

The programme for the next meeting of the Council of Governors which will take place:

On: **Wednesday 23rd May 2012**

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

If you are a Governor, member of our Trust or member of the public and would like to ask a question relating to an issue arising in these papers, please contact the Foundation Trust Secretary, Anna Pridmore:

email: anna.pridmore@york.nhs.uk or telephone: 01904 725075

All questions should be submitted by 12 noon on Monday 21 May 2012.

Time	Meeting	Attendees
3.15pm – 3.40pm	Pre-meeting of the Council of Governors Questions or comments on the Chairman's report	Governors with Chairman
3.40pm – 3.55pm	Private meeting of the Council of Governors	Governors with Chairman and Foundation Trust Secretary
4.00pm – 4.10pm	Specially convened meeting of the Council of Governors	Governors and public
4.10pm – 6.00pm	Council of Governors meeting	Governors and public

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

on: **Wednesday 23rd May 2012**

at: **4.10pm – 6.00pm**

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

A G E N D A				
No'	Item	Lead	Paper	Page
1.	<u>Chairman's Introduction</u> The Chairman will introduce the meeting and welcome any members of the Trust and of the public who are in attendance.	Chairman		
2.	<u>Apologies for absence</u> To receive any apologies for absence.	Foundation Trust Secretary		
3.	<u>Declaration of Interests</u> To receive the declarations of interests.	Chairman	A	5
4.	<u>Minutes from the meeting held in public on 22nd February 2012</u> To receive the minutes from the meeting held on 22 nd February 2012.	Chairman	B	11
5.	<u>Matters arising from the minutes</u> To consider any matters arising from the minutes.	Chairman		
6.	<u>Update from the private meeting held 23/5/12</u> To receive an update from the Chairman on the topics and decisions of the business discussed in the private meeting.	Chairman	Verbal	
7.	<u>Presentation from the Care Quality Commission</u> To receive a presentation on the work of the Care Quality Commission from Karen Westhead (CQC assessor).	Karen Westhead CQC	Verbal	

8.	<u>Update on Community Services</u> To receive a presentation on the Community Services, one year on from acquisition (1/4/11).	Mandy McGale, Jenny Carter	Verbal	
9.	<u>Chief Executive's Report</u> To receive an update on the planned acquisition of SNEY and to take questions or comments on the Trust performance reports and give the Trust's response to any questions submitted to the meeting. <ul style="list-style-type: none"> • Medical Director Report • Chief Nurse Report • Finance Director Report • Operating Performance Report 	Chief Executive	C D E F	21 31 41 47
10.	<u>Summary of Board minutes</u> To receive the summary of Board minutes from the Board meetings held in January 2012 to March 2012.	Chairman	G	51
11.	<u>Committee and other reports for Governors</u> To receive reports from the chairs of the committees, working groups and others: <ul style="list-style-type: none"> • Lead Governor report • Community & Membership Engagement Group • Home Team (Non-Executives) • Other 		H1 & H2 Verbal Verbal	77 & 87
12.	<u>Council of Governors Effectiveness Review – Workplan</u> To receive the proposed Workplan emanating from the Council of Governors Effectiveness Review (previously presented).	Chairman and Lead Governor	I	91
13.	<u>Any other business</u> To consider any other items of business.			
14.	<u>Next meetings</u> <ul style="list-style-type: none"> • 12 September 2012 – Open Day and Annual General Meeting (The York Hospital) • September 2012 (to be advised) – Optional Informal gathering for existing, re-elected and new Governors (Malton Hospital) • October 2012 (to be advised) – Council of Governors (new date to be set due to clash with Open Day) • 12 December 2012 – Council of Governors 			

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Changes to the Register of Governors' interests:

New declarations

Ms Rowena Jacobs— New appointed Partner Governor, University of York

Dr David Geddes—New appointed Partner Governor, North Yorkshire and York Primary Care Trust

Helen Mackman—Member of Vale of York Clinical Commissioning Group's Public Engagement Steering Group

Removal from declarations

Robert Thomas— Public Governor for Selby District

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Governor	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mr Paul Baines (Public: City of York)	Nil	Nil	Nil	Nil	Nil	Nil
Cllr John Batt (Partner: NYCC)	Director: Chain Lane Social Enterprise Ltd.	Nil	Nil	Nil	County Councillor: North Yorkshire County Council District Councillor: Harrogate District Council Member: The Grand Charity	County Councillor: North Yorkshire County Council
Dr Lee Bond (Staff: Consultant)	Nil	Nil	Nil	Nil	Nil	Nil
Mrs Helen Butterworth (Public: York)	Nil	Nil	Nil	Nil	Nil	Nil
Mr Phil Chapman (Patient/Carer)	Nil	Nil	Nil	Nil	Nil	Nil
Dr Jane Dalton (Public: Hambleton)	Nil	Nil	Nil	Trustee and Director North Yorkshire and York Forum	Nil	Researcher— Health and Social Care, University of York
Cllr Alexander Fraser (City of York Council)	Nil	Nil	Nil	Councillor — City of York Council ,	Councillor — City of York Council	Nil

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<i>Dr David Geddes</i> (Partner: NYY PCT)	Director —Medipex Executive Medical Director and Director — Primary Care, NHS North Yorkshire and York.	GP Partner —Clifton Medical Practice	Nil	Trustee —Clarence Gardens association. Medical Advisor —MIND @ Our Celebration	Partner of an employee of York NHS Foundation Trust.(Department of Gynaecology). GP —Harrogate District Foundation Trust OOH services.	Nil
<i>Ms Rowena Jacobs</i> (Partner: University of York)	Nil	Nil	Nil	Nil	Nil	Nil
<i>Mrs Alison MacDonald</i> (Staff: Nursing & Midwifery Class)	Director and Company Secretary—Health and Safety Consultancy	Nil	Nil	Nil	Nil	Nil
<i>Mrs Helen Mackman</i> (Public: City of York)	Nil	Nil	Nil	Nil	Member —Vale of York Clinical Commissioning group's Public Engagement Steering Group	Nil
<i>Mrs Mandy McGale</i> (Staff: Non-Clinical)	Nil	Nil	Nil	Nil	Nil	Nil
<i>Dr Jennifer Moreton</i> (Patients/Carer)	Nil	Nil	Nil	Nil	Member —CQC Registration Involvement Group Member—Ryedale LINK Ampleforth and Hovering Surgeries Patient Reference Group	Researcher —Health and Social Care, University of York

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Mr Nevil Parkinson <i>(Public: Selby District)</i>	Nil	Nil	Nil	Director —West Riding Masonic Charities Ltd	Nil	Nil
Mr James Porteous <i>(Public: York)</i>	Trustee —Notions Business and Marketing Consultants	Nil	Nil	President —British Polio Fellowship - Yorkshire Region, Leeds and North Yorkshire Region British Polio Fellowship Chairman —Wheelchair Users Advisory Panel (Harrogate District Hospital NHS Foundation Trust)	Nil	Nil
Cllr Caroline Patmore <i>(North Yorkshire County Council)</i>	Nil	Nil	Nil	Nil	Councillor —North Yorkshire County Council District Councillor—Hambleton District Council	Councillor —North Yorkshire County Council
Mrs Anne Penny <i>(Staff: Nursing)</i>	Nil	Nil	Nil	Nil	Nil	Nil
Mr Geoff Rennie <i>(Patient: Carer)</i>	Nil	Nil	Nil	Nil	Member —Ryedale LINK	Nil
Mrs Dianne Rhodes <i>(Public: Selby)</i>	Director & Company Secretary —Health & Safety Consultancy	Nil	Nil	Nil	Nil	Nil

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	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 or business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Cllr Joseph Richies (City of York Council)	TBA	TBA	TBA	TBA	TBA	TBA
Mr David Robson (Public: York)	Nil	Nil	Nil	Member - Management Committee for York Blind or Partially Sighted Society	Nil	Nil
Mr Martin Skelton (Staff: Clinical Professional)	Nil	Nil	Nil	Nil	Nil	Nil
Ms Catherine Surtees (York CVS)	Nil	Nil	Nil	Partnership Manager—York CVS	Partnership Manager —York CVS	Nil
Mr Brian Thompson (Patient: Carer)	Trustee —Thompson's of Helmsley Ltd	Nil	Nil	Nil	Nil	Nil
Mr Bob Towner (Public: City of York)	Nil	Nil	Nil	Vice Chairman —York Older Peoples Assembly	Vice Chairman —York Older Peoples Assembly Member —York Health Group Public and Patient Forum	Nil
Cllr Sian Wiseman (Public: City of York)	Nil	Nil	Nil	Nil	Councillor —City of York Council	Nil

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Minutes of the meeting of the York Teaching Hospital NHS Foundation Trust Council of Governors held on 22nd February 2012, in the Social Club, White Cross Road, York.

- Present:** Mr Alan Rose, Chairman
- Public Governors:** Mr Paul Baines, City of York
Mrs Helen Butterworth, City of York
Dr Jane Dalton, Hambleton
Mr Jim Porteous, City of York
Mrs Diane Rhodes, Selby District
Mr Bob Towner, City of York
Mrs Helen Mackman, City of York
Mr David Robson, City of York
Mr Nevil Parkinson, Selby District
- Patient/Carer Governors:** Mr Philip Chapman
Dr Jenny Moreton
Mr Geoffrey Rennie
- Appointed Governors:** Councillor Caroline Patmore, North Yorkshire CC
Councillor Sandy Fraser, City of York Council
Dr Rowena Jacobs, University of York
- Staff Governors:** Dr Lee Bond, Medical
Mrs Mandy McGale, Non-clinical
Mr Martin Skelton, Clinical Professional
Mrs Anne Penny, Staff Governor, Nursing
- Attendance:** Mr Patrick Crowley, Chief Executive
Mrs Anna Pridmore, Foundation Trust Secretary
Mr Michael Sweet, Non-executive Director
Professor Dianne Willcocks, Non-executive Director
Ms Libby Raper, Non-executive Director
Mr Garth Pickersgill, Board Administrator
Mrs Lucy Brown, Head of Communications
Mrs Penny Goff, Membership Development Manager
- Members of the public:** 5 members of the public attended the meeting.

12/1 Chairman's Introduction

Mr Rose welcomed the members of the public to the meeting.

12/2 Questions or Comments from the Public

The Chairman asked for and received questions and comments from the public.

Ms.Griffiths asked it the Council of Governors would consider methods of receiving

questions from the public. A discussion took place on the options, which included designing a method for asking for questions in advance or use the Governors' email address.

Mr. Yates raised the issue of improving engagement with the Trust membership, and the importance of "incentivising" this key group. A discussion took place on the different methods of communications that could be used to bring about improvement in this area; this included the Chairman's Letter.

Bob Towner welcomed the comments and made the point that the Council should always be looking at ways to improve its effectiveness.

Action: It was agreed the Chairman would receive any specific ideas from Trust Members.

12/3 Apologies for Absence

Apologies were received from:

Councillor Sian Wiseman, Public Governor, City of York
Mr Brian Thompson, Patient/Carer Governor
Councillor John Batt, Appointed Governor, North Yorkshire County Council
Councillor Joseph Riches, Appointed Governor, City of York Council
Ms Catherine Surtees, Appointed Governor, York CVS
Mrs Alison MacDonald, Staff Governor, Nursing Staff

12/4 Declaration of Interests

The latest update of the Governors' Declarations of Interests was provided at the meeting.

Action: The Chairman asked the members to forward any changes of the contents to the Foundation Trust Secretary as and when they occur.

12/5 Minutes of the Meeting held on 12th October 2011

The Chairman asked for any comments on the minutes of the last meeting.

Mr Bob Towner asked if there was any update on the tendering of the contract highlighted in the Nutrition Project report. The Chairman reported that a decision would be made about the Provider, but due to specific commercial issues he was unable to confirm the results. He did however advise that following the Board of Directors meeting he would notify everybody.

Action: The Chairman undertook to provide details of the outcome.

Helen Mackman asked for her summary of the Lead Governor's report to be added to the minutes of the December meeting as a true reflection of the content of her report.

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

Minutes of the Council of Governors meeting held on 22nd February 2012

12/6 Matters arising from the minutes

There were no matters arising from the minutes.

12/7 Update from the Private Meeting

The Chairman highlighted that the following issues were discussed in the private meeting:

- Mrs McGale gave an update on Community Services after one year.
- Review of the CoG.

12/8 Chairman's Letter

The Chairman informed the meeting of his intent to continue to write a regular (approximately three times a year) letter to all members of the Trust, to articulate the position of the Trust from his perspective and would welcome feedback.

During a discussion it was agreed that the first Chairman's letter was well received; however, there was a view that it was a little too formal. The Chairman explained that in his view it was important that the letter was delivered as a formal record; although he was conscious that there was a balance to be reached and he would take this into consideration.

There was also a discussion about the use of Twitter as a communications medium, as well as a marketing tool, particularly in engaging the younger members of the community. As a note, the Trust had been using Twitter since January 2012, but the 'follower' count was fairly low. The Communications Team continually keep these issues under review.

Sub-Committee and other Governors' Reports

Lead Governor Report

The Lead Governor's report can be found at Attachment 1 to the minutes. The report includes a look back on the introduction of the Governors' email address and summarises her engagement with the Vale of York Clinical Commissioning Group Public and Patient Congress, North Yorkshire LINKs and the City of York Overview and Scrutiny Committee.

Patient Focus Group

Mr Phillip Chapman, the Chairman of the Group, reported that at the last meeting there was a productive discussion about the Mobile Communications Policy. He summarised the discussion and highlighted some changes which would bring about improvements for both patients and staff. He also referred to the proposals by the Trust to form a new Patient Experience Group, into which Governors from the PFG would be invited.

Sustainability Group

The Group have re-evaluated the Trust's level of achievement for the last 6 months, with Minutes of the Council of Governors meeting held on 22nd February 2012

no noticeable change. Due to the lack of action from departments, the Group are requesting that a renewed importance to the Sustainability Objectives be made by the Board and that there is more active support from departments.

Travel and Transport Reference Group

Mr Phillip Chapman provided a summary of the last meeting of the Group, which covered the provision of secure lock-up facilities for cycles, the encouragement of car-sharing and the changes to Patient and Visitor car parking concessions. He also highlighted the proposals to charge Blue Badge holders in the future and a proposal that car park charges may rise in line with the rises in car park charges being proposed by the City of York Council.

Community and Membership Engagement Group

Dr Jane Dalton, the Chairman of the Group, provided a summary of the Group's plan of action to improve the engagement with the community and members, given that one of the duties of a publicly-elected Governor is to provide a trustworthy communication link, as well as having a responsibility to nurture the necessary "emotional" connections to supplement formal information delivery (e.g. The Chairman's newsletter and press releases).

As a trial to aid these connections, it was agreed at the CMEG meeting held on 22nd February 2102 that Lucy Brown, Head of Communications, would issue a briefing note describing the background and update on the acquisition. Governors who wish to do so can use this briefing to formulate a communication to their own constituencies. Governors will be asked to confirm any out-going text with Lucy in advance. Lucy would welcome details of the communication channels to be employed, so that she can add to the existing list of mechanisms, and continue building a network of stakeholders and interested parties with whom the Trust/Governors can liaise pre- and post-acquisition. This is an important and timely opportunity to raise the profile of the Trust and demonstrate the strength of the existing Governor network. It also paves the way for new East Coast Governors to get started with engagement post-acquisition.

Jane Dalton has some experience of carrying-out this type of activity in the Hambleton area, and would be happy to share her ideas with other Governors if this would be helpful.

The CMEG has also agreed the topics for two more YorkTalk presentations prior to 1st July: "End of Life Care" and "Behind the Scenes at the Emergency Department (ED)". It is proposed that the timing of the latter would helpfully coincide with publicity on the launch of the re-designed ED at York. The CMEG will re-visit YorkTalk topics at its next meeting in May.

12/9 Summary of the Board of Directors Minutes

The Council of Governors were asked for any comments/clarifications on the recent sets of Board of Directors minutes. A summary of the points raised follows:

Mr Bob Towner asked for clarification on the DNACPR issue, which was raised during the recent CQC visit. It was explained that the issue related to poor documentation and

improvement has been already being made in this area. Further explanation was provided on the requirement to consult with the patient. The policy states that this is not necessary; however, it is important that clinicians must capture and record all decisions that are made about a patient. Lee Bond added that the Medical Director has made it clear to all staff that all documentation must be done properly.

Mr Paul Baines asked for an explanation of the term “Ceiling of Care” and was informed that it could be summarised as “how far you would go to keep a patient alive”.

Mr Bob Towner asked about the 18-week backlog. The Chief Executive explained that the figures showed the position at the end of Q3; he recognised that there would be still be a backlog during Q4, but explained that the end of year report would show a significantly reduced position going into the new planning year position.

The Chairman brought the Council of Governors’ attention to Mr Towner’s comment in the “50+” magazine (Winter 2012) in regards to the alleged “creeping privatisation” of the NHS. The Chief Executive gave his assurance that NHS patients come first; he recognised the “private patient cap” threshold had changed in the proposed Health & Social Care bill, and this would in principle allow the Trust to undertake more private care. It is important that the Trust recruits the best quality consultants, some of who will look for facilities to provide private patient treatment. The current level of private patient income at the Trust (and in Scarborough) is slightly over 1%. There are proposals emerging in the Bill that may require Governor consultation if the level of private income changes by more than 5% of total revenue.

Mr Jim Porteous asked the question of how the hospital charges for private care. The Chief Executive explained that it is based on a calculated cost of delivery, with some mark up to cover other costs, balanced against the fees of private providers. He added that there is not a huge fee or insurance market in York, but as we enlarge it is something we must keep in mind. Mr Bob Towner thanked the Chief Executive for his assurances that the Trust is unlikely to be making significant changes in this area in the foreseeable future.

12/10 Performance Information

The Performance report was received by the Council of Governors.

There were a number of comments on the presentation of the data in the report, in particular the differences between the reports. The Governors explained that some were harder to read than others.

The Chairman and the Chief Executive reiterated that they were always looking to improve the reports. The information being used was largely dictated by outside reporting requirements, which required some detailed knowledge in both the rationale and interpretation of the data. The governors were assured that the intent is always to be open and transparent in the reporting and that they were receiving the same data as presented to the Board of Directors.

Mr Bob Towner asked about the red items on page 39 of the report and was assured by the Chief Executive that action plans were in place to mitigate them.

Mr David Robson asked about the reduction in the statistics for maternity. The Chief Executive explained that he was not aware of any migration of patients and the reduction in the statistic could be as a result of optimistic planning at the year start.

Mr Jim Porteous noted savings being made in the area of pressure sores and congratulated the Chief Nurse and her teams on their efforts.

The Governors noted the number of complaints attributable to staff attitude. It was confirmed that a small number of such complaints had been received and the Governors were assured that the Trust always expect the staff to uphold the Trust's Values and Standards at all times.

Mr Bob Towner asked whether the CQC re-visit reported at the last meeting had taken place and was informed that this had still to be scheduled.

To conclude this item, the Chairman asked the "Home Team" (non-executives) for an update on their activities to assure Trust performance:

Libby Raper explained that the Home Team was adding value to the normal assurance work of the NEDs. It had established a regular and more detailed operational update session and was able to report on the strong performance of the Trust over the winter period. They were, however, actively monitoring Norovirus, which had started to become apparent in the community. Effort continued to reduce the 18 week backlogs. A very detailed approach was being applied to each of the long and middle length waits, so as to be in a stronger position at the start of Q1 of next year; this effort has the support of the SHA, PCT and Monitor.

Mike Sweet then advised that work was being undertaken to improve information exchange, minimise paper output, and utilise electronic means, as well as making better use of the powerful database available to the Trust.

Efforts were also ongoing to develop a corporate dashboard that gathers all relevant data in one place for use by the Board. This should make the relevant Board reports shorter, using tables rather than words, with data being rated using a "traffic light" system (red, amber, green). The aim was also to move towards trend-driven data, to show the ups and downs as issues progress. Reporting would focus on 3 distinct areas: Quality & Safety, Finance & Performance and Access & Throughput. Each will be reported on monthly, with other items as appropriate being reported on quarterly.

