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 October 2013**
in: **The Blue Room, North Entrance, Scarborough Hospital**

Flu Vaccination: Occupational Health offices by Trust Headquarters on the ground floor from 8.00 – 9.00am and then again from 1.00pm - 2.15pm

Time	Meeting	Location	Attendees
8.30am - 9.10am	Non-Executive Director Meeting with Chairman	Discussion Room PGMC Scarborough Hospital	Non-executive Directors
9.15am – 12.00noon	**Board of Directors meeting held in public**	**Blue Room North Entrance Scarborough Hospital**	**Board of Directors and observers**
12.00pm – 1.00pm	Board of Directors to consider confidential information held in private	Blue Room North Entrance Scarborough Hospital	Board of Directors
1.00pm – 1.45pm	Lunch at Pat's place and option for 'flu vaccination		
1.45pm – 2.15pm	Facilitated visit re elective care at Scarborough	To be arranged	Board members, facilitated by Richard Morris
2.15pm – 3.00pm	Developing a Single Dashboard	Blue Room North Entrance Scarborough Hospital	Board of Directors

The core values of the Trust are:

- **Improve quality and safety**
- **Create a culture of continuous improvement**
- **Develop and enable strong partnerships**
- **Improve our facilities and protect the environment**

These will be reflected during all discussions in the meeting

York Teaching Hospital 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 30 October 2013**

At: **9.15am – 12.00noon**

In: **The Blue Room, North Entrance, Scarborough Hospital**

A G E N D A

No	Item	Lead	Comment	Paper	Page
Part One: General 9.15am – 9.40am					
1.	**Welcome from the Chairman** The Chairman will welcome observers to the Board meeting.	Chairman			
2.	**Apologies for absence** 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 September 2013.	Chairman		B	11
5.	**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chairman		Verbal	
5.1	13/116 Infection Control Dr Turnbull to update the Board on the discussions with PHE	Medical Director		Verbal	

No	Item	Lead	Comment	Paper	Page
5.2	13/116 Pressure Ulcer Reduction Plan Mr Proctor to update the Board on the discussions with the Commissioners about the CQUIN target	Chief Nurse		Verbal	
5.3	13/118 First to follow up ratio Mr Proctor to update the Board on the meeting held with the CCG during October	Chief Operating Officer		Verbal	
5.4	13/118 Resilience Planning Mr Proctor to update the Board on the progress of understanding the performance requirements attached to the additional non recurrent £2m	Chief Operating Officer		Verbal	
5.5	13/120 Recommendation from the Parliamentary Select Committee Mr Proctor to update the Board on the expectations around the recommendation for publishing within each ward the number of staff on duty.	Chief Nurse		Verbal	
6.	**Patient Experience** To hear a letter of complaint and compliment.	Medical Director Philip Ashton		Verbal	
Part Two: Quality and Safety **9.40am – 10.30am**					
7.	**Cancer Patient Experience Report** To review the report.	Chief Nurse		C	25
8.	**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	31 39 55 63

No	Item	Lead	Comment	Paper	Page
8. **Contd**	**Quality and Safety Performance issues continued** • Director of Infection Prevention and Control quarterly report	Chairman of the Committee		 D4	 73
9.	**Dementia Strategy update** To support the revised strategy.	Medical Director	Dianne Willcocks	E	75
Part Three: Finance and Performance **10.30am - 11.00am**					
10.	**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	83 93 107 119
Part Four: Workforce Strategy Committee **11.00am - 11.15am**					
11.	**Notes and associated documents from the meeting held on 5 June 2013** To receive the notes and discuss the implementation of a living wage.	Chairman of the Committee		G	129
Part Five: Governance **11.15am - 11.40am**					
12.	**Report of the Chairman** To receive an update from the Chairman.	Chairman		H	133
13.	**Report of the Chief Executive** To receive an update on matters relating to general management in the Trust.	Chief Executive		I	137
14.	**Monitor Quarter 2 Return** To approve the quarterly submission to Monitor.	Chief Executive		J	167

No	Item	Lead	Comment	Paper	Page
Part Six: Business Cases **11.40am – 12.00noon**					
15.	**Business Case 2013-14/55 Enhancement of Paediatric Cover (Scarborough)** To approve the business case.	Chief Executive	Libby Raper	K	175
Any Other Business					
16.	**Update on CLRN Transition Arrangement** To receive an update on the arrangements being put in place.	Director of Corporate Development		Verbal	
17.	**Next meeting of the Board of Directors** • The Board of Directors will hold a time-out meeting on the evening of 11th November and all day on 12th November 2013 • The next of the Board of Directors will be held on 27th November 2013 in the Boardroom, The York Hospital				
18.	**Any other business** To consider any other matters of business.				

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

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

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

- Contracting and tendering outlook

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Additions:

A

Changes:
Deletions:

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS founda-
Mr Alan Rose (Chairman)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Jennifer Adams *Non-executive Director*	**Non-executive Director** Finance Yorkshire PLC	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Spouse is ;clinical Director for Anaesthetics, Theatres, Critical Care,
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	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 **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 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
Ms Peta Hayward ***(Executive Director Director of Human Resources)***	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mrs Sue Holden ***Executive Director of Corporate Development***		**Director –** SSHCoaching Ltd		**Member -**Conduct and Standards Committee – York University Health Sciences **Act as Trustee** –on behalf of the York Teaching Hospital Charity		
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	Nil	**Member** of the NHS Elect Board as a member representative
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	Nil	Nil

B

York Teaching Hospital NHS
NHS Foundation Trust

Minutes of the meeting of the Board of Directors of York Teaching Hospital NHS Foundation Trust, held in public in the Blue Room, Scarborough Hospital on 25 September 2013.

Present:	Mr A Rose	Chairman of the Trust
	Mrs J Adams	Non-executive Director
	Mr P Ashton	Non-executive Director
	Mr A Bertram	Executive Director of Finance
	Mr P Crowley	Chief Executive
	Mrs S Holden	Executive Director of Corporate Development & Research
	Mr M Keaney	Non-executive Director
	Mr M Proctor	Deputy Chief Executive/Chief Operating Officer/ Chief Nurse
	Ms L Raper	Non-executive Director
	Mr M Sweet	Non-executive Director
	Dr A Turnbull	Medical Director
	Professor D Willcocks	Non-executive Director
Attendance:	Mr B Golding	Director of Estates and Facilities
	Mrs A Pridmore	Foundation Trust Secretary
	Mrs S Rushbrook	Director – Systems and Networks

Observers: 2 members of the quality audit team from KPMG.
2 members of the public
4 Governors

Mr Rose welcomed members of the public, governors and the audit team to the Board meeting. Mr Rose also welcomed Sue Rushbrook and Brian Golding to the Board meeting.

13/110 Apologies for absence

Apologies were received from Ms P Hayward, Executive Director of Human Resources

13/111 Declarations of Interests

The Board of Directors **noted** the changes made and interests declared. The members of the Board of Directors were asked to advise Mrs Pridmore of any further changes.

13/112 Minutes of the meeting held on 31st July 2013

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

13/113 Matters arising from the minutes

Mr Rose raised two items:

13/113.1 Listening exercise

Mr Rose advised the Board that questionnaires had been circulated to staff and governors on the listening exercise. The questions were theme-based and responses could be anonymous if the individuals so wished. Individuals had the option of responding by email, survey through slave monkey or by writing directly to the Chief Executive's office. The closing date for responses was at the end of September.

13/113.2 Monitor visit

Mr Rose advised that the Monitor visit that should have taken place earlier in the year had been postponed to around November. This will be after the KPMG review has been completed and the results of the listening exercise are known.

13/113.3 Francis Report

Mr Rose asked when the final report would be presented to the Board. It was confirmed it would be the November or December meeting.

The Board **noted** the comments.

13/114 Patient Experience

Mr Rose reminded the Board why the Board heard letters at the meeting ahead of conducting any business. He asked Board members to keep in mind the experiences the Board was about to hear that patients had when using the Trust's services.

A letter of complaint was read by Mr Keaney. A letter of compliment was read by Mrs Holden.

13/115 Patient Experience Report

Mr Proctor was asked to present the report. Mr Proctor explained that he felt the report in its current format did not provide the Board with the information or assurance it was seeking about patient experience. He felt the report said more about what people said about the organisation rather than describing what the Trust is doing to people. The report will be developed.

Mr Proctor advised that there would be some additional information around the cancer patient experience presented to the next Board meeting.

Mr Proctor referred to the Family and Friends initiative and advised that the response rate figure included in the report is not accurate. Due to a delay in a significant number of cards being received and processed by Picker, they were not included in the figures. Mr Proctor assured the Board that the cards were posted by the Trust on time; they just did not get to Picker at the right time. He added that had those cards been included there would have been significant improvement in the response rates.

Mrs Adams was pleased to hear Mr Proctor's comments and asked if the report could provide a more meaningful analysis of the nature of the complaints in order to identify areas for improvements. She also asked how Mr Proctor was considering using the Patient Experience Committee. Mr Proctor advised that he was in the process with Mrs Geary (Director of Nursing) of reviewing the functioning of the Committee. He would be asking Mrs Mackman (Lead Governor) for her input too.

Mr Rose asked Mr Proctor to comment on the comment in the report about the handling of complaints at Scarborough. He was keen to understand why systems have not improved in Scarborough, despite now being over one year in to the integration. Mr Proctor explained that the systems have improved and the complaints referred to (via the Ombudsman) are historic. Mr Proctor added that historically Scarborough did have a high number of complaints, which lead to a reputation for providing a poor service, and that this "legacy" will take a time to shed.

Dr Turnbull added that the quality of complaint handling had improved significantly. He had sensed a culture shift in handling and he also felt, like Mr Proctor, that volume of complaints was partly a cultural issue that he now expected to see reduced.

Mr Crowley commented that the Health Service Ombudsman (HSO) did result in complaints being quite old. He gave the example of a complaint he was currently overseeing that had been made prior to acquisition. Mr Crowley mentioned that he had continued to hold the weekly meetings with the complaints team, so he sees every complaint that is made to the Trust. He advised, for example, that at the meeting this week, there were 9 complaints, 7 from Scarborough and 1 from York.

Mrs Holden added that the token system was also being introduced in the Emergency Department. The Board **noted** the introduction of the token system, but was concerned that this would not provide any qualitative data. Mr Proctor advised that the Board was right that the token system would only provide quantitative data, but some governors are being trained to support the collection of a narrative from those that would like to give one when they are in the Emergency Department.

Dr Turnbull added that he was assured that the lack of narrative from the Emergency Department was not a significant issue, as historically the Emergency Department has very few complaints and generally receives good feedback on the quality of its services, even when very busy. Mr Proctor added that he has noted that there is a very clear correlation between length of stay and complaints.

Ms Raper asked Mr Proctor when the Board would see the revised report. Mr Proctor confirmed that it would be when the next quarterly report was due.

Action: To present the cancer patient experience report at the next Board meeting. Mr Proctor to provide a quarterly report on patient experience to the January 2014 meeting.

Mr Rose advised the Board that Mrs Scott (Director for Community Services) has asked the governor group involved in Community Services to work with her to develop some similar metrics to Family and Friends for the community to use, as Family and Friends does not extend to the community (yet).

13/116 Quality and Safety Committee

Ms Raper noted that there was a lot of crossover between the Quality and Safety Committee and the Finance and Performance Committee. She suggested that some of the items should be picked up together and proposed that Mr Proctor should comment on the Winter Resilience Plan within Finance and Performance. The Board agreed.

Ms Raper asked Dr Turnbull if he would comment on the specific items agreed that would be brought to the Board's attention.

Quality and Safety Dashboard - Dr Turnbull commented that this was a new dashboard that specifically provided information about metrics related to quality and safety. This was the first time the dashboard had been received by the Board. He drew the Board's attention to the varying sources of information used to develop the dashboard. Mr Turnbull commented that he would be having further discussions with the Non-executive Directors and others about the content of the dashboard. He added that the dashboard will be used by other groups, such as the commissioners.

Mr Ashton commented that the point Dr Turnbull made about the sources of information is very important. From an Audit Committee perspective it is important to understand that the generation of the information is not only from internal data, but is from external sources too.

The Board of Directors **noted** the dashboard.

Infection Control – Dr Turnbull commented on the C-Diff performance of the Trust. He reminded the Board that the Trust has an annual trajectory for C-Diff of 43 cases. For compliance purposes, this trajectory is divided equally by the four quarters, allowing the Trust a trajectory of 10.75 cases per quarter. In quarter 1, the Trust had experienced a significant rise in the number of cases of C-Diff and reported 21. During Q2, the Trust has identified a further 10 cases; there have been none reported in the last two weeks. The Trust consequently has seen a dramatic slow down in the number of cases of C-Diff in the organisation during the last quarter, putting us back on trajectory. He added that it does mean that the Trust, however, will as a consequence receive penalty fines for the cumulative number of cases in the year.

Dr Turnbull described the key actions that had been taken by the Infection Prevention Control Team. This includes:

- Reviewing the antimicrobial stewardship
- Continuing to refine the antimicrobial guidelines
- Redesigning the Root Cause Analysis process
- Introducing protocols for Hydrogen Peroxide Vapour (HPV) use
- The introduction of probiotics for some patients

Mr Rose asked Mrs Rushbrook (IT) and Mr Golding (Estates and Facilities) if there was anything else from their perspective that could be done. Mrs Rushbrook explained that everything that could be done was being done. From an Information Technology (IT) perspective they were working closely with the wards to ensure everything was as streamlined as possible and that full support was given to processes.

Mr Golding commented from an estates perspective. He confirmed that, again, everything that could be done was being done. He added that the environment was not the best and the Trust did suffer from a paucity of single rooms. He added that the Trust does have a clear and well-understood enhanced cleaning system in place.

Dr Turnbull reminded the Board that the Trust had invited Public Health England (PHE) to visit the Trust and provide some additional advice. The response the Trust has received is that PHE have reviewed the actions the Trust is already taking and feel at this stage they could not add anything, so will keep a watching brief over the request from the Trust. Dr Turnbull confirmed he will continue to encourage PHE to come to the Trust.

Action: Dr Turnbull to continue the discussions with PHE related to the support they could provide the Trust.

Mr Crowley added that he asks himself three questions in these circumstances:

The first question is -- is there enough concerted effort to address the C-Diff issues? To this question he has been able to answer yes, there is enough concerted effort. The Directors receive a weekly report on C-Diff and there are regular debates during the week on the objective being to eradicate avoidable C-Diff.

The second question is -- How is the Trust against trajectory? Dr Turnbull has already explained the improvements that have been seen during quarter 2.

The third question is -- how does the Trust compare with other Trusts? Mr Crowley reminded the Board that, only a couple of years ago, the Trust was one of the best performing Trust in the country on C-Diff. Now other Trusts have caught up and some are now better, but the Trust is still a very good performer against the very tight trajectory. He was keen to stress that the Trust was keen to eradicate avoidable C-Diff.

MRSA – Dr Turnbull advised that the Trust had now reported two cases of MRSA. He expressed his disappointment, as the Trust had a record of no cases for over 12 months. He felt this was statistical variation. Dr Turnbull reminded the Board that the annual trajectory was 6 cases.

Sepsis - Dr Turnbull referred to his Medical Director Report included in the pack. He asked the Board to note his comments on sepsis. Dr Turnbull summarised the work that was being done by clinicians around identifying sepsis. He explained that clinicians were being asked to use antibiotics as early as possible because of the large number of patients that die of septicemia. Dr Turnbull explained that an audit had been undertaken that reviewed the use of the sepsis 6 bundle. He reported that the audit showed that the Trust did not comply with the bundle. Dr Turnbull explained that the answer is through educating clinicians about the importance of identifying and responding in an urgent manner.

Pressure Ulcer Reduction Plan (PURP) – Dr Turnbull reminded the Board that in December 2012 the Trust invited some external support to audit the practice around pressure ulcers. As a result of that audit the PURP was developed. Dr Turnbull confirmed that he would bring an update on the plan to the next Board meeting

Action: Dr Turnbull to include in his report and update on the PURP for the October Board meeting.

Dr Turnbull added that, in summary, the plan has demonstrated a reduction in the number of incidents when a pressure ulcer occurs. He added that this also forms part of a Commissioning for Quality and Innovation (CQUIN) target. Mr Proctor explained that the target is measured on prevalence (the number of cases the Trust has) rather than new cases (incidence) and the target is set as a 50% reduction. This does make the target difficult to achieve. Currently there are discussions with the Commissioners to consider the target again. Mr Proctor agreed to update the Board at the next meeting.

Action: Mr Proctor to update the Board on the discussions with the Commissioners around the CQUIN target for pressure ulcers.

The Board noted that the nursing and midwifery plan had been included in the papers. Professor Willcocks commented that the plan was very good and seemed to provide a method of responding to the Francis Report.

The Board thanked Ms Raper, Mr Proctor and Dr Turnbull for their comments and the reports. The Board was **assured** about the topics covered and **noted** the assurances given in the notes from the Quality and Safety Committee meeting.

13/117 Care Quality Commission Reports

Mrs Adams commented on the reports received by the Trust. She was very pleased to see the positive comments included in the report and noted that York had passed all standards. Scarborough Emergency Department did not pass two of the standards checked and has received some compliance actions as a result. She added that is was important to note that the two days the CQC visited the Scarborough were the two busiest days they had had in the Emergency Department for many years. The activity was 12 % higher than had been expected. She added that the level of activity, however, did not excuse some of the shortcomings identified.

Mr Proctor agreed with Mrs Adams's summary. He advised that in terms of management response the team is working hard to rectify the issues. He added that it is fair to say that when staff are in the middle of a very busy session it is difficult to see that the situation might get worse and, historically, the response in Scarborough has been to bring more staff in, but staff may not be available and a better response approach needs to be adopted.

Dr Turnbull added that in terms of the infection control shortcomings these were inexcusable. The Infection Control Team are making changes to the provision of domestics and working on the productive ward programme. Infection Control has put in place a regime where they will undertake an audit twice a week and continue to review the systems.

Mr Proctor added that Emergency Department performance is an issue across the Trust. CQC saw the impact of the lack of beds in the system which results in patients not being moved out of the Emergency Department.

Mr Golding added that he felt from an Estates and Facilities perspective there were some very good points to take out of the reports. He advised that he has spent time reviewing the cleaning on both sites to try to ensure there is a balance and both sites have consistent cleaning regimes. In terms of the Emergency Department, this balancing work is not complete and gaps have been identified in the cleaning such as, at present, Scarborough Emergency Department does not have 24-hour clearing service in the Emergency Department. He confirmed that is being rectified.

The Board was advised that the CQC would return to the Trust to review the areas where compliance actions were identified.

The Board **noted** that CQC had recently changed their approach to audits. They will now be visiting mixture of Trusts who are considered to be of high, medium or low risks and the visits will be longer and more in-depth.

The Board were **assured** by the reports and the comments made.

13/118 Finance and Performance Committee

Mr Sweet commented that the Trust had introduced a new Corporate Dashboard from the 1st October. This would mean the information included in the performance pages would change to a new format. It was agreed that this and the Quality and Safety Dashboards would be complementary to each other, but would also have some cross-over.

Mr Sweet advised that there were a number of areas he wished to bring to the Board's attention. He asked Mr Proctor to comment on the first-to-follow-up work.

First to follow up – Mr Proctor asked Mrs Rushbrook to comment. Mrs Rushbrook explained that the Commissioners were seeking for the Trust to achieve a rate of 1:1.5. She advised that it had proved impossible for the Trust to be able to achieve this while remaining clinically safe. She explained that via the IT infrastructure and the internal patient system 'core patient database' (CPD) clinicians have been able to identify which patients requiring ongoing support from the Trust and cannot be discharged. Clinicians have then been asked to identify those patients that would be in the extended follow-up group, those patients that might need three follow-ups rather than four (for example) and then that group of patients that can be discharged into community care. Following this work, the Trust has achieved a ratio of 1:1.83. The Trust will be holding a meeting with the CCG to discuss the first to follow up ratio during October. Currently preparation work is being completed for that meeting.

Mr Proctor added that the level of follow up is at the lowest level possible whilst ensuring patients remain safe. Mr Proctor added that the Trust has received some comments from GPs in East Yorkshire who are not happy that their patients have been discharged when they are not requiring the achievement of this ratio. Mr Proctor explained that unfortunately the systems the Trust has in place do not allow the identification of which CCG the patient has been referred by. Mr Proctor added that at present there is £1m of follow up work the Trust is at risk of not being paid for by the CCG. The Trust cannot afford to continue to undertake work it is not paid for.

The Board asked Mr Proctor to update the Board at the next meeting on the results of the meeting.

Action: Mr Proctor to update the October Board on the meeting with the CCG around first to follow up ratio.

Ms Raper commented that this is an item that is regularly discussed at the Quality and Safety Committee. Dr Turnbull agreed and added that it is important that it is understood and seen that the Trust will not compromise safety, but in his opinion quality could be compromised by patients being discharged early. He added that consultants have received letters asking for patients to be taken back so they can receive their treatment at the hospital.

Mr Proctor did add that for the Trust there is a benefit in that it does create some capacity in the outpatients department which does mean the Trust can see patients quicker.

The Board **noted** the comments and assurances given by Mrs Rushbrook.

Resilience Plan – Mr Proctor advised that the Trust has an extensive and comprehensive acute strategy in place for the next 5 years. The resilience plan is a robust element of that strategy and does seek to increase capacity significantly across both main sties (Scarborough and York). The recruitment of staff is continuing and the plan does mean that there will be a need to recruit an additional 80-plus nurses, which means a net increase in establishment of qualified nurses of 60-65. At the moment a regional and national approach to recruitment is being developed which the Trust will use to help support the recruitment.

One of the key elements of the plan is an all-specialty assessment unit, although it will not be available this winter. Work on the review of the ward areas has been completed and an additional care of the elderly ward of 24 beds had been formed in York. This has reduced the number of surgical beds. This will not affect activity, but does mean that surgery have lost a dedicated ward.

Mr Rose asked the Board if they were satisfied with the information given by Mr Proctor regarding the winter plans. Mr Keaney asked Mr Proctor what level of increase in capacity was being envisaged. Mr Proctor advised that it would be 30 beds in York and 25 in Scarborough.

Mr Proctor added that the additional allocation of monies the Trust has been given will help to support this work and help support the community work. He added that it was felt that the additional monies were to support the whole area. The money would cover three areas: pre-hospital admission initiatives (to help reduce demand), equipment and Emergency Department. The money is not recurrent and is in place for 6 months. It is expected to help improve performance on the 4-hour target, although at present it is not clear how this will be measured.

The Board asked if there was any clarity about the relationship with the flu injections. Mr Proctor advised that it was not clear. The Board asked Mr Proctor to update the Board at the next meeting.

Action: Mr Proctor to update the October Board of Directors.

Professor Willcocks commented that the acuity and age of the patients is increasing and the plan needs to be robust to ensure this demand can be met. Mr Proctor agreed with the comments and added that the Quality and Safety Committee and the Finance and Performance Committee are aware of the workstreams that are involved in the delivery of the acute strategy.

The Board agreed that they would like to see the detailed plan. It was agreed it would be circulated.

Action: circulate the resilience plan to the members of the Board.

Mr Proctor explained that the acute strategy is a plan for the next three to five years for completion. A priority for the strategy is the introduction of an acute assessment unit, this will involve getting specialist to work together, and as explained this will not be in place this winter.

CQUIN- Mr Sweet asked Dr Turnbull to comment on the post-take ward round within 12 hours. Dr Turnbull explained that there is an issue related to this. Dr Turnbull explained that there was a bulge of arrivals between 8-10pm. This can mean that a patient will not be reviewed until the following morning. Dr Turnbull explained that a patient takes 73 minutes to clerk on average. Significant consultant presence is now in place at weekends. Currently the priorities are being reviewed and acted on. Consultant working hours are being reviewed.

Finance – Mr Bertram commented that the Trust is on plan, but there are some concerns behind this position relating to overspending pressures, CIP delivery and the risk of income receipt for additional work provided for the CCGs. Mr Sweet asked Mr Bertram to comment on the ability of the CCG to pay for the additional work undertaken to date. Mr Bertram

explained that debates are continuing with the CCG and the risk is identified on the risk register. Mr Bertram added that the 2% surplus the CCGs are being asked to make is being squeezed. The CCG is also introducing a referral support unit to York. This should help ensure the referrals are appropriate and all the tests that can be undertaken in the community are being performed there (again, to reduce referrals and admissions). Mr Bertram reminded the Board that the Trust has a PbR contract and fair payment is due for work done.

Mr Bertram also advised that at present the CCGs have still not received any referral data from the Commercial Support Unit; consequently the Trust is still supplying the CCGs with the information by way of interim support.

Mr Sweet asked Mr Bertram to remind the Board about the 30% threshold for non-elective work. Mr Bertram advised that he was hoping there would be changes to this next year. This year currently the Trust is £500k above plan; given this is at the 30% rate, the Trust has received short payment of around £1m for this work.

Mr Bertram referred to the outstanding capital monies. He explained that pressure was still being placed on the Department of Health, but all parties accepted by all parties that the obligation to pay the money remains. The Department of Health continues to work with the Treasury and it is expected that the money will be available by Christmas. At present the Trust is continuing to progress all the schemes, including the paediatric and outpatient scheme and Maple Ward 2.

Efficiency – Mr Sweet commented that there were the ongoing challenges around the achievement of the CIP and the high level of non-recurrent saving. Mr Sweet advised that the Finance and Performance Committee had received details about the panel work being undertaken to convert the non-recurrent savings to recurrent. He advised that the major focus of the panels is to review the schemes, so that changes can be made to help support the ongoing delivery of the CIP into 2014/15. Mr Crowley noted how KPMG had been impressed by the multi-year CIP plans the Trust had in place, comparing this favourably to other Trusts they had scrutinised.

Mr Sweet added that the Committee had sought assurance that the achievement of the savings did not have an impact on quality and safety. The committee had been advised that a very comprehensive process has been put in place so that no scheme would affect safety. Quality is subjective and it is how it is defined that will decide if a scheme impacts it. He added that on occasion there might be a perceived deterioration in quality but that safety would never be compromised. Mr Sweet added that the Committee had reviewed the new governance dashboard that reported on directorate delivery and the risks to that delivery.

Mr Sweet advised the Board that work was in hand to the format and content of the monthly Efficiency Report.

Mr Keaney asked if the increased income was “hiding” a deficit. Simply put, “Yes”. Mr Bertram advised that the team is working very hard to reduce the risk to the bottom line and ensure the Trust delivers the required CIP for this financial year.

Emergency Department – Mr Sweet asked Mr Proctor to comment on the Emergency Department. Mr Proctor reminded the Board of the comments already made around the performance at Scarborough. As already had been stated, the significant increase in the level of attendance for quarter 2 by around 5-6% over the normal levels of increase was dramatic.

Length of stay has also increased for the elderly by 2 days, acting as a bottleneck to ED, and at present this increase cannot be explained.

Mr Proctor confirmed that the Trust will not achieve the target for the 4 hour wait for quarter 2. It was confirmed that Monitor had been advised.

Ambulance turnaround target – Mr Proctor advised that the level of activity in the Emergency Department in Scarborough has impacted on the turnaround target. He explained that there is a dedicated area in Scarborough for ambulance admissions, but not one in York. It is difficult to manage without a dedicated area; consequently work is underway to create an area in York. Mr Proctor added that when the penalties are introduced, it will be very difficult for the Trust.

Mr Keaney enquired when the increased bed base capacity would be available. Mr Proctor advised that it would be in place by quarter 4. He added that it could be brought forward, but it does need investment and the Trust may not have the money available.

The Board agreed that they would like a full update on the winter resilience plan at the next Board meeting.

13/119 Scheme of Delegation

Mr Bertram presented the paper and asked the Board to consider the request to agree to a new level of authority to the Capital Planning Management Group. Mr Rose asked Mr Ashton to add any comments. Mr Ashton confirmed that the Audit Committee had discussed the proposal and agreed that it was an appropriate increase in authority.

The Board **approved** the amendment to the Scheme of Delegation with immediate effect.

Mr Crowley asked for the same review to be undertaken with the Capital Programme Board which is chaired by Mr Bertram but includes Mr Crowley as a member. It was agreed that a review would be undertaken.

Action: to consider increasing the authority of the Capital Programme Board to be undertaken during the next stage review.

13/120 Quarterly HR Report

Professor Willcocks commented on the report. She was keen to stress that the report demonstrated improvements in sickness and vacancy management although concerns remained with respect to community staff where action is in hand. She added that she felt the report provided excellent evidence of the improvements in systems overall.

Mr Ashton commented that much of the report is self-evident and clear. He noted that strides were being made in Scarborough in improving the level of sickness, whereas challenges obviously still existed in the community areas. He wondered if that related more to staff morale than anything else.

Mr Ashton also felt that the vacancies seemed to be at a reasonable level and the discussions earlier in the meeting confirmed that significant recruitment was being undertaken.

Temporary spend also seems to have reduced. Mr Crowley confirmed that view and explained that it was a number of small things that had made the difference including harmonising on-call.

The Board recognised that 40 of the 48 HR policies have now been fully harmonised and the Trust is working with one policy across the whole Trust, wherever possible.

Mrs Adams suggested that there should be a review of the information being received by the Board from the HR department. The additional information could include a breakdown of where staff are being deployed and by their role within the organisation.

Action: Ms Hayward to review the information provided to the Board in the quarterly reports.

Professor Willcocks supported the suggestion and added that in early September at the Workforce Strategy Committee it was agreed that there should be a review of HR information. Professor Willcocks also advised that the Workforce Strategy Committee had reviewed their annual report. She proposed that should be provided to the Board of Directors as it would offer more detailed information.

Action: Ms Hayward to circulate the annual report of the Workforce Strategy Committee

Ms Raper added that she is continuing to work with Ms Hayward on the introduction of benchmarking data in the HR report.

Mr Crowley commented that there had been significant progress since the acquisition, hundreds of new staff had been appointed new into the organisation and there had been noticeable advances in appraisals and building capacity and capability.

Mrs Holden advised that she has been working with Ms Hayward to identify talent in the organisation and develop the individuals so the organisation is supporting the succession planning. Mr Rose informed the Board that consistent with this initiative, the Remuneration Committee later in the day would be reviewing succession planning issues at Executive level.

Mr Ashton asked if the Trust was required to publish the numbers of qualified staff on the wards as had been reported recently on the media. Mr Proctor explained that it was not a requirement, and was a recommendation from the Select Committee. The Board discussed the issue and there was a mixed opinion as to whether it made any difference to publish the figures or not.

It was agreed that Mr Proctor would update the Board at the meeting in October 2013.

Action: Mr Proctor to update the Board on the recommendation from the Parliamentary Select Committee.

The Board **noted** the content of the report.

13/121 Report of the Chairman

Mr Rose reminded the Board that the Council of Governors had recently met and the Trust had held the Annual General Meeting (AGM) recently. Both events had been successful.

He advised that he and Mrs Pridmore had attended the Leeds and Yorkshire Partnership Membership Day and AGM. He advised that it was a well-run day, but did present the future in a more rosy light than maybe really so. He added that it led him to think about how the Trust presents the future. Mr Rose came to the conclusion that the Trust does owe it to the community to make sure it does not hide the difficult context within which the Trust is working.

The Board **agreed** with the Chairman's comments.

13/122 Report of the Chief Executive

Mr Crowley endorsed Mr Rose's comments and added that he had attended the Open Day for Whitby earlier in the week and he was pleased to be able to report that in Whitby they were clear that there were some difficult choices to make over the next few months and years that would affect the provision of services at Whitby. He added that he felt it was important that the Trust remained optimistic and ambitious, but honest and realistic.

The Board **agreed** with Mr Crowley's comments.

13/123 Quality Report

Mrs Pridmore advised that the governance process for the Quality Report had now been completed and the Council of Governors had received a presentation from the External Auditors on the limited assurance statement. Mrs Pridmore reminded the Board that the statement is limited in terms of what is reviewed, not in terms of opinion.

Mrs Pridmore also explained that the Quality and Safety Committee would receive a quarterly report on progress of achievement of the targets set in the report.

The Board **noted** the comments made.

13/124 Business Case 2012-13/183 Consultant Urologist

Mr Bertram referred to the process attached to Mr Crowley's Report. He explained that the system has been overhauled and new guidance had now been released to staff. The Board **noted** the revised guidance.

Mr Bertram outlined the business case and advised that the Corporate Directors and the Executive Group had reviewed and approved the case. Mr Bertram advised that the case would deal with a concerning on-call issue and bring some work currently not undertaken as part of normal activity back into standard in-hours business. He added that the business case also makes a contribution to fixed costs.

Mr Keaney commented that he had contacted the directorate to understand the case more fully. Mr Keaney advised that he would suggest that Board should be supportive of the business case.

The Board confirmed **approval** of the case.

Dr Turnbull added that the case does support the alliance working that has been formed and continues to be developed.

Mr Rose asked about the first-to-follow-up ratio reported in the business case (which remained unchanged between current and future). Mr Bertram commented that Urology have been a little slow in their review of the ratio. Their ratio is 1:1.9, which is viewed to be a safe level. Mr Bertram advised that he would expect the improvements in the ratio to be built in to the business case.

13/125 Any other business

There was two items of additional business:

Connecting for Health: Mrs Holden advised that 5 staff from the Connecting for Health initiative have been invited to spend some time in the Trust over the next six months. The purpose is to provide them with information about the impact of the policies they will be writing. They will start to be in the organisation in during the first week of October.

Awards: Mr Crowley advised that over the last few days it has become clear that a number of staff and teams have been shortlisted for awards, including Mrs W Scott (Director of Community Services), Mrs Holden, the Board and Mr Crowley.

13/126 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 30th October 2013 in The Blue Room, Scarborough Hospital.

Action list from the minutes of the 25 September 2013

Minute number	Action	Responsible office	Due date
13/115 Patient Experience Report	To present the cancer patient experience report at the next Board meeting.	Mr Proctor	October 2013
13/115 Patient Experience Report	To provide a quarterly report on patient experience to the January 2014 meeting.	Mr Proctor	January 2014
13/116 Quality and Safety Committee	To continue the discussions with PHE related to the support they could provide the Trust.	Dr Turnbull	October 2013
13/116 Quality and Safety Committee	To update the Board on the discussions with the Commissioners around the CQUIN target for pressure ulcers.	Mr Proctor	October 2013
13/118 Finance and Performance Committee	To update the October Board on the meeting with the CCG around first to follow up ratio.	Mr Proctor	October 2013
13/118 Finance and Performance Committee	To update the Board on the relationship between the additional non-recurrent Emergency Department monies and flu vaccines.	Mr Proctor	October 2013
13/118 Finance and Performance Committee	Circulate the resilience plan to the members of the Board.	Mr Proctor	October 2013
13/119 Scheme of Delegation	To consider increasing the authority of the Capital Programme Committee to be undertake during the next stage review	Mr Bertram/ Mrs Pridmore	February 2014
13/120 Quarterly HR Report	To update the Board on the recommendation from the Parliamentary Select Committee	Mr Proctor	October 2013
13/120 Quarterly HR Report	To review the information provided to the Board in the quarterly reports.	Ms Hayward	For the next quarterly report
13/120 Quarterly HR Report	To circulate the annual report from the Workforce Strategy Committee	Ms Hayward	By December 2013

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 October 2013

National Cancer Patient Experience Survey 2012/13

Action requested/recommendation

It is recommended that:

- The survey findings be shared with all staff groups involved in providing cancer care to patients and their relatives at the earliest opportunity
- The working group, set up in 2012, continues to meet on a quarterly basis to continue take forward the action plan devised in 2012. A new action plan will not be created but priorities from 2013 will be built into the existing plan and monitored
- The findings from the survey are fed back to patients, relatives, user and support groups associated with Cancer Care
- The Governors are briefed on the findings of the survey
- The survey is shared with the local Healthwatch organisations
- Patient comments and feedback from the survey are shared across the organisation and with primary and social care where this is appropriate (at the time of this paper, Quality Health have not released the patient comment report)

Summary

This paper summarises the key findings of the third National Cancer Patient Experience survey 2012/13, carried out by Quality Health on behalf of the Department of Health. This is the first National Cancer Patient Experience Survey carried out following the acquisition in July 2012. The results are joint findings from both York and Scarborough Hospitals. The 2011/12 comparisons referred to in the report have been achieved by joining the two data sets, from both York and Scarborough reports, into one dataset.

This is a mandated annual survey.

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

Implications for equality and diversity

Non identified

<u>Reference to CQC outcomes</u>

1, 4, 9, 16

Progress of report	Board of Directors – October 2013 York District Cancer Partnership Group – September 2013 Cancer Board – date tbc Clinical Nurses Specialist Group – date tbc
Risk	No risk
Resource implications	There are no identified resource implications
Owner	Beverley Geary, Director of Nursing
Author	Kay Gamble, Patient and Public Involvement Specialist
Date of paper	October 2013
Version number	V1

Board of Directors – 30 October 2013

National Cancer Patient Experience Survey 2012/13

1. Introduction and background

The National Cancer Patient Experience survey forms part of an annual mandatory requirement for the Trust.

This paper summarises the key findings of the third National Cancer Patient Experience survey 2012/13, carried out by Quality Health on behalf of the Department of Health. The survey provides information that the Trust can use to drive local quality improvements.

One hundred and fifty five acute hospital NHS Trusts providing cancer services took part in the survey, accounting for every Trust that provides adult cancer care in England.

All adult patients (16 and over) with a primary diagnosis of cancer who had been admitted to hospital as an inpatient or as a day case patient and were discharged between 1st September 2012 and 30th November 2012, were invited to take part in the postal survey.

A total of 1120 eligible patients from our Trust were sent a survey with 715 questionnaires returned completed. This represents a response rate of 69%, compared with the national response rate of 64%.

This is the first National Cancer Patient Experience Survey carried out following the acquisition of Scarborough and NE Yorkshire Healthcare NHS Trust in July 2012. The comparisons referred to in the full report (which can be accessed separately) have been achieved by Quality Health joining the two data sets, from both York and Scarborough 2011/12 reports, into one.

2. Overall Findings:

Overall responses to the 62 questions asked, shows that:

24 questions placed the Trust in the top 20% of Trusts
3 questions placed the Trust in the bottom 20% of Trusts
35 questions placed the Trust in the remaining 60% of Trusts

91% of patients rated their care as either excellent or very good
This was the score received for York Hospital in 2012 whilst Scarborough received 85%.

The findings from the survey are extremely pleasing for the Trust and recognise the improvements that have been made from past survey findings.

2.1 Key positive findings:

91% of respondents rated their care as either excellent or very good
91% of respondents said that they were given easy to understand written information about their test *

86% reported that staff gave complete explanation of purpose of the test *
87% reported that staff explained completely what would be done during the test *
94% reported that the CNS definitely listened carefully
93% reported that the CNS gave understandable answers to important questions all/most of the time
89% reported that staff explained how the operation had gone in an understandable way
87% reported that doctors gave understandable answers to important questions all/most of the time
88% reported that nurses did not talk in front of them as if they were not there
84% reported that they never thought they were given conflicting information
95% of patients reported that staff told them who to contact if worried post discharge

* these were all highlighted in the 2011/12 Board paper as areas requiring attention, particularly in relation to Scarborough Hospital. There has been an increase in these scores from the last survey resulting in the Trust being in the top 20% of Trusts in the majority of these questions. This again, is reflective of the work that has been carried out in the timeframe.

2.2 Key Areas for improvement:

80% of patients reported that they were always given enough privacy when discussing condition/treatment
92% of patients reported that they were always given enough privacy when being examined or treated
79% of patients reported that they had seen information about cancer research in the hospital *
25% of patients reported that they had been asked to take part in cancer research *

* these two questions were highlighted in the 2012-2014 action plan and work to improve our scores is currently ongoing.

3. Conclusion

The National Cancer Patient Experience survey has provided the Trust with some excellent feedback and a baseline going forward as one Trust following the acquisition in 2012. It highlights areas where the Trust is performing well and also highlighted the areas in which the Trust needs to improve in and prioritise action planning.

Staff are to be congratulated that the Trust scores within the highest 20% of Trusts on a number of questions with the majority of questions placing us within the middle 60% of Trusts, nationally. Whilst we are in the bottom 20% of Trusts for three questions, work is ongoing to improve in these areas. However, we should note that a threshold for placing a trust within the highest 20% of trusts and the lowest 20% of trusts can be very small.

Once again, the survey reflects the individualised holistic care that the cancer multi-disciplinary teams aim to deliver to patients. The improved quality in care and provision of information delivered by the clinical nurse specialist acting as the patient’s key worker continues to be evident across the Trust.

We value greatly that 91% of patients report their care as excellent or very good. The Trust is committed to listening to the views of our patients and acting upon their feedback and this survey allows us to build upon what our patients tell us is important to them.

A main priority from the 2011/12 survey was that we did not communicate nor provide

information to patients equitably across the whole Trust. It is therefore encouraging to see that our scores in these areas have increased and work continues to improve further in these areas.

4. Recommendation

It is recommended that:

- The survey findings be shared with all staff groups involved in providing cancer care to patients and their relatives at the earliest opportunity
- The working group, set up in 2012, continues to meet on a quarterly basis to continue take forward the action plan devised in 2012. A new action plan will not be created but priorities from 2013 will be built into the existing plan and monitored
- The findings from the survey are fed back to patients, relatives, user and support groups associated with Cancer Care
- The Governors are briefed on the findings of the survey
- The survey is shared with the local Healthwatch organisations
- Patient comments and feedback from the survey are shared across the organisation and with primary and social care where this is appropriate (at the time of this paper, Quality Health have not released the patient comment report)

5. References and further reading

Electronic copies of the National Cancer Patient Experience Survey can be accessed through the Trust website (http://www.yorkhospitals.nhs.uk/about_us/reports_and_publications/patient_surveys/) or by contacting kay.gamble@york.nhs.uk.

