York Teaching Hospital NHS
NHS Foundation Trust

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

on: **Wednesday 25 September 2013**
in: **The Blue Room, North Entrance, Scarborough Hospital**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Discussion Room, PGMC, Scarborough Hospital	Non-executive Directors
9.15am – 11.50pm	**Board of Directors meeting held in public**	**Boardroom**	**Board of Directors and observers**
12.00pm – 12.55pm	Board of Directors to consider confidential information held in private	Blue Room North Entrance Scarborough Hospital	Board of Directors
1.00pm – 2.30pm	Lunch & Optional Visit to Paediatric unit to hear about new facility plans	Pat's place & Paediatric Unit	Board of Directors
2.30pm – 4.00pm	Remuneration Committee	Blue Room North Entrance Scarborough Hospital	Remuneration Committee and Chief Executive

The core values of the Trust are:

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

These will be reflected during all discussions in the meeting

York Teaching Hospital NHS
NHS Foundation Trust

Restricted – Management in confidence

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

On: **Wednesday 25 September 2013**

At: **9.15am – 11.50am**

In: **The Blue Room, North Entrance, Scarborough Hospital**

A G E N D A					
No	***Item***	***Lead***	***Comment***	***Paper***	***Page***
Part One: General **9.15am - 9.30am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for absence** No apologies for absence received.	Chairman			
3.	**Declaration of Interests** To receive any changes to the register of directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chairman		A	5
4.	**Minutes of the Board of Directors meeting** To review and approve the minutes of the meeting held on 31st July 2013.	Chairman		B	9
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman		Verbal	
6.	**Patient Experience** To hear a letter of complaint and compliment.	Director of Corporate Development Michael Keaney		Verbal	

No	Item	Lead	Comment	Paper	Page
Part Two: Quality and Safety 9.30am – 10.30am					
7.	**Quarterly Patient Experience Report** To review the report and gain assurance around the processes in place.	Chief Nurse		C	19
8.	**Quality and Safety Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Patient Safety Dashboard • Medical Director Report • Chief Nurse Report	Chairman of the Committee		D D1 D2 D3	29 39 61 69
9.	**CQC Report** To receive the Reports from CQC following the recent visits.	Chief Nurse	Jennifer Adams	E	83
Part Three: Finance and Performance 10.30am – 11.00am					
10.	**Finance and Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Operational Performance Report • Finance Report • Trust Efficiency Report	Chairman of the Committee		F F1 F2 F3	143 153 161 171
11.	**Scheme of Delegation** To approve an amendment to the scheme of delegation.	Director of Finance	Philip Ashton	G	179
Part Four: Human Resources 11.00am – 11.10pm					
12.	**Quarterly HR report** To receive the quarterly report.	Deputy Director of Human Resources	Dianne Willcocks	H	183

No	Item	Lead	Comment	Paper	Page
Part Five: Governance 11.10am – 11.50pm					
13.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		I	187
14.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		J	191
15.	**Quality Report** To update the Board on the Quality Report process.	Foundation Trust Secretary		Verbal	
16.	**Business Case 2013-14/183: Consultant Urologist** To approve the business case.	Director of Finance	Michael Keaney	K	241
Any Other Business					
17.	**Next meeting of the Board of Directors** The next of the Board of Directors will be held on 30th October 2013 in the Blue Room, North Entrance, Scarborough Hospital.				
18.	**Any other business** To consider any other matters of business.				

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

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

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

- Assurance Framework and Corporate Risk Register
- Proposals around the CNST audits

Register of directors' interests
September 2013

York Teaching Hospital NHS
NHS Foundation Trust

Additions:

Changes: Mike Proctor is the Chief Nurse on the Board of Directors

Deletions: Elizabeth McManus is no longer a member of the Board of Directors

A

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

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

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultan-cies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or com-missioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Ms Peta Hayward ***(Executive Director Director of Human Resources)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mrs Sue Holden ***Executive Director of Corporate Develop-ment***		**Director –** SSHCoaching Ltd		**Member -**Conduct and Standards Committee – York University Health Sciences **Act as Trustee** –on behalf of the York Teaching Hospital Charity		
Dr Alastair Turnbull ***(Executive Director Medical Director)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Andrew Bertram ***(Executive Director Director of Finance)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	**Member** of the NHS Elect Board as a member representa-tive
Mr Mike Proctor ***(Executive Director Deputy Chief Executive, COO and Chief Nurse***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital NHS Foundation Trust, held in public in the Boardroom, The York Hospital on 31st July 2013.

Present:	Mr A Rose	Chairman of the Trust
	Mrs J Adams	Non-executive Director
	Mr P Ashton	Non-executive Director
	Mr A Bertram	Executive Director of Finance
	Mr P Crowley	Chief Executive
	Ms P Hayward	Executive Director of Human Resources
	Mrs S Holden	Executive Director of Corporate Development & Research (until item 13/100)
	Mr M Keaney	Non-executive Director
	Ms E McManus	Chief Nurse
	Mr M Proctor	Deputy Chief Executive/Chief Operating Officer
	Ms L Raper	Non-executive Director
	Mr M Sweet	Non-executive Director
	Dr A Turnbull	Medical Director
	Professor D Willcocks	Non-executive Director
Attendance:	Mr B Golding	Director of Estates and Facilities for item 13/108.1
	Mrs A Pridmore	Foundation Trust Secretary

Observers: 5 observers (including 3 governors)

Mr Rose welcomed members of the public and Governors to the Board meeting.

13/094 Apologies for absence

There were no apologies for absence.

13/095 Declarations of Interests

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

13/096 Minutes of the meeting held on 26th June 2013

Ms Raper asked for a minor adjustment to be made to minute number 13/087 Quality and Safety Committee – Family and Friends. She asked that the minute reflected that she reported that there continued to be some concern about the achievement of the target, rather than her just mentioning it. The remainder of the minutes were approved to be a true record of the meeting.

13/097 Matters arising from the minutes

There were no additional matters arising from the minutes; any specific items would be picked up as part of the meeting.

13/098 Patient Experience

Mr Rose reminded the Board why the Board heard letters at the meeting ahead of completing any business. He asked Board members to keep in mind the experiences the Board was about to hear that patients had when using the Trust's services.

A letter of complaint was read by Mrs Adams. A letter of compliment was read by Ms Hayward.

13/099 Quality and Safety Committee

Ms Raper highlighted the key points in the Quality and Safety Committee notes:

Dashboard – Ms Raper was pleased to be able to report that the first draft version of the revised dashboard would be presented to the next Committee meeting. She explained that it would cover three domains: Patient Safety, Clinical Effectiveness and Patient Experience. Ms Raper asked the Board to join her in supporting this key priority and ensure the resources are available to deliver it on an ongoing basis. Mr Crowley explained that he completely supported the development of the dashboard as a priority but he could not confirm that it would be the top priority for the organisation. He added that the information being collated into the report does already exist and so this is about getting it into one dashboard. The Board recognised the point he was making and noted the commitment to the development of the dashboard that had been shown.

Dr Turnbull added that within the recently published (July 2013) Keogh review into the 14 hospitals, several ambitions are identified; one of which relates to data. It states as follows:

The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.

Nursing and Midwifery Strategy – Ms Raper drew the Board's attention to the Implementation Plan Year 2013 included in the papers for the strategy. She supported the development of the more specific actions and advised that the Quality and Safety Committee would continue to review the implementation plan at its meetings on a regular basis.

C-Diff – Ms Raper asked Ms McManus to comment on the current C-Diff issues. Ms McManus explained that quarterly Director of Infection Prevention and Control report included in the papers does outline the current position. The Trust has been very challenged in achieving the trajectory and for a second quarter this has not been achieved. There has been considerable discussion about the issues at each Board meeting and in the Committees and relevant Groups across the months. Ms McManus outlined the actions it had been agreed would be taken. She also reminded the Board that although the Trust's relative performance is still good, one of the actions was to seek external support from Public Health England to see what additionally could be put in place and what had been the learning from other organisations. Ms McManus added that the members of the Executive Group had been reviewing the clinical practices around prescribing and the clinicians continue to challenge practice in the organisation.

Ms McManus described a group that has been set up that includes membership from the Clinical Commissioning Group. Mr Rose asked if the challenges in the group were both to the

Trust and the Commissioning Group. Ms McManus advised that the dialogue is very two-way.

Family and Friends – Ms McManus advised that the first formal results were published on 30th July 2013. She explained that the Trust had made a good start and the net promoter scores for the hospital sites were good. Ms McManus reminded the Board that there were two elements to the scores that the Board need to take into account; the first is the response rate and the outcome. Ms McManus was able to advise that due to the significant amount of work that had been undertaken by the teams, the response rate was 20%. The Board discussed the results and agreed that as a starting point they were good, but the Commissioners may move to more outcome measures. Professor Willcocks commented that at the Equality and Diversity Group a discussion had been held about how the Trust captures the data so that it can provide more intelligence about different groups and their needs and comments. Mrs Holden explained that following the discussion she had enquired about the opportunity for collecting such data and, at present, the Trust cannot change the form; it is prescribed nationally. She added that she hoped if enough Trusts picked the equality and diversity issue up then the form may be changed. She explained that the Trust would use other methods to pick up this information.

The Board enquired where the next phase would be rolled out. Ms McManus advised that it would be to maternity during October 2013 but this data would be collected more electronically. She added that the community data was not included in the Commissioning for Quality and Innovation (CQUIN) payment at present.

Mrs Adams asked how the comments people left were being used. Ms McManus explained that most people did not leave comments, but where they were being left the comments were being used by the Trust to help inform developments.

Summary Hospital-level Mortality Indicator (SHMI) – Dr Turnbull advised that the NHS Information Centre had recently published a new Summary Hospital – Level Mortality Indicator (SHMI) recently. The indicator is for non-specialist acute Trusts, and covers all deaths of patients admitted to hospital and those that occur up to 30 days after discharge from hospital. The SHMI for the Trust was 104 which is a significant improvement on the last SHMI of 108. Dr Turnbull confirmed that there is still more work to do to ensure the Trust achieves its aspiration of a SHMI of below 100.

Dr Turnbull added the Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. The HSMR compares the expected rate of death in a hospital with the actual rate of death. The current HSMR has fallen in the Trust but when it is rebased, as is the standard practice, it will rise. The Board enquired if there was a target that was being aimed for. Dr Turnbull advised that there is an aspiration to have a HSMR of below 90.

WHO Safety Briefings – Dr Turnbull reported to the Board that there was now nearly 100% compliance at York and as Clinical Patient Data (CPD) is now in place in Scarborough, the information should become readily available across the whole Trust.

National Early Warning Score (NEWS) – Dr Turnbull advised that the electronic system is used in York, Scarborough and Bridlington and allows for early escalation of the deteriorating patient. He advised that since its introduction, the Trust has seen more admissions to the High Dependency Unit (HDU). Referring to the Keogh review he added that there is an ambition included in the report which states:

We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

The NEWS system will help us achieve this objective.

Dr Turnbull also added that Consultant specific outcome data is included in his Board Report for the first time and will be available on the Trust's website.

End of life care – Dr Turnbull reminded the Board that the Liverpool Care Pathway (LCP) has been under review. It has now been recommended following a review of its use nationally that it is withdrawn from use and that it should be replaced with an End of Life Care Plan. A number of basic principles would be included in that no patient could be placed on the plan without it being approved by a senior clinician and such a decision could not be taken out of hours.

Dr Turnbull added that the use of the LCP in the Trust has been positive for the patients, their family members and staff. The Trust has never used it as a means for payment or to free up capacity. At present, discussions are being held with the palliative care consultants to establish some protocols and guidance for staff to mitigate the risk of no system being in place for patients that would have been placed on the pathway. Dr Turnbull added that this is a transitional period and while the Trust is in this period, it is important that good practice is maintained. Mrs Holden voiced concern about the withdrawal of the system without some guidance being in place. Dr Turnbull agreed with her concern and explained that is why he and the palliative care consultants have been mutually developing a planned approach to care and including additional training around difficult conversations.

Professor Willcocks added that she had received comments from people who are not at all pleased that the system has been removed. They are confused and upset about the change. She added that the letter from Dr Turnbull and Ms McManus was very useful. She suggested that it was reissued to show that the Trust has an alternative best practice approach that can be used.

Action: Dr Turnbull and Ms McManus to reissue the letter

Mr Crowley added that the change affects those that have not experienced the LCP. The outcome, however, must be that we serve the patients better.

The Board thanked contributors for the report.

13/100 Director of Infection Prevention and Control Quarterly Report

Ms McManus presented the report. She explained that it now consisted of a more succinct dashboard. Mr Keaney asked about the seasonal noro-virus. He had noted in the paper that it had closed a number of wards during the year. Mr Keaney was keen to understand the impact on admissions; how the Trust compared to other Trusts. Ms McManus explained that there is no comparative data available; it is more about how to prevent it from spreading once the virus gets into a community. She added that it is not classed as a hospital acquired infection, it generally is acquired in the community and once it gets into the hospital it does spread quite quickly. Mr Crowley added that the Trust is exploring the development of the corridor that runs through the centre of the hospital and change its usage into a logistics corridor. He added that the construction of the wards at present also leads to some

challenges in managing noro-virus because they lead on to one another. Mr Crowley explained that a bed review was also been undertaken as part of the acute review.

Ms McManus added that the Trust can do more to affect a change in the number of closed beds. She explained that each closure was not necessarily a ward, it could be a bay or a room but a balance between bays and rooms should be achieved.

Mr Rose enquired if infection control systems were now consistent across the whole organisation. Ms McManus confirmed the majority of the systems were consistent. There were, however, some areas where this was not the case and infection control was addressing those areas.

Ms Raper welcomed the dashboard and added that she was concerned that the data around prescribing was not robust enough at present.

The Board **noted** the new style report and were assured about the systems and processes in place.

13/101 Francis Report Update

Ms McManus presented the report and advised it was a position statement of where the Trust had reached in addressing the recommendations included in the Francis Report. She explained that the report describes the process being used to develop the final report which will be presented to the November or December Board meeting.

Professor Willcocks commented on the report that the Francis Report does not now sit alone and the Trust should be looking at the bigger picture of ensuring care is delivered within a safe environment that takes into account the quality of the service.

Professor Willcocks felt the task themes were correct and added that it is correct that the Trust has an open culture on quality and safety.

Ms Hayward added that the point is that this should fit in with usual business as opposed to doing something extra. It helps to have the priorities risk rated red – amber – green (RAG) and those priorities then fitting in with our priorities.

Mrs Adams queried the membership of the group identified. She asked if it should not include more front line staff. Ms McManus explained that front line staff had been consulted very early in the process and continued to be engaged in the debates that were being held. The comments and responses were being fed into the group.

The Board **noted** the report and the comments made. They were assured that progress was being made and encouraged by the comments made by Ms Hayward. The Board looks forward to receiving the final report in November or December.

Action: Final report to be presented to the Board of Directors

13/102 Healthcare Governance Unit Quarterly Report

Mr Ashton commented on the report. He was concerned that the data in the report was not appropriate for the Board meeting. He noted that an annual report was due for presentation to the Board in September. He raised a concern that the Audit Committee did used to have a

task group that reviewed the information from the Healthcare Governance Unit and he commented that it might be appropriate to revisit if the group should be reinstated.

The Board agreed with the comments made and it was proposed that discussion of the report was postponed until the annual report was received and further debate and consideration can be given to the information and processes that should be in place.

The Board **postponed** any discussion on the paper.

13/103 Finance and Performance Committee

Mr Sweet presented the deliberations from the Finance and Performance Committee.

Mr Sweet asked Mr Bertram to comment on the Finance Report, specifically in relation to fines and to any mechanism being put in place to recover money for the additional work the Trust has been undertaking above plan.

Mr Bertram advised that the Trust is ahead of the financial plan and trading above the plan has continued. He also explained that at present there was still no mechanism that had been put in place to recover additional monies.

Mr Bertram referred to the Income and Expenditure account and explained that he had introduced a new line to the income and expenditure report this month to capture and disclose actual and potential fines/contract penalties. Included in the position for Q1 are anticipated penalties of £670k. This comprises actual penalties of £70k for 52-week breaches, a £100k assessment of likely 18-week penalties and a £500k prudent assessment of the impact of the excess C-Diff to trajectory for Q1 (10 cases above trajectory at £50k per case). In the case of the C-Diff assumption this is clearly only a marker at this stage as the delivery is contractually measured for the full year.

The income position is based on coded and costed April and May activity and an estimate has been used for June (based on reported activity levels but using average specialty costs). The actual income levels for April and May have been higher than both planned and contracted. Summary activity data for June suggests continued high levels. At this stage, income is assessed to be £2.5m ahead of plan. The Commissioners are still experiencing delays in obtaining data and the Trust continues to share information through the Contract Management Board meetings. Mr Bertram added that although there is no identified mechanism in place, the contract does require payment for all legitimate work done.

Mr Rose enquired if the payment of a penalty is an offset item or is it required it is paid to the Commissioner for it to be used to improve the system in a similar way to the ambulance service penalty approach. Mr Bertram explained that it was different to the ambulance service approach. The mechanism is that following the completion of the reconciliation and the trading position being agreed, any penalties are netted off the amount owed. The penalty money stays with the Commissioner. Mr Crowley added that the levying of penalties does seem to be slightly counter intuitive and helpful and constructive discussions are being held with the Commissioners to look at what is sensible.

Mrs Adams asked if provision had been made around not achieving the Cost Improvement Programme and the CQUIN. Mr Bertram reminded the Board that the Annual Plan did include a significant level of provision.

Mr Keaney asked if the level of provision was satisfactory. Mr Bertram confirmed at this stage in the year (as at quarter 1) he believed it was satisfactory. Mr Bertram added that there are some areas of concern around CQUIN delivery and C-diff issues. He explained that he would prefer to ensure there is investment at this stage to prevent penalties being applied and also being required to make an investment.

Mr Crowley added that the additional work being undertaken does attract more income for the Trust but the marginal cost is a high percentage of the income so the benefits are eroded over a short space of time. He added that he was sure the Board recognised the interdependencies of each element and that the whole picture was very complicated and very finely balanced.

Mr Sweet thanked Mr Bertram for his presentation. Mr Sweet referred to CQUIN information and explained that as it was still so variable, he felt it was prudent to wait until the September Board meeting to feed back on the performance. The Board agreed with his suggestion.

Mr Sweet referred to the efficiency programme and explained that although there were some concerns about the delivery of the programme, his bigger concern was the level of non-recurrent savings that had been identified as opposed to recurrent. Mr Crowley commented that Mr Sweet had to remember the complex interdependencies that exist. Mr Crowley was not concerned about the balance between recurrent and non-recurrent at this stage. He agreed that difficult conversations may need to be held and plans of action put into effect, but the staff have to be motivated to be able to deliver. Mr Bertram added that panels are being used to increase the pressure with directorates along with other approaches including increased performance management and members of the corporate efficiency team being put in place in directorates. Additionally, back office functions are being reviewed.

Mr Rose asked Mr Proctor to comment how it feels to those being asked to deliver the savings. Mr Proctor explained that it has been the subject of a considerable amount of attention but does form part of everyday business. He added that it is a full team effort and both Dr Turnbull and Ms McManus play a key role in that by ensuring the proposed savings do not impact on quality and safety standards.

Mr Keaney suggested that the continued delivery of CIPs was reaching the stage where a step change was required to maintain that delivery. Mr Crowley explained that efficiency programmes were historically managed and were not particularly significant. These days they are very significant and important to the organisation to ensure that it continually ensures it is making choices that ensure efficiency is delivered. If that stops, the Trust will not be in a position where it can continue to have choices and move forward. The pressure will become greater and there will be more challenge as services are commissioned away from the Trust, which will result in less income being available, but the Trust still have the same cost base.

Mr Ashton added that interdependencies are important and continuing to undertake additional work not planned for is an inhibiting factor so it needs addressing. In essence, Directorates that undertake more work above plan have less room to manoeuvre.

Ms Hayward added that the finance report references an over spend on workforce. She felt it was important for the Board to understand the context. She explained the increase in numbers of whole time equivalents (WTE) because it is addressing the financial pressure of using temporary staff, which is more expensive.

Mr Sweet invited Mr Proctor to comment on the performance report. Mr Proctor advised that the Trust had achieved the 18-week target. The new to follow-up ratio position for July was

1:1.9. He added that this has been very challenging. He added that the Trust is committed to delivering 1:1.5 but a further assessment is needed to decide what additional measures need to be put in place to achieve this target and ensure the risk assessment is completed and reviewed by the CCG. The question must then be raised with the CCG if this is still their intention. Mr Crowley added that although the Trust is committed to the ratio, it is not recognised as supported by evidence.

It was agreed that there would be clearer information available to be shared with the October Board meeting.

The Board **noted** the comments and assurances given.

13/104 NHS 111 Service

Mr Proctor advised that there was not a great deal more to add that was not included in the paper. He advised that the service was receiving significant attention nationally and that the Yorkshire Ambulance Service's feedback was good and they were doing a good job.

13/105 Report of the Chairman

Mr Rose highlighted the follow points from his report:

First year review – Mr Rose advised that he had informed Monitor of the Trust's intention to undertake a review of the first year post acquisition. He informed the Board that Monitor had been very positive about the review and had expressed keen interest in seeing the review when it was completed.

Mr Rose referred to the work being undertaken to ensure there was meaningful integration with other parties. He asked Mr Proctor to update the Board on the work being undertaken by the Executives. Mr Proctor advised that there was now an Integrated Care Delivery Board in place which has membership of a number of agencies including the Trust, social services, community services and GP practices. The Board does link into the Neighbourhood Care Team and the work they are doing.

Healthwatch – Mr Rose also commented on Healthwatch. He advised that he and the Head of Patient and Public Involvement Specialist, Mrs Kay Gamble had met all the Healthwatch organisations in the area. Mrs Gamble was the key link to the groups and he asked Directors to ensure if they undertook any work with Healthwatch to make Mrs Gamble aware.

Goodbye to Ms McManus – Mr Rose asked the Board to join him in congratulating Ms McManus on her new role at the Chelsea and Westminster Hospital NHS Foundation Trust and to thank Ms McManus for all her work over the last 10 years. He added that other informal occasions had been arranged to say goodbye to Ms McManus.

Mr Rose added that there would be a meeting of the Remuneration Committee to discuss the approach to the Chief Nurse Role.

The Board **noted** the Chairman's report.

13/106 Report of the Chief Executive

Mr Crowley presented his report and highlighted the complexities of what the organisation is addressing currently. He specifically referred to the development of the acute services and the strategic alliances with Harrogate and Hull and their different approaches.

Mr Crowley discussed the listening exercise that had been launched as part of the first year review following the acquisition. He asked Board members if they would contribute to the preparation work by framing questions that might be included in a consultation document. The Board discussed the approach to staff feedback and how staff is feeling. Mr Crowley explained that this review will give staff the opportunity to reassess their work.

Ms Raper commented that the wrap round item (organ donation) on Staff Matters was an excellent example of staff working in the organisation. The Board agreed.

Mr Crowley referred to the 2nd stage review confirmed by Monitor and explained that this is an excellent opportunity to have some additional consultancy work and the Trust is embracing the approach. The review will look at risks to quality.

The Board **noted** Mr Crowley's comments and his report.

13/107 Monitor Quarterly Report

Mr Bertram advised that the financial submission to Monitor was a financial risk rating (FRR) of 3 in line with the plan. He explained that the information provided could be cross-checked with the finance report included in the papers.

Mrs Pridmore advised that the governance risk rating (GRR) would be amber-green. This is as a result of the performance against the C-Diff trajectory. The Board asked if there would be a further impact on the governance rating as a result of the Trust not achieving the trajectory for two quarters. Mr Pridmore advised that Monitor always have the opportunity to escalate a governance rating and if that was the case they would have a further discussion with the Trust. Mr Crowley did comment that he felt that as there was a planned review arranged around quality that they may decide to pick it up as part of that review.

The Board **noted** the comments and the results and the submission to Monitor.

13/108 Any other business

There were two items of additional business:

13/108.1 Catering project film

Mr Golding was welcomed to the meeting by Mr Rose. Mr Rose asked Mr Golding to present the film. A short film was shown that demonstrated what the new restaurant would look like and Mr Golding advised that it had been agreed that it would be called Ellerby's after a member of catering staff who had died recently just prior to his retirement.

13/108.2 Memorandum of Understanding held with the University of York

Mr Crowley advised that the item had been included for information. It demonstrated the close links that were now developing between the University of York and the Trust. It also provided evidence of the more formal partnership between the two parties.

The Board **noted** the agreement and the increased development of the relationship and the benefits that were expected for all parties involved.

13/109 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 25th September 2013 in The Blue Room, Scarborough Hospital. A Board meeting will be held on 14th August in the Boardroom in York Hospital. Mr Rose advised that the September meeting was likely to be observed by members of the audit team reviewing quality.

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

Patient Experience Report

Summary

This report provides a detailed update from the Patient Experience Team.

Action

The Board is asked to discuss and note the report and is encouraged to discuss areas of specific interest.

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

Implications for equality and diversity

No implications for equality and diversity.

Sustainability assessment

Reference to CQC outcomes

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

Progress of report	This report is written for the Board of Directors.
Risk	No additional risks indicated.
Resource implications	None identified.
Owner	Beverley Geary, Deputy Chief Nurse
Author	Wendy Brown, Lead Nurse Patient Experience
Date of paper	9 September 2013

Version number	Version 1

Board of Directors – 25 September 2013

Patient Experience Quarterly Report

1. Introduction

Patient Experience is a key element of quality alongside providing clinical excellence and safe care.

The Patient Experience Report aims to present a rounded picture of patient experience and as such, provides information on all aspects of experience, i.e. positive feedback and concerns and complaints.

The report presents a wide range of information from different sources, including the following:

- Complaints
- PALS activity
- Patient and Public Involvement activity
- National Surveys
- NHS Choices Feedback
- Comments Cards

The different methods of feedback have their strengths and weaknesses. Using all methods of information available enables the Trust to better understand the patient's experience of the services offered and delivered, and is beneficial to help prioritise areas for improvement.

2. Overview

1. Complaints

The Trust received 102 new complaints in July and August 2013. In the same period last year the Trust received 120 complaints.
Where poor experience is reported, actions are then taken to ensure improvements are made and these will be featured in future reports.

The Trust responds to the majority of complaints within 30 days, this meets the NHS Complaints regulations
9 of the 102 responses to complaints received in July and August were not responded to within the agreed time frame.

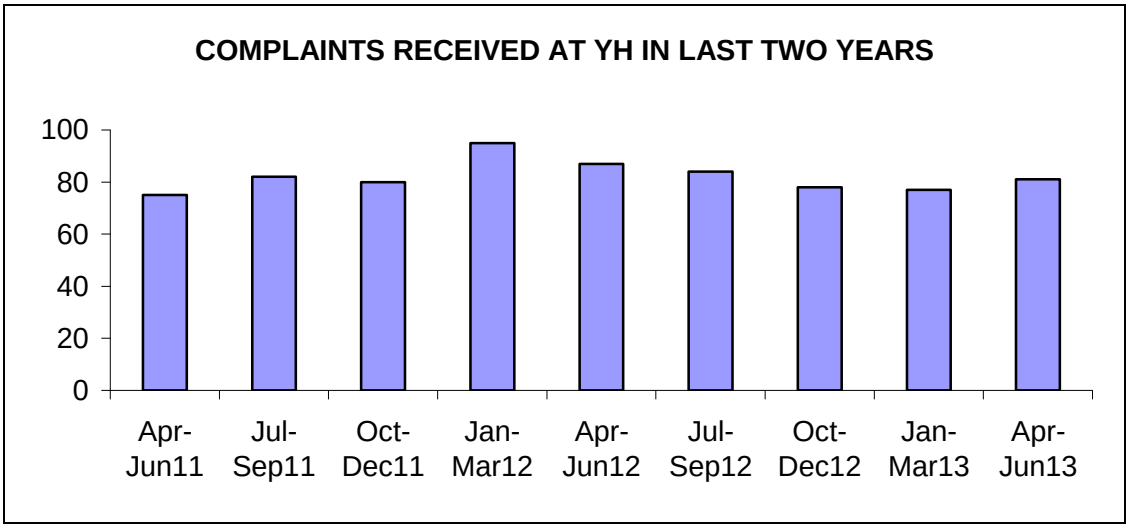
Complaint themes in July and August

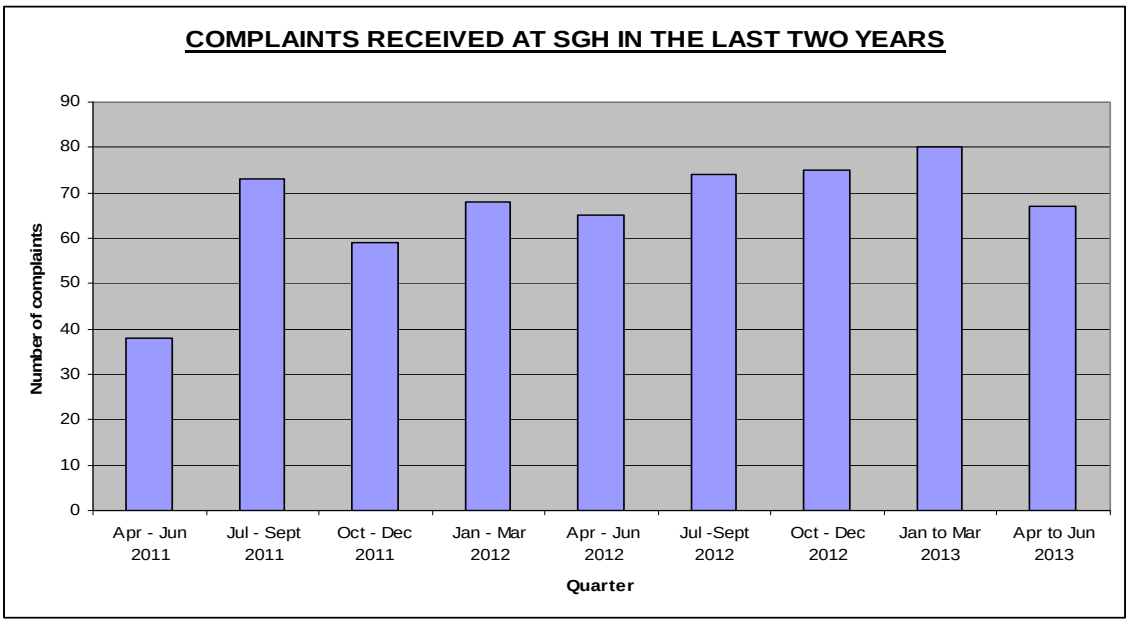
Complaints by subject	York	Scarborough
All aspects of clinical treatment	41	24
Communication/information	3	7
Appointments, delay/cancellation (out-patient)	2	
Appointments, delay/cancellation (in-patient)	3	
Patients' privacy and dignity	1	
Attitude of Staff	1	4
Admissions, discharge and transfer arrangemen		2

Consent to treatment	1	1
Patients' property & expenses	2	
Discharge		1
Complaint Handling		1

The overall trend in the number of complaints received annually suggests that there has been no significant change in the numbers of complaints received in the past two years.

Complaints relating to community services have been handled by the complaints team based at York Hospital since April 2011.





Examples of complaint action plans

(Y13/14-092):
Patient's relative was unhappy with their attendance at the Emergency Department, issues included reception service and system, and lack of information for different clinics/areas. Action includes ongoing awareness updates for staff regarding effective customer care, and review and improvement to public/patient information – the relative and patient have been

invited to contribute to this.

(S13/14-096):
Education Supervisor in ED working with a junior doctor on missed clavicle fracture. Details in e-portfolio of doctor with review of complaint and films.
Additional appointment offered to a patient who had concerns about an unsightly scar.

(Y13/14-082):
A patient complained about the service from the Sexual Health clinic which resulted in a number of actions for improvement, these include: a written policy to be introduced to ensure consistency of consultations and better clinic preparation, staff to receive training in the principles of motivational interviewing and peer supervision to be introduced.

Complaints referred to the Health Service Ombudsman
HSO information for the period July and August 2013

The HSO delivered its decision on 2 York complaints, which it had reviewed. Neither was upheld.

Decisions were given on 2 Scarborough complaints. One was upheld for poor complaint handling and incurred a payment of £250 to the complainant for redress. The other was partially upheld on clinical grounds due to poor records, failure to properly assess the patient and failure to request a CT scan. It was upheld for poor complaint handling, again incurring a payment of £250.

HSO recommended payments for complaint handling deficiencies are an emerging theme at Scarborough due to poor complaints handling performance. Contributory factors include the standard of investigation, evidence and written reports. The Lead Nurse and Head of Patient Experience provide feedback to Investigating Officers relating to the quality of reports received. Discussions with the Director of Operations and Assistant Director of Nursing are held on an as required basis in relation to complaint themes and the quality of responses.

Resources within the Patient Experience team at Scarborough have also impacted on performance in a small number of cases. The Lead Nurse and Head of Patient Experience review the status of all complaints handled on the Scarborough site weekly to mitigate this risk.

2. Patient Advice & Liaison Service (PALS)
The Trust handled 1026 PALS contacts in July and August 2013. Of these 257 were handled on the Scarborough site and 769 were handled on the York site.
PALS themes in this period include –

York site:

- Concerns raised regarding discharge arrangements across the Trust.
- Increased number of calls from social care staff with concerns relating to patient discharges, e.g. medication queries
- 4 concerns re Out of Hours Service forwarded to Harrogate Hospital. Enquirers find it hard to comprehend that a service based within York Hospital is managed externally and therefore outside of our jurisdiction.

Scarborough site:

- Enquiries about all aspects of clinical treatment
- General advice
- Out Patient appointments
- Enquiries about ophthalmology appointments
- Enquiries about neurology appointments

Changes made as a result of PALS intervention
A patient checked the Trust website for information relating to Healthcare at Home Pharmacy; the detail was incorrect which resulted in the patient experiencing a delay in collecting prescribed drugs.
Action: Communications Team amended the information and will work more closely with Healthcare at Home to ensure information is updated when necessary.

A patient wishing to access medical records highlighted a problem with links to the application form.
Action: Communications Team amended the webpage.

PALS were contacted by a bereaved relative who was very unhappy with several issues including mortuary access and clinical questions regarding patient's condition and cause of death.
Action:
Lead Nurse for Patient Experience offered apologies and condolences; she provided explanations regarding the Coroner's involvement and arranged a viewing of the body. Specialist nurse met with family to discuss events leading up to death and possible cause of death. Family provided with the phone number of the Consultant's secretary if they would like further discussion.
Action: Lead nurse discussed all issues with the relevant Matron, action plan drawn up to address leaning at ward level.

3. <u>Patient & Public Involvement (PPI) activity</u>

The Friends and Family Test:
All adult inpatient wards (IP) and emergency departments (ED) across the Trust continue to embed the national Friends and Family Test into their practice. The response rate has dropped from 24.3% in July to 17.05% in August. This is below what we are required to achieve for the target of a 20% response rate in quarter 4.

Inpatients across the Trust continue to perform well but our Emergency Departments are struggling to gain the response rate required.

	Responses	Eligible	Response rate
Obs Ward	0	142	0.00%
Scarb ED	111	2660	4.17%
York ED	600	4081	14.70%
Total ED	711	6883	10.33%

	Responses	Eligible	Response rate
Brid IP	1	102	0.98%
Scarb IP	312	911	34.25%
York IP	694	2183	31.79%

Total IP	1007	3196	31.51%

	Responses	Eligible	Response rate
Trust	1718	10079	17.05%

A token system is now being procured for both Emergency Departments and will be place in October 2013. Additionally, Governors have been invited to volunteer in both emergency departments to help improve the responses received. An information session is being held for Governors on 4th and 9th October at both York and Scarborough respectively.

The Friends and Family Project Steering Group met during August and will continue to meet every six weeks to ensure that the Trust meets required targets across the Trust and agrees reporting and governance arrangements.

Ward and Department FFT 'Champions' were identified and attended a FFT forum during August both at Scarborough and York sites, with staff from Bridlington Hospital also attending.

Maternity Services FFT

The Friends and Family Test was rolled out across the maternity services pathway this month. Maternity staff, across hospital and the various community settings ask women at four different touch points how likely they are to recommend:

- Our antenatal service to friends and family (asked at 36 week antenatal appointment across the community and hospital)
- Our Labour ward/birthing unit/homebirth service (asked at discharge from labour ward or discharge from postnatal ward)
- Our postnatal ward (asked at discharge from ward/birth unit/following a home birth)
- Our postnatal community service (asked at discharge from the care of the community midwifery team to the care of the HV/GP)

The same methodology is being used as for Inpatients and the Emergency Department which consists of an A5 postcard with the option to complete on-line.

The Maternity Services Project group is due to meet in September to review the implementation of FFT across maternity services. This element of FFT is due for national roll-out in October but the Trust has commenced FFT early in order to mitigate against any issues and risks identified during this early implementation phase.

National Survey Programmes

National Cancer Patient Experience Survey 2012/13
This report summarises the key findings of the third National Cancer Patient Experience Survey. It provides key findings from the survey about the patient's experience of cancer services provided by York Teaching Hospital NHS Foundation Trust. It is the first Cancer Patient Experience survey to be carried out following acquisition of Scarborough and North East Yorkshire HealthCare NHS.

The results are positive for the Trust and show that we have improved in areas where the 2011/12 survey highlighted there was a need to. In questions asked around diagnostic tests,

clinical nurse specialists, support for people with cancer, operations, ward nurses, information given before leaving hospital, hospital care as a day patient/outpatient we have improved on the majority of questions compared to the previous survey.
The survey shows that 91% of patient's reported that their care was either 'excellent/very good'.

Questions where the Trust requires to improve and which formed part of the National Cancer Patient Experience Survey Action Plan 2012-2014 are around Cancer Research and patient being offered a written assessment and care plan.

The Trust, when comparing the combined findings from 2011/12 have improved in the majority of areas, and this provides the Trust with a very credible snapshot of what our patients feel about the services they access.

A full summary report will go to the Board of Directors in October 2013.

CQC National Inpatient Survey 2012

This was the first patient survey to provide us with a combined analysis for York Hospital and Scarborough Hospital sites. The number of patients taking part in the survey is larger than previous years. This is due to the sample being doubled to 1700 to reflect the new organisation.

The Picker Institute was commissioned by 72 UK trusts to undertake the Inpatient Survey 2012 which asks the views of adult inpatients having at least one overnight stay in hospital during August 2012. the survey covers the issues that patients consider important in their care and offers an insight into their experience.

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

Key Positive Findings:

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

Key Negative Findings:

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

Doctors:
49% of patients reported that they did not always get opportunity to talk to a doctor
30% of patients said that they did not always get clear answers to questions

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

Whilst the report highlights areas where the Trust is performing well and where we need to improve, it is important that we understand that the two hospital sites compare differently in

relation to some questions which may not immediately highlight areas for focus if we simply looked at the overall report.

All directorates produce a detailed action plan containing areas for focus which links to the overall Trust Inpatient action plan

4. Patient Feedback

NHS Choices Feedback and Comment Cards
Patients, their carers and families are able to freely comment on any aspect of services using Trust comments cards or through the NHS Choices website.
Patients using the NHS Choices website in July and August 2013 gave York and Scarborough Hospitals an overall rating 4.5 stars, i.e. Extremely likely to recommend

A selection of the comments made by patients who have posted feedback on NHS Choices or who have completed comment cards are included below. The comments are very valuable in reflecting what matters most to patients. The comments are fedback at individual ward level where applicable and can provide a useful insight into priorities for action and improvement for ward teams.

"Treatment so good I could move to Scarborough.

Nobody wants to end up in hospital whilst on holiday but I did. I usually use these forums to complain about bad service but not in this case. After being admitted to A&E I was treated with the up most respect and care. I was then kept in overnight on Holly Ward. Now I have had spells in some of Yorkshires biggest private hospitals but take it from me the care and attention I received at Scarborough was definitely equal and in many respects better. The ward was clean the staff helpfully friend and had time for you. The food was excellent. The doctors polite.
The NHS comes in for a lot of bad press well make no mistake it works in Scarborough."

Visited in August 2013. Posted on NHS Choices August 2013

"Procedure made bearable!

Yesterday I had a 'procedure' carried out in the Day Unit by a doctor and colleagues in the Gynaecology/Urology dept. Throughout the whole experience I was treated with kindness, dignity and respect and I would like to extend my thanks to the whole team."

Visited in August 2013. Posted on NHS Choices 30 August 2013

"Thank you everyone

Thank you for the care that I received last week when I came in for a minor surgical procedure.

Everyone who treated me could not have been kinder. The anaesthesia and surgical teams explained their roles in a very reassuring way and the staff on Haldane were superb. I was treated with efficiency, dignity, care and friendliness all the time.
I would not hesitate to recommend the hospital.
Thank you again for making a difficult day as easy as it could have been."

Visited in August 2013. Posted on NHS Choices 27 August 2013

Examples of feedback received in July/ August from Comment Cards
"Wonderful service, excellent care. Very professional staff and very caring. Cannot praise them enough."

"Staff exceptional – really caring, helpful and sympathetic. Lovely people."
Comment card completed following procedure on Vascular Imaging Unit.

Compliments
Positive feedback is collected every quarter and will be included in future Patient Experience reports at the end of each quarter.

The issues most frequently raised by complainants across all Care Groups relate to clinical treatment & nursing care and staff attitude and communication. This finding is echoed in patient experience information, both positive and negative gathered through general feedback.

The fact that issues of 'attitude' and 'communications' are frequently commented on by patients and their families highlights their importance in the overall experience.

The Trust places great importance on Values Based Recruitment. Scenarios and questions designed to explore communication and a real understanding of what matters to patients feature in the Trust's recruitment processes. Patient Experience is featured in all induction programmes for our registered and non registered nursing workforce and for medical staff.

The Lead Nurse Patient Experience is currently working with NHS Elect to develop customer care training, aimed in the first instance at sisters/matrons who will then be expected to cascade the training to their areas of responsibility/teams
This training will encourage a common approach with clear expectations & fits with the Trust's Values and Personal Responsibility Framework

The first session, on 27 September 2013, will be delivered in partnership with NHS Elect. Further information will be contained in future reports.

Healthwatch
From 1 April 2013 York LINk was replaced by Healthwatch.
The Health and Social Care Act 2012 stated that Healthwatch would be the new consumer champion for health and social care for adults, children and young people. Members of the Patient Experience Team have met with Healthwatch to agree ways of partnership working. Healthwatch will work with the Trust to ensure the public are involved with, engaged in and informed about decisions taken about healthcare across the city. Information from reports produced by Healthwatch will be included in future Patient Experience reports.

3. Recommendation

The Board is asked to discuss and note the report and is encouraged to discuss areas of specific interest.

Author	**Wendy Brown, Lead Nurse Patient Experience**
Owner	**Beverley Geary, Director of Nursing**
Date	**September 2013**

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York Teaching Hospital NHS
NHS Foundation Trust

Quality & Safety Committee – 18th September 2013 – Neurosciences Seminar Room

Attendance: Libby Raper
Jennie Adams
Philip Ashton
Beverly Geary
Alastair Turnbull
Anna Pridmore

The meeting was observed by a member of the KPMG team.

