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 26th November 2014**
in: **The Boardroom, York Hospital**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Therapists Resource Room	Non-executive Directors
9.15am – 12.00 Noon	**Board of Directors meeting held in public**	**Boardroom**	**Board of Directors and observers**
12.05pm – 1.00pm	Board of Directors to consider confidential information held in private	Boardroom	Board of Directors
1.05pm-1.55pm	CQC Regulatory update concentrating on the Duty of Candour Delivered by Andrew Davidson and Steven Evans from Hempsons LLP	Boardroom with working lunch	Board of Directors
2.00 – 4.00pm	Remuneration Committee	Boardroom	Non-executive Directors

The values, drivers and motivations of the Trust are:

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

These will be reflected during all discussions in the meeting

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 26th November 2014**

At: **9.15am – 12.00 Noon**

In: **The Boardroom, York Hospital**

A G E N D A					
No	**Item**	**Lead**	**Comment**	**Paper**	**Page**
Part One: General **9.15am – 9.40am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for Absence** • Beverley Geary	Chairman			
3.	**Declaration of Interests** To receive any changes to the register of directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chairman		A	7
4.	**Minutes of the Board of Directors meeting held on 30th October 2014** To review and approve the minutes of the meeting held on 30th October 2014.	Chairman		B	11
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman			
6.	**Patient Experience** "Hello my name is….. " update	Emma Day – Assistant Director of Nursing			

No	Item	Lead	Comment	Paper	Page
Part Two: Quality and Safety 9.40am -10.15am					
7.	**Quality and Safety Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Patient Safety Dashboard • Medical Director Report • Chief Nurse Report • Safer Staffing • Pressure Ulcer Reduction Plan update	Chairman of the Committee		C C1 C2 C3 C4 C5	27 35 61 69 75 83
8.	**Annual Director of Infection Prevention and Control Report** To receive for approval the annual and quarterly reports from the Director of Infection Prevention and Control.	Medical Director		D	95
Part Three: Finance and Performance 10.15am – 11.00am					
9.	**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		E E1 E2 E3	119 127 137 149
10.	**Procurement update** To receive an update report on procurement	Finance Director		F	161
Part Four: HR issues 11.00am-11.10am					
11.	**Living Wage** To receive an update on the Living Wage	Director of Corporate Development and HR	Philip Ashton	G	173

No	Item	Lead	Comment	Paper	Page
Part Five: Estates and Facilities 11.10am- 11.20am					
13.	**H&S Annual Report** To receive the annual report	Director of Estates and Facilities	Mike Sweet	H	177
Part Six: Community Services/ Integration Developments 11.20am- 11.30am					
15.	**Community Services** To provide and update on the progress of the introduction of the Community Hubs	Deputy Chief Executive			
16.	**Integration developments** To provide an update on any other developments around integration across the local health and social care system	Deputy Chief Executive			
Part Seven: Governance 11.30am-11.50am					
17.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		I	193
18.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		J	197
19.	**Governance Review update** To receive an update on the governance project	Director of Corporate Development and HR	Dianne Willcocks	K	200
Any other business					
20.	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 28th January 2015 in the Boardroom York Teaching Hospital.				

No	Item	Lead	Comment	Paper	Page
21.	**<u>Any other business</u>** To consider any other matters of business.				

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

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

Register of directors' interests
November 2014

York Teaching Hospital NHS
NHS Foundation Trust

Additions: No changes

Changes: No changes

Deletions: No deletions

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

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

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

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Board Room, The York Hospital, on 29th October 2014

Present:	**Non-executive Directors**	
	Mr A Rose	Chairman
	Mrs J Adams	Non-executive Director
	Mr P Ashton	Non-executive Director
	Mr M Keaney	Non-executive Director
	Ms L Raper	Non-executive Director
	Mr M Sweet	Non-executive Director
	Professor D Willcocks	Non-executive Director
	Executive Directors	
	Mr P Crowley	Chief Executive
	Mrs B Geary	Chief Nurse
	Mrs S Holden	Executive Director of Corporate Development & HR
	Mr M Proctor	Deputy Chief Executive, Chief Operating Officer
	Dr A Turnbull	Medical Director
	Corporate Directors	
	Mrs S Rushbrook	Corporate Director of Systems and Networks
Attendance:		
	Mrs A Pridmore	Foundation Trust Secretary
	Mr S Petty	Chaplain for item 14/145
Observers:	Mr R Hyde	Member of the public
	Mrs M Jackson	Governor for York
	Mrs S Miller	Governor for Ryedale and East Yorkshire
	Mrs J Moreton	Governor for Ryedale and East Yorkshire
	Mr P Baines	Governor for York
	Mrs J Anness	Governor for Ryedale and East Yorkshire
	Mrs L Pratt	Chair of HealthWatch York

14/144 Apologies for absence

Apologies were received from Mr A Bertram, Executive Director of Finance and Mr B Golding, Corporate Director of Estates and Facilities

The Board congratulated Mrs Geary on her appointment as Chief Nurse and welcomed her to the Board.

14/145 Patient Experience – Chaplain Rev. S Petty

Rev. Petty described to the Board the involvement of the Chaplaincy in patient experience. Rev. Petty is moving to a new Trust in December and the Board thanked him for the significant contribution he and his extended team of staff and volunteers have made to the Trust during his tenure.

14/146 Declarations of Interests

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

14/147 Minutes of the meeting held on the 24th September 2014

Ms Raper asked for correction to be made to minute 14/136 -- Audit Committee key issues. She asked that the minutes be adjusted to include the comment that this adjustment will give greater connectivity between the committees. The Board **agreed** with the amendment. The reminder of the minutes was approved as a true record of the meeting.

14/148 Matters arising from the minutes

Workforce Mitigation

Following the discussion at the last Board of Directors, Mrs Holden presented the workforce mitigation paper for discussion.

Mrs Holden outlined the broad picture of the elements that are creating the challenges around workforce issues. She commented that these issues are not just local issues, but are reflected nationally. Mrs Holden added that these issues are requiring the organisation to think differently about how to use technology, how to be innovative so as to develop individuals and processes differently and requiring the organisation to challenge itself around the decisions it makes about the delivery of services. Fundamentally, it is about making sure that the right people are looking after the right patients at the right time.

Mr Ashton commented that he welcomed the paper and was very supportive of comments made by Mrs Holden. He did feel that the key aspects in the paper were around training and development and ensuring that the organisation maintained the right skill mix and employed the best people for the job.

The Board agreed with his comments and Professor Willcocks added that a further area of intervention that could be included was health and wellbeing. She added that she felt this paper presented a challenge to the Workforce Strategy Committee and obviously remained of concern to the whole Board. Mrs Holden agreed to add health and wellbeing to her paper.

Action: Mrs Holden to update her paper and incorporate health and wellbeing into the paper.

It was also agreed the paper would be included in the discussions being held at the next Workforce Strategy Committee meeting.

Action: Mrs Holden to take the paper to the next Workforce Strategy Committee meeting.

Ms Raper enquired if the paper extended to clinical staff too. Mrs Holden confirmed it extended to all groups of staff.

Dr Turnbull supported the paper and added that the requirement to move to seven day working is integral to this and impacts on flexible working and job planning. Dr Turnbull added that maternity leave is becoming a more significant factor with clinicians, as a larger proportion of trainees are female. Mrs Holden added that the other element is the age profile of the workforce.

Mr Crowley explained that the paper is about setting the context for the workforce plan. Mr Crowley asked for an update on the use of NHS Professionals. Mrs Holden advised that the Trust had given notice to NHS Professionals and would cease to use them from April 2015. Mr Rose asked why the Trust would not be using NHS Professionals in future. Mrs Holden explained that it had been the plan to create an in-house bank of staff for some time; this will allow the Trust to connect more closely with existing staff and reduce possible safety issues that could arise from using staff who are not generally part of the organisation. She added that this had been anticipated as part of the Integration Plan.

The Board **noted** the content in the paper and the agreed actions.

14/149 Quality and Safety Committee

Ms Raper referred to the Patient Safety and Quality report and confirmed that the Committee was still carefully watching the maternity dashboard, where there are still a number of areas giving rise for concern, particularly around staffing.

SHMI - Ms Raper advised that she would like to ask Dr Turnbull to comment on the Summary Hospital Mortality Indicators (SHMI) that had been recently published. She explained that the Committee shared Dr Turnbull's disappointment at the results. Dr Turnbull confirmed that the results (a very slight increase) were disappointing. He tabled a document that provided details of the latest SHMI. The report showed the Trust SHMI for the period April 2013 to March 2014 was 99.4. This represented a slight increase from 97.6 in the previous reporting period. Dr Turnbull explained that the figure indicates that the Trust does not have 'excess deaths' over and above those expected, and does show that 17 lives were "saved".

Dr Turnbull added that, despite the increase in the SHMI index score, the absolute number of observed deaths at the Trust fell from 2,999 to 2,913 and there was a reduction in the number of cases overall, down by 293 to 75,813 -- giving a crude mortality rate of 3.8%.

Dr Turnbull added that community hospitals are not captured as yet in the SHMI information, but weekly review meetings do take place and he is assured about the quality of care being given in the community hospitals. He added that each site has clinical governance reviews that look at mortality.

Dr Turnbull explained that there are some medical conditions that have been highlighted from the report and these are being specifically investigated, as they are seen as having a higher than expected number of deaths. He explained that the investigations will include reviewing the coding that has taken place.

Mrs Rushbrook added that a lot of work has been undertaken to improve coding and she is very pleased that coding now captures co-morbidities, but there is more work to improve the coding of patients who have left the hospital and not died.

Mrs Rushbrook added that the GPs are being asked to use the Core Patient Database (CPD) system used in the Trust, although they are keen to use their own system. Such a move would help with the information used by the Trust in the community. Dr Turnbull suggested that the use of CPD should be made mandatory.

Dr Turnbull provided the breakdown of the SHMI; York in this reporting period had a SHMI of 95 and Scarborough 107. This gives a Trust SHMI of 99. Dr Turnbull went on to suggest that it is possible that the disparity between York and Scarborough sites was being investigated, but might be related to the quality of care given.

Dr Turnbull advised that he would take the monthly trend to the Quality and Safety Committee to ensure the Trust remains sighted on the issue.

Action: Dr Turnbull to bring monthly trends on mortality data to the Quality and Safety Committee

Serious incidents – Ms Raper commented that the Committee had discussed serious incidents (SIs) at it last meeting and had been made aware that the Trust has a particularly robust approach to serious incidents and could be seen as over-reporting, but in the Committee's view this was the right thing to do. Dr Turnbull added that the metrics are used by the CCG and the regulators will not regard high reporting as unusual or inappropriate.

Patient Experience Report – Ms Raper commented on the report being revised and a new format of the report being available at the next quarter, as Kay Gamble settles into her new role.

Information Governance – Ms Raper asked Dr Turnbull to comment on the information governance issue. Dr Turnbull advised that there had been two recent information breaches: One related to a loss of a ward handover list in the hospital grounds; it was found by a member of staff and no further damage was caused by the incident. The second related to a member of staff inappropriately accessing patient records. This has resulted in the individual being dismissed. The Information Commissioner will be informed and it is anticipated that the Commissioner will be satisfied that the breach has been contained.

Dr Turnbull added that as a result of the loss of the ward list, staff have been reminded not to take ward lists out of the ward areas. It had also been agreed to put bins at the reception entrance to remind staff to dispose of lists before they leave the building. The Board asked for an explanation as to why ward lists were printed. Mrs Rushbrook explained that it was an aid to ensure the member of staff had undertaken the tasks that needed to be completed. She added that staff add to the information on the list and at the end of the shift update the patient record. She added that in an attempt to reduce or prevent the printing of ward lists, each ward has a laptop to update the patient record. It was agreed that as the Trust continues to move away from the use of paper, the incidents of printing ward lists would diminish.

The Board **noted** the update and the assurance given.

Chief Nurse Report – Ms Raper asked Dr Turnbull if he would outline the issues to the Board around the Cheshire West ruling and the implications for the Trust around the Deprivation of Liberty (DOLs) legislation.

Dr Turnbull outlined the issues and explained that the Cheshire West ruling (which was made as a result of circumstances in a community setting, not an acute setting) will have significant implications for the Trust. The ruling could affect those groups of patients where the Trust is unable to let the patient leave the premises for a clinical reason. In these circumstances, the Trust would need to complete the process to satisfy the DOLs requirements.

The issue is very complicated and at present there is no guidance to support the organisation to work through the implications.

It was **agreed** that this item should be brought back to the Board at a future meeting. The Board was advised that a presentation from the legal advisors had been arranged for the December Board meeting.

Professor Willcocks commented that HealthWatch were reviewing hospital discharges as part of their work programme this year, so it would be useful to link this into their review. It was **agreed** that would be a helpful approach.

Acuity Audit – Ms Raper referred to the acuity audit included in the papers and asked Mrs Geary to explain the background to the outcome of the audit. Mrs Geary explained the background to the audit and advised that the audits that had been undertaken had not provided satisfactory results. After the first audit was run in July, further training was given to staff and a second audit was run. Again, the data that came out of the audit was not satisfactory. Since those audits have taken place, and following the discussion at the Quality and Safety Committee, some further facts have been established. Mrs Geary explained that there is now a better understanding of the data; the first audit was undertaken manually and the second audit was undertaken electronically and supported by IT, but the model suggested that night staff were not needed in some key areas. This has helped explain some of the interpretation of the model and the tables sitting behind the model. It has also been established that the tool is not validated for use in sensitive areas such as the High Dependency Unit (HDU) or Intensive Care Unit (ITU)

As a result, a number of actions have been agreed; this formulates a plan going forward. Mrs Geary explained that she is already working closely with the HR team to review the work undertaken previously around acuity; this will allow the Trust to confirm the staffing models being used and will include reviewing the use of professional judgement.

Mrs Geary explained that she has arranged that a further audit will be run at the beginning of November and will be supported by the Patient Safety Team. Work is also underway to review the functionality of the Electronic Staff Record system (ESR) and the possibility of introducing a further model. Finally, a new validation system has been introduced which will require final validation and sign-off by the Chief Nurse.

Mrs Geary added that he Quality and Safety Committee has agreed to hold an extra meeting in December specifically to review these issues.

Ms Raper added that the Committee does feel more reassured by the actions that have been put in place and by the additional understanding of the limitations of the tool.

Mr Rose summarised the discussion by confirming the link between the analysis of the levels of acuity and the typical level of staffing the Trust would expect to put in place in each ward setting.

Dr Turnbull added that there was a caveat in that the tool may underestimate the requirements for staffing at night.

Mrs Holden commented that exploiting the ESR module would support the consistency of information; at present information is provided from different points, so does run the risk of not being consistent.

The Board **noted** the comments, were assured by the plan being put in place and looks forward to receiving further report at the December meeting.

Junior Doctors – Ms Raper commented that Dr Turnbull had raised with the Committee the recent concerns raised by junior doctors about senior level cover. Dr Turnbull explained the issue and advised that action had been taken in the short-term to resolve the concern. The action included employment of a locum doctors to undertake the on-call night work. Further work is being undertaken to find a more permanent solution.

Safer Staffing – Mrs Geary advised that each month the Trust is required to provide a report to the Board on safer staffing. She explained this month's report had been discussed in detail at the Quality and Safety Committee and was available for the Board. She advised that the paper does contain significant additional information and will be available as usual on the website.

Action: Mrs Geary to circulate the paper outside the Board meeting.

The Board **noted** the report and the discussions held at the Quality and Safety Committee.

14/150 Infection Prevention Control Quarterly Report

Dr Turnbull presented the report and outlined the key points for the Board. He reported on the C-Diff position and highlighted that the Trust was below trajectory in the number of cases that had been reported for the year so far, but in September the Trust had exceeded the monthly trajectory of five cases. As a result, a further review is being undertaken and increased compliance with prescribing of antibiotics is being demanded, along with the prescribing of pro-biotics.

Dr Turnbull advised that the Trust had closed a ward due to an outbreak of Norovirus this week. He advised that he was working with the media to ensure the usual consistent message is sent to members of the public.

In terms of antimicrobial resistance, 7% of E-Coli strain is now resistant to antibiotics; this is becoming a significant risk nationally. Methicillin-Sensitive Staphylococcus Aureus (MSSA) is above trajectory and work is underway to review the reasons for this; the Trust has also put in place a nurse specialist to manage lines. Finally, the Trust has launched its 'flu campaign. 16% of staff have received a vaccination since the start of the campaign. The flu trolleys will be visiting all departments across the Trust, including today's visit for Board members to be vaccinated.

Dr Turnbull advised that he is required to inform the Board of the state of preparedness of the Trust with regards to Ebola. Dr Turnbull reminded the Board that cases of Ebola have been found beyond Africa -- in Europe as well as America. He advised that the Trust is set to ask the three key questions of ED attendees and has acquired some personal protective equipment (PPE). He explained that testing for masks was underway and there were clear routes of contact locally. A task and finish group has been established to ensure the Trust is fully prepared.

The Board asked if there were isolation facilities at all sites. Dr Turnbull explained that isolation facilities only exist at two sites: York and Scarborough, where the emergency departments are. He added the Bridlington Minor Injuries Unit (MIU) do not receive such patients.

Mr Rose commented that he had heard in the media that there had been a request that all hospital Trusts should consider sending a doctor to West Africa; did the Trust have anyone that was going? Dr Turnbull advised that he understood there was a doctor who may be going.

The Board **approved** the quarterly Infection Prevention Control Report.

14/151 "Being Open" Policy

Dr Turnbull advised that the policy had been presented to the Board as a draft for comment. The redevelopment of the policy was as a result of an internal audit report recommendation, along with the introduction of the Duty of Candour. Dr Turnbull explained the different between "being open" and the Duty of Candour.

Professor Willcocks referred to the training information and made the observation that the policy stated there was no formal training. She suggested that the principles of the policy should be added to all training programmes. Dr Turnbull agreed with the suggestion and confirmed he would have it included.

Mrs Adams reflected on the link with the policy and the National Learning and Reporting System (NLRS) report included in the papers. She commented that the NLRS report reflects the size of the challenge the policy will be required to cover.

The Board discussed the workload and received assurance from Dr Turnbull that although it would increase the workload, family liaison officers were being introduced and they should be able to manage the workload. He added that the challenge is in making sure that the documentation is kept up-to-date.

The Board asked if the policy was consistent with the Serious Incident Policy. Dr Turnbull confirmed that was the case.

Dr Turnbull added that he would expect CQC to be sighted on this issue when they visit the Trust in March, so an important aspect of embedding the policy is making sure staff are aware of it and use it.

The Board considered the policy and **agreed** it was at an advanced stage of development and should be approved by the Board at this stage. Board members were requested to send any further comments directly to Dr Turnbull.

The Board **approved** the policy.

14/152 Quality Governance Framework

Mrs Pridmore presented the document and explained that the document was a development from the previous version approved by the Board during the acquisition of Scarborough and North East Yorkshire Healthcare NHS Trust. She advised that the document had been consulted on widely during the process and was presented to Board on this occasion for final approval by the Board.

Mrs Holden commented on the governance structure included in the report and asked the Board to note that the structure reflects a particular point in time. The current governance review will be examining the structure and any amendments will be made to the document will be included in the next version.

Mr Rose asked if the document would be updated on an annual basis. Mrs Pridmore confirmed that was the expectation.

The Board **approved** the Quality Governance Framework.

14/153 National Cancer Patient Survey

Professor Willcocks commented that the report showed lots of good news. She noted that the survey had received a high response rate and it was clear that the care was responsive, proactive and the quality was good. She noted the recommendations included in the report and agreed with them.

Mrs Geary reinforced the comments made by Professor Willcocks and suggested that the Trust should be celebrating the achievements.

Mr Rose asked Mr Crowley to confirm where the Board should send its congratulations. Mr Crowley suggested it should go to the Cancer Board and from there it would be circulated to the various departments.

Action: Mr Rose to write a letter on behalf of the Board congratulating the staff involved in the excellent survey results.

14/154 Finance and Performance Committee

Mr Keaney reminded the Board that he had now taken on the Chairing of the Committee. Mr Keaney provided the highlights from the Committee.

Efficiency Report – Mr Keaney reminded the Board of the £24m target, of which the Trust has delivered £13.3m to date. He reminded the Board that there is a £1.7m in-year planning gap and the achievement of the target is continuing to get harder. He added that the Committee had understood that efficiency panels were being run and Directorates such as General Medicine and the Emergency Department in Scarborough would be having their panels shortly.

Mr Rose asked if the appointment of a number of new Directorate Managers had created a delay in achieving some of the efficiencies. Mr Crowley confirmed that the change in

Directorate Management had been less disruptive than might have been the case, because of the constant engagement and support that had been given.

Mr Crowley added that the national context that was outlined in the King's Fund piece that was recently published shows the balance of the challenges for all organisations is very difficult.

Mr Keaney referred to the risk rating document presented to the Committee. He outlined the importance of the document and the value the Committee will place on it.

Access Targets – Mr Keaney commented that the Trust had failed the 18 week target as expected, due to the current amnesty that is in place nationally, and the 14 day breast cancer target has not been achieved, but improvements have been made since the service was relocated. The Emergency Department target has been failed, but the Committee was advised about a 4 hour turn-round group that had been put in place. Mr Keaney asked Mr Proctor if he would comment on the group and inform the Board of the purpose of the group.

Mr Proctor referred to the 18-week target. He advised that at present there has been no impact on the backlog, but the additional work will start to impact on the backlog. There has been some discussion with staff groups around pay rates. The Trust tries to be as consistent as possible. These additional payments have only been possible because the Trust is paid at tariff-plus for the extra work.

Mrs Holden added that a clear message has gone out to the Directorates to remind them that any issues around payment should be raised as part of the Performance Management Meetings (PMMs).

Mr Crowley commented that some middle-grade doctors have identified that they can work a locum shift at another Trust and receive a higher level of pay, rather than undertaking extra work in York or Scarborough.

It was agreed that this was a further issue that should be discussed with the Workforce Strategy Committee.

Action: The Workforce Strategy Committee should discuss the pay rates at the next meeting.

Mr Proctor referred to the 4-hour turnaround group. He explained this group was largely about getting stakeholders together to collectively engage in resolving the issues. In Scarborough, the Fresh Start project has three main strands – the first is about ensuring the bed managers are given as much notice as possible that a patient will be admitted. The second strand is about ensuring patients that can be discharged are identified as early as possible and the paperwork is completed as quickly as possible. The third strand is about the resilience measures; these are all being used in York. Mr Proctor added that he expected the Trust to achieve the target by quarter 4, for all types, although he added that there have to be caveats that could cause more problems. The Board was reminded that it is important to remember that the achievement of the 4 hour target is a whole system approach, and is affected by the situation in the downstream wards. Part of the improvement work includes ensuring discharges are arranged earlier in the day and that there is better use the discharge lounge.

Ambulance handover – Mr Keaney referred to the concerns around the ambulance turn round times in Scarborough – he added that the view seems to be that Scarborough needs the same facility as the York Emergency Department. Mr Proctor explained that historically Scarborough has not had an issue with ambulance turn round times; much has happened at Scarborough that affects the area, including a reduction of the number of beds during the building phase of Maple 2 (Lilac Ward). He explained that he would like to understand the impact of the temporary changes before committing the Trust to spending further capital that may prove unnecessary.

Commissioning for Quality and Innovation (CQUIN) – Mr Keaney asked Dr Turnbull to comment on the Dementia & Delirium and the 12 hour review CQUINs.

Dr Turnbull advised that the Trust had failed Q1, but had achieved Q2.

In terms of the 12 hour review target, this is proving problematic at Scarborough and there is a concern that it is impacting directly on the quality of care. He added that the trajectory is very difficult to achieve.

Finance Report – Mr Keaney explained that he was keen to understand the size of the amount spent around agency staff, where it was and what can be done about it.

Mrs Holden advised that in April 2014 the spend was 4.29% of the pay bill, but in September it had increased to 6.18% across the Trust. She explained that the majority is medical staffing. The vacancy rate in York is 5.13%; 8.8% for specialist doctors, and 8% related to SHO level. In Scarborough the vacancy rate is 14.46%; 30.13% for Specialist doctors and 15.34% for consultant vacancies. She added that this is an indication of the whole workforce challenge that exists. The spend on agency in April 2014 was £565,680 and by September it had risen to £1,049,310. Medical elderly and acute in York were two areas that have not historically used agency staff, but in the last two months they have started to use them; some of this is as a result of the number of staff on maternity leave. She commented that at this stage work is being undertaken to address the issues; she added that despite the vacancy rate the Trust is still providing excellent and safe care. As discussed earlier in the meeting, this is a reflection of the national picture. The Board discussed the options and agreed redeployment of the staff was one option that should be reviewed, along with the development of key roles, such as the Advanced Care Practitioners (ACPs). Mrs Holden assured the Board that she and the other Directors are aware of the risks and are actively managing them. The Board accepted her comments, but remained concern about the position.

Tenders- Mr Keaney asked if there was any further information to provide to the Board around the outstanding tenders. Mr Crowley advised that there was nothing specific to add at this stage. He advised that the City of York (Out-of-hours) tender was being submitted during the week; the Clifton Park tender had been submitted.

Mr Keaney advised that the report showed a deficit of £1.9m, which takes into account the ambulance penalty charges of £600,000, which are currently in the process of being agreed by the CCG.

Mr Sweet added that while the trading in August was typically low, it had been expected that the position would improve in September; this had not happened, therefore activity and revenue had been lower than expected last month.

Mr Crowley commented that one month of reduced activity is unlikely to affect the final year position.

The Board **agreed** with the comments made.

14/155 Workforce Strategy Minutes

Professor Willcocks summarised the minutes and outlined the work being undertaken.

She highlighted the work being undertaken by the Committee, specifically the increased membership of the Committee and the learning hub work. Professor Willcocks referred to the health and wellbeing work that is going on and its importance around ensuring staff feel valued and staff self-monitoring their health. Professor Willcocks referred to the report provided to the Committee by Mrs Scott around Community and advised that York and Scarborough GPs have different expectations on what work the community nurses should be doing compared to the expectations of the Trust.

Professor Willcocks also advised that it had been agreed that the Committee would meet every two months instead of quarterly, to help address the workload issues and in response to the number of important issues it is tackling.

The Board **noted** the report.

14/156 Human Resources Strategy Quarterly Report 1 April 2014 – 30 June 2014

Mrs Holden advised that the report had been changed and would in future follow a theme; the next theme is an aging workforce and a description of how the Trust is engaging the challenge of establishing a younger workforce. She also advised that she has reviewed the functioning of the recruitment team and is considering centralising the recruitment team across the two main sites. Mr Crowley supported the work that Mrs Holden was undertaking and explained that he had been frustrated that the recruitment had not been centralised in the organisation. Professor Willcocks added that she felt it would improve the specifications for all roles and ensure there were complementary skills in the organisation.

The Board **agreed** that the proposal should be developed and Mrs Holden should progress with centralising the recruitment function.

Mrs Holden referred to the information included in the report around nurse education and explained that the table shows why there is a need to invest differently in education. She added that currently there is no clear career development framework for non-registered staff.

Mr Sweet complimented the report and welcomed the introduction of a theme. He suggested that a future theme should be the challenge around nursing recruitment and absolute numbers. Mr Sweet welcomed the innovative approach the Trust is taking to overseas recruitment the intention to introduce an in-house bank across the Trust and, centralising of recruitment, but was concerned that the prospect of recruiting from overseas was taking longer than had been envisaged.

Mrs Holden advised that progress of linking with NLAG around the overseas recruitment had been deferred by the Board at NLAG; therefore the Trust was now talking directly to the company involved. She added that there is a balance to consider when recruiting staff from overseas; experience from elsewhere has shown that there is a need to provide cohort accommodation and pastoral care after the initial recruitment investment.

Mr Rose asked Mrs Geary if she had been involved in such a large recruitment of overseas staff before. Mrs Geary confirmed she had not been personally involved before, but the NLAG recruitment had been successful and she had recently been made aware that Harrogate had recruited 25 overseas nurses 6 months ago. She added that some of the recruitment has been successful, but some staff have then moved on elsewhere. She added that there is a lot of pastoral support needed to make it a success, including offering 3-months free accommodation.

The Board **noted** the work being undertaken and the challenges ahead. The Board **confirmed** it was supportive of the proposal to centralise the recruitment process.

14/157 Education Strategy

Mrs Holden presented the paper and explained that it represented a comprehensive approach. She added that the there were challenges around the funding model in use, which needed to be addressed. She asked the Board to consider what metrics it would like reported to the Board on a regular basis. Mrs Holden proposed that she would present a quarterly report on HR, education, R&D, and the OD strategy.

The Board asked if education was now integrated across the Trust. Mrs Holden confirmed that it was. She added that the multi-professional approach around education still required some further work. Work had started prior to acquisition with Scarborough and continues now; the Trust has a simulation suite which is being developed to utilise to support learning from serious incidents.

She added that there is a further strategy around leadership which she will bring to the Board for information.

Action: Mrs Holden to provide a copy of the leadership strategy to the Board.

14/158 Fit and Proper Person Test

Mrs Adams presented the paper and reminded the Board that Monitor introduced a fit and proper person test some time ago, but the new CQC test does cover more staff. She advised that work is underway to discover who should be covered. She added that it is the Board's responsibility to ensure the criteria is satisfied and must be formally reported each year. Mrs Pridmore suggested that the formal reporting should be included in the Annual Governance Statement, which is signed off by the Trust at the end of the financial year.

Mr Rose asked if compliance with the code is included in the recruitment process. Mrs Holden confirmed that it was. Mrs Holden added that it was being embedded into the recruitment process and revised contracts for both Executive and Non-executive Directors were being put in place. The Executive contracts will be in place once the portfolios have been agreed and the specific job descriptions have been completed.

The Board **noted** the key elements in the paper.

14/159 Report of the Chairman

Mr Rose referred to the recent paper published by Mr Simon Stevens and advised that more consideration of the detail will take place at the time-out. He added that part of its expectation is that acute Trusts will work more closely with primary care.

Mr Rose congratulated Mrs Geary again and advised that the Trust had also appointed a Chief Operating Officer – Juliet Walters; her start date had not as yet been agreed.

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

14/160 Report of the Chief Executive

Mr Crowley commented on the recent investigation undertaken by Monitor. He commented that he was disappointed that the organisation had been sucked into the process, but having been in that position the Trust had participated fully and derived as much out of it as possible. He advised that it had had a significant impact on the Trust and there had been a lot of interest and expressions of good will received.

The Chairman put out a note to the organisation and Governors following the feedback conversation with Monitor, which provided an excellent summary of the conversation. Monitor was assured that the Trust was sighted on the issues and was assured about the issues being addressed by the Trust. He added that the Trust will now be expected to deliver on the undertakings given to Monitor. The Trust now has a green governance rating.

Mr Crowley advised that a letter would be received by the Trust in near future.

Mr Crowley also reflected on the recently published King's Fund letter setting out the challenges to the whole system across the country, which very much mirrored the York experience.

The Board **noted** the report.

Mrs Raper added that she would like the Board to note and congratulate the work undertaken by the Arts Team around the car park in York. The Board had noted the work being undertaken.

14/161 Monitor Quarterly Return

Mrs Pridmore presented the information to be included in the quarterly return to Monitor. She outlined that it reflected the discussions the Board had already held around performance and did not identify any other issues.

The Board considered the information and **agreed** that it should be submitted to Monitor.

14/162 Annual Report from the Audit Committee

Mr Ashton presented the report and advised that the report would be presented to the Governors at the December meeting. He advised that the report does reflect the work the Audit Committee has undertaken during the year.

The Board **noted** the report and **agreed** it should be presented to the Council of Governors at their December meeting.

Action: Mrs Pridmore to ensure the report is included the agenda for the Council of Governors.

14/163 2013-14/157 Medical Staffing Cardiology Review

Professor Willcocks commented that she believed the business case was compelling and convincing. She summarised the case and the benefits. Dr Turnbull added that this was a good example of the delivery of complex services across both sites. He added his support for the case and the 7 day service.

Mr Crowley added that the timing was very good and the decision to reinforce the service demonstrated the Trust's ongoing commitment to Scarborough and North Yorkshire.

The Board **approved** the business case.

14/164 Next meeting of the Board of Directors

The next meeting of the Board of Directors will be held in the Board Room, The York Hospital, on 26 November 2014.

14/165 Any other business

There was no other business.

Outstanding actions from previous minutes

Minute number and month	Action	Responsible office	Due date
13/134 Dementia Strategy	To include an update on the dementia strategy in his board report on a quarterly basis.	Dr Turnbull	February 2014
14/055.1 2013 - 14/127: Bridlington Orthopaedic Elective Surgery	Evaluation Report pending the release of further capital	Mr Bertram	November 14
14/041 Patient Experience - Matron refreshment	Update the Board on the progress of the introduction of the new nursing structure	Mr Proctor/ Mrs Geary	December 14
14/083 Finance and Performance Committee	Include dementia screening in his Medical Director report.	Dr Turnbull	July 2014

14/131Quality and Safety Committee	A further report of the F&F should be presented to the next Board meeting	Mrs Geary	October 2014
14/131Quality and Safety Committee	Update the Board on the completed development of the Quest tool at the Board meeting in November.	Mrs Geary	November 2014

Action list from the minutes of the 29 October 2014

Minute number	Action	Responsible office	Due date
14/148 Matters arising – Workforce Mitigations	Update paper and incorporate health and wellbeing into the paper.	Mrs Holden	Immediate
14/148 Matters arising – Workforce Mitigations	Take the paper to the next Workforce Strategy Committee meeting.	Mrs Holden	Next Workforce Strategy meeting
14/149 Quality and Safety Committee – SHMI	Bring monthly trends on mortality data to the Quality and Safety Committee	Dr Turnbull	Next Quality and Safety Committee
14/149 Quality and Safety Committee – Safer Staffing	Circulate the paper outside the Board meeting.	Mrs Geary	Immediate
14/153 National Cancer Patient Survey	Write a letter on behalf of the Board congratulating the staff involved in the excellent survey results.	Mr Rose	Immediate
14/154 Finance and Performance Committee	Discuss the pay rates at the next meeting.	Professor Willcocks	At the next Workforce Strategy Committee
14/157 Education Strategy	Provide a copy of the leadership strategy to the Board.	Mrs Holden	November

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Quality & Safety Committee – 19th November 2014, Ophthalmology Seminar Rom - York Hospital

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

Apologies: Anna Pridmore

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last meeting notes dated 20th October 2014**		Firstly the committee welcomed Brian Golding, Director of Estates and Facilities who features later in the agenda. The Committee approved the previous meetings notes as a true and accurate record. The Committee welcomed the draft of the new integrated report which was tabled at the meeting. The Committee congratulated all involved on the significant progress made. The Committee undertook to review the content and pass any comments on to Sue Rushbrook in order to facilitate a move to the Report by the time of the next meeting. The Committee noted that the Maternity Governance issue will be discussed as part of the Supplementary Chief Nurse Report. The Committee discussed the quarterly review of falls. AJT advised that Monitor has been in contact to applaud the Trust on its open reporting around patient falls. The Committee stressed the need for		To be discussed at Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			stronger national guidance facilitation consistency of reporting, AJT to raise this with the advisory panel. DP and BG confirmed that the 6 monthly Quality Report progress update is currently being collated and indicated a positive position with regards to 30% targeted reduction in falls. The Committee look forward to an update on the Quality Report from AP at the next meeting	The Committee noted the regulators comments and were encouraged by progress regarding falls reduction.	
2	**Matters arising**		There are no matters arising that are not covered by agenda items.		
3	**Integrated Dashboard for discussion** Patient Safety Clinical Effectiveness Patient Experience		The Committee based its discussions on the data and information provided in the circulated Paper B 'Patient Safety and Quality Report. **Serious Incidents (SIs)** The Committee drew attention to the significant rise in the SI's declared this month. DP confirmed that this was due to the delays in identification and categorisation of pressure ulcers in August and this back log has now been cleared. BG advised the Committee that Matron training around validation and categorisation has now commenced. DP explained that there has been a change in the SI process so that learning can be improved and disseminated to all clinical staff. **Clostridium Difficile** AJT confirmed that the Trust remain below trajectory for C-Diff for the month of October. The Committee discussed the factors that increase the	The Committee noted the comments made and the actions being taken in the areas of both training and improved dissemination	AJT to explain the spike in SIs at Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			risk of C-Diff and where the majority of cases are occurring. They then went on to discuss the Infection Prevention Nurse resource and future plans for the team. AJT updated the Committee on the Antimicrobial Stewardship day that was held on the 18th November. Actions have been put in place to raise Consultant compliance. The Committee noted the compliance with dementia screening and the implementation of the NICE recommendations. The Committee members agreed that the NICE figures should be annotated. Committee members asked for an update around electronic prescribing. AJT confirmed that the EMP Board continues to meet and that software is being developed. AJT will bring an update to the January Committee meeting. The Committee drew their attention to the Themes for clinical claims settled 01.01.12 – 30.09.14. AJT highlighted an individual claim currently being investigated from before the acquisition of Scarborough. AJT and BG updated the Committee regarding the Scarborough Maternity Dashboard and related issues. The confirmed that focussed discussions had taken place with the Directorate. The Committee noted that the Community Dashboard now contained locality data which is very positive. The Committee was concerned about the variation of Community Hospital Friends and Family responses. BG confirmed that the new	The committee was pleased to learn of progress on this important development The Committee noted the robust Directorate discussions The Committee welcomed the	AJT to update at Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Assistant Chief Nurse for Community will lead on the family and friends test for the Community Dashboard.	appointment	
4	**Supplementary Medical Director Report** Information Governance Consultant appointments Serious incident figures		AJT drew the Committees attention to the Gentamicin audit and explained the calculated risk in prescribing this drug. The key action to ensure nurses are aware of giving a prompt first dose ties in with the work being undertaken around Sepsis.		
5	**Annual Infection Prevention Control Report**		AJT introduced the Director of Infection Prevention and Control Annual Report. The report shows that the Trust is reporting more instances of MSSA then other Trusts in the region. A new Infection Prevention Nurse is now in post to concentrate on reducing these occurrences and a no touch technique will be used by all clinical staff. The Committee discussed the impending restriction to ward access and the adherence of staff to the restricted interconnecting doors. The Committee expressed that they are supportive of the firm line being taken on this issue. Brian updated the Committee on the future reconfiguration of ward specialties to prevent any need to use the interconnecting doors. The Committee discussed the Water Safety Group and the high level of compliance on water testing. All water and taps on Trust sites are free from bacteria.		AJT to take to Board
6	**Supplementary Chief Nurse Report**		BG updated the Committee on the current position around international recruitment. The Trust is no longer planning to recruit in collaboration with	The Committee noted the amended approach	SH to discuss at Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
	Nursing and Midwifery strategy Chief Nurse Team Acuity and dependency Audit International recruitment Midwifery Early warning Trigger Tool Patient Experience		North Lincolnshire and Goole. It was highlighted that the Nurses being recruited in Portugal are newly qualified and this would be a risk for the Trust. Other international areas are now being looked in to. The Committee agreed that the Acuity and Dependency audit will be discussed at the Winter Q&S meeting scheduled for 09/12/14. The first use of the trigger tool took place on the 5th November and the data received from this will be analysed at the Chief Nurse Time out. The Committee asked about the full roll out schedule, BG undertook to update at the next meeting. The Committee welcomed BGs update on use of the Special Care Baby Unit cots and accepted that this was being reviewed by the ongoing work on child safeguarding policies and procedures. BG will update the Committee on any progress.		
7	**Safer Staffing Report**		The Committee showed great interest in the Safer Staffing report and noted that the vacancy figures are going down. BG confirmed that community staffing and staffing at night will be looked at as a priority. Safer Staffing Boards are now on display on all wards and Matron training is ongoing. Roles and responsibilities around validation will be highlighted during this training. The Committee expressed concern over ward environments, BG explained that the Environment Steering Group will be re-introduced and peer walk rounds will be put in place for Matrons to challenge		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			each other.		
8	**Pressure Ulcer update**		The Committee agreed that the data in the report should be refined to include if the Pressure Ulcer deteriorated or developed under our care. The Committee received confirmation from BG that the Wound Care Plan has been mandated as part of the CQUIN, although difficulties have been encountered when implementing this. BG to bring an update to the next Committee meeting.	The Committee noted the work being undertaken	
9	**Safeguarding Children Annual Report**		BG confirmed with the Committee that the report has been modified since being added in to the Committee papers. Much of the content will stay the same however recommendations will be highlighted. BG to bring updated report to the next Committee meeting.	The considerable amount of work that has been undertaken can be seen from the action plan and the Committee look forward to receiving the updated report	To be presented to the December Board meeting
10	**Estates and Facilities strategy**		The Committee asked that for future reports there be an executive summery together with clear references to CQC priorities. Brian undertook to provide this. Brian presented the Estates and Facilities strategy to the Committee and a discussion was held over the significant achievements in the first two years of the integration highlighting what had been the top priorities during this time. Brian gave an update on the CIP programme projects included in the strategy which was well received by the Committee. Brian explained the variance between sites of the ownership and the routine of cleaning. This triangulates with the data in the IPC report.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Solutions are being looked at.		
11	**Health and Safety annual report**		Brian introduced the Health and Safety Annual report which is based on the Health and Safety of Staff. The Committee noted the relevance of much of this report to Staff. The Chair undertook to review with colleagues on the Workforce Strategy Committee.		Brian to take to Board
12	**Dates of meetings up to 2016**		The Committee were happy with the dates arranged for 2015 Committee Meetings and agreed that July 2015 may need to be changed. The Committee noted that the Meeting on the 17th March coincides with the CQC visit.		
13	**Any other business**		AJT informed the Committee that the Trust has no outliers amongst its Surgeons on the Surgeon Outcome data on NHS Choices.		AJT to update Board
14	**Next Meeting**		20th January 2015 13.30 – 15.30 York Hospital Boardroom		

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York Teaching Hospital NHS
NHS Foundation Trust

C1

Patient Safety and Quality Report

November 2014

Our ultimate objective To be trusted to provide safe, effective, sustainable healthcare for the communities we serve

Index

Executive summary

- The SHMI for the period April 2013 to March 2014 was published on the 23rd October as 99.4. This represents a slight increase for the Trust although remains within the 'as expected' range.

- 35 Serious Incidents (SIs) were declared in October.

- No Never Events were reported. The Never Event illustrated from April in previous reports has been de-logged with the Commissioners.

- Patient falls remains the most frequently reported incident category.

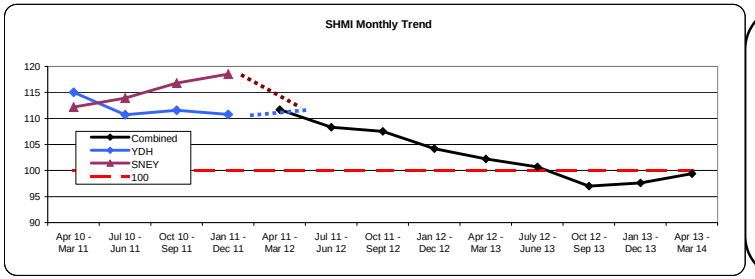
- Two cases of toxin positive c. difficile were identified in October.

- Compliance with dementia screening for patients admitted to hospital was 92% in October

- An update on implementation of NICE recommendations is included in the Clinical Effectiveness section of this report.

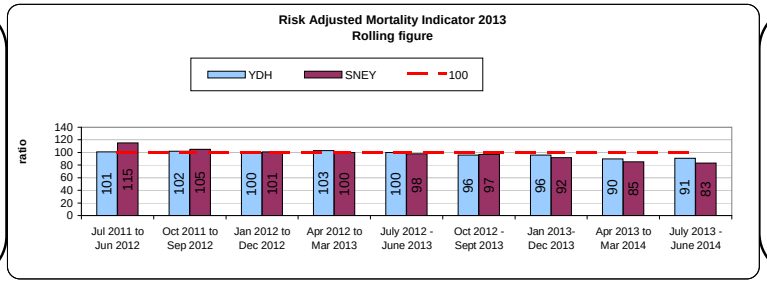
Patient Safety

Mortality



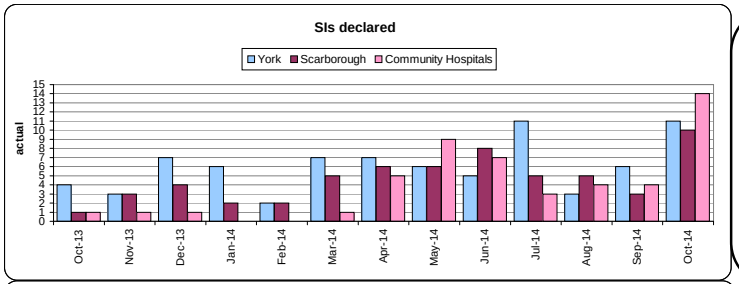
The SHMI for the period April 2013 to March 2014 was published on 23rd October. The Trust indicator figure is 99.4 which represents a slight increase although remains within the 'as expected' range.

Data source: Information Centre



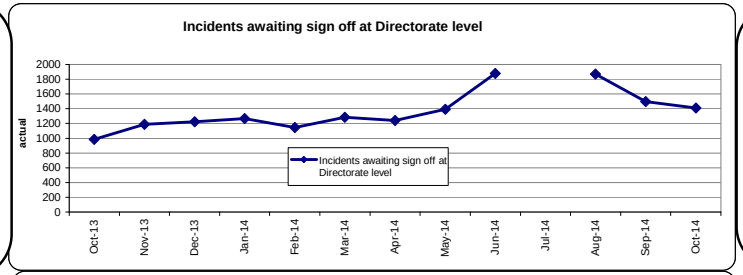
The Risk Adjusted Mortality Indicator (RAMI) for the reporting period July 2013 to June 2014 indicates only small variation from the previous reporting period.
The Board should be aware that these RAMI figures are slightly at variance to those previously presented due to annual re-base undertaken by CHKS.
Data source: CHKS - does not include deaths up to 30 days from discharge.

Measures of Harm



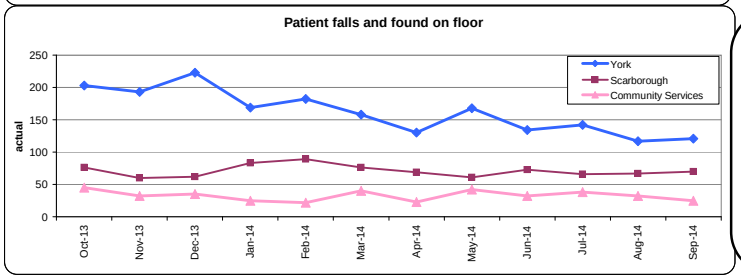
There were 35 serious incidents (SIs) reported in October. 23 related to pressure ulcers, (14- Community, 8- YH, 1- SH) of which several were before October but the validation process had been protracted. Six SIs were as a result of patient falls, two maternity (SH), 1 surgical error (SH), 1 delayed diagnosis (YH), 1 delayed diagnosis in ED (SH) and 1 H&S (SH).

Data Source: Datix



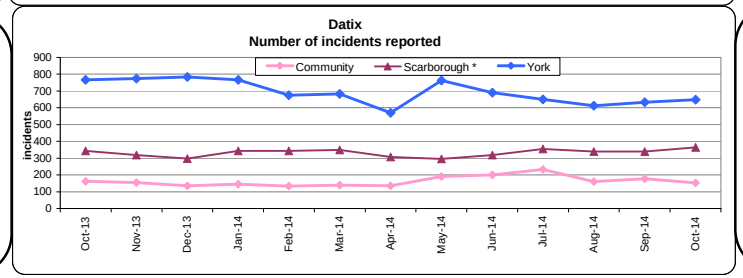
At the time of reporting there were 1408 incidents awaiting sign-off by the Directorate Management Teams. Risk and Legal are working with the Directorates to facilitate the timely completion of incident investigations.

Data Source: Datix



Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During September there were 121 reports of patients fallingat York Hospital, 70 patients at Scarborough and 25 patients within the Community Services.
These figures may increase as more investigations are completed.

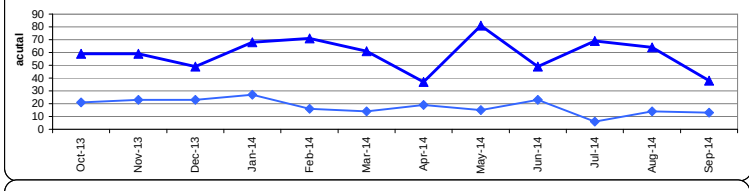
Data Source: Datix



The total number of incidents reported in the Trust during October was 1150. 649 incidents were reported on the York site, 365 on the Scarborough site and 152 from Community Services.

Data Source: Datix

Pressure ulcers - York
On admission and since admission

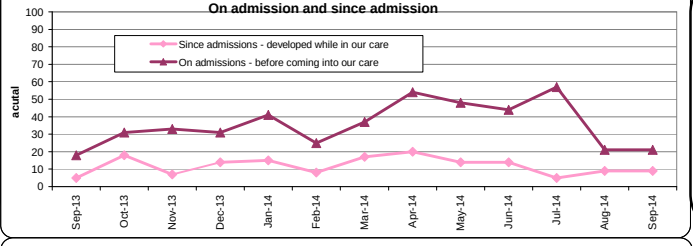


During September 13 pressure ulcers were reported to have developed on patients since admission to York Hospital.

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

Data Source: Datix

Pressure ulcers - Scarborough
On admission and since admission

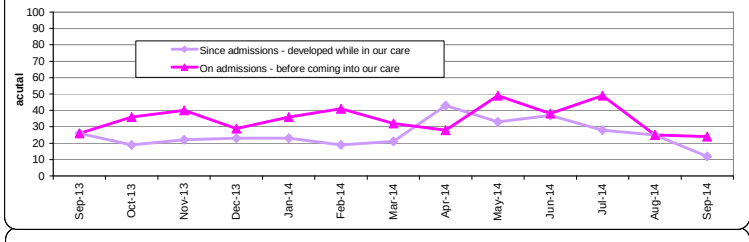


During September, 9 pressure ulcers were reported to have developed on patients since admission to Scarborough Hospital.

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

Data Source: Datix

Pressure ulcers - Community
On admission and since admission

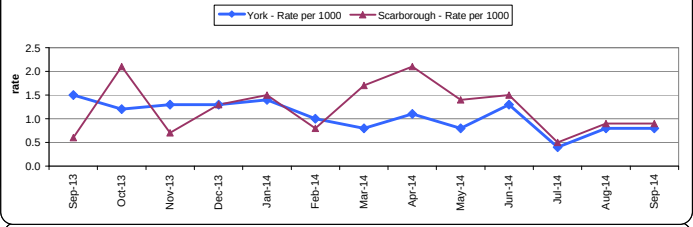


During September12 pressure ulcers were reported to have developed on patients in our community hospitals or community care.

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

Data Source: Datix

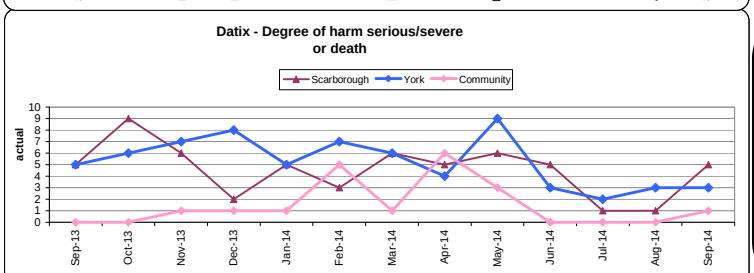
Since admissions
Pressure ulcers - Rate per 1000 bed days



The rate of pressure ulcer development In September in York Hospital in was 0.8/1000 bed days.

The rate of pressure ulcer development in Scarborough Hospital in September was 0.9/1000 bed days.

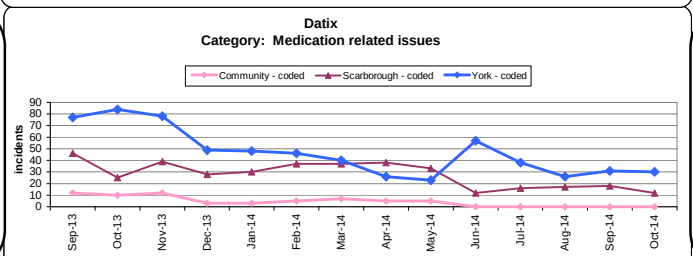
Datix - Degree of harm serious/severe or death



During September a total of 9patient incidents were reported which resulted in serious or severe harm or death.

Data Source: Datix

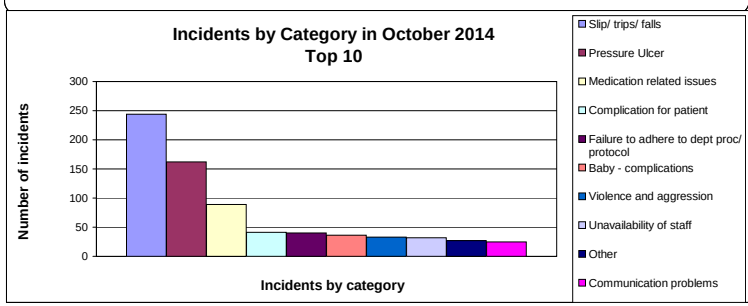
Datix
Category: Medication related issues



During October there was a total of 42 medication related incidents reported, although this figure may change following validation.

Data Source: Datix

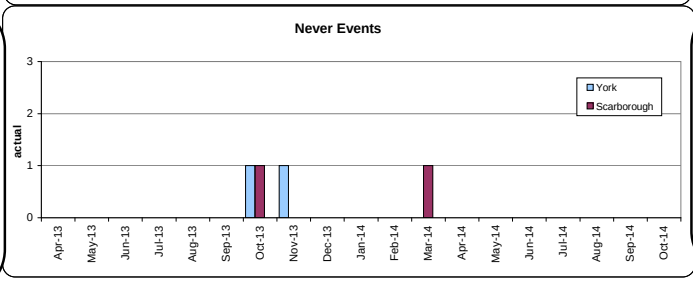
Incidents by Category in October 2014
Top 10



Incidents relating to slips, trips and falls remains the largest category of reported incidents, with pressure ulcers the second largest category.

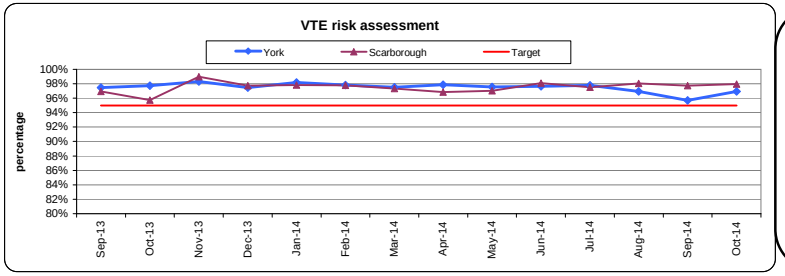
Data Source: Datix

Never Events



There were no Never Events declared in October.