Author	**Kay Gamble, Patient and Public Involvement Specialist**
Owner	**Beverley Geary, Director of Nursing**
Date	**October 2013**

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York Teaching Hospital NHS
NHS Foundation Trust

Quality & Safety Committee – 22nd October 2013, Alastair Turnbull's Office

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

Apologies: Alastair Turnbull

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1	**Last meeting notes dated 18 September 2013**		The minutes were agreed. Actions from the minutes will be picked up during the meeting.		
2	**Matters arising**		AP gave a round up of the KPMG report that has recently been completed and touched upon their recommendations. LR reminded the Committee that it had been agreed that AJT would update the Committee monthly on the first to follow up. In his absence, AP summed up the conversation that had been held at the Finance and Performance Committee. She explained that the meeting with the CCG had been held on Friday 18th October. The meeting reviewed the detailed registers covering 24 specialties and 272 recognised conditions where a patient was being followed up by the consultant. She added that the CCG had asked to test a sample of the conditions	The Committee was assured by the comments made.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
2.	Matters arising cont'd		clinically to assure themselves that the safety bar was appropriately set. This work will be undertaken shortly. JA asked if there had been a rise in complaints because of this initiative. BG confirmed there had not been.		
3	**Structure of the Dashboard**		LR reminded the Committee of the context of the dashboard and of its purpose. She explained that she had understood that the intention was to move to a single dashboard in time and she was expecting the dashboard to be incorporated into a more holistic version. JA raised the point that she felt that staffing levels should be included in the dashboard from a quality and safety perspective. DP explained that there is some national recognition about the gaps in staffing rotas. DP went on to describe the development work that is being undertaken around medical and nursing staff. The Committee discussed the introduction of the Executive Summary and agreed it was very beneficial. The Committee discussed ways of developing the relationship between the executive summary and the body of the dashboard, and noted that this is a priority for further development. BG suggested putting the dates against Serious Incident (SI), pressure ulcers, etc. reports within the dashboard of when they occurred/were reported. DP will review the comments and take them into account for the production of the next version. The Committee agreed this continued to be a developing agenda.	The Committee was delighted with the progress of the development of the Quality and Safety dashboard.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
4.	**Integrated Dashboard**	1.1,1.4, 1.9, 1.10, 1.11, 1.13, 1.15	The Committee agreed they would concentrate on the key items in the dashboard. **Pressure Ulcers** - BG updated the Committee on the pressure ulcer reduction programme. She explained that there are a significant number of complex issues with the current process. The developed action plan for the whole organisation will need to be flexed in terms of time and content, dependent on the setting of the care (acute or community). BG explained that any occurrence of the pressure ulcer (grade 4) is a mandatory SI. She explained that 4 of the SI declared this month are as a result of declaring 4 pressure ulcer cases late. She reminded the Committee of the importance of the timeliness of completing an investigation and that the commissioned report that was published in December did identify that some pressure ulcers had not been identified as SI As a result, there has been an increase in the number to address the old incidents. BG commented that she thought the picture was more accurate and the culture around pressure ulcers had now changed and the Trust was more aware of pressure ulcers. BG went on to explain that the issues were not just around culture and education, but also related to some difficulties in obtaining appropriate equipment particularly in the community. She explained that Harrogate hold the contract for the equipment. The Trust is in the process of seeking to appoint an individual who will act as the coordinator. **Nursing Care indicators** - The Committee asked about the waterlow score (pressure ulcer score) and why it seemed the score was so low. BG explained	The Committee was assured by the comments made by BG and the attention being given to the issues, it did note the significant work that needs to be undertaken.	Mike Proctor to update the Board on progress against the Pressure Ulcer Reduction Programme.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
4.	Integrated Dashboard cont'd		that it was in part to do with the mechanisms around the Nursing Care Indicators (NCI). The sample size is five patients, and depending on the individual patient factors the results may not reflect the delivery of care in that area. BG is in the process of developing an early warning trigger tool and other indicators to demonstrate quality of care in clinical areas which will eventually replace NCIs.		
			Patient Safety Walkrounds - PA raised the point that he would like to see some additional robustness to be put into the system of walkrounds. He explained that the NEDs find the walkrounds to be one of the most valuable information sources. PA commented that he had noted on some occasions the visits are cancelled without much notice and are not rearranged. He also commented that the summary of the visit should be available within an agreed timetable so that it is fresh in the memory of those that undertook the visit. LR added that she felt there was a gap in the system around the clarity of how the reported issues were checked on and signed off. DP suggested raising this topic at the Board of Directors meeting**.**	The Committee gain significant assurance from the Patient Safety Walkrounds and would like to gain more from seeing some of the suggestions made being put in place.	Alastair Turnbull to update the Board.
			Maternity - LR noted that the number of c-sections undertaken in the Trust seemed very high. BG will ask for a detailed response and assurance regarding the number from the Head of Midwifery.		
			Family and Friends - BG explained that the Trust had seen a dip in September in the number of completed comments. She added that it had been noted that when the wards are busy or attendance increases in the Emergency Department (ED) then	The Committee noted the use of the Governors and the impact they had on the responses.	Mike Proctor to update the Board on Family and Friends.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
4.	Integrated Dashboard cont'd		the response rates are not as high. During September a number of governors were placed in the ED and they had a very positive effect on the number of responses the Trust received. As was reported last month the Trust is introducing the token system and it is expected that will also have a positive impact on the number of responses the Trust receives. The Trust has introduced the system in maternity; this is going well. **Complaints** - JA had noted that the number of complaints recorded in Scarborough had seemed to be unusually high. BG agreed they did seem high, but she did feel that some of it was related to the historic reputation which was discussed at the Board meeting in September. She explained that there was no clear theme or trend in the complaints and no specific increase in one area. She gave the example of a Trust that had been part of the Keogh review and once the report was made public their complaints increased by 100% and have continued to increase. The Committee asked again if it would be possible to receive a breakdown of the complaints at the meeting. **Flu vaccination** - DP explained that the winter monies for next year are tied to the number of staff who take up the flu vaccination this year. She advised that the target has been set at 75%. **CQUIN** – It was noted by the Committee that the Trust had achieved all the targets for quarter 1 and all but the pressure ulcer target for quarter 2.	The Committee was concerned to see the increase in complaints, but was reassured by the comments made.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
5.	**Supplementary Medical Director Report**		The Committee went through the Supplementary Medical Director Report. **Serious Incidents** - The committee discussed each of the incidents and were assured by the information provided. Work to develop these reports continues.	The Committee was assured by the information provided.	
6.	**Supplementary Chief Nurse Report**	3.9,2.18	The Committee discussed the Supplementary Chief Nurse Report. **Nursing and Midwifery Strategy** - BG explained that she had been at a meeting with the Chief Nursing Officer and other local Chief Nurses and Director of Nursing where the use of the 6Cs was being discussed. She reminded the Committee that the Trust was signed up to the 6Cs and that she felt that there was evidence of some good practice where activities are already undertaken, but acknowledged there is more work to do. **Staff recruitment** - The Committee recognised the significant efforts that were being made to increase the nurse establishment across the Trust, and acknowledged the concerns regarding recruitment that were raised by BG. JA asked about the visibility of using senior nursing staff on wards to help with staffing gaps. BG did explain the challenges that are involved in using senior staff that way, including backfilling their current roles. BG explained that lots of Trusts were recruiting nurses at present in part in response to the Francis report and so the availability of nursing staff is low. She added that the local Trusts were considering if it would be more effective if they were to recruit as a group. BG	The Committee noted the challenges being faced, but were reassured by the comments made and the actions being taken.	Mike Proctor to comment on the issues around staff recruitment.

	Agenda Item	AFW	Comments	Assurance	Attention to Board
6.	Supplementary Chief Nurse Report		described the two one stop shops that had been arranged. She explained that they will be an opportunity for potential staff to undertake the pre-employment checks to speed up some of the recruitment process. BG also referred to the work being undertaken around the matrons and the restructuring of the matron role so that it is more clinically focused. The Committee referred to the work that had been undertaken as part of the Workforce Committee on the establishment on particular areas. JA asked if this recruitment had been completed. BG confirmed that the immediate high risk issues had been addressed, although there was a minor administration matter that was to be resolved. BG described the system in place for managing risks around staffing on the wards. She explained that an assessment of the risk areas is made at the beginning of every shift and staff are moved and allocated accordingly. **Resilience plan** - The plan increases beds in some specific areas, the current position is that no escalation beds have been opened in York, but the escalation beds are open in Scarborough. When the beds are opened in York a team will be pulled together to ensure staff, equipment and ancillary support is in place. **CQC** - The Committee asked if the requirements that were described in the recent CQC report would be completed. BG confirmed they would be.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
7.	**Quarterly DIPC Report**		The Committee noted the dashboard and the improved performance recorded. It was agreed that the Board of Directors would approve the document.		The Board of Directors to approve the report.
8.	**Cancer Survey**		The Committee went through the cancer survey and noted some very positive results. It was agreed that the report should be forwarded to Monitor as their new Risk Assessment Framework does ask that they are informed of third party reports on the Trust.		Board to note the report and proposal to forwarded the report to Monitor.
9.	**Any other business**		There was no other business.		
10.	**Date and time of next meeting**		The next meeting will be held on 20 November at 2pm in the LaRC Conference Room.		

York Teaching Hospital NHS Foundation Trust NHS

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Patient Safety and Quality Dashboard

Report: October 2013

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

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Executive summary

- There were no 'Never Events' reported in the Trust during September.

- Ten Serious Incidents (SIs) were declared.

- Four SIs were as a result of patients developing category 4 pressure ulcers.

- Two cases of c. diff were identifed.

- An update on revalidation section has been added to this report.

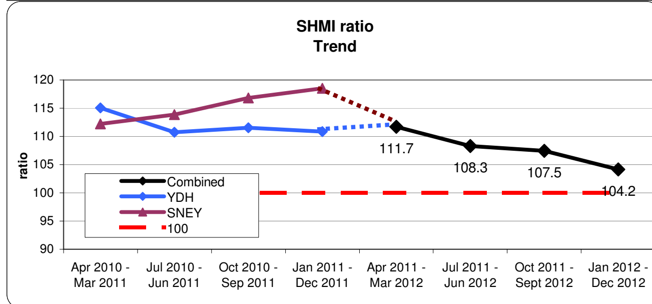
- Results from the National Paediatric Diabetes Audit are presented.

- A sample of the PROMs results from the period April 2012 - March 2013 are included.

York Teaching Hospital NHS Foundation Trust

Patient Safety

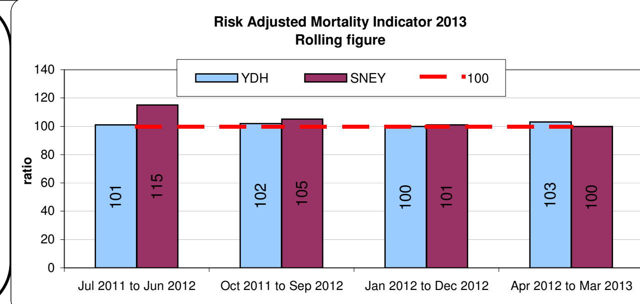
Mortality



The Trust combined Summary Hospital-level Mortality Indicator (SHMI) is 104.2 and indicates a gradual decrease over the last 12 months.

The next SHMI report for the period April 2012 to March 2013 will be published by the Information Centre on the 29th October.

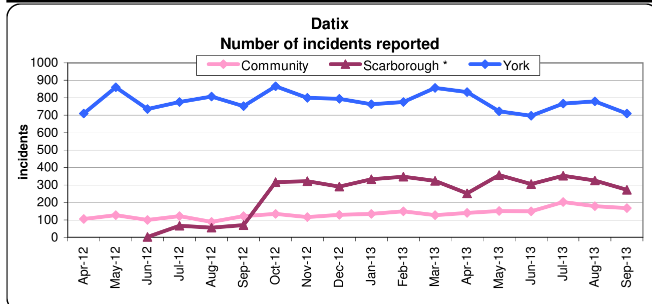
Data source: Health and Social Care Information Centre.



The risk adjusted mortality indicators (RAMI) for both acute hospital sites have remained stable for the last threee reporting periods.

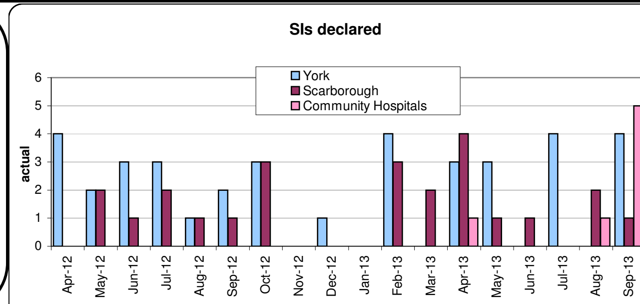
Data source: CHKS - does not include deaths up to 30 days from discharge.

Measures of Harm

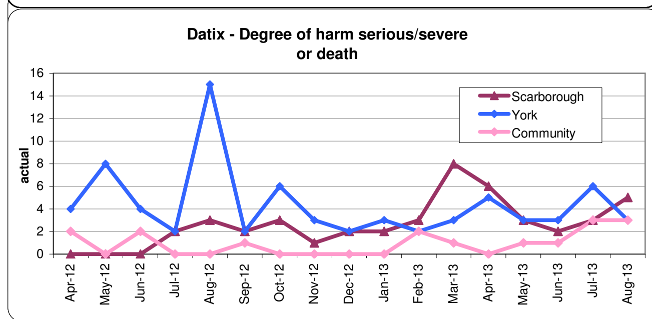


The toatl number of incidents reported in the Trust during September was 1149. This represents a slight decrease on all sites from last month. The reduction in the number of incidents reported on the Scarborough site for the last two months are thought to be due to under-reporting rather than an actual reduction in the incidence.

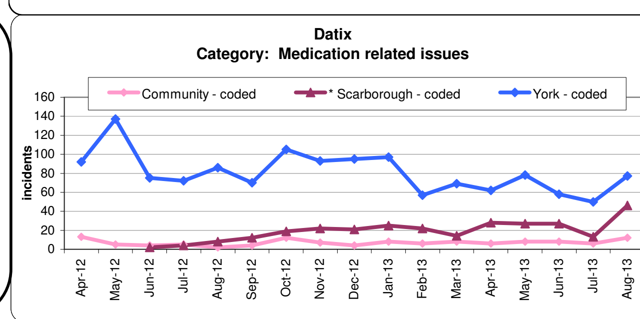
Data Source: Datix



There were ten serious incidents (SIs) reported in September; four due to the development of category four pressure ulcers, two due to patients sustaining severe injury whilst falling in hospital, one due to c.diff, one due to loss of hospital equipment, one due to sub-optimal care and one due to media attention.

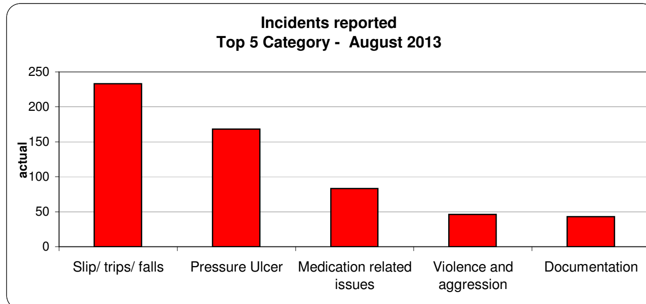


Eleven of the incidents reported during August were graded as serious or severe. All of these are being investigated using a detailed root cause analysis methodology.



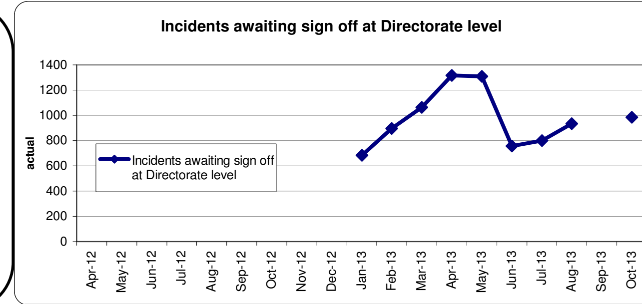
Approximately 12% of incidents reported relate to errors involving medicines. Of these half are due to failures in the administration processes with the majority of the others due to dispensing or prescribing errors. Work on developing EPMA continues.

Data Source: Datix



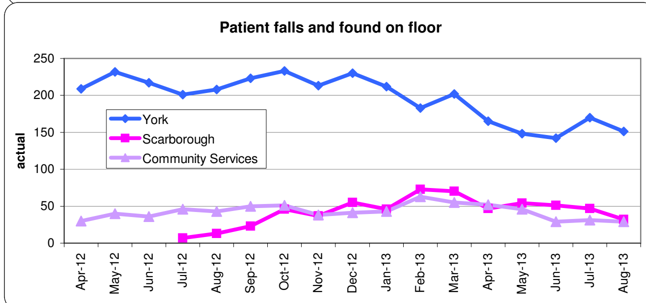
The top three category of incident reported remains unchanged, however during August there was an increase in the number of incidents attributable to violence and aggression and also to documentation errors.

Data Source: Datix



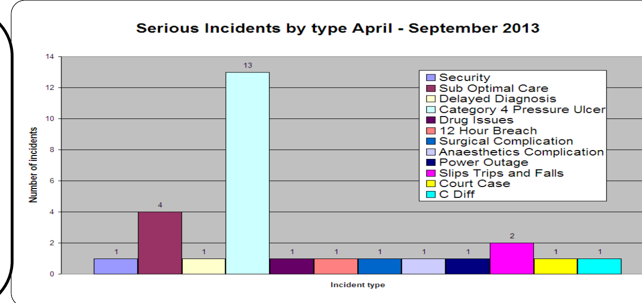
There has been a further increase in the number of incidents awaiting investigation or final approval. Approximately 30% of these incidents are from the Elderly and Acute Medicine Directorates, which are large directorates. The Head of Risk and Legal Services reviews all incident summaries on a weekly basis such that, if required, an incident can be identified and escalated accordingly

Data Source: Datix



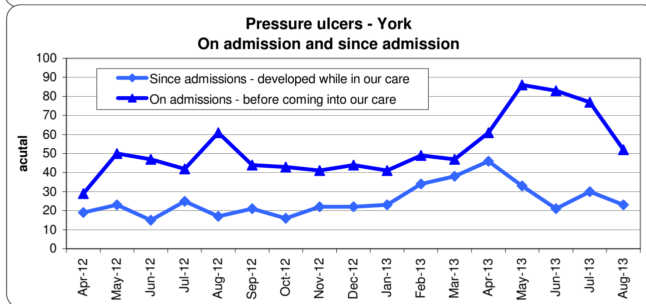
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust.

Data Source: Datix



There have been 28 SIs reported in the Trust since April 2013. The largest number (13) are attributable to category four pressure ulcers.

Data Source: Datix

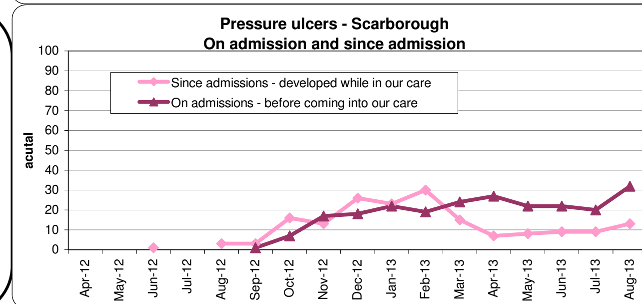


The problems previously identifed with the accuracy of incidents related to pressure ulcers reported on Datix have been resolved.

During August a total of 23 pressure ulcers were reported to have developed on patients in York Hospital.

These figures should be considered as approximations to allow for the coding time period.

Data Source: Datix

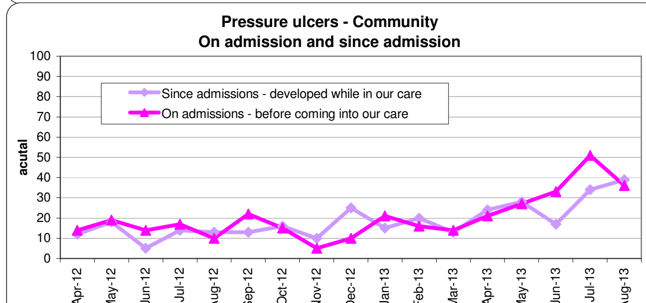


The problems previously identifed with the accuracy of incidents related to pressure ulcers reported on Datix have been resolved.

During August a total of 13 pressure ulcers were reported to have developed on patients in Scarborough Hospital.

These figures should be considered as approximations to allow for the coding time period.

Data Source: Datix

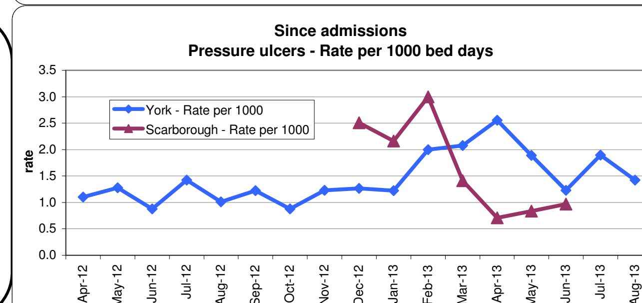


The problems previously identifed with the accuracy of incidents related to pressure ulcers reported on Datix have been resolved.

During August a total of 36 pressure ulcers were reported to have developed on patients in our community hospitals or community care.

These figures should be considered as approximations to allow for the coding time period.

Data Source: Datix

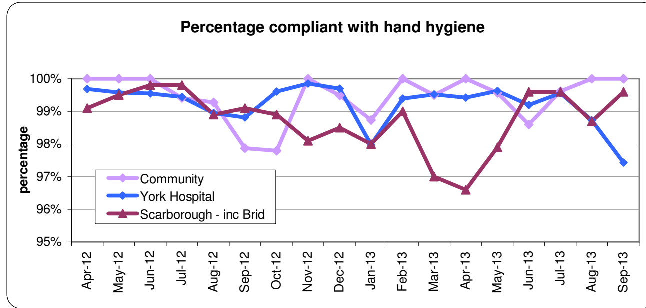


The rate of pressure ulcers development in York Hospital in August was 1.4/1000 bed days.

The calculation for patients in Sacrborough Hospital is outstanding.

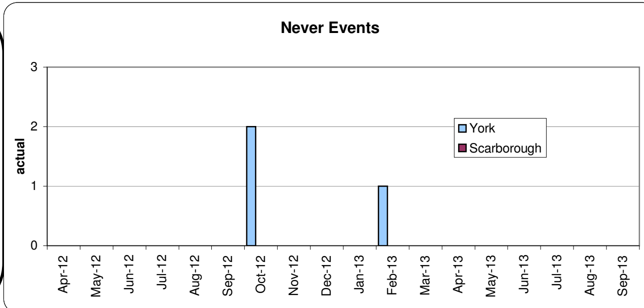
These figures should be considered as approximations to allow for the coding time period.

Data Source: Datix

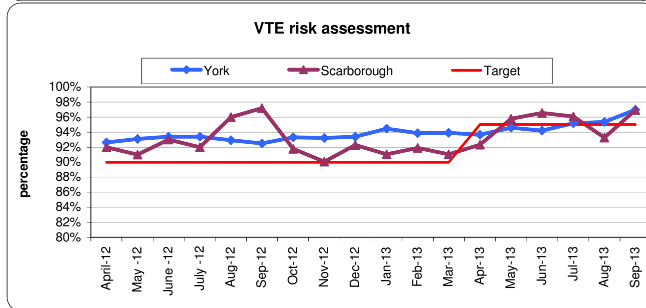


Hand hygiene compliance was recorded as 100% for all community sites during August. Scarborough figures which include Bridlington Hospital demonstrate a very slight reduction.
The importance of hand hygiene reamins high as we enter the season of Norovirus.

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

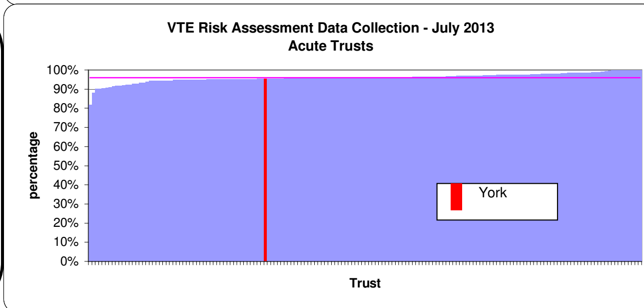


There have been no 'never events' reported since February 2013.



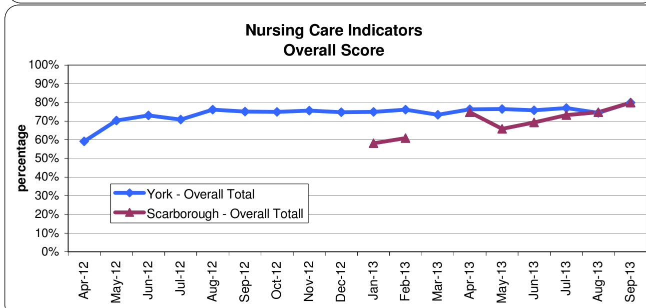
Target has been achieved above 95% with VTE risk assessment compliance rates. Aim to sustain compliance above 95%.

Data Source: Systems & Network Services

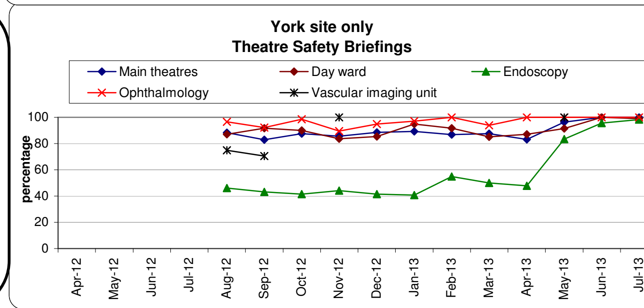


The Trus is currently 112th out of 164 acute trusts for compliance with VTE risk assessment.

Data Source: NHS England



The nursing care indicators are calculated from an audit of care from a sample of 5 patients per ward. Each ward is audited once a month. Scarborough March 2013 data is not available.
Both Scarborough and York hospitals have reported a compliance rate of 80% in September.
A breakdown of the scores for each indicator from April 2013 is provided in the table below.



Excellent rates of compliance with theatre safety briefings continues to be reported.

Data Source: Signal

York

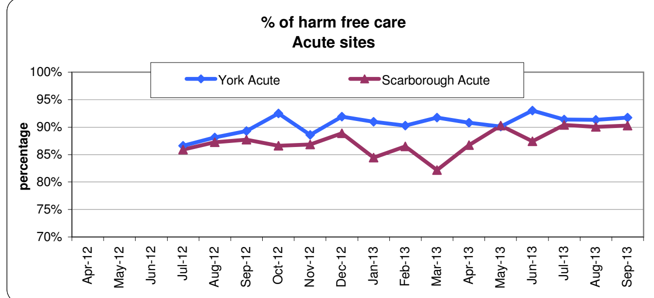
Average of Score	Date					
Criteria	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Combined Assessment Tool Demographics	95%	94%	97%	99%	97%	100%
Waterlow	75%	65%	59%	69%	66%	72%
Falls Assessment	71%	68%	72%	77%	73%	74%
Manual Handling	79%	76%	77%	79%	81%	81%
Nutritional Assessment	65%	71%	71%	67%	63%	73%
Comfort Round	69%	74%	78%	76%	76%	85%
Patient Questionnaire	97%	96%	98%	no data	80%	N/A
Critical Care	93%	91%	96%	100%	100%	95%
Overall Total	76%	77%	76%	77%	75%	80%

Scarborough

Average of Score	Date					
Criteria	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Combined Assessment Tool Demographics	90%	87%	87%	88%	92%	99%
Waterlow	70%	65%	60%	82%	70%	65%
Falls Assessment	77%	72%	71%	78%	78%	86%
Manual Handling	79%	78%	70%	77%	79%	87%
Nutritional Assessment	58%	42%	52%	55%	57%	65%
Prescription Documentation	86%	83%	82%	no data	no data	no data
Comfort Round	70%	67%	83%	84%	91%	89%
Critical Care	98%	N/A	N/A	N/A	N/A	N/A
Overall Total	75%	66%	69%	73%	75%	80%

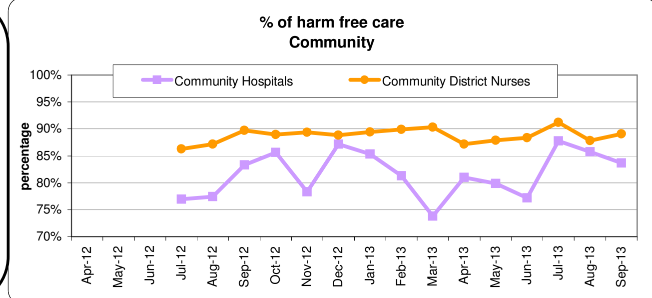
A breakdown of the indicators is provided in the Chief Nurse Report.

Safety Thermometer



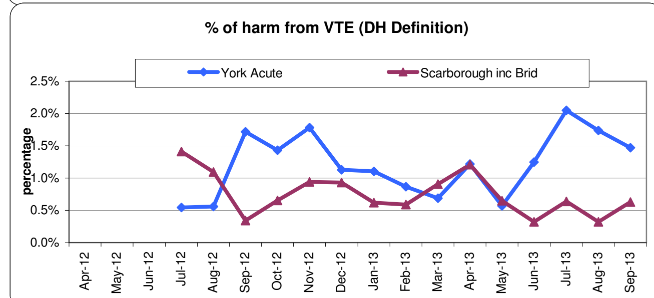
Percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE. Measured as a monthly prevalence score.

Data source: Safety Thermometer



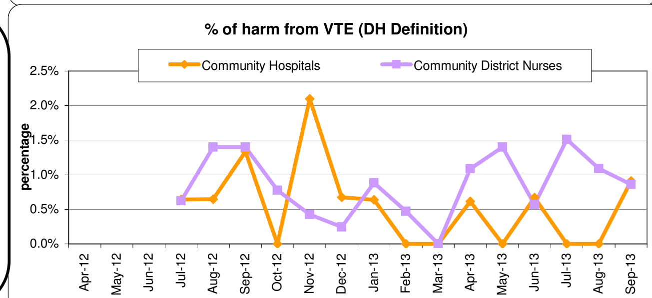
Percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE. Measured as a monthly prevalence score.

Data source: Safety Thermometer



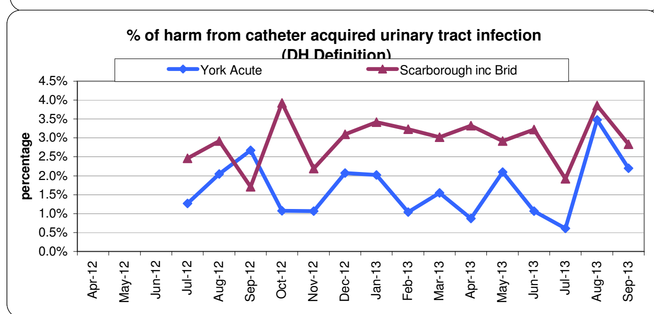
Percentage of patients affected by VTE as measured by the Department of Health (DH) definition, monthly measurement of prevalence.

Data source: Safety Thermometer



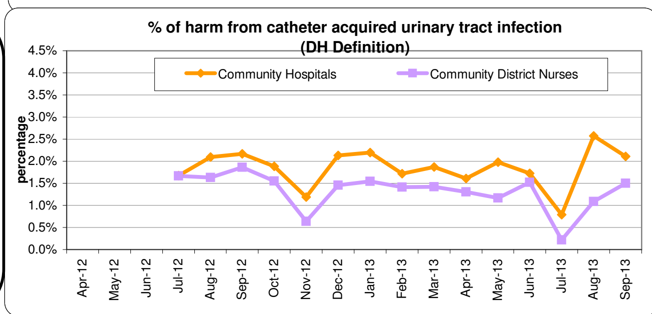
Percentage of patients affected by VTE as measured by the DH definition, monthly measurement of prevalence.

Data source: Safety Thermometer



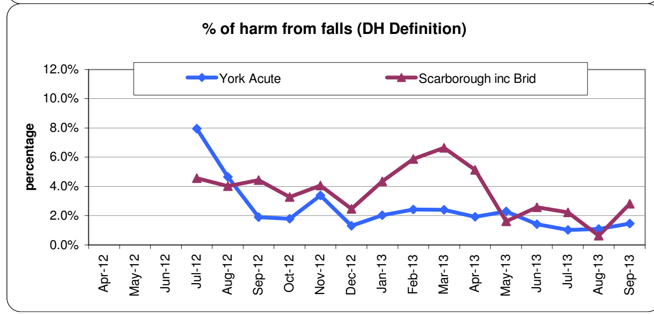
Percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence.

Data source: Safety Thermometer



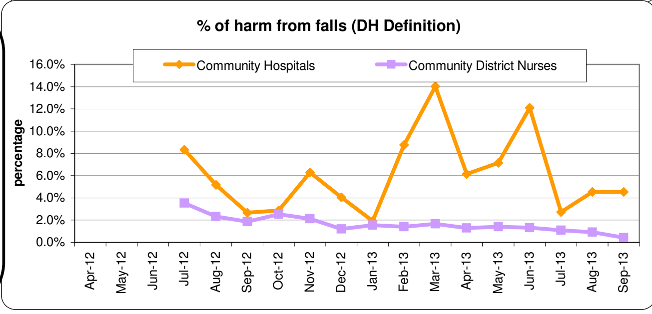
Percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence.

Data source: Safety Thermometer



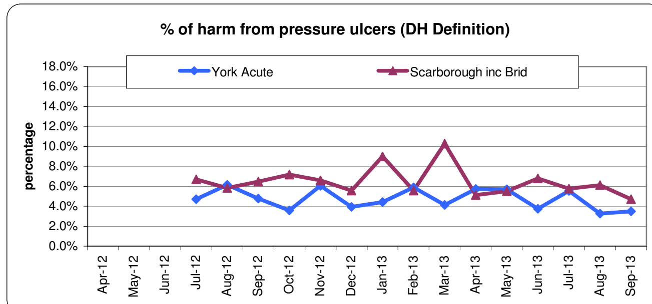
Percentage of patients affected by falls as measured by the Department of Health data definition, monthly measurement of prevalence.

Data source: Safety Thermometer



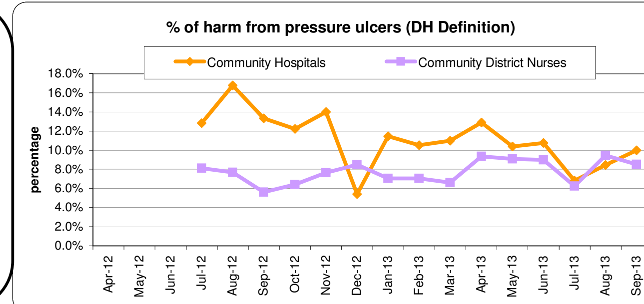
Percentage of patients affected by falls as measured by the Department of Health data definition, monthly measurement of prevalence.

Data source: Safety Thermometer



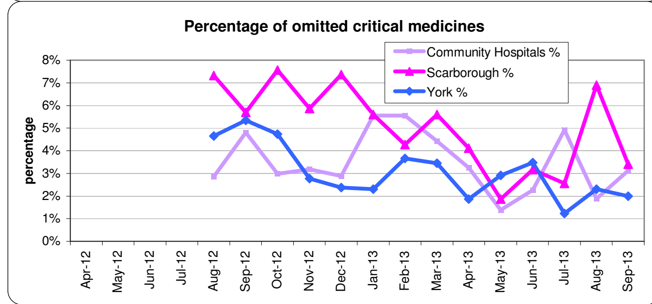
Percentage of patients affected by pressure ulcers as measured by the Department of Health data definition, monthly measurement of prevalence. Counts all ulcers old and new.

Data source: Safety Thermometer



Percentage of patients affected by pressure ulcers as measured by the Department of Health data definition, monthly measurement of prevalence. Counts all ulcers old and new.

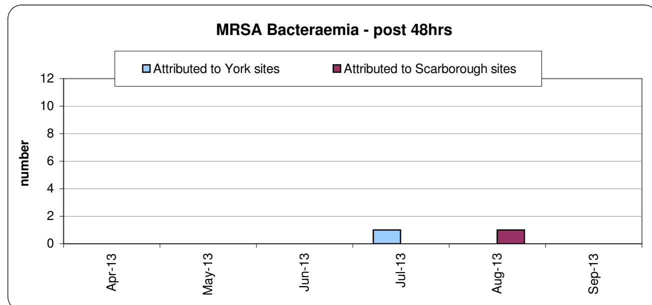
Data source: Safety Thermometer



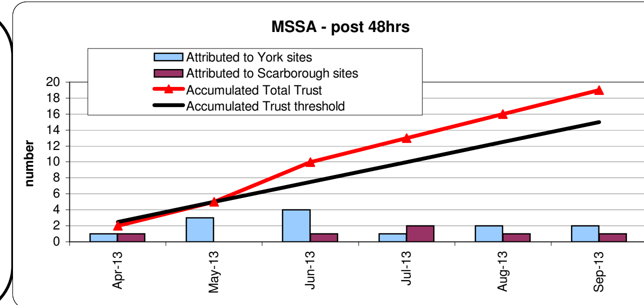
The Trust measures this additional indicator, for local reporting only.

Data source: Safety Thermometer

Infection Control

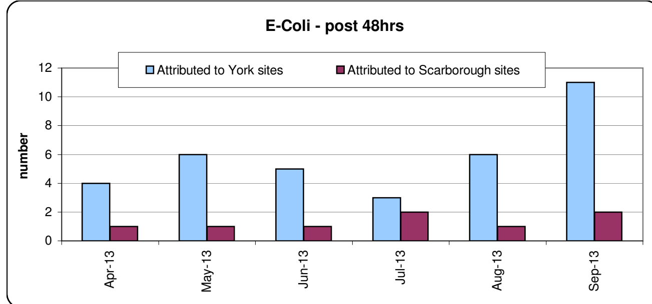


There were no patients in the Trust identifed with healthcare associated bacteraemia during September.

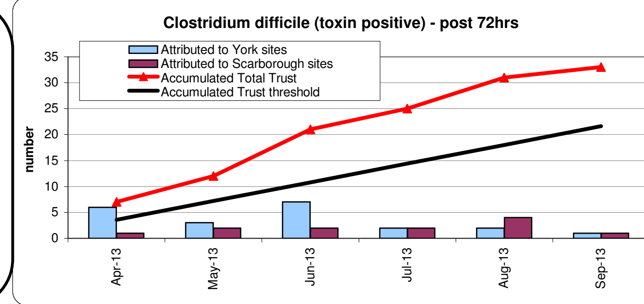


Three cases of MSSA were identifed in the Trust during September.

The Trust is beyond the local trajectory target by four cases for this time period.



No trajectory for this indicator. Most cases are usually UTI related. Annual IP Point Prevalence 2013 rate 1.8%. 2012 2%, 2011 4.1%



Two cases of c. diff were identifed in the Trust during September.

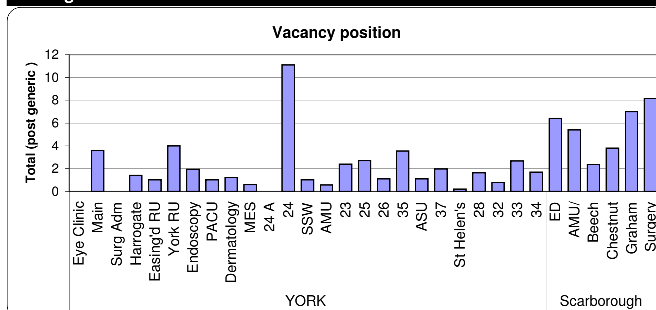
The Trust is beyond the trajectory for this time period by >11 cases, although there has been a significant reduction in c. diff cases in the last three months.

RCA shows inappropriate antimicrobial use a recurring theme in terms of type and duration.

DIPC QUARTERLY INFECTION PREVENTION REPORT FOR TRUST BOARD. Q2 2013

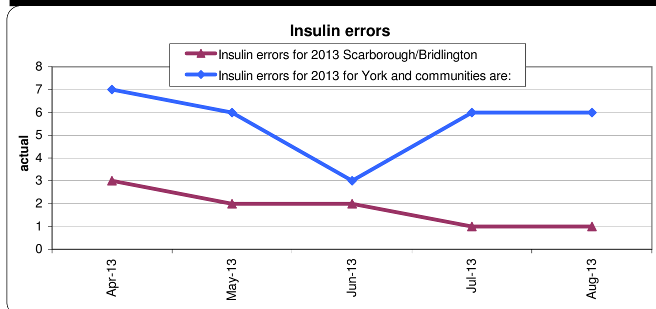
Parameter		Annual threshold/ target	Q1	July	Aug	Sept	Q3	Q4	YTD	Q2 TREND	COMMENTS
MRSA Bacteraemia attributable to Trust	York sites		0	1	0	0			1		
	Scarborough sites		0	0	1	0			1		
	Trust	0	0	1	1	0			2		
MSSA Bacteraemia attributable to Trust	York sites		8	1	2	2			13		
	Scarborough sites		2	2	1	1			6		
	Trust	30	10	3	3	3			19		
E Coli Bacteraemia attributable to Trust	York sites		14	3	6	11			34		
	Scarborough sites		3	2	1	2			8		
	Trust	Not set	17	5	7	13			42		
Clostridium difficile Associated Diarrhoea attributable to Trust	York sites	26	16	2	2	1			21		
	Scarborough sites	17	5	2	4	1			12		
	Trust	43	21	4	6	2			33		
CDI per 100000 bed days attributable to Trust	York sites		26.44	10.37	9.71	4.71			17.26		
	Scarborough sites		17.14	20.57	42.39	9.9			20.53		
	Trust		23.41	13.79	19.97	6.38			18.32		
Elective MRSA admission screening	York sites	100%	90%	Not available	Not available	Not available			90%		
	Scarborough sites	100%	89%	90%	Not available	Not available			90%		
	Trust	100%	90%	90%	Not available	Not available			90%		
Emergency MRSA admission screening	York sites	100%	79%	Not available	Not available	Not available			79%		
	Scarborough sites	100%	93%	93%	Not available	Not available			93%		
	Trust	100%	86%	93%	Not available	Not available			90%		
Antimicrobial pathway compliance	York sites		Not available								
	Scarborough sites		Not available								
	Trust		Not available								
Ventilator acquired pneumonia	York sites		0	0	2	0			2		
	Scarborough sites		1	0	0	0			1		
	Trust		1	0	2	0			3		
CVC associated infections in ICU	York sites		1	0	0	0			1		
	Scarborough sites		0	Data not available					0		
	Trust		1	0	0	0			1		
Trust attributed CAUTI (Safety Thermometer data)	York sites		9	3	4	2			18		
	Scarborough sites		9	0	2	0			11		
	Trust		18	3	7	2			30		
VIP score for peripheral cannula	York sites		Not available								
	Scarborough sites		Not available								
	Trust		Not available								
Hand hygiene compliance	York sites	100%	100%	100%	99%	100%			100%		
	Scarborough sites	100%	98%	100%	98%	100%			99%		
	Trust	100%	99%	100%	99%	100%			100%		

Staffing



The 'vacancy position' illustrates the number of Band 5 registered nurse vacancies on the acute hospital sites. There is currently a strong focus on reducing the number of Band 5 vacancies. The number of vacancies has been largely influenced by the establishment review and recent investment. Due to a large attrition rate from the July and early September recruitment rounds, processes have been streamlined even further to enable job offers to be made in a more timely fashion. There are additional supported recruitment rounds taking place on both the Scarborough and York sites on the 10th and 16th October respectively and 'one stop' recruitment shops will be held on both sites on the 26th October.

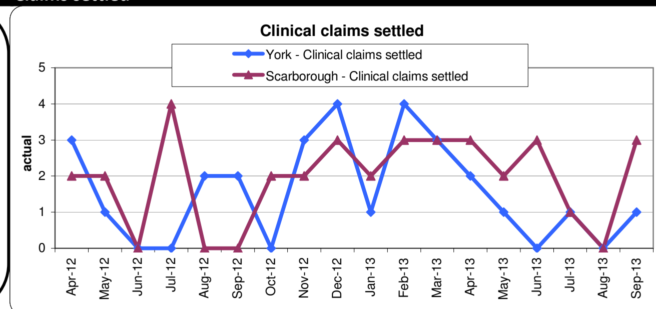
Insulin errors



Medication errors involving insulin that have been reported on Datix.