Apologies: There were no apologies for absence.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last meeting notes dated 24th July 2013**		LR welcomed Philip Ashton to the Committee. The Committee welcomed Beverly Geary in her new role as Director of Nursing to the Committee. LR outlined the purpose of the group and how the group related to other Board Committees. AT advised that he was now the executive lead for Infection Prevention Control and holds the title of Director of Infection Prevention and Control. LR welcomed the addition of the reference to Assurance Framework and Corporate Risk Register on the agenda and asked all to review for completeness. The Q&S Committee welcomed the introduction of the dashboard and noted the adoption of benchmarked formats. It was recognised that the		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	Last meeting notes dated 24th July 2013 cont'd		Q&S dashboard does include important data from external sources, specifically relating to the Trust's performance around quality and safety. It noted the piloting of a corporate dashboard and stressed the need for alignment as these develop. PA pointed out, from an Audit Committee perspective, that the Audit Committee needed to be assured that all dashboards are rigorous and consistent. **First: follow up ratio** – AT advised that a meeting with the CCG was programmed to be held in October 2013 to discuss the delivery of the target of 1:1.5 follow ups. He explained that there are some concerns about achieving the target both within the Trust and within Primary Care. He added that from the Trust's perspective, Consultants will not discharge any patient they feel it would be unsafe to discharge. AT added that this initiative does have an impact on patient choice in that some patients have been very distressed that they have been discharged and it is not how they would like their care delivered by the hospital. It was agreed that AT would update the Q&S Committee on a monthly basis. The Committee reviewed the notes from the meeting held on 25th July and confirmed that in the light of the agenda there were no further matters arising from the minutes.		
2	**Quality Governance Framework guidance published by Monitor**		AP advised the Committee that she had developed a 'comply or explain' document to be used as evidence against the guidance. She advised that it was in the final stages and would be being reviewed by the Corporate Directors. She explained that the	The Trust is considering and developing a method of demonstrating compliance with the guidance released by Monitor.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
2	Quality Governance Framework guidance published by Monitor cont'd		document would be included in the November Board pack. AP added that the document would serve as the basis for the updating of the Quality Governance Framework.		
3	**Integrated dashboard** - SI Internal Audit Report - Patient walk rounds - Consultant appointments - Mortality programme update - VTE - IPC update	1.1, 1.4, 1.9, 1.10, 1.11, 1.13, 1.15 CRR 7,19, 4,20, 44,45	LR asked AT to update the Committee on the progress against the Internal Audit Report on Serious Incidents (SI). AT advised that he, along with the responsible manager and the Chief Executive, had met with Internal Audit to discuss the findings of the report and confirm compliance with the recommendations. AT explained that the SI process is constantly changing and being updated and ensuring that there is involvement from the Directorates and that the reports are accurate and reflect the incident. He added that there is also some work being undertaken to discuss how the commissioners feel about the SI reports. The Committee asked AT to remind them of the headlines of the report. AT advised that the issues identified related to the timeliness of reports, the content of reports and the need to involve more clinicians in the process. AT also advised that as the new rules for Coroners have now come into force, the Trust is working closely with the Coroners to ensure the reports are produced in the timeline that is appropriate. AT summarised the development of the pilot dashboard and highlighted the metrics that were included. He explained that the metrics included internal data, and data from external sources such as CHKS and Dr Foster. He added that the dashboard over time will largely replace the information that	The Committee was delighted to receive the draft dashboard and took assurance from the information included. The Committee will spend some time outside the meeting working with	AT to comment on the pilot dashboard.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3	Integrated dashboard cont'd		was included in the Chief Nurse and Medical Director reports. AT acknowledged the hard work that had gone into developing the dashboard. The Committee agreed that significant work had been completed in the development of the dashboard. The Committee reviewed the dashboard and AT commented on the key points: **Mortality** – AT referred to the dashboard and reminded the Committee of the three stages in the mortality reviews. The Committee discussed the stages and noted that coding continues to be a concern to AT. **Never events** – AT confirmed there had been no never events. **VTE** – The Committee recognised on going progress. AT explain that August data was validated. **Theatre Safety Briefings** – The Committee noted the significant improvement in recording of use of the system. AT explained that currently Scarborough remained a paper system, although plans are in place to move to the electronic system. **CQUIN** – AT identified that the Trust did have some challenges to achieving the targets related to pressure ulcers, Consultant post-take ward rounds in 12 hours and length of stay. Other targets are still challenging, but AT felt the Trust was at this stage making good progress to achieve them. **Safety thermometer** – BG commented and advised that the Trust is demonstrating good performance.	AT to develop and refine the dashboard.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3	Integrated dashboard cont'd		against the benchmarking that is being undertaken**.** **DIPC** – AT confirmed that he is delighted to have been appointed DIPC. He advised that there had been a further MRSA case in the Trust in August and a Root Cause Analysis is being undertaken. In terms of C-Diff the Trust is still in breach of its trajectory, but there has been a reduction in the rate of cases. The Trust has undertaken a number of actions including asking consultants to check the length of a course of antibiotics, redesigning the RCA documentation and from October in York and November in Scarborough any patient over the age of 65 with a prescription for antibiotics will also be prescribed probiotics. The Trust has also introduced Hydrogen Peroxide Vapour (HPV) as a method of clearing an area. There are very clear defined criteria for its use. **Public Health England** - AT updated the Committee on the support requested from Public Health England. AT advised that they had heard from Public Health England that from the information the Trust had provided, they were doing everything they should do, so Public Health England were holding a watching brief over the request for further support. **Leadership Walk rounds** – The Committee discussed the information and asked for some assurance to come back to the Committee that the actions coming out of the walk rounds had been implemented. **Escalation Beds and Resilience Plan** – AT advised that a robust approach was being taken to the Resilience Plan. He explained that there are some	The Committee was assured by the comments made by AT and the comments received from Public Health England.	At to update the Board on C-Diff.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3	Integrated dashboard cont'd		beds in the Trust that have been in place on a more permanent basis than was expected. Work was underway to ensure those beds were funded and would become part of the permanent bed stock. He added that there have been some issues at Scarborough recently in managing the patient flow as the bed stock is not sufficient. This has had an impact on elective work. The Committee noted that there would be more funding for nurses, but not doctors. AT explained that the clinical workforce cannot be flexed in the same way. The Trust does try to avoid using locums generally and would not employ locums just because it was a bit busier than normal. The Trust does, however, have a number of Advanced Clinical Practitioners that are being introduced to the Trust. **Maternity services** – BG advised that there has been a huge amount of work around both sites on training to address the outstanding issues. This work has been undertaken as part of the work around CNST. A Local Supervisory Authority visit is planned for October 2013. BG will update the Committee at the next meeting.	The Committee was assured that significant work was being undertaken to ensure the plans were put in place. The Committee looks forward to receiving the plans at the Board meeting in due course.	AT to comment on the Resilience Plans.
4	**Medical Director report**		**Sepsis** - AT presented his supporting paper and referred to the Sepsis update included. He summarised the work that had been done in the Trust to improve the way the Trust responds to patients with sepsis. **Information Governance Group** - AT advised that the Information Governance Group had met recently. He summarised the work they were undertaking and described the new 'ISIR grading tool' that had been introduced by the information commissioner. **Patient Safety Group** - AT summarised the recent meeting of the Patient Safety Group. He advised that	The Committee was pleased to hear of the work of the Information Governance Group and assured by the comments made by AT.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
4	Medical Director Cont'd		this report and the dashboard covered all the information that was discussed in the Patient Safety Group. He added that the Trust could now also declare compliance with the NPSA spinal alter.		
5	**Chief Nurse Report** - Nursing and Midwifery Strategy - CQC feedback - Pressure Ulcers - External Audit Comment on the Quality Report	3.9, 2.18	**Nursing and Midwifery Strategy** – BG advised that the Nursing and Midwifery Strategy was being launched at the AGM. The action plan associated with the strategy was included in the papers. The Committee were delighted to see the plan and noted that it was aligned to the 6 Cs. BG confirmed that she would update the Committee on a quarterly basis. **CQC** – BG commented that the Trust had commented on the draft reports from the CQC following their recent visit. The Trust had now received the final reports and these would be part of the Board papers. The reports for York were very good and showed full compliance. The report for Scarborough was also very good, but had two areas were work was identified. Those actions are being carried out. **Pressure Ulcer Reduction Plan** – BG updated the Committee on the pressure ulcer reduction plan. She highlighted the difficulties in the community specifically around patients in their own environment. The Trust invited external support last December to review the systems the Trust is now taking stock against those findings and agreeing areas to focus on. These will be brought to the Q&S Committee. A Pressure Ulcer Panel has been established which is looking at various elements of the plan. **Staff** - BG commented on the recruitment of staff following the focussed work on the establishment and acuity of patients.	The receipt of the final reports from CQC. The Committee will be discussing the reports in detail at the next meeting.	BG to update the Board on the Pressure Ulcer Reduction Plan. BG to update the Board on the recruitment of staff.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
5	Chief Nurse Report cont'd		**Nursing Documentation** - BG highlighted the work being undertaken around the nursing documentation review. She explained that the review will ensure that the documentation is streamlined and appropriate care planning and risk assessment is maintained. **External report on Quality Report** – AP advised the Committee that the Limited Assurance Report prepared by External Audit on the Quality Report had been presented to the Audit Committee at their meeting in September and had also been presented to the Council of Governors. She added that the Q&S Committee were due to receive a quarterly update report on the Quality Report. It was agreed that this would be brought to the meeting in November.	The Committee was assured by BG's comments.	
6	**Patient Experience Report** - Family and Friends		**Patient Experience –** BG presented the patient experience report and explained the work she is undertaking around reviewing how patient experience information is captured and how the Trust uses the PPI leads. She explained that she was working closely with the staff to review all their systems and processes and the links to Governors and the patient and public. **Health Service Ombudsman** – BG referred to the complaints referred to the Health Service Ombudsman, she confirmed that currently there are two cases the Trust is dealing with. It was agreed the next quarterly report would be presented to the Committee in November. **Family and Friends** – BG referred to the Family and Friends section of the report. She explained that the area of difficulty was still in the Emergency Departments, but she has arranged a meeting with a number of Governors who have expressed an interest in helping the departments to obtain the feedback.	The Committee was assured by the comments made by BG around the review and development of the report and noted the work that was being undertaken around Family and Friends.	BG to update the Board on the Family and Friends.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			She explained that the Trust had also invested in the token system, which has been successfully adopted in other Trusts. This will be in place over the next few weeks, but as it is only a token that is posted, it does mean that the Trust will not gain any of the qualitative data from patients.		
7	**Cancer Survey**		It was agreed to postpone this item until the next meeting, when the full report would be available.		
8	**Any other Business**		There was no other business.		
9	**Dates for meetings Work programme**		The dates of the meetings were agreed from January 2014 and it was noted that the work programme would be updated in the normal way.		

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York Teaching Hospital NHS
NHS Foundation Trust

Patient Safety and Quality Dashboard

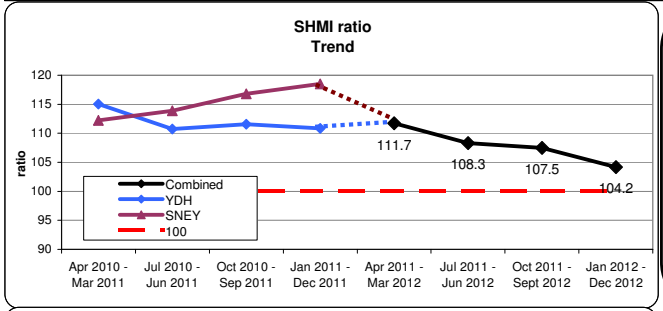
Report: September 2013

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

Index

Patient Safety

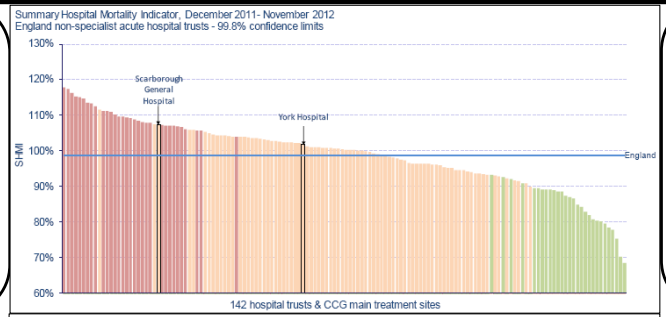
Mortality



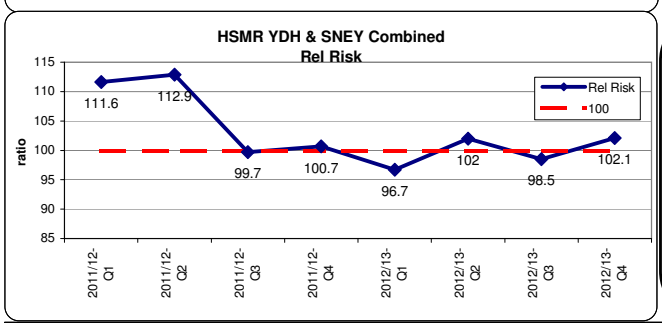
The combined Summary Hospital-level Mortality Indicator (SHMI) is 104.2 and indicates a gradual decrease over the last 12 months.

The next SHMI report for the period ending March 2013 will be published on 29th October.

Data source: Health and Social Care Information Centre.

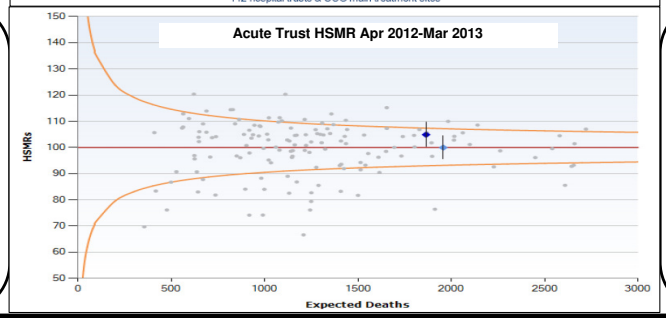


The SHMI report from December 2011-November 2012 illustrates the position for both hospital sites in comparison with other Trusts in England.
Scarborough Hospital at that time had a SHMI of 107 which is non-significantly higher than England, and is ranked 25th highest, York Hospital had a SHMI of 102 and is ranked 62nd highest.
Data source: Public Health England:



The Hospital Standardised Mortality Ratio (HSMR) indicates no significant change over the last 12 months

Data source: Dr Foster Intelligence

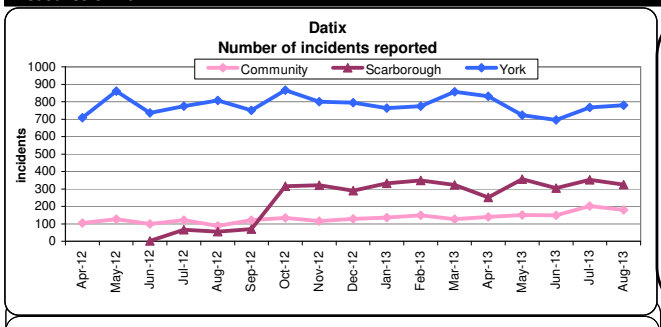


The background points show the HSMR for the financial year for each acute non-specialist trust in England

National Average
99.8% Control Limits
Acute Trusts (non-specialist)
York Teaching Hospital NHS Foundation Trust Apr 2012-Mar 2013
York Teaching Hospital NHS Foundation Trust Apr 2012-Mar 2013 rebased

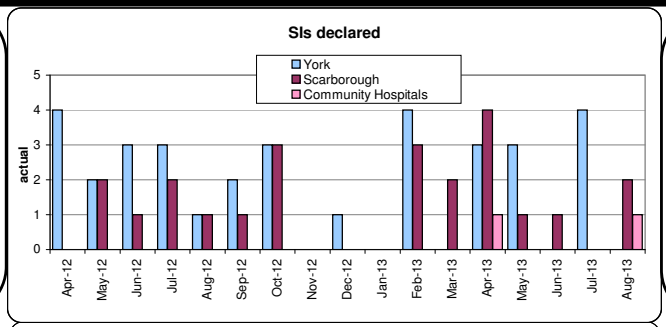
Data Source: Dr Foster Intelligence

Measures of Harm

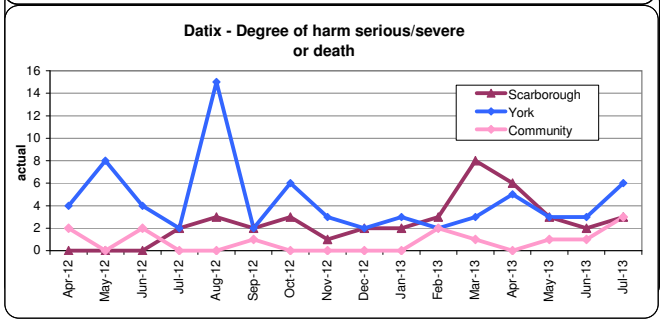


The total number of incidents reported in July was 1322 and 1284 incidents were reported in August.

Data Source: Datix

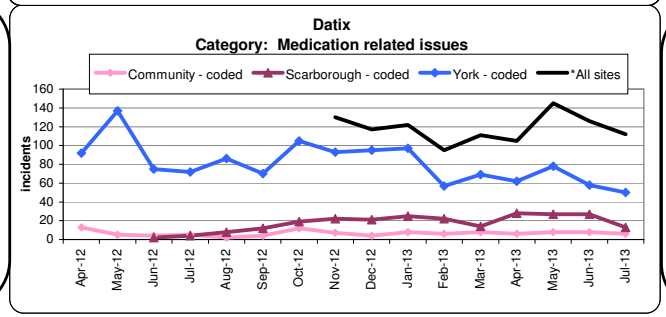


The were four serious incidents (SIs) declared in July, two due to development of category 4 pressure ulcers, one due to intubation difficulties in maternity and one due to a power outage. There were three Sis reported in August, two due to development of category four pressure ulcers and one due to an extended (>12 hour) wait in the Emergency Department at Scarborough Hospital.



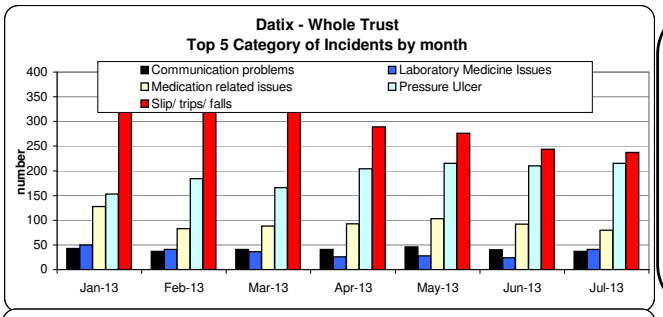
Nine incidents reported in July resulted in a serious outcome.

Data Source: Datix



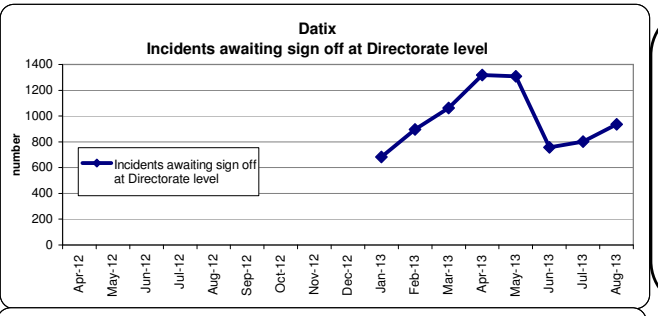
At the time of reporting, 69 incidents relating to medicines have been reported. As some incidents are still under investigation it is expected that this number will increase.

Data Source: Datix



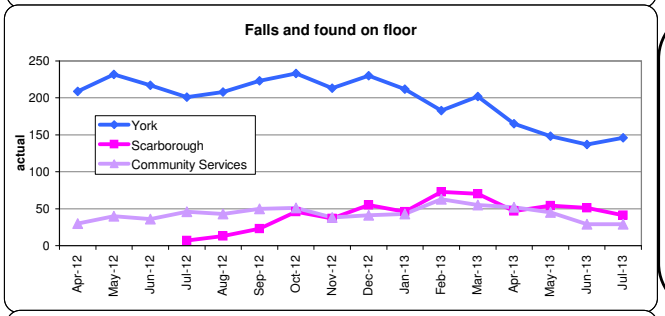
The five categories of incident most frequently reported remains unchanged. It should be noted that Laboratory Medicine issues relate to incidents in many directorates, they are not all attributable to the Laboratory Medicine Directorate.

Data Source: Datix



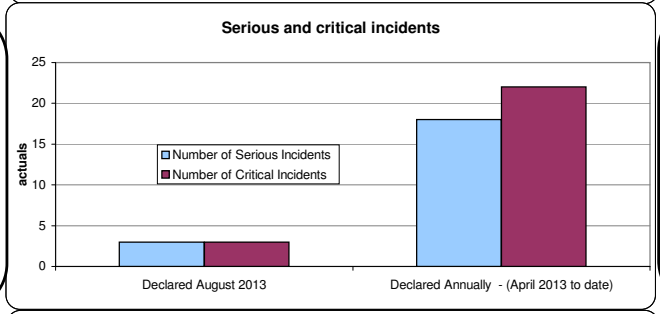
There has been a slight increase in the number of incidents awaiting investigation or final approval of the investigation during August. The Risk and Legal Dept have reviewed all incidents awaiting investigation to ensure that serious incidents have been investigated as a priority.

Data Source: Datix

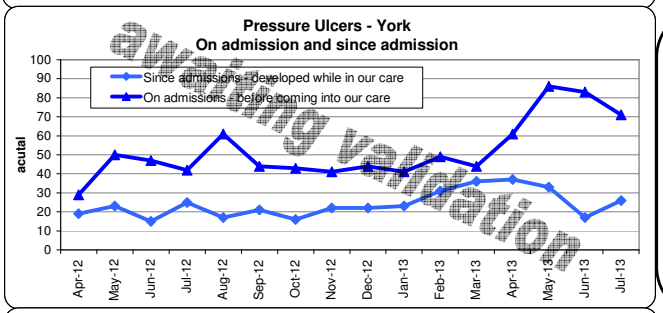


Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust.

Data Source: Datix

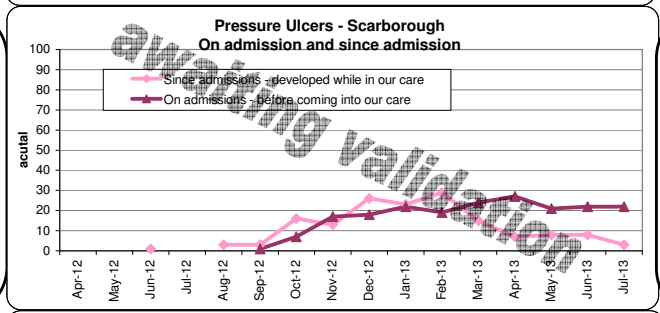


To date the Trust has declared 18 serious incidents and an additional 22 critical incidents have been investigated.



Data accuracy cannot be assured for the months of June and July due to problems with the datix system. Currently being investigated.

Data Source: Datix



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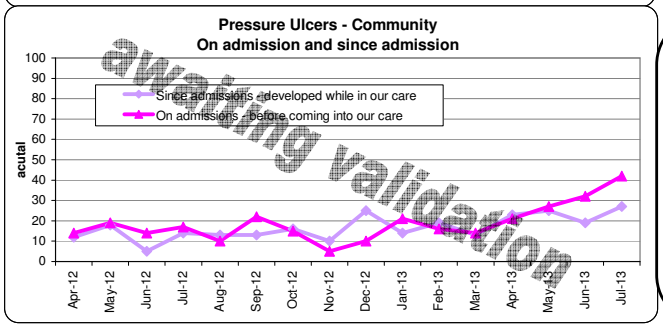
Data Source: Datix



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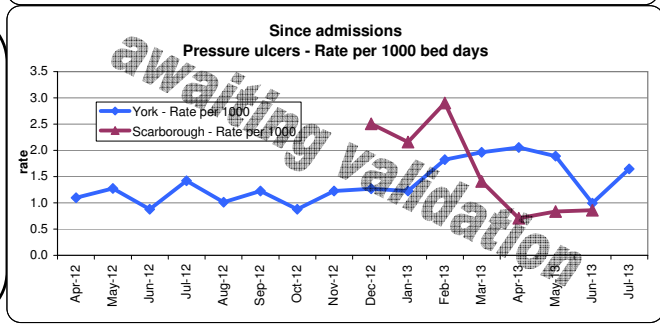

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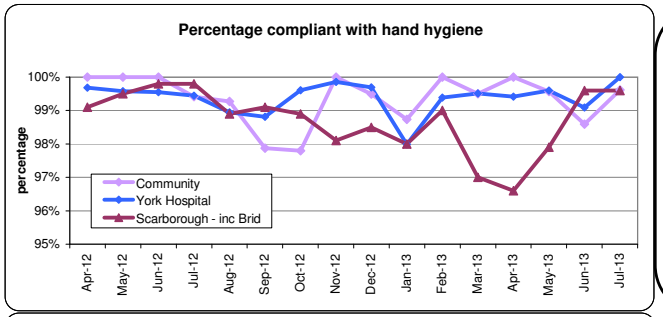
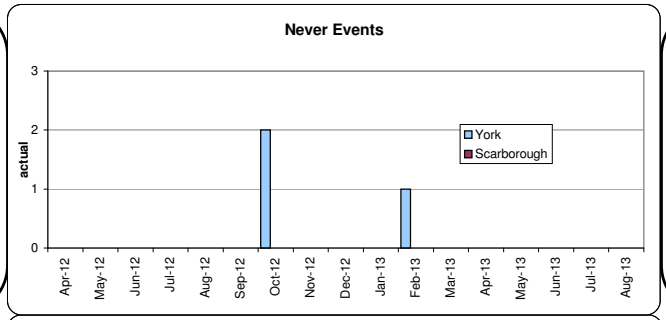
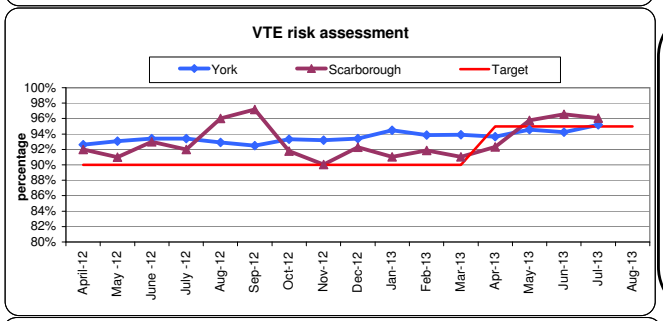


Hand hygiene compliance was recorded as above 99% for all sites during July. Scarborough figures include Bridlington Hospital.

Please note, scale starts at 90% to show detail.

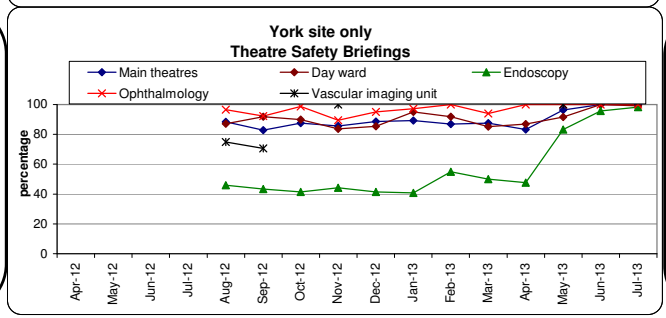


There have been no 'never events' reported since February 2013.



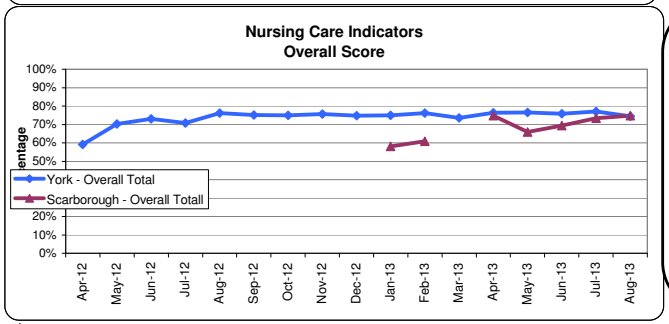
Compliance rates with VTE risk assessment are not available for August at the time of reporting.

Data Source: Systems & Network Services



Good rates of compliance with theatre safety briefings continues to be reported.

Data Source: Signal



The nursing care indicators are calculated from an audit of care from a sample of 5 patients per ward. Each ward is audited once a month. Scarborough March 2013 data not available.

A breakdown of the scores for each indicator from April 2013 is provided in the table below.

York

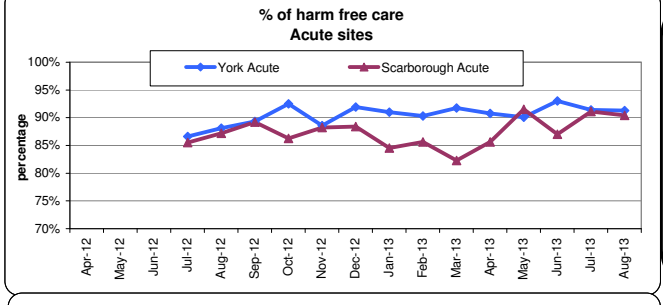
Average of Score	Date				
Criteria	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Combined Assessment Tool Demographics	95%	94%	97%	99%	97%
Waterlow	75%	65%	59%	69%	66%
Falls Assessment	71%	68%	72%	77%	73%
Manual Handling	79%	76%	77%	79%	81%
Nutritional Assessment	65%	71%	71%	67%	63%
Comfort Round	69%	74%	78%	76%	76%
Patient Questionnaire	97%	96%	98%	no data	80%
Critical Care	93%	91%	96%	100%	100%
Overall Total	76%	77%	76%	77%	75%

Scarborough

Average of Score	Date				
Criteria	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Combined Assessment Tool Demographics	90%	87%	87%	88%	92%
Waterlow	70%	65%	60%	82%	70%
Falls Assessment	77%	72%	71%	78%	78%
Manual Handling	79%	78%	70%	77%	79%
Nutritional Assessment	58%	42%	52%	55%	57%
Prescription Documentation	86%	83%	82%	no data	no data
Comfort Round	70%	67%	83%	84%	91%
Critical Care	98%	N/A	N/A	N/A	N/A
Overall Total	75%	66%	69%	73%	75%

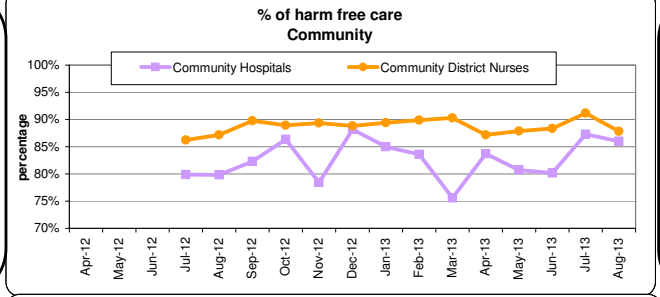
A breakdown of the indicators is provided in the Chief Nurse Report.

Safety Thermometer



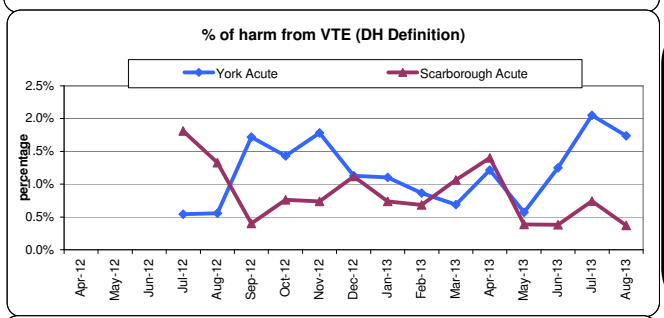
Percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE. Measured as a monthly prevalence score.

Data source: Safety Thermometer



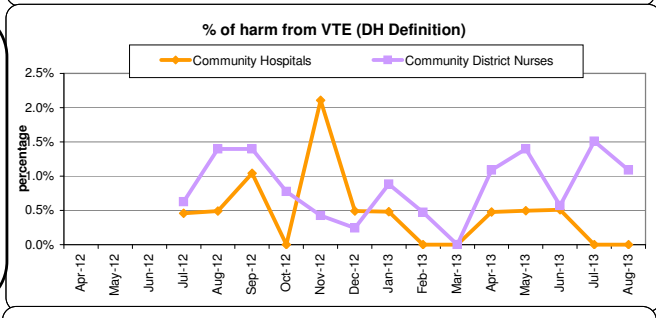
Percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE. Measured as a monthly prevalence score.

Data source: Safety Thermometer



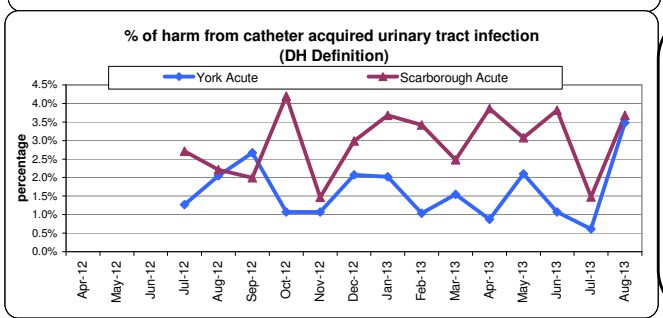
Percentage of patients affected by VTE as measured by the Department of Health (DH) definition, monthly measurement of prevalence.

Data source: Safety Thermometer



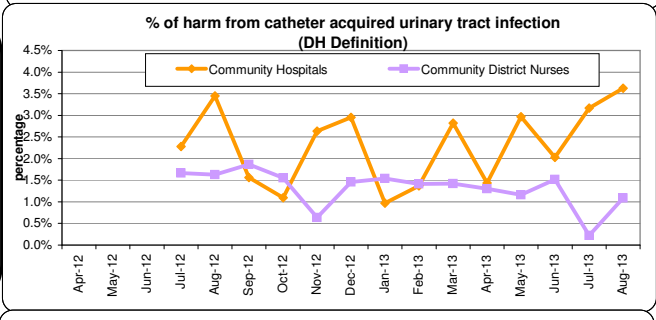
Percentage of patients affected by VTE as measured by the DH definition, monthly measurement of prevalence.

Data source: Safety Thermometer



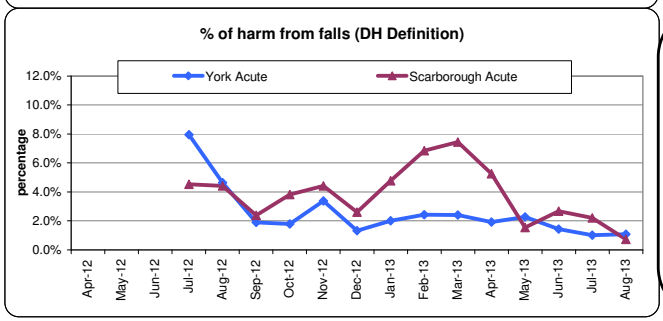
Percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence.

Data source: Safety Thermometer



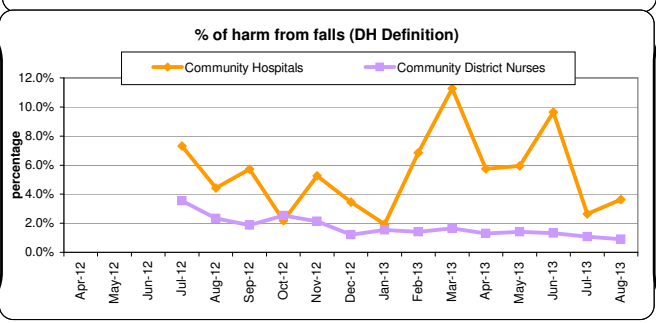
Percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence.

Data source: Safety Thermometer



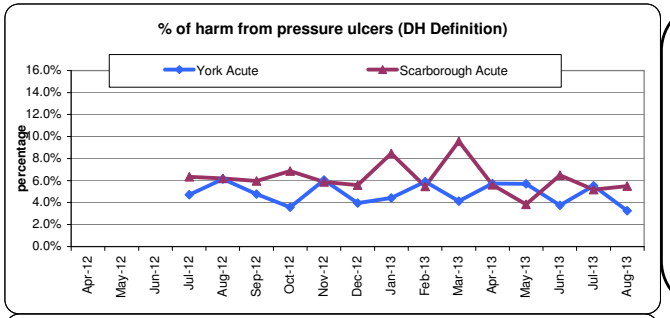
Percentage of patients affected by falls as measured by the Department of Health data definition, monthly measurement of prevalence.

Data source: Safety Thermometer



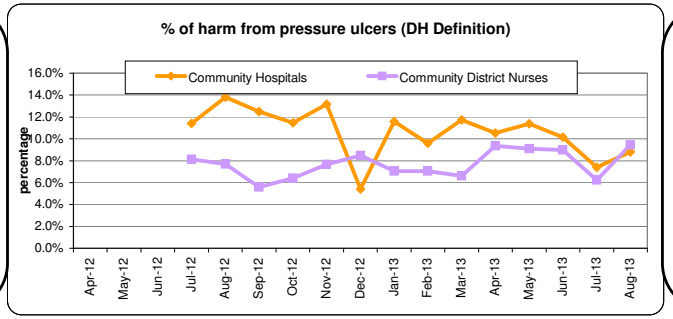
Percentage of patients affected by falls as measured by the Department of Health data definition, monthly measurement of prevalence.

Data source: Safety Thermometer



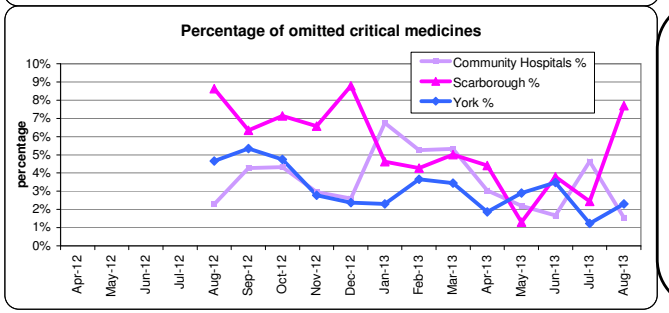
Percentage of patients affected by pressure ulcers as measured by the Department of Health data definition, monthly measurement of prevalence. Counts all ulcers old and new.

Data source: Safety Thermometer



Percentage of patients affected by pressure ulcers as measured by the Department of Health data definition, monthly measurement of prevalence. Counts all ulcers old and new.

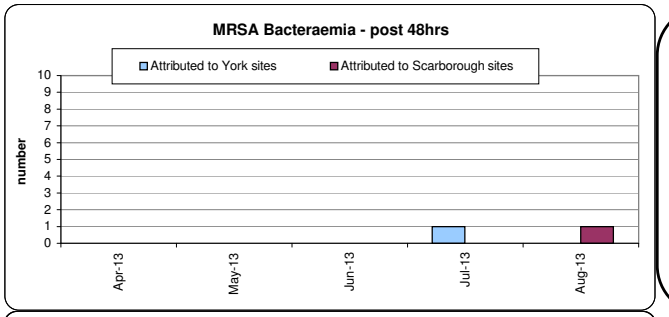
Data source: Safety Thermometer



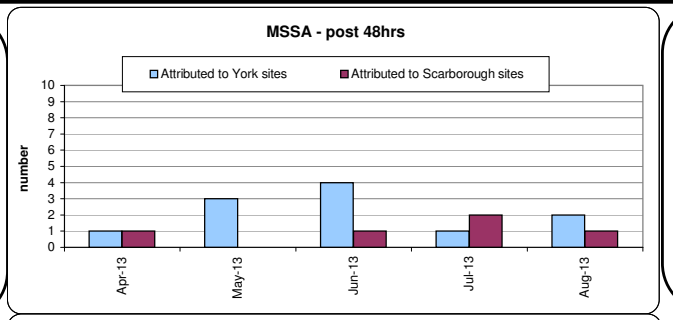
The Trust measures this additional indicator, for local reporting only.

Data source: Safety Thermometer

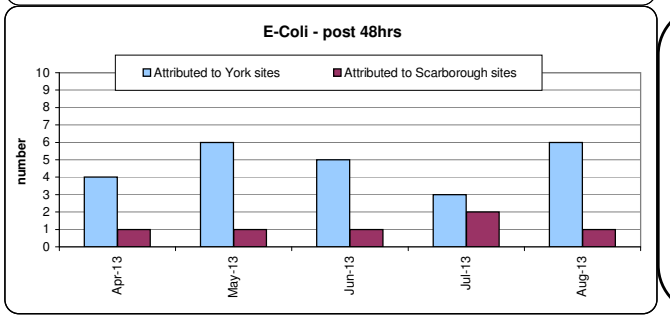
Infection Control



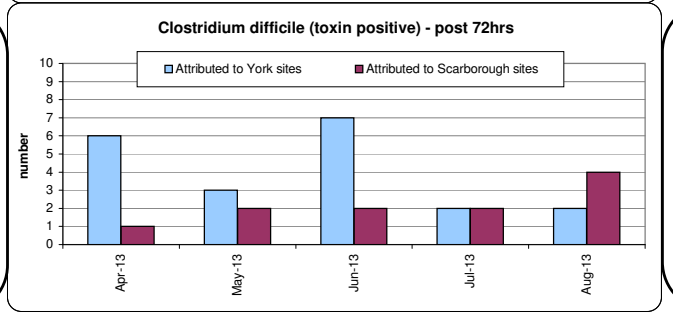
Patient admitted to York with bacteraemia 4 weeks previous. In patient stay in Hull pre re- admission to York. Issues with info/detail from Hull lead to delayed diagnosis on the re-admission to York wich meant this case was defined as re-cuurent within the 14 day deadline.



Over local trjectory for this time period - 10/13.
RCA done on cases deemed by the Microbiologist to be of benefit i.e avoidbale infections. 7 requested to July only 3 held.
4 line or cannula related.
3 soft tissue, 1 urinary sepsis, inflamed aorta. All BC`s taken 48 hours post admission.



No trajectory for this indicator. Most cases are usually UTI related. Annual IP Point Prevalence 2013 rate 1.8%. 2012 2%, 2011 4.1%

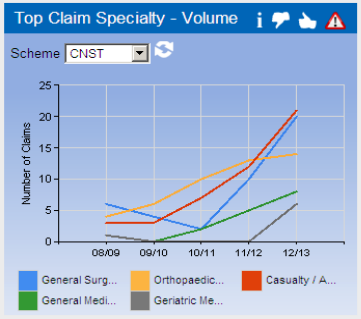


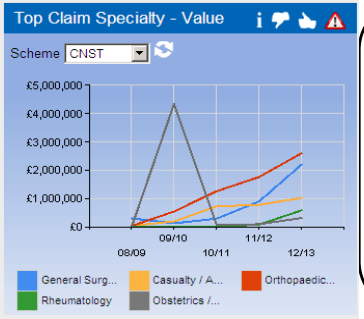
Over trajectory for this time period.

RCA shows Antimicrobial use a recurring theme in terms of type and duration in avoidable cases.

Outcome of audit of clear prescribing pathway consistent with this.

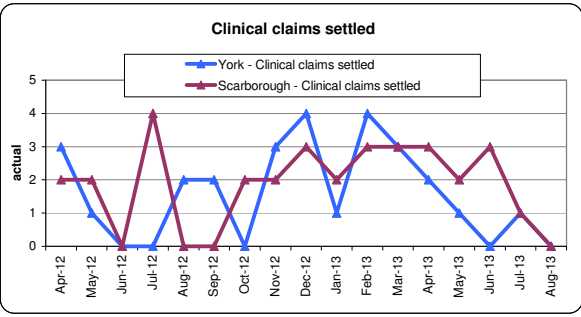
Claims settled





Information provided by the NHS LA indicates that for 2012/13 the directorates of emergency medicine and general surgery had the highest volume and financial value of clinical claims.

Data Source: NHS Litigation Authority



No litigation claims were settled during Augusts

Data Source: Risk and Legal Services

Leadership Walkrounds

Date	Location	Participants	Actions & Recommendations
3rd July 2013	ICU & HDU (York)	Peta Hayward Richard Morris Chris Morris Phillip Ashton	• Patient flow – Directorate team to continue monitoring and liaise with Bed managers and Directorates as appropriate. • Implement and continue to review CI actions. • On going work with Staff (With OD) to help with issues of culture, the importance of expectations. • Business case for clinical information system being developed.
10th July 2013	Ward 35 & Ward 37 (York)	Diane Palmer Sue Hendry Mike Sweet Sandeep Kesavan David Hesletine Gerry McGonigal	**Ward 37** • Concern expressed about the length of time it takes to get a psychiatric assessment undertaken for patients on the ward and there is a problem with the availability of psychiatric medical cover provided by Bootham Park Hospital – Steve Reed to discuss with Corporate Directors. • Patients who are delayed from being discharged due to shortage of equipment or beds in the community have a longer than necessary length of hospital stay – this is being considered within the 'Acute Services Strategy' led by Sarah Lovell. • Chairs for patients who are at risk of falling are not in sufficient numbers – a risk assessment of suitable chairs will be undertaken by the Directorate Management Team. • Assurance to be given that the Estates work will not be delayed. • **Ward 35** • Concern about the space between each bed to be raised with IPC. • Low / floor beds have been used very successfully to prevent harm to patients at risk of falling out of bed. Unfortunately only a small number are available – a risk assessment of suitable beds to be undertaken by the Directorate Management Team. • Sometimes patients who are fit for discharge to Selby Hospital are unable to be transferred as their GPs do not provide support to Selby Hospital – this is being considered within the 'Acute Services Strategy' led by Sarah Lovell. • At times some patient on this ward are confused or disorientated and there is a risk that they may leave the ward – Estates to advise if the entrance door can be locked and swipe access arranged. • A better location / facilities for Board Rounds should be sought.
19th July 2013	Chestnut and Beech wards (Scarborough)	Diane Palmer Chris Whilde Dr Humphriss Tracey Wright	**Beech Ward** • The provision and supervision of trainee medical staff is to be monitored– particularly as the middle grade support is limited. • Analysis and possible re-provision of the in-patient bed base to be undertaken by Joanne Southwell and Mandy McGale • Allocation of telemetry to be reviewed and monitored by Acute Medicine Directorate Management Team. **Chestnut Ward** • The staffing establishment should be reviewed. • Consider if additional training on MCA/DOL is required. • Environmental issues to be considered within the Capital Plan.

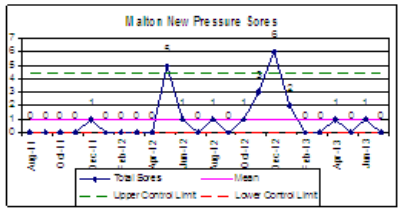
Date	Location	Participants	Actions & Recommendations
1st August 2013	Ward 33 and York Renal Unit (York)	Diane Palmer Melinda Howard Gillian Younger Libby Raper Vicky Davey	**Renal Unit** • Hospital patients can wait 2 hours for transport home after their treatment. • The floors are very slippery, there is a non slip surface around one sink which should be applied to other sinks. • There is a shortage of porters to support the patients coming from wards. A business case is going to Corporate Directors • Kitchen is very small and warm. • The number of hours of support to the unit from catering staff doesn't seem to be adequate. • The store room needs to be redesigned. • The nurse's station is in the middle of the unit, it needs to be de-cluttered and then possibly re-designed. **Ward 33** • Nurse staffing identified as a problem on a previous visit. There is agreement that the establishment should be increased, recruitment is planned and NHSP support is being arranged with immediate effect, the night shift still feels under established and is being reviewed. • Getting support for patients sectioned under the Mental Health Act is regularly a problem. • The ward has two escalation beds but this causes problems with space in the bays. • The ward is often used as a thoroughfare. • Nursing care indicator boards are not illustrating the position in a user friendly manner.
6th August 2013	Haworth (Scarborough)	Diane Palmer Joanne Southwell Dr Smith Mike Kearney Andrea Wilson	**Hawthorn Unit** • There can be lengthy delays for patients waiting for medicines prior to discharge home. • Due to the additional demand for ambulatory care the number of registered nurses is scheduled to increase and the Directorate Management Team are considering extending the opening hours of the unit, although this will require additional funding and diagnostic (particularly radiology) support.

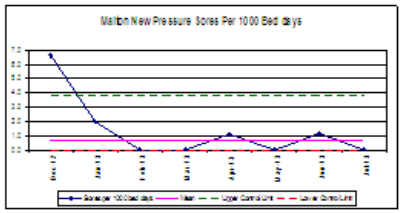
Community Hospitals Patient Safety Dashboard

Malton Community Hospital
Patient Safety Dashboard – August 22nd 2013

Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul13
Number of incidents reported on - Datix web	17	24	22	25
Number of medication related incidents	1	3	1	1
Number of new clinical litigation cases	0	0	0	0
Number of settled clinical litigation cases	0	0	0	0
Number of formal complaints	1	0	0	1
Number of Serious Incidents (SIs)	0	0	0	0
Number of Critical Incidents (CIs)	0	0	0	0

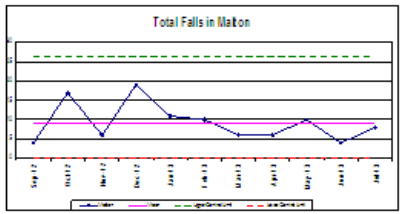
Pressure Ulcers (Datix)

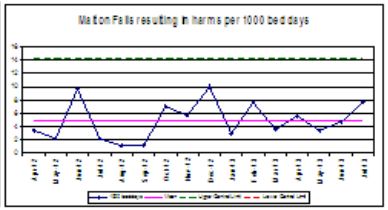




No new pressure ulcers at Malton in July

Falls (Datix)





8 falls in July
Target 20% reduction in falls 13/14: Mean number of Falls with harm per 1000 beds days to not exceed 3.8 per month: July = 8

Deaths & Mortality reviews	Apr 13	May 13	Jun	Jul 13
Number of in-hospital deaths	2 (5.4%)	4 (10.3%)		
Number of morality reviews				

Activity	Apr 13		May 13		Jun 13		Jul 13	
Ward	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye
Admissions	21	34	19	16	32	49	43	76
Discharges	23	14	21	19	30	46	40	77
Delayed Transfer of Care	Data not available yet							
Length of hospital stay – mean *(previous yr)*	26.5 (27)		24.4 (20)		19.1 (21)		18.6 (25)	

IPC	Apr 13		May 13		Jun 13		Jul 13	
Ward	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye
Compliance with hand hygiene	100%	100%	100%	100%	75%	100%	100%	100%
Compliance with glove use	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with bare below the elbow	100%	100%	100%	100%	100%	100%	100%	100%
CDIFF >72hrs: *(Acc Year to Date)*	0	0	0	0	0	0	0	0

Harm Free Care - Safety Thermometer Prevalence data	Apr 13		May 13		Jun 13		Jul 13	
Ward	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye
VTE *(% of patients with a VTE)*	0%	0%	7% *(1 old)*	0%	7% *(1 old)*	0%	7% *(1 old)*	7% *(1 old)*
Falls *(% of patients who fell)*	17% *(3 low harm)*	46% *(1 low, 3 mod, 3 sev harm)*	0%	13% *(2 low harm)*	23% *(3 low harm)*	18% *(2 mod harm)*	14% *(1 mod, 1 low harm)*	15% *(1 no, 1 low harm)*
Pressure Ulcers *(% of patients with a new PU - CQUIN)*	5% *(1 cat 2)*	6% *(1 cat 3)*	0%	0%	0%	0%	0%	0%
Pressure Ulcers *(% of patients with an old PU - CQUIN)*	5% *(1 cat 2)*	13% *(2 cat 2)*	0%	20% *(1 cat 2, 2 cat 3)*	23% *(3 cat 2)*	27% *(2 cat 2, 1 cat 4)*	0%	7% *(1 cat 4)*
UTI *(% of patients)*	23% *(3 new, 1 old)*	20% *(3 old)*	50% *(5 new, 2 old)*	6% *(1 new)*	30% *(3 new, 1 old)*	0%	14% *(2 old)*	22% *(2 new, 1 old)*
Empty Admin Boxes	41%	20%	28%	6%	7%	63%	28%	69%
Omission code 4	41%	20%	0%	20%	30%	72%	28%	7%
Omitted Critical Medicines	0%	0%	0%	0%	0%	18%	0%	23%

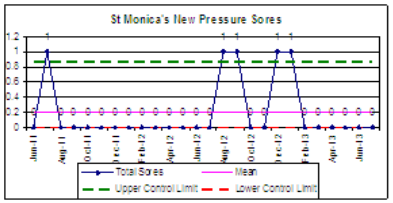
RCA feedback and action planning	1 RCA outstanding due 31/8/13 – feedback at next meeting

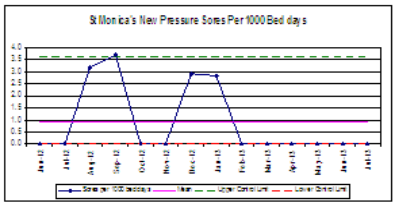
Risks	Apr 13	May 13	Jun 13	Jul 13
Total number of risks on risk register				
Top 3 risks at Malton				

ST MONICA'S Community Hospital
Patient Safety Dashboard – August 20th 2013

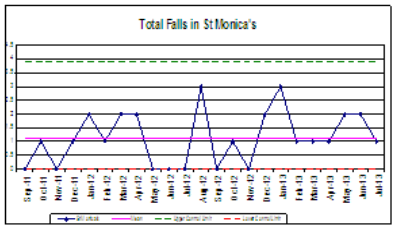
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13
Number of incidents reported on - Datix web	2	5	6	4
Number of medication related incidents	0	0	0	1
Number of settled clinical litigation cases	0	0	0	0
Number of formal complaints	0	0	0	0
Number of Serious Incidents (SI's)	0	0	0	0
Number of Critical Incidents (CI's)	0	0	0	0

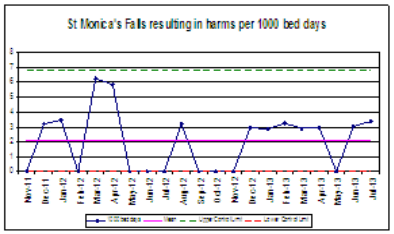
Pressure Ulcers





Falls





1 fall in July with Harm.

