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 29th October 2014**
in: **The Boardroom, The York Hospital, Wigginton road, York, YO31 8HE**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-executive Director Meeting with Chairman	Classroom 4, Post Graduate Centre	Non-executive Directors
9.15am – 12.45pm	**Board of Directors meeting held in public**	**Boardroom**	**Board of Directors and observers**
12.45pm - 1.30pm	Lunch		
1.30pm - 2.40pm	Board of Directors to consider confidential information held in private	Boardroom	Board of Directors
2.45pm – 3.30pm	Tender discussion (S&R Urgent Care)	Boardroom	Board of Directors
3.45pm – 4.15pm	Remuneration Committee	Boardroom	Non-executive Directors & Chief Executive

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 29th October 2014**

At: **9.15am – 12.45pm**

In: **The Boardroom, The York Hospital, Wigginton road, York, YO31 8HE**

A G E N D A					
No	**Item**	**Lead**	**Comment**	**Paper**	**Page**
Part One: General **9.15am – 9.55am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for Absence** • Brian Golding • Andrew Bertram	Chairman			
3.	**Declaration of Interests** To receive any changes to the register of directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chairman		A	7
4.	**Patient Experience** Stuart Petty (Chaplain for York) reflections.	Chaplain		Verbal	
5.	**Minutes of the Board of Directors meeting held on 24th September 2014** To review and approve the minutes of the meeting held on 24th September 2014.	Chairman		B	11
6.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman			

No	Item	Lead	Comment	Paper	Page
6.1	**Workforce Mitigation** To discuss and note the information included in the paper.	Director of Corporate Development and HR and Chief Nurse	Philip Ashton	C	29
Part Two: Quality and Safety **9.55am – 10.55am**					
7.	**Quality and Safety Performance Issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Patient Safety Dashboard • Medical Director Report • Chief Nurse Report • Acuity Audit • Patient Experience Report	Chairman of the Committee		D D1 D2 D3 D4 D5	35 41 67 75 93 101
8.	**Quarter 2 Director of Infection Prevention and Control Report** To receive for approval the quarterly reports from the Director of Infection Prevention and Control.	Medical Director		E	113
9.	**Being Open Policy** To receive the draft policy for consultation.	Medical Director		F	119
10.	**Quality Governance Framework** To approve the revised Quality Governance Framework.	Chief Nurse		G	159
11.	**National Cancer Patient Survey** To receive the report and noted the recommendation being made.	Chief Nurse	Dianne Willcocks	H	195

No	Item	Lead	Comment	Paper	Page
Part Three: Finance and Performance 10.55am – 11.30am					
12.	**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		I I1 I2 I3	201 211 221 233
Part Five: HR reports 11.30am – 12.00noon					
13.	**Workforce Strategy Minutes** To receive the Workforce Strategy Minutes from the meeting held on 18 September 2014.	Chairman of the Committee		J	245
14.	**Human Resources Strategy Quarterly Performance Report – 1 April 2014 – 30 June 2014** To review the report and approve the recommendations.	Director of Corporate Development and HR	Mike Sweet	K	257
15.	**Education Strategy 2014-2017** To consider the recommendations included in the report.	Director of Corporate Development and HR	Philip Ashton	L	269
16.	**Fit and Proper Person Test** To discuss the requirement of the regulations.	Director of Corporate Development and HR	Jennie Adams	M	321
Part Six: Governance 12.00noon – 12.30pm					
17.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		N	327

No	Item	Lead	Comment	Paper	Page
18.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		O	331
19.	**Monitor Quarterly Return** To approve the quarterly return to be submitted to Monitor.	Foundation Trust Secretary		P	335
20.	**Audit Committee Annual Report** To receive the Annual Report from the Audit Committee which will be presented to the Council of Governors at their December meeting.	Chairman of the Audit Committee		Q	341
Part Seven: Business Cases **12.30pm – 12.45pm**					
21.	**2013-14/157: Medical Staffing Cardiology Review**	Deputy Chief Executive	Dianne Willcocks	R	351
Any Other Business					
22.	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 26th November 2014 in the Boardroom, The York Hospital.				
23.	**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:

- 2014/15 -59B and 2014/15-60B Selby and Malton Trial Community Hubs

'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.

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York Teaching Hospital NHS
NHS Foundation Trust

Additions: No changes

Changes: No changes

Deletions: No deletions

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

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	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies 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 Committee Room, Bridlington Hospital, Bridlington on 24 September 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
Mrs B Geary	Interim Chief Nurse
Mr M Proctor	Deputy Chief Executive, Chief Operating Officer
Dr A Turnbull	Medical Director

Corporate Directors

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

Attendance:

Mrs A Pridmore	Foundation Trust Secretary
Mr P Brunt	Patient from Bridlington
Mrs M McGale	Director of Operations – Scarborough
Mr P Bowker	Assistant Director of Operations

Observers: Mr Bowker, Manager of Bridlington Hospital, was present for parts of the proceedings.

14/126 Apologies for absence

Apologies were received from Mrs S Holden, Executive Director of Corporate Development & HR

14/127 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.

14/128 Minutes of the meeting held on the 30 July 2014

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

14/129 Matters arising from the minutes

There were no matters arising from the minutes.

14/130 Patient Experience – Experience of a patient using the Bridlington Orthopaedic Service

The Chairman welcomed Mr Brunt to the meeting. Mr Brunt explained that he had been a patient of the newly located Orthopaedic service in Bridlington; he had undergone his operation in May 2014. Mr Brunt was very complimentary about the care he received, the quality of the surgery and his recovery. He said that the service was very professional and the hospital was a very friendly place. He did, however, also identify some areas where improvements could be made. He particularly noted that it was very difficult to return equipment that he no longer needs. He explained that he had been able to return his crutches to the ward, but the community equipment was still waiting to be collected by the community services provider.

The Board discussed the interrelationship between the main service and support services such as the equipment library and physiotherapy. Mr Brunt explained that his physiotherapy had not been provided by the Trust, but by the community services provider. He had seen them as arranged and they had provided him with some exercises, but that was the extent of the service; he would have appreciated a further opportunity to be shown some more exercises so that there was some variation in the work he was doing to rehabilitate himself.

The Board **noted** that a fair proportion of the patients using the new Bridlington service would be from East Riding of Yorkshire, and hence (currently) under the community healthcare of a different Trust (unlike patients in North Yorkshire and York, who are covered by this Trust). The Board accepted the points being raised and **agreed** that some further work with the EroY provider would be of benefit to the patients, to ensure the patient was experiencing an excellent service throughout the pathway.

Action: Peter Bowker and Wendy Scott to address.

The Board thanked Mr Brunt for his time and his comments. Mr Brunt left the Board meeting.

14/131 Quality and Safety Committee

Ms Raper advised that the Committee had welcomed Mr Keaney to the Committee as an observer. Ms Raper highlighted the key issues that the Committee wished to raise with the Board.

Integrated Dashboard – Ms Raper commended the continued development of the integrated dashboard and stressed the importance of a single information portal for the Non-executive Directors (and others). Mrs Rushbrook commented that the dashboard had been developing over a number of months and there were now a number of duplication areas between the dashboard and the Patient Quality and Safety Report. She recommended to the Board that this work should now be finalised and one report produced. She advised that the Board can then revisit the Integrated Dashboard and agree if there is any further information the Non-executive Directors particularly would like adding.

Mr Crowley reminded that it had been agreed to develop the finance and performance aspects of the report first, followed by the quality and safety and then the workforce data. He supported Mrs Rushbrook's recommendation of going to one report and develop it further from that point.

The Board **noted** the points raised and **agreed** with the recommendation made.

Serious Incidents – Ms Raper advised that the Committee had held a good discussion about the overarching process including timescales and reporting arrangements to ensure additional assurance was being gained.

Patient Experience – Ms Raper advised that the Committee welcomed the appointment of Kay Gamble as the Head of Patient Experience. The Committee also were looking forward to the step-up in performance around patient experience. She added that the Committee reviewed the Family and Friends (F&F) information and were disappointed in the results around staff.

Professor Willcocks added that the Workforce Committee had looked at the information around the staff return and were very clear that the situation was not acceptable and that even more concerning was being raised that the second round of seeking returns was demonstrating to be an even lower return. She added that there has been some excellent work on the patient F&F test, but that work does need to link across to the staff. Mrs Geary advised that at present staff are asked electronically through the Picker system to complete the questionnaire only, so there is a lot of work being undertaken around developing suggestions of how the collection could be undertaken in different ways.

Mr Crowley added that originally the tool used information including to the payroll number, and some staff believed that this meant they could be identified – hence lowering the participation rate. This time the collection of responses is asking staff to identify the department they work in, which it is hoped will overcome this initial concern. Mr Crowley added that he had included the item in staff brief, so he hoped that would help with ensuring staff will complete the information. Mr Golding added that he has a significant group of staff that do not have access to computers during the day and so it makes it difficult for them to complete the tool. Other members of the Board suggested that it was more a cultural issue rather than a technology issue, in that staff are too busy to respond to this kind of request. It was **agreed** by the Board that they would like a further report to be presented to the next Board of Directors.

Action: A further report of the F&F should be presented to the next Board meeting – Mrs Geary.

Clostridium-difficile (C-Diff)– Ms Raper asked Dr Turnbull to comment on the performance around C-Diff. Dr Turnbull was pleased to advise the Board that the Trust had seen only 19 cases of C-Diff to date this financial year. This is a significant improvement on last year and the Trust is well below the current trajectory. He added that he was disappointed that there had been two cases identified last week, one in York and one in Scarborough. Prior to those cases, York had not seen a case for 86 days, and there had been no cases in Scarborough for 13 days.

Dr Turnbull advised that systems were being tightened-up on the Post-Infection Review (PIR) process, which includes root cause analysis (RCA). RCAs are being sent back to clinicians to review and more clarity is being obtained around which cases of C-Diff were

avoidable and which were not. This is part of a national process, although guidance has as yet not been released. The Trust has consequently identified some existing guidance used at Hull Trust which it has been proposed to the CCG that the Trust adopts until the DH releases its guidance. Dr Turnbull advised that of the cases the Trust has seen it has been assessed that the majority were avoidable.

In terms of compliance with the prescribing of probiotics, there has been an improvement in the level of compliance; Dr Turnbull confirmed that his department is continuing to seek a higher level of compliance. The Trust has also completed a schedule of deep cleans. All of these initiatives should help to continue to improve the trajectory.

In respect of MRSA, the Trust has not seen any further cases for over 12 months. He added that the Government has re-drawn the rules for screening patients for MRSA. This supports what the Trust was finding; i.e. that patients were being given antibiotics when they were only carriers of the organism. He advised that the reporting of the level of screening for MRSA will change in the future, following the introduction of the new rules.

Nursing recruitment and safer staffing – Ms Raper invited Mrs Geary to present the safer staffing information. Mrs Geary advised that this was the fourth return the Trust had completed and it showed much the same picture as previous returns. Mrs Geary explained the detail included in the report and explained that staffing meetings continue to be held on a daily basis and staff are redeployed around the sites to ensure appropriate staffing levels are maintained.

She added in terms of recruitment there is work going on with the non-registered workforce. The Trust is over-recruiting to band 2 roles, with the expectation that some staff already in band 2 roles could be trained and up-skilled to fulfil a band 3 role, using the Cavendish Framework. Mrs Geary added that this is not a practice that is common to the Trust, but it is a practice that is used commonly in other organisations. The last recruitment was completed in September, for both York and Scarborough. That recruitment was a one-stop-shop event, at which a further 13 registered nurses were appointed; unfortunately, only one elected to work at Scarborough.

The Trust is also working with North Lincs. and Goole Foundation Trust (NLAG) to undertake some overseas recruitment, probably recruiting staff from Spain. NLAG have already had success in using Spanish nurses.

Mrs Adams explained that she was still uncomfortable with the staffing levels included in the report and challenged the team on whether enough was being done to address this.

The Board had a robust discussion about the work that was being undertaken to ensure staff levels were appropriate. Mr Crowley summarised by saying that the team are working very hard to ensure the correct establishment is maintained. He added that in the past he had had a debate with the then Director of HR about what was an acceptable staffing level for nursing.

The Board recognised and accepted that there are very difficult challenges around the recruiting of registered staff, given the national picture.

Dr Turnbull commented that historically there would have been a voice of concern from the consultant body on the level of nursing, but he felt this concern had lessened and, following significant investment, consultants were now more assured.

Mr Keaney asked if the executive could give some indication of when the Board would see some of these initiatives having an effect.

Mrs Geary commented that improvements are already being seen in York from the work done and a large number of registered nurses (recruited during the summer) will be starting with the Trust throughout September and October, but they will need to complete a six month preceptorship. Although the Trust managed to recruit 50 registered nurses earlier in the year, some have now chosen to work at other Trusts. So, the cohort starting in September and October will be smaller than had originally been expected. There are also the additional 13 registered nurses that were recruited during September and who will start in the next couple of months. It is expected that if the plans for international recruitment are successful and the Trust does complete the international recruitment, there will be a significant number of nurses joining the Trust in around six months however this depends upon a number of factors and more detail will be know whe n the links have been made with NLAG. At present, Mrs Geary advised she has completed some scoping work with NLAG and arrangements for the two HR departments to be in touch with each other have been made. The Board discussed the change in the nature of illness and age profile of the patients the Trust is caring for at present. Patients have higher acuity and are older, resulting in higher bed occupancy levels than used to be the case and this impacts on the number and type of nurses that are needed.

Mrs Geary agreed she would update the Board at the next meeting. She also added that in her exception report she would like to include a section on staffing levels, which breaks down in to both registered and non-registered workforce vacancies and the level of bank and agency nursing staff used, broken down by site.

Action: Mrs Geary to update the Board at the October meeting. Mrs Geary agreed to add further staffing information to her Chief Nurse Report and work with HR to provide the appropriate detail.

Ms Raper asked if the Workforce Strategy Committee workplan included review of packages of recruitment and a consideration about how the money is being spent and if it is the best approach. Professor Willcocks confirmed it was not on the Workplan, but agreed it would be included.

Action: Professor Willcocks to include recruitment approach on the forward work programme of the Workforce Strategy Committee.

The Board went on to discuss the important point that had been raised during the discussion about the challenges of recruiting staff to work in Scarborough. Mr Proctor explained that the issue was more of a general economy issue in the region. The challenge the Trust has had around consultant and other staff group appointments in Scarborough has been that if they live in the Scarborough area, their partners find it difficult to find employment, because there are not a significant number of roles in the area. A large proportion of the work opportunities in the Scarborough economy is seasonal.

Professor Willcocks suggested that the Trust should get involved with other agencies in a similar way to how the Trust is involved in a network of agencies in the York area. Members of the Board asked if it was possible to provide staff transport between York and Scarborough to ease the issue. Mr Crowley confirmed it was something that was being considered.

The Board **noted** the comments and the points that had been made.

QUEST Tool - Ms Raper advised that the Committee had received an update on the development of the tool, she asked Mrs Geary to update the Board.

Mrs Geary reminded the Board of the background to the introduction of the tool and that the Trust had been undertaking a pilot of the system. She advised that the Trust was now ready to 'go live' with part 1 of the tool at the end of September, but part 2 requires some further development work, to be completed before that can go live, but it is expected it will go live in November.

Action: Mrs Geary to update the Board on the completed development of the Quest tool at the Board meeting in November.

Mrs Rushbrook added that it is her intention that the burden of populating the tool will not remain with the nursing team. She will ask her team to populate the tool.

Mr Geary asked the Board to note appendix 2 of the report and advised that she would be discussing the flow chart at the next Nursing Board meeting.

The Board **noted** the report from the Quality and Safety Committee.

14/132 Operation Fresh Start

Mr Rose welcomed Mrs McGale to the Board meeting and asked her to update the Board on Operation Fresh Start.

Mrs McGale advised that Operation Fresh Start was the new name for the Perfect Week, as it had moved on from a specific pilot week to an implementation project. The project was split into a number of workstreams, including:

Command and Control
HR
Pharmaceutical
PTS and discharge lounge
Equipment
Emergency Department
Nursing
Communications
Review of pledges

Mrs McGale explained the objective of each of the workstreams. The Board asked if she had the support she needed to ensure the success of the project. Mrs McGale confirmed she did have the support she needed. She added that the Steering Group overseeing the implementation will meet later in October and a Non-executive Director would be part of that project. Mrs McGale advised that the project would report directly to the Executive Board and asked if the Board of Directors would like to receive a regular report. The Board discussed what information they would like to receive and **agreed** that as the information from the Executive Board is fed to the Board of Directors through the minutes, and Mr Ashton was a member of the Steering Group, they were satisfied not to receive regular reports directly from Mrs McGale, but would seek the information from the Executive Board and Mr Ashton. It was also **agreed** that, as this project would

fundamentally change how Scarborough works, progress would also be seen through the performance data, including a reduction in outliers, improvements in patient flow and earlier discharge of patients.

Dr Turnbull enquired if access to investigations had been picked-up as part of the project. Mrs McGale confirmed that was the case; she advised that it would be through the Command and Control workstream. She added that, in addition to the points already raised, all patients will have an identified plan and the hospital will introduce “visual hospital” principles, so each day questions will be asked about what a patient is waiting for and why are they in a bed; is there something the Trust should be doing that has not been arranged?

Mr Proctor reflected on the York site. He advised that he was a member of the Collaborative Integration Board, which is a subcommittee of the Health and Wellbeing Board. This Board is a multi-agency Board and he is anticipating bringing items from Operation Fresh Start to discuss at this Board, so that they can be implemented into the York site, as appropriate.

Ms Raper congratulated Mrs McGale on her hard work and achievements to date. She added that she saw this as an opportunity to embed continuous development on the site too.

Mr Keaney was keen to be assured that the levels of improvement are sustainable permanently and asked about how the mindset would be changed. Mrs McGale explained the methodology being used and some of the psychology sitting behind the actions. She added that the Intensive Support Team have supported the Trust in the past, around various aspects of performance. The team are very interested in the Command and Control workstream and it has been agreed that a member of the team will work with the Trust to support the introduction of the new systems, while learning about the Command and Control workstream. Mrs McGale added that she is also seeking some support around how to get the best out of the Command and Control workstream, by testing it out with the army.

Mr Bertram added that Operation Fresh Start is essentially two projects; the first is the Command and Control steam, which Mrs McGale has been describing. There is a net investment requirement and the Trust is in discussion with the CCG about the funding, although once the approach is working the expectation is that it will be self-funding and there may even be some additional savings to identify.

The second project is in the Emergency Department; this plan has been approved through the Executive Directors and Mrs McGale is now developing a plan to ensure it is a recurrent plan.

Professor Willcocks added her congratulations to Mrs McGale.

It was **agreed** that further information would be provided through the identified routes; additionally, some information may be provided through the Finance and Performance Committee.

14/133 End of Life Care Annual Report

Professor Willcocks reminded the Board that they had received a presentation from the Dr Saxby about the end of life care we provide. She added that the report shows the progress that has been made since that presentation.

Dr Turnbull explained that the report shows the progress that has been made nationally and locally around the replacement of the Liverpool Care Pathway. He advised that the process that had been put in place by the Trust was now multi-disciplinary and multi-agency and involved significant training and education and responded in a very professional and effective way to the national agenda.

Professor Willcocks added that the diagram included in the report shows how the pathway works. Dr Turnbull added that the Amber pathway does have some elements that reflect the good parts of the Liverpool Care Pathway, but it also has key new elements included in it.

Dr Turnbull also asked the Board to note the national audit included in the report. He confirmed that the results were disappointing nationally and the Trust's own performance was not satisfactory, but he did not feel there was a significant amount of work to be completed to achieve a satisfactory level of compliance and his expectation was that the Trust will become compliant quickly.

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

14/134 Patient Led Assessment of the Care Environment (PLACE) 2014

Mr Keaney commented that he felt this was a very good report, although he had noted some areas where the Trust was below the national average, particularly around privacy and dignity and food.

Mr Golding agreed he advised that he was pleased with the results and noted that improvements had been made in Scarborough through the decorating programme.

Mr Golding advised that the food element of the assessment did not have a comparator line. The Trust was improving the catering services available across the whole organisation with the introduction of the central production unit based in York, which will be opened in December 2014.

The privacy and dignity score at York represents a significant improvement from last year. Mr Golding expected those improvements to continue with the introduction of the new ward at Scarborough, where over 50% of the space is dedicated to single rooms.

Mr Golding advised that the report will be presented to those involved in the assessment later in the week. Mr Rose asked that the document be included in the Council of Governors agenda for the October meeting.

Action: Mrs Pridmore to include the PLACE report in the Council of Governors agenda

Mr Rose asked if HealthWatch had been involved in the assessment. Mr Golding confirmed they had been and it was agreed that acknowledgement of their involvement should be included in the report.

Mr Crowley added that he felt the report was a comprehensive and digestible report that highlighted some excellent work. He felt the assessors had been hard, but fair, in their judgements. With regard to the catering department, he added that they had done an excellent job over the last few months while there had been significant disruption during the construction phase. He asked the Board to join him in congratulating the whole team at York in their endeavours to keep a high standard of service during significant construction disruption.

The Board thanked Mr Golding for his report and echoed the comments made by Mr Crowley.

14/135 Finance and Performance Committee

Mr Sweet advised that there were a significant number of items he wished to draw to the attention of the Board.

Short term strategy – Mr Sweet advised that the Finance and Performance Committee had received a paper outlining the split between unplanned care and planned care. It was understood that both streams were progressing well. Mr Sweet also referred to the ward reconfiguration, ambulance handovers and the recruitment of GPs and the challenges around management staffing; he asked Mr Proctor to comment on those topics.

Mr Proctor advised that there had been some difficulties around management; he advised that three new Directorate Managers would be coming into post over the next few weeks and there was a new lead for unplanned care. He added that Mrs Booth had done an excellent job keeping the strategy going while the organisation recruited a replacement member of staff.

In terms of ward reconfiguration, Mr Proctor advised that there are still some final points to agree with the orthopaedic department before the moves can take place, but those discussions should be concluded in the next few days. He reflected on the complexity of the reconfigurations and outlined the extent of the preparation work that needed to be completed before the moves could take place. He also made the observation that the new Chief Operating Officer (current recruitment process underway) may also like to provide some input into the final reconfiguration.

With regard to the recruitment of GPs, Mr Proctor advised that work is underway reviewing the role.

Mr Proctor referred to the strategy and confirmed the strategy had been split into two streams, which reflected the two Boards -- Acute and Surgical -- that have historically been in place. Mr Proctor advised that the Surgical Board will be replaced by the Planned Care Board and will broaden its remit to cover the whole organisation; Mr Crowley is now seeking a new Chairman for the Committee and has asked for expressions of interest from the Consultants. Chairs of both the Planned and Unplanned Boards will work closely with the Corporate Directors.

Efficiency Programme – Mr Sweet reported to the Board that the Committee received overall assurance about the achievement of the target, but noted that the recurrent CIP was still very low (44%). He added that some directorates seem to be having trouble achieving their targets. He advised that as next month is half way through the year he has asked for some more detail on the directorates that are struggling to be presented to the Committee.

Mr Bertram advised that the Trust is in a better position in absolute terms and in the split between recurrent and non-recurrent CIP compared to this time last year but he confirmed there is absolutely no complacency within the programme management. There are risks in the system related to the changes in staff, both directorate managers and the finance team. Part of a response to those risks has been to strengthen the Performance Management Meeting process. There have also been changes to the Corporate Efficiency Team which have settled down very quickly.

Referring to the CIP panels, Mr Bertram explained that the process has changed in the panels too. It used to be that the agenda was driven only by the Directorate. Now, half the meeting is for the Directorate to lead; the other half of the meeting is led by the Executive Directors. In that second part of the meeting, the Directorate is provided with management data, such as Service Line Reporting (SLR system). Mr Bertram added that there is a need to constantly re-invent the programme, to make sure that it does not become stale. He advised that S. Tees, which is currently receiving more concentrated attention from Monitor, has made contact with the Trust recently to learn about our SLR system; they are impressed with our system and approach. They have offered the Trust the opportunity to learn about being in turnaround, which will give York an opportunity to take the best from it and incorporate it into our systems where appropriate.

Mr Crowley added that the engagement with the Directorates has changed. The nature of the debate and the emphasis has changed; it is now the notion of reducing waste through finessing the systems and processes we have in place. Mr Crowley referred to the Monitor Quarter 1 report, which reflected challenges that exist across the whole of the NHS. Mr Crowley commented that the Trust cannot afford to allow the complexities that exist in the system to suffocate or allow us to loose sight of the benefits the organisation can gain from the integration. The Board discussed the changes that are being made around the Directors' portfolios and the changes to the Business Intelligence Unit and the intention that the unit should be more forward-thinking.

The Board **noted** the comments made and the achievements made this financial year.

Performance – Mr Sweet asked Mr Proctor to comment on a number of key indicators, including 18-week admitted pathway.

Mr Proctor reminded the Board that a plan had been identified that would address the backlog over the next six to nine months. The only patients that would still be over 18 weeks would be those either with more complex needs or those that choose to go over the time.

Mr Proctor added that the Department of Health, through NHS England and the CCGs, provided additional money to clear any backlog and pay for extra waiting list sessions. Very little notice was give of the additional money and very few organisations have been able to put on the additional sessions and obtain the additional staff needed to run them.

At the Trust, it is struggling to stream the backlog and recently it has increased. This is, in part, due to staffing issues in theatres where staff were recruited, but have also secured roles at other Trusts. The position is now improving. The central money for waiting list initiatives is being made available until the end of September, but it is anticipated that it will need to be available for longer to make a difference. Mr Proctor added that the team is looking at what other ways can be introduced to speed-up the improvements.

Mrs Rushbrook added that as people are being asked to do more, more ways of removing waste from the system have to be found. She advised that with the 18 week pathway, it had been identified that it takes 15 days for 80% of the referrals to receive an appointment, she was confident that this could be reduced significantly.

Mr Bertram talked about the Collaborative Improvement Board meeting, at which both CCGs are represented. He outlined some of the discussions the Board was holding around the IMAS tool. He explained that the concept of working together to be able to sort the issues out in the local economy was high on the agenda, part of which was the continuation of the amnesty on the breach of 18 weeks.

Emergency Department - Mr Sweet summarised the performance as improvements at York, but the situation was deteriorating in Scarborough. Mr Proctor explained that in overall performance terms things were difficult in Scarborough. He confirmed that the Trust would not achieve quarter 2 and it was not anticipated that the Trust would achieve quarter 3 either. He advised that Scarborough usually improves in quarter 3, but historically it is the worst quarter for York. He explained the measures that need to be put in place, but advised that they will not be in place at the beginning of quarter 3.

Mr Proctor added that there were noticeable improvements in York for the ambulance turnround times, but Scarborough recently has experienced some problems. Scarborough has not always had a problem with ambulance turnround. It has developed in part because of the number of vacancies in the department, but also because of the reduction in the number of beds at Scarborough. The construction of Maple 2 does give the Trust the opportunity to escalate the number of beds available, but that is not open at present. Mr Rose asked about the split target and if that is helping. Mr Proctor confirmed it was. He explained that historically the bed managers were advised late in the day about patients that needed to be admitted. This initiative ensures that the identification is passed on earlier.

14 day cancer fast track – Mr Sweet asked Mr Proctor to update the Board on the action plan. Mr Proctor reminded the Board of the history to the challenges in the service. He explained that the service has now been centralised on the York site with the support of the CCG. The challenges around recruitment made it very difficult for the Trust to provide a clinically safe service. Mr Proctor added that, although it was the right thing to do at that moment, it was very important that the service was reinstated in Scarborough as soon as possible.

Mr Crowley added that the service is important to the population and sustaining a service that has poor performance results in a derogation of the whole service performance and can result in the service being centralised in a larger hospital. Mrs Adams felt this was an example of the merger between the hospitals working, where the Trust can recruit further staff in York and build in sessions at Scarborough.

Mr Crowley commented that there are two points that come to mind when consideration is being given to moving services; firstly, is the service clinically viable and secondly is it financially viable? There are times when achieving the targets that are agreed by Monitor and the Department of Health may not result in the best care for the patient and may mean that we achieve the target set by the regulator, but we could be providing a better service to our patients. Dr Turnbull added that this is a debate the Trust will have again and again. The Trust never set out to provide full panoply of services at Scarborough. We will provide breast services at Scarborough, but other services may in the future need to be reviewed to see if they are clinically safe to provide. Decisions will need to be made about services both at York and Scarborough and it may be that in the future patients who would have historically come to York for some services may be moved to Scarborough and visa versa. Mr Proctor added that the Trust takes every opportunity it can to explain that services will need to be provided appropriately and safely to all patients. Mr Crowley added that the Ophthalmology discussions that are currently being held are an example of this.

Mr Proctor commented on the 14 day fast track pathway and explained that it was designed to allow patients to move quickly through the system and reflect the level of concern their GP had. He added that it makes it difficult to manage the referrals differently and does result in some patients being seen quicker than other at the expense of those other patients.

The Board **noted** the comments.

Commissioning for Quality and Innovation (CQUIN) – Mr Sweet asked Dr Turnbull to provide some further information about the position of the CQUIN related to dementia and delirium and senior review.

Dr Turnbull advised the Trust failed the target in the first quarter by 1.4% which was very disappointing. The quarter 2 target was also vulnerable, but he did expect it to be achieved.

Professor Willcocks asked if it could be agreed when the future discussion included in the Board work programme around dementia and delirium could be held. It was agreed that there would be an update presented to the November Board.

Action: Update to be provided to the Board by Mrs Geary and Dr Turnbull at the November Board.

In relation to the 12 hour senior review, the Trust had a target of 65% for quarter 1 and achieved 73% for Scarborough. The target was set higher for quarter 2 in Scarborough at 70% at present Scarborough is showing at 68%. The targets for York were different. For quarter 1 &2 the target was 80% which the Trust is expecting to achieve.

6 week referral to diagnostic tests – Dr Turnbull commented that there is pressure with both the MRI and CT scanners. He advised that some outsourcing of imaging to the Nuffield would reduce the problems, but the reporting should be completed by the Trust's radiologists. He added that there are some issues in recruiting some radiologists, particularly MRI radiologists, who are very specialist. He anticipated there would be a business case brought to the Board in the near future for the appointment of an additional radiologist.

The Board **noted** the comments made.

Finance report - Mr Sweet summarised the financial position at the end of the month and asked Mr Bertram to update the Board on key negotiation points with the CCG. Mr Bertram reminded the Board of the two key negotiation points; the first being the penalty for failing the ambulance turnround time. He advised that the VOYCCG are supportive of reinvesting the fines into a strategy, as are Scarborough and Ryedale CCG. The other key point was the marginal non-elective tariff issue. At this point, those discussions have not concluded, but Mr Bertram was sure that they would be a feature of the discussions the Trust would have with Monitor when they visit Monitor on 20 October.

Mr Bertram confirmed the ambulance penalties amount was £500,000 to date and he anticipates the CCGs will be willing to provide to that level for the strategy.

Mr Bertram confirmed the Continuity of Services rating (CoS rating) was a 4. Should that begin to deteriorate, Monitor would be interested in discussing with the Trust what forward plans exist to recover the position.

Mr Bertram referred to the national Q1 picture and advised that 86 foundation trusts are posting a deficit; there had been only 40 in quarter 4. It demonstrates a massive deterioration in the financial position of Trusts and amounts to an aggregate deficit of £167m. Mr Bertram also advised that Monitor has written to all Trusts to ask for monthly information on the I&E position and the capital expenditure. They specifically require management information on the planned I&E position, the actual I&E position and the out turn for the year. They are asking for the same information on capital. As a result of this request, Mr Bertram advised he would amend his Board report so it included this data. He advised that the return to Monitor this month showed an out turn for the year of approaching a £1m deficit, this would still likely be within the tolerances of delivering a CoS rating of 4; currently the Trust is £0.4m adrift from that position.

Capital Planning update – Mr Sweet advised that the Committee had received a detailed report on the progress of the capital plan. He proposed that Mr Golding should update the Board on a number of projects, including the Scarborough maternity theatre upgrade, Maple and Lilac Wards, Scarborough paediatrics and the refurbishment of the Mallard Restaurant.

Scarborough maternity theatre upgrade: Mr Golding advised that at present the upgrade is struggling to pass its final testing. The area must achieve 110%, to allow for deterioration over time; at present it has only achieved 100%, so has not passed the test. At present the Trust is in discussion with the contractors about remedial work to ensure the area can pass the test. The department will be moving into the area in November 2014.

Maple Ward and Maple Ward 2 now called Lilac Ward; Mr Golding advised that Maple ward had been moved into Graham ward, so the hospital lost 30 beds, but the intention is to reopen Maple Ward in October, following the completion of the disruptive construction of Lilac Ward. It is anticipated that Lilac Ward will be handed back to the Trust at the end of January 2015, so that it can be commissioned and be open to patients at the beginning of March 2015. Discussions are also underway around Haldane Ward and its move into Lilac Ward, so work can be completed on Haldane, following which further discussions are being held as to which ward will be next.

Scarborough Paediatric department: Mr Golding advised that some redesign work on the outpatient area is being planned and funding solutions are being sought with further consideration being given at the November Board time out.

Mallard Restaurant: Mr Golding advised that the main restaurant will be opened in November. The main kitchen will be open in December, although there are some issues that require discussion and resolution with the main contractor that have pushed the programme slightly behind plan.

The Board **noted** the updates.

Annual report of the Finance and Performance Committee – Mr Sweet asked the Board to note that the annual report summarised the activities of the Finance and Performance Committee.

The Board **noted** the report and **agreed** that it would be valuable evidence to provide to Monitor on the work of the Committee.

Mr Rose reminded the Board that Mr Sweet was stepping down from being the Chairman of the Committee and asked the Board to join him in thanking Mr Sweet for his hard work and diligence as Chairman of the Committee.

The Board joined the Chairman in his thanks to Mr Sweet for his work with the Committee.

14/136 Audit Committee key issues

Mr Ashton advised that recently the Audit Committee held a time out and agreed that the communication between the Audit Committee and other key committees could be improved. The Audit Committee agreed that minor adjustments would be made to its agenda to ensure that the four Board Committees would have an opportunity to report to the Audit Committee on areas where they see key risks emerging. Likewise, it was agreed that where the Audit Committee receives information from Audit Reports that should be discussed in the key Committees, it would expect that information to flow to that Committee. Mr Ashton gave an example of this in the “being open” audit, recently completed.

Mr Ashton also asked the Board to note that the Audit Committee had considered its terms of reference and work programme in light of the revised Audit Committee Handbook and some minor changes had been made to the documents. Mr Ashton asked the Board of Directors to approve the revised terms of reference.

The Board of Directors considered the documents and **approved** the amendments.

Ms Raper did comment that she welcomed the more formal slot on the Board agenda for the Audit Committee and the circular nature of the increased communication.

14/137 Governance Documents

Mr Ashton advised that the Audit Committee had reviewed the governance documents at its last meeting and he confirmed that the Committee was satisfied with the changes that

had been proposed. He recommended the Board of Directors approve the changes to the document.

The Board considered the documents and agreed the changes to the documents.

14/138 Human Resources Strategy Quarterly Report 1 April 2014 – 30 June 2014

Mr Rose suggested that, as Mrs Holden was not present at the meeting, this paper should be held over until the next meeting. He did however ask Professor Willcocks if she had any particular comment she would like to make at his stage. Professor Willcocks commented that she felt the new way of presenting the information was very helpful. She looked forward to a full debate at the next Board meeting.

It was agreed that the paper would be included in the next meeting of the Board when Mrs Holden would be present.

14/139 Education Strategy

Mr Rose asked Mrs Rushbrook if she had any particular comments she would like to make about the paper. Mrs Rushbrook commented that she noted the strategy was heavily reliant on IT; this provided her with a level of anxiety, as a proportion of the workforce does not have immediate access to a computer.

It was agreed that the paper would be included in the next meeting of the board, when Mrs Holden would be present.

14/140 Report of the Chairman

Mr Rose referred to the visit to Monitor's offices that will take place in October; he advised that there would be a comprehensive pack put together for the team and a meeting had been arranged for the team to meet beforehand. He added that a crucial point to bring out to Monitor is the development work that the Trust is undertaking to support the demands around reconfiguration, including the changes in the Directors' portfolios.

Mr Rose commented that he had been at a Chairs' event recently, at which the audience had been advised that NHS England were intending on making a 15% cut from their management structure and 10% in that of the CCGs. The expectation is that there will be more collaboration across the CCGs as a result, but at present the message does not seem to be consistent, as there are other parties that don't believe they will see CCGs reconfiguring.

Mr Rose referred to the Open Day. He had received a number of messages and comments that were very complimentary about the day. He added that he felt the AGM had also gone satisfactorily.

Mr Rose updated the Board on the Chairman appointment, he advised that the campaign would be launched at the end of September and would run for five weeks.

The Board **noted** the Chairman's report and the comments made.

14/141 Report of the Chief Executive

Mr Crowley commented that the Trust should be welcoming the Monitor investigation. He was looking forward to accounting for the Trust's actions and hearing Monitor's views.

The Board **noted** the letter sent to clinical colleagues that Mr Crowley published as part of his Board report.

14/142 Next meeting of the Board of Directors

The next meeting of the Board of Directors will be held in the Board Room, York Hospital on 29 October 2014.

14/125 Any other business

There was no other business.

Outstanding actions from previous minutes

Minute number and month	Action	Responsible office	Due date
13/134 Dementia Strategy	To include an update on the dementia strategy in his board report on a quarterly basis.	Dr Turnbull	February 2014
14/055.1 2013 - 14/127: Bridlington Orthopaedic Elective Surgery	Evaluation Report pending the release of further capital	Mr Bertram	November 14
14/041 Patient Experience - Matron refreshment	Update the Board on the progress of the introduction of the new nursing structure	Mr Proctor/ Mrs Geary	December 14
14/063 Quality and Safety Committee	Provide the six monthly acuity audit report.	Mrs Geary	June 14
14/083 Finance and Performance Committee	Include dementia screening in his Medical Director report.	Dr Turnbull	July 2014
14/112 Quality and Safety Committee	Dr Turnbull to circulate the summary document on sign up to safety. Board to receive an update from the Quality and Safety Committee on the 'Sign up to Safety' campaign.	Dr Turnbull	Immediate October 14

14/114 Finance and Performance Committee	The IMAS report to be presented to the Board of Directors through the Finance and Performance Committee.	Mr Proctor	October 14

Action list from the minutes of the 24 September 2014

Minute number	Action	Responsible office	Due date
14/131Quality and Safety Committee	A further report of the F&F should be presented to the next Board meeting	Mrs Geary	October 2014
14/131Quality and Safety Committee	Update the Board at the October meeting on the progress against international recruitment.	Mrs Geary	October 2014
14/131Quality and Safety Committee	Add further staffing information to her Chief Nurse Report and work with HR to provide the appropriate detail.	Mrs Geary	October 2014
14/131Quality and Safety Committee	Include recruitment approach on the forward work programme of the Workforce Strategy Committee.	Professor Willcocks	Immediate
14/131Quality and Safety Committee	Update the Board on the completed development of the Quest tool at the Board meeting in November.	Mrs Geary	November 2014
14/135 Finance and Performance Committee	Update to be provided to the Board on dementia and delirium at the November Board.	Mrs Geary/ Dr Turnbull	November 2014

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

Workforce Mitigation

Action requested/recommendation

The Board are asked to accept the report and support the activities outlined to address workforce recruitment challenges.

Summary

The Board of Directors are aware of a number of approaches which have been implemented over the last year to address known risks to providing appropriate and well trained staff. This report collates all of the interventions which have been implemented as well as outlining pending actions to assist in addressing a national shortfall in trained and untrained staff in key care areas.

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 actions outlined within this paper may impact positively in responding to need by looking to increase our workforce diversity and look to enhance inclusive practices when recruiting.

Reference to CQC outcomes

This report focuses upon safe staffing a pre-requisite of safe care.

Progress of report	Corporate Directors
Risk	The risk of failing to recruit staff or address through different means concerns re skill mix is that we would be unable to provide the highest quality of care we aspire to.
Resource implications	Resources implication detailed in the report
Owner	Sue Holden – Director HR and Corporate Development Beverley Geary – Chief Nurse
Author	Sue Holden – Director HR and Corporate Development Beverley Geary – Chief Nurse
Date of paper	October 2014
Version number	1

Board of Directors – 29 October 2014

Workforce Mitigations

1. Introduction and background

Following a number of reviews looking at workforce issues and the changing demography of our workforce, particularly the increasing age profile, it was felt that the Board would benefit form a comprehensive over view of all actions which the Trust has taken to reduce the risks associated with recruitment challenges across the workforce.

Particular attention has been given to nurse shortages, however the Trust is experiencing difficulties in recruitment for medical positions as well and therefore a comprehensive review of the whole workforce has been undertaken to look at the skill mix required to provide safe staffing.

2. Discussion

It is essential to consider the workforce as a whole and look at the skill mix required to deliver safe, effective care. Nationally there is an acknowledged shortage of care staff, it is anticipated that this shortage will increase until at least 2016 (RCN, 2014). This has been created through a number of factors outside of the Trust's control:

- Nationally , poorly co-ordinated workforce planning
- Reduction in training numbers
- Tardiness in developing alternative roles
- Increased demand
- Increased number of providers outside of the NHS
- Increasingly complex market
- Ageing workforce
- NHS wage constraints
- NHS less attractive as an employer following a number of national scandals – increased attractive agency model of working.

The Trust has implemented a number of activities to try and address the concerns of an increasingly difficult recruitment market. A number of these interventions commenced prior to the current difficulties and focused on how we could release staff to have more time to care.

2.1 Interventions

Development Interventions

The Trust recognising the need to create greater supervisory time for ward managers implemented a workforce review and identified additional funds to enable ward sisters to have time to supervise and therefore develop staff. The 'It's my ward' program saw over a 100 ward sisters undertake a development program focussing on upskilling them so that they could ensure that their staff kept the patient at the centre of decision making.

The program also enabled the ward sisters to develop greater confidence and a core set of competencies to enable them to manage more effectively. The development of the ward

Sisters SAS meetings enhanced the sharing of good practice along with increased problem solving capability in order to be able to respond more efficiently through shared decision making and peer support.

The Trust has developed a comprehensive range of leadership development programs for staff at all levels. All of the programs reinforce trust values and the need to work as an effective team member. Leadership is seen as a key strand to enabling our staff to optimise the capability of staff to ensure that patients get the best possible care.

A key part of enabling our workforce to be more efficient and therefore more able to focus on direct patient care, is the implementation of a number of enabling technologies these include:

- Electronic observations
- EDN's
- Notify
- Ward checklist

Recruitment Interventions

In October 2013 the Trust took the decision to try some new approaches to recruitment of nurses in response, at the time, to the seasonal winter pressures and the investment as a result of the establishment review. This incorporated One Stop Shop events (including an element of generic recruitment) and City Campaigns (London and Glasgow). There has been varying success leading to a focus on the One Stop Shops with the greatest returns in terms of volume of appointable candidates.

The vacancy position has reduced significantly in terms of HCAs with a reserve list of appointable candidates on both York and Scarborough site. The registered nurse position has improved significantly at York with around 60 vacancies which represent a vacancy factor of around 5.8%. This has all been achieved through additional activity within recruitment to support and prioritise the need through generic campaigns which replicate a centralised model. Work is continuing to evaluate this approach and the implications in terms of resource to implement a centralised recruitment service.

The Trust has explored international recruitment and scoped the potential to work in partnership with others in the region such as NLAG to ensure value for money. However, this needs to be balanced with the needs of the workforce and an individual campaign is being explored simultaneously.

There remains an aspiration to move a centralised recruitment model with evidence demonstrating that this would be more efficient process both in terms of the applicants' experience and the potential to reduce the overall cost to the organisation of recruiting. The key risk area remains the attrition rate between a job offer and converting this into appointment which is devolved to the department. On a more strategic level, it does not fit with our strategy of being identified as an employer of choice and reflects poorly in terms of first impressions. The use of a generic model clearly demonstrates the impact in terms of the numbers being appointed and the reduction in vacancies but this can not be sustained without investment in a central model. The additional benefit would be the ability to have one central measure for vacancies with the introduction of establishment control through ESR and this has been supported by the Workforce Strategy Committee. However, this will only be effective with a central recruitment team.

Skill Mix Interventions

The Trust is leading the approach across the region in developing alternative roles which fulfil the current demand for care using the Calderdale framework. This framework enables service to identify the specific role deficit and develop competencies within a recognised framework which creates a role specific for service need. By using this framework we are currently working across a number of areas to identify new roles which will be banded 2 – 4, thereby supplementing the registered workforce and providing greater opportunity for the rights skills to be deployed at the right time. This also has an additional benefit in that it will develop a career structure for non-registered staff supplementing retention.

In more complex roles we have developed the Advanced Clinical Practice role; this will create roles which will supplement and be complimentary to our medical workforce in especially hard to recruit areas such as ED, Elderly and Acute Medicine. It is our intention to continue this program of development to ensure that we have a balanced workforce where we are confident that patients are receiving care from staff with the correct level of skill and knowledge. This has and will continue to require regular reviews of the skill mix in key areas. The Trust has committed that this will not undermine the Safer Staffing Alliance recommendation of 1 : 8 for registered staff in ward areas during the day

The Trust is in the process of bringing in – house our own bank provision. This will enable staff that are fully committed to the Trust to work additional shifts at times of need. There is recognition that this improves patient safety and team working due to staff being familiar with Trust processes.

We are currently working with staff side to look at how we can create greater opportunities for staff who wish to retire. We are also looking at developing a program to buddy with schools to increase younger people's awareness of the opportunities which the Trust can offer in terms of employment including the development of summer contracts to offer young people a taster of working within the NHS.

3. Conclusion

Significant work has been undertaken to address current workforce gaps and to address anticipated workforce issues of the future.

These include a number of interventions to support staff currently in post and also the creation of new roles to support medical and nursing teams. There has been a targeted recruitment campaign over the last eleven months with successful outcomes in terms of the numbers appointed.

4. Recommendation

The Board is requested to note the national; and therefore organisational challenges in recruitment, and acknowledge the current and planned work streams to mitigate the risks.

5. References and further reading

Nursing and Midwifery Strategy 2012

Author	**Sue Holden, Director – Corporate Development and Human Resources** **Beverley Geary, Chief Nurse** **Natalie McMillan – Head of Human Resources**

Owner	**Sue Holden, Director – Corporate Development and Human Resources** **Beverley Geary, Chief Nurse**
Date	**October 2014**

York Teaching Hospital NHS Foundation Trust

Quality & Safety Committee – 22nd October 2014, Classroom 4 Post Graduate Centre, York Hospital

Attendance: Libby Raper, Philip Ashton, Alastair Turnbull, Beverley Geary, Anna Pridmore, Diane Palmer, Liz Jackson

Apologies: Jennie Adams

	Agenda Item	Comments	Assurance	Attention to Board
1	**Last meeting notes held on 16th September 2014**	The Committee gave warm congratulations to Beverley Geary for her substantive appointment as Chief Nurse. **Integrated Dashboard –** DP advised the Committee that progress was being made around integrating the Performance and Patient Safety dashboard with the monthly performance report. A draft of the new layout will be brought to the Committee for discussion in the near future. The Committee agreed that the prime objective was to provide the best possible information without losing the progress made so far in the provision and level of information the Committee receives.	The Committee were pleased to see that progress was being made, but were clear that they were very keen that the level of data received currently must be maintained.	
2	**Matters arising**	AJT commented on the recent conversation around Information Governance and advised that the breach will be reported to the information commissioner. The information Commissioner will require the Trust to be able to demonstrate that the issue is not on-going and that sanctions have been taken. The Trust will include evidence that demonstrates those two factors when it reports the issue.	The Committee noted the comments made and the action being taken	
3	**Integrated Dashboard**	The Committee drew attention to the SCBU section of the Maternity dashboard. AJT explained pressure on the	The Committee agreed they would continue to keep the	

	Agenda Item	Comments	Assurance	Attention to Board
		SCBU cots. BG confirmed that every admission to SCBU is discussed at the maternity governance meeting and no risks have been highlighted. BG will speak to the directorate about the reporting and establish if the reporting levels have been set correctly. The new safeguarding lead is reviewing processes currently in place and it is anticipated that a paper will come to Quality and Safety Committee in November in advance of any discussion at Board. The Committee reviewed the executive summary **SHMI -** AJT shared the updated SHMI with the Committee. There has been a net increase of one point following a slight rise in deaths on both acute sites. Work will continue with all the elements pf the Patient Safety Strategy. The Committee raised concern over the increase in the SHMI at Scarborough particularly. The Trust's SHMI score covering the period April 2013 to March 2014 was 99 which demonstrate deterioration from the last reported position of 98. **Serious Incidents** – The Committee discussed the breakdown of the 13 Sis. The majority of which (12) were due to slips, trips and falls or pressure ulcers. BG and DP explained that as a result of the work the monthly falls steering group has been doing; there is more awareness of the importance of preventing falls. The data is currently being validated and figures will be available for next month's Committee meeting. **Action: BG to bring the figures to the next meeting** The Trust is in a similar position to other Trusts in relation	SCBU area under review until the actions had taken effect. The Committee shared AJT's disappointment and recognised the work being undertaken to understand the deterioration The Committee found the work being undertaken around falls and pressure ulcers encouraging, but recognised there was still significant work to be complete before the Committee will be satisfied	AJT to update the Board

	Agenda Item	Comments	Assurance	Attention to Board
		to pressure ulcer reporting. We are currently awaiting validation of the data prior to presenting to the Committee. **Clostridium difficile** - AJT confirmed that the Trust had exceeded the C-Diff trajectory for the month of September, although the Trust was below trajectory for the quarter and for the year. There have been great improvements in the prescribing of pro-biotics and anti-microbials and there is now Consultant representation on the C-Diff Operational group. AJT added that there is some evidence of a link between three of the cases on one ward. Work is that BG explained that 3 occurrences have taken place on one ward and ICT are involved. A possible deep clean may be needed and plans are in place with the ward sister. **Dementia Screening** – DP was happy to advise the committee that the CQUIN for this quarter had been met with over 90% of necessary patients receiving dementia screening. Scarborough achieved 100% in the moth of September. The Committee noted the developments to the Community Hospital Dashboard. It was confirmed that the Community Risk Register needs to be updated. BG explained that this will form part of the portfolio of the new community assistant director of nursing. The Committee acknowledged the comprehensive notes from the patient safety walk rounds.	The Committee were assured by AJT and DP's comments that this is a true reflection of results.	
4	**Family and Friends report**	BG informed the Committee that Patient Experience will be purchasing a new system that will analyse data around complaints and identify themes. With the Patient Experience Lead new in post this is a work in progress	The Committee noted the changes and the report. There remains a concern for the Committee around the	

	Agenda Item	Comments	Assurance	Attention to Board
		and will mean the future reports will be considerably different. The Committee discussed what information should be included on the new 'Knowing How You're Doing meetings. It was agreed that these should be kept streamlined so that information can always be up to date.	performance on the FFT, but the Committee was assured that improvements were being made.	
5	**Supplementary Medical Director Report**	**Information Governance** – AJT updated the Committee on current work being undertaken with Junior Doctors to reduce the production of hand held patient lists. **National incident reporting** - The Committee discussed the National Reporting and Learning System Report in detail, the Trust remains within the mid band of reporters and is close to the mean in each type of incidents reported. The Committee noted the variance in definitions from different organisations. The Committee understood that work continues to ensure the information submitted is accurate and submitted on time. DP reminded the Committee about the relationship between the reporting and the Duty of Candour and being open policy.	The Committee noted that this report did provide an opportunity to reflect on the Trust's position against peers.	AJT to update the Board
6	**Quarterly reports from the Director of Infection Prevention Control**	There have been no instances of MRSA in the last quarter. The Trust is however, above trajectory for MSSA. The Committee was concerned about the invasive equipment being used in the renal department. AJT confirmed that the IV device specialist nurse is leading a project trialling new equipment.		
7	**Supplementary Chief Nurse Report**	The Committee discussed the Deprivation of Liberty legislation and how the Trust is concerned about the Cheshire West ruling and the implications for the Trust. BG confirmed that these issues apply to everywhere in the UK. The safeguarding team are working well.	The Committee understood the concern and the challenge being put in the system. They were assured by the description of the work	BG to update the Board

	Agenda Item	Comments	Assurance	Attention to Board
		This has been placed on the risk register.	being undertaken by the safeguarding team.	
8	**Quality Report**	AP led a discussion around the content and level of information that should be included in the Quality Report and how to demonstrate the strategies that add quality to patient experience. The Committee discussed the recommendations and agreed that further work need to be undertaken to establish the level of appropriate consultation that should take place around the development of the priorities. The Committee agreed that a mock version of the report should be developed to discuss at the next meeting. AP added that there was information that was currently included in the Annual Report that could usefully be included in the Quality Report. AP will prepare a draft format for the report to consider at the next Committee meeting.	The Committee were pleased that the discussion around the report had started earlier than had been the case in the past and were assured by the thinking that was currently being undertaken.	
9	**Acuity Audit**	BG introduced the Acuity Audit. The Committee agreed that the main areas of concern of this audit were if staffing levels were appropriate and if they were accurate. BG explained that Matrons and Ward Sisters should be using their professional judgement when using the Safer Nursing Care tool to assess the acuity and dependency of the patients on their wards. She added that the figures from the first audit raised a number of concerns, so a second audit was undertaken to check if the concern was around the tool being used or the understanding of the categories by staff. The second audit confirmed that it seemed to be both a lack of understanding by staff and some concerns about the logarithms sitting behind the tool.	The Committee were assured by the support offered from the Patient Safety Team for the re-audit and look forward to seeing results in December.	BG to update the Board

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee agreed that the Matrons should be accountable for the results from their own areas but they will need the appropriate support. BG informed the Committee of a new non-clinical role within the Chief Nurse Team who will be able to support this. It was also suggested and agreed the Patient Safety would be able to provide some additional support to the wards on the validation of the figures.		
10	**Quality Governance Framework**	The Committee confirmed that they were satisfied with the draft Quality Governance Framework and agreed it should be submitted to the Board of Directors for final approval		
11	**Dates for meetings 2015/16**	The dates for future meetings have now been arranged this was not discussed in detail due to time restraints.		
12	**Any other business**	AJT informed the Committee that GP trainees in Paediatrics in Scarborough had raised concerns around the lack of Senior cover during the night. This was flagged as an immediate safety issue and acted on accordingly. Currently the Trust has employed middle grade locum doctors to cover the time. Further work is being undertaken to develop a final solution.. AJT assured the Committee that the Consultants on call do not live far from the Hospital should there be an emergency. Currently two nights a week there is a Consultant resident on call.		

York Teaching Hospital NHS
NHS Foundation Trust

D1

Patient Safety and Quality Report

October 2014

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

Index

Executive summary

- The SHMI for the period January to December 2013 was published on the 30th July as 97.6. The next SHMI is due to be published on 23rd October.

- 13 Serious Incidents (SIs) were declared in September.

- No Never Events were reported.

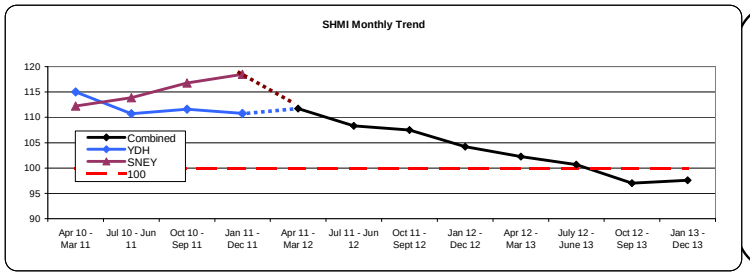
- Patient falls remains the most frequently reported incident category.

- Six cases of toxin positive c. difficile were identified in September.

- Compliance with dementia screening for patients admitted to hospital was 94% in September.

Patient Safety

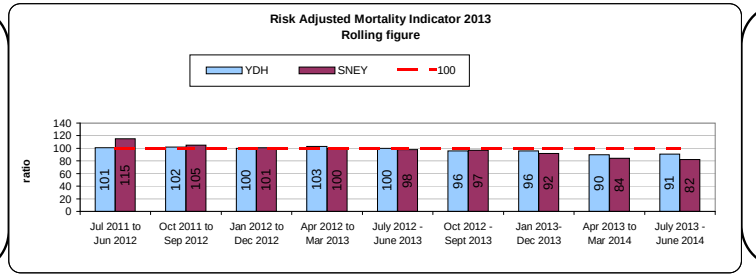
Mortality



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 .

The SHMI for the period April 2013 to March 2014 is due to be published on 23rd October 2014.

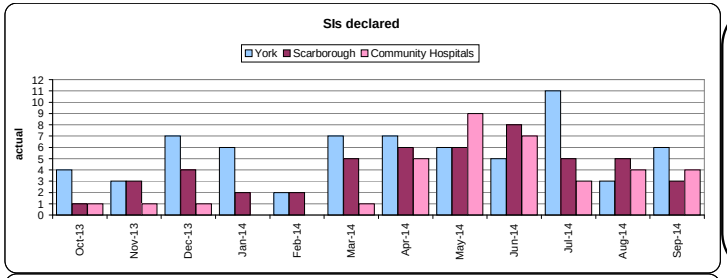
Data source: Information Centre



The Risk Adjusted Mortality Indicator (RAMI) for the reporting period July 2013 to June 2014 indicates only small variation from the previous reporting period.

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

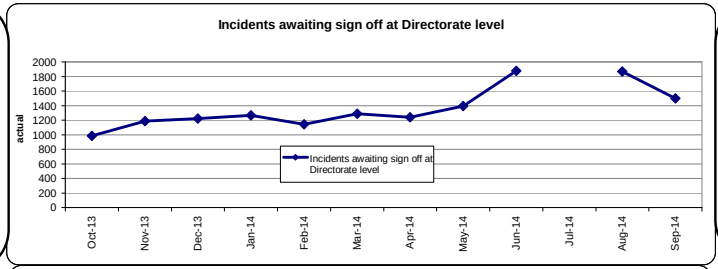
Measures of Harm



There were 13 serious incidents (SIs)reported in September

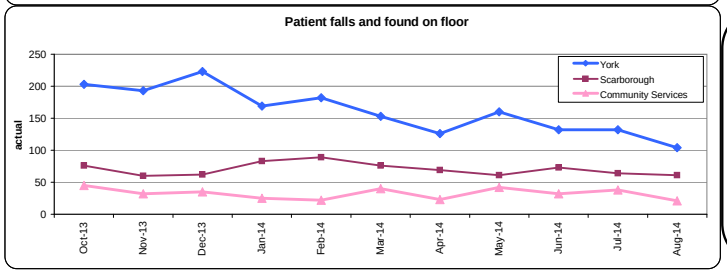
Six of the SIs related to category 3 pressure ulcers, six to patient falls and one due to delayed diagnosis.

Data Source: Datix



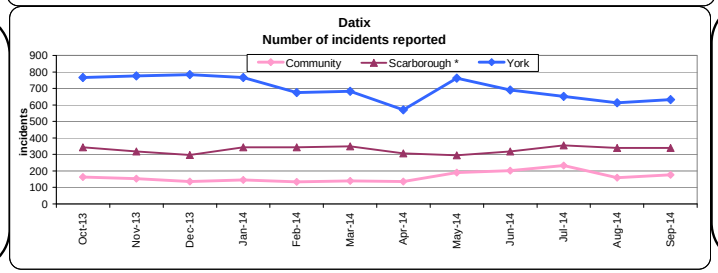
At the time of reporting there were 1498 incidents awaiting sign-off by the Directorate Management Teams. Risk and Legal are working with the Directorates to facilitate the timely completion of incident investigations.

Data Source: Datix



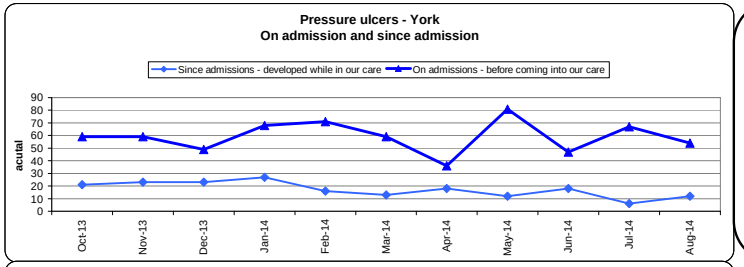
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During August there were 104 reports of patients fallingat York Hospital, 61 patients at Scarborough and 21 patients within the Community Services.
These figures may increase as more investigations are completed.

Data Source: Datix



The total number of incidents reported in the Trust during September was 1150. 633 incidents were reported on the York site, 340 on the Scarborough site and 177 from Community Services.

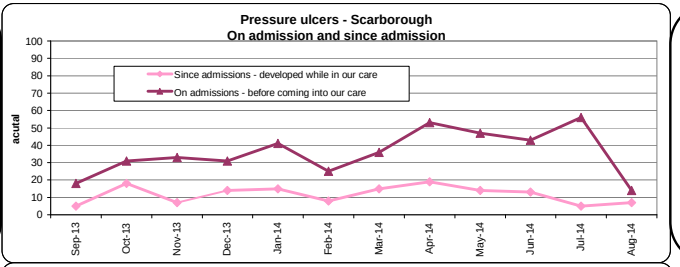
Data Source: Datix



During August 12 pressure ulcers were reported to have developed on patients since admission to York Hospital.

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

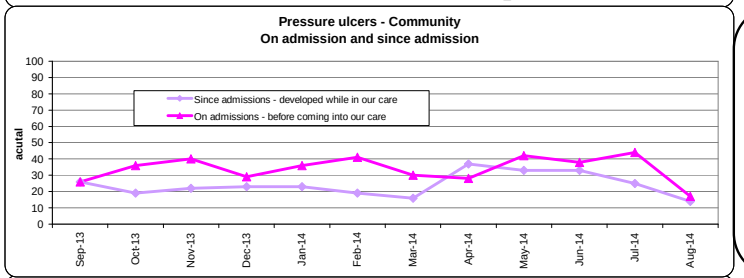
Data Source: Datix



During August, 7 pressure ulcers were reported to have developed on patients since admission to Scarborough Hospital.

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

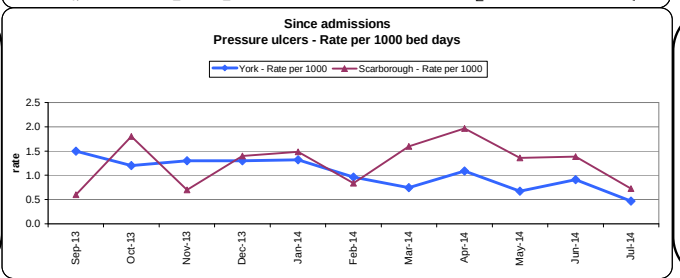
Data Source: Datix



During August 14 pressure ulcers were reported to have developed on patients in our community hospitals or community care.

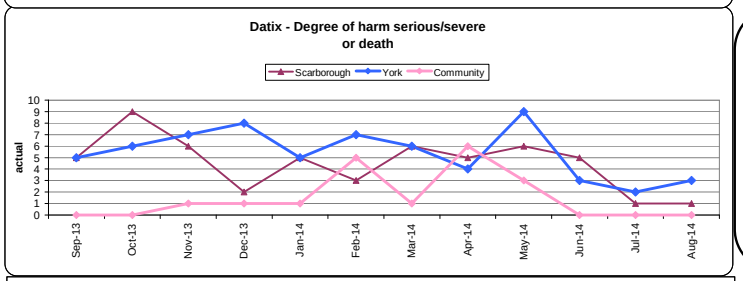
These figures should be considered as approximations as not all investigations have been completed.

Data Source: Datix



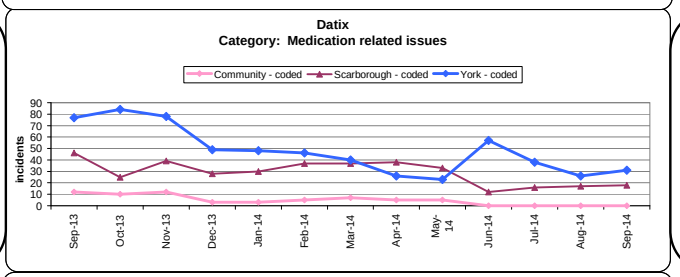
The rate of pressure ulcer development In July in York Hospital in was 0.5/1000 bed days.

The rate of pressure ulcer development in Scarborough Hospital in July was 0.7/1000 bed days.



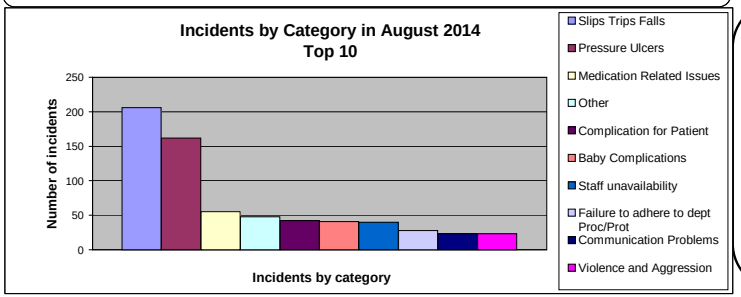
During August a total of 4 patient incidents were reported which resulted in serious or severe harm or death.

Data Source: Datix



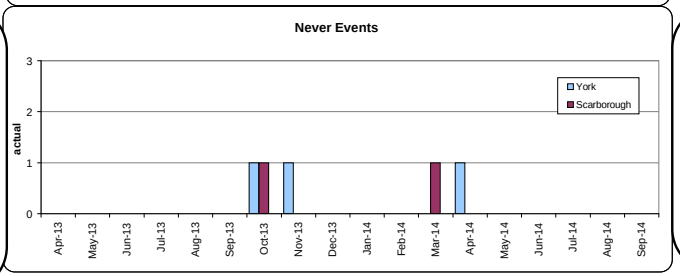
During August there was a total of 43 medication related incidents reported, although this figure may change following validation.

Data Source: Datix



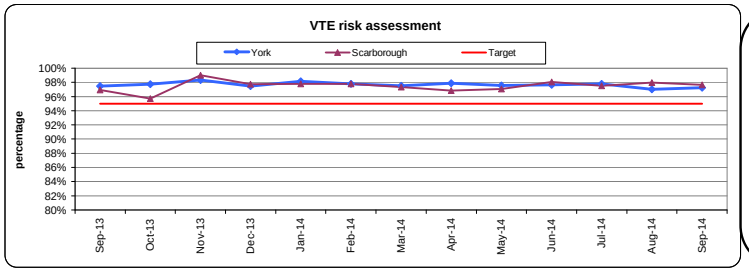
Incidents relating to slips, trips and falls remains the largest category of reported incidents, with pressure ulcers the second largest category.

Data Source: Datix



There were no Never Events declared in September.

Data Source: Datix

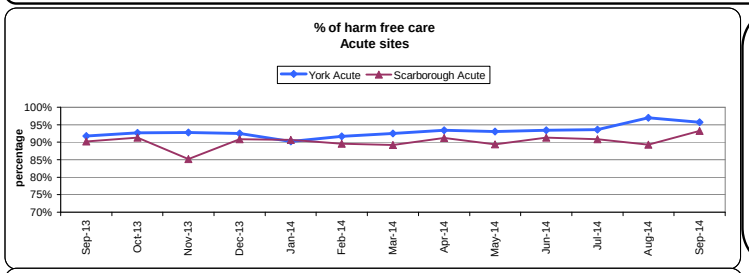


The target of 95% of patients receiving a VTE risk assessment has been maintained on both sites during September.

Data Source: Systems & Network Services

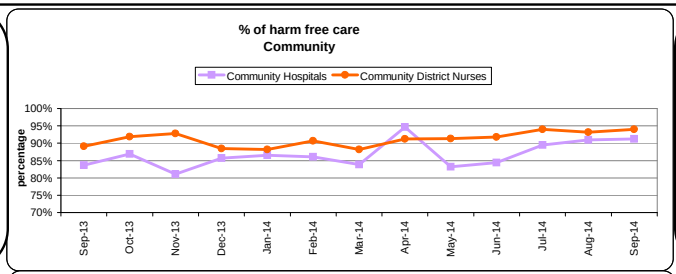
Safety Thermometer

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.



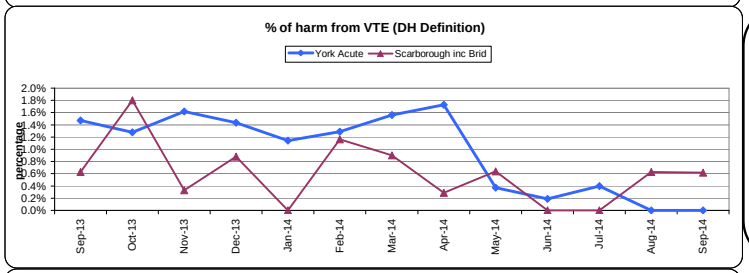
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In September 96% of patients at York and 93% at Scarborough were audited as receiving care 'free from harm' on the acute hospital sites.

Data source: Safety Thermometer



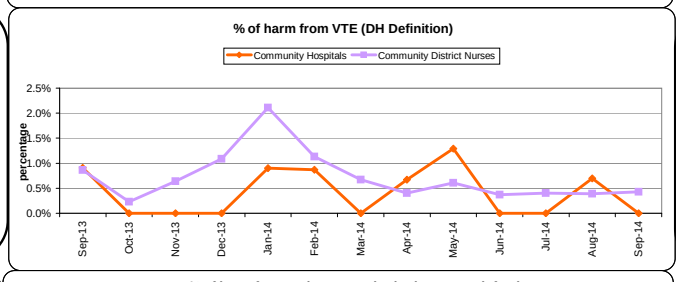
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In September 91% of patients in our community hospitals and 94% of patients in our care in the community received care 'free from harm'.

Data source: Safety Thermometer



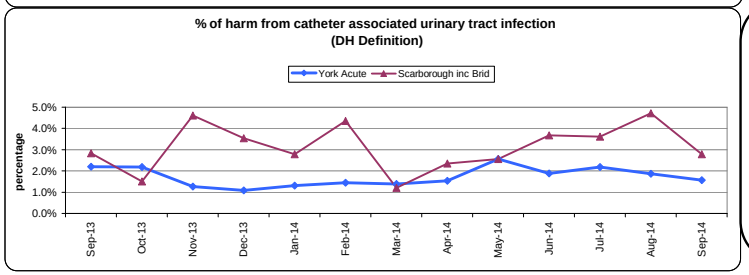
The percentage of patients affected by VTE as measured by the Department of Health (DH) definition, monthly measurement of prevalence, was 0 in York and 0.6% in Scarborough acute hospitals in September.

Data source: Safety Thermometer



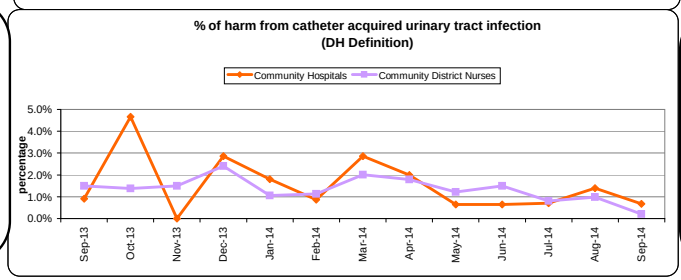
The percentage of patients affected by VTE as measured by the DH definition, monthly measurement of prevalence was 0 in community hospitals and 0.43% in community care in September.

Data source: Safety Thermometer



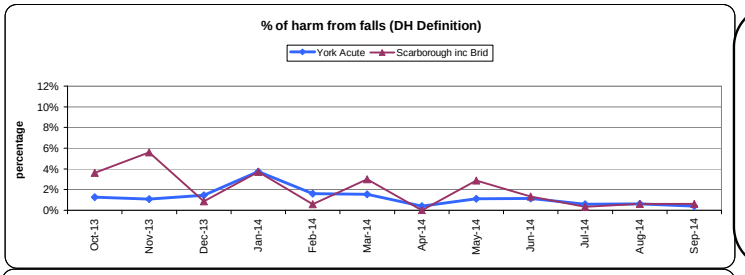
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 1.6% in York and 2.8% in Scarborough acute hospitals in September.

Data source: Safety Thermometer



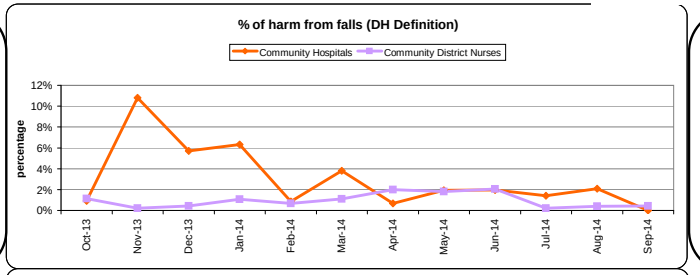
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 0.68% in community hospitals and 0.21% in community care in September.

Data source: Safety Thermometer



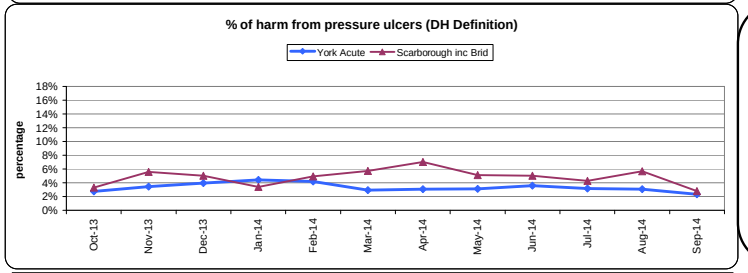
The percentage of patients suffering harm from falls as measured by the Department of Health data definition monthly measurement of prevalence was 0.4% for York and 0.6%for Scarborough acute hospitals in September.

Data source: Safety Thermometer



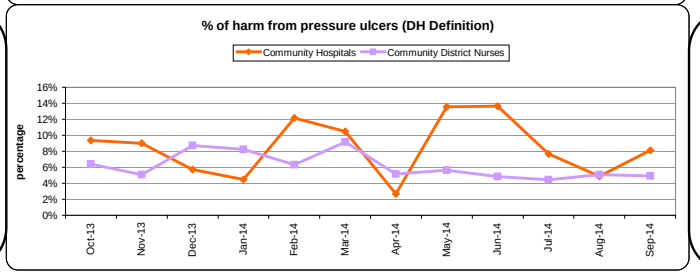
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 0 in community hospitals and 0.4% in community care in September.

Data source: Safety Thermometer



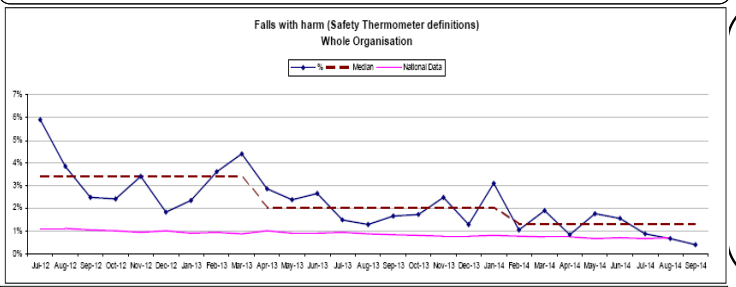
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 2.3% for York and 2.8% for Scarborough acute hospitals in September.

Data source: Safety Thermometer



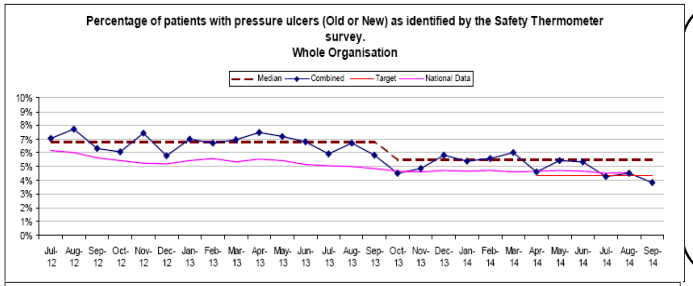
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 8.0% in community hospitals and 4.9% in community care in September.

Data source: Safety Thermometer



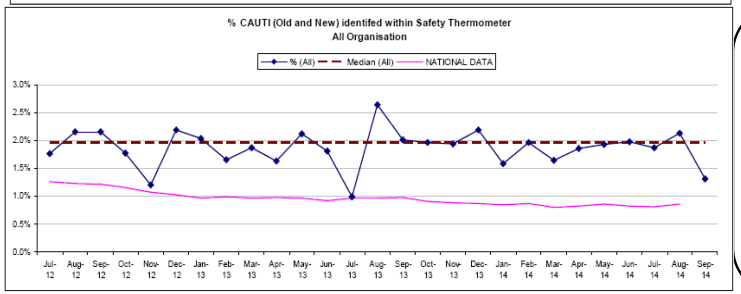
The Trust wide total number of falls with harm as measured for the Safety Thermometer, is now below the reported national average.