12/11 Acquisition of Scarborough and Other Issues

The Chief Executive informed the Council of Governors following the amendment of the acquisition date to 1st July 2012 a press release had been published. The Board of Directors would meet with Monitor's Board of Directors on the 29th March 2102 and Monitor's Compliance Board has been scheduled for 13th April 2012, which would consider the risk rating for the enlarged Trust. An early draft of the Transaction Agreement would be discussed with the SHA and completed by 8th March 2012; ongoing effort will continue with the SHA on what happens in the period between April and June to include the subsidy to Scarborough and the Trust assuming of a level of responsibility for Scarborough from 1st April 2012. A public Acquisition Meeting will take place in the

PGMC Lecture Theatre, York Hospital on 12th March and planning has commenced to hold a meeting with the City of York Councillors in April.

12/12 Annual Report (2011-2012) – Council of Governors section - draft

The Chairman asked for any comments, changes or any new input for the report to be forwarded to the Foundation Trust Secretary.

12/13 Elections

The Chairman highlighted the timetable for the elections for Governors for 2012 provided at the meeting. He explained that the September dates were subject to change and are likely to be re-programmed for October. Details will be issued under separate cover.

Action: The Chairman requested any issues to be forwarded to him or the Foundation Trust Secretary.

12/14 Time and Dates of next meetings

Monday 12th March 2012, Post-Grad Lecture Theatre, York Hospital (Joint meeting with CoYC LINK re Scarborough Acquisition and related matters). The meeting will commence at 6.30pm.

The next Council of Governors meeting will take place Wednesday 23rd May 2012 at the White Cross Social Club, White Cross Road, York. The private meeting will commence at 3.15pm and the public meeting will commence at 4.00pm.

12/15 Any other business

There being no further points for discussion the Chairman closed the meeting at 1750 hrs.

Attachments:

1. The Lead Governor's Report.

Lead Governor Report to Council of Governors Wednesday 22 Feb 2012

Quality account

The Governors' Quality Account group had considered a quality and safety priority to be put forward for external audit. The Council of Governors was asked to note the report and recommended that compliance with the World Health Organisation Safer Surgery Checklist be put forward for external audit.

Work continues on the appraisal of the Council of Governors with the completion of a questionnaire that has gone to all governors, the non-executive team, and directors, and staff who liaise regularly with governors. We've also received welcome feedback from members of the public who attend our Council meetings. We aim to provide a detailed report which in turn should lead to a productive and positive way forward for the Council of Governors. I'd like to share a quote from our Chief Executive with you. This came out of a one to one discussion that I had with Patrick last month – *"I do believe that the very existence of governors has a profound effect on how we now work and the considerations we need to make. Rarely does a day go by without us having to consider why, how and what we do, without considering what the governor view might be and whether or not this is something we should share or consult on"*.

It is one year on from the introduction of our Governor e-mail address. I can report that we've had a total of 122 contacts. Of these 37 were about conferences, training opportunities or meetings outside our area, 23 about membership and 36 with comments, enquiries, issue or complaints. There is usually a flurry of mail after the Chairman's newsletter has gone out to members. I do have a more detailed breakdown on the use of the email address if governors would like me to supply these outside this meeting.

I attended the first Vale of York Clinical Commissioning Group Public and Patient Congress earlier this month. It was an excellent networking day with a variety of stakeholders. We were introduced to the roles and responsibilities of the commissioning group and to its emerging patient and public engagement culture and systems. There was plenty of opportunity to give feedback to the commissioning group on its vision and values and on how we could all be involved in future decisions about priorities, strategies and service design. Our Patient Experience team gave an excellent presentation on the recent Emergency Department re-design project which was a good example of how different agencies can work together in a valuable and productive way.

I participated in a North Yorkshire LINK meeting at Northallerton earlier this month where there was a series of presentations on End of Life Care in the Hambleton area. It was particularly interesting to hear from Sue Bryan who is the Virtual Ward Team Leader for this Trust, with responsibilities that include St Monica's in Easingwold. Participants in the event were keen to know more about the role of governors in that area.

I attended the City of York Overview and Scrutiny Committee this week. There was a large public delegation to challenge the PCT's decision to cut funding across a number of voluntary sector organisations and in particular that of the Blind and Partially Sighted

Society. This society supports patients in the community but essentially provides a service to patients of this Trust when they are possibly at their most vulnerable. I'm in discussions with the Directorate Manager for that area to offer an informal session for governors to enable us to understand the strategies that are in place to give the best possible service to this sector of patients.

Because of my involvement in the Arts Strategy group I was invited to an event to recognise the retirement of the Chairman of Paintings in Hospitals in the North of England. This organisation is significant for this Trust in terms of enhancing the environment for both staff, patients and visitors with many items from its collection hanging in the main corridors, wards and departments.

As part of the work towards the acquisition of Scarborough Trust, there's been a series of public presentations in partnership with the local LINKs. I attended both the Scarborough and Malton presentations given by Mike Proctor which went extremely well, both in terms of the level of information and in the active participation of the public who attended. The mood of both those meetings was generally very positive.

In order that Governors may start to get to know Scarborough Hospital, I have arranged with their Director of Facilities for a visit to take place on Friday 30 March.

Helen Mackman

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Council of Governors – 23 May 2012

Medical Directors Report – Patient Safety April 2012 report

Action requested/Recommendation

The Council of Governors is asked to note the report and discuss any areas of interest.

Summary

The Medical Directors report provides both assurance against the implementation of the Quality & Safety Strategy approved earlier this year and evidence in support of our Quality Account.

Content of the report is as follows:

- Quality & Safety Dashboard – acute page 7
- Quality & Safety Dashboard – community page 8
- Key priorities
- Deteriorating Patient
- Consultant appointments
- Medicines management
- Risk and legal services information (SULs, AIRs, Claims etc)

Strategic Aims

Please cross as appropriate

- | | |
|---|-------------------------------------|
| 1. Improve Quality | <input checked="" type="checkbox"/> |
| 2. Improve our effectiveness, capacity and capability | <input checked="" type="checkbox"/> |
| 3. Develop stronger citizenship through our working with partners | <input type="checkbox"/> |
| 4. Improve our facilities and protect the environment | <input type="checkbox"/> |

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 April 2012.

Risk	Associated risks have been assessed
Resource implications	There are no resource implications.
Owner	Alastair Turnbull, Medical Director
Author	Michelle Carrington, Assistant Chief Nurse
Date of paper	April 2012
Version number	Version 17

Council of Governors – 23 May 2012

Medical Directors Report – Patient Safety April 2012 report

1. Key patient safety priorities

Our priorities continue to be to reduce our harm rate and mortality as underpinned by our Quality & Safety Strategy.

We are focussing work on:

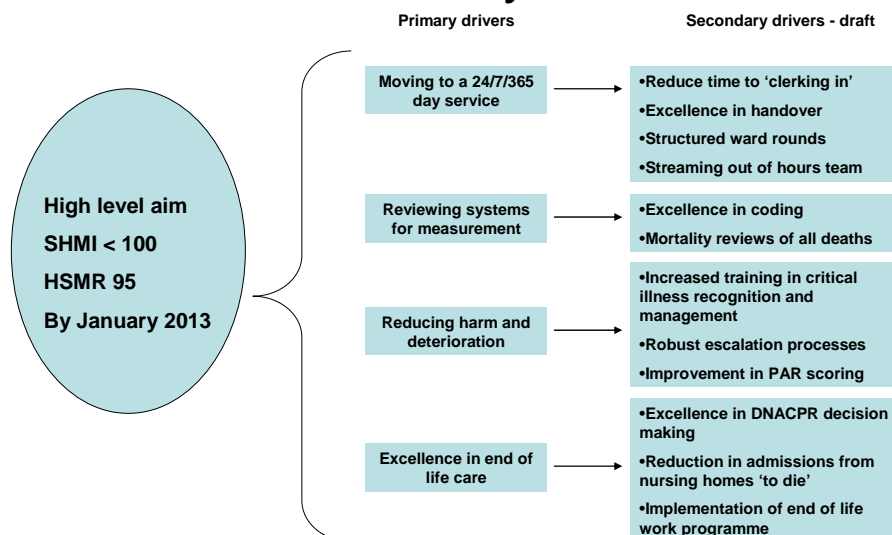
- Mortality reduction
- Deteriorating patient
- Medication errors
- Ensuring application of pre-operative safety briefings

A full review of the Q&S strategy is underway and will come to Board for consultation in May.

2. Reducing mortality programme – NHS Quest

NHS Quest is 'a network of NHS Foundation trusts aspiring to achieve a level of excellence in quality which is beyond all current expectations'. We joined NHS Quest around 6 months ago. The programme focuses on a collaborative approach to reducing harm and mortality. The launch event occurred in March where work stream leads were taken through the outline of the programme. There are four elements to the programme described in the following driver diagram:

York mortality drivers



The secondary drivers are in draft and are being worked up and agreed with team members.

The Medical Director is the overall programme lead. Invites for wider team members will be going out from the Medical Director this month. Reporting structure will be through Executive Board and

Board of Directors.

Crash call analysis

In March we had 18 calls entered onto the crash call log in switchboard. 9 of these were true crash events.

Work is ongoing to ensure collection of calls at switchboard is more robust and also to ensure that ward staff make the call for help using the most appropriate telephone number (average of around 20% of calls are made to the wrong number).

3. Deteriorating patient (PAR scoring, SBAR and safety briefings)

Measurement of PAR scoring continues via the Nursing Care Indicators (NCIs) – full report in Chief Nurse report. The 'Deteriorating Patient Group' will now form part of our mortality reduction programme working with NHS Quest. Actions and recommendations will be through Acute Board and Executive Board.

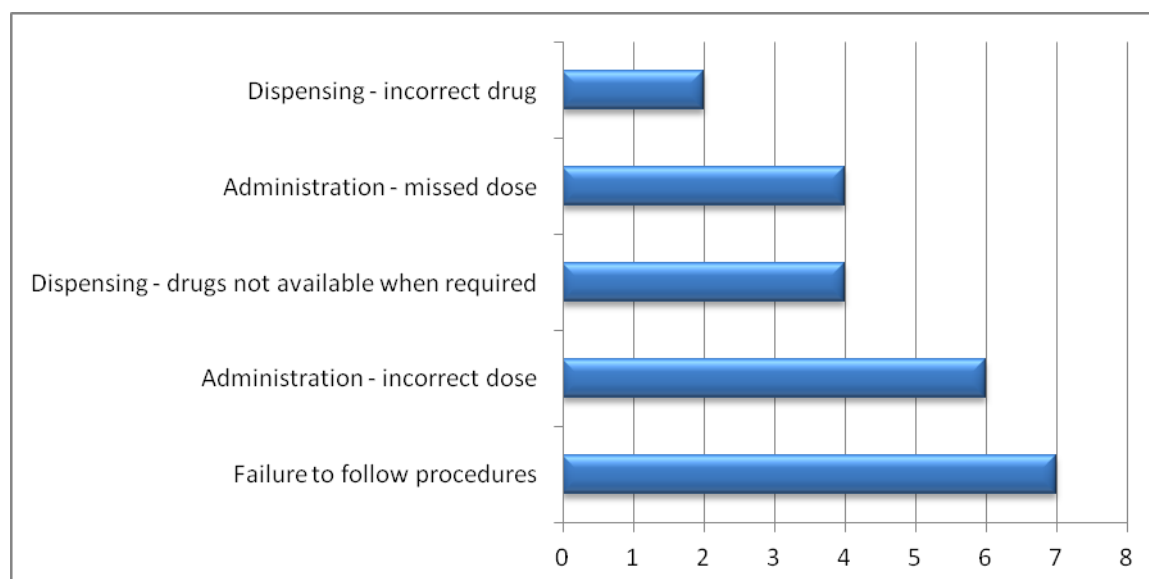
4. Consultant appointments

Appointments in *March*:

- **Consultant Elderly Medicine:**
Appointed: Karen Goodman & Gerard McGonigal
- **Locum Consultant in Obstetrics & Gynaecology**
Appointed: Mariya Mohammed

5. Medicines management

There were 89 medication related AIRS reported in this period. Of these 41 were uncoded and analysis was conducted on the remaining 48.



Top 5 reported medication AIRS

The top 5 reported medication AIRS account for 48% of the total. Failure to follow procedures concerned inappropriate management of medicines at ward level and failure to follow clinical procedures. Administration – incorrect dose errors mainly concerned critical medicines. Dispensing- drugs not available when required were mainly non-stock drugs not being supplied on

time. Administration – missed dose errors mainly concerned critical medicines. Dispensing – incorrect drug involved dispensing and discharge process errors.

Missed doses audit

Missed doses by definition are medication errors which can be avoided.

The consequences of missed doses on individual patients range from no harm to death depending on the clinical situation and the drug.

Missed doses can lead to increased morbidity and length of hospital stay. Missed doses can occur as a result of errors during the prescribing, dispensing, supply or administration of the medication.

Critical medicines are medicines where timeliness of administration is crucial to prevent death and serious harm. As a result of the NPSA rapid response alert issued in 2010 and recommendations from last year's missed doses audit, saw the following actions being implemented across the Trust:

1. A list of Critical Medicines is available on all wards and on the pharmacy X-drive making it easily accessible to all staff.
2. Medicines management training swatches have been distributed to all wards across the Trust.
3. Flow charts indicating what staff must do when a medication is not available to be administered to a patient have been distributed to all wards across the Trust.

This year's audit included the evaluation of 3,160 prescribed doses across the acute trust. 5 charts from each ward were randomly selected.

Summary of findings

A total of 176 prescription charts were reviewed across the Trust. Out of the 3,160 medication doses intended to be administered to patients, only 88.83% (2,807) were administered.

11.17% (353) doses were missed/omitted doses (including both critical and non-critical medications).

Of the 353 missed doses across the Trust, 5.1% (18) were missed doses involving critical medicines.

On comparing the data to last year's audit, there has been an overall reduction in missed doses from 13.60% to 11.17%.

However, there has been an increase in the missed doses that are attributable to no code / signature being entered on the drug chart and code 4 – medications not available

Code 0 = 100 missed doses (28.05%) - Previous audit 13.65%

Code 4 = 58 missed doses (16.43%) - Previous audit 9.16%

All ward sisters and matrons have been informed of the findings of the audit and have been asked to take actions where required.

Discussions are taking place on how to obtain ongoing data relating to missed doses, with particular importance on critical medicines. This is likely to be included as part of the Quality & safety strategy, working towards "no harm" wards.

Discussions are also ongoing as to whether the hospital drug chart should be modified to include a section for nurses to enable them to document their actions when medicines are not available.

6. Risk and Legal Information

6.1 Adverse Incident Reports

In March 2011 we had 640 clinical AIRS and 72 non-Clinical AIRS, plus Community Airs 93 in total: 83 Clinical, 10 Non clinical

Obstetric AIRS 91 in total: 82 Clinical, 9 Non clinical

6.2 Serious Untoward Incidents

In March 2012, the Trust has declared no SUIs

There are no SUItCASEs to be presented this month

6.3 Never Events

There have been no Never Events

6.4 Claims & Inquests

In March the Trust received 6 Clinical Negligence Claims.

1 Clinical Negligence Claim settled in March.

No inquests have been heard in March.

6.5 NPSA Alerts

CAS Alerts

The Trust has the following outstanding NPSA alerts.

There is an action plan for achieving compliance with these, updated weekly.

Alert Reference	Summary of alert	Deadline for compliance
NPSA/2012/RRR001	Harm from flushing of naso gastric tubes before confirmation of placement	02/09/2012
NPSA/2011/PSA001 and NPSA/2009/PSA004B and NPSA/2011/RRR003	Safer Spinal (Intrathecal), Epidural And Regional Devices Part A and part B plus RRR003	02/04/2012 and 02/04/2013 RAC has agreed that we will not be declaring compliance with this alert as the risks of doing so are too great.
NPSA /2011/RRR002	Keeping Newborn Babies With A Family History Of Mcadd Safe In The First Hours And Days Of Life	26/04/2012 – alert closed 05/04/2012

7. Out of hours discharges

Recent national press and television coverage following an FOI request in The Times has drawn attention to apparent concerns over discharges from hospital of vulnerable patients between the hours of 11 o'clock at night and 6 o'clock in the morning. The national average of such discharges

is approximately 3.5%. York Hospital provided information in respect of this FOI request, citing a figure of 2.3%. Last year 1,931 patients were discharged between 23.00 hrs and 06.00 hrs. Of these 85% were aged less than 50 and the largest single group comprised children. Patient groups discharged at these times include post-partum mothers, patients who take their own discharge, those who abscond, urgent transfers to tertiary centres, patients admitted to the observation ward after assessment in A & E and young patients who are found to have negative investigations on AMU and express a desire to go home. Of our three elderly wards there is an absolute embedded practice of avoiding discharges at such times and we are aware of no incidences of this occurring. Such discharges do not take place as a response to bed pressures despite current average occupancy levels being in excess of 90%.

8. Proposed changes to consultant appointment process

The Board of Directors were presented with a paper relating to proposed significant changes to the consultant appointment process. They refine the process in which the Board are currently engaged and are designed to make the current system more efficient, more clinically accountable and yet retain objectivity, transparency and fairness. The attention of the Board was drawn to the key changes pertaining to the current process.

9. Recommendation

The Council of Governors is asked to note the report and discuss any areas of interest.




Author	Michelle Carrington, Assistant Chief Nurse
Owner	Alastair Turnbull, Medical Director
Date	April 2012

Quality & Safety Dashboard

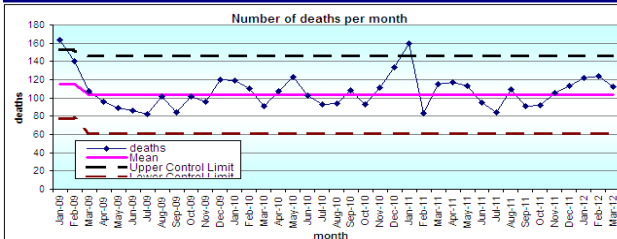
March 2012

Performance Scorecard - Acute Hospital

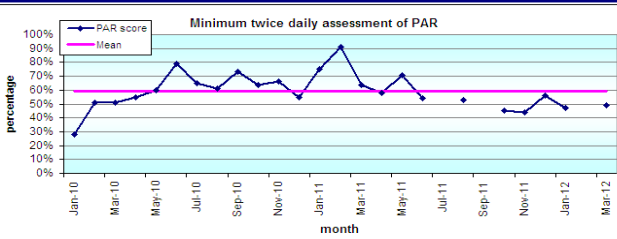
Area	Metric	Units	Mar-12	Target
High Level Aims	1. Inpatient Mortality	Percentage	2.5	
	2. HSMR - All admissions (Q3 2011/12)	Ratio	94.6	90.0
	3. Never events	Number	0	0
Nursing Care Indicators	4. PAR (Patient at Risk) score	Percentage	49%	95%
Deteriorating patient	5. Monthly Crash Calls Per 1000 Discharges	Rate	2.3	
Falls prevention	6. Falls and found on floor (Feb '12)	Number	247	
High Risk Medications	7. Percentage of Eligible Patients with VTE Prophylaxis or Full Anticoagulation	Percentage	94.4%	90%
	8. Eligible patients with a VTE risk assessment complete	Percentage	91.3%	90%
Pressure sores	9. Pressure sores per 1000 bed days - On admission (Feb '12)	Rate	3.1	
	10. Pressure sores per 1000 bed days - Since admission (Feb '12)	Rate	1.4	
EMSA	11. Eliminating mixed sex accommodation breaches- unjustified	Number	0	

Status Key - Where there is no definitive target for a measure, the status colour refers to -
 - a sustained improvement (using SPC methodology)
 - where the outcome is within expected variation (no improvement)
 - special cause or sustained drop in performance

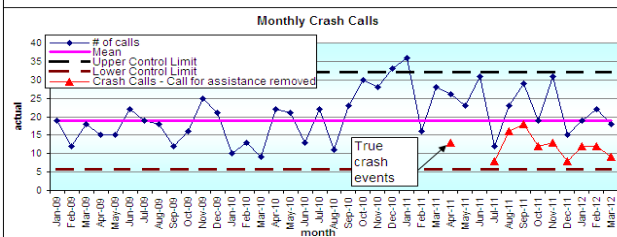
Data in Statistical Process Control (SPC) charts



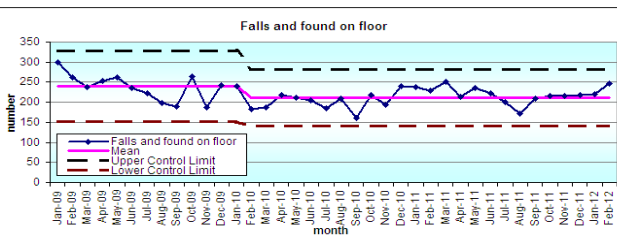
1. figures do not include deaths from community



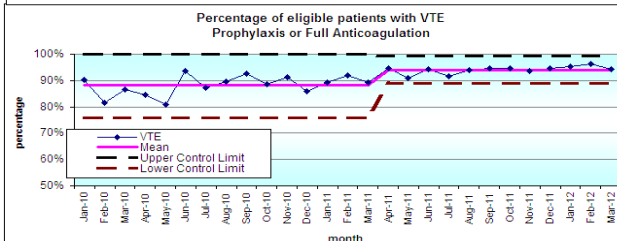
4. No nursing care indicator data collected in July-11, Sept-11 and Feb-12.



