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 30th April 2014**
in: **The Blue Conference Room, Scarborough Hospital**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Seminar Room Postgraduate Centre Scarborough Hospital	Non-executive Directors
9.15am – 11.55am	**Board of Directors meeting held in public**	**Blue Conference Room Scarborough Hospital**	**Board of Directors and observers**
12.10pm – 1.15pm	Board of Directors to consider confidential information held in private including lunch	Blue Conference Room Scarborough Hospital	Board of Directors
1.20pm - 1.55pm	Visit to Maternity Theatre		
2.00pm – 2.30pm	Research and Education	Blue Conference Room Scarborough Hospital	Board of Directors
2.35pm – 3.05pm	Governance Review	Blue Conference Room Scarborough Hospital	Board of Directors
3.15pm – 4.30pm	Remuneration Committee	Blue Conference Room Scarborough Hospital	Non-executive Directors

The values, drivers and motivations of the Trust are:

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

These will be reflected during all discussions in the meeting

York Teaching Hospital NHS
NHS Foundation Trust

Restricted – Management in confidence

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

On: **Wednesday 30th April 2014**

At: **9.15am – 11.55am**

In: **The Blue Conference Room, Scarborough Hospital**

A G E N D A					
No	**Item**	**Lead**	**Comment**	**Paper**	**Page**
Part One: General **9.15am – 9.45am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for Absence**	Chairman			
3.	**Declaration of Interests** To receive any changes to the register of directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chairman		A	7
4.	**Minutes of the Board of Directors meeting** To review and approve the minutes of the meeting held on 26th March 2014.	Chairman		B	11
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman			
5.1	14/053 Chief Executive Report To receive a presentation on the 'perfect week'.	Director of Operations (Scarborough)			
6.	**Patient Experience** Patient Survey results	Director of Nursing		Verbal	

No	Item	Lead	Comment	Paper	Page
Part Two: Quality and Safety 9.45am – 10.30am					
7.	**Quality and Safety Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Patient Safety Dashboard • Medical Director Report • Chief Nurse Report to include Safer Staffing Project • Annual report of the Quality and Safety Committee	Chairman of the Committee		C C1 C2 C3 C4	27 35 55 61 77
8.	**Annual Patient Experience – Complaints, concerns and compliments** To receive and approve the report.	Director of Nursing		D	87
9.	**Safeguarding Adults Annual Report** To receive the annual report.	Director of Nursing	Mike Sweet	E	95
10.	**Director of Infection prevention control quarter 4 report** To receive and approve the report.	Director of Infection Prevention Control		F	145
11.	**Presentation on the End of Life Care pathway** To receive a short presentation from the Palliative Care Team on the system that has replaced the Liverpool Care Pathway at the Trust.	Medical Director and Palliative Care Consultant – Ms Carina Saxby			
Part Three: Finance and Performance 10.30am – 10.55am					
12.	**Finance and Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed.	Chairman of the Committee		G	153

No	Item	Lead	Comment	Paper	Page
12. Cont	• Operational Performance Report • Finance Report • Trust Efficiency Report			G1 G2 G3	163 177 189
Part Four: Workforce **10.55am – 11.10am**					
13.	**Staff survey results** To receive a summary of the staff survey.	Interim Director of HR	Mike Keaney	H	199
Part Five: Strategy Work **11.10am – 11.25am**					
14.	**Patient Safety Strategy** To receive for debate and approval.	Medical Director	Jennie Adams	I	205
Part Six: Governance **11.25am – 11.45pm**					
15.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		J	235
16.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		K	239
17.	**Submission to Monitor** Quarter 4 submission to Monitor.	Director of Finance		L	245
Part Seven: Business Cases **11.45am-11.55am**					
18.	**Business Case 2013/14 – 148 Elderly Directorate Consultant Investment** To receive for approval the above business case.	Director of Finance	Diane Willcocks	M	255
Any other business					
19.	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 28th May 2014 in the Boardroom, York Hospital.				

20.	**<u>Any other business</u>** To consider any other matters of business.

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

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

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

External Audit
Terms of Reference for the Corporate Risk Committee

Register of directors' interests
April 2014

York Teaching Hospital NHS
NHS Foundation Trust

Additions: No additions

A

Changes: Mrs J Adams Spouse is no longer a Clinical Director for Anaesthetics, Theatres, Critical Care,

Deletions: Ms P Hayward resigned from being a Director of the Trust

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

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

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

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Boardroom, The York Hospital, on 26 March 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
Ms P Hayward	Executive Director of Human Resources
Mr M Proctor	Deputy Chief Executive/Chief Operating Officer/ Chief Nurse
Mrs S Holden	Executive Director of Corporate Development & Research
Dr A Turnbull	Medical Director

Attendance:

Dr D Beverley	RO officer for item 14/044
Mrs S Rushbrook	Director of Systems and Networks
Mr B Golding	Director of Estates and Facilities
Mrs B Geary	Director of Nursing
Mrs A Pridmore	Foundation Trust Secretary

Observers: 7 Governors, 1 person from Healthwatch York and 6 students and lecturer from the York St John University.

14/037 Apologies for absence

There were no apologies for absence received by the Board.

14/038 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.

14/039 Minutes of the meeting held on the 26 February 2014

Ms Hayward asked for an amendment to be made to minute 14/026 around the vacancy factor discussion. Ms Hayward explained that she was referring to the meeting of the

vacancy panel in her discussion and that the vacancy panel on considering the vacant roles approve over 90%.

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

14/040 Matters arising from the minutes

14/014 Francis Report – "Open and Honest Care"

Mr Proctor referred to the paper included in the pack and asked the Board to consider the proposal that had been put forward. Mr Proctor explained the "open and honest care" programme and what developments had been made in the programme to date. He outlined the data that would be published as part of the programme and what the processes were. Mr Proctor advised that a pilot of the process has been offered to the Trust, and in order for the Trust to take advantage of this pilot a number internal processes need to be modified. The Trust has therefore developed a 'task and finish' group to complete this work.

Mr Proctor proposed that the Trust should take advantage of the pilot offer, once this internal work has been completed, and bring that report back to the Board of Directors for review and for final approval to become part of the programme.

A number of the Board members echoed their support for the Trust's involvement in the programme and the approach being taken. Ms Raper did raise a concern that the data should be consistent with all other data considered by the Trust. Mr Proctor confirmed that would be the case.

The Board **agreed** with the proposal and requested the pilot document be presented to the April or May Board, dependent on when it was available, so a final decision could be made.

Action: Mr Proctor to present the pilot document to the April or May Board for review and a final decision about the Trust's involvement in the programme would be made at that stage.

14/025 Finance and Performance – Challenges to Scarborough Emergency Department

Mr Proctor advised that the challenges that had been seen in Scarborough were as a result of the effect of an outbreak of Norovirus. He advised that once the outbreak had disappeared the performance improved. Mr Proctor reminded the Board that, as a small hospital site, Scarborough can be significantly affected by such an event. Mr Proctor confirmed that the Emergency Department were now meeting the targets.

The Board discussed the shortage of beds that Scarborough Hospital has and the beneficial effect there will be to the patients and the hospital from moving the elective patients to Bridlington. The Board noted that the feedback from patients had been very positive.

The Board thanked Mr Proctor for his comments and were **assured** by the information received.

14/041 Patient Experience – Matron Refresh

Mr Proctor reminded the Board of the background to the Review that had recently been undertaken around the role of the matron in the organisation. He referenced the work back to the findings of the Francis Report and the introduction of the Nursing and Midwifery Strategy.

Mr Proctor summarised the Matrons' role and the changes that have been made. He highlighted that the role is about quality and safety, patient environment and understanding how the patients feel they have been cared for. Following the completion of the appointment process, the Matrons make up a smaller group of nurse leaders. The Matrons will work closely with the Corporate Nursing Team to provide consistent and appropriate nursing leadership across the whole organisation.

Mr Proctor advised that the new structure is not completely appointed to; there are 7 posts that are currently still unfilled. Mr Proctor explained that some of those posts are currently undertaken by secondee personnel and the posts need to be appointed to substantively. There are however a small number that the Trust will need to advertise, as they require very specialist training and qualifications which currently are not within the Trust.

In terms of the Patient Experience Team, Mr Proctor explained that the intention is to broaden its role, so it they can provide appropriate support to the new Matron Team.

Mr Proctor also reported that Mrs Holden had been supporting the development with the introduction of a bespoke development programme to bring the Matron Team together.

Mr Rose enquired how the changes were being communicated. Mr Proctor explained that the changes were embedded into the Nursing and Midwifery Strategy which had been widely circulated, but information was also being included in Team Brief and the Executive Board had discussed the change in detail and was very supportive.

Mr Proctor confirmed that at present there is no matron structure in the community hospitals. The current community structure was introduced just over a year ago and has 5 locality managers in post – who in effect combine an operational management role with a matron-like role; this structure needs to stay in place so that the full benefits can been obtained. He did add, however, that work was underway to look at an Assistant Director of Community. This person would provide professional oversight, leadership and accountability.

Mr Ashton asked if Mr Proctor could summarise what had been taken <u>out</u> of the matrons' role. Mr Proctor advised that the job description had been defined differently so that there was more focus on patient experience. He added that the previous role had been developed in a variety of ways by the matron in post and the directorate, dependent on what their needs were. This had resulted, in effect, in 20 different job descriptions. Discussions are being held with the directorate managers to understand what gaps they see have developed following the change. Mrs Adams asked if the introduction of the new structure would result in increased costs. Mr Proctor confirmed that would not be the case. The directorate managers had been advised that there would not be any extra

resources to address any gaps; any gaps would need to be addressed within existing resources.

Mr Rose asked Mrs Geary to comment on how she felt about the new structure. Mrs Geary confirmed that it was a very exciting time for nursing in the Trust, but also quite difficult for some people. She added that she is looking forward to working with the team and building cohesive and high quality leadership across the organisation. Mrs Geary added that the matrons will take up their new roles from 30 March 2014. She added that a further benefit of the restructure has been that the directorates have had the opportunity to look at senior roles within nursing and as a result of changing some roles are able to consider introducing some new services.

Professor Willcocks asked if the Nursing Board had met and what role it would play. Mrs Geary advised that it had met and were currently in the process of finalising its terms of reference. She added that a key part of the work of the group is to gain assurance about nursing in the organisation. She added that Mr Crowley would be chairing the meeting.

Mr Crowley added that the Board should not underestimate the difficulties that both Mr Proctor and Mrs Geary have had during the process, but the results are excellent. The Trust has a validated team of matrons that are all geared up to deliver a key aspect of the care the Trust provides. Mr Crowley added that he had experience of a number of restructures and the development of a programme of long term gains. In his experience the Trust has not always followed through on the aims and objectives of the restructure so it has not worked. The Board must remember that the introduction of the new structure is not the end of the process, but the start and that this is an investment in the long- term future of the Trust, so that qualitative benefits can be delivered over the coming years.

The Board **noted** the points and the assurance given by the Executive Directors. Mr Rose proposed and it was **approved** that a further presentation would be made at the end of calendar year.

Action: Mr Proctor and Mrs Geary to update the Board on the progress of the introduction of the new nursing structure

14/042 Quality and Safety Committee

Ms Raper reminded the members of the Board that there was an open invitation to attend the Quality and Safety Committee.

Ms Raper went on to highlight the following items from the Quality and Safety Committee:

CNST review – She commented that the Committee had discussed the review, but she noted that Mr Crowley had referred to the review in his Chief Executive Report too.

Serious Incidents (SI) – Ms Raper confirmed that this is an ongoing priority for the Committee and the Committee continue to keep a close eye on the development of systems. Dr Turnbull added that he level of reporting has now improved and there is a culture change occurring at Scarborough Hospital. There is better dissemination of reporting and that it is occurring at an earlier stage too. Work is also underway to bring the complaints and the SI process together.

C-Diff – Dr Turnbull advised that the year-end position was 65 cases, which is significantly above the trajectory. At the time of the Board meeting, York had been 21 days since the last reported case, Scarborough had been 24 days and the community hospitals had been 34 days.

During the year the Trust had developed in the management of side rooms, cohorting of patients and ensuring the clinical environment was cleaned to the high standards. Dr Turnbull added that he and Dr Todd had been able to secure approval for the use of co prescribing VSL3 a probiotic with antibiotics. This should be introduced over the next few weeks, initially in York and then in Scarborough and the community.

Family and Friends – Mrs Geary confirmed that at present there were differences between the two emergency departments. She explained that there is an organisational steering group which is overseeing information. Mrs Geary added that Ward 37 has a champion who supports the process on each shift and this is being reviewed for the whole organisation. She added that patient experience will be looking at this in more detail.

Mrs Geary advised that the system does not use real time data and feedback from patients is used by staff. In terms of the development, it is planned that a further pilot will be started in October 2014 in outpatients in advance of the live date. Mrs Adams asked how the issues in the emergency department could be teased out. Mrs Geary explained that it was a shot in time in the department and that with the new matrons in place there would be helping to increase the response rate.

Mr Proctor added that there is an inconsistency in the system as the National Patient Survey has always provided evidence of good practice and has been well responded to, so the response rate of Family and Friends seems to be a little at odds, but there are some simple changes that could be made to improve responses.

Pressure Ulcer Reduction Plan (PURP) - Ms Raper commented that the report included in the board pack does show that performance has not improved as yet for acute and community. Mr Proctor commented that improvements had been made and there had been some reduction. Mr Proctor added that the acute target would be achieved.

Post meeting note – Mr Proctor reviewed the information after the Board meeting and wrote to the Chairman and Non-executive Director who had raised the issue and the Chief Executive to confirm that his information had been incorrect. He corrected his statement and advised that the acute target would not be achieved. Mr Proctor confirmed in the email exchange that he would bring a further paper to the next Board meeting that would provide some clarity about the position.

Action: Mr Proctor to bring a further paper to the April Board.

Foetal remains – Dr Turnbull advised that this refers to remains that are before 23 week gestation. He advised, following a national FOI request the BBC had published, the way foetal remains had been disposed of at this Trust. The approach taken at some other Trusts had led to members of the public being upset. The Medical Director of NHS England Professor Sir Bruce Keogh has now written to all Medical Directors asking for Trusts to offer disposal of such remains by burial or cremation. Dr Turnbull assured the

Board that the Trust already adopted that policy and all parents of such remains were offered the opportunity of a burial or cremation.

The Board **noted** the comments and assurance.

14/043 End of Life Care Pathway

Dr Turnbull advised that there were three components to this topic:

a) An organisation called the Leadership Alliance has developed some guidance following the withdrawal of the Liverpool Care Pathway. The Trust withdrew usage of the pathway some 12 months ago and has replaced it with clinical guidance. There is currently no national tool and care for patients at the end of their life is individualised.
b) The Leadership Alliance also identified that patients must be managed in a sensitive and appropriate manner towards the last days of their life.
c) The Trust must take the wishes of the patient and the family into account when helping them to plan the pathway.

Dr Turnbull added that the Board needs to receive assurance on compliance and that appropriate approaches are being adopted. Dr Turnbull advised that the palliative care consultant would be able to attend the Board in April to give a more detailed presentation to the Board on the system adopted. He added that this would be a slightly updated presentation from the one given to the Governors a few months ago.

The Board **confirmed** that they would appreciate receiving that presentation.

Action: Palliative care consultant to attend the April Board to give a presentation on the end of life care.

DNACPR –Dr Turnbull advised that the new version of the form would be available in the next month. And updated video was also being produced which will support people learning how to complete.

Professor Willcocks added that this information was timely, as York holds a week event in May called “a good death”. She encouraged the Trust to get involved and join the debates that are held around this topic during the week. Dr Turnbull confirmed he would ensure the Trust was involved.

14/044 GMC Revalidation Annual Report

Mr Rose welcomed Dr Beverley to the meeting and asked Dr Turnbull to introduce the item. Dr Turnbull explained that this was an additional item for the Board to consider and Dr Beverley had a paper to table. Dr Turnbull outlined the importance of the role the Revalidation Officer plays in the Trust and asked Dr Beverley to present his paper.

Dr Beverley described the work that he had been undertaking this year and highlighted the achievements. He advised that at October 2013 the Trust had recorded a 99.56% completion rate of annual appraisals, which was above the 95% threshold required by NHS England. Dr Beverley also advised that the Trust now had 80 consultants trained to

undertake enhanced appraisals, which means that there are now sufficient appraisers to mean each one only needs to appraise 5 clinicians each year.

The Trust, as at 31 December 2013, has completed 430 appraisals. In August 2013 the Trust rolled-out a staggered approach to appraisals so that not all doctors are appraised at the same time. Of the outstanding appraisals, 16 have taken place and require final sign-off, 4 have requested appraisal deferment and for the final 20 the Professional Standards team is in active discussion with the clinicians to ensure that appraisals are completed as quickly as possible.

Dr Beverley referred to the quality of appraisals and advised that this was now a requirement along with the requirement that patient feedback was part of the appraisal process. Dr Beverley also advised that the Trust now requires a reference from a Responsible Officer for all new doctors being employed by the Trust.
Dr Beverley asked the Board to note the progress and the action plan included in the paper.

Mr Rose asked Dr Beverley if he felt the system was tough enough. Dr Beverley felt it was, as everyone is required to be validated.

Dr Turnbull added that there is a national debate at the moment and it depends on what validation is for as to the view of the toughness of the system. If the validation is designed to prevent a Shipman case occurring again, then it is not tough enough; if, on the other hand, it is designed to provide assurance, then it is well-designed. Dr Turnbull did add, and Dr Beverley agreed, that it also depends on the quality of the appraisal.

Dr Turnbull also asked the Board to formally recognise the contribution of Dr Beverley as the Responsible Officer and for his clinical work as a highly experienced consultant with many years experience.

The Board thanked Dr Beverley for all his work and contribution to the Trust.

Mr Rose asked what the process was for the appointment of a further RO, following the retirement of Dr Beverley. Mr Crowley advised that following the resignation of Mr Mainprize, Dr Turnbull with Mr Crowley were reviewing the support to the Medical Director, before deciding on how to recruit to the role. In the meantime Dr Turnbull will be the RO.

14/045 Finance and Performance Committee

Mr Sweet highlighted the following points from the discussions at the Finance and Performance Committee:

Operational Report

Short-term Acute Strategy – In relation to the 4 hour ED challenge, the Trust is now achieving the target in both York and Scarborough.

The Trust is considering formulating a stretch target in which the 95% target will refer to only type 1 ED cases (excludes Minor Injury Units).

In terms of ambulance handover, January and February saw an improvement in the handover times. This year the fines have been able to be re-invested into the development of systems; for 2014/15 the Trust is expecting any fines incurred to the levied by the CCG.

Efficiency – Mr Sweet reported the excellent progress that had been made in the month to secure overall delivery of the CIP for the 2013/14 financial year. He asked the Board to join him in congratulating the team for their work and everyone else for ensuring the delivery occurred. The Board congratulated everyone involved.

Mr Sweet did add that there was still a concern on the level of non-recurrent savings. Mr Bertram had reported to the Committee that for next year the worst case would be a cost improvement programme of £29m, but it could be as low as £24m. This is the 5th year of minimum 4% savings. For 2014/15 there are a number of significantly large schemes that are expected to be delivered. There are also a small number of directorates that have not achieved their targets during the year; those directorates will be looked at in some detail over the next 12 months. Mr Sweet also added that work is underway to provide specific assurance in relation to the management of vacancies and delivery of the vacancy factor. The team will develop a set of principles with Directorates that are to be considered when a temporary vacancy is taken as part of delivery of any vacancy factor. The point of this work is to provide assurance that safety is not being compromised. Mr Sweet advised that the final piece of work that will be completed over the next few weeks relates to the understanding the Committee has asked for on the impact on CIPs if mandatory (higher) staffing levels are introduced.

18-weeks – Mr Sweet reminded the Board that the Trust currently have an issue in relation to patients waiting more than 36 weeks for treatment. Mr Proctor advised the improvements had been made and of the 180 patients there were at the start of the process there are now only 40 on the admitted pathway. He added that it is expected that the backlog will be cleared in the next month. Mr Sweet added as a way of assurance that while considerable attention is being given to 36 weeks, attention is also being given to those patients reaching 18 weeks, to ensure a further backlog does not occur.

Commissioning for Quality and Innovation (CQUIN) – Mr Sweet commented that the expectation is that most of the targets will be achieved. CQUIN is 2.5% of the Trust's income and amounts to approximately £9m for 2013/14. At present for 2014/15 the Committee has not seen the detail of programme as this has not yet been fully agreed with Commissioners.

Finance Report – Mr Sweet advised the Board that at month 11 there was a reported surplus of £1.4m, which was £1.1m behind the planned surplus level, but did demonstrate a marginal improvement from last month.

In relation to contract settlements, Mr Bertram advised that there has been considerable discussion and negotiation with Specialised Commissioners and he was confident that payments will ultimately be made in line with the reported financial position. Mr Bertram added that he was expecting changes to be in place next year and for NHS England to seek more quality, innovation, productivity and prevention (QIPP) schemes as at both a local and national level Specialised expenditure was unaffordable. . He added that the

position with Scarborough & Ryedale CCG has been agreed and is reflected in the Board papers. Discussions are still being held with Vale of York CCG to agree a settlement position for the end of the year and these were close to conclusion.

Mrs Adams asked if the Trust would be able to spend £6m capital in the final weeks of the financial year. Mr Bertram and Mr Golding confirmed that they expected sufficient schemes would come to fruition so as not to trip any of Monitor's query thresholds.

The Board **noted** the comments and assurance given by the Committee.

14/046 Senior Information Risk Officer's Report

Mr Bertram presented the annual report. He advised that his responsibility is shared with Dr Turnbull, who is the Caldicott Guardian, and support is provided by the Information Governance team. Mr Bertram advised that the "Caldicott 2" report had recently been released; the team were working though the implications.

Mr Bertram reflected on the number of freedom of information requests that are received by the Trust. He reported that there had been a marked increase in the last 12 months; with the Trust now receiving over 2 enquiries every office working day.

Mr Bertram added that the report explains that the Trust has appointed a chief clinical information officer, who has specific responsibilities for improving clinical data, including the writing and recording of clinical episodes.

Mr Bertram advised that the Board is asked to note the report.

Mr Sweet asked for some further assurance on the IG toolkit. He noted that the information security assurance had dipped. Mrs Rushbrook explained that the toolkit changes each year and the kit become more stringent each year. Mr Bertram added that it also reflects the introduction of Scarborough data into the report for the first time. Historically, Scarborough scored lower than York.

Mr Rose asked if the Audit Committee look at this work. Mr Ashton confirmed they do through the work of Internal Audit.

Mrs Holden added that the IG team where aware that during the next 12 months more work would be required to ensure the "protected characteristics" are identified in Trust information, as required by legislation.

Dr Turnbull added that this was a specific interest of his. There are key changes that are introduced as a result of Caldicott 2 around data-sharing.

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

14/047 Workforce Strategy Committee

Professor Willcocks commented on the draft notes included in the Board papers. She highlighted the nursing establishment work and review of other staffing models and

highlighted that the Committee is concerned about the implications and would be seeking some assurance.

Professor Willcocks also referred to the Family and Friends; the patient methodology would be applied to staff and noted that the Trust would be required to take into account any concerns raised by staff. This process has not started as yet, but it is expected that there will be a CQUIN target attached to it.

The Board **noted** the comments and draft notes from the meeting.

14/048 Independent assessment of educational quality

Mrs Holden presented her report and explained the report is produced as part of the function of the Yorkshire and Humber Health Education Board; they independently review quality data related to all educational provision within the Trust. The report outlines the assessment of the Trust in complying with quality standards of education provision outlined in the Learning and Development Agreement. Mrs Holden explained the complex nature of the benchmarking.

Mrs Holden advised that the Trust has performed well across a number of metrics and continues to demonstrate high quality educational experience and provision for staff across all grades and professions. She explained how the Deanery visits influence the scores and how there are occasions when unannounced visits may be undertaken. These are triggered when a concern is raised. This does include when a trainee who may have experienced difficulty in the organisation has used the process to highlight their problem.

Mr Rose noted that the report showed the Trust was performing well and was the 4th biggest Trust in the region against the elements of assessment and spend. Mrs Holden emphasised that we should be raising our expectations on this topic, commensurate with the size and influence our Trust now has and aspires to have.

The Board **noted** the detail in the report and the comments made by Mrs Holden.

14/049 Comprehensive Local Research Network (CLRN) research metrics

Mrs Holden presented her report and explained the data is produced by the Comprehensive Local Research Network and outlines activity within York Hospital in relation to recruitment of patients into portfolio adopted research trials across the whole organisation.

Mrs Holden reminded the Board that historically the Trust had hosted the CLRN, but following national changes and the decision by the Trust not to tender for continuing to host the network. The hosting of the network is being taken on by Sheffield Teaching Hospital NHS Foundation Trust.

Mrs Holden explained that these were the last set of metrics for the local research network. She explained that the information shows that there has been proactive increase locally in studies including patients. Mrs Holden highlighted that the NEYNL MO was showing at amber. The reason for this related to two studies where there were

governance issues that could not be resolved to ensure the studies were signed within the 30 day allowance.

Mr Rose enquired how Harrogate had recruited such a significant number of patients to studies. Mrs Holden explained that it related to online recruitment for an online dermatology study.

The Board discussed the funding and noted that there was a difference between portfolio studies, non-portfolio studies and research portfolio studies.

Dr Turnbull added that research activity presented at national conferences is not part of the research that generates income for the Trust, but it does relate to the clinical excellence awards.
Mrs Adams asked if there was a conflict of interest for Sheffield taking on the hosting, because of being an academic health centre. Mrs Holden confirmed that she was aware of the conflict and would be keeping it under review.

The Board **noted** the report.

14/050 Acute Strategy update

Mr Crowley updated the Board on the progress against the strategy. He referred to the Bridlington development and improvement in patient flow. He advised that the change demonstrated a commitment to Bridlington, the east coast and improving the services available for patients serviced by that area. The work will improve capacity on both sites for elective and non-elective patients.

The developments in York in ED related to the introduction of ambulatory care and an ambulance receiving area. He added that there is work also being undertaken to merge the Short Stay Ward and Acute Medical Unit into one area. Capital changes are needed to create a further high dependency capacity. This is being looked at by an appropriate group of staff.

In terms of workforce, a draft rota for acute physicians is currently being consulted on and work is being undertaken around job planning to the Trust is able to deliver 7 day a week, 24 hours a day working. Mr Crowley added that this working is likely to result in some level of investment. At present one of the consultants, Mr N Durham, is leading the consultation work with the medical staff and he has received a very positive response.

The elderly service developments are still being progressed and a further time-out has been arranged.

Mrs Adams asked where the improvements in the acute strategy relate to Scarborough Hospital. Mr Proctor explained that the principles are the same in Scarborough, although the implementation will be slightly different. Some of the work around the development of the “acute village” is being brought forward and at present the Trust is at the design stage of the patient flow. The GP out of hours and minor injuries tender is slightly complicating the model.

The Board **noted** the report.

14/051 Community Hub update

Mr Proctor updated the Board on the developments. He advised that the Trust would be leading the development of two hubs. The first is being agreed with Scarborough and Ryedale CCG and would be based at Malton Hospital. The second is being commissioned by Vale of York CCG and will be based at Selby Hospital. Mr Proctor outlined the different approaches the two CCGs have to the development of the hubs. The hub based at Malton is beginning to see all the parties coming together and begin to design what might be included. For the Selby hub, the CCG has asked the Trust to develop and submit a business case; their requirement is that for every £1 spent on the hub, services £3 should be removed from the acute services – an extremely challenging concept.

Mr Proctor advised that he would start to share some of the modelling around the Malton.

There are two main benefits, the first being the ratio of savings, but the Trust did note that the release of savings had to be sustainable and would need to see a tangible reduction in admissions. The second benefit would be the reduction of length of stay.

The Board **noted** the comments

14/052 Report of the Chairman

Mr Rose led on from the community hub discussion and asked if there are “gaps” between the various proposed pilot hubs where a proportion of the population would not be covered (i.e. would rely upon the existing Community Services supplied by the Trust). He also raised concern about the variations of measurement and review of the various models.

Mr Proctor reminded the Board that Priory Med have their own pilot, which the Trust will look at. The intention is that, in due course, there is one model generated that is used for all hubs, but at present there is a lot of aspects of caution and caveats.

Professor Willcocks asked about the timescales. Mr Proctor explained that it was difficult to say, as there are a lot of assumptions that might not come to fruition. He added that his expectation is that our hubs will be up and running by the beginning of Quarter 3 next year (1/10/14).

Mr Sweet asked if this development negates the requirement for the CCG to tender the Community Services contract. Mr Proctor confirmed he did not know the answer, but as the development is a medium- to long-term strategy he would expect 5 years to make it work.

Mr Rose also wished to raise his thanks to Ms Hayward as this is her last Board meeting. She will leave the Trust at the end of the week. Mr Rose thanked Ms Hayward for her hard work and diligence with respect to the HR Department and her role as an Executive Director.

Mr Crowley echoed the comments made by Mr Rose. He highlighted the achievements over the last 10 years, which had made significant difference to sickness, absence, recruitment and being announced as HR Director of the Year 2012. Mr Crowley wished her well.

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

14/053 Report of the Chief Executive

Mr Crowley presented his report and congratulated Occupational Health on their recent achievements; he again noted that the achievements were under the leadership of Ms Hayward.

Mr Crowley asked the Board to also note the achievements around the CNST assessment and again thank all those involved in the success.

Mr Crowley drew the Board's attention to the "perfect week" section in his report. He explained that this will take place during May.

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

14/054 Operational Plan 2014-16

Mrs Holden presented the report. She explained that the financial section of the report would be discussed in the private section of the Board meeting. Mrs Holden commented that the Governors had been involved in reviewing the plan and had commented that the report was clear to read. Mrs Holden explained how the plan had been developed to include the monitoring of progress against the Integrated Business Plan and cross - referencing the range of current strategy developments.

The document will be submitted to Monitor on 4th April.

The Board reviewed the document and **noted** the content. The Chairman and Chief Executive will sign off the document prior to submission.

14/055 Business Cases

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

14/055.1 2013 -14/127: Bridlington Orthopaedic Elective Surgery

Mr Keaney summarised the business case and supported approval of the case by the Board of Directors.

The Board discussed and supported the principle of the first phase of this case being a pilot to test the use of Bridlington as an elective surgery area. It was requested by the Board that a further report was presented towards the end of calendar year that summarises the evaluation of the pilot. The Board **agreed** that release of the requested capital for the new build theatre was conditional on a satisfactory evaluation.

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

14/055.2 2013-14/150: Replacement of a Surgical Ward (Haldane) on Scarborough site

Mr Sweet summarised the business case and supported approval of the case by the Board of Directors.

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

14/055.3 2013-14/84: Integrated Model for York, Scarborough and Harrogate in Clinical Neurophysiology

Mr Ashton summarised the business case and supported approval of the case by the Board of Directors.

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

14/056 Next meeting of the Board of Directors

The next meeting of the Board of Directors will be held in the Blue Room, Scarborough Hospital on 30th April 2014.

14/057 Any other business

There was no other business

Outstanding actions from previous minutes

Minute number and month	Action	Responsible office	Due date
13/134 Dementia Strategy	To include an update on the dementia strategy in his board report on a quarterly basis.	Dr Turnbull	February 2014
13/119 Scheme of Delegation (September)	To consider increasing the authority of the Capital Programme Committee to be undertake during the next stage review	Mr Bertram/ Mrs Pridmore	April 2014
13/120 Quarterly HR Report (September)	To circulate the annual report from the Workforce Strategy Committee	Ms Hayward	By December 2013

Action list from the minutes of the 26th February 2013

Minute number	Action	Responsible office	Due date
14/031 Chief Executive Report	Detail about the staff survey to be included in the March meeting.	Ms Hayward	March 14
14/040 Open and Honest programme	Mr Proctor to present the pilot document to the Board for review and a final decision about the Trust's involvement in the programme would be made at that stage.	Mr Proctor	April/May 14
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
14/043 End of Life Care	Palliative care consultant to attend the April Board to give a presentation on the end of life care.	Ms Carina Saxby/ Dr Turnbull	April 14
14/055.1 2013 - 14/127: Bridlington Orthopaedic Elective Surgery	Evaluation Report pending the release of further capital	Mr Bertram	November 14

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Quality & Safety Committee – 22 April 2014 Room 4 Post Graduate Centre, York Hospital

Attendance: Libby Raper, Jennie Adams, Philip Ashton, Mike Proctor, Beverley Geary, Diane Palmer, Anna Pridmore

Apologies: Alastair Turnbull

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last meeting notes 18th March 2014**		Accepted as a true record. It was noted that the agenda for the April meeting had the Corporate Risk Register and Assurance Framework items attached so ensuring the Committee remains aware of the specific risks being managed in the organisation. The Committee welcomed Mike Proctor to the meeting and Diane Palmer who was standing in for Alastair Turnbull.		
2	**Matters arising**		The Committee discussed two issues related to NICE guidance. The first one related to a document that AT had tabled at the last meeting that showed a number of items pending against NICE guidance. DP explained that on occasions clinicians may not be able to respond quickly about the Trust's level of compliance. Work is underway to chase them up for statements around compliance. The system does allow the Trust to explain if it is not compliant with the guidance.	The comments made by DP provided assurance to the Committee on the process for implementing NICE guidance	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
	Matters arising continued		The second issue related to Carbapenem resistant enterobacteriaceae (CRE). The Committee discussed the recent email exchange and agreed that AT should update the Board on the impact of CRE. The Committee went on to discuss the affect the estate has on the rate of infection and the other quality issues. The Committee concluded that there was a lot that could be considered by the Committee. It was suggested and agreed that Brian Golding should be asked to attend the Quality and Safety Committee twice a year. The Committee went on to discuss the capital programme and its relationship with quality and safety. The conclusion of the discussion was that an annual meeting with the Finance and Performance Committee should be held to discuss the annual programme.		AT to comment
3	**Integrated Dashboard**	AFW 1.1, 1.4, 1.9,1.10, 1.11, 1.13, 1.15 CRR 7,19,4,20, 44, 45	Never event – DP outlined the details of the never event and advised that the investigation had not been completed, but was well underway. She advised that it was a wrong site surgery never event. Serious incidents (SI) – DP explained that of the 13 SI declared across the Trust 6 related to patient falls. The Committee discussed the falls and understood that discussions were being held with the commissioners about falls and the work being undertaken to reduce the opportunity for falls to occur. The Committee noted that there were no SI reports	The comments on the integrated dashboard provided the Committee with assurance that progress was being made generally. The Committee noted the comments about falls and the discussion being held with the commissioners. The Committee were pleased to see that it was recognised that the Trust was being transparent.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			included in the papers. DP explained that this was because the Executive Board had not met to accept them; they would be included in next month's papers. The Committee noted that the community dashboards had not been fully updated and asked for them to be updated for the next meeting. It was confirmed that they would be. The Committee noted that the trajectory for C-Diff for the next financial year had increased to 59. The Committee also discussed the changes to the rules related to the reporting of C-Diff and understood that where a Root Cause Analysis attributes an incidence of C-Diff to the Trust, then the case would count against the Trust's trajectory. The Committee discussed the National Learning and Reporting System document included in the pack. It was noted that the report was not very current and DP explained how the system worked. She added that the system does not supply very up to date information. DP described the additional work that had been undertaken to validate some of the levels of harm that were being proposed through the DATIX system. She added the CQC would use this system as background information. The Committee discussed the latest mortality figures, but understood that they were embargoed until the day of the Board meeting. The Committee reviewed the safety thermometer information and noted that there was good	The Committee noted the increase in the trajectory and the change to the rules	AT to comment

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			benchmarking included in the report. The Committee discussed the percentage of harm graph and it was noted that the validation that was being put in place at ward level could take a little while to ensure it is working properly. DP added that having confidence in the DATIX system and working with the Matrons should ensure the system is robust. BG commented about the training that was being put in place for Matrons and advised that DP had attended the last session to provide some training around patient safety. The session was well received and effective. The Committee discussed the Family and Friends data and noted that the results were more encouraging. BG commented that there is an on-going challenge with the emergency department due to the type of patients in the area. They are patients that want to be treated and leave rather than spend time completing a form.	The Committee took assurance from the benchmarking data included in the report The Committee took assurance from the comments made about the training of the matrons.	
4	**Draft Quality Report priorities**		DP advised that the Quality Report will include a number of the priorities included in the patient safety strategy along with the CQUIN priorities around quality and safety. The draft report will be discussed with the Governors later in the week and the final report will be presented to the Quality and Safety Committee next month in advance of being presented to the Board for approval.		
5	**Medical Director supplementary report**		DP presented the report and commented on the sign up to safety campaign. DP explained that the campaign does include a number of existing		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			initiatives that are in place in the organisation. The Trust will sign up to the campaign. The Committee discussed the mortuary at Scarborough and understood that it had now become a body store rather than a mortuary. The difference between the two is a mortuary can conduct post mortems where as a body store is only a body store. The Committee reviewed the antibiotic audit and felt the results were disappointing. The Committee discussed the principles of healthy competition between clinicians and agreed it was successful. It was agreed that the audits should be included as part of the discussions during the patient safety walk rounds. DP will ensure they are included in the next set of walk rounds.	The Committee were assured by the planned inclusion of the audit in the patient safety walk rounds	
6	**Chief Nurse supplementary report**		BG presented the Chief Nurse Report. She referred to the senior nursing restructuring and advised that the final areas are being recruited to. An advert for a further matron at Scarborough has been published along with an advert for two secondment posts and the senior nurse for safeguarding and a lead nurse for the end of life care. The matrons are now in their new roles and are starting to demonstrate the drive they have to get on with the job. They are looking at the quality and safety aspects of the role and keen to engage with the directorate managers. Work is also underway to ensure the link between the directorate manager and the matron is strong.	The Committee was assured by the comments made and the progress of implementing the revised structure.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			BG referred to the safer staffing project and reminded the Committee that the Trust had received a letter from NHS England describing the expectations which include a Board report describing the staffing a capacity and capability following an establishment review, using evidence based tolls where possible. This should be presented every six months. Information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this will be displayed at ward level. A Board report containing details of planned and actual staffing on a shift by shit basis at ward level for the previous month. This report is to be published on the website. This will be received by the Board at the June meeting. The Committee discussed the shift patters and the establishment and understood that the establishment levels had been put in place. There is still work being undertaken to consider night shifts and long shifts and the impact escalation beds have on the establishment.	The Committee were assured by the development and noted the key information being required.	BG to comment
7	**Pressure Ulcer Reduction Plan**		MP presented the paper that outlined that there have been some data issues around the recording of the pressure ulcer CQUIN which has resulted in the Trust under reporting prevalence. This means that the Trust has not achieved the CQUIN for acute patients in full, but has achieved the CQUIN for community patients. The Trust has negotiated a part payment of the CQUIN as a result. The data quality issues have now been resolved.	The Committee were assured by the report and the comments made by MP.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
8	**Safeguarding Adults Annual Report**		BG presented the report and explained that it was an ever increasing agenda as described in the report. She commented that significant progress had been made by Nicola Cowley the lead nurse in developing the agenda and ensuring the Trust was compliant with all the requirements.	The Committee were assured by the detail included in the report and the comments given by BG	
9	**Draft Annual Report of the Quality and Safety Committee**		The Committee reviewed the draft annual report and agreed that it should be presented to the Board of Directors		To be included in the Board papers
10	**Any other business**		The Committee's attention was drawn to the performance report from Birmingham Children's Hospital. It was suggested that the reports should be reviewed to see the layout and the type of information included. BG mentioned that work was underway with the patient experience team to consider their structure. A listening exercise has been completed and the results are being considered with the development of recommendations and an action plan.		
11.	**Date and time of next meeting**		The next meeting will be held on 20 May2014 at 13.30 in Boardroom, York Hospital		

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York Teaching Hospital NHS
NHS Foundation Trust

Patient Safety and Quality Report

April 2014

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

Index

Executive summary

- There was one 'Never Event' identified in the Trust at Scarborough Hospital during March.

- Thirteen Serious Incidents (SIs) were declared across the Trust, of which six related to patient falls.

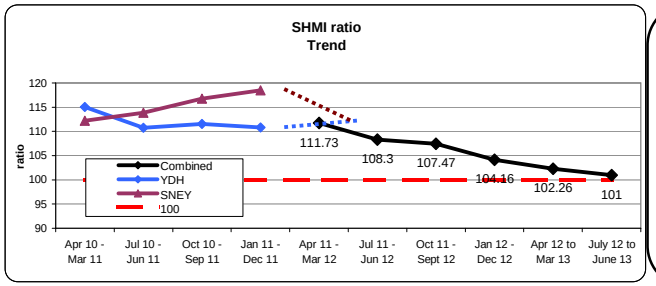
- Four cases of c. diff were identified in March.

- The updated summary Hospital level Mortality Indicator will be published by the Information Centre on the 30th April.

- Comparison of the trust Safety Thermometer data indicates reporting above the national average in all categories. A system to validate this prevalence data is being developed.

Patient Safety

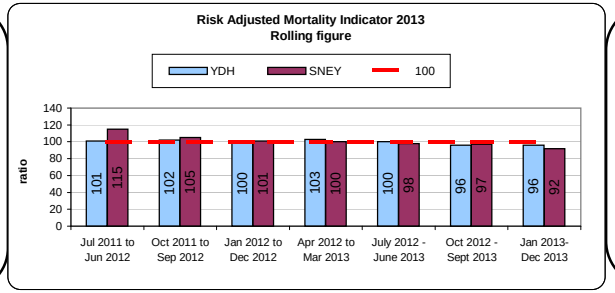
Mortality



The latest report SHMI for the period 2012-2013 indicates the Trust to be in the 'as expected'range. The SHMI is 101(100.7) and represents a continued reduction.

The next SHMI report is due on 30th April.

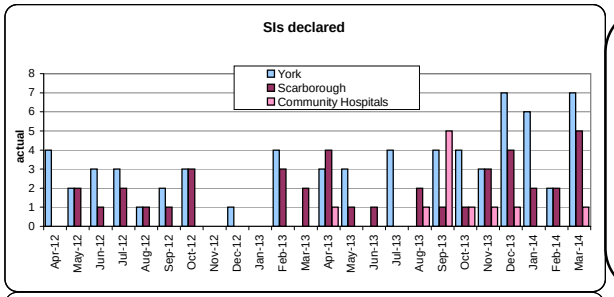
Data source: Information Centre



The Risk Adjusted Mortality Indicator (RAMI) for the reporting period January 2013- December 2013 has remained constant for York Hospital compared to the last reporting period. At Scarborough Hospital there has been a small reduction.

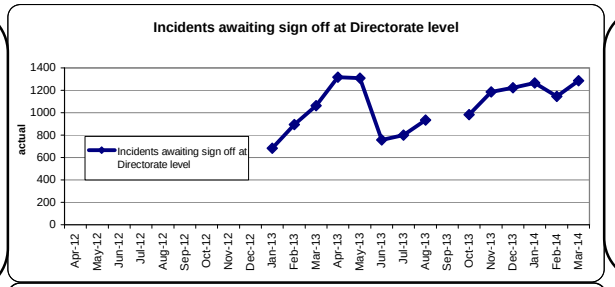
Data source: CHKS - does not include deaths up to 30 days from discharge.

Measures of Harm



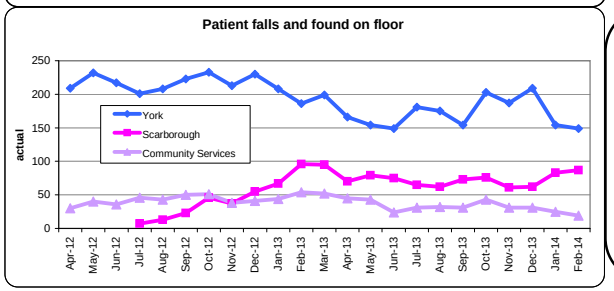
There were thirteen serious incidents (SIs) reported in March, seven from York Hospital, four falls and one category 4 pressure ulcer. Five from Scarborough Hospital, two falls, one system failure in maternity, one over-exposure to radiation and one wrong site (Never Event) surgery. There was one SI from the Community Hospitals due to a category 4 pressure ulcer.

Data Source: Datix



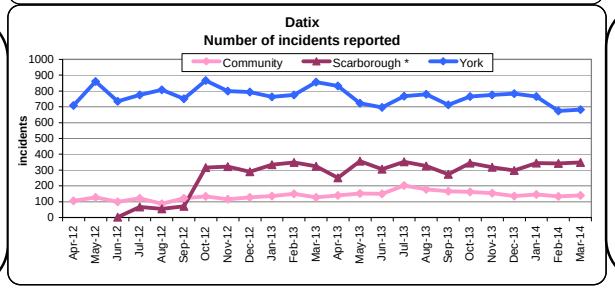
At the time of reporting there were 1286 incidents awaiting sign-off by the directorate managers.

Data Source: Datix



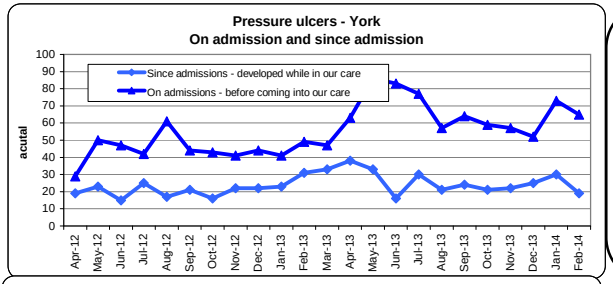
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. 149 patients fell and were found on the floor at the York site, 87 patients at Scarborough and 19 patients within the Community Hospitals in February. The March data is awaiting validation.

Data Source: Datix



The total number of incidents reported in the Trust during March was 1170. 682 incidents were reported on the York site, 349 on the Scarborough site and 139 at the Community Hospitals.

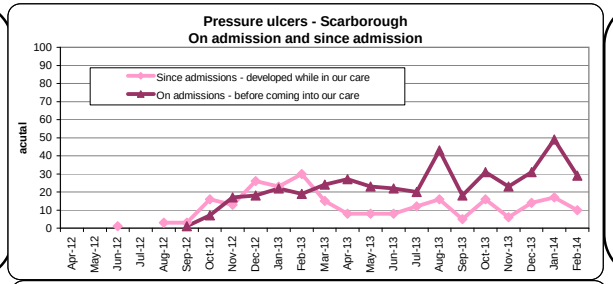
Data Source: Datix



During February a total of 19 pressure ulcers were reported to have developed on patients in York Hospital.

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

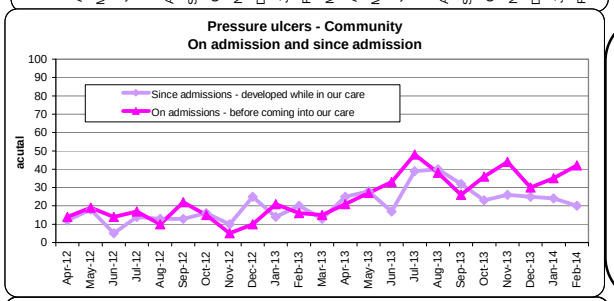
Data Source: Datix



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

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

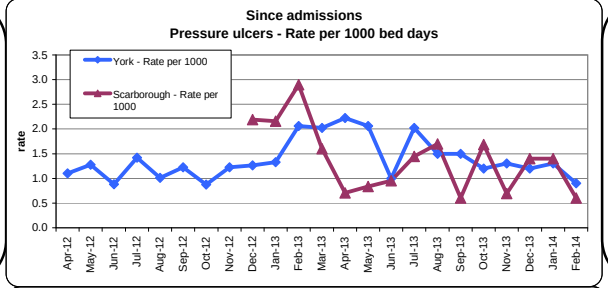
Data Source: Datix



During February a total of 20 pressure ulcers were reported to have developed on patients in our community hospitals or community care.

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

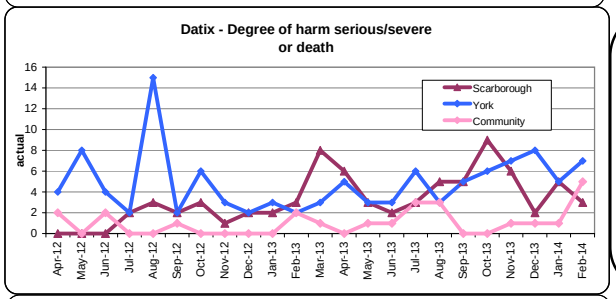
Data Source: Datix



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

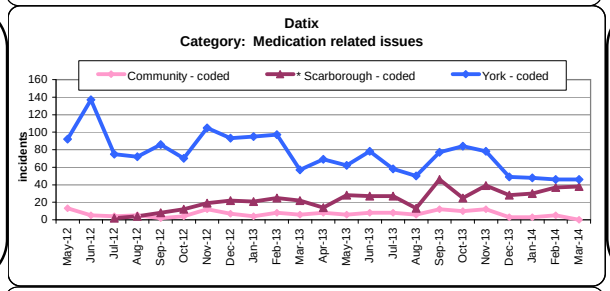
The rate of pressure ulcer development in Scarborough Hospital was 0.6/1000 bed days.

These figures should be considered as approximations as not all investigations have been completed.
Data Source: Datix

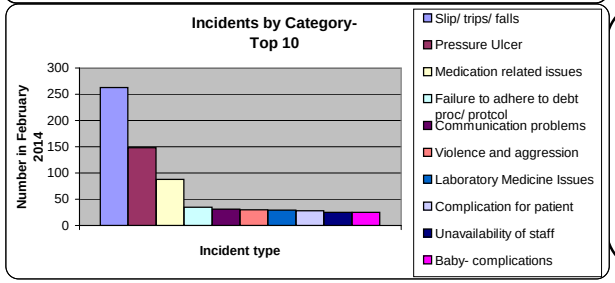


During February a total of 15 patient incidents were reported which resulted in serious or severe harm.

Data Source: Datix

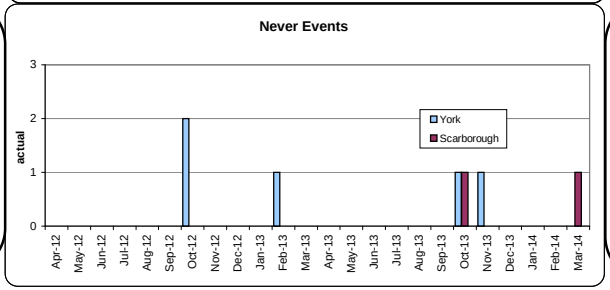


During March there was a total of 84 medication related incidents reported, although this figure may change following validation.



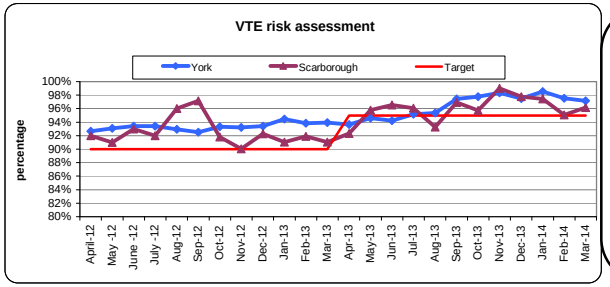
During February, 263 incidents were reported as a slip/ trip/ fall, 148 pressure ulcers and 88 medication related incidents.

Data Source: Datix



There was one Never Event declared at Scarborough in March relating to wrong surgery site.

Data Source: Datix



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

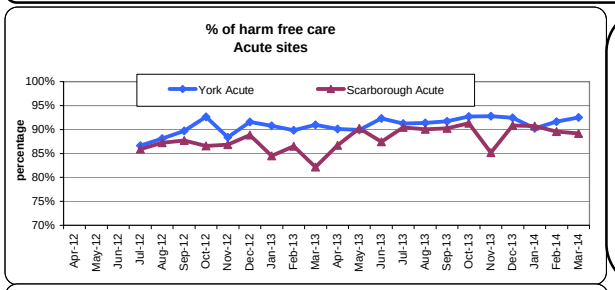
However we must ensure that this is completed for all patients and in a timely manner.

Data Source: Systems & Network Services

Safety Thermometer

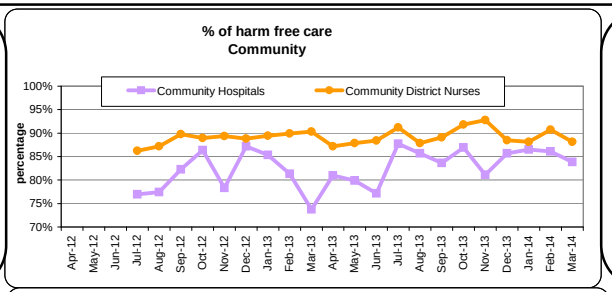
Safety Thermometer

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



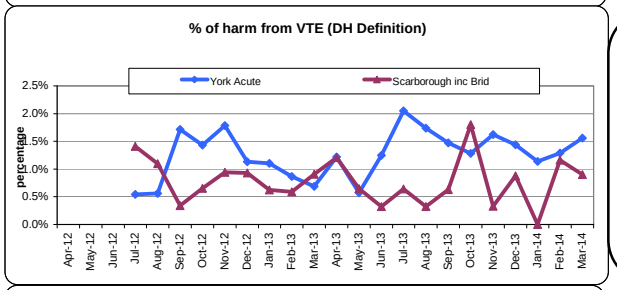
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In March 92.53% of patients at York and 89.19% at Scarborough were audited as care 'free from harm' on the acute hospital sites.

Data source: Safety Thermometer



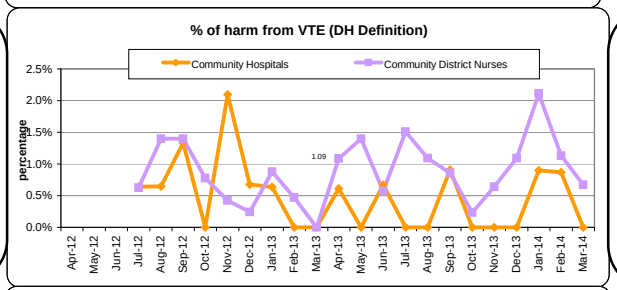
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In March 83.81% of patients in our community hospitals and 88.17% of patients in our care in the community received care 'free from harm'.

Data source: Safety Thermometer



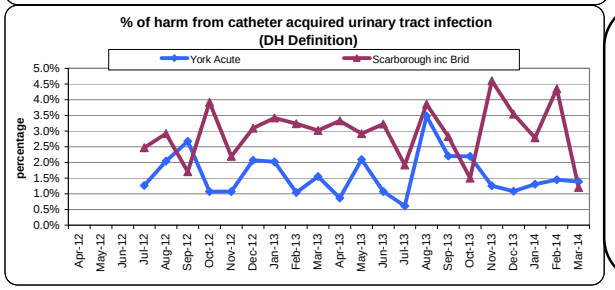
The percentage of patients affected by VTE as measured by the Department of Health (DH) definition, monthly measurement of prevalence, was 1.56% in York and 0.90% in Scarborough acute hospitals in March.

Data source: Safety Thermometer



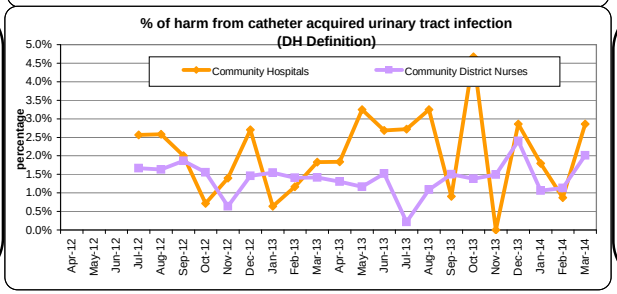
The percentage of patients affected by VTE as measured by the DH definition, monthly measurement of prevalence was 0.00% in community hospitals and 0.67% in community care in March.

Data source: Safety Thermometer



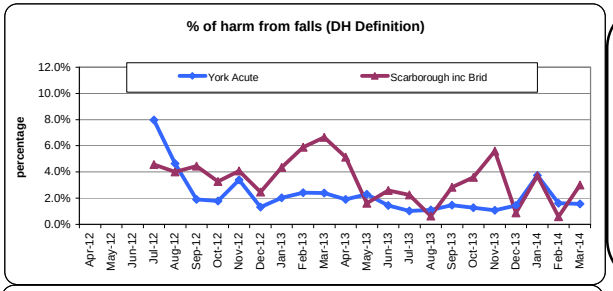
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 1.39% in York and 1.20% in Scarborough acute hospitals in March.

Data source: Safety Thermometer



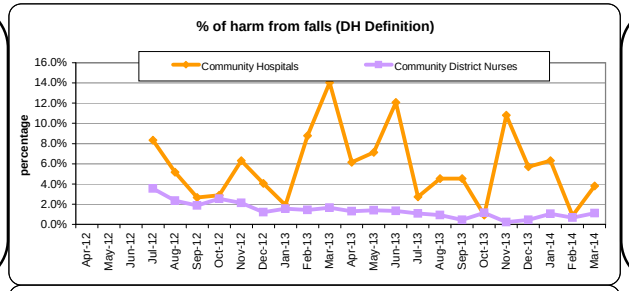
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 2.86% in community hospitals and 2.01% in community care in March.

Data source: Safety Thermometer



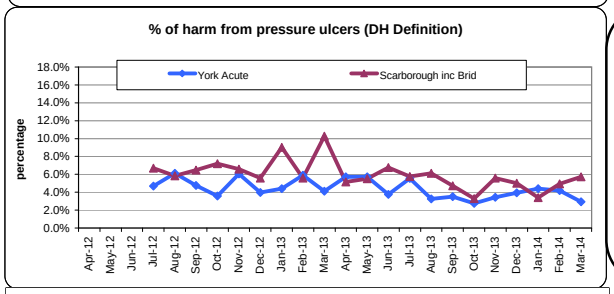
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 1.56% for York and 3.00% for Scarborough acute hospitals in March.

Data source: Safety Thermometer



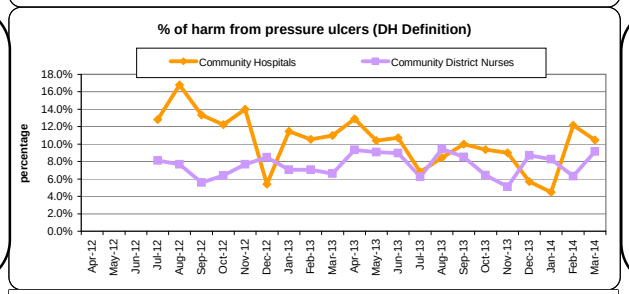
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 3.81% in community hospitals and 1.12% in community care in March.

Data source: Safety Thermometer



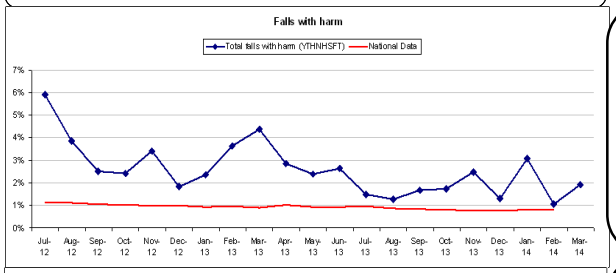
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 2.95% for York and 5.71% for Scarborough acute hospitals in March.

Data source: Safety Thermometer



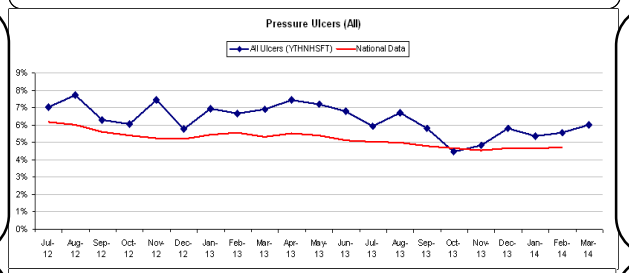
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 10.48% in community hospitals and 9.15% in community care in March.