Data source: Safety Thermometer



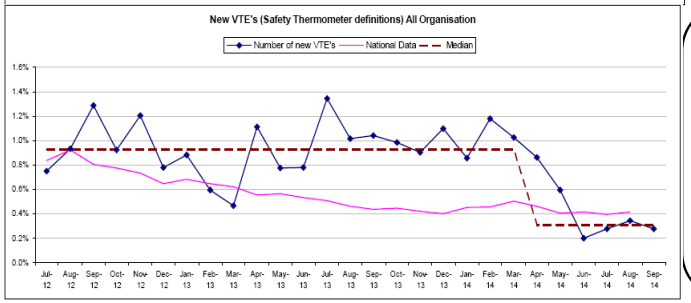
The Trust wide total number of pressure ulcers as measured for the Safety Thermometer is similar to the reported national average.

Data source: Safety Thermometer



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

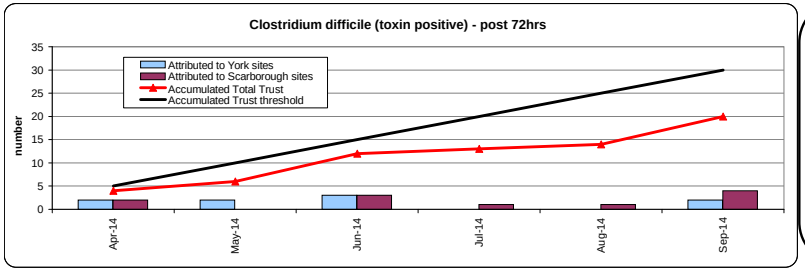
Data source: Safety Thermometer



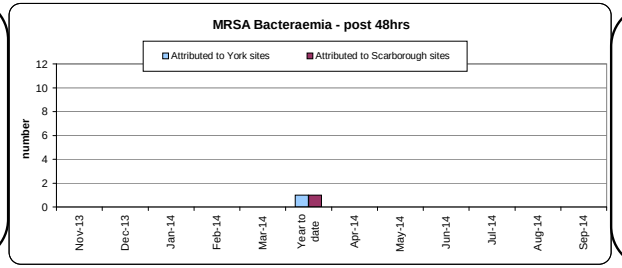
The Trust wide total number of patients with a new VTE as measured for the Safety Thermometer is below the reported national average.

Data source: Safety Thermometer

Infection Control

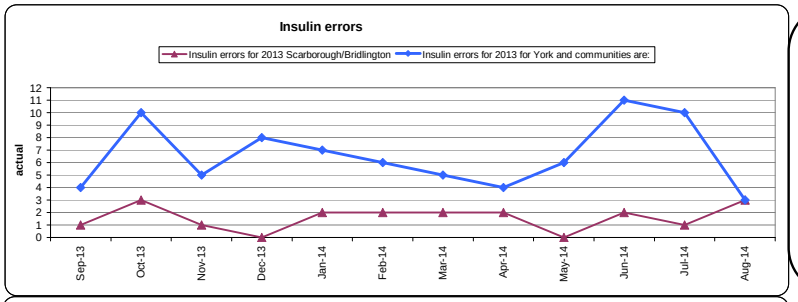


Two cases of c.diff were identified in York and four in Scarborough during September . The Trust remains below trajectory with a total of 20 cases identified since 1st April 2014.



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

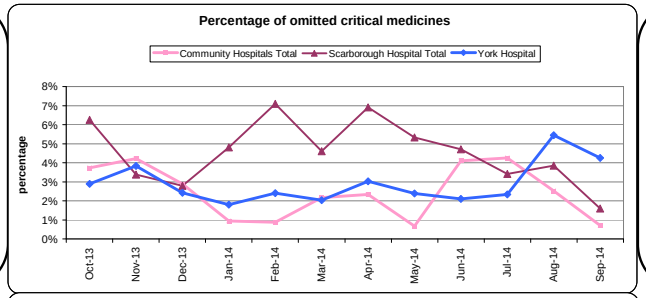
Drug Administration



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

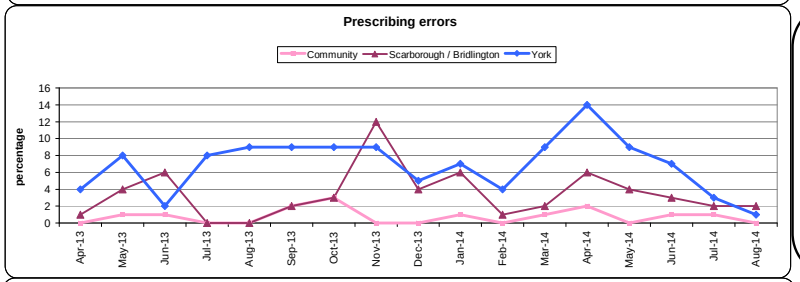
The data for September is awaiting validation.

Data Source: Datix



The audit of critical medicines missed during September indicated 3.9% for Scarborough, 5.5% for York and 2.5% for Community Hospitals.

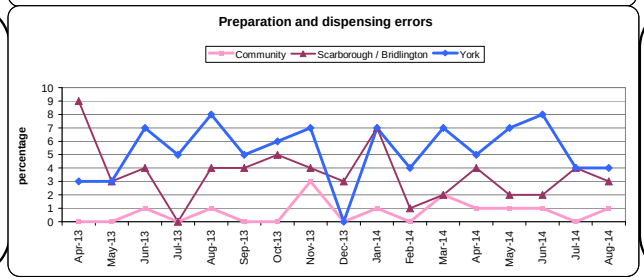
Data Source: Safety Thermometer (local)



There were three prescribing related errors in August; two from Scarborough and one from York.

The data for September is awaiting validation.

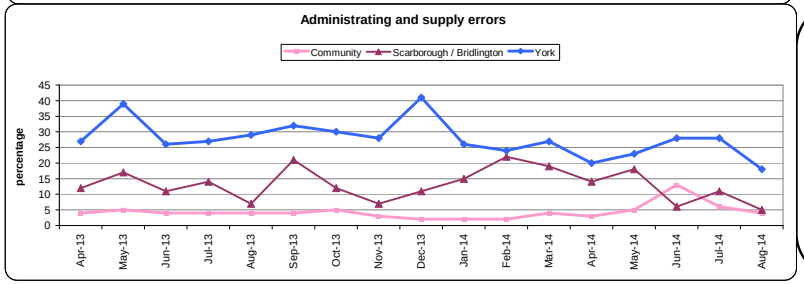
Data Source: Datix



There were eight preparation/dispensing error in August; four from York, three from Scarborough and one from Community.

The data for September is awaiting validation.

Data Source: Datix

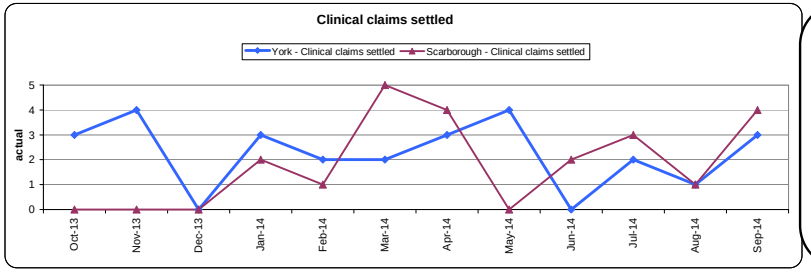


There were 27 administrating/supplying errors in September; 18 from York, five from Scarborough and four from Community.

The data for September is awaiting validation.

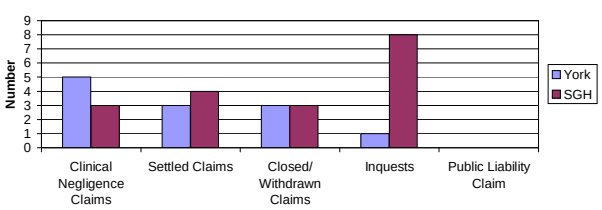
Data Source: Datix

Litigation



Seven clinical claims were settled in September, four attributed to the Scarborough site and three to the York site.

Data Source: Risk and Legal Services



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

The were nine Coroner's Inquests.

Data Source: Risk and Legal

York Teaching Hospital NHS Foundation Trust

Themes for clinical claims settled 01.01.2012 to 30.09.2014

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

Patient Safety Walkrounds – August / September 2014

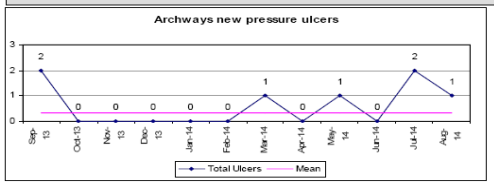
Date	Location	Participants	Actions & Recommendations
Friday 1st August	Cardio Respiratory Department	Patrick Crowley – Chief Executive Dr Nigel Durham – CD Jennie Adams – NED Jane Allen – Head of Cardiac Research Angela Howcroft – Operational Support Manager	• There is no space within the department to carry out ad hoc ECG's during outpatient clinics. • Cardiac ultrasound room (ground floor) is on occasions used for transoesophageal ultrasound, however there is no space for patients to recover from the procedure. • The lift to access the department is on route to the very busy outpatient department and at times patients arriving by patient transport are left waiting for the lift in wheelchairs in this area. • Electro physiologists in Leeds request data, the best way to send this is in the form of floppy discs but these are no longer compatible with the current system and they haven't access to encrypted USB storage. • Storage of large amounts of paperwork associated with reveal devices/pacemakers is currently stored in the department. **Action:** An in depth look at processes by Systems and network would be beneficial • Since the DoH has taken over the training of cardiac physiologists there is now a national shortage of cardiac physiologists. The department has BSC accreditation and needs to invest in training staff in order to retain them.
Tuesday 2nd September	Monkgate Health Centre, York	Brian Golding, Executive Director Dianne Willcocks, Non-Executive Director Ian Fairley, Consultant Chris Foster, Matron Tina Ramsey, Sister Ginny Smith, Manager	• Discussed recent events incident reports, and identified the most common theme as being delayed reporting of test results. We discussed the dispersed nature of the service and that in some locations staff are only present for 1 day of the week, making sample management challenging. • Sexual health occupies part of Monkgate Health Centre, a building owned by NHS Property Services Limited, which is in multiple occupancy. The building itself is fairly dilapidated, and generally overcrowded. There was a discussion about the long term future of the site, and it was agreed that it would be preferable to seek relocation to a modern facility, within easy walking distance of the City Centre. • A store cupboard contains the IT hub and an air compressor for the neighbouring dental surgery. The room overheats when the compressor runs. It was agreed that the fire officer should be contacted to assess the risk estates to consider the relocation of the compressor. • It was noted that the clinic rooms have poor sound attenuation, and patients waiting outside the clinics can overhear consultations. It is difficult to see how this can be improved given the constraints of the building form and construction. • There was some discussion about the level of domestic cover provided to the clinics. In particular there was concern that the toilets are heavily used, including for sample collection, but only cleaned at the end of the day. It was agreed with facilities management to discuss the cleaning arrangements.
Tuesday 2nd September	Therapy Service York Hospital	Dr Alastair Turnbull – Director Melanie Liley – DM Mike Sweet- NED	• Slips, trips & falls particularly within physiotherapy are seen as the major harm events. • Within psychology the main risks were perceived as patients becoming physically ill such as sustaining a convulsion whilst using an off-site facility within the grounds of Bootham Park Hospital. Psychology mitigate against potential harm through tight clinical supervision and the ability to discuss with colleagues the outcomes of a session and in large part do not deal with patients of significant risk of suicide. • Datix reporting was felt to work well although there were concerns that incidents reported from the wards may "bypass" therapies who are not always directly involved in feedback from events. Safety concerns in relation to dietetics were primarily around the viability, sustainability and comprehensive nature of an intestinal failure unit at the Scarborough site. • The main gym at the York site which remains subject to temperature fluctuation and is part of a capital bid for refurbishment and air conditioning. • The facilities in the Chapel at Bootham Park Court are of a high quality and the environment is suitable but would benefit from the addition of extra panic alarms to some of the clinic rooms and the administrators desk in the entrance, and a review of the lighting – there are dark areas. • One significant emergent theme for this Service is that while employing c 550 staff they are not seen as a Directorate and, at times they feel "out of the loop" in learning from events they are not formally part of the proceedings of Executive Board. As an interim solution receipt of the Executive Board papers would be a positive way ensuring therapy services receive reports which indicate learning from claims, incidents and complaints.
Tuesday 9th September	Specialist Medicine (Main OPD, Dermy OPD & Macmillan Unit) Scarborough Hospital	Mike Proctor – Director Dr Mark Quinn – CD Karen Cowley – DM Pauline Guyan – Matron Mike Keaney – NED Heather Pickering	**Chemotherapy Department** • Staffing issues - Business case currently with finance will address staffing issues Permission already being sort to recruit for a B4 Co-ordinator and B2 HCA to assist with tasks currently undertaken by current staff • Waiting times for first treatment - First treatments currently stand at 4 weeks. Ideal 1 week which will be achieved once business case proposals in place • Community -York community do a lot of line care, Hickman lines are cleaned in community. Scarborough community does not do this. Patients present to the unit. **Action:** Mike Proctor to raise with Wendy Scott **Outpatients Department A & B** • Dermatology Suite - Minor ops theatre is utilised for urodynamics when dermatologists are not here. Not ideal, low risk of contamination **Outpatients Department C** • Rooms - Predominantly utilised for oncology. Some rooms are suites divided by a desk with consulting areas on either side. **Haworth Unit** • Rooms - 2 clinic rooms, 2 treatment rooms, 2 consulting rooms all vary in size and could be more visually appealing.
Monday 15th September	Audiology Springhill House Scarborough	Diane Palmer – Deputy Director Jennie Adams – NED Gemma Cuss – DM Kate Illey – Head of Audiology	• Trip hazard due to uneven surface outside. **Action:** Directorate Manager to request Estates department to review. • Hedges do not get cut regularly. **Action:** Directorate Manager to request Estates department to review. • There is no alert for deaf people when the fire alarm sounds and no clear exit signs. **Action:** Directorate Manager to request Estates department to review. • There is no patient call button in the toilet. **Action:** Directorate Manager to request Estates department to review. • No obvious fire exit signs in the waiting area. **Action:** Directorate Manager to request Estates department to review. • Treatment room: o Flaking paint around the sink o Paper on trolley o Chair with torn fabric o Carpet on floor o Large boxes of equipment o No alert buttons **Action**: Head of Audiology, Infection Prevention and Estates department to review.
Friday 19th September	ED and Haworth Unit Scarborough Hospital	Brian Golding, Executive Director Libby Raper, Non-Executive Director Jo Southwell, Directorate Manager Ed Smith, Lead Clinician Simon Etches, Lead Nurse	**Emergency Department** • Three areas of concern were identified, which were compromising patient safety and impacting on access targets: o Flow out of the department, leading to extended waits for admission o Incremental activity increases o Limited physical capacity • Downstream bed availability was reported to be the most pressing issue. The reopening of Maple ward is planned for November, and there will be additional surgical beds once Lilac ward is completed early in the New Year. Because of the limited overall capacity, GP referrals only go directly to the wards in a limited number of cases. It was noted that this had worked much better during Perfect Week. The team felt that patients could be safer in wards awaiting admission, rather than on trolleys in an overcrowded department. • The ambulance turnaround position was reported as worsening. Working with the capital planning team on a proposal to convert the Dales Theatre into an ambulance handover bay. • The department rely heavily on agency and bank. The department are considering different staffing models which may ease this position. • The department reported that they take complaints very seriously, and always look for learning form AIRS, currently running at 20-25 per week – although it was felt that overall they probably under report minor issues due to other pressures within the department. • Blockages to flow out of Emergency Department. **Action:** Continue to work with acute board to explore opportunities. **Howarth Unit** • It was explained that a full review of the service, in conjunction with the Lawrence Unit at Bridlington is underway. • It was reported that the unit gets good comments from Friends and Family feedback. • In common with its sister operation, the Lawrence Unit at Bridlington, the Haworth unit has had a very low AIRS numbers. Since the leadership walkround of the Lawrence Unit in July the team advised that they had reviewed the low reporting in both Units and considered it to be correct.
Friday 19th September	Waters and Johnson Bridlington Hospital	Diane Palmer – Deputy Director Dr Jones – CD Rob Parnaby – DM Emma Day – Matron	**Waters Ward** • Patient falls is the most frequent concern/ incident. The Directorate are pro-active in reviewing learning from RCA. • Junior doctors had previously expressed concern about the process for contacting a consultant. **Action**: A simple guide for contacting a consultant and escalation has been developed. **Johnson Ward** • Patient falls is the biggest incident on the ward. • Concern about delirium CQUIN policy. • If cannulas inserted are not recorded on CPD, then the nurses cannot record care.
Tuesday 24th September	Main MSK Physio Dept Orthotic Dept Haworth Unit Physio and OT dept Scarborough Hospital	Diane Palmer – Deputy Director Mike Lee - Principal Therapist Sandra Van Der Kooij	**Gym in Hawthorn Unit** • The uneven surface of the floor could be a trip hazard. **Action**: Discussion with Estates. • Treatment room – no sink, lots of paper, boxes and clutter. **Action:** Raise with Estates department. • Splint room is currently used as a meeting room. **Action:** To discuss with IPC. **Orthatic treatment room** • The shelves need to be replaced with cupboards. **Action:** Infection Control Team to advise.
			Physiotherapy Department • No mat to absorb the moisture at the front door. • The skirting has been removed and has left uneven glue on the walls. **Action**: Raise with Estates department. • Bariatric wheel chair not big enough. **Action:** Raise with Estates department.
Monday 29th September	Ward 33 and Renal Unit York Hospital	Diane Palmer – Deputy Director Sharon Lewis – DM Eleanor King – DDM (Renal) Melinda Howard – Lead Nurse Chris Morris – Matron Libby Raper – NED	**Renal Unit** • Potential embolism risk of dialysis lies have been reported to MHRA. **Action:** Alternative lines are being reviewed. • Chairs are not high enough in the waiting area for some patients to get out of. **Action:** Directorate to review. **Ward 33** • Acuity and dependency has been redone but results are not yet available. • Escalation beds are no longer open. • Door to ward 35 is not bolted. **Action:** report to Estates. • The staffing board is not kept up to date. **Action:** Matron to ensure this is maintained.
Tuesday 30th September	Duke of Kent SCBU Childrens clinic Scarborough Hospital	Mike Proctor – Deputy Chief Executive Jennie Adams – None-Executive Director Liz Vincent – Directorate Manager Child Health Sally Alexander - Deputy Directorate Manager Child Health Nicola Lockwood – Matron Child Health Hannah Coughlan – Duke of Kent Ward Sister Sharon Addey – SCBU Ward Sister	The visit was a 6 month follow up to **Duke of Kent Ward** following concerns raised in October 2013 in response to 2 SIs. The main focus of the visit was to monitor progress with the improvement plan developed as a result of the SIs. • There has been a significant change in the nursing team. Including the appointment of a Matron for acute paediatric across sites and a Band 7 Ward Sister for Duke of Kent. • The focus on a "safety first" culture and introduction of safety briefings to the ward has seen a positive increase in incident reporting. • Elective surgery was suspended to ease workload on the ward in October 2013. A review of Paediatric surgery recommends that surgery recommences at Scarborough, but with several pre-conditions. o successful recruitment o assessing the business case o Commissioner support. • There have been 2 unsuccessful attempts to recruit to consultant paediatric posts. The Directorate is holding an open day on the 3rd October. • Lack of out of hours support from the local CAMHS team is a long standing issue with no improvements to date. • A scenario exercise has identified actions to improve the nurses visibility of very sick, work has commenced to enable this improvement **SCBU** • A recent security incident resulted in staff receiving abusive telephone calls and threats to their safety. **Action** - Upgrade to CCTV, escalation guidance for, LSCB to review case as a multi agency lessons learned exercise. • There have been a number of babies arrive on the unit from the Maternity theatre that were cold. A plan for improvement has begun with Maternity staff.

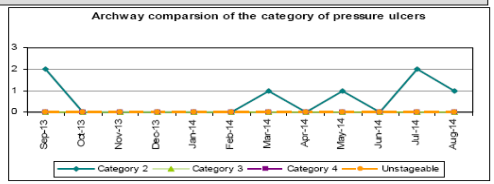
Archway's Community Hospital & East and West Locality Patient Safety Dashboard –

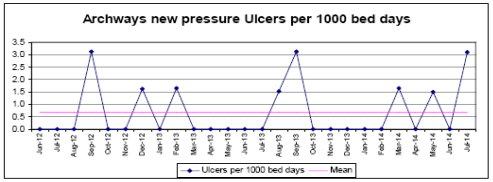
Archway's Community Hospital Datix Incident Reporting	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Number of incidents reported on - Datix web	10	11	14	12	12	7	11	8	14	7	29	19
Number of medication related incidents	0	0	2	1	0	1	2	0	1	0	0	0
Number of settled clinical 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	1	0
Number of Serious Incidents (SI's)	0	0	0	0	0	0	0	0	0	0	0	0
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	0

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

Pressure Ulcer Incidence – Archway's Community Hospital



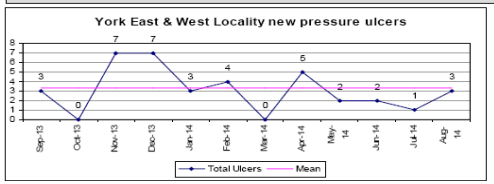


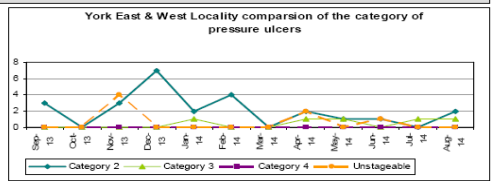


The new Wound Management policy is being launched across the patch, this includes guidance for staff on the prevention and management of pressure ulcers.

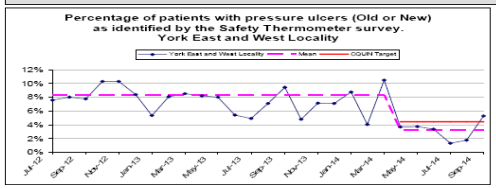
Future audit on compliance with this policy will take place.

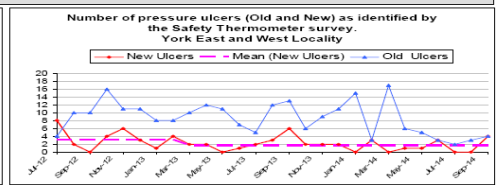
Pressure Ulcer Incidence –East and West Locality



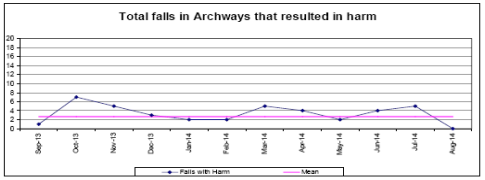


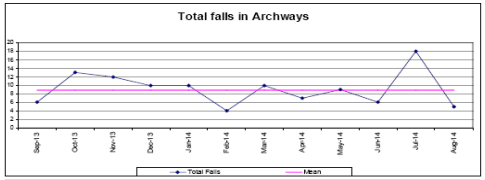
Pressure Ulcer Prevalence –East and West Locality (CQUIN)

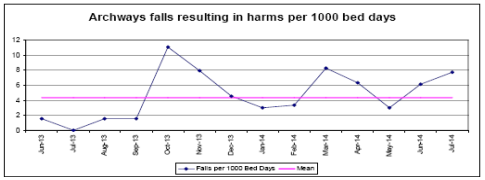




Falls Incidence – Archway's Community Hospital







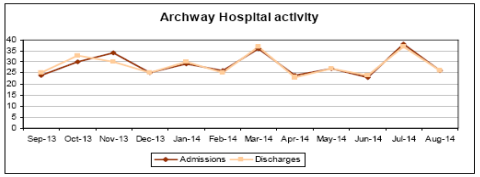
New falls assessment and care planning documentation is being rolled out across the patch.

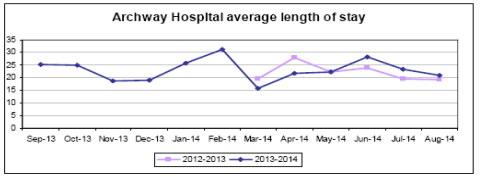
All staff will receive a training session on falls prevention as part of this roll out.

Archway's Deaths & Mortality Reviews

St Monica's Community Hospital Deaths & Mortality reviews	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Number of in-hospital deaths	1 (4%)	0 (0%)	1 (3.3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (2.7%)	0 (0%)
Number of mortality reviews	1	0	1	0	0	0	0	0	0	0	0	0

Archway's Activity





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

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

Safety Thermometer Data – Archway's & North Locality

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

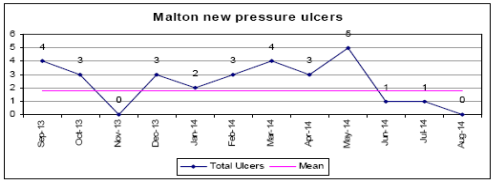
East & West Locality	Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14		Apr 14		May 14		Jun 14		Jul 14		Aug 14		Sep 14	
Ward	East	West	East	West	East	West	East	West	East	West	East	West	East	West	East	West	East	West	East	West	East	West	East	West
New VTE's	0	0	1	2	0	3	0	3	1	1	0	0	1	1	1	2	1	0	1	1	1	1	0	1
Falls with harm	0	2	0	0	0	2	0	2	0	1	0	1	1	2	0	3	3	1	0	0	0	0	1	0
Pressure Ulcers	7	1	3	7	6	7	5	10	2	6	6	9	6	2	2	5	4	2	2	0	4	1	4	2
New CAUTI	1	0	0	1	3	2	1	0	0	1	1	1	1	0	1	0	1	1	0	1	0	0	0	0
Total Harms	**8**	**3**	**4**	**10**	**9**	**14**	**6**	**15**	**3**	**9**	**7**	**11**	**9**	**5**	**4**	**10**	**9**	**4**	**3**	**2**	**5**	**2**	**5**	**3**

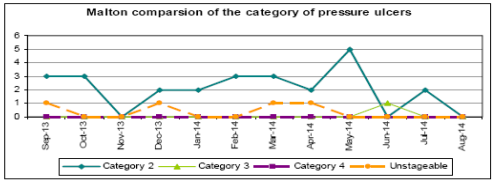
Malton Community Hospital & Scarborough South Ryedale Locality
Patient Safety Dashboard – 18/09/14

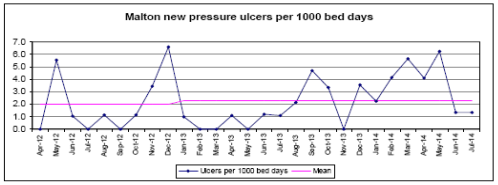
Malton Community Hospital Datix Incident Reporting	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Number of incidents reported on - Datix web	30	22	20	23	25	14	25	11	32	17	16	26
Number of medication related incidents	1	1	2	0	0	0	0	0	1	1	1	1
Number of settled clinical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

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

Pressure Ulcer Incidence – Malton Community Hospital



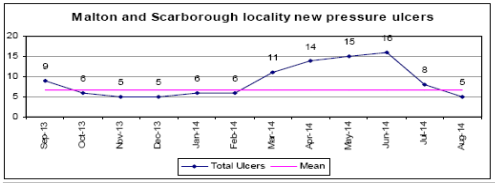


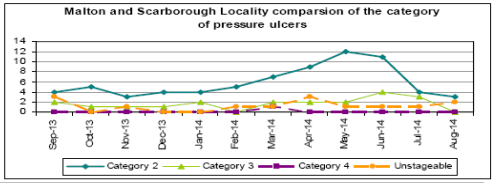


Following an increase up to May the numbers of pressure ulcers reported has fallen below the mean.

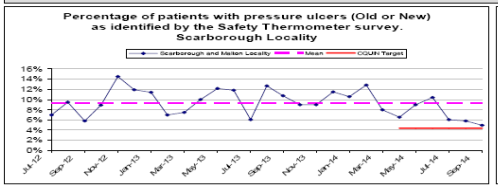
The new Wound management policy (containing guidance on pressure ulcer prevention and management) is being launched across the patch.

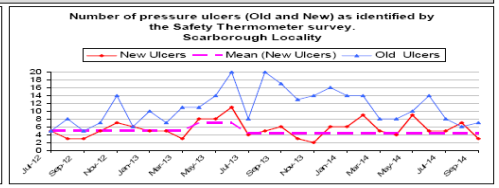
Pressure Ulcer Incidence – South Ryedale & Scarborough Locality



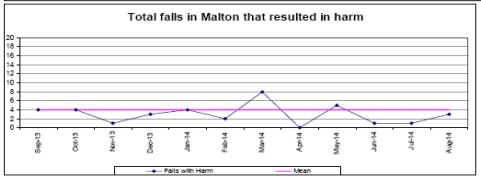


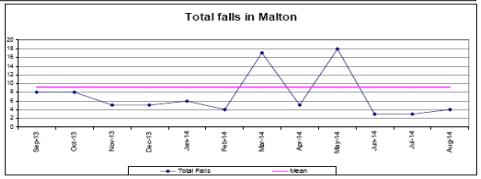
Pressure Ulcer Prevalence – Scarborough and Malton Locality (CQUIN)

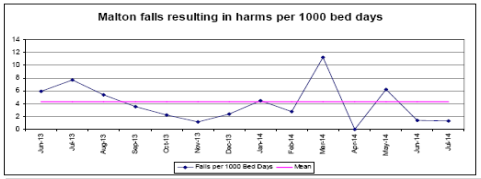




Falls Incidence – Malton Community Hospital







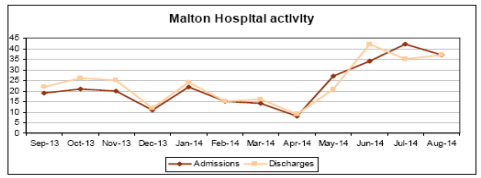
New inpatient assessment and care plan documentation is being rolled out across all community hospitals.

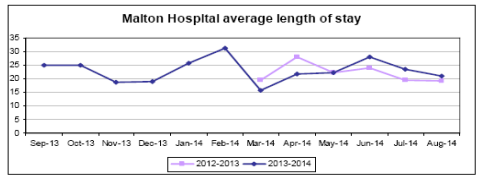
Along with this roll out there will be a falls training package for all staff.

Malton Deaths & Mortality Reviews

Malton Community Hospital Deaths & Mortality reviews	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Number of in-hospital deaths (percentage discharged as died)	5 (52%)	6 (12.8%)	5 (11.9%)	5 (12.8%)	5 (13.5%)	5 (13.9%)	5 (10.6%)	1 (3.7%)	2 (7.1%)	9 (21.4%)	2 (5.7%)	3 (8.1%)
Number of mortality reviews	0	0	1	2	3	0	5	1	2	8	2	3

Malton Activity





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

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

Safety Thermometer Data

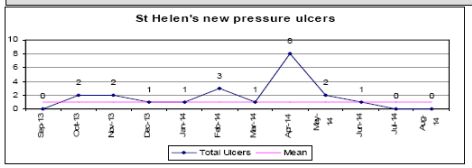
Malton Hospital	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14
New VTE's	0	0	0	0	1	0	0	1	0	0	0	0
Falls with harm	0	11	6	5	1	2	1	1	1	0	1	0
New Pressure Ulcers	16	3	1	1	8	1	2	4	6	0	1	1
New CAUTI	2	0	1	0	0	1	2	0	1	1	0	0
Total Harms	**18**	**14**	**8**	**6**	**10**	**4**	**5**	**6**	**8**	**1**	**2**	**1**
Empty Admin Boxes	4	4	5	13	16	0	2	10	5	0	0	0
Omission Code 4	4	4	4	10	5	0	1	5	2	0	0	0
Omitted Critical Medicines	1	2	1	0	0	0	0	1	0	1	0	0

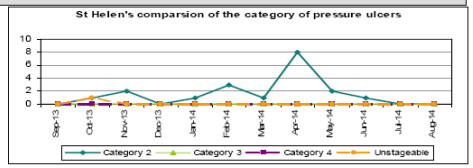
Scarborough & South Ryedale Locality	Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14		Apr 14		May 14		Jun 14		Jul 14		Aug 14		Sep 14	
Ward	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye	Scar	Rye
New VTE's	0	0	0	0	2	0	1	0	2	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Falls with harm	3	0	1	0	0	0	1	1	0	0	1	1	4	0	2	0	1	0	1	0	2	0	1	0
Pressure Ulcers	10	6	10	6	10	12	15	5	12	3	7	5	8	3	13	7	11	5	10	3	10	5	11	2
New CAUTI	3	0	1	1	2	2	1	0	3	0	3	0	1	4	0	0	1	1	0	1	3	0	1	0
Total Harms	**16**	**6**	**12**	**7**	**14**	**14**	**18**	**6**	**17**	**4**	**11**	**7**	**13**	**7**	**15**	**7**	**13**	**6**	**11**	**4**	**15**	**5**	**13**	**2**

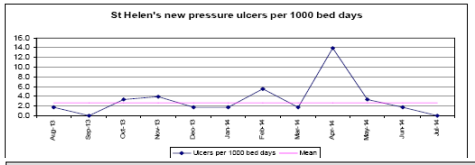
St Helen's Community Hospital
Patient Safety Dashboard – 15/10/2014

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

Pressure Ulcer Incidence –St Helen's Community Hospital



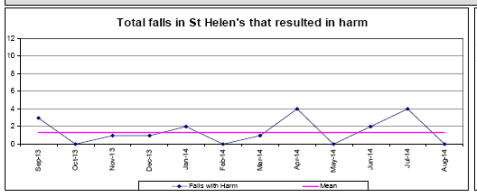


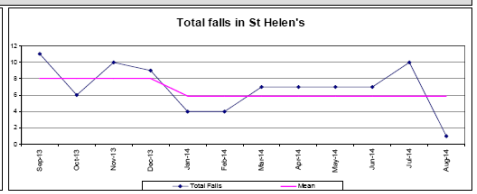


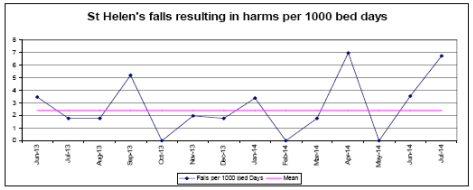
No New pressure ulcers reported at St Helens from June – August 2014.

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

Falls Incidence – St Helen's Community Hospital







One patient fell twice resulting in harm in July.

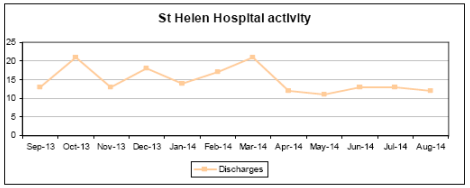
New assessment and care plan documentation being rolled out at community hospitals.

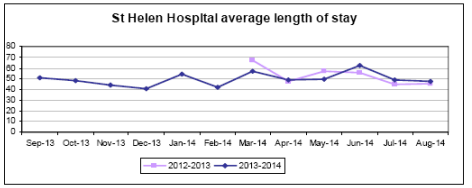
Alongside this roll out there will be falls prevention training for all staff.

St Helen's Deaths & Mortality Reviews

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

St Helen's Activity





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

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

Safety Thermometer Data – St Helen's

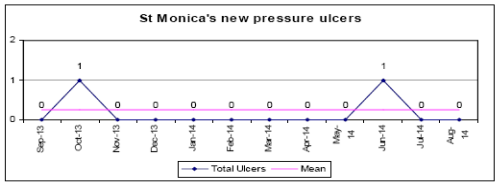
St Helen's Hospital	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14
New VTE's	0	0	0	0	0	1	0	0	0	0	0	0
Falls with harm	0	0	0	0	0	2	0	0	0	1	0	0
Pressure Ulcers	2	2	3	1	2	0	0	7	3	3	1	2
New CAUTI	0	0	0	0	0	0	0	0	0	1	0	1
Total Harms	**2**	**2**	**3**	**1**	**2**	**3**	**0**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

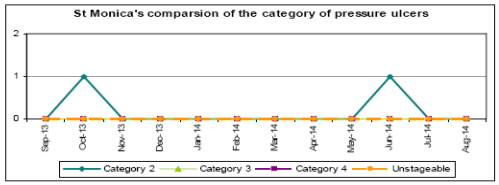
St Monica's Community Hospital & North Locality
Patient Safety Dashboard – 18/09/14

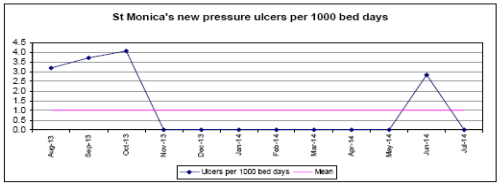
St Monica's Community Hospital Datix Incident Reporting	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 13
Number of incidents reported on - Datix web	3	3	6	2	4	8	5	3	5	5	7	3
Number of medication related incidents	0	1	1	0	2	0	1	0	1	1	1	0
Number of settled clinical litigation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

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

Pressure Ulcer Incidence – St Monica's Community Hospital



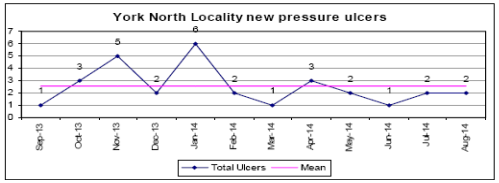


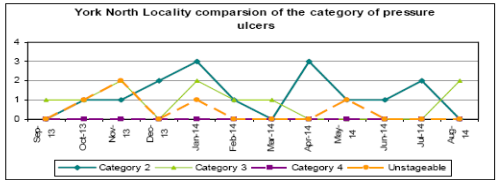


Only 1 new pressure ulcer developed at St Monica's this year.

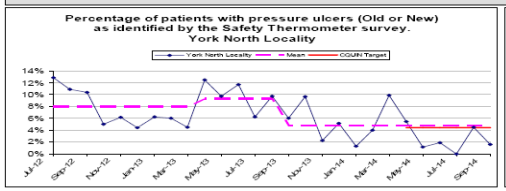
New Wound management policy being launched and rolled out across the patch. This contains guidance on the prevention and management of pressure ulcers.

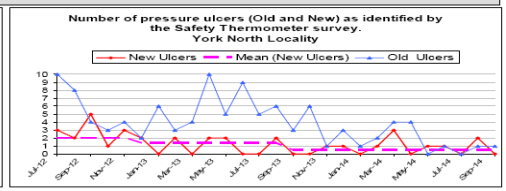
Pressure Ulcer Incidence – North Locality



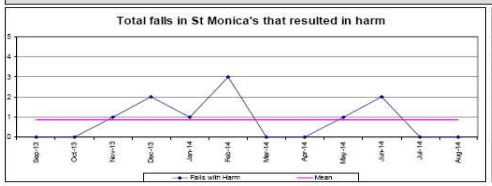


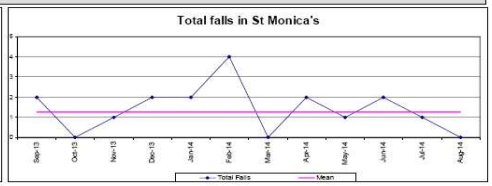
Pressure Ulcer Prevalence – North Locality (CQUIN)

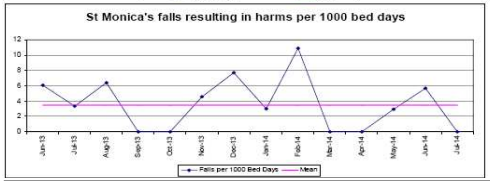




Falls Incidence – St Monica's Community Hospital





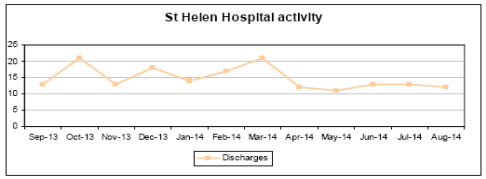


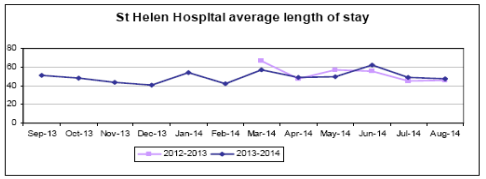
New assessment and care planning documentation is being launched across all community hospitals. All staff will receive a training session on falls prevention as part of this roll out.

St Monica's Deaths & Mortality Reviews

St Monica's Community Hospital Deaths & Mortality reviews	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Number of in-hospital deaths (percentage discharged as died)	3 (16.7%)	2 (18.2%)	2 (10.5%)	2 (15.4%)	4 (21.1%)	2 (14.3%)	2 (33.3%)	2 (11.1%)	4 (23.5%)	2 (22.2%)	3 (18.8%)	4 (20%)
Number of mortality reviews	3	1	1	1	3	0	2	2	1	0	1	2

St Monica's Activity





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

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

Safety Thermometer Data – St Monica's & North Locality

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

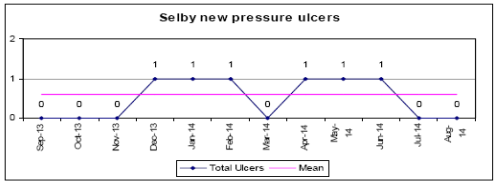
North York Locality	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14
New VTE's	0	0	0	1	0	0	0	0	0	0	0	1
Falls with harm	0	0	0	0	1	0	0	1	1	1	0	0
Pressure Ulcers	6	3	3	1	4	4	4	1	1	0	3	1
New CAUTI	1	1	1	1	0	2	0	1	2	0	0	0
Total Harms	**7**	**4**	**4**	**3**	**5**	**6**	**4**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

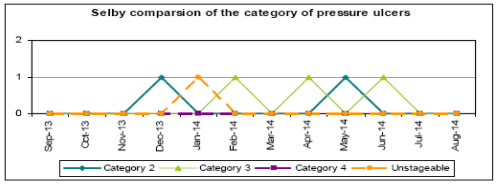
Selby Community Hospital & Selby Locality
Patient Safety Dashboard – 15/10/14

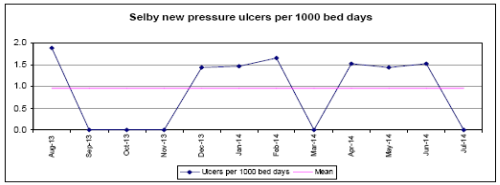
Selby Community Hospital Datix Incident Reporting	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Number of incidents reported on Datix web	14	18	16	14	11	10	11	7	17	25	16	12
Number of medication related incidents	2	4	0	0	0	0	0	0	0	2	0	1
Number of settled clinical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

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

Pressure Ulcer Incidence – Selby Community Hospital



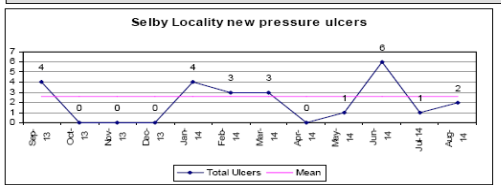


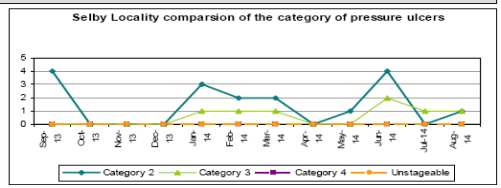


No new pressure ulcers reported in Selby in-patient ward from June to August 2014.

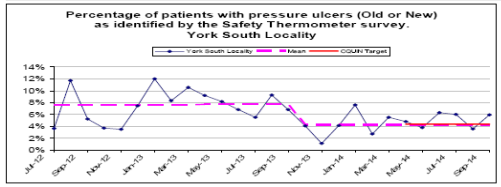
New Wound Management Policy ratified, (includes Pressure Ulcer Prevention and Management guidelines) – to be cascaded to all staff.

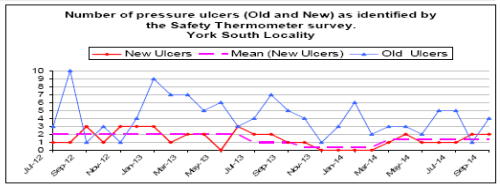
Pressure Ulcer Incidence – Selby Locality



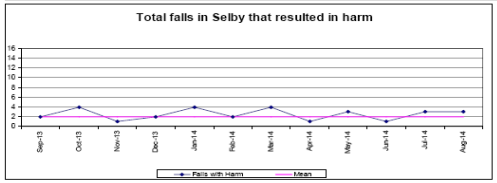


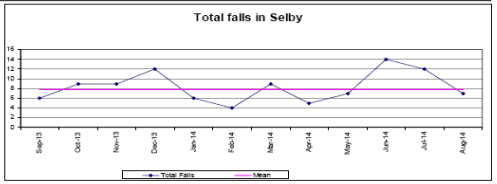
Pressure Ulcer Prevelance – Selby Locality (CQUIN)

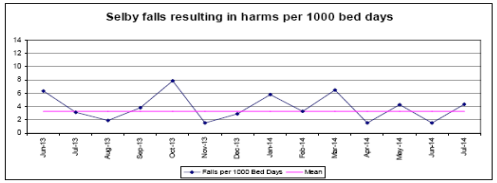




Falls Incidence – Selby Community Hospital







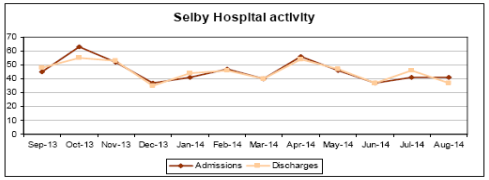
New in-patient assessment and care plan documentation being launched over the next month, currently being tested at three community hospitals.

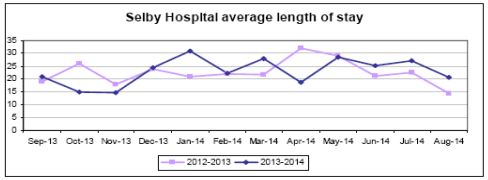
Along side the roll out of this new documentation a training package in falls prevention will be delivered to all staff.

Selby Deaths & Mortality Reviews

Selby Community Hospital Deaths & Mortality reviews	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Number of in-hospital deaths (percentage discharged as died)	5 (10.4%)	4 (7.3%)	6 (11.3%)	2 (5.7%)	3 (6.8%)	3 (6.5%)	3 (7.5%)	4 (7.4%)	3 (6.4%)	1 (2.7%)	4 (8.7%)	2 (5.4%)
Number of mortality reviews	4	4	6	1	2	2	2	3	3	1	0	0

Selby Activity





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

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

Safety Thermometer Data

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

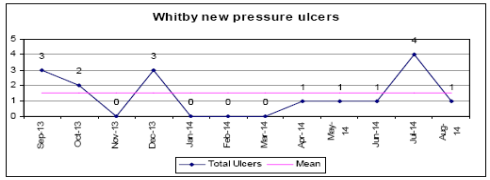
Selby Locality	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14
VTE	1	0	0	0	0	1	0	0	1	0	0	0
Falls	0	0	0	0	0	0	2	2	2	0	0	0
Pressure Ulcers	2	0	1	5	1	3	5	0	2	2	3	2
CAUTI	1	3	0	1	0	0	1	1	1	2	2	0
Total Harms	**4**	**3**	**1**	**6**	**1**	**4**	**8**	**3**	**6**	**4**	**5**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

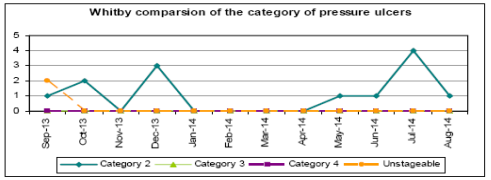
Whitby Community Hospital & Whitby Locality Patient Safety Dashboard –

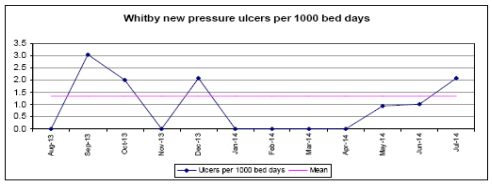
Whitby Community Hospital Datix Incident Reporting	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Number of incidents reported on - Datix web	17	34	24	16	14	18	15	14	27	21	14	15
Number of medication related incidents	0	2	1	0	0	1	1	1	1	2	1	1
Number of settled clinical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

Whitby Locality Datix Incident Reporting	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Number of incidents reported on - Datix web	2	8	8	3	4	2	4	9	6	11	10	8
Number of medication related incidents	1	0	0	0	0	0	0	0	0	0	0	0
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0	0	0	0
Number of formal complaints	N/K	N/K	N/K	N/K	N/K	N/K	0	0	0	0	0	0
Number of Serious Incidents (SI's)	N/K	N/K	N/K	N/K	N/K	N/K	0	0	0	0	0	0
Number of Critical Incidents (CI's)	0	0	0	0	0	0	0	0	0	0	0	0

Pressure Ulcer Incidence – Whitby Community Hospital



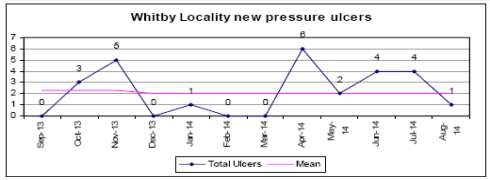


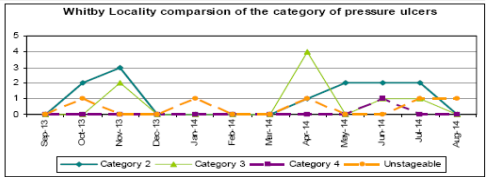


New wound management policy being launched across the patch, this contains guidance for staff on the prevention and management of pressure ulcers.

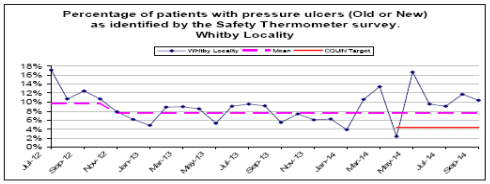
Audit of compliance with the policy will take place in the new year.

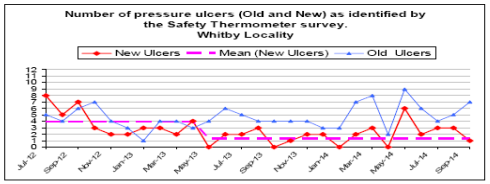
Pressure Ulcer Incidence – Whitby Locality



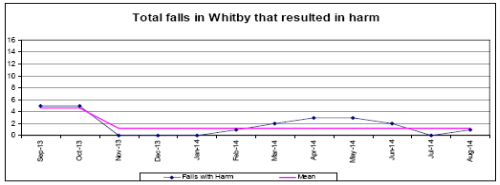


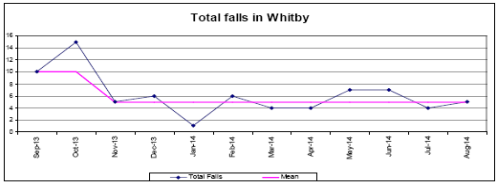
Pressure Ulcer Prevalence – Whitby Locality (CQUIN)

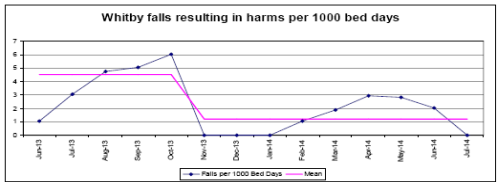




Falls Incidence – Whitby Community Hospital







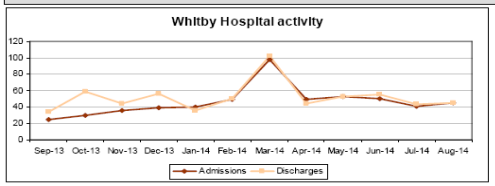
New falls assessment and care planning documentation will be rolled out across the community hospitals in November and December 14.

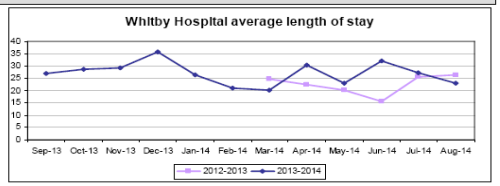
All staff will receive a training session on falls prevention as part of this roll out.

Whitby Deaths & Mortality Reviews

Whitby Community Hospital Deaths & Mortality reviews	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Number of in-hospital deaths	6 (17.6%)	4 (6.8%)	5 (11.4%)	1 (1.8%)	0 (0%)	4 (8%)	5 (4.9%)	3 (6.8%)	7 (13.2%)	5 (9.1%)	1 (2.3%)	6 (13.3%)
Number of mortality reviews	1	0	0	2	0	2	1	2	4	1	2	2

Whitby Activity





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

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

Safety Thermometer Data – Whitby & Whitby Locality

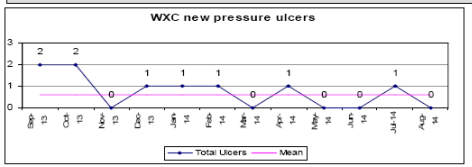
Whitby Hospital	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
New VTE's	0	0	0	0	0	0	1	0	0	0	0	0
Falls with Harm	1	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers	5	2	1	2	5	4	1	7	3	1	3	2
New CAUTI	3	0	0	1	0	2	0	0	0	0	0	0
Total Harms	**9**	**2**	**1**	**3**	**5**	**6**	**2**	**7**	**3**	**1**	**3**	**2**
Empty Admin Boxes	4	7	1	1	0	0	6	2	2	1	1	0
Omission Code 4	4	2	0	0	1	3	4	2	2	0	0	1
Omitted Critical Medicines	0	0	0	0	0	0	0	0	2	0	3	0

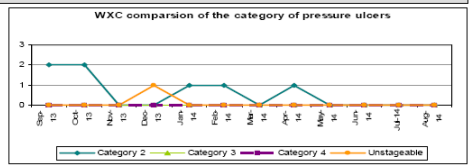
Whitby Locality	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14
New VTE's	0	0	0	0	0	1	0	0	0	0	0	0
Falls with harm	0	0	0	1	0	2	1	1	3	0	0	0
Pressure Ulcers	1	4	4	1	4	7	2	9	6	6	5	9
New CAUTI	0	0	1	1	1	2	2	3	1	0	0	0
Total Harms	**1**	**4**	**5**	**3**	**5**	**12**	**5**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

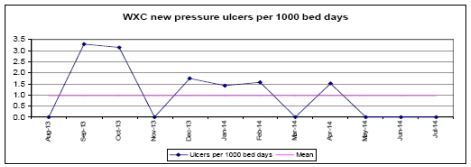
White Cross Court Community Hospital
Patient Safety Dashboard – 15/10/2014

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

Pressure Ulcer Incidence –White Cross Court Community Hospital

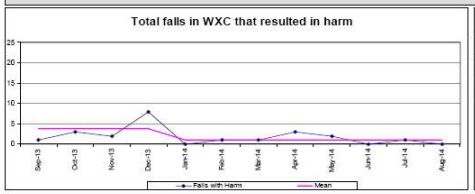


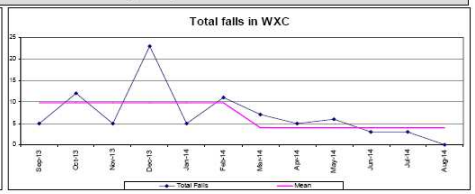


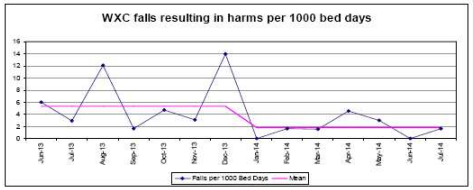


New wound management policy ratified Includes guidance on Pressure Ulcer prevention and management – to be disseminated to all staff.

Falls Incidence – White Cross Court Community Hospital







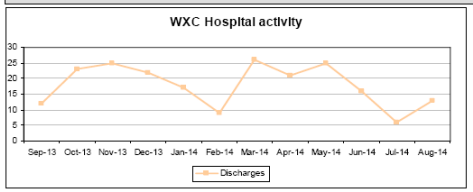
New falls assessment and care plan documentation being launched in all community hospitals.

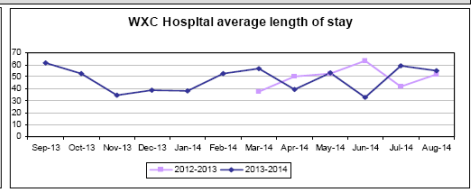
This launch will include a training session on falls prevention for all staff.

White Cross Court Deaths & Mortality Reviews

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

White Cross Court Activity





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

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

Safety Thermometer Data – White Cross Court

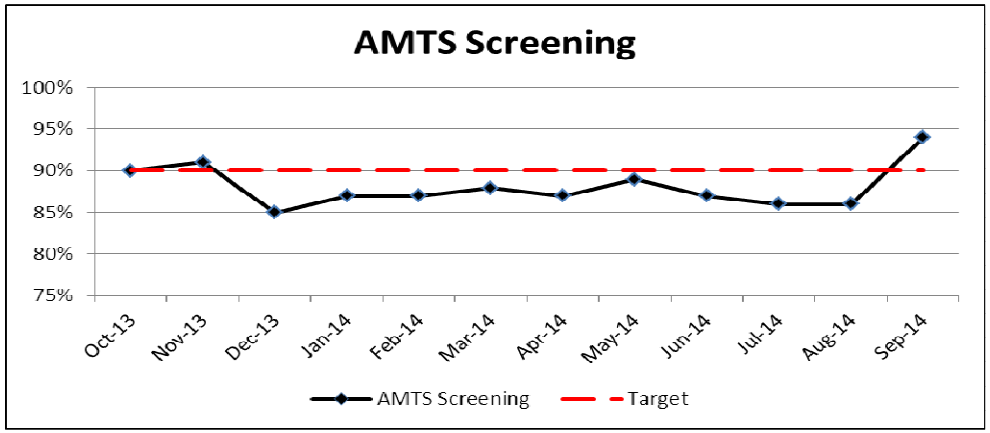
WXC Hospital	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14
New VTE's	1	0	1	0	0	1	0	0	0	0	0	0
Falls with harm	1	0	1	0	0	0	0	2	0	0	0	0
Old Pressure Ulcers	0	1	2	2	2	1	1	5	4	3	3	2
New CAUTI	0	1	1	1	0	0	0	0	0	0	1	0
Total Harms	**2**	**2**	**5**	**3**	**2**	**2**	**1**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

Dementia

Percentage of Patients Meeting the AMTS screening target (Trust)												
Indicator	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
AMTS Screening	90%	91%	85%	87%	87%	88%	87%	89%	87%	86%	86%	94%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Patients Meeting the AMTS screening target (York)												
Indicator	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
AMTS Screening	96%	93%	88%	91%	94%	95%	93%	92%	90%	90%	88%	93%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Patients Meeting the AMTS screening target (Scarborough)												
Indicator	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
AMTS Screening	85%	93%	83%	85%	80%	80%	79%	87%	86%	86%	87%	100%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

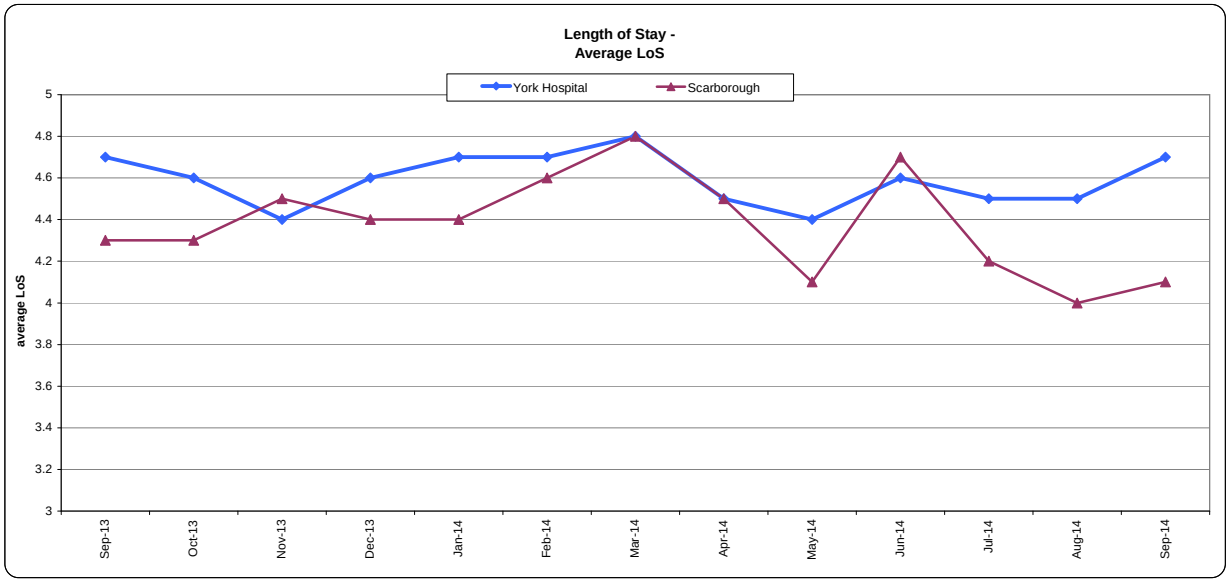
The Trust achieved the target for dementia screening in September.

Data source: Signal



Clinical Effectiveness Dashboard

Clinical Effectiveness



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

Data source: Signal

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

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

Maternity Dashboard - York and Scarborough

York Teaching Hospital NHS
NHS Foundation Trust

York Maternity Dashboard:

			Measure	Data source	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Flag Source	September	October	Novenber	December	January	February	March	April	May	June	July	August	September	Av. Monthly YtD	Action Log completed (Date)	Notes
Activity	Births	Bookings	1st m/w visit	CMIS from Jan CPD	≤302	302-329	≥330	prev. stats	301	343	330	316	399	316	291	273	249	226	291	226	286	296		
		Bookings <13 weeks	No. of mothers	CMIS from Jan CPD	≥90%	76%-89%	≤75%	CQUIN	88%	87%	89%	88%	86%			82%	81%	87%		98%		1		
		Bookings ≥13 weeks (exc transfers	No. of mothers		< 10%	10%-20%	>20%	CQUIN								18.0%				2.2%		10.1%		
		Bookings ≥ 13wks seen within 2 wk	No. of mothers	Mat Rec	≥90%	76%-89%	≤75%	CQUIN												100.0%		100.0%		
		Births	No. of babies	CMIS	≤295	296-309	≥310	prev. stats	296	293	279	285	295	234	285	248	287	288	302	311	289	284		
		No. of women delivered	No. of mothers	CMIS					289	283	274	276	288	230	279	242	285	288	296	309	287	275		
	Closures	Homebirth service suspended	No. of closures	Comm. Manager	0-3	4-6	7 or more		1	6	6	4	1	2	4	0	2	0	0	0	1	2		
		Homebirth service suspended	No. of women	Comm. Manager	0	1	2 or more		0	2	0	0	0	1	0	0	0	0	0	0	0	0		
		Escalation Policy implemented	No. of times	Comm. Manager	3	4-5	6 or more		5	3	3	2	3	0	2	1	2	4	4	2	1	2		
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	0	0	1	1	0	0	0	0		
		SCBU closed to admissions	In utero transfers	Transfer folder	0	1	2 or more		4	3	0	3	0	0	0	0	5	0	1	1	0	1		
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	29.7	28.4	28.4	29.8	31.0	31.0	28.5	29.0	29.0	29.0	29.8	30.5		29.5		
		HCA's	Ratio	Matron				staffing paper	20.02	20.02	20.02	21.01	19.43	19.43	19.43	19.43	19.43	18.83	19.43	19.03		19.6		
		1 to 1 care in Labour		Risk Team	≥75%	61%-74%	≤60%									75.6%	75.0%	77.8%	79.8%	83.9%	78.1%	78.4%		
		L/W Co-ordinator supernumary %		Risk Team					55	48	47	45	51	80	65	71	51	50	45	61	48	55.1		
		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	76.0		
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10		10	10	10	10	10	10	10	10	10	10	10	10	10	10.0		
		Supervisor : M/w ratio 1 :	Ratio	Rota	12	13-15	15	SHA	15	13	13	13	12	13	14	14	14	14	14	14	14	13.6		
Clinical Indicators	Neonatal/Maternal Morbidity	Spontaneous Vaginal Births	No. of svd	CMIS	≥65%	64%	≤63%		63.5	68.3	64.8	62.1	61.7	61.5	59.6	58.0	58.5	65.6	62.7	61.4	64.4	62.5		
		Operative Vaginal Births	No. of instr. births	CMIS	≤15%	16-19%	≥20%	prev. stats	8.4	10.9	10.7	12.9	9.5	15.8	12.6	22.4	19.9	14.6	12.7	13.2	11.8	13.5		
		C/S Deliveries	Em & elect	CMIS	≤24%	24.1-25.9	≥26%	prev. stats	27.7	20.8	24.0	24.5	28.8	22.6	27.7	25.8	26.0	23.3	27.3	22.8	20.8	24.8		
		Eclampsia	No. of women	CMIS	0		1 or more		0	0	0	0	1	0	0	0	1	0	0	0	0	0.2		
		Undiagnosed Breech in Labour	No. of women	CMIS	2 or less	3-4	5 or more	prev. stats	1	3	3	1	1	0	0	0	2	1	3	0	0	1.2		
		ICU transfers	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	1	0	1	2	0	0	0	0	2	0	0	0	0.5		
		HDU on L/W	No. of days	Handover Sheet					15	25	15	14	18	17	11	10	30	30	20	20	15	18.5		
		Uterine Rupture from Jan 14	No of women	CPD	0	1	2 or more						0	0	0	0	0	0	0	0	0	0.0		
		BBA	No. of women	Risk Team - Datix	1	2-3	4 or more	prev. stats	2	6	4	1	4	2	3	4	5	3	4	3	7	3.7		
		Meconium Aspirate	No. of babies	SCBU sister	0	1	2 or more	prev. stats	0	0	0	0	0	1	0	0	0	0	0	0	0	0.1		
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	1	0	0	0	0	0	0	0	0	0	1	0	0	0.2		
	Risk Management	SI's	Total	Risk Team	0	1	2 or more		0	0	0	0	0	0	0	0	1	0	0	0	0	0.1		
		PPH > 2L	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		4	7	7	1	1	2	1	1	5	4	4	1	2	3.1		
		Shoulder Dystocia - True	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	RCOG	3	6	6	3	0	0	2	1	3	5	2	3	7	3.2		
		3rd/4th Degree Tear	% of tears (vaginal b	CMIS	≤1.5%	1.6-6.1%	≥6.2%	RCOG	3.7	3.4	6.1	2.8	4.7	4.4	6.8	5.4	5.3	6.4	6.3	3.2	4.4	4.8	February 2013	April 2013 - range of goals reviewed
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		90	90	89	99	94	96	95	96	94	92	91	91	91	92.9		
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		48	55	50	69	78	81	81	78	83	74	71	71	46	68.1		
		Training cancelled	No. of staff affected	Risk Team	0		≥1		7	1	0	1	1	0	0	0	0	0	0	0	0	0.8		
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		0	0	1	0	3	0	1	3	0	3	3	1	1	1.2		
		Formal	Total	Matron	0	1-4	5 or more		1	2	1	2	2	1	0	2	0	0	1	0	2	1.1		
	New Claims		Total	Directorate Manager	0	1	2 or more		1	0	0	0	2	1	0	1	0	0	0	0		0.4		

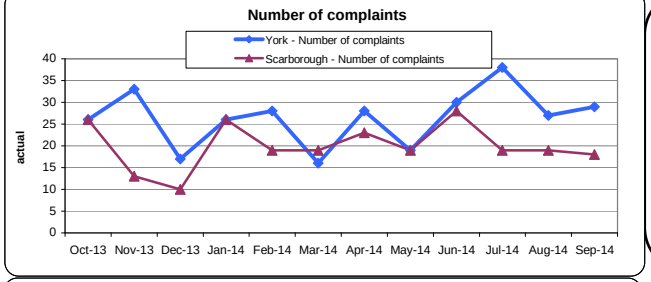
Scarborough Maternity Dashboard:

York Teaching Hospital NHS
NHS Foundation Trust

			Measure	Data source	No Concern(green)	Of Concern (Amber)	Concerns (Red)	Flag Source	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Av. Monthly YtD	Action Log completed (Date)	Notes
Activity	Births	Bookings	1st m/w visit	IS - Evolution	≤200	201-249	≥250	prev. stats	222	199	165	249	190	201	193	183	185	187		119	197		
		Bookings <13 weeks	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	81%	96%	100%	100%	100%	100%	96%	90%	95%	89%			95%		
		Bookings <13 weeks (exc transfers etc)	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	TBC	96%	n/a	n/a	n/a	n/a	89%	100%	100%	100%			97%		
		Bookings ≥ 13wks seen within 2 wks	No. of mothers		≥90%	76%-89%	≤75%	CQUIN							3.0		0.1	0.1			1.1		
		Births	No. of babies	IS - Evolution	≤170	171-189	≥190	prev. stats	145	131	124	145	128	119	116	119	124	132	158	145	132		
		No. of women delivered	No. of mothers	IS - Evolution	≤170	171-189	≥190	prev. stats	142	129	122	143	126	118	119	119	125	134	158	145	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	1	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	1	0	0	0	0		
		Escalation Policy implemented	No. of times	Matron	3	4-5	6 or more		0	0	0	0	0	0	0	0	1	0	0	0	0		
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	0	0	1	0	0	0	0		
		MLU Closure	No. of closures	Matron	0	1-2	3 or more														#DIV/0!		MLU closed from 1/10/13 M/w led care provided on
		MLU Closure	No. of women	Matron	0	1-2	3 or more														#DIV/0!		MLU closed from 1/10/13 M/w led care provided on
		SCBU closed to elective admissions	In utero transfers	Risk Team	0	1	2 or more		16	3	22	8	4	4	7	26	10	4	21	10	11		
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	43.0	43.0	43.0	41.0	38.0	43.0		
		HCA's	WTE	Matron				staffing paper	19.59	19.59	19.59	18.32	18.32	18.32	18.32	17.92	17.12	17.12	16.72	15.92	18.07		
		1:1 care in labour		IS - Evolution					96%	98%	99%	96%	98%	99%	88%	86%	87%	88%	88%	92%	93%		
		L/W Co-ordinator Supernumary %		L/W Manager					56%	56%	62.9%	41.93%	55.3%	64.5%	64.5%	70.9%	75%	58%	50%	50%	60%		
		Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	40	40	40	40	40	40	40	40	40	40	40	40	40		
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10	Safer Childbirth	3	3	3	3	3	3	3	3	3	3	3	3	3		
		Supervisor : M/w ratio 1 :	Ratio	Matron	15	16-19	20	NMC	13	13	13	14	14	14	14	14	14	14	14	14	14		
Clinical Indicators	Neonatal/Maternal Morbidity	Spontaneous Vaginal Births	No. of svd	IS - Evolution	≥65%	64%	≤63%		64.8%	65.6%	67.7%	68.3%	71.9%	72.3%	76.7%	68.9%	64.0%	76.5%	70.3%	75.9%	70.2%		
		Operative Vaginal Births	No. of instr. births	IS - Evolution	≤15%	16-19%	≥20%	prev. stats	8.3%	6.1%	4.0%	3.4%	4.7%	5.9%	3.4%	6.7%	6.5%	3.8%	9.5%	9.0%	5.9%		
		C/S Deliveries	Em & elect	IS - Evolution	≤24%	24.1-25.9	≥26%	prev. stats	24.8%	26.0%	26.6%	26.9%	21.9%	21.0%	19.8%	23.5%	29.0%	18.9%	20.9%	15.2%	22.9%		
		Eclampsia	No. of women	IS - Evolution	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0	0		
		Undiagnosed Breech in Labour	No. of women	Risk Team	2 or less	3-4	5 or more	prev. stats	1	1	0	0	0	0	1	1	0	0	0	0	0		
		ICU transfers	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	0	0		
		HDU on L/W	No. of days	Risk Team					2	5	4	2	3	1	3	0	0	2	2	2	2		
		P/N Hysterectomies < 7days p/n	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	0	0		
		BBA	No. of women	IS - Evolution	1	2-3	4 or more	prev. stats	1	0	1	1	1	0	0	0	0	3	2	0	1		
		Meconium Aspirate	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	1	0	1	0	0	1	0	0	0	0	0		
		Diagnosis of HIE	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	1	0	0	0	0	0		
	Risk Management	SI's	Total	Risk Team	0	1	2 or more		0	0	0	0	1	0	1	0	0	0	0	1	0		
		PPH > 2L	No. of women	IS - Evolution	1 or less	2-3	3 or more		0	1	1	0	1	0	2	0	0	2	0	0	1		
		Shoulder Dystocia - True	No. of women	IS - Evolution	1 or less	2-3	3 or more	RCOG	4	0	0	1	1	0	0	1	1	0	1	0	1		
		3rd/4th Degree Tear	% of tears (vaginal b	IS - Evolution	≤1.5%	1.6-6.1%	≥6.2%	RCOG	1.4%	0.8%	2.5%	4.9%	4.0%	0.0%	0.4%	0.7%	1.6%	0.0%	1.3%	0.8%	1.5%		
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		85	92	98	91	93	93	91	90	94	93	93	93	92		
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		79	82	90	37	92				77	92	92	92	78		
		Training cancelled	No. of staff affected	Risk Team	0		≥1		0	0	1	0	0	0	0	0	0	0	0	8	1		
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		1	3	1	1	3	2	0	1	0	1	2	3	2		
		Formal	Total	Matron	0	1-4	5 or more		1	1	1	1	1	0	2	0	0	0	1	4	1		
	New Claims	New Claims	Total	Risk Team	0	1	2 or more		0	0	0	0	2	1	0	1	0	1	1	0	1		

Patient Experience Dashboard

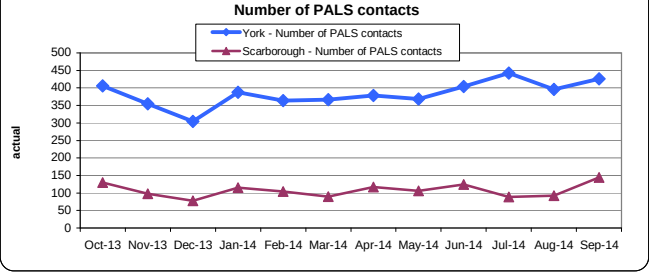
Patient Experience



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

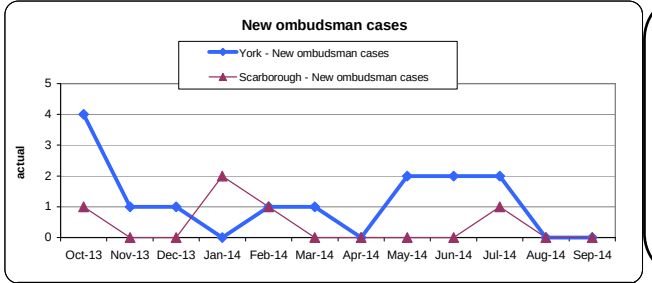
Complaints registered in Scarborough relate to Scarborough Hospital and Bridlington Hospital.

There were 29 new complaints registered to the York site and 18 to the Scarborough site in September.

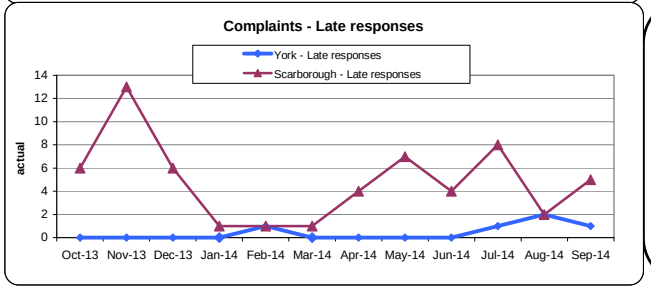


There were 426 PALS enquiries at York Hospital and 144 PALS enquiries at Scarborough in September.

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



There were no new ombudsman cases reported in September.



There was five late responses to complaints at the Scarborough site and one at the York site in September.

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.

Friends & Family Test Results

York Teaching Hospital NHS
NHS Foundation Trust

01 Jul 2014 - 31 Jul 2014

Your Friends & Family Test Score is....	69	Last month your score was....	64

Survey type	Score this month	Score last month
Accident & Emergency	55	47
Inpatient	76	73

Highest score
Lowest score
Negative score

Top 3 most improved wards/services this month	6 Month Average	This Month	Improvement	Trend
St Helen's	39	67	28	
North East Community Team - antenatal	51	75	24	
Selby Community Team - postnatal	84	100	16	

Top 3 consistently high performing wards/services	6 Month Average	This Month	Improvement	Trend
CCU York	96	88	-8	
Kent	96	97	1	
Ward 37	96	100	4	

Top 3 consistently low peforming wards/services	6 Month Average	This Month	Improvement	Trend
A&E York	38	49	11	
St Helen's	39	67	28	
North East Community Team - antenatal	51	75	24	

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

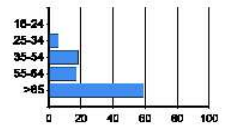
Who responded?

Response Rate			
Survey type	Eligible Patients	Patient Responses	Response Rate
Accident & Emergency	7244	1680	23%
Inpatient	3246	1352	42%
Trust Total	10490	3032	29%

Male or Female: 38% / 62%

Age Profiles %

Please note that the graph below does not show data from the maternity FFT surveys as the age bandings are different.