Data Source: Datix

Claims settled



Four litigation claims were settled during September.

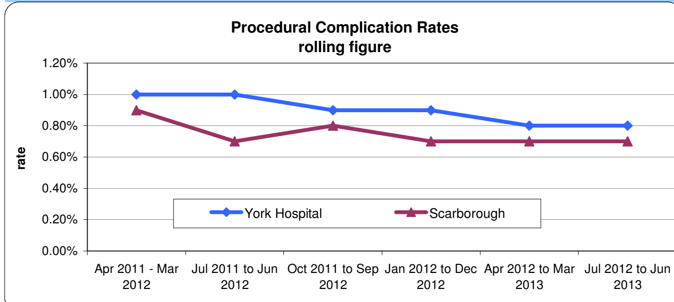
Data Source: Risk and Legal Services

Patient Safety Walkrounds

Date	Location	Participants	Actions & Recommendations
3rd September 2013	Endoscopy/ CCU/ Cardio Respiratory Unit (Scarborough)	Mike Proctor Dr Humphriss Chris Whilde Tracey Wright Diane Willcocks	**Endoscopy** • Issues discussed third endoscopy room, single sex accommodation, acute inpatients and general running of the department. • Requirement for a third sink in the cleaning room. CW to get costs and action appropriately • Doors to department been damaged by trolleys, CW to check for potential solution following advice from fire officer. **CCU** • Hoover not working. CW to check with facilities about a replacement. • Assessment room being used as a bed. CW to review. • Carpets in clinical areas. Think this is planned to be removed but not happened yet. CW to check with infection control on policy and facilities with timescale for removal. • Curtains in 4 bedded area not large enough. Sr B to look into getting replacements. **CRU** • Privacy and dignity • Lack of storage space • Only one sink • Wheelchair access to toilet • Carpet in secretaries office. CW and Jan Tebb to source new carpet/flooring
13th September 2013	Stroke Unit (Scarborough)	Diane Palmer Chris Whilde Ed Jones Emma Day Marian Simpson Jennie Adams	• The number of incidents being reported has over the last 12 months has reduced. • The ward does have a number of patients who are at risk of falling. From time to time they have to nurse patients on a mattress on the floor due to the limited availability of ultra-low profile beds. • The Senior Sisters have to undertake a significant amount of admin work. • Some but not all medical staff are providing cross-cover over the York and Scarborough site. • The fire exit corridor at the end of the ward is partially blocked with items which are being stored from the laboratory. • The lock on the door at the end of the ward can easily be opened.
23rd September 2013	Ward 16/ Breast Clinic (Stoma Nurses/ Urology Specialist Nurses) (York)	Sue Holden Glenn Miller Helen Franks Katie Holgate Michael Sweet Tracey Ward	• **Awaiting actions/ recommendations** • some areas of the ward do not have wifi which leads to a delay in recording observations and a delay in accessing results during ward rounds • failure to risk assess and use appropriate mattresses in PACU has been attributed to development of pressure ulcers • where there are escalation beds in use the bays seem cluttered with wires and equipment, and when bariatric equipment is in use moving around the bed space is particularly difficult • The ward is often used as a thoroughfare to Ward 14.

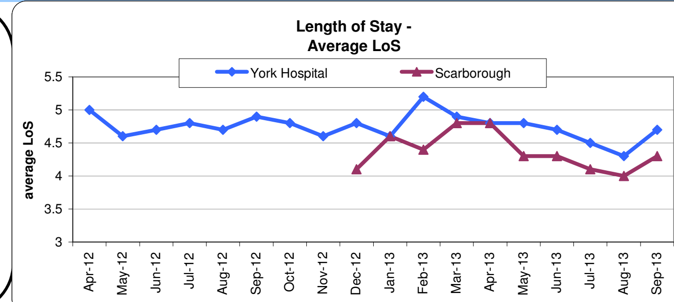
Clinical Effectiveness Dashboard

Clinical Effectiveness



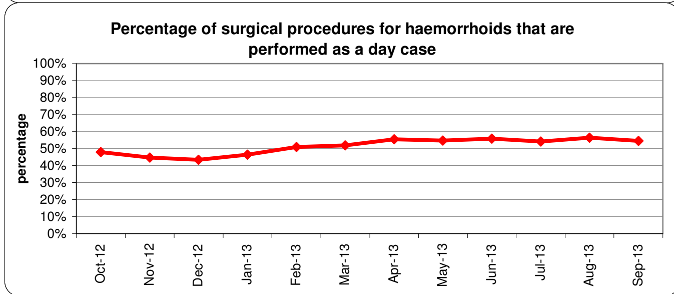
Complication rates related to specific clinical procedures have remained steady in the last reporting period. The procedures may be within the current spell of care or in a preceding period of up to six months.

Data source: CHKS



The Length of Stay (LOS) for in-patients (excluding day cases and babies), indicates a slight rise in September.

Data source: CHKS



The Trust is an outlier on the number of surgical procedures for haemorrhoids that are performed as a day case.

Data source: Health and Social Care Information Centre. Data rolling one year period, six months in arrears.

Corporate Risk Register (Quality and Safety issues)

September 2013

- No new risks have been added to the register this quarter.

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
Exceeding trajectories for C. diff	15	Feb-11
Secondary care patients at risk of sub-optimal care due to lack of psychiatry liaison.	12	Jan-06
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	5	Sep-07
Risk to compliance with Children's safeguarding standards due to levels of staff trained at levels 2 and 3	6	Sep-12

Revalidation Update

Background

Revalidation for all GMC licensed doctors commenced in December 2012, starting with Responsible Officers, clinical directors and senior consultants.

Doctors are required to undertake annual appraisals with a trained 'Enhanced' appraiser, and undertake a 360 / MSO review, including colleague and patient feedback.

Up until the end of September 2013, the Responsible Officer has made:

o Total recommendations: 68

o Positive recommendations: 66

o Deferrals: 2

o Non-engagements: 0.

Maternity Dashboard - York and Scarborough

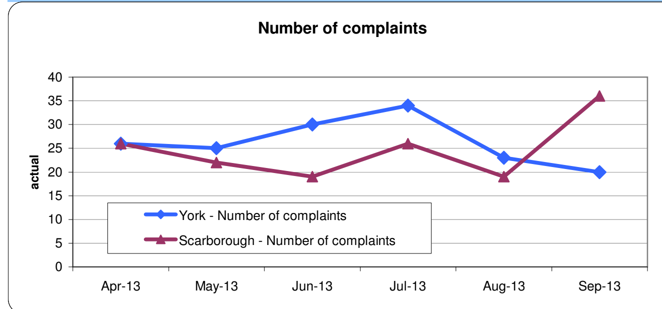
		Measure	Data source	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	Flag Source	April	May	June	July	August	Sept	Av. Monthly YtD	Action Log completed (Date)	Notes
	Births York	No. of babies	CMIS	=295	296-309	=310	prev. stats	295	274	241	299	282		279		
	Birth Scarborough							121	147	108	140	154	135	134		
	Homebirth rate York		Com Manager													
	Hom birth rate Scarborough															
Staffing	M/W per 1000 births York	Ratio	Matron	=35.0	34.9-31.1	=31.0	DH	29.5	30.0	30.5	30.5	30.1		30.0		
	M/W per 1000 births Scarborough									44.0	44.0	44.0	44.0	44.0		
	C/S Deliveries York	Em & elect	CMIS	=24%	24.1-25.9	=26%	prev. stats	25.4	31.4	25.3	21.1	24.8		25.6		
	C/S Deliveries Scarborough							19.8	19.0	17.6	17.9	16.2	20.0	20.2		
Risk Management	SI's York	Total	Risk Team	0	1	2 or more		0	0	0	1	0	0	0		
	SI's Scarborough							0	0	0	0	0	0	0		
	PPH >2L York	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		2	0	2	2	5		2		
	PPH >2L Scarborough							2	0	0	0	0	1	1		
	3rd/4th Degree Tear York	% of tears (vaginal births)	CMIS	=1.5%	1.6-6.1%	=6.2%	RCOG	8.2	4.8	6.1	5.9	4.2		5.3	February 2013	April 2013 - range of goals reviewed & updated following publication of RCOG HES data
	3rd/4th Degree Tear Scarborough							0.8	2.1	0.9	1.4	2.6	0.0	1.5		

Performance Schedule 2013/14 - CQUIN

Goal Name	Description of Goal	Outcome Q1
IOFM technologies	tbc requested from CA	
International & commercial activity - exploiting commercial intellectual property	tbc requested from CA	
Carers for people with Dementia - signposting	tbc requested from CA	
Friends & Family Test - Phased Expansion	Delivery of Friends and Family rollout for maternity services	
Friends & Family Test - Increased Response Rate	Improve patient experience. F&FT will provide timely, granular feedback from patients about their experience.	
Friends & Family Test - Improved Performance staff survey	annually - Feb14	
NHS Safety Thermometer - Improvement	The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the Safety Thermometer on the day of each monthly survey for York Hospital and Scarborough Hospital	
NHS Safety Thermometer - Improvement	The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the Safety Thermometer on the day of each monthly survey for Community Services	
Dementia - Find	patients >75 admitted as an emergency who are reported as having: known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question	
Dementia - Assess	Number of above patients reported as having had a diagnosis assessment including investigations	
Dementia - Refer	Number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners	
Dementia - Clinical Leadership	annual - Mar13 & mar14	
Dementia - Supporting Carers	Provider must demonstrate that they have undertaken a monthly audit of carers of people with dementia at both York and Scarborough Hospitals to test whether they feel supported and report the results to the Board. Provider and commissioner should work together to agree the content of the audit.	
VTE - Risk Assessment	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool	
VTE - Root Cause Analysis	The number of root cause analyses carried out on cases of hospital associated thrombosis	
Care of the Deteriorating Patient - AMU Admissions	Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions	
Care of the Deteriorating Patient - AMU Admissions	Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions	
Care of the Deteriorating Patient - AMU Admissions	Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions	
Care of the Deteriorating Patient - AMU Admissions	Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions	
Care of the Deteriorating Patient - AMU Admissions	Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions	
Care of the Deteriorating Patient - Identification, Response & Management	Timeliness of vital signs recording, response and the management of all Deteriorating Patients across acute sites.	
Care of the Deteriorating Patient - NEWS & PAWS	Full implementation of NEWS and PAWS across York and Scarborough Hospitals by Q4, excludes paediatrics, SCBU, obstetrics, ICU/HDU and Day Cases	
LOS in Elderly Medicine Bed Base	Reduce the average Length of Stay on Elderly Medicine Bed Base at York Teaching Hospital NHS Foundation Trust	
LOS in Elderly Medicine Bed Base	Reduce the average Length of Stay on Elderly Medicine Bed Base at York Teaching Hospital NHS Foundation Trust	
LOS in Elderly Medicine Bed Base	Reduce the average Length of Stay on Elderly Medicine Bed Base at York Teaching Hospital NHS Foundation Trust	
Effective Discharge - Nursing Risk Assessments	To make details of nursing assessments for nutrition, falls and pressure sores available to NCTs	
Respiratory - Asthma	Identify and audit 50 consecutive attendances diagnosed as asthma during the previous quarter at least 20 to be aged 19 or over.	
Stroke - Level 2 Accreditation	Six monthly - demonstrate milestones met	
Haem - joint score physio assessment	Quarterly	
Haem		
Neonate		
Renal		
Cystic Fibrosis		

Patient Experience Dashboard

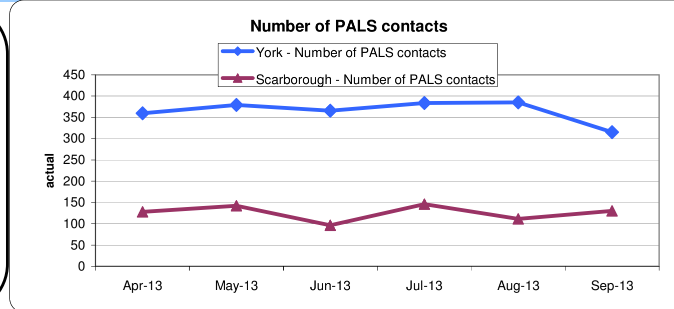
Patient Experience



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

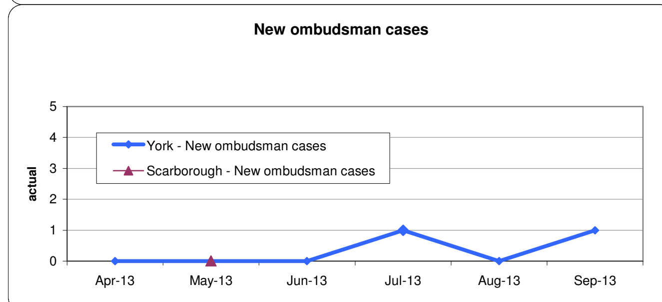
Complaints registered in Scarborough relate to Scarborough Hospital and Bridlington Hospital.

There has been an increase in the number of complaints received from Scarborough.



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

The number of PALS contacts is September was 355 for the York area and 130 for the Scarborough area.

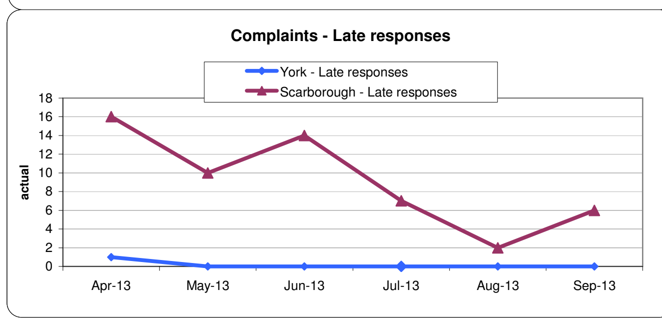


In York during 2012/2013, six cases were referred to the HSO, this represents 1.9% of the total number ofcomplaints received. Since April 2013, there have been two cases refered to the HSO.

In Scarborough during 2012/2013, nine cases were referred to the HSO, this represents 3.1% of the total number of complaints received. Since April 2013, no cases have been refered to the HSO.

Complaints by subject	York: Sept 13
All aspects of clinical treatment	14
Attitude of staff	4
Admissions, discharge and transfer arrangements	1
Patients' privacy and dignity	1

The majority of complaints for all sites related to aspects of clinical treatment.



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 extebded deadline is not met

The number of late responses to complaints in Scarborough has decreased over the last three months.

Complaints by directorate	York: Sept 13
Theatres Anaesthetics and Critical Care	1
Community Services (Malton Hospital)	1
Emergency Medicine	3
Elderly Medicine	2
Head & Neck	1
Specialist Medicine	3
Medicine (General & Acute)	2
Obstetrics and Gynaecology	4
Orthopaedics & Trauma	1
General Surgery & Urology	2

Friends & Family Test Results

01 Aug 2013 - 31 Aug 2013

Highest score
Lowest score
Negative score

Top 3 most improved wards this month

Ward	6 Month Average	This Month	Improvement	Trend
A&E Scarborough	27	53	26	
Johnson	50	72	22	
Ward 26	29	50	21	

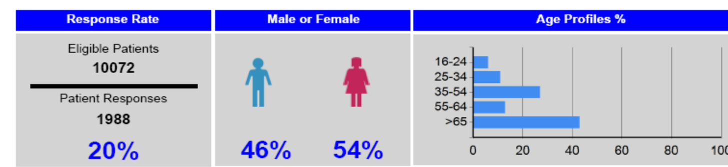
Top 5 consistently high performing wards

Ward	6 Month Average	This Month	Improvement	Trend
CCU York	100	100	0	
ITU	100	100	0	
Labour Ward - Scarbough	100	100	0	
Selby Community Team - postnatal	100	100	0	
Ash	94	98	4	

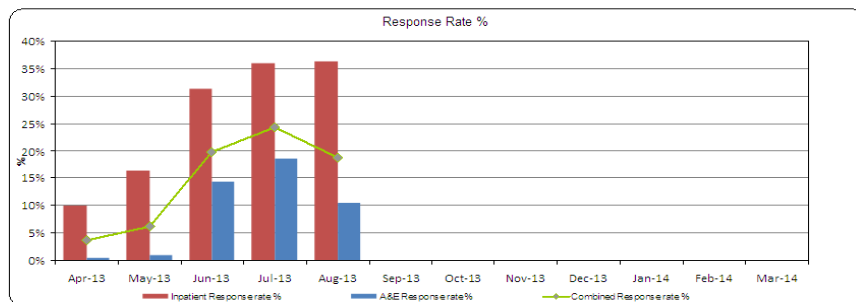
Top 5 consistently low performing wards

Ward	6 Month Average	This Month	Improvement	Trend
Whitby Community Team - antenatal	0	0	0	
Ward 37	25	0	-25	
A&E Scarborough	27	53	26	
Ward 26	29	50	21	
Selby Community Team - antenatal	45	45	0	

Who responded?



Friends and Family Test
The Friends and Family Test (FFT) continues to be 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”.



Response Rate - Inpatients - All Sites			
Month	No. Eligible	No. of responses	Inpatient Response rate %
Apr-13	3,420	344	10.06%
May-13	3,417	559	16.36%
Jun-13	3,245	1,013	31.22%
Jul-13	3,447	1,243	36.06%
Aug-13	3,189	1,160	36.38%
Sep-13			
Oct-13			
Nov-13			
Dec-13			
Jan-14			
Feb-14			
Mar-14			

Response Rate - A&E Patients - All sites			
Month	No. Eligible	No. of responses	A&E Response rate %
Apr-13	6,887	30	0.44%
May-13	6,658	64	0.96%
Jun-13	6,742	965	14.31%
Jul-13	7,086	1,317	18.59%
Aug-13	6,883	727	10.56%
Sep-13			
Oct-13			
Nov-13			
Dec-13			
Jan-14			
Feb-14			
Mar-14			

Response Rate - Combined			
Month	No. Eligible	No. of responses	Combined Response rate %
Apr-13	10,307	374	3.63%
May-13	10,075	623	6.18%
Jun-13	9,987	1,978	19.81%
Jul-13	10,533	2,560	24.30%
Aug-13	10,072	1,887	18.74%
Sep-13			
Oct-13			
Nov-13			
Dec-13			
Jan-14			
Feb-14			
Mar-14			

Figures in relation to Maternity are not included in the results above as the national roll-out commences in October 2013. The Trust commenced its implementation in August 2013. Official figures are not available at the time of reporting, but returns indicate a response rate that will achieve the required response rate.

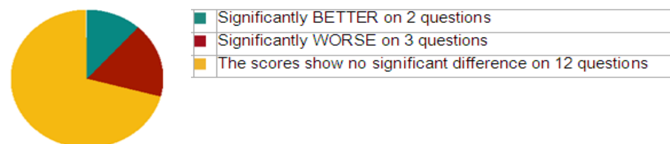
The results for September 2013 are not available until mid September but our number of returns for the Emergency Departments has decreased during September which will result in the overall response rate being lower than August. As a Trust we must reach a minimum response rate of 20% throughout Quarter 4.

A token collection system is currently being procured for both Emergency Departments and will be available from the supplier mid October*. A number of Governors attended a briefing session on the Friends and Family Test and will now support the initiative in the York Emergency Department. Two Governors are supporting FFT at the Scarborough Emergency Department. Volunteers are also being recruited.
* (subject to invoice payment)

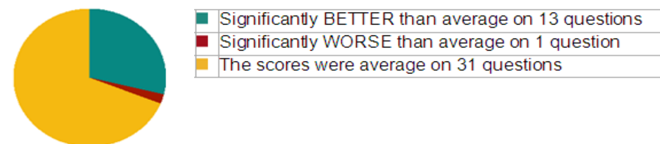
Maternity Survey 2013

The results of the national maternity survey 2013 were received by the Trust in September 2013. As yet the CQC reports have not been realised. The Maternity Survey was carried out by the Picker Institute on behalf of York Teaching Hospital NHS Foundation Trust. This is a joint report which covers both Scarborough and York Hospitals and compares the findings from the last survey in 2010 to the results from York Hospital. The results will be presented back to the Directorate teams by Picker over the next 4-6 weeks and key priorities identified and taken forward.
Our results at a glance

Have we improved since the last survey?
A total of 17 questions were used in both the 2010 and 2013



Compared to the 2010 survey, your Trust is:



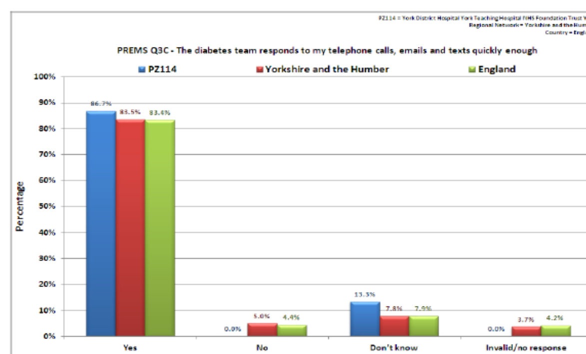
Individualised PDU PREMS Report

The National Paediatric Diabetes Audit (NPDA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP), and managed by the Royal College of Paediatrics and Child Health (RCPCH) since April 2011. A Patient and Parent Reported Experience Measure (PREM) enables the experience of children and young people with diabetes and carers to be captured, analysed and acted upon resulting in a greater understanding of how they perceive the service and, most importantly, help identify necessary service improvements.
This is the first PREM for diabetes services across England and Wales reported by the NPDA.
The report analyses the responses on each of the PREM questions for 2012-13 for PZ114 - York District Hospital York Teaching Hospital NHS Foundation Trust Y&H (Number of participants for your PDU is 30).
Results are displayed on an individual Paediatric Diabetes Unit (PDU) level. The aggregate respective figures from all other PDUs in your Regional Network and for the whole of England and Wales and are provided for comparison.

PREMS Q7 - On a 0 to 10 scale, how likely is it that you would recommend this clinic to a friend or another family with a child who has diabetes? (0 being not at all likely and 10 being extremely likely)

Percentage	PZ114	Yorkshire and the Humber	England
0	0.0%	0.4%	0.3%
1	0.0%	0.2%	0.2%
2	0.0%	0.2%	0.3%
3	0.0%	0.5%	0.5%
4	0.0%	0.6%	0.7%
5	0.0%	2.6%	2.6%
6	0.0%	2.3%	2.1%
7	3.3%	4.0%	5.2%
8	3.3%	12.3%	12.8%
9	16.7%	16.3%	18.1%
10	73.3%	58.2%	55.2%
Invalid/no response	3.3%	2.3%	2.0%
Mean	9.65	9.07	9.02

A score of 9 or 10 (green) indicates a high level of satisfaction.
A score of 5-8 (amber) indicates a medium level of satisfaction that requires attention.
A score of <5 (red) indicates a poor level of satisfaction and is cause for concern.



Overall this is an excellent result with strong patient endorsement.

Beverage rounds

A trial looking at the possible benefits of a ward based Catering Service Operative providing patient food and beverage services is being trialled on Ward 23. The existing service involves catering staff being present on the ward at meal times only. Beverage rounds are provided by health care assistants and water jugs replenished by the domestic services team. The pilot is looking at the impact on the patients' experience of increasing the time that the catering service operative is on the ward. Early feedback from patients is very positive

Love the sandwich round
Excellent Service
Love it

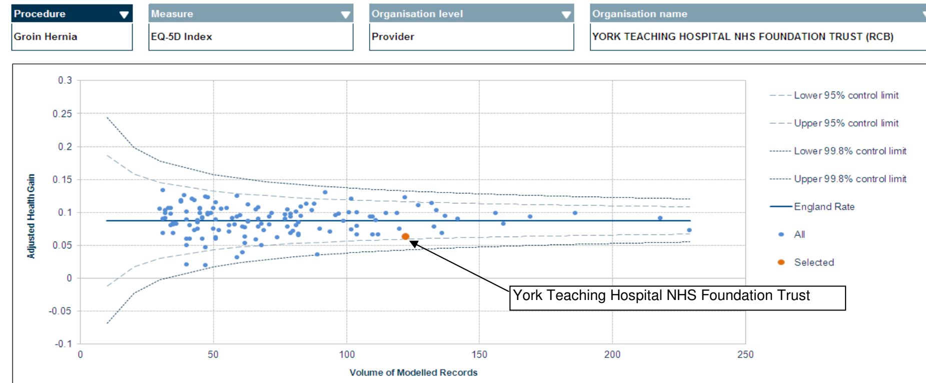
Feedback from nursing staff is positive . Staff have more time to help patients – the pilot has released time for nursing staff

Early feedback from the Catering Service Operatives is also very positive focussing on improved job satisfaction, and what they like most about this new aspect of their role.
The service operatives on ward 23 say the new role has improved their job satisfaction they really enjoy communicating and spending time with the patients, being able to understand their nutritional requirements and being able to deliver these on a regular basis, offering patients snacks and drinks, throughout the day. The Catering Service Operatives involved can really see the contribution they are able to make to improving the patients' experience.
This initiative meets with our Trust Values

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

PROMS

PROMs - Adjusted scores funnel plot
April 2012 to March 2013 (published 14th August 2013)



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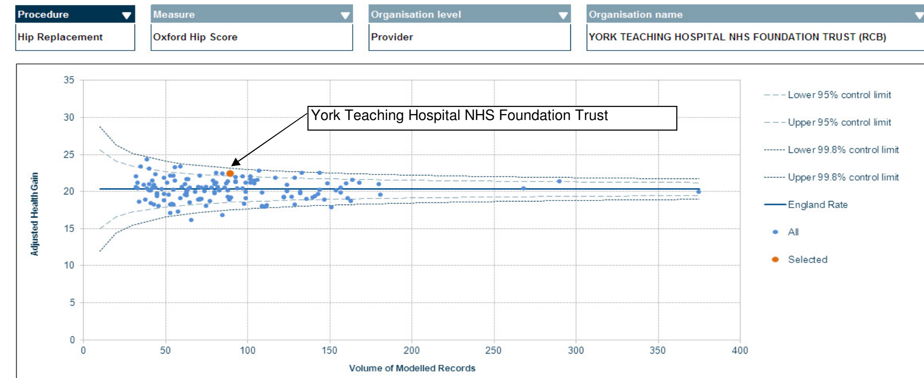

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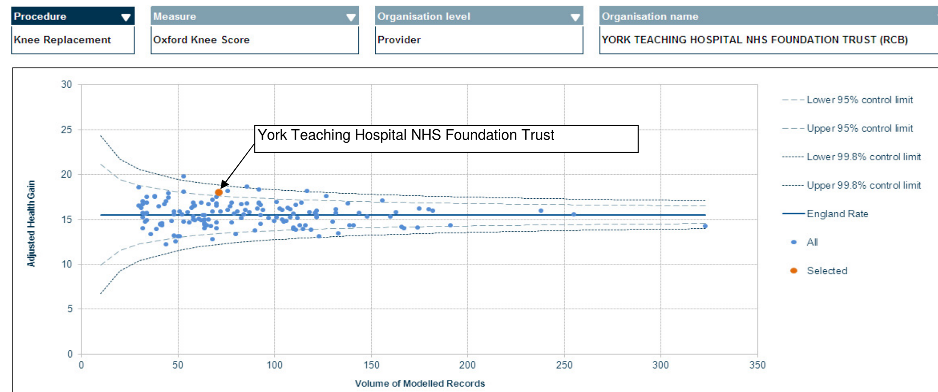

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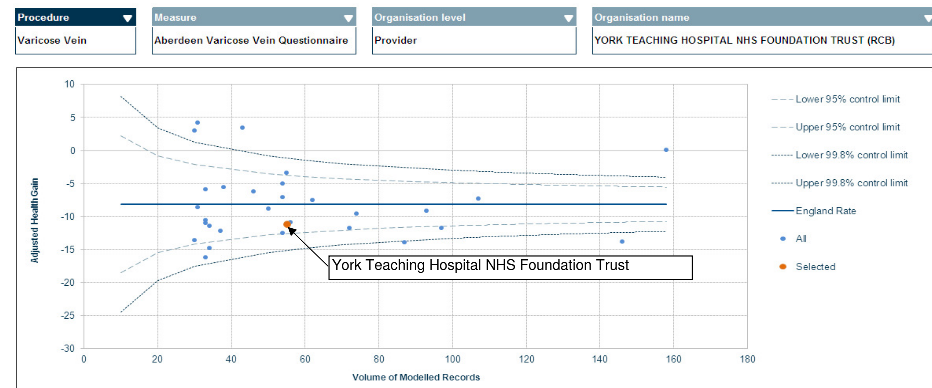


D2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 October 2013

Medical Director's 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

No implications for equality and diversity.

Reference to CQC outcomes

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

Progress of report	This report is only written for the Board of Directors.
Risk	No additional risks indicated other than those reported on the 'Risk Register' item.
Resource implications	None identified
Owner	Dr Alastair Turnbull, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	23rd October 2013
Version number	1

Board of Directors – 30 October 2013

Medical Director's Report

1. Introduction

In the report this month:

1. Surgical Outcomes
2. Stroke Accreditation
3. Influenza
4. Consultant appointments

2. Surgical Outcomes

The remaining three of ten specialist surgical societies have published outcomes data for individual hospital consultants, including mortality rates, in September. These are:

- upper gastrointestinal cancer surgery
- head and neck cancer surgery
- bowel cancer surgery.

This completes the staged 'pilot' publication of this data that started in June this year.
It is part of NHS England's drive for greater transparency and a commitment to providing patients with more information about their treatment to help the NHS drive up quality of care.

Along with previous reports, this information will be signposted from the NHS Choices website: www.nhs.uk/consultantdata/.

The data sets show the number of times a consultant has carried out a procedure, mortality rates and whether clinical outcomes for each consultant are within expected limits.
Dr Mike Bewick, Deputy Medical Director at NHS England, said: "This has been the start of a major journey towards complete transparency in the NHS.

"Putting information like this into the public domain increases accountability and empowers commissioners to make more informed decisions about the services they buy for their communities.
"Most importantly it drives up quality and standards of care for patients.

"The overall results show that mortality rates for almost all surgeons are within the expected range. But in the majority of cases the key issue is, how will an operation or procedure improve the quality of a patient's life.

"This is part of a journey towards a culture of complete transparency in the NHS and we need to build on what we have started. As part of this, working with HQIP, we are asking for public feedback on the data and we will be working with patient groups and the specialist societies to inform how we can ensure the data that we publish in the future is as easy to understand as possible for patients and the public.

"I would like to thank surgeons and the surgical specialties who have published these reports for the way they have embraced this important piece of work."

The data will be refreshed annually and reporting of data in this way will be mandatory from 2014/15. Over time, it is expected that the data will include more clinical specialties.

3. Stroke Accreditation

Stroke Accreditation – Scarborough
Pre-visit meeting – 23 September 2013

Summary of progress against six key areas for improvement:

1. Medical Staffing

Feedback from August 2012:

Current staffing levels are inadequate for the stroke workload. 300 stroke admissions per year require a minimum of 16 DCC per week .The sustainability of the current service is in doubt with difficulty in recruiting to new/replacement posts. A daily dedicated in-hours consultant rota for stroke needs to be developed as soon as possible, utilising all of the consultant resources available. A separate out of hours rota including thrombolysis should also be developed with partner organisations. Solutions need to be explored for full 7 day cover for stroke and TIA. This could include acute physicians, telemedicine and stroke specialist nurses.

What have we progressed since?

- Appointed Dr Christos Dimopoulos to a substantive Stroke physician post at Scarborough hospital in July 2013.
- Gained approval to recruit to 1 year supernumerary training programme for Dr El-Nour to gain specialist registration as part of succession planning for Dr John Paterson.

What are we planning to do in next 2 months?

- Gained agreement from the accreditors that they support telemedicine ward rounds.
- Determine resource requirements and rota for 24/7 lysis and agree timetable.
- Determine what additional support to the rota can be provided by successful recent neurology recruitment.
- Confirm contribution from Dr Paterson/Dr Dimopoulos to on-call rota (weekday and weekend).
- Gain agreement from participants in current York rota on providing telemedicine cover and move to new rota frequency (by end October).
- Ensure required technology in place (TBC).
- Agree start date for weekend ward round (TBC).

What are we planning to do beyond the Peer review visit?

- Appoint Dr El-Nour to 1 year supernumerary training programme.

What evidence will be provided in November?

- 24/7 day rota timetable - Identification of lead clinician with specialist stroke training to enable thrombolysis & hyperacute treatment decisions to be made 24/7.
- 7 day ward round timetable.
- Breakdown of DCC sessions available on the Scarborough site.

2. Staffing

Feedback from August 2012:

The business case has identified appropriate staffing levels for the service. The most essential component of this is the band 6 nursing staff sufficient to cover 24/7 (this will ensure that the consultant workload can be optimised and that stroke patients will get timely and appropriate care). Therapy levels should also achieve those identified in the business case (plus adequate speech and language therapy). With appropriate efficiencies elsewhere in the pathway, there will be no need to staff up to 16 beds.

What have we progressed since?

- Financial approval to appoint 5.0 wte Band 6 Stroke nurse specialists (providing a 24/7 Band 6 presence) and 5.1wte Band 5 Staff nurses to Acute stroke unit.
- Business case for Stroke accreditation (also approved in May 2013) to increase 1.7 wte Physio, 2.2 wte OT and 0.5 wte SALT for Acute Stroke unit at Scarborough.
- Staff appointed via recruitment in July-September has led to the following cover for PT and OT for the acute site:
    - Physio- 1WTExB6, 1WTExB5
    - OT- 1WTExB6, 0.5WTExB5
    - Generic Therapy Support workers 2.5WTExB3.
- SALT –0.4 wte at Scarborough and 0.5wte at Bridlington.
- Psychology support – Have a 0.6wte Stroke support nurse working on ASU and in community for psychological support for all stroke patients. The post holder receives regular supervision from a clinical psychologist. This has almost eradicated referrals to the clinical psychology service.
- There is no dedicated Social worker for the Stroke unit so Section 2 referrals are made to the Social worker team and in complex cases a social worker attends the weekly MDT.

What are we planning to do in next 2 months?

- Start dates of nursing staff in two phases – 30 September and 21 October.
- The therapy recruitment will facilitate full therapy services from October 2013.
- Clarify Dietetic staffing.

What are we planning to do beyond the Peer Review visit?

- Develop the roles of Stroke nurse specialists to provide a supporting role to the Stroke physicians and provide a catalyst to improve performance against all key stroke quality markers.

What evidence will be provided in November?

- Nurse staffing rotas
- Clarification of staffing levels across all disciplines.

3. In house stroke pathway

Feedback August 2012:

This is currently inequitable. All patients should be admitted to HASU whether or not they need thrombolysis and we recommend that 2/3 directly monitored HASU beds are implemented on the stroke unit. Responsibility for decision making and the safe delivery of thrombolysis should be vested with a person who has appropriate training skills and experience, demonstrable at annual appraisal etc.

What have we progressed since?

- The financial approval to appoint additional nursing staff has ensured a 3 bed hyper acute stroke bay can delivered within the Acute stroke unit at Scarborough. 5.0 wte Band 6 Stroke nurse specialists (providing a 24/7 Band 6 presence) and 5.1wte Band 5 Staff nurses from 11 November 2013.
- Installation of bed side monitoring equipment to enable close monitoring.

What are we planning to do in next 2 months?

TIA provision

- Agree weekend TIA provision at York.
- Nursing recruitment to Band 6 posts will facilitate 7 day TIA clinics. Radiology Directorate manager to identify short term solution for weekend ultrasound.
- Complete operational policy to ensure all patients assessed by a specialist stroke practitioner.

HASU service

- Review of protocols for Hyper-acute stroke patient to ensure all patients admitted to HASU whether or not thrombolysis is needed .November 2013.
- Delivery of 7 day ward rounds via 5 day Stroke physician cover and 2 day On call Physician consultant to cover weekends using telemedicine/teleconference with on call Stroke consultant at York.
- Undertake assessment of governance implication of new model
- Ensure IT equipment can support model.

- Improve percentage of patients receiving a structured assessment, aspirin and swallowing assessment.

24/7 thrombolysis

- Replicate York A & E governance for thrombolysis mortality reviews.
- two SGH clinicians to join York thrombolysis rota.
- Agree days to be covered by clinicians joining rota.
- Identify IT issues with telemedicine kit.
- Test equipment by using to deliver lysis on local rotas.
- Pilot joint rota.
- Go live with medical rota.
- Review Alteplase protocol to ensure it is used with its marketing authorisation; to be administrated by appropriately trained staff, immediate access to imaging and re-imaging.
- ID responsible person for thrombolysis.
- Review stroke discharge from ASU/ SRU at Bridlington.
- Assess patients for rehab to SRU at Bridlington.

What are we planning to do beyond the Peer review visit?

- Monitor and manage the effective/appropriate use of the Hyper acute stroke unit bed in relation to hospital bed pressures.

What evidence will be provided in November?

- TIA operational policy containing 24/7 rota.
- Hyper acute stroke unit pathway/protocols.
- 7 day ward round timetable.
- Alteplase protocol.
- Review of protocol for transfer to and from rehab unit at Bridlington hospital.

4. ESD and Community services

Feedback from August 2012

The lack of a functioning ESD service is a serious inefficiency in the stroke pathway. This requires implementation as soon as possible and will quickly lead to improvements in lengths of stay, discharge planning and hence reductions in bed capacity. We fully support the current proposals. There is also a current lack of specialist rehabilitation support in the community which leads to the most disabled patients needing to spend longer in rehabilitation inpatient beds than is necessary. There is also some evidence that social care is not uniformly responsive across the whole catchment geography which is of concern.

What have we progressed since?

- Appointed 1WTE B6 Physiotherapist and 0.5WTE B6 OT to the community stroke team (previously no service).

What are we planning to do in next 2 months?

- Finance Director to discuss business case for delivery of a full ESD/Community service with commissioning leads.
- Review of social care provision to patients discharged from Scarborough/Bridlington.

What are we planning to do beyond the Peer review visit?

- Delivery of full ESD/community service.

What evidence will be provided in November?

- Community therapy activity information.

5. Data

Feedback from August 2012

It is mandatory that all patients are entered into SINAP and SSNAP. It is not appropriate that this is done by the stroke nurse coordinator. Support for this may be available from the Clinical Alliance. This data should be used to drive clear clinical governance arrangements for stroke e.g. mortality meetings, review of thrombolysis.

What have we progressed since?

- Appointed a SSNAP database administrator in March 2013.
- First SSNAP data submission – August 2013.
- Established regular thrombolysis governance sessions.

What are we planning to do in next 2 months?

- Establish regular mortality sessions, underpinned by SSNAP data.
- Review performance measures for the Scarborough Stroke Service.

What are we planning to do beyond the Peer review visit?

- Utilisation of all SSNAP data to improve Stroke service.

What evidence will be provided in November?

- SSNAP data report (available in October 2013).
- Evidence of governance sessions re thrombolysis and mortality meetings.
- Local performance measures data used to monitor performance.

6.Scanning

Feedback from August 2012
CT scanning needs to be undertaken in compliance with National guidelines. Review of the CT downtime protocol needs to include pre-alert to YAS during planned and unplanned downtime. A clear planning process needs to be put in place for this.

What have we progressed since?

- Review of performance April-August re 1hr/24hr performance.
- Review & update CT downtime protocol to ensure plan for downtime.
- Meet with Stroke team, Radiology and ED team to review CT scan performance and action plan to improve.
- Developed means of using SSNAP data collection to ensure real time access to scanning performance (replicating York Hospital).

What are we planning to do in next 2 months?

- Understand with Radiology and ED current CT pathways, agree standardised pathway scanning for urgent and non-urgent patients, including out of hours.
- Ensure YAS aware of CT downtime protocol.
- Liaise with HDFT to share downtime protocol.
- Ensure B6 HASU nurses at Scarborough are able to, and proactive in, requesting CT scans (replicating York Hospital).
- Establish a pigeon hole in Radiology / CT for HASU nurses to put CT requests 24/7 Trial 1 week in Scarborough where all CT scan requests are undertaken urgently straight from ED (replicating York exercise Aug13).
- Ensure CT requests identify the CT breach time re urgency.
- Agree a Solution for Sunday morning radiologist presence at Scarborough.
- Analyse SSNAP data re CT performance.

What are we planning to do beyond the Peer review visit?

- Use and SSNAP and local performance data to monitor real time performance against urgent/non urgent pathways.

What evidence will be provided in November?

- CT downtime protocol.
- CT scan pathway.
- CT performance data – SSNAP/internal.

4. Influenza

Influenza vaccinations have commenced and all staff will receive a letter (Appendix 1) from the Trust Chief Executive, Medical Director and Chief Nurse in their October payslip reminding them of their

responsibilities relating to influenza prevention.

The Minister for Health has linked a required increase in staff uptake of the influenza vaccination to funding for Winter Pressures in the Trust. This means that the Winter Pressure allocated funding of £250million will only be shared next year by NHS Trusts whose staff flu vaccination rates achieve 75% this Winter. Last year we achieved an overall uptake rate of 49.57% so we must achieve a considerable increase in the number of staff receiving the vaccination in order to be able to benefit from the Winter Pressure financial support.

In addition to flu vaccinations being available at various points throughout the Trust there will be a 'flu station' at the 'Working together for our future' conference which will be held at York Racecourse on the 8th November.

5. Consultant appointments

Dr Clare Johnston

Consultant Neurologist

Dr Georgios Tzimas

Consultant Neurologist

Dr Ianthe Abbey

Consultant in Paediatrics

6. Recommendations

To accept the report and note:

- the significant preparation work for Stroke Accreditation in Scarborough
- that the Board of Directors will receive a monthly update on the number of staff receiving influenza vaccination.

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**23rd October 2013**

Appendix 1

York Teaching Hospital NHS
NHS Foundation Trust

Dear colleague

As we approach our busiest season, influenza outbreaks become a greater threat to ourselves and our patients. It is imperative that you take steps to protect those you care for, colleagues, family and yourself against flu by **getting vaccinated.**

This year the Minister for Health Jeremy Hunt has linked a required increase in staff uptake of the vaccine with the funding for Winter Pressures in the Trust. This means that the Winter Pressure allocated funding of £250million will only be shared next year by NHS Trusts whose staff flu vaccination rates this winter have hit 75%. Last year we achieved an overall uptake rate of 49.57% so we have a long way to go.

As health care workers we can make the biggest impact in preventing the spread of flu. As well as taking action to protect yourself, you have the potential to influence and encourage your colleagues to get their flu jab. Please use the attached evidence to dispel any misconceptions you or your colleagues may have, by reinforcing the benefits of immunisation and reassuring people that it is safe and effective. I am asking you all to think about the impact on others if you decide not to be vaccinated.

By protecting yourself against flu, you not only set an example to colleagues and peers but also help to continue providing high quality compassionate care to those we care for. If you feel you need more information about the national seasonal flu campaign for staff visit http://www.nhsemployers.org/flu .