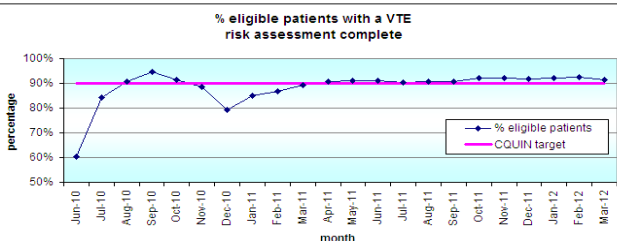
5. From July we are now able to filter out crash calls 'for assistance'. True crash call events are the red triangle.



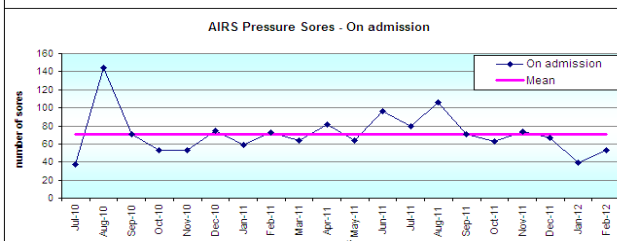
6. These figures do not include incidents from community. Web based reporting for AIRS from Nov-11.



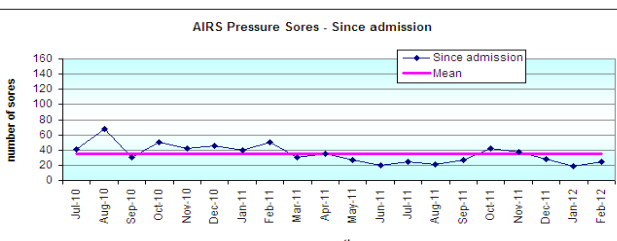
7. These figures include eligible patients. Limits recalculated from April 11.



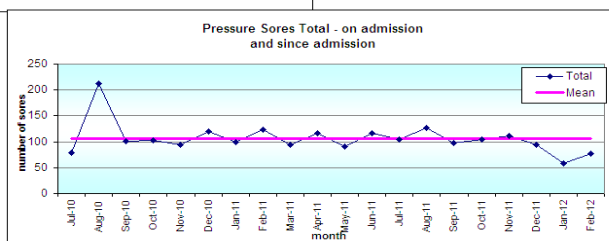
8.



9. This chart details number of pressure ulcers on admission only. Figures do not include community units.



10. This chart details number of pressure ulcers since admission only. Figures do not include community units.



Quality & Safety Dashboard

March 2012

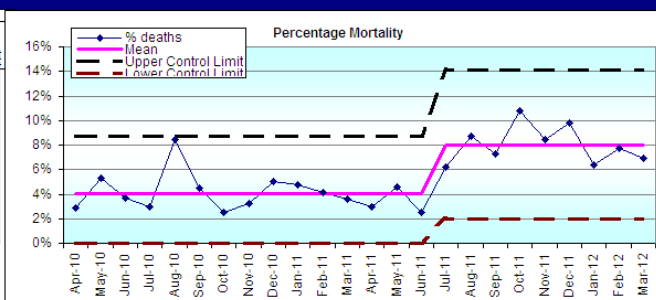
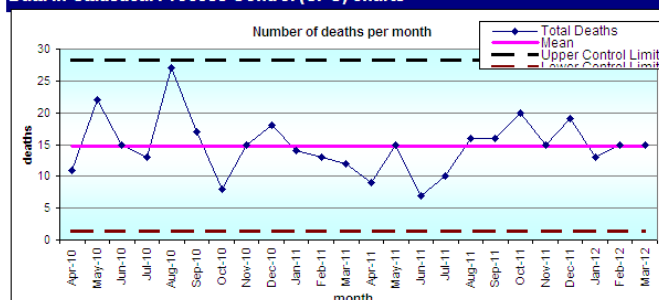
Performance Scorecard - Community

Area	Metric	Units	Mar-12	Target
High Level Aims	1. Mortality	Percentage	6.9	
	2. Never events	Number	0	
Falls prevention	3. Falls and found on floor (Feb'12)	Number	21	
Pressure sores	4. Pressure sores - On admission (Feb'12)	Number	9	
	5. Pressure sores - Since admission (Feb'12)	Number	4	

Status Key - Where there is no definitive target for a measure, the status colour refers to -

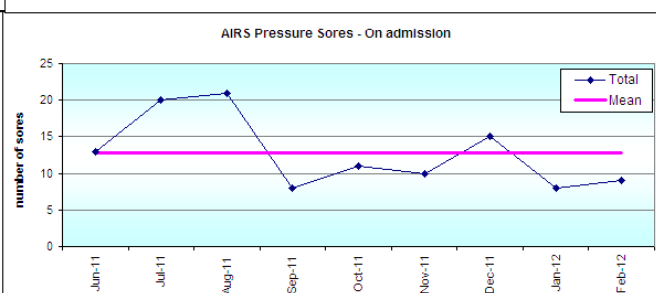
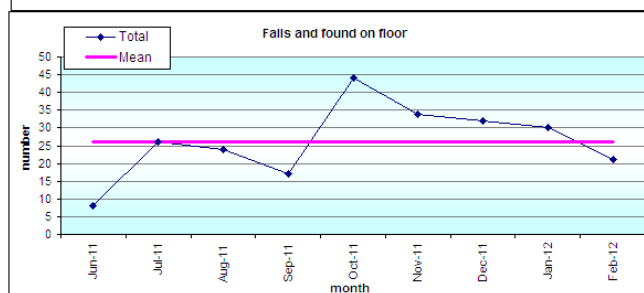
- a sustained improvement (using SPC methodology)
- where the outcome is within expected variation (no improvement)
- special cause or sustained drop in performance

Data in Statistical Process Control (SPC) charts



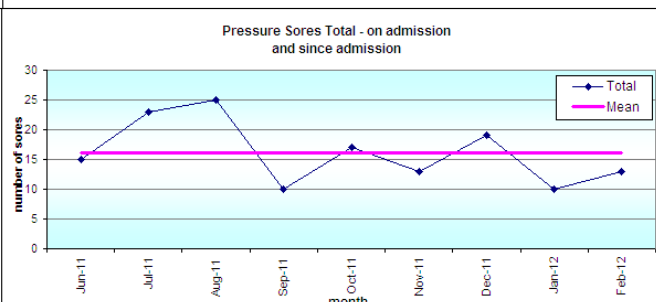
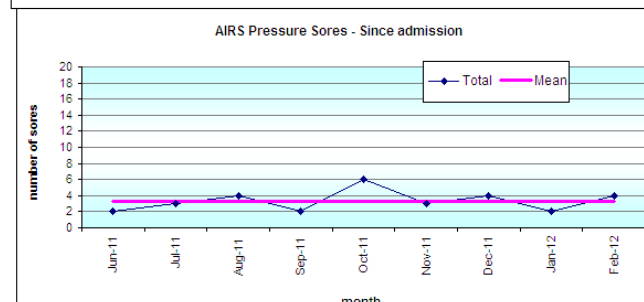
1. Now includes all sites - Archways, St Monica's Hospital, The New Selby War Memorial Hospital along with Whitby and Malton Hospital.

1. Less electives discharges due to theatre closures results in the increased mortality percentage.



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

4. Data includes all community (Archways, Selby, St. Monicas, Whitby and Malton and virtual wards) Further work needed to refine Datix coding for the 'on admission' and 'since admission' coding for community sores.



5. Data includes all community (Archways, Selby, St. Monicas, Whitby and Malton and virtual wards) Further work needed to refine Datix coding for the 'on admission' and 'since admission' coding for community sores.

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Council of Governors – 23 May 2012

Chief Nurses Report – Quality of Care April 2012 report

Action requested/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.

Summary

The Chief Nurse report provides both assurance against the implementation of the Quality & Safety Strategy and evidence in support of our Quality Account. This slightly revised format now includes updates on key elements of progress and challenges to the national patient care priorities.

Content of the report is as follows:

- Key priorities
- Nursing care indicators
- Nursing and midwifery workforce
- Update on professional issues
- Patient experience
- CQUIN

Strategic Aims

Please cross as appropriate

- | | |
|---|-------------------------------------|
| 1. Improve Quality | <input checked="" type="checkbox"/> |
| 2. Improve our effectiveness, capacity and capability | <input checked="" type="checkbox"/> |
| 3. Develop stronger citizenship through our working with partners | <input type="checkbox"/> |
| 4. Improve our facilities and protect the environment | <input type="checkbox"/> |

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 April 2012.

Risk	Associated risks have been assessed.
Resource implications	Risk regarding CQUIN income.
Owner	Elizabeth McManus, Chief Nurse
Author	Michelle Carrington, Assistant Chief Nurse
Date of paper	April 2012
Version number	Version 17

Council of Governors - 23 May 2012
Chief Nurses Report – Quality of Care April 2012 report
1. Key priorities
The High Impact Actions (HIAs) for nursing and midwifery along side the nursing care indicators (NCIs) are the priorities for improving standards of care and the patient experience.
1.2 Summary of changes since last report
<ol style="list-style-type: none"> 1. There have been 2 grade 3 pressure ulcers in the month of March – local benchmarking is difficult as different grades / categories used. However from April categories will be the same. 2. There has been one fall resulting in serious harm in the month of March 2012 (community hospital), however there was one fall resulting in serious harm during February (fractured neck of femur) root cause analysis complete. The RCA will be presented to Executive Board as part of the Medical Directors report.
2. Nursing Care Indicators (NCIs)
<p>March NCI results can be found at appendix 1.</p> <p>A full review of the questions in the NCIs has been undertaken in March. Some amendments have been made to ensure they are still fit for purpose and better reflect nursing practice. This will to some extent explain why the scores may be lower than we would wish. An example would be:</p> <p>Waterlow assessment for patients on the SKIN bundle – the requirement is for reassessment every 3 days. We know that this does not happen consistently and has made little difference to patient outcome. All other reassessments are repeated each week. Therefore we have changed the question to reflect weekly reassessment of waterlow.</p> <p>Intentional rounding (patient comfort rounds) update:</p> <p>An audit of rounding is now to be included in the nursing care indicators from April (patients with comfort round documentation and compliance with completion).</p>
3. Harm Free Care
<p>Harm free care is a new mind set in patient safety improvement changing the culture of patient safety language into one of harm prevention rather than number of harms that may occur.</p> <p>Harm free care is defined nationally as the absence of four harms:</p> <ul style="list-style-type: none"> • Pressure ulcers • Falls • Urinary catheter infections and

- VTE

The case for change was discussed at Board of Directors in March.

4. Nursing and Midwifery Workforce

Calderdale framework

The Calderdale Framework is a transformational service development tool that enables services to evaluate the competencies required of the staff delivering that service. It facilitates the development of new roles, a flexible and competent workforce with transferable skills, who can work across professional boundaries.

Since the last Chief Nurse report the Calderdale team have trained 3 individuals as facilitators of the Framework. The first service area to undertake service and task analysis is Ward 31; with service analysis scheduled for June 2012 and task analysis in July. Ward 31 will be supported throughout the process by the Calderdale Team. The Trusts trainee facilitators will use the Ward 31 experience to supplement their facilitator training before rolling out the framework in their own service areas. The Vascular Imaging Unit, Sexual Health, Day Unit and Ward 15 are also scheduled to commence service review using the Framework in the forthcoming months.

It is envisaged that the development of new roles identified through the Framework will dovetail with the apprenticeship pilot and the Certificate in Higher Education so that any new roles identified are underpinned with the appropriate theoretical educational programme.

Review of Temporary Workforce Provision

NHS Professionals (NHSP) has provided a temporary nursing and support worker workforce solution to York Acute Trust since 2004. Community services and Scarborough run a combination of an internal bank and the use of agency provision to cover their temporary workforce needs. NHSP will introduce a mandatory new pricing framework in April 2012; the pricing framework operates on 'thresholds' based on historic demand for temporary staff. The wider organisation has been offered an extension to current provision in light of the potential acquisition of Scarborough and the wider community.

This extension enables a review of the wider organisations temporary workforce needs; to ensure that the future model moving provides value for money, robust governance and is able to meet the demands of a complex organisation.

The review will commence in April 2012 and will present an options appraisal in September 2012; it is anticipated that the options for consideration are;

- Adoption of the NHSP pricing framework and roll out of provision to the wider organisation
- Establishment of an internal bank, exploiting the e roster bank module
- A hybrid model including an option for existing staff to work on a bank basis and bank only provision through NHSP or another temporary workforce provider

The revised model must be fully operational across the wider organisation by April 2013.

5. CQC revisit

The CQC visited the trust on Thursday 15th March 2012 in response to an anonymous letter received concerning standards of care and environment on ward 23. 2 Inspectors visited the

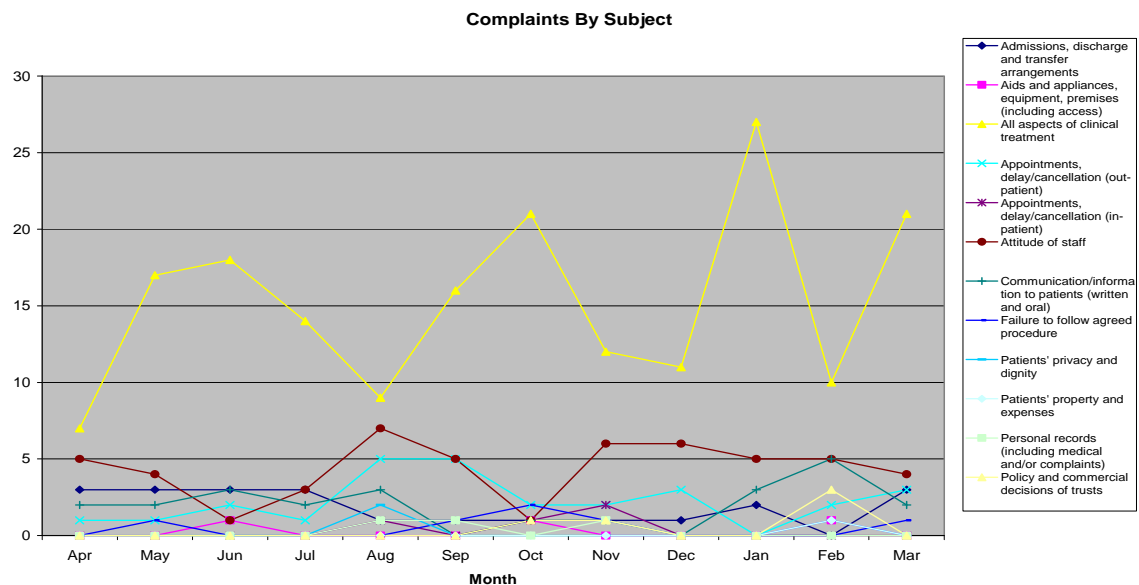
ward and found the claims completely un-substantiated.

The CQC also visited the Trust on 21 March 2012 as part of a national review on consent for those services regulated for termination of pregnancies. The CQC feedback indicates that the Trust is fully compliant in this area.

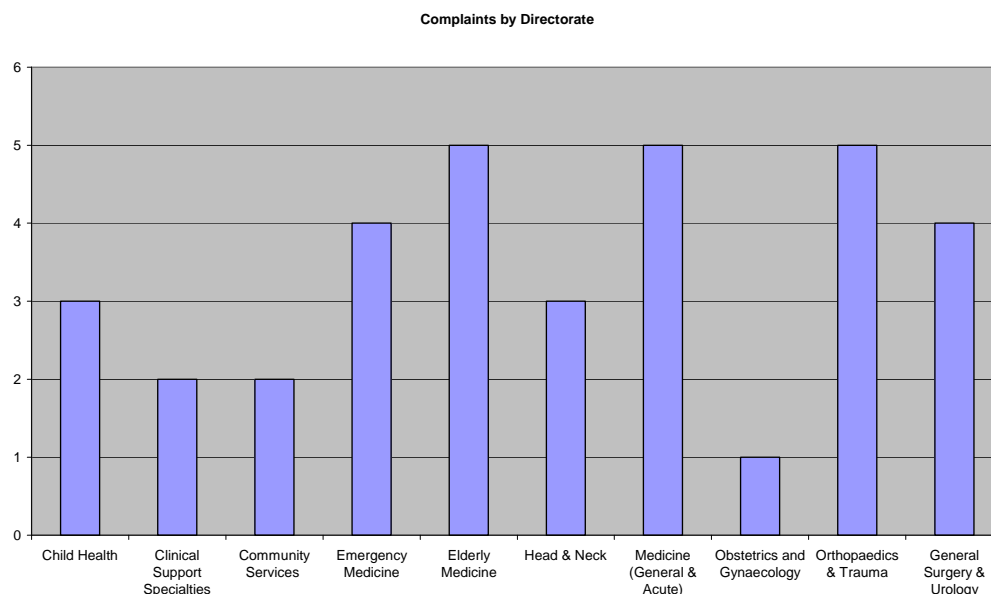
6. Patient experience

Complaints:

The following graph shows complaint themes over time. Further more detailed information will be available once the new bespoke software is in place due to be implemented as detailed in the Systems and Network integration plan.



Complaints by directorate:



There were 34 new complaints this month.

The top 3 complaint issues are:

- Aspects of clinical care / treatment 65%
- Staff attitude 11%
- Admissions/Discharges & Appointment Delay/Cancelled both 9%

Improvements in complaints processes:

15 % of complaints extended this month, down from 35%

26% of complaints returned to PET late, down from 35%

PALs

There were 385 PALs contacts this month.

Example of how PALs have helped:

A patient was asked to attend an out patient gynaecology physiotherapy class post surgery. This was held on ward G2 which is a post natal ward.

The patient was very upset as the surgery she had undergone had left her unable to have children. The area has acknowledged the distress this caused and will alter the invite letter in future to make this clear. They are also looking to hold the classes in a different location.

PPI update

National Surveys.

Inpatient Survey 2011:

Feedback to staff and patients will take place during May following the CQC report and the lifting of the embargo.

Cancer Care Survey 2011:

Co-opting patients to complete the survey continues. The Trust has a current response rate of 60% which places us in the top grouping nationally.

Accident & Emergency 2011:

Co-opting patients to complete the survey will commence in May.

Outpatient Survey:

Feedback to patients and staff is taking place this month. An action plan is being developed.

York LINKs update:

Access to Food in Hospital:

York LINKs presented their Access to Food in Hospital report to matrons involved in their visit carried at a special presentation this month. Further details will appear in Staff Matters.

Overall their findings were positive.

The Trust has now responded to the recommendations and will take forward the Trust's actions accordingly over the next year.

HealthWatch:

The new Health and Social Care Bill means that LINKs will change and become a Local HealthWatch. Locally, HealthWatch will continue to provide the 'consumer voice' of the local population but their function will change from that of an advisory role to taking a representative and influencing role on the new Local Authority Health and Wellbeing Board. LINKs will continue to make sure that local people have a voice on health and social care issues whilst preparing to handover to Local HealthWatch in April 2013; later than had previously been expected due to delays in the Health and Social Care Bill being passed. Representation from the trust is via the Chairman and PPI lead.

Other PPI activity:

PPI Specialist has been working with one of the Clinical Leads to develop a patient experience questionnaire to be used across four surgical wards from late April 2012. Surgical Board are now considering the questionnaire. It is hoped that governors from the hospital will be involved in capturing the information across these wards.

Changes made as a consequence of PPI

Following the Patient and Public Involvement in ED findings and subsequent recommendations, a sub group from the PCT/Trust and MH Trust are now looking at the how patients with mental health problems are signposted to ED. The existing pathway is being considered.

