmes or agendas are addressed. The Trust has in place an action plan following each meeting which is implemented within the agreed timelines.

The Board receives monthly information on the performance of the Trust and reviews any potential breach of the terms of the licence. The most recent example of this was at quarter 3 when the Trust reviewed the number of patients that were waiting more than 18 weeks for treatment. A thorough analysis identified the historic and operational reasons for a growth in the number of patients waiting in excess of 18 weeks and discussed a plan to ensure these patients' treatment were expedited with both Monitor and Commissioners. The plan, including a "planned failure" of the target, was subsequently agreed and delivered.

As part of the management of the operational performance of the Trust there is a weekly meeting that includes: the Chief Executive, Chief Operating officer, Director of Finance and Director of Systems and Network and the Director of Operations where there are detailed discussions about the current operational performance and any concerns or issues that might require action and forward planning. At the end of each week the Directorate Managers and the Deputy Director of Performance and the Director of Operations meet to review and escalate any performance issues that maybe coming apparent.

The Trust keeps the annul plan under review during the year. The Chief Executive provides a six month summary of performance against the annual plan in his Board report. During 2013/14 the Trust also underwent a review of the quality aspects of the annual plan through the second stage review process. The report identified that the Board was well informed and had an appropriate support system in place to review quality and safety issues. The Trust involves the governors in the development of the annual plan and strategic plan that is currently being developed. The intention is to hold a Board to Board meeting in July with the Governors and to reflect on the next five year strategy of the Trust.

5 The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include, but not be restricted to, systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Response

The Board considers the capabilities of the Board members during the year and at the beginning of 2013/14 increased the executive membership by adding a Director who specialised in organisational and corporate development. The Board recognised during the

continuing integration of Scarborough and formulation of a larger Trust the additional significance of organisational development in the effective functioning of the Trust. The Board has a Medical Director (who is the DIPC and Caldicott Guardian) and Chief Nurse as part of the executive management of the Board. The Board also includes attendance by the Director of Nursing and a further director has a background in midwifery. The Board reviews the capabilities of the Board members individually as part of the annual appraisal process, including discussion of succession planning

The Board makes collective decisions and takes into account the quality aspects of any decision made. During discussions in the Board meeting, the Chairman actively seeks the views of the Medical Director, Chief Nurse and Director of Nursing in terms of the implications on the quality of care of a decision. The Quality and Safety Committee also provides an additional opportunity for the Board to receive assurance on the impact on quality as the Committee reports to the Board on a monthly basis. The Quality and Safety Committee reviews papers in advance of the Board and provides the Board with the assurance it needs around the accurate and comprehensive nature of the papers.

Each Board meeting receives a patient experience item as the first item on the agenda. This sets the context of the Board meeting and helps to ensure that the rest of the meeting is linked to quality and safety of services and patients. The Board has, through the Quality and Safety Committee, reviewed the Quality Governance Framework and will undertake a further review later in the year.

The Trust was part of a second stage review of the annual plan during September, specifically related to quality. The report demonstrated that the Board had appropriate and robust systems in place to review quality on a monthly basis.

The Trust engages the Governors and users in the quality of services. The Trust has an active patient experience department where patients and carers are actively encouraged to be part of the development of services.

Members of the Board have a weekly meeting, specifically involving the Chief Executive, Chief Nurse and Director of Nursing where the complaints received by the organisation during the previous week are reviewed and an understanding of the scale and trend of the complaints is appreciated at a senior level. On a selective basis, the Chief Executive requests directors to personally supervise particularly sensitive or important complaints. There are number of reports that the Board of Directors receive on a monthly and quarterly basis which outlines the views and involvement of patients and the public in the work of the Trust.

The Trust also has a Patient Experience Steering Group which includes Healthwatch as part of its membership. This meeting collates information about patient experience and interprets it into future actions and ideas for strategy development.

The Medical Director and Chief Nurse meet weekly with the patient safety and risk and legal teams to review all infection control, mortality and serious incidents and other matters pertaining to patient safety and a summary of this meeting is presented weekly at the meeting of Executive Directors to ensure timely reporting and where required, immediate action.

Where there are issues or concerns raised by staff or patients there are a number of routes that can be used to ensure the Board is made aware of the issue when appropriate. The Directors, including the Non-executive Directors, undertake Patient Safety Walkrounds on a regular basis and speak to staff during those walkrounds. The walkrounds are also

undertaken at night.

Staff are also encouraged to raise concerns with their immediate managers or with a Director. The Chief Executive encourages staff to write to him directly on any matter they wish to raise with him and he has a policy that he will aim to respond to any enquiry within 24 hours.

The Medical Director, Chief Nurse and Director of Nursing raise quality issues at the Board monthly as part of their regular reporting. Recently the Finance and Performance Committee raised a quality issue with the Board around the potential effect there might be on a vacancy being held over in a directorate as part of a delivery savings programme. The issue was investigated by the finance team and it was proven that the process used to hold over a vacancy was tested to ensure it did not affect the quality of the service being provided.