Data Source: Datix

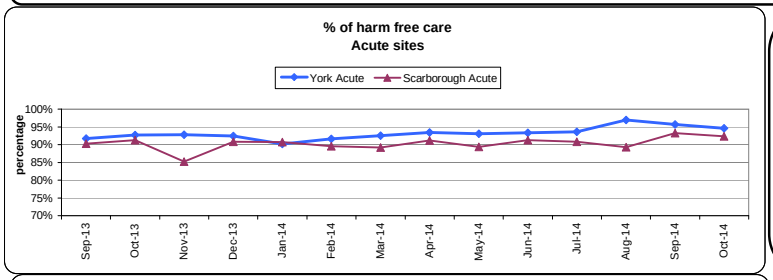


The target of 95% of patients receiving a VTE risk assessment has been maintained on both sites during October.

Data Source: Systems & Network Services

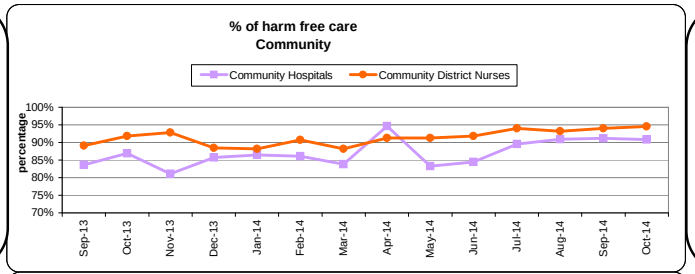
Safety Thermometer

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



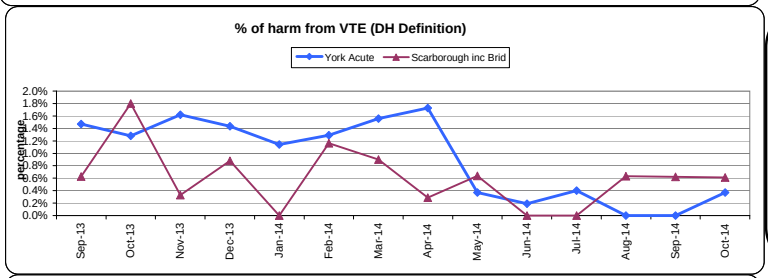
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In October 95% of patients at York and 925 at Scarborough were audited as receiving care 'free from harm' on the acute hospital sites.

Data source: Safety Thermometer



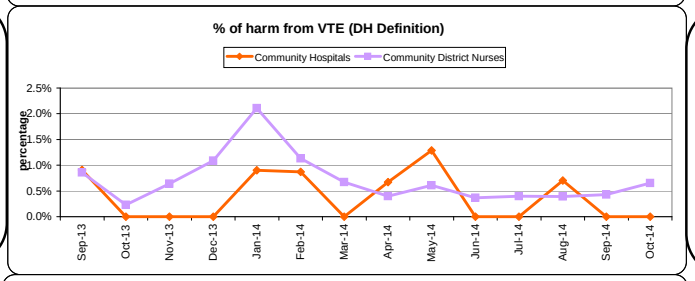
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In October 91% of patients in our community hospitals and 94% of patients in our care in the community received care 'free from harm'.

Data source: Safety Thermometer



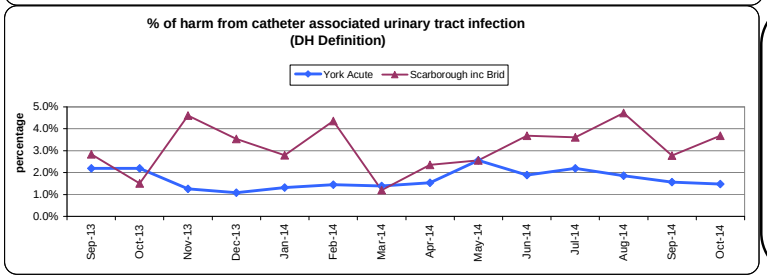
The percentage of patients affected by VTE as measured by the Department of Health (DH) definition, monthly measurement of prevalence, was 0.4% in York and 0.6% in Scarborough acute hospitals in October.

Data source: Safety Thermometer



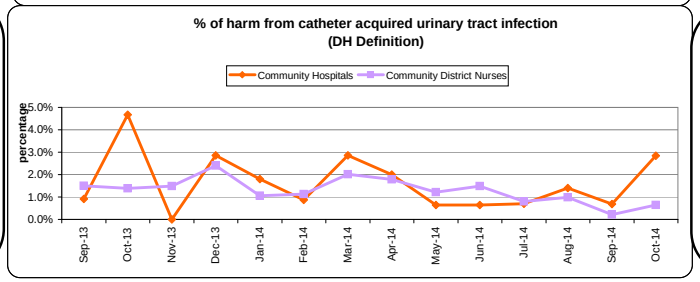
The percentage of patients affected by VTE as measured by the DH definition, monthly measurement of prevalence was 0 in community hospitals and 0.6% in community care in October.

Data source: Safety Thermometer



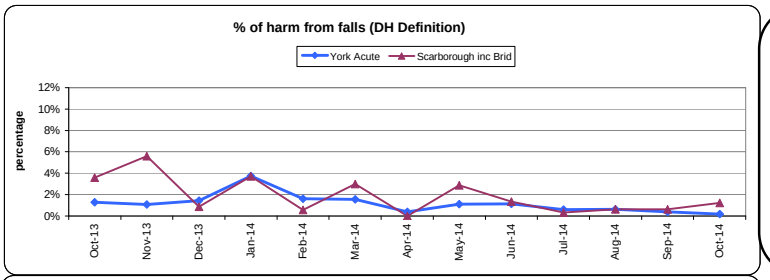
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 1.5% in York and 3.7% in Scarborugh acute hospitals in October.

Data source: Safety Thermometer



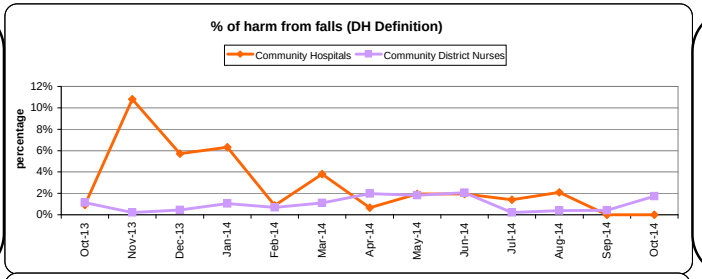
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 2.8% in community hospitals and 0.6% in community care in October.

Data source: Safety Thermometer



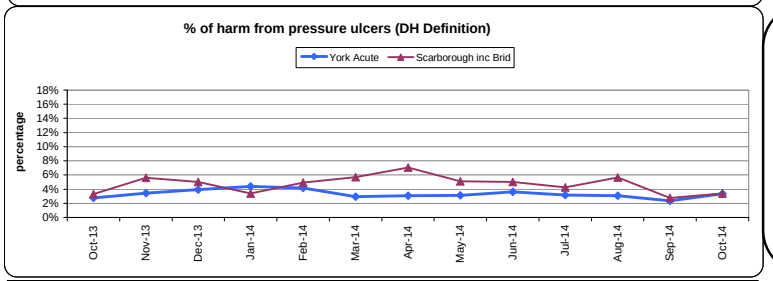
The percentage of patients suffering harm from falls as measured by the Department of Health data definition monthly measurement of prevalence was 0.2% for York and 1.2%for Scarborough acute hospitals in October.

Data source: Safety Thermometer



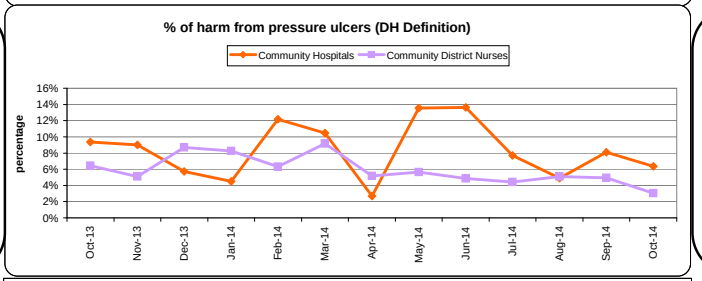
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 0 in community hospitals and 1.7% in community care in October.

Data source: Safety Thermometer



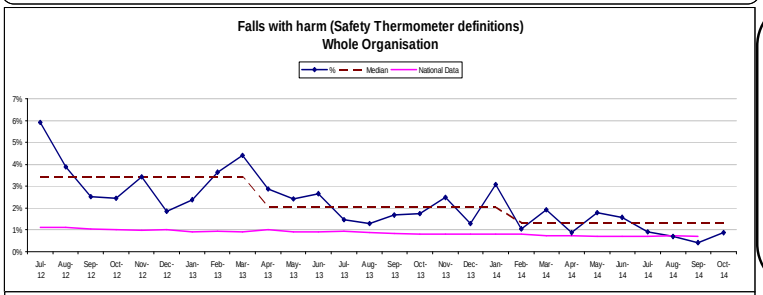
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 3.4% for York and Scarborough acute hospitals in October.

Data source: Safety Thermometer



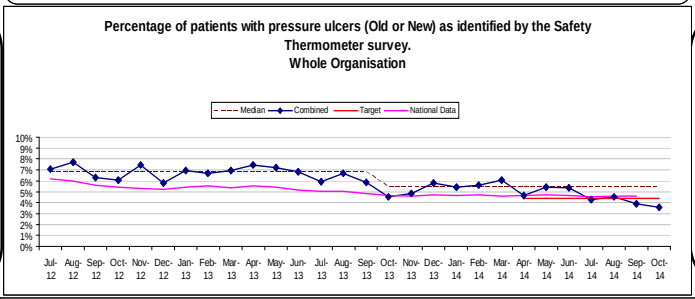
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 6.4%in community hospitals and 3% in community care in October.

Data source: Safety Thermometer



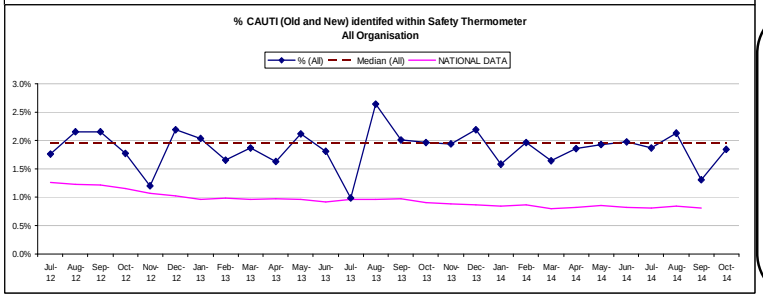
The Trust wide total number of falls with harm as measured for the Safety Thermometer, is slightly above the national average figure.

Data source: Safety Thermometer



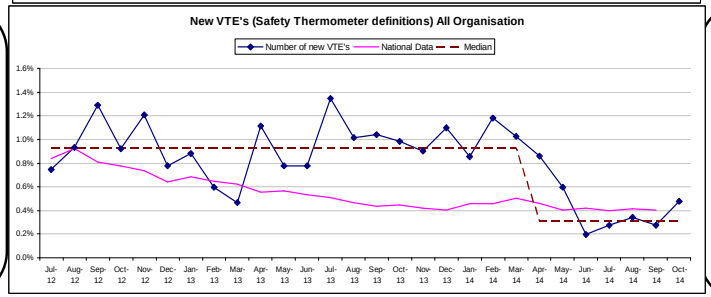
The Trust wide total number of pressure ulcers as measured for the Safety Thermometer is just below he reported national average.

Data source: Safety Thermometer



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

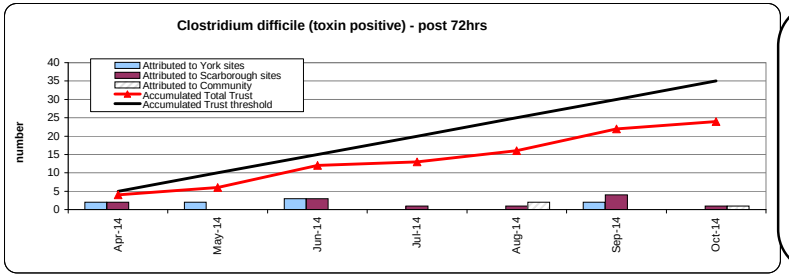
Data source: Safety Thermometer



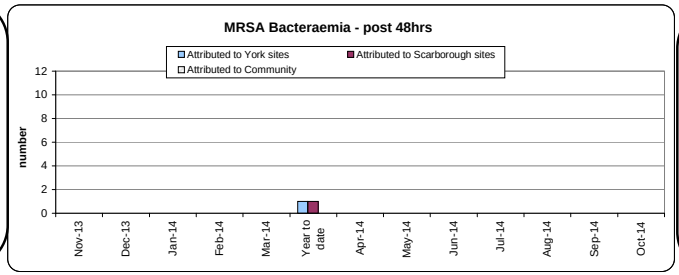
The Trust wide total number of patients with a new VTE as measured for the Safety Thermometer is above the reported national average.

Data source: Safety Thermometer

Infection Control

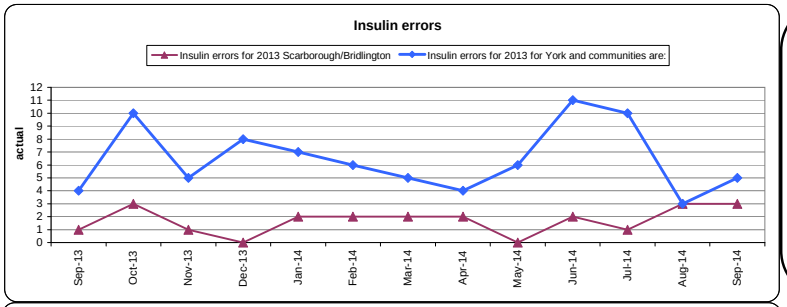


One case of c.diff was identified in York and one in Scarborough during September . The Trust remains below trajectory with a total of 24 cases identified since 1st April 2014.



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

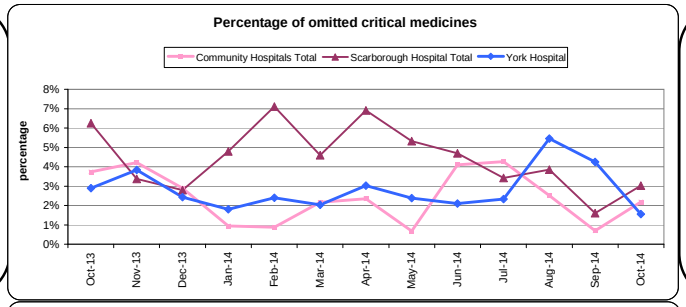
Drug Administration



There were five insulin related errors reported at York and Communities, and three at Scarborough/Bridlington in September.

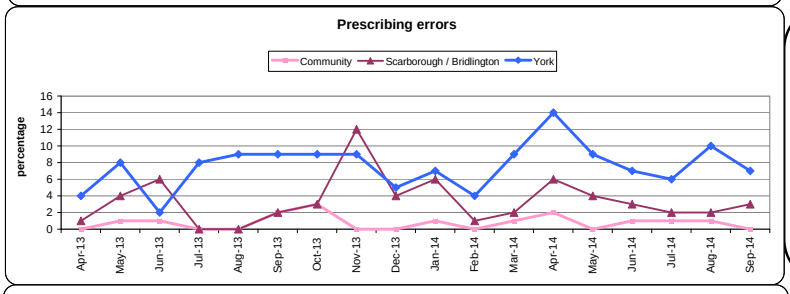
The data for October is awaiting validation.

Data Source: Datix



The audit of critical medicines missed during October indicated 3% for Scarborough, 5.5% for York and 2.2% for Community Hospitals.

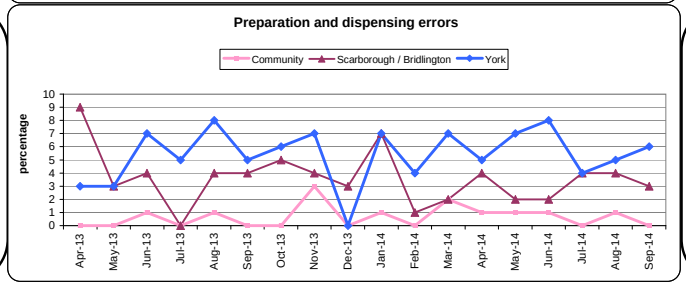
Data Source: Safety Thermometer (local)



There were three prescribing related errors in September; three from Scarborough and seven from York.

The data for October is awaiting validation.

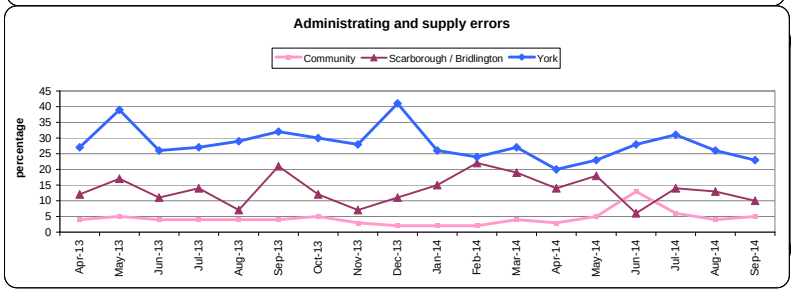
Data Source: Datix



There were nine preparation/dispensing error in September; six from York, three from Scarborough and one from Community.

The data for October is awaiting validation.

Data Source: Datix

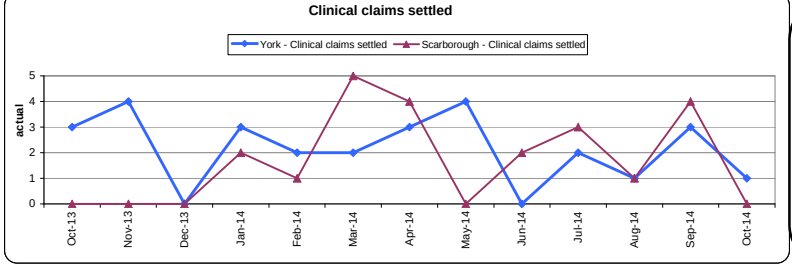


There were 38 administrating/supplying errors in September; 23 from York, ten from Scarborough and five from Community.

The data for October is awaiting validation.

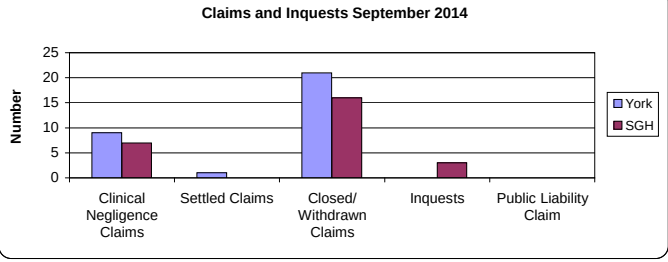
Data Source: Datix

Litigation



One clinical claim was settled in October which wasattributed to the York site.

Data Source: Risk and Legal Services



In September, five clinical negligence claims for York site were received and three were received for Scarborough. Four claims from Scarborough and three from York were settled. No public liability claims were received. York had three withdrawn/ closed claims and there were three from Scarborough.

The were nine Coroner's Inquests.

Data Source: Risk and Legal

York Teaching Hospital NHS Foundation Trust

Themes for clinical claims settled 01.01.2012 to 30.09.2014

Incident type	Total Damages	Total Number reported	Number (York)	Number (Scarborough)
Failure to refer to other speciality	£2,047,500	4	4	0
Failure to investigate further	£1,344,590	16	6	10
Delay in treatment	£1,265,000	3	1	2
Inadequate surgery	£1,249,316	14	6	8
Lack of appropriate treatment	£387,868	7	2	5
Inappropriate discharge	£333,000	4	1	3
Inadequate examination	£210,847	6	3	3
Failure to adequately interpret radiology	£107,613	11	6	5
Inadequate nursing care	£88,500	9	5	4
Not known	£60,000	3	0	3
Inadequate procedure	£58,880	4	2	2
Results not acted upon	£49,500	7	6	1
Inadequate interpretation of cervical smear	£37,500	1	1	0
Intraoperative burn	£30,000	4	3	1
Anaesthetic error	£27,500	1	1	0
Inadequate consent	£26,500	3	2	1
Failure to retain body part	£25,000	1	1	0
Lack of risk assessment/action in relation to fall	£24,250	2	2	0
Prescribing error	£22,500	2	2	0
Failure to act on CTG	£13,500	1	1	0
Lack of risk assessment/action in relation to pressure ulcer	£7,000	1	1	0
Maintenance of equipment	£5,000	1	1	0

Patient Safety Walkrounds – October 2014

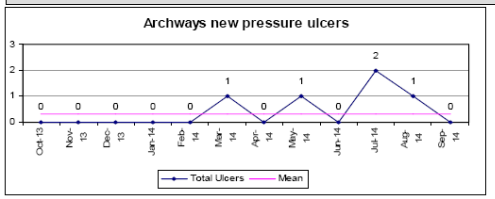
Date	Location	Participants	Actions & Recommendations
Tuesday 7th October 2014	Kent Ward Bridlington	Diane Palmer – Deputy Director Mark Andrews – Lead Clinician Paul Rafferty- DM Liz Charters- Matron Jennie Adams - NED	**Nurse Staffing** • The main concern is not establishment (although there is one vacancy outstanding) but the frequent removal of registered nurses to fill gaps on the wards at Scarborough Hospital. This represents a real safety concern for patients on the ward – particularly given the remoteness of the location and the variability of medical cover on the site. **Action**: To be discussed with site managers by Directorate Management Team. **Medical Staffing** • When operating is taking place on-site there is reasonable cover in the event of a deteriorating patient needing resuscitation or transfer to an acute hospital. Outside of operating time, at weekends and during the night the wards are covered by Medical Officers supplied by a locum agency. There are currently two of these working a week on and a week off. At the end of October the more qualified locum is leaving this post. This will result potential deterioration in the level of medical cover. **Action**: Directorate Management Team to ensure that locum provision is adequate to support an isolated site out of hours. **General Issues** • The quality of the physiotherapy provided does not achieve consistently the standard required. **Action**: to investigate if Humber Physiotherapy team (already working within Bridlington Hospital) could be used in some capacity. • Toilet facilities are in short supply and need to be allocated on a gender specific basis depending on the patients on the ward at the time. • Generally the procedures for escalating incidents and safety issues are informal. **Action**: Directorate Manager to reinforce the use of Datix for reporting incidents and to consider establishment of a Bridlington site specific governance group/meeting.
Tuesday 7th October 2014	Radiology York Hospital	Andrew Bertram- Director Dr Haselden- CD Steven Mackell- DM Lorraine Ford - Quality Manager Alison MacDonald- Lead Nurse Philip Ashton- NED	Report outstanding.
8th October 2014	Women's Unit Scarborough Hospital	Alastair Turnbull – Medical Director Jennie Adams - NED Kim Hinton - DM Adrian Evans -CD Louise Hayes - Clinical Lead Liz Ross - Matron Freya Oliver – Chief Midwife	**Women's Unit** • There has been a reduction in numbers of junior doctors in this speciality which has led to lack of availability of staff in clinics. **Action:** To prioritise patients with most immediate needs. Consultant establishment is increasing which will provide more clinic support – soon to be 7 in the department compared to 4 at a low point last year. **Ante- Natal Clinic** • Estates issues are being addressed by a programme of redecoration. **Pre and Post Natal Ward (Hawthorn)/ Maternity Unit** • A number of factors are currently contributing to a shortfall in midwife numbers. High levels of sickness absence and a high number of newly qualified midwives are the main issues. **Action**: To be closely monitored by Matron and Head of Midwifery. **Maternity Theatre Closure** • Significant delays in reopening this facility mean that patients continue to be put at additional risk from 10-15 minute delay in transfer to 1st floor. **Action:** Assurance has been received from Estates that the theatre will re-open by end of November 2014. **Out of Hours Theatre Incident** • An emergency c-section was delayed due to lack of a scrub nurse. **Action**: Situation to be closely monitored by Matron and Head of Midwifery.
Friday 10th October 2014	Stroke Unit Scarborough Hospital	Diane Palmer- Deputy Director Dr Jones- CD Rob Parnaby- DM Emma Day- Matron Mike Keaney- NED	• Ward Sisters continue to be heavily involved with administration work, particularly recruitment processes which were previously supported by HR. **Action**: A group is to be developed to look at relieving Sisters from some administration work. • Two consultants are retiring next year. **Action**: Clinical Director exploring possibilities to ensure that senior medical provision remains at an adequate level. • It is not unusual for a third of the patients on the unit to be medical / non stroke. **Action**: To be monitored by Directorate Management Team. • Several Malton and Whitby patients have GP led support rather than rehabilitation arranged through the acute Trust. **Action**: Directorate Management Team to monitor outcomes and where necessary advise of alternate pathways. • The gym is also used as a meeting room. **Action**: Directorate Management Team to review with physiotherapy service and IPC • Chairs are being stored in the fire exit corridor at the end of the ward. **Action**: Matron to have the corridor cleared immediately.

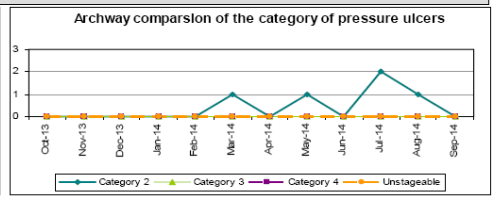
Archway's Community Hospital & York East and West Locality Patient Safety Dashboard –

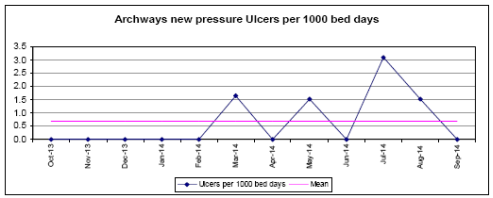
Archway's Community Hospital Datix Incident Reporting	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14
Number of incidents reported on - Datix web	11	14	12	12	7	11	8	14	7	29	19	23
Number of medication related incidents	0	2	1	0	1	2	0	1	0	0	0	0
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	0
Number of formal complaints	0	0	0	0	0	0	0	0	0	1	0	1
Number of Serious Incidents (SI's)	0	0	0	0	0	0	0	0	0	0	0	0
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	0

Locality East and West Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of incidents reported on - Datix web	14	11	23	12	15	16
Number of medication related incidents	2	1	4	2	1	0
Number of settled clinical litigation cases	0	0	0	0	0	0
Number of formal complaints	0	0	0	0	0	0
Number of Serious Incidents (SI's)	0	0	0	0	1	0

Pressure Ulcer Incidence – Archway's Community Hospital





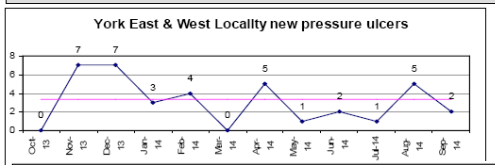


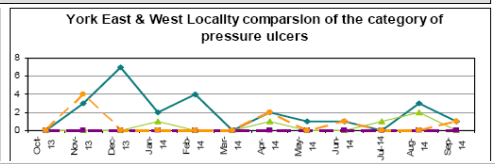
The new Wound Management policy is being launched across the patch, this includes guidance for staff on the prevention and management of pressure ulcers.

Future audit on compliance with this policy will take place.

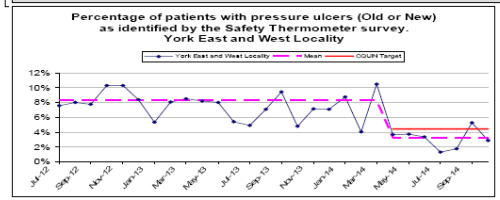
The Community Pressure Ulcer Prevention & Management Group is working on various work streams to reduce and manage pressure ulcers.

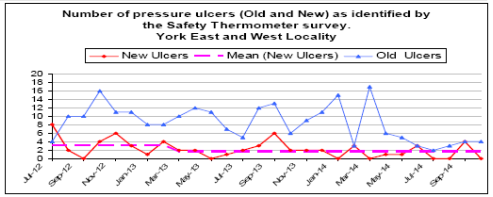
Pressure Ulcer Incidence – York East and West Locality



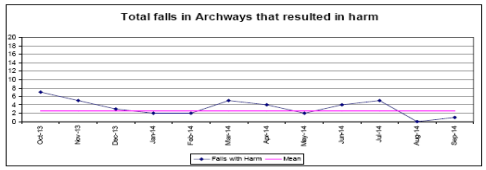


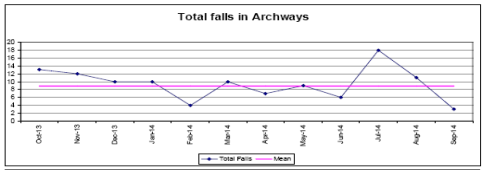
Pressure Ulcer Prevalence –York East and West Locality (CQUIN)

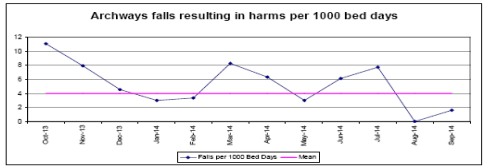




Falls Incidence – Archway's Community Hospital







New falls assessment and care planning documentation is being rolled out across the patch.

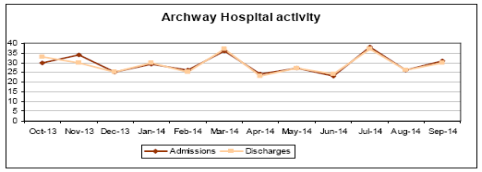
All staff will receive a training session on falls prevention as part of this roll out.

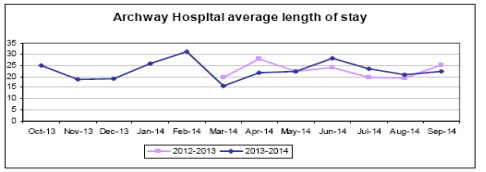
Their have not been any falls resulting in moderate or severe harm at Archways since before July 14.

Archway's Deaths & Mortality Reviews

St Monica's Community Hospital Deaths & Mortality reviews	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of in-hospital deaths	0 (0%)	1 (3.3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (2.7%)	0 (0%)	0 (0%)
Number of mortality reviews	0	1	0	0	0	0	0	0	0	0	0	0

Archway's Activity





The Friends and Family Test – Monthly Performance Community Hospitals – Archway's

Ward		May 14	Jun 14	Jul 14	Aug 14	Sep 14
Archways	Response rate	80%	15%	3.7%	45%	0.0%
	Eligible	20	20	27	20	23
	Responses	16	3	1	9	0

The process for handing out F&FT cards failed in September due to staff annual leave, this issue has since been addressed and processes are in place to ensure back up when staff are off.

Safety Thermometer Data – Archway's & York Locality

Archway's Hospital	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 13
New VTE's	0	0	0	0	0	0	1	0	0	0	0	0
Falls with harm	1	0	1	0	0	0	0	2	2	0	0	0
Pressure Ulcers	3	1	0	0	2	0	0	0	1	0	2	3
New CAUTI	0	2	0	0	0	1	0	0	0	0	0	0
Total Harms	**4**	**3**	**1**	**0**	**2**	**1**	**1**	**2**	**3**	**0**	**2**	**3**
Empty Admin Boxes	1	0	1	0	2	2	1	0	1	0	0	5
Omission Code 4	0	0	2	0	0	1	1	0	0	1	2	6
Omitted Critical Medicines	1	0	1	0	0	0	0	0	0	0	0	1

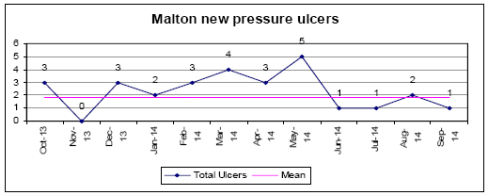
East & West Locality	Nov 13		Dec 13		Jan 14		Feb 14		Mar14		Apr 14		May 14		Jun 14		Jul 14		Aug 14		Sep 14		Oct 13	
Ward	East	West	East	West	East	West	East	West	East	West	East	West	East	West	East	West	East	West	East	West	East	West	East	West
New VTE's	1	2	0	3	0	3	1	1	0	0	1	1	1	2	1	0	1	1	1	1	0	1	0	0
Falls with harm	0	0	0	2	0	2	0	1	0	1	1	2	0	3	3	1	0	0	0	0	1	0	0	0
Pressure Ulcers	3	7	6	7	5	10	2	6	6	9	6	2	2	5	4	2	2	0	4	1	4	2	3	1
New CAUTI	0	1	3	2	1	0	0	1	1	1	1	0	1	0	1	1	0	1	0	0	0	0	0	1
Total Harms	**4**	**10**	**9**	**14**	**6**	**15**	**3**	**9**	**7**	**11**	**9**	**5**	**4**	**10**	**9**	**4**	**3**	**2**	**5**	**2**	**5**	**3**	**3**	**2**

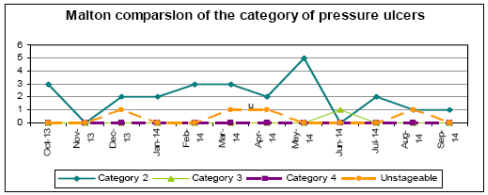
Malton Community Hospital & Scarborough South Ryedale Locality - Patient Safety Dashboard

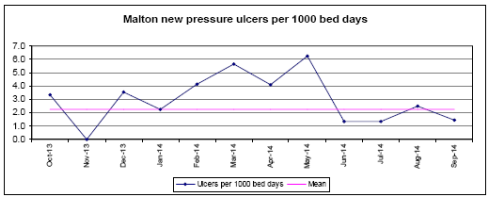
Malton Community Hospital Datix Incident Reporting	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of incidents reported on - Datix web	22	20	23	25	14	25	11	32	17	16	26	30
Number of medication related incidents	1	2	0	0	0	0	0	1	1	1	1	1
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	0
Number of formal complaints	0	0	0	0	0	0	0	0	0	0	0	1
Number of Serious Incidents (SI's)	3	0	1	0	0	0	0	0	1	0	1	0
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	0

South Ryedale & Scarborough Locality Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of incidents reported on - Datix web	33	33	35	32	22	18
Number of medication related incidents	1	0	2	1	1	1
Number of settled clinical litigation cases	0	0	0	0	0	0
Number of formal complaints	0	0	1	1	0	0
Number of Serious Incidents (SI's)	1	2	2	3	2	0

Pressure Ulcer Incidence – Malton Community Hospital



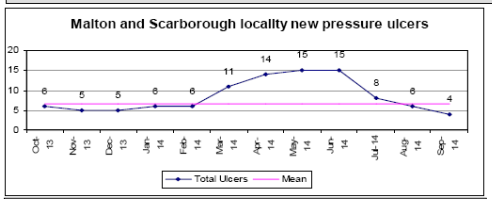


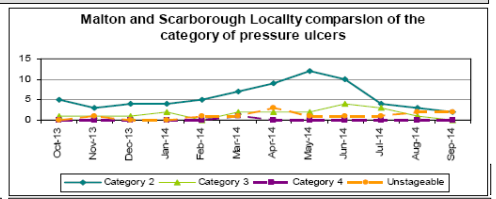


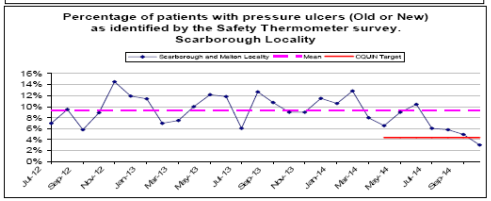
Following an increase up to May the numbers of new pressure ulcers reported has fallen and stayed below the mean.

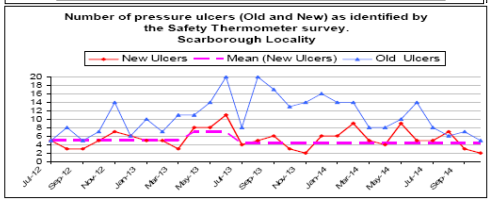
The new Wound management policy (containing guidance on pressure ulcer prevention and management) is being launched across the patch.

Pressure Ulcer Incidence – South Ryedale & Scarborough Locality

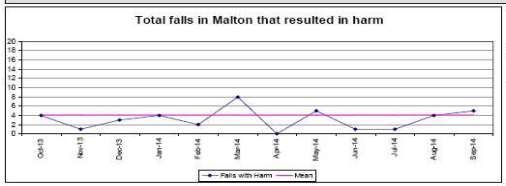


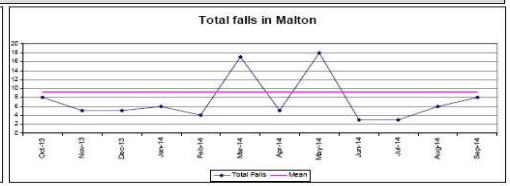


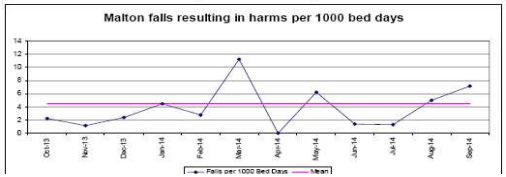




Falls Incidence – Malton Community Hospital







New inpatient assessment and care plan documentation is being rolled out across all community hospitals.

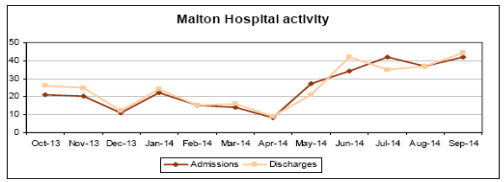
Along with this roll out there will be a falls training package for all staff.

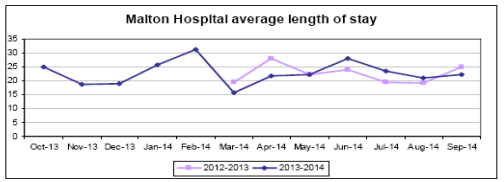
Staff have been asked to check all reports of moderate harm as some have been reported incorrectly and should have been low harm, Datix reports will be amended accordingly.

Malton Deaths & Mortality Reviews

Malton Community Hospital Deaths & Mortality reviews	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of in-hospital deaths (percentage discharged as died)	6 (12.8%)	5 (11.9%)	5 (12.8%)	5 (13.5%)	5 (13.9%)	5 (10.6%)	1 (3.7%)	2 (7.1%)	9 (21.4%)	2 (5.7%)	3 (8.1%)	1 (2.3%)
Number of mortality reviews	0	1	2	3	0	5	1	2	8	2	3	1

Malton Activity





The Friends and Family Test – Monthly Performance Community Hospitals - Malton

Ward		May 14	Jun 14	Jul 14	Aug 14	Sep 14
Malton	Response rate	50%	48.3%	65.5%	20%	34.5%
	Eligible	16	29	29	25	29
	Responses	8	14	19	5	10

Safety Thermometer Data

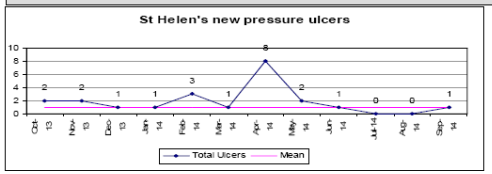
Malton Hospital	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14
New VTE's	0	0	0	1	0	0	1	0	0	0	0	0
Falls with harm	11	6	5	1	2	1	1	1	0	1	0	0
New Pressure Ulcers	3	1	1	8	1	2	4	6	0	1	1	1
New CAUTI	0	1	0	0	1	2	0	1	1	0	0	1
Total Harms	**14**	**8**	**6**	**10**	**4**	**5**	**6**	**8**	**1**	**2**	**1**	**2**
Empty Admin Boxes	4	5	13	16	0	2	10	5	0	0	0	2
Omission Code 4	4	4	10	5	0	1	5	2	0	0	0	1
Omitted Critical Medicines	2	1	0	0	0	0	1	0	1	0	0	1

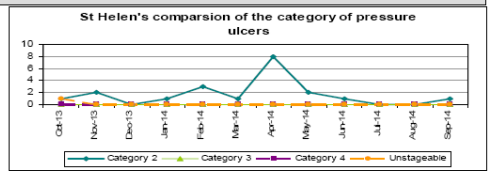
Scarborough & South Ryedale Locality	Nov 13		Dec 13		Jan 14		Feb 14		Mar14		Apr 14		May 14		Jun 14		Jul 14		Aug 14		Sep 14		Oct 14	
Ward	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye
New VTE's	0	0	2	0	1	0	2	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Falls with harm	1	0	0	0	1	1	0	0	1	1	4	0	2	0	1	0	1	0	2	0	1	0	1	0
Pressure Ulcers	10	6	10	12	15	5	12	3	7	5	8	3	13	7	11	5	10	3	10	5	11	2	3	2
New CAUTI	1	1	2	2	1	0	3	0	3	0	1	4	0	0	1	1	0	1	3	0	1	0	2	0
Total Harms	**12**	**7**	**14**	**14**	**18**	**6**	**17**	**4**	**11**	**7**	**13**	**7**	**15**	**7**	**13**	**6**	**11**	**4**	**15**	**5**	**13**	**2**	**7**	**2**

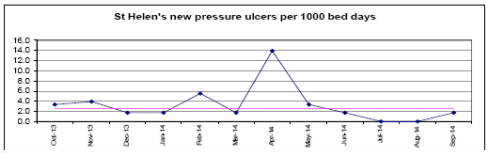
St Helen's Community Hospital
Patient Safety Dashboard – 15/10/2014

St Helen's Datix Incident Reporting	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 13
Number of incidents reported on - Datix web	12	14	16	8	14	13	20	16	23	17	8	15
Number of medication related incidents	2	0	0	0	1	1	0	2	1	1	0	1
Number of settled clinical litigation cases	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	0	0	0
Number of formal complaints	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	0	0	0
Number of Serious Incidents (SI's)	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	0	0	1
Number of Critical Incidents (CI's)	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	0	0	0

Pressure Ulcer Incidence –St Helen's Community Hospital

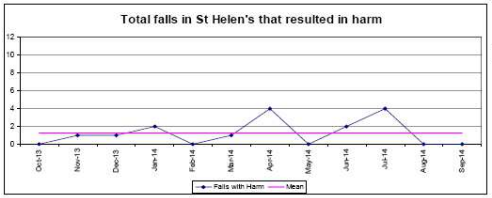


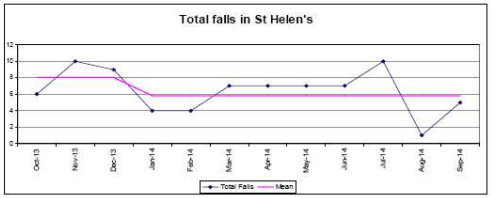


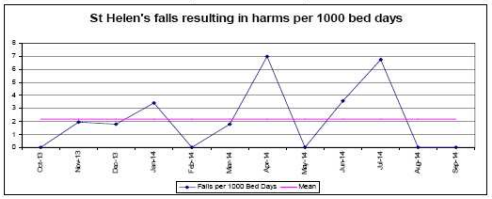


New Wound Management policy being launched, (this includes Guidance on pressure ulcer prevention and management).

Falls Incidence – St Helen's Community Hospital







One patient fell twice resulting in harm in July. There have been no falls resulting in harm since august.

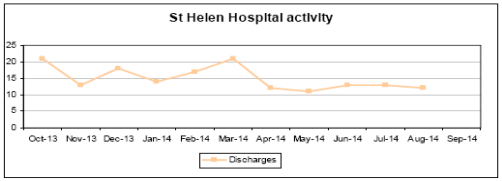
New assessment and care plan documentation being rolled out at community hospitals.

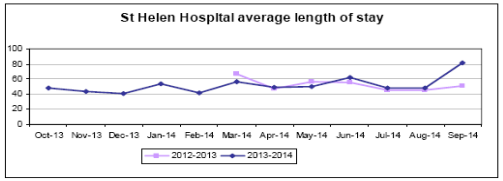
Alongside this roll out there will be falls prevention training for all staff.

St Helen's Deaths & Mortality Reviews

St Helen's Community Hospital Deaths & Mortality reviews	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 13
Number of in-hospital deaths	0	0	2	1	0	3	1	0	0	2	1	0
Number of mortality reviews	0	0	2	1	0	2	1	0	0	2	1	0

St Helen's Activity





The Friends and Family Test – Monthly Performance Community Hospitals – St Helen's

Ward		May 14	Jun 14	Jul 14	Aug14	Sep 14
St Helen's	Response rate	40%	50%	54.5%	55.6%	80.0%
	Eligible	10	10	11	9	10
	Responses	4	5	6	5	8

Safety Thermometer Data – St Helen's

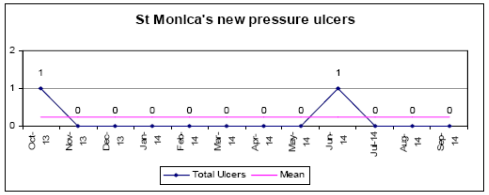
St Helen's Hospital	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14
New VTE's	0	0	0	0	1	0	0	0	0	0	0	0
Falls with harm	0	0	0	0	2	0	0	0	1	0	0	0
Pressure Ulcers	2	3	1	2	0	0	7	3	3	1	2	0
New CAUTI	0	0	0	0	0	0	0	0	1	0	1	1
Total Harms	**2**	**3**	**1**	**2**	**3**	**0**	**7**	**3**	**5**	**1**	**3**	**1**
Empty Admin Boxes	2	1	1	0	0	2	1	2	1	0	0	0
Omission Code 4	2	0	0	1	1	0	1	1	0	0	1	1
Omitted Critical Medicines	0	0	1	0	0	0	0	0	1	0	0	0

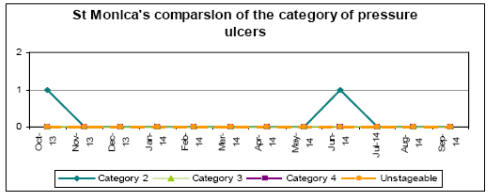
St Monica's Community Hospital & North Locality
Patient Safety Dashboard – 18/09/14

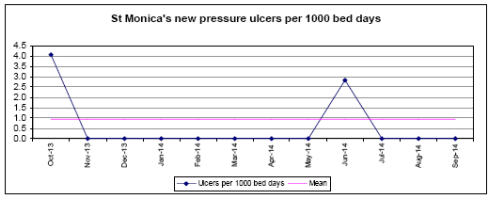
St Monica's Community Hospital Datix Incident Reporting	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 13	Sep 14
Number of incidents reported on - Datix web	3	6	2	4	8	5	3	5	5	7	0	3
Number of medication related incidents	1	1	0	2	0	1	0	1	1	1	0	0
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	0
Number of formal complaints	0	0	0	0	0	0	0	0	0	0	0	0
Number of Serious Incidents (SI's)	0	0	0	0	0	0	0	1	0	0	0	0
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	0

North Locality Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of incidents reported on - Datix web	8	13	5	15	8	14
Number of medication related incidents	0	1	1	1	0	2
Number of settled clinical litigation cases	0	0	0	0	0	0
Number of formal complaints	0	0	0	0	0	0
Number of Serious Incidents (SI's)	0	0	0	1	0	0
Number of Critical Incidents (CI's)	0	0	0	0	0	0

Pressure Ulcer Incidence – St Monica's Community Hospital



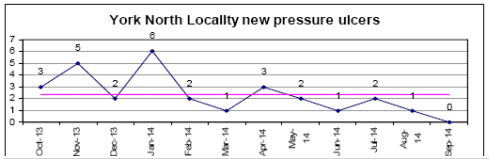


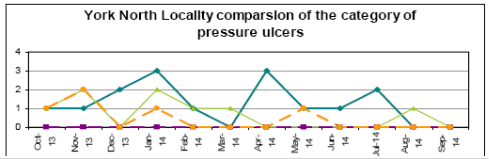


Only 1 new pressure ulcer developed at St Monica's this year.

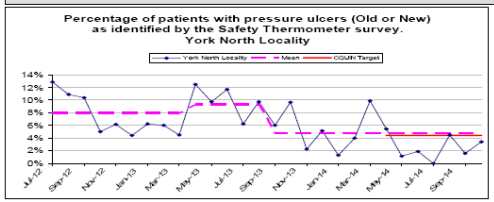
New Wound management policy being launched and rolled out across the patch. This contains guidance on the prevention and management of pressure ulcers.

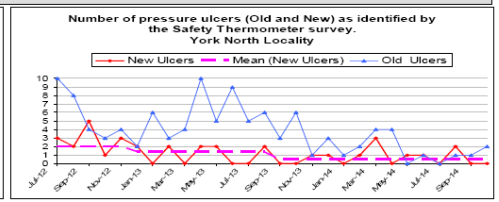
Pressure Ulcer Incidence – North Locality



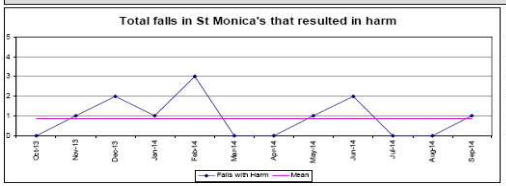


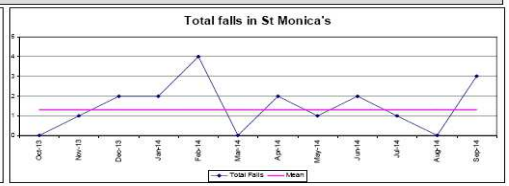
Pressure Ulcer Prevalence – North Locality (CQUIN)

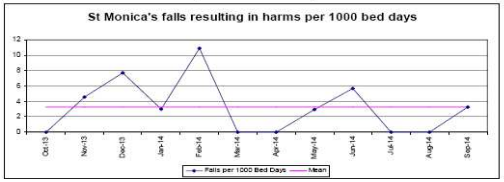




Falls Incidence – St Monica's Community Hospital





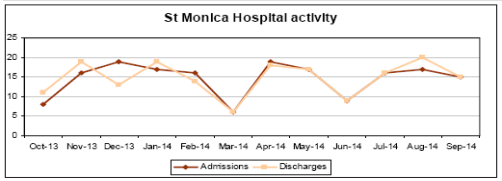


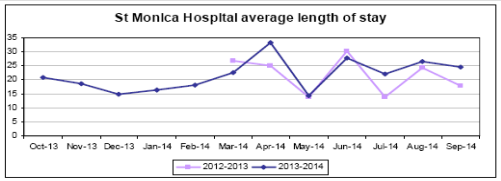
New assessment and care planning documentation is being launched across all community hospitals. All staff will receive a training session on falls prevention as part of this roll out.

St Monica's Deaths & Mortality Reviews

St Monica's Community Hospital Deaths & Mortality reviews	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of in-hospital deaths (percentage discharged as died)	2 (18.2%)	2 (10.5%)	2 (15.4%)	4 (21.1%)	2 (14.3%)	2 (33.3%)	2 (11.1%)	4 (23.5%)	2 (22.2%)	3 (18.8%)	4 (20%)	4 (26.7%)
Number of mortality reviews	1	1	1	3	0	2	2	1	0	1	2	0

St Monica's Activity





The Friends and Family Test – Monthly Performance Community Hospitals – St Monica's

Ward		May 14	Jun 14	Jul 14	Aug 14	Sep 14
St Monica's	Response rate	44.4%	50%	55.6%	20%	12.5%
	Eligible	9	6	9	10	8
	Responses	4	3	5	2	1

Safety Thermometer Data – St Monica's & North Locality

St Monica's Hospital	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14
New VTE,s	0	0	0	0	0	0	0	0	0	0	0	0
Falls with harm	0	0	0	0	0	0	0	1	0	0	0	0
Pressure Ulcers	1	1	1	0	3	0	0	2	0	0	1	1
New CAUTI	0	0	0	1	0	0	0	0	0	0	0	0
Total Harms	**1**	**1**	**1**	**1**	**3**	**0**	**0**	**3**	**0**	**0**	**1**	**1**
Empty Admin Boxes	1	3	1	0	3	1	3	1	1	0	2	1
Omission Code 4	1	1	0	1	0	3	0	3	1	0	0	0
Omitted Critical Medicines	0	0	0	0	1	2	0	0	0	0	1	0

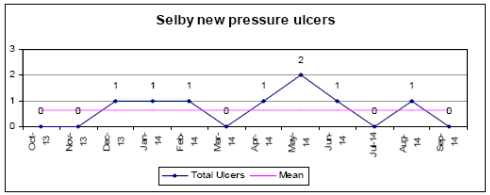
North York Locality	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14
New VTE's	0	0	1	0	0	0	0	0	0	0	1	1
Falls with harm	0	0	0	1	0	0	1	1	1	0	0	1
Pressure Ulcers	3	3	1	4	4	4	1	1	0	3	0	1
New CAUTI	1	1	1	0	2	0	1	2	0	0	0	0
Total Harms	**4**	**4**	**3**	**5**	**6**	**4**	**3**	**4**	**1**	**3**	**1**	**3**

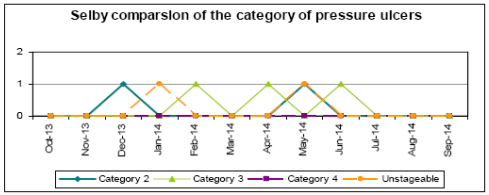
Selby Community Hospital & Selby Locality Patient Safety Dashboard – 15/10/14

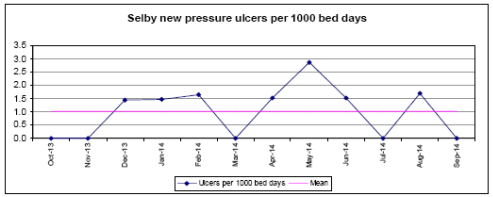
Selby Community Hospital Datix Incident Reporting	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 13
Number of incidents reported on Datix web	18	16	14	11	10	11	7	17	25	16	12	8
Number of medication related incidents	4	0	0	0	0	0	0	0	2	0	1	0
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	0
Number of formal complaints	0	0	0	0	0	0	0	0	0	0	0	1
Number of Serious Incidents (SI's)	0	0	1	1	0	0	1	0	1	0	1	0
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	0

Selby Locality Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of incidents reported on Datix web	14	12	14	9	9	13
Number of medication related incidents	1	0	0	0	0	0
Number of settled clinical litigation cases	0	0	0	0	0	0
Number of formal complaints	0	0	0	0	0	0
Number of Serious Incidents (SI's)	1	0	0	1	1	1

Pressure Ulcer Incidence – Selby Community Hospital



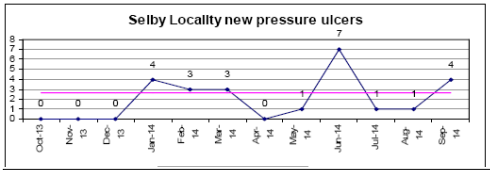


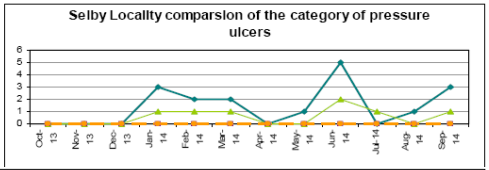


No new pressure ulcers reported in Selby in-patient ward in July or August 2014.

