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 July 2014**
in: **The Boardroom, York Hospital, Wigginton Road, York, YO31 8HE**

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Classroom 4, Post Grad, 5th Floor York Hospital	Non-executive Directors
9.15am – 12.00noon	**Board of Directors meeting held in public**	**Boardroom, York Hospital**	**Board of Directors and observers**
12.05pm – 1.00pm	Board of Directors to consider confidential information held in private	Boardroom, York Hospital	Board of Directors
Lunch 1.15pm at York Hospital Social Club with the Council of Governors			
2.00pm – 4.00pm	Board of Directors and Council of Governors joint meeting	York Hospital Social Club, White Cross Rd, York, North Yorkshire YO31 7LR	Board of Directors and the Council of Governors

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 July 2014**

At: **9.15am -12.00noon**

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

A G E N D A					
No	**Item**	**Lead**	**Comment**	**Paper**	**Page**
Part One: General **9.15am – 9.45am**					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for Absence** • Beverley Geary – Interim Chief Nurse • Andrew Bertram- Finance Director	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 25th June 2014.	Chairman		B	11
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman			
6.	**Patient Experience** Outcome from 'The Perfect Week'.	Deputy Chief Executive		C	23

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	Chairman of the Committee		D D1 D2 D3	49 57 79 89
8.	**Quarter 1 Director of Infection Prevention and Control Report** To receive and approve the quarter 1 report from the Director of Infection Prevention and Control.	Director of Infection Prevention Control	Brian Golding	E	103
Part Three: Finance and Performance 10.30am – 11.00am					
9.	**Finance and Performance issues** To be advised by the Chairman of the Committee of any specific issues to be discussed. • Operational Performance Report • Finance Report • Trust Efficiency Report	Chairman of the Committee		F F1 F2 F3	109 119 127 141
10.	**Report on the Intensive Care Support Team findings** To consider a report that outlines the results of the Intensive Care Support Teams findings.	Chief Operating Officer	Libby Raper	G	151
Part Four: Workforce 11.00am – 11.10am					
11.	**Annual Report from the Workforce Strategy Committee** To receive the annual report for information.	Interim Director of HR	Jennie Adams	H	165

No	Item	Lead	Comment	Paper	Page
Part Five: Strategy Work 11.10am – 11.25am					
12.	**Research and Development Strategy** To receive the strategy for approval.	Director of Corporate Development	Mike Keaney	I	175
13.	**Patient Safety Strategy** To receive the strategy for approval.	Medical Director	Diane Willcocks	J	187
Part Six: Governance 11.25am – 11.40pm					
14.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		K	207
15.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		L	221
16.	**Monitor Quarter 1 Submission** To approve the submission for Monitor at quarter 1.	Chief Executive		M	225
Part Seven: Integration 11.40am-11.50am					
17.	**Integration update report** To receive an update on the progress of integration.	Director of Corporate Development	Mike Sweet	N	231
Part Eight: Business Cases 11.50am – 12.00noon					
18.	**EPMA Business Case (2012/01)** To approve the business case.	Medical Director	Philip Ashton	O	237

No	Item	Lead	Comment	Paper	Page
Any other business					
19.	**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 24th September 2014 in the Committee Room Bridlington Hospital.				
20.	**Any other business** To consider any other matters of business.				

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

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

Tender Register

York Teaching Hospital NHS
NHS Foundation Trust

Additions: **Alan Rose** Member of The University of York Court
Alan Rose Member of The University of York Ethics Committee

A

Changes: No changes

Deletions: No deletions

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

B

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Blue Room, Scarborough Hospital, on 25 June 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
Mr M Sweet	Non-executive Director
Professor D Willcocks	Non-executive Director

Executive Directors

Mr P Crowley	Chief Executive
Mr A Bertram	Executive Director of Finance
Mrs S Holden	Executive Director of Corporate Development & Research/Interim Director of HR

Corporate Directors

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

Attendance:

Mrs A Pridmore	Foundation Trust Secretary

Observers: Two Governors and two member of the public.

14/089 Apologies for absence

Apologies were received from Ms L Raper, Non-executive Director, Mr M Proctor, Deputy Chief Executive, Chief Operating Officer and Chief Nurse, Dr A Turnbull, Medical Director, Mrs S Rushbrook, Corporate Director of Systems and Networks

14/090 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.

14/091 Minutes of the meeting held on the 28 May 2014

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

14/092 Matters arising from the minutes

Mr Sweet asked the Board to note that under minute 14/083 referring to the directorates that had a record of poor achievement, the Committee had asked to see progress reports.

Under the same minute there was an action for Mr Proctor to include a report following receipt of the Intensive Support Team's report for the Board to consider as part of the discussions at the June meeting. This has been delayed as the report was only recently received into the Trust and is being considered at present. It was proposed that Mr Proctor would include a report for the Board to consider at the July meeting.

Action: Mr Proctor to include a report on the Intensive Support Team's report for consideration at the July meeting.

Under minute number 14/082 it was noted that the action for Mrs Geary to supply a narrative for the Board members to consider had not been circulated. Mrs Geary was asked to ensure the narrative was circulated.

Action: Mrs Geary to circulate the narrative to Board members.

Under the same minute number it was noted that the Patient Safety Strategy should have been included within the papers for the Board to consider at the June meeting. The paper was not included. Mrs Adams commented that as Dr Turnbull was unable to attend the June Board meeting and following his request for the Quality and Safety Committee to have a further review of the paper, it had been agreed that it would be included for consideration by the Board of Directors in the July papers.

The Board **accepted** the change in programme and **noted** the reasons for the change.

Action: Dr Turnbull to include the Patient Safety Strategy for the Board to consider at the July meeting.

Under minute 14/084 Community Hubs and in the absence of Mr Proctor the Board asked for a further update on the Community Services improvements that have been put in place to be presented to the Board in the near future.

14/093 Patient Experience – Patient Experience Team

Mrs Geary introduced Caroline Milson, a nurse based in the community. The Board heard a story about a patient who was cared for in the community by the District Nurse Team. The story outlined that the patient was very clear in her wishes about how her treatment should be managed and the results of the team following her wishes.

The Board discussed the challenges the story raises for the Trust in how a patient is supported to make an informed decision. The Board recognised that this story was important and helpful to hear, as it put into context some of the differing challenges the District Nursing Team face compared to nursing teams in the acute sector. The Board agreed that the story had reminded them of the importance patient wishes play in the treatment given to patients.

The Board thanked Mrs Milson for her time and work.

14/094 Quality and Safety Committee

Mrs Adams reminded the Board that the Patient Safety Strategy would be presented at the next Board meeting. Mr Crowley added that in the last week the Executive Board and some senior managers had been involved in a time-out where the Patient Strategy had been discussed in some detail.

Mrs Adams commented that the number of serious incidents continues to grow because of now recording falls and pressure ulcers. She added that the Trust is learning from Root Cause Analysis (RCA) investigations and there is support to reduce the incidence of pressure ulcers seen in the community, but it is sometimes difficult to enforce a prevention regime within the home environment. This is recognised within our CQUIN which has different targets for the acute and the community settings.
Particularly.

Friends and Family Test – Mrs Adams asked Mrs Geary to comment on the performance of the Friends and Family Test. Mrs Geary commented that the Trust continues to do well overall, although there are some challenges for the York Emergency Department still to overcome. She outlined the work being undertaken and the discussions that were being held with the Directorate. Mrs Geary added that she had been advised that NHS England were considering the future of the use of the token system. She advised that she would update the Board when she knew any further information about their decision.

Infection Control – Mrs Adams asked Mrs Geary to comment on the significant improvement in C-Diff that has been seen by the Trust. Mrs Geary confirmed that there had been significant improvements. Nine cases had been reported this quarter against a trajectory of 15. Of those nine cases, two were reported in June. She added that there have been no cases of MRSA this quarter, two cases of SSA and 4 e-coli cases. It was also noted that the level of compliance with the antimicrobial prescribing was excellent.

Medical Director Report – Mrs Adams drew the Board's attention to the overall mortality rate and asked the Board to note the position of the Trust. The Board noted the position of the Trust and **agreed** that the mortality programme had been very successful and continued to be so. The report highlighted the areas of highest mortality for the Trust and the Board received assurance that these areas were reviewed by the MD and his team to identify any opportunities for improvement.

Mrs Adams commented that the Nursing Trigger Tool and the Open and Honest Pilot- were progressing and work with the IT department was ongoing to find solutions to outstanding technical issues. Mrs Adams asked that the Board to be kept up to date with progress on the implementation of the systems.

Action: Mrs Geary to keep the Board up to date on progress through the Quality and Safety Committee.

Estates and Facilities Issues – Mrs Adams explained that this paper had been requested by the Quality and Safety Committee as it became more apparent to the Committee that the estate issues were significant to ensure the Trust provided quality of care.

Mr Golding commented that the paper highlighted the key issues the Trust was facing around the estate. Mrs Adams asked for the Board to consider if the estate configuration was appropriately reflected in the Corporate Risk Register. It was agreed that it was not specifically noted on the Register. It was agreed that Mr Crowley would escalate to the Corporate Risk Committee to consider how it should be identified on the Register.

Mr Crowley commented that he felt the Quality and Safety Committee had been very effective in their work by making the connection and introducing estate issues to their agenda.

The Chairman asked the Board if they had any further comments to make with regard to the Quality and Safety Report.

Mr Sweet referred to the Annual Report from the Pressure Ulcer Reduction Programme and asked Mrs Geary why the Trust has an equipment library when the equipment in the community is the responsibility of the Harrogate Trust. Mrs Geary explained that it speeds up availability for our patients and we are able to re-distribute equipment quicker following decontamination.

Mr Sweet also asked why there was specific reference to some areas introducing 'comfort rounding' when he was of the understanding that 'comfort rounding' had always been across the whole hospital. Mrs Geary explained that it had not been across the whole hospital in the past, but was now.

Mrs Holden commented on the Tissue Viability Nurse Team and advised that a review of the team was being planned. Mrs Geary added that a Deputy Chief Nurse was being seconded to the Trust from the CCG and one of her areas of responsibility would be to address the issues that existed within the Tissue Viability Nurse Team.

The Board **noted** the report and thanked the Committee for their contribution. The Board also **noted** the assurances that were given by the Committee and the comments made Executives.

14/095 Safer Staffing Project – NHS England Nurse Staffing Return

Mrs Geary presented the report. She advised that the response at ward level had been very good and there were lessons that were being learnt from the first submission. Mrs Geary specifically mentioned the support that had been received from the IT department, specifically Mrs N Slater. The support had been excellent and had ensured the Trust was able to deliver the information on time.

Mrs Geary advised that the June Acuity Audit had been undertaken and was currently creating an action plan. She advised that this report would be presented to the next Workforce Strategy meeting and then be presented to the Board.

Mr Keaney asked Mrs Geary to comment on how sure she was that the plan was correct. She advised that the Acuity Audit informed the plan and was part of the assurance that

the plan was correct. She added that additionally the fill rate along with the expectation that the ratio would be 1:8 registered nurses to patients.

Referring to the table included in the report Mrs Geary explained that the information is published in hours and showed the Trust had an average fill rate of above 75%. Mr Rose asked if that was good. Mrs Geary felt it was good. Mrs Adams commented that she had looked at the NHS Choices website and advised that it was possible to compare fill rates and she could not find many with less than 90% fill rates. Mrs Geary commented that the Trust is working on a 1:8 ratio and then has a number of non-qualified staff supporting.

Mr Crowley added discussions about fill rates were continuing amongst the Executive Directors. The judgement of the Trust has in the past been that it is appropriate to have less than 100% so that there is flexibility and the fill rate is measured against the establishment of beds.

It was agreed that there was still considerable work to be undertaken with this initiative.

Professor Willcocks added that the Trust has taken some time to understand the requirements and worked on the quality of the data, the next emphasis should be on communication and having some clarity around the information and trends. The Board agreed with the comments.

Mrs Geary confirmed she would continue to work with the Quality and Safety Committee.

Mrs Holden added that she was working with Mrs Geary to look at the use of the internal bank.

14/096 Review of Patient Experience Service

Professor Willcocks commented on the document. She outlined that the process moved from a review of the team to a consideration of the service the Trust was providing around patient experience. She added that she felt it had been a quick but thorough piece of work. One of the key outcomes was the introduction of a head of service. This person was, she felt, going to be very important to ensuring the Trust provided the level of patient experience desired by the Trust and patients.

Professor Willcocks added that the review highlighted that there were lots of issues to resolve, including there being no parity across the sites and the use of different IT systems. She outlined the impact the current arrangements seemed to be having on the different elements of the teams. Professor Willcocks went on to explain that the intention of the revised structure and approach is to raise the profile of patient experience and improve the systems.

Mrs Geary added that historically the system had focused on complaints and not on patient experience.

Mr Sweet asked if the Trust goes back to the complainant after we have answered the complaint to confirm it has been answered. Mrs Geary confirmed that the Trust does. She added that the Matrons contact complainants directly and check the Trust has understood the complaint. They will also review the response and the complaint. There is also a

weekly meeting at which the complaints that have been received are reviewed by the Chief Executive and Chief Nurse; there are occasions at these meetings when very prescriptive action is requested by the Chief Nurse or Chief Executive.
Mr Crowley added that at those weekly meetings there is an opportunity to feed in further information that does help inform the discussion.

Mrs Geary advised that the role for the team is broadened to include information from Friends and Family Tests and other audits. The Board noted that the appointment of the Head of the service was key to the success of the patient experience service. Mr Rose asked if the Trust would only look at someone with an NHS background; Mrs Geary confirmed that would not be the case and the Trust would be happy to have applications from anyone from any background that had the skills to undertake the role.

The Board approved the recommendations and asked that a follow-up was provided to the Board in the next 6 months once the Head had been appointed.

14/097 Finance and Performance Committee

Mr Sweet commented that the meeting had been one with quite a lot of challenge around finance and performance. He commented that the new ambulance hand over bays have now opened and are resulting in a marked improvement in performance.

In relation to the efficiency programme he commented that the recurrent savings are high, but the planning gap is giving rise for concern. Mr Sweet added that at present the cost improvement plan is in line with last year – last year at this time there was also an in-month shortfall, but this was compensated by additional work from the CCG, leading to a positive income variance, and the Trust was able to offset from reserves. That flexibility does not exist this year. He added that he felt that it is symptomatic of the national NHS challenges that exist. The opportunities to the Trust are outlined within the 6 year plan which the Committee continues to keep under review. The plan does provide some clarity about how future delivery of the cost improvement agenda will be delivered and uses the Service Line Reporting system to help identify the key projects. Service Line Reporting will also help identify those services where the Trust is operating at a loss. Mr Bertram confirmed that the system was now embedded in the wider organisation and was supporting the Cost Improvement Programme by helping to identify schemes across all Trust sites.

Mr Sweet referred to the report the Trust had received from Monitor following the recent audit undertaken by them on the Cost Improvement Programme. Mr Sweet advised the report was positive and helpful and the Trust welcomed the recommendations which were in the main accepted by the Trust. One of the recommendations suggested that the Trust should take a more formal project management approach to all schemes within the programme. Mr Bertram commented that this was absolutely felt appropriate for key corporate schemes and for Directorates experiencing difficulty with delivery, but it was important that the Trust retained the culture and ethos around programme and scheme ownership that it had built with Directorates. Mr Bertram confirmed that not all schemes would therefore move to using a formal project management approach.

Mr Crowley added that the challenge is very significant and the priority is not to spend unnecessarily. The biggest opportunity and risk to the organisation was the development

of Bridlington, but the benefits of the work are beginning to be seen as the Trust has received approaches to undertake more work at the site.

Mr Sweet added that he would also like the Board to recognise the contribution that Mrs Hollings-Tennant made to the development of the Finance and Performance Committee and the Cost Improvement Programme work. Mrs Hollings-Tenant is moving on to a new role within the Trust.

Mr Sweet commented that a number of the access targets are causing concern, he asked Mr Crowley to comment.

Mr Crowley asked the Board to reflect back on the results of quarter 4. At quarter 4 the Trust failed four targets – 18 weeks as a planned fail, 14 day breast symptomatic, 62 day 1st treatment and C-Diff.

Over quarter 1 the Trust has demonstrated excellent performance against the C-Diff trajectory and does not expect to fail that trajectory. The team is confident that the 18 week target will be achieved on aggregate, although there are still risks to the performance at a speciality level. The Trust is also undertaking a productivity review of general surgery at present that will play into the future management of 18 weeks.

With regard to the 14 day breast symptomatic service there is a fundamental problem in specialist recruitment and as a result the Trust cannot sustain a one stop service. The issue has been recognised by the CCG and they are supportive of the service being centralised on the York site. This is not what the Trust would like to do and it is recognised that patients in Scarborough would like such a service to remain local. The Trust is committed to its obligations to take services to patients and deliver them as close to home as possible. With this in mind, the surgeons have agreed they will be the first line of the service and see patients with breast pain which is about 30% of the patients. The remainder of the patients are fast tracked to York for review. Both the GPs and Consultants are supportive of the adjustment to the service, but recognise that this provides less choice than the Trust would like to offer. The Board asked if York can accommodate the additional patients in the service. Mr Crowley confirmed that the service at York can for a short period of time. On a longer term basis there would need to be more investment made into the service.

The 62 day 1st treatment target is on track for achieving in quarter 1. There is constant pressure with this target and last quarter the Trust failed the target by 1.5 patients. The Trust is working with other providers to ensure the inter-provider transfer system works as well as possible.

In terms of the Emergency Department there have been a huge number of attendances during the quarter. There has been a conversation with Monitor on the issues and the team are undertaking some work that looks at why the Trust improved in quarter 4. The view is that there is a direct relationship between the Trust's improved performance and the additional funding that was available during that quarter. The Trust did see a drop in attendances during the winter months and good performance and was therefore confident that closing the additional winter capacity was appropriate. The team did underestimate the impact the extra posts had that was supported by the additional funding. So when it

was removed the winter capacity was closed, the Trust had few beds and had some discharge challenges too.

In June this year the Emergency Department at York saw the highest level of attendances since mid 2012 and the Scarborough Emergency Department peaked at its highest level for some years during the Perfect Week. Demand in the early part of June is some 15% higher than for the same period last year in York and 7% higher than for the first two weeks in May. This is replicated at Scarborough, albeit at a lower level of growth.

Mr Crowley advised that he was in discussion with the CCG and had held a conference call with Monitor. The Trust is continuing to work with the Urgent Care Board and they have been very supportive of the request for further investment. Unfortunately the CCG Governing Body felt unable to support the request.

It is anticipated for quarter 1 that the Trust will fail the Emergency Department target. To try and further support the Directorate the Trust has approved some non-recurrent spending to address some of the overnight pressures. He added that he would expect some extra monitoring from Monitor if the Trust does fail quarter 1.

Mrs Holden added that the Directorate has spent time learning form others to ensure the service is the best possible, so there is no lack of willingness to improve from the Directorate.

Professor Willcocks added that the Trust is a victim of its own success. When she has talked to ambulance staff they have been clear that people have asked to be taken to York Hospital.

Mrs Adams asked about the four bedded observation ward for the Emergency Department, as it is her understanding that it has been delayed. Mr Crowley advised that he shared her anxiety on the subject. It was a personal priority for Mr Crowley, but at this point the ambition outstretched the financial ability to afford the work. The ambulance bays cost more than was anticipated and so at this stage the development has been deferred. He added that when it has been discussed with the consultants there is a very definite split in opinion. Some are very keen and see it as very important, others are less sure. This split is in part due to the need to change working practices in the department.

Mr Sweet referred to the finance position and asked Mr Bertram if he would like to add anything to what has already been said. Mr Bertram confirmed that the position had already been covered. The position is challenging and activity is in line with plan. Expenditure is up on agency staff and penalties. This may lead to an impact on quality and access. Mr Bertram advised that he was concerned with the opening position for the year and that considerable work was underway with the finance team and Directorates to address the CIP shortfall and overspending pressures.

The Board **noted** the report.

14/098 Workforce Strategy Committee issues

As Chairman of the Committee, Professor Willcocks summarised the minutes from the last meeting. She commented that it was more of a transitional meeting, as it was the first since the departure of Ms Hayward.

Mrs Holden provided a short outline of the key workstreams being undertaken at present. They were a future orientation to utilise data to inform new roles, active planning for an aging workforce and the implication this has, review of skill mix and the development of forward workforce planning with directorates and focus on the development of non-registered workforce

14/099 5 year Strategic Plan

Mrs Holden introduced the plan and explained that it had been built from the work being undertaken with the Directors around building their strategic plans and cross-checked with the CCG plans. She added that there is a central triangulation of the plans but there is also an expectation that there will be gaps in coherence, as at present the plans do not go far enough.

Mr Ashton commented that he understood the purpose of the plan and felt it was a good job that had been done but, as Mrs Holden had stated, it was only a starting point. How did the Trust plan to develop some of the themes further? Mrs Holden explained that a lot of them have been developed and there is more detail, but the summary statements provided do not necessarily show that.

The Board discussed the plan and recognised that it was a document that would be discussed with the Council of Governors at the strategy session following the Board in July. It would also be a document that was discussed further at the time out that would be held in the autumn.

The Board of Directors **approved** the strategy and the sustainability statement.

14/100 Report of the Chairman

Mr Rose specifically highlighted that Mr Ashton, Mr Keaney and Mrs Adams had all been reappointed by the Council of Governors for a further three years.

The Board **noted** his report.

14/101 Report of the Chief Executive

Mr Crowley highlighted the recent request Dr Turnbull had received to join the Monitor's Acute Advisory Group. He also confirmed that following the conference call with Monitor, Monitor would wait to see what the performance was for quarter 1 before taking any further action. The Trust would continue at this stage to have a governance rating of under review.

The Board **noted** the report.

14/103 Corporate Governance Statement

Mrs Pridmore outlined the reasons for the preparation of the statements and highlighted that they are required as part of the Monitor Licence. She added that the Board has been consulted on the content of the document and all comments have been included. The third statement relates to the training of governors. Mrs Pridmore confirmed that Governors had received training during the year as outlined in the report.

Mrs Holden commented about the Academic Health Sciences Network (AHSN) information and advised that the AHSN in its original conception was intended to have sufficient funding across the region to facilitate translational research and the development of continuous improvement. The signatures of all partner organisations was required for the original business case, this has been significantly amended following the reduction in funding. We have now received a 30k partner contribution; this was never part of the original discussion and places a further cost pressure in the system. As an organisation we have concerns regarding how we will benefit from this and would like this noting.

The Board **noted** the comments and approved the statement and certificates

14/104 Business Case – 2012-13/75: Interim Cardiology Developments

Mr Bertram outlined the purpose of the business case and highlighted that it was an interim solution and not the final solution. Mr Keaney summarised the business case and supported approval of the case by the Board of Directors.

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

14/105 Next meeting of the Board of Directors

The next meeting of the Board of Directors will be held in the Boardroom, the York Hospital, on 30 July 2014.

14/106 Any other business

Mr Simon Cox Accountable Officer for the Scarborough, Whitby and Ryedale CCG asked the Chairman to put on record the CCG's thanks to all those staff involved in the Perfect Week.

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	To consider increasing the authority	Mr Bertram/	September

Delegation (September)	of the Capital Programme Committee to be undertake during the next stage review	Mrs Pridmore	2014
14/055.1 2013 - 14/127: Bridlington Orthopaedic Elective Surgery	Evaluation Report pending the release of further capital	Mr Bertram	November 14
14/041 Patient Experience - Matron refreshment	Update the Board on the progress of the introduction of the new nursing structure	Mr Proctor/ Mrs Geary	December 14
14/063 Quality and Safety Committee	Provide the six monthly acuity audit report.	Mrs Geary	June 14
14/080 Matters arising – Perfect Week	Prepare a report on the Perfect Week for presentation to the Board in July.	Mrs McGale	July 2014
14/082 Quality and Safety Committee – Patient Safety Strategy	Patient Safety Strategy to be included in the Board papers for June.	Dr Turnbull	July 2014
14/083 Finance and Performance Committee	Include dementia screening in his Medical Director report.	Dr Turnbull	July 2014

Action list from the minutes of the 25 June 2014

Minute number	**Action**	**Responsible office**	**Due date**
14/092 Matters arising	Report on the Intensive Support Team's report for consideration at the July meeting.	Mr Proctor	July 2014
14/092 Matters arising	Include the Patient Safety Strategy for the Board to consider at the July meeting.	Dr Turnbull	July 2014
14/092 Matters arising	Circulate the narrative to Board members for the safer staffing information outside the Board meeting	Mrs Geary	July 2014
14/094 Quality and Safety Committee – Trigger Tool	Keep the Board up to date on progress through the Quality and Safety Committee.	Mrs Geary	September 2014

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 2014

The Perfect Week 19th to 26th May 2014 at Scarborough Hospital

Action requested/recommendation

The Board is asked to note the outcomes and support the implementation of the principles of Perfect Week into a sustainable operational model.

Summary

Over the years Scarborough Hospital has faced a series of challenges in relation to patient flow both within the hospital and across the whole Health and Social Care system. The operational management of the bed base for non-elective and elective patients at times has been described as 'chaotic' with issues such as high bed occupancy levels, delayed discharges, outliers and long bed waits. The implication is that overcrowding in ED becomes the norm and directly impacts on the 4 hour Emergency Care Standard and Ambulance Turnaround Times. This is detrimental to patient safety, quality of care and negatively impacts on the patient experience.

It was broadly recognised that the 'whole system' needed to change.

The Perfect Week was a jointly commissioned initiative with Scarborough & Ryedale Clinical Commissioning Group and York Teaching Hospital Foundation Trust.

The aim of Perfect Week was to demonstrate how rapid improvements could be delivered producing a step change in quality, safety, patient experience and performance.

Perfect Week ran from Monday 19 May 2014 to the 26 May 2014 inclusive. This included a Bank Holiday weekend. The whole system, Health & Social Care, committed to going that extra mile to ensure that all delays to patients within the system were eliminated, reduced or captured. In addition to this staff and patients were interviewed every day to gain feedback about their experiences of the Perfect Week.

The week was very successful in delivering most of the identified outcomes, as described in the report.

It became very evident that a whole system saying "yes", commissioner, providers and social care, seeing the same issues, in real time, from a shared perspective, resulted in a more responsive system. This way of working reduced delays for patients and improved outcomes in quality, safety, patient experience and performance.

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 views of staff and patients have been taken into account in the design of the recommendations following Perfect week which take into account the Quality and Diversity requirements.

Reference to CQC outcomes

The implementation of the principles of Perfect Week into a sustainable operational model will take the relevant CQC outcomes into account.

Progress of report

Risk	There is a funding implication within the operational sustainable model described within this paper.
Resource implications	Resources implication detailed in the report
Owner	Mandy McGale, Director of Operations (YTH) Karen Mazingham, CSU Senior Delivery Manager
Author	Mandy McGale, Director of Operations (YTH) Karen Mazingham, CSU Senior Delivery Manager
Date of paper	July 2014
Version number	Version 1

Board of Directors – 30 July 2014

The Perfect Week 19th to 26th May 2014 **at Scarborough Hospital**

1. Introduction and background

Over the years, Scarborough Hospital has faced a series of challenges in relation to patient flow both within the hospital and across the whole Health and Social Care system. The operational management of the bed base for non-elective and elective patients at times has been described as 'chaotic' with issues such as high bed occupancy levels, delayed discharges, outliers and long bed waits. The implication is that overcrowding in ED becomes the norm and directly impacts on the 4 hour Emergency Care Standard and Ambulance Turnaround Times. This is detrimental to patient safety, quality of care and negatively impacts on the patient experience.

It was broadly recognised that the 'whole system' needed to change.

2. Aims / Objectives

The Perfect Week was described by Emergency Care Intensive Support Team (ECIST) as one possible approach to **test** different ways of working across the Health and Social Care Community in a focused period of time.

The Perfect Week was a jointly commissioned initiative with Scarborough & Ryedale Clinical Commissioning Group and York Teaching Hospital Foundation Trust.

The aim of Perfect Week was to demonstrate how rapid improvements could be delivered producing a step change in quality, safety, patient experience and performance.

Focusing on:

- Leadership and Culture
- Communication
- Attention to detail
- Escalation

The plan to achieve this was to test an operational approach that delivers:

- A bed management tool, called Visual Hospital.

This provides attention to detail for every patient in every bed, every two hours.

- A Command and Control Structure

To facilitate easy escalation of issues across Health & Social Care services. This was managed within the structure of a clinical major incident with Bronze, Silver and Gold Command structure.

- Test a Controller role

To ensure real time help and support at ward level for the delivery of identified patient safety outcomes.

- The whole Health and Social Care system working together to a common goal

Delivering a system that says “yes” was the fundamental aim of each of the three command structures and all the staff working across the health & social care boundaries to ensure delays were eliminated, reduced or captured.

- Implementing Safer Bundles

These set the standard at ward level and ED for delivering safe care through effective patient flow.

- Pledges

Health & Social Care colleagues developed up to five pledges within each service or ward to test improvement ideas or to identify process issues or gaps in service provision that results in delays to patients.

Perfect Week ran from Monday 19 May 2014 to the 26 May 2014 inclusive. This included a Bank Holiday weekend. The whole system, Health & Social Care, committed to going that extra mile to ensure that all delays to patients within the system were eliminated, reduced or captured. In addition to this staff and patients were interviewed every day to gain feedback about their experiences of the Perfect Week.

Perfect Week was designed to have the following outcomes:

“To recognise, reduce and eliminate delays for patients to create a safer patient experience and calmer ward environment and to improve partnership working”.

- Core Patient Database to be update real time
- Achievement of the 4 hour Emergency Service Standard (95% type 1)
- Reduction in length of stay for patients
- 50% of all discharges will be before 12pm
- All assessment wards will have available beds at all times to match demand
- Increased utilisation of the Discharge Lounge
- All delays across the Health & Social Care system will be escalated within the agreed command structure
- Reduction in delayed transfers of care
- Reduction in outliers
- Reduction in the number of unnecessary ward moves for patients
- No cancellation of elective surgery
- Improve ambulance turnaround times (100%)
- Discharge curve to match non-elective demand
- Compliance with VTE and AMTS
- Increased return rate for Friends and Family
- Improved compliance against ward or ED safer bundles
- Each pledge will have its own outcome measures

3. Project Methodology

To ensure that the project had a consistent approach and that the project delivered to plan the project team adopted the York Teaching Hospital Foundation Trust service improvement approach “Dial I For Improvement”. The use of the methodology ensured correct stakeholder analysis and engagement, a communication plan, the development of a project brief and project plan with measurable outcomes. This gave a sound structure to the project which ensured the timely delivery of the key deliverables. Following the completion of the Perfect Week project the methodology will be evaluated before phase two of this work “operation fresh start”.

In preparation for the perfect week the team completed a levels of care audit and also a stakeholder event with Scarborough Hospital Staff: “The Blue Room”.

3.1 Blue Room outcomes

The aim of the “Blue Room” was to ensure stakeholder engagement by gathering information and ideas from a range of staff both clinical and non-clinical around patient flow from admission to discharge at Scarborough Hospital. A total of 5 three hour sessions were facilitated and documented by the Corporate Improvement Team, from the 24 February – 28 February 2014 in the Blue Room at Scarborough Hospital. A total of approximately 100 staff attended these events.

The discussions were around four main topics:

- Admission to hospital
- In-patient stay
- Discharge Planning / Transfer
- Social Services / Care

Key themes:

- Delays in specialty assessments
- Inappropriate admission/transfer to wards.
- Patients often not in the most suitable area to receive the right care at the right time
- Cleaning of beds takes 40 minutes and is undertaken by nursing staff
- Better/earlier discussions with nursing homes are needed regarding patient discharges
- More physiotherapy would improve patients length of stay
- Reduce constant moving of patients between wards
- Phlebotomy timings need to be more flexible with their attendance on the wards
- Ward clerk working hours need reviewing – they don’t work at the busiest times leaving nursing staff to do admin tasks
- Porters are unable to transport patients with intravenous infusions and oxygen on their own
- Need better review of medical outliers – weekends are an issue
- Drug and alcohol nurse specialist needed to support and ongoing care of patients
- Standing hoists and weighing hoists needed to enable patients care
- Specialist chairs needed for elderly – overall lack of equipment
- Mental health referrals – slow to visit patients.
- Bed washing team essential to save time
- Longer opening hours for discharge lounge
- TTO delays with doctors signing off
- Pharmacy needs to be open longer
- Delays in getting patients to support services e.g. radiology
- A lot of paper work when transferring patients to community hospital
- No patient transfers on weekend to community hospital
- Limited weekend transport
- Slow delivery of equipment
- More training for junior doctors in discharging patients
- Better intermediate care needed
- Dedicated social care management required
- More joined up working with Social Services
- Continuing Health Care assessments need to be completed quickly

These themes were utilised to develop pledges, safer bundles or as part of the design for the

command and control structures.

3.2 Levels of Care Audit

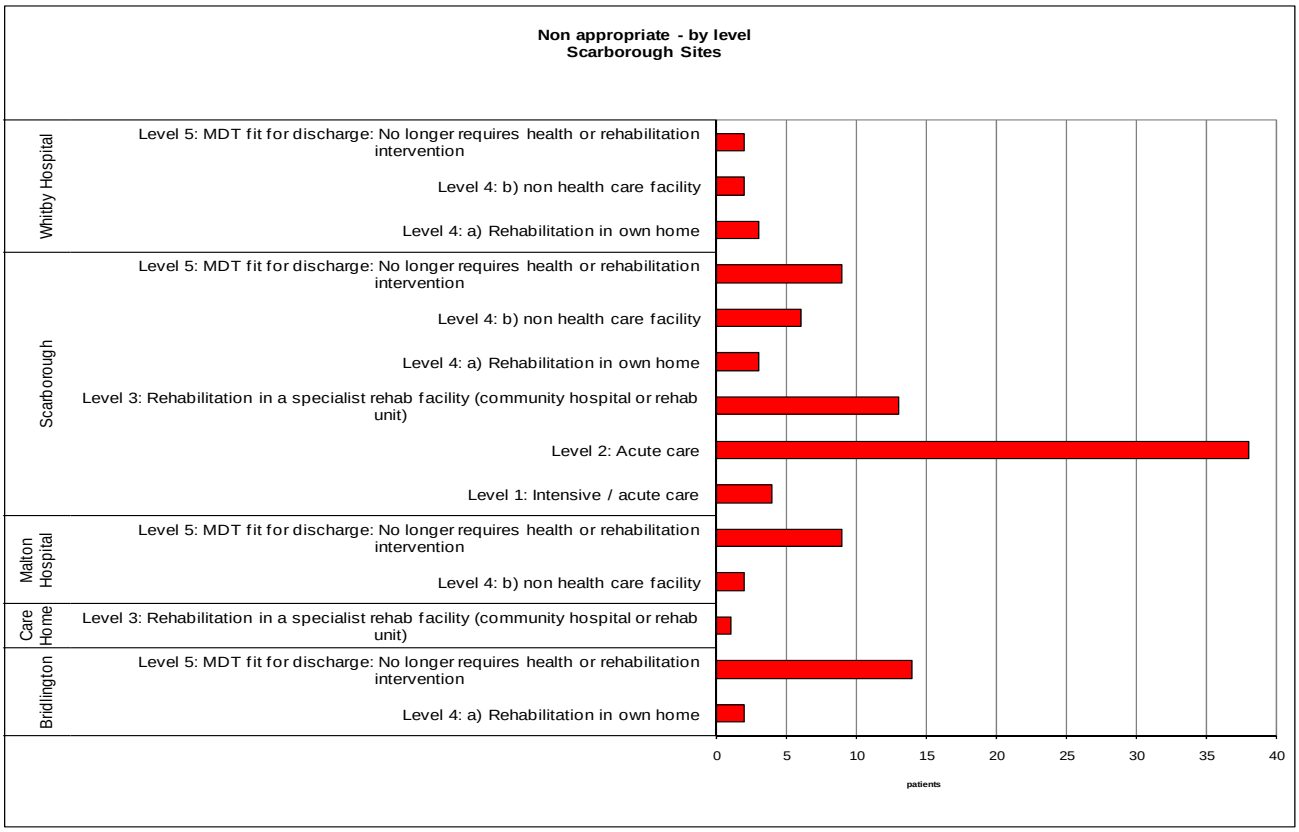
As part of the "Perfect Week" preparations, a Levels of Care audit was undertaken on the Scarborough site which included all the Acute, Community Hospitals and Rehabilitation/Care Home Units to assess if patients were in the right place to meet their needs. If they were not in the right setting, then information was collated as to where they should be and the cause of the delay in accessing a more appropriate setting.

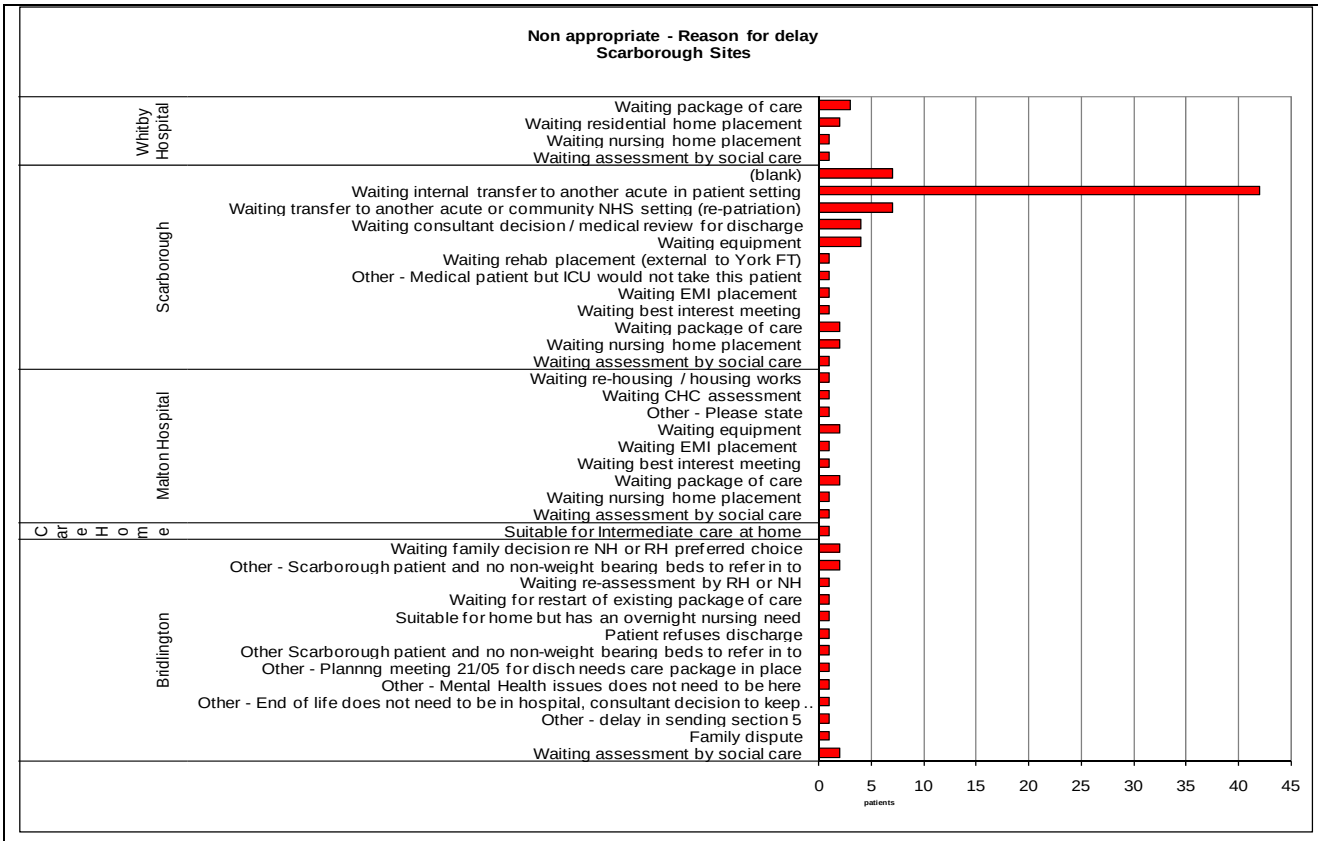
The audit looked at 5 levels of care

Level 1	Intensive / acute care
Level 2	Acute care
Level 3	Rehabilitation in a specialist rehab facility (community hospital or rehab unit)
Level 4	A: Rehabilitation in own home B: Non NHS rehabilitation or intermediate care setting (e.g. 101 Prospect Mount Road or Silver Birches/ Filey)
Level 5	MDT fit for discharge. No longer requires health or rehabilitation intervention

4. Key Findings

The audit clearly showed there are a number of patients who were either in an acute bed or a community hospital bed who were not in the best setting to meet their needs. In total 377 patients were assessed; 259 in Scarborough Hospital 9 in rehab / residential and 109 in community hospitals at Malton, Bridlington and Whitby. Of the 377 patients 108 or 28.6% were not in the appropriate setting.





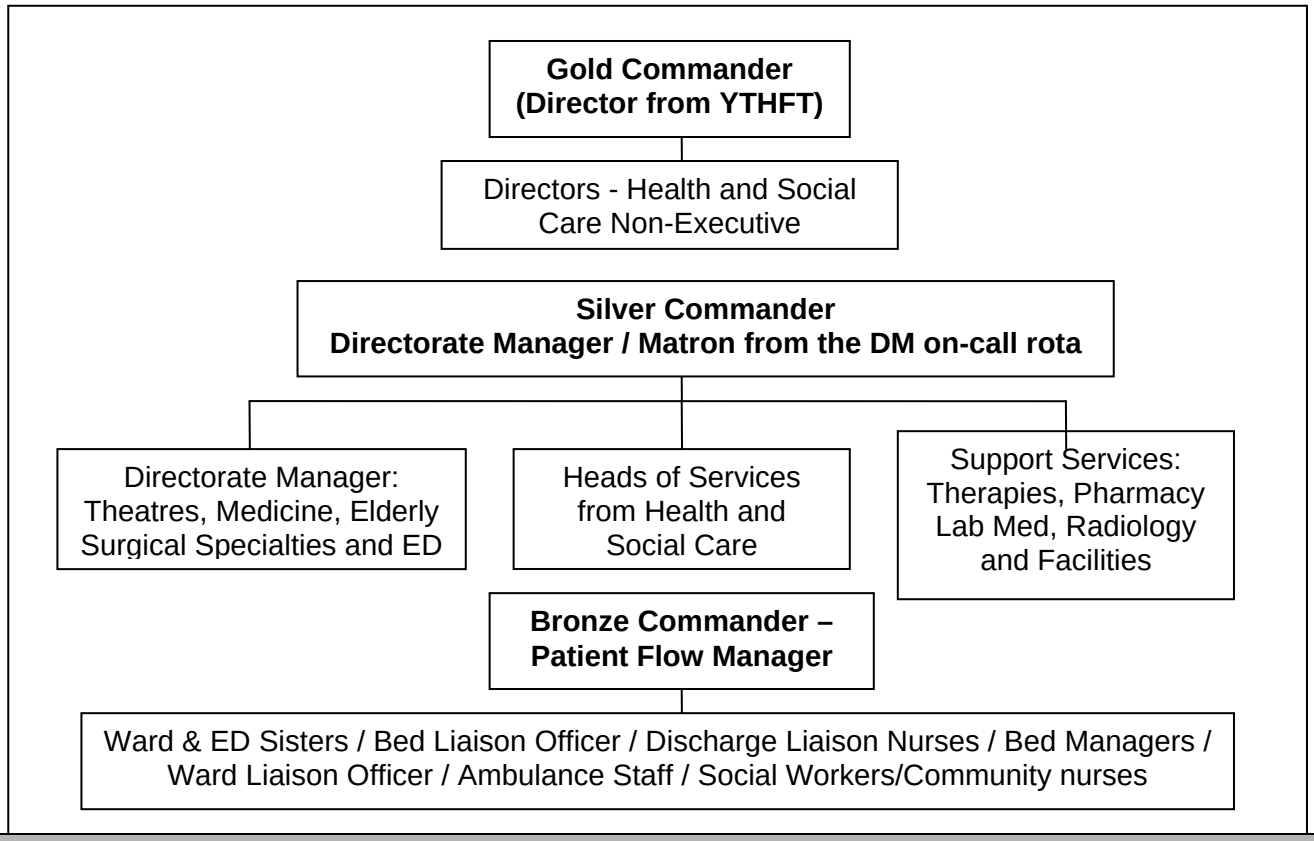
This information was considered when developing the key principles and outcome measures for the “perfect week”. In addition this information will be utilised at Contract management Board to inform discussions and funding priorities.

5. Perfect Week Approach

A steering group and operational structure was put in place, led by the Director of Operations, CSU Senior Delivery Manager, and Service Improvement Manager to ensure the successful delivery of this project. A significant level of engagement was achieved across the whole health & social care community.

5.1 Command & Control Structure

Throughout the week a full command structure was implemented with colleagues from health & social care activity engaged within each of the three command structures.



5.2 Bronze Command

This was the operational command centre and was made up of all staff at ward level, see operational diagram above at 5.1. All wards and ED adopted a zero tolerance approach to delays escalating all delays, clinical, environmental and non clinical, that they were able to resolve themselves to BC. The Bronze Commander then allocated the task to ensure that either all actions were completed within an agreed timescale or escalated to Silver Command if a solution was not found.

The Bronze Commander was responsible for the following data capture to be undertaken:

- 2 hourly, five times a day starting at 08:30 and finishing at 16:30 (Monday-Friday).
- 2 hourly, 3 times a day weekends and bank holidays starting at 08:30 and finishing at 12:30.

The number of patients:

- Due to be discharged today
- Medically unfit
- Possibly fit for discharge/awaiting reviews/results
- Ready to move to next destination but delayed
- Outlying

In addition, the Bronze Commander also captured, once a day, the number of patients:

- On the complex discharge pathway

- With a LOS 30 days or more
- The number still receiving acute care
- The number who do not have a discharge plan in place

5.2.1 Ward Liaison Officer

As part of Bronze Command the Ward Liaison Officers were ward based. Their primary focus was to ensure the ward was supported to enable the safe and timely discharge of patients. By introducing this additional role it enabled capacity to be created within the system to enable attention to detail at ward level and easy escalation of delays. Ward Liaison Officers were made up of staff who volunteered to undertake the role and came from within a variety of roles across the hospital and SWRCCG. Many of these staff were not usually in a clinical environment and came from administration, HR, Finance and IT background.

5.3 Silver Command

This was the tactical command centre and was led made up of Directorate Managers and Heads of Service, see operational diagram above at 5.1. These staff were freed up from their usual duties to ensure an immediate response was given to any delays. It was expected that Silver Command would resolve 99% of all issues referred to them referring only a minority to Gold Command. The Silver Commander will allocate the task to ensure that either all actions were completed or the delay escalated to the Gold Commander.

The Silver Commander was responsible for the following data capture to be undertaken 3 times a day at the following times 8am, noon and 6pm Monday - Friday. Weekends and Bank Holiday, 8am – noon.

- Number of Overdue EDDs (red ones)
- Number of patients due for discharge today
  - TTO complete
  - EDN complete

- Number of patients due for discharge tomorrow
  - TTO complete
  - EDN complete

- Number of high risk NEWS patients
- Number of incomplete VTEs
- Number of incomplete AMTs
- Available beds

In relation to ED:
- Number of pts in ED
- Number of current breaches
- Cumulative Pts in ED
- Cumulative breaches
- Pending Admissions

5.4 Gold Command

This was the strategic command centre and was made up of Directors from across health and social care, see structure diagram above at 5.1. These staff were freed up from their usual duties to undertake leadership walk rounds and interviews with staff and patients. In addition to this the Gold Commander allocated the task for any issues that were escalated from Silver

Command to ensure that either all actions were resolved or delays captured to understand any gaps to service provision.

5.5 Commanders Meeting Structure

The Bronze and Silver Commanders met every 2 hours throughout the day and the Silver Commander and Gold Commander met twice a day. The purpose of these meetings was to ensure a structured handover between each command structure and clarity the allocation and delivery of tasks.

5.6 Visual Hospital

This was delivered through the bronze command structure and transformed the way bed management was undertaken. This process ensures the bronze commander was aware of why every patient was in every inpatient bed every 2 hours. The criteria for visual hospital is:

- Home today
- Medically unfit
- Possibly fit for discharge
- Ready to move to next destination but delayed
- outliers

This detail forms the focus for identifying delays at ward level and generating escalation into the command structure.

5.7 Controller Role

The criteria was built into Silver Command as identified at 5.3. By focusing on these key performance indicators enabled Silver command to identify gaps in expected patient safety outcomes and ensure real time help and support at ward level to ensure these gaps were resolved.

The Whole Health and Social Care System Working together to a common goal
As identified in 2.0

Safer Bundles and pledges
As identified in 2.0

6. Communication

When running a whole system event it was recognised how essential effective communication would be. This was lead by Head of Communications, (YTH) and approached in the following ways:

<u>Prior to Perfect Week</u>

- Whole system briefing paper

Designed to be used by each of the organisations involved giving consistent information about Perfect week.

- Posters

These were displayed throughout the hospital to remind staff about Perfect week and how they could get involved.

- Staff briefings through ‘staff matters’

<u>During Perfect Week</u>

- Whole system daily briefing

The purpose was to give an update on the previous day’s activity during the Perfect Week and to share some of the feedback received so far.

- Early morning daily staff briefings

The purpose was to ensure all staff involved in the perfect week understood the priorities and focus for the day ahead.

- Staff de-briefings

At the close of each day staff de-briefings were held to capture what has worked well and less well to inform the planning for the following day.

- Staff feedback on video

To capture staff feedback in the moment during Perfect week.

<u>Following Perfect Week</u>

- Staff de-briefing sessions

These sessions enabled us to capture staffs reflections on what has worked well and less well to inform the structure for operation fresh start.

- Monthly staff briefings in ‘ staff matters’

To keep staff informed of actions and progress

- Circulation of Evaluation report.

7. Operational Overview

On the day before Perfect Week started, Sunday 18 May 2014, the hospital was on red alert and had opened some additional beds to create inpatient capacity. The ED emergency service standard was under pressure with a large number of patients waiting in ED for an inpatient bed. Ambulance turnaround times was also compromised as a result of the lack of capacity within ED caused by patients waiting for beds. Although this situation is not uncommon it did make the start of Perfect Week operationally difficult.

8. Analysis and Outcomes from Perfect Week

8.1 Improving Timeliness of Recording Patient’s Clinical Information

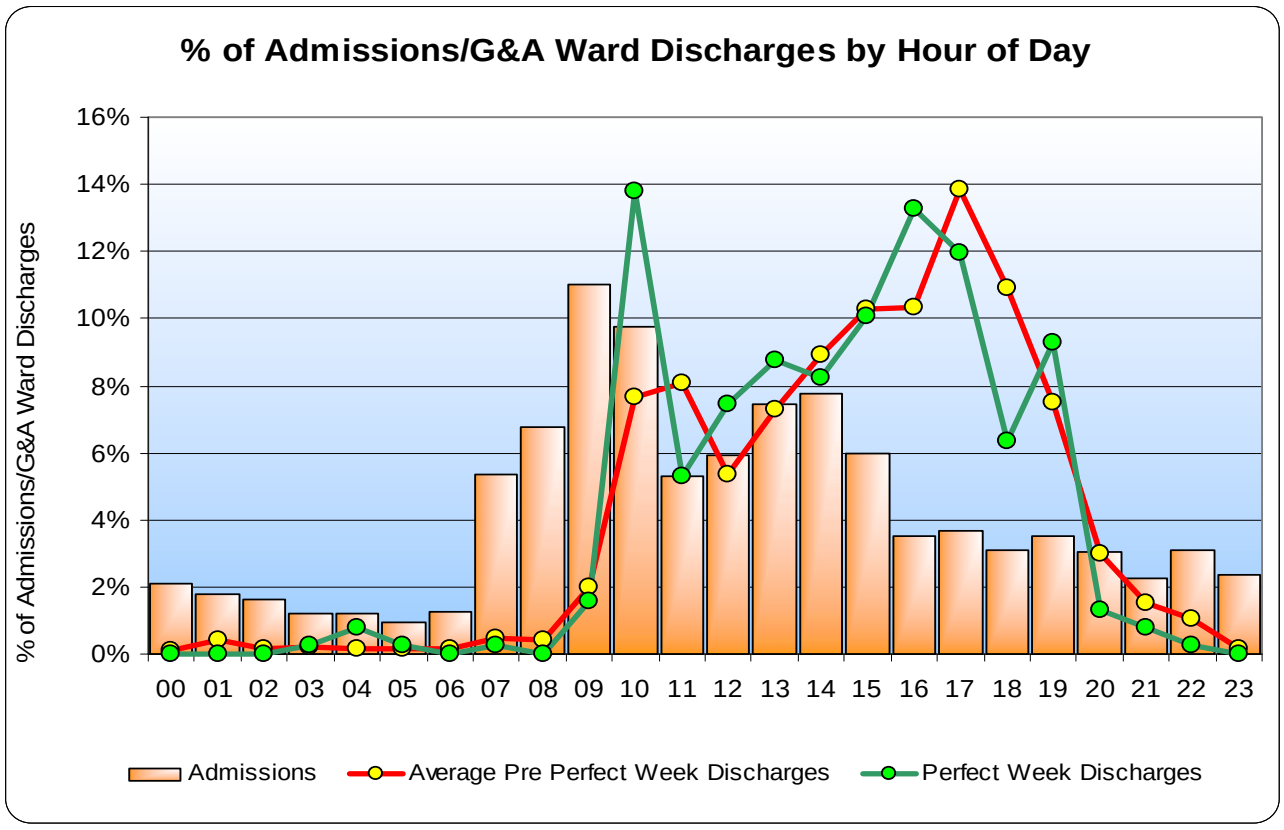
The table below shows that there were significant improvements in performance against the targets for: AMTS Dementia screening, Electronic Discharge Notifications (EDNs) being produced within 24 hours of patient discharge, clerking of patients onto Cherry ward within 4 hours and compliance with the 4 hour Emergency Department target during the 'Perfect Week'. In the 4 weeks following 'Perfect Week' only some of the improvements in performance have been maintained as indicated in the table below.

Performance against..	w/e 4 May	w/e 11 May	w/e 18 May	Perfect Week	w/e 1 Jun	w/e 8 Jun	w/e 15 Jun	w/e 22 Jun
AMTS	90.00%	86.30%	87.50%	92.75%	78.26%	90.28%	88.41%	86.15%
EDN 24hrs	39.10%	40.20%	41.80%	45.70%	39.20%	48.80%	53.50%	54.60%
4hr Clerk	94.40%	95.60%	87.20%	95.40%	90.79%	92.25%	95.10%	93.01%
12hr PTC	79.80%	74.70%	76.00%	78.50%	70.39%	69.01%	73.43%	68.53%
1hr NEWS	86.70%	88.50%	86.80%	87.50%	89.00%	87.90%	87.76%	86.65%
VTE	97.03%	97.64%	96.61%	97.87%	98.19%	99.06%	96.72%	98.60%
4 hour ED Target - Sboro ED	93.09%	85.41%	92.32%	95.01%	91.24%	92.63%	88.66%	91.06%
4 hour ED Target - Sboro Locality including Bridlington & Whitby MIUs	95.68%	91.01%	95.29%	97.07%	93.96%	95.35%	92.79%	94.53%

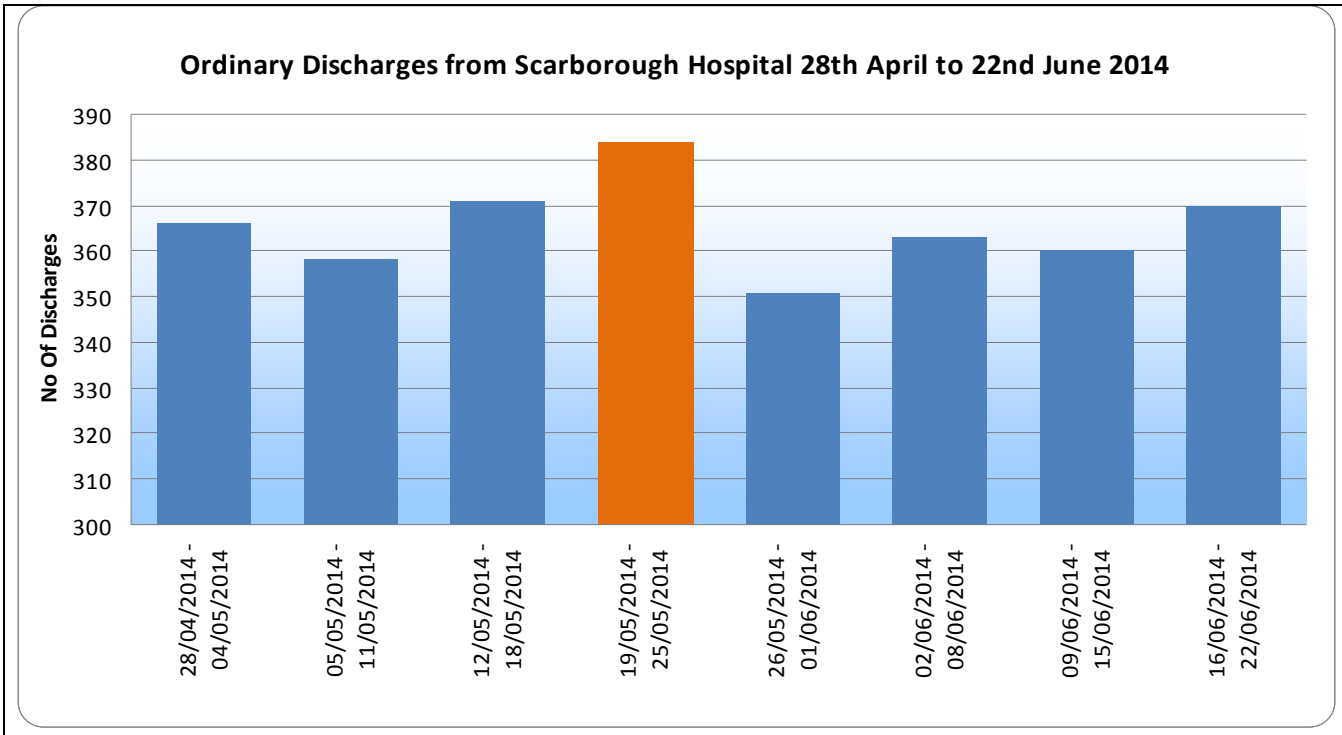
8.2 Earlier Patient Discharge

There was a clear shift in the discharge by hour profile during the ‘Perfect Week’, see chart below. Previously, for the 6 week period prior to the ‘Perfect Week’ there was, following a small peak at 11am, a steady increase peaking at 5pm in discharges. During the ‘Perfect Week’ there was a significant increase in discharges at 10am along with a later spike at 4pm.

This is illustrated by the fact that a higher proportion of discharges took place before 11am; 17% during the perfect week compared to 12% in the 6 weeks prior to the ‘Perfect Week’. Also, 70% of discharges took place before 5pm during the perfect week compared to 62% in the 6 weeks leading up to it. Patient flow through the system appears to have improved with use of the discharge lounge increasing from 4.7% to 9.5% during the 'Perfect Week'.



The overall average length of stay for spells of care ending in SGH general and acute wards fell from 4.68 (6 weeks prior to 'Perfect Week') to 4.33 days; a 7.5% reduction.
There was a 5% increase in ordinary discharges during the 'Perfect Week' compared to the average for the previous 3 weeks, the graph below illustrates that this was not sustained in the following 4 weeks.



8.3 Pharmacy Outcomes

The changes initiated within the 'Perfect Week' had a positive impact on Pharmacy outcomes.

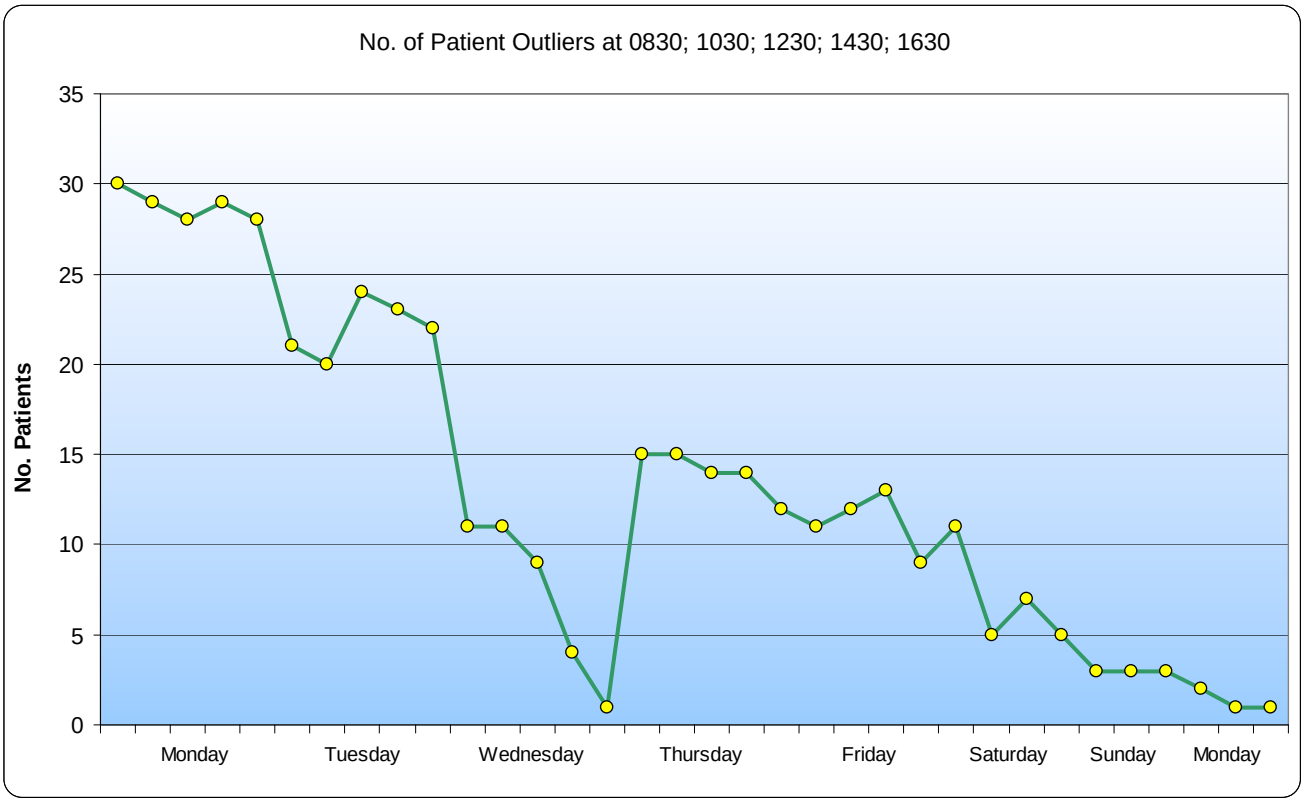
Feedback from the Pharmacy department showed that based on comparing the 'Perfect Week' to the previous week the percentage of patients with medicines reconciliation / pharmacist review increased from 76% to 95%. There was an increase in the supply of TTOs direct from wards from 16% to 25% and prescribing errors on TTOs reduced from 40% to 23%.