Target 20% reduction in falls 13/14: Mean number of Falls with harm per 1000 beds days to not exceed 1.7 per month: July = 3.4

Deaths & Mortality reviews	Apr 13	May 13	Jun 13	Jul 13
Number of in-hospital deaths	4 (19%)	1 (5.6%)	5 (41%)	0
Number of morality reviews	Data not yet collected on this measure			

Activity	Apr 13	May 13	Jun 13	Jul 13
Admissions	17	14	12	15
Discharges	18	14	12	15
Delayed Transfer of Care	Data not available yet			
Length of hospital stay – mean *(previous yr)*	24 (40)	13.1 (23)	30 (21)	13.9 (50)

IPC	Apr 13	May 13	Jun 13	Jul 13
% compliance with hand hygiene	100%	95%	95%	94.3%
% compliance with glove use	100%	100%	100%	100%
% compliance with bare below the elbow	88%	95%	95%	89%*
CDIFF >72hrs *(accumulative Whtby year to date)*	0	0	0	0

*Dr 67%

Harm Free Care - Safety Thermometer Prevalence data	Apr 13	May 13	Jun 13	Jul 13
VTE *(% of patients with a VTE)*	0%	0%	0%	0%
Falls *(% of patients who fell)*	9% (1 no harm)	33% (3 low harm)	10% (1 low harm)	23% (1 no harm, 1 low harm)
Pressure Ulcers *(% of patients with a new PU)*	0%	0%	0%	0%
Pressure Ulcers *(% of patients with an old PU)*	0%	0%	0%	0%
UTI *(% of patients)*	19% (1 old, 1 new)	12% (1 old)	20% (1 old, 1 new)	23% (1 old, 1 new)
Empty Admin Boxes	0	10%	0%	20%
Omission code 4	0%	12%	0%	23%
Omitted Critical Medicines	0%	0%	0%	0%

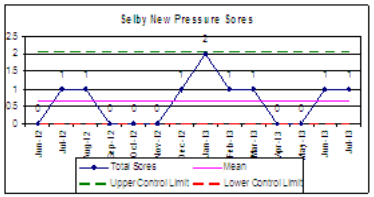
RCA feedback and action planning	No RCA's for July 13

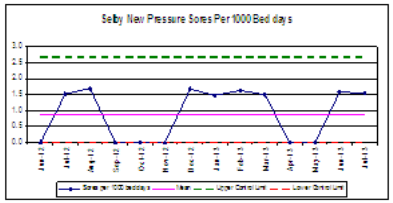
Risks	Apr 13	May 13	Jun 13	Jul 13
Total number of risks on risk register				
Top 3 risks at St Monica's				

SELBY Community Hospital
Patient Safety Dashboard – August 21st 2013

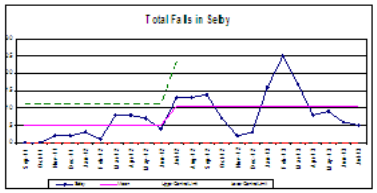
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13
Number of incidents reported on - Datix web	15	13	10	13
Number of medication related incidents	1	0	1	3
Number of settled clinical litigation cases	0	0	0	0
Number of formal complaints	0	0	0	0
Number of Serious Incidents (SI's)	0	0	0	0
Number of Critical Incidents (SI's)	0	0	0	0

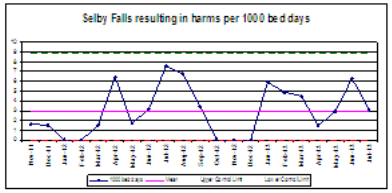
Pressure Ulcers





Falls





1 fall in July with Harm.

Target 20% reduction in falls 13/14: Mean number of Falls with harm per 1000 beds days to not exceed 2.32 per month: July = 3

Deaths & Mortality reviews	Apr 13	May 13	Jun 13	Jul 13
Number of in-hospital deaths	6 (2.6)	3 (5.7)	3 (5.9)	6 (10)
Number of morality reviews	Numbers not available yet			

Activity	Apr 13	May 13	Jun 13	Jul 13
Admissions	39	55	48	61
Discharges	39	53	51	60
Delayed Transfer of Care	Info not available yet			
Length of hospital stay – mean *(previous yr)*	32 (27)	29 (19)	21 (18)	22.9 (25)

IPC	Apr 13	May 13	Jun 13	Jul 13
% compliance with hand hygiene	100%	100%	100%	100%
% compliance with glove use	100%	100%	100%	100%
% compliance with bare below the elbow	100%	100%	100%	100%
CDIFF >72hrs *(accumulative Selby year to date)*	0	0	0	0

Harm Free Care - Safety Thermometer Prevalence data	Apr 13	May 13	Jun 13	Jul 13
VTE *(% of patients with a VTE)*	0%	0%	0%	0%
Falls *(% of patients who fell)*	4% *(1 no harm)*	10% *(1 no harm,1 moderate harm)*	5% *(1 no harm)*	4% *(1 no harm)*
Pressure Ulcers *(% of patients with a new PU)*	4%	0%	0	10%
Pressure Ulcers *(% of patients with an old PU)*	13%	14%	8%	10%
UTI *(% of patients)*	18% *(3 new, 1 old)*	23% *(3 new, 2 old)*	4% *(1 new)*	10% *(1 old, 1 new)*
Empty Admin Boxes	13%	23%	17%	14%
Omission code 4	0%	4%	0%	0%
Omitted Critical Medicines	4%	4%	0%	4%

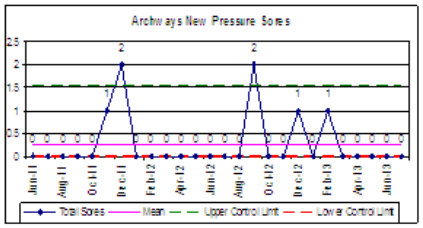
RCA feedback and action planning	

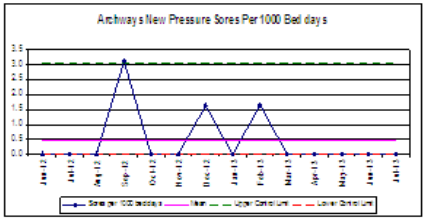
Risks	Apr 13	May 13	Jun 13	Jul 13
Total number of risks on risk register				
Top 3 risks at Selby				

ARCHWAYS Community Hospital
Patient Safety Dashboard – August 20th 2013

Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13
Number of incidents reported on - Datix web	12	10	8	12
Number of medication related incidents	0	0	0	0
Number of settled clinical litigation cases	0	0	0	0
Number of formal complaints	0	0	0	0
Number of Serious Incidents (SI's)	0	0	0	0
Number of Critical Incidents (SI's)	0	0	0	0

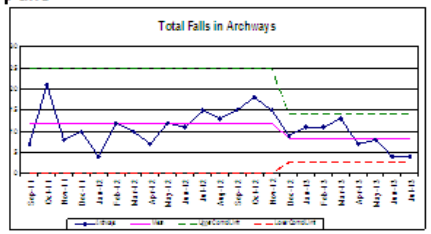
Pressure Ulcers

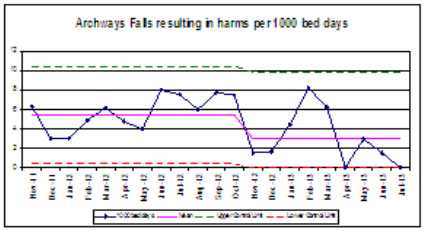




No Pressure ulcers developed on the ward at Archways for 187 days.

Falls





4 falls in July with 'No Harm'.

Target 20% reduction in falls 13/14: Mean number of Falls with harm per 1000 beds days to not exceed 4.28 per month: July = 0

Deaths & Mortality reviews	Apr 13	May 13	Jun 13	Jul 13
Number of in-hospital deaths	1 (3.4)	0	0	2 (5.6)
Number of morality reviews	Data not yet collected for this measure			

Activity	Apr 13	May 13	Jun 13	Jul 13
Admissions	30	22	22	36
Discharges	29	29	22	36
Delayed Transfer of Care	Data not yet available			
Length of hospital stay – mean *(previous yr)*	28 (26)	21 (22)	26 (16)	19 (22)

IPC	Apr 13	May 13	Jun 13	Jul 13
% compliance with hand hygiene	100%	100%	100%	100%
% compliance with glove use	80%	80%	100%	100%
% compliance with bare below the elbow	100%	100%	100%	100%
CDIFF >72hrs *(accumulative Archways year to date)*	0	0	0	0

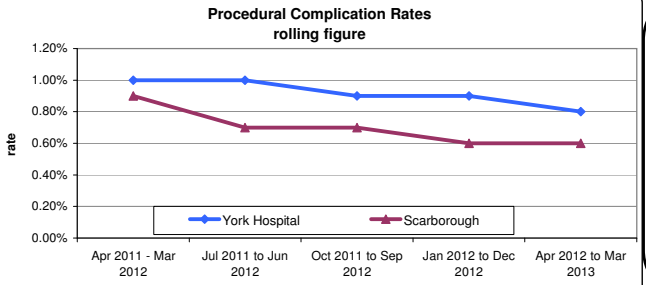
Harm Free Care - Safety Thermometer Prevalence data	Apr 13	May 13	Jun 13	Jul 13
VTE *(% of patients with a VTE)*	0%	0%	5% (1 old VTE)	0%
Falls *(% of patients who fell)*	9% (2 no harm)	9% (1 no harm, 1 low harm	0%	0%
Pressure Ulcers *(% of patients with a new PU-GRADE)*	0%	0%	0%	0%
Pressure Ulcers *(% of patients with an old PU - GRADE)*	4%	4%	5%	0%
UTI *(% of patients)*	23% (3 old, 2 new)	0%	10% (2 new)	11% (1 old, 1 new)
Empty Admin Boxes	28%	55%	15%	6%
Omission code 4	9%	22%	0%	12%
Omitted Critical Medicines	9%	0%	5%	0%

RCA feedback and action planning	

Risks	Apr 13	May 13	Jun 13	Jul 13
Total number of risks on risk register				
Top 3 risks at Archways				

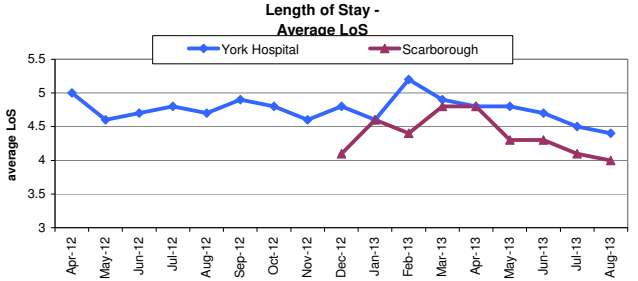
Clinical Effectiveness Dashboard

Clinical Effectiveness



Complication rates related to specific clinical procedures have reduced over the last 12 month period. The procedures may be within the current spell of care or in a preceding period of up to six months.

Data source: CHKS



The Length of Stay (LOS) for in-patients (excluding day cases and babies), indicates a steady reduction over recent months.

Corporate Risk Register (Quality and Safety issues)

September 2013

• No new risks have been added to the register this quarter.

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

Performance Schedule 2013/14 - CQUIN

Goal Name	Description of Goal	Outcome			
		Q1	Q2	Q3	Q4
IOFM technologies	tbc requested from CA				
International & commercial activity - exploiting commercial intellectual property	tbc requested from CA	awaiting confirmation			
Carers for people with Dementia - signposting	tbc requested from CA				
Friends & Family Test - Phased Expansion	Delivery of Friends and Family rollout for maternity services				
Friends & Family Test - Increased Response Rate	Improve patient experience. F&FT will provide timely, granular feedback from patients about their experience.				
Friends & Family Test - Improved Performance staff survey	annually - Feb14				
NHS Safety Thermometer - Improvement	The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the Safety Thermometer on the day of each monthly survey for York Hospital and Scarborough Hospital				
NHS Safety Thermometer - Improvement	The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the Safety Thermometer on the day of each monthly survey for Community Services				
Dementia - Find	patients >75 admitted as an emergency who are reported as having: known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question				
Dementia - Assess	Number of above patients reported as having had a diagnosis assessment including investigations				
Dementia - Refer	Number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners				
Dementia - Clinical Leadership	annual - Mar13 & mar14				
Dementia - Supporting Carers	Provider must demonstrate that they have undertaken a monthly audit of carers of people with dementia at both York and Scarborough Hospitals to test whether they feel supported and report the results to the Board. Provider and				
VTE - Risk Assessment	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool	awaiting confirmation			
VTE - Root Cause Analysis	The number of root cause analyses carried out on cases of hospital associated thrombosis				
Care of the Deteriorating Patient - AMU Admissions	Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions	awaiting confirmation			
Care of the Deteriorating Patient - AMU Admissions	Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions				
Care of the Deteriorating Patient - AMU Admissions	Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions	awaiting confirmation			
Care of the Deteriorating Patient - AMU Admissions	Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions				
Care of the Deteriorating Patient - AMU Admissions	Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions				
Care of the Deteriorating Patient - Identification, Response & Management	Timeliness of vital signs recording, response and the management of all Deteriorating Patients across acute sites.				
Care of the Deteriorating Patient - NEWS & PAWS	Full implementation of NEWS and PAWS across York and Scarborough Hospitals by Q4, excludes paediatrics, SCBU,				
LOS in Elderly Medicine Bed Base	Reduce the average Length of Stay on Elderly Medicine Bed Base at York Teaching Hospital NHS Foundation Trust	awaiting confirmation			
LOS in Elderly Medicine Bed Base	Reduce the average Length of Stay on Elderly Medicine Bed Base at York Teaching Hospital NHS Foundation Trust	awaiting confirmation			
LOS in Elderly Medicine Bed Base	Reduce the average Length of Stay on Elderly Medicine Bed Base at York Teaching Hospital NHS Foundation Trust	awaiting confirmation			
Effective Discharge - Nursing Risk Assessments	To make details of nursing assessments for nutrition, falls and pressure sores available to NCTs				
Respiratory - Asthma	Identify and audit 50 consecutive attendances diagnosed as asthma during the previous quarter at least 20 to be aged				
Stroke - Level 2 Accreditation	Six monthly - demonstrate milestones met				
Haem - joint score physio assessment	Quarterly				
Haem					
Neonate					
Renal					
Cystic Fibrosis					

Clinical Standards Group – September 13

Current status and risk issues with NICE Guidelines at the Trust on the 1st September 2013.

NICE Clinical Guidance

Site	Guidance	Compliant with evidence	Compliant	Partial			Not compliant		Pending	Total
				With action plan	No action plan required	No action plan	No action plan	With action plan		
York	Clinical Guidelines	22	34	35	8	2	0	0	20	**121**
Scarborough	Clinical Guidelines	17	12	2	1	8	0	0	66	**106**
York	Non-drug Technology Appraisal	3	12	0	2	0	0	0	1	**18**
Scarborough	Non-drug Technology Appraisal	2	6	0	0	0	0	0	8	**16**
York	Quality Standards	3	3	7	2	0	0	0	24	**39**
Scarborough	Quality Standards	2	4	2	0	1	0	0	30	**39**
York	Cancer Guidelines	3	1	2	3	0	0	0	0	**9**
Scarborough	Cancer Guidelines	1	0	0	7	0	0	0	1	**9**

Scarborough - 15 Clinical Guidelines that are not relevant
Scarborough - 2 Non Drug Technology Appraisals that are not relevant

York - Partial no action plan

Action plan but no timescales
CG110 Pregnancy and complex social factors

No Action plan
CG147 Lower limb peripheral arterial disease - **Recommendation:** Offer a supervised exercise programme to all people with intermittent claudication. **Response:** Not currently provided in York but available in Scarborough

Scarborough - Partial no action plan

Action plan but no timescales
CG035 Parkinson's disease
CG064 Prophylaxis against infective endocarditis
CG094 Unstable angina and NSTEMI
CG134 Anaphylaxis
CG151 Neutropenic Sepsis
QS002 Stroke
QS011 Alcohol Dependence

No Action plan
CG095 Chest pain/discomfort of recent onset
CG117 Tuberculosis
CG140 Opioids in palliative care

The Clinical Audit & Effectiveness will be contacting the Clinical Leads to ensure we have action plans and timescales.

Do Not Do's

Site	Number of Do Not Do's					
	Compliant	Non Compliant	CSC Agreed to remain non compliant	Not Applicable	Pending	Total
York	530	7	7	14	161	719
Scarborough	228	10	0	56	425	719

Medical Technologies and Diagnostic Guidance

Site	Guidance	Performed	Pending	Total
York	Medical Technologies	4	5	**9**
Scarborough	Medical Technologies	0	9	**9**
York	Diagnostic Guidance	1	0	**1**
Scarborough	Diagnostic Guidance	0	1	**1**

Interventional Procedures

Site	Guidance	Not Performed	Pending	Performed
York	Interventional Procedures	349	9	52
Scarborough	Interventional Procedures	382	23	5

York Maternity Dashboard

			Measure	Data source	April	May	June	July	August	Av. Monthly YtD	Action Log completed (Date)
Activity	**Births**	Bookings	1st m/w visit	CMIS	352	312	291	301		317	
		Bookings <13 weeks	No. of mothers	CMIS	87	89	265	274		122	
		Bookings ≥13 weeks (exc transfers	No. of mothers								
		Bookings ≥ 13wks seen within 2 wks	No. of mothers	Mat Rec							
		Births	No. of babies	CMIS	295	274	241	299		278	
		No. of women delivered	No. of mothers	CMIS	290	269	233	294		273	
	Closures	Homebirth service suspended	No. of closures	Comm. Manager	1	2	2			3	
		Homebirth service suspended	No. of women	Comm. Manager	1	0	0			1	
		Escalation Policy implemented	No. of times	Comm. Manager	3	1	0			2	
		Maternity Unit Closure	No. of closures	Matron	0	0	0	0		0	
		SCBU closed to admissions	In utero transfers	Transfer folder	1	1	0	0		1	
Workforce	**Staffing**	M/W per 1000 births	Ratio	Matron	29.5	30.0	34.8	34.8		30.8	
		HCA's	WTE	Matron	19.82	18.62	19.79	19.79		19.76	
		1 to 1 care in Labour		Risk Team							
		L/W Co-ordinator supernumary %		Risk Team	46	75	86	65		54	
		Consultant cover on L/W	av. hours/week	Rota	65	65	65	65		65	
		Anaesthetic cover on L/W	av.sessions/week	Rota	10	10	10	10		10	
		Supervisor : M/w ratio 1:	Ratio	Rota	13	13	13	13		13	
Clinical	**Neonatal/Maternal**	Spontaneous Vaginal Births	No. of svd	CMIS	59.6	56.9	56.8	67.2		61.0	
Indicators	**Morbidity**	Operative Vaginal Births	No. of instr. births	CMIS	14.9	11.7	17.8	11.7		13.2	
		C/S Deliveries	Em & elect	CMIS	25.4	31.4	25.3	21.7		25.8	
		Eclampsia	No. of women	CMIS	0	0	0	0		0	
		Undiagnosed Breech in Labour	No. of women	CMIS	2	1	1	1		1	
		ICU transfers	No. of women	Risk Team - Datix	0	0	1	2		0	
		HDU on L/W	No. of days	Handover Sheet	28	24	12	21		25	
		P/N Hysterectomies < 7days p/n	No. of women	Risk Team - Datix	0	0	0	0		0	
		BBA	No. of women	Risk Team - Datix	3	1	1	3		3	
		Meconium Aspirate	No. of babies	SCBU sister	0	0	0	0		0	
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	0	2		1	
	Risk Management	SI's	Total	Risk Team	0	0	0	1		0	
		PPH > 2L	No. of women	Risk Team - Datix	2	0	2	2		2	
		Shoulder Dystocia - True	No. of women	Risk Team - Datix	2	0	2	3		2	
		3rd/4th Degree Tear	% of tears (vaginal bi	CMIS	8.2	4.8	6.1	5.9		5.4	February 2013
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	80	73	80	90	90	79	
		YMET - Doctors	% of staff trained	Risk Team	37	64	69		39	43	
		Training cancelled	No. of staff affected	Risk Team	0	9	8			6	
	New Complaints	Informal	Total	Matron	0	2	2	1		1	
		Formal	Total	Matron	1	3	1	3		1	
	New Claims		Total	Directorate Manager	0	0	0			#DIV/0!	

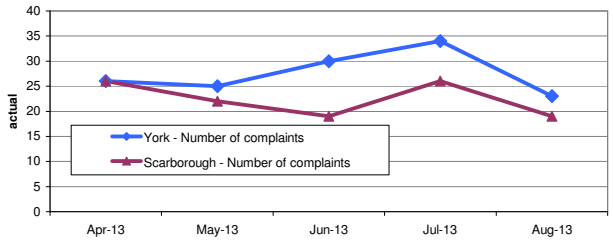
Scarborough Maternity Dashboard

			Measure	Data source	April	May	June	July	August	Sept	Av. Monthly YtD	Action Log completed (Date)
Activity	**Births**	Bookings	1st m/w visit	IS - Evolution	159	102	118	176	112		161	
		Bookings <13 weeks	No. of mothers	IS - Evolution	89%	79%	80.5%	86.9%	83.0%		87%	
		Bookings <13 weeks (exc transfers etc)	No. of mothers	IS - Evolution	94%	83%	96.9%	87.9%	98.9%		94%	
		Bookings ≥ 13wks seen within 2 wks	No. of mothers		CPD commencment							
		Births	No. of babies	IS - Evolution	121	147	108	140	154		134	
		No. of women delivered	No. of mothers	IS - Evolution	120	146	107	140	153		135	
	Closures	Homebirth service suspended	No. of closures	Comm Team Lead		0	0	0			0	
		Homebirth service suspended	No. of women	Comm Team Lead		0	0	0			0	
		Escalation Policy implemented	No. of times	Matron		0	0	0	0		1	
		Maternity Unit Closure	No. of closures	Matron		0	0	0	0		0	
		MLU Closure	No. of closures	Matron		1	0	0	1		1	
		MLU Closure	No. of women	Matron			0	0	0		0	
		SCBU closed to admissions	In utero transfers	Risk Team	0	0	0	0	0		0	
Workforce	**Staffing**	M/W per 1000 births	Ratio	Matron			44.0	44.0	44.0	44.0	44.0	
		HCA's	WTE	Matron					18.79		15.63	
		L/W Co-ordinator Supernumary %		L/W Manager								
		1:1 care in labour		IS - Evolution	94%	95%	95%	94%	96%		95%	
		Consultant cover on L/W	av. hours/week	Rota	40	40	40	40	40		40	
		Anaesthetic cover on L/W	av.sessions/week	Rota	4	4	4	4	4		4	
		Supervisor : M/w ratio 1:	Ratio	Rota	15	13	13	14	14		14	
Clinical	**Neonatal/Maternal**	Sponateous Vaginal Births	No. of svd	IS - Evolution	75.2%	75.5%	76.9%	76.4%	77.9%		73.4%	
Indicators	**Morbidity**	Operative Vaginal Births	No. of instr. births	IS - Evolution	3.3%	4.8%	4.6%	5.0%	4.5%		5.0%	
		C/S Deliveries	Em & elect	IS - Evolution	19.8%	19.0%	17.6%	17.9%	16.2%		20.2%	
		Eclampsia	No. of women	IS - Evolution	0	0	0	0	0		0	
		Undiagnosed Breech in Labour	No. of women	Risk Team		0			1		0	
		ICU transfers	No. of women	IS - Evolution	1	0	1	0	0		1	
		HDU on L/W	No. of days	Risk Team					0			
		P/N Hysterectomies < 7days p/n	No. of women	IS - Evolution	1	0	0	0	0		0	
		BBA	No. of women	IS - Evolution	2	1	1	1	4		1	
		Meconium Aspirate	No. of babies	IS - Evolution	0	0	0	0	0		0	
		Diagnosis of HIE	No. of babies	IS - Evolution	0	0	0	0	0		0	
	Risk Management	SI's	Total	Risk Team		0	0				0	
		PPH > 2L	No. of women	IS - Evolution	2	0	0	0	0		1	
		Shoulder Dystocia - True	No. of women	IS - Evolution	2	2	1	1	1		1	
		3rd/4th Degree Tear	% of tears (vaginal b	IS - Evolution	0.8%	2.1%	0.9%	1.4%	2.6%		1.5%	
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team				67	67			
		YMET - Doctors	% of staff trained	Risk Team				57	57			
		Training cancelled	No. of staff affected	Risk Team								
	New Complaints	Informal	Total	Matron	0	1		1	0		1	
		Formal	Total	Matron	2	0		1	1		2	
	New Claims		Total	Risk Team	0	2					0	

Patient Experience Dashboard

Patient Experience

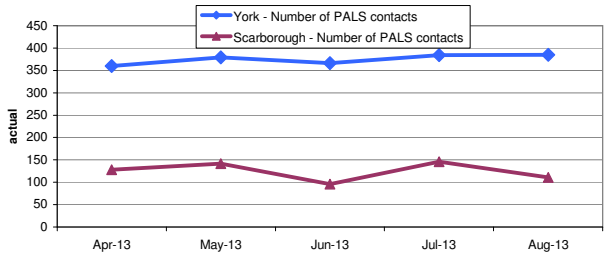
Number of complaints



Complaints registered in York relate to York Hospital and Community Services

Complaints registered in Scarborough relate to Scarborough Hospital and Bridlington Hospital

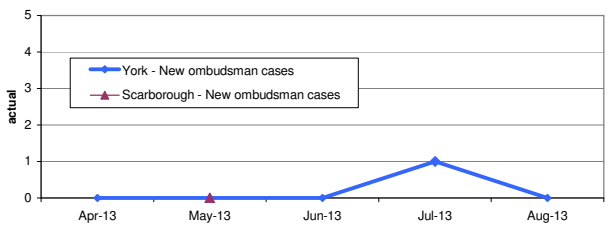
Number of PALS contacts



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

The number of PALS contacts is August was 385 for the York area and 111 for the Scarborough area.

New ombudsman cases



In York during 2012/2013, six cases were referred to the HSO, this represents 1.9% of the total number ofcomplaints received. Since April 2013, there has been one case refered to the HSO.

In Scarborough during 2012/2013, nine cases were referred to the HSO, this represents 3.1% of the total number of complaints received. Since April 2013, no cases have been refered to the HSO.

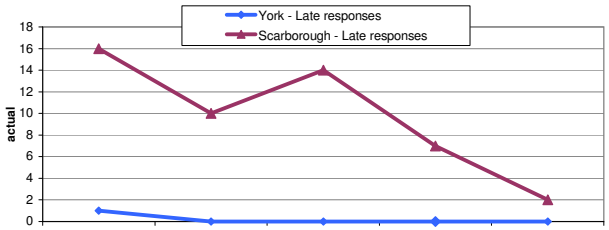
Complaints by subject

	York	S'boro
All aspects of clinical treatment	19	13
Communication/information	2	
Appointments, delay/cancellation (out-patient)	1	
Patients' privacy and dignity	1	
Attitude of Staff		2
Admissions, discharge and transfer arrangements		2

During August the Medical Directorate at Scarborough received the highest number of formal complaints (n=8).

The majority of complaints for all sites related to aspects of clinical treatment.

Complaints - Late responses



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

The number of late responses to complaints in Scarborough has decreased significantly over the last two months.

Friends & Family Test Results

01 Jul 2013 - 31 Jul 2013

Your Friends & Family Test Score is....	64	Last month your score was....	65

Top 3 most improved wards this month

Highest score
Lowest score
Negative score

Ward	Average To Date	This Month	Improvement	Trend
Ward 37	33	100	67	
Ward 26	23	58	35	
A&E Scarborough	21	53	32	

Top 5 consistently high performing wards

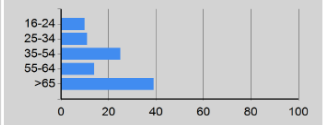
Ward	Average To Date	This Month	Improvement	Trend
CCU York	100	100	0	
ITU	100	100	0	
Maple	96	94	-2	
Ash	94	86	-8	
Lloyd	94	100	6	

Top 5 consistently low performing wards

Ward	Average To Date	This Month	Improvement	Trend
A&E Scarborough	21	53	32	
Ward 26	23	58	35	
Ward 37	33	100	67	
Johnson	43	62	19	
Ward 24	59	0	-59	

Who responded?

Response Rate	Male or Female	Age Profiles %
Eligible Patients 10533	46%	54%
Patient Responses 2561		
24%		



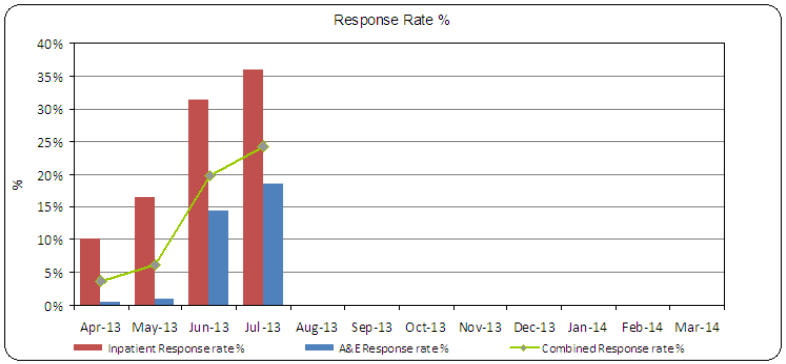
Complaints by directorate: Aug13	York
General Surgery & Urology	5
Medicine (General & Acute)	4
Elderly Medicine	3
Obstetrics and Gynaecology	3
Specialist Medicine	2
Theatres Anaesthetics and Critical Care	1
Child Health	1
Physiotherapy	1
Community Services (Malton Hospital)	1
Head & Neck	1
Sexual Health	1
Total	23

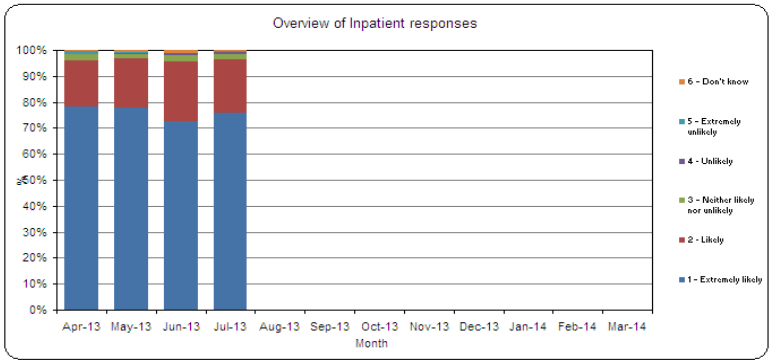
Complaints by directorate: Aug13	Scar
Medicine	8
Surgery	6
W&C	3
Facilities	1
Corporate	1
Total	19

Friends and Family Test

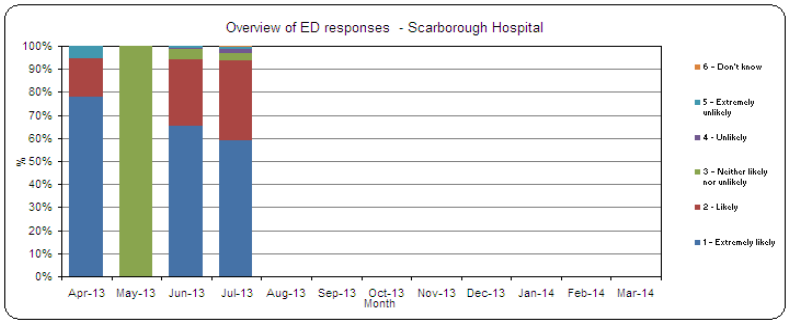
The Friends and Family Test (FFT) is a national initiative which asks the question "how likely are you to recommend our ward/emergency department to friends and family if they needed similar care or treatment?" The question, when we combine it with a follow-up question provides us with a mechanism to identify both good and poor quality patient experience and is much more than a score. It acts as a catalyst to ask 'why have patients awarded us this score?' The FFT further complements what we already do in relation to finding out, and acting upon, what our patients think about us through concerns, complaints, compliments, national and local surveys and it is this insight that enables us to make positive changes and celebrate success.

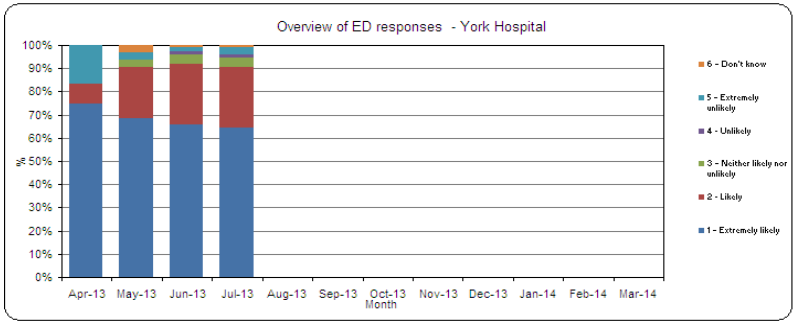
The FFT is linked to a CQUIN indicator which for 2013/14 is around implementation across inpatient wards, emergency departments and further roll-out across the maternity pathway (from October 2013) increasing from a required 15% response rate in quarter one to a minimum response rate of 20% in quarter four. The response rate for August is not available until mid September. The graph below details the Trust's response rate from the commencement of the test in April 2013.





A maternity services project group is overseeing the roll-out to maternity services across the antenatal, labour, postnatal pathways in hospital and community settings. This commenced in August.





Healthwatch Update

Healthwatch replaces the Local Involvement Networks (LINks) from April 2013. Healthwatch will, where LINks finished, continue to be the consumer champion for health and social care. All Local Authority areas have commissioned a local Healthwatch which will work with local communities to enable patients and the public to share their views about health and social care. Healthwatch will ensure that the experiences of members of the public are understood and taken into account in the commissioning and delivery of health and social care.

The Healthwatch is responsible for signposting to local health and social care services and additionally to independent advocacy in relation to NHS complaints.

Healthwatch has (unlike LINks) a strategic seat and voice on the Health and Wellbeing (H&W) Board. Healthwatch will use this seat to ensure that the population have their say on issues that they feel are important to them through the H&W Board.

There are three local Healthwatch organisations which the Trust will have direct contact with; East Riding of Yorkshire, City of York and North Yorkshire.

During July the Chairman and the PPI Specialist met with all three Healthwatch organisations with the purpose of:

- developing closer working arrangements between YTHFT and Healthwatch
- providing background to the YTHFT and to discuss and agree key working relationships across both organisations
- providing an update on the development of local Healthwatch.

The key agreements were; to have an open and transparent relationship with each other, that feedback from the public to Healthwatch would be discussed directly with the YTHFT Patient Experience Team and that the main contacts from the Trust would be Kay Gamble and Lucy Brown.

City of York Governors and the PPI Specialist attended the first Quarterly Healthwatch Assembly which brings together key partner organisations across the City of York including YTHFT, CoY Council, YAS, Public Health, VOYCCG, Leeds & York Partnership. The Assembly replaces the previous LINks Stakeholder meeting and the Social Health Information Networking Engagement York (SHINEY) meetings.

Patient Story 1

Lead Nurse Patient Experience was asked to speak to the distressed relatives of a patient who had been transferred to York Hospital from a neighbouring hospital for surgery. She died the day after surgery. The family told ward staff that they did not wish to be contacted overnight in the event of the patient deteriorating or dying. They were subsequently contacted at 01.00 hours to be informed their relative had died. The relatives were told by the ward staff that they could view the body at any time. They came to the hospital at approximately 09.30am expecting to be able to see their relative and were referred to the Bereavement Suite by ward staff. The Bereavement Suite staff contacted the Mortuary and were told that the earliest a viewing could be arranged for was 13.30 hours that day, the family were distressed and angry.

They were also unhappy that they had not received any explanation about the cause of death and what had happened since they had visited her the previous day. The family were unaware that as the patient had died within 1 day of having surgery that the doctor would be required to discuss her cause of death with HM Coroner. The Lead Nurse Patient Experience arranged for the family to attend the Mortuary. A member of the surgical team also met with the family in the Mortuary and explained what had happened in the post operaive period and why it had been necessary to inform MH Coroner of the death..

The relatives were extremely grateful and reassured that the communication issues would be addressed.

Patient Story 2

I write to express appreciation for the medical treatment my wife received recently at the York District Hospital. Despite the need for treatment becoming apparent on the last day of the Ebor races, at the start of the bank holiday weekend, she was dealt with, with great consideration and expert care. A wait of six hours in A&E on Saturday was regrettable but understandable and the staff could not have been more considerate, from the triage nurse through to the A&E doctor and on to the orthopaedic doctor. The Senior Registrar, saw my wife with very little delay and organised scans and a second opinion from the Hull Spinal Unit most efficiently.

All the nursing and support staff on Ward 28 were terrific. I wanted to put this on record.

Please accept our very great thanks.

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D2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

Medical Director's Report

Summary

This report provides an update from the Medical Director.

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

Implications for equality and diversity

No implications for equality and diversity.

Reference to CQC outcomes

This report includes reference to a report relating to Outcome 8.

Progress of report	This report was discussed at Executive Board.
Risk	None
Resource implications	None identified
Owner	Dr Alastair Turnbull, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	18th September 2013
Version number	1

Board of Directors – 25 September 2013

Medical Directors Report - September 2013

1. Introduction

In the report this month:

1. Sepsis update
2. Hospital mortality review processes
3. Infection prevention and control update
4. VTE risk assessment
5. Consultant appointments
6. Patient Safety and Quality Dashboard.

2. Sepsis update

World Sepsis Day is 13th September 2013

In the developed world, sepsis is dramatically increasing by an annual rate of between 8 – 13%.

Sepsis arises when the body's response to an infection injures its own tissues and organs. It may lead to shock, multiple organ failure, and death, especially if not recognised early and treated promptly. Sepsis remains the primary cause of death from infection despite advances in modern medicine, including vaccines, antibiotics, and acute care with hospital mortality rates between 30 and 60%.

Global goals;

1. Place sepsis on the development agenda. The declaration will increase the political priority given to sepsis by raising awareness of the growing medical and economic burden of sepsis.

2. Ensure that sufficient treatment and rehabilitation facilities and well trained staff are available for the acute and long term care of sepsis patients.

3. Support the implantation of international sepsis guidelines to improve earlier recognition and more effective treatment of sepsis and enable adequate prevention and therapy for all people throughout the world.

4. Mobilize stakeholders to ensure that strategies to prevent and control the impact of sepsis globally are targeted at those who are most in need.

5. Involve sepsis survivors and those bereaved by sepsis in planning strategies to decrease sepsis incidence and improve sepsis outcomes at local and national levels.

International and national surveys indicate that 20 – 40% of sepsis patients that require treatment in the intensive care unit developed sepsis outside the hospital. The incidence of sepsis developing after surgery trebled from 1997 to 2006.

Sepsis is often diagnosed too late, because the clinical symptoms and laboratory signs that are currently used for the diagnosis of sepsis, like raised temperature, increased pulse or breathing rate,

or white blood cell count are unspecific.

The Trust Sepsis Working Group met on the 15th August.

The following findings from a recent audit were presented:

1. 22% of the patients met sepsis scoring criteria based on a raised wbc as the second parameter highlighting the importance of having the results of the Full Blood Count available rapidly

2. PAR scores at time zero were distributed as follows;

Score	Number of patients
0	1
1	1
2	3
3	5
>3	3

Only 57% would trigger based on PAR 3 or more.

3. 64% (9 of the 14) patients met criteria for severe sepsis

4. Initial antibiotic choice appropriate to;

Clinical working diagnosis	36%
Microbiological isolate	21%

5. Sepsis 6 bundle compliance within 1 hour

High flow O2	29%
Blood cultures x2	14%
IV antibiotics	0%
Iv fluids	43%
Lactate measured	36%
Hrly urine recorded	36%

Full bundle compliance 0%

6. Time zero to blood culture taken:

<60 mins	36%
60-120 mins	21%
120-180 mins	7%
180-240 mins	0%
>240 mins	7%
Not recorded	21%

7. Time zero to first iv antibiotics:

<60 mins	0%
60-180 mins	14%
180 - 300 mins	29%
300 - 420 mins	29%
> 420 mins	14%
Not known	7%.

Discussion at the meeting also included how we integrate signposts to sepsis in technology and in the current deteriorating patient pathway. The group agreed that:

- we would add as an appendix to the deteriorating patient policy; guidelines for sepsis management.

- update the antimicrobial poster which will have specific advice regarding sepsis
- use material from World Sepsis Day to raise awareness – week commencing 16th September.

3. Hospital mortality review processes

1. Retrospective Case Record Review

Background
Reviewing the care and events leading to a patient death in hospital can provide insight into potential improvements for safer healthcare delivery. Quality improvement is a major driver to mortality review and is required of all clinicians. Evidence supports the role of mortality review in quality improvement. To date the process of this has been inconsistent within the Trust. Reviews which are undertaken to an agreed methodology can indicate patterns, trends, and opportunities for improvement and training and can allow identification of patients at risk from an adverse event. Whilst most hospital deaths are inevitable, a significant proportion are avoidable and a standardised approach is needed to identify these and learn from them.

Morbidity and mortality reviews are already well established in some specialties and this paper seeks to build on those.

Introduction
A clinically led team in the Trust have developed a mortality review proforma designed to facilitate of retrospective case note review following the death of a patient in hospital. Such approaches have been shown to lead to improved understanding of events immediately before the death and the ability to identify and quantify unanticipated deaths and adverse events. As a result of system changes following mortality analysis some hospitals have reported a reduction in mortality rates.

The proposed proforma supports standardized review of deaths and over time several of the data fields will be populated directly from the Core Patient Database (CPD).

Stage of Development
The Core Mortality Review Proforma (Appendix 1) has been developed and tested in several directorates including Medicine and Elderly Care and should be used in most specialties to support retrospective case note review. There are also five specialty specific proformas for use in; the Emergency Department (ED) (Appendix 2), General Surgery (Appendix 3), Community Hospitals (Appendix 4), Orthopaedics and Trauma (Appendix 5) and Paediatrics (Appendix 6).

Process
In normal circumstances it is expected that whenever an in hospital death occurs review will take place within six weeks of the patients death. The review should be undertaken by the consultant responsible for the patients care at the time of death or the GP in the case of patients who die in a community hospital.

Where a mortality review identifies a clinical incident not previously reported, this should be reported via the Datix system. Serious incidents should be reported directly to the Risk Management Team or the Medical Director

In time, this process should dovetail with the requirements of the (new) role of Medical Examiner, yet to be implemented widely in England and Wales...

Learning and Dissemination
A copy of the completed Mortality Review proformas should be sent to the Deputy Director of Patient Safety, who will produce a quarterly summary report for the Trust Executive Board and Board of Directors. Most importantly the mortality reviews should form a structured part of a specialities Clinical Governance activity, either within the context of specific “Morbidity and mortality”

meetings or within the rolling programme of Clinical Governance half days. It is important that contemporary notes are kept of these.

2. Review of Diagnostic Groups with a 'higher than expected' Summary Hospital-level Mortality Indicator

Background
The Summary Hospital-level Indicator (SHMI) reports mortality at Trust level across the NHS in England. The Department of Health is committed to implementing the SHMI as the single hospital-level indicator for the NHS in England.

The SHMI is the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die, on the basis of average England hospital figures given the characteristics of the patients treated there. If a patient dies whilst in hospital or within 30 days of discharge from hospital their death will be attributed to the Trust providing their care.

The value published is evaluated as to whether the mortality within the Trust can be described as either 'as expected' as, 'lower than expected' or 'higher than expected'.

As expected deaths are based on the following factors:
- The condition the patient is in hospital for
- Other underlying conditions the patients suffers from
- The age of the patient
- The sex of the patient
- The method of admission to hospital (non-elective/elective/unknown).

Process
To date the Trust has focused on review of all in patient deaths regardless of diagnostic groupings or SHMI. We know however that some diagnostic groups have a higher than expected SHMI and that some of these groups have been reported in several SHMI calculations.

We therefore propose that where diagnostic groups are identified as having a 'higher than expected' SHMI a review of all patient deaths in that diagnostic group should be undertaken. In such cases, the patient level details will be sent to the Clinical Director on a monthly basis and a review should be undertaken to identify any adverse events, opportunities for improvement in clinical care or inaccuracies in clinical coding. We are required to share at times the results of these reviews with external bodies such as regulators and commissioners.

4. Infection prevention and control

1. MRSA bacteraemia

One case was reported in August. The patient had been identified with MRSA colonisation in October 2012, was admitted to Scarborough Hospital electively in July 2013. Screening on admission identified the patient to be MRSA positive and a decolonization regimen was commenced. The patient was discharged from hospital midway through treatment. When the patient was re-admitted, decolonization was not re-commenced. MRSA bacteraemia was identified from swabs taken when the patient was transferred to Malton Hospital.

2. C. diff

The Trust has reported 31 cases of C.diff to date this year and the trajectory for the same period is 18. There have been no additional cases in the last two weeks.

3. CDI reduction strategy update

- The Trust C. diff clinical lead has been appointed and commenced responsibilities (Dr Smale)
- Clinicians have been reminded of the fundamental importance of antimicrobial stewardship and audit results have been presented at Exec Board
- The RCA process has been redesigned and MD /DIPCC has reminded clinicians of requirement and importance of participating in RCA
- Guidelines have been agreed for revising the use of PPI drugs
- New protocol agreed for increased use of HPV decontamination at both sites
- Antimicrobial stewardship posters being redesigned
- Policy agreed for implementation of co prescribing of pharmaceutical probiotic preparation to almost all patients aged > 65 years treated with antibiotics.

4. Care Quality Commission (CQC) actions required at Scarborough Hospital

The CQC visit in August highlighted shortcomings in cleanliness and IPC within Scarborough ED.

Actions :

- Directors have agreed in principle resourcing for enhanced cleaning regime following review of domestic services and in the interim the Domestic Services Manager has redeployed staff to enhance the domestic input into ED
- Productive ward lead requested to work with immediate effect with Sister Diffey to rationalise and re provide storage aimed at de- cluttering to facilitate effective cleaning
- Equipment cleaning poster left with nursing staff that outlines who is responsible for cleaning what, against what frequency and with what product
- Detailed discussion took place regarding responsibility and ownership of the multidisciplinary team for a clean safe environment through compliance with IP polices, SOP`s and Domestic standards
- IPN `s to continue twice weekly audits and ad hoc inspections.

5. Influenza Vaccination programme

The flu vaccination campaign will commence in the next month. Details will feature in next months Board Report. Preparations are under way and Directors have discussed options for encouraging vaccination.

5. VTE risk assessment

VTE risk assessment should be undertaken and where necessary prophylaxis prescribed on all adult in-patients, except where cohort exemptions have been agreed with the Medical Director. Some clinical teams are still not achieving the minimum compliance rate of 95%, therefore clinical directors are asked to review their directorate compliance and to discuss with the Medical Director those areas where compliance is less than 95%.

6. Consultant appointments

None during July or August.

7. Patient Safety and Quality Dashboard

A new style Patient Safety and Quality Dashboard is presented this month.