6 The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Response

The Trust has recently undertaken a nursing staff establishment audit and increased the number of nurses in the organisation. The Workforce Strategy Committee, a committee of the Board reviews the detail in advance of the Board and provides support to the Board on the future development of staffing in the organisation.

The Board reviews its membership regularly and specifically on each occasion that there is a vacancy in the Board.

2.1 Certification on AHSCs and governance

The Board is asked to approve the statement associated with this certificate. Again this is required to be submitted to Monitor by the end of the month.

For NHS foundation trusts:

• that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or
• whose Boards are considering entering into either a major Joint Venture or an AHSC.

The Board is satisfied it has or continues to:

• ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence;
• have appropriate governance structures in place to maintain the decision making autonomy of the trust;
• conduct an appropriate level of due diligence relating to the partners when required;
• consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities;
• consider implications of the partnership on the trust's governance processes;
• conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk;

• comply with any consultation requirements;
• have in place the organisational and management capacity to deliver the benefits of the partnership;
• involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services;
• address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework);
• ensure appropriate commercial risks are reviewed;
• maintain the register of interests and no residual material conflicts identified; and
• engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.

Response

The Trust is a signatory to the original partnership submission to establish the AHSN Yorkshire and the Humber. The Trust has in place full governance processes relating to any research activity and successfully satisfied the requirements of a MHRA inspection last year. The York Teaching Hospital NHS Foundation Trust operates a Research and Development Committee with strong lay membership, a steering group for the Clinical Research Facility and has Board representation via the Director of Corporate Development. We subscribe to Medipex® and utilise their services regarding protection of intellectual property issues arising through practice. We can confirm that activity is reported through the sub-committees of the Board.

2.2 Training of Governors

For this declaration the proforma does not give the option of a written response, it is purely a confirm statement.

The Trust has provided training to governors through a number of forums including: within the Council of Governors meeting with presentations from the Medical Director, Chief Nurse, and the Deputy Chief Executive. The regular presentations from the Chief Executive also support their development and understanding of the Trust.

There have also been specific sessions held for Governors on finance, nursing and estates

The statement included in the proforma is as follows:

The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Response

Confirmed.

3. Recommendation

The Board is asked to consider and approve the attached statements prior to their submission to Monitor.

Author	**Anna Pridmore, Foundation Trust Secretary**
Owner	**Alan Rose, Chairman**
Date	**June 2014**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 June 2014

Business Case 2012-13/75: Interim Cardiology Developments

Action requested/recommendation

The Board of Directors is asked to approve the business case.

Summary

The aim of the business case is to gain approval for the implementation of an interim solution to the development needs of the Cardiology service while a long term solution to VIU capacity is put in place. The long term solution is being developed alongside vascular surgery to provide new lab capacity.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report Corporate Directors

Risk	No risk.
Resource implications	Resources implication detailed in the report.
Owner	Dr Maurice Pye, Consultant for Medical Specialities
Author	Jordon McKie, Directorate Manager - General & Acute Medicine
Date of paper	June 2014
Version number	Version 2

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2012-13/75

2. Business Case Title

An interim solution to facilitate an increase in Cardiology activity and income, in line with the Trust's Integrated Business Plan

3. Management Responsibilities & Key Contact Point

The business case 'Owner' should be the appropriate Clinical or non-clinical Director, or where appropriate the lead Clinician nominated by the respective Clinical Director. The 'Author' will be the named manager supporting the Owner of the business case, who will have responsibility for the development and writing of the business case, and <u>will</u> be the key contact point for enquiries.

Business Case Owner:	**Dr Maurice Pye**

Business Case Author:	**Jordan Mckie**
Contact Number:	**772 5484**

4. Issue(s) to be addressed by the Business Case

Describe the background and relevant factors giving rise to the need for change. Relevant data (e.g. BCBV data, etc.) *<u>must</u> be included to support the background described.*

The aim of the business case is to gain approval for the implementation of an interim solution to the development needs of the Cardiology service while a long term solution to VIU capacity is put in place. The long term solution is being developed alongside vascular surgery to provide new lab capacity.

The strategic aim for Cardiology across the Trust is to where possible and clinically appropriate, repatriate activity from neighbouring Trusts, developing wide ranging expertise for the region.

The service has a long established case for the repatriation of Percutaneous Coronary Intervention (PCI) for the Scarborough locality and the implantation of Complex Devices. The development of this case is not only a promising development but underpins the sustainability of the intervention service in the Trust, with increasing scrutiny on services and developing specialist specifications. In order to move this forward, the General and Acute Medicine directorate are proposing an interim solution, utilising the VIU in its only available session (Friday afternoon) as well as introducing a three session day on a Monday and Wednesday. This will accommodate Complex Device work, allowing some staff to be trained in VIU to manage this workload.