Data source: Safety Thermometer



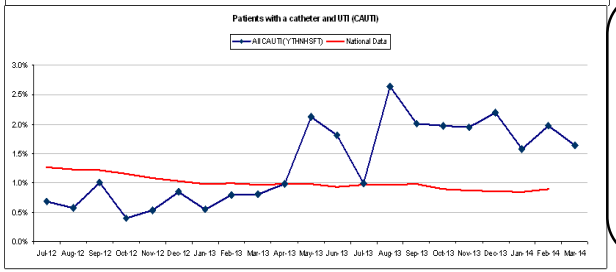
The Trust wide total number of falls with harm as measured for the Safety Thermometer indicates the Trust to be above the national average.

Data source: Safety Thermometer



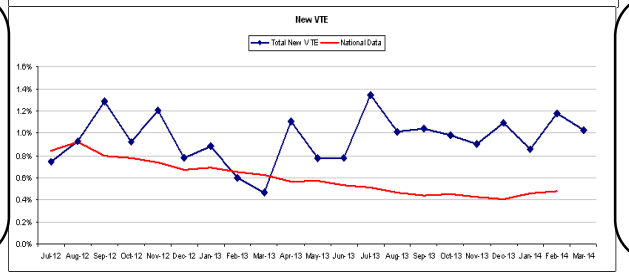
The Trust wide total number of pressure ulcers as measured for the Safety Thermometer is above the national average.

Data source: Safety Thermometer



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

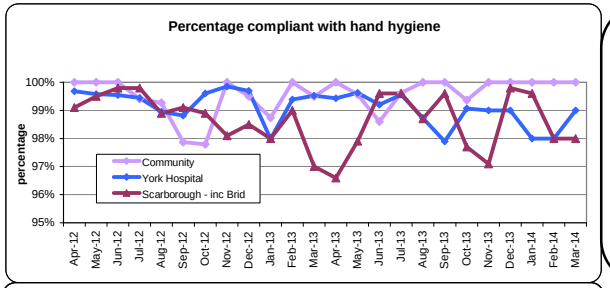
Data source: Safety Thermometer



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

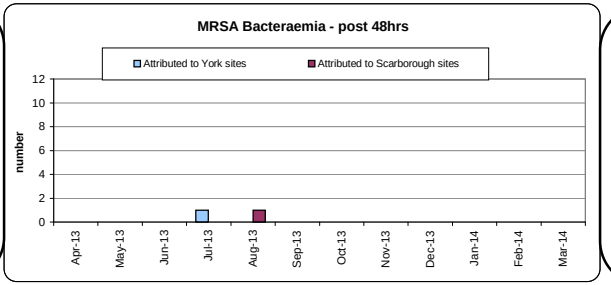
Data source: Safety Thermometer

Infection Control

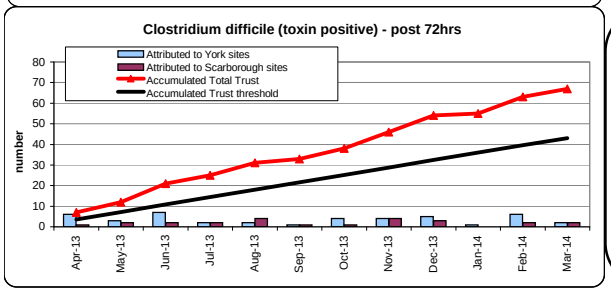


Hand hygiene compliance for York was 99% and Scarborough was 98% in March whilst the Community Hospitals achieved 100%.

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

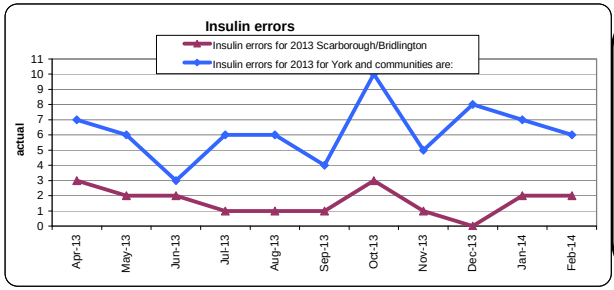


There were no patients in the Trust identifed with healthcare associated bacteraemia during March.



Four cases of c. diff were identifed in the Trust during March, taking the accumulated Trust total to sixty seven. (final year end)

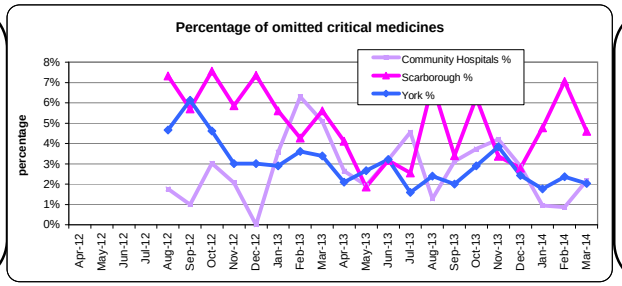
Drug Administration



There were six insulin related errors reported at York and two at Scarborough in February.

The data for March is awaiting validation.

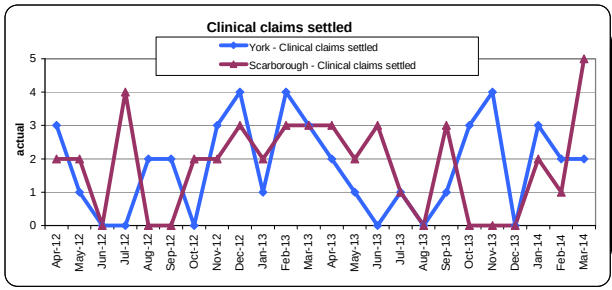
Data Source: Datix



Whilst the number of omitted critical medicines has decreased in the last month at the York and Scarborough sites, omitted medicines remains a concern.

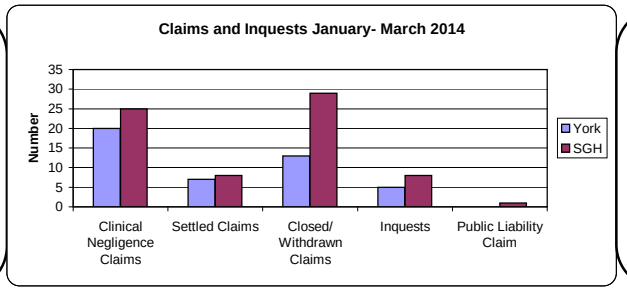
Omitted Medicines has increased at the Community Hospitals from 0.87% to 2.17% in March.

Litigation



In total, seven clinical claims were settled in March, two on the York site and five on the Scarborough site.

Data Source: Risk and Legal Services



Between January and March 2014 there were 20 Clinical Negligence Claims at York and 25 at Scarborough; 7 settled claims at York and 8 at Scarborough; 13 closed. Withdrawn claims at York and 29 at Scarborough and 5 inquests at York compared to 8 at Scarborough.
There was also a pubic liability claim relating to a pothole in the road at the main entrance of Scarborough Hospital, resulting in the claimant sustaining an injury.

Patient Safety Walkrounds

Date	Location	Participants	Actions & Recommendations
Monday 10th March 2014	Ward 34, Sleep Service and Cardiac rehab. (York Hospital)	Diane Palmer – Deputy Director for Patient Safety Dianne Willcocks – NED Jordan McKie – DM Nigel Durham – CD Liz Charters – Matron Jayne Pateraki – Specialist Nurse Christine Rallinson – Cardiac Rehab Lead	Ward 34 • Six beds in a bay leaves very little space for equipment or visitors. • The nursing establishment is to be re-considered taking the 2 additional beds into account and the NIV support. • The system to record observations is often slow. • IT screen in the middle of the ward with patients identifiable data. • Call bells are old with buttons missing. • No designated area to speak to relatives. Sleep service • Often there are not beds available for NIV or appropriately trained staff. • The service works well but the team could work better if in-hospital and community service was not split. • There is a need for an inpatient heart failure specialist nurse.
Thursday 13th March 2014	Ward 24 (York Hospital)	Bev Geary – Director of Nursing Steven Reed – Directorate Manager Diane Willcocks - NED	• Lack of equipment –Staff and DM reported long delays from ordering and authorising equipment to its delivery. • Disposable towel dispenser in rooms pose a potential risk. • Delay to discharge; frail patient nearing 60 day stay due to absence of care package.
Friday 21st March 2014	Graham Ward (Scarborough Hospital)	Diane Palmer – Deputy Director for Patient Safety Dr Jones – CD Steve Reed – DM Emma Day – Matron Mike Keaney - NED	• Not enough low profile beds available. • Not enough hoists to aid standing. • Mobile telephone needed at the nurses station at the far end of the ward. • Doors near the access ramp open outwards and quickly. • When staff are identified for the ward next year this should be coordinated by a Senior Nurse to ensure that skill-mix and experience is appropriate.
Friday 21st March 2014 (rescheduled from 11th March)	Paediatrics (Scarborough Hospital)	Patrick Crowley – Chief Executive Dr Venkatesh – CD Liz Vincent – DM Nicola Lockwood – Matron Jennie Adams - NED	Duke of Kent Ward • Child Health directorate team are leading an improvement programme There is no sense of complacency in this and clearly there is much work still to be done. • Band 6 tier of management is now in place and in a small number of exploratory discussions on the ward there is an enthusiasm and real sense of purpose about the change management process and a demonstrable satisfaction in the improvements already being made. • There continues to be concerns about the out of hours support from CAMHS. Special Care Unit • No patient safety concerns identified.

Cancelled walkrounds

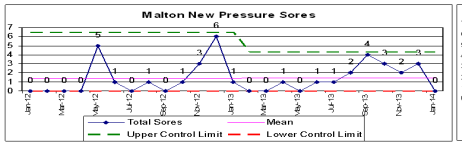
Friday 7th March 2014	8.30am-10am	Scarborough Hospital	Maple/ Haldane wards **CANCELLED AS CD UNAVAILABLE**	Diane Palmer- Deputy Director *Ms McNaught- CD Unavailable* Amanda Stanford- DM David Thorpe- Matron Jennie Adams- NED
Tuesday 18th March 2014	2pm-4pm	Scarborough Hospital	Specialist Medicine **CANCELLED BY MIKE PROCTOR**	Mike Proctor- Director Dr Quinn- CD Karen Cowley- DM/ Matron Alan Rose- NED

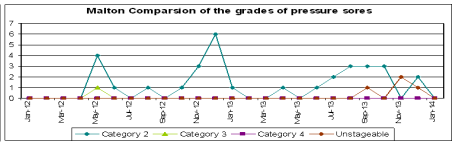
York Teaching Hospital NHS
NHS Foundation Trust

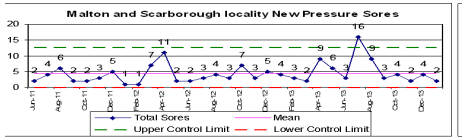
Malton Community Hospital
Patient Safety Dashboard – 20th March 2014

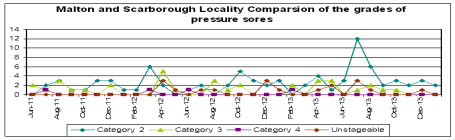
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of incidents reported on - Datix web	17	24	22	25	32	27	20	20	22	21	14	
Number of medication related incidents	1	3	1	1	0	1	1	1	0	0	0	
Number of new clinical litigation cases	0	0	0	0	0	0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

Pressure Ulcers

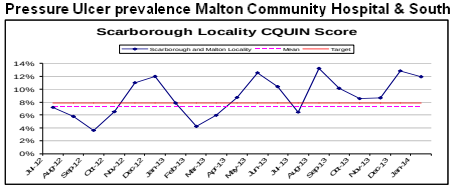


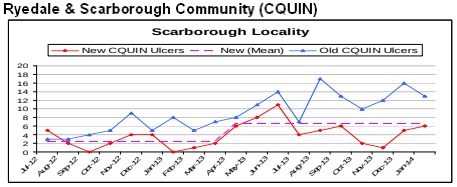




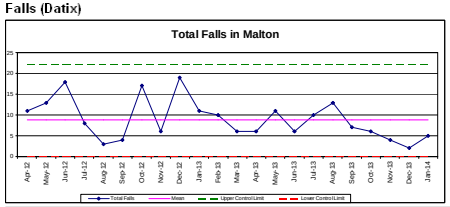


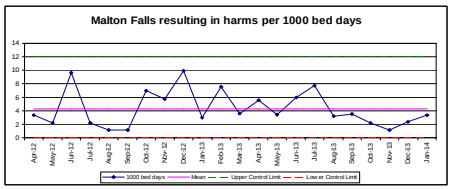
Pressure Ulcer prevalence Malton Community Hospital & South Ryedale & Scarborough Community (CQUIN)





Falls (Datix)



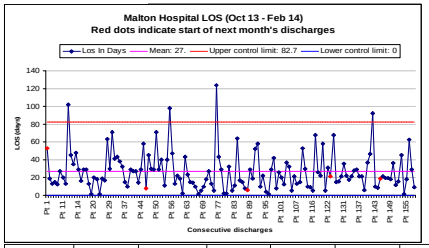


Target of 20 % reduction in falls over 13/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14
Mean falls with harm per 1000 bed days (Trajectory <3.8 per month)	5.6	3.4	5.9	7.7	3.2	3.5	2.2	1.2	2.4	3.4

Mean across year so far as of Jan = 3.9

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

Length of Stay Graph



Activity	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar14	
	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye
Admissions	21	34	19	16	32	49	43	76	19	72	19	69	21	13	20	10	11	22	22	13	15	11		
Discharges	23	14	21	19	30	46	40	77	25	75	22	74	26	20	25	15	12	26	24	15	15	21		
length of hosp stay – mean *previous yr	26.5 *27	30.3 *NR	24.0 *20.1	24.8 *NR	17.3 *9.1	22.3 *NR	17.5 *NR	20.0 *NR	24.2 *NR	26.1 *NR	19.9 *NR	42.5 *8.8	31.8 *11.8	33.1 *14.8	24.3 *15.1	36.8 *22.3	23.9 *15.3	29 *15.5	30 *30.5	39 *16.5	31 *24.5	30 *26.8	*19.9	*22.5

NR=No Record on 'Signal'

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

Harm Free Care - Safety Thermometer Prevalence data	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14	
Ward	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye	Fitz	Rye
Overall Ward Harm Free	82%	93%	93%	80%	92%	91%	93%	85%	100 %	83%	79%	83%	93%	100 %	80%	93%	100 %	92%	100 %	100 %	90%	100 %
VTE (% of patients with a VTE)	0%	0%	7% (1 old)	0%	7% (1 old)	0%	7% (1 old)	7% (1 old)	0%	8% (1 old)	0%	0%	0%	0%	0%	0%	20% (3 old)	0%	7%	0%	0%	6%(1 new)
Falls (% of patients who fell)	17% (3 low harm)	46% (1 low, 3 mod, 3 sev harm)	0%	13% (2 low harm)	23% (3 low harm)	18% (2 mod harm)	14% (1 mod, 1 low harm)	15% (1 no, 1 low harm)	6% (1 low harm)	8% (1 low harm)	42% (1 NH, 3 LH, 2 MH)	0%	14% (2 no harm)	8% (1 no harm)	33% (4 low harm 1 no harm	0%	40% (4 low harm 2 mod harm	0%	36% (3 Low harm 2 Mod harm	0%	10% (1 low harm)	0%
Pressure Ulcers (% of patients with a new PU- CQUIN)	5% (1 cat 2)	6% (1 cat 3)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	14% (1 cat 2)	0%	0%	7% (1 cat 2)	0%	7% (1 cat 3)	0%	0%	10% (1 cat 2)	6% (1 cat 2)
Pressure Ulcers (% of patients with an old PU - CQUIN)	5% (1 cat 2)	13% (2 cat 2)	0%	20% (1 cat 2, 2 cat 3)	23% (3 cat 2)	27% (2 cat 2, 1 cat 4)	0%	7% (1 cat 4)	6% (1 cat 2)	16% (1 cat2, 1 cat3)	0%	28% (3 cat2, 1 cat4)	14% (1 cat 2, 1 U)	23% (2 cat2, 1 U)	6% (2 cat 2)	7% (1 cat 2)	0%	0%	0%	7% (1 cat 2)	20% (1 cat 2 & 1 cat 3)	17% (3 cat 2)
UTI (% of patients)	23% (3 new, 1 old)	20% (3 old)	50% (5 new, 2 old)	6% (1 new)	30% (3 new, 1 old)	0%	14% (2 old)	22% (2 new, 1 old)	22% (2 new, 2 old)	8% (1 new)	21% (3 old)	7% (1 new)	7% (1 new)	15% (2 old)	26% (3 old 1 new)	7% (1 old)	6% (1 new)	7% (1 new)	0%	7% (1 new)	10% (old)	11% (2 new)
Empty Admin Boxes	41%	20%	28%	6%	7%	63%	28%	69%	28%	33%	7%	43%	7%	23%	6%	21%	26%	7%	36%	53%	90%	39%
Omission code 4	41%	20%	0%	20%	30%	72%	28%	7%	22%	25%	14%	14%	7%	23%	0%	28%	20%	7%	36%	33%	30%	11%
Omitted Critical Medicines	0%	0%	0%	0%	0%	18%	0%	23%	0%	0%	7%	0%	0%	8%	13%	0%	0%	7%	0%	0%	0%	0%

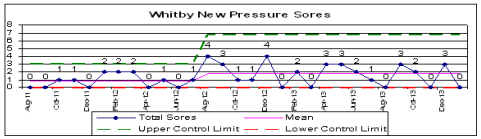
RCA feedback and action planning	RCA for a fractured neck of femur following a fall showed that staff need education around the risk assessment process and associated interventions required on care plan. Lyeanda Berry (Senior nurse Quality & Performance and Darren Fletcher (Patient Safety Manager) have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

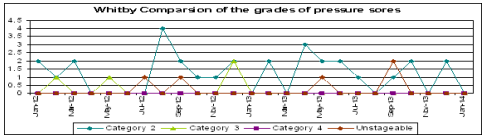
WHITBY Community Hospital
Patient Safety Dashboard – 6th March 2014

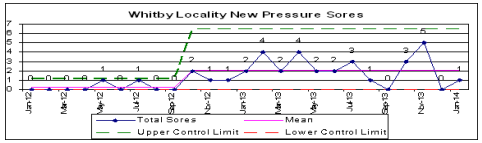
Datix Incident Reporting Whitby Hospital	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan14	Feb 14	Mar 14
Number of incidents reported on Datix web	26	22	19	18	17	14	33	18	11	3	10	
Number of medication related incidents	0	1	3	0	0	0	2	1*	0	0	0	
Number of settled clinical litigation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

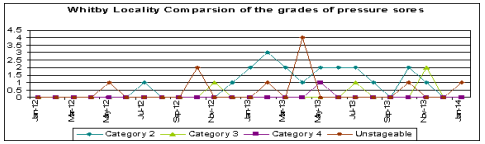
*Zoromorph not signed for

Pressure Ulcers

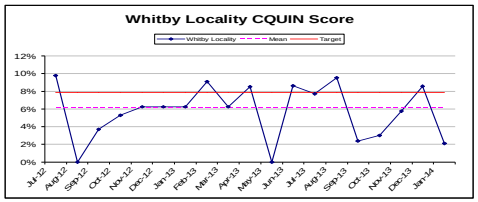


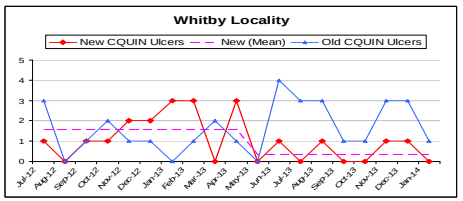




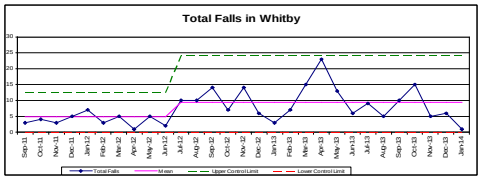


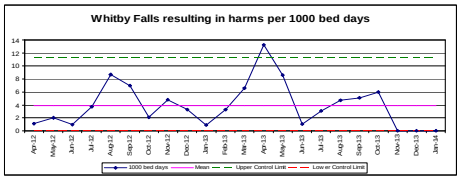
Pressure Ulcer prevalence Whitby Hospital and Whitby Community Services (CQUIN)





Falls (Datix)





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

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

Mean so far up to Dec= 4.8

York Teaching Hospital NHS
NHS Foundation Trust

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

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

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

Harm Free Care - Safety Thermometer Prevalence data	Apr 13		May 13		Jun 13		Jul 13		Aug 13		Sept 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14	
	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM
Overall Ward Harm Free	93%	100%	78%	89%	100%	100%	87%	100%	93%	89%	100%	94%	87%	90%	91%	100%	100%	100%	100%	100%	100%	94%
VTE (% of patients with a VTE)	0%	5% (1 new)	0%	11% (2 old)	7% (1 old)	6% (1 old)	0%	0%	7% (1 old)	0%	0%	5% (1 new)	7% (1 old)	5% (1 old)	9% (1 old)	0%	7% (1 old	20% (3 old)	0%	7%	7%	0%
Falls (% of patients who fell)	13% (2 no harm)	10% (2 no harm)	14% (2 low harm)	11% (2 low harm)	57% (1 sev, 3 mod, 4 low)*	12% (2 low harm)	6% (1 no harm)	0%	6% (1 no harm)	0%	0%	6% (1 no harm)	7% (1 mod harm)	0%	0%	7% (1 no harm)	0%	0%	0%	0%	0%	0%
Pressure Ulcers (% of patients with a new PU- CQUIN)	7% (1 cat 2)	0%	0%	0%	0%	6% (2 cat2)	13% (2 cat 2)	0%	0%	10% (2 cat 2)	0%	0%	7% (1 U)	5% (1 cat 2)	9% (1 cat 2)	0%	7% (1 cat 2)	0%	0%	0%	0%	5% (1 cat 2)
Pressure Ulcers (% of patients with an old PU - CQUIN)	0%	10% (2 cat 3)	7% (1 cat 2)	16% (1 cat 3, 2 cat2)	7% (1 cat2)	6% (1 cat4)	6% (1 cat 2)	5% (1 cat2)	0%	5% (1 cat 2)	7% (1 cat2)	12% (2 cat 2)	7% (1 cat2)	10% (1cat2, 1 cat 3)	0%	5% (1 cat 2)	0%	0%	0%	13% (2 Cat 2)	13%(2 cat 2)	11% (1cat 1 &1 cat 3)
UTI (ward harms) (% of patients)	26% (4 old)	10% (1 new, 1 old)	14% (2 new)	27% (5 new)	7% (1 new)	12% (2 old)	13% (1 new, 1 old)	21% (4 old)	13% (1 new, 1 old)	5% (1 new)	21% (2 new, 1 old)	6% (1 new)	13% (2 new)	40% (5 new 2 old)	9% (1 old)	10% (1 old 1 new)	7% (1 new)	0%	0%	0%	7% (1 old)	0%

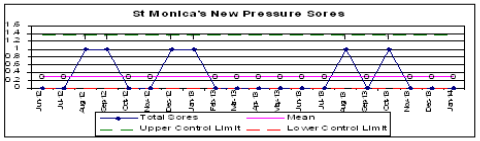
RCA feedback and action planning	No RCAs for Whitby site since last meeting

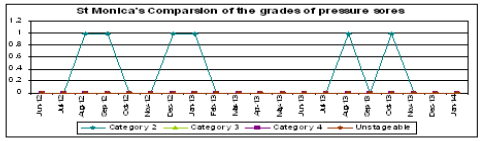
ST MONICA'S Community Hospital
Patient Safety Dashboard – March 13th 2014

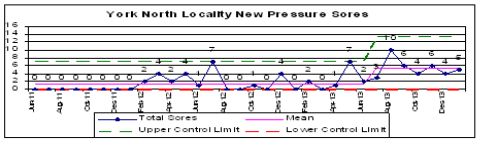
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of incidents reported on - Datix web	2	5	6	4	7	2	3	6	2	4	7	
Number of medication related incidents	0	0	0	3	0	0	0	2	0	1*	0	
Number of settled clinical litigation cases	0	0	0	0	0	0	0	0	0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

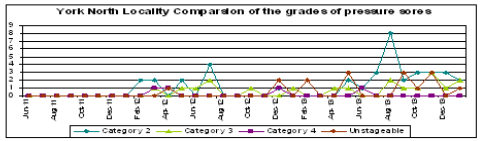
*Pt had two medicine chartsin use, marked 1 of 2 and 2 of 2, the pharmacist reviewed his medicine charts and added 'Warfarin apc' to his second chart (2 of 2). This was already on the first medicine chart (1 of 2) and was being administered from this prescription. The ward staff noticed this and did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

Pressure Ulcers

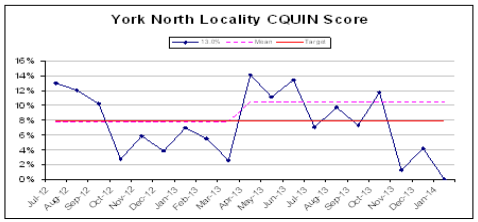


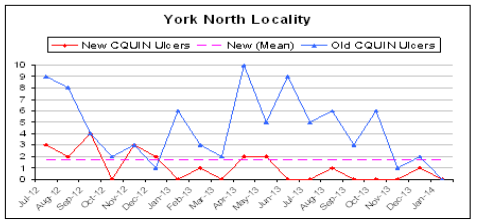




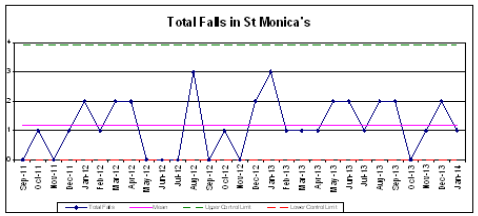


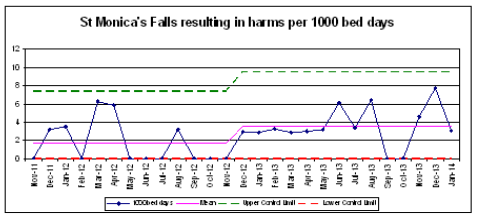
Pressure Ulcer prevalence St Monica's, North Ryedale and North York Community Services (CQUIN)





Falls





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

Mean so far up to Jan = 3.1

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

*as of 23/12/13

York Teaching Hospital NHS
NHS Foundation Trust

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

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

*Dr 67%

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

RCA feedback and action planning	No RCA's taken place since the last meeting.

Risk Register

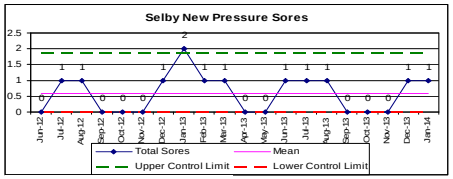
Top 3 Risks on Risk Register	
1.	Failure to meet CQUIN pressure ulcer target
2.	Clinical Governance around MIU.
3.	North York Fire Service work to be carried out following recent review of site.

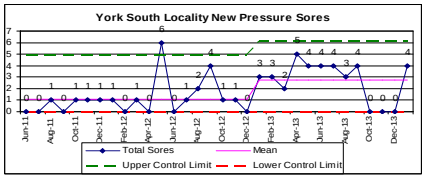
York Teaching Hospital NHS
NHS Foundation Trust

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

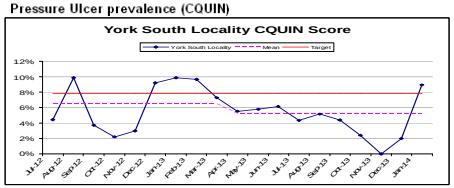
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of incidents reported on - Datix web	15	13	12	20	10	14	17	16	16	11	9	13
Number of medication related incidents	1	0	1	3	0	2	4	0	0	0	0	0
Number of settled clinical litigation cases	0	0	0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

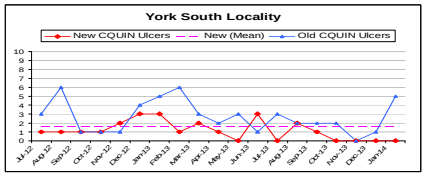
Pressure Ulcer incidence (DATIX)



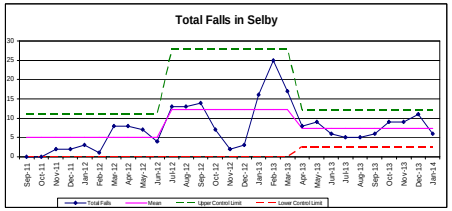


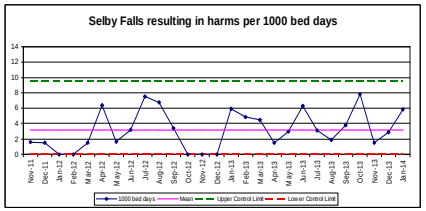
Pressure Ulcer prevalence (CQUIN)





Falls (In-patients only)





Falls target (In patients only)

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

Mean falls with harm per 100 bed days so far (Apr-Feb =)

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

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

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

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

Harm Free Care - Safety Thermometer Prevalence data

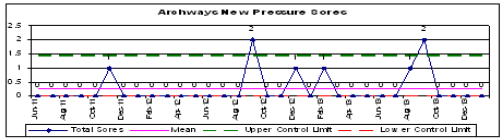
Selby Hospital	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Overall Ward Harm free	**90%**	**100%**	**100%**	**95%**	**100%**	**100%**	**100%**	**100%**	**100%**	**91%**	**91%**	**90%**
VTE (% of patients with a VTE)	0%	0%	0%	0%	10% (2 old)	5% (1 old)	0%	0%	4%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

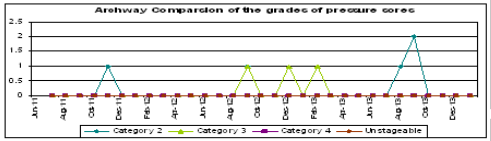
RCA feedback and action planning	No RCA's since last meeting

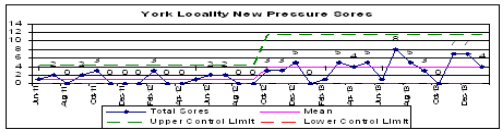
ARCHWAYS Community Hospital
Patient Safety Dashboard – March 25th 2014

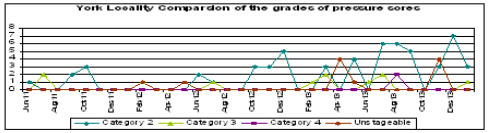
Datix Incident Reporting	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Number of incidents reported on - Datix web	12	10	8	12	10	10	11	14	12	13	9	
Number of medication related incidents	0	0	0	0	0	0	0	2	1	0	2	
Number of settled clinical litigation cases	0	0	0	0	0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

Pressure Ulcers

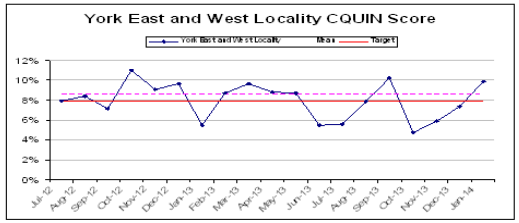


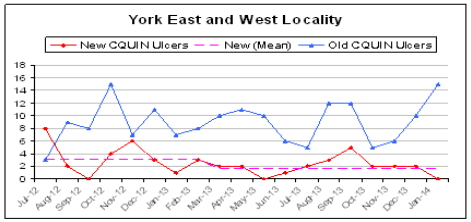




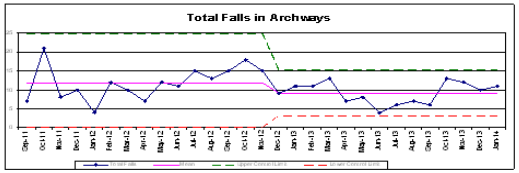


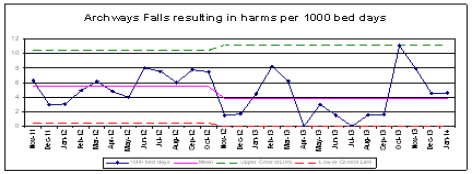
Pressure Ulcer prevalence Archways Community Hospital & York East & West Locality (CQUIN)



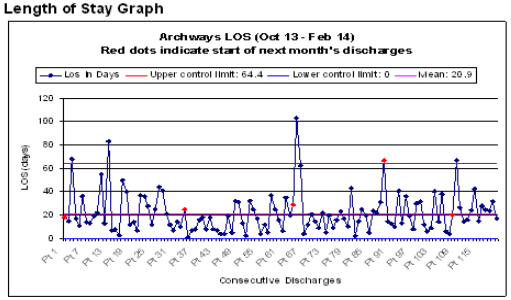


Falls





Length of Stay Graph



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

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

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

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

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

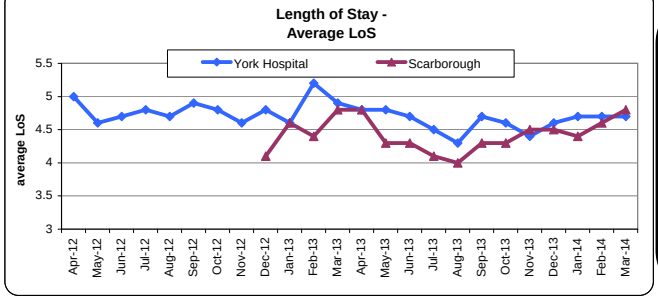
*Nurse 80%, support staff 50%, **Dr 50%

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

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

Clinical Effectiveness Dashboard

Clinical Effectiveness



The Length of Stay (LOS) for in-patients (excluding day cases and babies) was 4.7 days for York Hospital and 4.8 days for Scarborough Hospital during March.

Data source: Signal

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

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

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

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

Maternity Dashboard - York and Scarborough

York Maternity Dashboard:

York Teaching Hospital NHS
NHS Foundation Trust

			Measure	Data source	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Flag Source	Mar	April	May	June	July	August	September	October	Nov	Dec	Jan	Feb	March	Av. Monthly YtD
Activity	Births	Bookings	1st m/w visit	CMIS from Jan CPD	≤302	302-329	≥330	prev. stats	286	352	312	291	301	317	275	261	277	274	374	346	289	304
		Bookings <13 weeks	No. of mothers	CMIS from Jan CPD	≥90%	76%-89%	≤75%	CQUIN	90%	87%	89%	91%	91%	89%	88%	87%	89%	88%	86%			89%
		Bookings ≥13 weeks (exc transfer	No. of mothers		≥90%	76%-89%	≤75%	CQUIN														
		Bookings ≥ 13wks seen within 2 w	No. of mothers	Mat Rec	≥90%	76%-89%	≤75%	CQUIN														
		Births	No. of babies	CMIS	≤295	296-309	≥310	prev. stats	260	295	274	241	299	282	296	293	279	285	295	234	285	278
		No. of women delivered	No. of mothers	CMIS					247	290	269	233	294	271	289	283	274	276	288	230	279	271
	Closures	Homebirth service suspended	No. of closures	Comm. Manager	0-3	4-6	7 or more		5	1	2	2	0	1	1	6	6	4				3
		Homebirth service suspended	No. of women	Comm. Manager	0	1	2 or more		2	1	0	0	0	0	0	2	0	0				1
		Escalation Policy implemented	No. of times	Comm. Manager	3	4-5	6 or more		3	3	1	0	1	0	5	3	3	2			2	2
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		SCBU closed to admissions	In utero transfers	Transfer folder	0	1	2 or more		0	1	1	0	0	2	4	3	0	3	0	0	0	1
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	30.3	29.5	30.0	30.5	30.5	30.1	29.7	28.4	28.4	29.8	31.0	31.0		29.9
		HCA's	WTE	Matron				staffing paper	19.14	19.82	18.62	20.62	20.62	19.82	20.02	20.02	20.02	21.01	19.43	19.43		19.88
		1 to 1 care in Labour		Risk Team																		
		L/W Co-ordinator supernumary %		Risk Team					48	46	75	86	65	48	55	48	47	45	51	80	65	58
		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
		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
		Supervisor : M/w ratio 1 :	Ratio	Rota	15	16-19	20	SHA	13	13	13	13	13	15	15	13	13	13	12	14	14	13
Clinical Indicators	Neonatal/Maternal Morbidity	Spontaneous Vaginal Births	No. of svd	CMIS	≥65%	64%	≤63%		61.5	59.6	56.9	56.8	67.2	62.7	63.5	68.3	64.8	62.1	61.7	61.5	59.6	62.0
		Operative Vaginal Births	No. of instr. births	CMIS	≤15%	16-19%	≥20%	prev. stats	15.8	14.9	11.7	17.8	11.7	12.4	8.4	10.9	10.7	12.9	9.5	15.8	12.6	12.7
		C/S Deliveries	Em & elect	CMIS	≤24%	24.1-25.9	≥26%	prev. stats	22.7	25.4	31.4	25.3	21.1	24.8	27.7	20.8	24.0	24.5	28.8	22.6	27.7	25.1
		Eclampsia	No. of women	CMIS	0		1 or more		0	0	0	0	0	0	0	0	0	0	1	0	0	0
		Undiagnosed Breech in Labour	No. of women	CMIS	2 or less	3-4	5 or more	prev. stats	0	2	1	1	1	4	1	3	3	1	1	0	0	1
		ICU transfers	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	0	0	1	2	1	0	1	0	1	2	0	0	1
		HDU on L/W	No. of days	Handover Sheet					29	28	24	12	21	15	15	25	15	14	18	17	11	19
		Uterine Rupture from Jan 14	No of women	CPD	0	1	2 or more												0	0	0	0
		P/N Hysterectomies < 7days p/n	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	0	0	0	0	1	0	0	0	1				
		BBA	No. of women	Risk Team - Datix	1	2-3	4 or more	prev. stats	8	3	1	1	3	7	2	6	4	1	4	2	3	3
		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	1	0	0
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	0	0	1	0	2	1	1	0	0	0	0	0	0	1
	Risk Management	SI's	Total	Risk Team	0	1	2 or more		0	0	0	0	1	0	0	0	0	0	0	0	0	0
		PPH > 2L	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		4	2	0	2	2	5	4	7	7	1	1	2	1	3
		Shoulder Dystocia - True	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	RCOG	6	2	0	2	3	1	3	6	6	3	0	0	2	2
		3rd/4th Degree Tear	% of tears (vaginal l	CMIS	≤1.5%	1.6-6.1%	≥6.2%	RCOG	5.5	8.2	4.8	6.1	5.9	4.2	3.7	3.4	6.1	2.8	4.7	4.4	6.8	5.1
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		81	80	73	80	90	90	90	90	89	99	94	96	95	88
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		30	37	64	69	69	39	48	55	50	69	78	81	81	59
		Training cancelled	No. of staff affected	Risk Team	0		≥1		0	0	9	8	44	0	7	1	0	1	1	0	0	0
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		1	0	2	2	1	1	0	0	1	0	3	0	1	1
		Formal	Total	Matron	0	1-4	5 or more		2	1	3	1	3	3	1	2	1	2	2	1	0	2
	New Claims		Total	Directorate Manager	0	1	2 or more		0	0	0	0	1	0	1	0	0	0	2	1	0	0

Scarborough Maternity Dashboard:

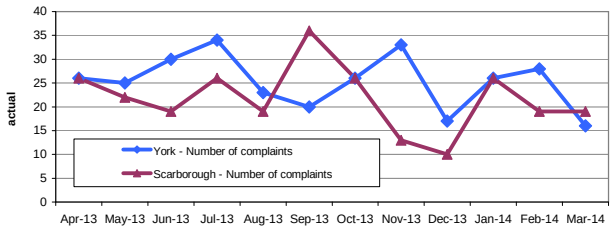
York Teaching Hospital NHS
NHS Foundation Trust

			Measure	Data source	No Concern(green)	Of Concern (Amber)	Concerns (Red)	Flag Source	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Av. Monthly YtD
Activity	Births	Bookings	1st m/w visit	IS - Evolution	≤200	201-249	≥250	prev. stats	176	159	102	118	176	112	171	171	188	165	232	173	127	158
		Bookings <13 weeks	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	93%	89%	79%	81%	87%	83%	82%	81%	96%	100%	100%	100%	100%	90%
		Bookings <13 weeks (exc transfers etc)	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	98%	94%	83%	97%	88%	99%	86%	TBC	96%	n/a	n/a	n/a	n/a	92%
		Bookings ≥ 13wks seen within 2 wks	No. of mothers		≥90%	76%-89%	≤75%	CQUIN	awaiting CPD commencment													
		Births	No. of babies	IS - Evolution	≤170	171-189	≥190	prev. stats	120	121	147	108	140	154	135	145	131	124	145	128	119	133
		No. of women delivered	No. of mothers	IS - Evolution	≤170	171-189	≥190	prev. stats	118	120	146	107	140	153	133	142	129	122	143	126	118	132
	Closures	Homebirth service suspended	No. of closures	Comm Team Leader	0-3	4-6	7 or more		0		0	0	0	0	0	0	0	0	0	0	0	0
		Homebirth service suspended	No. of women	Comm Team Leader	0	1	2 or more		0		0	0	0	0	0	0	0	0	0	0	0	0
		Escalation Policy implemented	No. of times	Matron	3	4-5	6 or more				0	0	0	0	0	0	0	0	0	0	0	0
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0		0	0	0	0	0	0	0	0	0	0	0	0
		MLU Closure	No. of closures	Matron	0	1-2	3 or more				1	0	0	1	2							0
		MLU Closure	No. of women	Matron	0	1-2	3 or more					0	0	0	1							0
		SCBU closed to admissions	In utero transfers	Risk Team	0	1	2 or more		1	0	0	0	0	0	0	1	1	2	1	0	4	0
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0
		HCA's	WTE	Matron				staffing paper	17.26	18.55	18.55	18.55	18.55	18.79	18.79	19.59	19.59	19.59	18.32	18.32	18.32	18.29
		1:1 care in labour		IS - Evolution					96%	94%	95%	95%	94%	96%	96%	96%	98%	99%	96%	98%	99%	96%
		L/W Co-ordinator Supernumary %		L/W Manager												56%	56%	n/a	41.93%	n/a	n/a	56%
		Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	40	40	40	40	40	40	40	40	40	40	40	40	40	40
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10	Safer Childbirth	3	3	3	3	3	3	3	3	3	3	3	3	3	3
		Supervisor : M/w ratio 1 :	Ratio	Matron	15	16-19	20	NMC	15	15	13	13	13	15	15	13	13	13	14	14	14	14
Clinical	Neonatal/Maternal	Sponateous Vaginal Births	No. of svd	IS - Evolution	≥65%	64%	≤63%		75.0%	75.2%	75.5%	76.9%	76.4%	77.9%	70.4%	64.8%	65.6%	67.7%	68.3%	71.9%	72.3%	71.9%
Indicators	Morbidity	Operative Vaginal Births	No. of instr. births	IS - Evolution	≤15%	16-19%	≥20%	prev. stats	3.3%	3.3%	4.8%	4.6%	5.0%	4.5%	8.1%	8.3%	6.1%	4.0%	3.4%	4.7%	5.9%	5.3%
		C/S Deliveries	Em & elect	IS - Evolution	≤24%	24.1-25.9	≥26%	prev. stats	20.0%	19.8%	19.0%	17.6%	17.9%	16.2%	20.0%	24.8%	26.0%	26.6%	26.9%	21.9%	21.0%	21.5%
		Eclampsia	No. of women	IS - Evolution	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		Undiagnosed Breech in Labour	No. of women	Risk Team	2 or less	3-4	5 or more	prev. stats			0			1	0	1	1	0	0	0		0
		ICU transfers	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	1	0	1	0	0	1	0	0	0	0	0	0	0
		HDU on L/W	No. of days	Risk Team										0	2	2	5	4	2	3		2
		P/N Hysterectomies < 7days p/n	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	1	0	0	0	0	0	0	0	0	0	0	0	0
		BBA	No. of women	IS - Evolution	1	2-3	4 or more	prev. stats	1	2	1	1	1	4	1	1	0	1	1	1	0	1
		Meconium Aspirate	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	1	0	0	0	0	0	0	1	0	1	0	0
		Diagnosis of HIE	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Risk Management	SI's	Total	Risk Team	0	1	2 or more				0	0	0	0	0	0	0	0	0	1	0	0
		PPH > 2L	No. of women	IS - Evolution	1 or less	2-3	3 or more		0	2	0	0	0	0	1	0	1	1	0	1	0	1
		Shoulder Dystocia - True	No. of women	IS - Evolution	1 or less	2-3	3 or more	RCOG	0	2	2	1	1	1	0	4	0	0	1	1	0	1
		3rd/4th Degree Tear	% of tears (vaginal l	IS - Evolution	≤1.5%	1.6-6.1%	≥6.2%	RCOG	0.0%	0.8%	2.1%	0.9%	1.4%	2.6%	0.8%	1.4%	0.8%	2.5%	4.9%	4.0%	0.0%	1.9%
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%						67	67	77	85	92	98	91	93		86
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%						57	57	53	79	82	90	37	92		70
		Training cancelled	No. of staff affected	Risk Team	0		≥1						0	0	0	0	0	1	0	0		0
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		1	0	1	1	1	0	0	1	3	1	1	3	2	1
		Formal	Total	Matron	0	1-4	5 or more		2	2	0	1	1	1	0	1	1	1	1	1	0	1
	New Claims		Total	Risk Team	0	1	2 or more		0	0	2	0	1	0	0	0	0	0	0	2	1	1

Patient Experience Dashboard

Patient Experience

Number of complaints

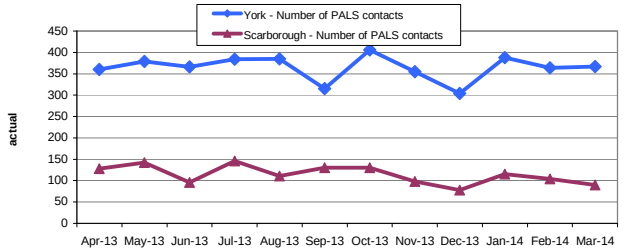


Complaints registered in York relate to York Hospital and Community Services.

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

There were 16 new complaints registered to the York site and 19 to the Scarborough site in March.

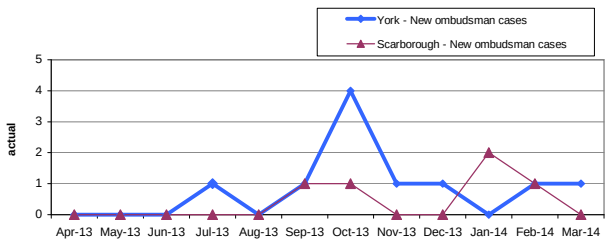
Number of PALS contacts



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

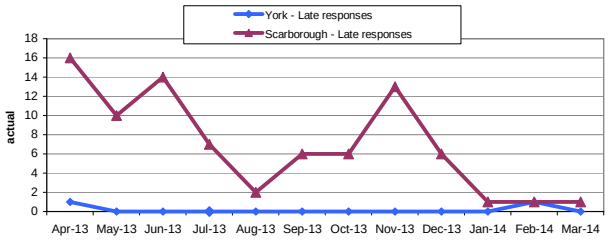
There were 367 PALS enquiries at York Hospital and 90 PALS enquiries at Scarborough in March.

New ombudsman cases



There was one new ombudsman case at the York site in March.

Complaints - Late responses



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

There was one late response to a complainant at the Scarborough site compared to none at the York site in March.

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

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

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

Friends & Family Test Results

York Teaching Hospital NHS
NHS Foundation Trust

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

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

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

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

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

Who responded?

Response Rate	Male or Female	Age Profiles %
Eligible Patients 9520	47%	16-24, 25-34, 35-54, 55-64, >65
Patient Responses 2483	53%	0 20 40 60 80 100
26%		

Patients extremely likely to recommend our Trust said:	Patients unlikely or extremely unlikely to recommend our Trust said:
"Friendly and caring staff as well as being very efficient."	"I live 150 miles away. On the whole the service was excellent."
"All the staff were extremely friendly and helpfull."	"No reasons at all except good."

Produced by: picker Institute Europe

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

Calculating the Net Promoter Score:

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

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

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

The FFT score is calculated as:

percentage of people extremely likely to recommend

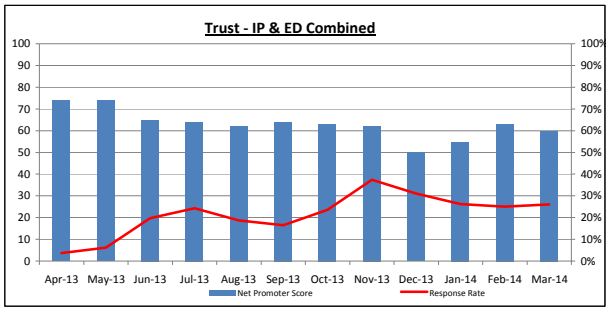
minus

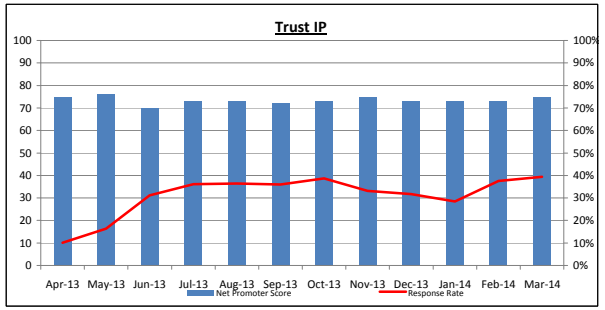
percentage of people not likely to recommend

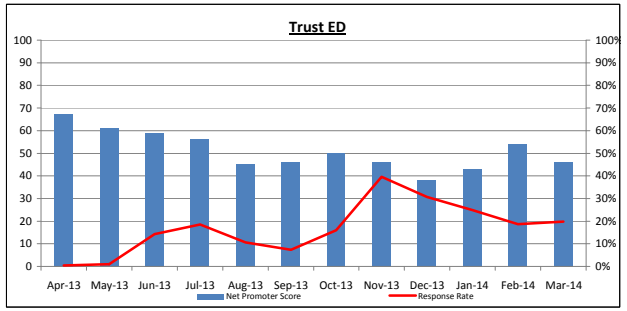
The Friends and Family Test
Inpatients/Maternity and the Emergency Department

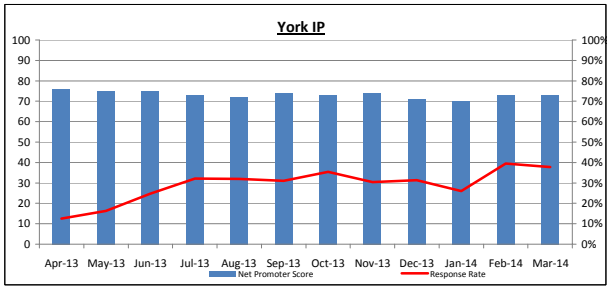
The Friends and Family Test (FFT) has now been rolled out across the Trust, with all adult inpatients, those attending ED and women accessing maternity services being asked the question "would you recommend this ward/ED/antenatal/labour and postnatal service to your family and friends".

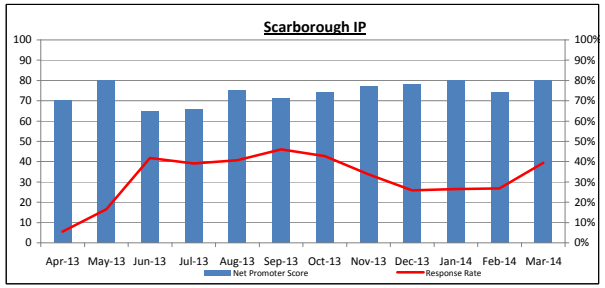
	Q1	Q2	Q3	Q4
Response Rate	9.80%	20.04%	30.43%	25.81%

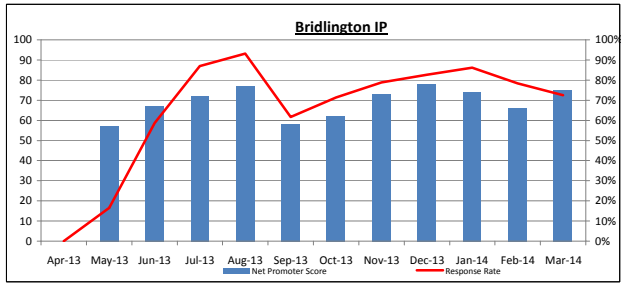








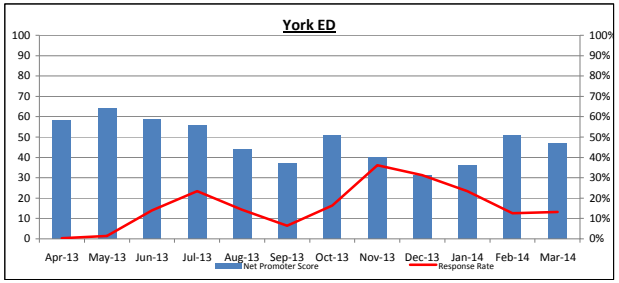




		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Trust	Response Rate	3.63%	6.18%	19.81%	24.30%	18.74%	16.50%	23.60%	37.40%	31.08%	26.23%	25.06%	26.07%
	Net Promoter Score	74	74	65	64	62	64	63	62	50	55	63	60

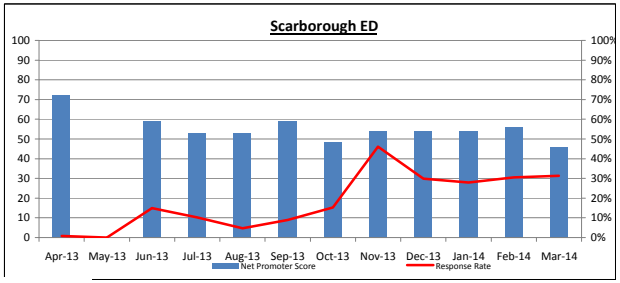
Inpatient Performance

		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
York IP	Response Rate	12.47%	16.28%	24.84%	32.20%	31.92%	31.06%	35.42%	30.44%	31.29%	26.06%	39.45%	37.81%
	Net Promoter Score	76	75	75	73	72	74	73	74	71	70	73	73
Sboro IP	Response Rate	5.52%	16.51%	41.77%	39.14%	40.66%	46.08%	42.69%	33.69%	25.91%	26.44%	26.83%	39.36%
	Net Promoter Score	70	80	65	66	75	71	74	77	78	80	74	80
Brid IP	Response Rate	0.00%	16.48%	58.65%	86.92%	93.14%	61.62%	71.43%	78.81%	82.61%	86.15%	78.38%	72.45%
	Net Promoter Score		57	67	72	77	58	62	73	78	74	66	75
Combined	Response Rate	10.06%	16.36%	31.22%	36.06%	36.38%	36.04%	38.66%	33.18%	31.72%	28.49%	37.59%	39.36%
	Net Promoter Score	75	76	70	73	73	72	73	75	73	73	73	75



ED Response Rate by Site - March 2014

Hospital	Eligible Patients	Total Responses	Response Rate	Net Promoter Score
York ED	4118	545	13.23%	47
Scarborough ED	2343	733	31.28%	46
Overall	**6461**	**1278**	**19.78%**	**46**



ED Performance

		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
York ED	Response Rate	0.30%	1.40%	14.00%	23.42%	14.26%	6.44%	16.38%	36.10%	31.23%	23.39%	12.58%	13.23%
	Net Promoter Score	58	64	59	56	44	37	51	40	31	36	51	47
Sboro ED	Response Rate	0.80%	0.04%	14.90%	10.15%	4.70%	8.87%	15.18%	46.02%	29.81%	27.93%	30.44%	31.28%
	Net Promoter Score	72	-100	59	53	53	59	48	54	54	54	56	46
Combined	Response Rate	0.44%	0.96%	14.31%	18.59%	10.56%	7.33%	15.94%	39.61%	30.76%	24.93%	18.67%	19.78%
	Net Promoter Score	67	61	59	56	45	46	50	46	38	43	54	46

		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
York IP	Eligible	2301	2236	2126	2267	2177	2128	2312	2122	2074	2318	1985	2092
	Responses	287	364	528	730	695	629	819	646	649	604	783	791
Sboro IP	Eligible	1033	1090	1015	1073	910	831	944	834	853	904	764	869
	Responses	57	180	424	420	370	347	403	281	221	239	205	342
Brid IP	Eligible	86	91	104	107	102	102	112	118	115	130	111	98
	Responses	0	15	61	93	95	61	80	93	95	112	87	71
Combined	Eligible	3420	3417	3245	3447	3189	3061	3368	3074	3042	3352	2860	3059
	Responses	344	559	1013	1243	1160	1037	1302	1020	965	955	1075	1204

		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
York ED	Eligible	4567	4381	4413	4505	4223	3885	4218	3787	4066	3843	3697	4118
	Responses	12	63	618	1055	602	250	691	1367	1270	899	465	545
Sboro ED	Eligible	2320	2277	2329	2581	2660	2244	2405	2075	2063	1962	1915	2343
	Responses	18	1	347	262	125	199	365	955	615	548	583	733
Combined	Eligible	6887	6658	6742	7086	6883	6129	6623	5862	6129	5805	5612	6461
	Responses	30	64	965	1317	727	449	1056	2322	1885	1447	1048	1278

Wards with high % response rates

Bridlington:
Lloyd 100%
Waters 74%
Johnson 65%

Scarborough:
CCU 100%
Ann Wright 80%
Ash 54%

York:
Ward 39 100%
Ward 25 100%
CCU 100%

Wards with low % response rates

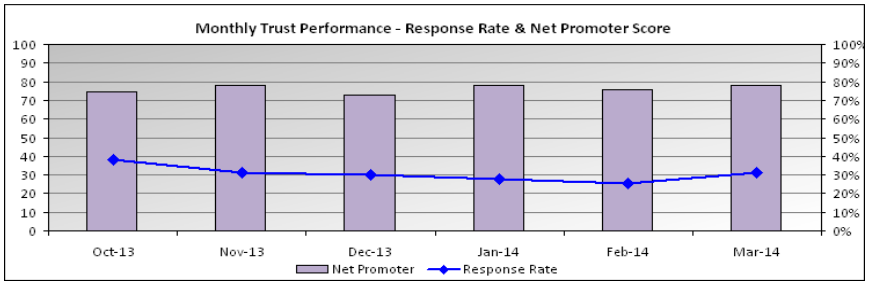
Scarborough:
Willow 19%
Beech 15%
Maple 5%

York:
Ward 24 14%
Ward 28 14%
Ward 23 22%

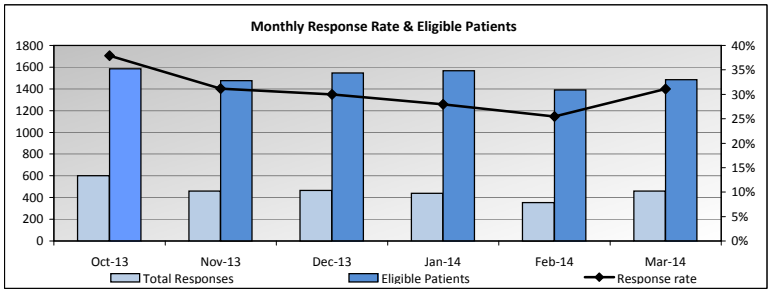
Maternity FFT
The maternity FFT achieved 27.93% in January 2014. The Labour and Birth FFT question will be changed to be asked at the same time following discharge from the postnatal ward. Feedback from women and staff showed that asking the FFT question to a mother following birth was not the most appropriate time. From 1st March, the two questions will be combined on to one FFT card.