Occupational Health & Wellbeing Service is supportive of the programme to assist you, please contact them as they will be happy to arrange specific sessions to vaccinate groups of your staff. They will be holding lots of clinics, walking about your work areas and attending to those of you who work shift patterns. If you would them to make a specific visit just for your area please contact 01904 721661 and for Scarborough, Whitby, Ryedale contact 01723 342168 and discuss your needs with them.

Yours sincerely

Patrick Crowley
Chief Executive

Dr Alastair Turnbull
Medical Director

Michael Proctor
Chief Nurse

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 October 2013

Chief Nurse Report – Quality of Care

Action requested/recommendation

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

Summary

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

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

Implications for equality and diversity

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

Reference to CQC outcomes

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

Progress of report	Executive Board.
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Mike Proctor, Chief Nurse
Author	Beverley Geary, Director of Nursing
Date of paper	October 2013

Version number	Version 1

Board of Directors – 22 October 2013

Chief Nurse Report – Quality of Care

1. Key priorities

Nursing and Midwifery Strategy

The Nursing and Midwifery strategy was recently launched at both main sites and at the Community Nursing Forum.
Priorities have been identified and work towards the implementation plan has begun.

The strategy 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

Ward Sisters and Matrons are beginning to identify their local priorities and developing plans to address these taking into consideration risks and existing development plans.

The delivery of the local action plans will be managed via the Matrons group with assurance and challenge from the Chief Nurse Advisory Group.

Early indications are that the ward teams would like to look at new ways of measuring quality of care delivered and also identifying risk.

The Early Warning Trigger tool is being considered as a replacement for Nursing Care Indicators and will be discussed at a number of nursing forums to agree adoption and roll out or alternatives. Development of this continues and progress and planned dates for pilots will be highlighted in future reports.

2. Pressure Ulcer Reduction Plan (PURP)

Progress against the PURP

It is 8 months since the PURP was approved and a full review of progress against the plan has just taken place. A detailed report on the review and recommendations will be tabled for the Quality and Safety Committee and Board of Directors.

It is also worth noting that where a real focus on any initiative a significant rise in the reporting of incidents would be expected that this usually happens after 4-6 months of the commencement. The potential of this was flagged at the onset of the PURP.
It is also noteworthy, that with a programme of work of this size and complexity any sustained improvement could take up to 18 months to 2 years.

Nationally and locally, the reduction of pressure ulcers have become more of a priority and

assurance has improved. Gaps in process and knowledge have been exposed and plans to address this put in place.
Staff report that they feel more empowered to make changes and improve care but have struggled to implement pressure reduction strategies systematically and reliably. The Tissue Viability Nurses (TVNs) also report increased referrals and delivery of education.

Main challenges:
The provision of pressure relieving equipment in community services remains a high priority and also a significant challenge. The main issue being the contractual arrangements in place with Harrogate Trust which are being debated through Contract Management Board.

Despite a significant programme of education a knowledge gap regarding the application of the correct categories for pressure ulcers still exists. In addition, the appropriate provision of treatment and the ability to recognise a pressure ulcer versus another type of wound is also present; however this is improving.

It has been difficult for key clinical leaders to ensure pressure ulcer prevention strategies are implemented, monitored and escalated reliably. It has also taken longer than anticipated to standardise all reference material to underpin knowledge, support decision making and management due to differing processes and clinical opinion.

Undertaking high quality and timely Root Cause Analysis for our most significant pressure ulcers (category 3 & 4) has required intensive improvement work and remains high on the agenda in order to gather and use the emerging learning.

There were some issues with effective when transferring or discharging patients with regards to skin integrity which could potentially lead to gaps in care.

There is a significant issue of attribution of ulcers in community services. There is evidence that we are attributing many more ulcers as '*developed whilst in our care'* than we can influence or realistically prevent and this requires swift resolution with our commissioners.

There was no measure of competency in pressure ulcer prevention and management for registered and unregistered nursing staff.

Key successes to date:

Equipment:
A process to hire pressure relieving equipment in urgent and appropriate situations has been agreed for community services. This means that despite the contractual difficulties patients do not need to wait for the appropriate equipment.

After a large scale audit we have agreed a standard for future purchasing of chairs and agreed processes for choosing and requesting equipment.

The appointment of a Tissue Viability Nurse Assistant for Equipment (TVNa) in York Hospital has dramatically increased provision of mattresses in particular and reduced calls to Medical Engineering Department. The feasibility of this role is being explored in other areas of the organisation.

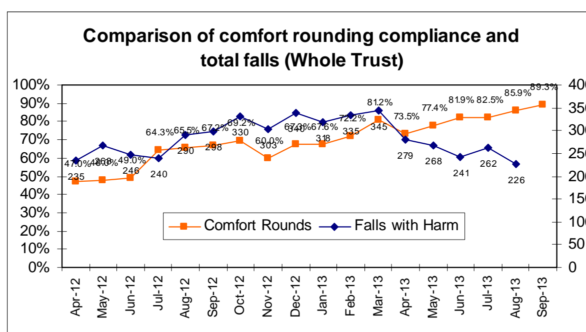
Capability:
A competency assessment tool has been developed for registered nurses with an agreement that this will be part of their yearly appraisal from April 2013.

Guidance for patients who refuse to comply with pressure reduction strategies has been developed and agreed by TVNs to aid and evidence decision making.

Comfort rounding:

A network of ‘skin champions’ post education and engagement events has been developed for peer support and to share good practice. This feedback and learning from these events are very positive.

There has been an increase in the use of comfort rounding and the emerging data demonstrates a reduction in falls resulting in harm.



Date, reporting and investigation:

A monthly ‘Pressure Ulcer Panel’ chaired by Chief Nurse Team was set up a number of months ago to gain assurance, extract and share learning and apply the definition of ‘avoidable / unavoidable’ consistently.

Learning from the panels is widely disseminated and discussed monthly with the Matrons.

Due to the incidence of pressure sore in some patients with plaster casts work has begun to review plaster cast products. Additional monitoring of these patients has also been agreed in order to reduce the trend of pressure ulcer development in this group.

Since the start of the PURP we have now declared all our category 4 ulcers as serious incidents compared to the previous year.

Outcomes so far:

Since February 2013 to date we have had 9 category 4 ulcers. 5 of these were in community services and 4 in acute settings. All of these have been declared as Serious Incidents, a robust RCA undertaken and reported to the Commissioners.

Whilst comparison is difficult due to the validity of data for the same time period last year it appears that we reported around 12-15 category 4 ulcers.

Our safety thermometer data (ST) results remain high due to the number of pressure ulcers which developed *before* patients came into our care however we seen a reduction in the number of pressure ulcers which developed while in our care.

Next steps:

An action plan will then be developed which will refocus our priorities and aim to embed best practise, increase reliably and pressure ulcer prevention strategies; and improve assurance, with the overall aim of reducing the incidence and eliminating all avoidable pressure ulcers.

3. Midwifery Update

Virtual antenatal and parent education

The development of on-line antenatal and parent education has been filmed and will be

available on the Hospital website very soon. There will be some overlap with existing face to face group classes with a view to discontinuing some of these in the New Year. This has been developed with the aim to provide easily accessible and consistent information provided by local midwives and release time to care. All women will continue to have appointments with their Midwife and be able to ask any individual questions they may have.

Teenage pregnancy and multiple birth classes will continue along with individual one to one education for those with special requirements. The Midwives will continue and extend their work with Children's centres in 'time and space' sessions and 'bumps to babes' which are targeted on more vulnerable groups.

This initiative has recently received coverage on local and some national news. The stories gave a negative slant as they were inaccurately reported suggesting that we had stopped antenatal education.

Local Supervising Authority (LSA) Audit
The annual LSA audit of the Supervisors of Midwives practice took place cross site on 2nd October 2013
This was attended by a representative from VACCU (Vulnerable Adults and Children's Commissioning Units) on behalf of the CCGs, the MSLC and the University of York
The Supervisors gave a presentation of their achievements, challenges and opportunities.
Verbal feedback on the day was very good and is a reflection of the successful joint working of the Supervisors of Midwives team cross site. A formal report will be submitted by the LSA Midwifery Officer in the next month, this will be summarised and submitted to the Trust Board.

4. Staffing

In line with the delivery of the Nursing and Midwifery strategy – (priorities 1, 2, and 4) and following the comprehensive establishment review and budget exercise; approved staffing models for all wards have now been agreed.

The establishment review led to a significant investment in the nursing workforce including the conversion of apprentice and cadet posts into Health Care Assistants' positions, investment in additional Registered Nurses, and investment of substantive workforce in areas that have previously relied on temporary workforce for flexible capacity.

Wards will receive their published approved models and budget information throughout October. This will give details of budgeted establishment by shift, RN to patient ration and skill mix for each area.

In order to ensure established teams and reduce reliance on temporary workforce there is a focus on reducing the number nurse vacancies in particular those of band 5 registered nurses.
Currently there are a number of vacancies; this has been largely influenced by the establishment review and recent investments in workforce.

Due to a large attrition rate from the July and early September recruitment rounds, processes have been further streamlined to enable job offers to be made at interview subject to satisfactory references. In addition, there are further centrally supported recruitment rounds taking place on both the Scarborough and York sites on the 10th and 16th October respectively and 'one stop' recruitment shops will be held on both sites on the 26th October.

In order to reduce staffing gaps due to staff vacancies, the vacancy control process for the

replacement of band 5 and band 2 posts has been streamlined to enable wards to begin the recruitment process immediately upon receipt of a resignation.

Midwifery staffing
National recommendations for Maternity services are to have 35 Midwives per 1000 births. York site have 29 Midwives per 1000 births – this is flagged red on the York Midwifery dashboard).

Scarborough site have 44 Midwives per 1000 births (Green on the Scarborough dashboard) The integration of York and Scarborough Trust has resulted in the ratio coming more into line with national recommendations at 34 Midwives per 1000 births (Amber)

Redesign of how the maternity service is delivered with the overall workforce is part of the Midwifery workforce strategy and plan 2013-15 and action will address any outlying areas.

The Chief Nurse Team are currently working with Human Resources to ensure accurate and up to date nursing and midwifery vacancies are reported and monitored on a regular basis and that any areas of risk are escalated without delay in order that any remedial action can be taken

5. Patient Experience

Friends and Family Test
The results for September 2013 are not available until mid September but our number of returns for the Emergency Departments has decreased during September which will result in the overall response rate being lower than August. As a Trust we must reach a minimum response rate of 20% throughout Quarter 4.

A token collection system is currently being procured for both Emergency Departments and will be available from the supplier mid October*. A number of Governors attended a briefing session on the Friends and Family Test and will now support the initiative in the York Emergency Department. Two Governors are supporting FFT at the Scarborough Emergency Department. Volunteers are also being recruited.

Maternity Services FFT
The Friends and Family Test was rolled out nationally across maternity services from 1st October 2013. A month's trial period took place prior to the national roll out.
There are 4 touch points for Maternity (Antenatal, Labour and birth, Postnatal Hospital and Postnatal Community)

Following a review of the trial in September and discussion at the Maternity Services Liaison Committee (MSLC) a decision was made to have touch points 2 and 3 together on the same card to avoid giving out cards directly following birth followed quickly by a second card on the postnatal ward. This is in line with some other Maternity services.

Feedback from F&F will be a standing agenda item on the MSLC.

An additional question 'What *is the one thing you would change to improve your experience?'* was suggested and agreed at the MSLC to provide additional qualitative information for the group to review.

The Maternity Services Project group is due to meet again in November to review the first months data from picker

6. Eliminating Mixed Sex Accommodation

In recent months have we seen an increase in the number of single sex accommodation breaches' reported in the Vascular Imaging Unit at the York site. This is due mainly due to increased activity, capacity and demand and complexity of cases.

Whilst historically we have had very few single sex breaches in this area we saw 24 declared over a 4 week period in the summer, these related to 2 episodes of care and were over a 2 month reporting period. The cases have been discussed with the commissioners and at the Area Team in order to agree if they were reportable as per DOH guidelines'.

A number of actions have been taken to mitigate the risk of any further breaches and we have been working closely with Commissioners' to adhere to the published DOH guidelines and also to find workable solutions in order to promote privacy and dignity.

A recent meeting has taken place with representatives from the Trust, Commissioners and the CQC to agree guidelines and a system for declaring breaches and agreeing reportable breaches, (appendix 2).

Given that the expectation is that activity will continue to increase medium to long term solutions would be for a significant capital investment and a full redesign of the area.
The Directorate is already developing plans to this effect; however, the interim solutions suggested at appendix 1 will mitigate any risk of inappropriate reporting and promote the provision of privacy and dignity in the intervening period.

7. CQC Inspection

The Board will be aware that the Trust was subject to an unannounced Care Quality Commission inspection at Scarborough w/c 26th July.

Draft reports were received for comment and factual accuracy and were returned to the CQC within the prescribed timeframe.

The final report has now been received and is in the public domain.

In response to the report a detailed action plan to achieve compliance with Outcome 4 (Care and Welfare of people who use services) and Outcome 8 (Cleanliness and Infection Control) has been developed and submitted to the CQC for approval.
All actions are due to been completed by the end of December 2013.

On completion and delivery of the action plan the expectation is that a re-inspection of these standards will be undertaken by the Care Quality Commission.

Given the external scrutiny and internal commitment to improving quality and standards the delivery of the action plan overseen and managed by the Director of Nursing, Medical Director and Deputy Director of Healthcare Governance.

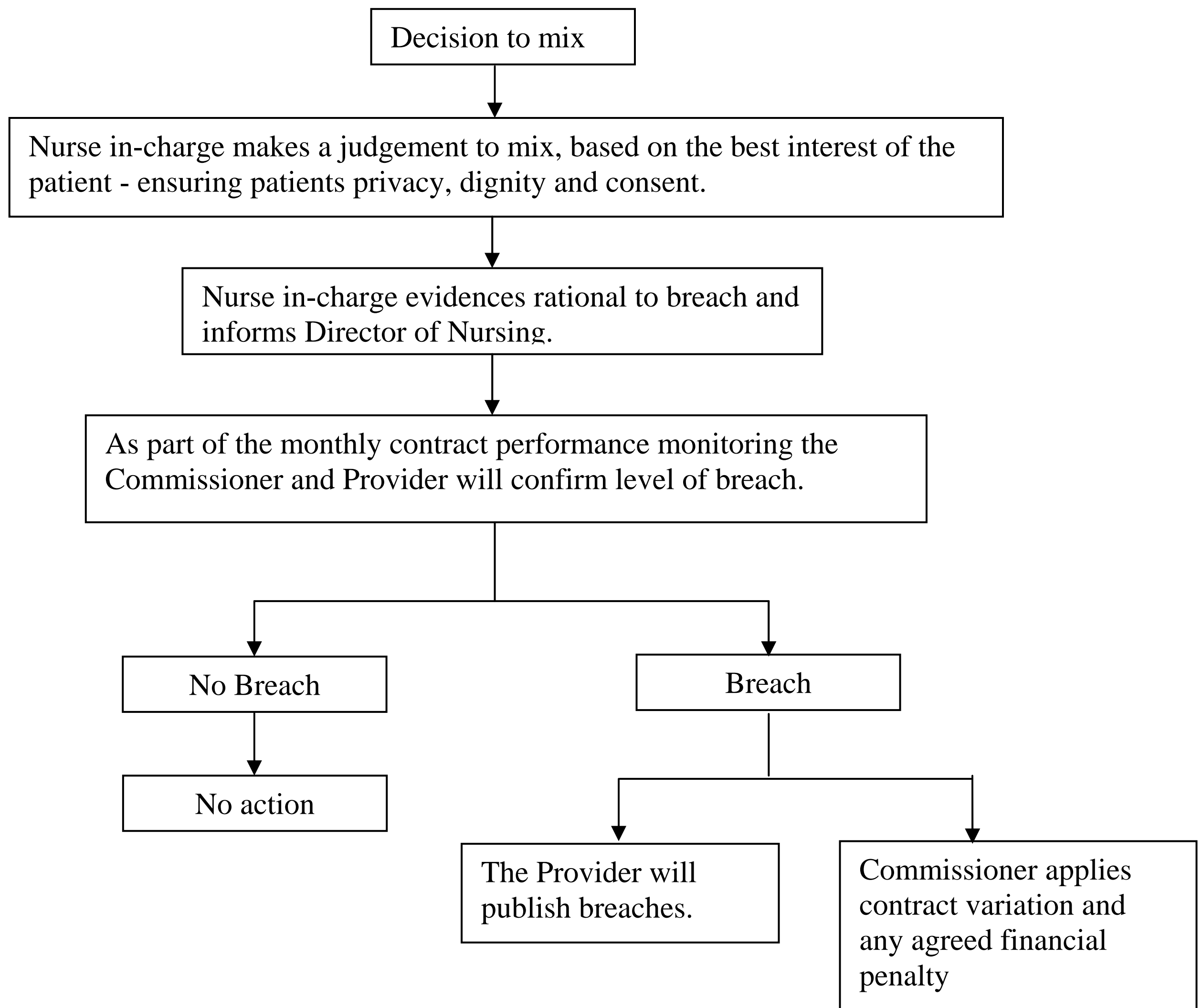
Progress on delivery of the action plan will be reported to the Board.

8. Recommendation

The Board of Directors 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, Director of Nursing
Owner	Michael Proctor, Chief Nurse
Date	October 2013

Flow chart for declaring and reporting breaches



D4

DIPC QUARTERLY INFECTION PREVENTION REPORT FOR TRUST BOARD. Q2 2013

Parameter		Annual threshold/ target	Q1	July	Aug	Sept	Q3	Q4	YTD	Q2 TREND	COMMENTS
MRSA Bacteraemia attributable to Trust	York sites		0	1	0	0			1		
	Scarborough sites		0	0	1	0			1		
	Trust	0	0	1	1	0			2		
MSSA Bacteraemia attributable to Trust	York sites		8	1	2	2			13		
	Scarborough sites		2	2	1	1			6		
	Trust	30	10	3	3	3			19		
E Coli Bacteraemia attributable to Trust	York sites		14	3	6	11			34		
	Scarborough sites		3	2	1	2			8		
	Trust	Not set	17	5	7	13			42		
Clostridium difficile Associated Diarrhoea attributable to Trust	York sites	26	16	2	2	1			21		
	Scarborough sites	17	5	2	4	1			12		
	Trust	43	21	4	6	2			33		
CDI per 100000 bed days attributable to Trust	York sites		26.44	10.37	9.71	4.71			17.26		
	Scarborough sites		17.14	20.57	42.39	9.9			20.53		
	Trust		23.41	13.79	19.97	6.38			18.32		
Elective MRSA admission screening	York sites	100%	90%	Not available	Not available	Not available			90%		
	Scarborough sites	100%	89%	90%	Not available	Not available			90%		
	Trust	100%	90%	90%	Not available	Not available			90%		
Emergency MRSA admission screening	York sites	100%	79%	Not available	Not available	Not available			79%		
	Scarborough sites	100%	93%	93%	Not available	Not available			93%		
	Trust	100%	86%	93%	Not available	Not available			90%		
Antimicrobial pathway compliance	York sites		Not available								
	Scarborough sites		Not available								
	Trust		Not available								
Ventilator acquired pneumonia	York sites		0	0	2	0			2		
	Scarborough sites		1	0	0	0			1		
	Trust		1	0	2	0			3		
CVC associated infections in ICU	York sites		1	0	0	0			1		
	Scarborough sites		0	Data not available					0		
	Trust		1	0	0	0			1		
Trust attributed CAUTI (Safety Thermometer data)	York sites		9	3	4	2			18		
	Scarborough sites		9	0	2	0			11		
	Trust		18	3	7	2			30		
VIP score for peripheral cannula	York sites		Not available								
	Scarborough sites		Not available								
	Trust		Not available								
Hand hygiene compliance	York sites	100%	100%	100%	99%	100%			100%		
	Scarborough sites	100%	98%	100%	98%	100%			99%		
	Trust	100%	99%	100%	99%	100%			100%		

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 October 2013

Update on Dementia

Action requested/recommendation

The Board is asked to note the findings shows in this report and:

- Support the revised strategy for dementia
- Confirm it wishes to receive a regular report containing the recommended information as laid out by the National Audit of Dementia

Summary

It is estimated that at any one time a quarter of acute hospital beds in the NHS are occupied by patients with dementia. How hospitals care for patients with dementia is the subject of significant national and local attention. In 2008 a National Audit of Dementia (NAD) was established to examine the quality of care offered to this group of vulnerable patients. It examines both organisational structures and how this translates into care received by individual patients. Care for patients with dementia is also the subject of a national CQUIN designed to improve the diagnosis of patients with cognitive impairment and, from 2013, the experience of those who care for patients with dementia. A requirement of the CQUIN is that the Board of Directors receives the results of the survey of carers every six months.

This paper provides the results of the initial six months of surveys, current performance on screening for dementia and details on the recommendation from the most recent NAD regarding the information that should be presented regularly to Boards. It also presents as an appendix a draft strategy for dementia for the organisation.

The Board is asked to note the findings presented in the report, to review the draft strategy and also to confirm if it wishes to receive the suggested regular updates.

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

There are no implications for equality and diversity.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	The report and draft strategy have been discussed at the Dementia Task and Finish Group
Risk	No risk
Resource implications	Resources will be required to develop a dashboard of clinical indicators for dementia. Elements of the dementia strategy will require resource to be delivered.
Owner	Dr Alastair Turnbull, Medical Director
Author	Steve Reed, Directorate Manager for Elderly Medicine
Date of paper	October 2013
Version number	1

Board of Directors – 30 October 2013

Update on dementia

1. Introduction and background

It is estimated that at any one time a quarter of acute hospital beds in the NHS are occupied by patients with dementia. How hospitals care for patients with dementia is the subject of significant national and local attention. In 2008 a National Audit of Dementia (NAD) was established to examine the quality of care offered to this group of vulnerable patients. It examines both organisational structures and how this translates into care received by individual patients. Care for patients with dementia is also the subject of a national CQUIN designed to improve the diagnosis of patients with cognitive impairment and, from 2013, the experience of those who care for patients with dementia. A requirement of the CQUIN is that the Board of Directors receives the results of the survey of carers every six months.

This paper provides the results of the initial six months of surveys, current performance on screening for dementia and details on the recommendation from the most recent NAD regarding the information that should be presented regularly to Boards. It also presents as an appendix a draft strategy for dementia for the organisation.

The Board is asked to note the findings presented in the report, to review the draft strategy and also to confirm if it wishes to receive the suggested regular updates.

2. Developing a strategy for dementia

There has been much work undertaken across both acute sites, in partnership with external organisations, to improve standards of care for patients with dementia. Following the integration a decision was taken to review the work undertaken to date and to develop a strategy to build on this work. This would provide a guide to the ongoing work required and develop a standardised approach across the new organisation. To achieve this a time out day was arranged with a wide range of stakeholders to determine key priorities across a range of workstreams. The outputs of this session, together with recommendations from the latest NAD, have been summarised in the strategy document in Appendix A.

2.1 Delivering the dementia CQUIN

In 2012 both acute sites implemented a screening tool for doctors to assess cognitive function in non-elective patients aged over 75. The CQUIN requirement was for this to be carried out on 90% of patients across three consecutive months. For 2013-14 the CQUIN requirement is to maintain this standard of performance. The charts in Appendix B show performance over the last 12 months and the sustained improvement that has been made. This includes the move to recording this information through CPD on the Scarborough site (previously a manual audit).

In 2013-14 a new requirement was included to conduct a monthly survey of carers of patients with dementia. The survey asks a short number of key questions regarding how supported individuals felt and the information that was provided to them. The summarised results are shown in Appendix B. It is possible to see that carers report feeling supported whilst patients are in hospital and involved in discharge planning. Particularly on the York

site, carers are aware of the ‘This is me’ document. The survey has identified that further work is required to ensure that information leaflets on local services are provided to carers and plans are in place for this.

Since July 2012 the York site has piloted a Mental Heath Assessment Liaison Team. As well as providing rapid assessments for patients admitted with dementia or delirium the team have been a key factor in delivering the CQUIN requirements. Part of the strategy in Appendix A would be to ensure that this team are made permanent and that the service is expanded to cover the wider organisation.

2.2 Providing assurance to the Board

The recent NAD provided a set of recommendation on the information that the Board should routinely receive to provide assurance regarding the care being offered to patients with dementia. This included:

- Evidence relating to Trust performance against Dementia CQUIN targets
- Clinical information on admission rates, falls, intra-hospital ward transfers, treatment and discharges, in which people with dementia can be identified.
- Evidence that person centred care is practiced throughout the Trust, for example using “This is Me” or a similar personal information document.
- Evidence that a training programme is underway addressing competencies and skill development for staff working with people with dementia, and that this is suitable for a range of competency levels and roles.
- Evidence from local audit of in-hospital prescription of antipsychotics that their prescription is in line with guidance.
- Trust Board members should undertake training to become a dementia friend.
- Trusts should consider including this information in their Quality Accounts. Health Boards should consider including this information in their Quality and Safety Committee Reports.
- The Trust Board/Council of Governors/Board of the Health Board should be made aware of any incidents of discharge taking place after midnight or when carers/family receive less than 24 hours notice of discharge. This should be a routinely reported statistic, and these occurrences should be reviewed and investigated.

Currently the required clinical information is not captured and presented routinely so further work would need to carried out with Systems and Network Services to facilitate this.

3. Conclusion

It is possible to see from section 2.1 the progress that has been made against the CQUIN target for identifying patients with dementia. The carers audit shows carers feel supported but further work is required on how information on local services is provided. We plan to do more detailed sessions with carers to explore these topics in more depth. The strategy presented in Appendix A summarises the further work required to improve the quality of care offered. Section 2.2 shows the recommended information that should be presented to the Board to evidence these improvements routinely. Further work will be required to collate this information and ensure it can be used to drive changes in practice.

4. Recommendation

The Board is asked to note the findings shows in this report and:

- Support the revised strategy for dementia

- Confirm it wishes to receive a regular report containing the recommended information as laid out by the National Audit of Dementia

5. References and further reading

The results of the second National Audit of Dementia can be found on the website of the Royal College of Psychiatrists (http://www.rcpsych.ac.uk/pdf/NAD%20NATIONAL%20REPORT%202013.pdf)

Author	**Steve Reed, Directorate Manager for Elderly Medicine**
Owner	**Dr Alastair Turnbull, Medical Director**
Date	**October 2013**

Dementia strategy DRAFT 2013 - 2015

Vision: YTH will deliver high quality, holistic, patient-centred, safe and compassionate care. We will work with you and your family to meet your needs including appropriate assessment, treatment and safe and timely discharge. Delivery will be overseen by the Executive Team and implementation will be led by an experienced operational group.

Mission: To deliver on the NDS (2009) in relation to ensuring a highly trained workforce, a high quality clinical service delivered in an appropriate environment alongside support for carers and relatives.

Values:

- Patient-centred
- Delivery of safe, dignified, high quality and compassionate care
- High quality, well-educated staff
- Learning and improving environment
- Right skill mix in the right place at the right time
- Consultation, patient involvement and engagement
- Managing expectations: what are you expecting from us and what can we deliver for you?
- No discrimination
- Needs-related
- Standardised, shared communications and information, leading to consistency of care
- Efficient use of resources
- High quality care at lowest cost

Context:

* Changing Workforce
* Acute Board and Community Services Transformation Board
* Health & Social Care Integration

* Financial Challenges
* Competition
* Changes to Commissioning Bodies & Clinical Networks

* Demographic Changes
*Increasing Patient Experience & Choice
*Francis Report

Service Delivery Priorities

Patient pathway documentation	Patient and carer experience	Delivery of high quality clinical care	Skilled workforce	Governance /leadership	Effective liaison and multi agency working
Empower clinical teams to redesign pathways of care to eliminate preventable delays/ /link to nursing documentation group	Implement agreed patient identification tool (such as Forget-me-not)	Ensure daily senior geriatrician specialist presence alongside agreed psychiatry input on ward 37	Ensure delivery of an agreed training programme for all staff (training from basic mandatory to higher level modules delivered at York University)	Identify clinical leadership within the Trust for dementia (medical/nursing)	Develop a service specification for psychiatric liaison / agree a way forward for a 7 day liaison service
Ensure cross Trust use of the Dementia care plan and ensure commencement in AMU/ assessment area	Prevent unnecessary ward moves	Develop a protocol for challenging behaviour	Ensure delivery of person centred care	Ensure Board of Directors receive information with regard to delivery of services for patients with dementia	Ensure effective liaison with primary care, CMHT, voluntary and charitable organisations
Explore shared electronic records with mental health/discharge documentation and GP links	Ensure effective, clear, appropriate communication at all stages from admission to discharge. This to include signposting to community services.	Ensure use of common assessment tools /shared single assessment. This to include delirium assessment	Measure and record training / evaluate and develop for future	Development of a dementia dashboard identifying patients with dementia across services and ensuring this info is shared at all levels	Build on expertise and best practice across sites to standardise care
Develop a standardised assessment of functioning	Monitor feedback and results from the carers questionnaire and implement any agreed actions. Include evidence of carers assessments	Development of a dementia friendly environment which is fit for purpose	Identify Dementia Champions at ward level and ensure effective communication and support to these champions	Identify important quality markers e.g. Length of stay, readmissions, falls, fractures, pressure sores	Participate as part of the national, regional and local dementia action alliance
Ensure effective delirium assessment at point of admission	Ensure user/carer involvement in service delivery / complaint action plans	Ensure delivery of quality End of Life care	Maximise the use and deployment of volunteers including dining companions		Attend and participate in local and regional dementia meetings
	Ensure staff are aware of the expert carer and include them in care as early as possible. Initial assessment of care needs to include carer feedback	Ensure delivery of mood screening			
	Identify consent and Power of Attorney issues on admission	Ensure anti psychotic prescribing is in line with guidance			
	Creation of an environment where at every point of contact people and places are dementia-aware .				

Commissioning Drivers:	Enablers:
Care Close to Home	Management and Governance Structures
Urgent Care Reform	Organisational Culture
Management of Long Term Conditions	Effective communication
QIPP	Skilled, capable and flexible workforce
Avoidance of hospital admissions	Leadership
Improved access to services	Information Management and Technology

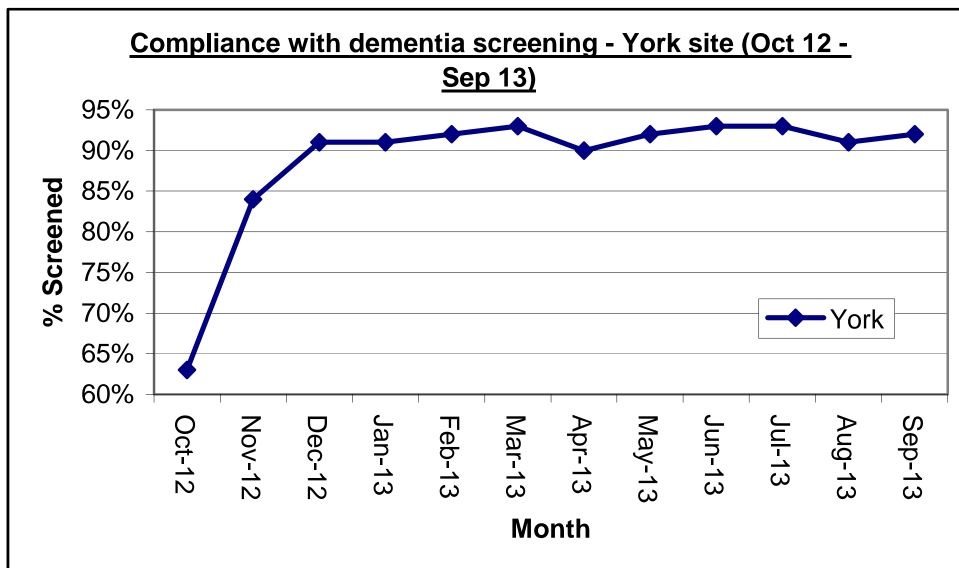
Appendix B

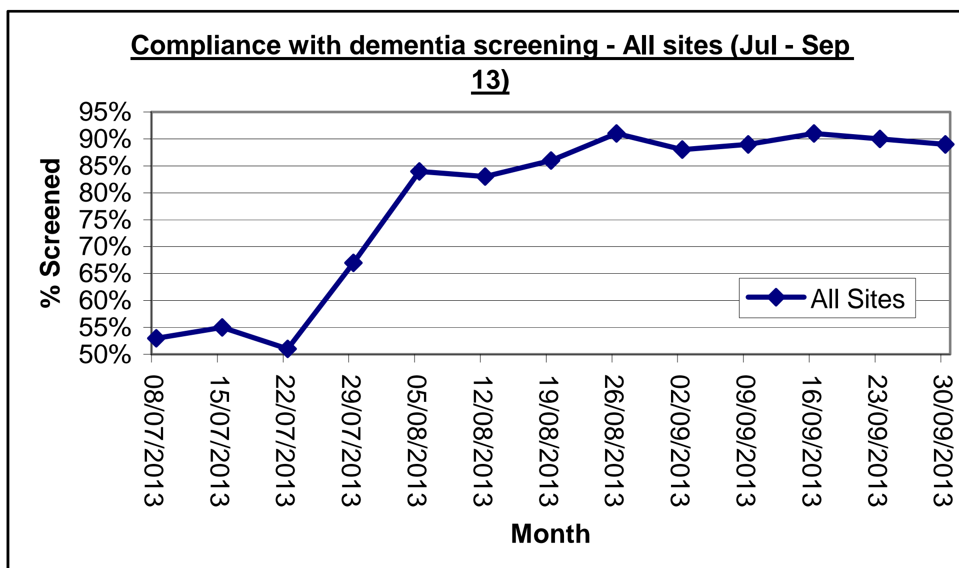
Data to support CQUIN compliance

Screening

The expected standard is that at least 90% of patients over the age of 75 are screened for cognitive impairment using a standard test. The results of this are inputted to CPD and are sent to the patient's GP with the electronic discharge notification. This system has been running electronically on the York site for over a year and has been adopted in Scarborough following the move to CPD.

The charts below show the improved, and sustained, compliance.





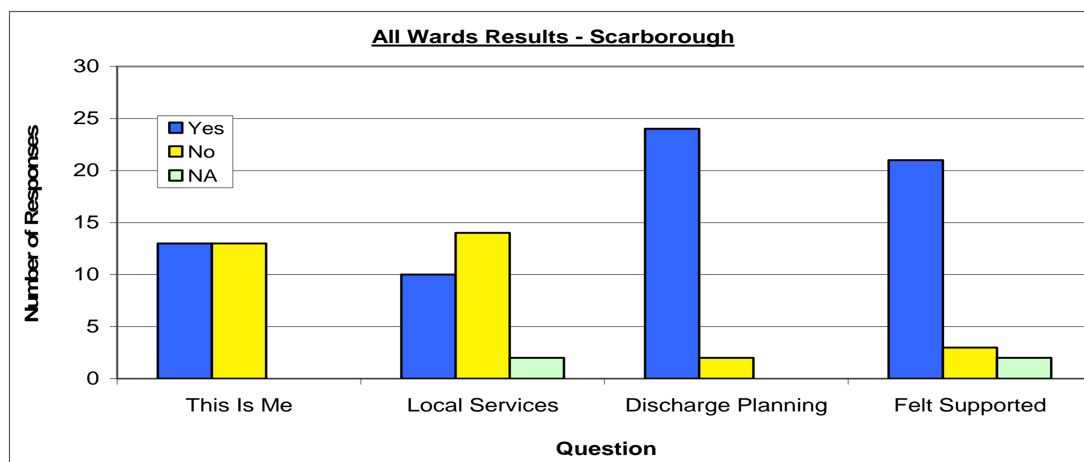
Carers Survey

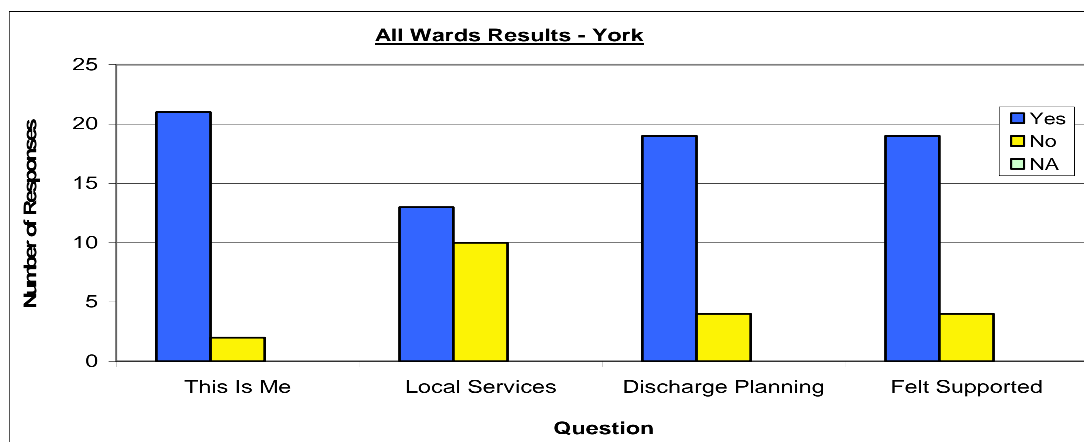
Each month ten carers of patients with dementia who have been recently discharged are contacted to take part in a simple survey. They are asked four main questions:

1. Were you given the 'This is Me' form?
2. Were you made aware of local support services?
3. Were you involved in discharge planning?
4. Did you feel supported whilst your (*relative/friend*) was in hospital?

The results from the first five months of surveys have been analysed and the results are shown in the charts below. Following this we have identified that further work is required to improve how the information we have on local services is given to carers. This will be built into the training sessions that are being held for ward staff, we are making displays more prominent and reviewing visiting times.

The Trust Patient and Public Involvement Lead is currently establishing the best means of organising focus groups or similar to allow a more in depth exploration with carers of their experiences.





