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 28th May 2014**
in: **Boardroom, York Hospital**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Room 4 PGMC	Non-executive Directors
9.15am - 12.15pm	**Board of Directors meeting held in public**	**Boardroom, York Hospital**	**Board of Directors and observers**
Lunch 12.15pm - 1.00pm			
1.00pm - 2.30pm	Board of Directors to consider confidential information held in private including lunch	Boardroom, York Hospital	Board of Directors
2.35pm - 3.30pm	Year End Accounts	Boardroom, York Hospital	Board of Directors and External Audit

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 28th May 2014**

At: **9.15am – 12.15pm**

In: **The Boardroom, York Hospital**

A G E N D A					
No	**Item**	**Lead**	**Comment**	**Paper**	**Page**
Part One: General **9.15am – 9.45am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for Absence**	Chairman			
3.	**Declaration of Interests** To receive any changes to the register of directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chairman		A	5
4.	**Minutes of the Board of Directors meeting** To review and approve the minutes of the meeting held on 30th April 2014.	Chairman		B	9
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman			
6.	**Patient Experience** Patient Experience Team review	Director of Nursing		Verbal	

No	Item	Lead	Comment	Paper	Page
Part Two: Quality and Safety 9.45am – 10.30am					
7.	**Quality and Safety Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Patient Safety Dashboard • Medical Director Report • Patient Safety and Quality Improvement quarterly report • Chief Nurse Report	Chairman of the Committee		C C1 C2 C3 C4	25 29 55 61 65
Part Three: Finance and Performance 10.30am – 11.15am					
8.	**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		D D1 D2 D3	75 81 87 93
Part Five: Strategy Work 11.10am – 11.30am					
9.	**Update on the development of the community hubs** To receive an update on the community hubs.	Deputy Chief Executive		Verbal	
Part Six: Governance 11.30am – 12.15pm					
10.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		E	103
11.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		F	107

No	Item	Lead	Comment	Paper	Page
Any other business					
12.	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 25th June 2014 in the Blue room Scarborough Hospital.				
13.	**Any other business** To consider any other matters of business.				

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

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

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

Assurance Framework and Corporate Risk Register
Capital Board programme
Staffing information

Register of directors' interests
May 2014

York Teaching Hospital NHS
NHS Foundation Trust

Additions: No additions

A

Changes: No changes

Deletions: No deletions

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

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

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

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Blue Conference Room, Scarborough Hospital, on 30 April 2014.

Present:

Non-executive Directors

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

Executive Directors

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

Corporate Directors

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

Attendance:

Mrs A McGale	Director of Ops (Scarborough), for item 14/061
Mrs A Pridmore	Foundation Trust Secretary
Dr C Saxby	Palliative Care Consultant, for item 14/067

Observers: 2 Governors, 3 students and lecturer from the York St John University.

14/058 Apologies for absence

There were no apologies for absence received by the Board.

14/059 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.

14/060 Minutes of the meeting held on the 26 March 2014

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

14/061 Matters arising from the minutes

14/053 Chief Executive Report – Perfect Week (Scarborough)

Mr Rose welcomed Mrs McGale to the meeting and invited her to explain the "perfect week" to the Board.

Mrs McGale explained the purpose of the perfect week and that it was taking place at Scarborough Hospital for 8 days from 19 May 2014. She added that there would be a planning week from 12 May where people would be invited to attend various training and planning sessions. There would also be a detailed pack of information that will be supplied to all those involved.

The event will involve the whole hospital. All staff have been asked to consider what 5 pledges they would put forward for the week.

Mrs McGale invited the whole Board to become involved in the 8 days and confirmed that at the June Board meeting there would be a paper highlighting the highs and lows of the week along with the learning.

The Board confirmed their support for the event and Ms Raper added that she was looking forward to it. Ms Raper asked how expectations were being managed. Mrs McGale explained that planning is in progress for what to communicate to the public and patients. There is also clear information for staff about what is expected of them.

The Board noted that detailed information would be circulated in the next week or so and that they would be given an opportunity to ask any further questions at that time.

The Board thanked Mrs McGale for her presentation.

14/042 Quality and Safety Committee – Pressure Ulcer Reduction Plan (PURP)

Mr Proctor confirmed the additional post-meeting note in the minutes was correct and he had discovered after the March Board meeting that the information he had provided the Board had been incorrect. He confirmed that the Quality and Safety Committee had received a detailed report that outlined the data issues around the recording of the pressure ulcers Commissioning for Quality and Innovation (CQUIN) which resulted in the Trust under-reporting prevalence. He advised that this means that the Trust has not achieved the CQUIN for acute patients in full, but has achieved the CQUIN for community patients.

14/062 Patient Experience – Inpatient Survey

Mrs Geary reminded the Board that although they had received the report at the March meeting it had not been discussed in any great detail at that meeting.

Mrs Geary highlighted areas for which the Trust had improved over the last 12 months, particularly around the Scarborough site at which there had been improvements in a number of nursing areas around communication. In terms of the doctors, there had been

improvement at both sites in the last 12 months, but the score at Scarborough was still lower than the York site.

In terms of keeping belongings safe the Scarborough site had again scored very well in this area, as had the York site. Hospital food at the Scarborough site has also seen an improvement in all aspects and has scored higher than the York site.

With regard to discharge, patients reported that their discharge is often delayed, and this is reported more in Scarborough than York, but the survey also showed that staff at the Scarborough site communicate the delay more than staff on the York site.

Overall in terms of patients being treated with dignity and respect there were noticeable improvements at the Scarborough site and the scores at both sites are now very similar and in terms of the patients' views on quality of care again there had been a noticeable improvement, particularly at the Scarborough site.

Mr Rose asked about the different patterns between the two sites and if there were signs that there were more improvements around the Scarborough site, as we had anticipated as part of the acquisition Mrs Geary explained that there were strengths and development areas on all sites and that although Scarborough had started at a lower base they had made significant improvements over the last couple of years. She added that the leadership organisational development work that had been undertaken had helped with the developments. Mr Rose asked if the Trust could now say that the in-patients at Scarborough Hospital could be considered as satisfied as the in-patients at York Hospital. Mrs Geary said that would be better to say that the in-patients in Scarborough Hospital were more content than in the past and that there was a greater degree of confidence and satisfaction, which she felt was a testament to the work that had been completed at ward level.

The Board considered the comments and concluded that they were delighted to see the improvements, but not complacent. The Board added that it had pledged to see more consistent standards between all the sites.

The Board congratulated all those involved in the improvements that had been made and recognised that work continues to ensure that consistency is achieved and maintained.

14/063 Quality and Safety Committee

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

Carbapenem-resistant Enterobacteriaceae (CRE) infection – Ms Raper asked Dr Turnbull to comment on the recent discussions that had been held. Dr Turnbull explained that CRE is a family of germs that are difficult to treat because they have high levels of resistance to antibiotics. *Klebsiella* species and *Escherichia coli (E. coli)* are examples of Enterobacteriaceae, a normal part of the human gut bacteria that can become carbapenem-resistant. In a healthcare setting, CRE infections most commonly occur among patients who are receiving treatment for other conditions. Patients whose care requires devices like ventilators, catheters, and patients who are taking long courses of certain antibiotics are most at risk for CRE infections. Some CRE bacteria have become

resistant to most available antibiotics. Infections with these germs are very difficult to treat, and can be deadly. Dr Turnbull added that in recent months the Trust has had patients with CRE on both main sites and have had to isolate those patients for a number of days. There are national concerns about the increase occurrence of this infection and a tool kit has been published which shows the lessons learnt from other countries. Dr Turnbull added that national guidance has been published which the Trust is largely compliant with; the only elements needing further work are the education of clinical staff about the infection and the number of single rooms the Trust has available. As the Trust sees more cases there will be more demand for single rooms and increased cleaning.

Dr Turnbull added that he was working with Mr Golding and Mrs Booth to address the estate issues. The Board asked if Mr Bertram and Mr Golding were diverting capital resources to support any developments that were needed. Mr Bertram and Mr Golding confirmed that they were working with Dr Turnbull on understanding the possible changes to the estate that would be needed.

Dr Turnbull confirmed that it would become a measure within the organisation and stressed that the most important aspect was to ensure the infection did not become embedded in the organisation.

Mortality figures – Summary Hospital-level Mortality Indicator (SHMI)

Ms Raper asked Dr Turnbull to advise the Board on the SHMI figures that had been published on the day of the Board.

Dr Turnbull advised that overall SHMI for the Trust for this reporting period which was Oct 12 – Sept 13 was 97; for the York site it was 93 and for the Scarborough site it was 104. This is an improvement on the last report given to the Board.

Below is the table showing the progressive improvements that have been made over a number of years

	Apr 11 - Mar 12	Jul 11 - Jun 12	Oct 11 - Sep 12	Jan 12 - Dec 12	Apr 12 - Mar 13	July 12 - June 13	**Oct 12 - Sep 13**
York	110	105	105	102	99	96	**93**
Scarborough	115	117	112	106	108	108	**104**
Overall	112	108	107	104	102	101	**97**

Dr Turnbull confirmed he was still reviewing those areas that seemed to have a high mortality rate, such as COPD and vascular disease.

The Board **noted** the achievements, the continuing on going work and the assurance given.

Safer staffing project

Ms Raper asked Mrs Geary to comment on the project. Mrs Geary drew the Board's attention to the paper included in the Board pack. She explained the background to the project and the importance CQC place on the information and the assurance they will seek about the Trust following the expectations. Mrs Geary drew the Board's attention to

the expectations and advised that they were reflected in the strategy and work being undertaken. She assured the Board that they would receive a six-monthly report describing the staffing capacity and capabilities after an establishment review had been undertaken. The Board would also receive a report on a monthly basis from June 2014 containing details of planned and actual staffing on a shift-by-shift basis.

The Trust will also publish information about the nurses and midwives and care staff deployed for each shift, compared to what has been planned at ward level. This again will start in June. Finally, the Trust will the monthly report provided to the Board on the Trust's website with a link to the Choices website.

Mrs Geary explained that a task and finish group had been established to ensure the objectives were achieved and training had been given to matrons. She stressed the idea was to ensure this was ward-led and a project officer had been appointed to ensure the right mechanisms are in place to deliver the project.

Action: Mrs Geary to include the monthly safer staffing report in the Chief Nurse report from June 2014.

Mrs Geary to provide a six monthly acuity audit report from June 2014 as required.

It was agreed that this would be considered by the Workforce Strategy Committee at their next meeting on 4th June 2014. The minutes from that meeting will be considered by the Board of Directors in June.

Ms Raper added that it was something that was included in the Quality and Safety agenda too, and the Committee would be updating the Board from a quality perspective on a regular basis.

Action: minutes from the Workforce Strategy meeting to be held in June to be presented to the Board of Directors at the June meeting

Annual Report

Ms Raper drew the Board's attention to the annual report of the Committee and asked the Board to note it.

The Board **noted** the report.

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

14/064 Annual Patient Experience - complaints, concerns and compliments

Mrs Geary presented the report and highlighted the number of complaints received by the Trust during the year.

She explained each week the Chief Executive, Chief Nurse, Director of Nursing and Patient Experience Team review the complaints that have been received. Mrs Geary advised that there was considerable work underway in looking at how the Patient

Experience Team works at present. She advised that she would bring the results of the work to the next Board of Directors. Mrs Geary added that at present the lead nurse role for patient experience is vacant and an advert has been placed for the appointment of a lead for patient experience. The advert does not stress that the individual needs to have clinical experience. On reviewing what other organisations have done, often they have appointed someone with a customer services background and this has proved to be very successful.

Action: Mrs Geary to present the results of the listening exercise with the Patient Experience Team to the Board of Directors in May 2014.

The Board discussed the document and Mrs Adams noted the report did not include any benchmarking data and asked if it was possible to see more detailed information particularly around benchmarking. The Board discussed the proposal and agreed that it was not necessary to see the level of detail Mrs Adams was proposing for the Board, but that if she would like to see more detail she should seek it directly from the team. The Board did ask how the Trust compares to other organisations. Mrs Geary advised that the level of complaints received in the Trust is lower than other organisations of a similar size. She added that since the Keogh reviews some organisations have seen a significant increase in the number of complaints.

The Board **noted** the report and the number of complaints received by the Trust during the year.

14/065 Safeguarding Adults Annual Report

Mrs Geary presented the report. The Board understood that the service is not directly commissioned by the CCG, but is a mainstream service that is embedded into the contract and it is expected that Trusts will provide this service as part of their portfolio.

Mr Sweet commented that he thought it was an excellent report, but he was concerned about the proposal to move the team to Malton. Mrs Geary explained that the purpose of moving it to Malton was to ensure that the team was together, and ensure that issues raised in Scarborough and York were easily accessible by the whole team.

Mrs Geary added that at present recruitment is underway for the appointment of a Lead Nurse in Safeguarding. The intention is that adult and child safeguarding will be brought together, this will be led by a Lead Professional for Safeguarding who will take responsibility for the whole safeguarding agenda.

Mr Crowley added that there are some issues to resolve around child safeguarding specifically because there are differences on each site.

Mr Sweet asked about the PREVENT agenda and how it would be delivered. Mrs Geary confirmed that it was a challenging agenda and negotiations are underway with the commissioners.

The Board **noted** the report and the work that has been undertaken by Nicola Cowley.

14/066 Director of Infection Prevention Control quarterly report

Dr Turnbull presented the report and highlighted that it has been 24 days since York had a case of C- Diff and 13 days for Scarborough and 63 days since there was a case in the community.

During April this year there have been 2 cases of C-Diff and the Trust has an annual trajectory of 59.

Dr Turnbull added that he is reviewing any occasions where a consultant is not complying with the prescribing guidelines below 75% of the time.

The Board noted the report and raised their concern around the level of training being undertaken. Dr Turnbull advised that it was concerning and advised that work was underway to improve compliance. He added that hand hygiene days were being run, the hard group to reach are the doctors, but it is being mandated for doctors to attend training sessions.

The Board **approved** the report.

14/067 End of Life Care Pathway

Dr Saxby was invited to give her presentation to the Board. Dr Saxby gave her presentation on end of life care and how the organisation manages the service. She reflected the developments that have been undertaken over the last 12 months since the removal of the Liverpool Care Pathway. Dr Saxby talked to the Board about the number of patients that still are not able to have their last days of life in their preferred location.

The Board discussed the comments made about the number of people who die in institutions rather than at their preferred location and Mr Proctor asked if organisations were better at determining what the progress of the patient might be would that enable more people to be able to have their last days of life in their preferred location. Dr Saxby commented that there were some conditions where it was difficult to determine last stages of life. Dr Saxby agreed that if GPs and hospital doctors were enabled to have these conversations with patients earlier in their disease (i.e. participate in Advance Care Planning discussions) then we would better be able to identify preferred place of care and suitable ceilings of care for some patients. She did confirm that discussions around the final days of life should always be held with the family and the patients to ensure they were fully involved in the decision-making process.

Mr Ashton asked how many patients are aware that they are reaching the end of their life when they are in the final days. Dr Saxby commented that in St Catherine's Hospice those conversations are held in advance of a patient becoming unaware of their circumstances. In hospital, more patients are less aware at the time that discussions about end of life and care plans are commenced. In that case, those discussions should always happen with the family. She added that the care plan would start when the patient has received all the care that is possible to manage the illness and deterioration is still continuing.

Mrs Adams added that she felt that there was a role for Dr Saxby in the community to educate the GPs and others. Dr Saxby explained that St Catherine's Hospice does already have a large education programme which works in the community.

The Board thanked Dr Saxby for her presentation and noted that the Governors had already received a similar presentation.

The Board concluded that the right developments were being made and the progress was good and would lead to an excellent system that will support our patients and relatives at a difficult time of life.

The Chairman would confirm the adherence to national guidance that a Non-Executive Director is nominated as the lead lay person for end-of-life-care on the Trust Board.

14/068 Finance and Performance Committee

Mr Sweet referred to the notes from the committee meeting and highlighted the progress being made around the acute strategy.

He asked the Board to note that the efficiency target had been achieved. He added that for 2014/15 the CCG had agreed that there would not be a 4% efficiency target applied to the community services. He added that the Committee will be receiving additional information about the rules of recruitment and the achievement of directorates around the efficiency agenda. Mr Sweet added that the Committee received an internal audit report which gave significant assurance to the efficiency systems in place. It gave the Committee additional assurance.

Mr Sweet asked Mr Bertram if he would explain the efficiency target for 2014/15. Mr Bertram explained that the initial target was suggested as £27.5m. Mr Bertram added that following three specific developments the target has been adjusted down to £24m, which is broadly the same target as in 2013/14.

The three specific adjustments were:

a) The progression of negotiations on the contract has removed the 4% efficiency requirement from community services. This has been removed as it would be counter to the intentions of the CCG to develop these services. This releases approximately £1m from the programme.
b) The efficiency team has been able to convert £1m from non-recurrent to recurrent savings in conjunction with Directorates.
c) As a result of the national pay settlement, there is £1.5m that can be applied to the target.

Mr Bertram advised that he had written to Monitor in advance of the recent Annual Plan Review discussion confirming that our efficiency target was 5.8%.

In terms of the plans for 14/15, at present these are well progressed and there are a significant number of plans to deliver the target. This does not yet total 100%. Work continues to ensure plans are in place to deliver the full programme. Mr Bertram added that the continued delivery of the efficiency target year-on-year is becoming more difficult

for all Trusts and that he expected the 2013/14 review of NHS performance will show a significant number of Trusts that have not achieved their targets. He reminded the Board that it was exceptional work by all those involved to achieve the 2013/14 target. The Board **agreed** with the comments made by Mr Bertram.

Mr Crowley asked if the expenditure controls put in place towards the end of the year were being monitored for their effect. Mr Bertram confirmed that expenditure was monitored and it was noted that there was a downward trend towards the end of the year.

Mr Sweet drew the Board's attention to the comments in the notes around the access performance. He congratulated the Emergency Department on their performance, particularly around achieving the self-imposed "type 1" target at York. Mr Proctor added, however, that since Easter there had been deterioration in performance. The escalation area in Scarborough has been closed to make way for the development of Maple 2. In York the escalation area was closed in March. The Trust experienced a big spike in admissions on Good Friday and at present the Trust is on the upper control limits and at present the Trust is working towards recovering. The perfect week described by Mrs McGale will help the Trust to understand how good performance in Scarborough could be.

Dr Turnbull added that there had been difficult decisions around diversions to other organisation over the last few weeks and the Trust has been on amber or red alert during most of that time.

Mr Sweet also drew the Board's attention to the comments around delayed transfer of care; he advised that the City of York was one of the worst performers in this area. Mr Proctor commented that it was unfair to suggest that the delays were just about waiting for care packages. Mr Proctor referred to a case study that he would at some stage like to present to the Board. It relates to a patient who had a discharge planned for day 9 and was actually discharged on day 200+. Mr Proctor advised that on occasions the delays are due to the patient or the relatives rejecting the offer of alternative care when there is no clinical reason for the patient remaining in hospital, when this is not their first choice of accommodation. At this point the delay becomes an NHS delay. In future, where a patient does not clinically need to be in hospital, and the relatives or patient have rejected the alternative care proposed because it is not their first choice, consideration is being given to moving the patient out of hospital and into temporary care accommodation until their first choice care becomes available.

Mr Sweet drew the Board's attention to the comments in the notes around CQUIN. He advised that there had been a number of CQUIN failures this year, but these had been addressed as part of the concluding contract negotiations for 2013/14. Mr Sweet added that the CQUIN targets for 14/15 had not as yet been confirmed.

The Board discussed the implications of the Duty of Candour. Dr Turnbull added that when a serious incident is presented to the SI Group he expects consideration to be given to ensuring the Trust has satisfied the duty. The Duty of Candour relates to moderate or severe harm to patients and the Trust will be obliged to advise a patient when such an event has occurred. The Trust has a "being open" policy, which does dictate that staff will be open and honest with patients about incidents.

The Board asked if Mrs Geary and Dr Turnbull to provide a report to the Board in the near future on the clarity of the policy and the duty.

Action: Dr Turnbull and Mrs Geary to present a paper providing further clarity on the duty and current policy on being open.

Mr Sweet commented on the first-to-follow-up discussions and Mr Bertram advised that the CCG had been pressing for even tighter first-to-follow-up ratios for the new year, but Mr Bertram continued in negotiating the requirement out of the contract. Dr Turnbull added his frustration around the use of such a crude tool as a single ratio. He explained that patients are assessed in clinic and the need for follow-up will depend on clinical need.

Mr Crowley commented that the Trust has the conditions register and must continue to monitor compliance against the register.

Mrs Rushbrook added that the ratio was simply about a pure number of first appointments against the number of follow-ups and does not take into account the conditions or what the clinician's expertise is or the pathway management.

Mr Bertram confirmed that it was helpful in planning and setting work from an accounting perspective, but nothing more.

Mr Sweet referred to the finance report and confirmed that the Trust had incurred £2m of penalties related to C-Diff and 18-week performance. He added that the expectation is that these penalties will not be incurred in 2014/15. He advised that the capital expenditure was marginally behind the plan at the end of the year but that the variance was not considered material on Monitor's assessment.

Mr Sweet asked Mr Bertram to comment. Mr Bertram commented that the provisional year-end reported position for 2013/14 is a deficit of income against expenditure of £0.955m. This position includes a fixed asset impairment charge of £3.693m (non-cash backed) associated with Trust capital schemes and the need to write down IT assets transferred to the Trust under the TCS initiative. Excluding the technical impairment charge, the Trust has returned a surplus of income over expenditure of £2.738m.

He added that it is important for the Board to understand the underlying performance assessment, stripping-out the technical impairment charge and further exceptional items relating to donated asset income and restructuring costs (MARS and Redundancy). This position is also used by Monitor for their assessment of the Trust. This underlying performance position is assessed as a £3.122m surplus of income over expenditure.

In relation to the contract income position, the final year-end agreements have been reached with all commissioners, except for Harrogate and Rural District CCG and Hambleton, Richmond and Whitby CCG. These positions are reflected in the above performance. These are negotiated positions and cover all contract matters. The positions are inclusive of contract penalties levied by the CCGs, majority CQUIN delivery, fair payment for follow-up work done in line with the conditions register above the ratio of 1:1.5 and include final settlement for disputed activity and data validation checks.

In the case of HaRD CCG the total contract value is £4.5m. The Trust believes the year-end value of activity less penalties totals £4.7m but the CCG maintains the position is £4.5m. Negotiations continue around this position but clearly the settlement will not materially impact on the reported overall position.

The Board **noted** the report from the Finance and Performance Committee.

14/069 Staff Survey

Mrs Holden presented the report. She advised that the Board needed to look at this in context. This version covered the whole organisation and previous years did not.

The Board was concerned that 22% of staff reported that they had experienced harassment and bullying. 36% of staff reported experiencing work-related stress and only 61% of staff would recommend the Trust.

Mrs Holden informed the Board that the results of the staff survey were disappointing and there are clear areas for improvement. She outlined that it was important to appreciate the context of the report and recognize that this was the first survey where the totality of responses from across all sites and areas were being represented.

Mrs Holden outlined to the Board the actions which had already been undertaken to address the issues.

The corporate team had already agreed to spend time out discussing improving our engagement across the wider organisation, given mergers and acquisition research suggests a dip in morale around 18 months we recognize the need to develop a plan to increase senior managerial profile and presence.

HR managers are meeting with directorate managers to develop directorate action plans to address local issues identified within the survey to demonstrate impact as the staff survey appears at odds with how patient's experience their care.

Mrs. Holden emphasised the need for us to keep a balanced view recognising that we have to counter negative press, low staff morale and focus constructively on discussing the great care and services we do deliver and ensuring that our approach is balanced in terms of recognising we can always improve but we do have a solid foundation on which to move forward. The Trust has also invested in the development of 'fairness' champions to work with staff to address issues where they believe that they are not being managed in a fair manner; the hope is that this will improve staff engagement early to resolve issues informally. We are also launching the staff friends and family test which will give the organisation a greater sense of how staff feel on a regular basis, it will also provide an opportunity to target interventions.

Mrs Holden added that the appraisal section was also an interesting response. In the past the concern was around appraisals not being carried out, but now the concern is about the quality of the appraisals. She added that specific work on key leadership positions is being undertaken and ensuring there is more organisational and corporate visibility of the leadership of the organisation.

Dr Turnbull added that he was concerned that there was a lack of access to hand washing facilities.

Mr Crowley added that he was very disappointed by the results, but if there was a comparison over time, it had to be recognised that the organisation is much more complex and the Trust is now in the second year of integration. There were rapid improvements made before the Trust integrated. He added that through the media everyone is encouraged to not to focus on the good in the NHS. Mr Crowley felt the Board should regard the report as settling of the integration and should be used as a baseline position in the future.

Mr Proctor added that in 2011, prior to the Scarborough Hospital becoming part of York Teaching Hospital, the score for those recommending the Trust was only 30%.

Mrs Holden referred to the harassment and bullying and explained that there would be a review with staff side on the implementation of the sickness absence policy. The anecdotal evidence is that the implementation of the policy at the Scarborough site has been received by some as harassing and bullying, in the main because people are being held to account more tightly than in the past.

The Board discussed the findings and discussed the level of stress being expressed. It was noticed that nationally all organisations are reporting higher levels of stress being expressed by staff.

Mrs Adams added that the visibility of the senior team was very important and echoed the commitment around the listening exercise.

The Board noted the comments and the work being undertaken.

14/070 Patient Safety Strategy

It was agreed that the discussion about the strategy would be postponed until the May Board meeting.

Action: to include the strategy on the agenda for the May meeting.

14/071 Report of the Chairman

The Chairman drew the Board's attention to his report. He advised that it has now been confirmed publicly that Bootham Park Hospital would be vacated shortly by the Mental Health Trust.

He referred to the current issues at Hull Hospital. He advised that there is an interim Chief Executive and interim Chairman in place at present. He suggested that the Trust should continue to focus on the specific clinical alliances that are under development with Hull, despite the level of uncertainty caused by their Board changes and their imminent disappointing CQC Report.

Mr Rose referred to the recent public meeting in Bridlington. He advised there were about 50 people attending, including the CCG, Mental Health Trust and some of our Governors.

Mr Crowley added that there was a small group of critics at the meeting who were seeking to reinstate old debates, and their concerns were discussed and their questions answered. Mr Rose advised that the town councillor who attended the meeting was very pleased with the progress and work that had been put in by the Trust.