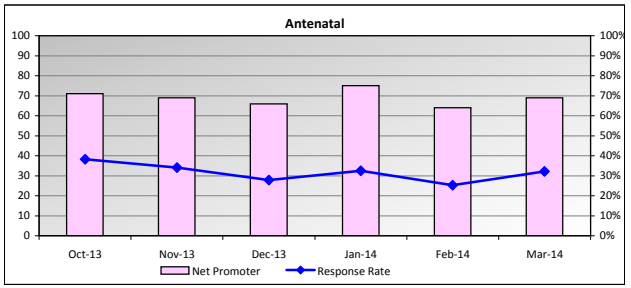
Trust Performance:

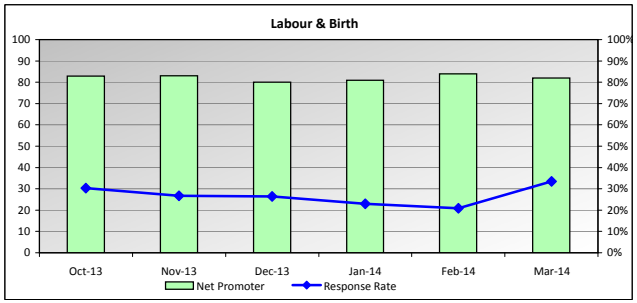
Report Month	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know	Total Responses	Eligible Patients	Response rate	FFT Score
Oct-13	77.37%	19.13%	2.16%	0.83%	0.17%	0.33%	601	1585	37.92%	74
Nov-13	80.00%	17.39%	1.74%	0.43%	0.22%	0.22%	460	1477	31.14%	78
Dec-13	75.43%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

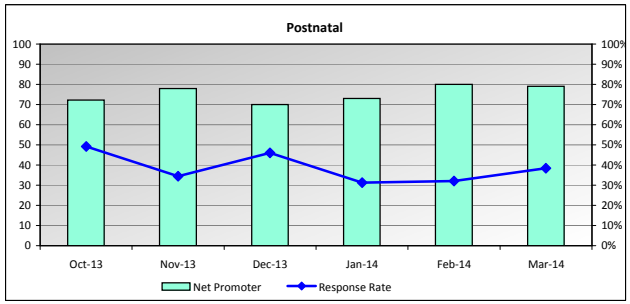


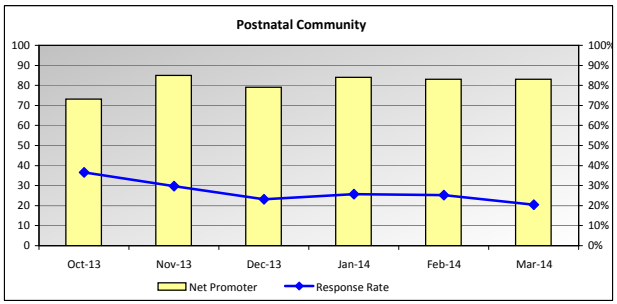
		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Q3	Q4
Total	Response Rate	37.92%	31.14%	30.01%	27.93%	25.47%	31.06%	33.09%	28.21%
	Net Promoter	74	78	73	78	76	78		
Antenatal	Response Rate	38.20%	34.06%	27.79%	32.46%	25.33%	32.11%	33.33%	29.81%
	Net Promoter	71	69	66	75	64	69		
Labour & Birth	Response Rate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











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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 April 2014

Medical Director's Report

Action requested/ recommendation

Board of Directors are requested to:

- note the 'Sign up to Safety' campaign and receive updates on progress in future reports
- receive the monthly Antibiotic Prescribing Audit Results for March 2014
- receive the HCAI Annual Summary for 2013/14.

Summary

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

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

Implications for equality and diversity

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	This report is only written for the Board of Directors.
Risk	No additional risks indicated other than those reported on the ‘Risk Register’ item.
Resource implications	None identified
Owner	Dr Alastair Turnbull, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	17th April 2014
Version number	1

Board of Directors – 30 April 2014

Medical Directors Report

1. Introduction

In the report this month:

- 'Sign up for Safety' campaign
- Consultant Appointments
- Monthly Antibiotic Prescribing Audit Results for March 2014
- HCAI Annual Summary.

1. 'Sign up for Safety'

On 28th March, the Secretary of State for Health launched the 'Sign up for Safety' campaign which aims to halve avoidable harm and save up to 6,000 lives in next 3 years.

Each NHS organisation will be invited to 'Sign up to Safety' and set out publicly their ambitious plans for reducing avoidable harm, such as medication errors, blood clots and bed sores over the next three years. The NHS Litigation Authority, which indemnifies trusts against law suits, has agreed to review the plans and, when approved, reduce the premiums paid by all hospitals successfully implementing them.

Hospitals are now being approached to pledge their support to the movement and all trusts will receive an invitation to join over the next few months.

Other plans to improve patient safety as part of the 'Sign up for Safety' package include:

- Consulting on the threshold for duty of candour to include significant harm, as part of the Care Quality Commission's (CQC) registration requirements (as recommended by the Dalton-Williams review)
- Recruiting 5,000 safety champions as local change agents, identifying where there is unsafe care and developing solutions to fix it
- Creating a new Safety Action for England (SAFE) team that will consist of senior clinicians, managers and patients with a proven track record in tackling unsafe care. They will ensure that fast, flexible and intensive support is available where it is needed most
- Launching a dedicated section of the NHS Choices website in June called 'How Safe is my Hospital'. The online tool will give everyone the ability to compare hospitals in England across a range of patient safety indicators
- Developing new reliable measures of avoidable hospital death rates and severe harm.

2. Consultant appointments

There were no Consultants who commenced employment in the Trust in March.

3. Monthly Antibiotic Prescribing Audit Results for March 2014

Elderly Medicine – York: Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded			% antibiotics prescriptions with DURATION / review date recorded		
	Jan '14	Feb '14	Mar '14	Jan '14	Feb '14	Mar '14
23	**56%**	**75%**	**88%**	**67%**	**75%**	**100%**
24	**80%**	**75%**	**100%**	**80%**	**75%**	**100%**
25	**100%**	**100%**	**80%**	**0%**	**67%**	**70%**
26	**80%**	**100%**	**100%**	**60%**	**100%**	**100%**
35	**n/a**	**75%**	**100%**	**n/a**	**100%**	**100%**
37	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
39	**25%**	**n/a**	**100%**	**25%**	**n/a**	**100%**
ASU	**100%**	**n/a**	**100%**	**100%**	**n/a**	**100%**

Hosp average	58%	72%	70%	58%	75%	72%
Trust average	68%	76%	70%	68%	74%	72%

Elderly Medicine – Scarborough: Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded			% antibiotics prescriptions with DURATION / review date recorded		
	Jan '14	Feb '14	Mar '14	Jan '14	Feb '14	Mar '14
Ann Wright	**100%**	**100%**	**67%**	**100%**	**100%**	**67%**
Oak	**91%**	**100%**	**80%**	**100%**	**100%**	**80%**
Stroke	**100%**	**33%**	**n/a**	**100%**	**100%**	**n/a**

Hosp average	78%	82%	69%	77%	72%	73%
Trust average	68%	76%	70%	68%	74%	72%

General Surgery & Urology and Obstetrics & Gynaecology – York: Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded			% antibiotics prescriptions with DURATION / review date recorded		
	Jan '14	Feb '14	Mar '14	Jan '14	Feb '14	Mar '14
11	**83%**	**90%**	**100%**	**100%**	**90%**	**100%**
14	**0%**	**45%**	**100%**	**67%**	**86%**	**100%**
16	**33%**	**75%**	**40%**	**33%**	**75%**	**60%**
G1	**0%**	**80%**	**25%**	**67%**	**60%**	**25%**

Hosp average	58%	72%	70%	58%	75%	72%
Trust average	68%	76%	70%	68%	74%	72%

General Surgery & Urology and Obstetrics & Gynaecology – Scarborough: Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded			% antibiotics prescriptions with DURATION / review date recorded		
	Jan '14	Feb '14	Mar '14	Jan '14	Feb '14	Mar '14
Ash	**n/a**	**50%**	**n/a**	**n/a**	**0%**	**n/a**
Haldane	**75%**	**75%**	**100%**	**71%**	**88%**	**100%**
Maple	**54%**	**47%**	**47%**	**38%**	**53%**	**67%**

Hosp average	78%	82%	69%	77%	72%	73%
Trust average	68%	76%	70%	68%	74%	72%

Head & Neck – York: Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded			% antibiotics prescriptions with DURATION / review date recorded		
	Jan '14	Feb '14	Mar '14	Jan '14	Feb '14	Mar '14
15	**44%**	**40%**	**44%**	**56%**	**67%**	**89%**

Hosp average	58%	72%	70%	58%	75%	72%
Trust average	68%	76%	70%	68%	74%	72%

Medicine – York: Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded			% antibiotics prescriptions with DURATION / review date recorded		
	Jan '14	Feb '14	Mar '14	Jan '14	Feb '14	Mar '14
32	**57%**	**100%**	**100%**	**71%**	**100%**	**100%**
33	**17%**	**92%**	**50%**	**50%**	**85%**	**67%**
34	**33%**	**50%**	**65%**	**53%**	**50%**	**60%**
AMU	**70%**	**83%**	**83%**	**50%**	**33%**	**44%**
CCU	n/a	n/a	**100%**	n/a	n/a	**100%**
SSW (21)	**92%**	**91%**	**100%**	**92%**	**82%**	**100%**
31	**29%**	**75%**	**88%**	**43%**	**63%**	**50%**

Hosp average	58%	72%	70%	58%	75%	72%
Trust average	68%	76%	70%	68%	74%	72%

Medicine – Scarborough: Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded			% antibiotics prescriptions with DURATION / review date recorded		
	Jan '14	Feb '14	Mar '14	Jan '14	Feb '14	Mar '14
AMU	**87%**	**100%**	**73%**	**80%**	**100%**	**60%**
Beech	**71%**	**95%**	**64%**	**71%**	**73%**	**64%**
CCU	**80%**	**100%**	**100%**	**60%**	**33%**	**100%**
Chestnut	**79%**	**100%**	**88%**	**57%**	**0%**	**88%**
Graham	**100%**	**86%**	**100%**	**100%**	**71%**	**100%**
Willow	**67%**	**100%**	**n/a**	**100%**	**25%**	**n/a**

Hosp average	78%	82%	69%	77%	72%	73%
Trust average	68%	76%	70%	68%	74%	72%

Orthopaedics & Trauma – York: Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded			% antibiotics prescriptions with DURATION / review date recorded		
	Jan '14	Feb '14	Mar '14	Jan '14	Feb '14	Mar '14
28	**38%**	**80%**	**30%**	**31%**	**100%**	**70%**
29	**67%**	**100%**	**100%**	**67%**	**100%**	**100%**

Hosp average	58%	72%	70%	58%	75%	72%
Trust average	68%	76%	70%	68%	74%	72%

Orthopaedics & Trauma – Scarborough: Results by ward

Ward	% antibiotic prescriptions with INDICATION recorded			% antibiotics prescriptions with DURATION / review date recorded		
	Jan '14	Feb '14	Mar '14	Jan '14	Feb '14	Mar '14
Aspen	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Holly	**33%**	**82%**	**29%**	**33%**	**82%**	**57%**

Hosp average	78%	82%	69%	77%	72%	73%
Trust average	68%	76%	70%	68%	74%	72%

4. HCAI Annual Summary

Health care acquired infections attributed to York Teaching Hospitals NHS Foundation Trust:

MRSA bacteraemia

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Attributed to York sites*	0	0	0	1	0	0	0	0	0	0	0	0	1
Attributed to Scarborough sites*	0	0	0	0	1	0	0	0	0	0	0	0	1
Total Trust	0	0	0	1	1	0	0	0	0	0	0	0	2

MSSA bacteraemia

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Attributed to York sites	1	3	4	1	2	2	0	1	1	1	1	3	20
Attributed to Scarborough sites	1	0	1	2	1	1	0	3	0	1	4	1	15
Total Trust	2	3	5	3	3	3	0	4	1	2	5	4	35
Trust threshold	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	30
Accumulated Trust threshold	2.5	5	7.5	10	12.5	15	17.5	20	22.5	25	27.5	30	30

Ecoli bacteraemia

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Attributed to York sites	4	6	5	3	6	11	6	7	5	9	7	7	76
Attributed to Scarborough sites	2	0	1	3	3	1	6	3	6	1	0	6	32
Total Trust	6	6	6	6	9	12	12	10	11	10	7	13	108

Clostridium difficile (toxin positive)

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Attributed to York sites	6	3	7	2	2	1	4	4	5	1	6	2	43
Attributed to Scarborough sites	1	2	2	2	4	1	1	4	3	0	2	2	24
Total Trust	7	5	9	4	6	2	5	8	8	1	8	4	67
York threshold	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	2.16	26
Scarborough threshold	1.41	1.41	1.41	1.41	1.41	1.41	1.41	1.41	1.41	1.41	1.41	1.41	17
Trust threshold	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	43
Accumulated Trust threshold	3.6	7.2	10.8	14.4	18	21.6	25.2	28.8	32.4	36	39.6	43	43

York sites* includes York, Malton, Selby, St Monicas and Whitby hospitals and community care units
Scarborough sites* includes Scarborough and Bridlington.

4. Recommendations

Board of Directors are requested to:

- note the 'Sign up to Safety' campaign and receive updates on progress in future reports
- receive the monthly Antibiotic Prescribing Audit Results for March 2014
- receive the HCAI Annual Summary for 2013/14.

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**16 April 2014**

C3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 April 2014

Chief Nurse Report – Quality of Care

Action requested/recommendation

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

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	Executive Board.
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Michael Proctor, Chief Nurse
Author	Beverley Geary, Director of Nursing
Date of paper	March 2014
Version number	Version 1

Board of Directors - 30 April 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
-

The implementation plan for year two of the strategy has been agreed and the Senior Nursing team will be working with clinical teams to determine local priorities. Matrons will report upon progress within their areas and the delivery of local action plans will be monitored through the Nursing Board.

2. Senior Nursing restructure

As reported in previous Chief Nurse reports; in order focus senior nursing roles in the delivery of quality care for patients a significant restructure of senior nursing roles has been undertaken. The new Matron team in now in post, however due to vacancies following a robust selection process a number of gaps still exist, in order to mitigate any risk interim measures have been put in place.

All vacancies will be advertised nationally within the next week or so and it is anticipated that selection process will begin at the end of April.

The new Matron team have begun a development programme to establish them in their new role. The programme will focus upon patient experience and quality of care and include training in skills such as RCA investigation.

Individual personal development plans will be agreed in order to support the team and facilitate continuous improvement.

3. Safer Staffing Project

How to Ensure the right people, with the right skills, are in the right place at the right time.

As part of the nursing and Midwifery strategy and in line with recent national guidance a Safer Staffing Project has been established to assess compliance against recommendations, implement any required changes, ensure 6 monthly acuity audits are undertaken and to review any systems and processes that are currently in place to ensure clinical areas have safe staffing levels.

An assessment of compliance, action plan and actions to date is detailed in a separate report.

4. Medicines Management

Compliance
All acute medical wards, community units and the majority of surgical wards have had a full compliance inspection. Themes for improvement are safe and secure storage of medicines, knowledge of standard operating procedures for controlled drugs and staff not being up to date with medicines management statutory and mandatory training.

The lead nurse medicines management will be delivering a presentation to the senior nurses at the Professional Nurse Leaders Forum to address the issues identified. Each individual ward also has an action plan for improvement.

Non medical prescribing
Declaration of competence for non medical prescribers is a national requirement, in line with this the Trust requires all non medical prescribers to declare competence on an annual basis. This request is issued in February for submission by the end of March.

The response rate, this year has been high with 104 responding in the required time frame there are a small number outstanding. The medicine management nurse is working through the review of each response to ensure safe practice is being continued. NMP/PGD group have discussed and agreed a process to manage the outliers.

Statutory and mandatory training
Overall uptake for medicines management training for the year to January 2014 has been poor (22%).

Face to face sessions have been delivered in Scarborough since May 2013.
The current Medicines Management programme has undergone a major review and is currently being developed into an e-learning package that will be uploaded to the new HUB system. It is hoped that this will increase uptake. In addition, a task and finish group has been established to review all Statutory and Mandatory training undertaken by the nursing workforce (Registered or non registered) it is anticipated that changes the requirement of training will achieve better compliance and uptake.

5. Open and Honest Care

It was agreed at March Board of Directors that the Trust should adopt the Open and Honest Care initiative. As a result; and in order to ensure a state of readiness a Task and Finish group was established with key stakeholders to identify and gaps and to address the following issues:

1. Establish the process for gathering the 7 routine patient experience questions
2. Put in place a process for asking 3 questions, from 5 staff at the time harm occurs. (This needs to include how this will be achieved out of hours.)
3. Training for appropriate staff will need to be agreed and delivered.
4. Modification of Root Cause Analysis tools to include staffing questions in terms of planned and actual staffing levels for the 24 hour period preceding the point that harm was identified. The processes for ensuring wards have this information available will need to be embedded.
5. An agreement on internal processes for validating data, which will also require a review of Trust timelines in order to meet both the Trust's and the Open and Honest programme's deadlines each month.
6. Nomination of 2 individuals to upload data to the publish on site each month.
7. Identify a process to agree an improvement story each month.
8. Agree Communication plan; internal and external.

The group met in April and an action is being developed to address the gaps as identified

above – in order that our internal processes meet with the deadlines for publication of Open Honest Care. As advised by the North of England project lead, an internal pilot – which will be presented to the Board of Directors, will begin in June, this will provide the Board with an example of the final document and ensure approval of the compact is signed off.

6. Midwifery

Maternity services - 3/4th degree tears

At a recent Quality and Safety Committee meeting and some scrutiny of the Midwifery dashboard; questions were raised regarding about the number of 3 & 4 degree tears.

A multidisciplinary group formed in Maternity services in May 2013 to specifically look at 3rd and 4th degree tear rates following receipt of a letter from the Royal College of Obstetricians and Gynaecologists (RCOG) in April 2013.

It had also been and discussed within the Directorate previously as the rates of 3/4th degree tears were higher than expected on the Maternity dashboard on the York site.

The RCOG letter addressed to Clinical Directors detailed 11 intrapartum indicators derived from Hospital Episode Statistics (HES) data 2011/12. This data showed 3/4th degree tear rates to be higher than the national mean on the York site in all groups and for Scarborough site it showed lower than the national mean for unassisted births and higher for assisted birth.

The multidisciplinary group meet bi monthly and consists of an Obstetrician and senior Midwives/Supervisors of Midwives and risk managers from each site with an aim to;

- Review current practice
- Identify trends and training needs
- Review reporting of tears to see if they are comparable to HES data
- Form an action plan and share any good practice

Data and case reviews;

- From June 2013 we use the same indicators as HES to ensure our statistics are comparable
- Weekly multidisciplinary review of all 3/4th degree tears at risk meeting
- Included in daily multidisciplinary handover meeting on Labour Ward
- Recorded as part of the monthly incident summary
- Presented for discussion at O&G Clinical Governance and Labour Ward Forum
- Documented monthly on the maternity dashboard

A number of initiatives' to reduce 3/4th degree tears have been introduced into midwifery practice including a professional reflection on practice following a 3/4th degree tear completed by the practitioner. A proforma for this has been developed and is reviewed by the Labour ward lead to identify any themes.

A theme identified is when women are transferred to Labour Ward when in advanced labour they seem less able to listen to instructions and be in control of their body.

- Survey of midwifery practice in relation to perineal care in labour, episiotomy experience and practice including different birth positions was devised by the Matrons for all Midwives to complete.

The results of this were;

- No practice issues identified with care of perineum in second stage of labour
- Experience, confidence and knowledge of episiotomy variable

Actions taken from this survey are;

- Education on Maternity mandatory training to include episiotomy, recognition of 3/4th degree tears and repair of perineal trauma
- Poster developed and displayed on Labour Wards re episiotomy practice
- Multidisciplinary training DVD to illustrate diagnosis and repair of 3/4th degree tears

Whilst last May (2013) the monthly rates of 3/4th degree tears were higher than the national mean, numbers have reduced data will be pulled from HES data this will be published by each Trust. The local group continues to meet and monitor rates. The Board will receive updates in future reports.

7. Patient Experience

Patient Experience Review
As previously reported a full review of the Patient Experience Team (PET) has been commissioned. This aims to examine the current function of the team, establish the focus given to patient involvement, the processes around complaints management and the provision of training in all aspects of PPI. In addition, a PPI strategy will be developed with implementation plan.

Update:
A gap analysis has been completed regarding training and education and whether complaint responders/investigators have the received appropriate training to support the PE agenda. The results have been collated and shared at the Patient Experience Steering Group meeting the next step is to examine what training exists and to develop the appropriate training for different staff groups.

A listening exercise has been undertaken with the whole team to gain their opinion and insight into development that may be needed, the data is currently being collated and themes will be identified. Contact with other organizations is being made in order to share best practice and learn.

On completion of the background work an action plan will be developed with key risks, recommendations and next steps. This will be presented to the Board of Directors' for approval.

Annual update
complaints:
A total of 687 complaints were received and investigated by the Trust during 2013/14 compared to 603 received during 2012/13. The figure of 687 includes 123 complaints resolved outside the procedure in accordance with the 2009 Complaints Regulations.

During 2013/14, 14 complainants were accepted by the Ombudsman for review on completion of the Trust's investigation. Following review and or investigation by the Parliamentary Health Service Ombudsman (PHSO), two complaints were partly upheld, two complaints were not upheld. We are still awaiting the outcome of the Ombudsman's review for the remaining 10 complaints. Overview and themes of these cases will be presented to the Patient Experience Steering Group.

Compliments:
A total of 6875 positive patient feedback was recorded by the Patient Experience Team across the whole Trust, in the form of letters, cards and emails. The following comments are typical of those expressed by many patients:

Mr F wrote “At a time when the NHS in general and the hospitals in particular are presented so negatively in the Press and the Media I write this letter as a token of my thanks and gratitude to your Hospital for the excellent care and attention I received…From the moment of arrival…I was treated with the utmost courtesy and had the most excellent clinical, medical and nursing care.”

During 2013/14, there was no significant change in the number of registered complaints; however we have seen an increase in the number of complaints handled outside procedure. This demonstrates prompt and effective handling of appropriate concerns and follows the good practice advocated by the Care Quality Commission and the Parliamentary Health Service Ombudsman, and commented on in the Clywd Report. There has been an increase overall in the number of patients and users contacting PALS, this follows annual upward trends.

Patient Surveys
The results of all the Trust’s Annual Surveys have been generally positive. In particular the results of the National Inpatient and Cancer Surveys were very encouraging. We are pleased to report and significant improvement in patients being asked to give their views on the quality of their care.

The Friends and Family Test continues to be rolled out in line with Department of Health guidance. In general the response rates meet the current requirements, and work continues in the FFT steering group to increase areas of low response.

Work during 2014/15 will build on that already undertaken, focusing on ensuring lessons are learned from both complaints and concerns, as well as seeking assurance that all actions have been undertaken. In addition, work will continue to ensure learning from complaints and from other sources of feedback such as the real time surveys, our patient and user groups, and from our staff in order to enhance the patient experience.

A detailed annual Patient Experience report will be presented to Board of Directors in April.

8. Recommendation

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

Author	**Beverley Geary, Director of Nursing**
Owner	**Michael Proctor, Chief Nurse**
Date	**April 2014**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 April 2014

Safer Staffing Project

Action requested/recommendation

The Board are asked to receive the report on progress to achieving the recommendations from Hard Truths and the expectation of The National Quality Board in relation to getting Nursing and Midwifery staffing right.

Summary

There are established and evidenced links between patient outcomes and whether organisations have the right people, with the right skills, in the right place at the right time. Compassion in Practice emphasised the importance of getting this right. The publication of the report of the Mid-Staffordshire NHS Foundation Trust Public inquiry, and more recent reviews by Sir Bruce Keogh, Don Berwick's review into patient safety and the Cavendish review into the role of healthcare assistants and support workers also highlight the risks to patients of not taking the issue of safe staffing seriously.

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

Outcome 13

Progress of report	This report is only written for the Board of Directors.
Risk	No risk
Resource implications	No resource implications
Owner	Michael Proctor, Chief Nurse
Author	Beverley Geary, Director of Nursing
Date of paper	April 2014
Version number	Version 1

Board of Directors – 30 April 2014

Safer Staffing Project

1. Introduction and background

There are established and evidenced links between patient outcomes and whether organisations have the right people, with the right skills, in the right place at the right time. Compassion in Practice emphasised the importance of getting this right. The publication of the report of the Mid-Staffordshire NHS Foundation Trust Public inquiry, and more recent reviews by Sir Bruce Keogh, Don Berwick's review into patient safety and the Cavendish review into the role of healthcare assistants and support workers also highlight the risks to patients of not taking the issue of safe staffing seriously.

There has been much discussion and debate about defining staffing ratios in the NHS howeve, there is no single ratio or formula that can calculate the answers to complex questions as the right answer will differ across and within organisations. Reaching the answer requires the use of evidence, evidence based tools and the exercise of professional judgement. Above all, it requires openness and transparency, within organisations and with patients and the public.

To aid organisations to make decisions using tools, resources and examples of good practice the NHS England Chief Nursing Officer, Jane Cummings, along with the National Quality Board has developed guidance that sets out expectations of commissioners and providers in relation to getting nursing, midwifery and care staffing right. The expectation is that all organisations should be meeting these currently or taking active steps to ensure that they do within a prescribed timeframe.

The guidance is set out in 10 core expectations in respect of getting nursing and midwifery care staffing right. It also provides practical advice on how each expectation can be met.

In order to address the recommendations a Safer Staffing Project has been established to assess compliance with the guidance, implement any changes that may be required, ensure acuity audits are undertaken and to review any systems and processes that are in place.

This paper outlines progress against the 10 expectations and gives some insight into the ongoing work to ensure that the right staff are in the right place at the right time.

2. Getting the right Staff in the Right Place at the Right Time

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

In April 2014 a letter was sent to all CEO's and Chief Nurses from Sir Mike Richards, Chief Inspector of Hospitals (CQC) and Jane Cummings, Chief Nursing Officer for England which issued clear guidance from*, Hard Truths: The Journey to Putting Patients First* , these are associated with publishing staffing data regarding nursing, midwifery and care staff.

A timetable of actions is attached at appendix 1 and the expectation is that all organisations

will adhere to the guidance in a staged approach however there are a number of milestones in the first phase, which will focus on all inpatient areas; including acute, community, mental health, maternity and learning disability. These are listed below:

- A Board report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible. To be presented to the Board every six months

- Information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level

- A Board report containing details of planned and actual staffing on a shift-by-shift basis at ward level for the previous month. To be presented to the Board every month.

- The monthly report must also be published on the Trust's website, and

Trusts will expected to link or upload the report to the relevant hospital(s) webpage on NHS Choices

The commitments are to publish staffing data from April 2014 and at the latest, by the end of June 2014.

Two stock-takes of progress will be undertaken to establish where all organisations are against the recommendations, these will be as follows:

	Date issued	**Date to be returned**
Stock-take 1	23rd April 2014	30th April 2014
Stock-take 2	28th May 2014	6th June 2014

These will require minimal data input however, future CQC inspections will require evidence of full compliance within the prescribed timeframes.

Boards are required to, at any point in time, be able to demonstrate that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient to provide safe care.

In order to establish priorities and identify gaps in compliance a gap analysis of the 10 expectations was undertaken by some of the Chief Nurse team, this was presented to the Nursing Board In March 2014.

3. Conclusion

The commitment to publish staffing levels in ward areas and at public board meetings will be mandated no later than June 2014, a significant amount of work has been undertaken to ensure that we are compliant with all recommendations within the prescribed timeframes.

4. Recommendation	
The Board are asked to receive the report on progress to achieving the recommendations from Hard Truths and the expectation of The National Quality Board in relation to getting Nursing and Midwifery staffing right.	
5. References and further reading	
Hard Truths: The Journey to Putting Patients First, **Department Of Health, January 2014** How to ensure the right people, with the right skills are in the right place at the right time: *A guide to nursing, midwifery and care staffing capacity and capability,* **National Quality Board, November 2013.**	
Author	**Beverley Geary, Director of Nursing**
Owner	**Michael Proctor, Chief Nurse**
Date	**April 2014**

Hard Truths Commitments Regarding the Publishing of Staffing Data

Timetable of Actions

	Action Required by Trusts:	By When:	Periodicity:	National Quality Board Expectation(s):	Further Guidance:
A	The Board receives a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in NQB report page 12 and reflects a realistic expectation of the impact of staffing on a range of factors. This report: • Draws on expert professional opinion and insight into local clinical need and context • Makes recommendations to the Board which are considered and discussed • Is presented to and discussed at the public Board meeting • Prompts agreement of actions which are recorded and followed up on • Is posted on the Trust's public website along with all the other public Board papers	June 2014	Every Six Months	1, 3 and 7	NQB pages 12, 18-22 and 42

B	The Trust clearly displays information about the nurses, midwives and care staff present and planned in each clinical setting on each shift. This should be visible, clear and accurate, and it should include the full range of patient care support staff (HCA and band 4 staff) available in the area during each shift. It may be helpful to outline additional information that is held locally, such as the significance of different uniforms and titles used. To summarise, the displays should: • Be in an area within the clinical area that is accessible to patients, their families and carers • Explain the planned and actual numbers of staff for each shift (registered and non-registered) • Detail who is in charge of the shift • Describe what each member of the team's role is • Be accurate	From April and by June 2014 at the latest	Each shift	8	NQB pages 48-51
C	The Board: • Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis • Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap • Evaluates risks associated with staffing issues • Seeks assurances regarding contingency planning, mitigating actions and incident reporting • Ensures that the Executive Team is supported to take	From April and by June 2014 at the latest	Monthly	1 and 7	NQB pages 12, 13 and 45

	decisive action to protect patient safety and experience • Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website).				
D	The Trust will ensure that the published monthly update report specified in Row C [i.e. the Board paper on expected and actual staffing] is available to the public via not only the Trust's website but also the relevant hospital(s) profiles on NHS Choices. The latter can be achieved either by placing a link to the report that is hosted on the Trust website on the relevant hospital(s)' newsfeed on their NHS Choices webpage or by uploading the relevant document to the relevant hospital(s)' NHS Choices newsfeed. For Trusts with multiple hospital sites that have their own NHS Choices webpages, this will require the separate posting of the Trust Board report to each hospital newsfeed. However, this is likely to reach more patients given that patients tend to review hospital, not Trust, NHS Choices webpages. This approach will also allow you to highlight hospital-specific plans and achievements, which may be of particular interest to a public audience. Given these requirements, the update reports should be written in a form that is accessible and understandable to patients and the public. This is likely to include ensuring that the information on staffing is not embedded within hundreds	By June 2014	Monthly	1 and 7	

	of pages of other Board papers. Your own NHS Choices web editor(s), who already provide your Trust and hospital-specific content to NHS Choices, will be able to advise you further on their preferred mechanism for making these documents available on NHS Choices – either via a link or by uploading a .pdf of the Board paper. NHS Choices will also be liaising directly with each Trust's web editors with further information.				
E	The Trust: • Reviews the actual versus planned staffing on a shift by shift basis • Responds to address gaps or shortages where these are identified • Uses systems and processes such as e-rostering and escalation and contingency plans to make the most of resources and optimise care	Immediate	Each Shift	2	NQB pages 16 and 17

C4

York Teaching Hospital NHS

NHS Foundation Trust

Annual Report of the Quality & Safety Committee

April 2014

Introduction

The Committee is a committee of the Board and provides assurance to the Board on the quality and safety aspects of the Trust's performance. The Committee also reviews information in more detail to ensure there is an understanding of the initiatives in place in the organisation and how they help the organisation to delivery its quality and safety objectives and ongoing strategies.

Overview of the year 13/14

The Committee has met 10 times during the year. The Committee includes membership from:
Ms L Raper, Chairman of the meeting, Non-executive Director
Mrs J Adams, Non-executive Director
Mr P Ashton, Non-executive Director

Mr Ashton joined the Committee in June 2013. He was previously a member of the Finance and Performance Committee.

There are a number of officers who attend the Committee on a regular basis, for financial year 2013/14 they include:

Dr A Turnbull, Medical Director
Ms E McManus, Chief Nurse (until October 2013)
Mrs B Geary, Director of Nursing (from October 2013)
Mrs A Pridmore, Foundation Trust Secretary

Ms D Palmer, Deputy Director of Patient Safety has attended the meetings on some occasions when she has been able to provide additional assurance to the members of the Committee on patient safety aspects.

Dr K Mainprize, Deputy Medical Director has attended when Dr Turnbull has been unavailable to attend the meeting.

Attendance at the Committee during the last year is as follows

The Non-executive Directors met in December 2013 to discuss the

Name	Attendance
Ms Raper	10/10
Mrs Adams	10/10
Mr Ashton	5/8
Dr Turnbull	7/10
Ms McManus	6/6
Mrs Geary	4/5
Mrs Pridmore	7/10

relationship between the Quality and Safety Committee, Finance and Performance Committee, Workforce Strategy Committee, Audit Committee and Nominations Committee. The meeting reflected on any shared agenda items and considered the assurance framework. The meeting agreed which assurance items would be attached to which committees.

The Terms of Reference for the Committee requires the Committee to consider a number of reports during the year including performance metrics, Chief Nurse information and Medical Director information at each meeting. The Committee also considers the Quality Report on a quarterly basis and considers the draft annual report and the Quality Governance Framework

Work of the Committee

During the year the Committee has considered the following:

a) Performance information

The Trust has been developing an information booklet that provides a concise set of data that the Committee uses to understand the performance of the Trust on a quality and safety basis. Additionally and supporting this information the Chief Nurse and Medical Director provide supplementary information.

During the year the Quality and Safety Committee has raised concerns around C-Diff, CQUIN targets, mortality measure, Serious Incident reporting following the internal Audit Report, Family and Friends, PROMs and VTE assessment.

b) Chief Nurse information

The Chief Nurse and Director of Nursing reports have provided additional supporting information about quality processes employed in the organisation.

✓ **Nursing and Midwifery Strategy –** the strategy was approved by the Board of Directors during the year. The Board requested the Quality and Safety Committee to regularly review the implementation plan associated to the strategy. The Committee has seen the document on a quarterly basis. Regular assurance has been given to the Board on the progress of implementation.

✓ **Nursing Care Indicators –** the Committee has reviewed the indicators on a regular basis as part of both the Chief Nurse Report and performance booklet. At the February meeting the Director of Nursing advised that the Trust would not be using Nursing Care Indicators any longer and these would be replaced by the Quality, Effectiveness and Safety Trigger Tool which identifies the potential for deteriorating standards in the quality of care delivered in a defined area, usually a Ward or Clinical Team.

✓ **End of Life Care –** This item was brought to the Committee by both the Chief Nurse and Medical Director. The Committee discussed the effect of not continuing to use the Liverpool Care Pathway and it was recognised that a new system would need to be introduced. The Committee has received information on the development and the Board has received a presentation on the end of life care pathway. The Council of Governors have also received a presentation on the revised approach to end of life care. This element of care is now executively led by the Medical Director.

✓ **Pressure ulcer plan –** The Director of Nursing has regularly updated the Committee on the progress of the implementation and the effectiveness of the plan. The Committee has updated the Board regularly on progress and the requirement for continued vigilance in this area. The Committee continues to keep a focus on this area.

✓ **Senior nurse restructuring and nurse staffing –** this topic was picked up in part by the Workforce Strategy Committee and reported to the Board through that Committee. The Director of Nursing described the senior nurse restructuring and the Committee have kept the Board informed of progress. This has been further strengthened by additional presentations given to the Board of Directors.

✓ **Patient experience –** the Chief Nurse and Director of Nursing report has provided information about patient experience. This information has been shared with the Board as part of the assurance process.The Committee raised concerns over the Trusts depth of learning from complaints, and has welcomed the work to better understand this in the context of the broader review of Patient Experience.

✓ **Maternity services –** the Committee raised concerns about the services during the year and have received detailed updates on the delivery of maternity services. These updates have provided the Committee with assurance around the delivery of services. The Board received assurance through the Committee.

✓ **National reports including Francis, Clwdd-Hart, Berwick –**the Director of Nursing provided updates on the national reports and a summary of the impact on the Trust from the findings included in the reports. The Committee challenged the visibility of the Trusts learning from the Francis Report, whilst having received assurance around key recommendations. The Committee continues to seek evidence of learning as part of its review of the reports it receives on a monthly basis.

✓ **Mental Health services –** the Director of Nursing is specifically trained in mental health services. This has helped the Trust continue to develop the relationship with Leeds and York Partnership NHS Foundation Trust. Both the Medical Director and the Director of Nursing have worked together during the year to progress the introduction of an acceptable model of care and gain an understanding of how psychiatric liaison can be provided in an affordable way. This issue has appeared on the Corporate Risk Register for sometime with little progress. This year progress has been made through the discussions held by the Medical Director and Director of Nursing with the Commissioners and the service provider. The Committee has been kept up to date with progress and has provided assurance to the Board. The issues have not been fully resolved as yet and further discussions and work will need to be completed over the next financial year.

✓ **Nursing documentation review –** this review was begun early in the year and the Chief Nurse, supported by the Corporate Nursing team, undertook a review and, as a result, amendments to nursing documentation were put in place. The Quality and Safety Committee requested updates during the progress of the review and were updated on the progress since implementation later in the year. The Committee passed on the assurance they had received to the Board of Directors.

✓ **Friends and Family test –** the Chief Nurse, before she left the Trust and now the Director of Nursing have regularly updated the Committee on the progress of the test. The Committee noted initially that there were issues with the introduction of the Test. The Committee has received assurance and provided that assurance to the Board that the results of the Friends and Family tests have been progressing and improving. The Committee will continue to keep it under review.

✓ **Child protection training -**The Director of Nursing has presented this item to the Committee and highlighted the challenges that exist. Updates have been received by the Committee and assurance has been provided to the Board.

✓ **Advanced Clinical Practitioners –** the Trust introduced Advanced Clinical Practitioners earlier this year. The Committee discussed the quality and safety value of their introduction. The Committee provided assurance to the Board on the use of a model of care that used Advanced Clinical Practitioners.

✓ **Elimination of mixed sex accommodation –** the national expectation has for a number of years been the elimination of mixed sex accommodation. The Chief Nurse and the Director of Nursing more latterly have updated the Committee on the rare occasions during the year where this elimination has failed. The Board has also been advised and received assurance about the reasons for the incident.

✓ **CQC inspections -** the CQC visited both Scarborough and York hospital sites during the year. The report from York demonstrated that the

CQC were satisfied with the areas reviewed. The Scarborough report identified some issues and CQC visited Scarborough hospital on a second occasion and confirmed the actions had been completed satisfactorily. The Board received the reports in public session and the Quality and Safety Committee reviewed the comments in detail.

✓ **Patient safety including falls –** both the Medical Director and the Director of Nursing has reported on falls to the Committee during the year. The Trust has introduced a falls group that works with patients and staff to help prevent falls occurring in hospital. The Medical Director reported to the Committee on the themes that were identified following Root Cause Analysis taking place on each occasion a fall happens. It was agreed during the year that all falls would give rise to a serious incident being reported. The Committee received regular updates and assurance on the progress to reduce the number of falls in hospitals and the attendant additional issues patients experience.

c) Medical Director information

The Medical Director provides additional supporting information about safety processes employed in the organisation including mortality information and Serious Incident information.

✓ **Information Governance –** the Medical Director has presented updates to the Committee during the year on information governance.

✓ **Quality Report updates** – the Committee has received quarterly updates on the achievement of the identified priorities in the report. The Committee will also take the lead in considering the developing Quality Report for 2014/15.

✓ **Flu vaccination –** this year all Trusts were given a target of 75% of all front line staff receiving a flu vaccination. This target was associated to money that would be released to the Trust is future years through the CCG for the support of winter working. The Trust achieved 78% of all front line staff receiving a flu vaccination.

✓ **Keogh Report/ Mortality data –** this report followed on from the Francis enquiry 2 published in February 2013. Professor Sir Bruce Keogh was requested by the Prime Minister in February 2013 to review quality of care and treatment provide by those NHS trusts and NHS foundation trusts that are persistent outliers on mortality indicators. The Committee was provided with a summary of the findings and insight into the inspections as the Medical Director of the Trust was requested to be part of one of the investigations. The Trust was not one of the outlier Trusts, but continued to review the benchmarking data. The Committee received regular information on the mortality indicators including SHMI, RAMI and HSMR. This information has shown that during the year the Trust has improved. One of the Trust's priorities for the Quality Report was to have an HSMR of below 100. This was created as a priority before the acquisition of Scarborough and North East Yorkshire Healthcare NHS Trust and so related only to York. York

as a site achieved this target this year. The Committee continues to keep this under close review.

- ✓ **Never events –** the Trust reported three never events to the Committee during the year. There were two related to retained objects and one was an air-embolism. The Trust undertook an investigation into each of the never events and has provided a final report to the parties involved. The Committee was advised of the events and has been provided with assurance about the actions that have been undertaken to prevent the situation arising again.

- ✓ **Dr Foster –** the Medical Director updated the Board on the work of Dr Foster and the implications for the Trust. The Medical Director also updated the Committee on the work the Trust is engaged with NHSQUEST and CHKS.

- ✓ **Suitcases –** the Committee received regular information about the results of investigations in to serious incidents through the Suitcase documents. These documents were provided to the Board of Directors in private session as they contain confidential information that could identify individual patients.

- ✓ **Consultant appointments –** the Medical Director updated the Committee on the appointments made during the year and demonstrated the benefits of those additional consultants being in post.

- ✓ **Safety Walk rounds –** the Medical Director provided regular information about the walk rounds that occur during the month. The Committee sought assurance that the arrangements for the walk rounds always included an executive director and continues to place importance on these activities.

- ✓ **SI internal Audit Report –** at the end of 2012/13 Internal Audit produced an internal audit report which gave limited assurance to the SI process used in the organisation. Since that report work has been undertaken to ensure the systems are improved and the Medical Director has provided assurance to the Committee that the systems have been developed. It is understood that this is a system that continues to develop as thinking develops around the requirements. The Committee received assurance and continues to seek further dialogue with the Medical Director on the systems in use.

- ✓ **Stroke accreditation –** the Committee was provided with assurance that the Trust had achieved the required accreditation levels both at Scarborough and York during the year. The Committee provided this assurance to the Board and confirmed stroke would continue to be a topic the Committee would keep under review.

- ✓ **Surgical outcomes –** the Medical Director has regularly updated the Committee on surgical outcomes during the year. He has provided assurance to the Committee on the information. This assurance has in turn been passed on to the Board.

- ✓ **Director of Infection Prevention and Control –** Executive responsibility for infection prevention and control moved to the Medical Director when the Chief Nurse left the Trust. The Medical Director has continued to provide the Committee with regular updates on the progress of implementing the Trust's formulary and systems that reduce the number of cases of infection such as C-Diff. The Trust breached its trajectory during the year and the Committee has been keen to understand the work that has been taking place to improve practice across the organisation and understand the reasons for the breach. The Committee has regularly provided updates to the Board.

d) Foundation Trust Secretary

The Foundation Trust Secretary provided information related to governance aspects of the Trust specifically she provided information about the following:

- ✓ **Quality Governance Framework** – The Trust developed the Quality Governance Frameworks during the acquisition of Scarborough and North East Yorkshire Healthcare NHS Trust and it was last approved by the Board in 2012. During this financial year the Committee has reviewed a revised version of the document and recommended that the Board should spend some time reviewing the whole document prior to the Board approving it. This work will take place during April. The Committee will continue to have oversight of the action plan attached to the framework.

- ✓ **Quarterly Quality Report –** The Foundation Trust Secretary has presented a quarterly report to the Committee on progress against the priorities identified in the Quality Report. This information has been underpinned by the various performance reports also received by the Quality and Safety Committee and the Board of Directors.

Meetings for the coming year

The Committee will continue to meet before the Board meeting and work closely with the other Board Committees. The Committee reviews its work programme at every meeting and requests timetable updates to be provided on a regular basis. The Committee will seek to continue to challenge any areas where there is an actual or perceived lack of quality or safety in the organisation and will continue to require assurance on progress of quality and safety initiatives. The Committee will also continue to share its thinking with the other Board Committees to ensure related agendas are considered from a quality and safety perspective.

Conclusion

The Committee has been successful in supporting the Board through the provision of a more detailed focus on key issues of quality and safety. This year, the Committee has given additional focus to the development of strong and consistent data (including that from our community services), the provision of timely intelligence, and the additional understanding that Non-

executive Director engagement across the Trust from scheduled and also unannounced walk rounds brings. The committee welcomes the increasing use of benchmarked and trend data.

We look forward to the refreshed and refocused Patient Experience work across the Trust during 2014/15

Libby Raper Chairman of the Quality and Safety Committee
April 2014

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Director – 30 April 2014

Patient Experience – Complaint, Concerns and compliments - 1 April 2013 to 31 March 2014

Action requested/recommendation

The Board is asked to note the detail in the report and the level of complaints received by the Trust, and to support the on-going work to review the patient experience function and procedures.

Summary

The paper provides a summary of the number of complaints, concerns and compliments that had been received during the year and the developments that have been made during the year in ensuring the Trust responds and learns from the patients' experience.

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 Regulation 19 - Outcome 17

Progress of report	This report was written for the Board of Directors
Risk	No specific risks are identified in the report
Resource implications	Resources implication detailed in the report
Owner	Beverley Geary, Director of Nursing
Author	Wendy Brown, Lead Nurse for Patient Experience
Date of paper	April 2014

Board of Director – 30 April 2014

Patient Experience – Complaint, Concerns and compliments - 1 April 2013 to 31 March 2014

1. Introduction and background

The Trust has an integrated Patient Experience Team (PET) to manage and handle complaints, concerns and feedback in accordance with its complaints policy.

The Patient Experience Team comprises 10.8 WTE staff (Head of Patient Experience, Patient and Public Involvement Specialist, Patient Experience Team Leader, Complaints Officers and PALS Officers as well as administrative support), plus the Lead Nurse for Patient Experience. The Lead Nurse for Patient Experience is responsible for the day to day operational management of the team, while the Director of Nursing has executive responsibility.

The functions of the Patient Experience team are:

- The management of complaints in accordance with the NHS Complaints Procedure
- Operation of the Patient Advice and Liaison Service (PALS)
- Coordination and management of Patient and Public Involvement activity (PPI)

This report covers each of these functions.

2. The Patient Experience Team Functions

Concerns and Complaints

This report details the nature and number of complaints and concerns received and managed by the Trust during 2013/14. We have declared compliance with CQC Regulation 19 - Outcome 17.

Data collection and analysis

Both complaints and PALS data are entered onto the Trust's Datix reporting system. As well as recording the number of formal complaints and PALS contacts, a vast amount of qualitative data are entered into the data set, as follows:

- the nature of concerns reported,
- evidence of actions undertaken and resulting outcomes arising from both concerns and formal complaints.

All concerns and complaints are categorised to enable more detailed analysis of themes and have included categories such as care and treatment (medical and nursing), attitude of staff, choose and book, communication, discharge arrangements, and patient transport. However, data collection and analysis is limited due to the current software arrangements for complaints and PALS.

Formal complaints and PALS information are discussed separately in this report to address specific issues relating to each.

The table below is a legally required summary of the number of complaints received by the Trust during the financial year.

Complaints

Number of complaints registered 1 April 2013 to 31 March 2014	**Number of complaints which you have decided were well founded i.e. upheld**	**Number of complaints which were referred to the Parliamentary and Health Service Ombudsman**
564	As at 31/3/14, 64 cases are still current. Of the closed complaints, 80% generated actions for improvement	14

1.Subject Matter of Complaints	**Subject Matter**	**No of Complaints Received**
	Aspects of clinical treatment	388
	Attitude of staff	53
	Admission/discharge/transfer	30
	Appointments delay/cancel-outpatient	25
	Communication & information	25
	Privacy & dignity	10
	Hotel Services	4
	Appointments delay/cancel-inpatient	10
	Personal records	2
	Aids/appliances/equipment/premises	2
	Consent to treatment	1
	Policy & commercial decisions	3
	Complaints handling	1
	Patients property	6
	Patient's status	1
	Other	3
2. Any matters of general importance arising out of those complaints, or the way in which they were handled	In accordance with the 2009 complaints regulations, 123 complaints were resolved outside the procedure, which gives a total of 687 complaints. Following review and or investigation by the Parliamentary Health Service Ombudsman (PHSO), two complaints were partly upheld, two complaints were not upheld, and one complaint is closed for further work. In the remaining nine cases, the Trust is awaiting the outcome of the initial review.	
3. Any matters where action has been taken to improve services as a consequence of those complaints	Examples of action plans: Complainant raised concerns regarding signage in the Medical Elective Suite, and discrepancies in the patient information leaflet for lumbar puncture and their actual experience. Signage to be reviewed and improved and the leaflet to be amended to	

	ensure consistency with the care pathway. Patient's relative was unhappy with their attendance at the Emergency Department. Issues included reception service and system, and lack of information for different clinics/areas. Action includes ongoing awareness updates for staff regarding effective customer care, and review and improvement to public/patient information – the relative and patient have been invited to contribute to this. A patient complained about the service from the Sexual Health Clinic which resulted in a number of actions for improvement. These include: a written policy to be introduced to ensure consistency of consultations and better clinic preparation, staff to receive training in the principles of motivational interviewing, and peer supervision to be introduced.
4. Any trends that have been identified	A number of complaints refer to areas being short staffed and there is a general perception that there are not enough staff to care for patients. Complaints relating to waiting time for surgery in gynaecology – the directorate is reviewing demand and capacity, and looking at ways to reduce waiting times. Complaints relating to waiting time and environment of phlebotomy taking services at York Hospital have reduced since the relocation and redevelopment of the service.

A total of 687 complaints were received and investigated by the Trust during 2013/14 compared to 603 received during 2012/13. The figure of 687 includes 123 complaints resolved outside the procedure in accordance with the 2009 Complaints Regulations.

Of these 687 complaints:

- In the year 2013/14, 14 complainants were accepted by the Ombudsman for review on completion of the Trust's investigation. Following review and or investigation by the Parliamentary Health Service Ombudsman (PHSO), two complaints were partly upheld, two complaints were not upheld. For the remaining ten complaints, the Trust is still awaiting the outcome of the Ombudsman's review.
- On one occasion the Chief Executive requested an independent external review of a complaint. The external review concurred with the Trust's findings.
- On one occasion, the Trust was approached to provide correspondence to the complainant in large print which was provided accordingly.
- All formal complaints were received in the English language. However, one request was made by a complainant for the use of the Trust's Interpreting Service.

Further scrutiny

- All complaints received are reviewed on a weekly basis by the Chief Executive, Director of Nursing and the Lead Nurse for Patient Experience.
- All complaints are analysed qualitatively by the Patient Experience team.
- Issues raised in complaints relating to professional conduct are forwarded to the Medical Director or the Director of Nursing. Issues relating to patient safety are raised with the

Patient Safety Team. Complaints featuring issues relating to medication are forwarded to the Lead Nurse for Medicines Management. Complaints are also forwarded to the Trust's Safeguarding Leads as appropriate.

- Wards receiving a higher than expected number of complaints during 2013/14 were raised with the Directors of Nursing. A review of the complaints was held and an action plan agreed. This included the delivery of customer service training for all staff within the department and a review of the leadership within the service.
- Since September 2013 the Trust has sent out a new monitoring form / protected characteristics. The number of returns is reported to the Trust's Equality and Diversity Group.
- All complaints are risk assessed (Red Amber Green - RAG rated) on receipt to assess the seriousness of the complaint about the service/care or treatment. This assessment is undertaken to help identify the right course of action (complaints investigation, Root Cause Analysis (RCA) or Serious Incident Investigation) to be the taken by the Trust.
- To meet complaints legislation, all complainants are given options as to how they wish the Trust to pursue their complaint and how to receive the outcome. Those complainants who choose to attend a meeting are aware at the outset that meetings may take a period of time to co-ordinate and the dates are agreed with them.

During the year the Trust has also seen:

- Enhanced and collaborative working between the Patient Experience Team, matrons, and clinical/department teams.
- Customer services training for staff (undertaken by the Lead Nurse Patient Experience and members of the team) has been delivered to small pockets of staff around the organisation. Patient Experience training is included in the Trust's induction programme for all newly appointed Health Care Assistants and Band 5 Nurse Induction. Customer service/Patient Experience training was undertaken for the Child Health Directorate and Oncology Outpatients in response to concerns and complaints concerning the attitude and behaviour of staff.
- NHS Elect have, in partnership with the Lead Nurse Patient Experience and ODIL, delivered Customer Care training aimed in the first instance at Matrons and Ward Sisters. Complaints received are anonymised and used in training to help staff at all levels of the organisation understand what matters to our patients and their families.
- The concerns and complaints policy sets out clear processes, roles and responsibilities for staff, focusing on achieving the best outcome for patients. The policy was most recently audited by Internal Audit in November 2012. The overall an opinion of high Assurance is given on the systems and processes in place to manage complaints across the enlarged organisation based on the objectives tested as part of this review.

Learning from Concerns, Complaints and Compliments

The Trust places a high value on concerns, complaints and compliments as a resource to provide assurance that the care and treatment provided at our hospitals and community services meets the needs and expectations of patients and the public in terms of quality, outcome and safety. We recognise that complaints can provide us with valuable insight into where further improvements can be made. Compliments enable us to feedback to staff when they are providing an excellent service. Patients, their families and visitors are encouraged to share any concerns or suggestions they have with us so that their comments and suggestions can be investigated and responded to, and so that we can learn lessons from their experiences.

Since July 2013 the Patient Experience Team has put in place a process whereby complaints for the year to date on York and community sites are reviewed on a monthly basis.

The Directorates receive information on the issues from each complaint and the actions identified through the investigation. The Directorates are asked to provide an update into whether actions have been completed and, if so, where the evidence of this is held.

Feedback has been very positive, with the majority of Directorates now being up to date regarding provision of action plans and increasingly compliant with evidencing completion.

Lack of cross-site software has prevented this from being rolled out across the Scarborough site but this is being gradually addressed. In 2014 we want to replicate this good practice across the whole Trust

The nature and number of complaints (and PALS contacts) are described in the Patient Experience Quarterly Report which is submitted to Trust Board.

Positive feedback - Compliments
A total of 6875 positive patient feedback was recorded by the Patient Experience Team across the whole Trust, in the form of letters, cards and emails. The following comments are typical of those expressed by many patients:

Mr F wrote “At a time when the NHS in general and the hospitals in particular are presented so negatively in the Press and the Media I write this letter as a token of my thanks and gratitude to your Hospital for the excellent care and attention I received…From the moment of arrival…I was treated with the utmost courtesy and had the most excellent clinical, medical and nursing care.”

Mr C wrote “None of us relish a visit to the hospital, we often don’t look forward to some of the treatment we have to receive and I’m sure, like myself, many patients are very anxious about what is before them. We are also very aware of the bad press that shadows our NHS hospitals. I hope in writing to you and the staff, that you will enjoy receiving this letter in recognition of the excellence of your service.”

3. Conclusion

During 2013/14, the Trust has seen no real change in the number of registered complaints; however we have seen a significant increase in the number of complaints handled outside procedure. This demonstrates prompt and effective handling of appropriate concerns and follows the good practice advocated by the Care Quality Commission and the Parliamentary Health Service Ombudsman, and commented on in the Clwyd Report. There has been an increase overall in the number of patients and users contacting PALS, this follows annual upward trends.

The board will also be aware that there is currently a review into the systems and functionality of the patient experience team and its procedures.
This review is ongoing and recommendations and a detailed action plan will come to Board following approval by the Patient Experience Steering Group,

4. Recommendation

The Board is asked to note the detail in the report and the level of complaints received by the Trust, and to support the ongoing work to review the patient experience function and procedures.

Author	Wendy Brown, Lead Nurse for Patient Experience
Owner	Beverley Geary, Director of Nursing
Date	April 2014

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 30 April 2014

Safeguarding Adults – Executive Summary

Action requested/recommendation

This paper outlines to the board the rising profile of Safeguarding Adults and its role within the Trust. It asks the Board to:

- Note Progress and development
- Have an awareness Key challenges, national drivers and priorities for the future.
- Be assured of ongoing work and management of risk
- Give approval to share progress externally to specific bodies and the public (There is also an expectation that the Trust will publish the Safeguarding Adults annual reports in line with other organisations under the Safeguarding Adults Multi-agency process)

Summary

As a provider of Health Care, York Teaching Hospital NHS Foundation Trust (referred to as the Trust) is committed to safeguarding vulnerable adults in our care.

The Trust is expected to offer assurance to and participate with external agencies to ensure a multi-agency approach to maintaining safety throughout its services.

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 attached report evidences the Trust Commitment to Safeguarding vulnerable adults in our care whether concerns are raised by or against our service.

It is follows the lead of Local Authority Safeguarding Adults Boards to ensure that the Trust identifies where abuse may have occurred and, where it has

occurred by Trust shortfalls, assurance publicly of the Trust intention to address.

The information within this report highlights trends whilst maintaining the confidentiality of individuals involved.

Reference to CQC outcomes

Safeguarding Adults is basis of Outcome 7 of the Care Quality Commission essential standards.

Progress of report	The report has been sent to members of the Trust Safeguarding Adults Group for comment and approval.
Risk	Risk are identified within the report with actions to address and minimise where possible.
Resource implications	Resources implication detailed in the report
Owner	Beverley Geary, Director of Nursing
Author	Nicola Cowley, safeguarding Adults Operational Lead
Date of paper	April 2014
Version number	1

Board of Directors - 30 April 2014

Safeguarding Adults – Executive Summary

1. Introduction and background

As a provider of Health Care, York Teaching Hospital NHS Foundation Trust (referred to as the Trust) is committed to safeguarding vulnerable adults in our care.

The Trust is expected to offer assurance to and participate with external agencies to ensure a multi-agency approach to maintaining safety throughout its services.

The 2013 Safeguarding Adult report is attached and includes appendices as follows:

- ☐ The Role of the Safeguarding Adults Team
- ☐ Safeguarding Adults Proposed Structure
- ☐ Multi-Agency representation
- ☐ Safeguarding Adults Operational Plan and outstanding action summary
- ☐ Safeguarding Adults Team activity (Jan 2013 – Dec 2013)

2. Executive Summary

The Board is asked to note the contents of the Safeguarding Adults Annual report which outlines the National and local context of Safeguarding Adults together with new drivers relevant to vulnerable adults who receive health care. It identifies the impact of new legislation and outlines the need for Trust commitment to embed the growing Safeguarding Adults agenda.

The annual report details the safeguarding adult's activity for 2013 and an analysis of trends where safeguarding concerns have been raised against the Trust.

Progress

The Trust Safeguarding Adults Team provides safeguarding adults advice, support and administration for staff that suspect, know of or observe abuse of vulnerable adults. It also provides support and advice strategically and operationally to staff for Mental Capacity Act, Deprivation of Liberty, Therapeutic Restrictions and caring for patients with Learning Disabilities. This service has been active since September 2011 and served Scarborough, Whitby and Ryedale following integration in July 2012.

There has already been significant progress in Safeguarding Adults within the Trust with the introduction of Safeguarding Adults Training as part of the Statutory/Mandatory Training programme. Other operational advances include:

- ☐ policy development and review,
- ☐ training strategy and needs analysis
- ☐ Team expansion.