7. Commissioning for Quality & Innovation (CQUIN) Payment Framework

Work has started with our commissioners to develop the CQUIN suite of indicators for 2012 / 13. Acute / community and specialist commissioning CQUIN attract a total of £10 million. National indicators for acute services for 2012/13 are:

- VTE assessment (no change)
- Patient experience (no change)
- Dementia care (new) and
- Safety thermometer (new)

We are awaiting the final detail of these indicators.

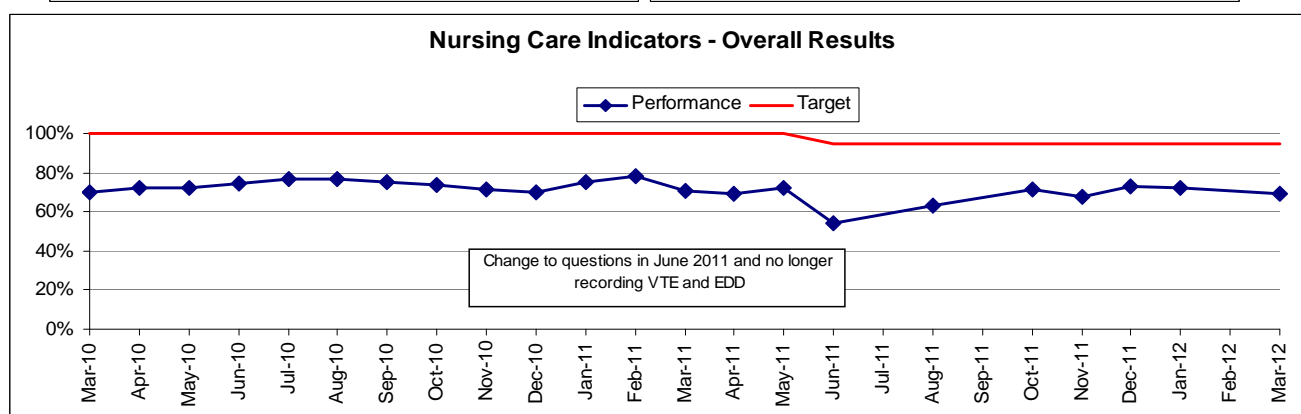
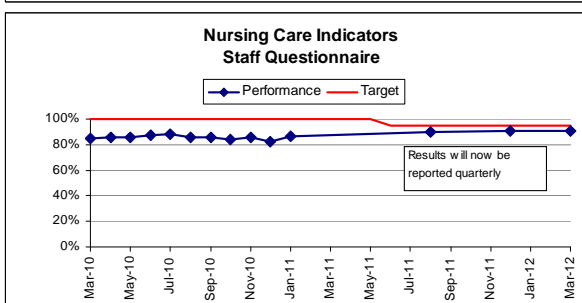
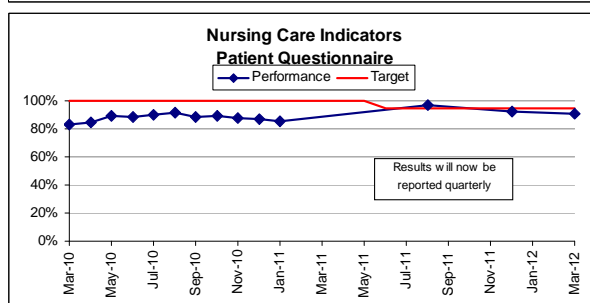
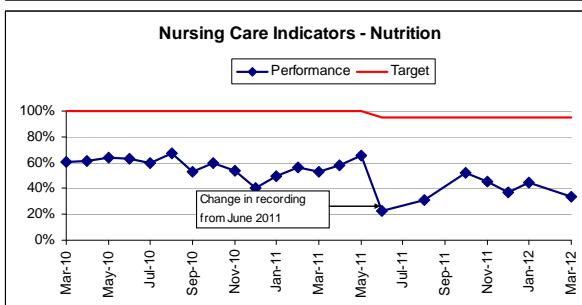
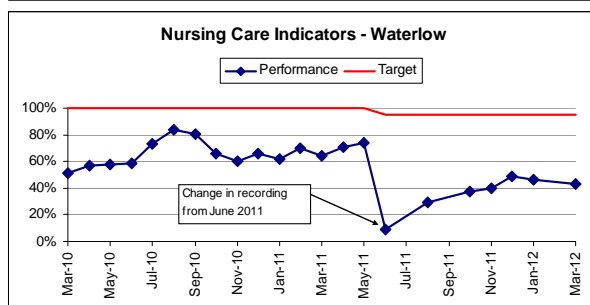
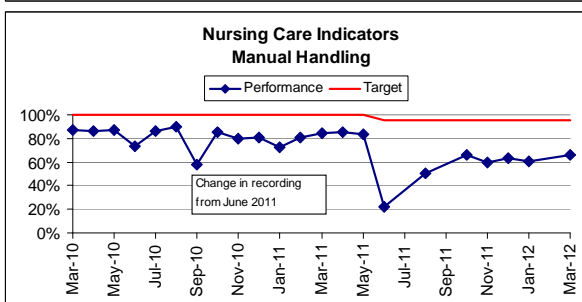
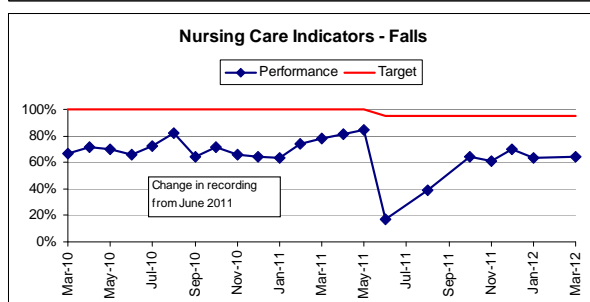
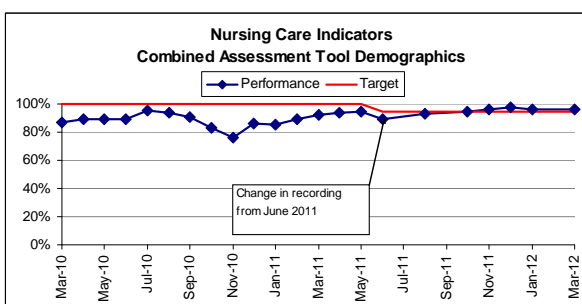
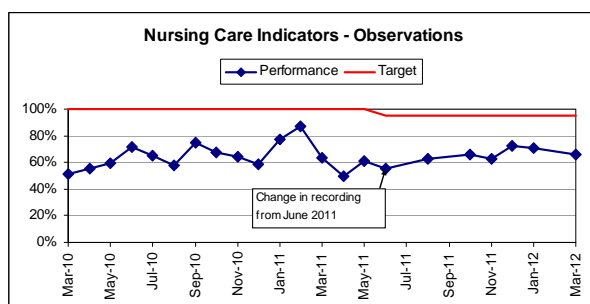
A CQUIN delivery group has been established to manage CQUIN going forward and this group will report into Corporate Directors, Executive Board and Board of Directors. Future reporting will be through the Corporate Dashboard.

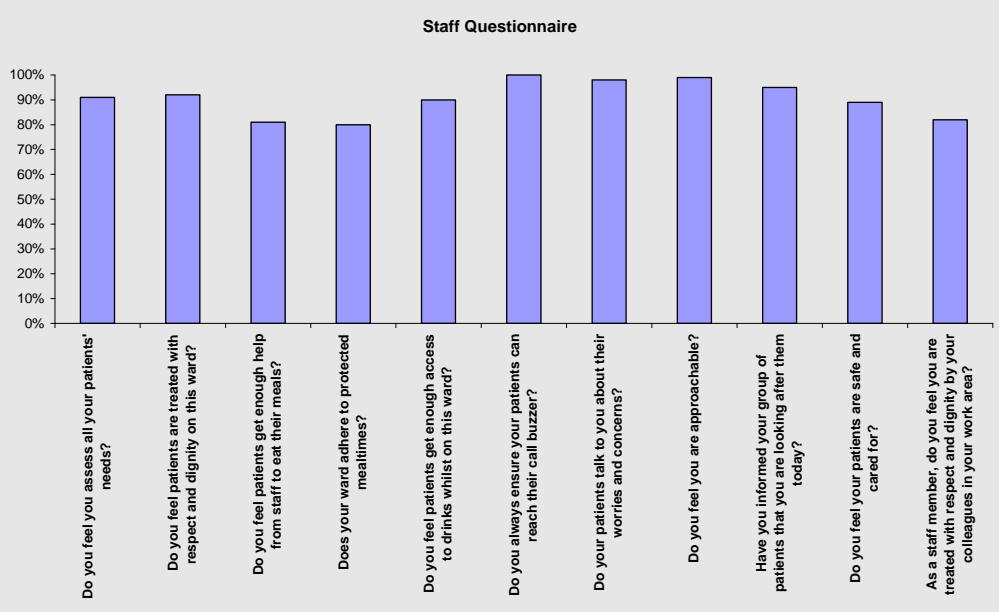
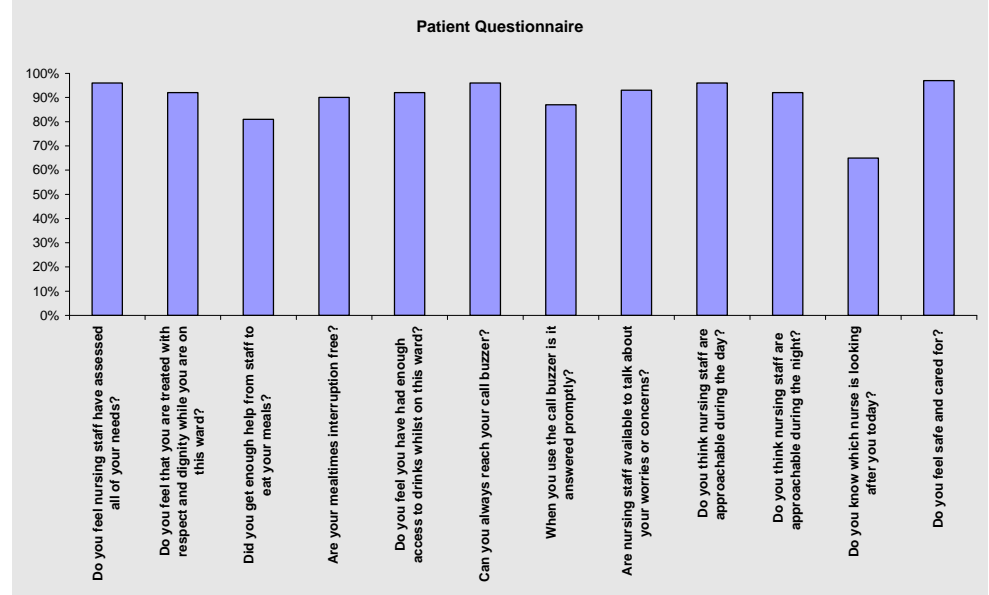
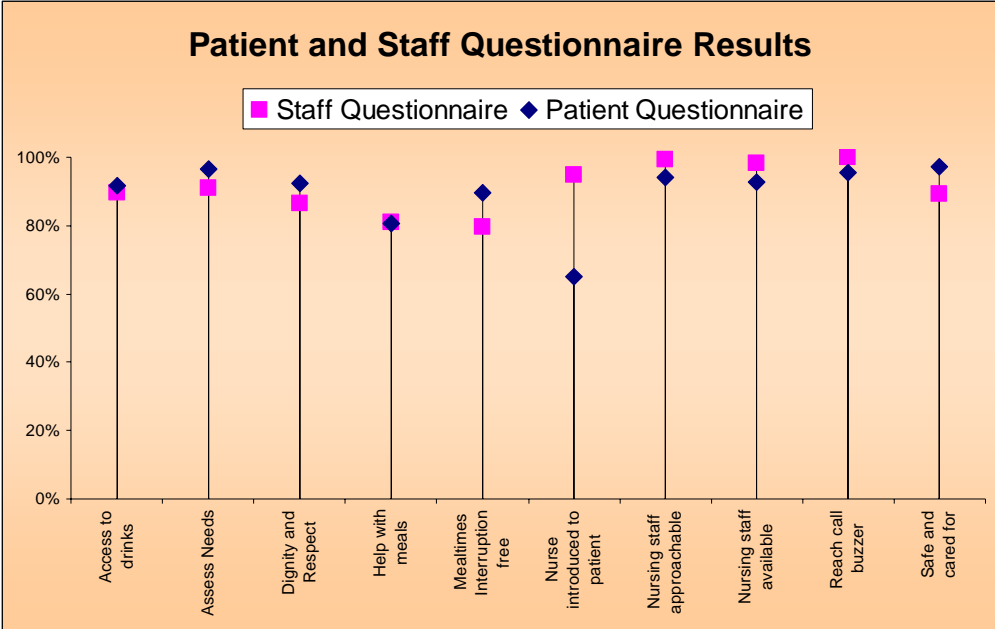
8. Recommendation

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.

Author	Michelle Carrington, Assistant Chief Nurse
Owner	Elizabeth McManus, Chief Nurse
Date	April 2012

Nursing Care Indicators results (prior to change in questions, April report will show the new question results)





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Board of Directors – 25 April 2012

Finance Report

Action requested/recommendation

To note the contents of this report.

Summary

This report details the financial position for the year ended 31st March 2012.

At the end of March, there is a net I&E surplus for the year of £0.65m means the Trust finished broadly on plan. CIPs achieved by the year end totalled £15.3m, resulting in the CIP position finishing ahead of plan by £1.1m. Income for NYY and other PCTs is estimated to be ahead of plan. Cash at £7.6m is higher than plan. Capital programme spend for the year was £1.0m behind plan.

The Trust finished the year with a provisional Monitor Financial Risk Rating of 3, which is on plan.

Strategic Aims

Please cross as appropriate

- | | |
|---|-------------------------------------|
| 1. Improve Quality | <input checked="" type="checkbox"/> |
| 2. Improve our effectiveness, capacity and capability | <input checked="" type="checkbox"/> |
| 3. Develop stronger citizenship through our working with partners | <input checked="" type="checkbox"/> |
| 4. Improve our facilities and protect the environment | <input checked="" type="checkbox"/> |

Implications for equality and diversity

None directly identified.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report Prepared for presentation to the Board of Directors.

Risk There are financial risk implications identified in the report.

Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	May 2012
Version number	Version 1

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST

Financial Report for the Period 1 April 2011 to 31 March 2012

High Level Overview

A net I&E surplus for the year of £0.65m means the Trust finished broadly on plan.

CIPs achieved by the year end totalled £15.3m, resulting in the CIP position finishing ahead of plan by £1.1m.

Income for NYY and other PCTs is estimated to be ahead of plan.

Cash at £7.6m is higher than plan,

Capital programme spend for the year was £1.0m behind plan.

The Trust finished the year with a provisional Monitor Financial Risk Rating of 3, which is on plan.

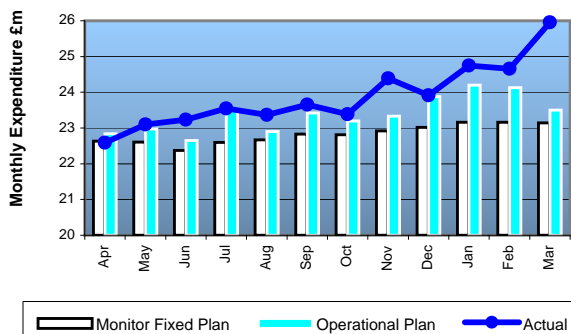
Net Income & Expenditure



The actual net I&E surplus is £0.65m for the period, compared to the plan for the year of £0.70m.

Key variances against Operational Budget: Clinical Income +£4.21m, Other income balance +£1.22m, Expenditure +£5.48m

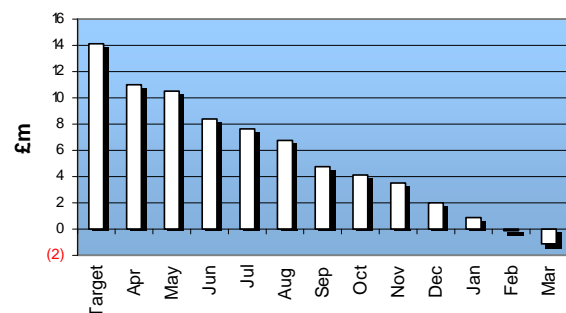
Expenditure



At the end of March there is an adverse variance against operational expenditure budgets of £6.02m. This comprises:-

- Operational pay being £2.219m overspent.
- Drugs £0.975m overspent, mainly due to overspending on high cost excluded drugs partially offset by underspending on Lucentis and HIV drugs.
- Clinical supplies £2.3m overspent with continence products in the community and hire of the MRI mobile unit key overspends.
- CIPs are £1.018m ahead of plan, and there are £1.544m other overspending including planned slippage.

CIP Outstanding Requirement

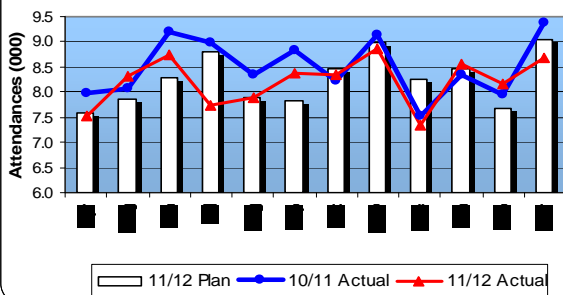


The full year efficiency requirement is £14.2m. With £15.3m cleared at the year end the target has been overachieved by £1.1m.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST

Financial Report for the Period 1 April 2011 to 31 March 2012

Outpatient First Attendances



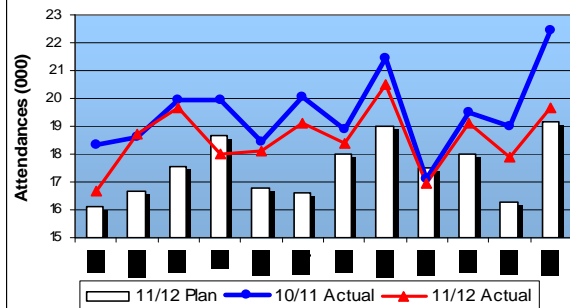
Annual Plan (Attendances) 99,141

Variance at end of March: (Attendances) -633 (-0.6%).

T&O (+26%), Haematology (+9%), GUM (+8%), Urology (+10) ahead of plan.

Ophthalmology (-11%), Obstetrics (-69%), Gynaecology (-14%), Dermatology (-11%) behind plan.

Outpatient Follow Up Attendances



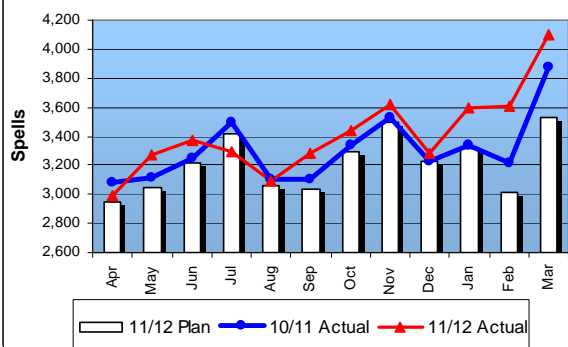
Annual Plan (Attendances) 210,336

Variance at end of March: +12,178 attendances (+5.8%)

T&O (+41%), Rheumatology (+10%), Dermatology (+20%), GUM (+11%), Oncology (+25%), ENT (+11%), Orthodontics (+59%) ahead of plan.

Ophthalmology (-2%), Obstetrics (-31%) behind plan.

Elective Activity



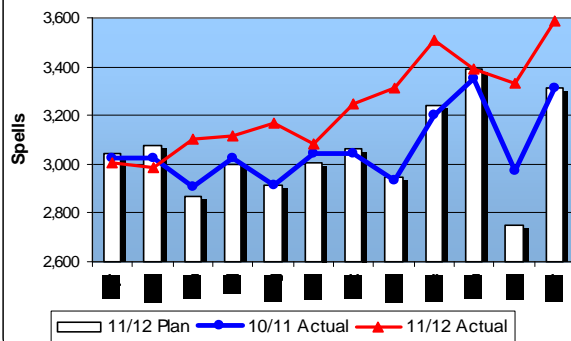
Annual Plan (Spells) 38,601

Variance at end of March: +2,343 spells (+5.2%): inpatient -766; daycase +3,109.