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York Teaching Hospital NHS Foundation Trust

Finance and Performance Committee –30 October 2013 Ward 35 Seminar Room

Attendance: Mike Sweet, Chairman
Mike Keaney
Debbie Hollings-Tennant
Lucy Turner
Andrew Bertram
Anna Pridmore
Graham Lamb
James Hayward (for item 3)

Apologies: Liz Booth

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes Minutes Dated 22nd October 2013**		The notes were approved as a true record of the meeting.		
2.	**Matters arising**		**Use of probiotics –**the Committee asked AB to advise what the costs were for the use of probiotics. AB advised that they were in the region of £60k per annum. He added that the case had been considered by the Corporate Directors and the final elements of the system were being put in place before the system was introduced. **Winter monies –**AB explained that the Trust's performance this year in relation to the up take of the flu vaccination will be linked to the level of funding the Trust potentially receives next year. AB added that		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
2.	Matters arising cont'd		the Trust has an ambitious programme to improve uptake which has already been launched. **Local Authority Contracts –** GL confirmed that the Trust has signed the contracts, and is now waiting for the Local Authority to sign them and return a completed copy.		
3.	**Capital programme**	4.6	The Committee welcomed James Hayward to the meeting and asked him to present the capital programme update. JH updated the Committee on the progress on the Capital programme schemes. JH outlined the importance of the assessment unit and the link to the Acute Strategy, but advised that the Scarborough unit would not be available for 3 to 4 years. He advised that at present Scarborough had an assessment unit in place, but its location was not ideal. It was agreed that Mike Proctor would be asked to update the Board as to the short term strategies being developed. JH advised that there had been some slippage against the original capital programme specifically in relation to the catering strategy and the Maple Ward 2 scheme. JH outlined the key schemes that are progressing this year including the new car park at Scarborough, Maple Ward 2, Paediatrics and Maternity Theatre Refurbishment. For York the schemes include main kitchen/ dining room, Emergency Department, Decontamination Facilities.	The Committee were assured by the update and discussion around the progress of the capital programme	Mike Proctor to update the Board of Directors on assessment Centre plans Capital programme update to be included in the November Board agenda

	Agenda Item	AFW	Comments	Assurance	Attention to Board
3.	Capital programme cont'd		The Committee thanked him for the presentation and the update. It was agreed there should be a further discussion around capital programme at the November Board meeting.		
4.	**Operational Report**		The Committee reviewed the new dashboard and noted the key information included. The Committee asked what "performance notice" referred to on the schedule. LT explained that it was a process by which written notice was served by the CCG around the Trust's failure to achieve a target. It was a document that laid out the action that needed to be taken to achieve the target. This action maybe the responsibilities of other parties such as the CCG. Contract clauses were essentially enforced by direct fine or by the issuing of a performance notice dependent on the agreed schedule. LT highlighted the key areas of concern. She outlined concern with the ongoing achievement of the **access targets**. She advised that there has been a significant reduction in the number of people waiting **36 weeks** for their treatment, although this does remain a concern during quarter 3. There are no patients waiting over **52 weeks**. The **18 week** target for admitted and non-admitted had been achieved for quarter 2. With regard **Yorkshire Ambulance Service (YAS)** there had been significant progress between August and September and there is evidence that during October the handovers have continued to improve. The number of occasions where an ambulance	The Committee noted the improvements in the access targets and was please to see no patients had waited more than 52 weeks. The Committee noted the improvements in the systems and the continued work being undertaken.	Mike Proctor to provide an update on the latest position

	Agenda Item	AFW	Comments	Assurance	Attention to Board
4.	Operational Report cont'd		waited more than 60 minutes to handover a patient have continued also to reduce. The Committee asked that if the Trust had been subject to penalties at this stage what the level would have been. LT advised that it would have been in the order of £690k. She reminded the Committee that when the penalties are in place in quarter 3 then any money paid as part of penalties will be used to improve the systems between the ambulance service and the Trust. LT added that the Trust has been working with YAS to understand some of their data. There is also some redesign work being carried out that will ensure there continues to be improvements in the systems. **First to follow up –**AB advised that the meeting with the CCG had been held on Friday 18th October. The meeting reviewed the detailed registers covering 24 specialties and 272 recognised conditions where the patient was being followed up by the consultant. He added that the CCG had asked to test a sample of the conditions clinically to assure themselves that the safety bar was appropriately set. This work will be undertaken shortly. AB added that the CCG had accepted that, subject to the validation work around the conditions register, the Trust was due payment for the work carried out and discussed what other Quality, Innovation, Productivity and Prevention (QIPP) schemes could be developed as an alternative to the first to follow up. AB added that although the 1.1.5 follow up ratio had not been achieved there had been a significant reduction in follow ups. It was agreed that Mike Proctor and Sue Rushbrook would update the Board. **Cancer –** LT advised that 5 out of the 7 targets were		Mike Proctor and Sue Rushbrook to update the Board on the first to follow up

	Agenda Item	AFW	Comments	Assurance	Attention to Board
4.	Operational Report cont'd		achieved. The Trust has failed to achieve the 14 day breast symptomatic and 62 day screening targets during August. In the case of the breast symptomatic target the challenge remains the issue of patient availability. Risk sharing has been discussed with Harrogate Trust in relation to the 62 day screening target, this has been agreed and the target should be achieved for quarter 2.		
		2.12 2.13	**Choose and Book –** the Trust has a target of to have a number of appointments slots available. The interface software has not been working properly during August and September which has meant the Trust has underachieved against this target. The issue with the software has been resolved.		
			In relation to **Commissioning for Quality and Innovation (CQUIN)** LT advised that the Trust was expecting full payment for all targets with the exception of pressure ulcers for Q2.		
			Pressure Ulcers –The target is based on prevalence as opposed to indication which would be a more realistic measure. Discussions are being held with the CCG about reviewing the target and a report has been prepared to demonstrate the case. The Committee asked if Mike Proctor would provide an update on progress.		Mike Proctor to update the Board on the position regarding pressure ulcers
			C-Diff – LT advised that there had been noticeable improvements in the performance and a marked drop in the number of cases being declared in the Trust. During September only 1 case was declared. The Trust ended Quarter 2 one case over trajectory– this is a significant improvement.		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
4.	Operational Report cont'd		AB commented that he, PC, MP and SR had attended a couple of briefings with the consultants to raise with them a number of issues, including contract penalties and CQUIN. He reported that the meeting had been very positive and productive. There had been about 100 consultants at the lunchtime meeting and slightly fewer in the early evening session. The consultants were very supportive and clearly understood what the Trust objectives are around targets, CIPs, CQUINs etc. The sessions had taken place in York and were scheduled to be repeated in Scarborough on Thursday. The committee welcomed of the new dashboard and the increase in information available and requested a "teach-in" to broaden their understanding.		
5.	**Finance Report**	2.15 3.1 3.11	GL reported that the end of September marks the end of quarter 2. The I&E reported position of a £0.2m deficit against a planned surplus of £0.5m produces an adverse variance against plan of £0.7m. GL explained that the £0.2m deficit included restructuring costs of 0.5m (MARS) and £0.3m donated asset income which is both excluded from Monitors financial risk rating (FRR) assessment, therefore Monitor would see the Trust as broadly in balance. The Monitor FRR for quarter 2 is provisionally 3 which is on plan. The Continuity of Services Risk Rating (COSRR) will provisionally be 4, Monitor is using this metric from 1 October. In terms of income the Trust is £3.8m ahead of plan. Clinical income is £3.4m ahead; other income is £0.4	The Committee noted the FRR and the COSRR and understood that as part of the Board papers there was a short paper explaining the implications of the introduction of the Risk	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
5.	Finance Report Cont'd		ahead of plan. Commissioning contracts are £4.8m ahead of plan which may lead to an affordability issue with the CCGs. The Committee asked if the CCG will have enough money to pay for the work. AB explained that it is still not clear what the regime will be, should these circumstances arise and that continued discussion about this matter takes place at senior level between the Trust and CCGs. It was noted that £2.0m of the overtrade is for Specialist Commissioning Services from NHS England With regard to financial penalties the Trust has incurred the following: • 52 week breaches -£95k • 18 week breaches - £257k • MRSA/mixed sex/ trolley waits £12k In terms of expenditure the Trust is £4.5m ahead of plan. This primarily relates to the CIP shortfall against plan and pay being £1.7m ahead and ECP work to meet access targets. In terms of cash, there is £20.3m in the bank which is £12.3m behind plan; this reflects the non receipt of the £15m capital support originally expected in September. AB added that HR have been undertaking significant work to identify where escalations areas have been open for a significant length of time and are still being staffed by temporary staff. The areas are not being closed and the staff are being transferred to a permanent workforce. The capital programme was discussed earlier and the slippage of £2m had been noted.	Assessment Framework Assurance was taken from the	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
5.	Finance Report Cont'd		AB advised that the discussions continue around the £15m capital support due for payment by the Treasury. He explained that the payment is likely to be split into two instalments. One will be released shortly and the second payment will be made next year. AB outlined the likely financial elements of the 2014/14 Framework and it was agreed that the Chief executive provide an overview for the Board.	information give in the presentation and the information discussed earlier around the capital programme.	Patrick Crowley to an overview for the Board
6.	**Tender list**		The Committee reviewed the list and noted the current position of the contracts and the tender work being undertaken. It was agreed this document would be included in the private board papers for commercially confidential reasons.		
7.	**SLR update**	3.1 3.9	The Committee reviewed the paper and noted the work that had been undertaken around the reference costs.		
8.	**Efficiency Report**		DHT presented the paper and outlined that at period 6 the Trust had achieved £12,512k savings in full year terms. This month the Trust identified £2,865k savings which leaves a negative Monitor variance of £2.6m. At the half way position the Trust has achieved 53% of the full year target. DHT referred to chart 3 which compared the progress this year with the profile last year. She had observed that the level of outstanding CIP was slightly higher than last year but formed a similar delivery timeline. Referring to the current planning gap of £4.7m		Pat Crowley to provide a view on the risk of not achieving the year end target

	Agenda Item	AFW	Comments	Assurance	Attention to Board
8.	Efficiency Report Cont'd		recurrent, DHT referred the Committee to chart 4 which outlined the risk profile and commented that she felt there was an increase in the risk of not achieving this years plan. DHT advised that the first 10 review panels had been completed and the next set are being planned. She added that as a parallel piece of work a review was being undertaken by the resource management team who will be meeting with finance managers to discuss further work that could be done. The Committee enquired about the four clinical areas that had not received green governance ratings and what work was being undertaken to move them to green. DHT explained the Ian Jackson was working with the four areas to ensure their quality issues around the CIPs are resolved.		
9.	**Workforce efficiencies**		It was agreed that this paper would be discussed in detail at the next meeting.		
10.	**Foundation Trust key performance indicators**		This paper was provided for information to follow up from the document prepared by Grant Thornton. The paper was noted by the Committee and an updated version requested once comparative data from other trusts was available.		
11.	**Dates of next meetings**		The Committee noted the dates		
12.	**Next meeting**		The next meeting will be on Tuesday 19th November at 10am in Board Room, York Hospital		

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York Teaching Hospital NHS Foundation Trust

Performance Headlines 2013/14 – September

Access

18 weeks: Significant reduction in people waiting 36 weeks for their treatment and 0 patients waiting over 52 weeks. There remains concern about the achievement of patients waiting more than 36 weeks by the end of Q3. In relation to other data items for September the validation process has not been completed, early indications suggest we have achieved both the admitted and non admitted pathways.

Cancer - 5 out of the 7 targets were achieved. The 14 day breast symptomatic and 62 day screening have failed for August. In the case of the breast symptomatic target the challenge remains the issue of patient availability together with reduced clinics in Scarborough due to lack of radiology cover. We have discussing risk sharing with Harrogate Trust in relation to the 62 day screening target, this has been agreed and the target should be achieved for Q2.

No **sleeping accomodation** breaches this month.

Ethnicity: Due to the progress made against this target the performance notice is due to be closed.

Failed **ED** all types 95% target on both sites - both in month and for Quarter.

Ambulance Handover for Q2: 83.7%.
There has been significant improvement in this area September to August. This target relates to ED however YAS are unable at the moment to identify where the patient has been 'handed over' to i.e. a ward or the ED dept so the position is expected to improve. We have also implemented a solution that enables us to validate the data received from YAS on a daily basis, we have already started to dispute some of the timings.

Choose and Book target 6% slot unavailability
Interface software issues in August and September have resulted in underachievement against this target.
Software problem now resolved.

CQUINS

Friends and Family - target 20% by Q4. We achieved 19.9% for Q2 and further work is being undertaken in ED to help achieve this target.

Pressure ulcers:
This target is based on prevalence as opposed to indication which would be a more realistic measure. A report is being prepared for CCG detailing significant achievements.

Care of the deteriorating patient - Significant improvement is being made in both the achievement of the 4hr clerking and the 12 hours post take.
Discussion around medical model ongoing.

NEWS within 1 hour of prescribed time - target 70% (York site only Q2)
Proposed change to this indicator has not been finalised with the CCG. Achieved target against indicator currently in the contract (month on month improvement).
To be discussed at September CMB.
nb: 70% Q2 target has been achieved as a joint organisation, although failure at York site

Elderly length of stay:
Currently above trajectory, however measure will be for Q4 length of stay only

Stroke accreditation - Scarborough site
Progress report required for Q2 written and to be approved by CQUIN PMM
This accounts for £900,000 of indicator
Accreditation visit to go ahead in November

Quality and Safety

Cdiff: currently over YTD trajectory
Q2 12 cases against trajectory of 11 with a significant reduction in September - 2 cases

MSSA: currently over YTD trajectory, however there is a slight reduction in Q2 against Q1

eDN (IDL) within 24 hours
Data has been provided to the Clinical Directors for them to discuss with their teams on ways in which performance in relation to this target can be improved.

eDN - Quality Audit
Awaiting finalisation of audit terms from East Riding CCG

Finance Penalties

Key Performance Indicators
April - August 2013 (approximate value)

18 weeks: £223,000
52 weeks: £95,000
Cdiff: £650,000
MRSA: £5,000
EMSA: £6,000
ED 12 hour trolley wait: £1,000
ED 4 hour target: not yet calculated (2% of service line per month)

CQUINS
Potential financial risk for Q2 - Indicator delivery not yet confirmed;
Safety Thermometer Pressure Ulcers: £225,000

Monitor Penalties

Quarter 2:

ED: 95% target: 1 monitor point

18 weeks: 92% incomplete pathway: 1 Monitor point

Cdiff: 1 Monitor point

Performance Headlines 2013/14 - September

Indicator	Section	Page
18 Weeks		1
Percentage of patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	Access	1
Zero tolerance RTT waits over 52 weeks	Access	1
Zero tolerance RTT waits over 36 weeks by Q3	Access	1
% of patients seen within 18 weeks for direct access audiology	Access	1
Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	Access	1
Inpatients	Access	1
Sleeping Accommodation Breach	Access	1
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	Access	1
No urgent operation should be cancelled for a second time	Access	1
All patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system on admission within 48 hours at York hospital and Scarborough hospital	Access	1
Delayed transfers of care: number of bed days	Access	1
Hospital admissions where the patients' ethnic group was recorded in electronic patient records	Access	1
Percentage of emergency admissions where A&E attendance in previous 24 hours and patient discharged from A&E	Quality & Safety	7
% Compliance with WHO safer surgery check list	Quality & Safety	7
% non-elective spells with operation within 2 days of admission	Quality & Safety	7
Readmissions within 30 days – Elective	Quality & Safety	7
Readmissions within 30 days – Non-elective	Quality & Safety	7
Number of medication errors affecting CYP (under 19yrs old)	Quality & Safety	7
Number of medication errors causing serious harm affecting CYP (under 19yrs old)	Quality & Safety	7
Discharge Notifications	Quality & Safety	9
Immediate Discharge letters – 24 hour standard: York Hospital	Quality & Safety	9
Immediate Discharge letters – 24 hour standard: Scar/Brid hospitals	Quality & Safety	9
Immediate Discharge Letters (IDLs) handed to patients on Discharge	Quality & Safety	9
Percentage of IDLs that meet the minimum quality for IDLs (SIGN standard)	Quality & Safety	9
Quality of ED IDLs - York	Quality & Safety	9
Quality of ED IDLs - Scarborough	Quality & Safety	9
Outpatients	Access	2
Trust waiting time for Rapid Access Chest Pain Clinic	Access	2
Reduction in number of hospital cancelled first and follow up outpatient appointments for non clinical reasons - YORK	Access	2
Reduction in number of hospital cancelled first and follow up outpatient appointments for non clinical reasons- SCARBOROUGH	Access	2
North Yorkshire Commssioners Only - First: Follow Ratios will be capped at 1:2.1 for Q1, 1:1.5 for Q2. This is subject to the Speciality Review which once complete if a revision is required to the ratio it will be applied prospectively	Access	2
Outpatient clinics cancelled with less than 14 days notice	Access	2
Provider failure to ensure that 'sufficient appointment slots' are available on Choose & Book	Access	2

Indicator	Section	Page
Emergency Department	Access	2
Percentage of A & E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Access	2
A&E: % attendances at Type 1 units where the patient spent four hours or less in A & E from arrival to transfer, admission or discharge	Access	2
	Access	2
	Access	2
Recording of **compliance** with patient handover arrangements in A&E	Access	2
All handovers between ambulance and A & E must take place within 15 minutes	Access	2
All handovers between ambulance and A & E must take place within 15 minutes	Access	2
Trolley waits in A&E	Access	2
A&E: % attendances for cellulitis and DVT that end in admission	Access	2
A&E: % re-attending (unplanned)	Access	2
A&E: % left department without being seen	Access	2
A&E: 95th percentile for time to initial assessment	Access	2
Service experience - any worsening in the aggregate score of national patient survey	Access	2
Monthly report to show patient satisfaction score for A&E department	Access	2
Cancer	Access	3
Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Access	3
Percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	Access	3
Percentage of patients waiting no more than 62 days for first definitive treatment following a consultant’s decision to upgrade the priority of the patient (all cancers)	Access	3
Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	Access	3
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	Access	3
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regime	Access	3
Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	Access	3
Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	Access	3

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Mortality - SHMI - to maintain or improve against the 12/13 outturn position	Quality & Safety	7
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Proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours of first contact with a health professional	Quality & Safety	8
Percentage of patients presenting with stroke with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter for anti-coagulation	Quality & Safety	8
Percentage of patients and carers with joint care plans on discharge from hospital. Percentage of patients with confirmed stroke who have a copy of their joint care plan on discharge from hospital subject to exceptions included in guidance (except patients RIP or who refuse a health/social care assessment/intervention)	Quality & Safety	8
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Women who see a midwife or maternity healthcare professional by 12 weeks and 6 days of pregnancy	Quality & Safety	8
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% of women initiating breast feeding.	Quality & Safety	8
Number of term babies admitted to NICU or SCBU	Quality & Safety	8
Number of adverse midwifery/obstetric related incidents	Quality & Safety	8
Number/percentage of women recorded as smoking by 12 weeks and 6 days	Quality & Safety	8
Number of babies born between 32 and 36 weeks	Quality & Safety	8
Number of babies born between 28 and 31 weeks	Quality & Safety	8
Number of babies born between 24 and 27 weeks	Quality & Safety	8
Number of babies born under 24 weeks	Quality & Safety	8
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9 Level 2 Accreditation to be achieved at Scarborough Hospital by end of Q3	CQUINS	6

Contracted Performance Requirements 2013/14: Access Targets

Indicator	Consequence of Breach	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
18 Weeks							
Percentage of admitted patients starting treatment within a maximum of 18 weeks from referral	**Monthly:** **Specialty fail:** 37.5% of Contract Month Elective Care 18 Weeks Revenue for specialty Performance Notice **Quarterly:** 1 Monitor point	**90%**	90.2%	90.9%	90.3%	90.1%	90.4%
Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from referral	**Monthly:** Specialty fail: 12.5% of Contract Month Elective Care 18 Weeks Revenue for specialty Performance Notice **Quarterly:** 1 Monitor point	**95%**	95.0%	95.2%	95.7%	95.2%	95.3%
Percentage of patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	**Monthly:** Specialty fail: 50% of Contract Month Elective Care 18 Weeks Revenue for specialty Performance Notice **Quarterly:** 1 Monitor point	**92%**	92.0%	92.1%	91.5%	92.0%	92.0%
Zero tolerance RTT waits over 52 weeks	£5000 per patient waiting over 52 weeks	**0**		2	3	0	
Zero tolerance RTT waits over 36 weeks by Q3	Performance Notice (VoY)	**0**		266	306	234	
% of patients seen within 18 weeks for direct access audiology	Performance Notice	**95%**	99.9%	100.0%	99.8%	99.9%	99.9%
Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	2% of revenue from provision of service line	**99%**	99.0%	99.1%	99.3%	99.4%	99.3%
Inpatients							
Sleeping Accommodation Breach	£250 per patient per day	**0**	0	19	5	0	24
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	Non payment of costs associated with cancellation and non payment or reimbursement of re-scheduled episode of care	**0**	0	0	0	0	0
No urgent operation should be cancelled for a second time	Non payment of costs associated with cancellation and non payment or reimbursement of re-scheduled episode of care	**0**	0	0	0	0	0
All patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system on admission within 48 hours at York hospital and Scarborough hospital	Exception Report to be provided where the target failed in any one month (ER)	**95% by Q4 (Elective)**		82.6%	82.6%	81.5%	
Delayed transfers of care: number of bed days	Performance Notice	**TBA**		338	392	323	
Hospital admissions where the patients' ethnic group was recorded in electronic patient records	Performance Notice (VoY)	**98%**		86.2%	85.9%	88.8%	

Contracted Performance Requirements 2013/14: Access Targets

Indicator	Consequence of Breach	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Outpatients							
Trust waiting time for Rapid Access Chest Pain Clinic	Performance Notice (ER)	**98%**		100.0%	100.0%	100.0%	
Reduction in number of hospital cancelled first and follow up outpatient appointments for non clinical reasons - YORK	Performance Notice (ER)	**York Baseline 11.1% to achieve 10.74% By Q4**		11.6%	11.9%	11.3%	
Reduction in number of hospital cancelled first and follow up outpatient appointments for non clinical reasons- SCARBOROUGH	Performance Notice (ER)	**Scarborough baseline 11.2% to achieve 10.7% by Q4**		16.8%	16.0%	17.5%	
North Yorkshire Commssioners Only - First: Follow Ratios will be capped at 1:2.1 for Q1, 1:1.5 for Q2. This is subject to the Speciality Review which once complete if a revision is required to the ratio it will be applied prospectively	£	**1:1.5 (Q2 on)**	2.06	1.93	1.79	1.85	1.85
Outpatient clinics cancelled with less than 14 days notice	Performance Notice (VoY)	**3% reduction**		250	199	218	
Provider failure to ensure that 'sufficient appointment slots' are available on Choose & Book	Performance Notice (ER)	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**		6.0%	5.8%	8.8%	
Emergency Department							
Percentage of A & E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**95%**	96.3%	95.0%	93.6%	93.5%	94.1%
A&E: % attendances at Type 1 units where the patient spent four hours or less in A & E from arrival to transfer, admission or discharge	Performance Notice	**Q1 90%; Q2 90%; Q3 95%**	York: 95.0% Scar: 95.1% Total: 95.1%	York: 95.1% Scar: 89.2% Total: 92.9%	York: 91.3% Scar: 89.4% Total: 90.6%	York: 93.1% Scar: 87.1% Total: 90.9%	York: 93.2% Scar: 88.6% Total: 91.5%
Recording of **compliance** with patient handover arrangements in A&E	£5 per patient from Q3 onwards	**Q1 90% Q2 90% Q3 95%**	82.3%	84.6%	82.2%	84.5%	83.7%
All handovers between ambulance and A & E must take place within 15 minutes	£200 per patient waiting over 30 minutes from Q3	**> 30min**	595	258	310	194	762
All handovers between ambulance and A & E must take place within 15 minutes	£1000 per patient waiting over 60 minutes from Q3	**> 60min**	135	87	107	90	284
Trolley waits in A&E	£1000 per breach	**> 12 hrs**	0	1	0	0	1
A&E: % attendances for cellulitis and DVT that end in admission	Quarter: Performance Notice	**> 12/13 Avg**	17.0%				17.3%
A&E: % re-attending (unplanned)	Quarter: Performance Notice	**> 5%**	3.0%	3.1%	3.2%	3.2%	3.2%
A&E: % left department without being seen	Quarter: Performance Notice	**> 5%**	3.0%	4.3%	4.9%	4.9%	4.7%
A&E: 95th percentile for time to initial assessment	Quarter: Performance Notice	**>15mins by end Q2**		85	88	93	
Service experience - any worsening in the aggregate score of national patient survey	Annual: Performance Notice						
Monthly report to show patient satisfaction score for A&E department	Performance notice	**none**		56	45	46	

Contracted Performance Requirements 2013/14: Access Targets

Indicator	Consequence of Breach	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Cancer (one month behind due to national reporting timetable)							
Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**85%**	88.2%	87.9%	87.4%		
Percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**90%**	98.7%	93.3%	84.4%		
Percentage of patients waiting no more than 62 days for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	**Monthly:** 2% of revenue from provision of service line	**85%**	none	100.0%	none		
Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**96%**	99.3%	99.1%	98.4%		
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**94%**	95.3%	96.7%	100.0%		
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regime	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 1 Monitor point	**98%**	100.0%	100.0%	98.1%		
Percentage of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 0.5 Monitor point	**93%**	95.6%	94.6%	93.8%		
Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	**Monthly:** 2% of revenue from provision of service line **Quarterly**: 0.5 Monitor point	**93%**	94.7%	87.4%	92.3%		

Indicator	Target	Weighting	Financial Value	Q1 Actual	Jul	Aug	Sep	Q2 Actual	Comments
N1: Friends and Family Test [To improve the experience of patients in line with the domain 4 of the NHS Outcomes Framework]									
1.1 Friends & Family Test Phased Expansion - Delivery of Friends and Family rollout for maternity services		0.0375%	£135,000	Milestones for delivery: End Oct and End March 2014					
1.2 Friends and Family Test - Increased Response Rate Provider achieving an increase in response rate that improves on Q1 and is 20% or over	Q1: 15% Q4: 20%	0.0500%	£180,000	9.8%	24.3%	18.7%	16.2%	19.9%	
1.3 Friends and Family Test - Improved performance on the Staff Friends and Family Test Provider having a better result in 2013/14 compared with 2012/13 (70.4), or remaining in the top quartile		0.0375%	£135,000						
N2: Safety Thermometer									
2 NHS Safety Thermometer - Improvement Reduction in prevalence of the number of patients recorded as having a category 2-4 pressure ulcer (old or new)	2.9%	0.0625%	£225,000	5.4%	5.4%	4.1%	4.2%	4.6%	Acute
	3.95%	0.0625%	£225,000	9.9%	6.9%	9.3%	9.5%	8.6%	Community
N3: Dementia									
3.1a Dementia - Number of patients >75 admitted as an emergency who are reported as having known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question	90%	0.0750%	£270,000	94.0%	93.9%	92.2%	91.3%	92.5%	
3.1b Dementia - Number of above patients reported as having had a diagnosis assessment including investigations	90%			97.6%	98.1%	100.0%	100.0%	99.2%	
3.1c Dementia - Number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners	90%			99.0%	100.0%	100.0%	100.0%	100.0%	
3.2 Dementia - Clinical Leadership10/09/2013 named lead clinician and submit training plan to be delivered by March 2014		0.0125%	£45,000	Reported twice (pre-April 2013, March 2014)					
3.3 Dementia - Supporting Carers of People with Dementia - monthly audit 6 monthly - Report on feedback from Carers to Commissioners		0.0375%	£135,000	6 monthly reporting					

Indicator	Target	Weighting	Financial Value	Q1 Actual	Jul	Aug	Sep	Q2 Actual	Comments
N4: VTE									
4.1 VTE Risk Assessment	95%	0.1250%	£450,000	95.0%	95.5%	95.9%	97.0%	96.1%	
4.2 VTE Root Cause Analysis				96.15%	100.0%	75.0%	100.0%	93.3%	Q2 provisional as still within '90 day rule'
N5: Care of the Deteriorating Patient									
5.11 Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions - 80% of admissions through AMU and Cherry will be reviewed within 4 hours of admission	80%	0.4000%	£1,440,000	79.8%	92.1%	88.0%	84.8%	88.4%	York
	Q4: 80%					72.4%	78.9%	74.1%	Scarborough
5.12 Care of the Deteriorating Patient on Acute Medical Assessment Units at York and Scarborough Hospitals - Admissions - 80% of all acute medical, elderly medical and orthogeriatic patients to have a Consultant post take ward round consultation within 12 hours of arrival.	80%			67.4%	72.3%	71.0%	70.8%	71.4%	York
	Q4: 80%					50.3%	56.6%	52.9%	Scarborough
5.2 Care of the Deteriorating Patient at York and Scarborough Hospitals - Identification, Response & Management - Adults (excluding Obstetrics, ICU/HDU, SCBU, Day Cases, Children and Paediatrics). - Number of patients who have observations recorded producing NEWS score within 1 hour of prescribed time - No of patients with NEWS score trip with escalation of care within 15 minutes to appropriate clinician. - Quality of escalation response - Trust to produce a quaterly report on actions taken and improvements made to care pathways	Q2 70% York; Q3 80% Y&S; Q4 90% Y&S	0.4000%	£1,440,000	64.7%	64.3%	65.7%	66.3%	65.5%	1hr Obs
	Q2-4				Quarterly audit				Quality of escalation response
5.3 Full implementation of NEWS and PAWS across both York and Scarborough Hospitals by Q4, excluding Paediatrics, SCBU, Obstetrics, ICU/HDU and Day Cases.		0.1000%	£360,000	Implementation plan to be agreed by Q2					

Indicator	Target	Weighting	Financial Value	Q1 Actual	Jul	Aug	Sep	Q2 Actual	Comments
N6: Reduce Length of Stay on Elderly Medicine Bed Base									
6a: A reduction in the average length of stay in the acute elderly medicine bed base of York	100% 9 days; 75% 9.2 days; 50% 9.5 days	0.0500%	£180,000	9.62	10.73	9.49	11.06	10.84	
6b: A reduction in the average length of stay in the acute elderly medicine bed base of Scarborough Hospitals	100% 10 days; 75% 10.16 days; 50% 10.32 days	0.0500%	£180,000	11.17	10.02	10.81	11.22	10.71	
6c: A reduction in the average length of stay in the acute elderly medicine bed base of the rehab beds at White Cross Court and St Helen's.	100% 50 days; 75% 51.17 days; 50% 52.3 days	0.1000%	£360,000	53.14	43.08	52.63	57.00	48.79	
N7: Effective Discharge									
7.1 Effective Discharge - Self-Management Care Plans on Discharge Q1 Clinical Engagement, Q2 Implementation, Q3 & Q4 Rollout	Q4: 60%	0.2500%	£900,000	Implementation plan to be agreed by Q2					
7.2 Effective Discharge - Nursing Assessments - 80% of patients to have a combined nursing risk assessment on emergency admission with a LoS greater than 24 hrs - 100% of these assessments should be made available to the NCT via access to CPD		0.0500%	£180,000	Implementation Plan by Q2 and full implementation by Q4					
N8: Respiratory									
8.1 Respiratory - Asthma - bi-annual audit of patients attending ED with asthma discharged home with completed care bundle	75%	0.0500%	£180,000	Q2 baseline only					Under 19
	75%								Over 19
N9: Stroke Accreditation									
9 Level 2 Accreditation to be achieved at Scarborough Hospital by end of Q3		0.5000%	£1,800,000	Q2 and Q3 only					

Contracted Performance Requirements 2013/14: Quality and Safety

Indicator	Consequence of Breach	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Infection Prevention							
Rates of Clostridium difficile	*Schedule 4 part H (confirm calc)* **Quarterly:** 1 Monitor point	**> 43**	21	4	6	2	12
Zero tolerance MRSA - **NO LONGER A MONITOR TARGET FROM OCT 2013**	Non payment of inpatient episode **Quarterly:** 1 Monitor point	**0**	0	1	1	0	2
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) cases	Non payment of inpatient episode (VoY)	**30**	10	3	3	3	9
Mortality							
Mortality - HSMR - to maintain or improve against the 12/13 outturn position	Performance Notice	**>= 12/13**					
Mortality - SHMI - to maintain or improve against the 12/13 outturn position	Performance Notice	**>= 12/13**	1.04				
Number of Inpatient Deaths	none - monitoring only	**none**		188	170	163	
Inpatients							
Percentage of emergency admissions where A&E attendance in previous 24 hours and patient discharged from A&E	Performance Notice	**tba**		3.0%	3.0%	3.5%	
% Compliance with WHO safer surgery check list	Non-compliance of any areas will require RCA and Remedial Action Plan £500 penalty if not achieved within 3 consecutive months (ER)	**95%**	Written assurance				
% non-elective spells with operation within 2 days of admission	Quarterly: Performance Notice	**>2012/13 average**					
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	394	102	to follow	to follow	to follow
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	1267	427	to follow	to follow	to follow
Number of medication errors affecting CYP (under 19yrs old)	Performance Notice (ER)	**none**					
Number of medication errors causing serious harm affecting CYP (under 19yrs old)	Performance Notice (ER)	**none**					

Contracted Performance Requirements 2013/14: Quality and Safety

Indicator	Consequence of Breach	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Stroke/TIA							
Proportion of stroke patients who spend >90% of their time on a stroke unit	Performance Notice (ER)	**80% (York)**	86.0%	89.7%	88.9%	to follow	to follow
Proportion of people at high risk of stroke who experience a TIA are assessed and treated within 24 hours of first contact with a health professional	Performance Notice (ER)	**60% (VoY) 75% (ER)**	74.5%	76.3%	73.2%	to follow	to follow
Percentage of patients presenting with stroke with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter for anti-coagulation	Performance Notice (ER)	**60%**	70.8%	100.0%	80.0%	to follow	to follow
Percentage of patients and carers with joint care plans on discharge from hospital. Percentage of patients with confirmed stroke who have a copy of their joint care plan on discharge from hospital subject to exceptions included in guidance (except patients RIP or who refuse a health/social care assessment/intervention)	Performance Notice (ER)	**85%**					
% of stroke patients scanned within 24 hours of hospital arrival	Performance Notice	**100%**	86.9%	75.6%	82.0%	to follow	to follow
Maternity							
Women who see a midwife or maternity healthcare professional by 12 weeks and 6 days of pregnancy	Performance Notice	**90%**	91.6%	94.4%	91.6%	to follow	to follow
Number/percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service – subject to patient consent	Performance Notice (VY)	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%
Percentage of maternity patients recorded as smoking at delivery that are referred to a smoking cessation service– subject to patient consent	Performance Notice (VY)	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%
% of women initiating breast feeding.	Performance Notice	**60%**	68.3%	73.3%	70.8%	70.4%	71.5%
Number of term babies admitted to NICU or SCBU	Performance Notice	**none**	29	12	16	12	40
Number of adverse midwifery/obstetric related incidents	Performance Notice	**none**	0	0	0	0	0
Number/percentage of women recorded as smoking by 12 weeks and 6 days	Performance Notice	**none**	202	90	63	72	225
Number of babies born between 32 and 36 weeks	Performance Notice	**none**	65	18	18	27	63
Number of babies born between 28 and 31 weeks	Performance Notice	**none**	4	2	4	4	10
Number of babies born between 24 and 27 weeks	Performance Notice	**none**	4	1	3	1	5
Number of babies born under 24 weeks	Performance Notice	**none**	0	0	0	0	0
Number of babies put to the breast within 1 hour of birth (Breast feeding initiation report)	Performance Notice	**none**	641	322	308	302	932

York Teaching Hospital NHS Foundation Trust

Contracted Performance Requirements 2013/14: Quality and Safety

Indicator	Consequence of Breach	Threshold	Q1 Actual	Jul	Aug	Sep	Q2 Actual
Discharge Notifications							
Immediate Discharge letters – 24 hour standard: York Hospital	Quarterly: Performance Notice (VoY) £3k per quarter (ER)	**90% - Q2** **92% - Q3** **93% - Q4**		data to follow			
Immediate Discharge letters – 24 hour standard: Scar/Brid hospitals	Quarterly: Performance Notice (VoY) £3k per quarter (ER)	**30% - Q2** **60% - Q3** **90% - Q4**		data to follow			
Immediate Discharge Letters (IDLs) handed to patients on Discharge	Quarterly: Performance Notice	**98%**	Written assurance				
Percentage of IDLs that meet the minimum quality for IDLs (SIGN standard)	Quarterly: Performance Notice (VoY) £7k per quarter (ER)	**90% Q4**					
Quality of ED IDLs - York	Quarterly: £6k per quarter (ER)	**Q1: 80%** **Q2: 83%** **Q3: 85%** **Q4: 90%**	Quarterly audit of 60 Pts				
Quality of ED IDLs - Scarborough	Quarterly: £6k per quarter (ER)	**Q2 - 30%** **Q3 - 60%** **Q4 - 90%**	Quarterly audit of 60 Pts				

F2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 October 2013

Finance Report

Action requested/recommendation

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 30th September 2013.

At the end of September, there is an Income and Expenditure deficit of £0.2m (after restructuring costs of £0.5m) against a planned surplus for the period of £0.5m, and an actual cash balance of £20.3m. The Income and Expenditure position places the Trust behind it's 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

None directly identified.

Reference to CQC outcomes

No reference to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director

Author	Graham Lamb – Deputy Finance Director
Date of paper	October 2013
Version number	Version 1

Briefing Note for the Finance & Performance Committee Meeting 22 October 2013
Briefing Note for the Board of Directors Meeting 30 October 2013

Subject: September 2013 Financial Position (Q2)

From: Andrew Bertram, Finance Director

Summary Reported Position for September 2013

The attached income and expenditure account shows an actual £0.2m deficit of income over expenditure. This is £0.7m behind the Trust's operational plan of an expected surplus of income over expenditure of £0.5m.

Of note is that the position includes restructuring costs of £0.5m relating to redundancy and MARS and donated income of £0.3m. Both are excluded in Monitor's assessment of our position. Underlying performance is therefore reported as a broadly balanced I&E.

Income Analysis

The income position is based on coded and costed April to August activity and an estimate has been used for September (based on reported activity levels but using average specialty costs). At this stage overall income is assessed to be £3.8m ahead of plan. This represents a very modest increase on that reported last month (£3.5m).

This remains of concern in terms of CCG affordability. The position is openly discussed with the CCGs in the Contract Management Board and the associated Finance and Performance Subgroup meetings. Agreed actions to manage the position include the follow up reduction work and the CCG's planned implementation of a Referral Support Service (RSS). This is being piloted in two Practices for a limited number of specialties. The process will involve checks of all referrals to ensure all primary care pre-work up and alternative management has been undertaken and the appropriateness of the referral will be assessed. It is the CCG's assessment that the RSS will reduce demand into the hospital.

We are continuing to report actual and potential contract penalties and the Board need to be aware of further instances having occurred. Included in the position to date are anticipated penalties of £1m. This comprises actual penalties of £95k for 52-week breaches, a £255k assessment of likely 18-week RTT penalties at specialty level, a £71k assessment of the ED 4-hour target breach in Q2, a £550k assessment of the impact of the excess c diff to trajectory (11 cases above trajectory at £50k per case) and a small number of minor penalties. In the case of the c diff assumption this is clearly only a marker at this stage as the delivery is contractually measured for the full year. There is time to correct the position although this is increasingly challenging. Of note is the Q1 c diff position in comparison to that of Q2 where cases in excess of trajectory fell from 10 to 1.

Also of note is that an assessment of £0.7m has been made as to the value of follow up work undertaken in addition to the 1:1.5 new to follow up patient ratio. The reality is over £1.2m worth of work has been done in addition to the ratio of 1:1.5 but the clinical safety evidence is now strong to argue for payment. The ratio has fallen from 1:2.1 to 1:1.8, delivering a significant QUIPP for the CCGs. We are now assuming payment for the work between 1:1.8 and 1:1.5 at the prudent level of at least £0.5m. I expect this position to improve further following review of the QUIPP scheme with the CCGs as, I believe, the CCG's argument for non-payment is diminishing in the face of clear auditable patient follow up safety data.

Expenditure Analysis

Pay is reported as £1.7m overspent. This is the net position after release of reserves for escalation areas and other agreed developments. Pressures in the main relate to premium costs associated with the continued and necessary use of temporary staff plus costs associated with higher than planned levels of Extra Contractual Work necessary to meet access targets. ECP budgets are £0.6m overspent against plans, with notable pressures of £0.2m in both Radiology (delivery 6-week scanning access) and Endoscopy (delivery of diagnostic capacity).

The balance of the pay cost pressure is not easily attributable to a single issue but is varied in nature. These pressures form part of the PMM discussions with directorates. A notable pressure area is agency staff to support unplanned increased Chlor Cleans on site (£0.1m) as part of our infection control strategy.

Drug costs are over spent by £1.5m with this almost exclusively relating to pass through drug costs excluded from tariff (particularly high cost rheumatology and oncology drugs). There is corresponding additional income in this regard. There are no operational drug pressures to report in terms of regular tariff funded drug expenditure. Pressure in this budget area is causing the CCGs and Specialist Commissioners concern.

Clinical supplies and services are under spending against planned levels with other costs also showing an under spend position. There are no issues I would wish to bring to the Board's attention.

The report shows that the CIP programme is impacting adversely on the position by £2.6m. This is dealt with in the CIP report. Whilst this represents a £1m variance improvement from last month this is clearly placing pressure on the reported income and expenditure position but being compensated for by additional income and slippage on planned developments.

Contracting Matters

Other than issues of additional work having been provided above plan and contract penalties (both discussed above and in the report) there are no issues with the Trust's main commissioners to bring to the Board's attention.

Contracts with the Local Authorities have now been signed by York and have been returned to the LAs for signature. At the time of writing this briefing we are awaiting return of signed copies from both NYCC and CYC.

Other Issues

With regard to the outstanding but agreed £15m capital support there are no issues I wish to bring to the Board's attention. Discussions continue and the release of funds is expected imminently.

Future Contracting Issues

I recently attended a briefing from the Department of Health concerning the likely contractual framework for next year. At this stage most aspects still require formal ratification but there are some interesting developments likely to occur that I would wish to share with the Board.

Firstly, it is likely that the tariff deflator assumption in our financial model (currently -1.3%) will be worse in the final settlement. Early indications are this is likely to be between -1.6% and -1.9%. This shouldn't be taken in isolation as tariff setting is a complicated process and there may be compensatory gains elsewhere and the assessment of inflationary pressures is not yet complete, but the Board should be aware that any settlement is likely to be worse than our planning assumptions.

Secondly, there has been much debate about the 2008/09 baseline and 30% marginal tariff for non-elective activity. Indications are that the rate and baseline will remain but Trust's that have experienced significant growth in this area will have the right to request a formal review potentially leading to a baseline uplift. Detail is not yet available as to the process but we will be considering this route given the pressures we experience. There are likely to be public transparency requirements on the CCG associated with any review and Monitor have indicated they expect to be informed of the outcome by the CCG. Monitor have also confirmed that they intend to take a more formal role with regard to the assurance that 70% non-elective savings have been appropriately re-invested in admission avoidance activity. This is also the case for CCG savings from re-admission savings. This will be an issue for our locality.

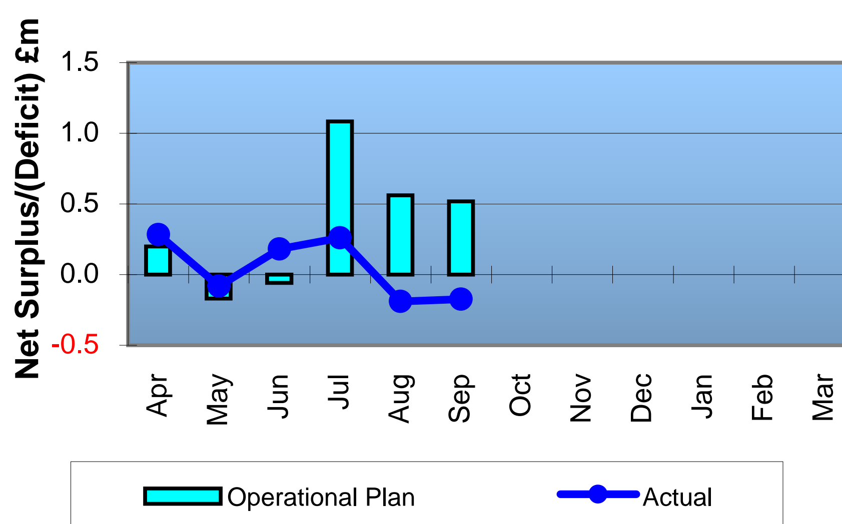
Thirdly, there are developing processes for deviations from national tariff. A process of a "modification" to tariff is described for services that can demonstrate they are financially unviable under national tariff arrangements. This will not be a license for FTs to cherry pick loss making services and seek higher tariffs but, subject to strict review by Monitor, the opportunity will formally exist for consideration to be given to long-term tariff support for services (particularly at small units like Scarborough) that are demonstrably not financially viable.

CQUIN will remain at 2.5% and financial contract penalties will also remain. There is likely to be a cap on the number of local CQUIN schemes (it was suggested this will be 9) as the DH have expressed some concern over the level in some areas. This will remain 0.5% for national schemes and 2% for local schemes. There is a clear intent within the DH to reduce the burden of financial penalties away from the perceived excessive levels with c diff for example. We can expect lower level sanctions, but still material over a cumulative impact, for trajectory breaches.

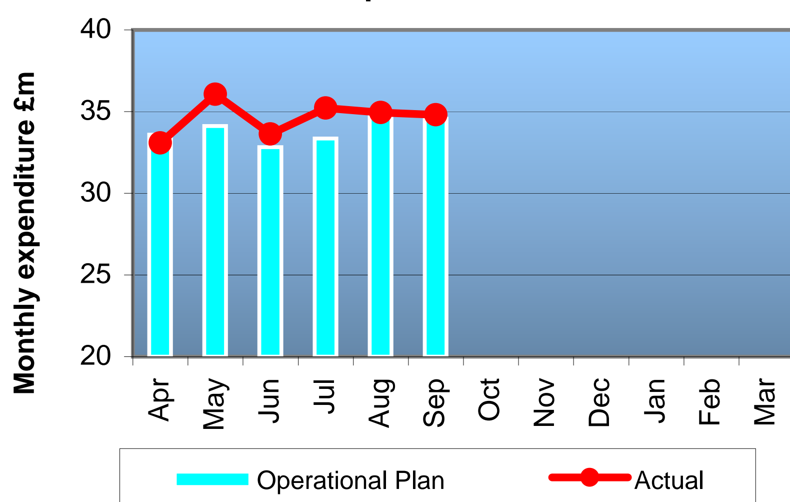
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 30 September 2013

High Level Overview

* A net I&E deficit for the period of £0.2m means the Trust is £0.7m behind plan.
* CIPs achieved at the end of September total £12.5m. The CIP position is running £2.6m behind plan.
* Income from all contracts is assessed to be ahead of plan by £4.8m.
* Cash balance is £20.3m, and is £12.3m behind plan. £15m PDC is still awaited.
* Capital spend totalled £5.1m, and is behind plan.
* The provisional Monitor Financial Risk Rating is 3, which is on plan.