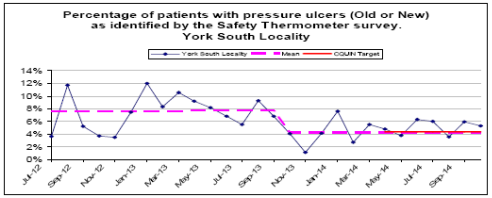
New Wound Management Policy ratified, (includes Pressure Ulcer Prevention and Management guidelines) – to be cascaded to all staff.

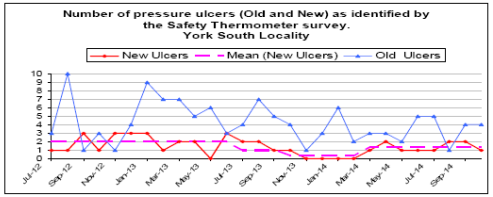
Pressure Ulcer Incidence – Selby Locality



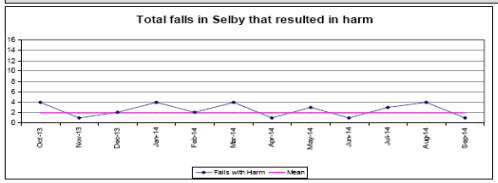


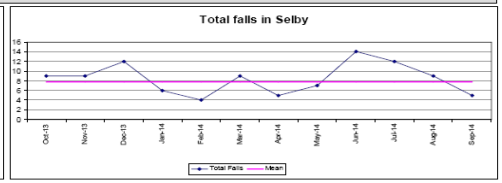
Pressure Ulcer Prevelance – Selby Locality (CQUIN)

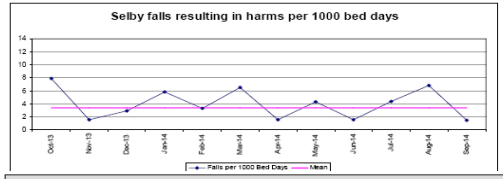




Falls Incidence – Selby Community Hospital







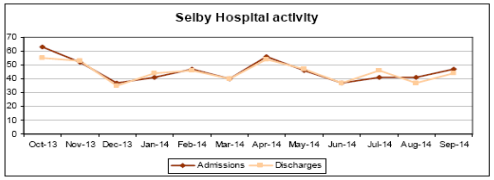
New in-patient assessment and care plan documentation being launched over the next month, currently being tested at three community hospitals.

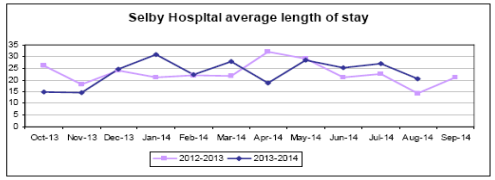
Alongside the roll out of this new documentation a training package in falls prevention will be delivered to all staff.

Selby Deaths & Mortality Reviews

Selby Community Hospital Deaths & Mortality reviews	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of in-hospital deaths (percentage discharged as died)	4 (7.3%)	6 (11.3%)	2 (5.7%)	3 (6.8%)	3 (6.5%)	3 (7.5%)	4 (7.4%)	3 (6.4%)	1 (2.7%)	4 (8.7%)	2 (5.4%)	2 (4.5%)
Number of mortality reviews	4	6	1	2	2	2	3	3	1	2	1	0

Selby Activity





The Friends and Family Test – Monthly Performance Community Hospitals - Selby

Ward		May 14	Jun 14	Jul 14	Aug 14	Sep 14
Selby IPU	Response rate	23.53%	25%	41.7%	55.6%	39.1%
	Eligible	17	16	24	9	23
	Responses	4	4	10	5	9

Safety Thermometer Data

Selby Hospital	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14
New VTE's	0	0	1	0	0	0	0	0	0	1	0	0
Falls with harm	0	0	1	0	2	0	0	1	0	2	0	0
Pressure Ulcers	1	2	1	1	1	0	3	4	4	0	4	3
New CAUTI	0	0	1	0	0	0	1	0	0	1	0	1
Total Harms	**1**	**2**	**4**	**1**	**3**	**0**	**4**	**5**	**4**	**4**	**4**	**4**
Empty Admin Boxes	4	3	1	1	3	1	2	3	3	0	0	0
Omission Code 4	1	0	1	3	0	0	0	0	5	0	0	1
Omitted Critical Medicines	1	2	0	1	1	1	0	1	3	0	0	0

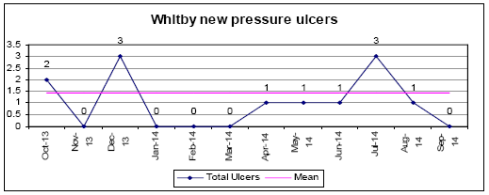
Selby Locality	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14
VTE	0	0	0	0	1	0	0	1	0	0	0	1
Falls	0	0	0	0	0	2	2	2	0	0	0	1
Pressure Ulcers	0	1	5	1	3	5	0	2	2	3	2	2
CAUTI	3	0	1	0	0	1	1	1	2	2	0	0
Total Harms	**3**	**1**	**6**	**1**	**4**	**8**	**3**	**6**	**4**	**5**	**2**	**4**

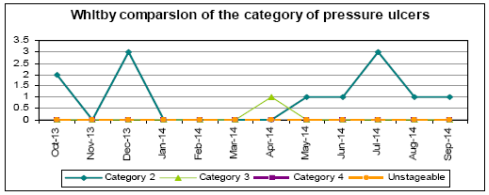
Whitby Community Hospital & Whitby Locality - Patient Safety Dashboard

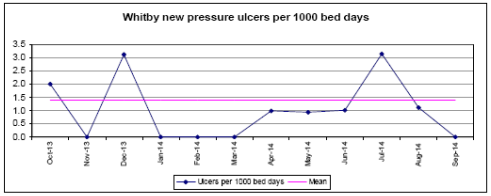
Whitby Community Hospital Datix Incident Reporting	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of incidents reported on - Datix web	34	24	16	14	18	15	14	27	21	17	18	14
Number of medication related incidents	2	1	0	0	1	1	1	1	2	1	2	0
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	0
Number of formal complaints	0	0	0	0	0	0	0	0	0	0	0	0
Number of Serious Incidents (SI's)	0	0	0	0	0	0	1	0	1	0	0	0
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	0

Whitby Locality Datix Incident Reporting	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of incidents reported on - Datix web	8	8	3	4	2	4	9	6	11	10	8	5
Number of medication related incidents	0	0	0	0	0	0	0	0	0	0	0	0
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	0
Number of formal complaints	N/K	N/K	N/K	N/K	N/K	0	0	0	0	0	0	0
Number of Serious Incidents (SI's)	N/K	N/K	N/K	N/K	N/K	0	0	0	0	0	0	0

Pressure Ulcer Incidence – Whitby Community Hospital



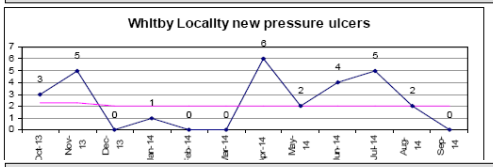


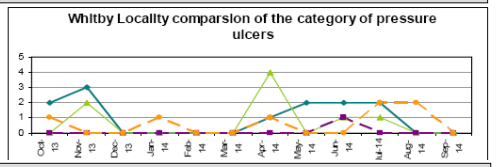


New wound management policy being launched across the patch, this contains guidance for staff on the prevention and management of pressure ulcers.

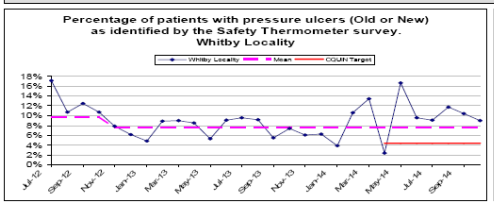
Audit of compliance with the policy will take place in the new year.

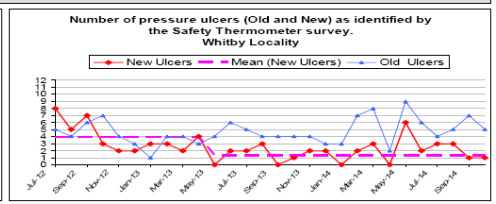
Pressure Ulcer Incidence – Whitby Locality



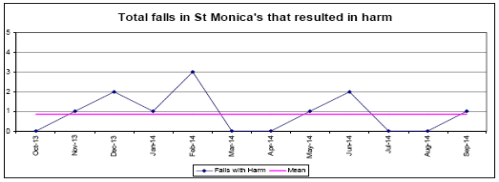


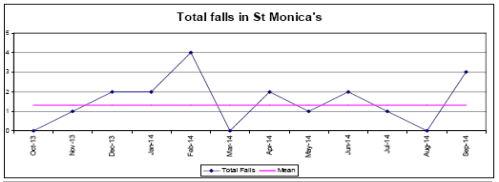
Pressure Ulcer Prevalence – Whitby Locality (CQUIN)

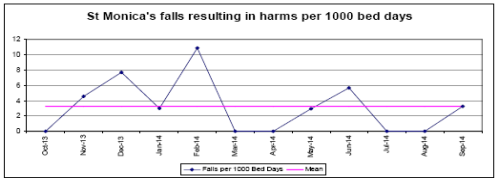




Falls Incidence – Whitby Community Hospital







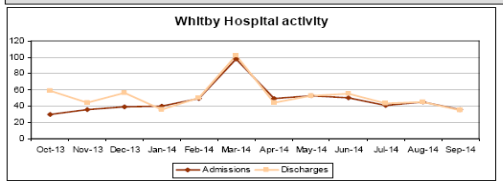
New falls assessment and care planning documentation will be rolled out across the community hospitals in November and December 14.

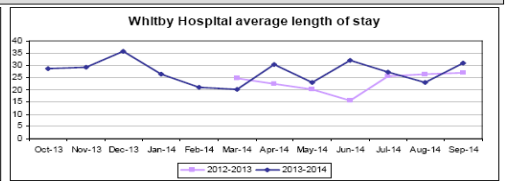
All staff will receive a training session on falls prevention as part of this roll out.

Whitby Deaths & Mortality Reviews

Whitby Community Hospital Deaths & Mortality reviews	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of in-hospital deaths	4 (6.8%)	5 (11.4%)	1 (1.8%)	0 (0%)	4 (8%)	5 (4.9%)	3 (6.8%)	7 (13.2%)	5 (9.1%)	1 (2.3%)	6 (13.3%)	6 (17.1%)
Number of mortality reviews	0	0	2	0	2	1	2	4	1	2	2	0

Whitby Activity





The Friends and Family Test – Monthly Performance Community Hospitals – Whitby

Ward		May 14	Jun 14	Jul 14	Aug 14	Sep 14
Whitby	Response rate	39.4%	48.5%	58.8%	43.5%	90.0%
	Eligible	33	33	34	23	10
	Responses	13	16	20	10	9

Safety Thermometer Data – Whitby & Whitby Locality

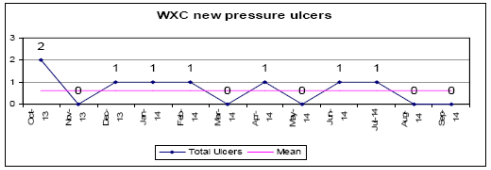
Whitby Hospital	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14
New VTE's	0	0	0	0	0	1	0	0	0	0	0	0
Falls with Harm	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers	2	1	2	5	4	1	7	3	1	3	1	4
New CAUTI	0	0	1	0	2	0	0	0	0	0	0	1
Total Harms	**2**	**1**	**3**	**5**	**6**	**2**	**7**	**3**	**1**	**3**	**1**	**5**
Empty Admin Boxes	7	1	1	0	0	6	2	2	1	1	0	0
Omission Code 4	2	0	0	1	3	4	2	2	0	0	1	1
Omitted Critical Medicines	0	0	0	0	0	0	0	2	0	3	0	0

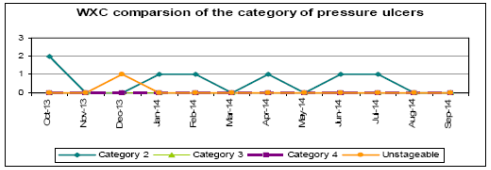
Whitby Locality	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14
New VTE's	0	0	0	0	1	0	0	0	0	0	0	0
Falls with harm	0	0	1	0	2	1	1	3	0	0	0	0
Pressure Ulcers	4	4	1	4	7	2	9	6	6	5	7	2
New CAUTI	0	1	1	1	2	2	3	1	0	0	0	0
Total Harms	**4**	**5**	**3**	**5**	**12**	**5**	**13**	**10**	**6**	**5**	**7**	**2**

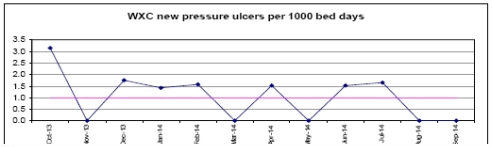
White Cross Court Community Hospital
Patient Safety Dashboard – 15/10/2014

WXC Datix Incident Reporting	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of incidents reported on - Datix web	26	12	35	12	18	13	13	28	18	28	4	15
Number of medication related incidents	0	0	2	1	1	1	0	2	0	1	0	3
Number of settled clinical litigation cases	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	0	0	0
Number of formal complaints	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	0	0	0
Number of Serious Incidents (SI's)	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	0	0	0
Number of Critical Incidents (CI's)	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	0	0	0

Pressure Ulcer Incidence –White Cross Court Community Hospital

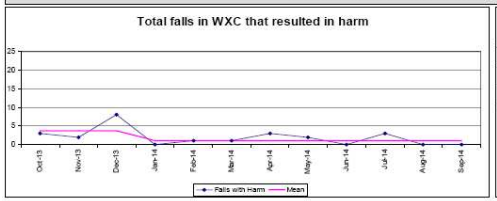


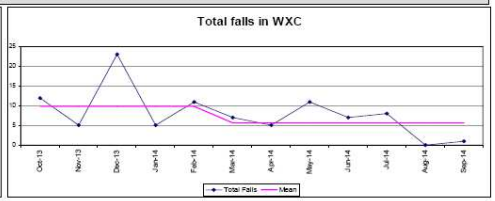


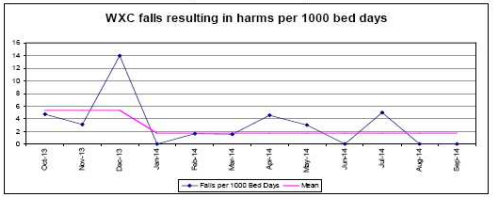


New wound management policy ratified Includes guidance on Pressure Ulcer prevention and management – to be disseminated to all staff.

Falls Incidence – White Cross Court Community Hospital







New falls assessment and care plan documentation being launched in all community hospitals.

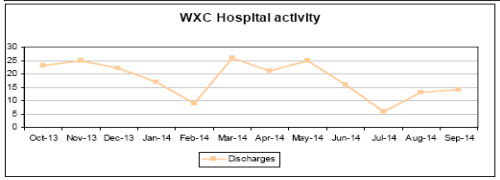
This launch will include a training session on falls prevention for all staff.

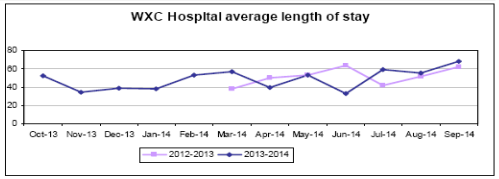
No patients have sustained harm from a fall at WXC since July.

White Cross Court Deaths & Mortality Reviews

WXC Community Hospital Deaths & Mortality reviews	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
Number of in-hospital deaths	0	2	5	1	1	1	1	2	1	0	2	3
Number of mortality reviews	0	1	2	1	0	0	0	1	1	0	1	0

White Cross Court Activity





The Friends and Family Test – Monthly Performance Community Hospitals – White Cross Court

Ward		May 14	Jun 14	Jul 14	Aug 14	Sep 14
WXC	Response rate	9.1%	85.7%	20%	36.4%	0.0%
	Eligible	22	14	5	11	11
	Responses	2	12	1	4	0

Safety Thermometer Data – White Cross Court

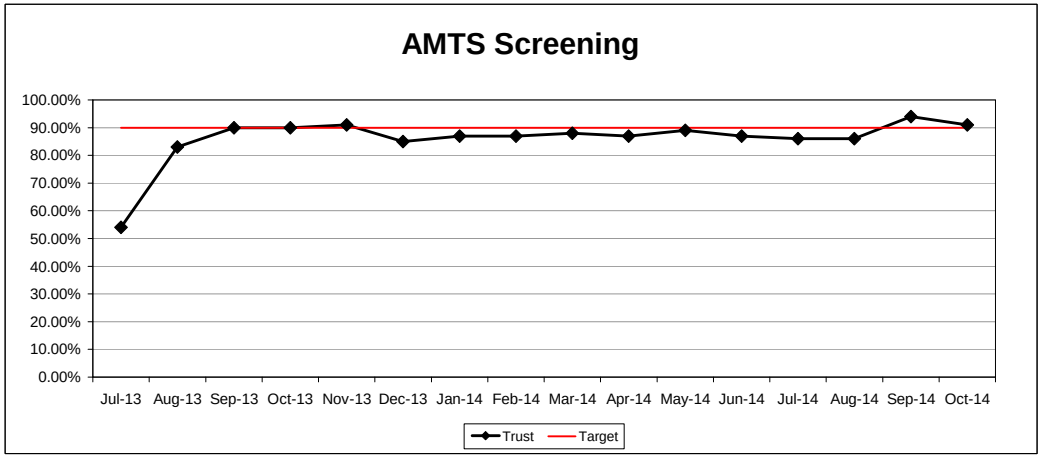
WXC Hospital	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14
New VTE's	0	1	0	0	1	0	0	0	0	0	0	0
Falls with harm	0	1	0	0	0	0	2	0	0	0	0	0
Old Pressure Ulcers	1	2	2	2	1	1	5	4	3	3	2	0
New CAUTI	1	1	1	0	0	0	0	0	0	1	0	0
Total Harms	**2**	**5**	**3**	**2**	**2**	**1**	**7**	**4**	**3**	**4**	**2**	**0**
Empty Admin Boxes	4	2	2	1	2	7	1	5	1	0	3	3
Omission Code 4	1	1	1	0	0	5	1	3	1	0	0	0
Omitted Critical Medicines	2	0	0	2	0	0	0	3	1	0	0	1

Dementia

Percentage of Patients Meeting the AMTS screening target (Trust)												
Indicator	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
AMTS Screening	91%	85%	87%	87%	88%	87%	89%	87%	86%	86%	94%	91%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Patients Meeting the AMTS screening target (York)												
Indicator	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
AMTS Screening	93%	88%	91%	94%	95%	93%	92%	90%	90%	87%	94%	92%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Patients Meeting the AMTS screening target (Scarborough)												
Indicator	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
AMTS Screening	93%	83%	85%	80%	80%	79%	87%	86%	86%	87%	100%	92%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

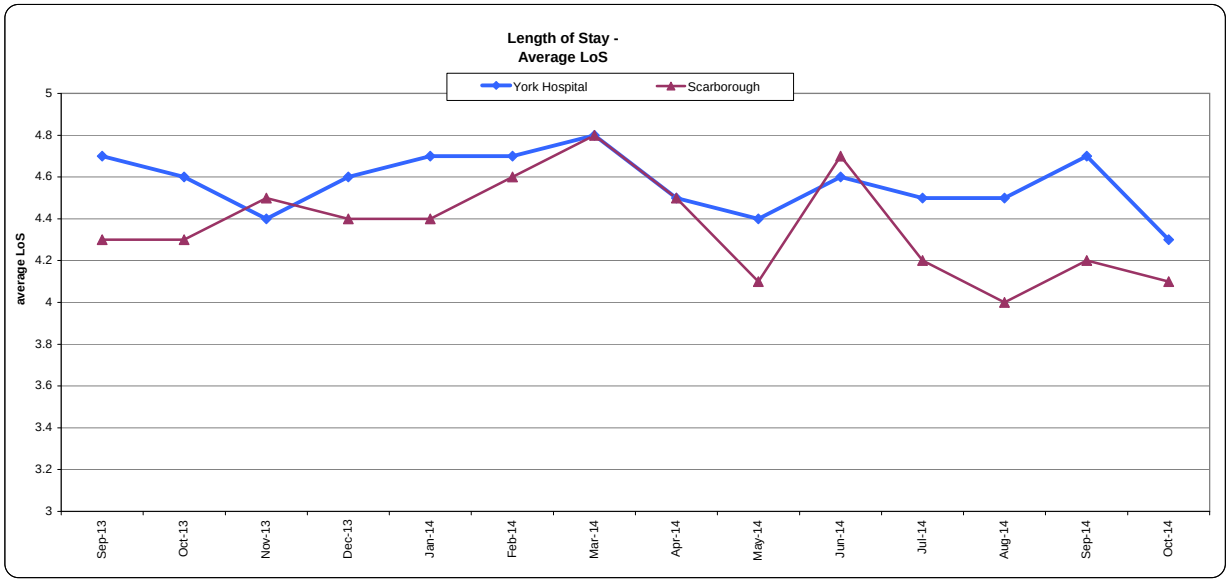
The Trust achieved the target for dementia screening in October.

Data source: Signal



Clinical Effectiveness Dashboard

Clinical Effectiveness



The Length of Stay (LOS) for in-patients (excluding day cases and babies) reduced on both acute sites during October when compared with the previous month.

Data source: Signal

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

Description	Change	Value Current Period	Value Previous Period	Site Numerator	Site Denominator	Peer 25th Percentile	Peer 75th Percentile	Peer Average	Peer Numerator	Peer Denominator	Rating
Data Quality Index (HRGv4 based)	Current period is 1% worse than previous period.	95.2	96	170,251	178,897	95.5	96.8	95.7	16,044,869	16,766,363	Red
% FCEs with palliative care code	Current period is 3% better than previous period.	0.70%	0.73%	1,242	176,535	1.01%	0.64%	0.80%	132,758	16,598,587	Amber
% Deaths with Palliative care code	Current period is 0% better than previous period.	15.45%	15.45%	300	1,942	26.12%	16.37%	21.38%	37,174	173,908	Green
% Sign or symptom as a primary diagnosis	Current period is 4% better than previous period.	10.93%	11.35%	19,302	176,535	11.82%	9.27%	10.10%	1,676,070	16,598,587	Amber
Complication Rate Attributed	Current period is 5% better than previous period.	0.74%	0.78%	1,012	136,224	0.89%	0.62%	0.80%	112,648	14,038,872	Amber
Misadventure rate	Current period is 1% better than previous period.	0.06%	0.06%	75	136,224	0.12%	0.06%	0.10%	13,685	14,038,872	Green
Outpatient DNA Rate	Current period is 15% better than previous period.	5.50%	6.40%	34,166	623,657	9.00%	7.20%	8.60%	1,291,827	15,028,137	Green
Mortality	Current period is 8% better than previous period.	1.44%	1.58%	1,968	136,224	1.47%	1.15%	1.22%	170,757	14,038,872	Amber
Rate of emergency readmission to hospital within 14 days - COPD	Current period is 1% worse than previous period.	16.40%	16.30%	161	979	18.90%	13.70%	17.60%	17,865	101,590	Amber
Risk adjusted mortality index 2014	Current period is 5% better than previous period.	101	106	1,674	1,664	94	82	89	135,895	152,616	Red
Rates of deaths in hospital within 30 days of Non-elective surgery	Current period is 2% worse than previous period.	1.70%	1.70%	156	9,128	1.70%	1.00%	1.40%	13,829	990,245	Amber
Rates of deaths in hospital within 30 days of Elective surgery	Current period is 16% worse than previous period.	0.02%	0.02%	6	27,767	0.04%	0.02%	0.03%	868	2,854,362	Amber
Discharge to usual place of residence within 28 days of emergency admission from there with a hip fracture	Current period is 5% better than previous period.	54.00%	51.40%	355	658	43.00%	56.00%	49.30%	24,255	49,223	Amber

Maternity Dashboard - York and Scarborough

York Teaching Hospital NHS
NHS Foundation Trust

York Maternity Dashboard:

			Measure	Data source	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Flag Source	November	December	January	February	March	April	May	June	July	August	September	October	Av. Monthly YtD	Action Log completed (Date)	Notes
Activity	Births	Bookings	1st m/w visit	CMIS from Jan CPD	≤302	302-329	≥330	prev. stats	330	316	399	316	291	273	249	226	291	264	324	229	296		
		Bookings <13 weeks	No. of mothers	CMIS from Jan CPD	≥90%	76%-89%	≤75%	CQUIN	89%	88%	86%			82%	81%	87%		98%			1		
		Bookings ≥13 weeks (exc transfers	No. of mothers		< 10%	10%-20%	>20%	CQUIN						18.0%				2.2%			10.1%		
		Bookings ≥ 13wks seen within 2 wk	No. of mothers	Mat Rec	≥90%	76%-89%	≤75%	CQUIN										100.0%			100.0%		
		Births	No. of babies	CMIS	≤295	296-309	≥310	prev. stats	279	285	295	234	285	248	287	288	302	311	303	316	287		
		No. of women delivered	No. of mothers	CMIS					274	276	288	230	279	242	285	288	296	309	287	314	275		
	Closures	Homebirth service suspended	No. of closures	Comm. Manager	0-3	4-6	7 or more		6	4	1	2	4	0	2	0	0	0	1	1	2		
		Homebirth service suspended	No. of women	Comm. Manager	0	1	2 or more		0	0	0	1	0	0	0	0	0	0	0	0	0		
		Escalation Policy implemented	No. of times	Comm. Manager	3	4-5	6 or more		3	2	3	0	2	1	2	4	4	2	1	5	3		
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	1	1	0	0	0	0	0		
		SCBU closed to admissions	in utero transfers	Transfer folder	0	1	2 or more		0	3	0	0	0	0	5	0	1	1	0	0	1		
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	28.4	29.8	31.0	31.0	28.5	29.0	29.0	29.0	29.8	30.5			29.5		
		HCA's	Ratio	Matron				staffing paper	20.02	21.01	19.43	19.43	19.43	19.43	19.43	18.83	19.43	19.03			19.6		
		1 to 1 care in Labour		Risk Team	≥75%	61%-74%	≤60%							75.6%	75.0%	77.8%	79.8%	83.9%	78.1%		78.4%		
		L/W Co-ordinator supernumary %		Risk Team					47	45	51	80	65	71	51	50	45	61	48	43	54.3		
		Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	76	76	76	76	76	76	76	76	76	76	76	76	76.0		
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10		10	10	10	10	10	10	10	10	10	10	10	10	10.0		
		Supervisor : M/w ratio 1 :	Ratio	Rota	12	13-15	15	SHA	13	13	12	13	14	14	14	14	14	14	14	14	13.6		
Clinical Indicators	Neonatal/Maternal Morbidity	Sponateous Vaginal Births	No. of svd	CMIS	≥65%	64%	≤63%		64.8	62.1	61.7	61.5	59.6	58.0	58.5	65.6	62.7	61.4	64.4	58.2	62.2		
		Operative Vaginal Births	No. of instr. births	CMIS	≤15%	16-19%	≥20%	prev. stats	10.7	12.9	9.5	15.8	12.6	22.4	19.9	14.6	12.7	13.2	11.2	14.9	13.6		
		C/S Deliveries	Em & elect	CMIS	≤24%	24.1-25.9	≥26%	prev. stats	24.0	24.5	28.8	22.6	27.7	25.8	26.0	23.3	27.3	22.8	21.1	25.6	24.9		
		Eclampsia	No. of women	CMIS	0		1 or more		0	0	1	0	0	0	1	0	0	0	0	1	0.2		
		Undiagnosed Breech in Labour	No. of women	CMIS	2 or less	3-4	5 or more	prev. stats	3	1	1	0	0	0	2	1	3	0	0	1	1.1		
		ICU transfers	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	1	2	0	0	0	0	2	0	0	0	0	0.4		
		HDU on L/W	No. of days	Handover Sheet					15	14	18	17	11	10	30	30	20	20	15	25	18.9		
		Uterine Rupture from Jan 14	No of women	CPD	0	1	2 or more				0	0	0	0	0	0	0	0	0	0	0.0		
		BBA	No. of women	Risk Team - Datix	1	2-3	4 or more	prev. stats	4	1	4	2	3	4	5	3	4	3	7	4	3.7		
		Meconium Aspirate	No. of babies	SCBU sister	0	1	2 or more	prev. stats	0	0	0	1	0	0	0	0	0	0	0	0	0.1		
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	1	0	0	1	0.2		
	Risk Management	SI's	Total	Risk Team	0	1	2 or more		0	0	0	0	0	0	1	0	0	0	0	0	0.1		
		PPH > 2L	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		7	1	1	2	1	1	5	4	4	1	2	2	3.0		
		Shoulder Dystocia - True	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	RCOG	8	3	0	0	2	1	3	5	2	3	7	5	3.3		
		3rd/4th Degree Tear	% of tears (vaginal b	CMIS	≤1.5%	1.6-6.1%	≥6.2%	RCOG	6.1	2.8	4.7	4.4	8.8	5.4	5.3	6.4	6.3	2.3	3.5	2.2	4.5	February 2013	April 2013 - range of goals rev
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		89	99	94	96	95	96	94	92	91	91	91	89	92.6		
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		50	69	78	81	81	78	83	74	71	71	46	46	66.5		
		Training cancelled	No. of staff affected	Risk Team	0		≥1		0	1	1	0	0	0	0	0	0	0	0	0	0.7		
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		1	0	3	0	1	3	0	3	3	1	1	1	1.2		
		Formal	Total	Matron	0	1-4	5 or more		1	2	2	1	0	2	0	0	1	0	2	0	1.0		
	New Claims		Total	Directorate Manager	0	1	2 or more		0	0	2	1	0	1	0	0	0	0	0	0	0.4		

Scarborough Maternity Dashboard:

	Measure	Data source	No Concern(green)	Of Concern (Amber)	Concerns (Red)	Flag Source	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Av. Monthly YtD	Action Log completed (Date)
Bookings	1st m/w visit	IS - Evolution	≤200	201-249	≥250	prev. stats	199	185	249	190	201	193	183	185	187		119		195	
Bookings <13 weeks	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	96%	100%	100%	100%	100%	96%	90%	95%	89%				96%	
Bookings <13 weeks (exc transfers etc)	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	96%	n/a	n/a	n/a	n/a	89%	100%	100%	100%				97%	
Bookings ≥ 13wks seen within 2 wks	No. of mothers		≥90%	76%-89%	≤75%	CQUIN						3.0		0.1	0.1				1.1	
Births	No. of babies	IS - Evolution	≤170	171-189	≥190	prev. stats	131	124	145	128	119	118	119	124	132	158	146	145	132	
No. of women delivered	No. of mothers	IS - Evolution	≤170	171-189	≥190	prev. stats	129	122	143	126	118	119	119	125	134	158	145	145	132	
Homebirth service suspended	No. of closures	Comm Team Leader	0-3	4-6	7 or more		0	0	0	0	0	0	0	1	0	0	0	0	0	
Homebirth service suspended	No. of women	Comm Team Leader	0	1	2 or more		0	0	0	0	0	0	0	1	0	0	0	0	0	
Escalation Policy implemented	No. of times	Matron	3	4-5	6 or more		0	0	0	0	0	0	0	1	0	0	0	0	0	
Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	0	1	0	0	0	0	0	
MLU Closure	No. of closures	Matron	0	1-2	3 or more														#DIV/0!	MLU closed from 1
MLU Closure	No. of women	Matron	0	1-2	3 or more														#DIV/0!	MLU closed from 1
SCBU closed to elective admissions	In utero transfers	Risk Team	0	1	2 or more		3	22	8	4	4	7	26	10	4	21	10	8	11	
M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	44.0	44.0	44.0	44.0	44.0	44.0	43.0	43.0	43.0	41.0	38.0	38.0	42.5	
HCA's	WTE	Matron				staffing paper	19.59	19.59	18.32	18.32	18.32	18.32	17.92	17.12	17.12	16.72	15.92	15.92	17.77	
1:1 care in labour		IS - Evolution					96%	99%	96%	98%	99%	88%	86%	87%	88%	88%	92%	93%	93%	
L/W Co-ordinator Supernumary %		L/W Manager					56%	62.9%	41.93%	55.3%	64.5%	64.5%	70.9%	75%	58%	50%	50%	58%	60%	
Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	40	40	40	40	40	40	40	40	40	40	40	40	40	
Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10	Safer Childbirth	3	3	3	3	3	3	3	3	3	3	3	3	3	
Supervisor : M/w ratio 1 :	Ratio	Matron	15	16-19	20	NMC	13	13	14	14	14	14	14	14	14	14	14	14	14	
Spontaneous Vaginal Births	No. of svd	IS - Evolution	≥65%	64%	≤63%		65.6%	67.7%	68.3%	71.9%	72.3%	76.7%	68.9%	64.0%	76.5%	70.3%	76.0%	71.0%	70.8%	
Operative Vaginal Births	No. of instr. births	IS - Evolution	≤15%	16-19%	≥20%	prev. stats	6.1%	4.0%	3.4%	4.7%	5.9%	3.4%	6.7%	6.5%	3.8%	9.5%	9.0%	5.5%	5.7%	
C/S Deliveries	Em & elect	IS - Evolution	≤24%	24.1-25.9	≥26%	prev. stats	26.0%	26.6%	26.9%	21.9%	21.0%	19.8%	23.5%	29.0%	18.9%	20.9%	15.2%	22.8%	22.7%	
Eclampsia	No. of women	IS - Evolution	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0	0	
Undiagnosed Breech in Labour	No. of women	Risk Team	2 or less	3-4	5 or more	prev. stats	1	0	0	0	0	1	1	0	0	0	0	0	0	
ICU transfers	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	0	0	
HDU on L/W	No. of days	Risk Team					5	4	2	3	1	3	0	0	2	2	2	2	2	
P/N Hysterectomies < 7days p/n	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	0	0	
BBA	No. of women	IS - Evolution	1	2-3	4 or more	prev. stats	0	1	1	1	0	0	0	0	3	2	0	2	1	
Meconium Aspirate	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	1	0	1	0	0	1	0	0	0	0	0	0	
Diagnosis of HIE	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	1	0	0	0	0	0	0	
SI's	Total	Risk Team	0	1	2 or more		0	0	0	1	0	1	0	0	0	0	1	1	0	
PPH > 2L	No. of women	IS - Evolution	1 or less	2-3	3 or more		1	1	0	1	0	2	0	0	2	0	1	3	1	
Shoulder Dystocia - True	No. of women	IS - Evolution	1 or less	2-3	3 or more	RCOG	0	0	1	0	0	0	1	1	0	1	0	0	0	
3rd/4th Degree Tear	% of tears (vaginal b	IS - Evolution	≤1.5%	1.6-6.1%	≥6.2%	RCOG	0.8%	2.5%	4.9%	4.0%	0.0%	0.4%	0.7%	1.6%	0.0%	1.3%	0.7%	2.1%	1.6%	
YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		92	88	91	93	93	91	90	94	93	93	93	94	93	
YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		82	90	87	92				77	92	92	92	92	78	
Training cancelled	No. of staff affected	Risk Team	0		≥1		0	1	0	0	0	0	0	0	0	0	6	0	1	
Informal	Total	Matron	0	1-4	5 or more		3	1	1	3	2	0	1	0	1	2	3	1	2	
Formal	Total	Matron	0	1-4	5 or more		1	1	1	1	0	2	0	0	0	1	4	0	1	
New Claims	Total	Risk Team	0	1	2 or more		0	0	0	2	1	0	1	0	1	1	0	0	1	

This paper provides an update on current status and risk issues with NICE Guidelines at the Trust on the 1st November 2014.

NICE Clinical Guidance

Guidance	Site	Compliant with evidence	Compliant without evidence	Partially compliant			Not compliant	Pending	Not Relevant	Total Guidance
				No action plan required as agreed by CSG	With action plan	No action plan				
Clinical Guidelines	Y	28	33	11	39	0	0	14	1	**126**
	S	24	26	6	15	3	0	41	11	**126**
	Trust	11	22	10	31	2	0	49	1	**126**
Non-Drug Technology Appraisal	Y	4	9	2	0	0	0	1	0	**16**
	S	4	6	0	0	0	0	3	3	**16**
	Trust	2	9	2	0	0	0	3	0	**16**
Quality Standards	Y	6	6	5	16	2	1	30	2	**67**
	S	4	6	3	8	3	0	41	3	**68**
	Trust	2	2	2	11	2	0	49	0	**68**
Cancer Guidelines	Y	5	0	3	1	0	0	0	0	**9**
	S	2	0	6	0	0	0	1	0	**9**
	Trust	2	0	5	1	0	0	1	0	**9**

Guidance	Site	Performed	Not Performed	Pending	Total
Medical Technologies	Y	5	4	1	**10**
	S	4	4	2	**10**
	Trust	3	3	4	**10**
Diagnostic Guidance	Y	3	3	3	**9**
	S	2	4	3	**9**
	Trust	2	3	4	**9**
Interventional Procedures	Y	56	381	9	**446**
	S	17	419	10	**446**
	Trust	49	386	11	**446**

Pending
The Clinical Effectiveness Team is now fully staffed and the guidelines that are pending will be taken as our priority.

Partial with no action plan

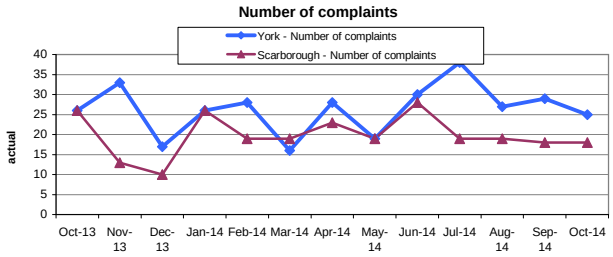
Site	Code	Title	Comment	Clinical Lead
SGH	CG134	Anaphylaxis	Awaiting response from Trish Lee re. Nursing Procedure – emailed 20th October.	Andy Volans
SGH	CG163	Idiopathic Pulmonary Fibrosis	Waiting for response from York	David Ford
SGH	CG174	Intravenous Fluid Therapy in Adults in Hospital	CH arranging to meet Colin Jones	Colin Jones
SGH	QS002	Stroke	To compare to York baseline	John Paterson
Both	QS040	Psoriasis	To compare site baselines	Calum Lyon
Both	QS063	Delirium	Being taken to dementia steering group for actions and timescales by Pamela Hayward-Sampson	Ed Jones/Sandeep Kesavan

We now have 185 pending Do Not Do's in comparison to 499 at the last CSG meeting in September. A total reduction of 314.
The Clinical Effectiveness Team are arranging to meet Clinical Leads/Director to establish compliance of outstanding do not do's

Site	Number of Do Not Do Recommendations					
	Compliant	Non Compliant	CSC Agreed to remain non compliant	Not Applicable	Pending	Total
Y	707	3	10	28	**61 (7.5%)**	809
S	590	0	18	77	**124 (15%)**	809

Patient Experience Dashboard

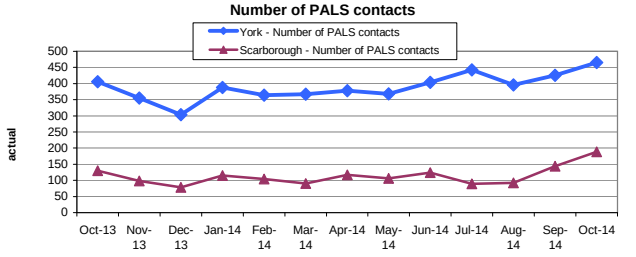
Patient Experience



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

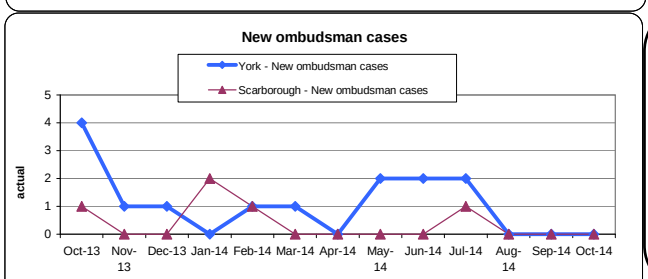
Complaints registered in Scarborough relate to Scarborough Hospital and Bridlington Hospital.

There were 25 new complaints registered to the York site and 18 to the Scarborough site in October.

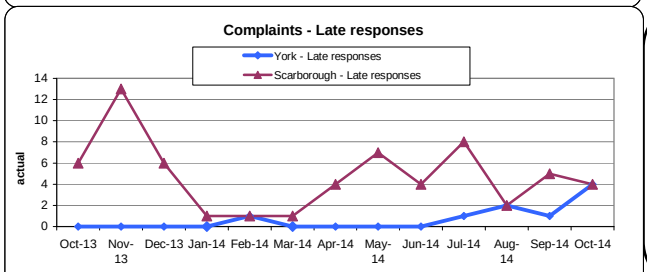


There were 465 PALS enquiries at York Hospital and 188 PALS enquiries at Scarborough in October.

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



There were no new ombudsman cases reported in October.



There was four late responses to complaints at the Scarborough site and four at the York site in October.

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

Complaint themes this month, e.g. staff attitude, increased numbers in an area (Y, S)
a) All aspects of clinical treatment continues to be a theme at SGH.
b) SGH has seen a slight increase in complaints regaqrding admissions, discharge and transfer arrangements.
c)

Any other concerns, comments, considerations relating to complaint handling
a) The quality of some complaint reports from SGH is still a cause for concern.
b) Holding letter being sent out to complainants warning of delays due to change in process and Chief Nurse team checks
c) Directorates not keeping complaints team informed if there is a delay and not always getting pinks in on time when Qcing reports.

Action plan example:
S14/15-112 - Concerns re the requesting of follow up scans as part of a maternity complaint. The Clinical Director has reminded all junior doctors of the importance of completing request cards as asked for on ward rounds. Reviewed by Matron.
S14/15-110 - DDM for specialist medicine reported and assured complaints that Pharmacy have introduced a new pre-printed prescription pad which aids Consultants to complete with the aim to eliminate error - action complete on 9/10/14.

Friends & Family Test Results

York Teaching Hospital NHS
NHS Foundation Trust

01 Aug 2014 - 31 Aug 2014 — **Inpatient / A&E**

Your Friends & Family Test Score is....	58	Last month your score was....	64

Highest score
Lowest score
Negative score

Top 3 most improved performing wards/services	6 Month Average	This Month	Improvement	Trend
A&E York	40	67	27	
Ward 25	75	90	15	
Ward 35	71	86	15	

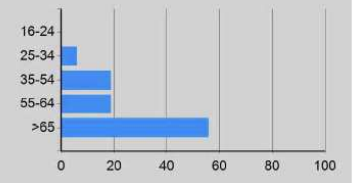
Top 3 consistently high performing wards/services	6 Month Average	This Month	Improvement	Trend
CCU York	97	100	3	
Ward 31	92	90	-2	
Lloyd	90	70	-20	

Top 3 consistently low peforming wards/services	6 Month Average	This Month	Improvement	Trend
A&E York	40	67	27	
Ward 33	52	50	-2	
A&E Scarborough	54	34	-20	

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

Who responded?

Response Rate	Male or Female	Age Profiles %
Eligible Patients 9944	45%	55%
Patient Responses 2549		
26%		



Patients extremely likely to recommend our Trust said:	Patients unlikely or extremely unlikely to recommend our Trust said:
"Very professional and caring team work. "	"Most staff wonderful-several extremely rude obnoxious and upsetting. "
"Fantastic by all the staff."	"Felt like I was left on my own with very little assistance. "

Produced by: picker Institute Europe

ating the Net Promoter Score:

: possible score the Trust t is 100, where 100% of nts are 'extremely likely' to mend ('promoters'). The sible score is -100, where f people are 'not likely' to nd ('detractors'). Everyone either likely nor unlikely', or 'extremely unlikely' to nd the ward or department unts as 'not likely'.

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

ple who are 'likely' to mend are included in the tion and are counted as al' (i.e. they are neither oters nor detractors).

T score is calculated as:

age of people extremely ely to recommend

minus

age of people not likely to recommend

S14/15-110 - DDM for specialist medicine reported and assured complaints that Pharmacy have introduced a new pre-printed prescription pad which aids Consultants to complete with the aim to eliminate error - action complete on 9/10/14.

October 2014			
Complaints by directorate/division (Datix)	**York**	**Scar**	**Total**
Child Health (Y)	1	0	1
Clinical Support Services (S)	0	2	2
Community Services (Y)	1	0	1
Corporate (Y, S)	0	0	0
Elderly Medicine (Y)	3	2	5
Emergency Medicine (Y)	1	6	7
Facilities (Y, S)	0	1	1
General Surgery & Urology (Y), Surgery (S)	4	3	7
Head & Neck & Ophthalmology (Y)	2	1	3
Medicine (General & Acute, Y), Medicine (S)	5	1	6
Obstetrics and Gynaecology (Y)	2	0	2
Operations (Y)	1	0	1
Orthopaedics (Y)	2	2	4
Pharmacy (Y)	0	0	0
Physiotherapy (Y)	0	0	0
Radiology (Y)	1	0	1
Sexual Health (Y)	0	0	0
Specialist Medicine (Y)	0	0	0
Theatres Anaesthetics & CC (Y)	2	0	2
Total	**25**	**18**	**43**

"Very professional and caring team work. "

"Fantastic by all the staff."

"Most staff wonderful-several extremely rude obnoxious and upsetting. "

"Felt like I was left on my own with very little assistance. "

Produced by: picker Institute Europe

Making patient's views count

spital NHS

ion Trust

mend

October 2014			
Complaints by subject (Datix)	**York**	**Scar**	**Total**
Admissions, discharge and transfer arrangements	2	3	5
Aids, appliances, equipment, premises	0	0	0
All aspects of clinical treatment	19	12	31
Appointment delay/cancellation (inpatient)	0	0	0
Appointments, delay/cancellation (out-patient)	1	0	1
Attitude of staff	0	1	1
Communication/information to patients (written and oral)	1	0	1
Complaints handling	0	0	0
Consent to treatment	1	0	1
Failure to follow agreed procedure	**0**	**0**	0
Hotel services, including food	**0**	**0**	0
Mortuary and post mortem arrangements	**0**	**0**	0
Other	**0**	**2**	2
Patients' privacy and dignity	**0**	**0**	0
Patients' property and expenses	**0**	**0**	0
Patients' status, discrimination	0	0	0
Personal Records	1	0	1
Policy and commercial decision of Trust	0	0	0
Total	**25**	**18**	**43**

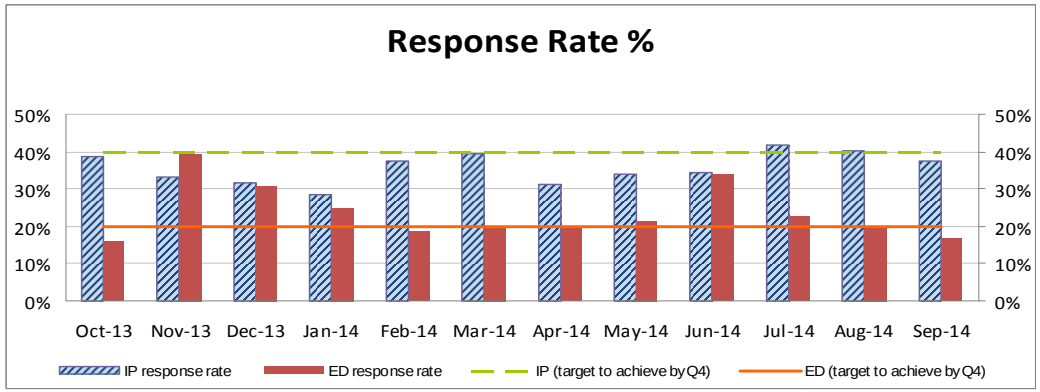
Pals Contact by Subject	**York**	**Scar**	**S+Y**
Action PLan	2	0	2
Admissions, discharge, transfer arrangements	21	6	27
Aids / appliances / equipment	4	0	4
Appointments, delay/cancellation (inpatient)	10	3	13
Appointments, delay/cancellation (outpatient)	57	24	81
Staff attitude	16	4	20
Any aspect of clinical care/treatment	55	89	144
Communication issues	37	18	55
Compliment / thanks	36	0	36
Environment / premises / estates	2	0	2
Failure to follow agreed procedure (including consent)	1	0	1
Hotel services (including cleanliness, food)	2	0	2
Requests for information and advice	178	42	220
Medication	3	0	3
NCMP	1	0	1
Car parking	5	0	5
Property and expenses	9	2	11
Personal records / Medical records	8	0	8
Safeguarding issues	1	0	1
Service Change	6	0	6
Support (eg benefits, social care, vol agencies)	4	0	4
Patient transport	5	0	5
Totals:	463	188	651

PALS themes this month, e.g. staff attitude, increased numbers in an area, topics (Y, S)
a) Patients unhappy regarding move of services from Scarborough to Bridlington contacts 15
b) Three contacts by husband and daughter in relation to patient not consenting to a procedure. Family would ideally like the patient sectioned in order to undergo surgery. However patient was deemed to have capacity. PALS liaised with safe guarding team and clinicians.
c)Datix 35232 Patient has had four admissions to hospital over the last few months. Patient is discharged but do not resolve the issue. Patient set for discvharge again. Husband requesting PALS attend discussion to get the familys point across to the clinicians. Meeting cancelled at last minute as patient now moved to sa surgical ward for investigations. Family advised this is the appropriate care plan.
d) SGH theme: Eye clinic being moved from SGH to BDH - significant concerns raised by many callers. PALS initially not aware of the changes and now dealt with 56 enquiries

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

The Friends and Family Test (FFT) is a patient experience tool whereby we ask patients "how likely are you to recommend our service to your friends and family if they needed similar care?". FFT has been rolled out across almost all of the Trust's activity, including: inpatients, ED, maternity services, community hospitals, community services, and outpatient clinics.

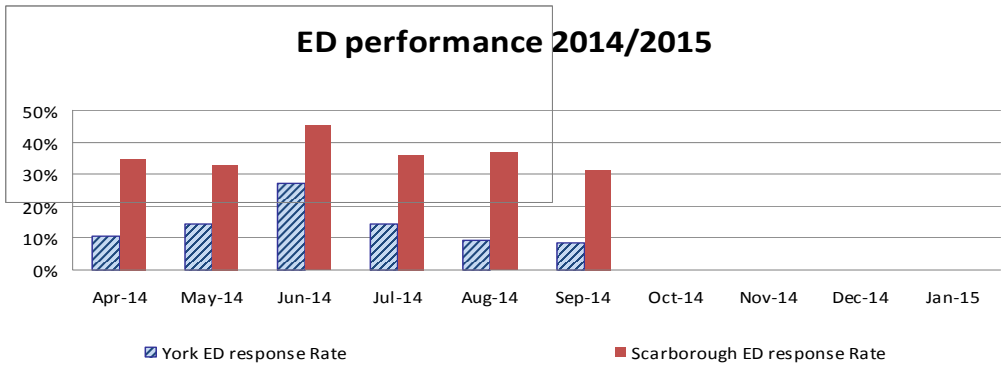
The Trust has a CQUIN target to achieve a 40% response rate across inpatients in March 2015. July and August 2014 achieved this response rate but in September it fell to 37.6%. It is imperative that awareness of FFT and its importance is now raised across all wards at York and Scarborough. Rates vary from under 20% (Cherry, Graham, Oak, ESA, W15, W21) to over 80% (Waters, Kent, W23). Clearly there will be some variance according to different patient groups, but some wards need to improve rates.



Inpatient Performance

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Trust	Eligible patients	2988	3206	3129	3246	2927	3205
	Responses	936	1088	1071	1352	1177	1205
	Response Rate	**31.3%**	**33.9%**	**34.2%**	**41.7%**	**40.2%**	**37.6%**
	Net Promoter Score	75	76	73	76	76	72
York	Eligible patients	2003	2182	2153	2187	1930	2123
	Responses	584	686	748	852	696	672
	Response Rate	**29.2%**	**31.4%**	**34.7%**	**39.0%**	**36.1%**	**31.7%**
	Net Promoter Score	75	77	72	73	76	70
Sboro	Eligible patients	872	830	810	895	855	917
	Responses	269	243	222	359	380	395
	Response Rate	**30.9%**	**29.3%**	**27.4%**	**40.1%**	**44.4%**	**43.1%**
	Net Promoter Score	76	69	74	77	75	74
Brid	Eligible patients	113	194	166	164	142	165
	Responses	83	159	101	141	101	138
	Response Rate	**73.5%**	**82.0%**	**60.8%**	**86.0%**	**71.1%**	**83.6%**
	Net Promoter Score	72	84	82	88	81	79

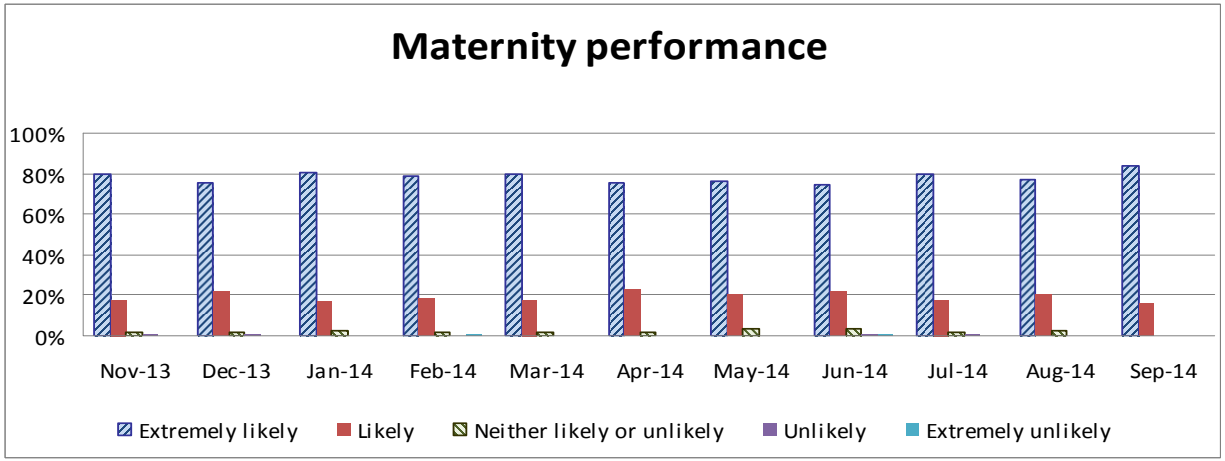
We have been focusing attentions on ensuring we reach another CQUIN target of 20% response rate target in ED over Q4. York ED has recently been achieving a response rate of below 10%. Scarborough ED receives a higher response rate and therefore the average has been around 20%. However, we are aware that relying on one site's success is not sustainable or fair, therefore work has begun to improve York ED's response rate. York ED is now using a combination of text messaging and A5 cards to capture more patients' views. Response rate to the text messages is good but we are only capturing mobile numbers for around 60% of patients. Therefore relying on text messaging alone would not result in any increase; the ED team at York are now also hand out cards to all attendants. The text message clearly states "if you completed a card, please ignore this message" so duplication is not an issue. The team is confident that figures in November will be much improved.