Turn round times for discharge prescriptions improved with 71% been dispensed within one hour (compared to 26%) and 95% been supplied within 2 hours (compared to 72%).Turn round times for in patient requests improved with 48% been supplied within one hour (compared to 30%) and 89% within 2 hours (compared to 59%).

	Pre perfect week	Perfect week
Medicines reconciliation		
Average number of patients with medicines reconciliation/initial pharmacist review at 5pm	76%	95%
Average number of patients requiring	68%	88%
Discharges		
Number of discharges	141	178
% of discharge done by usual ward team	16%	24%
% of discharges validated by a pharmacist within 15minutes	21%	65%
% of discharges validated by a pharmacist within 30 minutes	58%	83%
% of discharge prescriptions that required referral back to the prescribers	40%	23%
Dispensary		
% of TTOs dispensed within 1 hour	26%	71%
% of TTOs dispensed within 2 hours	72%	95%
% of requisitions dispensed within 1 hour	30%	48%
% of requisitions dispensed within 2 hours	59%	89%
% of MDS required for same day supplied for the same day		100%
No of times dispensary closed on time	0	5

8.4 Outliers

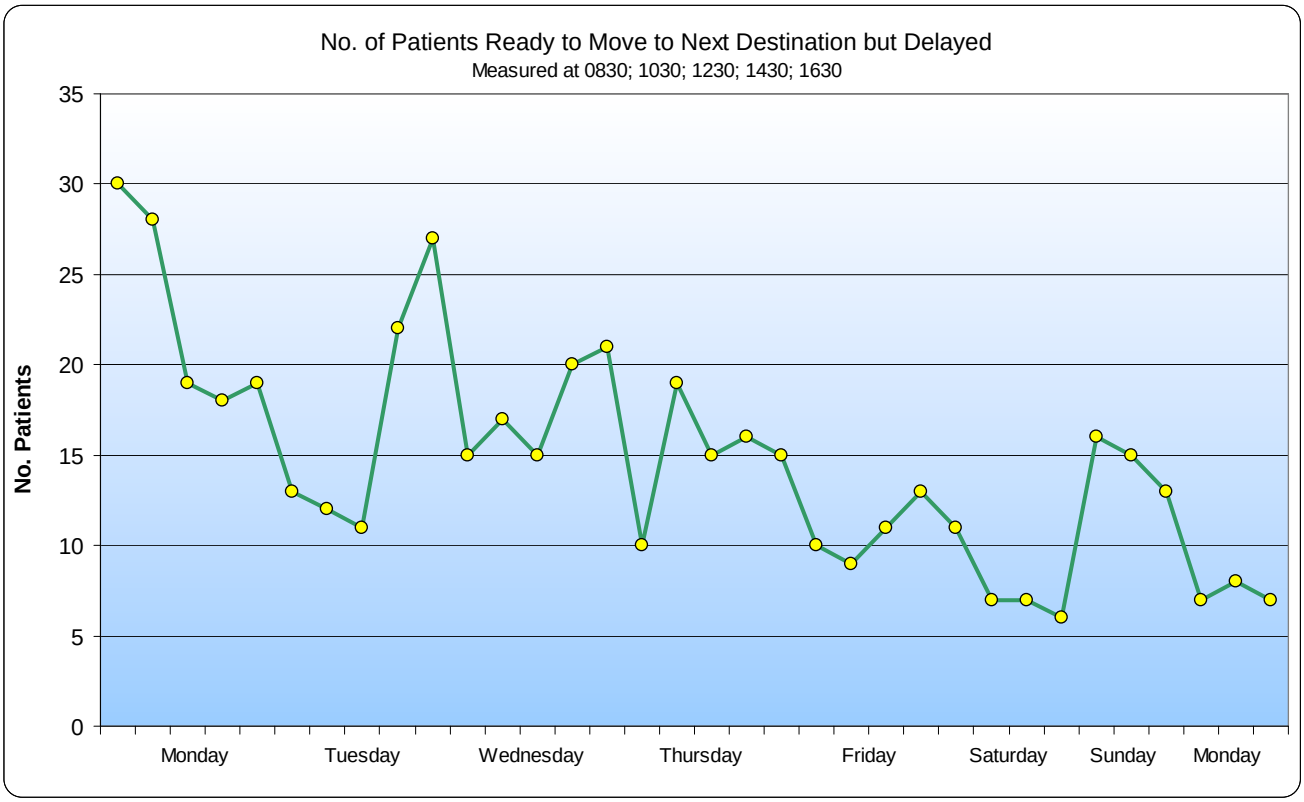
The number of patient outliers reduced steadily throughout the week.



From manual data collection

8.5 Patients Ready to move to next destination

The number of patients ready to move to their next destination but experiencing a delay also reduced steadily throughout the week, see chart below.

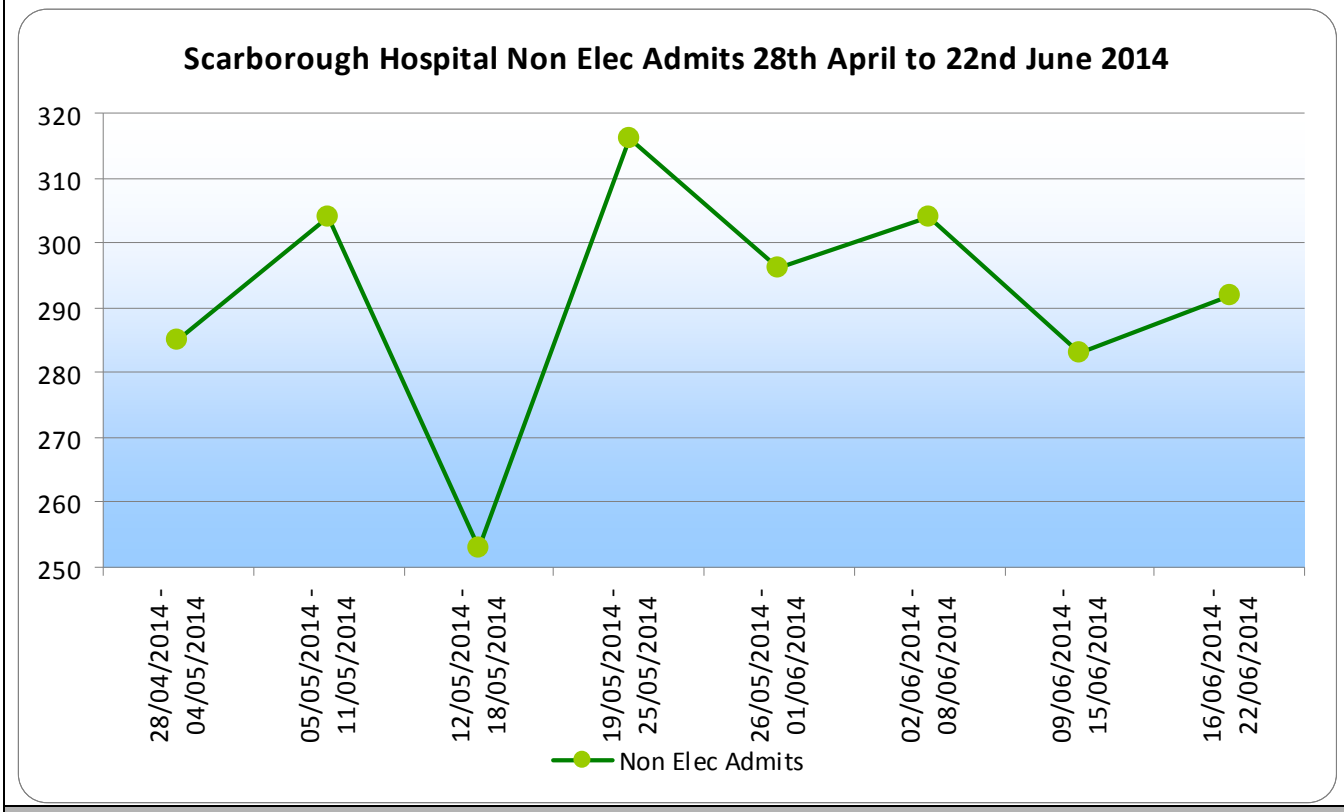


From manual data collection

8.6 Non Elective Demand

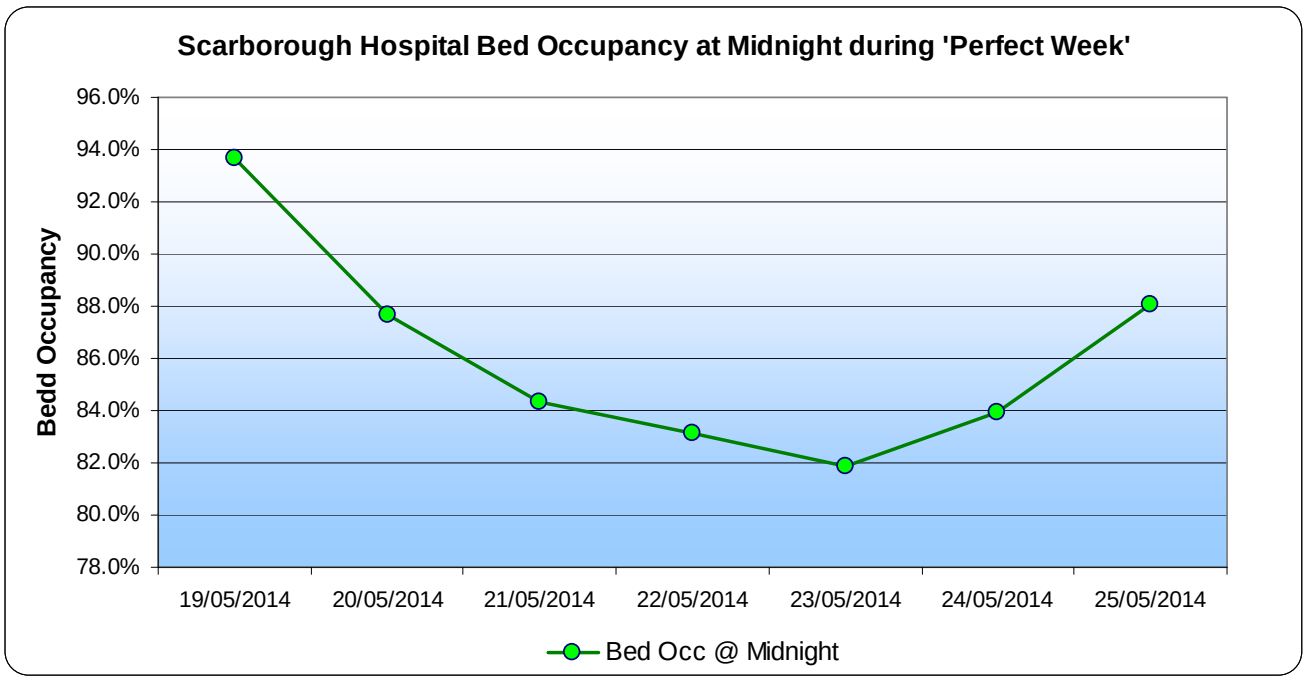
During the 'Perfect Week' Scarborough saw its highest Non Elective admissions compared to

the three weeks prior and four weeks afterwards.



8.7 Bed Availability

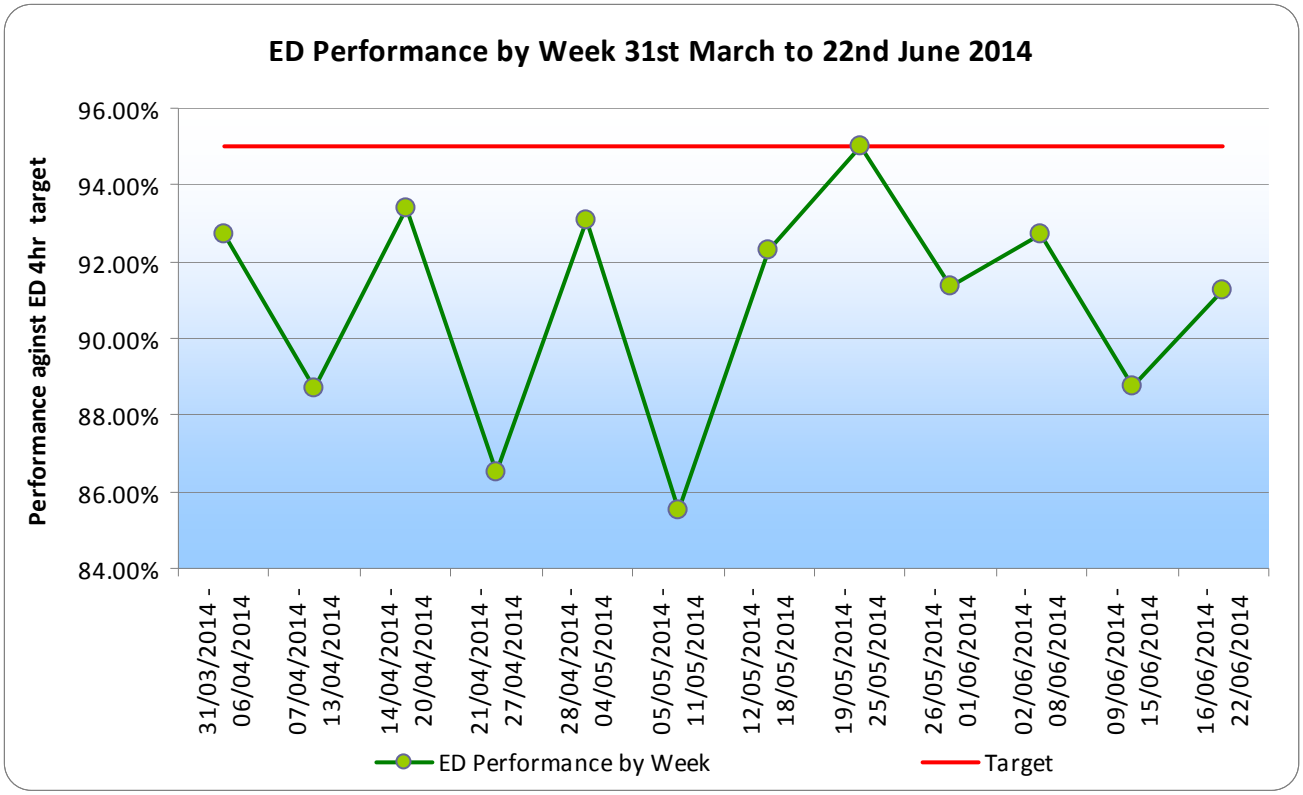
Bed availability improved throughout the week even though non-elective admissions were higher than in previous weeks (13% up on the average of the previous three weeks). This is illustrated in the two charts above and below, which show a spike in Non-elective admissions but also a reduction in bed occupancy as the week progressed from a starting point of 94.54% as at 23:59 on the 19th May.



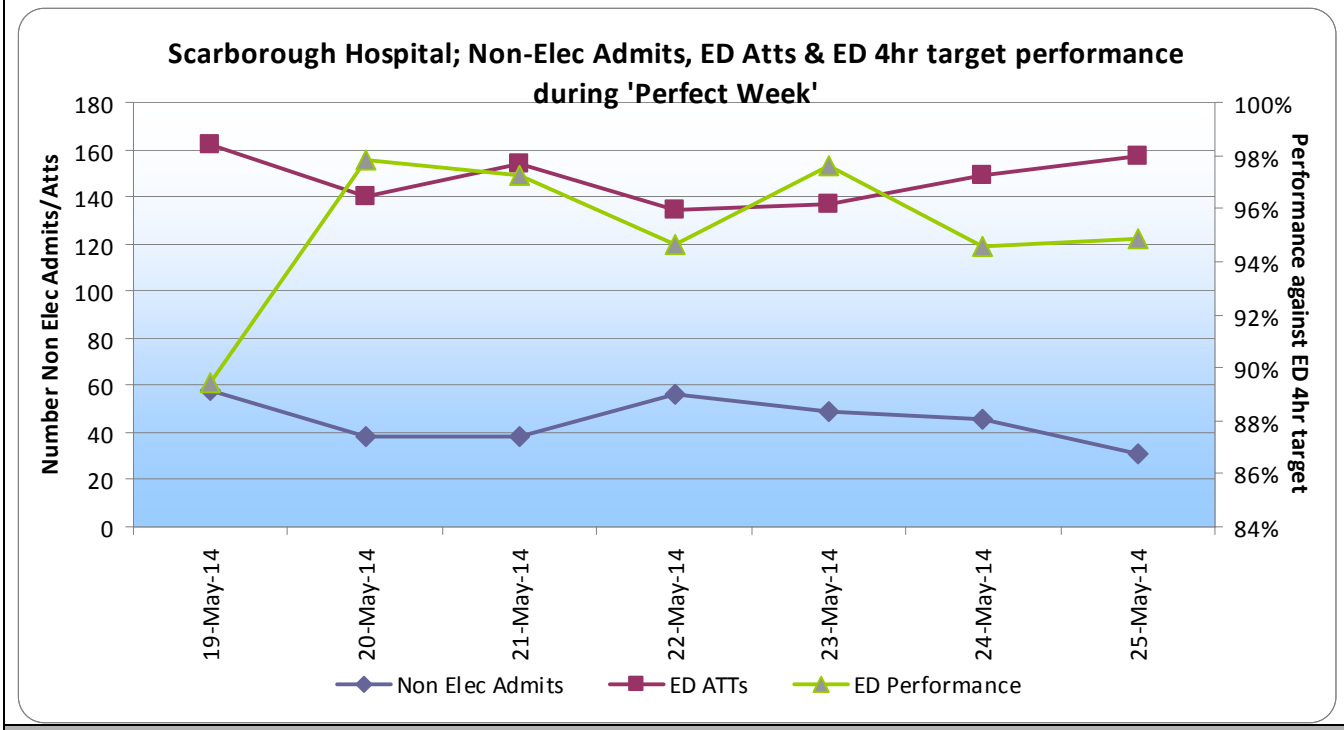
8.8 ED Performance

It was a busy week in ED (3% up on previous week). There were 33% less breaches and the 4

hour target of 95% was met for only the second week since March 2014.



Five of the daily attendance figures seen during 'Perfect Week' were above what could be expected on that particular day (this is calculated by looking at a one standard deviation increase on the average for the previous twelve month period). However even when coupled with the spike in Non-Elective admits the Scarborough ED department achieved solid performance throughout the 'Perfect Week'.

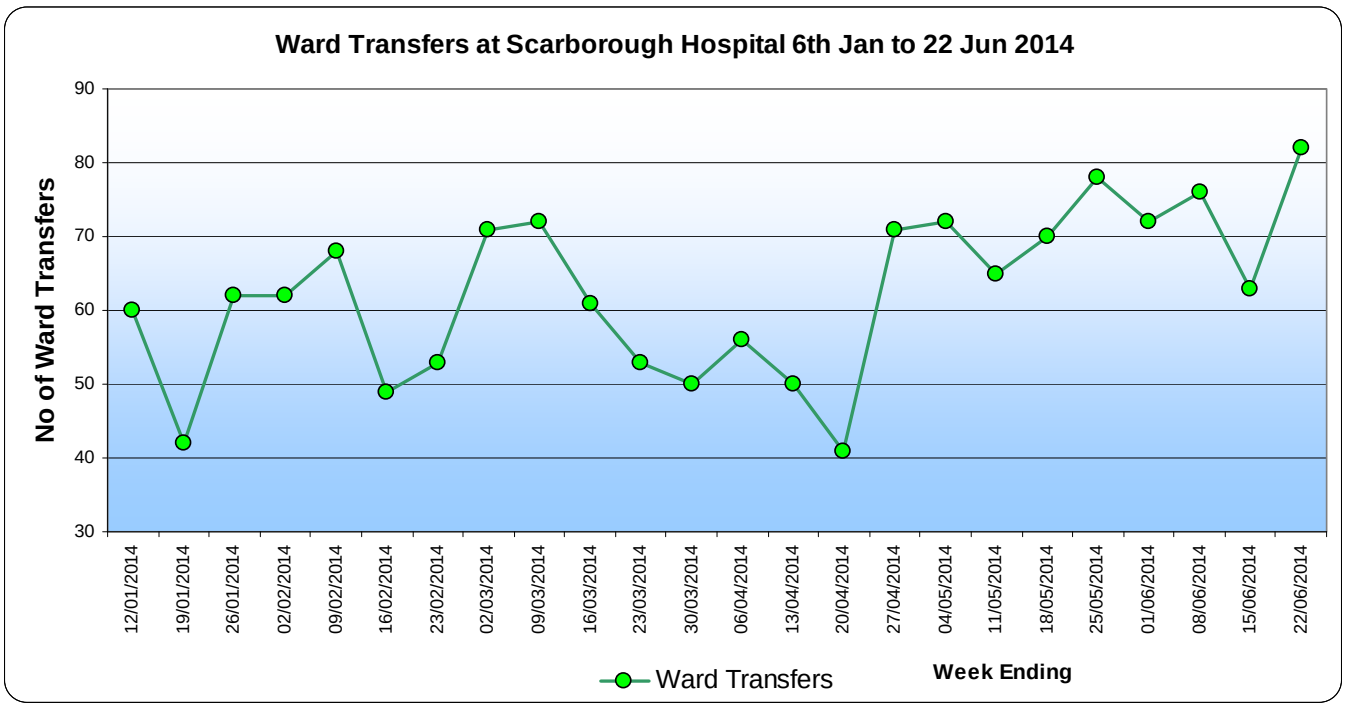


8.9 Transfers Between Wards

Transfers from the following wards are excluded: CCU, Cherry, Delivery Suite, Gastroenterology Unit, Hob, Intensive Care Unit, Stroke Unit & West Wing

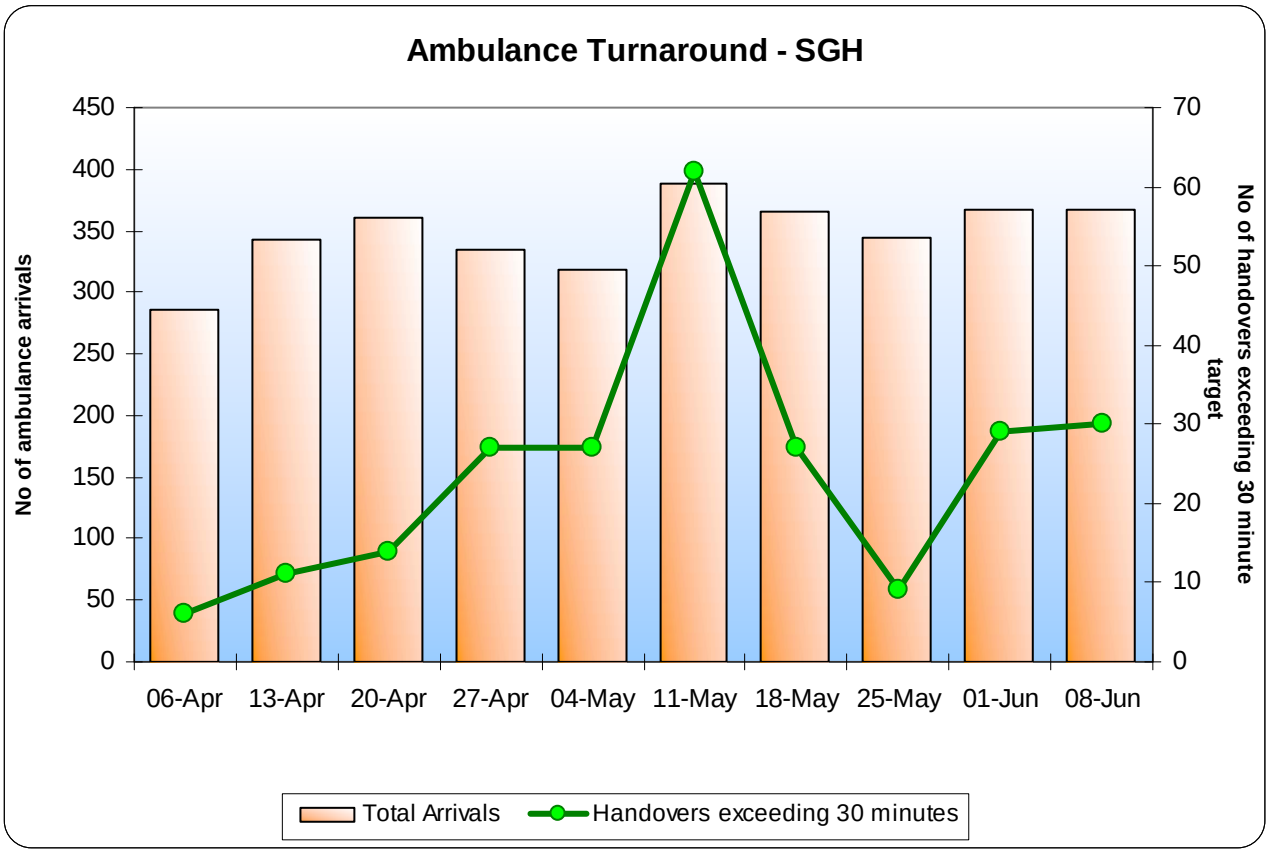
Transfers into the following wards are excluded: CCU, Cherry, Intensive Care Unit, Special Care Baby Unit & Stroke Unit.

The 'perfect week' saw one of the highest number of ward transfers over the last 6 months.

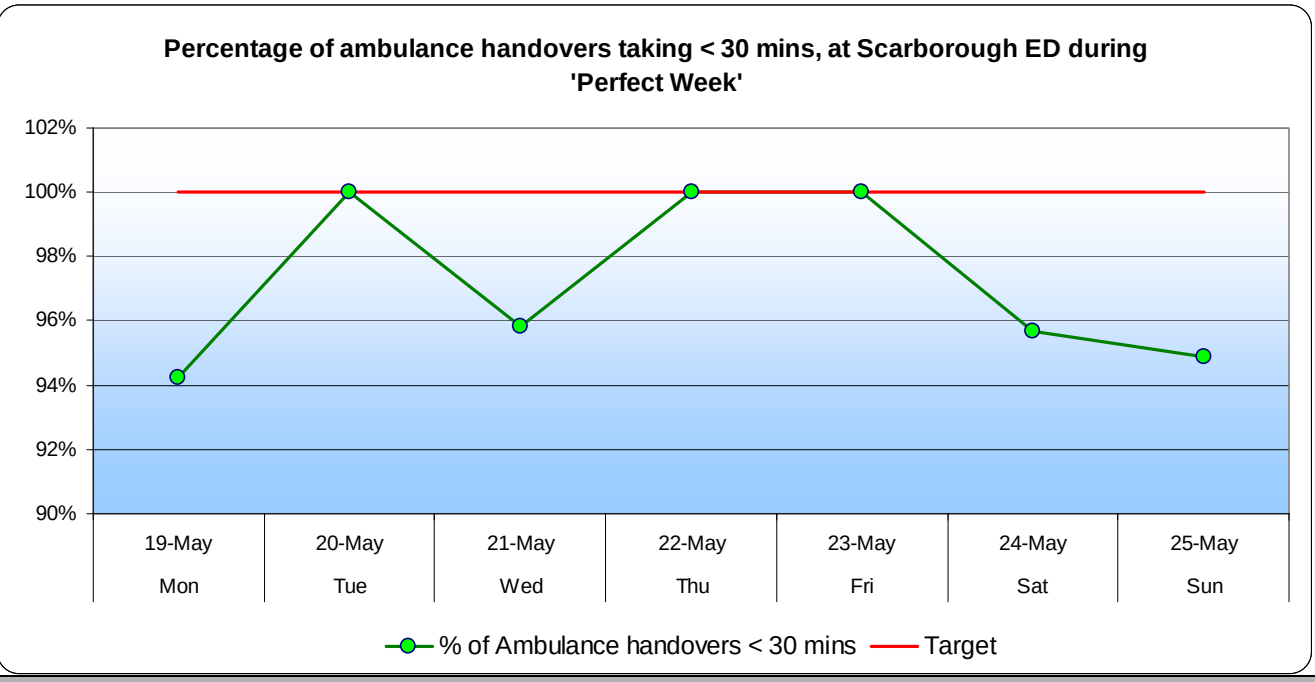


8.10 Ambulance Handovers

The perfect week saw Scarborough Hospital ED have the 2nd lowest number of ambulances fail to achieve the 30 minute target this financial year.

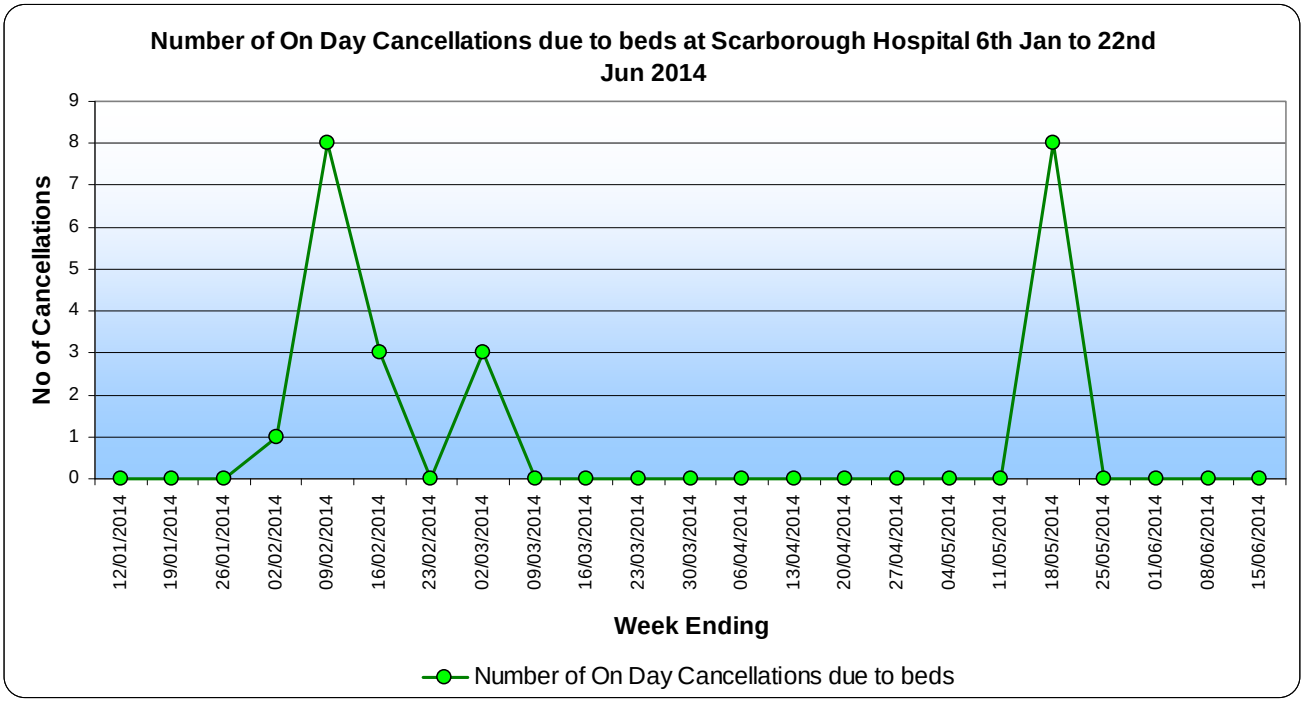


In fact the 'Perfect Week' saw 3 days with no ambulance handover breaches. Prior to the 'Perfect Week' potential fines for ambulance handovers at Scarborough were £10,686, during the 'Perfect Week' they were £2,600 and since then (up to 13th July) are £17,200. The chart below illustrates the daily performance.



8.11 Cancelled Operations due to Bed Shortages

There were no cancellations due to bed shortages during Perfect Week.



8.12 Bronze Command Evaluation

Bronze command were able to resolve around 120 issues. Some examples were:

- Transfer of pt to BDH
- Found delayed results of CT
- Arrange medical reviews of patients
- AMU not ready for patients from ED
- Expedite Gastro/CT/USS/Orthotic appointments.
- Arrange with Head porter for patient transfer

The following issues were the key themes that were escalated to Silver Command for resolution:

- The ability to repatriate non local patients back to their local hospitals following admission, treatment and stabilisation of the patient from any of the above hospitals
- Availability of beds and access to Malton and Whitby Hospitals
- The lack of availability of transport to transfer patients to other health care settings
- Non-availability of oxygen in the discharge lounge
- Issue of Infection Control contact at the weekend
- The inability to secure beds in other Trust for repatriation of patients
- Junior doctors not answering their bleeps at the weekend
- Responsiveness of radiology, particularly CT scan availability
- Delays in being able to access echocardiograms

"Being able to escalate issues, via the WLO, to Bronze Command took so much pressure off the nurses – They had more time than usual to spend with patients"
Carol Carrington
Sister, Haldane Ward

8.13 Ward Liaison Officer Evaluation

There were 39 WLO from a range of backgrounds across the hospital and CCG.

They were able to help and support ward staff in resolving issues at ward level. In total there

were around 127 issues that were resolved by the WLO at ward level. Examples of these issues were:

- Waiting for bed to be confirmed on a medical ward – rang 30 minutes later and bed ready
- Check time for USS – left message at 2pm, rang again 2.10pm – no answer, rang again – got no answer, rang again at 2.35pm - got answer
- Phoned for bed - Transfer of patient to Whitby
- Arranged for Infection Control to visit ward at 2pm, fogging arranged and bay reopened later that afternoon.
- Phoned discharge lounge – patient collected – new patient in bed within 30 minutes
- Spoke to Surecare to restart home care package, spoke to son to arrange/ensure things set up at home – patient ready for discharge.

"Working with the nursing team to ensure patient safety and discharge was one of the most satisfying jobs or projects I've been involved in and I will take this experience back into my day job"

Keith Young
IT Trainer

The following issues were the key themes escalated to Bronze command for resolution:

- The ability to repatriate non local patients back to their local hospitals following admission, treatment and stabilisation of the patient from any of the above hospitals
- Availability and access to beds at Malton and Whitby Hospitals
- The lack of availability of transport to transfer patients to other health care settings
- Access to equipment to support patient discharge or transfer out of the hospitals
- Access to Mental Health assessment and support, including CAMHs particularly out of hours
- Responsiveness of radiology, particularly CT scan availability
- Delays in being able to access echocardiograms
- Issues regarding the availability of Social Services and their ability to act in a timely fashion
- Doctor/senior decision making review of patients
- Access to therapies particularly Physiotherapy assessments out of hours.

8.14 Silver Command Evaluation

Silver command were able to resolve around 90 issues. Some examples were:

- Patients identified to go to Whitby and Malton Hospitals-no beds available
- Problem with accessing ultrasound-same patient with DVT from yesterday
- Patient for Neurology unable to go to York due to York bed issues
- Patients for Malton unable to go due to bed pressures from York.
- No OT equipment causing delays
- Oak patient for Bridlington not gone-identified yesterday
- Air mattress needed for Oak Ward
- Delay in pharmacy getting to Johnson Ward Bridlington
- Patient waiting social service input and Power of Attorney on Beech Ward
- Dr Humphriss update re ECHO need across Wards in Medicine- 7 requests-1 not needed, 1 to have as OPD, 2 urgent, 3 non urgent
- CT backlog of 7 today for inpatients
- Patient from Haldane due to go to Ward 32 York (waited for 3 days so far) no EDD arranged due to bed pressures at York.
- Bridlington patient needs social care assessment
- Bridlington pharmacy issue highlighted

- ED patients needs scan 12.48- not available until after 3pm – scan booked
- Dr handover needed for patient transferring to Bridlington-patient then unable to be accepted onto the Wolds Unit due to staffing issues
- Backlog from Radiology 64 ?what more detail needed.
- Profiling bed shortage-reported by District Nurses
- 3 patients on Willow Ward awaiting x-ray cannot go home without the results being reviewed
- Delay in transferring a patient fit for discharge from ICU to a medical ward

The following issues were the key themes that were escalated to Gold Command for resolution:

- Continuing Health Care Assessment delay
- Funding decision for End of Life
- Lack of availability of Child and Adolescent Mental Health services for assessment on a weekend.
- Demand for beds at Malton from York and Scarborough

"The command and control structure was extremely beneficial in ensuring a well coordinated approach to dealing with blockages and barriers in the health and social care system"
Chris King Jones
General Manager
North Yorkshire County Council

8.15 Gold Command Evaluation

There were only four issues escalated to Gold Command. Three of which were resolved. The other was captured as an issue that needs to be resolved.

Gold command focused on leadership walk rounds and interviewing staff and patients. Over 100 questioners were completed, approximately 55 patients and over 60 staff contributed their feedback. The key themes were as follows:

<u>Patients</u>

- Generally very positive about their hospital care.
- Caring staff
- Good food
- Clean hospital environment
- Some issues with communication about the patients not understanding their treatment plan or planned discharge date.
- Most patients didn't know about Friends and Family (This was possibly because it was too soon in their hospital stay.)

<u>Staff</u>

- Hospital feels calmer
- ED felt much calmer with no bed delays.
- Bed availability much better.
- Nobody saying 'No!
- Ward Liaison Officer excellent and releasing pressure on the nurses to care for patients.
- Having social services and pharmacy on the wards made a massive difference to patients
- A minority of staff found it difficult to work in a culture, and at a pace, where delays were no longer acceptable.
- Some staff felt there was repetition of information being requested.

- Mixture of feeling about the number of managers around. Some found it supportive and reassuring, others overwhelming.

"I was impressed that the staffs' enthusiasm, buzz and sense of 'we can do this!' was evident all week"
Patrick Crowley
Chief Executive Officer
York Teaching Hospital Foundation Trust

8.16 Pledges

We had 100 pledges form across the health and social care community.
The following table identifies those pledges that can be maintained without further investment and those that will require investment to implement.

Green No further funding required and can continue	Amber Possible funding required but requires further evaluation	Red Not sustainable without additional funding
44	33	23

An example of a pledge was that the pharmacy discharge team would proactively visit the wards as soon as the TTO were written instead of waiting for the ward to contact them. This has been assessed as sustainable and therefore this change in working practice will continue.

"Pharmacy excellent, much quicker!"
Staff Nurse, Beech Ward

8.17 Follow Up Staff Engagement Events

These were conducted over 3 sessions with approximately 90 staff attending from across health and social care. The key themes were:

- Ward Liaison Officers were a valuable resource at ward level.
- Whole system working together made a fantastic difference to patients and staff.
- Briefing worked well across health and social care.
- Having all staff working to the same plan across health and social care made a massive difference to reducing delays to patients
- Better collaborative working both internally and with external partners
- Calmer hospital despite being busy
- Staff felt upbeat because they felt they were able to provide better care for patients.
- We want this way of working all the time

9. Conclusion

"The acute care experience of patients at Scarborough Hospital was significantly enhanced. In addition the optimisation of patient management systems ensued improved staff satisfaction with their ability to provide the care the patient's deserve."
Dr Ed Smith
Consultant in Scarborough ED

Perfect Week gave an opportunity for health & social care to work together to a common goal. This was the first time that this had happened on this scale and with all partners fully engaged in the process. In addition, having the ability to test a new way of working through Visual

Hospital enabled a new bed management model to be tested. The command and control structure facilitated a clear escalation route for all organisations involved and provided an opportunity to develop effective multiagency problem solving and speedier responses to the needs of patients.

It became very evident that a whole system saying "yes", commissioner, providers and social care, seeing the same issues, in real time, from a shared perspective, resulted in a more responsive system. This way of working reduced delays for patients and improved outcomes in quality, safety, patient experience and performance.

"Everyone working together was most apparent when dealing with a patient at end of life who wanted to go home and by working together this was facilitated within hours of his request".
Simon Cox
Chief Operating Officer
Scarborough and Ryedale CCG

This focus on detail and escalation had a dramatic impact on the systems ability to deliver a calmer, safer hospital. It was noticeable how partners used this opportunity to get to know each other, and to forge improved working relationships across the health and social care community. This can often take many years to evolve. Perfect week gave an opportunity to 'fast track' this to a more solid foundation from which to build partnership working in the future.

We have shown how it can be done. We now need to make this way of working the norm.

10. Next Steps

Operation Fresh Start

Building a sustainable structure to support the principles of Perfect Week is a priority.
The aim is to ensure we focus on:

- Leadership and Culture
- Communication
- Attention to detail
- Escalation

The sustainable model is as follows:

- Continuing those pledges that had good patient outcomes and were cost neutral and understanding the investment required for those pledges that delivered effective patient outcomes and prioritising the investments required.

- Implementing Visual Hospital and a command and control structure 7 days a week. This will include:
  - Ward Liaison Officers.
  - Controller role
  - The whole Health and Social Care system working together to a common goal
  - Whole system escalation processes.

- Implementing the following on every ward at Scarborough and Bridlington Hospitals and ED.
  - Safer Bundles
  - A plan for every patient
  - Cultural assessments and safer briefings

This will be aligned to the 'It's My Ward' Competency Framework, ensuring leadership and ownership at ward level from Sisters / Charge Nurses.

- Implementing improved assessment in ED. This will include:
  - Ambulance Turnaround assessment nurses and escalation area.
  - Increase assessment capacity
  - Implement team nursing

There will be a cost associated with this and NHS Scarborough & Ryedale CCG, NHS East Riding CCG, North Yorkshire County Council, East Riding of Yorkshire County Council together with York Teaching Hospital Foundation Trust will be working together to ensure funding is identified for this essential investment.

Author	**Mandy McGale, Director of Operations (YTH)** **Karen Mazingham, CSU Senior Delivery Manager**
Owner	**Mandy McGale, Director of Operations (YTH)** **Karen Mazingham, CSU Senior Delivery Manager**
Date	**July 2014**

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Quality & Safety Committee – 22nd July 2014

Attendance: Libby Raper, Philip Ashton, Alastair Turnbull, Diane Palmer, Anna Pridmore, Pamela Hayward-Sampson, Liz Jackson
Observers: Mike Sweet
Apologies: Jennie Adams, Beverley Geary,

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last meeting notes 17th June 2014**		LR welcomed MS, PHS and LJ to the meeting. The Committee reviewed the minutes and approved them as a true record.		
2	**Matters arising**		**Friends and Family –** The Committee discussed the revised guidance that has been recently released by the Department of Health. The Committee noted that it was expected that the token system would be removed by April 2015. **Integrated Dashboard** – DP updated the Committee on the progress on migrating the quality data on to the main performance report. She advised that, a date has not yet been arranged for Systems and Network services to take over production of the report; this is in part to a further piece of software being introduced to the organisation. **Supplementary Medical Director Report – SI 2014/7371 System failure maternity services Scarborough**– AJT recapped on the serious incident summary. AP added that she had asked for a response from the Directorate, but as yet it		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			had not been received. AJT advised that he would discuss the SI further with the Directorate and provide a response to the next meeting of the Committee in September. **6 and 12 hour senior review -**AJT updated the committee on the 6 and 12 hour senior review. He explained that there are some challenges in the system around the availability of acute physicians. He commented that he felt the timings were not correct as yet. He felt that 6 hour reviews during the day could be undertaken a little quicker and 12 hour reviews outside normal working hours would be challenging to achieve and it might be more realistic if that was set to 14 hours. The working patterns of the senior doctors are being looked at to cover times where there is a rise in Acute Admissions. AJT commented that there is a national challenge around the recruitment of Acute Physicians. The Committee noted AJT's comments.		
3	**Patient Safety and Quality Report**		The Committee went through the executive summary of the report. **Serious Incidents -** AJT confirmed that the serious incidents were made up mainly of pressure ulcers and fractures as a result of patients falling. The Committee noted the comments and asked where the Trust is against the benchmarking. DP referred the Committee to the Safety Thermometer report which shows the comparison with the national and regional trends. She		MP to update the board on the Falls work

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			confirmed that the Trust is just above the national trend and in line with the regional. DP assured the group of the accuracy of the falls data and advised that the system has been enhanced so that Matrons are now required to validate all incidents. DP added that the new Falls Policy will be launched imminently which will redefine the standards of care and standardise practice. AJT and DP informed the Committee that there is currently work being undertaken to define the occasions when a fall is reportable as a if a fall is RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations).He added that RIDDOR reports come under the jurisdiction of the Health and Safety Executive (HSE). AJT updated the Committee on the C-Diff trajectory. The Trust is able to report to Monitor this quarter that it is below the trajectory of 15 cases. **Dementia Screening -** AJT explained the compliance with dementia screening and assured the Committee that work is being undertaken to improve compliance with the requirements. AJT described some of the approaches taken by Directorates to ensure compliance with the screening. **Patient Safety Walk Rounds -** The Committee discussed the Patient Safety Walk rounds. The Committee noted that there were a couple of reports that had not been included in the papers.	The Committee were assured by the clearer determination to reduce variability in care and improve Matron communication. The committee were impressed by the amount of days since the last C-Diff case on each site. The Committee was assured by the information included in the report and the comments made at the meeting.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			AJT informed the Committee that the reports were being finalised and will be included in his report prepared for the next meeting. **Maternity dashboard -** The Committee raised concerns about the Maternity dashboard and what appears to be a lack in midwifery staffing levels. DP assured the group that a skill mix review is taking place in Maternity. PHS advised she would liaise with the Head of Midwifery and update the Committee at the next meeting.		
4	**Patient Safety Strategy**		AJT confirmed with the Committee that the words with in the Patient Safety Strategy have now been finalised. It will be reformatted in to a booklet which will be made available to everyone. The committee discussed who should receive copies, it was agreed that that it would be disseminated to the Governors and should also be made available on the public website. DP assured the group that progress on the strategy will be contained within the Medical Directors Supplementary Report and the Quality and Safety Report every month. It was discussed and agreed by the Committee that a summary report should be produced every 6 months.	The Committee had reviewed the strategy in detail over the last few months and approved of the version being presented to the Committee and confirmed that the Board of Directors would be asked to approve the same version at the July Board meeting.	
5	**Clinical Audit Strategy and Policy**		The Committee welcomed the Clinical Audit Strategy and Policy with interest. It was agreed that the key themes and timescales should be more specific. The Committee raised concerns over how the	The Committee was assured	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			learning is disseminated through the organisation. The Committee discussed the various methods and agreed that a further discussion at the Audit Committee time out would be appropriate prior to the document being approved at the Board of Directors. It was noted that the Audit Committee had a responsibility to ensure clinical audit systems are effective. .	by the comments made and the intention for the Audit Committee to review the documents as part of the time out.	
6	**Supplementary Medical Directors report**		**Antibiotic prescribing -** AJT lead a discussion with the Committee over the Antibiotic Prescribing Audit results. The Committee were impressed by the rise in compliance. **Sign up to safety initiative -** DP updated the Committee on the National 'Sign up to Safety' initiative and introduced the five pledges and the chosen Patient Safety Priorities. She advised that Information will be published on the Trust's website and the national Sign up to Safety website. **Patient Safety Indicators -** The committee discussed the results of the Patient Safety indicators on NHS choices. DP confirmed that all information was submitted but not all was published. AJT advised that the latest Summary Hospital level Mortality Indicator (SHMI) would be published at the end of the month. He would be able to advise the Board of the latest figures at the Board meeting. **Care Quality Commission -** AJT confirmed to the		AJT to update the Board on the SHMI and the Intelligent Monitoring Support Summary

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Committee that the Trust will score a 6 in the CQC Intelligent Monitoring Report Summary.		
7	**DIPC and Q&S Report**		The Committee noted the report. Reference was made to C-diff levels being below trajectory, but higher levels of MSSA. AJT explained that as a result of the level of prescribing of a particular antibiotic resulting from MRSA screening, the strain of MRSA that is now being seen is increasingly resistant to the antibiotic Mupirocin. This is a challenge as it is an important line of defence in the management of the organism. AJT advised that he will be in correspondence with the regional DIPCs on this matter. AJT also commented on hand hygiene, he commented that more work was being undertaken to impress on all staff the need to improve hand washing techniques.	The Committee was assured by the report and noted that it was included in the Board of Directors agenda for approval at the July meeting.	
9	**Supplementary Chief Nurse Report**		PHS advised that the Senior Nurse Review was almost complete. The only post to fill is the Patient Experience Lead role which has been short listed with interviews being held in August. PHS updated the Committee on the Safer Staffing Project. The Trust currently has a high number of vacancies and continues to continuously recruit to Nursing posts. She advised that there will be a large number of newly qualified Nurses starting with the Trust in September, this will mean that the level of vacancies will be reduced significantly PHS explained that additionally resources were being put in place to support the escalation plans,	The committee were assured by the comments made by PHS and the significant attention being given to the recruitment of vacant posts	MP to update the board on Nurse Staffing vacancies

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			this includes to the recruitment of 26 registered nurses and 23 HCAs to staff a winter escalation ward. The Committee discussed where the qualified nursing staff were being sourced from. PHS explained that the Trust has a regular recruitment drive locally using the local recruitment shops, but the Trust also seeks qualified nurses from other areas across the country and Europe.		
10	**Patient Experience Report**		The Committee reviewed the Patient Experience Report and noted the comments in the report. The Committee commented that the introduction of the Patient Experience Lead will influence how the report is produced going forward.	The Report provided the Committee with an overview of the work of the Patient Experience Team.	
11	**Quarterly summary of PIM meetings**		The Committee received the report which provided a summary of the items that had been highlighted at the PIM meetings. DP offered to circulate a copy of the format of the meeting to provide members with more background information.	The Committee were happy to accept this document as assurance that these meetings are taking place.	
12	**Head of Midwifery Annual Report**		The Committee noted the report and the information included. They asked for some further information related to the staffing levels and it was agreed that PHS would seek some clarification from the Head of Midwifery	The Committee were assured by the information included in the report, but was seeking some further clarification.	
13	**Any other business**		AP advised that group that the Quality Governance Framework will be looked at in August. The Committee agreed that this should b opened up to all Non-Executive Directors for comment.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
14	**Other**		The next meeting will be 16th September 13.30 – 15.30 in Room 26, Trust Headquarters		

York Teaching Hospital NHS
NHS Foundation Trust

D1

Patient Safety and Quality Report

July 2014

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

Index

Executive summary

- 20 Serious Incidents (Sis) were declared in June.

- No Never Events were reported.

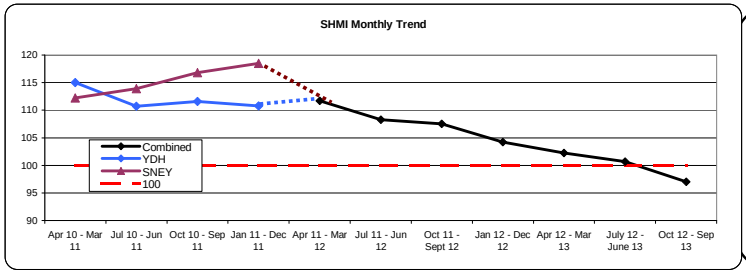
- Patient falls remains the most frequently reported incident category.

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

- Compliance with dementia screening for patients admitted to hospital is below the 90% target.

Patient Safety

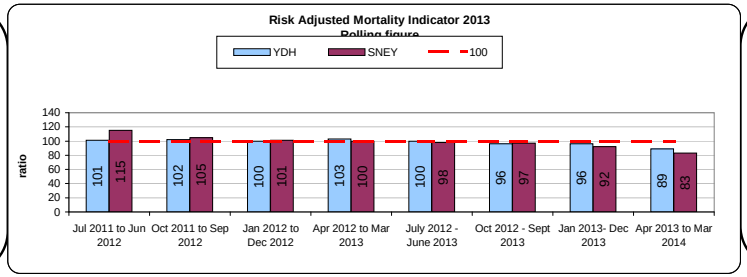
Mortality



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

The SHMI for the period January - December 2014 is due to be reported on 30th July 2014.

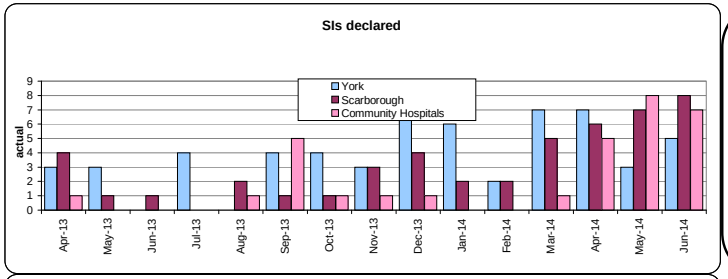
Data source: Information Centre



The Risk Adjusted Mortality Indicator (RAMI) for the reporting period April 2013- March 2014 indicates a reduction for both acute hospital sites.

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

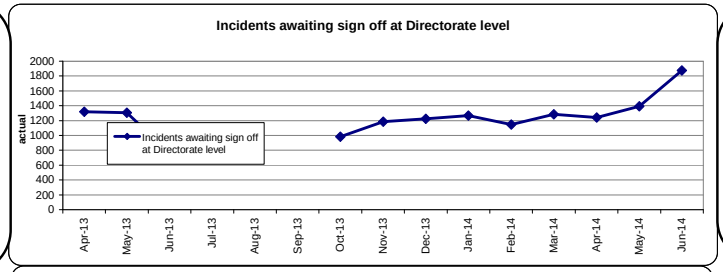
Measures of Harm



There were 20 Serious Incidents (SIs) reported in June.

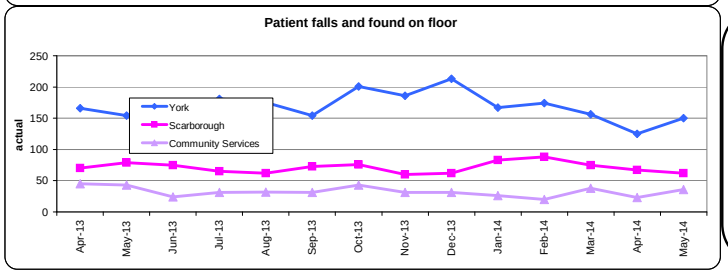
11 of the serious incidents were related to patient falls, one was a category 4 pressure ulcer, six were category 3 pressure ulcers, one due to an error with a medical device and one due to a delayed diagnosis.

Data Source: Datix



At the time of reporting there were 1877 incidents awaiting sign-off by the Directorate Management Teams. Risk and Legal are working with the Directorates to facilitate the completion of incident investigations.

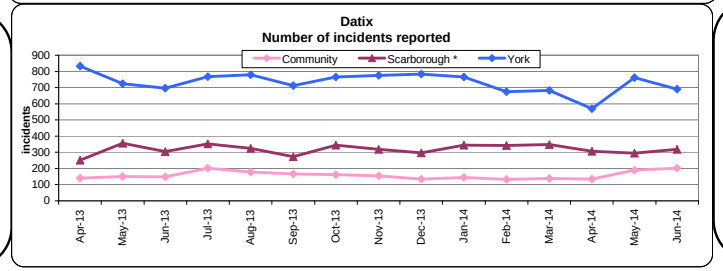
Data Source: Datix



Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. 150 patients fell and were found on the floor at the York site, 62 patients at Scarborough and 36 patients within the Community Hospitals in May.

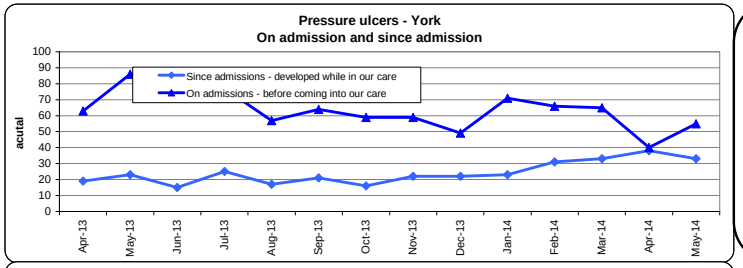
The figures may increase as more investigations are completed.

Data Source: Datix



The total number of incidents reported in the Trust during June was 1210. 691 incidents were reported on the York site, 318 on the Scarborough site and 201 from Community Care/Hospitals.

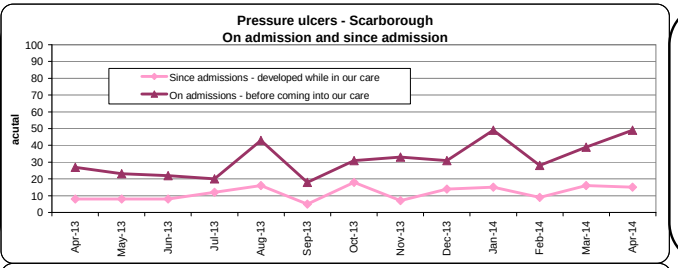
Data Source: Datix



During May a total of 55 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.

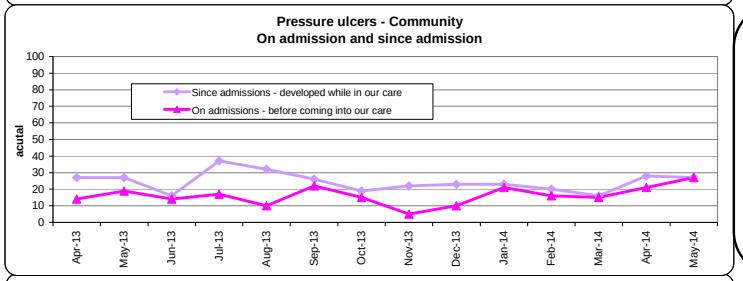
Data Source: Datix



During May a total of 15 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.

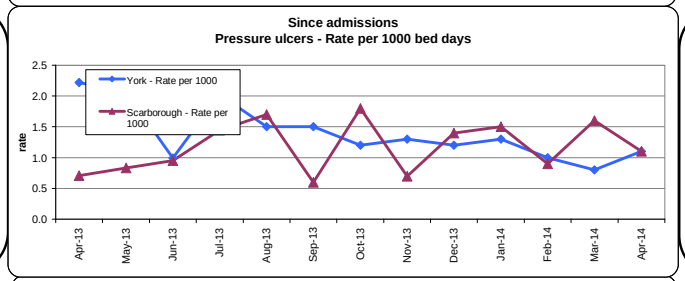
Data Source: Datix



During May a total of 27 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.

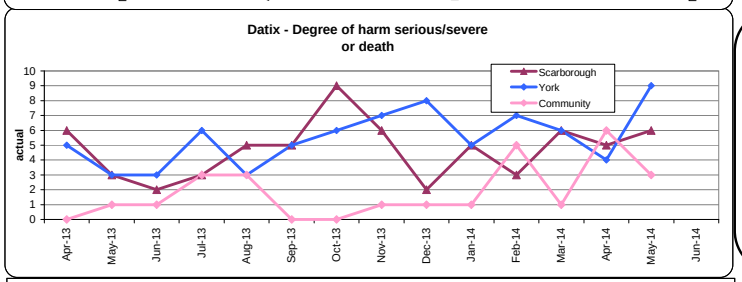
Data Source: Datix



The rate of pressure ulcer development In April in York Hospital in was 1.1/1000 bed days.

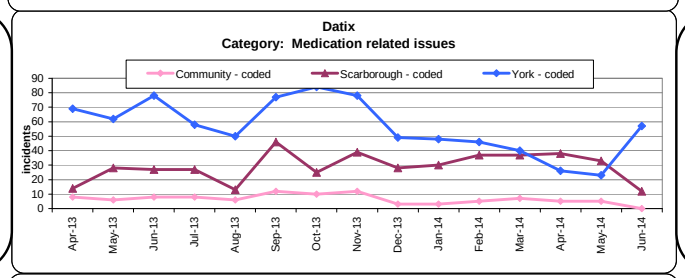
The rate of pressure ulcer development in Scarborough Hospital in April was 1.1/1000 bed days.

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



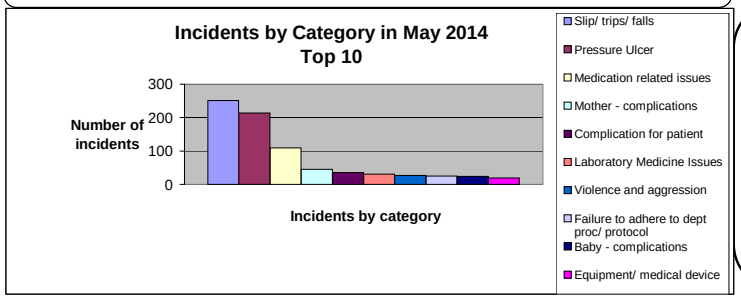
During May a total of 18 patient incidents were reported which resulted in serious or severe harm or death.

Data Source: Datix



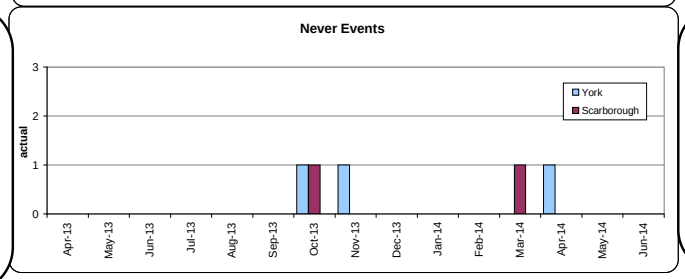
During June there was a total of 69 medication related incidents reported, although this figure may change following validation.

Data Source: Datix



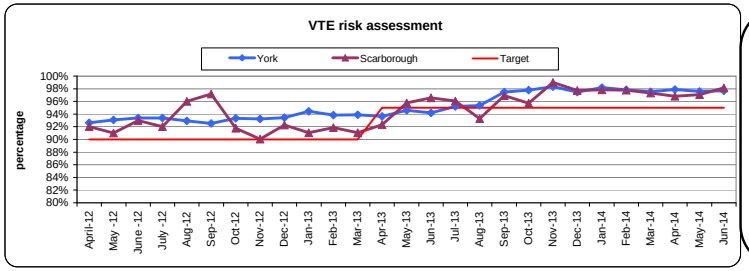
Incidents releting to slips, trips and falls remains the largest category of reported incidents, with pressure ulcers the second largest category.

Data Source: Datix



There were no Never Events declared in June.

Data Source: Datix



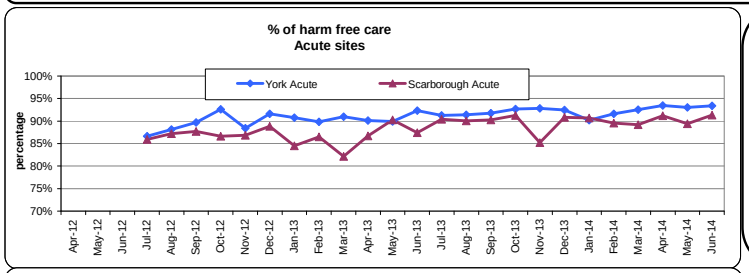
The target of 95% of patients receiving a VTE risk assessment has been maintained on both sites during June.