8. Recommendation	
The Board of Director's are requested to note and support the content of the report.	
Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**18th September 2013**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

Chief Nurse Report – Quality of Care

Action requested/recommendation

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

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	Executive Board.
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Mike Proctor – Chief Nurse
Author	Beverley Geary – Director of Nursing
Date of paper	September 2013

Executive Board – 25 September 2013

Chief Nurse Report – Quality of Care

1. Key priorities

Nursing and Midwifery Strategy

The Nursing and Midwifery strategy will be launched on Open Day 19.9.13. This is following wide consultation and collaboration with senior nurses throughout the organisation.
The strategy is aligned to national recommendations and the Chief Nursing Officers strategy for nursing (the '6C's') and has four focus areas:

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

An implementation plan for the Nursing and Midwifery Strategy has been developed and approved by the Board of Directors' and work is already underway to address the main focus areas and is attached at appendix 1.

In order to deliver the strategy and to give required and appropriate focus on quality and standards of care; and also the wider nursing agenda, a review of the role of the Matron across the organisation will be undertaken.
Some preparatory work has already began with the recommendation that a generic Matron position across the organisation is required with clear roles and responsibilities. Following this review the Matrons will be line managed by the Chief Nurse Team in order that nursing and midwifery issues are implemented and managed by the senior nursing team.

A meeting is planned in September to agree timescales, specialities and numbers, an update will be provided in subsequent reports.

2. Quality & Safety in care

Pressure Ulcer Reduction Plan (PURP)
The PURP has been in place now for the last 6 months and focussed work continues. Significant progress has be made in the following areas:

Equipment:

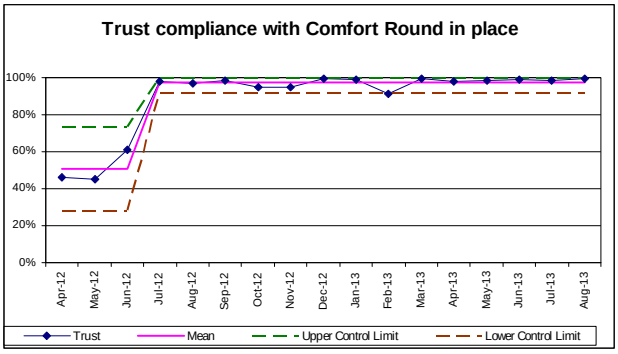
- Community services continue to review the systems and process for equipment provision. There continues to be difficulties in obtaining pressure relieving equipment in a timely fashion for at risk patients. This is mainly a contractual issue with our current providers and is being discussed at Contact Management Board (CMB).
- Tissue Viability Assistant (TVNa) equipment secondment has been extended to April 2014 with positive impact demonstrable at the York Hospital site. Community services will be appointing to a similar role.

Education:

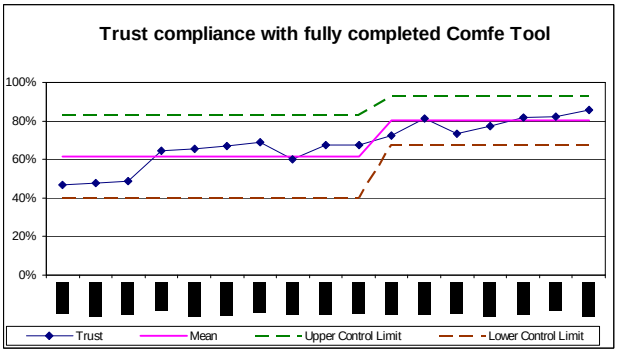
- Pressure ulcer prevention is now included on Statutory/ mandatory training for all nursing staff and AHP's.
- HYMS medical students receive pressure ulcer prevention training.

Comfort rounds are now implemented in all in-patient sites. A champion network has been established and compliance with comfort rounds is measured in the Nursing Care Indicators; a steady upward trend is evident. (see below)

Compliance with comfort rounding



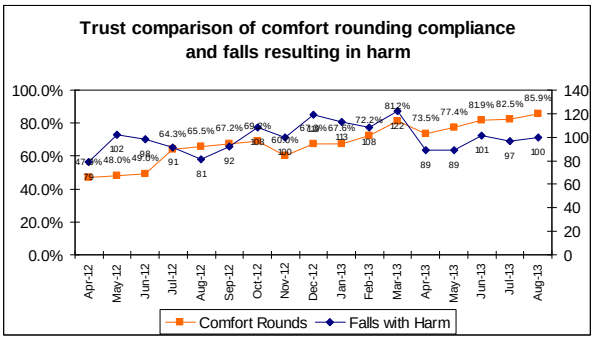
Measures percentage of patients with a COMFE tool in place

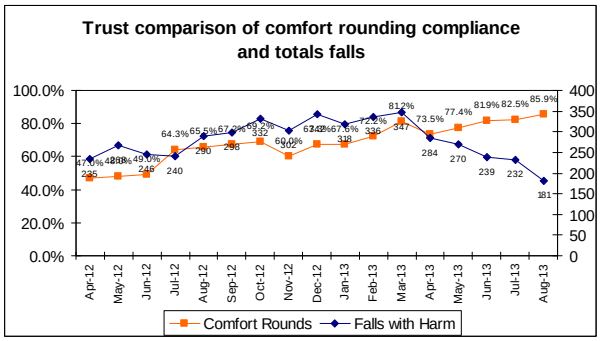


Measures percentage of patients with a COMFE tool in place and fully completed to frequency

Emerging data shown below demonstrates a correlation between increased compliance with comfort rounding and reduction in falls (more detailed report on falls in Medical Directors report).

Falls reduction and use of comfort rounding





In order to undertake a formal review of RCA's and to establish any themes a 'pressure ulcer panel' has been established. The main learning from the first three meetings is around communication of the patient's needs, gaps in documentation, assessment and categorisation of ulcers.

Feedback from the panel is now a standing item agenda on the monthly Matron's meeting.

Nutrition:

Nutritional operational group have taken on the work-plan directly related to pressure ulcer prevention and are working to ensure protected mealtimes are fully implemented. A policy to cover all in patient sites is been developed. Compliance is to be managed by ward sister with Matron support. Nutritional assessments continue to be monitored by Nursing Care

Indicators.
A review of Tissue Viability Service has commenced in order to ensure access, consistent delivery and best practice.

A six month review of the PURP with priorities, recommendations and a revised action plan will be presented to Executive Board in October.

3. Midwifery Update

The refurbishment of labour rooms on the York site is now completed. This has created 3 en-suite rooms, a further birthing pool room with shower and a visitors waiting area.
The refurbishment will improve women's privacy and dignity, promote active birth and increase patient choice for pool labour and birth.
The Maternity theatres ventilation work and refurbishment on the York site is completed with both theatres are now in use.

Staffing on the labour Ward (Scarborough site - which includes Maternity theatre) is highlighted as a risk and steps are being taken to mitigate this which include; changes in the utilisation and deployment of the workforce, additional training to increase midwifery skills in theatre and support from main theatre. Additional planning to ensure the Maternity theatre is staffed for emergency caesarean section 24 hours a day is currently underway.

Theatre upgrade
Planned essential work to upgrade the Maternity theatre on the Scarborough site will commence on 1st November 2013. The project is expected to take 20 weeks and to enable this the Midwifery Led Unit will close from 1st October 2013. Midwifery led care will continue on the Labour Ward at Scarborough and in the women's home where requested/preferred. Theatre training and preparation work will begin at the commencement and continue during the works.

CNST Informal Visit Feedback
An informal CNST assessment was undertaken on the 27th August 2013. Notes from both York Hospital and Scarborough Hospital were reviewed and all relevant staff were involved on the day of the visit.
The overall feedback was positive and the assessor noted the progress since the last information giving visit earlier this year. A number of risks have been identified and mitigating actions are currently being developed.

The recommendation is continue to prepare for the level 2 assessment in February 2013 and to review progress against the CNST action plan in December 2012.

Local Supervisory Authority
The 2013 LSA audit visit is planned for 2nd October. Verbal feedback from the LSA Midwifery Officer will be given on the day with a formal report and recommendations received at a later date. The LSA annual report and audit action plan is due to be reviewed locally via the Directorate Governance committee and will be reported to Board in October via the Chief Nurse report.

4. Nursing Documentation Review:

In order to streamline nursing records and to ensure appropriate care planning and risk assessments are undertaken a review of nursing documentation is underway.
Key priority areas have been identified and individual work-streams are in progress for the following areas:

- End of bed care plans
- Fluid and food charts
- Nursing handover
- Patient pathways

Recommended new versions of the revised documentation are planned for completion in September, examples of paper and electronic versions have been requested and will be discussed at the review group meeting.
In order to maintain version control and limit any new documents being introduced it has been agreed that all future nursing documentation will be ratified and approved by the Nursing Documentation Group and will be recorded on Q Pulse with an author and review date. The group is also working on a resilience plan in the event of a failure of IT systems.

5. Staffing

Following the detailed work focussing on staffing, establishment and acuity; work is now ongoing to ensure that the right skill mix and staffing numbers exist in each clinical area

Recruitment
Focused recruitment to address vacancies and the recent additional investment to increase the numbers of Registered Nurses continues. Early indications are that the response to the campaigns has been very good with a mixture of applications from newly qualified and experienced registrants.
Additional recruitment to meet the demands of the winter escalation had also begun.
The priority is to reduce reliance on temporary workforce and increase substantive appointments to band 5 and band 2 posts.

Centrally supported recruitment
The Chief Nurse Team are working closely with the HR recruitment team to establish centrally supported recruitment, particularly for band 5 nursing posts. Experience with band 2 Health Care Support workers is that centralised recruitment demonstrates more efficient use of resources, reduced time from leaver to replacement and reduced reliance on temporary workforce.

Roster management
In order to ensure that the nursing workforce is used efficiently and effectively a suite of performance indicators and clear expectations around roster management have been developed. Exception reports are now reviewed at Corporate Directors meeting on a monthly basis, these highlight areas that are non compliant with agreed indicators this will facilitate increased management focus and support will be concentrated in these areas.

6. Patient Experience

Friends and Family Test
All adult inpatient wards and emergency departments across the Trust continue to embed the national Friends and Family Test into their practice. The response rate has dropped from 24.3% in July to 17.05% in August. This is below what we are required to achieve for of 20% in quarter 4.

Inpatients across the Trust continue to perform well but our Emergency Departments are struggling to gain the response rate required.

A token system is now being procured for both Emergency Departments and will be place in October 2013. Additionally, Governors have been invited to volunteer in both emergency departments to help improve the responses received. An information session is being held for Governors on 4th and 9th October at both York and Scarborough respectively.
The Friends and Family Project Steering Group met during August and will continue to meet every six weeks to ensure that the Trust meets required targets across the Trust and agrees reporting and governance arrangements.

Ward and Department FFT 'Champions' were identified and attended a FFT forum during August both at Scarborough and York sites, with staff from Bridlington Hospital also attending.

Maternity Services FFT

The Friends and Family Test was rolled out across the maternity services pathway this month. Maternity staff, across hospital and the various community settings ask women at four different touch points how likely they are to recommend:

- Our antenatal service to friends and family (asked at 36 week antenatal appointment across the community and hospital)
- Our Labour ward/birthing unit/homebirth service (asked at discharge from labour ward or discharge from postnatal ward)
- Our postnatal ward (asked at discharge from ward/birth unit/following a home birth)
- Our postnatal community service (asked at discharge from the care of the community midwifery team to the care of the HV/GP)

The same methodology is being used as for Inpatients and the Emergency Department which consists of an A5 postcard with the option to complete on-line.

The Maternity Services Project group is due to meet in September to review the implementation of FFT across maternity services. This element of FFT is due for national roll-out in October but the Trust has commenced FFT early in order to mitigate against any issues and risks identified during this early implementation phase.

National Cancer Patient Experience Survey 2012/13

The results of the third National Cancer Patient Experience Survey have recently been received into the Trust. It provides key findings about patient's experience of cancer services provided by York Teaching Hospital NHS Foundation Trust. This is the first Cancer Patient Experience survey to be carried out following acquisition of Scarborough and North East Yorkshire HealthCare NHS.

The survey shows that 91% of patient's reported that their care was either 'excellent/very good'.

Overall, the results are positive and show that we have improved in the areas that required development highlighted in the 2011/12 survey. Responses around diagnostic tests, clinical nurse specialists, support for people with cancer, operations, ward nurses, information given before leaving hospital and hospital care as a day patient/outpatient have seen significant improvement compared to the previous survey.

Areas for development are around Cancer Research and patient being offered a written assessment and care plan.

When comparing the combined findings from 2011/12 we have improved in the majority of areas, and this provides the Trust with a very credible snapshot of what our patients feel about the services they access.

A full summary report will go to the Board of Directors in October 2013.

7. CQC Inspection

The Trust was subject to an unannounced Care Quality Commission inspection w/c 26th July. The team of 6 inspected both acute sites and Archways hospital.
The focus of the visit was around the following essential standards:

- Respecting and involving people who use services (outcome 1)
- Care and welfare of people who use services (outcome 4)
- Cleanliness and infection control (outcome 8)
- Staffing (outcome 3)
- Assessing and monitoring the quality of service provision (outcome 16)

High level feedback was given by the lead inspector at the end of the inspection period. Draft reports have been received into the trust for comments and factual accuracy these have been responded to and we await the final reports. These will be in the public domain and published on the CQC website.

Author	**Beverley Geary, Director of Nursing**
Owner	**Mike Proctor, Chief Nurse**
Date	**September 2013**

Nursing and Midwifery Strategy Implementation Plan: Year 2013

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

Priority 1	**Improve Patient Experience**

Number	**6C's**	**Action**	**Target Date**	**Update / Evidence**	**Lead**
1 a)	C1 C4	Develop PPI strategy.	December 2013	Meeting arranged for July 2013	Lead Nurse Patient Experience/ Deputy Chief Nurse
1b)	C2 C4	Introduce patient stories to key meetings.	September 2013	Weekly review of complaints by CN & CEO begun. Plan to introduce to Corporate Directors' Patient stories embedded in BOD meetings. Introduced to Matrons & CNAG	CNT
1c)	C4 C5	Clarify the role of ward sister in the management of and learning from complaints in their areas	September 2013	Ward Sisters meetings planned for July	Matrons, PPI team

1d)	C1 C4	Work with PPI team to identify priority areas for improvement and areas of best practice.	December 2013	Integral to PPI strategy	CNT / PPI team
1e)	C5 C6	Work with voluntary services team to develop the role of the volunteer.	November 2013		PPI / Voluntary Services team
1f)	C2 C4	Review of trust visiting policy in order to meet the needs of patients and relatives.	December 2013	Matrons currently working together to review and revise policy and present recommendations to Matrons/CNT meeting	Matrons
1g)	C6	Introduce Friends and Family Test	April 2013	Project plans agreed March 2013, FFT introduced in April 2013 to inpatient wards and Emergency Department	Lead Nurse for Patient Experience
1h)	C4 C5	Use Friends and Family evidence to provide real time feedback to staff and take actions where appropriate.	April 2013 and ongoing	Matrons are reviewing feedback themes to staff when boxes are emptied	Matrons
1i)	C2 C4	Implement in Maternity, Paediatrics and Out Patient Department ahead of national role out in order to embed.	August 2013	Implementation plans developed	Patient Experience Team

Priority 2	**Delivering High Quality Safe Patient Care**

Number	**6C's**	**Action**	**Target Date**	**Update / Evidence**	**Lead**
3a)	C5 C6	Strengthen nursing leadership by empowering ward sisters and charge nurses to ensure all care is of a high standard and meets values of the organisation		Ensure all ward sisters attend IMW programme and skills days.	ODIL Chief Nurse Team
3b)	C1 C6	Conduct bi-annual dependency and acuity audits and advise on actions.	April 2013 and ongoing	Results reported to workforce committee, approval from Board of changes to numbers and skill mix	HR/ CNT

3c)	C1 C2 C6	Work with patient safety and compliance teams to ensure delivery of patient safety strategy. Evidence	April 2013 and ongoing	Pressure Ulcer Reduction Plan Deterioration Patient initiative Work to decrease Missed Medications	Patient Safety Team Chief Nurse Team
3d)	C5 C6	Introduce a programme to review all documentation with the aim to ensure the patient is at the centre and to reduce bureaucracy. Increase dependence on CPD as primary patient record.	December 2013	Working group formed and met in June, work has begun to prioritise	Chief Nurse Team
3e)	C1 C3	Evaluate and review current status of productive ward principles across the organisation and identify key priorities and actions.	September 2013	Annual update received, meeting with Matrons and Productive Ward facilitator to be arranged	Chief Nurse Team Matrons
3f)	C1 C2	Introduce Advanced Clinical Practitioner's to facilitate early decision making and timely access to treatment.	August 2013	First cohort of trainees have commenced the 2 year programme 3 Trained in post by the end of July 2013	BG/NMc

Priority 3	**Measuring the impact of care**

Number	**6C's**	**Action**	**Target Date**	**Update / Evidence**	**Lead**
3a)	C5 C6	Review all nursing metric to ensure nurses and midwives have meaningful data to influence the delivery of care.	April 2014	Matrix rationalised May 2013 Meeting of Ward Sisters and Chief Nurse team to review metrics and identify priorities, follow up meeting planned for August 2013	CNT/HR
3b)	C3 C5	Pilot and evaluate the use of an EWTT to identify key risk and / or best practice.	April 2014	Triggers agreed, meetings with IT to establish an electronic system ongoing. Discussion with NEDs May 2013 with planned showcase of tool in September 2013 with a view to piloting.	Chief Nurse Team

3c)	C1 C3	**Utilise IT systems to give real time feedback** Explore feasibility of IT solutions to documentation	April 2014	Meetings to discuss planned	CNT/IT
3d)		Roll out electronic observations	April 2013	Electronic observations completion January 2013	
3e)		Implementation of MEWs	July 2013	MEW's rolled 8.7.13 Scarborough 21.7.13	CL
3f)	C3 C6	Introduce Senior Nurse walkabouts to all clinical areas to observe care delivery and support staff.	September 2013	Terms of reference drawn up, to be agreed at CNAG	CNAG

Priority 4	**Staff experience**

Number	**6C's**	**Action**	**Target Date**	**Update / Evidence**	**Lead**
4a)	C2 C4	Utilise staff survey feedback to understand key themes and identify priorities.	December 2013		CNT with HR Workforce team
4b)	C4 C6	Ensure all Nurses and Midwives receive a valid appraisal which includes an agreed development plan	April 2013-14	Ongoing work in all Directorates' to achieve annual appraisal	Matrons, Ward Sisters
4c)	C3	Explore and consider the training requirements of nurses and midwives and identify alternative methods of delivery.	April 2014		CNT / ODIL
4d)		Evaluate Band 5 induction programme.	December 2014		CNT with HR Workforce team
4e)	C3 C5	Introduce reviewed pre-ceptorship programme / policy and supportive	December 2014		CNT with HR Workforce team

		framework.			
4f)	C5 C6	Consider centrally supported recruitment process to reduce duplication, ensure recruitment in a timely fashion.			CNT/ Workforce
4g)	C4 C6	Works with HR to utilise e-rostering to make the most efficient use of resources.			CNT / HR

Assurance Processes

- Chief Nurse Advisory Group for approval, monitoring, identifying risks and progress
- Exceptions discussed at Matrons 1:1's and NMT 1/52 pm same as ops
- Quarterly update to Board via Chief Nurse report

Beverley Geary
Deputy Chief Nurse
July 2013

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

CQC Report

Summary

The final reports following the CQC visits earlier this year.

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

Implications for equality and diversity

No implications for equality and diversity.

Reference to CQC outcomes

These reports reflect all the outcome standards.

Progress of report	This report is only written for the Board of Directors
Risk	No additional risks indicated other than those reported on the 'Risk Register' item.
Resource implications	None identified
Owner	Mr Mike Proctor, Chief Nurse
Author	Care Quality Commission
Date of paper	September 2013
Version number	1

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

The York Hospital

Wigginton Road, York, YO31 8HE

Tel: 01904725045

Date of Inspections: 01 August 2013
31 July 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	York Teaching Hospital NHS Foundation Trust
Overview of the service	The York Hospital provides acute health care for about 350,000 people living in and around York. They also offer a range of specialist services, which are spread over a wider area of North Yorkshire, serving a total of approximately 500,000 people. The overall structure of the Trust changed in July 2012, when the York Teaching Hospital NHS Foundation Trust acquired additional responsibility for the management of Scarborough Hospital and other community based services on the East Coast.
Type of services	Acute services with overnight beds Blood and Transplant service Community healthcare service Diagnostic and/or screening service Long term conditions services Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 31 July 2013 and 1 August 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by local groups of people in the community or voluntary sector, talked with local groups of people in the community or voluntary sector, were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

What people told us and what we found

York Hospital is part of the York Teaching Hospital NHS Foundation Trust. A team of inspectors and a specialist advisor visited the site between 31 July and 1 August 2013.

The focus for the inspection was to look at the patient journey through accident and emergency (A&E) and admission to the hospital. We spent time observing practice and interactions between staff and people visiting the department. We spoke with a range of staff, including doctors and nurses, and with people who had been admitted to a ward following assessment and treatment in A&E. We visited Ward 14, the rapid assessment unit (RAU) and the medical assessment unit (MAU).

We found that people were treated with respect by the staff. People were aware of their treatment options and plans and they felt that they had been fully consulted and involved. One patient told us, "The staff are wonderful, they have explained everything to me." We saw that care and treatment was planned and delivered in a way that ensured people's safety and welfare.
We found the clinical areas in the departments we visited were clean and well maintained and there were systems in place to monitor this.

At the time of our visit we found there were sufficient staff in all of the areas and wards we visited and that systems were in place for monitoring staffing levels and the skills mix. However, several nursing and medical staff we spoke with told us that they felt there were insufficient staff available at times to deal with the workload, particularly if A&E was busy. To put this into context it is worth stating that during our inspection we were told the department was 'unusually quiet' so we were unable to assess what 'busy' would look and feel like.

We saw that there were systems in place to record and monitor comments and complaints.

We found that risks and untoward incidents were recorded and audited by staff at both departmental and board level. The provider had effective systems in place to identify, assess and manage risks to the health, safety and welfare of peoples who used the service and others.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

We found that people were treated with respect. We heard and saw people's consent to treatment being taken. When patients were brought into the unit we saw that staff greeted them and offered reassurance and support as necessary. We noted they talked with people in a courteous way, were respectful and talked about people's care needs in a confidential manner.

Everyone we spoke with said they had been involved in decisions taken about their care and informed about the options available to them. One person told us, "The doctor has explained everything and what needs to be done and checked that I am happy with his suggestions". People told us they understood the care and treatment choices available to them. Another person told us they had had to be undressed for a procedure and that this had been done in a sensitive manner and that they had been given time and privacy to get changed.
Staff told us they encouraged people to give feedback about their care and treatment.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We saw that people had their care and treatment planned and delivered in a way that ensured their safety and welfare.

We spoke with over thirty people over the two days of the inspection in both the A&E department and on the wards. People were happy with the way they had been treated and were complementary about their experiences. One person told us, "Very prompt and very courteous staff. My overall experience has been quite positive. I have not experienced the NHS as seen on TV. I have been in hospital before."

We say numerous examples of good practice and enriching experiences for people. For example we watched an interaction between a nurse and an elderly couple. The nurse asked them, "Are you both okay?" They both said they were. The nurse then asked, "Will you be travelling together?" They both expressed a wish to and the nurse concluded, "We will take care of everything for you. Please don't worry it's going to be fine." One of the couple then told us how important it was that they travelled together. This was organised without fuss. Another person told us, "I am one happy customer. The staff have been great. I have been checked over thoroughly and I am on my way home." Another person explained how they had, "come straight through from reception and was seen by a nurse and then asked to sit in this cubicle." They went on to say there had been no delay in being seen.

We visited the Rapid Assessment Team (RATS). This team provided rapid assessment to people over 65 years of age to facilitate safe rapid discharge home or arrange access to a further rehabilitation facility. The team is multi-disciplinary and is made up of a physiotherapist, occupational therapist and a social worker. At the time of the visit there were four people admitted on to the unit. We looked at over twenty care records, including those completed in A&E, and found that a range of assessments had been completed, which identified the person's problem and goals and the action to be taken to address these. We saw and heard staff communicating with different health and social care professionals to arrange a comprehensive and safe pathway of care. Examples of these were referrals to a dietician, a General Practitioner and other community teams.

During our visit we spoke with lead nurses, five senior doctors, several ambulance crew

staff, three reception staff and fifteen nursing staff. The staff we spoke with were knowledgeable and able to describe the different pathways of care for people.

We discussed the patient's pathway of care into A&E with the ambulance staff and observed the process. We observed that A&E staff interacted well with other staff, people receiving treatment and their relatives. One member of the ambulance staff told us, "The staff at York are competent and good. Of all the hospitals we go to York staff are the most polite." Another member of the ambulance crew told us, "When we bring people into York A/E they are greeted and it is not often we have to wait." The ambulance staff told us that when they telephoned the hospital to warn them that they would be bringing someone who was ill or needed specialist care that staff were always waiting and ready for them. All of the ambulance crews we spoke with told us that they feel that things had improved over the past three to four months with less delays and waiting time in A&E.

We spoke with a quality performance manager from the Clinical Commissioning Group (CCG) who was visiting the unit. They told us that for the past three months they have been working with the Trust, Yorkshire Ambulance Services and GPs to improve the patient pathway through A& E and to reduce waiting times. They also discussed other initiatives and improvements that had been identified. Examples of these were a project manager employed to oversee developments, an urgent care group established, psychiatric staff presence identified as a need in the area and the establishment of a place of safety for psychiatric assessment.

We saw that a range of advice leaflets were given to people about their treatments and were available to people to take home.

We observed staff updating colleagues and people about their care.

We saw in the waiting area that there was a designated area for children, separated by a half wall. The area was child friendly with toys; however the provider may wish to note that children were not protected from the sights or sounds from a busy A&E department which could be frightening or a risk to children and there was no separate entrance or resuscitation room for children.

We saw that there were three cubicles in the department that had been decorated with child friendly art work. We were shown a designated area for the use of bereaved families. The area was away from the main busy area and was quiet and peaceful. We saw that there were tea making and toilet facilities for the relatives to use.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

We saw that A&E and the other areas we visited were clean and tidy. During our visit we observed domestic staff, health care assistants and nurses continually cleaning. We saw that equipment had been labelled with green stickers stating that the equipment was clean and ready to use. This ensured that staff could see at a glance that equipment had been cleaned and it was fit for purpose.

Throughout the hospital we saw dispensers for aprons, gloves and hand sanitization were available. We also observed staff washing their hands following examination of patients.

There were effective systems in place to reduce the risk and spread of infection.

People commented to us about how clean the hospital was. One person told us, "The cleanliness here is good. I have seen them mopping and they do high up cleaning. The beds are always changed and it looked spotless in A & E and here." Another person told us, "It's nice and clean and fresh." When commenting about staff, one person said, "The staff who have looked after me so far have all washed their hands and worn gloves." Another person told us, "I have no complaints about anything ? it looks clean and tidy to me. Even the staff uniforms look clean and ironed."

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

We observed the pathway people took who presented themselves to the A&E department on foot. People presented at reception and the staff used a list to identify where people should go e.g. triage/major injuries or minor injuries. We spoke to some of the reception staff and asked them if they had received training to do this. The staff told us that they had not received nurse training in this area. One member of staff told us, "We get lots of other training and if we are worried we can go and get a nurse." The provider may wish to note that the current practice around the receiving of people in the minor injury and illness might be improved by the deployment of a nurse to assist with the assessment of people.

We discussed staffing levels and the skills mix with the lead nurse, a speciality doctor, consultant and five nurses. We observed staff across the department and they were very visible and responded quickly to people's requests for assistance. The staff we spoke with told us that during our visit it was particularly quiet and that when it was busy,' you never had sufficient staff.'

We spoke with a doctor who told us, "I think we are struggling with staffing, at night time there is no consultant on duty during the night and on busy nights like Fridays, Saturdays and Sundays." Another doctor we spoke with and the nursing staff confirmed this.

We spoke with the nurse in charge of the minor injuries area of the department. They told us that they have staff vacancies and that two staff were leaving at the end of the week. They told us that not all staff have completed the further training required to work across the two areas and only two staff were nurse prescribers. The manager told us the staff were willing to undertake this training but due to work pressures they were unable to release staff to do this. The manager told us that because of staffing and skills mix it could sometimes impact on waiting times. They told us the plan was to have a 10 to 15 minute wait time, the day we visited the waiting time was one hour.

We discussed the availability of psychiatric support for people. Staff told us there was no-one assigned to the unit and support was provided from Bootham hospital, which was close by. We spoke with a quality performance manager from the Clinical Commissioning Group (CCG) who told us that they have commissioned two twilight posts to work in A&E and one person had been recruited to improve the services.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of peoples who used the service and others.

Reasons for our judgement

We saw that in the unit there were post boxes and posters encouraging people to share their comments and complaints. The lead nurse told us that they review these regularly and developed action plans as required.
The manager showed us a monitoring sheet that was used on each shift to capture any incidents or concerns. Examples of these were ambulance issues, bed problems, staffing issues and waiting times. They told us that this was used to determine if root cause analysis is required and improvements to the service.

We saw that the unit was also trialling a quick risk form to capture issues at busy times e.g. aggression, violence, pressure sores and department workload issues. This ensured that issues were not missed at busy times because people are too busy to capture them using the electronic system.

We looked at the governance arrangements and how the Trust assessed and monitored the quality of its service. To allow us to make a judgement about the running of the hospital we reviewed all the information we held about the Trust and spoke to members of senior staff and the management team. We found the Trust had many systems in place that demonstrated the Trust actively collected and monitored information to support and drive improvements.

The Trust had reported all moderate and major incidents to the appropriate agencies, including events which 'should never happen' (never events) and information was sent routinely to the national reporting and learning systems. All of this information was seen by us and reviewed. Care Quality Commission's own risk profiling indicated that the Trust had sent us the required information about incidents and accidents. We had recently followed up incidents in the hospital and the Trust had provided the required information in a timely way and taken action to minimise future risks to people using the service.

We talked with doctors, consultants, matrons and senior staff at the hospital. Some people we spoke with told us they had been asked for their views about the care and treatment they had received. Some people also referred to the Friends and Family test, they had been asked, for example, to comment about whether they would recommend the hospital

to their friends and family. We saw evidence that there were ways for people to make suggestions or give feedback about their care and treatment, either verbally or in writing. This helped the Trust to gain people's views and ensure they were taking notice of people's comments.

Complaints and compliments were recorded on the Trust's monitoring systems and the information was used as a measure of peoples satisfaction and to make changes or improvements where required. A weekly meeting was held to discuss complaints and this was attended by the Chief Executive and the Director of Nursing. This change was, the Trust thought, a better way of seeing complaints as they were received and improved accountability.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Scarborough Hospital

Woodlands Drive, Scarborough, YO12 6QL Tel: 01723368111

Date of Inspections: 30 July 2013
29 July 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Cleanliness and infection control	✗ Action needed
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	York Teaching Hospital NHS Foundation Trust
Overview of the service	Scarborough Hospital offers acute health care to 220,000 residents living in Scarborough, Whitby, Ryedale and Bridlington. It provides a wide range of inpatient, day surgery, outpatient, diagnostic services and has an Accident and Emergency department. The overall structure of the trust changed in July 2012 when the York Teaching Hospital NHS Foundation Trust acquired additional responsibility for the management of Scarborough hospital and some community based services on the East coast.
Type of services	Acute services with overnight beds Community healthcare service Diagnostic and/or screening service Long term conditions services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 29 July 2013 and 30 July 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by local groups of people in the community or voluntary sector, talked with local groups of people in the community or voluntary sector, were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

Scarborough Hospital is part of the York Teaching Hospital NHS Foundation Trust.

A team of inspectors, an expert by experience and two specialist advisors visited Scarborough Hospital between 29 and 30 July 2013. We inspected Accident and Emergency (A&E), the Medical Assessment Unit (MAU ? known as Cherry Ward) and a number of maternity wards, including the delivery suite, the midwife led unit, ante-natal and post natal wards. We also spoke to people who had been admitted to Holly Ward, Willow Ward and the Intensive Care Unit

We observed some examples of good care being provided to people and a number of people told us about their positive experiences in the hospital. However, we were also told by a small number of people that their experiences, particularly whilst receiving care in A&E, had not been as good as it could have been. We also observed that some people did not always receive appropriate care and treatment in A&E because the provider's escalation procedures were not always effective in supporting basic care arrangements when demand was higher than anticipated for people attending the A&E department.

We also noted that the remedial action taken by senior managers, when staff shortages were highlighted by nursing staff and particularly when the A&E department was 'overstretched' and busy was not effective in deploying additional staff in a timely way to ameliorate the concerns raised.

Most areas of the hospital we visited were clean and hygiene and standards were good. This was not the case in the A&E department. Because of the impact of this shortfall the overall judgement was that people were not protected from the risk of infection because appropriate guidance had not been followed despite the good performance in other areas. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of peoples who used the service and others.

You can see our judgements on the front page of this report.

What we have told the provider to do

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

People we spoke with in all areas of the hospital felt they were listened to. One person, in the A&E department, told us, "The doctors and nurses have listened to what my husband needs, about his problems." People told us that staff explained their treatment to them in a way that they could understand. Comments included, "They talk in simple terms, not using fancy medical words I don't understand, that is important to me." Another person told us how the doctor had drawn a diagram to help them understand what had happened to them and what they were going to do to treat them.

Overall people told us they had been involved in their treatment and this was discussed with them on a regular basis.

Medical Assessment Unit
People who required assistance with their personal care said they were generally happy with the way they were treated and said that staff would make sure they were covered appropriately whilst in a state of undress and that doors/curtains were closed during examinations or conversations. People also told us that staff would knock on the door or ask before they entered a room. We saw there was separate accommodation for male and female, which met the Department of Health's requirements for the elimination of mixed sex wards. We saw that people's bedding and night attire were clean.

People told us overall they had had a good experience and they were informed and had enough information about their care and treatment. One person told us they came into hospital regularly and they were satisfied with the amount of information about care and treatment they received.

In two people care records we saw examples of where concerns had been raised about the quality of treatment they had previously received. We saw evidence to demonstrate the medical and nursing team had listened to their concerns and acted upon them.

Maternity
We spoke with people and their partners on four of the maternity wards. Everyone we

spoke with was positive about the care they were receiving. Everyone told us they had been treated with respect and dignity. One person told us, "I never really felt exposed during the labour, despite the position I was in."

Staff were visible and available. We saw staff provided assistance in a professional manner.

We noted, in the care records we examined, that people or those involved in their care had been consulted during any decision making process and this was clearly documented in the notes. This showed that staff took into account the type of decisions required and the wishes of those receiving care and treatment.

Throughout our visit, we observed a significant number of positive staff interactions. We observed staff supporting people when they appeared distressed, anxious or upset. We observed staff listening to what people were experiencing and taking appropriate action, for example providing pain relief or additional blankets if they were cold. We also heard staff explaining to people how they were attempting to support them and address their concerns.

Accident & Emergency
We spoke with people receiving treatment, relatives and staff. A small number of people told us they did not feel their privacy and dignity was fully respected. We did see, on four occasions, that curtains were not closed or that questions about sensitive matters were not always carried out discreetly. The people we spoke with told us staff were caring and sensitive and 'did their best.' One person told us, "I have no complaints about how I have been received here and treated". We observed staff talking to people in a friendly and polite manner. We saw that people's bedding and night attire was clean, apart from one example where a person was not attended to in a timely way and this resulted in a delay in their care needs being met.

We also noted that not all the nurse call bells were easily accessible to people in order for them to summon assistance. However, only 3 of the 10 available, however, only three of these were working. The provider may wish to note that all call bells should be in easy reach for people to use, including those fitted in toilet areas and should be routinely checked to make sure they are working.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Overall people experienced care, treatment and support that met their needs and protected their rights. The registered person did have procedures in place for dealing with emergencies which are reasonable expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services. However, these were not always effective in ensuring care needs were met within A&E. In addition to this, the levels of staffing available could also impact on the amount of time staff had to deliver basic care in the A&E department.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Overall people experienced care, treatment and support that met their needs and protected their rights. The registered person did have procedures in place for dealing with emergencies which are reasonable expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services. However, these were not always effective in ensuring care needs were met within A&E. In addition to this, the levels of staffing available could also impact on the amount of time staff had to deliver basic care in the A&E department.

Medical Assessment Unit
We looked at care records and saw that these provided specific details about the nursing needs of people. The care plans were pre-printed and outlined the care needs of the person and what actions staff should take to meet those needs. We asked staff about the care plans. One member of staff told us, "The care plans tell you how that person would like to be cared for. It tells us what we are going to do and the outcome we are expecting." However, we were concerned to find that not all relevant risk assessments had been completed for people, particularly for those with complex needs and who may exhibit challenging behaviours or be of risk to others. This is of particular concern as the Trust had experienced a serious untoward incident in the recent past, which could have been better managed had the correct actions and risk assessments been in place. That this recent learning has not been translated into more effective practice is an area of concern.

When talking about their experiences one person told us, "The nurses are brilliant, they are always around." Another person told us, "The staff are nice, they have been absolutely fantastic since I moment I was admitted."

Maternity
A specialist advisor in maternity care was part of the inspection team. We saw that people had their care and treatment planned and delivered in a way that ensured their safety and welfare. Within each of the maternity units, people had their own records that they brought into hospital with them, which detailed the progression of their pregnancy. Where necessary, we saw that people had consented to treatment and examination and people we spoke with confirmed this. Within all records looked at we found that a range of assessments had been completed, which were relevant to the clinical and nursing areas, as well as specific pathways of care being followed.

The staff we spoke with were able to describe the pathways of care for people accessing maternity services. We found that records had been well completed, risks had been assessed and their records had captured medical, health and social information.

People we spoke with were pleased with their maternity care. One person told us, "The staff have been excellent. I feel safe and completely at ease here." Everyone told us they felt safe and that staff were attentive but at the same time allowed families to get on with enjoying their experience.

We spoke with three members of staff who told us that an audit of care plans is regularly undertaken. One member of staff told us, "We are all involved in auditing care records, we do it as part of our supervision, it's good to read colleague's notes as you learn from them."

We found there was information available for people to support their discharge from hospital. One person, who was being discharged said, "I know what is happening now and in the weeks ahead." We saw detailed transfer of care from inpatient midwifery services to community midwifery services. The manager explained what safety precautions were taken for the safe transfer of medical and nursing notes from the hospital to clinics outside of the hospital. A range of advice leaflets were given to people about their treatments and support around breast and bottle feeding. One person and their partner told us, "We were made to feel we were in good hands, everything was explained to both of us, and everything here has been wonderful. It is of the highest calibre." We saw that their care and treatment was planned and delivered in a way that ensured the safety and welfare of both the mother and her baby.

The provider may wish to note that clinical guidelines need to be combined for both sites (York and Scarborough). Guidelines also need to be more robustly developed and targeted to specific staff detailing who is responsible for each task/procedure.

Accident & Emergency
The hospital has an emergency department and another, smaller area, which 'sees and treats' people with minor injury or illness.

We received differing views about people's experiences on both departments. One person told us, "The staff are wonderful, everyone is so helpful. I have been well looked after." Another person told us, "They have been very good. I have had a good experience and I have been treated like a human being." Another person said, "The staff are amazing they are so busy" and another comment was, "The staff pop in to check on me, I have been really well looked after".

However, this was not the experience other people described to us. One person said, "They never offered me or my husband a drink and we'd been up most of the night."

Another person told us, "They did not give me a buzzer so I could not call them if I needed to. I was right at the end of a corridor so not many people passed." People also described how they had had to repeatedly request attention for their relative, including asking for pain relief and other essentials such as a drink, blankets and assistance to use the toilet.

We were told by one person that their young relative had not been given pain relief in a timely way. We followed this up with the staff on duty and after a significant delay the young person was eventually given pain relief. There was no plausible reason given to us or the relative for the delay. We were also told by a number of people we spoke with that they had had to ask repeatedly for pain relief, despite them reporting this to the staff and staff recording this on their medical assessment notes. We were also aware of one person who needed to be assisted with their personal care, have their gown changed and be made comfortable. Staff had taken a soiled laundry trolley, sheets, gown and incontinence aids to the cubicle in readiness for this. However, due to the high demand on staff resources, this had not been done and the person had had a two hour wait for assistance.

For us to gain a better view about the service we returned to the A&E department at 9pm on the evening of 29 July 2013. We found the department was extremely busy and ambulance crews were waiting to hand people over to the care of the A&E nurses. The crews told us they usually had to wait a significant length of time before they could book people in as staffing was often 'tight' and there were often times when there were no spare cubicles due to the amount of people being seen and waiting to be admitted to a ward or discharged home. One member of crew told us, "The staff are very good but it is always busy." Another member of crew told us, "We often ring ahead to say we have a person for resuscitation but when we arrive usually there is no-one in there waiting." One member of crew told us he had had to press the alarm in resuscitation to alert staff of their arrival on three separate occasions. We were told by another member of crew that the consultant for A&E had recently held some joint training for Ambulance and A&E staff, which they thought would help to improve relationships and patient flow.

People we spoke with in A&E told us, "They could do with a lot more staff for example getting people water when they want it." Several people told us they had waited a long time, sometimes over four hours, before they had been seen by a doctor.

It is important to acknowledge that the department was extremely busy on the days and evening we visited. Not only were the recognised increasing demands on A&E nationally apparent but the department experienced a significant increase of more than 12% in the predicted demand for that period during our visit. Some people had a general acceptance of the need to wait in these circumstances. However, some people had had to wait in excess of four hours before they were seen by a doctor and others complained about the lack of information, particularly if they were waiting in the minor injury waiting area.

We followed the care of over thirty people. We looked at who had been admitted to the hospital from A&E. We spoke with staff on all of the areas we visited about the patient journey and tracked individuals care and treatment.
We looked at the care records. On the whole records had information relating to the person's care needs and included risk assessments with regard to pressure area care, the use of bedrails, risk of falls, manual handling and nutrition.

All the cubicles were full all of the time that we were in the department and the resuscitation area was also busy. Serious cases admitted via ambulance were appropriately prioritised though others did have to wait to be assessed and handed over to

hospital staff. Ambulance staff waiting with people that were awaiting assessment were seen to be attentive and responsive to the needs of the patients still in their care

However, those who presented themselves or were brought in by family to the department were not always assessed in a timely way. Some people had relatives or friends waiting with them, while others, including some frail older people, were on their own. We did not notice any member of staff verbally checking on these people, offering them a drink or checking if pain relief they had been given was effective.

Staff were struggling to ensure people's needs were met. However, we did note some good practices whilst visiting the department. When the level of admissions was quieter, we noted quick assessment of ambulance patients on arrival and good team work between the nurses and health care assistants.

Staff were busy and were doing their best but it was clear that the department was too busy for them to be able to manage the volume of people, provide basic needs and be proactive. The senior managers in the hospital were aware that the department was experiencing exceptional demand and that this was impacted by a reduced number of discharges that day meaning that beds within the hospital were in short supply. This further exacerbated the problems being faced in A&E. We had some concern that this situation was not responded to quickly enough to secure the additional resources needed that evening.

As part of the inspection we shadowed the bed manager who was extremely busy trying to find accommodation for people who required admission. We saw that people who were coming to hospital for planned surgical procedures were being admitted via the A&E department. This put further pressure on the unit which was already struggling to cope. At the time we were shadowing there were significant breaches in A&E time targets with people waiting well over 4 hours for a bed. There were many medical and surgical "sleep outs" throughout the hospital. That is that patients were not always able to be placed on the wards dealing with their identified area of need. We saw the bed manger continually reviewing people on the wards and in A&E for possible transfer or discharge but this was not successful in reducing the demands of the situation at that time.

As part of our inspection we also observed a 'bed' meeting on 29 July 2013. At this meeting the ward coordinators discussed the situation in relation to admissions, discharges and any staff shortage concerns with matrons and the clinical site managers. We heard at this meeting about the unexpectedly high number of beds being occupied and the high number of people being admitted through A&E and there being a shortage of beds not only in Scarborough but also in the surrounding areas, which reduced further opportunities to deal with demand. However, by the time the Trust had arranged to open up an escalation ward, at 5pm, they could not find additional agency or bank staff to work on those wards. In our view, it was clear by 11am on 29 July 2013 that staff were unable to cope with the demand and that this was having a detrimental impact on some of the people receiving care and treatment. An earlier decision to open up escalation beds would have given more time and might have been more effective in ensuring that additional resources could have been arranged.

Generally people admitted to wards in Scarborough Hospital did receive safe and appropriate care. However, whilst acknowledging the significant difficulties of increased demand on the day of our inspection, some people with A&E did not always receive care which ensured their welfare and safety.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

Some people were not protected from the risk of infection because appropriate guidance had not been followed in all areas of the hospital.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at infection control and the levels of cleanliness on all the wards we visited. We also looked at in house audits. These were evidence-based and related to key clinical procedures or care processes. For example, hand hygiene, cleaning and decontamination that can reduce the risk of infection if performed appropriately. We noted a variation between the areas we visited, some performing better than others.

Medical Assessment Unit
Overall we observed the level of infection control around staff cleaning their hands before attending to people was of a good standard. This was confirmed by the people we spoke with. People told us that the ward was always clean and people told us they did not have any concerns about cleanliness. Overall cleanliness was noted as satisfactory.

We saw that the ward area had alcohol gel and information for people and relatives on the importance of hand washing.

We saw people were being nursed in side rooms, with notices informing people of the increased risk of infection. Personal protective equipment (PPE) was available outside each room and we observed staff following infection control procedures. We noted from the medical care records that staff had specific information relating to the best practice around infection control and the staff we spoke with confirmed they knew how to prevent cross infection and best practice.

Maternity
We found the ward and clinical areas in the Maternity service were clean and well maintained apart from some minor issues which we were told were in hand.

We looked around the different ward areas, including the communal bathroom areas. We found these to be clean and well maintained. Some minor issues were pointed out and discussed with the lead nurse. We saw that equipment had been labelled stating that the equipment was clean and ready to use. This ensured that staff could see at a glance that

equipment had been cleaned and was fit for purpose.

We saw liquid antibacterial hand gel was available at the end of each people's bed and throughout the ward. We observed staff using this. We also observed personal protective equipment such as aprons and gloves were available and again we saw staff using these. We observed staff, including domestic staff, cleaning the environment and changing bedding.

We spoke with the lead nurse and five members of staff about infection prevention and control procedures within the maternity unit. The staff we spoke with demonstrated a good knowledge and understanding of the procedures. We saw that infection control audits were undertaken and staff confirmed this. The staff told us that regular audits were undertaken by the lead nurse and the domestic staff. They said that action plans would be developed for any issues identified. We saw that the area had a 'productive ward' display which showed that the previous audit showed 100% for hand Hygiene and 97% for ward cleanliness.

We were told that all staff received regular training and updates about infection control and ward cleanliness. We saw that the area had a number of standard operating procedures and policies in place in relation to infection control. The staff showed us, and we saw that there were procedures outlining how to clean and decontaminate clinical areas.

Accident & Emergency
This area of the hospital was not clean and staff were not adhering to infection control procedures. We raised a number of concerns with the lead nurse. For example, blood and other bodily fluid spillages were not being cleaned up properly, which meant these had dried onto the floors, trolley rails and bed rails without being treated with cleaning products. We also saw used commodes being used to hold back curtains around cubicles. We did not observe any cleaning of cubicles, wheelchairs or trolleys in-between patients.

Gloves and aprons were not being routinely used. We found low and high level dust and that tables and chairs had not been cleaned effectively. Toys in the play area, which were accessible to children, were heavily stained and dirty. We were also concerned to find a toilet brush on a work top which had dried toilet tissue and faeces on it.
When equipment is cleaned it should be labelled so that staff can see it is ready to use. We saw no evidence of these labels being used.

The poor standards of cleanliness we saw in the A&E department was not entirely linked to the volume of patients and in any event the levels of cleanliness should have been picked up as part of the local audits in that department. Also the emergency plans to assist areas in times of predictable high demand should include additional support from ancillary and cleaning staff, if required, to keep the area clean.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

We spoke with over forty staff during the inspection. This included staff on all the wards we inspected and in the A&E department.