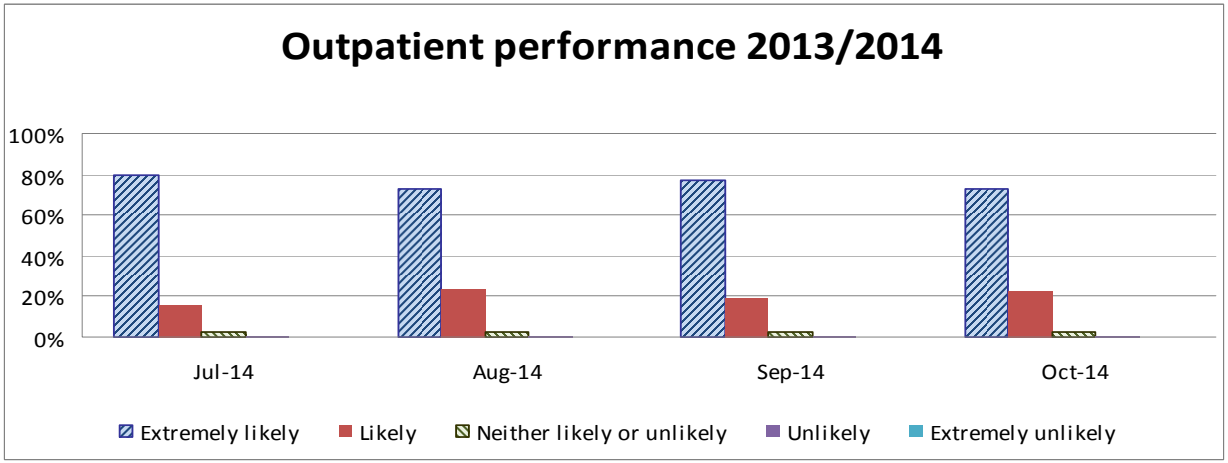
ED Performance

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Trust	Eligible patients	6467	6970	6863	7244	7017	6611
	Responses	1260	1502	2329	1650	1402	1101
	Response Rate	**19.5%**	**21.6%**	**33.9%**	**22.8%**	**20.0%**	**16.7%**
	Net Promoter Score	54	40	47	55	44	48
York	Eligible patients	4079	4356	4283	4451	4305	4265
	Responses	429	636	1162	647	404	362
	Response Rate	**10.5%**	**14.6%**	**27.1%**	**14.5%**	**9.4%**	**8.5%**
	Net Promoter Score	37	11	31	49	67	61
Sboro	Eligible patients	2388	2614	2580	2793	2712	2346
	Responses	831	866	1167	1003	998	739
	Response Rate	**34.8%**	**33.1%**	**45.2%**	**35.9%**	**36.8%**	**31.5%**
	Net Promoter Score	63	61	63	59	34	41

Maternity FFT
Maternity service figures remain at around 25%. This has been similar since July 2014, and a much reduced figure than 41% in April.
Despite falling response rates, the responses themselves remain very positive



Outpatients FFT
Around 150 outpatient services across the Trust are now implementing FFT. One area to highlight is Radiology at York Hospital, particularly X-Ray and MRI services, where nearly 2000 cards were completed in October. This accounts for over a third of all responses across the Trust that month. We are in the process of producing a Staff Matters story to showcase the good work in Radiology despite the current disruption in the department.



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

Almost all community services are now carrying out FFT. Numbers of responses are low, however we appreciate the circumstances are more challenging than in a ward environment, eg. less time, reduced chances of anonymity.

As well as working to ensure we meet our CQUIN targets we are progressing plans to display qualitative feedback across the Trust. The new “knowing how we’re doing boards” to be displayed on all inpatient wards are in the final stage of completion and should start to go up in December. Approximately 15 will go up per month, with each being replaced every 3-4 months.

Commissioning for Quality and Innovation (CQUIN) 2014/15

The CQUIN requirements for 2014/2015 are detailed below:

Q1 – Staff Friends and Family Test roll-out : COMPLETED

Q1 – Patient Friends and Family Test – improved response rate (Q1 A&E >15%, IP >25%; Q4 A&E >20%, IP >30%) : COMPLETED

Q2 – Patient Friends and Family Test roll-out to Day Case, Outpatients and Community Hospitals and Services : COMPLETED TO DATE

Q4 – Patient Friends and Family Test – improved response rate (March 2015 IP > 40%) : on track to succeed

C2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Medical Director's Report

Action requested/recommendation

Board of Director's should:

- Note the results of the gentamicin audit recently reported
- Note the most recent results of the monthly antibiotic and probiotic prescribing audit
- Be aware of the progress with the Flu Campaign.

Summary

This report provides an update from the Medical Director on Patient Safety related issues.

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	This report is only written for the Board of Director's
Risk	No additional risks have been identified others than those specifically referenced in the paper.
Resource implications	None identified
Owner	Dr Alastair Turnbull, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	November 2014
Version number	Version 1

Board of Directors – 26 November 2014

Medical Director's Report

1. Introduction and background

In the report this month:

- Gentamicin Audit
- Antimicrobial Prescribing Audit
- Flu Campaign.

Please note that next months report will include details of the Consultant Outcomes Publications which were published on 9th October by the Healthcare Quality Improvement Partnership. Full details are available on www.hqip.org.uk/consultant-outcomes-publication.

2. Gentamicin Audit

Antimicrobial Stewardship Team
Gentamicin Audit 2014

Gentamicin is an important mainstay of the Trust's approach to treating infections with narrow spectrum antibiotics. However it is a medicine which requires care when prescribing to ensure there are no contra-indications to its use and to select the correct dose. In addition gentamicin levels must be monitored and it is essential that this monitoring starts after the first dose as the results determine when subsequent doses should be prescribed. When care is not taken errors occur.

Gentamicin prescribing and monitoring in York (YH) and Scarborough (SH) hospitals is audited by the pharmacy antimicrobial team annually and the table below shows a comparison of the key indicators compared to previous audits:-

	2014	2012-13	2011
Number of gentamicin courses audited	**43** (YH 22 SH 21)	**37**	**16**
Correct dose prescribed	**86%**	**75%**	**50%**
Serum creatinine normal	**98%**	**91%**	**81%**
Initial gentamicin level taken	**77%**	**94%**	**54%**

Results from Gentamicin Audit 2014

In May and June 2014 the pharmacy antimicrobial team audited gentamicin prescriptions in York and Scarborough hospitals, looking in depth at 4 key areas:-

1. Prescribing
2. Administration
3. Monitoring
4. Duration of therapy

43 gentamicin courses were audited, 79% in surgery and 12% in medicine.

1. Prescribing of gentamicin

Compliance with completion of the Trust gentamicin prescription chart was audited:-

Gentamicin prescribing standard audited	% of prescriptions complying with standard	Results by hospital (NB results were similar unless indicated)
Gentamicin prescribed on gentamicin prescription chart	**100%**	
Gentamicin cross-referenced on Trust prescription chart	**91%**	YH 100% SH 81%
Gentamicin prescription chart attached to Trust prescription chart	**30%**	YH 5% SH 57%
Allergy box completed on gentamicin prescription	**98%**	
Essential checks completed on gentamicin prescription chart	**84%**	YH 95% SH 71%
Serum creatinine below upper limit of normal range	**98%**	
Indication documented on gentamicin prescription	**53%**	YH 50% SH 57%
Height documented on gentamicin prescription	**63%**	
Weight documented on gentamicin prescription	**70%**	
Correct dose prescribed for the 1st dose	**86%**	
Number of incorrect doses administered • 1 • 2 • 3 • 4 • 5	No. of patients **5** **-** **1** **-** **1**	

2. Administration of gentamicin

Gentamicin is a critical drug and must be given at the correct time. The timing of the first dose in relation to the prescribed time was audited:-

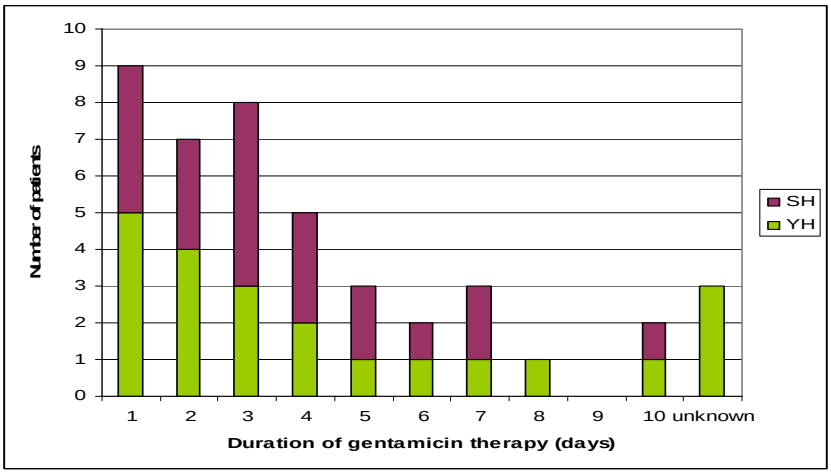
Time interval between prescribed time of 1st dose and actual time gentamicin given	% of gentamicin courses	Results by hospital	
less than 1 hour	**42%**	YH 27%	SH 57%
1-2 hours	**35%**	YH 32%	SH 38%
2-4 hours	**9%**	YH 18%	SH 0%
more than 4 hours	**9%**	YH 14%	SH 5%
unknown	**5%**	YH 9%	SH 0%

Over half of the first doses of gentamicin were given more than an hour later than the prescribed time. The audit did not investigate the reasons for the late administration times so it is not possible to comment on why this occurred.

3. Monitoring of gentamicin

It is essential that a gentamicin level is taken at the correct time, 6-14 hours, after the first dose. The results inform prescribers of the safe dosage interval for subsequent doses. The levels should be documented on the gentamicin prescription chart. Four monitoring standards were audited:-

Monitoring standard	Compliance with monitoring standard	Results by hospital (NB results were similar unless indicated)
Gentamicin level taken after the first dose (n = 43)	**77%**	YH 55% SH 100%
Initial gentamicin level taken at the correct time (n = 33)	**91%**	
Correct dosage interval prescribed after 1st dose (n = 30 as 3 pts had no further doses)	**97%**	
Initial gentamicin level documented on prescription chart (n = 33)	**61%**	YH 75% SH 52%



4. Duration of gentamicin therapy

Adverse effects are more likely with prolonged courses of gentamicin. Therefore the gentamicin prescription chart advises prescribers to review gentamicin therapy with a microbiologist if a course longer than 5 days is required. Course lengths were recorded in the audit:-

There were 32 courses of gentamicin of 5 days or less and 8 courses of 6 – 10 days. The audit did not investigate if the longer courses had been discussed with a microbiologist.

Action points identified from the audit results

The target for all of the above prescribing standards is 100% but this was only met for one of the standards; use of the gentamicin prescription chart. In order to meet 100% for the other standards the following action points have been identified for healthcare professionals:-

Prescribers

- Always cross-reference gentamicin on the Trust prescription chart
- Improve completion of all sections of the gentamicin prescription chart, especially
  - Allergy box
  - Essential checks
  - Indication
  - Height
  - Weight
- When starting gentamicin ensure nurses are aware so that it is given at the correct time
- Ensure gentamicin level is always taken after the 1st dose
- Improve documentation of gentamicin level(s) on the gentamicin prescription chart
- Always review with the microbiologist if gentamicin duration > 5 days.

Prescribers and nursing staff

- Always ensure that the gentamicin prescription chart is securely attached to the Trust prescription chart.

Action points for ward pharmacists

- ensure prescribers are familiar with the correct use of the gentamicin prescription chart to ensure safe prescribing of gentamicin.

3. Antimicrobial prescribing audit

SUMMARY OF ANTIMICROBIAL PRESCRIBING AUDIT RESULTS
July – October 2014

INDICATION on antibiotic prescription	Jul	Aug	Sep	Oct	Nov
York Hospital	83%	80%	85%	89%	
Scarborough Hospital	88%	71%	80%	92%	
Trust average	85%	77%	83%	90%	

DURATION / REVIEW DATE on antibiotic Rx	Jul	Aug	Sep	Oct	Nov
York Hospital	84%	79%	89%	88%	
Scarborough Hospital	84%	55%	79%	88%	
Trust average	84%	70%	85%	88%	

% patients >65 years co-prescribed VSL#3 *	Jul	Aug	Sep	Oct	Nov
York Hospital			51%	42%	
Scarborough Hospital			62%	68%	
Trust average			56%	53%	

% of patients on antibiotics	Jul	Aug	Sep	Oct	Nov
York Hospital	32%	25%	25%	24%	
Scarborough Hospital	29%	30%	35%	26%	

ELDERLY MEDICINE DIRECTORATE	Jul	Aug	Sep	Oct	Nov
Number of antibiotic prescriptions audited	52	52	52	44	
Antibiotic prescriptions with INDICATION	87%	81%	94%	89%	
Antibiotic prescriptions with DURATION / REVIEW	81%	79%	100%	84%	
% patients >65 years co-prescribed VSL#3 *			77%	77%	

MEDICINE DIRECTORATE	Jul	Aug	Sep	Oct	Nov
Number of antibiotic prescriptions audited	109	105	105	100	
Antibiotic prescriptions with INDICATION	87%	79%	85%	89%	
Antibiotic prescriptions with DURATION / REVIEW	88%	77%	83%	87%	
% patients >65 years co-prescribed VSL#3 *			55%	46%	

ORTHOPAEDICS & TRAUMA DIRECTORATE	Jul	Aug	Sep	Oct	Nov
Number of antibiotic prescriptions audited	20	23	10	14	
Antibiotic prescriptions with INDICATION	86%	83%	80%	93%	
Antibiotic prescriptions with DURATION / REVIEW	93%	61%	80%	100%	
% patients >65 years co-prescribed VSL#3 *			43%	0%	

GENERAL SURGERY & UROLOGY AND GYNAECOLOGY DIRECTORATES	Jul	Aug	Sep	Oct	Nov
Number of antibiotic prescriptions audited	**51**	**69**	**68**	**61**	
Antibiotic prescriptions with INDICATION	**84%**	**68%**	**79%**	**93%**	
Antibiotic prescriptions with DURATION / REVIEW	**80%**	**57%**	**81%**	**93%**	
% patients >65 years co-prescribed VSL#3 *			**25%**	**56%**	

HEAD & NECK DIRECTORATE	Jul	Aug	Sep	Oct	Nov
Number of antibiotic prescriptions audited	**14**	**1**	**11**	**12**	
Antibiotic prescriptions with INDICATION	**71%**	**100%**	**45%**	**83%**	
Antibiotic prescriptions with DURATION / REVIEW	**79%**	**100%**	**64%**	**67%**	
% patients >65 years co-prescribed VSL#3 *			**0%**	**0%**	

* the audit did not investigate if any of the patients >65 years who were not on VSL#3 met any of the exclusion criteria

4. Flu Campaign

The compliance with staff flu vaccinations are illustrated in the table below:

	HEADCOUNT	% UPTAKE	TOTAL
419 AHP & Psychological Medicine Directorate	**497**	**30**	**151**
419 Acute and Emergency Med Dir Scarborough	**142**	**20**	**28**
419 Applied Learning and Research Directorate	**184**	**20**	**37**
419 COMMUNITY Directorate	**727**	**10**	**76**
419 Chairman & CEO Directorate	**48**	**29**	**14**
419 Chief Nurse Team Directorate	**48**	**44**	**21**
419 Child Health Directorate	**242**	**28**	**67**
419 Child Health Scarborough Dir	**70**	**27**	**19**
419 Emergency Department Dir	**150**	**51**	**76**
419 Estates & Facilities Directorate	**1087**	**17**	**181**
419 Finance Directorate	**157**	**15**	**23**
419 General Medicine Scarborough Dir	**172**	**27**	**47**
419 General Surgery & Urology Directorate	**340**	**42**	**143**
419 General and Acute Medicine Dir	**496**	**26**	**130**
419 Head & Neck Specialties Directorate	**179**	**28**	**51**
419 Human Resources Directorate	153	**20**	**30**
419 Laboratory Medicine Dir	264	**37**	**98**
419 Medical Governance Directorate	13	**31**	**4**
419 Medicine For Elderly Directorate	285	**32**	**90**
419 Medicine for Elderly Dir - Scarborough	184	**26**	**47**
419 Operations Management Dir Scarborough	33	**9**	**3**
419 Operations Management Directorate	42	**36**	**15**
419 Ophthalmology Directorate	122	**34**	**41**
419 Orthopaedics & Trauma Dir Scarborough	99	**40**	**40**
419 Orthopaedics & Trauma Directorate	134	**44**	**59**
419 Pharmacy Directorate	164	**64**	**105**
419 Radiology Directorate	305	**52**	**159**
419 Sexual Health Directorate	95	**31**	**29**
419 Specialist Medicine Directorate	277	**31**	**86**
419 Systems & Network Services Directorate	379	**21**	**80**
419 Theatres Anaesthetics & Critical Care	539	**44**	**235**
419 Theatres Anaesthetics & Critical Care Dir Scarborough	189	**35**	**66**
419 Womens Health Directorate	393	**31**	**121**

5. Recommendations	
Board of Director's should: • Note the results of the gentamicin audit recently reported • Note the most recent results of the monthly antibiotic and probiotic prescribing audit • Be aware of the progress with the Flu Campaign.	
Author	**Diane Palmer, Deputy Director for Patient Safety**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**November 2014**

C3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Chief Nurse Report – Quality of Care

Action requested/recommendation

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

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	Executive Board & Quality and Safety Committee
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	November 2014
Version number	Version 1

Board of Directors– 26 November 2014

Chief Nurse Report – Quality of Care

1. Key priorities

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

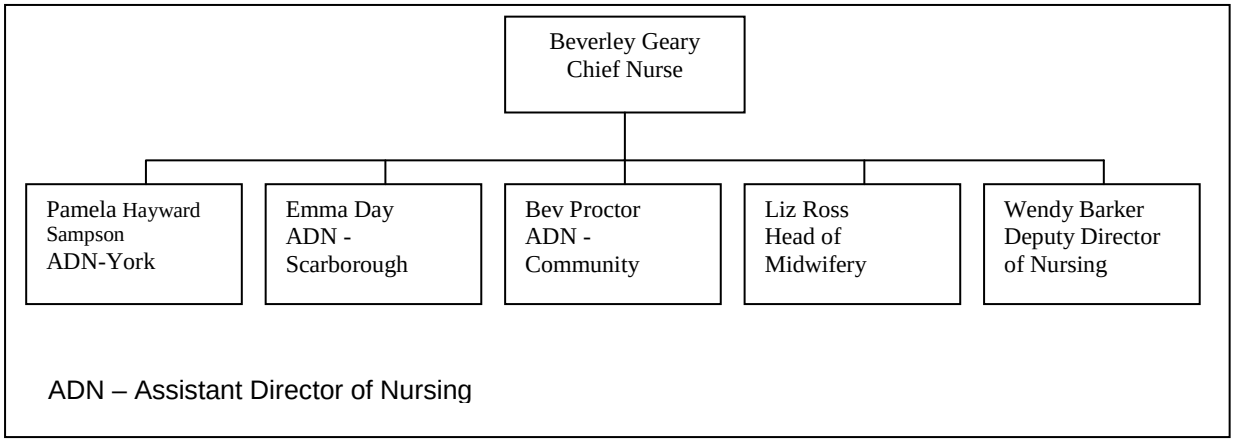
- Patient Experience
- Delivering High Quality Safe Patient Care
- Measuring the impact of care delivery
- Staff Experience

As the Committee are aware a significant restructure of senior nurses

Environment
As part of improving patient and staff experience and improving patient safety the Senior Nurse team is beginning a programme of environmental audits. Working with teams from estates the Matrons will lead peer reviews; initially of ward areas. Using Productive methodology Ward Sisters will undertake a local 'de-cluttering' of their areas to ensure a clean and well organised ward.

2. Chief Nurse Team

Following recent appointments there has been a number of changes to the Chief Nurse team.
A number of the team are in secondments, this is due to external secondments and the trailing of a different role for the ADN in Community Services. It is anticipated that within the next six to nine months the roles required will be determined and the permanent team will be in post.



3. Nurse staffing – Acuity and Dependency Audits

One of the key recommendations from Hard Truths was the expectation that Board of Directors would receive a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available).
Previously acuity and dependency was undertaken manually by a small team; the detail of this

work was considered by the Workforce Strategy Committee and presented to the Board of Directors, staffing levels for most areas have been set on the results of this work.
Recently this work has been repeated using the Safer Nursing Care Tool (SNCT)

The recommendation from the team that developed the tool is that professional judgement should also be exercised, currently the ward Sisters and Matrons are undertaking a 'professional judgement' assessment of staffing requirements. This compares current staffing models with those deemed necessary for each particular ward. This will be validated by the Assistant Directors of Nursing to establish any areas of risk.

The facility to capture acuity and dependency is being explored and if feasible will be developed and incorporated into Safety Thermometer, which captures patient safety information once a month for every inpatient. This will provide a 'snap shot' every month and therefore 12 data points per year. This method is to be tested in November, December and January before the next full audit in February.

Other work that needs to be completed to ensure the audits remain accurate and appropriate includes reviewing the work previously undertaken to confirm the rationale around the methodology and validate that work so that it can be used as a base line. This work has started with Sian Longhorne from HR.

International recruitment
The committee are aware that the recruitment team have explored the feasibility of working with NLAG hospitals to undertake a programme of international recruitment. The decision of the NLAG trust board was to postpone their recruitment until next year. Therefore we are meeting with Search Recruitment on 17th November to look at costings and timescales. A verbal update will be given to the Board following the meeting.

4. Midwifery

Review of maternity services
During the due diligence work undertaken pre acquisition of Scarborough hospital some risks were identified with the services provided.

In the past six months a number of incidents relating to maternity services at Scarborough have been declared as either a serious or critical incident. A number of additional quality and safety performance improvement meetings have been held with the Medical Director and Chief Nurse in order to identify any problems or areas for action and to support the Directorate. At the most recent meeting it was agreed that a comprehensive review of maternity services will be undertaken at Scarborough Hospital.

The objective of the review is to provide the Trust Board that the services delivered are of the required standard. Terms of reference have been developed and agreed and will include the following:

- A review of all claims received in the last 36 months to confirm lessons learned process and identify any themes.
- A review of all SI/CI's in the last 24 months to confirm actions have been implemented and identify any themes.
- A review of AIRs in the last 12 months to confirm actions have been completed and identify any themes.

A Senior Midwife and an Obstetrician from other organisations have been approached to act as a 'critical friend' and to add external scrutiny. Additional Q&S meetings have been planned to review the progress on a regular basis, agree the action plan and understand any issues. The findings

and action will be reported to the Committee on a regular basis.

SCBU Cots
At the October Q&S Committee a concern was raised regarding the availability of cots on Special Care Baby Unit at Scarborough hospital - it was noted that this was consistently RED rated on the midwifery dashboard.

On investigation it was identified that over the last 12 months (ending 31.10.14) 20 babies with significant (and often complicated) social care involvement have been placed in SCBU cots as a place of safety. Of those, 14 proceeded to be discharged into foster care or similar. In terms of inpatient numbers, this represents 9% of the workload. This practice will be reviewed as part of the ongoing work into child safeguarding policies and procedures.

5. Early Warning Trigger Tool

The early warning trigger tool has been adopted as a replacement to Nursing Care Indicators and following a previous pilot the tool was rolled out across the organisation this month and was conducted as part of the data collection for safety thermometer day.

At the time of writing the information is being collated however, early indications are that no areas are triggering red. Some of the themes include ward areas showing sickness above 3%, appraisals less than 95%, Matron environmental audits less than and unfilled bank shifts.

A Board report with all results is being developed and will be submitted to board monthly. Nursing board will scrutinise the results and receive and action plans for areas in special measures.

6. Patient Experience

Healthwatch Enter and View Visits

Healthwatch (York)
A focus of Healthwatch (HW) York's work-plan for 2014/2015 is Discharge from Hospital. A planned Enter and View visit from members of HW to York Hospital took place on Friday 24th October 2014 to our Discharge Lounge and other wards across the Trust. The Enter and View members spoke to patients who had been discharged from the ward and were waiting in the Discharge Lounge to go home. Additionally, some patients who were being discharged home directly from the ward were also interviewed as part of the visit. HW asked patients if they would also be willing for a member from the visit to contact them two weeks after returning home to discuss their final discharge experience.

At the Patient Experience Steering Group in November, Sian Balsom (HW Manager) thanked the Trust for welcoming and supporting the Enter and View team and said that the visit had been well received. The Trust will have a de-brief with HW once all the feedback from the visit has been collated and ahead of HW producing their Draft report from the Enter and View visit.

Healthwatch (North Yorkshire)
As with HW York, HW North Yorkshire is also focussing on Discharge from hospital and has written to us to give two weeks statutory notice of an Enter and View visit to Scarborough Hospital on 12th November 2014.

HW North Yorkshire's focus is wider than that of HW York in that the Enter and View letter has notified the Trust that whilst looking at Hospital Discharge and post Hospital support arrangement, they are also looking at the quality of hospital inpatient facilities. The visit will see members visit parts of our inpatient and outpatient facilities between 10am and 4pm.

Members of the Trust will meet with the team during the course of the visit and will have a de-brief

at the end of the day with HW NY.
7. Recommendation
The Board is asked to receive the update report and current work-streams of the Chief Nurse Team for information.

Author	**Beverley Geary, Chief Nurse**
Owner	**Beverley Geary, Chief Nurse**
Date	**November 2014**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Staffing Exception Report

Action requested/recommendation

The Board are asked to receive the exception report for information

Strategic Aims	**Please cross as appropriate** (double click on the grey box check or uncheck the box)
1. Improve Quality and Safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☒
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

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

Reference to CQC outcomes

Outcome 13

Progress of report	Quality and Safety Committee
Risk	Potential risk to quality of care if staffing levels or skill mix are inappropriate
Resource implications	Potential resources implications where staffing falls below planned or where acuity or dependency increases due to case mix.
Owner	Beverley Geary, Chief Nurse

Author	Nichola Greenwood, Chief Nurse Team
Date of paper	November 2014
Version number	Version 1

Board of Directors – 26 November 2014

Staffing Exception Report

1. Introduction and background

The Board of Directors are aware that from May 2014 all organisations are required to report actual versus planned staff in public. This is the sixth submission to NHS choices of data of actual against planned staffing for day and night duty in hours; by ward.

As previously reported work continues to refine the reports in order to give an accurate reflection of the staffing levels on a shift by shift basis. As a result we have continued to base the return on the average bed occupancy rates by ward at 12 midday and 12 midnight, given that the staffing establishment is set on the number of beds on each ward; taking bed occupancy rates into consideration gives a more precise reflection of the safety of the staffing levels. Further work continues to further refine and simplify the process and also to give the greatest accuracy in order that the Board are assured that all areas are staffed appropriately and safely.

A detailed breakdown is attached at appendix 1.

2. High level data by site

		Day		Night	
Site Code	Site Name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
RCBAW	Archways Intermediate Care Unit	92.1%	89.6%	103.2%	96.6%
RCBNH	Bridlington And District Hospital	107.1%	84.5%	115.8%	129.1%
RCBL8	Malton Community Hospital	121.1%	109.1%	106.5%	113.2%
RCBCA	Scarborough General Hospital	86.6%	98.1%	104.0%	122.9%
RCB07	Selby And District War Memorial Hospital	95.4%	101.4%	118.6%	108.7%
RCBTV	St Helens Rehabilitation Hospital	82.3%	80.6%	89.8%	90.0%
RCB05	St Monicas Hospital	111.7%	94.6%	99.7%	100.0%
RCBG1	Whitby Community Hospital	79.4%	65.6%	82.7%	76.6%
RCBP9	White Cross Rehabilitation Hospital	82.3%	84.9%	191.2%	92.1%
RCB55	York Hospital	92.3%	88.1%	107.8%	115.4%

3. Exceptions

York site

Ward 11 - Over established with RN's reflects the fill rate of over 100%. As a result of this there has been a deliberate under recruitment of HCA's reflecting in the less than 80% fill rate.

Ward 14 – Day HCA fill rate less that 80% due to vacancies and sickness. Night full rate for RN and HCA above 100% due to bed occupancy.

Ward 15 – HCA night fill rate over 100% due to 1:1 requirement

Ward 16 – RN day fill rate below 80% due to vacancies, recruited to, pending start data. Some short term sickness.

Ward 17 - RN fill rate 168% day and 177% night fill rate due to low bed occupancy. HCA fill rate 48% 1 HCA on maternity leave.

Ward 23 – HCA day fill rate reflected in requirement for enhanced supervision of patients and new starters working supernumerary.

Ward 25 – Night fill rate; RN greater than 100% due to due to bed occupancy. HCA greater than 100% reflected in requirement for enhanced supervision of patients

Ward 26 – HCA day fill rate 105% reflected in requirement for enhanced supervision of patients and new starters working supernumerary..

Ward 28 – Greater than 100% fill rate for both RN and HCA due to bed low occupancy and requirement enhanced patient supervision.

Ward 29 – Above 100% fill rate for RN and HCA due low bed occupancy

Ward 31 – Night fill rate above 100% for RN and HCA due to low bed occupancy

Ward 32 – 77% RN fill rate due to 2 RN vacancies, recruited pending start dates, some short term sickness. 111% and 157% HCA nights respectively, due to requirement for enhanced supervision of patients.

Ward 33 – HCA fill rate below 80% due 3 HCA leavers, with recruitment undertaken but pending start dates. 102% HCA fill rate Night reflects enhanced supervision of patients.

Ward 34 –102% HCA Night fill rate reflects requirements for enhanced supervision of patients.

Ward 35 – 105% HCA day and night fill rate due to requirement for enhanced supervision of patients and new starters working supernumerary.

Ward 36 – 102% HCA fill rate due to bed occupancy. 112% RN fill rate due to bed occupancy and requirement to provide staff to support hyper acute stroke patients.

Ward 37 – HCA day fill rate less than 80% due to long and short term sickness absence. Night HCA fill rate 135% due to requirement for enhanced supervision of patients.

AMU – Night fill rate over 100% for RN and HCA is due to enhanced supervision of patients and

newly qualified nurses working supernumerary.

SSW – HCA fill rate 125% Night, reflects requirement for enhanced supervision of patients.

CCU – 103% and 108% fill rate for RN day and night due to bed occupancy. 66.9% HCA fill rate due to deliberate delay in recruiting to HCA's. This does not affect patient care and safety.

ESA – 170% and 135% fill rate of RN and HCA Day and 142% RN night reflects low bed occupancy

ICU - 116% and 128% RN fill rate day and night reflects bed occupancy. HCA fill rate remains below 80% on a night due to deliberate under recruitment. This does not affect patient care.

G1 – HCA 75% due to vacancies, recruitment undertaken, pending start dates. 101% RN and 144% HCA night fill rate reflects requirement for enhanced supervision of patients.

G2 and G3 – HCA day fill rate of below 80% due to vacancies, recruited pending start dates, along with 1.8wte long term sickness.
70% day fill rate for RM is due to vacancies, recruited pending PIN numbers from NMC and start dates.
RM and HCA night higher than 100% fill rate due to low bed occupancy.

Scarborough site

ITU – Reporting fill rates of 62% for Registered Nurses . There are 4.5 vacancies. Recruited two new Registered Nurses this week and previous recruits are reaching the end of induction times. Activity on the unit has remained very high. Recruited to the HCA vacancy .

Ann Wright – Fill rate of 193.5% for HCA to provide enhanced supervision

Oak – Fill rate of 120 % for HCA day staff is due to RN awaiting PIN number in the HCA figures.

Duke of Kent – The fill rate for RN 239% for day staff and 240% for night. HCA 178.8% for day staff and 293.7% for night staff. This is due to the bed occupancy levels.

Kent – The ward is showing 191% the result of flexing staff so nights may be 1+1 instead of 2+0, and also down to occupancy levels, which are often high during the day but drop down at night.

Actions and Mitigation of risk
At least daily staffing meeting are taking place to deploy staff to high risk areas. Where there is low activity (for example Duke of Kent) these staff are moved to other wards in order to improve levels.

4. Vacancies by Site

	York		Scarborough		Bridlington	
	RN	HCA	RN	HCA	RN	HCA
Actual Vacancies	48.22	22.29	34.67*	11.07	3.71	0
Pending Start	15.9	11.52	4	8	1.6	0
Outstanding Posts	32.32	10.77	30.67*	3.07	2.11	0

These figures include *4.5 of the vacancies in Emergency Department and 2.2 discharge at SGH as part of operation fresh start which are in addition to existing budgeted establishment.

The Trust attended a RCN career's fair on 10/11th November 2014 in which RNs were interviewed for positions at York and Scarborough Hospitals. These candidates are now being progressed to commence in posts in the New Year.

5. Recommendation

The Board are asked to receive the exception report for information.

6. References and further reading

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

Author	**Nichola Greenwood, Chief Nurse Team**
Owner	**Beverley Geary, Chief Nurse**
Date	**November 2014**

Fill rate indicator return

Org: RCB York Teaching Hospital NHS Foundation Trust — **Staffing: Nursing, midwifery and care staff**

Period October_2014-15

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

http://www.yorkhospitals.nhs.uk/about_us/reports_and_publications/safer_staffing_data/

Validation alerts (see control panel)	Hospital Site Details		Only complete sites your organisation is accountable for	Main 2 Specialties on each ward		Day				Night				Day		Night	
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
	Site code *The Site code is automatically populated when a Site name is	Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
		YORK HOSPITAL - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1742.43548	1834	1046.83871	659	651.666667	724.67	651.666667	568.49	105.3%	63.0%	111.2%	87.2%
		YORK HOSPITAL - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1927.01613	1653	1284.67742	990.17	961.693548	1081	641.129032	655	85.8%	77.1%	112.4%	102.2%
		YORK HOSPITAL - RCB55	15	120 - ENT	101 - UROLOGY	1543.94531	1458.5	1157.95898	1109.5	935.085938	922.5	311.695313	363	94.5%	95.8%	98.7%	116.5%
		YORK HOSPITAL - RCB55	16	100 - GENERAL SURGERY		2337.42669	1804.5	999.699413	1031	1259.67155	1221	586.398827	506.83	77.2%	103.1%	96.9%	86.4%
		YORK HOSPITAL - RCB55	17	420 - PAEDIATRICS		718.448276	1211.5	478.965517	231.92	558.62069	990	0	296.84	168.6%	48.4%	177.2%	-
		YORK HOSPITAL - RCB55	23	430 - GERIATRIC MEDICINE		1818	1471.5	1136.25	1225.66	700.733333	649.5	700.733333	659.5	80.9%	107.9%	92.7%	94.1%
		YORK HOSPITAL - RCB55	25	430 - GERIATRIC MEDICINE		1716	1581.5	1072.5	874.25	653.2	673	653.2	704.16	92.2%	81.5%	103.0%	107.8%
		YORK HOSPITAL - RCB55	26	430 - GERIATRIC MEDICINE		1822	1477.58	1138.75	1203.82	696.133333	642.5	696.133333	637.42	81.1%	105.7%	92.3%	91.6%
		YORK HOSPITAL - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1929.33351	1648.33	1071.85195	937.83	620.782334	640	620.782334	670	85.4%	87.5%	103.1%	107.9%
		YORK HOSPITAL - RCB55	29	110 - TRAUMA & ORTHOPAEDICS		1385.21739	1436.83	692.608696	643.59	509	651	254.5	304.5	103.7%	92.9%	127.9%	119.6%
		YORK HOSPITAL - RCB55	31	370 - MEDICAL ONCOLOGY		1896.68807	1681.25	842.972477	709	617.497248	651	308.748624	326.75	88.6%	84.1%	105.4%	105.8%
		YORK HOSPITAL - RCB55	32	320 - CARDIOLOGY		2183.70486	1688.75	1455.80324	1628.75	744.965131	682.66	744.965131	1174.25	77.3%	111.9%	91.6%	157.6%
		YORK HOSPITAL - RCB55	33	301 - GASTROENTEROLOGY	361 - NEPHROLOGY	1803.7581	1451.42	1352.81857	1004.42	689.925566	653.08	689.925566	707.08	80.5%	74.2%	94.7%	102.5%
		YORK HOSPITAL - RCB55	34	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1818.75	1541.92	1364.0625	1138	685.6875	679.67	685.6875	702.5	84.8%	83.4%	99.1%	102.5%
		YORK HOSPITAL - RCB55	35	430 - GERIATRIC MEDICINE		1809.78402	1515	1131.11501	1188	689.13067	640.5	689.13067	724.58	83.7%	105.0%	92.9%	105.1%
		YORK HOSPITAL - RCB55	36 - Acute Stroke Unit	430 - GERIATRIC MEDICINE		1607.36842	1516	1004.60526	1030.5	904.263158	1019	602.842105	547	94.3%	102.6%	112.7%	90.7%
		YORK HOSPITAL - RCB55	37	430 - GERIATRIC MEDICINE		1371.42857	1223.25	1600	1240.42	706.428571	651	706.428571	955.5	89.2%	77.5%	92.2%	135.3%
		YORK HOSPITAL - RCB55	39	430 - GERIATRIC MEDICINE		1364.21053	1129.25	1136.84211	1039.25	703.315789	630	351.657895	346.5	82.8%	91.4%	89.6%	98.5%
		YORK HOSPITAL - RCB55	Acute Medical Unit	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2581.875	2073.5	2151.5625	1780.5	1487.8125	1533	1190.25	1217.75	80.3%	82.8%	103.0%	102.3%
		YORK HOSPITAL - RCB55	Coronary Care Unit	320 - CARDIOLOGY		1507.5	1557.75	188.4375	126	1212	1311	0	66	103.3%	66.9%	108.2%	-
		YORK HOSPITAL - RCB55	Extended Stay Area	100 - GENERAL SURGERY	120 - ENT	968.225806	1648.08	484.112903	653.5	465.008065	660.25	0	472.17	170.2%	135.0%	142.0%	-
		YORK HOSPITAL - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3208.33333	3743.58	291.666667	262.5	2536.11111	3257.5	230.555556	187	116.7%	90.0%	128.4%	81.1%
		YORK HOSPITAL - RCB55	Short Stay Ward	300 - GENERAL MEDICINE		1770.86262	1467.86	1328.14696	1240.87	667.489362	589.58	667.489362	840.25	82.9%	93.4%	88.3%	125.9%
		YORK HOSPITAL - RCB55	G1	502 - GYNAECOLOGY		1740	1648.08	870	653.5	654	660.25	327	472.17	94.7%	75.1%	101.0%	144.4%
		YORK HOSPITAL - RCB55	G2	501 - OBSTETRICS		1729.56522	1211	864.782609	497	684	660	342	497.5	70.0%	57.5%	96.5%	145.5%
		YORK HOSPITAL - RCB55	G3	501 - OBSTETRICS		617.5	798.5	308.75	212.5	465.75	655	0	0	129.3%	68.8%	140.6%	-

Fill rate indicator return

Org: RCB York Teaching Hospital NHS Foundation Trust — **Staffing: Nursing, midwifery and care staff**

Period October_2014-15

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

http://www.yorkhospitals.nhs.uk/about_us/reports_and_publications/safer_staffing_data/

Validation alerts (see control panel)	Hospital Site Details: Site code *The Site code is automatically populated when a Site name is	Hospital Site Details: Hospital Site name	Only complete sites your organisation is accountable for: Ward name	Main 2 Specialties on each ward: Specialty 1	Main 2 Specialties on each ward: Specialty 2	Day: Registered midwives/nurses: Total monthly planned staff hours	Day: Registered midwives/nurses: Total monthly actual staff hours	Day: Care Staff: Total monthly planned staff hours	Day: Care Staff: Total monthly actual staff hours	Night: Registered midwives/nurses: Total monthly planned staff hours	Night: Registered midwives/nurses: Total monthly actual staff hours	Night: Care Staff: Total monthly planned staff hours	Night: Care Staff: Total monthly actual staff hours	Day: Average fill rate - registered nurses/midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses/midwives (%)	Night: Average fill rate - care staff (%)
		ARCHWAYS INTERMEDIATE CARE UNIT	Archways	925 - COMMUNITY CARE SERVICES		890.454545	820	1113.06818	997.5	356.5	367.75	713	689	92.1%	89.6%	103.2%	96.6%
		MALTON COMMUNITY HOSPITAL - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		893.571429	1082.5	1563.75	1706.67	660.785714	704	660.785714	748	121.1%	109.1%	106.5%	113.2%
		SELBY AND DISTRICT WAR MEMORIAL HOSPITAL - R	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1020.65217	973.92	1020.65217	1035	300.347826	356.34	600.695652	653	95.4%	101.4%	118.6%	108.7%
		ST HELENS REHABILITATION HOSPITAL - RCBTV	St Helens	430 - GERIATRIC MEDICINE		1017.83333	837.25	1272.29167	1025	397.038462	356.58	397.038462	357.25	82.3%	80.6%	89.8%	90.0%
		WHITBY COMMUNITY HOSPITAL - RCBG1	War Memorial	925 - COMMUNITY CARE SERVICES		1123.63636	746	1685.45455	880.75	453.818182	341	907.636364	638	66.4%	52.3%	75.1%	70.3%
		WHITBY COMMUNITY HOSPITAL - RCBG1	Abbey	925 - COMMUNITY CARE SERVICES		681	686.08	1135	969.5	370.4	341	370.4	341	100.7%	85.4%	92.1%	92.1%
		BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Johnson	430 - GERIATRIC MEDICINE		995.089286	1013.42	1393.125	1242.92	611.964286	598.17	305.982143	336	101.8%	89.2%	97.7%	109.8%
		BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		693.75	1022.75	555	776.25	241.5	462	0	178.5	147.4%	139.9%	191.3%	-
		BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Waters	430 - GERIATRIC MEDICINE		957.8125	997.42	957.8125	984.17	589.375	609	294.6875	325.5	104.1%	102.8%	103.3%	110.5%
		ST MONICAS HOSPITAL - RCB05	St Monicas	925 - COMMUNITY CARE SERVICES		450.201613	503	681.733871	645	372	371	372	372	111.7%	94.6%	99.7%	100.0%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1370	1235.25	1141.66667	1212.5	669.777778	680	334.888889	648	90.2%	106.2%	101.5%	193.5%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ash	100 - GENERAL SURGERY		1038.28125	914.75	830.625	747.25	516.0625	450.25	0	21	88.1%	90.0%	87.2%	-
#REF!		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Beech	300 - GENERAL MEDICINE		1833.75	1529.53	1604.53125	1428.44	1095.75	931	730.5	682	83.4%	89.0%	85.0%	93.4%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Cherry	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2016.25289	1766.01	1613.00231	1454.42	1281.38697	1558.33	1025.10957	1407.75	87.6%	90.2%	121.6%	137.3%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2463.21429	2053.5	447.857143	580.25	1275.42857	1198.5	318.857143	352.5	83.4%	129.6%	94.0%	110.6%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1840.71429	1504.25	1380.53571	1346	719.267857	660	719.267857	703.5	81.7%	97.5%	91.8%	97.8%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Duke of Kent	420 - PAEDIATRICS		675	1207	168.75	403.5	247.2	726	123.6	297	178.8%	239.1%	293.7%	240.3%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Maple	100 - GENERAL SURGERY		2049.67105	1548.83	1434.76974	1172.62	1202.16949	959.5	601.084746	538.75	75.6%	81.7%	79.8%	89.6%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Haldane	100 - GENERAL SURGERY	502 - GYNAECOLOGY	1377.85714	959.42	1148.21429	1104.5	654.952381	598.5	327.47619	304.5	69.6%	96.2%	91.4%	93.0%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1316.25	1167	1096.875	1116.75	655.5	638.5	655.5	640.5	88.7%	101.8%	97.4%	97.7%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE		2211.42857	1824	368.571429	231	1500	1725	0	11.5	82.5%	62.7%	115.0%	-
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Oak	430 - GERIATRIC MEDICINE		1835.10516	1703.59	1605.71702	1927.33	703.466094	892.5	703.466094	924.25	92.8%	120.0%	126.9%	131.4%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Stroke	430 - GERIATRIC MEDICINE		1748	1429.67	874	817.75	1020	930.5	340	382.5	81.8%	93.6%	91.2%	112.5%
		SCARBOROUGH GENERAL HOSPITAL - RCBCA	Hawthorn	501 - OBSTETRICS		870.83499	758	435.417495	345	619.860987	701	0	310	87.0%	79.2%	113.1%	-
		BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Lloyd	100 - GENERAL SURGERY		1035	910.25	862.5	181.5	90	106	90	51.5	87.9%	21.0%	117.8%	57.2%
		WHITE CROSS REHABILITATION HOSPITAL - RCBP9	Whitecross Court	430 - GERIATRIC MEDICINE		896.666667	738	1120.83333	952	343	655.75	343.083333	316	82.3%	84.9%	191.2%	92.1%
			Total			78221.4049	71403.82	53967.5333	48595.02	38407.5242	41046.83	23587.9795	26832.24				

C5

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Pressure Ulcer Reduction Plan Update

Action requested/recommendation

The Board is asked to note the information included in the report and specifically support the following actions:

- Launch and disseminate the revised wound prevention and management policy and appendices.
- Further development of the root cause analysis tool for pressure ulcers.
- Disseminate learning from Serious Incident investigations.
- Increase the use of the Wound Care Passport between the acute and community settings.
- Wound care passport to follow patients between the acute and community settings.
- Agree the process for recording recurrence of pressure ulcers.

Summary

This report provides an update of the acute and community pressure ulcer reduction plans and includes additional information related to the pressure ulcer CQUIN schemes.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

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

Progress of report	Quality & Safety Committee
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse
Author	Sarah Fiori, Patient Safety Manager
Date of paper	October 2014
Version number	Version 1

Board of Directors – 26 November 2014

Pressure Ulcer Reduction Plan – update report November 2014

1. Introduction and background

In the report this month:

- Summary of progress with the Pressure Ulcer Reduction Plans
- Number of category 2, 3 and 4 Pressure Ulcer incidents reported in Q1 (developed *or* deteriorated in our care)
- Learning from Serious Incidents (SIs)
- Safety Thermometer Pressure Ulcer Prevalence Report
- Patient wound care passport
- Definition of recurrence rates of pressure ulcers.

2. Update on the Pressure Ulcer Prevention and Management plans

Progress with the Pressure Ulcer Reduction Plans for Acute and Community Services (Appendix A) have been reviewed and approved by the Pressure Ulcer Steering Group. Progress against the plans is good with significant work taking place during October relating to the launch of the Wound Prevention and Management Policy.

3. Report of the number of new category 2, 3 and 4 pressure ulcer incidents reported in Q1 (developed *or* deteriorated in our care)

The tables below summarise the number of category 2 – 4 and unstageable pressure ulcer incidents reported April to June 2014.

Trust Total (Datix)			
	April 14	May 14	June 14
Cat 2	53	43	48
Cat 3	10	9	12
Cat 4	1	0	0
Unstageable	15	7	4
Total	79	59	64

Acute Sites			
	April 14	May 14	June 14
Cat 2	26	15	24
Cat 3	4	6	5
Cat 4	1	0	0
Unstageable	8	5	2
Total	39	26	31

Community Hospitals

	April 14	May 14	June 14
Cat 2	11	10	3
Cat 3	1	0	2
Cat 4	0	0	0
Unstageable	1	0	0
Total	13	10	5

Community Teams			
	April 14	May 14	June 14
Cat 2	18	18	21
Cat 3	6	3	5
Cat 4	0	0	1
Unstageable	6	2	2
Total	30	23	29

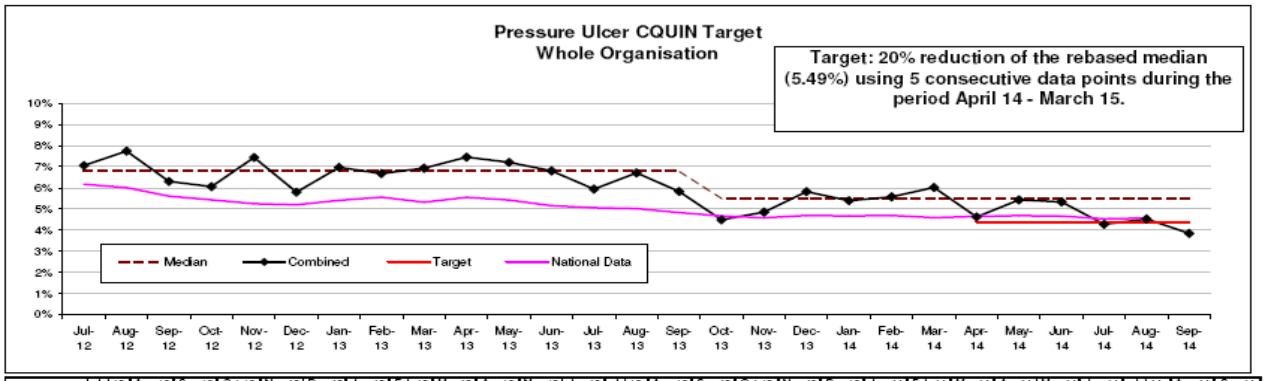
4. Learning from Serious Incidents.

The table below summarises the learning from ten serious incident pressure ulcers which were reviewed in Q1.

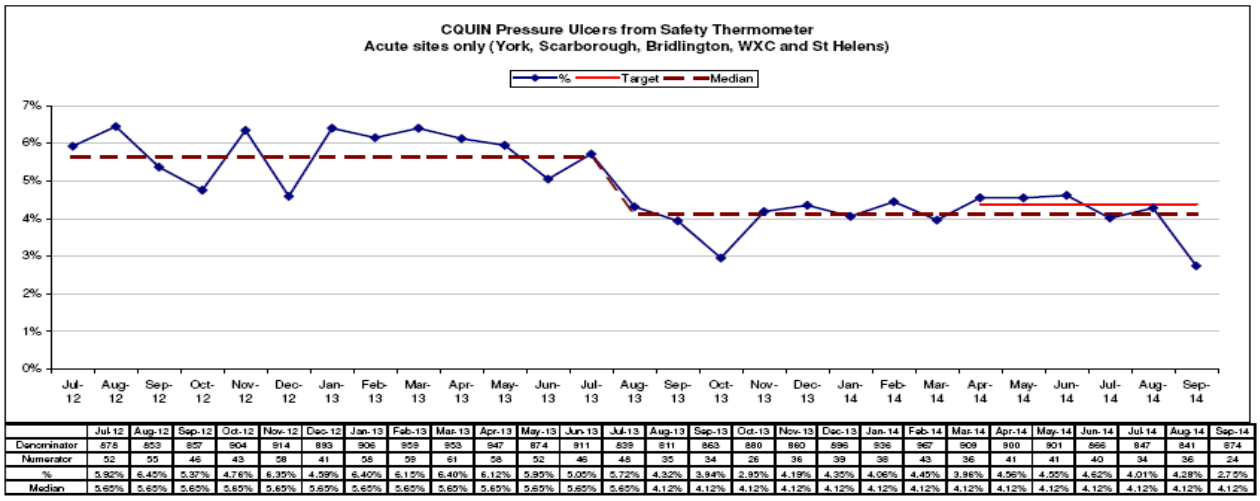
Numbers and categories of pressure ulcers	Total of nine patients reviewed. There were 5 category 4 ulcers reviewed and 5 category 3 ulcers. One patient had 2 ulcers. One ulcer was de-escalated at panel as it was a laceration to the arm from a fall at home and not a pressure ulcer.
Settings pressure ulcer developed or deteriorated	3 ulcers developed or deteriorated in acute settings, 5 in community and 1 in a community hospital.
Area of the body affected	2 patients had device related ulcers (under plaster cast and under a body brace). 1 patient had ulcers to both ischial tuberosity (paraplegic patient from a wheelchair cushion). 4 patients had sacral ulcers and 2 patients had heel ulcers.
Avoidable / unavoidable information	Panel deemed 4 ulcers to be avoidable. The remaining were unavoidable as all aspects of the prevention and management pathways were followed. These patients displayed significant non compliance or were end of life.
Lessons learnt / actions	Of the avoidable ulcers, the following lessons were learnt: • Communication between plaster room and the ward requires improvement, care of the cast was not communicated / followed. • The wheelchair centre issued a trial cushion to a paraplegic patient which was unsuitable. The patient had no sensation below the waist and did not recognise development of a pressure ulcer in between district nurse visits. • A patient was not referred back to district nursing services when early stages of pressure ulcer development were evident. Became unwell and wound deteriorated further. • No risk assessment completed on admission and 48 hours later when completed, patient had early stages of ulcer formation but no interventions were put in place. Ulcer was incorrectly categorised as a 2 and so delay in referral to TVN for support and advice.
Process for dissemination	Learning from serious incidents is discussed at Matrons meetings. Individual actions are discussed within the clinical teams on a case by case basis.