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

Data Source: Systems & Network Services

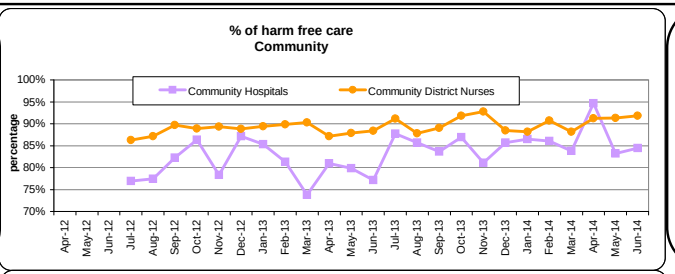
Safety Thermometer

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.



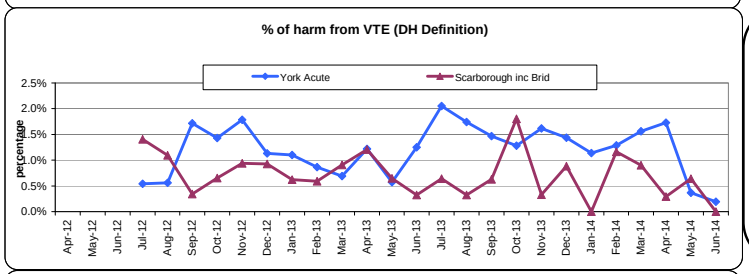
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In June 93.4% of patients at York and 91.3% at Scarborough were audited as care 'free from harm' on the acute hospital sites.

Data source: Safety Thermometer



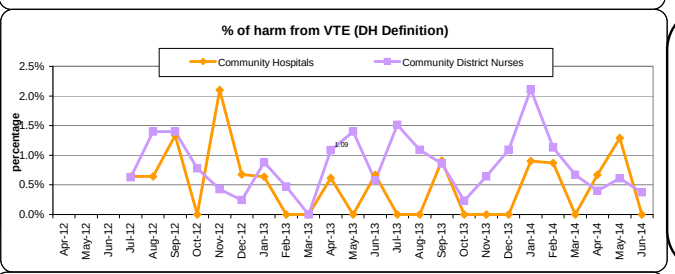
The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In June 84.4% of patients in our community hospitals and 91.8% of patients in our care in the community received care 'free from harm'.

Data source: Safety Thermometer



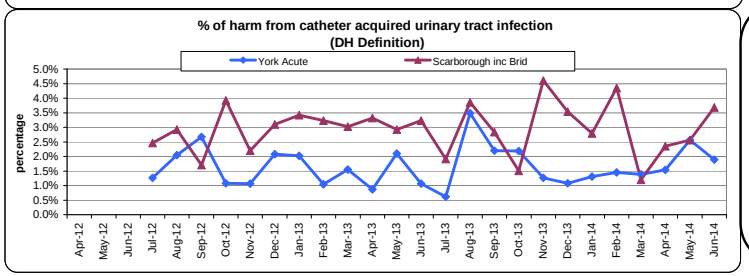
The percentage of patients affected by VTE as measured by the Department of Health (DH) definition, monthly measurement of prevalence, was 0.19% in York and 0 in Scarborough acute hospitals in June.

Data source: Safety Thermometer



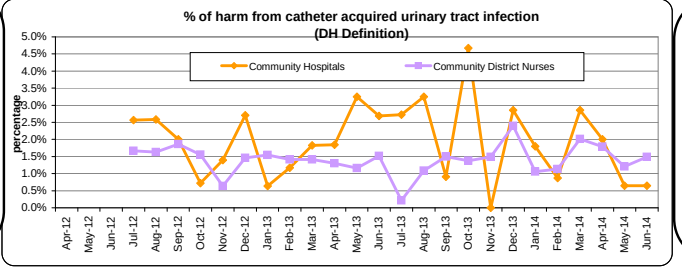
The percentage of patients affected by VTE as measured by the DH definition, monthly measurement of prevalence was 0.37% in community hospitals and 0 in community care in June.

Data source: Safety Thermometer



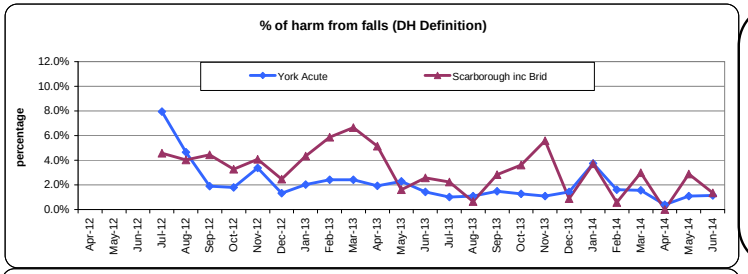
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 1.89% in York and 3.68% in Scarborough acute hospitals in June.

Data source: Safety Thermometer



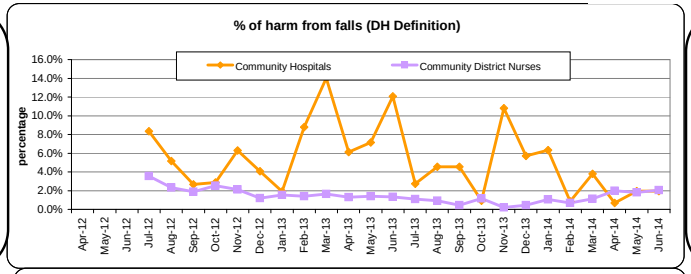
The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence, was 0.65% in community hospitals and 1.49% in community care in June.

Data source: Safety Thermometer



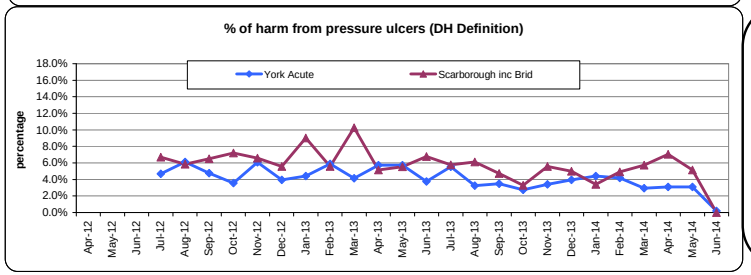
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 1.14% for York and 1.34%for Scarborough acute hospitals in June.

Data source: Safety Thermometer



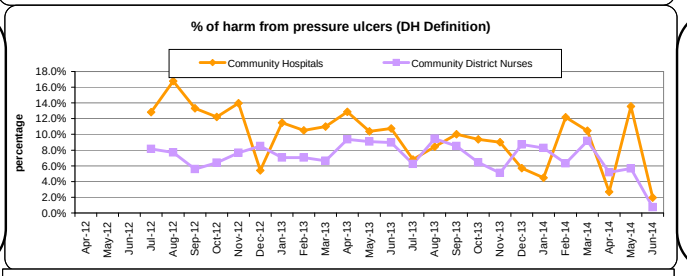
The percentage of patients affected by falls as measured by the Department of Health data definition monthly measurement of prevalence was 2% in community hospitals and 2.05% in community care in June.

Data source: Safety Thermometer



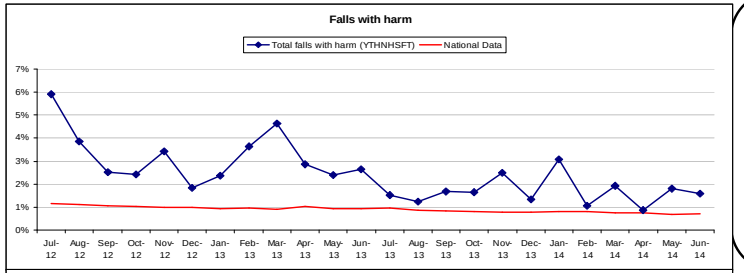
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 0.19% for York and 0 for Scarborough acute hospitals in June.

Data source: Safety Thermometer



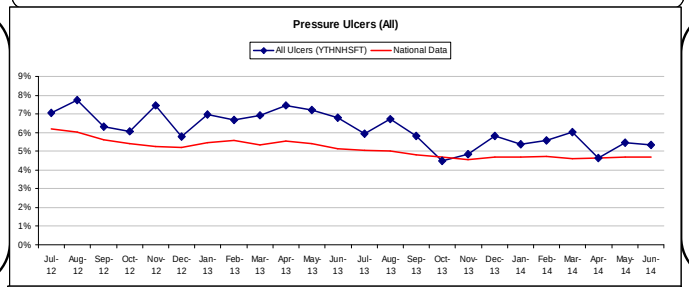
The percentage of patients affected by pressure ulcers as measured by the Department of Health data definition monthly measurement of prevalence was 1.95% in community hospitals and 0.75% in community care in June.

Data source: Safety Thermometer



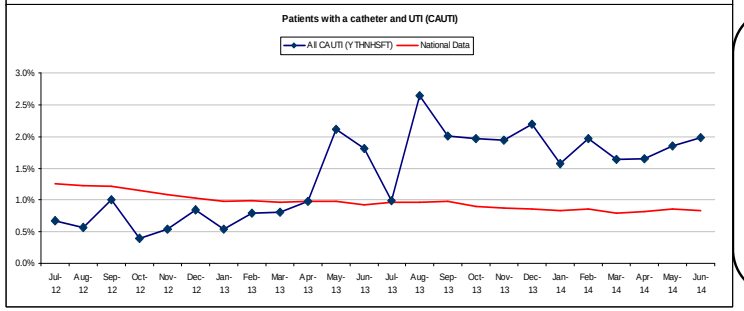
The Trust wide total number of falls with harm as measured for the Safety Thermometer, remains above the national average.

Data source: Safety Thermometer



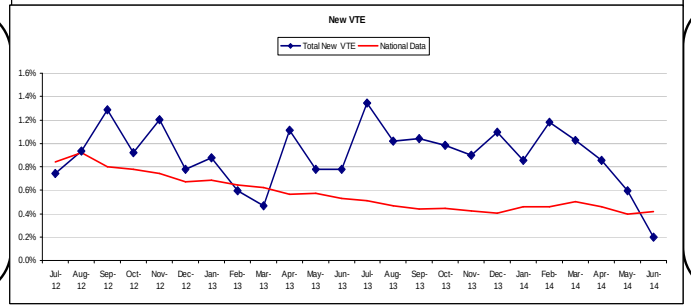
The Trust wide total number of pressure ulcers as measured for the Safety Thermometer remains above the national average.

Data source: Safety Thermometer



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

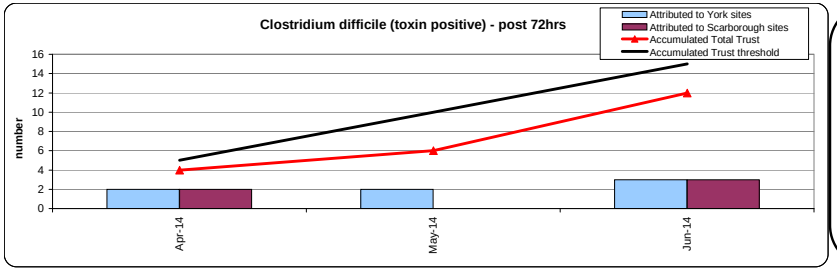
Data source: Safety Thermometer



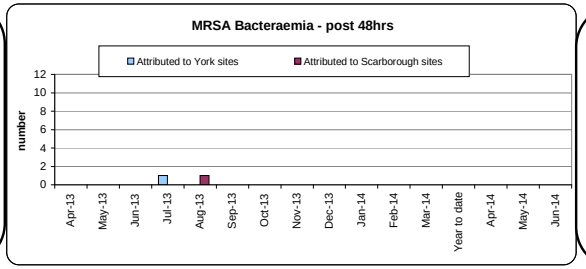
The Trust wide total number of patients with a new VTE as measured for the Safety Thermometer is now reported as significantly below the national average.

Data source: Safety Thermometer

Infection Control

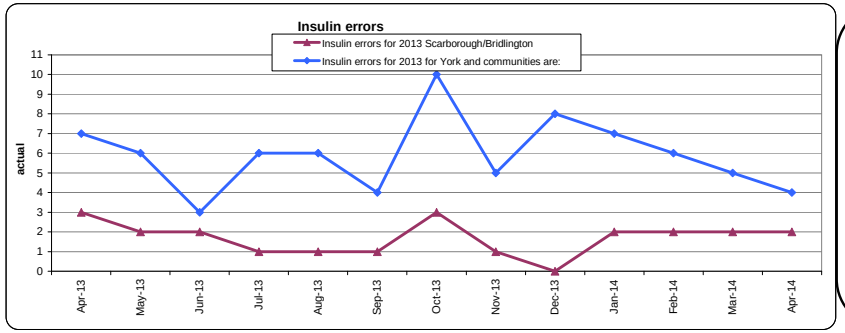


Six cases of c. diff were identifed in the Trust during June. The Trust remains below trajectory at the end of June, with a total of 12 cases identified sine 1st April 2014.



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

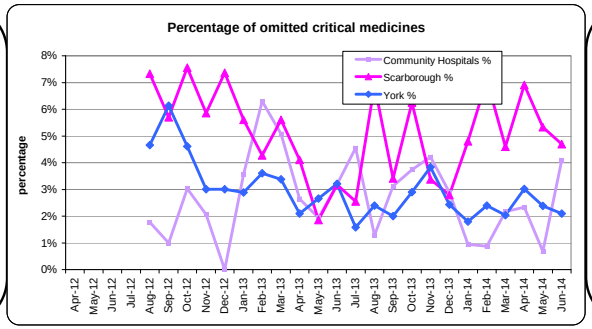
Drug Administration



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

The data for is awaiting validation.

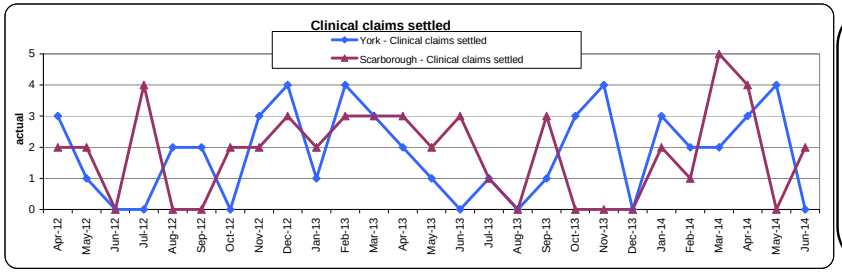
Data Source: Datix



The audit of critical medicines missed during June indicated 4.7% for Scarborough, 2.1% for York and 4.1% for Community Hospitals.

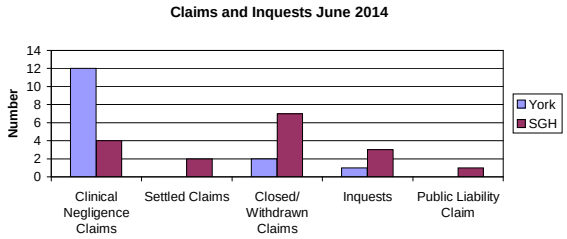
Data Source: Safety Thermometer

Litigation



In total, two clinical claims were settled in June, which were both attributed to the Scarborough site.

Data Source: Risk and Legal Services



In June, 12 clinical negligence claims for York site were received and four were received for Scarborough. Two claims from Scarborough were settled, whereas no claims from York were settled.

York had two withdrawn/ closed claims and there were seven from Scarborough.

The were four Coroner's Inquests and one Public/ Employment Liability Claim
Data Source: Risk and Legal

Patient Safety Walkrounds

Date	Location	Participants	Actions & Recommendations
Wednesday 4th June 2014	Orthopaedic Theatres & OPD (York Hospital)	Sue Rushbrook – Director Dr P Campbell – CD Paul Rafferty – DM Liz Charters – Matron Mike Sweet – NED	**Awaiting report**
Tuesday 10th June 2014	ED & UCC (York Hospital)	Dr Turnbull – Director Dr Williams – CD Wendy Quinn – DM Lee Fry – Matron Jill Wilford – Matron Jennie Adams – NED	**Awaiting report**
Thursday 12th June 2014	Diabetes Centre (York Hospital)	Dr Nigel Durham, Clinical Director Jordan McKie, Directorate Manager Sue Rushbrook, Systems & Network Director Kirsty Burlinson, Deputy Directorate Manager Chris Morris, Matron Tara Kadis, Diabetes Specialist Nurse Team Leader Tricia Fairburn, Diabetes Specialist Nurse	• Discussion regarding reduction of length of stay, ascertained that the fast paced nature of the unit is not always good for Diabetes patients, can cause problems when trying to turn things around quickly. • Discussed incident regarding patient with prolonged stay. Patient on AMU (hypoglycaemic) was put on a sliding scale, transferred to another ward and no one identified the need for the scale upon transfer. Patent did not receive treatment. Felt communication breakdown between AMU and SSW and not Diabetes. • Within last 6 months, stat and mandatory training has made a big difference as patients are being identified on wards and appropriate referrals now being made to Diabetes Inpatient Nursing Team. Nurse education and knowledge has improved. Minimum of 4 tests per day and increased monitoring. Electronic flag and track now in place to enable easy identification of patients who require diabetes management. • Concerns raised regarding the number of patients being admitted from GP via Bed Management Team. Patients could be sign-posted to Diabetes Centre as an outpatient rather than being admitted. Structured work to be done with bed managers. • Ongoing concerns regarding the induction of junior doctors and lack of diabetes knowledge e.g. inappropriate prescribing for Diabetes patients. • Electronic Flag – filters for hypo and hyperglycaemia. **Action:** To reiterate to doctors and ensure they know how to do this. • Prescribing errors – junior medical staff. Errors on EDN re non-insulin and insulin dependant patients. **Action:** Online training being developed. To reiterate at induction and ensure recording on AIRS form. Non-insulin and Insulin dependant to be changed to Type 1 and Type 2. • Direct GP Admissions. **Action:** GP to phone Diabetes directly from September 2014. Bed Management Team to redirect patients to Diabetes. Matron to pick up. • Cross cover for Specialist Nurses. **Action:** Role profiles of nurses to be revisited with view to initiating cross cover of IP and OP teams.
Tuesday 17th June 2014	Cherry Ward (Scarborough Hospital)	Mike Proctor – Director Dr Ed Smith – CD Joanne Southwell – Deputy Director of Operations Tracey Wright – Matron Bridget Gledhill – Ward Sister	• CPD not always reliable (no printers working that morning) • No private space for staff to discuss patients • Bed pressures can lead to some degree of chaos and patient environment then becomes less safe. It was agreed to implement the recommendations from perfect week. • Lack of Privacy which is an information governance issue. Yellow bay backs onto the doctor's handover room, and can cause disturbance to patients. **Action:** Facilities Management to investigate soundproofing of the connecting door. • Patient mix, particular problems related to detox patients and patients absconding or going missing. **Action:** Ensure staffing numbers are appropriate each shift to monitor patients and maintain compliance with absconding patient's policy.
Thursday 19th June 2014	Fracture Clinic & Holly (Scarborough Hospital)	Diane Palmer – Deputy Director Paul Rafferty – DM Liz Charters – Matron Jennie Adams – NED	• The environment in the fracture clinic is poor, access to the disabled toilet is difficult and there is no space for wheelchairs in the waiting room. **Action:** Matron to discuss with Estates.
			• Boxes of dressings, etc are stored on the treatment room trolleys. **Action:** Matron to purchase a storage system. • Cleaning schedule has been requested. • There are two desks in one consulting room and at times both desks are being used while there is a patient in the room. **Action:** Directorate Management Team to consider where additional desk / work station can be placed. • Incident reported by a junior doctor (although not reported on Datix) that plaster wasn't applied properly in ED – The Junior doctor was advised of the need to report incidents on Datix. This particular incident has been rectified, although a training need in ED may have been identified. **Action:** Deputy Director of Patient Safety. • Datix log-out is too quick. **Action:** Deputy Director of Patient Safety to discuss if log-out can be lengthened. • When the patient's weight is estimated there is no place to record that it is estimated on the nursing assessment. **Action:** Deputy Director of Patient Safety to discuss if estimate can be indicated on the record. • The nursing establishment is under review, but there is a concern that there will not be flexibility **Action:** To await the outcome of the review.
Wednesday 25th June 2014	AMU & SSW (York Hospital)	Diane Palmer – Deputy Director Dr N Durham – CD Jordan McKie - DM / Kirsty Burlinson – DDM Lee Fry - Matron	• If the frailty unit is closed, there is no control over the number of patients arriving from GP's. **Action**: for Directorate Management Team, there is a plan to have ambulatory patients in an arrivals bay. • There is piped air which looks similar to the oxygen floor meter. **Action:** for Ward Team - ensure that the flow meters are not handled by people who are not regular ward staff (eg ambulance personnel). • On both AMU and SSW there is a lengthy wait for a mental health review, often waiting for 16hrs until the patient has finished treatment. **Action:** To be monitored by the Directorate Management Team. • Each bed space has only one socket, despite the regular requirement for medical equipment which relies on electricity. **Action:** Directorate Management Team to discuss with Estates Dept. • There is a significant delay in obtaining ultra-low profile beds. **Action:** Patient Safety to discuss with the Medical Equipment Team. • There are not enough computers on Ward 21. **Action:** Directorate Management Team to discuss with Systems and Networks.
			• There are significant gaps at the Registrar level. **Action:** for Clinical Director - Consider innovative ways to recruit, perhaps not relying solely on doctors in training.

Community Hospital Dashboards

09/07/2014 updated data

York Teaching Hospital NHS
NHS Foundation Trust

Malton Community Hospital & South Ryedale Locality
Patient Safety Dashboard – DATE 17th July 2014

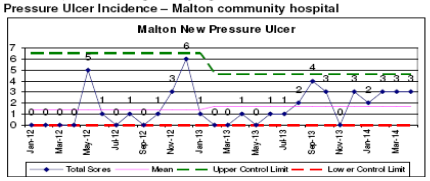
Malton Community Hospital Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of incidents reported on - Datix web	11	32	15									
Number of medication related incidents	0	1*	1**									
Number of settled clinical litigation cases	0											
Number of formal complaints	0											
Number of Serious Incidents (SI's)												
Number of Critical Incidents (CI's)												

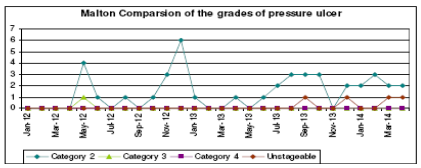
*Insulin ordered 2 days previously from SGH – not arrived resulting in patient missing dose
**Lunchtime Insulin missed

Locality South Ryedale Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of incidents reported on - Datix web	12	7	6									
Number of medication related incidents	1*	0	1**									
Number of settled clinical litigation cases												
Number of formal complaints												
Number of Serious Incidents (SI's)												
Number of Critical Incidents (CI's)												

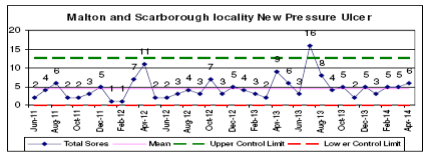
* Double dose of Insulin given
** Drew up incorrect drugs into syringe – realised mistake before administering to patient

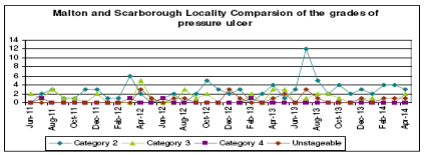
Pressure Ulcer Incidence – Malton community hospital



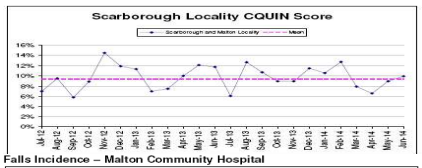


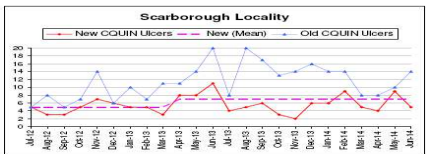
Pressure Ulcer Incidence - Locality South Ryedale



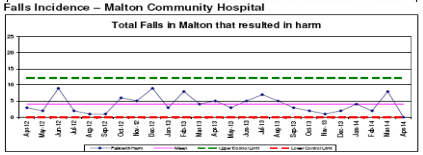


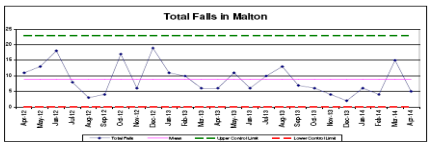
Pressure Ulcer Prevalence – Scarborough and Malton Locality (CQUIN)

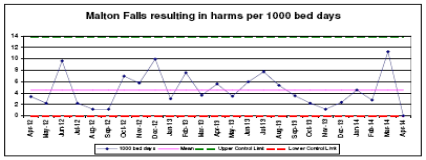




Falls Incidence – Malton Community Hospital







Target of 20 % reduction in falls over 13/14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Mean falls with harm per 1000 bed days (Trajectory <4.28 per month) **Malton**	0											

Malton Community Hospital Deaths & Mortality reviews	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of in-hospital deaths	4%	7%	22%									
Number of morality reviews	1	3 *	3**									

*2 Signal ** 9 Signal

Malton Community Hospital Activity	Apr 14		May 14		Jun 14		Jul 14		Aug 14		Sept 14		Oct 14		Nov 14		Dec 14		Jan 15		Feb 15		Mar15	
	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	8	20	27	4	34	0																		
Discharges	9	18	21	7	41	0																		
length of hosp stay – mean *previous yr*	29	45	28	37	24	0																		
DToC																								

IPC	Apr 14		May 14		Jun 14		Jul 14		Aug 14		Sept 14		Oct 14		Nov 14		Dec 14		Jan 15		Feb 15		Mar15	
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	-	-	-																		
% compliance with glove use	100	100	100	-	-	-																		
% compliance with bare below the elbow	100	100	100	-	-	-																		
CDIFF >72hrs (Acc year to date)																								

Harm Free Care - Safety Thermometer Prevalence data	Apr 14		May 14		Jun 14		Jul 14		Aug 14		Sept 14		Oct 14		Nov 14		Dec 14		Jan 15		Feb 15		Mar15	
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
Overall Ward Harm Free	67%	100 %	80%	100 %	86%	-	95%	-																
VTE *(% of patients with a VTE)*	0%	0%	10%(new)	7% (old other)	0	-	0	-																
Falls *(% of patients who fell)*	1 L/H 11%	1 N/H 7%	10% LH	7% NH	4% LH 4% NH	-	5% NH	-																
Pressure Ulcers *(% of patients with a **new** PU- CQUIN)*	1 Cat 2 (11%)	0%	10% (cat 2)	0%	7% (cat2)	-	0%	-																
Pressure Ulcers *(% of patients with an **old** PU - CQUIN)*	0%	7% (cat2)	10% (cat2)	14% (cat2)	11% (cat2) 4% (cat 3)	-	0%	-																
UTI *(% of patients)*	33% new	0%	10% new	7% New	11% old 14% new	-	25% new	-																
Local Measures																								
Empty Admin Boxes	0%	14%	80%	14%	18%	-	0%	-																
Omission code 4	4%	7%	30%	14%	7%	-	0%	-																
Omitted Critical Medicines	0%	0%	10%	7% N/A	0%	-	5%	-																

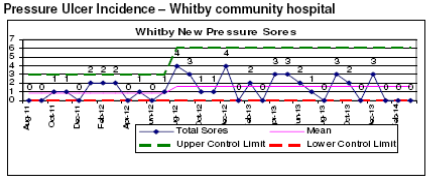
* No Data on Signal

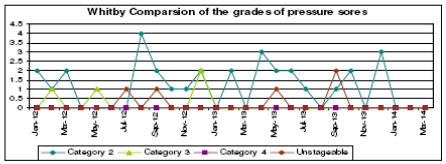
Whitby Community Hospital & Locality
Patient Safety Dashboard – DATE

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

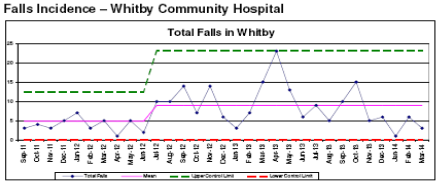
Locality Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of incidents reported on - Datix web												
Number of medication related incidents												
Number of settled clinical litigation cases												
Number of formal complaints												
Number of Serious Incidents (SI's)												
Number of Critical Incidents (CI's)												

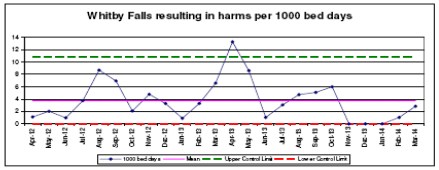
Pressure Ulcer Incidence – Whitby community hospital





Falls Incidence – Whitby Community Hospital





Target of 20 % reduction in falls over 13/14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Mean falls with harm per 1000 bed days (Trajectory <4.28 per month) **Whitby**												

Whitby Community Hospital Deaths & Mortality reviews	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of in-hospital deaths												
Number of morality reviews												

Activity	Apr 14		May 14		Jun 14		Jul 14		Aug 14		Sept 14		Oct 14		Nov 14		Dec 14		Jan 15		Feb 15		Mar15	
	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	17	24																						
Discharges	15	20																						
Mean Length of stay *previous yr	50 (21)	27 (21)																						

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																						
% compliance with glove use	100	100																						
% compliance with bare below the elbow	100	100																						
CDIFF >72hrs *(accumulative Whitby year to date)*																								

Harm Free Care - Safety Thermometer Prevalence data	Apr 14		May 14		Jun 14		Jul 14		Aug 14		Sept 14		Oct 14		Nov 14		Dec 14		Jan 15		Feb 15	
	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%																				
VTE *(% of patients with a VTE)*	1 New (7%)	0%																				
Falls *(% of patients who fell)*	1 n/h (7%)	0%																				
Pressure Ulcers *(% of patients with a new PU- COUIN)*	0%	0%																				
Pressure Ulcers *(% of patients with an old PU - COUIN)*	0%	0%																				
UTI *(ward harms) (% of patients)*	0%	12% (1 old &1new)																				

S T– Local measures	Apr 14		May 14		Jun 14		Jul 14		Aug 14		Sept 14		Oct 14		Nov 14		Dec 14		Jan 15		Feb 15		Mar15	
	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM	Abb	WM
Empty Admin Boxes (% missed doses)	20	17																						
Omission code 4 (% drug not available)	0%	22%																						
% Omitted Critical Medicines	0%	0%																						

ST MONICA'S Community Hospital and York North Locality
Patient Safety Dashboard – 10th July 2014

York Teaching Hospital NHS
NHS Foundation Trust

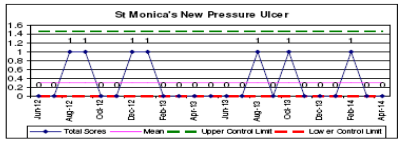
St Monica's - Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of incidents reported on - Datix web	3	5	4									
Number of medication related incidents	0	1*	0									
Number of settled clinical litigation cases	0	0	0									
Number of formal complaints	0	0	0									
Number of Serious Incidents (SI's)	0	1**	0***									
Number of Critical Incidents (CI's)	0	0	0									

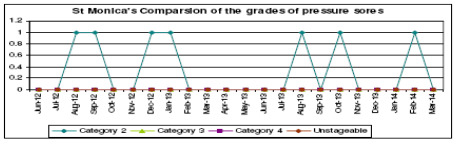
*Administration of medication set at2mm gave 15mm in 4 hrs (near miss) Syringe driver **fall resulting in fracture ***dosage level of Morphine prescribed by OOH

York North DN – Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of incidents reported on - Datix web	8	12	5									
Number of medication related incidents	0	2*	**1									
Number of settled clinical litigation cases	0	0	0									
Number of formal complaints	0	0	0									
Number of Serious Incidents (SI's)	0	0	0									
Number of Critical Incidents (CI's)	0	0	0									

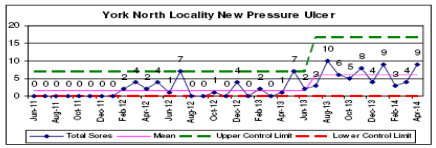
*1 –t intima cannula left insitu no policy/procedure by york, **1 Lost urgent blood request from Heworth/Hospital/Patholgy labs

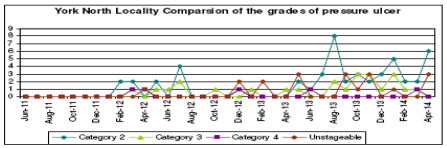
Pressure Ulcers Incidence - St Monica's Community Hospital



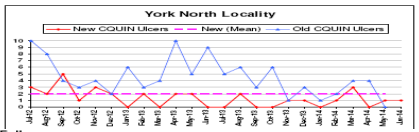


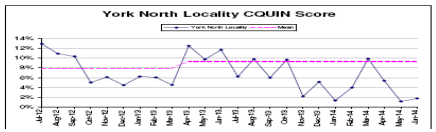
Pressure Ulcers Incidence - York North DN Teams



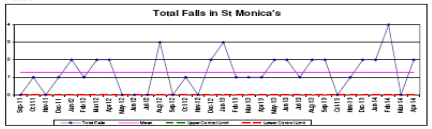


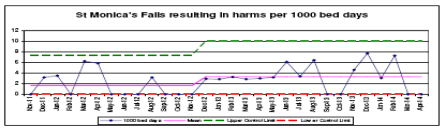
Pressure Ulcer prevalence St Monica's, North Ryedale and North York Community Services (CQUIN)





Falls





St Monica's Falls	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Mean falls with harm per 1000 bed days	0											

St Monica's -Activity	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Admissions	19	17	9									
Discharges	18	17	9									
Length of hospital stay – mean *(previous yr)*	33 (25)	14(13.1)	28 (20)									

St Monica's - Deaths & Mortality reviews	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of in-hospital deaths (%)	11%	23.5	22									
Number of morality reviews	2 *(0)	4* (0)	2*(0)									

St Monica's IPC compliance	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
% compliance with hand hygiene	100%	-	100%									
% compliance with glove use	100%	-	100%									
% compliance with bare below the elbow	100%	-	100%									
CDIFF >72hrs (accumulative Whitby year to date)												

York North Community IPC compliance	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
% compliance with hand hygiene	100	92	-									
% compliance with glove use	100	100	-									
% compliance with bare below the elbow	100	92	-									

St Monica's Safety Thermometer Prevalence data	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
VTE *(% of patients with a VTE)*	0%	0%	0%									
Falls *(% of patients who fell)*	0%	0%	8% (Low) 8% (no									
Pressure Ulcers *(% of patients with a new PU)*	0%	0%	8% (1 Cat 2)									
Pressure Ulcers *(% of patients with an old PU)*	0%	0%	8% (1 Cat 2)									
UTI *(% of patients)*	1 new (8%)	0	0									
Empty Admin Boxes	8% 8% N/A	27%	8%									
Omission code 4	25%	0	25%									
Omitted Critical Medicines	17%	0	0									

York North Community Teams Safety Thermometer Prevalence data	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
VTE *(% of patients with a VTE)*	0%	4% Old PE	1% Old PE									
Falls *(% of patients who fell)*	0%	1% no harm	1% Low Harm									
Pressure Ulcers *(% of patients with a new PU)*	0%	1%(Cat 2)	0%									
Pressure Ulcers *(% of patients with an old PU)*	5% (cat 2)	0%	1% (U)									
UTI *(% of patients)*	0%	1% new UTI	1% (old UTI)									

Hospital	Ward		May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
St Monica's Easingwold	St Monica's	Response rate	44.44%										
		Eligible	9										
		Responses	4										

No RCA's taken place since the last meeting.

SELBY Community Hospital & Selby Locality
Patient Safety Dashboard –

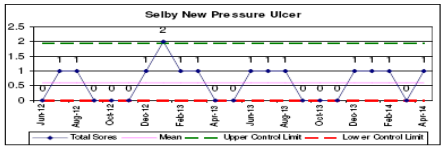
Selby community hospital Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of incidents reported on - Datix web	7	17	25									
Number of medication related incidents	0	0	2*/**									
Number of settled clinical litigation cases	0											
Number of formal complaints	0											
Number of Serious Incidents (SI's)	1*											
Number of Critical Incidents (CI's)	0											

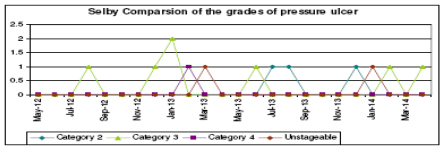
*dose of med given in error after discontinued by GP
** Due to manufacturing difference dose of Butran's Patch incorrect

York South DN Teams Datix Incident Reporting	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of incidents reported on - Datix web	14	10	12									
Number of medication related incidents	1**	0	0									
Number of settled clinical litigation cases	0											
Number of formal complaints	0											
Number of Serious Incidents (SI's)	1*											
Number of Critical Incidents (CI's)	0											

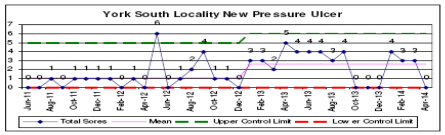
*Community patient with a category 3 pressure ulcer
**patient given duplicate does of insulin

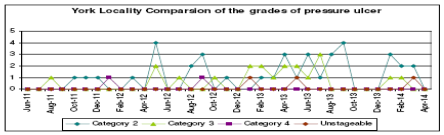
Pressure Ulcer Incidence - Selby community hospital



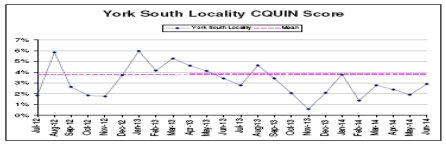


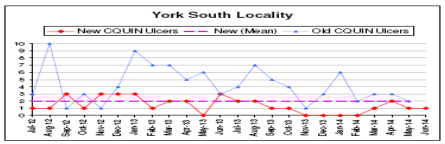
Pressure Ulcer Incidence – York South Locality DN Teams



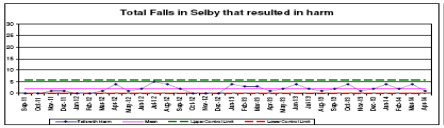


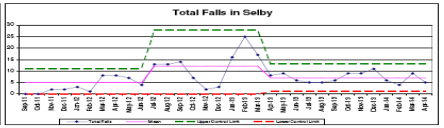
Pressure Ulcer Prevalence Safety Thermometer data - Selby Locality (CQUIN)

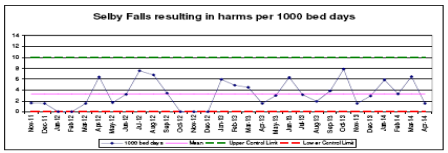




Falls Incidence – Selby community hospital







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

Selby Community hospital Deaths & Mortality reviews	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Number of in-hospital deaths	4 (7%)	2 (4%)										
Number of morality reviews	4	0										

*(nil report on mortality review 25.06.14)

Selby community hospital IPC	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
% compliance with hand hygiene	100	100	100									
% compliance with glove use	100	100	100									
% compliance with bare below the elbow	100	100	100									
CDIFF >72hrs	0	0	0									

South York IPC	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
% compliance with hand hygiene	100	96	100									
% compliance with glove use	100	96	100									
% compliance with bare below the elbow	100	100	100									

Selby Safety Thermometer Prevalence data	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Overall Harm free care %	*100%*	*95 %*	*95%*	*95%*								
VTE *(% of patients with a VTE)*	0	0	0	0								
Falls *(% of patients who fell)*	0%	5% (1 no harm)	10% (1 no harm, 1 low harm)	9% no harm								
Pressure Ulcers *(% of pt's with new PU- CQUIN)*	0%	5% cat 2	0%	5% cat 3								
Pressure Ulcers *(% of pt's with old PU- CQUIN)*	0%	5%cat 2 5% cat3	14% cat3 5%cat2	9% cat3 5% cat2								
CaUTI *(% of patients)*	9% (2 old UTI)	19% (1 new, 3 old)	19% (4 new)	5% old 9% new								
Local measures												
Empty Admin Boxes	5%	9%	14% 5% no chart	14%								
Omission code 4	0%	5% N/A	6%	23%								
Omitted Critical Medicines	5% 23% N/A	0%	6% 29%N/A	14%								

York South DN Teams Safety Thermometer Prevalence data	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Overall Harm free care %	*100%*	*100%*	*97.3%*	*100%*								
VTE *(% of patients with a VTE)*	0%	4% old PE	1%new 2% Old	1%new 3% Old								
Falls *(% of patients who fell)*	2% (low)	4% (low)	3% (low)	0%								
Pressure Ulcers *(% of pt's with new PU - CQUINS)*	2% Cat2	0%	1% cat2	0%								
Pressure Ulcers *(% of pt's with old PU - CQUINS)*	2% cat 2	0%	1% cat 2	0%								
CaUTI *(% of patients)*	9%	1% (new UTI)	1% (old UTI)	3% new 1%old								

Risk Register

Top 3 Risks on Risk Register	
1	Lack of bookable care for fast track packages
2	Community equipment
3	Night staffing at WXC & St Helens hospitals

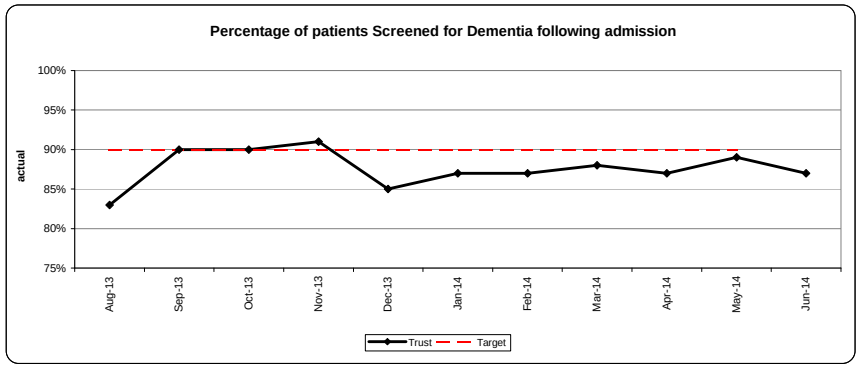
Dementia

Percentage of Patients Meeting the AMTS Screening Target (Trust)												
Indicator	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Percentage of Patients Meeting the AMTS Screening Target	54%	83%	90%	90%	91%	85%	87%	87%	88%	87%	89%	87%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Patients Meeting the AMTS Screening Target (York)												
Indicator	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Percentage of Patients Meeting the AMTS Screening Target	93%	91%	92%	96%	93%	88%	91%	94%	95%	93%	92%	90%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Percentage of Patients Meeting the AMTS Screening Target (Scarborough)												
Indicator	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Percentage of Patients Meeting the AMTS Screening Target	8%	76%	90%	85%	93%	83%	85%	80%	80%	79%	87%	86%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

During June only 87% of patients admitted to the Trust were screened for dementia.

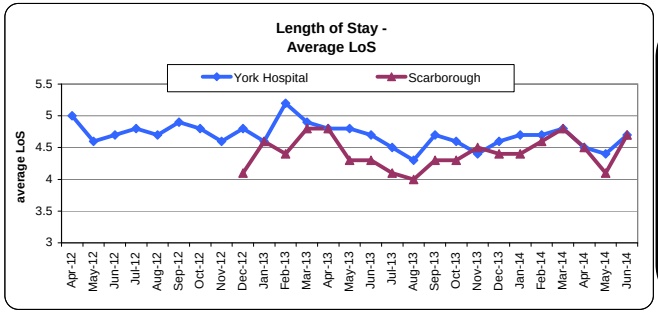
Scarborough Hospital continues to fail to achieve the 90% compliance rate for dementia screening.

Data source: Signal



Clinical Effectiveness Dashboard

Clinical Effectiveness



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

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: Jul 2013 to May 2014 Peer time period: Jul 2013 to May 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.	95.8	95.9	153,831	160,644	95.2	96.8	95.7	7,024,401	7,337,227	Amber
% FCEs with palliative care code	Current period is 8% better than previous period.	0.69%	0.75%	1,106	159,474	1.02%	0.60%	0.79%	57,159	7,252,484	Amber
% Deaths with Palliative care code	Current period is 6% better than previous period.	14.94%	15.98%	270	1,807	25.45%	15.08%	20.49%	15,654	76,400	Green
% Sign or symptom as a primary diagnosis	Current period is 4% better than previous period.	10.87%	11.28%	17,333	159,474	12.10%	8.94%	10.15%	736,161	7,252,484	Amber
Complication Rate Attributed	Current period is 11% better than previous period.	0.69%	0.77%	853	124,405	0.91%	0.60%	0.82%	50,634	6,152,961	Amber
Misadventure rate	Current period is 13% better than previous period.	0.05%	0.06%	63	124,405	0.12%	0.06%	0.09%	5,785	6,152,961	Green
Outpatient DNA Rate	Current period is 17% better than previous period.	5.50%	6.60%	30,568	558,528	9.30%	7.20%	8.50%	1,097,697	12,904,509	Green
Readmissions 7 days	Current period is 6% better than previous period.	2.90%	3.10%	3,671	127,887	3.50%	2.60%	3.00%	189,445	6,269,687	Amber
Readmissions 30 Days	Current period is 12% better than previous period.	6.10%	6.90%	7,558	124,405	7.40%	5.50%	6.30%	389,496	6,152,961	Amber
Mortality	Current period is 11% better than previous period.	1.41%	1.59%	1,756	124,405	1.47%	1.14%	1.23%	75,890	6,152,961	Amber
Infection rate following caesarean section	Current period is 22% better than previous period.	0.29%	0.37%	3	1,052	0.46%	0.11%	0.32%	197	61,272	Amber
Rates of deaths in hospital within 30 days of Non-elective surgery	Current period is 0% worse than previous period.	1.70%	1.70%	143	8,173	1.90%	1.10%	1.50%	6,244	420,639	Amber
Rates of deaths in hospital within 30 days of Elective surgery	Current period is 2% better than previous period.	0.02%	0.02%	5	25,577	0.04%	0.02%	0.03%	407	1,307,034	Amber
Discharge to usual place of residence within 28 days of emergency admission from there with a hip fracture	Current period is 7% better than previous period.	54.40%	51.00%	306	562	41.10%	55.40%	48.40%	10,769	22,269	Amber

NICE and NCEPOD

Guidance	Site	Compliant with evidence	Compliant without evidence	Partially compliant			Not compliant		Pending	Total guidance
				With action plan	No action plan required as agreed by CSG	No action plan	No action plan	With action plan		
Clinical Guidelines	Y	27	26	39	9	3	0	0	19	**123**
	S	21	14	7	2	9	0	0	61	**114***
Non-drug Technology Appraisal	Y	3	10	0	2	0	0	0	2	**17**
	S	2	5	0	0	0	0	0	8	**15****
Quality Standards	Y	4	3	10	2	1	0	0	31	**51**
	S	4	3	3	0	3	0	0	37	**50*****
Cancer Guidelines	Y	4	0	2	3	0	0	0	0	**9**
	S	1	0	0	7	0	0	0	1	**9**

Site	Number of Do Not Do's					
	Compliant	Non Compliant	CSC Agreed to remain non compliant	Not Applicable	Pending	Total
Y	632	11	3	22	132	800
S	321	17	0	59	403	800

Guidance	Site	Performed	Pending	Total
Medical Technologies	Y	4	4	**8**
	S	1	7	**8**
Diagnostic Guidance	Y	2	2	**4**
	S	1	3	**4**
Interventional Procedures	Y	53	15	**68**
	S	10	24	**34**

No.	Title	Site	Compliant		Partially compliant				Not compliant				Pending
			With evidence	Without evidence	With action plan	Action Plan end date MM/YY	No action plan required as agreed by CSG	No action plan	No action plan	No action plan required as agreed by CSG	With action plan	Action Plan end date MM/YY	
NCEPOD 001	Acute kidney Injury (Adding insult to Injury)	Y	0	12	1	***10/15***	1	0	0	0	0	-	0
		S	0	0	0	-	0	0	0	0	0	-	14
NCEPOD 002	Emergency Admissions (A Journey in the right Direction)	Y	0	12	5	***01/15***	0	3	0	0	0	-	0
		S	0	10	7	***11/14***	0	0	0	0	3	***11/14***	0
NCEPOD 003	Death in Acute Hospitals (Caring to the End)	Y	13	0	0	-	1	0	0	0	0	-	0
		S	0	10	2	***11/12***	0	0	0	0	1	***11/12***	1
NCEPOD 004	Severely Injured Patient (Trauma: Who Cares)	Y	0	20	8	***07/14***	4	0	0	1	2	***07/14***	0
		S*	0	20	9	***?***	1	0	0	1	0	-	0
NCEPOD 007	Systemic Anti-Cancer Therapy (For Better for Worse)	Y**	0	21	2	***05/14***	0	0	0	0	0	-	0
		S	0	25	0	-	0	0	0	0	0	-	0
NCEPOD 008	Parenteral Nutrition (A Mixed Bag)	Y	0	18	2	***05/14***	0	0	0	0	4	***06/12***	0
		S***	16	0	0	-	0	0	0	0	0	-	0
NCEPOD 009	Emergency & Elective Surgery in the Elderly (An Age Old Problem)	Y	0	13	0	-	0	7	4	0	0	-	0
		S	0	0	0	-	0	0	0	0	0	-	24
NCEPOD 011	Paediatric Surgery (Are we there yet?)	Y*	16	0	0	-	0	0	0	0	0	-	0
		S	0	0	0	-	0	0	0	0	0	-	20
NCEPOD 012	Peri-operative Care (Knowing the Risk)	Y	0	8	2	***09/13***	1	0	0	0	0	-	0
		S	0	7	1	***08/14***	1	0	0	0	1	***08/14***	1
NCEPOD 013	Cardiac Arrest (Time to Intervene)	Y	21	1	0	-	0	0	0	0	0	-	0
		S	0	0	0	-	0	0	0	0	0	-	22
NCEPOD 014	Bariatric Surgery (Too Lean a Service)	Y	0	15	0	-	0	0	0	0	1	***01/14***	0
		S	**Not relevant**										
NCEPOD 015	Alcoholic Liver Disease (Measuring the Units)	Y	0	7	13	***09/14***	0	0	2	0	4	***09/14***	0
		S	0	18	0	-	0	4	4	0	0	-	0
NCEPOD 016	Subarachnoid Haemorrhage (Managing the Flow)	Y	0	0	0	-	0	0	0	0	0	-	11
		S	0	0	0	-	0	0	0	0	0	-	11

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	July	August	September	October	Novenber	December	January	February	March	April	May	June	Av. Monthly YtD	Action Log completed (Date)	Notes
Activity	Births	Bookings	1st m/w visit	CMIS from Jan CPD	≤302	302-329	≥330	prev. stats	313	325	278	308	301	305	394	316	291	273	249	226	298		
		Bookings <13 weeks	No. of mothers	CMIS from Jan CPD	≥90%	76%-89%	≤75%	COUIN	91%	89%	88%	87%	89%	88%	86%			82%	81%	87%	87%		
		Bookings ≥13 weeks (exc transfers	No. of mothers		≥90%	76%-89%	≤75%	COUIN										23.00					
		Bookings ≥ 13wks seen within 2 wk	No. of mothers	Mat Rec	≥90%	76%-89%	≤75%	COUIN															
		Births	No. of babies	CMIS	≤295	296-309	≥310	prev. stats	299	282	296	293	279	285	295	234	285	248	287	288	281		
		No. of women delivered	No. of mothers	CMIS					294	271	289	283	274	276	288	230	279	242	285	288	275		
	Closures	Homebirth service suspended	No. of closures	Comm. Manager	0-3	4-6	7 or more		0	1	1	6	6	4	1	2	4	0	2		2		
		Homebirth service suspended	No. of women	Comm. Manager	0	1	2 or more		0	0	0	2	0	0	0	1	0	0	0		0		
		Escalation Policy implemented	No. of times	Comm. Manager	3	4-5	6 or more		1	0	5	3	3	2	3	0	2	1	2		2		
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	0	0	0	0	1	1	0		
		SCBU closed to admissions	In utero transfers	Transfer folder	0	1	2 or more		0	2	4	3	0	3	0	0	0	0	5	0	1		
Workforce	Staffing	M/W per 1000 births	Ratio	Matron	≥35.0	34.9-31.1	≤31.0	DH	30.5	30.1	29.7	28.4	28.4	29.8	31.0	31.0					29.9		
		M/W per births	Ratio	Matron				safer childbirth								24.8					33.0		
		HCA's	WTE	Matron				staffing paper	20.62	19.82	20.02	20.02	20.02	21.01	19.43	19.43					20.05		
		1 to 1 care in Labour		Risk Team															75.00				
		L/W Co-ordinator supernumary %		Risk Team					65	48	55	48	47	45	51	80	65	71	51	50	56		
		Consultant cover on L/W	av. hours/week	Rota	40		≤40	Safer Childbirth	76	76	76	76	76	76	76	76	76	76	76	76	76		
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10		10	10	10	10	10	10	10	10	10	10	10	10	10		
		Supervisor : M/w ratio 1 :	Ratio	Rota	12	13-15	15	SHA	13	15	15	13	13	13	12	13	14	14	14		14		
Clinical Indicators	Neonatal/Maternal Morbidity	Sponateous Vaginal Births	No. of svd	CMIS	≥65%	64%	≤63%		67.2	62.7	63.5	68.3	64.8	62.1	61.7	61.5	59.6	58.0	58.5	65.6	62.8		
		Operative Vaginal Births	No. of instr. births	CMIS	≤15%	16-19%	≥20%	prev. stats	11.7	12.4	8.4	10.9	10.7	12.9	9.5	15.8	12.6	22.4	19.9	14.6	13.5		
		C/S Deliveries	Em & elect	CMIS	≤24%	24.1-25.9	≥26%	prev. stats	21.1	24.8	27.7	20.8	24.0	24.5	28.8	22.6	27.7	25.8	26.0	23.3	24.8		
		Eclampsia	No. of women	CMIS	0		1 or more		0	0	0	0	0	0	1	0	0	0	1	0	0		
		Undiagnosed Breech in Labour	No. of women	CMIS	2 or less	3-4	5 or more	prev. stats	1	4	1	3	3	1	1	0	0	0	2	1	1		
		ICU transfers	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	2	1	0	1	0	1	2	0	0	0	0	2	1		
		HDU on L/W	No. of days	Handover Sheet					21	15	15	25	15	14	18	17	11	10	30	30	18		
		Uterine Rupture from Jan 14	No of women	CPD	0	1	2 or more								0	0	0	0	0	0	0		
		P/N Hysterectomies < 7days p/n	No. of women	Risk Team - Datix	0	1	2 or more	prev. stats	0	1	0	0	0	1						2			
		BBA	No. of women	Risk Team - Datix	1	2-3	4 or more	prev. stats	3	7	2	6	4	1	4	2	3	4	5	3	4		
		Meconium Aspirate	No. of babies	SCBU sister	0	1	2 or more	prev. stats	0	1	0	0	0	0	0	1	0	0	0	0	0		
		Diagnosis of HIE	No. of babies	SCBU Paed	0	1	2 or more	prev. stats	2	1	1	0	0	0	0	0	0	0	0	0	1		
	Risk Management	SI's	Total	Risk Team	0	1	2 or more		1	0	0	0	0	0	0	0	0	0	1	0	0		
		PPH > 2L	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		2	5	4	7	7	1	1	2	1	1	5	4	3		
		Shoulder Dystocia - True	No. of women	Risk Team - Datix	2 or less	3-4	5 or more	RCOG	3	1	3	6	6	3	0	0	2	1	3	5	2		
		3rd/4th Degree Tear	% of tears (vaginal b	CMIS	≤1.5%	1.6-6.1%	≥6.2%	RCOG	5.9	4.2	3.7	3.4	6.1	2.8	4.7	4.4	6.8	4.4	4.1	4.9	4.6	February 2013	April 2013 - range of goals rev
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		90	90	90	90	89	99	94	96	95	96	94	92	93		
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		69	39	48	55	50	69	78	81	81	78	83	74	67		
		Training cancelled	No. of staff affected	Risk Team	0		≥1		44	0	7	1	0	1	1	0	0	0	0	0	0		
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		1	1	0	0	1	0	3	0	1	3	0	3	#DIV/0!		
		Formal	Total	Matron	0	1-4	5 or more		3	3	1	2	1	2	2	1	0	2	0	0	#DIV/0!		
	New Claims		Total	Directorate Manager	0	1	2 or more		1	0	1	0	0	0	2	1	0	1	0	0	1		

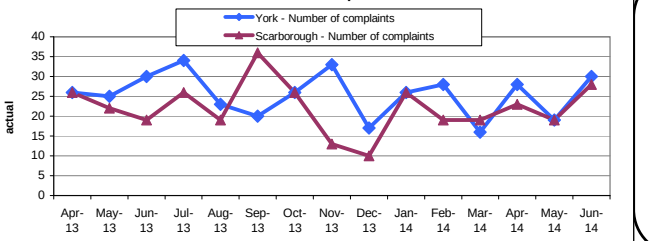
Scarborough Maternity Dashboard:

			Measure	Data source	No Concern(green)	Of Concern (Amber)	Concerns (Red)	Flag Source	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Av. Monthly YtD	Action Log completed (Date)	Notes
Activity	Births	Bookings	1st m/w visit	IS - Evolution	≤200	201-249	≥250	prev. stats	200	169	185	216	196	165	247	190	156	79	89		187		
		Bookings <13 weeks	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	87%	83%	82%	81%	96%	100%	100%	100%	100%	76%	72%		90%		
		Bookings <13 weeks (exc transfers etc)	No. of mothers	IS - Evolution	≥90%	76%-89%	≤75%	CQUIN	88%	99%	86%	TBC	96%	n/a	n/a	n/a	n/a	2%			92%		
		Bookings ≥ 13wks seen within 2 wks	No. of mothers		≥90%	76%-89%	≤75%	CQUIN										3.0					
		Births	No. of babies	IS - Evolution	≤170	171-189	≥190	prev. stats	140	154	135	145	131	124	145	128	119	119	119	125	133		
		No. of women delivered	No. of mothers	IS - Evolution	≤170	171-189	≥190	prev. stats	140	153	133	142	129	122	143	126	118	119	119	125	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	1	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	1	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	1	0		
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	0	0	0	0	0	0	0	0	0	0	1	0		
		MLU Closure	No. of closures	Matron	0	1-2	3 or more		0	1	2										0	MLU closed from 1/10/13 M/w led care provided on L/W	
		MLU Closure	No. of women	Matron	0	1-2	3 or more		0	0	1										0	MLU closed from 1/10/13 M/w led care provided on L/W	
		SCBU closed to admissions	In utero transfers	Risk Team	0	1	2 or more		0	0	0	1	1	2	1	0	4	0	0	0	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	43.0	43.0	44.0		
		HCA's	WTE	Matron				staffing paper	18.55	18.79	18.79	19.59	19.59	19.59	18.32	18.32	18.32	18.32	17.92	17.12	17.82		
		1:1 care in labour		IS - Evolution					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	5	4	4	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		
		Anaesthetic cover on L/W	av.sessions/week	Rota	10		≤10	Safer Childbirth	3	3	3	3	3	3	3	3	3	3	10	10	3		
		Supervisor : M/w ratio 1 :	Ratio	Matron	15	16-19	20	NMC	13	15	15	13	13	13	14	14	14	14	14	14	14		
Clinical Indicators	Neonatal/Maternal Morbidity	Sponateous Vaginal Births	No. of svd	IS - Evolution	≥65%	64%	≤63%		76.4%	77.9%	70.4%	64.8%	65.6%	67.7%	68.3%	71.9%	72.3%	74.8%	68.9%	64.0%	71.9%		
		Operative Vaginal Births	No. of instr. births	IS - Evolution	≤15%	16-19%	≥20%	prev. stats	5.0%	4.5%	8.1%	8.3%	6.1%	4.0%	3.4%	4.7%	5.9%	4.2%	12.6%	8.8%	5.3%		
		C/S Deliveries	Em & elect	IS - Evolution	≤24%	24.1-25.9	≥26%	prev. stats	17.9%	16.2%	20.0%	24.8%	26.0%	26.6%	26.9%	21.9%	21.0%	21.8%	23.5%	28.8%	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		
		Undiagnosed Breech in Labour	No. of women	Risk Team	2 or less	3-4	5 or more	prev. stats	1	1	0	1	1	0	0	0	0	1	1	0	1		
		ICU transfers	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	1	0	0	0	0	0	0	0	0	0	0		
		HDU on L/W	No. of days	Risk Team						0	2	2	5	4	2	3		3	0	0	2		
		P/N Hysterectomies < 7days p/n	No. of women	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	0	0	0	0	0	0	0	0		
		BBA	No. of women	IS - Evolution	1	2-3	4 or more	prev. stats	1	4	1	1	0	1	1	1	0	0	0	0	1		
		Meconium Aspirate	No. of babies	IS - Evolution	0	1	2 or more	prev. stats	0	0	0	0	0	1	0	1	0	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	1	0	0		
	Risk Management	SI's	Total	Risk Team	0	1	2 or more		0	0	0	0	0	0	0	1	0	1	0	0	0		
		PPH > 2L	No. of women	IS - Evolution	1 or less	2-3	3 or more		0	0	1	0	1	1	0	1	0	2	0	0	1		
		Shoulder Dystocia - True	No. of women	IS - Evolution	1 or less	2-3	3 or more	RCOG	1	1	0	4	0	0	1	1	0	0	1	1	1		
		3rd/4th Degree Tear	% of tears (vaginal b	IS - Evolution	≤1.5%	1.6-6.1%	≥6.2%	RCOG	1.4%	2.6%	0.8%	1.4%	0.8%	2.5%	4.9%	4.0%	0.0%	0.4%	0.7%	1.6%	1.9%		
	Training Attendance	YMET - Midwives	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		67	67	77	85	92	98	91	93	93	91	90	94	87		
		YMET - Doctors	% of staff trained	Risk Team	≥75%	61%-74%	≤60%		57	57	53	79	82	90	37	92				77	70		
		Training cancelled	No. of staff affected	Risk Team	0		≥1		0	0	0	0	0	1	0	0	0	0	0	0	0		
	New Complaints	Informal	Total	Matron	0	1-4	5 or more		1	0	0	1	3	1	1	3	2	0	1	0	1		
		Formal	Total	Matron	0	1-4	5 or more		1	1	0	1	1	1	1	1	0	2	0	0	1		
	New Claims		Total	Risk Team	0	1	2 or more		1	0	0	0	0	0	0	2	1	0	1	0			

Patient Experience Dashboard

Patient Experience

Number of complaints

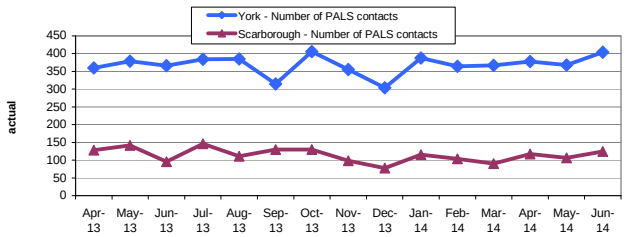


Complaints registered in York relate to York Hospital and Community Services.

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

There were 30 new complaints registered to the York site and 28 to the Scarborough site in June.