During our inspection we looked at agreed staffing levels and rotas for all areas we inspected.
We discussed staffing levels and the overall skills mix with senior managers, lead nurses, consultants, qualified staff and health care assistants. We also attended an urgent 'crisis' meeting as part of our review of the Trust. This meeting had been called to discuss the issues relating to people's care, staffing levels and the lack of capacity for people to be admitted to Scarborough and other hospitals in the area. We were told that the trust was actively trying to recruit qualified nurses and had struggled to attract new applicants. Agency and bank staff were used extensively around the hospital.

Medical Assessment Unit
People and staff that we spoke with told us they thought there were enough staff at ward level and that they could effectively meet people's needs. We reviewed the numbers of staff on duty and saw that there were staff of all grades available both on the day and night shifts and that staff were always supported by a senior member of staff who was designated to run the ward. Staff spoke positively about their work and that the staff team worked together to help make sure people received a good level of care and attention.

Maternity
Staff were visible at all times and responded quickly to people's requests for assistance. The staff we spoke with told us they each had their own people to care for.

We spoke with a doctor who told us, "It has been a really good experience [on the maternity ward] with lots of training from the staff, the registrar and consultants. Staffing levels are reduced on the registrar rota however there is a locum, sometimes there is only one registrar covering everything which doesn't seem enough."

Staff we spoke with told us they received lots of training by attending courses or e-learning. All of the staff we spoke with told us they felt supported by their colleagues and management in undertaking their role.

We saw that some staff had undertaken further training to enable them to undertake the role of 'supervisor of midwifes'. We discussed this role with the staff we spoke with who told us that the supervisors were always available and supportive.

We discussed and saw that student midwifes who were on placement to the unit were allocated a mentor. We saw on the off duty that students work at least three shifts per week with their mentor.

While the manager told us that there were some vacancies, we found good systems in place for monitoring staffing levels and skills mix in the maternity unit. One member of staff told us," Staffing has recently improved since the review of the midwife led unit because we now have an extra midwife available on the delivery suite." Another member of staff told us, "There is a good team ethos within this unit".

Accident & Emergency
A specialist advisor in accident and emergency was part of the inspection team.

It is acknowledged that on the days of our inspection visit, there were exceptional attendances at A&E. While this raised questions about the Trust's emergency planning arrangements and the implementation of their escalation procedures, it did mean that we were not able to fully assess the efficacy of the staffing arrangements in general.
However we spoke to four ambulance staff about the patient journey and they told us that they often had to wait with people because staff were busy.

Some A&E staff also told us they thought staffing levels were too low and this could mean care and nursing needs could not always be met. One member of staff told us, "We can't manage with the staffing levels we have and we have told the senior managers this."

Another person told us that when agency staff were used, which was regularly, the standards dropped because they 'did not know the routines or the systems in place.' There were also concerns about the training staff within the department received to support their work. For example, it is expected that staff working on the A&E department would have specific training around advanced life saving. This was not always the case.

It was also of concern that people presenting themselves at A&E were not assessed by a nurse. The reception staff made decisions about who was to remain in "minor injuries and illnesses" area and who was to be seen more urgently by a nurse for assessment for a move to "the majors" area of A&E. This could result in a serious matter being overlooked.

The provider may wish to note that this current practice around the receiving of people in the minor injury and illness area might be improved by the deployment of a nurse to assist with the assessment of people.
While overall the staffing arrangements within the hospital did meet the required standards, the provider may wish to note that the arrangements in A&E would benefit from review.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of peoples who used the service and others.

Reasons for our judgement

We looked at the governance arrangements and how the Trust assessed and monitored the quality of its service. To allow us to make a judgement about the running of the hospital we reviewed all the information we held about the Trust and spoke to members of senior staff and the management team. We found the Trust had many systems in place that demonstrated the Trust actively collected and monitored information to support and drive improvements. Notwithstanding this, it was disappointing that during our visit the Scarborough Hospital site the need to instigate an escalation procedure as a result of the high demand for accident and emergency care was not actioned in a more timely way.

The Trust had reported all moderate and major incidents to the appropriate agencies, including events which 'should never happen' (never events) and information was sent routinely to the national reporting and learning systems. All of this information was seen by us and reviewed. Care Quality Commission's own risk profiling indicated that the Trust had sent us the required information about incidents and accidents. We had recently followed up incidents in the hospital and the Trust had provided the required information in a timely way and taken action to minimise future risks to people using the service.

We talked with doctors, consultants, matrons and senior staff at the hospital. Some people we spoke with told us they had been asked for their views about the care and treatment they had received. Some people also referred to the Friends and Family test, they had been asked, for example, to comment about whether they would recommend the hospital to their friends and family. We saw evidence that there were ways for people to make suggestions or give feedback about their care and treatment, either verbally or in writing. This helped the Trust to gain people's views and ensure they were taking notice of people's comments.

Complaints and compliments were recorded on the Trust's monitoring systems and the information was used as a measure of peoples satisfaction and to make changes or improvements where required. A weekly meeting was held to discuss complaints and this was attended by the Chief Executive and the Director of Nursing. This change was, the Trust thought, a better way of seeing complaints as they were received and improved accountability.

Staff we spoke with confirmed that regular audits were undertaken across the whole hospital and reports submitted for consideration by the Trust where necessary. Audits covered a variety of topics including cleanliness, care plans and care notes, medicines and prescription charts.

We could see that there were systems in place for audits and the monitoring of quality and procedures. Senior staff told us that any issues raised during audits, including complaints received and comments about peoples experiences were not always routinely followed up at ward level. Despite this we noted that there were regular meetings at the executive board level to discuss issues relating to ward level matters. We were provided with minutes from these meetings which confirmed this. The hospital is also involved in other auditing initiatives, outside of the Trust, as an extension of their efforts in trying to improve services.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Overall people experienced care, treatment and support that met their needs and protected their rights. The registered person did have procedures in place for dealing with emergencies which are reasonable expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services. However, these were not always effective in ensuring care needs were met within A&E. In addition to this, the levels of staffing available could also impact on the amount of time staff had to deliver basic care in the A&E department.
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: Some people were not protected from the risk of infection

This section is primarily information for the provider

screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	because appropriate guidance had not been followed in all areas of the hospital.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Archways Intermediate Care Unit

1-26 Clarendon Court, York, YO31 8HT

Date of Inspection: 01 August 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	York Teaching Hospital NHS Foundation Trust
Overview of the service	Archways Intermediate Care Unit is managed by York Teaching Hospital NHS Foundation Trust and is registered to provide nursing care and treatment of disease, disorder or injury. The unit can accommodate up to 22 people and is designed to prevent unnecessary admission to or facilitate early discharge from hospital.
Type of services	Long term conditions services Rehabilitation services
Regulated activities	Nursing care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 1 August 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by local groups of people in the community or voluntary sector, talked with local groups of people in the community or voluntary sector and used information from local Healthwatch to inform our inspection.

What people told us and what we found

During our inspection we looked at how people were respected and involved in the care, support and treatment they received. We found that people had been involved in the planning and delivery of their treatment whilst staying at the unit. People we spoke with told us they felt respected and listened to. We spoke with eight people who were staying at Archways for their rehabilitation.

People told us their stay had been made comfortable. They said they were treated well by the staff. One person told us, "The care is very good and the staff are excellent. The food is alright. I have been cared for very well during my stay here."

We saw from people's medical and care records that they were supported to retain their independence as much as possible during their treatment. The records we reviewed were person centred and included essential risk assessments, which had been kept under review, to enable appropriate treatment, care and support to be given.

Observations on the day of inspection, people we spoke with and records we looked at confirmed that there were sufficient staff to meet peoples care needs. People told us they were supported as and when needed.

We saw that the provider had systems in place to make sure people were safely cared for. This included policies and procedures and quality monitoring systems. There was information available to help people make a complaint if they were not satisfied with the care and treatment during their stay.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People we spoke with told us they had agreed to and understood the care and treatment they received. People told us that all the staff on the unit, including the Occupational Therapist and Physiotherapist, involved them in their treatment programme. One person told us, "I have total control over my care and support". Another said, "All my treatment was explained fully. I was given time to think about different options and could ask questions about how I was progressing." Another person commented about how their treatment had been organised. They told us, "I have been involved in every step of my treatment plan. I have had a say in all my therapy and care." This meant that people could express their views and were involved in making decisions about their care and treatment.

People were able to tell us about their medical conditions and what their treatments were. We saw during our visit that people were very relaxed and confident when being approached by the nursing staff.

Medical and care records we reviewed included very specific information about peoples conditions and what specific and intensive treatments and support they required.

This information provided details about how nursing staff and other health care professionals should support people throughout their stay at Archways. This also helped to ensure people's rights were respected and taken into account.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

During our visit we spent time speaking to people and looking at their care and treatment plans. People we spoke with told us that they were, 'very well looked after' by the staff at the unit. One person told us, "The nurses help me to see to my personal care and there is always plenty of staff. I cannot fault them." Another person said, "The care is absolutely wonderful. It is like a first class hotel. They have time for you and help you. You could not have better in a private nursing home." One person told us, "The care and treatment I have received is second to none. My whole experience from being in hospital to coming here is very positive". Another person said, "I know that all the staff are supporting me to reach my goal of going home. The physio, nurses, care staff and therapists encourage me to push myself a little bit more each day."

We also had the opportunity to speak to the visiting General Practioner for the unit who told us, "This unit is ideally situated to provide complex medical care where the full supplement of a therapist is needed. This is a good unit. Person centred care is provided. Staffing is good although there is only one qualified nurse on at night for two floors."

During our visit we observed people's privacy and dignity being maintained at all times. For example there were signs on bathroom doors when in use. We observed staff knocking on people's bedroom doors. We also observed staff speaking with people in quiet voices in communal areas, so as not to be overheard.

We looked at four peoples records. These records showed what support was needed to promote a person's independence, and what progress had been made. Records we looked at were detailed and clear and showed how people were being rehabilitated, so that they could live their lives as independently as possible. All the necessary risk assessments had been completed. We saw from the records we looked at, that care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

All records we looked at had been signed and dated by the staff carrying out the assessments. Daily records were completed by the nursing staff and these showed when any medical intervention was needed with the outcomes for people being recorded.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

When we visited the service we looked at the policies and procedures that were in place in relation to the control of infection. We looked around the communal areas and people's bedrooms. We found them to be clean and tidy. There was soap and disposable hand towel dispensers available though out all communal areas and in individuals bedroom. We saw staff regularly washing their hands. People told us they thought the premises were clean. Comments from people included, "It's always very, very clean." One person told us, "The doctor always washes her hands". Another said, "My bedroom gets mopped and dusted every day. The cleaners are really nice they keep this place spotless."

We spoke with the domestic staff on duty. They told us that two domestic staff were on duty each day until the afternoon and then another domestic worked from 14:00hrs until 20:00hrs. They told us that they had a set routine for tasks each day and that they worked to cleaning schedules. We saw the schedules for daily and weekly cleaning, which had been ticked when completed . We also saw monthly audits that were carried out by the domestic supervisors. We saw that 100% was achieved on the majority of these audits. These had been completed in areas such as treatment rooms, bedrooms and sluice facilities. This showed that there were effective systems in place to reduce the risk and spread of infection.

We noted that colour coded cleaning equipment was available and colour coded labels were used to identify areas and the equipment to be used for cleaning those areas. Cleaning liquids were stored in a cupboard in a locked room. Cleaning staff confirmed that they had enough equipment to carry out their jobs properly. They told us that they had received training in infection control procedures. They also told us that if any new cleaning equipment or products were to be used, they were shown how to use them properly and safely. For example wearing gloves and a face mask for protection when using a certain cleaning chemical.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

People told us that the staff at the unit were kind and helpful. One person said, "There are plenty of staff here. Sometimes there are more staff on than other times and they all get on well together." Another person told us, "The care is very good and the staff are excellent. I have been cared for very well during my stay here."

We asked for and were given copies of staff rotas for weeks ending 28th July 2013 and 4th August 2013. We were informed by the unit manager that the staffing levels for the unit were as follows. Two trained staff and two health care assistants each shift. The shifts started at 7.30am until 3.30pm, 12.30pm until 8.30pm and the night shift was 8.15pm until 7.45 am. There was an overlap of staff between 12.30pm and 3.30pm. This allowed for handovers as the manager informed us this was done three times daily.

The rotas we looked at did not include the hours of the unit manager or other health care professionals that worked on the unit, for example the occupational health therapist or physiotherapist. When we looked at rotas to check staffing numbers, these were consistent with the agreed staffing plan for the unit at all times.

We were informed by the unit manager that a ward manager and staff nurse had been appointed and that a 30 hour health care assistant post was vacant and was to be advertised. This meant there were enough staff on duty, with varying skills and expertise to meet people's assessed needs.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

All of the people we met during our visit spoke highly about the care and treatment they were receiving. People told us that they would speak to a nurse if they had any concerns or complaints about their care and treatment. We saw that there was a public noticeboard which contained a variety of leaflets for people, their relatives and visitors. One of the leaflets included the telephone number of the People Advice and Liaison Service (PALS). This is a service that acts as an advocate on behalf of people using the hospital services.

We were informed by the unit manager that all complaints go to the Trust's complaints team, where the Trusts complaints procedure would be followed. The manager told us that monthly meetings were held where they discussed any learning from issues that had arisen. We were informed there had been no complaints and there were no on-going investigations regarding the unit. The manager told us that any minor concerns raised by people would be dealt with by the nursing staff caring for them. If the concern/complaint could not be resolved by staff on the unit, people would always be advised to contact PALS. This meant that people were given support to make a comment or complaint where they needed assistance.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 17 September 2013 Ward 35 Seminar Room

Attendance: Mike Sweet, Chairman
Mike Keaney
Debbie Hollings-Tennant
Lucy Turner
Andrew Bertram
Anna Pridmore
Graham Lamb
The meeting was observed by a member of the KPMG team

Apologies: Liz Booth

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last Meeting Notes Minutes Dated 23rd July 2013**		The notes were approved as a true record of the meeting.		
2	**Matters arising**		The Committee asked Mr Bertram to provide an update on the first: follow up ratio. Mr Bertram advised that a review meeting with the CCG is planned to discuss the first: follow up ratio. Mr Bertram reminded the Committee that the target rate was aspirational. The Trust has been collecting data which it will use with the CCG to demonstrate what is possible and safe for patients. The Committee also noted that the ratio will vary from specialty to specialty. Referring to the discussion about C-Diff and the prescribing of anti microbials Mr Bertram advised that		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
2	Matters arising cont'd		the Trust was in the final stages of agreeing the use of probiotics in the Trust. Mr Bertram explained that the probiotic being considered, is simple to use, in that it is sprinkled on food and is intended to reduce the problems some patients experience with antibiotics. He advised the Committee that there was a cost associated with the introduction of probotics, but the final cost was still being determined. Mr Bertram updated the Committee on the progress of Public Health England attending the Trust to review what further work could be undertaken to ensure the Trust was doing everything to ensure best practice was maintained with antimicrobial prescribing.	The introduction of probiotics will provide support to the impact of antibiotic prescribing.	
3	**Operational Report**		LT tabled an up to date summary of the corporate dashboard and Mr Sweet advised that a revised version of Signal would be in place from 1 October 2013 as part of a corporate dashboard. LT highlighted the areas where there were concerns about performance. 18 Weeks – The three targets are expected to be met once the final validation work is completed. There are two incomplete pathways greater than 52 weeks. These are being addressed urgently. First: follow up ratio – The Committee agreed to defer the discussion to the Board meeting. The Committee understood that there was some concern about the implications for some patients of a 1:1.5 ratio. Cancer – LT reminded the Committee that due to the need for validation the figures were always two months behind. She advised that there were two patients that fell outside the target; one of those patients was too unwell to be treated. The aggregated	The Committee took assurance from the clarity of the report being presented and the fact that the challenges were being recognised and addressed. The Committee was concerned about the level of challenge that currently exists in the Trust on a number of measures.	Mike Proctor to update the Board on the position regarding first : follow up ratios

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3	Operational Report cont'd		July position was 88.89% against a target of 90%. Emergency Department – LT informed the Trust that the target had not been achieved in August and there was a significant risk to the Trust achieving the target for the quarter. LT explained that the challenges in York and Scarborough are different. The challenges in Scarborough relate in part to the availability of beds, where as in York they are more related to problems that arise overnight. The Committee asked about the development of the winter resilience plan. Mr Bertram explained that the plan in York had been completed and would be presented to Board with the Scarborough plan once the final elements of that had been completed. Mr Bertram advised that within Scarborough the development of the Maple Ward 2 has been postponed to ensure that the proposed decant ward (the old Graham Ward) can be used as an escalation area if the need arises during the winter. The Committee agreed that it would be helpful if Mr Proctor would provide an update to the Board on the plan. The Committee asked Mr Bertram to comment on the national winter money that had been awarded to the Trust. Mr Bertram explained that from the information received by the Trust the money was related to three schemes – Community/ED Rapid Response, A&E patient flow and patient equipment. At present how these monies relate to the annual flu jab is not clear. Mr Bertram explained that the Trust had submitted three bids, one for York, one for Scarborough and one for some capital support to enable the		Mike Proctor to update the Board on the A&E position for Q2 Mike Proctor to update the Board on the development of the winter resilience plan

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3	Operational Report cont'd		construction of an assessment centre at each site.. Mr Bertram explained that these non recurrent additional monies will ease short-term winter pressure but will not solve the underlying issues; a medium term solution would be the development of the assessment centre. This continues as a Trust priority but it is disappointing to note that at this stage this particular aspect of the bid does not seem to have been supported. More information on the clarity of the successful bids and the flow of funds to the Trust are still awaited. The Board noted that the additional funding is an item included in the Chief Executive's report – the Committee agreed to ask the Chief Executive to comment. Ambulance handovers - LT explained that there had been serious delays at times during the last month, which resulted in an increase in the delay of handovers from ambulances in the Trust. This was as a result of the increase in the number of attendances, delayed medical reviews and the flow of patients. The Committee was keen to understand the reasons why the Trust was not achieving the target and also if the resilience plan will help address the target. Mr Bertram confirmed that the plan will help address the issues. Given the scale of the potential penalties and the lack of improvement in performance M Proctor to be asked to brief the Board on the actions being taken to address the problem.. C-Diff – the Trust continues to be challenged on the number of C-Diff cases, although the numbers of new cases have slowed down in the last 2 months. The Trust has a yearly trajectory of 43. To date the Trust has recorded 31 cases across the organisation. This		Chief Executive to comment on the additional funding Mike Proctor to brief the Board on the YAS handover position Proposed that Monitor be notified that the Trust will breach the C-Diff target for Q2 along with the significant risk that it will breach the ED 4 hour target.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3	Operational Report Cont'd		position is placing compliance with this target at quarter 2 in question. MRSA – The Trust has had one further case of MRSA. This means the Trust has had 2 cases this year against a zero expectation. Mixed Sex accommodation – The Trust breached the requirements on two occasions during August. This affected five patients. The problem is concentrated in one department and a business case is being developed that will, amongst other things, address the problem. Discussions are taking place with commissioners also as to potential solutions.		
4	**CQUIN**	2.12 2.13	Commissioning for Quality and Innovation (CQUIN) – The Committee received an update of the position of all the CQUIN targets. LT identified that the Trust did have some challenges to achieving the targets related to pressure ulcers, Consultant post-take ward rounds in 12 hours and length of stay. Other targets are still challenging, but LT felt the Trust was at this stage making good progress to achieve them.	Progress is being made to the achievement of the targets, although it is clear that there are still some challenges to overcome	Alastair Turnbull to comment on the post-take ward round.
5	**Finance Report**	2.15 3.1 3.11	GL presented the finance report. He highlighted that the income and expenditure shows an actual deficit of £0.2m. This is behind plan. He added that the position does include restructuring costs of £0.5m relating to redundancy and MARS and these are excluded in Monitors assessment of the Trust's position. Therefore the underlying performance is reported as £0.3m surplus against a planned position of £0.5m, returning an FRR of 3. GL summarised the income position and highlighted that the summary data suggests that for August there has been a fall in activity bringing the Trust nearer to	The Committee was assured that the discussions about the additional work being undertaken are openly being discussed with the CCG, Contract Management Board and the Trust resulting in significant efforts being made to mitigate any risks.	Andrew Bertram to comment on the risk of the CCG's ability to pay for the additional work

	Agenda Item	AFW	Comments	Assurance	Attention to Board
5	Finance Report Cont'd		the level of planned activity. However, the exception to this is the activity at Scarborough in the Emergency Department. At this stage income is assessed as £3.5m ahead of plan. The Committee asked about the ability of the CCG to pay for the additional activity. Mr Bertram advised that the issue remains a risk and has been included on the Corporate Risk Register. Discussions are being held within the Contract Management Board and there are two key measures that the CCG are putting in place. The first is the first :follow up ratio, discussed earlier in the meeting and the second is a new Referral Support Service (RSS). This is a pilot and involves two practices – Haxby and Priory. A GP will make a referral which will be checked to ensure that the GP has undertaken all the investigative checks and tests and appropriate alternative treatment that should be undertaken in primary care before the referral is passed on to the Trust. This step is included in the 18 week time, therefore the CCG have set tight timelines for this check to be completed. It is in the Trust's interest that this review is undertaken as it does mean that the Consultants do not have to arrange for tests that should have already been completed and this will support the follow up reduction work. Measures have been put in place to ensure that the RSS does not adversely effect the time available to YFT to treat patients as some concern exists over the adverse impact on RTT times where referrals are returned for action to the GP before onward progression to the Trust. The Trust's Patient Access leads have been involved in the process and will be monitoring the output from the RSS to ensure no adverse impact on patient waiting times. GL explained that the report includes information	The Committee were assured by the conservative approach that had been taken to the production of the report.	Andrew Bertram to update the Board on the financial impact of the 30% threshold for non-elective work.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
5	Finance Report Cont'd		about the contract penalties that have been imposed. He highlighted that the report includes anticipated penalties of £979k. In addition an assessment of £969k has been made for the cost of the follow up work undertaken above the 1:1.5 new patient follow up ratio. This income has not at this stage been included in the reported position. At this stage no provision has been made for possible CQUIN non-achievements. GL reported on the expenditure and highlighted that the pay budget was overspent by £1m. He explained the reasons for the overspend and the Committee had described to it the work that was being undertaken in the Workforce Strategy Committee including fundamental work to confirm establishment levels for some areas at Scarborough that have traditionally been staffed with bank and agency. HR were in the process of an intensive recruitment campaign to convert some of these long standing roles that are filled by agency staff into employees of the Trust. GL reported on contracting matters - Contracts with the Local Authorities have now been agreed but currently remain unsigned. They should be signed in the next few weeks. The £15m capital support has not been received by the Trust, but discussions continue with the DH around when the money will be released. Concern was expressed as to when the monies will be paid as non-receipt will soon impact our capital schemes.		Andrew Bertram to update the Board on the capital issues
6	**Efficiency Report**	3.1 3.9	DHT presented her report. She highlighted that at the end of period 5 the Trust has achieved £9,036k efficiencies in full year terms against a target of	The Committee was assured by the performance of the CIP, but recognised there was much work	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
6	Efficiency Report Cont'd		£23,363k. Of this £5.5m is non recurrent. There are in place a further £13,379 of plans which leaves a £948k gap. In terms of 4 year plans there is currently a £12,965k gap which is being addressed by Directorates. DHT referred the Committee to table 3. She explained that the table profiled progress this year compared to last year. DHT presented the risk assessment documents to the Committee. She described the process that is used to develop the risk score and explained that the two domains are finance and quality and safety. DHT described the process through which Directorates need to demonstrate their ability to achieve a green rating on quality and safety. The Committee discussed appendix 2 and clarified how the financial risk ratings were identified. The Committee recognised the improvements that have been put into the system to target those that are not delivering and provide support to them to facilitate delivery. DHT gave examples of support that has been put in place. The Committee asked about the implementation of plan Bs. It was recognised that these plans were already starting to be put in place in some Directorates. DHT reminded the Committee that a programme of meetings with Directorates and Executive Directors led by the Chief executive has been put in place to help develop plan Bs where necessary and to maintain the pressure on CIPs. Mr Bertram advised that hospital-wide briefing on CQUIN and CIP targets was taking place through Team Brief and scheduled	needed to achieve the Trust's planned position. The Committee gained significant assurance from the description that DHT gave around the formulation of the risk matrix for each scheme and the strength of the evidence that is required before a Directorate can receive a green rating in terms of the quality and safety impact of CIP schemes.	Mr Bertram to provide an overview of the CIP position

	Agenda Item	AFW	Comments	Assurance	Attention to Board
6	Efficiency Report Cont'd		Doctor briefings. MS summarised by saying we are seeing a slow down in the achievement of CIPs and there is concern that the planned savings for the remainder of 13/14 contain more recurrent and high risk plans than seems reasonable given current performance. The planned September review of CIP achievement will be critical to the planning of the remainder of 13/14 and its impact on 14/15.. Referring to the non-recurrent element he felt that was high and does place a significant risk to the year end. Finally he confirmed that the Committee would like to see an updated estimate of the year end position and likely non-recurrent carryover at the next meeting.		
7	**Acute Strategy**		SL was not able to attend the meeting. SL had submitted a position paper for the Committee to consider. It was agreed she would be attending the meeting in November and would provide a detailed update at that meeting together with time lines for each work stream and a specific update on the planned assessment centres. Given SL's absence and the recognised significance of the Acute Strategy M Proctor to be asked to provide an update to the Board.		Update on progress of the Acute Strategy by M Proctor.
8	**Work Programme**		The Committee reviewed and updated the work programme. The Committee noted the proposed dates for the meetings from January 2014 and confirmed that they would prefer to hold the meetings on a Tuesday provided that this gives sufficient time for all the reports to be prepared.		

9	**Next meeting**		The next meeting will be on Tuesday 22nd October at 10am in Ward 35 Seminar Room, York Hospital		

F1

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

Corporate Dashboard

Action requested/recommendation

The Executive Board is asked to note the report.

Summary

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

- *All 3 targets will be met at aggregate level*
- *We may report 2 incomplete pathways greater than 52 weeks*

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

First to follow up ratios – target 1:1.5: Combined Trust position year to date is 1.98. However, August only was 1.79.

14 Day Breast Symptomatic – target 93%: Combined Trust position for Jul 87.43**%.** These breaches have largely been caused by patient choosing to wait longer than 14 days.

62 Day Cancer Screening – target 90%: Combined Trust position for July 88.89%. This was due to 2 patients falling outside of the target. One was too ill to be treated at the initial TCI.

ED 4 hour target – All Types & Type 1 – target 95%: The trust has failed both of these targets both on aggregate and at site level.

Ambulance handovers greater than 30 mins – target 0: Combined position 417.

MRSA: 1 case in August, 2 YTD.

CDiff : yearly target 43, YTD target 18: Combined site position 31. It is now clear that the Trust will breach the Q2 threshold also.

Mixed Sex Accommodation Breaches: 2 occasions in VIU at York, which affected 5 patients

The following national CQUINs have been RAG rated Red

[some based in project plans rather than data thus reflected in the scorecards]

Pressure Ulcers: Very challenging nationally set trajectory which needs to be hit by Sept 2013 and maintained through Q3 & 4.

VTE Risk Assessment - target 95% & VTE Route Cause Analysis – target 95% by Q4: Investment is needed to achieve the second element of this indicator.

The following local CQUINs have been RAG rated Red

[some based in project plans rather than data reflected in the scorecards]

Dementia: Currently failing target for case finding question on Scarborough site. Ongoing action plan to improve uptake of real time electronic AMTS assessment on CPD at Scarborough site.

VTE - Assessment & Root Cause Analysis: Currently failing on the Scarborough site. Ongoing action plan to improve uptake of real time electronic VTE assessment on CPD & we continue to embed new process for RCAs in Scarborough

Stroke Level 2 Accreditation at Scarborough Hospital: Indicator split into 2 elements. End Q2 report to be submitted detailing progress on accreditation. Level 2 accreditation to be achieved by end Q4.

Consultant Post-take ward round in 12 hrs – target 80%: York performance currently 68.99%. 80% target is to be met at both sites by Q4.

% Patients with PAR/NEWs who have observations in 1hr of prescribed time – target month on month improvement: data for York site only at present until CPD IP roll out at Scarborough. Scarborough site will be assessed from Q3 only.

Effective Discharge - Self Management Plans: Need to establish timetable for going live with heart failure text in eDN to meet Q2 milestone; support move towards uniformity in COPD service models at acute hospital sites.

Reduction in elderly LoS York Hospital – target 9 days in Q4

Reduction in elderly LoS Scarborough Hospital – target 9.65 days in Q4

Reduction in elderly LoS WXC & SH – target 50 days in Q4

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

Implications for equality and diversity

No implications for equality and diversity.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report	This report is only produced for the Executive Board and Board of Directors.
Risk	No risk.
Resource implications	No resource implications.
Owner	Mike Proctor, Deputy Chief Executive
Author	Lucy Turner, Deputy Director of Performance
Date of paper	12 September 2013
Version number	Version 1

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

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

Targets - YTHFT & SNEY

18 Weeks (Acute and Community) and Access Targets

Metric	Target	Status	Sparkline	Jul-13	Aug-13
18 Week Admitted (M C)	90%	Green		90.81%	
18 Week Non-Admitted (M C)	95%	Green		95.16%	
18 Week Total Backlog (M C)	92%	Green		92.09%	
Number of Incomplete RTT pathways greater than 52 weeks (M C)	0	Red		2	
18 Week Audiology (C)	95%	Green		100%	99.76%
Diagnostics - 6 Week Wait (C)	99%	Green		99.14%	99.27%
Outpatient Clinics - First to Follow Up Ratio (YTD) (C)	1.5	Red		2.02	1.98

Cancer

Metric	Target	Status	Sparkline	Jul-13	Aug-13
14 Day Fast Track (M C)	93%	Green		94.55%	
14 Day Breast Symptomatic (M C)	93%	Red		87.43%	
31 Day 1st Treatment - Cancer (M C)	96%	Green		99.06%	
31 Day Subsequent Treatment - Anti Cancer Drug (M C)	98%	Green		100%	
31 Day Subsequent Treatment - Surgery (M C)	94%	Green		96.67%	
62 Day Cancer (M C)	85%	Green		91.4%	
62 Day Cancer - Screening (M C)	90%	Red		88.89%	

Emergency Department (Type 1 and Type 3)

Metric	Target	Status	Sparkline	Jul-13	Aug-13
ED 4 Hour Target - All Types (M)	95%	Red		95.01%	93.57%
ED 4 Hour Target - Type 1 Only	95%	Red		92.86%	90.6%
Number of 12 Hour Trolley Waits	0	Green		1	0
Number of Ambulances with handover greater than 30 mins	0	Red		345	417

Infection Prevention and Control

Metric	Target	Status	Sparkline	Jul-13	Aug-13
MRSA Bacteraemia >48hrs (YTD) (C)	0	Red		1	2
CDIFF >72hrs (YTD) (M C)	18	Red		25	31
MSSA >48hrs (YTD) (C)	13	Red		13	16
E-Coli >48hrs (YTD) (C)				23	30

Inpatient

Metric	Target	Status	Sparkline	Jul-13	Aug-13
Elective Operations Cancelled On The Day For Non-Clinical Reasons Not Readmitted within 28 days (C)	0	Green		0	0
Number of Urgent Elective Operations cancelled for a 2nd time (C)	0	Green		0	0
Breaches of Mixed Sex Accommodation (M C)	0	Red		19	5

Care Quality Indicators (CQUINS)

Metric	Target	Status	Sparkline	Jul-13	Aug-13
Acute - VTE Risk Assessment (M C)	95%	Red		95.46%	84.54%
Safety Thermometer - Pressure Ulcers - Acute	2.9%	Red		5.4%	4.1%
Safety Thermometer - Pressure Ulcers - Community	3.95%	Red		5.96%	9.27%
Dementia case finding question asked	90%	Red		93.9%	85.14%
Dementia inpatients with completed diagnostic assessment	90%	Green		98.1%	100%
Dementia inpatients who have had a diagnostic assessment referred for further diagnostic advice or follow up	90%	Green		100%	100%
Admissions through AMU will be reviewed within 4 hours of admission	80%	Green		92.11%	88%
Patients admitted through AMU to have a Consultant post take ward round consultation within 12 hours of arrival	80%	Red		72.32%	70.98%
Percentage of patients who have observations recorded producing NEWS score within 1 hour of prescribed time	63.83%	Green		63.83%	69.37%
Percentage of patients with NEWS score trip with escalation of care within 15 minutes to appropriate clinician	77.93%	Green		77.93%	79.41%
Friends and Family Test - Increased Response Rate	15%	Green		24.3%	
Percentage of patients requiring & receiving Intraoperative Fluid Management (IOFM) - Trust	85%	Green		97.94%	96.63%

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

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

Targets - YTHFT

18 Weeks (Acute and Community) and Access Targets

Metric	Target	Status	Sparkline	Jul-13	Aug-13
18 Week Admitted (M C)	90%	Green		91.61%	
18 Week Non-Admitted (M C)	95%	Green		96.08%	
18 Week Total Backlog (M C)	92%	Green		93.21%	
Number of Incomplete RTT pathways greater than 52 weeks (M C)	0	Red		1	
18 Week Audiology (C)	95%	Green		100%	99.76%
Diagnostics - 6 Week Wait (C)	99%	Green		98.56%	99.01%

Cancer

Metric	Target	Status	Sparkline	Jul-13	Aug-13
14 Day Fast Track (M C)	93%	Green		94.83%	
14 Day Breast Symptomatic (M C)	93%	Red		89.74%	
31 Day 1st Treatment - Cancer (M C)	96%	Green		98.68%	
31 Day Subsequent Treatment - Anti Cancer Drug (M C)	98%	Green		100%	
31 Day Subsequent Treatment - Surgery (M C)	94%	Green		95.83%	

Emergency Department (Type 1 and Type 3)

Metric	Target	Status	Sparkline	Jul-13	Aug-13
ED 4 Hour Target - All Types (M)	95%	Red		96.15%	93.32%
ED 4 Hour Target - Type 1 Only	95%	Red		95.07%	91.24%
Number of 12 Hour Trolley Waits	0	Green		0	0
Number of Ambulances with handover greater than 30 mins	0	Red		76	234

Infection Prevention and Control

Metric	Target	Status	Sparkline	Jul-13	Aug-13
MRSA Bacteraemia >48hrs (YTD) (C)	0	Red		1	1
CDIFF >72hrs (YTD) (M C)	11	Red		15	17
CDIFF >72hrs Monthly	2.2	Green		1	2
MSSA >48hrs (YTD) (C)	8	Red		9	11
E-Coli >48hrs (YTD) (C)				17	22

Inpatient

Metric	Target	Status	Sparkline	Jul-13	Aug-13
Elective Operations Cancelled On The Day For Non-Clinical Reasons Not Readmitted within 28 days (C)	0	Green		0	0
Number of Urgent Elective Operations cancelled for a 2nd time (C)	0	Green		0	0
Breaches of Mixed Sex Accommodation (M C)	0	Red		19	5

Care Quality Indicators (CQUINS)

Metric	Target	Status	Sparkline	Jul-13	Aug-13
Acute - VTE Risk Assessment (M C)	95%	Green		95.18%	95.25%
Dementia case finding question asked	90%	Green		92.84%	90.64%
Dementia inpatients with completed diagnostic assessment	90%	Green		98.63%	100%
Dementia inpatients who have had a diagnostic assessment referred for further diagnostic advice or follow up	90%	Green		100%	100%
Reduction in Average Length of Stay in York Hospital Elderly Bed Base (Days)	9	Red		10.73	9.49
Reduction in Average Length of Stay in Elderly Bed Base WXC and St Helens (Days)	50	Red		51.1	53.9
Improved utilisation of the Elderly Bed Base in Community Hospitals	85%	Green		92.17%	94.55%

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

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

Targets - SNEY

18 Weeks (Acute and Community) and Access Targets

Metric	Target	Status	Sparkline	Jul-13	Aug-13
18 Week Admitted (M C)	90%	Red		88.75%	
18 Week Non-Admitted (M C)	95%	Red		93.74%	
18 Week Total Backlog (M C)	92%	Red		90.35%	
Number of Incomplete RTT pathways greater than 52 weeks	0	Red		1	
Diagnostics - 6 Week Wait (C)	99%	Green		99.93%	99.6%

Cancer

Metric	Target	Status	Sparkline	Jul-13	Aug-13
14 Day Fast Track (M C)	93%	Green		93.73%	
14 Day Breast Symptomatic (M C)	93%	Red		83.33%	
31 Day 1st Treatment - Cancer (M C)	96%	Green		100%	
31 Day Subsequent Treatment - Anti Cancer Drug (M C)	98%	Green		100%	
31 Day Subsequent Treatment - Surgery (M C)	94%	Green		100%	

Emergency Department (Type 1 and Type 3)

Metric	Target	Status	Sparkline	Jul-13	Aug-13
ED 4 Hour Target - All Types (M)	95%	Red		93.56%	93.86%
ED 4 Hour Target - Type 1 Only	95%	Red		89.18%	89.43%
Number of 12 Hour Trolley Waits	0	Green		1	0
Number of Ambulances with handover greater than 30 mins	0	Red		269	183

Infection Prevention and Control

Metric	Target	Status	Sparkline	Jul-13	Aug-13
MRSA Bacteraemia >48hrs (YTD) (C)	0	Green		0	0
CDIFF >72hrs (YTD) (M C)	7.5	Red		7	11
CDIFF >72hrs Monthly	1.5	Red		2	4
MSSA >48hrs (YTD) (C)	5	Green		4	5
E-Coli >48hrs (YTD) (C)				5	6

Inpatient

Metric	Target	Status	Sparkline	Jul-13	Aug-13
Elective Operations Cancelled On The Day For Non-Clinical Reasons Not Readmitted within 28 days (C)	0	Green		0	0
Number of Urgent Elective Operations cancelled for a 2nd time (C)	0	Green		0	0
Breaches of Mixed Sex Accommodation (M C)	0	Green		0	0

Care Quality Indicators (CQUINS)

Metric	Target	Status	Sparkline	Jul-13	Aug-13
Acute - VTE Risk Assessment (M C)	95%	Red		96.07%	60.4%
Dementia case finding question asked	90%	Red		94.49%	75.95%
Dementia inpatients with completed diagnostic assessment	90%	Green		97.03%	100%
Dementia inpatients who have had a diagnostic assessment referred for further diagnostic advice or follow up	90%	Green		100%	100%
Reduction in Average Length of Stay in Scarborough Hospital Elderly Bed Base (Days)	9.65	Red		10.02	10.81

Targets - Community

Community Infection Control

Metric	Target	Status	Sparkline	Jul-13	Aug-13
MRSA Bacteraemia >48hrs (YTD) (M C)				0	1
MSSA >48hrs (YTD) (C)				0	0
CDIFF >72hrs (YTD) (M C)				3	3
E-Coli >48hrs (YTD) (C)				1	2

Community Inpatient

Metric	Target	Status	Sparkline	Jul-13	Aug-13
Admissions - Ordinary				178	147
Admissions - Day				109	93
Average Length of Stay (Days) - Archways				19.7	18.7
Average Length of Stay (Days) - Malton				18.6	8.4
Average Length of Stay (Days) - St Monicas				13.9	24.3
Average Length of Stay (Days) - Selby War Memorial Hospital				22.9	13.7
Average Length of Stay (Days) - Whitby				25.4	22.9

Community Outpatient

Metric	Target	Status	Sparkline	Jul-13	Aug-13
Outpatient Attendances - First				1062	869
Outpatient Attendances - Subsequent				2223	1638
Outpatient Attendances - Total				3285	2507
Outpatient DNA Rate				7.24%	8%

Community Referrals

Metric	Target	Status	Sparkline	Jul-13	Aug-13
GP Referral				274	197
Self Referral				31	20
Social Services				8	6
York Hospital / Scarborough Acute Services				97	53
Community Hospital				12	4
Other				192	127
Rejected				0	0

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York Teaching Hospital NHS
NHS Foundation Trust

Briefing Note for the Finance & Performance Committee Meeting 17 September 2013
Briefing Note for the Board of Directors Meeting 25 September 2013

Subject: August 2013 Financial Position (Month 5)

From: Andrew Bertram, Finance Director

Summary Reported Position for August 2013

The attached income and expenditure account shows an actual £0.2m deficit of income over expenditure. This is £0.8m behind the Trust's operation plan of an expected surplus of income over expenditure of £0.6m.

Of note is that the position includes restructuring costs of £0.5m relating to redundancy and MARS. This is excluded in Monitor's assessment of our position. Underlying performance is therefore reported as £0.3m surplus against the planned surplus of £0.6m.

Income Analysis

The income position is based on coded and costed April to July activity and an estimate has been used for August (based on reported activity levels but using average specialty costs). Summary activity data for August suggests activity has fallen back in line with planned levels following higher levels in the earlier months of the year. This is common place for August. Of notable exception to this was ED attendances at the Scarborough site where high levels of activity have been reported. At this stage, overall, income is assessed to be £3.5m ahead of plan. This is broadly static from last month's reported position.

This is of concern in terms of CCG affordability. The position is openly discussed with the CCGs in the Contract Management Boards and the associated Finance and Performance Subgroup meetings. Agreed actions to manage the position include the follow up reduction work and the CCG's planned implementation of a Referral Support Service (RSS). This is shortly to be piloted in 2 main Practices for a limited number of specialties. The process will involve checks of all referrals to ensure all primary care pre-work up and alternative management has been undertaken and the appropriateness of the referral will be assessed. It is the CCG's assessment that the RSS will reduce demand into the hospital.

We are continuing to report actual and potential contract penalties and the Board need to be aware of further instances having occurred. Included in the position to date are anticipated penalties of £979k. This comprises actual penalties of £95k for 52-week

breaches, a £223k assessment of likely 18-week RTT penalties at specialty level, a £650k prudent assessment of the impact of the excess c diff to trajectory (13 cases above trajectory at £50k per case) and a small number of minor penalties. In the case of the c diff assumption this is clearly only a marker at this stage as the delivery is contractually measured for the full year. There is time to correct the position although this is becoming increasingly challenging.

Also of note is that an assessment of £969k has been made as to the value of follow up work undertaken in addition to the 1:1.5 new patient to follow up patient ratio. This risk income has been removed in full from the reported position, assuming non-payment. This relates primarily to July and August activity. Following the October review of the follow up initiative with the CCG it may be possible to secure payment for some of this work.

Expenditure Analysis

Pay is reported as £1.0m overspent. This is the net position after release of reserves for escalation areas and other agreed developments. Pressures in the main relate to premium costs associated with the continued and necessary use of temporary staff plus costs associated with higher than planned levels of Extra Contractual Work necessary to meet access targets.

The balance of the pay cost pressure is not easily attributable to a single issue but is varied in nature. These pressures form part of the PMM discussions with directorates.

Drug costs are over spent by £1.1m with this almost exclusively relating to pass through drug costs excluded from tariff (particularly high cost rheumatology and oncology drugs). There is corresponding additional income in this regard. There are no operational drug pressures to report in terms of regular tariff funded drug expenditure. Pressure in this budget area is causing the CCGs concern.

Clinical supplies and services are under spending against planned levels with other costs also showing an under spend position. At this stage there are no issues to bring to the Board's attention.

The report shows that the CIP programme is impacting adversely on the position by £3.5m. This is dealt with in the CIP report. This is clearly placing pressure on the reported income and expenditure position but being compensated for by additional income and slippage on planned developments.

Contracting Matters

Other than issues of additional work having been provided above plan and contract penalties (both discussed above and in the report) there are no issues with the Trust's main commissioners to bring to the Board's attention.

Contracts with the Local Authorities remain unsigned and work continues to bring these to a close. This work is currently with the Local Authorities to complete and there are no

outstanding actions on the Trust. These are low value contracts and payments continue to be made on account to the Trust. This position represents low risk.

Other Issues

With regard to the outstanding but agreed £15m capital support I can confirm that discussions continue to be active between the Trust and both the DH and the National Trust Development Authority (NTDA). As a reminder to the Board our plan assumes receipt in quarter 2 in line with the usual national PDC draw down timetable.

It looks unlikely the Q2 drawdown will be achieved by the DH and we are currently working with Richard Douglas from the DH on providing assurance to Monitor that this issue will be resolved and is beyond the control of the Trust.

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

High Level Overview

* A net I&E deficit for the period of £0.2m means the Trust is £0.8m behind plan.

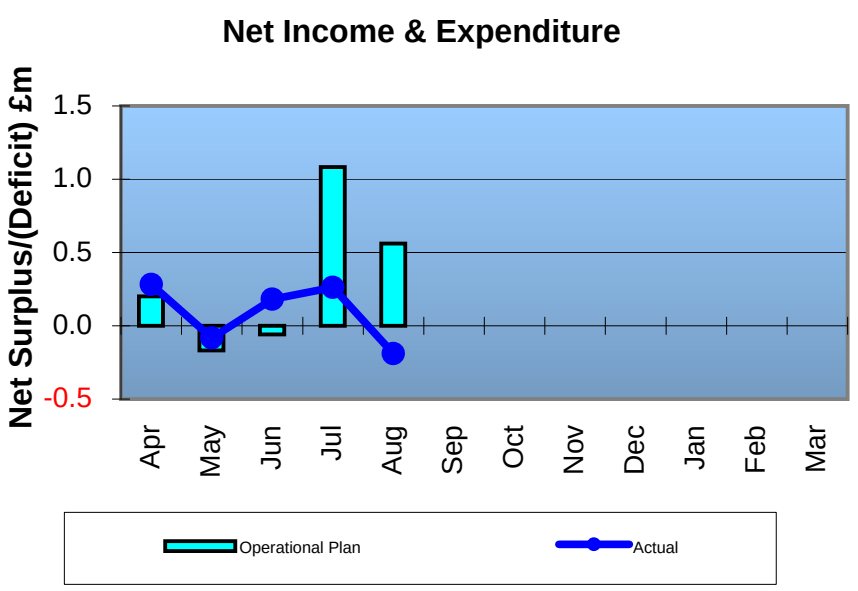
* CIPs achieved at the end of August total £9m. The CIP position is running £3.5m behind plan.

* Income from all contracts are assessed to be ahead of plan by £3.3m.

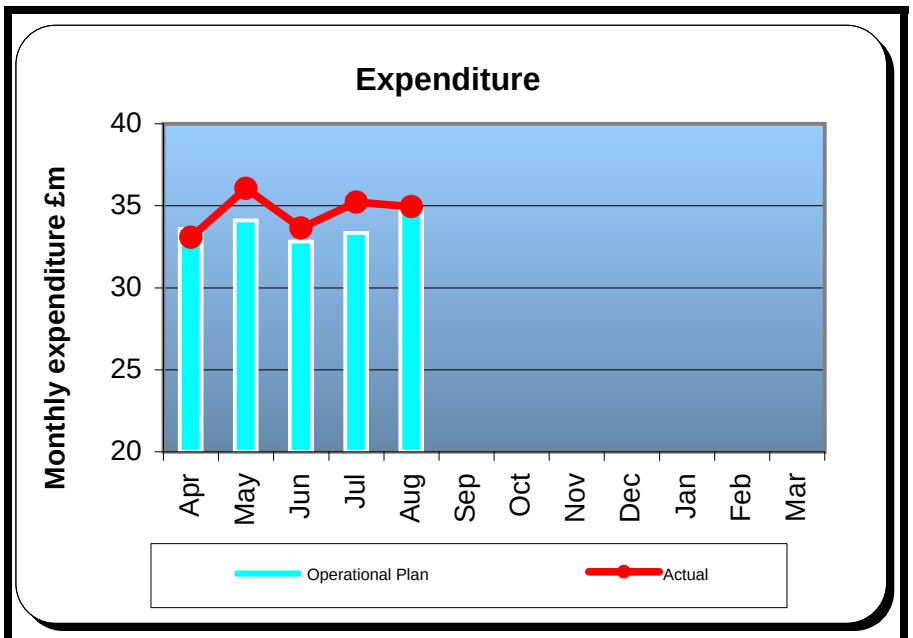
* Cash balance is £25.0m, and is £2.1m behind plan.

* Capital spend totalled £3.9m, and is behind plan.