A business case was approved by the Trust Board in 2007 to develop a service to implant complex devices, including cardio defibrillators (ICDs) and cardiac re-synchronisation therapy (CRT). Commissioners did not support this at the time as devices could at the time be procured more cheaply at Tertiary Centres. Nevertheless, we developed a service to provide long term follow up for local patients to avoid trips to Leeds, and have received positive feedback from patients.

Commissioners are now keen to develop a local service, and smaller Trusts have since developed such services, including Harrogate and District NHS Foundation Trust. This would represent a significant improvement for patients due to shorter waiting times, shorter journeys and a smooth pathway from referral, to treatment, to follow up. We would propose to develop this service for the population of the newly integrated organisation.

Tariffs are favourable and the cost of the devices has significantly reduced, to the extent that estimated contribution has increased since the financial model presented as part of the 2007 business case.

As well as the strategic goal, it has been established that demands on the current Cardiology service at the York site are at the point where expansion is necessary.

The Cardiology lab on the York site is used from 09.00-17.00 Monday to Thursday and 09.00-13.00 on a Friday (the Friday PM is the only vacant session). The lab is available until 23.00 Monday, Tuesday and Thursday; and Fridays until 19.00 for post-procedure complications (this is no PCI list on a Wednesday).

The number of daily procedures performed is far higher when compared with other hospitals locally and nationally; leading to fatigue and stress for consultant, nursing and administrative staff. Figure 1.1 details the number of procedures performed by the Cardiologists from November 2010-2011. Figure 1.2 estimates the time in hours per procedure and compares this with the maximum number of hours available in the current VIU footprint.

Figure 1.1 – No. Procedures undertaken by York Cardiologists

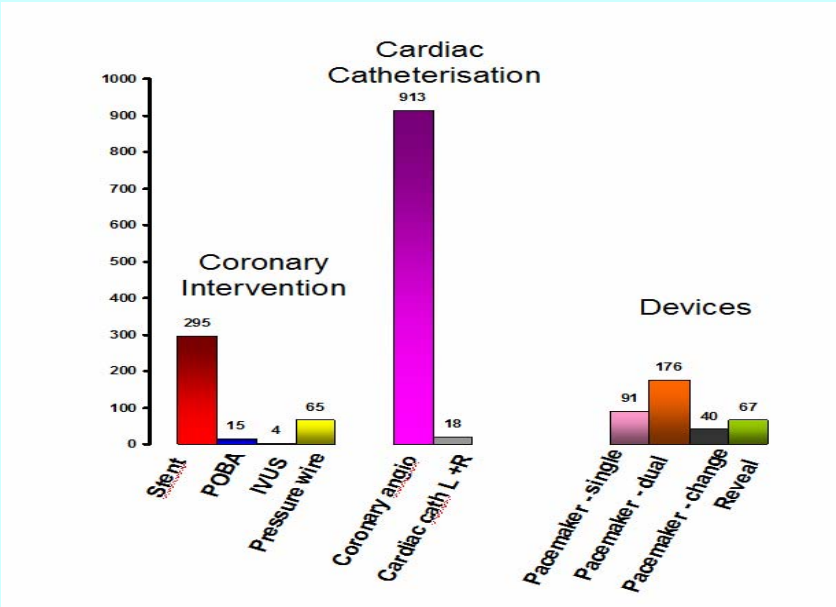

Figure 1.2 – Analysis of procedures undertaken by Cardiologists by length of procedure.

	Procedure		No. of procedures	Total No.	Min. time in mins/ case	Min. total time in hrs	Max. time in mins/ case	Max. total time in hrs
Coronary Intervention	PCI		295	379	80	505.3	100	631.7
	POBA		15					
	IVUS		4					
	Pressure wire		65					
Cardiac catheter.	Coronary angiography		913	931	30	456.5	45	684.8
	L & R cardiac catheter.		18		45	13.5	60	18
Devices	PPM	Single	91	374	45	68.3	60	91
		Dual	177		60	176	90	264
		Box change	40		30	20	45	30
	Reveal in/explant		67		20	22.3	30	33.5
Total hours	*NB: Maximum hours available in VIU is **1355** assuming 52 weeks worked*					**1262**		**1753**

Figure 1.2 demonstrates that the Trust is maximising the VIU capacity available to the Cardiologists, by listing 4 cases per list on average. This is high when considering the complexity and uncertainty involved in some of the cases (for example, many patients are listed for a diagnostic procedure and proceed to a complex intervention). In addition, clinical outcomes are good when compared with other providers, indicating that the service is provided to a high quality whilst maximising the use of available resources.

In summary, the service is unable to expand in terms of scale and scope due to the space restrictions in the lab and recovery space for patients.