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

14/072 Report of the Chief Executive

Referring to his report, Mr Crowley highlighted that work was underway around the planning of the Open Day. He advised that a group had been formed to discuss the development. He asked if a Non-executive Director would like to be involved in the development.

Mr Crowley also referred to the development of the strategic plan which is currently underway and advised that the plan would be presented to the June Board. Governors and NEDs will be involved.

Action: Strategic Annual Plan to be presented to the June Board.

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

14/073 Submission to Monitor Quarter 4

The Board of Directors reviewed the draft submission to Monitor and **approved** the papers.

14/074 Business Cases

The Board was asked to consider and approve the following business case:

14/074.1 2013/14 – 148 Elderly Directorate Consultant Investment

Professor Willcocks summarised the business case and supported the approval of the case by the Board of Directors.

The Board of Directors considered and **approved** the business case.

14/056 Next meeting of the Board of Directors

The next meeting of the Board of Directors will be held in the Boardroom, York Teaching Hospital, on 28 May 2014

14/057 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
14/040 Open and Honest programme	Mr Proctor to present the pilot document to the Board for review and a final decision about the Trust's involvement in the programme would be made at that stage.	Mr Proctor	April/May 14
13/119 Scheme of Delegation (September)	To consider increasing the authority of the Capital Programme Committee to be undertake during the next stage review	Mr Bertram/ Mrs Pridmore	June 2014
13/120 Quarterly HR Report (September)	To circulate the annual report from the Workforce Strategy Committee	Ms Hayward	By December 2013
14/055.1 2013 - 14/127: Bridlington Orthopaedic Elective Surgery	Evaluation Report pending the release of further capital	Mr Bertram	November 14
14/041 Patient Experience - Matron refreshment	Update the Board on the progress of the introduction of the new nursing structure	Mr Proctor/ Mrs Geary	December 14

Action list from the minutes of the 30th April 2014

Minute number	Action	Responsible office	Due date
14/063 Quality and Safety	Include in the monthly safer staffing report in the Chief Nurse report	Mrs Geary	June 14
14/063 Quality and Safety Committee	Provide the six monthly acuity audit report.	Mrs Geary	June 14
14/064 Annual Complaints Report – complaints, concerns and compliments	Present the results of the listening exercise with the Patient Experience Team to the Board of Directors	Mrs Geary	May 14

Minute number	Action	Responsible office	Due date
14/068 Finance and Performance Committee	Present a paper providing further clarity on the duty of candor and current policy on being open	Dr Turnbull and Mrs Geary	June 14
14/072 Chief Executive Report	Strategic Annual Plan to be presented to the Board of Directors	Mr Crowley Mrs Holden	June 14

Blank page

C

York Teaching Hospital NHS
NHS Foundation Trust

Quality & Safety Committee – 20 May 2014 York Hospital Boardroom

Attendance: Libby Raper, Jennie Adams, Philip Ashton, Beverley Geary, Alastair Turnbull, Liz Jackson

Apologies: Anna Pridmore

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last meeting notes 22nd April 2014**		Accepted as a true record. The Committee discussed the issue under matters arising regarding the work in place to chase up statements around compliance of NICE guidance. AT confirmed that this also included NCEPOD. Minutes from Clinical Standards Committee will be circulated to the Committee. The Committee reviewed last months discussion re Estate issues relating to Quality and Safety. AP to action the scheduling of discussion. Community dashboards still not fully updated. BG to action.	AT confirmed that this is discussed and actioned at Clinical Standards Committee.	
2	**Matters arising**		BG briefed the Committee regarding recent developments around Safer Staffing. The bringing forward of the national timetable will exert additional pressure on our system, with the requirement to upload data by 10th June for simultaneous national publication on NHS Choices site on 24th June. The Committee expressed significant concern over the timetable, particularly	BG outlined the revised approach to ensure compliance	BG to brief the Board

	Agenda Item	AFW	Comments	Assurance	Attention to Board
	Matters arising continued		in relation to this Trusts scheduling of Board and Committee meetings.		
3	**Integrated Dashboard**	**AFW** MD3,4,5 COO1 CN1,3,4,5 **CRR** 44,20	**Linked with Item 6** The Committee reviewed the Never Events, which AT explained had now risen to 2 for the period. The Committee supported the proposal to fast track Trust awareness of such occurrences. Serious Incidents. The Committee discussed both this months and last months SIs. BG explained the developments internally regarding consistency of Pressure Ulcer reporting CDiff. The committee noted the current trajectory. The committee noted the most recent mortality data, and discussed the need to continue to understand any difference across sites - with benchmarked targets to reflect this. Walkrounds, the Committee confirmed its intention to understand any emerging themes from walkround cancellation, and requested that the reason be noted in the papers. Incidents requiring sign off at Directorate level – then Committee noted the unfortunate levelling off of the trajectory. The committee discussed the Stethoscope charts, produced by CHKS	AT assured that all Surgeons will be made aware of these incidents prior to the investigation being completed so not to delay learning. The Committee noted the work of the Pressure Ulcer Steering Group The committee noted the useful benchmarking of this information	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
	Integrated Dashboard continued		Friends and Family. The committee asked that the most recent data be presented, ideally in the committee papers, but certainly to Board. The committee noted the very useful breakdown of information by ward. AT briefed on the most recent NRLS information. The committee noted the improvement in recorded reporting, and noted that further work was required at both main sites.		
4	**Draft Quality Report**		As agreed at last months Board, comments from Board members had been collated and subsequently discussed by the Committee with Diane Palmer. The Committee established 4 principles to underpin the approach: Demonstrate Continuous Improvement, ensure appropriate consistency of focus, benchmark wherever possible and align with the Patient Safety Strategy. The Committee reviewed the achievability of a number of priorities, including 12 Hour review, IPC and a cdiff target. The committee asked for additional patient experience measures to be included, for example a promoter score in the top quartile. BG to discuss with the patient experience group and advise as to the appropriate wording.		AT and BG to update Board
5	**Supplementary Medical Director report**	**AFW** MD2 **CRR**	The Committee discussed how the reduction in Falls is on the trajectory. A new policy, assessment tool and implementation plan has	The committee was briefed on the ongoing focus of the Falls Steering Group.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
		4	been developed and looking to be launched summer 2014 possibly by using a Rapid Spread approach.		
6	**National Reporting and Learning System**		**Linked with item 3**		
7	**Patient Safety Strategy**		The Committee had a useful and detailed discussion on this item, noting that it is the first time the Trust has developed such a strategy. It was agreed that further work would be appropriate to develop identifiable outcomes, link sections to ongoing areas of improvement activity, and more clearly reference other key Trust Strategies.		AT to give an update at Board and to present the finished Strategy the following month.
8	**Quarterly Summary of the PIM meetings**		Noted but not discussed, due to time pressure.		
9	**Supplementary Chief Nurse report**	**AFW** CN1,3,5	**Discussed in item 2**		
10	**Any other business**		None		
11.	**Date and time of next meeting**		The next meeting will be held on 17th June 2014 13:30 – 15:30 LaRC Conference Room		

York Teaching Hospital NHS
NHS Foundation Trust

C1

Patient Safety and Quality Report

May 2014

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

29

Index

Executive summary

- There was one 'Never Event' identified in the Trust at York Hospital during April.

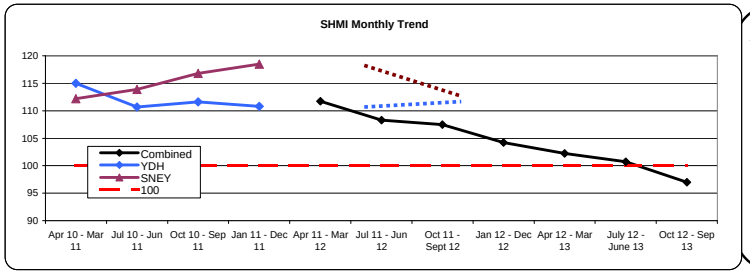
- 18 Serious Incidents (SIs) were declared across the Trust, of which seven related to patient falls and six related to pressure ulcers.

- Four cases of c. diff were identified in April.

- The SHMI for the period October 2012 to September 2013 is 97..

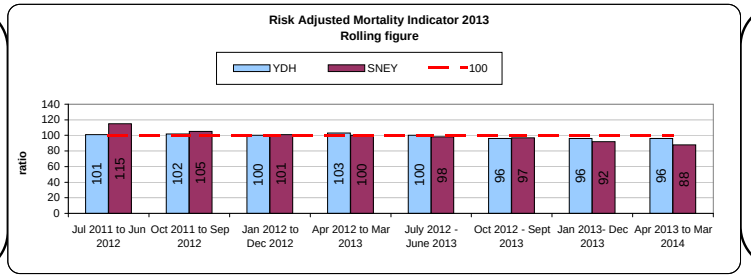
Patient Safety

Mortality



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

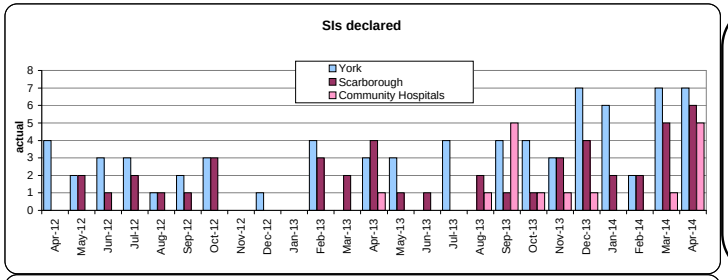
Data source: Information Centre



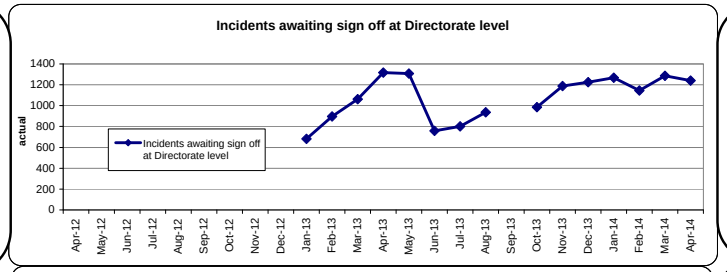
The Risk Adjusted Mortality Indicator (RAMI) for the reporting period April 2013- March 2014 has remained constant for York Hospital compared to the last two reporting periods. At Scarborough Hospital there continues to be a reduction.

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

Measures of Harm

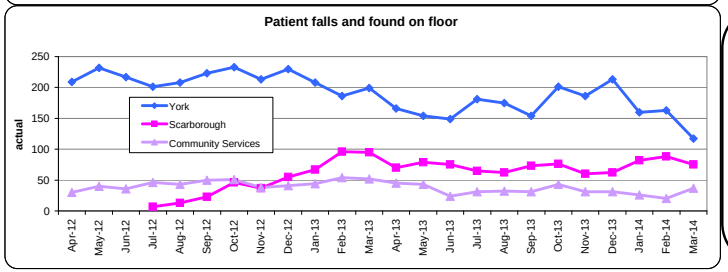


There were 18 serious incidents (SIs) reported in April. Seven from York Hospital; two falls and two category 4 pressure ulcers and one category 3 pressure ulcer, one wrong site surgery, one delayed diagnosis. Six from Scarborough/Bridlington Hospital; three falls, one wrong diagnosis, one staff involved with the Police and one absconded patient. There were five SI from the Community; one category 4 pressure ulcer, two category 3 pressure ulcers, two falls.



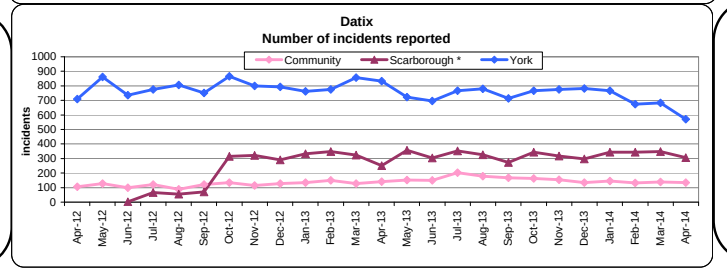
At the time of reporting there were 1240 incidents awaiting sign-off by the directorate managers.

Data Source: Datix



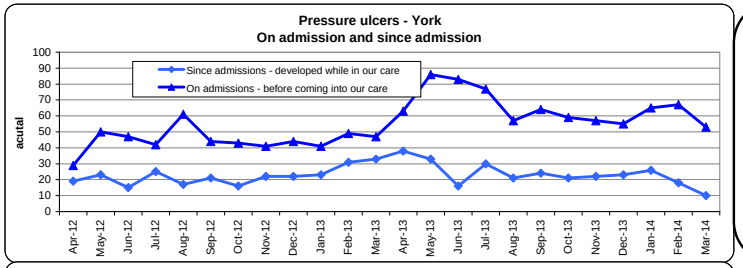
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. 117 patients fell and were found on the floor at the York site, 75 patients at Scarborough and 37 patients within the Community Hospitals in March.

Data Source: Datix



The total number of incidents reported in the Trust during April was 1012. 570 incidents were reported on the York site, 307 on the Scarborough site and 135 from Community Care/Hospitals.

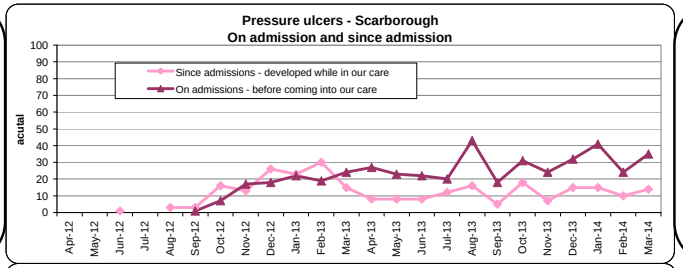
Data Source: Datix



During March a total of 10 pressure ulcers were reported to have developed on patients in York Hospital.

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

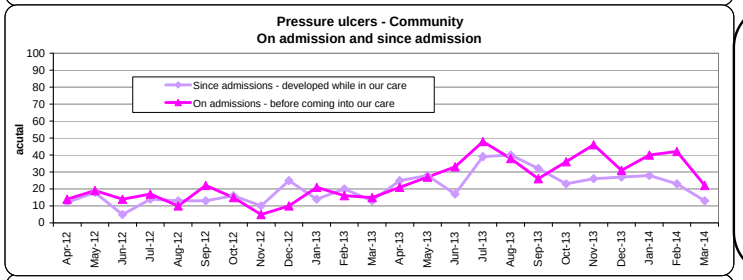
Data Source: Datix



During March a total of 14 pressure ulcers were reported to have developed on patients in Scarborough Hospital.

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

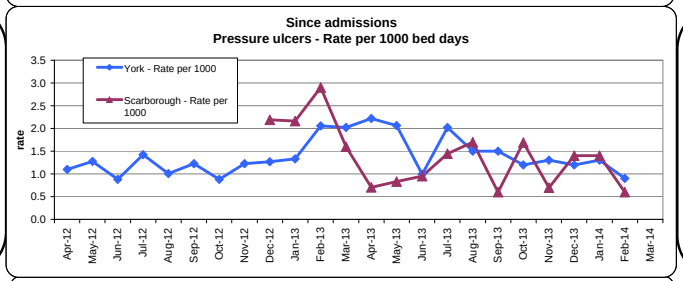
Data Source: Datix



During March a total of 13 pressure ulcers were reported to have developed on patients in our community hospitals or community care.

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

Data Source: Datix

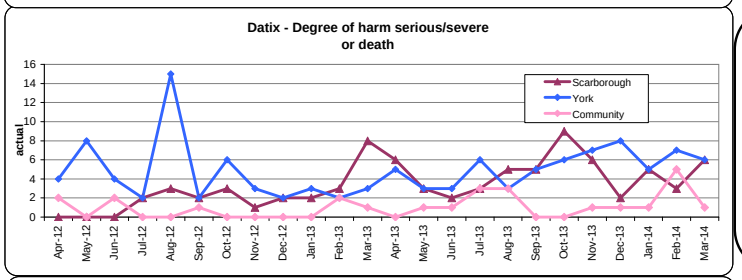


The rate of pressure ulcer development in York Hospital in February was 0.9/1000 bed days.

The rate of pressure ulcer development in Scarborough Hospital in February was 0.6/1000 bed days.

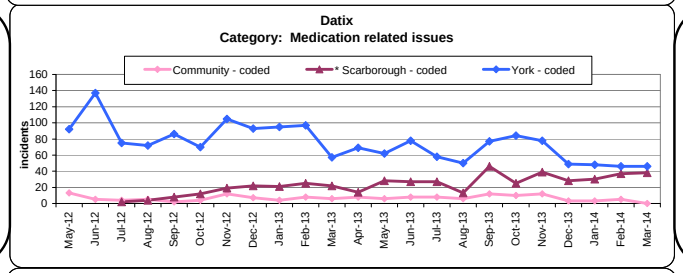
The March data is not available at the time of reporting.

Data Source: Datix



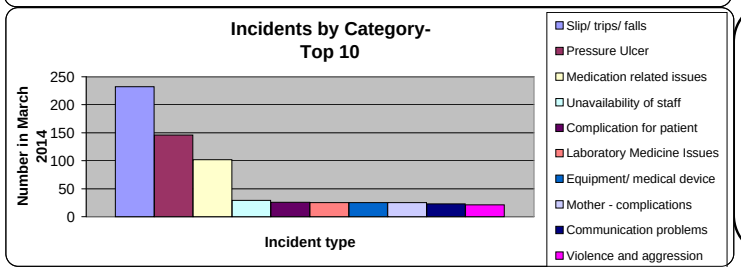
During March a total of 13 patient incidents were reported which resulted in serious or severe harm.

Data Source: Datix



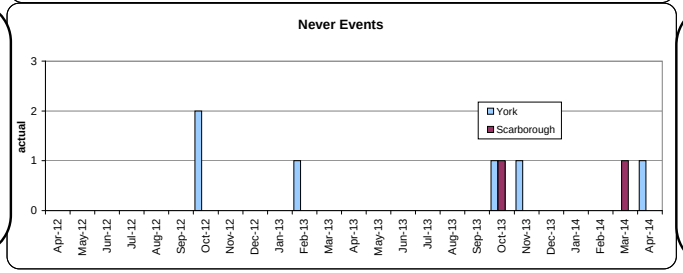
During March there was a total of 84 medication related incidents reported, although this figure may change following validation.

Data Source: Datix



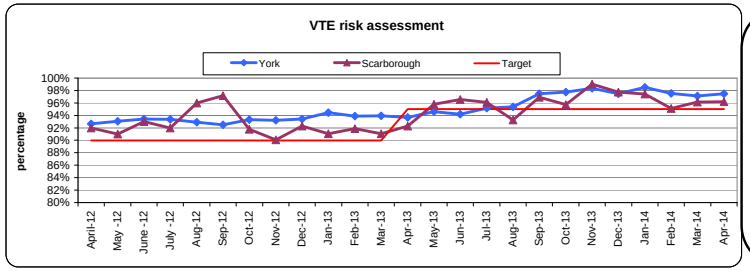
During March, 232 incidents were reported as a slip/ trip/ fall, 146 pressure ulcers and 102 medication related incidents.

Data Source: Datix



There was one Never Event declared at York in April relating to wrong surgery site.

Data Source: Datix



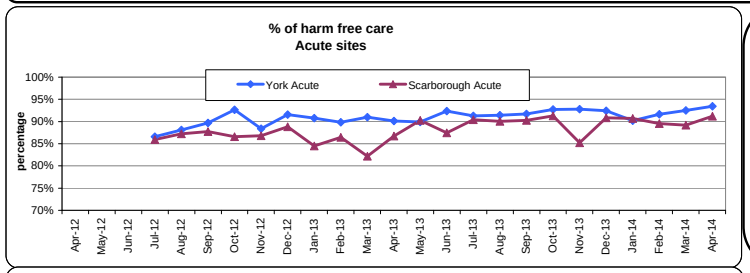
The target of 95% of patients receiving a VTE risk assessment has been maintained on both sites during April.

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

Data Source: Systems & Network Services

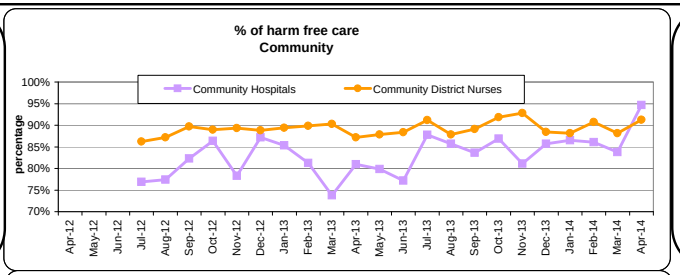
Safety Thermometer

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



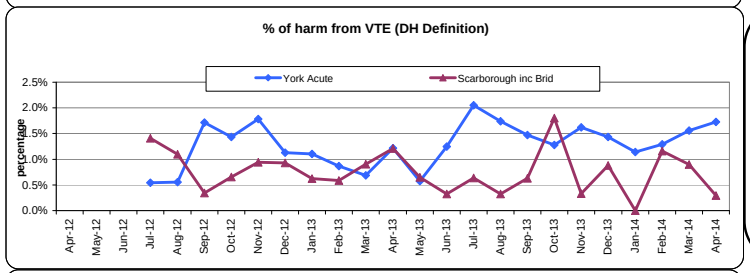
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In April 93% of patients at York and 91% at Scarborough were audited as care 'free from harm' on the acute hospital sites.

Data source: Safety Thermometer



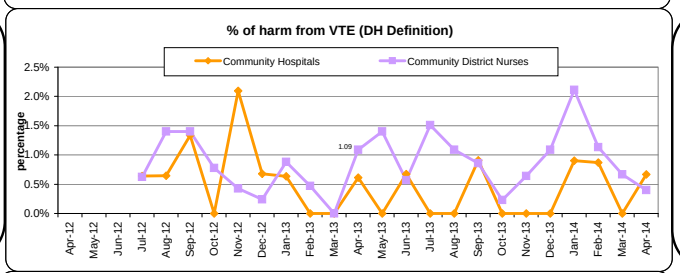
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In April 95% of patients in our community hospitals and 91% of patients in our care in the community received care 'free from harm'.

Data source: Safety Thermometer



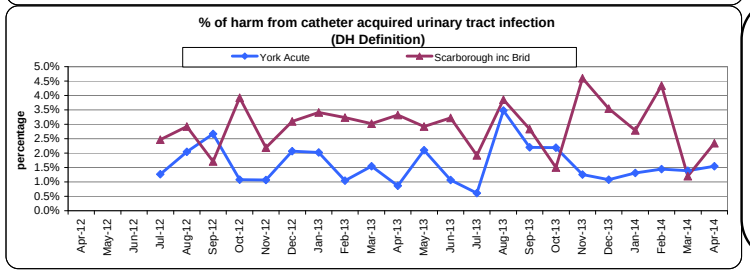
The percentage of patients affected by VTE as measured by the Department of Health (DH) definition, monthly measurement of prevalence, was 1.7% in York and 0.3% in Scarborough acute hospitals in April.

Data source: Safety Thermometer



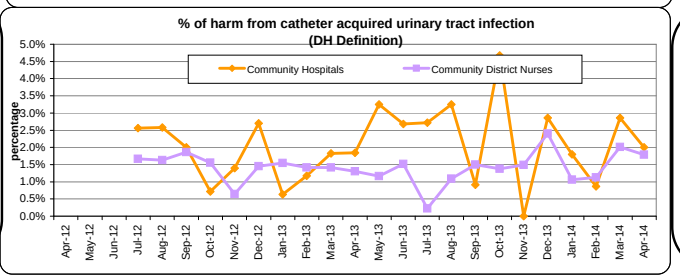
The percentage of patients affected by VTE as measured by the DH definition, monthly measurement of prevalence was 0.7% in community hospitals and 0.4% in community care in April.

Data source: Safety Thermometer



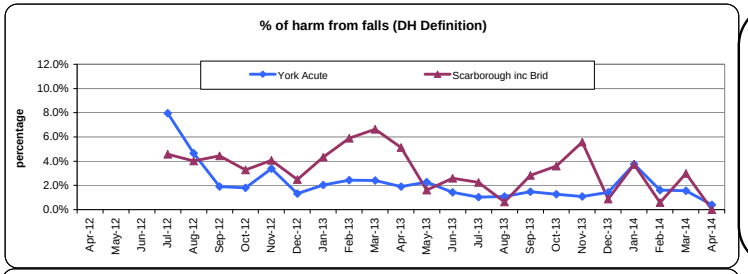
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 1.5% in York and 2.4% in Scarborough acute hospitals in April.

Data source: Safety Thermometer



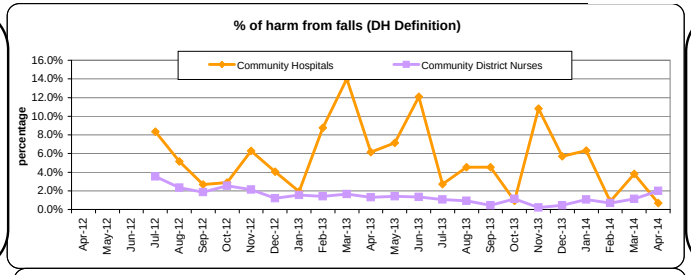
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 2% in community hospitals and 1.8% in community care in April.

Data source: Safety Thermometer



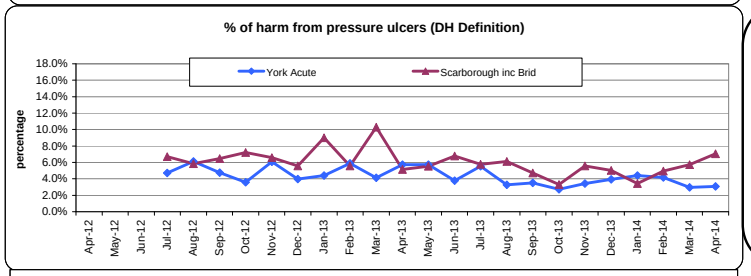
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 0.4% for York and 0 for Scarborough acute hospitals in April.

Data source: Safety Thermometer



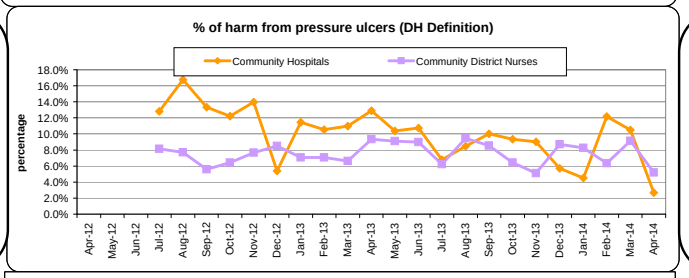
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 0.7% in community hospitals and 2% in community care in April.