- ☐ Significant increase in staff awareness of the and support offered by Safeguarding Adults Team
- ☐ Regular audit/compliance review to identify areas of need

Strategic progress has been identified in:

- ☐ Representation at three safeguarding adult boards
- ☐ Participation in development of Multi-agency Strategy review
- ☐ Local development programmes for sub groups from Safeguarding Adults Boards, e.g.: Training/competences setting, peer review groups, Winterbourne, and Section 136 Place of safety working group.
- ☐ Action planning for National Strategies (e.g.: PREVENT, DoH Safeguarding Adults Assurance Framework)
- ☐ 2014 Priority setting for emergent government directives, ruling and legislation (e.g.: The Care Bill, Cheshire West judgement, Francis recommendations)
- ☐ Trust Board awareness of the agenda

Risks and Challenges

Although there has been significant progress the profile of Safeguarding Adults has continued to rise both locally and nationally placing increasing demand on the safeguarding adults team. It is recognised that to deliver an effective service in this ever-developing climate more resources are required. As such a business plan outlining the need for increased capacity to meet demand and requirement for further development within the Trust has been submitted. A proposed structure is included in the annual report and mirrors external organisational structures.

Additionally Trust-wide, data indicates a steady increase and intensity in the work now managed by the Safeguarding Adults team

Emerging legislation, policy/strategies and Inquiries will place further focus on safeguarding adults within the Trust and there will be an expectation of assurance that the Trust is following obligations and recommendations from national Inquiries

These include:

The Care Bill,

Supreme Court Judgement (Deprivation of Liberty Safeguards) Cheshire West Case

Improved Mental Health Services

Frances Report

Winterbourne

The proposed structure for the Safeguarding team includes a Lead for Adult Safeguarding whose priorities will include robust strategic and operational planning to ensure the guidance and recommendations relating to the Trust are embedded.

The Prevent Strategy is the Government's counter terrorism strategy and there is an

expectation from NHS England that it is embedded into everyday safeguarding activity including training. PREVENT is a specified requirement within the NHS Standard Contract for provider organisations. (See DoH Building Partnership, Staying Safe – The Healthcare Sector's contribution to the HM Gov Prevent Strategy). Actions to mitigate and minimise risks are shown on page 31 of the annual report. In addition a specific PREVENT briefing paper has been prepared and will be submitted to the Quality and Safety Committee in due course.

The training obligations alone for the Strategy are immense and cannot be facilitated alone by the Safeguarding Adults Team. The delivery of this strategy was highlighted as a risk and delivered to the Board in February 2013.

Implementation of the PREVENT Strategy now forms part of the Safeguarding Adults Team Operational Action Plan and work has already begun to implement training and policy.

As declaration of progress is part of contractual obligations/assurance to the Clinical Commissioning Group and local Safeguarding Adults Boards it is proposed that that the operational plan current position is reported quarterly to the Quality and Safety Committee and the Safeguarding Adults Group in advance of the declaration submission to the CCGs.

3. Conclusion

The Safeguarding Adults Agenda Profile has greatly risen and in doing so to has assurance and expectation required from health providers. National context and the Trust integration have contributed to the need for a larger safeguarding adult's resource to support patients and staff. The Trust will need to focus resources to continue assurance strategically and offer operationally an effective service. An active operational planning system is working towards addressing what is required along with minimising and eliminating risks.

4. Recommendation

This paper outlines to the board the rising profile of Safeguarding Adults and its role within the Trust. It asks the Board to:

- ☐ Note Progress and development
- ☐ Have an awareness Key challenges, national drivers and priorities for the future.
- ☐ Be assured of ongoing work and management of risk
- ☐ Give approval to share progress externally to specific bodies and the public (There is also an expectation that the Trust will publish the Safeguarding Adults annual reports in line with other organisations under the Safeguarding Adults Multi-agency process)

5. References and further reading

The Care Bill, (https://www.gov.uk/government/uploads/system/attachmentdata/file/198104/9520-2900986)

Supreme Court Judgement (Deprivation of Liberty Safeguards) Cheshire West Case
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300106/DH_Note_re_Supreme_Court_DoLS_Judgment.pdf

Improved Mental Health Services
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

Francis Report
http://www.kingsfund.org.uk/projects/francis-inquiry-report

Winterbourne View
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

PREVENT

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215251/dh_131934.pdf	
Author	**Nicola Cowley, Safeguarding Adults Operational Lead**
Owner	**Beverley Geary, Director of Nursing**
Date	**April 2014**

York Teaching Hospital NHS
NHS Foundation Trust

York Teaching Hospital NHS Foundation Trust Safeguarding Adults

Annual Report 2013

1.0 Introduction

As a provider of health care, York Teaching Hospital NHS Foundation Trust (referred to as the Trust) is committing to safeguarding vulnerable adults in our care.

The Trust offers assurance to and participates with external agencies to ensure a multi-agency approach to maintaining the safety of patients both in and out of acute services.

The Trust Safeguarding Adults team provides safeguarding adults advice, support and administration for staff that suspect, know or observe abuse of vulnerable adults. This service has been active since September 2011 and this served Scarborough, Whitby and Ryedale following integration from July 2012.

Information regarding other services provided by the Safeguarding Adults Team is shown at Appendix 1.

2.0 National Context and developments

Safeguarding Vulnerable Adults continues to be a high priority nationally. Local Authority Safeguarding Adults and Commissioning Groups expect commitment and assurance from service providers that Safeguarding Adults is embedded within an organisation.

This includes:

- Commitment to patient choice, control and accountability including support and protection for those in the most vulnerable situations
- Safeguarding adults is a core responsibility to delivery of effective health care
- Safeguarding is integral to patient care
- Health services have a duty to ensure the safety of all patients but must provide additional support for patients who are less able to protect themselves from harm or abuse
- Prevention from harm and abuse can be promoted through the provision of high quality care
- Effective responses to allegations of harm and abuse that are in line with organisational, clinical and multi-agency procedures
- Using learning to improve service to patients

Additionally there have been several high profile reports/drivers where Safeguarding Adults underpins the recommendations:

- ☐ **Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report (December 2013)**
- ☐ **Patients First and Foremost – the initial government response to the report to the Mid-Staffordshire NHS Foundation Trust Inquiry – Robert Francis QC.**
- ☐ **The Care Bill**
- ☐ **Supreme Court Judgement (Deprivation of Liberty Safeguards) – Cheshire West**
- ☐ **No Health without Mental Health (DOH)**
- ☐ **PREVENT Strategy (Home Office)**

A briefing paper at appendix 2a) describes Safeguarding implications linked to National Drivers/legislation.

3.0 Local Context 2013

York Teaching Hospital NHS Foundation Trust has a seat on the North Yorkshire County Council, City of York Council Boards and following integration with Scarborough NHS, East Riding Safeguarding Adults. The CCGs Health Partnership Group pulls together all health provider organisations within the region and is a forum for sharing best practice and disseminating information and compliance requirements for this agenda.

All Boards continue to provide strong leadership and objective scrutiny of the remit and responsibilities of the partner agencies. Please see Appendix 2b) for Multi-agency representation.

3.1 Safeguarding Adults Group

The York Teaching Hospital NHS Foundation Trust Safeguarding Adult Group was established in November 2010, its purpose is;

- To monitor safeguarding adult strategies to ensure that they operate within the context of national and local policies
- To discuss Governmental and strategic drivers and assess the impact upon York Teaching Hospital NHS Foundation Trust

- To ensure adult safeguarding arrangements locally reflect the City of York and North Yorkshire Adult Safeguarding Boards' Procedures
- To evaluate practice and identify gaps in assurance
- To analyse findings from audits and evaluate implications for practice
- To prioritise and agree the annual work programme for Safeguarding Adults
- To disseminate lessons learnt from Serious Case Reviews (SCR)
- To ensure two-way sharing of information between the Trust and the Safeguarding Boards as required in order to strengthen the multi-agency framework of practice

The Group offers assurance through the Corporate Risk Management Group and provides routine reporting through to the City of York, North Yorkshire and East Riding Safeguarding Boards.

4.0 Achievements during 2013

4.1 Resources

It was recognised that following integration there could be a lack of resource and insufficient capacity which would impact on the Trust's ability to safeguard vulnerable adults. At the time of integration the Trust Safeguarding Adults Team consisted of:

- ☐ A Safeguarding Specialist Nurse who is responsible for lead operational responsibility for Safeguarding Adults and in addition acting as Learning Disability Liaison Nurse.
- ☐ A Safeguarding Support Officer. This role was to provide operational advice and training across the organisation.

A further post was funded through Transforming Community Services and following integration was utilised to recruit one full time post to cover the new sites both for safeguarding adult support and Learning Disability Liaison. Recruitment to this post was made in September 2012.

4.2 Policies and Procedure

The Trust's Safeguarding Adults Policy and Procedures have been reviewed for the integrated organisation. The following policies also are the responsibility of the Safeguarding Adults agenda:

- Clinical Restraint Policy
- Mental Capacity Act Guidance
- Deprivation of Liberty's Guidance
- Learning Disability Specification

In addition during 2013 further guidance has been incorporated under Safeguarding Adults as follows:

- ☐ Electronic Flagging patient with specific care approach (NHS Protect Guidance)

4.3 CQC Inspection

During 2012/2013 the Trust underwent a number of inspections by the Care Quality Commission in various areas. Safeguarding Adults is covered by Outcome 7 – "Safeguarding People who use our services from abuse". The inspections did not focus on this outcome for their inspection. However, it is recognised that a consistent approach to Safeguarding Adults and all aspects included in the agenda is essential and as such an integrated Training and Audit programme was introduced from April 2013.

4.4 Training

Training is now fully embedded in Trust induction and statutory and mandatory training for York Sites – Level 1 and 2). This programme has been available for all sites since April 2013. Key individuals in high risk areas have received level 2 training (how to respond to a safeguarding concern) and the Trust has a training plan for the delivery of level 1 and further level 2 training on a 3 year rolling programme.

The organisation has trained a numbers of staff at level 3, conducting multi agency investigations and level 4, chairing multi agency case conferences. However there are plans to increase the staff trained at this level to assist with internal safeguarding investigations.

5 Assurance framework

As part of Multi-agency working the Trust has an obligation to give assurance to Safeguarding Adults Boards and Commissioning Groups. This is done by way of self-declaration with follow-up "challenge" meetings to provide evidence. The standards are RAG rated and form the basis of the Safeguarding Adults Operational Plan – see appendix 3.

In summary standards typically cover the following areas:

- Statutory requirements within Human Resource Department Recruitment Policies and Procedures.

- Policies and procedures in:
    - Safeguarding Adults
    - Mental Capacity Act
    - Deprivation of Liberty Safeguards
    - PREVENT Strategy
    - Learning Disabilities Awareness

- Comprehensive Training Needs Analysis and Training Strategy covering the above, with different levels of training delivered to different staff groups dependent on their role.

- Board representation and designated strategic and operational leads

6 Safeguarding Adults Team Activity

6.1 Safeguarding Adults

During 2013 the Safeguarding Adults Team produced quarterly statistics for consideration at the Safeguarding Adults Group. All new cases are considered by the Quality and Safety weekly team meeting to ensure cases are considered in the context of datex reports, deaths, Serious Incidents and claims.

In addition the Safeguarding Adults Team have fully participated in Trust Compliance Reviews (38 to date) to monitor knowledge and address gaps with robust specific area action plans.

Please see Appendix 4a) for 2013 Safeguarding Adults analysis.

6.2 Mental Capacity Advice (Including Assessment of Capacity/Best Interest Support)

The Safeguarding Adult team also provide support to ensure Trust staff complies with the Mental Capacity Act. Best Interest support would include attendance at Best Interest meetings to ensure the principles of the Act are followed.

Please see Appendix 4b for Mental Capacity Act activity.

6.3 Protection of adults identified through MAPPA and MARAC processes

Since January 2012 representation from the Safeguarding Adult Team has been made at Multi Agency Public Protection and Risk Assessment

Committees. These meetings are chaired by the probation and police respectively. Risks to staff and public can be highlighted at these meetings and therefore an effective cascade system and risk management planning approach has been necessary.

Dependent on the level/nature of the risk posed a risk management plan may be created. This is cascaded on a "needs to know basis" to the Emergency Department, Bed Managers and Security and any other relevant party e.g. child protection/Substance misuse Specialist nurses.

As it was acknowledged that this system was not robust (particularly outside of core hours). The Safeguarding Adult Team has therefore developed an electronic flagging system with appropriate policy guidance. The electronic system is now ready and the team are waiting policy approval.

To contribute to the meetings research is carried out to establish Acute Trust attendance and any incidence occurring from these visits. This information contributes to a multi-agency risk assessment and management plan.

There are currently 25 relevant Risk Management Plans in force. These are reviewed for relevance quarterly in the Risk Management Review Group which comprises of:

Safeguarding Adults Lead
MAPPA point of contact
Head of Security or their deputy
A nominated Bed Manager.

6.4 Learning Disability Service

Two members of the safeguarding team are also responsible for supporting people with learning disabilities to receive acute care.

The Team provide Inpatient support includes per the Learning Disability Service Specification in the following areas:

1) Individual Needs Assessment and summary
2) Ward support
3) Carer support
4) MCA advice

Some planned inpatient stays may involve complex care planning leading up to admission. Complex Care planning is also used in other acute contact and a complex planning checklist tool is used.

Typical actions in complex care planning would include:

1) Familiarisation/desensitising programme
2) MDT (internal and external)
3) Individual Needs Assessment and summary
4) Ward support
5) Carer support
6) MCA advice

Please see Appendix 4c for Learning Disability activity for 2013.

7 Operational Plan 2014 and Priorities

The overall work plan is attached at Appendix 3. The main priorities for 2014 are

- Revision of policies to ensure they are fit for service provision
- Revision of data collection information for more meaningful reporting
- Quarterly reporting schedule to the Risk and Assurance Committee and the Board of Directors.
- Implementation and management of PREVENT Strategy
- Team Expansion and centralisation/relocation

In addition to the above priorities our focus for next year has to be to support training provision for all staff to ensure that staff have the same level of understanding as pre-integration staff along with continuing awareness raising of the support the Safeguarding Adults Team can offer.

As this awareness grows it is accepted that demand on the team will increase and capacity to provide a service to a wider site may prove problematic. As such consideration will be given based on quarterly report findings to expand the current team.

The Safeguarding Adults Team has found that they deal with sensitive information and the current York location does not afford the confidentiality required in some cases. To address the Team are relocating to Malton Hospital in Early in 2014. This aims to:

- ☐ improve support within the team,
- ☐ protect confidentiality
- ☐ Improve accessibility to all Trust staff particularly Community.
- ☐ Encourage staff based on acute sites to become actively involved in liaising with patients who are at risk of harm and abuse

8 Conclusion

Alerts have increased from last year and the team has increased by a third. The work of the team has intensified with investigations increasing per case holder. There are also strict time scales enforced to the process which increases pressure on the team.

There has also been increased demand for advice and support with Mental Capacity Act adherence.

The biggest change in commitment is in training which has more than doubled This has to be seen as positive as awareness is pivotal to ensuring processes are followed.

Already this awareness of the team is growing amongst colleagues across the sites. This has greatly assisted when investigating alleged abuse and where expertise is required for external agencies. Additionally where there is learning from allegations there has been much support from departments to promote changes in process.

Following internal re-structuring the Trust has recognised the need for more resources to meet increased demand and a designated strategic and operational lead. This is in line with governance structures for Safeguarding Adults in other organisations and re-enforces the Trust commitment to the agenda. A business case has been submitted with provisional approval. See Appendix 5.

Nicola Cowley
Safeguarding Adults Operational Lead
April 2014

Appendix 1 – The Role of the Safeguarding Adults Team

The Hospital Safeguarding Adults Team has the following responsibilities

a) Managing alerts administratively (database)
b) Subsequent investigations
c) Training strategy/Needs analysis and delivery on:

    - Safeguarding Adults
    - MCA
    - DOLs
    - Clinical restraint awareness
    - Learning Disabilities

d) Audit
e) Annual reporting
f) Policy development/monitoring
g) Day to day Staff support for:
    - ☐ Safeguarding Adults
    - ☐ MCA
    - ☐ DOLs
    - ☐ Clinical restraint awareness
    - ☐ Learning Disabilities
h) Learning Disability Liaison – supporting patients with LD to access acute services
i) MARAC/MAPPA research and meeting attendance/contribution
j) Risk Management of Violent and Aggressive individuals (aged 16 and over)
k) Lead Agency Board Meetings and sub group attendance and contribution
    - CYC
    - NYCC
    - East Riding

The team currently consists of 3 full time staff:

1) 1 x Safeguarding Adults assessment officer (York)
2) 1 x Safeguarding Adults assessment officer (SWR) with responsibilities for LD Liaison for SWR sites
3) Operational Lead with responsibilities for:
    a. operational development/implementation of the Safeguarding Adults Agenda
    b. Line management of Safeguarding Adults assessment officers.
    c. Specific safeguarding adult's investigation case load (HR/Complaints) and LD Liaison for York site.

Appendix 2a) – National Strategy and Drivers – Impact on Safeguarding Adults

REPORT TO:	**Safeguarding Adults Group**
REPORT FROM:	**Nicola Cowley, Safeguarding Adults**
REPORT DATE:	**23/01/2014**
REPORT STATUS:	**Information/Awareness**
REPORT SUBJECT:	**National Strategy and Drivers – Impact on Safeguarding Adults**

PURPOSE

The purpose of this report is to highlight National Legislation/Strategies and Drivers that link and impact on Safeguarding Adults for Trusts to the Safeguarding Adults Group.

Background

The profile of Safeguarding Adults has been increasing over recent years and as such Care providers are responsible for assuring service users and commissioners of their commitment to embed Safeguarding Adults in policies and ethos.

The main emerging strategies and drivers are as follows:

a) Francis Report
b) Winterbourne
c) The Care Bill (Draft)
d) Dementia Strategy
e) Mental Health Act
f) Supreme Court Judgement – April 2014

Information

Francis report

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

The report published early 2013 made 290 recommendations**,** groups 21 specific directives. All of these directly or indirectly link to Safeguarding Adults. The above report outlines how vulnerable patients in our care can be safeguarded if the following is considered:

- ☐ **Prevention**
- ☐ **Detection**
- ☐ **Acting promptly**
- ☐ **Accountability**
- ☐ **Training**

Winterbourne

http://www.nhs.uk/CarersDirect/guide/practicalsupport/Documents/Winterbourne%20View%20Summary%20Document%20final%2010.12.12.pdf

This report predominantly focuses on findings and subsequent actions for individuals placed in homes out of areas and the use of restraint however the review found that, amongst other things, multi-agencies failed to pick up on nearly 1590 incidents which included visits to Emergency Departments. The progress of the Winterbourne actions locally is reported at the City of York Safeguarding Adults Board.

c) The Care Bill

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198104/9520-2900986-TSO-Factsheet07-ACCESSIBLE.pdf

The Care Bill will gain Royal Ascent in April 2014. It consolidates many pieces of legislation. Its aim is to “promote well-being and integration”. It is also a response to the Francis Report and provides new ratings for hospitals.

It places heavy focus on safeguarding outlining responsibilities for Local Authorities and multi-agencies. It also puts Safeguarding Adult Boards on statutory footing (akin to Safeguarding Children Boards). Full regulation and guidance will be available from October 2014 with formal implementation of the Bill April 2015.

Local Authorities are responsible for reviewing and assessing for edibility of resources. This may reduce the amount of cases held by social workers and as such there are risks that some safeguarding issues may not be identified by care managers. There is also a risk that current

claimants and beneficiaries will no longer qualify for funding which will increase risks of poverty and its associated impact.

The new statute includes an overarching well-being principle, which includes safeguarding adults wherever practicable. It will provide clear guidance for local social services authorities who will have the lead co-ordinating responsibility for safeguarding. As part of that responsibility, the statue will place a duty on local authorities to investigate adult protection cases or cause an investigation to be made other agencies, in individual cases

Full regulation and guidance will be available from October 2014 with formal implementation of the Bill April 2015.

Work will be required by the Trust to review recommendations from the care bill and benchmark our organisation against them.

Dementia Strategy

https://www.gov.uk/government/policies/improving-care-for-people-with-dementia

The Dementia Strategy was introduced in 2009. The Trust has a Dementia Strategy group and working action plan – there is representation from the Safeguarding Adults Group where capacity allows: Dementia awareness training is delivered by e-learning based on job role/area of work.

Mental Health Act

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

The link between physical and mental health is widely acknowledged however physical causation of illness is the main focus in acute (general) hospital settings. The principles of the above report can form the basis of implementing and embedding mental health care. A priority for the safeguarding adult's team in 2014 is to develop a mental health service together with robust policy guidance for staff caring for patients who are sectioned and/or suffer mental health issues. This will involve working together with Leeds and York Partnership NHS Foundation Trust to agree a service level agreement to call upon their expertise where necessary.

Supreme Court Judgement – April 2014

http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

A recent court ruling has implied major changes to the criteria of applying for Deprivation of Liberty (DoLs) authorization. Previous application for authorization have been as follows:

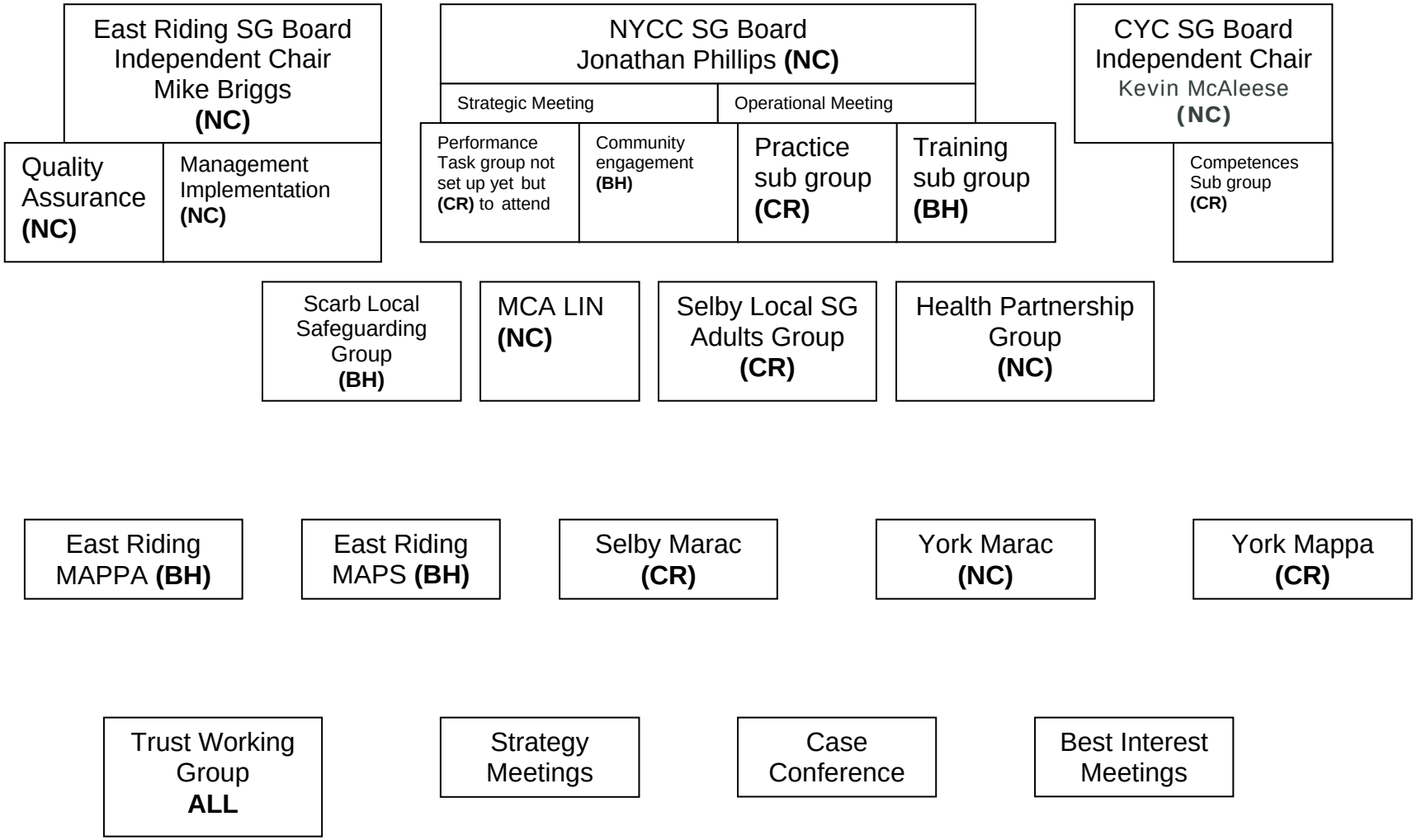
Lacks capacity
Relatives denied by the Trust to take patient home
Patient actively attempting to or asking to leave.

On initial reading of the ruling it appears that now anyone lacking capacity in a hospital setting and is under "constant supervision" may require a deprivation of liberty authorisation - regardless of whether they are actively attempting to or asking to leave.

To review the impact of this I will be working with my colleagues both Trust and Local Authority departments who manage DoLs application (the Safeguarding Adults Team, the local authorities, NYCC, CYC and ERYC).

Nicola Cowley
Safeguarding Adults Operational Lead
April 2014

Appendix 2b – Multi-agency Representation



Appendix 3 – Safeguarding Adults Operational Plan

York Teaching Hospital NHS
NHS Foundation Trust

SAFEGUARDING ADULTS OPERATIONAL PLAN

	REQUIRED STANDARD	CQC outcome	Position/ Evidence	ACTION/Evidence	REVIEW DATE
Policy and Procedures					
1.1	The Provider will ensure that it has up to date organisational safeguarding adult's policies and procedures which reflect and adhere to the Local Safeguarding Adults Board policies.	**7a, 7k**		**Safeguarding Adults Policy**	**April 2015**
1.2	The Provider will ensure that organisational safeguarding policies and procedures give clear guidance on how to recognise and refer adult safeguarding concerns and ensure that all staff have access to the guidance and know how to use it			**Safeguarding Adults Policy**	**April 2015**
1.3	The Provider will ensure that all			**Paragraph submitted to Virtual Policy**	**June**

	relevant policies and procedures are consistent with and referenced to safeguarding legislation, national policy / guidance and local multi-agency safeguarding procedures .			**Approval April 2014**	**2014**
1.4	All policies and procedures are consistent in relation to Mental Capacity Act 2005 and consent	**2A, 2b, 2c, 2E, 2H**		**Paragraph submitted to Virtual Policy Approval April 2014**	**June 2014**
1.5	Have an up to date 'whistle-blowing' procedure, which is referenced to local multi-agency procedures and covers arrangements for staff to express concerns			**Whistle Blowing Policy**	
1.6	Have an up to date policy and procedure covering the Deprivation of Liberty Safeguards 2009.			**Deprivation of Liberty Safeguards Policy**	
1.7	Have up to date policy(s) and procedure(s) covering the use of all forms of restraint.	**7F, 7G, 7H**		**Clinical Restraint Policy Title change to be considered**	**May 2014**
1.8	A supervision policy is in place and that safeguarding practice is included appropriately as a standard item			**In discussion over standard assurance/requirement.**	

Governance					
2.1	Identify a person with overall organisational responsibility for safeguarding adults. For NHS Trusts, this will be a Board-level Executive Director.	**7A,16B**		**Beverley Geary (Director of Nursing) Libby Raper (Non-executive Trust Board member)**	
2.2	Identify a named person with responsibility for overseeing and supporting safeguarding practice and will ensure sufficient capacity to effectively carry out these roles.	**7A, 16B**		**Lead Professional for Adult Safeguarding Post vacancy wef April 2014**	**May 2014**
2.3	Will identify a named health professional with lead responsibility for ensuring the effective implementation of the Mental Capacity Act and the Deprivation of Liberty Safeguards.			**Lead Professional for Adult Safeguarding Post vacancy wef April 2014**	**May 2014**
Internal Systems					
2.4	There is a system for capturing the experiences and views of service users, including the monitoring of complaints and incidents, in order to identify and refer safeguarding concerns and inform constant service improvement.	**1J**		**Regular/Liaison with PETs, TOR for consultation arrangements. Complaints Process and Policy.**	
2.5	Effective system for identifying	**4B 16A,**		**Quarterly reporting**	

	and recording safeguarding concerns, patterns and trends through it's governance arrangements including; risk management systems, patient safety systems, complaints, PALS and human resources functions, and that these are referred appropriately according to multi-agency safeguarding procedures.	**7A, !6c, 16D, 16E**		**Data collection** **Safeguarding Adults Administration Process.** **In addition:** 1) Pressure Ulcer Protocol 2) Serious Incident Cases 3) DAtix reporting system 4) Compliance inspection programme which audit staff knowledge of Safeguarding Adults/MCA/DOLs	
2.6	Identify and analyse the number of complaints and PALs contacts that include concerns of abuse or neglect and include this information in their annual safeguarding or complaints report reviewed by their board.	**4B 16A**		**Regular/Liaison with PETs, TOR for consultation arrangements.** **Complaints Process and Policy.** **Quarterly reporting** **Data collection** **Safeguarding Adults Administration Process**	
2.7	Ensure that there are effective systems for recording and monitoring Deprivation of Liberty applications to the authorising body/Court of protection.			**Quarterly reporting** **Data c collection** **Deprivation of Liberty Policy guidance**	
2.8	Review the effectiveness of the organisations safeguarding arrangements at least annually			**Audit Programme/Compliance Review Programme** ***Separate action plans held following outcome of reviews (Trust area specific)***	
2.9	Have in place robust annual audit				

	programmes to assure itself that safeguarding systems and processes are working effectively and that practices are consistent with the Mental Capacity Act (2005)			**Audit Programme/Compliance Review Programme** ***Separate action plans held following outcome of reviews (Trust area specific)***	
2.10	Consider the organisational implications of any Serious Case Review(s) and will devise and submit an action plan to the local responsible safeguarding board to ensure that any learning is implemented across the organisation			**Serious Case Review Policy Guidance** **Serious Incident Policy**	
Multi-Agency Working					
3.1	Co-operate with any request from the Safeguarding Boards to contribute to multi-agency audits, evaluations, investigations and Serious Case Reviews, including where required, the production of an individual management report.	**7B, 6A 24A**		**Recognised Membership and documented attendances**	
3.2	Will ensure that any allegation, complaint or concern about abuse from any source is managed effectively and referred according to the local multi-agency safeguarding procedures.			**Safeguarding Adults Policy Guidance** **Multi-Agency Policy** **Complaints Policy and Procedures**	

3.3	Ensure that all allegations of neglect or abuse against members of staff (including staff on fixed term contracts, temporary staff, locums, agency staff, volunteers', students and trainees) are referred according to local multi-agency safeguarding procedures			**Performance Management Policy an d Procedures**	
3.4	Ensure that a root cause analysis is undertaken for all hospital, care home and community acquired category 3 and 4 pressure ulcers and that a multi-agency referral is made where abuse or neglect are believed to be a contributory factor.			**Safeguarding Adults Policy Guidance** **Wounds Prevention and Management Policy** **Pressure Ulcer Protocol**	
3.5	Ensure that organisational representatives / practitioners make an effective contribution to safeguarding case conferences / strategy meetings where required as part of multi-agency procedures.			**Safeguarding Adults Policy Guidance** **Safeguarding Adults Meeting Structure** **Documented attendance in individual cases within folder.** **Data base** **Quarter Reports**	
3.6	Ensure senior representation on the Local Safeguarding Adults Board and contribution to their			**Documented attendances and inclusion in minutes**	

	subgroups				
Recruitment and Employment					
4.1	Ensure safe recruitment policies and practices which meet the NHS employment check standards, including enhanced Criminal Record Bureau (CRB) checks for all eligible staff. This includes staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees.	**12A, 12B, 12C**		**Recruitment/Selection and Appointment Policy** **Your Selection – Recruitment and Selection Training**	
4.2	Ensure that post recruitment criminal checks are repeated for eligible staff in line with national guidance / requirements			**Recruitment/Selection and Appointment Policy**	
4.3	Ensure that their employment practices meet the requirements of the Independent Safeguarding Authority (IAS) scheme and that referrals are made to the ISA where indicated, for their consideration in relation to inclusion on the adults barred list			**Recruitment/Selection and Appointment Policy**	
4.4	Ensure that all contracts of employment (including volunteers, agency staff and contractors) include an explicit responsibility for			**In discussion over standard assurance/requirement. Currently standard National NHS Contract is used.**	**May 2014**

	safeguarding adults.				
4.5	Ensure that all safeguarding concerns relating to a member of staff are effectively investigated and that any disciplinary processes are concluded irrespective of a person's resignation and that "compromise agreements" are not allowed in safeguarding cases			**Performance Management Policy and procedure**	
Training					
5.1	Ensure that all staff and volunteers undertake safeguarding training appropriate to their role and level of responsibility and that this will be identified in an organisational training needs analysis and training plan.			Training Strategy TNA Training Programme	
5.2	Ensure that all staff (including those on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees), have undertaken safeguarding awareness training at the point of induction. This must include information about how to report concerns within the service or directly into the multi-agency procedures			Training Strategy TNA Training Programme	
5.3	Ensure that all staff who provide			Training Strategy	

	care and/or treatment, undertakes training in how to recognise and respond to abuse (How to make an alert) at least every 3 years			TNA Training Programme **Quarterly audit programme** ***Separate action plans held following outcome of reviews (Trust area specific)***	
5.4	Ensure that all staff, (including locums, temporary / agency staff and volunteers) who provide care or treatment understands the principles of the Mental Capacity Act 2005 and consent processes at the point of induction.			**Quarterly audit programme** ***Separate action plans held following outcome of reviews (Trust area specific)*** **Training Strategy/training needs analysis.**	
5.5	Ensure that all staff and volunteers undertake Mental Capacity Act 2005 and consent training, including the Deprivation of Liberty Safeguards, appropriate to their role and level of responsibility and that this will be identified in an organisational training needs analysis and training plan.			**Quarterly audit programme** ***Separate action plans held following outcome of reviews (Trust area specific)*** **Training Strategy/training needs analysis.**	
5.6	Undertake a regular comprehensive training needs analysis to determine which groups of staff require more in depth safeguarding adults training. As a minimum this will include all			**Training Strategy/training needs analysis.**	

	professionally registered staff with team leadership roles undertaking multi-agency training in how to recognise and respond to abuse				
5.7	Ensure a proportionate contribution to the delivery of multi-agency training programmes as required by local safeguarding boards.			Not asked. The safeguarding adults team are trained to the appropriate level to contribute to multi-agency training programmes where requested.	
Mental Capacity Act Specific					
	All staff and service users have easy access to the MCA 2005 COP			**All directorates have a copy**	
	All members of staff have access to relevant MCA 2005 training programmes?			**Training Strategy/training needs assessment**	
	The MCA 2005 has been included in all other relevant training programmes?			**Training Strategy/training needs assessment**	
	There are specific policies covering the MCA 2005			**MCA Guidance**	
	The MCA 2005 has been			**Paragraph submitted to Virtual Policy**	**Sept**

	integrated into all the organisations relevant policies and procedures			**Approval April 2014**	**2014**
	All appropriate staff understand the eligibility criteria for IMCA referral and are aware of the referral process			**Quarterly audit programme** ***Separate action plans held following outcome of reviews (Trust area specific)*** **Training Strategy/training needs assessment**	
	There is a Multi-agency LIN and this organisation is regularly represented			**Nicola Cowley** **Attendance documented and included in minutes**	
	The organisation has a wide variety of systems in place to help people to make decisions (interpreters, Sign language etc)			**Patient Access Services** **Learning Disability Liaison Service**	
	The organisation has MCA 2005 - leaflets including in other languages, easy read, and access to sign language, interpreters and advocates. (More than 4 in the list) posters etc)			☐ **Information leaflets being developed for availability of wards and patient areas across sites** ☐ **Approval from Patient access** ☐ **Approved Safeguarding Adults Group – March 2014**	**May 2014**
	The organisation has clear MCA 2005 compliant guidance on assessing and recording capacity			**MCA Guidance**	

	The organisation has clear guidance on identifying the Best Interests decision maker and their role			**MCA Guidance**	
	All relevant staff in the organisation are aware and implement the principle of Best Interests as stated in the MCA 2005 CoP			**Audit Programme/Compliance Review Programme.** ***Separate action plans held following outcome of reviews (Trust area specific)***	
	The organisation has specific guidance for staff on the role, remit and responsibilities of LPAs			**MCA Guidance**	
	The organisation has specific guidance and systems in place for staff regarding ADRT			**MCA Guidance**	
	The organisation has specific guidance and systems in place on the relationship between the MH act 1983 and MCA 2005		**Policy draft developed**	**Service level agreement to be drawn up and on completion policy guidance can be developed. Safeguarding team to hold data based Awaiting update on MHA arrangements**	**Further progress by June 2014**

	The organisation monitors the numbers of staff who have undertaken specifically MCA training			**Training Strategy/ TNA**	
	The organisation reviews its policies/procedures in accordance with local agreements to ensure they comply with the MCA 2005			**Paragraph submitted to Virtual Policy Approval April 2014**	**June 2014**
	The LIN, or its equivalent partnership network, reviews its terms of reference and membership at least yearly		**n/a**		
	The organisation monitors its use of decision making support services/tools (translators, sign language etc)			**Patient Access Services** **Learning Disability Liaison Service**	
	The organisation reviews annually the use, and accessibility of all its MCA 2005 information material (leaflets, posters etc)			**Audit Programme/Compliance Review Programme** ***Separate action plans held following outcome of reviews (Trust area specific)***	
	The organisation has systems and processes in place to monitor and ensure that assessments of			**Audit Programme/Compliance Review Programme** ***Separate action plans held following outcome of reviews (Trust area specific)***	

	mental capacity are being undertaken by all appropriate staff and these assessments and subsequent recording complies with the MCA Code of Practice.				
	The organisation has systems in place that monitor staff to ensure they are following best interests principles both in terms of best practice and recording as stated in the MCA 2005 CoP			**Audit Programme/Compliance Review Programme** ***Separate action plans held following outcome of reviews (Trust area specific)***	
Learning Disability (6 Lives)					
	There are mechanisms to identify and flag patients with learning disabilities			**Flagging Policy Action Plan:** **Stage 1) flagging other individuals underway.** **Stage 2) to implement LD flag.**	**June 2014**
	Protocols ensure that reasonable adjustments have been made to pathways of care			**Service Specification**	
	People with learning disabilities are involved in providing easy to understand information:			**Service Specification**	

	Protocols support (family) carers by providing information on Carers Act, Mental Capacity Act, DDA			**Service Specification**	
	Staff training and induction routinely include: LD Awareness Legislation Human Rights Communication Techniques Person centred approaches Adult safeguarding			**Quarter Reporting** **Training Strategy/TNA**	
	Protocols encourage and support people with learning disabilities and their family carers to be involved on Boards, forums and planning and development of services			**Consultation in Friend and Family Test Implementation Group to ensure accessibility for view sought.**	**Ongoing**
	There is a planned schedule of audits that demonstrate how it supports people with learning disabilities and the results are routinely available.			**Audit Programme/Compliance Review Programme** ***Separate action plans held following outcome of reviews (Trust area specific)***	
				Documented attendance at community	

	There are formal relationships with partner organisations to support joint working and service co-ordination.			**meeting, partnership boards and local authority**	

	PREVENT	**RAG rating**	**Summary of evidence if compliant**	**Review date**
1.0	NHS provider trusts will identify an Executive lead with responsibility for Prevent		Beverley Geary	
2.0	Providers will identify an Operational Lead for Prevent and ensure that they are appropriately authorised and resourced to deliver the required national and local standards.		New Structure includes Lead Nurse for Adult Safeguarding. Recruitment to commence.	May 2014
3.0	The provider must have a procedure which is accessible to all staff, consistent with the Prevent Guidance and the Prevent Toolkit and clearly sets out how to escalate Prevent related concerns and make a referral.		Included in Safeguarding Adults revised policy – submitted to policy approval committee. Development plans for individual policy for the prevent agenda.	Policy in situ by September 2014
4.0	The provider must have a training plan that identifies the Prevent related training needs for all staff, include a programme to deliver 'HealthWRAP' and sufficiently resource that programme with accredited HealthWRAP facilitators		**To develop and include in safeguarding Adults TNA and strategy.** All Safeguarding Adults Team completed HEALTHWRAP training	**Training rolled out Oct 2014**
5.0	NHS Trusts and larger independent providers will ensure that implementation of the Prevent agenda is monitored through the Trusts audit cycle		The audit programme will be developed following training roll out and be included in all future Safeguarding Adults Agenda Audit Programmes, internal compliance reviews.	September 2015

25/04/2012

Reviewed April 2014
Nicola Cowley

OPERATIONAL PLAN summary of working actions

	REQUIRED STANDARD	CQC outcome	Position/ Evidence	ACTION	REVIEW DATE
Internal Action Plan/CQC					
1.3	The Provider will ensure that all relevant policies and procedures are consistent with and referenced to safeguarding legislation, national policy / guidance and local multi-agency safeguarding procedures .			**Paragraph submitted to Virtual Policy Approval April 2014**	**June 2014**
1.4	All policies and procedures are consistent in relation to Mental Capacity Act 2005 and consent	**2A, 2b, 2c, 2E, 2H**		**Paragraph submitted to Virtual Policy Approval April 2014**	**June 2014**
1.8	A supervision policy is in place and that safeguarding practice is included appropriately as a standard item			**In discussion over standard assurance/requirement.**	

2.2	Identify a named person with responsibility for overseeing and supporting safeguarding practice and will ensure sufficient capacity to effectively carry out these roles.	**7A, 16B**		**Lead Professional for Adult Safeguarding Post vacancy wef April 2014**	
2.3	Will identify a named health professional with lead responsibility for ensuring the effective implementation of the Mental Capacity Act and the Deprivation of Liberty Safeguards.			**Lead Professional for Adult Safeguarding Post vacancy wef April 2014**	
4.4	Ensure that all contracts of employment (including volunteers, agency staff and contractors) include an explicit responsibility for safeguarding adults.			**In discussion over standard assurance/requirement.**	
	The MCA 2005 has been integrated into all the organisations relevant policies and procedures			**Paragraph submitted to Virtual Policy Approval April 2014**	**June 2014**
	The organisation has MCA 2005 - leaflets including in other languages, easy read, and access to sign language, interpreters and advocates. (More than 4 in the list) posters etc)			☐ **Information leaflets being developed for availability of wards and patient areas across sites** ☐ **Approval from Patient access** ☐ **Approved Safeguarding Adults**	**May 2014**

				Group – March 2014	
	The organisation has specific guidance and systems in place on the relationship between the MH act 1983 and MCA 2005		**Policy draft developed**	**Service level agreement to be drawn up and on completion policy guidance can be developed. Safeguarding team to hold data based Awaiting update on MHA arrangements**	**Ongoing**
	The organisation reviews its policies/procedures in accordance with local agreements to ensure they comply with the MCA 2005			**Paragraph submitted to Virtual Policy Approval April 2014**	**June 2014**
Learning Disability (6 Lives)					
	There are mechanisms to identify and flag patients with learning disabilities		**Flagging Policy Action Plan**	**Stage 1 flagging other individuals underway.** **Stage 2 to implement LD flag.**	**June 2014**
	Protocols encourage and support people with learning disabilities and their family carers to be involved on Boards, forums and planning and development of services			**Consultation in Friend and Family Test Implementation Group to ensure accessibility for view sought.**	**Ongoing**
PREVENT – CCG assurance					
2.0	Providers will identify an Operational Lead or			New Structure includes Lead Nurse for Adult Safeguarding. Recruitment to commence.	

	Prevent and ensure that they are appropriately authorised and resourced to deliver the required national and local standards.			
3.0	The provider must have a procedure which is accessible to all staff, consistent with the Prevent Guidance and the Prevent Toolkit and clearly sets out how to escalate Prevent related concerns and make a referral.		Included in Safeguarding Adults revised policy – submitted to policy approval committee.	
4.0	The provider must have a training plan that identifies the Prevent related training needs for all staff, include a programme to deliver 'HealthWRAP' and sufficiently resource that programme with accredited HealthWRAP facilitators		**To develop and include in safeguarding Adults TNA and strategy.**	All Safeguarding Adults Team completed HEALTHWRAP training
5.0	NHS Trusts and larger independent providers will ensure that implementation of the Prevent agenda is monitored through the Trusts audit cycle		The audit programme will be developed following training roll out and be included in all future Safeguarding Adults Agenda Audit Programmes, internal compliance reviews.	
CCG Assurance				
1.8	The provider will ensure that a clinical / professional supervision policy is in place and that safeguarding practice is included as a standard item.	**In discussion with John Keith re wording.**	Processes in place for staff support, reflective practice sessions, Safeguarding Adults Team feedback process to alerters, Matron's meetings. 1) Plans to explore Schwarz Rounds 2) Matron re-structure development to focus on clinical support	
4.4	The provider should ensure that all contracts of employment (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) include an explicit reference to staffs responsibility for safeguarding adults.	**In discussion with John Keith re wording.**	Nationally used NHS Contract is used.	
ERSAB ASSURANCE				

	There is a strategic plan for safeguarding adults and it is an integral part of quality		The strategy needs to be reviewed in line with integration under three safeguarding adult boards 1) Strategy to be reviewed 2) Consultation and agreement from Trust Safeguarding Adults Group 3) Approval from Patient Safety Group **COMPLETION BY APRIL 2014**
	1.2 The organisations safeguarding strategy, planning and delivery, involves and takes account of patients, users and carers experience		Patient experience of hospital safeguarding is often difficult to obtain due duration of admission, mental capacity and family involvement. The Team need to explore what other Trusts have done to address this. 1) Liaison with Patient Involvement Officer 2) Agenda item on Trust Safeguarding Adults Group for membership and discussion for mechanisms for consulting patients/family in family options **PROGRESS EXPECTED BY END April 2014**
	1.3 The organisations safeguarding strategy, planning and delivery, involves and takes account of patients, users and carers experience		Patient experience of hospital safeguarding is often difficult to obtain due duration of admission, mental capacity and family involvement. The Team need to explore what other Trusts have done to address this. 1) Liaison with Patient Involvement Officer 2) Agenda item on Trust Safeguarding Adults Group for membership and discussion for mechanisms for consulting patients/family in family options 3) **PROGRESS EXPECTED BY END April 2014**
	1.3 Adult safeguarding is effectively resourced		1) Increase demand noted 2) Business case submitted and agreed 3)Revised Team Structure to match and fulfil strategy 4) Recruitment expected by **September 2014**
	2.11 The organisation has processes for quality assuring decisions relating to safeguarding interventions		External membership of Quality Assurance with East Riding Board **Internal** Safeguarding Adults Team Staff Supervision (monthly) Weekly Case Management. Programme to audit cases under quality assurance to be developed by **SEPT 2014**
	4.3 Appropriately trained and experienced staff review and manage safeguarding concerns.		Training Strategy Training Needs Analysis Training Programme based on job role to include Safeguarding

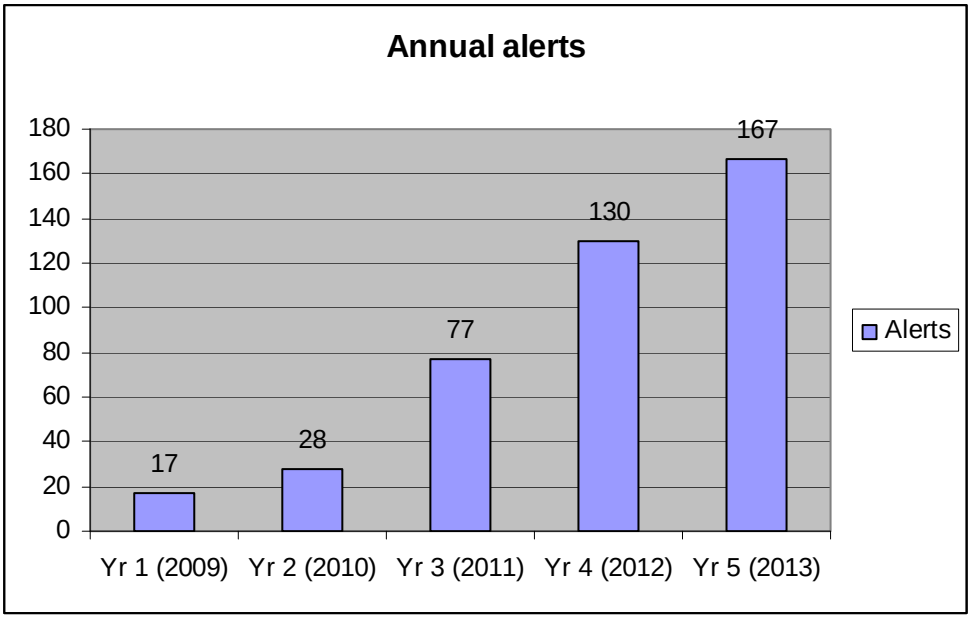
			Adults/MCA/DOLS/Clinical Restraint awareness and Learning Disability) Safeguarding Adults Team Specific training at higher level – accessed externally. TNA to be amended to include broader remit for accessing high levels of training externally (e.g.: **Matrons to access Safeguarding Investigation Training – SEPT 2014)**
	5.3 The organisation shares relevant information related to the safeguarding of adults in a secure and timely manner.		Time scale adherence affected by reduced resource and increased demand which is being addressed by Business case and plans to recruit. (**SEPT 2014)**

Reviewed March 2014
Nicola Cowley

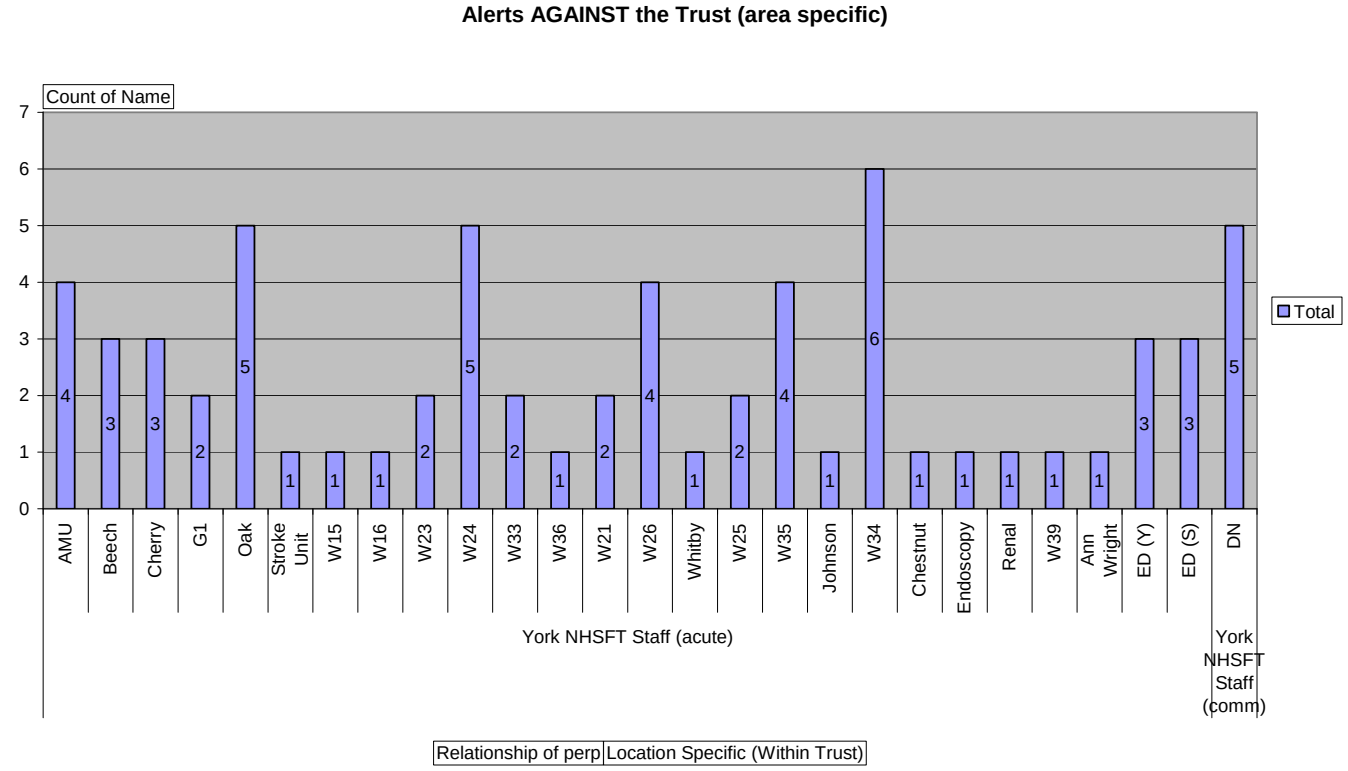
Appendix 4 Safeguarding Adults team Activity

a) Safeguarding Adults

There were 167 safeguarding adults alerts received in 2013. This figure relates to **all** alerts referred through the Safeguarding Adults Team raised either **against** or **by** the Trust. The table below shows the safeguarding adults alert activity since records commenced.



Of the 167 alerts 61 were raised against acute staff and 5 against community staff. These alerts were raised against the following areas:



The following table gives the outcomes of Safeguarding Adults Investigations. Some of these investigations are still ongoing:

York NHSFT Staff (acute)	AMU	Not Determined / Inconclusive Not Substantiated Partially Substantiated	1 1 2
	AMU Total		4
	Beech	Not Safeguarding Partially Substantiated Ongoing	1 1 1
	Beech Total		3
	Cherry	Not Determined / Inconclusive Not Safeguarding Not Substantiated	1 1 1
	Cherry Total		3
	G1	Not Substantiated Substantiated	1 1
	G1 Total		2
	Oak	Not Safeguarding Partially Substantiated Substantiated	1 2 2
	Oak Total		5
	Stroke Unit	Not Safeguarding	1
	Stroke Unit Total		1
	W15	Not Safeguarding	1
	W15 Total		1
	W16	Substantiated	1
	W16 Total		1
	W23	Partially Substantiated Substantiated	1 1
	W23 Total		2
	W24	Not Safeguarding Not Substantiated Substantiated	2 2 1
	W24 Total		5
	W33	Not Determined / Inconclusive Substantiated	1 1
	W33 Total		2
	W36	Partially Substantiated	1
	W36 Total		1
	W21	Not Safeguarding Substantiated	1 1
	W21 Total		2
	W26	Not Substantiated Partially Substantiated Substantiated	1 1 1
	W26 Total		3
	Whitby	Not Determined / Inconclusive	1
	Whitby Total		1
	W25	Partially Substantiated Substantiated	1 1

	W25 Total		2
	W35	Partially Substantiated Substantiated	3 1
	W35 Total		4
	Johnson	Ongoing	1
	Johnson Total		1
	W34	Not Determined / Inconclusive Not Substantiated Substantiated	3 2 1
	W34 Total		6
	Chestnut	Partially Substantiated	1
	Chestnut Total		1
	Endoscopy	Ongoing	1
	Endoscopy Total		1
	Renal	Not Safeguarding	1
	Renal Total		1
	W39	Ongoing	1
	W39 Total		1
	Ann Wright	Ongoing	1
	Ann Wright Total		1
	ED (Y)	Not Determined / Inconclusive Not Safeguarding	1 2
	ED (Y) Total		3
	ED (S)	Not Safeguarding Not Substantiated Substantiated	1 1 1
	ED (S) Total		3
York NHSFT Staff (acute) Total			60
York NHSFT Staff (comm)	DN	Not Determined / Inconclusive Not Safeguarding Not Substantiated Ongoing	1 1 2 1
	DN Total		5
York NHSFT Staff (comm) Total			5
Grand Total			65

The investigations found that 13 of the 65 allegations were substantiated and 13 were partially substantiated.

The themes emerging following investigation are as follows:

Discharge	Partially Substantiated	Beech	1
		Oak	1
		W35	1
	Partially Substantiated Total		3
Discharge Total			3
General care	Partially Substantiated	AMU	1
		W23	1
		W36	1
		W26	1
		W25	1
		W35	1
		Chestnut	1
	Partially Substantiated Total		7
	Substantiated	G1	1
		Oak	1
		W16	1
		W24	1
		W33	1
		W21	1
		W26	1
		W34	1
		ED (S)	1
	Substantiated Total		9
General care Total			16
Pressure Ulcer	Partially Substantiated	AMU	1
		Oak	1
		W35	1
	Partially Substantiated Total		3
	Substantiated	Oak	1
		W23	1
		W25	1
		W35	1
	Substantiated Total		4
Pressure Ulcer Total			7
			26

Where an allegation have been either substantiated or partially substantiated Matrons have been involved and aware of actions required or already undertaken to address.

Appendix 4b) Mental Capacity Act/Deprivation of Liberty Safeguard Support

There were 23 documented Mental Capacity Act enquiries and 4 Deprivation of Liberty enquiries.

There is a national concern about the lack of applications for authorisation under Deprivation of Liberty from acute hospitals. The Trust are no exception to low numbers of applications (4 in 2013).

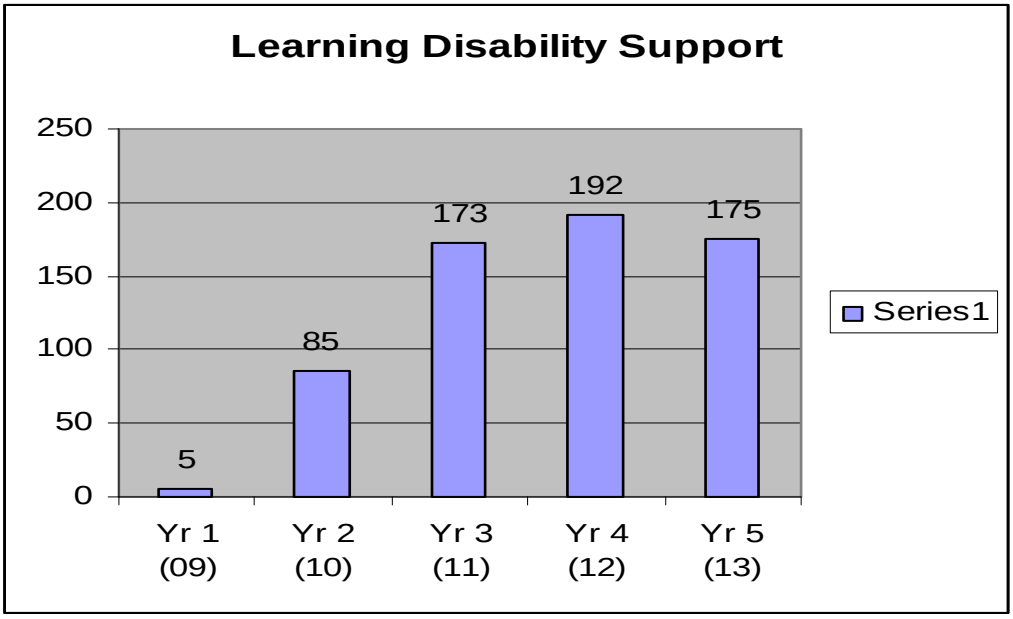
The Team are addressing this by liaising with the Mental Capacity Advisor from NYCC and arranging training sessions for ward staff.

Appendix 4c) Learning Disability Service

The Learning Disability Service was introduced in November 2009 with the appointment of the Learning Disability Liaison Nurse whose role was to offer support to patients with a learning disability requiring acute health care.