General Surgery (+10%), Urology (+8%), Haematology (+19%), Oncology (+131%), MaxFax (+13%), Rheumatology (+11%), Anaesthetics (22%) ahead of plan

Ophthalmology (-10%), Gynaecology (-19%), ENT (-20%) behind plan

Non Elective Activity



Annual Plan (Spells) 36,617

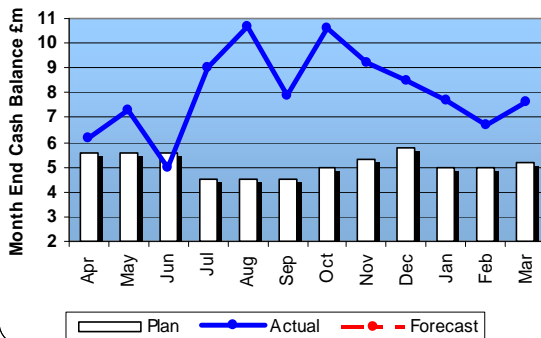
Variance at end of March: +2,230 spells (6.1%)

General Medicine (+12%), Elderly Medicine (+6%), Trauma and Orthopaedics (+16%), ENT (+44%), Urology (+25%), MaxFax (49%), Paediatrics (12%) ahead of plan

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST

Financial Report for the Period 1 April 2011 to 31 March 2012

Cash Position

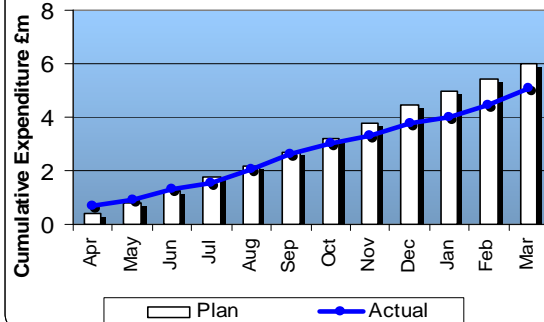


Cash balances at the end of March totalled £7.6m, £2m higher than plan, mainly due to capital slippage

Monitor Liquidity Ratio

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

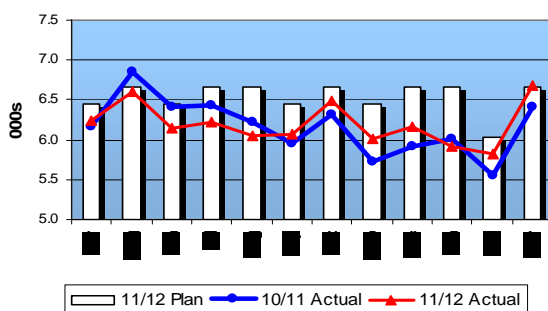
Capital Programme



Capital expenditure at the end of March totalled £5.1m, and was £1m behind plan.

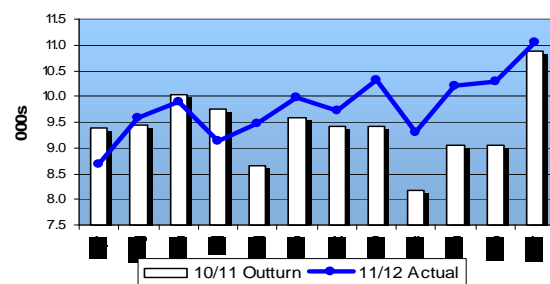
Schemes in progress include: MRI, pharmacy robot, maternity ventilation, endoscopy environment, linen storage, automated switchboard, lift replacement, radiology reporting, estates compliance, pathology cut up and works in ED.

ED Attendances



Annual Plan (Attendances) 78,471
Variance at end March: -4,059 attendances (-5.2%)

Referrals (All Sources)



Annual plan 112,876 referrals (based on 2010/11 outturn)

Variance at end of March: +4,727 referrals (+4.2%)

GP referrals +552 (1%)

Cons to Cons referrals +588 (+5%)

Other referrals +3,587 (+10%)

Council of Governors – 23 May 2012

Corporate Dashboard – Quarter 4

Action requested/recommendation

The Council of Governors is asked to note the report.

Summary

The Trust's performance against the key performance indicators (KPIs) is reported to Monitor on a quarterly basis. Failure to deliver on any of these KPIs will attract a Monitor "weighting" affecting our governance rating.

The dashboard for Q4 shows that the Trust is compliant in all but one of the indicators – 18 week admitted – 95th percentile treatment time. The reason for this was because of the plan agreed between the Trust, PCT and Monitor to focus attention in Q4 on the reduction of those patients who had waited longer than 18 weeks in preparation for the introduction of the new "incomplete pathways" target (8% aggregate). This strategy was successful in reducing the backlog by 400 patients.

The remaining "red" on this dashboard refers to our MRSA total which was 6. The national objective for MRSA for this Trust was 2 cases. The Monitor de minimis (the level above which we attract a weighting score affecting our Governance rating is 6).

Actions are already in place to ensure that KPIs are delivered for Q1. Principle areas of risk are Cancer 62 day and 14 day (fast track) referrals.

Strategic Aims

Please cross as appropriate

- | | |
|---|-------------------------------------|
| 1. Improve Quality | <input checked="" type="checkbox"/> |
| 2. Improve our effectiveness, capacity and capability | <input checked="" type="checkbox"/> |
| 3. Develop stronger citizenship through our working with partners | <input type="checkbox"/> |
| 4. Improve our facilities and protect the environment | <input type="checkbox"/> |

Implications for equality and diversity

No implications for equality and diversity.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report	This report is only produced for the Executive Board and Board of Directors.
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Risk	There is no risk.
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Resource implications	There are no resource implications.
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Owner	Gordon Cooney, Director of Performance
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Author	Lucy Turner, Deputy Director of Performance
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Date of paper	May 2012
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Version number	Version 1
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Quarterly Dashboard



Safety

Metric	Target	Status	Sparkline	2011-Q3	2011-Q4
CDIFF >72hrs (YTD) (M)	52	Green		24	34
MRSA Bacteraemia >48hrs (YTD) (M)	2	Red		1	6
MSSA >48hrs (YTD)				13	23
E-Coli >48hrs (YTD)				46	60

Quality

Metric	Target	Status	Sparkline	2011-Q3	2011-Q4
Cancer: 14 Day Fast Track (M)	93%	Green		95.5%	
Cancer: 14 Day Breast Symptomatic (M)	93%	Green		95.7%	
Cancer: 31 Day 1st Treatment (M)	96%	Green		98.7%	
Cancer: 31 Day Subsequent Treatment - Surgery (M)	94%	Green		94.1%	
Cancer: 31 Day Subsequent Treatment - Anti Cancer Drug (M)	98%	Green		99.5%	
Cancer: 62 Day Cancer (M)	85%	Green		87.1%	
Cancer: 62 Day Cancer - Screening (M)	90%	Green		96%	
Percentage of Patients spending less than 4 hours in the Emergency Department - All Types (M)	95%	Green		96.74%	96.65%

Patient Experience

Metric	Target	Status	Sparkline	2011-Q3	2011-Q4
18 Week Admitted - 95th Percentile Treatment Time (Weeks) (M)	23	Red		22	35
18 Week Non-Admitted - 95th Percentile Treatment Time (Weeks) (M)	18.3	Green		14	15

Care Quality Indicators (CQUINS)

Metric	Target	Status	Sparkline	2011-Q3	2011-Q4
Acute - VTE Risk Assessment (M S C)	90%	Green		100%	91.9%

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Summary of Board of Directors minutes

This report provides the Council of Governors with a summary of the discussions held at the Board of Directors.

Summary of the minutes of the Board meeting held on 25th January 2012

Learning from patient feedback

The Board has for the last year received letters of complaint and compliment at Board meetings, interspersed with presentations from staff or other patient feedback items. Ms McManus reflected on the last year; she believes that the mix of letters and presentations has improved the Board understanding and knowledge of the issues patients are experiencing and the problems they have, along with the depth of appreciation of some of the excellent work staff do. The letters have enabled the Board to receive information at different levels, so enhancing their understanding and assurance.

The Board discussed the time spent in Board around learning from patient feedback. All members of the Board felt it represented a good use of Board time and would wish to continue having the letters. Professor Willcocks added that she felt the Trust during the year had invested substantially in the voice of the patient in the appointment of specific members of staff and changes in systems. She asked that each year an annual reflection of the impact of the investment was undertaken and presented to the Board.

Action: Annual reflection on the investment made in ensuring the Trust is learning from patient feedback.

Mr Crowley added that he was very supportive of continuing the receipt of letters at Board. He added that the Board had rightly not got into the debate on the whys and wherefores of the letters, but he did feel that the Board should have more focus on what was looked at around the root cause of some of the letters, in terms of the issue being one of behaviours or system. Mr Crowley gave the example of the interaction of patients and staff in the elderly services. where there are comments that some patients would be cared for better if they were in the right environment. Dr Turnbull added that community hospitals in the main provide care to elderly patients as an alternative to acute care.

Action: Mr Rose proposed that the discussion around the Trust's strategy towards care of the elderly should be the subject of a further discussion at a future Board session.

In summary Mr Rose said that Board would carry on receiving letters, and that there should be items brought in from Scarborough/Bridlington, community services and community hospitals.

Chief Nurse Report

Mrs Palazzo raised a number of points:

Complaints – Mrs Palazzo asked about the use of the operation of the Datix system and the way the

system only logs where the patient enters the organisation rather than where the complaint relates to. Ms McManus confirmed that was how the system worked. She advised she would need to investigate if the system can be changed to show where the complaint originated rather than how the patient came into the Trust. Mr Crowley suggested that it might just be how the categories of complaints works that need to be adjusted.

Initiatives on nutrition and hydration – Mrs Palazzo congratulated Ms McManus on the work, but asked if she was now sure that the Trust was compliant with the CQC requirements. Ms McManus reminded the Board that at the recent visit in July, CQC had identified an area (Ward 37) where the standards of care around hydration and nutrition fell short of the acceptable standard. Considerable work has been undertaken in the ward and some of the improvements have now been rolled out further. An example would be the use of red jugs. Monitoring also continues as part of the general monthly audits. Ms McManus added that the Trust is also using volunteers to help in some aspects of the hydration and nutrition. Volunteers are used to support meal times by helping with hand washing, or sitting with a patient while they eat their meal, (but not feeding the patient).

Dr Turnbull added that it should be remembered that the CQC undertook a specific nutrition and hydration review in the early part of 2011 and the Trust was commended for excellent work.

CQC report – Mrs Palazzo noted the re-inspection report from the CQC. Ms McManus advised that there are two further reports the CQC would be coming back to the Trust to follow up, and Ms McManus was expecting them any day as the action plans had now been completed. Ms McManus agreed that the report was excellent news.

Pressure ulcer audits – Mrs Palazzo again noted the excellent results of the audits, she added that it was very good to see that the initiative was for the benefit of patients, but the Trust had also benefited financially. Ms McManus added that the primary focus was to improve the quality of care for patients; she added that it was now part of everyday work. Ms McManus advised that she would bring some further information around care rounds to the Board in the next few months.

Action: Ms McManus to include care rounds in her Chief Nurse report.

Quality report – Ms McManus asked the Board to approve that the external auditors would audit MRSA and 62-day cancer as part of the requirements of the Quality report. She added that the Governors are also asked to choose a specific quality metric to also be audited. The Governors had chosen World Health Organisation (WHO) surgical checklist.

The Board approved the audit for MRSA and 62-day cancer and noted the choice of the Governors.

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

Medical Director Report

Ms Raper raised a number of areas where she was seeking further assurance and information.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) - Ms Raper asked Dr Turnbull to comment on the training being rolled out around the DNACPR and if Dr Turnbull is comfortable with the timetable and if he believed the CQC will be satisfied with the rollout.

Dr Turnbull advised that the CQC had looked at the policy and application of the policy. The Trust is

now undertaking daily audits which are beginning to show noticeable improvements in the administration of the DNACPR document. The training DVD is available on Horizon for all to access. Other training has included targeted sessions delivered by the solicitor with elderly and general medicine which were very well received. A further session has been arranged for the surgical directorate. The training is also being rolled out to other groups of staff to ensure that everyone who has a role in making sure the documentation is completed correctly are fully trained. Matrons and staff nurses have also had some specific training to provide them with support around their role in the completion of the DNACPR documentation. At present the training is not part of the statutory and mandatory training, but consideration is being given to including it.

Falls resulting from serious harm – Ms Raper asked why the data stopped at October 2011. Dr Turnbull advised that the data had been prepared for the December Board meeting, but since this data there had been one fall in December that had resulted in harm to a patient. Ms McManus added that there have been a couple of patients who have died following a fall, in each case the coroner carried out their investigation and had ruled that the fall was not due as a result of lack of care given by the Trust.

Ms McManus added that the key point is staff recognising avoidable and unavoidable falls; she is currently trying to demonstrate that the care rounds are reducing the number of falls experienced. Dr Turnbull added that the Trust now includes any fall as part of the root cause analysis (RCA) process.

Consultation appointment – Ms Raper expressed concern about the process for appointment of consultants in SNEY and York. She asked if there was now one system used across both Trusts and what safeguards were included in the system to ensure SNEY did not appoint a consultant that would not be required in the enlarged organisation.

Dr Turnbull advised that the process of appointment is effective and innovative; he added that when he discussed the process with other Medical Directors it is clear that the system used in the Trust has significant benefits other systems do not have. Currently the Trust is looking at how the system can be refined further, specifically around the use of the assessment centre. Dr Turnbull added that the Trust is also applying the same process to the appointment of locum consultants.

Ms Raper asked Dr Turnbull to comment on the alignment of the system with SNEY. Dr Turnbull advised that he was not yet fully assured that the alignment was in place, but he was assured that any applicant for appointment made in York or SNEY is advised that the post may be working across both sites, although there have been a small number of appointments.

Mrs Palazzo asked how the cross-working issue would be addressed post-acquisition. Mr Crowley explained that decisions about consultant appointments would be made centrally and not at a hospital level, so any cross-working would be included in the job specification. Professor Willcocks added that the directorates are all at different states of readiness and so getting a coherent approach must acknowledge those differences. Mr Crowley explained that he was assured that the recruitment process would be able to address those differences in the enlarged organisation. He added that the Trust may have more challenges with the existing consultants where they have accepted appointments on the basis that they would be working between Harrogate and York and have located their families accordingly, so asking them to work across in Scarborough may have to be addressed.

Adverse incident reports (AIRs) – Ms Raper asked Dr Turnbull if he was able to supply any trend data for AIRs. Dr Turnbull confirmed that he was arranging for the data to be included in his report.

Action: AIRs trend data to be included in the Medical Director report.

SUItCASE reports – Ms Raper thanked Dr Turnbull of the reports. The Board discussed the reports and noted the detail and Dr Turnbull's comments about the engagement of directorates in the production of the reports.

Clinical negligence claims – Ms Raper asked if the number of claims was high. Dr Turnbull advised that it was not particularly exceptional, but it had been noted that solicitors did tend to have peaks of work being completed during the year – those being at Christmas and at the beginning of the summer holiday.

Walk rounds – Dr Turnbull referred to a paper he had previously circulated produced by the Institute for Healthcare improvement and described the process used for safety walk rounds and the learning being obtained from them. Dr Turnbull agreed to circulate the document again.

Action: Dr Turnbull to circulate the paper produced by the Institute of Healthcare Improvements

Professor Willcocks asked if there was an equivalent system for night time walk rounds. Dr Turnbull advised that it would be the same as the day walk rounds.

Breast prostheses – Dr Turnbull provided some back-ground to the current issue with breast implants. He explained the history of the Polly Implant Prostheses (PIP) and stated that about 40,000 women in the UK are affected, a large proportion of which had private surgery. Studies currently show that a ruptured implant does not increase the risk of cancer, but other complications, mainly cosmetic but also some psychological, may be experienced. Dr Turnbull advised that the Trust had received a number of referrals and guidance had been given to those patients.

At present the NHS nationally had been very clear that a patient can have the implant removed and replacements will not be implanted. The Trust has received guidance, but removal without putting an implant back would leave women with a poor cosmetic result. There is further advice to be published nationally.

The breast surgeons have been very proactive and have produced a specific consent form which collects the specific data required. The PCT have been in touch with the Trust and asked for information on the patients that are coming forward.

The Board **thanked** Dr Turnbull for his comments.

Director of Infection Prevention and Control Quarterly Report

Ms McManus explained that there were some concerns around the environmental aspects of cleaning. The concerns being raised have not been evidenced on the compliance reviews, but Mr Golding is undertaking some work around the recruitment and retention of cleaning staff and work is being undertaken to identify the thematic list by infection control and the corporate nursing team. Ms McManus added that she would expect any risk aspects to be discussed in the Risk and Assurance Committee at the next meeting.

Mr Rose asked if Dr Turnbull could comment on the flu vaccination campaign. Dr Turnbull advised he would bring the information back to the next Board of Directors, but the percentage of up take has

been lower than in previous years, due to the integration with Community Services

Action: Dr Turnbull to include flu vaccination campaign in the next MD report.

Mr Rose asked Ms McManus if the DIPC responsibility would remain with Ms McManus on a Trust wide basis following the acquisition. Ms McManus advised it would.

Follow-up from Internal Audit Work around procurement

Mr Ashton advised that the document included in the Board pack has been presented to the Audit Committee and the Audit Committee proposed that the Board of Directors should be aware of the progress in relation to the issue.

Mr Ashton summarized the findings of the report. Professor Hutton noted that the report does demonstrate some generic issues around procurement, rather than specific to the process for the purchase of one piece of equipment, which suggest the issues are systemic.

The internal audit team is working through the process to ensure the actions are clear and there are definitions that need to be clarified.

Mr Bertram added that traditionally the NHS has focused on procurement rather than equipment selection and how the Trust decides to use X product rather than Y is not always clear. He added that he was not surprised by the reports; the process has been shown to be robust, but there are ways in which it can be improved. Discussions have been held at the Executive Board around the potential for continued rationalisation of equipment and consumables and discussions around objectives for the interim head of procurement around the ongoing management of contracts have taken place.

Mr Bertram advised that there are examples of excellence in the Trust in terms of equipment selection e.g. pathology laboratory equipment review and selection. This is being rolled out constantly to new areas, the latest example being an orthopedic trauma equipment tender exercise currently underway.

The Board thanked the Audit Committee for the report and asked to continue to be kept informed of progress.

Chairman's items

Mr Rose reminded the Board of the preparation work being undertaken on 22 February on the session in the afternoon for the Board to Board.

The Board **noted** the comments in his report.

Board review

Mr Rose reminded the Board that it had undergone a review 12 month ago at which point a number of recommendations were made. Mr Rose advised he had reviewed the recommendations and provided some evidence to the level of implementation in his report.

The Board discussed the report and **noted** the evidence.

Chief Executive report

The Board received and discussed the Chief Executive's report.

The Board noted the report.

Amendment to the current Constitution

Mr Rose explained that as a result of the approval process of the acquisition of SNEY the Trust was required to amend the constitution to allow for an extension of the Governors with a period of office of 2 years to 2 years 6 months. This will allow for the acquisition to be completed and the election process to be completed. The Board asked if the Council of Governors had considered the change and if they were happy for the change to take place. Mrs Pridmore confirmed that the Governors had discussed the change and recommended approval of the change to the Board of Directors.

The Board of Directors approved the change and asked Mrs Pridmore to submit the change to Monitor for final approval.

Action: Mrs Pridmore to submit the change to Monitor for final approval.

Annual fire safety report and strategy

Mr Golding presented the Annual fire safety report and strategy. He outlined the work that had been undertaken during the year and the key point included in the report.

The Board noted the work that had been undertaken during the year around the compartmenting of the main street and understood that work had not begun on the theatres.

The Board thanked Mr Golding for his report.

Operational performance report

18-week RTT -Ms Raper asked Mr Cooney if he could confirm the backlog was being managed and the relevant authorities have approved the approach.

Mr Cooney confirmed that he had approached Monitor and discussed the potential impact of failing the target. He confirmed that Monitor were satisfied with the proposed approach. The PCT have also confirmed that they are satisfied with the approach. To achieve the results, there is considerable micro management being undertaken on the activities by Mr Cooney and his team.

The PCT has requested a detailed report from the Trust on the level of backlog work being addressed; this is common to a request received by all Trusts from PCTs.

Cancer services -The cancer target is assessed on a quarterly basis. There are weekly meetings at patient level to establish where each patient has got to in their pathway.