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

Complaint themes this month, e.g. staff attitude, increased numbers in an area (Y, S)
a) SGH has seen an increase in complaints this month for Women's Services
b)
c)

Any other concerns, comments, considerations relating to complaint handling
a) Pink folders need to be in for QC'ing purposes the same day as the e-docs and this is not happening.
b) Directorates raised concerns re lack of complaint staff presence at SGH and the amount of times work is coming back into complaints and then the division
c)

Action plan example:
Complaint Ref: S14/15-100 - Plan for management of children presenting with bloody diarrhoea.Consultant in ED developing a Paediatric handbooks which will contain various guidance and instruction for managing this presentation.
Complaint Ref: S14/15-095 - No interpreter information in ED. This is currently being put in place and staff made aware of how to book interpreters when required.

PALS themes this month, e.g. staff attitude, increased numbers in an area, topics (Y, S)
a) Communications
PALS continue to receive calls for the Eye Dept. New issues with length of time getting through to Contact Centre
Unable to get through to Ultrasound and PET. Dermatology on Voicemail. Misdirection through the Portal.
DN referrals SPA new number still people not aware and ringing the old which they are stating just rings.
b) Habitual Callers - PALS are being contacted repeatedly by same people.
This Month felt overwhelming for the team with the number of challenging individuals.
c) Amendments requested to Datix but still awaiting action.
Retinal screening code asked to be removed from Specialist Medicine as now in General Medicine
d) Pain Services concerns raised in the August 2014 Dashboard from SGH. New letter with correct contact details sent out to service users and referrals made to the CCG and GPs. General enquiries are being resolved by the DM and DDM by calling patient's as and when required.
e) From the August 2014 Dashboard there were a number of contact re telephone not being answered in Audiology. DDM now has the lines covered.

PALS contacts by category	YH	SGH	S+Y
Action PLan	4	0	4
Admissions, discharge, transfer arrangements	19	3	22
Appointments, delay/cancellation (inpatient)	5	4	9
Appointments, delay/cancellation (outpatient)	34	20	54
Staff attitude	8	3	11
Any aspect of clinical care/treatment	54	32	86
Communication issues	40	25	65
Compliment / thanks	47	0 *	47
Alleged discrimination (eg racial, gender, age)	1	0	1
Environment / premises / estates	2	1	3
Foreign language	1	0	1
Failure to follow agreed procedure (including consent)	2	0	2
Hotel services (including cleanliness, food)	4	8	12
Requests for information and advice	157	35	192
Medication	4	0	4
Other	3	0	3
Car parking	1	0	1
Privacy and dignity (including care and comfort)	6	12	18
Property and expenses	13	1	14
Personal records / Medical records	13	0	13
Safeguarding issues	1	0	1
Signer (interpreter services)	2	0	2
Support (eg benefits, social care, vol agencies)	2	0	2
Patient transport	3	0	3
Totals:	426	144	570

Total September 2014			
Complaints by directorate/division (Datix)	York	Scarb	S+Y
Child Health (Y)	1	0	1
Clinical Support Services (S)	0	1	1
Community Services (Y)- 1 Malton and 1 Selby	2	0	2
Corporate (Y, S) - Lead IO is Deputy Chief Nurse	1	0	1
Elderly Medicine (Y)	1	1	2
Emergency Medicine (Y)	4	5	9
Facilities (Y, S)	0	0	0
General Surgery & Urology (Y), Surgery (S)	6	0	6
Head & Neck & Ophthalmology (Y)	0	1	1
Medicine (General & Acute, Y), Medicine (S)	2	2	4
Obstetrics and Gynaecology (Y)	6	5	11
Orthopaedics (Y)	1	2	3
Pharmacy (Y)	1	0	1
Physiotherapy (Y)	2	0	2
Radiology (Y)	0	0	0
Sexual Health (Y)	0	0	0
Specialist Medicine (Y)	1	1	2
Theatres Anaesthetics & CC (Y)	1	0	1
Total	**29**	**18**	**47**

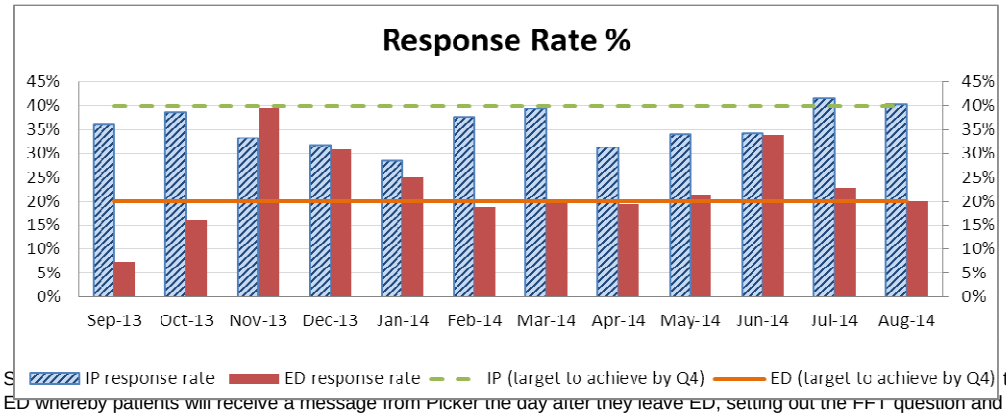
Total September 2014			
Complaints by subject (Datix)	York	Scarb	S+Y
Admissions, discharge and transfer arrangements	0	0	0
Aids, appliances, equipment, premises	0	0	0
All aspects of clinical treatment	25	10	35
Appointment delay/cancellation (inpatient)	0	0	0
Appointments, delay/cancellation (out-patient)	0	0	0
Attitude of staff	0	5	5
Communication/information to patients (written and oral)	3	1	4
Complaints handling	0	0	0
Consent to treatment	0	0	0
Failure to follow agreed procedure	**0**	**0**	0
Hotel services, including food	**1**	**0**	1
Mortuary and post mortem arrangements	**0**	**0**	0
Other	**0**	**1**	1
Patients' privacy and dignity	**0**	**1**	1
Patients' property and expenses	**0**	**0**	0
Patients' status, discrimination	0	0	0
Policy and commercial decision of Trust	0	0	0
Total	**29**	**18**	**47**

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

The Friends

The Friends and Family Test (FFT) is a patient experience tool whereby we ask patients "how likely are you to recommend our service to your friends and family if they needed similar care?". FFT has now been rolled out across almost all of the Trust's activity, including: inpatients, ED, maternity services, community hospitals, community services, and several outpatient clinics at York, Scarborough and Bridlington. A FFT Project Manager (12 months fixed term) has been in post since late August.

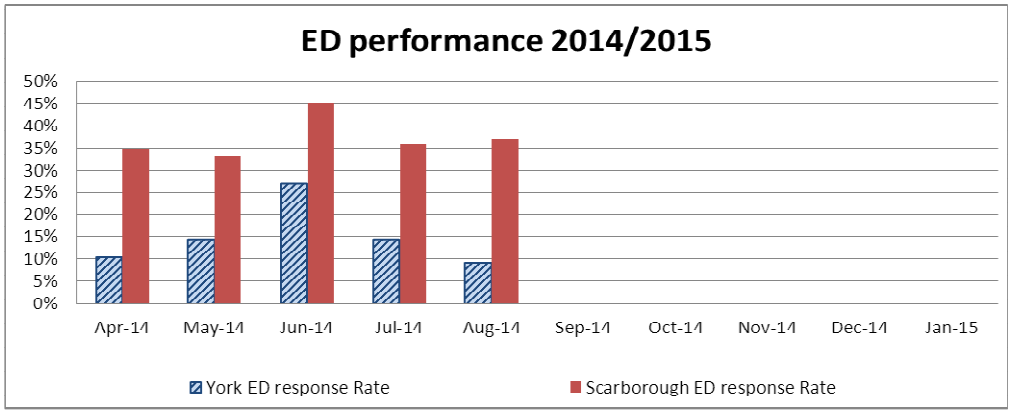
The Trust is on target to meet CQUIN requirements for 2014/15 of a 40% response rate across inpatients in March 2015 and a 20% response rate in ED over Q4. Please note that "net promoter scores" are no longer calculated or monitored. The focus for the Trust is ensuring we remain on target but also to ensure we are using the valuable qualitative feedback received from patients.



Inpatient Performance

		Apr-14	May-14	Jun-14	Jul-14	Aug-14
Trust	Eligible patients	2988	3206	3129	3246	2927
	Responses	936	1088	1071	1352	1177
	Response Rate	**31.33%**	**33.94%**	**34.23%**	**41.65%**	**40.21%**
	Net Promoter Score	75	76	73	76	76
York	Eligible patients	2003	2182	2153	2187	1930
	Responses	584	686	748	852	696
	Response Rate	**29.16%**	**31.44%**	**34.74%**	**38.96%**	**36.06%**
	Net Promoter Score	75	77	72	73	76
Sboro	Eligible patients	872	830	810	895	855
	Responses	269	243	222	359	380
	Response Rate	**30.85%**	**29.28%**	**27.41%**	**40.11%**	**44.44%**
	Net Promoter Score	76	69	74	77	75
Brid	Eligible patients	113	194	166	164	142
	Responses	83	159	101	141	101
	Response Rate	**73.45%**	**81.96%**	**60.84%**	**85.98%**	**71.13%**
	Net Promoter Score	72	84	82	88	81

S the 20% system in York ED whereby patients will receive a message from Picker the day after they leave ED, setting out the FFT question and asking them to respond with a number correlating to their answer (ie 1 for extremely likely, 2 for likely, etc). Patients then receive a follow-up message asking for qualitative feedback. Picker uses this method for other Trusts and average a 20% response rate to the text messages. People without a mobile number will be given a card to complete.

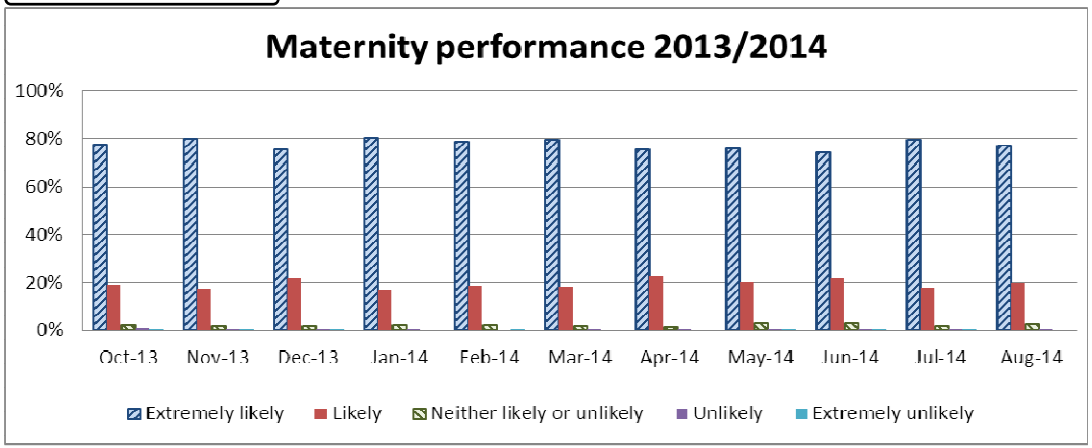


ED Performance

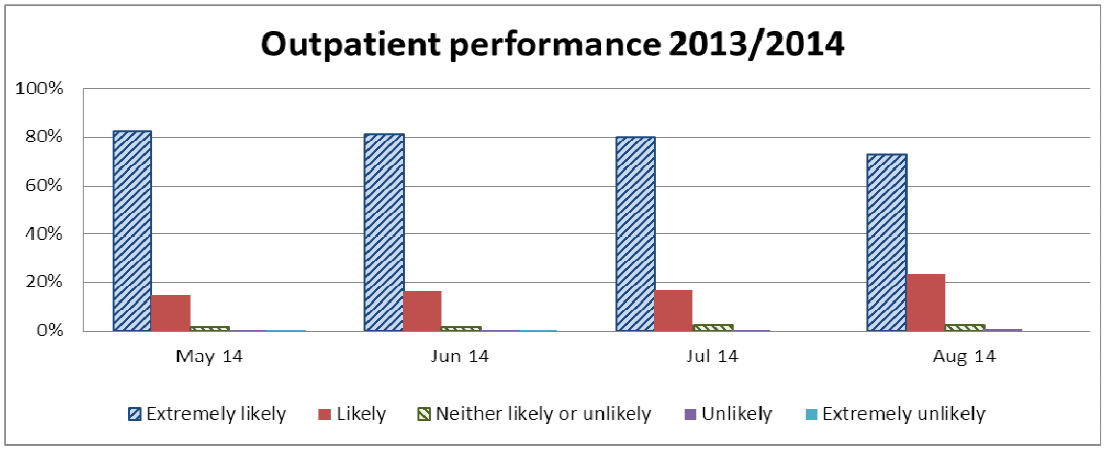
		Apr-14	May-14	Jun-14	Jul-14	Aug-14
Trust	Eligible patients	6467	6970	6863	7244	7017
	Responses	1260	1502	2329	1650	1402
	Response Rate	**19.48%**	**21.55%**	**33.94%**	**22.78%**	**19.98%**
	Net Promoter Score	54	40	47	55	44
York	Eligible patients	4079	4356	4283	4451	4305
	Responses	429	636	1162	647	404
	Response Rate	**10.52%**	**14.60%**	**27.13%**	**14.54%**	**9.38%**
	Net Promoter Score	37	11	31	49	67
Sboro	Eligible patients	2388	2614	2580	2793	2712
	Responses	831	866	1167	1003	998
	Response Rate	**34.80%**	**33.13%**	**45.23%**	**35.91%**	**36.80%**
	Net Promoter Score	63	61	63	59	34

Maternity FFT
Maternity services continues to perform well and has moved from implementation of FFT to really using the data and feedback to make positive differences to the service - for patients and staff. A case study of best practice is currently with NHS England to be considered as an entry for PENNA (Patient Experience Network National Awards). and action from the FFT.

Trust Perfrmance:



Outpatients FFT
Since implementing FFT across outpatients in May 2014 we have had received around 6000 FFT cards back from patients. It is not possible to calculate an eligible patient denominator due to the nature of repeat appointments at outpatients, however we can see that the overwhelming majority of respondents are very likely to recommend our services to friends and family.



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

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

The Community Services FFT workstream group now meets monthly, attended by representatives from district nursing, intermediate day care, specialist nursing, and more. These services are now implementing FFT. Staff in these areas are concerned that response rates may not be high due to the patient having reduced changes of anonymity; they are likely to hand the card back directly to the caregiver rather than posting in a box on a ward, etc. Many are housebound and could be unable to use the freepost option. We plan to monitor this closely and if after 6 weeks of running FFT in community services we see very limited responses, we will work with community staff to create an alternative method of capturing FFT responses from these patients. Community hospitals continue to have strong response rates.

Some Day Case patients are now being included in FFT, for example the eye day case units at York and Scarborough, and Lloyd ward at Bridlington (which sees a large volume of day case patients). More day case services will start rolling out FFT in the coming months.

Comment cards are now being used in the majority of our outpatient services.

York	Scarborough	Bridlington
Specialist medicine	Specialist Medicine	Specialist Medicine
Radiology	Acute / General Medicine	Acute / General Medicine
Therapies	Elderly Medicine	Elderly Medicine
Psychology	Head and Neck	Head and Neck
Surgery	Surgery	Surgery
Obstetrics and Gynaecology		Orthopaedics
General Medicine		
Elderly Medicine		

not calculate eligible response rates for outpatients in an appropriate way for FFT purposes, but the comments will be fed back to all services and will be used to make local service improvements.

Commissioning for Quality and Innovation (CQUIN) 2014/15

The CQUIN requirements for 2014/2015 are detailed below:

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

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

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

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

Medical Director's Report

Action requested/recommendation

Board of Directors are asked to:

- note the National Incident Reporting update.
- note the results of the antibiotic and probiotic prescribing audit
- note the results of the Orthopaedic Surgical Site Infection Surveillance Report
- note the Trust's improved position in the Macmillan Cancer Support, Patient Experience Survey.

Summary

This report provides an update from the Medical Director.

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

Implications for equality and diversity

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

Reference to CQC outcomes

The content of this report does provide some assurance of our compliance with the CQC essential standards of quality and care.

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

Board of Directors – 29 October 2014

Medical Director's Report

1. Introduction and background

In the report this month:

- Consultant appointments
- National Incident Reporting Update
- Antimicrobial Prescribing Audit and Probiotic Audit
- Flu Campaign
- Orthopaedic Surgical Site Infection surveillance report
- Cancer Patient Experience survey.

2. Consultant appointments

Dr Alison Gill
Consultant in Respiratory Medicine
Commenced: 29/09/2014

Mr Nichola Brown
Locum Consultant in Maxillofacial Surgery
Commenced: 08/09/2014

Dr Richard Hoefield
Consultant Renal Medicine
Commenced: 15/09/2014

3. National Incident Reporting Update

The National Reporting and Learning System, Patient Safety Incident Report for the period 1st October 2013 to 31st March 2014 is summarised below.

The Trust is in the middle 50% of reporters. The top 10 incidents reported by type are illustrated, indicating that the Trust reports significantly more incidents in the 'patient accident' category when compared with all acute teaching organisations.

In the 'incidents reported by degree of harm' section, the Trust appears to report more incidents with harm when compared with all acute teaching organisations. To be confident that our reports are accurate we need to ensure that incident investigators are aware that in determining harm from an incident the NRLS requirement is to calculate 'actual harm' rather than 'potential harm'.

National Reporting and Learning System

Organisation Patient Safety Incident Report

Reported incidents between 1 October 2013 to 31 March 2014

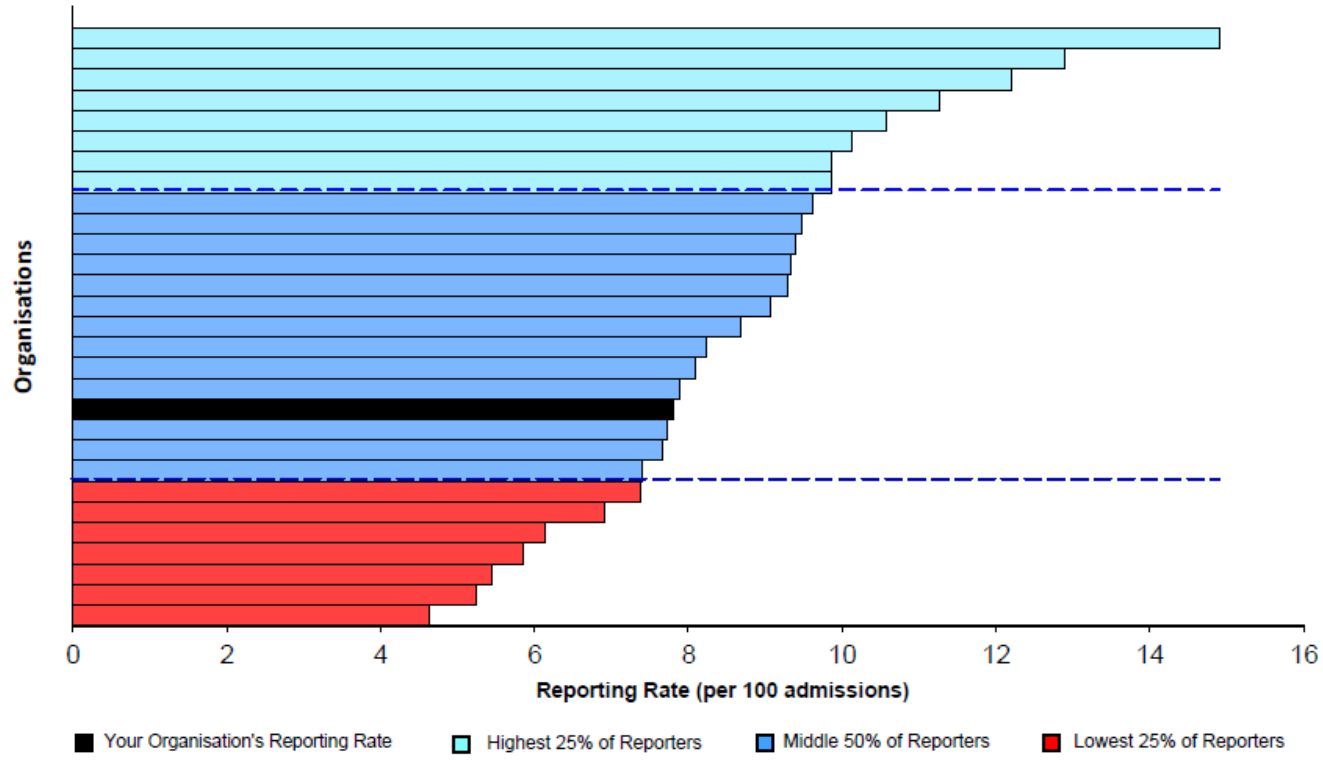
York Teaching Hospital NHS Foundation Trust

Organisation type: **Acute teaching organisation**

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 1 October 2013 and 31 March 2014. Your organisation reported 5,333 incidents (rate of 7.80) during this period.

Figure 1: Comparative reporting rate, per 100 admissions, for 29 Acute teaching organisations.



The median reporting rate for this cluster is 8.69 incidents per 100 admissions

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

How regularly do you report?

Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 6 out of the 6 months between October 2013 and March 2014.

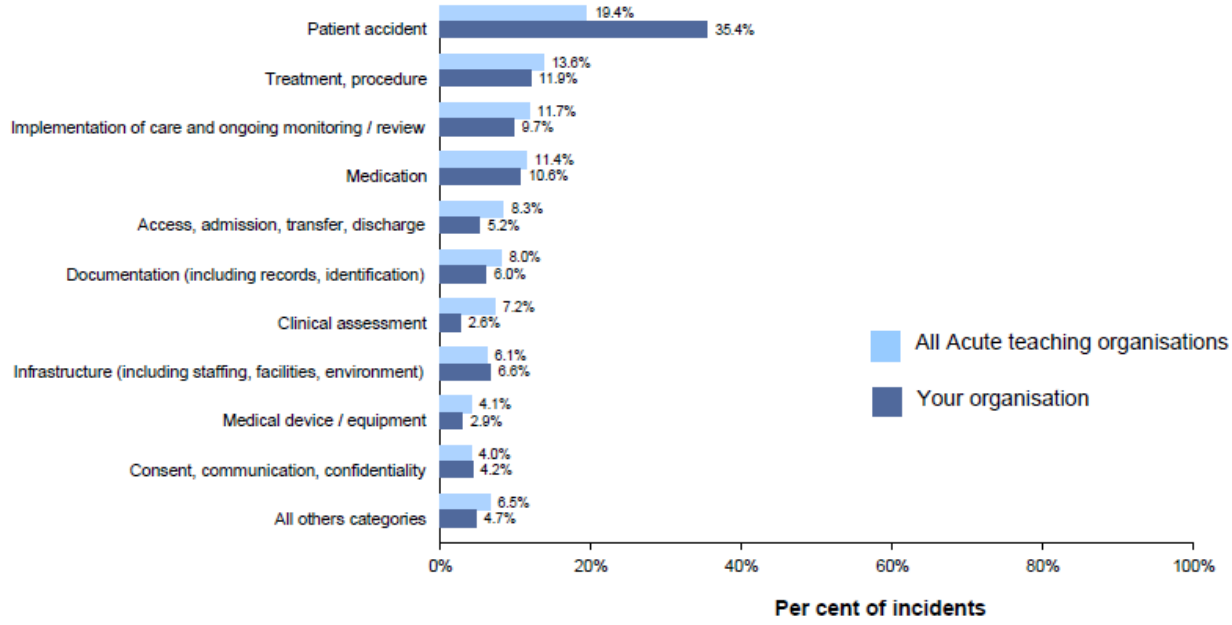
Report regularly: Incident reports should be submitted to the NRLS at least monthly.

Fifty percent of all incidents were submitted to the NRLS more than 28 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 73 days after the incident occurred.

Report serious incidents quickly: It is vital that staff report serious safety risks promptly both locally and to the NRLS, so that lessons can be learned and action taken to prevent harm to others.

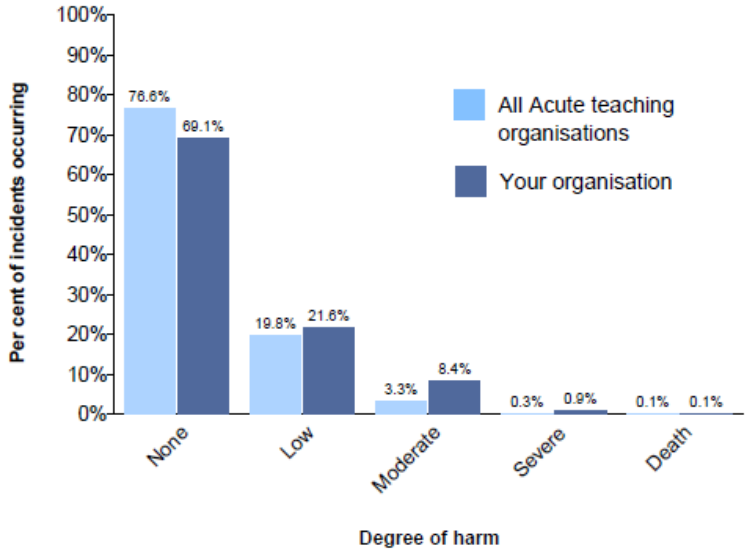
What type of incidents are reported in your organisation?

Figure 2: Top 10 incident types



If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

Figure 3: Incidents reported by degree of harm for Acute teaching organisations



Your figures:	None	Low	Moderate	Severe	Death
	3,683	1,150	447	49	4

Do you understand harm?

Nationally, 69 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

Further information for you

The NRLS helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. Alerts and other learning resources can be found at www.england.nhs.uk/ourwork/patientsafety/psa/ and national data can be found at: www.nrls.npsa.nhs.uk/patient-safety-data/.

Reviewing the results of the NHS staff survey relating to incident reporting alongside this report will provide an important indicator of your reporting culture.

Ref: Yourdata_RCB_Sep2014

4. Antimicrobial Prescribing Audit and Probiotic Audit – September 2014

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

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

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

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

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

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

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

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

5. Flu Campaign

The Flu Campaign as part of our resilience planning for the Winter has commenced.

Dr Turnbull and Mrs Geary have written to all staff urging them to attend one of the drop-in sessions to get vaccinated.

6. Orthopaedic SSI Surveillance Summary Report

Mandatory Orthopaedic Surgical Site Infection Surveillance – Project Number 2708

Introduction
There is a Department of Health mandatory requirement that all Trusts complete surgical site infection surveillance for at least 3 months every fiscal year for at least one type of Orthopaedic procedure.

Aim
To complete the annual mandatory 3 months of orthopaedic surgical site surveillance following Total Knee Replacement Surgery.

Method
All patients undergoing surgery following Total Knee Replacement were included in the surveillance. Theatre lists were checked to ensure all relevant patients were included.

The information required for each patient was collected using the theatre and demographic records in Core Patient Database (CPD). The ward completed evaluation documentation of wound status prior to discharge. Some patients were contacted post discharge (with their consent) by telephone for follow up of wound healing. The laboratory database was checked for wound specimen results.

Results
252 patients were included in the surveillance from York (112 patients) and Scarborough Hospitals (140 patients). Nil infections that meet the inclusion criteria have been reported for this period of surveillance.

The national benchmark for surgical site surveillance rates for Total Knee Replacement surgery is 0.6%. All this is implant surgery any infection that occurs up to one year post surgery would meet the inclusion criteria set by PHE. The patients will be assessed at one year using Core Patient Database and laboratory database records.

Conclusion
Public Health England reports all national surgical site surveillance. York Trust did not have any cases of surgical site infection during the surveillance period. the report for 2012 to 2013 is currently available at the following link:
https://www.gov.uk/government/uploads/attachment_data/file/325449/SSI_annual_report2012_to_13_final.pdf

Actions Planned	Responsibility	Timescale
Feedback to Orthopaedic Directorate	Jane Tully and Jane Balderson	October 2014
Follow up SSI at one year post surgery	Jane Tully and Jane Balderson	Jan- June 2015

7. Cancer Patient Experience Survey

The Cancer Patient Experience Survey: Insight Report and League Table, recently published by MacMillan Cancer Support has ranked the Trust in the top 10 most improved trusts, with an improved score of 14 and only one score failing.

10 most improved NHS Trusts, 2014

Top 10 most improved Trusts – ranked by number of scores showing statistically significant improvement, then by number of scores showing statistically significant fall

Trust	Strategic Clinical Network	Number of scores improving	Number of scores falling
The Dudley Group NHS Foundation Trust	West Midlands	14	0
York Teaching Hospital NHS Foundation Trust	Northern England	14	1
University Hospital of South Manchester NHS Foundation Trust	Greater Manchester, Lancashire and South Cumbria	14	1
Luton and Dunstable Hospital NHS Foundation Trust	East Midlands	13	0
Mid Essex Hospital Services NHS Trust	East of England	13	0
Nottingham University Hospitals NHS Trust	East Midlands	13	0
North Bristol NHS Trust	South West	12	0
Portsmouth Hospitals NHS Trust	Wessex	12	1
South Devon Healthcare NHS Foundation Trust	South West	10	0
St George's Healthcare NHS Trust	London	10	0

8. Recommendations

Board of Directors are asked to:

- note the National Incident Reporting update.
- note the results of the antibiotic and probiotic prescribing audit
- note the results of the Orthopaedic Surgical Site Infection Surveillance Report
- note the Trust's improved position in the Macmillan Cancer Support, Patient Experience Survey.

Author	**Diane Palmer, Deputy Director for Patient Safety**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**October 2014**

D3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

Chief Nurse Report – Quality of Care

Action requested/recommendation

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

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

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

Board of Directors - 29 October 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

We continue to make significant progress in the delivery of the objectives of the second year, a full update is attached at appendix 1.

Early Warning Trigger Tool (EWTT)
In order to measure the quality of care within clinical areas the Board of Directors approved the adoption of an EWTT to replace NCI's. An electronic tool has been developed to support data capture and interpretation and training for ward staff and Matrons is planned to begin in October with 'go live' planned in November.

2. Falls Reduction

The Board are aware that a significant work-stream is the reduction of falls across the whole organisation, with a specific objective to reduce falls resulting in harm. The new Falls 'Slip, Trip and Falls Inpatient' Policy has been revised and is ready to be launched. In addition a new patient risk assessment tool has been developed and we are exploring ways to utilise IT in order to replace the existing tool.
A launch of the new policy, assessment tool and implementation plan is planned when the assessment is ready to be changed on our IT system, however, a pilot will commence in Community Hospitals this month.
A new training programme has also been developed and is ready to be launched.

To support the organisational launch and roll out a number of resources have been prepared to raise awareness for staff and patients, these include:

- Patient/carer falls awareness leaflet
- Patient/visitor falls awareness poster
- Staff – top tips poster in reducing the risk of falls
- Staff – post fall checklist

An analysis of incidents and SI reports has identified a number wards with high patient falls. These areas will be prioritised for additional education, training and support which will be bespoke to the ward depending upon the issues highlighted.

A detailed report on themes and learning from serious incidents will be presented in another paper.

3. Midwifery

The UNICEF Baby Friendly Initiative (BFI) Stage 3 assessment was undertaken in July, it has been shown where trusts achieve full accreditation it has been shown to have positive affects on the initiation and sustainability of breast feeding this significant health benefits to both mother and baby.

The results of the assessment was that the organisation met most of the criteria relating to full accreditation of UNICEF BFI standards and the staff involved were commended for the efforts made.

- York site met all of the criteria relating to full accreditation.
- Scarborough met most but not all criteria relating to full accreditation.

Action required before full accreditation (planned for January 2015); are that the two standards not fully met on Scarborough site (standard required 80%) need to be reassessed, these are as follows:

1. Evidence of an increase in the number of mothers who had an opportunity for a discussion about feeding their baby in pregnancy (Result 72%)
2. Evidence of an increase in the number of mothers who are aware how to recognise effective feeding (Result 73%)

In order to achieve this the infant feeding coordinator from the York site is providing support to the Scarborough team with training, audit of records and collation of data.

Colposcopy Quality Assurance Reference Centre visit (September 2014.)

The Quality Assurance Reference Centre is part of Public Health England, which is an executive agency of the Department of Health.

The purpose of the QARC is to monitor the performance of the National Health Service Cervical Screening Programme (NHSCSP) so that standards are maintained.

All colposcopy units are visited on a three yearly basis with the aim to ensure that the NHSCSP national guidelines are followed. The visiting team consists of the QA Colposcopy Chair (a Consultant Colposcopist), QA Nurse Colposcopist chair (a Nurse Colposcopist), and two members of the QA team.

Colposcopy/colposcopist performance is continually audited and the data is submitted quarterly to the QA.

Verbal feedback provided on the day the visiting team had no concerns with the clinical running of the services on each site. It was commented that the merged Trust work towards standardisation of processes and information.

The full report will be published in November.

4. Nursing Recruitment

The subject of international recruitment of nurses has previously been discussed at Nursing Board, Corporate Directors and more recently at the Board of Directors.

A number of neighbouring Trusts have already very successfully recruited nurses from Spain

(Harrogate & Northern Lincolnshire and Goole Trust (NLAG)).

Whilst recent recruitment campaigns at York have been very successful given the difficulties we are experiencing in recruiting to Registered Nurses at our Scarborough site the proposal that that we partner with NLAG on a campaign to employ a small cohort of nurses to address some of the gaps was made and the feasibility of this explored.

NLAG are currently in the process of obtaining executive approval their next campaign and expect that in the next few weeks' decisions will be made around timescales. This will enable us to plan our involvement and give some indication of when any newly-recruited nurses from any agreed campaign would be able to join the Trust.

Based on a previous scoping exercise; it is anticipated that from the planning the campaign to candidate relocation takes from 2-4 months. Our advantage in partnering with NLAG is that they are an experienced international recruiter, working with a framework agency (Search) who provide comprehensive support to both the employer and their candidates throughout the full recruitment process, including at the relocation stage.

The Recruitment Team have undertaken a piece of work to obtain proposals from the same agency (and also a range of others) should we wish to conduct our own campaign at a future stage. However, due to NLAG's existing relationship with Search, and without any unforeseen circumstances, their proposed campaign will proceed more quickly than any option which would involve the Trust commissioning a supplier of its own.

Updates regarding the proposals and any plans will be included in future reports.

5. Safeguarding

5.1 Adult Safeguarding update

Cheshire West Supreme Court Judgement.
Recent seminars to raise awareness of MCA and the new ruling were well attended by Senior Medical staff. Formal direction is still not yet available from DoH or NHS England on how this ruling should be implemented in acute settings. In the meantime DoLs authorisation requests have increased and being managed on a common sense basis. The implementation of this ruling has been highlighted as a risk to the Trust.

PREVENT – Home Office Strategy for Counter Terrorism.
Whilst this has been highlighted as a risk (and on the Corporate Risk Register) since 2012 we are under increasing pressure to implement the Strategy. However the training obligations at this time cannot be fulfilled (annual 3hour face-to-face to all front-line staff).
A meeting is planned with NHS England PREVENT coordinator to review the implementation plan and to establish a way forward that reduces any risk.

Exclusion Policy – In light of several incidents where patients and visitors demonstrated unacceptable behaviour a piece of work is ongoing to develop and update the former policy. The anticipated completion date is expected to be November 2014 and a communication plan will follow.

Mental Health Support Group
This group was developed in order the raise the awareness of the significant numbers of patients with Mental Health issues, to improve patient experience, mitigate risk and to deal some of the difficulties staff experience due to lack of experience in dealing with this group of patients.
In addition, to the group will triangulate any information and share any learning from incidents and feedback.

The core remit of group is as follows:

i. Establish SLA with Mental Health Providers
ii. Staff training and awareness raising
iii. Policy development and guidance
iv. Develop audits of the care of patients with mental ill-health in an acute setting.

Scarborough Acute site has secured an SLA with Tees Esk and Weir. There is some progress with Leeds York Partnership, but this is limited due to the relocation of services however we are still working with the team to continue this work.

53 staff have been identified to attend Mental Health First Aid Training. This was implemented following feedback from staff and also as a recommendation from an SI. The first cohorts report that the training is helpful and given them a good insight into the needs of this vulnerable group.

The Emergency Department Liaison Service started on 29th September 2014 with twilights only, this will increase on 20th October to provide an 8am – 12am service. We are currently out to recruit for a 24/7 service and early indications are very positive. We are developing outcomes measures and how to collect user feedback with Leeds and York Partnership Trust and the CCG.

In addition to the work above we have recently signed a concordat to work with multiple partners to improve outcomes for patients with Mental Health problems; the lead agency is the police.

Significant progress is being made in the management of patient with mental health problems within the organisation which is positive for patient and staff safety and experience.

5.2 Children's safeguarding

The new Head of Safeguarding commenced her post on 1st October 2014. The Board will be aware that the initial objective was to examine the Safeguarding Children service across the organisation and establish any risks that may exist.

Over the coming months a full review of the systems of the safeguarding children team, and the safeguarding children processes across the Trust will be undertaken of the work, with recommendation of any changes or developments being reported to the Trust Board where appropriate.

It has already been identified within the Annual Report, a key issue for the trust is the low uptake of Safeguarding Children training; current uptake across all 3 levels is below the CCG expected KPI of 95%, with uptake of Level 2 training (now available via an e-learning package as well as some face to face sessions) being the lowest at 36%. (NB: Level 2 training is to be undertaken by all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers).

On a more positive note, in the financial year 2013-14 there have been some significant developments within the service, such as:

- Identification of a dedicated Safeguarding Children budget;
- Child Protection Reflective Supervision has been embedded in key areas such as Maternity, Child Health, Health Visiting, School Nursing and the Emergency Department;
- Revision & launch of safeguarding children systems & processes within York Hospital Maternity Unit;
- Review of safeguarding processes in Emergency Department and associated development plan devised.

The Annual Report for Safeguarding Children, which will be submitted to the Trust Board next month, in addition, a comprehensive Safeguarding Children Action Plan will be developed by the end of December 2014, this will be monitored by the Head of Safeguarding & will feed in to

relevant Trust & multi-agency governance groups & Boards.

6. Patient experience - Staff Friends and Family Test (FFT)

The Staff FFT ran the survey for a 2-month period during Quarter 1 (Q1 via an on-line survey and postcard solution which received a disappointing response rate of 8%.

One of the main issues appeared to be the requirement for staff to use their employee number to access the survey. In response to this concern, during Q2 we removed the need for staff to use their employee number and instead, asked staff to select their Directorate and Staff Group. It was hoped that this would see an increased response rate and would provide us with useful quantitative and qualitative data at Directorate level.

As a small percentage of staff had responded using the postcard option in Q1, the Trust decided to run Q2 via the on-line survey only.

Q2 was launched on 1 September after the summer holiday period for a period of 3 weeks, with the key messages:

- On line questionnaire
- No requirement for personal number
- Low response rate for Q1, therefore we really need staff to tell us their experiences to help improve services.

The survey was promoted at the recent Health & Wellbeing Fair in Scarborough, where staff completed the survey on the day. We are currently awaiting the responses and report for Q2 from our external contractor, Capita.

The new style Staff Brief format saw the Chief Executive explaining the importance of staff engaging with the Staff Friends and Family test. The National Staff Survey will be implemented shortly which provides the same questions for Q3. During this period, we will be focussing on a communication campaign to engage with staff to raise further awareness of the test and share the results from Q1 & 2 on a corporate and directorate level. We will also be considering how we implement Q4, with initial thoughts looking to target areas linked to staff engagement scores from the staff survey.

All other aspects of Patient Experience activity will be addressed in the quarterly update which is detailed in a separate report.

7. Recommendation

The board is asked to receive the update report and current work-streams of the Chief Nurse Team for information.

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

Appendix 1
October 2014 update:

York Teaching Hospital NHS
NHS Foundation Trust

Nursing and Midwifery Strategy Implementation Plan: Year 2, 2014

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

C1 -Care
C2 -Compassion
C3 -Competence
C4 -Communication
C5 -Courage
C6 -Commitment

Priority 1	**Improve Patient Experience**

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
1a	C1 C4	Develop Patient Public Involvement (PPI) strategy.	Revised Dec 2014	• Work plan agreed in Patient Experience Committee. • Delay in the development of a strategy due to the in-depth review of PPI activity in order to inform the new strategy. • Service users being involved in development of maternity bereavement service Scarborough site. • MSLC chair being involved in Friends & Family Test (FFT) action plan written by Head of Midwifery	• Recommendations for in-depth review approved at Executive Board. • New appointment to lead PPI agenda and the integration of Patient Experience team (Kay Gamble) • New lead to start writing the strategy	Lead Nurse Patient Experience/ Director of Nursing
1b	C2 C4	Undertake a review of the Patient Experience service, function and capacity and make recommendations to the Nursing Board.	June 2014	• Questionnaires re: training circulated. • Review of processes completed. • Review of the Patient Experience Team (PET) completed • Results of training questionnaire presented at the Patient Experience Committee. • Outcome of review of PET agreed at PPI	• Completed • New Lead in Post	Chief Nurse Team

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
				Steering Group • Board of Directors agreed recommendations. • New job description Agenda for Change (AFC) matched.		
1c	C4 C5	Strengthen the role of ward sister in the management of and learning from complaints in their areas	July 2014	• Afternoon of discussion and presentations planned on Patient experience and complaints management for Professional Nurse Leadership Forum (PNLF). • NHS Elect training commenced. • Midwifery Ward sisters involved in the management of complaints with support from the Matron • Complaints and patient experience included in Maternity mandatory training for all staff	• Discussions took place at PNLF. • NHS Elect training completed.	Matrons, PPI team
1d	C1 C4	Continue to develop the patient experience steering group to include further work around PPI. Undertake a benchmarking exercise as to what groups are the Trust involved in and what are we doing in house, (i.e. older peoples forum on York site)	Dec 2014	• The dementia delivery group is reviewing what PPI activity is undertaken across sites and is developing a plan to further build on the work to date. • Healthwatch presented at the Patient Experience PNLF, which was well attended by ward sisters and clinical nurse specialists. The ward sisters worked in groups, reviewing complaints and best practice. Pledges were made to improve the patient experience and will be reviewed in 6 months. • MSLC group. Communication sub group attended by Maternity Matron looking at FFT processes and staff experience. • Home birth support group has been set up to involve users also	• Integral to PPI strategy • Dementia delivery group developed an action plan	Chief Nurse Team / PPI team
1e	C5 C6	Explore and agree the priorities of the new Matron group in the delivery of the PPI	Sept 2014	Development programme planned for April 2014, started working with Organisational Development Integrated Learning (ODIL) team re: ongoing programme	• Development plan in place • Coaching taking place. • Completed	Matrons/ Chief Nurse Team/ Lead for Patient

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
		agenda				Experience
1f	C2 C4	Review of Trust visiting policy in order to meet the needs of patients and relatives.	Revised Sept 2014	New Matron group to review and revise policy in conjunction with the protected meal time policy and present recommendations to Matrons meeting / Nursing Board	• Nursing Board dates timetabled. • Review visitors code integrated across all directorates/services.	Matrons
1g	C6	Introduce Friends and Family Test for OPD, Community services and community inpatient areas.	Oct 2014	FFT commenced in community hospitals ahead of roll out, data report will be produced June 2014	• Up and running in community services inpatient units. Work progressing to roll out in community nursing teams (patients seen at home)	Patient Experience Team
1h	C1 C2 C4	Improve Patient involvement in the Safeguarding Adults Process Early identification (at start of hospital journey) of vulnerable adults and embed prevention of and protection from abuse in care planning	Revised Dec 2014	• Generic patient information Leaflet development – awaiting approval and publication • Family/patient specifically involved in Safeguarding Adults Process leaflet – awaiting approval and publication • PPI to be included in membership of Safeguarding Adults Governance Group • Vulnerable adult recognition on ED admission proforma (Scarborough Acute)	• Cost scoping exercise delayed publication – revised target date Dec 2014 • PPI to be included in membership of Safeguarding Adults Governance Group completed. • Vulnerable adult recognition on ED admission proforma completed at both York and Scarborough. Revised action – Audit after 3 months for value.	Lead Nurse for Safeguarding Adults
1i	C1 C2 C3	Develop guidance for Mental Health Support in acute setting to support patients who have develop Mental ill-health in acute settings	April 2015	Phase 1 1) Task and Finish Group 2) Policy Development 3) Staff Training (MH First Aid) 4) Service Level agreement with MH Provider Phase 2 1) Business case for MH support Team 2) Recruitment	Phase 1 update: 1) Established 2) On-going 3) Partial completion 4) On-going	Lead Nurse for Safeguarding Adults
1j		Maternity Friends and	Ongoing	• Quarterly action plans developed in	• Quarter one report going to	Head of

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
		Family Test Feedback		Maternity from qualitative FFT feedback with user representatives input	Maternity Services Liaison Committee 02.10.2014. • Confirmed user input into the action plan • Confirmed involvement from the Clinical Commissioning Group (CCG)	Midwifery

Priority 2	Delivering High Quality Safe Patient Care

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
2a	C5 C6	Strengthen nursing leadership by empowering ward sisters and charge nurses to ensure all care is of a high standard and meets values of the organisation	Ongoing	• Reviewed the It's My Ward Programme with skills days on-going. • Ward Sisters meeting commenced, Director of Nursing Q&A session at each. • Increased attendance and input at PNLF • Consultation with Ward Sister planned re: reporting structures. • Plan to work with ODIL to review and evaluate the IMW programme.	• Work is progressing to develop a leadership programme based on 'It's my Ward' programme to support the development of the band 6 nurses. First cohort planned for January 2015. • Plans to further develop the philosophy behind 'It's my ward' programme to develop 'It's my well run ward'.	ODIL Chief Nurse Team
2b	C1 C6	Ensure the right staff are in the right place at the right time.	Ongoing (planned April & Oct)	• Safer Staffing Project commenced • Meeting with Keith Hurst took place in April 2014, Matrons trained in the awareness of the AUKUH tool, presentation to Ward Sisters during May 2014. • Acuity Audit commenced for 2 weeks in June. • Staffing SOP reviewed and daily staffing meetings in place. • Publishing of daily staffing at ward level commenced • Submission of staffing data via UNIFY commencing June 2014 •	• Acuity and dependency audit repeated in September 2014. Waiting results. • Safer staffing declared data discussed at the September Board. Agreed to explore a more meaningful way of presenting the staffing information that will provide the NEDs with the assurance that they need regarding staffing. • Need accurate up to date information re: use of temporary workforce and ratio. • Additional paper completed reviewing issues around Scarborough - vacancies by area,	Chief Nurse Team

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
					including Bank / Agency activity and the recruitment. • Looking at worst case scenario for winter and contingency plan (keeping 1:8 ratio)	
2c	C1 C2 C6	Work with patient safety and compliance teams to ensure delivery of patient safety strategy.	April 2014 and ongoing	• Pressure Ulcer Reduction Plan updated and action plan for 2014/15 developed – update to Board June 2014. • Business case developed to identify nursing resource required to support Electronic Prescribing. • Supervisors of midwives will be undertaking work around medication errors and missed meds	• Pressure Ulcer Panel in place to assure learning. • Work to reduce missed medications continues. • EPMA (Electronic Prescribing and medicines administration) project gives us a great opportunity to iron all of the issues before full implementation. Jennie Booth Lead Nurse Medicines Management is setting up a forum of clinicians to take forward. • September 2014 - introduction of Falls Panel. This is based on the philosophy of the pressure ulcer Panel. To assure the Trust of actions taken, change in practice and dissemination of learning. • Reduction in falls resulting in serious harm. October 2014 launched new inpatient falls policy. • New resources and training package launched for inpatients falls reduction.	Patient Safety Team & Chief Nurse Team
2d	C5 C6	Continue to review nursing documentation in order to reduce paperwork and to have consistent records across the organisation	ongoing	3 work streams full established that focus upon: 1. Pathways - This work is significant as there are over 26 pathways. The first plan is to look at the generic aspect of all pathways and then wok with IT to	3 work streams update A significant amount of paperwork has been reduced with assessments electronic 1. Work is on-going and progressing	Chief Nurse Team

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
				determine how this moves from paper to electronic. 2. Single record of care - The draft is complete and is out with ward sisters for consultation. The Comfee tool has been changed within this and has been well received. The final draft will be complete within the next month. 3. Discharge- Electronic discharge nursing document has been written in draft and is planned for approval in June. This will then require a pilot and implementation plan.	as planned. Next stage is link to IT systems. 2. New Comfee tool revised and launched. Now being used. Admission packs of core care plans (pain, hygiene, mobility, communication etc.) ready to be piloted October 2014. Combined nursing assessment on acute wards now electronic. 3. Draft in place. Due to be piloted December 2014 – care of the elderly wards.	
2e	C1 C3	Lead the work on falls reduction across the organisation, review the documentation and assessment process in order to streamline and ensure a consistent approach across the organisation	Sept 2014	• Falls Steering Group set up, membership agreed. • Terms of reference approved. • Delivery groups at both main sites and community. • Strategy to be developed. • Revised risk assessment and implementation plan in draft. To be shared with ward sisters via the documentation steering group in June 2014.	• New Inpatient Falls policy ready to be launch. Postponed as electronic tool not finalised for implementation. To be launched during Blue Thursday. • New resources in place to support staff (patient information leaflet, patient poster, falls sticker, staff poster) • New Falls training package for inpatient staff ready for roll out. • September 2014 – first Falls Panel held (review of RCA to assure learning disseminated).	Chief Nurse Team
2f	C1 C2	Introduce Advanced Clinical Practitioner's to facilitate early decision making and timely access to treatment.	May 2014 And ongoing	• Second cohort of trainees recruited to development of the ACP role continues in collaboration with clinical and educational teams	• Work continues. • No new update.	CLAD, Chief Nurse Team
2g	C1	Infection Prevention (IP) Improve and sustain competency in IP	Permanent Objective	• Weekly feedback of IP performance data to Quality and Safety Group and Directorate Leads. • Quarterly performance data presented to Board of Directors via DIPC report Trust	• CDI and MRSA bacteraemia incidence remain under trajectory (cases of CDI continue to occur). • IV specialist role appointed to the IPT.	IPT, Chief Nurse Team

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
		clinical practice and invasive device management that ensures the prevention of avoidable harm from Healthcare Associated Infection (HCAI) through: Implementation and audit of the IP Annual Plan, policies and guidelines that reflect regulatory and legislative requirements and IP risks/priorities. Effective use of IP performance data and the Trust performance framework to ensure accountability and responsibility for the prevention and control of HCAI and patient safety from Ward to Board. E-Learning packages that facilitate education and understanding Develop a Directorate Assurance Framework New Matron team to devise an approach to prioritise this agenda		Performance Framework and meetings (PIM`s) • Directorate Risk Registers • IP and Internal Audit reports • PIR/RCA reports • E-Learning packages implemented via CLAD learning Hub	• Proactive programme of high level HPV disinfection delivered to high risk areas during Aug/Sept. No new update. Work streams progressing.	Matrons

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
		and raise awareness in their clinical areas				
2h	C3 C4 C6	Formalise Trust wide approach to shared learning from Safeguarding Adults Investigations where actions are identified.	Sept 2014	• Full Matron/ward sister involvement in Safeguarding Adults Investigation	• Completed – matron consultation and involvement in Safeguarding Adults Investigations. • Evidence can be provided as part of anonymised case studies.	Matrons/Lead Nurse for Safeguarding Adults
2i		Third and forth degree tear rate	Dec 14	• Multidisciplinary working group to audit, review practise and recommend actions to reduce rates	• Work progressing on schedule • This is not unique to York trust. There is new National work underway. York Trust will take an active role in this piece of work. Current performance status is Amber against target.	Head of Midwifery

Priority 3	Measuring the impact of care

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
3a	C5 C6	Introduce Early Warning Trigger Tool to highlight potential problem areas and to ensure nurses and midwives have meaningful data to influence the delivery of care.	Sept 2014	• Testing phase on-going, pilot commenced • Early warning trigger tool being trialled on Hawthorn ward	• The Trust has been using the National Early Warning Score and deteriorating patient escalation policy for 12 months. The policy is currently under review by the deteriorating patient group. • Over the past year we have seen an overall improvement in hospital mortality and a reduction in cardiac arrests.	Chief Nurse Team
3b	C3 C5	Introduce Nursing Dashboard to give an overview of key quality indicators for all areas	May 2014 and ongoing	• Draft Dashboard developed, project team identified to work in conjunction with the EWTT • This has been developed as a stand alone dashboard and is complete other than the background ward specific information. • Maternity dashboard established and	• Dashboard presented at the June Professional Nurse Leadership Forum (PNLF). More work re: data collection needed • The Dashboard is working progress. • Further support is required from IT (relating to populating and	Chief Nurse Team

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
				reviewed at Directorate Clinical Governance meetings	drawing of data)	
3c	C1 C3	Explore feasibility of IT solutions to documentation	Ongoing	• Assessment documents now electronic • A business case has been written to support a band 7 project role for a senior nurse to support the development, training and education at ward level and to provide the clinical expertise (workforce).	• Further work is being undertaken to move more nursing documentation using the IT system.	Chief Nurse Team /IT
3d	C1 C6	Develop a Nursing Policy and procedures' Group in order to ensure all polices are up to date and reflect current best practice	June 2014 and ongoing	• Initial meeting to plan TOR, wider meeting to involve all key stake holders planned for April 2014. • Maternity guidelines groups established cross site	• Work is progressing, no new update.	Chief Nurse Team
3e	C3 C6	Evaluate the Productive Ward programme and agree next steps	April 2014	• Evaluation of impact of targeted work at Scarborough site very positive for most areas. • Meeting planned to consider future approach – evaluation undertaken – project suspended due to project support needed for safer staffing initiative.	• No change in position. • Work is progressing to ensure 'It's My Ward' programme with an additional module called 'It's my well run ward'. • An accelerated leadership programme is being developed for band 6 nurses. This is an exciting development for aspiring nurse leaders to develop and enhance their leadership skills.	Chief Nurse Team
3f	C2 C3 C4	Work with the compliance unit to review delivery of actions from visits to clinical areas in order to provide assurance to the Nursing Board re: quality of care	Dec 2014	• A review of all audits undertaken at ward and department level will start in June. This will link to the CQC 5 questions. The plan is to streamline and reduce repetition and develop achievable actions plans. The group will process map in June and develop recommendations and subsequent implementation plan. • Patient safety walk a rounds planned, undertaken on G1	• Process mapping completed and all clinical audits reviewed. An up dated plan to be developed. • Audit schedule linked into the CQC 5 questions.	Chief Nurse Team / Compliance Unit
3g	Ci C2	Open and Honest	Revised Dec 2014	• Introduce this initiative to publish patient safety and experience data.	• Work progressing and on schedule	Chief Nurse Team

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
	C4 C6			• Task and finish group set up. Pilot begun on both acute sites		
3h	C3 C4 C6	Safeguarding Adults Team to report quarterly Safeguarding Adults Activity to Matrons and ward Sisters at relevant meetings.	Sept 2014	• Quarterly reporting of activity to Safeguarding Adults Governance Group • Board reporting	• Quarter report to be circulated to matrons following approval at Safeguarding Adults Governance Group (standing agenda item)	Lead Nurse for Safeguarding Adults

Priority 4	Staff experience

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
4a	C2 C4	Utilise staff survey feedback to understand key themes and identify priorities.	April 2014 and ongoing	• Family and Friends staff questionnaire was undertaken in June. The results will be shared with matrons. • Staff 'listening exercises' considered in Maternity following staff survey results. Multidisciplinary group arranged to develop action plan. • Maternity newsletter developed for staff to help improve communication	• From September all nurses will be able to speak to the Chief Nurse on a one to one basis at a series of new monthly surgeries planned to take place across the Trust. • A Culture Barometer has been developed and to be piloted in October. Plan role out December 2014.	Chief Nurse Team with HR Workforce team
4b	C4 C6	Ensure all Nurses and Midwives receive a valid appraisal which includes an agreed development plan	Ongoing	• Ongoing work in all Directorates' to achieve annual appraisal. • Chief Nurse Team meeting with external partners to explore electronic solutions to include revalidation – meeting taken place. • Attendance at NMC Re-validation event June 2014. • HR is working on an IT solution for appraisal and is currently in the early stages, with a steering group set up. The IT Company is showcasing the example in June.	• Ongoing monitoring of appraisal rates by matrons	Matrons, Ward Sisters
4c	C3	Explore and consider the training	Ongoing April 2015	• Review of Statutory & Mandatory training	• Completed.	Chief Nurse Team/

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
		requirements of nurses and midwives and identify alternative methods of delivery.		requirements for Nursing & Midwifery staff commenced, task and finish group set up to conduct this work and report to nursing Board • Mandatory maternity specific training reviewed annually in line with current guidance		ODIL
4d	C4 C6	Develop the knowing how we are doing boards to reflect what patients and relatives and staff want to see and include positive patient feedback and also work that we have done to reflect patient feedback and measure the effectiveness of this change	September 2014	• Sisters and Matrons discussion and suggestions have begun. Recommendations made May 2014. • The ward sisters have met with one ADN and their opinions have been acknowledged. It has been agreed that the laminate will be removed form the boards, which will leave them blank. The boards will then be converted in July to include daily safer staffing and patient experiences, using family and friends and patient feedback. "Use said, we did". • Positive patient feedback given on monthly mandatory maternity training, at staff meetings with Matron and sent out to staff via e-mail.	• Changes made to knowing how we are doing boards to fit client group	Chief Nurse Team with HR Workforce team
4e	C5 C6	Consider centrally supported recruitment process to reduce duplication, ensure recruitment in a timely fashion.	April 2014 and ongoing	• Work continues with an aim to reduce vacancies • One stop shop recruitment is working well, as did the city tour to Glasgow with a number of registered nurses recruited. The recruitment process is working well, with changes to the VC process and DBS. • Cross site recruitment for midwives at Band 5 commenced in Maternity	• Fast Track recruitment process for Band 5 and Health Care Assistants (HCA's) • One stop shop recruitment model continues to be used.	Chief Nurse Team with HR Workforce team
4f	C4 C6	Continue to work with HR to utilise e-rostering to make the most efficient use of resources.	Sept 2014	• principles of e-roster commenced on paper roster at Scarborough site • Maternity in preparation for e-roster implementation	• Community inpatients have implemented a process for Admin team to input the rota with support from e-rostering manager and HR.	Chief Nurse Team with HR Workforce team

NO	6C's	Action	Target	Evidence	October 2014 update	Lead
		Introduce e-rostering at Scarborough site				
4g	C4 C6	Conduct an evaluation of the local induction arrangements for Nurses and Midwives	Dec 2014	• New Matrons group to work with Ward Sisters to introduce a robust system across the organisation that represents local priorities.	• Induction packages reviewed and in place for band 5&6 midwives. Band 7 development package commenced.	Matrons
4h	C1 C4 C6	Development of Supervision model and implementation	Revised Dec 2014	-	• A task and Finish group set up to develop a Supervision of patients Guidance following incidents across sites.	Lead Nurse for Safeguarding Adults/Director of Nursing

Assurance Processes

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

Beverley Geary
Chief Nurse

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

Acuity Audit

Action requested/recommendation

The Board is asked to discuss the information and approve the plan included in the report.

Summary

Hard Truths – The journey of putting patients first was published by the Department of Health in January 2014. It made five recommendations which aligned to the 10 recommendations already made by the National Quality Board (NQB). One of those recommendations was the expectation that Board of Directors would receive a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in NQB report and reflects a realistic expectation of the impact of staffing on a range of factors.

This report is the first of those reports to be received.

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 has been prepared for the Quality and Safety Committee
Risk	The paper does describe the concerns around the validity of the data and the challenges that it is thought exist in the system. At this stage they are concerns rather than actual risks.
Resource implications	The collection of this information my involve the need for additional resources
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	October 2014
Version number	Version 2

Board of Directors – 29 October 2014

Acuity Audit

1. Introduction and background

Hard Truths – The journey of putting patients first was published by the Department of Health in January 2014. It made five recommendations which aligned to the 10 recommendations already made by the National Quality Board (NQB). One of those recommendations was the expectation that Board of Directors would receive a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in NQB report and reflects a realistic expectation of the impact of staffing on a range of factors.

A paper was submitted to the Board of Directors in May that outlined the timetable for the acuity audits as follows - *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.*

As the Board are aware significant work has been previously undertaken on acuity and dependency, this was undertaken manually by a small team; the detail of this work was considered by the Workforce Strategy Committee and presented to the Board of Directors, staffing levels for most areas have been set on the results of this work.

2. Audits

In preparation for undertaking the Audits the Trust has provided extensive training to Matrons, Sisters and ward staff.

The initial training, to all Matrons and the Chief Nurse team was provided by Keith Hurst who developed the Safer Nursing Care Tool. This training was rolled out to all ward sisters and locality managers.

Since May the Trust has undertaken two acuity audits. The first was arranged for the first two weeks in June. The outcome of that audit provided some results that could not be validated and so the audit was repeated during the first two weeks of August. The second audit results have been reviewed and as with the initial audit the data is ambiguous. (See attachment 1).

2.1 Audit methodology

The audit was based upon the *Safer Nursing Care Tool* which was developed by Keith Hurst and is used in a wide range of acute hospitals to determine staffing levels based upon the acuity and dependency of patients.

As the Board is aware there is no one formula to calculate staffing requirements, however the Keith Hurst tool is one that is recommended for Acute Trusts and he includes a caveat to

his tool that the data should come from a number of sources and he impresses the importance that professional judgement must be used with any completion of the tool.

Keith Hurst (2012). <u>Safer Nursing Care Tool Staffing Multipliers: Method and Results</u>

The national definitions are:

Level 0: Needs met by providing **normal ward care**

Level 1A: Acutely ill patients **requiring intervention** or those who are **unstable** with a greater **potential to deteriorate**

Level 1B: Patients are **stable** but are **dependant on nurses** to assist the patient in **most or all daily living activities**

Level 2: Requires **expert intervention** and/or **specialist care/environment**

Level 3(A): Patients needing **advanced respiratory support** and/**or therapeutic support of multiple organs**.

Following the initial audit and the results that patients who were receiving 1:1 supervision (falls risk etc.) were being defined as level 3 an additional level was included for the subsequent audit:

Level 3B: Patients receiving **direct and constant supervision** on an **individual one to one basis**.

2.2 Plan

In order to assure the Board that staffing levels are appropriate the following steps will be taken:

The results on dependency levels from both audits would suggest that the Chief Nurse Team and Matrons has some work to complete on supporting staff in understanding the definitions, particularly around the use of the 3B definition. This work will be supported by the Patient Safety Team.

As a consequence, over the next 4 weeks, the matrons will be undertaking a ‘professional judgement’ assessment of staffing requirements. This compares current staffing models with those deemed necessary for each particular ward.

At Nursing Board there will be a discussion about the introduction of a small team of senior nurses to undertake the next audit in February and in preparation for this further training will be provided to ensure that they fully understand the data collection process.

Work is already being undertaken within the HR team to begin to use the Establishment Control Module capacity within ESR, this will provide the Board with real time monitoring of establishments’.

The facility to capture acuity and dependency is being explored and if feasible will be developed and incorporated into Safety Thermometer, which captures patient safety information once a month for every inpatient. This will provide a ‘snap shot’ every month and therefore 12 data points per year.

Together with the real time (ESR) data which will give real clarity of the actual staffing numbers in post, an analysis of the 12 data points will provide evidence of what the planned staffing models should be.

Other work that needs to be completed to ensure the audits remain accurate and appropriate includes reviewing the work previously undertaken to confirm the rationale around the methodology and validate that work so that it can be used as a base line. This work has started with Sian Longhorne from HR. A further acuity audit will be undertaken with the support of the patient safety team in November. AN extra meeting of the Quality and Safety Committee will be held in December to review the results of the audit. A further audit will be undertaken in January to embed and confirm the new approach is successful. Ensuring any adjustments have been made.

3. Conclusion

This is the first audit of acuity and dependency that has been undertaken by the nursing workforce.

Staffing requirements should not be adjusted solely on one assessment. There should be a minimum of 6 full data points to demonstrate the validity of the findings before any permanent changes should be made.

The recommendation from Hard Truths is that the audit is undertaken twice yearly but we aspire to undertake monthly audits when the data collection processes are robust.

Challenges remain to ensure the information included in the audit is accurate and meaningful. Those challenges are around the electronic tool and the collection of data in the Trust.

There are also other pieces of work that have been previously completed in the organisation that need to be brought together to ensure full benefit is being taken of historic work and agreed staffing levels are appropriate. The priority for confirming staffing levels are nights and community.

4. Recommendation

The Board of Directors is asked to note the information included in the report.

5. References and further reading

DH (2014). Hard Truths – the journey to putting patients first
Keith Hurst (2012). Safer Nursing Care Tool Staffing Multipliers: Method and Results

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

Attachment 1

Acuity & Dependency Levels (August Audit 2014)

Ward	Level 0	Level 1A	Level 1B	Level 2	Level 3A	Level 3B
G1	321	4	195	0	0	0
ICU/HDU	0	0	0	249	107	3
ESA	188	6	0	0	0	0
Ward 11	154	4	167	0	0	0
Ward 14	396	193	98	1	0	0
Ward 15	316	33	323	0	0	3
Ward 16	234	68	50	8	0	0
Ward 17	189	14	6	0	0	6
SSW	154	160	226	0	0	20
AMU	54	345	152	25	0	3
Ward 23	41	23	316	0	0	5
Ward 25	74	77	137	6	0	0
Ward 26	140	17	241	2	0	2
Ward 28	105	13	217	0	0	2
Ward 29	134	0	50	0	0	0
CCU	18	40	12	97	0	0
Ward 31	37	56	37	97	0	0
Ward 32	199	63	112	0	0	4
Ward 33	91	7	117	0	0	7
Ward 34	80	14	250	44	0	27
Ward 35	137	5	194	0	0	8
Ward 36/ASU	97	20	91	10	0	0
Ward 37	44	0	210	0	0	30
Ward 39	79	0	163	0	0	10
AMU	322	104	108	11	0	0
Ann Wright	67	1	150	1	0	9
Ash Ward	235	12	26	0	0	1
Aspen	2	29	0	0	0	0
Beech	184	32	72	12	0	7
CCU	126	9	48	361	0	0
Chestnut	123	23	128	1	0	11
Duke of Kent	130	47	34	1	0	7
Graham	78	3	4	0	0	0
Haldane	192	3	80	0	0	0
Holly	36	33	206	0	0	0
ICU	0	1	0	32	33	0
Oak	102	30	323	0	0	1
Stroke	18	25	79	0	0	0
Willow	98	11	0	0	0	0
Archways	36	9	111	0	0	0
St Helen’s	25	16	203	12	0	0
WXC	101	0	138	0	0	0
Selby	105	0	157	0	0	0
Fitzwilliam	264	1	71	0	0	0
St Monica’s	66	1	29	0	0	0
Johnson	255	0	92	0	0	0
Kent	29	6	16	0	0	0
Lloyd	83	4	0	0	0	0

Waters	201	0	108	0	0	0
Abbey	91	1	101	0	0	5
War Memorial	103	0	100	0	0	0

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

Patient Experience Report

Action requested/recommendation

To support the recommendations in this paper

Summary

This report provides a detailed update from the Patient Experience Team

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 direct references to CQC outcomes, although most indicators in this report are monitored as part of CQC regulation compliance.

Progress of report	Quality & Safety Committee and Board of Directors
Risk	No additional risks indicated

Resource implications	None identified
Owner	Beverley Geary, Director of Nursing
Author	Kay Gamble, Lead for Patient Experience
Date of paper	7th October 2014
Version number	Version 1

Board of Directors – 29 October 2014

Patient Experience Report – Quarter 2 2014/15

1. Introduction and background

The purpose of this report is to provide an update to the Board of Directors on patients' experience of York Teaching Hospital NHS Foundation Trust

The Patient Experience Quarterly Report presents a broad overview and provides information on all aspects of patients' experience of our services.

The report provides information from different sources, including:
- Complaints
- PALS activity
- NHS Choices Feedback
- Friends and Family Test
- National Patient Surveys

2. Overview

The table below details the number of complaints received in, split by our two main hospital sites.

top positive and negative themes show similar results to previous quarters. The report details those themes below.

	York	Scarborough	total
New complaints Q2 (July to Sept 2014)	94	56	150
Q2 Last year (July to Sept 2013	75	81	156

The Trust responds to the majority of complaints within 30 days, this meets the NHS Complaints regulations. 19 responses due in Quarter 2 were not responded to within the agreed time frame.

Medicine & Acute Medicine, Emergency Medicine and Obstetrics and Gynaecology are the areas that received the highest number of complaints in Quarter 2.

3. Top themes raised through complaints in Quarter 2

The top positive and negative themes show similar results to past quarters and these are detailed below. A new information system system is currently being explored which will, in future, provide the Board with a greater understanding and breakdown of these themes.

All aspects of clinical care and treatment
Attitude of Staff
Communication and Information

Complaints by Directorate in Quarter 2	
Directorate	
Child Health	2
Clinical Support Services	1
Elderly Medicine	9
Emergency Medicine	26
Facilities	1
Medicine (General & Acute)	27
Specialist Medicine	8
General Surgery & Urology	16
Head and Neck & Ophthalmology	16
Obstetrics & Gynaecology	19
Orthopaedics and Trauma	8
Anaesthetics, Theatres & Critical care	4
Community Services (District Nursing)	4
Sexual Health	2
Radiology	3
Corporate	1
Pharmacy	1
Physiotherapy	4

Where poor experience is reported, actions are then taken to ensure improvements are made.

4. Examples of learning and action plans

S14/15-100: Concerned the lack of a plan for management of children presenting with bloody diarrhoea. The Consultant in the Emergency Department is developing a Paediatric handbook which will contain various guidance and instruction about managing this.

S14/15-095: There was no information available to Emergency Department staff about how to contact interpreters. This is being put in place and staff are being advised how to book interpreters when required.

5. Complaints referred to the Health Service Ombudsman (HSO)

There were 3 new Ombudsman's cases in Quarter 2:

HSO Y14/15-03 Acute and General Medicine, W32. Patient's family are unhappy with discharge arrangements. Patient was assessed as ready for discharge and had capacity. There were also concerns about Cardiology Care.
HSO Y14/15-04 Obstetrics & Gynaecology. Complainant has concerns following childbirth in very difficult circumstances. Social Services involved.
HSO Y14/15-05 Head & Neck. Patient is concerned about the non-provision of warfarin following day case surgery. Investigation shows arrangements vary according to commissioners. In this case it should have been the GP.

The HSO delivered its decision on 1 complaint, which was not upheld:

HSO Y14/15-02 Clinical Support Services. Complainant was unhappy with the mortuary procedure for releasing bodies at Scarborough. Although the complaint was not upheld by the Ombudsman, the Standard Operating Procedure was updated as a consequence of this complaint.

6. Positive feedback

Positive feedback is collected every quarter. A total of 1955 letters, cards and emails were recorded by the Patient Experience Team in the most recently reported quarter. The Friends and Family Test provides additional feedback each month, with the majority of the 1500 monthly comments, being positive.

Themes from compliments mirror those issues raised in complaints, i.e. clinical care and treatment, communication and staff attitude. These are the issues that are important to patients. Positive feedback is used in customer care training.

7. Patient Advice & Liaison Service (PALS)

The Trust handled 1589 PALS contacts in Quarter 2. Of these 325 were handled on the Scarborough site and 1264 were handled on the York site. PALS themes in this period include:

- Concerns relating to the changes to the pain clinic service at Scarborough. The incorrect telephone number for contacting the CCG was amended. Callers to PALS were referred to the CCG or their GP as per advice from the Directorate. The Directorate resolved other enquiries by directly contacting patients.

- Concerns that telephone calls to the audiology clinic at Scarborough were unanswered. PALS raised this with the DDM who has addressed the problem by improving cover.

A relative was concerned that the seating in the ICU relative's room was in a poor state. This was raised with the Unit and purchase of new seating was quickly approved. The Lead Sister for the Unit wants relatives to find the waiting rooms a place of rest and privacy.

8. Patient & Public Involvement (PPI)

The Friends and Family Test

The Friends and Family Test (FFT) is asked of patients in all acute and community inpatient wards, those attending the Emergency Department (ED), women accessing antenatal, labour and postnatal community services. The Trust continues to roll out to Outpatients on all sites and community services in-line with national guidelines and CQUIN requirements.

The Trust receives between 1500 to 1750 comments per month from the FFT which are shared across the Trust with wards and departments. The FFT cards are collected on a weekly basis by the Patient Experience Team and whilst the majority of comments are positive, where comments are negative and require immediate action, these are scanned back to the ward or department immediately prior to being sent off to our provider Picker for data inputting. The FFT is a valuable source of feedback, which when used in conjunction with other feedback from PALS, Complaints, national surveys and staff feedback can provide the Trust with an overall understanding of what patients, accessing our services, feel about their experience and also highlight areas where we need to improve. An area of focus for the Patient Experience Team is to work with Picker (our FFT provider) and the Area Team of NHSE to develop tools to be able to theme the FFT feedback and link it with other sources of feedback to provide a comprehensive view. This will be one of the

priorities, moving forward.

The FFT Steering Group continues to oversee the roll-out, monitor performance and future development of FFT. The development of the '*knowing how we are doing board*s' across the Trust is currently underway which will see feedback from FFT and other sources on their wards being displayed for staff, patients and relatives to see what patients are saying about their experience. The *Knowing how we are doing'* boards will also provide information on a quarterly basis about what improvements have been made as a result of feedback – '*You Said We Did'.*

The E&D facilitator provides advice to the FFT Steering Group to ensure the Trust makes the FFT as accessible as possible to patients. We have now ensured that those whose first language is not English can access cards with different languages through the on-line survey. The on-line survey additionally enables users to increase the size of the text for those who prefer a larger font.

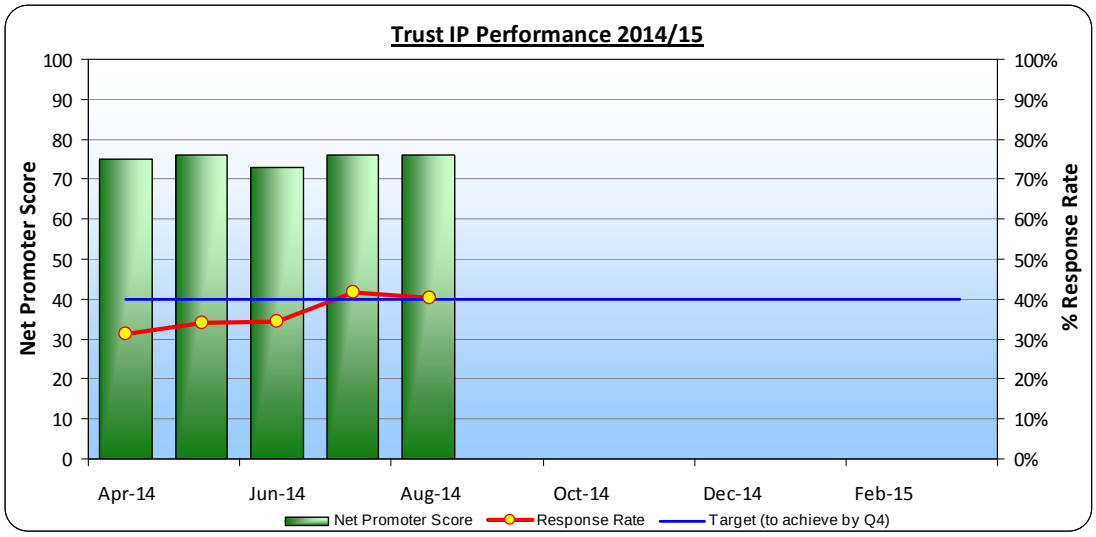
The Friends and Family Test – roll-out
Project work-streams for community services and outpatients meet regularly to implement FFT in across the whole trust. During September, the FFT was rolled out and is now being delivered across:

Community Services (partial roll-out):
District Nursing
Fast Response Team
Intermediate Care Team
Health Visiting
Specialist Nursing

Outpatients (partial roll-out):
York Main Outpatients
Specialist Medicine including Rheumatology, Dermatology, Haematology, Chemotherapy
Radiology including VIU, Breast Screening, MIR, X-ray,
Selby/Bridlington Outpatients
Scarborough Outpatients
Head & Neck – all sites
Ophthalmology – all sites
Malton MIU

Inpatients – Bridlington, Scarborough and York Hospitals
The chart below shows the consistent net promoter score of 76 and a response rate of 40% for acute inpatient wards for July and August. All inpatients are asked to provide feedback via an A5 card or on-line survey via a QR code on the card. From April 2015 the net promoter score is being replaced with a different scoring system. This has yet to be determined by NHS England.

At the time of writing the report September performance was not available. The response rate has increased from Q1 to the CQUIN Q4 target of 40%. The Trust must now maintain or increase this response rate for 2014/2015.