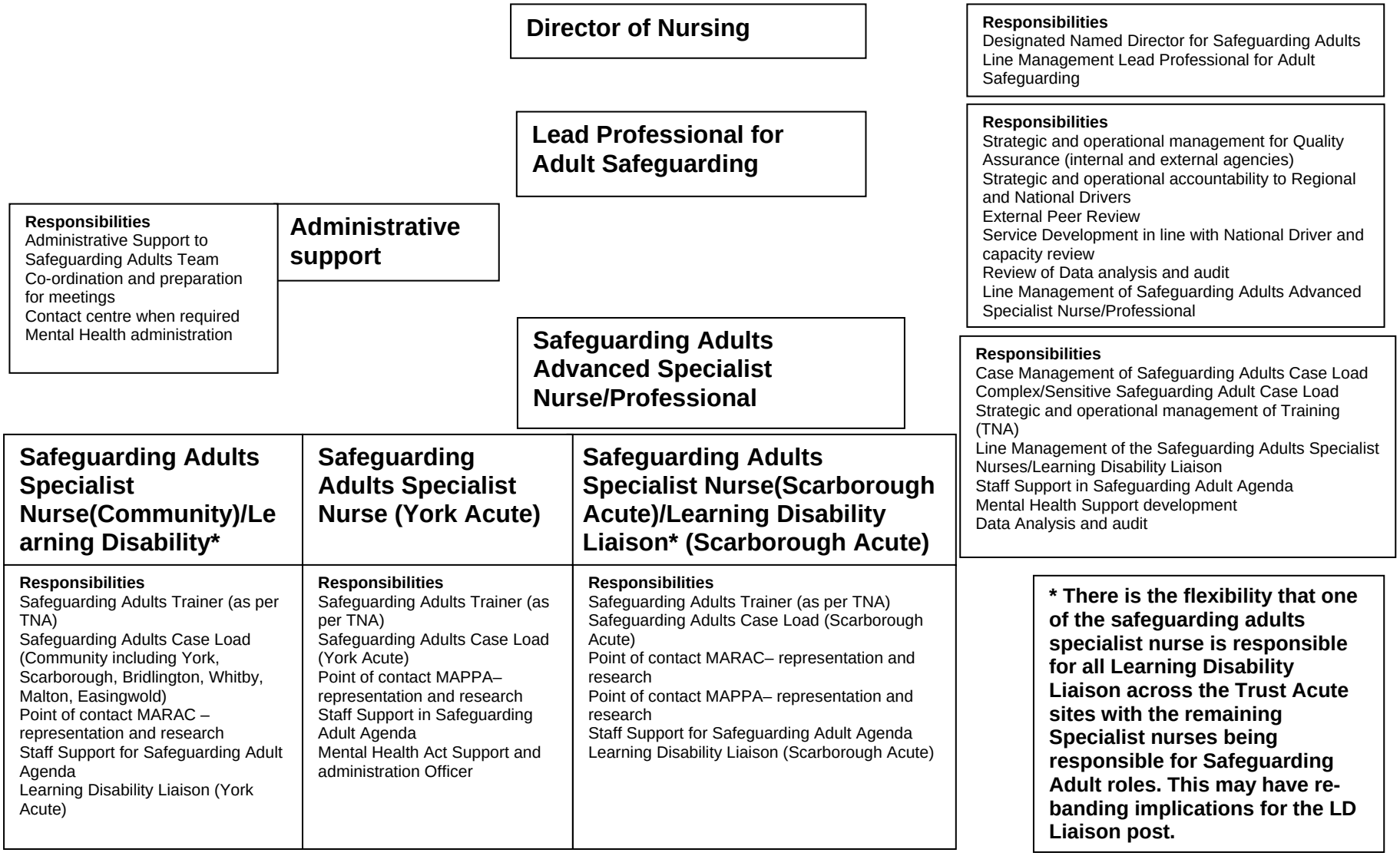
This role was expanded to include safeguarding adults in May 2011. Following integration in July 2012 a dual post for safeguarding and learning disability liaison was created to support Scarborough Whitby Ryedale sites.

The number of referrals have been as follows:



The reduction in referrals for 2013 could be attributed to the necessity of prioritisation. Due to increased demand the learning disability team have no longer had the capacity to plan for patients with a learning disability who were not regular attenders at either acute hospitals – this is something that could be provided in the past.

The team are hopeful that this will improve once there is more capacity.


Director of Nursing
Responsibilities
Designated Named Director for Safeguarding Adults
Line Management Lead Professional for Adult Safeguarding
Lead Professional for Adult Safeguarding
Responsibilities
Strategic and operational management for Quality Assurance (internal and external agencies)
Strategic and operational accountability to Regional and National Drivers
External Peer Review
Service Development in line with National Driver and capacity review
Review of Data analysis and audit
Line Management of Safeguarding Adults Advanced Specialist Nurse/Professional
Administrative support
Responsibilities
Administrative Support to Safeguarding Adults Team
Co-ordination and preparation for meetings
Contact centre when required
Mental Health administration
Safeguarding Adults Advanced Specialist Nurse/Professional
Responsibilities
Case Management of Safeguarding Adults Case Load
Complex/Sensitive Safeguarding Adult Case Load
Strategic and operational management of Training (TNA)
Line Management of the Safeguarding Adults Specialist Nurses/Learning Disability Liaison
Staff Support in Safeguarding Adult Agenda
Mental Health Support development
Data Analysis and audit
Safeguarding Adults Specialist Nurse(Community)/Learning Disability*
Responsibilities
Safeguarding Adults Trainer (as per TNA)
Safeguarding Adults Case Load (Community including York, Scarborough, Bridlington, Whitby, Malton, Easingwold)
Point of contact MARAC – representation and research
Staff Support for Safeguarding Adult Agenda
Learning Disability Liaison (York Acute)
Safeguarding Adults Specialist Nurse (York Acute)
Responsibilities
Safeguarding Adults Trainer (as per TNA)
Safeguarding Adults Case Load (York Acute)
Point of contact MAPPA– representation and research
Staff Support in Safeguarding Adult Agenda
Mental Health Act Support and administration Officer
Safeguarding Adults Specialist Nurse(Scarborough Acute)/Learning Disability Liaison* (Scarborough Acute)
Responsibilities
Safeguarding Adults Trainer (as per TNA)
Safeguarding Adults Case Load (Scarborough Acute)
Point of contact MARAC– representation and research
Point of contact MAPPA– representation and research
Staff Support for Safeguarding Adult Agenda
Learning Disability Liaison (Scarborough Acute)
* There is the flexibility that one of the safeguarding adults specialist nurse is responsible for all Learning Disability Liaison across the Trust Acute sites with the remaining Specialist nurses being responsible for Safeguarding Adult roles. This may have re-banding implications for the LD Liaison post.

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 April 2014

DIPC Quarterly Report - Q4 2013/14

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	This report has not been presented elsewhere
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	April 2014
Version number	1

DIPC QUARTERLY INFECTION PREVENTION REPORT FOR TRUST BOARD. Q4 2013 - 2014										
Parameter		Annual threshold/ target	Q1	Q2	Q3	Jan	Feb	Mar	YTD	Notes
MRSA Bacteraemia attributable to Trust	Community								0	
	Elderly			1					1	
	Head + Neck								0	
	Medicine			1					1	
	Obstetrics + Gynaecology								0	
	Ophthalmology								0	
	Paediatrics								0	
	Specialist Medicine								0	
	Surgery + Urology								0	
	Trauma + Orthopaedics								0	
	Trust		0	2	0	0	0	0	2	
MSSA Bacteraemia attributable to Trust	Community								0	
	Elderly		3	1		1		1	6	
	Head + Neck								0	
	Medicine		2	3	3		4	2	14	
	Obstetrics + Gynaecology								0	
	Ophthalmology								0	
	Paediatrics				1				1	
	Specialist Medicine		2	1					3	
	Surgery + Urology		2	4	1	1	1	1	10	
	Trauma + Orthopaedics		1						1	
	Trust	30	10	9	5	2	5	4	35	
MSSA per 100000 bed days attributable to Trust	York		14.1	9.2	3.6	4.9	5.5	16.1	8.9	
	Scarborough + Bridlington		6.9	13.7	10.1	9.9	41.7	10.0	12.7	
	Community hospitals		0.0	0.0	0.0	0.0	0.0	0.0	0.0	
	Trust		10.4	9.6	5.2	5.9	16.2	12.5	10.2	
	National rate		8.25	8.32	6.87					
E coli Bacteraemia attributable to Trust	Community		1	1	1	1			4	
	Elderly		4	8	12	2	1	4	31	
	Head + Neck					1			1	
	Medicine		6	4	7	3	1	4	25	
	Obstetrics + Gynaecology				1				1	
	Ophthalmology								0	

Parameter		Annual threshold/ target	Q1	Q2	Q3	Jan	Feb	Mar	YTD	Notes
attributable to Trust	Paediatrics							1	1	
	Specialist Medicine		2	4	4	1	2		13	
	Surgery + Urology		5	8	8	2	2	4	29	
	Trauma + Orthopaedics			2			1		3	
	Trust	Not set	18	27	33	10	7	13	108	
Elective MRSA admission screening (report produced by SNS Team)	York sites	100%	90%	83%	89%	88%	85%	87%	87%	
	Scarborough sites	100%	89%	90%	87%	96%	94%		91%	
	Trust	100%	90%	87%	88%	92%	90%		89%	
Emergency MRSA admission screening (report produced by SNS Team)	York sites	100%	79%	65%	70%	68%	70%	73%	71%	
	Scarborough sites	100%	93%	89%	91%	95%	93%		92%	
	Trust	100%	86%	89%	91%	82%	82%		86%	
Clostridium difficile Infection (CDI) attributable to Trust	Community		2	2	2		2		8	
	Elderly		6	5	13		1	1	26	
	Head + Neck								0	
	Medicine		7	5	5		2	1	20	
	Obstetrics + Gynaecology								0	
	Ophthalmology								0	
	Paediatrics								0	
	Specialist Medicine		1			1		2	4	
	Surgery + Urology		5		1		3		9	
	Trauma + Orthopaedics								0	
	Trust	43	21	12	21	1	8	4	67	
CDI per 100000 bed days attributable to Trust	York		24.8	5.5	19.6	4.2	22.2	10.7	15.6	
	Scarborough + Bridlington		17.1	23.9	26.8	0.0	2.1	20.0	20.3	
	Community hospitals		19.5	19.9	20.3	0.0	63.5	0.0	19.9	
	Trust		24.0	15.0	24.0	2.9	26.0	13.4	17.5	
	National rate		15.60	15.05	14.4					
CDI Saving Lives care bundle compliance	York	95%	69%	67%	91%	85%	92%	85%	82%	
	Scarborough + Bridlington	95%	25%	54%	78%	82%	67%	N/A	61%	
	Trust	95%	47%	61%	85%	84%	80%	85%	74%	
	Community			1	1				2	
	Elderly		1	2	9			2	14	
	Head + Neck								0	
	Medicine		6		4			1	11	

Parameter		Annual threshold/ target	Q1	Q2	Q3	Jan	Feb	Mar	YTD	Notes
Completed CDI post infection review	Obstetrics + Gynaecology								0	
	Ophthalmology								0	
	Paediatrics								0	
	Specialist Medicine		1			1			2	
	Surgery + Urology		4	1					5	
	Trauma + Orthopaedics								0	
	Trust		12	4	14	1	0	3	34	
Deaths where Clostridium difficile is reported on certificate	Community								0	
	Elderly		1	1	4				6	
	Head + Neck								0	
	Medicine		1		1				2	
	Obstetrics + Gynaecology								0	
	Ophthalmology								0	
	Paediatrics								0	
	Specialist Medicine								0	
	Surgery + Urology						1	1	2	
	Trauma + Orthopaedics								0	
	Trust		2	1	5	0	1	1	10	
Readmissions within 30 days where CDI is diagnosed on admission - NB: refers to discharging directorate	Community		2						2	
	Elderly		1	1					2	
	Head + Neck								0	
	Medicine		2	1	2				5	
	Obstetrics + Gynaecology								0	
	Ophthalmology								0	
	Paediatrics								0	
	Specialist Medicine				1				1	
	Surgery + Urology		1						1	
	Trauma + Orthopaedics								0	
	Trust		6	2	3	0	0	0	11	
Antimicrobial pathway compliance with	York sites		44%	49%	53%	Reported by directorate from January 2014				
	Scarborough sites		67%	54%	61%					
	Anaes,Theatre and Crit care					88%	83%	N/A	86%	
	Elderly					83%	85%	89%	86%	
	Emergency					87%	N/A	73%	80%	

Parameter		Annual threshold/ target	Q1	Q2	Q3	Jan	Feb	Mar	YTD	Notes
indication (information from Antimicrobial Stewardship Team)	Head + Neck		Reported by hospital site up to December 2013 2014			44%	40%	44%	43%	
	Medicine					67%	90%	84%	80%	
	Obstetrics + Gynaecology					0%	80%	25%	35%	
	Specialist Medicine					29%	75%	88%	64%	
	Surgery + Urology					55%	64%	77%	65%	
	Trauma + Orthopaedics					46%	87%	47%	60%	
	Trust		56%	52%	57%	55%	76%	66%	66%	
Antimicrobial pathway compliance with duration or review date (information from Antimicrobial Stewardship Team)	York Hospital		57%	56%	59%	Reported by directorate from January 2014				
	Scarborough Hospital		67%	61%	60%					
	Anaes,Theatre and Crit care		Reported by hospital site up to December 2013 2014			47%	50%	N/A	49%	
	Elderly					73%	91%	89%	84%	
	Emergency					80%	N/A	60%	70%	
	Head + Neck					56%	67%	89%	71%	
	Medicine					70%	58%	82%	70%	
	Obstetrics + Gynaecology					67%	60%	25%	51%	
	Specialist Medicine					43%	63%	50%	52%	
	Surgery + Urology					68%	65%	86%	73%	
	Trauma + Orthopaedics					44%	94%	71%	70%	
	Trust		62%	59%	60%	61%	69%	69%	66%	
Ventilator acquired pneumonia in ICU (information provided by ICU)	York ICU		0	2	0	1	0	0	3	
	Scarborough ICU		1	0	2	0	0	0	3	
	Trust		1	2	2	1	0	0	6	
CVC associated infections in ICU (information provided by ICU)	York ICU		1	0	0	0	0	0	1	
	Scarborough ICU		0	0	0	0	0	0	0	
	Trust		1	0	0	0	0	0	1	
Trust attributed CAUTI (Safety Thermometer data)	York		3	6	6	5	2	0	22	
	Scarborough + Bridlington		9	2	5	2	3	0	21	
	Community hospitals		6	3	5	0	0	2	16	
	Trust		18	11	16	7	5	2	59	
	Anaes,Theatre and Crit care	95%	100%	100%	100%	100%	99%	100%	100%	
	Community	95%	100%	100%	100%	100%	100%	100%	100%	
	Elderly	95%	98%	98%	98%	100%	98%	100%	99%	
	Emergency	95%	100%	98%	100%	100%	90%	100%	98%	

Parameter		Annual threshold/ target	Q1	Q2	Q3	Jan	Feb	Mar	YTD	Notes
Hand Hygiene compliance	Head + Neck	95%	100%	100%	100%	100%	100%	100%	100%	
	Medicine	95%	99%	99%	99%	98%	96%	99%	98%	
	Obstetrics + Gynaecology	95%	100%	100%	100%	100%	100%	100%	100%	
	Ophthalmology	95%	100%	100%	100%	100%	100%	100%	100%	
	Paediatrics	95%	100%	100%	100%	100%	100%	100%	100%	
	Clinical support	95%	99%	98%	99%	100%	100%	98%	99%	
	Radiology	95%	100%	100%	100%	98%	100%	100%	100%	
	Sexual Health	95%	99%	100%	100%	100%	100%	No return	100%	
	Specialist Medicine	95%	100%	91%	100%	100%	100%	99%	98%	
	Surgery + Urology	95%	100%	99%	97%	97%	100%	98%	99%	
	Trauma + Orthopaedics	95%	100%	100%	100%	100%	100%	97%	100%	
	Trust	95%	100%	99%	100%	100%	99%	99%	99%	
Environment audit results	York sites	95%	96%	96%	97%	96%	97%	97%	97%	
	Scarborough sites	95%	93%	93%	94%	93%	95%	91%	93%	
	Trust	95%	95%	95%	96%	95%	96%	94%	95%	
Infection Prevention training attendance (attendance reports provided by Corporate, Learning and Development Team)	Anaes,Theatre and Crit care		31%	44%	64%	59%	45%	42%	47%	
	Community		53%	46%	46%	51%	47%	17%	46%	
	Elderly		17%	73%	80%	40%	40%	33%	52%	
	Emergency		7%	25%	11%	7%	29%	18%	15%	
	Head + Neck		12%	18%	48%	48%	96%	54%	37%	
	Medicine		18%	54%	64%	43%	36%	27%	43%	
	Obstetrics + Gynaecology		118%	86%	76%	113%	130%	90%	98%	
	Ophthalmology		7%	27%	27%	70%	60%	70%	32%	
	Paediatrics		18%	41%	36%	53%	41%	30%	35%	
	Radiology		12%	11%	34%	7%	40%	4%	18%	
	Sexual Health		8%	39%	23%	0%	12%	23%	20%	
	Specialist Medicine		18%	34%	59%	51%	76%	25%	41%	
	Surgery + Urology		44%	47%	49%	31%	44%	19%	43%	
	Therapies (AHPs)		28%	59%	71%	82%	74%	41%	56%	
	Trauma + Orthopaedics		19%	54%	66%	37%	68%	21%	45%	
	Trust		27%	44%	50%	46%	56%	34%	47%	

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Finance and Performance Committee – 22nd April, Post Graduate Classroom 4 YTH

Attendance: Mike Sweet, Chairman
Mike Keaney
Lucy Turner
Andrew Bertram
Graham Lamb
Liz Booth
Anna Pridmore
Steve Kitchen
Mike Davison

Apologies: Debbie Hollings-Tennant

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last Meeting Notes Minutes Dated 18th March 2014**		The notes were approved as a true record of the meeting. It was noted that the agenda for the April meeting had the Corporate Risk Register and Assurance Framework items attached so ensuring the Committee remains aware of the specific risks being managed in the organisation.		
2	**Matters arising**		There were no matters arising from the minutes		
3	**Short Term Acute Strategy**		LB advised that the capital development work around York ED was going to plan. This scheme is due to complete later in June. In relation to Scarborough, currently decisions are being made about the number of trolley spaces for ambulance admissions and the department is working with the architects to design the area. This project is a longer	The Committee were assured about the progress of the capital work and the achievement of the target in June 14.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			term scheme linked to the Paediatric build that forms part of the post acquisition capital developments. The Trust has been consulting with the clinical workforce around changing the rotas for acute and general physicians. The next stage of this development is for the new job plans to be agreed. The job plans will ensure that there is a multi-disciplinary approach in support of the proposed Acute Assessment Centre. The case for the Acute Assessment Area is being developed with consideration being given to bed levels, rapid diagnostic support, a discharge area and scope for ambulatory care facilities. The committee discussed the recent pilots involving GPs working alongside ED. LB explained this was being evaluated in the context of a longer term arrangement as part of the urgent care development work.	The Committee was assured by the comments about the development of the Acute Assessment Unit.	
4	**Efficiency Report**	CRR 39	SK presented the report and highlighted that the target for 2013/14 was £23.4m and that the Trust had actually delivered £26.2m. This represented over delivery of £2.8m. Table 4 of the report was reviewed by the Committee. It was noted that the percentage of recurrent schemes to non-recurrent schemes had not substantially changed between February and March. Therefore there would be a carry forward of non-recurrent savings. The Committee discussed the updated target for the CIP for 2014/15 recognising the latest position with commissioner negotiations and evaluation of non-recurrent schemes. AB commented that the CCGs have agreed not to impose a 4% efficiency target on the Trust's Community Services as it does not fit with their longer term strategy of developing the services in	The CIP target had been achieved for the year 2013/14 and congratulations go to all those involved throughout the Trust.	AB to comment on the updated CIP target for 14/15.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			community. The Committee commented that they do still need to understand the vacancy factor element previously discussed, along with the principles of under and over achievements and mandatory staffing levels. It was agreed that would be presented to the next meeting.. SK commented on table 5 included in the report. He outlined that the table showed the plan for the next four years and that at present the Trust had plans for £48m of savings. Given the scale of the challenge the Committee asked that it be provided with an overview of the possible "big ticket" items that will be required to achieve the target. SK referred the Committee to the governance ratings and noted that all directorates now had a green governance rating. It was agreed that some further work would be undertaken to refresh the governance ratings as new schemes were introduced going forward. The Committee reviewed the performance of each of the directorates and noted the areas where there was underperformance. The Committee asked how under and over performance is addressed with the directorates. AB advised that the directorates that over perform keep the benefit to carry forward to the next year plus a percentage "cash back" is offered as an incentive. The directorates that underperform have their target increased by the balance not achieved. Additionally, where a directorate's behaviour demonstrates efficiencies, but they are not able to be directly quantified financially, then the Trust runs a CIP credit scheme where such a directorate would receive recognition against their target to encourage efficient behaviour.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			The Committee asked if Monitor had reported on their audit around CIP. AB advised that Monitor would be providing their report on their audit around efficiency over the next few weeks as part of their formal annual plan feedback and agreed that its content would be brought to the attention of the Committee. The Committee received the Internal Audit Report on the Cost Improvement Programme and noted that significant assurance could be taken from the report. It was agreed that progress on the recommendations in the report would be reviewed at the end of Q2.	The internal audit report provided significant assurance around the systems in place	
5	**Operational Report**	AFW DoF7 COO3 CRR 36	The Committee discussed the key points from the report. **Access – 18 weeks –** LT reminded the Committee that the work being undertaken around patients that had waited 36 weeks was to achieve no 36 week waiters by the end of Q4. This was not quite achieved. There are a small number of patients that do not yet have a date for treatment; and some patients have chosen not to accept their proposed date. The CCG has been informed and work will continue to ensure the backlog is cleared. In terms of the new year patients being treated within 18 weeks, the Monitor aggregate target for April is expected to be achieved, but there are some issues at a specialty level which are being addressed. **Expected Discharge Date (elective)** The Trust failed the 95% trajectory for quarter 4. Improvements have been made over the last couple of months and it is understood that there will continue to be a trajectory included in the 2014/15 contract.	The Committee noted the progress made and the continued work on ensuring all patients are treated within 18 weeks. The Committee noted the trajectory had been failed and the improvements that have been made. The Committee was pleased to	MP to comment

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Emergency Department - there has been excellent progress made over the last few months and the department has achieved the target for the quarter. Additionally over the Easter bank holiday period the department continued to maintain the level of performance without any additional support which historically would have been in place. Intensive Support Team – LB advised that the team had visited the two main sites and had also reviewed community services. The feedback the Trust had received was very positive and it was felt that we were doing everything we could do. They were however, quite critical of the commissioning of community services and had discussed this with the CCG. **Scarborough cancellation of theatre lists –** LB advised that the number of cancellations is being monitored and there have been no cancellations over the last 2 weeks. The processes that have now been put in place are beginning to demonstrate results. **Ambulance turnround times –** LT advised that improvements are also being made in this area. There will always be a level of failure due to the nature of how ambulances arrive. When the additional bays are available in York that will also improve the performance. LB added that there is still a data quality issue that has not been fully resolved. This is being addressed with the Ambulance Trust. The Committee was particularly pleased to note that ambulance waits of more than 60 minutes, waits that attract a £1k fine, had reduced dramatically in Q4 **Cancer –** The delivery of the targets remains difficult. 62 day screening target was missed in January and February	see the continued improvements in the Emergency Department. The Committee was assured by the comments made by LB. The Committee noted the improvements made.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			which may result in the Trust not achieving the target for the quarter. The 14 day symptomatic breast target will be failed for the quarter. The issues are as reported last month. Recruitment is underway and a suitable candidate may have been found. **Delayed transfer of care –** LB explained that packages of care have been of concern to the Trust for a considerable period of time. There are a number of patients who have been medically fit for discharge, but the teams have not been able to discharge the patients because of issues at the local authority with the care packages. The team are working with social services to ensure improvements are made. The Committee discussed the cost in terms of bed days to the Trust of patients being kept in hospital who are medically fit for discharge. It was noted that it is a significant number - between 1000-2000 bed days per month - and is amongst the highest in the country . At present this has improved but the issue remains. The Committee asked if Scarborough had the same issue. LB advised that it did not have the same issue and indeed there have been occasions where York has been able to transfer patients out to other care facilities in the Scarborough area from York. **Commissioning for Quality and Innovation (CQUIN) –** LT advised that there have been some data issues around the recording of the pressure ulcer CQUIN which has resulted in the Trust under reporting prevalence. This means that the Trust has not achieved the CQUIN for acute patients in full, but has achieved the CQUIN for community patients. The Trust has negotiated a part payment of the		MP to comment MP to explain

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			CQUIN as a result. The data quality issues have now been resolved. The committee noted that as all year-end contract positions had been finalised (except one small contract) and no further financial risk existed from CQUIN. There were a number of CQUIN targets the Trust did not achieve in quarter 4 including: • dementia target for the number of patients over 75 admitted as an emergency who are reported as having a known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding questions. This remains a challenge for the Scarborough site. • The care of the deteriorating patient as measured by the post-take 12 hour senior review has not been achieved at Scarborough. • The Trust also did not achieve the Q4 elderly length of stay target • Although the NEWS 1 hour target of 85% was not achieved for the full quarter it was achieved by the quarter end. The Committee discussed the C-Diff trajectory changes for this next financial year and noted that the trajectory had increased to 59, and that the fines had decreased for any case above the trajectory. It was also noted that where a Root Cause Analysis attributes an incidence of C-Diff to the Trust, then only under these circumstances would the case count against the Trust's trajectory for contract penalty purposes. The Committee also discussed the new duty of candour	The Committee noted the changes made to the trajectory	AJT to comment AJT to explain

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			and how that would impact on the Trust. It was understood that systems were being put in place. The Committee also discussed the meetings that were being held by the Trust with the CCG around the conditions register. AB advised that 5 of the 8 meetings had been held without any further challenge to the register. In fact the neurology register was extended given the imminent release of new NICE guidelines which are expected to require 12 month specialist follow up for MS. It was noted that given the work undertaken in 2013/14 the proposals from the CCG for the F to FU targets for 2014/15 are not acceptable to the Trust.	The Committee noted the update and were assured by the comments made by AB	
6	**Finance Report**	AFW DoF2 DoF3 DoF5 DoF7 CRR 35,40, 41	AB tabled a paper which outlined the year end position. The reported income and expenditure position was a deficit of £0.995m. AB advised that after taking into account non-cash impairment charges of £3.693m (which relate to downward revaluations on completed capital schemes and the write down of IT assets transferred to the Trust under the TCS property initiative)the Trust delivered a trading surplus of £2.7m. In assessing underlying performance Monitor excludes these impairment charges, donated asset income of (minus £0.624m) and restructuring payments (£1.003m). As a result Monitor will assess the Trust's underlying performance as delivering a surplus of £3.117m. AB advised that the final year end position has been agreed with all the CCGs with the exception of Harrogate. He was expecting those negotiations to be completed in the near future.	The Committee were assured by the report given by AB and the results for the end of the year.	AB to comment

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			In terms of cash the year-end balance is £25.315m which is slightly behind plan because of the change in timing for the £3m balance of strategic capital, now due in 2014/15. AB reminded the Committee that a paper was submitted to Monitor around the capital spend a few months ago where the Trust revised the capital forecast. The actual performance has fallen slightly short of that revised forecast, but would be deemed immaterial by Monitor as at 8% the variance is outside their threshold. There are no further issues to bring to the attention of the Committee around capital.		
7	**KPIs from Grant Thornton**		The Committee noted the content of the report and the assurance given. The Committee discussed the relationship of the variances and understood how they related to the FT sector.	The Committee were assured by the information included in the report.	
8	**SLR Report update**		MD presented the report and highlighted the key changes that have occurred over the last 12 months. He advised the Committee of the developments that would be made over the next few months and summary report included in the papers. MD explained that the team is now preparing a consolidated 9 month position which it expects to complete by late April early May. The committee discussed the first cut SLR information for all the Trusts sites/services. This provided an interesting insight into loss making and profit making services. The committee discussed the role this analysis will have in the efficiency programme and also with commissioners of services on the East Coast going forward. It was noted this was early days in this work and much validation work was	The Committee were assured by MD's comments and the paper submitted	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			necessary with clinical directorates but the committee recognised the importance of this information in the coming years. Evidence from the paper clearly indicated the benefit Of "deep dives" and the Committeee encouraged the team to undertake as many of these as practical. MD also described the work he was currently undertaking with the integration of the costing team and the corporate efficiency team and the benefits that will arise from that integration.		
9	**Capital Planning Report update**		The Committee noted the work that had been undertaken. It also noted the move to undertake more in house work and asked if the Trust would continue to use independent costing evaluations. AB explained that Brian Golding was considering which skills to bring in-house and which to continue to buy in. MS commented on the benefits and assurance provided by having some form of independent review of tenders to ensure good value for money.. POST MEETING NOTE: The Trust's capital plans will be tabled at the May Board meeting.	The Committee noted the report	
10	**Any other business**		There was no further business to discuss.		
11	**Next meeting**		The next meeting will be on Tuesday 20th May at 9.30am Ward 37 Seminar Room		

York Teaching Hospital NHS
NHS Foundation Trust

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Monthly Performance Report

March 2014

York Teaching Hospital NHS
NHS Foundation Trust

Performance Headlines 2013/14 – March

Access

18 weeks: Zero patients waited over 52 weeks for treatment in March. Continued reduction in patients waiting over 36 weeks for their treatment, from 114 in February to 54 in March. All remaining Admitted patients have admission dates.

As briefed last month, the admitted target has been failed as planned in February and March to achieve no patients waiting over 36 weeks for treatment. The non admitted and incomplete targets both achieved.

Recording of Expected Discharge Date (elective): the Trust failed the 95% trajectory for this indicator for Q4, although improvements have been made over the last 2 months.

Reduction in number of hospital cancelled first and follow up OPAs for non clinical reasons: Continued improvement on both sites.

ED: 97.3% achieved for all types in February (target 95%), Q4 achieved. 96.2% Achieved for all types in Q4. Type 1 achieved on York site but not on Scarborough site. On aggregate 94.8%.

The Emergency Care Intensive Support Team has visited both York and Scarborough acute sites and Community. The initial early feedback has been very positive.

Ambulance Handover: reduction in the number of ambulances waiting over 30 mins for handover. Capital work commenced on York site.

Cancer 6**2 Days Screening**: Target missed for January and February. Achieving Q4 will be challenging.

Symptomatic Breast: Ongoing concern regarding target due to patient choice and reduced radiology cover at Scarborough site. Target not achieved for Q4. Recruitment plans now in place however unlikely to impact until Quarter 2.

Delayed Transfers of Care: Continue to be a challenge and is the receiving focussed work to ~~reduce. Currently over 500 bed days per month~~

CQUINS

Dementia: the Trust has again failed the case finding question target in March. This has resulted in a fail for Q4. This indicator remains a national CQUIN in 2014/15.

Care of the deteriorating patient: There is a significant risk that the 12 hour post take review was not achieved at the end of Quarter 4 due to issues on the Scarborough site.

NEWS: Obs within 1 hr of prescribed time for Q4 achieved 82.6% against a target of 85%. Financial penalty value of £175k.

Elderly length of stay: Although improved on both sites in March currently above trajectory for Q4.

Respiratory - Asthma bundle: this target will not be met for Q4. Financial value £180k.

Quality and Safety

Cdiff: Cumulative end of year position of 67 cases against a total yearly target of 43. Note 4 cases in March.

Stroke patients scanned with 24 hrs of hospital arrival: The Trust continues to be unable to achieve the 100% target for this indicator. Although overall performance improved to 96.6%.

Finance Penalties

Key Performance Indicators
April - March 2013/14 (approximate value)

18 weeks: £406,000
52 weeks: £105,000
Cdiff: £1,200,000
MRSA: £9,860
EMSA: £6,750
ED 12 hour trolley wait: £1,000
ED 4 hour target: £136,071

Total: **£1,864,681**

Monitor Issues

Quarter 4:
~~Actua~~l

18 weeks: Planned fail for February and March. Monitor aware.

Cdiff: over YTD trajectory

14 day Breast Symptomatic: 81.3% delivery against target of 93%

62 day Screening: Quarterly 1 monitor point

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Contracted Performance Requirements 2013/14: Access Targets

Indicator	Consequence of Breach	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Jan	Feb	Mar	Q4 Actual
18 Weeks									
Percentage of admitted patients starting treatment within a maximum of 18 weeks from referral	**Monthly:** **Specialty fail:** 37.5% of Contract Month Elective Care 18 Weeks Revenue for specialty Performance Notice **Quarterly:** 1 Monitor point	**90%**	90.2%	90.4%	90.8%	90.4%	88.7%	75.6%	84.7%
Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from referral	**Monthly:** Specialty fail: 12.5% of Contract Month Elective Care 18 Weeks Revenue for specialty Performance Notice **Quarterly:** 1 Monitor point	**95%**	95.0%	95.3%	95.7%	95.8%	96.1%	95.8%	95.9%
Percentage of patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	**Monthly:** Specialty fail: 50% of Contract Month Elective Care 18 Weeks Revenue for specialty Performance Notice **Quarterly:** 1 Monitor point	**92%**	92.0%	92.0%	92.0%	92.0%	92.6%	95.0%	95.0%
Zero tolerance RTT waits over 52 weeks	£5000 per patient waiting over 52 weeks	**0**	1	0	0	0	0	0	0
Zero tolerance RTT waits over 36 weeks by Q3	Performance Notice (VoY)	**0**	277	226	173	143	114	54	56
% of patients seen within 18 weeks for direct access audiology	Performance Notice	**95%**	99.9%	99.9%	100.0%	99.3%	99.9%	98.8%	99.4%
Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	2% of revenue from provision of service line	**99%**	99.0%	99.3%	99.0%	98.8%	99.5%	99.6%	99.3%
Inpatients									
Sleeping Accommodation Breach	£250 per patient per day	**0**	0	24	3	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 patient's treatment to be funded at the time and hospital of the patient 's choice	Non payment of costs associated with cancellation and non payment or reimbursement of re-scheduled episode of care	**0**	1	0	0	0	0	0	0
No urgent operation should be cancelled for a second time	Non payment of costs associated with cancellation and non payment or reimbursement of re-scheduled episode of care	**0**	0	0	0	0	0	0	0
All patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system on admission within 48 hours at York hospital and Scarborough hospital	Exception Report to be provided where the target failed in any one month (ER)	**95% by Q4 (Elective)**	81.5%	82.2%	83.2%	84.2%	86.3%	87.1%	85.9%
Delayed transfers of care: number of bed days	Performance Notice	**None - indicator to inform 14/15**	799	1053	1444	517	570	578	1665
Hospital admissions where the patients' ethnic group was recorded in electronic patient records	Performance Notice (VoY)	**End Q3 >88%** **End Q4 >90%**	89.6%	88.8%	90.3%	91.6%	93.3%	91.5%	92.1%

Contracted Performance Requirements 2013/14: Access Targets

Indicator	Consequence of Breach	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Jan	Feb	Mar	Q4 Actual
Outpatients									
Trust waiting time for Rapid Access Chest Pain Clinic	Performance Notice (ER)	**98%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Reduction in number of hospital cancelled first and follow up outpatient appointments for non clinical reasons - YORK	Performance Notice (ER)	**York Baseline 11.1% to achieve 10.74% By Q4**	12.6%	11.6%	10.0%	10.3%	12.4%	11.0%	11.2%
Reduction in number of hospital cancelled first and follow up outpatient appointments for non clinical reasons- SCARBOROUGH	Performance Notice (ER)	**Scarborough baseline 11.2% to achieve 10.7% by Q4**	18.0%	16.8%	15.6%	14.8%	12.7%	11.2%	12.9%
North Yorkshire Commssioners Only - First: Follow Ratios will be capped at 1:2.1 for Q1, 1:1.5 for Q2. This is subject to the Speciality Review which once complete if a revision is required to the ratio it will be applied prospectively	£	**1:1.5 (Q2 on)**	2.06	1.85	1.86	1.91	1.89	1.82	1.87
Outpatient clinics cancelled with less than 14 days notice	Performance Notice (VoY)	**Baseline 258 End Q2 <258 End Q3 <254 End Q4 <250**	744	667	491	140	112	118	370
Provider failure to ensure that 'sufficient appointment slots' are available on Choose & Book	Performance Notice ER and VOY	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	4.18%	6.8%	5.0%	2.7%	5.9%	4.9%	4.6%
Emergency Department									
Percentage of A & E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**95%**	96.3%	94.1%	93.4%	95.6%	95.5%	97.3%	96.2%
A&E: % attendances at Type 1 units where the patient spent four hours or less in A & E from arrival to transfer, admission or discharge	Performance Notice	**Q1 90%; Q2 90%; Q3 95%**	York: 95.0% Scar: 95.1% Total: 95.1%	York: 93.2% Scar: 88.6% Total: 91.5%	York: 90.9% Scar: 91.0% Total: 90.9%	York: 95.2% Scar: 92.0% Total: 94.1%	York: 96.0% Scar: 89.9% Total: 93.9%	York: 96.3% Scar: 96.2% Total: 96.3%	York: 95.9% Scar: 92.9% Total: 94.8%
Recording of **compliance** with patient handover arrangements in A&E	£5 per patient from Q3 onwards	**Q1 90% Q2 90% Q3 95%**	82.3%	83.7%	92.3%	90.1%	91.4%	91.1%	90.8%
All handovers between ambulance and A & E must take place within 15 minutes	£200 per patient waiting over 30 minutes from Q3	**> 30min**	595	762	699	134	124	106	364
All handovers between ambulance and A & E must take place within 15 minutes	£1000 per patient waiting over 60 minutes from Q3	**> 60min**	135	284	280	31	21	6	58
Trolley waits in A&E	£1000 per breach	**> 12 hrs**	0	1	0	0	0	0	0
A&E: % attendances for cellulitis and DVT that end in admission	Quarter: Performance Notice	**> 12/13 Avg**	17.0%	17.3%	23.7%				22.0%
A&E: % re-attending (unplanned)	Quarter: Performance Notice	**> 5%**	3.0%	3.2%	3.1%	2.7%	2.3%	2.4%	2.4%
A&E: % left department without being seen	Quarter: Performance Notice	**> 5%**	3.0%	4.7%	4.3%	2.6%	3.0%	2.9%	2.8%
A&E: 95th percentile for time to initial assessment	Quarter: Performance Notice	**>15mins by end Q2**	61	89	80	76	65	66	68
Service experience - any worsening in the aggregate score of national patient survey	Annual: Performance Notice								
Monthly report to show patient satisfaction score for A&E department	Performance notice	**none**	62	49	45	43	54	60	52

Contracted Performance Requirements 2013/14: Access Targets

Indicator	Consequence of Breach	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Jan	Feb	Mar	Q4 Actual
Cancer (one month behind due to national reporting timetable)									
Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**85%**	92.1%	91.4%	89.1%	80.5%	87.0%	not available yet	not available yet
Percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**90%**	98.2%	91.4%	92.4%	87.5%	89.5%	not available yet	not available yet
Percentage of patients waiting no more than 62 days for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	**Monthly:** 2% of revenue from provision of service line	**85%**	100.0%	100.0%	100.0%	100.0%	n/a	not available yet	not available yet
Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**96%**	99.3%	99.3%	99.3%	96.8%	96.5%	not available yet	not available yet
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**94%**	95.5%	97.8%	97.1%	94.1%	100.0%	not available yet	not available yet
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regime	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**98%**	100.0%	99.5%	99.6%	100.0%	100.0%	not available yet	not available yet
Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 0.5 Monitor point	**93%**	95.6%	94.2%	95.9%	89.1%	94.7%	not available yet	not available yet
Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 0.5 Monitor point	**93%**	94.7%	93.1%	85.6%	82.5%	81.3%	not available yet	not available yet

Indicator	Target	Weighting	Financial Value	Q1 Actual	Q2 Actual	Q3 Actual	Jan	Feb	Mar	Q4 Actual	Comments
N1: Friends and Family Test [To improve the experience of patients in line with the domain 4 of the NHS Outcomes Framework]											
1.1 Friends & Family Test Phased Expansion - Delivery of Friends and Family rollout for maternity services		0.0375%	£135,000								
1.2 Friends and Family Test - Increased Response Rate Provider achieving an increase in response rate that improves on Q1 and is 20% or over	Q1: 15% Q4: 20%	0.0500%	£180,000	9.8%	19.9%	30.4%	26.2%	25.1%	26.1%	25.8%	
1.3 Friends and Family Test - Improved performance on the Staff Friends and Family Test Provider having a better result in 2013/14 compared with 2012/13 (70.4), or remaining in the top quartile		0.0375%	£135,000								
N2: Safety Thermometer											
2 NHS Safety Thermometer - Improvement Reduction in prevalence of the number of patients recorded as having a category 2-4 pressure ulcer (old or new)	2.9%	0.0625%	£225,000	5.7%	4.7%	3.8%	4.1%	4.5%	4.0%	4.2%	Acute
	7.46%	0.0625%	£225,000	9.4%	8.3%	7.0%	7.5%	7.5%	9.4%	8.2%	Community
N3: Dementia											
3.1a Dementia - Number of patients >75 admitted as an emergency who are reported as having known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question	90%	0.0750%	£270,000	94.0%	92.5%	90.4%	88.6%	89.0%	88.8%	88.8%	
3.1b Dementia - Number of above patients reported as having had a diagnosis assessment including investigations	90%			97.6%	99.2%	99.1%	98.8%	99.3%	100%	99.3%	
3.1c Dementia - Number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners	90%			99.0%	100.0%	98.9%	98.5%	99.0%	100%	99.1%	
3.2 Dementia - Clinical Leadership10/09/2013 named lead clinician and submit training plan to be delivered by March 2014		0.0125%	£45,000								
3.3 Dementia - Supporting Carers of People with Dementia - monthly audit 6 monthly - Report on feedback from Carers to Commissioners		0.0375%	£135,000								

Indicator	Target	Weighting	Financial Value	Q1 Actual	Q2 Actual	Q3 Actual	Jan	Feb	Mar	Q4 Actual	Comments
N4: VTE											
4.1 VTE Risk Assessment	95%	0.1250%	£450,000	95.0%	96.1%	97.8%	98.2%	96.8%	96.8%	97.3%	
4.2 VTE Root Cause Analysis				100.0%	95.0%	92.3%	42.9%	75.0%	50.0%	50.0%	Q4 provisional
N5: Care of the Deteriorating Patient											
5.11 Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions - 80% of admissions through AMU and Cherry will be reviewed within 4 hours of admission	Q4: 80%	0.4000%	£1,440,000	80.3%	88.4%	81.7%	77.7%	88.7%	86.2%	84.0%	York
	Q4: 80%				74.1%	80.0%	78.8%	80.8%	88.7%	83.1%	Scarborough
5.12 Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions - 80% of all acute medical, elderly medical and orthogeriatic patients to have a Consultant post take ward round consultation within 12 hours of arrival.	Q4: 80%			68.5%	71.5%	74.1%	81.7%	87.5%	84.8%	84.5%	York
	Q4: 80%				52.9%	60.6%	61.9%	65.1%	67.0%	65.1%	Scarborough
5.2 Care of the Deteriorating Patient at York and Scarborough Hospitals - Identification, Response & Management - Adults (excluding Obstetrics, ICU/HDU, SCBU, Day Cases, Children and Paediatrics). - Number of patients who have observations recorded producing NEWS score within 1 hour of prescribed time - No of patients with NEWS score trip with escalation of care within 15 minutes to appropriate clinician. - Quality of escalation response - Trust to produce a quaterly report on actions taken and improvements made to care pathways	Q2 70% Y&S; Q3 80% Y&S; Q4 85% Y&S	0.4000%	£1,440,000	67.3%	70.5%	80.0%	79.6%	82.1%	85.9%	82.6%	1hr Obs
	Q2-4						Quarterly audit				Quality of escalation response
5.3 Full implementation of NEWS and PAWS across both York and Scarborough Hospitals by Q4, excluding Paediatrics, SCBU, Obstetrics, ICU/HDU and Day Cases.		0.1000%	£360,000								

Indicator	Target	Weighting	Financial Value	Q1 Actual	Q2 Actual	Q3 Actual	Jan	Feb	Mar	Q4 Actual	Comments
N6: Reduce Length of Stay on Elderly Medicine Bed Base											
6a: A reduction in the average length of stay in the acute elderly medicine bed base of York	100% 9 days; 75% 9.2 days; 50% 9.5 days	0.0500%	£180,000	9.62	10.84	10.10	11.95	11.46	10.21	11.22	
6b: A reduction in the average length of stay in the acute elderly medicine bed base of Scarborough Hospitals	100% 10 days; 75% 10.16 days; 50% 10.32 days	0.0500%	£180,000	11.17	10.71	11.89	10.44	13.06	11.68	11.52	
6c: A reduction in the average length of stay in the acute elderly medicine bed base of the rehab beds at White Cross Court and St Helen's.	100% 50 days; 75% 51.17 days; 50% 52.3 days	0.1000%	£360,000	53.14	48.79	43.53	44.47	45.73	57.04	50.75	
N7: Effective Discharge											
7.1 Effective Discharge - Self-Management Care Plans on Discharge Q1 Clinical Engagement, Q2 Implementation, Q3 & Q4 Rollout	Q4: 60%	0.2500%	£900,000				to follow				
7.2 Effective Discharge - Nursing Assessments - 80% of patients to have a combined nursing risk assessment on emergency admission with a LoS greater than 24 hrs - 100% of these assessments should be made available to the NCT via access to CPD		0.0500%	£180,000	Implementation plan agreed by Q2							
N8: Respiratory											
8.1 Respiratory - Asthma - bi-annual audit of patients attending ED with asthma discharged home with completed care bundle	75%	0.0500%	£180,000								Under 19
	75%										Over 19
N9: Stroke Accreditation											
9 Level 2 Accreditation to be achieved at Scarborough Hospital by end of Q3		0.5000%	£1,800,000								

Contracted Performance Requirements 2013/14: Quality and Safety

Indicator	Consequence of Breach	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Jan	Feb	Mar	Q4 Actual
Infection Prevention									
Rates of Clostridium difficile	*Schedule 4 part H (confirm calc)* **Quarterly:** 1 Monitor point	**> 43 annual**	21	12	21	1	8	4	13
Zero tolerance MRSA - **NO LONGER A MONITOR TARGET FROM OCT 2013**	Non payment of inpatient episode **Quarterly:** 1 Monitor point	**0**	0	2	0	0	0	0	0
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) cases	Non payment of inpatient episode (VoY)	**30 annual**	10	9	5	2	5	4	11
Mortality									
Mortality - HSMR - to maintain or improve against the 12/13 outturn position	Performance Notice (ER) with the exception of any imposed financial penalty (VOY)	**>= 12/13**							
Mortality - SHMI - to maintain or improve against the 12/13 outturn position	Performance Notice (ER) with the exception of any imposed financial penalty (VOY)	**>= 12/13**	1.04	1.02	1.01				published 30th April
Number of Inpatient Deaths	none - monitoring only	**none**	511	473	506	206	165	161	532
Inpatients									
Percentage of emergency admissions where A&E attendance in previous 24 hours and patient discharged from A&E	Performance Notice - (VoY) with the exception of any imposed financial penalty for breaches at Scarborough Hospital	**Baseline 3.8% End Q2 <3.8% End Q3 <3.4% End Q4 <3%**	3.0%	3.2%	2.9%	3.0%	2.8%	2.4%	2.7%
% Compliance with WHO safer surgery check list	Non-compliance of any areas will require RCA and Remedial Action Plan £500 penalty if not achieved within 3 consecutive months (ER)	**95%**	Written assurance						
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	394	310	285	91	to follow	to follow	to follow
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	1267	1076	1057	364	to follow	to follow	to follow
Number of medication errors affecting CYP (under 19yrs old)	Performance Notice (ER)	**none**							
Number of medication errors causing serious harm affecting CYP (under 19yrs old)	Performance Notice (ER)	**none**							
Stroke/TIA									
Proportion of stroke patients who spend >90% of their time on a stroke unit	Performance Notice (ER)	**80% (York)**	86.0%	90.0%	93.7%	87.5%	91.5%	to follow	to follow
Proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours of first contact with a health professional	Performance Notice (ER) with the exception of any imposed financial penalty for breaches at Scarborough (VoY)	**60% (VoY) 75% York (ER)**	74.5%	78.8%	76.3%	85.2%	90.3%	to follow	to follow
Percentage 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 for anti-coagulation	Performance Notice (ER) with the exception of any imposed financial penalty for breaches at Scarborough (VoY)	**60%**	70.8%	81.8%	79.3%	90.9%	85.7%	to follow	to follow
Percentage of patients and carers with joint care plans on discharge from hospital. Percentage of patients with confirmed stroke who have a copy of their joint care plan on discharge from hospital subject to exceptions included in guidance (except patients RIP or who refuse a health/social care assessment/intervention)	Performance Notice (ER) with the exception of any imposed financial penalty for breaches at Scarborough (VoY)	**85% by Q4 for York site only (ER)**							
% of stroke patients scanned within 24 hours of hospital arrival	Performance Notice	**100%**	86.9%	81.7%	85.7%	81.9%	96.6%	to follow	to follow

Contracted Performance Requirements 2013/14: Quality and Safety

Indicator	Consequence of Breach	Threshold	Q1 Actual	Q2 Actual	Q3 Actual	Jan	Feb	Mar	Q4 Actual
Maternity									
Women who see a midwife or maternity healthcare professional by 12 weeks and 6 days of pregnancy	Performance Notice	**90%**	91.6%	93.3%	90.4%	92.3%	89.4%	91.4%	91.1%
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	Performance Notice	**100% (VoY) 95% (ER)**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percentage of maternity patients recorded as smoking at delivery that are referred to a smoking cessation service– subject to patient consent	Performance Notice (VoY)	**90% offered a referral, 100% of those consenting referred VoY and ER**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% of women initiating breast feeding.	Performance Notice	**60%**	68.3%	71.5%	69.6%	67.0%	71.1%	68.3%	68.7%
Number of term babies admitted to NICU or SCBU	Performance Notice	**none**	29	40	29	6	10	6	22
Number of adverse midwifery/obstetric related incidents	Performance Notice	**none**	0	0	0	0	0	0	0
Number/percentage of women recorded as smoking by 12 weeks and 6 days	Performance Notice	**none**	202	225	128	92	68	57	217
Number of babies born between 32 and 36 weeks	Performance Notice	**none**	65	63	75	21	22	20	63
Number of babies born between 28 and 31 weeks	Performance Notice	**none**	4	10	8	0	0	0	0
Number of babies born between 24 and 27 weeks	Performance Notice	**none**	4	5	3	0	0	0	0
Number of babies born under 24 weeks	Performance Notice	**none**	0	0	0	0	0	1	1
Number of babies put to the breast within 1 hour of birth (Breast feeding initiation report)	Performance Notice	**none**	641	932	870	294	196	278	768
Discharge Notifications									
Immediate Discharge letters – 24 hour standard: York Hospital	Quarterly: Performance Notice (VoY) £3k per quarter (ER)	**90% - Q2 92% - Q3 93% - Q4**		65.3%	69.1%	72.9%	73.6%	74.4%	73.3%
Immediate Discharge letters – 24 hour standard: Scar/Brid hospitals	Quarterly: Performance Notice (VoY) £3k per quarter (ER)	**30% - Q2 60% - Q3 90% - Q4**		32.5%	36.7%	36.6%	35.8%	38.7%	37.0%
Immediate Discharge Letters (IDLs) handed to patients on Discharge	Quarterly: Performance Notice (VoY)	**98%**	Written assurance						
Percentage of IDLs that meet the minimum quality for IDLs (SIGN standard)	Quarterly: Performance Notice (VoY) £7k per quarter (ER)	**90% Q4**							
Quality of ED IDLs - York	Quarterly: £6k per quarter (ER)	**Q1: 80% Q2: 83% Q3: 85% Q4: 90%**	Quarterly audit of 60 Pts		Quarterly audit of 60 Pts	Quarterly audit of 60 Pts			
Quality of ED IDLs - Scarborough	Quarterly: £6k per quarter (ER)	**Q2 - 30% Q3 - 60% Q4 - 90%**	Quarterly audit of 60 Pts		Quarterly audit of 60 Pts	Quarterly audit of 60 Pts			

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 April 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 year ended 31 March 2014.

At the end of the financial year the Trust is reporting an Income and Expenditure (I&E) deficit of £1.0m against a planned surplus for the period of £2.4m. This position is after a technical adjustment for impairments of £3.7m, restructuring costs of £1.0m, and donated asset income of £0.6m all of which are discounted by Monitor in their assessment of the Trust's underlying performance. The underlying operating I&E position after discounting these is issues is a surplus of £3.1m. The Trust has an actual cash balance of £25.3m. The underlying Income and Expenditure position places the Trust ahead of 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	April 2014
Version number	Version 1

Briefing Note for the Finance & Performance Committee Meeting 22 April 2014
Briefing Note for the Board of Directors Meeting 30 April 2014

Subject: 2013/14 Outturn Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for the Year 2013/14

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

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

The table below provides an audit trail between the reported accounts position and Monitor's underlying assessment.

	2013/14	***2012/13***	
Reported Income and Expenditure Position	**(£0.955m)**	***£70.3m***	**Opening Position**
Gain on absorption of Scarborough	-	*(£68.9m)*	This represents the net gain from the transferred Scarborough assets. Under absorption accounting principles this will be included in our reported I&E position but excluded by Monitor in their underlying performance assessment.
Receipt of revenue funding for £5m strategic capital investment	-	*(£5.0m)*	Originally anticipated as PDC but paid as revenue. Under accounting rules this will be included in our I&E position (recognised as income) but excluded by Monitor in their underlying performance assessment.
Property Impairments	£3.693m	*£3.5m*	Relates to impairments from District Valuer assessments of fixed assets. This is a non-cash adjustment and is excluded in Monitor's underlying performance assessment.
Donated Asset Income	(£0.624m)	*(£0.5m)*	Income from the charity to purchase capital assets. Excluded by Monitor in their underlying performance assessment.
MARS and Redundancy Payments	£1.008m	*£0.8m*	Restructuring costs excluded by Monitor in their underlying performance assessment.
Underlying Surplus	**£3.122m**	***£0.2m***	**Underlying surplus as assessed by Monitor**

Contract Income Position

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

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

Contract Penalties

The Trust has incurred a number of contract penalties for 2013/14. These total £1.9m and are summarised as follows:

- 52 weeks - £105K
- 18 weeks - £406k
- MRSA - £10k
- EMSA - £8k
- ED 4 hour - £136k
- Diagnostic waiting times - £17k
- C Diff £1.2m

Cash Position

Cash is slightly behind plan mainly due to the final £3m of the strategic acquisition capital being withheld from the Trust until 2014/15.

Cash	**Plan**	**Actual**
End of year balance	£27.692m	£25.315m

Capital Expenditure Summary

The Board are aware that Monitor requested a revised capital forecast from the Trust midway through the year. This plan totalled £18.8m. Actual performance has fallen slightly short on quarter 4 schemes but this is deemed an immaterial variance by Monitor at only 8%. There are no issues in relation to capital that I would wish to report to the Board.

Capital	**Revised Plan Submitted to Monitor**	**Actual**
Total Spend	£18.772m	£17.287m
% variance from plan		8%

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 31 March 2014

High Level Overview

* A net I&E deficit for the year of £1.0m, after a technical adjustment for fixed asset impairments of £3.7m, means the Trust is £3.4m behind plan.

* Applying Monitor's principles for assessing underlying performance (removing impairments, donated asset income and restructuring costs) the Trust has returned a £3.1m surplus.

* CIPs achieved at the end of March total £26.2m. The CIP position is £2.8m ahead of plan.

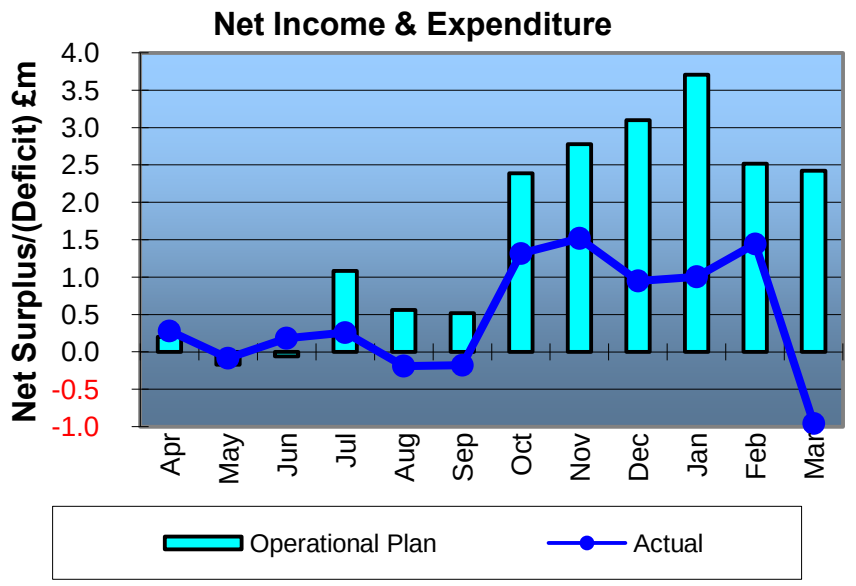
* Income from all contracts is assessed to be ahead of plan by £17.7m, net of penalties.

* Cash balance is £25.3m, and is £2.4m less than plan.

* Capital spend totalled £17.3m, and is £1.5m lower than plan.

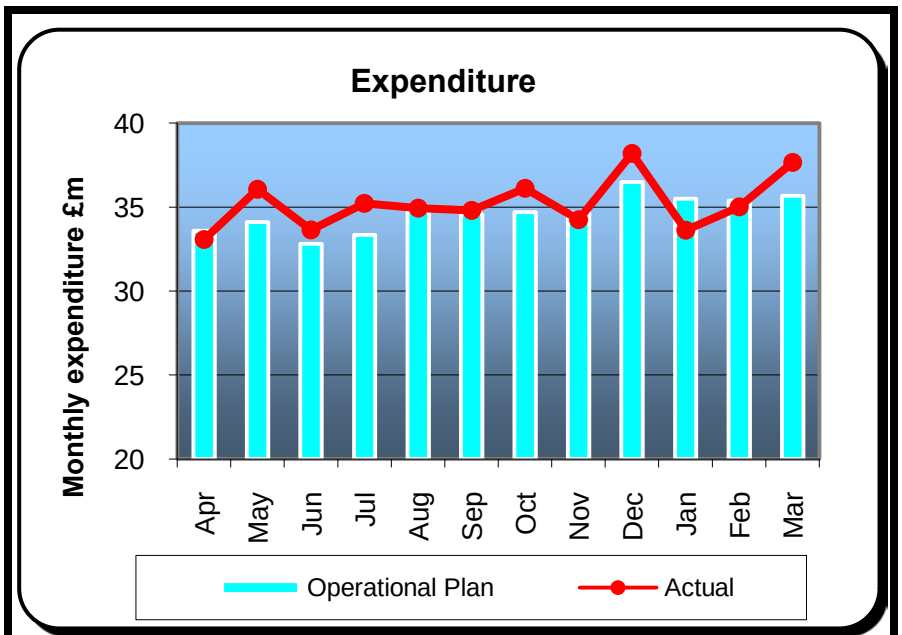
* The provisional Monitor Financial Risk Rating is 3, which is on plan.