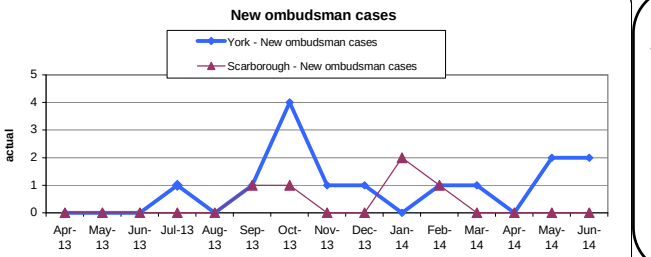
Number of PALS contacts



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

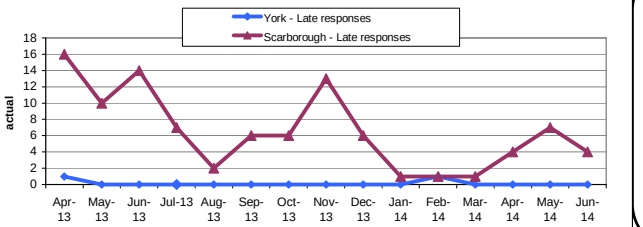
There were 368 PALS enquiries at York Hospital and 106 PALS enquiries at Scarborough in May.

New ombudsman cases



There were two new ombudsman cases reported from the York site, and none at the Scarborough site in June.

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 seven late responses to complainants at the Scarborough site compared to none at the York site in May.

Complaints by directorate/division (Datix) June 2014	York	Scarborough
Child Health (Y)	0	0
Clinical Support Services (S)	2	0
Community Services (Y)	3	0
Corporate (Y, S)	0	1
Elderly Medicine (Y)	4	4
Emergency Medicine (Y)	1	5
Facilities (Y, S)	0	0
General Surgery & Urology (Y), Surgery (S)	3	4
Head & Neck & Ophthalmology (Y)	2	3
Medicine (General & Acute, Y), Medicine (S)	6	5
Obstetrics and Gynaecology (Y)	6	1
Orthopaedics (Y)	1	3
Pharmacy (Y)	0	0
Physiotherapy (Y)	1	0
Radiology (Y)	1	0
Sexual Health (Y)	0	0
Specialist Medicine (Y)	0	1
Theatres Anaesthetics & CC (Y)	0	1
Total	**30**	**28**

Complaints by subject (Datix) June 2014	York	Scarborough
Admissions, discharge and transfer arrangements	1	2
Aids, appliances, equipment, premises	0	0
All aspects of clinical treatment	23	11
Appointment delay/cancellation (inpatient)	1	0
Appointments, delay/cancellation (out-patient)	1	2
Attitude of staff	3	3
Communication/information to patients (written and oral)	1	4
Complaints handling	0	0
Consent to treatment	0	0
Failure to follow agreed procedure	**0**	0
Hotel services, including food	**0**	1
Mortuary and post mortem arrangements	**0**	0
Other	**0**	1
Patients' privacy and dignity	**0**	3
Patients' property and expenses	**0**	0
Patients' status, discrimination	0	1
Policy and commercial decision of Trust	0	0
Total	**30**	**28**

Complaint themes this month, e.g. staff attitude, increased numbers in an area (Y, S)

a) SGH seen an increase in the attitude of staff.

b) SGH have had a number of concerns raised by contacts initially wishing to complain about Audiology and the Pain Service, but managed to keep in PALS. This will be covered in PALS report.

Friends & Family Test Results

York Teaching Hospital NHS
NHS Foundation Trust

01 Jun 2014 - 30 Jun 2014 — **Inpatient / A&E**

Your Friends & Family Test Score is....	55	Last month your score was....	55

Highest score
Lowest score
Negative score

Top 3 most improved performing wards/services	6 Month Average	This Month	Improvement	Trend
Beech	76	100	24	
Ward 25	70	89	19	
Ward 32	78	95	17	

Top 3 consistently high performing wards/services	6 Month Average	This Month	Improvement	Trend
CCU York	98	94	-4	
Kent	96	92	-4	
Lloyd	96	93	-3	

Top 3 consistently low peforming wards/services	6 Month Average	This Month	Improvement	Trend
A&E York	36	31	-5	
A&E Scarborough	57	63	6	
Haldane	58	53	-5	

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

Who responded?

Response Rate	Male or Female	Age Profiles %
Eligible Patients **9992**	45%	16-24, 25-34, 35-54, 55-64, >65
Patient Responses **3400**	55%	0 20 40 60 80 100
34%		

Patients extremely likely to recommend our Trust said:

"Very friendly atmosphere with really helpful and efficient staff."

"I was treated with dignity and respect at all times. "

Patients unlikely or extremely unlikely to recommend our Trust said:

"My family are all young I hopefully will noy have to vist an op ward."

"Wait time for discharge was extreme."

Produced by: picker Institute Europe — Making patients' views count

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

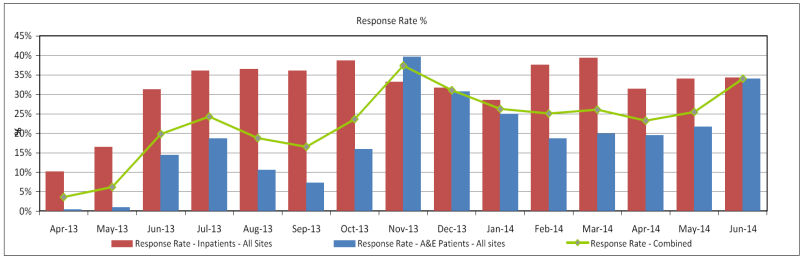
percentage of people not likely to recommend

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".The Trust achieved the CQUIN requirements for Q4 and now focuses on the 2014/15 requirments on increased response rate in ED and Inpatients; roll out to community hospital inpatients, all outpatients, day cases and community services. The FFT Steering group and project workstreams continue to meet and take forward the implementation and development of FFT across the Trust. The focus for the Trust, in addition to roll-out is to ensure that the qualitative feedback gained through FFT is used to effectively inform patients of what we are doing to improve their experience of our services. Of 855 comments for April, only 8 comments were negative. A FFT Project Manager is currently being recruited to on a fixed one year contract.

York ED is struggling to achieve the required response rate each month and is being supplemented by the good response rate at Scarborough ED. The Directorate are developing plans for the longer term to increase and maintain the response rate in ED. NHS England is reviewing the use of token systems for the purpose of FFT as some trusts use only the token system to capture quantitative feedback and not qualitative feedback. This Trust provides patients with a comment card to use in conjunction with the token. Qualitative feedback has reduced since the implementation of FFT but this will form part of future plans to improve responses in ED. The Trust awaits guidance from NHS England about the future of token systems.

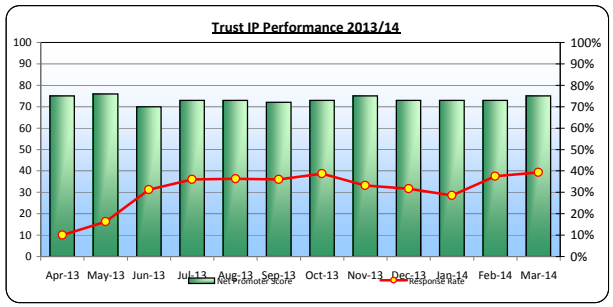
The Friends and Family Test rolled out to Community Hospital Inpatients at the beginning of May, ahead of the national roll-out date of December 2014. Reports will be produced from June 2014.

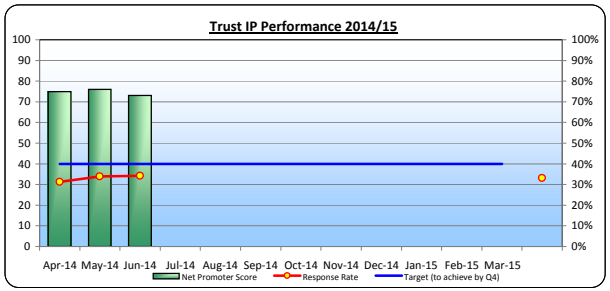


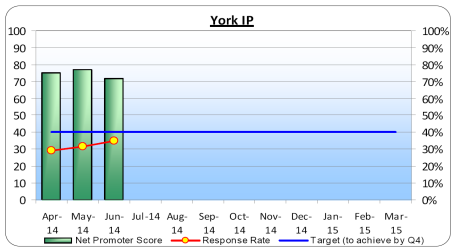
Inpatients:

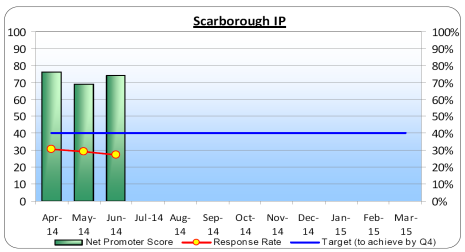
		Apr-14	May-14	Jun-14
Trust	Eligible patients	2988	3206	3129
	Responses	936	1088	1071
	Response Rate	**31.33%**	**33.94%**	**34.23%**
	Net Promoter Score	75	76	73
York	Eligible patients	2003	2182	2153
	Responses	584	686	748
	Response Rate	**29.16%**	**31.44%**	**34.74%**
	Net Promoter Score	75	77	72
Sboro	Eligible patients	872	830	810
	Responses	269	243	222
	Response Rate	**30.85%**	**29.28%**	**27.41%**
	Net Promoter Score	76	69	74
Brid	Eligible patients	113	194	166
	Responses	83	159	101
	Response Rate	**73.45%**	**81.96%**	**60.84%**
	Net Promoter Score	72	84	82

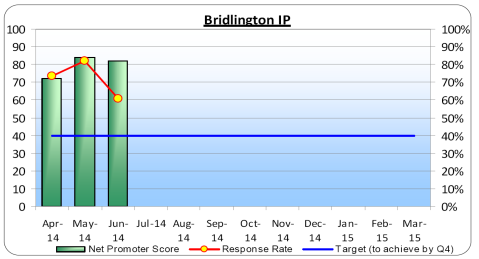
Combined Quarterly Perforamce		No. Eligible	Responses	Target	Response Rate
2013-14	Q1	30,369	2,975	15%	9.80%
	Q2	29,611	5,933	20%	20.04%
	Q3	28,098	8,550	20%	30.43%
	Q4	27,149	7,007	20%	25.81%
2014-15	Q1	29,623	8,186	n/a	27.63%



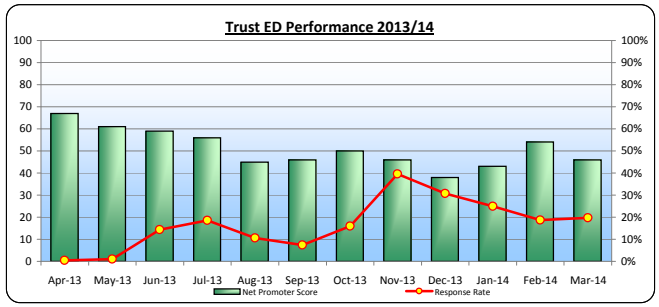




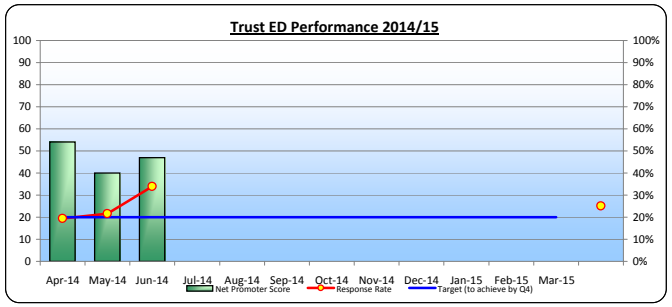


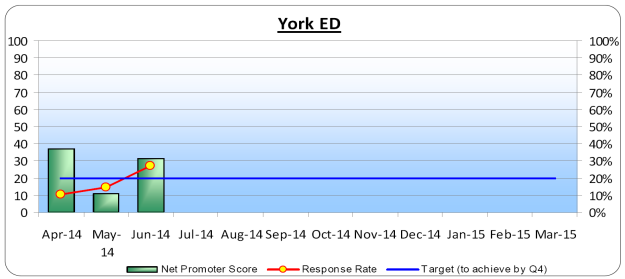


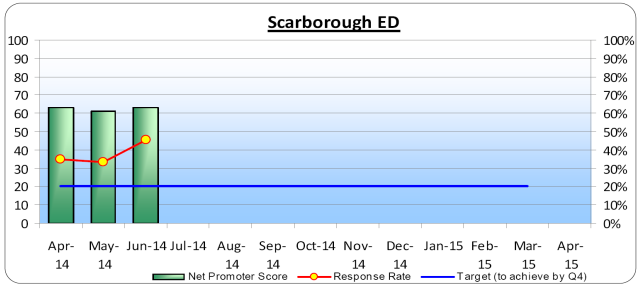
ED Performance



		Apr-14	May-14	Jun-14
Trust	Eligible patients	6467	6970	6863
	Responses	1260	1502	2329
	Response Rate	**19.48%**	**21.55%**	**33.94%**
	Net Promoter Score	54	40	47
York	Eligible patients	4079	4356	4283
	Responses	429	636	1162
	Response Rate	**10.52%**	**14.60%**	**27.13%**
	Net Promoter Score	37	11	31
Sboro	Eligible patients	2388	2614	2580
	Responses	831	866	1167
	Response Rate	**34.80%**	**33.13%**	**45.23%**
	Net Promoter Score	63	61	63





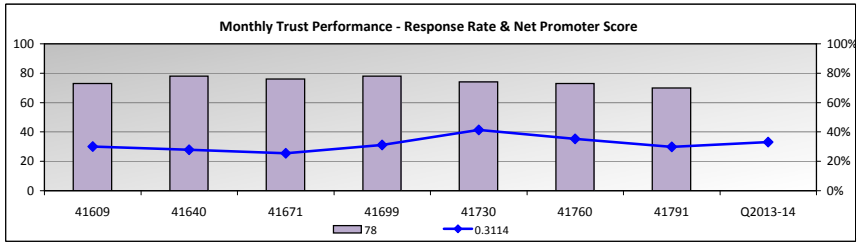


Friends and Family Test - April 2014 data				
Trust Name	**IP Response Rate %**	**IP FFT Score**	**A&E Response Rate**	**A&E FFT Score**
York Teaching Hospital NHS Foundation Trust	31	75	19.5	54
Hull & East Yorkshire Hospitals NHS Trust	39	82	14	63
Harrogate & District NHS Foundation Trust	40	75	21	60
Calderdale and Huddersfield NHS FT	37	75	21.5	49
Leeds Teaching Hospitals NHS Trust	40	74	16	46
Barnsley Hospital NHS Foundation Trust	29	81	15	63
Doncaster & Bassetlaw Hospitals NHS FT	29	74	16.5	54
Northern Lincs & Goole NHS FT	29	71	6	64
Airedale NHS Foundation Trust	44	73	14	58
Bradford Teaching Hospitals NHS FT	33	68	13	49
The Rotherham NHS Foundation Trust	29	76	22	60
Mid Yorkshire Hospital NHS Trust	32	76	24.5	64
Sheffield Teaching Hospitals NHS FT	36	78	23.5	47

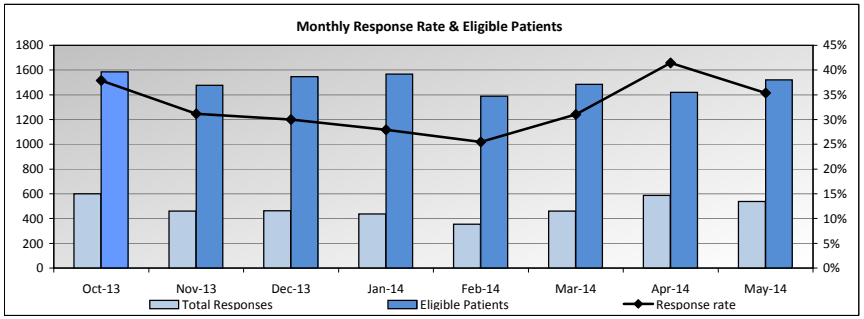
Maternity FFT

The FFT across the maternity pathway continues to achieve a good response rate and net promoter scores. April saw an increase to the 41% response rate, the highest rate since it commenced. The directorate produces quarterly action plans from the qualitative feedback received from patients and actions to address feedback which is considered negative. Staff from across the maternity directorate and the Maternity Services Liaison Committee are involved in agreeing plans and action from the FFT.

Trust Performance:

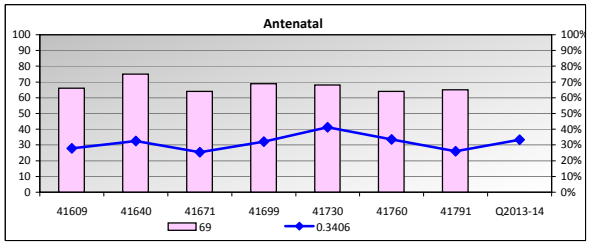


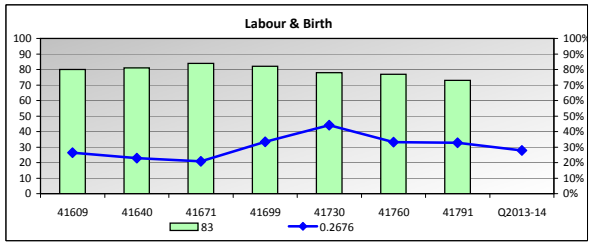
		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Q3	Q4
Total	Response Rate	37.92%	31.14%	30.01%	27.93%	25.47%	31.06%	41.44%	35.39%	33.09%	28.21%
	Net Promoter	74	78	73	78	76	78	74	73		
Antenatal	Response Rate	38.20%	34.06%	27.79%	32.46%	25.33%	32.11%	41.30%	33.60%	33.33%	29.81%
	Net Promoter	71	69	66	75	64	69	68	64		
Labour & Birth	Response Rate	30.35%	26.76%	26.43%	22.90%	20.92%	33.50%	44.13%	33.25%	27.89%	25.86%
	Net Promoter	83	83	80	81	84	82	78	77		
Postnatal	Response Rate	49.21%	34.48%	46.10%	31.27%	32.01%	38.41%	47.02%	39.23%	43.21%	33.91%
	Net Promoter	72	78	70	73	80	79	70	75		
Postnatal Community	Response Rate	36.61%	29.73%	23.20%	25.75%	25.17%	20.45%	34.20%	37.22%	29.88%	23.73%
	Net Promoter	73	85	79	84	83	83	82	79		

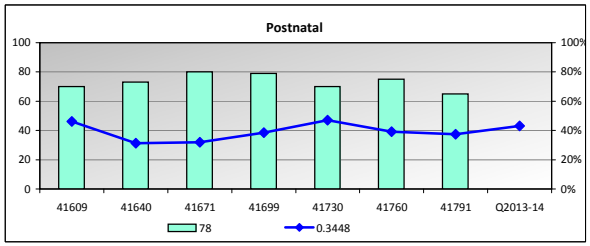


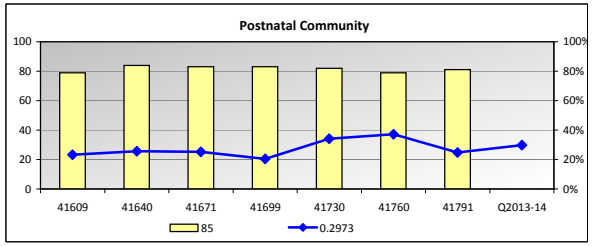
Trust Performance

Report Month	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know	Total Responses	Eligible Patients	Response rate	FFT Score
Oct-13	77.37%	19.13%	2.16%	0.83%	0.17%	0.33%	601	1585	37.92%	74
Nov-13	80.00%	17.39%	1.74%	0.43%	0.22%	0.22%	460	1477	31.14%	78
Dec-13	75.43%	21.98%	1.72%	0.65%	0.22%	0.00%	464	1546	30.01%	73
Jan-14	80.37%	17.12%	2.28%	0.23%	0.00%	0.00%	438	1568	27.93%	78
Feb-14	78.81%	18.64%	1.98%	0.00%	0.56%	0.00%	354	1390	25.47%	76
Mar-14	79.39%	18.22%	1.74%	0.22%	0.00%	0.43%	461	1484	31.06%	78
Apr-14	75.51%	22.62%	1.36%	0.34%	0.00%	0.17%	588	1419	41.44%	74
May-14	76.02%	20.07%	2.97%	0.37%	0.19%	0.37%	538	1520	35.39%	73









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

A project work-stream has been set up to implement the roll out to Day Cases and Outpatients and a separate work-stream has been set up to implement FFT across Community Services. The latter group has not yet met, but is due to have its first meeting in June.

Comment cards, as used across our inpatient areas, are being used in the roll-out for outpatients. Pilot areas commenced early May in Neurology, Dermatology, Oncology treatment and OPD, Rheumatology, MES, Haematology treatment and OPD and VIU. Services to be roll out during June are Therapies, Renal, Selby War Memorial Hospital OPD, Sexual Health, X-ray/CT/MRI/Ultrasound
Eye day case (Scarborough).

Commissioning for Quality and Innovation (CQUIN) 2014/15

The CQUIN requirements for 2014/2015 are detailed below:

Q1 – Staff Friends and Family Test roll-out
Q1 – Patient Friends and Family Test – improved response rate (Q1 A&E >15%, IP >25%; Q4 A&E >20%, IP >30%)
Q2 – Patient Friends and Family Test roll-out to Day Case, Outpatients and Community Hospitals and Services
Q4 – Patient Friends and Family Test – improved response rate (March 2015 IP > 40%)

D2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 2014

Medical Director's Report

Action requested/recommendation

Board of Directors are asked to:

- Note the Consultants new to the Trust this month
- Note the compliance with the antimicrobial prescribing guidelines
- Consider the benefits of the Sign up to Safety Campaign for the Trust
- Be aware of the Patient Safety information published on the NHS Choices website
- Note the updated CQC Intelligent Monitoring Report
- Note the Director of Infection Prevention and Control Quarter 1 report.

Summary

This report provides an update from the Medical Director.

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

Implications for equality and diversity

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

Reference to CQC outcomes

The most recently published Care Quality Commission, Intelligent Monitoring Report is summarised in this report.

Progress of report	This report is written for the Board of Director's.
Risk	No additional risks have been identified others than those specifically referenced in the paper.
Resource implications	None identified
Owner	Dr Alastair Turnbull, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	July 2014
Version number	2

Board of Directors – 30 July 2014

Medical Director's Report

1. Introduction and background

In the report this month:

- Consultant Appointments
- Antibiotics Prescribing Audit Results June 2014
- Sign up to Safety
- Patient Safety on NHS Choices.
- Updated CQC Intelligent Monitoring Report
- Director of Infection Prevention and Control Quarter 1 report.

2. Consultant appointments

Miss Laura Wakely
Consultant in Ophthalmology
Commenced: 30/06/2014

3. Monthly Antibiotic Prescribing Audit Results June 2014

- The indication must be documented on all antibiotic prescriptions
- The duration or a review date must be documented on all antibiotic prescriptions

ELDERLY MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	43	45	56	52	50	41
Antibiotic prescriptions with INDICATION	77%	84%	88%	85%	92%	93%
Antibiotic prescriptions with DURATION / REVIEW	77%	91%	88%	90%	96%	88%

MEDICINE DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	105	107	110	144	82	88
Antibiotic prescriptions with INDICATION	66%	86%	76%	73%	95%	88%
Antibiotic prescriptions with DURATION / REVIEW	67%	69%	66%	79%	88%	90%

ORTHOPAEDICS & TRAUMA DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	23	21	19	13	19	10
Antibiotic prescriptions with INDICATION	43%	86%	37%	46%	89%	90%
Antibiotic prescriptions with DURATION / REVIEW	39%	90%	68%	69%	89%	90%

GENERAL SURGERY & UROLOGY AND GYNAECOLOGY DIRECTORATES	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	65	74	65	70	66	76
Antibiotic prescriptions with INDICATION	58%	61%	60%	80%	85%	78%
Antibiotic prescriptions with DURATION / REVIEW	63%	72%	69%	77%	92%	79%

HEAD & NECK DIRECTORATE	Jan	Feb	Mar	Apr	May	Jun
Number of antibiotic prescriptions audited	16	15	9	12	21	15
Antibiotic prescriptions with INDICATION	44%	40%	44%	33%	43%	87%
Antibiotic prescriptions with DURATION / REVIEW	56%	67%	89%	83%	38%	73%

4. Sign up to Safety

Sign up to Safety is a national campaign that aims to make the NHS the safest healthcare system in the world; building on the recommendations of the Berwick Advisory Group. The aim is to reduce avoidable harm in the next three years by 50% and as a result save 6,000 lives. By signing up to the campaign organisations commit to listening to patients, carers and staff. They commit to learning from what they say when things go wrong and taking action to improve patient's safety.

The campaign is being organised by a National Co-ordinating and Support Group which is chaired by Sir David Dalton. System wide support will be provided in the form of:

- Expert clinical patient safety input from NHS England to assist in the development of improvement plans
- Monitor and NHS Trust Development Authority offering leadership and advice to develop local improvement plans
- NHS Litigation Authority will review trust's plans and if the plans are robust and will reduce claims trusts will receive a financial incentive to support implementation of the plan
- The Care Quality Commission will consider trust improvement plans as a key source of evidence to demonstrate meeting the five domains of safety and quality
- The Department of Health will work to ensure that the policy framework supports the campaign and the development of a culture of safer care.

An 'Alliance of Improvement Experts' will offer provider organisations improvement support and advice.

By signing up to the campaign the Trust will be expected to commit to strengthening our patient safety by:

- Describing the actions we will take in response to five campaign pledges
- Turning our proposed actions into a safety improvement plan
- Identify two or more patient safety improvement areas to focus on from a national menu of high priority issues and two or more from local priorities.

The Sign up to Safety pledges are:

1. put safety first
2. continually learn
3. honesty
4. supporting local collaborative learning
5. support- give staff the time and support to improve and celebrate the process.

5. Patient Safety on NHS Choices

NHS Choices are now publishing data showing how hospitals across England perform on a range of patient safety indicators. The emphasis is on how hospitals recognise and report problems with safety, how well they are fulfilling their nurse staffing requirements, preventing blood clots and how staff rate them. Hospitals are ranked by infection control and cleanliness, their CQC rating, safe staffing levels, and patient safety reporting.

Some hospitals do not have data for every indicator, shown as n/a (data not available). This can be because:

- the hospital is not required to report on a particular indicator
- the data isn't yet available
- the hospital has not submitted data for this indicator.

The ratings for this indicator are displayed with different coloured icons:

- green = good
- blue = OK
- red = poor.

Ratings for some hospitals in our region are indicated in the table below.

Hospital	Infection control and cleanliness	CQC national standards	Recommended by staff	Safe staffing (%)	Patients assessed for blood clots	Patient safety notices complete to time-scale	Open and Honest reporting
York	/	/	Blue	90	Green	Green	Blue
Scarborough	Blue	Green	Blue	85	Green	Green	Blue
Pontefract	Green	Green	Red	115	Green	Green	Red
St. James Leeds	Red	Green	Red	96	Green	Green	Blue
LGI Leeds	Blue	Green	Red	94	Green	Green	Blue
Dewsbury	Blue	Red	Red	91	Green	Green	Red
Pinderfields	Blue	Red	Red	92	Green	Green	Red
Harrogate	Blue	Green	Green	105	Green	Green	Blue
Airedale	Red	Green	Blue	95	Green	Green	Green
Hull	Blue	Red	Red	85	Green	Red	Blue
Bradford Royal	Red	Red	Blue	90	Green	Green	Green

6. CQC Intelligent monitoring report Summary

The CQC uses intelligent monitoring of more than 150 different indicators to enable them to direct their resources and focus their inspections to where they are most needed. Together with local information from partners and the public, this monitoring helps the CQC to decide when, where and what to inspect.

The results of the intelligent monitoring work groups the 160 acute NHS trusts into six priority bands for inspection based on the likelihood that people may not be receiving safe, effective, high quality care.

Band 1 is the highest priority trust for inspection and band 6 the lowest.

A summary of the Trust's most recent report is indicated below. The Trust remains in the band 6 category.

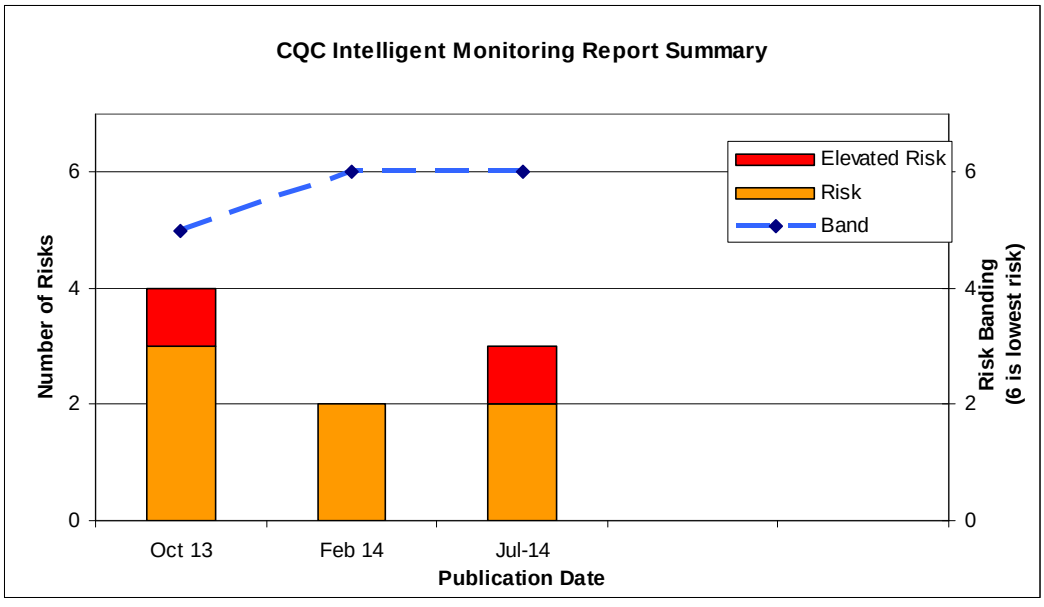
The latest version of the Care Quality Commission (CQC) Intelligent Monitoring Report is due to be published on the 29th July. The table below illustrates a summary of the Trust position.

Report Summary

	October 2013	March 2014	July 2014
Band *	**5**	**6**	**6**
Number of 'Risks'	3	2	2
Number of 'Elevated risks'	1	0	1
Overall Risk Score	5	2	4
Number of Applicable Indicators	87	92	96
Proportional Score	0.03	1.09%	2.08%
Maximum Possible Risk Score	174	184	192

Risk and Elevated Risk Breakdown

Risks	Stroke - 1 hour scanning	Never Events (x3)	Never Events (x4)
	Ambulance Turnaround	** Staff to Bed Occupancy	** Staff to Bed Occupancy
	** Staff to Bed Occupancy		
Elevated Risks	Whistleblowing Alerts	None	*** Referral to Treatment



* **Note on banding:** CQC categorises trusts into one of six summary bands, with band 1 representing highest risk and band 6 with the lowest. These bands have been assigned based on the proportion of indicators that have been identified as 'risk' or 'elevate'.

** **Staff to bed occupancy:** is a composite indicator with 4 components. These are data on medical and dental staff, nursing staff, other clinical and midwifery staff. In relation to individual components, the midwifery staffing component is an eleva.

*** **Referral to treatment:** this is a composite indicator with 10 access target components. The rating refers to the period 1st March to 31st March 2014, with the elevated risk score being attributed to RTT times for completed admitted pathways (% within 1).

7. Director Infection Prevention and Control Quarterly Infection Prevention Report 2014 – 2015

Director Infection Prevention and Control QUARTERLY INFECTION PREVENTION REPORT FOR TRUST BOARD. Q1 2014-2015							
Parameter		Annual threshold/ target	Apr	May	Jun	YTD	Notes
MRSA Bacteraemia attributable to Trust	Community					0	
	Elderly					0	
	Head + Neck					0	
	Medicine					0	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine					0	
	Surgery + Urology					0	
	Trauma + Orthopaedics					0	
	Trust		0	0	0	0	
MSSA Bacteraemia attributable to Trust	Community					0	IV Nurse roll to be established within Infection Prevention from July to manage practice and standards in relation to intravenous devices outside of Critical Care
	Elderly		2			2	
	Head + Neck					0	
	Medicine		3	2	3	8	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics			1		1	
	Specialist Medicine		1			1	
	Surgery + Urology		1			1	
	Trauma + Orthopaedics				1	1	
	Trust	30	7	3	4	14	
MSSA per 100000 bed days attributable to Trust	York		36.3	16.9	17.1		
	Scarborough + Bridlington		10.3	0.0	10.7		
	Community hospitals		0.0	0.0	0.0		
	Trust		23.0	9.3	12.6		
E coli Bacteraemia attributable to Trust	Community		4	1		5	Many appear to be endogenous infection without sepsis
	Elderly		2		4	6	
	Head + Neck					0	
	Medicine			4	1	5	
	Obstetrics + Gynaecology			1		1	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine		3	1	1	5	
	Surgery + Urology		3	3	2	8	
	Trauma + Orthopaedics					0	
	Trust	Not set	12	10	8	30	
Elective MRSA admission screening (report produced by SNS Team)	York sites	100%	82%	86%	89%		
	Scarborough sites	100%	76%	83%	81%		
	Trust	100%	79%	84%	85%		
Emergency MRSA admission screening (report produced by SNS Team)	York sites	100%	64%	71%	71%		Flag required on CPD to alert staff that a screen is required. IT have been approached
	Scarborough sites	100%	77%	74%	76%		
	Trust	100%	71%	73%	74%		

Parameter		Annual threshold/ target	Apr	May	Jun	YTD	Notes
Clostridium difficile Infection (CDI) attributable to Trust	Community					0	
	Elderly		2		3	5	
	Head + Neck					0	
	Medicine		1		3	4	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine			2		2	
	Surgery + Urology		1			1	
	Trauma + Orthopaedics					0	
	Trust	59	4	2	6	12	CDI under threshold
CDI per 100000 bed days attributable to Trust	York		12.9	11.3	17.1		
	Scarborough + Bridlington		20.7	0.0	32.0		
	Community hospitals		0.0	0.0	0.0		
	Trust		13.1	6.2	18.9		
CDI Saving Lives care bundle compliance	York	95%	90%	95%	97%		
	Scarborough + Bridlington	95%	88%	76%	95%		
	Trust	95%	89%	85%	91%		
Outstanding CDI post infection review	Community					0	Cases allocated to microbiologist with a view to improved compliance in completing PIR
	Elderly		2		3	5	
	Head + Neck					0	
	Medicine		1		3	4	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine			2		2	
	Surgery + Urology					0	
	Trauma + Orthopaedics					0	
	Trust		3	2	6	11	
Deaths where Clostridium difficile is reported on certificate	Community					0	
	Elderly		1			1	April 2014 - Part 1(b) on death certificate
	Head + Neck					0	
	Medicine					0	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine					0	
	Surgery + Urology					0	
	Trauma + Orthopaedics					0	
	Trust		1	0	0	1	
Readmissions within 30 days where CDI is diagnosed on and thought to be reason for admission - NB: refers to discharging directorate	Community					0	
	Elderly			1		1	
	Head + Neck					0	
	Medicine					0	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine					0	
	Surgery + Urology					0	
	Trauma + Orthopaedics					0	
	Trust		0	1	0	1	

Parameter		Annual threshold/ target	Apr	May	Jun	YTD	Notes
Antimicrobial pathway compliance with indication (information from Antimicrobial Stewardship Team)	Anaes,Theatre and Crit care						Changes have been made to the Trust prescription chart to prompt prescribers to document indication and course length on antimicrobial prescriptions
	Elderly		85%	92%	93%		
	Emergency						
	Head + Neck		33%	43%	87%		
	Medicine		73%	95%	88%		
	Obstetrics + Gynaecology						
	Specialist Medicine						
	Surgery + Urology		80%	85%	78%		
	Trauma + Orthopaedics		46%	89%	90%		
	Trust		73%	87%	85%		
Antimicrobial pathway compliance with duration or review date (information from Antimicrobial Stewardship Team)	Anaes,Theatre and Crit care						
	Elderly		90%	96%	88%		
	Emergency						
	Head + Neck		83%	38%	73%		
	Medicine		79%	88%	90%		
	Obstetrics + Gynaecology						
	Specialist Medicine						
	Surgery + Urology		77%	92%	79%		
	Trauma + Orthopaedics		69%	89%	90%		
	Trust		80%	87%	85%		
Ventilator acquired pneumonia in ICU (information provided by ICU)	York ICU		0	0	0	0	
	Scarborough ICU		0	0	0	0	
	Trust		0	0	0	0	
CVC associated infections in ICU (information provided by ICU)	York ICU		0	0	0	0	
	Scarborough ICU		0	0	0	0	
	Trust		0	0	0	0	
Trust attributed CAUTI (Safety Thermometer data)	York		1	0	0	1	
	Scarborough + Bridlington		1	1	0	2	
	Community hospitals		3	0	1	4	
	Trust		5	1	1	7	
Hand Hygiene compliance	Trust	Trust wide hand hygiene observations under review. Current audits highlight inconsistency in interpretation and application of the World Health Organisation 5 moments and do not provide assurance that hand hygiene practice is compliant.					
Environment audit results	York sites	95%	97%	90%	96%	94%	Change of matron patch in May
	Scarborough sites	95%	96%	84%	91%	90%	
	Trust	95%	97%	91%	95%	92%	
Infection Prevention training attendance (attendance reports provided by Corporate, Learning and Development Team)	Trust	Statutory mandatory face to face training currently not available - awaiting e-learning to go live (delay caused by learning hub).					

8. Recommendations

Board of Directors are asked to:

- Note the Consultants new to the Trust this month
- Note the compliance with the antimicrobial prescribing guidelines
- Consider the benefits of the Sign up to Safety Campaign for the Trust
- Be aware of the Patient Safety information published on the NHS Choices website
- Note the updated CQC Intelligent Monitoring Report
- Note the Director of Infection Prevention and Control Quarter 1 Report.

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

D3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 30 July 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	Quality and Safety Committee – 22 July 2014
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	July 2014
Version number	Version 2

Board of Directors - 30 July 2014

Chief Nurse Report – Quality of Care

1. Key priorities

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

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

A number of key priorities and work-streams have been identified and progress continues. A quarterly update was included in the last Chief Nurse report and all actions continue.

In addition, additional work has been commissioned to examine certain Clinical Nurse Specialist (CNS) roles.

TVN review
The Board are aware of the increased focus to further reduce the incidence of pressure ulcers. Following an independent review of our services a Pressure Ulcer Reduction Plan (PURP) was developed, updates and priorities came to Board of Directors in June.

As part of the reduction initiative a full service review of Clinical Nurse Specialists - Tissue Viability (TVNs) has been identified as a priority. This will ensure that we have a service that supports both staff and patients in wound prevention and management.

The TVN review has already commenced and has completed the following:

- A review of all TVN job descriptions, banding and job plans
- A 2 week diary exercise to describe their day to day work
- A review of the educational and meeting attendance commitments for the TVNs both internal and external
- A review of the contractual arrangements for community TVNs
- A scoping exercise of other Organisations to determine the number and remit of their TVN service
- A review of national guidance on the number and remit of TVNs

The Trust TVNs have been involved with all steps in the process and welcome a service review in order to provide clarity of expectation and reduce the variation they accept exists.

The Chief Nurse and Patient Safety teams plan to explore moving towards the development of a 'Skin Team' where all nurses involved in supporting patients with a variety of skin conditions are under the same team as the ultimate aim. This could include a group of specialists' e.g TVNs, dermatology nurses and vascular nurses to meet service requirements. This is a significant piece of work and a scoping exercise may need to be taken to establish the feasibility. Interim arrangements have been implemented in order for the TVNs to be managed consistently and to

share the same objectives and afford clearer sign-posting for staff for support and advice and to reduce the current number of processes involved to reach the right specialist at the right time for the right patient.

2. Senior Nurse Review

The senior nurse review is nearing completion with almost all posts filled or at various stages of the recruitment process.

Following the review a number of posts remained vacant, the updated position is detailed below:

Post	Speciality	Update
Matron Theatres	Theatres – cross site	Secondment Filled
ADN	Community Services	JD matched
EOL Lead Nurse	Cross site	Position Filled, to start September
Lead Nurse – Adult Safeguarding	Cross site	Position Filled
Lead – Patient Experience	Cross site	Shortlisted
Safeguarding Lead Professional	Cross site	Interview Date Set
Matron	Health Visiting / School Health	Secondee in post
Matron	Paediatrics – cross site	Position Filled

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

Post	Speciality	Update
Matron	Medicine - Scarborough	Post filled
Matron	Acute Medicine York	Review Date Set

A formal review of the restructure will be undertaken later in the year, the results and feedback will come to Board on completion.

3. Mental Health

Specialist mental health services at York site are provided by Leeds York Mental Health Partnership (LYMHP) and until recently an informal agreement has been in place whereby the administration team from Bootham park would deal with the legalities of patients who were detained under the Mental Health Act (MHA).

A number of projects are underway with LYMHP including expanding the psychiatric liaison service and looking at pathways of care for patients with mental health problems who require our acute services.

From a safeguarding perspective, collaboration has been sought on a more formal basis and an action plan was developed (appendix 1) and work is underway to deliver this. However, following a recent CQC inspection of Bootham Park Hospital services will be relocated to other areas, this will include the MHA administrator services and staff which will move in early August.

Options are as follows:

1. Develop our own administrate function with detailed standard operating procedures and escalation and train Senior Managers to act as panel members in the event of an appeal against a section or a Mental Health Tribunal.

2. Set up a formal Service Level Agreement (SLA) with LYMHP who will undertake a review of all paperwork and in the case of an appeal against detention would appoint managers to act on our behalf on a case by case basis.

Following a review of sections applied and appeals around 10 patients were detained under the MHA last year, in the last 15years one patient has appealed against the detention.

A meeting has recently taken place with representatives from the Trust and LYMHP to discuss options and the agreement has been reached that a formal SLA should be set up and work has started to enact this.

Recent feedback from staff would suggest that many nurses have little or no experience of dealing with patients with a mental health issues and whilst some Mental Health First Aid training has been undertaken in high risk areas training designed to address difficulties that may be experienced in acute care settings and how to undertake risk assessments is being explored with LYMHP; with a plan to extend this to other high risk areas in the future.

4. Adult Safeguarding

The Board were previously alerted to the Cheshire West Supreme Court Judgement as part of the Safeguarding Adults Annual report and associated papers (April 2014) following the judgement in March.

The judgement is significant in the determination of whether arrangements made for care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty.

Any deprivation of liberty for such an individual must be authorised in accordance with one of the following legal regimes:

- a deprivation of liberty authorisation or Court of Protection order under the Deprivation of Liberty Safeguards (DoLS) in the Mental Capacity Act 2005,
- Or (if applicable) under the Mental Health Act 1983.

As a result there is now a revised test for deprivation of liberty. The Supreme Court has clarified that there is a deprivation of liberty in the following circumstances:

- The person is under continuous supervision **and** control
  And
- is not free to leave,
  And
- The person lacks capacity to consent to these arrangements.

The above is known as ‘the acid test’.

The Judgement has implications for all provider organisations caring for patients lacking capacity to consent to be accommodated in hospital and to receive the care and treatment they require.

Issues include:

1) The judgement and the new revised test was based on community settings, the regime is particularly poorly suited to short term planned and unplanned deprivations of liberty in hospital as well as patients who are Persistent Vegative State and who did not previously have the opportunity to consent to such treatment. This would mean significant implications for patients on ICU and patients with dementia.

2) There is a lack of clarity from the Supreme Court judgement regarding what is meant by *continuous supervision and control*.

The advice from solicitors and supervisory bodies in response to Cheshire West is ambiguous and conflicting, in order to ensure compliance in the absence of clear guidance the Trust has committed representation to the MCA DoLS Support Network Group led by the Partnership Commissioning Group (for all the CCG areas). The purpose of this group is to develop a network of information exchange and support organisations to embed the principles of the Mental Capacity Act at every level of patient contact and decision making.

In order to agree collaborative ways of working and to develop consistent practices and documentation we will contribute to initiatives to drive up the level of compliance and the quality in the application of Mental Capacity Act and Deprivation of Liberty Safeguards in health organisations.

The current education initiatives from the network group are:

- a number of evening Conferences aimed at Senior Medical Staff and Managers (details to be circulated)

- MCA and DoLS Seminars for junior doctors and nursing managers to be delivered locally (details and times yet to be agreed)

Additionally, the Local Authority Safeguarding Adults Boards have recognised the need for multi-agency support in light of the Supreme Judgement of Cheshire West, we are represented on this group and are currently contributing to the working action plan. This also gives an opportunity to work with other similar sized trusts to share best practice in the implementation and interpretation of this judgement in and Acute Hospital.

5. Safer staffing project

As the Board are aware significant work is being undertaken at all sites to ensure safe staffing levels. This includes completion of the NHS England safer staffing return, acuity audit and review of some specialist roles.

Board are updated regularly in relation to progress against the obligations in response to the National Quality Board, *'Hard Truths'* and the demonstration of compliance with a number of recommendations to provide assurance about safe staffing; ensuring that the right staff are in the right place at the right time.

In order to demonstrate compliance with some of the domains an audit has been undertaken to assess the effective use of the daily staffing meetings (Clinical Effectiveness reference number 2757) A detailed report will go to Board in July.

The Chief Nurse team is also working with representatives from the HR Recruitment team to address vacancies and to forward plan for staff to work in winter escalation areas.

NHS Choices Nurse Staffing return:
This is the second submission to NHS choices of data of actual against planned staffing for day and night duty in hours by ward.

The June report detailed high level exceptions and details action taken to address short falls and mitigate risk on a daily basis.

Given the return of the first dataset was required at short notice a number of changes were made to the data collection and validation of the figure in response to the lessons learned. This has also

included numbers based upon average bed occupancy rates, as a result of this we feel that the figures are more accurate that the previous submission. As a result the June return shows an overall staffing rate of 92.5%.

	Day		Night	
Site Name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
St Monicas Hospital	86.5%	83.1%	96.8%	96.8%
Selby and District War Memorial Hospital	85.4%	95.6%	109.5%	98.7%
York Hospital	93.9%	97.0%	101.4%	116.1%
Scarborough General Hospital	93.7%	98.2%	103.7%	110.8%
Whitby Community Hospital	97.8%	93.1%	106.1%	96.8%
Malton Community Hospital	110.7%	111.0%	113.7%	147.8%
Bridlington and District Hospital	99.8%	99.2%	102.6%	146.7%
White Cross Rehabilitation Hospital	108.5%	103.8%	91.8%	130.7%
St Helens Rehabilitation Hospital	96.1%	110.4%	117.7%	117.5%

*Detailed at appendix 2

Exceptions:

York Site
Paediatrics (care staff 54.3%) – as previously reported this area have a small number of untrained staff.

York ICU (care staff 36.9%) – as previously reported ICU have a small number of untrained staff (2) who do not provide direct care to patients there is work ongoing to look at the untrained budgeted establishment in order to determine best value for money.

1:1 and specialling:
A number of areas show an over 100% fill rate. This is due to the 'specialling' of patients who require a higher level of observations. These areas are:

Ward 37
Ward 39

Scarborough
ITU (55.4% Care staff) – as with the York site these staff are not involved in direct care represent very low numbers. All level 3 (ICU) patients have 1:1 RN to patient ratio.

White Cross Court
This area was over established due to a programme of acceleration improvement work which commenced in May. The area is a step down only slow stream rehab ward.

Malton Community Hospital
The fill rates (110% RN, 111% Care Staff) are representative of the recent developments closing one ward and increasing bed numbers on another which afforded an increase in nursing numbers.

Work continues to refine and develop validation and collection methods with a view to reducing the burden at ward level and also to be assured of data accuracy. As this month, returns will be validated by the Chief Nurse before submission.

6. Patient experience

Improving patient experience remains a priority for the organisation. In order to refocus the agenda and develop and organisational strategy a full review of the service has been undertaken and a new Lead for Patient Experience will be recruited in the next month.

NHS Elect training is currently underway with all Matrons having received train the trainer programmes and ward Sisters from all sites participating. The feedback from staff is excellent and the training will continue until all ward Sisters have completed.

In addition, in order to maintain focus at ward level the Patient Experience Team led half day sessions as part of the Professional Nurse Leaders Forum. This was an opportunity for teams of senior nurses from across the Trust to work together in improving the Patient Experience.

There was a focus for nurses to gain an understanding of their role in the early intervention and management of concerns at ward level and to understand the power of patient feedback and how this can be used to make a positive difference to the quality of care.

Healthwatch York and Cloverleaf Advocacy attended the sessions and spoke to staff about how people who contact their organisations and speak about '*What it feels like to have concerns and how it feels to make a complaint as a patient or relative'.*

Other sessions included:

- senior nurses sharing how feedback from patients and relatives is used in their ward/department
- reviewing anonymous complaints and actions plan; determining what a good response looks like and whether the actions are achievable and do they demonstrate sustainable improvement?
- The function of the Patient Experience Team and how it can support you
- Group work focussing on how we can use concerns and complaints to make improvements
    - *What I can do right now to improve the patient experience*
    - *What my ward/department can do to improve the patient experience*
    - *What the Trust/other ward and departments can do to help us improve the patient experience*

The groups presented their priorities to the Forum and discussed how, as ward leaders, they were going to action these priorities and to cascade learning at ward level. The work will be taken forward through future Forums.

A detailed quarterly report on all aspects of patient experience will go to Board in July.

7. 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.

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

York Teaching Hospital NHS
NHS Foundation Trust

Mental Health Implementation Plan
2014/2015

Principle	How to meet/Evidence required	Action to implement	Responsibility	Time Scale	Update July 2014
1) Improving Patient Care	1) Expert Resources 2) Training 3) Policy Guidance 4) Risk Management Planning	Service Level Agreement to be sought for guidance and support Multi-agency involvement/information sharing Staff Training Resource development Integration in Safeguarding Adults Training Needs Analysis and Strategy Policy review/integration Development of Observation Policy and Risk Management Tool	Trust Mental Health Service Development Working Group (MHSDWG)	To be advised following meeting of MHSDWG and dependent on approval from Trust wide awareness.	Meeting 10/07/2014. Terms of proposed SLA discussed for Board approval. Contact name secured (Neil McAdam)
2) Leadership, Assurance	1) Trust wide Awareness	Key department leads awareness of project	Nicola Cowley Lead Nurse for	By End of September	

and Accountability		**development and approval of this action plan** ☐ **Board** ☐ **Matrons** ☐ **Ward sisters/charge nurses** ☐ **Stake Holders** ☐ **Public and Patient Involvement**	**Safeguarding Adults**	**2014**	
	2) Governance working Group	**Multi-Team working group** **Terms of Reference** **Task and finish projects**			
	3) Trust Board Awareness **4) Clinical Commissioning Group awareness and support**	**Briefing Paper** **Involvement and invitation for participation in the Multi-team working group**			
	5) CQC impact	**Research of minimal and linked standards to inform action planning** **For escalation and feedback to Director of Nursing**			

		For inclusion in the Safeguarding Adults quarterly report			
3) Transparency	**1) Reporting** **2) External Reporting/accountability** **3) Documentation**	**System for feedback to Director of Nursing (QS)** **For inclusion in the Safeguarding Adults quarterly report** **Liaison with stakeholder to ascertain what assurance maybe required/expected and** **Consistent documentation with standard essential information prompts to support staff**	**Trust Mental Health Service Development Working Group**	**To be advised following meeting of MHSDWG and dependent on approval from Trust wide awareness.**	
4) Monitoring	**1) Data Collection** **2) Supervision Model** **3) Trend Monitoring** **4) Audit**	**For inclusion in Safeguarding Adults Reporting mechanisms** **Protocol and guidance for supervision following incidents involving Mental Health** **For inclusion in Safeguarding Adults Reporting mechanisms** **To be include in roles of Trust Mental health Service**	**Trust Mental Health Service Development Working Group**	**To be advised following meeting of MHSDWG and dependent on approval from Trust wide awareness.**	

	5) Quality Assurance	**Development Working Group** **Research and development of Safety assurance Tool (Dashboard)**			

Nicola Cowley
July 2014

References

A positive and proactive workforce (DOH/Skills for Health 2014)
Meeting the needs and reducing distress (NHS Protect 2014)

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Appendix 2

Org: RCB York Teaching Hospital NHS Foundation Trust

Period: June_2014-15

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

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

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night	
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	RCB55	York Hospital - RCB55	G1	502 - GYNAECOLOGY	100 - GENERAL SURGERY	1566	1509.33	783	622.83	626.4	651.17	313.2	407	96.4%	79.5%	104.0%	129.9%
	RCB55	York Hospital - RCB55	Extended Stay Area	100 - GENERAL SURGERY	120 - ENT	822.15	832.5	411.075	398.49	420	388.5			101.3%	96.9%	92.5%	
	RCB55	York Hospital - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1566	1544.5	978.75	837	600.3	674.25	600.3	593.75	98.6%	85.5%	112.3%	98.9%
	RCB55	York Hospital - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1761.75	1648	1174.5	1025.33	978.75	1042.42	652.5	617.83	93.5%	87.3%	106.5%	94.7%
	RCB55	York Hospital - RCB55	15	120 - ENT	101 - UROLOGY	1566	1602.5	1174.5	1013	939.6	990	313.2	330	102.3%	86.2%	105.4%	105.4%
	RCB55	York Hospital - RCB55	16	100 - GENERAL SURGERY		1957.5	1964	783	766	1226.7	1188	613.35	551	100.3%	97.8%	96.8%	89.8%
	RCB55	York Hospital - RCB55	17	420 - PAEDIATRICS		1174.5	1188.5	783	425.5	939.6	968			101.2%	54.3%	103.0%	
	RCB55	York Hospital - RCB55	Short Stay Ward	300 - GENERAL MEDICINE		1566	1510	1174.5	1460	600.3	605.17	600.3	757.5	96.4%	124.3%	100.8%	126.2%
	RCB55	York Hospital - RCB55	Acute Medical Unit	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2349	2033.25	1957.5	1601.5	1500.75	1472.25	1200.6	1198.66	86.6%	81.8%	98.1%	99.8%
	RCB55	York Hospital - RCB55	23	430 - GERIATRIC MEDICINE		1566	1457.5	978.75	1141.92	600.3	648.5	600.3	894.5	93.1%	116.7%	108.0%	149.0%
	RCB55	York Hospital - RCB55	25	430 - GERIATRIC MEDICINE		1566	1330.5	978.75	1054	600.3	630.17	600.3	713.67	85.0%	107.7%	105.0%	118.9%
	RCB55	York Hospital - RCB55	26	430 - GERIATRIC MEDICINE		1566	1543.25	978.75	1052.75	600.3	654.17	600.3	609	98.5%	107.6%	109.0%	101.4%
	RCB55	York Hospital - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1761.75	1593.5	978.75	969.33	600.3	630	600.3	745.5	90.4%	99.0%	104.9%	124.2%
	RCB55	York Hospital - RCB55	29	110 - TRAUMA & ORTHOPAEDICS		1566	1274.25	783	629	600.3	619.5	300.15	304.25	81.4%	80.3%	103.2%	101.4%
	RCB55	York Hospital - RCB55	Coronary Care Unit	320 - CARDIOLOGY		1566	1468.67	195.75	134.5	1252.8	1264.58			93.8%	68.7%	100.9%	
	RCB55	York Hospital - RCB55	31	370 - MEDICAL ONCOLOGY		1761.75	1558.25	783	767.33	600.3	630	300.15	316.08	88.4%	98.0%	104.9%	105.3%
	RCB55	York Hospital - RCB55	32	320 - CARDIOLOGY		1761.75	1600.23	1174.5	1614.58	600.3	657.67	600.3	1320	90.8%	137.5%	109.6%	219.9%
	RCB55	York Hospital - RCB55	33	301 - GASTROENTEROLOGY	361 - NEPHROLOGY	1566	1262.5	1174.5	1303.17	600.3	574.25	600.3	1020.5	80.6%	111.0%	95.7%	170.0%
	RCB55	York Hospital - RCB55	34	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1566	1524.5	1174.5	1114	600.3	644.25	600.3	694.75	97.3%	94.8%	107.3%	115.7%
	RCB55	York Hospital - RCB55	35	430 - GERIATRIC MEDICINE		1566	1393.5	978.75	1097	600.3	609.17	600.3	639.5	89.0%	112.1%	101.5%	106.5%
	RCB55	York Hospital - RCB55	37	430 - GERIATRIC MEDICINE		1174.5	1298.83	1370.25	1385.67	600.3	639.92	600.3	763.25	110.6%	101.1%	106.6%	127.1%
	RCB55	York Hospital - RCB55	39	430 - GERIATRIC MEDICINE		978.75	1119.5	978.75	950.5	600.3	594.5	300.15	345.66	114.4%	97.1%	99.0%	115.2%
	RCB55	York Hospital - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		4307	4093.67	392	144.5	3589	3371	326	92	95.0%	36.9%	93.9%	28.2%
	RCB55	York Hospital - RCB55	36	430 - GERIATRIC MEDICINE		1566	1412.5	978.75	972	900.45	914	600.3	577.5	90.2%	99.3%	101.5%	96.2%
	RCBP9	White Cross Rehabilitation Hospital - RCBP9	Whitecross Court	430 - GERIATRIC MEDICINE		783	849.92	978.75	1015.67	600.3	551	300.15	392.25	108.5%	103.8%	91.8%	130.7%
	RCBTV	St Helens Rehabilitation Hospital - RCBTV	St Helens	430 - GERIATRIC MEDICINE		783	752.58	978.75	1080.5	293.625	345.5	293.625	345	96.1%	110.4%	117.7%	117.5%
	RCBL8	Malton Community Hospital - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		989.775	1095.91	1385.685	1538.75	580.668	660	580.668	858	110.7%	111.0%	113.7%	147.8%
	RCB07	Selby and District War Memorial Hospital - R	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1074.4875	917.75	1074.4875	1027.08	315.183	345	630.366	622	85.4%	95.6%	109.5%	98.7%
	RCB55	York Hospital - RCB55	Archways	925 - COMMUNITY CARE SERVICES		887.76	783	1109.7	1011.5	340.308	344.5	680.616	681.5	88.2%	91.2%	101.2%	100.1%
	RCBG1	Whitby Community Hospital - RCBG1	War Memorial	925 - COMMUNITY CARE SERVICES		851.13	815.92	1276.695	1191.84	340.452	392.5	680.904	659	95.9%	93.4%	115.3%	96.8%
	RCBG1	Whitby Community Hospital - RCBG1	Abbey	925 - COMMUNITY CARE SERVICES		638.3475	641.01	1063.9125	986.57	340.452	330	340.452	330	100.4%	92.7%	96.9%	96.9%
	RCBCA	Scarborough General Hospital - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1174.5	1050.42	978.75	959.25	574.2	605	287.1	405	89.4%	98.0%	105.4%	141.1%
	RCBCA	Scarborough General Hospital - RCBCA	Ash	100 - GENERAL SURGERY		880.875	798.25	704.7	584	600.3	413.5	0	21	90.6%	82.9%	68.9%	

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RCB York Teaching Hospital NHS Foundation Trust

Period: June_2014-15

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Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night	
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	RCB55	York Hospital - RCB55	G1	502 - GYNAECOLOGY	100 - GENERAL SURGERY	1566	1509.33	783	622.83	626.4	651.17	313.2	407	96.4%	79.5%	104.0%	129.9%
	RCBCA	Scarborough General Hospital - RCBCA	Beech	300 - GENERAL MEDICINE		1566	1487.42	1370.25	1207.83	939.6	978	626.4	660	95.0%	88.1%	104.1%	105.4%
	RCBCA	Scarborough General Hospital - RCBCA	Cherry	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1957.5	1742.5	1566	1580.58	1533.375	1580.25	1226.7	1289	89.0%	100.9%	103.1%	105.1%
	RCBCA	Scarborough General Hospital - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2153.25	2085.42	391.5	373.25	1252.8	1276.5	313.2	308	96.8%	95.3%	101.9%	98.3%
	RCBCA	Scarborough General Hospital - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1566	1544.91	1174.5	1098.58	613.35	660	613.35	660	98.7%	93.5%	107.6%	107.6%
	RCBCA	Scarborough General Hospital - RCBCA	Duke of Kent	420 - PAEDIATRICS		1370	1240	392	413	626	649	313	308	90.5%	105.4%	103.7%	98.4%
	RCBCA	Scarborough General Hospital - RCBCA	Maple	100 - GENERAL SURGERY		2153	1768.68	1370	1112.3	1148	1003.5	574	578.75	82.1%	81.2%	87.4%	100.8%
	RCBCA	Scarborough General Hospital - RCBCA	Haldane	100 - GENERAL SURGERY	502 - GYNAECOLOGY	1174.5	1097.83	978.75	942.17	600.3	609	300.15	315	93.5%	96.3%	101.4%	104.9%
	RCBCA	Scarborough General Hospital - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1174.5	1158.67	978.75	1135	600.3	629.33	600.3	619.5	98.7%	116.0%	104.8%	103.2%
	RCBCA	Scarborough General Hospital - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE		1958	1697.5	392	213.5	1566	1729	0	0	86.7%	54.5%	110.4%	#DIV/0!
	RCBCA	Scarborough General Hospital - RCBCA	Oak	430 - GERIATRIC MEDICINE		1566	1781	1370.25	1795	600.3	945.25	600.3	896.5	113.7%	131.0%	157.5%	149.3%
	RCBCA	Scarborough General Hospital - RCBCA	Stroke	430 - GERIATRIC MEDICINE		1566	1527.5	783	805.75	939.6	944.5	313.2	330	97.5%	102.9%	100.5%	105.4%
	RCBNH	Bridlington and District Hospital - RCBNH	Johnson	430 - GERIATRIC MEDICINE		978.75	907.18	1370.25	1278.26	600.3	639.75	300.15	313.67	92.7%	93.3%	106.6%	104.5%
	RCBNH	Bridlington and District Hospital - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		978.75	999.5	783	855.75	600.3	577.5	0	252	102.1%	109.3%	96.2%	#DIV/0!
	RCBNH	Bridlington and District Hospital - RCBNH	Waters	430 - GERIATRIC MEDICINE		978.75	1025	978.75	973.5	600.3	630	300.15	315	104.7%	99.5%	104.9%	104.9%
	RCB05	St Monicas Hospital - RCB05		925 - COMMUNITY CARE SERVICES		630	544.91	795	660.33	372	360	372	360	86.5%	83.1%	96.8%	96.8%

Org: **RCB** **York Teaching Hospital NHS Foundation Trust**
Period: **June_2014-15**

		Day				Night				Day		Night	
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
Site Code	Site Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
RCB05	St Monicas Hospital	630	544.91	795	660.33	372	360	372	360	86.5%	83.1%	96.8%	96.8%
RCB07	Selby and District War Memorial Hospital	1074.4875	917.75	1074.4875	1027.08	315.183	345	630.366	622	85.4%	95.6%	109.5%	98.7%
RCB16	Bootham Park Hospital	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
RCB55	York Hospital	41056.16	38546.73	24228.275	23491.4	21118.558	21405.94	12203.516	14173.4	93.9%	97.0%	101.4%	116.1%
RCBCA	Scarborough General Hospital	20260.125	18980.1	12450.45	12220.21	11594.125	12022.83	5767.7	6390.75	93.7%	98.2%	103.7%	110.8%
RCBG1	Whitby Community Hospital	1489.4775	1456.93	2340.6075	2178.41	680.904	722.5	1021.356	989	97.8%	93.1%	106.1%	96.8%
RCBL8	Malton Community Hospital	989.775	1095.91	1385.685	1538.75	580.668	660	580.668	858	110.7%	111.0%	113.7%	147.8%
RCBN1	Cross Lane Hospital	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
RCBN2	St Mary's Hospital	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
RCBNH	Bridlington and District Hospital	2936.25	2931.68	3132	3107.51	1800.9	1847.25	600.3	880.67	99.8%	99.2%	102.6%	146.7%
RCBP9	White Cross Rehabilitation Hospital	783	849.92	978.75	1015.67	600.3	551	300.15	392.25	108.5%	103.8%	91.8%	130.7%
RCBTV	St Helens Rehabilitation Hospital	783	752.58	978.75	1080.5	293.625	345.5	293.625	345	96.1%	110.4%	117.7%	117.5%

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 2014

DIPC Quarterly Report – Q1 2014/15

Action requested/recommendation

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

Summary

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

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

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

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

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

Director Infection Prevention and Control QUARTERLY INFECTION PREVENTION REPORT FOR TRUST BOARD. Q1 2014-2015							
Parameter		Annual threshold/ target	Apr	May	Jun	YTD	Notes
MRSA Bacteraemia attributable to Trust	Community					0	
	Elderly					0	
	Head + Neck					0	
	Medicine					0	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine					0	
	Surgery + Urology					0	
	Trauma + Orthopaedics					0	
	Trust		0	0	0	0	
MSSA Bacteraemia attributable to Trust	Community					0	IV Nurse roll to be established within Infection Prevention from July to manage practice and standards in relation to intravenous devices outside of Critical Care
	Elderly		2			2	
	Head + Neck					0	
	Medicine		3	2	3	8	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics			1		1	
	Specialist Medicine		1			1	
	Surgery + Urology		1			1	
	Trauma + Orthopaedics				1	1	
	Trust	30	7	3	4	14	
MSSA per 100000 bed days attributable to Trust	York		36.3	16.9	17.1		
	Scarborough + Bridlington		10.3	0.0	10.7		
	Community hospitals		0.0	0.0	0.0		
	Trust		23.0	9.3	12.6		
E coli Bacteraemia attributable to Trust	Community		4	1		5	Many appear to be endogenous infection without sepsis
	Elderly		2		4	6	
	Head + Neck					0	
	Medicine			4	1	5	
	Obstetrics + Gynaecology			1		1	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine		3	1	1	5	
	Surgery + Urology		3	3	2	8	
	Trauma + Orthopaedics					0	
	Trust	Not set	12	10	8	30	
Elective MRSA admission screening (report produced by SNS Team)	York sites	100%	82%	86%	89%		
	Scarborough sites	100%	76%	83%	81%		
	Trust	100%	79%	84%	85%		
Emergency MRSA admission screening (report produced by SNS Team)	York sites	100%	64%	71%	71%		Flag required on CPD to alert staff that a screen is required. IT have been approached
	Scarborough sites	100%	77%	74%	76%		
	Trust	100%	71%	73%	74%		

Parameter		Annual threshold/ target	Apr	May	Jun	YTD	Notes
Clostridium difficile Infection (CDI) attributable to Trust	Community					0	
	Elderly		2		3	5	
	Head + Neck					0	
	Medicine		1		3	4	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine			2		2	
	Surgery + Urology		1			1	
	Trauma + Orthopaedics					0	
	Trust	59	4	2	6	12	CDI under threshold
CDI per 100000 bed days attributable to Trust	York		12.9	11.3	17.1		
	Scarborough + Bridlington		20.7	0.0	32.0		
	Community hospitals		0.0	0.0	0.0		
	Trust		13.1	6.2	18.9		
CDI Saving Lives care bundle compliance	York	95%	90%	95%	97%		
	Scarborough + Bridlington	95%	88%	76%	95%		
	Trust	95%	89%	85%	91%		
Outstanding CDI post infection review	Community					0	
	Elderly		2		3	5	Cases allocated to microbiologist with a view to improved compliance in completing PIR
	Head + Neck					0	
	Medicine		1		3	4	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine			2		2	
	Surgery + Urology					0	
	Trauma + Orthopaedics					0	
	Trust		3	2	6	11	
Deaths where Clostridium difficile is reported on certificate	Community					0	
	Elderly		1			1	April 2014 - Part 1(b) on death certificate
	Head + Neck					0	
	Medicine					0	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine					0	
	Surgery + Urology					0	
	Trauma + Orthopaedics					0	
	Trust		1	0	0	1	
Readmissions within 30 days where CDI is diagnosed on and thought to be reason for admission - NB: refers to discharging directorate	Community					0	
	Elderly			1		1	
	Head + Neck					0	
	Medicine					0	
	Obstetrics + Gynaecology					0	
	Ophthalmology					0	
	Paediatrics					0	
	Specialist Medicine					0	
	Surgery + Urology					0	
	Trauma + Orthopaedics					0	
	Trust		0	1	0	1	

Parameter		Annual threshold/ target	Apr	May	Jun	YTD	Notes
Antimicrobial pathway compliance with indication (information from Antimicrobial Stewardship Team)	Anaes,Theatre and Crit care						Changes have been made to the Trust prescription chart to prompt prescribers to document indication and course length on antimicrobial prescriptions
	Elderly		85%	92%	93%		
	Emergency						
	Head + Neck		33%	43%	87%		
	Medicine		73%	95%	88%		
	Obstetrics + Gynaecology						
	Specialist Medicine						
	Surgery + Urology		80%	85%	78%		
	Trauma + Orthopaedics		46%	89%	90%		
	Trust		73%	87%	85%		
Antimicrobial pathway compliance with duration or review date (information from Antimicrobial Stewardship Team)	Anaes,Theatre and Crit care						
	Elderly		90%	96%	88%		
	Emergency						
	Head + Neck		83%	38%	73%		
	Medicine		79%	88%	90%		
	Obstetrics + Gynaecology						
	Specialist Medicine						
	Surgery + Urology		77%	92%	79%		
	Trauma + Orthopaedics		69%	89%	90%		
	Trust		80%	87%	85%		
Ventilator acquired pneumonia in ICU (information provided by ICU)	York ICU		0	0	0	0	
	Scarborough ICU		0	0	0	0	
	Trust		0	0	0	0	
CVC associated infections in ICU (information provided by ICU)	York ICU		0	0	0	0	
	Scarborough ICU		0	0	0	0	
	Trust		0	0	0	0	
Trust attributed CAUTI (Safety Thermometer data)	York		1	0	0	1	
	Scarborough + Bridlington		1	1	0	2	
	Community hospitals		3	0	1	4	
	Trust		5	1	1	7	
Hand Hygiene compliance	Trust	Trust wide hand hygiene observations under review. Current audits highlight inconsistency in interpretation and application of the World Health Organisation 5 moments and do not provide assurance that hand hygiene practice is compliant.					
Environment audit results	York sites	95%	97%	90%	96%	94%	Change of matron patch in May
	Scarborough sites	95%	96%	84%	91%	90%	
	Trust	95%	97%	91%	95%	92%	
Infection Prevention training attendance (attendance reports provided by Corporate, Learning and Development Team)	Trust	Statutory mandatory face to face training currently not available - awaiting e-learning to go live (delay caused by learning hub).					