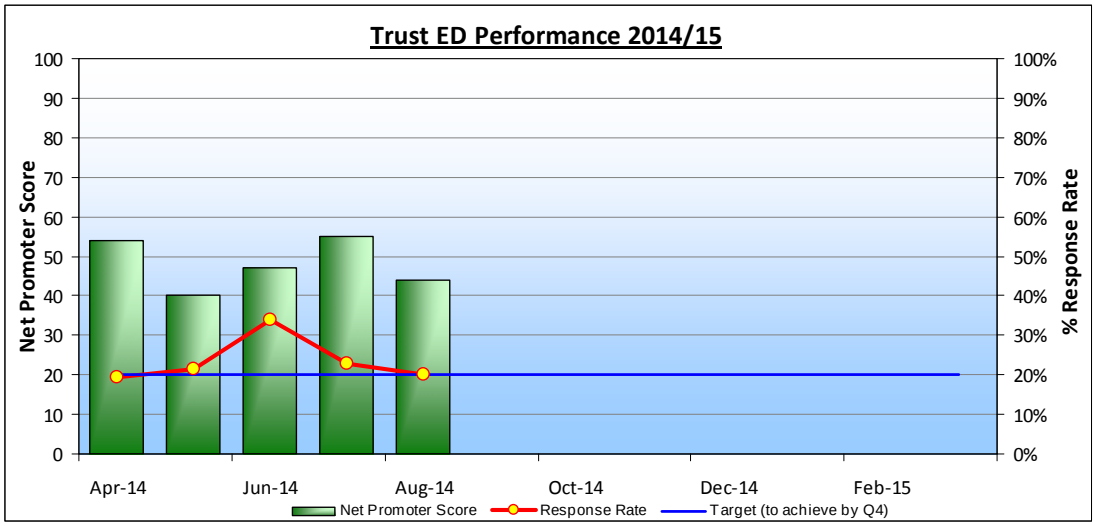
Emergency Department – Scarborough and York Hospitals

The chart and table below show inconsistency within the Emergency Departments. York Hospital ED are not achieving the required response rate to meet the national CQUIN whilst Scarborough ED continue to achieve higher than the required response rate and are supplementing the ED score overall.

Patients who attend, but who are not admitted to the ED are given a token and a comment card to use at the end of their visit. From 1st April 2015 new NHS England guidance has asked that all token systems are removed from trusts. The FFT Steering group discussed new guidance at its meeting in September and considered that using text messaging as an alternative way of asking the FFT question should be further explored and implemented.

From October 2014, York ED will move to a text messaging option where patients are sent a text to their mobile. Approval has been given by Information Governance, with the ED department being fully supportive of this approach. Scarborough ED will remain using the token and card system until the Trust is confident in this new approach. Scarborough ED will move over to text messaging in the near future ahead of the 1st April 2015 deadline.

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Trust	Eligible patients	6467	6970	6863	7244	7017	
	Responses	1260	1502	2329	1650	1402	
	Response Rate	**19.48%**	**21.55%**	**33.94%**	**22.78%**	**19.98%**	
	Net Promoter Score	54	40	47	55	44	
York	Eligible patients	4079	4356	4283	4451	4305	
	Responses	429	636	1162	647	404	
	Response Rate	**10.52%**	**14.60%**	**27.13%**	**14.54%**	**9.38%**	
	Net Promoter Score	37	11	31	49	67	
Sboro	Eligible patients	2388	2614	2580	2793	2712	



Community Hospitals

All community hospital inpatients from May 2014 are now asked to complete the FFT feedback card. The table below details the response rate. Ryedale ward was closed from June 2014.

Hospital	Ward		May-14	Jun-14	Jul-14	Aug-14	FFT Score
Archway's Community Intermediate Care	Archways	Response rate	80.0%	15.0%	3.7%	45.0%	56
		Eligible	20	20	27	20	
		Responses	16	3	1	9	
Malton, Norton & District Hospital	Ryedale (ward closed)	Response rate	33.3%	0.0%	0.0%	0.0%	n/a
		Eligible	6	0	0	0	
		Responses	2	0	0	0	
Malton, Norton & District Hospital	Fitzwilliam	Response rate	50.0%	48.3%	65.5%	20.0%	80
		Eligible	16	29	29	25	
		Responses	8	14	19	5	
New Selby War Memorial Hospital	Selby Inpatient Ward	Response rate	23.5%	25.0%	41.7%	46.7%	50
		Eligible	17	16	24	15	
		Responses	4	4	10	7	
St Helen's Rehabilitation Hospital	St Helen's	Response rate	40.0%	50.0%	54.5%	55.6%	60
		Eligible	10	10	11	9	
		Responses	4	5	6	5	
St Monica's Easingwold	St Monica's	Response rate	44.4%	50.0%	55.6%	20.0%	100
		Eligible	9	6	9	10	
		Responses	4	3	5	2	
Whitby Hospital	Abbey	Response rate	30.8%	31.3%	41.2%	41.7%	60
		Eligible	13	16	17	12	
		Responses	4	5	7	5	
Whitby Hospital	War Memorial	Response rate	45.0%	64.7%	76.5%	45.5%	80
		Eligible	20	17	17	11	
		Responses	9	11	13	5	

White Cross Court Rehabilitation Hospital	White Cross Court	Response rate	9.1%	85.7%	20.0%	36.4%	50
		Eligible	22	14	5	11	
		Responses	2	12	1	4	
Trust		Response rate	39.8%	44.5%	44.6%	37.2%	73
		Eligible	133	128	139	113	
		Responses	53	57	62	42	

National Patient Surveys

Cancer Patient Survey 2014

The Department of Health commissioned survey was released for publication during September 2014. A separate report, providing a detailed summary, is going to The Board of Directors in October 2014 separately but a brief summary is given below:

Overall responses to the 62 questions asked, shows that:
36 questions placed the Trust in the top 20% of Trusts
0 questions placed the Trust in the bottom 20% of Trusts
26 questions placed the Trust in the remaining 60% of Trusts

93% of patients rated their care as either excellent or very good an increase of 2% compared to 2012/13.

The findings from the survey are extremely pleasing for the Trust and recognise the improvements that have been made from past survey findings. Many of the tumour groups had percentages above the national percentage such as Colorectal with 92% of responses above the national percentage, Urology with 85% and Haematology with 83% being in the top 3.

The results reflect the hard work and dedication of the Cancer Clinical Nurse Specialists, the Clinical Teams including the Diagnostic Services and the myriad of other staff involved in cancer patient care. However, we are not complacent and will work together on the areas that need improvement and expect to show those improvements in the 2015/2016 results.

Emergency Department Patient Experience survey 2013

This CQC survey will be released to trusts during October 2014 and key findings will be reported to the Board of Directors in November 2014.

Healthwatch

The Trust continues to build strong working relationships with the local Healthwatch organisations, particularly Healthwatch North Yorkshire and Healthwatch York, with Trust staff attending Healthwatch Health Assemblies and Healthwatch York's AGM. The focus of Healthwatch (York) AGM and their workplan for 2014/2015 was Discharge from Hospital both in terms of discharge from outpatient and also discharge from hospital as an inpatient. Dr Turnbull addressed the AGM with regard to being discharged as an outpatient.

Healthwatch (York) and the Trust have been working together to arrange their first Enter and View visit which will see Healthwatch spend a day speaking to patients in the discharge lounge about their discharge from the ward which continues from work-plan for the year. Findings from the Enter and View will be discussed at the Patient Experience Steering Group and the Q3 Patient Experience Quarterly Report.

Elderly Medicine – extended visiting trial

As reported in the last paper, The Elderly Directorate at York has been trialling extended visiting times from November 2013 with the aim of increasing partnership working between relatives and carers following a number of comments, concerns and complaints around relatives not being able to talk to staff during the old visiting times. The Older People's Liaison Group was involved in the initial decision to extend the hours. The extended visiting times during the trial are 2.30pm to 7.30pm. Visiting times across the trust are currently 2.00pm to 3.30pm and 6.30pm to 8pm. Scarborough hospital has open visiting hours. The PPI Specialist has agreed with the directorate to carry out an independent evaluation following the extended visiting times. The evaluation will consider what has worked well with extended visiting; what hasn't work well; what could be better; of what has worked wll – could more of this be done; of what has not worked well – are there actions that would improve this. All grades of staff would be included in the evaluation including ward. AHP, Discharge Liaison, cleaning and catering staff. Volunteers will also spend time on all the Elderly wards speaking to patients and relatives and friends of patients. A project brief has been agreed and a small group set up to take this forward. The findings were due at the end of Quarter 1 this has now been extended to end of October as more 1:1 interviews with patients and relatives is being carried out along with additional feedback from staff involved in the extended visiting trial. A report will be produced and will go to the Patient Experience Steering Group in November.

Patient Experience Review Recommendations:

Integrated IT System

One of the recommendations from The Patient Experience Review paper (June 2014) included integrating the Patient Experience Team. One of the major barriers has been not having access to the same IT functions and access to the same information on both the Scarborough and York site. This has resulted in the registering and management of complaints and PALS information being carried out on separate sites and on separate IT systems. The Governance team have been seeking solutions to providing an integrated IT system which would enable one system to be accessed trust wide and further provide information from a range of sources including PALS, Complaints, AIRS, and SIs. Datix web is an option which would enable Risk and Legal and Patient Experience information to be recorded and linked on one system. If the Trust agrees that this is the preferred option, a process to migrate to one system would commence with an integrated system being in place from 31st March 2015.

Patient Experience Quarterly Report

In-line with moving to an integrated IT system, it is planned to review the Patient Experience Quarterly Report to ensure that it provides the Trust with the information and assurances that it requires. A task and finish group will be set-up to undertake the review with representation from our Non Executive Directors and Governors being sought. This is expected to commence October 2014.

Weekly Complaint Review meetings

The weekly complaint review meetings continue to take place with the previous week's complaints being reviewed by the Chief Executive/Deputy Chief Executive, Chief Nurse and Lead for Patient Experience.

Patient Experience Steering Group (PESG)

The PESG continues to meet on a quarterly basis chaired by the Chief Nurse with representatives from across the Trust including Matrons, Directorate Managers, Patient Experience, Governors, a NED and has representation from Healthwatch. A key focus is to consider complaints referred to the Health Services Ombudsman, FFT feedback, National patient surveys, complaints and PALS feedback. The 'How to Complain Leaflet' is being reviewed, with a change of title and emphasis, from how to complain to how the Trust seeks and values feedback from patients, relatives and carers.

9. Conclusion

The Trust receives a significant amount of feedback from complaints, PALS, Friends and Family Test, patient surveys and letters/cards of compliment. Feedback is shared with Trust staff and is used in customer care training to give real time examples of what matters to our patients. The review of the '*Knowing how we are doing'* boards will further enhance this feedback mechanism.

Late responses remain a concern in complaint handling, particularly as they may add to the poor impression of our services often held by complainants. Concerns about communication and attitude continue to be common themes in complaints.

Work on supporting and implementing the Family and Friends test continues, along with excellent patient engagement on a variety of projects. The findings from the National Cancer Patient Experience Survey are extremely encouraging and demonstrate the hard work that has been carried out by the team involved in providing cancer services.

10. Recommendation

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

Author	**Kay Gamble, Lead for Patient Experience**
Owner	**Beverley Geary, Director of Nursing**
Date	**September**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

DIPC Quarterly Report – Q2 2014/15

Action requested/recommendation

The Board of Directors is asked to note this report and any specific actions for Clinical Directors, Directorate and Clinical Managers in relation to actions required to prevent and reduce patient harm from avoidable infection.

Summary

The report summarises Healthcare Associated Infection incidence and performance against related key infection prevention priorities across the Trust.

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

Implications for equality and diversity

The 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

Registered providers of health care must ensure that systems are in place to manage and monitor the prevention and control of infection if they are to comply with the legislation.

Ref: Health and Social Care Act 2008 – Code of Practice for health and adult social care on the prevention and control of infections and related guidance Dec 2009 (The Hygiene Code).

Progress of report	Quality and Safety Committee – 22 October 2014
Risk	No risk
Resource implications	The cost and operational impact of HCAIs together with improvement and financial penalties that may be incurred through external regulation and inspection (CQC, Monitor) and Commissioners.
Owner	Dr Alastair Turnbull, Director of Infection Prevention and Control (DIPC)
Author	Vicki Parkin, Deputy DIPC
Date of paper	October 2014
Version number	1

Director Infection Prevention and Control QUARTERLY INFECTION PREVENTION REPORT FOR TRUST BOARD. Q2 2014-2015								
Parameter		Annual threshold/ target	Q1	Jul	Aug	Sept	YTD	Notes
MRSA Bacteraemia attributable to Trust	Community		0	0	0	0	0	
	Elderly		0	0	0	0	0	
	Head + Neck		0	0	0	0	0	
	Medicine		0	0	0	0	0	
	Obstetrics + Gynaecology		0	0	0	0	0	
	Ophthalmology		0	0	0	0	0	
	Paediatrics		0	0	0	0	0	
	Specialist Medicine		0	0	0	0	0	
	Surgery + Urology		0	0	0	0	0	
	Trauma + Orthopaedics		0	0	0	0	0	
	Trust		0	0	0	0	0	
MSSA Bacteraemia attributable to Trust	Community		0				0	IV Device specialist role established in IPT form 1st Sept
	Elderly		2	1	1		4	
	Head + Neck		0				0	
	Medicine		8	5		1	14	
	Obstetrics + Gynaecology		0				0	
	Ophthalmology		0				0	
	Paediatrics		1				1	
	Specialist Medicine		1				1	
	Surgery + Urology		1			1	2	
	Trauma + Orthopaedics		1				1	
	Trust	30	14	6	1	2	23	
MSSA per 100000 bed days attributable to Trust	York		23.1	17.6	5.9	11.8	17.5	
	Scarborough + Bridlington		7.0	31.1	0.0	0.0	8.6	
	Community hospitals		0.0	0.0	0.0	0.0	0.0	
	Trust		14.8	18.8	3.4	6.4	12.7	
E coli Bacteraemia attributable to Trust	Community		5				5	
	Elderly		6	1	2	1	10	
	Head + Neck		0				0	
	Medicine		5		2		7	
	Obstetrics + Gynaecology		1				1	
	Ophthalmology		0				0	
	Paediatrics		0				0	
	Specialist Medicine		5	1			6	
	Surgery + Urology		8	4	3	6	21	
	Trauma + Orthopaedics		0				0	
	Trust	Not set	30	6	7	7	50	
Elective MRSA admission screening (report produced by SNS Team)	York sites	100%	86%	88%	88%	92%		
	Scarborough sites	100%	80%	68%	85%	85%		
	Trust	100%	83%	80%	87%	90%		
Emergency MRSA admission screening (report produced by SNS Team)	York sites	100%	69%	73%	70%	74%		Flag required on CPD to alert staff that a screen is required. IT have been approached
	Scarborough sites	100%	76%	74%	70%	72%		
	Trust	100%	72%	74%	70%	73%		

Parameter		Annual threshold/ target	Q1	Jul	Aug	Sept	YTD	Notes
Clostridium difficile Infection (CDI) attributable to Trust	Community		0		2		2	
	Elderly		5	1	1	3	10	
	Head + Neck		0				0	
	Medicine		4			1	5	
	Obstetrics + Gynaecology		0				0	
	Ophthalmology		0				0	
	Paediatrics		0				0	
	Specialist Medicine		2				2	
	Surgery + Urology		1			1	2	
	Trauma + Orthopaedics		0			1	1	
	Trust	59	12	1	3	6	22	CDI under threshold
CDI per 100000 bed days attributable to Trust	York		13.5	0.0	0.0	11.8	8.7	
	Scarborough + Bridlington		17.5	10.4	10.1	41.4	19.0	
	Community hospitals		0.0	0.0	40.5	0.0	6.9	
	Trust		12.7	3.1	9.4	19.1	11.6	
CDI Saving Lives care bundle compliance	York	95%	94%	67%	87%	86%		
	Scarborough + Bridlington	95%	86%	81%	79%	85%		
	Trust	95%	88%	74%	83%	86%		
Outstanding CDI post infection review	Community		0					4 PIR awaiting Microbiology review. 5 in completion process
	Elderly		0	1		3		
	Head + Neck		0					
	Medicine		1			1		
	Obstetrics + Gynaecology		0					
	Ophthalmology		0					
	Paediatrics		0					
	Specialist Medicine		1					
	Surgery + Urology		0			1		
	Trauma + Orthopaedics		0			1		
	Trust		2	1	0	6	9	
Deaths where Clostridium difficile is reported on certificate	Community						0	
	Elderly		1	1		2	4	all Part 2
	Head + Neck						0	
	Medicine			1			1	Part 1b
	Obstetrics + Gynaecology						0	
	Ophthalmology						0	
	Paediatrics						0	
	Specialist Medicine						0	
	Surgery + Urology						0	
	Trauma + Orthopaedics						0	
	Trust		1	2	0	2	5	
Readmissions within 30 days where CDI is diagnosed on and thought to be reason for admission - NB: refers to discharging directorate	Community						0	
	Elderly		1				1	
	Head + Neck						0	
	Medicine						0	
	Obstetrics + Gynaecology						0	
	Ophthalmology						0	
	Paediatrics						0	
	Specialist Medicine						0	
	Surgery + Urology					1	1	
	Trauma + Orthopaedics						0	
	Trust		1	0	0	1	2	

Parameter		Annual threshold/ target	Q1	Jul	Aug	Sept	YTD	Notes
Antimicrobial pathway compliance with indication (information from Antimicrobial Stewardship Team)	Anaes,Theatre and Crit care							
	Elderly		90%	87%	87%	94%		
	Emergency							
	Head + Neck		54%	71%	100%	45%		
	Medicine		85%	87%	79%	85%		
	Obstetrics + Gynaecology							
	Specialist Medicine							
	Surgery + Urology		81%	84%	68%	79%		
	Trauma + Orthopaedics		75%	86%	83%	80%		
	Trust		82%	83%	77%	83%		
Antimicrobial pathway compliance with duration or review date (information from Antimicrobial Stewardship Team)	Anaes,Theatre and Crit care							
	Elderly		91%	81%	79%	100%		
	Emergency							
	Head + Neck		65%	79%	100%	64%		
	Medicine		86%	88%	77%	83%		
	Obstetrics + Gynaecology							
	Specialist Medicine							
	Surgery + Urology		83%	80%	57%	81%		
	Trauma + Orthopaedics		83%	93%	61%	80%		
	Trust		84%	84%	70%	85%		
Ventilator acquired pneumonia in ICU (information provided by ICU)	York ICU		0	0	0	1	1	
	Scarborough ICU		0	0	0	Awaiting data	0	
	Trust		0	0	0	0	0	
CVC associated infections in ICU (information provided by ICU)	York ICU		0	0	0	0	0	
	Scarborough ICU		0	Awaiting data	Awaiting data	Awaiting data	0	
	Trust		0	0	0	0	0	
Trust attributed CAUTI (Safety Thermometer data)	York		1	0	1	2	4	
	Scarborough + Bridlington		2	1	2	0	5	
	Community hospitals		4	1	1	1	7	
	Trust		7	2	4	3	16	
Hand Hygiene compliance	Trust	HH tool revised, trialled and tested. Audits to re-commence 1st Nov 2014 following educational launch with Matrons and Ward Managers Oct 2014						
Environment audit results	York sites	95%	94%	94%	96%	97%	95%	
	Scarborough sites	95%	90%	93%	95%	95%	93%	
	Trust	95%	92%	94%	96%	96%	94%	
	Anaes,Theatre and Crit care					24		

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

Being Open & Duty of Candour Policy

Action requested/recommendation

The Board is asked to review the accompanying policy "Being Open with Patients" with a view to making comment prior to final, wide dissemination throughout the Trust.

This Policy is a key part of the Trust's commitment to openness and transparency following harm events and forms a significant component to our response to the Mid Staffs enquiry which included a recommendation that every healthcare organisation and everyone working for them must be "honest, open and truthful in all their dealings with the patients and the public and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful".

Since the publication of the Francis Report this recommendation has been enshrined into a standard contractual requirement and subsequently a Statutory Duty (Care Act 2014), known as the Duty of Candour.

In 2009 the NPSA reviewed its guidance in respect of best practice for healthcare professionals and Board members regarding effective communication with patients and their families when things go wrong. This guidance describes the principles of being open, delineates best practice around communication and sets clear guidelines which are an integral part of the attached policy.

The Board must demonstrate a commitment to implementing the principles of being open, evidence that these are aligned with the NRLS Framework and ensure that the values accompanying "Being Open" are a component of the Trust's risk management and clinical governance processes. It must ensure that appropriate education is in place, that appropriate dissemination of this essential policy has taken place and that there are sufficient resources committed to supporting this process. Key to the successful implementation of this policy is our improving the culture of awareness in respect of the principles of being open and ensuring that our staff have the information and skills to support patients through such events.

A recent internal audit of the previous "Being Open Policy", whilst drawing attention to generally high levels of professional awareness around the principles of "Being Open" raised several areas of concern specifically in respect of the effectiveness of promotion of the policy, the quality of documentary evidence providing assurance that "Being Open" is consistently applied and thus has satisfied our legal duty of candour, ensuring that robust systems for monitoring compliance are in place and ensuring that we have a

proper process for assessing harm events according to their level of harm and thus the need to implement this Policy. In addition concerns were raised regarding staff training and board assurance regarding compliance with "Being Open".

It is essential that these issues are addressed and the Board is thus asked to consider the attached Policy and make comment prior to final version. A process will be agreed for its widespread dissemination throughout the Trust.

Following publication of the internal audit report the system of classification of incidents reported via Datix has been reviewed such that any incident potentially causing "moderate harm" is reviewed urgently by the Compliance Unit and Patient Safety Team to ensure proper classification. In addition the SI process is being amended such that its checklist includes reference to "Being Open". Furthermore a new process has been implemented for ensuring liaison with patients and their families (Family Liaison Officer role). The Chief Executive and Patient Safety Team will agree the several ways in which the Policy is disseminated and the Trust will publish on its website details of "Being Open" and look to producing a staff information leaflet outlining our approach to this.

By implementing the above it is envisaged that firstly and most importantly as an organisation we are able to implement effectively for patients and their families the principles of "Being Open", secondly that we will be able to demonstrate for external scrutiny that we can do this effectively and finally we will become compliant with legislation pertaining to "Duty of Candour".

Summary

This report provides an update from the Medical Director.

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

Implications for equality and diversity

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

Reference to CQC outcomes

The content of this report does provide some assurance of our compliance with the CQC essential standards of quality and care.

Progress of report	This report is written for the Board of Director's.
Risk	None
Resource implications	None identified
Owner	Dr Alastair Turnbull, Medical Director
Author	Helen Noble, Head of Patient Safety
Date of paper	October 2014
Version number	1

York Teaching Hospital NHS
NHS Foundation Trust

Being Open with Patients Policy

This policy and procedures may evoke safeguarding adults concerns and as such please refer to the Safeguarding Adults Policy or contact the Trust Safeguarding Adults Team for guidance. This policy and procedures may evoke the need to follow the Mental Capacity Act. Please refer to the Mental Capacity Guidance or contact the Trust Safeguarding Adults Team for guidance.

Author:	Helen Noble, Head of Patient Safety
Owner:	Dr Alastair Turnbull, Medical Director
Publisher:	Healthcare Governance Directorate
Date of first issue:	1 May 2007
Version:	4
Date of version issue:	All staff working with patients/carers
Approved by:	
Date approved:	Xxx 2014
Review date:	Xxx 2017
Target audience:	All staff working with patients/carers
Relevant Regulations and Standards	CQC Essential standards of Quality and Safety NHS Standard Contract & Care Act 2014.
Links to Organisational/Service Objectives, business plans or strategies	Patient Safety Strategy Risk Management Strategy

Executive Summary

This policy exists to ensure that patients and their families are told openly about patient safety incidents that affect them and receive an appropriate apology and are kept informed of investigations

This is a controlled document. Whilst this document may be printed, the electronic version is maintained on the Q-Pulse system under version and configuration control. Please consider the resource and environmental implications before printing this document.

Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
1	1 May 2008	Nichola Greenwood	Withdrawn, held on Horizon Archive	New policy
2	May 2008	Nichola Greenwood	Held on Horizon	New Template Further emphasis on monitoring arrangements
3	June 2010	Elaine Miller	Horizon	RMSAT
4	May 2014	Helen Noble	Horizon	Patient circumstances

Contents

Executive Summary

All patient safety incidents causing harm should be acknowledged and reported as soon as they are identified.

Ensure confidentiality at all stages of the process.

Patients and carers should be told what happened as soon as practicable.

An apology should be given and clear reference made in the case notes of the discussion.

Treat patients and relatives sympathetically and with consideration and compassion throughout. Provide information on accessing the Patient Advisory and Liaison Services and other relevant support groups.

Managers should ensure staff feel supported throughout the investigation.

Root Cause Analysis (RCA) should be used to uncover the underlying causes of the patient safety incident

Ensure a multi-disciplinary discussion takes place with the patients and/or their carers following an incident that led to harm and document this including reference to any planned investigation.

Disseminate findings to all staff so they can learn from patient safety incidents. In cases of moderate/severe harm, patients, relatives and carers should be offered a written summary of the investigation and outcomes.

1 Introduction & Scope

This policy will apply to all staff working for York Teaching Hospital NHS Foundation Trust who have a role in providing safe care.

The Trust's ultimate objective is to be trusted to deliver safe, effective healthcare to our community and this policy supports this in delivering the Trust Values.

The principles of Being Open must be applied to any incident, complaint or claim which results in harm to the patient as a result of healthcare treatment provided in the Trust.

It is a requirement under the NHS Standard Contract, 2013/14, to ensure that patients and their families are told openly about patient safety incidents that affect them. The Trust must ensure those patients and their families:

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

This policy should also be read in conjunction with the Trust Adverse Incident Reporting Policy and Serious Incident policy (available on Staffroom).

2 Definitions / Terms used in policy

DATIX data collection system used by the Trust collates data and generates reports and information

NRLS – National Reporting and Learning System is a confidential and anonymous computer based system developed by the National Patient Safety Agency for the collection and analysis of patient safety information.

RCA – Root Cause Analysis is a systematic process whereby the factors that contribute to the incident are identified and, seeks to understand the underlying causes

Patient Safety Incident - any unintended or unexpected incident that could have or did lead to harm for one, or more, patients

PALS – Patient Advisory and Liaison Service.

3 Policy Statement

Being open involves:

- Acknowledging, apologising and explaining when things go wrong
- Conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring
- Providing support for those involved to cope with the physical and psychological consequences of what happened.

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

The existence of this policy meets the requirements outlined in the NPSA Safer Practice Notice No.10 and the NHLSA (2013) “Saying sorry is the right thing to do” guidance.

The Chief Medical Officer’s consultation document, *Making Amends, DH 2003* also outlines processes to encourage openness in the reporting of adverse events. This would encompass:

“a duty of candour requiring clinicians and health services managers to inform patients about actions which have resulted in harm”. Openness and honesty towards patients are supported and actively encouraged by many professional bodies including the Medical Protection Society, the Medical Defence Union and the General Medical Council, whose Good Medical Practice guide contains the following statement on a clinician’s “duty of candour”:

You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

- *Put matters right (if that is possible)*
- *Offer an apology*
- *Explain fully and promptly what has happened and the likely short-term and long-term effects*

"If the patient is an adult who lacks capacity, the explanation should be given to a person with responsibility for the patient, or the patient's partner, close relative or a friend who has been involved in the care of the patient, unless you have reason to believe the patient would have objected to the disclosure. In the case of children the situation should be explained honestly to those with parental responsibility and to the child, if the child has the maturity to understand the issues."
(General Medical Council 2001 p10)

This policy incorporates the 'Duty of Candour' which was made a contractual obligation in April 2013 and reinforces the fundamental obligation to be open and honest in the event of an incident where patient harm has occurred. The 'Duty of Candour' has also been written into the latest revision of the NHS Constitution.

4 Training

There is no formal training associated with this policy. Appendix 1 describes the procedure that should be used. Where further clarification is required this can be obtained from the policy Author.

5 Trust Associated Documentation

- Risk Management Policy & Procedure
- Adverse Incident Reporting Policy
- Serious Incident Policy
- Claims Policy and Procedure
- Concerns and Complaints Policy
- Disciplinary Policy
- Consent Policy
- Information Governance Policy
- Discharge Policy
- Health and Safety Policy
- Resuscitation Policy

- Whistleblowing Policy
- Safeguarding Policies

6 External References

- National Patient Safety Agency (2004),Seven Steps to patient safety: A guide for NHS staff, NPSA, London
- National Health Service Litigation Authority (2009) Apologies and Explanations, Letter to all Chief Executives, and Finance Directors all NHS bodies, NHSLA, London
- General Medical Council,Good Medical Practice (2013), Protecting patients guiding doctors (3rd edition),General Medical Council, London
- Being Open – Communicating Patient Safety Incidents to patients and their carers,NPSA 2009
- NPSA Safer Practice Notice, No 10.
- Building a Culture of Candour: a review of the threshold for the duty of candour and of the incentives for care organisations to be candid, March 2014
- A promise to learn-a commitment to act, Improving the Safety of Patients in England. National Advisory Group on Safety of Patients in England. August 2013
- Mental Capacity Act 2005
- Both the revised (2013) NHS constitution and a guidance handbook are available to download at www.england.nhs.uk/2013/03/26/nhs-constitution/
- The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry,February 2013

Further information and e-learning module can be found at
www.npsa.nhs.uk/

7 Appendices

Appendix 1	Procedure
Appendix 2	Grading of Patient Safety Incidents to determine level of response
Appendix 3:	Equality Analysis
Appendix 4:	Checklist for Review and Approval
Appendix 5:	Implementation Plan

8 Ten Principles of Being Open (NPSA 2009)

The following set of principles has been developed to help healthcare organisations create and embed a culture of *Being Open.*

i. Acknowledgement

- All patient safety incidents, complaints and claims should be acknowledged and reported as soon as they are identified.
- In cases where the patient and/or their carers inform healthcare staff when something untoward has happened, it must be taken seriously from the outset.
- Any concerns should be treated with compassion and understanding by all healthcare staff.
- Denial of a patient's concerns will make future open and honest communication more difficult.

ii. Truthfulness, Timeliness and Clarity of Communication

- Information about a patient safety incident must be given to patients and/or their carers (with appropriate consent), in a truthful and open manner by an appropriately nominated person.
- Patients want a step-by-step explanation of what happened, that considers their individual needs and that is delivered openly and clearly.
- Communication should also be timely: patients and/or their carers should be provided with information about what happened as soon as practicable.
- It is also essential that any information given is based solely on the facts known at the time.
- Staff should explain that new information may emerge as an incident investigation is undertaken, and patients and/or their carers should be kept up-to-date with the progress of an investigation.
- Patients and/or their carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

- They should not receive conflicting information from different members of staff.
- Medical jargon, which they may not understand, should be avoided.

iii. Apology

- Patients and/or their carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident.
- The decision on which staff member should give the apology should take into consideration seniority, relationship to the patient, and experience and expertise in the type of patient safety incident that has occurred.
- Verbal apologies are essential because they allow face-to-face contact between the patient and/or their carers and the healthcare team. This should be given as soon *as* staff are aware an incident has occurred.
- It is important not to delay for any reason, as delays are likely to increase the patient's and/or their carer's sense of anxiety, anger or frustration.
- **An apology is not an admission of liability.**

iv. Recognising Patient and Carer Expectations

- Patients and/or their carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident and its consequences in a face-to-face meeting.
- They should be treated sympathetically, with respect and consideration.
- Confidentiality must be maintained at all times.
- Patients and/or their carers should also be provided with support
- This involves consideration of special circumstances that can include a patient requiring additional support, such as an independent patient advocate or a translator.
- When appropriate, information on accessing the Patient Advisory and Liaison Services (PALS) and other relevant support groups like Cruse Bereavement Care, the

Independent Complaints Advisory Service (ICAS) and Action against Medical Accidents (AvMA) should be given to the patient as soon as it is possible.

v. Professional Support

- The Trust's Open and Just Culture creates an environment in which all staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents.
- Managers should ensure that staff feel supported throughout the incident investigation process as they too may have been traumatised by being involved.
- They should not be **unfairly** exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration.
- Where there is reason for the Trust to believe a member of staff has committed a **punitive or criminal act**, the Trust will take steps to preserve its position, and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation.
- Staff will also be encouraged to seek support from relevant professional bodies.

vi. Risk Management and Systems Improvement

- The principles of Root cause analysis (RCA) should be applied to uncover the underlying causes of a patient safety incident.
- Investigations should focus on improving systems of care, which will then be reviewed for their effectiveness.

vii. Multi-disciplinary Responsibility

- Most healthcare provision involves multi-disciplinary teams and communication with patients and/or their carers following an incident that led to harm. This will ensure that the *Being Open* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

viii. Clinical Governance

- *Being Open* has the support of patient safety and quality improvement processes through the governance framework, in which patient safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence.
- It also involves a system of accountability through the Chief Executive to the Board of Directors to ensure these changes are implemented and their effectiveness reviewed.
- The findings are disseminated to staff so that they can learn from patient safety incidents.
- These actions are monitored to ensure that the implementation and effects of changes in practice following a patient safety incident by the Trust's Risk Review Group, Patient Safety Group, Health Safety and Non-Clinical Risk Group and Board of Directors.

ix. Confidentiality

- Full respect must be given to the patient's and/or their carer's and staff's privacy and confidentiality.
- Details of a patient safety incident, complaint or litigation should at all times be considered confidential.
- Staff should adhere to the Trust's confidentiality policy, Caldicott principles and relevant Codes of Conduct. However in order to learn from incidents, it will be necessary for discussions to take place in forums such as the SI Group, Risk Review meetings, Directorate meetings. In all of these discussions, the identity of the patient concerned should be on a need-to-know basis and, where practicable, reports should be anonymous.
- In addition, it is good practice to inform the patient and/or their carers about who will be involved in the investigation before it takes place and give them the opportunity to raise any objections.

x. Continuity of Care

- Patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion.
- If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made, by the relevant clinicians and managers, if possible.

9 The Being Open Process

9.1 Incident Detection or Recognition

A patient safety incident may be identified by:

- a member of staff at the time of the incident.
- a member of staff retrospectively when an unexpected outcome is detected.
- a patient and/or their carers who expresses concern or dissatisfaction with the patient's healthcare either at the time of the incident or retrospectively.
- incident detection systems such as incident reporting or medical records review.
- other sources such as detection by other patients, visitors or non-clinical staff.

The top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the patient and with appropriate consent. Where incidents are defined as Adverse Incidents, Critical Incident or Serious Incidents (SI) the following should be undertaken:

- acknowledgement and apology
- completion of Datix incident form
- Incident investigation.

9.2 Patient Safety Incidents Occurring Elsewhere

- A patient safety incident may have occurred in another organisation, not the Trust.
- The individual who first identifies the possibility of an earlier patient safety incident should ensure that contact is made with the other organisation to establish whether the matter has been recognized and whether the incident is being investigated.
- In all circumstances, the Trust's Head of Risk and Legal Services should be notified who will ensure that this organisation is kept informed of the outcome of the investigation.

9.3 Criminal or Intentional Unsafe Act

- Patient safety incidents are almost always unintentional.

If at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, the line manager, the Head of Risk and Legal Services, the Medical Director and the Chief Executive should be notified immediately.

9.4 Initiating the Being Open Process

Initial Assessment to Determine Level of Response

All incidents should be initially assessed to determine the level of response required. The level of response to a patient safety incident depends on the nature of the incident (see Appendix 2).

Preliminary Team Discussion

- A decision will be made by the Trusts SI decision makers in accordance with the Trust's SI policy, as to whether the patient safety incident should be declared as an SI/CI. If so, a Lead Investigator will be appointed to lead the investigation.

- If an SI is not declared, the most senior health professional involved in the patient safety incident, as well as the senior clinician responsible for the patient's care should meet as soon as possible after the event to agree their response to the incident.
- Managers should also provide information on the support systems currently available for professionals distressed by patient safety incidents. These include counseling services offered by their professional bodies, stress management courses for staff that have the responsibility for leading *Being Open* discussions and mentoring for staff who have recently taken on a *Being Open* leadership role.
- Managers should also be mindful of the Trust's responsibilities under the Stress Management policy (available on Staffroom).

9.5 Timing

The initial Being Open discussion with the patient and/or their carers should occur as soon as possible after recognition of the patient safety incident. Factors to consider when timing this discussion include:

- clinical condition of the patient. Some patients may require more than one meeting to ensure that all the information has been communicated to and understood by them.
- availability of key staff involved in the incident and in the *Being Open* process.
- availability of the patient's family and/or carers.
- availability of support staff, for example a translator or independent advocate, if required.
- patient preference (in terms of when and where the meeting takes place and who leads the discussion).
- privacy and comfort of the patient.
- arranging the meeting in a sensitive location.

9.6 Choosing the individual to communicate with patients and/or their carers

This liaison person should ideally be the most senior person responsible for the patient's care or someone with experience and expertise in the type of incident that has occurred. The individual should have received training in communication and should:

- preferably be known to the patient and/or their carers.
- have a good grasp of the facts.
- be senior enough or have sufficient experience and expertise in relation to the type of patient safety incident.
- avoid excessive use of medical jargon.
- should offer an apology, reassurance and feedback to patients and/ or their carers.
- be culturally aware and informed about the specific needs of the patient and/ or their carers.

In exceptional circumstances if the healthcare professional cannot attend the meeting they may delegate an appropriate substitute. The qualifications, training and scope of responsibility of this person should be clearly defined. This is essential for effective communication with the patient, their family and carers without jeopardizing the rights of the healthcare professional, or their relationship with the patient.
If for any reason it becomes clear during the initial discussion that the patient would prefer to speak to a different healthcare professional, the patient's wishes should be respected. A substitute with whom the patient is satisfied should be provided from within the same Speciality.

Responsibilities of junior healthcare professionals

Junior staff or those in training should not lead the *Being Open* process except when all of the following criteria have been considered:

- the incident resulted in low harm.
- they have expressed a wish to be involved in the discussion with the patient, their family and carers.

- the senior healthcare professional responsible for the care is present for support.
- the patient, their family and carers agree.

However trainees should be offered the opportunity to give an apology where appropriate.

9.7 Patient safety incidents related to the environment

In such cases a senior manager of the relevant service will be responsible for communicating with the patient and/or their carer. Where necessary, the Consultant may be present at the initial *Being Open* discussion to assist in providing information on the likely effects of the injury.

9.8 Involving healthcare staff who made mistakes

Some patient safety incidents that resulted in moderate harm, or death will arise from errors made by healthcare staff. In these circumstances the member(s) of staff involved may or may not wish to participate in the *Being Open* discussion with the patient and/or their carers.

Every case where an error has occurred needs to be considered individually, balancing the needs of the patient and/or their carers with those of the healthcare professional concerned. In cases where the healthcare professional who has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting.

Initial *Being Open* discussion

This is the first part of an ongoing communication process. Many of the points raised should be expanded on in subsequent meetings with the patient, their family and carers.

- There should be an expression of genuine sympathy, regret and an apology for the harm that has occurred.

- It should be made clear to the patient and/or their carers that new facts may emerge as the incident investigation proceeds.
- The patient's and/or carer's understanding of what happened should be taken into consideration, as well as any questions they may have.
- There should be consideration and formal noting of the patient's and/or carer's views and concerns, and demonstration that these are being heard and taken seriously.
- Appropriate language and terminology should be used when speaking to patients and/or their carers. For example, using the terms 'patient safety incident' or 'adverse event' may be at best meaningless and at worst insulting to a patient and/or their carers.
- If a patient's and/or their carer's first language is not English, or they have other communication difficulties, their language needs should be addressed as well as providing information in both verbal and written formats. In these circumstances. assistance can be provided by interpretation and translation
- Patients/Carers should be given a complaints leaflet to read if they indicate that they wish to make a complaint. In these circumstances, the Head of Patient Experience should be advised that a complaint may be forthcoming.

It is essential that the following **do not** occur:

- Speculation
- attribution of blame
- denial of responsibility
- provision of conflicting information from different individuals.
- defensiveness

9.9 To be recorded in the case notes:

- The chronology of clinical and other relevant facts.
- Details of the patient's, their family and carers' concerns and complaints.

- A repeated apology for the harm suffered and any shortcomings in delivery of care that led to the patient safety incident.
- A summary of factors that contributed to the incident.
- Information on what has been and will be done to avoid. recurrence of the incident and how these improvements will be monitored.

9.10 Particular patient circumstances

The approach to *Being Open* may need to be modified according to the patient's personal circumstances.

When a patient dies:

- consider information needed on the processes that will be followed to identify the cause of death
- consider open channels of communication, ensuring where appropriate contact details are given to family and carers should any further information be required.

Usually the *Being Open* discussions and any investigations occur before the Coroner's inquest.In certain circumstances the Trust may consider it appropriate to wait for the Coroner's inquest before holding the discussion with the family. In any event an apology should be issued as soon as possible after the patient's death, together with an explanation that the Coroner's process has been initiated and a realistic timeframe of when the family and carers will be provided with more information.

Patient with mental health issues

Being Open for patients with mental health issues should follow normal procedures unless the patient also has cognitive impairment.
The only circumstances in which it is appropriate to withhold patient safety incident information is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm.

Patients with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorized a person to act on their behalf by a Lasting Power of Attorney. In these cases, steps must be taken to ensure that this extends to decision making and to the medical care and treatment of the patient.
The *Being Open* discussion would be conducted with the holder of the power of attorney. Where there is no such person, the clinicians may act in the patient's best interest in deciding who the appropriate person is to discuss incident information with, regarding the patient as a whole and not simply their medical interests. However, patients with cognitive impairment should, where possible, be involved directly in communications about what has happened. Where appropriate, a referral to the Safeguarding Team should be considered.

Patients with learning disabilities

Where a patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired.
If the patient is not cognitively impaired they should be supported in the *Being Open* process by alternative communication methods (e.g. given the opportunity to write questions down). An advocate, agreed on in consultation with the patient should be appointed. Appropriate advocates may include carers, family or friends.

Patients with specific communication requirements

A number of patients will have particular communication difficulties, such as hearing impairment. Please ensure you meet attendees specific requirements for example book an interpreter, information available in preferred format e.g. large print

Patients who do not agree with the information provided

Sometimes the patient, their family and carers may not accept the information provided or may not wish to participate in the *Being Open* process. In this case, the following should be considered:

- Look for a mutually agreeable solution.
- Write a comprehensive list of the points that the patient, their family and carers disagree with and reassure them you will follow up these issues.
- Ensure the patient, family and carers are fully aware of the formal complaints procedure.

9.11 Documentation

The incident report and record of the investigation and analysis process will be recorded on the incident database (Datix). Staff should ensure completion of the tick box on the Datix form to indicate that the patient/family have been informed.

See Appendix 1-Procedure

10 Equality Analysis

In the development of this policy the Trust has considered evidence to ensure understanding of the actual / potential effects of our decisions on people covered by the equality duty. A copy of the analysis is attached at Appendix 3.

11 Accountability

Operational implementation, delivery and monitoring of the policy reside with:-

- The Medical Director is accountable for the effective implementation of this policy across the Trust.

12 Consultation, Assurance and Approval Process

12.1 Consultation Process

The Trust will involve stakeholders and service users in the development of its policies.

Consultation has taken place with the following stakeholders:

- Medical Director
- Chief Nurse
- Patient Safety Group
- Risk and Legal
- Internal Audit

12.2 Quality Assurance Process

Following consultation with stakeholders and relevant consultative committees, this policy has been through quality assurance checks prior to being reviewed by the authorising committee to ensure it meets the standards for the production of policy and equalities

legislation and is compliant with the Development and Management of Policies policy.

12.3 Approval Process

The approval process for this policy complies with that detailed in section 6.3 of the Development and Management of Policies Policy. The approving body for this policy is the Patient Safety Group.

The Checklist for Review and Approval has been completed and is included as Appendix 4 .

13 Review and Revision Arrangements

On reviewing this policy, all stakeholders identified in section 6.1 will be consulted. The persons responsible for review are:

- Patient Safety Team

Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the Patient Safety Group.

14 Dissemination and Implementation

14.1 Dissemination

Once approved, this policy will be brought to the attention of all relevant staff working at and for York Hospital NHS Foundation Trust following the completed Plan for dissemination of the policy (See Appendix 5)

This policy is available in alternative formats, such as Braille or large font, on request to the author of the policy.

14.2 Implementation of Policies

This policy will be implemented throughout the Trust by communication with all Clinical Directors, Directorate Managers, Lead Investigators, Risk Reviewers, Matrons and Consultants.

In addition to this the Policy Author will collate the following evidence to demonstrate compliance with this policy:

- Annual Audit of Serious Incidents, complaints and other adverse incidents
- Patient Safety Group Agendas, minutes and other papers

15 Document Control including Archiving Arrangements

15.1 Register/Library of Policies

This policy will be stored on Staffroom, in the policies and procedures section and will be stored both in an alphabetical list as well as being accessible through the portal's search facility and by group. The register of policies will be maintained by the Healthcare Governance Directorate.

If members of staff want to print off a copy of a policy they should always do this using the version obtainable from Staffroom but must be aware that these are only valid on the day of printing and they must refer to the intranet for the latest version. Hard copies must not be stored for local use as this undermines the effectiveness of an intranet based system.

15.2 Archiving Arrangements

On review of this policy, archived copies of previous versions will be automatically held on the version history section of each policy document on Q-Pulse. The Healthcare Governance Directorate will retain archived copies of previous versions made available to them. Policy Authors are requested to ensure that the Policy Manager has copies of all previous versions of the document.

It is the responsibility of the Healthcare Governance Directorate to ensure that version history is maintained on Staffroom and Q-Pulse.

15.3 Process for Retrieving Archived Policies

To retrieve a former version of this policy from Q-Pulse, the Healthcare Governance Directorate should be contacted.

16 Monitoring Compliance and Effectiveness

Monitoring the effectiveness of this policy will provide assurance to the Trust that the specified risks are being managed appropriately.

The aim will be to prioritise monitoring of the most important aspects of the policy initially based on previous experience of risk incident data.

The processes which ensure effective feedback of the results of monitoring and audit into the Trust will be clearly identified. These processes will ensure that the evidence for the effectiveness of this policy is appropriately assessed and reported, that further monitoring and audit is planned based on previous findings and, that recommendations and action plans are produced and monitored appropriately.

The Head of Risk and Legal Services will be responsible for ensuring that the monitoring and audit of this policy takes place as detailed below:

16.1 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and ensure effective review, the policy will be monitored as follows:-

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
a. process for encouraging open communication between healthcare organisations, healthcare teams, staff and patients and their carers.	Audit of two SIs Ten randomly selected claim files per year Ten randomly selected complaint files per year 20 randomly selected patient incident reports where differing degrees of harm have been identified	All this will be undertaken by the use of Audit Checklists and will be undertaken by the Risk and Legal Services Senior Managers.	Quarterly Annual	SI Group Patient Safety Group	SI Group Patient Safety Group	SI Group Patient Safety Group

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
b. process for acknowledging, apologising and explaining when things go wrong	See a)	See a)	See a)	See a)	See a)	See a)
c. Requirements for truthfulness, timeliness and clarity of communication	See a)	See a)	See a)	See a)	See a)	See a)
d. Provision of additional support as required	As part of reviewing the documentation the audit should consider whether additional support has been provided to support either staff involved in the	Risk and Legal Services Senior Managers	See a)	See a)	See a)	See a)

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
	incident or, as part of the investigation into the circumstances for it, and by whom. This will be recorded within the file					
e. Requirement For documenting all communication	See a)	See a)	See a)	See a)	See a)	See a)

16.2 Standards/Key Performance Indicators

CQC Essential standards of Quality and Safety, outcome 1b,4b,16b March 2010
NHS Standard Contract
Care Act 2014

Appendix 2 Grading of Patient Safety Incidents to determine level of response

Incident	Level of Response
No harm (including prevented patient safety incidents)	Patients are not usually contacted or involved in investigations and these types of incidents are outside the scope of Being Open Policy. Individual Healthcare Organisations decide whether 'no harm' events (including prevented patient safety incidents)are discussed with patients, their families and carers, depending on local circumstances and what is in the best interest of the patient.
Low Harm	Unless there are specific indications or the patient requests it, the communication investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Reporting to the Risk Management team will occur through standard incident reporting mechanisms and be analysed centrally to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. Communication should take the form of an open discussion between the staff providing the patient's care and the patient, their family and carers and formally documented. **Apply the principles of *Being Open***
Moderate harm, severe harm or death	A higher level of response is required at department or local level in these circumstances. There must be an open and documented discussion/investigation planned by the lead investigator with the patient/family/carers. A discussion/decision needs to be made as to whether external investigators are required **Apply the *Being Open* process.**

Appendix 3 Equality Analysis

To be completed when submitted to the appropriate committee for consideration and approval.

Name of Policy	Being Open with Patients Policy
1.	**What are the intended outcomes of this work?** To ensure that patients and their families are told openly about patient safety incidents that affect them and receive an appropriate apology, support and are kept informed of investigations
2	**Who will be affected?** Patients, relatives, carers, staff
3	**What evidence have you considered?** NPSA Safer Practice Notice No.10 2005 NHLSA (2013) "Saying sorry is the right thing to do" guidance. Chief Medical Officer's consultation document, *Making Amends, DH 2003* Comments from Medical Director, Quality and Safety Team, Patient Safety Group members, Virtual Policy Review Group, Head of Risk and Legal, Internal Audit and Directorate Managers and Clinical *Leads* (May – August 2014)
a	**Disability –** No impact
b	**Sex –** No impact
c	**Race -** Interpreters would be obtained where appropriate.
d	**Age** – No impact
e	**Gender Reassignment** -
f	**Sexual Orientation** - No impact
g	**Religion or Belief** - No impact
h	**Pregnancy and Maternity**. - No impact
i	**Carers –** This policy exists to ensure that carers and relatives are supported and involved and kept informed in the event of an adverse incident, providing that the patient has given consent for information to be released to them.
j	**Other Identified Groups** – None identified

4.	**Engagement and Involvement**	
a.	Was this work subject to consultation?	Yes
b.	How have you engaged stakeholders in constructing the policy	By circulation of the document for consultation and many have provided feedback and suggestions for improvement
c.	If so, how have you engaged stakeholders in constructing the policy	As above
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs The Medical Director, Quality and Safety Team, Patient Safety Group members, Head of Risk and Legal, Internal Audit and Directorate Managers and Clinical Leads have all had copies of the document circulated to them and their feedback has been used to ensure that the document is workable and fully informs and supports patients and their carers/relatives. (May – August 2014) The key outcome is a document which works in practice and ensures that staff are open, honest and compassionate with patients, carers and relatives in the event of a patient safety incident occurring.	
5.	**Consultation Outcome** *Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups*	
a	Eliminate discrimination, harassment and victimisation	No impact
b	Advance Equality of Opportunity	No impact
c	Promote Good Relations Between Groups	Positive impact
d	What is the overall impact?	No impact
	Name of the Person who carried out this assessment: Head of Patient Safety	
	Date Assessment Completed May 2014	
	Name of responsible Director Medical Director	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Committee, together with any suggestions as to the action required to avoid/reduce this impact.

Appendix 4 Checklist for Review and Approval

Authors need to be confident that their policy meets all of the criteria identified below before submitting this to the appropriate committee(s) for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Development and Management of Policies**		
	Is the title clear and unambiguous and meets the requirements of page 3 of the Development and Management of Policies Policy?	Y	
	Is it clear whether the document is a policy, procedure or protocol?	Y	
	Does the style and format of the policy meet the requirements of section 3.2 of the Development and Management of Policies Policy?	Y	
	Does the policy contain a list of definitions of terms used?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Is the method described in brief?	Y	
	Are individuals involved in the development identified?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	
	Is there evidence of consultation with all relevant stakeholders and users?	Y	
4.	**Content**		
	Is the document linked to a strategy?	Y	Patient Safety Strategy Risk Management

	Title of document being reviewed:	Yes/No	Comments
			Strategy
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
	Does it meet all of the requirements of external agencies/bodies where applicable?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are supporting references cited in full?	Y	
	Are local/organisational supporting documents referenced?	Y	
	Are all associated documents listed and updated?	Y	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
	If appropriate, have the staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		
	Does the dissemination plan identify how this will be done and is it clear?	Y	
	Does the plan include the necessary training/support to ensure compliance?	Y	
	Does the policy detail what evidence will be collated to demonstrate compliance with it?	Y	
8.	**Document Control**		
	Does the document identify where it will be held?	Y	
	Have archiving arrangements for superseded documents been addressed?	Y	
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Y	

	Title of document being reviewed:	Yes/No	Comments
	Is there a plan to review or audit compliance with the document?	Y	
10.	**Review Date**		
	Is the review date identified?	Y	
	Is the frequency of review identified? If so, is it acceptable?	Y	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation, evidencing, monitoring and review of the documentation?	Y	

Policy Owner's Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval. (This can be completed electronically with an electronic signature)			
Name	Dr A Turnbull	Date	May 2014
Signature	*Dr A Turnbull*		
Committee Approval			
If the Chair or Vice Chair of the committee is happy to approve this document, please sign and date here and enter the name of the committee/group. The Policy Author will contact the secretary/administrator of the committee/group to obtain a signed copy of this checklist. The Policy Author will then submit this together with the approved policy (ensuring the "draft" watermark is removed) to the Policy Manager for logging and publication.			
Name		Date	
Signature			
Committee/ Group title			
For Policy Manager's use only			
Is there a signed and completed Checklist for Review and Approval accompanying the policy?			Y

Is the policy logged on Qpulse?	Y
Has the old version of the policy been archived? (if applicable)	Y
Has the policy been published on Staffroom?	Y
Author notified that policy has been published?	Y

Appendix 5 Plan for the dissemination of a policy

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Being Open with Patients Policy
Date finalised:	
Previous document in use?	Yes
Dissemination lead	Head of Patient Safety
Which Strategy does it relate to?	Patient Safety/Risk Management
If yes, in what format and where?	Electronic – stated departments
Proposed action to retrieve out of date copies of the document:	Healthcare Governance Directorate will hold archive

To be disseminated to:	All staff
Method of dissemination	• Article for inclusion in team brief • Published on Staffroom
who will do it?	Policy Author/Policy Manager
and when?	On approval
Format (i.e. paper or electronic)	Electronic

Dissemination Record

Date put on register / library	On approval
Review date	Xx 2017
Disseminated to	As above
Format (i.e. paper or electronic)	Electronic
Date Disseminated	On approval
No. of Copies Sent	As above
Contact Details / Comments	Helen Noble Extn 771 2341

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 29 October 2014

Quality Governance Framework

Action requested/recommendation

The Board of Directors is asked to consider the recommendation from the Quality and Safety Committee and approve the document.

Summary

This paper provides a revised Quality Governance Framework.

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

CQC plays an important part in informing the development of the aspects of quality included in the framework.

The Framework is based on the requirements published by Monitor.

Progress of report	An earlier draft of the framework has been discussed by the Quality and Safety Committee and by the Non-executive held a meeting to discuss the detail in the report. The Corporate Directors received a presentation on the Framework from the Medical Director and Interim Chief Nurse The Quality and Safety Committee has reviewed a final draft prior to formulating a recommendation to the Board of Directors
Risk	There are some risks highlighted within the document
Resource implications	Resources implication detailed in the report.
Owner	Alastair Turnbull, Medical Director Beverley Geary, Interim Chief Nurse
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	October 2014

Quality Governance Framework and Plan for York Teaching Hospital NHS Foundation Trust

Introduction

The Trust provides a comprehensive range of acute hospital and specialist healthcare services to approximately 530,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles. The services are delivered from then sites including

York Hospital
Scarborough Hospital
Bridlington Hospital
Whitby Hospital
Malton Hospital
Selby War Memorial Hospital
Archways Community Intermediate Care Inpatient Facility
White Cross Court Rehabilitation Centre
St Monica's Hospital Easingwold
St Helens Rehabilitation Hospital

The organisation has robust governance systems and processes in place ensuring that the quality of clinical services are continually assessed, examined and improved. The vision for the organisation is;

"to be a healthcare organisation that is recognised locally and nationally as delivering outstanding clinical services that meet the needs of its varied population and supports services that matter to patients."

Structure

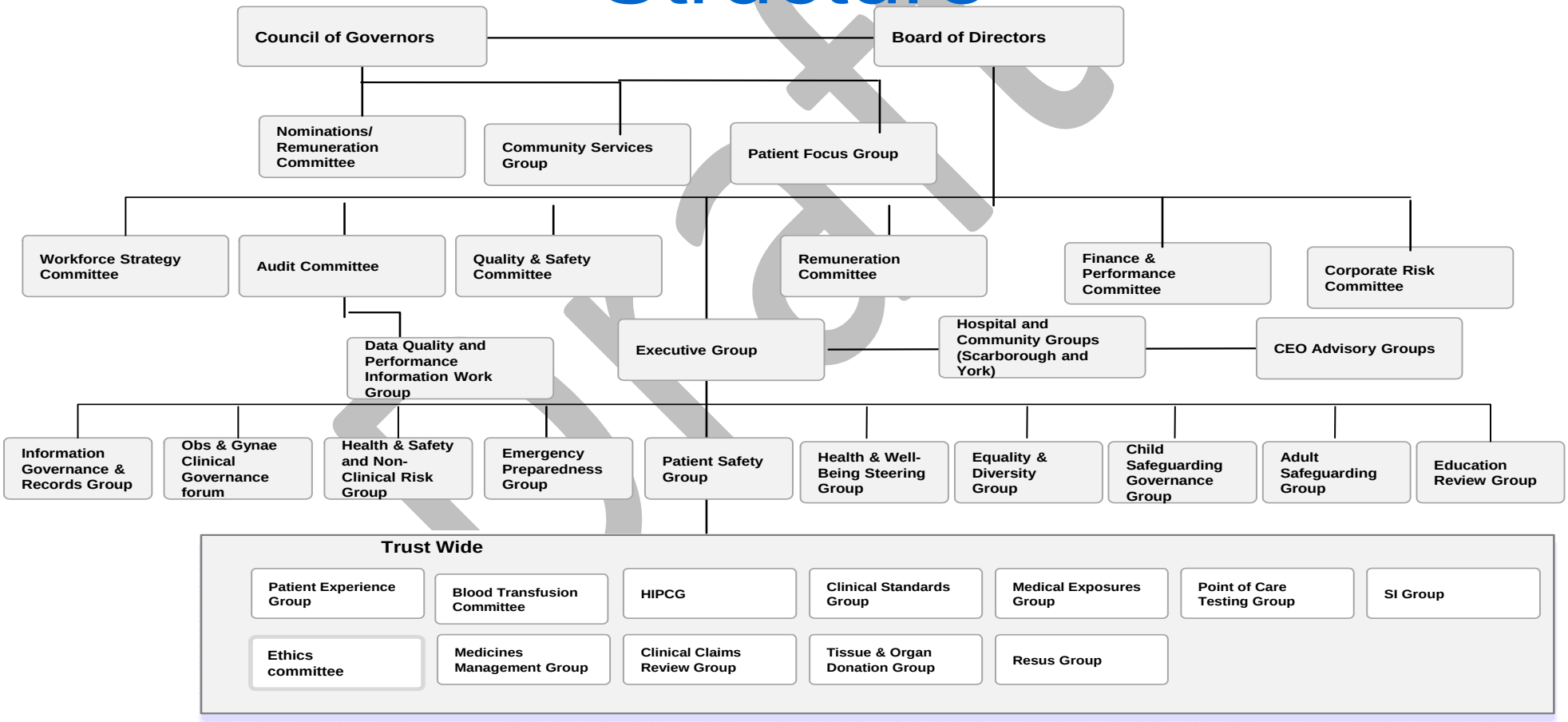
To maintain assurance in relation to clinical quality and safety the Board of Directors has establish a Board Committee, the Quality and Safety Committee. The Board of Directors has provided delegated authority to the Quality and Safety Committee to seek assurance around the quality and safety employed across the Trust. The Quality and Safety Committee is a formal committee of the Board of Directors. The leads for clinical quality and safety are the Medical Director and the Interim Chief Nurse. Each Director will have specific functions thereby ensuring that accountability is clear.

The Patient Safety Group, which is chaired by the Medical Director, oversees the quality and safety governance arrangements across the organisation along with the Clinical Standards Group. The Patient Safety Group ensures that clinical quality and safety in the Trust attains appropriate top quartile standards and achieves the high level aims of the Safety Strategy. Through a defined reporting schedule the Patient Safety Group receives highlight reports and assurance from the various groups that feed into it. The Medical Director and Chief Nurse on a monthly basis, report to the Board of Directors on issues relating to patient safety, clinical outcomes and patient experience. The Patient Safety Group is a subcommittee of the Corporate Risk Management Group.

The Executive Board is the key Group that receives information from the Patient Safety Group on the clinical risks and assurances identified in the organisation. The minutes of the Executive Board are received by the Board of Directors.

Clinical quality in the directorates is managed through the performance management process. Through the Directorate Executive Performance meetings the directorate teams are held to account for the delivery of safe and effective clinical services. Performance Improvement Quality and Safety Meetings are also held with the Directorates. These meetings, chaired by the Medical Director, are used as a vehicle through which clinical practice is driven forward. The executive leads for clinical quality and safety are the Medical Director and Interim Chief Nurse. Each Director will have specific functions thereby ensuring that accountability is clear.

Overarching Governance Structure



4.3 Compliance

The clinical management of all directorates includes regular reporting on agreed KPIs. These indicators cover patient safety, clinical effectiveness and patient experience. The KPIs take into account external reporting requirements as well as internal requirements based on directorate performance and service ambitions. The Medical Director has a team supporting him in delivery of the clinical governance agenda. They provide an essential function through which a standardised approach to clinical governance policy and process will be driven.

The Trust has split the responsibility for quality and safety. The Chief Nurse is responsible for quality and the Medical Director is responsible for safety. The Medical Director delivers patient safety through his clinical governance team and the Chief Nurse and Director of Nursing delivery quality through the use of the corporate team and the links with the nursing establishment across the Trust.

The Trust also has a Compliance Team in place provides assurance against CQC, NHSLA and NCEPOD compliance.

To support the Quality Governance Framework analysis for 2013/14 the Trust has completed a self assessment against the Board Governance Assurance Framework work – Quality module.

Trust Compliance against Monitor's Quality Governance Framework, the Quality Governance Framework and Implementation Plan

The Trust has reviewed and updated the quality governance framework that is currently in place.

York Teaching Hospital NHS Foundation Trust

Compliance against Monitor's Quality Governance Framework

1. STRATEGY	Compliance	Monitor Risk Rating (MRR)
1a: Does quality drive the Trusts strategy?	• Yes. There is a board approved Patient Safety Strategy along with a board approved Nursing and Midwifery Strategy and a revised strategy for patient experience is being developed, this will included complaints. •	**MRR: Amber/green**
1b: Is the Board sufficiently aware of potential risks to quality?	• Yes. The Board receives regular quality, safety and performance reports. The Board Assurance Framework and Risk Register are considered quarterly. Activity is underpinned by an Integrated Governance structure. The Board receives an update from the Quality and Safety Committee at each Board meeting. The Trust has in place a Patient Safety and Quality report which is considered in detail by the Quality and Safety Committee and is received by the Board and reported on to the Board by the Quality and Safety Committee.	**MRR : Amber**

2. CAPABILITIES AND CULTURE	Compliance	Monitor Risk Rating (MRR)
2a. Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	• Yes. The Trust has established directors who are focused on patient care and quality. All directors play an active part in Board meetings and are able to challenge all areas related to quality. • Non-Executive Directors form the membership of the Quality and Safety Committee.	**MRR: Amber/green**
2b. Does the Board promote a quality-focused culture throughout the Trust?	• Yes. The Board of Directors agrees the priorities for the organisation and these are reflected in the Annual Plan. • The Quality and Safety priorities are identified as part of the Quality Report and are shared at an early stage with staff, the CCGs and key stakeholders.	**MRR: Amber/green**

3. STRUCTURES AND PROCESSES	Compliance	Monitor Risk Rating (MRR)
3a. Are there clear roles and accountabilities in relation to quality governance?	• Yes. The Interim Chief Nurse is accountable for quality governance. This is supported by the Medical Director being responsible for patient safety. • Recently there has been a restructure of the senior nursing team within the organisation to ensure that nursing and midwifery is focused on quality of care. The Trust has embedded the appropriate clinical governance arrangements across the organisation. • The directorates are held to account through performance management meetings and through the clinical quality and safety performance improvement meetings.	**MRR: Amber/green**
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	• Yes. There are established incident reporting and monitoring processes in place. • There are directorate level performance management processes. • The Trust has a quality and safety performance management meeting with each directorate held twice a year. • The Board of Directors consider the Board Assurance Framework, Performance Dashboards and the Risk Register.	**MRR: Amber/green**

3c: Does the Board actively engage patients, staff and other key stakeholders on quality?	• The Executive Patient Experience Group was established in April 2012. This group's work has been reviewed and appropriate adjustments have been made to the functioning of the group • The Chief Executive and the interim Chief Nurse, review every complaint on a weekly basis • The Interim Chief Nurse has reviewed the patient experience departments and developed a revised approach to the development of the department. This has been implemented. • There is active engagement with frontline staff on quality • The Council of Governors is engaged in the quality agenda • The Council of Governors are included as part of the arrangements for the development of the Quality Report. • The Trust has acted on the recommendations included in the Francis and Berwick reports. • There will be ongoing engagement with external stakeholders across the enlarged organisation • Patients, the public and local stakeholders are involved in developing the Annual Plan and Quality Report	**MRR: Amber**

4. MEASUREMENT	Compliance	Monitor Risk Rating (MRR)
4a: Is appropriate quality information being analysed and challenged?	• Yes. Clinical quality performance metrics will be harmonised across the enlarged organisation. • The Board of Directors receives monthly quality performance reports. • Quality performance metrics are in-line with national targets, CQUINs and locally agreed stretch targets • The development of quality metrics in the community would enhance the information being analysed •	**MRR : Amber**
4b: Is the Board assured of the robustness of the quality information?	• Yes. Data quality has been the subject of internal audit reviews and this will continue going forward. • The Data Quality Group, which reports through to the Audit Committee will continue to drive data quality improvements across the enlarged organisation.	**MRR: Amber**
4c: Is quality information being used effectively?	• Yes. Information is used to drive the quality agenda • Information is presented at all levels throughout the organisation to support quality improvement	**MRR: Amber**

To Support Compliance against Monitor's Quality Governance Framework

1. Strategy
Does quality drive the Trust's Strategy? The Trust uses its 'Our Commitment To You' document as the basis for improving quality and safety in the organisation, along with the Nursing and Midwifery Strategy and the Patient Safety Strategy. These documents have been communicated across the organisation and to key stakeholders. The 'Our Commitment To You' document outlines the overall vision and identifies four strategic themes. The first of these themes is to improve quality and safety. Each of the strategic themes is underpinned by specific objectives and priorities for the Trust. The Nursing and Midwifery Strategy supports the theme and describes the approach that nursing and midwifery have adopted across the Trust to ensure quality and safety is maintained. We aim to be recognised as one of the safest hospitals nationally and internationally by delivering safe, evidence based care and acting and learning when we identify a need for improvement. Our Patient Safety Strategy focuses on reducing mortality, development of patient safety behaviours and skills, reduction of variation in practice and development of a culture which is open and honest and where support is provided when things go wrong. The Quality Governance Framework, Integration Plan and the Quality and Safety Leadership in the organisation has incorporated the identified risks for the Trust and those identified as part of the acquisition of Scarborough and includes the recommendations from the Reporting Accountant and due diligence work which has been undertaken as part of the transaction process. These have been reviewed as part of the review of the Quality Governance Framework. The Trust has introduced a Nursing and Midwifery Strategy which identifies the key priorities for the organisation as patient experience, delivering high quality, safe patient care, measuring the impact of care delivery, and staff experience. These priorities influence how the Trust develops strategy. The Board of Directors has considered the objectives and priorities together and with the Assurance Framework. They are used to embed quality and safety into the organisational culture. The Board of Directors believes quality and safety is the central spoke for all activity in the Trust, and this is reflected in the strategies and activities of the Quality and Safety Committee. Progress against these Strategies is reflected in the Chief Nurse and Medical Director reports. The Trust has recently reviewed the management of key elements of patient experience (including complaints, PPI, PALS) and has developed a revised approach that brings all the key elements together under the control of a central management team. This will enable the Trust to have a clearer understanding of the patient's whole experience as opposed to individual element. The Trust produces an annual Quality Report which describes the priorities for patient safety and quality and the Trust's achievements in the previous year. The report is approved by the Board of Directors and is developed with the support of the Council of Governors. The report also includes commentary from our stakeholders such as the CCG. This document provides an additional driver to the development of strategy and is used by the Quality and Safety Committee to gain assurance around the strategies being developed and implemented. The Trust has put in place a full accountability framework for the delivery of the CQUIN targets. The targets are discussed at the Quality and Safety Committee and the Finance and Performance Committee and form a key driver to improving quality across the organisation and informing strategy developments across the Trust. The Patient Reported Outcome Measures is another system that is used to support the development of strategies in the organisation.

Example good practice as proposed by Monitor	Evidence
Quality is embedded in the Trust's overall strategy - The Trust's strategy comprises a small number of ambitious Trust-wide quality goals covering safety, clinical outcomes and patient experience which drive year on year improvement - Quality goals reflect local as well as national priorities, reflecting what is relevant to patient and staff - Quality goals are selected to have the highest possible impact across the overall Trust - Wherever possible, quality goals are specific, measurable and time-bound - Overall Trust-wide quality goals link directly to goals in divisions/services (which will be tailored to the specific service) -There is a clear action plan for achieving the quality goals, with designated lead and timeframes - Applicants are able to demonstrate that the quality goals are effectively communicated and well-understood across the Trust and the community it serves -The Board regularly tracks performance relative to quality goals	The Nursing and Midwifery Strategy and Patient Safety Strategies outline the key objectives for the Trust. Underpinning this is the document 'Our Commitment to You'. The four strategic themes are included in the Board papers. The Trust has also in the process of developing a Patient Experience Strategy which links the key aspects of a patient's journey through the hospital. The quality and safety priorities identified as part of the Quality Report for the Trust are shared with staff, the CCG, Governors and local LINKs and is published on the NHS Choices website. The Report is developed through the Trust having a clear understanding of the expectations of the community. The Nursing and Midwifery strategy describes the culture of quality standards that are expected in the organisation. The Chief Nurse has introduced and made explicit the use of the 6 'C's' in the strategy. The Board of Directors developed an additional Board Committee that focuses on Quality and Safety across the organisation. The Quality and Safety Committee seeks assurance on all issues associated with clinical quality and safety. Assurance is sought through the Chief Nurse and Medical Director's reports along with the Quality and Safety performance report. The type if information includes: • Historically the Trust used Nursing Care Indicators, now the Trust is moving to Early Warning Trigger Tool (EWTT) • Quality Dashboards are being introduced to give more robust data • Clinical Quality and Safety KPIS • SUI details and associated actions • CHKS/Dr Foster analysis • Patient Experience information • Family and Friends information • Infection prevention and control information • Quality Governance Framework implementation plan The Strategic Plan and the Annual Plan are developed through understanding the Directorate goals and the expectations of the Community the Trust services and by working with the key stakeholders including the CCGs, local councils and voluntary services. The Quality Governance Framework includes a fully developed action plan which is

	reviewed by the Quality and Safety Committee on a six monthly basis. The Board of Directors have access to significant information which is summarised through a further performance report and is provided to the Board of Directors and the Executive Board on a monthly basis. The Directorates across the Trust consider their dashboards and compliance against objectives such as VTE and hand hygiene, locally through the Performance Management Meetings. Up to date quality and safety information relating to the Trust is provided for stakeholders on the Trust website. This information will include : • Infection Control • PROMs • Privacy & Dignity (same sex accommodation) • Chaplaincy services • Performance reports
MRR	**Amber/green**

1. Strategy

Is the Board sufficiently aware of potential risks to quality?

The Board of Directors is kept informed of risks to quality and safety primarily through the extensive systems that are in place. The Chief Nurse report focuses on quality of care and the Medical Director report focuses on safety. Dashboards continue to be used and will be enhanced to demonstrate levels of compliance and risk areas. The Trust is currently developing a performance booklet that provides one place for all performance results to be considered together.

The Board of Directors receives an updated quarterly Assurance Framework and Corporate Risk Register. The Trust is currently reviewing the content of the Assurance Framework and Corporate Risk Register and the risk processes employed in the Trust to ensure there is sufficient understanding in the Trust about the risks the Trust carries. The Corporate Risk Register process will be expanded to incorporate a monitoring system which will be designed to highlight escalating risks across the organisation. The Board of Directors will use these reports to assess risks to the organisation, provide challenge and agree actions to mitigate the risks. The Trust has a Board Committee that focuses on Quality and Safety Performance across the organisation. This Committee meets 10 times a year in advance of the Board meeting and reports on its findings to the Board meeting.

The Medical Director chairs a weekly quality and safety meeting which seeks to consider the deaths that occurred during the week, any incidents that have arisen during the week and any quality concerns that were raised through complaints or adverse incidents.

The Chief Nurse, Chief Executive and the complaints team review all the complaints that have been received by the Trust during the pervious week and highlight any that raise additional concerns.

All efficiency initiatives are required to provide evidence of their suitability from a quality perspective and receive a governance rating. These are reviewed by the Medical Director and Chief Nurse. Any proposal that has a low governance rating will be considered in detail by the patient safety group.

Each directorate in the organisation maintains and update its own local risk register. Directorate risk registers are discussed at both the Performance Management Meetings and locally in Directorates. All risk registers reflect both internal risks and also potential external impacts such as commissioning intentions and NICE guidance. Significant risks identified from the Directorate risk registers are added to the Corporate Risk Register that is considered by the Board of Directors.

Members of the Board of Directors have links to different parts of the organisation through committee attendance, walk rounds and support to quality related initiatives and the development of strategies.

Example good practice as proposed by Monitor	Evidence
▪ The Board regularly assesses and understands current and future risks to quality and is taking steps to address them ▪ The Board regularly reviews quality risks in an up-to-date risk register ▪ The Board risk register is supported and fed by quality issues captured in directorate/service risk registers ▪ The risk register covers potential future external risks to quality (e.g. new techniques/technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks ▪ There is clear evidence of action to mitigate risks to quality ▪ Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment) ▪ Initiatives with significant potential to impact quality are supported by a detailed assessment that could include: - 'Bottom-up' analysis of where waste exists in current processes and how it can be reduced without impacting quality (e.g. Lean) - Internal and external benchmarking of relevant operational efficiency metrics (of which nurse/bed ratio, average length of stay, bed occupancy, bed density and doctors/bed are examples which can be markers of quality) - Historical evidence illustrating prior experience in making operational changes without negatively impacting quality (e.g. impact of previous changes to nurse/bed ratio on patient complaints) ▪ The Board is assured that initiatives have been assessed for quality ▪ All initiatives are accepted and understood by clinicians ▪ There is clear subsequent ownership (e.g. relevant clinical director) ▪ There is an appropriate mechanism in place for capturing front-line staff concerns, including a defined whistleblower	The Chief Nurse and Medical Director reports are considered monthly by the Board of Directors. The reports capture quality and safety performance from across the enlarged organisation. The Quality and Safety Committee provide a summary of the discussions from their session held in advance of the Board of Directors. The items included in the Assurance Framework and Corporate Risk Register are associated with the agenda of a Board Committee. The Board Committee will develop its work programme to take account of the risks and the assurances in place. Through the governance structure existing reporting functions are strengthened and expanded to ensure the Board of Director's receive appropriate information from which to make valued judgements in relation to quality and safety. Information will derived from the following sources: • Chief Nurse and Medical Director reports • Performance management meetings • Quality and Safety Committee • Additional subject matter based information from the Chief Nurse or Medical Director as appropriate • Audit Committee • Safety Walk rounds The organisation continues to actively benchmark itself against peers both nationally and regionally, using recognised tools and metrics e.g. NHS Quest, Dr Foster and CHKS. The Trust's Patient Safety strategy and dashboards include relevant national and local metrics to monitor quality related performance. Where risks or poor performance are identified the responsible directorate will be required to develop action plans that will be monitored through the performance management framework. All efficiency initiatives across the organisation are considered by the Efficiency Committee a work stream of the Strategic Executive Group. All initiatives are, and will continue to be, reviewed by the Chief Nurse and/or Medical Director and will not proceed unless they are confident there will not be any adverse impact on patient safety and quality. All efficiencies are now required to have a 'governance rating' too. All proposed initiatives will be risk assessed and monitored by the directorate management team for the potential impact on quality of care. All initiatives will be monitored and tracked through the Performance Management process.

policy ▪ Initiatives' impact on quality is monitored on an ongoing basis (post-implementation) ▪ Key measures of quality and early warning indicators identified for each initiative ▪ Quality measures monitored before and after implementation ▪ Mitigating action taken where necessary	Policies across the organisation have been standardised including the 'Whistleblowing' policies. The Whistleblowing Policy is publicised widely across the enlarged organisation through the intranet, team brief and staff side. The use of the policy is reported to the Board.
MRR	**Amber/green**

2. Capabilities and culture

Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?

The Board of Directors membership was reviewed in 2012, and it will continue to be reviewed going forward, to ensure the Board of Directors has the correct membership to execute its role effectively. There is at least one Board Away Day a year which will have a defined agenda including items that relate to patient safety, clinical effectiveness and patient experience.

The Medical Director and the Chief Nurse maintain responsibility for reporting quality and safety to the Board of Directors. The Medical Director and Chief Nurses keep the Board of Directors informed of any quality and safety policy changes that may impact on the Organisation.