Data source: Safety Thermometer



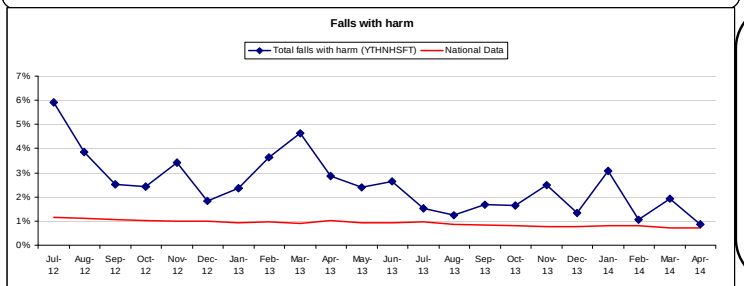
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 3% for York and 7% for Scarborough acute hospitals in April.

Data source: Safety Thermometer



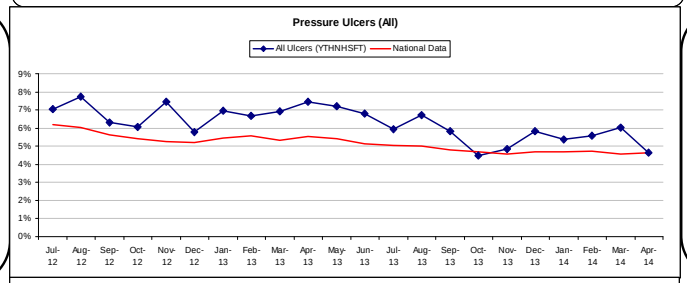
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 3% in community hospitals and 5% in community care in April.

Data source: Safety Thermometer



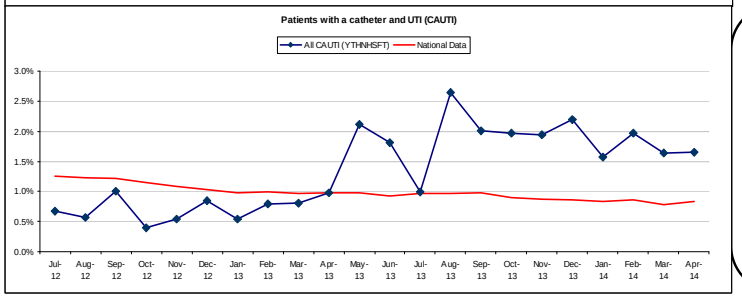
The Trust wide total number of falls with harm as measured for the Safety Thermometer indicates the Trust to be almost in-line with the national average.

Data source: Safety Thermometer



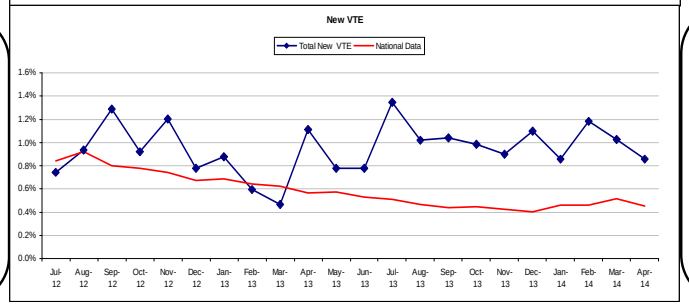
The Trust wide total number of pressure ulcers as measured for the Safety Thermometer is in-line with the national average.

Data source: Safety Thermometer



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

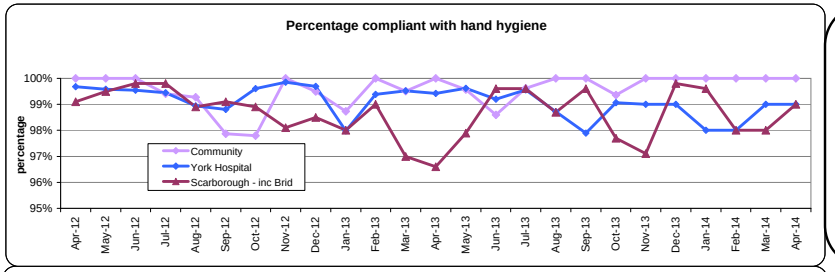
Data source: Safety Thermometer



The Trust wide total number of patients with a new VTEas measured for the Safety Thermometerr emains above the national average.

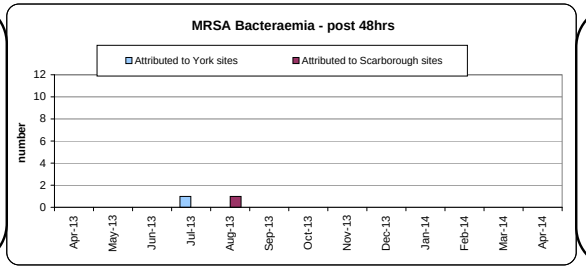
Data source: Safety Thermometer

Infection Control

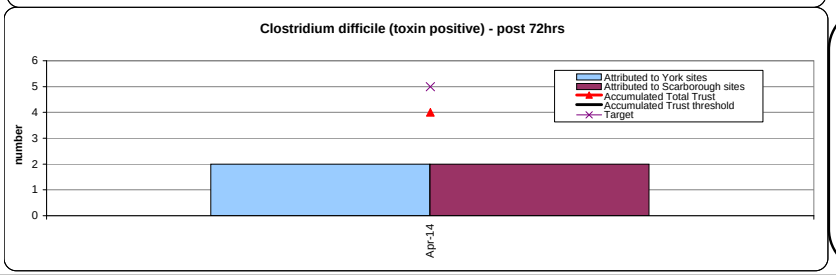


Hand hygiene compliance for York was 99% and Scarborough was 99% in April whilst the Community Hospitals achieved 100%.

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

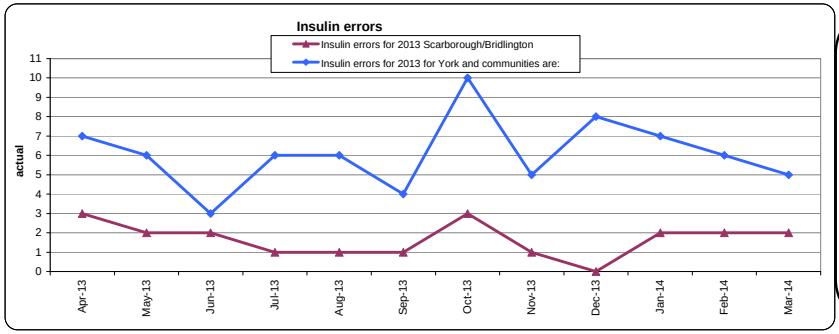


There were no patients in the Trust identifed with healthcare associated bacteraemia during April.



Four cases of c. diff were identifed in the Trust during April.

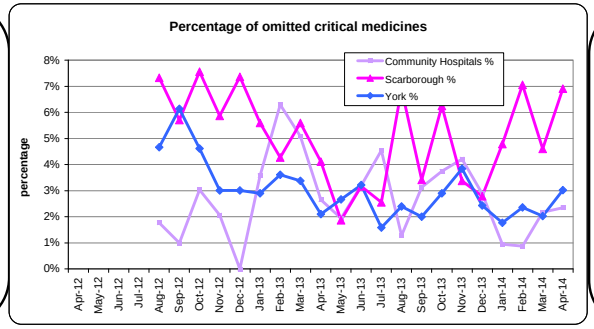
Drug Administration



There were five insulin related errors reported at York and two at Scarborough in March.

The data for April is awaiting validation.

Data Source: Datix

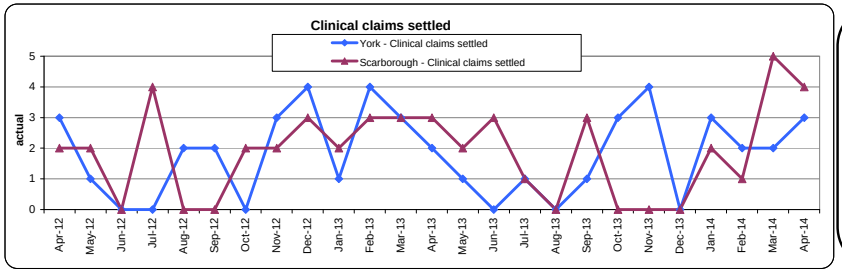


Whilst the number of omitted critical medicines has decreased in the last month at all sites.

Data source: monthly prevalence

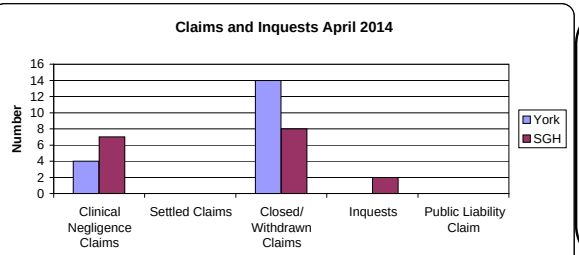
Medicines Incidents	Month: April 2014				
	No of incidents reported	Site			
		York Hospital	Scarborough Hospital	Community Hospital	Community Care
Prescribing	29	21	6	**	2
Preparing drugs	9	4	4	**	1
Dispensing	9	5	3	**	1
Administering	36	19	13	**	4
Monitoring	1	1	0	**	0
Providing advice on medicine errors	**	**	**	**	**
Total errors	102	60	34	**	8

Litigation



In total, seven clinical claims were settled in April, three on the York site and four on the Scarborough site.

Data Source: Risk and Legal Services



In April, 11 clinical negligence claims were received. 22 claims were withdrawn.

The were two Coroner's Inquests.

Data Source: Risk and Legal

Patient Safety Walkrounds

Date	Location	Participants	Actions & Recommendations
Monday 28th April 2014	Maxillio Facial Clinic, OPD, Scarborough Hospital	Diane Palmer- Deputy Director of Patient Safety Jennie Adams – NED Gemma Cuss – DM Jim Taylor - CD	• Room is very warm, a portable air conditioner was used last Summer but this is less than ideal. • Printer and filing cabinets are in the Consultants room where clinical procedures are carried out. • Specialist Orthodontic clinic equipment is in the Max-Fax room, which makes the room appear cluttered. • Waiting area is in a long corridor line. • During the Winter, patients are cared for in a variety of wards due to the bed demands. In Spring/ Summer the patients are on Ash Ward and this works very well as the nursing staff have Max-Fax knowledge and medical staff know where to find the patients. • Many of the Max-Fax patients are very elderly / frail and are not fit for travel to other sites of the Trust for example York or Bridlington. • No digital dictation or integration of clinical IT for pathology or radiology results.

Cancelled walkrounds

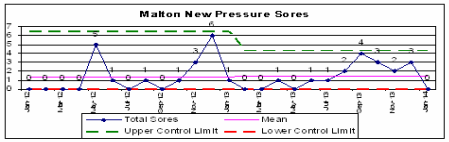
9th April - Theatres/ ITU, Scarborough Hospital
22nd April - Sexual Health, Monkgate Health Centre

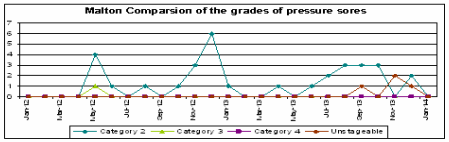
York Teaching Hospital NHS
NHS Foundation Trust

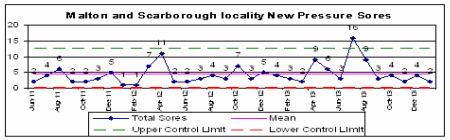
Malton Community Hospital
Patient Safety Dashboard – 20th March 2014

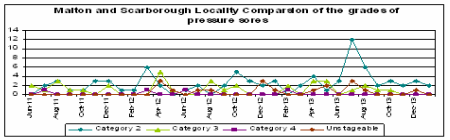
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of incidents reported on - Datix web	17	24	22	25	32	27	20	20	22	21	14	
Number of medication related incidents	1	3	1	1	0	1	1	1	0	0	0	
Number of new clinical litigation cases	0	0	0	0	0	0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

Pressure Ulcers

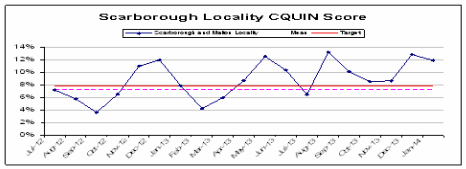


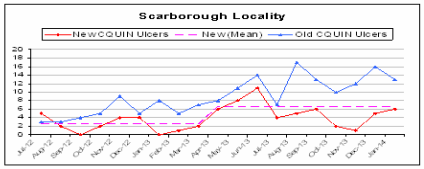




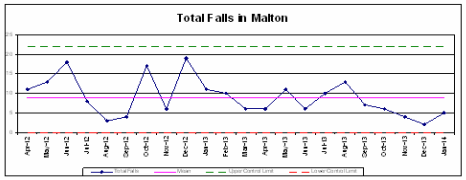


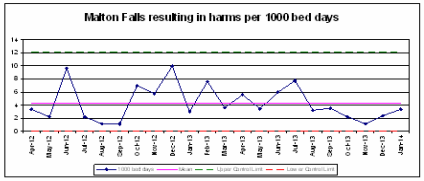
Pressure Ulcer prevalence Malton Community Hospital & South Ryedale & Scarborough Community (CQUIN)





Falls (Datix)



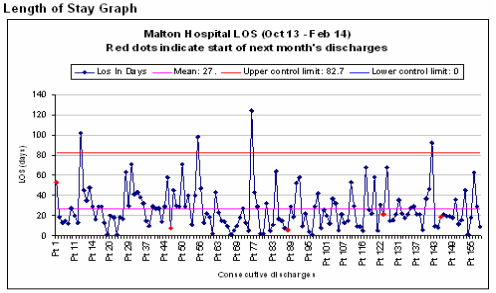


Target of 20 % reduction in falls over 13/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Mean falls with harm per 1000 bed days (Trajectory <3.8 per month)	5.6	3.4	5.9	7.7	3.2	3.5	2.2	1.2	2.4	3.4		

Mean across year so far as of Jan = 3.9

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

Length of Stay Graph



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

Activity	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14	
	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye
Admissions	21	34	19	16	32	49	43	76	19	72	19	69	21	13	20	10	11	22	22	13	15	11		
Discharges	23	14	21	19	30	46	40	77	25	75	22	74	26	20	25	15	12	26	24	15	15	21		
length of hosp stay – mean *previous yr	26.5 *27	30.3 *NR	24.0 *20.1	24.8 *NR	17.3 *9.1	22.3 *NR	17.5 *NR	20.0 *NR	24.2 *NR	26.1 *NR	19.9 *NR	42.5 *6.8	31.8 *11.8	33.1 *14.8	24.3 *15.1	36.8 *22.3	23.9 *15.3	29 *15.5	30 *30.5	39 *16.5	31 *24.5	30 *26.8	*19.9	*22.5

NR=No Record on 'Signal'

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

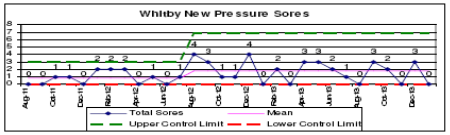
Harm Free Care - Safety Thermometer Prevalence data	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14	
Ward	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye
Overall Ward Harm Free	82%	93%	93%	80%	92%	91%	93%	85%	100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

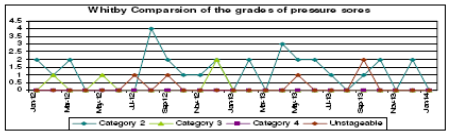
WHITBY Community Hospital
Patient Safety Dashboard – 04th April 2014

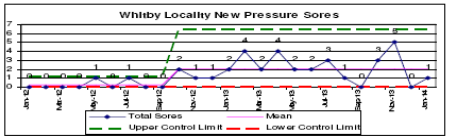
Datix Incident Reporting Whitby Hospital	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan14	Feb 14	Mar 14
Number of incidents reported on Datix web	26	22	19	18	17	14	33	18	11	3	10	
Number of medication related incidents	0	1	3	0	0	0	2	1*	0	0	0	
Number of settled clinical litigation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

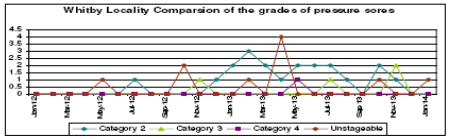
*Zoromorph not signed for

Pressure Ulcers

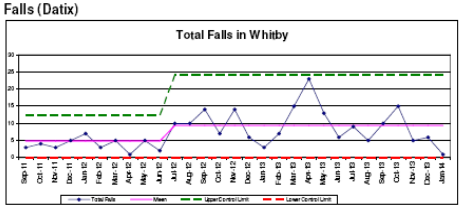


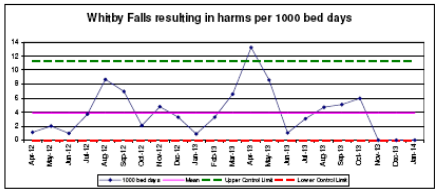






Falls (Datix)





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

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

Mean so far up to Dec= 4.8

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

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

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

Harm Free Care - Safety Thermometer Prevalence data	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14	
	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM
Overall Ward Harm Free	93%	100%	78%	89%	100%	100%	87%	100%	93%	89%	100%	94%	87%	90%	91%	100%	100%	100%	100%	100%	100%	94%
VTE (% of patients with a VTE)	0%	5% (1 new)	0%	11% (2 old)	7% (1 old)	6% (1 old)	0%	0%	7% (1 old)	0%	0%	5% (1 new)	7% (1 old)	5% (1 old)	9% (1 old)	0%	7% (1 old	20% (3 old)	0%	7%	7%	0%
Falls (% of patients who fell)	13% (2 no harm)	10% (2 no harm)	14% (2 low harm)	11% (2 low harm)	57% (1 sev, 3 mod, 4 low)*	12% (2 low harm)	6% (1 no harm)	0%	6% (1 no harm)	0%	0%	6% (1 no harm)	7% (1 mod harm)	0%	0%	7% (1 no harm)	0%	0%	0%	0%	0%	0%
Pressure Ulcers (% of patients with a new PU- CQUIN)	7% (1 cat 2)	0%	0%	0%	0%	6% (2 cat 2)	13% (2 cat 2)	0%	0%	10% (2 cat 2)	0%	0%	7% (1 U)	5% (1 cat 2)	9% (1 cat 2)	0%	7% (1 cat 2)	0%	0%	0%	0%	5% (1 cat 2)
Pressure Ulcers (% of patients with an old PU - CQUIN)	0%	10% (2 cat 3)	7% (1 cat 2)	16% (1 cat 3, 2 cat 2)	7% (1 cat 2)	6% (1 cat 4)	6% (1 cat 2)	5% (1 cat 2)	0%	5% (1 cat 2)	7% (1 cat2)	12% (2 cat 2)	7% (1 cat2)	10% (1cat2, 1 cat 3)	0%	5% (1 cat 2)	0%	0%	0%	13% (2 Cat 2)	13%(2 cat 2)	11% (1cat 1 &1 cat 3)
UTI (ward harms) (% of patients)	26% (4 old)	10% (1 new, 1 old)	14% (2 new)	27% (5 new)	7% (1 new)	12% (2 old)	13% (1 new, 1 old)	21% (4 old)	13% (1 new, 1 old)	5% (1 new)	21% (2 new, 1 old)	6% (1 new)	13% (2 new)	40% (6 new 2 old)	9% (1 old)	10% (1 old 1 new)	7% (1 new)	0%	0%	0%	7% (1 old)	0%

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

RCA feedback and action planning	No RCAs for Whitby site since last meeting

Risk Register

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

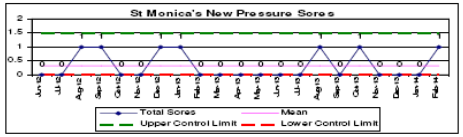
York Teaching Hospital NHS
NHS Foundation Trust

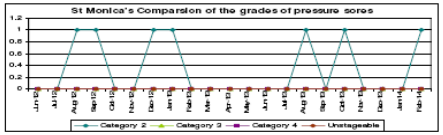
ST MONICA'S Community Hospital
Patient Safety Dashboard – May 08th 2014

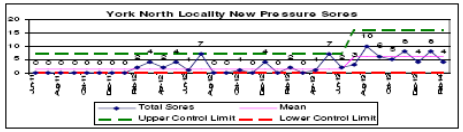
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of incidents reported on - Datix web	2	5	6	4	7	2	3	6	2	4	7	
Number of medication related incidents	0	0	0	3	0	0	0	2	0	1*	0	
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0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

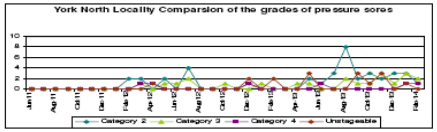
*Pt had two medicine charts in use, marked 1 of 2 and 2 of 2. the pharmacist reviewed his medicine charts and added Warfarin apc' to his second chart (2 of 2). This was already on the first medicine chart (1 of 2) and was being administered from this prescription. The ward staff noticed this and did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

Pressure Ulcers

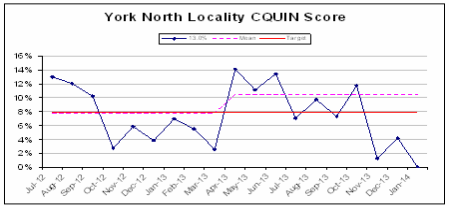


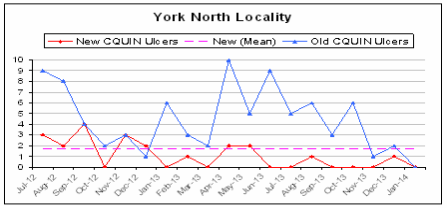




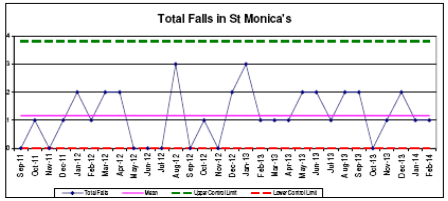


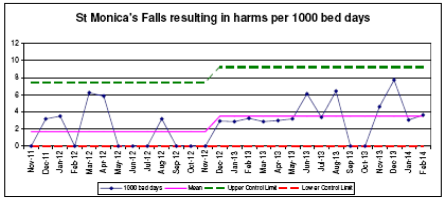
Pressure Ulcer prevalence St Monica's, North Ryedale and North York Community Services (CQUIN)





Falls





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

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

*as of 23/12/13

York Teaching Hospital NHS
NHS Foundation Trust

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

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

*Dr 87%

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

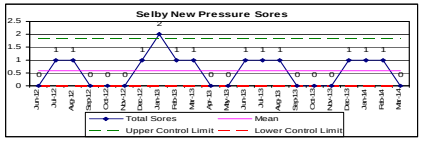
RCA feedback and action planning	RCA for fractured neck of femur following a fall showed that Comfort rounds need to be more frequent for patients at high risk of falling.

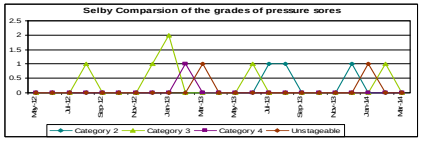
Risk Register

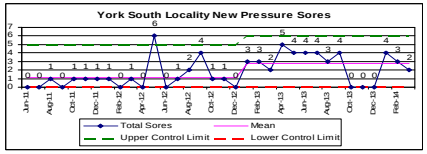
Top 3 Risks on Risk Register	
1.	Lack of storage at St Monica's
2.	Lack of bank staff provision
3.	Staffing establishment

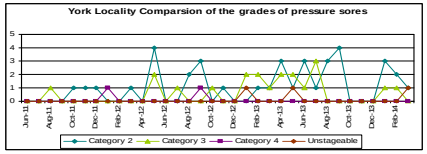
SELBY Locality Inc Selby Hospital
Patient Safety Dashboard – 09th April 2014

Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of incidents reported on - Datix web	15	13	12	20	10	14	17	16	16	11	9	13
Number of medication related incidents	1	0	1	3	0	2	4	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	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	0	1	1	0	0
Number of Critical Incidents (SI's)	0	0	0	0	0	0	0	0	0	0	0	0

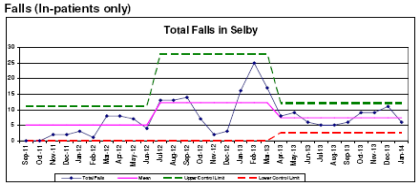


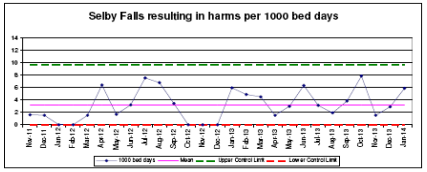






Falls (In-patients only)





Falls target (In patients only)

Target of 20 % reduction in falls over 13/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Mean falls with harm per 1000 bed days (Trajectory <2.32 per month)	1.5	3.0	6.3	3.0	0	4	7.9	1.6	3.1 (3.3)	4		

Deaths & Mortality reviews In Patients only	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of in-hospital deaths (%)	1 (2.6)	3 (5.7)	3 (5.9)	6 (10)	8 (17)	5 (11)	4 (7.4)	6 (11.3)	2 (5.7)	3 (6.5%)	4(9%)	3(7.5%)
Number of morality reviews	1	3	3	4	8	4	4	3	1	2	2	2

Activity	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Admissions to Hospital	39	55	48	61	43	45	63	52	37	41	47	40
Discharges from hospital	39	53	51	60	47	45	54	53	35	44	47	40
Length of hospital stay – mean *(previous yr)*	32 (27)	29 (19)	21 (18)	22.4 (25)	14.3 (20.1)	21.1 (18.9)	15.3 (26)	14.7 (18)	24.5 (24)	29.4 (21)	23 (22)	28 (22)

To be discussed – possibility of DN teams data to include: Numbers on case load, admissions to case load, discharges form caseload, contacts.