* The provisional Monitor Financial Risk Rating is 3, which is on plan.



Key Period Operational Variances			
	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. Lucentis)	149.7	153.4	3.7
Clin.Inc.(Lucentis)	4.2	3.3	-0.9
Other Income	22.3	22.9	0.6
Pay	-118.4	-119.4	-1.0
Drugs	-14.6	-15.6	-1.1
Consumables	-17.4	-17.2	0.2
Other Expenditure	-18.2	-20.7	-2.4
	7.5	**6.7**	**-0.8**



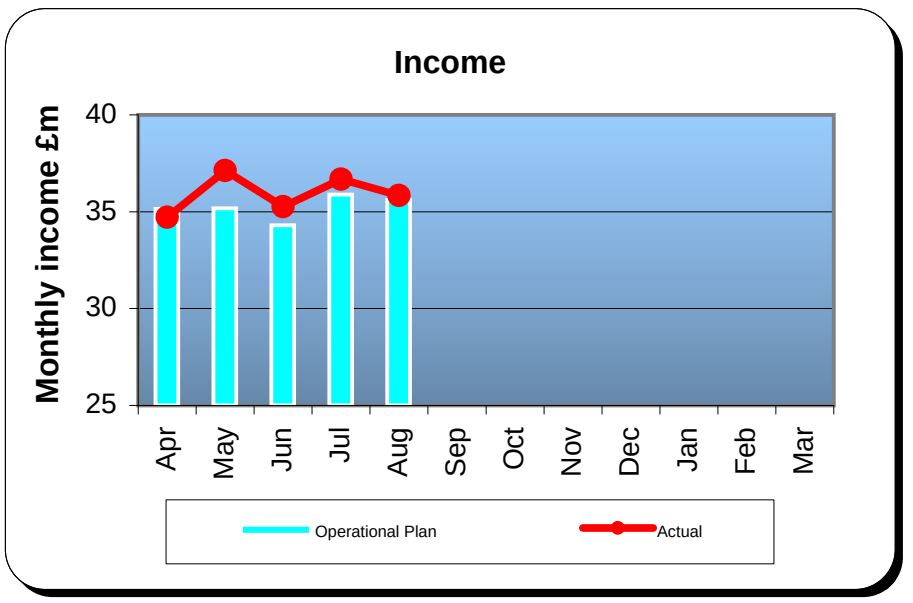
At the end of August there is an adverse variance against operational expenditure budgets of £4.3m. This comprises:-

- Operational pay being £1.0m overspent.
- Drugs £1.1m overspent, mainly due to pass through costs linked to drugs excluded from tariff.

- Clinical supplies £0.2m underspent.

- Other costs are £1.6m underspent, primarily due to slippage on planned investments

- Restructuring costs (MARS and redundancies) are £0.5m overspent
- CIPs are £3.5m behind plan

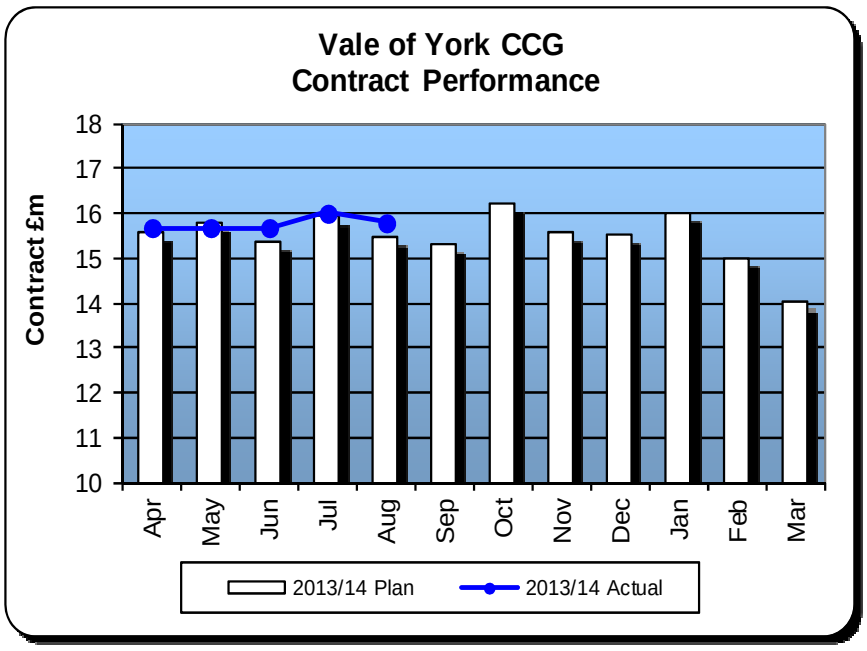


At the end of August income is ahead of plan by an estimated £3.5m. This comprises:

- Elective and day case income are ahead of plan by £0.8m.
- Non elective income is ahead of plan by £0.4m.
- Community income is marginally ahead of plan by £0.3m.
- Out patient income is broadly on plan.
- A&E is ahead of plan (£0.5m).

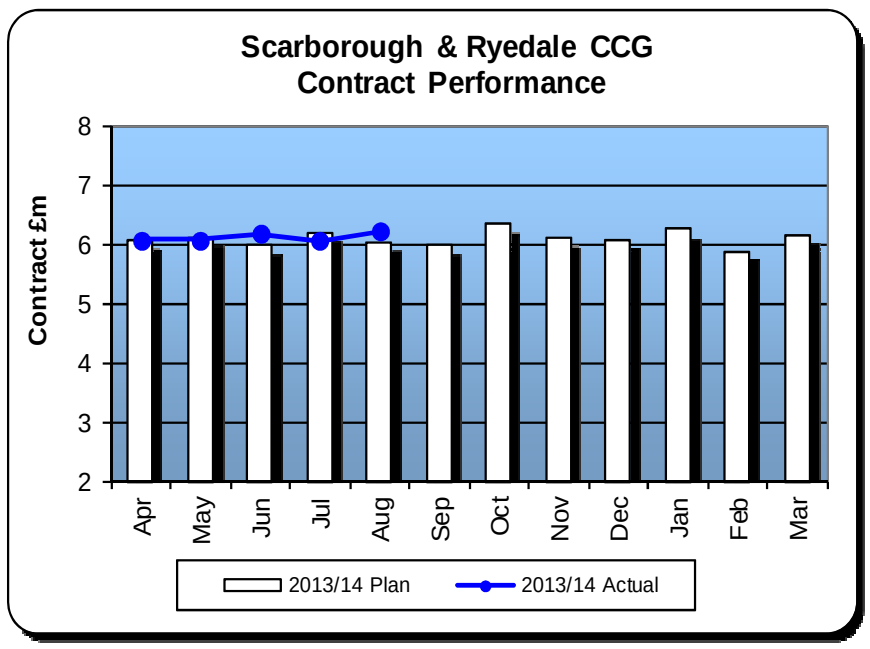
- Other clinical income is ahead of plan by £2.8m.
- Other income is £0.6m ahead of plan
- Contract penalties and the effect of CCG QIPP schemes are estimated at £1.9m.

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



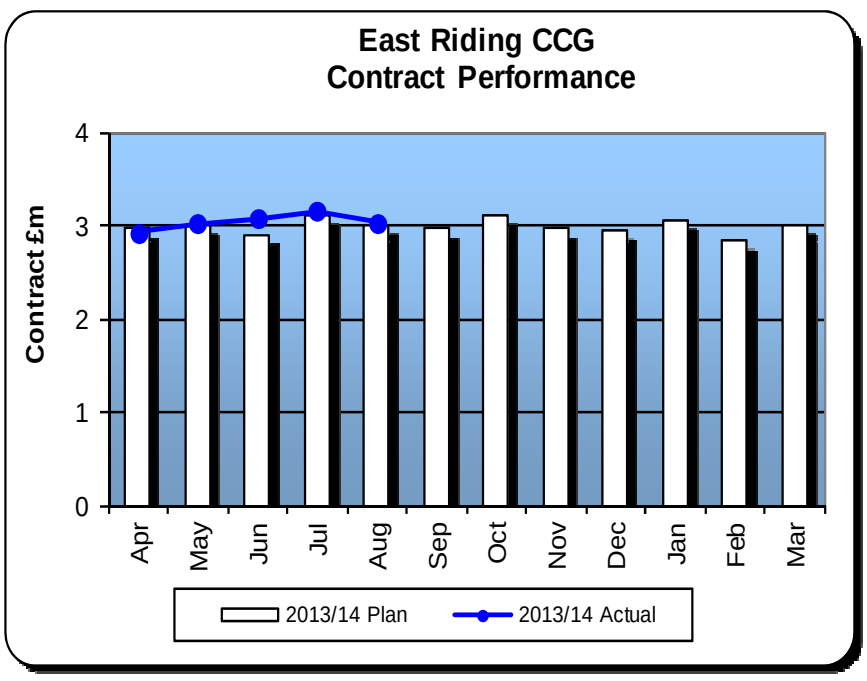
The contract value is £185.7m.

The contract is ahead of plan by £0.693m ahead of plan and includes estimates for the month of August. The actual value has been reduced to take account of anticipated contract penalties. This is a marker at this stage, and corrective action may improve the position.



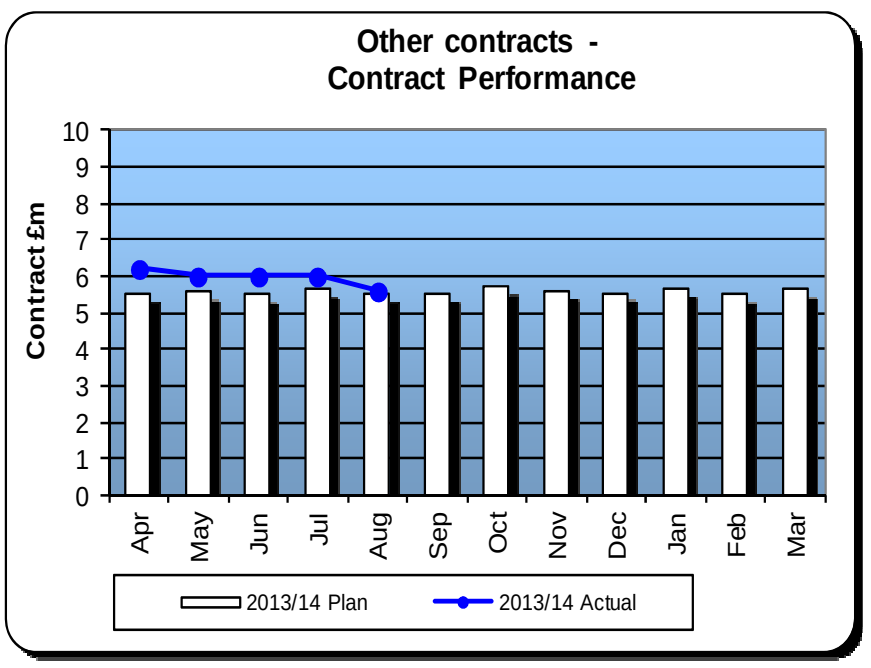
The contract value is £73.1m.

The contract is marginally ahead of plan by £0.245m, and includes estimates for August and penalties, which may reduce if corrective action improves the position.



The contract value is £35.8m

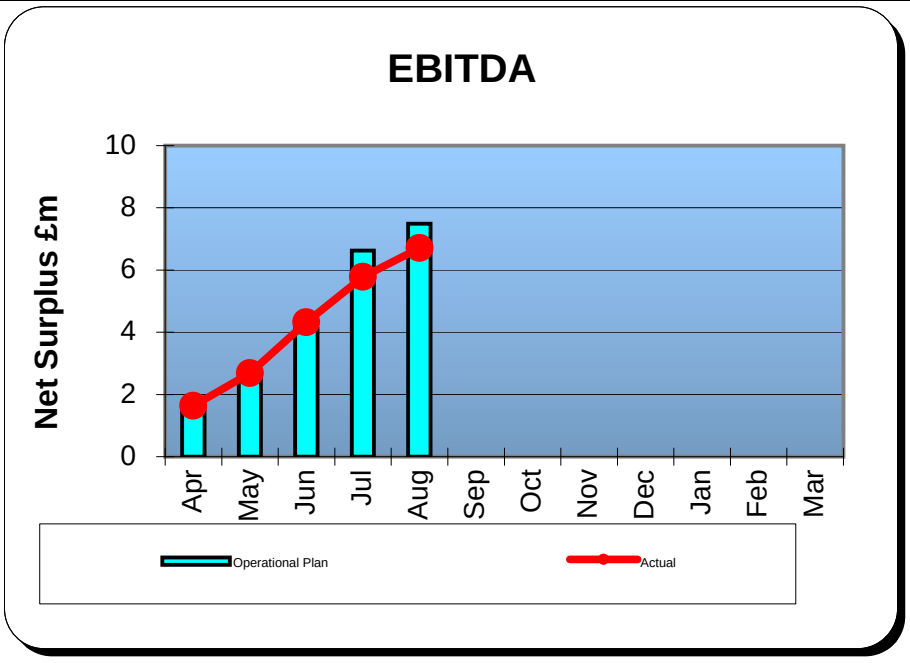
The contract is marginally ahead of plan by £0.239m, and includes estimates for August and penalties, which may reduce if corrective action improves the position.

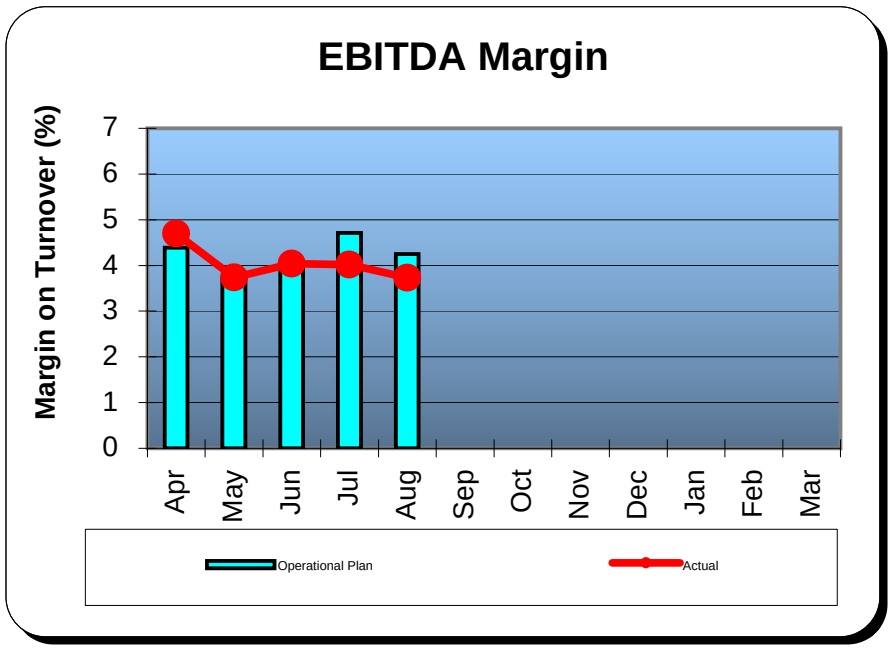


The total contract value is £67.0m

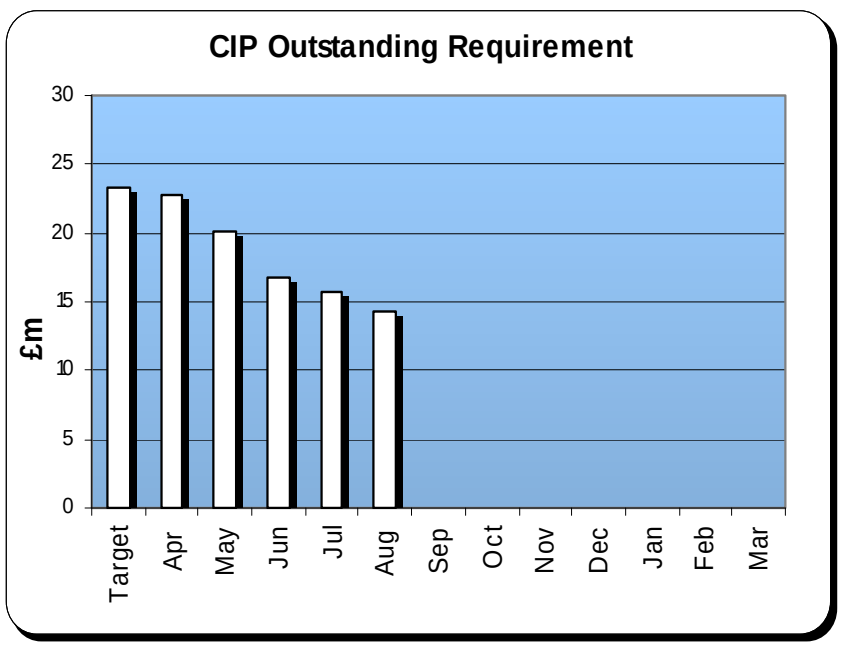
These include the smaller CCG contracts, NHS England (both public health services and prescribed specialist services), and Local Authority contracts. Overall contracts are ahead of plan by an estimated £2.1m, within which Prescribed specialist services are £2.538m ahead of plan, and Hambleton, Whitby and Richmondshire CCG is £0.4m ahead of plan. These positions include estimates for August.

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

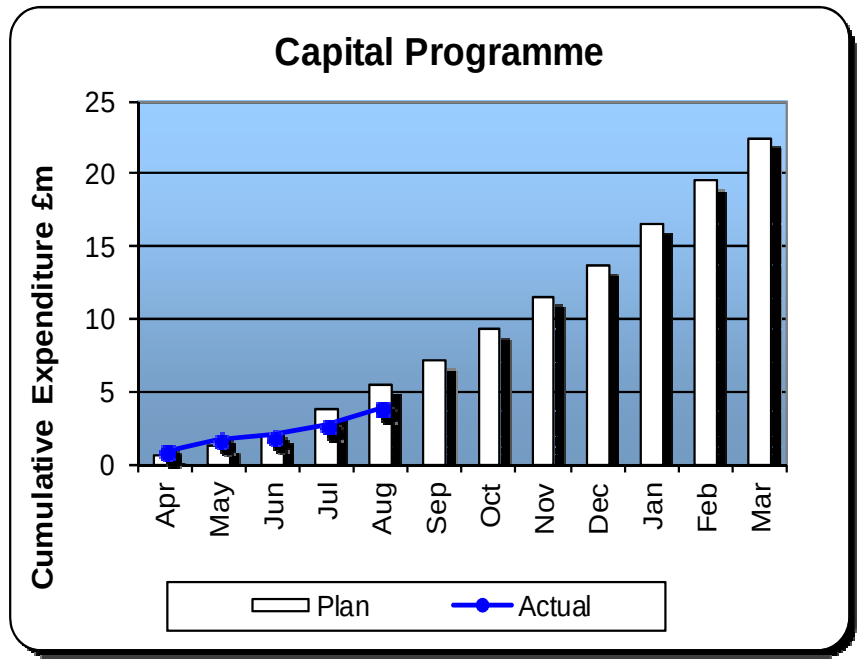




Actual EBITDA at the end of August is £6.71m (3.73%), compared to operational plan of £7.49m (4.25%), and is reflective of the overall I&E performance.



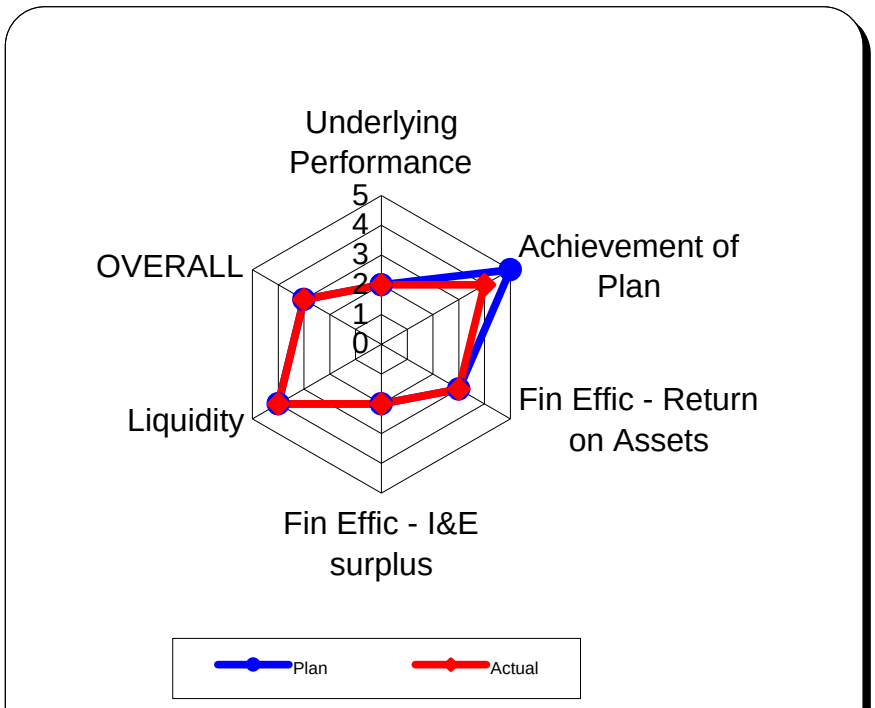
The full year efficiency requirement is £23.4m. At the end of August £9.0m has been cleared.



Capital expenditure to the end of August totalled £3.89m and is behind plan.

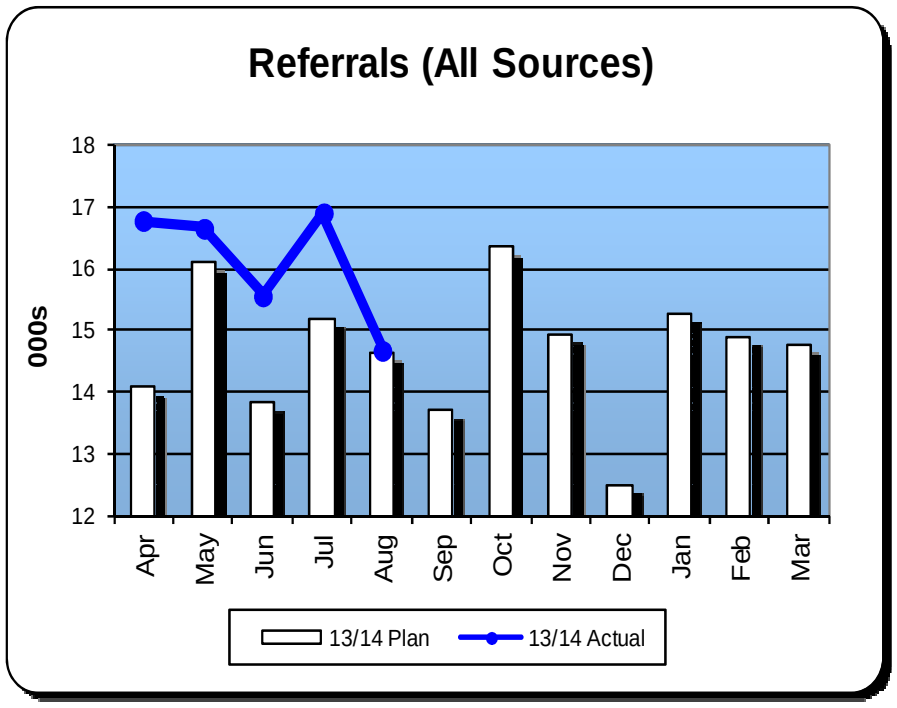
The capital programme for the remainder of 2013/14 is to be finalised in September but schemes with significant in year spend to date include the pharmacy robot now complete, improvements to the maternity birthing environment, the upgrade of ward kitchens in York. The carbon & energy scheme has also started.

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



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

The 'Achievement of Plan' is behind the plan submitted to Monitor and is reflective of the I&E position being behind plan.



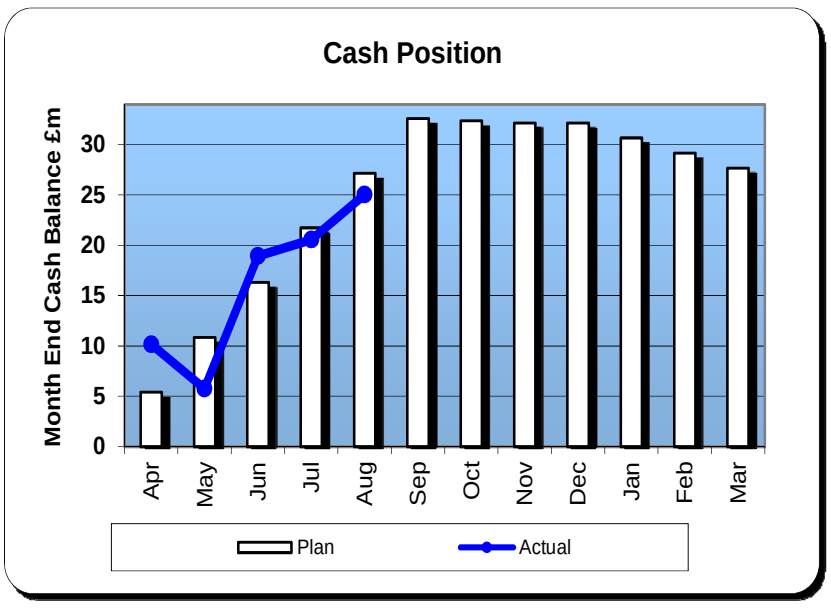
Annual plan 176,742 referrals (based on full year equivalent of 2012/13 outturn)

Variance at end of August: +6,520 referrals (+9%)

GP referrals +4,728 (+11%)

Cons to Cons referrals +1,715 (+17%)

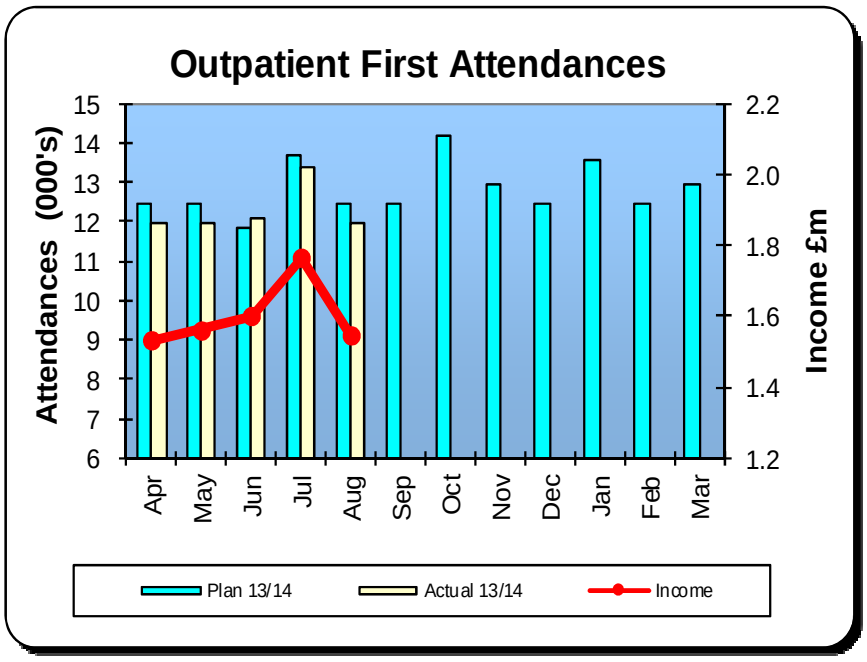
Other referrals +77 (+0%)



The cash balances at the end of August totalled £25.04m and is slightly behind plan. It includes the £12m transitional income support for the whole year, received in June, but the £15m additional PDC for capital is still awaited.

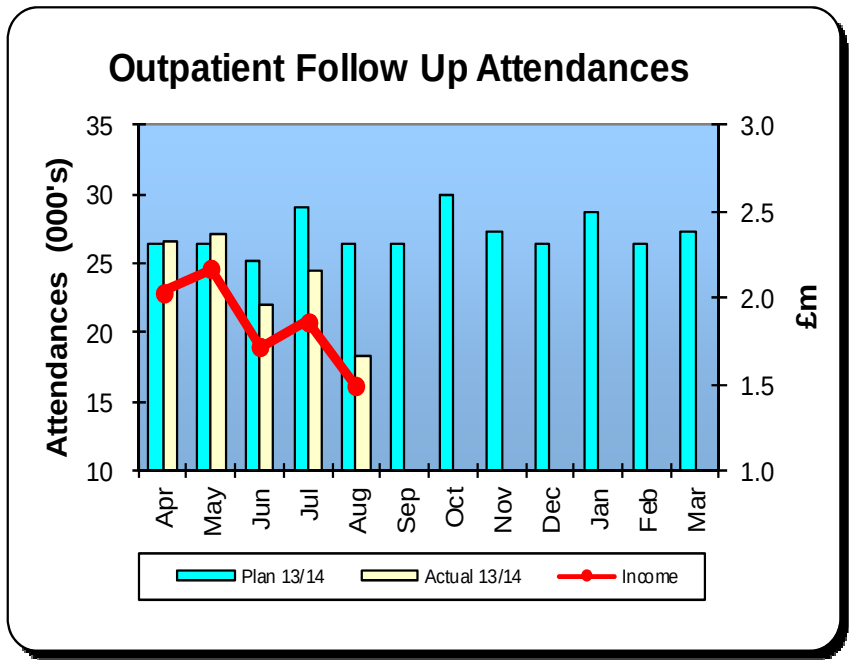
Monitor Liquidity Ratio					
Risk Rating	5	4	3	2	1
Days Cover	60	25	15	10	<10
Trust Actual Days		31			

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



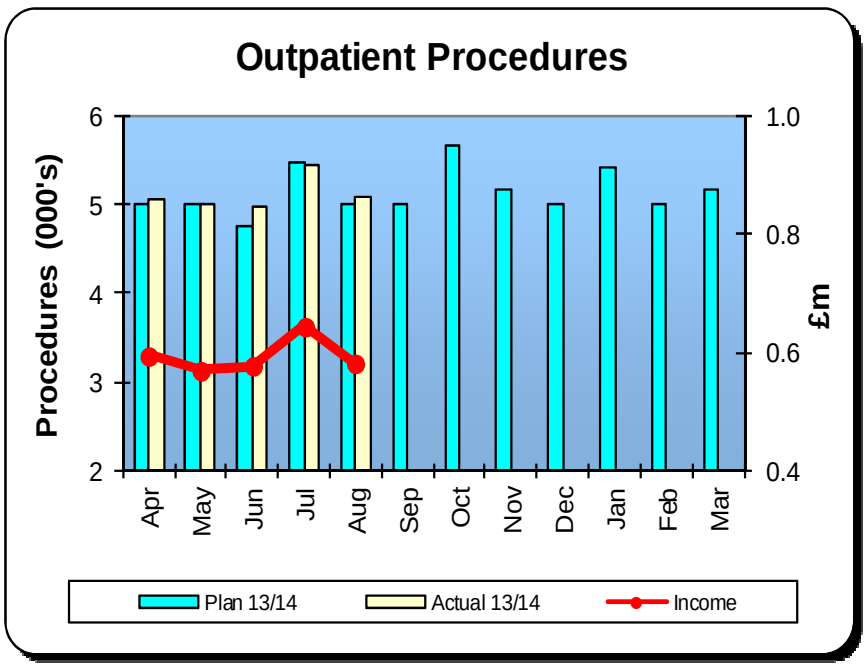
Annual Plan (Attendances) 154,195
Variance at end of August: -1,626 attendances (-3%).

Main variances: Opthalmology -1,491 (-18%), ENT -457 (+12%), Gastroenterology -307 (-13%), Cardiology +1,015 (-17%)



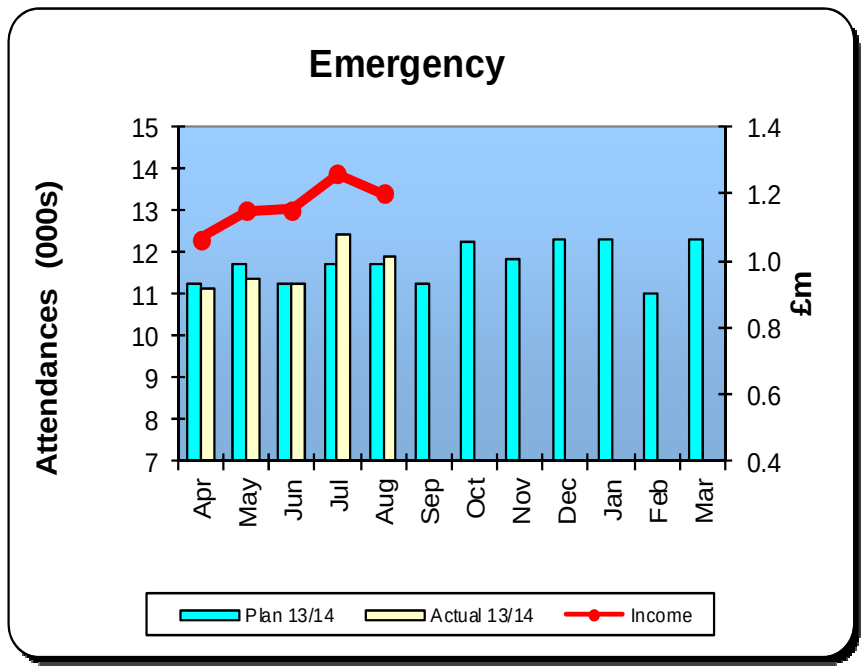
Annual Plan (Attendances) 325,838
Variance at end of August: -14,922 attendances (-11%).

Main variances: General Surgery -961 (-10%), Urology -1,150 (-22%), Opthalmology -10,049 (-32%), Anaesthetics -1,502 (-44%), and Medical Oncology +2,923 (+50%)



Annual Plan (Procedures) 61,660
Variance at end August: +358 procedures (+1.4%).

Main variances: ENT +468 (+14%), Orthodontics +774 (+26%), Dermatology +477 (+7%), Cardiology -393 (-18%), and Gynaecology -672 (-29%).



Annual Plan (Attendances) 140,970
Variance at end August: +360 (+0.6%).

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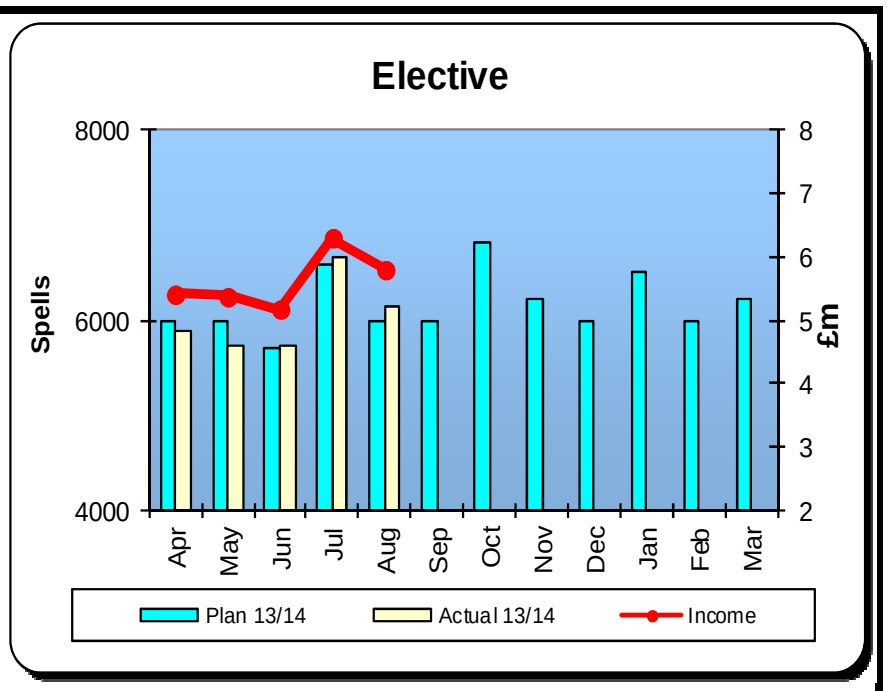
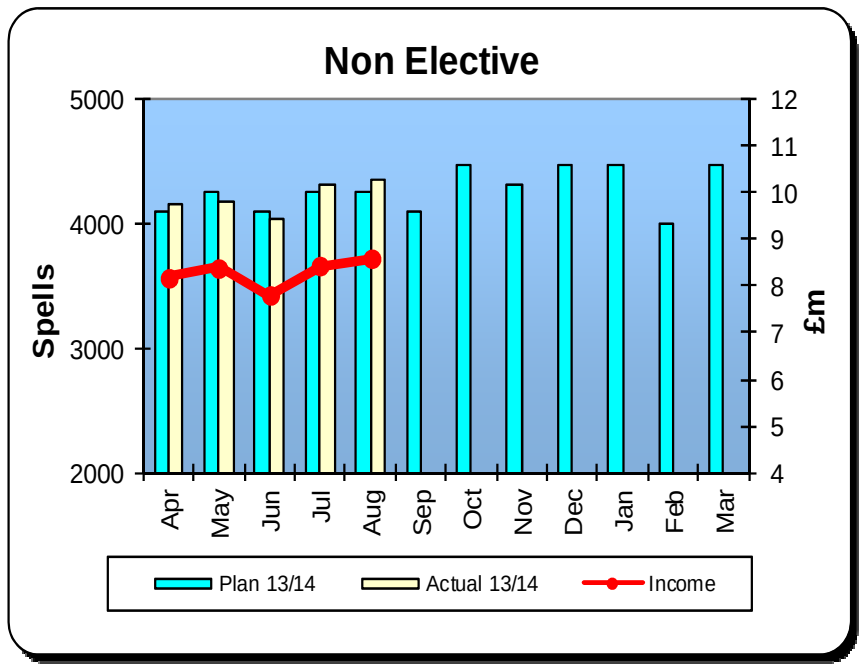


Annual Plan (Spells) 74,033
Variance at end of August: -107 spells (-0.4%): inpatient -29; daycase -78

Main variances: General surgery -215 (-6%), Urology +330 (+8%), Gastroenterology -986 (-18%), and Haematology +342 (+22%).



Annual Plan (Spells) 51,245
Variance at end of August: +65 spells (+0.3%).

Main variances: Geriatric medicine +264 (+7%), Paediatrics -425 (-13%), and Trauma & Orthopaedics +250 (+23%).

Contract Penalties

Other Penalties	YTD Actual	Penalty £000	Comments
Clostridium Difficile	31	650	Annual target 43; period target 18. £50k penalty per case over target. (August estimate included)
52 week breaches	19	95	£5k penalty per breach per month. 12 GenSur (York); 2 GenSur (Scar); 2 Ophthal (Scar); 2 Gynae (York). 1 Urology (York).
18 week breaches:			Figures are estimates and awaiting confirmation.
- Admitted (90% target, weighting 37.5%)	n/a	45	GenSur £9k; Gynae £14k; Anaes £5k: Rheumatology £3k.
- Non-admitted (95% target, weighting 12.5%)	n/a	19	Gen Sur £3k; Urology £4k
- Incomplete pathways (92% target, weighting 50%)	n/a	98	GenSur £31k; Gynae £13k; Urology £15k; T&O £16k; Opthalmology £10k.
- Estimate for August	n/a	61	An estimate for the month of August has been included.
First to Follow up ratio	n/a	968	The ratio stands at 1.93 cummulatively to August against a target of 1.5, giving an estimated penalty of £968,000.
MRSA	2	5	Not yet discharged. Penalty estimated and will be the HRG income.
Mixed Sex breaches	24	6	VIU
		1947	

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

Efficiency Programme Update

Action requested/recommendation

To note the contents of the report.

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. Delivery in August is behind plan, and the Monitor variance remains significantly behind plan by (£3.5m). There is also a planning shortfall of (£0.9m) for the current year.

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

Implications for equality and diversity

There are no implications for equality and diversity.

Reference to CQC outcomes

There is no reference to CQC outcomes.

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

Board of Directors – 25 September 2013

Efficiency Position Update at August 2013

1. Executive Summary

The full year plan to Monitor is £23,363k.

In period 5 we have achieved £9,036k in full year terms.

In August 2013 we are behind the Trust plan to Monitor by **(£3,504k)**.

Table 1 below provides a high level summary of progress.

Table 1 – Executive Summary – August 2013	Total
	£'000
In year target	
In year target	**23,363**
In year delivery	
Delivery - recurrent	3,502
Delivery – non-recurrent	5,534
Total delivery	**9,036**
Delivery (gap)/ Over achievement	**(14,327)**
In year planning	
Further in year plans	**13,379**
In year planning (gap)/surplus	**(948)**
Part year Monitor position	**(3,504)**
Future planning	
4 year target	71,464
4 year plans total	58,499
4 year planning (gap)/surplus	**(12,965)**

2. Introduction and background

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

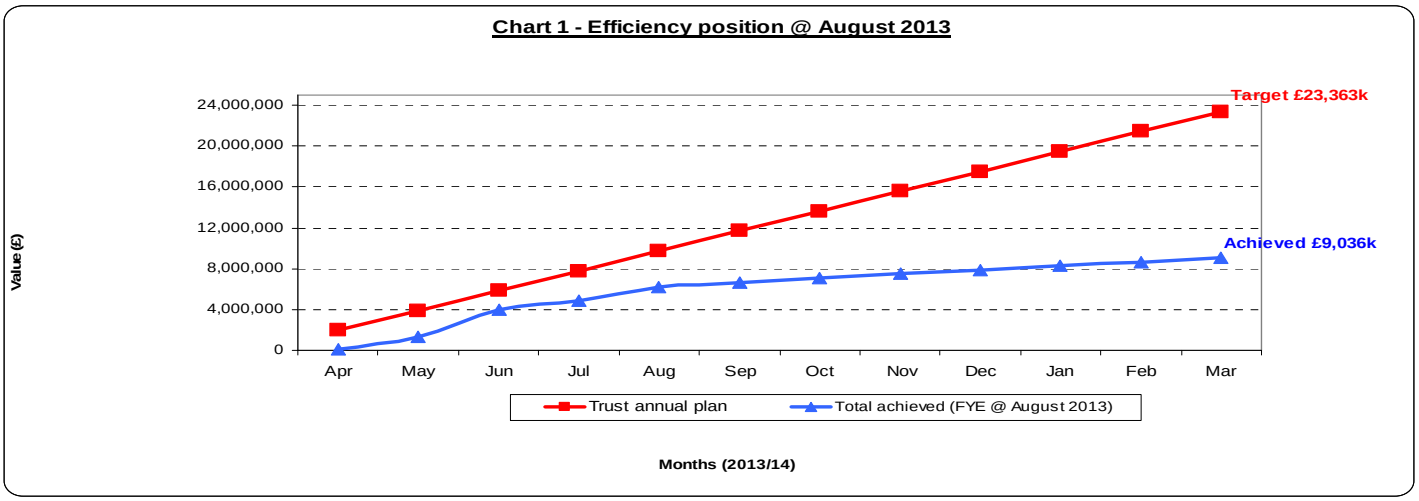
3. Efficiency position report

This report covers the period of 5 months to August 2013.

3.1 Trust plan to Monitor

The combined position is **(£3,504k)** behind the trust plan to Monitor as at August 2013; see Table 2 and Chart 1 below.

Table 2	YTD July	August 2013	**Total YTD**
	£,000	**£,000**	**£,000**
Trust plan	**7,788**	1,947	**9,734**
Achieved	**4,886**	1,344	**6,230**
Variance	**(2,902)**	**(603)**	**(3,504)**



3.2 Full year position summary

As at August 2013, £9,036k has been achieved in full year terms against the plan of £23,363k (see Table 3 below). This is made up of £3,502k of recurrent and £5,534k non-recurrent schemes.

Table 3	**July 2013**	**August 2013**	**Change**
	£,000	**£,000**	**£,000**
Expenditure plan – 13/14	23,363	23,363	0
Target – 2013/14	**23,363**	**23,363**	**0**
Achieved - recurrently	2,872	3,502	630
Achieved - non-recurrently	4,785	5,534	749
Total achieved	**7,657**	**9,036**	**1,379**
Gap to achieve	**(15,706)**	**(14,327)**	**1,379**
Further plans	15,059	13,379	(1,680)
(Gap)/Surplus in plans	**(647)**	**(948)**	**(301)**

3.3 Workforce overview

Chart 2 below shows the impact of the Trust's Efficiency programme on workforce expenditure. Budgeted WTE has seen an increase of 19 in the month. Table 4 below details the current vacancy gap.

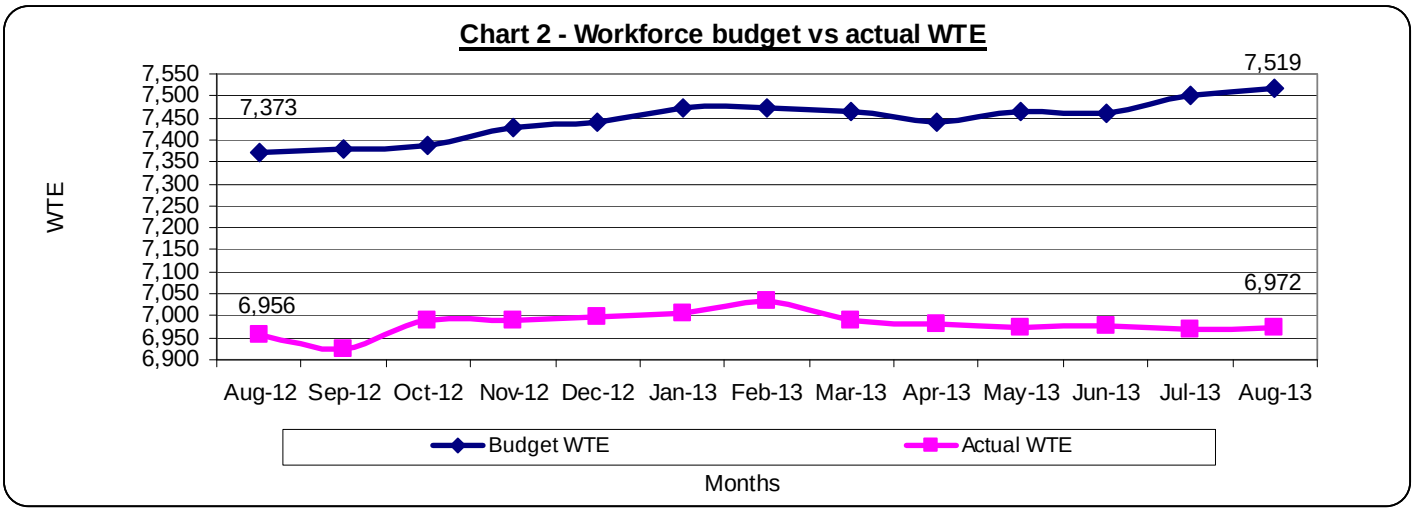


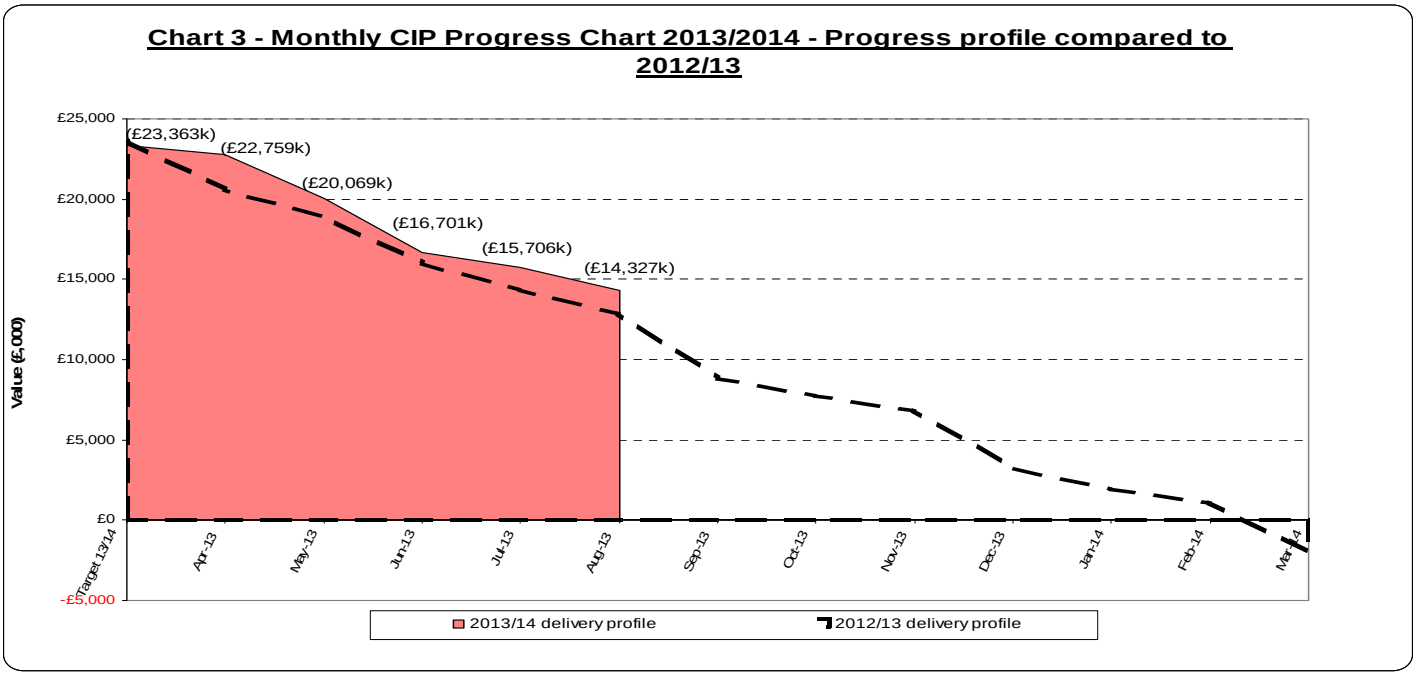
Table 4

	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Budget WTE	7,373	7,381	7,387	7,430	7,441	7,474	7,472	7,465	7,440	7,464	7,459	7,500	7,519
Actual WTE	6,956	6,925	6,991	6,990	6,997	7,004	7,034	6,990	6,982	6,974	6,978	6,969	6,972
Vacancy Gap %	5.6%	6.2%	5.4%	5.9%	6.0%	6.3%	5.9%	6.4%	6.2%	6.6%	6.4%	7.1%	7.3%

Actual WTE numbers have seen a small increase of 3 across the Trust. Staffing levels are below budgeted levels due to the impact of staff turnover.