Outpatient services for Cardiology were shown to have a capacity gap in 2013/14 of 2,627 first attendances and 2,338 follow up attendances. Despite the extensive work undertaken to increase capacity and reduce new to follow up ratios across the Trust the service still has a capacity gap which is estimated at 583 and 160 for first and follow up attendances respectively (to be verified as part of 2014/15 planning). This is planned to grow year on year for the next three years.

5. Options Considered

List below the alternative options considered to resolve the issue(s) presented in section 4 above. This should include consideration of alternative workforce and clinical models.

Description of Options Considered
1. Do nothing.
2. Do nothing until long term option established

3. Utilise Scarborough Cath Lab
4. Develop interim option on York site to facilitate new workload as well as addressing some capacity issues
5. Develop interim solution to address either current capacity issues or new workload

6. The Preferred Option

6.1 Preferred Option

Detail the preferred the option together with the reasons for its selection. This must be supported with appropriate data in demonstrating how it will address the issue(s) described in section 4 above.

Option 4 is the preferred option.

The option proposed is to utilise a Friday afternoon list and introduce three session working on a Monday and Wednesday in VIU. This will allow enough capacity to commence the complex device service.

In order to undertake this activity, appointments of a various clinical staff will be required. Included in this would be a consultant, middle grade doctor and cardiac physiologist appointment that would all reinforce the current service, providing much needed additional capacity.

The option addresses the issues raised in section 4 for the following reasons –

1. **Complex Devices**

As stated capacity will be provided to enable the complex device service to commence. Three session working provides some physical capacity, and the case includes the recruitment of staff to support the departments involved in the service (Medical staff, nursing, VIU staff and cardiac technicians).

2. **Demands on current Cardiology Service at the York site**

By increasing the medical workforce in Cardiology, capacity can be provided to meet the demand on the service from both an inpatient and outpatient perspective. The 6th consultant and additional middle grade doctor is key to this. This is evidenced in the latest annual planning process.

In addition, the cardio respiratory service will be able to provide capacity for the increased demand for the procedures undertaken by the team through the appointment of an additional Cardio Physiologist.

In order to facilitate this option, inpatient capacity would need to be made available to accommodate the increase in patient numbers. Ward 32 would be able to provide this following the implementation of a case to provide Neurology inpatient care in another area of the Trust. This case is being developed by the Specialist Medicine Directorate.

6.2 Other Options

Detail the reasons for rejecting the remaining options listed under section 5, together with supporting detail.

Option 1 would not provide a solution to any of the issues outlined in the case. Doing nothing will simply cause further problems for the Cardiology service in both the short and long term.

Option 2 would provide a long term solution, however by waiting for the development to occur further delays would be introduced to support the Cardiology service capacity issues. By starting some device implantation, the service could support a new appointment and take a phased approach to some of the work being repatriated.

Option 3 will be explored further alongside this development. The service aspires to provide a local service where appropriate and device implantation could fall into this category. However, at present work is being undertaken to ensure the lab at Scarborough is being fully utilised and cardio/respiratory services on site are developed in order to provide a foundation to this.

Option 5 is not entirely unviable but would be a missed opportunity to develop the service alongside ensuring sustainability of the current service.

7. Trust's Strategic Objectives

7.1 Alignment with the Trust's Strategic Objectives

The Trust has identified four strategic 'frames' that ensure there is a focus for its emerging priorities and objectives and assists in the communication to staff, patients and other stakeholders. The four strategic 'frames' are:

1 *Quality and Safety*
2 *Effectiveness, Capacity and Capability*
3 *Partners and the Broader Community*
4 *Facilities and Environment*

In this context listed below are four principle objectives that fit to the strategic frames. Indicate using the table below to what extent the preferred option is aligned with <u>at least one</u> of these principle objectives.

Strategic Objective	Aligned? Yes/No	If Yes, how is it Aligned?
To provide safe and quality services to all patients underpinned by the specific steps set out in the driver diagram as part of the Quality and Safety Strategy. This includes developing and learning from performance indicators (e.g. PROMs, NCI, etc). Ensuring compliance with	Yes	An interim solution supports the longer term goal of expansion of VIU. This expansion supports the Trust's aspiration to develop (i) existing Interventional Cardiology services to the NE Coast population; (ii) new Interventional Cardiology Services to the York,

national requirements - NPSA, NICE and implementation of results of clinical audit strategies and ensuring consultation and engagement of patients, visitors and staff.		North and NE Yorkshire population; thereby improving the accessibility of these services to patients.
To provide excellent healthcare with appropriate resources, strong productivity measures and strong top quartile performance being indicative of this. The service will be based on 'needs based care' and staff understand how they contribute to the Trust's successes.	Yes	The interim option represents an improvement in the accessibility of high quality services, which identify the Trust as a credible provider of regional services.
To be an exemplar organisation that is responsive to the local and broader community needs and is recognised and trusted. To engage fully in all aspects of community discussion relating to health and provide expert advice and leadership as required. To work with other groups to support the adoption of a consistent approach in the community and demonstrate that the Trust is a community orientated organisation able to achieve and deliver all local and national outcomes.	Yes	The expansion of the Cardiology services will enable local and NE Coast patients to access a more local service in a more timely fashion. It is recognised that Cardiology Intervention rates for North Yorkshire are lower than the national average. Intervention is known to have a positive impact on outcomes. This development also offers patients choice of a local provider Vs tertiary providers.
To provide a safe environment for staff, patients and visitors, ensuring that all resources are used as efficiently as possible	Yes	