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York Teaching Hospital NHS
NHS Foundation Trust

Finance and Performance Committee – 22nd July 2014, Room 26, Trust Headquarters, YH

Attendance: Mike Sweet, Chairman
Lucy Turner
Andrew Bertram
Graham Lamb
Libby Raper
Anna Pridmore
Lisa Gray

Apologies: Mike Keaney, Liz Booth, Steven Kitching

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last Meeting Notes Minutes Dated 17 June 2014**		The notes were approved as a true record of the meeting.		
2	**Matters arising**		**Bed Reconfiguration** – LT advised that the final proposal had been discussed at a recent Executive Board. A few outstanding issues were raised late and these are being picked up by LB. **Emergency Department** – MS asked whether there has been any progress made in relation to a GP(s) supporting the Trust in ED. LT confirmed that this was being progressed,	The committee was assured that these issues were being addressed And that the plan would soon be finalised The committee was assured that progress being made and asked for this item to be kept on the agenda.	MP to provide an update

	Agenda Item	AFW	Comments	Assurance	Attention to Board
4	**Efficiency Report**	CRR 39	AB was delighted to confirm that Steve Kitching has been successfully recruited to this post. SK will commence in the post from 1st August 2014. The current planning gap has reduced from £6.4m last month to £4.6m this month. Concern was expressed that the forward plan assumes more recurrent savings than are currently being achieved and that there are only 8 months left in the year. The current Monitor variance (£1.6m) is still behind plan; this is resulting in pressure being put on the Trust's financial position. The committee expressed concern about the non-recurrent proportion of achieved CIP. At 54% this has grown significantly from last month. It was agreed that a new chart showing the recurrent – non recurrent split be included in the report AB advised the committee that once a CIP saving has been claimed it is removed from a directorate's budget so that it can no longer be spent. This is important for managing finances in-year but he recognised that the benefit of taking such non-recurrent windfall opportunities was short term. AB informed the committee that a series of CIP panel meetings with Directorates and the Chief Executive are planned to assist directorates in sourcing further efficiency savings. The format of these meetings has been developed further. In the first half of the meeting directorates will present how they are making or planning to make savings, and the second half will be an executive view on the directorate to inform them of where they believe the directorate can make savings. SLR data will be presented along with benchmarking data and Better Care Better Value indicators. AB referred to the governance rating and noted that only three directorates currently have a green rating despite the	The committee was assured that although the Trust was behind plan, there are firm plans in place to help improve the Trust's current situation.	PC to make additional comments

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Trust being half way through July. This raised concerns with the Committee around the resources available to the team to support delivery of the plans. AB confirmed that the issue is not currently with the Efficiency Team, but with Directorates. LT explained that the Trust is currently managing a number of senior vacancies within the operational areas. As are result contingency arrangements are being put in place and this makes it difficult for the Directorates affected to focus on and deliver the plan. However, recruitment is currently underway for DMs and individuals should be in place over the coming months, which will improve the current situation. AB informed the Committee that the Trust is currently looking at using project managers to assist struggling directorates, as was suggested by Monitor. MS asked for the report format to be reviewed with particular regard to commentaries. AB agreed that the report had been in the current format for some time and it was a good time to refresh the presentation of the information and develop this to include specific contemporary narrative describing current actions and delivery plans.		
5	**Operational Report**	**AFW** DoF7 COO3 **CRR** 36	**Access Targets –** **18 weeks** – LT advised the CCG has agreed to waive the fine in relation to the patients who waited over 52 weeks. LT confirmed that all three 18 week targets have been achieved on aggregate as a Trust for quarter 1, although T&O and ENT continue to fail the admitted target at speciality level and several areas on the non-admitted target. LT confirmed that there has been an increase in the number of patients on the incomplete backlog waiting over	The Committee were assured that plans are in place, and that alternatives are also being looked at with the assistance from IMAS. The Committee recognised that the Trust is continuing to liaise with both the CCG and Monitor over the issues currently being faced.	MP to cover issues at Board in relation to the long term achievement of 18 weeks, ED pressures Ambulance Handovers and issues with Radiology and Diagnostics for

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			18 weeks. This has increased by 428 since the end of Q4. IMAS (Interim Management and Support) have been commissioned to review RTT management. They recently visited the Trust and following a benchmarking exercise provided a report. The report is positive in terms of the Trust's current approach to RTT management with a very favourable review of the Trust's information systems and processes. However, the report identified potential improvements to the Trust's current management in relation to the 18 weeks target, including: 1. Monthly Performance 2. Capacity and Demand planning for 18 weeks 3. System-wide roles and responsibilities including specific commissioner actions and engagement. LT advised that to clear the backlog and keep new referrals within the 18 weeks target the Trust would have to fail repeatedly over a number of months. Such action will require careful management with stakeholders and regulators. IMAS agreed to continue to support the Trust to facilitate this work if necessary. LT confirmed to the Committee that independently of the above the Trust is likely to meet the target in Q2. LR raised concerns about capacity and demand. LT advised that in a number of specialities the Trust currently does not have enough capacity to meet demand, which continues to increase. This creates significant pressures on the Trust, especially given the difficulties of recruiting in some areas. **Cancer-** **14 day Fast Track** – LT confirmed there continues to be a significant increase in referrals. This is putting strain on the		the Trust as a whole.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			service, and means delivery of this target is not assured for Q1. LT advised that national initiatives are under way to promote the importance to GPs of increasing fast track referrals which will add further to the pressures. Data suggests rates are now increasing nationally. **14 day Symptomatic Breast** – LT confirmed the service changes have been made and elements of the service will be provided from York for Scarborough patients from 1st August 2014 until such times as a full Scarborough service can be re-established. **Emergency Department** – LT advised that the Trust failed to meet the 95% target for June and for Q1. Attendance was very high in June - it was above the upper control limits. LT confirmed Scarborough has introduced some further controls which should result in delivery of the target in ED except on the occasions where the failure is due to a lack of beds. The Perfect Week report which Mike Proctor will present to the Board also has additional plans to help achieve the target. York is considering splitting the 4 hour target. ED staff would be required to make a referral for a bed within the first 2 hours, so giving 2 hours for a bed to be sourced before the patient breaches. A PMM is taking place later this week with ED to discuss this plan. **Ambulance Handover** – LT advised that there were over £300,000 fines in Q1. Following the opening of the Ambulance Assessment Unit in York the position has improved significantly, however at the same time Scarborough declined due to the high volume of ambulance activity There are plans being scoped to establish a handover area in Scarborough given the recent success in		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			York. **Diagnostics and Radiology** – LT advised that Radiology is finding it very difficult recruit to the vacant posts, and to help alleviate the problem, staff have been moved around the Trust's sites. However, this approach does not address the underlying issues. Two Sonographers have now returned to work following maternity leave and long term sick, it is hoped that this will now improve the situation. Several areas are struggling to deliver and the increase in fast track cancer referrals is impacting on the 18 weeks delivery. **Commissioning for Quality and Innovation (CQUIN)** – LT advised the committee that schemes have been agreed with Scarborough Whitby Ryedale/East Riding of Yorkshire CCG and Vale of York CCG. Final negotiations are taking place with NHS England regarding specialised service CQUINS. As a consequence a large number of schemes rated "amber" last month are now "green". There was one fail in relation to Dementia & Delirium. LT advised that the importance of the matter has been raised with consultants on all the sites at their Board meetings to make sure all medical assessments are completed in full at all times. Improvement is expected. **Infection Prevention** – The committee were advised there is currently a system issue with Infection Prevention but LT advised that this issue was in hand. **Transmission of IDLs to GP in 24hr of discharge** – The Trust continues to fall behind the target LT advised that there is an issue with GPs disputing receipt of emails or		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			faxes within the required 24 hours. The Committee had concerns that Monitor would be concerned at the Trust's ED and 14 day symptomatic breast performance. However, AP confirmed discussions have already taken place with Monitor to make them aware of the issues the Trust is facing, and the plans we have in place. Whilst failure is an issue, we are in active discussion already about our plans to remedy.		
6	**Finance Report**	**AFW** DoF2/ 3/5/7 **CRR** 35, 40, 41	The Committee were advised that the income and expenditure position for Q1 shows a £0.5m deficit, this is behind plan. AB advised the Committee that they should be aware that the declared position is attributable to a number of issues. Firstly in Q1 the Trust incurred contract penalties related to ED ambulance turnarounds issues. AB advised that he is approaching the CCGs with a request that the penalty is reinvested in delivering the solution to the problems, as oppose to supporting the CCG bottom line. At York the Trust has invested around £1m in the construction of the turnaround bays and £0.2m in additional staffing for the unit. Similar investment will be required at Scarborough. If the penalty is upheld and the CCG refuse to re-invest then AB expressed real concern about the Trust's ability to address the issue financially. AB also confirmed that the application of the 30% rule to non-elective activity and the penalties for 30 day readmission rules have resulted in the CCGs withholding £2.5m of income to the Trust for work that has been undertaken. Current national policy requires the CCGs to invest these monies in schemes to help manage emergency demand down. The CCGs have not invested this resource in Q1 and so the Trust has requested that the	The committee were assured by the plans to ask the CCG to reinvest the money into the Trust to help provide solutions to issues the Trust is currently facing. The committee were also assured by the fact that all contract details have been agreed and are due to be signed.	PJC is to discuss the financial position at Board, including the monies we are requesting to be re-invested in the Trust and the likely stance of Monitor.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			£2.5m is re-invested in the Trust to assist with the costs of managing the excess demand. The committee took particular note of the paragraph in AB's report that states "Clearly *we are approaching something of a watershed with regard to our finances. Our performance in Quarter 2 plus the response from our commissioners to our request for support will shape the actions the Board must take going forward*" The financial position was discussed in great detail and the Committee expressed its full endorsement of the approach that is being followed, and will be recommending that the Board does likewise. **Expenditure Analysis** - The Committee were advised that the pay budgets and provisions are £1m over spent in June. This is due to the Trust having to use a large number of locums and agency staff due to staff shortages. There are substantive funded vacant posts which need to be filled, as the Trust is now being placed under significant pressure due to the premium costs of agency staff. **Contracting Matters** – AB advised the Committee that contract details have now been agreed with all CCGs. Further to AB's report stating that contracts between the NHSE and the commissioners he was able to confirm to the committee that immediately prior to the meeting they had received clarification that this issue has now been resolved.		PJC to advise the Board in relation to Locum and Agency staff.
7	**Capital Planning update (deferred from June)**		This paper is deferred to the September meeting. The chair stated that the committee is not prepared to receive reports at such short notice unless there is pressing need. Brian Golding is to be invited to the September meeting to present the paper. AB confirmed to the committee there was no risk in deferring the paper to September's meeting. The Finance	The committee was assured that there was no risk to the Trust from deferring the paper to September.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			Report confirms that capital spend is broadly in line with plan.		
8	**Tender Register**		MS deferred this item.		
9	**Any Other Business**		There was no other business		

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York Teaching Hospital NHS
NHS Foundation Trust

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Monthly Performance Report

June 2014

Information Team
Systems and Network Services

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Apr	May	Jun	Q1 Actual
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail:** £400 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**90%**	91.1%	91.3%	90.3%	90.9%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	**Specialty fail**: £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TCB	**95%**	96.6%	97.2%	96.6%	96.8%
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	**Specialty fail:** £100 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**92%**	94.3%	93.6%	93.3%	93.3%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	0	3	1	1

Access Targets: Cancer

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

Indicator	Consequence of Breach	Threshold	Apr	May	Jun	Q1 Actual
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	87.3%	85.7%		
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	48.3%	41.3%		
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	99.5%	99.0%		
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	96.9%	96.3%		
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	100.0%	100.0%		
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	92.9%	87.1%		
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	91.4%	100.0%		
62 Day Consultant Upgrade	General Condition 9	**85%**	none	none		

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Apr	May	Jun	Q1 Actual
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£200 fine per patient below performance tolerance (maximum 8% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	94.6%	94.3%	93.0%	93.9%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**> 30min**	112	203	219	534
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**> 60min**	61	90	73	224
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**> 12 hrs**	0	0	0	0
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	96.1%	To follow	To follow	To follow

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Apr	May	Jun	Q1 Actual
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**TBC**				93
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	**TBC**				104

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Apr	May	Jun	Q1 Actual
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**59**	4	2	6	12
Number of Clostridium difficile due to "lapse in care"	*TBC*	**TBC**	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**108**	12	10	8	30
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) cases	**Quarterly:** General Condition 9	**35**	7	3	4	14
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	0	0	0	0
Notification of MRSA Bacteraemia to be notified to commissioner within 2 working days	General Condition 9	**100%**	n/a	n/a	n/a	n/a
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 14 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a	n/a	n/a
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a
Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	79.6%	82.5%	80.9%	81.0%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95% by Q4 TBC**	68.2%	74.2%	76.1%	73.0%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Apr	May	Jun	Q1 Actual
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 fine per patient below performance tolerance	**99%**	97.9%	96.7%	98.5%	97.6%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	0	0
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hosp	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	0	0	1	1
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	8	35	20	63
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	£200 in respect of each excess breach above threshold	**95%**	97.1%	97.1%	97.6%	97.2%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.6%	To follow	To follow	To follow
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	7.5%	5.4%	To follow	To follow
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 89% Q2 - 90% Q3 - 92% Q4 - 95%**	82.0%	84.9%	90.4%	85.9%
Delayed Transfer of Care to be maintained at a minimum level	TBC	**TBC**	400	555	593	1548
Trust waiting time for Rapid Access Chest Pain Clinic	None	**99%**	100.0%	100.0%	100.0%	100.0%
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance			
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**200 per month**	110	101	137	348
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**Baseline 784; end Q2 745; end Q4 722**	733	743	760	2236
% of ED Admissions With a NEWS Score		**TBC**	78.1%	79.7%	78.5%	78.8%
% Compliance with WHO safer surgery checklist	No financial penalty	**100%**	100.0%	100.0%	100.0%	100.0%
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	91	2 month coding lag	2 month coding lag	2 month coding lag
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	342	2 month coding lag	2 month coding lag	2 month coding lag
Reduction in the number of inappropriate transfers between wards and other settings during night hours (Reduction in avoidable site transfers within the Trust after 10pm)	General Condition 9	**Q2 onwards 80 p.m. (TBC)**	87	91	78	256

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Apr	May	Jun	Q1 Actual
Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	General Condition 9	**80% by site**	91.9%	84.9%	87.0%	87.9%
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	91.6%	90.6%	99.4%	93.7%
Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	**95%**	100.0%	100.0%	100.0%	100.0%
Proportion of stroke patients who spend >90% of their time on a stroke unit	Non delivery of 90% at Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £5k in line with respective finance baselines (TBC)	**80%**	78.2%	86.5%	one month behind	
Proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours of seeing a health professional	Non delivery of Q4 £5,000 In line with GC9 where the provider fails to meet the quarterly trajectory an action plan will be delivered. Maximum sanction of £2k in line with respective finance baselines (TBC)	**70% (TBC)**	84.6%	89.7%	one month behind	
Proportion of patients presenting with stroke with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	General Condition 9	**65%**	90.0%	100.0%	one month behind	
Percentage of stroke patients and carers with joint care plans on discharge from hospital to have a copy of their care plan (except RIP or who refuse health/social care assessment/intervention)	General Condition 9	**70%**	n/a	n/a	one month behind	
Patients who require an urgent scan on hospital arrival, are scanned with in 1 hr of hospital arrival (TBC)	No financial penalty	**50%**	81.8%	81.0%	one month behind	
Proportion of stroke patients scanned within 24 hours of hospital arrival	No financial penalty	**90% (TBC)**	90.1%	90.4%	one month behind	
Transmission of IDLs to GPs within 24 hours of discharge (Q1-Q3 elective and non-elective activity IP only excluding DC, Maternity and by end Q4 to include surgical DC activity too) - Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology.	Failure to deliver the quarterly target will result in the application of a £4k penalty per quarter Maximum sanction of £16K per annum based upon respective commissioners financial baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	73.7%	75.0%	79.5%	76.0%
Immediate Discharge Letters (IDLs) handed to patients on Discharge	General Condition 9	**98%**	Annual letter of assurance to be provided to CMB			
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver quarterly trajectories at Trust aggregate level for each quarter will result in the application of a £10K sanction relating to each underperforming quarter. Maximum sanction of £40k per fiscal year. The penalty will be applied by the commissioners in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 95%**	Quarterly audit			
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	Failure to deliver the quarterly target will result in the application of a £6k penalty per quarter. Maximum sanction of £24k in line with respective finance baselines (TBC)	**Q1 - 90%** **Q2 - 91%** **Q3 - 93%** **Q4 - 94%**	Quarterly audit			
All Red Drugs to be prescribed by provider effective from 01/04/14	£50 penalty for any request to primary care for prescription of Red Drugs (TBC)	**100% list to be agreed**	CCG to audit for breaches			
All Amber Drugs to be prescribed by provider effective from 01/04/14	No financial penalty	**100% list to be agreed**	CCG to audit for breaches			
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	87.2%	86.8%	86.0%	86.1%

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Complaints and PALS												
New complaints this month	51	38	58									
Complaints at same month last year	52	48	49									
Number of complaints upheld (cumulative)*	not known yet	not known yet	not known yet									
Number of complaints partly upheld (cumulative)**												
Number of Ombudsman complaint reviews	0	2	0									
Number of Ombudsman complaint reviews upheld	0	0	0									
Number of Ombudsman complaint reviews partly upheld	0	1	1									
Late responses this month (at the time of writing)***	4	7	4									
Top 3 complaint issues												
Aspects of clinical treatment	39	27	34									
Admission/discharge/transfer arrangements	5	2										
Appointment delay/cancellation - outpatient	3											
Staff attitude		4	6									
Communications			5									
New PALS queries this month	495	474	528									
PALS queries at same time last year	488	521	462									
Top 3 PALS issues												
Information & advice	107	118	168									
Staff attitude	61											
Aspects of clinical treatment	53	87	99									
Appointment delay/cancellation - outpatient		66	59									
**note: upheld complaints are reported quarterly to allow for investigation timescales*												
***note: we do not record partly - if a complaint generates 1 or more actions for improvement then it is reorded as upheld*												
****note: if extensions are made in agreement with the complaint, responses are not considered late*												
Serious Incidents												
Number of SI's reported	19	21	20									
% SI's notified within 2 working days of SI being identified*	89%	76%	70%									
% SI's closed on STEIS within 6 months of SI being reported	50%	0%	0%									
Number of Negligence Claims	11	14	16									
* this is currently under discussion via the 'exceptions log'												
Pressure Ulcers**												
Number of Category 2	86											
Number of Category 3	26											
Number of Category 4	3											
Total number developed while in our care (care of the organisation) - a	28											
Total number developed while in our care (care of the organisation) - c	33											

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Falls* **												
Number of falls with moderate harm	10											
Number of falls with severe harm	8											
Number of falls resulting in death	0											
Safeguarding												
% of staff compliant with training (children)	quarterly submission		45%									
% of staff compliant with training (adult)	quarterly submission		39%									
% of staff working with children who have review CRB checks	quarterly submission											
Prevent Strategy												
Attendance at the HealthWRAP training session	3 in total	3 in total										
Number of concerns raised via the incident reporting system	nil	nil										

** 190 Pressure Ulcers were reported in total-but the breakdown here does not include 50 which have not yet been reviewed

*** 220 Falls reported in total - but the breakdown here does not include 46 which have not yet been reviewed.

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 2014

Finance Report – June 2014

Action requested/recommendation

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

Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 30 June 2014.

At the end of June the Trust is reporting an Income and Expenditure (I&E) deficit of £0.5m against a planned deficit for the period of £0.4m. The Income & Expenditure position places the Trust behind its Operational plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

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

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

Subject: June 2014 (Quarter 1) Financial Position

From: Andrew Bertram, Finance Director

Summary Reported Position for June 2014

The reported income and expenditure position for quarter 1 is that of a £0.5m deficit. This is slightly behind plan.

This represents an improvement from the £2.5m deficit reported in month 2 but there are two important issues that the Board should be aware of in relation to this movement.

Firstly, during quarter 1, we have incurred contract penalties of £330k related to ED ambulance turnaround issues. The Board are aware of the long standing difficulties but are also aware of the very recent success from the construction and staffing of the ambulance turnaround bays at York. We have formally approached our commissioners to request that the penalties incurred in quarter 1 for ambulance turnaround breaches are fully re-invested in providing the solution to this problem. The York scheme has cost around £1m in capital investment and £0.2m in additional recurring staffing investment. We are currently scoping the potential a similar scheme for the Scarborough site. If our commissioners choose not to re-invest the penalties then our ability to deliver and sustain solutions for patients arriving via ambulance will be compromised given our current financial position.

Secondly, during quarter 1, our commissioners have withheld £2.5m due to the impact of the 70% saving on the marginal rate non-elective tariff and due to the non-payment for certain readmissions. This is entirely in keeping with the current operating framework. However, the Board are aware that our commissioners have an obligation to re-invest these funds in schemes designed to reduce non-elective admissions, ED attendances and readmissions. Our commissioners have not commenced any new schemes during quarter 1 with these funds. The Board are aware of the success of the numerous and various winter schemes initiated in quarter 4, and the Trust's ability during this period to deliver the 4-hour ED access target. These schemes all stopped on the 31 March, non-elective activity levels have increased and the 4-hour ED target has been breached. The Trust's cost base has been adversely impacted from this additional work. We have formally approached our commissioners for recognition of this additional work, recognition of the impact of the removal of the winter schemes and recognition that they have yet to use these funds as directed. We have specifically requested recognition of the financial burden placed on the Trust during quarter 1.

I absolutely recognise that seeking this additional income is a risky strategy but it is a strategy that I believe the Trust should pursue. Our relationship with our commissioners is a collaborative relationship and all parties have expressed their desire to ensure financially viable secondary care provision within their patch. I feel it is entirely appropriate for funds raised through charging a penalty to be explicitly and expressly used to deliver a

sustainable solution in providing a better quality of services to our patients. It is also the case that through the national agenda there is absolute clarity on the expectations and obligations of commissioners in regard to the re-investment of marginal rate non-elective and readmission savings. In adopting this strategy we are simply pursuing this agenda for the benefit of our patients and for the benefit of our Trust.

This position returns a provisional COSR rating of 4, which is in line with our planned position. Failure to secure this additional income will cause our COSR rating to deteriorate down to level 3. This would be likely to invoke regulatory action and the need for a financial recovery plan. It is the case that seeking additional income for the issues described would form part of that recovery plan, further endorsing this action.

Clearly we are approaching something of a watershed moment with regard to our finances. Our performance in quarter 2 plus the response from our commissioners to our request for support will shape the actions the Board must take going forward.

CIP performance is £1.6m (year-to-date) behind the required savings level. This represents an improvement from month 2 and remains in line with the position reported this time last year. This is contributing to the financial pressure we are experiencing at this stage in the year. This issue is dealt with in detail in the efficiency report.

Income Analysis

The reported income position includes coded and costed data for April and May and an estimate has been included for June, as is usually the case. There are no additional income issues I would wish to bring to the Board's attention outside of the two risk income issues described above.

Contract penalties (excluding ambulance turnaround) have increased to £365k. Details are provided in the finance report and performance report.

Expenditure Analysis

Pay budgets and provisions are £1.0m over spent for June. Operational budgets are under spending but locum and agency medical staff and nursing staff expenditure is running at an unaffordable premium level. The agency spend to date totals £2.1m. Clearly there are substantive funded vacant posts offsetting this position but the premium cost on the use of agency is placing significant pressure on our finances. Pressure areas include: medical agency staff in Scarborough for Elderly, Acute Medicine and Ophthalmology and medical staff agency spend at York in ED. There is also considerable nursing agency expenditure in General Medicine, specifically AMU/SSW and Ward 33.

Pay spend (including agency) totalled £24.5m in June. This is in line with the average for April and May. Concerted attempts to recruit substantively must continue as an annual agency expenditure bill of around £8m represents a significant premium on costs.

There are no material pressures to report in terms of other operational budgets.

The report shows that the CIP programme is impacting adversely on the position by £1.6m. This is the most material adverse impacting issue on our expenditure and is dealt with in the CIP report. Despite the level of pressure this is consistent with the opening position in previous years.

2013/14 Contract Reconciliation

There are no issues to report to the Board in relation to developments with the final year end reconciliation process. The Board are aware that contract settlements for 2013/14 have not been agreed with HaRD CCG and HRW CCG. These disputes are not material at £0.4m in total and have been appropriately represented in our accounts. The usual national reconciliation process continues.

Contracting Matters

I am pleased to be able to report to the Board that contract details have now been agreed with all CCGs. This includes the finance and activity schedules for Vale of York which have proved difficult to bring to a conclusion due to affordability pressures. Contracts have not been signed yet as there still remains a residual issue between NHSE (Specialised Commissioning) and our commissioning CCGs. This is an allocation issue and whilst we have been involved in the supply and analysis of data the matter is between NHSE and CCGs. Until this matter is resolved contracts are unlikely to be signed.

Agreeing finance and activity schedules is an important step and monthly invoicing is now in line with these agreements. Even though formal contracts are not yet in place, payments are being made on account to the Trust and cash flow is not being compromised. I expect the NHSE/CCG issue to be closed imminently as this has now been formally escalated through the Area Team for resolution.

Other Issues

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

I would like to share with the Board overview details of the acute sector performance for 2013/14 now that Monitor and the TDA have published quarter 4 results.

For 2013/14 34 of the 83 acute FTs finished the year in deficit. This represents 41% of the acute FT sector and is a doubling of the number of deficit Trusts reported in 2012/13. Of particular note is the fact that the FT sector as a whole reported a significant reduction in net surplus from £491m in 2012/13 down to £133m in 2013/14.

In terms of the non-FT acute sector; 25 of the 62 Trusts reported deficits (40%). For this sector an overall net deficit of £311m was reported.

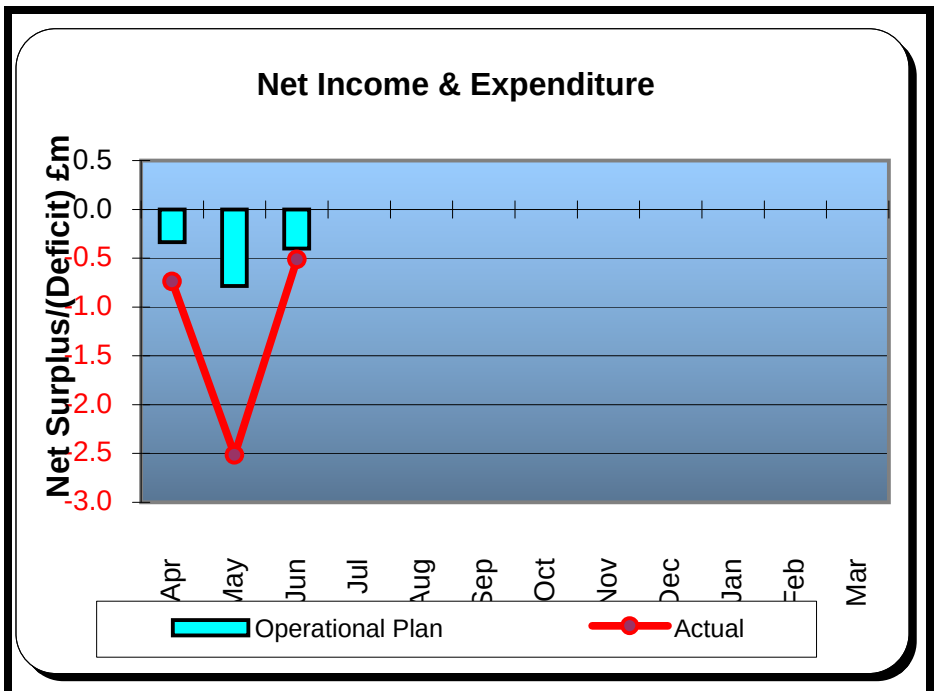
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2014 to 30 June 2014

High Level Overview

* A net I&E deficit for the period of £0.5m means the Trust is £0.1m behind plan.
* CIPs achieved at the end of June total £7.8m. The CIP position is running £1.6m behind plan.

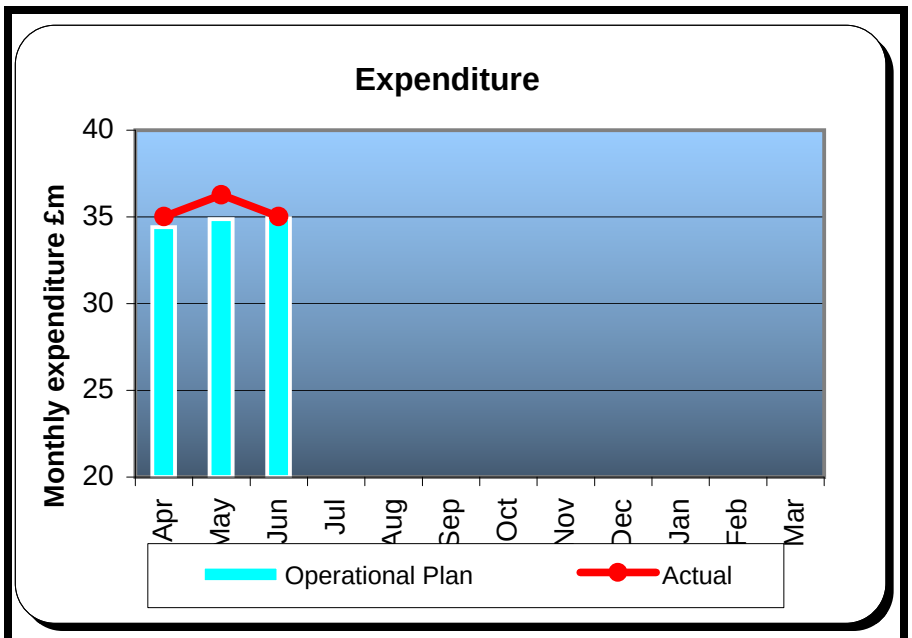
* Contracts are currently unsigned, however estimated overall actual activity value is forecast to be £0.2m behind overall contract total.

* Cash balance is £28.7m, and is £0.4m ahead of plan.
* Capital spend totalled £4.9m, and is in line with the plan.
* The Continuity of Service Risk Rating is 4.



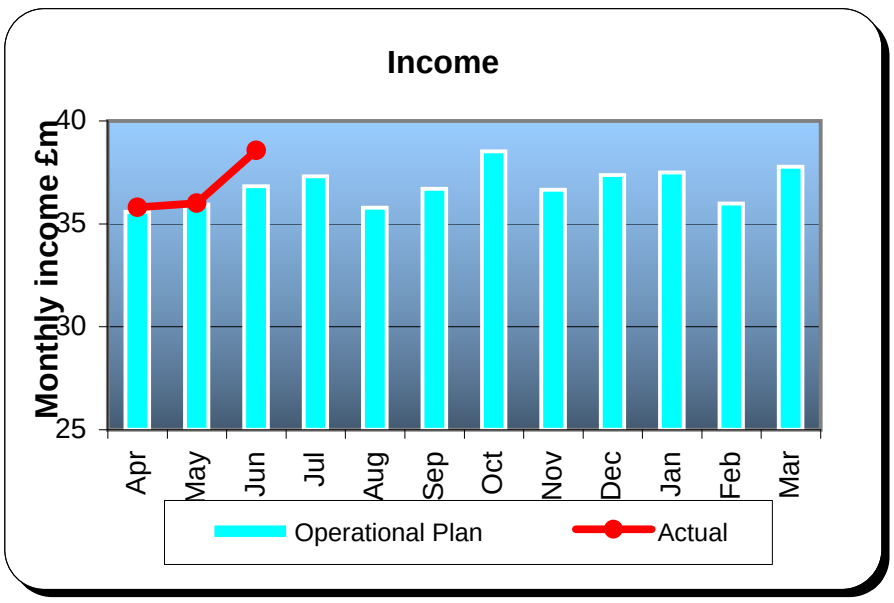
Key Period Operational Variances			
	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. VET)	92.2	94.7	2.6
Clin.Inc.(VET))	3.6	2.4	-1.2
Other Income	12.6	13.3	0.7
Pay	-72.7	-73.7	-1.0
Drugs	-10.4	-10.2	0.2
Consumables	-11.2	-10.8	0.4
Other Expenditure	-14.5	-16.3	-1.8
	-0.4	**-0.5**	**-0.1**

(VET = Vitreous Eye Treatments)



At the end of June there is an adverse variance against operational expenditure budgets of £2.1m. This comprises:-

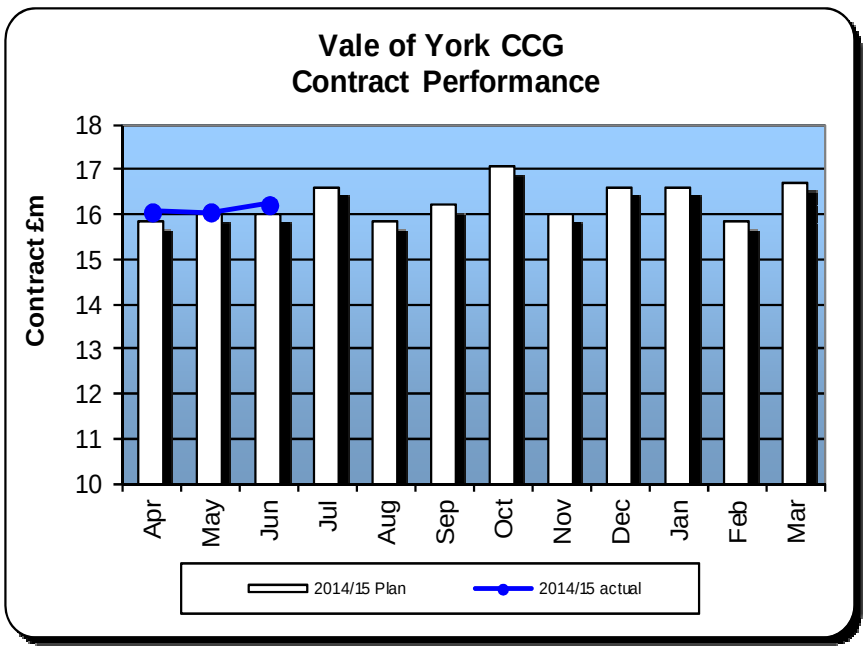
- Operational pay being £1.0m overspent, predominantly due to a premium paid for agency staff covering vacant posts
- Drugs £0.2m underspent
- Clinical supplies £0.4m underspent.
- Other costs are in balance
- Restructuring costs are £0.1m overspent
- CIPs are £1.6m behind plan



At the end of June income is marginally ahead of plan by £2.0m. This comprises:

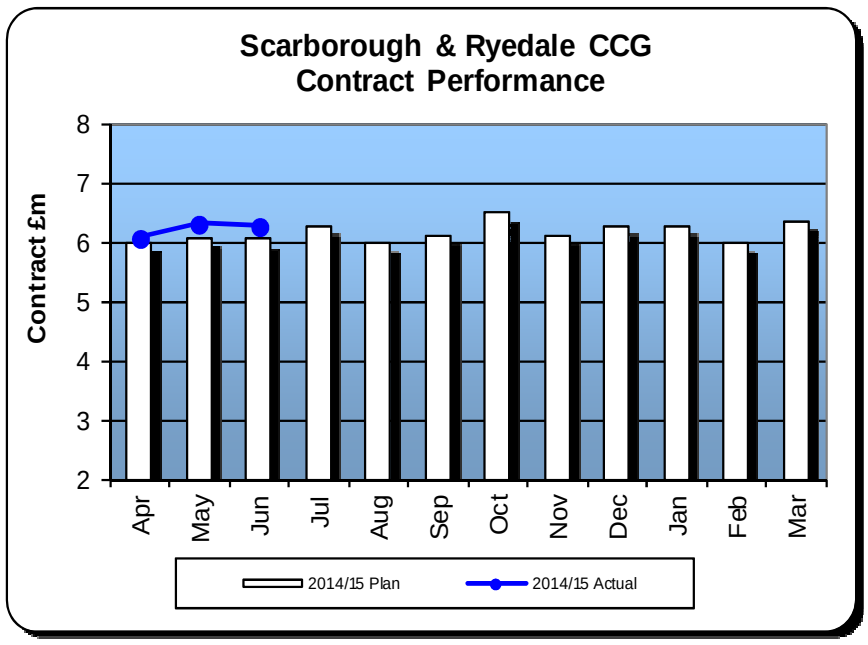
- Elective and day case income are behind plan by £0.4m.
- Non elective income is £2.4m ahead of plan
- Out patient income is behind plan by £0.4m
- A&E income is behind plan by £0.2m
- Other clinical income is ahead of plan by £0.3m.
- Other income is £0.7m ahead of plan
- Potential contract penalties and fines are estimated at £0.4m.

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



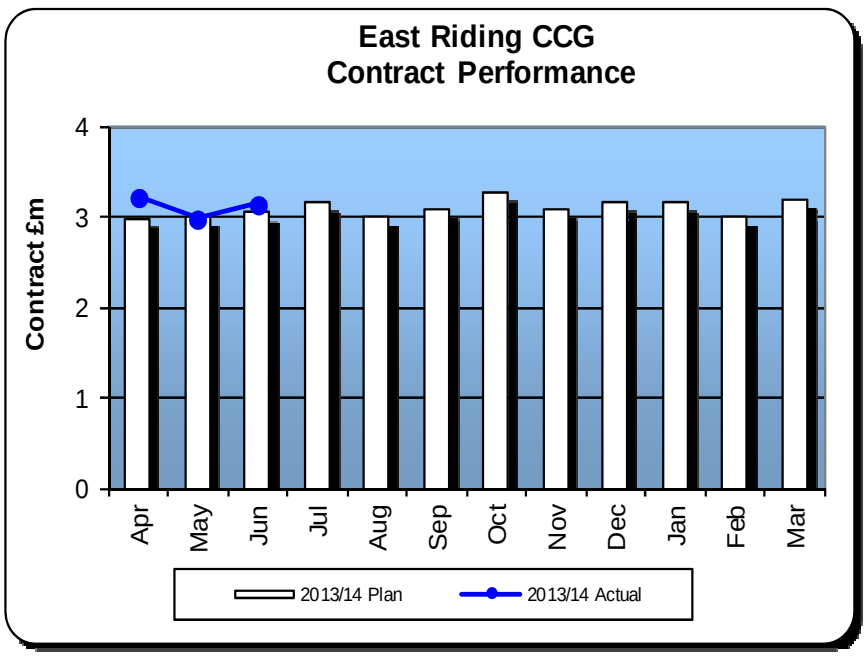
The contract value is estimated to be £195.4m.

The contract is not signed yet, however the estimated actual value to date is forecast to be marginally ahead of contract by £0.1m. This position includes estimates for June and the plan is phased in twelfths until finalised.



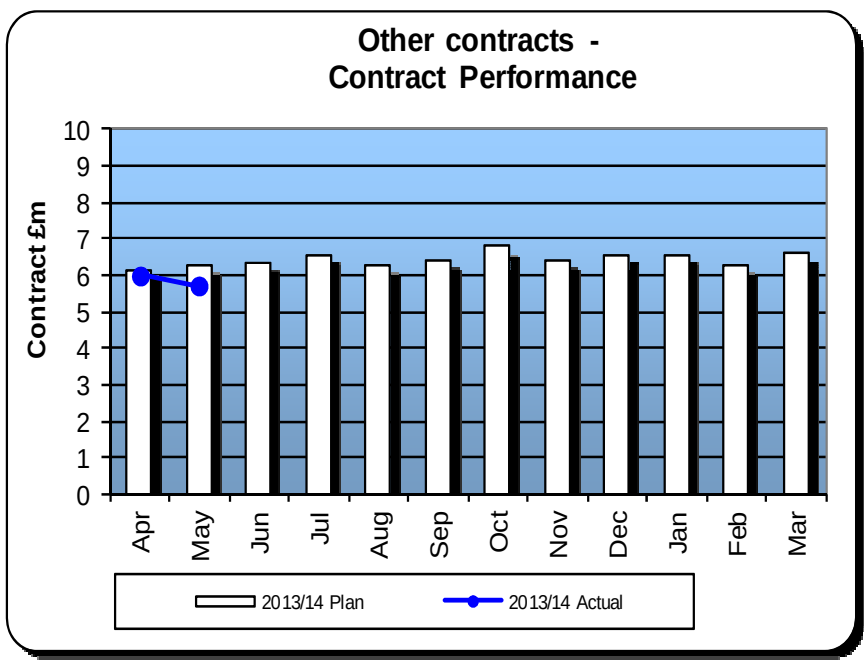
The contract value is estimated to be £73.7m.

The contract is not signed yet, however the estimated actual value to date is forecast to be ahead of contract by £0.5m. This position includes estimates for June and the plan is phased in twelfths until finalised.



The contract value is estimated to be £37.2m.

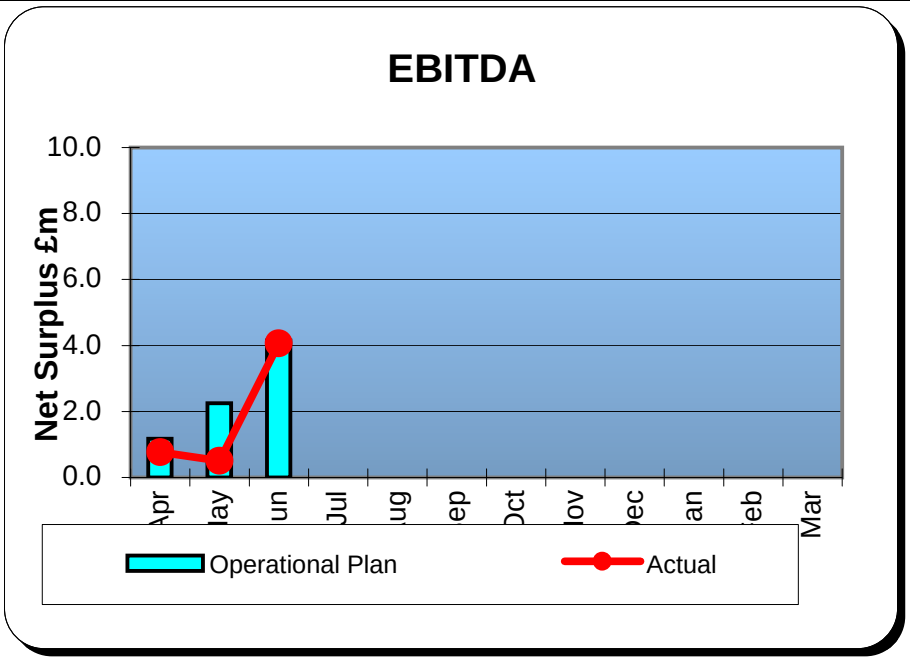
The contract is not signed yet, however the estimated actual value to date is forecast to be marginally ahead of contract by £0.2m. This position includes estimates for June.

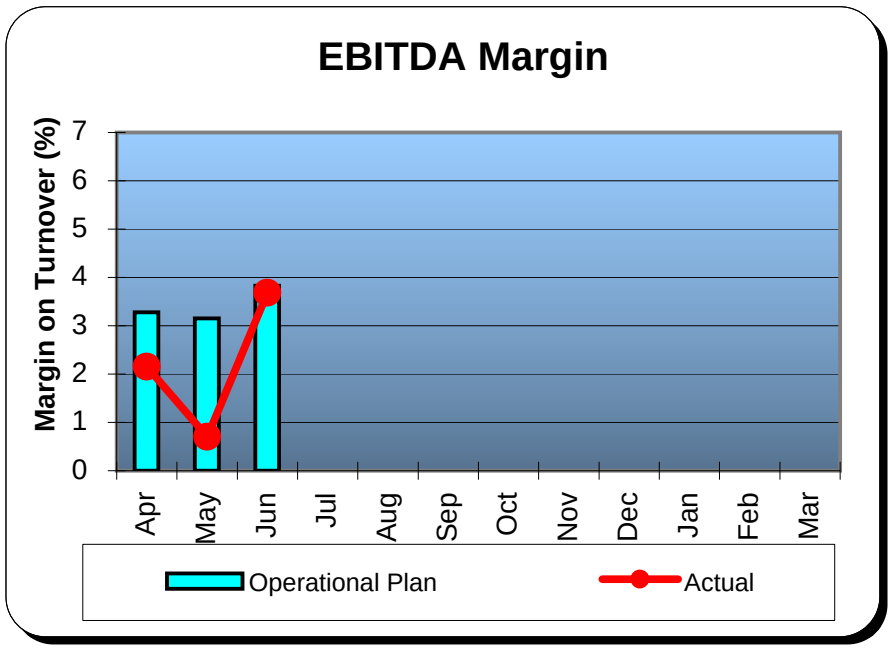


The contract value is estimated to be £77.2m.

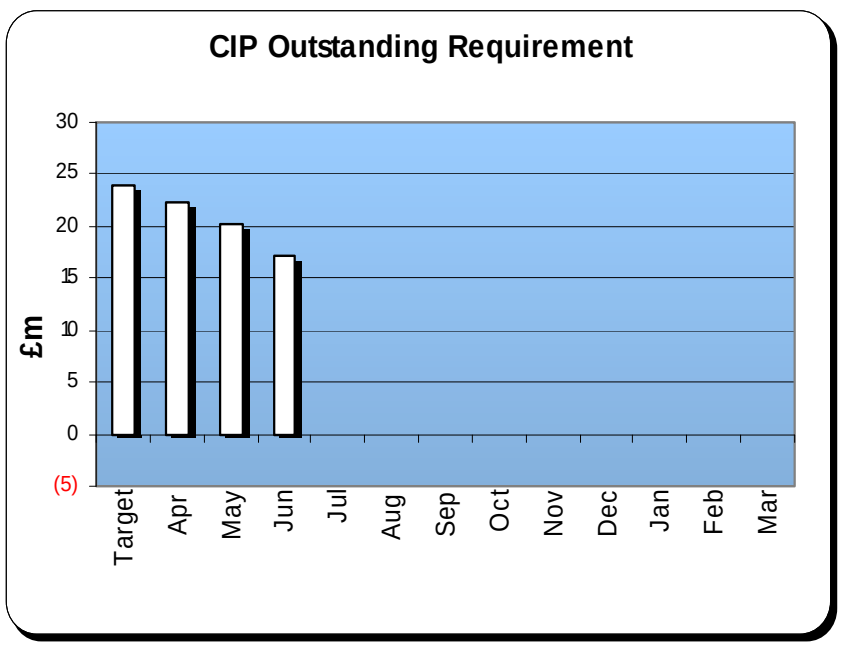
These include the smaller CCGs, NHS England (both public health services and prescribed specialist services), and Local Authority contracts. Overall, the actual position is estimated to be behind contract by £1.0m. The contracts are not yet signed, and the actual value is estimated at this stage. A high volume of uncoded data may affect the allocation of income against individual contracts, and particularly the undertrade on the prescribed specialist services of -£0.9m.

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

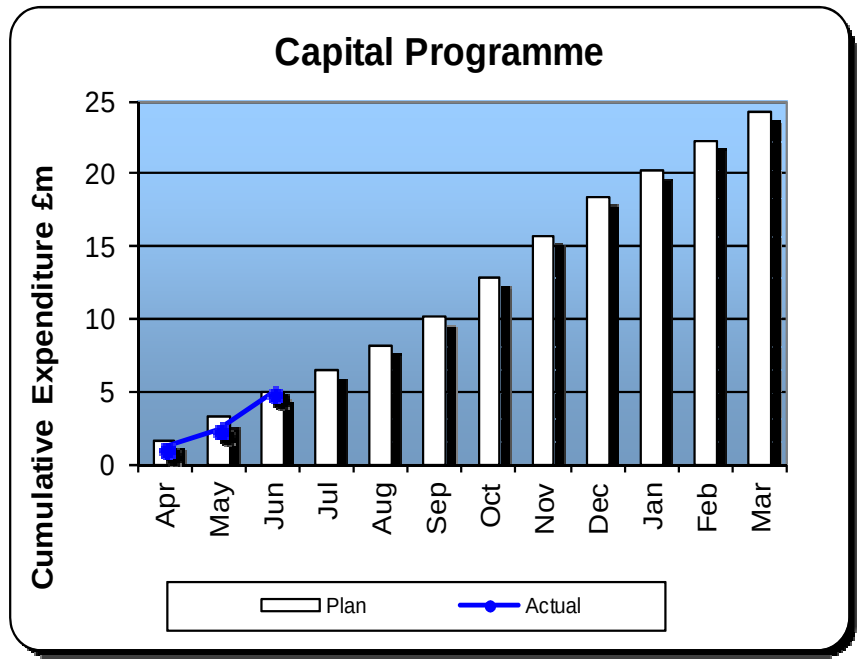




Actual EBITDA at the end of June is £4.01m (3.68%), compared to operational plan of £4.12m (3.83%), and is reflective of the overall I&E performance.



The full year efficiency requirement is £24.0m. At the end of June £7.8m has been cleared.



Capital expenditure to the end of June totalled £4.9m and is in line with plan.

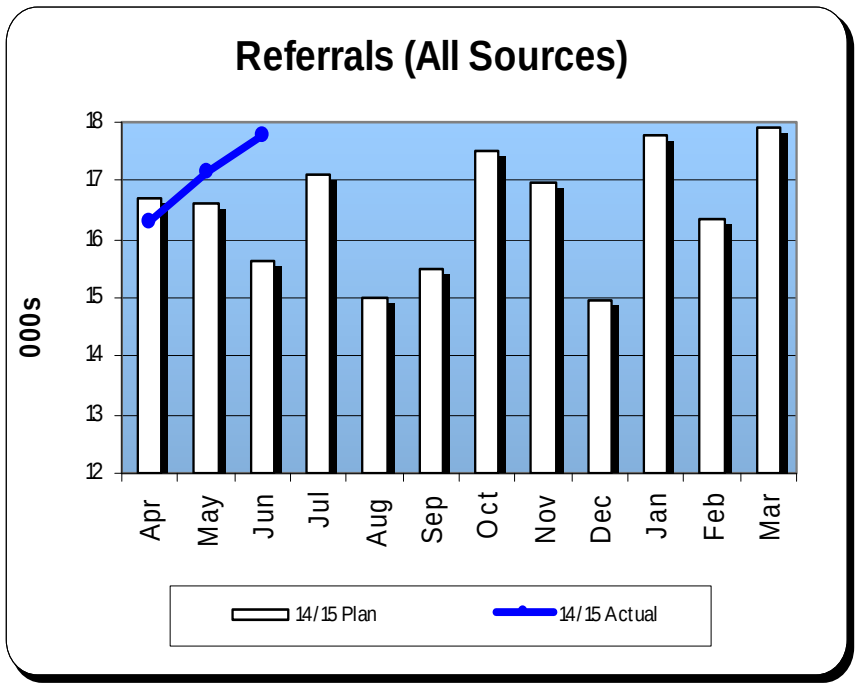
Capital schemes with significant in year spend to date include the on going upgrade of the York Hospital restarurant and kitchens, Endoscopy decontamination expansion and the carbon & energy scheme. In Scarborough the nearly completed new carpark and the maternity theatres upgrade .

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

Continuity of Service Risk Rating (CoSSR):

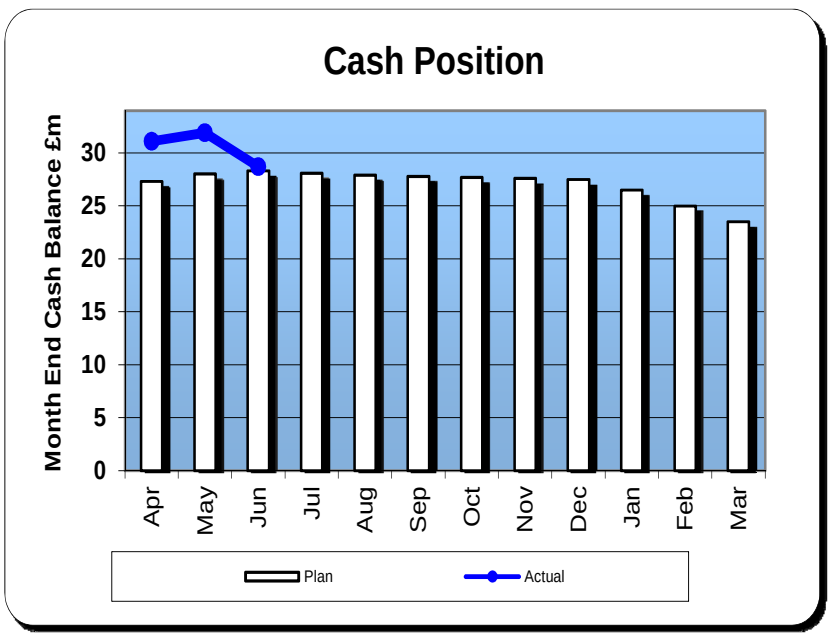
Debt Service Cover rating	3
Liquidity rating	4
Overall CoSSR	**4**

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



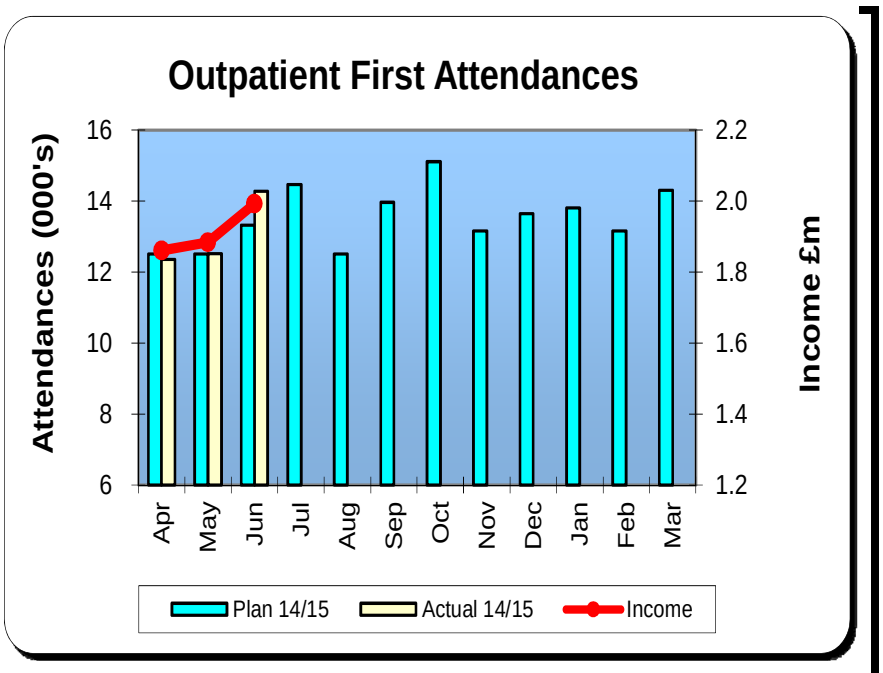
Annual plan 198,057 referrals (based on full year equivalent of 2013/14 outturn)

Variance at end of June: +2,287 referrals (+4.7%)
GP referrals +1,384 (+4.9%)
Cons to Cons referrals -782 (-10.4%)
Other referrals +1,685 (+12.9%)



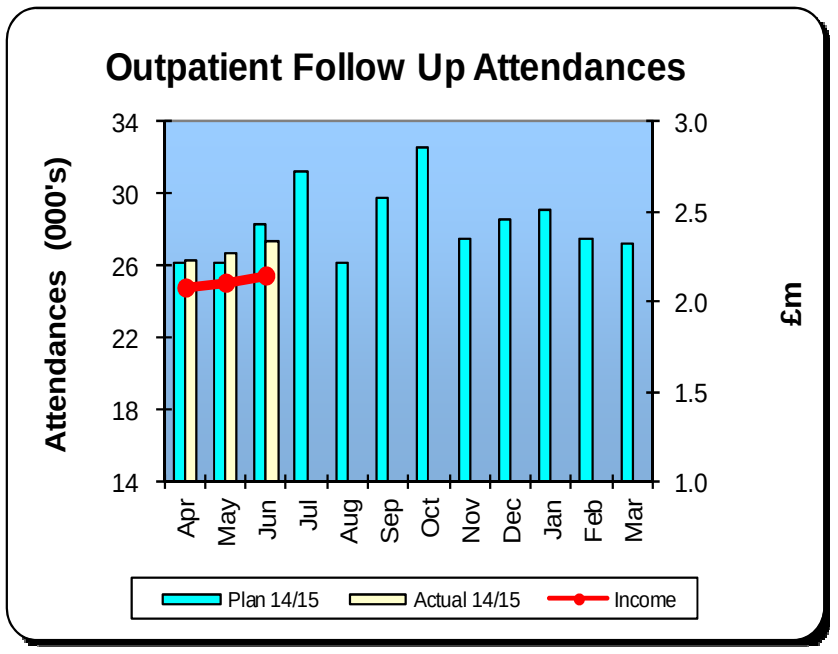
The cash balances at the end of June totalled £28.7m, and is £0.4m ahead of plan.