5. Safety Thermometer Pressure Ulcer Prevalence Report

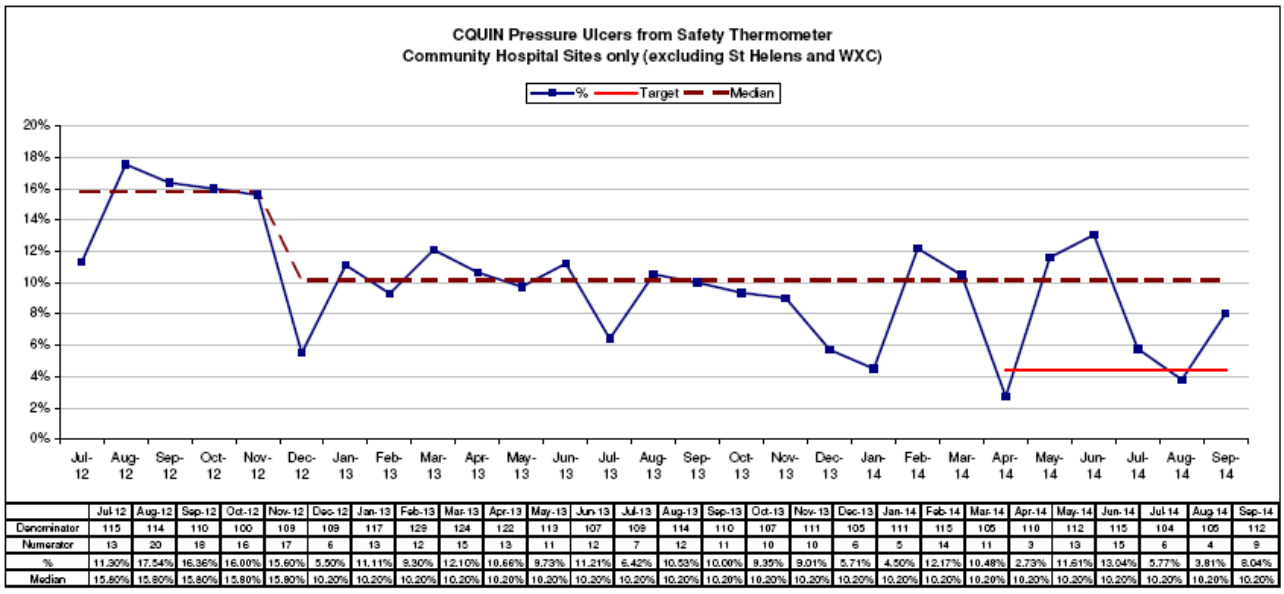
The tables below illustrate the pressure ulcer prevalence inaccordance with the Safety Thermometer definition.



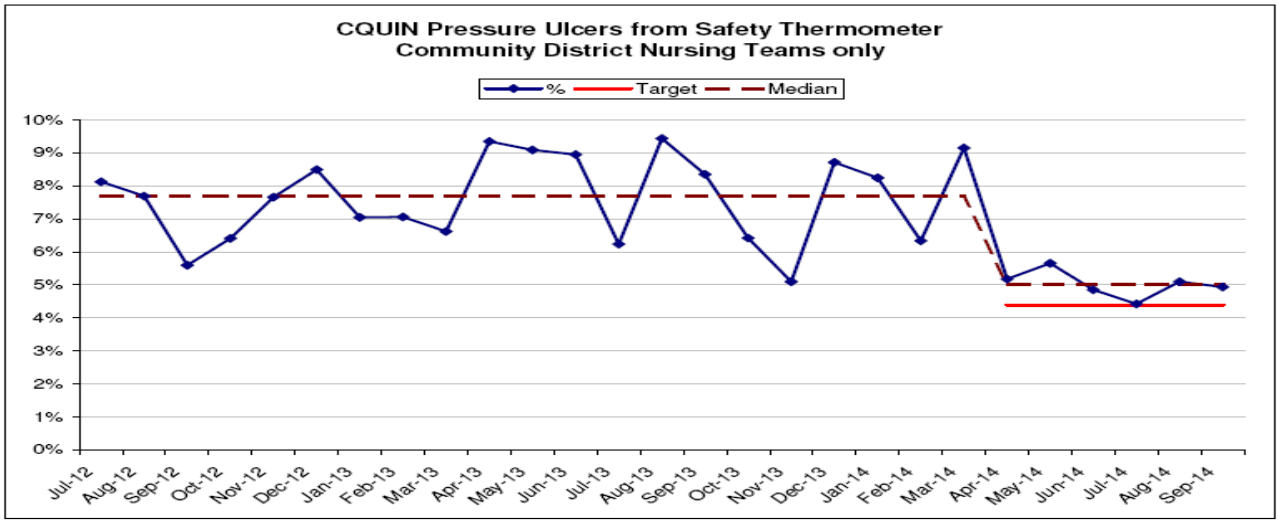
	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Denominator	1473	1396	1396	1519	1493	1414	1477	1513	1500	1529	1416	1543	1413	1476	1440	1423	1442	1460	1520	1524	1462	1512	1508	1517	1448	1456	1452
Numerator	104	108	88	92	111	82	103	101	104	114	102	105	84	99	84	64	70	85	82	85	88	70	82	81	62	66	56
%	7.06%	7.74%	6.30%	6.06%	7.43%	5.80%	6.97%	6.68%	6.93%	7.46%	7.20%	6.80%	5.94%	6.71%	5.83%	4.50%	4.85%	5.82%	5.39%	5.58%	6.02%	4.63%	5.44%	5.34%	4.28%	4.53%	3.86%
Median	6.80%	6.80%	6.80%	6.80%	6.80%	6.80%	6.80%	6.80%	6.80%	6.80%	6.80%	6.80%	6.80%	6.80%	6.80%	5.49%	5.49%	5.49%	5.49%	5.49%	5.49%	5.49%	5.49%	5.49%	5.49%	5.49%	5.49%
Target																						4.39%	4.39%	4.39%	4.39%	4.39%	4.39%



	Jul-12	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	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Denominator	878	853	857	904	914	893	906	858	953	847	874	911	839	811	863	880	860	896	936	967	909	900	901	866	847	841	874
Numerator	52	55	46	43	58	41	58	58	61	58	52	46	48	35	34	26	36	39	38	43	36	41	41	40	34	36	24
%	5.92%	6.45%	5.37%	4.76%	6.35%	4.59%	6.40%	6.15%	6.40%	6.12%	5.95%	5.05%	5.72%	4.32%	3.94%	2.95%	4.19%	4.35%	4.06%	4.45%	3.96%	4.56%	4.55%	4.62%	4.01%	4.28%	2.75%
Median	5.65%	5.65%	5.65%	5.65%	5.65%	5.65%	5.65%	5.65%	5.65%	5.65%	5.65%	5.65%	5.65%	4.12%	4.12%	4.12%	4.12%	4.12%	4.12%	4.12%	4.12%	4.12%	4.12%	4.12%	4.12%	4.12%	4.12%



	Jul-12	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	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Denominator	115	114	110	100	109	109	117	129	124	122	113	107	109	114	110	107	111	105	111	115	105	110	112	115	104	105	112
Numerator	13	20	18	16	17	6	13	12	15	13	11	12	7	12	11	10	10	6	5	14	11	3	13	15	6	4	9
%	11.30%	17.54%	16.36%	16.00%	15.60%	5.50%	11.11%	9.30%	12.10%	10.66%	9.73%	11.21%	6.42%	10.53%	10.00%	9.35%	9.01%	5.71%	4.50%	12.17%	10.48%	2.73%	11.61%	13.04%	5.77%	3.81%	8.04%
Median	15.80%	15.80%	15.80%	15.80%	15.80%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%	10.20%



6. Patient wound care passport

The Clinical Support Unit CQUIN delivery group has agreed that the Trust Wound Care Passport (Appendix B) is suitable for continued use between the acute and community settings.

Whilst there is evidence that the passport is well used for the patient leaving hospital there is limited evidence of use from community to the hospital setting. A group has been established to consider how we can achieve more effective utilisation of the Wound Care Passport throughout the Trust.

7. Definition of recurrence rates of pressure ulcers.

The Clinical Support Unit CQUIN delivery group has agreed that:

- A recurrent pressure ulcer should be defined as 'ulceration at any stage that occurs at the same anatomical site as the initial ulcer within 12 months from the time of complete closure of the initial ulcer'.

A group has been established to consider how incidence and learning from recurrence of pressure ulcers can be recorded and disseminated.

8. Recommendations

The Board is asked to note the information included in the report and specifically support the following actions:

- Launch and disseminate the revised wound prevention and management policy and appendices.
- Further development of the root cause analysis tool for pressure ulcers.
- Disseminate learning from Serious Incident investigations.
- Increase the use of the Wound Care Passport between the acute and community settings.
- Wound care passport to follow patients between the acute and community settings.
- Agree the process for recording recurrence of pressure ulcers.

Author	**Sarah Fiori, Senior Nurse Patient Safety Team**
Owner	**Beverley Geary, Chief Nurse**
Date	**November 2014**

Appendix A

Pressure Ulcer Reduction (Acute)

Project Description: Note for CQUIN this plan needs to be considered alongside the community PU reduction plan.

Executive Sponsor:	Bev Geary
Project Lead:	Diane Palmer
Project Manager:	Sarah Flori
Service Improvement Lead:	
Contracting Meeting:	

Detailed Plan

v3 sept 14

			Completion Date	RAG (type Green, amber or green)	Comments
		GOVERNANCE & REPORTING			
		Authority, Approach, Roles & Controls			
		Outline Business Case			
		Establish Project Board membership & meeting schedule			
		Business Case			
		Project Initiation Documentation			
		Establish reporting route & accountability			
		Measures, data collection, analysis & reporting			
		Agree measures (including balancing measures)			
		Establish data collection mechanisms & reporting schedule			
		Scope: York and Scarborough Acute Hospitals			
	1	**All pts to have 24/7 access to pressure relieving equipment (Lead: Senior Nurse Patient Safety - Sarah Flori)**			
	1.1	Appoint on a substantive basis 'TVNA-E' (York site) to maximize the use and efficiencies of pressure relieving mattresses and cushions; expand the role to manage TNP and other Tissue Viability related equipment	30-Jun-14		Achieved.
	1.2	Review and update processes to reflect change in equipment provision service with appointment of TVNA-E post	31-Jul-14		Achieved.
	1.3	Review provision of pressure relieving equipment in theatres and out patient areas and make recommendations to Chief Nurse	31-Jul-14		Review completed. To be presented at next Pressure Ulcer Steering Group (PUSG) on 1.10.14.
	1.4	Review provision of bariatric pressure relieving equipment in hospital sites and make recommendations to Chief Nurse	31-Jul-14		Review completed. To be presented at next PUSG on 1.10.14.
	1.5	Standardise procurement of pressure relieving equipment i.e. chairs, cushions, mattresses across acute sites	31-Aug-14		Achieved and operationalised.
	2	**Maintain provision of tissue viability training and education to nursing, midwifery, medical and AHP staff (Lead: Sarah Flori)**			
	2.1	Review and standardise statutory mandatory training in pressure ulcer prevention across hospital sites	30-Jun-14		Achieved and operationalised.
	2.2	Standardise HCA and RN induction education	30-Jun-14		Achieved and operationalised.
	2.3	Ensure all reference material and supportive documentation is standardised and cascaded to all clinical areas	31-May-14		Achieved and operationalised.
	2.4	Sustain visible presence of TVN's in order to provide ad-hoc and flexible training	31-May-14		Achieved and operationalised.
	2.5	Commence assessment of competence of all RN's by Ward Sister or delegated other (in patient assessment of risk, care planning, equipment choices and documentation)	01-Nov-14		Competence tool developed, dates agreed for introduction at Professional Nurse Leaders Forums (PNLF).
	2.6	Ward Sisters to complete competency assessment of all current RNs and new staff within 3 months of commencement	31-Mar-15		The period for completion has been agreed to be extended in line with the introduction of 'Learning Hub'.
	2.7	Link competency to appraisal system by July 2014	09-Sep-14		Achieved.
	2.8	Collaborate with Leeds and York Partnership NHS Foundation Trust to explore SLA for provision of Tissue Viability Service for Mental Health Service in York	31-Dec-14		Whilst remaining keen to develop SLA this work has been delayed due to organisational change within Leeds and York Partnership NHS Foundation Trust.
	2.9	Explore potential for collaboration between Tissue Viability Service and local Health and Social Care community	30-Sep-14		To be discussed in more detail at PUSG on 1.10.14.
	3	**Embed and sustain comfort rounds across all hospital sites (Lead: Chief Nurse Team)**			**This aspect of work will be led by the documentation steering group and a quarterly update will be viewed by the Pressure Ulcer Steering Group.**
	4	**Improve processes to ensure timely access to wound support and advice for all patients (Lead: Sarah Flori)**			
	4.1	Re-launch 'wound prevention and management policy'	31-Jul-14		Approved.
	4.2	Publicise and implement referral criteria to acute services staff	31-Jul-14		Achieved.
	4.3	Standardise TVN service provision across acute sites i.e. standardise patient assessment process, service provision and recording of activity	31-Aug-14		For discussion at next PUSG on 1.10.14.
	4.4	Explore potential for collaboration between Tissue Viability Service and associated professionals i.e. dermatology, vascular and podiatry	31-Aug-14		This will be incorporated into 4.3.
	5	**Consolidate and centralize trust assurance data and agree reporting structure (Lead: Sarah Flori)**			

	5.1	Pressure Ulcer Panel to be held monthly with agreed terms of reference	30-Apr-14		Achieved.
	5.2	Quarterly report to Board and subgroups reflecting incidents, ST, learning and progress against action plan	30-Apr-14		Achieved. Next report to be submitted to October Board of Directors 29.10.14.
	5.3	All category 3 and 4 pressure ulcers developed or deteriorated in our care to be declared SI's with full RCA	30-Apr-14		Achieved.
	5.4	Education programme for staff completing RCA to be agreed and delivered to timescales	30-Jun-14		Achieved. Matrons have received preliminnary RCA training. The next stage of RCA training is in planning and for discussion at next PUSG 1.10.14.
	5.5	Resources to support staff with reporting and investigating process to be disseminated across acute sites	31-Mar-14		Achieved.
	5.6	Full implementation of safety cross in acute hospitals and managed by Matrons	30-Jun-14		To be further reviewed with Matrons and Sisters as to how this will work with early warning trigger tool.
	5.7	Undertake safety thermometer (ST) for acute sites every month	ongoing		Achieved and operationalised.
	5.8	Establish process for validation of all safety thermometer data	30-Apr-14		Achieved and operationalised.
	5.9	Implement process for validation of acute safety thermometer data	30-Jun-14		Achieved and operationalised.
	5.11	Develop audit programme for measuring compliance with pressure ulcer standards, process and outcomes	31-Jul-14		Annual audit has been developed as part of the Wound Prevention and Management Policy.
	5.12	Undertake audit and develop action plan	30-Sep-15		Annual audit plan to be discussed and agreed by PUIP at next meeting 1.10.14.
	6	**Improve the nutritional status of patients in our care to prevent skin breakdown** [Lead: Nutrition Operational Group]			**This aspect of work is being led by the Nutrition Group and a quarterly update will be reviewed by the Pressure Ulcer Steering Group.**

Pressure Ulcer Reduction

Project Description:

Executive Sponsor:	Bev Geary
Operational Project Lead:	Wendy Scott / Annette Wilkes
Project Manager:	All Horton
Service Improvement Lead:	All Horton
Contracting Meeting:	

Detailed Plan COMMUNITY PRESSURE ULCER PREVENTION AND MANAGEMENT GROUP MEETING

v18-01.10.2014

			Responsible/ Actioned By	CI Team Support	RAG (type 'Green', 'Amber' or 'Red')	Start Date	Completion Date
		GOVERNANCE & REPORTING					
		Authority, Approach, Roles & Controls					
		Outline Business Case	n/a	n/a	n/a	n/a	n/a
		Establish Project Board membership & meeting schedule	tbc	tbc	tbc	tbc	tbc
		Business Case	n/a	n/a	n/a	n/a	n/a
		Project Initiation Documentation	n/a	n/a	n/a	n/a	n/a
		Establish reporting route & accountability	tbc	tbc	tbc	tbo	tbo
		Measures, data collection, analysis & reporting					
		Agree measures (including balancing measures)	tbc	tbc	tbc	May-14	tbo
		Establish data collection mechanisms & reporting schedule	tbc	tbc	tbc	May-14	tbo
		Other					
		CIT Performance Feedback	tbc	tbc	tbc	tbc	tbc
		CIT Follow-Up/Revisit	tbc	tbc	tbc	tbc	tbc
1		**Risk Screening Tool and Patient Information Leaflet - All Horton**					
	1.1	Risk screening tool rolled out	LB		Green	Mar-14	Completed
	1.2	Risk screening tool education inc AHP's	LB/TVN'S		Green	Mar-14	Completed
	1.3	Risk screening tool pilot audit AHP, DN and ICT		AH	Green	May-14	Completed
	1.4	Risk screening tool final audit 3 months		AH	Green	Jun-14	Completed
	1.5	Risk screening tool final audit 6 months		AH		Oct-14	Oct-14
	1.6	Develop patient information leaflet and disseminate	LB	AH	Green	Nov-13	Completed
	1.7	Audit delivery of patient information leaflet		AH	Amber	May-14	Oct-14
	1.8	Amend contact numbers in patient information leaflet	AH	AH	Green	Aug-14	completed
2		**Hand-Over Practice Lyeanda Berry**					
	2.1	Scope current handover practice	LB/AG/GT	AH	Amber	May-14	Dec-14
	2.2	Develop template for best practice based on SBAR/safety tool	LB/AG/GT	AH	Amber	Oct-14	Dec-14
	2.3	Pilot template and amend	LB/AG/GT	AH			
	2.4	Develop roll-out plan	LB/AG/GT	AH			
	2.5	Roll out documentation	LB/AG/GT	AH			
3		**Equipment Bev Proctor + CET**					
	3.1	Review and improve the process of HIRE equipment for pressure ulcer care	BP/RG/KW	AH		Jun-14	No CIT involvement
	3.2	Provide education and training re equipment	TVNs/KU	AH		Jun-14	No CIT involvement
	3.3	Review and develop a referral system for tracking urgent hire equipment	KW/E LMS	AH		Jun-14	No CIT involvement
	3.4	Develop a robust process to reconcile all urgent hire equipment	KW/ AH	AH		tbo	No CIT involvement
	3.5	Trial a test of change of equipment urgent hire process	KW/AH	AH		tbo	No CIT involvement
4		**Education and Training Gemma Hancock**					
	4.1	Competency tool to be developed	GH	AH	Green	Apr-14	Completed
	4.2	Pilot of competency tool	GH	AH	Green	Jul-14	Completed
	4.3	Training to be provided on the tool	TVN's	AH		Oct-14	Dec-14
	4.4	Team leaders to assess their staff using the competency tool	Team L's/LM's	AH		Oct-14	Jan-16
	4.5	Ensure a process for central training record	TVN	AH	Green	May-14	Completed
	4.6	Standardisation of Statutory and Mandatory training PUP	TVN	AH	Green	Apr-14	Completed
5		**Improved Datix Reporting Linda Mcdonaugh, Lyeanda Berry**					
	5.1	Agree standard for Datix reporting	LM/LB	AH	Green	May-14	Completed
	5.2	Audit of Datix to determine compliance	LM/LB	AH	Green	May-14	Completed
	5.3	Ensure all DN Team Leaders can amend datix reports	LM/LB	AH	Green	May-14	Completed
	5.4	Deliver datix training to DN Teams	LM/LB	AH	Amber	Sep-14	Jan-16
	5.5	Establish process for validation of all safety thermometer data	DF	AH	Green	Jun-14	Completed
	5.6	Implement process for validation of acute safety thermometer data	DF	AH	Amber	Jul-14	Mar-15
6		**Root Cause Analysis Linda Mcdonaugh, Lyeanda Berry**					
	6.1	Develop and agree RCA tool	LM/LB	AH	Green	Feb-14	Completed
	6.2	Roll out RCA tool	LM/LB	AH	Green	Feb-14	Completed
	6.3	Agree training programme for RCA	LM/LB	AH	Green	May-14	Completed
	6.4	Roll out education programme	LM/LB	AH	Amber	Sep-14	Jan-16

	6.5	Audit of RCA completion	LM/LB	AH	Amber	Aug-14	Mar-15
7		Documentation All Horton, TVN's, DN's					
	7.1	Develop wound care plan	TVN's,DN's	AH	Green	Mar-14	Completed
	7.2	Roll out wound care plan	TVN's,DN's	AH	Amber	Jun-14	Oct-14
	7.6	Pilot wound care plan	TVN's	AH	Amber	Aug-14	Oct-14
	7.3	Agree PURAT	TVN's,DN's	AH	Amber	May-14	Oct-14
	7.4	Roll out PURAT documentation	TVN's,DN's	AH		Oct-14	Dec-14
	7.5	Launch PU Wound Policy	BC/MC		Amber	Mar-14	Oct-14
	7.7	Audit compliance with above documentation	DN's	AH	Amber	Jul-14	Jan-15
	7.8	PU care plan	TVN		Amber	Jul-14	Oct-14
	7.9	Tool to improve nutritional status for pressure ulcers	Doc Group		Amber	Jun-14	Nov-14
8		Interface with Carers/Care Agencies Joyce Sims/Ann Potter					
	8.1	Identify key individuals and agree work plan	JS/AP		green	Apr-14	completed
	8.2	Identify strategy for improved documention and support	JS/AP		Amber	May-14	Apr-15
9		Non-oonoordanoe/Refusal of Care or Advioe Gemma Hanoook					
	9.1	Non compliance documentation to be developed	GH		Green	Apr-14	Completed
	9.2	Submission of compliance documentation to Business Forum	GH		Green	Jun-14	Completed
	9.3	Further redesign of compliance documentation required	tbc			tbo	tbo
	9.4	Launch tool	tbc			tbo	tbo
	9.5	Audit tool	tbc			tbo	tbo

York Teaching Hospital NHS
NHS Foundation Trust

The aim of this Passport is to improve wound care communication between care settings.
TO BE KEPT BY THE PATIENT

WOUND CARE PASSPORT

Patient Information	
Name:	
DOB:	
NHS Number:	
Address:	
Telephone:	
GP & Practice:	
GP Telephone:	
District Nurse:	
DN Telephone:	

Allergies to wound care products

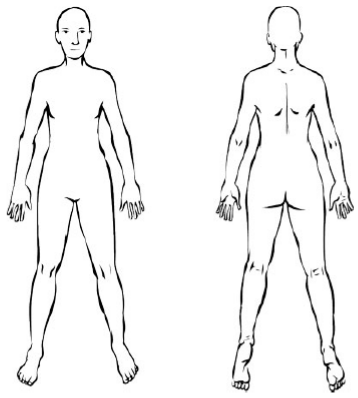
Author: S Fiori & Liz Jackson. Owner: Tissue Viability, Version 2, Issued September 2014

Type of wound/s (category (EPUAP 2009) if pressure ulcer). Document any 'recurrent pressure ulcers' defined as 'a pressure ulcer that has developed again within the past 12 months over the same anatomical position'.
Document any healed pressure ulcers from within the past 12 months.

Location of wound/s – Use the body map opposite to identify the site of any wounds (number if more then one)

Investigations and Treatments

Equipment



Communication – to include any specific information i.e. Safeguarding Alerts – Date and sign each entry.

Continue overleaf

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D

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Director of Infection Prevention and Control, Annual Report 2013/14

Action requested/recommendation

The Board of Director's are requested to accept this report as assurance of standards of care for patients and to note areas of both risk and significant 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	Quality and Safety Committee
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Alastair Turnbull, Medical Director
Author	Vicki Parkin, Deputy Director of Infection Prevention and Control
Date of paper	November 2014
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Director of Infection Prevention and Control

Annual Report

2013/14

Author: Vicki Parkin, Deputy Director Infection Prevention and Control
Owner: Dr A Turnbull, Director of Infection Prevention and Control

Governance: Presented to Board of Directors
Date of Report: October 2014

Contents

1. Introduction

This report covers the period from 1st April to 31 March 2014 and aims to provide assurance of effective infection prevention. York Teaching Hospital NHS Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). Assurance of response by the Trust in relation to performance and compliance with key regulation and assurance standards (Appendix 1) is provided to the Board of Directors, our Commissioners, Monitor, Public Health England (PHE) and the Patient Safety Committee through quarterly and annual reports from the Director of Infection Prevention & Control (DIPC).

The Board of Directors, managers and staff must continue to develop and maintain the leadership and responsibility required for the provision of effective Infection Prevention, and ensure that it is incorporated and embedded into all organisational policies, clinical protocols and objectives in relation to patient safety and the regulatory requirements of the Health and Social Care Act 2008/Code of Practice of the Prevention and Control of HCAI guidance 2010 against which the CQC inspect compliance.

2. Executive Summary

2013/14 was a challenging year for the Trust in relation to Infection Prevention, not least due to challenging HCAI national reduction targets set by PHE, but also due to a 50% reduction in Infection Prevention Team capacity through long-term sickness. However, through re-prioritisation of objectives and cross site rotation, the Team has delivered its 2013/14 Annual Plan objectives and continued to maintain significant achievements in service delivery and improvement that have, with full Trust engagement, been successful in the containment of clusters and outbreaks of infection.

Early indications are of a reduction in Clostridium difficile infection (CDI) incidence during Q1 and Q2 of 2014/15 following output in excess of trajectory during 2013/14. However, we must maintain vigilance and continue to critically evaluate through the CDI Operational Group, Post Infection Review and the Antimicrobial Stewardship Group the value and impact of existing and revised reduction initiatives; use of Probiotics, monitoring of the use Proton Pump Inhibitor drugs and enhanced, high level environmental disinfection regimes.

Other HCAI incidence is reported in section 4 of this report

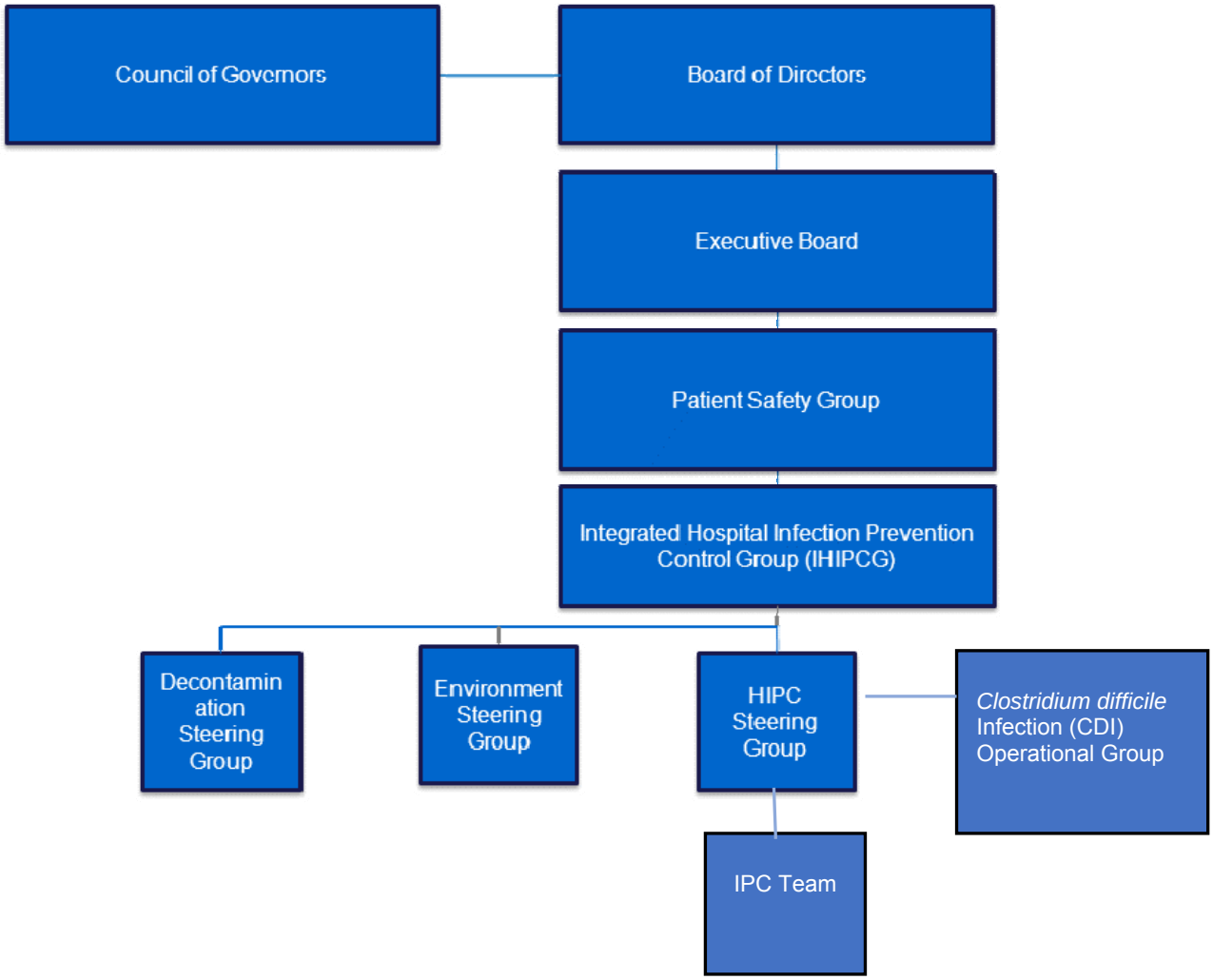
Audit and surveillance activity continues to monitor HCAI incidence and compliance with IP policy facilitating local ownership, benchmarking and a measure of compliance with local and national standards that drive service change and improvement.

Collaboration with external agencies with regard to hand hygiene has led to a re-modelling of the WHO Hand Hygiene Observational Audit Tool to ensure better understanding of and compliance with the key five key moments for effective hand hygiene.

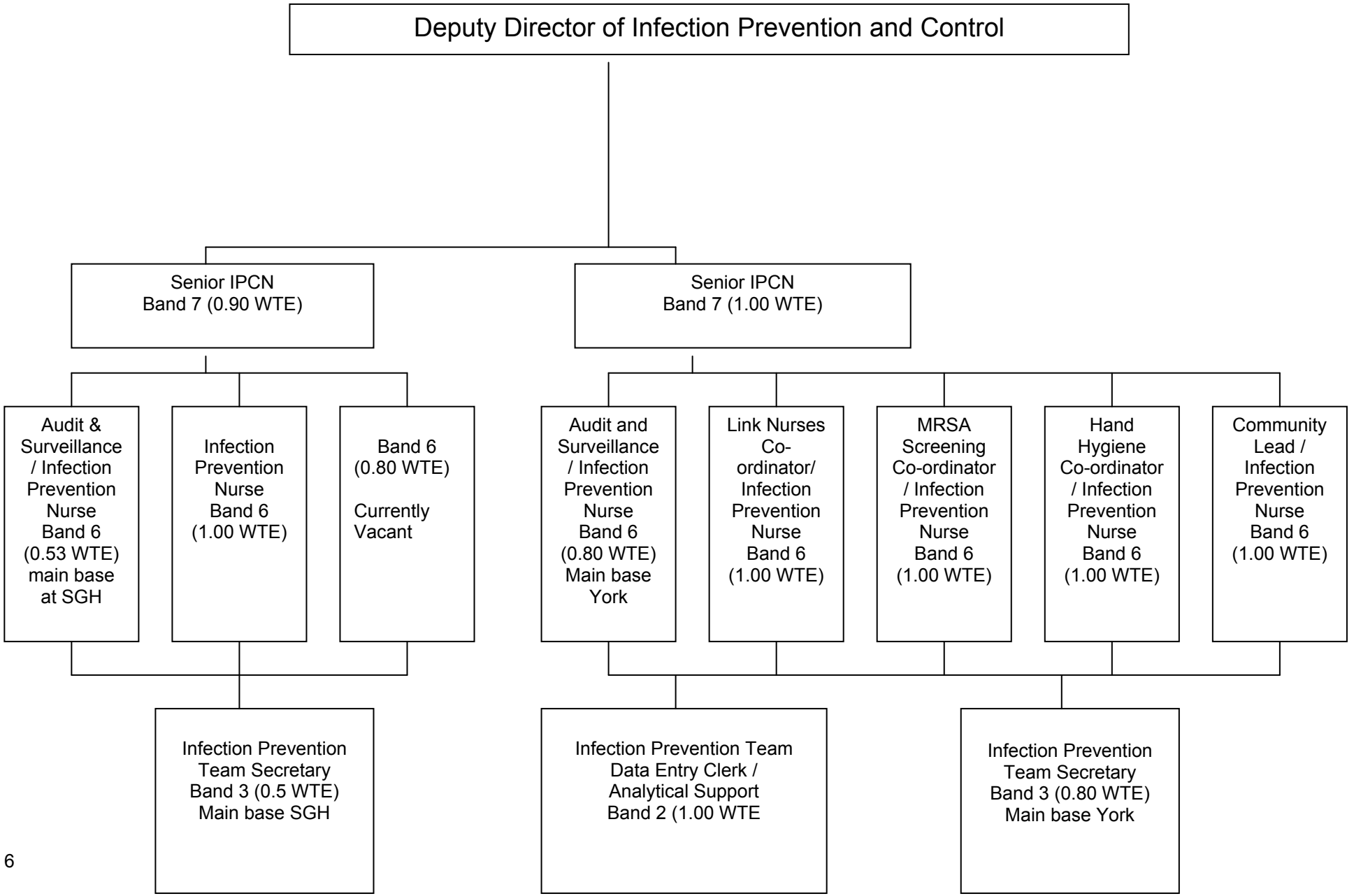
Working with the Trust Learning Hub through Corporate Learning and Development, the Infection Prevention Team have re-developed all statutory and mandatory educational resources into e-learning packages. Supported and enhanced by two Master Class events in relation to hand hygiene and Aseptic Non Touch Technique (ANTT), the Trust continues to support Infection Prevention in developing a knowledgeable and competent workforce.

The development of a pro-active, high level decontamination service using Hydrogen Peroxide Vapour (HPV) has been a key multidisciplinary initiative within the Trust CDI reduction strategy 2012/15. Endorsed by our partner organisations within the QUEST framework, early incidence trends post implementation demonstrates reduction in incidence.

3. Infection Prevention Governance Structure



Integrated Infection Prevention Team Structure 2013/14



4. HCAI Performance (App 2)

MRSA Bacteraemia – 2 cases occurred during the year, one on each acute site, against a national de minimus trajectory of 6. PIR was conducted.

MSSA Bacteraemia - 35 cases occurred against a local combined trajectory of 30. Post Infection Review identified invasive device use and mostly chronic, colonised wounds as contributory factors. Funding has been identified to appoint an invasive device specialist nurse to oversee the insertion and ongoing care of devices, standardise and make electronic documentation and the education of staff across the trust. The Trust has agreed to procure a nationally recognised Aseptic Non Touch Technique (ANTT) e-learning package which is a unique and internationally renowned best practice framework that supports health care workers to practice safely and efficiently when inserting and manipulating invasive devices. It aims to standardise and reduce variation in practice improving safety and reducing harm.

Clostridium difficile infection (CDI) – 67 cases occurred against a combined (York and Scarborough) national trajectory of 43; however this was without consideration of the impact of community hospital cases. PIR identified course length and indication as contributory factors. Introduction of monthly audit and feedback of compliance with Trust antimicrobial formulary has begun to foster Clinician engagement and ownership showing reduced incidence trends later in the year. The CDI Operational Group with the lead clinician for CDI continues to identify initiatives for improvement within the Trust CDI reduction strategy 2012/15 - available from the Infection Prevention Team (IPT).

Norovirus – At its peak from Dec to Feb 2013/14 Norovirus led to the closure of between 8-10 wards on each acute site compromising acute and elective activity. The locking of interlinking ward doors at York to prevent them being used as corridors, enhanced disinfection and media communication with the public and visitors sought to reduce incidence of this airborne infection with minimal impact. A detailed plan for reducing the impact on acute care in the future is being developed with key stakeholders within commissioning, intermediate and primary care.

Quarterly HCAI performance and assurance reports are submitted to the Board of Directors, Commissioners and the Quality and Safety Group.

5. Hand Hygiene

During February 2014 the Trust commissioned an external audit of hand hygiene compliance that showed inconsistency in local interpretation and application of the WHO 5 moments criteria for effective hand hygiene leading to the reporting of 100% compliance in all areas of the Trust without the expected variation for such a procedure. An improvement plan has been devised including:

- revision of the hand hygiene policy/ guidelines
- revision of the observation audit tool to ensure understanding and consistency.
- Trust wide staff education programme
- Public awareness stands at Trust open days
- Posters to promote easy access to hand wash facilities and inform visitors of the availability and location of hand wash facilities throughout the Trust

6. Audit and Surveillance

Audit and surveillance activity monitors performance against national and local IP standards and guidance enabling benchmarking and comparison. App4 outlines activity for the year.

The IP team commissioned the Internal Audit Dept to audit compliance on the Scarborough site with the newly integrated MRSA policy. Providing limited assurance, actions were developed and agreed to initiate improvements

7. Policies and Guidelines

All polices and guidelines are up to date and have been reviewed to reflect national/ local evidence and standards and are available to all staff via the IP intranet webpage and externally via the Trust internet site

8. Antimicrobial Stewardship

A detailed improvement plan has been put in place for antimicrobial prescribing in summary this includes the following improvement strategies

- Detailed audit and improvement work in poorer performing areas. This will involve multi-disciplinary team members.
- Inclusion of antimicrobial prescribing on induction programmes for medical staff.
- Initiating prescribing of VSL#3 probiotics in conjunction with antibiotics in high risk groups in order to reduce cases of antibiotic associated diarrhoea
- Escalation of audit results to directorate and corporate level within the Trust the Hospital Infection Prevention Control Group (HIPCG) and Medical Director. Poorly performing areas will be held to account.
- Smaller targeted audits are planned regarding ensuring antibiotics are stopped, de-escalated and reviewed in an effective manner.

The Trust is taking part in the European Antibiotic awareness day late 2014 in order to engage with staff and patients regarding safe and effective use of antibiotics. We hope to engage primary care and CCG colleagues in this important initiative.

9. Clean Safe Environment

Following the comprehensive cleaning review, an independent company (i-clean) carried out a full review of cleaning services and gave recommendations that were in line with the findings of the comprehensive cleaning review.
Work streams were identified to deliver the recommendations and to ensure services are delivered cost effectively whilst continuing to ensure that the Trust has effective and efficient cleaning arrangements in place throughout its property portfolio which give assurances to patients, Trust Board, commissioners and regulators that robust procedures are effectively established and remain a priority.

Facilities continue to work closely with Infection prevention and Matrons to ensure provision of a clean, safe environment is that of every individual and is embedded as routine best practice.

The Scarborough Environment Steering Group continues to be represented by a multidisciplinary team of nursing, infection prevention, estates, domestic, procurement and portering staff and has been key to initiating significant environmental improvements to enhancing patient and staff experience. A full report is available from the Assistant Head of Estates.

Patient Led Assessments of the Care Environment (PLACE) began on all in-patient sites from 26th February 2014 through to June. The National average for the cleanliness element of the assessment was 97.25%; the Trust average was 99.54%. This was an improvement on the 2012/13 Trust average of 97.46% demonstrating improved patient experience.

Following a CQC inspection that required action to be taken on the Scarborough Emergency Dept a business cases was submitted for additional cleaning hours. The unit now has a 24 hour cleaning service which enables the correct level of cleanliness to be maintained. Additional hours were also approved for the introduction of a disinfection (chlor clean) team at York which is in addition to the existing domestic team.

During December 2013 all domestic assistants received refresher training in relation to enhanced cleaning through a set of questions aimed at assessing knowledge and understanding of the cleaning and disinfection process when using chlor clean. This provdes assurance that training is effective and that correct procedures are being followed and will be repeated during 2014 to ensure competency and consistency.

A tender process was undertaken for an updated cleanliness monitoring system which gives real time cleanliness scores and has a fully integrated action planning process for ensuring effective actions and re-audit.
The trial of the new system on two wards at York Hospital is expected to commence in December 2014.

Refer to Appendix 5 for cleaning scores.

10. Decontamination

Daily chlorine disinfection of all wards in addition to Hydrogen Peroxide Vapour (HPV) disinfection of all areas where CDI occurred were implemented to reduce potential environmental reservoirs and the risk of further cases from this source. HPV decontamination was subsequently extended to all available areas regardless of infection. The IPT is represented on the Decontamination Steering Group that reports to the HIPCG.

11. Capital and Estates

The IPT have worked collaboratively throughout the year with Capital and Estates Departments to ensure infection prevention is designed into projects to create a safe and optimum environment:

- Theatre Upgrades Scarborough and Bridlington sites - Maternity, Ophthalmic, Orthopaedics.
- Endoscopy York site– upgrade and relocation.
- Radiology CT scanner upgrade York site.
- Surgical ward re build Scarborough site.

12. Patient Information

Patient information in relation to HCAI is available on the Trust internet and intranet sites. CDI information is distributed by IPN`s on diagnosis to all cases which is part of a North Yorkshire initiative aimed at informing GP`s of cases within their practice and improving antimicrobial prescribing through awareness of current or previous infection.

13. Education and Training

To increase uptake of training and improve access for all staff groups we have developed a set of e-learning packages. This comprises of a series of scenario based questions and rag rated answers. When a candidate responds, they are taken to a rationale of why their answer is correct (green) mostly correct (amber) or wrong (red) thus even for incorrect responses learning is taking place. We have recently been asked for permission by Corporate Learning and Development to share our particular training resource between other trusts in the region and also a hospital in Lancashire.

Link Workers:

Number of members
York- 65
Scarborough-50

2 monthly meetings have continued with average attendance of 15 people per meeting in York

The variation in attendance is due to the difficulty to release staff from clinical areas however clinical visits in particular on the Scarborough site have been undertaken as additional support to capture staff in their own areas

Topics covered

- Hand Hygiene (HH) compliance and HH facilities audit reports shared
- *C.difficile* case management using practical clinical scenarios
- Surgical site infections Saving Lives care bundles. Process of wound healing presented by Tissue Viability Nurse. Demonstration of Easywarm blanket
- Skin care and Hand Hygiene WHO 5moments framework presented Gojo (Trust supplier of HH products)
- Discussion of cannula audit results focussing on improving and changing practice
- Overview of MRSA policy and current changes
- Water safety discussed by Consultant Microbiologist
- Multi drug resistance awareness
- HCAI trajectory performance

Allied Health Professionals are to be invited to join the Link Worker network during 2014/15.

14. Conclusion and Recommendations

This report aims to provide assurance that the Trust is compliant with the Health and Social Care Act 2008 (Hygiene Code) regulatory requirement and standards as described in Appendix 1.

Over the period 2013/2014 we have had to adapt ever more to the changing nature of the organisation in terms of client base, activity and capacity. Our bed occupancy has increased, as have the numbers of complex procedures undertaken in the organisation. Our patients are more vulnerable requiring more medical intervention. Thus we have had to review acutely our protective measures and invest more in a proactive approach with reference to Infection Prevention to protect our patients. During this time we researched comprehensively the process of high level pro active environmental decontamination. We have reinforced good prescribing practice along with the proposal of introducing probiotics in conjunction with controlled antimicrobial use. We have changed our investigative process for HCAI to ensure that we can ascertain lessons learned and form action plans aimed at preventing/reducing harm and enhancing Patient Safety.

Our priorities for 2014/15 are outlined within the Annual Plan for that period available form IPT.

Appendix 1

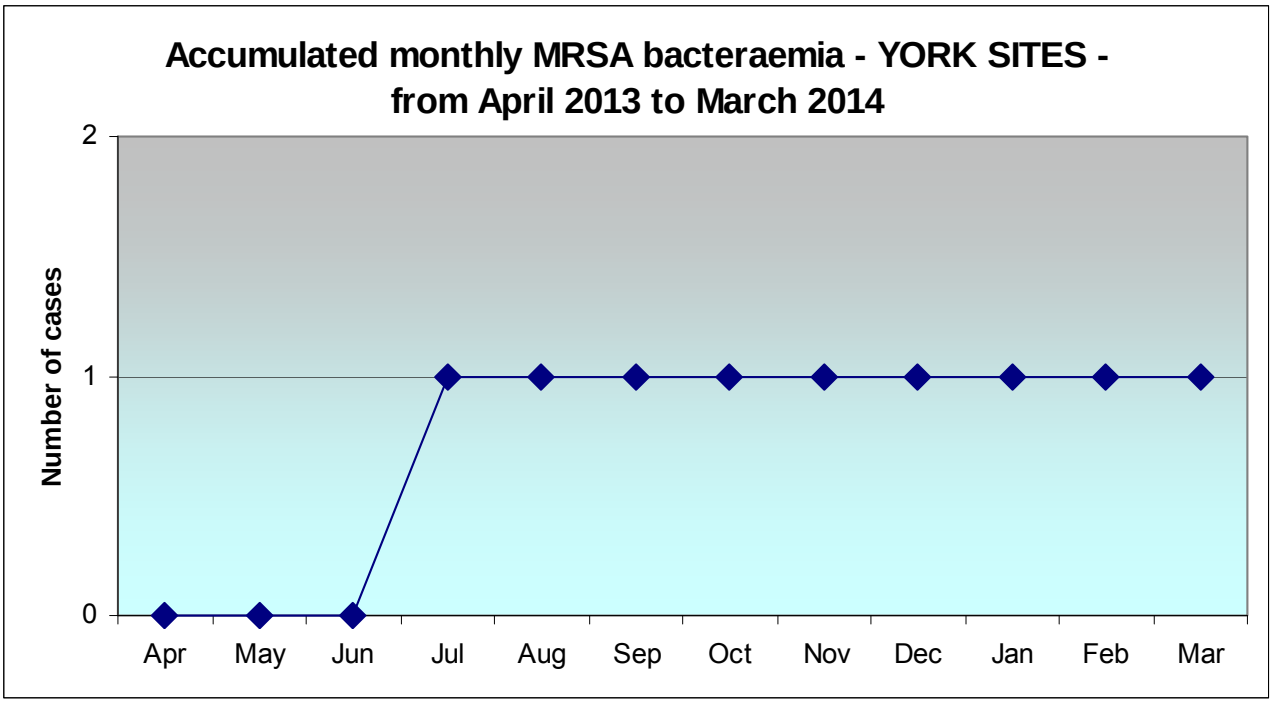
Key Regulation & Assurance Standards:

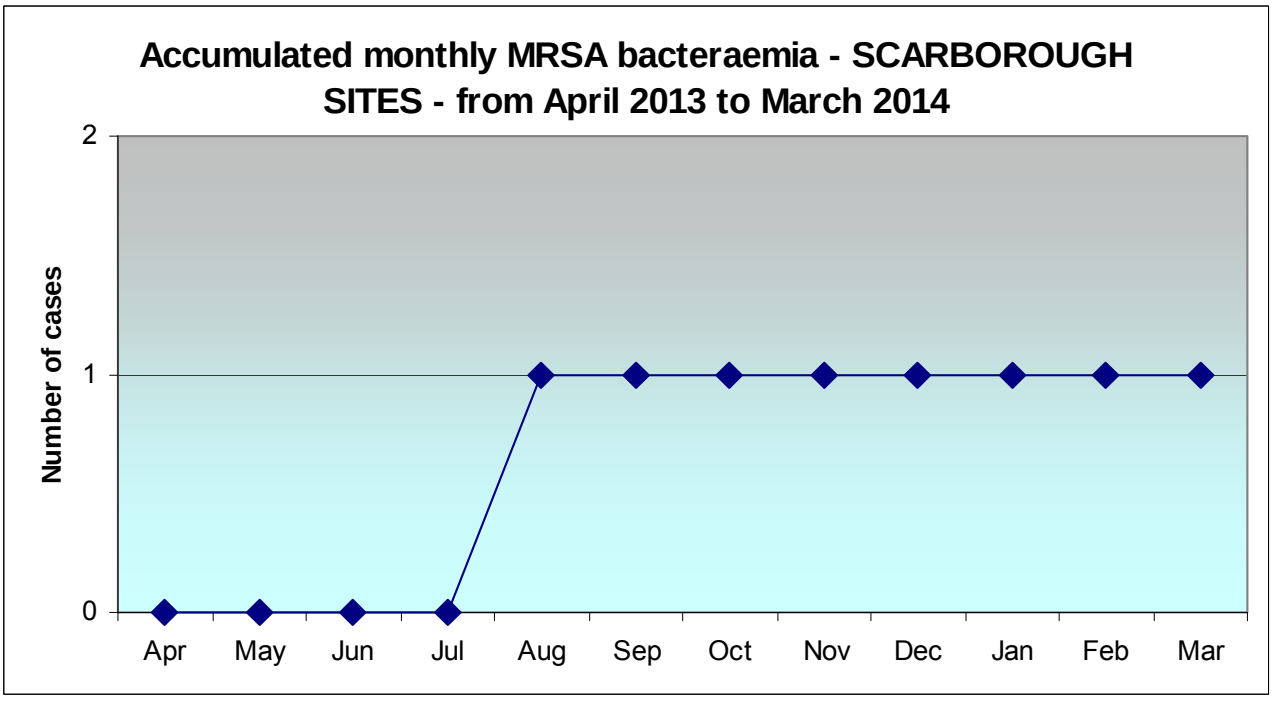
- The Health and Social Care Act 2009: Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance – Hygiene Code 2010 refer to Appendix 1.1 for compliance criteria
- NHS Outcomes Framework 2013/14. Domain 5
- NHSLA Risk Management Standards for Acute Trusts 2013/14. Standard 4 .6
- NICE Infection Prevention & Control Quality Standard 61. April 2014
- Monitor Requirements
- Care Quality Commission (CQC) – Essential Standards of Quality & Safety 2009, outcome 8
- National Evidence Based Guidelines for Preventing Healthcare Associated Infections in NHS Hospitals in England 2013 (EPIC 3)
- Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Surveillance Subgroup Report of HCAI Surveillance Priorities – Recommendations for HCAI
- Norovirus Guidance 2010 & Development Objective
- Trust Infection Prevention Risk Register
- Trust Infection Prevention Policies and Guidelines
- Directorate Assurance Framework Template