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

York Teaching Hospital NHS
NHS Foundation Trust

Harm Free Care - Safety Thermometer Prevalence data

Selby Hospital	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Overall Ward Harm free	90%	100%	100%	95%	100%	100%	100%	100%	100%	91%	91%	90%
VTE *(% of patients with a VTE)*	0%	0%	0%	0%	10% *(2 old)*	5% *(1 old)*	0%	0%	4% (1 old)	4% (1 old) 4% (1 new)	0%	5%(1 old)
Falls *(% of patients who fell)*	4% *(1 no harm)*	10% *(1 no harm,1 moderate harm)*	5% *(1 no harm)*	4% *(1 no harm)*	0%	0%	0%	0%	9% (2 no harm)	4% (1 low harm)	4% (1 no harm)	18%(2 no harm 1 low harm)
Pressure Ulcers *(% of patients with a new PU)*	4%	0%	0%	10%	0%	0%	7%	0%	0%	0%	4%	0%
Pressure Ulcers *(% of patients with an old PU)*	13%	14%	8%	10%	25%	15%	14%	0%	13%	4%	4%	10% (1cat 2 1 unstageable)
UTI *(% of patients)*	18% *(3 new, 1 old)*	23% *(3 new, 2 old)*	4% *(1 new)*	10% *(1 old, 1 new)*	15% *(2 old, 1 new)*	10% *(2 new)*	14% *(2 new)*	9% (2 new)	9% (2 new)	4% (1 new)	9% (2 new)	5% (1 new)
Empty Admin Boxes	13%	23%	17%	14%	30%	20%	14%	19%	13%	4%	4%	14%
Omission code 4	0%	4%	0%	0%	10%	0%	7%	5%	0%	4%	13%	0%
Omitted Critical Medicines	4%	4%	0%	4%	5%	5%	14%	5%	9%	0%	4%	5%

RCA feedback and action planning	No RCA's since last meeting

No of risks on Risk Register	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14
						18	18		18	

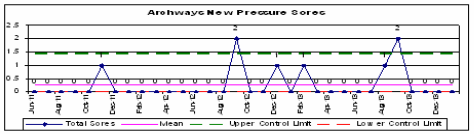
	Top 3 Risks on Risk Register
1.	Access to temporary staffing for Community Nursing and the IPU to cover sickness, vacancies
2.	Incorrect skill mix identified for IPU
3.	Community Equipment issues- hire costs unfunded

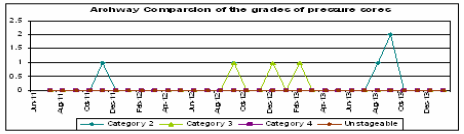
York Teaching Hospital NHS
NHS Foundation Trust

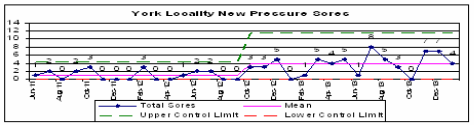
ARCHWAYS Community Hospital
Patient Safety Dashboard – March 25th 2014

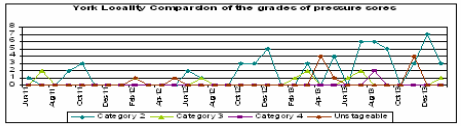
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of incidents reported on - Datix web	12	10	8	12	10	10	11	14	12	13	9	
Number of medication related incidents	0	0	0	0	0	0	0	2	1	0	2	
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	
Number of formal complaints	0	0	0	0	0	0	0	0	0	0	0	
Number of Serious Incidents (SI's)	0	0	0	0	0	0	0	0	0	0	0	
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	

Pressure Ulcers

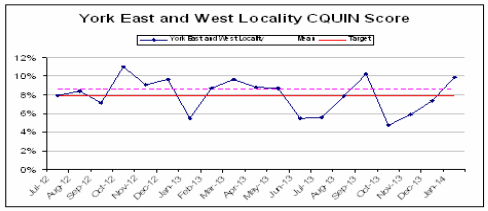


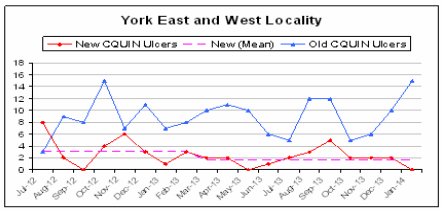




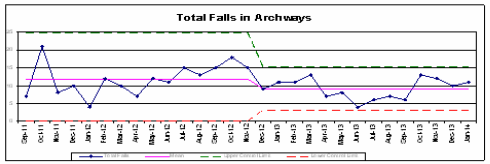


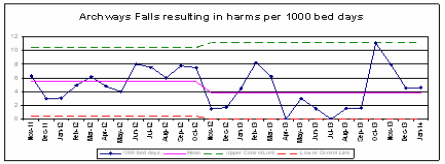
Pressure Ulcer prevalence Archways Community Hospital & York East & West Locality (CQUIN)



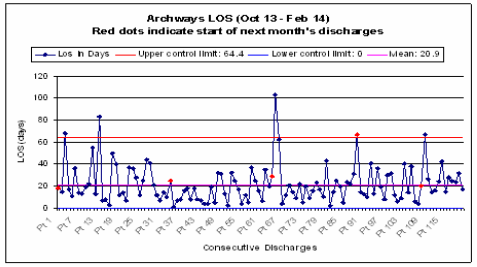


Falls





Length of Stay Graph



York Teaching Hospital NHS
NHS Foundation Trust

Target of 20 % reduction in falls over 13/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Mean falls with harm per 1000 bed days (Trajectory <4.28 per month)	0	2.56	1.5	0	1.5	0	9.5	7.9	4.5	4.5		

Mean falls with harm per 100 bed days so far (as of Jan) = 3.19

Deaths & Mortality reviews	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of in-hospital deaths	1 (3.4%)	0	0	2 (5.6%)	0	1 (4%)	0	1 (3.3%)	0	0	0	
Number of morality reviews	0	N/A	N/A	1	N/A	1	N/A	1	N/A	0	0	

Activity	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Admissions	30	22	22	36	33	24	30	34	25	29	26	
Discharges	29	29	22	36	33	25	33	30	25	30	25	
Length of hospital stay – mean *(previous yr)*	28 (26)	21 (22)	26 (16)	19.7 (22)	18.7 (27.7)	24.7 (21.4)	24.5 (29.3)	15.2 (23.8)	22.4 (15.8)	26 (27.6)	31 (32.7)	(19.6)
DToC							2			2		

IPC	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
% compliance with hand hygiene	100%	100%	100%	100%	100%	100%	82%*	100%	100%	100%	100%	
% compliance with glove use	80%	80%	100%	100%	100%	100%	80%	100%	100%	100%	100%	
% compliance with bare below the elbow	100%	100%	100%	100%	100%	100%	87%**	100%	100%	100%	100%	
CDIFF >72hrs *(accumulative Archways yearto date)*	0	0	0	0	0	0	0	0	0	0	0	

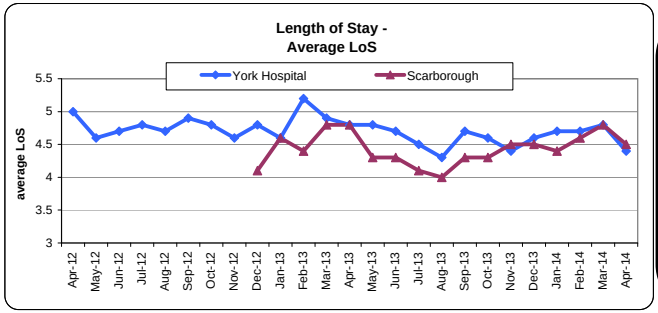
*Nurse 80%, support staff 50%, **DI 50%

Harm Free Care – Safety Thermometer Prevalence data	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Overall Ward Harm free	**100%**	**100%**	**100%**	**100%**	**100%**	**95%**	**100%**	**95%**	**89%**	**94%**	**100%**	
VTE *(% of patients with a VTE)*	0%	0%	5% (1 old VTE)	0%	0%	0%	0%	0%	0%	0%	0%	
Falls *(% of patients who fell)*	9% (2 no harm)	9%(1 no harm, 1 low harm	0%	0%	10% (2 low harm)	0%	0%	4.7% (1 low harm)	0%	5% (1 low Harm)	0%	
Pressure Ulcers *(% of patients with a new PU- CQUIN)*	0%	0%	0%	0%	0%	4.5%	0%	0%	0%	0%	0%	
Pressure Ulcers *(% of patients with an old PU- CQUIN)*	4%	4%	5%	0%	0%	0%	4.5%	14%	5.26%	0%	0%	
CaUTI *(% of patients) (Ward Harms)*	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Empty Admin Boxes	28%	55%	15%	6%	10%	18%	0%	4.7%	0%	5%	0%	
Omission code 4	9%	22%	0%	12%	5%	4.5%	0%	0%	0%	10.5%	0%	
Omitted Critical Medicines	9%	0%	5%	0%	0%	4.5%	0%	4.7%	0%	5%	0%	

RCA feedback and action planning	No RCA completed at Archways or York East/West Locality since last meeting. (1 RCA for cat 4 pressure ulcer in progress)

Clinical Effectiveness Dashboard

Clinical Effectiveness



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

Data source: Signal

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

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

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

Description	Change	Value Current Period	Value Previous Period	Site Numerator	Site Denominator	Peer 25th Percentile	Peer 75th Percentile	Peer Average	Peer Numerator	Peer Denominator	Rating
Data Quality Index (HRGv4 based)	Current period is 0% worse than previous period.	94.3	94.6	160,754	170,398	95.3	96.8	95.8	14,292,526	14,921,993	Red
% FCEs with palliative care code	Current period is 0% better than previous period.	0.70%	0.70%	1,159	166,586	1.00%	0.57%	0.75%	110,868	14,761,226	Amber
% Deaths with Palliative care code	Current period is 8% worse than previous period.	16.00%	14.87%	318	1,988	23.74%	14.21%	19.04%	30,396	159,610	Amber
% Sign or symptom as a primary diagnosis	Current period is 8% better than previous period.	10.87%	11.82%	18,106	166,586	11.93%	9.07%	10.11%	1,491,835	14,761,226	Amber
Outpatient DNA Rate	Current period is 14% better than previous period.	5.70%	6.60%	35,149	613,666	10.00%	7.00%	9.00%	2,112,947	23,507,752	Green
Readmissions 7 days	Current period is 5% better than previous period.	2.90%	3.00%	4,019	138,948	3.60%	2.80%	3.10%	400,235	12,787,991	Amber
Readmissions 30 Days	Current period is 6% better than previous period.	6.40%	6.80%	8,681	135,136	7.50%	5.80%	6.50%	808,931	12,511,505	Amber
Mortality	Current period is 5% better than previous period.	1.48%	1.56%	1,996	135,136	1.54%	1.19%	1.26%	157,733	12,511,505	Amber
Infection rate following caesarean section	Current period is 60% better than previous period.	0.18%	0.43%	2	1,142	0.43%	0.08%	0.32%	429	134,826	Amber
Rates of deaths in hospital within 30 days of Non-elective surgery	Current period is 3% better than previous period.	1.70%	1.70%	149	8,757	1.70%	1.10%	1.40%	12,794	899,350	Amber
Rates of deaths in hospital within 30 days of Elective surgery	Current period is 7% worse than previous period.	0.03%	0.02%	7	27,659	0.04%	0.02%	0.03%	831	2,542,714	Amber
Discharge to usual place of residence within 28 days of emergency admission from there with a hip fracture	Current period is 14% better than previous period.	56.00%	49.20%	334	596	41.60%	55.30%	48.60%	21,654	44,568	Green

Maternity Dashboard - York and Scarborough

York Maternity Dashboard:

York Teaching Hospital NHS
NHS Foundation Trust

			Measure	Data source	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Flag Source	May	June	July	August	September	October	Novenber	December	January	February	March	April	Av. Monthly YtD
Activity	Births	Bookings	1st m/w visit	CMIS from Jan CPD	≤302	302-329	≥330	prev. stats	312	291	301	317	275	261	277	274	374	346	289		302
		Bookings <13 weeks	No. of mothers	CMIS from Jan CPD	≥90%	76%-89%	≤75%	CQUIN	89%	91%	91%	89%	88%	87%	89%	88%	86%				89%
		Bookings ≥13 weeks (exc transfer	No. of mothers		≥90%	76%-89%	≤75%	CQUIN													
		Bookings ≥ 13wks seen within 2 w	No. of mothers	Mat Rec	≥90%	76%-89%	≤75%	CQUIN													
		Births	No. of babies	CMIS	≤295	296-309	≥310	prev. stats	274	241	299	282	296	293	279	285	295	234	285	248	276
		No. of women delivered	No. of mothers	CMIS					269	233	294	271	289	283	274	276	288	230	279		271
	Closures	Homebirth service suspended	No. of closures	Comm. Manager	0-3	4-6	7 or more		2	2	0	1	1	6	6	4	1	2	4	0	2
		Homebirth service suspended	No. of women	Comm. Manager	0	1	2 or more		0	0	0	0	0	2	0	0	0	1	0	0	0
		Escalation Policy implemented	No. of times	Comm. Manager	3	4-5	6 or more		1	0	1	0	5	3	3	2	3	0	2	1	2
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0	0
		SCBU closed to admissions	In utero transfers	Transfer folder	0	1	2 or more		1	0	0	2	4	3	0	3	0	0	0	0	1
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	30.0	30.5	30.5	30.1	29.7	28.4	28.4	29.8	31.0	31.0			29.9
		M/W per births	Ratio	Matron				safer childbirth										24.8			33.0
		HCA's	WTE	Matron				staffing paper	18.62	20.62	20.62	19.82	20.02	20.02	20.02	21.01	19.43	19.43			19.96
		1 to 1 care in Labour		Risk Team																	
		L/W Co-ordinator supernumary %		Risk Team					75	86	65	48	55	48	47	45	51	80	65	71	61
		Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	76	76	76	76	76	76	76	76	76	76	76	76	76
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10		10	10	10	10	10	10	10	10	10	10	10	10	10
		Supervisor : M/w ratio 1 :	Ratio	Rota	12	13-15	15	SHA	13	13	13	15	15	13	13	13	12	13	14	14	13
Clinical	Neonatal/Maternal	Sponateous Vaginal Births	No. of svd	CMIS	≥65%	64%	≤63%		56.9	56.8	67.2	62.7	63.5	68.3	64.8	62.1	61.7	61.5	59.6	58.0	61.9
Indicators	Morbidity	Operative Vaginal Births	No. of instr. births	CMIS	≤15%	16-19%	≥20%	prev. stats	11.7	17.8	11.7	12.4	8.4	10.9	10.7	12.9	9.5	15.8	12.6	15.7	12.5
		C/S Deliveries	Em & elect	CMIS	≤24%	24.1-25.9	≥26%	prev. stats	31.4	25.3	21.1	24.8	27.7	20.8	24.0	24.5	28.8	22.6	27.7	25.8	25.4
		Eclampsia	No. of women	CMIS	0		1 or more		0	0	0	0	0	0	0	0	1	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	CMIS	2 or less	3-4	5 or more	prev. stats	1	1	1	4	1	3	3	1	1	0	0	0	1
		ICU transfers	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	1	2	1	0	1	0	1	2	0	0	0	1
		HDU on L/W	No. of days	Handover Sheet					24	12	21	15	15	25	15	14	18	17	11	10	16
		Uterine Rupture from Jan 14	No of women	CPD	0	1	2 or more										0	0	0		0
		P/N Hysterectomies < 7days p/n	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	0	0	1	0	0	0	1					
		BBA	No. of women	Risk Team - Datix	1	2-3	4 or more	prev. stats	1	1	3	7	2	6	4	1	4	2	3	4	3
		Meconium Aspirate	No. of babies	SCBU sister	0	1	2 or more	prev. stats	0	0	0	1	0	0	0	0	0	1	0	0	0
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	1	0	2	1	1	0	0	0	0	0	0		1
	Risk Management	SI's	Total	Risk Team	0	1	2 or more		0	0	1	0	0	0	0	0	0	0	0	0	0
		PPH > 2L	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		0	2	2	5	4	7	7	1	1	2	1	1	3
		Shoulder Dystocia - True	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	RCOG	0	2	3	1	3	6	6	3	0	0	2	1	2
		3rd/4th Degree Tear	% of tears (vaginal	CMIS	≤1.5%	1.6-6.1%	≥6.2%	RCOG	4.8	6.1	5.9	4.2	3.7	3.4	6.1	2.8	4.7	4.4	6.8	4.4	4.8
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		73	80	90	90	90	90	89	99	94	96	95	96	90
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		64	69	69	39	48	55	50	69	78	81	81	78	65
		Training cancelled	No. of staff affected	Risk Team	0		≥1		9	8	44	0	7	1	0	1	1	0	0	0	0
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		2	2	1	1	0	0	1	0	3	0	1		#DIV/0!
		Formal	Total	Matron	0	1-4	5 or more		3	1	3	3	1	2	1	2	2	1	0		#DIV/0!
	New Claims		Total	Directorate Manager	0	1	2 or more		0	0	1	0	1	0	0	0	2	1	0		0

Scarborough Maternity Dashboard:

York Teaching Hospital NHS
NHS Foundation Trust

			Measure	Data source	No Concern(green)	Of Concern (Amber)	Concerns (Red)	Flag Source	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	Av. Monthly YtD
Activity	Births	Bookings	1st m/w visit	IS - Evolution	≤200	201-249	≥250	prev. stats	207	159	176	165	200	159	200	169	185	216	196	165	247	190	156		187
		Bookings <13 weeks	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	87%	90%	93%	89%	79%	81%	87%	83%	82%	81%	96%	100%	100%	100%	100%		90%
		Bookings <13 weeks (exc transfers etc)	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	97%	96%	98%	94%	83%	97%	88%	99%	86%	TBC	96%	n/a	n/a	n/a	n/a		92%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers		≥90%	76%-89%	≤75%	CQUIN			awaiting CPD commencment														
		Births	No. of babies	IS - Evolution	≤170	171-189	≥190	prev. stats	117	135	120	121	147	108	140	154	135	145	131	124	145	128	119		133
		No. of women delivered	No. of mothers	IS - Evolution	≤170	171-189	≥190	prev. stats	116	132	118	120	146	107	140	153	133	142	129	122	143	126	118		132
	Closures	Homebirth service suspended	No. of closures	Comm Team Leader	0-3	4-6	7 or more		0	0	0		0	0	0	0	0	0	0	0	0	0	0		0
		Homebirth service suspended	No. of women	Comm Team Leader	0	1	2 or more		0	0	0		0	0	0	0	0	0	0	0	0	0	0		0
		Escalation Policy implemented	No. of times	Matron	3	4-5	6 or more		2	1			0	0	0	0	0	0	0	0	0	0	0	0	0
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		2	1	0		0	0	0	0	0	0	0	0	0	0	0	0	0
		MLU Closure	No. of closures	Matron	0	1-2	3 or more						1	0	0	1	2								0
		MLU Closure	No. of women	Matron	0	1-2	3 or more							0	0	0	1								0
		SCBU closed to admissions	In utero transfers	Risk Team	0	1	2 or more		0	0	1	0	0	0	0	0	0	1	1	2	1	0	4		0
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0
		HCA's	WTE	Matron				staffing paper	15.79	15.46	17.26	18.55	18.55	18.55	18.55	18.79	18.79	19.59	19.59	19.59	18.32	18.32	18.32	18.32	17.82
		1:1 care in labour		IS - Evolution					98%	91%	96%	94%	95%	95%	94%	96%	96%	96%	98%	99%	96%	98%	99%		96%
		L/W Co-ordinator Supernumary %		L/W Manager					0	0								56%	56%	n/a	41.93%	n/a	n/a		56%
		Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	40	40	40	40	40	40	40	40	40	40	40	40	40	40	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	3	3		3
		Supervisor : M/w ratio 1 :	Ratio	Matron	15	16-19	20	NMC	15	15	15	15	13	13	13	15	15	13	13	13	14	14	14	14	14
Clinical	Neonatal/Maternal	Spontaneous Vaginal Births	No. of svd	IS - Evolution	≥65%	64%	≤63%		74.4%	74.1%	75.0%	75.2%	75.5%	76.9%	76.4%	77.9%	70.4%	64.8%	65.6%	67.7%	68.3%	71.9%	72.3%		71.9%
Indicators	Morbidity	Operative Vaginal Births	No. of instr. births	IS - Evolution	≤15%	16-19%	≥20%	prev. stats	1.7%	4.4%	3.3%	3.3%	4.8%	4.6%	5.0%	4.5%	8.1%	8.3%	6.1%	4.0%	3.4%	4.7%	5.9%		5.3%
		C/S Deliveries	Em & elect	IS - Evolution	≤24%	24.1-25.9	≥26%	prev. stats	22.2%	18.5%	20.0%	19.8%	19.0%	17.6%	17.9%	16.2%	20.0%	24.8%	26.0%	26.6%	26.9%	21.9%	21.0%		21.5%
		Eclampsia	No. of women	IS - Evolution	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
		Undiagnosed Breech in Labour	No. of women	Risk Team	2 or less	3-4	5 or more	prev. stats	0	0	1	1	0	1	1	1	0	1	1	0	0	0	0	1	1
		ICU transfers	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0		0
		HDU on L/W	No. of days	Risk Team												0	2	2	5	4	2	3			2
		P/N Hysterectomies < 7days p/n	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0		0
		BBA	No. of women	IS - Evolution	1	2-3	4 or more	prev. stats	1	2	1	2	1	1	1	4	1	1	0	1	1	1	0		1
		Meconium Aspirate	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	1	0	0	1	0	0	0	0	0	0	1	0	1	0		0
		Diagnosis of HIE	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
	Risk Management	SI's	Total	Risk Team	0	1	2 or more		0	0			0	0	0	0	0	0	0	0	0	1	0		0
		PPH > 2L	No. of women	IS - Evolution	1 or less	2-3	3 or more		0	2	0	2	0	0	0	0	1	0	1	1	0	1	0		1
		Shoulder Dystocia - True	No. of women	IS - Evolution	1 or less	2-3	3 or more	RCOG	1	1	0	2	2	1	1	1	0	4	0	0	1	1	0		1
		3rd/4th Degree Tear	% of tears (vaginal	IS - Evolution	≤1.5%	1.6-6.1%	≥6.2%	RCOG	0.9%	3.0%	0.0%	0.8%	2.1%	0.9%	1.4%	2.6%	0.8%	1.4%	0.8%	2.5%	4.9%	4.0%	0.0%		1.9%
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%								67	67	77	85	92	98	91	93			86
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%								57	57	53	79	82	90	37	92			70
		Training cancelled	No. of staff affected	Risk Team	0		≥1		0	0					0	0	0	0	0	1	0	0			0
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		1	0	1	0	1	1	1	0	0	1	3	1	1	3	2	0	1
		Formal	Total	Matron	0	1-4	5 or more		2	2	2	2	0	1	1	1	0	1	1	1	1	1	0	2	1
	New Claims		Total	Risk Team	0	1	2 or more		0	0	0	0	2	0	1	0	0	0	0	0	0	2	1	0	1

How to Interpret The Charts

Statistical Process Control (SPC) Chart

These charts are constructed using statistical process control (SPC) principles and use control limits to indicate variation from the national mean. The display shows both two standard deviation (95%) control limits and three standard deviation (99.8%) control limits. Values within these limits (the light grey section) are said to display 'normal cause variation' in that variation from the mean can be considered to be random. Values outside these limits (in the light green or orange sections) are said to display 'special cause variation' at a two standard deviation level, and a cause other than random chance should be considered. Values outside these sections (in the dark green or red sections) also display 'special cause variation' but against a more stringent test.

Variation at the two standard deviation level can be considered to raise an alert, and variation at the three standard deviation level to raise an alarm.

The two charts on the left show a trust whose performance on this indicator is better than the national picture by a degree that is unlikely to be explained by random chance

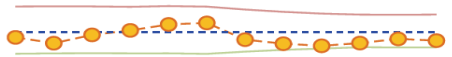
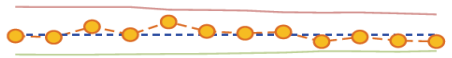
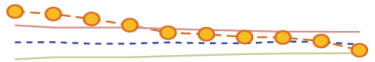
The two charts on the left shows a trust whose performance on this indicator does not differ from the national picture by more than can be explained by random chance

The two charts on the left show a trust whose performance on this indicator is worse than the national picture by a degree that is unlikely to be explained by random chance

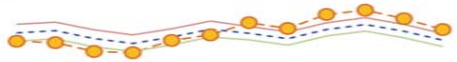
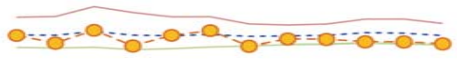
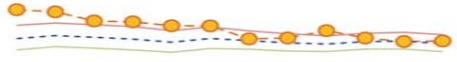
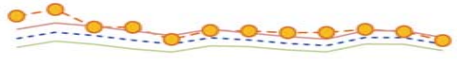
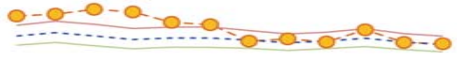
The chart on the left is for an indicator that does not have a desired direction for improvement. The Trust shown in this example is within the expected range based on the national picture.