3.4 Delivery profile and further plans

The current full year deficit is £ (14,327k). Savings achieved by month are shown in Chart 3 below. The broken line shows delivery in 2012/13 which has been added for information.



Further plans have been formulated amounting to £13,379k. These are summarised in Table 5 below.

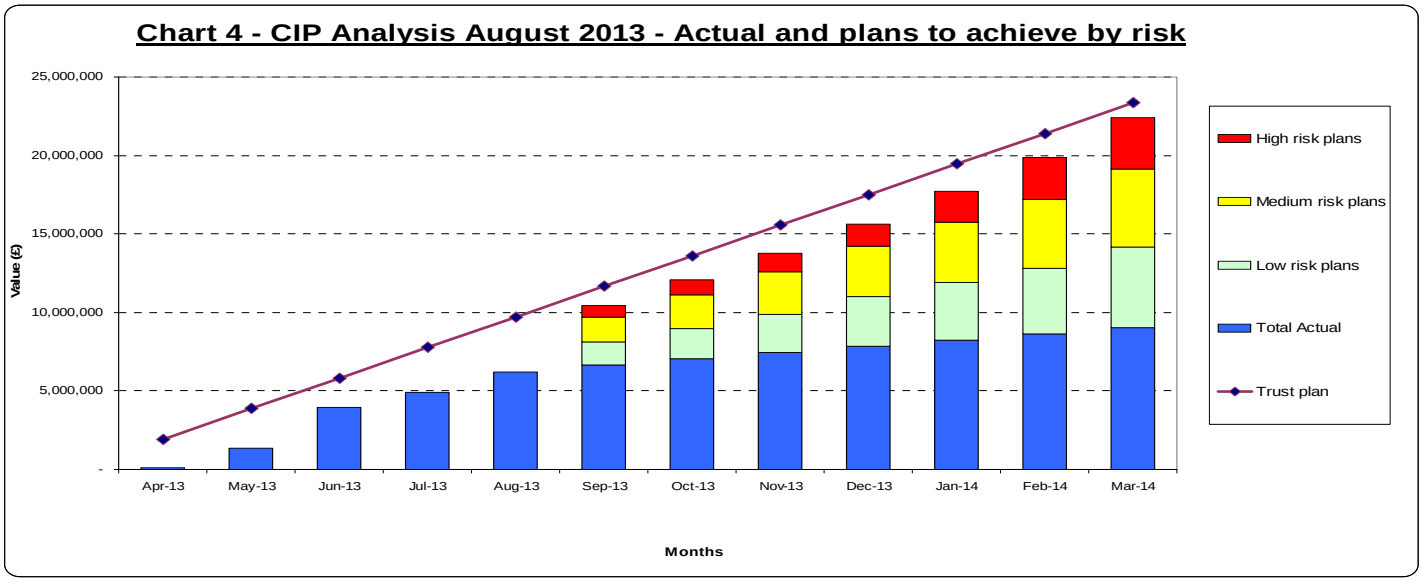
Table 5 – Further plans 2013/14

Risk	Gap Full Year	Plans - Recurrent	Plans - Non Recurrent	**Plans Total**	Shortfall in plans
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Low		3,739	1,374	**5,113**	
Medium		4,615	365	**4,980**	
High		3,174	112	**3,286**	
Total	**(14,327)**	**11,528**	**1,851**	**13,379**	**(948)**

3.5 Risk profile of further plans and forecast risk to delivery

Directorate plans are each assigned a risk rating.

The overall August 2013 position is summarised in Chart 4 below. The bottom section has been used to represent savings achieved; with low, medium and high risk plans shown ascending, as detailed on the legend.



Significant work is continually carried out to re-assess, remove or re-profile plans to ensure an up to date position.

3.6 Four year plans

Directorates are required to develop four year plans and Table 6 below summarises this position. There is currently a shortfall of (£12,965k) over 4 years on the base target.

Significant work is on going to reduce the impact of the non recurrent carry forward and schemes continue to be developed and assessed. The shortfall in plans offers a high risk to delivery.

Table 6 - 4 Year efficiency plan summary – August 2013					
Year	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Base target	23,363	16,364	15,868	15,868	**71,464**
Plans	22,415	20,491	7,175	8,418	**58,499**
Variance	**(948)**	**4,127**	**(8,693)**	**(7,450)**	**(12,965)**

3.7 Finance risk rating

In year delivery is behind the same point last year with £9,036k (39%) delivered in August 2013 against £10,766k (46%) in August 2012.

4. Conclusion

Delivery in August 2013 is behind plan with £9,036k (39%) of full year schemes being delivered against the Trust plan of £23,361k; this compares with £10,766k (46%) in August 2012. This progress is significantly behind our Monitor profile by (£3,504k) in month 5.

We currently have a planning deficit in year of (£948k), which has slipped marginally from the July 2013 position.

The 4 year planning position highlights a shortfall in base plans of (£12,965k); this has improved from the July 2013 position but is still considered high risk.

5. Recommendation

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

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

Amendment to Scheme of Delegation

Action requested/recommendation

The Board of Directors is asked to approve this amendment to the Trust's Scheme of Delegation.

Summary

A request for a minor amendment to the Scheme of Delegation for low value capital business cases is detailed below.

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

Implications for equality and diversity

There are no implications for equality and diversity

Reference to CQC outcomes

There is no direct reference to CQC outcomes

Progress of report	Audit Committee – 16 September 2013 Board of Directors – 25 September 2013
Risk	There are no specific risks for escalation
Resource implications	There are no resource implications
Owner	Andrew Bertram, Finance Director
Author	Sheila Wilson, Head of Corporate Finance
Date of paper	9 September 2013
Version number	Version 1

Board of Directors – 25 September 2013

Amendment to Scheme of Delegation

1. Introduction and background

The Trust's Scheme of Delegation was last approved in April 2013. This report recommends a minor amendment to Section 4, the Approval of Business Cases.

2. Approval of Business cases

The current Scheme of Delegation delegates authority to the Chief Executive to approve business cases from £50k to £300k. The Chief Executive applies and discharges this responsibility through the Capital Programme Board. In the case of capital business cases only, we wish to amend the Scheme of Delegation to allow the Capital Programme Management Group (CPMG) to approve capital business cases up to £100k.

The CPMG comprises members of the Trust's Capital and Finance Teams, including James Hayward and Sheila Wilson. The CPMG reports monthly through to the Capital Programme Board (Chaired by the Finance Director and including the Chief Executive, Deputy Chief Executive and Director of Estates & Facilities).

The CPMG has significantly enhanced reporting processes to support the management of the programme. The group regularly manages low value, typically replacement and maintenance schemes, but currently has no delegated authority. This introduces unnecessary delays into the process as these schemes subsequently require approval by the Capital Programme Board.

The Capital Programme Board wishes to delegate responsibility to the CPMG for capital schemes up to the value of £100k. It is the view of the Capital Programme Board that the CPMG has earned this level of autonomy in its actions, reporting developments and management of the programme.

3. Conclusion

Low value capital business cases can be effectively managed by the Capital Programme Management Group. There is a clear reporting hierarchy through to the Capital Programme Board and on to the Board of Directors.

4. Recommendation

This proposal was presented to the Audit Committee at its meeting on 16 September 2013. The proposal was supported by the Audit Committee and is now recommended to the Board of Directors.

The Board of Directors is asked to approve the amendment to the Scheme of Delegation, granting delegated authority for capital schemes up to a value of £100k to the Capital Programme Management Group.

Author	**Sheila Wilson, Head of Corporate Finance**
Owner	**Andrew Bertram, Finance Director**
Date	**September 2013**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

Human Resources Strategy Quarterly Performance Report 1 April 2013 to 30 June 2013

Action requested/recommendation

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

Summary

The attached document provides updated information for the period April to June 2013, relating to key Human Resources indicators including, sickness, recruitment & retention and workforce expenditure.

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

Implications for equality and diversity

There are no implications for equality and diversity.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report

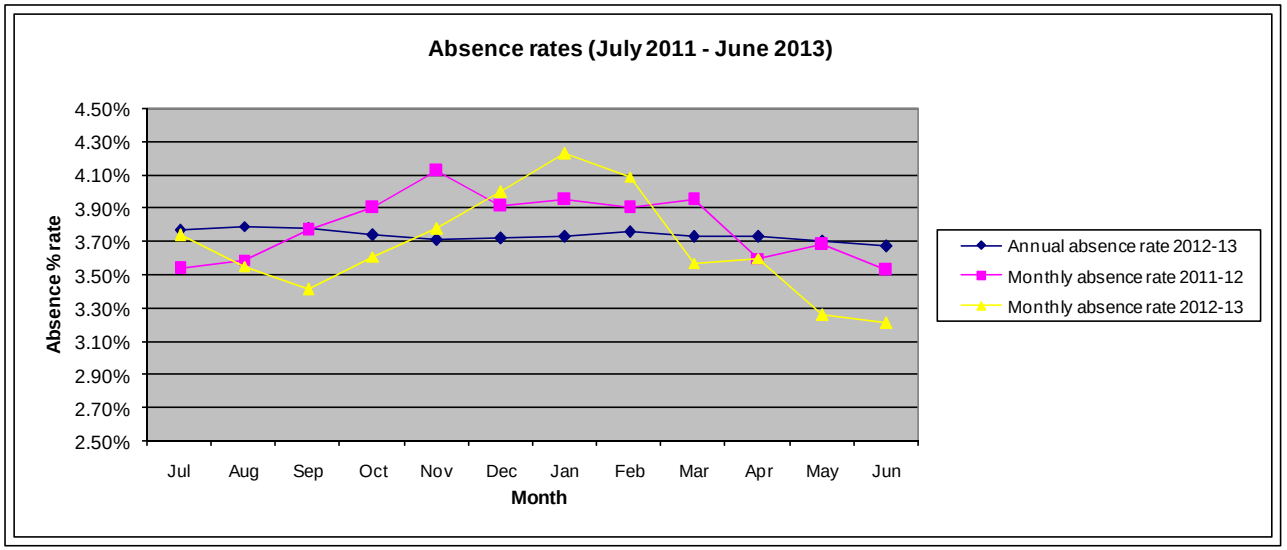
Risk	No risk.
Resource implications	None.
Owner	Peta Hayward, Director of Human Resources
Author	Siân Longhorne, Workforce Information Manager
Date of paper	August 2013
Version number	Version 1

York Teaching Hospital NHS Foundation Trust
Human Resources Strategy Performance Report
Key Indicators Trust Summary
Covering Period April - June 2013

Key Indicator	This quarter (Apr - Jun 13)			Previous quarter (Jan - Mar 13)			Last year (Apr - Jun 12)			Regional Average	Up/down/no significant change	Status R/A/G
	Quarter average	Annual	LTS*	Quarter average	Annual	LTS*	Quarter average	Annual	LTS*			
Sickness	3.36%	3.67%	95	3.96%	3.73%	97	3.60%	3.74%	111	Most recently published data covers the quarter Jan-Mar 13. The average absence for acute trusts in the Yorkshire & Humber region for this period was 4.53% and this trust was ranked first of acute trusts.	**No significant change**	
Comments: Significant progress continues to be made in absence rates at Scarborough Acute hospital with a continued reduction in the annual rate and monthly rates consistently lower than in the same month of previous years. Absence rates for York Acu hospital staff have also been promising in the first quarter of this year with the monthly rate in each month lower than in the same month of 2012. Absence rates within the Community settings still give some cause for concern but HR is continuing to work closely with Community Managers to address this.												
Active Vacancies (FTE) Defined as vacancies approved by VC group	**Vacancies (average over quarter)**	**Vacancy rate (No. of vacancies/staff in post+number of vacancies)**		**Vacancies (average over quarter)**	**Vacancy rate (No. of vacancies/staff in post+number of vacancies)**		**Vacancies (average over quarter)**	**Vacancy rate (No. of vacancies/staff in post+number of vacancies)**		The NHS Information Centre no longer publishes these figures	**No significant change**	
	133.28	1.60%		136.36	1.92%		117.57	1.70%				
Vacancies within budgeted establishment (Finance data)	**Budgeted establishment**	**Actual paid**	**Variance**	**Budgeted establishment**	**Actual paid**	**Variance**	**Budgeted establishment**	**Actual paid**	**Variance**	No regional figures available	**No significant change**	
	7447.56	6978.39	-6.30%	7464.96	6989.57	-6.37%	7372.04	6928.92	-6.01%			
Comments: Vacancy rates remains a difficult metric to calculate accurately due to the differences between the information held in financial systems (e.g. budgets & establishment) and in the ESR HR & payroll system (e.g. staff in post). One of the key aims that the organistion set out in the Workforce Planning return for 2013/14 to Health Education Yorkshire & the Humber was to reduce vacancy rates but further work is being undertaken to look at how this can be more accurately measured.												
Maternity Leave	**FTE on Maternity Leave at end of quarter**	**As % of staff in post**		**FTE on Maternity Leave at end of quarter**	**As % of staff in post**		**FTE on Maternity Leave at end of quarter**	**As % of staff in post**				
	142.93	2.07%		140.74	2.02%		141.48	2.04%		No regional figures available	**No significant change**	
Comments: Maternity leave rates continue to be fairly consistent. Any operational challenges created by higher than average maternity leave in particular areas continue to be managed through the Workforce PIM & vacancy control processes.												
Turnover (FTE)	10.39%			10.37%			9.64%			12.5% (Yorkshire & the Humber regional average)	**No significant change**	
Comments: Turnover across the integrated organisation has not changed significantly since the end of the last quarter although the turnover rate at Scarborough Acute hospital remains slightly higher than turnover amongst York Acute and Community Services staff.												
Appraisal activity	83.71%			81.37%			55.51%			National average for acute trusts in 2012 staff survey was 84%	**Up**	
Comments: Most areas within the organisation have made significant progress towards achieving the target of a 95% appraisal activity rate. Those areas which still require significant further improvement have been subject to additional scrutiny, including a meeting with the CEO and HR Director to describe a plan of action to achieve the target.												
Temporary workforce spend		**Spend**			**Spend**			**Spend**				
	NHSP Spend	£535,057.00			£568,012.00			£553,539.00				
	Bank	£349,350.00			£437,404.00			£339,116.00				
	Agency inc. external medical locums	£1,628,422.00			£2,179,015.00			£1,525,574.00				
	Overtime Spend	£329,954.00			£346,690.00			£247,157.00				
	Total temporary workforce spend	**Total spend**	**% of paybill**		**Total spend**	**% of paybill**		**Total spend**	**% of paybill**	No benchmarking figures currently available	**Down**	
		£2,842,783	3.98%		£3,531,121	4.90%		£2,665,386	3.78%			

Temp	**Comments:** Temporary workforce spend was lower in this quarter than last but slightly higher than in the same period last year. Agency spend continues to account for the largest proportion of temporary workforce expenditure (57% of spend in this quarter). It should be borne in mind that due to the integration of the Trust's information management systems in the last year and the impact this had in some cases on payments being made, the comparable figures for previous periods, whilst reflecti actual spend in the period, may not accurately reflect usage in the period.
Compromise agreements	In the period from April to June 2013, the Trust agreed 1 COT3. This was in relation to an Employment Tribunal claim that had been submitted and it was financially beneficial to agree to this claim and was approved by the Treasury. The Trust has also agreed 4 compromise agreements within this quarter, which were all connected to individuals wishing to leave under the Mutually Agreed Resignation System (MARS).

*LTS = staff on long term sickness absence classed as 29 days or more



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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

Chairman's Report

Action requested/recommendation

The Board of Directors is asked to note the report.

Summary

This paper provides an overview from the Chairman.

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

Implications for equality and diversity

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

Reference to CQC outcomes

There is no reference to CQC outcomes.

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

Board of Directors – 25 September 2013

Chairman's Report

1. Strategy and Context

Some of you will have read my sobering letter to Governors sent in private this month. It purported to give them a balanced view of the tough environment we face and I will repeat the essence of it here:

Chris Hopson, our terrier-like leader of The Foundation Trust Network (FTN), used the phrase last week "storm clouds are gathering over the NHS", and it does feel a little like that, both nationally and locally. A continuing outlook for real tariff decreases, a confusing and tightening regulatory environment, relentless media stories of a largely negative ilk, the ongoing threat of Any Qualified Provider" (AQP) competition and planned transfers of funding from health to social care in '15-'16. Locally, a main commissioner that is sending mixed messages and has insufficient capacity to develop coherent plans with providers, potential CQUIN fines that will be pressed, a first-to-follow-up ratio "target" that is unsubstantiated from credible evidence and may indeed be unsafe in some instances (if pushed all the way), no real prospect of re-formulated aggregate funding levels that will treat North Yorkshire and York more favourably and challenging reconfiguration decisions for services at several Trust locations which may be unpopular in some eyes. The growing and ageing populations of York and North Yorkshire also continue to demand better and more services, and are still often unsure as to where to get them.

Of course, all is not so negative and you all know Patrick and I are both glass half-full people – so let's remember what we all know is a wide range of real achievements and things to celebrate across our services: Achieving the vast majority of targets and metrics in care, finance, etc.; An integration process that has defied cynicism and is delivering an increasingly cohesive model of care from multiple sites – with the vast majority of clinicians and other staff working well to make changes happen in the best interests of the patients and the Trust. CQC reports are largely good and fair, with no significant concerns, Friends and Family test comments are very positive, several excellent capital projects are proceeding and more are in the pipeline. New partnerships and third-party relationships are being built (e.g. the enhancement of the translational research unit at Yh with the U. of Y). Specialty-level alliance discussions are proceeding sensibly on many fronts with Harrogate and Hull – which again should yield care improvements and efficiencies over time.

Half a year gone; Let's take the best, cope with the challenging context and aim to deliver an annual performance that a can stand comparison with that "special" year of 2012-13!

2. Governance, Governors and Community

Our Governors met last week in Scarborough. Topics included a very well received update on the Trust's leading response to the national Review of The Liverpool Care Pathway. Patrick and I also gave Governors a candid summary of the context and causes of choppy waters ahead, as well as details, of course, of the main "hot-spots" of C.Diff and the acute pathways.

We are now capturing in writing (for the web/public reports) the Governor feedback from the wide array of projects, committees, etc. that Governors are engaged in, which provides a more

transparent account of what they do – potentially to be read by candidate Governors, Trust Members and others.
The Open Afternoon at York appeared to be lively, well-supported and interesting -- followed by our usual Annual General Meeting in the Chapel – which was our typically sober affair!
Although we predominantly and accurately accounted for our successful 2012-2013, we also chose to give the attendees a dose of the reality of the period ahead, warning of increased uncertainties and a bumpy ride.

Thank you to all Directors and other staff who have supported the Monitor-related discussions in the last week or so. We will look forward to some candid and valuable feedback.

3. Recommendation

The Board of Directors is asked to note the report.

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

Chief Executive Report

Summary

The Board is asked to note the report.

Action

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

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

Implications for equality and diversity

No implications for equality and diversity.

Sustainability assessment

None directly identified at this stage.

Reference to CQC outcomes

This report references the CQC recent visits and the results of those visits

Progress of report	This report is written for the Board of Directors.
Risk	No additional risks indicated.
Resource implications	None identified.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	September 2013

Version number	Version 1

Board of Directors – 25 September 2013

Chief Executive Report

1. Introduction

As I write I do so in the satisfaction of having closed the "old year" with what proved to be yet another successful Open Day and Annual General Meeting. Can I thank the Chair and my colleagues for a superb set of presentations at the meeting and both the immediate and subsequent feedback I have received on our behalf has been humbling.

I would also like to formally welcome our KPMG colleagues to the Foundation Trust and our Board meeting today. I have been impressed by their easy but highly professional approach to the review and look forward to the outcome in due course. I know we all welcome the opportunity such a review presents that can only serve to strengthen our organisation.

It would be remiss of me not to also "welcome" Mike Proctor to the Board in his new role as Chief Nurse and I look forward to working with him in this capacity together with Beverley Geary as Director of Nursing. I know the feel and touch for nursing and midwifery that Mike so clearly expressed at the AGM struck a chord with the audience and we should all look forward to building on this in the coming months. Mike also formally launched the Nursing and Midwifery strategy at the AGM which was well received.

I remain concerned about the pressures that are bearing down on our services overall but I am equally optimistic that there is a growing recognition amongst partner organisations that these pressures can only be relieved with whole system solutions. The Medical Director will report on our management of C Difficile against trajectory, a key concern, and the Deputy Chief Executive will outline in his performance report the measures we are taking to provide a sustainable solution for reducing the longest waits in our Emergency Departments in both Scarborough and York. The Finance Director will report a balanced position financially but of course this masks the underlying yet compensating risks associated with the slippage in our efficiency programme and projected additional income that is being generated through a level of additional activity compared with plan. Clearly, the latter is a concern for our host CCGs and the finances of our local economy in the longer term but quite appropriately provides respite for the strains and challenges that the organisation is facing.

The welcome news that some £2m has been allocated to us to help with managing our winter pressures and in particular our performance against the 4 hour target must be mitigated against that fact that finance alone will not soley provide the solutions we require. However, a recognition of those challenges we uniquely face, together with a number of other high profile Trusts nationally, can only serve to raise the profile of the growing fragility of the Health and Social care system overall and in particular for us in North Yorkshire. Details of how this additional resource will be utilised have not yet been agreed but of course I will endeavour to keep you briefed as this becomes clearer.

Finally, I have attached for information the latest guidance for business case development within the organisation. The guidance has been amended to reflect the changing nature of the organisation and importantly the role our central improvement and efficiency teams must play in validating all proposals against best practice and the latest innovations.

2. Improve Quality and Safety

All hospital sites were busy throughout the month, particularly at Scarborough where as a result of high non elective demand the hospital was on Red Alert for most of the month. Scarborough also had one ward partially closed and White Cross Court was closed with Diarrhea &Vomiting during the month. Critical Care, non elective admissions and ED attendances saw high levels of activity continue across the whole Trust. Most elective activity has been accommodated throughout the month.

2a. Flu

On September 15th the minister for health Jeremy Hunt declared that the winter pressure funding for the NHS would be linked to an increase in flu vaccine uptake with an expectation that within a two year period the level of uptake for all Trusts would be 75%. Whilst we have historically performed relatively well in our levels of flu vaccine, it will require a significant increase to achieve this level. We will start the programme the first week in October, and as well as the range of measures taken in previous years we are looking at any other actions that may help achieve the 75% threshold. This includes an even greater level of communication, potentially having a wider group of people able to offer the vaccine, and consideration of an approach that requires formal opt-out."

3. Create a culture of continuous improvement

3a. CQC

As the Board is aware CQC visited the Trust during the last week in July. They reviewed both Scarborough in terms of the emergency services, Cherry Ward and Maternity services. At York they visited Archways, Emergency Department, AMU and other admitting wards at York.

Recently the Trust received the final reports of the visits. The documents are included as part of the Board pack this month and whilst I am able to report that they are largely positive there are a number of actions required of us in respect of the Scarborough site. It is important to note that the Scarborough report did receive some adverse publicity on publication.

4. Develop and enable strong partnerships

4a. Revalidation

The revalidation team recently submitted a Organisational Readiness Self Assessment report to the NHS revalidation support team and I am pleased to report that we have been rated "green". Can I thank the whole team involved for such a good outcome. I know how hard this has been and the attention to detail that has been required throughout the process.

4b. York Clinical Research Facility

Earlier this month I was extremely pleased to formally launch on the Trusts behalf, together with the University of York, the York Clinical Research Facility (CRF). This is a key milestone cementing for the first time a formal partnership with the university in developing research and development. I believe this will provide the opportunity not just to grow and exploit the opportunity for commercial research income in the future but will also demonstrate that we are a "serious" teaching institution, hopefully providing the platform to continue to attract the

best and brightest into our services in the future.

Clinicians from the Trust and medical researchers from the University will work together in the York CRF on a wide range of early phase research, including Phase I clinical trials, studies that aim to identify novel biomarkers, and fundamental research into how the human body functions in health and disease.

The Trust already conducts many clinical trials, both among its patients, and with healthy volunteers who help in the earliest phases of research. Specialised research staff and cutting-edge pharmacy facilities make York Hospital an ideal place to introduce laboratory innovations into healthcare with the assurance of essential NHS safeguards.

5. Improve our facilities and protect our environment

5a. Combined heat and power contract for York Hospital

Following the decision of the Board to provide authority for the contract to be signed subject to planning approval and electricity board approval I am pleased to report that both of these approvals have now been received. The contract was signed in August in line with the delegated authorities agreed with the Board.

5b. Place scores

Each year the Trust is required to undertake audits around the patient environment. This year the Trust has undertaken the Patient Led Assessment of the Care Environment (PLACE) which has replaced the Patient Environment Action Team (PEAT). The Trust invited the Governors to be part of the Team undertaking the assessment, consequently they had significant involvement in undertaking the audits that were used to formulate the scores and the local feedback has been shared with the Governors involved. As a result of the audits detailed action plans have been drawn up and are currently being implemented. The Trust has now received the national annual scores and is currently reviewing them. It is expected that the results will be published on the website and further detail will be presented to the Board next month. The Trust will continue to monitor the scores annually and used them to benchmark between all sites and other hospitals.

6. Recommendation

The Board is asked to discuss and note the report and is encouraged to discuss areas of specific interest.

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

York Teaching Hospital NHS
NHS Foundation Trust

York Teaching Hospital NHS Foundation Trust

Business Case Guidance Manual

Contents

Owner: **Andrew Bertram, Finance Director**

Author: **Graham Lamb, Deputy Finance Director**

Date: **August 2013**

1. Introduction

Business cases are tangible evidence that due consideration and assessment has been given of the options, implications, and risks for the Trust in addressing identified issues and meeting stated objectives. They form a key element of an informed decision-making process within the organisation, and are required in order to demonstrate evidence of compliance with the Trust's 'Scheme of Delegation'.

The production of a business case should not be regarded as a 'hurdle to be got over' in order to quickly expedite a favourable decision by the approving decision making Board or Director. Such an approach invariably leads to temptation to short cut the production of the business case, which can be evident in the lack of detail and analysis displayed in the final case. This in turn leads to ongoing challenges to the information contained in the business case, resulting in the need for numerous iterations to the documentation before those approving the business case are satisfied they have sufficient information on which to base a decision.

Business cases are an important end point in a careful process of evaluation and assessment of the issue to be addressed, the options to be considered, and plans necessary to ensure successful implementation of the preferred option, if approved. If a robust process has been followed then the detail in the business case will reflect this, will reduce the level of challenge, and make the decision-maker's role easier.

This guidance manual takes the reader through the steps necessary to develop a robust and well evidenced business case, using the standard proforma established by the Trust.

2. When is a Business Case Required?

A business case will normally be required where an investment is proposed that results in a commitment to additional capital and/or revenue expenditure (including any proposal which will generate additional income) not yet formally approved by the appropriate Board or individual in accordance with the Trust's Scheme of Delegation.

This requirement applies equally to developments included in the Trust's Annual plan, where they have not already been subject to the rigour of the business case process.

In terms of which Board or individual is authorised to approve certain levels of expenditure, section 4 of the Trust's 'Scheme of Delegation' sets out the following:

Delegated Limit	Delegated To	Exceptions
Less than £15,000	Not applicable, but Prime Budget Holder should satisfy themselves that the initiative is fully resourced.	
£15,000 to £50,000	Revenue - Prime Budget Holder, normally through the Executive Performance Management meeting. Capital – Capital Programme Management Group.	
Greater than £50,000 to £300,000	Chief Executive (with reassigned responsibility to the Director of Finance), normally through the Corporate Directors meeting.	All new (not replacement) consultant appointments to be approved by the Board of Directors.
Greater than £300,000 to £1,000,000	Executive Board	All new (not replacement) consultant appointments to be approved by the Board of Directors.
Greater than £1,000,000	Board of Directors	And all PFI proposal

For the purpose of determining which delegated (authorising) Board or Director applies, the value of the business case (for the purpose of assessing the delegated limit) shall be the total cost of the capital (and/or non-recurring revenue), plus the recurring revenue costs in the first full year.

All business cases in excess of £50,000 value are recorded on a central register maintained by the Foundation Trust Secretary. The register

includes copies of the business cases, and documentary evidence of their approval e.g. Board minute, memo, etc.

For approvals of value of £50,000 or less, the respective Prime Budget Holder should ensure that the decision making process has been documented, and is available for subsequent audit if required.

3. Business Case Process

Business cases will be subject to rigorous assessment both prior to, and post approval. The assessments will explore the business case linkages with the Trust's 5 year strategic plan, Integration plan, and commissioning priorities (by the Business Intelligence Unit), and the Improvement opportunities (by the Corporate Improvement Team), together with more frequent post implementation reviews.

The overall process is illustrated at **Appendix A**.

Prior to Submission to Corporate Directors

The following steps should be followed:

- An initial discussion should take place with the Chief Executive and Director of Finance at the next possible Executive PMM (EPMM) to gain agreement as to whether the proposal can proceed to the development of a business case. Where there is not a timely EPMM, it is recommended that a brief discussion should be arranged with the CEO/FD outside of the EPMM arena.

- Upon agreement to proceed, the business case should be developed in accordance with rest of the guidance contained in this document. It is important that in developing the business case consideration is given to quality improvement (evidenced over the three quality domains of Quality & Safety, Access & Flow, and Finance & Efficiency), alternative workforce models (supported by the Trust's Workforce team), and best practice/ alternative models of service delivery.

- The draft business case should now be shared with the Trust's 'Business Intelligence Unit' and 'Corporate Improvement Team for assessment of strategic fit and improvement opportunities.

- The business case should then be presented in final form to the EPMM for decision as to whether to proceed to the Corporate Directors. Where there is no timely EPMM or in the event of cancellation, the default position should then be direct submission to the Corporate Directors.

Submission to Corporate Directors

All business cases greater than £50,000 value are reviewed and approved by the Corporate Directors team for onward submission to the final

approving Board or individual. The team meets every Monday afternoon, and it is the Author's (see section 4) responsibility to liaise with the Chief Executive's office to ensure that it is placed on the agenda and the papers are made available.

The Director of Finance will notify as a minimum the Owner, Author, and Finance Manager of the outcome for the Business Case following the Corporate Directors meeting and of any further necessary actions required.

Post Implementation Review

At the time of its approval, the approving Board or Director will decide if the business case will be subject to Post Implementation Review. Those business cases chosen for review will be subject to the following process.

The achievement of the benefits identified in any approved business case is essential to the ultimate delivery of the objective(s) of the business case. In order to ensure that the benefits identified in any approved business case are being realised, post implementation reviews will be undertaken at 3, 6, and 12 months following approval, by the Trust's Corporate Improvement Team. The outcome of these reviews will be reported back to the approving Board or Director.

Where benefits are not being realised 6 months after approval support will be provided by the Improvement Team to assist in realising the identified benefits. Where benefits are still not being realised 12 months after approval the approving Board or Director will be asked to consider the withdrawal of funding support: in effect withdrawing approval for the business case.

The above Post Implementation Review process will initially be conducted on a test basis in order to ascertain the benefits of the process itself, set alongside gaining an understanding of the resource and time implications involved in conducting such Reviews.

4. Responsibility for the Preparation & Submission of Business Cases

Each business case will have an **Owner** and an **Author**.

The **Owner** will normally be the appropriate Clinical or non-clinical Director, or where appropriate, the lead Clinician nominated by the respective Clinical Director. The Owners role is one of sponsoring the business case, and having responsibility for its presentation to the approving Executive Board or individual. Presentation of business cases to and requiring ultimate approval by the Board of Directors will be made by one of the Executive Directors. Responsibility for completed papers for the Board of Directors meeting will remain with the business case owner.

The **Author** will be the named manager supporting the Owner having lead responsibility for the development and writing of the business case, and will be the key contact point for all enquiries. The Author is most likely to be the manager responsible for the implementation of the business case once approved.

As the very first step in the business case process, the Author must obtain via e-mail a unique business case identification number from the secretary to the Foundation Trust Secretary (Cheryl Gaynor). The e-mail should as a minimum contain:

- the title of the business case
- the author's name, and
- A brief description of the issue to be addressed.

In reply to the author, the Foundation Trust office will copy in other key managers within the Trust alerting them to the fact that the business case is under development. It is the joint responsibility of the business case author and all Trust department managers to ensure that all relevant resource implications are identified and included where appropriate. The unique identifying number will appear on all business case documentation and will assist location on the business case register.

The Author must ensure that sufficient time is planned before submission to enable all aspects of the case to be undertaken satisfactorily (e.g. financial analysis, obtaining of other supporting evidence, etc.), and discussed with appropriate senior finance, performance, and other key Directors and operational managers. This is particularly important as:

- Business cases will be predominantly capital or revenue, and this in turn can influence the people it will be necessary to involve in developing the business case. For capital business cases the involvement of the Capital Programme Management Group is essential, whereas revenue business may well require input from personnel in performance, commissioning, financial management, etc.

  For ease of definition, a capital business case will be one where there are capital costs involved and where any revenue costs predominantly arise as a consequence of the capital investment itself e.g. financing costs, maintenance costs, etc. Revenue business cases by default will be those that do not meet the capital criteria.

- The relative complexity and/or sensitivity of the business case will also influence the time and degree of involvement of others in its development. The number of potential solutions to consider will tend to increase the complexity of the business case. Relatively simple business cases will be those where there are very few options (normally just two i.e. do nothing, and the obvious preferred solution), and the detailed facts of the case relatively easy to digest.

  More complex business cases will tend to have a number of possible options where the best solution is not immediately obvious, and depending on level of complexity may need to employ more structured analytical techniques such as cost/benefit analysis, benefit points scoring, sensitivity analysis, detailed financial analysis (e.g. discounted cash flow, internal rate of return, payback), etc.

  The relatively complexity of the business case will influence the level of analysis and work required in its development. The Corporate Directors will be seeking assurance when reviewing business cases that the range of options and degree of supporting analysis reflect the complexity of the case in question.

5. Completion of the Business Case Proforma

To guide the Author in ensuring that all business cases, as a minimum, cover the range of essential criteria, standard business case proforma have been developed to support the process, and these must be used without exception **(Appendix Bi and Appendix Bii)**.

In order to provide sufficient information to the respective decision making Board/ Director in assisting them make their decision, the expectation is that supporting evidential information is appended to the business case. The level of supporting information will be influenced by the respective complexity of the business case, with the expectation that as a business case becomes more complex, significantly more supporting analysis will be appended to the business case, particularly in arriving at the preferred option where many are available. For complex business cases a detailed project plan may be requested at the point of approval.

The business case should be written in a concise and business like manner. A general rule is that it is the quality not quantity of the information provided that assists those being asked to approve a business case make their decision.

In terms of content, after the title and identification of the Owner and Author of the business case, it is expected that as a minimum the following will be provided:

(a) Issue(s) to be addressed by the business case

This introductory section is crucial and should effectively set out the background and case of need for the business case. Its focus should be to clearly establish what the key issue(s) is/are that require(s) addressing.

Any temptation to move straight to any discussion of a solution should be resisted at this point.

(b) Options considered

The various options that have been considered as a means of addressing the issue(s) presented in the previous section should be described under this section. The number of possible options will vary from case to case, and authors are encouraged to be as creative as possible in identifying all possible solutions. The review of alternative workforce models and/or best practice/ alternative methods of service delivery should always be considered as part of the option appraisal.

Any temptation to limit the number of viable options provided should be resisted, but should always include the 'do nothing' option.

Being able to demonstrate and evidence to the decision-makers that due consideration has been given to a wide range of possible options will instil more confidence in the preferred option.

Dependant upon the complexity and potential value of the business case, where there are many possible solutions the use of more structured analytical techniques such as cost/benefit analysis, benefit points scoring, sensitivity analysis should be considered. The results from the use of such techniques should be appended to business case in evidencing the results and recommended option.

(c) The Preferred option

The preferred solution to business case should be identified, together with the reason(s) why it is preferred over other available options. Any evidence supporting the choice such as the results from the use of analytical techniques mentioned above should be appended to the business case. The reasons for rejecting the other options should also be explained.

(d) Alignment with the Trust's strategic objectives

The Trust has identified four strategic 'frames' that ensure there is a focus for its emerging priorities and objectives and assists in the communication to staff, patients and other stakeholders. The four strategic 'frames' are:

1 Quality and Safety
2 Effectiveness, Capacity and Capability
3 Partners and the Broader Community
4 Facilities and Environment

These strategic 'frames' inline with the national agenda, advocate increased patient choice, better access times, safer, cleaner hospitals and improved patient satisfaction and outcomes. In this context listed below are four principle objectives that fit to the strategic frames.

- To provide safe and quality services to all patients underpinned by the specific steps set out in the driver diagram as part of the Quality and Safety Strategy. This includes developing and learning from performance indicators (e.g. PROMs, NCI etc). Ensuring

compliance with national requirements - NPSA, NICE and implementation of results of clinical audit strategies and ensuring consultation and engagement of patients, visitors and staff

- To provide excellent healthcare with appropriate resources, strong productivity measures and strong top quartile performance being indicative of this. The service will be based on 'needs based care' and staff understand how they contribute to the Trust's successes.

- To be an exemplar organisation that is responsive to the local and broader community needs and is recognised and trusted. To engage fully in all aspects of community discussion relating to health and provide expert advice and leadership as required. To work with other groups to support the adoption of a consistent approach in the community and demonstrate that the Trust is a community orientated organisation able to achieve and deliver all local and national outcomes.

- To provide a safe environment for staff, patients and visitors, ensuring that all resources are used as efficiently as possible

<u>It is not required, and in many cases not possible, that a business cases will align with all four principle objectives, but as a minimum it should align with at least one of the objectives.</u>

The Trust's Business Intelligence Unit should have had the opportunity to review the 'strategic fit' of the business case with the Trust's 5 year strategic plan, and the date of their review together with any comments made should be included.

(e) <u>Benefit(s) of the business case</u>

The benefits that are expected to accrue from the preferred option <u>must</u> be identified and presented in <u>measurable</u> terms across the three domains of service improvement: Quality & Safety, Access & Flow, and Finance & Efficiency.

The benefits identified should be tangible and capable of being evidenced ideally through some form of measurement. This is a key section which will be used as part of the post implementation review process.

The Trust's Corporate Improvement Team should have had the opportunity to review the quality improvements identified in the

business case, and the date of their review together with any comments made should be included.

(f) Summary Project Plan

This section seeks to provide assurance to the decision makers that due consideration has been given to the implementation of the preferred option (if approved). The expectation is that the business case can clearly identify the necessary steps together with timescales and responsible individuals that must be satisfactorily undertaken to ensure successful implementation.

(g) Risk analysis

The identification of the key risks to the Trust if it were to proceed with the preferred option is a key section of the business case. Equally important is the identification of possible actions to mitigate the risks.

(h) Risk of not proceeding

This section seeks clarification of the risks to the organisation if it were not to proceed with the preferred option.

(i) Consultant, and Non-Trading Grade Doctor impact

Where the business case involves a proposed change in Consultant / non-Training Grade Doctor Manpower, it is a requirement that before submission of the business case to the Executive Board for discussion that the manpower planning process has been followed **(Appendix C)**. This includes appropriate discussions with the lead Non-Executive Director, and the provision of relevant information to the Job Planning Assessment committee. This section can only be satisfactorily completed after this process has been followed.

The job plan associated with new posts or changes to existing posts must be submitted with the business case.

(j) Stakeholder consultation and involvement

Often the successful implementation of a business case is dependent upon the commitment and ownership of the solution by stakeholders both within and outside (especially commissioners) the organisation. This section requires evidence that the appropriate signup has been received from the key stakeholders that are critical in delivering the identified benefits and making the implementation of the business

case a success. The potential impact of the business case on internal clinical support specialties and central services e.g. estates and facilities, should not be overlooked when completing this section.

It is a mandatory requirement that consultation should take place with the Trust's Business Intelligence Unit, Service Improvement team, and Workforce team in developing the business case.

(k) Sustainability

The Trust is committed to the development of sustainable solutions in the delivery of its services, including minimising its carbon footprint. This section requires consideration of the impact of the business case in terms of carbon emissions and the use of natural resources through addressing five simple questions. Further assistance, if required, in assessing the impact of the business case may be gained from the Trust's Energy Manager, Brian Golding.

(l) Alliance Working

The Trust has the stated objective of developing and enhancing both clinical and non-clinical alliance arrangements with Harrogate & District NHS Foundation Trust, and Hull and East Yorkshire Trust. The business case should clearly identify how these objectives will be supported.

(m) Integration

The integration of clinical and non-clinical services following the acquisition of the Scarborough and North East Yorkshire NHS Trust in July 2012 is a key priority for the Trust. The business case should clearly identify how it links in with the Directorate's Integration plan.

It is also important that current non-integrated services discuss prospective new appointments in anticipation of future integration.

(n) Impact on Community Services

As the Trust is a provider of both Acute and Community services, the business case should identify whether it will have an impact on Community Services and/or provide an opportunity to better integrate Acute and Community Services, stating clearly what the impact will be.

(o) Impact on the Ambulance Service

Where a business case has any impact on the ambulance service in terms of changes to patient flows, these should be detailed along with any response from the Ambulance service to the proposed changes.

(p) Market analysis (where the business case is predicated on securing new or increased business)

Where a business case is predicated on securing new or increased business (and income), it is important that the basis of the assessed change in business is clearly stated outlining the key assumptions made, and wherever possible supported with evidence appended to the business case.

Evidence may come in numerous guises including calculations, correspondence from commissioners confirming their commitment to purchase, trend analysis (e.g. of referrals), demographic data, competitor analysis, etc.

(q) Financial Analysis

A standard financial proforma has been created **(Appendix Bii)** to support the process, and must be completed in all cases by the appropriate Finance representative supporting the Author of the business case.

The proforma seeks to establish the net financial impact of the business case by establishing the current baseline, and comparing the situation following implementation of the business case. Where appropriate it deals with planned changes in activity and the consequential impact on income, and with capital or revenue expenditure implications.

Where a business case is predicated on the securing new or increased business, there is an expectation that after deducting new costs from new income, a net contribution (surplus) is made towards overheads. Although each business case will need to be considered on its merits, as a general guide minimum target contributions should be 20% of income

Quite often the development of supporting financial data for a business case can take some time and involve conversations between different finance professionals. Where the financial implications and risks of the business case are significant then a discussion on these should be arranged with the Director of Finance (or other senior

Finance staff) prior to submission of the case to the Corporate Directors.

The business case narrative provides for a direct summary of the financial proforma, and a commentary of the key features and risks.

In terms of explaining the finances, both the financial proforma and the financial analysis section contained within the business case itself should be capable of standing alone without the need to refer to the other.

(r) Recommendation for Post Implementation Review

The author is asked to recommend to the approving Board whether the business case should be subject to a post implementation review, and explain the reason(s) for their decision.

In general it would be expected that a business case is recommended for a post implementation review where it is considered to have as a minimum a moderate level of risk to full achievement of the objectives as stated in the business case. As examples, risk may be as a result of the business case being relatively complex involving and depending upon a number of different parties either within and/or external to the Trust to ensure full delivery, or is predicated on an assessment (e.g. demand for a service) that can not be fully proven at the time the business case is written.

(s) Date

Once completed the business case should be dated.

6. Business Case Post Implementation Reviews, and Post Project Evaluation

Post Implementation Review

Post Implementation Review (PIR) is not applied to all business cases. Only business cases chosen at the point of their approval by the approving Board (Board or Directors, Executive Board, or Corporate Directors) will be subject to PIR. By definition, this means that only business cases in excess of £50,000 may be subject to PIR.

Determination of whether a business case will be subject to PIR will be at the discretion of the respective Board at the time of its approval, and will be subject to consideration of the recommendation made by the business case owner, and whether it is believed there is sufficient risk in the business case to warrant a retrospective examination as to the achievement of its stated objectives.

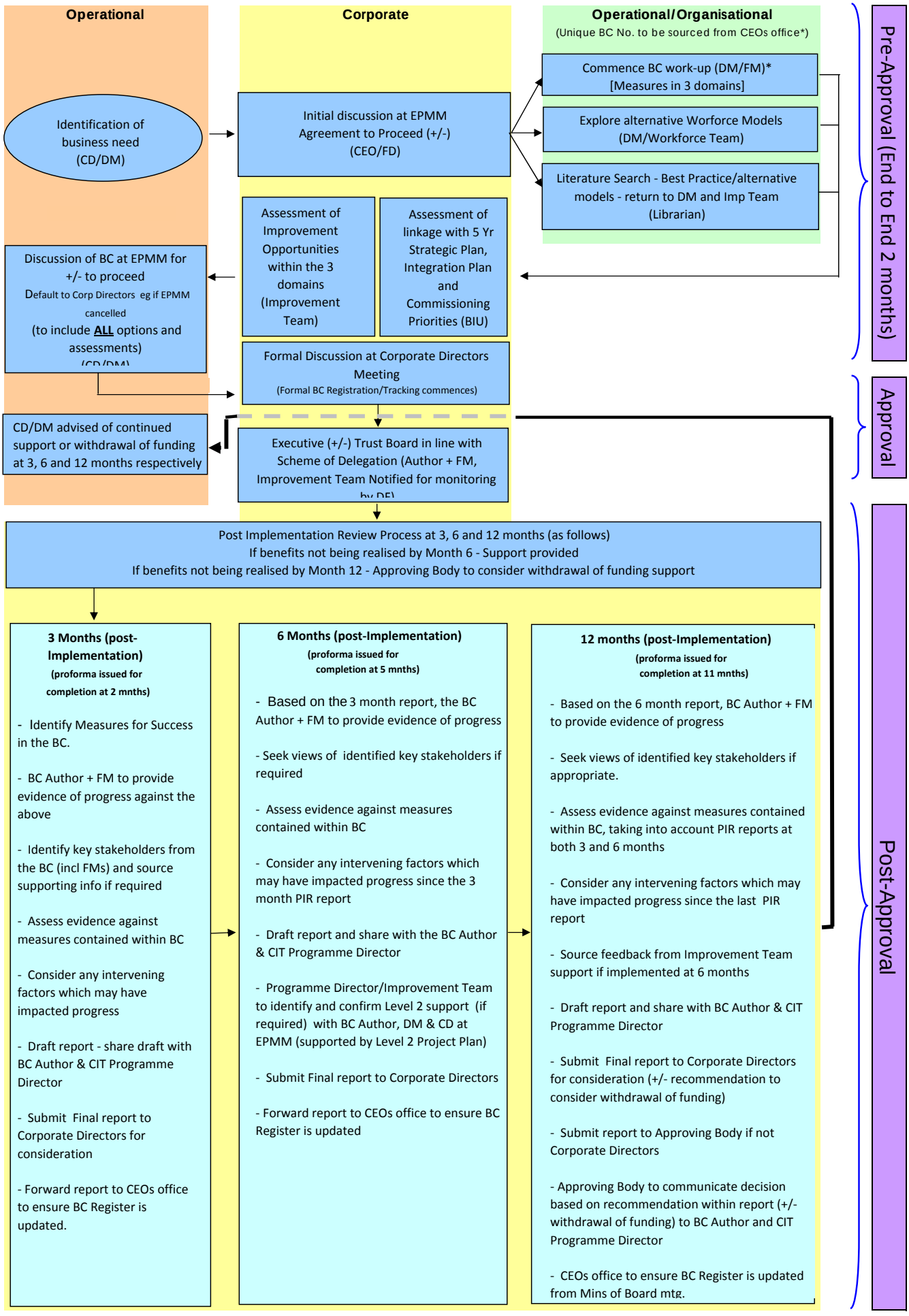
Once a business case has been selected for PIR, it will be recorded on the register referred to in section 2 above.