Key Period Operational Variances	Plan £m	Act.£m	Var. £m
Clin.Inc.(excl. Lucentis)	180.0	184.6	4.6
Clin.Inc.(Lucentis)	5.2	4.0	-1.2
Other Income	26.9	27.2	0.4
Pay	-142.0	-143.7	-1.7
Drugs	-17.4	-18.8	-1.5
Consumables	-20.6	-20.5	0.1
Other Expenditure	-23.2	-24.6	-1.4
	8.8	**8.1**	**-0.7**



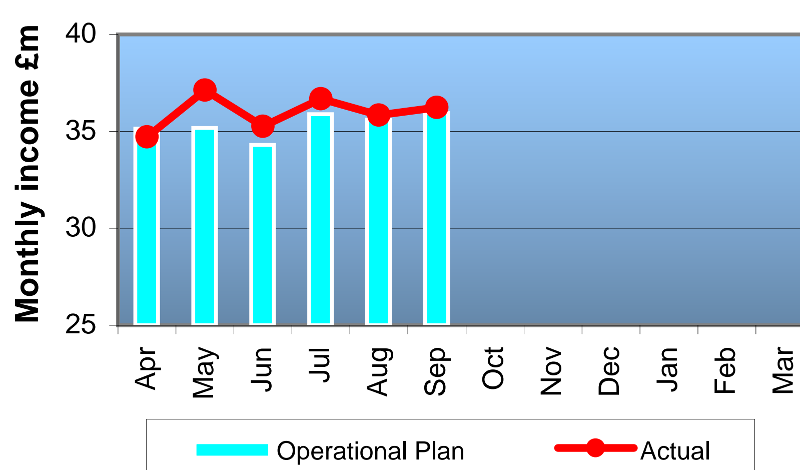
At the end of September there is an adverse variance against operational expenditure budgets of £4.5m. This comprises:-
- Operational pay being £1.7m overspent.
- Drugs £1.5m overspent, mainly due to pass through costs linked to drugs excluded from tariff.

- Clinical supplies £0.1m underspent.

- Other costs are £1.7m underspent, primarily due to slippage on planned investments

- Restructuring costs (MARS and redundancies) are £0.5m overspent

- CIPs are £2.6m behind plan

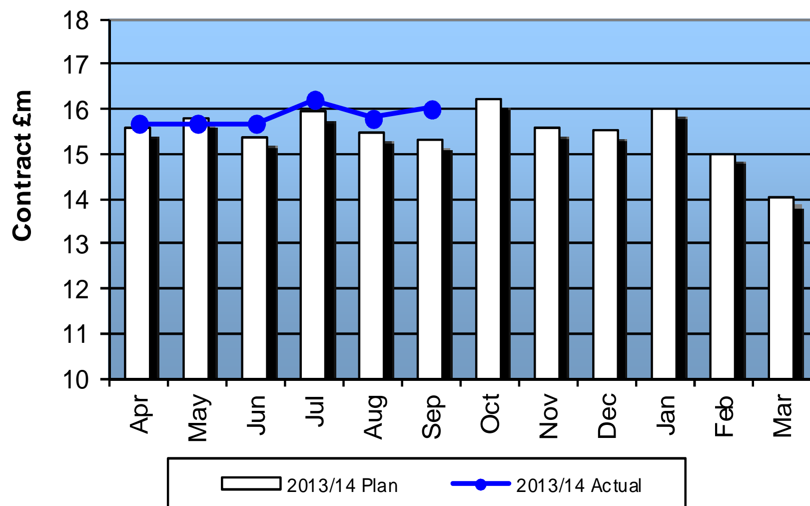


At the end of September income is ahead of plan by an estimated £3.8m. This comprises:

- Elective and day case income are ahead of plan by £0.8m.
- Non elective income is ahead of plan by £0.9m.
- Community income is marginally ahead of plan by £0.3m.
- Out patient income is ahead of plan by 0.9m
- A&E is ahead of plan £0.5m.

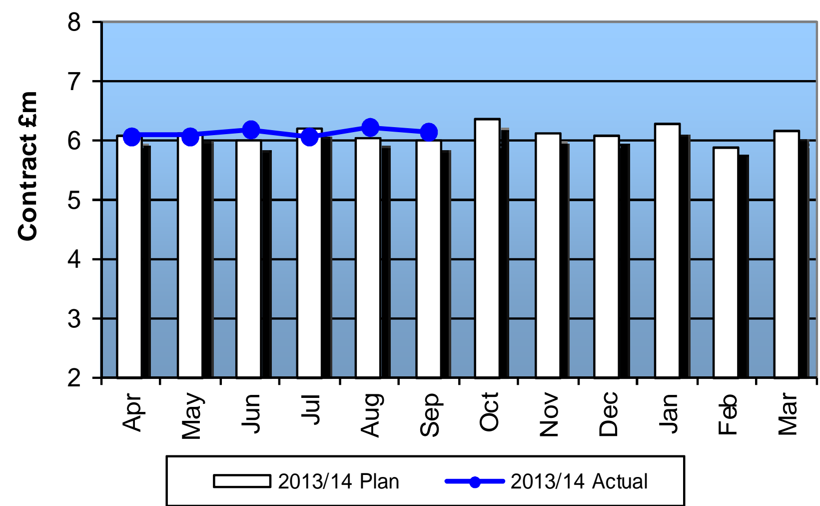
- Other clinical income is ahead of plan by £1.6m.
- Other income is £0.4m ahead of plan
- Contract penalties and the effect of CCG QIPP schemes are estimated at £1.6m.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 30 September 2013



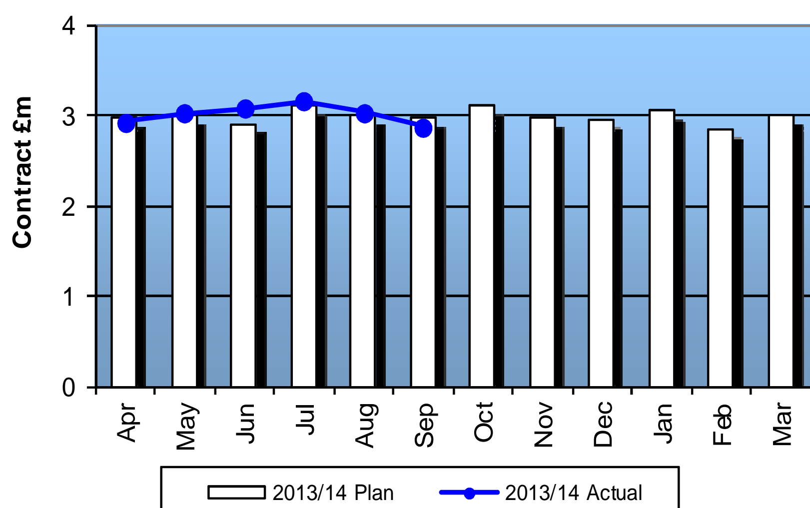
The contract value is £185.7m.

The contract is ahead of plan by £1.6m ahead of plan and includes estimates for the month of September.
The actual value has been reduced to take account of anticipated contract penalties.



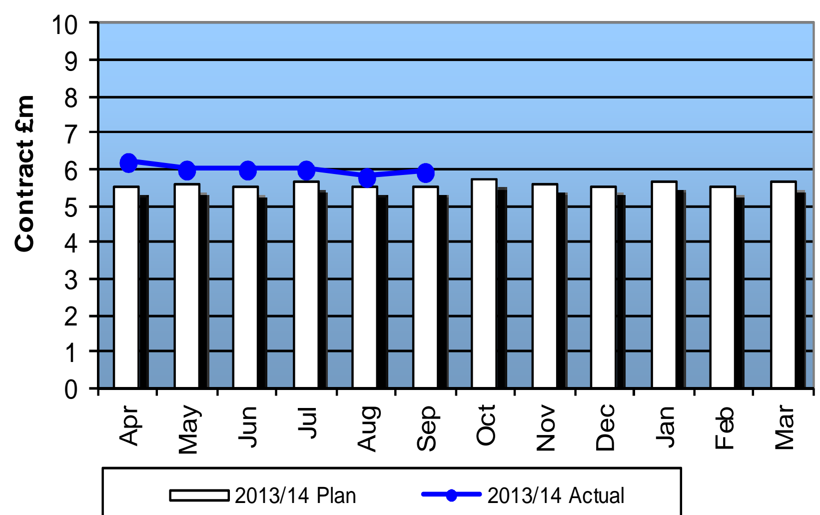
The contract value is £73.1m.

The contract is marginally ahead of plan by £0.4m, and includes estimates for September. The actual value has been reduced to take account of anticipated contract penalties.



The contract value is £35.8m

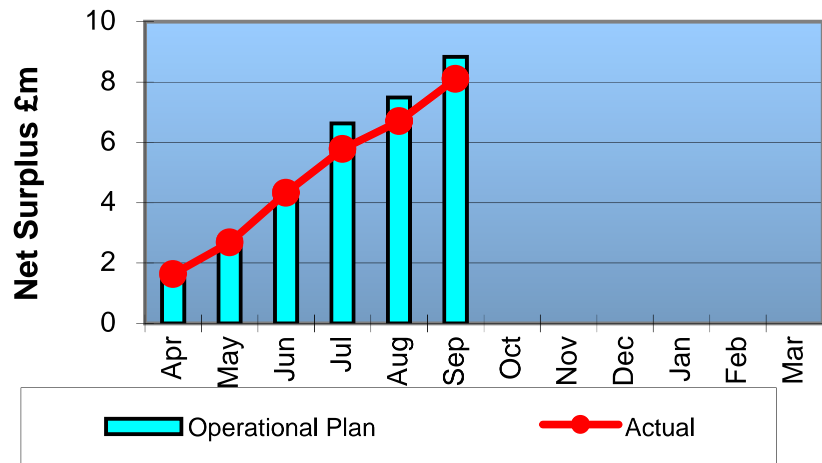
The contract is marginally ahead of plan by £0.1m, and includes estimates for September. The actual value has been reduced to take account of anticipated contract penalties.

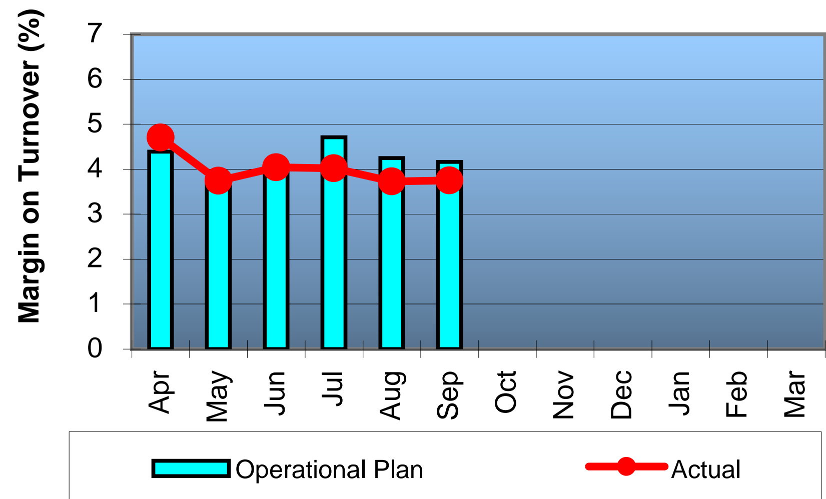


The total contract value is £67.0m

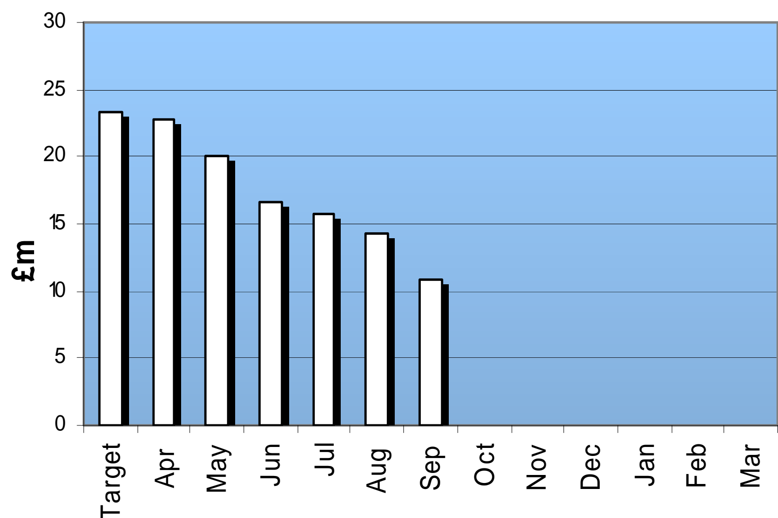
These include the smaller CCG contracts, NHS England (both public health services and prescribed specialist services), and Local Authority contracts. Overall contracts are ahead of plan by an estimated £2.7m. Prescribed specialist services are £2.0m ahead of plan, and Hambleton, Whitby and Richmondshire CCG is £0.5m ahead of plan. These positions include estimates for September.

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 30 September 2013

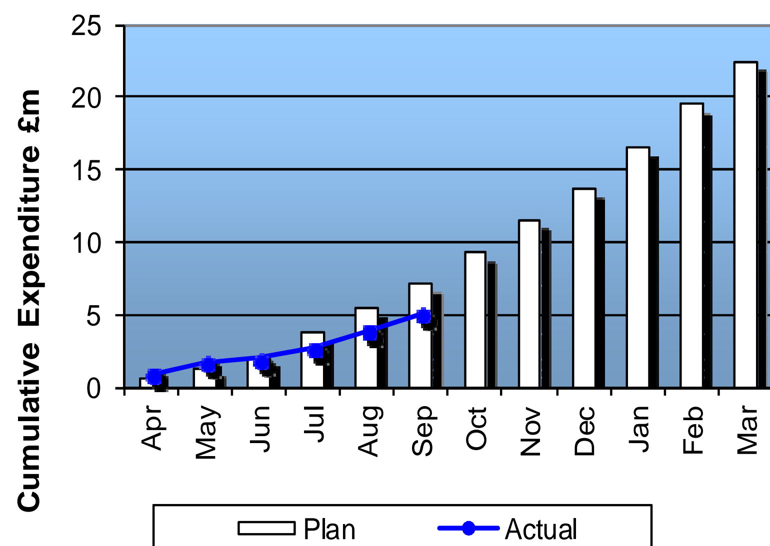




Actual EBITDA at the end of September is £8.1m (3.75%), compared to operational plan of £8.8m (4.16%), and is reflective of the overall I&E performance.

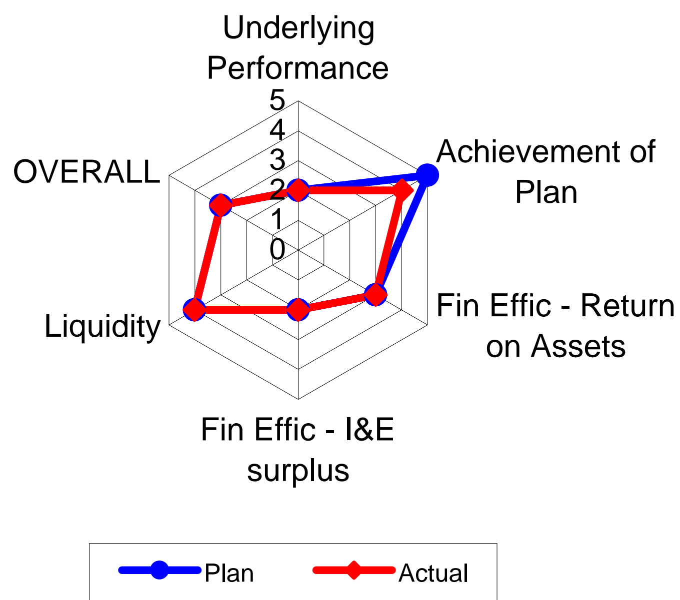


The full year efficiency requirement is £23.4m. At the end of September £12.5m has been cleared.



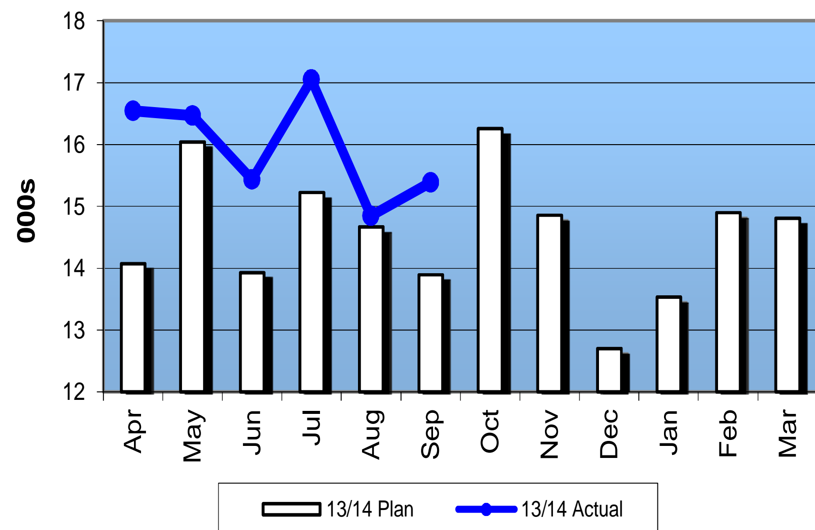
Capital expenditure to the end of September totalled £5.1m and is behind plan.

Capital schemes with significant in year spend to date include the pharmacy robot now complete, the maternity theatre upgrade at SGH upgrade of ward kitchens in York, 2nd CT scanner replacement. The carbon & energy scheme has also started.



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

The 'Achievement of Plan' is behind the plan submitted to Monitor and is reflective of the I&E position being behind plan.



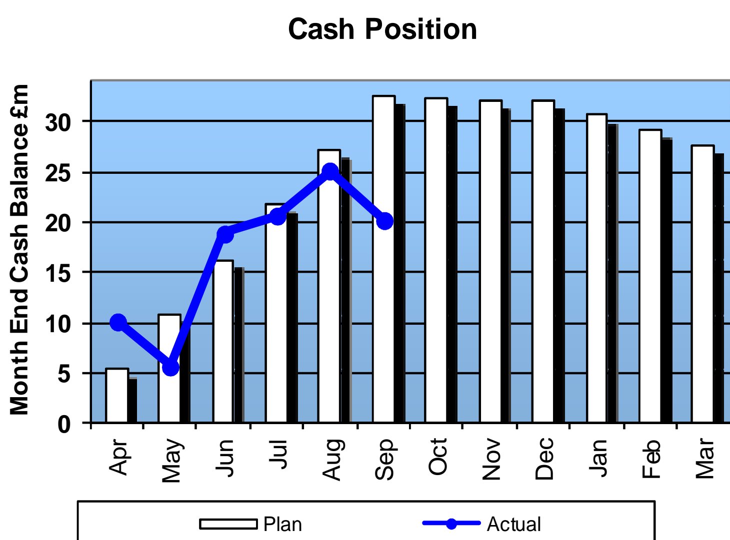
Annual plan 174,884 referrals (based on full year equivalent of 2012/13 outturn)

Variance at end of September: +7,906 referrals (+9%)

GP referrals +5,087 (+10%)

Cons to Cons referrals +361 (+3%)

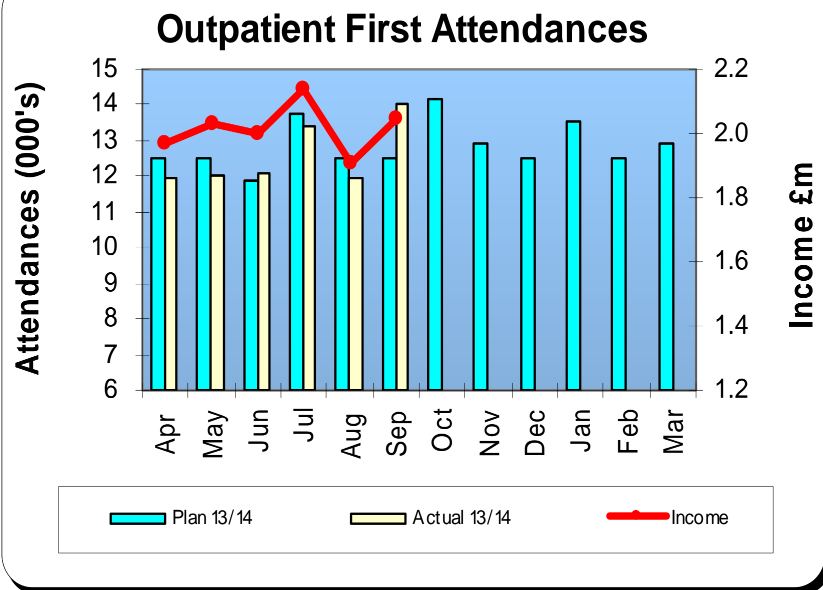
Other referrals +2,458 (+11%)



The cash balances at the end of September totalled £20.3m and is £12.3m behind plan. The position includes the £12m transitional income support for the whole year received in June, however £15m additional PDC for capital is still awaited.

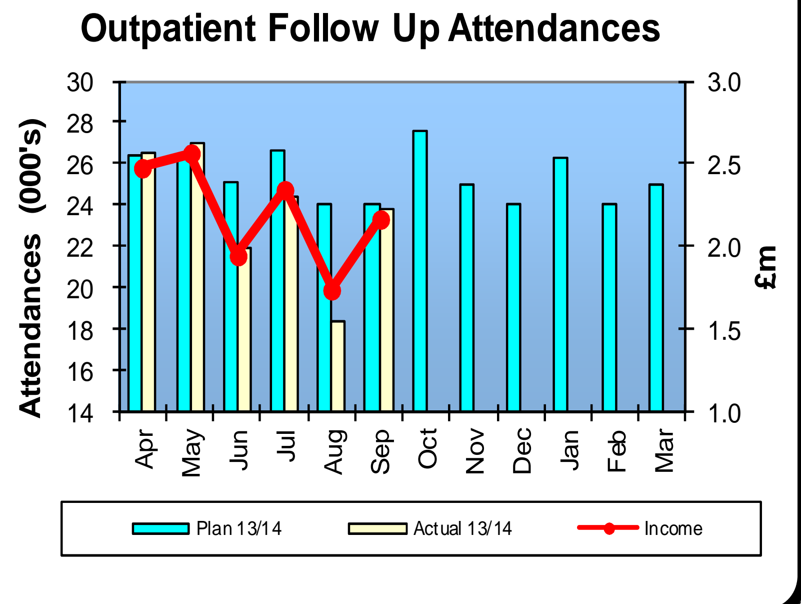
Monitor Liquidity Ratio					
Risk Rating	5	4	3	2	1
Days Cover	60	25	15	10	<10
Trust Actual Days		31			

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 30 September 2013



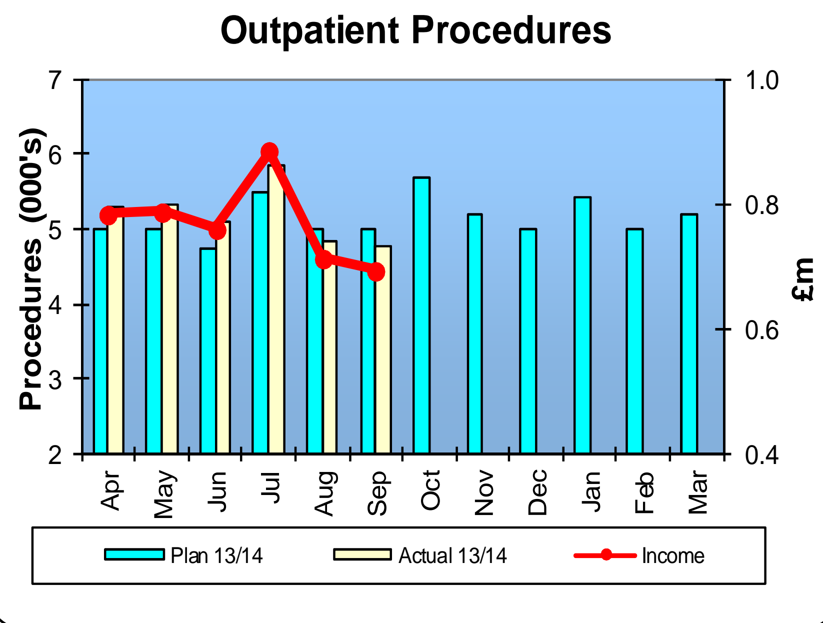
Annual Plan (Attendances) 154,195
Variance at end of September: -1,840 attendances (-2%).

Main variances: Opthalmology -1,961 (-19%), ENT -516 (-11%), Gastroenterology -356 (-13%), Cardiology +1,554 (-21%)



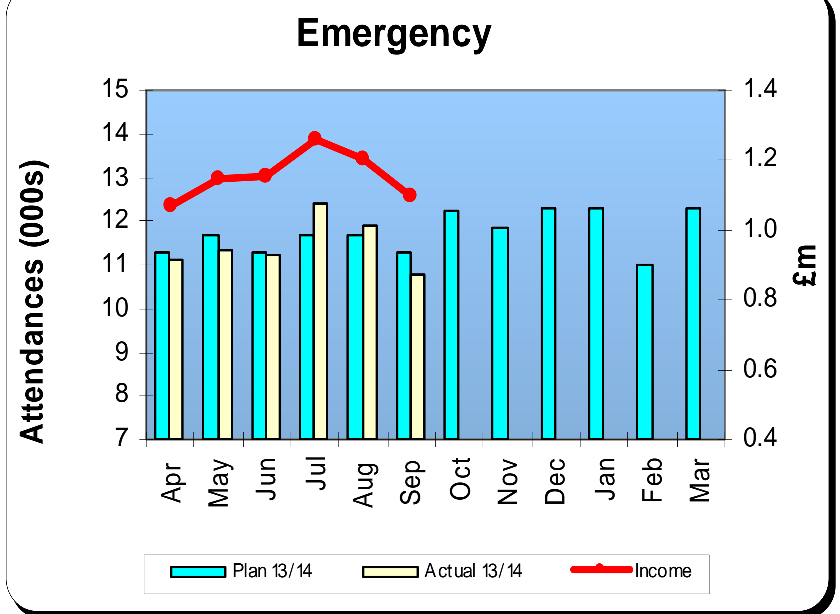
Annual Plan (Attendances) 325,838
Variance at end of September: -21,183 attendances (-13%).

Main variances: General Surgery -1,539 (-13%), Urology -1,439 (-23%), Opthalmology -12,149 (-31%), Anaesthetics -1,962 (-47%), and Medical Oncology +3,602 (+50%)



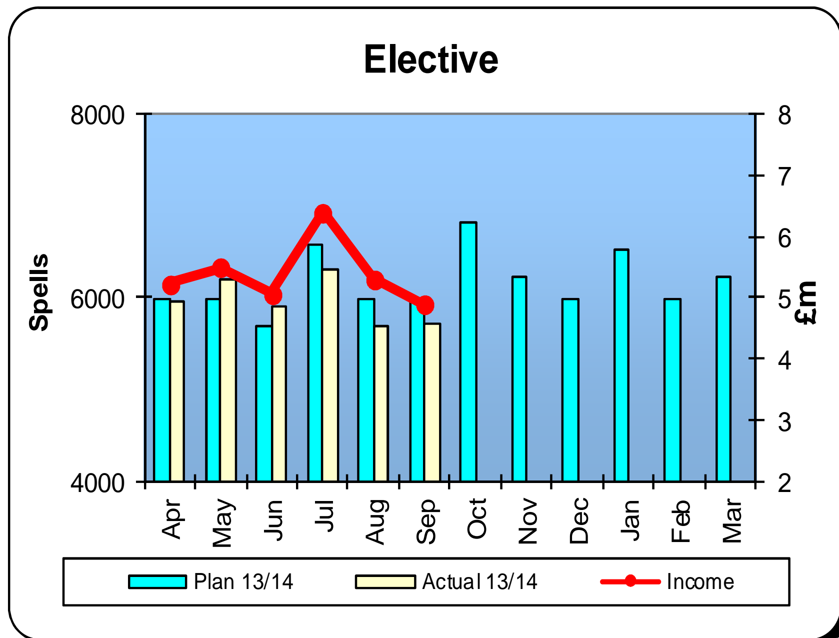
Annual Plan (Procedures) 61,660
Variance at end September: +244 procedures (+0.8%).

Main variances: ENT +480 (+12%), Orthodontics +889 (+25%), Dermatology +96 (+1%), Cardiology -253 (-9%), and Gynaecology -816 (-29%).



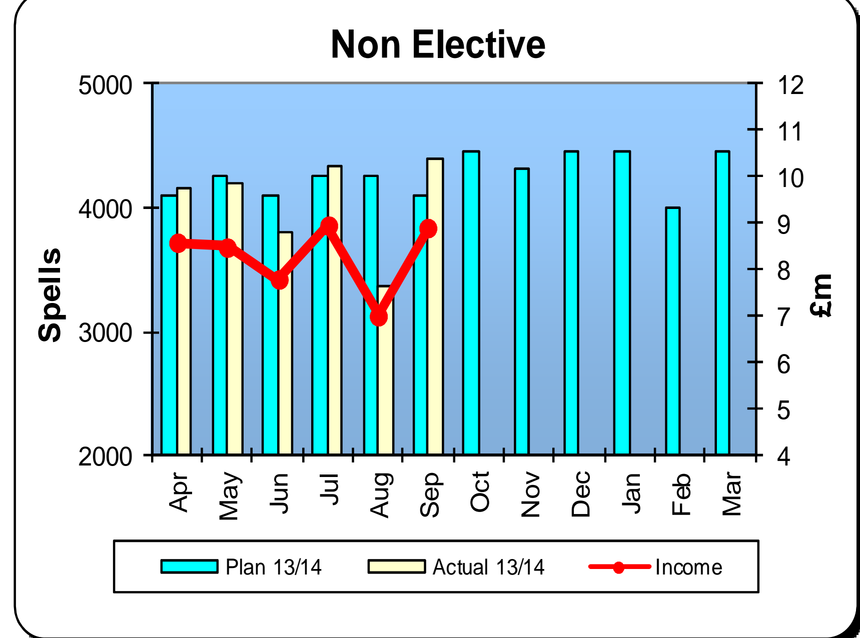
Annual Plan (Attendances) 140,970
Variance at end September: -141 (-0.2%).

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
Financial Report for the Period 1 April 2013 to 30 September 2013



Annual Plan (Spells) 74,033
Variance at end of September: -1295 spells (-3.0%): inpatient -306; daycase -989

Main variances: General surgery -480 (-9%), Urology +253 (+5%), Gastroenterology -1266 (-19%), and Haematology +376 (+19%).



Annual Plan (Spells) 51,245
Variance at end of September: -1,181 spells (-5%).

Main variances: Geriatric medicine +183 (+4%), Paediatrics -600 (-15%), and Trauma & Orthopaedics +293 (+22%).

Contract Penalties

Other Penalties	YTD Actual	Penalty £000	Comments
Clostridium Difficile	33	550	Annual target 43; period target 22. £50k penalty per case over target.
52 week breaches	19	95	£5k penalty per breach per month. 12 GenSur (York); 2 GenSur (Scar); 2 Ophthal (Scar); 2 Gynae (York). 1 Urology (York).
18 week breaches:			Figures are estimates and awaiting confirmation.
- Admitted (90% target, weighting 37.5%)	n/a	70	GenSur £22k; Gynae £20k; Anaes £6k: Rheumatology £3k, Urol;ogy £3k.Haematology £4k, cardiology £3k.
- Non-admitted (95% target, weighting 12.5%)	n/a	67	Gen Sur £17k; Urology £13k Anaesthetics £7k, Gastro £4k, T&O £2k, Rheumatology £2kcardilogy £1k.
- Incomplete pathways (92% target, weighting 50%)	n/a	36	GenSur £11k; Gynae £4k; Urology £7k; T&O £7k; Opthalmology £2k,
- Estimate for September	n/a	84	An estimate for the month of September has been included.
First to Follow up ratio	n/a	718	The ratio stands at 1.90 cummulatively to September against a target of 1.5, giving an estimated penalty of £718,000.
MRSA	2	5	Penalty estimated and will be the HRG income.
Mixed Sex breaches/Trolly wait	24	7	VIU / Trolly Waits
		1,632	

APPENDIX A

YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
SUMMARY INCOME & EXPENDITURE POSITION
FOR THE PERIOD 1st APRIL 2013 to 30th SEPTEMBER 2013

	ANNUAL PLAN	PLAN FOR PERIOD	ACTUAL FOR PERIOD	PERIOD VARIANCE
	£000	£000	£000	£000
INCOME				
NHS Clinical Income				
Elective Income				
Tariff income	25,909	12,695	12,901	206
Non-tariff income	578	283	64	-219
Planned same day (Day cases)				
Tariff income	37,506	18,378	19,058	680
Non-tariff income	525	257	367	110
Non-Elective Income				
Tariff income	98,342	48,161	49,128	967
Non-tariff income	1,537	753	650	-103
Outpatients				
Tariff income	61,480	30,125	30,108	-17
Non-tariff income	5,611	2,806	3,727	921
A&E				
Tariff income	12,397	6,073	6,624	551
Non-tariff income	612	300	300	0
Community				
Tariff income	1,024	494	595	101
Non-tariff income	33,417	16,690	16,939	249
Other				
Tariff income	0	0	0	0
Non-tariff income	98,162	48,171	49,777	1,606
Fines and Contract Penalties		0	-1,632	-1,632
	377,100	**185,186**	**188,606**	**3,420**
				0
	377,100	**185,186**	**188,606**	**3,420**
Non-NHS Clinical Income				
Private Patient Income	1,088	544	514	-30
Other Non-protected Clinical Income	1,879	943	883	-61
	2,967	**1,488**	**1,397**	**-90**
Other Income				
Education & Training	13,804	6,902	7,004	102
Research & Development	8,027	4,014	4,226	212
Donations & Grants received of PPE & Intangible Assets	0	0	0	0
Donations & Grants received of cash to buy PPE & Intangible Assets	240	120	300	180
Other Income	16,837	8,350	8,309	-41
Transition support	11,985	5,992	5,992	0
	50,892	**25,378**	**25,831**	**453**
Total Income	**430,960**	**212,051**	**215,834**	**3,782**
EXPENDITURE				
Pay costs	-290,982	-141,992	-143,731	-1,739
Drug costs	-35,095	-17,364	-18,848	-1,484
Clinical Supplies & Services	-41,706	-20,642	-20,513	129
Other costs (excluding Depreciation)	-54,685	-25,817	-24,105	1,712
Restructuring Costs	0	0	-537	-537
CIP	10,851	2,595	0	-2,595
Total Expenditure	**-411,617**	**-203,220**	**-207,734**	**-4,514**
EBITDA (see note)	**19,343**	**8,831**	**8,100**	**-732**
Profit/ Loss on Asset Disposals	0	0	-5	-5
Fixed Asset Impairments	-300	0	0	0
Depreciation	-10,854	-5,427	-5,427	0
Interest Receivable/ Payable	65	33	44	12
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	-135	-104	31
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	-5,566	-2,783	-2,783	0
Taxation Payable	0	0	0	0
NET SURPLUS/ DEFICIT	**2,418**	**519**	**-175**	**-694**

F3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30th October 2013

Efficiency Programme Update

Action requested/recommendation

To note the contents of the report.

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. Delivery in September is behind plan, and the Monitor variance remains significantly behind plan by (£2.6m). There is also a planning shortfall of (£2.4m) for the current year.

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

There are no implications for equality and diversity.

Reference to CQC outcomes

There is no reference to any CQC outcomes.

Progress of report	Finance and Performance Committee
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	October 2013

Board of Directors – 30th October 2013

Efficiency Programme Update

1. Executive Summary

The full year plan to Monitor is £23,363k.

In period 6 we have achieved £12,512k in full year terms.

In September 2013 we are behind the Trust plan to Monitor by **(£2,595k)**.

Table 1 below provides a high level summary of progress.

Table 1 – Executive Summary – September 2013	Total
	£'000
In year target	
In year target	**23,363**
In year delivery	
Delivery - recurrent	4,846
Delivery – non-recurrent	7,666
Total delivery	**12,512**
Delivery (gap)/ Over achievement	**(10,851)**
In year planning	
Further in year plans	**8,445**
In year planning (gap)/surplus	**(2,406)**
Part year Monitor position	**(2,595)**
Future planning	
4 year target	71,464
4 year plans total	57,674
4 year planning (gap)/surplus	**(13,790)**

2. Introduction and background

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme.

3. Efficiency position report

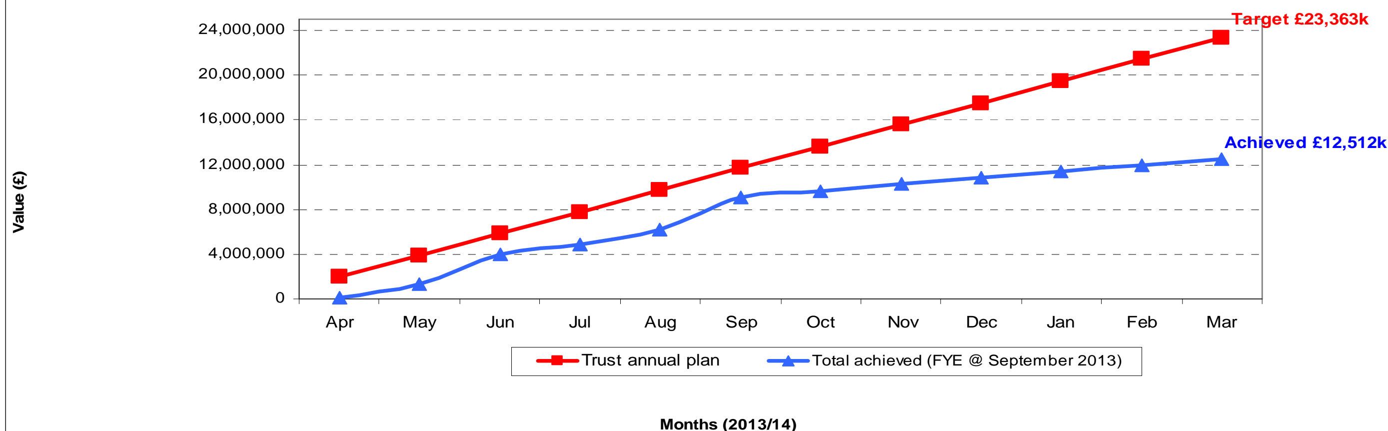
This report covers the period of 6 months to September 2013.

3.1 Trust plan to Monitor

The combined position is **(£2,595k)** behind the trust plan to Monitor as at September 2013; see

Table 2 and Chart 1 below.

Table 2	YTD August	September 2013	Total YTD
	£,000	£,000	£,000
Trust plan	9,734	1,947	11,681
Achieved	6,230	2,856	9,086
Variance	(3,504)	909	(2,595)



3.2 Full year position summary

As at September 2013, £12,512k has been achieved in full year terms against the plan of £23,363k (see Table 3 below). This is made up of £4,846k of recurrent and £7,666k non-recurrent schemes.

Table 3	Aug 2013	Sept 2013	Change
	£,000	£,000	£,000
Expenditure plan – 13/14	23,363	23,363	0
Target – 2013/14	23,363	23,363	0
Achieved - recurrently	3,502	4,846	1,344
Achieved - non-recurrently	5,534	7,666	2,132
Total achieved	9,036	12,512	3,476
Gap to achieve	(14,327)	(10,851)	3,476
Further plans	13,379	8,445	(4,934)
(Gap)/Surplus in plans	(948)	(2,406)	(1,458)

3.3 Workforce overview

Chart 2 below shows the impact of the Trust's Efficiency programme on workforce expenditure. Budgeted WTE has seen no change in the month. Table 4 below details the current vacancy gap.

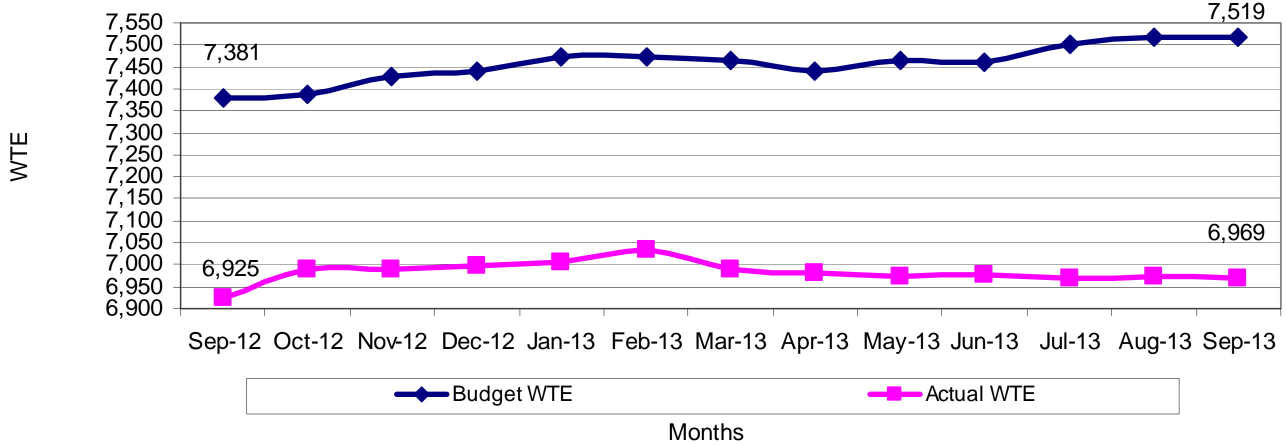


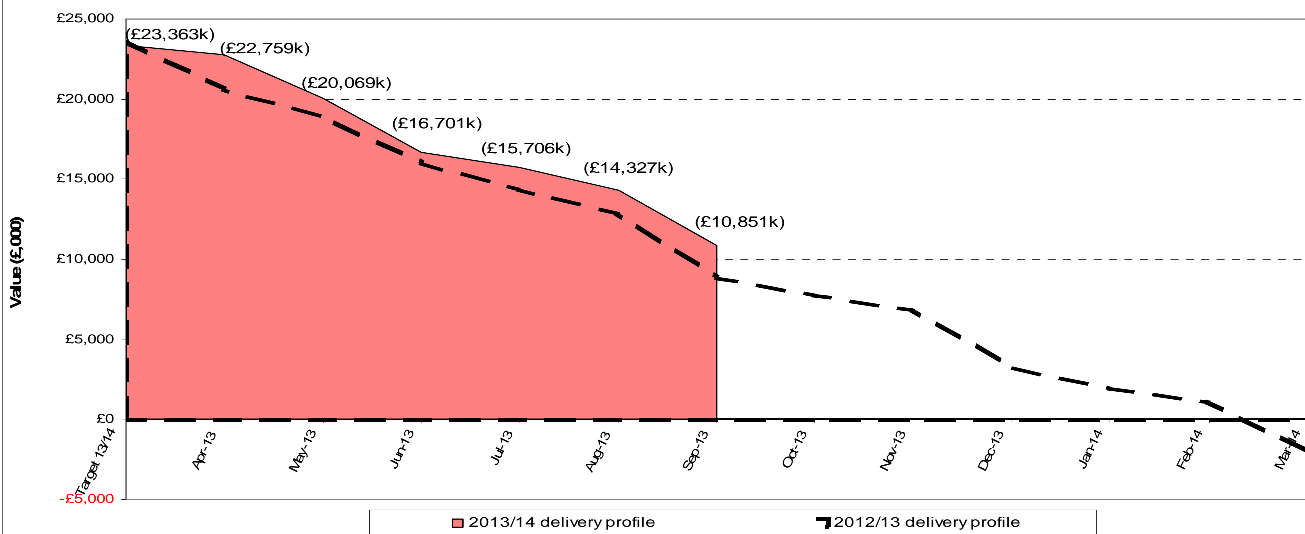
Table 4

	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Budget WTE	7,381	7,387	7,430	7,441	7,474	7,472	7,465	7,440	7,464	7,459	7,500	7,519	7,519
Actual WTE	6,925	6,991	6,990	6,997	7,004	7,034	6,990	6,982	6,974	6,978	6,969	6,972	6,969
Vacancy Gap %	6.2%	5.4%	5.9%	6.0%	6.3%	5.9%	6.4%	6.2%	6.6%	6.4%	7.1%	7.3%	7.3%

Actual WTE numbers have seen a small decrease of 3 across the Trust. Staffing levels are below budgeted levels due to the impact of staff turnover.