York Teaching Hospital NHS Foundation Trust (HES: Quarterly)

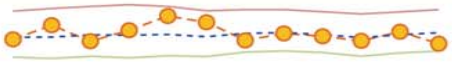
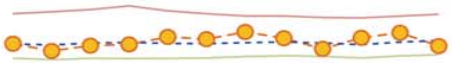
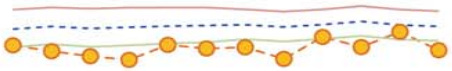
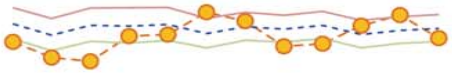
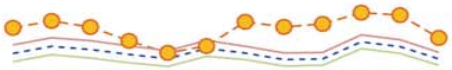
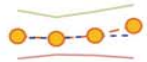
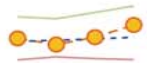
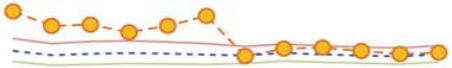
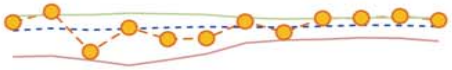
Preventing people from dying prematurely

Metric Name	Period	Value	Mean	Chart	Trend
Hospital mortality from conditions amenable to healthcare (Standardised Mortality Ratio)	RY Q2 1314	89.5	100.0		
In-hospital mortality in low risk diagnosis groups (Standardised Mortality Ratio)	RY Q2 1314	85.3	100.0		
In-hospital perinatal mortality, including still births (Crude rate per 1000 births)	RY Q2 1314	0.57	4.94		
Summary Hospital-level Mortality Indicator (HED - SHMI)	RY Q2 1314	96.1	99.1		

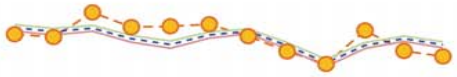
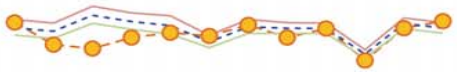
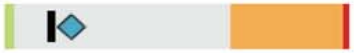
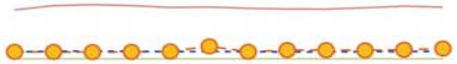
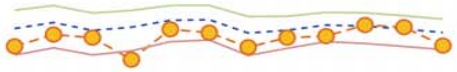
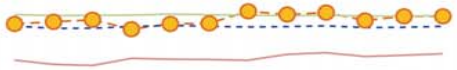
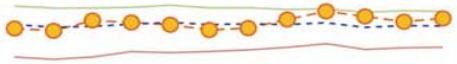
Enhancing quality of life for people with long term conditions

Metric Name	Period	Value	Mean	Chart	Trend
Emergency admissions for Ambulatory Care Sensitive Conditions (Crude rate per 100,000 admissions)	Q2 1314	225.4	206.5		
Average Length of Stay for emergency admissions for Ambulatory Care Sensitive Conditions	Q2 1314	6.10	5.40		
Emergency admissions for asthma, diabetes and epilepsy in under 19 year olds (Crude rate per 100,000 admissions)	Q2 1314	223.2	216.0		
Average Length of Stay for emergency admissions for asthma, diabetes, and epilepsy in under 19 year olds	Q2 1314	1.09	1.46		
Emergency admissions for patients age 65 and over with Dementia (Crude rate per 100,000 admissions)	Q2 1314	122.6	147.2		
Average Length of Stay for patients age 65 and over admitted in an emergency with Dementia	Q2 1314	14.4	13.8		
Average Length of Stay for patients age 65 and over admitted in an emergency	Q2 1314	10.1	9.87		
Average Length of Stay for patients age 65 and over admitted for or with a fall	Q2 1314	7.84	7.72		

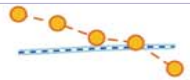
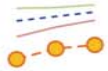
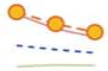
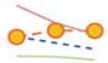
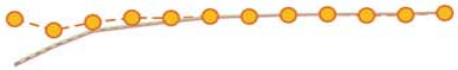
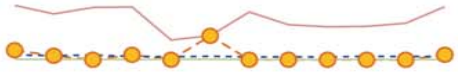
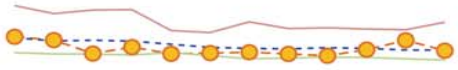
Helping people recover from episodes of ill health or following injury

Metric Name	Period	Value	Mean	Chart	Trend
Emergency re-admissions: Percentage within 30 days of an elective admission	Q2 1314	5.91	6.81		
Emergency re-admissions: Percentage within 2 days of an elective admission	Q2 1314	0.90	1.10		
Emergency re-admissions: Percentage within 30 days of a non-elective admission	Q2 1314	12.5	14.1		
Emergency re-admissions: Percentage within 2 days of a non-elective admission	Q2 1314	2.24	2.74		
Average Length of Stay for elective admissions	Q2 1314	2.94	3.09		
Average Length of Stay for non-elective admissions	Q2 1314	5.31	4.87		
Patient Reported Outcome Measures for hip replacement (Adjusted average health gain)	1213	22.5	20.1		
Patient Reported Outcome Measures for knee replacement (Adjusted average health gain)	1213	18.1	15.4		
BADS Day Case Rate	Q2 1314	82.2	81.6		
Daycase to Inpatient Conversion Ratio	Q2 1314	4.55	4.44		
Fractured Neck of Femur: Percentage operated on within 48 hours	Q2 1314	86.7	76.8		

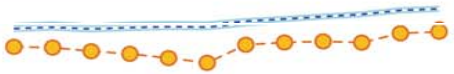
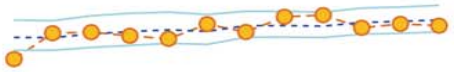
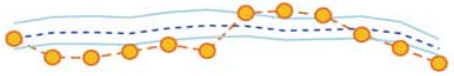
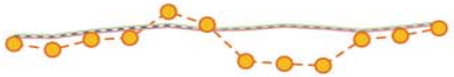
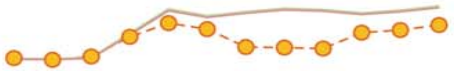
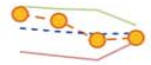
Ensuring that people have a positive experience of care

Metric Name	Period	Value	Mean	Chart	Trend
Friends and Family Score: In-Patient	Q3 1314	65.1	60.9		
Friends and Family Score: Accident & Emergency	Q3 1314	43.9	55.5		
A&E 4hr Wait (Percentage seen within 4 hours)	Q3 1314	93.4	94.7		
Diagnostic waits: Percentage of patients waiting over 5 weeks	Q2 1314	6.28	5.62		
Inpatient Referral to Treatment (RTT) waiting times (95th percentile waiting time, in weeks)	Q2 1314	30.0	21.9		
Cancellations of elective surgery for non-clinical reasons (Crude rate per 1000 procedures)	Q2 1314	7.79	8.37		
Cancer waits: Percentage with first out-patient appointment within 14 days of GP referral	Q2 1314	94.2	95.2		
Cancer waits: Percentage waiting less than 31 days from diagnosis to first treatment	Q2 1314	99.3	98.4		
Cancer waits: Percentage waiting less than 62 days from GP referral to first treatment	Q2 1314	89.5	87.0		

Treating and caring for people in a safe environment; and protecting them from avoidable harm

Metric Name	Period	Value	Mean	Chart	Trend
Patient safety incidents (Crude rate per 100 admissions)	APR12-SEP12	2.77	6.82		
Patient safety incidents causing at least moderate harm (Proportion of all incidents reported)	APR12-SEP12	12.3	6.09		
Harm free care: Percentage of patients with no harms recorded	RY Q3 1314	94.9	96.9		
Pressure ulcers: Percentage of patients with a newly acquired pressure ulcer (category 2,3 and 4)	RY Q3 1314	1.54	1.12		
Venous Thromboembolism (VTE): Percentage of patients with a hospital acquired VTE	RY Q3 1314	1.00	0.68		
VTE Assessments: Percentage of patients undergoing a VTE assessment on admission	Q1 1314	94.7	95.4		
Medication errors (Crude rate per 1000 bed days)	APR12-SEP12	3.52	7.24		
MRSA bacteraemia (Crude rate per 100,000 occupied bed days)	Q2 1314	18.8	11.8		
Clostridium difficile bacteraemia (Crude rate per 100,000 occupied bed days)	Q2 1314	15.0	15.7		
MSSA bacteraemia (Crude rate per 100,000 occupied bed days)	Q2 1314	11.3	8.24		

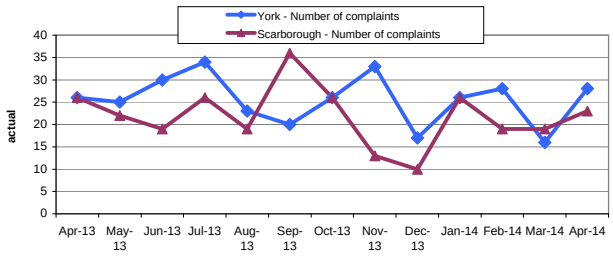
Additional metrics to aid interpretation and understanding of the organisation

Metric Name	Period	Value	Mean	Chart	Trend
Depth of coding: Mean number of secondary diagnoses	Q2 1314	3.13	3.67		
Mean Charlson comorbidity score	Q2 1314	3.25	2.98		
Palliative care: Proportion of palliative care episodes (ICD10: Z515) per 1000 episodes	Q2 1314	6.33	6.92		
Palliative care: Proportion of episodes with palliative medicine as main specialty per 1000 episodes	Q2 1314	0.03	0.44		
Use of integrated palliative care pathway: Proportion of episodes with diagnosis Z518 per 1000 episodes	Q2 1314	0.85	2.35		
Full Time Equivalent (FTE) nurses per occupied bed day	Q2 1314	1.86	1.94		
Full Time Equivalent (FTE) medical staff per occupied bed day	Q2 1314	0.69	0.88		
Overall sickness: Percentage of Full Time Equivalent (FTE) days available	Q2 1314	3.28	3.67		
Staff recommendation of the trust as a place to receive treatment (Percentage)	2013	61.0	62.3		
Staff recommendation of the trust as a place to work (Percentage)	2013	57.0	56.5		

Patient Experience Dashboard

Patient Experience

Number of complaints

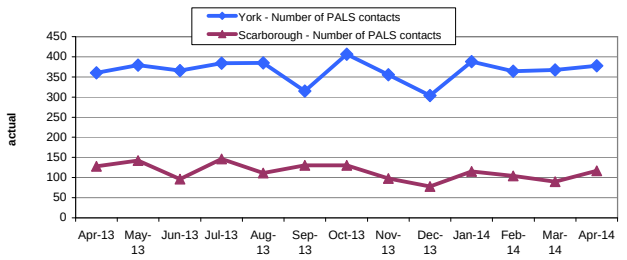


Complaints registered in York relate to York Hospital and Community Services.

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

There were 28 new complaints registered to the York site and 23 to the Scarborough site in April.

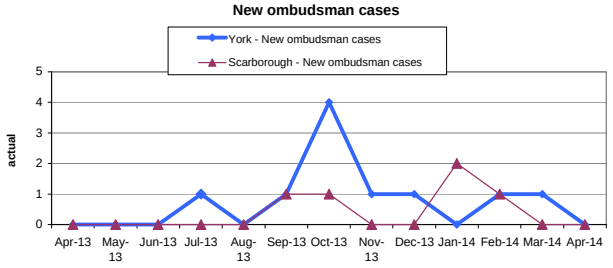
Number of PALS contacts



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

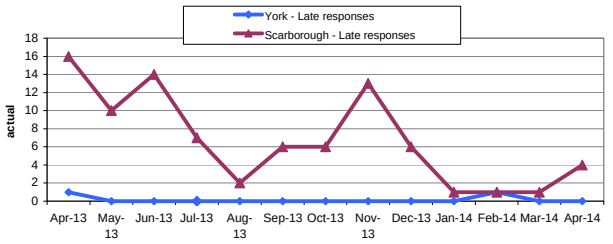
There were 378 PALS enquiries at York Hospital and 117 PALS enquiries at Scarborough in April.

New ombudsman cases



There were new ombudsman case at the York site in April.

Complaints - Late responses



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

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

Friends & Family Test Results

York Teaching Hospital NHS
NHS Foundation Trust

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

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

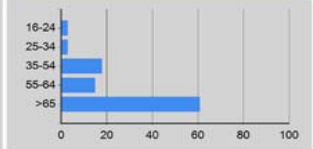
Top 3 most improved performing wards/services	6 Month Average	This Month	Improvement	Trend
Beech	59	92	33	
Ward 28	78	100	22	
Graham	72	89	17	

Top 3 consistently high performing wards/services	6 Month Average	This Month	Improvement	Trend
CCU York	96	100	4	
Lloyd	94	93	-1	
Ash	91	85	-6	

Top 3 consistently low peforming wards/services	6 Month Average	This Month	Improvement	Trend
Discharge Lounge - Scarborough	0	0	0	
A&E York	43	47	4	
A&E Scarborough	52	46	-6	

Who responded?

Response Rate	Male or Female	Age Profiles %
Eligible Patients 9520 / Patient Responses 2483 — 26%	47%	53%



Patients extremely likely to recommend our Trust said:

"Friendly and caring staff as well as being very efficient."

"All the staff were extremely friendly and helpfull."

Patients unlikely or extremely unlikely to recommend our Trust said:

"I live 150 miles away. On the whole the service was excellent."

"No reasons at all except good."

Produced by: picker Institute Europe

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

Calculating the Net Promoter Score:

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

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

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

The FFT score is calculated as:

percentage of people extremely likely to recommend

minus

percentage of people not likely to recommend

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

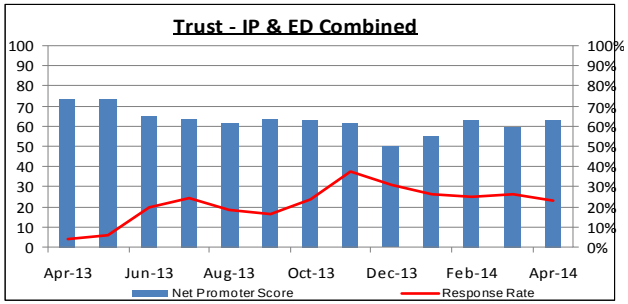
York Complaints by subject March 2014	
All aspects of clinical treatment	11
Appointments, delay/cancellation (out-patient)	2
Communication/information to patients (written and oral)	1
Attitude of staff	1
Admissions, discharge and transfer arrangements	1
Totals:	16

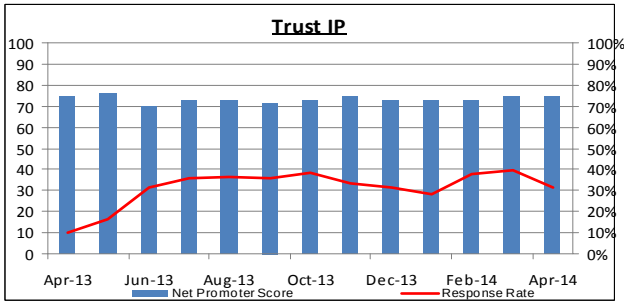
Scarborough's Top three complaint issues from DATIX March 2014	
1. All aspects of clinical treatment	12
2. Attitude of staff	4
3. Admissions, discharge and transfer arrangements	2

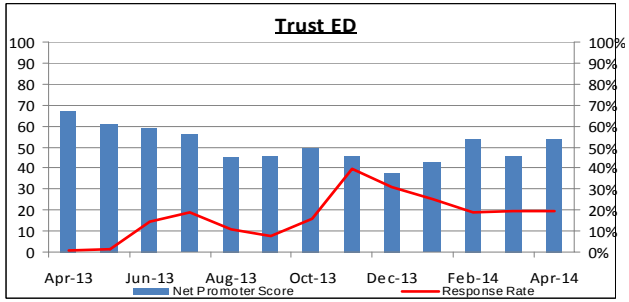
The Friends and Family Test
Inpatients/Maternity and the Emergency Department

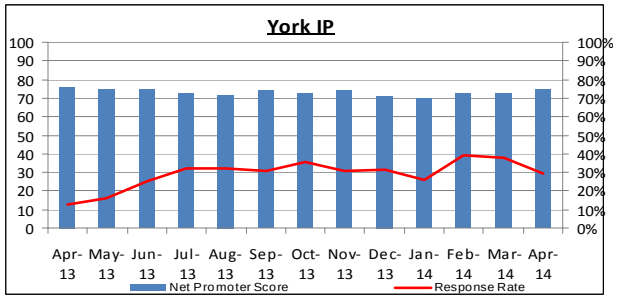
The Friends and Family Test (FFT) has now been rolled out across the Trust, with all adult inpatients, those attending ED and women accessing maternity services being asked the question "would you recommend this ward/ED/antenatal/labour and postnatal service to your family and friends".The Trust achieved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

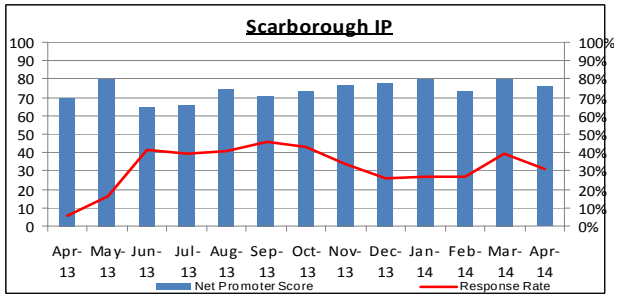
	Q1	Q2	Q3	Q4
Response Rate	9.80%	20.04%	30.43%	25.81%

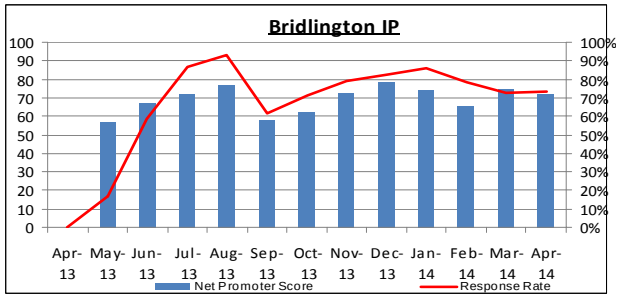






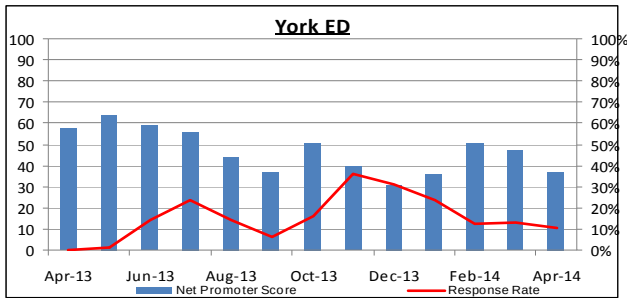






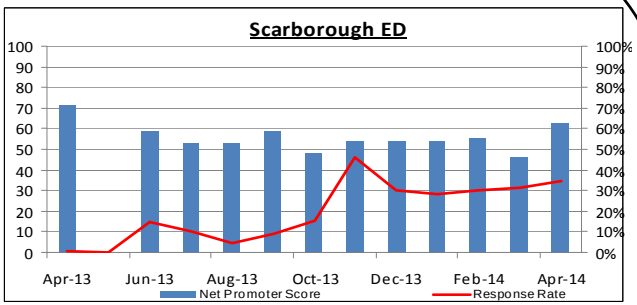
		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14
Trust	Response Rate	3.63%	6.18%	19.81%	24.30%	18.74%	16.50%	23.60%	37.40%	31.08%	26.23%	25.06%	26.07%	23.23%
	Net Promoter Score	74	74	65	64	62	64	63	62	50	55	63	60	63

		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
York IP	Response Rate	12.47%	16.28%	24.84%	32.20%	31.92%	31.06%	35.42%	30.44%	31.29%	26.06%	39.45%	37.81%	29.16%
	Net Promoter Score	76	75	75	73	72	74	73	74	71	70	73	73	75
Sboro IP	Response Rate	5.52%	16.51%	41.77%	39.14%	40.66%	46.08%	42.69%	33.69%	25.91%	26.44%	26.83%	39.36%	30.85%
	Net Promoter Score	70	80	65	66	75	71	74	77	78	80	74	80	76
Brid IP	Response Rate	0.00%	16.48%	58.65%	86.92%	93.14%	61.62%	71.43%	78.81%	82.61%	86.15%	78.38%	72.45%	73.45%
	Net Promoter Score		57	67	72	77	58	62	73	78	74	66	75	72
Combined	Response Rate	10.06%	16.36%	31.22%	36.06%	36.38%	36.04%	38.66%	33.18%	31.72%	28.49%	37.59%	39.36%	31.33%
	Net Promoter Score	75	76	70	73	73	72	73	75	73	73	73	75	75



ED Response Rate by Site - April 2014

Hospital	Eligible Patients	Total Responses	Response Rate	Net Promoter Score
York ED	4079	429	10.52%	37
Scarborough ED	2388	831	34.80%	63
Overall	**6467**	**1260**	**19.48%**	**54**



		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
York ED	Response Rate	0.30%	1.40%	14.00%	23.42%	14.26%	6.44%	16.38%	36.10%	31.23%	23.39%	12.58%	13.23%	10.52%
	Net Promoter Score	58	64	59	56	44	37	51	40	31	36	51	47	37
Sboro ED	Response Rate	0.80%	0.04%	14.90%	10.15%	4.70%	8.87%	15.18%	46.02%	29.81%	27.93%	30.44%	31.28%	34.80%
	Net Promoter Score	72	-100	59	53	53	59	48	54	54	54	56	46	63
Combined	Response Rate	0.44%	0.96%	14.31%	18.59%	10.56%	7.33%	15.94%	39.61%	30.76%	24.93%	18.67%	19.78%	19.48%
	Net Promoter Score	67	61	59	56	45	46	50	46	38	43	54	46	54

		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
York IP	Eligible	2301	2236	2126	2267	2177	2128	2312	2122	2074	2318	1985	2092	2003
	Responses	287	364	528	730	695	629	819	646	649	604	783	791	584
Sboro IP	Eligible	1033	1090	1015	1073	910	831	944	834	853	904	764	869	872
	Responses	57	180	424	420	370	347	403	281	221	239	205	342	269
Brid IP	Eligible	86	91	104	107	102	102	112	118	115	130	111	98	113
	Responses	0	15	61	93	95	61	80	93	95	112	87	71	83
Combined	Eligible	3420	3417	3245	3447	3189	3061	3368	3074	3042	3352	2860	3059	2988
	Responses	344	559	1013	1243	1160	1037	1302	1020	965	955	1075	1204	936

Wards with high % response rates

Bridlington:
Lloyd - 100%
Waters - 74%
Johnson - 65%

Scarborough:
Ann Wright - 80%
Ash - 54%
Cherry - 50%

York:
Ward 14 - 75%
Ward 25 - 100%
CCU - 76%

		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
York ED	Eligible	4567	4381	4413	4505	4223	3885	4218	3787	4066	3843	3697	4118	4079
	Responses	12	63	618	1055	602	250	691	1367	1270	899	465	545	429
Sboro ED	Eligible	2320	2277	2329	2581	2660	2244	2405	2075	2063	1962	1915	2343	2388
	Responses	18	1	347	262	125	199	365	955	615	548	583	733	831
Combined	Eligible	6887	6658	6742	7086	6883	6129	6623	5862	6129	5805	5612	6461	6467
	Responses	30	64	965	1317	727	449	1056	2322	1885	1447	1048	1278	1260

Wards with low % response rates

Scarborough:
Maple - 5%
Beech – 15.5%
Willow - 19%

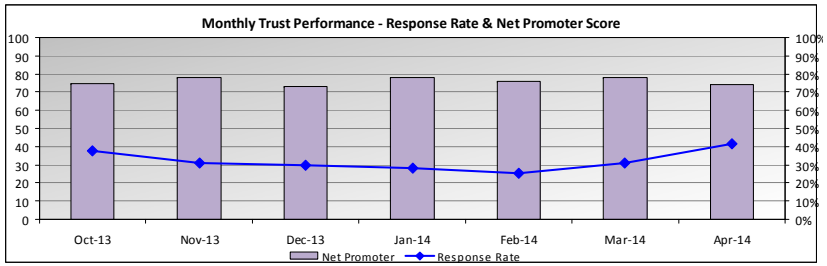
York:
Ward 24 – 14%
Ward 28 – 14%
Ward 15 – 20%

Maternity FFT

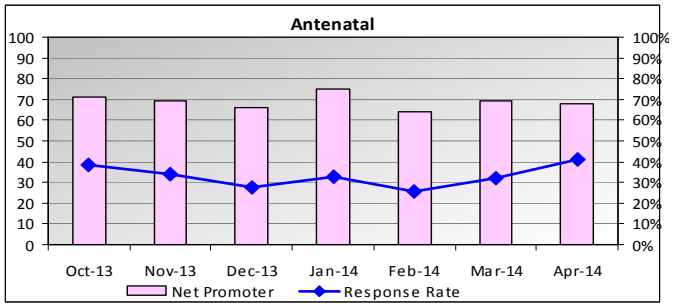
The Labour and Birth FFT question has been changed to be asked at discharge from the postnatal ward. Feedback from women and staff showed that asking the FFT question to a mother following birth was not the most appropriate time. The response rate for April increased significantly this month.

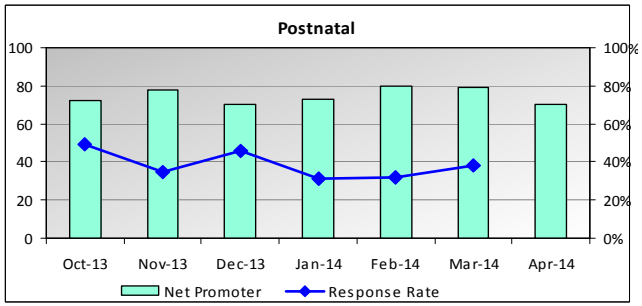
Trust Performance:

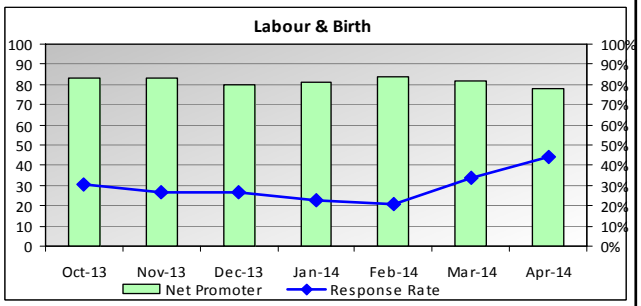
Report Month	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know	Total Responses	Eligible Patients	Response rate	FFT Score
Oct-13	77.37%	19.13%	2.16%	0.83%	0.17%	0.33%	601	1585	37.92%	74
Nov-13	80.00%	17.39%	1.74%	0.43%	0.22%	0.22%	460	1477	31.14%	78
Dec-13	75.43%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

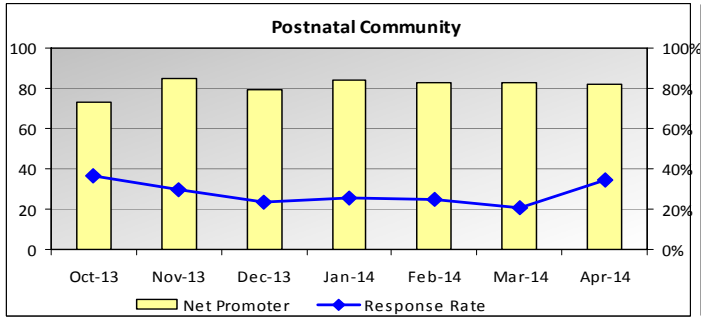


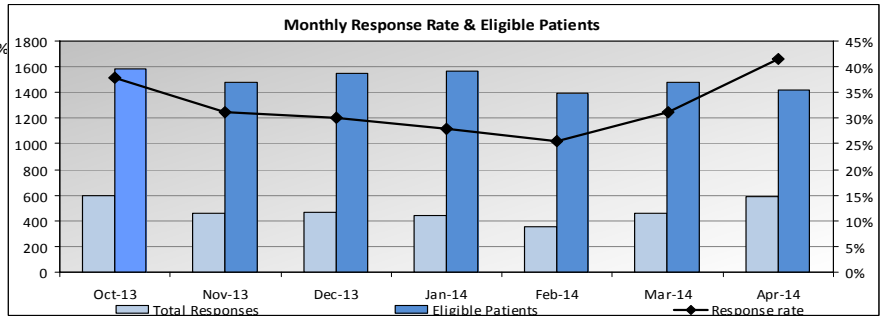
		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	Q3	Q4
Total	Response Rate	37.92%	31.14%	30.01%	27.93%	25.47%	31.06%	41.44%	33.09%	28.21%
	Net Promoter	74	78	73	78	76	78	74		
Antenatal	Response Rate	38.20%	34.06%	27.79%	32.46%	25.33%	32.11%	41.30%	33.33%	29.81%
	Net Promoter	71	69	66	75	64	69	68		
Labour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











C2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 May 2014

Medical Director's Report

Action/Recommendation

Board of Directors are requested to:

- note the good progress in reduction of the SHMI and also that further reduction is still to be achieved, particularly in the diagnostic groups with more than ten excess deaths.