* The Continuity of Service Risk Rating is 4.



Key Period Variances

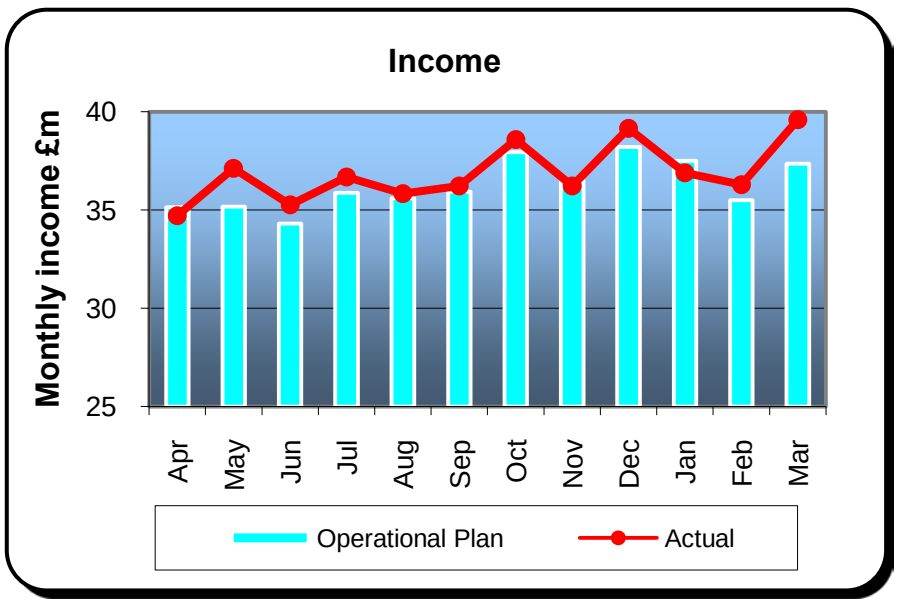
	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. Lucentis)	369.3	374.5	5.1
Clin.Inc.(Lucentis)	10.3	9.8	-0.5
Other Income	55.4	58.4	2.9
Pay	-286.3	-289.6	-3.3
Drugs	-34.9	-38.5	-3.6
Consumables	-40.8	-42.4	-1.7
Other Expenditure	-70.7	-73.0	-2.3
	2.4	**-1.0**	**-3.4**



At the end of March there is an adverse variance against operational expenditure budgets of £7.0m. This comprises:-

- Operational pay being £3.3m overspent.
- Drugs are £3.6m overspent, mainly due to pass through costs linked to drugs excluded from tariff

- Clinical supplies £1.7m overspent.
- Other costs are £0.2m overspent
- Restructuring costs are £1.0m overspent
- CIPs are £2.8 ahead of plan

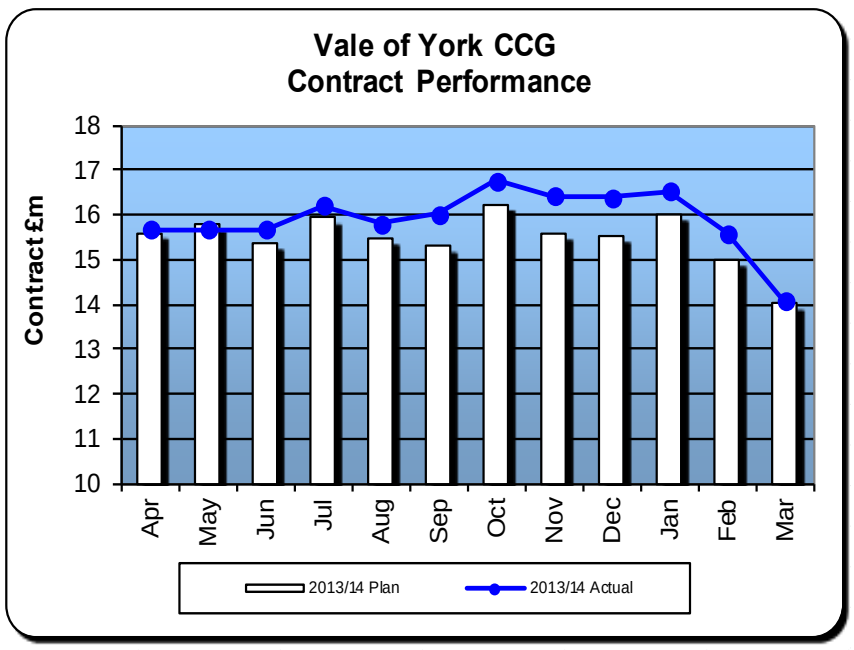


At the end of March income is ahead of plan by an estimated £7.5m. This comprises:

- Elective and day case income are ahead of plan by £1.8m.
- Non elective income is £0.3m below plan.
- Community income is marginally ahead of plan by £0.6m.
- Out patient income is behind plan by £0.7m
- A&E is ahead of plan £0.4m.

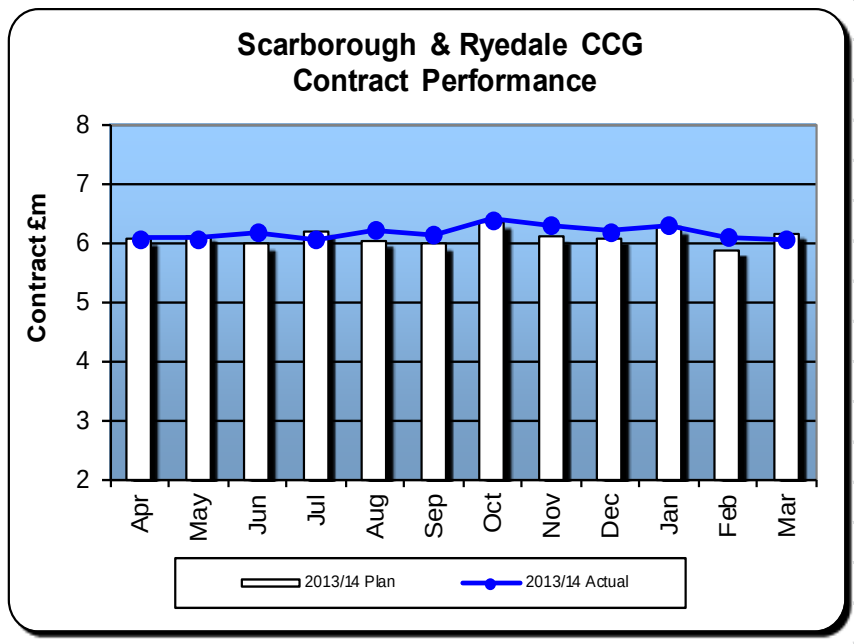
- Other clinical income is ahead of plan by £4.7m.
- Other income is £2.9m ahead of plan
- Contract penalties including CDiff are estimated at £1.9m.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 31 March 2014



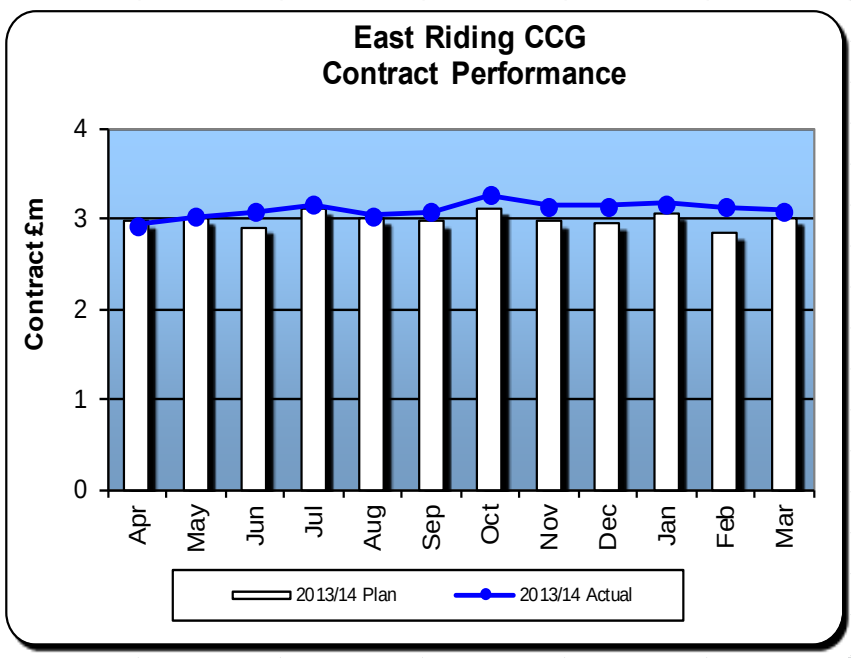
The contract value is £185.7m.

The contract is £5.0m ahead of plan at the year end.



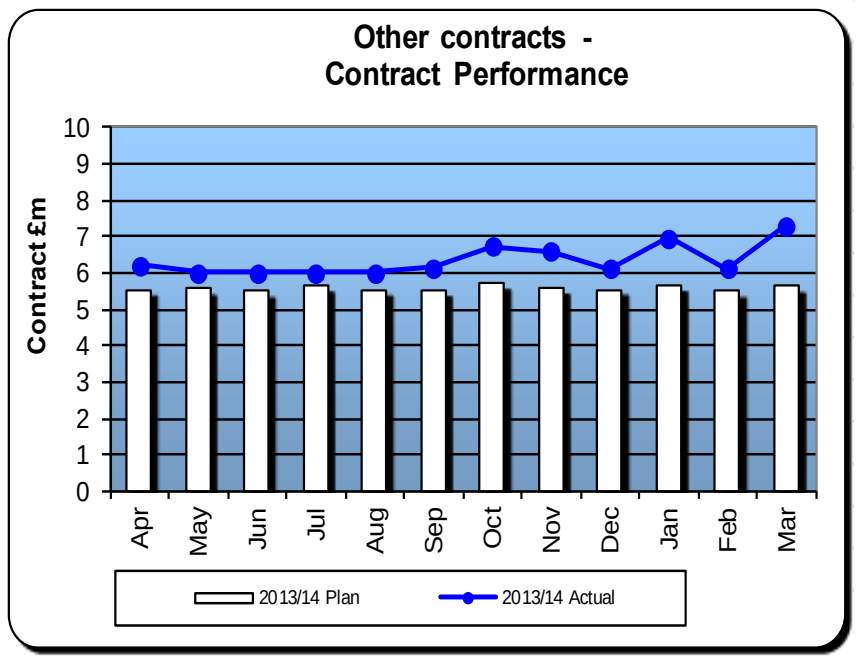
The contract value is £73.1m.

The contract is ahead of plan by £0.9m at the year end.



The contract value is £35.8m

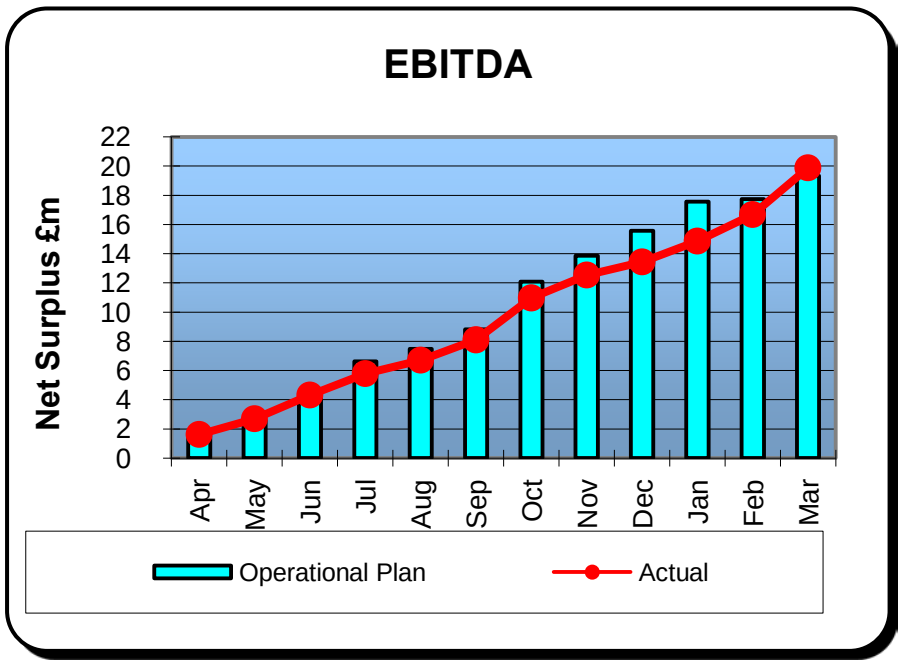
The contract is ahead of plan by £1.4m, at the year end.

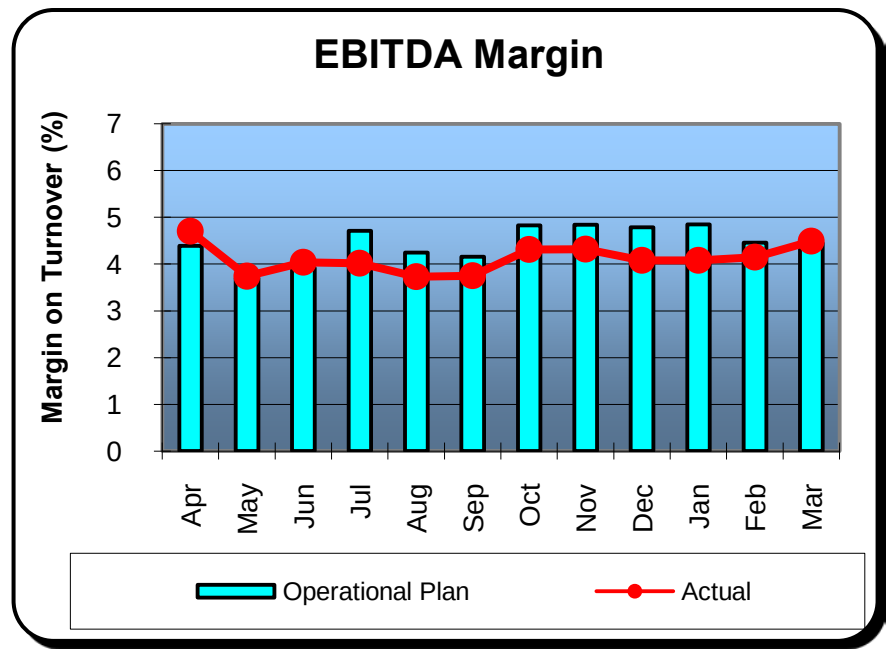


The total contract value is £67.0m

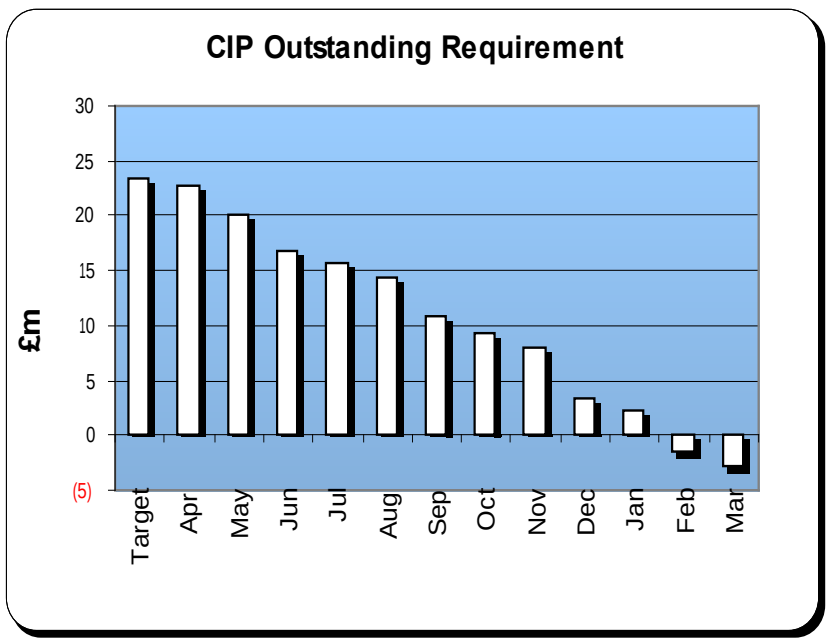
These include the smaller CCG contracts, NHS England (both public health services and prescribed specialist services), and Local Authority contracts. Overall contracts are ahead of plan by an estimated £9.3m. Prescribed specialist services are £6.3m ahead of plan, and Hambleton, Whitby and Richmondshire CCG is £0.9 ahead of plan at the year end.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 31 March 2014

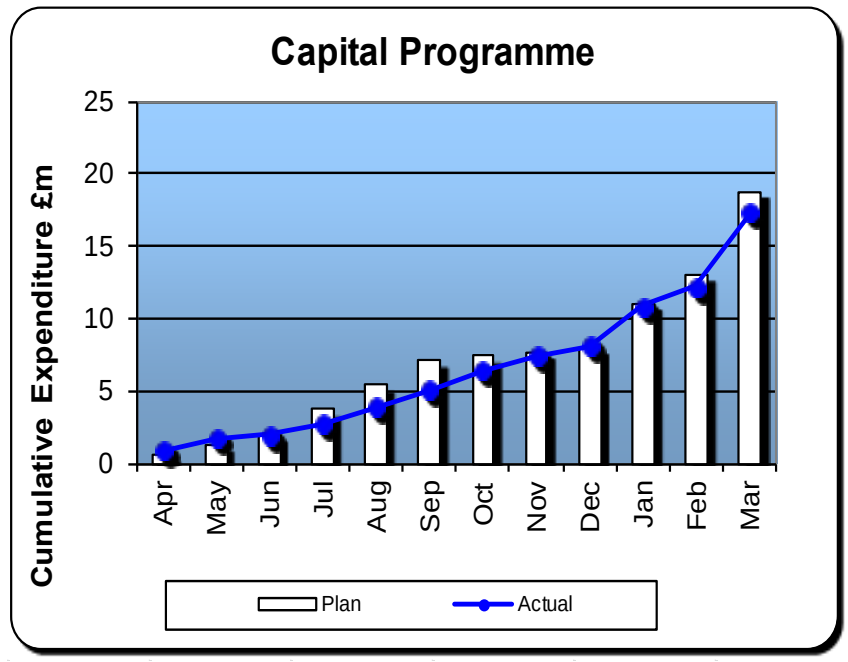




Actual EBITDA at the end of March is £19.9m (4.49%), compared to operational plan of £19.3m (4.45%), and is reflective of the overall I&E performance.



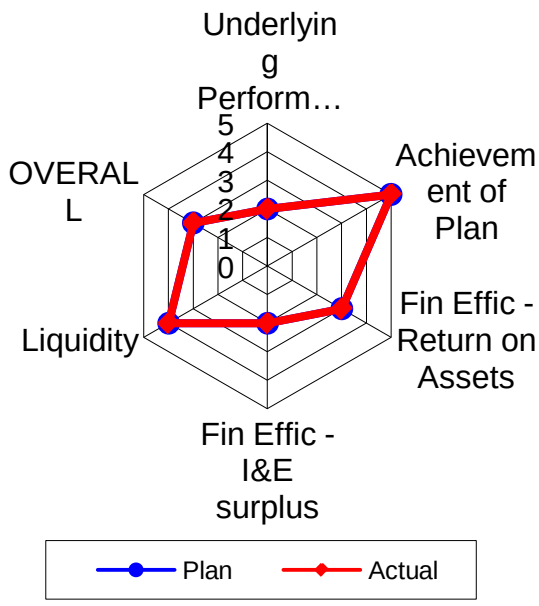
The full year efficiency requirement is £23.4m. At the end of March £26.2m has been cleared.



Capital expenditure to the end of March totalled £17.3m and is £1.5m behind plan due to

Capital schemes with significant in year spend to date include the completed upgrade of ward kitchens in York, the on going upgrade of the Mallard restarurant and kitchens, Endoscopy decontamination expansion and the carbon & energy scheme. In Scarborough the nearly completed new carpark, maternity theatres upgrade and the Bridlington standby generator.

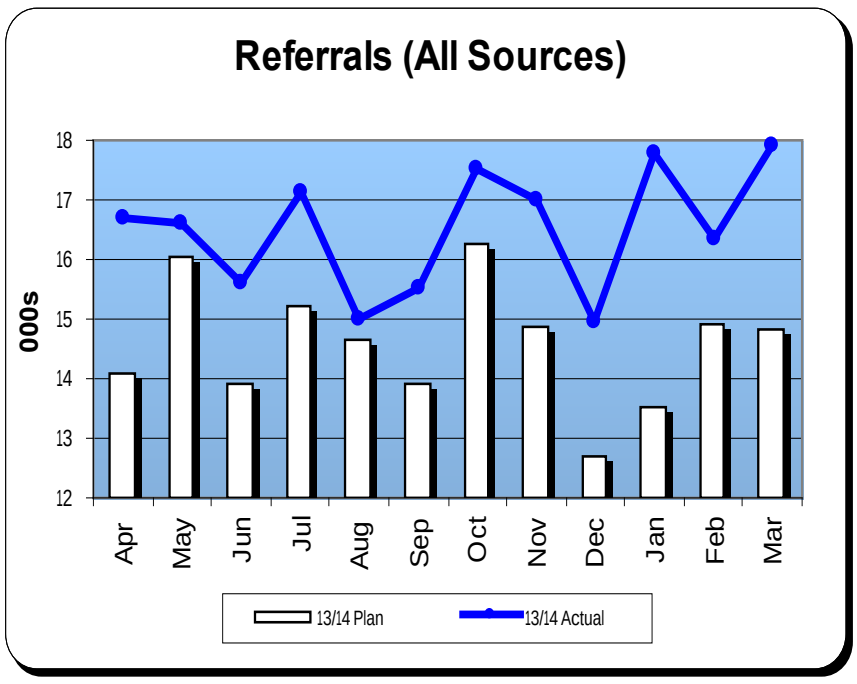
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 31 March 2014



The Trust's provisional overall FRR for the year to date is 3, which is in line with the plan submitted to Monitor.

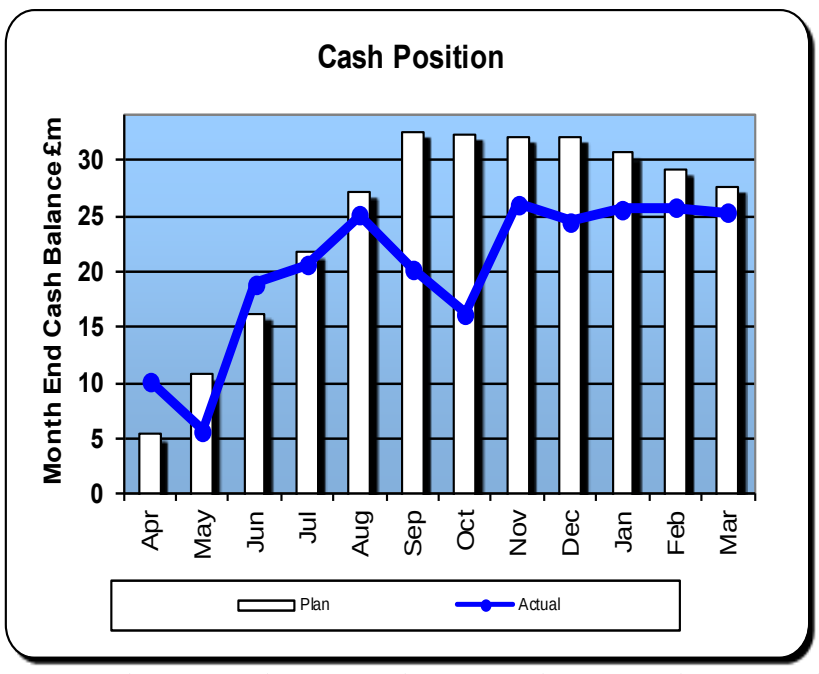
Continuity of Service Risk Rating (CoSSR):

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



Annual plan 174,884 referrals (based on full year equivalent of 2012/13 outturn)

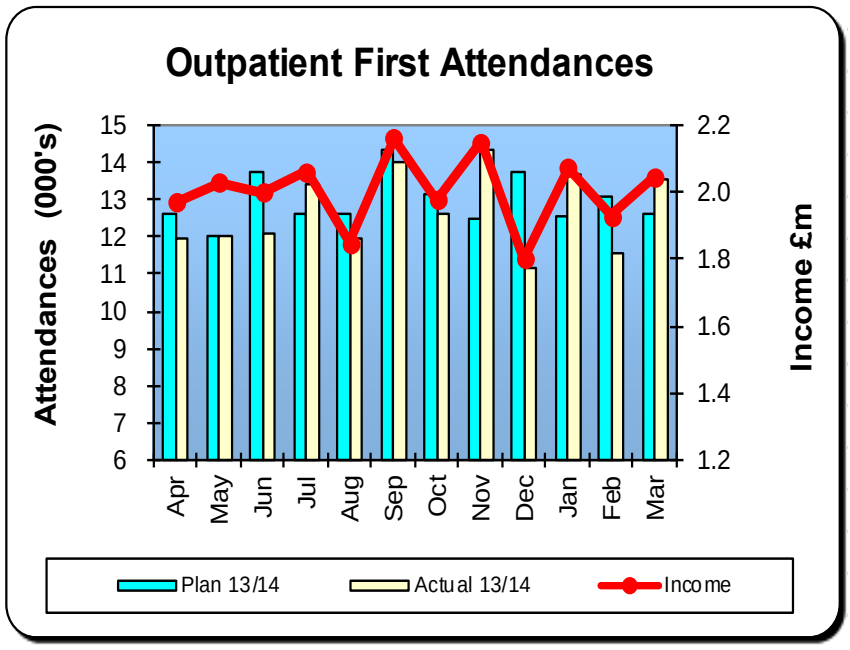
Variance at end of March: +23,173 referrals (+13%)
GP referrals +15,960 (+16%)
Cons to Cons referrals -468 (-2%)
Other referrals +7,681 (+17%)



The cash balances at the end of March totalled £25.3m, and is £2.4m behind plan due to outstanding debtors re: clinical overtrade income.

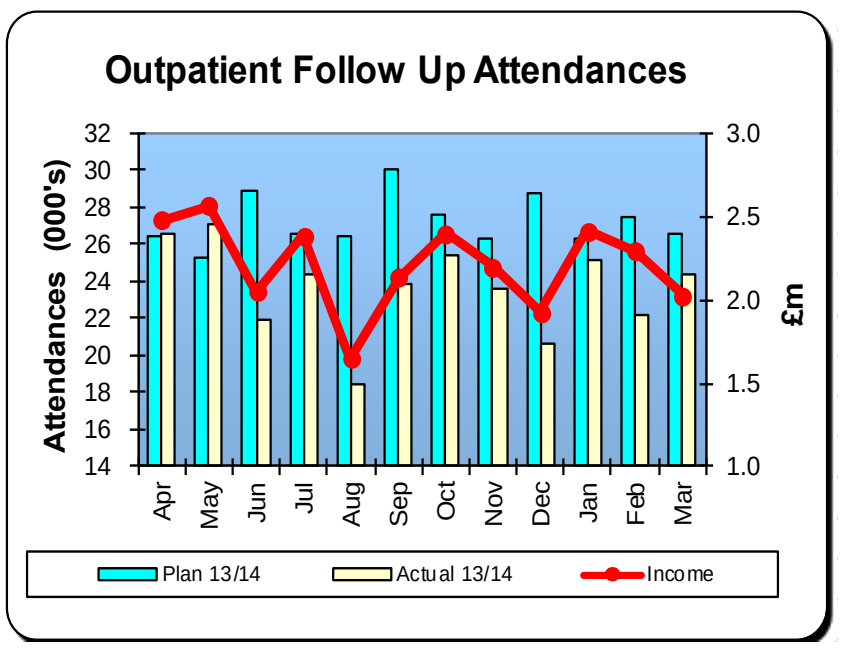
Monitor Liquidity Ratio					
Risk Rating	5	4	3	2	1
Days Cover	60	25	15	10	<10
Trust Actual Days		45			

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 31 March 2014

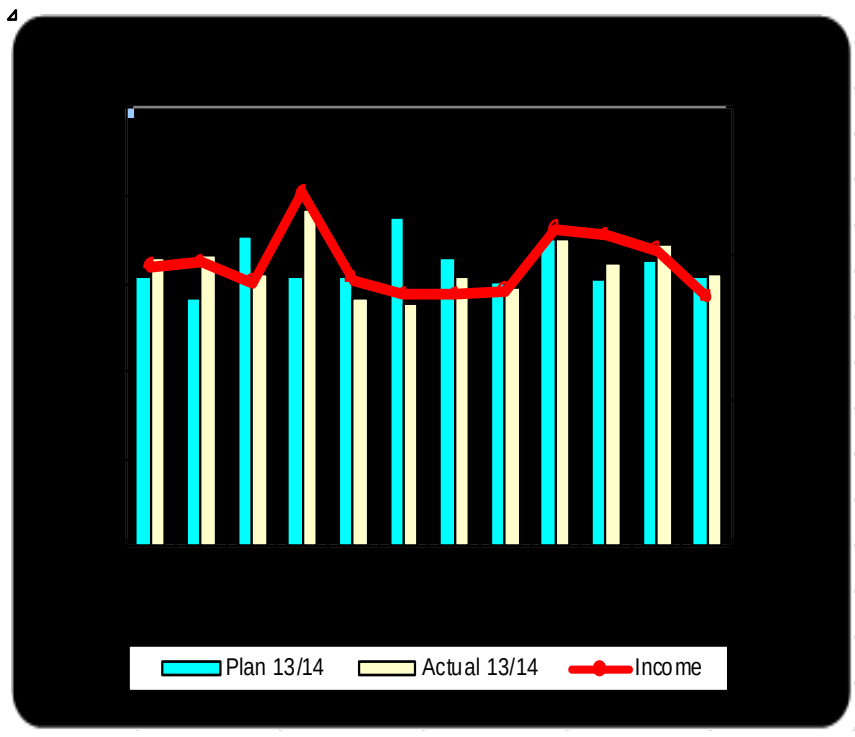


Annual Plan (Attendances) 155,566
Variance at end of March: -3,145 attendances (-2%).

Main variances: Opthalmology -3,526 (-17%), ENT -909 (-10%), Gastroenterology -788 (-14%), Cardiology -3,051 (-21%)

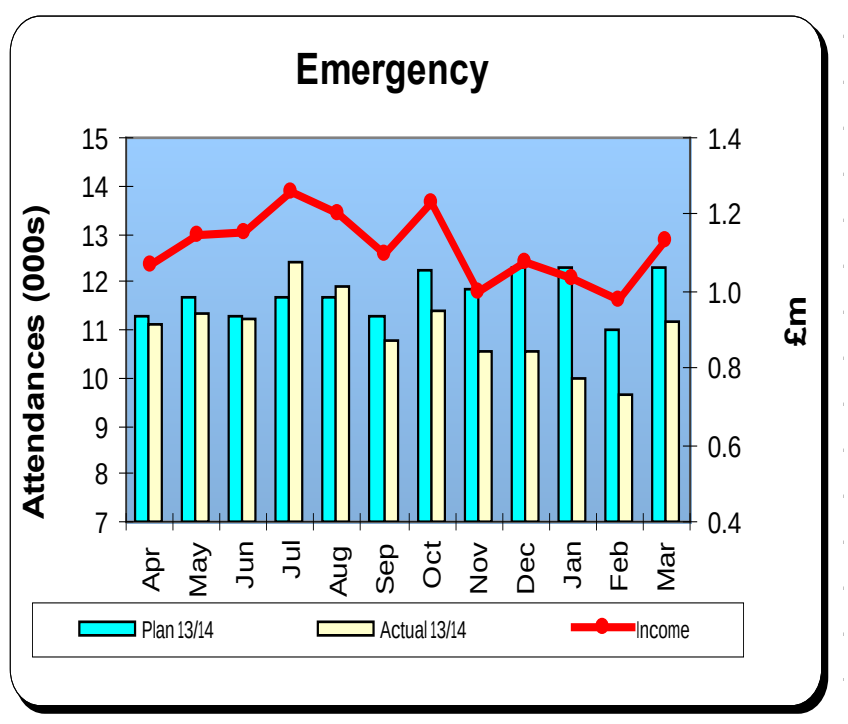


Annual Plan (Attendances) 326,649
Variance at end of March: -43,445 attendances (-13%).



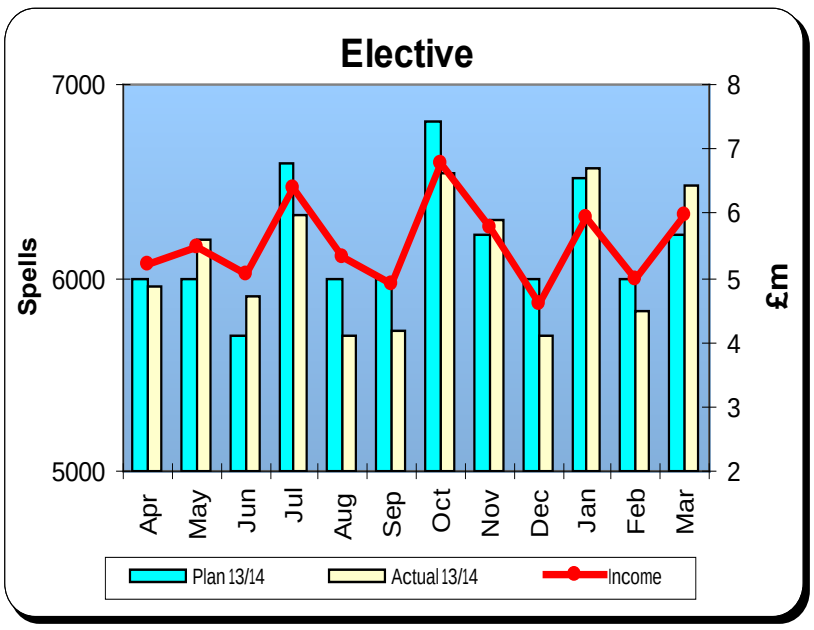
Annual Plan (Procedures) 62,554
Variance at end of March: -106 procedures (-0.2%).

Main variances: ENT +632 (+8%), Orthodontics +2,153 (+30%), Trauma and Orthopaedics +287 (+125%), Cardiology +188 (+3%), and Gynaecology -1,464 (-26%).



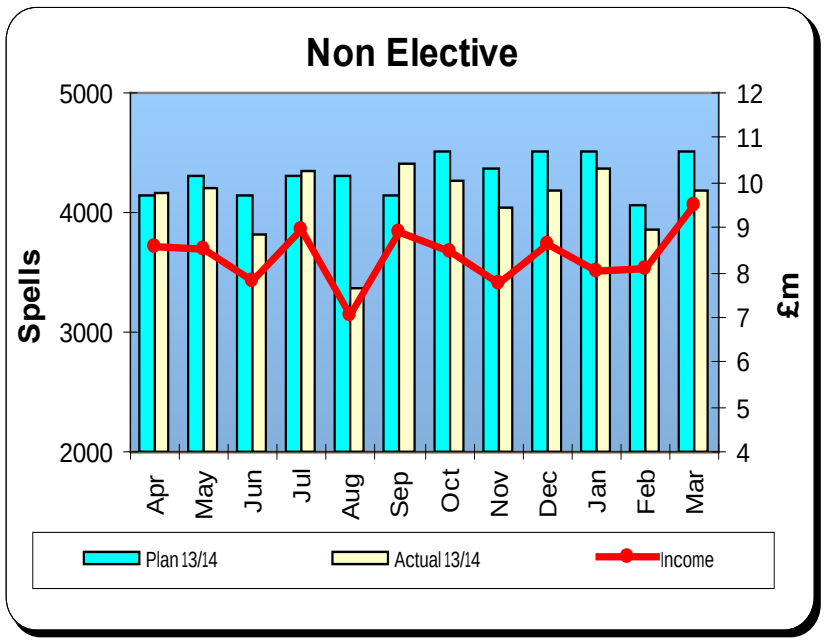
Annual Plan (Attendances) 140,970
Variance at end of March: -8,875 attendances (-6.3%).

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 31 March 2014



Annual Plan (Spells) 74,033
Variance at end of March: -812 spells (-1%): inpatient -489; daycase -323

Main variances: General surgery -719 (-7%), Urology +633 (+6%), Gastroenterology -1,815 (-14%), and Haematology +804 (+21%).



Annual Plan (Spells) 51,871
Variance at end of March: -2,660 spells (-5%).

Main variances: Cardiology +1,077 (+74%), Thoracic Medicine +1,376 (+52%), and Trauma & Orthopaedics +354 (+13%). Medical Oncology -93 (-35%) Paediatrics -773 (-10%)

Contract Penalties

Other Penalties	YTD Actual	Penalty £000	Comments
52 week breaches	21	105	£5k penalty per breach per month. 12 GenSur (York); 3 GenSur (Scar); 2 Ophthal (Scar); 2 Gynae (York). 1 Urology (York), 1 Urology (Scar).
18 week breaches:			Figures are estimates and awaiting confirmation.
- Admitted (90% target, weighting 37.5%)	n/a	182	GenSur £29k; Gynae £36k; Anaes £8k: Rheum. £3k, Urology £19k.Haematology £4k, T&O £45k, Max Fac £13k, ENT £4k, Opthal £13k.
- Non-admitted (95% target, weighting 12.5%)	n/a	149	Gen Sur £43k; Urology £26k Anaesthetics £16k, Gastro £22k, T&O £6k, Rheumatology £17k cardilogy £3k.
- Incomplete pathways (92% target, w'ting 50%)	n/a	75	GenSur £24k; Gynae £6k; Urology £13k; T&O £13k; Opthalmology £2k, An estimate for March has been included above.
MRSA	2	10	Penalty is the HRG income.
EMSA/Trolly wait	27	8	EMSA breaches in VIU (19 = £6k); Trolley wait (1 = £1k)
CDiF	67	1,200	Annual target 43, 24 over target. £50k penalty, per case above target.
A&E Performance	n/a	136	Faliure to admit, transfer or discharge patients within 4 hours of arrival. Target 95%, actual at quarter 3 93.2%. Target achieved in January. Penalty relates to 2% of cost in quarter 3.
Diagnostics		17	6 weeks target 99%. December and January 98.5%, estimated pass at expect to pass February, relates to specific radiology, NPU and cardiology tests
		1,882	

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
SUMMARY INCOME & EXPENDITURE POSITION
FOR THE PERIOD 1st APRIL 2013 to 31st MARCH 2014

	ANNUAL PLAN	PLAN FOR PERIOD	ACTUAL FOR PERIOD	PERIOD VARIANCE
	£000	£000	£000	£000
INCOME				
NHS Clinical Income				
Elective Income				
Tariff income	25,909	25,909	26,028	119
Non-tariff income	578	578	135	-443
Planned same day (Day cases)				
Tariff income	37,576	37,576	39,474	1,899
Non-tariff income	525	525	799	274
Non-Elective Income				
Tariff income	98,995	98,995	98,769	-226
Non-tariff income	1,537	1,537	1,474	-63
Outpatients				
Tariff income	61,550	61,550	60,167	-1,383
Non-tariff income	5,611	5,611	6,294	683
A&E				
Tariff income	12,397	12,397	13,805	1,408
Non-tariff income	612	612	-424	-1,036
Community				
Tariff income	1,024	1,024	1,067	43
Non-tariff income	33,459	33,459	33,966	507
Other				
Tariff income				
Non-tariff income	99,855	99,855	104,582	4,727
Fines and Contract Penalties - CDiF penalty	0	0	-1,200	-1,200
- Other fines and penalties	0	0	-682	-682
	379,627	**379,627**	**384,254**	**4,627**
				0
	379,627	**379,627**	**384,254**	**4,627**
Non-NHS Clinical Income				
Private Patient Income	1,088	1,088	1,043	-45
Other Non-protected Clinical Income	1,879	1,879	1,849	-30
	2,967	**2,967**	**2,892**	**-75**
Other Income				
Education & Training	14,150	14,150	15,256	1,106
Research & Development	8,027	8,027	8,152	125
Donations & Grants received of PPE & Intangible Assets	0	0	0	0
Donations & Grants received of cash to buy PPE & Intangible Assets	240	240	624	384
Other Income	17,997	17,997	19,333	1,336
Transition support	11,985	11,985	11,985	0
	52,399	**52,399**	**55,349**	**2,951**
Total Income	**434,993**	**434,993**	**442,495**	**7,502**
EXPENDITURE				
Pay costs	-286,300	-286,300	-289,594	-3,294
Drug costs	-34,885	-34,885	-38,490	-3,605
Clinical Supplies & Services	-40,755	-40,755	-42,439	-1,684
Other costs (excluding Depreciation)	-50,909	-50,909	-51,087	-178
Restructuring Costs	0	0	-1,008	-1,008
CIP	-2,798	-2,798	0	2,798
Total Expenditure	**-415,647**	**-415,647**	**-422,618**	**-6,971**
EBITDA (see note)	**19,346**	**19,346**	**19,877**	**531**
Profit/ Loss on Asset Disposals	0	0	3	3
Fixed Asset Impairments	-300	-300	-3,693	-3,393
Depreciation	-10,854	-10,854	-11,273	-419
Interest Receivable/ Payable	65	65	113	48
Interest Expense on Overdrafts and Working Capital Facilities	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0
Interest Expense on Non-commercial borrowings	-270	-270	-228	42
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	-31	-31
PDC Dividend	-5,566	-5,566	-5,723	-157
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**2,421**	**2,421**	**-955**	**-3,376**

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G3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 30 April 2014

Efficiency Programme Update – March 2014

Action requested/recommendation

The Committee is asked to note the March 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 key highlight of the report is delivery of £26.2m against the target of £23.4m which gives an ***over delivery of £2.8m for the year***, which is a significant achievement.

The current draft target for 2014/15 is £25.5m. Work continues to reduce this to the lowest possible level.

4 year planning has moved on a year, in the main body of the report, and shows a (£27.9m) shortfall.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

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

Finance and Performance Committee – 22nd April 2014

Efficiency Position Update at March 2014

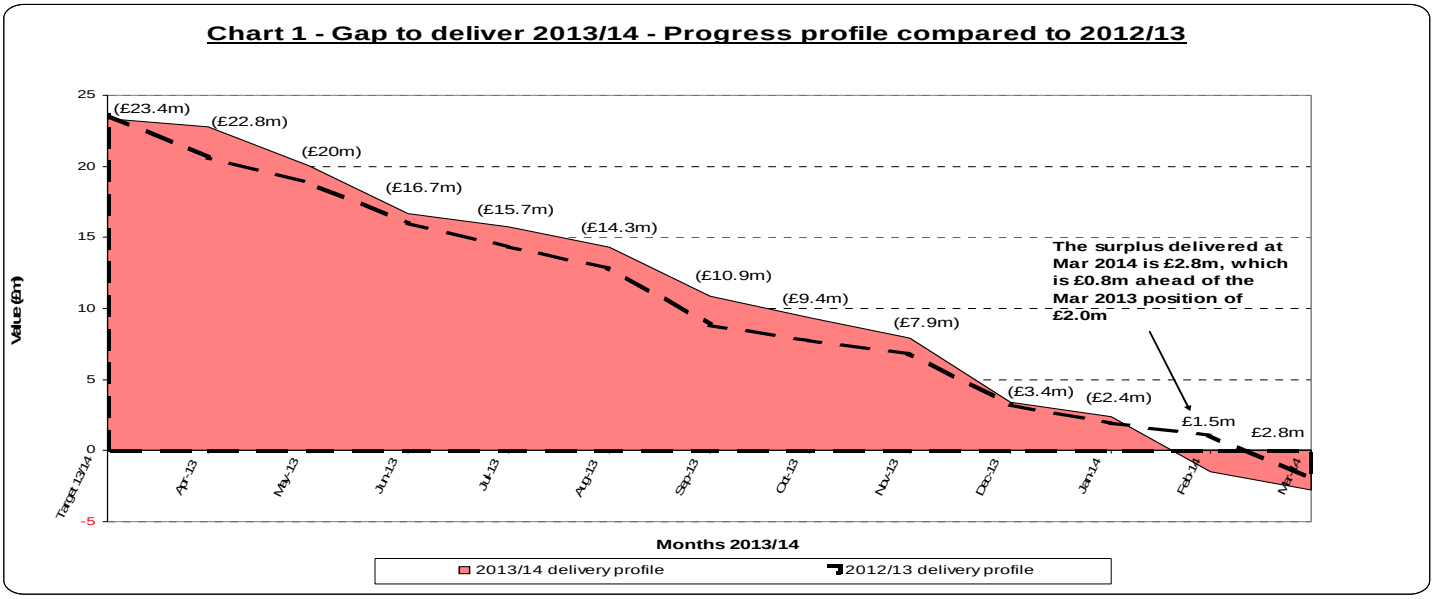
1. Executive Summary

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

See table 1 and chart 1 below.

Table 1 – Executive Summary – March 2014	Total
	£'m
TARGET	
In year target	**23.4**
DELIVERY	
Final in year delivery	**26.2**
Final in year delivery surplus	**2.8**
Part year delivery surplus - Monitor variance	**-**
PLANNING	
In year planning surplus/(gap)	**-**
FINANCIAL RISK SCORE	
Overall Trust financial risk score	**4 (Amber/Green)**

Position – current year vs. 2012/13



Governance	Risk to delivery
Current month Of the 32 Directorates and Corporate HQ functions 32 areas have completed their governance assessments as at February 2014.	**Current month** The final year end position is £26.2m delivered against a target of £23.4m, giving an over delivery of £2.8m. The position at March 2013 was £2.0m over delivered.
Last Month In February 2014, 32 areas had completed their governance assessments.	**Last Month** In February 2014, the planning surplus was £1.9m, if high and medium risk plans were removed.

2. Introduction and background

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

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

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

2.1 Trust plan to Monitor

The final combined position is £2.8m ahead of the Trust plan to Monitor as at March 2014; see Tables 2 & 3 and chart 2 below.

Table 2	YTD February	March 2014	**Total YTD**
	£m	**£m**	**£m**
Trust plan	**21.4**	1.9	**23.4**
Achieved	**23.3**	2.9	**26.2**
Variance	**1.9**	**1.0**	**2.8**

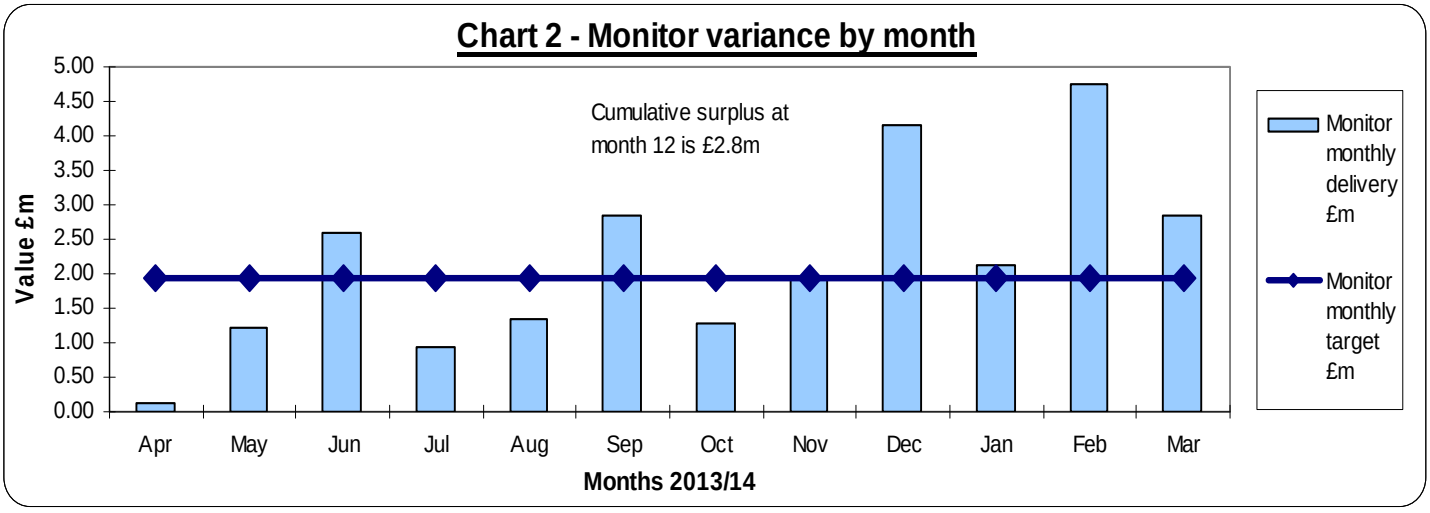


Table 3 – Monitor variance by month and cumulative variance

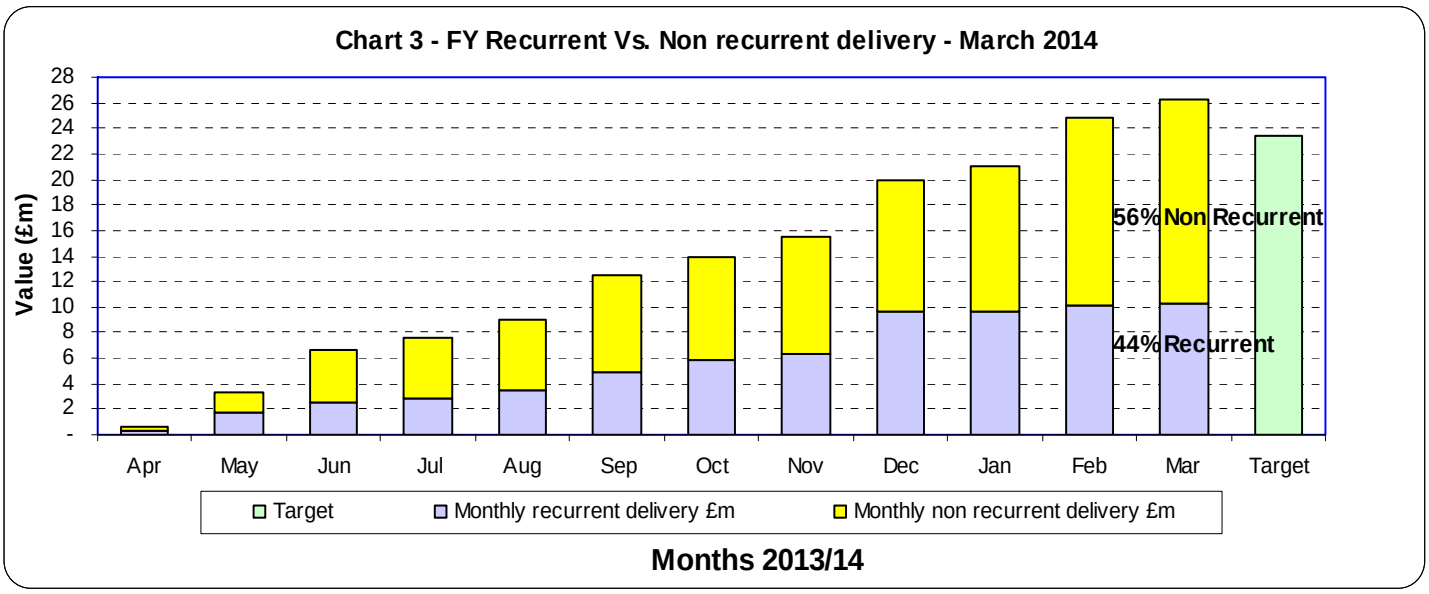
Months	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total 13/14**
Monthly delivery £m	0.14	1.22	2.59	0.94	1.34	2.86	1.29	1.93	4.15	**2.11**	4.76	2.85	**26.17**
Monthly target £m	1.95	1.95	1.95	1.95	1.95	1.95	1.95	1.95	1.95	**1.95**	1.95	1.95	**23.36**
Variance £m	-1.81	-0.73	0.65	-1.01	-0.60	0.91	-0.66	-0.02	2.20	**0.17**	2.81	0.91	2.81
Cumulative variance	-1.81	-2.54	-1.89	-2.90	-3.50	-2.60	-3.25	-3.27	-1.07	**-0.91**	1.90	2.81	

2.2 Full year position summary

As at March 2014, **£26.2m** has been achieved in full year terms against the plan of £23.4m (see Table 4 below).

Table 4	Jan 2014	Feb 2014	Change
	£m	£m	£m
Expenditure plan – 13/14	23.4	23.4	0
Target – 2013/14	**23.4**	**23.4**	**0**
Achieved - recurrently	10.2	10.3	0.1
Achieved - non-recurrently	14.7	15.9	1.2
Total achieved	**24.9**	**26.2**	**1.3**
Surplus achieved	1.5	2.8	1.3
Further plans	0.4	-	(0.4)
(Gap)/Surplus in plans	**1.9**	**2.8**	**0.9**

The March 2014 position is made up of £10.3m (44%) of recurrent and £15.9m (56%) non-recurrent schemes. This compares with £10.4m (44%) recurrent and £15.2m (56%) non-recurrent at March 2013 - see chart 3 below. The recurrent position has improved by £0.1m in March 2014.



2.3 Four year planning

Directorates are required to develop four year plans and Table 5 below summarises this position. ***It should be noted*** the position has been moved on a year in the main body of the report to highlight the challenge we face as an organisation and now includes 2017/18 (App 1&2 reflects the final position for 2013/14). There is currently a planning shortfall of (£27.9m) over the next 4 years.

Work has been on going, and will continue, to reduce the impact of the non recurrent carry forward and schemes continue to be developed and assessed. The draft target for 2014/15 is set as £25.5m. The shortfall in plans offers a high risk to delivery.

Table 5 - 4 Year efficiency plan summary – March 2014					
Year	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**Total**
	£m	**£m**	**£m**	**£m**	**£m**
Base target	25.5	16.8	16.8*	16.8*	**75.9**
Plans	23.2	11.9	8.2	4.7	**48.0**
Variance	**(2.3)**	**(4.9)**	**(8.6)**	**(12.1)**	**(27.9)**

***Targets for 2016/18 are indicative at this stage, based on 2015/16.*

2.4 Finance risk rating

Final delivery in March 2014 has exceeded the same point last year with final delivery standing at £26.2m (112%) against £25.6m (108%) in March 2013.

A new risk scoring process has been developed in 2013/14 and will continue in to 2014/15. This 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 under/over delivery by Directorate is shown in Appendix 3 for information.

The overall trust risk rating is 4 which is an amber/green risk.

2.5 Governance risk rating

The governance rating, detailed in Appendix 1, is a relatively new process and we are in the process of implementation. All areas have now self assessed their schemes, and a full review with the Clinical Efficiency Lead is now almost completed.

To enable a green rating to be achieved, the Directorate must have assessed 100% of their in year efficiency plans against the Trust Risk Assessment System. A red rating represents <80% of plans assessed. This process should be carried out quarterly.

Plans which are identified as high risk through this process following review with the Clinical Efficiency Lead will be presented to the Finance and Performance Committee quarterly.

In addition high risk schemes will be presented to a sub-committee of the Patient Safety Group, Chaired by the Trust Medical Director, for information.

3. Conclusion

Delivery in March 2014 has over achieved the plan with £26.2m (112%) of full year schemes being delivered against the Trust plan of £23.4m; this compares with £25.6m (108%) in March 2013. Recurrent delivery has improved by £0.1m in the month.

The current draft target for 2014/15 is £25.5m. Work continues to reduce this to the lowest possible level.

The 4 year planning position has been moved forward 1 year in the main body of the report and this highlights a shortfall of (£27.9m), which offers a high level of risk.

4. Recommendation

The Committee is asked to note the March 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	**April 2014**

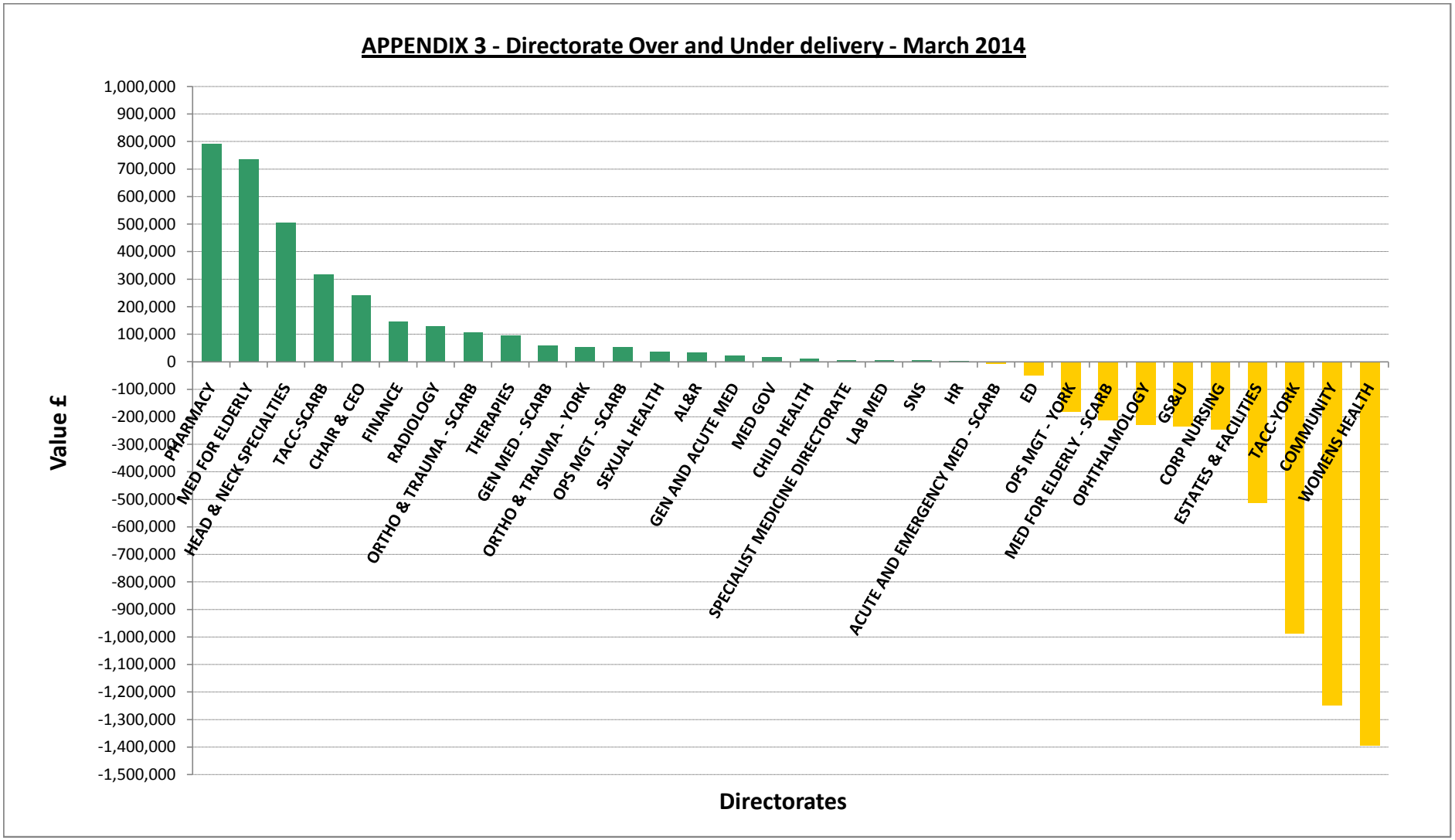
RISK SCORES - MARCH 2014 - APPENDIX 1

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

RISK SCORES - MARCH 2014 - APPENDIX 2

DIRECTORATE	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
COMMUNITY	40%	1	40%	1	17%	1	50%	1	4	1
TACC YORK	59%	1	59%	1	44%	1	58%	1	4	1
WOMENS HEALTH	31%	1	31%	1	19%	1	68%	2	5	1
OPHTHALMOLOGY	55%	1	55%	1	35%	1	61%	2	5	1
MEDICINE FOR THE ELDERLY SCARBOROUGH	63%	1	63%	1	9%	1	109%	5	8	2
GS&U	86%	2	86%	2	56%	2	85%	4	10	2
SPECIALIST MEDICINE	100%	5	100%	5	48%	1	52%	1	12	3
ED YORK	91%	3	91%	3	63%	2	108%	5	13	3
GEN MED SCARBOROUGH	108%	5	108%	5	28%	1	82%	4	15	3
SEXUAL HEALTH	112%	5	112%	5	16%	1	90%	4	15	3
ED SCARBOROUGH	99%	4	99%	4	88%	3	124%	5	16	4
TACC SCARBOROUGH	134%	5	134%	5	57%	2	83%	4	16	4
LAB MED	100%	5	100%	5	46%	1	93%	5	16	4
RADIOLOGY	109%	5	109%	5	10%	1	95%	5	16	4
CHILD HEALTH	101%	5	101%	5	32%	1	109%	5	16	4
THERAPIES	106%	5	106%	5	59%	2	100%	5	17	4
GEN MED YORK	101%	5	101%	5	64%	2	119%	5	17	4
T&O YORK	106%	5	106%	5	63%	2	139%	5	17	4
T&O SCARBOROUGH	116%	5	116%	5	74%	3	123%	5	18	4
HEAD AND NECK	191%	5	191%	5	95%	4	118%	5	19	5
MEDICINE FOR THE ELDERLY	186%	5	186%	5	137%	5	152%	5	20	5
PHARMACY	110%	5	110%	5	110%	5	266%	5	20	5
CORPORATE										
OPS MANAGEMENT YORK	19%	1	19%	1	13%	1	25%	1	4	1
CORPORATE NURSING	58%	1	58%	1	39%	1	76%	3	6	1
ESTATES AND FACILITIES	76%	2	76%	2	38%	1	97%	5	10	2
MEDICAL GOVERNANCE	143%	5	143%	5	0%	1	64%	2	13	3
HR	101%	5	101%	5	33%	1	74%	3	14	3
AL&R	121%	5	121%	5	33%	1	92%	5	16	4
SNS	100%	5	100%	5	36%	1	92%	5	16	4
OPS MANAGEMENT SCARBOROUGH	118%	5	118%	5	18%	1	113%	5	16	4
FINANCE	187%	5	187%	5	99%	4	108%	5	19	5
CHIEF EXEC	180%	5	180%	5	103%	5	96%	5	20	5
TRUST SCORE	**112%**	**5**	**112%**	**5**	**44%**	**1**	**97%**	**5**	**16**	**4**

APPENDIX 3 - Directorate Over and Under delivery - March 2014



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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 April 2014

Results of the 2013 NHS Staff Survey

Action requested/recommendation

The Board of Directors is asked to read the attached report and discuss.