Support structures for the Medical Director were enhanced in 2012. The Chief Nurse role has, during the year, been held by the Deputy Chief Executive and Chief Operating Office. Currently the former Director of Nursing is acting as the interim Chief Nurse until a substantial appointment has been made. The Interim Chief Nurse is supported by the Corporate Nursing Team. Members of the Board of Directors through their membership of key quality and safety groups will continue to consider and challenge quality and safety information.

The Medical Director, Interim Chief Nurse and Chief Executive together with one of the Non Executive Directors have received specific training in relation to patient safety and quality (LIPS and IHI safer patients' initiative) during the last five years. The Medical Director has recently completed the Kings Fund Strategic Medical Director Programme.

The Executive Directors collectively are responsible for different aspects of quality.

Example good practice as proposed by Monitor	**Evidence**
▪ The Board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review (either through participation in Audit Committee or relevant quality-focused committees and sub-committees) ▪ The capabilities required in relation to delivering good quality governance are reflected in the make-up of the Board ▪ Board members are able to: - Describe the Trust's top three quality-related priorities - Identify well- and poor-performing services in relation to quality, and actions the Trust is taking to address them, - Explain how it uses external benchmarks to assess quality in the organisation (e.g. adherence to NICE guidelines, recognised Royal College or Faculty measures) - Understand the purpose of each metric they review, be	• The Board Development Programme includes regular development sessions that relate to quality and safety e.g. CQC, Patient Feedback, annual risk management awareness training. • There is a well established Quality and Safety Committee • The Medical Director and Interim Chief Nurse continue to take the lead for quality and safety at the Board. • All Non-executive Director posts are and will continue to be competency tested to ensure the skills required by the Board are tested before appointment. • Board members approve the Corporate Risk Register on a quarterly basis and the Interim Chief Nurse and the Medical Director identify in their reports the key risks within the organisation around quality and safety. • Non-executive Board members continue to keep their skills and knowledge up to date through their links with the Directorates and Executives. • The Board does receive information about how the Trust benchmarks against other organisations e.g.CHKS, Dr Foster, NICE guidance, but this is being

able to interpret them and draw conclusions from them - Be clear about basic processes and structures of quality governance - Feel they have the information and confidence to challenge data - Be clear about when it is necessary to seek external assurances on quality e.g. how and when it will access independent advice on clinical matters ▪ Specific examples of when the Board has had a significant impact on improving quality performance (e.g. must provide evidence of the Board's role in leading on quality) ▪ The Board conducts regular self-assessments to test its skills and capabilities and has a succession plan to ensure they are maintained ▪ Board members have attended training sessions covering the core elements of quality governance and continuous improvement	developed further. • The Board of Directors is involved with reviewing the Quality Report through the Quality and Safety Committee. The Board receives regular reports on quality and safety performance and risks across the organisation. • The Audit Committee will continue to receive an annual review from Internal Audit relating to the effectiveness of governance arrangements in place in the organisation. • Board members will undertake leadership walk rounds to gain an understanding of quality, safety and risk issues across the organisation • The Board carries out an annual self assessment to test its capabilities through the annual appraisal system of all members of the Board. Other examples of evidence to demonstrate Board involvement and knowledge awareness will include: • Board discussions relating to CQC compliance and the quarterly compliance report • Council of Governor's committee such as the Patient Focus Group • Use of patient feedback letters at the Board of Directors meetings – complaints and 'thank you" letters owned by Executives and Non Executives • NEDS are linked to specific areas of business in the organisation • A NED has responsibility for chairing the Quality and Safety Committee
MRR	Amber

2. Capabilities and culture

Does the Board promote a quality-focused culture throughout the Trust?

Through the Nursing and Midwifery Strategy, the Patient Safety Strategy and supporting objectives the Trust demonstrates commitment to providing high quality and safe care throughout the whole organisation. The governance arrangements ensure that the Board members are represented on a number of key quality committees and groups thereby ensuring they play an active role in the quality agenda. The Quality and Safety Committee (a Board Committee) receives assurance on the implementation of the Nursing and Midwifery Strategy and the Patient Safety Strategy. The Committee will also have sight and understanding of the actions being completed in the implementation plan so gaining additional assurance about the Strategies. The Committee's agenda is linked to the Assurance Framework and Corporate Risk Register so the Committee can assure itself that its work programme is addressing the issues that are linked to risk and assurance.

The Board of Directors' agenda has been developed to emphasise and promote the importance of quality and safety, which is discussed in the first part of the Board agenda. Complaints, compliments and patient and staff stories will continue to feature as part of the Board meeting.

The arrangements in place put a quality and safety culture at the centre of the Trust's priorities. The Trust uses leadership walk rounds across the organisation as a focus for promoting quality and safety. The Organisational Development and Learning Strategy promote the Vision and Values for the organisation and ensure that staff remain fit for future practice and deliver safe and effective healthcare. The Trust has in place a personal responsibility framework that defines the responsibilities placed on all staff. The Trust is also utilising the 'Institute for Health Improvement' (IHI) methodology to assist individual and organisational learning. The Board of Directors aims to provide support and opportunity for staff to highlight issues of safety and quality through sharing good practice, identifying areas for improvement and encouraging escalation of issues.

A communications plan for the Trust will be used to promote the quality and safety culture and allow staff to identify with the organisation. The plan will include expanding some existing mechanisms including Staff Matters and Risky Business.

Example good practice as proposed by Monitor	**Evidence**
▪ The Board takes an active leadership role on quality ▪ The Board takes a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations) ▪ The Board regularly commits resources (time and money) to delivering quality initiatives ▪ The Board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally by Board members) ▪ The Board encourages staff empowerment on quality ▪ Staff are encouraged to participate in quality / continuous improvement training and development	Board members continue to be involved in a leadership capacity to encourage a Trust wide commitment to improving quality. Board development, a revised governance structure and support for Executive Directors is in place to ensure that quality is promoted across the organisation. The following good practices are in place across the organisation. • The Medical Director and the Interim Chief Nurse hold a weekly quality and safety meeting with briefings from key members of their staff, which has a clear agenda discussing patient deaths, adverse incidents reported, SIs, complaints received, infection prevention data, claims received and settled, inquests, safeguarding, NPSA alerts, MDA alerts and DH alerts. This meeting acts as quick identifier for potential risks and mitigating actions

▪ Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment) ▪ Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery) ▪ Internal communications (e.g. monthly newsletter, intranet, notice boards) regularly feature articles on quality	• Board members undertake regular Patient Safety Rounds • The Quality and Safety Committee reviews the NRLS report and challenges the performance. • The senior nursing team undertake quality walk rounds • Governors are involved with unannounced visits to wards • Monthly and yearly staff awards recognising contribution to patient safety specifically are awarded by the Trust • The Executive Board members lead on a number of quality initiatives e.g. Interim Chief Nurse for Patient Experience • The Trust has included complaints and PPI as part of the Patient Experience service so that there is a cohesive approach to quality. The organisation continues to promote a 'no blame' culture that encourages reporting and learning. The no blame culture will be communicated through specific policies for AIRS, CIs and SIs. The learning from serious and adverse incidents and audit will continue to be communicated through Suitcases, at Executive level, and Briefcases throughout the organisation. The Trust is continuing to develop and enhance the SI systems to ensure leaning is maintained and evidenced. Learning from other organisations and events will continue to be shared with the Board of Directors through the Medical Director and Interim Chief Nurse monthly reports. Team Brief and the Staff Matters publications currently include references and articles on quality and safety on a regular basis. The Trust also produces a publication call Risky Business which updates staff on issues related to quality and safety and risk. The Trust has identified Ms L Raper as the Non-executive Lead for quality in the organisation
MRR	Amber/green

3. Structures and Processes	
Are there clear roles and accountabilities in relation to quality governance? A governance structure has been set out for the organisation together with a fully developed management structure. The Board is ultimately accountable for delivering quality within the organisation and has identified the Medical Director and Interim Chief Nurse as responsible for providing assurance to the Board on quality and safety. Board members, through their job descriptions and membership of key quality committees, have clearly defined accountabilities in relation to governance. To provide further assurance the governance structure includes a Board Committee, the Quality and Safety Committee. Terms of reference for committees and groups are clearly defined to ensure clear roles and accountabilities together with defined reporting structures and frequencies. This approach is to support the appropriate flow of information relating to quality governance to the Board of Directors and throughout the organisation. The Board of Directors is responsible for ensuring that the Nursing and Midwifery Strategy and Patient Safety Strategy are supporting the objectives and are communicated to staff so that the priorities are understood and acted on. The Board will be able to triangulate the effectiveness of communications with the information and assurance received through Board reporting and, through the Patient Safety walks rounds and visits to clinical areas.	
Example good practice as proposed by Monitor	**Evidence**
▪ Each and every board member understands their ultimate accountability for quality ▪ There is a clear organisation structure that cascades responsibility for delivering quality performance from 'Board to ward to Board' (and there are specified owners in-post and actively fulfilling their responsibilities) ▪ Quality is a core part of main Board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions ▪ Quality performance is discussed in more detail each month by a quality-focused board sub-committee with a stable, regularly attending membership	At Board level the Interim Chief Nurse and Medical Director lead on individual elements of the Nursing and Midwifery Strategy and Safety Strategy. The Trust has identified a Non-executive lead for quality and Safety. All the Corporate Directors have portfolios that collectively cover the organisation. The Directors attend (or have deputies attending) specific meetings where quality governance is discussed including; • Quality and Safety management meetings • Quality and Safety Committee • The Executive Board where Clinical Directors are members • Nursing Board and Clinical Standards Committee Clinical Directors, Directorate Managers and Matrons are currently held accountable for achievement of local targets. Progress against local targets and goals are monitored through the corporate performance information which is reviewed at Performance Management and Performance Improvement meetings. Directorates keep contemporary risk registers and significant risks are reviewed by the Board of Directors on a quarterly basis through the Corporate Risk Committee. Directorates throughout the organisation are aware of the process for escalating risks corporately.

	Currently significant work is being undertaken to validate and improve the directorate risk register. This work relates to the reviewing of the escalation system for risks. Responsibility for governance is currently included in the job descriptions of all the key leadership roles and this practice will be expanded across the enlarged organisation.
MRR	Amber/green

3. Structures and Processes	
Are there clearly defined, well understood processes for escalating and resolving issues and managing performance? As part of the integration process both Boards have taken the opportunity to consider the current systems and processes in operation and have as a result revised the governance arrangements that will be in place for the organisation. The arrangements have been following an iterative process and building on recommendations from due diligence reports and Reporting Accountant reports (information obtained as part of the acquisition of SNEY). All employees in the organisation continue to be made aware of their responsibilities associated with quality, safety and other risk issues. All staff are encouraged to identify and escalate any concerns directly to their managers, to the HR department or by utilising the Whistleblowing Policy. Senior staff including medical staff can also report issues to the Senior Independent Director. The management of performance takes place at a Directorate level through the various Performance Management Meetings. Performance across the organisation is reported to the Board of Directors by the Chief Operating Officer. The Directorate Risk Registers feed into the Corporate Risk Register which is used as another mechanism for capturing and escalating risks to Board. The Healthcare Governance Unit monitors and escalates any issues to ensure a co-ordinated approach. The Nursing team has been strengthened by undertaking a review and restructuring the role of the Matrons and Sisters and developing the Corporate Nursing Team. The Board has introduced a further board committee responsible for risk. The Corporate Risk Committee meets on a quarterly basis and reviews the Corporate Risk Register and Assurance Framework in advance of the Board. The Committee holds the Corporate Directors to account for the risks and assurances identified on the documents. The Medical Director report identifies potentially significant issues relating to individual practitioners to the Board. The Interim Chief Nurse report identifies significant individual and professional reputation issues. The HR Director reports any further significant staff issues to the Board.	
Example good practice as proposed by Monitor	**Evidence**
▪ Boards are clear about the processes for escalating quality performance issues to the Board - Processes are documented - There are agreed rules determining which issues should be escalated. These rules cover, amongst other issues, escalation of serious untoward incidents and complaints ▪ Robust action plans are put in place to address quality performance issues (e.g., including issues arising from serious untoward incidents and complaints). With actions having: - Designated owners and time frames - Regular follow-ups at subsequent Board meetings ▪ Lessons from quality performance issues are well-	The governance structure provides for a series of governance meetings across the organisation to monitor and track delivery of quality governance, and to ensure issues are captured, monitored and escalated where appropriate. • Performance management structures are in place across organisation. • Key performance indicators are articulated throughout the organisation and measurement systems are in place. Aggregate data will be supplied through Medical Director and Chief Nurse Reports but data will continue to be analysed at site/locality level to ensure individual trends are not masked. E.g., Maternity data. • Governance and management structures are in place across the organisation that support both culture and systems change required to drive up standards in relation to patient safety.

documented and shared across the Trust on a regular, timely basis, leading to rapid implementation at scale of good-practice ▪ There is a well-functioning, impactful clinical and internal audit process in relation to quality governance, with clear evidence of action to resolve audit concerns - Continuous rolling programme that measures and improves quality - Action plans completed from audit - Re-audits undertaken to assess improvement ▪ A 'whistleblower'/error reporting process is defined and communicated to staff; and staff are prepared if necessary to blow the whistle ▪ There is a performance management system with clinical governance policies for addressing under-performance and recognising and incentivising good performance at individual, team and service line levels	• An Internal Audit Programme reviewed on an annual basis to ensure it is picking up the organisational risks is in place. The Trust makes use of the existing audit alliance within North Yorkshire • The Corporate Risk Committee has responsibility for understanding and reviewing the Corporate Risk Register and Assurance Framework and will raise any areas of concern with the appropriate Director or with the Board of Directors. • The Performance Management Meetings will develop to encompass the enlarged organisation. The Patient Safety Group provides an additional environment for escalating issues, monitoring actions and sharing learning. Any issues identified is escalated through to the Board of Directors as appropriate through the key quality and safety reports. Ongoing learning and continuous improvement will continue to be encouraged within the organisation through action planning, and sharing lessons learned. Examples include Briefcase, Suitcase and Performance Management Meetings, which are been shared across the organisations.
MRR	Amber/green

3. Structures and Processes	
Does the Board actively engage patients, staff and other key stakeholders on quality? The Trust has engaged stakeholders as part of undertaking business and will continue to encourage all key stakeholders to be actively engaged in quality discussions and activities, including being involved and commenting on the development of the Quality Report and the priorities included in the report each year. The Council of Governors represents members of the Trust and is made up of public, stakeholder and staff governors. The Quality Report and the Annual Report will continue to be publicly available through the internet and hardcopy documents. The Board receive reports on the Annual Patient and Staff Surveys, and regular reports on the CQC assessments as they occur. Through the Assurance Framework, Corporate Risk Register and the Interim Chief Nurse and Medical Director's reports the Board will be kept informed of patient related information including SIs, CIs, and infection control and morality rates. Where any significant patient care or reputational issues arise the Board of Directors are informed at the earliest opportunity. Staff will continue to be encouraged by the Board of Directors to be involved in all aspects of quality within their area of expertise. Staff will be empowered to encourage patients to be involved through providing feedback to staff either in specific focus groups or on a more general basis.	
Example good practice	**Evidence**
Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance ▪ The Board actively engages patients on quality, e.g: - Patient feedback is actively solicited, made easy to give and based on validated tools - Patient views are proactively sought during the design of new pathways and processes - All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the Board - The Board regularly reviews and interrogates complaints and serious untoward incident data - The Board uses a range of approaches to bring patients	The Trust uses a number of different forums to engage staff, patients and other key stakeholders from across the enlarged organisation on issues of quality and safety building on existing mechanisms. The Membership and Governors representation represents the wide geographical patch covered by the Trust and links have been established to ensure there is total representation in the development of quality reports and priorities. An executive-led Patient Experience Group exists to ensure themes and trends are recognised in the Annual Plan and by the Governors groups. The Trust also has in place the following: • Annual patient surveys will be considered by the Board of Directors and published on the website with coordinated action plans developed through the Patient Experience Teams. • Feedback from staff will continue to be actively encouraged through the staff survey, leadership walk rounds, through Trust Brief and other departmental meetings. • Staff will continue to be engaged with delivery of quality improvement initiatives.

into the Board room (e.g. face-to-face discussions, video diaries, ward rounds, patient shadowing) ▪ The Board actively engages staff on quality, e.g.: - Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (e.g. monthly „temperature gauge" plus annual staff survey) - All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the Board ▪ The Board actively engages all other key stakeholders on quality, e.g.: - Quality performance is clearly communicated to commissioners to enable them to make educated decisions - Feedback from PALS and LINks is considered - For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway - The Board is clear about Governors' involvement in quality governance.	• Matrons will continue to encourage patients and where appropriate visitors/ relations of patients to be involved in issues identified as a complaint. • Patient feedback will be sought on a regular basis through focused work within directorates and wards e.g. current redesign processes in ED supported by 24 hour customer feedback undertaken by governors/ development of a patients' safety DVD to highlight the impact of harm on individual. • Input from LINks, PPI, PALS, and the Overview and Scrutiny Committee. • Nursing Care Indicators gather monthly patient data from every ward. • The Governors are involved in the development of the quality report and are a key element of the PLACE system. The Governors have membership at the Patient Experience Group. Regular updates are given to the Governors around quality and safety issues at the Council of Governors meeting
MRR	Amber

4. Measurement	
Is appropriate quality information being analysed and challenged? The current Trust dashboard provides composite information including quality information and is provided to the Board of Directors on a monthly basis. Some of the systems which support the dashboards are 'real time' system available to Board members to consider during the month. The Clinical Patient Database (CPD) is in place in all key clinical areas so staff can update clinical records in real-time. The Board will continue to consider the Outcome Framework, Everyone Counts Planning and the Risk Assessment Framework along with local documents such as the CCG commissioning intentions and their Strategic Plans when they are published and other key pieces of national guidance (CQC/HSMR/CQUIN) which may inform quality information and data capture requirements. This information is used to inform the Trust's objectives and annual planning. Key performance indicators are in place that demonstrates both aggregate and site based performance using Directorate/Specialty quality and safety indicators.	
Example good practice	**Evidence**
▪ The Board reviews a monthly 'dashboard' of the most important metrics. Good practice dashboards include: - Key relevant national priority indicators and regulatory requirements - Selection of other metrics covering safety, clinical effectiveness and patient experience (at least 3 each) - Selected 'advance warning' indicators - Adverse event reports/ serious untoward incident reports/ patterns of complaints - Measures of instances of harm (e.g. Global Trigger Tool) - Monitor's risk ratings (with risks to future scores highlighted) - Where possible/appropriate, percentage compliance to agreed best-practice pathways - Qualitative descriptions and commentary to back up quantitative information ▪ The Board is able to justify the selected metrics as being: - Linked to Trust's overall strategy and priorities - Covering all of the Trust's major focus areas - The best available ones to use - Useful to review ▪ The Board dashboard is backed up by a 'pyramid' of more	The Board of Directors does receive performance information against key metrics through a suite of reports provided by the Executive Directors. The Trust has mortality review in place to enable more detailed understanding of themes and trends in mortality and care reviews. This includes a review of every patient that dies having their care reviewed by a senior clinician. The quality and safety objectives are monitored through the use of directorate level dashboards and Performance Improvement Meetings, which then feed up to the Board of Directors. The Quality and Safety Committee reviews quality performance metrics as part of its monthly discussions and provides assurance to the Board against its findings. These mechanisms ensure the identification of unacceptable variation. • The Quality and Safety dashboard identifies the specific key metrics that have been agreed and these cover patient safety and clinical effectiveness. • The Performance Dashboard includes key safety and quality measures and is available in real time and provides the Board of Directors with the most up to date information. The relationship between all dashboards is a triangulation of information at the Board meeting where there is an opportunity to test the dashboards against each other.

granular reports reviewed by sub-committees, divisional leads and individual service lines ▪ Quality information is analysed and challenged at the individual consultant level ▪ The Board dashboard is frequently reviewed and updated to maximise effectiveness of decisions; and in areas lacking useful metrics, the Board commits time and resources to developing new metrics	At directorate level dashboards continue to include a RAG rating and an area dedicated to monitoring of Infection Prevention and Control. CHKS data will be analysed at directorate level and mortality rates will also be explored down to consultant level.
MRR	Amber

4. Measurement	
Is the Board assured of the robustness of the quality information? On behalf of the Board of Directors the Audit Committee is responsible for considering data quality throughout the organisation. The Audit Committee has an established working group with responsibility for specifically reviewing data quality information. The group will continue to report to every Audit Committee on its work. The Group will include the performance of Service Line Reporting and the impact on data quality as the organisation implements the system.	
Example good practice	**Evidence**
▪ There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness - Each directorate/service has a well-documented, well-functioning process for clinical governance that assures the Board of the quality of its data - Clinical audit programme is driven by national audits, with processes for initiating additional audits as a result of identification of local risks (e.g. incidents) - Electronic systems are used where possible, generating reliable reports with minimal ongoing effort - Information can be traced to source and is signed-off by owners ▪ There is clear evidence of action to resolve audit concerns - Action plans are completed from audit (and subject to regular follow-up reviews) - Re-audits are undertaken to assess performance improvement ▪ There are no major concerns with coding accuracy performance	Each directorate/service has a clinical governance process that identifies where issues of data quality exist and this will be monitored through the Medical Director's office and through performance monitoring. Quality and safety performance is also monitored through the Performance Improvement Meetings which the Medical Director chairs. Both clinical and internal audit teams undertake audits that provide assurance of the systems in place and that improvements in performance are being made. Audit also tests the robustness of data capture processes in place. The Internal Audit programme is reviewed annually and approved by the Audit Committee. Utilising internal audit will seek to give assurance that recommendations have been implemented across the enlarged organisation. The Audit Committee review the Assurance Framework and Corporate Risk Register as part of their assurance. The Clinical Audit programme is aligned across the organisation ensuring that essential audits are carried out throughout all appropriate locations. The Quality Report includes the clinical audits undertaken during the year. The clinical audit programme is driven by national audits e.g. NCEPOD with additional audits being undertaken as a result of risks identified locally. Action plans are put in place where audits identify specific actions and are reviewed and monitored for progress. The Trust has rolled out CPD across the Trust. This is a real-time system that captures data including quality data. The information captured can be traced to the source as it is signed off by the owner. The Trust has a Data Quality Group in place that reports to the Audit Committee and reviews the quality of information in the organisation.

	Compliance with the Information Governance toolkit is undertaken by both Trusts and will continue to be assessed across the enlarged organisation.
MRR	Green

4. Measurement	
Is quality information being used effectively? The Board continues to use quality information as a source of assurance of the governance processes in place and expects the information to reflect the performance of the organisation in relation to quality and safety. Through the Trust's committees and groups and the associated reporting mechanisms the Board of Directors receives a comprehensive portfolio of information which is scrutinised both for good practice and to identify governance risks. During 2013/14 the Trust was subject to an annual plan stage 2 review – risk to quality. The review provided significant assurance that the Trust had the information and systems in place. It also identified some areas for improvement including the development of a single dashboard for use across the organisation.	
Example good practice	**Evidence**
Information in Quality Reports is displayed clearly and consistently Information is compared with target levels of performance (in conjunction with a R/A/G rating), historic own performance and external benchmarks (where available and helpful) Information being reviewed must be the most recent available, and recent enough to be relevant 'On demand' data is available for the highest priority metrics Information is 'humanised'/personalised where possible (e.g. unexpected deaths shown as an absolute number, not embedded in a mortality rate) Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance	The Board receives information presented through the Medical Director and Chief Nurse reports and Performance Report. The reports have been refined to focus on quality of care and safety and will use dashboards enhanced to demonstrate compliance and risk areas. The Board also receives performance information from quality and safety and wider performance across the Trust. Statistical process charts and run charts are used to demonstrate improvements and where there areas for improvement. Key performance indicators form the basis of both reports and enable concise exception reporting. The organisation assists the public and its staff in understanding the national benchmarking data by presenting information in clear formats. Membership to NHS Quest will provide the opportunity to benchmark further upper quartile performance. As a national quality dashboard is developed this will be used to standardise presentation and manage performance across the enlarged organisation. Reports will demonstrate where improvement has been made and how learning has been spread across the entire organisation. Reports will also highlight where trends are occurring and risks need managing. Datix Web is used across the enlarged organisation and provides a central reporting

	system for identifying incidents for reporting locally and nationally.
MRR	Amber

Implementation Plan for the Quality Governance framework – August 2014

Strategy				
Action	**Link to QGF**	**Review and Deliver by**	**Responsible officer**	**Management responsibility**
Develop and agree the Public and Patient Involvement Strategy for the organisation.	1a	December 2014	Interim Chief Nurse	Director of Nursing
Develop and agree the 2015/16 Corporate Governance Strategy and Plan for the organisation.	1a	May 2015	Chairman Chief Executive	Foundation Trust Board Secretary
Revise and agree the Safety Strategy for the organisation. The Strategy will include a comprehensive delivery plan with agreed timeframes	1a	July 2014	Medical Director	Deputy Director for Patient Safety
Commence the process for the development of the 2014/15 quality and safety plans and quality accounts.	1a	October 2014	Medical Director	Medical Director
Standardise policies across the organisation, develop and implement a planned programme for policy update and implementation.	1a	January 2015	Chief Executive	Assistant Director of Healthcare Governance Unit
Complete action plan from the Safeguarding business case to ensure one signal executive lead for the Trust	1b	December 2014	Interim Chief Nurse	Directorate Manager and Lead for Safeguarding

Complete review of risk management systems and follow up training. Review of risk reporting across the whole organisation	1b	December 2014	Chief Executive	Assistant Director of Healthcare Governance
Develop a comprehensive Healthcare Governance Training Programme for the organisation. Training programme to cover accountability for CQC, NHSLA and risk management training based on the risks and needs identified.	1b	December 2014	Chief Executive	Assistant Director of Healthcare Governance Unit
Assessment of compliance against agreed national standards	1b	April 2014	Chief Executive	Assistant Director of Healthcare Governance
Introduction and implementation of EWTT and NQD	1b	September 2014	Interim Chief Nurse	Assistant Director of Nursing
Develop and implement safeguarding processes and training needs around adult and child safeguarding	1b	December 2014	Interim Chief Nurse Chief Executive	Interim Chief Nurse

Capability and culture				
Action	**Link to QGF**	**Review and Deliver by**	**Responsible officer**	**Management responsibility**
Review the process walk rounds across the organisation.	2a	April 2015	Medical Director	Deputy Director for Patient Safety
Develop and implement a communication plan to raise awareness and develop understanding of the quality governance plan.	2b	March 2015	Chief Executive	Head of Communications
Develop a planned programme of medicines management for the organisation.	2b	December 2014	Medical Director	Medicines Management Group
Compliance against IPC strategy and implementation of changes	2b	October 2014	Medical Director	Deputy DIPC

Structures and processes				
Action	**Link to QGF**	**Review and Deliver by**	**Responsible officer**	**Management responsibility**
Review and agree the reporting structure for Patient Safety Group to ensuring all sub groups report effectively.	3a	December 2014	Medical Director	Assistant Director of Healthcare Governance Unit
Review the approach to the implementation of compliance reviews across the organisation	3b	November 2015	Chief Executive	Assistant Director of Healthcare Governance

Measurements				
Action	**Link to QGF**	**Review and Deliver by**	**Responsible officer**	**Management responsibility**
Introduce a more robust complaints report	4a	April 2015	Interim Chief Nurse	Head of Patient Experience
Implement a quarterly Claims Report for directorates across the organisation.	4a	December 2014	Assistant Director of Healthcare Governance Unit	Head of Risk and Legal Services
Learning from events and disseminating that learning across the organisation	4c	March 2015	Interim Chief Nurse	Senior Nursing Team
External benchmarking for quality metrics to continue to be developed as part of Board reporting	4c	October 2014	Chief Nurse Medical Director	Assistant Director of Patient Safety
Development and enhancement of the SI system to ensure learning is maintained and evidenced	4c	October 2014	Medical Director	Associate Director of Healthcare Governance

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

National Cancer Patient Experience Survey 2014

Action requested/recommendation

It is recommended that:

- The survey findings are shared with all staff groups involved in providing cancer care to patients and their relatives at the earliest opportunity. – completed 25/9/14 by the Cancer Manager
- The working group, set up in 2012, continues to meet to develop the 2014-2015 action plan building on the 2012-2014 plan.
- The findings from the survey are fed back to patients, relatives, user and support groups across the Trust.
- The findings from the survey are fed back to the local CCGs to support the development of their own action plans as a result
- The Governors are briefed on the findings at a future Council of Governors meeting
- The survey is shared with our local Healthwatch organisations.
- Patient comments and feedback from the survey are shared across the organisation and with primary and social care where this is appropriate (at the time of this paper, Quality Health have not released the patient comments report).

Summary

This paper summarises the key findings of the National Cancer Patient Experience survey 2014, carried out by Quality Health on behalf of the Department of Health. The survey is a Trust-wide survey covering Scarborough Hospital and York Hospital.

This is a mandated annual survey.

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

Outcomes 1, 4, 9, 16

Progress of report	Board of Directors – 29th October 2014 York District Cancer Partnership Group – 3rd December 2014 Cancer Board – December 2014 Clinical Nurses Specialist Group – date tbc
Risk	No risk
Resource implications	There are no identified resource implications
Owner	Beverley Geary, Chief Nurse
Author	Kay Gamble, Lead for Patient Experience
Date of paper	4th October 2014
Version number	V2

Board of Directors – 29 October 2014

National Cancer Patient Experience Survey 2014

1. Introduction and background

The National Cancer Patient Experience survey forms part of an annual mandatory requirement for the Trust.

This paper summarises the key findings of the National Cancer Patient Experience survey 2014, carried out by Quality Health on behalf of the Department of Health. The survey provides information that the Trust can use to drive local quality improvements.

One hundred and fifty three acute hospital NHS Trusts providing cancer services took part in the survey, accounting for every Trust that provides adult cancer care in England.

All adult patients (16 and over) with a primary diagnosis of cancer who had been admitted to hospital as an inpatient or as a day case patient and were discharged between 1st September 2013 and 30th November 2013, were invited to take part in the postal survey.

A total of 1145 eligible patients from our Trust were sent a survey with 744 questionnaires returned completed. This represents a response rate of 71%, compared to the national response rate of 64%.

This is the second National Cancer Patient Experience Survey carried out following the acquisition of Scarborough and NE Yorkshire Healthcare NHS Trust in July 2012 and therefore provides us with a mechanism to clearly compare our results to the 2012/13 survey and allow us to see where we have improved and what our key priorities are.

2. Overall Findings:

Overall responses to the 62 questions asked, shows that:

36 questions placed the Trust in the top 20% of Trusts
0 questions placed the Trust in the bottom 20% of Trusts
26 questions placed the Trust in the remaining 60% of Trusts

93% of patients rated their care as either excellent or very good an increase of 2% compared to 2012/13.

The findings from the survey are extremely pleasing for the Trust and recognise the improvements that have been made from past survey findings. Many of the tumour groups had percentages above the national such as Colorectal with 92% of responses above the national percentage, Urology with 85% and Haematology with 83% being the top 3.

The results reflect the hard work and dedication of the Cancer Clinical Nurse Specialists, the Clinical Teams including the Diagnostic Services and the myriad of other staff involved in cancer patient care. However, we are not complacent and will work together on the areas that need improvement and expect to show those improvements in the 2016 results.

2.1 Key positive findings:

93% of respondents rated their care as either excellent or very good
89% reported that they were always treated with respect and dignity
90% of respondents said that they were given easy to understand written information about their test
88% reported that staff gave complete explanation of purpose of the test
90% reported that staff explained completely what would be done during the test
93% reported that the CNS definitely listened carefully
93% reported that the CNS gave understandable answers to important questions all/most of the time
90% reported that staff gave complete explanation of what would be done during their operation
88% reported that doctors gave understandable answers to important questions all/most of the time
88% reported that they had confidence and trust in all doctors treating them
88% reported that nurses did not talk in front of them as if they were not there
97% of patients reported that staff told them who to contact if worried post discharge
92% reported that they were given the right amount of information about condition and treatment

2.2 Key Areas for improvement:

66% reported that they were able to discuss worries or fears with staff during visit
65% reported that family definitely given all information needed to help care at home (this % places the Trust in the highest 20% of trusts nationally, but remains an area for improvement)
83% reported that they had seen information about cancer research in the hospital
93% reported that they were always given enough privacy when being examined or treated (this % is only 2% above the lowest 20% of Trusts and whilst a 1% rise from 2012/13 will be reviewed to improve in this area).

2.3 Tumour Site reporting – positives

The survey additionally reports the 62 questions broken down into tumour sites. Where the number of respondents is less that 20, the answers are not published, although patients comments will be published in due course and will be a valuable source of feedback for the Trust.

With such positive survey results, it is impossible to summarise all tumour sites; below is an example of some of the areas where patients report highly on questions; where improvements have been made on past surveys and where improvements are required from this survey:

Head & Neck:
70% reported that they taking part in cancer research was discussed with patient – this is an increase from 35% in 2013
75% reported that they had been told about side effects that could affect them in the future – this is an increase from 50% in 2013
91% reported that they were definitely involved in decisions about care and treatment
89% reported that their views were definitely taken into account by doctors and nurses discussing treatment

Gynaecological:

100% rated their care excellent or very good
94% reported that they had been given the name of CNS in charge of their care

Lung: (this is an tumour site that has historically not had enough respondents for the Trust to receive a breakdown, however in 2014 more patients responded and it is therefore really beneficial for the Trust that we can, for the first time, have feedback and allow comparisons with other tumour sites where required.

97% reported that they had been given the name of CNS in charge of their care
100% reported that they got understandable answers to important questions all/most of the time
93% reported that the CNS definitely listened carefully the last time spoken to
87% reported that they felt they were sensitively told they had cancer
96% reported that staff gave a complete explanation of purpose of test(s)

2.4 Tumour site reporting – areas for improvement:
All tumour sites are considering areas for improvement currently and it is not possible to summarise all tumour sites in this report. As an example of the areas being considered, below are some potential areas of improvement for the UGI tumours;

65% reported that they felt they were sensitively told they had cancer (National 81%)
60% reported that they had been given written information about the type of cancer they had (National 66%)
71% reported that they got understandable answers to important questions all/most of the time from Hospital Doctors (National 81%)
71% reported that they had confidence and trust in all doctors treating them (National 83%)
43% reported that they had confidence and trust in all ward nurses (National 67%)

Please refer to full National Cancer Patient Experience survey for breakdown of other tumour sites.

3. Conclusion

The 2014 National Cancer Patient Experience survey has provided the Trust with some excellent feedback. It highlights areas where the Trust is performing well and also highlights the areas in which the Trust needs to improve and prioritise action planning.

Staff should be congratulated that the Trust scores within the highest 20% of Trusts on the majority of questions with the remaining questions placing us within the middle 60% of Trusts, nationally and no questions placing us in the bottom 20%.

We should also note that a threshold for placing a trust within the highest 20% of trusts and the lowest 20% of trusts can be very small and therefore there are responses where the Trust borders on being in the top % of trusts on a number of questions but equally could move into the bottom or middle %.

Once again, the survey reflects the individualised holistic care that the cancer multi-disciplinary teams aim to deliver to patients. The improved quality in care and provision of information delivered by the clinical nurse specialist acting as the patient's key worker continues to be evident across the Trust.

We value greatly that, not only do such a large number of patients take the time to complete the questionnaire but also that 93% of those patients report their care as excellent or very good. The Trust is committed to listening to the views of our patients and acting upon their

feedback and this survey, along with the national Friends Family Test allows us to build upon what our patients tell us is important to them.

A main priority from the 2011/12 survey was that we did not communicate nor provide information to patients equitably across the whole Trust. It is therefore encouraging to see that our scores in these areas have increased and work continues to improve further in these areas.

4. Recommendation

It is recommended that:

- The survey findings are shared with all staff groups involved in providing cancer care to patients and their relatives at the earliest opportunity. – completed 25/9/14 by the Cancer Manager
- The working group, set up in 2012, continues to meet to develop the 2014-2015 action plan building on the 2012-2014 plan.
- The findings from the survey are fed back to patients, relatives, user and support groups across the Trust.
- The findings from the survey are fed back to the local CCGs to support the development of their own action plans as a result
- The Governors are briefed on the findings at a future Council of Governors meeting
- The survey is shared with our local Healthwatch organisations.
- Patient comments and feedback from the survey are shared across the organisation and with primary and social care where this is appropriate (at the time of this paper, Quality Health have not released the patient comments report).

5. References and further reading

Electronic copies of the National Cancer Patient Experience Survey, including patient comments can be accessed through the Trust website or by contacting kay.gamble@york.nhs.uk from 1st November 2014.

Author	**Kay Gamble, Patient and Public Involvement Specialist**
Owner	**Beverley Geary, Chief Nurse**
Date	**October 2014**

York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 21 October 2014, Ward 37 Seminar Room, York Hospital

Attendance: Mike Keaney, Chairman
Mike Sweet
Andrew Bertram
Liz Booth
Lisa Gray
Steven Kitching
Graham Lamb
Anna Pridmore
Lucy Turner

Apologies: There were no apologies

	Agenda Item	Comments	Assurance	Attention to Board
1	**Last Meeting Notes Minutes Dated 16 September 2014**	The notes were approved as a true record of the meeting.		
2	**Matters arising**	All matters arising from the previous meeting are on the agenda this month to discuss.		
3	**Short term Acute Strategy**	LB informed the committee that the 'Implementing the Unplanned Care Strategy' paper presented last month had now been launched. LB confirmed that business cases were under way in terms of nursing, therapies and pharmacy and were appropriate would be sent to the Board for approval. LB confirmed she would be meeting with clinicians in January 2015	The committee was assured that the paper had been through Board and the strategy was moving forwards, and making good progress.	

	Agenda Item	Comments	Assurance	Attention to Board
		to discuss their rotas, and how the night time on call rota would be developed.		
4	**Efficiency Report**	SK informed the Committee that the overall delivery for September was £13.3m, which is 55% of the £24m target, which is an improvement of £2.7m, since August 2014 and better than the position in September 2013. The current in-year planning gap in September 2014 is £1.7m, which is an improvement on August 2014 (£2.6m). SK informed the Committee that this was encouraging, and that the Trust is ahead of September 2013 which showed a planning gap of £2.4m. The four year planning gap has closed from £22.2m in August 2014 to £20.3m in September 2014. 46% (£6.1m) of the £13.3m delivery is recurrent, which SK confirmed is a significant improvement from the £4.6m in August 2014 position. SK informed the committee that this is not where the Trust would like to be, but it was an improvement on the position in September 2013 which was 39% recurrent delivery. SK informed the Committee that Dr Ian Jackson has been supporting the Quality Impact Assessments currently being carried out, and that he is pleased to confirm 19 areas have now self assessed, and have a rating of green. This leaves 8 clinical areas, and 5 corporate areas to finalise. SK explained that the majority of clinical areas that are still to self assess, are ones that have had gaps in the Directorate management team. This continues to be a short term risk, but SK advised the committee that additional support was being given to these areas. Both MK and MS remained concerned about the outstanding assessments. They recognise the challenges in place, but asked that these assessments be completed as quickly as possible General Medicine and ED in Scarborough are of particular concern as they have only delivered 5% & 6% of their overall targets, and have showed no delivery in August and September 2014. SK advised the Committee that both areas were due to attend their	The Committee was assured by the improvement in delivery, and the reduction in the in year planning gap. The committee was assured by the encouraging progress being made in most areas with their self assessment, and the additional support being put in place for areas with particular concern.	The Board are to be informed of the gaps in the Governance Risk Scores, but to advise the committee is pleased with the progress being made.

	Agenda Item	Comments	Assurance	Attention to Board
	Efficiency Report Cont'd	efficiency panels over the coming weeks, where the efficiency programme will be reinforced, so that the areas start to make progress. The Committee confirmed that the position although still challenging does feel better than it did last year. They confirmed that the Committee would continue to seek assurance on progress each month. SK added that he believed the Trust would achieve the target for this financial year. MS raised his concerns over areas that are not making any progress. SK explained that these areas are receiving extra support, for example, ED in Scarborough are being supported by ED in York. SK advised the Committee that Wendy Pollard had been appointed into the role of Deputy Head of Resource Management, so completing recruitment into the efficiency team. SK informed the committee that the Efficiency Group is currently being reviewed in term of its activities by the Chief Executive and Director of Finance. AB informed the Committee he was encouraged by the reduced planning gap, but was concerned that it is getting harder for the Trust to find savings. However, AB, MP and PC have been proactive in their communications with South Tees Hospital NHS Foundation Trust, who are currently undergoing a financial turnaround, and they plan to shadow their Turnaround Board to give them fresh new ideas. The Trust is continually looking for new ways to refresh the programme, so that it continues to move forwards. SK shared with the committee the Efficiency Risk Rating Tool, which looks at Directorates in year delivery, and to log the money saved. This is an 18 month work programme, and will help the team to prioritise areas struggling, and show the team what is driving our losses. It will be discussed within the Corporate Efficiency Group, help check that areas are not missing efficiencies that other areas have been able to implement. It will also equip the Trust with the information needed to discuss efficiency savings with CCG's to explain that despite the Trust's best efforts to be as efficient as	The committee was assured that the Trust is constantly looking for ways to refresh the programme so that it continues to becoming more efficient.	MK to discuss the Efficiency Risk Rating Tool at Board.

	Agenda Item	Comments	Assurance	Attention to Board
	Efficiency Report Cont'd	possible certain services are still losing money, and need to be focussed on moving forwards. MK asked how Board would know if there was an improvement, SK explained that the data the Trust receives has an element of benchmarking against peer Trusts, eg. the Trust would receive information with regard to 'Better Care Better Value' which will be benchmarked against other hospitals this in turn will drive further efficiencies. The document still has data to be added in so MK asked for this to be brought back to the Committee, but noted that this was a move in the right direction. It was agreed the document would be presented to the Committee initially every 2 months.	The committee was assured this was a good document to start using, and were keen to see it progress when more data was input.	
5	**Operational Report**	**Access Targets –** **18 weeks –** LB confirmed that the Trust had achieved the non-admitted and incomplete pathway targets at aggregate level, although there were significant specialty level fails and challenges. The admitted target was failed as planned in line with the current national agreement to help Trusts to reduce their backlog. However, LB advised that there have been some issues around additional activity which has been raised with the CCGs. LB confirmed the CCGs have been supporting the Trust during this period. Short-term changes in waiting list initiative (WLI) rates for agenda for change staff have now been agreed, and this is helping to increase the amount of WLIs that are being provided internally. This has resulted in an additional 54 lists being booked in over the next 6 weeks. Additionally, LB confirmed 123 patients have been provided with care at other hospitals. She confirmed she was confident that the existing backlog would be clear by the end of December 2014. MS enquired which other providers were being used, LB advised they were Harrogate and District NHS Foundation Trust, Nuffield Hospital and Spires Healthcare. LB advised that the Trust would be paid an additional 15% of tariff to complete the WLI work. She confirmed that the Trusts that had taken some patients would also receive the enhanced payment.	The Committee was assured that processes had been put in place for the additional activity to go ahead, and that the Trust would have the backlog cleared by December. The Committee understood and were satisfied that the patients who had been moved to other providers were being provided with a high standard of care.	

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		LB also advised that each Directorate had been set a task, and each Directorate had confirmed that their PTL was now up to date, and these are being presented at weekly performance meetings. **Cancer –** **14 Day Fast Track –** LB informed the Committee that the Trust had failed the target for July and August, and it was unlikely that the Trust would achieve Q2. This is largely due to the increase in referrals. Skin referrals have increased by 37% in comparison to the same time last year. Active recruitment of a Dermatology consultant is on-going. LB also confirmed that work has been continuing with CCG's, to assess referrals; additionally the pathway proformas have been redesigned. **14 Day Symptomatic Breast –** LB informed the Committee that the Trust failed the target in July and August, and the Trust is unlikely to achieve the target for Q2. However, LB confirmed performance has significantly improved since the service was moved to York in August, and in October the Trust is overachieving. LB advised the Committee that the Trust is continuing to attempt to recruit staff to provide the service in Scarborough, so that the services can be moved back as soon as possible. The intention of the Trust was that this was only a temporary move to ensure patients were seen within the required time line. **31 Day Subsequent Treatment (Surgery) –** LB advised that there are currently 3 patients who breached the time out of 57, not 4 which was stated in the papers, and confirmed this information would be updated ready for the Board of Directors. **Emergency Department –** LB advised the Trust failed to deliver in Q1 & Q2, and informed the Committee that disappointingly York failed by approximately 20 patients. LB shared with the Committee a paper named the 'Four Hour Turnaround Group – Action Tracker'. LB advised this group had been put together as a forum that could coordinate an approach to help relieve the pressure on the emergency department and hit the	The Committee was assured that work is on-going with the CCG's and GP's to ensure the trust can meet the target going forwards. The Committee were pleased to hear of the improvement in the performance in the service, and encouraged the team to continue to seek a final solution to the service being moved back to Scarborough	MP to discuss the 4 hour turnaround group - action tracker at Board.

	Agenda Item	Comments	Assurance	Attention to Board
		required targets. The group will support the work being undertaken around improving patient flow across the whole hospital. The group will enable the Trust to refresh processes. The implementation of the other associated groups has been received with enthusiasm and exceptional clinical buy in. LB discussed several actions on the document with the committee, sharing that one of the actions for early notification through paramedics of patients requiring a bed has already commenced, as paramedics in the ambulances tend to diagnose well, and know if the patient needs to be admitted. AB asked how this would work. LB explained that when paramedics phoned the emergency department in advance the paramedics would inform the nurse that in their view the patient might need to stay in hospital; this would enable the nurse to contact the bed managers so ensuring there is advanced notice that there might be a further patient requiring a bed. This process would take place before the patient is assessed in the department, so the information would be given on a provisional basis. MS questioned how this would help the Trust, and LB explained that it enables the Trust to start to plan for the need for a further bed earlier than would traditionally be the case. MK questioned whether there had been any progress on the development of an ambulance handover bay in Scarborough. AB confirmed that an assessment of the need would first need to be completed. This assessment is underway at present. This assessment is in part due to the issue around ambulance delays only existing for the last six months. The project would take about £1m out of the capital project and as a result delay other schemes so the Board must be assured it is the right thing to do. AB added that it is believed that once the Maple ward re-opens the situation will be improved as this puts a further 30 beds back into the bed stock for the Trust. AB also informed the Committee that Maple ward 2 would be opened in April 2015, which would hopefully further reduce the pressure. The Committee discussed the fact that at present there is more	The Committee was assured that progress was being made, and MS asked to have updates on the action tracker presented to the Committee on a regular basis, at first monthly.	

	Agenda Item	Comments	Assurance	Attention to Board
		information provided to the Committee from the York side and less about Scarborough. AB commented that it was his assumption going forwards was that the Chief Operating Officer when in post, would become part of the Committee and represent both Scarborough and York. **CQUIN** **(1.2) Friends and Family response rate in ED & IP –** LB explained that the amber rating was due to further deterioration of performance at ED. She explained that a text messaging solution was now being trialled to see if this would help improve the situation. She reminded the Committee that the token system in ED has now been removed as required. **(3.1a) Dementia & Delirium –** MK commented on the dementia & delirium CQUIN and said he was pleased to see this CQUIN was green, following the improvement plan that has been put in place at Scarborough. **(7a) Care of the deteriorating patient –** LB confirmed that the target for Q1 had been achieved. However discussions for an improvement plan were in place with clinicians at Scarborough to mitigate the current vacancies in GIM that will impact on Q2's increased target. **Infection Prevention and Quality and Safety** **6 weeks referral to diagnostic test –** LB advised that currently there are some challenges around this target; One of the challenges in the system is due to patients being transferred from another Trust. This was initially a temporary measure to address some sickness the in the department, but it has now become more of a permanent fixture, therefore a more robust system needs to be put in place. Discussions are continuing with the other trust. In terms of MRI outsourcing it has now been agreed that Radiology	The Committee remains concerned about the continued deterioration in performance, but noted the new system being tested. The Committee was assured that the implementation of the improvement plan has demonstrated improvements in the dementia and delirium CQUIN The Committee was assured that discussions were on-going to help resolve the challenges around GIM, The Committee noted the issue and agreed it would review again next month. The Committee were concerned about the performance and the points raised by LB. It was agreed that a further update should be given at the next meeting.	AJT to inform the Board of CQUIN 7a, and note 3.1a.

	Agenda Item	Comments	Assurance	Attention to Board
		will commence MRI outsourcing in November 2014.		
6	**Finance Report**	GL informed the Trust that at the end of September 2014 the Trust is reporting an Income & Expenditure deficit of £1.8m, against a planned surplus of £0.1m, which is a decline in the position reported in August 2014 (£1.1m). GL informed the Committee that the major reason behind this was a rise in the average spend on pay, although other expenditure was not up, and a drop in activity against plan. GL confirmed the reported position assumes reinvestment of money from the CCG's, one of which is for ambulance turnaround penalties the Trust has incurred. Positive discussions have been held with the CCG in regards to reinvesting the money, but there is a slight concern that this will fall into year end conversations. MK questioned if this could cause the Trust issues. AB confirmed that it was a concern, but with the improved position in York, and hopefully Scarborough too once Maple ward re-opens it is hoped the CCG will re-invest earlier. MK also asked if there were any caveats around the reinvestment of the money. AB advised that the guidance is clear and it is expected the CCG will invest as per the requirements of the guidance. AB reminded the Committee that the Trust has also asked the CCGs to reinvest the 70% money for the marginal rate non elective tariff and re-admission savings, as the Trust does not believe this money has been reinvested. These conversations are continuing. The Trust's position at the end of quarter 2 is a provisional COSR rating of 4, which is in line with the Trust's planned position. GL informed the Committee that the Trust would be raising the discussion around the marginal rate at the next Collaborative Improvement Board. MK raised concerns that the Trust may drop to a COSR rating of 3,	The committee was assured that talks were positive in relation to reinvestment from the CCG's, and that these talks were continuing to move forward. The committee were also assured by our liquidity being at the strongest it has ever been.	MP to inform the Board of the risk of not receiving the reinvestment money from the CCG.

	Agenda Item	Comments	Assurance	Attention to Board
		but AB confirmed that the liquidity of the Trust is currently at the strongest it has ever been, and feels that this should hold the Trust in good stead. AB advised that the recent pay dispute had now been resolved, and agenda for change staff are now being paid double rather than time and a half for additional shifts. AB informed the Committee it is important that during October and November the Trust recovers from the September position. He added that to date key indicators would suggest that this recovery is underway. AB confirmed contracts have now been signed with the Vale of York CCG, but are still outstanding with Scarborough and Ryedale CCG due to a single issue that has not been concluded. He advised that he believes the issue will be resolved shortly.	The committee was assured that we continued to question the CCG's over how the money is being reinvested.	PJC to inform the Board of reduced income and the plan to increase this in October and November to recover.
7	**Monitor Quarterly Return**	AP shared with the committee the quarterly Monitor return for Q2. AP informed the Committee that there were four metrics the Trust was not compliant with. These are: 1. Referral to treatment time, 18 weeks in aggregate, admitted patients 2. A&E Clinical Quality – total time in A&E under 4 hours 3. Cancer 2 weeks (all cancers) 4. Cancer 2 weeks (breast symptoms) AP confirmed that Monitor are aware of the current issues in these areas, which the Committee have discussed in depth during this and previous meetings. AP referred to the information on Executive Directors turnover, which Monitor now requires to be submitted AP also informed the Committee that the turnout for the Governor elections, which was good was reported in Q2 as well. It was noted that there were some areas where turnout had been lower than had been the case in previous elections.	The committee was assured that work is already underway in relation to the four metrics that are non-compliance, and pleased that there was no unexpected non-compliance. The committee was assured by the stability of the Executive Directors. The committee was pleased with the turnout for the Governor Elections.	

	Agenda Item	Comments	Assurance	Attention to Board
8	**Tender Update**	AB informed the Committee of three tenders that are currently ongoing. These are: **Sexual Health** AB confirmed the bid has just been submitted for services which the Trust currently provides. It is expected the Trust will hear back about this tender within the next few weeks. **Clifton Park Hospital** AB confirmed the Trust was in the final stages of putting a tender together for Clifton Park Hospital, which is due in by 24 October 2014. It is thought the Trust may hear back about this before Christmas, but it could be at the start of the new year. **Urgent Care and Out of Hours Provider** AB confirmed the tender for this has been submitted, and the Trust was awaiting formal notification of the outcome.	The Committee was assured by the activity currently being undertaken to bid for services.	PJC to update the Board on the tenders the Trust is currently bidding for.
9	**Proposed dates for 2015/16**	Committee members confirmed they could attend all proposed dates. Therefore these will be the set dates for the committee going into 2015/16.		
10	**Any Other Business**	MS asked for the Reference Costs (Outcome) to be added to 18 November 2014 work programme. . It was agreed the MK and AP would review the Terms of Reference and included in the agenda for the next meeting.		

York Teaching Hospital NHS
NHS Foundation Trust

Monthly Performance Report

September 2014

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail:** £400 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**90%**	90.9%	87.6%	77.5%	79.1%	81.6%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail**: £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TCB	**95%**	96.8%	96.1%	95.9%	95.8%	95.9%
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	**Specialty fail:** £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**92%**	93.3%	93.8%	93.6%	93.4%	93.4%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	1	0	0	0	0

Access Targets: Cancer

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

Indicator	Consequence of Breach	Threshold	Q1 Actual	Jun	Jul	Aug	Q2 Actual
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	86.1%	85.1%	89.8%	85.2%	
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	45.6%	46.5%	71.0%	80.6%	
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	98.6%	97.6%	96.9%	98.5%	
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	96.4%	95.5%	96.4%	88.9%	
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	100.0%	100.0%	98.7%	98.0%	
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	87.8%	84.6%	89.9%	85.7%	
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	96.6%	100.0%	100.0%	94.1%	
62 Day Consultant Upgrade	General Condition 9	**85%**	50.0%	100.0%	-	-	

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£200 fine per patient below performance tolerance (maximum 8% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	93.9%	93.0%	92.5%	92.5%	92.6%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**> 30min**	481	168	144	177	489
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**> 60min**	207	90	84	81	255
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q1 Actual**	**Jul**	**Aug**	**Sep**	**Q2 Actual**
	NHS VALE OF YORK CCG	30mins - 1hr	176	26	15	29	70
		1hr - 2hrs	101	7	10	15	32
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	141	64	65	73	202
		1hr - 2hrs	56	27	40	33	100
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	96	46	30	46	122
		1hr - 2hrs	26	32	24	26	82
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	27	10	10	14	34
		1hr - 2hrs	5	8	3	3	14
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	5	1	0	0	1
		1hr - 2hrs	0	0	1	0	1
	OTHER	30mins - 1hr	36	21	24	15	60
		1hr - 2hrs	19	16	6	4	26
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**> 12 hrs**	0	1	1	0	2
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	97.4%	96.1%	To follow	To follow	To follow

Mortality

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

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**59**	12	1	3	6	10
Number of Clostridium difficile due to "lapse in care"	*TBC*	**TBC**	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**108**	30	6	7	7	20
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) cases	**Quarterly:** General Condition 9	**35**	14	6	1	2	9
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	0	0	0	0
Notification of MRSA Bacteraemia to be notified to commissioner within 2 working days	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 14 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a	n/a
Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	87.9%	88.1%	87.9%	90.0%	88.7%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	71.2%	74.3%	70.8%	73.1%	72.7%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 fine per patient below performance tolerance	**99%**	97.6%	98.6%	98.4%	98.0%	98.3%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	0	0	0
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hosp	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	1	0	0	0	0
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	63	47	6	22	75
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	£200 in respect of each excess breach above threshold	**95%**	97.2%	97.5%	97.1%	97.2%	97.3%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.7%	99.6%	To follow	To follow	To follow
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	5.9%	6.3%	10.0%	Not available	Not available
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 89% Q2 - 90% Q3 - 92% Q4 - 95%**	85.9%	85.7%	85.7%	87.7%	86.4%
Delayed Transfer of Care to be maintained at a minimum level	TBC	**TBC**	1548	760	636	592	1988
Trust waiting time for Rapid Access Chest Pain Clinic	None	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance				
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**200 per month**	348	198	157	163	518
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**Baseline 784; end Q2 745; end Q4 722**	2236	753	687	847	2287
% of ED Admissions With a NEWS Score		**TBC**	78.8%	80.6%	78.9%	80.1%	79.8%
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	371	131	2 month coding lag	2 month coding lag	2 month coding lag
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	1247	421	2 month coding lag	2 month coding lag	2 month coding lag
Reduction in the number of inappropriate transfers between wards and other settings during night hours (Reduction in avoidable site transfers within the Trust after 10pm)	General Condition 9	**Q2 onwards 80 p.m. (TBC)**	256	76	89	104	269

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	General Condition 9	**80% by site**	87.9%	91.2%	78.9%	81.3%	84.0%
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	93.7%	99.8%	98.6%	97.5%	98.6%
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%	100.0%	100.0%	100.0%
Proportion of stroke patients who spend >90% of their time on a stroke unit	Non delivery of 90% at Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £5k in line with respective finance baselines (TBC)	**80%**	86.9%	89.5%	90.3%	one month behind	one month behind
Proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours of seeing a health professional	Non delivery of Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £2k in line with respective finance baselines (TBC)	**70% (TBC)**	86.7%	86.8%	90.9%	one month behind	one month behind
Proportion of patients presenting with stroke with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	General Condition 9	**65%**	95.0%	100.0%	100.0%	one month behind	one month behind
Percentage of stroke patients and carers with joint care plans on discharge from hospital to have a copy of their care plan (except RIP or who refuse health/social care assessment/intervention)	General Condition 9	**70%**	n/a	n/a	n/a	n/a	n/a
Patients who require an urgent scan on hospital arrival, are scanned with in 1 hr of hospital arrival (TBC)	No financial penalty	**50%**	82.6%	75.0%	55.0%	one month behind	one month behind
Proportion of stroke patients scanned within 24 hours of hospital arrival	No financial penalty	**90% (TBC)**	91.6%	97.5%	96.6%	one month behind	one month behind
Transmission of IDLs to GPs within 24 hours of discharge (Q1-Q3 elective and non-elective activity IP only excluding DC, Maternity and by end Q4 to include surgical DC activity too) - Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology.	Failure to deliver the quarterly target will result in the application of a £4k penalty per quarter Maximum sanction of £16K per annum based upon respective commissioners financial baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	76.0%	78.7%	74.9%	78.0%	77.3%
Immediate Discharge Letters (IDLs) handed to patients on Discharge	General Condition 9	**98%**	Annual letter of assurance to be provided to CMB				
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver quarterly trajectories at Trust aggregate level for each quarter will result in the application of a £10K sanction relating to each underperforming quarter. Maximum sanction of £40k per fiscal year. The penalty will be applied by the commissioners in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	Quarterly audit				
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver the quarterly target will result in the application of a £6k penalty per quarter. Maximum sanction of £24k in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 94%**	Quarterly audit				
All Red Drugs to be prescribed by provider effective from 01/04/14	£50 penalty for any request to primary care for prescription of Red Drugs (TBC)	**100% list to be agreed**	CCG to audit for breaches				
All Amber Drugs to be prescribed by provider effective from 01/04/14	No financial penalty	**100% list to be agreed**	CCG to audit for breaches				
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	86.6%	87.3%	86.6%	86.9%	86.9%

Never Events

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

District Nursing Activity Summary

Indicator	Source	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	n/a	1817	762	599	670	2031
	Community nurse/service	n/a	748	325	167	256	748
	Acute services	n/a	876	398	336	433	1167
	Self / Carer/family	n/a	481	176	181	156	513
	Other	n/a	231	104	92	82	278
	Grand Total	n/a	4153	1765	1375	1597	4737
Community Adult Nursing Contacts	First	n/a	2612	1008	712	761	2481
	Follow up	n/a	32184	10268	10256	11428	31952
	Total	n/a	34796	11276	10968	12189	34433
	First to Follow Up Ratio	n/a	12.3	10.2	14.4	15.0	12.9
Community Hospitals average length of stay (days)	Archways	n/a	23.4	23.4	20.1	22.2	22.1
	Malton Community Hospital	n/a	24.5	22.8	17.4	16.0	18.6
	St Monicas Hospital	n/a	24.5	20.5	24.7	24.1	23.2
	The New Selby War Memorial Hospital	n/a	13.8	18.0	11.1	17.1	15.6
	Whitby Community Hospital	n/a	21.1	20.1	18.4	22.9	20.3
	Total	n/a	20.4	20.8	17.6	19.6	19.4
Community Hospitals admissions. Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	8	2	2	0	4
		Emergency	66	36	24	31	91
	Malton Community Hospital	Elective	4	1	2	7	10
		Emergency	89	42	35	37	114
	St Monicas Hospital	Elective	9	7	3	3	13
		Emergency	36	9	14	12	35
	The New Selby War Memorial	Elective	68	21	19	22	62
		Emergency	71	20	22	24	66
	Whitby Community Hospital	Elective	0	0	1	0	1
		Emergency	152	41	44	38	123
	Total	Elective	89	31	27	32	90
		Emergency	414	148	139	142	429

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

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

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

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

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York Teaching Hospital NHS Foundation Trust

Board of Directors – 29 October 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 September 2014.

At the end of September the Trust is reporting an Income and Expenditure (I&E) deficit of £1.8m against a planned surplus of £0.1m for the period. The Income & Expenditure position places the Trust behind its Operational plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

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

Briefing Note for the Finance & Performance Committee Meeting 21 October 2014
Briefing Note for the Board of Directors Meeting 29 October 2014

Subject: September 2014 (Month 6, Q2) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for September 2014

At the close of Q2 the Trust remains in a deficit financial position. Our plan for the month of September predicted a very modest £0.1m improvement in our position but our reported deficit has increased from £1.1m at August to £1.8m at September. Against our planned year-to-date surplus of £0.1m we are currently operating £1.9m short.

With the exception of a £0.3m higher than average spend on pay, there are no material changes to expenditure trends but early indications for September activity is that it fell considerably short of planned levels and therefore income did not match expectations.

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

The reported position assumes reinvestment of all current ambulance turnaround penalties. These total £596k. The original assumption around receipt of CCG support related to the marginal rate non-elective tariff and readmissions savings remains in our reported position.

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

This position returns a provisional COSR rating of 4, which is in line with our planned position. Whilst we are reporting a deficit it is within the tolerances used by Monitor. Failure to secure this additional income will cause our COSR rating to deteriorate down to level 3.

CIP performance is £2.4m (year-to-date) behind the required savings level. Whilst this is materially impacting on our reported I&E position this continues to represent better performance than this time last year, when set against last year's delivery trajectory. This issue is dealt with in detail in the efficiency report.

Income Analysis

The reported income position includes coded and costed data for April through August and an estimate has been included for September, as is usually the case. Activity and income levels for September are down against plan across the board. Of note are the plans now in place for stepping up activity levels during Q3. These plans relate to initiatives to catch up

lost activity and are also in support of the national initiative to reduce patient backlogs. This work is expected to have a positive impact on the Trust's financial position. Directorate PMMs (both operational and executive) will focus heavily on delivery of this additional activity over the coming months.

Contract penalties (excluding ambulance turnaround) have increased to £684k. Details are provided in the finance report and performance report.

Expenditure Analysis

Pay budgets and provisions are £2.1m overspent for September, following a trend established earlier in the year. Operational budgets are under spending but locum and agency medical staff and nursing staff expenditure is running at an unaffordable premium level. The agency spend to date totals £4.9m, with £1m spent/charged in September alone. Overall pay in September was £0.3m higher than the average for April to August. Clearly there are substantive funded vacant posts offsetting this position but the premium cost on the use of agency is placing significant pressure on our finances. Pressure areas include: medical agency staff in Scarborough for Elderly, Acute Medicine and Ophthalmology and medical staff agency spend at York in ED. There is also considerable nursing agency expenditure in General Medicine, specifically AMU/SSW and Ward 33.

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

There are no material pressures to report in terms of other operational budgets.

The report shows that the CIP programme is impacting adversely on the position by £2.4m. This is the most material adverse issue impacting on our expenditure and is dealt with in the CIP report.

Contracting Matters

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

Other Issues

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

Monitor Monthly Return

The Board will be aware that Monitor now require from all Foundation Trust's the completion of a monthly return for the Department of Health. The Trust's return for September is shown below. Although we are reporting in September increased pressure on the I&E position, the forecast outturn for I&E at September remains unchanged to that reported at August, and shows a forecast £800k deficit. This is based on an expectation that Trust income will grow in the latter half of the year, and this is something that will require close monitoring.

York Teaching Hospital NHS FT
YORKHOSPITAL
RCB
DH monthly reporting data collection
V1.0.0
30/09/2014

DH monthly reporting data collection

The Department of Health has mandated regular, monthly, reporting from FTs of data to assist the DH in controlling and forecasting expenditure against the two Departmental Expenditure Limits (DELs), capital and revenue.
You MUST submit a return. You must complete every yellow cell your return.
Please upload your completed template to your Monitor portal outbox with content type 'Trust return' and activity 'Return for DH'
The deadline for submission of completed return templates is NOON on Friday 24 Oct 2014

DH monthly reporting data from York Teaching Hospital NHS FT as at 30 Sep 2014

Question No	Question text	Plan value from 14-15 APR or latest re-planned value in £m at 30 Sep 2014	Actual Value in £m at 30 Sep 2014	Forecast value in £m as at 31 March 2015
		only enter numbers below	only enter numbers below	only enter numbers below
1	What is the trust's **Surplus / (deficit) before impairments and transfers by absorption**	0.203	-1.804	-0.800
2	What is the trust's **Capital Expenditure, net of disposals, on an accruals basis**	10.100	10.103	24.300

	In the rows below you have the opportunity to add any comments about the information above or provide any feedback to Monitor about this data collection
comments	
feedback	

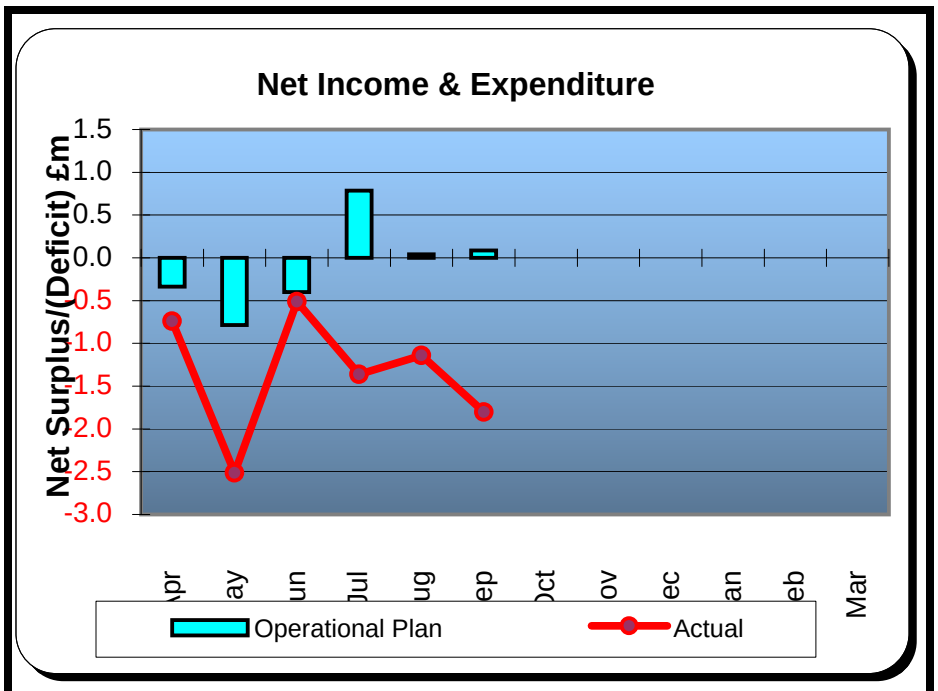
Please enter your name and contact details in case of any queries arising.

Completed by (name) on behalf of the trust	Graham Lamb	Job title	Deputy Finance Director	Date	24/10/2014	email	Graham.Lamb@York.nhs.uk

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

High Level Overview

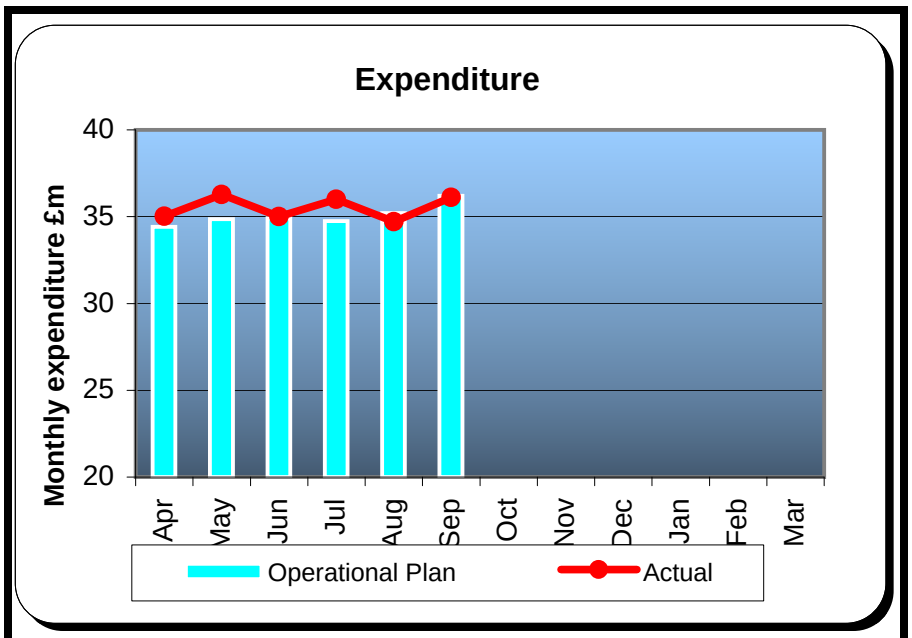
* A net I&E deficit for the period of £1.8m means the Trust is £1.9m behind plan.
* CIPs achieved at the end of September total £13.3m. The CIP position is running £2.4m behind plan.
* All contracts are now signed with the exception of S&RCCG and associates. The estimated overall actual activity value is forecast to be under contract by £1.6m.
* Cash balance is £32.3m, and is £4.5m ahead of plan.
* Capital spend totalled £10.08m, and is in line with the plan.
* The Continuity of Service Risk Rating is 4.



Key Period Operational Variances

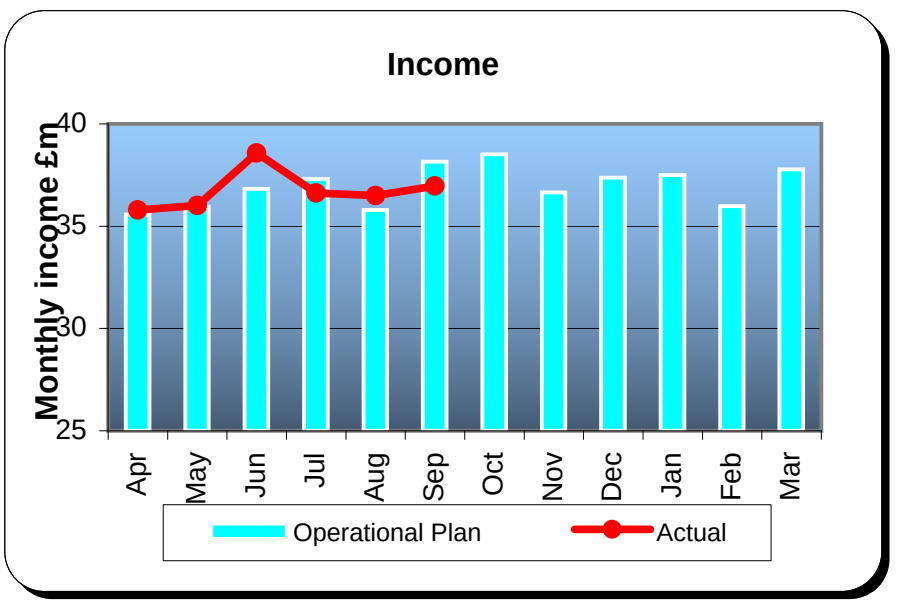
	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. VET)	189.0	189.1	0.1
Clin.Inc.(VET))	5.6	5.1	-0.5
Other Income	25.1	26.3	1.2
Pay	-145.7	-147.8	-2.1
Drugs	-20.9	-20.9	0.1
Consumables	-22.4	-21.8	0.5
Other Expenditure	-30.6	-31.8	-1.2
	0.1	**-1.8**	**-1.9**

(VET = Vitreous Eye Treatments)



At the end of September there is an adverse variance against operational expenditure budgets of £2.8m. This comprises:-

- Operational pay being £2.1m overspent, predominantly due to a premium paid for agency staff covering vacant posts
- Drugs £0.1m underspent
- Clinical supplies £0.5m underspent.
- Other costs are £1.2m underspent
- Restructuring costs are £0.1m overspent
- CIPs are £2.4m behind plan

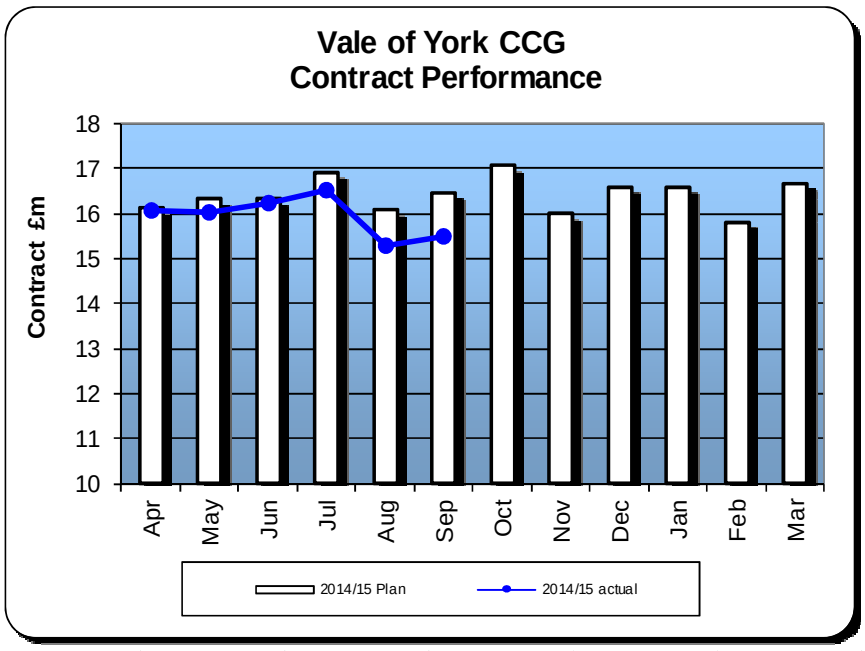


At the end of September income is ahead of plan by £0.8m. This comprises:

- Elective and day case income are behind plan by £1.6m.
- Non elective is ahead of plan by £3.1m.
- Out patient income is behind plan by £1.8m
- A&E income is behind plan by £0.2m
- Other clinical income is ahead of plan by £0.1m.
- Other income is £1.2m ahead of plan

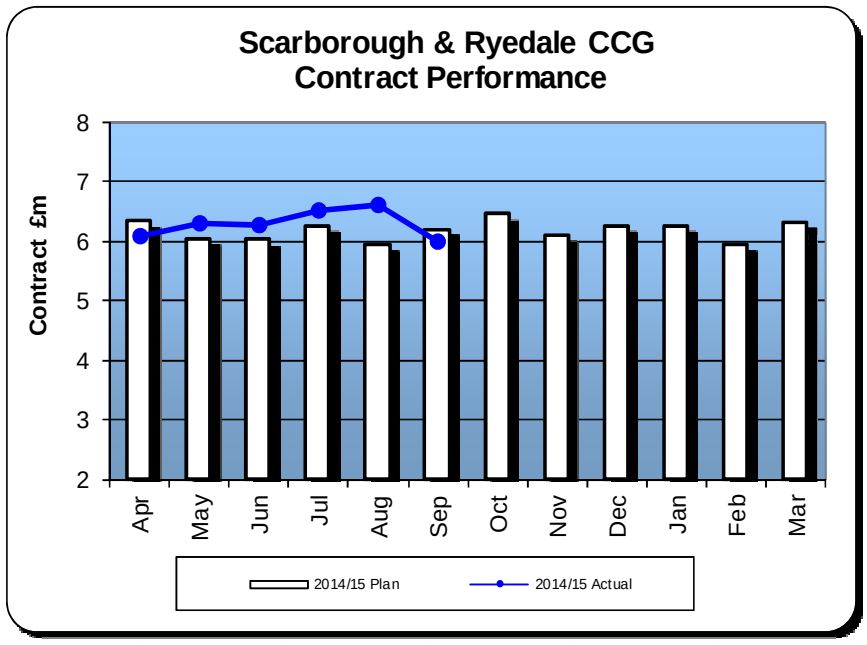
- Potential contract penalties and fines are estimated at £0.7m, included within the lines above.