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



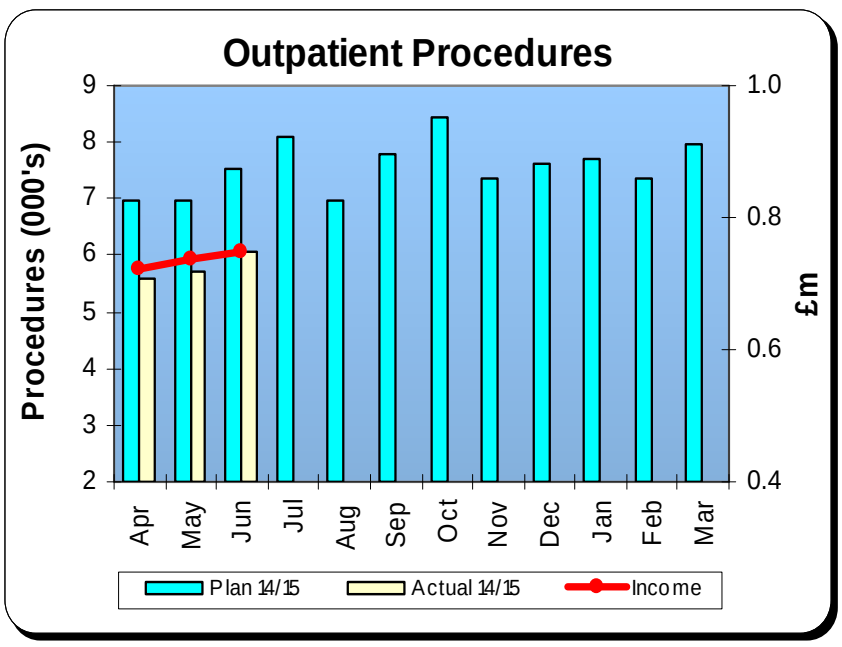
Annual Plan (Attendances) 162,401
Variance at end of June: +605 attendances (+1.6%).

Main variances: Opthalmology +654 (+17%), ENT +48 (+3%), Gastroenterology -254 (-21%), Cardiology -160 (-5%)



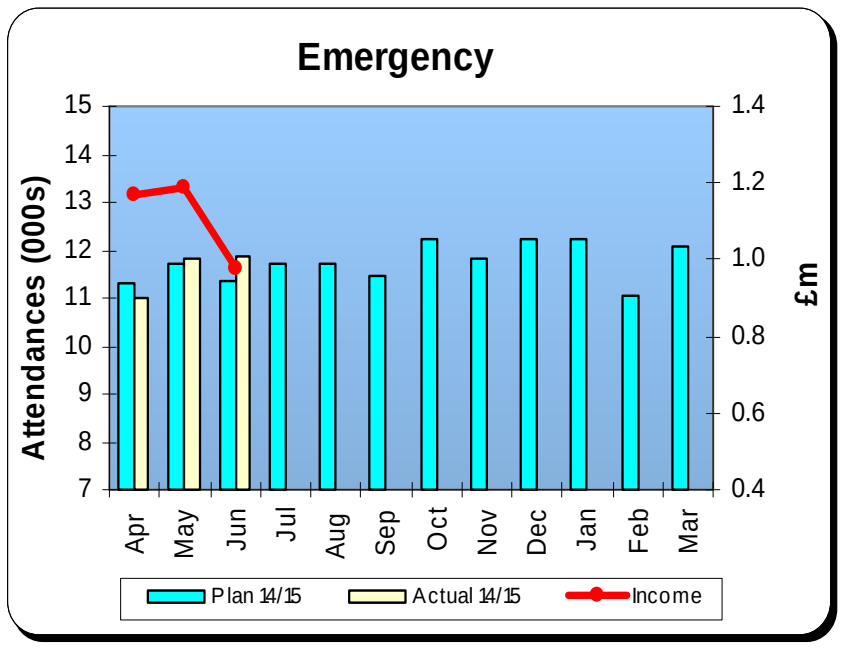
Annual Plan (Attendances) 340,039
Variance at end of June: -253 attendances (-0.3%).

Main variances: General Surgery +442 (+9%), Urology +101 (+5%), Opthalmology +618 (+5%), Anaesthetics -83 (-10%), and Medical Oncology -204 (-4%)



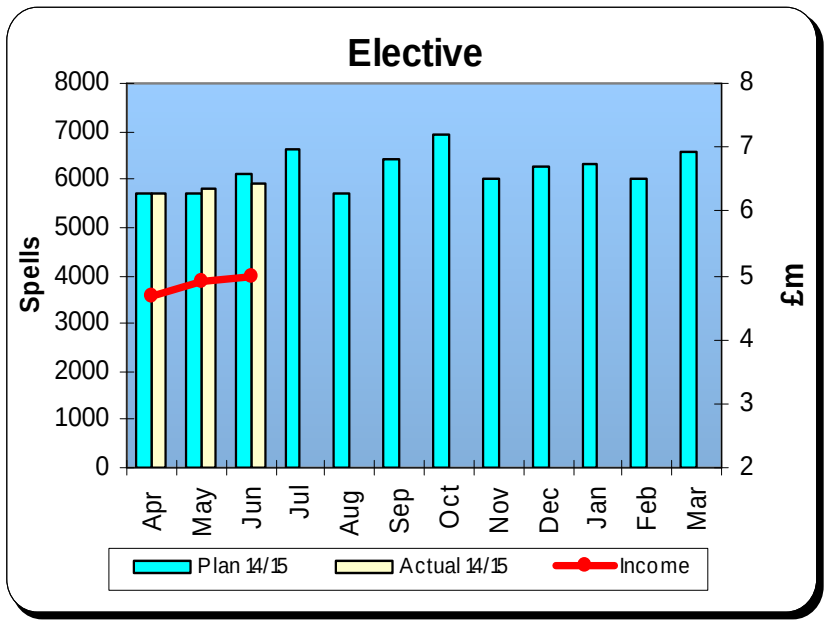
Annual Plan (Procedures) 90,710
Variance at end of June: -4,144 procedures (-19%).

Main variances: Gynaecology +96 (+10%), Orthodontics +137 (+6%), Trauma and Orthopaedics -642 (-75%), Cardiology -208 (-17%), and ENT -365 (-16%).



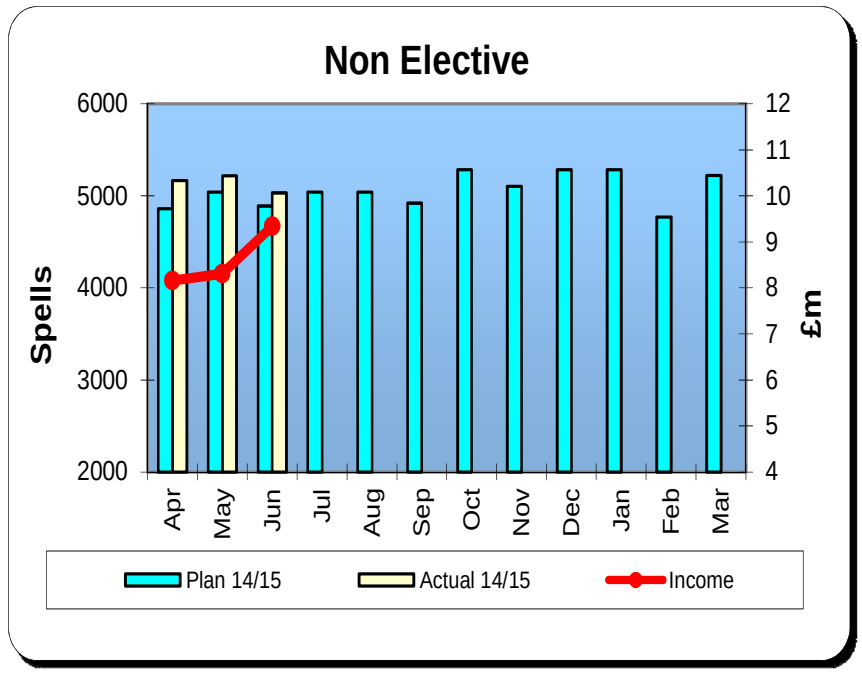
Annual Plan (Attendances) 140,831
Variance at end of June: +342 attendances (+1.0%).

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



Annual Plan (Spells) 74,445
Variance at end of June: -253 spells (-1.4%): inpatient +24; daycase -277

Main variances:) General Medicine +161 (+40%), Gastroenterology +129 (+5%),Urology -80 (-3%), and Haematology -204 (-19%)



Annual Plan (Spells) 60,765
Variance at end of June: +599 spells (+4%).

Main variances: ENT +65 (+30%) Gastroenterology +236 (+25%). Cardiology -42 (-7%), Thoracic Medicine -90 (-10%), and Trauma & Orthopaedics -25 (-3%).

Contract Penalties

Penalties	YTD Actual	Penalty £000	Comments
52 week breaches	3	20	£5k penalty per breach per month. 1 Urology , 3 Other specialties.
18 week breaches:			Figures are estimates and awaiting confirmation.
- Admitted (90% target, weighting 37.5%)	n/a	28	GenSur £3k; T&O £19k; ENT £5k.
- Non-admitted (95% target, weighting 12.5%)	n/a	12	Cardiology £1.0k; resp. medicine £2.7k; Rheumatology £3.4k.
- Incomplete pathways (92% target, w'ting 50%)	n/a	30	T&O £8k' Gastro £ 5k; ENT £5k, Gastro 5.3k.
Cancer waits		104	Cancer 2 week waits/ Breast symptom two week waits.
NHS Numbers			
A&E 4 hr performance	n/a	104	Faliure to admit, transfer or discharge patients within 4 hours of arrival. Target 95%. Fine is £200 per breach.
Ambulance handover			Ambulance handover exceding 30 (£200 each) and 60 minutes (£1,000 each).value assumed at £330kAttempts being made to recover from CCG's.
Diagnostics		67	6 weeks target 99%. relates to tests including radiology, NPU, cardiology tests and endoscopies.
		365	

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

	ANNUAL PLAN	PLAN FOR PERIOD	ACTUAL FOR PERIOD	PERIOD VARIANCE
	£000	£000	£000	£000
INCOME				
NHS Clinical Income				
Elective Income				
Tariff income	27,474	6,484	5,894	-590
Non-tariff income	169	40	25	-15
Planned same day (Day cases)				
Tariff income	35,029	8,267	8,511	244
Non-tariff income	651	154	113	-41
Non-Elective Income				
Tariff income	94,313	23,009	25,351	2,342
Non-tariff income	1,840	449	459	10
Outpatients				
Tariff income	58,817	13,866	13,563	-303
Non-tariff income	4,688	1,106	965	-141
A&E				
Tariff income	14,059	3,430	3,266	-164
Non-tariff income	490	120	71	-49
Community				
Tariff income	1,112	271	295	24
Non-tariff income	34,034	8,544	8,384	-160
Other				
Tariff income	0	0		0
Non-tariff income	121,633	30,042	30,614	572
Potential Fines and Contract Penalties			-365	-365
	394,309	**95,782**	**97,146**	**1,364**
				0
	394,309	**95,782**	**97,146**	**1,364**
Non-NHS Clinical Income				
Private Patient Income	976	244	238	-6
Other Non-protected Clinical Income	1,722	431	452	21
	2,698	**674**	**690**	**15**
Other Income				
Education & Training	14,026	3,506	3,611	104
Research & Development	2,005	501	811	310
Donations & Grants received of PPE & Intangible Assets	0	0	0	0
Donations & Grants received of cash to buy PPE & Intangible Assets	600	150	150	0
Other Income	17,109	4,685	4,918	233
Transition support	12,218	3,055	3,055	0
	45,958	**11,897**	**12,544**	**648**
Total Income	**442,965**	**108,353**	**110,380**	**2,027**
EXPENDITURE				
Pay costs	-299,858	-72,676	-73,678	-1,002
Drug costs	-41,922	-10,378	-10,165	213
Clinical Supplies & Services	-45,584	-11,185	-10,792	393
Other costs (excluding Depreciation)	-50,109	-11,532	-11,583	-51
Restructuring Costs	0	0	-96	-96
CIP	16,165	1,573	0	-1,573
Total Expenditure	**-421,308**	**-104,198**	**-106,314**	**-2,116**
EBITDA (see note)	**21,657**	**4,155**	**4,066**	**-89**
Profit/ Loss on Asset Disposals	0	0	0	0
Fixed Asset Impairments	-300	0	0	0
Depreciation	-10,854	-2,714	-2,714	0
Interest Receivable/ Payable	100	25	43	18
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	-67	-106	-39
Interest Expense on Commercial borrowings	0	0	0	0
Interest Expense on Finance leases (non-PFI)	0	0	0	0
Other Finance costs	0	0	0	0
PDC Dividend	-7,204	-1,801	-1,801	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**3,129**	**-402**	**-512**	**-110**

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

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

	ANNUAL PLAN	PLAN FOR PERIOD	ACTUAL FOR PERIOD	PERIOD VARIANCE
	£000	£000	£000	£000
INCOME				
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Outpatients				
Tariff income	58,817	13,866	13,563	-303
Non-tariff income	4,688	1,106	965	-141
A&E				
Tariff income	14,059	3,430	3,266	-164
Non-tariff income	490	120	71	-49
Community				
Tariff income	1,112	271	295	24
Non-tariff income	34,034	8,544	8,384	-160
Other				
Tariff income	0	0		0
Non-tariff income	121,633	30,042	30,614	572
Potential Fines and Contract Penalties			-365	-365
	394,309	**95,782**	**97,146**	**1,364**
				0
	394,309	**95,782**	**97,146**	**1,364**
Non-NHS Clinical Income				
Private Patient Income	976	244	238	-6
Other Non-protected Clinical Income	1,722	431	452	21
	2,698	**674**	**690**	**15**
Other Income				
Education & Training	14,026	3,506	3,611	104
Research & Development	2,005	501	811	310
Donations & Grants received of PPE & Intangible Assets	0	0	0	0
Donations & Grants received of cash to buy PPE & Intangible Assets	600	150	150	0
Other Income	17,109	4,685	4,918	233
Transition support	12,218	3,055	3,055	0
	45,958	**11,897**	**12,544**	**648**
Total Income	**442,965**	**108,353**	**110,380**	**2,027**
EXPENDITURE				
Pay costs	-299,858	-72,676	-73,678	-1,002
Drug costs	-41,922	-10,378	-10,165	213
Clinical Supplies & Services	-45,584	-11,185	-10,792	393
Other costs (excluding Depreciation)	-50,109	-11,532	-11,583	-51
Restructuring Costs	0	0	-96	-96
CIP	16,165	1,573	0	-1,573
Total Expenditure	**-421,308**	**-104,198**	**-106,314**	**-2,116**
EBITDA (see note)	**21,657**	**4,155**	**4,066**	**-89**
Profit/ Loss on Asset Disposals	0	0	0	0
Fixed Asset Impairments	-300	0	0	0
Depreciation	-10,854	-2,714	-2,714	0
Interest Receivable/ Payable	100	25	43	18
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	-67	-106	-39
Interest Expense on Commercial borrowings	0	0	0	0
Interest Expense on Finance leases (non-PFI)	0	0	0	0
Other Finance costs	0	0	0	0
PDC Dividend	-7,204	-1,801	-1,801	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**3,129**	**-402**	**-512**	**-110**

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

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 30 July 2014

Efficiency Programme Update – June 2014

Action requested/recommendation

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

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2014/15 target is £24m and full year delivery in June 14 is £7.8m, leaving a gap to be delivered of (£16.2m). There is a significant planning gap of (£4.6m) following a review of all in year plans.

The Monitor variance is (£1.6m) behind plan.

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

Implications for equality and diversity

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

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

Reference to CQC outcomes

There are no references to CQC outcomes.

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

Board of Directors - 30 July 2014

Efficiency Programme Update – June 2014

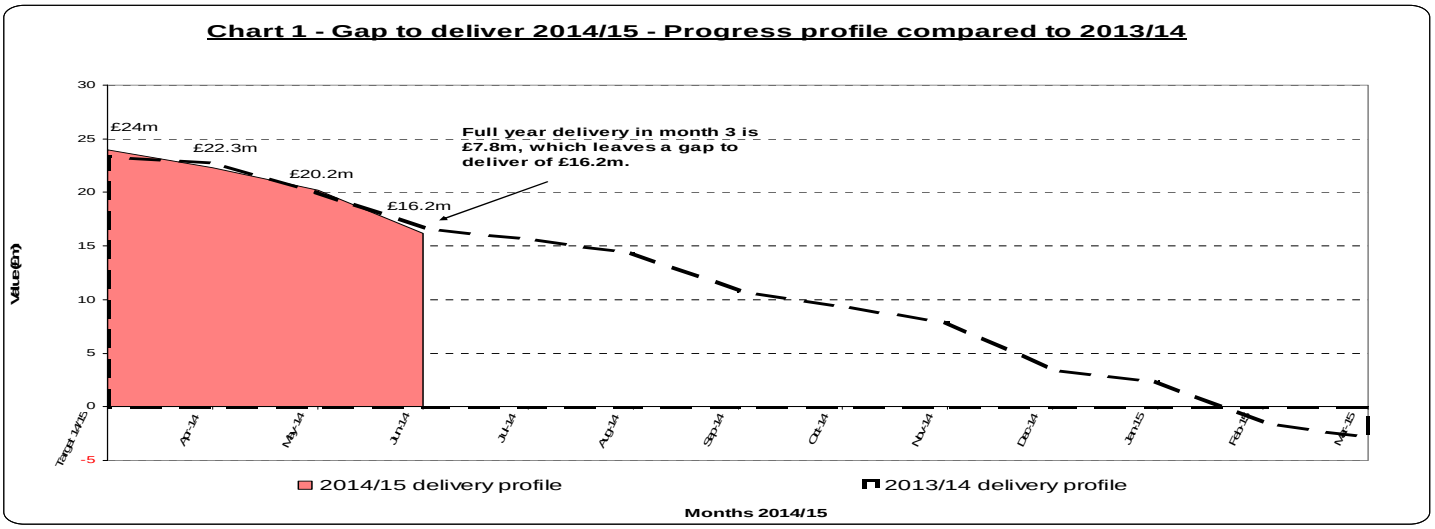
1. Executive Summary

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

See table 1 and chart 1 below.

Table 1 – Executive Summary – June 2014	Total
	£'m
TARGET	
In year target	**24.0**
DELIVERY	
In year delivery	**7.8**
In year delivery shortfall	**(16.2)**
Part year delivery shortfall - Monitor variance	**(1.6)**
PLANNING	
In year planning surplus/(gap)	**(4.6)**
FINANCIAL RISK SCORE	
Overall Trust financial risk score	**(2 Red/Amber)**

Position – current year vs. 2013/14



Governance	Risk to delivery
Current month Of the 32 Directorates and Corporate HQ functions 3 remain as green. Work has started on reviewing new schemes.	**Current month** The current planning gap is (£4.6m), which is an improvement but still of concern. Full year delivery in June 2014 is £7.8m which has improved by £4.0m from May 2014, which is positive. The Monitor variance is (£1.6m) adverse.
Last Month Of the 32 Directorates and Corporate HQ functions 3 remain as green. Work is about to start on reviewing new schemes.	**Last month** The planning gap was (£6.4m), which is a concern. Full year delivery in May 2014 was £3.8m which has improved by £2.1m from April 2014, which is positive.

	The Monitor variance was (£2.7m) adverse

2. Introduction and background

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

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

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

2.1 Trust plan to Monitor

The combined position is (£1.6m) behind the Trust plan to Monitor as at June 2014; see Tables 2 & 3 and chart 2 below.

Table 2	May YTD 2014	June 2014	Total YTD
	£m	£m	£m
Trust plan	4.0	2.0	**6.0**
Achieved	1.3	3.1	**4.4**
Variance	(2.7)	**1.1**	**(1.6)**

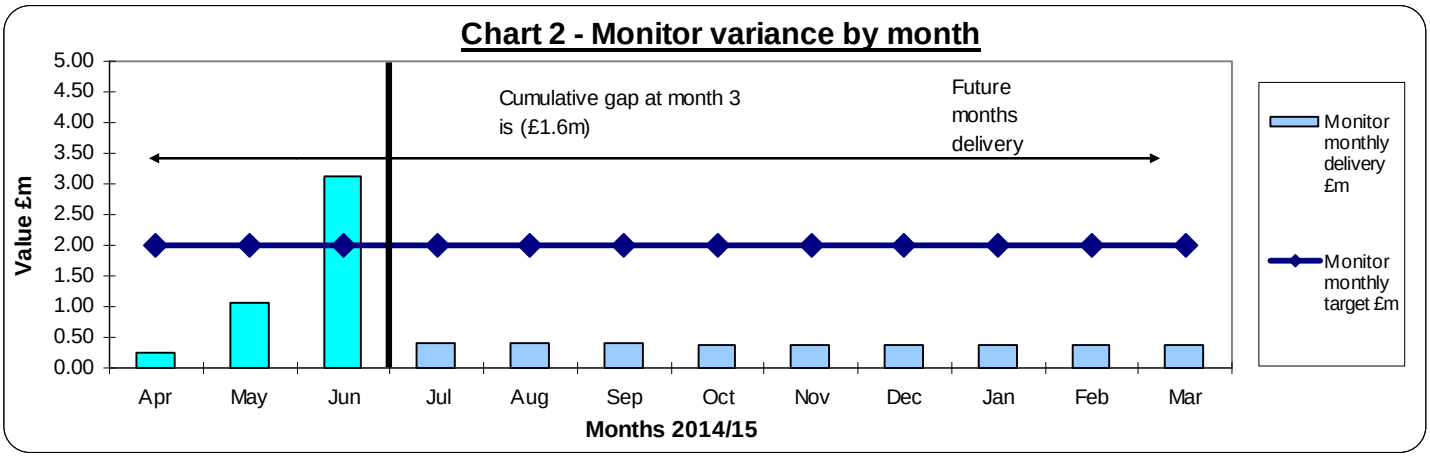


Table 3 – Monitor variance by month and cumulative variance

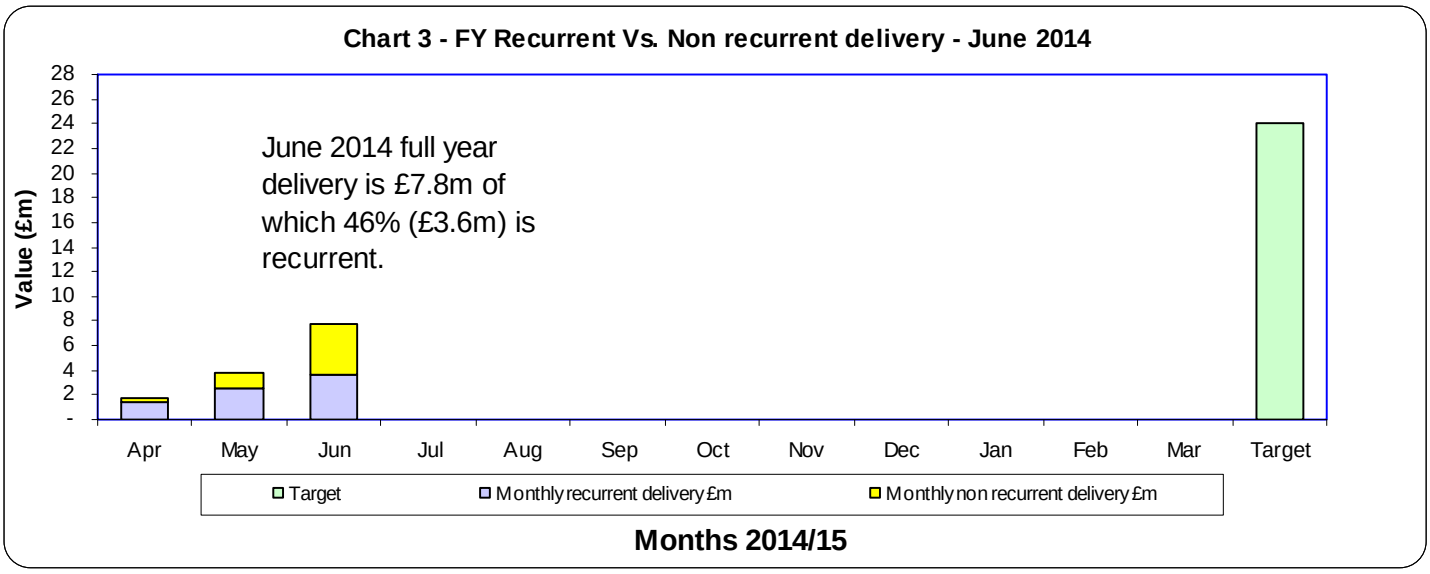
Months	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 14/15
Monthly delivery £m	0.3	1.1	3.1	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	**7.8**
Monthly target £m	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	**24.0**
Variance £m	-1.8	-1.0	1.1	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	-1.6	-16.2
Cumulative variance	-1.8	-2.7	-1.6	-3.2	-4.8	-6.4	-8.0	-9.6	-11.3	-12.9	-14.5	-16.2	

2.2 Full year position summary

As at June 2014, **£7.8m** has been achieved in full year terms against the plan of £24.0m (see Table 4 below).

Table 4	May 2014	June 2014	Change
	£m	£m	£m
Expenditure plan – 14/15	24.0	24.0	0
Target – 2014/15	**24.0**	**24.0**	**0**
Achieved - recurrently	2.6	3.6	1.0
Achieved - non-recurrently	1.2	4.2	3.0
Total achieved	**3.8**	**7.8**	**4.0**
Shortfall	20.2	16.2	**4.0**
Further plans	13.8	11.6	(2.2)
(Gap)/Surplus in plans	**(6.4)**	**(4.6)**	**1.8**

The June 2014 position is made up of £3.6m (46%) of recurrent and £4.2m (54%) non-recurrent schemes. This compares with £2.5m (37%) recurrent and £4.2m (63%) non-recurrent at June 2013 - see chart 3 below.



2.3 Further planning and assessed risk to delivery

Further plans have been formulated amounting to £11.6m, which gives a shortfall in the planning position of (£4.6m). Plans are summarised in Table 5 below.

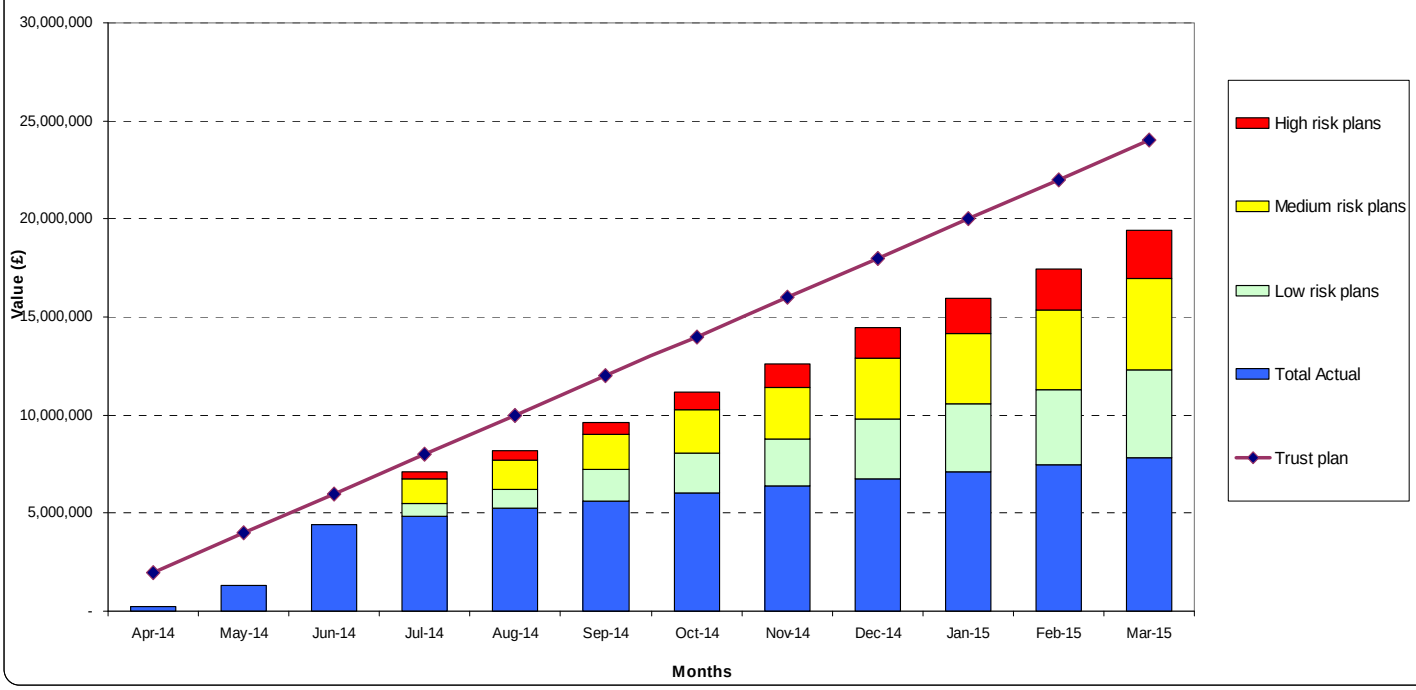
Table 5 – Further plans 2014/15

Risk	Gap Full Year	Plans - Recurrent	Plans - Non Recurrent	**Plans Total**	Gap in plans
	£m	**£m**	**£m**	**£m**	**£m**
Low		2.9	1.6	**4.5**	
Medium		4.2	0.4	**4.6**	
High		2.4	0	**2.4**	
Total	**16.2**	**9.5**	**2.1**	**11.6**	**(4.6)**

Directorate plans are each assigned a risk rating.

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

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



Significant work is continually carried out to re-assess, remove or re-profile plans to ensure an up to date position. There is an in year planning gap of **(£4.6m)**, which has improved by £1.8m in the month, however this remains a high risk position. Work is ongoing to improve this position.

2.4 Four year planning

Directorates are required to develop four year plans and Table 6 below summarises this position. There is currently a shortfall of (£26.1m) over 4 years on the base target; this has improved by £4.7m in the month.

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

Table 6 - 4 Year efficiency plan summary – June 2014

Year	2014/15	2015/16	2016/17	2017/18	Total
	£m	£m	£m	£m	£m
Base target	24.0	16.8	16.8	16.8	**74.4**
Plans	19.4	13.3	9.8	5.8	**48.3**
Variance	**(4.6)**	**(3.5)**	**(7.0)**	**(11.0)**	**(26.1)**

2.5 Finance risk rating

In year delivery is ahead of the same point last year with £7.8m (33%) delivered in June 2014 against £6.7m (29%) in June 2013.

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

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

2.6 Governance risk rating

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

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

3. Conclusion

In June 2014 £7.8m worth of full year schemes has been delivered against the Trust plan of £24.0m, leaving a delivery gap of (£16.2m); this compares with £6.7m delivery in June 2013. The part year Monitor profile is (£1.6m) behind plan in month 3.

We currently have a planning gap in year of (£4.6m), which has improved from period 2, but remains high risk.

The 4 year planning position highlights a shortfall in base plans of (£26.1m), which has improved from period 2, but also remains high risk. Work is ongoing to improve the overall planning position.

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

4. Recommendation

The Committee is asked to note the June 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	**July 2014**

RISK SCORES - JUNE 2014 - APPENDIX 1

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

RISK SCORES - JUNE 2014 - APPENDIX 2

DIRECTORATE	Yr1 Target (£000)	4Yr Target (£000)	Yr 1 Plan v Target		Yr 1 Delivery v Target		Y1 Recurrent Delivery v target		4 Yr Plan v Target		Risk Score	
			%	Score	%	Score	%	Score	%	Score	Total Score	Monitor Rating
TACC YORK	2,421	5,768	40%	1	10%	1	6%	1	22%	1	4	1
GEN MED SCARBOROUGH	982	2,511	23%	1	2%	1	0%	1	35%	2	5	1
RADIOLOGY	1,901	3,800	37%	1	9%	1	1%	1	41%	2	5	1
T&O YORK	789	2,331	31%	1	15%	1	4%	1	33%	2	5	1
SPECIALIST MEDICINE	1,850	5,345	35%	1	6%	1	6%	1	55%	3	6	1
ED YORK	501	1,426	73%	3	17%	1	13%	1	27%	1	6	1
WOMENS HEALTH	2,342	4,464	43%	1	19%	1	15%	1	56%	3	6	1
GS&U	1,717	4,794	61%	2	25%	1	14%	1	47%	2	6	1
HEAD AND NECK	480	1,863	66%	2	20%	1	17%	1	51%	3	7	1
OPHTHALMOLOGY	875	2,667	78%	3	26%	1	26%	2	31%	2	8	2
TACC SCARBOROUGH	870	2,435	69%	2	36%	2	25%	2	40%	2	8	2
CHILD HEALTH	1,247	2,999	63%	2	11%	1	3%	1	92%	5	9	2
LAB MED	1,672	4,022	66%	2	41%	2	26%	2	60%	3	9	2
MEDICINE FOR THE ELDERLY	174	1,717	77%	3	2%	1	1%	1	103%	5	10	2
T&O SCARBOROUGH	324	1,298	116%	5	39%	2	18%	1	35%	2	10	2
GEN MED YORK	1,672	5,114	100%	4	18%	1	2%	1	86%	5	11	2
SEXUAL HEALTH	491	1,129	63%	2	49%	2	37%	2	71%	5	11	2
ED SCARBOROUGH	404	1,329	100%	5	3%	1	0%	1	102%	5	12	3
MEDICINE FOR THE ELDERLY SCARBOROUGH	817	1,698	106%	5	4%	1	0%	1	91%	5	12	3
THERAPIES	1,367	3,772	102%	5	22%	1	4%	1	75%	5	12	3
COMMUNITY	1,648	4,390	94%	4	35%	2	33%	2	104%	5	13	3
PHARMACY	(188)	611	101%	5	101%	5	101%	5	164%	5	20	5
CORPORATE												
MEDICAL GOVERNANCE	75	178	42%	1	25%	1	0%	1	18%	1	4	1
CORPORATE NURSING	334	496	35%	1	35%	2	9%	1	24%	1	5	1
OPS MANAGEMENT SCARBOROUGH	329	638	60%	2	10%	1	0%	1	44%	2	6	1
HR	448	1,171	48%	1	20%	1	6%	1	50%	3	6	1
AL&R	185	420	57%	2	45%	2	0%	1	49%	2	7	1
SNS	1,137	2,557	80%	3	20%	1	13%	1	51%	3	8	2
ESTATES AND FACILITIES	2,878	7,804	64%	2	20%	1	12%	1	71%	5	9	2
OPS MANAGEMENT YORK	239	419	80%	3	3%	1	0%	1	81%	5	10	2
CHIEF EXEC	75	448	176%	5	160%	5	160%	5	29%	1	16	4
FINANCE	251	1,116	109%	5	109%	5	85%	5	83%	5	20	5
TRUST SCORE	**30,308**	**80,731**	**77%**	**4**	**28%**	**1**	**15%**	**1**	**64%**	**4**	**10**	**2**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 2014

ECIST Report

Action requested/recommendation

The board is asked to note and discuss the findings of the ECIST visit focussed on emergency care.

Summary

This report outlines the results of the Intensive Care Support Teams findings.

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	No other internal groups – shared with main commissioners
Risk	No risk

Resource implications	To be determined – report not a request for resources
Owner	Michael Proctor, Deputy Chief Executive & Chief Operating Officer
Author	Michael Proctor, Deputy Chief Executive & Chief Operating Officer
Date of paper	July 2014
Version number	Version 1

Interim Management and Support

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SE1 6LH

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Mobile:07825256603
e-mail:Coreeneastes@nhs.net
mobile: 07791739945

Re-York Teaching Hospital Foundation Trust

Management in Confidence

By email

7/5/14

Mike proctor
Deputy Chief Executive York teaching Hospital NHS Trust

Dear Mike

Thank you for inviting the Emergency Care Intensive Support Team to carry out a review focussing on patient flow along the acute emergency care pathway and the whole system review of urgent care.

Our team consisted of Mairead Mc Cormick Intensive Support Manager ECIST, and Coreen Eastes intensive Support Manager ECIST.

It was great to see the progress that has been made against previous ECIST recommendations. Despite the significant challenges of merging York, Scarborough and the community. We would like to commend the organisation for the programme of work implemented to rise to these challenges. It was very clear to us that as an organisation working hard to offer a quality service for the local population a lot of work has been undertaken to improve processes and leadership while acknowledging these processes are on-going.

This report seeks to offer reassurance on the improvements and programmes that are already either in place or in progress. We also aim to offer further advice and support for improvements in the future to sustain and optimise patient flow.

1. Executive Summary

The hospital has embarked upon an **improvement programme** that has many features of good practice. We found clear evidence of an appropriate focus on improving internal patient flow.

Based on evolving new models and coupled with investment to bolster the clinical workforce leadership appears to be focussed and determined to achieve a step change in patient care. The **discharge profile** for both Scarborough and York does not support early flow and therefore we **would recommend** the principles of the SAFER bundle to left shift the majority of the discharges initially by 2pm and moving towards a 12 midday peak. The SAFER bundle has been shared with the Trust and forms the basis of "the perfect week".

Workforce is a significant challenge for the organisation particularly on the Scarborough site. We have been reassured that the Trust has identified this as high risk and that every effort is being made to find solutions and improve the situation. We encourage joint working between clinical staff on both sites to share resources where possible and support rotation. The most pressing being the senior cover in ED and we understand discussions are progressing about sustainability and mitigation of risk.

Scarborough has demonstrated creativity and resilience through limited resources however a particularly lean workforce will compound the recruitment problem and equally affect retention of existing workforce.

Mental health provision is inadequate and response times do not provide either a good patient experience or the four hour standard. We were advised that this is being reviewed by commissioners with a view to potentially implementing a liaison service. We **recommend** this model and have seen improved outcomes for patients through a commissioned liaison service in other parts of the country.

The geography proves a particular challenge in this area for Community services however significant progress has been made over the past 18months. Commissioning intentions are unclear and therefore accountability impacted. We appreciate that the transfer of contracts has contributed to the confusion although the split across both York & Scarborough is described as unbalanced causing variation in service delivery particularly around community nursing. We **strongly recommend** that these are reviewed and intentions made clear with clearly defined measurables understood by all. We fully agree with the proposed models of single point of access and integration. The pilot was being launched on the Monday following our walk through and we believe there will be benefits for all from this. We **recommend** that integration with social care is considered and a benefits analysis undertaken of how this could help the whole health economy with the discharge to assess model of care.

Complex Discharge processes have variation between York & Scarborough sites. Scarborough site appears more streamlined and effective although we have been advised that work is on-going between both sites to align processes and response times. **Community hospitals** are described as having significant variation in acceptance and referral criteria through contracting causing confusion impacting on occupancy. ECIST have offered to undertake a review of community hospital provision and to work with commissioners and providers to move towards more care at home as a future model. Evidently the largest cohorts of patients impacting on length of stay are the **frail elderly** cohort.

We **recommend** that there is a real opportunity for the Trust with CCG's and local authority through the BETTER CARE fund to agree a strategic vision for the frail elderly pathway as an integrated service, sharing risk, resources and expertise to support prevention of admission or early discharge to assess. There are many examples of frail Elderly models that we can share with the trust however it is clear that the Trust has already started to think through how this might be delivered. This will require a very definite step change in how these patients are managed and as already indicated a degree of risk share accepted across the organisations.

1.1 Both **Emergency Departments** have implemented robust streaming models that are embedded in practice. This offers a see and treat service delivered by ENP's and supported by a middle grade. We were advised that the demand rises in the summer months particularly in Scarborough and the aim is to secure a dedicated middle grade throughout this period. Patients presenting with major illness are streamed through to rapid assessment in majors. Both departments have good processes in place to support early assessment and decision making and data supports referral to specialities within adequate time frames.

1.2 **Children in ED (Scarborough)** the environment has been designed to support segregation of children in the ED however the staffing model does not support best practice. It is recognised that there are recruitment difficulties however we **recommend** that a joint working group is established between ED, GP's and paediatricians to review unscheduled care for children based on the recommendations within "standards for children & young people in emergency care settings" RCPCH 2012 which is an intercollegiate committee with recommendations that support best outcomes for children in ED settings. This should be a whole systems approach considering the options of training a cohort of ED staff to meet the standards recommended. A review of available skills across all sites and units would be useful as a benchmark to understand the gap.

1.3 Workforce- recruitment to middle grade posts and nursing posts is a particular challenge for Scarborough and a significant threat for the future. We appreciate the challenges with local employment and attracting people to the area and there is a workforce strategy in the trust to help mitigate. We support the plans in place to develop advanced nurse practitioners although this will take approx. 3-5 years to embed and therefore this is a high risk for the health economy. We were reassured that the Trust has identified this high risk and working towards solutions. The consultant workforce in ED is reviewing how they can provide senior cover in the near and distant future. Nursing numbers are reasonable across both sites however there is a gap in Resus cover in Scarborough. Resus requires a dedicated team and flexing this team from majors will impact on rapid assessment in majors and create delays for this group of patients. We **recommend** that the nursing and medical team are allocated to Resus as a dedicated team rather than utilising staff from majors to cover. Patients requiring

Resus are usually approx. 5-6% of total attendance which will provide the guide for staffing on a 1:2 patient ratio as per RCN guidance.

1.4 Mental health- the current arrangements for mental health are inadequate as the team are not on site. We were advised they have a six hour turn around which will not support the four hour standard and is a poor experience for these patients who are often already distressed and anxious. It is also resource intensive for ED nursing staff who may not have the skill set to deliver specialised care for patients with mental health problems. We raised this with Becky Case from a commissioning perspective and were advised that metal health provision was being reviewed. **We recommend** that a dedicated liaison service is commissioned for emergency care. ECIST would be happy to provide examples of sites where this is already being provided.

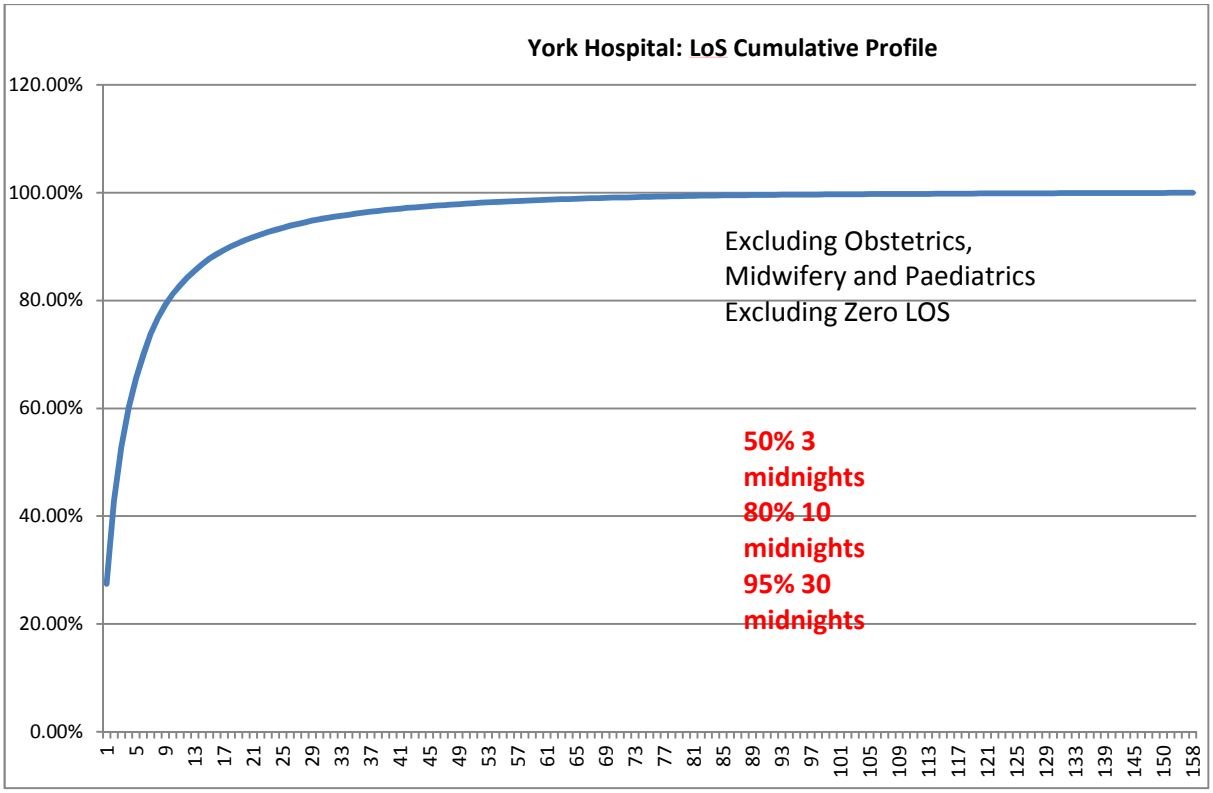
1.5 **Escalation-** needs attention with clear measurable internal professional standards which have accountable owners and that are measured, reported and reviewed for effectiveness. Response times from specialities need to be incorporated into the professional standards and expected actions agreed against these triggers. **We recommend** that the trust considers implementing a full capacity protocol when all escalation triggers have been implemented. We have provided an example of a protocol developed by the Royal Liverpool to Ed Smith lead ED Consultant for discussion at Trust board. We **recommend** that a link with the Royal Liverpool is made to not only discuss implementation but also learning from the running of such a policy since they went live in November 2013.

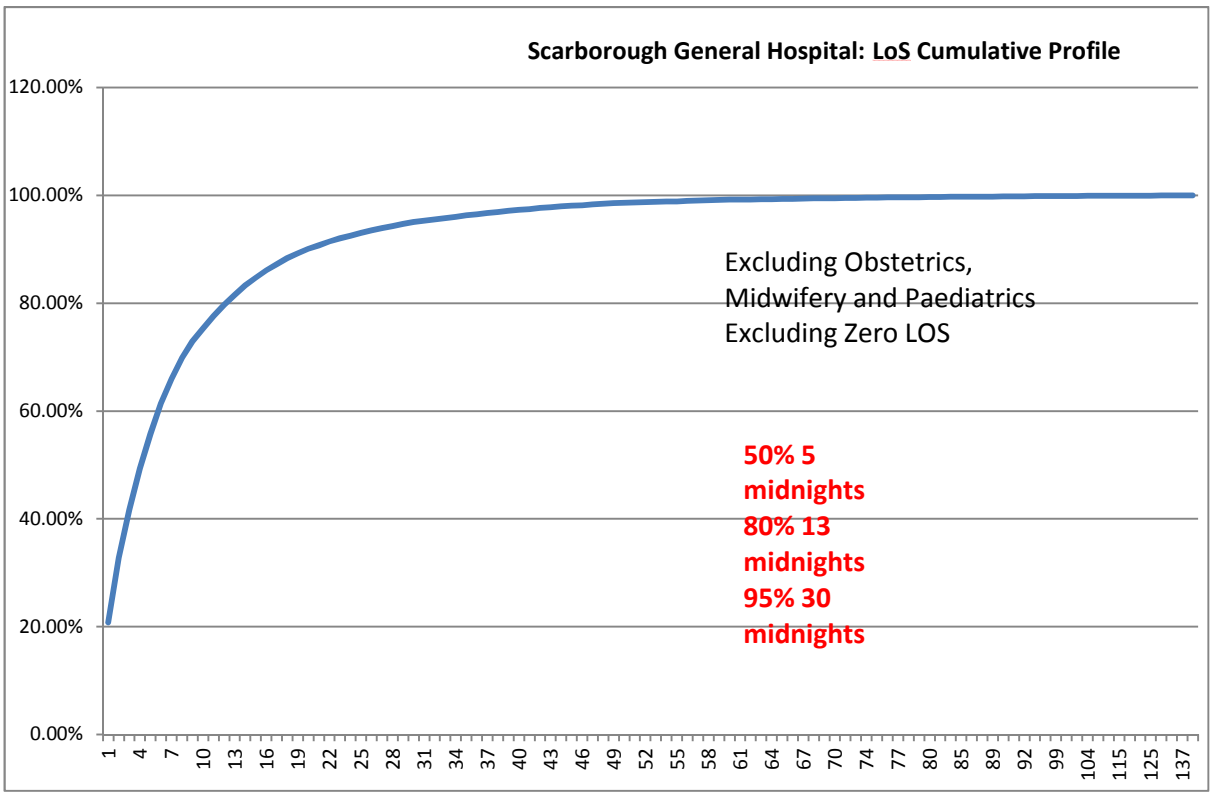
1.6 **Ambulatory Emergency Care** (AEC) at the hospital is under developed although we are assured that this is a work in progress. AEC presents a really great opportunity to reduce overnight admissions and you should be aiming for approx. 30% of the take going through AEC. The current "day treatment centre" is an ideal environment to develop this service as it already provides a service for DVT and cellulitis amongst other treatments and has good facilities. The national ambulatory care network shares best practice and supports development of services. The network can be accessed via www.ambulatoryemergencycare.org.uk

1.7 **AAU-**Both assessment units are achieving a good length of stay based on an assessment model however ED remains the default for GP referrals. Senior decision making is robust and early on the AAU's, there was evidence of good planning. The medical model for both units varies as the availability of acute physicians on the Scarborough site is more limiting and therefore this is covered by general medical on call in the evenings and at weekends. The units are inhibited by the lack of "pull through" to the base wards compounded by the late discharge profile. This affects the capacity of the assessment units to function as such at the times when the majority of their referrals peak. The SAFER bundle "F" representing flow establishes an increased use of discharge lounge by transferring one patient from all regular receiving base wards to the discharge lounge by 10am. The second part of the flow is that each base ward has a patient identified from the units that they will take onto their ward by 10am.This offers capacity for the first surge in admissions and enables the assessment areas to function. ED should not be accepted as a default position for GP referrals as the risks of stacking ambulances are no less than patient waiting for an assessment space in the assessment units. This sharing of risk is widely supported by the colleges as can be seen in full capacity protocols.

1.8 Short stay- In order to sustain flow we **recommend** that the Trust aims for a cumulative profile of 50% 2 midnights, 75% 7 midnights and 95% 21 midnights. The data below represents the current profile and although complex discharge tends to get a lot of focus

there will be substantial gain on focusing on the 2 and 7 midnights. Early daily senior review 7 days per week and a frail elderly model supporting discharge to assess will have the highest impact on LOS.





The inpatient wards- This should be your top priority.

All patients (and the teams caring for them) need to know four things:

- What is going to happen to me today?
- What is going to happen to me tomorrow?
- What do I need to achieve to go home?
- When can I expect to go home?

For every patient to respond reliably to these questions, it is essential that every patient has a medical care plan, signed off by their consultant, which contains an expected date of discharge (EDD), clinical and functional criteria for discharge (CDD) and a differential diagnosis. The Royal Colleges expect every patient to have an EDD within 12 hours of admission, which is a *maximum*. Without an EDD or CDD, the team lacks a target to aim for or certainty in relation to the point at which a patient's condition is 'good enough' for them to be allowed home. During our visit, we found some evidence of care plans that reliably contained consultant set EDDs and CDDs, however there is still variation and gaps so this is an important area that needs to be addressed.

"SAFER" bundle

Once established, care plans need to be managed on a daily basis. Without **daily review** by a clinical decision maker (ideally a consultant), things will slip and bed days will be wasted. The traditional, twice weekly consultant ward round is a guarantee of a longer than necessary length of stay. Decisions get delayed until the round, and then are all made at once, creating a tsunami of work for junior doctors and nurses. Good practice is daily senior review of the care plans of every patient in every bed. This should be led by the patient's consultant. Most hospitals approach this through board rounds, where the consultant runs down the patient list to ensure their care plan is on track. Deteriorations are picked up quickly and unnecessary delays can be addressed. We **strongly recommend** that daily senior review is implemented as it will increase discharges, improve flow but more importantly improve patient safety. There are inconsistencies with the use of EDD's, these should be Consultant set and patients fully informed about their EDD's to support better planning and influence behaviour that currently results in late discharges. Daily ward rounds and board rounds are essential to support adequate discharges and reduction in length of stay (LOS) to optimise patient flow. The Trust described moving towards seven day working to support the delivery of daily review which is best practice.

Two useful tactics to support patient flow are: the *ward round check list* and *'one-stop' ward rounds*. The ward round check list, such as that described by Dr Gordon Caldwell (*Improving Quality and Safety on Ward Rounds*, Caldwell, G. Western Sussex Hospitals 2009) is an excellent tool to ensure that all key issues are systematically considered during rounds. Other Trusts have introduced their own checklists, to improve on Caldwell's approach. The one-stop ward rounds aim to reduce batching of jobs till the end of the round (which will mean that some patients don't get discharged until the following day and that some jobs are not completed at all). The round is best supported by a computer on wheels (COWs) but paper systems also work well. During the round, the whole team completes tasks related to patients as they are decided (e.g. imaging referrals and blood forms are completed) and before moving onto the next patient). After the round, the junior doctors have fewer tasks to complete and can focus on activities aimed at expediting discharges. There was some very good practice in Scarborough of TTO's being written the day before and finalised on the ward round. This impacts significantly on early discharge and a key measurable is to look at peak dispensing times in pharmacy. This should be before 12 midday if one stop is in place and we **recommend** that the Trust uses this as a KPI to support early discharge.

There is a need to review the pathway for **frail older people** to ensure that they are managed assertively and their length of stay kept to a minimum. The current pathway supports some of this with the rapid response/navigation team but needs to be expanded. ECIST **recommends** moving to a discharge to assess model of care particularly for patients with dementia who decompensate rapidly in hospital often resulting in a requirement for CHC and placement, which could be avoided for some patients if early discharge back to home environment is supported.

Fit for discharge-There was evidence in the notes and from feedback that sometimes when a Consultant reviews a patient and confirms they are fit for discharge that this decision is reversed following a therapy review. Evidence suggests that unless therapists have a true benchmark of what is "normal" for a patient then the target can be aspirational and therefore contribute to increased length of stay. We **recommend** that therapists/rapid response form part of the ambulance handover so that normal state can be benchmarked from point of entry. There are good examples of this in Brighton Royal County hospital and West Middlesex with evidence of reduction on admissions from ED and AAU.

1.9 **Bed management**-The current system used to manage beds (although we only observed Scarborough) does not meet the demands of the service. A more robust predictor tool is required and an active log of actions to be undertaken with named leads at each bed meeting. ECIST are happy to provide examples of predictor tool which can be adapted for use within the Trust. Senior leadership of the site and management of capacity require consistency and appropriate representation at daily operational/capacity meetings. Models that work well have a dedicated senior leader for flow who co-ordinates the team, ensures adequate information is available to inform a productive meeting and ensures people are accountable for their actions via line managers etc. These actions should be auditable and available for RCA to provide assurances for the Trust that escalation processes are effective and that patient safety is at the root of all decision making. We **recommend** that there is consistency of managing the site during day hours particularly and support the Trust's move towards the flow co-ordinator role.

1.10 **Discharge**-The discharge process varies from Scarborough and York and needs to be Consistent as per the executive summary. Discharge should be owned by ward managers and complex processes supported by the discharge co-ordinators. We were impressed with the educational role delivered at Scarborough to the ward staff which is an "enabling" process rather than a "taking away" responsibility for all discharg

2. Governance

The established urgent care group plays an important role in shaping the vision for unscheduled care. Clinical representation is critical to the success as is representation across the health economy. Commissioners benefit from being clear of the role of the Board and the number of work streams reporting into it. The 2004 DH paper, **Emergency Care Networks Checklist**, shows how networks can improve patients' care by uniting all the members of a health community and provides a "how to" guide to create this key mechanism for achieving and managing co-operation. We **recommend** that the network considers this guidance and uses a comprehensive dashboard to measure success. We can provide examples of comprehensive dashboards implemented successfully in other organisations if helpful. We would **recommend** that this is the ideal forum to plan the frail elderly pathway and consider how you would like to measure

successful implementation across the heath economy. It may be useful to undertake this work now ahead of winter so that the pathway can be established in advance Q3 &4 which tend to be the most challenging for organisations.

3. Commissioning

Commissioning is not clearly understood across the health economy and in general providers reported that they are unclear about how they are measured. Although there is a reported dissatisfaction amongst GP's in relation to community services there was lack of clarity around what this dissatisfaction was, and how it could be addressed. When the commissioner where ask what their vision for the system was for future commissioned Urgent Care Community Service, it was again not a clear or defined single joint commissioned model. On further discussion it would appear that under the Transforming Community Service, all three community arms of the PCT where transferred into the acute trust. However the acute trust as a provider has not been able to transform or modernise the services as one directorate, due to having to maintain three block contracts with three different budgets. This has and is leading to a service provision being based on post code rather than patient needs or demand. While ECIST fully understands that each CCG within the system will want to commission locally based services to meet their population, we strongly **recommend** that the three CCG agree a standard single principal output driven specification for Urgent Community Services. These can be localised in each of the hub areas and that has the flexibility of a single budget.

There is some lack of clarity about what services are available outside of the acute sector and how these services are accessed. A baseline mapping of these services did not exist however this is now a work in progress and needs to form the foundation for discussion around service specifications which we **recommend** should be outcome driven.

We were informed that services were inequitable an example being district nursing services provision 24/7 versus 8am-10pm service. The planned hub model was described and we support this particularly for the large geographical area that the system covers. There is a real opportunity to grow services such as ambulatory care in the community and frail elderly hot clinics etc within such a hub model, especially due to the community services being integrated with the acute. .

As you work with commissioners to develop your strategy, we **strongly recommend** that you draw on the available evidence base, and also the recommendations from the Colleges, to avoid energy and money being wasted on initiatives that have not been shown to be effective. The following is a list of publications that may be of help:

- Cooke, M. Et al (2004) Reducing Attendances and Waits in Emergency Departments: a Systematic Review of Present Innovations

- King's Fund (2010) Avoiding Hospital Admissions: What does the research evidence say? ;

- Acute Medical Care: Right Person in the Right Setting First Time (2007) Report of the Acute Medicine Task Force

- Royal College of Surgeons (2011) Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners.

- Department of Health (2010) Ready to Go : Planning the Discharge and Transfer of Patients from Hospital and Intermediate Care

- OSHA (2004) Good Practice Guide for Ambulance Services and their Commissioners.

ECIST **recommends** the emerging strategy needs to improve the alignment of incentives and levers for change.

4. Use of information

There is widespread information available in the health economy but weak evidence that this is shared to provide a more seamless process. Accessibility to patient information is challenging due to the variety of IT systems which does not support continuity particularly around long term conditions. We **recommend** that the urgent care group develops an information strategy ensuring available information is shared and used to inform decision making. Examples of good practice include information on usage of services by “frequent flyers” and the development and sharing of a joint action plan across the health economy to reduce visits. We appreciate that a unified system may be in the distant future however consideration needs to be given on access and training for those who will require the information to make decisions that will directly impact on the patient’s care.

5. Primary Care

There is an out of hour’s service provided by the acute trust. This has very positive feedback and can be easily accessed by ED who can refer directly .There is a robust ENP service and 1 GP however this GP also covers home visits and this creates a gap in service delivery.

There appears to be good primary care services in the area within hours and an example of good practice at priory medical that all urgent care is given priority in the am and activity is not capped. During our visits GP’s raised concerns regarding district nursing services being accessed through a single point of access. Although supportive of the principle the main concerns are regarding the amount of information that will be required to access the service and the impact on GP’s time. This should be explored in the pilot and an opportunity given for GP’s to feedback. ECIST support a single point of access however it should support better outcomes for patients and ease the process of referral as a successful measure.

Referral to the acute Trust are clunky and speciality specific. Some require clinician to clinician conversations whilst others go through bed managers. In our experience clinician to clinician referral can result in appropriate advice and redirection reducing impact on the acute take however there must be quick access & response times for GP's to support this operationally. We can provide linkage with sites where this practise is well established and has reduced the acute medical take by providing early advice, through ambulatory pathways or early response from urgent community services to maintain patients at home. Early pregnancy clinic appointments were highlighted as a particular issue and therefore we **recommend** that the acute trust reviews this process of referral.

6. Community services

During our meeting, community nursing was described as a higher volume of contact episodes against current block contract. This originates from a lack of benchmarking which has now been undertaken to understand the demand. ECIST are keen to support a review of caseloads. We **recommend** that all caseloads are reviewed every six months to understand caseload profiling and capacity. We recommend this is undertaken as a peer review supported by the lead nurses for each district. It is important to understand who is delivering what and whether the more basic tasks are being undertaken by senior staffing affecting productivity and cost effectiveness. Regular reviews will ensure that only necessary work is being undertaken and creates a more realistic picture of true demand. Rationalising caseloads will release capacity to improve quality for more complex cases.

A fast response team within intermediate care supports early discharge and there is also a night service. We would suggest this is good practise however is vulnerable in the current commissioned levels as intermediate care are unable to refer to re-ablement and waits to long term care provision can be as high as 21 days+. Impinging on the capacity of the team which will impact in turn impacts on hospital discharge.

The current discharge teams are not integrated however we support an integrated model therefore removing duplication and hand-offs between services. We are happy to offer support to facilitate this process and provide examples of this working well in other organisations.

Health and social care are fragmented to a degree with some overlap. We **recommend** mapping some patient journeys to demonstrate this and consider the case for integrated services of the future particularly around the frail elderly pathway.

The CCG has invested in a significant range of admissions avoidance and facilitated discharge schemes. These are principally aimed at people with long term conditions and end of life care. End of life care was described as a really good service throughout our walk through.