7.2 Business Intelligence Unit Review

The Business Intelligence Unit must review all business cases for 'Strategic fit' to the Trust's 5 year plan. The date that the business case was reviewed by the BIU together with any comments which were made must be provided below.

Date of Review	07/04/2014
Comments by BIU	Further discussion to be had with specialist commissioning with Device implantation being reviewed nationally. Recommend engagement with Hull around other issues as well as this. Some discussions already taking place.

8. Benefit(s) of the Business Case

8.1 Benefit(s)

The identification at the outset of the benefit(s) that arise from the business case is crucial to ensuring that a robust evaluating of the progress and delivery of the business case objectives is possible during the post implementation reviews.

*Clearly detail and **quantify** the expected benefits that will accrue to the Trust from the preferred option in each of the three domains of service improvement. The benefits identified must be tangible, and capable of being evidenced ideally through some form of measurement.*

Description of Benefit	Metric	Quantity Before	Quantity After
Quality & Safety			
Time waiting for device implantation	LoS	York Average 2 weeks	York Average 2 days
Patient Experience Survey – to formulate gather baseline before implementation	Patient Survey		
CCAD compliance – 12 month review by national body	National review		
How will information be collected to demonstrate that the benefit has been achieved? Signal and Pathway documentation			
Access & Flow			
Increased outpatient capacity	Outpatient clinic templates	583 FA, 16 FU as per planning 14/15	0 and 0 respectively
Improved outpatient waiting times			
• Average Waiting Times			
- New Patient Urgent - New Patient routine - Follow Up		10 weeks 19 weeks 8 weeks	6 weeks 8 weeks 8 weeks
• Longest Waiting Times			
- New Patient Urgent - New Patient routine - Follow Up		13 weeks 20 weeks 18 weeks	Expect a reduction in each
Improved utilisation of VIU	All sessions used		Additional 41 sessions per year
How will information be collected to demonstrate that the benefit has been achieved? Outpatient clinic reports VIU information			
Finance & Efficiency			
Increased contribution from the cardiology service	Planned	Current	£271k

(CIP)	income against planned expenditure	level	increase
Increased surplus as per service line reporting system (SLR)	SLR	£124k	Over £150k
Reduction in need for ECP funding	Budget reports	£141k	£0k
How will information be collected to demonstrate that the benefit has been achieved? Budget reports, SLAM and SLR.			

8.2 Corporate Improvement Team Review

The Corporate Improvement Team must review all business cases across the three quality domains. The date that the business case was reviewed by the IT together with any comments which were made must be provided below.

Date of Review	01/05/2014
Comments by CIT	Meeting with Gordon Cooney. Reviewed benefits of case to have clear measurable outcomes. Happy to proceed.

9. Summary Project Plan

Detail below the specific actions, individuals responsible for their delivery, and timescales that must be done in order to realise the intended benefits of the preferred option of this business case. For example, these may include acquisition of key space requirements, or equipment, IT software/ hardware; the recruitment of key personnel, training, implementation of systems, change in business and/or clinical processes, etc. ***All fields must be completed****.*

Description of Action	Timescale	By Who?
Business case circulation to key stakeholders	March 2014	Jordan Mckie
Business case submission to corporate directors	May 2014	Jordan Mckie
Business case approval	May 2014	Corporate Directors, Executive Board, Board of Directors
See project plan (appendix a)		

10. Risk Analysis:

Identify the key risks to the Trust of proceeding with the preferred option, and what actions can be taken to mitigate them should they arise.

Identified Risk	Proposed Mitigation
Activity exceeds or falls below planned levels, requiring further expansion or causing inefficiencies	Cardiology Directorate develops a robust plan to demonstrate utilisation of the lab. Utilisation of the Scarborough lab also under review with the potential for some developments here once capacity identified.
A number of issues could arise regarding inpatient capacity, causing delays in transferring patients from other hospitals or additional bed days due to patients in hospital awaiting a Cardiology bed post-procedure.	Alignment of this and Neuro/Stoke business cases, from the approvals and capital planning processes, through to works and opening. Robust operational policy to ring fence part of Ward 32, with beds that only open when VIU is operating.
Commissioners may not support the repatriation of work from Leeds and Hull; commissioners may not support the development of new services at the Trust, or the expansion of existing ones.	Ensure early engagement of activity plans with commissioners, identifying what is existing activity currently commissioned elsewhere, and what is new activity. Ensure activity is linked to outcomes and any relevant national guidelines, ensure support from relevant networks.