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



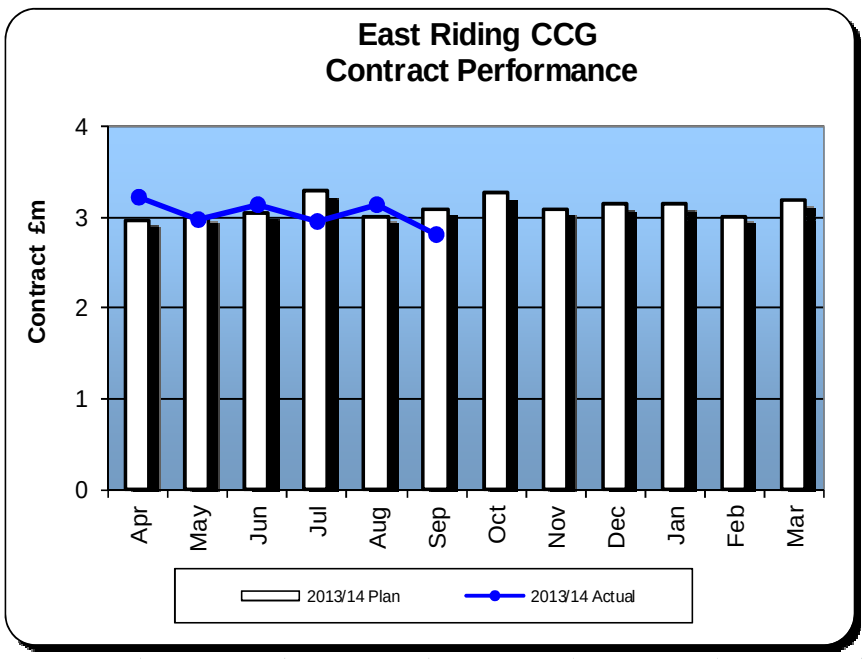
The contract value is estimated to be £195.1m.

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



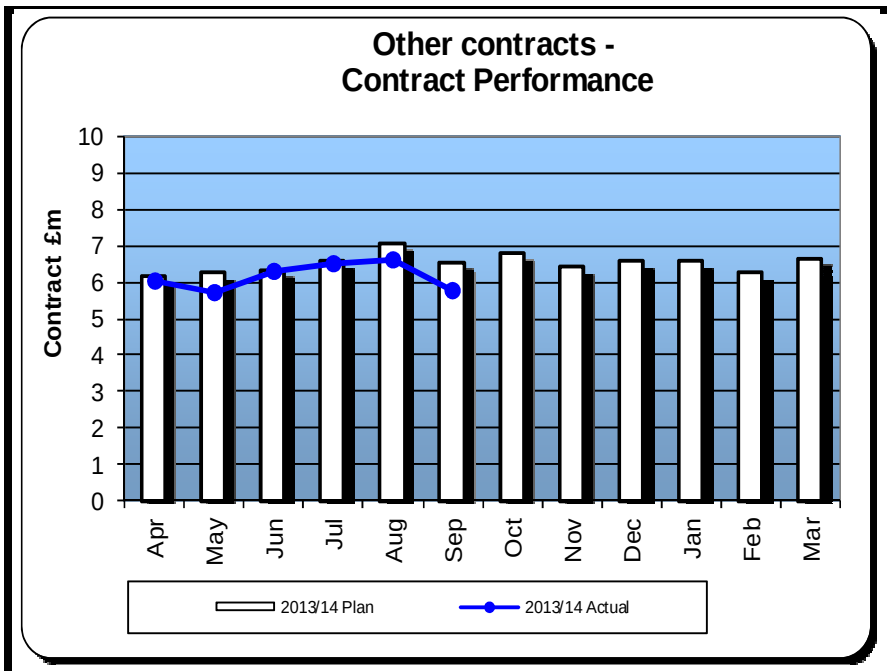
The contract value is estimated to be £73.7m.

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



The contract value is estimated to be £36.9m.

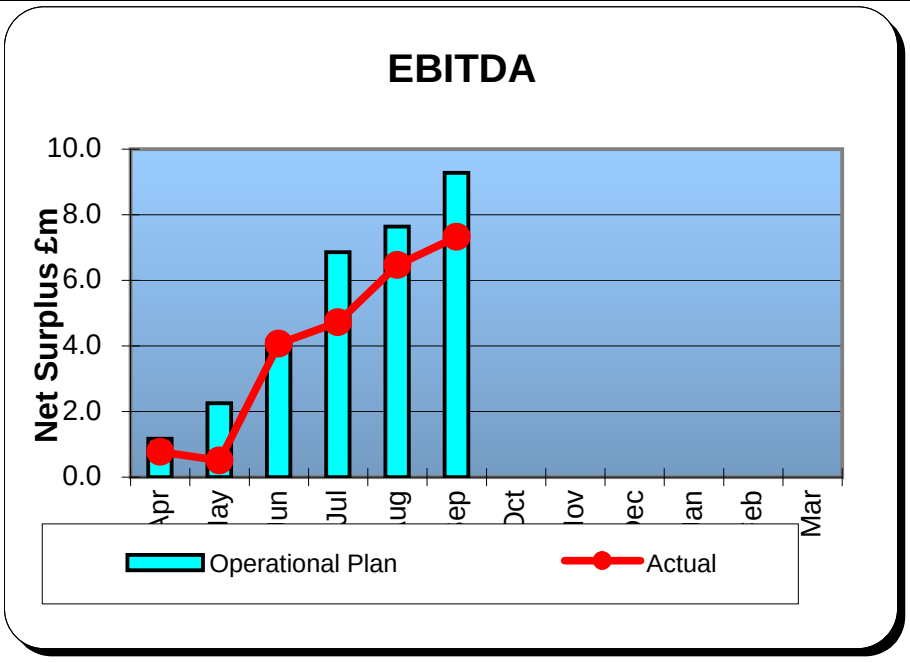
The contract is not yet signed, however the estimated actual value to date is forecast to be in balance with the provisional contract. This position includes estimates for September.

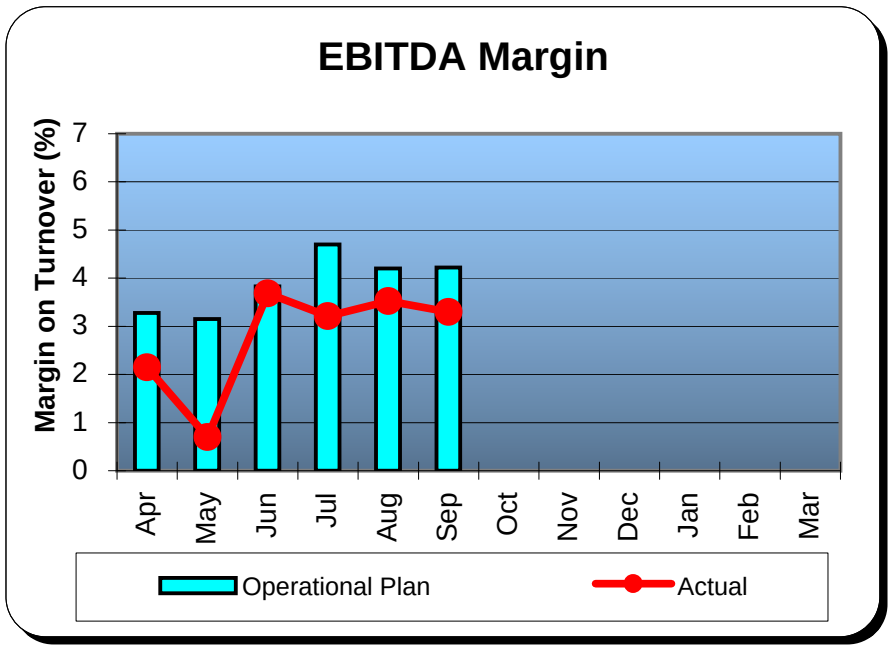


The contract value is estimated to be £77.7m.

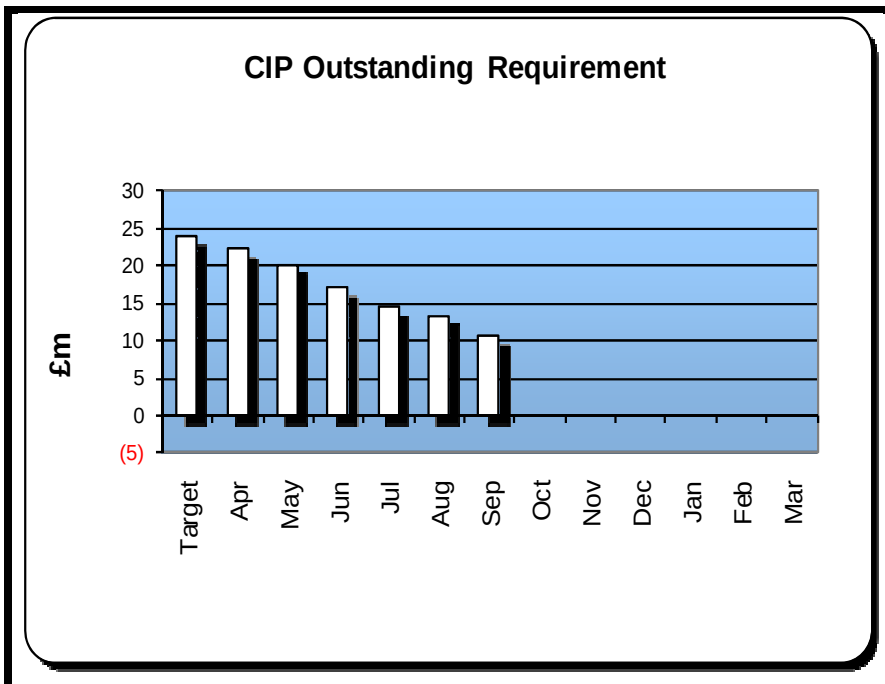
These include the smaller CCGs, NHS England, and Local Authority contracts. Other than for thwe HRWCCG all other contracts are signed. Overall, the actual position is estimated to be behind contract by £0.9m. The position includes estimates for September. A high volume of uncoded data may affect the allocation of income against individual contracts, and particularly the undertrade on the prescribed specialist services of £0.2m.

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

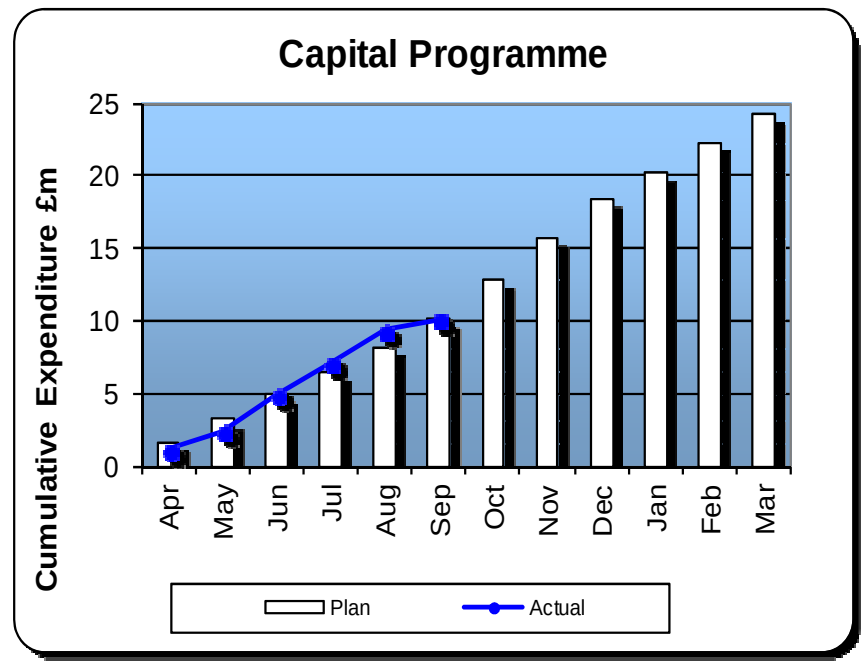




Actual EBITDA at the end of September is £7.323m (3.30%), compared to operational plan of £9.276m (4.22%), and is reflective of the overall I&E performance.



The full year efficiency requirement is £24.0m. At the end of September £13.3m has been cleared.



Capital expenditure to the end of September totalled £10.08m and is in line with the plan.

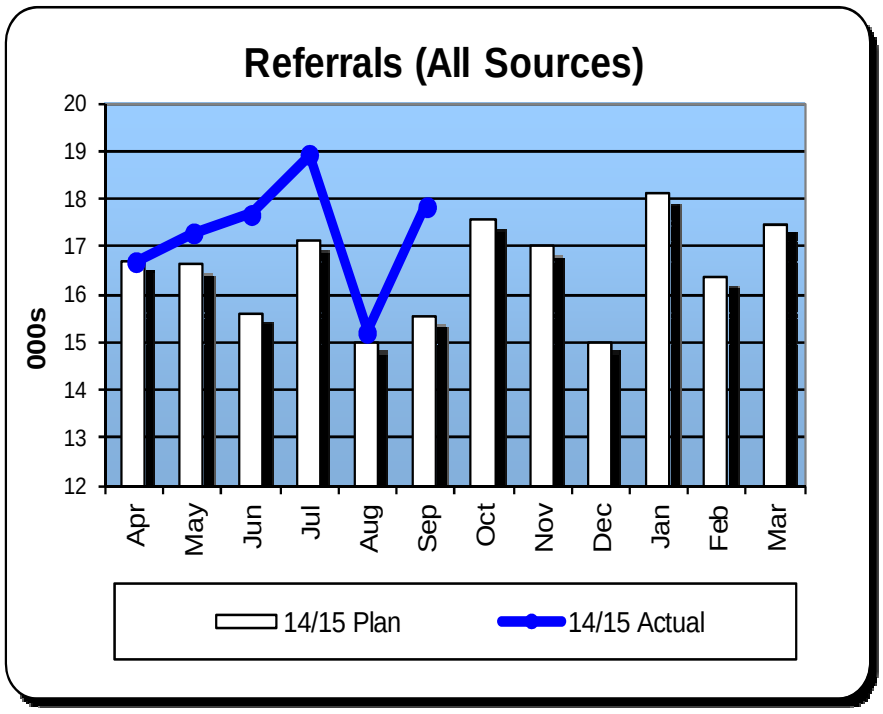
Capital schemes with significant in year spend to date include the on going upgrade of the York Hospital restarurant and kitchens, Endoscopy decontamination expansion and the nearly completed carbon & energy scheme. In Scarborough phase 1 of the new carpark is completed and significant progress on Maple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

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

Continuity of Service Risk Rating (CoSSR):

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

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



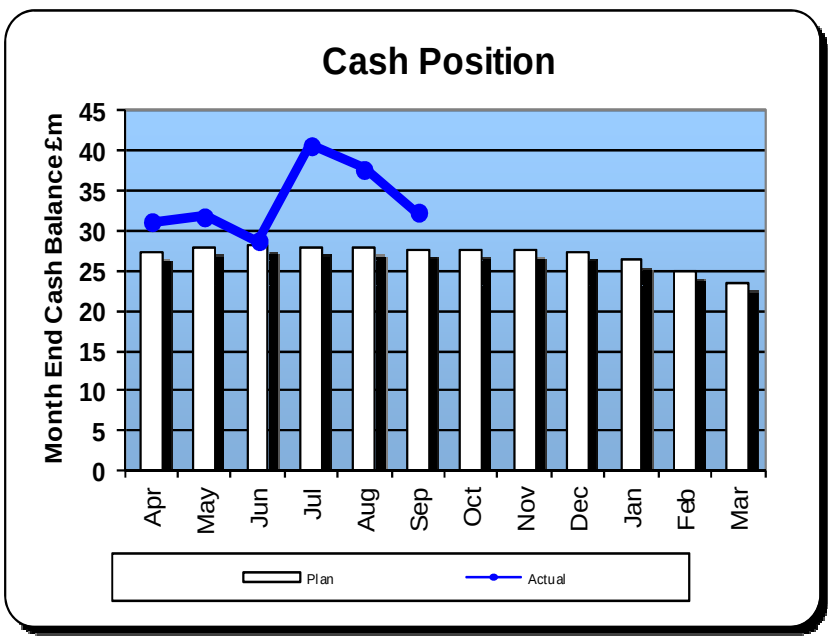
Annual plan 198,057 referrals (based on full year equivalent of 2013/14 outturn)

Variance at end of September: +7,067 referrals (+7.3%)

GP referrals +3,480 (+6.1%)

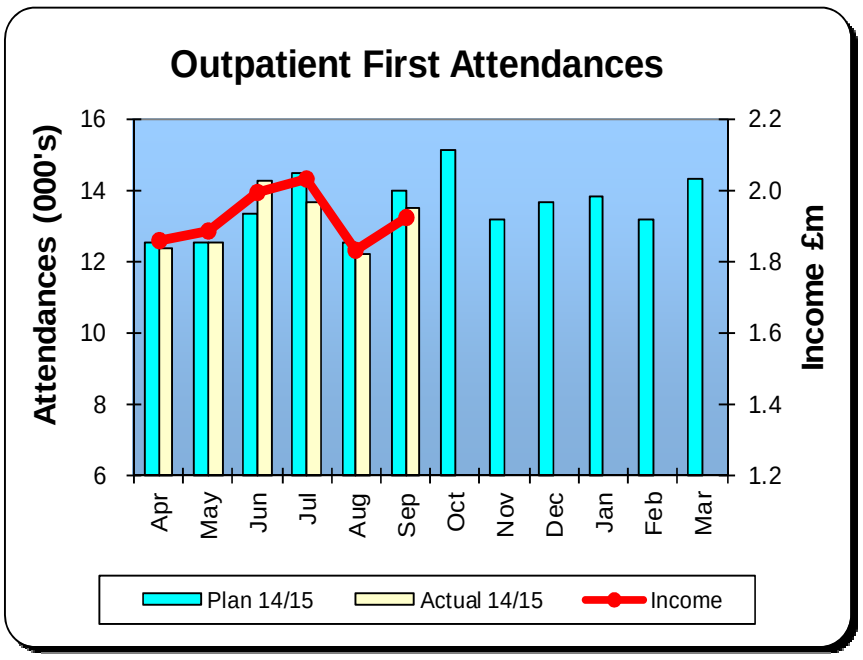
Cons to Cons referrals -629 (-4.4%)

Other referrals +4,216 (+16.4%)



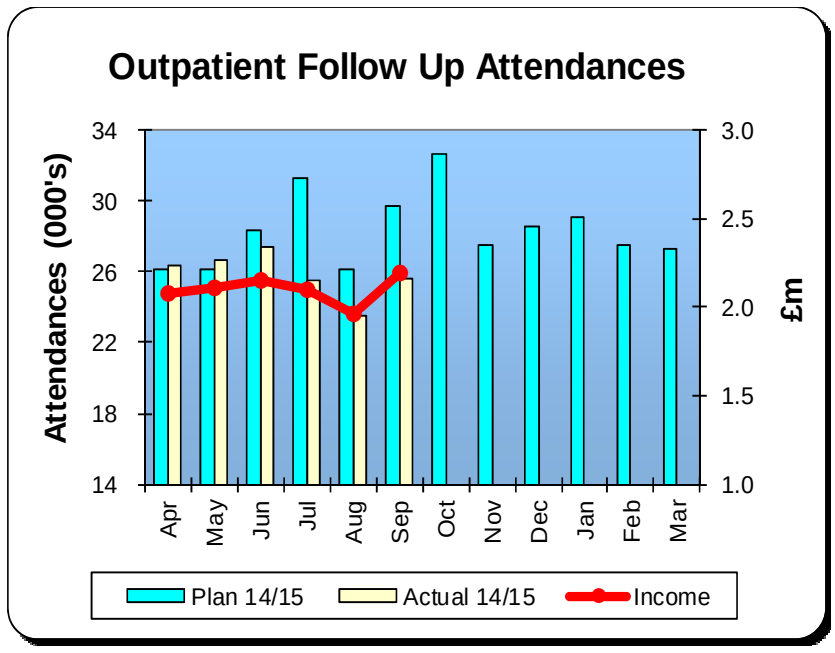
The cash balances at the end of September totalled £32.3m. This is £4.5m ahead of plan due to the transitional funding received for Scarborough.

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



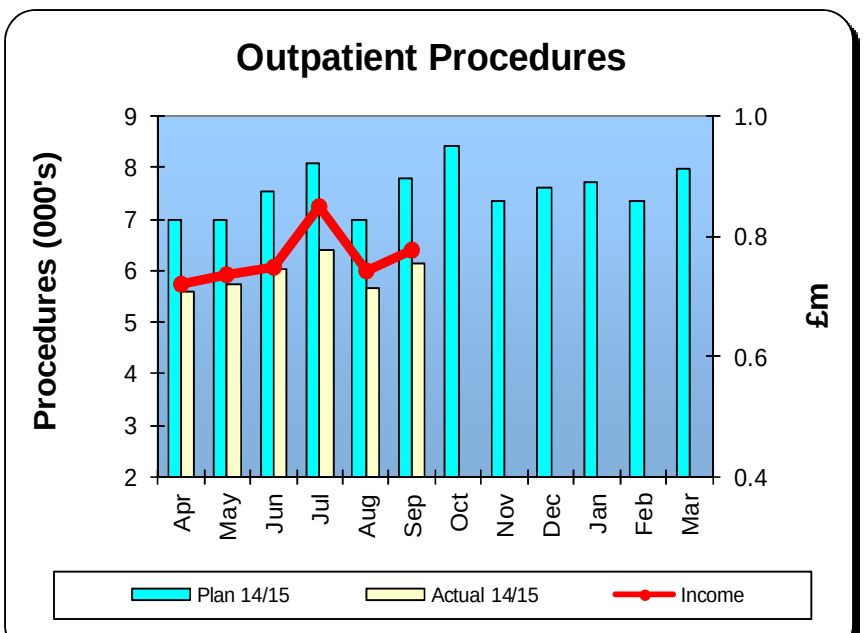
Annual Plan (Attendances) 162,401
Variance at end of September: -1,071 attendances (-1.3%).

Main variances: Opthalmology +199 (+2%), Obstetrics Zero Tariff +507, Medicine Specialties -619 (-5%),Clinical Neurophysiology -273 (23%), Paediatrics +346 (15%), Rheumatology -298 (-5%), Geriatric medicine -273 (-12%), Trauma and Orthopaedics -111 (-1%)



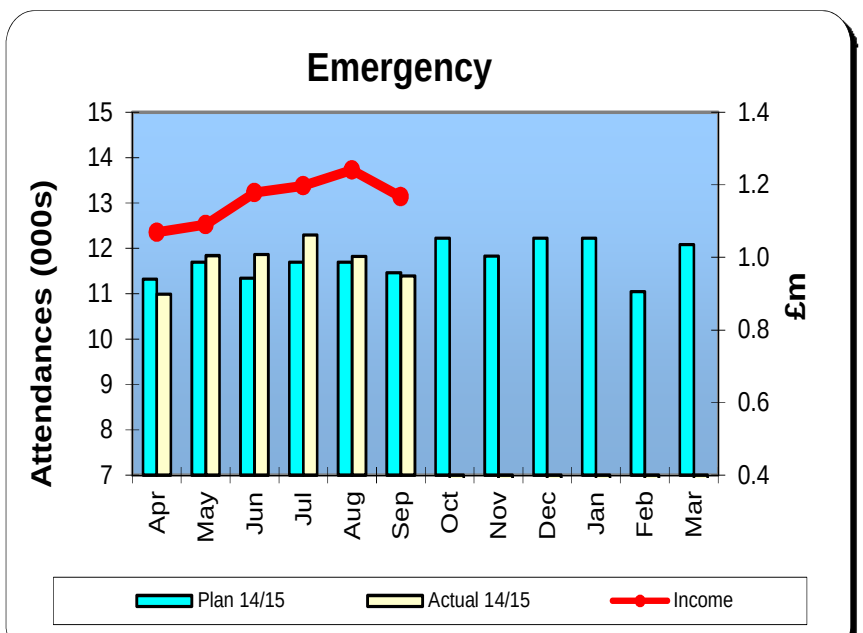
Annual Plan (Attendances) 340,039
Variance at end of September: -11,493 attendances (-7%).

Main variances: General Surgery +840 (8%), Trauma and Orthopaedics+847 (7%) Pallative Medicine +718 (+57%), Paediatrics -614 (-11%), Gynaecology -1,854 (-39%), and Obstetrics and Midwifery Zero Tariff -7,954 (-30%)



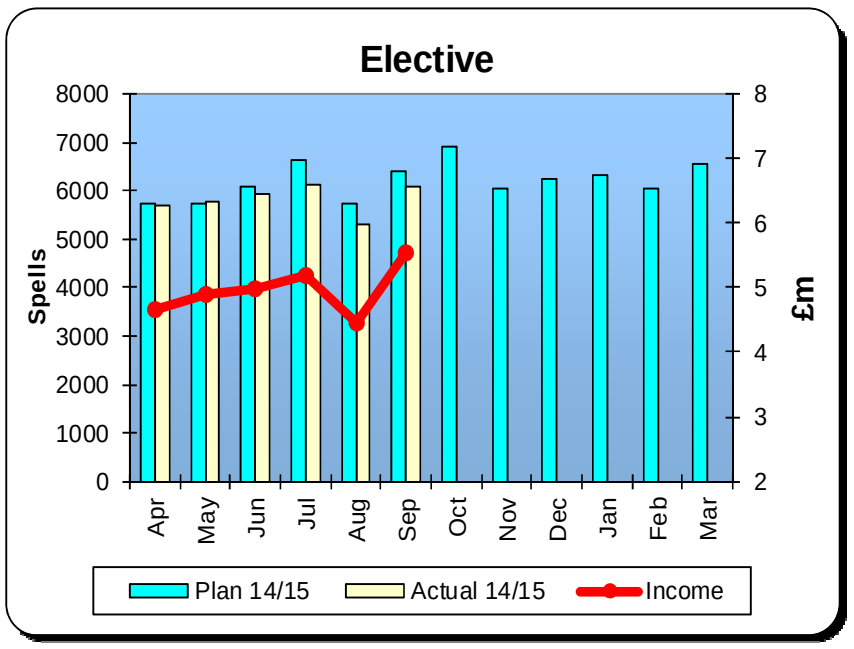
Annual Plan (Procedures) 90,710
Variance at end of September: -8,855 procedures (-20%).

Main variances: Dermatology -1,181 (-13%), Opthalmology -4,961 (-46%), Trauma and Orthopaedics -1,105 (-62%), Restorative Dentistry -446 (-56%), and ENT -1,003 (-20%).



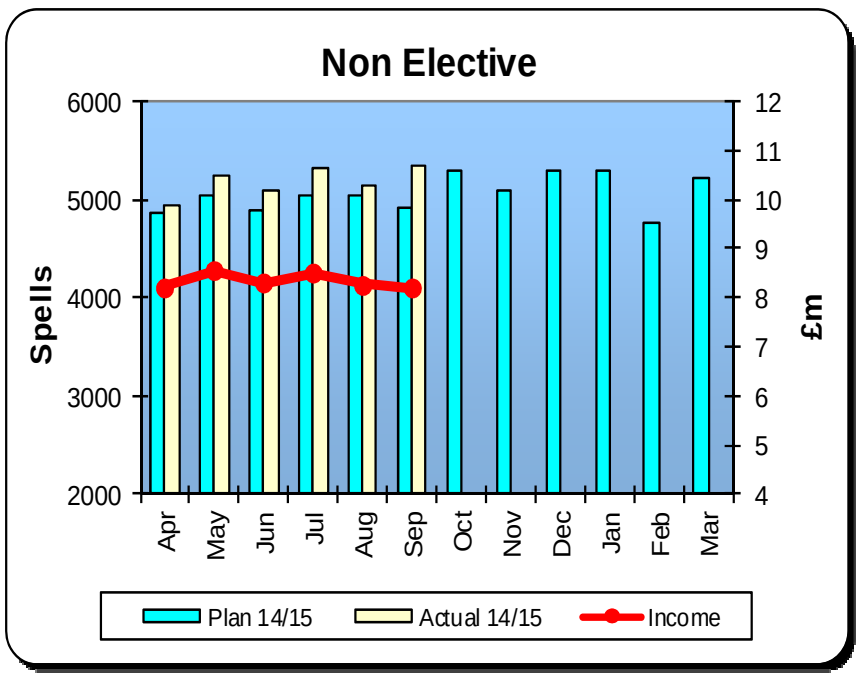
Annual Plan (Attendances) 140,831
Variance at end of September: +994 attendances (+1.4%).

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



Annual Plan (Spells) 74,445
Variance at end of September: -1,547 spells (-5.7%): inpatient -94; daycase -1,453

Main day case variances: General Medicine +272 (+31%), General Surgery -282 (-8%), Haematology -325 (-15%), Medical Oncology -488(-12%), Urology -354 (-7%)



Annual Plan (Spells) 60,765
Variance at end of September: +1,203 spells (+4%).

Main variances: Gastroenterology +430 (+23%), General Surgery +303 (+9%), Endocrinology +418 (+30%), Obstetrics +407 (+9%), General Medicine -547 (-72%).

Contract Penalties

Penalties	Penalty £000	Comments
52 week breaches	0	£5k penalty per breach per month. Agreement reached to recind penalties following review of cases.
18 week breaches:		Figures include estimates in early months.
- Admitted (90% target, weighting 37.5%)	57	GenSur £3k; T&O £29k; ENT £13k:
- Non-admitted (95% target, weighting 12.5%)	15	Cardiology £1.0k; resp. medicine £2.7k; Rheumatology £5.2k.
- Incomplete pathways (92% target, weighting 50%)	33	T&O £8k; Gastro £ 5k; ENT £4k, Gastro 5.3k.
Cancer waits	168	Cancer 2 week waits/ Breast symptom two week waits.
NHS Numbers	0	
A&E 4 hr performance	315	Faliure to admit, transfer or discharge patients within 4 hours of arrival. Target 95%. Fine is £200 per breach.
Ambulance handover	0	Ambulance handover exceding 30 (£200 each) and 60 minutes (£1,000 each). Value assumed at £596k Attempts being made to recover from CCG's.
Diagnostics	96	6 weeks target 99%. relates to tests including radiology, NPU, cardiology tests and endoscopies.
	684	

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

	ANNUAL PLAN	PLAN FOR PERIOD	ACTUAL FOR PERIOD	PERIOD VARIANCE
	£000	£000	£000	£000
INCOME				
NHS Clinical Income				
Elective Income				
Tariff income	27,092	13,352	11,878	-1,474
Non-tariff income	169	83	71	-12
Planned same day (Day cases)				
Tariff income	35,044	17,096	17,026	-70
Non-tariff income	651	318	248	-70
Non-Elective Income				
Tariff income	94,305	46,302	49,350	3,048
Non-tariff income	1,840	903	1,000	97
Outpatients				
Tariff income	58,563	28,657	27,173	-1,484
Non-tariff income	4,688	2,288	1,955	-333
A&E				
Tariff income	14,058	6,902	6,725	-177
Non-tariff income	490	241	218	-23
Community				
Tariff income	1,112	545	609	64
Non-tariff income	34,229	17,067	16,820	-247
Other				
Tariff income	0	0		0
Non-tariff income	123,549	60,803	61,107	304
				0
	395,790	**194,557**	**194,180**	**-377**
				0
	395,790	**194,557**	**194,180**	**-377**
Non-NHS Clinical Income				
Private Patient Income	976	488	553	65
Other Non-protected Clinical Income	1,722	861	921	60
	2,698	**1,349**	**1,474**	**125**
Other Income				
Education & Training	14,434	7,217	7,485	268
Research & Development	2,005	1,002	1,631	629
Donations & Grants received of PPE & Intangible Assets	0	0	0	0
Donations & Grants received of cash to buy PPE & Intangible Assets	600	300	300	0
Other Income	17,614	9,093	9,271	178
Transition support	12,218	6,109	6,109	0
	46,871	**23,722**	**24,796**	**1,075**
Total Income	**445,359**	**219,627**	**220,450**	**823**
EXPENDITURE				
Pay costs	-297,290	-145,668	-147,815	-2,147
Drug costs	-42,156	-20,949	-20,851	98
Clinical Supplies & Services	-45,179	-22,351	-21,803	548
Other costs (excluding Depreciation)	-49,616	-23,753	-22,522	1,231
Restructuring Costs	0	0	-136	-136
CIP	10,685	2,370	0	-2,370
Total Expenditure	**-423,556**	**-210,351**	**-213,127**	**-2,776**
EBITDA (see note)	**21,803**	**9,276**	**7,323**	**-1,953**
Profit/ Loss on Asset Disposals	0	0	0	0
Fixed Asset Impairments	-300	0	0	0
Depreciation	-10,854	-5,427	-5,427	0
Interest Receivable/ Payable	100	50	87	37
Interest Expense on Overdrafts and Working Capital Facilities	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0
Interest Expense on Non-commercial borrowings	-415	-212	-184	28
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	-3,602	-3,602	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**3,130**	**85**	**-1,803**	**-1,888**

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

York Teaching Hospital NHS Foundation Trust

Board of Directors - 29 October 2014

Efficiency Programme Update – September 2014

Action requested/recommendation

The Committee is asked to note the September 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 September 14 is £13.3m, leaving a gap to be delivered of (£10.7m). There is a planning gap of (£1.7m) following a review of all in year plans.

The Monitor variance is (£2.4m) behind plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

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

Briefing note for the Finance & Performance Committee Meeting 21 October 2014

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

Summary reported position for September 2014

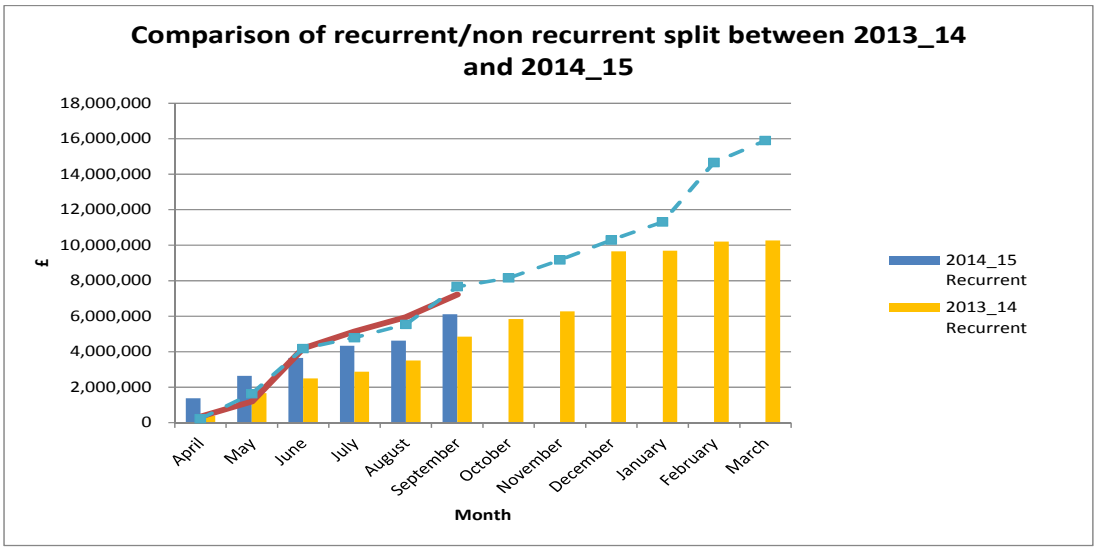
Current position – highlights and risks

Delivery - Overall delivery is £13.3m in September 2014 which is 55% of the £24m annual target. This has improved from the last reported position in August 2014 by £2.7m. This compares favourably with the September 2013 delivered position of £12.6m (54%) of target, which is encouraging.

In year planning – The in year planning gap has closed from (£2.6m) in August 2014 to (£1.7m) in September 2014. This improvement is also encouraging; and is ahead of the position in September 2013 which showed a (£2.4m) planning gap.

Four year planning – The four year planning gap has closed from (£22.2m) in August 2014 to (£20.3m) this month.

Recurrent vs. Non recurrent – Of the current £13.3m delivery £6.1m (46%) is recurrent, which is a significant improvement from the August 2014 position of £4.6m. Although this is not where we would want to be ideally, I am pleased to report this position is ahead of the September 13 position which was £4.8m (39%) delivered recurrently. The work continues to identify recurrent schemes. **See chart below.**



Quality Impact Assessments (QIA) – The quality Impact Assessments are currently being carried out with support from Dr Ian Jackson. 19 areas have

now self assessed and are rated as green, which leaves 8 clinical areas and 5 corporate areas to finalise self assessment. The majority of clinical areas remaining are areas where there have been gaps in the Directorate management team.

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

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

General Medicine Scarborough and Ed Scarborough are areas of particular concern having delivered only 5% & 6% of their target respectively, and have showed no delivery in August and September 2014. Both areas are also red rated in terms of their QI Assessments.

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

The Resource Management team - The structure has been finalised with the Director of Finance and recruitment is underway. Two interview panels have been held on W/C 13th October 2014 for the Deputy Head of Resource Management and a Costing Analyst within the costing and SLR team. Further posts will be recruited in the coming months.

Efficiency Panels – are now 2/3 completed i.e. 14 from a total of 21. Significant potential opportunities are being identified. This information is currently being populated on to the matrix. The outcome from the panels will determine the future efficiency work plan for both the resource management and directorate teams.

Efficiency Group meeting – The role of the Efficiency Group meeting is currently under review with the Chief Executive and Director of Finance.

Board of Directors - 29 October 2014

Efficiency Programme Update – September 2014

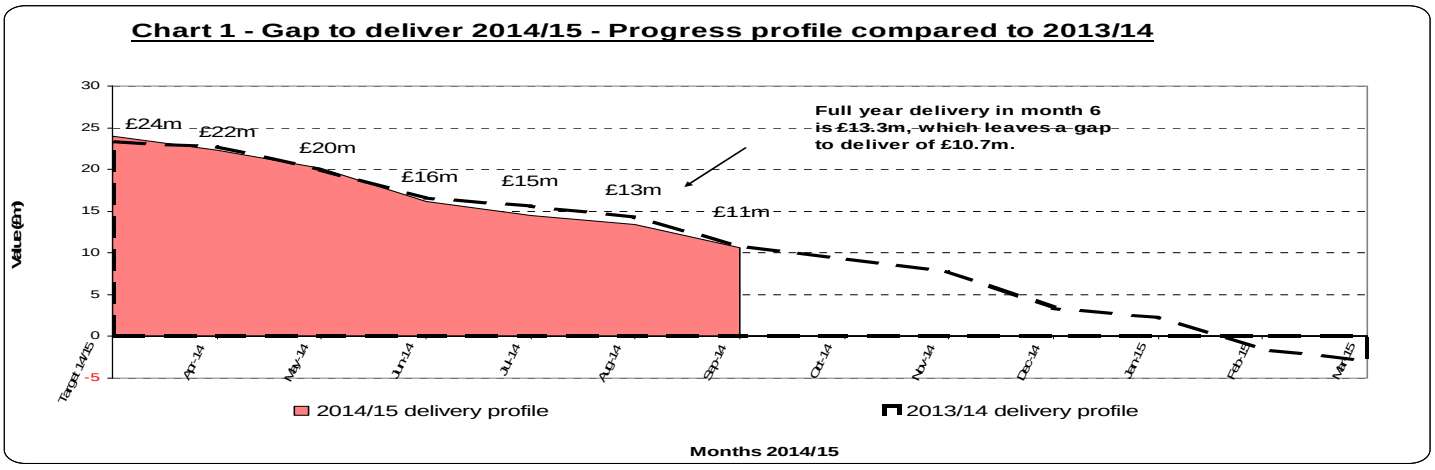
1. Executive Summary

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

See table 1 and chart 1 below.

Table 1 – Executive Summary – September 2014	Total
	£'m
TARGET	
In year target	**24.0**
DELIVERY	
In year delivery	**13.3**
In year delivery shortfall	**(10.7)**
Part year delivery shortfall - Monitor variance	**(2.4)**
PLANNING	
In year planning surplus/(gap)	**(1.7)**
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 19 are now green. Work is on-going to assess the remaining directorates.	**Current month** The current planning gap is (£1.7m), which is an improvement on the previous month. Full year delivery in September 2014 is £13.3m which has improved by £2.7m from August 2014. The Monitor variance is (£2.4m) adverse.
Last Month Of the 32 Directorates and Corporate HQ functions 9 are now green. Work has started on reviewing new schemes.	**Last month** The current planning gap is (£2.6m), which is comparable to last month and remains a concern. Full year delivery in August 2014 is £10.6m which has improved by £1.1m from July 2014. The Monitor variance is (£2.9m) adverse.

2. Introduction and background

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

3. Trust plan to Monitor

The combined position is (£2.4m) behind the Trust plan to Monitor as at September 2014; see Tables 2 & 3 and chart 2 below.

Table 2	August YTD 2014	September 2014	Total YTD
	£m	£m	£m
Trust plan	10.0	2.0	**12.0**
Achieved	7.1	2.5	**9.6**
Variance	(2.9)	**0.5**	**(2.4)**

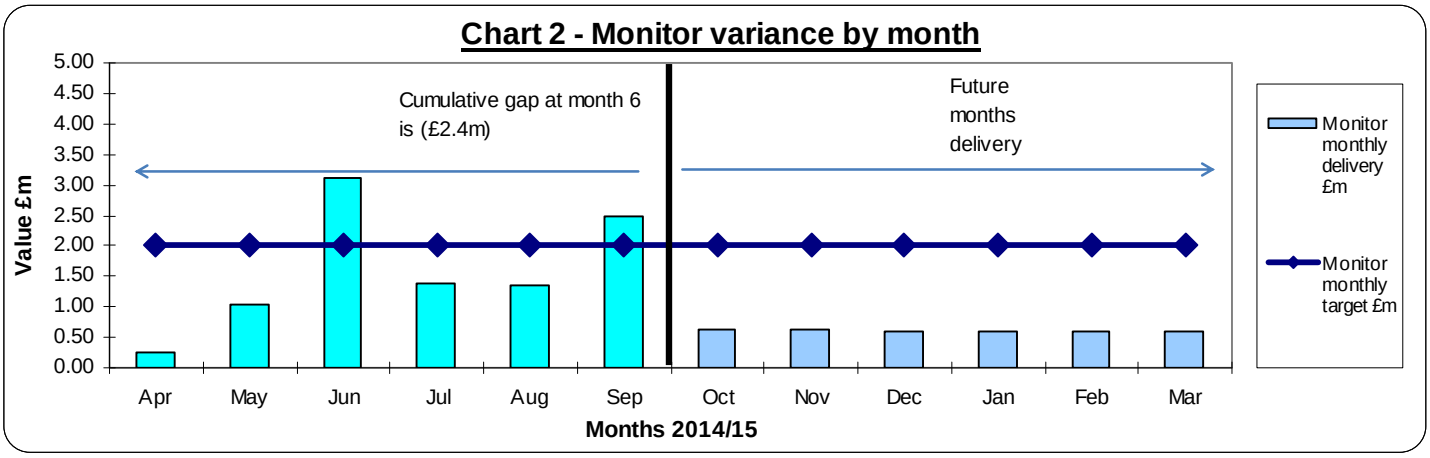


Table 3 – Monitor variance by month and cumulative variance

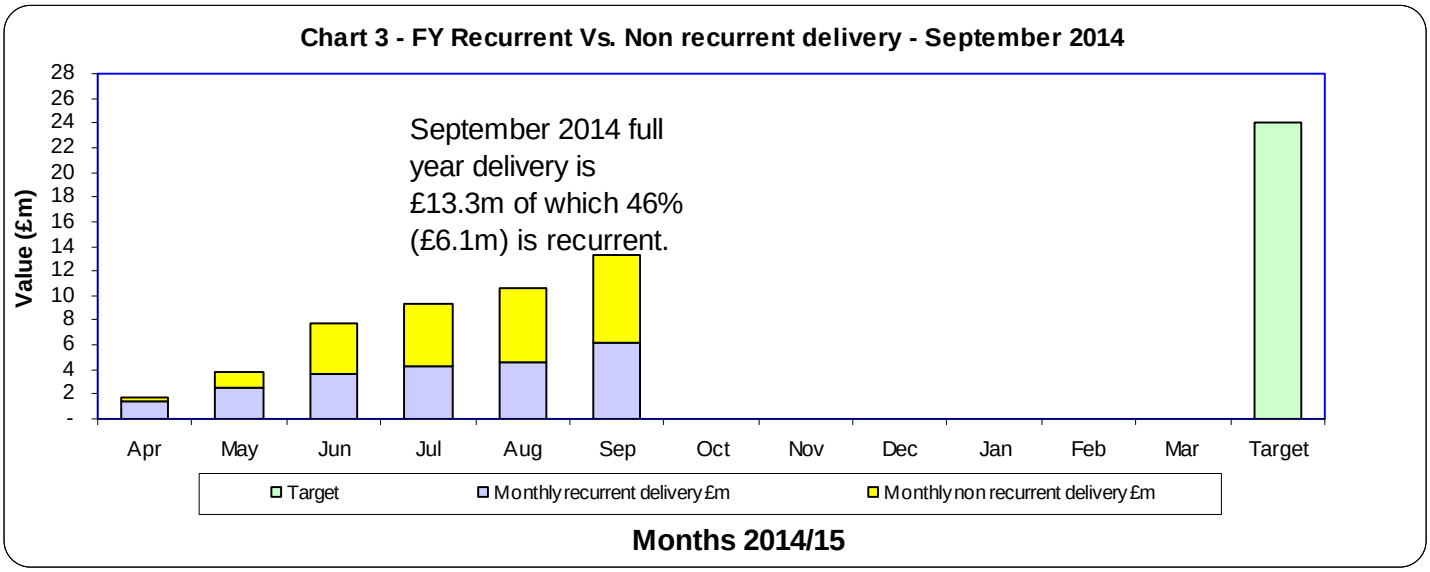
Months	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 14/15
Monthly delivery £m	0.3	1.0	3.1	1.4	1.3	2.5	0.6	0.6	0.6	0.6	0.6	0.6	**13.3**
Monthly target £m	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	**24.0**
Variance £m	-1.8	-1.0	1.1	-0.6	-0.7	0.5	-1.4	-1.4	-1.4	-1.4	-1.4	-1.4	-10.7
Cumulative variance	-1.8	-2.7	-1.6	-2.2	-2.9	-2.4	-3.7	-5.1	-6.5	-7.9	-9.3	-10.7	

3.1 Full year position summary

As at September 2014, **£13.3m** has been achieved in full year terms against the plan of £24.0m (see Table 4 below).

Table 4	August 2014	September 2014	Change
	£m	£m	£m
Expenditure plan – 14/15	24.0	24.0	0
Target – 2014/15	**24.0**	**24.0**	**0**
Achieved - recurrently	4.6	6.1	1.5
Achieved - non-recurrently	5.9	7.2	1.3
Total achieved	**10.5**	**13.3**	**2.8**
Shortfall	13.4	10.7	**-2.8**
Further plans	10.8	9.0	**(-1.8)**
(Gap)/Surplus in plans	**(2.6)**	**(1.7)**	**0.9**

The September 2014 position is made up of £6.1m (46%) of recurrent and £7.2m (54%) non-recurrent schemes. This compares with £4.8m (39%) recurrent and £7.7m (61%) non-recurrent at September 2013 - see chart 3 below.



3.2 Further planning and assessed risk to delivery

Further plans have been formulated amounting to £9m, which gives a shortfall in the planning position of (£1.7m). Plans are summarised in Table 5 below.

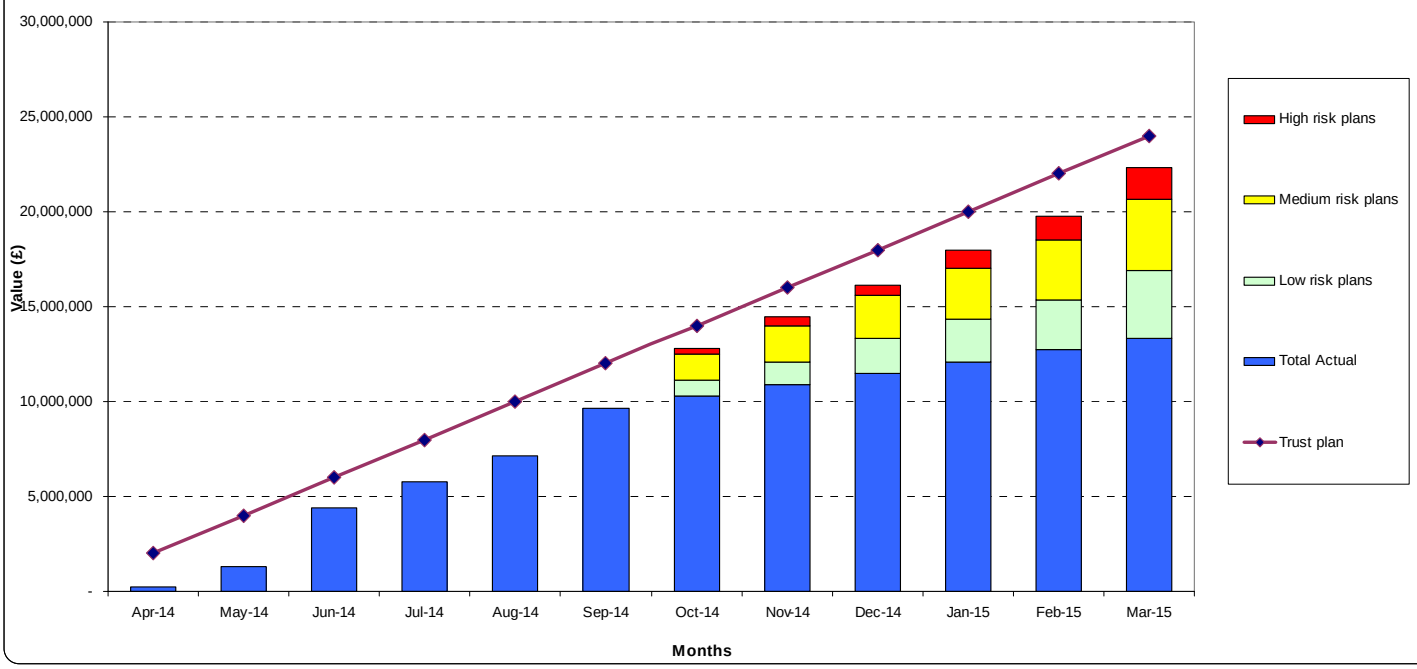
Table 5 – Further plans 2014/15

Risk	Gap Full Year	Plans - Recurrent	Plans - Non Recurrent	**Plans Total**	Gap in plans
	£m	**£m**	**£m**	**£m**	**£m**
Low		2.5	1.0	**3.6**	
Medium		3.4	0.4	**3.8**	
High		1.6	0.1	**1.6**	
Total	**10.7**	**7.5**	**1.5**	**9.0**	**(1.7)**

Directorate plans are each assigned a risk rating.

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



Significant work is continually carried out to re-assess, remove or re-profile plans to ensure an up to date position. There is an in year planning gap of **(£1.7m)**, this has improved from the August position but remains a high risk position. Work is ongoing to improve this.

3.3 Four year planning

Directorates are required to develop four year plans and Table 6 below summarises this position. There is currently a shortfall of (£20.3m) over 4 years on the base target; this has improved by £1.9m in the month.

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

Table 6 - 4 Year efficiency plan summary – September 2014

Year	2014/15	2015/16	2016/17	2017/18	Total
	£m	£m	£m	£m	£m
Base target	24.0	16.8	16.8	16.8	**74.4**
Plans	22.3	15.4	10.8	5.7	**54.1**
Variance	**(1.7)**	**(1.4)**	**(6.1)**	**(11.1)**	**(20.3)**

3.4 Finance risk rating

In year delivery is ahead of the same point last year with £13.3m (56%) delivered in September 2014 against £12.6m (54%) in September 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.

3.5 Governance risk rating

Currently 19 Directorates have re-assessed there schemes using the new Quality and Safety report. Work is on-going within the other directorates to ensure up to date governance assessments are carried out.

4. Conclusion

In September 2014 £13.3m worth of full year schemes has been delivered against the Trust plan of £24.0m, leaving a delivery gap of (£10.7m); this compares with £12.5m delivery in September 2013. The part year Monitor profile is (£2.4m) behind plan in month 6.

We currently have a planning gap in year of (£1.7m), which remains high risk.

The 4 year planning position highlights a shortfall in base plans of (£20.3), which has improved from period 5, but also remains high risk. Work continues to improve the overall planning position.

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

5. Recommendation

The Committee is asked to note the September 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	**October 2014**

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

RISK SCORES - SEPTEMBER 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
GEN MED SCARBOROUGH	982	2,511	27%	1	5%	1	1%	1	39%	1	4	1
RADIOLOGY	1,901	3,800	41%	1	21%	1	1%	1	42%	2	5	1
SPECIALIST MEDICINE	1,850	5,345	57%	1	15%	1	10%	1	60%	3	6	1
WOMENS HEALTH	2,342	4,464	46%	1	24%	1	17%	1	58%	3	6	1
GS&U	1,717	4,794	80%	2	49%	2	18%	1	67%	3	8	2
T&O YORK	789	2,331	75%	2	51%	2	17%	1	51%	3	8	2
TACC YORK	2,421	5,768	64%	2	56%	2	51%	3	33%	1	8	2
OPHTHALMOLOGY	875	2,667	78%	2	58%	2	58%	3	37%	1	8	2
ED YORK	501	1,426	77%	2	31%	1	13%	1	94%	5	9	2
HEAD AND NECK	480	1,863	74%	2	58%	2	35%	2	57%	3	9	2
COMMUNITY	1,648	4,390	60%	2	35%	1	33%	2	97%	5	10	2
ED SCARBOROUGH	404	1,329	95%	4	6%	1	0%	1	101%	5	11	2
CHILD HEALTH	1,247	2,999	68%	4	25%	1	3%	1	75%	5	11	2
GEN MED YORK	1,672	5,114	97%	4	27%	1	8%	1	92%	5	11	2
TACC SCARBOROUGH	870	2,435	103%	5	61%	2	27%	1	54%	3	11	2
MEDICINE FOR THE ELDERLY SCARBOROUGH	817	1,698	107%	5	30%	1	25%	1	91%	5	12	3
THERAPIES	1,367	3,772	94%	4	57%	2	21%	1	83%	5	12	3
SEXUAL HEALTH	491	1,129	94%	4	63%	2	37%	2	86%	5	13	3
MEDICINE FOR THE ELDERLY	174	1,717	128%	5	72%	3	23%	1	104%	5	14	3
T&O SCARBOROUGH	324	1,298	130%	5	111%	5	57%	3	40%	1	14	3
LAB MED	1,672	4,022	99%	4	75%	4	54%	3	77%	5	16	4
PHARMACY	-188	611	101%	5	101%	5	101%	5	171%	5	20	5
CORPORATE												
MEDICAL GOVERNANCE	77	180	58%	1	41%	2	17%	1	25%	1	5	1
CORPORATE NURSING	334	496	42%	1	42%	2	16%	1	30%	1	5	1
OPS MANAGEMENT SCARBOROUGH	329	638	61%	2	14%	1	2%	1	45%	2	6	1
SNS	1,137	2,557	86%	3	35%	1	17%	1	53%	3	8	2
ESTATES AND FACILITIES	2,878	7,804	56%	1	39%	1	23%	1	76%	5	8	2
AL&R	185	420	70%	2	57%	2	0%	1	55%	3	8	2
HR	446	1,169	98%	4	70%	3	14%	1	69%	3	11	2
OPS MANAGEMENT YORK	239	419	106%	5	29%	1	0%	1	96%	5	12	3
CHIEF EXEC	75	448	259%	5	243%	5	160%	5	43%	2	17	4
FINANCE	251	1,116	128%	5	128%	5	87%	5	88%	5	20	5
TRUST SCORE	**30,308**	**80,731**	**93%**	**4**	**56%**	**2**	**25%**	**1**	**73%**	**4**	**11**	**2**

Present:
Professor Dianne Willcocks, Non Executive Director (Chair)
Natalie McMillan, Assistant Director Resourcing
Sue Holden, Director of Corporate Development (via speaker phone)
Libby Raper, Non Executive Director
Dr J Thow, Clinical Strategy Lead
Pamela Hayward-Sampson, Assistant Chief Nurse
Sian Longhorne, Workforce Information Manager
Wendy Scott, Director of Community Services
Gail Dunning, Deputy Director Applied Learning and Research
Anne Devaney, Deputy Director Applied Learning and Research
Apologies:
Patrick Crowley, Chief Executive
Melanie Liley, Directorate Manager for Therapies
Beverley Geary, Director of Nursing

Becky Blackburn, Human Resources Advisor & Zinnia Ritz, Human Resources Manager (for minutes)

The minutes of the meeting have been drafted to reflect how the items were listed on the agenda however the meeting did not follow that order.

	Agenda Item	Comments	Assurances	Attention to the Board
1	Apologies for Absence	These were received from Melanie Liley, Patrick Crowley and Beverley Geary		
2	Matters arising from the last minutes	The minutes from the last meeting were agreed.		
3	Matters arising	• <u>Future agenda items</u> SH felt that with regard to future agenda items, that a number of items were strategic and some operational. She proposed that the operational aspects were removed going forward. She said that the next workforce strategy meeting particularly needs to look at our non-registered workforce and challenges regarding recruitment and retention for medics and nursing staff. SH observed that sometimes the areas of concern were disproportionate to the issues and more of an evidence based approach needed to be taken, looking at risks, what is being done and what still needs to be done. DW agreed that there was disproportionate attention paid to the nurse workforce as there was a need		

		to get considerations set alongside other professional and support groups. **Action: These items to be added to the next agenda.** • <u>Workforce update on Elderly and Anaesthetics</u> NMc informed the committee that it was recommended in the paper that the data should be based on a workforce model fit for the future, rather than all the focus being on what has happened in the past. This workforce modelling is progressing but the recent doctors' intake and other pressures have taken priority. Work on this will now be resumed. It was proposed by NMc that she would bring this to the next meeting, which was agreed. Regarding general workforce priorities around medical posts, NMc noted that it is important to make the middle grades more attractive by providing development opportunities and make these roles more rewarding. **Action: NMc to bring a further update to the December meeting.** • <u>Integrated provision of training</u> SH said there was greater integration of communications. There is a combined communications strategy for medics/non medics and registered/unregistered staff included in the educational strategy now. This was endorsed at the last meeting. • <u>Staff Friends and Family Test</u> ZR said that the response rate for Q1 was low at 8%. Part of the reason for this was that staff had been asked to provide their employee number to access the survey. Q2 of the survey was currently underway, and the decision had been taken remove the requirement for the employee number as well as making the survey accessible on-line only. Initial reports suggested that the response rate would be similar to Q1. ZR confirmed that she was exploring ideas on how to improve the rate for Q4, which included working with the Communications team on feeding back responses and engaging with staff directly to get a better understanding of why the response rate was so low LR asked if there was any comparative data and if so where do we as a trust sit. ZR said that at the NHS Employer event on SFFT that she recently attended, the lowest response rate was 4% and the highest was 55% - but that this was the exception. She said the response rates were mostly around the 20% mark. The feedback from other trusts was that they hadn't done anything significantly		

		differently to us. PHS expressed that staff are often asked to complete many different surveys and perhaps we could consider limiting the number of surveys so as to encourage staff to complete this survey. DW suggested asking staff to complete the survey in teams meeting and suggested exploring different ways of gathering the information so as to increase the response rate and in turn increase the qualitative information from staff. LR agreed and suggested that we need to think of mechanisms we already have and 'piggy back' onto them to make things simpler. NEDs asked fo urgent attention to this. **Action: ZR to consider alternative mechanisms for implementing SFFT for Q4**		
4 & 5	HR Directorate & Learning & Research Overview (Note items 4 and 5 were discussed together)	SH invited questions from the committee on the reports: Page 1: DW commented on the '6 month amnesty' regarding staff engagement with the learning hub and questioned if this was the language we should use with staff. SH said this language was appropriate in the context. She didn't want to get into any sense of judgement. AD stated that the information on the learning hub came from ESR and some of it was out of date. She said it was important to get ESR up to date and then as a result, compliancy records would be more up to date. PHS said that feedback at ward level was very good. AD agreed and the Consultants feedback has been excellent too. LR asked that once the amnesty had finished, what percentage would be reached towards the statutory and mandatory training compliance and whether any targets had been set? SH said that there were set targets for statutory and mandatory training, which would be an increasing target starting at 50% by the end of year 1; 70% by the end of year 2; and 95% by the end of year 3. AD provided an update on the number of completed certifications, saying that the figure was 4500, an increase of 2500, since the previous figure provided by SH from 2 weeks ago. SH said that in the January board report, she will bring a bench-mark set of data as to where the Trust is. She said that the release in Staff Matters had been cancelled, so consequently the launch was delayed this month. Page 4: NMc informed the committee that we had been successful in securing a	The committee were assured by the information within the reports	

		place on the regional Ageing Workforce group. Dawn Preece would be the Trust's representative. DW enquired about the Health Kiosks in the report. ZR explained the health kiosk that had recently been piloted in 2 areas: Facilities and Anaesthetics for one month as a means of engaging staff about their health & wellbeing. 560 staff had participated in the pilot. DW said that she thought this was a great way of highlighting health issues in a non-challenging way. Page 5: SH referred to the last point, page 5 regarding Equality and Diversity. She said there were challenges regarding using information in the system to support those with protected characteristics. She recently had a meeting with Sue Rushbrook on this subject. She said they can now use patient data from the front of the file, for example regarding patients who access a hearing clinic and this can feed into the E&D data. It is acknowledged that there is a need but currently this is not linked to other services DW explained that she had attended Healthwatch. She said that hearing deficits was a big issue identified and patients shared their stories on this. Healthwatch were delighted that York hospital is taking up the challenge.		
6	Terms of Reference	The committee were asked if they had any comments about the draft Terms of Reference. DW commented on the benefits of having a shared agenda across the directorate. She said there was a need to be forward - looking about the workforce but that it was important to consider the present also though. LR said that from a recent meeting of the audit committee that it would be useful if adverse audit findings would flow to the next meeting so that they would understand the context of their work. SH said you can't inform the future without recognising the present and the past. She said it was important to recognise patterns and learn from them. PHS suggested that they remove the Assistant Director of Workforce (Nursing) role from the membership list. It was also recognised that there had been changes to individuals' titles and this should be resolved by December's meeting **Action: ToR to be finalised with amended membership**	The committee approved the Terms of Reference	
7	HR Strategy Annual Performance	NMc said that there had been a change of format to the Quarterly Report. She said that is was more thematic, with the last quarterly report focussed around the nurse staffing and workforce issues. She said there was a challenge around how	The committee were assured by the information	

	Report	to bring data that means something and maintaining the principle of bringing the key headlines. She said that feedback on what works and what doesn't would be useful. She said that for example, turnover was static over last 10 years and queried whether or not this needed to be brought to the report if it doesn't change. She felt that assurance and headlines would be the best approach, but sought opinion on how to go about doing this. LR suggested that in terms of focus that we should maybe present to the committee areas of risk. DW suggested a supplementary, commentary paper directing the reader through the main paper and highlighting risks identified by knowledgeable managers. DW acknowledged that different readers/audiences have different information needs, therefore the full commentary and a supplementary guide would be useful. SH said that the issue of turnover is important as it puts information into perspective and questioned how this information should be presented differently to the board. DW said that a static rate can be positive news at time of change. NM said that the nursing turnover rate was 5% whereas the Trust's turnover rate was 10% overall. She said that this comparatively low figure for nursing was a result of the campaigns led by recruitment team such as the one stop shop at weekends and open days. This has led to a reduction in the vacancy position by a third. She acknowledged that there will always be a turnover rate due to the lead in time of someone leaving and someone else being recruited and suggested that perhaps the establishment data should be represented differently, e.g. 105% to take into account the consistent turnover. **Action: A separate discussion with LR to take place regarding establishment figures to take into account the vacancy lead-in times.** DW referred to the volunteers report and said she was keen for integration to continue. However, she said she was concerned about our appraisal compliance. ZR said that there were two separate papers regarding a different approach to talent management and appraisals on today's agenda. DW mentioned employee relations and said she would like to get some benchmarking on this. She feels that robust action is being taken appropriately and noted that the temporary workforce spend was reduced due to the changed use of the skill mix. She said that a more creative approach had been taken and this needs noting. DW suggested that this is something that could be highlighted, to demonstrate good practice to build on. NMc agreed and said that	within the reports	

		by the 1st April 2015, the Trust will use solely an in-house bank. DW enquired about the use of e-rostering. NMc said the implementation of e-rostering was due to start in Scarborough. This will mean that the Trust will be able to deploy staff where needed. She said it will happen at the same time we move to the in-house bank. DW noted that the report on the Corporate HR team's activities were really positive. SH informed the committee that the events team will be managed by Lucy Brown in Communications from the 1st October. This will provide more time for Dawn Preece to lead the Trust's employee engagement strategy, which includes a review on engagement using twitter, blogs, using communication methods that work best for individuals. In relation to the Occupational Health update, SH advised that generally demand for their services is outstripping capacity. She said there needs to be some thought put to what needs to be done longer. DW said that there needed to be consideration of increasing mental health challenges and how we respond to these. NMc said that in response to the staff survey outcomes regarding stress a HR Manager had been seconded to work alongside colleagues in OH as a dedicated resource to look into mental health issues. **Action: Update on progress the work pertaining to mental health issues to be highlighted in future reports.**		
8	Staff Health, Wellbeing & Engagement Strategy	It was noted that the paper sets out the principles and actions and was a comprehensive report. SH said that with regards to staff engagement needs to be approached differently. SH said that she has asked staff side to work with her in an open way and to consider the cultural needs of the Trust as one organisation, and expectations of staff. SH said we needed to move towards less policy driven decision making and more knowledge based decision making and posed the question of how to engage with union members differently due to the potential variability of using a less policy driven approach. SH said that Dawn Preece had been working with the unions on this. LR said she had seen a poster that there would be a meeting every weekend for Alcoholics Anonymous in the Boardroom which she thinks is a very appropriate use of trust space.	The committee were assured by the information within the reports	
9	SWOT analysis –	NMc referred to the ESR paper, acknowledging Sian as the author and lead for	The committee	

	ESR Self Service and Establishment Control	this work. She said the Trust was not fully exploiting the ESR system as it had primarily been set up within finance but it is nationally used as an HR system and the Trust is unique in its use of this. It is not being fully exploited as a tool for workforce reporting. The establishment control function provides an opportunity to address the current issue around one central figure for the vacancy position especially given the focus around nurse staffing levels. Currently, there is not one central source with different systems and therefore different figures quoted which led to the information losing credibility.BG had given her apologies and PHS was deputising for her; both have given their full support to this given its relevance to nurse staffing levels. DHT said that she was extremely supportive of this in principle. However, she needed to understand further the impact to her team. SL said that a lot of organisations are using self-service The capacity/function is there to empower managers so they can potentially manage their own budgets, reduce number of paper forms and increase the quality of the Equality and Diversity data that is held, as well as reducing margins for error and increasing the credibility of our data. LR checked that we had the go ahead organisationally to progress, which was confirmed.	endorsed the principles of ESR self service and establishment control	
10	York Community Nursing Workload and Staffing Levels	WS said that Professor Keith Hurst had been invited to share his paper which is an audit tool for staffing levels to lead to safer nursing care. The Department of Health wants to mandate use of the tool for community as well as acute settings. It has been piloted across community providers: Scarborough, Ryedale, York and Selby. A local audit was carried out the year before and the findings of this research have correlated with that. This added a quality score that hadn't been used before in community services. Anecdotally, they already knew that Scarborough and Ryedale were more stretched. The quality score, which is part of the tool, involves asking patients as well as staff about their experience. It has allowed for benchmarking against other providers. The audit demonstrated that the Community is significantly under-resourced and that the skill mix is not right; particularly, Scarborough and Ryedale in comparison with other providers. Nurses are carrying out a significant number of Level 1 tasks when they should be carrying out Level 3/4 tasks to avoid admissions to hospitals. A competency framework has been developed for Health Care Assistants, for example carrying out insulin injections. The Trust has an ageing workforce and it is losing	The committee welcomed the report and sought an update paper to seek assurances on progress	

		experienced district nurses and is struggling to recruit in these areas. We need to think creatively about skill mix, which includes the type of staff and perhaps rotating staff to the community so that it becomes a more attractive option. A monthly audit is being carried out to understand how this changes over time. The career progression route currently is that nurses can't do a band 6 district nurse role until they have done a qualification for this. There is a national forum next week to support district nurses round a broader portfolio. DW asked how staff are responding. WS said that staff are responding really well and added that Professor Keith Hurst had fed back the audit results which was really helpful. SH said that she chaired the York Partnership Group with York, who are considering commissioning different qualifications including health and social care. GD said that work was being done for non-qualified staff to support Band 3's in gaining a qualification. The Calderdale framework was particularly focussing on community. NMc commented how encouraging it was that departments are looking beyond simply trying to recruit and offer financial incentives and using different workforce models and new roles. NMc queried where did the community data fit in with the discussions at the committee at the end of 2013 around safe staffing levels and nursing establishment figures? She was interested to know if 'safe' staffing becomes the end goal and where does the 'column' with aspirational levels fit in with these discussions? WS said that the safe staffing levels are in the community was an unknown and this was the picture nationally. SH said that the report has highlighted where the waste is and how technology can be used differently to reduce waste, highlighting that staff are constrained by the level of technology. WS added that according to the benchmarking exercise, the Trust has the highest level of travel compared to other 'like for like' areas. DW said that technology issues get in the way of patients being able to stay at home for end of life care. She said that the Trust needs to challenge the use of technology and improve. WS informed the committee that she had submitted a bid to a nursing fund for increased technology. The Vale of York Clinical Commissioning Group (CCG) is		

		prepared to buy all nurses in the patch a hand - held device. PHS said that currently there are errors in hand over and the use of hand-held devices would reduce this. DW said this report was really helpful and enabled the committee to get a better grip on the pressure points. DW said that she would like to see a paper in support of work on-going in Community. **Action: Update paper to be presented at a future committee meeting.**		
11	ODIL Leadership Development Strategy Paper	GD presented the Leadership strategy particularly highlighting that the organisation needs leaders at every level and that the style of leadership is situational which is non- hierarchical. The underpinning driver for all the programmes is individual's understanding themselves and self development. SH noted that the Board needed to be assured that there is a thread from band 2/3 to our Board regarding our values and personal responsibility framework. Talent development principles and changes to the appraisal system build a picture of this. LR enquired what the trigger for individual staff was. SH said that was in talent development paper. LR said we needed to be consistent that this links to the appraisal process. DW agreed that the Board needed to be more aware of this and that it would be helpful to showcase the figures that show each year and the indicative set of outcomes following this.		
12	Talent Development Principles	SH said development is driven by individuals and now the Trust needs to link to business and what individuals are delivering. It is about being competency based but there should be equity of access and it is about directing individuals where there are development needs and also providing opportunities for individuals to self declare an interest. SH said that health education has had their budget reduced by 50% and next year, leadership development will have to be significantly funded at local level. Fortuitously, we have not relied on national courses and funding but have developed our own. DW asked the question if the Trust could sell on our leadership programme externally. SH said there are discussions with NHS Elect regarding this. This could include training others to deliver training but need to be mindful of our resourcing issues. SH said that the providers of the national programme are reluctant to share materials and Trusts will now be charged for it. DW said she was encouraged by the paper and welcomed the principles of	The committee welcomed the report and sought an update paper to seek assurances on progress	

		fairness surrounding leadership development. DW noted that the committee would be keen to see how it progresses. **Action: It was agreed that it would be helpful for the Board to have sight of these papers.**		
13	Appraisal and Performance Management approach	ZR referred that as a Trust there has been a shift towards the personal responsibility framework and values and the proposed appraisal framework used this to enable staff and managers to consider not only what people did but also how they did this in terms of their behaviours. ZR said that framework provided an overall summary of expected behaviours from staff and managers. Furthermore the framework provided positive and negative behaviours based on our values. This would be linked to pay progression as well as talent development. ZR said that they were currently considering incorporating the appraisal and performance management policies into one to support this framework. SH said she has discussed this with Directorate Managers and has had a very positive response. She said that they need a framework for difficult conversations. It is shifting the dynamic to a managed workforce, which is quite evolutionary. She said that this approach aligns with other papers and responds to the needs of a developing workforce going forward. LR said she was extremely supportive of the new appraisal documentation which is a very good development. She agreed that simplification and alignment are important. LR- said she would like it if the appraisal paperwork had greater emphasis that we are here for patients. SH confirmed that this is in the documentation in the first points. LR asked that this was reinforced within the values behaviours. DW said that the framework is conduct focussed and questioned how to integrate capability and safety into this. SH said that individual managers can articulate the capability aspects through the setting of objectives with staff. ZR confirmed that this would complement and be added to the existing performance framework and therefore would still incorporate capability. PHS said that it could also be used in the preceptorship for nursing staff.	The committee welcomed the approach outlined within the report	
14	Re-employed NHS Pensioners	SH said that there have been some considerations around staff who retire, regarding limiting the contract period to those who have retired and come back. She said that at some trusts, for example Sheffield, people aren't brought people	The committee welcomed the report and sought	

		back to the same job/ band if they retire and return – the culture is that it isn't an automatic 'right' to return. SH said that the current position of the trust is creating a worsening ageing workforce problem. She said that the policy is written as though it is a right for individuals to come back and we need to consider whether this meet organisational need, for example, we don't struggle to recruit to administrative roles. SH said that she needed to start a different conversation with staff-side and reach a mutually agreed decision including being clear about what the role of the individual will be when they come back. She said that we need to be clear about open ended contracts. DW suggested benchmarking with other public sector organisations, such as higher education. The committee look forward to hearing more dialogue on this matter.	an update paper to seek assurances on progress	
15, 16 & 17	Workforce Strategy Committee Annual report; Workforce Planning for the future; Summary of the Annual Workforce Planning return (for information only)	DW noted that the annual Workforce Strategy paper has gone to the Board of Directors and was well received.		
18	AOB	Any other business – none reported		
19	Date of next meeting	3rd December 2014 2pm – 4pm, Boardroom, York Hospital		

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

Human Resources Strategy Quarterly Performance Report – 1 April 2014 – 30 June 2014

Action requested/recommendation

The Board of Directors is asked to consider the following recommendations in relation to potential actions and solutions to address current nursing workforce challenges:

- Urgently consider the development of new roles & identify pilot areas where they should be implemented – specifically band 3 & 4 support roles
- Development of opportunities for gaining healthcare experience (short term, e.g. summer contracts) to attract a younger workforce
- Pro active succession planning to minimise potential risks relating to senior and experienced nursing posts becoming vacant through retirements. This may potentially involve the development of an internal talent pool
- Support more open discussions around alternatives when posts (in particular Specialist Nursing posts) become vacant rather than default being to replace like for like

Support the continued exploration of innovative recruitment approaches, potentially including international recruitment

Summary

The attached document provides updated information for the period April - June 2014, relating to key Human Resources indicators including; sickness, recruitment & retention and workforce expenditure.

The main body of the paper demonstrates a shift in focus for this report. The report will focus in each quarter on a different key workforce theme. This report highlights the nursing workforce challenges faced by this organisation and other NHS organisations both regionally and nationally. The intelligence and analysis presented in this report is intended to inform discussion about actions required and potential solutions to address these challenges.

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	Executive Board – 17th September 2014
Risk	No risk
Resource implications	No resource implications
Owner	Sue Holden, Director of Applied Learning & Research
Author	Siân Longhorne, Workforce Information Manager
Date of paper	August 2014
Version number	Version 1

Board of Directors – 29 October 2014

Human Resources Strategy Quarterly Performance Report – 1 April 2014 – 30 June 2014

1. Introduction and background

Appendix A presents information relating to a range of key Human Resources indicators including sickness and temporary workforce expenditure.

Organisational performance against some of these metrics highlight some concerns. In particular, temporary workforce spend in this quarter is higher than in both the previous quarter and the same quarter of the 2013/14 financial year. The number of vacancies as a percentage of establishment and the percentage of the workforce on maternity leave have both increased recently which correlates to the increased demand for temporary staffing.

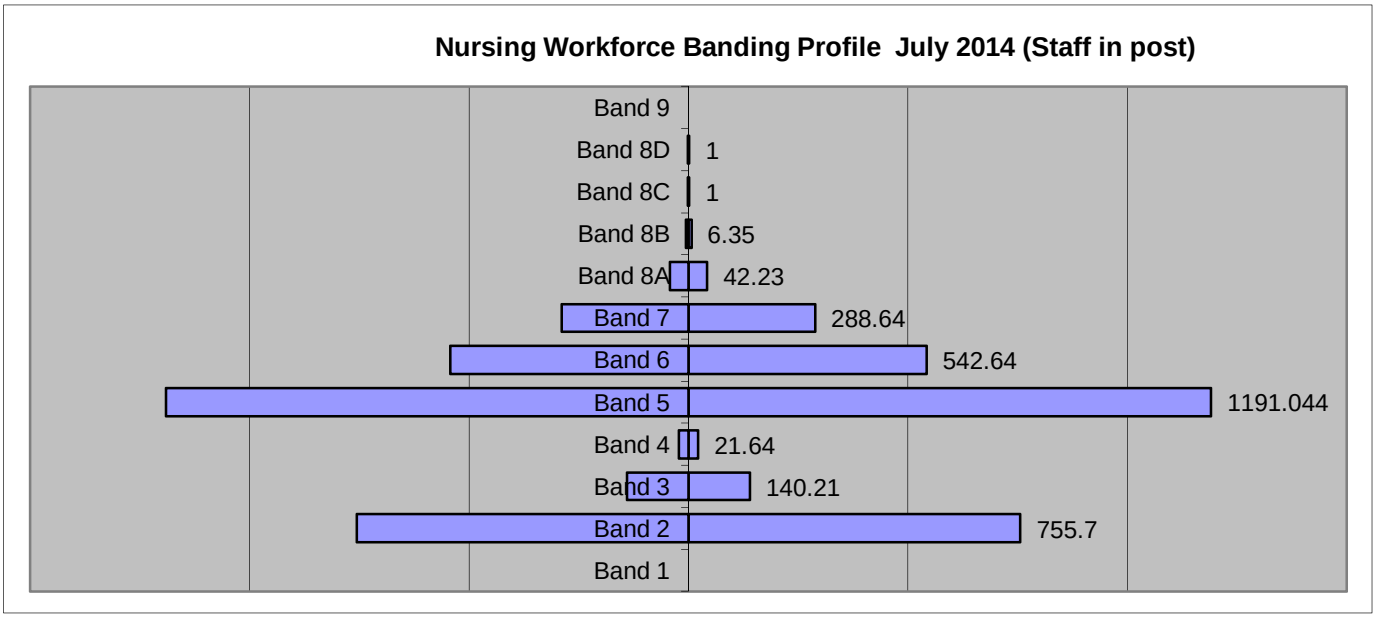
Appraisal rates in the first six months of 2014 have been well below the organisation's target of 95%.