Summary

The attached report presents the organisation's headline results from the NHS Staff Survey 2013.

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).

The results of the survey do present differences between groups. This will be analysed in more detail and actions identified where necessary.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report Corporate Directors Feb 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	April 2014
Version number	Version 1

Board of Directors – 30 April 2014

Results of the 2013 NHS Staff Survey

1. Introduction and background

The following summarises the key findings from the 2013 staff survey. This paper is intended to provide headlines only. Further, more detailed analysis will be undertaken to understand particular issues across different sites, staff groups and specialties.

2. Staff Survey Results

Response rate

The Trust achieved a response rate in the survey of 54%. This is above the average of 49% for acute trusts and higher than the response rate of 51% in 2012. The highest response rate achieved by an acute trust in the 2013 survey was 78%.

Overall staff engagement

The overall staff engagement score is based on responses to a number of survey questions. The Trust's score in 2013 was 3.66 which was not significantly changed from last year but was below the average score of 3.74 for acute trusts.

28 key findings

Of the 28 key findings presented in the 2013 staff survey results;

- 7 scores were better than the average for acute trusts. There were no scores in the best 20% of acute trusts.
- 5 scores were average compared to other acute trusts
- 16 scores were worse than the average for acute trusts, including 6 which were in the worst 20% of acute trusts.

For this Trust, for the Key Findings for which there was a direct comparator from the 2012 survey;

- The score for 1 key finding showed a statistically significant improvement,
- The scores for 4 key findings showed statistically significant deteriorations,
- For 22 scores there was no statistically significant change.

Top and bottom ranked scores

For each of the 28 key findings, scores for every acute trust in England were placed in order from 1 (top/best ranked score) to 141 (bottom/worst ranked score). The top five key findings, i.e. those ranked closest to 1, and the bottom five key findings, i.e. those ranked closest to 141 are shown here.

Top five ranking scores

Note – for most key findings a higher score is better. Where this is not the case, this has been indicated.

- Key finding (KF) 5 – Percentage of staff working extra hours (lower score better);
  - Trust score 2013 – 68%
  - National 2013 average for acute trusts – 70%
  - Trust score 2012 – 66%

- KF13 – Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (lower score better);
  - Trust score 2013 – 31%
  - National 2013 average for acute trusts – 33%
  - Trust score 2012– 30%

- KF28 – Percentage of staff experiencing discrimination at work in last 12 months (lower score better);
  - Trust score 2013 – 9%
  - National 2013 average for acute trusts – 11%
  - Trust score 2012 – 8%

- KF27 – Percentage of staff believing the Trust provides equal opportunities for career progression or promotion;
  - Trust score 2013 – 90%
  - National 2013 average for acute trusts – 88%
  - Trust score 2012 – 91%

- KF19 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (lower score better);
  - Trust score 2013 – 22%
  - National 2013 average for acute trusts – 24%
  - Trust score 2012 – 21%

Bottom five ranking scores

- KF10 – Percentage of staff receiving health & safety training in last 12 months;
  - Trust score 2013 – 68%
  - National 2013 average for acute trusts – 76%
  - Trust score 2012 – 72%

- KF1 – Percentage of staff feeling satisfied with the quality of work & patient care that they are able to deliver;
  - Trust score 2013 – 74%
  - National 2013 average for acute trusts – 79%
  - Trust score 2012 – 74%

- KF26 – Percentage of staff having equality & diversity training in last 12 months;
  - Trust score 2013 – 46%
  - National 2013 average for acute trusts – 60%
  - Trust score 2012 – 43%

- KF12 – Percentage of staff saying hand washing materials are always available;

    - Trust score 2013 – 50%
    - National 2013 average for acute trusts – 60%
    - Trust score 2012 – 54%

- KF15 – Fairness & effectiveness of reporting procedures;
    - Trust score 2013 – 3.45
    - National 2013 average for acute trusts – 3.51
    - Trust score 2012 – 3.49

Each of the 5 bottom ranked scores are within the worse 20% of acute trusts.

Largest changes since the 2013 survey

Where staff experience has improved since 2012

- KF7 – Percentage of staff appraised in last 12 months;
    - Trust score 2013 – 85%
    - Trust score 2012 – 76%

Where staff experience has deteriorated since 2012

- KF11 – Percentage of staff suffering work related stress in last 12 months (lower score better);
    - Trust score 2013 – 36%
    - Trust score 2012 – 31%

- KF25 – staff motivation at work;
    - Trust score 2013 – 3.83
    - Trust score 2012 – 3.93

- KF3 – Work pressure felt by staff (lower score better);
    - Trust score 2013 – 3.12
    - Trust score 2012 – 3.01

- KF10 – Percentage of staff receiving health & safety training in last 12 months;
    - Trust score 2013 - 68%
    - Trust score 2012 – 72%

With the exception of KF11, the scores for the above findings are worse than average for acute trusts. With regards to KF11 however, this is the second year in a row where the score has shown a statistically significant deterioration (the score in 2011 was 21%).

Staff recommendation of the Trust as a place to work or receive treatment

The score for question 12d within the staff survey is related to CQUIN payments for acute trusts participating in the National NHS Staff Survey.

Question 12d asks “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.” The Trust’s score for this question was 61% and the average score for acute trusts was 64%.

Question 12d, along with others, make up Key Finding 24 – Staff Recommendation of the Trust as a place to work or receive treatment. The Trust’s score for this Key Finding was 3.58, and was worse than the average score for acute trusts of 3.68. The score was not

significantly different from the 2012 score.

3. Conclusion

The results of the survey highlight particular areas where experiences of staff at this organisation are better or worse than those of staff at other acute trusts. Where it is deemed that an issue requires action, this will be discussed and agreed with appropriate groups or at relevant meetings.

4. Recommendation

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

5. References and further reading

2013 National NHS Staff Survey Results from York Teaching Hospital NHS Foundation Trust

Author	**Siân Longhorne, Workforce Information Manager**
Owner	**Sue Holden, Director of Applied Learning & Research**
Date	**April 2014**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 April 2014

Patient Safety Strategy

Summary

This document and associated action plan provide an account of the Trust strategic approach to patient safety and associated priorities over the next two years.

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 much of this document compliments our approach to the CQC regulation compliance.

Progress of report	This document has been produced following wider consultation with clinicians and in consideration with national recommendations.
Risk	No additional risks indicated other than those already reported on the risk register.

Resource implications	None identified.
Owner	Dr Alastair Turnbull, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	16th April 2014
Version number	1

York Teaching Hospital NHS
NHS Foundation Trust

Patient Safety Strategy
2014-2016

Introduction

The safe care of patients entrusted to York Teaching Hospital NHS Foundation Trust is our top priority and we are working tirelessly to ensure the continued improvement of patient care. Our ultimate objective is to be trusted to deliver safe, effective healthcare to our community.

We aim to be recognised as one of the safest hospitals nationally and internationally, delivering safe, evidence-based care and acting and learning when we identify a need for improvement.

But this alone is not enough. Our patients and their families must receive their care with compassion and consideration and our resources have to be used wisely and to greatest effect.

The Trust recognises the value of working with patients and carers. We welcome patient partnership and strive to support patients to be more involved in their care. Additionally we seek to ensure that the patient voice is heard throughout the Trust including commissioning services and in our training programmes.

We are committed to the education, training and development of our staff. We want to ensure that our clinical staff are skilled and motivated and that our leaders can identify and develop patient safety behaviours and skills.

In adopting this strategy we will focus on enhancing our culture of transparency in order to improve and provide support when things go wrong.

We recognise that our staff work in situations where risks are inherent and we will strive to maintain a working environment with safe and supportive systems of work, and an environment that also recognises responsibility and accountability. We will continue to encourage reporting of errors and incidents in order to learn from them however, we will not tolerate neglect or wilful misconduct.

How we are doing?

We have achieved tangible improvements in patient safety over recent years. Examples include a fall in mortality rates and better incident reporting.

Individuals, wards, departments and directorates have all made a contribution to improve patient safety. However, we know that our mortality rates are still higher than some of our peer organisations and that care is not always delivered in a consistent manner, 24 hours a day, seven days a week.

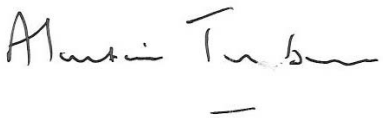
We must now take further action to reduce harm, variation in practice and to improve efficiency whilst always ensuring safe care.

The majority of our patients tell us that they would recommend our hospitals to their family and friends but there is variation between wards, departments and individuals.

When we get it wrong, the story our patients tell us is both powerful and moving and we promise to continue to learn from these stories.

We will continue to celebrate success and to promote and adopt best practice.

Patrick Crowley
Chief Executive



Dr. Alastair Turnbull
Medical Director

Patient Safety Strategy Implementation Plan

This Strategy has been developed following consultation with our staff. In addition, we have compared our systems and practices with other hospitals and considered national and international guidance on improving safety.

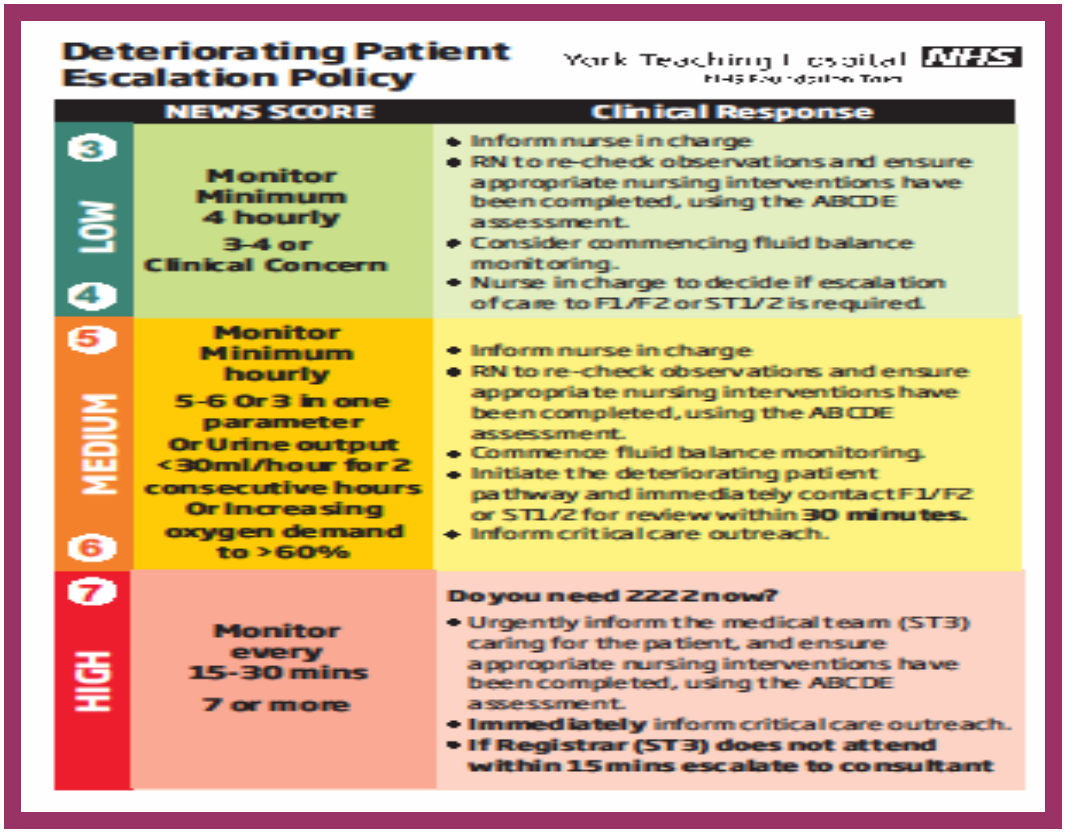
Our guiding principle is to provide safe, patient-centered care to a consistent,high standard. To achieve this we have established six key streams of work:

- Ensuring consistency of care, 24 hours a day, seven days a week
- Reduction of harm by early detection of the patient at risk of deteriorating
- Reducing mortality and improving mortality indicators
- Excellence in end of life care
- Infection prevention and control
- Action on areas of frequent harm.

Many of us focus on improvement for our patients, every day. This Strategy does not seek to exclude any of this work rather it helps us collectively to focus on those things we know can have the most impact, for the greatest number of our patients.

Clinical leaders continually review our systems of work to ensure that patients who are admitted to our hospitals do not experience undue delay in assessment, diagnostics, treatment or review by a senior clinician. We are working towards delivering a seven day service with no variation in timeliness or safety and quality of experience.

We are striving to improve the safety of those who are vulnerable to unexpected deterioration by enhanced training and the implementation of systems to support early recognition of the risk of deterioration. This is being supported by policies and clinical guidelines for initiation of early responses, interventions and, where necessary, escalation. This includes recent guidance around urgent and effective response to sepsis.



Deteriorating Patient Escalation Policy

York Teaching Hospital NHS

NEWS SCORE		Clinical Response
3 LOW 4	Monitor Minimum 4 hourly 3-4 or Clinical Concern	• Inform nurse in charge • RN to re-check observations and ensure appropriate nursing interventions have been completed, using the ABCDE assessment. • Consider commencing fluid balance monitoring. • Nurse in charge to decide if escalation of care to F1/F2 or ST1/2 is required.
5 MEDIUM 6	Monitor Minimum hourly 5-6 Or 3 in one parameter Or Urine output <30ml/hour for 2 consecutive hours Or Increasing oxygen demand to >60%	• Inform nurse in charge • RN to re-check observations and ensure appropriate nursing interventions have been completed, using the ABCDE assessment. • Commence fluid balance monitoring. • Initiate the deteriorating patient pathway and immediately contact F1/F2 or ST1/2 for review within **30 minutes.** • Inform critical care outreach.
7 HIGH	Monitor every 15-30 mins 7 or more	**Do you need 2222 now?** • Urgently inform the medical team (ST3) caring for the patient, and ensure appropriate nursing interventions have been completed, using the ABCDE assessment. • **Immediately** inform critical care outreach. • **If Registrar (ST3) does not attend within 15 mins escalate to consultant**

We have developed and are refining systems for mortality review which will be consistently applied in all clinical areas including our community hospitals.

We will ensure that recognised strategies for reduction of mortality such as multidisciplinary ward rounds and *care bundles* are implemented - in all clinical areas. Many are currently in place and their implementation will be audited by review of compliance.

For our patients approaching the end of life and for their families and carers, our focus will be on the safety *and* experience of care. This includes patients who die suddenly or after a very brief illness. Our aim is to ensure that people approaching the end of life receive care which is aligned to their needs and preferences, is compassionate and delivered in accordance with agreed principles.

We have begun work on the implementation of electronic prescribing and medicines administration (EPMA), recognised to improve aspects of patient safety and helping to address one of our most frequent causes of avoidable harm. We will audit

compliance with administration of medicines focusing specifically on critical medicines and on antimicrobial stewardship.

We will use every opportunity to learn from incidents, complaints and litigation by reflecting on our practice and where necessary changing systems of work to ensure that patients are safe in our care and that repetition of avoidable harm is prevented.

The Serious Incident (SI) and Critical Incident (CI) procedures continue to evolve to ensure appropriate dissemination of change and learning, and work is now focusing on learning from litigation and complaints. In responding to these events we recognize the implication and responsibilities on our duty of conduct.

We also take every opportunity to learn from national benchmarking including national audit publications such as National Confidential Enquiry into Patient Outcome and Death (NCEPOD)and inspections from our regulators. We have developed along with our local commissioners several patient safety initiatives which are being managed through the contracting for quality and innovations aspect of the contract.

A culture of safety

We encourage and require all our staff to report adverse events and unsafe conditions, to take action when it is needed and to seek assistance when concerned that the quality and safety of the care being delivered is threatened.

Our aim is to promote an open culture. Staff should be aware that that they are accountable for their actions however we want to develop and maintain an environment that feels safe, recognising that they will not be blamed for system faults in their work environment beyond their control.

We openly share safety information and focus on learning and improving from incidents, complaints and litigation. Whilst emphasising the importance of avoiding blame we will move towards a culture that will not tolerate non compliance with agreed procedures.

Patient Safety Walkrounds have provided valuable opportunities for senior leaders to discuss safety issues with frontline staff. As a commitment to developing our culture of safety we aim to undertake four walkrounds each month and to provide a monthly summary report to the Trust Board.

Fundamental to building on the successes of the Trusts current work on patient safety- as evidenced by a sequential fall in our mortality indicators- is placing it firmly and foremost on the agenda of all. At Trust Board, assurance of safe effective and compassionate care will continue to lead proceedings. The Boards subcommittees will develop, informed by an evolving Safety Booklet of data and similar scrutiny will prevail at Executive Board but with a focus on actions required by Directorates. Use of Clinical Governance sessions will be reviewed to ensure consistency and individual clinicians will be expected to demonstrate their commitment to

improvement. We will work with our Governors and seek their help with this strategy. Mindful of our growing and dispersed organization we will examine ways of better sharing learning, consistently throughout the Trust, for example by Joint Performance Improvement Meetings. More and more do we recognize the importance of designing safe systems that reduce harm arising from human factors and behaviors.

Partnering with other organisations

We aim to make good use of peer review to support analysis and to facilitate learning, both within and outside of formal systems. CHKS provides us with healthcare intelligence to support the delivery of safe and effective care.

We are one of 13 Foundation Trusts who are members of NHS QUEST; a network for Foundation Trusts who wish to focus relentlessly on improving quality and safety.

The Trust has also developed working relationships with other organisations such as Hull Hospital on the clinical pathway alliance, The Improvement Academy on mortality reviews, York University on patient incident reporting and the Global Sepsis Alliance.

Involving patients in safety

We want our patients to:

- Be involved as much as they want be in decisions about their care and treatment
- Let us know if anything of concern is noticed
- Be sure that we identify them correctly
- Ensure that they understand what we are planning to do before consenting to treatment
- Know what medicines they are taking and why
- Inform us of allergies
- To alert us to non compliance, for example with hand hygiene.

Harnessing the power of Information Technology

The Trust benefits from an integrated, effective and sophisticated Information Technology (IT) system. This has facilitated development of NEWS, escalation and result notification. It is fundamental in EPMA. Increasingly compliance can be measured electronically but most importantly clinicians will increasingly use smart systems, both to inform and document their work. It is essential that as such systems expand and develop they become even more accessible and user-friendly, thus ensuring consistent clinical engagement.

Costs and Efficiency

Cost improvement and safety improvement are not mutually exclusive, and there is ample international evidence to the converse. Length of patient stay in hospital will

be reduced for example, by avoidance of harm and reduction of prescribing costs. Equally by tiered processes of assurance from Directorate to Executive level the Trust will examine proposed cost improvement programmes (CIPs) to ensure that at all times the CIP and patient safety programmes are aligned.

Our staff

This strategy has referred to the essentiality of cultural factors but human factors are also key. Evidence indicates a clear link between the number of medical and nursing staff and safer patient outcomes. The Trust is committed to a process of continued review and of transparency and to a programme of focussed continuous professional development for staff. Professional capabilities and behaviours profoundly impact on the patients' experience.

To enable us to achieve this we will focus on the following six key areas of work.

1. Ensuring consistency of care, 24 hours a day, 7 days a week

The principle of 'equality of treatment or clinical outcome regardless of the day of the week' is a challenging yet intuitive concept. Evidence suggests that where there is inconsistent access to clinical services over a seven day period, patients suffer delays to their treatment and this contributes to less favourable outcomes.

We have begun to evaluate the requirement for developing our services for safer care. Seven day working does not necessarily mean operating all services 24 hours a day however, it will mean an extension to the working day or elements of a service becoming more accessible over the seven day period.

Reviews of serious untoward incidents and mortality reviews, observations of working practice and data collection, describe a system where patients can wait too long to be seen or treatment initiated and this can be a significant and contributing factor in failure to rescue some patients. We also know that ward rounds, where crucial decisions are made around patient management, can be variable and that adding structure, including checklists, to this will help prevent missed opportunities and reduce variation.

'Out of hours' there is still some inequity in workload, though recent changes have addressed many of these. Lack of clarity around some roles remains and is a focus for the 24/7 acute hospital 'out of hours' initiatives.

Nationally there is a shortage of junior doctors in training. This reduction in workforce will potentially have a significant impact to 'out of hours' where junior doctors have traditionally been the predominant medical workforce. As a result and in line with national work, we are committed to developing the Advanced Clinical Practitioner role and to ensuring a more consistent senior, (including consultant) presence. This process has begun, for example in obstetrics and anaesthetics. The planning implications of this are formidable and the Trust will be ever vigilant of the importance of learning arising across the organisation.

Our aim is to:

- Ensure that patients who are admitted to hospital for urgent treatment are assessed promptly
- Ensure excellence and consistency in ward round practices
- Stream the ‘out of hours’ roles and methods of working.

To achieve this we will:

- Remodel pathways of care
- Improve staff capability and capacity to enhance the workforce ‘out of hours’
- Improve communication and patient prioritisation
- Continue to develop advanced clinical practitioner roles
- Promote multidisciplinary ward and board rounds
- Further develop the ward round checklist
- Ensure patients have a daily senior medical review.

2. Reducing Mortality and Improving Mortality Indicators

Mortality reviews

Learning all we can from critically examining care that patients receive before they die can teach us how to deliver safer care. This element of the strategy will continue to refine systems which ensure that a standardised approach will be taken to performing mortality reviews. Where trends can be identified, learning from reviews can be cascaded efficiently and improvements to patient safety occur where required.

Clinical coding

We know that our published mortality rates describe more deaths than expected in some areas. We know that this can be improved by making positive changes to the quality of our clinical documentation and clinical coding alongside delivering safer care. This will enable us to have increased confidence in our mortality data and to accurately reflect the care that is being delivered. Being able to compare ourselves externally enables us to strive to be the best and to learn from other high achieving organisations. Confidence in our coding processes enables us to use our data more effectively and fundamental to this is better documentation, recorded electronically, and close alignment between clinicians and coders. This contributes to better death certification as we move to introduction of the Medical Examiner role.

Our aim is to:

- Promote and develop the existing processes of mortality review for all patients who die in our hospitals
- Develop processes for dissemination of learning from mortality review
- Improve the depth of clinical coding.

To achieve this we will:

- Ensure that all in-patient deaths are reviewed by a consultant within four weeks of the death occurring
- Promote discussion of learning from mortality review at department governance meetings
- Provide a six monthly report of all deaths occurring in the Trust
- Monitor depth of coding via the mortality review process.

3. Reducing harm from avoidable physiological deterioration

Problems surrounding the management of the deteriorating patient are often multi-factorial.

Outcome data shows that we are still performing slightly below average in terms of the number of cardiac arrests occurring in the Trust. Examining the care of patients who deteriorate has allowed us to understand the problem, including inaccurate early warning scores, failure to inform the senior nursing staff of deterioration, delay in senior medical review and failure of some patients being seen by a Consultant in the 24 hours prior to Critical Care admission.

The move to electronic observations has allowed improved compliance with early warning recognition and development of a robust escalation policy.

To improve the medical response, we have developed a deteriorating patient pathway to support the junior doctors in the initial assessment. The escalation policy is a graded response which ensures a structured and timely approach to the deteriorating patient.

By empowering all members of the team we will generate an open, receptive culture around the deteriorating patient.

We know we must further embed good practice to prevent patients developing pressure ulcers or falling while in our care and have ambitious plans for staff training, audit and support.

Patients miss doses of key medication more often than we would want and there is variation in our discharge processes around medication practice. Audit shows that our highest number of reported adverse incidents relate to medicines. We will be developing a robust plan to support safer medicines management including but not exclusively a system for electronic prescribing and medicines administration (EPMA).

Our aim is to:

- Increase knowledge of critical illness recognition and management
- Have a clear process for early detection of the deteriorating patient
- Establish robust escalation processes uniformly throughout the Trust
- Promote robust risk assessment and intervention for patients at risk of harm.

To achieve this we will:

- Provide training in acute illness recognition, management and escalation
- Audit use of the deteriorating patient pathway and policy
- Audit use of the sepsis management bundle of care
- Develop a patient observation policy
- Extend the use of safety briefings
- Increase Critical Care Outreach support at both acute sites.
- Critically review cardiac arrests regularly.
- Continue to promote better management of patients with diabetes
- Review and expand the pressure ulcer and falls reduction plans
- Develop a medicines management plan which includes electronic prescribing.

4. Excellence in end of life care

Of the 500,000 people who die each year in the UK only 18% die at home, yet 60% wish to do so.

End of Life Care is an inclusive term for the care and management of patients identified as being in the last year of their life. Throughout this time, patients may come into contact with our services to varying degrees dependent on the acuity and nature of their illness or disease. The Trust is committed to improving experiences throughout this time.

Although every individual may have a different idea about what would, for them, constitute ‘a good death’, for many this would involve:

- Being treated as an individual, with dignity and respect
- Being without pain and other symptoms
- Being in familiar surroundings
- Being in the company of close family and/or friends.

Our aim is to:

- Ensure appropriate inclusive and well documented Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision making
- Ensure appropriate, agreed ceiling of care decision making
- Promote excellence in care planning at the end of life.

To achieve this we will:

- Develop the role of the Lead Nurse for End of Life Care
- Continue to audit DNACPR decision making and agreement on ceiling of care
- Continue roll out of AMBER*/advance care planning
- Work with local commissioners to implement the AMBER/Advanced Care Planning booklet
- Link with mortality review processes and specifically DNACPR decision making
- Work with local commissioners to ensure that people at the end of their lives have care in their preferred place.

5. Infection prevention and control

Hospital acquired infection remains a threat to the well being of our patients.

Levels of *Clostridium Difficile*, Methicillin-resistant *Staphylococcus aureus*, Methicillin-sensitive *Staphylococcus aureus and Escherichia coli* are collected weekly and Root Cause Analysis (RCA) undertaken by the treating clinician where appropriate.

The emergence of antimicrobial resistance is a key concern and we will continue to both develop a restrictive antimicrobial formulary and audit compliance with antimicrobial prevention guidelines including documentation of indication and course length.

Data on hand hygiene and bare below the elbows compliance are routinely collected and adherence to the Infection Prevention and Control (IPC) Policy will be universally required throughout the Trust.

The Director of Infection Prevention and Control (DIPC), Deputy DIPC and Hospital Infection Prevention and Control Committee will continue to monitor and report to the Trust Board of Directors data on IPC compliance, and continue to promote a culture amongst all staff of infection prevention awareness.

6. Areas of identified concern

This strategy has identified key foci for improvement but analysis of harm events in the Trust identifies other recurrent themes around avoidable harm. These include morbidity and mortality from falls, and the development of pressure ulcers. Each of these will be the focus of specific actions for the Patient Safety team working with the Chief Nurse's Team. Each requires a multidisciplinary approach, identifying improvements made in other hospitals and rigorous incident reporting. Each will be subject to Root Cause Analysis via the Serious Incident process. Progress will be reported from Ward to Board.

* AMBER is a systematic approach used in hospitals to manage the cre of patients facing an uncertain recovery and who are at risk of dying in the next one to two months.

Monitoring Progress

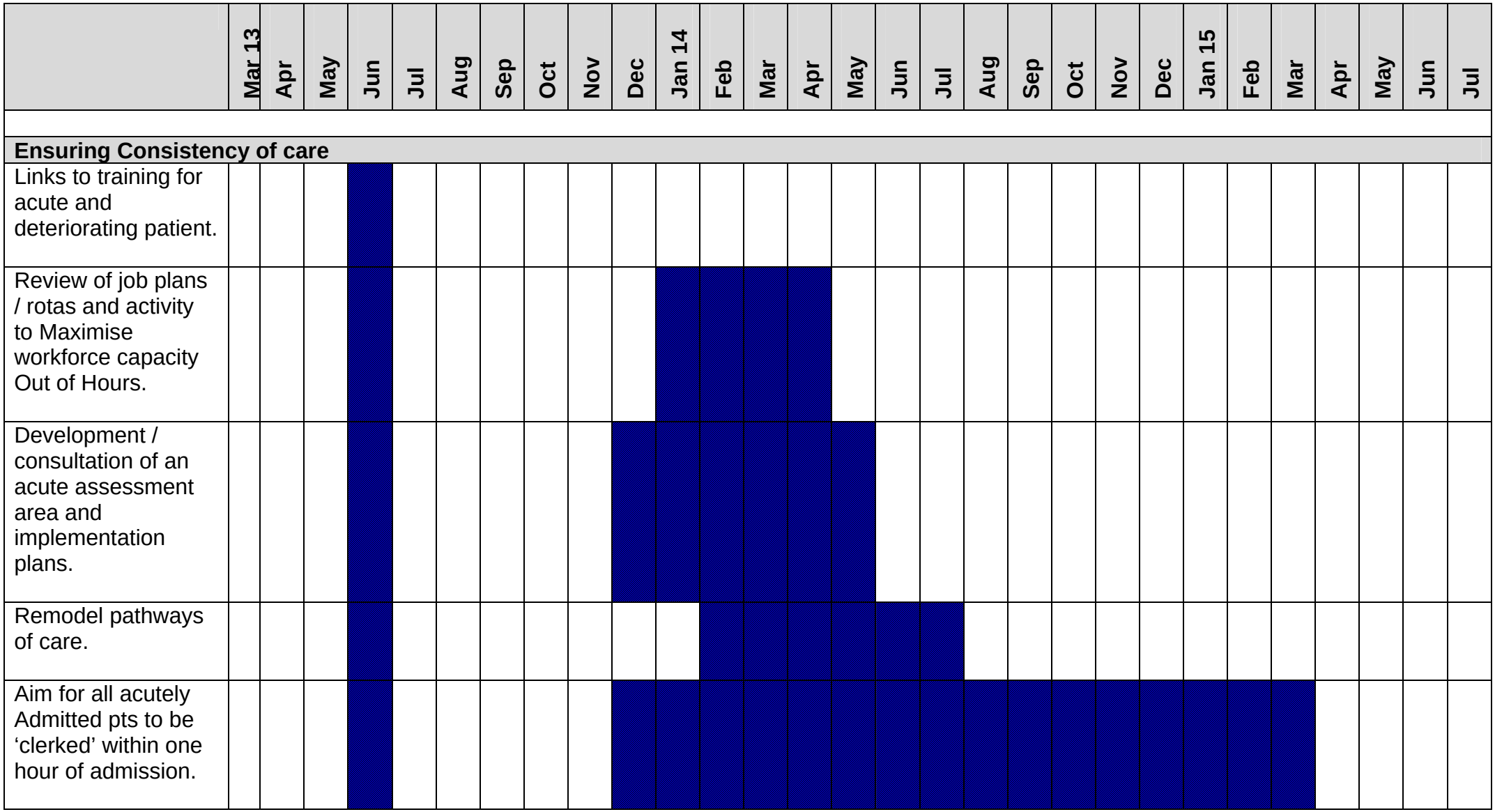
Progress with implementation of the Patient Safety Strategy will be reported monthly to the Executive Board and Trust Board. Progress with CQUIN will be monitored quarterly with local commissioners.

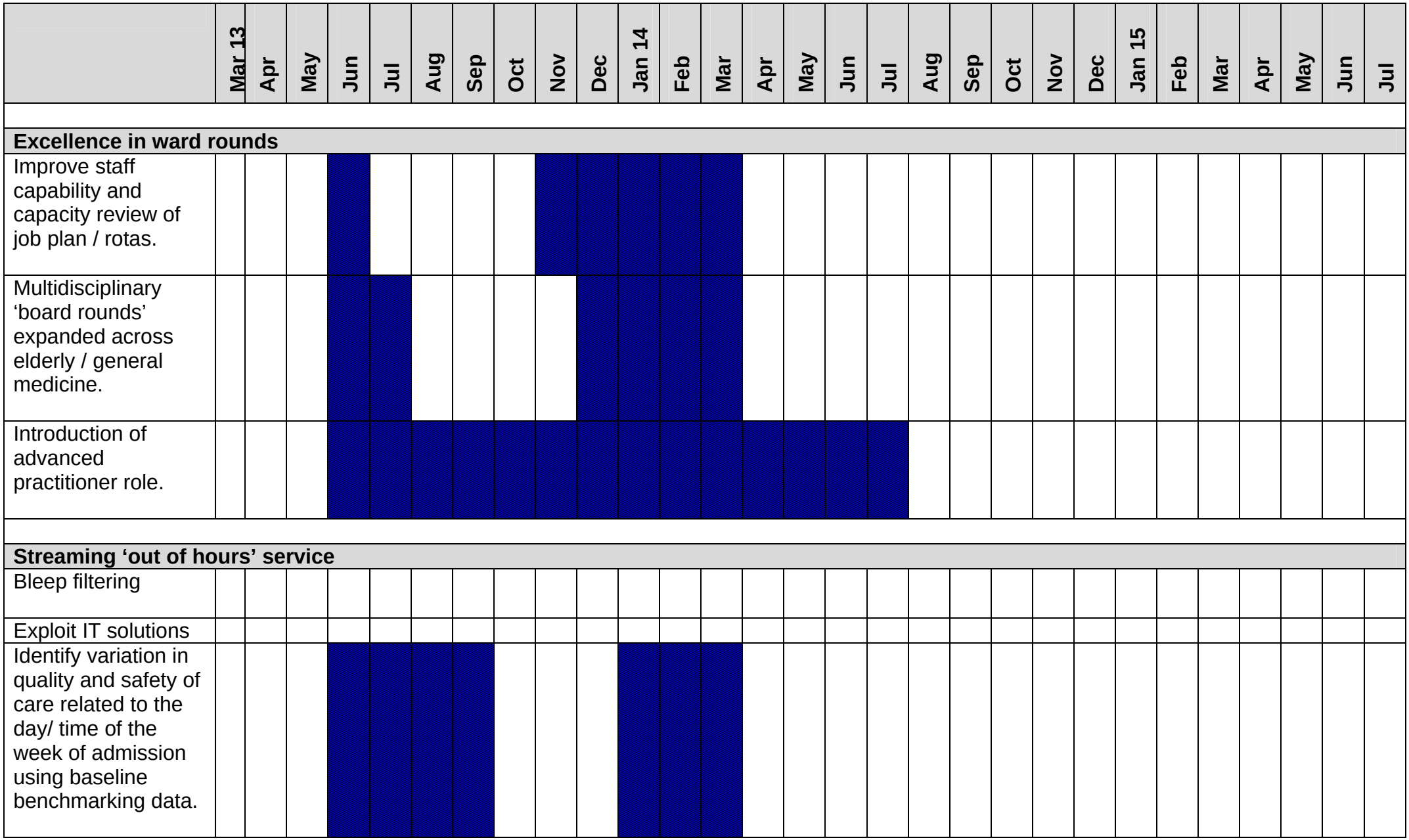
The Trust Patient Safety Group will have responsibility for ensuring that the individual streams of work supporting the strategy implementation have adequate and appropriate support to achieve success and that they are progressing in accordance with their project plans.

Contributors

Layla Al-Ani
Lyeanda Berry
Michelle Carrington
Cat Lunness
Helen Noble
Diane Palmer
Loo Parker
Vicki Parkin
Jonathan Redman
Neil Todd

Patient Safety Strategy Implementation Plan 2013/ 2014/ 2015

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Excellence in ward rounds
Improve staff capability and capacity review of job plan / rotas.
Multidisciplinary 'board rounds' expanded across elderly / general medicine.
Introduction of advanced practitioner role.
Streaming 'out of hours' service
Bleep filtering
Exploit IT solutions
Identify variation in quality and safety of care related to the day/ time of the week of admission using baseline benchmarking data.

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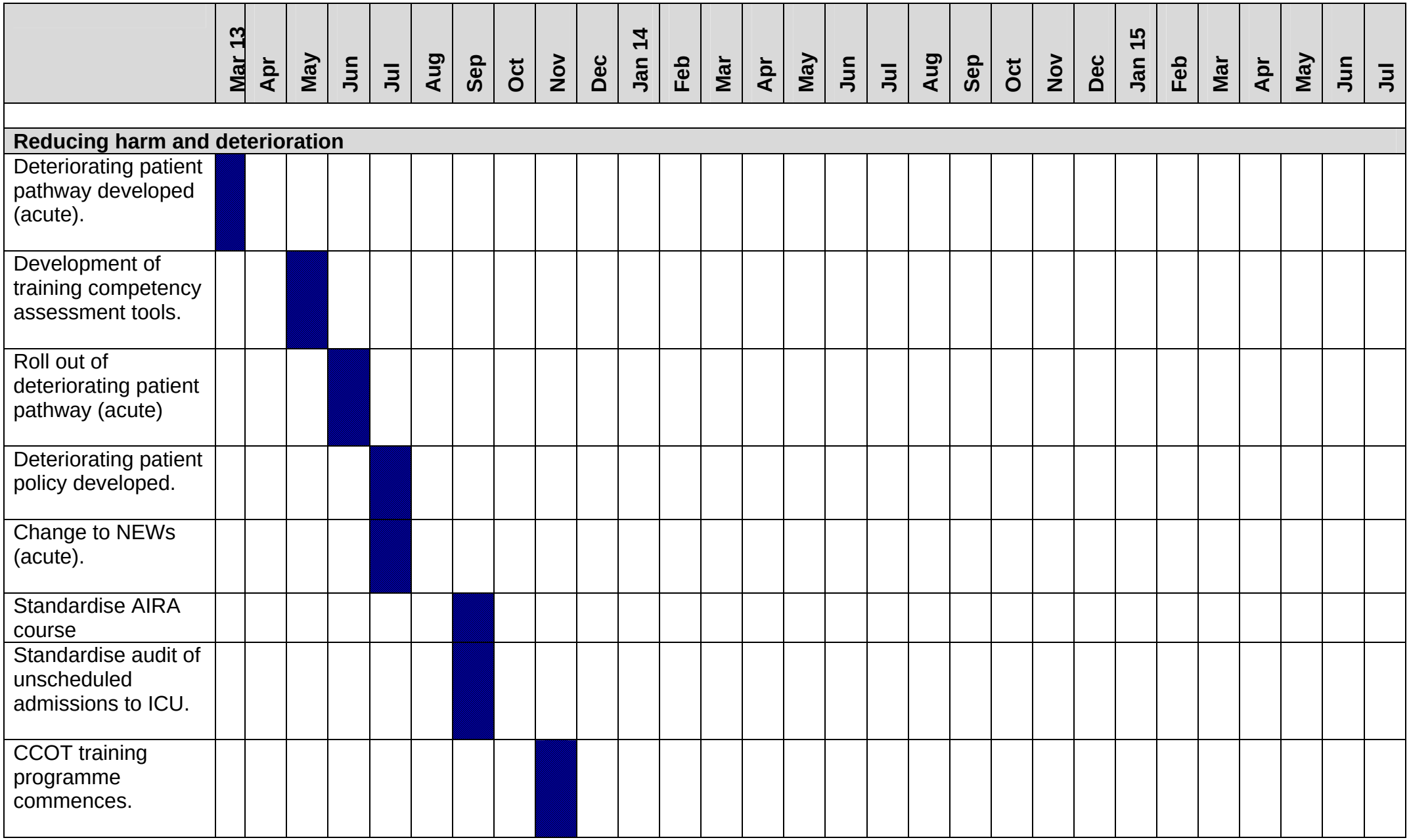
Post take ward round (PTWR) checklist.																													
Daily senior review and acute physician on AMU.																													
Improve communication and patient prioritization.																													
Reducing mortality																													
Mortality reviews of all in-patient deaths.																													
Produce quarterly summary report of mortality reviews.																													
Clinicians to review clinical coding.																													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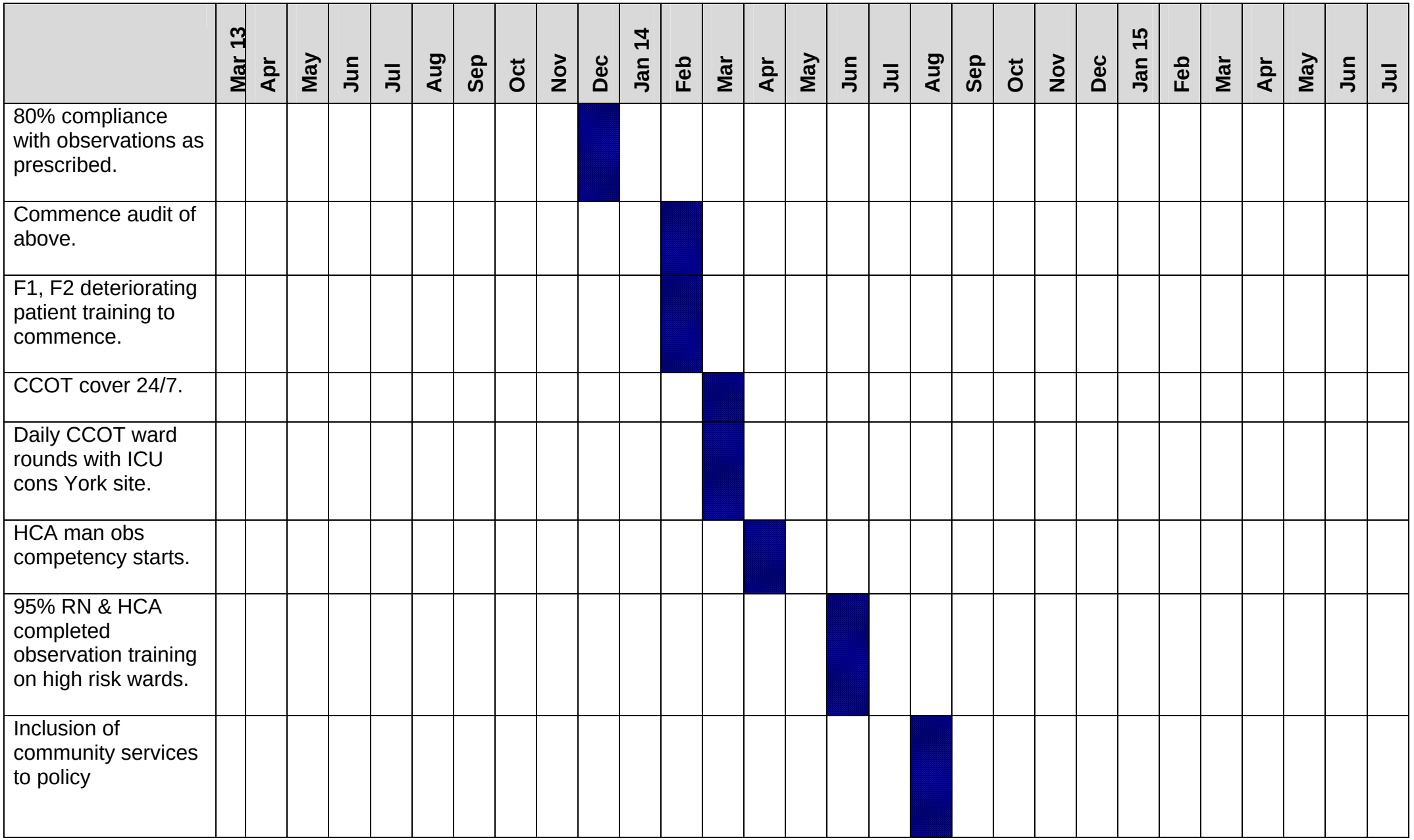
Reducing harm and deterioration
Deteriorating patient pathway developed (acute).
Development of training competency assessment tools.
Roll out of deteriorating patient pathway (acute)
Deteriorating patient policy developed.
Change to NEWs (acute).
Standardise AIRA course
Standardise audit of unscheduled admissions to ICU.
CCOT training programme commences.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80% compliance with observations as prescribed.
Commence audit of above.
F1, F2 deteriorating patient training to commence.
CCOT cover 24/7.
Daily CCOT ward rounds with ICU cons York site.
HCA man obs competency starts.
95% RN & HCA completed observation training on high risk wards.
Inclusion of community services to policy

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Sisters and Det pt champions attending AIRA in high risk wards competent.																													
95% senior nurses and patient safety champions attended AIRA course.																													
Quarterly audit of cardiac arrests.																													
Registrar training plan in place.																													
CCOT achieve competencies.																													
Sepsis																													
Identify clinical leads.																													
Development of sepsis policy.																													

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Develop measurement of improvement.																													
In-patient diabetes																													
Yearly mandatory training in place.																													
Electronic flags in place.																													
Resolution of business case.																													
Insulin rounds on all wards.																													
Snacks available 24/7.																													
Diabetes cons ward rounds 3 times a week.																													
Blood glucose monitoring above 75%.																													

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Insulin prescribing errors no more than 6%.																													
Hypoglycaemic episodes no more than 2.5%.																													
No insulin never events / SI.																													
Reaudit compliance insulin rounds.																													
Reduce patient falls																													
RCA completed in time for all falls with serious harm.																													
Identify lead consultants in falls each acute site.																													
Integrated falls policy agreed.																													
Establishment of trust wide falls prevention group.																													

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80% compliance with falls assessment.																													
Falls champions identified on all wards.																													
Falls champions completed Falls Safe training.																													
Commence falls education programme.																													
Integrated falls awareness programme.																													
95% compliance with falls assessment.																													
Falls with harm rate <5% per 1000 bed days in elderly services York.																													

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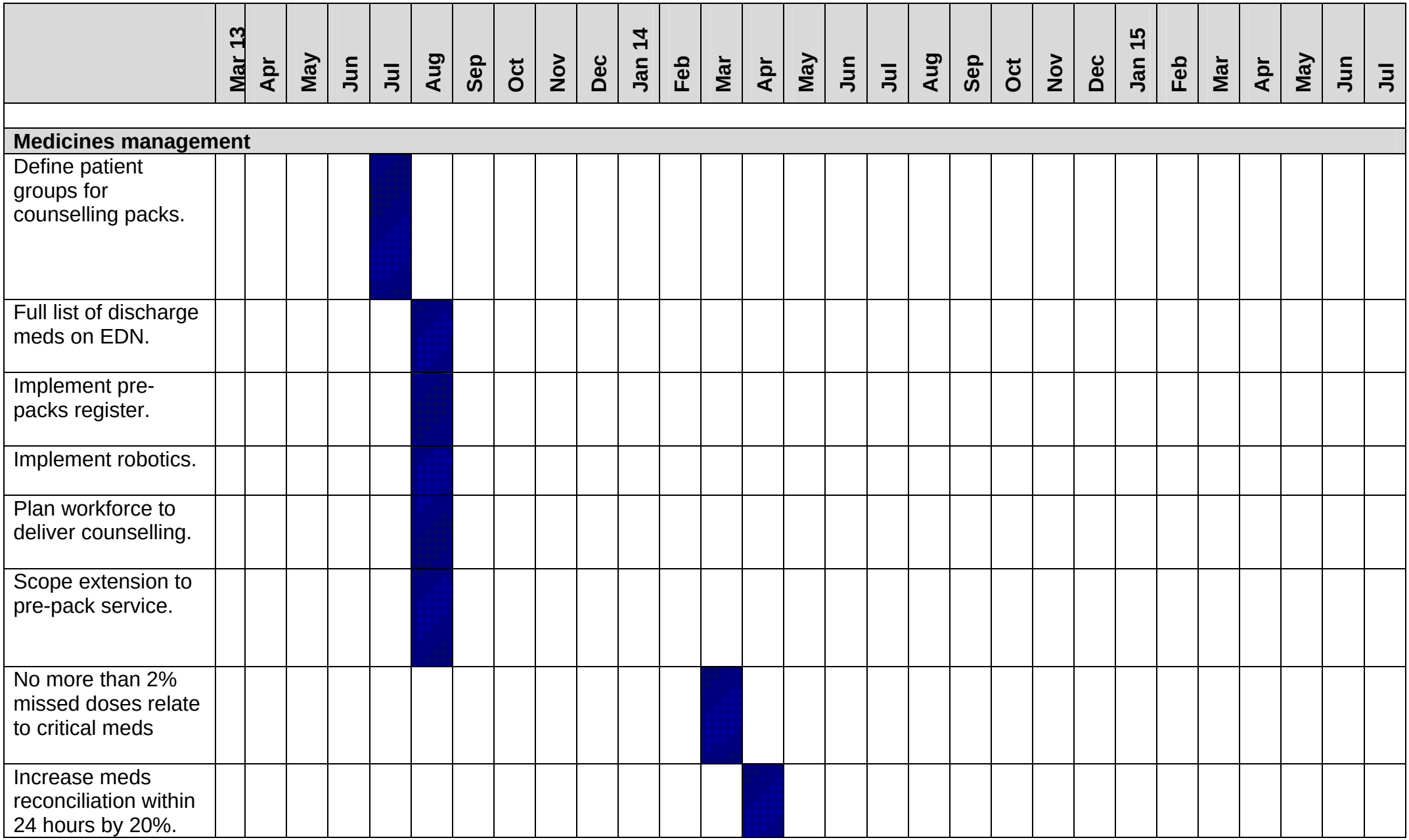
95% pts have comfort rounding in place.																													
95% of patients who fall have post falls sticker in notes.																													
95% patients 'at risk' of falling have initial intervention sticker in notes.																													
Reduce pressure ulcers																													
50% reduction and no cat 3 or 4.																													
50% reduction and no avoidable cat 3 or 4.																													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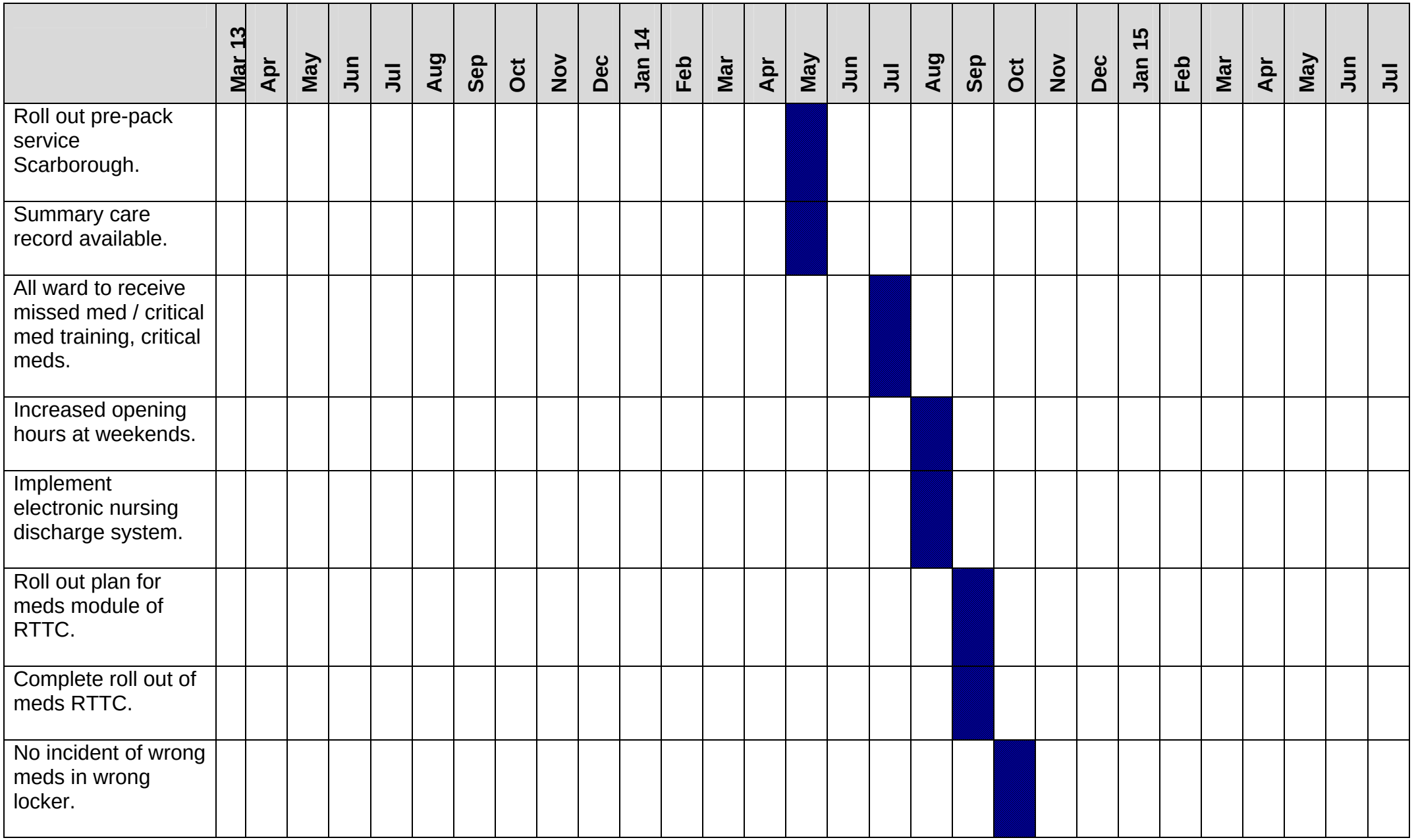
Medicines management
Define patient groups for counselling packs.
Full list of discharge meds on EDN.
Implement pre-packs register.
Implement robotics.
Plan workforce to deliver counselling.
Scope extension to pre-pack service.
No more than 2% missed doses relate to critical meds
Increase meds reconciliation within 24 hours by 20%.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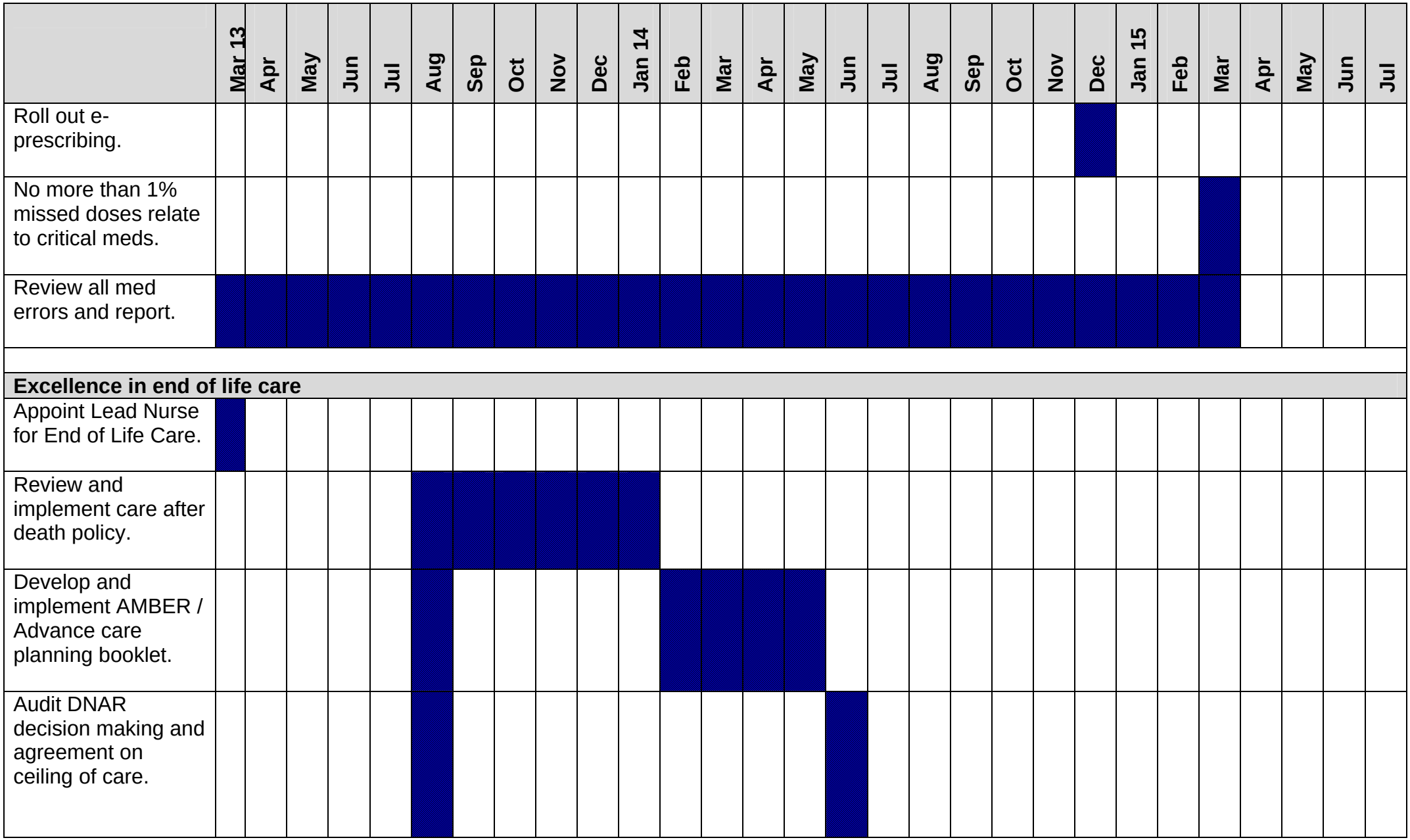
Roll out pre-pack service Scarborough.
Summary care record available.
All ward to receive missed med / critical med training, critical meds.
Increased opening hours at weekends.
Implement electronic nursing discharge system.
Roll out plan for meds module of RTTC.
Complete roll out of meds RTTC.
No incident of wrong meds in wrong locker.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Roll out e-prescribing.
No more than 1% missed doses relate to critical meds.
Review all med errors and report.
Excellence in end of life care
Appoint Lead Nurse for End of Life Care.
Review and implement care after death policy.
Develop and implement AMBER / Advance care planning booklet.
Audit DNAR decision making and agreement on ceiling of care.