Summary

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

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

Implications for equality and diversity

No implications for equality and diversity.

Reference to CQC outcomes

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

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

Date of paper	28th May 2014
Version number	1

Board of Directors – 28 May 2014

Medical Directors Report

1. Introduction

In the report this month:

- Summary Hospital-level Mortality Indicator (SHMI) update
- Consultant appointments
- Patient Safety Strategy update.

2. Summary Hospital-level Mortality Indicator (SHMI) update

The Trust SHMI for the period October 2012 – September 2103, was 97, which represents a significant reduction (100.7) from the previous reporting period. There were 21.6 excess deaths identified.

The Trust SHMI of 97 is within the 'as expected' range.

The diagnostic groups with more than 10 excess deaths are:

- Congestive heart failure, nonhypertensive
- Acute cerebrovascular disease
- Chronic obstructive pulmonary disease and bronchiectasis
- Cancer of bronchus, lung.

3. Consultant appointments

Mr David Cash
Locum Consultant in Orthopaedics.

4. Patient Safety Strategy update

Ensuring consistency of care

Excellence in ward rounds
Planned roll out of 'board rounds' on Beech and Chestnut wards (medicine) by the end of July 2014 currently in planning phase.

Perfect ward round piloted on Ward 33 on the 7th May. A visit is planned to Royal Exeter and Devon Trust (NHS QUEST partner) for the 19th/20th May to look at the effectiveness of their ward round process.

Streaming out of hours service
Decisions are currently being made around the Consultant Physician rotas and sign up for clinical leads for two projects; Consultant Assessment on Cherry Ward and reorganising junior doctor on calls into an acute rotation. Although on the York site this has been shown to have an impact on reduction to time to clerking due to the reduced numbers of medical staff on the Scarborough site this is still in development.

Post take ward round checklist
An audit of the compliance with the PTWR checklist at York Hospital has been completed and next steps are to be agreed. Arrangements to be made for a similar audit to be undertaken on the Scarborough site to provide an overview Trust wide.

Reduction of harm by early detection of the patient at risk of deteriorating

Improved recognition and management of the deteriorating patient
95% RN and HCA attended observation training on 'high risk wards' by March 2014.

A decision was made by the Chief Nurse Team not to pursue competency assessment following the AIRA course.

A decision was made by the Chief Nurse Team not to pursue specialist competency assessment programmes for HCAs but that this should be incorporated into the general HCA induction programme.

Some flexible ad-hoc training now being delivered for Medical Registrars. The plan is to develop into a more structured programme with post grad involvement.

The Deteriorating Patient Pathway was used in 75% appropriate cases by April 2014. A recent audit of unplanned admissions to ICU across both sites demonstrated that this pathway is not always being used. However increased management plans, escalation and response is improving, documented in the main health record. The Deteriorating Patient group are to decide if promotion of the pathways should continue. It was agreed an audit of unplanned admissions to ICU will take place at least annually, commencing February 2014. The first audit was completed and findings and recommendations reported through Acute Board.

95% compliance with full set of observations done within 20 minutes of admission to ward 14, 28 and AMUs has been achieved. IT system has been prioritising compliance with routine observations 'as prescribed' across all wards and plan to deliver the ability to measure this within the next six months. 87% of routine observations are now being completed 'as prescribed'.

Improved recognition and management of the patient with sepsis
Clinical leads have been identified and a policy and measurement plan is being developed. *Further progress:* CQUIN agreed, qualitative measures based on building the infrastructure to achieve compliance with severe sepsis 6 bundle.

Hypoglycaemic episodes - Latest figures for the month of April indicates a rate of 2.79%. The rate of insulin prescribing errors is 6.6%. *Further progress*: development of an RCA tool for all insulin errors in development.

Reduce in-patient falls
The policy has been modified to include new risk assessment tool and implementation plan.

43.5% of areas have identified Falls Champions. Of the identified champions, 45% have completed and passed the E-Learning package. In total, 226 staff members have registered for the E-learning across the Trust, of which 89 staff members have completed and passed the module (39.4%).

Further progress: CQUIN for falls agreed.

Reduce pressure ulcers
Reported through Chief Nurse report - Progress report February 2013-February 2014 due to go to Board May.

Medicines management work programme
It was agreed no more than 2% of missed doses relate to critical medicines by March 2014. The latest figures – 1.8% whole Trust (data from monthly Safety Thermometer).

No incident of wrong drug in wrong locker from March 2014.

Implement electronic nursing discharge system has been delayed due to development work required by Systems and Network. Predicted to be in place in six months time.

The roll out of e-prescribing has been delayed due to development work required by Systems and Network. Predicated roll out to wards in 12 months. Project Manager appointed.

Increase medicines reconciliation within 24 hours by 20% by April 2014. Current measure is via CPD. More pharmacy staff are undertaking reconciliation than previous, yet the compliance figure does not reflect an improvement. The pharmacy team are undertaking a detailed piece of work to review the measurement tool and look at process to understand when the issues are.

Increase weekend pharmacy opening hours (8pm weekdays and extended hours weekend) by March 2014. This is currently in the planning stage, business case in development.

Reducing mortality and improving mortality indicators

Mortality reviews continue to be undertaken in all specialties and all sites.

The Trust has agreed to be part of the regional group considering mortality reviews.

Excellence in End of Life Care

Care After Death Policy
The Care After Death Policy is currently under review and should be ready for publication June/July.

Advance Care Planning booklet
The Advance Care Planning booklet has been agreed and will be available following the implementation of the Last Days of Life care plan. Advance Care Planning will be promoted during 'Dying Matters' week 12-18th May.

AMBER
The Amber Care Bundle is currently in use on three wards and is due to be introduced to a fourth at the end of May. We plan to have implemented the tool on a total of five wards by the end of July. It was predicted that AMBER would be embedded on 10 wards by August but this is behind schedule due to difficulties with sustainability. This has been the experience of organisations throughout the country.

National audit - DNACPR
As part of the national audit a review of DNA CPR/ Ceiling of Care was carried out on 50 sets of notes. Results will be published on the 15th May. Recommendations to improve DNA CPR compliance are to be discussed at the next meeting on 10th June 2014.

5. Recommendations

Board of Directors are requested to:

- Note the improvement in SHMI but to be aware of the diagnostic groups with greater than 10 excess deaths
- Note the progress with the Patient Safety Strategy.

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**28 May 2014**

C3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 May 2014

Patient Safety and Quality Performance Improvement Meetings (PIM's)

Summary Report January - March 2014

Action Requested/Recommendation

The responsibility for actions to be completed as a result of the PIM's is to be held by the directorate involved. A summary for the next quarter will be produced and presented to the Quality and Safety Committee in July 2014.

Summary

This is a summary of the Patient Safety and Quality Performance Improvement meetings (PIM's) for the quarter Jan- March 2014. The responsibility for actions to be completed as a result of the PIM's is to be held by the directorate involved. A summary for the next quarter will be produced and presented to the Quality and Safety Committee in July 2014.

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	For Quality and Safety Committee only.
Risk	Any risks identified are also recorded on the Risk Register.
Resource implications	N/A
Owner	Dr Alastair Turnbull, Medical Director
Author	Sarah Fiori, Patient Safety Manager
Date of paper	May, 2014
Version number	Version 1

Board of Directors – 28 May 2014

Patient Safety and Quality Performance Improvement Meetings (PIM's)

Summary Report - Jan- March 2014

1. Introduction and background

This is a summary report of the Patient Safety and Quality Performance Improvement meetings (PIM's) for the quarter Jan- March 2014.

Number of PIM's for this period: 4
Directorates Attending:
Elderly
Laboratory Medicine
Ophthalmology
Theatres and Anaesthetics.

2. Areas of Concern and Good Practice:

Areas of Concern:
Elderly: Staffing. LOS CQUIN due to delayed discharges. Elderly outliers. Age related policy differs across York and Scarborough. Clusters of MRSA and Clostridium difficile identified.
Laboratory Medicine: IT systems between sites incompatible. Directorate risk register needs updating. Recording and actions for abnormal results by ward staff. Internal transport to meet needs of pathology inadequate. Safe needle devices highlighted as not fit for purpose in some areas.
Ophthalmology: Staffing vacancies.
Theatres and Anaesthetics: Staffing vacancies. Booking endoscopy patients on the open access route in York is causing some difficulties. The endoscopy unit is not big enough at York to meet JAG recommendations for screening in the future, plan to recruit non medical endoscopists, infrastructure yet to be defined. CSSD; York has out of date air handling plant and the auto claves are due for replacement. There is an overdue report on future provision at York.
Areas of Good Practice:
Elderly: Winter escalation ward worked well at SGH. Beverage service Ward 23.
Laboratory Medicine: Electronic document controls working well.
Ophthalmology: Outpatient volunteer group recognised as bringing improvements.
Theatres and Anaesthetics: Process to match staff to list availability. Band 3 posts developed to scrub for minor procedures. Organisation of endoscopy bookings improved significantly. Outreach service 24/7 in Scarborough will be established in the next 2 months. Establishment of the surgical lab in Scarborough has been reported as very successful.

3. Conclusion

Each directorate have actions based on the PIM's attended.

4. Recommendation	
The responsibility for actions to be completed as a result of the PIM's is to be held by the directorate involved. A summary for the next quarter will be produced and presented to the Quality and Safety Committee in July 2014.	
Author	**Sarah Fiori, Patient Safety Manager**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**May 2014**

C4

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 May 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.
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Michael Proctor, Chief Nurse
Author	Beverley Geary, Director of Nursing
Date of paper	May 2014
Version number	Version 1

Board of Directors – 28 May 2014

Chief Nurse Report – Quality of Care

1. Key priorities

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

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

A number of key priorities and work-streams have been identified and progress is being made toward these, updates are as follows:

Early Warning Trigger Tool

In order to give an early indication that care could be compromised, an EWTT has been developed, this, in conjunction with a nursing quality Nursing Dashboard will give an overview of the quality of care in all areas.

Representative pilot sites have now received their training and will 'go live' on 14 May.

This monthly assessment supports early detection of potential of triggers that may indicate issues in the quality of care or the ability to provide this; in order to provide intensive support and direction to targeted areas with robust action planning with demonstrable outputs. The pilot is for 3 months at which point an evaluation will be undertaken and reported back to Board with recommendations for any changes and further implementation.

Pressure Ulcer Reduction Programme
As the Board is aware, significant work has already been undertaken to reduce the incidence of pressure ulcers and a detailed Pressure Ulcer Reduction Plan has previously been agreed.
In addition to the current action plan a steering group has been set up to undertake a review of progress to date, discuss other actions required and to monitor SI's (category 3 and 4) and disseminate learning from panels.

On review of other Trusts' categorisation and declaration it appears that not all external reporting is the same, therefore; the group will review the practices in other similar organisations and make recommendations regarding which ulcers are attributed to care in our organisation and therefore which are reported externally. This is particularly significant given the proposed external reporting as part of the Open and Honest agenda.

Falls strategy
In line with our plans to reduce in-patient falls an organisational steering group has now been set up to determine priorities and to establish a detailed work-plan.

A working group is currently reviewing the existing policy, the falls risk assessment tool and the

falls intervention plans in order to re-write them to: reflect current best practice, agree 1 approach across the whole organisation and to streamline processes. The recommendations from this group will come to the steering group in May to be agreed, and on completion work will begin on a communication and education strategy.

A Matron from each main site has been identified to work on a detailed reduction plan with clear time limited objectives, this will include a review of the current bed rails policy and any additional safeguarding considerations, once agreed by the Falls Steering Group this will come to Board for information and approval.

In addition, and for added rigor; we have employed the assistance of Francis Healey from NHS England (previously NPSA) to re-examine our proposals and advise on and supplementary work required.

2. Safer Staffing Project
***How to Ensure the right people, with the right skills, are in the right place at the right time*.**

Safer Staffing Project – update

As detailed in our Nursing and Midwifery strategy year 2 work-plan we are committed to ensuring safe staffing levels in all areas of the organisation.

In response to the National Quality Board (NQB) publication '*Getting the Right Staff in the Right Place at the Right Time'* a safer staffing project – led by the Chief Nurse team was set up to review the guidance and advise the Nursing Board re: the implementation of any changes required.
More recently; Jane Cummings, Chief Nursing Officer for England & Professor Mike Richards as Chief Inspector of Hospitals wrote to all provider organisations' detailing the expectations of all *Hard Truths'* (Department of Health) timeframes for responses and action were given.
Following receipt of this the Trust is obliged to demonstrate compliance with a number of recommendations to provide assurance about safe staffing, a stock take of where all providers in relation to the expectations was undertaken in late April, we responded with actions, plans and timeframes.

The 10 recommendations within *Safe staffing; Right people; Right Skills, Right place, Right time.* Have been reported in previous papers.

'*Hard Truths': The journey to putting patients first,* identifies 5 domains within which they identify key actions required, cross referenced against the 10 NQB recommendations. An update and Trust progress against these actions is detailed in the following table.

In order to ensure that matrons and ward Sisters are aware of the expectations placed upon them, the Chief Nurse team are facilitating 6 training workshops across the Trust during May, where attendance has been mandated.

Action required	Deadline	NQB recommendations	Progress
A) The Board receives a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in NQB report page 12 and reflects a realistic expectation of the impact of staffing on a range of factors.	June 2014	1, 3,7	The Trust will undertake acuity and dependency audits using the evidence-based Safer Nursing Care Tool. Six monthly audits during 2014 will be 2-15 June and 1-14 December.

			The first audit will be completed on paper in the absence of access to the tool electronically at ward level, therefore a member of the Chief Nurse team will manually input 2 weeks data for every ward - It should be noted that this requires significant resource and a speedy resolution to enable access to the electronic tool is welcomed. The results of these audits will be reported to the Board.
B) The Trust clearly displays information about the nurses, midwives and care staff present and planned in each clinical setting on each shift. This should be visible, clear and accurate, and it should include the full range of patient care support staff (HCA and band 4 staff) available in the area during each shift. It may be helpful to outline additional information that is held locally, such as the significance of different uniforms and titles used.	June 2014	8	Effective from 2 June 2014, all inpatient wards will display the planned versus actual staffing numbers for each shift. These will be displayed within the clinical area using a standardised template. Differentiation of staff uniforms is already provided within the bedside information folders.
C) The Board: Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap Evaluates risks associated with staffing issues Seeks assurances regarding contingency planning, mitigating actions and incident reporting Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website).	June 2014	1, 7	Daily staffing shortages are captured using a standardised form within a shared drive in the Q drive. This is updated daily and is managed by the Assistant Directors of Nursing in conjunction with the Matrons and bed managers out of hours. Exceptions will be reported to Board via the Chief Nurse team.

			Furthermore, a summary of Datix reports relating to staffing issues will also be provided to Board
D) The Trust will ensure that the published monthly update report specified in Row C [i.e. the Board paper on expected and actual staffing] is available to the public via not only the Trust's website but also the relevant hospital(s) profiles on NHS Choices.	June 2014	1, 7	To be agreed
E) The Trust: Reviews the actual versus planned staffing on a shift by shift basis Responds to address gaps or shortages where these are identified. Uses systems and processes such as E-rostering and escalation and contingency plans to make the most of resources and optimise care	Immediate	2	As above As above. Also, active recruitment campaigns in operation, including city tours, one-stop and international recruitment. Standard operating procedure in place relating to the daily management and escalation of staff.

3. Medicines Management - Nursing

Compliance **-** Visits have taken place to outpatient areas in York and Scarborough and these will be ongoing. It is the first time these areas have been visited. There has also been a successful re-inspection following a high level of non compliance at initial visit.

Non medical prescribing - 112 annual declarations of competence have been reviewed and approved, 6 are awaiting further information or discussion to clarify points, 8 have had an agreed deadline extension for various reasons and there are 5 who have not responded and are being managed through HR processes. The Non- medical prescribing CPD days continue to be developed with the first event being held in June.

General - PGD training had been delivered to all the band 6 team leaders in community and to the nurses in Ophthalmology outpatients in Bridlington.

The lead nurse is currently leading an insulin safety group as a sub group of Think Glucose. This group is reviewing and standardising all insulin prescription documentation in order to provide consistency Trust wide.

In order to ensure a consistent approach to the management of patients requiring intrathecal therapy in the community, an operational policy and supporting competencies has been developed and approved in conjunction with Assistant Director of Nursing, Pain team and community nursing team.

Work to prepare for EPMA continues with the trialling of alternative drug trolleys and the development of a business case to support implementation.
Work continues to support Health care assistants in the community to administer insulin, through a task and finish group.

4. Open and Honest Care

"O*pen and Honest Care: Driving Improvement"* was piloted in the North West in 2010 (Transparency) with eight Acute Trusts voluntarily publishing information on their websites on falls and pressure ulcers reported in their trusts, alongside commentary describing the improvements being made to care delivery. It is part of the key actions of the Nursing Strategy: *Compassion in Practice* (2012) that sets out to support organisations to become more transparent and consistent in publishing safety, experience and improvement data; with the overall aim of driving improvements in care, practice and culture.

To date, 29 Trusts have signed up to the project and following discussion at March Board of Directors it was agreed that the organisation should adopt the Open and Honest Care initiative. As a result; a task and finish group was established with key stakeholders to identify and gaps.

The group includes representatives from a number of teams, including Patient safety, Patient Experience, communications and the senior nursing team. The group are currently undertaking a review of organisational processes relating to the gathering of data in order to ensure that we are confident that we are reporting accurate data before we 'go live' in the public domain.
and publish on our website and on NHS choices has Before the Trust can 'go live' with publishing data as part of open and honest care, it is essential that there is robust assurance that data which is put in the public domain is accurate.

The Board is required to formally approve the Open and Honest Care 'Compact' once satisfied that all processes are aligned, before publication of the first data set.

5. Senior Nurse Restructure- Update

The new Matron came into post last month and all previous post holders are now in new positions. A development programme for Matrons began in April and the feedback and evaluation has been very positive, further development days are planned.

Given the significant changes in personnel and the development of new roles a number of gaps exist at senior level, these are listed below with update as to the recruitment process.

Post	Speciality	Update
Matron	Theatres – cross site	Secondment advertised & closed
AND	Community Services	JD to be matched
EOL Lead Nurse	Cross site	Short-listing completed – interview date set
Lead Nurse – Adult Safeguarding	Cross site	Short-listing completed – interview date set
Lead – Patient Experience	Cross site	JD to be approved
Safeguarding Lead Professional	Cross site	JD sent again for matching:
Matron	Health Visiting / School Health	
Matron	Paediatrics – cross site	

In addition due to planned maternity leave and promotion the following posts will be vacant in the near future:

Post	Speciality	Update
Matron	Medicine - Scarborough	Out to advert
Matron	Acute & Emergency Medicine York	Secondment advertised & closed

Currently all areas are covered via cross – cover arrangements or secondees. The Chief Nurse Team is working with the recruitment team to arrange timely assessment centres in order to facilitate early interview dates and ensure that all posts are filled.

6. Nursing Quality Dashboard

The Nursing Quality Dashboard has been developed to provide high level data for the Matrons meeting on a monthly basis, providing data for the previous month. To date the data is not fully complete as the team is working with key stakeholders to provide validated information. The next stage will be to provide the detail behind the high level data, for example in March there were a total of 35 complaints, 16 at York and 19 at Scarborough. We are working with the Patient experience team to provide detail at ward and department level, as not all of these complaints relate specifically to quality of care. Information relating to specific wards and areas will be provided as tabs to view the detail which will highlight any areas of concern. Whilst the dashboard is work in progress it is anticipated that together with the EWTT it will give an overview of the quality of care in all areas across the organization. An example of the current dashboard can be found as Appendix 1.

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, Director of Nursing**
Owner	**Michael Proctor, Chief Nurse**
Date	**May 2014**

Chief Nurse Team Quality and Safety Dashboard May 2014 Version 3

			Measure	Data Source	Trajectory	RAG	Jan-14	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Patient Safety		Observations		Signal	**90%**	Amber				87%								
		Combined Assessment			**80%**													
		PURP Overall		Datix	**50%**													
		Cat 4 (York)		Matrons Returns														
		Cat 3		Matrons Returns														
		Cat 2		Matrons Returns														
		Unstageable		Matrons Returns														
		Cat 4 (Scarborough)		Matrons Returns														
		Cat 3		Matrons Returns														
		Cat 2		Matrons Returns														
		Unstageable		Matrons Returns														
		Cat 4 (Community)		Matrons Returns														
		Cat 3		Matrons Returns														
		Cat 2		Matrons Returns														
		Unstageable		Matrons Returns														
		Falls	Number of Patients	Datix			279	282	236	175								
		Falls With Harm (Moderate/Severe)	Number of Patients	Datix			10	19	7	14								
		Safety Thermometer Overall	Number of Patients	Signal			1520	1524	1462	1512								
		New UTI		Signal			33	47	31	38								
		Critical Missed Meds	Number of Patients	Signal			25	33	24	34								
		New DVT	Number of Patients	Signal			4	8	5	4								
		New PE	Number of Patients	Signal			8	10	7	6								
Workforce	**Staffing**	Vacancies Overall	%															
		York																
		Scarborough																
		Community																
		Recruitment Overall																
		York																
		Scarborough																
		Community																
		Sickness Overall	%	e Rostering														
		York																
		Scarborough																
		Community																
		Bank/Agency Use																
Clinical Indicators	**Infection Prevention**	MRSA Bacteraemia York	Number of Patients		**0**	Green	0	0	0	0								
		MRSA Bacteraemia Scarborough	Number of Patients		**0**	Green	0	0	0	0								
		MRSA Screening - Elective York	%	Signal	**0**		88%	85%	87%	83%								
		MRSA Screening - Elective Scarborough																
		MRSA Screening - Non-Elective York	%	Signal	**0**		68%	70%	73%	64%								
		MRSA Screening - Non-Elective Scarborough	%		**0**													
		C DIF Toxin Trust Attributed All Sites	Number of Patients		**59**	Red	1	8	4	4								
		C Diff York	Number of Patients				1	6	2	2								
		C Diff Scarborough & Bridlington	Number of Patients				0	2	2	2								
		C Diff Community Hospitals	Number of Patients				0	0	0	0								
		MSSA Bacteraemia York	Number of Patients		**Less than 30**	Green	1	1	3	6								
		MSSA Bacteraemia Scarborough	Number of Patients		**Less than 30**	Green	1	4	1	1								
		MSSA Bacteraemia Community	Number of Patients		**Less than 30**					0								
		E-Coli Bacteraemia York	Number of Patients		**None Set**		9	7	7	8								
		E-Coli Bacteraemia Scarborough	Number of Patients		**None Set**		1	0	6	0								
		E-Coli Bacteraemia Community	Number of Patients		**None Set**					4								
	Risk Management	SI's	Number				8	4	13	18								
		CI's	Number				2	2	0	0								
		Never Events	Number		**0**	Red	0	0	1	1								
	EWTT	High Risk Areas Identified	Yes/No	EWTT														
		WARD/DEPT NAME																
	Patient Experience	Friends and Family Test																
		York	%		**1st Quarter - 25% 4th Quarter - 30%**		26%	39%	38%									
		ED - York	%		**1st Quarter - 15% 4th Quarter - 20%**		23%	13%	13%									
		Scarborough	%		**1st Quarter - 25% 4th Quarter - 30%**		26%	27%	39%									
		ED - Scraborough	%		**1st Quarter - 15% 4th Quarter - 20%**		28%	30%	31%									
		Community	%															
		Bridlington	%				86%	78%	72%									
		Complaints Total	Number					47	35									
		York	Number					28	16									
		Scarborough	Number					19	19									
		Community	Number															
		Themes																
		Staff Attitude							3									
		Patient Care							2									
		Communication																
		Other							3									