We do however continue to see improvements in the organisation's sickness absence rates and continue to compare favourably with the absence rates of other similar organisations in the region.

The main body of this report focuses on the nursing workforce and the challenges currently facing this organisation and other NHS organisations regionally and nationally including the shortfall in supply of registered nurses to meet demand and the age profile of the current workforce, specifically in relation to experienced and senior nursing staff.

2. Current nursing workforce profile

Staff in post



The above graph shows the banding profile of the nursing workforce (based on staff in post) as at July 2014. This includes both registered nursing and non-registered roles providing support to nursing.

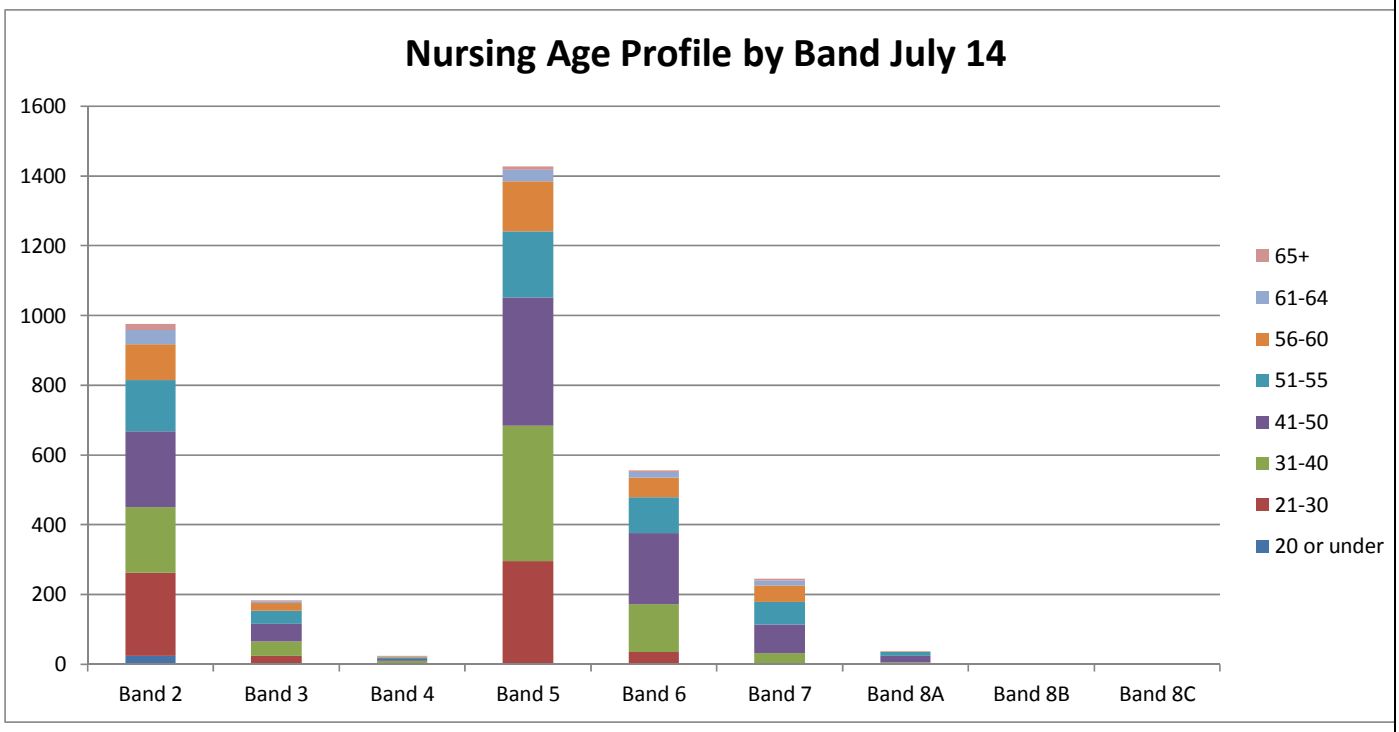
The above clearly demonstrates a gap between band 2 and band 5 in the nursing workforce. There are very real opportunities here to reshape the nursing workforce to provide benefits to the service and our patients but also to provide a more structured career framework for those entering the workforce at HCA level who would welcome the opportunity to progress but who do not want to pursue a nursing degree.

The vast majority of band 3 roles are in the Community setting. There are a very small number of band 3 posts in the acute setting including midwifery, sleep services, dermatology and A&E at Scarborough. The very small number of band 4 support roles that exist are mostly nursery nurses.

It is difficult to quantify an accurate vacancy rate at this point in time due to the way in which the Trust's electronic systems are set up – information contained within the finance general ledger showing budgeted establishment does not easily map to information held on ESR. This issue is also exacerbated by the way in which headroom is built into nursing budgets and therefore the difference between establishment and staff in post is not a true vacancy rate.

Ward/Outpatient/Community Nursing

The majority of our current nursing workforce are based on wards, in outpatient areas or in the community. The following is an age profile analysis of staff working in these settings. This also includes Midwives, Health Visitors, qualified and trainee Advanced Clinical Practitioners, Matrons and Lead Nurses.



Overall, a little less than a third of the nursing workforce are aged 51+. These are the staff who might reasonably be expected to consider retirement or flexible retirement over the next 5-10 years.

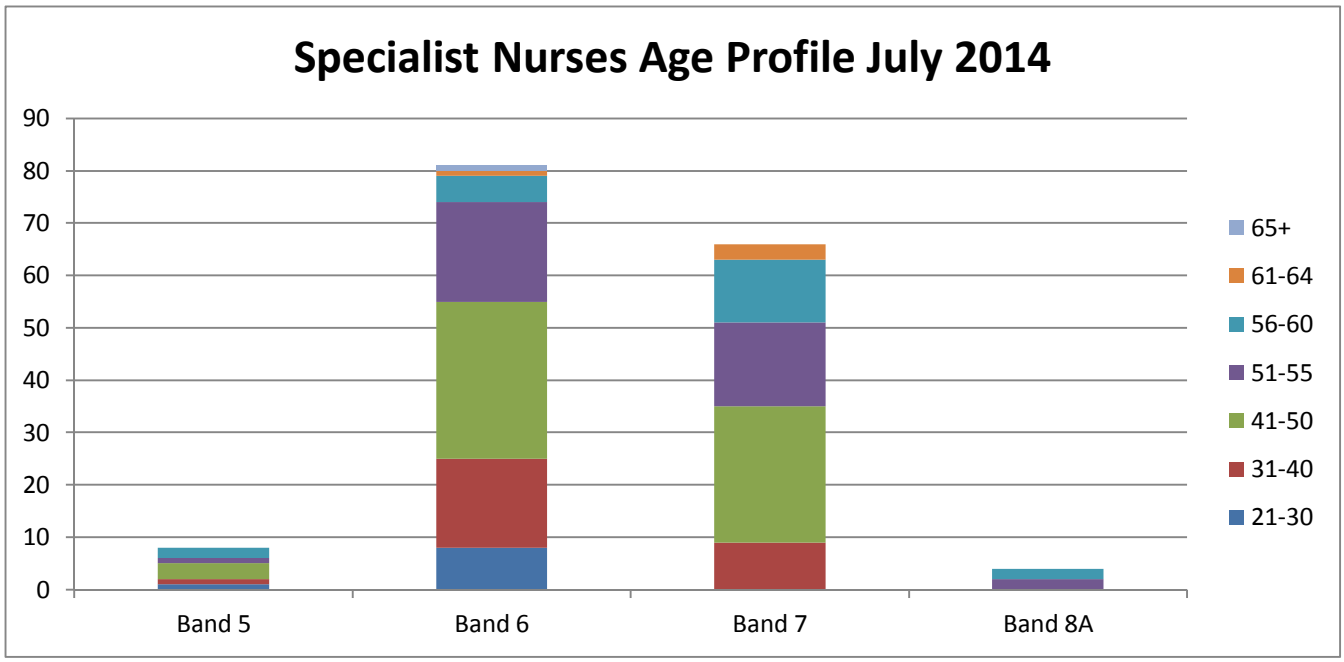
With regards to band 2 & 3 staff, the current age profile does not cause too much concern as there is a fairly even spread across all age bands. Also, as noted in the nursing supply narrative below, recruitment to these roles is currently successful.
The age profile for band 5 nursing in itself is also not of significant concern with a fairly even spread across the bands and approximately a quarter of staff aged 51+.

There is however a concern around the age profile of more senior nursing staff. Whilst it is to be expected that the average age for staff in this group would be higher (due to usual patterns of career progression) it is concerning that more than half of band 7 staff working in these settings are aged 51+. Whilst the proportion of band 8A nursing staff aged 51+ is reflective of the overall nursing profile, it is worthy of note that more than half are aged between 41-50 and some of these staff may have the option of retiring at 50.

This detail does support the need to proactively invest time in succession planning for senior nursing roles as it is likely that a number of vacancies will arise at this level in the short to medium term.

Specialist Nurses

The Trust employs more than 150 Specialist Nurses at bands 5 to 8A in a number of different areas. The age profile for this group of staff is shown below.



Overall, 40% of Specialist Nurses are aged 51+ with an additional 37% aged between 41-50. This current profile and the potential number of retirements in the short to medium term should prompt discussions about how vacancies could be filled as they arise as it may provide opportunities to explore new roles.

Flexible retirees

A piece of work was recently undertaken to identify staff who had drawn their NHS pension and returned to work. Through this exercise it was identified that at least 100 registered nursing staff and almost 40 HCAs have returned to work under these arrangements. The majority of these staff appear to have returned to the same role on the same salary point (in most cases this was the top of the scale).

Whilst the supply of registered nursing staff is certainly a challenge currently and therefore there is an argument for supporting flexible retirement for this group, this needs to be balanced against the risk of the consequences of shifting the age profile of the workforce to the right. Anecdotally, it also seems to be the case that these agreements are made with more consideration for individuals' preferences than for service needs.

Health & Wellbeing

In the Staff Survey 2013, there were a number of key findings relating to the theme of health and wellbeing;

- Key Finding 3 - work pressure felt by staff
- Key Finding 5 - % working extra hours
- Key Finding 11 - % suffering work related stress
- Key Finding 20 - % feeling pressure to attend work when feeling unwell

In the staff survey questionnaire, respondents are required to identify which staff group they belong to. The scores for all four key findings listed above for staff who identified themselves as belonging to either the adult/general nurses or other registered nurses group were worse than the Trust score. Around 80% of nurses who responded to the survey said that they work extra hours every week and around 40% said that in the last year they had suffered with work related stress.

The scores for three of the findings for staff who identified themselves as HCAs were also worse than the Trust score with 40% saying that they had suffered with work related stress in the last year and 34% saying that they felt pressure to attend work when they felt unwell.

Sickness absence rates

The organisation's absence rate for the year to the end of June 2014 was 3.54%.

The absence rate for registered nursing staff 3.80% which was the equivalent of more than 78 FTE staff. The top reason for absence, accounting for more than 4,500 absence days was stress, anxiety and depression.

For HCAs the absence rate was much higher at 5.17% which was the equivalent of almost 48 FTE staff. The top reason for absence for this group was also stress, anxiety and depression accounting for more than 2,700 absence days.

2.1 Nursing supply

Recruitment

In terms of unregistered workforce, the Trust's generic process for recruitment of HCAs continues to be successful. By the end of the year, the team will have coordinated 11 campaigns (five in Scarborough, six in York) and up to now, conversion rates have been strong. There's room for improvement in terms of how the campaigns are executed but as far as the outcomes are concerned, these are positive and don't present us with any concerns at this stage.

As regards registered workforce, specifically in relation to Staff Nurses, the organisation is continuing to experience difficulty in filling vacancies. Through turnover alone, it was forecast that the organisation would need to find somewhere in the region of 200 FTE Staff Nurses in the 2014-15 financial year. Adding in unfilled vacancies, plans for service reconfiguration in Scarborough and Bridlington and winter provision, the figure rose to an estimated 300 FTE. The recruitment of Staff Nurses is administered locally under the Trust's devolved model of

recruitment, and there have been 150 adverts to try and attract experienced and newly qualified candidates to the Trust (January 2014 - to date). In addition to this number, the Recruitment Team have been working to augment the recruitment of nurses through the devolved system by running additional, centrally supported campaigns during 2014. This has required additional resource and been achieved by staff working additional hours and over-time. Through these additional campaigns, different approaches to recruitment have been tried (eg. Glasgow city recruitment, 'One stop shop' style campaign days, interviews based at University of York to coincide with qualification dates).

While supply of candidates is a well-known issue due to the saturation of Staff Nurses vacancies within the Health Service nationally, the Trust has shown an ability to attract reasonable numbers of appointable candidates: in the period from March-May 2014, 94 appointable candidates were identified following interview via the centrally supported campaigns alone. However, this top level figure only tells us so much and there are a number of problems for the Trust to contend with, principally:

Appointable - Appointed conversion rate: Based on centrally supported recruitment activities during this period, the conversion rate is currently running at 62% which is very low for bulk campaigns. Herein lie a number of issues:

- Many candidates are pending registration and therefore unavailable for an immediate start. This has the effect of making them less attractive to wards who have an immediate need and are consequently slower to respond to candidates than they might be in respect of an already registered candidate.
- Time taken to onboard: onboarding is the stage between interview and candidate commencement, and encompasses amongst other things completion of employment checks, communication with the candidate and agreement around their assignment. Onboarding is conducted locally by the department by whom the candidate will be employed. A good onboarding process takes 6-8 weeks. Notwithstanding that many applicants are newly qualified and therefore unavailable to start work in a registered role until September 2014, it's frequently been the case, that beyond an initial Trust generic offer letter sent by Recruitment, some applicants have not even been contacted by their assigned department within this timescale and are therefore choosing to pursue other options. It is the Recruitment department's experience that the Trust is poor at onboarding nurses following bulk campaigns.
- Due to the number of opportunities available nationally, candidates have an unprecedented level of choice of places to work as a Staff Nurse and are therefore exercising their options to find the vacancy that suits them best.
- Due to the way in which vacancies are being advertised individually at the Trust, there are huge amounts of duplication going on with the same candidates going round and round the system seeking their ideal vacancy. This can paralyse the process and leave wards or hospitals which are perceived as being less desirable without candidates - e.g. Newly qualified candidates tend to choose not to take up roles in Scarborough because they know opportunities are available in York; in other cases, offers of appointment to some medical wards are being declined in favour of other available options, creating concentrations of vacancies in particular areas
- There is in some cases a lack of willingness to flex to accommodate candidates. While it may not always be possible to be flexible in relation to working patterns, there have been instances of a few experienced candidates not pursuing their interest because Matrons have been unable to meet their salary expectations (i.e. to be paid at the top of their band).

Supply of newly qualified nursing staff

Health Education England's LETBs (Local Education & Training Boards) use workforce plans submitted by provider organisations each year to support their education commissioning decisions for the coming years. Within these plans, organisations are required to forecast their

requirements for all staff groups. Ultimately, those graduates from the education places commissioned by the LETBs become a significant part of the workforce supply pool.
The table below shows the number of nursing staff in post each year from 2009 to 2014 at this organisation (including Scarborough for the whole period but only including Community from 2012) and the number of nursing education places commissioned from HEIs in Yorkshire & the Humber. The number of places that are commissioned to be provided by the University of York are also shown as this would historically have been expected to provide our primary pool of newly qualified nursing staff.

	2009	**2010**	**2011**	**2012**	**2013**	**2014**
Staff in post FTE	1592.62	1638.30	1665.37	2044.73*	2048.09	2073.11
Education Commssions (Yorks & Humber)	2316	2146	1848	1805**	1815	2010
Education Commissions (University of York)	232	214	184	188	188	227

*There was an increase in staff in post of 380 FTE between 2011 and 2012 of which 300 FTE was staff transferring from the Community.
**In 2012 entry into the registered nursing profession became degree only

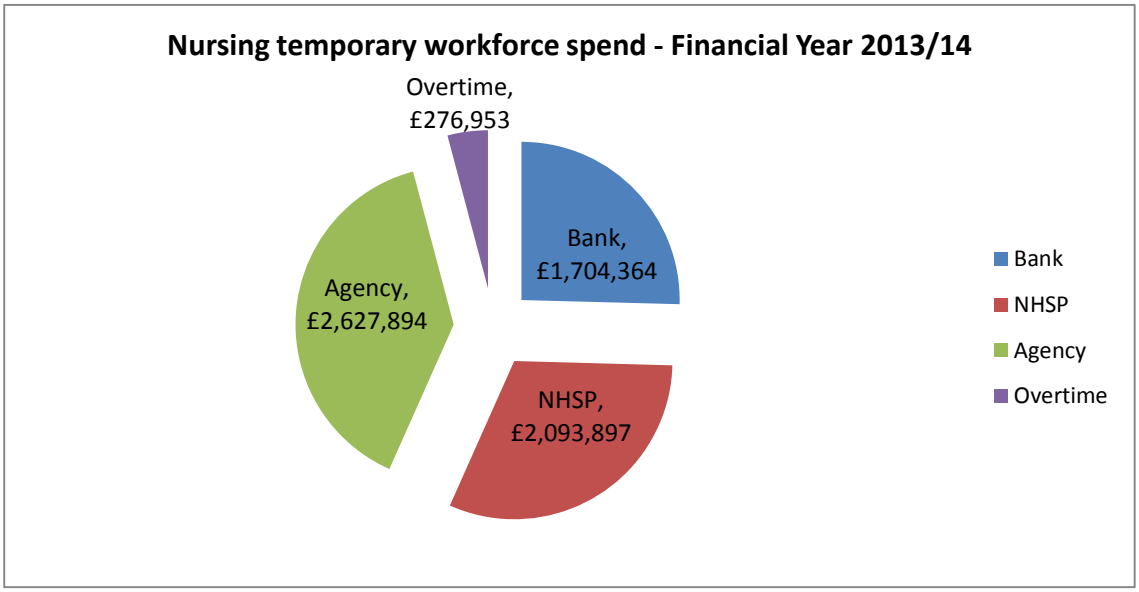
Apart from the transfer of Community staff to this organisation since 2009, there has been an additional increase of 180 FTE nursing staff in post. Whilst the number of commissioned education places has increased for the coming academic year this is still lower than the number of commissions made in 2009 and those who enrol for courses starting 2014 will not enter the supply pool until 2017.

It must be borne in mind that whilst 2010 places are commissioned in the region and 227 from the local university, these figures are not reflective of ultimate supply due to reasons including attrition. Health Education England's 'Workforce Plan for England' reports that attrition rates from nursing education can be in excess of 20%. It is also the case that some of those who do qualify may move out of the area or would be looking to work part time. This clearly demonstrates therefore a significant shortfall in filling a requirement for 300 FTE posts (as mentioned above).
When providers submitted workforce plans in 2012 for the following five years, overall forecasts for nursing staff requirements showed a reduction in numbers. Education commissions were made on this basis, however the workforce actually grew, likely as a result of the issues highlighted through the Francis report and other factors including the assumptions made in plans about reductions in activity which did not occur and that plans were based on affordability.
On the basis of the forecasts in the plans indicating a reduction in nursing workforce requirements, in 2011 and 2012, SHAs reduced the number of education commissions they made. The Workforce Plan for England therefore highlights that outputs may fall for the coming three years unless action is taken to improve attrition and quality of candidates to offset the reduced commissions.

According to information published by the Health & Social Care Information Centre the number of qualified nursing, midwifery and health visiting staff employed (contracted as per ESR, rather than establishment, i.e. actual demand) within the NHS in England increased by almost 6,500 FTE from 307,634 FTE in May 2013 to 314,082 FTE in May 2014. This represented an increase of more than 2%. In the Yorkshire and Humber region over the same period, the number of qualified nursing, midwifery and health visiting staff employed increased by almost 500 FTE to 32,360. This represented an increase of 1.5%.

Supply of temporary staff

In the previous financial year, the organisation spent £6.7 million on temporary nursing workforce as below.



In the first quarter of the current financial year, spend on temporary nursing workforce was £1.8 million.

Bank provision by NHS Professionals (York)

Reports from NHSP who supply bank nurse staff for the York Hospital site highlight a significant increase in demand during the first quarter. More than 70,000 net hours were requested in the period which is the equivalent of approximately 150 FTE staff each week. This was a 15% increase in demand compared to the previous quarter (Jan-Mar 2014) and a 44% increase compared to the same quarter in 2013.

Sickness and vacancies are consistently the top reasons for bank staff demand through NHSP. However, since the end of 2013 there has been a continual rise in demand for temporary staffing for specialing of patients.

In the first quarter of the previous financial year (April – June 2013) there were approximately 5,500 bank hours requested to provide specialing. This accounted for 11% of all demand in that period. In the third quarter (October to December 2013), demand for the reason of specialing had risen by more than three quarters and accounted for 16% of all demand. In both May and June 2014 more than 5,000 hours were requested for specialing and overall in the first quarter of the current financial year the number of hours requested for this reason accounted for more than 21% of demand. This increase continued into July (most recent data available) with more than 6,000 hours requested – the equivalent of almost 37 FTE staff.

In the quarter April – June 2014, NHSP successfully filled 50% of shifts with bank staff with an additional 20% of requests being filled by agency. Whilst this is a lower percentage fill than the historic fill rates achieved by NHSP, the number of hours being filled is higher. However, the

supply of flexible workers is not sufficient to meet the full demand.

We recently approached NHSP to request they arrange some long term placements for high risk areas with significant vacancies. NHSP were unable to arrange this with their own bank staff and although they successfully co-ordinated a small number of long term placements with staff sourced through other agencies, this again was not sufficient to meet our full needs.

Bank provision (Scarborough)

Bank provision at the Scarborough Hospital site is managed by an in-house team. Detailed reporting on demand and usage started at the end of 2013.

In the first quarter of the current financial year more than 35,000 net hours were requested to meet temporary staffing demand (average 11,768 hours requested per month). This is the equivalent of a requirement for 72 FTE staff each week. This was a reduction in demand compared to the last quarter of the previous financial year when more than 46,000 hours were requested (average 15,441 hours requested per month). However, in July demand increased to 14,418 hours.

Overall fill rates for temporary staff demand at Scarborough for each month since November 2013 have been in excess of 80%. Recently however, the percentage of shifts filled with internal bank staff has reduced slightly, therefore increasing the reliance on more expensive agency staffing.

3. Conclusion

The primary concern identified through the information above is that there is not sufficient supply of registered nursing staff to meet current demand. From what is known about commissions for nursing education and the number of registered nurses entering the supply pool each year this situation is unlikely to improve in the short to medium term and recruitment into registered nursing posts is likely to continue to be challenging.

The current structure of the nursing workforce does not provide any real career framework or opportunities for progression for unregistered nursing support staff.

The age profile of senior nursing staff (band 6 upwards) gives some cause for concern and there is a need to develop plans to address the risks in relation to this.

4. Recommendation

The Board of Directors is asked to consider the following recommendations in relation to potential actions and solutions to address current nursing workforce challenges:

- Urgently consider the development of new roles & identify pilot areas where they should be implemented – specifically band 3 & 4 support roles
- Development of opportunities for gaining healthcare experience (short term, e.g. summer contracts) to attract a younger workforce
- Pro active succession planning to minimise potential risks relating to senior and experienced nursing posts becoming vacant through retirements. This may potentially involve the development of an internal talent pool
- Support more open discussions around alternatives when posts (in particular Specialist Nursing posts) become vacant rather than default being to replace like for like

- Support the continued exploration of innovative recruitment approaches, potentially including international recruitment

5. References and further reading

Health Education England. 'Workforce Plan for England. Proposed Education and Training Commissions for 2014/15

Picker Institute Europe. '2013 National NHS Staff Survey. Results from York Teaching Hospital NHS Foundation Trust.'

Author	**Sian Longhorne, Workforce Information Manager**
Owner	**Sue Holden, Director of Corporate Development & Interim Director of HR**
Date	**September 2014**

York Teaching Hospital NHS Foundation Trust
Human Resources Strategy Performance Report
Key Indicators Trust Summary
Covering Period April - June 2014

Key Indicator	This quarter (Apr - Jun 14)			Previous quarter (Jan - Mar 14)			Last year (Apr - Jun 13)			Regional Average	Up/down/no significant change	Status R/A/G
	Quarter average	Annual	LTS*	Quarter average	Annual	LTS*	Quarter average	Annual	LTS*			
Sickness	3.32%	3.54%	97	3.72%	3.56%	97	3.36%	3.67%	95	Most recently published data covers the quarter Jan-Mar 14. The average absence for acute trusts in the Yorkshire & Humber region for this period was 4.39% and this trust was ranked second of acute trusts.	**No significant change**	
Comments: Absence rates in both the acute and community settings have reduced slightly since the start of 2014 and the overall Trust absence rate continues to compare favourably to the rate in other similar organisations.												
Active Vacancies (FTE) Defined as vacancies approved by VC group	**Vacancies (average over quarter)**	**Vacancy rate (No. of vacancies/staff in post+number of vacancies)**		**Vacancies (average over quarter)**	**Vacancy rate (No. of vacancies/staff in post+number of vacancies)**		**Vacancies (average over quarter)**	**Vacancy rate (No. of vacancies/staff in post+number of vacancies)**		The NHS Information Centre no longer publishes these figures	**Down**	
	117.34	1.64%		156.9	2.16%		133.28	1.60%				
Vacancies within budgeted establishment (Finance data)	**Budgeted establishment**	**Actual paid**	**Variance**	**Budgeted establishment**	**Actual paid**	**Variance**	**Budgeted establishment**	**Actual paid**	**Variance**	A local acute trust has begun to co-ordinate a regional quarterly data collection of workforce metrics which incudes vacancies. However, there is not consistency in terms of how trusts calculate this metric and arguably is not valid as a benchmark.	**No significant change**	
	7583.57	7064.42	-6.85%	7623.28	7107.39	-6.77%	7447.56	6978.39	-6.30%			
Comments: Vacancy rates remains a difficult metric to calculate accurately due to the differences between the information held in financial systems (e.g. budgets & establishment) and in the ESR HR & payroll system (e.g. staff in post).												
Maternity Leave	**FTE on Maternity Leave at end of quarter**		**As % of staff in post**	**FTE on Maternity Leave at end of quarter**		**As % of staff in post**	**FTE on Maternity Leave at end of quarter**		**As % of staff in post**			
	192.31		2.73%	178.43		2.53%	142.93		2.07%	Benchmarking data is available for a small number of trusts participating in the regional quarterly data collection mentioend above. The average rate of maternity leave as at March 14 was 2.31%.	**Up**	
Comments: Although maternity leave rates have historically been consistent, there are areas which regularly have much higher than average rates. Overall, the rate of maternity leave Any operational challenges created by higher than average maternity leave in particular areas continue to be managed through the Workforce PIM & vacancy control processes.												
Turnover (FTE)	10.40%			10.20%			10.39%			12.5% (Yorkshire & the Humber regional average)	**No significant change**	
Comments: Turnover rates at the organisation have been consistent at just over 10% since integration.												
Appraisal activity	72.15%			72.41%			83.71%			National average for acute trusts in 2013 staff survey was 84%	**Down**	
Comments: The Trust has a target of 95% for appraisal activity rates. Whilst significant progress was made towards achieving this and the Trust's score for the key finding in the 2013 staff survey relating to appraisal was average for acute trusts, the reported rate of appraisals has been below 75% in each month since the start of 2014.												
Temporary workforce spend		**Spend**			**Spend**			**Spend**				
	NHSP Spend	£571,591.00			£562,747.00			£535,057.00				
	Bank	£444,891.00			£454,777.00			£349,350.00				
	Agency inc. external medical locums	£2,132,095.00			£1,826,265.00			£1,628,422.00				
	Overtime Spend	£305,377.00			£285,840.00			£329,954.00				
	Total temporary workforce spend	**Total spend**	**% of paybill**		**Total spend**	**% of paybill**		**Total spend**	**% of paybill**	No benchmarking figures currently available	**Up**	
		£3,453,954	4.69%		£3,129,629	4.27%		£2,842,783	3.98%			
	Comments: Temporary workforce spend has inceased since last quarter and is 0.71% higher as a % of the paybill than in the same quarter of last year. Agency spend accounted for almost 62% of all temporary workforce expenditure. Regular reports from NHSP relating to the provision of bank nursing staff at York indicate a significant increase in demand. This correlates with the challenges presented nationally with a shortfall in supply of registered nursing staff.											
Time taken to conclude disciplinary cases	**0-30 days**	8										
	31-90 days	10										
	91-180 days	5										
	181+days	2			Not available			Not available		No benchmarking figures available		
	Number of current cases:	16 (as at 31st Aug 14)										
	Comments: This is the first time that infomation relating to time taken to conclude disciplinary cases has been presented in this way. Of the two cases which took more than 181 days to resolve, one was delayed on the advice of Occupational Health due to the health of the individual. The other case was due to a parallel investigation taking place which needed to be resolved prior to the disciplinary. The number of cases this quarter remains consistent with previous periods.											
Compromise agreements	There were no COT3s or settlement agreements made in the quarter April - June 2014											

*LTS = staff on long term sickness absence classed as 29 days or more

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

Education Strategy 2014-2017

Action requested/recommendation

It is essential we start to plan for a changed workforce. Increasing expectation by our patient's demand that we can demonstrate staff have the necessary skills and decision making ability to provide the best care possible.

The implementation plan will outline the timeframe to achieve this change, however the Board are asked to:

1. Approve the implementation of 'self declaration' with 'knowledge assessment' for statutory and mandatory elements of training.

2. Approve the development of extended faculty to enable the use of local education facilitators.

3. Acknowledge the changing funding structure.

4. Support and approve the development of inter-professional learning model, including implementation of integrated clinical faculty.

5. Approve the implementation plan.

Summary

In 2013 Health Education England was established to inform reform and review the way in which education to support health professionals was commissioned and quality assured. The setting up of regional Education and Training Boards brought into one structure under-graduate, post-graduate medical education, and registered non-medical training and non-registered training processes.

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	Initially presented at the Workforce Strategy Committee - 10 Mar 14 Chair of Executive Board approved out of committee on 18 Aug 14 and will have this action noted at the next meeting.
Risk	No risk
Resource implications	Resources implications will be detailed in the Implementation Plan
Owner	Sue Holden, Director Corporate Development
Author	Sue Holden, Director Corporate Development
Date of paper	June 2014
Version number	Version 2

Board of Directors – 29 October 2014

Education Strategy 2014-2017

1. Introduction and background

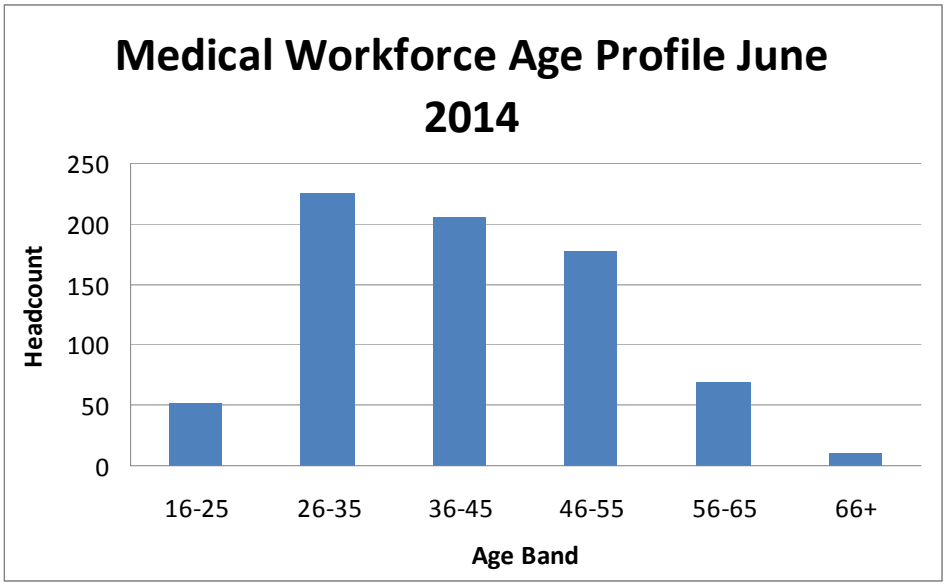
In 2013 Health Education England was established to inform reform and review the way in which education to support health professionals was commissioned and quality assured. The setting up of regional Education and Training Boards brought into one structure under-graduate, post-graduate medical education, and registered non-medical training and non-registered training processes.

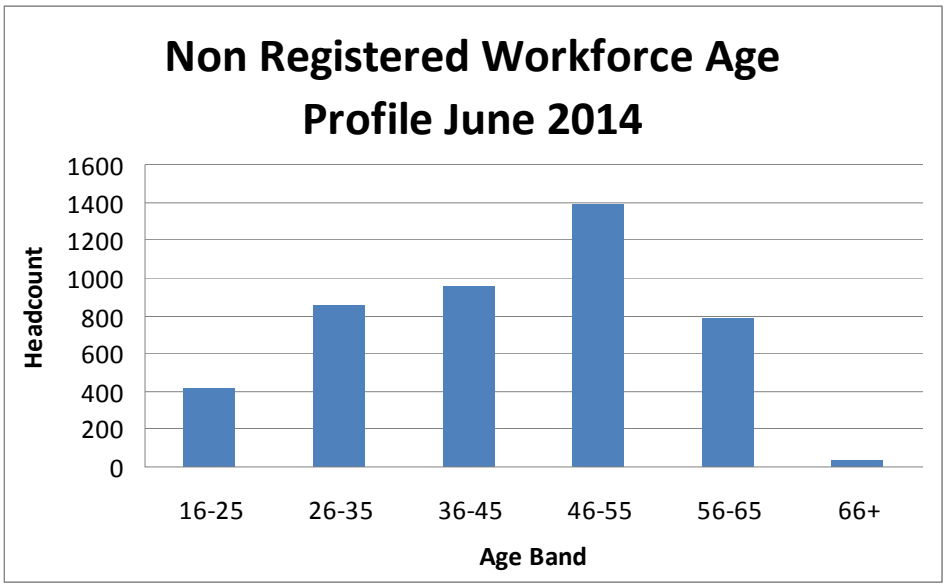
As an organisation we have made inroads into looking to deliver inter-professional learning experiences, especially related to leadership and development, however we now need to consider implementing a framework which will allow our staff to learn together the key clinical skills to ensure patient's receive the best possible care. The focus on team work has never been greater across the whole of the NHS enabling individuals to acquire clinical skills together, to the same assessed standard will improve our quality of provision. Creating scenario based interventions where multi professional learning underpinned by human factors experiences reinforces the need for clear leadership, excellent communication and team contribution will also support our patient safety strategy.

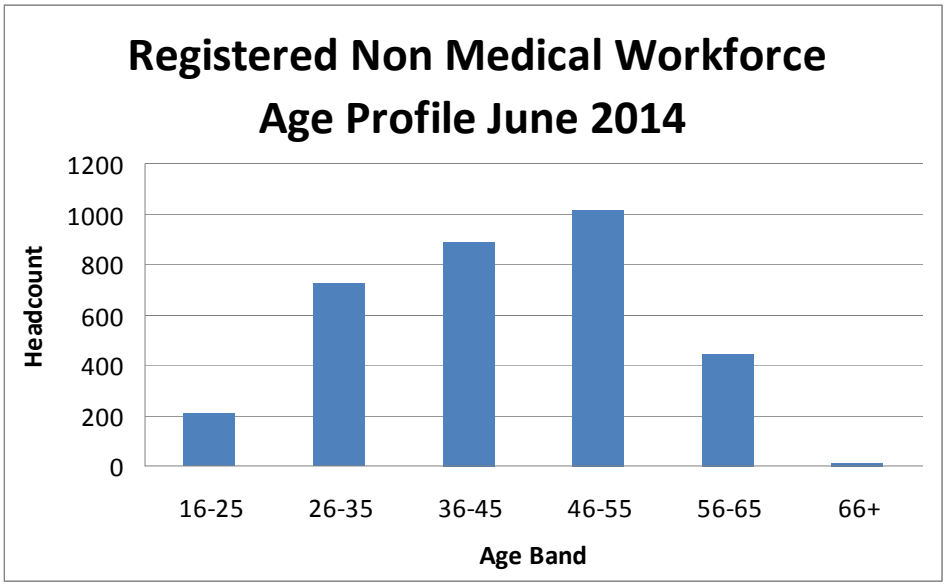
Underpinning all our education provision is a reliance on accurate information, evidence based interventions and up to date guidance. The Library Service continues to develop the role of clinical librarian to support practice based interventions. They also support individual personal development through the provision of learning resources.

In 2013 we commissioned a new learning management system to support the implementation of increased access to online learning along with self management of individual's learning records. We also developed the Trust values to highlight individual personal responsibility, this foundation has enabled the introduction, from April 2014, and the potential for staff to self declare competence. This is a significant shift in the maturity of the Trust in implementing and enacting its values in a tangible way so that staff can feel valued for their contribution and respected to declare and identify their own learning needs.

The following demographic data relates to staff employed by the Trust at the time of this report:


Medical Workforce Age Profile June 2014
250
200
150
100
50
0
Headcount
16-25
26-35
36-45
46-55
56-65
66+
Age Band


Non Registered Workforce Age Profile June 2014
1600
1400
1200
1000
800
600
400
200
0
Headcount
16-25
26-35
36-45
46-55
56-65
66+
Age Band


Registered Non Medical Workforce Age Profile June 2014
1200
1000
800
600
400
200
0
Headcount
16-25
26-35
36-45
46-55
56-65
66+
Age Band

Our workforce profile reinforces the need to look to develop a more flexible and responsive workforce, as well as a need to challenge traditional boundaries. An enabler to this is the provision of multi-disciplinary education, by learning together staff can recognise and value each others contribution to high quality, safe patient care.

2. Discussion

Staff are required to evidence appropriate learning on three levels:

1. Statutory required learning - that learning which is laid down in statute (law) i.e. fire training, equality and diversity etc.

2. Core learning described and mandated by the organisation which is deemed necessary to support delivery of the business i.e. information governance.

3. Speciality specific learning - learning that is required to maintain specific skills/competencies i.e. advance life support.

The funding streams to support this learning are managed and then devolved via Health Education Yorkshire and the Humber. Commencing in the financial year 2014/2015 Health Education England has implemented a re-distribution of funding. Historically, funding has been through:

- Medical and Professional Education and Training (Medical) (MPET)
- Service Increment for Training (SIFT) (backfill costs)
- Support Staff Learning and Development Fund (Band 1-4)

The funding streams have been allocated and managed separately with only medical staff having any element of budget to cover placement experience. In 2014 there will be money to support non-medical education and training placement costs, specifically targeted at ensuring a quality placement experience. This funding is <u>not</u> additional funding it has been created by reducing the funding and number of junior doctors' places. This will impact on the number of doctors able to support a service contribution and is intended to create a changed workforce configuration.

We recognise the need to develop new roles to support service and have introduced a programme of planned development of Advanced Clinical Practitioners. We are starting to review what roles should be developed with the non-registered workforce to compliment this shift. The purpose of these changes is to ensure that doctors undertake activities where they add greatest value to the patient experience.

Nationally, we know there is a planned reduction in doctors in training, a shift towards extended increased GP training and a consolidation and reduction in speciality training posts. The workforce needs to be trained and developed to meet the changed needs of patients, an increased elderly population with complex needs and specialist services centralised in a smaller number of acute providers. This will result in a changing requirement for non-medical staff to ensure their skills and knowledge are complementary and responsive to patient requirements.

Level 1 Training

A review of all statutory training has been undertaken. This has resulted in streamlining the programme, increased focus on non-face to face provision, and a requirement of annual review only for those areas which we are required by law to do. The new learning

management system - Learning Hub - will be the main vehicle through which staff will access this program. There will also be the opportunity to self declare competence following knowledge assessment, for elements of the program, ensuring staff take responsibility for their learning needs.

Level 2 Training

This training has been highlighted by the organisation as beneficial to patient experience and is responsive to the changing environment in which we all practice. The Learning Hub will enable some of this to be undertaken online, via webex webinar. The use of webinar and webex will also increase access for staff that are not site based. A significant element of this provision will be via face to face training by subject specialists.

Level 3 Training

These programmes will be developed within specialist areas and are specific to speciality i.e. midwifery. All learning of this nature will be provided within/by the speciality with a requirement to record learning for staff and update their personal record.

Consideration has been given to how we move towards inter-professional learning. To facilitate this we will start to develop skills training which will be open for all staff groups, assessed using the same framework and reviewed regularly to ensure maintenance of competence. We will develop clinical skills training in a modular format and create skills passports to ensure staff have the ability to move flexibly around the organisation with the confidence they are providing a consistent level of knowledge and skill. We will increasingly introduce ‘simulation’ to underpin learning and highlight the impact of decision making and team work. We will start to develop ‘simulated after incident reviews (SAIRs). These will enable teams involved in Serious Incidents to review their practice to highlight areas for improvement and development and implement change. This approach reinforces the Trust values of ‘listening in order to improve’ and will improve patient safety, through rapid cascade of learning. After Incident Reviews will be multi-disciplinary and will focus on the human factors that contribute to error.

We will develop a simulation strategy and identify faculty to support this provision. This is in keeping and aligned to an increased focus in under graduate education on simulated practice.

To facilitate these changes we will identify local education facilitators (LEF) who will form a Trust-wide resource to champion learning and support staff to maintain their practice evidence based. These LEFs will need to satisfy quality criteria and will be recognised across the organisation for their contribution to learning. By developing these roles we create increased capacity and capability thereby creating a sustainable learning environment. LEFs will link directly with the corporate education team, highlighting in a timely manner areas where further education and training is required.

The creation of dispersed faculty will improve:

- Access
- Consistency
- Quality
- Responsiveness

This approach also enables us to capitalise on core expertise whilst ensuring we develop capability more widely across the organisation.

A further element of the strategy will be to plan the development of new roles as previously mentioned. This work has already commenced with the recruitment of qualified Advanced Clinical Practitioners (ACPs) and training cohorts of ACPs. We intend to work with directorates to identify where alternative roles could be developed which support the registered workforce, these will include support worker roles which have a health and social care focus. It is intended to build on the 'Calderdale Framework' to assess and accredit such roles.

3. Conclusion

It is essential we start to plan for a changed workforce. Increasing expectation by our patient's demand that we can demonstrate staff have the necessary skills and decision making ability to provide the best care possible.

The implementation plan will outline the timeframe to achieve this change.

4. Recommendation

The Board are asked to:

1. Approve the implementation of 'self declaration' with 'knowledge assessment' for statutory and mandatory elements of training.

2. Approve the development of extended faculty to enable the use of local education facilitators.

3. Acknowledge the changing funding structure.

4. Support and approve the development of inter-professional learning model, including implementation of integrated clinical faculty.

5. Approve the implementation plan.

Author	**Sue Holden, Director Corporate Development**
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Date	**June 2014**

Organisational Development & Improvement Learning (ODIL) - Leadership Training

Introduction

The ODIL team exists to support the organisation to achieve its purpose of providing quality and safe health care to its community. This is done by supporting staff to work in the most effective way they can, working with individuals, teams and whole departments to develop the way in which people work both independently and together. This is done through coaching, mentoring and mediation, leadership programmes, team development and bespoke OD interventions, as well as through the education of staff in tools and techniques that will help them to make positive changes using improvement methodology & manage conflict.

Key Team Objective

In working with the human dimension of organising and working, the ODIL team aim to improve organisational performance through developing human processes and creating an adaptive and continually learning organisation. This is in line with the educational strategy's objectives by planning for a changed workforce and demonstrating that staff have the necessary self, team & organisational awareness, knowledge, skills and decision making ability to provide the best care possible.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributor	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/a						
Level 2 Beneficial to Patient Experience	● Leadership programmes are designed to respond to the individual, complex and evolving environments that staff work, to maximise patient/client experience in all areas of the organisation. ● Ability for learning to be applied to individual and current environments of delegates to increase impact of training through use of 1:1 & team coaching ● All programmes reviewed annually/'in the moment' in response to key local/national initiatives. ● Open and Closed cohorts currently provided (eg CD, IMW, Matrons) depending on clinical need to maximise impact on Patient experience	●Further Development of Learning Technologies to support learning required (e.g. Webinars, Web Ex) including Team Coaching, in order to support cross site learning. 2 members of the team have been trained in the use of webex to facilitate Virtual Actions Learning Sets. ●Continue to evaluate and amend current programmes based on feedback from delegates and relevant stakeholders. ●Delegates to indicate in evaluation/ALS how patient experience has been/will be affected by the learning on programme	TE (HC FAH)	external programme Faculty CLAD	Ongoing	● Face to face is preferential for many of ODIL's offerings due to the nature of the work/number of delegates. ● Releasing staff to train in these technologies may present a challenge ● Access to internet based applications, ie webex,IT equipment, and room availability limited at times. This method may not appeal to some staff.	●The first cohort of a Consultant Development programme has recently started.
Level 3 Specialist Learning	See interprofessional learning						

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributor	Target Date	Risks / Issues	Progress against Actions
Interprofessional Learning	Both Senior Leaders and Emerging Leaders programmes to be designed in the main as inter-professional programmes, with associated Action Learning Sets incorporated to harness this experience. Closed cohorts are delivered where there is identified need/ benefit in doing this (e.g. Consultants new to the organisation or senior consultants considering role of Clinical Director/Deputy/Clinical Lead, Matrons, Ward Sisters). Focus links specialist area of practice.	Consultants Development Programme is to be evaluated on its completion. Support also provided to trainee advanced care practitioners by the use of action learning sets & individual coaching. Continue to encourage multidisciplinary learning	TE (HC FAH)	external programme Faculty CLAD	Ongoing re	Consultants having time to complete courses due to job plans.	
Skills Passport	●All leadership programmes have a programme portfolio that aims to be a pre-curser to the skills passport.	● Introduce the portfolio to all programmes with potential to go electronic. ● Potential use of Learning Hub to centralise recording of competencies achieved/courses & programmes attended. ● Explore academic providers for portfolio as accreditation process, including all leadership progs, and soft skills (inc introduction to coaching, effective conversations, making every patient and relative contact count and customer care) ● Maintain link for existing programmes eg Senior Leaders programme and link to negotiated study prog and seek a link for emerging leaders to a diploma level prog. ● Support the achievement of CME points for medical staff by using skills passport Link to talent management	TE (HC FAH)	external programme Faculty CLAD	Apr-15	● Current capability of Learning Hub as a central database to produce a skills passport. ● Cost implication of buying portfolios and access to IT and the portfolio if electronic, depending on where hosted. Development of Talent Management Strategy. Evidence of applying learning in practice. Link to Development Centres	●Many staff already have portfolios, a cultural shift is required for engage staff in their wider use.
Simulated Learning	Use of simulation exercises within pr	Further development of simulated int	TE				

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributor	Target Date	Risks / Issues	Progress against Actions
Learning Education Facilitators	Development of faculty of LEF's to support embedding of Leadership		TE				

Supporting Funding Streams): N/A

Organisational Development & Improvement Learning (ODIL) - Team Development & Bespoke OD Interventions.

Introduction The ODIL team exists to support the organisation to achieve its purpose of providing quality and safe health care to its community. This is done by supporting staff to work in the most effective way they can, working with individuals, teams and whole departments to develop the way in which people work both independently and together. This is done through coaching, mentoring and mediation, leadership programmes, team development and bespoke OD interventions, as well as through the education of staff in tools and techniques that will help them to make positive changes using improvement methodology & manage conflict.

Key Team Objective In working with the human dimension of organising and working, the ODIL team aim to improve organisational performance through developing human processes and creating an adaptive and continually learning organisation. This is in line with the educational strategy's objectives by planning for a changed workforce and demonstrating that staff have the necessary self, team & organisational awareness, knowledge, skills and decision making ability to provide the best care possible.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/a	Development of faculty of LEF's to support embedding of OD					
Level 2 Beneficial to Patient Experience	Learning & Development offered by ODIL in relation to this: • NHS Elect (Train the trainer) Customer Care training. Compulsory for all Ward Sisters/Matrons • Making your patient and relative contact count • Effective Conversations • Introduction to coaching skills for managers.	●Ongoing evaluation of the programmes. Link to WBL, Learning Hub	TE HC (ZN AR)	NHS Elect Leadership Academy CLAD	Aug-14	NHS withdrawal	●Programmes currently being delivered
	●Bespoke OD interventions to consider the impact of the intervention on patient experience in contracting (ie Its my ward)		FAH HC		ongoing	sustainability	OD Contracting forms ask the question 'what's the impact on the service to patients if no OD intervention occurs' to be used in prioritisation
		●Consideration of where Webex could be used as part of the ODIL offering as its key facility is to enhance the sharing of and access to information eg: Action Learning Sets.	TE AR		Apr-15	targeted' v 'rest of organisation'	
		●Evaluate IMW programme started with intent of making recommendations for development of future ward sisters	GD FAH	Clinical Audit Team Corporate Nursing	Dec-14	Sustainability Demonstration of impact/ROI	Clinical Audit team report published May 2014-action in progress

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 3 Specialist Learning		●Continue to contract on a request basis and engage with wider organisation for bespoke interventions which impact on team specific issues.	FAH GD HC		ongoing		
		●Marketing of Leadership Academy programmes with specialist groups	TE		ongoing		
		●Team Coaching to be offered as a service	HC		ongoing		
Interprofessional Learning	●Both Senior Leaders and Emerging Leaders programmes are designed in the main as inter-professional programmes, with associated Action Learning Sets incorporated to harness this experience. ●Closed cohorts are delivered where there is identified need/ benefit in doing this (e.g. Consultants Development or senior consultants considering role of Clinical Director/Deputy/Clinical Lead, Matrons, Ward Sisters). This focus links specialist area of practice.	● Consultants Development Programme is to be evaluated on its completion. ● Support also provided to trainee advanced care practitioners by the use of action learning sets & individual coaching. Continue to encourage multidisciplinary learning	TE	Army External programme 'Faculty'	Ongoing	●Consultants having time to complete courses due to job plans. Focus on 'self awareness' -v 'team development'	

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Skills Passport	● All leadership programmes have a programme portfolio that aims to be a pre-curser to the skills passport.	● Introduce the portfolio to all programmes with potential to go electronic. ● Potential use of Learning Hub to centralise recording of competencies achieved/courses & programmes attended. ● Explore academic providers for portfolio as accreditation process, including all leadership progs, and soft skills (inc introduction to coaching, effective conversations, making every patient and relative contact count and customer care) ● Maintain link for existing programmes eg Senior Leaders programme and link to negotiated study prog and seek a link for emerging leaders to a diploma level prog. ● Support the achievement of CME points for medical staff by using skills passport	TE GD		Apr-15	●Current capability of Learning Hub as a central database to produce a skills passport. ●Cost implication of buying portfolios and access to IT and the portfolio if electronic, depending on where hosted.	● Many staff already have portfolios, a cultural shift is required for engage staff in their wider use.
Simulated Learning		Deevelopment of 'team development' stand alone days			Apr-15	● Capacity and ability to be responsive to the timeframe required when SAIRS take place. Unsure what commitment this would be yet.	
Learning Education Facilitators	Development of faculty of LEF's to support embedding of OD						

Supporting Funding Streams): SSLDF External e.g Council

Organisational Development & Improvement Learning (ODIL) - Coaching Mentoring & Mediation

Introduction The ODIL team exists to support the organisation to achieve its purpose of providing quality and safe health care to its community. This is done by supporting staff to work in the most effective way they can, working with individuals, teams and whole departments to develop the way in which people work both independently and together. This is done through coaching, mentoring and mediation, leadership programmes, team development and bespoke OD interventions, as well as through the education of staff in tools and techniques that will help them to make positive changes using improvement methodology & manage conflict.

Key Team Objective In working with the human dimension of organising and working, the ODIL team aim to improve organisational performance through developing human processes and creating an adaptive and continually learning organisation. This is in line with the educational strategy's objectives by planning for a changed workforce and demonstrating that staff have the necessary self, team & organisational awareness, knowledge, skills and decision making ability to provide the best care possible.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/A						
Level 2 Beneficial to Patient Experience	● Currently offer Team Coaching and 1:1 coaching to support individuals/teams and their services to respond to changing patient need and changing environments. ● Coaching skills training offered to staff	● Consideration of where Webex could be used as part of/as a supplement to, the ODIL offering. E.g. Coaching or Mentoring, as a blended approach. ● Exploration of Health Coaching to benefit patient experience	HC		Apr-15	● Face to face is preferential for many of ODIL's offerings due to the nature of the work/number of delegates. ● Releasing staff to train in these technologies may present a challenge ● Access to internet based applications, ie webex,IT equipment , and room availability limited at times. This method may not appeal to some staff.	HC attended a Health Coaching conference March 2014
	● Mediation currently offered across the organisation to support difficult relationships that may impact on service and patient experience		HC			● Capacity of mediators - only 12 for entire organisation.	
		● Mentoring - develop this service & skills training, to establish best practice and allow staff to reach their potential and that of the service to patients	HC		Apr-15		● Introduction to Mentoring day taken place (March 2014).
Level 3 Specialist Learning		● Identify people to progress to develop the faculty of coaches in specific areas at a number of levels ● Coaching supervision to support quality of coaching.	HC		Apr-15	● Capacity of staff to coach/train at a higher level	CPD taken place and is planned for 2014-15

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Interprofessional Learning		● Inter professional coaching faculty to share learning. Exploit knowledge form partnership working.	HC		Apr-15		
Skills Passport		● Develop a portfolio for coaches based on coaching competencies that all coaches are expected to achieve - used as part of QA process. ● Log attendance at supervision on Learning Hub.	HC		Apr-15		
Simulated Learning	use of simulation in training scenarios	Develop/use of existig scenarios in training	HC		Apr-15		
Learning Education Facilitators	Development of faculty of LEF's to support embedding coaching, mentoring, mediation		HC		Apr-15		

Supporting Funding Streams): SSLDF External e.g. Council

Organisational Development & Improvement Learning (ODIL) - Service Improvement

Introduction

The ODIL team exists to support the organisation to achieve its purpose of providing quality and safe health care to its community. This is done by supporting staff to work in the most effective way they can, working with individuals, teams and whole departments to develop the way in which people work both independently and together. This is done through coaching, mentoring and mediation, leadership programmes, team development and bespoke OD interventions, as well as through the education of staff in tools and techniques that will help them to make positive changes using improvement methodology & manage conflict.

Key Team Objective

In working with the human dimension of organising and working, the ODIL team aim to improve organisational performance through developing human processes and creating an adaptive and continually learning organisation. This is in line with the educational strategy's objectives by planning for a changed workforce and demonstrating that staff have the necessary self, team & organisational awareness, knowledge, skills and decision making ability to provide the best care possible.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/A						
Level 2 Beneficial to Patient Experience	● Level 1, an introduction to Service improvement Learning is only offered as a free standing module. ● Levels 2 and 3 Service Improvement learning programmes are offered as both freestanding modules and also attached to all leadership programmes ● All programmes are continuously evaluated.		GD/AR		ongoing	Proposal to support Apprenticeship training & assessemnt of learning/achievement ? From Aug 2014 with all levels of SI training- unknown demand to date	● Levels 1 & 3 are new offerings, ● Level 2 has recently been revised following evaluation.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 3 Specialist Learning	● Level 3 is a 3 day programme designed to support those undertaking larger improvement projects. Closed modules are offered within the organisation for some staff on internal leadership programmes ie Clinical Director & New Consultants so that the content can be tailored to their specific needs. ● Service Improvement learning is also delivered for external partner organisations, University of York, HYMS and the Deanery providing this learning to students in training & those on post registration programmes.		GD/AR	Deanery. Link to PG. HYMS: Link to LARC. York University: CIT	ongoing	Capacity v demand management	● Level 3 - recently designed.
Interprofessional Learning	all levels of training programmes open to all staff						
Skills Passport	●Project plans and assessment are documentation that are contained within the leadership & bespoke programme portfolios.	assessment of competence of applic	GD/AR		ongoing		
Simulated Learning	simulation used on all programmes						
Learning Education Facilitators	Development of faculty of LEF's to support embedding of Service Improvement-Improvement Champions					Readiness of Learning Hub	Discussions with CLAD & with DMs re identifying Champions

Supporting Funding Streams): SSLDF

Work Based Learning - Clinical

Introduction The Work Based Learning - Clinical team are focussed on the development of learning opportunities for bands 1-4 clinical staff & currently sit within Corporate Learning. The HR Workforce team lead on the training, education & role development of the unregistered workforce bands 1-4

Key Team Objective To integrate a partnership working to enable the development of bands 1-4 clinical staff in response to service need, with an initial work focus on the further development of HCAs & other support workers (AHPs)

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/A						
Level 2 Beneficial to Patient Experience	Mandatory training for unregistered clinical staff, who are required by the Organisation to acquire & maintain their clinical skills, appropriate to band/role to enable them to deliver care based on the best available evidence & best practice	Establish the current position relating to the agreed approach by the Organisation to the development of HCAs by the WBL & HR Workforce teams. To support the design & implementation of a framework to facilitate a blended learning approach-content, delivery & methods	TBC	HR Workforce, Learning & technologies team, CDT, Corporate Nursing, AHP Leads,HEIs, Other external bodies	TBC	May be duplication & silo working currently	Review of Directorate/team structure
Level 3 Specialist Learning	The breadth & depth of non registered role development may vary depending on the clinical speciality area & requirements of the role within that area. Initial scoping work is underway to further support the development of HCAs in enhancing their skills in partnership with WBL, HR Workforce & Corporate Nursing	Determine the specific service requirements	TBC	as above	TBC	Insufficient capacity within clinical areas for staff to attend training & achieve assessment of competence	
Interprofessional Learning	Link to Post Grad, HYMS, Clinical education & CDT tabs		TBC		TBC		
Skills Passport	Core clinical skills training obtained in the organisation will need to be transferable, OSCE format (OCN accreditation)	Link to Learning Hub tab			TBC		
Simulated Learning	Link to Post Grad, HYMS, Clinical education & CDT tabs		TBC		TBC		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Learning Education Facilitators	Potential for LEFs to be actively involved in supporting unregistered staff assessment & development. Potential to appoint additional Peripatetic LEFs.	Identify role and structure of LEFs and Peripatetic LEFs within clinical areas across organisation.	TBC	Corporate Nursing, CDT, AHP Leads	TBC	insufficient capacity for LEFs working within clinical areas to train & assess staff to achieve competence	

Supporting Funding Stream's): ACP funding, SSLDF

Clinical Development Team

Introduction The Clinical Development Team is part of the wider Applied Learning & Research Directorate. Our role is to facilitate learning and development in clinical practice ensuring best practice through a sound evidence base.

Key Team Objective To support the organisation in providing appropriate clinical skills training, maintaining training in line with current guidance and best practice, promoting best outcomes and harm reduction where required. Providing targetted training where required, as identified by evaluations or highlighted areas for improvement and development.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	N/A						
Level 2 Beneficial to Patient Experience	Mandatory training for allied healthcare professionals, who are duty bound by their professional bodies & the Organisation to acquire & maintain their clinical skills to enable them to deliver care based on the best available evidence & best practice	Continue to support the design & implementation of a more blended learning approach-content & delivery & methods e.g. Elearning, Webinar, Train the trainer. To support the existing supervision and competency pathway to ensure follow up actions are undertaken in the local area e.g. recording of attained competence on Learning Hub.	MK (TL)	Learning Technologies Team	Mar-15	Currently there is an increased demand for development & delivery of skills competence based training because of raised awareness relating to Q&S, changing workforce/roles & larger organisation. It is envisaged this will continue to increase going forward. There is limited resource within the team (WTE 1.8). There is no capacity to develop training relating to learn from incidents e.g. near misses, SIs AIs	
Level 3 Specialist Learning	As above. Currentlly input into specialist areas as & when requested e.g.Core clinical skills training is not currently provided for paediatrics.	e.g. work with specialsit team to develop appropriate training packages for Paediatric Skills.	MK (TL)		01/09/2014 -ongoing as & when	as above. The changes to highlighted in Clinical Education tab is likely to identify additional workstream relating to specialist areas e.g Imms & Vaccs	Links have been made with the educators for the Yorkshire and Humber Paediatric Critical Care Operational Delivery Network (PCC ODN) and training has been planned which will focus on Paediatric Critical Care with Resuscitation and Stabilisation.
Interprofessional Learning	Link to Post Grad, HYMS, Clinical education tabs		MK (TL)	Learning Technologies Team, Post Grad, HYMS, Clinical Education Team		Roles sitting outside of the Directorate including Clinical Educators & Specialist Nurses do not link into this strategy/framework	
Skills Passport	Current core clinical skills training obtained in the organisation is transferable, OSCE format	Link to Learning Hub tab	MK (TL)		Dec 15		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Simulated Learning	Link to Post Grad, HYMS, Clinical education tabs		MK (TL)	Learning Technologies Team, Post Grad, HYMS, Clinical Education Team, Skills Technicians			
Learning Education Facilitators	Link to Clinical Education tab						

Supporting Funding Stream(s): N/A

Clinical Education

Introduction This newly formed team is responsible for supporting the development & embedding of clinical education within the organisation for all non-medical staff. There is a key focus on identifying & supporting non-med students in high quality placement & learning environments in order to give assurance to the HEYH & the organisation & receive tariff

Key Team Objective The introduction of the non-med Tariff for non medical students has brought the opportunity to re-focus on the quality & provision of education & improving the learning environment for all non-medical students. This will enable a high quality learning environment to be created for all clinical staff including medical students

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	Requirement from HEE -Let B to provide evidence of a quality student placements/experience for non-medical students. Best Practice Guidance doc (2014)	Ensure the quality assurance indicators for students working in the organisation are achieved	MK	HEE,HEIs, LetB steering group, Education Strategy Group	Mar-15	non-med tariff funding is dependant on evidencing quality student placements & learning experience	All outcomes in Quality Placement in Healthcare-Best Practice guidance-HEYH 2014-3 key themes -6 outcomes- must be achieved for 2014/15
Level 2 Beneficial to Patient Experience	The achievement of All outcomes in Quality Placement in Healthcare - Best Practice guidance - HEYH 2014 will help to underpin the skills & knowledge of students & staff to be complimentary & responsive to patient requirements	Link to WBL - Clinical tab	MK	WBL - Clinical Team, Learning Technologies Team, HR, Corporate Nursing, AHP Leads, HYMS, Post Grad, CDT	Mar-15		
Level 3 Specialist Learning	Non-medical student allocation covers the full range of specialist clinical areas/learning environments-scoping work (in addition to PPQA) is required to determine specific requirements & current provision/outcomes for students in these areas		MK	PLFS (PEFs)	Mar-15		
Interprofessional Learning	Interprofessional Learning opportunities need to be identified for all non-medical students	Link into Post Grad/HYMS/CDT/Resus implementation plan	MK	WBL - Clinical Team, Learning Technologies Team, HR, Corporate Nursing, AHP Leads, HYMS, Post Grad, CDT	Mar-15		
Skills Passport	n/a						

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Simulated Learning	Interprofessional Learning opportunities using simulation will need to be identified for all non-medical students	Link to Post Grad, HYMS, Clinical education, CDT tabs	MK	WBL - Clinical Team, Learning Technologies Team, HR, Corporate Nursing, AHP Leads, HYMS, Post Grad, CDT	Mar-15		
Learning Education Facilitators	Appointment of Clinical Skills (education) Facilitator posts (CEFs) x 2 to address LetB Sch 4 QA requirements of non-medical practice placement provision. It is envisaged that the CEFs will work closest with the LEFs working closely in clinical practice (when identified)	Assessment of learning environments against Sch 4 Best Practice requirements. Support the creation of the LEFs. Link to WBL-Clinical tab. Pilot, evaluation and future roll-out of "Living the Values" document for non-medical students, supported by Mentors in practice. Creation of LEF posts & structure & framework.	MK	HEYH, Corporate Nursing, AHP Leads, HR, HEIs	Mar-15	PLF roles will cease to be supported by Let B March 2015. No clarity re LEF role as yet	

Supporting Funding Stream(s): Let B sched 4 non med tariff

Resuscitation Team

Introduction The Clinical Development Team is part of the wider Applied Learning & Research Directorate. Our role is to facilitate learning and development in clinical practice ensuring best practice through a sound evidence base.

Key Team Objective To support the organisation in providing appropriate clinical skills training, maintaining training in line with current guidance and best practice, promoting best outcomes and harm reduction where required. Providing targetted training where required, as identified by evaluations or highlighted areas for improvement and development.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	Basic Life support is currently delivered on an annual basis, as per the Resuscitation Council recommendations.	Elearning packages to be sourced to provide and appropriate level of knowledge for differing clinical staff according to their level of proficiency appropriate to their role. This would be followed by practical skills training, possibly be a role of a registered LEF.	TL	Internal Faculty	review impact June 2014	Proposal following submission of business case for BLS to be 3 yearly with exceptions i.e. target for non-attendance (?perf man) & provision more frequently for those who identify need with line managers support. This does create issues around forward planning (actual numbers) & may pose further risk, although curently attendance at BLS is less than 50% & for some people it is not known if they have attended annually, so there is already 'identified risk	
Level 2 Beneficial to Patient Experience	ILS training is currently to staff who require it for their role, delivered as per the Resuscitation Councils recommendations.	Link with the Lead Nurse for Deteriorating Patients and determine a way that AIRA and ILS could be used collectively to support the Patient Safety Strategy. Link to PG strategy	TL	Internal Faculty	review impact June 2014	Capacity released from BLS delivery may enable more capacity for ILS delivery to high risk areas/clinical staff, althogh this has yet to be determined	
Level 3 Specialist Learning	PBLS & PILS are provided locally, any staff member with responsibility for caring for children should undertake PBLS as a minimum and this has required annual updating. ALS is run locally and provide training for critical care clinicians. The resuscitation team delivers an interactive session on DNACPR, GD/TL are members of DNACPR group & contribute to Stratgey/actions	Introduce a similar system to BLS (As per Level 1 action) Introduce a 2 day face to face ALS course for F1 Doctors Further work is required to develop a blended learning approach for DNACPR.	TL	internal Faculty External Faculty	Ongoing	Factors outside of control re staffon shopfloor adopting DNACPR guidance CQC previous visit/recommendations	

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Interprofessional Learning	All the above courses outlined are multidisciplinary Course which incorporate simulation as a teaching tool.	Link to PG Clinical simulation & CDT, Clinical Education tab	TL	internal Faculty External Faculty	Ongoing		
Skills Passport	Staff may holde & require a progression through levels of Resus training -BLS-ILS-ALS	Identifying need of individual staff groups v clinical need	TL	ongoing	Ongoing		
Simulated Learning	Simulation training is used within all resus programmes including additional specialist interventions e.g. midwifery	Other courses to be developed for simulation are: AIRA (Acute Illness Recognition & Assessment) and RAMSI (Recognition and Management of the Seriously Ill). Link to PG CDT Clinical Education tabs	TL	internal Faculty External Faculty	Ongoing		Dr Claire Wensley, Consultant Paediatrician is liasing with the Hull based Sim Fellow to secure further training for both York & Scarborough Sites.
Learning Education Facilitators	Development of LEFs to support existing Resus faculty	See Action from Level 1	TL		Ongoing		

Supporting Funding Stream(s): ALS/ILS

Medical Devices

Introduction The Medical Device Training team offer 2 types of training. Training based on individual Medical Devices, and training based on the general principles in the use of Medical Devices.

Key Team Objective To ensure quality training is available to all appropriate staff requiring it, so making a safer patient environment in relation to the safe use of Medical Devices.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	Medical Device Awareness training is currently delivered on the Statutory training programme. An e-learning package has been developed for Dr's to complete as part of either their induction to the Trust and or their revalidation.	A Knowledge assessment tool is in development. E-learning to be developed for all staff (other than Dr's) as an alternative to face to face training, should staff not pass their knowledge assessment.	KU			There is a potential that completion of an e-learning package for staff that have not passed the knowledge assessment would not be sufficient. To this end face to face training should not be ruled out completely.	
Level 2 Beneficial to Patient Experience	Medical Device Open Days have been developed to allow staff to drop in to training sessions on a set day to receive the training on specific Medical Devices. Ward Walks (where the trainers visit the ward areas) are also being arranged.	Medical Devices Open Days have been set for 2014 to cover 8 main geographical areas.	WM			Only a selected number of devices can be covered through these training days, and in no way could all devices be cover for all specialities using this training format	
Level 3 Specialist Learning	Bespoke training sessions are developed and delivered as and when required for specialist areas.	N/A	KU				
Interprofessional Learning		Interprofessional learning can be achieved for medical devices, but suitability would depend on the specific device and clinical area.	KU				
Skills Passport	The Medical Device Matrix gives managers an overview of their staffs' Medical Device training, allowing the manager to see what their local areas training needs are.	Linking the Medical Device Matrix to the new Learning Hub, so that staff can view their own training requirements for Medical Devices.	KU & WM			There are approximately 1600 different medical devices in the Trust, so to add these devices individually to the learning hub would probably be an impossible task. There needs to be some form of link from the Learning Hub to the Matrix to ensure staff have a wider understanding of device training they require.	

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Simulated Learning	Training is provided to areas as and when required after an incident, and posters are developed to share best practice, to enable staff to learn from issues that have been raised.	Develop training sessions in line with Resus and Clinical Development Team that covers simulation of training skills, learning from events that have previously occurred within our organisation and if possible learn from other organisations. Link to PG tab	KU				
Learning Education Facilitators	There is an online training resource available for Link Trainers. This will help trainers find user manuals, competency documents, e-learning & training packages relevant to specific devices.	Work with the LEF's to be a local guide & trainer for Medical Device training and resources.	KU & WM			The Trust Intranet system need some development to assist easy access to user manuals, training packages etc… Staff Room needs a specific training area that then need to be sub-divided for specialist areas to own. These areas can then be developed so appropriate information can be developed and made available	

Supporting Funding Stream(s):

Learning Hub

Introduction

The work of the new technologies team in 2014 is concentrating on the development and roll out of the new online learning system, Learning Hub. A new team structure will be finalised by July 2014 utilising CLAD staff with appropriate skills. Once the usage of LH has become embedded within the organisation and any issues arising from the roll out have been resolved, then the team will move on to content development for different specialities within the Trust. They will provide gatekeeper activities for the system which will need regularly updating to ensure learning is current, produced in an interactive format and linked to the latest copies of policies etc. There will be liaison with policy holders to ensure currency of data. LH can generate reports on training activity so the team will be able to provide training activity and compliance data to add in to the metrics already reported by HR to the Board.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	Pilot and roll out of LH in June 2014	Troubleshooting usage of system by new users. Develop a hotline for user enquiries.	SW	LT / Other Staff	Jun-14	There is no understanding of the level of support required by staff initially when LH is rolled out.	
		Finish off Learner and Manager data verification.	SW	LT / other staff	Dec-14		
		Timetable user awareness sessions for rest of the year and advertise the new stat / mand process.	SW	LT / other staff	Start June 2014		
		Develop / upload information sheet for the first page of LH containing 'how to' information for users	SW	LT / other staff	May-14		
		Train departmental link advisers in the system to enable them to access it and act as a point of assistance for local staff e.g. helping them to login / book course.	SW	CLAD / other staff	Dec-14		
		Development of SOPs for system use by LT staff e.g. entering data, process for developing new packages	SW	LT / other staff	Oct-14		
		Move / convert current Training Tracker packages to LH format e.g. those currently used in HYMS / junior doctor / IT inductions.	SW	LT / other staff	Jan-14		
		Develop process and templates for reporting on training activity in conjunction with HR metrics already provided to Board.	SW	CLAD / WBL/ ODIL/ HR	Sep-14		
		Identify quiet spaces within the organisation with PCs to signpost users to, to complete their online training. Book areas at set, regular periods for access by learners and advertise. Needs to tie in with learning environment work done by ODIL.	SW	LT staff	Current PC access provision - Nov. 2014.		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
		Regular updates on system and usage to all staff	SW	LT / other staff	Ongoing		
Level 2 Beneficial to Patient Experience	Other training	Identifying and inputting external users who have an SLA with York e.g. Leeds partnership group	SW	LT staff	Feb-15		
		Identify other systems used within the organisation to record training e.g. Q Pulse and discuss how this training should be placed on LH instead so there is only one system to access for all training information.	SW	LT staff	Apr-15		
Level 3 Specialist Learning		Inputting other training that is non stat / mand and is currently hosted on NLMS e.g. Mamma Mia induction, HEE Ed sups programme	SW	LT staff	Feb-15		
		Work with specialties / groups within the Trust to develop core e-learning targetted at certain staff e.g. insulin awareness programme.	SW	LT staff	Ongoing - start Feb 2015		
Interprofessional Learning		Work with SNS to explore Webinar functionality and usage and review (with SMEs) training that can utilise this tool. Explore links from LH to webinar.	SW	LT staff / HYMS/ PGME / CLAD	Aug-15		
		Identify groups of staff / individuals who are having difficulty (or not) accessing LH	SW	All ALAR teams	May-15		
		LH system hosting moved to external servers so that all staff (esp. Community) can access from Internet / mobile devices.	SW	LT / SNS	Jun-15		
Skills Passport		Develop a clinical passport type process that all staff can access when leaving the organisation which records their training and dates whilst employed or on placement at York. For non training staff - possibly links into HR leaving processes?	SW	HR	Dec-15		
Future projects	Future projects	Identify areas that need regular review and establish 'gatekeeper' processes for LT team.	SW	LT staff	Jun-15		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
		Consolidate link advisers role (maybe link with local clinical educators?) to push information into the organisation	SW	Other ALAR teams	Mar-16		
		Explore other LH functionality e.g. Mahara for online appraisal documentation and the e portfolio section. The latter could be developed for HCAs and ACPs in the first instance.	SW	NM / AD / BG	Jul-16		
		Share basic expertise / e learning packages regionally with other hospitals but also social work, local authorities etc	SW		Jul-16		
		Explore income generation potential through development of bespoke e learning modules	SW		2017		
Simulated Learning		Work with specialties / groups within the Trust to develop core e-learning as a response to critical incidents which could support debrief simulations.			2017		
Learning Education Facilitators		See above					

Work Based Learning - Non Clinical - Bands 1- 4

Introduction The work based learning team (non clinical) will concentrate on two areas of work a) development of learning opportunities for bands 1-4 non clinical staff working with others e.g. ODIL and b) organisational learning with direct reference to AIRS and SI's. The requirements for NHSLA are changing from passive (standard driven) to proactive (learning from incidents).