Appendix 2

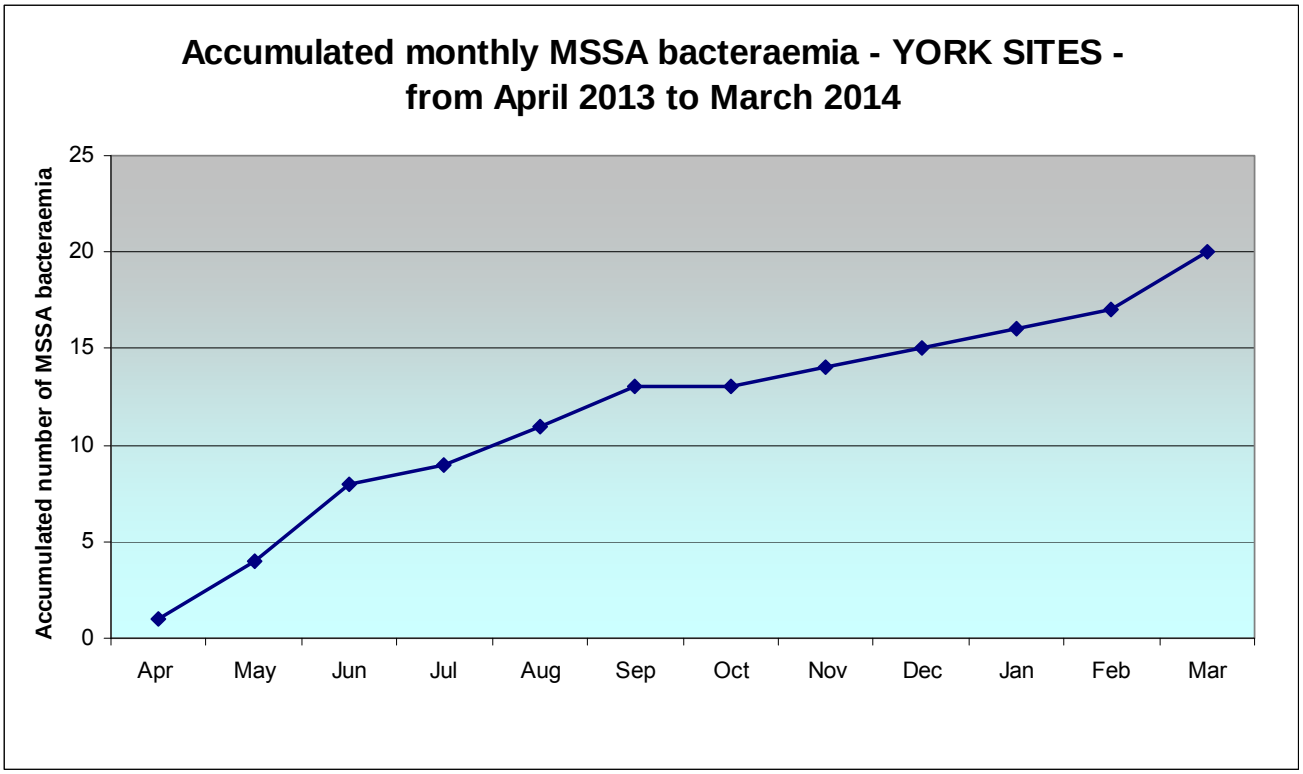
HCAI performance 2013 to 2014

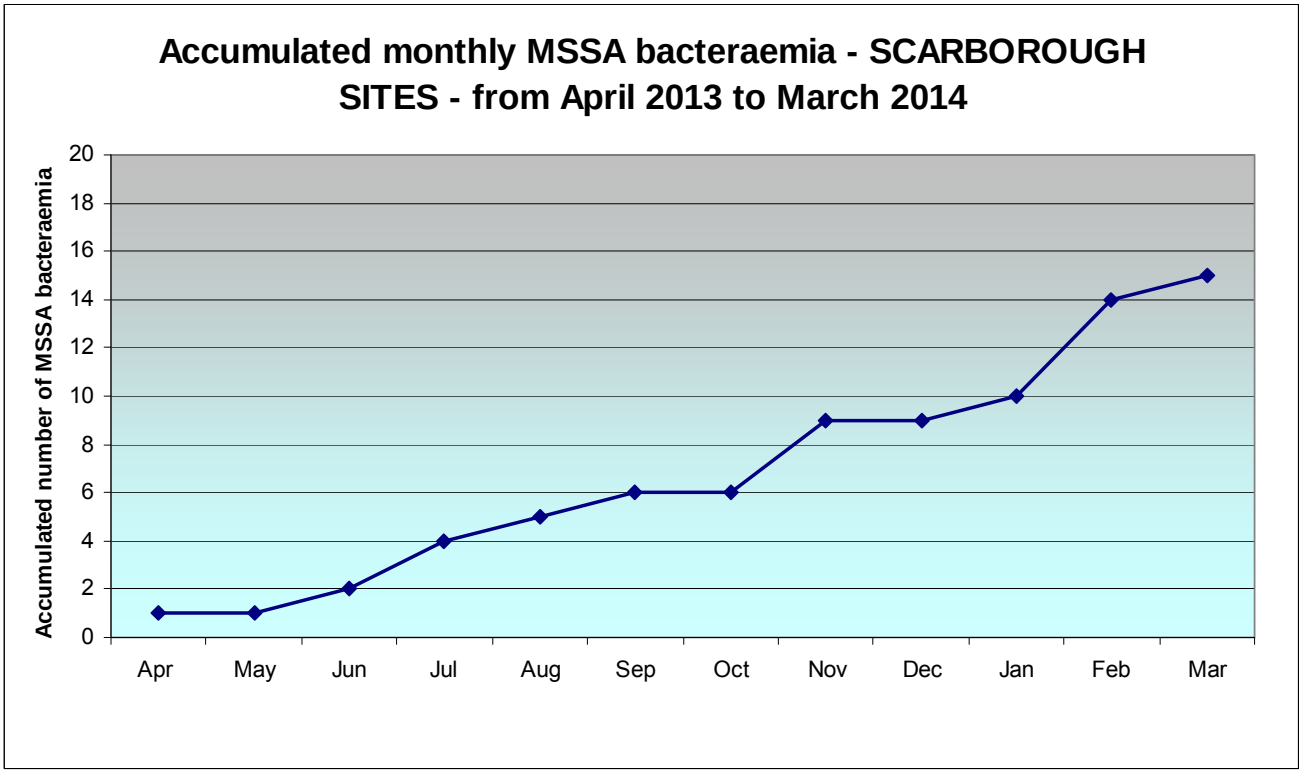
MRSA bacteraemia



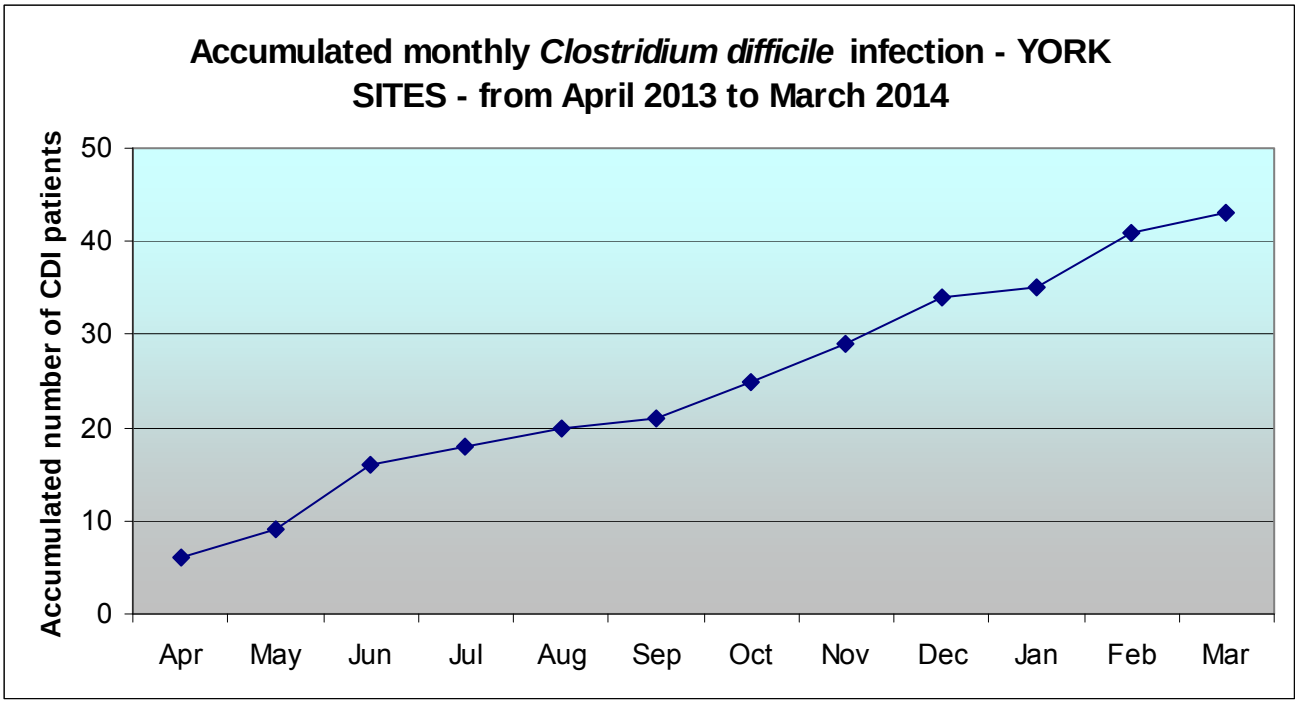


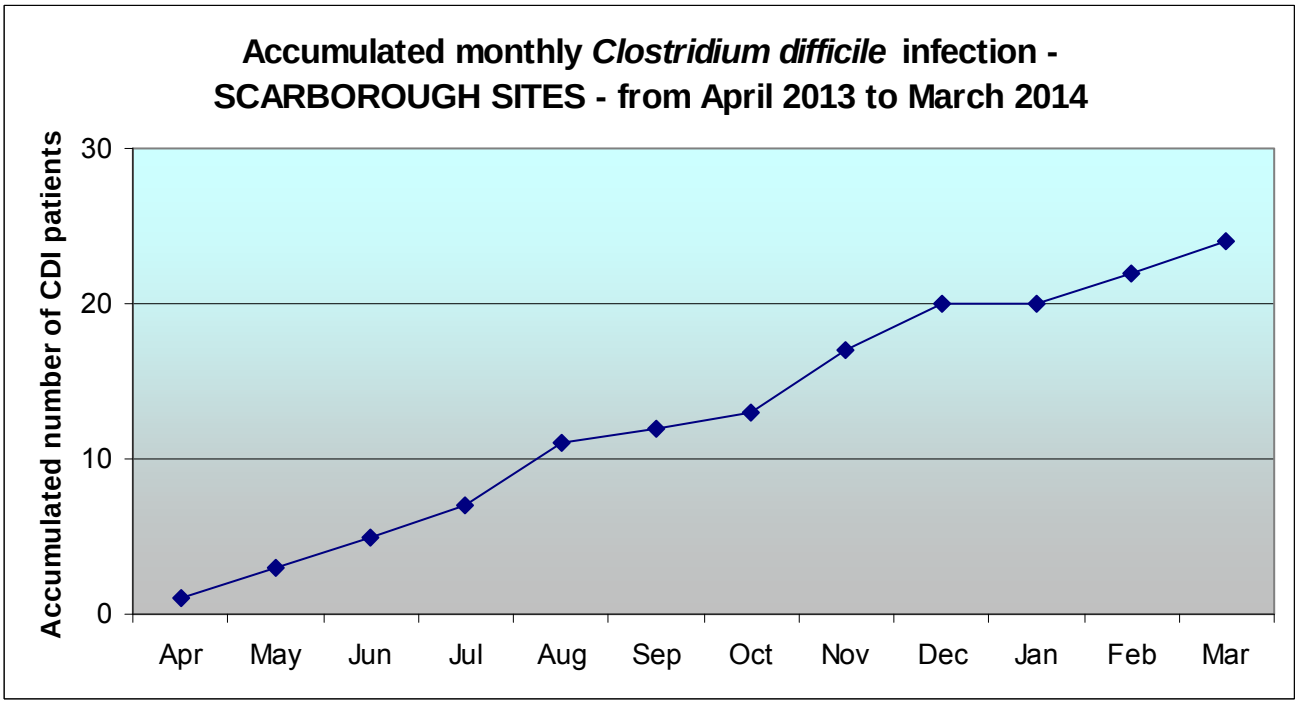
MSSA bacteraemia





Clostridium difficile toxin positive

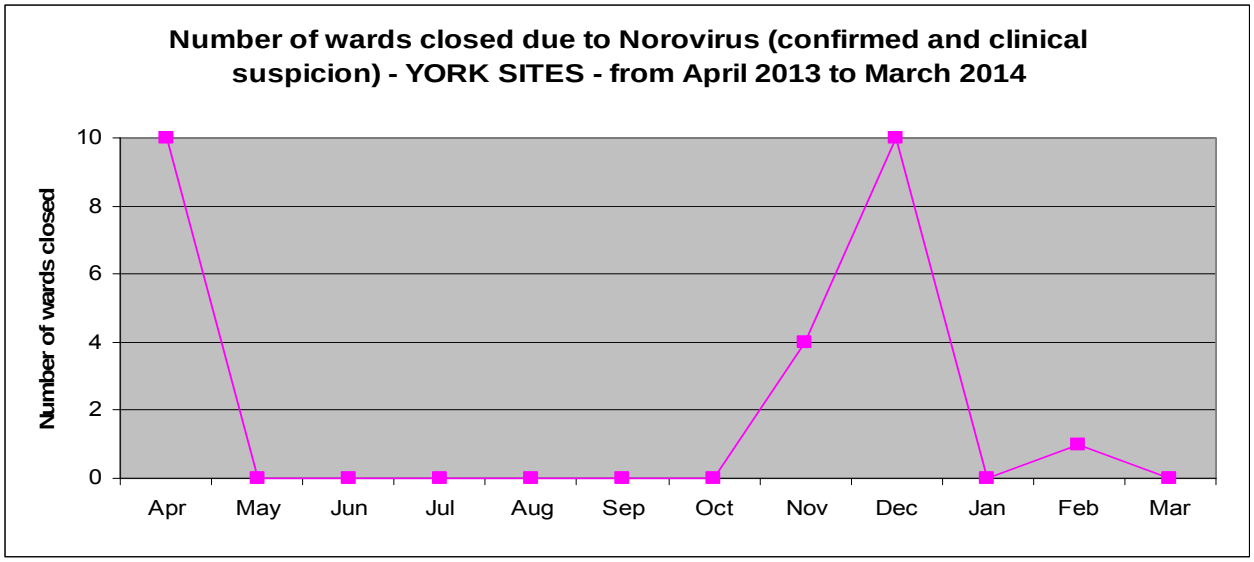


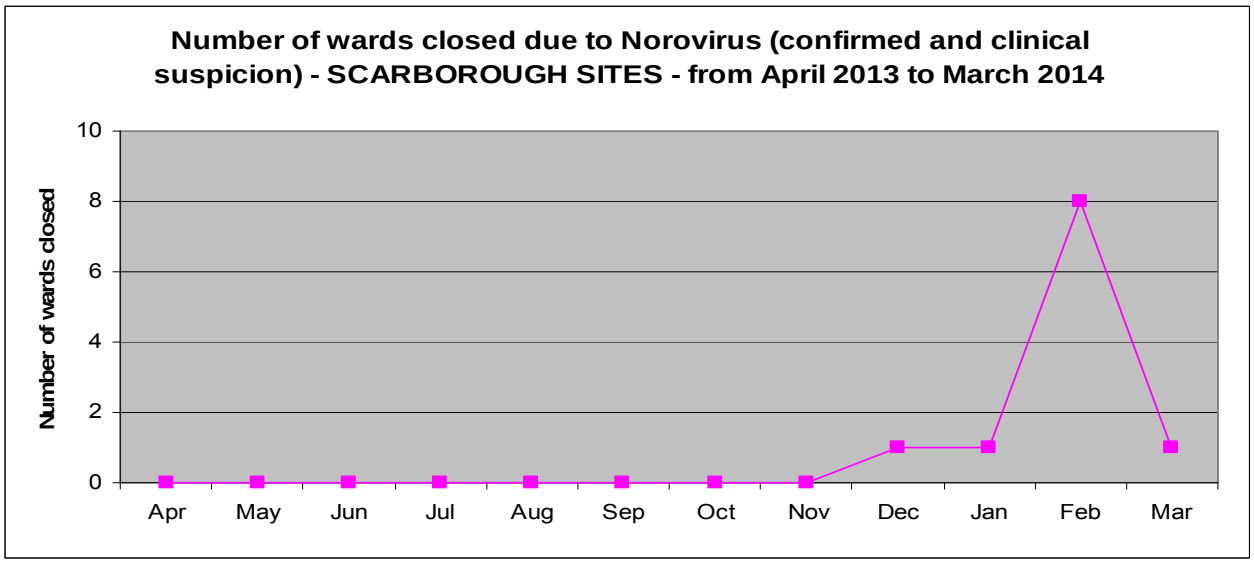


Appendix 3

Outbreaks and Clusters

Norovirus





Clostridium difficile 027 cluster Oak Ward - October to December 2013

- Six patients affected between first case on 15th October 2013 to last case 16th December 2013.
- Ward closed from 24th October 2013 until partial re-opening 08th November 2013 following high level disinfection of the whole ward and support to staff in the form education relating to effective case management

- Two further cases after partial re-opening led to re-closure to admissions and further disinfection of non clinical areas – corridor, sluice and nurses station. Ward fully opened 20th December 2013.

Vancomycin Resistant Enterococci (VRE)

Identified incidentally from wound cultures. As greater than 2 cases were identified on one ward a programme of whole ward screening was implemented for several weeks. The ward was closed between 7th March and 22nd March 2014 to facilitate high level of the whole unit. Guidelines are being revised.

Carbapenemase producing Enterobacteriaceae (CPE)

An imported case from Egypt not identified on admission. This pre empted the need for heightened awareness for CPE risk assessment and screening. One further case occurred that required whole ward screening until the index case was discharged. High level disinfection of the whole was deployed.

A robust risk assessment tool is now in place to identify patients with a history of a hospital stay outside the UK or within the UK in known high risk Trust. Guidelines have been produced.

Appendix 4 Surveillance and Audit plan – April 2013 to March 2014

Start date	SURVEILLANCE	Method	Comments and Outcome	Report date
On-going	Mandatory MRSA, MSSA and E Coli bacteraemia and *Clostridium difficile* reporting	Web-link case reporting as occurs	Reported by DH as one Trust from April 2013	On-going
On-going	Bacteraemia, MRSA, *Clostridium difficile* and ESBL incidence	Monthly reporting to Trust	Reported by ward, directorate and Trust on Trust shared drive. Aim to enhance assurance and awareness by improving access and reporting via Signal and Trust Performance, Q&S framework	On-going
April 2012	Deaths relating to *Clostridium difficile*	Ongoing data collection	To measure compliance among medical staff reporting presence of *Clostridium difficile* where there is a link to cause/ contributory factor of death, identifying areas of improvement through PIR process	On-going
April 2012	Readmissions relating to *Clostridium difficile*	Ongoing data collection	To report numbers of cases, monitor for increase and cause of relapse	On-going
2011	Clinical support visits	Work place IPN visit	IPN`s to work with ward staff to support and develop IP knowledge and compliance in clinical practice	On-going
November 2012 YORK ONLY	Readmissions with Surgical site infection	Ongoing data collection	To review methods available to allow regular data collection and reporting of patients readmitted within 30 days with surgical site infection identifying areas of improvement	September 2013
October 2012 SCARBOROUGH ONLY	Surgical site infection surveillance following Caesarean Section	HPA SSISS protocol	6 month data collection of all cases with 30 day follow up after surgery	October 2012

Start date	AUDIT	Method	Comments and Outcome	Completed
On-going	Clinical environment audits	Monthly audits by matron/ clinical lead	Rolled out all sites January 2013	On-going
On-going	Hand hygiene compliance audits	Trust wide monthly audits in each clinical area	To monitor compliance with the WHO 5 moments for hand hygiene standard	On-going
On-going	Saving Lives (SL) High Impact Interventions (now made obsolete by DH)	DH tools Trust wide monthly audits in each clinical area	July 2013 – replaced with more effective measures agreed with project Improvement Director maintaining SL methodology where appropriate	July 2013
Annual	Hand hygiene and sharps facilities audit	Annual audit of hand hygiene and sharps facilities in all clinical areas	Annual audit to establish policy compliance	May 2013
April 2013	Catheter related Urinary Tract Infection audit of documentation	Point prevalence	Annual review To link with Safety Thermometer data published on Signal	June 2013
April 2013	Central Venous Catheter audit of infection rates and documentation	Point prevalence	Annual review Matching Michigan in place in Scarborough critical care ICU staff monitor in York	June 2013
July 2013	TPN monitoring	Case review and follow up	To assist surgical teams with data gathering for TPN related line infections identifying risk and areas of improvement	Review December 2013
July 2013	Cannula documentation review	Random checks	To review paper copy cannula documentation prior to introduction of cannula e-records	September 2013

Appendix 5 Cleanliness Audit Results April 2013 to March 2014

York	Target	April		May		June		July		August		September		October		November		December		January		February		March		Annual %	
Very high	98	98	►	98	►	97	▼	97	►	97	►	97	►	98	▲	97	►	97	►	97	►	96	▼	97	▲	97	
High	95	93	▼	93	►	92	▼	92	►	92	►	94	▲	94	►	94	►	93	▼	92	▼	92	►	93	▲	92	
Significant	85	92	▲	92	►	92	►	87	▼	91	▲	89	▼	91	▲	83	▼	82	▼	90	▲	87	▼	86	▼	89	
Low	75	88	►	88	►	83	▼	96	▲	92	▼	80	▼	86	▲	76	▼	79	▲		▼	87	▲	94	▲	86	
Bathrooms & WC's	95	96	▲	96	►	95	▼	96	▲	96	►	96	►	96	►	96	►	96	►	95	▼	94	▼	97	▲		
Total audits carried out		149		169		165		163		161		160		156		139		123		146		142		146		1819	
Audits attended by nursing		12		12		6		13		11		13		12		12		11		18		10		10			

Scarborough	Target	April		May		June		July		August		September		October		November		December		January		February		March		Annual %	
Very high	98	98	►	99	▲	98	▼	97	▼	97	►	96	▼	97	▲	98	►	97	►	97	►	97	►	97	►	97	
High	95	91	▼	96	▲	96	►	96	►	94	▼	94	►	93	▼	95	►	95	►	95	►	92	▼	95	▲	94	
Significant	85	90	▲	88	▼	73	▼	92	▲	92	►	91	▼	93	▲	92	▼	91	▼	94	▲	92	▼	88	▼	90	
Low	75	83	►		▼	71	▲	81	▲	86	▲		▼	91	▲	78	▼		▼	74	▲		▼	77	▲	80	
Bathrooms & WC's	95	94	▲	98	▲	93	▼	95	▲	95	►	97	▲	96	▼	94	▼	96	▲	97	▲	94	▼	91	▼		
Total audits carried out		39		27		34		40		33		44		38		41		31		34		31		33		425	
Audits attended by nursing		7		12		4		7		5		13		3		3		1		2		3		1			

Bridlington	Target	April		May		June		July		August		September		October		November		December		January		February		March		Annual %	
Very high	98	97	▼	97	►	96	▼	97	▲	94	▼	96	▲	98	▲	96	▼	98	▲	98	►	97	▼	98	▲	97	
High	95	96	▼	96	►	96	►	94	▼	94	►	94	►	95	▲	96	▲	94	►	96	▲	95	▼	97	▲	95	
Significant	85	95	▼	98	▲	99	►	95	▼	96	►		►	95	►	83	▼		►	86	►	97	▲	92	▼	94	
Low	75		▲	87	▲	91	►	92	▲		►		►		►		►		►	96	►	82	▼	98	▲	91	
Bathrooms & WC's	95	96	▼	96	►	92	▼	94	▲	84	►	90	▲	92	▲	93	▲	96	▲	98	▲	94	▼	95	▲		
Total audits carried out		18		23		14		25		16		13		21		19		11		22		16		17		215	
Audits attended by nursing		0		5		2		0		1		0		0		4		2		0		0		2			

Malton	Target	April		May		June		July		August		September		October		November		December		January		February		March		Annual %
Very high	98		►		►		►		►		►		►		►		►		►		►		►		►	
High	95	97	▼	97	►	99	▲	98	▼	99	▲	98	▼	99	▲	99	►	95	▼	97	▲	95	▼	97	▲	98
Significant	85	97	▲	99	▲		▼	98	▲	99	▲		▼	97	▲	97	►		▼	98	▲	99	▲		▼	98
Low	75	73	►		▼		►		►		►	97	▲	60	▼		▼		►		►		►		►	77
Bathrooms & WC's	95		▲	99	▲	100	▲	99	▼	100	▲	99	▼	99	►	99	►	98	▼	99	▲	97	▼	100	▲	
Total audits carried out		12		8		4		8		10		6		8		8		4		9		8		4		89
Audits attended by nursing		0		0		0		0		0		0		0		0		0		1		0		0		

Whitby	Target	April		May		June		July		August		September		October		November		December		January		February		March		Annual %
Very high	98		▼		►		►		►		►		►		►		►		►		►		►		►	
High	95	97	▼	98	▲	97	▼	97	►	96	►	97	▲	98	▲	97	▼	97	►	97	►	97	►	97	►	97
Significant	85	96	▼		▼	96	►	97	▲	96	►	96	►	96	►	96	►	97	►	97	►	95	▼		▼	96
Low	75	94	▲	98	▲	98	►	99	▲	98	►		►	98	►	97	►	100	►	100	►	98	▼	100	▲	98
Bathrooms & WC's	95		▼	97	▲	97	►	98	▲	99	►	97	▼	98	▲	99	▲	98	▼	99	▲	99	►	99	►	
Total audits carried out		10		9		9		12		9		9		10		9		8		9		12		7		113
Audits attended by nursing		0		0		0		0		0		0		0		0		0		0		0		0		

SELBY	Target	April		May		June		July		August		September		October		November		December		January		February		March		Annual %
Very high	98	99	▼	99	►	98	▼	99	▲	99	►	99	►	99	►	99	►	100	▲	99	▼	99	►	99	►	99
High	95	99	▼	99	►	97	▼	98	▲	98	►	99	▲	100	▲	98	▼	99	▲	99	►	99	►	99	►	97
Significant	85	99	▼	99	►		▼		►		►	94	►		▼	98	▲	99	▼	99	►		▼	97	▲	92
Low	75		▲		►		►		►		►		►		►		►		►		►		►		►	
Bathrooms & WC's	95	99	▼	99	►	99	►	99	►	99	►	98	▼	100	▲	98	▼	100	▲	99	▼	99	►	99	►	
Total audits carried out		13		10		9		12		9		11		8		11		8		14		9		11		125
Audits attended by nursing																										
Audits attended by nursing		0		0		0		0		0		0		0		0		0		0		0		0		

No score in this risk

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York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 18 November 2014 Ophthalmology Seminar Room

Attendance: Mike Keaney Chairman
Mike Sweet,
Andrew Bertram
Lucy Turner
Steve Kitching
Mark Hindmarsh
Sue Rushbrook

Apologies: Graham Lamb
Liz Booth
Anna Pridmore

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last Meeting Notes Minutes Dated 21 October 2014**		The notes were approved as a true record of the meeting with the following amendments. Page 13 – AB confirmed that agreement had been reached for double time for ECP lists until further notice. Page 14 – AB confirmed the tender for OOH and Urgent Care had been submitted for the Scarborough locality. Page 8 – LT confirmed 123 patients had been offered appointments at other hospitals. Page 11 – ED token system has been removed from York. It is still running in Scarborough and will be withdrawn in February.		
2	**Matters arising**		No items to discuss not on the agenda.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3	**Short Term Acute Strategy**		LT presented a summary of the 4-hr turnaround group summary schemes. SR advised the committee of the work done with the recent two hospital boards on key activity and process data. Specifically this looked at patients: • Admitted • Not admitted but have investigation • Not admitted and do not have an investigation. An examination of breaches was performed and the data shared with the two Boards. This showed a key analysis of the impact of the discharge curve on bed capacity. The data was presented to the Boards for York and Scarborough specifically. The data and the discussion supported the new approach being taken regarding operational delivery – the establishment of the COBRA meetings for each site, chaired by the Chief Executive. MK asked how the COBRA meetings fit with the action trackers prepared and in use. MS commented on how key this meeting was to ensure rapid review of performance. SR explained this was not to replay the acute strategy as this is managed by the Acute Board. SR and LT explained that the COBRA meetings will be used to provide senior operational oversight of in the moment delivery. MS asked for sight of the presentations to the hospital Boards – SR to provide. MK challenged the committee for a view on Q4 delivery of the 4-hr target. SR confirmed the work underway to place the Trust in the best possible position for Q4 delivery. This includes detailed	The committee were assured by the presentation and engagement by the hospital boards. The COBRA meetings were seen as a very positive assurance step.	PC to provide an overview to the Board on the first meetings.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			analysis of all breaches – SR gave the example of orthopaedic admission breaches being examined and actions being considered to address. MS requested an update next time on the longer term strategy and particularly the developing plans for Acute Assessment Units.		
4	**Efficiency Report**		SK provided an overview of the reported position for October. The planning gap has closed down to £1m for the year, representing a marked improvement from last month and from this time last year. Overall delivery is £14.6m, representing 61% of the £24m target. Clinical assessments of CIP plans continue to progress with a small number now outstanding. This work will continue. Directorate Manager changes and gaps remain key risks in some areas. Work is being targeted to support these areas. Progress is on track with CIP panel meetings. MK asked about the plans to close the panning gap. MK commented on the risk around having this gap and SK and AB described actions to address this including work on new schemes with directorates and including pressing over delivery where this is possible. MS challenged on the continued worrying non-recurrent trend. SK reiterated the trial nature of some schemes but recognised the challenge this brings. SR added the need for the development of transformation ideas to efficiency and productivity as was recently discussed at the Board time out. The committee noted the Board agreed to debate the possibility for	The committee were assured by the continued efforts of the CET at refreshing the programme and re-energising ideas but wanted to debate with the Board the potential for external help and support in progressing real	AB to provide an overview to the Board on the forecast outturn position based on latest projections and non-recurrent

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			external help in this regard at the next meeting. MK challenged SK on the impact of the rollover of failed targets on directorate new year targets. MK questioned whether directorates are geared to even delivering in-year targets. SK described the work with directorates to ensure base level delivery but noted the challenge the rollover brings. MS asked for a view on clinical engagement. SK responded this is still variable although continued attention to developing engagement is very much part of the efficiency work. AB confirmed developing this agenda is a key element to the CET work. MS questioned the work to ensure engagement over the Christmas period on this agenda. SK assured the key work plans for this time including key CIP meetings, Q3 submission to Monitor and numerous CET meetings with directorate teams. The committee discussed the report describing poor performing directorates in some detail. MS requested this report was updated quarterly as the information was extremely useful to the committee.	transformational change.	levels.
5	**Operational Report**		SR described the latest developments with the finance and performance report. The target is to complete the report in the current financial year to ensure full and comprehensive information insight and, importantly, reporting on all directorate action plans to ensure target delivery. LT described how the report was currently being used in practice with directorates. MS requested an update to the report to describe progress against the trajectories shared with Monitor. SR and LT confirmed this can be achieved and will be	The committee were assured with the continued development and iterative process. The plans to include directorate improvement plans alongside trajectory delivery were highly anticipated.	SR to provide an insight to the Board on the developing plans for directorate improvements to be included in the performance report.

Agenda Item	AFW	Comments	Assurance	Attention to Board
		developed for next time. LT provided an overview of key performance issues: • 18-wk admitted passed at aggregate level. LT provided an overview of difficult issues at specialty level and plans to recruit additional capacity to address these concerns. Reference was made to the next iteration of the performance report will include directorate actions at specialty level. • Non-admitted backlog has reduced a little and validation of the incomplete pathway data continues. Discussions with directorates have focused heavily on correcting this position where there are problems with data. MS and MK challenged on the work being done to validate data and sought assurance that this was being taken seriously by directorates. • LT reported on the degree of elective cancellations, particularly on the Scarborough site. Non-elective pressures have placed significant operational pressure on the site and the data shows this has increased recently. • 14-day cancer fast track failed in Q2. LT explained we are still working with the CCGs to redefine proformas, educate referrers and to look at pathways for alternative access (eg. using plastics and/or maxillo facial as an alternative to dermatology). • 14-day symptomatic performance is significantly improving (Sept and Oct) although patient choice in November has caused a downturn in performance. This is still very much under close management and is a Trust		SR to comment on the position in relation to the expected backlog position after the conclusion of the additional paid work.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			risk. • ED 4-hr performance noted but discussed elsewhere in the agenda. Noted the COBRA initiative. MK questioned the frequency of the COBRA meetings and AB And SR explained the daily frequency of intervention at directorate and operational team level with alternate week intervention from COBRA. MS requested a December meeting to look specifically at ED performance and the Monitor trajectories. • CQUIN – main risk issue is senior review at Scarborough failed at Q2 and looking unlikely for Q3. • Diagnostic issues were raised by LT particularly in cystoscopy (plan in place for additional capacity) and non-obstetric ultrasound (major capacity recruitment difficulties). This target looks under threat for Q3. Additional MRI scanning is being purchased from the Nuffield and additional external reporting capacity is being bought in. • Mixed sex accommodation breach noted on the York site. LT explained the position and the circumstances.		Anna to convene the F&P Committee for a short meeting prior to the December informal Board (16 December at the latest) to discuss ED and Monitor trajectories. AT to provide an update to the Board on progress with the senior review CQUIN at Scarborough.
6	**Finance Report**	2.15 3.1 3.11	AB presented an overview of the finance report. He reported an I&E surplus of £0.9m, some £3.1m behind plan. Whilst still in deficit it is of note that the position has improved by £1m from that reported last month. The CIP position and impact on the monthly position had been discussed in the efficiency report. MS and MK discussed the approach being taken with		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			the inclusion of income relating to ambulance turnaround fines and marginal rate non-elective CCG savings. They were pleased to note the CCG engagement with turnaround fines but remained concerned over the lack of clarity of the CCG position with regard to the reinvestment of marginal rate non-elective tariff savings. AB provided feedback on the recent South Tees visit. The CE, DCE and FD had recently been given access to the transformation board at South Tees. Key learning points include the McKinsey input providing engagement, implementation capacity, generation of new ideas, pace of delivery, challenge to outdated practice. The committee noted the Board's current discussion in this regard. MK challenged the committee again on the current levels of agency and locum staffing expenditure. MK described his recent walk round the Scarborough site and the feedback from staff of the negative impact of current vacancy levels. AB explained that, recognising this initiative was only addressing the symptom of high locum expenditure, a joint finance and HR working group is evaluating alternative management and procurement of agency medical staff. A number of suppliers have recently presented their systems and a product evaluation is currently underway. The committee will be kept up to date with progress. MS requested an update on the latest forecast outturn position for the Trust. AB confirmed that at this stage the forecasting tools used by the finance team still suggest a £1m deficit for the Trust. This position will be reported through to Monitor. This is being kept under constant review.		SH to provide an update on the latest recruitment initiatives to reduce current vacancy levels.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			The committee noted that an update SLA report and feedback on the Reference costs exercise are due for the January committee. Terms of references for F&P committee are also due for review in January.		AP to update the work programme.
7	**Any Other Business**		None discussed.		
8	**Next meeting**		The next meeting is to be arranged in December.		

York Teaching Hospital NHS
NHS Foundation Trust

Monthly Performance Report

October 2014

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Q2 Actual	Aug	Sep	Oct
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail:** £400 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**90%**	90.9%	81.6%	77.5%	79.1%	86.7%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail**: £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TCB	**95%**	96.8%	95.9%	95.9%	95.8%	95.0%
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	**Specialty fail:** £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**92%**	93.3%	93.4%	93.6%	93.4%	93.2%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	1	0	0	0	0

Access Targets: Cancer

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

Indicator	Consequence of Breach	Threshold	Q1 Actual	Q2 Actual	Jul	Aug	Sep
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	86.1%	85.9%	89.8%	85.2%	82.2%
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	45.6%	78.6%	71.0%	80.6%	90.2%
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	98.6%	97.9%	96.9%	98.5%	98.2%
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	96.4%	94.9%	96.4%	88.9%	96.9%
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	100.0%	99.1%	98.7%	98.0%	100.0%
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	87.8%	87.6%	89.9%	85.7%	86.9%
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	96.6%	93.8%	100.0%	94.1%	91.3%
62 Day Consultant Upgrade	General Condition 9	**85%**	50.0%	-	-	-	-

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Q2 Actual	Aug	Sep	Oct
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£200 fine per patient below performance tolerance (maximum 8% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	93.9%	92.6%	92.5%	92.5%	90.6%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**> 30min**	481	489	144	177	177
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**> 60min**	207	255	84	81	103
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q1 Actual**	**Q2 Actual**	**Aug**	**Sep**	**Oct**
	NHS VALE OF YORK CCG	30mins - 1hr	176	70	15	29	40
		1hr - 2hrs	101	32	10	15	30
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	141	202	65	73	66
		1hr - 2hrs	56	100	40	33	36
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	96	122	30	46	49
		1hr - 2hrs	26	82	24	26	24
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	27	34	10	14	8
		1hr - 2hrs	5	14	3	3	6
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	5	1	0	0	1
		1hr - 2hrs	0	1	1	0	0
	OTHER	30mins - 1hr	36	60	24	15	13
		1hr - 2hrs	19	26	6	4	7
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**> 12 hrs**	0	2	1	0	0
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	97.4%	To follow	97.5%	To follow	To follow

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Q2 Actual	Aug	Sep	Oct
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**TBC**	93				
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	**TBC**	104				

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Q2 Actual	Aug	Sep	Oct
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**59**	12	10	3	6	2
Number of Clostridium difficile due to "lapse in care"	*TBC*	**TBC**	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**108**	30	20	7	7	7
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) cases	**Quarterly:** General Condition 9	**35**	14	9	1	2	6
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	0	0	0	0
Notification of MRSA Bacteraemia to be notified to commissioner within 2 working days	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 14 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a	n/a
Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	87.9%	88.7%	87.9%	90.0%	90.7%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	71.2%	72.7%	70.8%	73.1%	72.0%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Q2 Actual	Aug	Sep	Oct
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 fine per patient below performance tolerance	**99%**	97.6%	98.3%	98.4%	98.0%	98.5%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0.0%	0	0	2
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hosp	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	1	0	0	0	0
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	63	75	6	22	43
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	£200 in respect of each excess breach above threshold	**95%**	97.2%	96.9%	97.2%	96.1%	97.0%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.7%	To follow	99.6%	To follow	To follow
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	5.9%	6.5%	10.0%	3.7%	Not available
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 89% Q2 - 90% Q3 - 92% Q4 - 95%**	85.9%	86.4%	85.7%	87.7%	86.4%
Delayed Transfer of Care to be maintained at a minimum level	TBC	**TBC**	1548	1988	636	592	437
Trust waiting time for Rapid Access Chest Pain Clinic	None	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance				
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**200 per month**	348	518	157	163	223
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**Baseline 784; end Q2 745; end Q4 722**	2236	2287	687	847	850
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	371	2 month coding lag	91	2 month coding lag	2 month coding lag
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	1247	2 month coding lag	389	2 month coding lag	2 month coding lag
Reduction in the number of inappropriate transfers between wards and other settings during night hours (Reduction in avoidable site transfers within the Trust after 10pm)	General Condition 9	**Q2 onwards 80 p.m. (TBC)**	256	269	89	104	103

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Q2 Actual	Aug	Sep	Oct
Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	General Condition 9	**80% by site**	87.9%	84.0%	78.9%	81.3%	85.3%
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	93.7%	98.6%	98.6%	97.5%	Not available
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%	100.0%	100.0%	100.0%
Proportion of stroke patients who spend >90% of their time on a stroke unit	Non delivery of 90% at Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £5k in line with respective finance baselines (TBC)	**80%**	86.9%	90.5%	90.3%	92.1%	one month behind
Proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours of seeing a health professional	Non delivery of Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £2k in line with respective finance baselines (TBC)	**70% (TBC)**	86.7%	86.0%	90.9%	81.8%	one month behind
Proportion of patients presenting with stroke with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	General Condition 9	**65%**	95.0%	100.0%	100.0%	100.0%	one month behind
Percentage of stroke patients and carers with joint care plans on discharge from hospital to have a copy of their care plan (except RIP or who refuse health/social care assessment/intervention)	General Condition 9	**70%**	n/a	n/a	n/a	n/a	n/a
Patients who require an urgent scan on hospital arrival, are scanned with in 1 hr of hospital arrival (TBC)	No financial penalty	**50%**	82.6%	70.8%	55.0%	80.0%	one month behind
Proportion of stroke patients scanned within 24 hours of hospital arrival	No financial penalty	**90% (TBC)**	91.6%	96.5%	96.6%	95.0%	one month behind
Transmission of IDLs to GPs within 24 hours of discharge (Q1-Q3 elective and non-elective activity IP only excluding DC, Maternity and by end Q4 to include surgical DC activity too) - Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology.	Failure to deliver the quarterly target will result in the application of a £4k penalty per quarter Maximum sanction of £16K per annum based upon respective commissioners financial baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	76.0%	77.3%	74.9%	78.0%	80.2%
Immediate Discharge Letters (IDLs) handed to patients on Discharge	General Condition 9	**98%**	Annual letter of assurance to be provided to CMB				
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver quarterly trajectories at Trust aggregate level for each quarter will result in the application of a £10K sanction relating to each underperforming quarter. Maximum sanction of £40k per fiscal year. The penalty will be applied by the commissioners in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	Quarterly audit				
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver the quarterly target will result in the application of a £6k penalty per quarter. Maximum sanction of £24k in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 94%**	Quarterly audit				
All Red Drugs to be prescribed by provider effective from 01/04/14	£50 penalty for any request to primary care for prescription of Red Drugs (TBC)	**100% list to be agreed**	CCG to audit for breaches				
All Amber Drugs to be prescribed by provider effective from 01/04/14	No financial penalty	**100% list to be agreed**	CCG to audit for breaches				
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	86.6%	86.9%	86.6%	86.9%	87.1%

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Q2 Actual	Aug	Sep	Oct
Never Events	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	**0**	0	0	0	0

District Nursing Activity Summary

Indicator	Source	Threshold	Q1 Actual	Q2 Actual	Aug	Sep	Oct
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	n/a	1817	2031	599	670	726
	Community nurse/service	n/a	867	1131	336	433	360
	Acute services	n/a	691	829	167	256	265
	Self / Carer/family	n/a	481	513	181	156	143
	Other	n/a	231	278	92	82	90
	Grand Total	n/a	4153	4737	1375	1597	1584
Community Adult Nursing Contacts	First	n/a	2612	2612	712	761	805
	Follow up	n/a	32184	32184	10256	11428	10929
	Total	n/a	34796	34796	10968	12189	11734
	First to Follow Up Ratio	n/a	12.3	12.9	14.4	15.0	13.6
Community Hospitals average length of stay (days)	Archways	n/a	23.4	22.1	20.1	22.2	22.2
	Malton Community Hospital	n/a	24.5	18.6	17.4	16.0	17.2
	St Monicas Hospital	n/a	24.5	23.2	24.7	24.1	19.4
	The New Selby War Memorial Hospital	n/a	13.8	15.6	11.1	17.1	15.5
	Whitby Community Hospital	n/a	21.1	20.3	18.4	22.9	19.0
	Total	n/a	20.4	19.4	17.6	19.6	18.0
Community Hospitals admissions. Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	8	4	2	0	0
		Emergency	66	91	24	31	27
	Malton Community Hospital	Elective	4	10	2	7	6
		Emergency	89	114	35	37	47
	St Monicas Hospital	Elective	9	13	3	3	5
		Emergency	36	35	14	12	8
	The New Selby War Memorial	Elective	68	62	19	22	23
		Emergency	71	66	22	24	29
	Whitby Community Hospital	Elective	0	1	1	0	4
		Emergency	152	123	44	38	45
	Total	Elective	89	90	27	32	38
		Emergency	414	429	139	142	156

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Complaints and PALS												
New complaints this month	51	38	58	57	46	47	43					
Complaints at same month last year	52	48	49	59	42	56	52					
Number of complaints upheld (cumulative)*	not known yet	not known yet	not known yet	not known yet	not known yet	not known yet	not known yet					
Number of complaints partly upheld (cumulative)**												
Number of Ombudsman complaint reviews	0	2	0	3	0	0	0					
Number of Ombudsman complaint reviews upheld	0	0	0	0	0	0	0					
Number of Ombudsman complaint reviews partly upheld	0	1	1	2	0	0	0					
Late responses this month (at the time of writing)***	4	7	4	9	4	1	8					
Top 3 complaint issues												
Aspects of clinical treatment	39	27	34	39	37	35	31					
Admission/discharge/transfer arrangements	5	2		3	2		5					
Appointment delay/cancellation - outpatient	3				1							
Staff attitude		4	6	10	6	5						
Communications			5	3	0	4						
Other							2					
New PALS queries this month	495	474	528	531	488	570	653					
PALS queries at same time last year	488	521	462	563	498	445	536					
Top 3 PALS issues												
Information & advice	107	118	168	140	158	192	42					
Staff attitude	61				15							
Aspects of clinical treatment	53	87	99	104	93	86	89					
Appointment delay/cancellation - outpatient		66	59	67	56	65	24					
**note: upheld complaints are reported quarterly to allow for investigation timescales*												
***note: we do not record partly - if a complaint generates 1 or more actions for improvement then it is reorded as upheld*												
****note: if extensions are made in agreement with the complaint, responses are not considered late*												
Serious Incidents												
Number of SI's reported	19	21	20	19	13	13	35					
% SI's notified within 2 working days of SI being identified*	89%	76%	70%	94%	100%	100%	100%					
% SI's closed on STEIS within 6 months of SI being reported	50%	0%	0%	0%	0%	0%	0%					
Number of Negligence Claims	11	14	16	15	21	8	16					
* this is currently under discussion via the 'exceptions log'												

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Pressure Ulcers**												
Number of Category 2	43	40	37	22	29	28						
Number of Category 3	12	9	10	5	5	8						
Number of Category 4	1	0	0	0	0	0						
Total number developed/deteriorated while in our care (care of the organisation) - acute	35	27	24	15	24	28						
Total number developed/deteriorated while in our care (care of the organisation) - community	32	29	27	19	18	20						
Falls***												
Number of falls with moderate harm	10	8	7	3	3	3						
Number of falls with severe harm	8	6	4	1	2	2						
Number of falls resulting in death	0	0	0	0	0	0						
Safeguarding												
% of staff compliant with training (children)			45%	45%	47%	51%	54%					
% of staff compliant with training (adult)			39%	40%	43%	40%	52%					
% of staff working with children who have review CRB checks												
Prevent Strategy												
Attendance at the HealthWRAP training session	3 in total	3 in total	3 in total	3 in total	3 in total	3 in total						
Number of concerns raised via the incident reporting system	nil	nil	nil	nil	nil	nil						

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Finance Report

Action requested/recommendation

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

Summary

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

At the end of September the Trust is reporting an Income and Expenditure (I&E) deficit of £0.9m against a planned surplus of £2.2m for the period. The Income & Expenditure position places the Trust behind its Operational plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

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

Briefing Note for the Finance & Performance Committee Meeting 18 November 2014
Briefing Note for the Board of Directors Meeting 26 November 2014

Subject: October 2014 (Month 7) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for October 2014

At the close of month 7 the Trust remains in a deficit financial position. Our plan for the month of October predicted a significant £2m in-month improvement in our position but in reality the improvement has been £1m. Our reported deficit to date has therefore improved from £1.8m at September to £0.9m at October. Against our planned year-to-date surplus of £2.2m we are currently operating £3.1m short.

Assumptions remain in our reported position for both ambulance turnaround penalties and for receipt of financial support in relation to costs incurred by the Trust as a result of delayed or failed investment of the 70% marginal non-elective rate savings and readmission savings by our CCGs.

Both main CCGs have indicated that, coupled with improvement plans for ambulance turnaround performance, they would be willing to consider reinvestment of the penalties. This work is being progressed. Discussions continue with both CCGs over the availability of funds to support our claims in relation to marginal rate non-elective tariff and readmissions savings.

This position returns a provisional COSR rating of 4, which is in line with our planned position. Whilst we are reporting a deficit it is within the tolerances used by Monitor.

CIP performance is £2.7m (year-to-date) behind the required savings level. Whilst this is materially impacting on our reported I&E position this continues to represent marginally better performance than this time last year, when set against last year's delivery trajectory. This issue is dealt with in detail in the efficiency report.

Income Analysis

The reported income position includes coded and costed data for April through September and an estimate has been included for October, as is usually the case. Clinical activity and income levels for October are £0.5m less than plan across the board. Of note are the plans now in place for stepping up activity levels during Q3, with significant additional activity arranged for November. These plans relate to initiatives to catch up lost activity and are also in support of the national initiative to reduce patient backlogs. This work is expected to have a positive impact on the Trust's financial position.

Contract penalties (excluding ambulance turnaround) have increased further this month, following an established trajectory. Details are provided in the finance report and performance report.

Expenditure Analysis

Pay budgets and provisions are £2.9m overspent for October, following a trend established earlier in the year. The deterioration for the month of October is significant at £0.8m. Operational pay budgets continue to under spend but locum and agency medical staff and nursing staff expenditure is running at an unaffordable premium level. The agency spend to date totals £5.6m. Clearly there are substantive funded vacant posts offsetting this position but the premium cost on the use of agency is placing significant pressure on our finances. Pressure areas include: medical agency staff in Scarborough for Elderly, Acute Medicine and Ophthalmology and medical staff agency spend at York in ED. There is also considerable nursing agency expenditure in General Medicine, specifically AMU/SSW and Ward 33.

Concerted attempts to recruit substantively must continue as an annual agency expenditure bill of around £9m represents a significant premium on costs.

Drug expenditure has deteriorated by £0.4m in month and is now showing a £0.3m overspend but this is directly related to high out of tariff drug costs for which direct recharges are made to the commissioners. The level is running ahead of plan though and will be of concern to the Trust's commissioners. There are no other material pressures to report in terms of other operational budgets.

The report shows that the CIP programme is impacting adversely on the position by £2.7m. This has been the most material adverse issue impacting on our expenditure to date but has now been overtaken by the pressure on pay budgets. The detail of the CIP position is dealt with in the efficiency report.

Contracting Matters

We remain in the final stages of discussions with Scarborough and Ryedale CCG over our last contract requiring signature. We have a single outstanding issue to address. At present this contract includes a CQUIN related to the delivery of a Stroke Early Supported Discharge Service (ESD) but, to date, we have been unable to agree commissioning arrangements with the CCG for this service. Clearly we can't accept a contract where our success or failure of delivery of a CQUIN is entirely dependent on the CCG's decision, or financial ability, to commission a service. This matter will be brought to a conclusion shortly and active discussions continue.

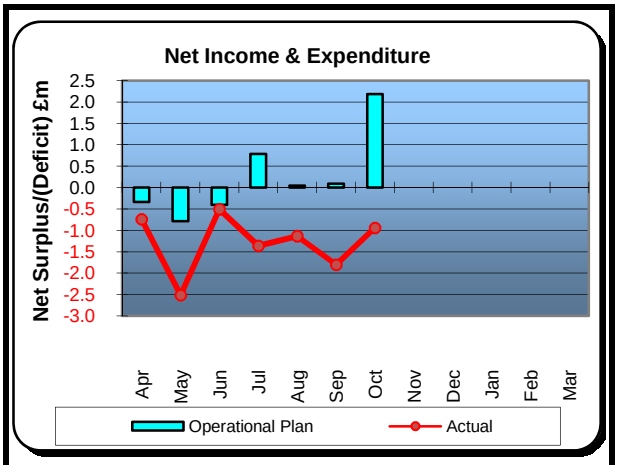
Other Issues

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

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

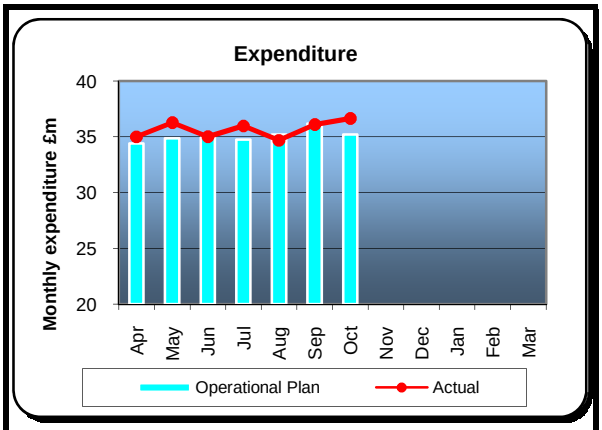
High Level Overview

* A net I&E deficit for the period of £0.9m means the Trust is £3.1m behind plan.
* CIPs achieved at the end of October total £14.6m. The CIP position is running £2.7m behind plan.
* All contracts are now signed with the exception of S&RCCG and associates. The estimated overall actual activity value is forecast to be under contract by £2.8m.
* Cash balance is £27.8m and is in line with plan.
* Capital spend totalled £12.4m, and is in line with the plan.
* The Continuity of Service Risk Rating is 4.



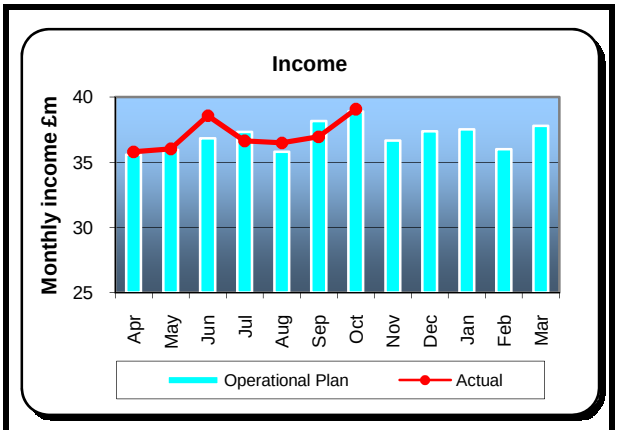
Key Period Operational Variances			
	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. VET)	222.5	222.4	-0.2
Clin.Inc.(VET))	6.9	6.2	-0.7
Other Income	29.1	31.0	1.9
Pay	-169.7	-172.6	-2.9
Drugs	-24.5	-24.8	-0.3
Consumables	-26.1	-25.7	0.3
Other Expenditure	-36.1	-37.4	-1.3
	2.2	**-0.9**	**-3.1**

(VET = Vitreous Eye Treatments)



At the end of October there is an adverse variance against operational expenditure budgets of £4.2m. This comprises:-

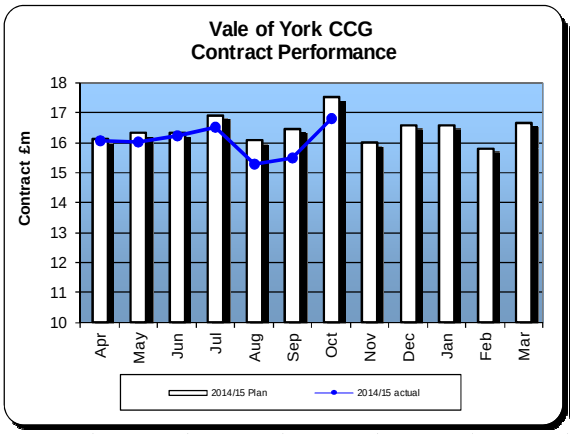
- Operational pay being £2.9m overspent, predominantly due to a premium paid for agency staff covering vacant posts
- Drugs £0.3m overspent
- Clinical supplies £0.3m underspent.
- Other costs are £1.7m underspent
- Restructuring costs are £0.3m overspent
- CIPs are £2.7m behind plan



At the end of October income is ahead of plan by £1.0m. This comprises:

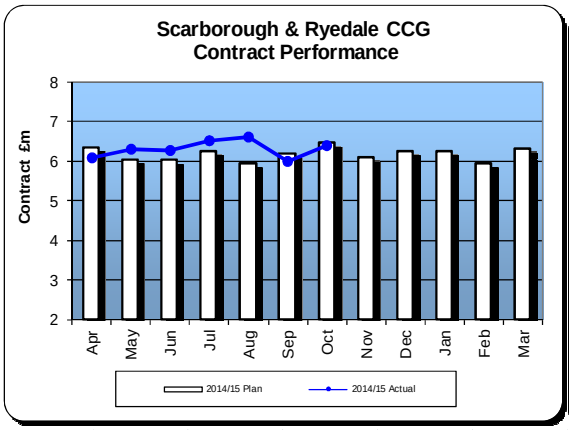
- Elective and day case income are behind plan by £2.2m.
- Non elective is ahead of plan by £3.1m.
- Out patient income is behind plan by £1.4m
- A&E income is ahead of plan by 0.5m
- Other clinical income is behind plan by £0.8.
- Other income is £1.8m ahead of plan
- Potential contract penalties and fines are estimated at £0.9m, included within the lines above.

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



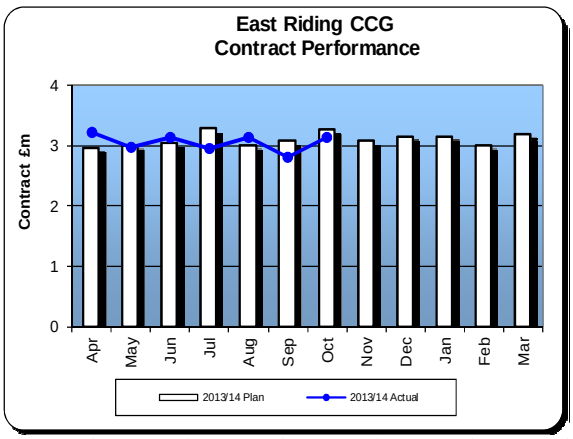
The contract value is £195.2m.

The contract is now signed and the estimated actual value to date is forecast to be under contract by £2.3m. This position includes estimates for October.



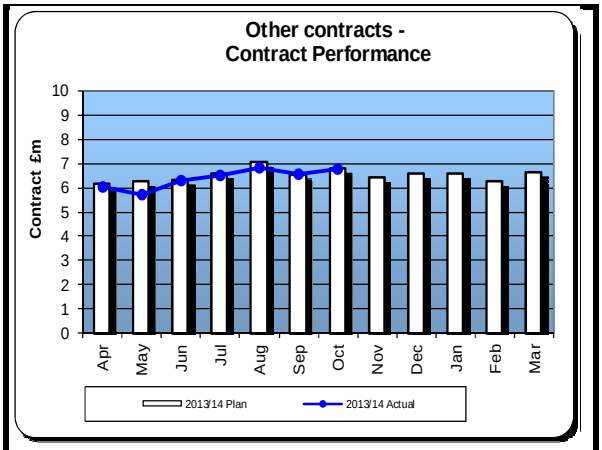
The contract value is estimated to be £73.7m.

The contract is not yet signed, however the estimated actual value to date is forecast to be ahead of the provisional contract by £0.9m. This position includes estimates for October.



The contract value is estimated to be £36.9m.

The contract is not yet signed, however the estimated actual value to date is forecast to be under the provisional contract by £0.4m. This position includes estimates for October.



The contract value is estimated to be £77.7m.