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One of the key issues that we considered during our visit was the extent to which services across the emergency care pathway say “yes” to appropriate referrals, rather than saying “no”. There are many different ways to say ‘no’. These include unnecessary assessment processes, poor telephone answering services or complex processes that have to be completed before a patient can be accepted by a service.

We noted from our discussions during our visit that, there are a complex set of options for admissions avoidance and for discharge support. In order to maximise impact, reduce duplication and get best value from services it is important to make the right thing to do, the easy thing to do. Work on a Single Point of Access was described as being under way. ECIST agree that these are important steps in the right direction and that pace of delivery and expansion of the single point to all providers in the system will provide more Yes’s than No’s.

There appears to be significant variability between the community bed provision and how they have been contracted and provided by medical input. Occupancy level vary and they currently do not provide a discharge to assess model although we would encourage this to be undertaken in patient’s home wherever possible. During our visit there appeared to be not clear agreed process between all parties for discharging without prejudice. We **recommend** that this is considered as an option to support discharge from the Acute Trust, to free capacity for the more acutely unwell. Any future model should see a planned reduction in community beds with early turnaround for the frail elderly from ED and AAU preventing decompensating and reducing LOS. These models will only work if all systems are joined up with a common goal.

Further work

We hope that this report is of help to you in further refining your priorities. We appreciate that some of our suggestions are already being progressed and it will take time to embed some of these for long term sustainability.

We agreed at our feedback session that the Trust would benefit from a length of stay review, review of community beds and a caseload review for community nursing. We also offered support to CCG’s to help facilitate commissioning intentions for community services if that would be useful.

ECIST are happy to offer on-going support to the organisation and we ask you to consider your priorities and agree time frames with Mairead & Coreen for the reviews as above.

With best wishes

Mairead McCormick

Intensive Support Manager
ECIST

Coreen Eastes

Intensive support manager
ECIST

Action plan following Emergency Care
Intensive Support Team visit

Action Plan							Progress Monitoring - 6 months						End of Year Risk
CATEGORY	Issue	Initial Risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date	Risk at review(H/M/L)	Evidence	Further action/s	Operational Lead	Responsible Lead	Target Date	Risk (H/M/L)
Workforce	Difficuly to recruit to Acute care/Emergency Department posts	H	Develop attractive recruitment package to secure senior staff	Wendy Quinn	Mike Williams, Ed Jones	01/06/2014							
		M	Rotate staff across sites	Wendy Quinn	Mike Williams, Ed Jones	Sep-14							
		L	Review workforce and explore alternative roles	Wendy Quinn	Bev Geary								
		L	Review staffing to support resus	Wendy Quinn Jo Southwell	Bev geary	Aug-14							
Mental Health	Inadequate Psychiatric care	M	Discussions held with Leeds Partnership and Commissioners to agree a model of care (RAID)	Liz Booth/Mandy McGale	Mike Proctor	Nov-14							
Community Services	Integrated teams	M	To integrate discharge teams and standardise complex discharge processes	Annette Wilks,Julie Plaxton	Wendy Scott Liz Booth	Sep-14							
	Commissioning intentions	H	To agree a coordinated commisioners approach to support unplanned care		Wendy Scott Mike Proctor								
		L	To undertake a case load review to optimise capacity	Annette Wilks	Wendy	Jun-14							
Discharge processes	Discharge profile does not support flow	L	Perfect Week planned in Scarborough that will focus on preventing delays across the whole of the health and social care system. This will then be built into a sustainability plan.		Mandy McGale	Sep-14							
		L	Safer bundles have been trialed as part of the Perfect Week planned in Scarborough, this will be incorporated in a sustainability plan.	Becky Hoskins	Mandy McGale/Liz Booth	Sep-14							
Paediatrics	Staffing model does not support best practice	M	Review staffing model and ratios in Scraborough ED	Liz Vincent	Bev Geary	Sep-14							
Therapy Services	Conflict between medically fit and safe discharge	M	To agree assessment criteria and agreement on normal state when admitted		Melanie Liley								
Bed management	Current bed management system does not meet the demands of the service	L	Predictor tool been trialed as part of the Perfect Week planned in Scarborough, this will be incorporated in a sustainability plan.		Mandy McGale	Sep-14							

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 2014

2014 Annual Report of the Workforce Strategy Committee

Action requested/recommendation

The Board of Directors is requested to note the Annual Report of the Workforce Strategy Committee.

Summary

This report provides an annual outline of the Workforce Strategy Committee.

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	The report has been approved by the Workforce Strategy Committee.
Risk	No risk.

Resource implications	There are no resource implications.
Owner	Sue Holden, Director of Corporate Development and Interim Director of Human Resources
Author	Chair, Workforce Strategy Committee
Date of paper	July 2014
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Annual Report of the Workforce Strategy Committee

July 2014

Introduction

The Workforce Strategy Committee looks to ensure that external considerations which will impact upon the workforce are reviewed and factored into planning and development of workforce changes and interventions. It provides assurance to the Board that the Trust plan up to 2025 for the future workforce is functionally fit and innovative enough to respond to changing patient demands.

The Committee will monitor progress against the strategic plans, and present their findings to the Board for consideration. For the purpose of the Committee, workforce is defined as all employees of the organisation. (Volunteers, governors, contractors and agency staff may be included in considerations as appropriate)

Overview of the year June 2013 to March 2014

The Committee has met 4 times during the year. The Committee includes membership from:

Professor Dianne Willcocks, Chairman of the meeting, Non-executive Director
Ms Libby Raper, Non-executive Director (Deputy Chair)
Mr Patrick Crowley, Chief Executive
Ms Libby McManus, Chief Nurse (until October 2013)
Ms Lucy Connolly, Head of Workforce Nursing
Mrs Sue Holden, Director of Corporate Development
Miss Peta Hayward, Director of Human Resources
Mrs Natalie McMillan, Assistant Director of Resourcing
Ms Debbie Hollings- Tennant, Head of Corporate Efficiency
Dr Johnathan Thow, Clinical Strategy Lead

Mrs Beverley Geary, Director of Nursing joined the committee to represent Nursing in December 2013 when Mrs Libby McManus left the organisation in October 2013.

There are a number of additional attendees who attended the Committee where it was beneficial for a particular agenda item or for information, for financial year 2013/14 they include:

Ms Melanie Lilley, Head of Therapies (June, September 2013 and March 2014)
Miss Sian Longhorne, Workforce Information Manager (June 2013)
Miss Vicki Mallows, HR Manager, Resourcing (March 2014)
Dr Alistair Turnbull, Medical Director (March 2014)

Attendance at the Committee during the last year is as follows. The agenda items for discussion and dates to be discussed were agreed by the Committee.

Name	Attendance
Professor Dianne Willcocks	4/4
Ms Libby Raper	4/4
Mr Patrick Crowley	1/4
Ms Libby McManus	½ (until October 2013)
Ms Lucy Connolly	4/4
Mrs Sue Holden	4/4
Mrs Natalie McMillan	3/4
Ms Debbie Hollings- Tennant	2/4
Dr Johnathan Thow	2/4
Mrs Beverley Geary	2/2 – in attendance from December 2013

The Terms of Reference for the Committee requires the Committee to;

- Formulate recommendations for presentation to the Board of Directors on any strategic workforce proposals;
- Identify external forces which impact upon the Trust Workforce, and determine the Trust response and interventions;

General roles and functions

- To receive the workforce related strategies to include: HR, OD, Nursing, Non-Registered, Education, Medical and Equality and Diversity and to forward them to the Board for approval
- To receive workforce reports, identifying trends, benchmark comparators and monitoring reports on key workforce indicators e.g. sickness, turnover, temporary workforce spend, statutory and mandatory training.
- To receive specific reports that provide more detailed analysis of workforce metrics where further assurance or understanding is sought.
- To present any strategic plans relating to workforce to the Board for approval and then receive regular monitoring reports of progress against these plans.
- To receive information on relevant benchmark reports to understand how workforce indicators may compare and understand where variations may or may not be appropriate.
- To receive updates on current topics for consideration from the Director of Corporate Development and Interim HR Director.
- To submit a highlight report to the Board of Directors on a quarterly basis, and escalate any areas of concern identified for further discussion and resolution
- To provide assurance to the Board of Directors

Workforce Planning

- To receive workforce data which demonstrates delivery of strategic plans.
- To consider the make up of the total workforce resource and whether the balance remains appropriate e.g. different contract types, bank provision, overtime, agency, locums.
- To consider flexible interventions where workforce risks are identified and monitor progress against agreed goals.
- To identify where changing roles would be beneficial, including a focus on developing the non-registered workforce, and apprentices.
- To sign off final workforce plans that are required to be submitted to any external body e.g. HEE/Monitor

Workforce Interventions

- To consider where OD interventions would be beneficial and approve the prioritisation and approach taken: with any effect on strategy being confirmed by the Board
- To understand where workforce risks may exist and agree where support or investment may be best directed to address or reduce these risks.

Work of the Committee

During the year the Committee has considered the following:

a) Chief Nurse Information:

- **Nursing Establishment Review** – The Chief Nurse and Head of Workforce (Nursing) have provided regular updates and assurances to the Committee around the review that had been undertaken into the nursing establishments. The Committee were assured that the outcome of this review was that each ward/ department area establishment would be RAG rated and each ward would have a staffing level sheet outlining their establishment, which would be agreed with the Ward Sisters. The Committee discussed the investment in nurse staffing levels was to look beyond eliminating "reds" and towards what could be classified as a 'professionally recommended' model. This would result in significant investment of around £2.2million. The Committee approved the existing staff models which were based on existing budgetary bed base and for the discussion to be taken to Directors. The Committee continues to focus on the nursing establishment.

- **Alternative staffing models –** The Committee were assured that the nursing review presented an opportunity to create new and different roles and look beyond traditional boundaries. The Committee acknowledged that work was already happening with regards to Advanced Clinical Practitioners and that the community setting would be ideal for the Calderdale Framework to determine what competencies and therefore roles the service requires. The Committee agreed that links needed to be made with the Corporate Efficiency Team and the temporary workforce

plan to provide assurances around discussions about aspirational staffing levels and to align with the efficiency agenda and the challenges we face in terms of any investment. The Committee continues to focus on alternative staffing models.

- **Advanced Clinical Practitioners –** The Trust introduced Advanced Clinical Practitioners (ACPs) last year with the second cohort of trainees due to start in 2014. The Committee discussed the value these roles had added in an attempt to move away from traditional staffing models and noted the plans to invest in further ACPs.

b) <u>Director of HR Information:</u>

- **HR Performance data** – The Director of HR has presented regular updates during the year on key workforce performance metrics and initiatives, including progress against the Staff Health, Wellbeing & Engagement strategy.

- **Workforce metrics and planning** – A presentation on workforce planning was given highlighting the main key themes and outlined how the workforce and efficiency agendas were aligned and recommendations were presented on how this could be further integrated and improved. The Director of HR has provided regular updates on the piloting of robust workforce plans aligned to the efficiency agenda and has brought the discussion to the Committee around the availability of benchmarking workforce data, with specific reference being made to collation of equality and diversity data. The committee acknowledged the requirement to deliver an efficiency saving of £24m and effective workforce planning will play a major part in achieving this. The committee will continue to keep a focus on this area.

- **Living wage -** The issue of whether the Trust should adopt the national Living Wage for affected staff was considered by the Committee including its impact on probationary periods and within the context of the outcome from the national pay award discussions. The Committee supported adopting the living wage and were assured that a paper was sent to the Board for consideration. The Committee supported further exploration of being an accredited Living Wage employer.

- **Volunteer Strategy –** The Volunteer Strategy was discussed to decide the purpose and direction of how volunteering was viewed and used in the Trust. The various options to support our volunteer workforce being reflective of our age profile, making links to schools to develop potential future employees as well as formal links being made to the Health & Wellbeing Strategy to support existing staff were considered. The Committee were assured that the corporate social responsibility principles had been broadly supported and were in line with external organisations. The Committee gave assurance to supporting future focussed projects in the coming year.

- **Staff Survey –** The broad outcomes from the 2012 and 2013 Staff Survey's were reviewed and discussed by the Committee. Specific areas

that the Committee sought assurances on were appraisal compliance rates (which had increased between 2012 and 2013) and staff experiences which had deteriorated and were around work pressure and staff feeling stressed. The Committee were assured that further analysis was being undertaken to understand these themes in more detail as well as the development of Directorate level actions plans to address local specific issues. The Committee requested and were given assurance that the stress related outcomes were being picked up through the Health & Wellbeing Steering Group. It was acknowledged by the Committee that the Staff Friends and Family Test was being introduced from 1 April, which would provide a regular 'temperature check' as to the climate within the organisation.

- **Rostering Implementation –** The Assistant Director of HR (Resourcing) provided assurances that significant progress had been made on the implementation of electronic rostering within the organisation. Specifically, the trialling of central rostering within two specialties, which had already seen real benefits in some areas with respect to prospective rostering, a focus on the 'performance' around how the workforce are utilised, through holding managers to account, and implementation of 'bank' software. The Committee were assured that the monitoring of these targets will be managed through a monthly performance report to Corporate Directors. The Committee continues to focus on rostering and provide assurances to the Board.

- **Integration 1 year on -** The Committee were assured that following the integration the Directorate of Human Resources had prioritised different areas for harmonisation to ensure that practices across the Trust were consistent. This included the merger of two staff side committees and the ratification of a new on call and rest break agreement being approved covering all sites.

- **Centralised versus devolved resourcing model –** The Committee were presented with a paper around proposals to move to a centralised model of resourcing for generic Band 5 nurses, similar to the model already in place to recruit Health Care Assistants. The Committee were given assurances that a centralised model would be driven by values and the interview and selection of candidates would be retained by departments to ensure the right team 'fit'.

c) <u>Director of Corporate Development information:</u>

- **Corporate Development Overview -** The Director of Corporate Development has presented regular updates during the year, which included highlight reports from the Equality & Diversity Committee.

- **Statutory & Mandatory training** - The concept of self-declaration was discussed for professional registered staff who were required to work to their own code of conduct to support evidence requirements in order to comply with our statutory mandatory training requirements. The Committee endorsed the self-declaration concept and managed risk taking within this. The Committee were assured that progress was underway to

launch the Learning Hub to enable staff to take personal responsibility for their statutory and mandatory learning.

- **Education Strategy** – A paper was presented to consider how investment in education would like as a result of the changes in the education tariff. There were three strands for consideration how to target investment, make it cost effective and how it impacts across the organisation. The principle was to look towards an integrated provision of training model for all staff groups as the skills and the levels to which they were being trained was the same. The Committee continues to focus on this.

- **Managing Talent** – The proposed strategy for managing talent within the Trust was presented to the Committee and how this would provide natural links to the appraisal process and the OD strategy. It was acknowledged that there were several key strands to this work, with the next phase to map the succession planning requirements and review what further development may be required to place individuals in the best possible position to compete for roles going forward. The Committee were assured that this strategy was to focus on all levels and would not be at the expense of bringing fresh challenge into the organisation.

- **It's My Ward** – The Committee were assured that the It's My Ward programme had been implemented for Ward Sisters and an independent evaluation had been undertaken. The Committee acknowledged that support was continuing to support Ward Sisters to exercise these skills and authority.

- **Equality and Diversity** – The committee received reports relating to the work of the E & D group now re-named the Fairness forum outlining the approach to raising awareness across the organisation relating to access issues. The committee also supported the development of workforce metrics to better understand the needs of our workforce relative to protected characteristics.

- **Organisational and Improvement Learning Team (ODIL) –** The committee welcomed a greater understanding of the process for prioritisation of requests and recognised the need to target this resource at areas across the organisation where there were specific issues relating to delivery through poor team dynamics. The committee have reviewed interventions through the Directors report and accept the need to create greater awareness of the way in which ODIL can support the organisation in managing change.

d) <u>Medical Director Information</u>

- **Medical workforce –** The Medical Director attended the Committee in March 2014 to present the outcomes of a paper which had been produced following a belief that the organisation had fewer doctors (non consultant doctors) than other organisations. The Committee was provided with a summary of the findings. The Committee were assured that the Trust's approach was to explore and enhance the non-consultant medical workforce. This has been evidenced through the introduction of the

Advanced Clinical Practitioner model, however extended to but was not limited to developing Clinical Technicians. The Committee continues to focus on the medical workforce.

Meetings for the coming year

The Committee will continue to meet on a quarterly basis and a record of the meeting and it proposals will be provided to the Board for consideration. The Terms of Reference of the committee, agenda items to be discussed and timescales for consideration will be agreed by the Committee. The agreed agenda items will be reviewed by the Committee on a regular basis to ensure it reflects changes to be factored in for discussion and agreement.

Conclusion

The Committee has been successful in supporting the Board through the provision of a more detailed focus on key issues to be considered in terms of developing and maintaining a robust workforce and workforce strategy fit for the future.

This year, the Committee is keen to support the Trust to becoming an accredited living wage employer.

Professor Dianne Willcocks
Chair of the Workforce Strategy Committee
July 2014

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 2014

Research and Development Strategy 2014 - 16

Action requested/recommendation

The Board of Directors is asked to ratify these proposals and actively support their implementation.

Summary

This document sets out the strategic direction for Research and Development for York Teaching Hospital NHS Foundation Trust for 2014 – 16. This strategy will be reviewed in 2016 in light of the impending changes to the national research infrastructure.

In 2011 Professor Dame Sally Davies (Chief Medical Officer for England) commented 'Health research matters to each and every one of us'.

Research plays a vital role in improving outcomes for patients by increasing our understanding of health and disease, by developing and refining interventions and by enhancing service delivery. Our vision is to i) strengthen the research culture within the Trust and imbed research as a core activity and ii) establish a national and international reputation for delivering excellent research whether that be generated by ourselves or others.

We will do this within the context of a sustainable infrastructure that manages this activity to the highest standards.

We intend to:

- increase the opportunities for patients to participate in, and benefit from, research
- attract, develop and retain staff who have the capability or potential to generate and / or conduct high quality research
- strengthen our research partnerships
- maximise our involvement in research in order to contribute to the economic stability of 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 the protected groups identified by the Equality Act.

Reference to CQC outcomes

The general principles underpinning the CQC's outcomes also apply to research governance. In addition, the Research Governance Framework for Health and Social Care (2nd edition, 2005) is listed in the CQC's Schedule of Applicable Documents in relation to Outcomes 2, 4 and 9.

There is explicit reference to the conduct of research in relation to consent (outcome 2A) and the conduct of clinical trials of investigational medicinal products (outcome 9G). Outcomes 1E and 4 refer to the use of published research findings to inform choices about treatment and delivery of care. The results of research projects are also relevant to outcome16A which is concerned with gathering information about the safety and quality of the service from all relevant sources.

Progress of report	Revised strategy for 2014 – 2016. Due to changes to the Executive Board on 18 Jun 14 this paper has not yet been formally presented to them; it will be presented to them at the 20 Aug 14 meeting.
Risk	None identified
Resource implications	More efficient use of resources by more conscious organisational management of its R&D business
Owner	Sue Holden, Director of Applied Learning and Research
Author	Christine Davey, Research Adviser
Date of paper	10 March 2014
Version number	Version 1

Board of Directors – 30 July 2014

Research and Development Strategy 2014 - 16

1. Introduction and background

This document sets out the strategic direction for Research and Development for York Teaching Hospital NHS Foundation Trust for 2014 – 16. This strategy will be reviewed in 2016 in light of the impending changes to the national research infrastructure.

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2. Strategic Aims for Research and Development

2.1 Aims and Objectives 2010 – 2013

During the past three years the Trust's research portfolio (York Hospital site) has been harmonised around 12 clinical specialties where the majority of the clinical research has taken place. Funding for Consultant SPA research time and research nurse capacity has been aligned with those 12 specialties which are: Anaesthetics, Cardiology, Dermatology, Emergency medicine, Gastroenterology, Obstetrics and Gynaecology, Oncology, Ophthalmology, Renal medicine, Rheumatology, Sexual Health and Stroke.

We have seen a steady increase in the number of research projects taking place within York Teaching Hospital NHS Foundation Trust (YTHFT). At the beginning of the previous strategy (2009 /2010), 201 research projects were active in YTHFT and 2458 patients were recruited to these studies. At the end of the period covered by the strategy (2012/13), 346 research projects were active in YTHFT (253 in York and 93 in Scarborough) and 3772 patients* were recruited to these studies (3503 in York and 269 in Scarborough). *This recruitment figures only relates to studies on the National Institute for Health Research

(NIHR) portfolio - about 70% of all the studies we do - so is an underestimate of the total figure.

It is becoming evident, however, that without further investment, YTHFT may reach a critical point in terms of the maximum number of studies it can host.

During the lifetime of the previous strategy we have seen the successful completion of a number of investigator led studies, including several clinical trials of investigational medicinal products. These latter studies were generated by staff working in Anaesthetics, Ophthalmology, Renal Medicine and Sexual Health; four of the departments previously highlighted as having staff with the experience and capability to generate their own research.

The number of projects initiated by Trust staff, particularly projects funded by external grant funding, has not increased. However in 2012 we made our first major national research funding application (to the Health Technology Assessment programme) in which a Consultant in the Trust was named as Chief Investigator. This application was submitted with the collaboration and support of the NIHR Research Design Service. Although the application was unsuccessful, the submission of such a major research funding application is a step forward for the Trust.

YTHFT continues to have a well developed research management and governance infrastructure including a tried and tested system for managing Standard Operating Procedures for research. The Trust has demonstrated that it is has the capability to run good quality trials that meet the regulatory requirements and this was reinforced by a successful statutory inspection by the Medicine and Healthcare products Regulatory Agency (MHRA) in May 2012.

We currently have two part time CLRN funded research management and governance staff (0.8 and 0.9 wte respectively) based in the R&D Unit. The objective for the Trust to have benchmark measures in place to demonstrate the effectiveness of our procedures has been overtaken by the implementation of performance measures by the NIHR, notably their high level objective that all NIHR Portfolio studies should receive NHS permission from an NHS research site within 30 days of that site receiving a valid application.

A process for ensuring correct categorisation of investigative projects has been implemented in the Trust with medical input provided by the Clinical Lead for Research (Mr Andy Coatesworth).

Two Lead Research Nurse Co-ordinators have been appointed to ensure that research nurses and clinical trial assistants are provided with appropriate management and support. They have been in post since 2010.

The Unit has maintained a good working relationship with colleagues at the University of York and continues to share the expertise of the R&D Unit in order to facilitate co-sponsorship of some clinical trials of investigational medicinal products (CTIMPs). There has been renewed interest amongst local NHS Trusts in collaborating on research management and governance procedures and, to this end, a Memorandum of Understanding has recently been signed between ourselves and two other NHS Trusts: Hull and East Yorkshire Hospitals NHS Trust and North Lincolnshire and Goole Hospitals NHS Trust. This recent development will be taken forward in the strategy for 2014 - 16.

The HYMS Experimental Medicine Unit, now known as the York Clinical Research Facility, (CRF) is well established and generating research income in its own right. It is successfully running, and has already run, a number of early phase studies including a ‘First in man’

study of a treatment vaccine for Leishmaniasis; a study funded by the Wellcome Trust and co-sponsored by YTHFT and the University of York.

York CRF was successful in applying for and being allocated a Pharmaceutical Graduate Management trainee for nine months. Her project looked at promoting the CRF's services and increasing commercial activity. As a result of this work the CRF was relaunched in October 2013 with a new name and new website. The University of York has entered into a risk sharing strategy with the Trust in order to secure the future funding of the CRF for the next five years.

Following the Trust's acquisition of Scarborough and North East Yorkshire Healthcare NHS Trust (SNEY) in July 2012 the R&D Unit has been responsible for all research activity taking place within the services that were previously part of SNEY. The transition of research governance services has been relatively straightforward with all new research projects since July 2012 being approved through the R&D Unit. There have been some delays to the alignment of the research Standard Operating Procedures (SOPs) in the combined organisation due to ongoing issues with integration of some of the Trust's core services (e.g. adverse incident reporting and use of CPD).

Scarborough and its associated hospitals share many clinical services with Hull and East Yorkshire Hospitals NHS Trust and any potential collaborative ways of working with Hull would be particularly beneficial to them.

2.2 The Changing Landscape

The R&D strategy is being updated against a backdrop of significant change within the NHS. Changes to the commissioning of health services in England and to the education and training of the health workforce have recently been implemented. We are also on the cusp of changes to the national research infrastructure. The details of these latter changes are not yet finalised and therefore their likely impact nationally, regionally, and locally is difficult to gauge.

The recent and upcoming changes to the national research infrastructure include:

- The creation of nine 'Collaboration in Leadership for Applied Health Research and Care' networks (CLAHRCs)
- The creation of 15 Academic Health Science Networks (AHSNs).
- The reconfiguration of the existing topic specific and comprehensive local research networks (currently 102 in total) into 15 local Clinical Research Networks (LCRNs). The LCRNs will map onto the geographical footprint of the AHSNs.

CLAHRCs are a relatively new initiative designed to 'bridge the gap' between health research and clinical practice as nationally we do not currently have systematic ways to ensure research is effectively translated to frontline NHS services. Each CLAHRC is a partnership between relevant organisations such as NHS trusts, councils and universities. Our local CLAHRC covers Leeds, York and Bradford.

AHSNs have been created with the following aims in mind:

- To improve health and reduce inequalities in population health by focusing on the chronic diseases which make the biggest impact on mortality in a particular region
- To transform the quality and efficiency of health services in the network through supporting the development, testing and rapid adoption of effective service innovations whether developed internally or outside the NHS

- To generate wealth in regions by developing a wealth creation system

York Teaching Hospital NHS Foundation Trust sits within the Yorkshire and Humber AHSN.

The new Clinical Research Networks will be structured around 30 specialties that will be grouped into 12 themes. The themes are:

- Cancer
- Diabetes, metabolic and endocrine disorders, renal disorders
- Stroke and cardiovascular disease
- Children
- Reproductive health and childbirth, genetics, haematology
- Dementias and neurodegeneration (DeNDRoN), neurological disorders
- Mental health
- Primary care, ageing, oral and dental health, health services and research delivery, public health
- Dermatology and musculoskeletal disorders
- Anaesthesia peri-operative medicine and pain management, critical care, injuries and emergencies, surgery
- Ear nose and throat, infectious diseases and microbiology, ophthalmology, respiratory
- Gastroenterology, hepatology

Each LCRN will determine how to configure its local specialty groups. Those groups will report to the relevant CRN National Specialty Leads at the National Institute for Health Research (NIHR).

York Teaching Hospital NHS Foundation Trust will sit within the Yorkshire and Humber LCRN. The host organisation of our LCRN will be Sheffield Teaching Hospital NHS Foundation Trust. The latter will have responsibility, amongst other things, for distributing funding for research delivery across the member organisations of the LCRN.

The new LCRNs come into place formally in April 2014 and a transition process to take us from the old to the new structure is currently in place. However it is expected that the delivery of research at the coal face will remain much the same for the next financial year. The move to the new LCRN is a major undertaking and we will need to be flexible and respond appropriately to the opportunities and challenges this brings during the lifetime of the 2014 -16 strategy.

2.3 Aims and Objectives 2014 – 2016

In order to realise our strategic aims for R&D we will focus on the following key areas:

- Research leadership
- Research capability and capacity
- Research partnerships

2.3.1 Research leadership

This strategy will strive to foster a positive culture of research throughout the Trust. To achieve this It will be important that research activity is appropriately supported, valued, rewarded and encouraged. This will require active support at all levels of the organisation from Trust Board through to clinical services. The leadership for R&D in the Trust is headed by the Director of Applied Learning and Research supported by a Clinical Lead for Research,

an R&D Group and an established R&D Unit all of whom are accountable to the Trust Board. In addition we will seek to create a number of research champions who will take a role in providing leadership for research in their particular clinical area and develop a mentorship scheme for new researchers.

In the last few years much has been gained from the professional leadership that has been put in place for research staff, especially for research nurses and clinical trials assistants. Such leadership will become ever more important as we move to the new LCRN structure and have to enable, and support, our research staff to work flexibly.

2.3.2 Research capability and capacity

In strengthening the research culture within the Trust we will seek to expand the number of clinical areas that are involved in delivering research. The appointment of some new consultants with an interest in research has resulted in a revival of research in a number of clinical areas where we have not previously had a strong research portfolio and we intend to build on this impetus. We will also actively seek opportunities to be involved in research which is led by nurses and allied health professionals.

In striving to extend the reach of our research activity, and in order to respond flexibly to the impending changes in national research infrastructure, we will manage centrally all the research income we generate so this can be directed to where it is most required. We expect any excess income to be used primarily to address issues that impact on our capacity to host research studies.

One of our key objectives is to support and develop high quality research that is initiated by Trust staff. The main focus of support for Trust generated research will be in the areas where we have acknowledged activity and expertise and / or where there are clear opportunities for development. Collaboration with the University of York is also an important factor in this.

At York Hospital the departments of Anaesthesia / Critical Care, Gastroenterology, Ophthalmology, Renal Medicine and Sexual Health have all been active in initiating and successfully completing research projects during the lifetime of the previous strategy. At Scarborough Hospital, the Combined Gastroenterology Unit in the Department of Surgery also has a successful track record in generating its own research.

With regard to other departments where new opportunities may lie, the Trust's increasing collaboration with the Centre for Infection and Immunology at the University of York and the immunological basis of many rheumatological conditions make Rheumatology a specialty where we will look to generate collaborative research. Gastroenterology is another speciality where we will actively explore opportunities for such collaboration. This list is not exhaustive and we will continue to support other clinical specialties and actively work with other departments who wish to develop their research potential.

During the period of this strategy we will strive to secure funding from a national research funding body for a project generated by a member of Trust staff.

2.3.3 Research partnerships

Partnerships and collaborative working will be vital in allowing us to move forward and realise our research ambitions.

We will continue to foster existing research partnerships with departments at the University of York, including the Hull York Medical School, but we will also actively seek new

collaborations with other staff and departments at the University. The creation of credible clinical academic posts based within the Trust would be a significant step forward and this possibility will be explored during the lifetime of this strategy. Potential collaborations with other local academic institutions, such as York St John University, will also be actively explored.

Developing relationships with commercial partners, such as pharmaceutical and medical device companies, will also continue to be an integral part of our activity over the next two years; this will ensure that the Trust benefits from external funding and will also enable our research portfolio to be expanded.

York Teaching Hospital NHS Foundation Trust will seek to establish greater involvement in the local CLAHRC and to be actively engaged in the Yorkshire and Humber AHSN. As a member organisation of Yorkshire and Humber LCRN it will play a significant role in helping the LCRN to achieve the NIHR's objectives.

The York CRF intends to develop further its activity in facilitating early phase trials for commercial as well as non-commercial sponsors. There are also opportunities to extend its reach into other types of studies. The Trust has invested in the environment to ensure that the facility is commercially viable and ready to exploit any business opportunities which are aligned to the Trust's values and objectives.

Patient and public involvement (PPI) continues to be high on the national research agenda. We have already made progress in this area by having significant lay representation on our R & D group however there is more we could do to advance this aspect of PPI within the Trust. We will increase the opportunities for patients and their families to be informed about, and involved in, our research and research processes.

3. Conclusion

This strategy intends to outline the Trust's aspirations for the next two years. An annual report will be presented to the Executive Board outlining progress made against plan.

The attached implementation plan outlines the actions and activity which we consider will enable the Trust to progress the Research and Development agenda in a considered and pragmatic manner.

4. Recommendation

The Trust Board is asked to ratify the R&D Strategy for 2014 - 2016

Author	**Dr Christine Davey, Research Adviser, R&D Unit**
Owner	**Mrs Sue Holden, Director of Corporate Development and Interim Director of Human Resources**
Date	**May 2014**

REALISING OUR STRATEGIC OBJECTIVES – IMPLEMENTATION PLAN			
Objective	**Action**	**Timescale**	***Lead Person* and Contributors**
1. Strengthen the research culture within the Trust	1.1 Give due recognition to research experience in new Consultant appointments 1.2 Raise awareness of research to new starters within the Trust 1.3. Develop the role of research champions in clinical areas 1.4 Publicise research activity to Trust Board and members of Trust staff 1.5 Publicise research publications authored by Trust staff	1.1 By 2/02/2015 1.2 Process in place by 4/08/2014 1.3 By 2/02/2015 1.4 Ongoing; formal process in place by 4/08/2014 1.5 Process in place by 4/08/2014	1.1 ***S.Holden*** Medical Director, HR Director 1.2 ***R&D management team*** 1.3 ***R&D management team*** 1.4 ***C.Davey*** 1.5 ***C.Davey***
2. Actively support and encourage Trust staff to pursue high quality research	2.1 Continue to support experienced researchers in developing investigator led studies 2.2 Actively support members of staff who are interested in, but new to, research 2.3 Actively encourage clinical nurses, allied health professionals and other non medical staff to become more involved in research 2.4 Provide active support through the development of a mentorship scheme 2.5 Ensure provision of effective research supervision 2.6 Support publication of Trust initiated research in good quality journals	2.1 Ongoing 2.2 Ongoing 2.3 Ongoing 2.4 Scheme in place by 2/02/2015 2.5 Ongoing 2.6 Ongoing	2.1 ***C. Davey and D.Phillips*** 2.2 ***C. Davey and D. Phillips*** 2.3 ***R&D management team*** 2.4 ***S.Holden, A. Coatesworth*** 2.5 ***A. Coatesworth*** Medical Director, Senior managers of non-medical researchers 2.6 ***C.Davey and D. Phillips*** R&D Group
3. Secure funding from a national research funding programme for Trust generated research project(s)	3.1 Support researchers to develop collaborations and submit grant applications, particularly for NIHR portfolio-eligible funding; 3.1.1 Disseminate information about national grant awards to researchers within the Trust 3.1.2 Provide support of R&D Unit Research Advisers for project development 3.1.3 Collaborate with the NIHR's Research Design Service 3.1.4 Develop an internal peer review process	3.1 Ongoing; One substantial grant awarded by 1/11/2016	3.1 ***C.Davey, D. Phillips, D.Foster*** R&D Group
4. Expand the work of the York Clinical Research Facility	4.1 Continue the safe conduct of early phase clinical trials and other forms of translational research 4.2 Actively market the work of the CRF externally and	4.1 Ongoing 4.2 Ongoing 4.3 By 2/02/2015	4.1. ***W.Rashid*** 4.2 ***W.Rashid*** 4.3 ***W.Rashid***

REALISING OUR STRATEGIC OBJECTIVES – IMPLEMENTATION PLAN			
Objective	**Action**	**Timescale**	***Lead Person* and Contributors**
	identify studies to use the facilities and skills of the CRF team 4.3 Work with colleagues at the University of York to identify further opportunities for collaboration e.g. translational research related to rheumatology		
5. Increase the income we generate through research activity	5.1 Maximise NIHR funding by meeting appropriate government initiation and delivery benchmarks for Portfolio studies 5.2 Seek to develop further the consultancy arm of the R&D Unit and offer services to academic and other partners 5.3 Develop and provide fee paying research related course(s) nationally e.g. for clinical trial assistants 5.4 Develop a marketing plan for attracting more device industry research	5.1 Ongoing 5.2 By 2/02/2015 5.3 By 2/02/2015 5.4 By 2/02/2015	5.1 ***D.Foster*** 5.2 ***C.Davey and D Phillips*** 5.3 ***C.Davey*** 5.4 ***W.Rashid*** C.Davey
6. Deliver robust and flexible financial management of our research income	6.1 Develop a process for managing research income centrally	6.1 Process in place by 31/03/2015	6.1 ***S.Holden*** R. Cooke, D. Foster
7. Streamline research management and governance services across the integrated organisation and our Clinical Alliance partners	7.1 Continue work on aligning research management and governance services at York and SNEY hospitals 7.2 Work with the Health Research Authority, Yorkshire and Humber Academic Health Science Network and the Yorkshire and Humber LCRN to implement any proposed national changes to research management and governance procedures 7.3 Align and share relevant research management and governance processes with Hull and East Yorkshire Hospitals NHS Trust and North Lincolnshire and Goole NHS Trust, as part of our existing Memorandum of Understanding	7.1 Ongoing; achieve by 2/02/2015 7.2 As and when required 7.3 Ongoing; achieve by 1/02/2016	7.1 ***D.Foster*** J.Holmes, R&D Unit admin team 7.2 ***D.Foster*** J. Holmes, R&D Unit admin team 7.3 ***D Foster*** R&D managers in HEY and NLAG

8. Create opportunities for patients and their families to be informed about, and involved in, Trust research and our research processes	8.1 Maintain an up to date section about research on the Trust's website 8.2 Place posters about Trust research in wards and departments 8.3 Provide written information about research at key places e.g. Reception, PALS 8.4 Include reference to research in Trust outpatient appointment letters 8.5 Include information about research in booklets for Inpatients 8.6 Develop a process for involving patients in the development of Trust initiated studies	8.1 Ongoing; update every 3 months 8.2 By 4/08/2014 8.3 By 4/08/2014 8.4 By 3/02/2014 8.5 By 4/08/2014 8.6 By 2/02/2015	8.1 ***C.Davey*** 8.2 ***H. Campbell, Sarah.Russell-Sharpe*** Research teams 8.3 ***C.Davey*** 8.4 ***H.Campbell*** 8.5 ***C.Davey*** Communications Team 8.6 ***C.Davey***
9. Continue to work with the National Institute for Health Research (NIHR) and the Yorkshire and Humber LCRN to provide professional support for research	9.1 Develop a flexible workforce who can work within and across the themes that make up the new LCRN structure 9.2 Continue to provide robust management, appraisal and team support for Research Nurses and other research staff 9.3 Maintain robust systems during and after the transition from the current clinical networks to the new LCRNs 9.4 Ensure collaborative working across the new LCRN in relation to provision of training in research skills and Good Clinical Practice	9.1 Ongoing 9.2 As and when required 9.3 Ongoing 9.4 Agreed programme by 1/04/2015	9.1 ***Hilary Campbell, Sarah Russell-Sharpe*** 9.2 ***Hilary Campbell, Sarah Russell-Sharpe*** 9.3 ***R&D management team*** 9.4 ***C.Davey***
10. Build and strengthen our research relationships with local universities, local NHS organisations and regional centres of national networks such as the AHSN and CLARHC	10.1 Continue to explore and develop opportunities with local academic institutions. 10.2 Work with academic partners to put in place credible clinical academic posts based in York 10.3 Maximise opportunities presented by the recent establishment of the York Tissue Bank 10.4 Develop joint strategy for R&D with the University of York 10.4.1 Explore establishment of a joint R&D office with the University of York 10.5 Investigate membership of the local CLAHRC 10.6 Exploit opportunities offered by the Yorkshire and Humber AHSN	10.1 Ongoing 10.2 By 1/11/2016 10.3 Ongoing 10.4 By 1/11/2016 10.5 By 4/08/2014 10.6 Ongoing; identify opportunities by 4/08/2014	10.1 ***R&D management team*** 10.2 ***S. Holden*** 10.3 ***W.Rashid*** S. Pollock 10.4 ***D.Foster*** S.Holden 10.5 ***C.Davey*** 10.6 ***C.Davey***

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 2014

Patient Safety Strategy

Action requested/recommendation

The Board is asked to approve the strategy and support the implementation of the strategy

Summary

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-consistently.

We aim to be recognised as one of the safest hospitals nationally and internationally, delivering safe, evidence-based care, partly by acting and learning when we identify a need for improvement.

The strategy has been developed through the Quality and Safety Committee. And has 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.

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

The development of the strategy has taken into account the CQC outcomes.

Progress of report	Quality and Safety Committee
Risk	No specific risks have been identified in this document.
Resource implications	The paper does not identify resources implication
Owner	Alastair Turnbull, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	July 2014
Version number	Version 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-consistently.

We aim to be recognised as one of the safest hospitals nationally and internationally, delivering safe, evidence-based care, partly by 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.

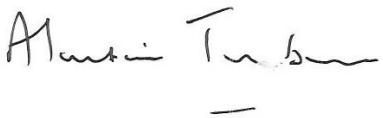
We must now take further action to reduce harm, diminish variation in practice and improve efficiency whilst always ensuring safe care.

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.

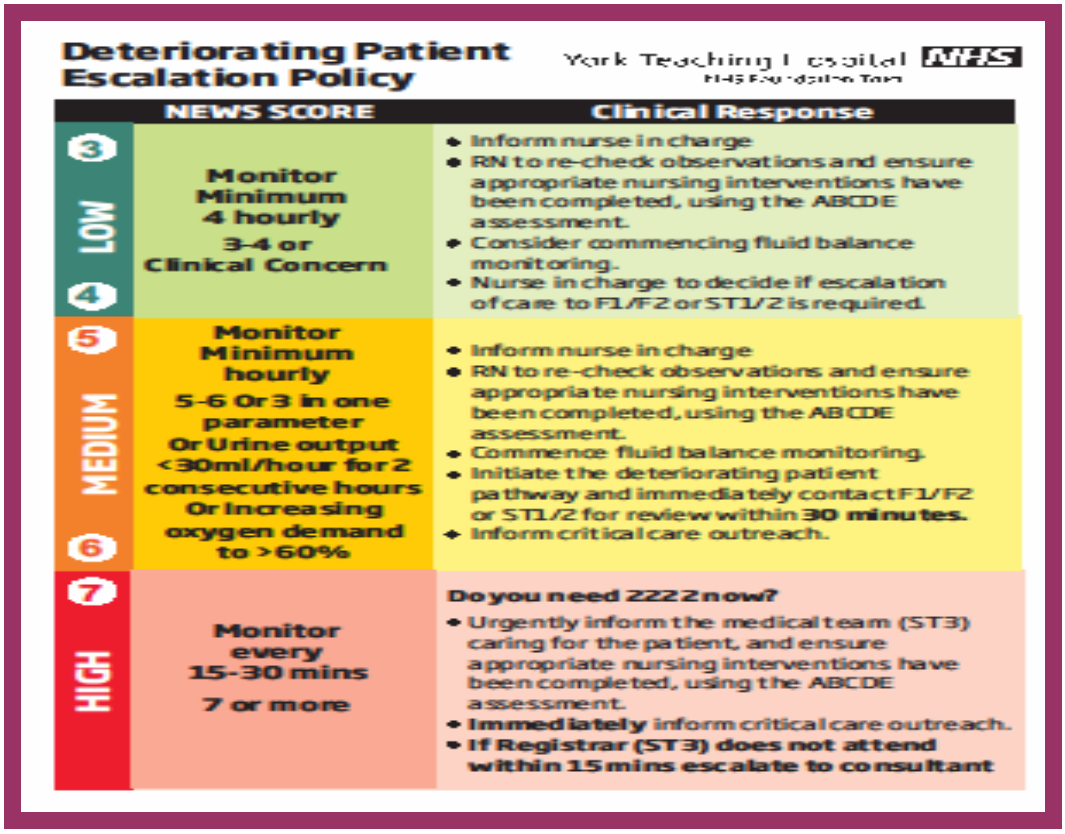
Our guiding principle is to provide safe, patient-centered care to a consistently high standard. To achieve this we will focus on six specific areas of work:

- 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. We plan to use the recently developed Learning Hub as a resource for the delivery of learning objectives following Sis and clinical legal claims. In responding to incidents, complaints and litigation, we recognize the implication and responsibilities on our duty of condour.

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.

The key aim of providing safe, patient centred care will be assisted by six driving principles:

- A culture of safety
- Partnering with other organizations
- Involving patients with safety
- Harnessing technology
- Costs and efficiency
- Developing our workforce.

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 Patient Safety and Quality Report 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 15 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 for this. 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.

Developing our workforce

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.

The skills and competencies of our staff are key to the delivery of safe, cost effective, high quality care. It is essential that we have sufficient staff to care for the number and acuity of our patients. We recognise that, in particular, numbers of training grade and non Consultant grade medical staff are low by comparison with most UK hospitals. Constraints remain with regard to the number of training grade medical staff required nationally. The Trust is committed to delivering alternatives approaches and investing as required.

As indicated in our Nursing and Midwifery Strategy, We will ensure that our new staff have a robust induction programme with a period of meaningful perceptorship and that our current staff are able to participate in mandatory training.

We will aim to strengthen our clinical leaders through clear role definition, development and direction.

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.

1.1 *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
- Ensure excellence and consistency in the use of safe systems including checklists
- Stream the 'out of hours' roles and methods of working.

1.2 *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.

1.3 *Outcomes:*

- 80% of all acute medical, elderly medical and orthogeriatric patients will be reviewed by a consultant within 12 hours of admission, with a view to continuous improvement aligned with the Royal College of Physicians guidance – reported as per CQUIN
- 100% use of the Post-take Check List on Acute Assessment Units – reported as audit to Patient Safety Group
- Consistently achieve 100% compliance with the WHO surgical safety checklist – reported in Patient Safety and Quality Report
- Over 90% of patients admitted acutely with delirium or dementia aged 75 years or over will have a dementia specific assessment and where necessary be referred for advice or treatment on all our hospital sites – reported as per CQUIN.

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.

2.1 *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.

2.2 *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.

2.3 *Outcomes:*

- Summary Hospital-level Mortality Indicator (SHMI) of 95 on both acute hospital sites – reported quarterly in Patient Safety and Quality Report
- Overall Hospital Standardised Mortality Ratio (HSMR) of 100 or less – reported annually in Patient Safety and Quality Report.

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 some of our highest 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) which has significant committed investment.

3.1 *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.

3.2 *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
- Develop a medicines management plan which includes electronic prescribing.

3.3 *Outcomes:*

- Redesign and test the modified clinical pathway for patients with severe sepsis at both acute hospital sites – reported as per CQUIN
- Reduction of in-hospital cardiac arrests
- Introduce a modified version of the National Early Warning System (NEWS) in our community hospitals – reported in Community Dashboard.

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.

4.1 *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.

4.2 *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
- Facilitate compliance with definition of ceiling of care by using both the Ward Round Checklist and the Admissions Clerking proforma.

* AMBER is a systematic approach used in hospitals to manage the care of patients facing an uncertain recovery and who are at risk of dying in the next one to two months.

4.3 *Outcomes:*

- Patients will have appropriate, inclusive and well documented DNACPR decision making – Reported by Compliance Reviews to DNACPR Group
- Patients will have appropriate and agreed ceiling of care decision making, detailing treatment options as relevant to the patient including whether or not

to transfer to a higher level of care or the application of a DNACPR order – Reported to the Patient Safety Group.

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, for example Carbapenamase-producing Enterobacteriaceae (CRE) 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.

5.1 *Our aim is to: Reduce the Incidence of Healthcare Associated Infections.*

5.2 *To achieve this we will:*

- Ensure awareness of IPC measure via staff education, particularly hand hygiene and aseptic non touch technique.
- Improve the quality of antimicrobial prescribing.
- Ensure as far as possible, isolated of potentially infected patient.
- Improve own facilities to make effective isolation better and reduce care to care spread.
- Ensure compliance with National Guidance including DH, CRE Toolkit.

5.3 *Outcomes:*

- The indications and course length for prescribing an antimicrobial will be recorded in 100% of cases – Reported in the Patient Safety and Quality Report.

- Less than 60 cases of C*lostridium difficile,* MSSA 29 cases, MRSA 6 cases – Reported in the Patient Safety and Quality Report.
- Reports of antibiotic resistant organisms – Reported in the Patient Safety and Quality Report.

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.

6.1 *Our aim is to:*

- Ensure that clinical staff understand the risk to patients of falling in hospital
- Identify which patient are at higher risk of falling in hospital
- To reduce the incidence of patients falling in hospital
- To reduce the number of patients who experience severe harm following a fall in hospital
- To reduce the incidence of pressure ulcer development for patients in our care
- To promote early identification and treatment for patients with pressure ulcers.

6.2 *To achieve this we will:*

- Develop an Organisational Patient Falls Reduction Group
- Review our falls risk assessment
- Develop falls specific individual care plans
- Review and expand the pressure ulcer reduction plans
- Develop a Pressure Ulcer Steering Group.

6.3 *Outcomes:*

- Reduce the development of pressure ulcers (as measured by the Safety Thermometer audit) by 20% - Reported in the Patient Safety and Quality Report.
- Root Cause Analysis of all category 3 and 4 pressure ulcers – Reported as per CQUIN.
- Establish a standardised approach to assessment and interventions for patients at risk of falling in hospital – Reported as per CQUIN.
- Report all patient incidents of severe harm following a fall as Sis – Reported to Commissioners.

- Reduce the number of patients who fall in hospital and incur severe harm by 30% - reported in the Patient Safety and Quality Report.

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. Outcomes will be reported in the Patient Safety and Quality Report, The Director of Infection Prevention and Control Report and the Director of Nursing's Report and monitored by the Quality and Safety Committee.

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
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Patient Safety Group
Quality and Safety Committee.

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 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	July 2014
Version number	Version 1

Board of Directors – 30 July 2014

Chairman's Items

1. Strategy and Context

The financial austerity around the nation, public sector and National Health Service is biting harder each day. Trusts that have previously been stable and secure in terms of finance are indicating deficits now or in the near future. The pressures on our finances are increasingly strong and we are just about holding our balanced position. Full credit to the team for achieving this. In the coming months, we will need to be particularly focused on this issue and taking tough steps, as appropriate. The Board's responsibility is to ensure that this does not compromise in any way our commitment to safety and the best possible quality and experience that the resources will allow. The ride is getting bumpier.

Please note our annual Board time-out this year will be the evening of November 13 and all day of Friday November 14. Venue and details to be confirmed. A major topic will be our capital plans.

2. Governance & Governors

I enclose two appendices for your information this month:

a) An update of the Non-Executive Director (NED) "linkages". This makes clear the main roles that each of the NEDs takes in the prosecution of their role, including Committees, strategic themes and other matters. Contact me if any further clarity is required.

b) An update, courtesy of our Lead Governor, Margaret Jackson, of the roles filled by members of our Council of Governors. The very fact that this takes eight pages to explain is testament to the way we have managed to engage Governors in the fabric of our Trust – hopefully always in appropriate ways that befit the role. We are committed to using Governors as one of our key ways of gaining two-way interaction with our communities and I hope that browsing this summary will give you a fuller sense of how and where this is occurring. Thank you to Helen Mackman and Margaret for tracking this so efficiently on our behalf. If Monitor is a kind of "Shareholder's Representative" of our financiers (the Government), Governors play the equivalent role in our communities. We cannot give them a dividend, so we should give them confidence that their Trust is being well-run, given the resources we are able to deploy.

As reported last time, elections are now underway to fill some Governor vacancies and those ending a term-of-office. We are pleased to be receiving clear interest across all constituencies including, importantly, the Staff Governor vacancies, which we are particularly keen to fill. Nominations are due by August 6 (contact: anna.pridmore@york.nhs.uk for details).

Lastly, I would like to give acknowledgement to all those who worked to prepare and contribute to a magnificent Celebration of Achievement event this month at York Racecourse. What a privilege to hear about and see such a range of individuals and teams nominated for the range of awards. Congratulations to the planners and all those involved in any way, not least the award winners!

3. Recommendation
The Board of Directors is asked to note the report and the two appendices.

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

YTH NEDs - Linkage -- at 23/7/14

NED	BoD,Rem, Char.Trust.	Risk	Audit	Q&S	F&P	WS	Strategic Theme	Includes:	Other
Alan	Y©	Y©					Strategic Overview	CE Governors Volunteers	Monitor; FTN; MPs/LAs HealthWatches; Chairs (NY,Reg,Nat.)
Philip	Y (SID)	Y	Y©	Y			Alliances & Collaborations; Procurement; IT	HEY (NLAG) HDFT Audit All. ©	
Dianne	Y (VC)					Y©	Elderly & Mental Health; EoLC; Patient Exp.	Dementia Learning Difficulties Social Care	JRF E&D YOPA
Libby	Y		Y	Y©		Y	Women & Childrens; Nursing	Maternity Sexual Health Safeguarding	Comms. Arts
Mike S	Y		Y		Y©		Community Services/Hubs; Capex & Estates	Health & Safety Transport, Catering	Ethics Telehealth
Jennie	Y (Charity©)			Y			Acute Pathways (Clinical Strategy)	EDs AMUs; Trauma/ITU	Fundraising; East Coast
Mike K	Y		Y		Y (© from 10/14)		Elective Services (Clinical Strategy)	Bridlington Private Patients Nuffield; Ramsey	Organ Donation © Education Board; Research; East Coast
Includes:		BAF; CRR	Int& Ext;compl; Dataqual	Quality; Safety; Nursing; CQuin	Fin; Ops; CQuin; Tenders; SLM	HR; OD; CEA; OH; Values			

Share out: Governor engagement, Walkarounds, H&W Boards, HealthWatch(es), Scrutiny Committees, CCG Meetings, Appeals, Appointment panels, MHPS, NEDs at other Trusts, Friends Orgs, Events; Speaking Events; **Clinical Directorates**: optional, based on interest and fit with strategic issues.

Governor involvement in York Teaching Hospital NHS Foundation Trust
Groups and Projects and in outside organisations

In addition to Governors' statutory duties and attendance at Council of Governor meetings, the Lead Governor endeavours to ensure that individual Governors have an equal opportunity to extend their experience and involvement in a variety of ways.

Being active partners in groups and projects offers us the ability to influence decision-making that affects a variety of services for patients. It gives us another level of assurance and critical examination as well as the chance to liaise with different disciplines across the Trust.

Membership of Trust groups, projects and committees is open to any governor.

This is a working document, maintained by the Lead Governor. All Governors will be kept up to date with any additional opportunities that may arise. Please help to keep this information up to date by providing news of any changes or additions that you're aware of.

Thank you

*Margaret Jackso*n

Lead Governor
13 July 2014

TRUST Groups and Committees	Trust Lead or contact and meeting frequency	Governor Membership	Purpose
Patient Experience Steering Group	Chair: Bev Geary, Director of Nursing Quarterly	Sue Wellington Helen Mackman	The Patient Experience Steering Group (PESG) is responsible for setting the strategic direction of Patient Experience across York Teaching Hospital NHS Foundation Trust. The Steering Group provides assurance to the Board of Directors that the Patient Experience agenda is being managed in accordance with all key policy and delivery drivers. Membership includes senior management, a non-executive director and 2 representatives from the Council of Governors. The CoG reps will be expected to gather evidence from Governor colleagues, across each of the constituencies, of issues that are important to users of the Trust's services. Mechanisms agreed between Governors, as to the most effective way of making this happen, include a governor meeting 3 weeks before each quarterly PESG to agree items for the CoG reps to take forward to the next PESG. *Currently the way Governors have input into this group is under review. Sue and Helen will continue to be the Governors who link to this work*
Maternity Services Liaison Committee	Lay Chair:	Penelope Worsley	• To identify and report to the Trust Board, the Vale of York GP Clinical Commissioning Group, and other relevant managers on the need for improvements or modifications in the care of expectant and nursing mothers and young children. • To discuss the implementation of national policy and monitor its progress. • To elicit the views of service users on the care provided and facilities available and report to the MSLC and Maternity Unit Managers and staff for action as appropriate. • (The Terms of Reference are currently being updated and will be finalised at the end of March 2013)

Charitable Funds Committee	Chair: Jennie Adams (NED)	Penelope Worsley Helen Noble	
Hospital Open Days and Events	Arranged through the Events Team which comes under HR		All Governors are invited to support the Trust Open Days or Events in their own area
Arts Strategy group	Chair: Dawn Preece, HR Lead Quarterly meetings	Helen Mackman Jeanette Anness	This group was set up to monitor and support the Trust's Art and Design Strategy. It receives regular reports from the Arts Officer and considers the way forward for the Trust in terms of funding, art installations and arts projects which include working with patients and making links between the Trust and the community.
York and District Cancer Partnership and York Cancer Locality Group	Trust contact: Jane Archer, Cancer Care Centre	Helen Mackman (as a patient, carer and Governor)	These groups provide recognised forums to enable users of cancer services to influence the development, commissioning, delivery and peer review of cancer and palliative care services. They provide a contact point for health professionals who want a link with people affected by cancer and enables direct channels of communication at directorate or Board level to drive the progress of the work plan. Regular reports are received on all targets relating to cancer services across the Trust's locality and peer reviews and operational matters are considered in terms of the most effective and safe delivery of services to this group of patients. The group includes directorate management, clinical and nursing staff and representation from commissioners,
Travel and Transport groups for Scarborough and York	Chair: Brian Golding	Sheila Miller Steve Hinchliffe With Terry Atherton in reserve	The Travel and Transport Group considers issues relating to staff and visitor travel, to and from properties owned or operated by York Teaching Hospital NHS Foundation Trust, including the following: Public Transport, Bus, Rail, Cycling, Taxis and Car Parking
Scarborough Nutritional Steering Group	Chair: Sue Waddington, Dietetics Manager, (meets quarterly)	Sue Wellington (as governor and patient)	A multidisciplinary group with Matrons, Dieticians, Catering staff and Specialist Nurses representing Scarborough, Whitby and Malton, to ensure the importance of nutrition and hydration is embedded in training and interdisciplinary working.
Equality & Diversity group	Chair and contact: Sue Holden	Ann Bolland Jenny Moreton	Future group work plans include: • Equality analysis • Receiving reports and work stream updates • Awareness campaigns, events and training programmes

Eye Clinic Partnership Group	Contact: Paul Mayor	Jo Riches Paul Baines	A forum to enable users of ophthalmology services to influence the development, commissioning, delivery and peer review of the service. It provides a contact point for health professionals who want a link with people affected by eye conditions and enables direct channels of communication at directorate or Board level to drive the progress of the work plan
Strategic Rewards & Recognition Group (SRRG)	Chair: Director HR	Vacancy for a staff governor	This group is mainly concerned with staff benefits issues and meets quarterly.
Renal Patient & Carer Reference Group	Contact: Kay Gamble	Penelope Worsley	• To ensure the views of patients and carers are at the centre of the implementation of the Renal National Service Framework in York Renal Services. • Give patients and carers views on present and future renal services to the renal Multi Disciplinary Team and the Regional Renal Network • Influence how renal services are developed and delivered in this area • Enhance two-way communication between patients, their families and those involved in delivering renal services. • Act as a reference group for specific projects such as pre dialysis education
Older People's Liaison Group	Contact: Sue Hendry Quarterly meetings	Helen Fields	• Updates about Trust services affecting older people. • Discussions on issues related to Trust services that concern older people. • A forum that can influence the planning, commissioning and delivery of services provided by the Trust • Comments invited about information provided by the Trust for older people and their carers.
Clinical Excellence Awards Committee February 2014	Chair: Director of HR	Helen Mackman Helen Fields	The Clinical Excellence Awards Scheme recognises and rewards NHS Consultants who perform over and above the standard expected of their role. Awards are given for quality, excellence and exceptional personal contributions. Governors provided lay membership of this committee.

Projects	Trust Lead	Governor membership	Project profile
Patient Experience on the Surgical Wards Survey project	Kay Gamble	Terry Atherton Sue Wellington Sheila Miller Jenny Moreton Paul Baines Penelope Worsley	The aim of this project is to establish patients' experience on the surgical wards after surgery. A survey programme was launched June 2011 when 4 Governors surveyed surgical and orthopaedic wards at York Hospital. There are plans to roll this out to Scarborough Wards. Governors would carry out surveys on the surgical wards using Electronic Tablets
Patient-led Assessment of the Care Environment 'PLACE' (replacement for the Patient Environment Action Team)	On-going, facilitated by Kay Gamble. Led by Carol Tarron from Estates	Caroline Patmore Paul Baines Sheila Miller Andrew Butler Jenny Moreton Jeanette Anness Sue Wellington Steve Hinchliffe Penelope Worsley Ann Bolland Margaret Jackson	The Department of Health and NHS Commissioning Board recommend that all hospitals, hospices and independent treatment centres providing NHS-funded care undertaken an annual assessment of the quality of non-clinical services and the condition of their buildings. These assessments (PLACE) look at: • How clean the environments are • The condition – inside and outside – of the building(s), fixtures and fittings • How well the building meets the needs of those who use it • The quality and availability of food and drinks • How well the environment supports people's privacy and dignity Assessments are carried out annually by people who use the hospital – relatives, carers, friends, patient advocates, Trust Members and Governors – supported by hospital staff. *The 2014 PLACE assessments have now all been completed.*
The Friends and Family Test (FFT) Communications sub-group	Contact: Lucy Brown, Communications Manager	Margaret Jackson Helen Noble: with the involvement of governors in	The FFT is a simple test of patient satisfaction. All acute trusts are required to implement this test which asks - "How likely are you to recommend our ward/department to your friends and family if they needed similar care or treatment?"