Emergency Department - The emergency department is achieving the four hour target but there are some issues about the achievement of the other targets. A meeting has been held with the Yorkshire Ambulance Service to discuss how we can assist in the turn round times for ambulances. The Trust is introducing a handover nurse for 6 weeks to evaluate the impact.

There had been a number of cancelled operations during the last month as a result of the shortage of beds; this was due in part to the time of the year and the current busy period. ITU/ HDU bed requirement could not be met, and Surgical Board has been asked to consider the issues and provide some solutions. Four patients were cancelled due to surgeon illness, which is unusual.

Mr Rose noted there was no information on community service. Mr Cooney advised that the dashboard was in development, and would focus on activity around the number of visits, handovers. There is however considerable development to be completed before the dashboard can be considered completed. Mr Cooney handed round a sample of the dashboard for the board to note. Mr Rose asked if there was considerable historical information that could be used. Mr Cooney advised that the historical data is not very reliable, but as time goes on the data will become more robust.

The Board **noted** the report.

Finance reports

Mrs Palazzo asked Mr Bertram if he would comment on the income being ahead of plan and the impact of that with the PCT. Mr Bertram advised that the current overtrading level has been recognised by the PCT and that there is continuous assessment of the position. This is causing the PCT additional financial problems and the Board should be aware of that. Mr Bertram also confirmed that there are no material contract disputes at this stage of the year.

Mrs Palazzo noted that the Trust was under-spent in Lucentis and the income was down. Mr Bertram explained that Ophthalmology are working hard to deliver the service. Mr Bertram advised that they have completely revised the model to ensure it is delivered in line with the National Institute of Health and Clinical Excellence (NICE) guidance and the service is now running ahead of plan month on month. Mr Ashton supported this position following his discussions with the Directorate.

Mrs Palazzo noted the outstanding debts and asked about the non-clinical debt. Mr Bertram explained that the debt is for the purchase of estate services. The PCT is the landlord and buys services from the Trust. The second part of the transaction is where the PCT will charge the parties occupying the premises which in the main are the Trust, so the Trust will be receiving an invoice in the near future. Mr Bertram confirmed he was not concerned about this debt and was in discussion with the PCT over concluding the PCT TCS recharge position.

Mrs Palazzo referred to the efficiency programme; she congratulated everyone on the excellent work that has been achieved. Mrs Palazzo asked about the workforce establishment being below normal levels, but there being an over-spend on staff. Mr Bertram explained that this position relates to a combination of factors including directorates managing their CIP delivery through a vacancy factor and trying ideas out to reduce pay spend as well as activity related pressures and associated additional staffing expenditure.

The Board **noted** the finance and efficiency report.

Q3 report to Monitor

The Board **noted** the declarations and asked Mr Bertram and Mrs Pridmore if there was anything they would like to draw to the Board's attention. Mr Bertram advised that the Board should note the change to the Financial Risk Rating worksheet.

Mr Bertram drew the Board's attention to the risk rating on the report for Q1 and 2. The Trust had reported and been advised by Monitor that it was a FRR of 3 in both quarters, however due to changes made by Monitor in Q3 it now showed a FRR of 2 for both Q1 and Q2. Mr Bertram was in discussion with Monitor over the changes. The Board **noted** the point made by Mr Bertram and asked if Monitor would retrospectively change a FRR. Mr Bertram advised that he did not expect this to be the case. The Board had received confirmation letters from Monitor that the FRR for those two quarters was 3.

Mrs Pridmore drew the Board's attention to the additional targets included in the Monitor declaration of performance. She advised that the Trust was working in accordance with national guidance for those Community Teams that are using CPD to record their activity, and as a systems supplier the Trust is working towards making CPD fully compliant with Community Information Data Sets (CIDS) standard by August 2013. For those Community Teams that are using SystmOne to record their activity, as a provider of services the Trust are awaiting confirmation from TPP (the company that supplies SystmOne) as to when SystmOne will be fully compliant with the CIDS standard. The Board **noted** the point and the recorded level of compliance.

The Board considered the rest of the self assessment and approved the document for submission to Monitor. It was **agreed** that the accompanying letter would be completed outside the Board meeting.

Acquisition Assurance Board (AAB)

Mr Ashton advised that the AAB had met on Monday 23rd January and had considered the papers for approval by the Board. The AAB would propose to the Board that as a result of last minute changes to the Heads of Terms and the impact of those changes the Board should not consider the Board Statements and Memoranda and Reporting Accountant Reports at this meeting, but should postpone consideration and approval to the February / March Board of Directors.

Mr Ashton explained that there were two significant changes made to the Heads of Terms. The first was to change the financial payment of capital,. This change does require a number of the acquisition documents to be reviewed and amended to reflect the 'deal'. Mr Ashton asked that the Board receives revised versions of the documents involved.

Action: The Board to receive revised versions of the documents once the review is completed.

Mr Ashton explained the second significant change related to the timeline. As a result of the national requirements around dissolution orders and transfer orders the acquisition transition would not be completed until 1st July 2012. This again has an effect and allows some additional time to consider the impact on the Trust and SNEY of the delay in completion provides. The biggest impact will be the need for the SHA to continue to support SNEY for the first quarter of 2012/13. Mr Crowley added that he had been in discussion with the SHA and they were keen to explore what options were available to allow the Trust to provide as much support as possible to SNEY, without being preempting the completion of the transaction.

The Board considered the proposal raised by Mr Ashton's report and **agreed** that the Reporting Accountant Reports and the Board Statements and Memoranda should not be approved by the Board at this meeting and should be postponed until the February/ March Board meeting.

Business Case

12/022.1 2011/28: Capacity shortfall in Ophthalmology

Professor Willcocks confirmed she had reviewed the business case and would recommend approval of the business case to the Board of Directors. The Board discussed the business case and noted the wider term vision and opportunity the appointment would provide and **approved** the business case.

12/220.2 2011/35: Dermatology

Mr Ashton confirmed he had reviewed the business case and would recommend approval of the business case to the Board of Directors. The Board **approved** the business case.

Executive Board minutes from the meetings held on 2011

The Board of Directors **noted** the minutes.

Draft minutes of the Audit Committee from 12th December 2011

The Board noted the draft minutes. Mr Ashton asked the Board to confirm approval of the current Standing Orders, Standing Financial Instructions and Scheme of Delegation. The Board confirmed there were no changes to the existing documents and confirmed the **approval**.

Mr Ashton asked the Board of Directors to approve the revised terms of reference of the Audit Committee. The Board **approved** the terms of reference. Mr Rose added that the Non-executive Directors would review the membership of the Board Committees over the next few weeks.

Summary of the minutes of the Board meeting held on 29th February 2012

Learning from patient feedback

Ms Raper read the compliment letter from a patient and Mr. Bertram read a letter from a complainant. The Board **noted** the detail in the letters and reflected on the impact the complaint would have on the individual and how it would be investigated.

Chief Nurse Report

Mr. Rose invited Ms Raper to comment on the report.

Ms Raper asked if Dr Turnbull would comment on the following items:

- a) The number of pressure ulcers that have been seen in the last financial year. Dr Turnbull agreed that it was concerning that there had been a recent rise in the number of cases. Currently the Root Cause Analysis (RCA) investigations are being undertaken. Once they are completed the results will be provided to the Board.

Action: Following completion of the RCA, the results should be included in the Chief Nurse report for presentation to the Board.

- b) The number of occurrences of MRSA. Dr Turnbull advised that at the end of January the Trust had

only had one case of MRSA. During the last month there have been three confirmed cases and there may be a fourth case. There is no common clinical theme to the cases. Dr Turnbull described the detail related to the three confirmed cases. The first case was a patient who had been Hull and was returned to York. The second patient had raised inflammatory markers on admission. The third confirmed case was a patient with end-stage renal failure and it was possibly an unavoidable event. The RCA showed there were no shortcomings in care for the patient. The fourth unconfirmed report was following a routine swab on a pressure ulcer after a patient had been admitted from a care home.

The Board discussed the perceived failings in the system and asked what had been done to ensure that systems are not allowing such cases to occur. Dr Turnbull advised that the Infection Control department, Ms McManus and he had been reminding staff of the importance of making sure that swabs are taken properly. The Trust is normally very rigorous about making sure that a patient is considered positive until it is shown that they are negative.

The Board **noted** the comments.

- c) Ms Raper asked Dr Turnbull if he could comment on the national news items. Ms Raper specifically asked Dr Turnbull to comment on the frontline nursing leadership. Dr Turnbull advised that the Trust is considering how the Trust appoints ward Sisters. Work is also being undertaken to ensure the Sisters' role is much more supervisory than it has been in the past.

Ms Raper asked if Dr Turnbull could explain the 'red tape challenge'. Dr Turnbull advised that this is about the making sure there is consistency of paperwork. Work is underway to make sure that SNEY and the community and the Trust have consistent documents.

Ms Raper asked if there was any work being undertaken around providing a method of identifying which uniforms were worn by which staff. Dr Turnbull advised that there a significant number of uniforms and as a result a short guide is not possible. Dr Turnbull added that an alternative approach has been taken. White boards on all wards show who is in charge of the ward and the details included in the bed information identify who will look after the patient, what types of procedures the patient should expect and what to do if the patient would like to complain. Dr Turnbull went on to advised the Board that the junior doctors would now be wearing uniforms which had 'Doctor' embroidered on them. Professor Willcocks added that the patient forum group was very interested in looking at the patient booklet work that was being undertaken by the patient experience team.

Ms Raper added that Mrs McGale had agreed that she would provide a guide to uniforms for Non-executive Directors.

- d) Ms Raper asked about the e-rostering. Dr Turnbull explained that the purpose was to bring together the efficiencies identified in the e-rostering and how the learning from that system can be used elsewhere in the organisation. Neither Trust has enjoyed high nursing levels, but some of the work that Ms McManus is undertaking is to look at the ward complements.

Ms Hayward suggested that the Assistant Chief Nurse who has been involved in the project (Ms Lucy Connolly) should come to the Board and give a presentation about the work. The Board **agreed** they would like to receive a presentation from Ms Connolly.

Action: arrange for Ms Connolly to give a presentation to the Board of Directors on e-rostering and the additional work around staffing on wards.

- e) Ms Raper enquired what 'acuity' meant. Dr Turnbull explained that it was a reference to how ill the patient is and the level of demand on staff. This obviously varies from ward to ward and patient to patient.
- f) Ms Raper asked if it would be possible to receive trend data on complaints rather than short-term snapshots. It was **agreed** that Ms Raper would pick the issue up with Ms McManus when she returned from leave. Mr. Sweet added that he was expecting that trends would be included in the new dashboard that was being developed by the small team looking at information supplied to Board.
- g) Ms Raper asked about the National Outpatient Survey. Dr Turnbull advised that it was embargoed at present, but would be included in the next Board meeting.

Action: the National Outpatient Survey to be included in the March agenda.

- h) Ms Raper asked about the National Cancer Care survey and the comment in the report about recipients of the survey suggesting that they were not aware of their condition. Dr Turnbull agreed that the concern was justified. He explained the system and how the surveys were sent to patients. Ms Hayward suggested that attaching a letter to front of the survey could resolve the issue if the letter explained the clinic the patient had attended.

The Board felt that was an excellent suggestion and Dr Turnbull **agreed** he would pass the suggestion on.

Professor Hutton asked if there were any data protection issues (DPA). Dr Turnbull added that potentially there could be a DPA issue, but the Trust does have a responsibility to be open with the registrar.

- i) Ms Raper enquired about the Commissioning for Quality & Innovation (CQUIN) Payments report. Dr Turnbull advised that the Dementia Care CQUIN is understood, but does present a challenge to the Trust. A dementia operations group has been formed to help address the issues. Mr. Cooney added that he had discussed national and local CQUINs with the commissioners. A proposal of 36 local targets had been suggested, as a result of the GP commissioning groups putting forward their ideas. The list has now been reduced to 14 local targets and the Trust is working on the data collection. There is a separate group called the CQUIN delivery group which has brought individuals together outside the Performance Management Meetings (PMM) to ensure CQUIN is being delivered. The group is lead by an Executive Director.

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

Medical Director Report

Dr Turnbull advised the Board that the Care Quality Commission (CQC) had attended the Trust during the week and he had now received informal feedback from their team. The CQC visited the York Hospital wards 37, 34 and 24 and St Helen's Rehabilitation Hospital. The CQC were looking at Outcome 5 (Nutrition and Hydration), 2 (Care to consent to treatment – this included the DNAR CPR issue) and 9 (Management of Medicines). The feedback included very positive comments from the CQC, including that they were highly delighted with the work that has been undertaken and that there had been stark improvements. They interviewed patients and staff and confirmed that the Trust was compliant with all outcomes. Dr Turnbull advised that Monitor had been advised, but the amendment

to the Governance rating would not occur until the formal report is received by Monitor. This he expected would be received by the Trust over the next couple of weeks.

Dr Turnbull referred to his monthly report. He asked the Board to **note** the Rheumatology peer review visit summary and the positive comments made in the report.

Dr Turnbull referred to the breakdown in the adverse incident reporting (AIRs). It is known that the Trust is a high reporter, which is healthy. The Trust is looking at the type of AIRs being reported and it has been shown that not all are strictly harm events, for example there are some AIRs that relate to levels of staffing. The expectation is that reporting will be improved following the introduction of the DATIX web.

Dr Turnbull referred to the stroke accreditation and reminded the Board of work the directorate had undertaken around improving the stroke service. He referred to a letter from the Deputy Chief Nurse of the North of England SHA, and quoted that the team should be congratulated on the excellent work and the strong leadership. She confirmed in the letter that the Trust had achieved level 2 accreditation for acute and rehabilitation services.

Dr Turnbull reported on mortality, Dr Turnbull tabled a paper that gave a Hospital Standardised Mortality Ratio (HSMR) overview. Dr Turnbull explained the breakdown of expected Summary Hospital Mortality Indicator (SHMI). HSMR has fallen recently to an absolute level of 99.6, this has been rebased and is now 110, but it is expected that month on month this will fall. The Board **agreed** as part of the Board to Board preparation they did require clarity on the SHMI and HSMR. Dr Turnbull advised the information would be included in the pack being prepared for the Board.

Dr Turnbull updated the Board on the serious untoward incidents (SUIs); he advised that there had been 11 SUIs declared in York since the beginning of the calendar year; SNEY had not declared any. Dr Turnbull added that there had been no never events.

Mr Sweet noted that the report suggested that there would be an annual report on SUIs. Mr Sweet asked if that was frequent enough and should it not be a six-monthly report. Dr Turnbull reminded the Board that they receive monthly figures and suitcase documents as part of the Medical Directors report. The Board **agreed** an annual report would be appropriate.

Ms Raper enquired if a never event in the community was the same as a never event in the acute Trust. Dr Turnbull advised it was.

Mr Rose noted that the Medical Director's report included a new dashboard for community services. Mr Rose thanked Dr Turnbull for the information.

The Board **thanked** Dr Turnbull for his comments.

Chairman's items

Mr. Rose referred to the further training for Non-executive Directors on the Board to Board, arranged for the 15 March; he advised that Mr. Ashton would not be able to attend, but all other Non-executive Directors would be available. He added that it is being suggested that a further session for the whole Board was being planned before 29 March 2012. It was agreed that the afternoon of the next Board of Directors' day (March 28) would be devoted to preparing for the Monitor visit.

Mr. Bertram advised that Mr. Crowley had spoken to Monitor about the format of the Board to Board

meeting on 29th March. Mr. Bertram advised that Monitor were beginning to formulate a structure for the session which they would advise the Trust about in the near future. He added that it was expected that there would be the request for a presentation that would be very prescriptive on the number of slides and subject matter.

Dr Turnbull added that he, Ms McManus and Mr. Cooney had held a telephone interview with Monitor the previous week. Dr Turnbull described the discussion as robust, assertive and searching, but there was a concern that Monitor had been given the impression that they believe that the Trust already had management control over SNEY, which is not the case.

The Board **noted** the comments.

Mr. Rose referred to his report and proposed that a Board paper (perhaps quarterly) recognizes the potential contract exposure that the organisation may have over the next couple of years, enabling the opportunity for improved strategic discussion of potential tenders prior to the event. The Board **agreed** that such contracts should be included in Board papers.

Mr. Rose invited Board members to attend a joint YTH/LINK public event on 12th March (1830hrs), at which there will be a presentation about the dissolution of SNEY. He added that he expected the discussion would be broadened into other areas, tailored to the York audience on this occasion. The meeting is taking place in the Post Graduate Centre, YH.

Mr. Rose also asked the Board to formally acknowledge Teresa Fenech's role in the achievements made to date around the acquisition and the hard work she has put in. She had taken the pressure of the executive team and allowed the day job to continue. Teresa has now taken up a position with the SHA. He added that Nicki McNaney, who was the Chief Nurse at SNEY, has now been appointed as the Director Lead for Integration work.

Mr. Rose also advised that when he attended the SNEY Board meeting, Sir Michael Carlisle suggested that during the first quarter of the next financial year there should be more attendance from other members of York at the SNEY Board meeting.

The Board enquired what would happen to Mr. Proctor's secondment to SNEY. Ms Hayward advised that it would continue up to the point of acquisition. Mr. Rose added that it would be appropriate if the management arrangements were consolidated, where feasible, in the coming financial quarter, and for Mr. Proctor to attend the YTH Board meeting. Mrs Pridmore added that care had to be taken to recognize that until the formal dissolution and acquisition had taken place, SNEY remained an independent organisation corporately. The Board recognized the point being made and the possibility of interim 'hosting' arrangements being put in place for the first quarter of 2012/13, assuming a positive outcome of the Monitor Board-to-Board and Compliance Board.

Mr. Bertram added that he and Mr. Crowley had met with the SHA to discuss the draft transaction agreement and the indemnities and warranties included in the agreement. There were two parts to the discussion. The SHA are still keen not to include indemnities and warranties in the agreement, but recognize the need for the Trust to protect itself. The SHA were also keen to explore a method of York being able to take management responsibility for SNEY from the beginning of April. The SHA were intent on having further discussions with SNEY.

The Board **noted** the comments in his report.

Chief Executive Report

In Mr. Crowley's absence, Mr. Bertram advised that there were two items he would wish to bring to the Board's attention:

- a) Senior Management Executive (SME). Mr. Bertram advised that the PCT were currently under significant pressure to get the contract for 2012/13 signed by 15 March 2012. The level of pressure will create some difficult negotiations for the Trusts involved. Additionally, the SME is less recognised by the new management of the SHA. One of the challenges for the PCT is that they are being required to deal with all historic debt issues by the end of the financial year 12/13, adding to the pressure the PCT is feeling. Mr Bertram advised that he would keep the Board apprised of contract developments.
- b) Acute Physician recruitment. Mr. Bertram advised that currently the Trust has established posts for three acute physicians. Recently one of the acute physicians has moved to Dundee and another one is moving back to the Medicine Directorate. Dr Turnbull confirmed that the development of the acute physician role has been successful and important to the Trust. The Trust will be seeking to replace the two vacant posts and a business case for an additional two posts will be submitted to the Board in due course. The challenge is that there is a small pool of such specialists, therefore, once it has been agreed that the additional appointments are needed, the Trust may need to quickly start the recruitment process. Mr. Bertram advised if that was the case he would use the Chairman's prerogative, as appropriate, with the full business case subsequently presented to the Board

The Board **noted** the comments.

Scheme of Delegation

Mr. Bertram explained the purpose of the changes included in the Scheme of Delegation. He advised that the changes reflect the changes in governance arrangements due to the enlargement and structure of the Trust and the changes represent a modest increase in authority for the Chief Executive. All new consultant appointments would continue to be approved by the Board and business cases over £1m will be approved by the Board. He added that all the changes are identified in the document through the "track changes". Mr. Bertram added that in terms of capital expenditure the intention is that the Board will receive additional information about the Capex programme. The Board already receives the programme for approval as part of the annual plan, but there will be the development of further information for the Board to receive during the year.

The Board discussed the changes and approved the document. It was requested that a review was undertaken within 12 months, including a note of which business cases have not been presented to the Board since its introduction. It was noted that should the levels appear to be unsatisfactory during the operation of the scheme the scheme can be reviewed and amended by the Board at any time.

The Board asked for one addition to be made, to ensure any investment in new types of activity or divestment, regardless of size, would be within the general matters of the document and hence subject to Board approval.

Action: Mrs Pridmore to draft the addition proposed by the Board.