These include the smaller CCGs, NHS England, and Local Authority contracts. Other than for the HRWCCG all other contracts are signed. Overall, the actual position is estimated to be behind contract by £1.0m. The position includes estimates for October. A high volume of uncoded data may affect the allocation of income against individual contracts, and particularly the undertrade on the prescribed specialist services of £0.2m.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
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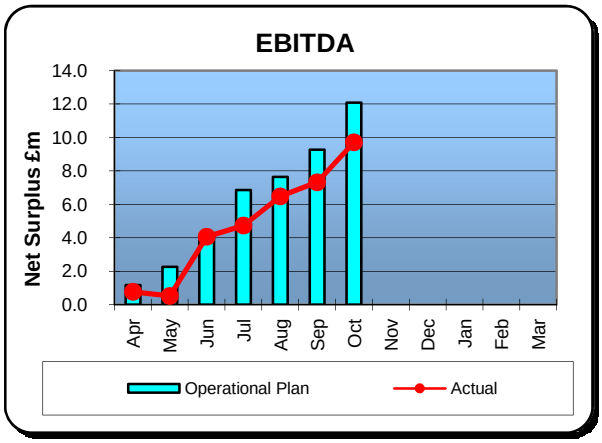
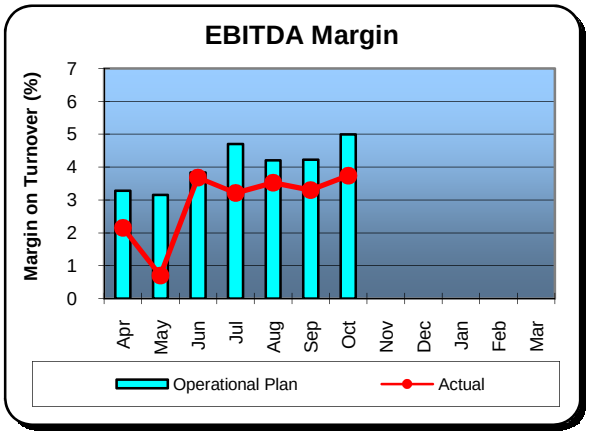
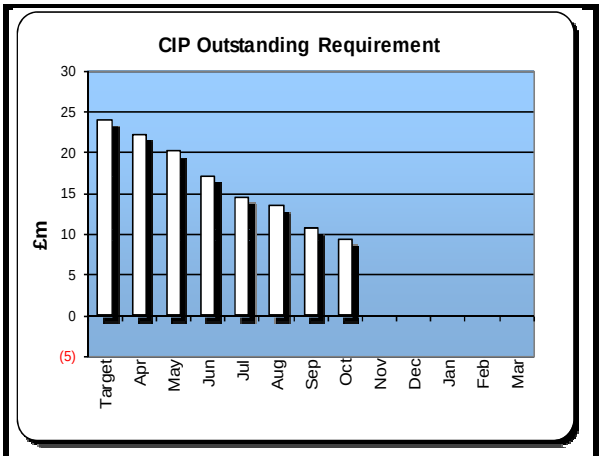
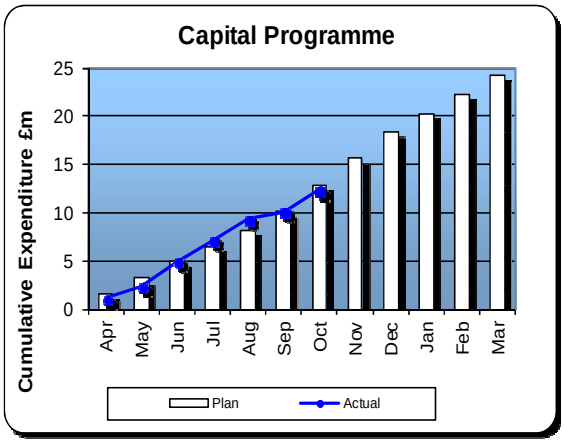




Actual EBITDA at the end of October is £9.704m (3.74%), compared to operational plan of £12.901m (4.99%), and is reflective of the overall I&E performance.



The full year efficiency requirement is £24.0m. At the end of October £14.6m has been cleared.



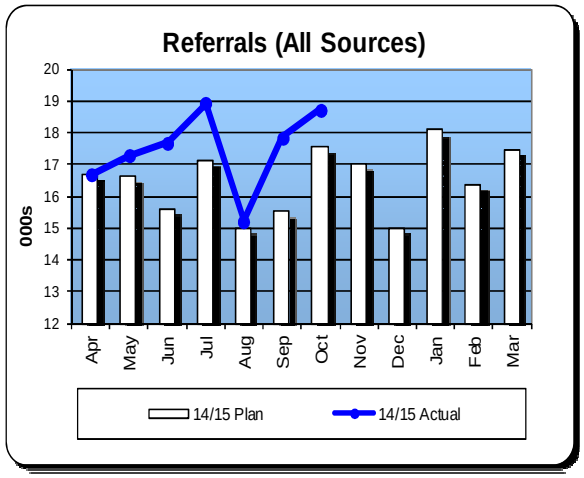
Capital expenditure to the end of October totalled £12.4m and is in line with the plan.

Capital schemes with significant in year spend to date include the on going upgrade of the York Hospital restarurant and kitchens, Endoscopy decontamination expansion and the completed carbon & energy scheme. In Scarborough phase 1 of the new car park is completed and significant progress on Maple 2 (Lilac ward) new build.

Continuity of Service Risk Rating (CoSSR):

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

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



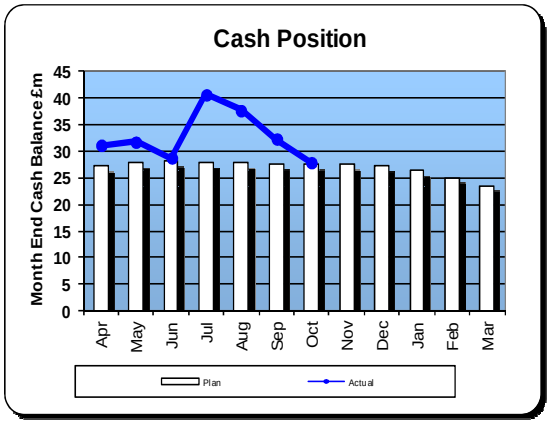
Annual plan 198,057 referrals (based on full year equivalent of 2013/14 outturn)

Variance at end of October: +8,258 referrals (+7.3%)

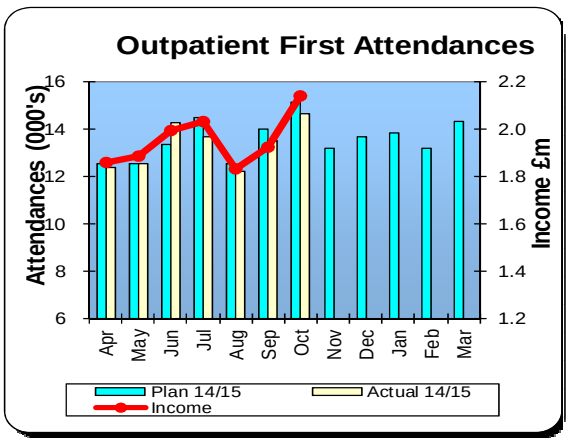
GP referrals +3,989 (+6.0%)

Cons to Cons referrals -441 (-2.67%)

Other referrals +4,710 (+15.4%)

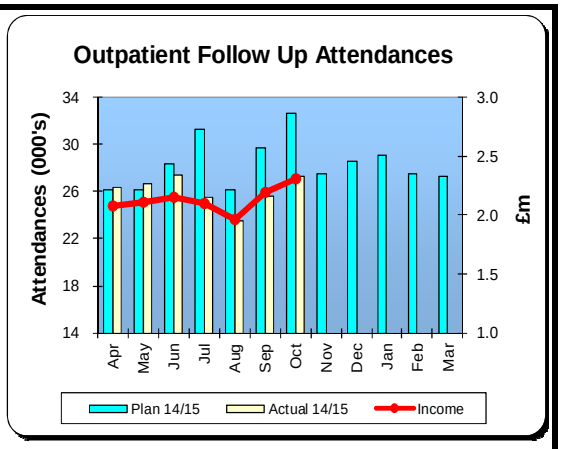


The cash balances at the end of October totalled £27.8m. This is in line with plan.



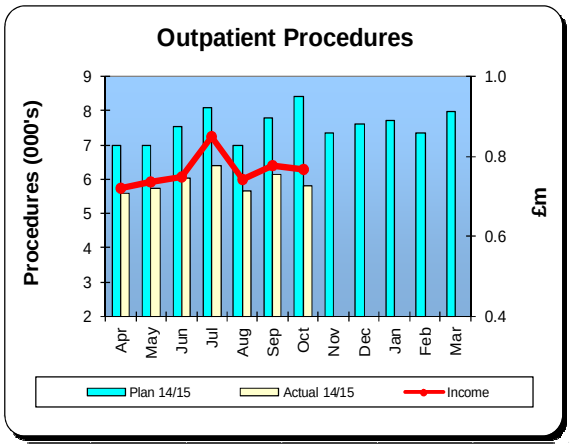
Annual Plan (Attendances) 162,401
Variance at end of October: -1,488 attendances (-1.6%).

Main variances: Obstetrics and Midwifery Zero Tariff +859 (21%), Clinical Neurophysiology -319 (-37%), Paediatrics +377 (14%), Rheumatology -325 (-18%), Geriatric Medicine -353 (-14%), Oral Surgery -315 (-7%), Medicine Specialties -1,155 (-8%), Dermatology -300 (-7%)



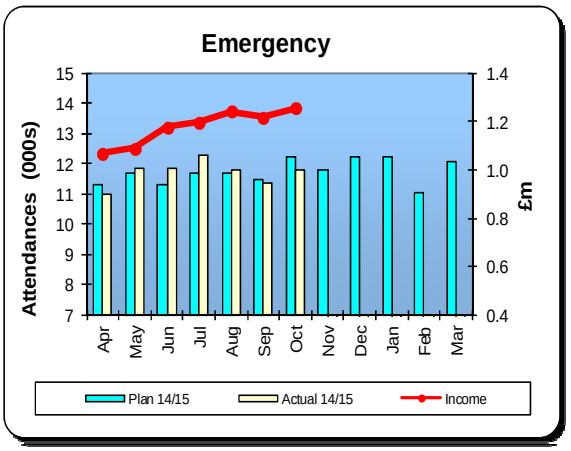
Annual Plan (Attendances) 340,039
Variance at end of October: -15,795 attendances (-8%).

Main variances: General Surgery +1,003 (8%), Trauma and Orthopaedics +1,042 (7%), Gynaecology -2,209 (-40%), Obstetrics and Midwifery Zero Tariff -10,442 (-34%), Ophthalmology -1,038 (-3%), Geriatric Medicine -1,303 (-38%), Medicine Specialties -3,104 (-10%)



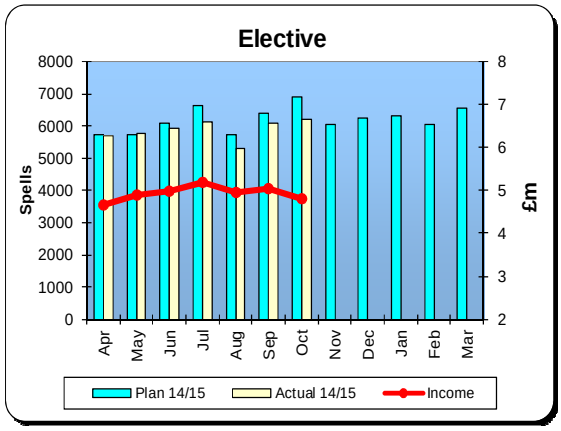
Annual Plan (Procedures) 90,710
Variance at end of October: -11,462 procedures (-22%).

Main variances: Dermatology -1,428 (-14%), Opthalmology -6,517 (-52%), Trauma and Orthopaedics -1,269 (-61%), Restorative Dentistry -530 (-56%), and ENT -1,215 (-21%).



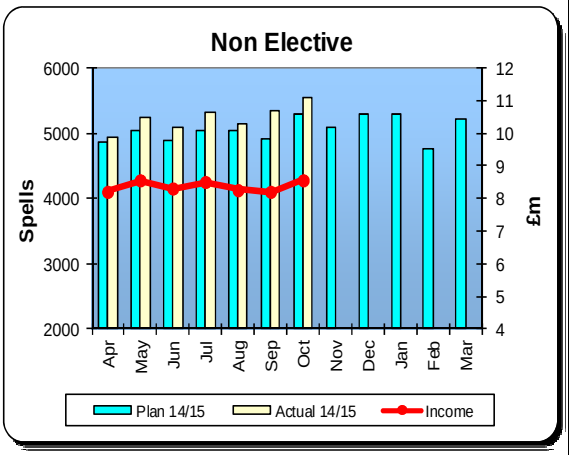
Annual Plan (Attendances) 140,832
Variance at end of October: +596 attendances (+0.7%).

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



Annual Plan (Spells) 74,445
Variance at end of October: -2,265 spells (-5.2%): inpatient -126; daycase -2,139

Main day case variances: General Medicine +325 (32%), General Surgery -334 (-8%), Haematology -389 (-15%), Medical Oncology -568 (-12%), Urology -576 (-10%), Ophthalmology -339 (-10%)



Annual Plan (Spells) 60,765
Variance at end of October: +1,472 spells (+4%).

Main variances: Gastroenterology +485 (22%), General Surgery +294 (8%), Endocrinology +465 (29%), Obstetrics and Midwifery +741 (12%), General Medicine -577 (-65%).

Contract Penalties

Penalties	Penalty £000	Comments
52 week breaches	0	£5k penalty per breach per month. Agreement reached to recind penalties following review of cases.
18 week breaches:		Figures include estimates in early months.
- Admitted (90% target, weighting 37.5%)	63	GenSur £3k; T&O £29k; ENT £13k:
- Non-admitted (95% target, weighting 12.5%)	52	Cardiology £2.0k; resp. medicine £11.7k; Rheumatology £7.9k, Gastroenterology £5.2.
- Incomplete pathways (92% target, weighting 50%)	76	T&O £8k; Gastro £ 5k; ENT £11k, Urology £8.4,Opthalmology £9.4k
Cancer waits	180	Cancer 2 week waits/ Breast symptom two week waits.
NHS Numbers	0	
A&E 4 hr performance	443	Faliure to admit, transfer or discharge patients within 4 hours of arrival. Target 95%. Fine is £200 per breach.
Trolly wait Mixed sex accomodation	2	
Ambulance handover	0	Ambulance handover exceding 30 (£200 each) and 60 minutes (£1,000 each). Value assumed at £738k Attempts being made to recover from CCG's.
Diagnostics	103	6 weeks target 99%. relates to tests including radiology, NPU, cardiology tests and endoscopies.
	919	

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

	ANNUAL PLAN	PLAN FOR PERIOD	ACTUAL FOR PERIOD	PERIOD VARIANCE
	£000	£000	£000	£000
INCOME				
NHS Clinical Income				
Elective Income				
Tariff income	27,092	15,853	14,282	-1,571
Non-tariff income	164	93	85	-8
Planned same day (Day cases)				
Tariff income	35,044	20,356	19,818	-538
Non-tariff income	674	401	309	-92
Non-Elective Income				
Tariff income	94,305	54,506	57,552	3,046
Non-tariff income	1,736	959	1,083	124
Outpatients				
Tariff income	58,563	34,090	32,055	-2,035
Non-tariff income	2,532	1,466	2,241	775
A&E				
Tariff income	14,059	8,125	8,442	317
Non-tariff income	-648	-381	-196	185
Community				
Tariff income	1,112	642	689	47
Non-tariff income	34,228	19,897	19,641	-256
Other				
Tariff income	0	0		0
Non-tariff income	127,500	73,395	72,550	-845
				0
	396,361	**229,402**	**228,551**	**-851**
				0
	396,361	**229,402**	**228,551**	**-851**
Non-NHS Clinical Income				
Private Patient Income	976	569	653	84
Other Non-protected Clinical Income	1,722	1,005	1,055	50
	2,698	**1,574**	**1,708**	**134**
Other Income				
Education & Training	14,434	8,420	8,763	343
Research & Development	2,005	1,170	1,899	729
Donations & Grants received of PPE & Intangible Assets	0	0	0	0
Donations & Grants received of cash to buy PPE & Intangible Assets	600	350	350	0
Other Income	17,482	10,439	11,078	639
Transition support	12,218	7,127	7,127	0
	46,740	**27,506**	**29,217**	**1,711**
Total Income	**445,798**	**258,481**	**259,476**	**995**
EXPENDITURE				
Pay costs	-296,223	-169,743	-172,597	-2,854
Drug costs	-42,149	-24,479	-24,804	-325
Clinical Supplies & Services	-45,051	-26,080	-25,738	342
Other costs (excluding Depreciation)	-49,636	-27,945	-26,369	1,576
Restructuring Costs	0	0	-263	-263
CIP	9,403	2,667	0	-2,667
Total Expenditure	**-423,656**	**-245,580**	**-249,771**	**-4,191**
EBITDA (see note)	**22,142**	**12,901**	**9,705**	**-3,196**
Profit/ Loss on Asset Disposals	0	0	0	0
Fixed Asset Impairments	-300	0	0	0
Depreciation	-10,854	-6,332	-6,332	0
Interest Receivable/ Payable	100	58	103	45
Interest Expense on Overdrafts and Working Capital Facilities	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0
Interest Expense on Non-commercial borrowings	-415	-247	-215	32
Interest Expense on Commercial borrowings	0	0	0	0
Interest Expense on Finance leases (non-PFI)	0	0	0	0
Other Finance costs	0	0	0	0
PDC Dividend	-7,204	-4,202	-4,202	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**3,469**	**2,179**	**-941**	**-3,120**

Note: EBITDA - earnings before interest, taxes, depreciation and amortisation.

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E3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Efficiency Programme Update – October 2014

Action requested/recommendation

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

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2014/15 target is £24m and full year delivery in October 14 is £14.6m, leaving a gap to be delivered of (£9.4m). There is a planning gap of (£1m) following a review of all in year plans.

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

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report is presented to the Board of Directors, Finance & Performance Committee and Efficiency Group.
Risk	The Efficiency Programme presents a significant financial risk to the organisation.
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Andrew Bertram, Director of Finance
Author	Steve Kitching, Head of Resource Management
Date of paper	November 2014
Version number	Version 1

Briefing note for the Finance & Performance Committee Meeting 18th November 2014
Briefing note for the Board of Directors Meeting 26th November 2014

Subject: October 2014 - Efficiency Position
From: Steven Kitching, Head of Resource Management

Summary reported position for October 2014

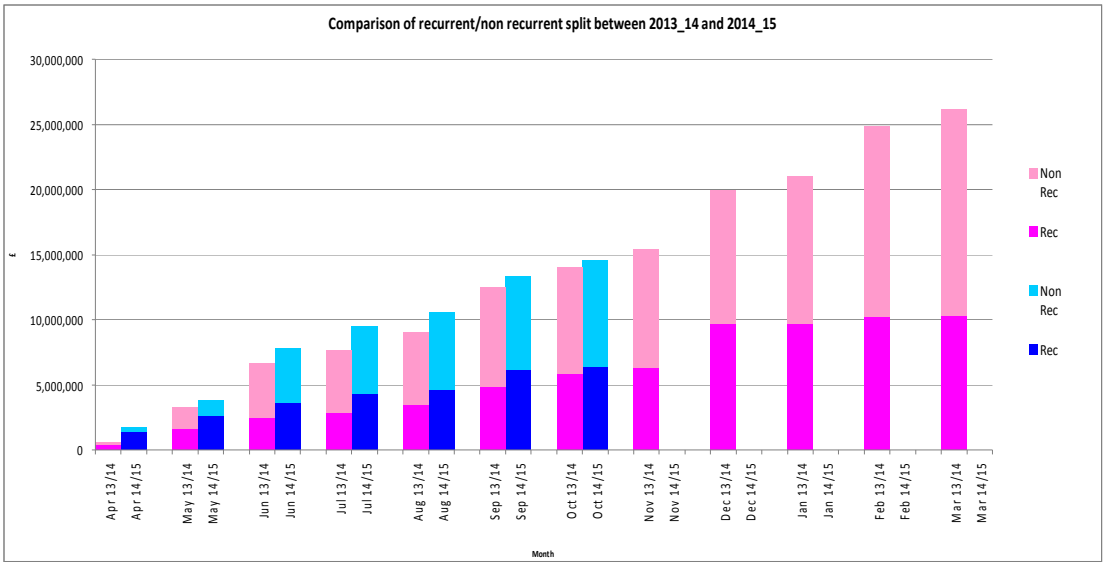
Current position – highlights and risks

Delivery - Overall delivery is £14.6m in October 2014 which is 61% of the £24m annual target. This has improved from the last reported position in September 2014 by £1.3m. This remains marginally ahead of the October 2013 delivered position of £14m (60%) of target, which is encouraging.

In year planning – The in year planning gap has closed from (£1.7m) in September 2014 to (£1.0m) in October 2014. This improvement is also encouraging; and is ahead of the position in October 2013 which showed a (£3.7m) planning gap.

Four year planning – The four year planning gap has closed from (£20.3m) in September 2014 to (£18.9m) this month.

Recurrent vs. Non recurrent – Of the current £14.6m delivery £6.4m (44%) is recurrent, which is only a small improvement from the September 2014 position of £6.1m. This position remains marginally ahead of the October 13 position which was £5.8m (42%) delivered recurrently. The work continues to identify recurrent schemes. **See chart below.**



Quality Impact Assessments (QIA) – The quality Impact Assessments are currently being carried out with support from Dr Ian Jackson. 21 areas have now self assessed and are rated as green, which leaves 6 clinical areas and 5 corporate areas to finalise self assessment. The majority of clinical areas remaining are areas where there have been gaps in the Directorate management team.

Key risks - The planning gap has improved within the month, however it remains a key focus of our work.

The significant changes to the Directorate and Finance Manager Structures and personnel remain a significant **short term** risk to both delivery and planning. The areas of highest concern have been identified and additional support is being directed to these areas within the limits of our current resource.

General Medicine Scarborough and Ed Scarborough were highlighted as areas of particular concern in September 2014 having delivered only 5% & 6% of their target respectively, General Medicine Scarborough has improved within the month to 14% delivered, but ED Scarborough remains static.

On going/future work
Following the high level CIP review carried out by Monitor in March 2014 and the subsequent action plan prepared for the Finance & Performance Committee, I can give the following progress report.

The Resource Management team – Recruitment to the team is ongoing, with 4 posts still vacant.

Efficiency Panels – 16 panels have now been completed from a total of 21. A number of Directorates have been requested to attend for a follow up panel and these meetings have now started, with General Surgery and Urology being the first. The Directorate Team have been asked to develop a work plan for the next Executive PMM linked to two external reports completed by Ernst & Young. The Directorate Manager has requested support from the Efficiency Team to complete this work.

Efficiency Group meeting – The role of the Efficiency Group meeting remains under review with the Chief Executive and Director of Finance. The role of this group will be informed from the recent visit to South Tees.

Board of Directors – 26 November 2014

Efficiency Programme Update – October 2014

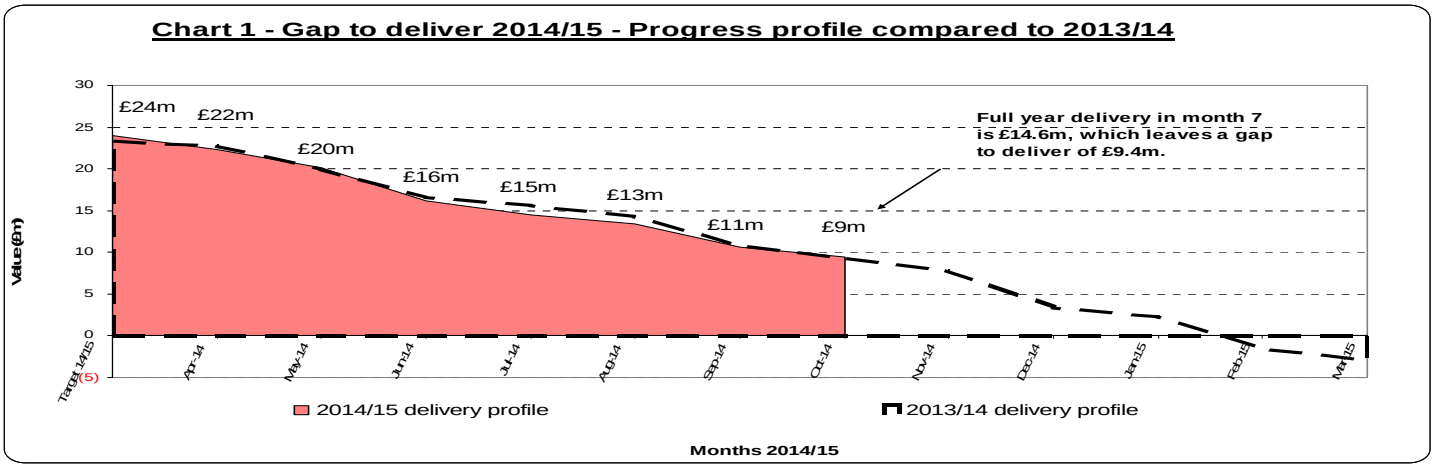
1. Executive Summary

This report provides a detailed overview of the Trust's Efficiency Programme.

See table 1 and chart 1 below.

Table 1 – Executive Summary – October 2014	Total
	£'m
TARGET	
In year target	**24.0**
DELIVERY	
In year delivery	**14.6**
In year delivery shortfall	**(9.4)**
Part year delivery shortfall - Monitor variance	**(2.7)**
PLANNING	
In year planning surplus/(gap)	**(1.0)**
FINANCIAL RISK SCORE	
Overall Trust financial risk score	**(2 Red/Amber)**

Position – current year vs. 2013/14



Governance	Risk to delivery
Current month Of the 32 Directorates and Corporate HQ functions 21 are now green. Work is on-going to assess the remaining directorates.	**Current month** The current planning gap is (£1.0m), which is an improvement on the previous month. Full year delivery in October 2014 is £14.6m which has improved by £1.3m from September 2014. The Monitor variance is (£2.7m) adverse.
Last Month Of the 32 Directorates and Corporate HQ functions 19 are now green. Work is on-going to assess the remaining directorates.	**Last month** The current planning gap is (£1.7m), which is an improvement on the previous month. Full year delivery in September 2014 is £13.3m which has improved by £2.7m from August 2014. The Monitor variance is (£2.4m) adverse.

2. Introduction and background

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme for October 2014. This includes;

1.1 Progress against the Monitor Plan
1.2 Analysis of full year delivery
1.3 Further plans and in year risk
1.4 Four year planning.
1.5 Financial risk rating
1.6 Governance risk assessment.

Directorate level detail is provided in the attached appendices 1&2.

2.1 Trust plan to Monitor

The combined position is (£2.7m) behind the Trust plan to Monitor as at October 2014; see Tables 2 & 3 and chart 2 below.

Table 2	September YTD 2014	October 2014	Total YTD
	£m	£m	£m
Trust plan	12.0	2.0	**14.0**
Achieved	9.6	1.7	**11.3**
Variance	(2.4)	**(0.3)**	**(2.7)**

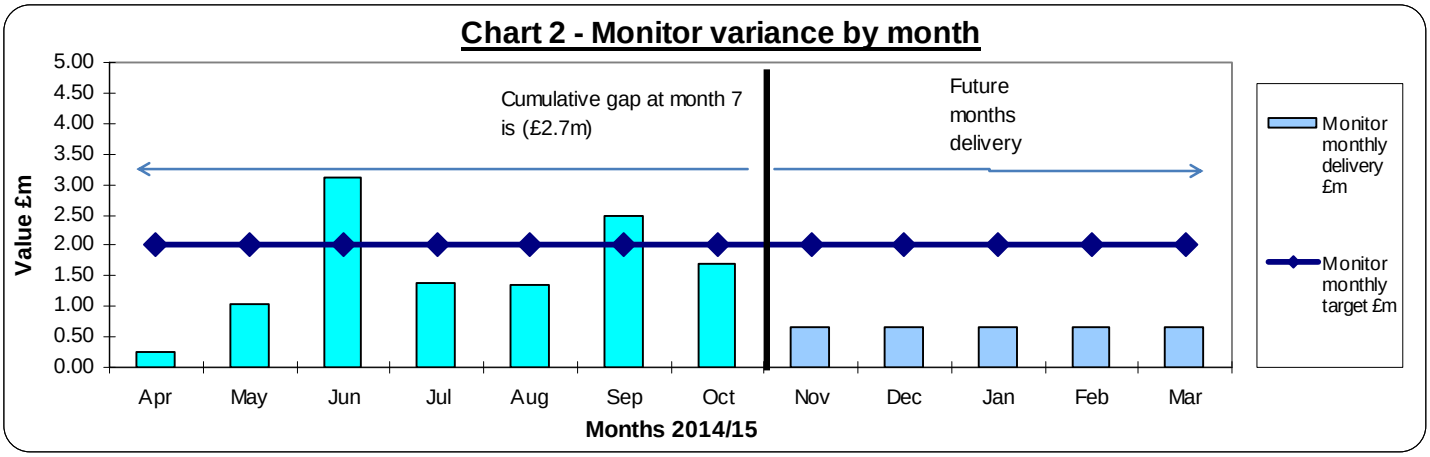


Table 3 – Monitor variance by month and cumulative variance

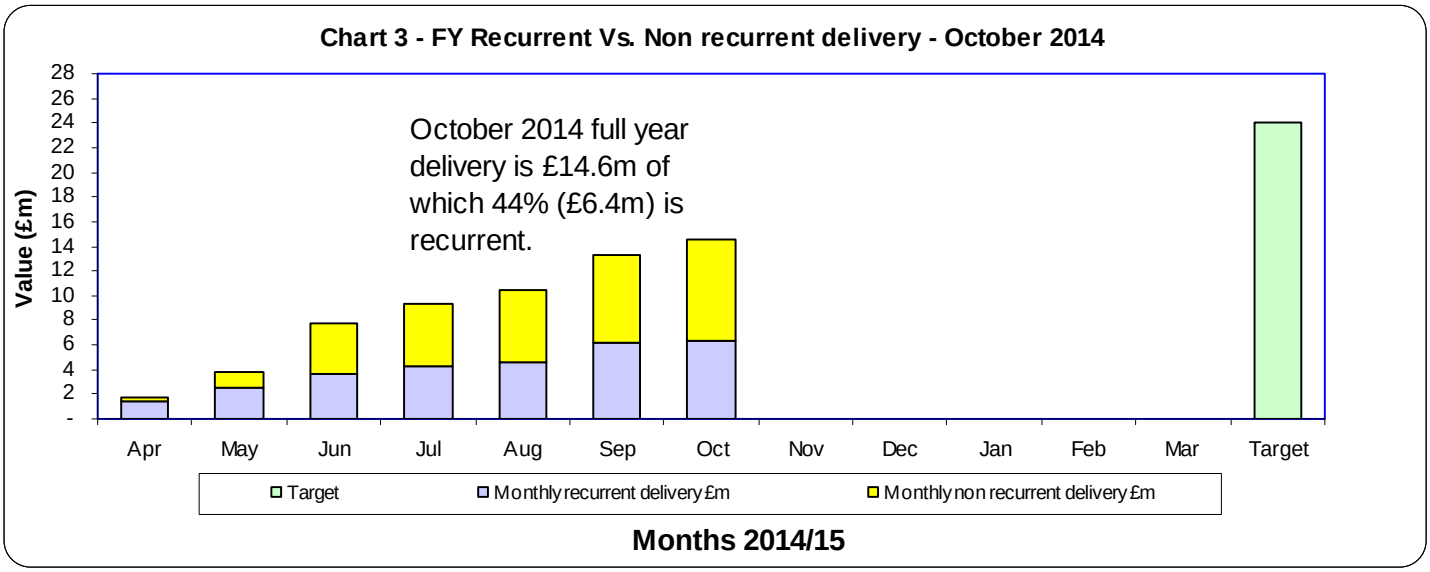
Months	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 14/15
Monthly delivery £m	0.3	1.0	3.1	1.4	1.3	2.5	1.7	0.6	0.6	0.6	0.6	0.6	**14.6**
Monthly target £m	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	**24.0**
Variance £m	-1.8	-1.0	1.1	-0.6	-0.7	0.5	-0.3	-1.3	-1.3	-1.3	-1.3	-1.3	-9.4
Cumulative variance	-1.8	-2.7	-1.6	-2.2	-2.9	-2.4	-2.7	-4.0	-5.4	-6.7	-8.0	-9.4	

2.2 Full year position summary

As at October 2014, **£14.6m** has been achieved in full year terms against the plan of £24.0m (see Table 4 below).

Table 4	September 2014	October 2014	Change
	£m	£m	£m
Expenditure plan – 14/15	24.0	24.0	0
Target – 2014/15	**24.0**	**24.0**	**0**
Achieved - recurrently	6.1	6.4	0.3
Achieved - non-recurrently	7.2	8.2	1.0
Total achieved	**13.3**	**14.6**	**1.3**
Shortfall	10.7	9.4	(1.3)
Further plans	9.0	8.4	(0.6)
(Gap)/Surplus in plans	**(1.7)**	**(1.0)**	**0.7**

The October 2014 position is made up of £6.4m (44%) of recurrent and £8.2m (56%) non-recurrent schemes. This compares with £5.8m (42%) recurrent and £8.2m (58%) non-recurrent at October 2013 - see chart 3 below.



2.3 Further planning and assessed risk to delivery

Further plans have been formulated amounting to £8.4m, which gives a shortfall in the planning position of (£1.0m). Plans are summarised in Table 5 below.

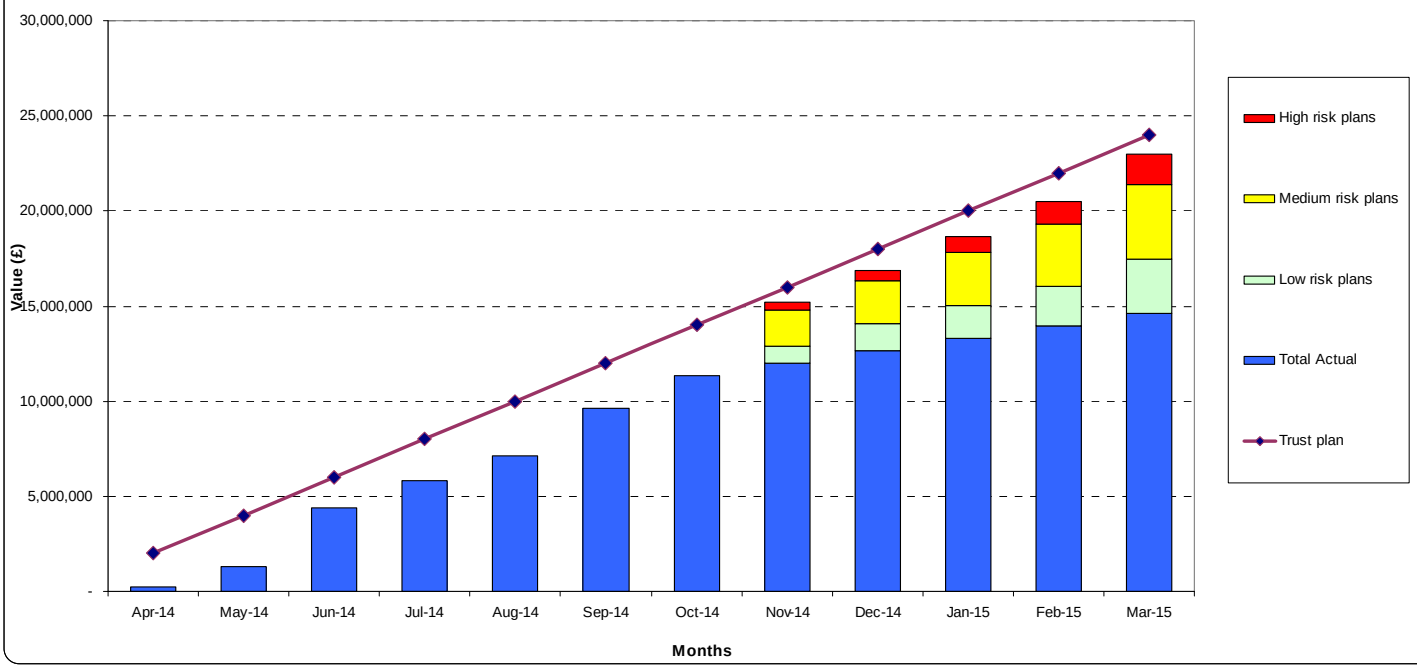
Table 5 – Further plans 2014/15

Risk	Gap Full Year	Plans - Recurrent	Plans - Non Recurrent	**Plans Total**	Gap in plans
	£m	**£m**	**£m**	**£m**	**£m**
Low		1.8	1.1	**2.9**	
Medium		3.5	0.5	**4.0**	
High		1.5	0.0	**1.5**	
Total	**9.4**	**6.8**	**1.6**	**8.4**	**(1.0)**

Directorate plans are each assigned a risk rating.

The overall October 2014 position is summarised in Chart 4 below. The bottom section has been used to represent savings achieved; with low, medium and high risk plans shown ascending, as detailed on the legend.

Chart 4 - October 2014 - Actual delivery and further plans to achieve by risk



Significant work is continually carried out to re-assess, remove or re-profile plans to ensure an up to date position. There is an in year planning gap of **(£1.0m)**, this has improved from the September position but remains a high risk position. Work is ongoing to improve this.

2.4 Four year planning

Directorates are required to develop four year plans and Table 6 below summarises this position. There is currently a shortfall of (£18.9m) over 4 years on the base target; this has improved by £1.4m in the month.

Work is on going to further improve the planning position however; the shortfall in plans offers a very high risk to delivery.

Table 6 - 4 Year efficiency plan summary – September 2014

Year	2014/15	2015/16	2016/17	2017/18	Total
	£m	£m	£m	£m	£m
Base target	24.0	16.8	16.8	16.8	**74.4**
Plans	23.0	15.9	11.0	5.6	**55.5**
Variance	**(1.0)**	**(0.9)**	**(5.8)**	**(11.2)**	**(18.9)**

2.5 Finance risk rating

In year delivery is in line with the same point last year with £14.6m (60.8%) delivered in October 2014 against £14m (60%) in October 2013.

The Directorate risk scoring schedule is attached as Appendix 1 and 2. It should be noted Directorates scoring a 1 or 2 on finance are considered high risk; directorates scoring a 4 or 5 are low risk.

The overall trust risk rating is 2 which is a red/amber risk.

2.6 Governance risk rating

Currently 21 Directorates have re-assessed there schemes using the new Quality and Safety report. Work is on-going within the other directorates to ensure up to date governance assessments are carried out.

3. Conclusion

In October 2014 £14.6m worth of full year schemes has been delivered against the Trust plan of £24.0m, leaving a delivery gap of (£9.4m); this compares with £14m delivery in October 2013. The part year Monitor profile is (£2.7m) behind plan in month 7.

We currently have a planning gap in year of (£1.0m), which remains high risk.

The 4 year planning position highlights a shortfall in base plans of (£18.9), which has improved from period 6, but also remains high risk. Work continues to improve the overall planning position.

Work is ongoing to reassess all schemes using the new governance risk assessment matrix.

4. Recommendation

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

Author	**Steve Kitching, Head of Resource Management**
Owner	**Andrew Bertram, Director of Finance**
Date	**November 2014**

RISK SCORES - OCTOBER 2014 - APPENDIX 1

DIRECTORATE	FINANCE					GOVERNANCE			
	R	RA	A	AG	G	R	RA	AG	G
GEN MED SCARBOROUGH	1	2	3	4	5	●	○	○	○
RADIOLOGY	1	2	3	4	5	○	○	○	●
SPECIALIST MEDICINE	1	2	3	4	5	○	○	○	●
WOMENS HEALTH	1	2	3	4	5	○	○	○	●
T&O YORK	1	2	3	4	5	○	○	○	●
OPHTHALMOLOGY	1	2	3	4	5	○	○	○	●
CHILD HEALTH	1	2	3	4	5	○	○	○	●
TACC YORK	1	2	3	4	5	○	○	○	●
COMMUNITY	1	2	3	4	5	○	○	○	●
GS&U	1	2	3	4	5	●	○	○	○
ED SCARBOROUGH	1	2	3	4	5	●	○	○	○
ED YORK	1	2	3	4	5	○	○	○	●
HEAD AND NECK	1	2	3	4	5	○	○	○	●
TACC SCARBOROUGH	1	2	3	4	5	○	○	○	●
THERAPIES	1	2	3	4	5	○	○	○	●
GEN MED YORK	1	2	3	4	5	○	○	○	●
MEDICINE FOR THE ELDERLY SCARBOROUGH	1	2	3	4	5	●	○	○	○
SEXUAL HEALTH	1	2	3	4	5	●	○	○	○
T&O SCARBOROUGH	1	2	3	4	5	○	○	○	●
MEDICINE FOR THE ELDERLY	1	2	3	4	5	●	○	○	○
LAB MED	1	2	3	4	5	○	○	○	●
PHARMACY	1	2	3	4	5	○	○	○	●
CORPORATE									
OPS MANAGEMENT SCARBOROUGH	1	2	3	4	5	●	○	○	○
MEDICAL GOVERNANCE	1	2	3	4	5	●	○	○	○
CORPORATE NURSING	1	2	3	4	5	●	○	○	○
HR	1	2	3	4	5	○	○	○	●
SNS	1	2	3	4	5	○	○	○	●
ESTATES AND FACILITIES	1	2	3	4	5	○	○	○	●
AL&R	1	2	3	4	5	●	○	○	○
OPS MANAGEMENT YORK	1	2	3	4	5	●	○	○	○
CHIEF EXEC	1	2	3	4	5	○	○	○	●
FINANCE	1	2	3	4	5	○	○	○	●
TRUST SCORE	1	2	3	4	5				

DIRECTORATE	Yr1 Target (£000)	4Yr Target (£000)	Yr 1 Plan v Target %	Yr 1 Plan v Target Score	Yr 1 Delivery v Target %	Yr 1 Delivery v Target Score	Y1 Recurrent Delivery v target %	Y1 Recurrent Delivery v target Score	4 Yr Plan v Target %	4 Yr Plan v Target Score	Risk Score Total Score	Risk Score Monitor Rating
GEN MED SCARBOROUGH	1,071	2,873	44%	1	14%	1	1%	1	48%	1	4	1
RADIOLOGY	1,901	3,800	43%	1	28%	1	2%	1	44%	1	4	1
SPECIALIST MEDICINE	1,984	5,891	39%	1	20%	1	12%	1	58%	2	5	1
WOMENS HEALTH	2,342	4,464	43%	1	25%	1	17%	1	61%	3	6	1
T&O YORK	789	2,331	82%	2	58%	1	17%	1	54%	2	6	1
OPHTHALMOLOGY	875	2,667	76%	2	58%	1	58%	2	37%	1	6	1
CHILD HEALTH	1,247	2,999	69%	1	29%	1	3%	1	77%	4	7	1
TACC YORK	2,421	5,768	72%	2	64%	2	51%	2	37%	1	7	1
COMMUNITY	1,648	4,390	41%	1	35%	1	34%	1	97%	5	8	2
GS&U	1,717	4,794	80%	2	54%	1	23%	1	75%	4	8	2
ED SCARBOROUGH	298	1,223	77%	2	3%	1	0%	1	85%	5	9	2
ED YORK	501	1,426	77%	2	31%	1	13%	1	94%	5	9	2
HEAD AND NECK	480	1,863	88%	2	63%	2	40%	2	67%	3	9	2
TACC SCARBOROUGH	870	2,435	109%	5	70%	2	27%	1	57%	2	10	2
THERAPIES	1,367	3,772	93%	3	63%	2	21%	1	85%	5	11	2
GEN MED YORK	1,672	5,114	100%	5	30%	1	8%	1	88%	5	12	3
MEDICINE FOR THE ELDERLY SCARBOROUGH	806	1,653	108%	5	30%	1	25%	1	94%	5	12	3
SEXUAL HEALTH	491	1,129	89%	2	70%	3	42%	2	86%	5	12	3
T&O SCARBOROUGH	324	1,298	117%	5	111%	5	57%	2	40%	1	13	3
MEDICINE FOR THE ELDERLY	174	1,717	128%	5	72%	3	23%	1	104%	5	14	3
LAB MED	1,672	4,022	100%	5	78%	3	55%	2	78%	4	14	3
PHARMACY	-188	611	101%	5	101%	5	101%	5	174%	5	20	5
CORPORATE												
OPS MANAGEMENT SCARBOROUGH	329	638	61%	1	14%	1	2%	1	45%	1	4	1
MEDICAL GOVERNANCE	77	180	58%	1	41%	1	17%	1	25%	1	4	1
CORPORATE NURSING	334	496	52%	1	52%	1	16%	1	37%	1	4	1
HR	892	1,614	63%	1	36%	1	7%	1	60%	2	5	1
SNS	1,137	2,557	87%	2	36%	1	18%	1	54%	2	6	1
ESTATES AND FACILITIES	2,878	7,804	59%	1	43%	1	26%	1	78%	4	7	1
AL&R	185	420	81%	2	68%	2	0%	1	59%	2	7	1
OPS MANAGEMENT YORK	239	419	106%	5	29%	1	0%	1	96%	5	12	3
CHIEF EXEC	75	448	309%	5	293%	5	170%	5	52%	2	17	4
FINANCE	251	1,116	141%	5	141%	5	99%	5	91%	5	20	5
TRUST SCORE	30,308	80,731	**89%**	**2**	**61%**	**2**	**27%**	**1**	**74%**	**3**	**8**	**2**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Procurement Update

Action requested/recommendation

The Board of Directors is asked to note the progress made against the national and local procurement strategies and to continue to promote and support the work of the Trust's Procurement Team.

The Board of Directors is asked to continue to support the role of Philip Ashton as the link procurement NED.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Board of Directors
Risk	No risk.

Resource implications	Resource implications are detailed in the report.
Owner	Andrew Bertram, Director of Finance
Author	Ian Willis, Head of Procurement
Date of paper	November 2014
Version number	Version 1

Board of Directors – 26 November 2014

Procurement Update

1. Introduction

In the Autumn of 2013 the Board of Directors received a presentation on the Trust's procurement strategy from Ian Willis, Head of Procurement. This presentation supported a subsequent discussion on matters of Trust procurement.

The purpose of this report is to provide an update to the Board of Directors on the work of the Trust's Procurement Team, an overview of assurance of the effectiveness of the Team and details of progress against local and national procurement strategies.

Since the initial presentation and discussion with the Board of Directors the national procurement strategy has been heavily promoted within the NHS. This has resulted in the identification of Philip Ashton as the link Non-executive Director for procurement. Meetings have taken place between Philip, Andrew Bertram and Ian Willis to discuss the procurement agenda.

2. Background to Procurement Expenditure Levels

The table below provides a summary of the value and volume of transactions relating to procurement activity. The table identifies:

- Areas directly under the control of the procurement team – general purchase order requisitioning, NHS Supply chain requisitioning (routine NHS typical stock items) and agency staffing.
- Areas where the procurement team provide active support to specialist buyers placed within, and members of, directorate teams – pharmacy (drug purchases), catering at Scarborough and Bridlington, Estates and specialist areas such as Capital purchasing.
- Areas where the procurement team provide advice only if and when required. These include utility purchasing and services from other Trusts (such as specialist patient imaging or pathology tests).

The analysis provided below relates to the most recent twelve month period and cannot therefore be reconciled back to the Trust's accounts. The identified lines are broadly in line with the reported expenditure detailed in the Trust's 2013/14 accounts with no material changes to purchasing patterns.

	Area	Sum of Inv Amount	Inv Count	% of Inv Amount	% of Inv Count
Control	Purchase Orders (inc York Catering)	£58m	46,367	37.17	43.04
	NHS Supply Chain	£14m	114	8.65	0.11
	Agency Staff	£11m	7,531	7.01	6.99
Active Support	Pharmacy	£33m	31,046	21.07	28.82
	Catering (Scar & Brid)	£0.7m	2,690	0.43	2.50
	Estates	£0.6m	2,561	0.38	2.38
	Other (Capital etc)	£24m	14,009	15.33	13.00
Advice (if required)	Utilities	£5m	1,122	3.35	1.04
	With Other NHS Trusts (Services, Tests etc)	£10m	2,296	6.60	2.13
		£157m	**107,736**	**100.00**	**100.00**

3. DH Procurement Strategy: Better Procurement, Better Value, Better Care

In August 2013 the Department of Health published and launched its Procurement Strategy. The key theme of this was the outlining of a requirement on the NHS to deliver £1.5bn of savings from a total non-pay expenditure level of £20bn.

To achieve this goal the NHS Procurement Strategy describes four strategic objectives. These are summarised as follows:

1. Delivering immediate efficiency and productivity gains by:
    - Combating Inflation
    - Key Supplier Engagement
    - NHS Supply Chain Quick Wins
    - Non-Permanent Staffing Contracts
    - Premises Initiatives
    - Establishment Costs
    - And a programme of Price Benchmarking

2. Improvements to procurement data, information and transparency through:
    - Development of an eProcurement Strategy
    - GS1 Coding (nationally accepted procurement bar coding standards)
    - Advertising Contract Opportunities to the Market Place

3. Improving outcomes at reduced cost through clinical procurement review and increased partnership working specifically through:
    - Medical Devices
    - Orthopaedics Appliances
    - And the development of an Advancing Quality Programme

4. Improve the leadership and capability of NHS Procurement Functions by:
    - Procurement Development Programme
    - Increasing Procurement awareness amongst clinical leaders
    - Working with HCSA (Health Care Supply Association) and CIPS (Chartered Institute of Purchasing and Supply)
    - Creating NED 'Champions'
    - Supporting CPD
    - The development of NHS Standards of Procurement

This national work is undoubtedly raising the profile of NHS procurement. Many components can be seen to be now starting to impact on the activities of the NHS. This strategy is a long term strategy and will continue to provide an overarching framework for improvement for our own procurement function and team.

An assessment has been made to ensure that our own local procurement strategy is consistent with this national strategy.

4. An Update of York Trust's Procurement Strategy

The Trust Procurement Strategy was drafted with the Trust's Strategic Plan Objectives in mind (improved quality and safety, developing and enabling strong partnerships, continuous service improvement and improvement of our facilities and protecting the environment).

As a reminder for the Board of Directors the Trust's local Procurement Strategy objectives are;

1. To increase contract coverage (continually improving quality and patient safety through targeted suppliers with reduced product variation)

2. To manage cost through control and procurement discipline (by limiting approved choices, maximizing purchasing power and releasing cash savings through supplier negotiation)

3. To be a good corporate citizen (to protect our environment and support SMEs)

4. To improve the Standards of Procurement across the Trust (improving quality and patient safety whilst ensuring legally and good practice compliant procurement)

Attached to this report is the detailed action plan describing the key elements of the Trust's procurement strategy and progress to date.

The Board of Directors should note the following key progress areas:

<u>Contract Procurement</u>

Significant progress has been made with regard to contract procurement. The original procurement strategy set a target to increase contract spend from £12m to £20m over three years. This project has significantly expanded and now incorporates other areas of Trust procurement. Current on-contract spend is approaching £67m with continual growth. This has been achieved by partnering more closely with the Crown Commercial Service, NHS Supply Chain and the North of England Commercial Procurement Collaborative.

eProcurement

90% all items bought by Purchase Order are now regulated by electronic catalogue. We have reduced the percentage of non-catalogue requests from 38% (July 13) to 27% (Sept 2014). The procurement strategy set a target of 35% by 2015 and 30% by 2016 (note services are not catalogued). As an example of targeted work in this area would be the reduction of catalogued available stationery items from 8,500 to 182.

Good Corporate Citizenship

We have completed and submitted assessment scores for the Good Corporate Citizenship Assessment in relation to procurement. We await feedback from this exercise but will share this with the Board as information becomes available.

Procurement Savings Tracker

All department procurement exercises are tracked in terms of savings achieved. The procurement strategy set a target rising to an expected £1.75m per annum. To date the savings tracker confirms savings of £1.65m achieved, well on track to deliver this year's target performance.

Development of Procurement Expertise

We are currently undertaking a Standards of Procurement assessment using DH material as part of the national procurement strategy. The findings will be used to develop further the local procurement strategy and action plan. We continue with a programme of increasing the level of professionally qualified staff within the department and to actively support CPD for staff already qualified. One of the team was recently recognized with a national award (emerging talent by HCSA) and team members have been nominated for the Trust's own monthly Star Award.

A full summary of the action plan is provided at Appendix A.

5. Procurement Assurance

The Board of Directors will be aware of the full programme of Internal Audit work providing assurance on Trust systems, processes and controls. The table below summarises all recent Internal Audit review work in relation to procurement activity within the Trust.

Of note is "significant assurance" in the case of all reports that directly relate to the efforts and work of the Trust's Procurement Team. Limited Assurance reports relate to areas where procurement exert influence and provide an advisory role. The use of Single Tender Action as a procurement route has been the subject of review through the Trust's Audit Committee and recommendations have been agreed to improve compliance by user directorates. There are very low numbers of Single Tender Actions within the Trust with all reported through to the Audit Committee.

Year	Ref	Title	Assurance	Comment
2011/12	Y1201	Non Framework Agency Staff (NHSP)	Limited Assurance	All recommendations fully implemented. Now moving towards a Nurse Bank across the Trust
	Y1231	Ward Stores	Significant Assurance	
	Y1254	Non Pay Expenditure	Significant Assurance	
2012/13	Y1359	Non Tender Procurement	Significant Assurance	
	Y1364	Non Pay Expenditure	Significant Assurance	
2013/14	Y1431	Single Tender Action	Limited Assurance	One recommendation still outstanding. Due to technical (system) issue it will complete in March 2015
	Y1432	E Tendering System	Significant Assurance	
	Y1465	Non Pay Expenditure	Significant Assurance	
	Y1468	Stock Delivery Management System	Significant Assurance	

6. Recommendation

The Board of Directors is asked to note the progress made against the national and local procurement strategies and to continue to promote and support the work of the Trust's Procurement Team.

The Board of Directors is asked to continue to support the role of Philip Ashton as the link procurement NED.