(FFT)		supporting the process	This sub-group was set up to take forward plans relating to engagement across the Trust and latterly to ensure the wider community understands the importance of the FFT.
Out-patient and Paediatric Strategic plans for Scarborough	Ref: James Hayward	Paul Baines	Paul provides a governor link to this project by keeping up to date on strategic plans and designs for OPD and the Paediatric Dept
Linking with Bridlington's Orthopaedic strategic proposals	Ref: James Hayward	Terry Atherton David Wheeler	Terry & David provide a link between Governors and the on-going development of services provided at Bridlington Hospital.
15 Steps, across all sites	Trust contact and trainer: Sue Holden	Sheila Miller, Jeanette Anness, Penelope Worsley, Terry Atherton, Sue Wellington, Steve Hinchliffe, Andrew Butler, Ann Bolland	Observations of wards and departments have been video recorded by each participant and used for staff training and development. *(Paul Baines and Les North held in reserve until this project is repeated next year, when the first group of governors will stand down)*

Council of Governors sub-groups & activities		**Governors**
The Nominations and Remunerations Committee	Chairman Alan Rose Trust contact: Anna Pridmore	The Lead Governor is automatically on this committee as Vice-Chair. Margaret Jackson (York), Ann Bolland (Selby), Steve Hinchliffe (Whitby), David Wheeler (Scarborough), Paul Baines (York) Jeanette Anness (Ryedale and East Yorkshire), Jane Dalton (Hambleton), Les North (Staff Governor), Mike Beckett (Voluntary Sector appointed), Rowena Jacobs (York University appointed)
Quality Account group	Trust contact: Anna Pridmore, with Fiona Jamieson and Diane Palmer	Margaret Jackson, Paul Baines, Sue Wellington
Annual Plan group	Trust contact: Anna Pridmore	Andrew Butler, Steve Hinchliffe, Sheila Miller, Jenny Moreton
Constitution group	Trust contact: Anna Pridmore	Jeanette Anness, Mike Beckett, Ann Bolland, Andrew Butler

Finance and Cost Improvement Programme (CIP) interest group	Trust Lead: Director of Finance, Andy Bertram	David Wheeler, Andrew Butler and Rowena Jacobs, along with any other Governors on an ad hoc basis
Appointment of External Auditors	Anna Pridmore, Andy Bertram and Sheila Wilson	A task and finish group: Helen Mackman, Helen Fields, Andrew Butler, Penelope Worsley
Appointment Prep Sub-group	Alan Rose, Anna Pridmore, Will Thornton	Margaret Jackson, Rowena Jacobs, David Wheeler
Presentations Group	Trust Lead: Alan Rose	Occasional Governor involvement, through the Chair, on an ad hoc basis Eg. reporting to the Trust AGM, supporting talks to groups in the community.
LOCALITIES: **The Governors' 'Patient Focus Meeting'**	Governor leads: Sue Wellington Helen Mackman	All Governors will be invited to meet 3 weeks prior to each meeting of the Trust Patient Experience Steering Group (the PESG). Feedback on patients' experience from our constituencies and the community is valuable and we are all encouraged to attend this Governors' Patient Focus meeting to ensure that our key messages are fed into the Trust's PESG through our two Council of Governor reps on that group. (see page 2 for reference to the PESG) ***York** *Local governors: Paul Baines, Helen Mackman, Margaret Jackson, Penelope Worsley, Helen Fields.* ***East Coast (Scarb, Whitby, Brid)** *Local governors: Steve Hinchliffe, Sue Wellington, David Wheeler, Terry Atherton* ***Hambleton, Ryedale and East Yorkshire** *Local governors: Sheila Miller, Jeanette Anness, Jane Dalton, Mike Beckett, Jenny Moreton* ***Selby** *Local governors: Andrew Butler, Ann Bolland* ***Staff Governors** *Les North (Community), Helen Noble (both for Scarborough & Bridlington)*

		***Appointed Governors** *Mike Beckett (Voluntary Sector), Rowena Jacobs (University of York), Cllr Caroline Patmore (North Yorkshire County Council), Cllr Jo Riches (City of York Council). Cllr Dee Sharpe (East Yorkshire Council)* *How Governors are able to feed into this group is currently under review*
Community Services Special Interest Group, relating to the whole patch.	links with a non-executive Director	*Sue Wellington, Terry Atherton (chairperson), Jeanette Anness, Steve Hinchliffe, Ann Bolland, Margaret Jackson and Les North*
Governor Conduct review group	Chaired by Anna Pridmore	*Helen Mackman, Steve Hinchliffe, Margaret Jackson, Rowena Jacobs, Paul Baines*

Non-Trust 'outside' groups	**Chair**	**Governor**
Vale of York Clinical Commissioning Group Patient Engagement Steering Group	Alan Maynard	Helen Mackman as lay member (not as a CoG rep)

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 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	July 2014
Version number	Version 1

Board of Directors – 30 July 2014

Chief Executive Report

Introduction

Many thank to all of you for attending the Celebration of Achievement Awards ceremony earlier this month. As ever the feedback was excellent, particularly from those who had attended for a first time, and I have no doubt that the event plays a crucial role in keeping staff motivated and engaged at a time when many of the influences on us could be considered to be negative. It has never been more important to focus on the values of our organisation as a way of reminding us all why we are here and why we all, together, do what we do.

As we move into the summer period we continue to be confronted by many challenges and frailties. For example, and as I have previously reported, the hospital sector in particular is in financial difficulty with some notable and high profile "casualties" and whilst our position has improved marginally at the end of Quarter 1 it remains fragile. This is compounded by the consistently high level of demand for acute care that not only challenges how we manage our capacity and the impact this has on our elective service but as we know to our cost a growth in acute activity only generates income at a marginal level that is directly affecting our ability to respond now, as well as clearly being unsustainable in the longer term. We are facing a number of challenges with recruitment to key roles, both clinically and managerially, and this is forcing some level of consolidation of services, albeit on a relatively small scale at present e.g. our commissioners have supported the pragmatic and partial centralisation of our breast service in York and a withdrawal of ophthalmology clinics in Whitby and Selby but this has inevitably attracted a degree of negative publicity.

However, we have to retain our optimism for the future and there is much to be cautiously optimistic about. The recent transfer of orthopaedics from Scarborough to Bridlington has been well received and provided relief to the Scarborough site. The development of the Scarborough Hospital site continues with the new Maple Ward now a reality and if we can build on the Perfect Week and improve the level of mutual support and integration with our CCGs and social service partners then our patients (and staff) can only benefit. The recent Rapid Improvement events in York offer the same opportunity that we must grasp. The project arrangements are now in place to lead the development of the community hubs in Malton and Selby and this work is generating a renewed enthusiasm for change across primary and secondary care that we now must harness. The recent decision to waive any penalties and intervention for failing 18 weeks in the coming months, allowing us to time to restore a better equilibrium to our waiting times, must be seen as a positive signal and recognition of the difficulties from the centre and in many respects a validation of the action we took earlier this year. I look forward to the debate with the Board in the autumn on our development plans for the York site which I believe we can realise, given the time and resource to do this. I recognise that everyone is feeling the pressure, clinically and managerially, and the feeling of "chaos" that this can create but we can evidence that the basic safety of our services continues to improve and I look forward the launch of the Patient Safety Strategy that can only help build on this. We have this week managed to complete the recruitment of 4 excellent candidates into our operational management team that will help with our resilience and perhaps offer a sign that the market is now improving.

I recognise that this is only a snapshot but it is vital that we continue to work hard to meet and address the challenges we face with discipline and ambition, whilst being realistic about the risks we face, all founded on the core values and mission of the Trust. I don't believe there is any other way.

Awards

As you know I passionately believe that our IT systems are excellent and most importantly are wholly aligned with the delivery, support and improvement of patient care. I am delighted to be able to advise you that the Trust has been short listed for two prestigious awards with EHealth Insider (EHI awards). The two categories are Digital NHS Trust for Health Board of the year and Best Use of IT to Promote Patient Safety. EHI awards are held in association with the CGI, a leading international IT company.

The awards ceremony is on 9th October and I would like the Board to join me in congratulating Sue and the team and wishing them every success on the night.

Federation Surgical Specialities Association

Last month I was pleased to be able to report that Alastair Turnbull had been invited to be part of the Monitor's Acute Advisory Group. I am equally delighted to be able to report this month that Professor John Macfie has been elected President of the FSSA (Federation Surgical Speciality Association). The Federation is the corporate body of the Specialty Surgical Associations, through which it represents and coordinates the views, aims and policies of surgeons from across the United Kingdom and Ireland. It is comprised of the Presidents of all the defined surgical specialities. The Trust continues to see members of staff being awarded these nationally important roles which the Trust can only benefit from. Congratulations to John on his tenure and I look forward to hearing about the work the federation is undertaking.

Procurement

NHS Procurement has developed a system called the Atlas of Variation. It is designed to provide greater transparency by comparing the prices paid by different trusts for the same types of products. This information will provide a benchmark nationally and an ability for us to better understand where better value is available and then act on this information to reduce costs. The first release of the Atlas covers 100 product lines that are supplied to trusts by NHS Supply Chain. By the end of 2014 it is intended that this will be expanded to 500 product lines. The release of this version of Atlas shows that the Trust appears in the top 10 (for lowest prices paid) for two items and in the top 10 overall as a ratio of savings versus turnover. I do believe this is worthy of note and I thank the procurement team for their continued diligence in all aspects of our procurement. Their role is largely in the background but is key to ensuring that we maintain the right balance al all times between quality and price and I am grateful for the opportunity to publicly recognise their contribution.

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

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 014

Monitor Quarter 1 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 1.

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	July 2014
Version number	Version 1

Continuity of Service Risk Ratings (indicators for 2014/15) for York Teaching Hospital

		Reported YTD to 30-Jun-14
Adjustments		
Material One-Off Adjustment (Revenue Available for Capital Service)		-
Material One-Off Adjustment (Capital Service)		-
Material One-Off Adjustment (Working capital balance (for use in CoS rating calculation))		-
Material One-Off Adjustment (Operating Expenses within EBITDA, Total)		-
Capital Service Cover		
PDC dividend expense	*from SoCI*	(1.801)
Interest Expense on Overdrafts and Working Capital Facilities	*from SoCI*	-
Interest Expense on Bridging loans	*from SoCI*	-
Interest Expense on Non-commercial borrowings	*from SoCI*	-
Interest Expense on Commercial borrowings	*from SoCI*	(0.106)
Interest Expense on Finance leases (non-PFI)	*from SoCI*	-
Interest Expense on PFI leases & liabilities	*from SoCI*	-
Other Finance Costs	*from SoCI*	-
Non-Operating PFI costs (eg contingent rent)	*from SoCI*	-
Public Dividend Capital repaid	*from SoCF*	-
Repayment of bridging loans	*from SoCF*	-
Repayment of non-commercial loans	*from SoCF*	(0.458)
Repayment of commercial loans	*from SoCF*	-
Capital element of finance lease rental payments - On-balance sheet PFI	*from SoCF*	-
Capital element of finance lease rental payments - other	*from SoCF*	(0.025)
Revenue Available for Capital Service		4.204
Capital Service		-2.390
Capital Service Cover metric		1.76x
Capital Service Cover rating		**3**
Liquidity		
Working capital balance (for use in CoS rating calculation)	*from SoFP*	16.049
Operating Expenses within EBITDA, Total	*from SoCI*	-106.218
Liquidity metric		13.6
Liquidity rating		**4**
Continuity of Service Risk Rating		**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 2014-15 by York Teaching Hospital

These targets and indicators are s **Key:** must complete

Definitions can be found in Appendix A of the Risk Assessment may need to complete

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

	Target or Indicator (p	Threshold or target YTD	Scoring under Risk Assessment Framework	Risk declared at Annual Plan	Scoring under Risk Assessment Framework	Quarter 1 Actual Performance	Achieved/Not Met	Any comments or explanations	Scoring under Risk Assessment Framework
	Referral to treatment ti	90%	1.0	No		90.9%	Achieved		
	Referral to treatment ti	95%	1.0	No		96.8%	Achieved		
	Referral to treatment ti	92%	1.0	No	0	93.3%	Achieved		00/01/1900
	A&E Clinical Quality- T	95%	1.0	No	0	93.9%	Not met	*This is a provisional figure an will be validated over the next few weeks*	No
AMENDED	Cancer 62 Day Waits f	85%	1.0	No		87.4%	Achieved	*This is a provisional figure an will be validated over the next few weeks*	
AMENDED	Cancer 62 Day Waits f	90%	1.0	No	0	96.4%	Achieved	*This is a provisional figure an will be validated over the next few weeks*	0
NEW	Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation					87.4%			

NEW	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach					96.4%				
	Cancer 31 day wait for	94%	1.0	No		95.1%	Achieved			
	Cancer 31 day wait for	98%	1.0	No		98.7%	Achieved			
	Cancer 31 day wait for	94%	1.0	No	0	0.0%	Achieved		0	
	Cancer 31 day wait fro	96%	1.0	No	0	98.8%	Achieved		0	
	Cancer 2 week (all can	93%	1.0	No		85.9%	Not met			
	Cancer 2 week (breast	93%	1.0	No	0	45.4%	Not met		No	
	Care Programme Appr	95%	1.0	No		0.0%	Not relevant			
	Care Programme Appr	95%	1.0	No	0	0.0%	Not relevant		0	
	Admissions had acces	95%	1.0	No	0	0.0%	Not relevant		0	
	Meeting commitment t	95%	1.0	No	0	0.0%	Not relevant		0	
	Ambulance Category A	75%	1.0	No	0	0.0%	Not relevant		0	
	Ambulance Category A	75%	1.0	No	0	0.0%	Not relevant		0	
	Ambulance Category A	95%	1.0	No	0	0.0%	Not relevant		0	
AMENDED	C.Diff due to lapses in	15	1.0	No	0	12	Achieved	*total cases =12*	0	
NEW	Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)					24				
NEW	C.Diff cases under review					12				
	Minimising MH delayed	<=7.5%	1.0	No	0	0.0%	Not relevant		0	
	Data completeness, M	97%	1.0	No	0	0.0%	Not relevant		0	
	Data completeness, M	50%	1.0	No	0	0.0%	Not relevant		0	
	Compliance with requi	N/A	1.0	No	0	N/A			0	
	Community care - refe	50%	1.0	No		100.0%	Achieved			
	Community care - refe	50%	1.0	No		71.7%	Achieved			
	Community care - activ	50%	1.0	No	0	98.9%	Achieved		0	
	Risk of, or actual, failu	N/A	Report by Exception	No						
AMENDED	CQC compliance actio	N/A		No			No			
AMENDED	CQC enforcement acti	N/A		No			No			
AMENDED	CQC enforcement acti	N/A		No			No			
AMENDED	Moderate CQC concer	N/A		No			No			
AMENDED	Major CQC concerns c	N/A		No			No			
	Trust unable to declare	N/A		No			No			

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 2014

Integration Report

Action requested/recommendation

The Board of Directors is asked to note the contents of this report and approve the following recommendations.

1. The development of a schedule of confirm and challenge session for each of the corporate directorates.
2. The requirement for each of the clinical directorates to develop a strategy and directorate plan which incorporates integration.

Summary

The attached report provides assurance to the Board of Directors on progress of the Integration Programme, post acquisition of Scarborough and North East Yorkshire Healthcare NHS 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

There are no references to CQC outcomes.

Progress of report	This paper is only written for the Board of Directors
Risk	Risks to integration are articulated in the integration risk register
Resource implications	There are no resource implications noted in this paper
Owner	Sue Holden, Executive Director for Corporate Development
Author	Lynda Provins, Head of the Business Intelligence Unit
Date of paper	July 2014
Version number	1

Board of Directors – 30 July 2014

Integration Update Report

1. Introduction and background

The purpose of this report is to provide assurance to the Board of Directors of progress of the Integration Programme post acquisition of Scarborough and North East Yorkshire Healthcare NHS Trust.

Since the acquisition in July 2012, the Trust has received significant assurance for the management of the process leading to the acquisition and the subsequent monitoring of the integration.

Detailed integration plans were developed for both the Corporate and Clinical Directorates and continue to be monitored monthly or quarterly for some corporate directorates.

2. Current Position

Reporting Structure

Monthly Corporate and Clinical Progress reports are presented and discussed at the Clinical Strategy Delivery Group, which is chaired by the Deputy Chief Executive. The representation of the group encompasses a number of key individuals who are in a position to bring information from their area including strategy, partnership working, efficiency planning, workforce, community, acute board strategy and operational management. This ensures that information, interdependencies and risk is examined from a number of different perspectives.

An example of this was an increased awareness of a number of interdependencies from other areas with Radiology. A presentation was requested from the Radiology Directorate and a number of individuals around the table were then tasked with supporting the Directorate.

Corporate Integration

Finance and Healthcare Governance have recently completed the actions contained within their integration plans and several of the other plans only have a limited number of actions outstanding.

Corporate Directorate	No. of Actions Outstanding	Plan due to be completed
Cancer	1	November 2014
Communications	2	December 2014
Corporate Governance	3	December 2014
Estates	6	September 2014
Human Resources	3	July 2014
Nursing	3	December 2014
Organisational Development	*	2015
Operations	5	November 2014
Patient Access	8	2015
Systems & Networks	7	2015

*OD plan still has a larger number of actions to be completed. However, this plan was very large and a significant

number of actions have been completed. This plan will be cross referenced with the emerging education strategy to ensure there is no duplication.

This would seem an appropriate time to conduct a series of confirm and challenge sessions with each of the Corporate Directors. The format of the session would encompasses their delivery against plan, whether initial financial CIPs have been achieved, especially with regards to previous benefit predictions linked to structures and whether there are any gaps or ongoing risks identified, which require further action.

Clinical Integration

Clinical integration continues to progress, although there are a number of areas that are still classed as single site directorates:

- Emergency Department/Acute Medicine (Scarborough)
- Emergency Department (York)
- General Medicine (Scarborough)
- General Medicine (York)
- Trauma & Orthopaedics (Scarborough)
- Trauma & Orthopaedics (York)

In order to inform the work on the Trust's operational and strategic plans, which were requested by Monitor, the Business Intelligence Unit asked the clinical directorates to draft a strategy. This process has begun and a number of the directorates have a substantial draft, which they are in the process of consulting on with their teams. The strategies will focus the clinical directorates on priorities including integration, alliance working and other strategies within the Trust including the Acute Board.

The next step in this work is to produce a directorate plan, which will be a central point for the strategy and integration by:

- capturing the actions required to implement the strategy
- providing an opportunity to identify any gaps and look at any further actions required in respect of integration
- subsume any outstanding actions from the integration plans
- coalescence of any directorate actions including impending business cases or business case review, governance work required, partnership working

The intention will be to have one plan, which forms a work plan for the directorate that can be monitored. The plans will continue to be monitored in the same way and will be reported into the Clinical Strategy Delivery Group and provide another source of information for performance management meetings. The work will continue to identify gaps and drive integration through the directorate plans in line with the Trust's strategic frames.

Benefits Realisation

A retrospect look at clinical benefits realised as a consequence of the acquisition has been looked at in order to capture developments since July 2012. The Clinical Strategy Delivery Group are monitoring this work, which has also tried to tie in a speculative comment about what would have happened if acquisition had not taken place. A similar piece of work is ongoing in respect of the corporate directorates.

3. Recommendation

The Board of Directors is asked to note the contents of this report and approve the following recommendations.

1. The development of a schedule of confirm and challenge session for each of the corporate directorates.
2. The requirement for each of the clinical directorates to develop a strategy and directorate plan which incorporates integration.

4. References and further reading

Integrated Business Plan 2012-2017
Operational Plan 2014-2019
Strategic Plan 2014-2019

Author	**Lynda Provins, Head of the Business Intelligence Unit**
Owner	**Sue Holden, Executive Director for Corporate Development**
Date	**July 2014**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 July 2014

Business Case 2012/01: Electronic Prescribing and Medicines Administration (EPMA)

Action requested/recommendation

The board is asked to approve this case.

Summary

In February 2014, the Department of Health's Safer Hospitals, Safer Wards Technology Fund (now known as Integrated Digital Care Fund) made an award to the Trust of £592k on the basis that there would be matched funding made available from the Trust to support the successful delivery of the project. This business case details the capital and revenue requirements to deliver the implementation and roll-out of the Electronic Prescribing & Medicines Administration scheme across the 3 main hospital sites (York, Scarborough and Bridlington). Future expansion into community hospitals will be linked to a separate bid for monies to 'Tech Fund 2' (NHS England) to improve the clinical reporting systems through enhanced IT infrastructure and will be subject to a separate 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 – 7th July 2014
Risk	Risk analysis detailed in section 10 of the report.
Resource implications	Resources implication detailed in the report.
Owner	Dr Alastair Turnbull, Medical Director
Author	David Pitkin, Chief Pharmacist Caroline Mulholland, Project Manager, Electronic Prescribing and Medicines Administration
Date of paper	July 2014
Version number	Version 2

APPENDIX Bi

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2012/01

2. Business Case Title

Electronic Prescribing and Medicines Administration (EPMA)

3. Management Responsibilities & Key Contact Point

The business case 'Owner' should be the appropriate Clinical or non-clinical Director, or where appropriate the lead Clinician nominated by the respective Clinical Director. The 'Author' will be the named manager supporting the Owner of the business case, who will have responsibility for the development and writing of the business case, and <u>will</u> be the key contact point for enquiries.

Business Case Owner:	**Alastair Turnbull**

Business Case Author:	**David Pitkin / Caroline Mulholland**
Contact Number:	**Ext 5974 / 4133**

4. Issue(s) to be addressed by the Business Case

Describe the background and relevant factors giving rise to the need for change. Relevant data (e.g. BCBV data, etc.) *<u>must</u> be included to support the background described.*

In February 2014, the Department of Health's Safer Hospitals, Safer Wards Technology Fund (now known as Integrated Digital Care Fund) made an award to the Trust of £592k on the basis that there would be matched funding made available from the Trust to support the successful delivery of the project. This business case details the capital and revenue requirements to deliver the implementation and roll-out of the Electronic Prescribing & Medicines Administration scheme across the 3 main hospital sites (York, Scarborough and Bridlington). Future expansion into community hospitals will be linked to a separate bid for monies to 'Tech Fund 2' (NHS England) to improve the clinical reporting systems through enhanced IT infrastructure and will be subject to a separate business case.

This paper requests the capital and revenue investment required for the establishment of a number of key fixed term nursing and pharmacy posts to support the development of

EPMA along with the IT hardware, software and other ward/Pharmacy equipment requirements to facilitate the roll-out of EPMA. Additional revenue will be required post implementation to ensure the continued development, audit and assurance of the system and the training of the large numbers of staff required to use it.

Background

Electronic prescribing can be described as:

'the utilisation of electronic systems to facilitate and enhance the communication of a prescription or medicine order, aiding the choice, administration and supply of a medicine through knowledge and decision support and providing a robust audit trail for the entire medicines use process'. (NHS Connecting for Health, 2007)

Patient safety and quality of care is the primary driver for implementing an electronic prescribing and medicines administration (EPMA) system in an acute setting. By itself an EPMA system will not generate significant cost savings for an organisation – but there are many non cash releasing savings resulting from an EPMA system: contributions towards reduced cases of Hospital acquired infections; contribution towards enhanced infection prevention through robust application of antimicrobial prescribing guidelines and contributions to potential reductions in length of stay generating capacity for additional activity as examples. An EPMA system is only one variable in these reductions however and as such it is difficult to quantify these as direct cost savings resulting from an EPMA system. The qualitative benefits of ePrescribing within the whole medicines use process are well recognised and detailed below.

At its simplest, EPMA improves the legibility and completeness of prescriptions and makes information about medicines available to the healthcare team at all times. The need to move paper prescriptions around an organisation is removed, patient safety issues associated with poor handwriting are addressed, the quality of care is improved as queries are reduced and efficiencies delivered as paper is no longer chased. Local formulary implementation is supported by reminders at the point of prescribing reducing the need to constantly update prescribers about local policy. This is a significant benefit with regards the prescribing of antimicrobial drugs.

The use of decision support additionally supports prescribers: guided prescribing can help to reduce inappropriate dosing, facilitate correct drug selection and reduce the incidence of incorrect selection when an allergy or contraindications are present. More advanced decision support can additionally provide information about monitoring and other warnings designed to reduce the risk of errors being made. This type of technology and the proven benefits it brings are already evident within the trust to a limited extent through its use of the ChemoCare oncology prescribing package.

The improved clarity of communication and the use of scheduling to prompt and support the administration of medicines generate a number of benefits. Reductions in missed doses have been demonstrated and the additional use of barcodes to check medicine selection and dosing also has positive benefits.

Communication across the care continuum at the transitions of care and access to information in a timely manner generate efficiency as well as safety benefits. Accurate and complete discharge summaries automatically created as part of the discharge process ensure that GPs are properly informed of medication changes and that patient's get the correct medication in a timely manner. Wider integration with the patient's record over time allows for more complex monitoring and support to be delivered, facilitating

prescriber compliance and improving the quality of care whilst integration with automated stock management systems (Omnicell) sited across the trust will allow for a more detailed management of pharmaceuticals with potentially significant efficiency savings.

Trust Position

YTHFT's medicines management risk register documents that neither prescribing practice nor drug administration at the Trust is considered consistent with medicines management policy, and as a consequence there is increased risk of avoidable patient harm occurring, seen through AIRs and SUI reporting. The Trust's Quality and Safety strategy includes reduction of administration and prescribing errors, and a number of recent initiatives led by pharmacy and nursing staff at YTHFT have been successful in improving practices and behaviour. However, it is clear from other trusts' experience and a process mapping exercise of one of the organisation's wards that an electronic system offers a far more efficient way of managing patients' medicines information and improving their safety than do the current paper-based processes. As insurance premiums for the Trust are now being based on claims history through the NHSLA it is anticipated that these additional safety measures will potentially benefit the Trust through reduction in potential litigation claims.

In the context of now being a larger and more diverse organisation - the standardisation of medicines management practices and availability of information to provide assurance and target resources will be even more important for YTHFT to maintain its position as a trusted provider of healthcare. In addition to improving clinical risk management, EPMA systems will enable YTHFT to achieve a number of national and local strategies, such as going paper light; exploiting mobile technologies to improve care quality; understanding and influencing better the uses and costs of medicines; monitoring more efficiently antibiotic prescribing; improve patient flow; reducing readmission rates, providing a complete patient care record and simplifying data collection for incident investigation, audit and research.

In 2010 the YTHFT Executive Board supported the development of a business case for the implementation of an EPMA system, and there is now commitment among all internal stakeholders to proceed with business case development. This will be guided by the resources published by Department of Health, including functional and technical specifications, system evaluation guidance and also implementation advice. In addition information has been gathered already from many of the trust's clinicians about expectations and requirements of an EPMA system, and also links made with similar organisations that are already using EPMA.

Work has commenced to further develop the Trust's electronic patient record to incorporate a Trust-wide electronic prescribing and medicines administration system. This will be developed in partnership with 'First Databank' that is now commissioned to provide the drug dictionary and decision support rule base and development support for members of the clinical teams. EPMA will exploit existing functionality such as results reporting and electronic discharge notification.

The implementation of EPMA will necessitate significant changes to medicines management processes across the whole organisation. It will drive a review of processes aligned with the Productive Ward methodology releasing time to care. It should not be underestimated the amount of resource required to ensure the system is effective, usable and safe for patients. Implicit in this is the need to influence the culture away from a paper based dependency to a more paper free mindset. Improvements have already been made to nursing drugs rounds, reducing the number of interruptions

and the duration of the drugs round, EPMA provides a further opportunity to support 'e-expansion' on the ward with the benefits that that will bring: immediate access to medication information and the associated time savings resulting from drug information being available electronically.

For changes of this magnitude and complexity to: take place in a safe way; provide the benefits of improved safety and efficiency; be sustainable enough to accommodate changes in the operating environment that are likely to place over the lifecycle of the package, all depends on having the right people in the right place to be able to support it. Dedicated clinical staff working collaboratively with IT and a dedicated project manager is instrumental to the success of the project both in the planning, implementation and maintenance phase. Additional revenue will be required post implementation to ensure the continued development, audit and assurance of the system and the training of the large numbers of staff required to use it.

Establishment of the following posts will be required to support the development, implementation and ongoing maintainance of the EPMA system and to ensure 'organisational readiness' for such a major complex change:

1) Seconding the current lead nurse medicines management (8a) to work on the EPMA project for 2 years fixed term with backfill from a registered nurse (1WTE Band 6)
2) Recruitment of additional nursing support for 2 years fixed term to support the medicines management EPMA lead nurse across York, Scarborough & Bridlington Hospitals (2 WTE Band 5)
3) Specialist pharmacist EPMA (1WTE Band 7) for a 2 year fix term period to support the implementation at Scarborough and Bridlington hospitals
4) Lead pharmacist for EPMA (1 WTE Band 8a) – permanent post
5) Recruitment of senior pharmacy technician (1 WTE Band 5) - permanent post
6) Recruitment of Band 4 Project support officer – permanent post

In addition to the nursing staff support identified above there will be Nursing champions identified on each ward and department to support local implementation of EPMA with the support of the project team. Four weeks of supernumerary time will be required around the time of go-live and for super-user training (based on lessons learnt from the rollout of Electronic Observations and the Care of the Deteriorating Patient).

The development of the IT solution (both hardware and software) will be undertaken from within the existing IT staffing establishment (already capitalised).

Additional expenditure is estimated below as c. £750k. This will be clarified and confirmed as the project develops. This will be subject to an additional business case as required:

IT Hardware - £275k (excl. VAT)
IT Software (licences) - £15k
Upgrade of IT network - £200k
Ward Furniture (trolleys, additional power/data) - £210k (excl. VAT)
Other (e.g. Pharmacy computer screens, OPD printers) - £50k (excl. VAT)

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
i) Do Nothing. Utilise the skills and expertise of the current workforce to undertake development and implementation activity within their existing roles. ii) Establish dedicated posts within the nursing and pharmacy teams to provide dedicated support to the EPMA project. Additional expenditure for IT hardware, IT software, ward furniture etc is essential to the roll-out of the project and will be committed irrespective of whether option i) or ii) is selected.

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 ii) is the preferred option.

Lessons learned from previous IT implementations across the organisation (E-obs, eDN, OrderComms) and feedback from early implementers of EPMA solutions (e.g. University Hospitals Birmingham, Doncaster and Bassetlaw, Harrogate) point to the need for a dedicated (ring fenced) workforce to support a safe, effective and timely deployment. This includes fixed term staff for the duration of the project along with permanent posts to support the ongoing maintenance and development of the system along with the necessary ongoing training.

6.2 Other Options

Detail the reasons for rejecting the remaining options listed under section 5, together with supporting detail.

Given the size and complexity of this project and the magnitude of organisational change associated with it, the 'Do Nothing' option is not considered practical. Even at the early design stage it is becoming very evident the amount of resource in terms of IT developers, clinician, nurse and pharmacist time that will need to be committed to ensure development happens in a timely way and that the resulting software is safe and fit for purpose. Inevitably the additional pressure on those individuals to continue to contribute to the project will have an impact on their clinical/operational roles both now and for the foreseeable future. Development will not cease completely post roll-out, the system will have to be constantly audited and the integrity of the data constantly reviewed.

Successful deployment of EPMA requires more than just an IT solution. Consideration also needs to be given to the work required on the periphery to equip the organisation with appropriate systems and process to allow a successful deployment. EPMA affords

the opportunity to review existing processes around ward rounds and drug rounds to maximise the benefits to patients, both in terms of safety of medicines administration and the timeliness of medication delivery. The magnitude of the task associated with the redesign, testing and implementation of critical processes around medicines management cannot be underestimated nor should the levels of engagement from nursing, pharmacy, clinician and IT staff to facilitate these changes.

Appendix 1: Nursing & Pharmacy input into Electronic prescribing medicines administration (EPMA), provides further detail around the specific roles of the EPMA workforce.

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	EPMA offers the opportunity to significantly improve patient safety by supporting doctors in prescribing, providing real-time data transfer and validation by pharmacists and assisting nurses in the administration of medicines. (Reference: MHRA Patient Safety Alerts; Quality and Safety Strategy around Missed Doses of Critical Medicines)
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	EPMA will support the efficient remodelling of medicines management processes through eliminating process duplication within prescribing, supporting targeted nurse administration

understand how they contribute to the Trust's successes.		rounds and immediate access to electronic drug records. Corporate finances will benefit from the ability to provide patient level detail for drugs which will enable full recovery of tariff excluded costs.
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	EPMA will help assure patients and the public that the organisation is committed to providing excellent care.
To provide a safe environment for staff, patients and visitors, ensuring that all resources are used as efficiently as possible	Yes	EPMA will contribute positively to the knowledge and process infrastructure of the hospital and ensure that staff resource currently used in resolving many of the difficulties of the paper-based system can be redeployed to areas where it can add more value for patients.

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	23rd April; 2nd July
Comments by BIU	Alignment with strategic objectives of trust confirmed (July '14)

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.*

There are a number of benefits that will accrue from this business case however it is acknowledged that these will be predominately qualitative rather than quantitative. These include benefits such as improved infection prevention and control through robust application of antimicrobial prescribing guidelines; releasing time to care for nursing staff through targeted drugs rounds as examples.

The following benefits are the 'Top Ten' as detailed in the Statement of Planned Benefits that will be reported quarterly to the Integrated Digital Care Fund (previously Safer Hospital, Safer Ward) and that will form the basis of Post Implementation Review of this business case.

A number of the anticipated benefits that could be realised are based on established and recognised research undertaken by various Universities and referenced in business cases that other Trusts have put forward for EPMA. Where relevant we have included a margin of error to reflect that the YTHFT is already a high reporting / data collecting Trust. A full suite of audits will be undertaken to baseline Trust specific data for this business case but it is recognised that there is a resource implication to do this (staff & time) and as such these will predominately be completed once the new posts are appointed to.

The full audit information is detailed in Appendix 2 (Audit Briefs to demonstrate Benefits Realisation).

Description of Benefit	Metric	Quantity Before	Quantity After
Improved compliance with prescribing standards & policies at the point of prescribing to improve patient outcomes e.g. antibiotics, VTE prophylaxis. Facilitated by access to decision support software.	£5k fine per Hospital acquired infection (14/15 rate). Assume 50% of reduction in fines attributable to enhanced prescribing	Fines allocated in 13/14 were c. £1.2m based on above trajectory case numbers.	Assume 50% of any reduction attributable to enhanced prescribing
Reduction in medicines related adverse events, including: wrong drug, dose, frequency all of which will improve patient safety. The premise of EPMA is that reduction of errors will reduce harm to patients which reduces LOS / additional tests / reputational loss. Accepted research from Sheffield University has allocated a figure of £1k per patient per moderate/severe error.	No' of Datix forms relating to avoidable prescribing & admin errors.	c. 80 medication errors per pc. 27 moderate / severe would be prevented through EPMA	Tending to zero. Conservative saving estimate of £10k per month is considered realisable

Reduction in avoidable medicines wastage from poor prescribing & process review to change behaviour (re-education) of all staff involved in medicines processes.	Drug returns baseline figure 13/14	Baseline audit re value of returned drugs	20% savings realised year 1, increasing
Improved efficiency of the discharge process reducing delays in discharging patients. (Perfect week at SGH demonstrated the benefits of enhanced communication between wards/Pharmacy that would be provided through EPMA system)	Audit of time to discharge (decision to transport)	Pre-implementation of time to discharge audit.	Improvement in time to discharge audit.
Improved data quality & associated efficiencies to support coding and costing (less duplication, more clinical involvement in data capture) and reporting leading to quality improvements and financial benefits	Time /motion studies pre-implementation	Use of clinical, nursing & pharmacist time duplicating tasks; chasing lost paper information etc	Release Pharmacy resource (Band 6) after year 3
Improved ability to accurately track PbR excluded medicines for all patients for recharge purposes leading to time savings through reduced challenges made. Metrics for under-recovery of costs against high cost drugs to be sought from ledger with improvements for health economy demonstrated.	Time spent resolving challenges from commissioners / value of un-attributed drugs	Time spent / Pre-implementation value.	Reduction in time spent / value tending to zero
Improved ability to substantiate compliance with CQUIN & NICE guideline compliance targets	Current CQUIN value is £750k. (EPMA will contribute to this but this benefit does not align solely with this business case.)	Current CQUIN compliance level	Compliance with future CQUINs (potential EPMA related CQUIN to be agreed for 15/16)
Improved management & control of medicines expenditure through enforcing Trust Formulary policy (e.g. Outpatient Prescribing) by using audit & analysis if prescribing data to drive changes in prescribing practice. Anticipated cost reduction by replacing non-formulary drugs with formulary ones	Number of non-formulary requests for drugs	Desktop audit of non-formulary drugs prescribed at Healthcare at Home; quantitative review of Datix reports to demonstrate process deviation	c. £100k+ saving through OP prescribing
Local Med Mgmt KPI will result in £1k breach for every recommendation of Red or Black drug or breach of Amber shared care guidelines	Fines levied	Baseline 14/15 financial year figures	Fines levied reducing to zero

Reduced stationery printing costs for inpatient / outpatient prescription forms	Purchase orders	£30k p.a.	Zero
Increased research income due to ability to use electronic prescribing in medication related research design. EPMA should facilitate the ease of data collection and information transfer to these companies.	Income received from research companies.	£65k p.a.	£5k p.a. increase (conservative)
On implementation of EPMA it would be anticipated that number of specific types of medication related incidents will be significantly reduced. NB: Early implementer sites acknowledge the emergence of other forms of medication error. One of the additional benefits of an in house solution is the potential for early mitigation of risk due to emergent errors/risk at the design phase. Appendix 2 (Audit Briefs to demonstrate Benefit Realisation) details the information that will be collected in order to demonstrate that the benefits have been achieved.			

8.2 Corporate Improvement Team Review

The Corporate Improvement Team must review all business cases across the three quality domains. The date that the business case was reviewed by the IT together with any comments which were made must be provided below.

Date of Review	23rd April (Initial discussion with GC); 3rd July 2014
Comments by CIT	Recommend PIR at 3, 6, 9, 12, 24, 36 months

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	July 2014	Exec Board
Commence Recruitment Process	June 2014	Nursing/Pharmacy Leads
Develop and agree work program	July 2014	PM and Nursing/Pharmacy Leads/ P Board
Acquire baseline metrics	Summer 2014	PM and Nursing/Pharmacy Leads
Recruit and train staff	Late Summer 2014	Nursing/Pharmacy Leads
Switch on decision support software (linked to eDN)	Summer 2014	IT
Devise and agree detailed project plans	*Sept 2014*	PM and Nursing/Pharmacy Leads
Identify and train ward champions	*Oct 2014*	Nursing leads
Test redesigned meds man processes	*Nov 2014*	PM and Nursing/Pharmacy Leads
Commence roll-out of redesigned meds man processes	*Jan 2015*	PM and Nursing/Pharmacy Leads
Test EPMA module in restricted ward environment (s)	*June 2015*	IT and Nursing/Pharmacy Leads
Obtain approval to proceed	*August 2015*	Project Board
Commence EPMA Roll-out	*Sept 2015*	IT, clinical and Nursing/Pharmacy Leads

10. Risk Analysis:

Identify the key risks to the Trust of proceeding with the preferred option, and what actions can be taken to mitigate them should they arise.

Identified Risk	Proposed Mitigation
Inability to recruit to key posts	Senior key personnel within nursing and pharmacy will be seconded from other posts within the team allowing skills and experience of working with CPD and understanding of practise and processes within the trust to be utilised. Backfill into more junior posts to be actively supported by trust recruitment team.
Inadequate clinical buy-in / user resistance to major change in existing practice	Clinical champions from every dept to support the project
Failure to get appropriate devices (hardware to run EPMA, drug trolleys, bar-code technology, etc) to enable easy & timely access to patients electronic records	Mini project underway to review the options for devices and trolleys
Failure to identify realisation of benefits	PM to develop business case to identify realisation of benefits (quality + safety, reduction in errors, etc).
Failure to develop effective product (software) to work as required.	Ensure full engagement in design process with system users and capture of non-standard elements of process.
Failure to apply lessons learned from other projects (e.g. NEWS, EDN, etc) implementation and deployment.	Appropriate plans for development, training engagement etc are in place and are acted upon. Development and application of effective hazard and risk matrix and mitigation plan.
Lack of supernumerary staff dedicated to support implementation	Identification of funds to allow development and recruitment to appropriate posts within nursing and pharmacy.
Lack of sufficient wireless coverage across the organisation.	Audit wireless coverage; identify areas of concern; mitigation through IT upgrade of wireless network (subject to separate business case)
Failure to train agency staff	Identification of funds to facilitate training staff and time.
Introduction of 'new' risks through introduction of EPMA (running duplicate systems through pilot/implementation)	Apply lessons learnt from previous deployments, application of robust testing & user acceptance protocols
Business continuity post implementation	Ensure full engagement with IT / CCIO to ensure clinical assurance of robustness of the system
External funding rescinded / parameters changed	Timely return of information as required, close liaison with the centre through the length of the funding

11. Risk of Not Proceeding:

Identify the key risks/ potential impact of not proceeding with the preferred option.

Failure to implement EPMA will mean that our patients will continue to be exposed to risk through prescribing and administration errors and a real opportunity to improve patient safety, reduce risk and improve the quality of care we offer our patients will have been missed. By not implementing EPMA the Trust will be left at a disadvantage relative to those at neighbouring trusts through lack of modern and efficient ways of providing medicines.

Staff will continue to work with inefficient paper systems resulting in duplication of work and waste or resource.

YTHFT will continue to struggle to understand accurately medicines prescribing and administration across the trust, except by periodic snap-shot audits. This misses an important opportunity to make informed decisions about targeting resources to improve practice and control costs.

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)

All Consultants and other Non-Training Grade Doctors will require training on the new EPMA system.

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		

Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**

12.2 Advisory Committee Review:

The Consultant Job Planning Advisory Committee must review all proposed job plans for new consultant posts, as well as any job plans for existing consultants where the proposed new post would have an impact on current working practices. The date that the job plans were approved by the Committee and any comments which were made must be provided below.

Date of Approval	
Comments by the Committee	

13. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the business case; the extent to which each support the proposal, and where appropriate, ownership for the delivery of the benefits identified above. Where external stakeholder support is vital to the success of the business case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment.

Examples of stakeholders include Lead Clinicians, support services (e.g. Systems & Network Services, Capital Planning re: accommodation), commissioners (e.g. Vale of York CCG, Scarborough CCG), patients & public, etc. ***Please bear in mind that most business cases do have an impact on Facilities & Estates services.***

Stakeholder	Details of consultation, support, etc.
Mandatory Consultation	
Patients	Announcement on the intention to commence with the EPMA project has been made on the public facing website
Governors	Announcement on the intention to commence with the EPMA project has been made on the public facing website; Trust Open Day
Medicines Management Group	EPMA Project Board will report to MMG
Chief Pharmacist	Through membership of EPMA Project Board & MMG
Medical Director	Through membership of EPMA Project Board & MMG
Chief Nurse	Through membership of EPMA Project Board & MMG
Director of Systems & Networks	Through membership of EPMA Project Board
Chief Clinical Information Officer	Through membership of EPMA Project Board
All prescribers, medical and non-medical	Through training sessions
All nursing staff	Through training sessions; identification of clinical champions per ward/area

All pharmacy staff	Through training sessions; protocol testing of decision support software
Allied health professionals using medicines information in patient care	Through training sessions; identification of clinical champions per ward/area
Other Consultation	
Finance	Input into development of business case & identification of realisable benefits
Resource Management	Input into development of business case & identification of realisable benefits
Trust Open Day	A stall has been arranged at the Open Day to engage with the entire organisation & public
Estates & Facilities	Will be engaged in good time should works be required to provide additional power/data points to support the rollout.

14. Sustainability

The Trust is committed to development of sustainable solutions in the delivery of its services, including minimising its carbon footprint. The following questions should be answered in the context of the impact of this business case has on the areas listed.

If assistance is required in assessing the sustainability impact of this business case, help is available from Brian Golding, Trust Energy Manager on (72)6498.

Will this Business Case:	Yes/No	If Yes, Explain How
Reduce or minimise the use of energy, especially from fossil fuels?	Yes	Shrinkage of the Trust's carbon footprint will result from limiting the production and transport of prescription stationary.
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?

Lessons learned from the development and deployment of the EPMA package will be made available to our colleagues in Hull and Harrogate.

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?

The EPMA is a clinical package and will be implemented across all sites within the trust.

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?

Ultimately EPMA will be rolled out to community prescribers (e.g. Health Visitors)

18. Impact on the Ambulance Service:

	Yes	No
Are there any implications for the ambulance service in terms of changes to patient flow?		√

If yes, please provide details including Ambulance Service feedback on the proposed changes:

19. Market Analysis:

Where the business case is predicated on securing new and/or increased business (and income), detail the evidence supporting the income projections.

N/A

20. Estimated Full Year Impact on Income & Expenditure:

Summarise the full year impact on income & expenditure for the specialty as a result of this business case. The figures should cross reference to the more detailed analysis on the accompanying 'Financial Pro Forma'.

	Baseline	Revised	Change
	£000	£000	£000
Capital Expenditure		954	954
Income		5	5
Direct Operational Expenditure		63	63
EBITDA	0	-58	-58
Other Expenditure		207	207
I&E Surplus/ (Deficit)	0	-265	-265
Existing Provisions	n/a		0
Net I&E Surplus/ (Deficit)	0	-265	-265
Contribution (%)	#DIV/0!	-53	-53
Non-recurring Expenditure	n/a	349	349

Supporting financial commentary:

The capital expenditure above relates to development of the EPMA system. £100k of this in 2014/15 is the cost of an external developer currently working within Systems & Network Services. This cost has been previously approved informally but not included in any previous business case. The remaining £104k relates to development input from the Pharmacist and Nursing support posts. **Capital expenditure on hardware, licensing and infrastructure is currently included in this business case at an estimate of £750k.** Further scoping work is required to establish a reliable cost estimate.

Non recurring revenue costs related to 5 fixed term posts supporting the EPMA project (Specialist Pharmacist, backfill for Medicines Management Lead Nurse, Project Support Officer, 2 x Band 5 nurses) over a 2 year period. In addition there are 2 Pharmacy posts (Lead Pharmacist, Technician) which are permanent posts - these will support implementation in the first 2 years and then provide ongoing support to the EPMA system. A small element of the Specialist Pharmacist and Medicines Management Lead Nurse within the 2 year implementation period is attributable to system development rather than roll out and has therefore been included in capital costs. Once the system is fully in place a Pharmacist post will be disestablished.

The proforma assumes that posts will be in place from 1st October 2014 and the system will be fully implemented by 1st October 2016.

Additional savings around off formulary prescribing are anticipated as the EPMA system will improve formulary compliance. However, this requires an audit to assess the potential size of the saving so this is not included in the business case financial proforma at this stage. There is also potential cost avoidance around c-difficile penalties. The annual target is expected to reduce by 12% based on previous year outturn. Assuming the Trust meets its target of 59 for 14/15, this will mean a target reduction of 7 cases for 15/16. If this reduction was not achieved a potential financial target of £35k could be applied. By triggering anti-microbial prescribing reviews the EPMA system will facilitate achieving this reduction, therefore avoiding penalties.

A separate business case for capital funding for the EPMA Project Manager and 0.50 wte admin support has been previously approved (2013-14/76), total value £132k.

Safer Hospital, Safer Wards funding has been secured to support the EPMA project of £592k capital funding, to be matched the trust with an additional £592k revenue or

capital funding - total £1,184k. This has been partly used to support implementation of Chemocare in Scarborough (£115k) and there is also a £200k planned contribution to the trusts wireless upgrade from this funding.

21. Recommendation for Post Implementation Review

	Yes	No
Is this business case being recommended for post implementation review?	√	

Reason(s) for the decision:

The post implementation review will provide both NHSE and the Trust with assurance that this significant financial investment is delivering certain stated benefits and value for money. This is a prerequisite of the award from NHSE being made and is considered best practise given the magnitude of investment and the benefits to patient safety balanced against the risk actually associated with the project. Corporate Improvement Team recommend review at the following intervals: 3, 6, 9,12, 24, 36 months.

22. Date:

17th July. 2014

GAL/22August2013

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	2012/01
TITLE:	Electronic Prescribing and Medicines Administration
OWNER:	Alastair Turnbull
AUTHOR:	David Pitkin / Caroline Mulholland

Capital

	Total	Planned Profile of Change			
		2014/15	2015/16	2016/17	Later Years
	£'000	£'000	£'000	£'000	£'000
Expenditure	954	498	420	36	0

Capital Notes *(including reference to the funding source)*:
The capital expenditure above relates to development of the EPMA system. £100k of this in 2014/15 is the cost of an external developer currently working within Systems & Network Services. This cost has been previously approved informally but not included in any previous business case. The remaining £104k relates to development input from the Pharmacist and Nursing support posts. **Capital expenditure on hardware, licensing and infrastructure is currently included in this business case at an estimate of £750k. Further scoping work is required to establish a reliable cost estimate.**

Revenue

	Total Change				Planned Profile of Change			
	Current	Revised	Change		2014/15	2015/16	2016/17	Later Years
	£'000	£'000	£'000	WTE	£'000	£'000	£'000	£'000
(a) Non-recurring			349		71	206	71	
(b) Recurring								
Income								
NHS Clinical Income	0	0	0		0	0	0	0
Non-NHS Clinical Income	0	0	0		0	0	0	0
Other Income	0	5	5		0	5	5	5
Total Income	**0**	**5**	**5**		**0**	**5**	**5**	**5**
Expenditure								
Pay								
Medical			0					
Nursing			0					
Other (please list):								
Executive Board & Senior Managers			0					
EPMA Pharmacist (B8a)		54	54	1.00	16	32	32	54
Pharmacy Technician (B5)		29	29	1.00	11	23	23	29
Pharmacist (B6)		-36	-36	-1.00				-36
	0	**46**	**46**	**1.00**	**28**	**55**	**55**	**46**
Non-Pay								
Drugs			0					
Clinical Supplies & Services			0					
General Supplies & Services			0					
Other (please list):								
Data bank subscription		47	47		23	47	47	47
Drugs administration charts		-30	-30				-15	-30
			0					
	0	**17**	**17**		**23**	**47**	**32**	**17**
Total Operational Expenditure	**0**	**63**	**63**		**51**	**102**	**87**	**63**
Impact on EBITDA	**0**	**-58**	**-58**	**1.00**	**-51**	**-97**	**-82**	**-58**
Depreciation		191	191				96	191
Rate of Return		16	16				8	16
			0					
Overall impact on I&E	**0**	**-265**	**-265**	**1.00**	**-51**	**-97**	**-186**	**-265**
								+ favourable (-) adverse
Less: Existing Provisions	**n/a**		**0**					
Net impact on I&E	**0**	**-265**	**-265**		**-51**	**-97**	**-186**	**-265**

Revenue Notes *(including reference to the funding source)*:
Non recurring revenue costs related to 5 fixed term posts supporting the EPMA project (Specialist Pharmacist, backfill for Medicines Management Lead Nurse, Project Support Officer, 2 x Band 5 nurses) over a 2 year period. In addition there are 2 Pharmacy posts (Lead Pharmacist, Technician) which are permanent posts - these will support implementation in the first 2 years and then provide ongoing support to the EPMA system. A small element of the Specialist Pharmacist and Medicines Management Lead Nurse within the 2 year implementation period is attributable to system development rather than roll out and has therefore been included in capital costs. Once the system is fully in place a Pharmacist post will be disestablished.

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			Board of Directors Only
	Owner	**Finance Manager**	**Director of Finance**
Signed		Natalie Elliot	
Dated		17/07/14	

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2014/15	2015/16	2016/17	Later Years
Elective (Spells)			0				
Non-Elective (Spells)							
Long Stay			0				
Short Stay			0				
Outpatient (Attendances)							
First Attendances			0				
Follow-up Attendances			0				
A&E (Attendances)			0				
Other (Please List):							
Best Practice Tarriff #NOF			0				
			0				

Income

	Total Change			Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000	Later Years £'000
NHS Clinical Income							
Elective income							
Tariff income			0				
Non-Tariff income			0				
Non-Elective income							
Tariff income			0				
Non-Tariff income			0				
Outpatient							
Tariff income			0				
Non-Tariff income			0				
A&E							
Tariff income			0				
Non-Tariff income			0				
Other							
Tariff income	0	0	0				
Non-Tariff income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**
Non NHS Clinical Income							
Private patient income			0				
Other non-protected clinical income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**
Other income							
Research and Development			0				
Education and Training			0				
Other income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**

Nursing and pharmacy input into Electronic prescribing medicines administration (EPMA)

1. Introduction and background

The introduction of EPMA will require a significant culture change in terms of medicine management processes in the organisation. It should not be underestimated the amount of resource required to ensure the system is effective, usable and safe for patients. Dedicated clinical staff working collaboratively with IT and project manager are instrumental to the success of the project both in the planning, implementation and maintenance phase.

2. Recommendation for pharmacy and nursing team requirements

Recruitment of the following posts will be required in order to fulfil the significant needs of the project.

1) Seconding the current lead nurse medicines management (8a) to work on the EPMA project for 2 years fixed term with backfill from a registered nurse (1WTE Band 6)
2) Recruitment of additional nursing support for 2 years fixed term to support the medicines management EPMA lead nurse across York, Scarborough & Bridlington Hospitals (2 WTE Band 5)
3) Specialist pharmacist EPMA (1WTE Band 7) for a 2 year fix term period to support the implementation at Scarborough and Bridlington hospitals
4) Lead pharmacist for EPMA (1 WTE Band 8a) – permanent post
5) Recruitment of senior pharmacy technician (1 WTE Band 5) - permanent post
6) Recruitment of Band 4 Project support officer – permanent post

In addition to the nursing support identified above Nursing champions will be identified on each ward and department to support local implementation of EPMA with the support of the project team. Four weeks of supernumerary time will be required around the time of go-live and for super-user training.

3. Roles: Planning, implementation and ongoing support

Pharmacy and nursing personnel will be required for the following functions during the different implementation phases.

- Continued development and testing of the system with IT.
- Process mapping and streamlining medicines management processes on the wards/clinics for prescribing, administration and discharge so they are fit for purpose prior to roll out of EPMA
- Providing a clinical view on hardware requirements for wards including terminals and trolleys.
- Baseline audits of processes in order to be able to measure the effect of EPMA e.g. allergies, missed doses, time to write discharges, completeness of information on outpatient prescriptions.
- Development of guidelines and SOPs governing the EPMA processes to ensure they are safe and effective
- Clinical engagement through a wide variety of fora and professional groups e.g. medical staff, ward meetings, pharmacy meeting, acute and surgical boards, PNLF.

- Development of presentations and training material in conjunction with the project manager and IT.
- Provide training to the multidisciplinary team
- Roll out support to ward and clinic areas
- Trouble shooting and communicating issues identified at rollout
- Post roll out audits with associated write ups and presentation.
- Participate in EPMA practice research

The personnel identified will work with the nursing "champions" for each ward in order to facilitate the introduction of EPMA

Ongoing support will be required from dedicated team members in order to be able to contribute to developments and troubleshoot in clinical areas and support the ongoing training particularly at induction of new staff and education of temporary nursing staff. A specialist nurse will lead on the roll out of other IT projects in relation to nursing.

4. Specific nursing aspects

The nursing roles described in section 2 will be defined as follows;

The **Band 6 specialist nurse medicines management** will be required to allow the current lead nurse medicines management to provide nursing leadership and direction for the EPMA project. (work programme attached) This post will be managed by the lead nurse medicines management.

The **Band 5 nurses** will be required to support the Lead Nurse, Medicines Management and the Band 6 specialist nurse medicines management during the EPMA secondment. They will work across York, Scarborough & Bridlington to facilitate the changes in nursing practice ensuring it is fit for purpose prior to the rollout of EPMA.

The **Band 4 project support officer** will be required to support the lead nurse medicines management in auditing current practice and facilitating change on individual wards. This post will be managed by the lead nurse medicines management.
The above roles will all have a cross site working requirement.

5. Specific pharmacy aspects

The pharmacy roles described above will be defined as follows;

The **Band 8a pharmacist** will be based primarily on the York site and will be responsible as the pharmacy lead for the EPMA project. They will line manage the band 7 pharmacist and pharmacy technician. They will be line managed by the Deputy Chief Pharmacist, York.

Key roles of the 8a include

- Close liaison with IT regarding EPMA development
- Co-ordinate specialist pharmacy support for EPMA e.g. antimicrobials team/ VTE team
- Presentations to multidisciplinary team
- Supporting go live in wards and department
- Audit of medicines management processes, baseline and implementation
- Production of training materials
- Process mapping pharmacy processes around EPMA in order to plan improvements or changes required.

- Develop guideline and SOPs for entering data onto EPMA systems to ensure safety. This will include monthly DM+D feeds, warnings for prescribers, formulary status.

The **band 7 pharmacist** will work primarily on the Scarborough site and will be involved in activities as described above as directed by the lead pharmacist. They will also be involved in backfilling senior pharmacist time at the Scarborough site in order to do presentations to clinicians and other multi-disciplinary team members.

The **band 5 pharmacy technician** will work cross-site. Their main focus will be on

- Data collection for audits
- Producing SOPs for pharmacy processes
- Training of nursing/pharmacy staff
- Support for implementation
- Running reports off EPMA system

Author	**Jennie Booth Lead Nurse Medicines Management** **Stuart Parkes Deputy Chief Pharmacist, York** **Caroline Mulholland Project Manager, EPMA**
Owner	**David Pitkin, Chief Pharmacist**
Date	**July 2014**

APPENDIX 2: Audit Briefs to demonstrate Benefit Realisation

The table below details the required baseline data that will be re-audited as part of the Post Implementation Review to demonstrate the improvements achieved by the rollout of EPMA.
Integrated Digital Care Fund (IDCF) aligns to the quantitative benefits detailed in Section 8.1 of the EPMA business case.
A number of qualitative audits are also included recognising that many of the improvement measures relate to patient safety, risk reduction and quality of service.

IDCF Ref.	TOPIC	DETAIL	BASELINE	MEASURE	ANTICIPATED RESULT	TIMESCALE
Quality & Safety						
1	Improved compliance with prescribing standards & policies at the point of prescribing to improve patient outcomes e.g. antibiotics, VTE prophylaxis	£5k fine (14/15 figures) per HAI, assume 50% reduction of fines attributable to enhanced prescribing; reduction in risk of Trust attracting additional penalties	Fines allocated in 13/14 were c. £1.2m	Reduction in HAI and therefore fines	50% of any reduction in HAI attributable to enhanced prescribing	Assess 12 months post inpatient implementation
	Improved infection control though robust application of antimicrobial prescribing guidelines	% compliance with trust antimicrobial prescribing guidelines	73% compliance with indication 80% compliance with duration.	Compliance with anti-microbial prescribing guidelines	Rising to 100% compliance with indication / duration prescribing	Re-audit 3 times post implementation *frequency to be agreed*
2	Reduction in medicines related adverse events, including wrong drug, dose, frequency	Recognised research identifies £1k unit cost per moderate/severe medication error	Datix returns show c. 27 / 84 incidents per month would be preventable through EPMA	Reduction in no. of medicines related adverse incidents per month	Minimum reduction of 10 moderate / severe cases p.c.m. from 6 months post implementation	6 months post implementation
	Staff knowledge of changes in work practice via user survey pre & post	Potentially Survey Monkey? What is staff awareness of EPMA, to confirm scope with	% of staff audit undertaken Sept. '14	Medicines Management survey	Improved knowledge re EPMA in line with	3 months post implementation rolling audit tied to

	implementation	Lead Nurse, Meds Mgmt.			scope of rollout	rollout programme
	Staff resource redeployed to areas where adds more value to patients	More effective use of time through reduction in prescription chart transcribing, duplicate information entry etc.	Baseline audit to be undertaken	Current time spent by: nurses chasing paper based system Dr's chasing paper based system Pharmacists chasing paper based system	Releasing time to care for all professionals involved in EPMA	Rolling process from 6 months post implementation
	Improved capacity within nursing workforce through the ability to undertake targeted drug rounds and introduction of automatic drug orders	Time / motion studies of current drug rounds.	Baseline metric to be developed	Current time spent by: nurses chasing paper based system Dr's chasing paper based system	Releasing time to care for	Rolling process from 6 months post implementation
	Reduction in number of medication associated incidents e.g. missed doses; wrong drug, doses, frequency	Monthly review of medication related Datix submissions already takes place	Ongoing review of Datix reports	% of unclear prescriptions; transcription errors; duplication errors	Anticipated up to 30% reduction in errors reported in 12 months post implementation	Monthly ongoing reporting as current practice
	Reduction in severity of medication associated incidents e.g. allergy contraindications	Monthly review of medication related Datix submissions already takes place	Ongoing review of Datix reports	% of documented allergy contraindications; % of miscalculated doses	Anticipated up to 30% reduction in errors reported in 12 months post implementation	Monthly ongoing reporting as current practice
	Qualitative improvements in customer satisfaction	Qualitative improvements in customer satisfaction to be measured through feedback survey (GPs and practice managers)	Baseline metric to be developed (link to EDN)	Improvement trajectory to be defined	Improvements on baseline metric	Timescale to be agreed
	Improved audit & research facility through access to detailed patient level drug usage data.	Improvement to timeliness of responses to medicines related FOI requests.	Baseline audit to be undertaken	Time taken to respond to drug related FOI requests	Quantifiable reduction in time taken to respond	12 months post implementation
Finance & Efficiency						
3	Reduction in avoidable	Assume reduction in wastage	Figure from	Drug returns via JAC	20% savings over	Re-audit 12 / 24 /

	medicines wastage	of drugs following improved prescribing & improved processes	13/14 re drug returns	reporting	1st year	36 months post implementation
5	Improved data quality & associated efficiencies to support coding and costing (less duplication, more clinical involvement in data capture) and reporting leading to quality improvements and financial benefits	Potential additional time 'front loaded' into system (i.e. data input of meds) should be offset through the rest of the process such as quicker orders to Pharmacy; time saved on drugs round	Time & motion studies pre implementation	Time saved during ward rounds; drug rounds; Pharmacy reconciliation & validation	Release Pharmacy resource (Band 6) after year 3 post implementation	Re-audit 12 / 24 / 36 months post implementation
6	Improved ability to accurately track PbR excluded medicines for all patients for recharge purposes leading to reductions in time spent dealing with challenges.	Current tracking rates are already good but it is anticipated that further medicines will need to be tracked in future	Pre - implementation value / time currently spent dealing with challenges	Value for un-attributed drugs Quantified time spent dealing with challenges	Reduction in value of un-attributed drugs to benefit of wider health economy / reduction in time spent	Re-audit post implementation (frequency t.b.c.)
7	Improved ability to substantiate compliance with CQUIN & NICE guideline compliance targets	Current CQUIN value is £750k (EPMA will contribute to this but this benefit does not align solely with this business case)	Current CQUIN compliance	Ongoing CQUIN data collection. Potential CQUIN to be attributed to EPMA for 15/16	Compliance with future CQUINS (non-recurrent income)	Re-audit 12 / 24 / 36 months post implementation
	Improved management & control of medicines expenditure through enforcing Local Medicines Management KPI (introduced 2014/15)	£1,000 fine for every recommendation of a 'Red' or 'Black' drug or a breach of 'Amber' Shared Care Guidelines.	Fines levied on financial year 2014/15	Measured through the ledger	Fines levied will reduce to Zero	Re-assess after FY 2015/16
8	Improved management & control of medicines expenditure through enforcing Trust Formulary policy (e.g. Outpatient	Outpatient prescriptions dispensed through Healthcare at Home are retrospectively audited for compliance to formulary. EPMA will ensure	Desktop review 2 months data for % formulary & % non-formulary.	Real time data collection	100% formulary prescribing through HaH Cost savings	6 months post implementation in OPD

	Prescribing) by using audit & analysis if prescribing data to drive changes in prescribing practice	100% compliance to Formulary through HaH.			identified – potential £100k +	
9	Reduced stationery printing costs for inpatient / outpatient prescription forms	The Trust currently spends c. £30k p.a. on prescription forms. EPMA should negate the need for any printed drugs charts & prescribing related documents.	£30k spent on OP; ED & IP prescription forms (2013/14)	Measured through Procurement orders.	Reduction to zero	12 months post implementation.
10	Increased research income due to ability to use electronic prescribing in medication related research design	The Trust receives income from research companies. EPMA should facilitate the ease of data collection and transfer to these companies. The anticipated value if c. £5k per company; a conservative estimate is £5k additional income p.a.	£65k p.a.	Measured through the ledger.	£5k p.a. increase	12 months post implementation.
Access & Flow						
4	Improved efficiency of the discharge process reducing delays in discharging patients	Focus on elements of discharge relating to production of EDN and provision of TTO's Delayed discharge audit as baseline	Time from decision to discharge to provision of EDN Time from TTO order to supply reaching patient	% of TTO's done at ward level % of TTO's dispensed within 1 hour % of TTO's dispensed within 2 hours	Improvements in trajectories of all measures	6 / 12 / 18 months post implementation
	Pre / post audit of reasons for admission	Reduction in medicine related re-admissions through providing GPs with additional real time discharge information & notification of medication changes	Retrospective review selected case notes (Gen. Med & Elderly Care)	To demonstrate reduction in medicines related re-admissions	Reduction in medicine related re-admissions post EPMA	Sample audits at 12 months post implementation