PIR will be conducted through the use of a proforma report **(Appendix D)** designed to gather key information on the progress in implementing the business case. The Trust's Corporate Improvement Team will coordinate the process to ensure that the reports are generated for consideration by the Corporate Directors and approving Board 3, 6, and 12 months following the date of approval. The respective Business Case Author and Finance Manager will have an explicit role in the timely population of the required information in the report, and this is detailed in the proforma report.

Post Project Evaluation

Due to the detailed and frequent review of the progress in implementing a business case through the PIR process described above, an additional post project evaluation for each business case once fully implemented is deemed unnecessary. However, in providing assurance on the business case management system Internal Audit reserves the right to select business cases at random for post project evaluation.

Business Case Process



APPENDIX Bi

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2. Business Case Title

3. Management Responsibilities & Key Contact Point

The business case 'Owner' should be the appropriate Clinical or non-clinical Director, or where appropriate the lead Clinician nominated by the respective Clinical Director. The 'Author' will be the named manager supporting the Owner of the business case, who will have responsibility for the development and writing of the business case, and <u>will</u> be the key contact point for enquiries.

Business Case Owner:	

Business Case Author:	
Contact Number:	

4. Issue(s) to be addressed by the Business Case

Describe the background and relevant factors giving rise to the need for change. Relevant data (e.g. BCBV data, etc.) *<u>must</u> be included to support the background described.*

5. Options Considered

List below the alternative options considered to resolve the issue(s) presented in section 4 above. This should include consideration of alternative workforce and clinical models.

Description of Options Considered

6. The Preferred Option

6.1 Preferred Option

Detail the preferred the option together with the reasons for its selection. This must be supported with appropriate data in demonstrating how it will address the issue(s) described in section 4 above.

6.2 Other Options

Detail the reasons for rejecting the remaining options listed under section 5, together with supporting detail.

7. Trust's Strategic Objectives

7.1 Alignment with the Trust's Strategic Objectives

The Trust has identified four strategic 'frames' that ensure there is a focus for its emerging priorities and objectives and assists in the communication to staff, patients and other stakeholders. The four strategic 'frames' are:

1 Quality and Safety
2 Effectiveness, Capacity and Capability
3 Partners and the Broader Community
4 Facilities and Environment

In this context listed below are four principle objectives that fit to the strategic frames. Indicate using the table below to what extent the preferred option is aligned with at least one of these principle objectives.

Strategic Objective	Aligned? Yes/No	If Yes, how is it Aligned?
To provide safe and quality services to all patients underpinned by the specific steps set out in the driver diagram as part of the Quality and Safety Strategy. This includes developing and learning from performance indicators (e.g. PROMs, NCI, etc). Ensuring compliance with national requirements - NPSA, NICE and implementation of results of clinical audit strategies and ensuring consultation and engagement of patients, visitors and staff.		
To provide excellent healthcare with appropriate resources, strong productivity measures and strong top quartile performance being indicative of this. The service will be based on 'needs based care' and staff understand how they contribute to the Trust's successes.		
To be an exemplar organisation that is responsive to the local and broader community needs and is recognised and trusted. To engage fully in all aspects of community discussion relating to health and provide expert advice and leadership as required. To work with other groups to support the adoption of a consistent approach in the community and demonstrate that the		

Trust is a community orientated organisation able to achieve and deliver all local and national outcomes.		
To provide a safe environment for staff, patients and visitors, ensuring that all resources are used as efficiently as possible		

7.2 Business Intelligence Unit Review

The Business Intelligence Unit must review all business cases for 'Strategic fit' to the Trust's 5 year plan. The date that the business case was reviewed by the BIU together with any comments which were made must be provided below.

Date of Review	
Comments by BIU	

8. Benefit(s) of the Business Case

8.1 Benefit(s)

The identification at the outset of the benefit(s) that arise from the business case is crucial to ensuring that a robust evaluating of the progress and delivery of the business case objectives is possible during the post implementation reviews.

*Clearly detail and **quantify** the expected benefits that will accrue to the Trust from the preferred option in each of the three domains of service improvement. The benefits identified must be tangible, and capable of being evidenced ideally through some form of measurement.*

Description of Benefit	Metric	Quantity Before	Quantity After
Quality & Safety			
How will information be collected to demonstrate that the benefit has been achieved?			
Access & Flow			
How will information be collected to demonstrate that the benefit has been achieved?			

Finance & Efficiency			
How will information be collected to demonstrate that the benefit has been achieved?			

8.2 Corporate Improvement Team Review

The Corporate Improvement Team must review all business cases across the three quality domains. The date that the business case was reviewed by the IT together with any comments which were made must be provided below.

Date of Review	
Comments by CIT	

9. Summary Project Plan

Detail below the specific actions, individuals responsible for their delivery, and timescales that must be done in order to realise the intended benefits of the preferred option of this business case. For example, these may include acquisition of key space requirements, or equipment, IT software/ hardware; the recruitment of key personnel, training, implementation of systems, change in business and/or clinical processes, etc. ***All fields must be completed****.*

Description of Action	Timescale	By Who?

10. Risk Analysis:

Identify the key risks to the Trust of proceeding with the preferred option, and what actions can be taken to mitigate them should they arise.

Identified Risk	Proposed Mitigation

11. Risk of Not Proceeding:

Identify the key risks/ potential impact of not proceeding with the preferred option.

12. Consultant, and other Non-Training Grade Doctor Impact

(Only to be completed where the preferred option increases the level of Consultant/ non-Training Grade input)

12.1 Impact on Consultant/ Non-Training Grade Doctor Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant/ Non-Training Grade Doctor to a maximum of 11. This section should illustrate the impact that the additional Consultant/ Non-Training Grade input created will have on the average number of PAs worked in the specialty, the frequency of the on-call rota, and the PA profile across the whole specialty team. Information is also required of each Consultant's/ Non-Training Grade Doctor's actual annual working weeks against the 41 week requirement.

The information below must be accompanied by the Trust's Capacity Planning Tool, and the Job Plan, which should be appended to, and submitted with the business case.

	Before	After
Average number of PAs		
On-call frequency (1 in)		

Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**

12.2 Advisory Committee Review:

The Consultant Job Planning Advisory Committee must review all proposed job plans for new consultant posts, as well as any job plans for existing consultants where the proposed new post would have an impact on current working practices. The date that the job plans were approved by the Committee and any comments which were made must be provided below.

Date of Approval	
Comments by the	

Committee	

13. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the business case; the extent to which each support the proposal, and where appropriate, ownership for the delivery of the benefits identified above. Where external stakeholder support is vital to the success of the business case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment.

Examples of stakeholders include Lead Clinicians, support services (e.g. Systems & Network Services, Capital Planning re: accommodation), commissioners (e.g. Vale of York CCG, Scarborough CCG), patients & public, etc. ***Please bear in mind that most business cases do have an impact on Facilities & Estates services.***

Stakeholder	Details of consultation, support, etc.
Mandatory Consultation	
Business Intelligence Unit	
Corporate Improvement Team	
Workforce Team	
Other Consultation	

14. Sustainability

The Trust is committed to development of sustainable solutions in the delivery of its services, including minimising its carbon footprint. The following questions should be answered in the context of the impact of this business case has on the areas listed.

If assistance is required in assessing the sustainability impact of this business case, help is available from Brian Golding, Trust Energy Manager on (72)6498.

Will this Business Case:	Yes/No	If Yes, Explain How
Reduce or minimise the use of energy, especially from fossil fuels?		
Reduce or minimise Carbon Dioxide equivalent emissions from NHS activity?		
Reduce business miles?		
Reduce or minimise the production of waste, and/or increase the re-use and recycling of materials?		
Encourage the careful use of natural resources, such as water?		

15. Alliance Working

How does this business case support the Trust's stated objective of developing and enhancing the clinical alliance arrangements with Harrogate & District NHS Foundation Trust, and Hull and East Yorkshire Trust?

16. Integration

Integration of clinical and non-clinical services following the acquisition of the Scarborough & North East Yorkshire NHS Trust is a key priority for the Trust. How does this business case link into the Directorate's Integration plan? Have current non-integrated services discussed new appointments?

17. Impact on Community Services

Will this business case have an impact on Community Services and/or provide an opportunity to better integrate Acute and Community Services? How will this impact?

18. Impact on the Ambulance Service:

	Yes	No
Are there any implications for the ambulance service in terms of changes to patient flow?		

If yes, please provide details including Ambulance Service feedback on the proposed changes:

19. Market Analysis:

Where the business case is predicated on securing new and/or increased business (and income), detail the evidence supporting the income projections.

20. Estimated Full Year Impact on Income & Expenditure:

Summarise the full year impact on income & expenditure for the specialty as a result of this business case. The figures should cross reference to the more detailed analysis on the accompanying 'Financial Pro Forma'.

	Baseline	Revised	Change
	£000	£000	£000
Capital Expenditure			0
Income			0
Direct Operational Expenditure			0
EBITDA	0	0	0
Other Expenditure			0
I&E Surplus/ (Deficit)	0	0	0
Existing Provisions	n/a		0
Net I&E Surplus/ (Deficit)	0	0	0
Contribution (%)	#DIV/0!	#DIV/0!	#DIV/0!
Non-recurring Expenditure	n/a		0

Supporting financial commentary:

21. Recommendation for Post Implementation Review

	Yes	No
Is this business case being recommended for post implementation review?		

Reason(s) for the decision:

22. Date:

GAL/22August2013

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	
TITLE:	
OWNER:	
AUTHOR:	

Capital

	Total £'000	Planned Profile of Change 2013/14 £'000	2014/15 £'000	2015/16 £'000	Later Years £'000
Expenditure	0	0	0	0	0

Capital Notes *(including reference to the funding source)*:

Revenue

	Total Change Current £'000	Revised £'000	Change £'000	WTE	Planned Profile of Change 2013/14 £'000	2014/15 £'000	2015/16 £'000	Later Years £'000
(a) Non-recurring								
(b) Recurring								
Income								
NHS Clinical Income	0	0	0		0	0	0	0
Non-NHS Clinical Income	0	0	0		0	0	0	0
Other Income	0	0	0		0	0	0	0
Total Income	**0**	**0**	**0**		**0**	**0**	**0**	**0**
Expenditure								
Pay								
Medical			0					
Nursing			0					
Other (please list):								
Executive Board & Senior Managers			0					
Support Staff			0					
WLIs			0					
			0					
	0	**0**	**0**	**0.00**	**0**	**0**	**0**	**0**
Non-Pay								
Drugs			0					
Clinical Supplies & Services			0					
General Supplies & Services			0					
Other (please list):								
Establishment Expenses			0					
			0					
			0					
	0	**0**	**0**		**0**	**0**	**0**	**0**
Total Operational Expenditure	**0**	**0**	**0**		**0**	**0**	**0**	**0**
Impact on EBITDA	**0**	**0**	**0**	**0.00**	**0**	**0**	**0**	**0**
Depreciation			0					
Rate of Return			0					
			0					
Overall impact on I&E	**0**	**0**	**0**	**0.00**	**0**	**0**	**0**	**0**
								+ favourable (-) adverse
Less: Existing Provisions	**n/a**		**0**					
Net impact on I&E	**0**	**0**	**0**		**0**	**0**	**0**	**0**

Revenue Notes *(including reference to the funding source)*:

	Owner	Finance Manager	Board of Directors Only Director of Finance
Signed			
Dated			

BUSINESS CASE - ACTIVITY & INCOME

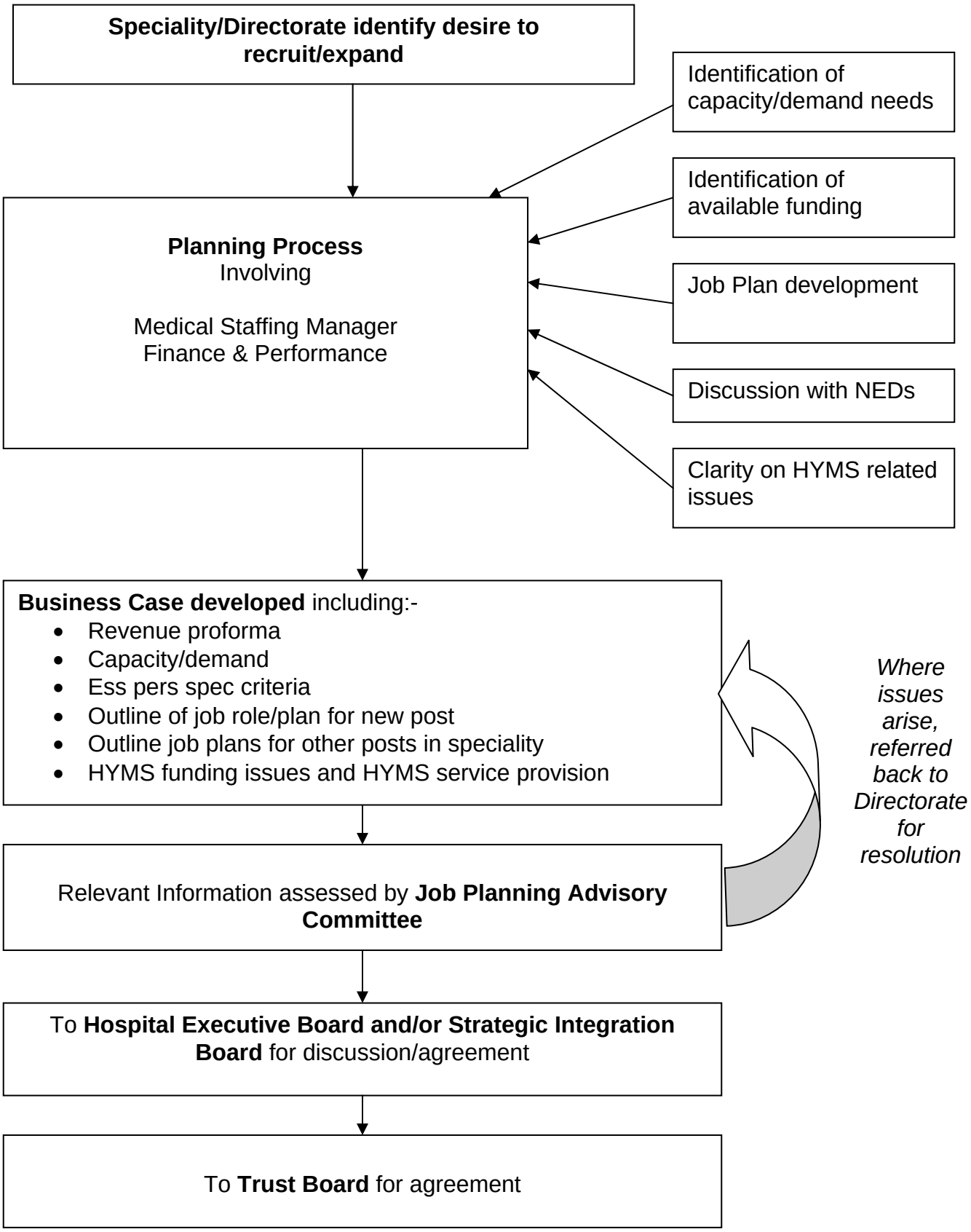
Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2012/13	2013/14	2014/15	Later Years
Elective (Spells)			0				
Non-Elective (Spells)							
Long Stay			0				
Short Stay			0				
Outpatient (Attendances)							
First Attendances			0				
Follow-up Attendances			0				
A&E (Attendances)			0				
Other (Please List):							
			0				
			0				

Income

	Total Change			Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	2012/13 £'000	2013/14 £'000	2014/15 £'000	Later Years £'000
NHS Clinical Income							
Elective income							
Tariff income			0				
Non-Tariff income			0				
Non-Elective income							
Tariff income			0				
Non-Tariff income			0				
Outpatient							
Tariff income			0				
Non-Tariff income			0				
A&E							
Tariff income			0				
Non-Tariff income			0				
Other							
Tariff income			0				
Non-Tariff income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**
Non NHS Clinical Income							
Private patient income			0				
Other non-protected clinical income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**
Other income							
Research and Development			0				
Education and Training			0				
Other income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**

CHANGES TO CONSULTANT MANPOWER PLANNING PROCESS



York Teaching Hospital NHS
NHS Foundation Trust

Trust Business Case

Post Implementation Review Report

Business Case Number						
Business Case Title						
Business Case Approved						
Post Implementation Review	**3 months**		**6 months**		**12 months**	

Report Issued for Completion	
Review Report Deadline	

Business Case Owner	
Business Case Author	
Corporate Improvement Team Rep	
Corporate Efficiency Team Rep	

CIT Tracking Code:

INTRODUCTION

The achievement of the benefits identified in any approved business case is essential to the ultimate delivery of the objective(s) of the business case. In order to ensure that the benefits identified in approved business case are being realised, Post Implementation Reviews (PIR) will be undertaken at 3, 6, and 12 months following approval on those business cases selected for PIR by the approving Board or Director. The PIR will be co-ordinated and conducted by the Trust's Corporate Improvement Team. The outcome of the PIR will be reported back to the approving Board (12 month only) and the Corporate Directors (all reports).

Where benefits are not being realised 6 months after approval, support may be provided by the Corporate Improvement Team to assist in realising the identified benefits. Where benefits are still not being realised 12 months after approval, the approving Board and Corporate Directors will be asked to consider the withdrawal of funding support: in effect withdrawing approval for the business case.

This Review Report will be the mechanism by which evidence will be submitted to the PIR process.

The Corporate Improvement Team will issue a PIR report, populated by information contained within the original Business Case, for completion by the Business Case Author together with their Finance Manager. This will occur 1 month in advance of each of the Review periods (i.e. at 2 months, 5 months and 11 months from the communicated date of Business Case approval, to allow submission to Corporate Directors at 3, 6 and 12 months.

Each Review Report will retain the previous Report's content to enable ease of referencing. Thus the content of the reports will be cumulative in nature.

Please see Appendix 1 attached, for further detail on the process.

1. Measures for Success - Benefit(s) of the Business Case

Details below sourced from the approved Business Case. Please provide information on progress to achievement of all benefits at the relevant review period (one review period per report).

Description of Benefit	Metric	Quantity Before	Quantity After		Progress 3 months	Progress 6 months	Progress 12 months
Quality and Safety					**Quality and Safety**		

How and by whom is the information in support of the above collected, to demonstrate that the individual benefit is being/has been achieved (including method, frequency, reporting structures etc). Where information was unavailable when the BC was approved this must now be confirmed asap for review purposes?
Additional Comments (e.g. any mitigation taken to address slippage in timescales etc):

Description of Benefit	Metric	Quantity Before	Quantity After		Progress 3 months	Progress 6 months	Progress 12 months
Access and Flow					**Access and Flow**		

How, and by whom is the information in support of the above collected, to demonstrate that the individual benefit is being/has been achieved (including method, frequency, reporting structures etc)?
Additional Comments (e.g. including any mitigation to address slippage in timescale etc):

Description of Benefit	Metric	Quantity Before	Quantity After		Progress 3 months	Progress 6 months	Progress 12 months
Finance and Efficiency					Finance and Efficiency		

How and by whom is the information in support of the above collected, to demonstrate that the individual benefit is being/has been achieved (including method, frequency, reporting structures etc)?
Additional Comments (e.g. including any mitigation to address slippage in timescale etc):

2. Project Plan

Sourced from the original Business Case showing the specific actions, individuals responsible for their delivery, and timescales to be done in order to realise the intended benefits of the business case. If necessary provide any revised timescales due to the delay in Business Case approval and then provide details on progress against timescale in the relevant review period for each action. Provide copies of current detailed plans in support of progress.

Description of Action	Timescale	By Who?	Revised Timescale (if applicable , due to delay in BC approval))	By Who?	Current Timescale at 3 months	Current Timescale at 6 months	Current Timescale at 12 months
Additional Comments (e.g. reasons for slippage on actions, together with detail of mitigating actions taken etc)							

3. Risks and Issues

Provide details of any Risks and Issues experienced. Those identified as potential risks in the original Business Case are shown below.
Note: Risks 'may' happen. Issues 'have' happened.

Identified Risk	Proposed Mitigation

Review Period	Risk or Issue (please specify)	Impact	Mitigation
3 months			
6 months			
12 months			

4. Stakeholders

Please indicate which of those Stakeholders originally identified within the Business Case (see below), retain an ongoing remit and remain key to the achievement of the Business Case benefits. Those identified may be contacted independently and given an opportunity to provide input to the review process. Key stakeholders must include Finance Managers, and their continued involvement evidenced. Add any subsequently identified Stakeholders to the list

Stakeholder	Details of consultation, support, etc.	Key Stakeholder with continued remit (Y/N)

List any Subsequently Identified Stakeholders	Details of consultation, support, involvement, etc	Key Stakeholder with continued remit (Y/N)

Provide evidence of the continued involvement of individual Key Stakeholders (e.g. letters, emails, meetings, Project Board members, Minutes of Meetings etc)

Review Period	Stakeholder Update
3 months	
6 months	
12 months	

5. Intervening Factors which have impacted on Progress

Provide details of any intervening factors, together with supporting evidence together with reasons why, which may have prevented progress as intended, e.g. Change of management team.

Review Period	Intervening Factors
3 months	
6 months	
12 months	

6. Financial Position

Please provide an update on the current financial position (usually provided by the Finance Manager), based on the Financial Summary submitted in support of the Business Case (see extract below – to be copied from the original BC) both in narrative form using the box provided for the relevant period, together with an updated Financial Summary as an attachment to this report.

Revenue		Total Change			
		Current	Revised	Change	
		£'000	£'000	£'000	WTE
(a) Non-recurring					
(b) Recurring					
Income					
	NHS Clinical Income	0	0	0	
	Non-NHS Clinical Income	0	0	0	
	Other Income	0	0	0	
	Total Income	**0**	**0**	**0**	
Expenditure					
	Pay				
	Medical			0	
	Nursing			0	
	Other (please list):				
	Executive Board & Senior Managers			0	
	Support Staff			0	
	WLIs			0	
				0	
		0	**0**	**0**	**0.00**
	Non-Pay				
	Drugs			0	
	Clinical Supplies & Services			0	
	General Supplies & Services			0	
	Other (please list):				
	Establishment Expenses			0	
				0	
				0	
		0	**0**	**0**	
	Total Operational Expenditure	**0**	**0**	**0**	
	Impact on EBITDA	**0**	**0**	**0**	**0.00**
	Depreciation			0	
	Rate of Return			0	
				0	
	Overall impact on I&E	**0**	**0**	**0**	**0.00**
	Less: Existing Provisions	**n/a**		**0**	
	Net impact on I&E	**0**	**0**	**0**	

Review Period	Financial Position (Narrative in support of the updated Financial Summary which should be attached)
3 months	
6 months	
12 months	

7. Corporate Improvement and Efficiency Joint Review - Summary

Review Period	Summary
3 months	
Recommendation:	

	Business Case Author	Corporate Improvement Team Representative	Corporate Efficiency Team Representative	Assistant Director of Resource Management	Corporate Improvement Team Programme Director
Signed					
Dated					

CIT Tracking Code:

Review Period	Summary Review
6 months	
Recommendation:	

	Business Case Author	Corporate Improvement Team Representative	Corporate Efficiency Team Representative	Assistant Director of Resource Management	Corporate Improvement Team Programme Director
Signed					
Dated					

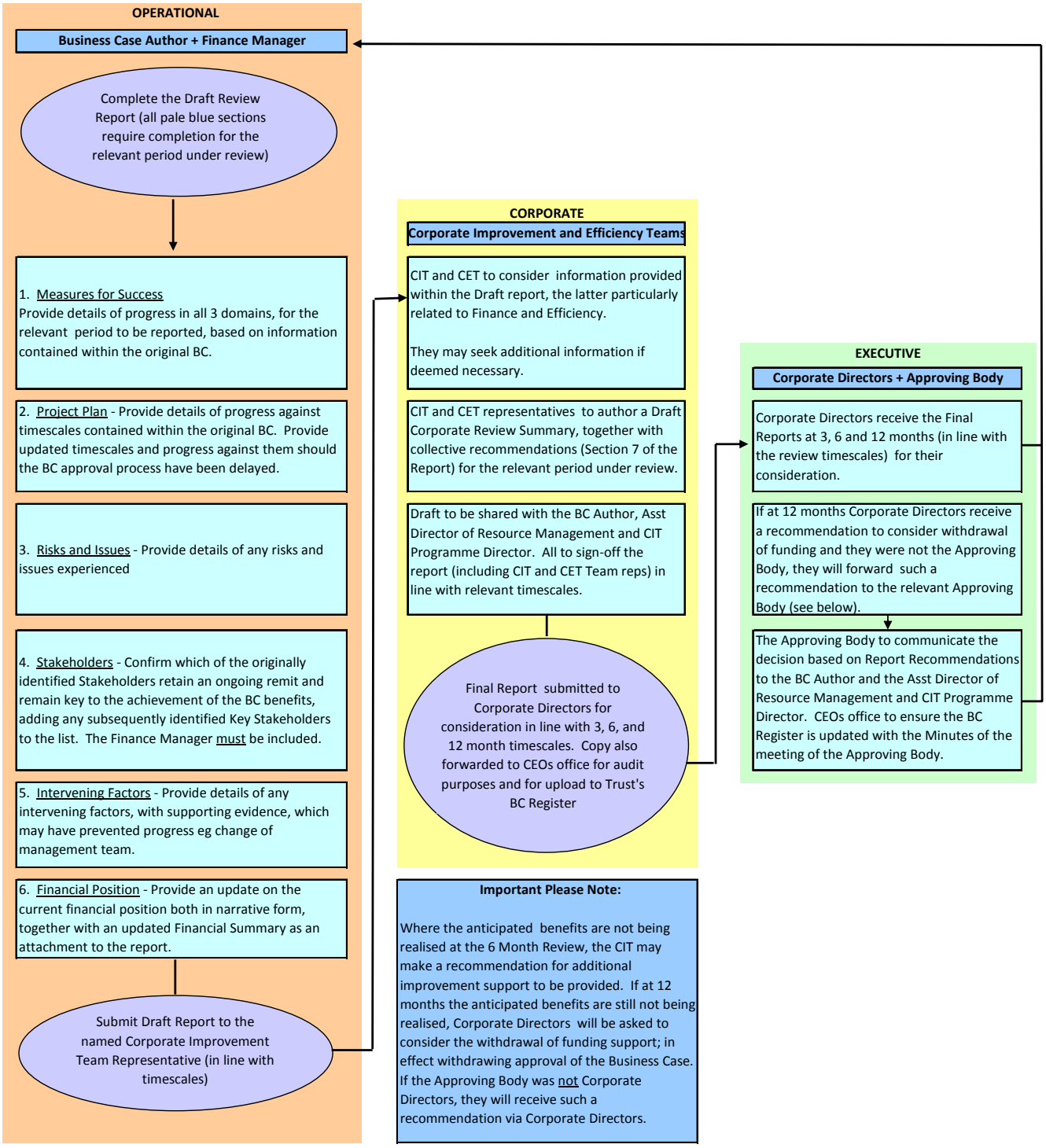
Review Period	Summary Review
12 months	
Recommendation:	

	Business Case Author	Corporate Improvement Team Representative	Corporate Efficiency Team Representative	Assistant Director of Resource Management	Corporate Improvement Team Programme Director
Signed					
Dated					

Trust Business Case - Post Implementation Review Report Process (3, 6 and 12 months)
(Please refer to the Trust's Business Case Guidance Manual and Business Case Documentation, particularly Appendix A)

The Corporate Improvement Team will issue a Post Implementation Review Report, populated by information contained within the original Business Case, for completion by the Business Case Author, together with their Finance Manager. This will occur 1 month in advance of each of the Review periods (ie at 2 months, 5 months and 11 months from the communicated date of Business Case approval, to allow submission to Corporate Directors at 3, 6 and 12 months. Each Review Report will retain the previous Report's content to enable ease of referencing. Thus the content of the reports will be cumulative in nature.

Reports **must** be completed by the stated deadline date shown on the front of the Report. All involved should be mindful of concluding any actions related to the Review eg Report drafting and completion, external contacts, meetings etc within the relevant timescale ie routinely 4 weeks).



CIT Tracking Code:

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 25 September 2013

Business Case 2013-14/183: Consultant Urologist

Action requested/recommendation

Approval of Business Case.

Summary

Business Case sets out the need to appoint a Consultant Urologist on the Scarborough site.

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

Implications for equality and diversity

Ensure paper demonstrates compliance with the public sector equality duties:

Eliminate unlawful discrimination, harassment and victimisation
Advance equality of opportunity and
Foster good relations between people who share particular characteristics and those that do not.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Corporate Directors.
Risk	No risk.
Resource implications	Resources implication detailed in the report.
Owner	Mr Glenn Miller, Clinical Director
Author	Mrs A Stanford, Directorate Manager

Date of paper	September 2013
Version number	Version 1

APPENDIX Ai

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2012-13/183

2. Business Case Title

Consultant Urologist

3. Management Responsibilities & Key Contact Point

Business Case Owner:	**Mr Glenn Miller, Clinical Director General Surgery & Urology**

Business Case Author:	**Amanda Stanford, Directorate Manager, General Surgery & Urology**
Contact Number:	**5051 / 1466**

4. Purpose of the Business Case

The aim of the business case is to support the joint appointment of a Consultant Urologist to ensure the sustainability of the Urology on call service on the Scarborough site and to improve and maintain adequate elective and outpatient capacity across both Scarborough and York sites.

With the integration of York and Scarborough Hospitals the Urology service became a fully integrated service. There are a number of cross site issues facing the Urology service:

1) There continues to be elective capacity issues on the York site, this post would undertake elective activity across both York and Scarborough. The main capacity issues are with flexible cystoscopy lists, the increasing demand is currently being met through waiting list initiatives on a Saturday on the Scarborough site and on an ad hoc basis on the York site. In full year terms, a total of £78k (& £22k YTD June '13) was spent on WLIs in 2012/13 across both sites (£51k - Scarborough site & £27k in York). This is predominantly to maintain an increasing demand for surveillance cystoscopy and an increase in fast track referrals. Currently referrals are up by 14% (118 patients) from plan.

2) There has been an overall 11% (242) increase in referrals into the Urology service on the Scarborough site April 12 to March 13 this is particularly linked to an increase in East Riding referrals. In addition there is a growing backlog of patients awaiting follow up outpatient review on the Scarborough this currently equates to 337 patients still waiting for an outpatient appointment. Although work is ongoing to reduce follow ups already within Urology there is still a significant demand on the Outpatient capacity that cannot be met with 3 Consultant Urologists. First to follow up ration for Urology on the Scarborough site is currently 1:1.85. There is also an increase in the inpatient waiting list which currently stands at 248 patients this will compromise the ability of the service to deliver on the 18 week admitted pathway target.
3) The Consultant Urologists on the Scarborough site currently undertake a 1:3 on call rota which is not sustainable, although consideration has been given to a joint on call between York and Scarborough it is felt that geographically this would be too difficult to achieve in the short to medium term. This appointment would provide a 1:4 rota.
4) There is currently no Consultant Urologist with an interest in female Urology on the Scarborough site it is therefore anticipated that this post would work in collaboration with the York based Consultant to provide a cohesive female urology service across sites.

In addition to the above the Directorate has recently appointed a Lead Clinician for the Urology service across sites and it is anticipated that they will work on the York site one day per week on a Friday. This appointment would enable backfill of the sessions dropped by the Lead Clinician to enable him to work on the York site.

The Urology Directorate are currently working up a business case for the development of a One Stop Urology service in Malton and this appointment would support this development in terms of adequate Consultant provision.

5. Options Considered

Description of Options Considered
1. Do Nothing
2. Appoint to a Locum Consultant Urologist
3. Appoint a Consultant Urologist
4. Appoint a Surgical Nurse Practitioner
5. Appoint a Speciality Doctor

6. Preferred Option

Option 1: Unable to sustain an acute on call rota 1:3 is untenable to existing Consultants. In addition the current Waiting List Initiatives would need to continue which is costly.
Option 2: A Locum would not provide a long term solution and the capacity

and on call issues identified are long term issues

Option 4: Appoint a Surgical Nurse Practitioner. Although this option has a number of benefits for the Urology service and forms part of the workforce strategy for Urology this option would not have any impact on the on-call demands currently placed on the Scarborough based Urology Consultants. However as there is no plan to expand further the Consultant numbers in Urology following this business case the workforce plan focusses on the development of non Consultant roles within this service.

Option 5: Appoint a Speciality Doctor. This post would have no impact on the on-call demands currently place on the Scarborugh based Urology Consultants

The preferred option is option 3

The appointment of Consultant Urologist has a number of benefits:

- Support the delivery of a sustainable acute 24/7 Urological service
- Support the aim to achieve a more sustainable service that improves access and enables the Directorate to deliver and national and local targets
- Supports the delivery of a One Stop Urology service
- Supports the integration of the Urology service and provides more flexibility with regard to managing variation in capacity and demand across sites.
- Allows Lead Clinician to work across both York and Scarborough sites

7. Alignment with the Trust's Strategic Objectives

Strategic Objective	Aligned? Yes/No	If Yes, how is it Aligned?
To provide safe and quality services to all patients underpinned by the specific steps set out in the driver diagram as part of the Quality and Safety Strategy. This includes developing and learning from performance indicators (e.g. PROMs, NCI, etc). Ensuring compliance with national requirements - NPSA, NICE and implementation of results of clinical audit strategies and ensuring consultation and engagement of patients, visitors and staff.	Yes	Ensures ability to deliver a safe and robust consultant delivered elective surgical service Ensure acutely admitted patients receive appropriate Consultant assessment and management, according to their need.
To provide excellent healthcare with appropriate resources, strong productivity measures and strong top quartile performance being indicative of this. The service will be based on	Yes	Supports agenda to improve patient experience and deliver safe, flexible service within the 18 week targets

'needs based care' and staff understand how they contribute to the Trust's successes.		
To be an exemplar organisation that is responsive to the local and broader community needs and is recognised and trusted. To engage fully in all aspects of community discussion relating to health and provide expert advice and leadership as required. To work with other groups to support the adoption of a consistent approach in the community and demonstrate that the Trust is a community orientated organisation able to achieve and deliver all local and national outcomes.	Yes	Supports the provision of elective surgical services out of Bridlington Hospital
To provide a safe environment for staff, patients and visitors, ensuring that all resources are used as efficiently as possible	Yes	Ensures all patients receive appropriate Consultant assessment and treatment, both acutely and electively according to the patients needs.

8. Benefit(s) of the Business Case

Detailed Description of the Benefit, including Measurable(s)	Before	After
Sustainable acute Urology on call	Unsustainable	Sustainable
Waiting List Initiatives undertaken to manage demand on a regular basis	WLI work every other Saturday at Scarborough	No WLI work required on a regular basis
National and local access and cancer targets to be improved across both York and Scarborough due to an increase in inpatient, diagnostic and outpatient capacity on both sites		
Reduction in both Outpatient and Inpatient backlogs	Outpatient FU Partial Booking 337 Inpatient backlog 70	

9. Summary Project Plan

Description of Action	Timescale	By Who?
Corporate Director approval	August 2013	
Executive Board Approval	August / September 2013	
Trust Board Approval	September 2013	

Advert for post to be placed	September 2013	Medical Staffing
Assessment Centre and Interviews to be held	October 2013	Medical Staffing
Clinics and theatre schedules to be reviewed and agreed	October 2013	Sam Peate/ Amanda Stanford/ Liz Hill
Appointment made into post	January 2014	

10. Risk Analysis:

Identified Risk	Proposed Mitigation
Unable to recruit suitable applicant into post	Consider appointment of Locum Consultant / Speciality Doctor
Reduction in referrals into the service	Reduction in the PA s of each Consultant accordingly to meet demand

11. Risk of Not Proceeding:

The risk of not proceeding with the preferred option is as follows:

- Unable to meet access targets due to significant waits for Outpatients and growing inpatient numbers

12. Consultant Impact

(Only to be completed where the preferred option increases the level of Consultant input)

12.1 Impact on Consultant Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant to a maximum of 11. This section should illustrate the impact that the additional Consultant input created will have on the average number of PAs worked in the specialty, the frequency of the on-call rota, and the PA profile across the whole specialty team. Information is also required of each Consultant's actual annual working weeks against the 41 week requirement.

	Before	After
Average number of PAs	12	12
On-call frequency (1 in)	1 in 3	1 in 4

Consultant Team Work Profile				
Name of Consultant	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**
Mr Simon Hawkyard	**41**	**41**	**12**	**12**

Mr Andrew Roberts	**41**	**41**	**12**	**12**
Mr Richard Khafagy	**41**	**41**	**12**	**12**
Mr Russ Wilson	**41**	**41**	**12**	**12**
Mr Koon Hung Chan	**41**	**41**	**12**	**12**
Mr Ben Blake-James	**41**	**41**	**12**	**12**
Mr Mustafa Hilmy	**41**	**41**	**12**	**12**
Mr Graeme Urwin	**41**	**41**	**5**	**5**
New Post	**41**	**41**	**12**	**12**

12.2 Advisory Committee Review:

The Consultant Job Planning Advisory Committee must review all proposed job plans for new consultant posts, as well as any job plans for existing consultants where the proposed new post would have an impact on current working practices. This section should provide the date that the job plans were assessed by the Committee and any comments which were made.

To be submitted by Mr Glenn Miller

13. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the business case; the extent to which each support the proposal, and where appropriate ownership for the delivery of the benefits identified above. Where external stakeholder support is vital to the success of the business case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment.

Examples of stakeholders include Lead Clinicians, support services (e.g. Systems & Network Services, Capital Planning re: accommodation), commissioners (e.g. NYY PCT), patients & public, etc.

Stakeholder	Details of consultation, support, etc.
Consultant Urologists	Discussion at Urology Directorate meetings undertaken and full support gained across both sites
Corporate Directors	Post discussed at Executive PMM and support gained for submission of BC for a permanent post
Theatres & Anaesthetic Directorates	Discussion regarding additional requirements
Outpatients	Discussion regarding additional requirements

14. Alliance Working

How does this business case support the Trust's stated objective of developing and enhancing the clinical alliance arrangements with Harrogate & District NHS Foundation Trust?

This post will not affect the current clinical alliance between York and Harrogate Urology teams and the on call arrangements will continue as per the Service Level Agreement

How does this business case support the Trust's stated objective of developing and enhancing the clinical and non-clinical alliance arrangements with Scarborough and North East Yorkshire NHS Trust, and what are the implications should the two Trusts progress with a more formal partnership?

Not applicable

15. Impact on the Ambulance Service:

	Yes	No
Are there any implications for the ambulance service in terms of changes to patient flow?		No

If yes, please provide details including Ambulance Service feedback on the proposed changes:

16. Market Analysis:

Where the business case is predicated on securing new and/or increased business (and income), detail the evidence supporting the income projections.

Additional activity associated with this BC is already included within 13/14 activity Plan/PbR tariff.

17. Estimated Full Year Impact on Income & Expenditure:

	Baseline	Revised	Change
	£000	£000	£000
Capital Expenditure	0	0	0
Income	41,579	42,066	487
Direct Operational Expenditure	21,877	22,273	396
EBITDA	19,702	19,793	91
Other Expenditure			0
I&E Surplus/ (Deficit)	19,702	19,793	91
Existing Provisions	n/a	0	0
Net I&E Surplus/ (Deficit)	19,702	19,793	91
Contribution (%)	47.4%	47.1%	18.7%
Non-recurring Expenditure	n/a		0

Supporting financial commentary:

The Income/Activity baseline figures reflected in this BC are based on General Surgery and Urology Directorate (across both sites) Income/Activity Plan 13/14. The additional activity associated with this BC has been included in the activity/income plan for 13/14 (£122k in PYT) and a provision has been made in the Financial Plans 13/14 for all of the costs (£99k in PYT) associated with this BC. This Business case is seeking to gain approval for the appointment of one additional Consultant Urologist in order to deliver level of planned activity for 2013/14. Non-Recurrent costs (£5k) relate to computer/office costs associated with the new appointment. The profile assumes start date 1st January 2014. Additional pay costs (in FYT) are: Consultant costs (based on 12 PAs incl. 5% on-call) - £115k; Nursing Costs (£8k - 0.37WTE for additional 1 outpatient clinic per week); Admin Cover (0.5WTE B3 and 0.5 B2 - £20k); Urology non-pay theatre costs incl. drugs (£102k), 2 additional LA flexi day theatre lists (£51k) and 2 additional GA main theatre lists (£89k) and costs associated with support services £15k - (£5k Medical Records; £6k Pharmacy & £4k for Domestic Service). . There is an overall contribution of £23k in 13/14 (£91k in full year terms) which will go towards GS&U's CIP.

18. Recommendation for Post Project Evaluation

	Yes	No
Is this business case being recommended for post project evaluation?	Yes	

Reason(s) for the decision:

To monitor income and activity projections to ensure delivery

19. Date:

8th August 2013

GAL/11jun2011

APPENDIX Aii

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	2012-13/183
TITLE:	Consultant Urologist
OWNER:	Mr Glenn Miller, Clinical Director General Surgery & Urology
AUTHOR:	Amanda Stanford, Directorate Manager, General Surgery & Urology

Capital

	Total	Planned Profile of Change			
		2013/14	2014/15	2015/16	Later Years
	£'000	£'000	£'000	£'000	£'000
Expenditure		0	0	0	0

Capital Notes *(including reference to the funding source)*:
There is no Capital expenditure associated with this business case.

Revenue

	Total Change				Planned Profile of Change			
	Current	Revised	Change		2013/14	2014/15	2015/16	Later Years
	£'000	£'000	£'000	WTE	£'000	£'000	£'000	£'000
(a) Non-recurring			5		5			
(b) Recurring								
Income								
NHS Clinical Income	41,288	41,774	487		122	487	487	487
Non-NHS Clinical Income	101	101	0		0	0	0	0
Other Income	191	191	0		0	0	0	0
Total Income	**41,579**	**42,066**	**487**		**122**	**487**	**487**	**487**
Expenditure								
Pay								
Medical (incl Jnr Doctors)	8,775	8,890	115	1.00	29	115	115	115
Nursing (1 Outpatient Clinic)	7,474	7,482	8	0.37	2	8	8	8
Other (please list):								
Admin (0.5 B3 Secretary and 0.5 wte B2 Audio Typist)	831	851	20	1.00	5	20	20	20
Medical Records (£1.8 per record) + Outpatients Dept		4	4		1	4	4	4
Pharmacy (0.2 wte B8a)		6	6	0.20	2	6	6	6
Theatre Costs (2 Day lists & 2 Main Theatre Lists) - WTEs		140	140	4.46	35	140	140	140
Waiting List	186	186	0		0	0	0	0
Vacancy Factor	-199	-199	0		0	0	0	0
	17,067	**17,360**	**293**	**7.03**	**73**	**293**	**293**	**293**
Non-Pay								
Drugs	1,263	1,288	25		6	25	25	25
M&S Maintenance	4,875	4,946	71		18	71	71	71
Contingency Non-Pay	0	2	2		1	2	2	2
Other (please list):								
Linen/Waste/Catering	0	4	4		1	4	4	4
CIP	-1,328	-1,328	0		0	0	0	0
	4,810	**4,912**	**102**		**26**	**102**	**102**	**102**
Total Operational Expenditure	**21,877**	**22,273**	**396**		**99**	**396**	**396**	**396**
Impact on EBITDA	**19,702**	**19,793**	**91**	**7.03**	**23**	**91**	**91**	**91**
Depreciation			0					
Rate of Return			0					
			0					
Overall impact on I&E	**19,702**	**19,793**	**91**	**7.03**	**23**	**91**	**91**	**91**
								+ favourable (-) adverse
Less: Existing Provisions	**n/a**							
Net impact on I&E	**19,702**	**19,793**	**91**		**23**	**91**	**91**	**91**

Revenue Notes *(including reference to the funding source)*:
The Income/Activity baseline figures reflected in this BC are based on General Surgery and Urology Directorate (across both sites) Income/Activity Plan 13/14. *The additional activity associated with this BC has been included in the activity/income plan for 13/14 (£122k in PYT) and a provision has been made in the Financial Plans 13/14 for all of the costs (£99k in PYT) associated with this BC*. This Business case is seeking to gain approval for the appointment of one additional Consultant Urologist in order to deliver level of planned activity for 2013/14. Non-Recurrent costs (£5k) relate to computer/office costs associated with the new appointment. The profile assumes start date 1st January 2014. Additional pay costs (in FYT) are: Consultant costs (based on 12 PAs incl. 5% on-call) - £115k; Nursing Costs (£8k - 0.37WTE for additional 1 outpatient clinic per week) Admin Cover (0.5WTE B3 and 0.5 B2 - £20k); Urology non-pay theatre costs incl. drugs (£102k), 2 additional LA flexi day theatre lists (£51k) and 2 additional GA main theatre lists (£89k) and costs associated with support services £15k - (£5k Medical Records; £6k Pharmacy & £4k for Domestic Service). . There is an overall contribution of £23k in 1

	Owner	Finance Manager	Board of Directors Only Director of Finance
Signed	**Glenn Miller**	Sanya Basich	
Dated	**8th August 2013**	8th August 2013	

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2013/14	2014/15	2015/16	Later Years
Elective (Spells)	21,236	21,892	656	164	656	656	656
Non-Elective (Spells)							
Long Stay	7,645	7,645	0	0	0	0	0
Short Stay	111	111	0	0	0	0	0
Outpatient (Attendances)							
First Attendances	19,206	19,964	758	190	758	758	758
Follow-up Attendances	35,727	36,746	1,019	255	1,019	1,019	1,019
A&E (Attendances)			0	0	0	0	0
Other (Please List):							
Outpatient Procedures	4,173	4,173	0	0	0	0	0
			0	0	0	0	0

Income

	Total Change			Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	Later Years £'000
NHS Clinical Income							
Elective income							
Tariff income	17,721	18,037	317	79	317	317	317
Non-Tariff income			0				
Non-Elective income							
Tariff income	16,558	16,558	0	0	0	0	0
Non-Tariff income			0				
Outpatient							
Tariff income	5,478	5,648	170	43	170	170	170
Non-Tariff income			0				
A&E							
Tariff income			0				
Non-Tariff income			0				
Other							
Tariff income	464	464	0				
Non-Tariff income	1,067	1,067	0	0	0	0	0
	41,288	**41,774**	**487**	**122**	**487**	**487**	**487**
Non NHS Clinical Income							
Private patient income			0	0	0	0	0
Other non-protected clinical income	101	101	0				
	101	**101**	**0**	**0**	**0**	**0**	**0**
Other income							
Research and Development			0				
Education and Training			0				
Other income (direct credit)	191	191	0	0	0	0	0
	191	**191**	**0**	**0**	**0**	**0**	**0**