11. Risk of Not Proceeding:

Identify the key risks/ potential impact of not proceeding with the preferred option.

Developing the service is a key stepping stone for the integration of the Cardiology service in the Trust by moving forward a development which benefits all stakeholders.

It also reinforces the foundation of the interventional cardiology service in the organisation, ensuring that the Trust meets developing specialist service specifications.

By not proceeding this foundation would be at risk.

12. Consultant, and other Non-Training Grade Doctor Impact

(Only to be completed where the preferred option increases the level of Consultant/ non-Training Grade input)

12.1 Impact on Consultant/ Non-Training Grade Doctor Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant/ Non-Training Grade Doctor to a maximum of 11. This section should illustrate the impact that the additional Consultant/ Non-Training Grade input created will have on the average number of PAs worked in the specialty, the frequency of the on-call rota, and the PA profile across the whole specialty team. Information is also required of each Consultant's/ Non-Training Grade Doctor's actual annual working weeks against the 41 week requirement.

The information below must be accompanied by the Trust's Capacity Planning Tool, and the Job Plan, which should be appended to, and submitted with the business case.

	Before	After
Average number of Pas	10.33	10.43
On-call frequency (1 in)	1 in 5	1 in 6

York based Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**
Dr Pye	**41**	**41**	**12**	**12**
Dr Crook	**41**	**41**	**12**	**12**
Dr Durham	**41**	**41**	**12**	**12**
Dr Megarry	**41**	**41**	**12**	**12**
Dr Gupta	**41**	**41**	**12**	**12**
Dr Gale	**41**	**41**	**2**	**2**
Dr Williams	**41**	**41**	**3**	**3**
New Consultant		**41**	**0**	**11**
Scarborough based Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**
Dr Houghton	**41**	**41**	**12**	**12**
Dr Ahmed	**41**	**41**	**12**	**12**
Dr Jacob/Dr Ghosh	**41**	**41**	**12**	**12**
Dr Memon	**41**	**41**	**4**	**4**

12.2 Advisory Committee Review:

The Consultant Job Planning Advisory Committee must review all proposed job plans for new consultant posts, as well as any job plans for existing consultants where the proposed new post would have an impact on current working practices. The date that the job plans were approved by the Committee and any comments which were made must be provided below.

Date of Approval	Awaiting job plan
Comments by the Committee	

13. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the business case; the extent to which each support the proposal, and where appropriate, ownership for the delivery of the benefits identified above. Where external stakeholder support is vital to the success of the business case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment.

Examples of stakeholders include Lead Clinicians, support services (e.g. Systems & Network Services, Capital Planning re: accommodation), commissioners (e.g. Vale of York CCG, Scarborough CCG), patients & public, etc. ***Please bear in mind that most business cases do have an impact on Facilities & Estates services.***

Stakeholder	Details of consultation, support, etc.
Mandatory Consultation	
Business Intelligence Unit	Draft case circulated
Corporate Improvement Team	Draft case circulated
Workforce Team	Draft case circulated
Other Consultation	
Capital Planning	Series of discussions regarding proposed plans and impact on the Trust site
Cardiology Service, York site	One to one meetings where appropriate, discussion at business and directorate meetings with Consultants, Ward 32 Sister, Matron, DDM, Cardiac Rehab Lead Nurse
Radiology Directorate	Steven Mackell involved with the work up of the case. Discussions taken place with Dr Pye and Radiology team.
Cardiology Service, Scarborough site	Discussions taken place between Dr Pye and consultants on Scarborough site.
Community Services	Discussion with Wendy Scott and circulation of business case.
VIU staff	Led by Alison MacDonald, Alison and VIU Manager are members of Directorate meeting
West Yorkshire Cardiac Network (WYCN)	Quarterly meetings attended by DM, Drs Pye and Megarry. Dr Pye is a member of the newly formed PCI sub-group of WYCN – will seek external stakeholder support (first meeting 8th May 2012).
Systems and Network Services	Ensure IT connectivity is sufficiently developed to facilitate the transfer of images between hospitals – already in process.

14. Sustainability

The Trust is committed to development of sustainable solutions in the delivery of its services, including minimising its carbon footprint. The following questions should be answered in the context of the impact of this business case has on the areas listed.

If assistance is required in assessing the sustainability impact of this business case, help is available from Brian Golding, Trust Energy Manager on (72)6498.

Will this Business Case:	Yes/No	If Yes, Explain How
Reduce or minimise the use of energy, especially from fossil fuels?	No	

Reduce or minimise Carbon Dioxide equivalent emissions from NHS activity?	No	
Reduce business miles?	No	
Reduce or minimise the production of waste, and/or increase the re-use and recycling of materials?	No	
Encourage the careful use of natural resources, such as water?	No	

15. Alliance Working

How does this business case support the Trust's stated objective of developing and enhancing the clinical alliance arrangements with Harrogate & District NHS Foundation Trust, and Hull and East Yorkshire Trust?