Author	**Ian Willis, Head of Procurement**
Owner	**Andrew Bertram, Director of Finance**
Date	**November 2014**

Appendix A

#	Action	Strategic Aim Met	Scope	Planned Objective/s	Target/s	RO	Timescales	Monitored or Reported	Update
a	Conduct a Purchasing & Contracting Review	1,2,3,4	All contracts or purchased for goods or services	• To identify any gaps in service provision. • Identify area for improved contracting and potential savings • Draft a report detailing any action (if needed)	Increase the value of spend under contract from £12M to £20M Increase the percentage of corporate expenditure covered by a purchase order from 40 to 50% To increase the savings made by from £1.35M per year to £1.75M per year (over the three years)	All Procurement	By end June 2014	Report to DoF	Contracted value Pharmacy £26M Agency c£8M NHSSC £13.5M PO £20+M Currently 43% In year £1.65M
b	Implement and share a visible Work Plan	1,2,3,4	All procurement activity	• A visible work plan that can be shared with stakeholders • A planned approach to matching resources to the demands placed on the department.	To publish an annual work plan (reviewed quarterly to maintain integrity and accuracy) to focus procurement effort.	Head of Procurement	By April 2014	Quarterly	Now visible and open to view at any point

#	Action	Strategic Aim Met	Scope	Planned Objective/s	Target/s	RO	Timescales	Monitored or Reported	Update
c	Evaluate Procurement resources	2,4	All staff and budget of the Purchasing Department	• To evaluate staffing resources within the procurement team and then act on these findings to ensure they: reflect the developing needs of the organisation • To evaluate budget for Procurement to ensure it reflects the demands placed on the department and the developing needs of the organisation	• A procurement team with the necessary skills to achieve the department's strategic objectives • A reduction in the transactional costs of procurement.	Head of Procurement	Ongoing over 3 years	Annually	All OK
d	A business case to expand and develop the Materials Management service	1,2,3,4	All goods purchased for ward & clinics currently managed by the Materials Management Team.	• To 'free up' valuable nursing time. • Capture unreported discrepancies and returns • To encourage materials management principles within wards and departments. • Reduce and control costs • Consolidate supply and improve CO2 output	• A Materials Management service for wards without MM (particularly Scarborough Hospital) • To reduce stock holding by 10% • To reduce spending by 5% • Reduce the number of deliveries made to the Trust	Head of Procurement and Procurement Officers.	By June 2014 3 Mths after BS approval 12 Mths after BS approval	BC to be prepared to seek funding for and unpacking service in York and a MM Service at SGH.	York approved and implemented SGH: pilot site under discussion

#	Action	Strategic Aim Met	Scope	Planned Objective/s	Target	RO	Timescales	Monitored or Reported	Update
e	Support Estates Procurement	1,2,3,4	All goods and services purchased by the Estates Department	• To dedicate resources into helping Estates investigate and review the current methods used to purchase goods and services within the department. • To investigate opportunities to enhance supply chain methodologies to improve, integrate and standardise within the Trust's mainstream purchasing systems.	Standardisation of order process, improved stock management, cost reduction from tendering and contract usage Increase the volume of order under PO cover Increase the value of expenditure covered by contract.	Specialist Procurement Officer (Capital & Estates)	From April 14 onwards	Annually	Workstream aligned with Senior Buyer having responsibility for FM. Consolidating spend across sites. Procurement training undertaken (STA / tendering) Smart forms introduced
f	Undertake the COINS Project	1,2,3,4	All purchased for goods or services	• A project to provide a focus on procurement activity related to Clinical Consumables, Orthopaedics and Indirect Spend. • Generate savings	Save £1M (extra) over 3 years	Head of Procurement & Corporate Efficiency Team	Over 3 years	Quarterly	Completed target ahead of schedule (within 18m)

#	Action	Strategic Aim Met	Scope	Planned Objective/s	Target	RO	Timescales	Monitored or Reported	Update
g	Improve the eProcurement Catalogue	1 & 2	All goods and services	• Expansion of the Trust-wide e-catalogue and reduction of non-catalogue requests • Simplification of the order process. • Clean data is exchanged between the Trust and the Supplier. • Speed of the purchase to payment cycle is increased. • Standardisation and control of the product and equipment via catalogue.	A reduction in the percentage of non-catalogue to catalogue requests from 40% to 20% of the total placed. (NB: Services are not catalogued so it is unlikely that we could ever get below the 20% figure)	Procurement Systems Development Officer	35% by 2015 30% by 2016 20% by 2017 (The acquisition of SNEY has meant we have lost some of the progress we had already made as they had traditionally done more non-catalogue requests)	Quarterly	July 13 was 38.28% NCR but this has steadily reduced to 27.26% by Sept 2014
h	Expand the use of CPA's	1 & 2	All goods and services	• To encourage the use of contracted items from the e-catalogue • Increase the speed of the purchase to payment cycle as CPA's are auto-emailed to suppliers	Increase the number of CPA's by 50%	Procurement Systems Development Officer	By 2016	Annually	CPA increase on hold. More use of smart forms instead.
i	Standardise products and services	1,2,3	All goods and services	• To standardise, where appropriate, all goods and services across all the hospital sites. • To facilitate the introduction of a list of e standardised medical devices / consumables that are effective both clinically and financially.	A list of standardised items published (and updated) on Staff Room and available to select from the eProcurement catalogue.	Specialist Procuremen t Officers (MSSE Links)	By 2016	Quarterly	11 items in use as a core list in Med Eng 182 Standard Stationery items Infusion

#	Action	Strategic Aim Met	Scope	Planned Objective/s	Target	RO	Timescales	Monitored & Reported	Update
l	Audit of current Third Sector, SME & BME's utilisation	3 & 4	Goods and services purchased throughout the Trust.	• Encourage and improve our involvement and trade with SME's (In so doing we cannot be in contravention of public procurement legislation and guidance).	• An audit report of our current utilisation of SME (to be done in collaboration with the GPS) • Increase, in £ the value of business placed with SME's.	Head of Procurement, Purchasing Manager and Contracts Manager	By End April 2014	Report end of 2014.	SME report done and information shared
m	Improve Sustainable Procurement	3 & 4	Goods and services purchased throughout the Trust	• To increase the number of sustainable supply sources available for procurement and to support central Government and Department of Health commitments in this area of policy	• To include sustainable factors in procurement decision making process (tenders). • To report how, by working with suppliers, we are reducing our impact on the environment.	Head of Procurement	Ongoing over 3 years.	Annually	Ongoing work on the online assessment tool. Ahead of cohort
n	Evaluate progress against the NHS Standards of Procurement	4	All Staff	• To improve the standard of procurement throughout the Trust	• 50% of Level 1 (Achieving) for each of the four domains (Leadership, Process, Partnership & People)	Head of Procurement	By end 2016	Annually	Ongoing work using the assessment tool (see printout)

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Impact of increase to National Living Wage

Action requested/recommendation

The Board is asked to decide whether to implement the national increase of 20p per hour at an estimated cost of £180,000 p.a so that the Trust continues to be able to market itself as paying the Living Wage. This would apply to the financial year 2015/16.

The Board is also asked to consider whether it wishes the Trust to become a fully-accredited Living Wage employer by requiring all contractors to pay their workers the living wage.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Discussed informally at Corporate Directors in November 2014
Risk	No risk.
Resource implications	Resources implication detailed in the report
Owner	Sue Holden, Director of HR and Corporate Development
Author	Vicki Mallows, HR Manager
Date of paper	November 2014
Version number	Version 1

Board of Directors – 26 November 2014

Impact of increase to National Living Wage

1. Introduction and background

The National Living Wage initiative is aimed at lifting low paid workers out of poverty. There are two levels of 'membership' – full accreditation, and a lower level where employers choose to pay the living wage to their directly employed staff.

The Trust chose the second option earlier this year and pays a locally agreed living wage supplement to those staff on Band 1 and the bottom three increments of Band 2 who otherwise would earn less than £7.65 per hour, [newly appointed staff do not receive this until they have successfully completed their four month probationary period]. The supplement 'tops up' their basic hourly rate to £7.65. This local agreement covers the period 1 April 2014 - 31 March 2015.

It was agreed that this would be reviewed prior to the end of March 2015, both to consider the principle of continuing to pay the supplement, and to review the affordability – taking into account the annual increases both to the Living Wage and the Agenda for Change payscales.

2. Estimated costs of national increase to Living Wage

The National Living Wage increase was announced on 3 November 2014, which is 20p per hour i.e. the new Living Wage hourly rate is £7.85. The Trust has up to 6 months to implement this increase, if it chooses not to, then it cannot continue to call itself a Living Wage employer.

As of the end of October 2014 there were approximately 555 staff in receipt of the local living wage allowance (this number varies monthly with starters/leavers). Of these, 63 are internal nurse bank workers and therefore it is difficult to estimate the impact of the 20p increase to their hourly rate as the hours they work will vary each week. Of the 492 substantive staff who have standard weekly contracted hours, they work a total of 14,115 hours per week, and therefore the increase will cost approximately £2800 per week. With on-costs this would be approximately **£179,475** p.a.

2.1 Provisos

In addition to not calculating the impact on internal bank workers' costs, the impact of bringing the Nurse Bank at York back in-house from NHSP has not been estimated. As yet we do not have the salary information from NHSP to be able to determine whether any of those workers will be eligible for the local living wage allowance if it is still payable from 1 March 2015.

2.2 Estimated impact of national increase to Agenda for Change payscales

The pay award for 2015/16 will be the same as for 2014/15 i.e. all Agenda for Change staff who are not eligible to receive incremental pay, will be given a 1 per cent non-consolidated payment in April 2014/15. Other staff will receive an increase of at least 1 per cent through incremental progression.

Those staff on the top of Band 1 (point 3 on the scale) will therefore receive a non-consolidated increase of 1% which will take their hourly rate of pay to £7.75 per hour. This is still 10p per hour less than the new national Living Wage rate.

2.3 Becoming a fully accredited Living Wage Employer

The local organisations that are accredited Living Wage Employers are:

Aviva	Joseph Rowntree Foundation & Housing Trust	City of York Council
	York Council for Voluntary Services (CVS)	York Citizens Advice Bureau

In addition York St John's University pays its employees the Living Wage but does not hold full accreditation.

In order to gain full accreditation the Trust would not only have to pay directly employed staff the living wage, but also require it's contractors to do the same. If current contractors refused to do so, the Trust would have to formally commit to including the living wage as an essential requirement in tending for future services (including renewal of existing contracts). There would need to be a timetable in place for all contracted staff to move to the Living Wage – the expectation is that would be completed within 3 years. There is also an annual accreditation licence fee – approximately £450.

3. Conclusion

Being able to market the Trust as paying the national Living Wage is part of our strategy to become the Employer of Choice in all locations that we provide services to. If the Trust chooses not to apply the 20p per hour increase from 1 April 2015, then we will no longer be able to do this. Given that in York particularly, the Trust competes against relatively large employers such as Aviva, City of York Council, and the Joseph Rowntree Foundation that pay the national Living Wage (and require their contractors to do the same), there is the risk that if the Trust stops doing so, we will be unable to attract the best quality candidates for Band 1 & 2 roles.

4. Recommendation

The Board is asked to decide whether to implement the national increase of 20p per hour at an estimated cost of £180,000 p.a so that the Trust continues to be able to market itself as paying the Living Wage. This would apply to the financial year 2015/16.

The Board is also asked to consider whether it wishes the Trust to become a fully-accredited Living Wage employer by requiring all contractors to pay their workers the living wage.

5. References and further reading

http://www.yorkcvs.org.uk/living-wage-coalition/

Author	**Vicki Mallows, HR Manager**
Owner	**Sue Holden, Director of HR and Corporate Development**
Date	**November 2014**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – November 2014

Health & Safety Annual Report 2013/14

Action requested/recommendation

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

Clear reporting arrangements need to be developed for the H&S/NCRG to report to the Board of Directors as part of the Trust's governance review.

Summary

This report informs the Board of Directors of activity relating to all aspects of health & safety from 1st April 2013 to 31st March 2014. It is a requirement for the Board of Directors to receive an annual Health and Safety report covering the Trust's health & safety activities, providing assurance on or relating to management of health and safety risks.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

Outcomes 10 and 11

Fundamental Standard from end November 2014 – regulation 15, premises & equipment

Progress of report	Paper seen by Quality & Safety Committee, November 14.
Risk	Considered as part of document.
Resource implications	As referred to in document.
Owner	Brian Golding, Director of Estates & Facilities
Author	Brian Golding, Director of Estates & Facilities
Date of paper	November 2014
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Health and Safety
Annual Report 2013/14

Executive Summary

Health and Safety is recognised by York Teaching Hospital NHS Foundation Trust to be critical to patients, staff, carers, contractors and visitors to our premises who use our services.

The Trust continued to meet the requirements of health and safety legislation throughout 2013/14. For 2014/15, the Trust will continue to progress its management of health and safety across the Trust, with particular focus on:

- prevention of injury to patients, staff and visitors;
- maximising the morale, reducing absence levels, improving staff retention and productivity ;
- preventing the loss of reputation to the Trust by preventing enforcement action and any resulting criminal or civil action being taken against the Trust or its officers;
- avoiding the damaging effects of financial penalties through uninsured losses;
- providing assurance against NHS and Care Quality Commission standards;
- reviewing existing health and safety arrangements to ensure continued compliance with relevant health and safety legislation;
- assessing, monitoring and providing assurance that all premises are fit for purpose;
- validating the results of, and addressing issues identified by the self assessment health and safety audit;
- raising the levels of health and safety training courses on offer;
- monitoring policy compliance and addressing any resulting issues related to health and safety induction and mandatory training.

1. Introduction

It is a requirement for the Trust Board of Directors (BoD)[1] to receive an annual Health and Safety (H&S) report covering the Trust's H&S activities; providing assurance on or relating to management of health and safety risks.

This report informs the BoDs of activity relating to all aspects of H&S from 1st April 2013 to 31st March 2014.

The group with overall responsibility for overseeing the management of Health and Safety in the Trust is the Health & Safety/Non-Clinical Risk Group (H&S/NCRG). This group brings together all of the Trust's leads with responsibility for health and safety and non-clinical risk.

The group meets on a quarterly basis, the membership of the H&S/NCRG can be seen in the following table as can the attendance record for each of the members.

[1] INDG 417 – Leading Health and Safety at Work

H&S/NCRG – Meeting Attendance Record 2013-2014

		3/5/13	6/9/13	11/12/13	14/2/14
Brian Golding (Chair)	Director of Estates and Facilities	√	√	√	√
Jacqueline Carter	Secretariat Service	√	√	√	√
Amanda Stanford	Directorate Manager	√			A
Andrew Millman	Consultant, Occupational Health	√	A	√	√
Andrew Bertram	Director of Finance	√	A	A	A
Anne Devaney	Applied Learning and Research	A	√	√	A
Brian Tomlinson*	HR Manager	√			
Colin Weatherill	H&S Manager – Scarborough	√	√	√	√
Elaine Miller	Head of Risk and Legal	√	A	√	√
Gillian Clarkson	Staff Side Representative		√		
Ian Morgan*	Risk and Legal Services		√		
Jan Aspinall	Deputy Director of Operations	√	A	√	A
Jenny Carter	Head of Community Services			A	
Kingsley Needham	H&S Manager –York	√	A	√	A
Linda Smith	Locality Manager, Community		A	√	√
Michelle Wayt	HR Manager	A	√	√	√
Peter Prokop*	H&S/ Equip. Manager Theatres			√	√
Richard Morris	Directorate Manager		A	A	A
Steve Mackell	Directorate Manager	√	√	A	

√ - attended, A - provided apologies, * - nominated deputy

The Group receives highlight reports from the Trust's health and safety committees and their sub committees and groups in line with the Trust's governance structure.

Meeting dates for 2014/15:

- 13th June 2014
- 5th September 2014
- 12th December 2014
- 27th February 2015

2. Key Legislation for 2013/2014

In 2013/14 the H&S/NCRG has kept abreast of new and upcoming Occupational Health and Safety (OH&S) legislation and guidance, particularly in relation to on-going work in the effective implementation of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and the Control of Asbestos regulations 2012 – Management and Working with Asbestos Approved Code of Practice L143 – (July 13).

Following on from the Löfstedt review into the UK H&S legislation and regulations; the UK Government programme of health and safety reform 'better regulation as a last resort' the H&S/NCRG noted in this year:

- Revised reporting requirements under the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (came into force Oct 13) - simplified and clarified the reporting arrangements of the regulations;

- Amendment to the Health Safety (First Aid) Regulations 1981 (Oct 13) - to remove the requirement for the HSE to approve first aid training qualifications;

- The Health and Safety Executive (HSE) consulted on eight revised Approved Codes of Practice (ACOPs) including:

    - Workplace health, safety and welfare;
    - Safe installation and use of gas systems and appliances;
    - Dangerous Substances and Explosive Atmospheres Regulations 2002;
    - The control of Legionella bacteria in water systems;
    - Control of Substances Hazardous to Health Regulations 2003;
    - Management and working with asbestos;
    - First aid Regulations 1981; and (May 2013);

- Informed of the HSE's on-going review programme for Approved Codes of Practice (Dec 13 & March 14);

- Amendments to the Health and Safety at Work Act 1974 (Dec13);

- The requirement to remove old versions of the H&S posters to the new 2009 version H&S poster (April 14);

- The H&S/NCRG noted the on-going move towards de-regulation in the field of health and safety both in the UK and in Europe - ***'The Red Tape Challenge'*** - to remove out of date, onerous and improve health and safety regulation.

- Enterprise and Regulatory Reform (ERR) Act 2013 – Civil Liability for breaches of health and safety regulations This removed employers' strict liability for injuries to employees in the work place.

3. Health and Safety Requirements

Health and Safety legislation requires the Trust has a system in place to proactively manage and control risks. In order to meet these legal requirements the Trust manages its risks based on the revised HSE's model 'Successful Health and Safety Management' (HSG65[2]). This is a continuous improvement model based on the Plan, Do, Check, Act.

During this reporting period, the H&S/NCRG approved or noted the following policies, plans and reports:

- Adverse Incident Reporting System (AIRS) Policy;
- Annual Fire Safety report;
- Control of Substances Hazardous to Health (COSHH) Policy;
- Electrical Safety plan;

[2] HSG65 (Third edition, published 2013)

- Fire Safety Policy;
- Heat wave plan;
- Lone Working Policy;
- Medical Devices Management Policy;
- Medical Gas Policy;
- Security Policy;
- Water Safety & Legionella Policy;

Following a review of Trust wide governance the Terms of Reference (ToR) and reporting arrangements for the H&S/NCRG require amending as the Risk & Assurance Committee no longer exists.

4. Health and Safety Executives key topics in health and social care

The HSE is the national independent regulator for health and safety in the workplace; this includes publicly and private owned health and social care settings, working in partnership with co-regulators in local authorities to inspect investigate and where necessary take enforcement action.

The HSE leads on employee health and safety and will consider investigation of patient or service user deaths or serious injuries, where there is an indication of a breach of health and safety law was a probable cause or a significant contributory factor. The HSE works with other regulators e.g. Care Quality Commission (CQC), General Medical Council (GMC) and Nursing and Midwifery Council (NMC), in meeting sector specific legislation to secure justice or necessary improvement in standards. The HSE will take enforcement action in cases where it is considered established standards e.g. NHS safety alerts, internal guidance or systematic management failure e.g. inadequate systems for risk assessment, controls or monitoring, have been identified as a contributing factor.

The HSE recognises the health & social care sector constitute a large and diverse workforce looking after a predominantly vulnerable population. This said, employees have the right to work in a healthy and safe workplace, and the people using services are entitled to care and support that is safe and takes their needs, freedom and dignity into account. Managing these competing demands sometimes presents unique and complex situations which can, if not effectively managed, result in serious harm to employees, people using care services and others. The HSE will support decisions to allow everyday activities to be undertaken provided a sensible, suitable and sufficient risk assessment has been carried out, documented and reviewed as necessary. This should identify and implement any sensible precautions to reduce the risk of significant harm to the individual concerned.

The HSE Health and Social Care Sector identified key topics:
Moving and Handling;
Sharps Injuries;
Slips Trips and Falls;
Excessive Work Pressure (Stress);
Workplace Violence;
Equipment Safety (Inc Bedrails, falls from windows);
Dermatitis;
Legionella;

Scalding and Burns.

The Trust has in place management systems, processes, supporting procedures and specific resource to identify risk and as appropriate, puts in place control measures to manage these risks.

Fire safety also remains an essential requirement to ensure the H&S of people present on our sites and is covered by a separate annual report for the Board.

5. Work Programme 2014-2015

The H&S/NCRG has identified the following key work streams for this year:

- Chair of H&S/NCRG has met with Emergency Planning Officer adviser and agreed that large scale evacuation would be considered by the Emergency Planning Group in the future;
- This format of the Annual Health & Safety Report to the BoDs to be reviewed and improved;
- Review the Datix reporting software and over the year continue to discuss and develop robust systems which capture and allow analysis of H&S events, assisting in producing and measuring key performance indicators (KPIs);
- Monitor the use of the Lone Worker devices issued in 2014;
- Perform a training needs/gap analysis of H&S training provision;
- To oversee the 2014 Health and Safety Audit, commencing Sept 2014.

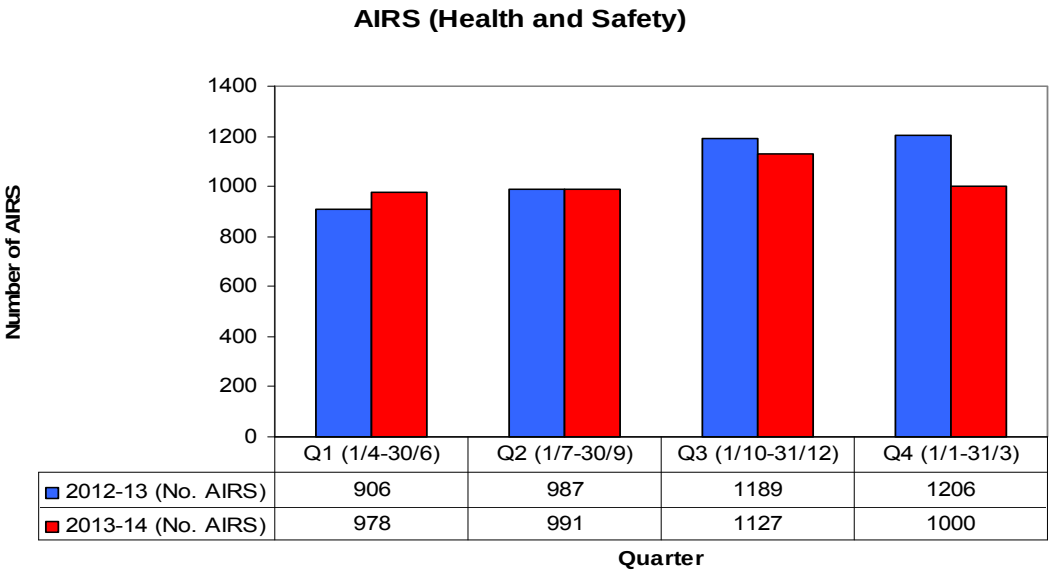
6. Health and Safety Accident and Incident Reporting System (AIRS) Reports; 2013/2014

The Trust has in place a comprehensive system to collect information from accident and incidents which occur in the Trust (Datix reporting system). The graph below compares the total number of reported health and safety incidents for patients, visitors and staff for 2012/13 compared with 2013/14.

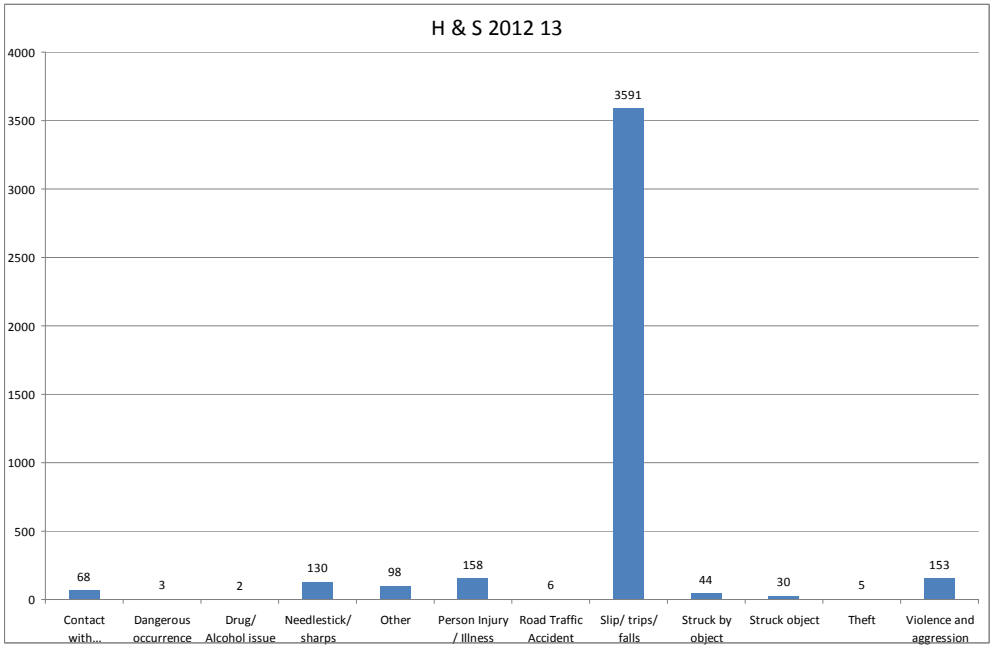
The number of AIRS reported in 2013-14 shows a slight decrease from 2012-13 during Q4, each of Q1, Q2 and Q3 relatively static demonstrating a reasonable reporting culture, which is a key requirement of a healthy and safe workplace. A number of staff members who do not have easy access to computer terminals may not be reporting due to being reliant on others to help them access DATIX; this in some way is surmounted by staff reporting incidents through to their line managers for reporting on Datix.

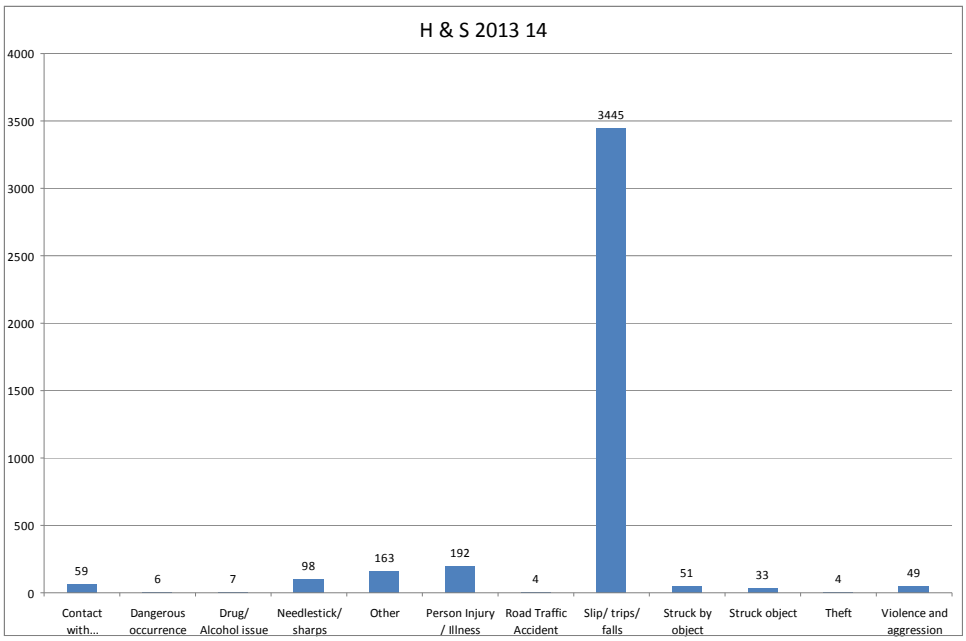
Further focus is required on ensuring staff are aware of what to report and how this can be achieved either by reporting on Datix themselves or via their line manager or through health and safety or the relevant department.

Graph 1



The following 2 graphs break down the AIRS (health & safety) reported by category:



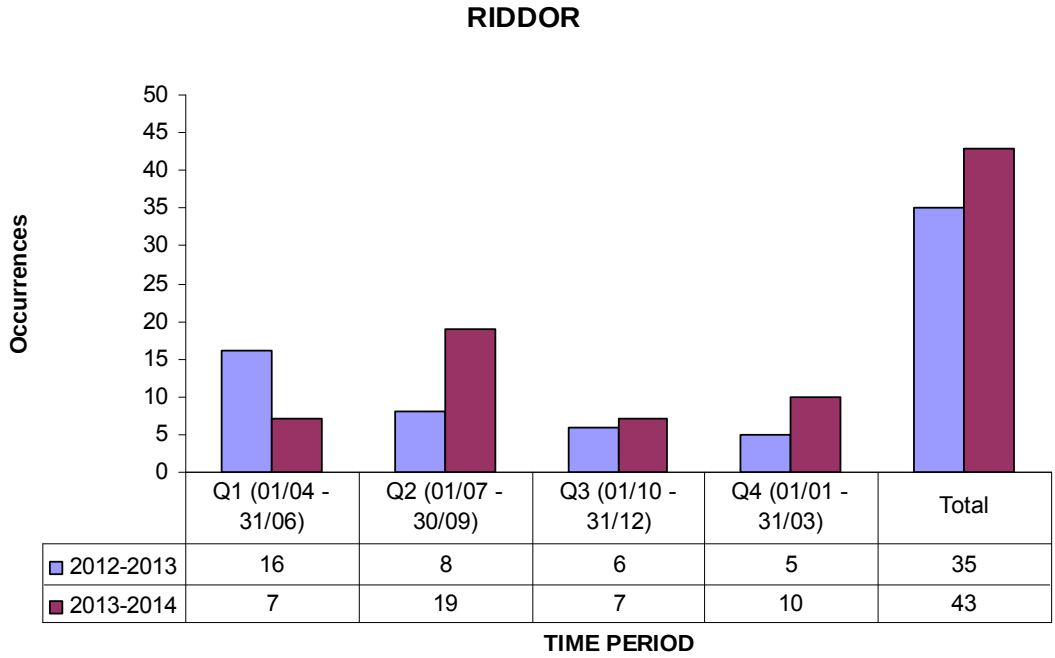


7. Health and Safety Reporting of Diseases and Dangerous Occurrence Regulation 2013 - RIDDOR Incidents for year 1st April 2013 – 31st March 2014

The Trust is required to report specific injuries, diseases and dangerous occurrences to the Health and Safety Executive (HSE) under the RIDDOR reporting system.

Graph 2 shows an increase in the number of reportable incidents from 35 in 2012-2013 to 43 in 2013-2014. From the data no clear seasonal trends can be seen, however a downward trend can be seen in 2012-2013. In 2013-2014, Q2 had a relatively high level of reporting which contributed to the overall result.

Graph 2

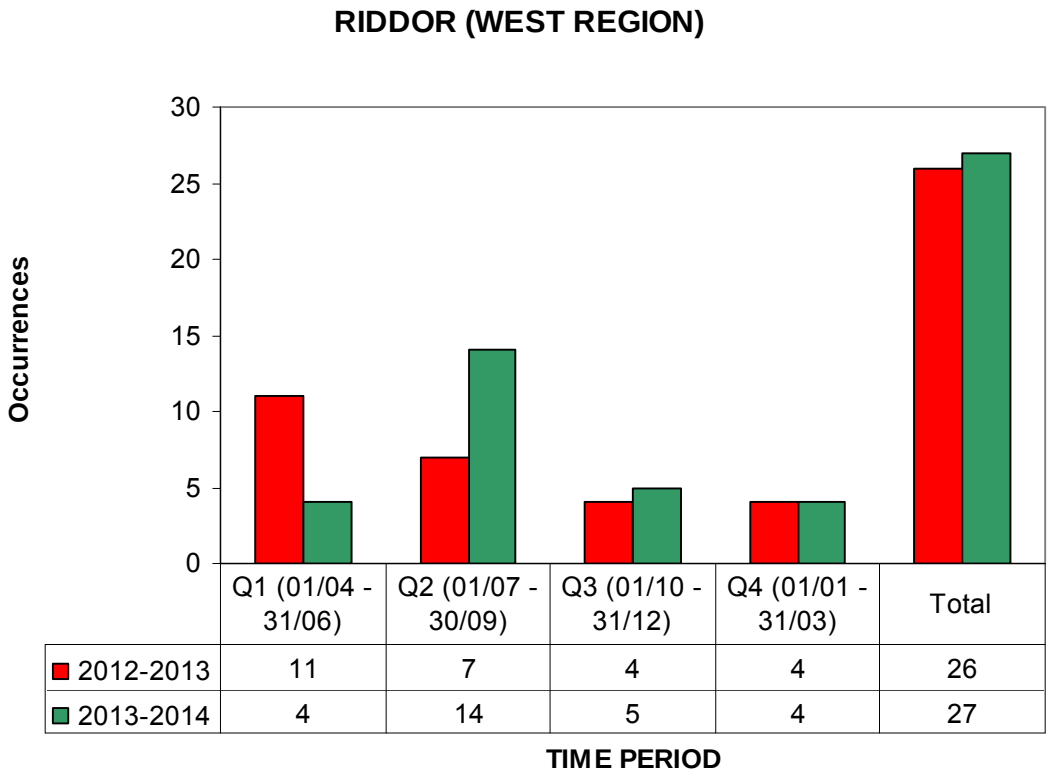


	Q1 (01/04 - 31/06)	Q2 (01/07 - 30/09)	Q3 (01/10 - 31/12)	Q4 (01/01 - 31/03)	Total
2012-2013	16	8	6	5	35
2013-2014	7	19	7	10	43

Graph 3 shows the reportable occurrences in the Western Region; Malton, Selby War Memorial, York and respective premises including associated Community Services.

Total number of reportable injuries increased from 26 in 2012-13 to 27 in 2013-14. It's worth noting that whilst the Western Regions overall performance remained equivalent to the previous year, in Q2 it experienced an unusually high level of reporting which was reflected in the overall performance of the Trust.

Graph 3

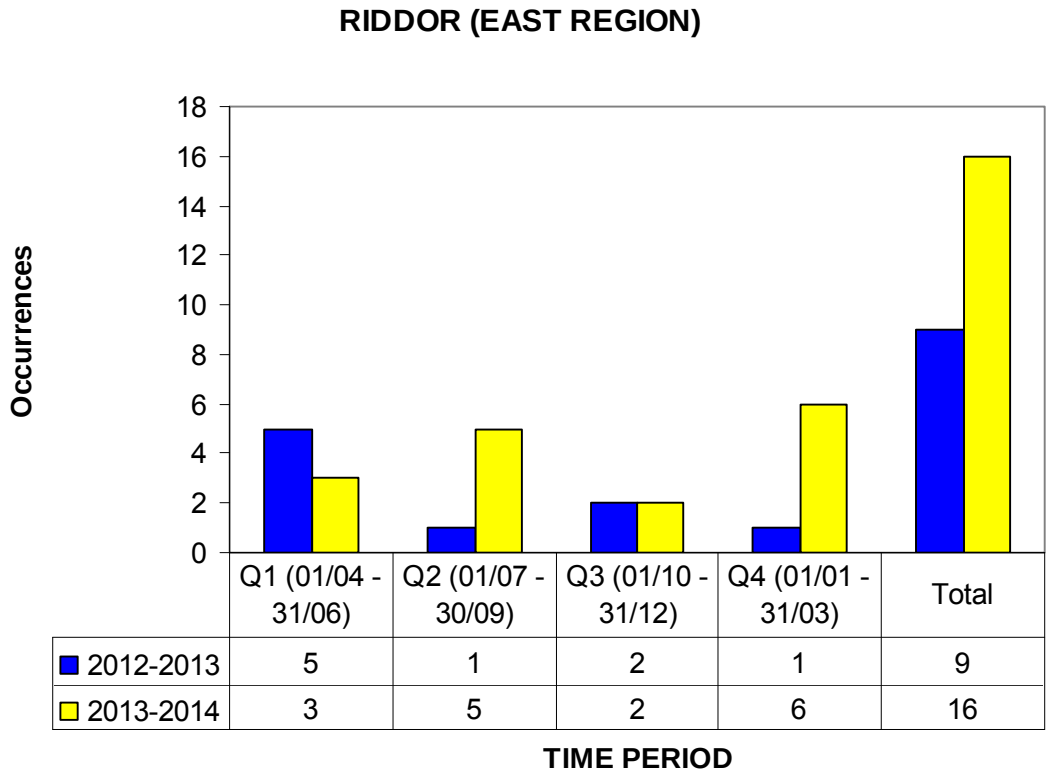


	Q1 (01/04 - 31/06)	Q2 (01/07 - 30/09)	Q3 (01/10 - 31/12)	Q4 (01/01 - 31/03)	Total
2012-2013	11	7	4	4	26
2013-2014	4	14	5	4	27

Graph 4 below shows the reportable occurrences in the Eastern Region; Bridlington, Scarborough, Whitby and respective premises including associated Community Services. Total number of reportable injuries increased from 9 in 2012-13 to 16 in 2013-14.

The overall trend for reporting RIDDOR's in the Eastern Region for 2013-2014 is upward as a result of relatively high reporting in Q2 and Q4. Q4 being an unusually high level of reporting.

Graph 4



Analysis of the RIDDOR reportable incidents has not identified any one area of concern with reportable accidents falling into categories of > 7 day absence, fractures, lacerations, major injuries, exposure to substances with causational factors including slips, trips, falls, contact with, muscle injuries / strains and collisions.

8. Self Assessment Audit

The H&S/NCRG received and discussed the Trust wide Health and Safety Audit.

In 2012-2013, the enlarged Trust's numerous sites gave the opportunity for a review of how we audited our health and safety management systems and general health and safety requirements going forward.

The audit tool has been trialled across a small group of departments/ directorates which allowed for its development whereby we ended with a tool which met the needs of the health and safety department, was user friendly for those completing it and also allowed

for further improvements to the document, should the need arise. Feedback received on the audit tool was very good with a number of suggested improvements being forthcoming.

When the audit tool was initially circulated it was completed by a total of thirty eight 'areas'. Some were departments, some were whole directorates some were small stand alone facilities. In the future and after further development, it is intended that the audit will be at departmental level with the ability to then reflect how an overall directorate is performing.

As the number of audits grows across the Trust, clearly the time needed to conduct audits will grow. It will, therefore, be necessary to have a balance of self assessments and face to face audits.

The audit tool is electronic. It is formed in two parts; a mandatory section made up of eight sub sections;

- Safety and Risk Management
- Incident reporting
- Fire Safety
- Slips, Trips and Fall Prevention
- Work related stress
- Infection Prevention (All areas and staff)
- Learning from experience
- Incident investigation

The second part is made up of fifteen risk specific standards;

- Infection Prevention
- Moving and handling people
- Lifting and moving of objects
- Human Tissue Act
- Control of Substances Hazardous to Health (COSHH)
- Violence and Aggression
- Clinical waste handling and disposal
- Display screen equipment
- Laser radiation and artificial optical radiation
- Ionising radiation
- Safety in patient areas
- Safe use and disposal of sharps
- Latex
- Medical equipment
- Resuscitation

Each sub section is awarded marks for a range of key questions asked. When totalled up, they are averaged to produce a mark across all criteria.

The overall percentage mark can, over time, provide an indicator by which an area can see its safety performance/compliance. It can also be a benchmark against other areas of the Trust.

9. Staff Training

The Trust provides a range of in-house training that contains elements of health & safety. The move to the Learning Hub will allow the organisation to analyse the numbers of staff trained in more detail.

10. Summary of some H&S Issues in 2013/14

In 2013/14 the Group has kept abreast of new and upcoming OH&S legislation and guidance, particularly in relation to on-going work in the effective implementation of the Health Safety (Sharps Instruments in Healthcare) Regulations 2001 and, Control of Asbestos regulations 2012 - Management and Working with Asbestos Approved Code of Practice L143 – (July 13).

Road safety at York Hospital reviewed – in response to a 2nd accident on the same road crossing at York Hospital, alteration to the crossing and traffic priority was completed.

Chlor-clean - with the significant increased use of CC for sanitising large surface areas to address concerns in regards to control of infections across the Trust led to staff across the Trust presenting with health concerns, with staff reporting symptoms of sore eyes, headaches and throat irritation. Staff were being referred to Occupational Health and post assessment with 24 staff diagnosed with work exacerbated asthma. This led to operational issues for the domestic departments on both York and Scarborough sites, as redeployment of staff to areas not using Chlor-clean was identified as the measure to reduce risk to staff. This matter was raised by Union colleagues to a regional level as a concern, the Trust provided information in the measures being taken to mitigate and manage this concern. This matter was reviewed by the H&S department, Microbiology and Infection Prevention Control and alternative chemicals and methods of IPC were considered. Locally, departments affected have put in place measures to mitigate the risk to individuals identified at risk and as of October 14, a decision was made to reduce the reliance on the use of Chlor-clean across the Trust with alternative methods such as Hydrogen Peroxide Vapour disinfection being used more widely across the organisation.

Ligature & Anchor Points - following an incident in October 13 a review of the Trust risk assessment for ligature and anchor points was undertaken on identified high risk areas at York and Scarborough. The result of this review was to commence a phased replacement of emergency pull cords and light switch cords in toilets, bathrooms and unobserved areas with anti-ligature alternative cords. Once completed in high risk areas, the replacement of pull cords will be rolled out across the Trust as part of the Estates planned maintenance schedules, minor works and capital programmes.

11. Conclusion

The Trust continues to work on continually improving the health and safety systems and processes, striving to embed these systems into the operational management across the organisation. In the year the H&SNCRG has worked to address operational issues as they have arose and support the groups, sub groups and committees in facilitating the

operational safety management, working in both non-clinical safety and as required supporting clinical safety functions.

The H&S/NCRG has highlighted corporate risk which the group would wish to highlight to the Board and makes the following recommendation for the Boards attention.

12. Recommendations

1. Clear reporting arrangements need to be developed for the H&S/NCRG to report to the BoD as part of the Trust governance review.

Owner:
Brian Golding, Director of Estates & Facilities and Chairman of the H&S/NCRG

Authors:
Kingsley Needham, Health and Safety Manager – York
Colin Weatherill, Health and Safety Manager - Scarborough

November 2014

References:

For the purpose of this report the following statutory requirements of the *Health and Safety at Work etc. Act 1974*

The *Management of Health and Safety at Work Regulations 1999*

Control of Substances Hazardous to Health (COSHH) Regulations 2002.

The Regulatory (Fire Safety) Reform Order 2005

HSG 65 third edition - Managing Health and Safety

INDG 417 – Leading Health and Safety at Work

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Chairman's Items

Action requested/recommendation

The Board of Directors is asked to note the report.

Summary

This paper provides an overview from the Chairman.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There is no reference to CQC outcomes.

Progress of report	This paper is only written for the Board of Directors
Risk	No risks
Resource implications	No resource implications

Owner	Alan Rose, Chairman
Author	Alan Rose, Chairman
Date of paper	November 2014
Version number	Version 1

Board of Directors – 26 November 2014

Chairman's Items

1. Strategy and Context

A number of us attended the Foundation Trust Network (FTN)'s Annual Conference last week. The organisation is about to be refreshed as "NHS Providers" – which I welcome as clarifying that it can now more explicitly represent NHS Trusts as well as FTs and its public profile will be more obvious.

The clear message coming through many of the speeches and sessions was absolutely consistent with one of the themes of our recent Time-out and something we have been discussing for a while: the likelihood that NHS sustainability will predominantly come through organisational collaboration in flexible ways. Through learning from other countries (e.g. New Zealand) it is clear that this will be "messy", varied and challenging in terms of governance and uncertainty. However, it is refreshing that the Secretary of State, the about-to-be-published Dalton Review and others were broadly agreeing that this must happen. This means a "loosening" of the rather rigid approaches by Regulators and others to payment mechanisms, organisational form and other "rules". A variety of models will be "allowed" to develop – indeed will be encouraged in some cases – and so the onus is on us to try to shape this locally and come up with credible proposals.

The ethos is that the local healthcare of our communities should be "more important" than the survival of specific existing organisational entities – but of course we know that this is much easier to espouse than to implement, when it can only be implemented through the careers and ambitions of individuals and the momentum of existing institutions – including our own! In combination with our Health & Wellbeing Board, commissioners, primary care colleagues, mental health colleagues, social care providers and a range of others, we need to progress a vision(s) for our communities.

A second issue at the conference, as well as in the press last week, was the extension of further transparency of surgical outcome data, for a new range of procedures, to individual practitioner level. This is challenging and sometimes controversial, but continues the national trend towards the release and availability of data about many aspects of healthcare. As a Trust, we should be aware of the implications of this for our staff and for the reputation of our organisation as a whole. In the broader sense, the Conference highlighted the explosion of access to healthcare data through digitalisation and miniaturisation (through Apps, wearable devices, telemedicine, etc.). We need to consider how we support and encourage these, design our own, respond to them, interface with them, etc.. Our patients and their families will become increasingly "informed" and demanding! Take a look at the new "MYNHS" (on the net) for new hospital-site-level comparisons on efficiency, food, safety, margins, etc.

Chairman's Actions: We have circulated off-line a business case regarding the enhancement of paediatrician consultant out-of-hours service in Scarborough. The case called for, in due course, four consultant appointments, designed to give safe out-of-hours cover and also to improve the chances of recruiting suitably qualified consultants, as the job plan includes work in York as well as Scarborough. This was reviewed by the Chairman and others during the month, agreed and through the normal consultant interview process I am delighted to report that three consultant appointments have been made.

2. Governance & Governors
The Corporate Risk Committee has begun its new approach to discussing in some detail with individual Directors the Risk Register and Assurance Framework topics that each Director is responsible for. An accelerated programme of reviewing these will be put in place over the coming couple of months. The purpose is to ensure tighter alignment between Director portfolios, these two registers, Board agenda time and what as a leadership team we are currently "worried about". Since the last Board, we can confirm the appointment of Juliet Walters, currently a Director at Morecambe Bay University Hospitals Trust, as our new Chief Operating Officer; Juliet is an extremely experienced Director and we look forward to her joining us full-time in the New Year. Work is underway to review the extent of our Member constituencies, to appropriately reflect current patterns of patient flows. Any small changes will be proposed to our Council of Governors in December.
3. Recommendation
The Board of Directors is asked to note the report.

Author	**Alan Rose, Chairman**
Owner	**Alan Rose, Chairman**
Date	**November 2014**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Chief Executive Report

Action requested/recommendation

The Board is asked to note the content of the report.

Summary

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

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	Report developed for the Board of Directors
Risk	No specific risks have been identified in this document.

Resource implications	The paper does not identify resources implication
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	November 2014
Version number	Version 1

Board of Directors – 26 November 2014

Chief Executive Report

I believe that the Board Time-out that we held this month will in time prove to be a key moment in the further development the Trust. We wrestled throughout the session with the difficult balance we have to strike, as the leading body of a major organisation, between setting out an ambitious programme of change whilst framing this in a difficult and challenging economic and political environment. We considered our high level priorities for capital development (including the challenges we face in financing these), the importance of establishing an appropriate influence on a rapidly changing health and social care environment and the complexity of our internal integration and reconfiguration strategy. I set out the importance of making progress on this broad agenda that is so vital to engaging with and motivating our staff at a time of significant operational pressure and I look forward to exploring more fully how we might provide the support and investment to do this.

I welcomed the debate at dinner, prior to the time out, which sought views on how we might enhance and improve our communication, engagement and visibility with all our staff regardless of their role and location. We all recognised the importance of this and the contribution we each can make that would complement the more formal mechanisms we are now developing in addition to Staff Brief, Staff Matters and Staffroom. As part of this programme I have committed to a regular staff surgery at each of our hospital locations and as I write this there is only Whitby to go this time round! The feedback so far is that the surgeries have been well received and in general have been extremely well attended. Above all else I have been struck by a consistent message of support of what we are trying to do and a recognition of how difficult it is but coupled with a huge desire to feel better informed and have their contribution more overtly valued.

This was most evident in Bridlington where there was concern about the continued poor level of utilisation of some of its facilities and a pervading sense of insecurity that is clearly a legacy of more than a decade of poor direction, leadership and management. Everybody was happy with the direction we are going but were keen to see the pace increased. They all recognised that the car park was usually full these days! In Bridlington I met Janine and Caroline who provide the linen and laundry service and have most recently taken on the job of cleaning curtains for the whole Trust, this having previously been a bought in service. This has not only saved costs but perhaps more importantly provided a sense of pride and ownership that was simply overwhelming. They knew their costs, they knew their service, they wanted to expand where appropriate and they felt a real part of the whole organisation and wanted everyone to know it. For me they were a fantastic example of living our values and a great example of what makes my job so rewarding. They also helped close the loop between the direction we are now setting as a Board and the reality of service delivery on the ground. This is a team effort, we all play a part and we can be confident that if we set a proper lead then others will follow.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley Chief Executive**
Date	**November 2014**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 26 November 2014

Governance Review – Improving Corporate Accountability by Aligning Strategy, Structure and Assurance – Update

Action requested/recommendation

The Board of Directors is requested to consider and agree the progress made against the Project Plan for the review of the Trust's corporate governance structures and arrangements.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

The project will support the Trust's readiness for the forthcoming CQC inspection.

Progress of report	This is a follow up from a previous Board of Directors report
Risk	Risks of not proceeding have been highlighted and reported.
Resource implications	Resources implication detailed in the report

Owner	Patrick Crowley, Chief Executive
Author	Helen Kemp-Taylor, Governance Review Project Manager
Date of paper	November 2014
Version number	Version 1

Board of Directors – 26 November 2014

Governance Review – Improving Corporate Accountability by Aligning Strategy, Structure and Assurance – Update

1. Introduction and background

The project was agreed and approved by the Board of Directors in August 2014.

It aims to connect and align a number of work streams, some of which are already underway including actions relating to the Integrated Business Plan; the Internal Audit Report "Strengthening Corporate Accountability through Staff Conduct and Competence" and guidance from the CQC on the "Fit and Proper Persons Test" requirement.

The aim of the project is to provide greater clarity of purpose and leadership, more purposeful transactions within the organisation and to remove any redundancy or duplicated effort at both an individual and collective level. It will provide stronger assurance to the Board and align the organisation's strategy against a clear and transparent structure.

The project plan, agreed by the Board of Directors, is kept under review by the Stakeholder and Steering Groups to ensure it remains appropriate, and relevant additional items will be considered for inclusion as the work progresses.

2. Progress

The agreed project plan is on target as set out below. The Stakeholder Group has met on two occasions and has approved all outputs and outcomes to date together with setting out the next steps. The Steering Group has met on one occasion to date.

Workstream 1 - Reporting Lines are Clear and Meetings are Purposeful

Agreement has been reached on the status conventions for Strategic, Corporate and Operational meetings and as work progresses these definitions will be tested. Corporate Directors have identified their key meetings and agreed the structure of Strategic and Corporate meetings. Further work in respect of Operational and External meetings will be continued.

The overarching Integrated Governance Structure which sets out the Trust's strategic and corporate meetings will be used to draw, and test lines of accountability, responsibility and assurance.

The work to date has identified the potential to improve reporting on clinical risks. As the Corporate Risk Committee operates at Strategic level, it was suggested that consideration be given to this becoming an overarching Trust Risk Committee to include Clinical and Non-Clinical Risk. This has been discussed with the committee and the working group has been tasked to identify options to report back to the Steering Group on this.

Workstream 2 - The Trust maximises the performance contribution from Directors and Senior Managers by setting out clear expectations of them.

Corporate Directors' portfolios have been reviewed and revised to reflect current leadership and professional responsibilities and accountabilities, and reflecting changes in the BoD makeup. These are subject to agreement of the Remuneration Committee that is due to meet on the 26th November.

Each Corporate Director now has an agreed organisational structure for their senior teams.

Workstream 3 - Decisions are made expediently and are delegated to the lowest appropriate level to support effective operational performance.

A paper was presented to the Board in October setting out guidance on the Fit and Proper Person Test, and how this will be implemented in the Trust. Further development of this work is linked to Workstream 2.

Workstream 4 – The Board of Directors receives meaningful assurance on the business of the organisation, and key issues are escalated appropriately.

There were no actions planned in this period for this workstream.

3. Next Steps

The Stakeholder Group will continue to meet on a monthly basis and will focus on the next stage of the project plan, which will be reviewed and agreed by the Steering Group before progress is reported to the Board in February.

Actions planned for completion before the end of January 2015 are as follows:

Workstream 1- Reporting Lines are Clear and Meetings are Purposeful

In respect of corporate meetings:

- Identify and agree the naming convention for Operational, Corporate and Strategic level meetings.
- Identify where the output from each agreed meeting should be reported to
- Agree a process for approving the set-up of further Corporate meetings
- Develop a template for meeting agendas which clearly distinguishes items for information, for discussion, and for decision, and includes both current and future facing issues
- Develop a template for reporting (exceptions) for the Corporate Directors Team and BoD and agree format and use
- Map and align reporting lines in the agreed structure.

Governance Reference Manual:

- Draft a chapter on reporting lines and meeting governance for the Governance reference manual.

Workstream 2 - The Trust maximises the performance contribution from Directors and Senior Managers by setting out clear expectations of them.

Corporate Directors to identify roles and/or individuals in their directorate structure with

"significant governance responsibility" and determine and agree the portfolio, responsibilities and accountabilities for these.

A matrix setting out the consistent application of titles to roles, responsibilities and accountabilities (including Chairing corporate meetings, financial delegations etc) to be developed.

Workstream 3- Decisions are made expediently and are delegated to the lowest appropriate level to support effective operational performance.

As policies are the means by which the Board delegates decision making responsibility and accountability, management of the process for ensuring the continuing fitness for purpose of policies and procedures, including prioritisation by assessing the impact on the Trust, is to be reviewed.

Ensure the Board is kept up to date with developments and is assured that change in regulations; status etc. is identified and actioned appropriately. e.g FPPT, Duty of Candour. This will include ensuring there is a process for the identification of all statutory and regulatory requirements and these are actioned appropriately.

Workstream 4– The Board of Directors receives meaningful assurance on the business of the organisation, and key issues are escalated appropriately.

Following the Board workshop in June the Risk Management Policy and Strategy is to be reviewed, revised and presented to the BoD for approval at the January 2015 meeting. This will include the Trust's architecture for identifying and mitigating risk, a statement on the Trust's Attitude to Risk, it's Appetite (the level of risk the BoD will manage) and Tolerance (who is responsible for managing which risks) and a BoD approved escalation process which shows how risks that exceed the risk appetite are escalated). The "Board Oversight" matrix is to be incorporated as part of the process.

As part of this work each Corporate Director is to complete the ("Board Oversight") risk matrix presented to the BoD on 25th June to inform and update the Corporate Risk register, and particularly to include future focussed risk.

Following structural changes as part of this review, there will be a high level review with the Board to clarify what the assurance framework is for and how it is to be developed and used to focus discussion. This is expected to reflect performance management outcomes and routine performance reports, and a review of the sources of assurance for sufficiency (against the revised structure and accountabilities). Consideration is to be given as to whether an integrated performance and assurance framework is appropriate.

4. Recommendation

The Board of Directors is requested to consider and agree the progress made against the Project Plan for the review of the Trust's corporate governance structures and arrangements.

Author	Patrick Crowley, Chief Executive
Owner	Helen Kemp-Taylor, Governance Review Project Manager
Date	November 2014