3.4 Delivery profile and further plans

The current full year deficit is £ (10,851k). Savings achieved by month are shown in Chart 3 below. The broken line shows delivery in 2012/13 which has been added for information.



Further plans have been formulated amounting to £8,445k. These are summarised in Table 5 below.

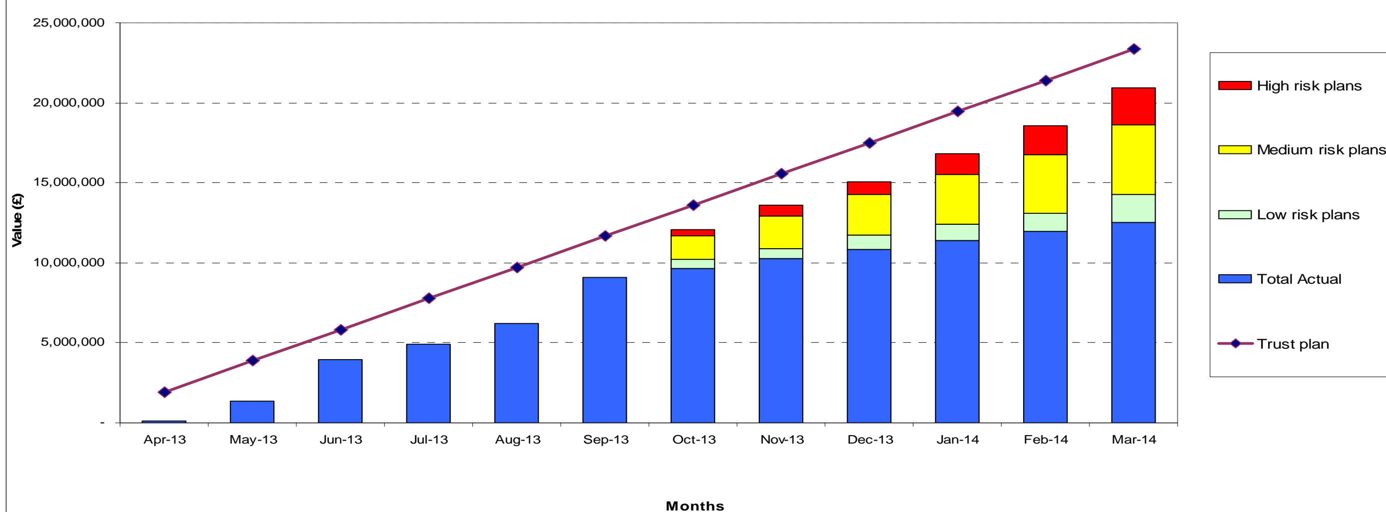
Table 5 – Further plans 2013/14

Risk	Gap Full Year	Plans - Recurrent	Plans - Non Recurrent	**Plans Total**	Shortfall in plans
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Low		1,109	680	**1,788**	
Medium		3,569	725	**4,294**	
High		2,191	171	**2,362**	
Total	**(10,851)**	**6,869**	**1,577**	**8,445**	**(2,406)**

3.5 Risk profile of further plans and forecast risk to delivery

Directorate plans are each assigned a risk rating.

The overall September 2013 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.



Significant work has been carried out to re-assess, remove or re-profile plans at the month 6 position to ensure a clear assessment of risk can be carried out.

3.6 Four year plans

Directorates are required to develop four year plans and Table 6 below summarises this position. There is currently a shortfall of (£13,790k) over 4 years on the base target.

Significant work is on going to reduce the impact of the non recurrent carry forward and schemes continue to be developed and assessed. The shortfall in plans offers a high risk to delivery.

Table 6 - 4 Year efficiency plan summary – September 2013

Year	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Base target	23,363	16,364	15,868	15,868	**71,464**
Plans	20,957	20,981	7,376	8,359	**57,674**
Variance	**(2,406)**	**4,617**	**(8,492)**	**(7,509)**	**(13,790)**

3.7 Finance risk rating

In year delivery is behind the same point last year with £12,512k (53%) delivered in September 2013 against £14,794k (62%) in September 2012.

A new risk scoring process has been developed and 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.

3.8 Governance risk rating

The governance rating, detailed in Appendix 1, is currently work in progress and is in the process of being implemented. The majority of areas have now self assessed their schemes and a full review with the Clinical Efficiency Lead is now underway.

To enable a green rating to be achieved, the Directorate must have assessed 100% of their in year efficiency plans against the Trust Risk Assessment System. A red rating represents <70% of plans assessed. This process should be carried out quarterly.

Plans which are identified as high risk through this process following review with the Clinical Efficiency Lead will be presented to the Finance and Performance Committee quarterly.

In addition high risk schemes will be presented to the Patient Safety Group, Chaired by the Trust Medical Director, for information.

4. Conclusion

Delivery in September 2013 is behind plan with £12,512k (53%) of full year schemes being delivered against the Trust plan of £23,361k; this compares with £14,794k (62%) in September 2012. This progress is significantly behind our Monitor profile by (£2,595k) in month 6.

We currently have a planning deficit in year of (£2,406k), which has slipped significantly following a full review at month 6.

The 4 year planning position highlights a shortfall in base plans of (£13,790k); this has slipped from the August 2013 position and is considered high risk.

5. Recommendation

The Board is asked to note the September 2013 position with its significant future potential risks to delivery. Significant and sustained action is required to close these gaps.

Author	**Steve Kitching, Deputy Head of Corporate Efficiency**
Owner	**Andrew Bertram, Director of Finance**
Date	**October 2013**

RISK SCORES - SEPTEMBER 2013										APPENDIX 1
DIRECTORATE	**FINANCE**					**GOVERNANCE**				
	R	**RA**	**A**	**AG**	**G**	**R**	**RA**	**AG**	**G**	
MEDICINE FOR THE ELDERLY SCARBOROUGH	**(1)**	2	3	4	5	○	○	○	●	
TACC YORK	**(1)**	2	3	4	5	●	○	○	○	
COMMUNITY	**(1)**	2	3	4	5	○	○	○	●	
WOMENS HEALTH	**(1)**	2	3	4	5	○	○	○	●	
OPHTHALMOLOGY	**(1)**	2	3	4	5	○	○	○	●	
SPECIALIST MEDICINE	**(1)**	2	3	4	5	○	○	○	●	
RADIOLOGY	1	**(2)**	3	4	5	○	○	○	●	
GS&U	1	**(2)**	3	4	5	○	○	○	●	
LAB MED	1	**(2)**	3	4	5	○	○	○	●	
ED YORK	1	**(2)**	3	4	5	●	○	○	○	
HEAD AND NECK	1	2	**(3)**	4	5	○	○	○	●	
T&O YORK	1	2	**(3)**	4	5	○	○	○	●	
MEDICINE FOR THE ELDERLY	1	2	**(3)**	4	5	○	○	○	●	
GEN MED SCARBOROUGH	1	2	**(3)**	4	5	○	○	○	●	
CHILD HEALTH	1	2	**(3)**	4	5	○	○	○	●	
ED SCARBOROUGH	1	2	**(3)**	4	5	○	○	○	●	
TACC SCARBOROUGH	1	2	**(3)**	4	5	○	○	○	●	
GEN MED YORK	1	2	**(3)**	4	5	●	○	○	○	
SEXUAL HEALTH	1	2	**(3)**	4	5	○	○	○	●	
THERAPIES	1	2	**(3)**	4	5	●	○	○	○	
T&O SCARBOROUGH	1	2	3	**(4)**	5	○	○	○	●	
PHARMACY	1	2	3	4	**(5)**	○	○	○	●	
CORPORATE										
OPS MANAGEMENT YORK	**(1)**	2	3	4	5	○	○	○	●	
ESTATES AND FACILITIES	**(1)**	2	3	4	5	○	○	○	●	
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	●	○	○	○	
SNS	1	2	**(3)**	4	5	○	○	○	●	
AL&R	1	2	3	**(4)**	5	●	○	○	○	
CHIEF EXEC	1	2	3	4	**(5)**	○	○	○	●	
FINANCE	1	2	3	4	**(5)**	○	○	○	●	
TRUST SCORE	1	**(2)**	3	4	5					

RISK SCORES - SEPTEMBER 2013										APPENDIX 2
DIRECTORATE	Yr 1 Plan v Target		Yr 1 Delivery v Target		Y1 Recurrent Delivery v target		4 Yr Plan v Target		Risk Score	
	%	Score	%	Score	%	Score	%	Score	Total Score	Monitor Rating
MEDICINE FOR THE ELDERLY SCARBOROUGH	49%	1	19%	1	6%	1	39%	1	4	1
TACC YORK	52%	1	32%	1	23%	1	41%	2	5	1
WOMENS HEALTH	32%	1	13%	1	6%	1	54%	3	6	1
OPHTHALMOLOGY	50%	1	13%	1	12%	1	59%	3	6	1
COMMUNITY	43%	1	10%	1	2%	1	60%	3	6	1
SPECIALIST MEDICINE	72%	2	44%	2	15%	1	36%	1	6	1
GS&U	87%	3	27%	1	19%	1	76%	5	10	2
LAB MED	63%	2	45%	2	19%	1	94%	5	10	2
RADIOLOGY	87%	3	62%	2	7%	1	73%	4	10	2
ED YORK	97%	4	21%	1	10%	1	81%	5	11	2
T&O YORK	78%	2	71%	3	41%	2	87%	5	12	3
HEAD AND NECK	104%	5	55%	2	37%	2	68%	3	12	3
GEN MED SCARBOROUGH	104%	5	45%	2	5%	1	88%	5	13	3
CHILD HEALTH	123%	5	46%	2	7%	1	123%	5	13	3
ED SCARBOROUGH	96%	4	48%	2	41%	2	119%	5	13	3
TACC SCARBOROUGH	95%	4	55%	2	37%	2	88%	5	13	3
MEDICINE FOR THE ELDERLY	105%	5	35%	1	31%	2	112%	5	13	3
SEXUAL HEALTH	98%	4	76%	4	15%	1	83%	5	14	3
GEN MED YORK	105%	5	51%	2	38%	2	123%	5	14	3
THERAPIES	103%	5	68%	3	46%	2	85%	5	15	3
T&O SCARBOROUGH	100%	5	85%	5	39%	2	103%	5	17	4
PHARMACY	101%	5	100%	5	100%	5	238%	5	20	5
CORPORATE										
OPS MANAGEMENT YORK	17%	1	14%	1	12%	1	45%	2	5	1
ESTATES AND FACILITIES	57%	1	34%	1	17%	1	69%	3	6	1
MEDICAL GOVERNANCE	72%	2	72%	3	0%	1	26%	1	7	1
OPS MANAGEMENT SCARBOROUGH	75%	2	42%	2	10%	1	51%	3	8	2
CORPORATE NURSING	48%	1	42%	2	39%	2	68%	3	8	2
HR	100%	4	42%	2	8%	1	74%	4	11	2
SNS	106%	5	49%	2	0%	1	79%	5	13	3
AL&R	105%	5	81%	5	17%	1	85%	5	16	4
CHIEF EXEC	132%	5	127%	5	108%	5	74%	4	19	5
FINANCE	124%	5	101%	5	72%	4	89%	5	19	5
TRUST SCORE	**90%**	**3**	**54%**	**2**	**21%**	**1**	**81%**	**5**	**11**	**2**

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York Teaching Hospital NHS
NHS Foundation Trust

Workforce Strategy Committee – 5 June 2013, Classroom 5 Post Graduate Centre (Minutes not yet approved by committee)

Attendance: Professor Dianne Willcocks
Libby Raper
Peta Hayward
Sue Holden
Natalie McMillan
Lucy Connolly
Melanie Liley
Jonathan Thow
Debbie Hollings-Tenant

Apologies: Patrick Crowley

	Agenda item	Comments	Assurance	Attention to Board
1.	Living Wage	The Committee was supportive of the Trust implementing the living wage. At this stage the thresholds for the new levels (from October) were not known, so a full assessment of the impact could not be done conclusively. It was felt a discussion at the October Board would be useful.	Analysis of costings to be undertaken to inform the Board discussion.	Board decision required.
	Establishment Review	An update on progress was provided. Establishments for all ward areas had now been done, including agreement on increases in establishments linked to resilience planning. Budgets had been aligned accordingly. A communication sheet had been agreed that would be issued to each ward, setting out their agreed staffing, as well as a reminder of some of the principles for how the 20% headroom build into budgets will be retained as a flexible response to issues such as sickness. An example of this sheet is attached. It was recognised that this work at present only covered the nursing workforce. In addition, the potential for	Establishments for each ward area will be clearly set out on an authorized staffing communication sheet, ensuring this fits with the establishment review work and that all parties are clear on the resource available and how this sits against national benchmarks.	Template communication sheet attached.

	Agenda item	Comments	Assurance	Attention to Board
		further investment in nurse staffing levels still required further debate. Other staff groups, eg therapies, will be looked at in the future.		
3.	Workforce Planning	The Committee received a presentation from Debbie and Natalie on our current workforce planning systems from both a Monitor perspective and as a process for informing future workforce requirements. This proposed how we could further align these approaches to ensure a single clear message and organisational understanding.	Further discussion via the Efficiency Committee and future review of Workforce Committee.	
4.	Centralization and Devolved Processes	There was discussion around how to achieve an appropriate balance between devolving responsibility and centrally managing processes. Two case studies were presented looking at recruitment and rostering.	Decision making on what whole systems require more central management would continue via Corporate Directors.	
5.	Integration 1 Year On	An overview of progress with integrating HR practices and systems was provided. The Committee was assured by the level of integration and alignment that had been achieved, in particular with policies and a single agreement for on-call. The outstanding areas were noted, including a number of remaining anomalies with banding differentials.	Formal monitoring via the Strategic Integration Group returns.	
6.	Enabling Potential – Managing Talent	A paper was presented on managing talent and how we might develop the potential of staff at different leadership levels. Key organisational leadership roles had been identified, and from this 16 individuals had been fast-tracked to undertake a 2-day development programme. It was suggested that managing talent was considered as part of the Trusts “one year on” review.	All key leadership roles will have undertaken some form of recognised leadership development. Further work on specifying and monitoring key leadership posts and post holders to be undertaken.	

Nursing Establishment Review
Ward 11

Your approved staffing model for 30 beds is;

	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Early	4+3	5+4	4+3	4+3	4+3	4+3	4+3
Late	4+2	4+2	4+2	4+2	4+2	4+1	4+1
Night	2+2	2+2	2+2	2+2	2+2	2+2	2+2

Escalation beds; You have 2 escalation beds and the staffing for these

	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Early	0	0	0	0	0	0	0
Late	0	0	0	0	0	0	0
Night	0	0	0	0	0	0	0

Your budgeted establishment to achieve the approved model above is;

	Whole time equivalent	**Money in budget**
B7	1.00	£55,722
B6	1.00	£46,470
B5	15.97	£553,681
B2	12.44	£329,073
Bank	-	£27,191
Total	**30.41**	**£1,012,137**

The wte will provide you with sufficient staff to cover the shifts within your agreed model as long as the resource is managed effectively.

The bank budget is to be used as and when required and is sufficient to provide cover for the levels of sickness and study leave we typically provide for. A 7.5 hour band 5 NHSP shift costs £120 at flat rate, £150 for night shifts and Saturdays and £185 on Sundays and Bank Holidays.

Workforce benchmark information;

Skill Mix (average) **59/41**
Staff to bed ratios **1.01**
RN to patient ratios **1:8, 1:8, 1:15**

Signature, Chief Nurse…………………………………………………..………..

Signature, Ward Sister…………………………………………………………

Expectations in managing your nurse establishment effectively

The resource provided is sufficient to staff your ward to the agreed model, as long as this is managed effectively, and in line with the rostering policy. This includes ensuring that annual leave is managed between 13% and 16% for each roster period. As a reminder, some of the key assumptions are set out below to help you.

Managing band 2 and band 5 vacancies
When a band 2 or band 5 member of nursing staff hands in their notice you should begin the recruitment process immediately (do not wait for them to leave). Band 2 and Band 5 posts that are part of your agreed staffing model and budget do not need to go through a full VC process. The recruitment team should be informed immediately and financial approval will need to be confirmed from your finance manager prior to a firm job offer being made.

Where a band 2 or band 5 vacancy is for a fixed period of time (e.g. maternity leave, secondment, sabbatical), you should fill the vacancy permanently i.e. the candidate should be offered a permanent contract with the Trust and be appointed onto a fixed term basis to your area, after this time they should be redeployed to another like for like vacancy in your directorate. If you find your directorate has no suitable vacancies then contact the recruitment team for support.

Supervisory/management time
Within your budget, provision has been made for 1 funded supervisory day (0.2 backfill on the band 5 line). This can be increased by managing the resources available to you flexibly. An example of this could be using efficiency arising from some staff working long days, or managing sickness absence to lower levels. Your staffing model and subsequent budgeted establishment is based on an assumption that all staff work traditional shifts (8 hours in length early and late) and a 10.5 hour night shift. However, if some staff work long days this can release some resource. The use of any non-recurrent efficiency arising from this (for example to increase supervisory days) needs to be discussed and agreed at a workforce performance meeting.

Maternity Leave
It is expected that you should be able to manage one member of staff on maternity leave at any time within your resources, through local efficiency, flexibility and judgements on staffing. If you have higher levels of maternity leave that you cannot manage within your resources you must discuss this with your matron in advance and a case would need to be submitted to vacancy control if more resource is felt necessary.

Changes to and deviation from your agreed staffing model
You should apply professional judgement to use resource flexibly day to day, ensuring safe staffing and staying within your budget. You should take into account a range of factors such as patient acuity/dependency.

If you wish to change your agreed staffing model on a more permanent basis rather than managing an ‘in the moment’ issue then this must be conducted in conjunction with your Matron and Directorate Manager (even if it is within the same cost envelope). Any revised model will need signing off by the Chief Nurse, Director of Finance and Head of Workforce (Nursing).

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 October 2013

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

There are no implications for equality and diversity.

Reference to CQC outcomes

There is no reference to CQC outcomes.

Progress of report	This paper is only written for the Board of Directors
Risk	No risks
Resource implications	No resource implications
Owner	Alan Rose, Chairman
Author	Alan Rose, Chairman
Date of paper	October 2013
Version number	Version 1

Board of Directors – 30 October 2013

Chairman's Items

1. Strategy and Context

The Foundation Trust Network (FTN) Annual Conference was attended by a number of Directors last week. The proceedings were heavily laden with organisations somewhat pre-occupied by their own procedural, structural and role changes (CQC, Monitor, NHSLA), as well as a predicable degree of angst about difficult times. For me, an important session was that on competition and collaboration; Anna has helpfully prepared a summary piece on this topic for us last week. The outlook is riddled with conflict, as different factions in the healthcare system lobby and press for "collaboration", whilst others clamour for more "choice". The powers-that-be, notably in the wake of the recent Bournemouth/Poole decision, are themselves shifting their position to try to juggle with this awkward conundrum. The evolution of this issue will no doubt affect the way we prosecute alliances and relationships in the future, both locally and regionally – indeed it is affecting the way we act now, so that we do not restrict options.

The coming month will include the important clinical conference with Hull (HEY) and also our annual Board time-out. I have asked Patrick to set the scene today for the former; at our time-out, at which our Clinical Strategic Leads and some others will join us, we will develop the ongoing topics of horizontal and vertical "integration", as we review our progress from the "depiction" we created this time last year.

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2. Governance, Governors and Community

Pat will also update today on the KPMG/Monitor feedback recently received. Suffice to say from me that the entire team, including the observed staff that report to Directors, were complimented on the way we handled this Review; the feedback is largely positive. Well done on telling it like it is.

The "listening exercise" elicited around 250 separate responses from staff – more than we expected; we will synthesise this for the November Board. We will also report this to Governors at the next opportunity, as well as making reference to it with Monitor. The inputs are telling and do highlight areas of strong support, but also a number of issues where we need to do better in cementing the integration and in optimising the performance and culture of our Trust. A full copy of the narrative returns is available for any Director who wishes to peruse the "raw" material and likes a good read.

A reminder that the annual regional NHS Christmas Carol concert will take place at York Minster at 1930hrs on Wednesday December 11th. This very enjoyable occasion -- solemn, uplifting and festive at the same time -- attracts some 2,000 NHS staff each year and I recommend it. As the "host city", and with the demise of the SHA, we are considering taking "ownership" of this event for future years.

3. Recommendation	
The Board of Directors is asked to note the report.	
Author	**Alan Rose, Chairman**
Owner	**Alan Rose, Chairman**
Date	**October 2013**

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York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 October 2013

Chief Executive Report

Summary

The Board is asked to note the report.

Action

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

No implications for equality and diversity.

Sustainability assessment

None directly identified at this stage.

Reference to CQC outcomes

This report references the CQC recent visits and the results of those visits

Progress of report	This report is written for the Board of Directors.
Risk	No additional risks indicated.
Resource implications	None identified.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	October 2013

Version number Version 1

Board of Directors – 30 October 2013

Chief Executive Report

1. Introduction

You will have by now had time to absorb the news that the Trust has been banded “5” by the CQC under its approach to what it terms “hospital intelligent monitoring”. This monitoring is a key element of the CQCs new operating model and by assessing all Trusts against 150 indicators we get a snapshot of where they judge us to be in relative terms with regard to the risks and assurances associated with the care we provide. All Trusts are banded in the range of 1 – 6 and as a 5 we are considered low risk. I firmly believe that in the context we are currently working, particularly in the early stages of integrating Scarborough Hospital in the organisation, that we should be pleased but not complacent with this outcome. The CQC is clear that this methodology is not in itself a ranking but it is also clear that it is a mechanism that will allow them to direct their resources at the most challenged organisations. As such we are likely to be inspected some way down the line. Whilst I am insistent that we are not complacent in this regard I am equally insistent that we recognise this as a positive signal of the work we are doing in bringing previously challenged services into our Trust and progressively raising the standards of care overall. This doesn’t happen by accident and despite the vulnerability we feel on a number of indicators, and the fragility of our financial position, we should thank everyone involved in continuing to focus on the underlying quality of our provision as a priority. This is undoubtedly what will tell in the end and is consistent with the values of the organisation.

In the last week I have had the pleasure to host visitors from the Department of Health and the NHS Confederation each of whom are keen to engage with front line services and influence in a meaningful way strategy for the NHS in the post election period. Michael O’Higgins, Chair of the Confederation, was particularly interested the dilemmas posed by choice and competition and the impediment this places on strategic planning, collaboration and integration and has committed to keep close to us in the coming months as our local agenda evolves and importantly the work we are doing with Hull and NLAG. Without going overboard I truly believe there is a desire to change the environment we are working in and we should, of course, seek to offer our support to this thinking at every opportunity.

In this vein and in an effort to support the NHS ongoing efforts to respond to the Francis Report the Trust has engaged with the Department of Health’s (DH) ‘Connecting with Patients and Service Users’ Programme. The programme has been designed to familiarise the department’s senior policy makers with the day to day running of hospital services. It is scheduled to run from October 2013 to November 2014 and York Hospital is set to host up to six visitors a week each month with the aim of helping policy makers fulfil their stewardship role of ensuring the health and care system delivers for public and patients. Sue Holden is coordinating this programme.

2. Operations and Performance

As you will all be aware September has been a challenging month with acute admissions significantly above plan and a high level of ED attendances on both our main sites. This continues to place real pressure on our finances and performance overall which we shall consider later in the agenda. It is pleasing to see an improvement in trajectory of the incidence of CDiff and importantly the Medical Director will brief you on a further positive

move in SHMI. Both these are key indicators to the underlying quality of our provision.

3. Quality Governance Review (KPMG)

Last week the Chair and I participated in a conference call with KPMG following the completion of the quality governance review initiated by Monitor as part of the annual planning assurance process.

As you know KPMG intervened at a number of levels including a desktop review of our governance system and processes, interviewed a number of Board Members and senior staff and attended the Quality and Safety Committee, Finance and Performance Committee and Board of Directors in September. I have subsequently circulated the final report to Board members for their information.

The final report is, on balance, a very positive report and highlights a number of good practice areas identified in the Trust. The report did also highlight some key actions where improvements could be made which largely related to winter planning, the SI system and the development of a consolidated dashboard – all improvements that we are working on and keen to implement.

Overall, KPMG were very complementary about the Trust and did say that they were quoting some of our good practice to other Trusts. I believe the report has some excellent material for us to reflect on and does to a degree provide assurance about the approach we have taken to the integration and the development of the organisation.

To complement this work I have attached for your information and comment a draft document designed to evidence the Trust's compliance with the quality governance framework. Monitor released guidance for Boards in April 2013 under which Trusts are required to either demonstrate compliance with the framework or have a rationale for any areas of non-compliance. Directors have reviewed this and I invite NEDs to contribute to its development over the coming weeks. I recommend that we review this annually and will agree with the Chair if and when this is appropriate.

4. Child Protection Service

Following the completion of the acquisition in July 2012, it was identified in common with the integration of other key services that there were significant complexities and issues to overcome in the consolidation and delivery of the child protection service serving the enlarged organisation.

One of the complexities was that the Trust inherited arrangements for Scarborough that include an existing service level agreement with Harrogate and the department has spent some time understanding the differences in provision between our two main localities, both in terms of system and culture. It has been agreed following discussions with Harrogate to cease the SLA on 31 March 2014 and the team is now working towards a full integration of the service in the intervening period. We have engaged external support and expertise to oversee this work and provide assurance on the final model and I am confident that we will be in a position to brief the Board fully on this in the new year. As you may appreciate we are in the process of reshaping the leadership of the team following Robin Balls retirement and in this light have invited the team to present to the Board in March on their structure, processes, approach and planned developments.

5. Recommendation	
The Board is asked to discuss and note the report and is encouraged to discuss areas of specific interest.	
Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley Chief Executive**
Date	**September 2013**

York Teaching Hospital NHS
NHS Foundation Trust

Action list from quality governance - how does a board know that its organisation is working effectively to improve patient care

1 **Good quality governance should be based on the following:**

Engage and cascade – engaging with stakeholders to set quality priorities and standards and communicating these across the whole organisation.

Assure and escalate – ensuring that high quality care is being delivered and risks to quality are being effectively managed.

The themes for Board assurance are underpinned by a range of management activities and assurance processes as follows:

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Engagement on quality	Does the Board lead on quality, engage effectively with others to set goals for improvement and performance monitoring	Chairman/ Chief Executive	Comply	NED Quality lead identified as Libby Raper Quality and safety committee dedicated to considering the quality and safety issues in advance of the BoD meeting. Executive lead Chief Nurse Quarter reports and quality governance provided to Board as part of CN report Board discussions with CCGs around QIPP and CQUIN. Contract management board reports to Board on an exception basis.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Gaining insight and foresight into quality	Are governance systems, processes and behaviours effective enough to help the board understand what stakeholders expect and believe the trust can deliver, and how this information will help the board understand what will help them improve the quality of care provided?	Chief Nurse/ Medical Director	Comply	Quality and safety committee dedicated to considering the quality and safety issues in advance of the BoD meeting. Reports prepared by CN, MD and Ops Dir Performance management metrics including Contract Management Board meetings with the CCG including discussion around quality and safety – CQUIN, QIPP Links between governors and patient experience through 15 steps and PLACE and Patient Experience Group. Use of nursing care indicators, family and friends, safety thermometer , Nursing and Midwifery Strategy, Safety Strategy Review of SI, CI and share organisational learning through the Clinical Directors to the Directorates. Trust values, personal responsibility framework.
Accountability for quality	Is everyone in the organisation clear about the standards expected of them in delivering high quality and safe care and the need to provide assurance in relation to care quality and the	Chief Nurse/ Medical Director	Comply	Professional Regulatory frameworks of all qualified clinical staff. Trust values and expectations, Values based recruitment, use of existing staff to support recruitment processes. Role of the Clinical Strategic Leads and use of the Executive Group. The use of appraisals and Chief

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
	escalation of any quality concerns?			Executive Briefings Performance Involvement meetings Executive performance management meetings. Compliance reviews Use of nursing care indicators, family and friends, safety thermometer, Nursing and Midwifery Strategy. Safety Strategy. Infection prevention and control Mortality reviews Review of Airs, SI, CI and share organisational learning through the Clinical Directors to the Directorates. Role of the Matron in maintaining quality standards Senior Nurse walk rounds Leadership walk rounds.
Managing risks to quality	Is there sufficient, relevant and reliable management information and performance metrics to identify and resolve risks?	Chief Nurse	Comply	Airs reports, SI and CI reports Complaints quarterly report Access to realtime information through Signal Compliance reports and reviews Risk Management Strategy Performance improvement meetings and use of root cause analysis

2 **Engagement on Quality**

Leadership - Does the Board provide a clear steer on the strategic and operational quality and quality outcomes it expects the organisation to achieve?
- does a quality culture exist across the different layers of clinical and non-clinical leadership? What is the evidence?

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Board leadership	Are there system level expectations, accountability for high performance and does the Board know that staff understand their role in the effective and high quality provision of care?	Chairman	Comply	Board reports Leadership Walk rounds Performance report Board committees – Finance and Performance and Quality and Safety Appraisal including 360 appraisals Board development programme
Skills and behaviours	Does the Board ensure that the right mix of skills, capabilities and capacity to oversee and test good quality governance is in place?	Chief Executive and Chairman	Comply	Recruitment of member of the Board Board time outs Board development and Board review is undertaken. The Board has an action plan in place to ensure improvements in the functioning of the Board are maintained Succession planning
Challenge	Does the Board ensure there is the right balance between trust, constructive debated and effective challenge?	Chief Executive and Chairman	Comply	Use of the Quality and Safety Committee and Finance and Performance Committee Format of the agenda Questions raised at Board

Culture - guides the behaviour of individuals and simultaneously is shaped by those behaviours.
- For quality governance the influence of organisational culture is critical to the development of attitudes around patient safety and quality improvements.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Sub – culture	Does the organisation manage the sub-cultures and ensure they do not undermine the Trust's main culture?	Chief Executive	Comply	Promotion of open, transparent culture across the organisation Executive Group Directorate have open door policy The Trust is explicit about aims and culture Chief Executive briefing
Cultural leadership	Does the organisation put patients first and demonstrate that it is an open and learning organisation?	Chief Executive and Chairman		Chief Executive Briefing Feedback to Patients Family and Friends Personal responsibility framework Quality and Safety Dashboard Reporting Systems

Clinical and non clinical leadership – proactive approaches to improve leadership skills can be employed along with activities with clinicians and managers that complement the assurance received by Board

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Clinical Leaders	Does the Trust ensure there is input to safety and quality improvements from clinicians? What is the participation at Board level of clinical	Chief Executive, Medical Director and Chief Nurse Medical Director and Chief Nurse	Comply Comply	Executive Group meetings with Clinical Directors and Executive Directors. Acute Group Directorate structure Clinically led PMM and PIM Clinician involvement in capital schemes

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
	leaders on quality and safety or the Quality and Safety Committee?			Strategic Integration Group Patient Safety meetings includes clinicians, lead by Medical Director with Non-executive Director involvement
Proactive approaches	Does the Trust use any of the proactive approaches identified in the guidance. Encourage active contribution from clinical leaders and staff towards setting the organisation's vision and corporate values • Involvement and participation in walk rounds by Board members • Joint ownership of feedback to staff, communicated via clinical leaders to avoid a them and us culture • Using Medical Engagement Scale to assess medical engagement in management and leadership • Integration of a range	Chief Executive/ Medical Director	Comply	Executive Board time outs to discuss clinical strategy Multi-discipline walk rounds including Board members Chief Executive Briefing feed back through staff Patient stories at Board Weekly review of all complaints involving the chief executive Quarterly patient experience to Board Trust involved in development of MES and has used in last 2 years. Engagement part of staff survey additional questions. Reviewed annually Themes reported monthly to commissioners New initiatives are given significant time at board during the settling in period and then are reported on a monthly or quarterly basis dependent on the subject All senior staff have access to the real time information system Signal to see local updates on clinical performance.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
	of patient feedback into • key performance indicators at clinical level • Presentations to Board on initiatives			
Ownership	Does management highlight to the Board unexpected trends or outliers in the main dashboard and changes to quality and risk profiles?	Chairman	Comply	Changes and unexpected trends are highlighted in the main Board reports including the performance report. Risks are also highlighted by the Board reports. The quarterly compliance report identifies the changes to the quality and risk profile and is discussed at the Corporate Risk Management Group and the Board of Directors.
Accountability	Does the Trust have strong triumvirate relationships between nurses, doctors and managers and can those be seen by the Board?	Chief Executive/ Director of Applied Learning and Development	Comply	Have strong triumvirate working within each management team leading each directorate. The team are represented at Executive Board, Acute Board, Surgical Board

2 **Communication –** proactive involvement of relevant internal and external stakeholders that is sustained and systematic and meaningful. The critical factor in enabling Trusts to realise their vision and values, to defined and achieve their strategic quality goals and objectives, to monitor outcomes and to understand where good care is optimised and also where it can be improved.

From Board to Ward – It is essential to have effective communication from the Board to the front line staff for quality improvements.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Development of strategic plans	Does the Trust involve staff in the development of strategic plans, eg quality improvements	Chief Executive	Comply	Initiatives are discussed with staff and suggested improvements are encouraged from staff. Each directorate has its own business planning round and are required to identify quality improvements as part of business planning.
Clinicians	Does the Board understand or have evidence of ongoing review of clinical developments and compliance with national guidance in order to determine organisational priorities?	Chief Executive	Comply	Review of Nice guidance is provided to the Board on a monthly basis. Significant changes as a result of clinical developments or compliance with national guidance is included in the appropriate Executive Director monthly board report with follow up information as required by the Board, CN, MD, CE. CSG also reviews clinical development and compliance with national guidance.
Accessible information	Does the information received by the Board have specific references to quality issues that the Board is considering as well as standing items such as policy updates, audit results, quality	Reporting Director	Comply	All Executive Director report provide information on quality issues as and when they become appropriate

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
	outcomes and performance benchmarks?			
Staff raising issues	Is the Board assured that staff know which individuals are accountable for quality beyond their immediate line-managers?	Chief Executive	Comply	Through leadership and management structures and published guidelines of governing bodies Whistle blowing policy Work is being undertaken to produce an accountability/ responsibility framework document for CQUIN targets
Seek and review results of staff feedback	Is the Board satisfied that sufficient information is received by the Board about staff feedback for the Board to have knowledge and understanding of the staff in the Trust? Does the Board use the staff survey to influence greater staff satisfaction and improved patient experience?	Director of HR	Comply	Board uses the staff survey and receives updates on the action plans being implemented as a result of the survey

Patient and Carers – Understanding quality means understanding what patients' experience. Patients, carers and families do have a significant role to play, not only in designing improvements, but in monitoring whether they have had the desired impact.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Engagement of patients in quality improvements	Has the Board evaluated the effectiveness of the engagement of patients and the other tools used to ensure patients are involved in quality improvements? NB one suggestion is process mapping.	Chief Nurse	Comply	Engage with governors in a number of initiatives including 15 Steps, patient experience, complaints, site visits. Governors also have links with matrons and non-executive directors. Patient experience groups where patients are asked to pass on their knowledge and experience to the Trust – Terms of reference and membership group.
Encourage participation	How does the Trust involve hard to reach groups such as children, older people, those with mental health conditions?	Chief Nurse	Comply	Through the use of expert user groups and development of specific user groups and audits
Patient stories	Does the Board hear patient stories from patients?	Chief Nurse	Comply	Letters are read at the start board meeting. The Board also here from the Chief Nurse and Medical Director on specific issues related to quality and safety. Introduction of the Quality and Safety Dashboard.
Responding to engagement	Does the Trust keep those who contribute their views informed of	Chief Nurse	Comply	In response to complaints the Trust does feedback to patients and does require staff to take ownership of any

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
	how the information is being treated, what to expect and the outcome? Do we encourage staff to take ownership by leading the Trust's response?			response. The Head of Patient Experience does ensure patients do receive feedback information. Areas of development of services do involve service users and others such as governors. Patients and public are kept informed of development through those groups.
Quality Report	Is there a direct link between the Quality Report and the Trust's Quality Strategy? Has the Trust introduced a monthly quality report to Board that mirrors the content of the quality report?	Chief Nurse/ Medical Director	Comply	Yes the Quality and Safety Committee review the Quality strategy and oversee the development of the Quality Report

Public, Governors' and members involvement – It is important to acknowledge the wider role of trust members, the public and their governors

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Shaping strategy	Is the Board assured that the public is involved in the shaping of strategy of services either through	Chief Executive	Comply	The CCG run public forums and consulted on their business plan. There was also a consultation with the public on the joint strategic needs document

	the CCG or by the Trust directly?			produced by the NHS and local authorities. The OSC also takes into account views of members of the public The Trust does engage with Governors during the preparation of the Annual Plan and the development of the Quality Report. The Governor external role does ensure that the views of the general public included in their feedback
Public engagement	Governors represent the Trust in the community and hold the Non-executive Directors to account. How does the Board ensure that the Trust is engaging the public in appropriate ways? Do the Governors challenge the Non-executive Directors on the quality Performance?	Chairman	Comply	The Governors hold the Non-executive Directors to account in a number of different ways. The Governors are a key part of the system employed for appraisal of Non-executive Directors. The Governors attend Board of Director meetings and other meetings where the Non-executive Directors are present. The Governors are given an opportunity to challenge the Non-executive Directors at the CoG meeting as the regularly present information.

Commissioners and partners – Commissioners should use patient experience to inform decisions about service development and strategy. There should be shared patient experience goals as part of a good working relationship.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Working in partnership	Does the Board understand the scope for improving patient	Chief Nurse / Medical Director	Comply	The introduction of the Nursing and Midwifery Strategy and the development of revised Safety Strategy. Regular

	experience in the Trust and across the whole health economy?			discussions with the Commissioners and other local organisations are held to support the improvement of patient experience. The Trust works with the CCG through the Contract Management Board and for specialist commissioning through the National Commissioning Board (NCB)
Integrate commissioners	Does the Trust engage with the CCG on identifying quality improvements?	Deputy Chief Executive	Comply	The Trust has worked with the CCGs locally and has identified key performance improvements through the CQUIN framework

Gaining insight and foresight into quality - Insight – the Trust must have knowledge and understanding about what its stakeholders expect from the Trust. **Foresight –** Effective use of information will help Boards respond effectively to future challenges.
Measurement, reporting and monitoring – Assurance and decision making processes rely on effective measurement and reporting of quality information. The Board has the responsibility of debating and agreeing a set of quality metrics.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
National standards	Does the Board clarify its priorities and expectations with regard to quality objectives?	Chief Executive	Comply	All strategies developed in the organisation reflect the national priorities and expectations
Integrated performance dashboard	Does the Board consider an integrated performance dashboard?	Chief Nurse/Medical Director	Comply	The Trust has a mature dashboard which is presented to the Board at each meeting. Development work is being undertaken to improve the use of dashboards in the organisation with the introduction of the Quality and Safety Dashboard and the revision of the

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
				Signal Dashboard.
Performance scorecard	Does the Board consider a performance scorecard aligned to the main strategic goals and review monthly historic data?	Chief Executive	Comply	The Trust has a live dashboard that identifies the key objectives for the Trust. Each of the Board papers relates the items back to the strategic themes for the Trust.
Quantitative versus qualitative	Does the Board see both 'hard' and 'soft data?	Chairman	Comply	Through the dashboards and the reports presented each month.

Data quality – Good data should underpin the assessment of performance and the information that is presented to the Board.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Six dimensions	Does the Board regularly review its arrangements for supporting how indictors are prepared and reported? The six dimensions of good data are: Accuracy Validity Reliability Timeliness Relevance Completeness	Chief Executive	Comply	Those preparing reports consider the six dimensions as part of the preparation of their report. Data management is within the remit of the Director – Systems and Networks. The Director attends the Board meetings.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Assurance Sources	Does the Board use Internal Audit and Clinical Audit assurance as a way to priorities a review of key aspects of data quality?	Chief Executive	Comply	The Board and Audit Committee use Internal Audit and Clinical Audit assurance. The Data Quality Group a subgroup of the Audit Committee is in the process of developing a program of work
Relationship with quality	Do the measures of quality reported to the Board actually reflect the quality of care as delivered to the patient?	Chief Nurse / Medical Director	Comply	The regular reports are accurate and do reflect the quality of care given to the patients. The introduction of the new dashboard supported by the Chief Nurse and Medical Director reports which provide both qualitative and quantitative data.
Data quality programmes	Has the Board established a data quality assurance programme?	Director of Finance	Comply	The Data Quality and Performance Group have undertaken a programme of work which is will be reviewed by the Audit Committee
Data quality strategy	Has the Board considered putting in place a data quality strategy?	Director of Finance	Comply	The Group are in the process of developing their work programme for the next 12 months which includes reviewing of the data quality policy which incorporates a strategy

Benchmarking – can provide useful perspective on the quality of services within the organisation.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Improving performance	Does the Board use benchmarking to	Chief Executive	Comply	Each of the Directors uses benchmarking data as appropriate to

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
	enhance performance?			their area of specialism. Examples of use of benchmarking include CHKS and NHS Elect.
Learning	Has the Trust put in place any peer review sessions around quality?	Chief Nurse/ Medical Director	Comply	The Trust has close working relationships with NHS Quest, CHKS, Dr Foster and NHS Elect. All these organisations provide support to peer review and benchmarking around quality. Involvement in national specialist peer reviews such as cancer and Jag and national assurance programmes such as CPA.
Greatest need	Does the benchmarking used by the Trust reflect where there is the greatest need or potential areas of improvement?	Medical Director	Comply	The data used by the Trust does support the identification of the areas where improvements could be made. The Trust also uses Public Health England and other national bodies to support some of this work. The Trust also uses financial benchmarking and data related to complaints, VTE and WHO checklist.
Internally –facing	Does the Trust use internal benchmarking between services?	Chief Operating Officer/ Medical Director	Comply	The Trust undertakes walk rounds and uses the information to support services internally. The Trust also seeks information externally to support the delivery of services in specialty areas.
Appropriateness	Does the Trust benchmark with	Chief Nurse/ Medical Director	Comply	The Trust works with a number of organisations including other NHS

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
	appropriate organisations at an appropriate level?			Trusts and external supporting organisations such as NHS Quest. The Trust is careful to make sure the appropriateness of the organisations and to validate their added value.

4 **Accountability for quality –** Accountability for quality begins and ends with the Board. However, the Board cannot discharge this responsibility alone and accountability for quality should be clear throughout the organisation.