The Board asked for an amended Board Capex Review paper to be developed and presented to the

Board.

Action: Development of a Board Capex Review paper for presentation to the Board.

Mrs Pridmore advised that now the Scheme of Delegation has been approved the corporate governance documents would be circulated to SNEY for them to present to their Board and implement from 1 April 2012.

Bridlington Land Deal

Mr. Bertram presented the report which had been prepared by SNEY. Mr. Rose advised that the SNEY Board had approved the paper at their meeting held on Tuesday 28th February 2012. The Board of Directors has received the paper to ensure the Trust understood the negotiations being undertaken and the financial benefits to the Trust.

The Board noted the paper and the approval by the SNEY Board and confirmed their support to the SNEY Board.

Operational performance report

Mr. Sweet asked Mr. Cooney to comment on the red items on the report.

Mr. Cooney advised that the 18-week (acute and community) and access target was failing, as per the corporate plan. The backlog has fallen by 250 patients. The patients who had been waiting the longest have been cleared off the list and the expectation is at the end of the quarter there will be 300 patients who have been untreated. The Trust has also received additional cash released nationally to support further work to address the backlog. Mr. Cooney added that despite the improvements the micro management will continue on the 18-week target.

Mr. Cooney referred to diagnostic waits, he advised that the target was not achieved this month, 5 out of 3,643 patients waited longer than 6 weeks, all patients are cystoscopies. Audiology is now achieving the target.

The Trust failed to achieve the 31 day subsequent treatment target – surgery target in December 2011, but the cancer target was achieved for quarter 3 and assurance has been given that the target for Q4 will also be met.

The Trust remains slightly above the PCT set target for first: follow-up ratio at 2:2, for which the target is 2:21.

Mr. Cooney referred to the Emergency Department and advised that the improved quality indicators might be causing an impact on some of the achievements of the targets.

With regard to cancelled operations, there were 6 on-the-day cancellations for non-clinical reasons during January. Three of these were due to clinical complications; two were due to lack of nursing staff and one was due to a more urgent patient.

The Board noted the report.

Finance report and Efficiency report

Mrs Palazzo commented that the 'home team' had gained significant assurance on the financial position, but she would like to ask Mr. Bertram to comment on the capital expenditure being behind plan. Mr. Bertram advised that the delay is purely due to timing issues and there has not been any prevention of the release of capital for cash management purposes.

Ms Hayward asked Mr. Bertram if he would comment on the outstanding invoice with the PCT. Mr. Bertram explained that the invoice related to extra duty payments the Trust had paid on taking on the community services. The payment actually relates to the month prior to the completion of the transaction and so has been charged to the PCT. The PCT are expected to pay the invoice before the end of the financial year.

Mrs Palazzo referred to the efficiency report and advised that she believed the Trust would make the plan this year. She asked the Board to send congratulations to every one involved for their hard work and dedication in achieving the targets. She added that the Board saw three year plans nearly 2 years ago and year three at that stage for some directorates were not very developed and high risk; what work has been done on those plans? Mr. Bertram explained the work that had been done and 6 year plans now existed in the Integrated Business Plan (IBP). Mr Bertram confirmed the significant input to this agenda coordinated by the corporate efficiency team.

Mrs Palazzo asked if the Trust is responsible for the whole 12 months of CIP for SNEY if the transaction is not completed until July, or only 9 months. Mr. Bertram advised that York has spent the last 12 months working with SNEY to develop their CIP systems and the requirement is that the Trust will undertake merger accounting and the full annual accounts for SNEY for 2012/13 will be incorporated into York's accounts.

Within the IBP there is a clear description of the CIP savings. The plans for years 1-3 achieve the required level overall but Mr Bertram advised the Board of the significant work that would be necessary to ensure successful deliver of the schemes.

The Board **noted** the finance and efficiency report.

Acquisition Assurance Board (AAB)

Mr. Ashton advised that the AAB had met on Monday 27th January and discussed the revised Integrated Business Plan (IBP) and Quality Governance Plan (QGP). He added that Monitor are expecting the revised IBP, QGP and the Integration Plan (IP) to be submitted to them on Friday 2nd March. He added that the Reporting Accountant would be attending the Board of Directors in March, when the Board would be considering the statements and memorandums and the Reporting Accountant reports. Mr. Ashton added that the AAB had agreed that the Board would receive a pack of all relevant papers associated with the memorandums and statements prior to the next Board.

Integrated Business Plan

Mr. Ashton advised that the AAB had considered the changes in the IBP and had received assurance from Mr. Bertram about those changes. Mr. Bertram explained the changes that had been made. He advised the majority of the changes were in section 6, the finance section, and related to the timing and cash flow of the fair value deal, the downside scenarios that were included and the efficiencies.

The Board considered the changes in the paper and noted the key points. The Board approved the IBP and agreed to its submission to Monitor.

Quality Governance Plan

Professor Willcocks described the changes that had been made to the QGP. She explained that the Trust has used a RAG (red – amber – green) risk-rating system for the Quality Governance Framework (QGF) for the two Trusts and has used Monitor's Risk Rating system for the combined organisation. Professor Willcocks asked the Board to note the challenges and mitigations included in the report and the implementation plan that is included.

The Board considered the report and agreed the risk ratings applied to the QGF and confirmed there were no risks identified that would prevent York from continuing with the acquisition. The Board noted the timetable included as part of the Implementation Plan and approved the dates. The Board agreed that future assurances received at Board would be supported by discussion at the (new) Quality and Safety Performance Committee.

Cooperation and Competition Panel (CCP)

Mr. Ashton asked the Board of Directors to note receipt of the report from the CCP. The Board noted the report.

HR quarterly report

Ms Hayward advised that the staff survey results were out, but the information was still embargoed; she was expecting to receive the full data information next week. Ms Hayward added that from a quick look at the data, York had improved on some areas and others had stayed the same. SNEY had improved on most indicators, but there is one that shows no improvement.

Ms Hayward advised that she would be including SNEY information in the next quarterly report presented to the Board, the Board will note that the figures will consequently be affected adversely. The Board noted the comments.

Professor Willcocks congratulated Ms Hayward on her report in terms of presentation and brevity. She asked if Ms Hayward was concerned about the level of vacancy levels being held. Ms Hayward advised that she was comfortable with the levels; she advised that there would be an increase in the number of people coming through the system.

The Board noted the report.

Catering Tender

Mr. Golding was welcomed to the meeting by the Chairman. Mr. Golding explained the process that the Project Board had undertaken during this tender. He advised that the recommendation from the Project Board is that the tender is awarded to the in-house bid. Mr. Sweet commented as a member of the Project Board that the standard had been very high and the in-house team had been able to demonstrate what was being asked for.

Mr. Golding added that the contract was tendered for York, but on the completion of the acquisition he would be reviewing the catering arrangements in SNEY and deciding how to take the service forward.

The cost for upgrading the facilities is £3m. The kitchen will be out of action for 6/8 months and the plan was that a temporary kitchen would be brought in to continue to provide the service, but that plan may be changed and the kitchen at Bridlington could be used and further efficiencies could be made.

The Board approved the recommendation and asked Mr. Golding to congratulate the team involved.

Executive Board minutes from the meetings held on 18th January 2012

The Board of Directors **noted** the minutes.

Draft minutes of the Risk and Assurance Committee 29th November 2012

The Board of Directors **noted** the minutes.

Summary of the minutes of the Board meeting held on 28th March 2012

Learning from patient feedback

Mr Rose read the compliment letter from a patient and Ms McManus read a letter from a complainant. The Board **noted** the detail in the letters and reflected on the impact the complaint would have on the individual and how it would be investigated.

Mr Crowley mentioned that he had received in the last week a number of emails from staff praising other members of staff, which was new. He added that he was delighted to receive such emails and had put forward one of the staff members for staff performer.

Chief Nurse Report

Ms Raper advised that the Home Team had discussed the report in some detail at their meeting. She advised she would like to draw the Board's attention to two points in the report.

The first was appendix 2, the patient experience team dashboard. Ms Raper asked if it would be possible to have some additional information about appendix 2 including some explanation about the dashboard, to raise the assurance the Board is gaining from the report.

The second related to item 5, update on professional issues; she asked if this item could become a quarterly item showing trend information unless there is an exception report that needs the attention of Board. Ms McManus agreed she would make the changes in her report.

Ms Hayward reminded the Board that Ms McManus was not present at the last Board and there was a discussion about staffing levels, she asked if there had been any progress on that discussion. Ms Raper advised that it had been discussed at the Home Team meeting. It was agreed that a further discussion would be held with Ms Raper, Ms McManus and Ms Hayward would discuss this outside the meeting and report back to the Board later in the year.

Action: a further report on staffing levels will be given to the Board in the future.

Ms McManus tabled a rapid adoption and spread initiative document which had the aim of reducing harm from pressure ulcers, falls, urinary catheter infections and VTE- harm free care. The measurement for this initiative is through the NHS Safety Thermometer, which is now a national 'Commissioning for Quality and Innovation' (CQUIN) for all acute and community areas for 2012/13. The paper outlined the progress so far and the case for change. Ms McManus explained that to effectively deliver the initiative to all patients the Trust needs one plan which can be implemented at local ward level and which integrates easily with existing workflows and routines. This will also

become an integral part of the Trust revised Patient Safety Strategy due for discussion at the Board in May 2012.

Action: presentation of the Patient Safety and Strategy document.

Ms McManus explained that the introduction of the initiative would have to be thought of differently in SNEY. Progress against the initiative will be reported through the Chief Nurse Report key performance indicators (KPI) rather than in detailed commentary.

The Board **noted** the action and **provided support** for the work being undertaken. Ms Raper will be the supporting Non-executive Director

Ms McManus referred to the productive ward standard documentation. She advised about the folders at the end of the beds with laminated dividers so that it is clear what information goes where. The folders have been implemented across the Trust, with the exception of the intensive care ward (ICU). The folders reduce variation where it can be reduced, but are flexible enough to ensure that some variation can still be in place.

The Board **noted** the report.

Quarterly Compliance Report

Mr Ashton commented that he felt this was an excellent report. The outcomes were explained clearly and he as a Non-executive gained a significant amount of assurance from the report. Mr Ashton asked if there was a method by which there could be a positive statement. Ms McManus explained that the Care Quality Commission Quality and Risk Profile (CQC QRP) provides an assessment of the Trust, but the information used is historic. The report presented is already prepared on an exception basis and identifies concerns in the first instance for the Risk and Assurance Committee. Mr Sweet mentioned that it would be useful if there could be a key explaining the various risk ratings.

After the Board considered the detail in the report it, was **accepted** by the Board as assurance around the level of compliance with the CQC outcome standards.

Medical Director Report

Mr Sweet advised that a detailed discussion had been held at the Home Team meeting. He asked Dr Turnbull to comment on the mortality and asked if the community dashboard included in the Board paper could include some target information. Dr Turnbull commented on the mortality point. He explained that the Trust had undertaken some work with the Public Health Observatory (PHO). Dr Turnbull circulated a document that showed the most recent figures of mortality for the Trust. It showed that the Trust was still an outlier for one mortality indicator. The PHO work and document 'the Acute Trust Quality Dashboard' shows that York is not an outlier, but the PHO would have some concerns about the data quality. Dr Turnbull explained the aspects of their concerns and advised that following a review of some coding information some anomalies had been found and discussions were now being held with Dr Foster.

Dr Turnbull drew the Board's attention to the work the Trust is undertaking with NHS Quest. He explained that the programme focuses on a collaborative approach to reducing harm and mortality. The programme was launched in March and has four elements – moving towards a 24/7/365 service, reviewing systems for measurement, reducing harm and deterioration and excellence in end of life care. The Trust is implementing all four of the elements, but three are recognised as reducing

mortality. At present work is being undertaken internally to set up the work streams.

Professor Hutton asked how this work links in with the deteriorating patient and Patient at Risk (PAR) score. Dr Turnbull explained that the electronic system was being introduced by the end of March and would be using the PAR score. He added that a similar system called Vitalpac is already used in SNEY.

The second review was the vascular review; the review rated the Trust “good”, with an excellent overall death rate around specific vascular procedures being below the national average.

Dr Turnbull reported to the Board that the Trust was not compliant with one NPSA alert. The alert relates to a device used to give spinal cord injections. At present there is no specific device and the department is continuing to evaluate different devices and will continue to seek a solution to put in place as soon as possible. The Trust is compliant with all other NPSA alerts.

The Board **noted** the work Dr Turnbull had reported on and the assurance given by the Home Team. The Board also **noted** that there was work ongoing with regard to the NPSA alert and the PAR score system.

Chairman’s items

The Chairman introduced his report. He suggested that there should be a standing item on the agenda around the integration. The Board **agreed** that it should exist for the next 18-24 months. Mr Rose added that on April 23rd there would be a presentation to the City of York Council of the acquisition. He invited all Board members to attend.

Mr Rose referred to the change in the Health and Social Care Bill around the requirements of having public Board meetings. The Board discussed the change in the legislation and how the Trust would arrange the Board meetings. No conclusion was drawn, although it is likely that there will be some combination of public and private services in due course. It was **agreed** that the Chairman and the Foundation Trust Secretary would discuss further with the Chief Executive.

The Board **noted** the comments.

Chief Executive Report

Mr Crowley drew the Board’s attention to the summary of the proceedings of the Risk and Assurance Committee included in his paper. The Board discussed the paper and **noted** the comments made by Mr Ashton, who also attended the meeting on this occasion.

Mr Rose mentioned to Mr Crowley that there was a more detailed paper that had been presented to the SNEY Board around the work streams.

Mr Crowley said he was aware of the paper and the summary in his paper was taken from it. Mr Crowley **agreed** the full paper would be circulated to the Board of Directors.

Mr Crowley mentioned that the Cooperation and Competition Panel (CCP) had now published a ruling on the complaint made by Assura. Mr Crowley asked Mr Bertram to explain the ruling. Mr Bertram reported that on 23 March the CCP published its findings in relation to the complaint around the MSK service (muscular skeletal service). The conclusion was that the decision by NYYPCT (the

commissioner) to give York the dual role of referring for further treatment and competing for referrals is expected to have a materially adverse impact on patients and taxpayers. The report talks about 'harm to competition and choice'. The CCP are now consulting on remedies, this consultation is open until 10 April 2012. The CCP have proposed remedies which at present are:

- 1 The PCT employs an independent choice manager
- 2 Independent patient choice information is published as a leaflet
- 3 Independent patient advice is linked in with charities and other organisations that patients use.
- 4 CCP invites suggestions from others.

The CCP will pass the recommendations to the Secretary of State.

The Board commented on the findings and **agreed** that the proposed remedies would be achievable. Mr Proctor added that there may be some learning for future tenders around such services which might be better utilized nationally through the Foundation Trust Network (FTN).

The Board **noted** the detail in the report and the actions being taken.

Annual Security Information Risk Officer Report (SIRO report)

Mr Bertram presented the SIRO report. He explained that the report had been discussed in detail at the Risk and Assurance Committee and the Committee had been assured by its content. The Trust attained a score of 87% on the Information Governance Toolkit, SNEY's score was 75% and the enlarged Trust will continue with a green rating. Mr Bertram added that the Trust continues to get an increasing number of freedom of information requests (FOI requests) some of which are FOI requests for information about what FOI requests the Trust has received.

The Board was asked to **note** the detail in the report and confirm they gained assurance about the information governance system included in the Trust. The Board confirmed it gained assurance from the report.

National Inpatient 2011 survey

The report summarises the key finding of the Inpatient Survey 2011 carried out by the Picker Institute, on behalf of the Trust. The Picker Institute was commissioned by 73 UK trusts to undertake the survey. The survey asks the views of adult inpatients' having at least one overnight stay in hospital during August 2011. The survey covers the issues that patients consider important in their care and offers insight into their experience.

Professor Hutton commented on the report, he raised some concern about the interpretation put on the report. Ms McManus **agreed** she would review the interpretation. The Board took **assurance** that the action planning would be undertaken with the support of the tool provided by Picker Institute. The **agreed** that the report identified the issues and it was **noted** that the Quality and Safety team would be responsible for ensuring the action plan was completed.

Staff Survey 2012

Ms Hayward tabled a document that showed the comparison between York and SNEY. The comparison showed deterioration in York's score, but the Board was reminded that this year included community services and it was recognized that this would have an effect on the score. SNEY has

shown significant improvement over the last 12 months, although from a poor base. The Board **noted** that there were some improvements that needed to be made around appraisals. Ms Haywood confirmed that there were some improvements being made to appraisal around how staff are involved. The Board commented that they were interested in the action plan, the key targets and expectation. Ms Hayward explained that the action plan would be discussed at the Corporate Directors meeting in April and focus on the quality of appraisals. She added that the action plan was a good indicator of the integration.

The Board was **assured** by the improvement demonstrated and acknowledged the reasons for the dip in the achievement around the York survey.

Operational performance report

Mrs Palazzo advised that the Home Team had reviewed the performance report. She advised that there was nothing specific to bring to the Board's attention, but she did ask Mr Cooney to explain the change in the report. Mr Cooney explained that the performance report was now split into three parts, combined performance, and individual trust performance. He added that the monitoring of both sites would continue to have their performance monitored individually and the Board will receive performance information on an individual basis and as a combined Trust.

The Board asked about the development of the dashboard for the community services. Mr Cooney confirmed that it was continuing to be developed.

The Board **noted** the report

Finance report and Efficiency report

Mr Bertram commented on the current negotiations being held around the contract. He advised that the PCT will have a balanced position at the end of the year, but with an underlying debt. The PCT is under pressure to address the historical debt by the end of the next financial year, when the CCGs will take over. Mr Bertram advised that extensive discussions continue on this matter.

Mr Sweet referred to the efficiency report and asked the Board to extend its congratulations to all those involved in the achievement of the CIP target. He commented that he was still concerned about the balance between the recurrent and non recurrent CIP. He noted that the reports showed £2.5m would be carried forward as it was achieved as non-recurrent CIP and was the £2.5m included in the target for this next year or additional to the target. Mr Bertram advised that it was already included. Mr Bertram added that the directorates have already started work on the target for the next financial year. Directorates will sometimes test the saving before confirming it is recurrent. Mr Sweet had noted the achievements of the acute and general medicine directorate and congratulated them on their success.

The Board **noted** the additional paper outlining the identified tender and contracting exposure and opportunities. The Board noted that there were a number that would require renewal over the next couple of years. Mr Rose asked how the Trust becomes aware of any tenders. Mr Bertram explained that there is access from a portal for all NHS published tenders.

The Board **agreed** that it would like to see the document on a quarterly basis. The table would be discussed again next month to agree which tenders merit Board-level discussion

The Board **noted** the discussion and **assurance** gained from the report

Financial Plan 2012/13

Mr Bertram explained that this was a plan for York only and approval by the Board would allow the finance department to set up the operational budgets for the year. He confirmed that there was nothing additional in the assumptions that the Board had not already seen as part of the Long Term Financial Model (LTFM). Mr Bertram drew the Board's attention to the appendices. The first appendix was the financial plan for SNEY for one year; as an NHS Trust they are only required to complete a one year plan. The second appendix was the financial plan for York, which shows surpluses rising each year, a satisfactory cash position and provides a financial risk rating of 3 for each of the three years.

The Board discussed the accounting arrangements for the merging of the SNEY accounts with York.

The income and expenditure anticipates a drop in activity, which fits with the drivers for reducing activity that already exists. Mr Bertram explained how the PCT gains its CIP.

The Board **approved** the plan and **noted** the financial plan for SNEY. The Board **noted** the intended course of action for integrating both organisations financially.

Acquisition Assurance Board (AAB)

Mr Ashton explained that the AAB had reviewed the pack at its meeting on 23 March. He recapped the stage the Trust had reached to in the process. The Board was asked to consider and approve a number of documents, following which the Board will attend the Board to Board meeting and Monitor will hold a Compliance meeting. After this the Board will receive Monitor's judgment on the financial risk rating and governance risk rating. This will be followed by approval from the DH Transaction Board and the filing of the dissolution order and transfer agreement.

Mr Ashton reminded the Board that the three due diligence reports had been received by the AAB and Board and that detailed discussions at the AAB and Board had taken place over the last few months around the findings. He advised that two additional pieces of work had been completed for the AAB. The first one demonstrates what action had been taken around the medium risks identified in the legal due diligence work and the second piece was around the analysis between agreed Heads of Terms and the proposed Transaction Agreement and where mitigations or warranties have not been transferred between the two and what action has been taken.