Chief Nurse Team Quality and Safety Dashboard May 2014 Version 3

			Measure	Data Source	Trajectory	RAG	Jan-14	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Patient Safety		Observations		Signal	**90%**	Amber				87%								
		Combined Assessment			**80%**													
		PURP Overall		Datix	**50%**													
		Cat 4 (York)		Matrons Returns														
		Cat 3		Matrons Returns														
		Cat 2		Matrons Returns														
		Unstageable		Matrons Returns														
		Cat 4 (Scarborough)		Matrons Returns														
		Cat 3		Matrons Returns														
		Cat 2		Matrons Returns														
		Unstageable		Matrons Returns														
		Cat 4 (Community)		Matrons Returns														
		Cat 3		Matrons Returns														
		Cat 2		Matrons Returns														
		Unstageable		Matrons Returns														
		Falls	Number of Patients	Datix			279	282	236	175								
		Falls With Harm (Moderate/Severe)	Number of Patients	Datix			10	19	7	14								
		Safety Thermometer Overall	Number of Patients	Signal			1520	1524	1462	1512								
		New UTI		Signal			33	47	31	38								
		Critical Missed Meds	Number of Patients	Signal			25	33	24	34								
		New DVT	Number of Patients	Signal			4	8	5	4								
		New PE	Number of Patients	Signal			8	10	7	6								
Workforce	**Staffing**	Vacancies Overall	%															
		York																
		Scarborough																
		Community																
		Recruitment Overall																
		York																
		Scarborough																
		Community																
		Sickness Overall	%	e Rostering														
		York																
		Scarborough																
		Community																
		Bank/Agency Use																
Clinical Indicators	**Infection Prevention**	MRSA Bacteraemia York	Number of Patients		**0**	Green	0	0	0	0								
		MRSA Bacteraemia Scarborough	Number of Patients		**0**	Green	0	0	0	0								
		MRSA Screening - Elective York	%	Signal	**0**		88%	85%	87%	83%								
		MRSA Screening - Elective Scarborough																
		MRSA Screening - Non-Elective York	%	Signal	**0**		68%	70%	73%	64%								
		MRSA Screening - Non-Elective Scarborough	%		**0**													
		C DIF Toxin Trust Attributed All Sites	Number of Patients		**59**	Red	1	8	4	4								
		C Diff York	Number of Patients				1	6	2	2								
		C Diff Scarborough & Bridlington	Number of Patients				0	2	2	2								
		C Diff Community Hospitals	Number of Patients				0	0	0	0								
		MSSA Bacteraemia York	Number of Patients		**Less than 30**	Green	1	1	3	6								
		MSSA Bacteraemia Scarborough	Number of Patients		**Less than 30**	Green	1	4	1	1								
		MSSA Bacteraemia Community	Number of Patients		**Less than 30**					0								
		E-Coli Bacteraemia York	Number of Patients		**None Set**		9	7	7	8								
		E-Coli Bacteraemia Scarborough	Number of Patients		**None Set**		1	0	6	0								
		E-Coli Bacteraemia Community	Number of Patients		**None Set**					4								
	Risk Management	SI's	Number				8	4	13	18								
		CI's	Number				2	2	0	0								
		Never Events	Number		**0**	Red	0	0	1	1								
	EWTT	High Risk Areas Identified	Yes/No	EWTT														
		WARD/DEPT NAME																
	Patient Experience	Friends and Family Test																
		York	%		**1st Quarter - 25% 4th Quarter - 30%**		26%	39%	38%									
		ED - York	%		**1st Quarter - 15% 4th Quarter - 20%**		23%	13%	13%									
		Scarborough	%		**1st Quarter - 25% 4th Quarter - 30%**		26%	27%	39%									
		ED - Scraborough	%		**1st Quarter - 15% 4th Quarter - 20%**		28%	30%	31%									
		Community	%															
		Bridlington	%				86%	78%	72%									
		Complaints Total	Number					47	35									
		York	Number					28	16									
		Scarborough	Number					19	19									
		Community	Number															
		Themes																
		Staff Attitude							3									
		Patient Care							2									
		Communication																
		Other							3									

Blank page

York Teaching Hospital NHS Foundation Trust

Finance and Performance Committee – 20th May 2014, Ward 37 Seminar Room, YH

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

Apologies: Anna Pridmore

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last Meeting Notes Minutes Dated 22nd April 2014**		LT raised the issue that the minutes from 22 April incorrectly stated that ED performance had been maintained through Easter. This was not the case. Other than this correction the notes were approved as a true record of the meeting.		
2	**Matters arising**		Monitor Feedback – AB advised that Q4 and CIP process review feedback were not expected until June. MK commented that the performance report now shows operations cancelled within 7 days for both Scarborough and York. C-diff – MS requested clarification as to the penalty position for 2014/15. LT confirmed that where the RCA confirms no fault of the Trust then while the case will count against the	The Committee awaits Monitor's review of the efficiency programme management.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Trust's trajectory it will not attract a penalty. MS requested an update on the conditions register discussions. AB confirmed 5 registers had been reviewed by the CCG, 3 more review meetings were booked and a senior clinical review group was being set up with the CCGs to provide oversight to the further development and refinement of the registers. Contract negotiations have moved away from the arbitrary ratios of 2013/14 but the CCG have requested that a cap be set at last year's outturn ratio. This is currently being considered in the context of the wider contract negotiations. EB provided an update on the recent intensive support team visit. The report has been received by the Trust and an action plan/response is now being prepared. This will be shared with the Committee in due course.	The Committee were keen to see continued updates on the work of this clinical review group in relation to the further development of the conditions register. The Committee will be seeking assurance when reviewing the action plan at the next meeting.	
3	**Short Term Acute Strategy**		EB provided an overview to the committee of current work. • Future Model – work underway to design the Assessment Unit. • Ambulatory Care for non-admitted ED patients – pathway design work is underway and generic documentation is being produced. Plans are being developed to test pathways. Next stage is discussion with commissioners to agree tariffs. • Workforce Development – work underway to develop roles and staffing structures. Business cases to be prepared. Careful consideration is needed as to mapping resource changes from new pathways to identify funding requirements and sources. • Frailty Model – work is underway to develop frailty care as oppose to the more traditional elderly care. This model is essentially needs driven care rather		MS proposed that a progress update be provided at a future Board afternoon session.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			than age driven care. EB provided the committee with an overview of the work underway to change the ward configuration on the York site. EB confirmed proposals to stack surgical wards at the south end of the site in close proximity to theatres. Proposals have been shared with the York Hospital and Community Board and are currently out to consultation. The plans seek to address a number of issues including; links to theatres, isolation, pre-op assessment, thoroughfares and critical care provision.		
4	**Efficiency Report**	3.1 3.9	MS asked DHT to confirm the CIP target for 2014/15. DHT confirmed the original planning assumption had been £29.5m based on non-recurrent carry over and the new year additional target. This had then been reduced by £2m following agreed new income schemes, £1m due to the CCGs removing CIP from community, £1m from a review of non-recurrent schemes (changing to recurrent) and £1.5m from the reduced pay award settlement. Taking these adjustments into account the target for 2014/15 was £24m. DHT presented an overview of the main efficiency report, describing month 1 performance which is ahead of the same point last year and includes an encouraging level of non-recurrent savings. The committee noted current plans totalled £16m following a full review of all schemes with Directorates. Taking into account April delivery the current year planning gap is £6.2m. Work continues with directorates to address this. DHT presented 4 papers to the committee. • Performance management of CIP delivery with the focus on poorly performing directorates	These papers and the accompanying question and discussion session provided a	AB to confirm the 2014/15 CIP position to the Board. AB to explain the Monitor variance v the YFT in-house variance

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			• The potential impact of specified minimum staffing levels and CIP delivery • Vacancy Factors and the calculation of a CIP • Analysis of high value schemes for the coming year(s) These papers were discussed in detail and assurance around process and delivery of CIPs was noted. MS requested that the paper on high value schemes be extended for the next meeting to include an overview of the high-level themes that will be essential to the delivery of the savings targets over the coming years. It was agreed that the Performance Management paper would be updated in 6 months time.	high level of assurance around the management of the efficiency programme and the maintenance of appropriate levels of nursing staff.	
5	**Operational Report**	2.12 2.13	LT introduced the new format performance report. LT invited comments from the committee on the content and format / style. 18 weeks – LT confirmed no patients had waited in excess of 52 weeks. There continues to be a reduction in 36+ week waiters. Despite some failures at specialty level the Trust achieved all 18-week targets on aggregate. MS questioned LT about areas of specialty concern and LT confirmed the incomplete pathway for T&O was an issue. Specific targeted work is underway with the directorate to address this. Symptomatic Breast – LT confirmed continued difficulties in this area. Recruitment plans are underway and return to performance is expected in Q2. 14-day fast track – LT explained that Trust data was showing a marked increase in fast track referrals with no corresponding increase in diagnosed cancers. This increase is causing operational pressure. Data has been	The performance report provided high assurance on the understanding of the breadth and scope of the Trust's performance as well as assurance on the Trust's relative performance. Discussion was able to readily focus on areas of weaker performance.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			compiled at GP practice level and is being discussed with the CCG. 62-day – target missed in Q4 by 1.5 patients (shared breach). MS asked what is being done to improve performance and LT advised that an analysis is being undertaken of every breach patient to identify where problems occurred and what corrective action can be taken. ED – LT advised that the target had not been met in April. Scarborough had been hit with high attendance levels and significant bed closures. York had high levels of admissions, particularly GP direct admits. EB advised that the committee should note that the winter funded schemes by the CCG had all stopped at the end of March. Discussions were underway with the CCG to attempt to secure new funding to re-start some schemes. The committee noted such schemes would be appropriate for penalty reinvestment, readmissions reinvestment or non-elective marginal rate reinvestment. Ambulance handover penalties were significant at £80k in April. Particular problems were being experienced on the York site. The committee noted the new handover area capital scheme is due to complete at the end of the month, following which improvement is expected. AS with ED penalty re-investment by the CCG would be appropriate. CQUINS – LT confirmed all 14/15 schemes are agreed with the exception of some residual work with specialised commissioner schemes. MS and MK asked questions about current delivery and LT provided an overview. Key areas included the roll out of the Friends and Family test and staff survey now underway. Dementia screening showed on the report as a failing area, particularly on the Scarborough site.		MP to provide an update on the expected Q1 outturn

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			AB provided an overview of the actions that had been discussed to improve this at the recent Scarborough Hospital and Community Board. The committee questioned the 12-hour senior post take review performance and noted delivery on both sites. The committee reviewed the full performance report and debated a number of performance issues identified in the report. Specific discussion took place around the 6-week diagnostic failure. LT advised this target had been affected by medium-term sonographer absence and work continues with the Directorate to address capacity problems. The Committee noted the full CQUIN list provided as a separate paper. The ED/Acute Strategy paper was noted by the Committee. The issue was discussed earlier in the meeting.		AJT to provide an overview of improvement plans for the Dementia screening CQUIN.
6	**Finance Report**	2.15 3.1 3.11	GL provided a summary of the finance report for the opening month of the 2014/15 financial year. The Committee discussed the position. No significant issues or concerns were identified for onward discussion at this early stage in the financial year.		AB to provide an update on the wider NHS financial scene.
7	**Any Other Business**		There was no further business to discuss.		

York Teaching Hospital NHS
NHS Foundation Trust

D1

Monthly Performance Dashboard

April 2014

Information Team
Systems Network Services

Access Targets: 18 weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Apr	May	Jun	Q1 Actual
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail:** £400 in respect of each excess breach above threshold **Quarterly:** 1 Monitor point TBC	**90%**	91.1%			
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail**: £100 in respect of each excess breach above threshold **Quarterly:** 1 Monitor point TCB	**95%**	96.6%			
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Specialty fail: £100 in respect of each excess breach above threshold **Quarterly:** 1 Monitor point TBC	**92%**	94.3%			
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	0			

Access Targets: Cancer

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

Indicator	Consequence of Breach	Threshold	Apr	May	Jun	Q1 Actual
14 Day Fast Track	**Quarterly:** £200 in respect of each excess breach above threshold 0.5 Monitor point TBC	**93%**	not available yet			
14 Day Breast Symptomatic	**Quarterly:** £200 in respect of each excess breach above threshold 0.5 Monitor point TBC	**93%**	not available yet			
31 Day 1st Treatment	**Quarterly:** £1000 in respect of each excess breach above threshold 0.5 Monitor point TBC	**96%**	not available yet			
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 in respect of each excess breach above threshold 0.5 Monitor point TBC	**94%**	not available yet			
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 in respect of each excess breach above threshold 0.5 Monitor point TBC	**98%**	not available yet			
62 day 1st Treatment	**Quarterly:** £1000 in respect of each excess breach above threshold 0.5 Monitor point tbc	**85%**	not available yet			
62 day Screening	**Quarterly:** £1000 in respect of each excess breach above threshold 0.5 Monitor point tbc	**90%**	not available yet			
62 Day Consultant Upgrade	General Condition 9	**85%**	not available yet			

Emergency Department

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

Mortality

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

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Apr	May	Jun	Q1 Actual
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**59**	4			
Number of E-Coli cases	**Quarterly:** General Condition 9	**108**	12			
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) cases	**Quarterly:** General Condition 9	**35**	7			
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0			
Notification of MRSA Bacteraemia to be notified to commissioner within 2 working days	General Condition 9	**100%**	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			
Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	79.6%			
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	68.0%			

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Apr	May	Jun	Q1 Actual
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 in respect of each excess breach above threshold	**99%**	97.9%			
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0			
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hosp	Non-payment of costs associated with cancellation and non- payment o reimbursement (as applicable) of re-scheduled episode of care	**0**	0			
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0			
Cancelled operations within 7 days of the TCI due to lack of beds	General Condition 9	**65 per month**	8			
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%**	95.7%			
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 in respect of each excess breach above threshold	**99%**	98.7%			
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	7.5%			
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 89% Q2 - 90% Q3 - 92% Q4 - 95%**	82.0%			
Delayed Transfer of Care to be maintained at a minimum level	TBC	**TBC**	400			
Trust waiting time for rapid Access Chest Pain Clinic	None	**99%**	100.0%			
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance			
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**200 per month**	110			
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**	725			
% of ED Admissions With a NEWS Score		**TBC**	78.1%			
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	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**	to follow			
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**	to follow			
Reduction in the number of inappropriate transfers between wards and other settings during night hours (Reduction in avoidable site transfers within the Trust after 10pm)	General Condition 9	**Q2 onwards 80 p.m. (TBC)**	87			
Care of the Deteriorating Patient 4hr target: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker	General Condition 9	**80% by site**	92.0%			
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	91.6%			
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%			

Quality and Safety

Indicator	Consequence of Breach (Monthly)	Threshold	Apr	May	Jun	Q1 Actual
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%**	to follow			
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)**	to follow			
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%**	to follow			
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%**	to follow			
Patients who require an urgent scan on hospital arrival, are scanned with in 1 hr of hospital arrival (TBC)	No financial penalty	**50%**	to follow			
Proportion of stroke patients scanned within 24 hours of hospital arrival	No financial penalty	**90% (TBC)**	to follow			
Transmission of IDLs to GPs within 24 hours of discharge (Q1-Q3 elective and non-elective activity IP only excluding DC, Maternity and by end Q4 to include surgical DC activity too) - Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology.	Failure to deliver the quarterly target will result in the application of a £4k penalty per quarter Maximum sanction of £16K per annum based upon respective commissioners financial baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	73.7%			
~~Immediate Discharge Letters (IDLs) handed to patients on Discharge~~	~~General Condition 9~~	**~~98%~~**	Annual letter of assurance to be provided to CMB			
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver quarterly trajectories at Trust aggregate level for each quarter will result in the application of a £10K sanction relating to each underperforming quarter. Maximum sanction of £40k per fiscal year. The penalty will be applied by the commissioners in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	Quarterly audit			
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver the quarterly target will result in the application of a £6k penalty per quarter. Maximum sanction of £24k in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 94%**	Quarterly audit			
All Red Drugs to be prescribed by provider effective from 01/04/14	£50 penalty for any request to primary care for prescription of Red Drugs (TBC)	**100% list to be agreed**	CCG to audit for breaches			
All Amber Drugs to be prescribed by provider effective from 01/04/14	No financial penalty	**100% list to be agreed**	CCG to audit for breaches			
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	87.2%			

Blank page

D2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 May 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 30 April 2014.

At the end of April the Trust is reporting an Income and Expenditure (I&E) deficit of £0.7m against a planned deficit for the period of £0.3m. 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	May 2014
Version number	Version 1

Briefing Note for the Finance & Performance Committee Meeting 20 May 2014
Briefing Note for the Board of Directors Meeting 28 May 2014

Subject: April 2014 Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for April 2014

This month's report contains less information than usual because of the work still underway to finalise contracts, agree activity plans and populate all associated monitoring documentation. The report is provided as an early indication of opening performance at high level. This is common practice in the first month of the financial year.

The attached income and expenditure account shows a planned £0.3m deficit for the month of April. The actual reported actual position is that of an income deficit against expenditure of £0.7m, with a resulting negative variance of £0.4m against plan.

Despite this variance there are no material concerns needing to be reported through to the Board at this stage.

Income Analysis

At this stage in the year the income position is a full estimate using planning expectations. April data is still to be fully coded and costed and the estimate will be updated for the May report. This is common in terms of an approach as the need to clinically code data after the month end, review the data and then submit to the national SUS system for pricing reconciliation all drive a national reconciliation timetable. High level activity analysis suggests nothing of significant concern with regard to overall variance from plan at this stage.

We have immediately tripped a number of contract penalties totalling an estimated (but not agreed) £136k. The most notable of the penalties is the ambulance turnaround time breach; early indications of which suggest is £62k for April. However, given the withdrawal of CCG winter-funded schemes at the end of March there is a debate to have as to the application of this penalty and, if this is applied, the use of the resource to support no further turnaround delays. The Board are aware the Trust's capital scheme to create an extended ambulance hand over area on the York ED site is close to completion. This coupled with additional staffing is expected to improve the position considerably.

Expenditure Analysis

Operational pay budgets are £120k over spent for April. This is currently being investigated with Directorate management teams. Pay overall is reported as £0.4m underspent but this is due to pay reserves held centrally for inflationary costs, approved

developments and locum support. As in previous years work will be undertaken to assess the extent of reserve application necessary to support agreed pressures and what residual operational pressure is for Directorates to manage.

There are no issues in relation to drug or clinical supplies and services expenditure that I would wish to bring to the Board's attention.

Other costs are showing a material underspend. This is attributable to the balance of non-pay reserves held for agreed developments and inflationary pressures. There are no operational issues I would wish to bring to the Board's attention.

The report shows that the CIP programme is impacting adversely on the position by £1.8m. This is dealt with in the CIP report. This is consistent with the opening position in previous years.

2013/14 Contract Reconciliation

The Board are aware that contract agreements for 2013/14 have been agreed with all parties with the exception of HaRD CCG and HRW CCG. These disputes are not material at £0.4m in total and have been appropriately represented in our accounts. We will now follow the usual national reconciliation process to agree a final position.

Contracting Matters

Contract discussions continue with our commissioners. Local Authority contracts signed last year were two-year contracts so remain in force. In relation to S&R CCG (and associates) we have agreed all contract matters but are currently being prevented from signing by a Specialised Commissioner issue. This is the subject of considerable debate at present and relates to commissioner allocations and not Trust activity. In the case of VoY CCG, whilst we have agreed all contract terms there remains a variance between the CCG's financial offer and our assessment of likely activity levels. This is the subject of considerable debate at present. This contract is also affected by Specialised Commissioning.

Where contracts are not yet in place, payments are being made on account to the Trust and cash flow is not being compromised.

Other Issues

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

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 30 April 2014

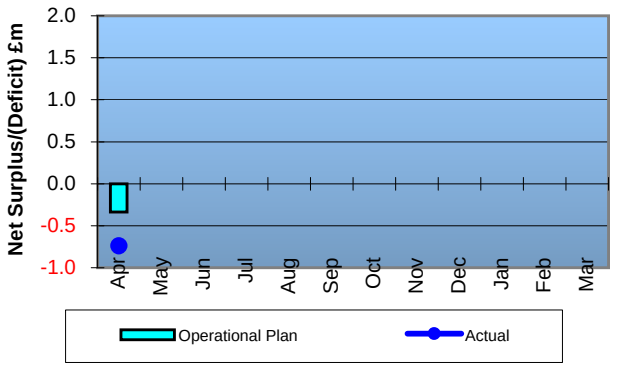
High Level Overview

A net I&E deficit for the period of £0.74m means the Trust is £0.4m behind plan.

CIPs achieved at the end of April total £1.7m. The CIP position is running £1.75m behind plan.

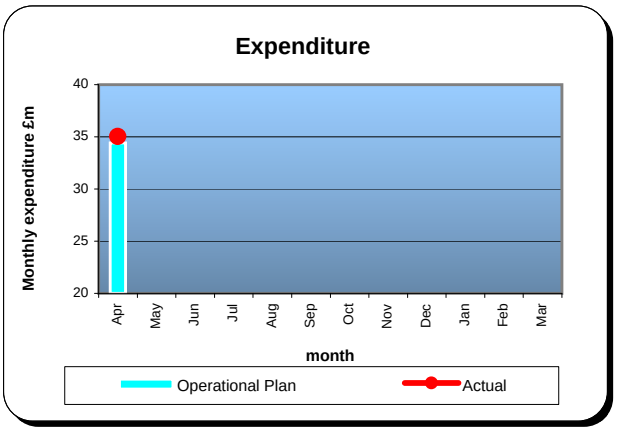
Cash balance is £31m

Net Income & Expenditure



Key Period Operational Variances			
	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. Lucentis)	30.6	30.7	0.0
Clin.Inc.(Lucentis)	0.9	0.9	-0.0
Other Income	4.0	4.2	0.2
Pay	-24.7	-24.3	0.4
Drugs	-3.5	-3.4	0.0
Consumables	-3.8	-3.6	0.1
Other Expenditure	-4.0	-5.2	-1.2
	-0.3	**-0.7**	**-0.4**

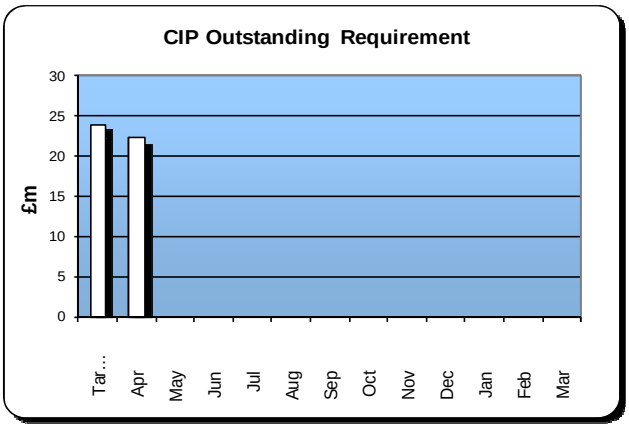
Expenditure



At the end of April there is an adverse variance against operational expenditure budgets of £0.61m. This comprises:-

- Operational pay being £0.36m underspent.
- Drugs £0.04m underspent
- Clinical supplies £0.14m underspent.
- Other costs are £0.61m favourable, primarily due to slippage against planned investments
- CIPs are £1.75m behind plan.

CIP Outstanding Requirement



The full year efficiency requirement is £24m. At the end of April £1.7m has been cleared.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
SUMMARY INCOME & EXPENDITURE POSITION
FOR THE PERIOD 1st APRIL 2014 to 30th APRIL 2014

	ANNUAL PLAN	PLAN FOR PERIOD	ACTUAL FOR PERIOD	PERIOD VARIANCE
	£000	£000	£000	£000
INCOME				
NHS Clinical Income				
Elective Income				
Tariff income	27,474	2,115	1,735	-380
Non-tariff income	169	13	3	-10
Planned same day (Day cases)				
Tariff income	35,029	2,697	3,066	369
Non-tariff income	651	50	22	-28
Non-Elective Income				
Tariff income	94,313	7,582	8,534	952
Non-tariff income	1,840	148	77	-71
Outpatients				
Tariff income	58,754	4,524	4,309	-215
Non-tariff income	4,688	361	251	-110
A&E				
Tariff income	14,059	1,130	1,130	0
Non-tariff income	490	39	30	-9
Community				
Tariff income	1,112	89	89	0
Non-tariff income	33,909	2,822	2,902	80
Other				
Tariff income				
Non-tariff income	121,633	10,014	9,572	-442
Fines and Contract Penalties			-136	-136
			0	0
	394,121	**31,584**	**31,584**	**0**
				0
	394,121	**31,584**	**31,584**	**0**
Non-NHS Clinical Income				
Private Patient Income	976	81	72	-9
Other Non-protected Clinical Income	1,722	144	135	-8
	2,698	**225**	**207**	**-18**
Other Income				
Education & Training	14,026	1,169	1,160	-9
Research & Development	2,005	167	311	144
Donations & Grants received of PPE & Intangible Assets	0	0	0	0
Donations & Grants received of cash to buy PPE & Intangible Assets	600	50	50	0
Other Income	16,432	1,371	1,467	97
Transition support	12,218	1,018	1,018	0
	45,281	**3,775**	**4,006**	**231**
Total Income	**442,100**	**35,584**	**35,797**	**214**
EXPENDITURE				
Pay costs	-303,269	-24,684	-24,323	361
Drug costs	-42,229	-3,472	-3,429	43
Clinical Supplies & Services	-45,956	-3,758	-3,622	136
Other costs (excluding Depreciation)	-51,278	-4,252	-3,645	606
Restructuring Costs	0	0	-8	-8
CIP	22,289	1,752	0	-1,752
Total Expenditure	**-420,443**	**-34,414**	**-35,027**	**-613**
EBITDA (see note)	**21,657**	**1,170**	**770**	**-400**
Profit/ Loss on Asset Disposals	0	0	0	0
Fixed Asset Impairments	-300	0	0	0
Depreciation	-10,854	-905	-905	0
Interest Receivable/ Payable	100	8	14	6
Interest Expense on Overdrafts and Working Capital Facilities	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0
Interest Expense on Non-commercial borrowings	-270	-10	-19	-9
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	-601	-601	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**3,129**	**-337**	**-740**	**-403**

D3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 May 2014

Efficiency Programme Update – April 2014

Action requested/recommendation

The Board is asked to note the April 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 April 14 is £1.7m, leaving a gap to be delivered of (£22.3m). There is a significant planning gap of (£6.2m) following a review of all in year plans; this compares with a (£4.7m) gap in April 2013.