Assurance – Boards should seek and obtain assurance about roles and responsibilities, that quality is appropriately covered in the Board meeting and in relevant Committees ad that there are relevant processes and structures in place to support the Corporate Governance Statement. Three definitions to consider:
Assurance – being assured because the Board has reviewed reliable sources of information and is satisfied with the course of action
Assumption – being satisfied that there is no evidence to the contrary; and
Reassurance – being told by the executive or staff that performance or actions are satisfactory

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Triangulation	Does the Board ensure it triangulates information?	Chairman	Comply	The Board uses a number of methods to triangulate information including the NEDs having contacts within the organisation, walk rounds and NEDs having links into some operational group meetings.

Assuring Monitor on quality governance –The Trust is required to assure Monitor that there are effective and sustainable quality governance arrangements in place.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Quality governance framework	Is the Board satisfied that the framework is up to date and used effectively in the organisation? Can the Board satisfy the obligations regarding governance of the quality of care in the licence?	Chief Executive	Comply	The framework was revised during the acquisition process. A further update is being undertaken at present, it is intended that the document will be reviewed on a regular basis, and at a maximum of every 2 years. Yes the Board can be satisfied.

The obligations referred to above are:

- Sufficient capacity at Board level to provide effective organisational leadership on the quality of care provided?
- The board's planning and decision making processes take timely and appropriate account of quality of care considerations
- Accurate, comprehensive, timely and up to date information on quality of care is collected
- The Board receives and takes into account accurate comprehensive timely and up to date information n quality of care
- The licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources
- There is clear accountability for quality of care throughout the licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Roles and responsibilities – The Board relies on its supporting structures to enable it to carry out its role efficiently. Problems do occur when the roles and responsibilities are not clear.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Committees	Does the approved structure and governance	Chief Executive	Comply	The Governance Structure is kept under review and is a live document that is

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
	arrangements fully incorporate the committees, working groups, clinical leaders, clinical teams and support services.			updated on a regular basis to reflect the changes in the approaches to topics, priorities and demands.
Escalation	Is the Board satisfied that the delegation of authority to the various committees and groups in the governance structure is appropriate?	Chief Executive	Comply	The Governance Structure is kept under review and is a live document that is updated on a regular basis to reflect the changes in the approaches to topics, priorities and demands. Board members are made aware of significant changes in the structures.
Audit Committee	Does the Board feel there is a clear and effective flow of information from the Committees including the Audit Committee to the Board on clinical quality?	Chairman of the Audit Committee	Comply	There is a clear and effective follow of information from the Board Committees to the Board. The Audit Committee continues to keep this under review and is undertaking some additional work to ensure the systems are providing the maximum information to the Board.
Audit Function	Does the Board understand the role that your audit functions have in supporting board assurance and quality governance?	Chairman of the Audit Committee	Comply	The Board is clear about the role the audit function has in supporting the board assurance and quality governance
Internal Audit	Does the Board feel that Internal Audit's role in relation to quality	Director of Finance	Comply	The Internal Audit plan is prepared on an annual basis and reflects the requirements of the Trust including

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
	governance is understood and clear? Does the work programme for Internal Audit reflect quality governance?			quality governance.
Clinical Audit	Does the Board feel that the link with Clinical Audit and the Board and the Audit Committee is strong enough to ensure good quality assurance is received around quality governance?	Chairman of the Audit Committee/ Medical Director	Comply	There is a clear link with the Board and Clinical Audit. The information the Medical Director provides to the Board Committee and the comments made at the Board of Directors meeting provide clear understanding for the Board on the results of Clinical Audits. The Audit Committee is working closely with the Medical Director and his team to ensure all appropriate information is provided to the Board in a timely manner.

5 **Managing risks to quality –** Risk management in the NHS is mapped at two overlapping levels – strategic and day to day staff/ patient operational level.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Risk Registers	Are the local risk registers effective in capturing the risks to quality within the Trust?	Chief Executive	Comply	The Trust has local risk registers for all the directorates and also considers the risks through a governance dashboard related to cost improvements programmes.

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
Board assurance framework	Does the Board Assurance Framework reflect the challenges around the quality?	Chief Executive	Comply	The Assurance Framework has a number of references to quality which demonstrates the challenges around quality the Trust faces.
Local Risk Registers	Does the Board feel that there are effective systems in place to understand current and future risks to quality?	Chief Executive	Comply	The Board is confident that there are effective systems in place to understand current and future risks to quality, through the Risk Management Strategy and other processes in place across the organisation such as the Patient Safety Group.
Incident recording and escalation	Does the Board feel that there are appropriate systems in place to record, report and escalate patient safety incidents?	Medical Director	Comply	A robust system is in place that has reviewed regularly by the Internal Audit Service
Clinical outcomes versus cost efficiency	Does the Board feel that processes are in place to ensure quality is not compromised by cost improvement programmes?	Director of Finance	Comply	All CIP projects are reviewed and approved by the Medical Director and Chief Nurse as part of the approval process. There is also a governance dashboard considering the risk to quality that each of the CIP projects might carry. CIP projects are on occasions discussed at the Patient Safety Group
Raising concerns	Does the Board feel that staff are explicitly told	Medical Director/ Chief Nurse	Comply	The Trust undertakes Patient Safety Walk Rounds which specifically

Theme	Challenge	Responsible officer	Comply or explain	Status/evidence
	that they should raise concerns where they feel quality is being compromised as a result of cost improvements or efficiencies?			consider quality. The Trust has a whistle blowing policy in place.
Quality impact assessments	Does the Board feel that the Trust uses quality impact assessments?	Medical Director/ Chief Nurse	Comply	The Medical Director and Chief Nurse sign a project off against a impact assessment
Post implementation review	Does the Trust have a post implementation plan against Cost Improvement Plans?	Director of Finance	Comply	Each CIP has a plan sitting behind it when it is proposed
Reporting	Does the CIP report reflect quality initiatives that are in place?	Director of Finance`	Comply	The Trust has a robust system of ensuring that the CIP reflect quality initiatives

Appendix A –How should the Trust Board gain assurance?

The Trust Board can gain assurance through:

- the development of a culture that encourages participation and is supported by resources to promote change. The board will need to put in place systematic processes that allow it to know that this is being effectively achieved by, for example: using a programme of quality-focused ward walks to allow two-way interaction with patients and staff; commissioning patient and (medical and clinical) staff surveys on understanding values and their impact, utilising peer reviews to test and challenge implementation to support the board's understanding that this is developing effectively;

- systematic and timely processes for engaging staff, commissioners, partners and patients in the creation, development and communication of quality indicators and goals. This should be visible to the board through specific communication and engagement plans and projects. Progress measured against wider engagement plans can be assessed directly through internal and clinical audit programmes or be triangulated via board-level engagement with stakeholders. Governors of NHS foundation trusts should provide constructive challenge to non-executive directors on the performance of the board of directors in this area;

- communicating data and information that the board receives to the relevant staff. Seek out and review staff feedback, underpinned by regular board to staff engagement, the use of regular staff and patient surveys and to test the effectiveness of communication and trends over time. The trust can also use internal audit functions to test the extent of staff awareness and the use of performance information used by the board;

- using public consultation to shape strategy and process design with outcomes from engagement and consultation fed back to those affected and the impact of this to be measured through board engagement;

- using patients to design improvements, and monitor impact, including incorporating involvement and feedback into project management systems for service pathway redesign;

- reflecting NHS commissioners', local authorities', and GPs' views in setting and monitoring quality goals and quality improvement strategies;

- the use of a strategic integrated performance dashboard that includes quality, performance, activity and finance targets aligned to strategic goals, which visibly cascades down to ward and service level dashboards;

- the use of ‘soft’ performance measurement, such as board visits and patient stories, which are supported by formal mechanisms for capturing, reporting and reacting to this information;

- a formalised strategic approach to data quality improvement aligned to quality governance. This should be supported by regular data quality metrics and a data quality assurance, process mapping and audit programme will allow the board to receive assurance that this is effective;

- actively benchmarking performance with comparable organisations based on risk assessing areas of greatest need; internal benchmarking and ‘peer reviews’; and a robust analysis of historical data;

- a clearly understood structure of assurance and baseline assessments supporting statements and declarations by the board to regulators;

- effective use of the internal audit and clinical audit functions to provide an overview of the quality governance assurances through a systematic review of the assurance processes;

- mapping quality improvement strategies to the Quality Governance Framework to ensure visibility at the board and within the organisations as to how trust quality activities are aligned with the regulatory regime. This will also assist board-level understanding of the effectiveness of quality governance assurance processes in identifying gaps in the audit and risk escalation processes;

- reviewing the audit committee, quality committees and supporting committee structures to ensure that they enhance, not impede, board assurance;

- identifying and addressing risks to trust quality objectives through regular review of the BAF and risk register, underpinned by a robust risk management framework.
- implementation of an audit programme that includes regular review that local risk registers are being completed correctly. Audit activity and risk management processes can be significantly enhanced through the use of risk management and incident reporting software systems if supported by risk management expertise and effective reporting to the board;

- increased incident reporting, supported by clear guidance on risk categorisation and staff training and culture. This should be triangulated with related management information such as complaints, Patient Advice and Liaison Service (PALS) activity, staff training and risk identification;

- CIP schemes beginning at clinical unit and ownership existing at individual level are based on effective and transparent QIAs, reporting and post-implementation review. Boards have visibility of staff involvement in CIP and associated risk identification and peer review of impact on services;

- staff know how and are able to raise concerns where they feel quality is compromised.

York Teaching Hospital NHS Foundation Trust

Board of Directors – 30 October 2013

Monitor Quarter 2 Return

Action requested/recommendation

To approve the proposed submission to Monitor.

Summary

On 1 October 2013, Monitor introduced the Risk Assessment Framework. This replaced the Compliance Framework. The transition arrangements for the use of the Risk Assessment Framework are as follows:

For quarter 2 Monitor will review the Financial Risk Rating and the Governance rating. For quarter 3 this will change to the Continuity of Services Risk Rating (COSRR) and a Governance rating.

The COSRR is on a 1-4 rating based on liquidity and capital service capacity, 4 being the best rating and 1 being the worst. A rating of 3 will result in some additional information being requested by Monitor. A rating of 4 will generally mean that no action will be taken beyond continuing to monitor the Trust. For quarter 2 the Trust will report on a dual basis – on the FRR and the COSRR.

The Trust will be formally rated on COSRR from quarter 3 (October – December) onwards.

In terms of the Governance rating, Monitor will take a number of key aspects into account, including performance, CQC judgements and third party information, quality governance information and the degree of risk to COSRR.

Monitor will assign 'green' governance rating where there are no concerns. Where potential material concerns are identified the governance rating will be replaced by a description of the concerns. If Monitor takes regulatory action a 'red' rating will be assigned.

Recently, the Trust received a letter from Monitor confirming that the Trust had been assigned a 'green' governance rating. The financial risk rating did not change from the position in quarter 1 as has already been explained.

The papers attached are the submission for quarter 2.

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

None directly identified.

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	October 2013
Version number	Version 1

Worksheet "Governance Statement"

In Year Governance Statement from the Board of York Teaching Hospital NHS Foundation Trust

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)

		Board Response
	For finance, that:	
4	The board anticipates that the trust will continue to maintain a continuity of service risk rating of at least 3 over the next 12 months.	Confirmed
	For governance, that:	
11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	Confirmed
	Otherwise	
	The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page	Confirmed

Signed on behalf of the board of directors

Signature		Signature	
Name	Alan Rose	**Name**	Patrick Crowley
Capacity	Chairman	**Capacity**	Chief Executive
Date	31 October 2013	**Date**	31 October 2013

Notes: *Monitor will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to*
In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a
This may include include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality
Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A

B

C

Declaration of risks against healthcare targets and indicators for 2013-14 by York Teaching Hospital

These targets and indicators are set out in the **Compliance Framework**

Definitions can be found in Appendix B of the Compliance Framework 13/14

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key: must complete / may need to complete

Target or Indicator (per Compliance Framework 13/14)	Threshold or target YTD	Risk declared at Annual Plan	Quarter 2 Actual Performance	Achieved /Not Met	Any comments or explanations
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	No	90.4%	Achieved	
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	No	95.3%	Achieved	
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	No	92.0%	Not met	*The target was breached in August 2013. The RAF requires the traget to be achieved in all months during the quarter*
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	No	94.1%	Not met	
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	No	0.0%	Achieved	*The Trust believes this target has not been achieved. Final performance will not be avaliable for a few weeks*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	No	0.0%	Achieved	*The Trust believes this target has not been achieved. Final performance will not be avaliable for a few weeks*
Cancer 31 day wait for second or subsequent treatment - surgery	94%	No	0.0%	Achieved	*The Trust believes this target has not been achieved. Final performance will not be avaliable for a few weeks*
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	No	0.0%	Achieved	*The Trust believes this target has not been achieved. Final performance will not be avaliable for a few weeks*
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	No	0.0%	Not relevant	
Cancer 31 day wait from diagnosis to first treatment	96%	No	0.0%	Achieved	*The Trust believes this target has not been achieved. Final performance will not be avaliable for a few weeks*
Cancer 2 week (all cancers)	93%	No	0.0%	Achieved	*The Trust believes this target has not been achieved. Final performance will not be avaliable for a few weeks*
Cancer 2 week (breast symptoms)	93%	No	0.0%	Not met	*The Trust believes there is a risk to delivery of this target. Final performance data will not be avalible for another 25 days*
Care Programme Approach (CPA) follow up within 7 days of discharge	95%	No	0.0%	Not relevant	
Care Programme Approach (CPA) formal review within 12 months	95%	No	0.0%	Not relevant	
Admissions had access to crisis resolution / home treatment teams	95%	No	0.0%	Not relevant	
Meeting commitment to serve new psychosis cases by early intervention teams	95%	No	0.0%	Not relevant	
Ambulance Category A 8 Minute Response Time - Red 1 Calls	75%	No	0.0%	Not relevant	
Ambulance Category A 8 Minute Response Time - Red 2 Calls	75%	No	0.0%	Not relevant	
Ambulance Category A 19 Minute Transportation Time	95%	No	0.0%	Not relevant	
Clostridium Difficile -meeting the C.Diff objective	22	No	33	Not met	
MRSA - meeting the MRSA objective	0	No	2	Achieved	
Minimising MH delayed transfers of care	7.5%	No	0.0%	Not relevant	
Data completeness, MH: identifiers	97%	No	0.0%	Not relevant	
Data completeness, MH: outcomes	50%	No	0.0%	Not relevant	
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	No	N/A	Not relevant	
Community care - referral to treatment information completeness	50%	No	100.0%	Achieved	
Community care - referral information completeness	50%	No	73.5%	Achieved	
Community care - activity information completeness	50%	No	99.8%	Achieved	
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	No		No	

CQC compliance action outstanding (as at 30 Sep 2013)	N/A	No	Yes
CQC enforcement action within last 12 months (as at 30 Sep 2013)	N/A	No	No
CQC enforcement action (including notices) currently in effect (as at 30 Sep 2013)	N/A	No	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Sep 2013)	N/A	No	No
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Sep 2013)	N/A	No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A	No	No

Results left to complete	0	0
Total Score	0	3.5
Overide Rating (if any)		
Compliance Framework Indicative Governance Risk Rating	GREEN	
Risk Assessment Framework Indicative Governance Rating		
Category		
Explanation		Enter details underlying a narrative rating here

Worksheet "Summary"

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High level summary of financial plan of YORKHOSPITAL

Financial Summary	Previous YE	Current Quarter			YTD			FY
£m	Actual	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Operating Revenue for EBITDA	403.7	106.8	108.7	1.9	210.6	215.8	5.3	428.0
Employee Expenses	(262.5)	(71.0)	(72.4)	(1.4)	(140.5)	(143.7)	(3.2)	(284.3)
Drugs	(30.5)	(7.7)	(8.7)	(1.0)	(15.2)	(17.0)	(1.7)	(30.8)
PFI operating expenses	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other costs	(91.7)	(23.5)	(23.5)	(0.0)	(46.0)	(46.5)	(0.5)	(94.0)
Clinical supplies	(40.4)	(11.3)	(11.8)	(0.5)	(22.2)	(22.4)	(0.1)	(45.1)
Decrease (increase) in inventories of finished goods & WIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Vehicle Fuel costs (ambulance trusts)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Non-clinical supplies	(6.4)	(1.7)	(1.8)	(0.1)	(3.4)	(3.6)	(0.2)	(6.9)
Cost of Secondary Commissioning of mandatory services	(3.3)	(1.2)	(0.8)	0.4	(2.3)	(1.5)	0.8	(4.6)
Research & Development expense	(4.4)	(1.2)	(1.1)	0.1	(2.4)	(2.1)	0.3	(4.9)
Education and training expense	(1.0)	(0.3)	(0.2)	0.1	(0.7)	(0.3)	0.3	(1.3)
Misc. other Operating expenses	(34.9)	(7.5)	(7.8)	(0.2)	(14.5)	(16.4)	(2.0)	(30.3)
EBITDA	19.1	4.6	4.1	(0.5)	8.8	8.6	(0.2)	18.9
Donations of PPE & intangible assets	0.5	0.1	0.0	(0.1)	0.2	0.0	(0.2)	0.5
Depreciation and amortisation	(8.8)	(2.7)	(2.7)	(0.0)	(5.4)	(5.4)	0.0	(10.9)
Impairment Losses (Reversals) net (on non-PFI assets)	(3.5)	0.0	0.0	0.0	0.0	0.0	0.0	(0.3)
Impairment Losses (Reversals) net on PFI assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Restructuring Costs	(0.8)	0.0	(0.4)	(0.4)	0.0	(0.5)	(0.5)	0.0
Operating Surplus	6.5	2.0	1.1	(1.0)	3.6	2.7	(0.9)	8.2
Net interest	(0.1)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0	(0.2)
Interest Income	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Interest Expense on Overdrafts and Working Capital Facilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Expense on Bridging loans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Expense on Non-commercial borrowings	(0.2)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(0.3)
Interest Expense on Commercial borrowings	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Expense on Finance leases (non-PFI)	*(0.0)*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Interest Expense on PFI leases & liabilities	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Other Non-Operating items	**63.9**	**(1.4)**	**(1.4)**	(0.0)	**(2.8)**	**(2.8)**	**(0.0)**	**(5.6)**
Gain (Loss) on Financial Instruments Designated as Cash Flow Hedges	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Gain (Loss) on Derecognition of Available-for-Sale Financial Assets	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Gain (Loss) on Derecognition of Non-Current Assets Not Held for Sale, Total	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Gain (Loss) from investments	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Dividend Income	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Share of profit (loss) from equity accounted Associates, Joint Ventures, Total	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Other Non-Operating income, Total	*69.0*	*0.0*	*0.0*	0.0	*0.0*	*(0.0)*	*(0.0)*	*0.0*
Other Finance Costs	*(0.0)*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
PDC dividend expense	*(5.0)*	*(1.4)*	*(1.4)*	(0.0)	*(2.8)*	*(2.8)*	*0.0*	*(5.6)*
PFI Contingent Rent	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Other Non-Operating expenses (incl. Misc)	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Income Tax (expense)/ income	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*0.0*	*0.0*	*0.0*
Net Surplus / (Deficit)	**70.4**	**0.6**	**(0.4)**	**(1.0)**	**0.7**	**(0.2)**	**(0.9)**	**2.4**
EBITDA % Income	4.7%	4.3%	3.8%	-0.6%	4.2%	4.0%	-0.2%	4.4%
CIP% of Op.Exp. less PFI Exp.	5.7%	5.4%	4.7%	-0.7%	5.5%	4.2%	-1.3%	5.4%
Pay CIPs as % Pay Costs	-5.8%	-6.2%	-4.3%	1.9%	-6.3%	-4.3%	1.9%	-6.2%

Worksheet "CoSRR"

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Continuity of Service Shadow Risk Ratings (pilot indicators for 2013/14)

Code	Item	Source	Historic Year to31-Mar-13	Reported Quarter to30-Jun-13	Reported YTD to30-Jun-13	Reported Quarter to30-Sep-13	Reported YTD to30-Sep-13	Reported Quarter to31-Dec-13	Reported YTD to31-Dec-13	Reported Quarter to31-Mar-14	Reported YTD to31-Mar-14
	Debt Service Cover										
IS04400	PDC dividend expense	*from SoCI*	(5.005)	(1.391)	(1.391)	(1.392)	(2.783)	-	(2.783)	-	(2.783)
IS04100	Interest Expense on Overdrafts and Working Capital Facilities	*from SoCI*	-	-	-	-	-	-	-	-	-
IS04110	Interest Expense on Bridging loans	*from SoCI*	-	-	-	-	-	-	-	-	-
IS04120	Interest Expense on Non-commercial borrowings	*from SoCI*	(0.210)	(0.053)	(0.053)	(0.051)	(0.104)	-	(0.104)	-	(0.104)
IS04130	Interest Expense on Commercial borrowings	*from SoCI*	-	-	-	-	-	-	-	-	-
IS04140	Interest Expense on Finance leases (non-PFI)	*from SoCI*	(0.021)	-	-	-	-	-	-	-	-
IS04150	Interest Expense on PFI leases & liabilities	*from SoCI*	-	-	-	-	-	-	-	-	-
IS04200	Other Finance Costs	*from SoCI*	(0.035)	-	-	-	-	-	-	-	-
IS04610	Non-Operating PFI costs (eg contingent rent)	*from SoCI*	-	-	-	-	-	-	-	-	-
CF07150	Public Dividend Capital repaid	*from SoCF*	-	-	-	-	-	-	-	-	-
CF07610	Repayment of bridging loans	*from SoCF*	-	-	-	-	-	-	-	-	-
CF07710	Repayment of non-commercial loans	*from SoCF*	(0.493)	(0.248)	(0.248)	-	(0.248)	-	(0.248)	-	(0.248)
CF07810	Repayment of commercial loans	*from SoCF*	(0.024)	-	-	(0.019)	(0.019)	-	(0.019)	-	(0.019)
CF07360	Capital element of finance lease rental payments - On-balance sh	*from SoCF*	-	-	-	-	-	-	-	-	-
CF07350	Capital element of finance lease rental payments - other	*from SoCF*	(0.107)	(0.050)	(0.050)	-	(0.050)	-	(0.050)	-	(0.050)
	Debt Service		-5.895	-1.742	-1.742	-1.462	-3.204	0.000	-3.204	0.000	-3.204
MEM0180	**Revenue available for Debt Service**		19.307	4.527	4.527	4.151	8.678	0.000	8.678	0.000	8.678
	Debt Service		-5.895	-1.742	-1.742	-1.462	-3.204	0.000	-3.204	0.000	-3.204
	Debt Service Cover metric		3.28x	2.60x	2.60x	2.84x	2.71x	0.00x	2.71x	0.00x	2.71x
	Debt Service Cover rating		4	4	4	4	4	1	4	1	4
	Liquidity										
	Cash for CoS liquidity purposes	*from SoFP*	0.339	2.541	2.541	2.947	2.947	0.000	0.000	0.000	0.000
IS02000	**Operating Expenses within EBITDA, Total**	*from SoCI*	-384.602	-102.579	-102.579	-104.618	-207.197	0.000	-207.197	0.000	-207.197
	Liquidity metric		0.3	2.2	2.2	2.5	2.6	0.0	0.0	0.0	0.0
	Liquidity rating		4	4	4	4	4	4	4	4	4
AMENDED	**Continuity of Service Risk Rating**		4	4	4	4	4	3	4	3	4

key to scoring

Debt 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

Worksheet "RiskRating"

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Risk Ratings based on Annual Planning return from YORKHOSPITAL

		Reported Quarter to30-Jun-13	Reported YTD to30-Jun-13	Reported Quarter to30-Sep-13	Reported YTD to30-Sep-13
Underlying performance					
EBITDA YTD	*from SoCI*	4.509	4.509	4.125	8.634
Operating Revenue for EBITDA YTD	*from SoCI*	107.089	107.089	108.743	215.832
EBITDA Margin metric		4.2%	4.2%	3.8%	4.0%
EBITDA Margin rating		**2**	**2**	**2**	**2**
Achievement of plan					
Actual EBITDA from SoCI		4.509	4.509	4.125	8.634
Planned EBITDA from SoCI (APR Plan)		4.166	4.166	4.643	8.808
EBITDA % of plan achived metric		108.3%	108.3%	88.8%	98.0%
EBITDA % of plan achived rating		**5**	**5**	**4**	**4**
Financial Efficiency					
Net return after financing costs, YTD	*from SoCI*	0.370	0.370	(0.006)	0.364
Opening Financing	*from SoFP*	181.645	181.645	205.442	181.645
Closing Financing	*from SoFP*	205.442	205.442	206.576	206.576
Net return after Financing metric		0.8%	0.8%	0.0%	0.4%
Net return after financing rating		3	3	3	3
Surplus / (deficit) YTD	*from SoCI*	0.178	0.178	(0.356)	(0.178)
Gain / (loss) on asset disposals	*from SoCI*	(0.005)	(0.005)	-	(0.005)
Gain / (loss) on transfers by absorption	*from SoCI*	-	-	-	-
I & R (Impairments & restructuring) expenses	*from SoCI*	(0.187)	(0.187)	(0.350)	(0.537)
Total IFRS Operating Revenue YTD	*from SoCI*	107.089	107.089	108.743	215.832
IS Surplus margin metric		0.3%	0.3%	0.0%	0.2%
IS Surplus margin rating		2	2	2	2
Financial Efficiency rating		**3**	**3**	**3**	**3**
Liquidity					
Cash for liquidity purposes	*from SoFP*	35.141	35.141	35.547	35.547
Operating expenditure within EBITDA YTD	*from SoCI*	102.579	102.579	104.618	207.197
WCF in terms of Operating Expenditure YTD		28.6	28.6	28.0	28.3
Liquidity days metric (WCF limited to 30 days)		30.8	30.8	30.6	30.9
Liquidity rating		**4**	**4**	**4**	**4**
Weighted Average Rating		**3.00**	**3.00**	**2.90**	**2.90**

Overriding rules

			Reported Quarter to30-Jun-13		Reported YTD to30-Jun-13	Reported Quarter to30-Sep-13		Reported YTD to30-Sep-13
3	Return submitted on time			YES			YES	
3	Return submitted complete and correct			YES			YES	
2	PDC dividend not paid in full						FALSE	
3	Year 2 OR Year 3 deficit planned excluding I &	NO						
2	Year 2 AND Year 3 deficit planned excluding I	NO						
3	One financial criteria scored at '2'		**3**	TRUE	**3**	**3**	TRUE	**3**
2	One financial criteria scored at '1'			FALSE			FALSE	
2	Two financial criteria scored at '2'			FALSE			FALSE	
1	Two financial criteria scored at '1'			FALSE			FALSE	
2	Unplanned breach of PBC ratios			FALSE			FALSE	
4	Less than 1 year as an Foundation Trust			FALSE			FALSE	
Limit due to overriding rules			**3**		**3**	**3**		**3**
Financial Risk Rating			**3**		**3**	**3**		**3**

key to scoring

Underlying performance		25%		
5	4	3	2	1
11%	9%	5%	1%	<1%

Achievement of plan		10%		
5	4	3	2	1
100%	85%	70%	50%	<50%

Net Return after financing		20%		
5	4	3	2	1
3%	2%	-0.5%	-5%	< -5%

IS surplus margin		20%		
5	4	3	2	1
3%	2%	1%	-2%	< -2%

Liquidity metric		25%		
5	4	3	2	1
60	25	15	10	<10

K

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 30 October 2013

Business Case 2012-13/55: Enhancement of Paediatric Cover (Scarborough)

Action requested/recommendation

The Board is asked to approve the business case.

Summary

We are embarking on a major review of Paediatric service provision across the Trust, this will include;

- A medical workforce review, to ensure a safe efficient service. (non compliant tier 2 rota on the Scarborough site)
- The integration of the medical staffing workforce.
- An integrated nursing workforce model – approved and work commenced.
- A new clinical service delivery model, associated with the new build on the Scarborough site, including development of a short stay assessment unit.
- Review of the roles of the paediatric nurse specialists
- Review of administration service to support paediatrics

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

There are no implication for equality and diversity.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report Corporate Directors – 14th October 2013

Risk No risk.

Resource implications	Resources implication detailed in the report.
Owner	Dr U Venkatesh, Clinical Director for Paediatrics Dr D Smith, Consultant for Children's Services
Author	Liz Vincent, Manager for Children's Services (Scarborough)
Date of paper	October 2013
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number	2013-14/55

2. Business Case Title

Enhancement of Paediatric medical Cover – phase 1 Conversion of Speciality Doctor post to consultant posts

3. Management Responsibilities & Key Contact Point

The business case 'Owner' should be the appropriate Clinical or non-clinical Director, or where appropriate the lead Clinician nominated by the respective Clinical Director. The 'Author' will be the named manager supporting the Owner of the business case, who will have responsibility for the development and writing of the business case, and will be the key contact point for enquiries.

Business Case Owner:	Dr U Venkatesh/Dr D Smith

Business Case Author:	L Vincent
Contact Number:	01723 385082

4. Purpose of the Business Case

State clearly the issue(s) to be addressed by this business case.

We are embarking on a major review of Paediatric service provision across the Trust, this will include;

- A medical workforce review, to ensure a safe efficient service. (non compliant tier 2 rota on the Scarborough site)
- The integration of the medical staffing workforce.
- An integrated nursing workforce model – approved and work commenced.
- A new clinical service delivery model, associated with the new build on the Scarborough site, including development of a short stay assessment unit.
- Review of the roles of the paediatric nurse specialists
- Review of administration service to support paediatrics

The first stage of this review was to ensure safe medical cover out of hours on the Scarborough site. To support paediatric inpatient service activity, maternity services with associated SCBU and Child related A&E activity.
A Business case was approved back in November 2012 to support a compliant tier 2 rota. This consisted of an upgrade of 2 vacant Trust Grade Doctor posts, to paediatric speciality Doctors and increase from 2 posts to 3 in total. (The original posts had not attracted suitable candidate and had been vacant for 2 plus years.)

The plan was to advertise these, now more attractive posts, although concern remained that these posts would still be difficult to recruit to. The Child Health Directorate has duly advertised these posts and was unable to secure any suitable applicants.

Alternative plans now need to be considered.
Plan B. To move to a consultant out of hours medical model. This case proposes a phased approach to establishing this model.

Phase 1
Convert the 3 speciality Doctor post to 2 consultant post with resident out of hour's commitment.
Phase 2
Replace 2 retiring consultants (Dr Lwin 5.12.13 and Dr Falconer March 14) with posts that include resident out of hour's commitments.

5. Options Considered

List below the alternative options considered to resolve the issue presented by this business case.

Description of Options Considered
Option 1 – Do nothing – Safe out of hours medical provision for paediatrics is essential to support the paediatric inpatient activity, maternity services, SCBU and Paediatric A&E activity
Option 2 – Go back to advert for 3 Speciality Doctor – we have been trying for almost 3 years. Lack of available middle grade paediatric Doctors is a nationally recognised problem, papers produced by the RCPCH acknowledge this and support models of resident consultant out of hours provision
Option 3 – Review the current medical model and introduce, using a phased approach, a resident out of hour's consultant led service.

6. Preferred Option

Detail the preferred option, identifying the reason(s) it was preferred over those options listed above.

Option 3
The Directorate is proposing that an alternative model of paediatric consultant service is implemented, this being a resident consultant

paediatric out of hour's service.
Phase 1
Convert the 3 specialty Doctor post to 2 consultant post with resident out of hour's commitment.

7. 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*

These strategic 'frames' inline with the national agenda, advocate increased patient choice, better access times, safer, cleaner hospitals and improved patient satisfaction and outcomes.

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 one or more 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	The proposal will allow for safe out of hours paediatric cover on the Scarborough site
To provide excellent healthcare with appropriate resources, strong productivity measures and strong top quartile performance being indicative of this. The service will be based on 'needs based care' and staff understand how they contribute to the Trust's successes.	Yes	The RCPCH has emphasised the potential benefits of consultant delivered care in it's 2012 report *Consultant delivered care* which concluded that "children would receive better care if they has 24/7 access to a consultant or equivalent senior doctor".
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.		
To provide a safe environment for staff, patients and visitors, ensuring that all resources are used as efficiently as possible	Yes	Provide safe out of hours paediatric services on the Scarborough site

8. Benefit(s) of the Business Case

Using the table below, clearly state the intended benefits that will accrue to the Trust from the preferred option. The benefits identified should be tangible, and capable of being evidenced, ideally through some form of measurement.

Typically, the benefit(s) described would ultimately be contributing towards one or more of the following: efficiency and/ or effectiveness gains, financial gains, operational continuity, regulatory compliance, social benefits, improved capability, improved patient and public outcomes, etc.

Detailed Description of the Benefit, including Measurable(s)	Before	After
Improved patient outcomes – safe out of hours service with senior medical decision making		Reduced length of stay
Improved patient outcomes – reduced admissions senior decision making		Reduced admissions
A building block for the paediatric service redesign work		New service delivery model – integrated paediatric service

Details of cash releasing/ income improving CIPs and/or non cash releasing 'notional' CIPs must be included above.		

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.

Description of Action	Timescale	By Who?
Covert the 3 Speciality Doctor post to 2 consultant posts with resident on call commitments	ASAP	U. Venkatesh D Smith/ L Vincent
Continue with service review		D Smith U Venkatesh/ I Vincent

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
Unable to recruit to posts for the Scarborough Site	Recent evidence suggests that posts will be attractive if they are part of an integrated service. The wider paediatric service review will address this

11. Risk of Not Proceeding:

Identify the key risks/ potential impact of not proceeding with the preferred option.

A non compliant rota for out of hours paediatric services with associated safety issues will remain

12. Consultant Impact

(Only to be completed where the preferred option increases the level of Consultant input)

12.1 Impact on Consultant Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant to a maximum of 11. This section should illustrate the impact that the additional Consultant 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 actual annual working weeks against the 41 week requirement.

	Before	After
Average number of PAs	12.14	10.88
On-call frequency (1 in)	1 in 5	1 in 8

Consultant Team Work Profile				
Name of Consultant	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**
Dr Venkatesh			**12 ***	**12**
Dr Falconer (Retiring March 14)			**12 ***	**10**
Dr Qunibi			**12 ***	**12**
DR Mack			**12 ***	**12**
Dr Rawashdeh			**12**	**10 (work to reduce in progress)**
Dr Suliaman			**12 ***	**12**
Dr Lwin(Retiring Dec 14)			**13**	**10**
New consultant post 1			**10 ***	**10**
New Consultant post 2			**10 ***	**10**

Please see attached sheet

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. This section should provide the date that the job plans were assessed by the Committee and any comments which were made.

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.
Consultant Paediatricians	On going

14. Sustainability

The Trust is committed to development of sustainable solutions in the delivery of its services, including minimising its carbon footprint. The following questions should be answered in the context of the impact of this business case has on the areas listed.

If assistance is required in assessing the sustainability impact of this business case, help is available from Brian Golding, Trust Energy Manager on (72)6498.

Will this Business Case:	Yes/No	If Yes, Explain How
Reduce or minimise the use of energy, especially from fossil fuels?	No	
Reduce or minimise Carbon Dioxide equivalent emissions from NHS activity?	No	
Reduce business miles?	No	
Reduce or minimise the production of waste, and/or increase the re-use and recycling of materials?	No	
Encourage the careful use of natural resources, such as water?	No	

15. Alliance Working

How does this business case support the Trust's stated objective of developing and enhancing the clinical alliance arrangements with Harrogate & District NHS Foundation Trust?

N/A

16. Integration

How does this business case support the Trust's emerging priority of integrating clinical and non-clinical services following the acquisition of the Scarborough & North East Yorkshire NHS Trust?

This proposal provides sustainable out of hours service on the Scarborough site and forms a building block for the integration of the paediatric service

17. Impact on the Ambulance Service:

	Yes	No
Are there any implications for the ambulance service in terms of changes to patient flow?		X

If yes, please provide details including Ambulance Service feedback on the proposed changes:

N/A

18. Market Analysis:

Where the business case is predicated on securing new and/or increased business (and income), detail the evidence supporting the income projections.

Not within the phase of the integration work

19. 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 £000	Revised £000	Change £000
Capital Expenditure			0
Income			0
Direct Operational Expenditure	230	227	-3
EBITDA	-230	-227	3
Other Expenditure			0
I&E Surplus/ (Deficit)	-230	-227	3
Existing Provisions	n/a		0
Net I&E Surplus/ (Deficit)	-230	-227	3
Contribution (%)	#DIV/0!	#DIV/0!	#DIV/0!
Non-recurring Expenditure	n/a		0

Supporting financial commentary:

This is Phase 1 of the review of the Paediatric Medical Model and the introduction of a resident out of hours consultant lead service. Ref Approved Business Case 2013-14/51 July 2013. This is the follow up BC to get request approval for the Conversion of 3 Speciality Doctors posts to 2WTE Consultant Posts by Exec and Trust Board for new Consultant Posts. This conversion of these posts is financially funded within the Directorate's budget for the Speciality Doctor Posts. Also included is the recurring 1K each Training budget requirement for Consultant Posts.

20. Recommendation for Post Project Evaluation

	Yes	No
Is this business case being recommended for post project evaluation?	x	

Reason(s) for the decision:

This will aid the Directorate in the future medical model planning.

21. Date:

15.7.13

APPENDIX Aii

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	2013-14/55
TITLE:	Enhancement of Paediatric Medical Cover- Phase 1. Conversion of 3 WTE Speciality Doctor Posts to 2WTE Consultant Posts
OWNER:	Dr U Venkatesh/Dr D Smith
AUTHOR:	Liv Vincent

Capital

	Total £'000	Planned Profile of Change 2012/13 £'000	2013/14 £'000	2014/15 £'000	Later Years £'000
Expenditure	0	0	0	0	0

Capital Notes *(including reference to the funding source)*:

Revenue

	Total Change				Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	Change WTE	2013/14 £'000	2014/15 £'000	2015/16 £'000	Later Years £'000
(a) Non-recurring								
(b) Recurring								
Income								
NHS Clinical Income			0		0	0	0	0
Non-NHS Clinical Income			0		0	0	0	0
Other Income	0	0	0		0	0	0	0
Total Income	**0**	**0**	**0**		**0**	**0**	**0**	**0**
Expenditure								
Pay								
Medical(Consultant)	0	225	225	2.00	113	113		
Medical Speciality Doctor	230	0	-230	-3.00	-115	-115		
Other (please list):								
			0					
	230	**225**	**-5**	**-1.00**	**-3**	**-3**	**0**	**0**
Non-Pay								
Drugs			0					
Clinical Supplies & Services			0					
General Supplies & Services			0					
Other (please list):								
Establishment Expenses(Training)	0	2	2	#	1	1		
			0					
			0					
	0	**2**	**2**		**1**	**1**	**0**	**0**
Total Operational Expenditure	**230**	**227**	**-3**		**-2**	**-2**	**0**	**0**
Impact on EBITDA	**-230**	**-227**	**3**	**-1.00**	**2**	**2**	**0**	**0**
Depreciation			0					
Rate of Return			0					
			0					
Overall impact on I&E	**-230**	**-227**	**3**	**-1.00**	**2**	**2**	**0**	**0**
Less: Existing Provisions	**n/a**		**0**					
Net impact on I&E	**-230**	**-227**	**3**		**2**	**2**	**0**	**0**

+ favourable (-) adverse

Revenue Notes *(including reference to the funding source)*:
This is Phase 1 of the review of the Paediatric Medical Model and the introduction of a resident out of hours consultant lead service. Ref Approved Business Case 2013-14/51 July 2013. This is the follow up BC to get request approval for the Conversion of 3 Speciality Doctors posts to 2WTE Consultant Posts by Exec and Trust Board for new Consultant Posts. This conversion of these posts is financially funded within the Directorate's budget for the Speciality Doctor Posts. Also included is the recurring 1K each Training budget requirement for Consultant Posts.

	Owner	Finance Manager	Board of Directors Only Director of Finance
Signed		M Dearing	
Dated		15/07/2013	

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2013/14	2014/15	2015/16	Later Years
Elective (Spells)			0				
Non-Elective (Spells)							
Long Stay			0				
Short Stay	8,066	8,066	0				
Outpatient (Attendances)							
First Attendances	4,829	4,829	0				
Follow-up Attendances	9,438	9,438	0				
A&E (Attendances)			0				
Other (Please List):							
			0				
NHS Non PBR Clinical Activity	5,558	5,558	0				

Income

	Total Change			Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	Later Years £'000
NHS Clinical Income							
Elective income							
Tariff income	194	194	0				
Non-Tariff income			0				
Non-Elective income							
Tariff income	5,814	5,814	0				
Non-Tariff income	2,101	2,101	0				
Outpatient							
Tariff income	2,354	2,354	0				
Non-Tariff income			0				
A&E							
Tariff income			0				
Non-Tariff income			0				
Other							
Tariff income			0				
Non-Tariff income	2,529	2,529	0				
	12,992	**12,992**	**0**	**0**	**0**	**0**	**0**
Non NHS Clinical Income							
Private patient income			0				
Other non-protected clinical income	272	272	0				
	272	**272**	**0**	**0**	**0**	**0**	**0**
Other income							
Research and Development			0				
Education and Training			0				
			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**

Phase 1 and Phase 2 Enhancement of Paediatric medical cover – out of hours cover
Basic activity capacity model

Current SGH Workforce	Current Number of PA's/ on call arrangement	Planned change	Revised PA's through job planning and efficiencies	Proposed on call /out of hours resident arrangement	Workable PA's minus any resident commitment
Phase 1					
Phase 1Speciality Doctor	Vacant	Convert to consultant post	10	4 PA's to resident per call every 8 days	6.5
Phase 1Speciality Doctor	Vacant	Convert to consultant post	10	4 PA's resident per call every 8 days	6.5
Phase1 Speciality Doctor	Vacant	No Funding	0	0	
Mr Mack	10 PA Contract 1 in 5	Recent job planning exercise unconfirmed at 12 PA's. (Calculation on worst case 12 PA)	12	1 in 8	12
U Venkatesh	12 PA Contract 1 in 5	Nil	12	1 in 8	12
Dr Qunibi	12 PA contract 1 in 5	NIL	12	1 in 8	12
Dr Suliaman	12 PA	Nil	12	1 in 8	12

	contract 1 in 5				
Dr Rawashdeh	12 PA Contract Currently absent from on call duties	Recent Job planning exercise unconfirmed at 10	10	1 in 8	10
Phase 2 A Falconer Retirement planned 31.3.14	12 PA contract 1 in 5	Reduced to 10 – 1.7.13. reduced paediatric PA to take on 2 PA's from HYMS. Replace post with 10 PA contract to include resident on out of hours	10	4 PA's to resident per call every 8 days =365 day divided by every 8 day X 4 PA's divided by X 52 weeks =3.5	6.5
Phase 2 Dr Lwin Retirement planned 5.12.13	13 PA contract No on call	Recent job planning exercise unconfirmed at 10. Replace post with 10 PA contract to include resident on out of hours	10	4 PA's to resident per call every 8 days	6.5
Total weekly PA's	**85**		**98**		**84**

Capacity conclusion Phase 1 and 2

Within the total PA consultant base re modelling we will loose 1 consultant PA per week
Will benefit from moving to a more robust clinical out of hours service
Have a financial surplus of £81 (FYE)