Mr Ashton added that the Transaction agreement addressed two main risks for the organisation. The first is about the possibility of an HR claim materialising in the first twelve months that had not been identified and the second was to address the impact of SNEY not achieving their projected surplus at the year end 2011/12. It was noted that the Transaction Agreement will not be signed by the Board until the end of June 2012 but is subject to some conditions precedent.

Mr Ashton added that today the Board will be approving the statements and should consider the statements already made.

Reporting Accountant

Mr Kirby and Mr Ward explained that they were attending the Board to hear the debate and gain assurance from the Board on the consideration and decision on the approval of the statements and memorandums. This evidence will allow Ernst and Young to complete their reports and sign their statements.

Memorandums and statement

Mr Ashton referred the Board to the paper supporting the pack and leading them through the required statements.

12/067.1 Working Capital and Financial procedures

Mr Ashton asked the Board to consider the statement and memorandum. He reminded the Board that they had received a draft version of the documents and the detail included was known to them. He reminded the Board that the Integrated Business Plan (IBP) underpinned the documents. The Board considered the statement, Memorandum and the information included in the IBP and **approved** the statement and memorandum. It was **agreed** that the Chairman should sign the statement.

12/067.2 Quality and Medical Statements

Mr Ashton explained that the Board was required to consider the Quality statement and Quality Governance Plan along with the Medical Director Statement and memorandum. The Board considered the statement related to the Quality Governance Plan and **noted** that statement was underpinned by the Quality Governance Plan and that the plan served as the document that described the quality governance arrangement for the enlarged organisation. The Board confirmed that it had seen the Quality Governance Plan on a number of occasions and were satisfied with the assurance received. The Board **approved** the statement. The Board reviewed the Medical Director Memorandum and considered the information included in it. The Board reflected that there was nothing included in the memorandum that not been discussed by the Board before. The Board considered the statement attached to the memorandum and **approved** the statement and memorandum. The Board of Directors **agreed** that the Chairman should sign the Quality Statement and the Medical Director should sign the Medical Director Statement.

12/067.3 Post Acquisition Integration Statements

Mr Ashton explained that the Board was required to consider the Post Acquisition Integration Statement and should reflect on the information included in the Integration Plan and Integration Programme Delivery, Governance and Risk Management document, as well as the Integrated Business Plan. The Board reflected on the documents and the statement and concluded that the Board was satisfied with the statement. The Board **approved** the statement and **agreed** that the Chairman should sign the statement.

12/067.4 Self Certification

Mr Ashton presented the Self Certification statement and the associated document showing the mitigations against each of the statements. The Board reviewed the assurances given and the statements within the Self Certification and **approved** the document. The Board **agreed** the Self Certification should be signed by the Chairman.

Integration Update

Mr Rose welcomed Mrs McNaney to the meeting.

Mrs McNaney described the processes in place to manage the integration work and the activities to date. She advised that there was a presentation that would be circulated to Board members outside the meeting, which summarised the description she had given around the process. Mrs McNaney

discussed with the Board how often they would like to receive an update on the progress of the integration. It was **agreed** that the integration update would become a standing item on the Board agenda.

Mrs McNaney presented the integration risk register, both clinical and corporate. It was noted that the registers would not generally be presented to the Board meeting; the registers would be part of the normal risk systems and any significant risk would be included on the Corporate Risk Register.

The Board **noted** the presentation given and the comments made and assurances given by Mrs McNaney.

Assurance Framework and Corporate Risk Register

Mr Ashton presented the Assurance Framework and Corporate Risk Register. He advised that the document had been considered in detail by the Corporate Directors and the Risk and Assurance Committee. He added that the Audit Committee had also considered the documents and recommend to the Board of Directors that the documents are **approved**. The Board reviewed the documents and considered the comments made by Mr Ashton.

The Board of Directors **approved** the Assurance Framework and Corporate Risk Register.

Business Cases

12/071.1 2012/002: Acute Physician Expansion

The Board considered the Business Case following a presentation by Mr Bertram. The Board **noted** the reasons for the increase in acute physicians and **approved** the Business Case.

The Board asked for post project evaluation to be undertaken.

Executive Board minutes from the meetings held on 18 January 2012

The Board of Directors **noted** the minutes.

Next meeting of the Board of Directors

The next formal meeting of the Board of Directors will be held on 25 April 2012, in the Boardroom, York Hospital.

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Council of Governors – 23 May 2012

Quality Report – Lead Governor

Action requested/recommendation

The Council of Governors is asked to note the report.

Summary

This report from the Lead Governor provides an update on the Quality report.

Strategic Aims

Please cross as appropriate

- | | |
|---|-------------------------------------|
| 1. Improve Quality | <input checked="" type="checkbox"/> |
| 2. Improve our effectiveness, capacity and capability | <input checked="" type="checkbox"/> |
| 3. Develop stronger citizenship through our working with partners | <input type="checkbox"/> |
| 4. Improve our facilities and protect the environment | <input checked="" type="checkbox"/> |

Implications for equality and diversity


There are no implications for equality and diversity.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report is only written for the Council of Governors.
Risk	No risk.
Resource implications	There are no resource implications.
Owner	Helen Mackman, Lead Governor
Author	Helen Mackman, Lead Governor
Date of paper	February 2012
Version number	Version 1


Council of Governors – 22 February 2012	
Quality Report - Lead Governor	
1. Introduction	
<p>A small group of Governors, on behalf of the whole Council of Governors, met with the Trust to discuss the draft Quality Report.</p> <p>Last year the Governors were asked to identify an area to be reviewed by the External Auditors and we choose Venous Thrombo-embolism (VTE) assessment. The Governors noted, in the report for this year, that significant progress has been made over the last 12 months and that the Trust is now recognised as a centre of excellence for VTE assessment. This year the Council of Governors has chosen the World Health Organisation (WHO) surgical checklist usage to be reviewed by the External Auditors. The Governors are aware the Trust has been working hard to achieve the target set, but there is still more work to do to achieve the standard of excellence expected by the Governors and the Trust. Over the next 12 months we will continue to ask for updates.</p> <p>The Governors were delighted to see that dementia care has been included by the Trust as one of the priorities for 2012/13. The Governors believe this to be a very important area. Feedback to Governors from their constituencies demonstrates that proper management and referral of patients improves the quality of care for this group of patients and their families. The Governors will continue to seek assurances during the year that progress is being made against this priority.</p> <p>The Governors agreed that the report was truly reflective of the work that has been undertaken in the Trust during 2011/12 and that the priorities set for 2012/13 are the correct ones. The Governors also noted that there were some areas where targets had not been reached during the last 12 months, but, through the Governor groups and the Council of Governor meetings in public, we will look for assurance from the Trust that progress is being made against these outstanding targets.</p> <p>We also look forward to seeing that the priorities identified in the Scarborough Quality Account are being successfully implemented by this Trust following completion of the acquisition.</p>	
2. Recommendation	
The Council of Governors are asked to note the report.	
Author	Helen Mackman, Lead Governor
Owner	Helen Mackman, Lead Governor
Date	May 2012



Freedom of Information

Governors' Meeting 26th April 2012

York Teaching Hospital **NHS**
NHS Foundation Trust



Fiona Jamieson

Assistant Director for Healthcare Governance

York Teaching Hospital **NHS**
NHS Foundation Trust



What is Healthcare Governance?

- Clinical Effectiveness (clinical audit/NICE guidance)
- Compliance with regulated activities
- Information Governance (including FOI)
- Policy Management
- Risk and Legal Services

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The FOI Act 2000

- Provides general right of access to information held by Public Authorities incl. Health bodies
- Promotes transparency and accountability
- Publication Schemes

York Teaching Hospital 
NHS Foundation Trust



Key Features

- Requests must be in writing
- ‘Purpose-blind’
- 20 days to respond
- Duty to confirm or deny
- Provide unless exemption applies

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Exemptions

- Absolute or qualified
- Public Interest Test
- Most applicable to Trust:
 - Personal information
 - Commercially sensitive
 - Future Publication

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Other grounds for refusal

Excessive Effort

i.e. 18 hours+ to collate response

Vexatious Requests

i.e. persistent or unreasonable

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Appeals and Enforcement

- Applicant has right to request review
- Next step is appeal to Information Commissioner (ICO)
- ICO issues Decision Notice
- The Information Tribunal
- Non-compliance will attract Enforcement Action

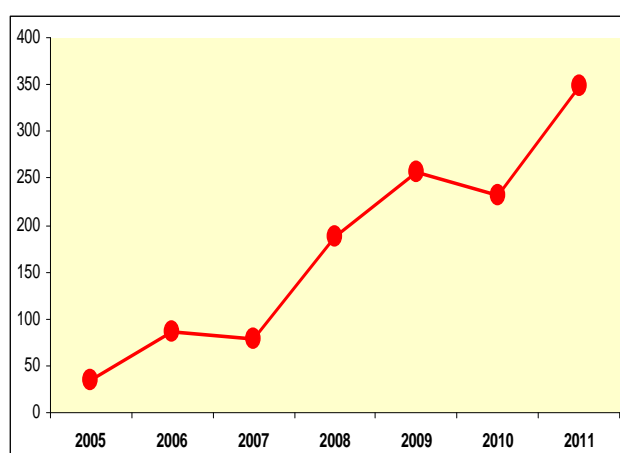
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FOI at York Hospital

- Processed by Information Governance team foi.requests@york.nhs.uk
- ISEB Qualified Staff
- Documented Policy & Procedures
- Resource Intensive

York Teaching Hospital **NHS**
NHS Foundation Trust

Requests Received 2005 -



York Teaching Hospital **NHS**
NHS Foundation Trust

Where do the Requests Come From?

- During 2011, 348 requests were received
- 101 requests overtly from either the media or a political party
- Private individuals
- Charities
- Students
- Other health organisations¹¹

York Teaching Hospital 
NHS Foundation Trust

What Type of Topics?

- Finance: expenditure on staff, equipment, income from private patients, debt written off
- HR: workforce planning, redundancies, disciplinaries, agency staffing
- Pharmacy: cancer drugs and applications, price of specialist medicines, committee minutes, medicines management
- Maternity: Staffing levels, complaints, incidents

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Issues for the Trust

- Increasing volume of requests
- Pressure on Finance, HR, Systems & Networks, Clinical
- Directors' involvement
- Estimated Cost of Compliance 2011
£45K - £50K
- Strong performance
- Legal obligation, but priority?

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NHS Foundation Trust

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Council of Governors – 23 May 2012

Lead Governor Report

Action requested/recommendation

The Council of Governors is asked to note the report.

Summary

This report provides an update from the Lead Governor.

Strategic Aims

Please cross as appropriate

- | | |
|---|-------------------------------------|
| 1. Improve Quality | <input checked="" type="checkbox"/> |
| 2. Improve our effectiveness, capacity and capability | <input checked="" type="checkbox"/> |
| 3. Develop stronger citizenship through our working with partners | <input type="checkbox"/> |
| 4. Improve our facilities and protect the environment | <input checked="" type="checkbox"/> |

Implications for equality and diversity

There are no implications for equality and diversity.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report is only written for the Council of Governors.
Risk	No risk.
Resource implications	There are no resource implications.
Owner	Helen Mackman, Lead Governor
Author	Helen Mackman, Lead Governor
Date of paper	February 2012
Version number	Version 1

Council of Governors – 22 February 2012
Lead Governor Report
1. Chairman's Appraisal
<p>The Chairman's appraisal process has started with an invitation to Governors and Trust Board members to assess whether our Chairman has fulfilled his objectives over the past year. Responses are due back by the end of this month and this will be followed by opportunities for individual conversations or group discussion. The Senior Independent Director and I will meet the Chairman to discuss our report and his objectives for 2012/2013. The final report will go to the Nominations Committee for consideration of the results and a review of the recommendations to be presented to the Council of Governors.</p>
2. Patient Experience Steering Group
<p>I have made reference before to the work that has gone on to develop a Trust Patient Experience Steering Group. This group will meet for the first time on Thursday 17 May. It has been agreed that two representatives from the Council of Governors are to be invited to join the group, giving us a real opportunity to influence the way patient experiences are used to effect change. Papers will be made available at our meeting on 23 May for governors to put themselves forward to join this group.</p>
3. Blind and Partially Sighted Society
<p>Since our last Council of Governors meeting, Governors have been made aware of the impact of the PCT's withdrawal of funds from some voluntary sector organisations and in particular from the Blind and Partially Sighted Society. This organisation has been complementing the care provided by this Trust by funding the role of an Eye Clinic Liaison Officer. We met with the Eye Department's Directorate Manager and the Liaison Officer to learn about this vital role and have used our good relationship with the non-executive Director team to highlight this issue to the Board. The result of this and of representations from a number of quarters has meant that the Blind and Partially Sighted Society has been given funding for another year.</p>
4. FOI's
<p>There have been some challenging issues to deal with recently via the Governor email address. This prompted me to arrange a session for us on how the Trust deals with Freedom of Information enquiries. This was attended by both non-executives and Governors and our thanks are due to Fiona Jamieson, Assistant Director of Healthcare Governance and her colleague for a very enlightening presentation. Fiona's 'hand-out' is included as Appendix A to this report.</p>

5. Scarborough Hospital Visit
A group of ten governors were the guests of Scarborough and North East Yorkshire Trust on Friday 30 March. We were given a warm welcome and invited to see recent developments at Scarborough Hospital as well as some of the older parts of the estate that are in need of modernisation and improvement. We were briefed on planned capital improvements and met managers, nurses and clinicians. Our sincere thanks go to Mike Proctor, Acting CEO, and to James Hayward, Director of Facilities, for their hospitality and for the impressive amount of effort that had gone into planning the day for us. Scarborough has much to offer York in terms of some innovative estates and service development and as a single, bigger organisation we will be able to share best practice which will benefit patients across the whole area.
6. Annual Report
Governors have been submitting reports to be included in the Trust's Annual Report. I have been liaising with non-executive Directors, the Foundation Trust Secretary and the Head of Communications to encourage a more dynamic and interesting approach to highlight, in a summary document, some of the important work that Governors have been engaged in over the past year.
7. Trust Open Day
Preparations are now well underway for the Trust's Open Day on 12 Sept 2012 with the theme <i>New Beginnings, Broader Horizons</i> . I will circulate more detail as it becomes available and set out opportunities for Governors to share and contribute to the event.
8. Yorkshire Ambulance Service Resuscitation Training
Ten of us, including Governors, staff, the Chairman and the Vice-Chair attended a presentation by Yorkshire Ambulance Service's Resuscitation Officer. This drew to our attention the importance of being confident to use the defibrillators that can be found in public buildings as well as in York Hospital. We'd like to see notices by these machines which stress that anyone who is first on the scene should be able take action by following the recorded instructions that begin as soon as the box is opened.
9. Surgical Ward Survey
Three Governors along with representatives from LINKs are currently taking part in a surgical ward survey. Our thanks to the Patient Experience Team for continuing to involve us in ways that help us to engage with patients in a meaningful way.
10. Regional Governors meeting
A Regional Governors Meeting was held at Harrogate Hospital this month, attended by three governors.
11. Art Strategy Group
I continue my involvement with the Trust's Arts Strategy Group and with the Cancer Partnership and Locality Groups and I now represent us on the Social and Healthcare

Information Network, York (SHINEY). This group is likely to have more impact as the Health and Wellbeing Board and the Clinical Commissioning Group develop their systems for patient and public engagement. I've attended both the York and the North Yorkshire LINKs AGMs which provided an excellent opportunity to network with representatives of other organisations as well as the LINKs members. This is the sort of community engagement that helps us to understand the issues that are important to users of this Trust's services.

12. GCC

And finally, in the interests of health and wellbeing (and fun!), seven Governors, including myself, have signed up for the Global Corporate Challenge which starts on 24 May and goes on until September. We can't promise to overtake the Chairman's team but we're going to have a damn good try!

13. Recommendation

The Council of Governors are asked to note the report.

Author	Helen Mackman, Lead Governor
Owner	Helen Mackman, Lead Governor
Date	May 2012

Council of Governors – 23 May 2012

Review of the Effectiveness of the Council of Governors

Action requested/recommendation

The Council of Governors are asked to read and comment on the draft work plan.

Summary

The attached report outlines proposed actions as a result of the inputs received during the Effectiveness Review, commissioned by the Nomination and Remuneration Committee, a sub-committee of the Council of Governors, regarding the workings of the Council of Governors.

Strategic Aims

Please cross as appropriate

- | | |
|--|-------------------------------------|
| Improve Quality | <input type="checkbox"/> |
| Improve our effectiveness, capacity and capability | <input type="checkbox"/> |
| Develop stronger citizenship through our working with partners | <input checked="" type="checkbox"/> |
| Improve our facilities and protect the environment | <input type="checkbox"/> |

Implications for equality and diversity

A fully effective Council of Governors would be one which considered and involved itself in issues of Equality and Diversity.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report	This report written for the Council of Governors and the Board of Directors
Risk	No risk
Resource implications	No resource implications
Owner	Alan Rose, Chairman
Author	Helen Mackman, Lead Governor

Date of paper
Version number

May 2012
Version 1

Council of Governors – 23 May 2012
Review of Effectiveness of the Council of Governors
1. Introduction
<p>Draft work plan for the period 1 June to 10 October (date of the planned inaugural meeting of the newly constituted Council of Governors)</p> <p>In the period leading up to the election of new governors, we aim to follow a clear programme of work for the Council of Governors (CoG) against which future reviews can measure effectiveness.</p> <p>It is proposed to firm up on the membership and objectives of the Council of Governors' sub-committee and its two sub-groups, ensure that our interface with the community is inclusive and dynamic and that we engage with the Trust through specific pieces of work to demonstrate that we are representative of the local community's key role in shaping local healthcare.</p>
1.1 Questioning and challenging
<p>Ultimately it is the Trust Board's decisions that set the strategic direction, but governors will continue to question and to challenge as part of the process towards the decisions made at Board level. We will report back to the CoG on our discussions and on any evidence that we may have that we have influenced particular strategic decisions.</p>
1.2 Good access to Trust leadership
<p>To assist in holding the Trust Board to account, we will ensure that there remains good access to Trust leadership with an expectation that the Trust's leaders will continue to approach governors in the same spirit of openness that we have experienced over the last year.</p>
1.3 Holding the non-executive team to account
<p>We will ensure that we continue to receive regular reports from the NED team after the acquisition.</p>
1.4 Membership of the CoG's sub-groups
<p>We will review the membership of the CoG's Nomination and Remuneration Committee and that of the Patient Focus Group and Community and Membership Engagement Group and plan a timeframe to open up these memberships for renewal.</p>
1.5 Patient Focus Group Review
<p>We anticipate that the Patient Focus Group will review and develop its objectives and processes in view of the launch of the Trust's new Patient Experience Steering Group, setting out criteria for governor representation on this new group.</p>

1.6 Community and Membership Engagement Group Review	
We expect the Community and Membership Engagement Group to review and develop its objectives and processes, including looking for more innovative ways to engage with members and the community, especially across the newly acquired constituencies.	
1.7 Governor involvement in Trust projects	
Governor involvement in specific projects, including the continuation of involvement in on-going projects, will be actively planned and encouraged. These projects provide another level of assurance and critical examination while giving opportunities for governors to liaise with a variety of disciplines across the Trust and with stakeholders. The provision of data as to where Governors are involved across the Trust, will be made available, both to the CoG, on the Trust's website and with a page on Horizon for staff.	
1.8 Trust provision of information	
Summaries in a more concise format will be requested to enable Governors to access and work more effectively with statistical data and information.	
1.9 Questioning the Trust in public	
It will be asked that items for agendas, or specific questions, be put forward by Governors to the Chairman or Lead Governor, in advance, two days before each meeting, to enable full Executive responses to be available at CoG meetings. We will encourage questions from members of the public to be submitted similarly by means of a statement on the published agenda and on the Trust's website.	
1.10 Making our statutory meetings accessible	
We will look at and contribute to all aspects of publicity, accessibility and location for the CoG meetings in public, particularly as we include the Ryedale and East Coast constituencies.	
1.11 Governors' training needs	
We will ensure that there is an induction plan in place for new governors and that the on-going training needs of all governors are recognised and met.	
2. Recommendation	
The Council of Governors are asked to read and comment on the draft work plan.	
Author	Helen Mackman, Lead Governor
Owner	Helen Mackman, Lead Governor
Date	May 2012