N/A

16. Integration

Integration of clinical and non-clinical services following the acquisition of the Scarborough & North East Yorkshire NHS Trust is a key priority for the Trust. How does this business case link into the Directorate's Integration plan? Have current non-integrated services discussed new appointments?

This case will be a key step in the integration of the Cardiology services across the Trust.

17. Impact on Community Services

Will this business case have an impact on Community Services and/or provide an opportunity to better integrate Acute and Community Services? How will this impact?

There may be some impact on the community service as Scarborough cardiac rehab is currently provided by the community team. It is unlikely that the case will cause an increase in the numbers of referrals, however, these may be done in a more timely fashion than the current system.

18. Impact on the Ambulance Service:

	Yes	No
Are there any implications for the ambulance service in terms of changes to patient flow?	X	

If yes, please provide details including Ambulance Service feedback on the proposed changes:

There is a potential impact on the ambulance service as a significant amount of activity is being transferred between providers.

However, many of these transfers are likely to be occurring already with patients travelling to Hull or Leeds rather than Scarborough or York at present.

19. Market Analysis:

Where the business case is predicated on securing new and/or increased business (and income), detail the evidence supporting the income projections.

There are two key drivers to the increase in activity highlighted in the case. These are discussed below.

- Increased outpatient cardiology activity

Despite the number of patients discharged from the service following the review of new to follow up ratios across the Trust, activity is still forecast to be ahead of capacity. This is due to increased referrals into the York service resulting in the capacity gap outlined in 2013/14 planning and continued in 2014/15.

- Develop of complex device service

This group of patients is already known to the service as follow up is provided by the Trust. This data has been used to forecast the amount of device work to be undertaken.

As with any repatriation of activity it has been assumed that non elective activity will not be subject to marginal rates over and above 08/09 levels.

20. Estimated Full Year Impact on Income & Expenditure:

Summarise the full year impact on income & expenditure for the specialty as a result of this business case. The figures should cross reference to the more detailed analysis on the accompanying 'Financial Pro Forma'.

	Baseline	Revised	Change
	£000	£000	£000
Capital Expenditure			0
Income	36,250	37,580	1,330
Direct Operational Expenditure	22,687	23,746	1,059
EBITDA	13,563	13,834	271
Other Expenditure			0
I&E Surplus/ (Deficit)	13,563	13,834	271
Existing Provisions	n/a		0
Net I&E Surplus/ (Deficit)	13,563	13,834	271
Contribution (%)	37.4%	36.8%	20.4%
Non-recurring Expenditure	n/a		0

Supporting financial commentary:

Business case assumes a start date of January 2015.

Medical expenditure is based upon an 11PA consultant starting in November 2014 (and 0.75 Bnd 4 Med Sec Support - in Gen Med A&C row). Nursing contains a 1WTE band 5 nurse for ward 32 starting in January 2015 and VIU nursing starting in June 2014 to begin training. The case also includes two band 7 cardio-respiratory physiologists, both stating in November 2014. The Rad/ISA/Admin staffing covers the remaining VIU staffing costs, beginning in January 2015.

Non pay expenditure relates to 130 Excluded devices (ICDs) per annum and the consumables used during their installation, It also contains an ECP reduction, which will no longer be required due to the extra consultant. Ward 32 costs are dependent on the Ward 38 business Case for Neurology, the 372K is one third of ward 32's budget, equivalent to Neurology's presence on the ward.

Income begins in January 2015 and relates to 130 additional elective procedures to fit the ICD's, 242 Outpatient appointments to cover attendances prior to and immediately after procedure which currently occur in Leeds, as well as the 390K which will be recovered for the excluded devices - although this will need to be agreed locally with commissioners.

21. Recommendation for Post Implementation Review

	Yes	No
Is this business case being recommended for post implementation review?		X

Reason(s) for the decision:

Given this is an interim solution, a subsequent case will be developed as part of the expansion of VIU. In order to develop that case, subsequent review of this development would be undertaken. It would therefore not be recommended to duplicate this review.