The Monitor variance is (£1.8m) behind plan, which is marginally better than the 2013/14 position at this stage.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

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

Board of Directors – 28 May 2014

Efficiency Programme Update – April 2014

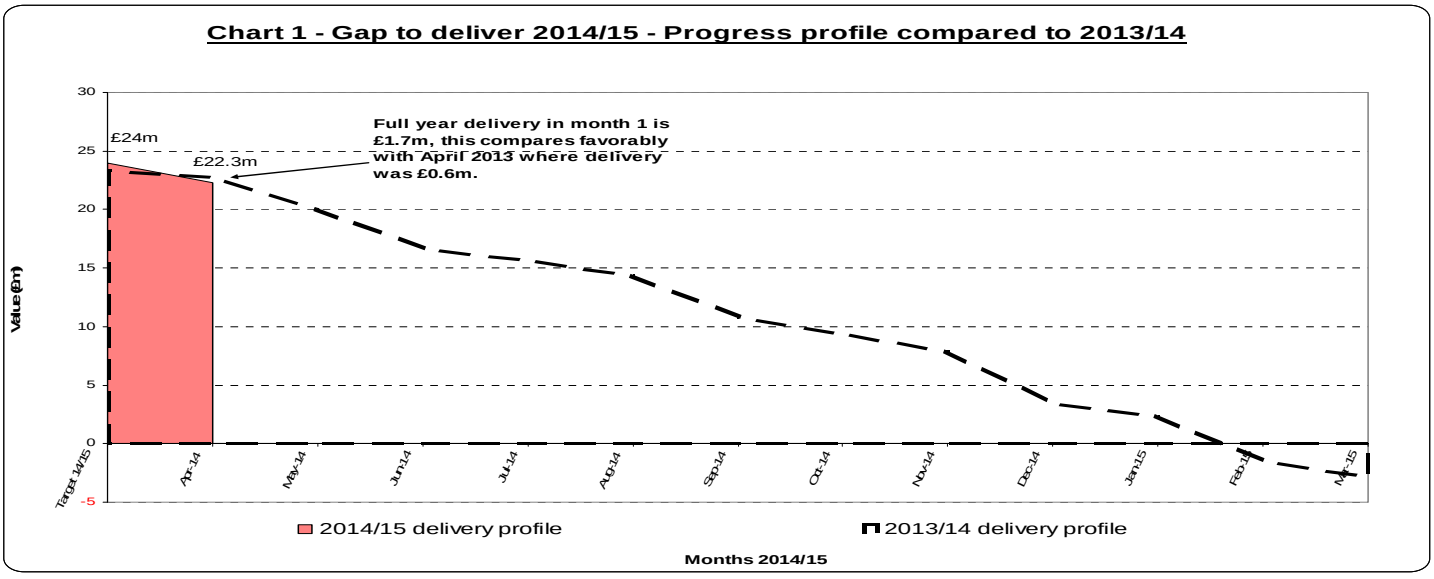
1. Executive Summary

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

See table 1 and chart 1 below.

Table 1 – Executive Summary – April 2014	Total
	£'m
TARGET	
In year target	**24.0**
DELIVERY	
In year delivery	**1.7**
In year delivery shortfall	**(22.3)**
Part year delivery shortfall - Monitor variance	**(1.8)**
PLANNING	
In year planning surplus/(gap)	**(6.2)**
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 5 remain as green. Work is about to start on reviewing new schemes.	**Current month** The current planning gap is (£6.2m). Full year delivery in April 2014 is £1.7m which compares favorably with April 2013 and the Monitor variance is (£1.8m) adverse.
Last Month Of the 32 Directorates and Corporate HQ functions 32 areas have completed their governance assessments as at March 2014.	**Last Year** In April 2013, the planning gap was (£4.7m). Full year delivery in April 2013 was £0.6m. The Monitor variance in April 2013 was (£1.8m) adverse.

2. Introduction and background

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

3.1 Progress against the Monitor Plan
3.2 Analysis of full year delivery
3.3 Further plans and in year risk
3.4 Four year planning.
3.5 Financial risk rating
3.6 Governance risk assessment.

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

2.1 Trust plan to Monitor

The combined position is (£1.8m) behind the Trust plan to Monitor as at April 2014; see Tables 2 & 3 and chart 2 below.

Table 2	April 2014	**Total YTD**
	£m	**£m**
Trust plan	2.0	**2.0**
Achieved	0.2	**0.2**
Variance	**(1.8)**	**(1.8)**

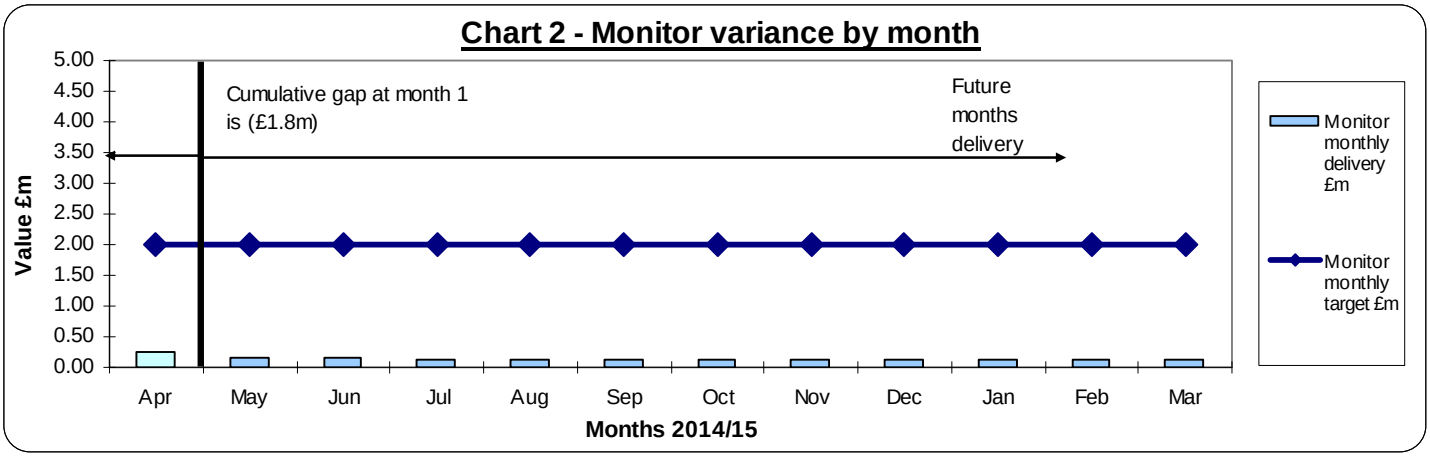


Table 3 – Monitor variance by month and cumulative variance

Months	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 14/15
Monthly delivery £m	0.25	0.15	0.14	0.14	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13	**1.7**
Monthly target £m	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	**24.0**
Variance £m	-1.8	-1.9	-1.9	-1.9	-1.9	-1.9	-1.9	-1.9	-1.9	-1.9	-1.9	-1.9	22.3
Cumulative variance	-1.8	-3.6	-5.5	-7.3	-9.2	-11.0	-12.9	-14.8	-16.7	-18.6	-20.4	-22.3	

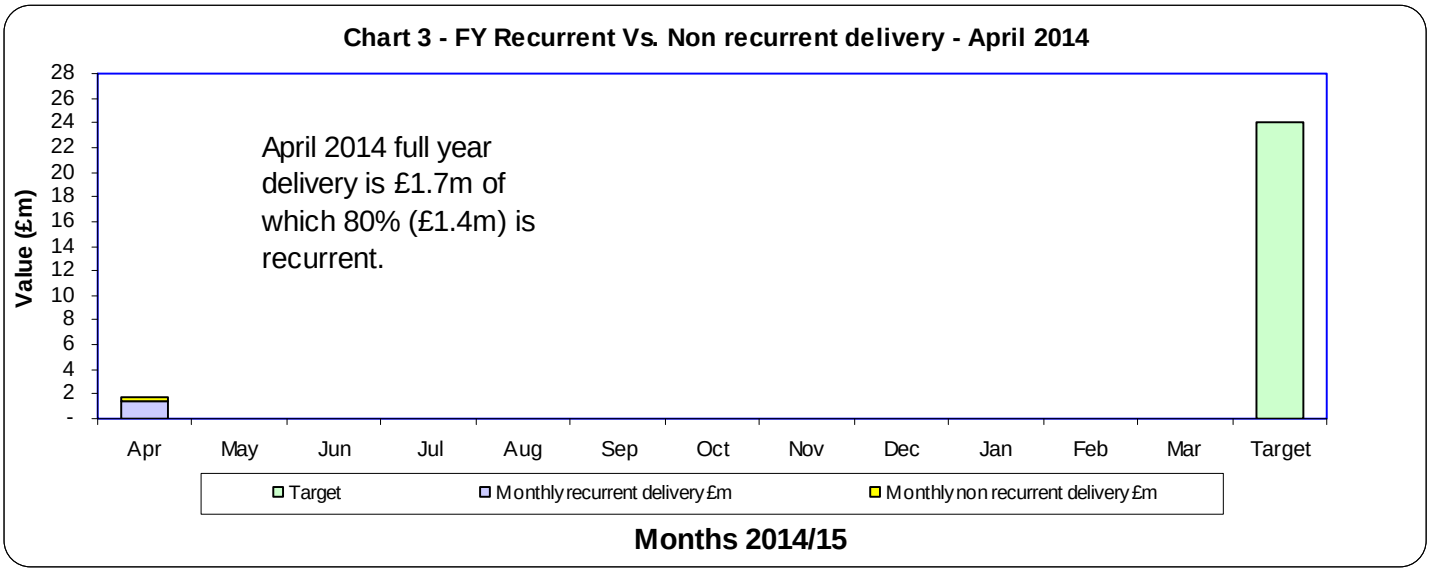
2.2 Full year position summary

As at April 2014, **£1.7m** has been achieved in full year terms against the plan of £24.0m (see Table 4 below).

Table 4	**April 2014**		**Change**

	£m	£m	£m
Expenditure plan – 14/15	24.0	-	0
Target – 2014/15	**24.0**	**-**	**0**
Achieved - recurrently	1.4	-	1.4
Achieved - non-recurrently	0.3	-	0.3
Total achieved	**1.7**	**-**	**1.7**
Shortfall	22.3	-	22.3
Further plans	16.0	-	16.0
(Gap)/Surplus in plans	**(6.2)**	**-**	**(6.2)**

The April 2014 position is made up of £1.4m (80%) of recurrent and £0.3m (20%) non-recurrent schemes. This compares with £0.4m (63%) recurrent and £0.2m (37%) non-recurrent at April 2013 - see chart 3 below.



2.3 Further planning and assessed risk to delivery

Further plans have been formulated amounting to £16.0m, which gives a shortfall in the planning position of (£6.2m). Plans are summarised in Table 5 below.

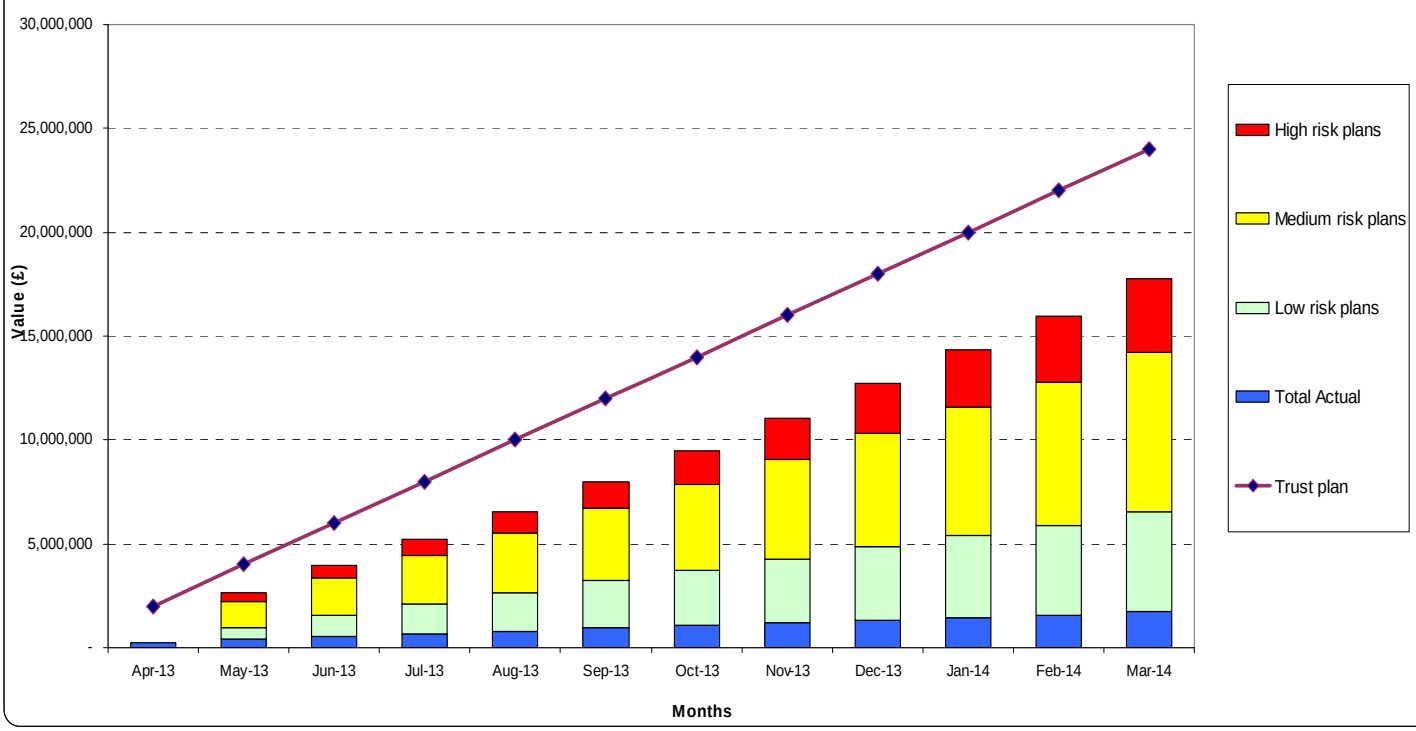
Table 5 – Further plans 2014/15

Risk	Gap Full Year	Plans - Recurrent	Plans - Non Recurrent	**Plans Total**	Gap in plans
	£m	**£m**	**£m**	**£m**	**£m**
Low		4.0	0.8	**4.8**	
Medium		6.7	1.0	**7.7**	
High		3.5	0	**3.5**	
Total	**22.3**	**14.2**	**1.8**	**16.0**	**(6.2)**

Directorate plans are each assigned a risk rating.

The overall April 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 - April 2014 - Actual delivery and further plans to achieve by risk



Significant work is continually carried out to re-assess, remove or re-profile plans to ensure an up to date position. There is an in year planning gap of **(£6.2m)** which is high risk. Work is ongoing to improve this position.

2.4 Four year planning

Directorates are required to develop four year plans and Table 6 below summarises this position. There is currently a shortfall of (£31.1m) over 4 years on the base target.

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

Table 6 - 4 Year efficiency plan summary – April 2014

Year	2014/15	2015/16	2016/17	2017/18	Total
	£m	£m	£m	£m	£m
Base target	24.0	16.8	16.8	16.8	**74.4**
Plans	17.8	11.4	9.8	4.3	**43.3**
Variance	**(6.2)**	**(5.4)**	**(7.0)**	**(12.5)**	**(31.1)**

2.5 Finance risk rating

In year delivery is ahead of the same point last year with £1.7m (7%) delivered in April 2014 against £0.6m (3%) in April 2013.

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

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

2.6 Governance risk rating

As the new schedules have been built a significant number of new schemes have been added, these will now need assessing for safety. The impact on the governance schedule are that a number of Directorates have dropped from their original green rating, it is not felt this change offers any further safety risk but is a consequence of new schemes at the beginning of the financial year.

It is expected all new schemes will have been assessed by the end of August 2014.

3. Conclusion

In April 2014 £1.7m worth of full year schemes has been delivered against the Trust plan of £24.0m, leaving a delivery gap of (£22.3m); this compares with £0.6m delivery in April 2013. The part year Monitor profile is (£1.8m) behind plan in month 1. The high level of recurrent delivery in the month, £1.4m (80%) is very positive.

We currently have a planning gap in year of (£6.2m), which is high risk.

The 4 year planning position highlights a shortfall in base plans of (£31.1m), which also offer a significant risk to delivery. Work is ongoing to improve the overall planning position.

It should be noted that a number of Directorates have dropped from their green governance rating; the reason for this is that as the new schedules are developed a significant number of new schemes are added and are awaiting assessment for safety. It is not felt this change offers any further safety risk.

4. Recommendation

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

Author	**Steve Kitching, Deputy Head of Corporate Efficiency**
Owner	**Andrew Bertram, Director of Finance**
Date	**May 2014**

RISK SCORES - APRIL 2014 - Appendix 1

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

RISK SCORES - APRIL 2014 - Appendix 2

DIRECTORATE	Yr1 Target (£000)	4Yr Target (£000)	Yr 1 Plan v Target		Yr 1 Delivery v Target		Y1 Recurrent Delivery v target		4 Yr Plan v Target		Risk Score	
			%	Score	%	Score	%	Score	%	Score	Total Score	Monitor Rating
SPECIALIST MEDICINE	1,850	5,345	24%	1	0%	1	0%	1	16%	1	4	1
T&O YORK	789	2,331	20%	1	4%	1	4%	1	30%	1	4	1
OPHTHALMOLOGY	875	2,667	51%	2	1%	1	1%	1	22%	1	5	1
RADIOLOGY	1,901	3,800	37%	1	4%	1	1%	1	41%	2	5	1
SEXUAL HEALTH	491	1,129	38%	1	12%	1	0%	1	38%	2	5	1
GEN MED SCARBOROUGH	982	2,511	50%	2	0%	1	0%	1	46%	2	6	1
WOMENS HEALTH	2,342	4,464	37%	1	14%	1	11%	1	52%	3	6	1
TACC YORK	2,421	5,768	60%	4	0%	1	0%	1	29%	1	7	1
TACC SCARBOROUGH	879	2,473	50%	2	22%	1	22%	2	33%	2	7	1
HEAD AND NECK	480	1,863	56%	4	2%	1	0%	1	37%	2	8	2
GS&U	1,708	4,756	63%	4	8%	1	8%	1	43%	2	8	2
THERAPIES	1,448	3,853	95%	4	0%	1	0%	1	56%	3	9	2
CHILD HEALTH	1,247	2,999	64%	4	0%	1	0%	1	73%	5	11	2
MEDICINE FOR THE ELDERLY SCARBOROUGH	817	1,698	78%	4	1%	1	0%	1	78%	5	11	2
GEN MED YORK	1,672	5,114	79%	4	2%	1	1%	1	79%	5	11	2
LAB MED	1,672	4,022	61%	4	31%	2	24%	2	56%	3	11	2
PHARMACY	-188	611	100%	5	0%	1	0%	1	151%	5	12	3
ED SCARBOROUGH	404	1,329	103%	5	0%	1	0%	1	103%	5	12	3
ED YORK	501	1,426	122%	5	0%	1	0%	1	87%	5	12	3
MEDICINE FOR THE ELDERLY	174	1,717	157%	5	0%	1	0%	1	111%	5	12	3
T&O SCARBOROUGH	324	1,298	199%	5	4%	1	4%	1	76%	5	12	3
COMMUNITY	2,443	5,185	106%	5	47%	2	11%	1	109%	5	13	3
CORPORATE												
HR	453	1,190	27%	1	0%	1	0%	1	42%	2	5	1
SNS	1,137	2,557	62%	1	0%	1	0%	1	42%	1	4	1
MEDICAL GOVERNANCE	70	158	24%	1	5%	1	0%	1	11%	1	4	1
AL&R	185	420	46%	1	0%	1	0%	1	44%	2	5	1
OPS MANAGEMENT SCARBOROUGH	329	638	50%	1	0%	1	0%	1	39%	2	5	1
ESTATES AND FACILITIES	2,878	7,804	73%	4	0%	1	0%	1	69%	4	10	2
OPS MANAGEMENT YORK	239	419	80%	4	0%	1	0%	1	81%	5	11	2
FINANCE	251	1,116	83%	4	0%	1	0%	1	78%	5	11	2
CORPORATE NURSING	334	496	159%	5	9%	1	9%	1	107%	5	12	3
CHIEF EXEC	75	448	152%	5	136%	5	136%	5	25%	1	16	4
TRUST SCORE			**74%**	**4**	**7%**	**1**	**6%**	**1**	**58%**	**3**	**9**	**2**

Blank page

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 May 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	May 2014
Version number	Version 1

Board of Directors – 28 May 2014

Chairman's Items

1. Strategy and Context

The signals from the "centre" (Monitor, DoH, FTN, commentators) continue to flag downward pressure on NHS, and particularly provider, finances – especially for '15/'16 and beyond. All scenarios point to reduced NHS budgets – not flat ones. The only "light" that one might detect is a potential flexibility in terms of Competition and Markets Authority (CMA) constraints on collaboration. Short of more explicit rationing, the partnering with other organisations, including the sharing of costs and activity, is one of the few ways the finances can be improved, as the traditional sources of improved productivity are gradually realised and depleted. Indeed, there is evidence that collaboration may be further encouraged by a broadening of the corporate forms that Trusts may be allowed to take (not just the current "Foundation Trust" model). The latter is being explored in the current Dalton review, due to report in October.

2. Governance & Governors

We look forward to our colleagues from Monitor attending the NED pre-meet, our public and private Board sessions in October.

Trusts have been asked to confirm Non-Executive "leads" on two issues in recent months. I am pleased to confirm the following for our Trust: Dianne Willcocks will lead on "end-of-life-care" and Philip Ashton will lead on "procurement". The aim is these will be "light touch" roles and in no way "operational". The purpose is to ensure that these NEDs will know a little more about these topics behind the scenes and that, when appropriate, they are raised at Board when the context warrants it.

The Governors are preparing for the recruitment of a new Chair of the Trust; The process will commence in September; interviews are provisionally scheduled for 8/9 December for 1/4/15 start date.

The afternoon of the July 30 Board meeting (in York) will be devoted to a Board-to-Board seminar with our Council of Governors. The agenda is currently to cover our 5-year Strategy and also a briefing on the nature of the topics we discuss in our private Board meetings. The occasion will; also give the chance for our Governors to meet and interact with Executives and NEDs in a different setting.

3. Recommendation

The Board of Directors is asked to note the report.

Author	**Alan Rose, Chairman**
Owner	**Alan Rose, Chairman**
Date	**May 2014**

Blank page

F

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 28 May 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	May 2014
Version number	Version 1

Board of Directors – 28 May 2014

Chief Executive Report

Perfect Week

I have set out below a brief overview of the Perfect Week that, with the support of the Board, ran from 19 to 26 May in Scarborough Hospital, along with Bridlington, Malton and Whitby Hospitals.

Perfect Week is an improvement programme from the Emergency Care Intensive Support Team from the Department of Health. Their role is to provide support to hospitals to improve their emergency and acute care. The work was jointly commissioned with Scarborough and Ryedale CCG, and staff across the health and social care community are involved, including the following organisations: Yorkshire Ambulance Service, North Yorkshire County Council, East Riding of Yorkshire Council, Tees, Esk and Wear Valleys NHS Foundation Trust, Humber NHS Foundation Trust, East Riding of Yorkshire Clinical Commissioning Group, and local GP practices.

The aim is to improve the way that patients move through the various steps in the whole health and social care system, from the ambulance service and GPs, through the hospital, and out into the community, be it social care, mental health, community services or back home.

Perfect Week follows the principles of a major incident with Bronze, Silver and Gold command structures in place.

Each ward and the emergency department produced a SAFER bundle which clarifies what they should be doing to deliver safe and timely care. Alongside this, each directorate, department and service has made up to five pledges to either improve patient experience, reduce delays, or better understand a particular issue.

A ward liaison officer role was introduced for the week, and these people play a key role in bronze command acting as a liaison between the ward staff and bronze commander. Many of the ward liaison officers are non-clinical staff who have not worked in a ward environment before. They did an excellent job and were crucial to the success of the week.

Although it is early days in terms of assessing and understanding the impact, the feedback we have had from many staff is that some of the pledges have made a significant difference.

We need to make sure any changes we introduce are sustainable for both this hospital and our health and social care partners, and this may take a few weeks and months. This means that it might feel as though we have taken a step forward to take two steps back. We know this may feel frustrating, and all we ask is that, whilst this is happening, staff continue to do the very best they can, and maintain the commitment and enthusiasm that has been so evident during the week, in the knowledge that the aim is for this to become the norm.

We will share regular updates once the week is over so that staff can see what is happening and what the future plans are. We will also be inviting staff to give their feedback about what it felt like to be involved and what they have learned.

Finally, a huge thank you to everyone who played their part. The sense of purpose and the way everyone pulled together as a team for the benefit of our patients was fantastic to see and a true credit to all of you.

Bootham Park Hospital

I have recently received a letter from Leeds and York Partnership NHS Foundation Trust describing their plans to vacate Bootham Park Hospital and Lime Trees as soon as possible. The letter advises that on an interim basis the trust will use two community units for the elderly to accommodate the patients from Lime Trees and patients from the elderly assessment unit at Bootham Park. The only exisiting estate they have to accommodate the 29 beds needed to replace wards 1 and 2 at Bootham Park Hospital is Peppermill Court. This facility is currently in use, but the service users can be transferred to other existing community units for the elderly at Meadowfields in York and Worsley Court in Selby.

As part of seeking a sustainable alternative to Bootham Park Hospital the Leeds and York Partnership NHS Foundation Trust has asked to work with us on planning our combined estate and infrastructure overall.

CQC Inspection

The Board will be aware that the CQC have committed to undertaking an inspection of all Acute Trusts by December 2015. The Inspections will be quite different in nature from those experienced before in as far as

- They are announced inspections (we will be given 6 weeks notice)
- A significant amount of data will be requested in advance
- The Board will be asked to make a presentation to the Inspecting team
- The Inspection Team will consist of specialists , and will be significantly larger than those experienced before
- It will involve public engagement in a different way ('listening workshops with the public and partners')
- They will cover key areas of the Trust (ED, Wards, Outpatients, etc)

Inevitably this means the organisation will be inspected within a year.

As an organisation, we need to be ready for such a significant event and as such I have asked Fiona Jamieson to begin overt planning and preparation of this as a priority, working with myself and the corporate team. This will involve learning from other organisations on their experience of the process, and identifying trends from published reports that we might begin to benchmark ourselves against.

Our Internal Compliance Review programme will begin to have a different focus, and we will work with the Matron's and Senior Managers groups to raise awareness and expectations within the organisation. We will seek to coordinate our various inspection programmes to replicate as far as possible the comprehensive nature of the new programme. I will shortly be briefing the Executive Board and set out the agenda and the approach the organisation is to take. I will continue to appraise the Board over the coming months.

Clinical Director for Anaesthetics, Theatres and ICU

I am pleased to announce the appointment of Dr Tariq Hoth as Clinical Director of the combined directorate of Anaesthetics, Theatres and ICU. Tariq replaces Jonathan Wilson who is stepping down In August. I wish Tariq every success in his new role and would like to place on record my thanks to Jonathan for the leadership and commitment he has provided during his time as Clinical Director.

CHKS awards

The Trust has again been successful on being named one of the top 40 hospitals as part of the CHKS awards. This is particularly important in the current climate as it is a clear demonstration of the organisations commitment over time to providing quality services, having won the award for 10 years running.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley Chief Executive**
Date	**May 2014**