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Introduce the AMBER Care Bundle in York Hospital as a pilot and then expand.																													
Link with mortality review processes to understand failures in DNACPR.																													
Work with CCGs on reduction of patients inappropriately admitted to hospital to die.																													
Commence training on AMBER / advance care planning booklet.																													

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 April 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	April 2014
Version number	Version 1

Board of Directors – 30 April 2014

Chairman's Items

1. Strategy and Context

The financial and planning year is effectively closed and the entire Trust should be congratulated on a strong performance across the vast majority of metrics. I feel the Trust has managed to balance its care and financial responsibilities very well, especially considering the aggregate performance of the NHS, including FTs, is slipping under the strain of sustained austerity. In the small number of areas where we have under-performed, clear efforts to address these are already reaping success (e.g. ED) and where the tide has not yet convincingly turned we are seeing intense managerial and clinical focus (e.g. C.Diff, pressure ulcers).

We enter the new financial year in a positive light and with everything to play for. My sense is that the acquisition is now "over" as an "event" and that our Trust stretching across much of North Yorkshire is now the norm about the way we think, work, seek assurance and relate to the many stakeholders and communities we serve. The consolidation and enhancement of all our services of course will take further years. However, I think this means we can free our minds somewhat to grapple with the shifting challenges of the vertical integration of care with our primary and social care cousins. This feels like a breakthrough year in this sphere of our work, after three years of "re-learning", consolidation and preparation in Community Services. The announcement this week of a formal federation of GPs in York (confusingly entitled the "Vale of York GP Federation"!), which covers one third of the York population and parts of the county around, signals the continuing restructuring of that part of the "market". We look forward to working with such groupings to improve and accelerate the re-shaping of care in our communities and the relationships with our secondary services.

The turbulence at Hull & East Yorkshire Hospitals Trust has come to a head this month with the change in leadership that brings an Interim CE and Interim Chair into place. We will work with them to ensure this does not derail the cautious progress we have been making together on selected clinical alliances at specialty level.

2. Governance & Governors

By the time we gather, the public meeting in Bridlington will have taken place and we can report back on the reaction of the community to the range of changes that are being rolled-out at that site. As we discussed last month, this is probably the most tangible piece of "reconfiguration" we have embarked upon since the acquisition and it symbolises our commitment to patient-focused, capital-backed strategic development. It is a good example of what we promised ourselves and our communities: to be on the front foot, to keep options open and to plan and act for the sustainable future for care in the communities we serve. The way we engage in Bridlington – working alongside the Council, media, HealthWatch, our Governors and other stakeholders – is an important statement about how we intend to act as a Foundation Trust should. We will tailor similar such events, as appropriate, in other of our locations in the months ahead.

On a governance note, I draw your attention to a national change in policy by which Executive Directors in health Trusts are now free to consider standing as Non-Executive Directors of any

kind of other health Trust. In addition, Non-Executive Directors can serve (as NED or Chair) in multiple Trusts at the same time.
3. Recommendation
The Board of Directors is asked to note the report.

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

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 April 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	April 2014
Version number	Version 1

Board of Directors – 30 April 2014

Chief Executive Report

Introduction

Its that time of year when we should all take a pause and reflect on the year we have just completed, taking pleasure in all that we have achieved whilst considering those areas we might have done better, and use that as a platform for clarifying and re-setting our priorities and approach to take the organisation as a whole another step forward.

I truly believe that our financial performance has been stunning in light of all the challenges we have faced and our clinical performance overall has been very good but inevitably challenged as the demands placed on us continue to grow in both volume and complexity. Clearly we have work to do in ensuring we continue to provide the safest services we can in the most accessible manner possible and a renewed focus on the opportunities presented by the vertical and horizontal integration of services is an essential pre-requisite of this.

You will consider a business case at Board today that recommends the appointment of additional consultant time to support the development and implementation of a community hub in both Malton and Selby. I believe this to be key to reinforcing our commitment to providing the very best services in the community, for the community, and a demonstration of our enthusiasm to innovate, experiment and lead initiatives of this nature that if successful will shape health and social care provision for the foreseeable future.

I have talked for sometime of the need to re-focus on realising the benefits of the integration of York and Scarborough Hospitals and as we begin a new year never has this been more important. Patient demands and expectations continue to grow and the financial “crisis” in the hospital sector continues to deepen. The integration presents a unique opportunity to respond to this positively and as a leadership team we must resolve to ensure that this happens by setting out our expectations of all our staff and providing a clear direction for service development and delivery in the short and longer term. The Bridlington project is a major signal of our intent as is the planned reconfiguration of wards and capacity in the York Hospital that will complement the changing needs of our patients, the need to improve patient flow and the priority of addressing the continued risk of cross infection between wards and ward areas. There can be no complacency and where appropriate there must be evident and clear leadership on all aspects of our business.

For this month I have added two items below. Firstly, you have an invitation to contribute to the planning and design of our Open Day that will help celebrate with our staff our achievements to date and our plans for the immediate future. Secondly, I have set out a short summary of how we will develop and present our longer term plans that will be submitted to Monitor in June. I hope you agree with me that these two items capture quite nicely the need to balance our recognition of todays efforts with the need to continue to evolve and develop our future. This is the nature of our business and the essence of why we do what we do.

In closing I would like to thank all our staff, together with every member of the Board, Executives and Non Executives, and our Governors for their personal contribution to our performance in the last financial year. Without the blend of skill, expertise, drive, challenge

and mutual support that we share and enjoy I have no doubt our community would be worse off.

Open Day 2014

The Trust's Open Day is a key part of our engagement strategy with the community we serve and our staff. As previously briefed the Trust's Open Day will rotate between York Hospital and Scarborough Hospital on a yearly basis. This year will see Scarborough Hospital hosting the event and the planning process is now commencing with an aim for the event to be held in September. The main purpose of the event is to have an open door policy to encourage communications between the Trust and the public by:

- Engaging with the community we serve and giving a positive image of the Trust
- Broadening the knowledge of the public (and staff) on operational aspects of the Trust
- Increasing awareness to the public (and staff) of career opportunities in the Trust/NHS
- Increasing awareness to the public (and staff) of volunteering opportunities
- Raising awareness of the NHS Trust Membership and Governors
- Linking the annual AGM which will be held on the same day

It is fundamental for everyone to be involved in this high profile event to ensure we showcase all the great aspects of our Trust and importantly reinforce our commitment to providing the highest quality services we can across the whole organisation. In preparation for this I would like to hear your views on what aspects of the Trust you feel we should be focusing on and including in the event.

Strategic and Operational Planning

To comply with guidance from Monitor ("Guidance for the Annual Planning Review 2014/15"), all NHS Foundation Trust are required to develop and complete two year Operational and five year Strategic Plans that for the relevant health community areas have to be congruent with one another. Monitor stresses the need to develop new transformational ways of working together within the local health economy to ensure delivery of the right care in the right setting.

The deadline date for the submission of the Operational Plans was early April 2014 and the deadline date for the submission of the Strategic Planning documentation is 30th June 2014 with formal sign off from NHS England expected in October 2014

In respect of our main CCG Organisations (Vale of York and Scarborough and Ryedale) some of the summary themes emerging from the both the Operational and Strategic Plans include;

- Good access to safe and high quality healthcare services with expert clinical support as locally as possible
- Support for people managing long term conditions
- The development of a "Community hub " concept of local access to a range of integrated health, social care and voluntary services to enable care to be delivered as close to the home setting as possible
- Support for sustainable and high quality hospitals providing urgent/emergency and planned care for a wide range of conditions
- Access to highly complex and specialist care where necessary
- Innovative solutions linking primary, community and secondary health care services
- Enabling timely discharge from hospital and admission avoidance where practicable by providing suitable care provision in community settings

These themes tie in fairly well with the broad planning goals inherent in our own Organisational Operational Plan and developing Strategic Plan which include:

- Continuation of the integration of York and Scarborough Hospital clinical services to improve clinical care pathways, maintain and enhance local access and deliver sustainable services in the future
- Development of Community services as a core part of our Organisational business/portfolio with key participation in the emerging Community hub concept with Primary care and Local Authority partners
- Separation and streamlining of acute and elective care to improve patient flow and care quality, maximising estate capacity
- Development of partnership working with key Health and Social Care partners to maintain and develop access to a range of general and specialist services across the healthcare communities promoting general sustainability, improved care pathways and cost effective provision.

As with our Operational Plan document, we are consulting with our Governor body in the development of the Strategic Planning document and there is a small group that is meeting to discuss this which interested Non Executive Directors would be welcome to join (nominations can be sent to Neil Wilson) .We would also intend to share the detail of the key themes and content of the Strategic Plan with Board members prior to its submission in June.

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

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 April 2014

Monitor Quarter 4 Return

Action requested/recommendation

To approve the proposed submission to Monitor.

Summary

The attached papers are the key documents included for submission to Monitor for quarter 4.

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 reference to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	There are performance risks identified in the paper.

Resource implications	Not directly identified.
Owner	Patrick Crowley, Chief Executive
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	April 2014
Version number	Version 1

Worksheet "Summary"

Click to go to index

High level summary of financial plan of YORKHOSPITAL

Financial Summary	Previous YE	Current Quarter			YTD			FY
£m	Actual	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Operating Revenue for EBITDA	403.7	107.9	112.7	4.8	428.0	442.5	14.5	428.0
Employee Expenses	(262.5)	(72.1)	(73.5)	(1.5)	(284.3)	(289.6)	(5.3)	(284.3)
Drugs	(30.5)	(7.8)	(9.0)	(1.2)	(30.8)	(34.8)	(4.0)	(30.8)
PFI operating expenses	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other costs	(91.7)	(23.9)	(23.5)	0.5	(94.0)	(97.2)	(3.2)	(94.0)
Clinical supplies	(40.4)	(11.5)	(12.2)	(0.7)	(45.1)	(46.1)	(1.1)	(45.1)
Decrease (increase) in inventories of finished goods & WIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Vehicle Fuel costs (ambulance trusts)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Non-clinical supplies	(6.4)	(1.7)	(1.7)	0.0	(6.9)	(7.4)	(0.5)	(6.9)
Cost of Secondary Commissioning of mandatory services	(3.3)	(1.2)	(0.7)	0.5	(4.6)	(2.9)	1.7	(4.6)
Research & Development expense	(4.4)	(1.2)	(1.5)	(0.3)	(4.9)	(4.8)	0.1	(4.9)
Education and training expense	(1.0)	(0.3)	(0.2)	0.1	(1.3)	(0.9)	0.4	(1.3)
Misc. other Operating expenses	(34.9)	(7.8)	(9.0)	(1.3)	(30.3)	(34.3)	(4.1)	(30.3)
EBITDA	19.1	4.1	6.8	2.7	18.9	20.9	2.0	18.9
Donations of PPE & intangible assets	0.5	0.1	0.0	(0.1)	0.5	0.0	(0.5)	0.5
Depreciation and amortisation	(8.8)	(2.7)	(3.1)	(0.4)	(10.9)	(11.3)	(0.4)	(10.9)
Impairment Losses (Reversals) net (on non-PFI assets)	(3.5)	(0.3)	(3.7)	(3.4)	(0.3)	(3.7)	(3.4)	(0.3)
Impairment Losses (Reversals) net on PFI assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Restructuring Costs	(0.8)	0.0	(0.4)	(0.4)	0.0	(1.0)	(1.0)	0.0
Operating Surplus	6.5	1.2	(0.4)	(1.6)	8.2	4.9	(3.3)	8.2
Net interest	(0.1)	(0.1)	(0.0)	0.0	(0.2)	(0.1)	0.1	(0.2)
Interest Income	0.2	0.0	0.0	0.0	0.1	0.1	0.0	0.1
Interest Expense on Overdrafts and Working Capital Facilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Expense on Bridging loans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Expense on Non-commercial borrowings	(0.2)	(0.1)	(0.1)	0.0	(0.3)	(0.2)	0.0	(0.3)
Interest Expense on Commercial borrowings	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Expense on Finance leases (non-PFI)	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Expense on PFI leases & liabilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Non-Operating items	53.9	(1.4)	(1.5)	(0.1)	(5.6)	(5.8)	(0.2)	(5.6)
Gain (Loss) on Financial Instruments Designated as Cash Flow Hedges	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Gain (Loss) on Derecognition of Available-for-Sale Financial Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Gain (Loss) on Derecognition of Non-Current Assets Not Held for Sale, Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Gain (Loss) from investments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dividend Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Share of profit (loss) from equity accounted Associates, Joint Ventures, Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Non-Operating income, Total	69.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Finance Costs	(0.0)	0.0	0.1	0.1	0.0	(0.0)	(0.0)	0.0
PDC dividend expense	(5.0)	(1.4)	(1.5)	(0.2)	(5.6)	(5.7)	(0.2)	(5.6)
PFI Contingent Rent	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Non-Operating expenses (incl. Misc)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Income Tax (expense)/ income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus / (Deficit)	70.4	(0.2)	(1.9)	(1.7)	2.4	(1.0)	(3.4)	2.4
EBITDA % Income	4.7%	3.8%	6.0%	2.2%	4.4%	4.7%	0.3%	4.4%
CIP% of Op.Exp less PFI Exp	5.7%	5.3%	8.4%	3.1%	5.4%	5.5%	0.4%	5.4%
Pay CIPs as % Pay Costs	-5.8%	-6.1%	-6.2%	-0.1%	-6.2%	-5.7%	0.5%	-6.2%
Net Surplus / (Deficit)	70.4	(0.2)	(1.9)	(1.7)	2.4	(1.0)	(3.4)	2.4
Change in working capital	1.8	0.0	0.0	0.0	(1.0)	(10.5)	(9.5)	(1.0)
(Increase)/decrease in inventories	(3.5)	0.0	0.0	0.0	0.0	(0.4)	(0.4)	0.0
(Increase)/decrease in tax receivable	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0
(Increase)/decrease in NHS Trade Receivables	(4.0)	(3.0)	0.0	3.0	(1.0)	3.6	4.6	(1.0)
(Increase)/decrease in Non NHS Trade Receivables	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(Increase)/decrease in other related party receivables	(0.8)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(Increase)/decrease in other receivables	(0.5)	0.0	0.0	0.0	0.0	(0.6)	(0.6)	0.0
(Increase)/decrease in accrued income	0.4	0.0	0.0	0.0	0.0	(11.3)	(11.3)	0.0
(Increase)/decrease in other financial assets	0.0	3.0	0.0	(3.0)	0.0	0.0	0.0	0.0
(Increase)/decrease in prepayments	(0.3)	0.0	0.0	0.0	0.0	(2.2)	(2.2)	0.0
(Increase)/decrease in Other assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Increase/(decrease) in Deferred Income (excl Donated Assets)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Increase/(decrease) in Deferred Income (Donated Assets)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Increase/(decrease) in Current provisions	0.0	0.0	0.0	0.0	0.0	(0.0)	(0.0)	0.0
Increase/(decrease) in post-employment benefit obligations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Increase/(decrease) in tax payable	0.0	0.0	0.0	0.0	0.0	(0.2)	(0.2)	0.0
Increase/(decrease) in Trade Creditors	4.4	0.0	0.0	0.0	0.0	(2.7)	(2.7)	0.0

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
79				Increase/(decrease) in Other Creditors	3.8		0.0	0.0	0.0		0.0	0.5	0.5		0.0	
80				Increase/(decrease) in accruals	2.3		0.0	0.0	0.0		0.0	(1.0)	(1.0)		0.0	
81				Increase/(decrease) in other Financial liabilities	0.0		0.0	0.0	0.0		0.0	3.6	3.6		0.0	
82				Increase/(decrease) in Other liabilities	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
83				Increase/(decrease) in Non Current provisions	0.4		0.0	0.0	0.0		0.0	(0.0)	(0.0)		0.0	
84				Non cash I&E items	(51.5)		4.3	6.8	2.5		16.7	21.8	5.1		16.7	
85				Tax expense/(refund)	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
86				Finance (income)/charges	0.1		0.0	0.0	0.0		0.0	0.1	0.1		0.0	
87				Share of (profit)/loss from equity accounted investments net of cash distributions received	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
88				Donations & Grants received of PPE & intangible assets (non cash)	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
89				Other operating non-cash (revenues)/expenses	0.1		(0.1)	0.0	0.1		(0.1)	2.5	2.6		(0.1)	
90				Depreciation and amortisation, total	8.6		2.7	3.1	0.4		10.9	11.3	0.4		10.9	
91				Impairment losses/(reversals)	3.5		0.3	3.7	3.4		0.3	3.7	3.4		0.3	
92				Unrealised (gains)/losses on foreign currency exchange	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
93				(Gain)/loss on disposal of property plant and equipment	(0.0)		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
94				(Gain)/loss on disposal of intangible assets	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
95				Share of (profit)/loss from investments	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
96				PDC dividend expense	5.0		1.4	0.0	(1.4)		5.6	4.2	(1.4)		5.6	
97				Other increases/(decreases) to reconcile to profit/(loss) from operations	(58.9)		0.0	0.0	0.0		0.0	(0.0)	(0.0)		0.0	
98				**Cashflow from operations**	**21.1**		**4.1**	**4.9**	**0.8**		**16.1**	**10.3**	**(7.8)**		**16.1**	
99				Cashflow from investing activities	(17.5)		(8.6)	0.0	8.6		(22.3)	(8.6)	13.7		(22.3)	
100				Property, plant and equipment - maintenance expenditure	(6.7)		(3.2)	0.0	3.2		(8.2)	(4.8)	3.4		(8.2)	
101				Property, plant and equipment - non-maintenance expenditure	0.0		(1.7)	0.0	1.7		(3.2)	0.0	3.2		(3.2)	
102				Plant and equipment - Information Technology	(2.9)		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
103				Plant and equipment - Other	(1.8)		(3.2)	0.0	3.2		(7.6)	(1.4)	6.2		(7.6)	
104				Property, plant and equipment - other expenditure	0.0		(0.5)	0.0	0.5		(3.3)	(2.5)	0.8		(3.3)	
105				Proceeds on disposal of property, plant and equipment	0.1		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
106				Purchase of investment property	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
107				Proceeds on disposal of investment property	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
108				Purchase of intangible assets	(0.0)		0.0	0.0	0.0		0.0	(0.2)	(0.2)		0.0	
109				Proceeds on disposal of intangible assets	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
110				Expenditure on capitalised development	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
111				Increase/(decrease) in Capital Creditors	(0.4)		0.0	0.0	0.0		0.0	0.3	0.3		0.0	
112				Payments for other capitalised costs	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
113				Purchase of subsidiaries net of cash acquired	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
114				Net bank balance acquired with subsidiaries	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
115				Proceeds from disposal of subsidiaries net of cash disposed	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
116				Net bank balance disposed with subsidiaries	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
117				Purchase of associates net of cash acquired	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
118				Net bank balance acquired with associates	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
119				Proceeds from disposal of associates net of cash disposed	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
120				Net bank balance disposed with associates	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
121				Purchase of joint ventures net of cash acquired	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
122				Net bank balance acquired with associates	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
123				Proceeds from disposal of joint ventures net of cash disposed	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
124				Net bank balance disposed with joint venture	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
125				Government grants received	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
126				Deposits and investments made	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
127				Deposits and investments liquidated	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
128				Other cash flows from investing activities	(5.7)		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
129				**Cashflow before financing**	**3.6**		**(4.5)**	**4.9**	**9.4**		**(4.2)**	**1.6**	**5.8**		**(4.2)**	
130				Cashflow from financing activities	1.6		0.0	0.0	(0.0)		19.1	15.0	(4.1)		19.1	
131				Public Dividend Capital received	7.1		0.0	0.0	0.0		15.0	12.0	(3.0)		15.0	
132				Public Dividend Capital repaid	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
133				PDC Dividends paid	(4.9)		(2.8)	0.0	2.8		(5.6)	(2.9)	2.7		(5.6)	
134				Interest (paid) on bridging loans	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
135				Interest (paid) on commercial loans	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
136				Interest (paid) on non-commercial loans	(0.2)		0.0	0.0	0.0		(0.3)	(0.2)	0.1		(0.3)	
137				Interest (paid) on overdraft and working capital facility	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
138				Interest element of finance lease rental payments - other	(0.0)		0.0	0.0	0.0		0.0	(0.0)	(0.0)		0.0	
139				Interest element of finance lease rental payments - On-balance sheet PFI	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
140				Capital element of finance lease rental payments - other	(0.1)		0.0	0.0	0.0		0.0	(0.1)	(0.1)		0.0	
141				Capital element of finance lease rental payments - On-balance sheet PFI	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
142				Interest received on cash and cash equivalents	0.2		0.0	0.0	(0.0)		0.1	0.1	0.0		0.1	
143				Movement in Other grants/Capital received	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
144				Donations received in cash	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
145				Drawdown of bridging loans	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
146				Repayment of bridging loans	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
147				Drawdown of non-commercial loans	0.0		2.8	0.0	(2.8)		10.4	6.7	(3.7)		10.4	
148				Repayment of non-commercial loans	(0.5)		0.0	0.0	0.0		(0.5)	(0.5)	(0.0)		(0.5)	
149				Drawdown of commercial loans	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
150				Repayment of commercial loans	(0.0)		0.0	0.0	0.0		(0.0)	(0.0)	0.0		(0.0)	
151				(Increase)/decrease in non-current receivables	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
152				Increase/(decrease) in non-current payables	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
153				Other cash flows from financing activities	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	

	F	G	I	J	K	M	N	O	Q
154	**Net increase/(decrease) in cash**	**5.2**	**(4.5)**	**4.9**	**9.4**	**14.9**	**16.6**	**1.7**	**14.9**
155									
156	**Cash at period end**	**12.8**	**27.7**	**25.3**	**(2.4)**	**27.7**	**25.3**	**(2.4)**	**27.7**
157	**Cash and Cash equivalents at period end**	12.8	27.7	25.3	(2.4)	27.7	25.3	(2.4)	27.7
158									
159	**Detailed Financial Summary**	**Previous YE**	**Current Quarter**			**YTD**			**FY**
160	**£m**	**Actual**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**
161	Community								
162	Co Cost & volume contract revenue	0.0	0.5	0.7	0.2	2.2	2.2	0.0	2.2
163	Co Block contract revenue	34.7	8.0	8.1	0.1	32.2	32.8	0.6	32.2
164	Ambulance								
165	Am Cost & volume contract revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
166	Am Block contract revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
167	Am Other clinical MS revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
168	Mental Health								
169	Mh Cost & volume contract revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
170	Mh Block contract revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
171	Mh Clinical partnership (s31) revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
172	Mh Secondary commissioning revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
173	Mh Other clinical MS revenue	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
174	Acute								
175	Ac Elective revenue	57.5	16.3	16.9	0.6	64.5	66.4	1.9	64.5
176	Ac Non-Elective revenue	95.8	22.8	25.6	2.7	90.6	100.2	9.6	90.6
177	Ac Outpatient revenue	60.1	15.6	16.7	1.1	61.7	66.5	4.8	61.7
178	Ac A&E revenue	12.0	3.3	3.1	(0.1)	13.0	13.4	0.4	13.0
179	Ac other revenue	83.0	28.3	25.5	(2.8)	112.0	102.7	(9.3)	112.0
180	Private patient revenue	1.0	0.3	0.3	(0.0)	1.1	1.0	(0.0)	3.0
181	Grants and donations in cash	0.2	0.0	0.2	0.1	0.2	0.6	0.5	0.2
182	Other operating revenues	59.4	12.7	15.7	3.0	50.6	56.6	6.0	48.7
183	**Total operating revenue for EBITDA**	403.7	107.9	112.7	4.8	428.0	442.5	14.5	428.0
184	Grants and donations of PPE and intangible assets	0.5	0.1	0.0	(0.1)	0.5	0.0	(0.5)	0.5
185	**Total operating revenue**	**404.2**	**108.0**	**112.7**	**4.7**	**428.4**	**442.5**	**14.0**	**428.4**
186									
187	Employee Expenses	(262.5)	(72.1)	(73.5)	(1.5)	(284.3)	(289.6)	(5.3)	(284.3)
188	Drugs expense	(30.5)	(7.8)	(9.0)	(1.2)	(30.8)	(34.8)	(4.0)	(30.8)
189	Supplies (clinical & non-clinical)	(46.8)	(13.2)	(13.9)	(0.7)	(51.9)	(53.5)	(1.5)	(51.9)
190	*Clinical supplies*	*(40.4)*	*(11.5)*	*(12.2)*	*(0.7)*	*(45.1)*	*(46.1)*	*(1.1)*	*(45.1)*
191	*Non-clinical supplies*	*(6.4)*	*(1.7)*	*(1.7)*	*0.0*	*(6.9)*	*(7.4)*	*(0.5)*	*(6.9)*
192	PFI expenses	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
193	Other expenses	(44.9)	(10.7)	(9.6)	1.2	(42.1)	(43.7)	(1.6)	(42.1)
194	*Decrease (increase) in inventories of finished goods & WIP*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
195	*Vehicle Fuel costs (ambulance trusts)*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
196	*Cost of Secondary Commissioning of mandatory services*	*(3.3)*	*(1.2)*	*(0.7)*	*0.5*	*(4.6)*	*(2.9)*	*1.7*	*(4.6)*
197	*Research & Development expense*	*(4.4)*	*(1.2)*	*(1.5)*	*(0.3)*	*(4.9)*	*(4.8)*	*0.1*	*(4.9)*
198	*Education and training expense*	*(1.0)*	*(0.3)*	*(0.2)*	*0.1*	*(1.3)*	*(0.9)*	*0.4*	*(1.3)*
199	*Misc. other Operating expenses*	*(34.9)*	*(7.8)*	*(9.0)*	*(1.3)*	*(30.3)*	*(34.3)*	*(4.1)*	*(30.3)*
200	**Total operating expenses within EBITDA**	**(384.6)**	**(103.8)**	**(106.0)**	**(2.2)**	**(409.1)**	**(421.6)**	**(12.5)**	**(409.1)**
201									
202	**EBITDA**	**19.1**	**4.1**	**6.8**	**2.7**	**18.9**	**20.9**	**2.0**	**18.9**
203	Depreciation and amortisation	(8.8)	(2.7)	(3.1)	(0.4)	(10.9)	(11.3)	(0.4)	(10.9)
204	*Depreciation and Amortisation - owned assets*	*(8.6)*	*(2.7)*	*(3.1)*	*(0.4)*	*(10.9)*	*(11.3)*	*(0.4)*	*(10.9)*
205	*Depreciation and Amortisation - assets held under finance leases*	*(0.1)*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
206	*Depreciation and Amortisation - PFI assets*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
207	Impairments & Restructuring	*(4.3)*	*(0.3)*	*(4.0)*	*(3.7)*	*(0.3)*	*(4.7)*	*(4.4)*	*(0.3)*
208	**Total operating expenses**	**(397.7)**	**(106.8)**	**(113.1)**	**(6.3)**	**(420.3)**	**(437.6)**	**(17.3)**	**(420.3)**
209	**Operating Surplus (Deficit)**	**6.5**	**1.2**	**(0.4)**	**(1.6)**	**8.2**	**4.9**	**(3.3)**	**8.2**
210	Profit (loss) on asset disposal	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
211	Net interest	(0.1)	(0.1)	(0.0)	0.0	(0.2)	(0.1)	0.1	(0.2)
212	Taxation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
213	PDC dividend	(5.0)	(1.4)	(1.5)	(0.2)	(5.6)	(5.7)	(0.2)	(5.6)
214	Other non-operating items	69.4	0.1	0.0	(0.1)	0.5	(0.0)	(0.5)	0.5
215	**Net Surplus / (Deficit)**	**70.4**	**(0.2)**	**(1.9)**	**(1.7)**	**2.4**	**(1.0)**	**(3.4)**	**2.4**
216									
217	EBITDA % of Op. revenue	4.7%	3.8%	6.0%	2.2%	4.4%	4.7%	0.3%	4.4%
218									
219	**EBITDA**	**19.1**	**4.1**	**6.8**	**2.7**	**18.9**	**20.9**	**2.0**	**18.9**
220	Change in Current Receivables	(5.4)	(3.0)	0.0	3.0	(1.0)	3.1	4.1	(1.0)
221	*(Increase)/decrease in tax receivable*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.1*	*0.1*	*0.0*
222	*(Increase)/decrease in NHS Trade Receivables*	*(4.0)*	*(3.0)*	*0.0*	*3.0*	*(1.0)*	*3.6*	*4.6*	*(1.0)*
223	*(Increase)/decrease in Non NHS Trade Receivables*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
224	*(Increase)/decrease in other related party receivables*	*(0.8)*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
225	*(Increase)/decrease in other receivables*	*(0.5)*	*0.0*	*0.0*	*0.0*	*0.0*	*(0.6)*	*(0.6)*	*0.0*
226	Change in Current Payables	8.2	0.0	0.0	0.0	0.0	(2.4)	(2.4)	0.0
227	*Increase/(decrease) in tax payable*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*(0.2)*	*(0.2)*	*0.0*

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
228				*Increase/(decrease) in Trade Creditors*	*4.4*		*0.0*	*0.0*	*0.0*		*0.0*	*(2.7)*	*(2.7)*		*0.0*	
229				*Increase/(decrease) in Other Creditors*	*3.8*		*0.0*	*0.0*	*0.0*		*0.0*	*0.5*	*0.5*		*0.0*	
230				Other changes in WC	(1.0)		3.0	0.0	(3.0)		0.0	(11.2)	(11.2)		0.0	
231				Change in Non Current Provisions	0.4		0.0	0.0	0.0		0.0	(0.0)	(0.0)		0.0	
232				Other non-cash items	(0.3)		(0.0)	(1.9)	(1.9)		0.2	(0.1)	(0.3)		0.2	
233				**Cashflow from operating activities**	21.1		4.1	4.9	0.8		18.1	10.3	(7.8)		18.1	
234				Capital expenditure (accruals basis)	0.0		(8.6)	0.0	8.6		(22.3)	(8.9)	13.4		(22.3)	
235				Asset sale proceeds	0.1		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
236				other investing cash flows	(17.5)		0.0	0.0	0.0		0.0	0.3	0.3		0.0	
237				**Cashflow before financing**	3.6		(4.5)	4.9	9.4		(4.2)	1.6	5.8		(4.2)	
238				Net interest	(0.2)		0.0	0.0	0.0		(0.3)	(0.2)	0.1		(0.3)	
239				*Interest (paid) on bridging loans*	*0.0*		*0.0*	*0.0*	*0.0*		*0.0*	*0.0*	*0.0*		*0.0*	
240				*Interest (paid) on commercial loans*	*0.0*		*0.0*	*0.0*	*0.0*		*0.0*	*0.0*	*0.0*		*0.0*	
241				*Interest (paid) on non-commercial loans*	*(0.2)*		*0.0*	*0.0*	*0.0*		*(0.3)*	*(0.2)*	*0.1*		*(0.3)*	
242				*Interest (paid) on bank overdrafts*	*0.0*		*0.0*	*0.0*	*0.0*		*0.0*	*0.0*	*0.0*		*0.0*	
243				*Interest element of finance lease rental payments - other*	*(0.0)*		*0.0*	*0.0*	*0.0*		*0.0*	*(0.0)*	*(0.0)*		*0.0*	
244				*Interest element of finance lease rental payments - On-balance sheet PFI*	*0.0*		*0.0*	*0.0*	*0.0*		*0.0*	*0.0*	*0.0*		*0.0*	
245				PDC dividends (paid)	(4.9)		(2.8)	0.0	2.8		(5.6)	(2.9)	2.7		(5.6)	
246				Movement in loans	(0.5)		2.8	0.0	(2.5)		9.9	6.1	(3.7)		9.9	
247				PDC received/(repaid)	7.1		0.0	0.0	0.0		15.0	12.0	(3.0)		15.0	
248				Donations received in cash	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	
249				other financing cashflows	0.1		0.0	0.0	(0.0)		0.1	(0.0)	(0.1)		0.1	
250				**Net cash inflow (outflow)**	5.2		(4.5)	4.9	9.4		14.9	18.6	1.7		14.9	
251																
252				**Cash at period end**	12.8		27.7	25.3	(2.4)		27.7	25.3	(2.4)		27.7	
253				**Cash and Cash equivalents at period end**	12.8		27.7	25.3	(2.4)		27.7	25.3	(2.4)		27.7	
254				**Non Safe Harbour investments at period end**	0.0		0.0	0.0	0.0		0.0	0.0	0.0		0.0	

Worksheet "CoSRR"

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Continuity of Service Shadow Risk Ratings (pilot indicators for 2013/14)

			Historic Year to 31-Mar-13	Reported Quarter to 30-Jun-13	Reported YTD to 30-Jun-13	Reported Quarter to 30-Sep-13	Reported YTD to 30-Sep-13	Reported Quarter to 31-Dec-13	Reported YTD to 31-Dec-13	Reported Quarter to 31-Mar-14	Reported YTD to 31-Mar-14
	Capital Service Cover										
IS04400	PDC dividend expense	*from SoCI*	(5 005)	(1 391)	(1 391)	(1 392)	(2.783)	(1 392)	(4 175)	(1 548)	(5 723)
IS04100	Interest Expense on Overdrafts and Working Capital Facilities	*from SoCI*	-	-	-	-	-	-	-	-	-
IS04110	Interest Expense on Bridging loans	*from SoCI*	-	-	-	-	-	-	-	-	-
IS04120	Interest Expense on Non-commercial borrowings	*from SoCI*	(0 210)	(0 053)	(0.053)	(0.051)	(0 104)	(0 066)	(0 170)	(0.058)	(0 228)
IS04130	Interest Expense on Commercial borrowings	*from SoCI*	-	-	-	-	-	-	-	-	-
IS04140	Interest Expense on Finance leases (non-PFI)	*from SoCI*	(0 021)	-	-	-	-	-	-	-	-
IS04150	Interest Expense on PFI leases & liabilities	*from SoCI*	-	-	-	-	-	-	-	-	-
IS04200	Other Finance Costs	*from SoCI*	(0 035)	-	-	-	-	(0 081)	(0 081)	0 050	(0.031)
IS04610	Non-Operating PFI costs (eg contingent rent)	*from SoCI*	-	-	-	-	-	-	-	-	-
CF07150	Public Dividend Capital repaid	*from SoCF*	-	-	-	-	-	-	-	-	-
CF07610	Repayment of bridging loans	*from SoCF*	-	-	-	-	-	-	-	-	-
CF07710	Repayment of non-commercial loans	*from SoCF*	(0 493)	(0.248)	(0 248)	-	(0 248)	(0 247)	(0 495)	-	(0.495)
CF07810	Repayment of commercial loans	*from SoCF*	(0 024)	-	-	(0 019)	(0 019)	-	(0 019)	-	(0 019)
CF07360	Capital element of finance lease rental payments - On-balance sheet PFI	*from SoCF*	-	-	-	-	-	-	-	-	-
CF07350	Capital element of finance lease rental payments - other	*from SoCF*	(0 107)	(0 050)	(0 050)	-	(0.050)	(0 030)	(0 080)	-	(0 080)
MEM9180	Revenue available for Debt Service		19 307	4 527	4 527	4 151	8 678	5 503	14 181	6 816	20 998
	Capital Service		-5 895	-1 742	-1 742	-1 462	-3 204	-1 816	-5 020	-1 556	-6.576
	Capital Service Cover metric		3 28x	2 60x	2.60x	2 84x	2 71x	3 03x	2 82x	4 38x	3 19x
	Capital Service Cover rating		4	4	4	4	4	4	4	4	4
	Liquidity										
	Cash for CoS liquidity purposes	*from SoFP*	0 339	2 541	2 541	2 947	2.947	18 188	18 188	19 962	19.962
IS02000	Operating Expenses within EBITDA, Total	*from SoCI*	-384 602	-102 579	-102 579	-104 618	-207.197	-108 444	-315 041	-105 969	-421 610
	Liquidity metric		0 3	2 2	2 2	2 5	2.6	15 1	15 6	17 0	17 0
	Liquidity rating		4	4	4	4	4	4	4	4	4

key to scoring

Capital Service Cover	50%		
4	3	2	1
2 5	1 75	1 25	<1.25

key to scoring

Liquidity	50%		
4	3	2	1
0	-7	-14	<-14

Declaration of risks against healthcare targets and indicators for 2013-14 by York Teaching Hospital

These targets and indicators are set out in the Risk Assessment Framework

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Quarter 4 Actual Performance	Achieved/Not Met
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	84.7%	Not met
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	95.9%	Achieved
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	95.0%	Achieved
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	96.2%	Achieved
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	0.0%	Achieved
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	0.0%	Achieved
Cancer 31 day wait for second or subsequent treatment - surgery	94%	0.0%	Achieved
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	0.0%	Achieved
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	0.0%	Achieved
Cancer 31 day wait from diagnosis to first treatment	96%	0.0%	Achieved
Cancer 2 week (all cancers)	93%	0.0%	Achieved
Cancer 2 week (breast symptoms)	93%	0.0%	Not met
Care Programme Approach (CPA) follow up within 7 days of discharge	95%	0.0%	Not relevant
Care Programme Approach (CPA) formal review within 12 months	95%	0.0%	Not relevant
Admissions had access to crisis resolution / home treatment teams	95%	0.0%	Not relevant
Meeting commitment to serve new psychosis cases by early intervention teams	95%	0.0%	Not relevant
Ambulance Category A 8 Minute Response Time - Red 1 Calls	75%	0.0%	Not relevant
Ambulance Category A 8 Minute Response Time - Red 2 Calls	75%	0.0%	Not relevant
Ambulance Category A 19 Minute Transportation Time	95%	0.0%	Not relevant
Clostridium Difficile -meeting the C.Diff objective	0	67	Not met
MRSA - meeting the MRSA objective	0	N/A	Not relevant
Minimising MH delayed transfers of care	<=7.5%	0.0%	Not relevant
Data completeness, MH: identifiers	97%	0.0%	Not relevant
Data completeness, MH: outcomes	50%	0.0%	Not relevant
Compliance with requirements regarding access to healthcare for people with a learning	N/A	N/A	Not relevant
Community care - referral to treatment information completeness	50%	10000.0%	Achieved
Community care - referral information completeness	50%	72.7%	Achieved
Community care - activity information completeness	50%	99.7%	Achieved

Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	No
CQC compliance action outstanding (as at 31 Mar 2014)	N/A	No
CQC enforcement action within last 12 months (as at 31 Mar 2014)	N/A	No
CQC enforcement action (including notices) currently in effect (as at 31 Mar 2014)	N/A	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 3	N/A	No
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 31 M	N/A	No
Trust unable to declare ongoing compliance with minimum standards of CQC registratio	N/A	No

In year Governance Statement from the Board

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)

For finance, that: **Board Response**

The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months. **Confirmed**

For governance, that:

The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards. **Confirmed**

Otherwise

The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk **Confirmed**

Signed on behalf of the board of directors

Signature Sign Here.

Name Alan Rose

Capacity Chairman

Date 30 April 2014

Signature Sign Here.

Name Patrick Crowley

Capacity Chief Executive

Date 30 April 2014

York Teaching Hospital NHS Foundation Trust

Board of Directors – 30 April 2014

Ensuring that developments to community and acute services are supported by senior geriatricians

Summary

The Board will be aware of the work the Trust is undertaking in relation to the development of Community Hubs. This Business Case seeks to appoint two Consultants in Elderly Medicine to specifically support this work and to provide the necessary capacity to deal with other likely demands on the service going forward.

Assumptions have been made in the case around likely income levels from supporting the Community Hub pilots.

There is a degree of speculation to this investment as the longer-term viability of the Community Hubs remains to be tested. However, it is fundamental to our strategy of ensuring we are the provider of choice for these projects going forward that we proactively recruit. It is essential to the success of the pilots that we are able to support the work having made timely appointments.

The Board of Directors is asked to approve this business case.

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	Corporate Directors Board of Directors
Risk	Details of associated risks are identified in the paper.
Resource implications	Resource implication is detailed in the report
Owner	Andrew Bertram, Finance Director
Author	Andrew Bertram, Finance Director
Date of paper	April 2014
Version number	1

APPENDIX Bi

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2013-14/148

2. Business Case Title

Ensuring that developments to community and acute services are supported by senior geriatricians

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:	**Dr John Coyle, Clinical Director**

Business Case Author:	**Steve Reed, Directorate Manager**
Contact Number:	**5608**

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.*

In September 2013 Medicine for the Elderly (York site) completed a job planning review to ensure that each inpatient ward received a daily consultant round and to maximise the time available to manage acute admissions. Following the appointment of an additional consultant in November 2013 the directorate were able to provide cover to acute admissions for 12 hours per day, Monday to Friday, and 15 hours cover across Saturday and Sunday. However, this only covered 41 weeks per year as it did not provide annual leave cover.

A similar job planning exercise is being undertaken in Scarborough in April 2014.

The directorate are currently facing several demands for additional consultant time to support various developments. For each development an estimate has been made for the additional requirement – this is shown as direct clinical care time only, SPA time

(plus 30%) would be in addition to this. These include:

- Community hub pilots run by York Hospital FT
- Community hub pilots run by other providers
- Nursing home outreach schemes being developed by commissioners
- Reconfiguration of AMU/SSW
- Frailty Unit
- 7 day working
- Shared care, specifically orthogeriatrics

Community Hub pilots run by York Hospital FT

York Hospital FT has been commissioned to run two pilot community hubs in Selby and Malton for frail older people. These hubs will be expected to provide an alternative to acute hospital stays for older people. This will include crisis reviews to prevent admission, case management to support those most at risk to maintain independence and providing services to allow patients to leave hospital earlier than now.

Whilst the final designs of the pilot services are to be determined it is explicit that senior medical cover will be required, though this could be a mixture of GP and consultant geriatrician. Indications from the proposal for the Selby hub suggest that up to 2.4WTE of consultant time could be required and funding is being identified for this. As the pilots need to be evaluated by March 2015 this cover needs to be in place as early in 2014-15 as possible. *Potential requirement 2-4WTE, initially the hubs are planning for 0.8WTE from October 2014.*

Community Hub pilots run by other providers

Vale of York CCG have indicated that they will commission a minimum of two additional pilot hubs run by GP providers. Medicine for the Elderly have already been approached by Priory Medical Group to discuss their proposals and potential support required. It is expected that any hub will require a level of consultant geriatrician support and expertise. *Potential requirement limited in short term*

Nursing home outreach schemes being developed by commissioners

A consultant geriatrician has just completed supporting a six month pilot with East Riding CCG to provide consultant and GP reviews of nursing home residents (to support advance care planning and medication review) which is being evaluated. Indications from commissioners are that they would wish to continue with this model and are keen for York Hospital FT to provide the consultant input. A similar scheme has been proposed in the Bridlington area. *Potential requirement up to 0.5WTE*

Reconfiguration of AMU/SSW

As part of the Acute Strategy proposals to reconfigure AMU and SSW (August 2014) it has been suggested that patients currently transferred under Acute Medicine on Short Stay Ward would remain under Medicine for the Elderly consultants. This would allow the Acute Physicians to increase their capacity to see new arrivals and provide ambulatory care. It will be necessary for Medicine for the Elderly to provide increased consultant input to the new area to ensure patients receive timely review and safe care. *Potential requirement is closely linked to Frailty Unit and 7 day working requirements.*

Frailty Unit

As described above the directorate are able to provide cover 12 hours per weekday to a Frailty Unit/Service. However, this can only be provided 41 weeks per year. Additional resource will be required to ensure that consultant leave can be covered and a reliable service provided. *Potential requirement 0.2WTE*

7 Day Working

NHS England is in the process of implementing standards for providing acute services across 7 days[1] which will impact on Medicine for the Elderly both in ensuring that new admissions are reviewed in a timely fashion across the whole week but also that inpatients receive regular reviews. *Potential requirement 0.7WTE, for the benefits described in the case 0.25WTE would be required*

Shared care

As part of Acute Board Workstream 4 models for a needs based system of care are being developed. This work has highlighted the unmet needs of patients in other specialties (especially surgical specialties) for liaison services from consultant geriatricians. As well as providing in-reach services to wards this also has the potential to support pre-operative assessment. Work has already commenced with orthopaedics to determine an appropriate model and what resource can be provided to support this. *Potential requirement 1-2WTE, initially for orthopaedic support this would be 0.4WTE*

Whilst the specific requirements for some of the developments listed above are in the process of being finalised it is clear that there is a requirement for additional consultant time to support both community and acute services. As a result of the time pressures to deliver evolving developments, especially community hubs and AMU/SSW reconfiguration, it may be necessary to commence recruitment processes with an element of uncertainty however this risk is mitigated by the range of demands on the service for additional resource. This demand will include the development of acute services on the Scarborough site.

Reducing the demand on Acute Services

The expectation from the service developments described above is to reduce the demand for inpatient beds within the acute and community hospitals. Closure of beds would free up medical capacity to meet the demands. The continued funding of community schemes will be dependant on activity (and resources) transferring from current care settings. As the impact of these changes become evident the long term medical staffing requirements will be better defined and can be planned for accordingly.

This case is a potential first phase to meet the demands listed above. As the benefits of reducing demand on acute services are understood from implementation of initial developments it will become clear how much resource has been released for further phases (and therefore the longer term requirements). This will coincide with increased clarity over the requirements for each development which will inform future cases as required.

[1] http://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf

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) Await final confirmation of each individual development and submit a business case accordingly
3) Appoint 2 consultants (either fixed term or substantive) and prioritise resource according to strategic priorities as a first stage in a longer term plan
4) Appoint 4 consultants (either fixed term or substantive)
5) Appoint 6 consultants (either fixed term or substantive)

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.

Option 3 is the preferred option. This will allow the directorate to respond to the highest priority demands and start to assess the impact (in terms of activity and resource transfer) prior to further appointments if required. It is proposed to mitigate risk through a combination of fixed term and substantive appointments. Recruitment of the additional sessions would include:

- Offering additional programmed activities to existing workforce
- Locum appointments either directly to Medicine for the Elderly posts or to backfill consultants in other specialties with geriatric training
- Substantive appointments

6.2 Other Options

Detail the reasons for rejecting the remaining options listed under section 5, together with supporting detail.

1) Do nothing.
This option would result either in Medicine for the Elderly being unable to provide the required support to the proposed developments above or in diverting clinical time away from inpatient areas with consequent risks to patient safety, experience and flow.

2) Submitting individual cases as requirements from developments are finalised
The timescales involved in either locum or substantive appointments mean that this option is unlikely to meet the requirements of the time critical developments

(community hubs/acute reconfiguration).

4) Appointing 4 consultants or 5) Appointing 6 consultants
Whilst the indications suggest this level of cover may be required, until both the short and longer term requirements are clearer it would be prudent to not to recruit to this level (making greater use of Additional Programmed Activities where needed in the short term). It is also questionable whether this level of available, suitable candidates would be available immediately.

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 Safety Strategy. This includes developing and learning from performance indicators (e.g. PROMs, NCI, etc). Ensuring compliance with national requirements - NPSA, NICE and implementation of results of clinical audit strategies and ensuring consultation and engagement of patients, visitors and staff.	Yes	Ensuring that senior medical opinions are available in a timely fashion whether in the community, on admission or whilst as an inpatient.
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	Yes	Timely assessment of patients will minimise admissions and for those who require this reduce the time spent in hospital.

understand how they contribute to the Trust's successes.		
To be an exemplar organisation that is responsive to the local and broader community needs and is recognised and trusted. To engage fully in all aspects of community discussion relating to health and provide expert advice and leadership as required. To work with other groups to support the adoption of a consistent approach in the community and demonstrate that the Trust is a community orientated organisation able to achieve and deliver all local and national outcomes.	Yes	These developments support the creation of community hubs, a key element of the health economy's integration of health and social care.
To provide a safe environment for staff, patients and visitors, ensuring that all resources are used as efficiently as possible		

7.2 Business Intelligence Unit Review

The Business Intelligence Unit must review all business cases for 'Strategic fit' to the Trust's 5 year plan. The date that the business case was reviewed by the BIU together with any comments which were made must be provided below.

Date of Review	15 April 2014
Comments by BIU	Supportive and think it is a good approach

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 (once staff are in post)

Quality & Safety			
Provide increased weekend consultant presence (evidence through job plan)	Number of hours covered	15	20
Provide cover later in the day, seven days per week (evidence through job plan)	Timetabled finish time	20:00 (earlier at weekends)	21:00
Provide 12hr cover per weekday for acute admissions 52 weeks per year (evidence through audit)	Number of weeks with 12hr cover per weekday	41 weeks	52 weeks
Increase support to junior medical staff at weekends (to be evidenced by structured feedback from junior doctors)	Qualitative feedback	Baseline pre-change to be established	Review three months after start
Provide clinical leadership to community hubs (evidence from job plans and audit)	Number of sessions provided to community hubs	0	8
Provide elderly medical expertise in the management of older people with traumatic injuries and elective orthopaedic surgery (evidence from job plans)	Number of ward rounds per week	0 (except review of elderly outliers)	3
Improvement in net promoter score for Ward 28 (evidence from Friends and Family scores)	Net promoter score	74 (Apr 13-Mar 14)	Improved
Information to come from job plans/rotas; qualitative feedback from junior doctor feedback sessions at end of rotation; Friends and Family test			
Access & Flow			
Reduction in admissions (from community hub pilot areas)	Number of admissions	2893 – Selby 10,158 – Malton	Predicted reduction between 20-40% in hub planning
Increase in Elderly Medicine same day discharges (exclude deaths and self discharge)	Number of same day discharges	Monthly average 35 (Apr-Dec 13)	Potential to improve to be determined by ongoing trial
Reduction in length of stay for Ward 28 (from orthopaedic inreach)	Mean LoS for patients discharged from Ward 28 (all specialties)	6 days	Reduced length of stay
Information from CPD (via signal or management information team)			

Finance & Efficiency			
Reduction in length of stay for ward 28 (freeing up beds for other utilisation)	See above		
Increase BPT for same day non-elective	Income from same day non-elective BPT	£0	Assessing financial opportunity
Reduce growth in demand (although income reduces this would be at 30% marginal rate)	Number of admissions	Planned 2.5% growth per annum	Growth below 2.5%
From finance reporting systems			

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	14 April 2014
Comments by CIT	Measures reviewed and clarification provided

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?
Business case approval	April 2014	Board of Directors
Advert for locum and substantive posts placed	April 2014	Medical Staffing
Recruitment process undertaken	May-July 2014	John Coyle
Developments to be prioritised agreed	May 2014	Deputy Chief Executive

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
Demands for consultant geriatrician time exceed available capacity	Demands to be prioritised in discussion with executive team

Demand for consultant geriatrician time reduces (due to success of schemes)	Limited recruitment in stage one and a mixture of fixed term and substantive posts to allow impact of schemes to be measured prior to further stages
Unable to recruit	Ensure that jobs are as attractive as possible and a mix of acute and community roles to attract a wide range of candidates. Utilising a variety of recruitment strategies.

11. Risk of Not Proceeding:

Identify the key risks/ potential impact of not proceeding with the preferred option.

Without expanding the consultant workforce it will not be possible to support the demands articulated in the narrative without stopping current activity. This risks the schemes described failing to deliver the expected benefits (or compromising the viability of schemes). Diverting current resource would either increase outpatient waiting times (increasing admissions) or reduce the frequency of consultant wards rounds delaying decisions on patient care (and increasing length of stay).

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	11.1	To be determined by nature of appointments and allocation of APAs

On-call frequency (1 in)	9	11 (but increased hours timetabled to be on site out of hours)

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**
Dr Corlett	**41**	**41**	**8**	**8**
Dr Goodman	**41**	**41**	**11**	**11**
Dr Hampson	**41**	**41**	**10**	**10**
Dr Harkness	**41**	**41**	**11**	**11**
Dr Heseltine	**41**	**41**	**12**	**12**
Dr Irwin	**41**	**41**	**8**	**8**
Dr Kesevan	**41**	**41**	**12**	**12**
Dr McGonigal	**41**	**41**	**10**	**10**
Dr McKay	**41**	**41**	**10**	**10**

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	9/4/14
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	Supported
Corporate Improvement Team	Reviewed measures

Workforce Team	Reviewed job plans
Other Consultation	
Deputy Chief Executive	Discussion of proposed plans and priorities
Director of Finance	Discussion of proposed plans and priorities
Director of Community Services	Discussion of proposed plans
Elderly Consultants	Aware of proposed plans
Clinical and Management Lead of Acute Board, Director of Ops (York)	Aware of proposed plans, supports proposed developments to improve acute care
Clinical Director for Orthopaedics and General Medicine	Aware of proposed plans. Orthopaedic Clinical Director strongly supports the proposed developments.

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?	No	
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?

No direct impact

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?

Supports development of Malton community hub which will impact on Scarborough acute activity

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?

Provides essential medical staffing support to community hub developments which are a key initiative towards greater vertical integration

18. Impact on the Ambulance Service:

	Yes	No
Are there any implications for the ambulance service in terms of changes to patient flow?		No

If yes, please provide details including Ambulance Service feedback on the proposed changes:

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'.

Income	17,930	17,930	203
Direct Operational Expenditure	11,582	11,822	240
EBITDA	6,348	6,108	-37
Other Expenditure			0
I&E Surplus/ (Deficit)	6,348	6,108	-37
Existing Provisions	n/a		0
Net I&E Surplus/ (Deficit)	6,348	6,108	-240
Contribution (%)	35.4%	34.1%	-118.2%
Non-recurring Expenditure	n/a	16	16

Supporting financial commentary:

The business case assumes a start date of September 2014.

The costs for the consultants are based upon two 10PA consultants at the third point on the cost scale plus on call and on costs. The A & C costs cover 0.5WTE band 3 and 1WTE band 4 support in line with recommended levels, at third point on the scale. The non-recurrent expenditure relates to IT, phone and office space at 8K per consultant. Consequently, total costs associated with this case are £240K.

The business case assumes a start date of September 2014. The costs for the consultants are based upon two 10PA consultants at the third point on the cost scale plus on call and on costs. The A & C costs cover 0.5WTE band 3 and 1WTE band 4 support in line with recommended levels, at third point on the scale. The non-recurrent expenditure relates to IT, phone and office space at 8K per consultant. Consequently, total costs associated with this case are £240K. It is assumed that, the Community Hub Pilots business case will provide funding for 1.4 WTE plus admin (£168k p.a.). In addition advanced negotiations are underway with East Riding CCG for support to their nursing home scheme (£15k) and developments in support of orthogeriatrics are anticipated to contribute £20k. Additional funding may be secured in support of additional developments.

21. Recommendation for Post Implementation Review

	Yes	No
Is this business case being recommended for post implementation review?	Yes	

Reason(s) for the decision:

To determine the impact of Stage 1 and further actions required

22. Date:

27/3/14

GAL/22August2013

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	2013-14/148
TITLE:	Ensuring that Developments to Community and Acute Services are supported by Senior Geriatricians
OWNER:	Dr John Coyle
AUTHOR:	Steve Reed

Capital

	Total £'000	Planned Profile of Change 2013/14 £'000	2014/15 £'000	2015/16 £'000	Later Years £'000
Expenditure	0	0	0	0	0

Capital Notes *(including reference to the funding source)*:
No Capital Expenditure is linked to this case

Revenue

	Total Change: Current £'000	Revised £'000	Change £'000	WTE	Planned Profile of Change: 2013/14 £'000	2014/15 £'000	2015/16 £'000	Later Years £'000
(a) Non-recurring			0		0	16	0	0
(b) Recurring								
Income								
NHS Clinical Income	17,914	17,914	203		0	118	203	203
Non-NHS Clinical Income	0	0	0		0	0	0	0
Other Income	16	16	0		0	0	0	0
Total Income	**17,930**	**17,930**	**203**		**0**	**118**	**203**	**203**
Expenditure								
Pay								
Consultant	2,220	2,426	206	2.00		120	206	206
Nursing	7,875	7,875	0					
Other (please list):								
Professional & Technical	70	70	0					
Admin & Clerical	489	523	34	1.50		20	34	34
			0					
	10,655	**10,895**	**240**	**3.50**	**0**	**140**	**240**	**240**
Non-Pay								
Drugs	557	557	0					
Clinical Supplies & Services	425	425	0					
General Supplies & Services	122	122	0					
Other (please list):								
Establishment costs/P&P/Misc	167	167	0					
	392	392	0					
	-737	-737	0					
	927	**927**	**0**		**0**	**0**	**0**	**0**
Total Operational Expenditure	**11,582**	**11,822**	**240**		**0**	**140**	**240**	**240**
Impact on EBITDA	**6,348**	**6,108**	**-37**	**3.50**	**0**	**-22**	**-37**	**-37**
Depreciation			0					
Rate of Return			0					
			0					
Overall impact on I&E	**6,348**	**6,108**	**-37**	**3.50**	**0**	**-22**	**-37**	**-37**
								+ favourable (-) adverse
Less: Existing Provisions	**n/a**		**0**					
Net impact on I&E	**6,348**	**6,108**	**-37**		**0**	**-22**	**-37**	**-37**

Revenue Notes *(including reference to the funding source)*:
The business case assumes a start date of September 2014. The costs for the consultants are based upon two 10PA consultants at the third point on the cost scale plus on call and on costs. The A & C costs cover 0.5WTE band 3 and 1WTE band 4 support in line with recommended levels, at third point on the scale. The non-recurrent expenditure relates to IT, phone and office space at 8K per consultant. Consequently, total costs associated with this case are £240K. It is assumed that, the Community Hub Pilots business case will provide funding for 1.4 WTE plus admin (£168k p.a.). In addition advanced negotiations are underway with East Riding CCG for support to their nursing home scheme (£15k) and developments in support of orthogeriatrics are anticipated to contribute £20k. Additional funding may be secured in support of additional developments.

	Owner	Finance Manager	Board of Directors Only: Director of Finance
Signed		Robert Woodward	
Dated		25/04/2014	

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2013/14	2014/15	2015/16	Later Years
Elective (Spells)	262	262	0				
Non-Elective (Spells)							
Long Stay	5,145	5,145	0				
Short Stay	1,592	1,592	0				
Outpatient (Attendances)							
First Attendances	2,057	2,057	0				
Follow-up Attendances	2,743	2,743	0				
A&E (Attendances)	0	0	0				
Other (Please List):							
			0				
			0				

Income

	Total Change			Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	Later Years £'000
NHS Clinical Income							
Elective income							
Tariff income	158	158	0				
Non-Tariff income			0				
Non-Elective income							
Tariff income	16,141	16,141	0				
Non-Tariff income			0				
Outpatient							
Tariff income	991	991	0				
Non-Tariff income			0				
A&E							
Tariff income			0				
Non-Tariff income			0				
Other							
Tariff income	624	624	0				
Non-Tariff income			0				
	17,914	**17,914**	**0**	**0**	**0**	**0**	**0**
Non NHS Clinical Income							
Private patient income		0	0				
Other non-protected clinical income		0	0				
	0	**0**	**0**	**0**	**0**	**0**	**0**
Other income							
Research and Development		0	0				
Education and Training		0	0				
Other income	16	16	0				
	16	**16**	**0**	**0**	**0**	**0**	**0**