22. Date:

11/03/2014

GAL/22August2013

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	2012-13/75
TITLE:	Interim Business Case for Cardiology Developments
OWNER:	Dr Maurice Pye
AUTHOR:	Jordan Mckie

Capital

	Total	Planned Profile of Change			
		2013/14	2014/15	2015/16	Later Years
	£'000	£'000	£'000	£'000	£'000
Expenditure	0	0	0	0	0

Capital Notes *(including reference to the funding source)*:
No Capital Expenditure is linked to this case

Revenue

	Total Change				Planned Profile of Change			
	Current	Revised	Change		2013/14	2014/15	2015/16	Later Years
	£'000	£'000	£'000	WTE	£'000	£'000	£'000	£'000
(a) Non-recurring			0		0	0	0	0
(b) Recurring								
Income								
NHS Clinical Income	36,250	37,580	1,330		0	249	1,330	1,330
Non-NHS Clinical Income	0	0	0		0	0	0	0
Other Income	0	0	0		0	0	0	0
Total Income	**36,250**	**37,580**	**1,330**		**0**	**249**	**1,330**	**1,330**
Expenditure								
Pay								
Medical	5,739	5,857	118	1.10		49	118	118
Nursing	9,663	9,764	101	1.00		64	101	101
Other (please list):								
Cardio-Resp Physiologist	856	943	87	2.00		36	87	87
Gen Med A & C	1,080	1,105	25	1.00		10	25	25
Rad/ISA/Admin		47	47			12	47	47
ECP Payments	382	271	-111			-50	-111	-111
	17,721	**17,986**	**265**	**5.10**	**0**	**121**	**265**	**265**
Non-Pay								
Drugs	2,377	2,377	0					
Clinical Supplies & Services	2,483	2,493	10			2	10	10
General Supplies & Services	106	106	0					
Other (please list):								
Ward 32 Costs	0	372	372			93	372	372
Excluded Devices	0	410	410			77	410	410
Consultant Training	0	2	2			1	2	2
	4,966	**5,760**	**794**		**0**	**172**	**794**	**794**
Total Operational Expenditure	**22,687**	**23,746**	**1,059**		**0**	**293**	**1,059**	**1,059**
Impact on EBITDA	**13,563**	**13,834**	**271**	**5.10**	**0**	**-44**	**271**	**271**
Depreciation			0					
Rate of Return			0					
			0					
Overall impact on I&E	**13,563**	**13,834**	**271**	**5.10**	**0**	**-44**	**271**	**271**
								+ favourable (-) adverse
Less: Existing Provisions	**n/a**		**0**					
Net impact on I&E	**13,563**	**13,834**	**271**		**0**	**-44**	**271**	**271**

Revenue Notes *(including reference to the funding source)*:
Business case assumes a start date of January 2015. Medical expenditure is based upon an 11PA consultant starting in November 2014 (and 0.75 Bnd 4 Med Sec Support - in Gen Med A&C row). Nursing contains a 1WTE band 5 nurse for ward 32 starting in January 2015 and VIU nursing starting in June 2014 to begin training. The case also includes two band 7 cardio-respiratory physiologists, both stating in November 2014. The Rad/ISA/Admin staffing covers the remaining VIU staffing costs, beginning in January 2015. Non pay expenditure relates to 130 Excluded devices (ICDs) per annum and the consumables used during their installation, It also contains an ECP reduction, which will no longer be required due to the extra consultant. Ward 32 costs are dependent on the Ward 38 business Case for Neurology, the 372K is one third of ward 32's budget, equivalent to Neurology's presence on the ward. Income begins in January 2015 and relates to 130 additional elective procedures to fit the ICD's, 242 Outpatient appointments to cover attendances prior to and immediately after procedure which currently occur in Leeds, as well as the 390K which will be recovered for the excluded devices - although this will need to be agreed locally with commissioners.

			Board of Directors Only
	Owner	Finance Manager	Director of Finance
Signed		Robert Woodward	
Dated		20/06/2014	

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2013/14	2014/15	2015/16	Later Years
Elective (Spells)	7,651	7,781	130		24	130	130
Non-Elective (Spells)							
Long Stay	4,643	4,643	0				
Short Stay	3,445	3,445	0				
Outpatient (Attendances)							
First Attendances	17,237	17,237	0		12	68	68
Follow-up Attendances	34,789	34,789	0		33	174	174
A&E (Attendances)	0	0	0				
Other (Please List):							
Excluded Devices			0		24	130	130
			0				

Income

	Total Change			Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	Later Years £'000
NHS Clinical Income							
Elective income							
Tariff income	4,826	5,597	771		145	771	771
Non-Tariff income	0	0	0				
Non-Elective income							
Tariff income	15,513	15,513	0				
Non-Tariff income	0	0	0				
Outpatient							
Tariff income	7,845	8,014	169		32	169	169
Non-Tariff income	0	0	0				
A&E							
Tariff income			0				
Non-Tariff income			0				
Other							
Tariff income	68	68	0				
Non-Tariff income	7,998	8,388	390		73	390	390
	36,250	**37,580**	**1,330**	**0**	**249**	**1,330**	**1,330**
Non NHS Clinical Income							
Private patient income		0	0				
Other non-protected clinical income		0	0				
	0	**0**	**0**	**0**	**0**	**0**	**0**
Other income							
Research and Development		0	0				
Education and Training		0	0				
Other income		0	0				
	0	**0**	**0**	**0**	**0**	**0**	**0**