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory Training	Bands 1-4 staff are historically a group that do not engage well with SM requirements	Develop a robust feedback process for departments and organisationally, through data capture, to ensure that these staff access S/M training.	**JC**	LEFs	Dec-14		
	To support development of 'a learning organisation' and meet new NHSLA criteria of learning from incidents.	1. Set up a process for obtaining information / looking for patterns within adverse incidents from the Datix system (AIRS). Also to obtain timely information from SIs	JC	Risk and legal / patient safety / simulation / other training teams.	Jan-15		
		2. Set up a process to link in with the different training teams so that training issues identified in 1 can be addressed.	JC	Risk and legal / patient safety / simulation / other training teams.	Jan-15		
		3. Provide background information and support in developing bespoke training.	JC	WBL team	Ongoing once team formed		
Level 2 Beneficial to Patient Experience	Customer services	Develop a new framework / content for the qualification to encompass more staff, working with accrediting organisation.	JC	MW / ODIL	Jun-15		
Level 3 Specialist Learning	New learning	Identify what experience / learning the organisation may need to provide differently for a more flexible workforce including quality assuring what is provided.	JC	Trust	Ongoing		
Interprofessional Learning	Apprenticeships	Open these up to all non clinical bands 1- 4 to reflect their learning requirements with respect to personal development and changing job requirements.	JC	MW / ODIL	Jan-16		
Skills passport		All learners will need to keep supporting documentation e.g. assessments in the form of a portfolio or designated area on LH.	JC	MW / SW / ODIL/ LEFs	Mar-15		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Simulated Learning		Staff will be involved in debriefs from CI/ SI		Deteriorating patient group/ CI/ SI response team	Ongoing		
Learning Education Facilitators	Links with WBL- clinical / ODIL						

Clinical Skills

Introduction

The teaching of clinical skills and the use of simulation in teaching / learning has become a national issue, not just for meeting training curricula but also as a learning tool in the response to patient safety incidents within the organisation. (Francis report). Immersive learning is recognised as the most effective in that the experience and knowledge gained is retained in a different way by all individuals involved. In order to prevent situations arising in the first place it is important that clinical staff have refresher training in how to recognise a deteriorating patient and deal effectively with the situation if it arises. It is and should be a whole team approach and so the training should cover the multidisciplinary team. See clinical skills strategy.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Interprofessional learning	Multidisciplinary teaching - Open up PG/UG skills teaching to non medics. Constraints would be numbers of attendees especially if the teaching is hands on, appropriateness of what is being taught to a mixed skill audience, availability of facilitators (would need extra brought in from clinical skills team) and syllabus timeframes in which to get the core group through practical assessments.	Review HYMS teaching and timeframes initially to see if involvement of other staff groups is possible / realistic.	JG / JW	PGS, EJ, GM, Clin skills team, medical educator.	Sep-16		
		Up skill / refresh current clinical skills facilitators to create 'breadth' so that more staff are available to support planned teaching and can assist others at peak times.	?MW	Clin skills teams	Ongoing		
	Human Factors training.	Discuss the feasibility / need for taking all non trainee doctors through Human factors training.	AD/ AC	AW / MW PG teams	Sep-14		
	Resource development	Work with the clinical skills teams to establish a central repository of created scenarios which have been tested and quality assured. These to be accessible to all training staff to reduce the need to constantly develop new resource.	AD/ AW/ MW	PG, Clinical skills, Resus	Jul-15		
		Review current training, staff leads and equipment resource. Create a centralised database for that information to be kept in a dedicated area of Staff Room.	AW/ MW	Clinical skills technicians	Aug-14		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Simulation	Clinical Skills technicians	Continue to support clinical skills apprentices through practical training until they reach a point where they can start supporting simulated sessions in the larger organisation as well as ALAR.	AW / MW	PG teams, HYMS, clin skills staff, CS regional network	Dec-15		
	Develop more simulated scenarios to support changing School curricula	Work with the regional simulation Fellows from Medicine and Surgery.	AW/MW	PG teams	Jul-16		
		Review possibility for a Trust simulation Fellow at the next round of HEE recruitment.	AD/ AC	AW / MW PG teams	Jul-14		
	Medical educator. Currently due to pressure of job plans any consultant with an interest in using the High Fidelity trainers for income generating courses is too busy with clinical work to develop this teaching.	Appoint a clinical skills facilitator with a specific medical remit for developing advanced simulation training for higher trainees as part of our regional responsibility but also to develop and facilitate training on the High Fidelity simulators. There are additional requirements for clinical skills teaching in the Foundation curriculum and at induction and this individual would be integral to all this as well as working closely with clinicians, Schools of medicine and Surgery and the Clinical skills and Resus teams to support more generic teaching.	MW/ AW	Consultants	Oct-14		
Organisational	Strategy	Write an organisational clinical skills strategy.	AD/ GD	MK, clinical skills working group.	Jul-14		
	Link to CDT	Develop a process for including other staff roles in training which is agreed with their managers.	MK	PLFs			

		ORGANISATIONAL EDUCATION STRATEGY					
	Applied Learning and Research Directorate York and Scarborough - **Health Library and Information service**						
Overall Workforce / Education strategy	**Current status**	**Task description**	**Actions**	**Lead**	**Contributors**	**Target Date**	**Progress**
	Background - Main aims are: to provide a library service which continues to underpin professional development and learning through access to peer reviewed literature and information to deliver high quality information to inform management and clinical decision making at point of need.; to raise the profile of the service; to increase electronic access to a greater breadth of information resources; **to train individuals and departments in effective information seeking strategies;** to support organisational development and KM activities; to deliver a full range of information services to support research, education and practice.; to empower our staff to develop their own information management skills. For more detail see Clinical Librarian action plan 2014/15.						
Level 1 Statutory Training	Current access to corporate induction is limited to that for junior doctors.	Increased involvement in organisational face to face induction	Get involved in HCAs induction making the session more interactive with a structured framework to work through and leading to the development of a study skills module	HB	Library team/ C Skilbeck	Jun-16	
Level 2 Beneficial to Patient Experience	Immediate access for staff to up to date information and evidence based practice supports patient safety and experience	Investigate use of social media/ mobile technologies	Investigate available technologies, barriers to use and how they could enhance the library service. Ensuring appropriate links with Learning Hub purpose and functionality.	JM	CLs and library team.	Dec-15	Would need permission organisationally to start utilising these given information governance challenges and lack of consistent mobile IT equipment in the Trust.
		Development and introduction of electronic LibGuides	Investigate and assess LibGuide provision	JM /HB	CLs and library team.	Sep-15	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Investigate remote access to stock and services	Undertake user surveys, arrange promotional roadshows and introduce appropriate services	HB	HB and library team	Sep-15	
		Develop an online enquiry service.	Investigate appropriate platform. The new Heritage management system is a potential option as it has a webpage which can be set up to do this which can be linked to from the OPAC.	HB/JM	CLs and library team.	Jul-16	Depends on purchase of Heritage
		Support for Knowledge Management work within the organisation	Offer support / get involved in Knowledge management projects where appropriate to build organisational expertise	JM	CLs and library team.	Ongoing	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Service - Investigate demand for / develop embedded CL support to more departments, teams and projects	Maintain presence at community sites and Clinical Governance meetings. Explore other opportunities - Bridlington, Grand Rounds, ACP training. Investigate other CL services re provision of evidence overviews and tiered standards of service.	JG/ MS	Library team	Ongoing	
Level 3 Specialist Learning	Access to specialist information supports learning	**Electronic** - Further development of YorLIG	Expand YorLIG to include more departments	JM	CLs and library team.	Ongoing	
		Review of current journal provision.	Investigate the reduction of local e journal provision by taking advantage of regional procurement process and increased YorLIG provision. This frees up funding for more targeted use e.g. to increase numbers of free ILLs available to departments and update the print reference resources. The library will continue to subscribe to key titles.	JM/ HB	CLs and library team.	Oct-14	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		E book provision	Investigate appropriate ebook platforms and readers.	JM /HB	CLs and library team.	Jul-16	Depends on purchase of Heritage
		Development and introduction of electronic LibGuides	Investigate and assess LibGuide provision	JM /HB	CLs and library team.	Sep-15	
		Training - Equalise access to training and literature searching services across the organisation.	Provide a remote literature searching request and training service. Visits and delivery of training to community sites and workplaces. Investigate screen casting and webex.	JG/ MS	Library team	Jun-15	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Ensure the training offer reflects and meets needs of user community and Trust as well as ALAR strategies	Undertake training needs analysis and review training frameworks. Create lesson plans and materials. Develop a study skills session. Target other groups e.g. GPs in training. Develop bitesize sessions open to all staff. Map sessions against KSF and / or professional competencies. Build on previous work in supporting ACPs.	JG/ MS	Library team	Dec-14	
		Development of cross site KM tools to assist CL efficiency and team working.	Examples Webex, Delicious, Diggo sites.	JG/ MS	Library team	Jan-16	
Interprofessional Learning	Library services support all users and can make links between different information sources to support multidisciplinary learning.	Development of 'Knowledge Centres'	Investigate local needs and similar provision in other Trusts. Implement on a requested basis.	JM	CLs and library team.	Aug-16	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Link with course providers within the organisation	Review with course providers what the information needs of current and new (ACPs) learners are and match to / purchase resources	HB	JM/ library team, CLs	Mar-15	
	Partnership working with other library professionals enhance the knowledge base which benefits staff	**External** - Review and renegotiate SLAs as required	Continue to develop external links within the region and build information partnerships through SLAs e.g. Leeds and York Partnership Trust, CCGs, HEE Y&H, YSJ, HYMS	HB		Ongoing	
Quality Assurance		**Organisation** - Libraries Quality Assurance Framework (LQAF).	Continue to engage with regional process	HB/ JM	CLs	Ongoing	
		Finance	Liaise with finance to secure ongoing resource funding.	HB		Ongoing	
		Review strategies and mechanisms to record and promote quality of CL activities.	Peer review of training. Establish performance indicators for literature searches. Follow up interviews about quality of literature search service and training.	JG/ MS	Library team	Dec-14	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Strategies	Review strategies and mechanisms to record and promote impact of CL activities	JG/ MS	Library team	Ongoing	
Operational		**Marketing** - Review marketing strategy and marketing materials	Use PESTLE, SWOT. Market segmentation exercises to be carried out with senior library team	Senior Library Team	Library team	Dec-14	
		Knowledge - Increase the skills and knowledge within the team through CPD activity	Collection and sharing of papers / info etc on X drive for other staff to review.	Senior Library Team	Library team	Ongoing	
		Management - Implemention of RFID technology	Install RFID (Radio-frequency identification) to enhance the circulation of library materials. Purchase equipment, train staff, tag stock and train library users. Implement and review.	JM /HB	Library team	Dec-14	

Overall Workforce / Education strategy	Current status	Task description	Actions	Lead	Contributors	Target Date	Progress
		Purchase new Library management system (LMS) to regional NHS preferred system - Heritage.	Survey the market and purchase appropriate system with enhanced functionality. Liaise with York St John and IT dept about implementation. Develop project plan. Investigate external hosting.	JM /HB	Library team	Dec-15	Funding has been obtained to purchase Heritage and a project plan is now being put together taking in to account YSJ plans.

Hull York Medical School (HYMS)							
Introduction	Undergraduate and Postgraduate medical education are changing, with increasing synergy between standards for training e.g. induction, educational supervisor / trainer training. Curricula and expectations re clinical skills and simulation training are also under review as there is a shift towards full registration with the GMC at the end of medical school. There is still a need to take into account training that is specifically targeted for medical students / staff through their curricula which may not be appropriate for other staff e.g. wet lab dissection. There is also a national move towards multi-professional training and the involvement of other clinical team members in that e.g. AHPs, especially when associated with Critical / Serious Incidents. Clinical teams are being reconfigured and that impacts on availability and quality of departmental training for students, so addressing this will be a challenge as well as getting 'buy in' from Trust teams and local managers. There is currently a review underway of the HYMS curriculum (2014). The changes are being supported but are presenting a high level of challenge in terms of new elements, increased expectations on clinical teaching and SSIPs and significant changes to timetable.						
Overall Workforce / Education Strategy	**Current Status**	**Action**	**Management Lead**	**External Contributors**	**Target Date**	**Risks / Issues**	**Progress against Actions**
Level 1 statutory training	**N/a**						
Teaching	Currently F1 doctors and other grades are involved directly in student teaching. Changes to the curriculum and those following the merger with Scarborough have resulted in some inequality in teaching provision.	Work with SNS and learning technologies team to understand webinars and then utilise this to deliver the same teaching content, simultaneously across both hospital sites for some topics.	GM / AF	PGS / EJ	Jun-15		
Level 3 Specialist learning	Deteriorating patient	Continue to support and build on current 5th year simulation training around team working, communication and recognising the critically ill/ deteriorating patient.	PGS / EJ	JG/ JW/ CL	Ongoing		
	Higher level teaching.	Encourage HYMS students to attend Grand Rounds and the non clinical elements of Foundation teaching.	PGS / EJ	GM / AF/ Assoc docs			
		To support quality assurance of this teaching, develop clinical teaching assessments.	GM / AF	PGS / EJ / HYMS Assoc Docs	Jun-15		
	QI Projects - Currently the status of these is unknown due to the curriculum review	Develop QI training for the students linking in with the ODIL team. Also for educational and clinical supervisors	PGS / EJ	MW/AW	Aug-15		
Interprofessional learning	Multidisciplinary teaching	Review areas of teaching / placement which might benefit from the inclusion of other clinical staff e.g nurses.	PGS / EJ	SLO teams	Jun-15		
	Induction	Move current induction materials from the current static software (TT) to LH which is a more interactive online system.	PGS / EJ	SW	Jan-14		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
		Review HYMS induction against that provided for Postgraduate doctors to ensure that both are consistent in message and content. Possibility of combining both?	PGS / EJ	AW/ MW	Mar-14		
	Assistantship - Changes in the curriculum mean that during this period 5th year students will be on hospital sites for an 8 week block. This will increase pressures in the clinical areas.	Develop a more robust system for buddying students with F1 doctors	PGS / EJ	MW/AW	Jun-16		
		Identify more clinical supervisors. To minimise impact on consultants, look at training ST3s / SAS doctors / ? Senior nurses for this role.	PGS / EJ	MW/AW / AC	Jun-16		
Skills passport	Students already have portfolios of work and assessment booklets.	Work with HYMS to have this converted to electronic	PGS / EJ	HYMS central	Ongoing		
Simulated learning	Clinical skills and simulation	Maintain communication with organisational clinical skills facilitators re developments in teaching which might support the new HYMS curriculum.	PGS / EJ	JG/JW / MKs team	Ongoing		
Careers	Currently undergraduate and Postgraduate doctors have separate Careers events.	Work with HEE Y&H to develop a mixed careers event.	PGS / EJ / MW /AW		Sep-16		
LEFs	N/a						

Post Graduate Medical Education

Introduction Undergraduate and Postgraduate medical education are changing, with increasing synergy between standards for training e.g. induction, educational supervisor / trainer training. Curricula and expectations re clinical skills and simulation training are also under review as there is a shift towards full registration with the GMC at the end of medical school. There is still a need to take into account training that is specifically targeted for medical students / staff through their curricula which may not be appropriate for other staff e.g. wet lab dissection. There is also a national move towards multi-professional training and the involvement of other clinical team members in that e.g. AHPs, especially when associated with Critical / Serious Incidents. The aim is to get to a stage where the training is proactive rather than reactive. Clinical teams are being reconfigured and that impacts on availability and quality of departmental training, so addressing this will be a challenge as well as getting 'buy in' from Trust teams and local managers.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory training		Review current induction programme and policy to ensure that it meets NHSLA expectations and is consistent across sites.	AD	AW/ MW	Sep-14		
Level 2 Beneficial to patient experience	All Postgraduate Education supports safe practice and patient safety	Build an extra day into the Foundation doctors programme on generic topics i.e. Teach the teacher and Ethics so that other clinical staff can be invited to take part and train with the doctors. Identify which staff groups may benefit from this type of training.	AW/MW	Foundation faculty	Aug-14		
Interprofessional learning	At every training opportunity to consider if a multi-professional approach is appropriate.	Develop networks with other training providers internally to agree a system / process for sharing / identifying / developing training opportunities	AW/ MW	CLAD / ODIL/ Simulation teams / AHPs	Ongoing		
		Work with the appropriate teams to consolidate current courses provided to support the deteriorating patient strategy i.e. RAMSI, AIRE. This includes review of content to ensure it is identical and delivered in the same way across all hospital sites. That suitable faculty are trained e.g. ACPs and the training is targetted at all staff. Eventually a hybrid of both courses needs to be developed for delivery to all staff.	AW/ MW	PG staff/ Simulation teams	Feb-15		
		Review other local teaching programmes for suitability to include non medical staff.	AW/MW	Nursing/ AHPs/ College tutors	Ongoing		
		Introduce York Pharmacy course for F1 doctors in Scarborough	MW/AW	Pharmacy- Lynn Ridley, Helen Holdsworth	Aug-14		
		Review junior doctor induction in line with LH implementation and to ensure that the programme is delivered consistently at both main hospital sites.	AD / AW/ MW	PG staff	Aug-14		
		Review junior doctor induction in line with HYMS student induction to provide a comparative experience.	AW/ MW	PGS/ EJ	Feb-15		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
		Review processes in GP VTS scheme to see if there are any areas of good practice which could be adopted for other trainees.	AW/MW	BJ/ KU/ GP tutors.	Jun-15		
		Identify possible routes to give junior doctors and ACPs more experience in Community settings.	AW/MW	PG and GP teams	Sep-15		
		Work with WBL team who will be setting up a process for informing ALAR teams about Critical and Serious Incidents that may have a training recommendation /requirement. Action / develop suitable learning when appropriate. Develop portfolio of scenarios that have been used. Would some learning from incidents be in the form of action learning sets?	AW/ MW	WBL / other training teams.	Ongoing		
		Continue to develop external partnerships with other hospitals and community / GP / Mental health to share good practice and developments. Continue to build on provision of training regionally e.g. surgical courses for CTs and develop new links e.g. CcRISP course,	AW/MW	PG teams/ regional MEMs	Ongoing		
Skills passport	All doctors in training are expected to maintain a current e portfolio of experience and assessments.						
Future		Explore whether Bridlington could be used as a venue for generic teaching between Scarborough, Hull, York.	AW/MW	PGS/ EJ	Apr-15		
Other medical grades		Encourage and utilise the SAS doctors more e.g. those who have completed the 'Leading from the front' training to 'market' this to other staff; also develop as staff educators.	AC plus DDME	AW/MW/AD	Ongoing		
		Work with HEE Y&H towards the changes that will be coming through medical education, where roles may become more generic and training / career routes alter accordingly e.g. more doctors in to GP/ psychiatry.	AD/ SH				

Corporate Learning & Development (CLAD)

Introduction With the implementation of the online Learning Hub (LH) some of the work of the CLAD team will change. The first step towards this is a restructure of this team together with the staff from work based learning (for non clinical staff) and the Learning technologies team. Out of this will fall three different teams across the two hospital sites (stat/ mand, Work based learning and Learning Technologies) with greater cross boundary working. The trusts personal responsibility framework underpins all levels of professionalism and training and needs to be identified as such in all new employment contracts and marketed to the organisation. There is still a general unawareness that it exists.

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
Level 1 Statutory training	Ongoing maintenance of the stat / mand programme	Team restructure. Identification of new / changed workstreams. Dedicated members of the team to support specific activities. Annual review of activity to feed in to ALAR training data for reporting to Board.	JC, MW, SW	AD / ODIL / PG/ HYMS/ Library	Oct-14		
	QA of stat/ mand content	Work with SMEs to establish quality indicators for their subjects. Random audit as a quality check.	JC/ MW	SMEs / ERG	Jun-16		
	Develop feedback / evaluation processes for courses	Work with training providers to design these elements and agree how the information will be collated and shared	MW	JC, SW, ODIL, Resus, Med ED	Mar-15		
	Ensure more robust mechanisms behind face to face learning	Development of centrally held lesson plans, objectives for the sessions as well as a current collection of all presentations / videos used for backfill purposes. Link to LH for the Knowledge assessments .	AD / GD	JC, MW, SW, ODIL, Resus, Med ED	Sep-15		
	Access issues 1.	Work with trust to address access to e learning provision using the recommendations from the In house skills audit 2014. These include the learning environment (quiet study space), availability of PCs, offsite staff and alternative provision where applicable. There needs to be equality of access for all levels of staff	AD /GD	Trust staff	Jun-16		
	Access issues 2. Lack of IT skills is preventing access by some staff to online learning.	Set up drop in sessions for staff to become more familiar with the concept of e learning and to provide some baseline guidance. This will work in conjunction with a new IT assessment for basic IT skills.	SW / JC	MW/ IT	Aug-15		
Workforce	Annual organisational TNA	Review / refresh. Set up a process for capture of internal and external learning available. Link to learning leave process?	MW	JC, BC, Trust managers	Jul-15		

Overall Workforce / Education Strategy	Current Status	Action	Management Lead	External Contributors	Target Date	Risks / Issues	Progress against Actions
	DNAs to training	Develop a process with HR and other training providers for notifying staff who do not attend for training. Automated emails?	MW	SW/ JC?	Mar-15		
	Collation of training data for those courses which do not necessarily sit within LH e.g. ODIL developed courses	Agree process with ODIL and other outliers and link this in with the Learning Technologies Team so data is in a consistent format. Agree what that format might be.		JC / MW / HR / ODIL/ other training areas			
	Develop a process to centrally record qualifications that staff enter the organisation with	Links to payroll, HR, develop a personal profile page for new staff which needs to be completed the first time they use LH and which is interrogatable? Simple process needs agreeing	MW	JC/ SW	Jul-15		
	Talent management	Develop a secondment register of departments willing to host staff looking at different working practices / roles and a process for doing so.	AD/ GD	JC/ MW	Jan-16		
	New learning leave policy implementation	To advertise the policy organisationally so that learning leave is applied for responsibly and in a timely fashion and managers are aware of potential overlaps. This will form part of ALAR reporting metrics eventually.	MW	WBL team	Mar-15		
	Supporting other departments	Review admin support currently agreed with other areas e.g. OD, CDT, Resus, manual handling etc in light of team reconfigurations especially in Scarborough to bring all arrangements in line.	JC/ MW		Oct-14		
	Supporting Trust partners	Discuss shared access to stat / mand and induction training to social work, local authority and other areas e.g. Hospice staff.	AD/ SH	JC/ MW	Sep-15		

	ORGANISATIONAL EDUCATION STRATEGY						
Applied Learning and Research Directorate York and Scarborough - Advanced Clinical Practitioners (ACPs)							
Workstream	**Task description**	**Actions**	**Lead**	**Contributors**	**Target Date**	**Progress**	
Introduction -staff are being recruited into these posts to support a number of organisational challenges: WTD which is having an impact on clinical areas in terms of staff being released for training; national reduction in junior doctor training places which will reduce the numbers of medical staff able do more generic clinical tasks; an ageing very specialised workforce; the need to support community as well as acute staff; the need to 'grow our own' specialists who become the bridge between traditional medical and nursing tasks and provide a more flexible workforce. They are being managed centrally initially and rotated through different clinical areas until their final speciality is 'fixed' towards the end of a two year MSc programme. There is a need to ensure that training mechanisms are robust, targeted, transparent and appropriate. 'Growing' these staff on an identified needs basis will support patient care through the availability of upskilled ward teams.							
Level 1 Statutory training	Induction	Co-ordinate / refine placement, corporate and clinical skills induction to meet national standards.	CS/ NM	AD	?		
Level 2 Beneficial to patient experience	Identify current skill level for each applicant and record that information centrally.	HR share recruitment forms. PGME to create spreadsheet of data for possible input into Learning Hub (LH) at a future date	Nat McMillan (NM)	AW	Jul-14		
	Support - Ensure that clinical skills teaching is monitored in terms of suitability for role.	Implement process for governance of practice / development of new skills.	BG		Jul-14		
	Ensure robust and appropriate supervision of practice	Discuss supervision of ACPs at Steering group and impact on current clinical supervisors. Develop a framework / process	BG/ NM	AD	Sep-04		
	Ensure appropriate line management in place	Discuss at Steering Group	BG / NM	AD	Sep-14		

Workstream	Task description	Actions	Lead	Contributors	Target Date	Progress	
	Ensure access to support mechanisms	At induction? Introduction to counselling, Occ H, slot ACPs into supporting doctors framework? Also access to team coaching and personal coaching for change.	NM / AD	AW/ HC/ FA-H	Jun-14		
	Raise awareness of ACPs work within the organisation	Team brief / Staff Matters/Senior clinicians and directorate meetings	NM		Aug-14		
Level 3 specialist training	Ensure that core clinical competencies are included in the two year MSc curriculum	Review core competencies	Bev Geary (BG)	Cathy Skilbeck (CS)	Jul-14	New cohort starts June 2014	
	Ensure that new curriculum meets organisations' expectations	Meet with University to finalise bespoke package	BG	CS	Jul-14		
	Increase capacity around non medical prescribing supervisors (DMPs)	Recruit additional consultants into this support role	BH/JB		Dec-15		
	Ensure ACPs are fit for final speciality role	At interview for speciality, identify what specific additional skills an individual may need. Identify how/ where this may be achieved. Also build this into the training for the next cohort	BG	AD/ AW / Maria Wilkinson (MW)	Sep-15		
	Evaluate local training programme	Identify quality indicators / benchmarks for training with the university and evaluate the programme on completion.	? University ? Trust feedback		Jun-16		
	Ensure educational supervision in clinical placements	Recruit additional consultants into this support role	AD/NM		Dec-15		

Workstream	Task description	Actions	Lead	Contributors	Target Date	Progress	
	Develop peer support for trainees	ALS and quality circles established within each cohort. Explicit within job description that qualified ACPs provide peer support and mentoring to new trainees.	NM/ODIL		Ongoing		
Interprofessional learning	Link core competencies with Foundation doctors training where possible so ACPs can access their sessions	AW to share competency lists with BG for review. BG to identify where ACPs may link in with Foundation programmes.	BG	CS / Anne Waddington (AW)	Jul-14		
	Support clinical skills teaching for all ACPs but particularly non nurses.	Meet with Sheffield Hallam re APACS course for clinical skills teaching on site	BG / AD	Skills technicians	Jul-14		
Skills passport	Create e portfolios for learning evidence and CPD recording	Explore and populate Mahara, an attachment to the LH	SW / NM	HR - other ALAR teams	Jul-15		
	Share ACP experience / good practice and raise profile regionally	At conferences / posters / published articles. Links with regional group and stakeholders.	BG/ NM		Ongoing		
Simulated learning	Develop ACPs to act as educators e.g. ALS instructors	Ensure ALS course is covered in core competencies and encourage ACPs to take on instructor status where appropriate.	BG	Resus team	Ongoing following initial course		
LEFs	N/A						

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York Teaching Hospital NHS Foundation Trust

Board of Directors – 29 October 2014

The Fit and Proper Person Requirement For Directors

Action requested/recommendation

The Board of Directors is requested to note the new 'fit and proper person' (FPPT) requirements for directors and 'equivalents', and to consider the actions proposed in this paper to ensure the Trust meets these requirements.

Summary

New regulations setting out fundamental standards of care will come into force for all care providers, including the Trust, on 1 April 2015. However, two of the new requirements – the fit and proper person (FPPT) requirements for directors and 'equivalents' (regulation 5) and the duty of candour (regulation 20) – will apply to NHS bodies from 1 October 2014 (or very closely after this date subject to Parliamentary approval).

This paper provides an overview of the requirements, the CQC's approach to regulating the requirements, and the actions proposed to ensure the Trust meets the requirements.

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

Implications for equality and diversity

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

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

identified by the Equality Act.

Reference to CQC outcomes

The project will support the Trust's readiness for the forthcoming CQC inspection.

Progress of report	This is a follow up from a previous Board of Directors report
Risk	Risks of not proceeding have been highlighted and reported.
Resource implications	Resources implication detailed in the report
Owner	Sue Holden, Director - Corporate Development and Director of Human Resources
Author	Helen Kemp-Taylor, Governance Project Manager
Date of paper	October 2014
Version number	Version 1

Board of Directors – 29 October 2014

The Fit and Proper Person Requirement For Directors

1. Introduction and Overview

New regulations setting out fundamental standards of care will come into force for all care providers, including the Trust, on 1 April 2015. However, two of the new requirements – the fit and proper person (FPPT) requirements for directors and 'equivalents' (regulation 5) and the duty of candour (regulation 20) – will apply to NHS bodies from 1 October 2014 (or very closely after this date subject to Parliamentary approval).

The purpose of this regulation is to require providers to take proper steps to ensure that their directors (both executive and non-executive) and 'equivalents' are fit and proper for the role. It makes clear that individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care. As such, they can be held accountable if standards of care do not meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

To meet this regulation, the Trust must carry out all necessary checks to confirm that persons who are appointed to the role of director (or similar senior level role, whatever it might be called) are of good character (as defined in Schedule 4, Part 2 of the regulations), have the appropriate qualifications, are competent and skilled (including that they show a caring and compassionate nature and appropriate aptitude), have the relevant experience and ability (including an appropriate level of physical and mental health, taking account of any reasonable adjustments), and exhibit appropriate personal behaviour and business practices. In addition, people appointed to these roles must not have been responsible for or known, contributed to or facilitated any serious misconduct or mismanagement in carrying on a regulated activity.

A process will be designed as part of the Governance project for this to be managed centrally.

<u>Overview of the new fit and proper person requirement</u>

An FPPT is not new as Foundation Trusts are required to ensure that Governors and Directors meet Monitor's FPPT test as part of their license. However the Monitor test is less demanding than the test under these Regulations. For example there is no equivalent to the restriction in appointing individuals who have been involved in serious mismanagement. It remains to be seen if Monitor amends their test to bring it into line with the FPPT contained in the Regulations.

The Regulations place the burden on employers to ensure that any person who is appointed as a director or who fulfills the role of director meets the FPPT. The Regulations appear to apply not only to executive and non-executive directors, but also to individuals who may act up into these roles.

It will apply to all directors and "equivalents" and it will be the responsibility of the Chairman to ensure that these people meet the fitness test and do not meet any of the 'unfit' criteria.

In addition to the usual requirements of good character, health, qualifications, skills and experience, the regulation goes further by barring individuals who are prevented from holding the office (for example, under a directors' disqualification order) and significantly, excluding from office people who:

"have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider".

This is a significant restriction. It will enable CQC to decide that a person is not fit to be a director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time, or working outside England.

CQC's approach

CQC will require the Chair of the Board of Directors to:

• Confirm to them that the fitness of all new directors has been assessed in line with the regulations.

• Declare to them in writing that they are satisfied that they are fit and proper individuals for that role.

A notification is already required following a new director level appointment.

The CQC may also ask the provider to check the fitness of existing directors and provide the same assurance to them.

There is no power in the Regulations enabling the CQC to remove a director.

The method of enforcement will be for the CQC to impose conditions on the registration of the provider requiring the removal of the director. A failure to comply with the condition will be an offence.

Unlike the original draft of the Regulations, there is no clear mechanism for challenging a decision. If it is the case that an individual has no right under the Regulations to contest a finding that they are unfit, the individual may be forced to adopt a more litigious approach such as judicial review

2. What does the Trust need to do?

The FPPT is generally a list of factors which the Trust would consider on recruitment anyway. Does the candidate have the right qualifications and skills? Are they fit and healthy to do the role (after any reasonable adjustments are made)? Have they been made bankrupt (or similar)? Have they committed any acts of serious misconduct or mismanagement? Some elements could be considered vague such as being responsible for serious mismanagement. The CQC is expected to produce guidance on this issue, but issues such as this may be expected to be discussed in interview anyway.

Actions:
The Executive Director of Human Resources and Corporate Development will :

- ensure that the Trust has appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, (which may include appropriate communication and leadership skills and a caring and compassionate nature), to undertake the role; which will be followed in all cases and relevant records kept.
- amend employment contracts:

  to set out clear expectations that all individuals will abide byThe Code of Conduct and Code of Accountability in the NHS and especially the three public service values of Accountability, Probity and Openness which are central to the work of the Trust together with the Seven Principles of Public Life as set out by the Committee on Standards in Public Life

  to make it clear that a finding of unfitness is a grounds for dismissal without notice

- ensure the fitness of directors is regularly reviewed to ensure that they remain fit for the role they are in, after determining how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.

- ensure the Trust has arrangements in place to respond to concerns about a person's fitness after they are appointed to a role, identified by itself or others, and these are adhered to.

The current Governance Project will identify all directors and "equivalents" in the Trust who the FPPT may apply to, and will ensure that they each have clearly defined roles supported by up to date employment contract, job descriptions and a person specification against which they will be reviewed.

3. Recommendation

The Board of Directors is asked to note the new fit and proper person requirements for directors and 'equivalents' and to consider the actions proposed to ensure the Trust meets these requirements.

Author	**Helen Kemp-Taylor, Governance Project Manager**
Owner	**Sue Holden, Director of Human Resources and Corporate Development**
Date	**October 2014**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 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	October 2014
Version number	Version 1

Board of Directors – 29 October 2014

Chairman's Items

1. Strategy and Context

A team of seven Directors attended the investigation meeting at Monitor last week. The session was highly interactive and all members of the team were able to contribute in a number of ways to the varied questioning and challenge. The focus, as planned, was on the ED and breast symptomatic performance. We await the formal report from Monitor and their response to our proposed undertakings. We took the opportunity to invite representatives of Monitor to meet with our Governors.

I was delighted this week to note a letter from the Secretary of State for Health sent to all Health and Wellbeing Boards effectively instructing them to fully involve providers in their structure. This vindicates the proactive approach we took to developing this structure in the City of York and will hopefully enhance the North Yorkshire Health and Wellbeing Boards activities.

We have also received a '5 Year Forward View' from Simon Stevens (Chief Executive, NHS England) outlining his views on the way the NHS will develop in the coming years. As a Board we will digest this and consider the implications for our strategy.

The Board will hold a private time-out discussion in November, which will cover three topics:

- Capital planning and the financing of investments
- Staff engagement
- The evolution of our vision for collaboration

2. Governance & Governors

The refreshed Council of Governors has now met for its first quarterly meeting – we look forward to working with a full slate and the induction sessions have begun. The committees and working groups will be also be refreshed, as appropriate.

Congratulations to Beverley Geary on her appointment to the substantive post of Chief Nurse for our Trust.

By the time of the Board meeting we will announce the outcome of the Chief Operating Officer appointment process.

3. Recommendation

The Board of Directors is asked to note the report.

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 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	October 2014
Version number	Version 1

Board of Directors – 29 October 2014

Chief Executive Report

My world has been dominated (to an extent) in recent weeks by the Monitor investigation and it was with some relief that we were finally able to attend the investigation last Monday and account for ourselves and our performance in what everyone recognises, nationally and locally, as the most difficult environment in which to deliver health services that can be recalled. I was proud to be part of the team that took the opportunity to present our case and I want to thank each and every member for the professional attitude, approach and collective spirit that was so evident throughout. I also want to thank everyone else for their input and support which proved so vital and the many supportive messages I received from up and down the organisation. I think this for me has been the most gratifying consequence of the process that demonstrated a collective and significant understanding of its importance amongst staff at all levels and a recognition of the consequences this might have for us. Whatever the outcome I am satisfied that we have approached this properly, with respect, and will undoubtedly be better for it.

Congratulations to Beverley Geary on her appointment as substantive Chief Nurse. Beverley has had a huge impact on the organisation since her appointment some two years ago and I am delighted we have been able to attract a Chief Nurse of her calibre and undoubted potential. I know her appointment has been well received throughout the organisation and I am delighted to confirm another excellent addition to our executive team. I am equally hopeful that by the time we meet we will have recruited a Chief Operating Officer and we can begin to plan the next stage of our development as an organisation with confidence.

You will be aware of the recent Kings Fund report that has clearly demonstrated the disconnect between national strategy and current thinking and the reality on the ground for organisations like ourselves. However, we cannot allow this to distract us from our obligation to provide the very best service to our community and it is therefore essential that we continue to focus on managing the right balance between our priorities of quality and safety, performance and finance. I was struck during the meeting at Monitor that we do this really well in the main and that is down to the common purpose that is evident around the Board table and the constructive challenge and inter-reaction that we are increasingly comfortable with.

Looking ahead and in light of our recent difficulties I am pleased to report that Maple Ward has re-opened on the Scarborough site and our winter escalation facility on Graham Ward opens this week. This should provide some welcome relief to our capacity and performance overall. In addition, the outcome of the Scarborough and Ryedale Unscheduled Care Centre tender is imminent I will update the Board if the outcome has been announced by the time we meet. Whatever the outcome, positive or negative, we will be in a position to plan the future of ED in Scarborough with greater certainty. I would also like to thank our tendering team for submitting the Clifton Park Centre tender in good time as I know how much work has been involved in this process.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley Chief Executive**

Date	**July 2014**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

Monitor Quarter 2 return

Action requested/recommendation

The Board is asked to approve the submission to Monitor to be made at the end of the month.

Summary

At the end of each quarter Monitor requires the Trust to submit a quarterly return on the performance and financial position of the Trust, This submission must be considered and approved by the Board.

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 specific reference

Progress of report	Report is prepared for the Board of Directors
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Patrick Crowley, Chief Executive
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	October 2014
Version number	Version 1

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Scoring under Risk Assessment Framework	Risk declared at Annual Plan	Performance	Achieved/Not Met	Performance	Achieved/Not Met	Any comments or explanations
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	No	90.9%	Achieved	81.6%	Not met	*Failed in line with amnisty to clear*
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	No	96.8%	Achieved	95.9%	Achieved	
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	No	93.3%	Achieved	93.4%	Achieved	
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	No	93.9%	Not met	92.6%	Not met	
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	No	88.0%	Achieved	0.0%	Achieved	*The figures are not avaliable at this stage*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	No	96.4%	Achieved	0.0%	Achieved	*The figures are not avaliable at this stage*
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local				87.4%		0.0%		
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service				96.6%		0.0%		
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No	96.4%	Achieved	0.0%	Achieved	*The figures are not avaliable at*
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	No	100.0%	Achieved	0.0%	Achieved	*The figures are not avaliable at*
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No	94.0%	Achieved	0.0%	Not relevant	*The figures are not avaliable at this stage*
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	No	98.6%	Achieved	0.0%	Achieved	*The figures are not avaliable at this stage*
Cancer 2 week (all cancers)	93%	1.0	No	86.1%	Not met	0.0%	Not met	*The figures are not avaliable at this stage*
Cancer 2 week (breast symptoms)	93%	1.0	No	45.6%	Not met	0.0%	Not met	*The figures are not avaliable at this stage*
Care Programme Approach (CPA) follow up within 7 days of discharge	95%	1.0	No	0.0%	Not relevant	0.0%	Not relevant	
Care Programme Approach (CPA) formal review within 12 months	95%	1.0	No	0.0%	Not relevant	0.0%	Not relevant	
Admissions had access to crisis resolution / home treatment teams	95%	1.0	No	0.0%	Not relevant	0.0%	Not relevant	
Meeting commitment to serve new psychosis cases by early intervention teams	95%	1.0	No	0.0%	Not relevant	0.0%	Not relevant	
Ambulance Category A 8 Minute Response Time - Red 1 Calls	75%	1.0	No	0.0%	Not relevant	0.0%	Not relevant	
Ambulance Category A 8 Minute Response Time - Red 2 Calls	75%	1.0	No	0.0%	Not relevant	0.0%	Not relevant	

Ambulance Category A 19 Minute Transportation Time	95%	1.0	No	0.0%	Not relevant	0.0%	Not relevant	
C.Diff due to lapses in care	30	1.0	No	12	Achieved		Achieved	
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and				24		0		
C.Diff cases under review				12		0		
Minimising MH delayed transfers of care	<=7.5%	1.0	No	0.0%	Not relevant	0.0%	Not relevant	
Data completeness, MH: identifiers	97%	1.0	No	0.0%	Not relevant	0.0%	Not relevant	
Data completeness, MH: outcomes	50%	1.0	No	0.0%	Not relevant	0.0%	Not relevant	
Compliance with requirements regarding access to healthcare for people with a	N/A	1.0	No	0.0%	Not relevant	N/A	Not relevant	
Community care - referral to treatment information completeness	50%	1.0	No	100.0%	Achieved	100.0%	Achieved	
Community care - referral information completeness	50%	1.0	No	71.7%	Achieved	71.2%	Achieved	
Community care - activity information completeness	50%	1.0	No	98.9%	Achieved	97.9%	Achieved	

Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No	No	No	
CQC compliance action outstanding (as at time of submission)	N/A		No	No	No	
CQC enforcement action within last 12 months (as at time of submission)	N/A		No	No	No	
CQC enforcement action (including notices) currently in effect (as at time of	N/A		No	No	No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision	N/A		No	No	No	
Major CQC concerns or impacts regarding the safety of healthcare provision (as	N/A		No	No	No	
Trust unable to declare ongoing compliance with minimum standards of CQC	N/A		No	No	No	

Worksheet "Sheet2"

Click to go to index

In Year Quality Governance Metrics of York Teaching Hospital

The Risk Assessment Framework (diagram 13) sets out that Monitor will use executive team turnover as one of the potential indicators of quality governance concerns. Please provide the information requested below and ensure that any changes are explained in your commentary:

	units	Quarter end 30 June 2014	Quarter end 30 September 2014
Executive Directors			
Total number of Executive posts on the Board (voting)	Posts	7	7
Number of posts currently vacant	Posts	2	2
Number of posts currently filled by interim appointments	Posts	2	1
Number of resignations in quarter	Resignations	-	-
Number of appointments in quarter	Appointments	-	-

List of Governors' elections for York Teaching Hospital

The Risk Assessment Framework requires a quarterly report of elections held and results as below:

Elections Held in the quarter ending 30 Sep 2014

Constituer	Full Name of Constituency	No. of can	No. of Vot	Turnout	No. of Elig	Date of election
Public	Bridlington	2	129	27.8%	464	23/09/2014
Public	York	7	865	14.0%	6,166	23/09/2014
Public	Scarborough	3	150	34.6%	434	23/09/2014
Public	Ryedale and East Yorkshire	4	577	34.5%	1,671	23/09/2014
Public	Selby	3	540	31.0%	1,743	23/09/2014
Staff	York	3	763	14.3%	5,345	23/09/2014
Staff	Scarborough and Bridlington	3	371	13.7%	2,715	23/09/2014

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 29 October 2014

Audit Committee Annual Report

Action requested/recommendation

That the Board of Directors receive the Annual Report from the Audit Committee.

Summary

This report consists of the Annual Report from the Audit Committee which will also be presented at the Council of Governors December meeting.

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

No direct reference to CQC outcomes to note.

Progress of report	The report was written for the Audit Committee
Risk	No risk.

Resource implications	There are no direct resource implications.
Owner	Philip Ashton, Chairman of the Audit Committee
Author	Philip Ashton, Chairman of the Audit Committee
Date of paper	October 2014
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Annual Report of the Audit Committee covering the financial year 2013/14

September 2014

Introduction

In accordance with best practice and the NHS Audit Committee Handbook, this report has been prepared to provide the Board of Directors with a summary of the work of the Audit Committee during the period April 2013–March 2014, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

This has been another challenging year for the Trust as it continues to integrate the additional sites following the completion of the acquisition process of Scarborough and North East Yorkshire NHS Trust (SNEY). The Trust has spent the last year working to ensure that the subsequent integration workstreams continue to be implemented successfully. The Trust has been working hard to improve the understanding and use of risk registers across the organisation and build on that work to clarify the key assurances used by the Directors to confirm performance across the Trust. The Audit Committee has continued to monitor the impact of integration on key systems through the Internal Audit programme and has supported the development of the risk and assurance systems across the Trust.

Overview of the year 2013/14

The Audit Committee has a membership of four Non-Executive Directors and during the 2013/14 financial year this comprised of:

- Mr Philip Ashton (PA) Chairman
- Mr Michael Sweet (MS)
- Mr Michael Keaney (MK) (Started December 2012)
- Mrs Libby Raper (LR) (Started December 2012)

Table 1: Audit Committee Attendance

	Meeting Dates					
	17/6/13	**16/9/13**	**9/12/13**	**24/3/14**	**19/5/14**	**27/5/14**
PA	✓	✓	✓	✓	✓	✓
MS	✓	✓	✓	✓	✓	✓
MK	✓	✓	✓	✓	✓	✓
LR	✓	✓	A*	✓	✓	✓

*A = Apologies

The Audit Committee met formally on six occasions during 2013/14 and all meetings were quorate. Members of the Committee also attended relevant Audit Committee training events during the course of the year.

The Committee is supported at all of its meetings by:

- Director of Finance
- Head of Corporate Finance

- Internal Audit (Head of Internal Audit and Internal Audit Manager)
- External Audit (Partner and Senior Manager)
- Foundation Trust Secretary

Other representatives (e.g. Local Counter Fraud Specialist) attended the Audit Committee as and when required.

The Committee received secretarial and administrative support from the Foundation Trust Secretary. There was a documented Audit Committee timetable which scheduled the key tasks to be undertaken by the Committee over the course of a year and this received an annual review. Detailed minutes were taken of all Audit Committee meetings and were reported to the Board of Directors.

Separate, private sessions were held with Internal Audit and External Audit prior to one Audit Committee meeting (end of year) as required.

Duties of the Committee

Following a review of the Audit Committee's Terms of Reference in March 2013, the key duties of the Audit Committee can be summarised as follows:

Governance, Risk Management & Internal Control
• Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives, primarily through the assurances provided by internal and external audit and other assurance functions.
Financial Management & Reporting
• Review the Foundation Trust's Financial Statements and Annual Report, including the Annual Governance Statement, before submission to the Board of Directors. • Ensure that systems for financial reporting are subject to review to ensure completeness and accuracy of information and compliance with relevant legislation and requirements. • Review the Trust's Treasury Management Policy, Standing Financial Instructions and systems in place to ensure robust financial management.
Internal Audit & Counter-Fraud Service
• Ensure an effective internal audit and counter-fraud service that meets mandatory standards and provides appropriate, independent assurance to management and the Audit Committee. • Review the conclusion and key findings and recommendations from all Internal Audit reports and review of regular reports from the Local Counter Fraud Specialist. • Monitor the implementation of Internal Audit and Counter Fraud

recommendations.
External Audit
• Ensure an effective external audit service. • Review the work and findings of external audit and monitor the implementation of any action plans arising.
Clinical & Other Assurance Functions
• Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. • Review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. Specifically, the Corporate Risk Management Group and the Patient Safety Group.

Work of the Committee/Group

The Committee currently organises its work under five headings *Work Groups*, *Internal Audit, External Audit*, *Governance Issues* and *Finance Issues*.

Work Groups - The Audit Committee has a work group reporting directly to it formed in 2010. This group reviews the data quality in the organisation.

The Group received a series of presentations on the data security and the impact of integration on a wide range of systems including Finance, IT and HR which provided significant assurance on the systems in place. The Data Quality Group introduced a paper to the Audit Committee which described the three lines of defence model

Updates were provided verbally at each Committee meeting on group / board objectives, activity and achievements.

Internal Audit - Internal Audit and Counter Fraud Services are provided by North Yorkshire NHS Audit Services (NYAS). The Chair of the Audit Committee and the Director of Finance sit on the Alliance Board which oversees NYAS at a strategic level. The Board met on three occasions during 2013/14.
An Internal Audit Charter formally defines the purpose, authority and responsibility of internal audit activity. This was originally approved in 2010 with a revised document reviewed and approved by the Alliance Board in July 2012.

The Audit Committee gave formal approval of the 2013/14 Internal Audit Operational Plan in March 2013.

The conclusions (including the assurance level and the corporate importance and corporate risk ratings) as well as all findings and recommendations of finalised Internal Audit reports are shared with the Audit Committee. The Committee can, and does, challenge Internal Audit on assurances provided, and requests additional information, clarification or follow-up work if considered necessary. All Internal Audit reports are discussed individually with the Audit Committee.

A system whereby all internal audit recommendations are followed-up on a quarterly basis is in place. Progress towards the implementation of agreed recommendations is reported (including full details of all outstanding recommendations) to the Director Team and the Audit Committee on a quarterly basis. The Chief Executive continues to review progress towards implementing recommendations made in limited assurance reports.

The Counter Fraud Plan was reviewed and approved by the Audit Committee and the Local Counter-Fraud Specialist (LCFS) presented bi-annual reports detailing progress towards achievement of the plan, as well as summaries of investigations undertaken.

External Audit - External Audit services were provided by Grant Thornton for 2013/14. During the 2013/14 financial year, the Audit Committee reviewed External Audit's Interim Report, Annual Governance Report and Management Letter in relation to the 2013/14 financial statements for York Teaching Hospital NHS Foundation Trust.

External Audit regularly updates the Committee on progress against their agreed plan, on any issues arising from their work and on any issues or publications of general interest to Audit Committee members.

The Audit Committee reviewed and approved the External Audit Plan in relation to the 2013/14 financial statements and the related audit fee in March 2013.

Governance issues - During 2013/14 the Audit Committee reviewed and, where appropriate, approved the following documents prior to submission to the Board of Directors:

- Assurance Framework and Corporate Risk Register in July, September, December 2013 and March 2014;
- Standing Orders, Standing Financial Instructions and Scheme of Delegation in September 2014;
- A review of compliance with the Code of Governance in May 2014.
- Approval of the procurement strategy and policy in March 2014

Additionally the Staff Registers of Interests and Gifts and Hospitality for the year ended 31 March were reported to the Audit Committee in May 2014.

- The Annual Governance Statement and the Head of Internal Audit Opinion were scrutinised by the Audit Committee prior to submission to

the Board. The Committee also reviewed the Corporate Governance Statement prepared for publication in June 2014.

In relation to the governance of the Audit Committee itself, the Committee undertook the following tasks during 2013/14:

- Review and approval of Audit Committee Terms of Reference and work programme at the time out meeting held in July 2014.
- Ongoing review and revision of the Audit Committee's timetable.
- The Audit Committee also reviewed the risk committee structures and supported the work of the revision of the Corporate Risk Register and Assurance Framework.

Financial issues - The Committee oversee and monitor the production of the Trust's financial statements. During the 2013/14 financial year, this included:

- Draft Accounts and Annual Report for the period 1 April 2013 to 30 March 2014
- Review of the risks identified in external and internal audit reports.
- Issues regarding end of year accounts;
- A formal Committee meeting on 27th May 2014 to approve the final accounts, Annual Governance and Annual Report for 2013/14 (including the Quality Account) prior to submission to the Board of Directors and Monitor.

The Audit Committee also reviewed and approved:

- Single Tender Actions
- the Treasury Management Policy in March 2014
- the Losses & Special Payments register in May 2014.

Clinical and other Assurance - The Audit Committee has received verbal updates on the activities of the Patient Safety Group and Compliance Unit. The Committee has had focussed discussion on the role and nature of clinical assurance and sought evidence of how that is derived from current governance systems.

The Internal Audit programme continues to incorporate clinically focussed system reviews and during 2013/14 included topics such as Mortality Review, Controlled Drugs Management and Do Not Resuscitate Order Management.

Assurance around the integration process was provided through verbal feedback on the activities of the Acquisition Assurance Board, presentations to the Audit Committee workgroup and Internal Audit work.

Meetings for the coming year

The Audit Committee is seeking to improve the communication between the other Board Committees and is keen to improve the fluidity of information across the committee structure.

The Committee will continue to seek assurance around the development, introduction and maintenance of systems and processes and will seek assurance around the introduction of the CQC fit and proper person test and the duty of candour requirements. The Committee has also developed a plan to receive regular information about clinical governance and the systems employed by the Trust.

Conclusion

In conclusion, as I reflect back on another year, I conclude that the Committee has had to deal with a workload that continues to increase, not only because of the on-going issues regarding the integration of systems after the acquisition of Scarborough and North East Yorkshire NHS Trust, but also because of the increasing burden of regulatory compliance, and the ever more explicit requirement to gain assurance from the considerable investment in clinical audit projects. In the complex environment in which our Trust operates, we can only expect more of the same in the future. I must therefore express my appreciation to the members of the Committee, to the Foundation Trust Secretary for her constant support, to the internal auditors for their high quality work and their frankness, openness and clarity in all their communications. Thanks also to the finance team for their cooperation with the work of the Committee, and the positive responses to our interventions, which are taken on board with commitment and energy, just the type of reaction we would wish for.

Philip Ashton Chairman of the Audit Committee
October 2014

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 29 October 2014

2014-15/157: 4th & 5th Cardiologists Business Case (incorporating all 5 recently approved Cardiology business cases by Corporate Directors)

Action requested/recommendation

Approval of the 4th & 5th Cardiologist Business Case

Summary

The Medicine Directorate has prepared 5 business cases relating to the development and improvement of cardiology services on the Scarborough site. The driving principle of these cases is to ensure safe provision of services on the Scarborough site. The cases relate to mobile recovery beds to support the catheter laboratory, CT angiography, myocardial perfusion imaging, cardio-respiratory department improvements and additional consultant medical staff. The cases have been evaluated separately and jointly by Corporate Directors. All cases have been approved by Corporate Directors but this specific case, being new consultant medical staff investment, requires Board approval. All other cases are of relatively low financial value requiring Corporate Director approval only.

This business case addresses the capacity gaps within cardiology at Scarborough Hospital with the recommendation for a staged appointment of 2 additional consultants, 1 to be appointed with immediate effect and the 2nd to be appointed upon the retirement of Dr Memon (0.4 WTE).

The financial summary for this case shows a financial loss in subsequent years. It is important that the Board are aware of the fact that when taken in conjunction with all other cardiology cases the overarching service developments are expected to break even. In the short term the cost of all cases and associated new income levels suggest an overall loss of £170k. Forward projections show this position quickly improving as we remove the leased mobile catheter laboratory recovery beds from site (with a permanent bed solution) and increase cardiology activity levels as all elements of investment come fully on line. In the short term the Directorate Management Team will be working with Corporate Directors to minimise costs through profiling of investments.

This specific business case is not a case that will generate a financial contribution to the Trust in its own right. But this case is a fundamental building block to put in place to ensure provision of safe and effective cardiology services on the Scarborough site.

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

Implications for equality and diversity

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

Following a review of Cardiology services and with assistance from York cardiology colleagues, the General Medicine Directorate recently submitted 5 business cases to Corporate Directors for approval with regard to Cardiology services in the broadest terms at Scarborough Hospital. These business cases were submitted as a co-dependant bundle and a brief explanation follows:

Business Case No 1 – Cardiorespiratory Dept expansion – approved by Corporate Directors. Staffing review undertaken and expansion of current establishment to provide reduced waiting times, provide one-stop cardiology echos, enhanced support to inpatients and diagnostic range of services.
Business Case No 2 – CT Angiography – approved by Corporate Directors. New service to the Trust, repatriating work from Hull and Leeds and meeting NICE guidance for Cardiology diagnostics. Reduction in waiting times and local service now available.
Business Case No 3 – Myocardial Perfusion – approved by Corporate Directors. Expansion of current provision allowing repatriation of work sent from York Teaching Hospital to Leeds. Reduction in waiting times.
Business Case No 4 – Cath Lab Recovery Area – approved by Corporate Directors. Provide ring-fenced recovery accommodation to pre and post procedure for Angiograms and Pacemakers. Currently these procedures are frequently cancelled due to bed pressures.
Business Case No 5 – 4th and 5th Consultant – approved by Corporate Directors and now awaiting approval from the Board of Directors. Appointment to these posts will provide much needed capacity at Scarborough Hospital in terms of outpatient clinics, inpatient ward cover, diagnostic tests and ward

referrals. It will allow repatriation of work previously sent to Hull to provide a local service to patients and increase income opportunities. A much needed daily, Monday to Friday, consultant referral availability including acute clinics and same day review of inpatients referred for cardiology opinion. Waiting times will be reduced enabling achievement of 18 week RTT and diagnostic waiting time targets. Further enhancement opportunities for specialised cardiology services on site dependent upon specialist interest at consultant appointment.

Progress of report	Approved by Corporate Directors on 29 September 2014 Business Case No 5 requires approval by Board of Directors
Risk	Risk of ability to recruit
Resource implications	Resources implication detailed in the attached report.
Owner	Joanne Southwell, Deputy Director of Operations
Author	Amanda Mullin, Deputy Directorate Manager for General & Acute Medicine
Date of paper	October, 2014
Version number	1

APPENDIX Bi

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2013-14/157

2. Business Case Title

Cardiology Medical Staffing Review

3. Management Responsibilities & Key Contact Point

The business case 'Owner' should be the appropriate Clinical or non-clinical Director, or where appropriate the lead Clinician nominated by the respective Clinical Director. The 'Author' will be the named manager supporting the Owner of the business case, who will have responsibility for the development and writing of the business case, and will be the key contact point for enquiries.

Business Case Owner:	**David Humphriss**

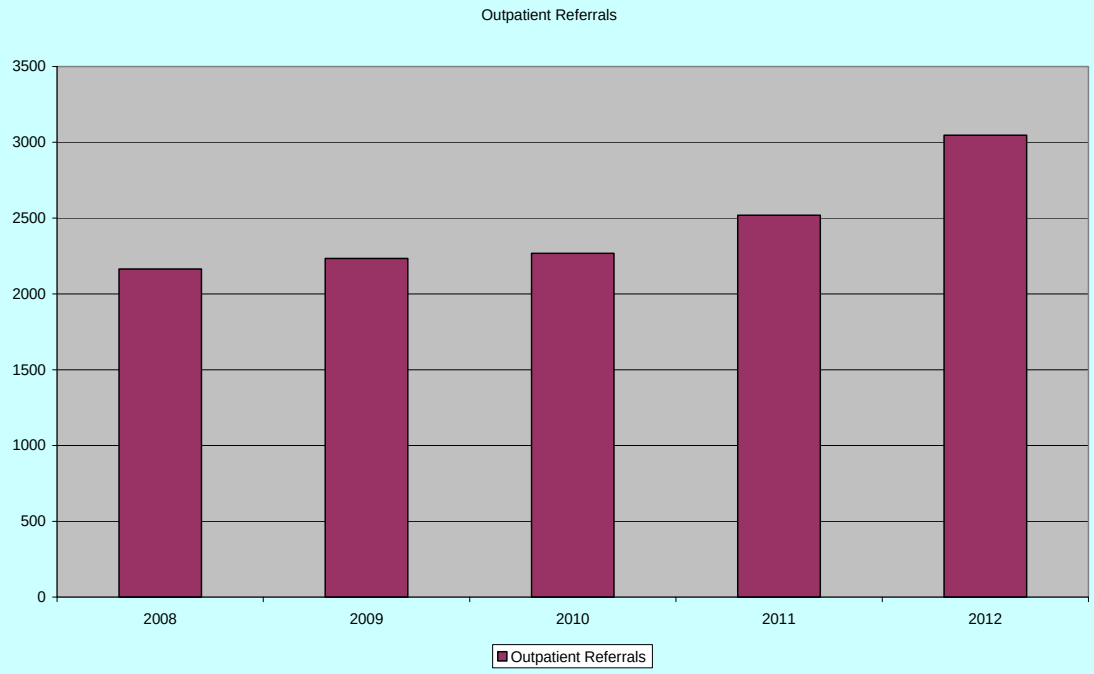
Business Case Author:	**Joanne Southwell**
Contact Number:	**01723 342122**

4. Issue(s) to be addressed by the Business Case

Describe the background and relevant factors giving rise to the need for change. Relevant data (e.g. BCBV data, etc.) *must be included to support the background described.*

The purpose of this business case is to seek budgeted resource in a phased approach for an initial additional 1.0 WTE Consultant Cardiologist, a further 0.60 WTE Consultant Cardiologist in approx 18 months an additional 1.0 WTE Specialty Doctor and an additional band 5 1.0 WTE CCU nurse..

Until early 2013 the cardiology service at Scarborough Hospital was provided by 3.0 WTE Consultants, Dr Houghton, Dr Memon and Dr Clarke. At that time, Dr Clarke and Dr Memon (who were both on the top of their pay scale with multiple clinical excellence awards) took retirement and were replaced by Dr Ahmad, a complex device specialist cardiologist, and the current NHS locum. The reduction in salaries enabled Dr Memon to return on a part time basis contracted for 0.4 WTE but he is expected to retire permanently within 18 months.



There has been a growth in cardiology referrals in the last 5 years of approximately 40%. This has significantly increased waiting times for new outpatients to be seen and has led to the stagnation of the backlog of follow up appointments with the longest waiters being 18 months overdue. This is currently being rectified by a series of waiting list initiatives that have been set up to minimise the governance risks and review of the backlog.

Guidance from the Royal College of Physicians recommend that Cardiology Job Plans have no more than 2 outpatient sessions per week to allow for other commitments including inpatient ward rounds and laboratory work. There are currently 9 clinics per week within the existing job plans, this business case would allow an extra clinic per week and all job plans would be reviewed to ensure that each clinic has maximum capacity available.

There have also been a number of changes to the cardiology service at Scarborough Hospital over the years which has led to increased demand, including a larger inpatient bed base and a new Cath Laboratory. Pacemaker referrals have increased as the guidance now is to as has demand for coronary angiography. With agreement within the integrated Cardiology service there are also new developments in the pipeline which will require additional resource;

- CT Coronary Angiography
- Increased Echo
- Increased Myocardial Perfusion Scintography Scanning
- Complex Devices (York site)
- Combined MDT
- An additional Nuclear Medicine session
- Rapid access one stop Heart Failure Clinic with Palliative Care
- Daily specialist input to AMU to cover same day specialist review

The Acute Board strategy proposes 7 day working with individual specialist rotas. This would not be possible with the current resource however increasing the numbers of WTE

consultants to 5.0 WTE would provide a sustainable Cardiology rota which may be possible as a separate entity to the GIM on call rota (This would require further discussion with plans for GIM).

In order to deliver a safe and sustainable cardiology service we seek to increase the Consultant Cardiologist establishment from 3.4 WTE to 5.0 WTE and to increase the number of Specialist Doctors from 4.0 WTE to 5.0 WTE. We also seek funding for a 1.0 WTE band 5 nurse to support the extra commitments within the unit.

5. Options Considered

List below the alternative options considered to resolve the issue(s) presented in section 4 above. This should include consideration of alternative workforce and clinical models.

Description of Options Considered
1. Do Nothing
2. Increase Consultant Cardiologist establishment from 3.4 WTE to 5.0 WTE with an additional 1.0 WTE Specialty Doctor and an additional 1.0 WTE band 5 nurse.

6. The Preferred Option

6.1 Preferred Option

Detail the preferred the option together with the reasons for its selection. This must be supported with appropriate data in demonstrating how it will address the issue(s) described in section 4 above.

The preferred option is option 2.

This will enable permanent additional outpatient clinics to be set up to meet the demand of new patients and the follow up backlog. It will improve our ability to see patients within 18 weeks, eliminating possible fines for patients breaching the target.

It will provide better throughput within the Cath Laboratory and negate the requirement to send patients to Hull in order to meet waiting time demands.

It will enable better provision of inpatient ward rounds, which will reduce length of stay on the ward and improve patient safety.

It will enable future development of services such as described in the commentary.

It will provide sufficient numbers to provide 7 day working and a specialist cardiology rota.

6.2 Other Options

Detail the reasons for rejecting the remaining options listed under section 5, together with supporting detail.

Do Nothing – we will continue to struggle to meet the demands of the service, waiting list initiatives will be provided on a constant basis in order to minimise governance risks associated with long waiting times.

We will continue to send Coronary Angiography patients to Hull in order to meet waiting time targets and will continue to lose the income associated with this.

We will be unable to sustain daily ward rounds, especially during periods of consultant leave and this will have a knock on effect on length of stay.

It will be increasingly difficult to modernise and innovate the service at Scarborough with such pressure on core activity which could result in a loss of existing consultants.

We will be unable to meet the requirements of the Acute Board for 7 day working and individual specialist rota's.

7. Trust's Strategic Objectives

7.1 Alignment with the Trust's Strategic Objectives

The Trust has identified four strategic 'frames' that ensure there is a focus for its emerging priorities and objectives and assists in the communication to staff, patients and other stakeholders. The four strategic 'frames' are:

1 *Quality and Safety*
2 *Effectiveness, Capacity and Capability*
3 *Partners and the Broader Community*
4 *Facilities and Environment*

In this context listed below are four principle objectives that fit to the strategic frames. Indicate using the table below to what extent the preferred option is aligned with <u>at least one</u> of these principle objectives.

Strategic Objective	Aligned? Yes/No	If Yes, how is it Aligned?
To provide safe and quality services to all patients underpinned by the specific steps set out in the driver diagram as part of the Quality and	YES	This will enable us to develop our services in line with NICE guidance to develop CT Coronary Angiography and Myocardial

Safety Strategy. This includes developing and learning from performance indicators (e.g. PROMs, NCI, etc). Ensuring compliance with national requirements - NPSA, NICE and implementation of results of clinical audit strategies and ensuring consultation and engagement of patients, visitors and staff.		Perfusion Scintography.
To provide excellent healthcare with appropriate resources, strong productivity measures and strong top quartile performance being indicative of this. The service will be based on 'needs based care' and staff understand how they contribute to the Trust's successes.	YES	This will enable us to provide increased Outpatient provision to meet the demands of waiting time targets. It will enable us to meet the angiography waiting time targets. Increased Ward Round provision will see a reduction in length of stay and improved patient safety.
To be an exemplar organisation that is responsive to the local and broader community needs and is recognised and trusted. To engage fully in all aspects of community discussion relating to health and provide expert advice and leadership as required. To work with other groups to support the adoption of a consistent approach in the community and demonstrate that the Trust is a community orientated organisation able to achieve and deliver all local and national outcomes.	YES	This will enable us to meet the waiting time demands eliminating the requirement to send patients to other healthcare providers for their diagnostic treatments. The Trust strategy sees Scarborough Hospital as the main provider of diagnostic procedures and York being a centre for interventional procedures.
To provide a safe environment for staff, patients and visitors, ensuring that all resources are used as efficiently as possible	YES	Increased Senior doctor presence on the ward will provide a safer environment to the patients ensuring that the needs of a deteriorating patient are identified earlier thus allowing treatment to be delivered in a more timely manner.

7.2 Business Intelligence Unit Review

The Business Intelligence Unit must review all business cases for 'Strategic fit' to the Trust's 5 year plan. The date that the business case was reviewed by the BIU together with any comments which were made must be provided below.

Date of Review	
Comments by BIU	

8. Benefit(s) of the Business Case

8.1 Benefit(s)

The identification at the outset of the benefit(s) that arise from the business case is crucial to ensuring that a robust evaluating of the progress and delivery of the business case objectives is possible during the post implementation reviews.

*Clearly detail and **quantify** the expected benefits that will accrue to the Trust from the preferred option in each of the three domains of service improvement. The benefits identified must be tangible, and capable of being evidenced ideally through some form of measurement.*

Description of Benefit	Metric	Quantity Before	Quantity After
Quality & Safety			
Reduced Follow up backlog	Length of backlog	18 months	0 months
Reduced No of patients sent to other healthcare providers	No of patient sent to Spire	80	0
NICE guidance provision of CT coronary angiography	Compliance	NO	YES
NICE guidance provision of Myocardial Perfusion Scintography	Compliance	Part compliance	YES
How will information be collected to demonstrate that the benefit has been achieved?			
Access & Flow			
Improved 18 week performance	breaches		0
Improved 6 week diagnostic performance	breaches		0
How will information be collected to demonstrate that the benefit has been achieved?			
Finance & Efficiency			
Reduced Length of stay on CCU	LOS		
Improved financial position	I&E		
How will information be collected to demonstrate that the benefit has been achieved?			

8.2 Corporate Improvement Team Review

The Corporate Improvement Team must review all business cases across the three quality domains. The date that the business case was reviewed by the IT together with any comments which were made must be provided below.

Date of Review	
Comments by CIT	

9. Summary Project Plan

Detail below the specific actions, individuals responsible for their delivery, and timescales that must be done in order to realise the intended benefits of the preferred option of this business case. For example, these may include acquisition of key space requirements, or equipment, IT software/ hardware; the recruitment of key personnel, training, implementation of systems, change in business and/or clinical processes, etc. ***All fields must be completed****.*

Description of Action	Timescale	By Who?
PMM approval to proceed with BC	March 2014	Joanne Southwell
Corporate Director approval obtained	August 2014	Joanne Southwell
VC approval obtained	September 2014	Joanne Southwell
Recruitment & retention process commenced	September 2014	Joanne Southwell

10. Risk Analysis:

Identify the key risks to the Trust of proceeding with the preferred option, and what actions can be taken to mitigate them should they arise.

Identified Risk	Proposed Mitigation
Inability to recruit	Locum provision

11. Risk of Not Proceeding:

Identify the key risks/ potential impact of not proceeding with the preferred option.

As described in the Do Nothing option.

12. Consultant, and other Non-Training Grade Doctor Impact

(Only to be completed where the preferred option increases the level of Consultant/ non-Training Grade input)

12.1 Impact on Consultant/ Non-Training Grade Doctor Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant/ Non-Training Grade Doctor to a maximum of 11. This section should illustrate the impact that the additional Consultant/ Non-Training

Grade input created will have on the average number of PAs worked in the specialty, the frequency of the on-call rota, and the PA profile across the whole specialty team. Information is also required of each Consultant's/ Non-Training Grade Doctor's actual annual working weeks against the 41 week requirement.

The information below must be accompanied by the Trust's Capacity Planning Tool, and the Job Plan, which should be appended to, and submitted with the business case.

	Before	After
Average number of PAs	39	57
On-call frequency (1 in)		

Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**
Tim Houghton	**41**	**41**	**12**	**12**
Imran Ahmad	**41**	**41**	**12**	**12**
Locum	**41**	**41**	**12**	**12**
Anwar Memon	**41**	**41**	**4**	**0**
New Consultant 1	**41**	**41**	**0**	**11**
New Consultant 2	**41**	**41**	**0**	**11**

12.2 Advisory Committee Review:

The Consultant Job Planning Advisory Committee must review all proposed job plans for new consultant posts, as well as any job plans for existing consultants where the proposed new post would have an impact on current working practices. The date that the job plans were approved by the Committee and any comments which were made must be provided below.

Date of Approval	
Comments by the Committee	

13. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the business case; the extent to which each support the proposal, and where appropriate, ownership for the delivery of the benefits identified above. Where external stakeholder support is vital to the success of the business case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment.

Examples of stakeholders include Lead Clinicians, support services (e.g. Systems & Network Services, Capital Planning re: accommodation), commissioners (e.g. Vale of York CCG, Scarborough CCG), patients & public, etc. ***Please bear in mind that most business cases do have an impact on Facilities & Estates services.***

Stakeholder	Details of consultation, support, etc.
Mandatory Consultation	
Business Intelligence Unit	
Corporate Improvement Team	
Workforce Team	
Other Consultation	
Director of Operations	Approval to proceed
Deputy Medical Director	Approval to proceed
CCG's	Discussed with approval to proceed
Integrated Cardiology Team	Approval to proceed

14. Sustainability

The Trust is committed to development of sustainable solutions in the delivery of its services, including minimising its carbon footprint. The following questions should be answered in the context of the impact of this business case has on the areas listed.

If assistance is required in assessing the sustainability impact of this business case, help is available from Brian Golding, Trust Energy Manager on (72)6498.

Will this Business Case:	Yes/No	If Yes, Explain How
Reduce or minimise the use of energy, especially from fossil fuels?	YES	Reduced transfer of patients to other healthcare providers to meet waiting time demands
Reduce or minimise Carbon Dioxide equivalent emissions from NHS activity?	NO	
Reduce business miles?	NO	
Reduce or minimise the production of waste, and/or increase the re-use and recycling of materials?	NO	
Encourage the careful use of natural resources, such as water?	NO	

15. Alliance Working

How does this business case support the Trust's stated objective of developing and enhancing the clinical alliance arrangements with Harrogate & District NHS Foundation Trust, and Hull and East Yorkshire Trust?

N/A

16. Integration

Integration of clinical and non-clinical services following the acquisition of the Scarborough & North East Yorkshire NHS Trust is a key priority for the Trust. How does this business case link into the Directorate's Integration plan? Have current non-integrated services discussed new appointments?

This business case links in with the integrated Directorate plans to repatriate work from Leeds and Hull with Scarborough Hospital leading on diagnostics and York becoming an interventional centre.

17. Impact on Community Services

Will this business case have an impact on Community Services and/or provide an opportunity to better integrate Acute and Community Services? How will this impact?

N/A

18. Impact on the Ambulance Service:

	Yes	No
Are there any implications for the ambulance service in terms of changes to patient flow?	Y	

If yes, please provide details including Ambulance Service feedback on the proposed changes:

Reduced number of patients travelling to Leeds and Hull for their diagnostic procedures.

19. Market Analysis:

Where the business case is predicated on securing new and/or increased business (and income), detail the evidence supporting the income projections.

20. Estimated Full Year Impact on Income & Expenditure:

Summarise the full year impact on income & expenditure for the specialty as a result of this business case. The figures should cross reference to the more detailed analysis on the accompanying 'Financial Pro Forma'.

	Baseline	Revised	Change
	£000	£000	£000
Capital Expenditure			0
Income	5,701	5,992	291
Direct Operational Expenditure	3,795	4,268	473
EBITDA	1,906	1,724	-182
Other Expenditure			0
I&E Surplus/ (Deficit)	1,906	1,724	-182
Existing Provisions	n/a		0
Net I&E Surplus/ (Deficit)	1,906	1,724	-182
Contribution (%)	33.4%	28.8%	-62.5%
Non-recurring Expenditure	n/a		0

Supporting financial commentary:

Funding source: Increase in Elective Repatriation of TOE & Growth in Elective and Non-Elective Pacemakers. Assumed Non-Elective Threshold applies. Additional Outpatient First and Follow Up Clinics. Income stream for New Outpatient activity requiring Echocardiograms or Stress Tests has been recorded in Business Case 2013-14/149: Cardio Respiratory Unit review. This Business Case also reflects 626 existing New OP attendances which should be recorded as OP Procedures. This change has been noted in the notification of Coding and Counting changes to CCG paper.

21. Recommendation for Post Implementation Review

	Yes	No
Is this business case being recommended for post implementation review?	Y	

Reason(s) for the decision:

To review the impact on waiting times and length of stay and to measure growth in income.

22. Date:

13 August 2014

GAL/22August2013

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	2013-14/157
TITLE:	Cardiology Medical Staffing Review
OWNER:	David Humphriss
AUTHOR:	Joanne Southwell

Capital

	Total	Planned Profile of Change			
		2014/15	2015/16	2016/17	Later Years
	£'000	£'000	£'000	£'000	£'000
Expenditure	0		0	0	0

Capital Notes *(including reference to the funding source)*:

Revenue

	Total Change				Planned Profile of Change			
	Current	Revised	Change		2014/15	2015/16	2016/17	Later Years
	£'000	£'000	£'000	WTE	£'000	£'000	£'000	£'000
(a) Non-recurring								
(b) Recurring								
Income								
NHS Clinical Income	5,664	5,955	291		72	276	285	291
Non-NHS Clinical Income	0	0	0		0	0	0	0
Other Income	37	37	0		0	0	0	0
Total Income	**5,701**	**5,992**	**291**		**72**	**276**	**285**	**291**
Expenditure								
Pay								
Medical	1,128	1,384	256		20	207	256	256
Nursing	1,238	1,275	37	1.32	5	32	37	37
Other (please list):								
Radiology		53	53		3	30	53	53
Admin	35	94	59		3	29	59	59
Prof & Tech CRU	398	398	0					
Other Staff		10	10		1	6	10	10
Pharmacy			0					
Pathology		13	13		1	7	13	13
	2,799	**3,227**	**428**	**1.32**	**32**	**311**	**428**	**428**
Non-Pay								
Drugs	101	101	0					
Clinical Supplies & Services	847	892	45		2	25	45	45
General Supplies & Services	10	10	0					
Other (please list):								
Establishment Costs	38	38	0					
Recovery Area			0					
			0					
	996	**1,041**	**45**		**2**	**25**	**45**	**45**
Total Operational Expenditure	**3,795**	**4,268**	**473**		**34**	**336**	**473**	**473**
Impact on EBITDA	**1,906**	**1,724**	**-182**	**1.32**	**38**	**-60**	**-188**	**-182**
Depreciation			0					
Rate of Return			0					
			0					
Overall impact on I&E	**1,906**	**1,724**	**-182**	**1.32**	**38**	**-60**	**-188**	**-182**
								+ favourable (-) adverse
Less: Existing Provisions	**n/a**		**0**					
Net impact on I&E	**1,906**	**1,724**	**-182**		**38**	**-60**	**-188**	**-182**

Revenue Notes *(including reference to the funding source)*:

Funding source:Increase in Elective Repatriation of TOE & Growth in Elective and Non-Elective Pacemakers. Assumed Non-Elective Threshold applies. Additional Outpatient First and Follow Up Clinics. Income stream for New Outpatient activity requiring Echocardiograms or Stress Tests has been recorded in Business Case 2013-14/149: Cardio Respiratory Unit review. This Business Case also reflects 626 existing New OP attendances which should be recorded as OP procedures. This change has been noted in the notification of Coding and Counting changes to CCG paper.

			Board of Directors Only
	Owner	Finance Manager	Director of Finance
Signed	Joanne Southwell	Lorraine Watson	
Dated	18/09/2014	18/09/2014	

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2014/15	2015/16	2016/17	Later Years
Elective (Spells)	688	796	108	43	98	103	108
Non-Elective (Spells)							
Long Stay	1,680	1,706	26	7	24	25	26
Short Stay			0				
Outpatient (Attendances)							
First Attendances	3,263	3,006	-257	92	-272	-264	-257
Follow-up Attendances	4,783	5,522	739	123	709	724	739
A&E (Attendances)			0				
Other (Please List):							
	3,647	3,647	0				
Outpatient Procedures		626	626		626	626	626

Income

	Total Change			Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000	Later Years £'000
NHS Clinical Income							
Elective income							
Tariff income	950	1,064	114	35	105	109	114
Non-Tariff income			0				
Non-Elective income							
Tariff income	3,235	3,351	116	31	107	112	116
Non Elective Threshold		-81	-81	-22	-75	-78	-81
Outpatient							
Tariff income	1,033	1,060	27	28	25	27	27
Non-Tariff income			0				
A&E							
Tariff income			0				
Non-Tariff income			0				
Other							
Tariff income	446	561	115		115	115	115
Non-Tariff income			0				
	5,664	**5,955**	**291**	**72**	**276**	**285**	**291**
Non NHS Clinical Income							
Private patient income			0				
Other non-protected clinical income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**
Other income							
Research and Development			0				
Education and Training			0				
Other income	37	37	0				
	37	**37**	**0**	**0**	**0**	**0**	**0**